

**FDA Virtual Town Hall Series –  
Immediately in Effect Guidance on  
Coronavirus (COVID-19) Diagnostic Tests Moderator: Irene Aihie  
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12:15 pm ET**

Operator: Good afternoon and thank you all for standing by. For the duration of today's conference, all participants' lines are in listen-only mode until the question and answer session. At that time if you a question press Star 1. Today's call is being recorded. If you have any objections you may disconnect at this time. It is my pleasure to introduce Miss Irene Aihie. Thank you, ma'am. You may begin.

Irene Aihie: Thank you. Hello, I am Irene Aihie of CDRH's Office of Communication and Education. Welcome to the FDA's 23rd in a series of virtual town hall meetings to help answer technical questions about the development and validation of tests for SARS CoV-2 during the public health emergency.

Today Timothy Stenzel, Director of the Office of In Vitro Diagnostic and Radiological Health in the Office of Product Evaluation and Quality and Toby Lowe, Associate Director of the Office of In Vitro Diagnostics and Radiological Health both in CDRH will provide a brief update.

Following opening remarks, we will open the line for your questions related to today's discussion. Please remember that we are not able to respond to questions about specific missions that might be under review. Now I give you Timothy.

Dr. Timothy Stenzel: Hello and thanks again for joining us and I look forward to today's call. Today we will not be answering any general questions about the HHS test statement of last week but we can address questions regarding data

recommendations to support EUA authorization.

If you have specific questions about your situation then please send them to [cdrh-eua-templates@fda.hhs.gov](mailto:cdrh-eua-templates@fda.hhs.gov) and we'll work closely with you to address your specific questions. We do as I said earlier welcome any questions today about how to seek an EUA and the data and recommendations whether it is for an LDT or for a kit.

Next, I wanted to lead into further discussion a little bit on our non-lab template that was recently posted. Now, this is primarily directed at home testing situation. Templates specifically addresses recommendations for molecular as well as direct antigen tests. They're also open to home serology tests.

So just want to reiterate that the recommendations in there are just that, recommendations that if you have alternative ways of addressing the data and submission please reach out to us. We have set recommended levels of sensitivity and specificity. And there may be alternatives to achieving the goal of having a net positive benefit versus risk equation. So we remain flexible in approaches and we'll welcome dialogue around that.

Also, there are in the templates there are mentioned there is mention that we'd like to hear from developers what their ideas are on reporting data and of course reporting data for maintaining, you know, vigilance on the public health situation with regards to, you know, how many positive tests to negative tests are being seen in the home or non-lab situation. You know, we think this is the important thing to facilitate if we can at the FDA.

However not having a finalized plan or not having a clear plan on how that data can be transmitted will not hold up our review and our decision. In other words, we say it's not a review decision issue. It is important and we would like to facilitate anywhere can - reporting. And so we do invite hearing from you about that as well. We will continue this meeting into September on a weekly basis so we welcome your attendance next month as well. With that I'll like to turn it over to Toby. Thanks

Toby Lowe: Thanks, Tim. Hi everyone. A couple updates from information we've put out for the past week. On Monday put out ,we updated one of our FAQs. We have an FAQ on recommendations for health care providers using SARS CoV-2 diagnostic test for screening in asymptomatic individuals. And we updated on Monday to provide some additional clarity on our recommendations for health care providers using tests for asymptomatic screening including off-label use.

And to go along with that we also on Monday posted a new Web page. We've had a lot of interest in screening testing and in pool sample testing. So we put up a new Web page on Monday that pulls together all of the available resources and recommendations that we've put out regarding pooling and screening testing.

So with that, that Web page can be found it's linked from the main devices COVID-19 page. And there was also an email that went out probably to everyone on this call on Monday with that new Website. If you're having trouble finding it just let us know and hopefully the information on there will be helpful. And with that, we can get started with questions.

Irene Aihie: Operator we'll now take questions. Please stand by while we - our operator gets back on the call.

Operator: Thank you. If you would like to ask the question please ensure your phone is not muted. press Star 1 and when prompted clearly record your first and last name so I may introduce you. Again that is star 1 to ask a question. And our first question is from (Ben Jamieson). Sir, you may go ahead.

(Ben Jamieson): Hi Tim and Toby. Thanks so much for the diligent work your team has been doing. These calls have been really helpful. And just looking forward to use at cases for testing. Are you having discussions around molecular testing for a patient before possibly giving them a vaccination just to avoid possibly giving an already sick patient a vaccine or a COVID double dose or usually not an issue I'm just curious on your thoughts on that.

Dr. Timothy Stenzel: That might be also a great question to ask of our colleagues over at CBER who are focused on vaccine development. I think, you know, potentially knowing an exposure history may or may not be important. I'm sure that's something that at least some vaccine sponsors are looking into. And of course, if you think there's value in taking a look at that we're very open to considering that. And so you could bring that to us at cdrh-eua-templates email address.

(Ben Jamieson): Excellent. Thank you.

Operator: And our next question is from (Josha Winn). Your line is open.

(Josha Winn): Hello. Can you hear me?

Dr. Timothy Stenzel: Yes.

(Josha Winn): Hi. Hello.

Dr. Timothy Stenzel: Hello.

(Joshua Winn): Hi. Thank you very much for the opportunity. My question adding that our EUA authorization recently this manufacturer went to have a contract manufacturer located in the US. For how to manufacture the EUA authorized product and then of course then production and validation agreement between each party. And my question today is do we need to get ACA authorization for the contract manufacturer and how ACA approaches this part?

Dr. Timothy Stenzel: Are you adding an additional manufacturing site or is this the original site that you're going to use for the test?

(Josha Winn): It's adding additional contract manufacturer site.

Dr. Timothy Stenzel: Yes. So just let your primary lead reviewer know that you're adding a site and in all likelihood we'll update the EUA to reflect that but that doesn't require

a submission of data or anything. Just, you know, follow the quality system requirements that are required for EUA authorization. Toby, is there anything else to add on that?

((Crosstalk))

Toby Lowe: Yes. If this is a EUA authorized test, if you send that information to your lead reviewer they'll be able to help you with any of the process steps that need to happen.

(Joshua Winn): Okay. The situation informed lead reviewer like for one month. And we haven't get like an approve sign so we don't know whether we can process this like a contract manufacture procedure will always be a need to wait the lead reviewers approve like approval letter of this.

Dr. Timothy Stenzel: Yes. So I can look into that if you send an email to the cdrh-eua-templates email address and ask to have it forwarded to Dr. Stenzel. But you can go ahead and, well that's a formality, you can go ahead and utilize that additional manufacturing site. And whatever formalities and paperwork is needed we'll work through those things quickly.

(Joshua Winn): Okay thank you. Thank you very much for your answers. Thank you very much. I don't have more questions.

Dr. Timothy Stenzel: All right thank you.

Operator: And our next question is from (Tom Sayer). You may go ahead.

(Tom Sayer): Yes good morning. Thank you so much for the opportunity. I've been following the sort of revolutionary thinking of Dr. Michael Mina suggesting that the infectious period of the disease is at CT levels of 30 and below. And there are a number of antigen tests that are very highly specific at that level of viral load but they don't meet the 90% specificity compared to RTC.

Do you - I looked at your template for non-lab EUA for non-lab tests and it still suggests that specificity has to be 90% compared to PCT. Do you have any comment on that? I mean are you relaxing that requirement given that the, you know, contagious period being that higher viral load as opposed to above the 30 CTU levels that PCR is sensitive to?

Dr. Timothy Stenzel: So yes I tried to address that a little bit at the beginning of the call was what our recommendations are. I didn't go into specificity there. The recommended sensitivity for non-lab home when there is a prescription is the templates is 80%.

And if it is not to involve a clinician prescribing the test then we recommend 90%. We obviously have authorized three direct antigen tests already that, you know, met the 80% bar. And two of them were able to achieve greater than 90% sensitivity.

That said, we absolutely see value in clearly being able to help identify folks who maybe are symptomatic, asymptomatic and but have viral levels of virus higher than more virus then say a cut off with a CT of 30. You know, if such validation probably will also include symptomatic individuals since it's hard to figure out when somebody is asymptomatic gets infected and begins to shed virus.

So we like to see that the performance of such tests on symptomatic people and perhaps a certain number of days after symptoms begin. So in the case of the authorization so far, it was dependent on data and how long the data was collected in those particular studies.

And we could authorize for those days or in some cases it may have been derived because sensitivity may fall off after a certain period of time for the direct antigen test as far as detecting something that molecular could detect beyond that period. But one of them we authorized up to twelve days after symptoms which is quite long for an antigen test and is quite good.

And so yes we wholeheartedly agree that and support, which is why we put the template out, the development of more and more tests that could be used in settings such as the home. And we very supportive of non instrumented direct antigen tests and there's a number in the pipeline. So we anticipate, you know, that some of those are going to be highly successful.

If they're, you know, so those are recommended sensitivities. If developers such as yourself or anybody else has ideas around how we can mitigate some of the potential safety issues, we're all ears. We're open to things like serial testing so testing not just once in the home situation that maybe twice and what interval spacing might be for those tests, you know, is to be determined by the particular test and any data that's accumulated in that setting.

So we're flexible. We're adaptable. We see the value in having a lot more tests out there that obviously the direct antigen tests are not as sensitive as the high sensitivity molecular assays and we understand that. And we agree that the focus is important to make sure that we identify those who are potentially ineffective rather than just, you know, a long tail of, you know, RNA being shredded perhaps, and not infectious. So hopefully that helps you encourages you to come in and have a dialogue about us about your ideas about how to bring something forward.

(Tom Sayer): So there's a strong support for focusing on frequency and cost rather than the high sensitivity with regard to catching asymptomatic people during their infectious period and as well as symptomatic people during the time when they're shedding enough virus where they're contagious as opposed to being so focused on high sensitivity that, you know, these very inexpensive antigen tests that could be used daily essentially would trigger any individual who is at the infectious stage of the disease.

And so I'd encourage you guys to to consider that shift in thinking from insistence on high sensitivity to the availability and frequency of testing that would be - become available at very - with a test that's less expensive that does catch the infectious stage of the disease as opposed to the long tail of, you

know, where CT values are much higher.

Dr. Timothy Stenzel: Well I may have not been as clear as I hoped but I would say that I think we're in complete agreement on those things, okay?

(Tom Sayer): Okay. Thank you so much.

Operator: And our next question is from (Andrew Lurillio). You may go ahead.

(Andrew Lurillio):Hi Tim and Toby thanks again for running all of these calls and answering everybody's questions. My question was about the HHS statement. So feel free to just skip me since I know you didn't want to focus on that but we were just wondering if that's kind of limited to COVID tests or if that also extends out to things like CDX, PGX and direct to consumer? Thank you.

Dr. Timothy Stenzel: Yes we encourage you to reach out for your specific situation to our templates email address and we'll endeavor to get back to you as soon as possible.

(Andrew Lurillio):Great thanks.

Dr. Timothy Stenzel: All right hanks.

Operator: Our next question is from (Jason Robotham). You may go ahead.

(Jason Robotham): Hi. I was wondering if there is a time frame post-EUA submission that we can expect a lead viewer to be assigned? I know in the past on these calls Dr. Stenzel you've mentioned a two-week time frame but it seems that they have shifted to just being contacted by an office contact who will then provide a weekly update.

So I don't know if that's the correct expectation or we should still expect a lead reviewer to be assigned within a certain time frame because it's our understanding that we cannot begin distribution until we have a lead reviewer



assigned.

Dr. Timothy Stenzel: So well I'm not sure that that's correct. So if you - if you're a test developer who qualifies, you know I'm assuming kit here, and you qualify for the notification pathway, whether you're serology, molecular, or direct antigen. Those are the three that we allow notification of. You simply follow the notification rule in the guidance.

Say that you've finished your validation and that you would - that you want to begin marketing. You'll get an immediate confirmation that we've received your email. And then within 24 hours, you should receive confirmation of the notification acknowledgment which you can use to show anybody that we've acknowledged your notification and you can begin marketing.

It's not you're marketing if you're - if you have a test that's allowed through notification assignment of a lead reviewer is not required in order to begin marketing and apologize for any misinterpretation there on - or not clear communication on our part.

We are simply overwhelmed with the number of applications. We allow notification pathways so that people can get to the market without having a EUA decision. It's your kit, you know, there are rules around how soon after you notify us that we want to see a EUA application. We then figure out when those applications come in if - what the priority rank is. And some of that is when we do receive it relative to others and if it's complete or not.

If there's anything that's incomplete, I've directed the office and whether it's the contact or a reviewer, that we give you feedback as soon as possible on anything that's incomplete. And then you can work if it's not a reviewer you have contact with it's another contract in the office, you get at least a weekly update.

You can submit that following information to them. They will assess whether the application is then complete and you can move up the priority scale because

complete applications will obviously have priority over incomplete applications.

And then as I've said before on the call there are certain things that absolutely require an EUA from kit manufacturers that we've prioritized because they can't market until they get that EUA authorization. So they know that this is, you know, well this is best we can do with the resources we have and the absolute number of applications that we have that we're trying to work through as quickly as possible. Do you understand?

(Jason Robotham): Right. I do understand. I don't want to get too specific. I know that we've submitted the EUA and it's been sent on for substantive review but we're going on almost four weeks without a lead reviewer assigned so I just thought - but that is helpful to know we can still market through the notification pathway.

And then I was also just wondering if we're going to be setting up a trial, specifically a finger stick trial so that we can further validate this as the point of care test, if we have questions around that trial set up should those questions just be directed to the EUA templates address or is there a more specific address we should send those to?

Dr. Timothy Stenzel: No just to the - our office for all EUA submissions that they have a contact assigned whether that's a reviewer or someone who is not a lead reviewer but you can be a contact to keep people updated. Whoever your contact is whether that's the contact or the lead reviewer you can ask that question of them. Since we are so inundated we have tried to endeavor to provide as much recommendations in the templates and for serology which I assume that's what you have.

We do have finger stick recommendations in there. So if those are clear enough you can follow those recommendations. If you have any questions about that template and your specific situation then I would reach out directly to whoever your contact is, whether that's the contact in the office or the lead reviewer.

(Jason Robotham): Okay. Thank you very much.

Operator: And our next question is from (Daniel Marcus). You may go ahead.

(Daniel Marcus): Hello again guys. Good afternoon. I have a preliminary question which speaks to a larger question about the Yale Saliva direct EUA. There's been confusion internally here, I mean among the folks on my side not with the FDA, as to whether that's an EUA for an actual kit, a product, or a method and if the latter actually exists in terms of is there a path for a method.

And I ask the question because it speaks to a larger question about what the level of interactivity is supposed to be between a sponsor and a reviewer once assigned because I get on these calls every week and this is the fourth consecutive week you guys are hearing from me -- I'm sure much to your chagrin -- you know, to be able to get questions answered that I'm not getting answered directly from a reviewer.

And I don't mean to be so specific I just know you guys work with three big buckets of diagnostic testing, serology tests, molecular tests and antigen tests but something of that doesn't fit into that bucket would, I would assume require a little bit more interactivity and guidance whereas that hasn't been provide.

So the latter was really more of a comment and an editorial that had question wrapped around it. But the initial question is about whether, you know, there's a distinction between a method and a product and if there's a pathway for it because there's no template or literature out there to be able to, you know, forward a similar path that you all did.

Dr. Timothy Stenzel: So I think Toby is going to take to the big question but I have a smaller question. Have you ever been assigned a lead reviewer and they have not been as responsive as you would hope?

(Daniel Marcus): Correct.

Dr. Timothy Stenzel: Okay.

(Daniel Marcus): So any specific questions, we met with a very terse if not dismissive response which is tantamount to hiding the ball which is something I don't imagine you guys want to do. So that's why I'm on this call.

Dr. Timothy Stenzel: So yes it has to do with, you know, more general things templates and recommendations about this it has more to do with the specifics of your application. Reach out to me please through the templates email address and I'll endeavor to get you a response. But once you have a lead reviewer it is my direction that you have very interactive reviews so we'll help...

(Daniel Marcus): Okay.

Dr. Timothy Stenzel: ...address that.

(Daniel Marcus): I appreciate that.

Dr. Timothy Stenzel: And Toby you want to take the biggest question on the Yale SalivaDirect authorization?

Toby Lowe: Yes absolutely. Sure so the Yale Saliva-Direct test was authorized as a test, as a complete test kit because it was authorized not a method. So the test that was authorized consists of the instructions for use that are authorized and all of the components that are specified in the authorized instructions for use.

Any laboratory that is interested in performing the test should reach out to Yale to request designation under their EUA. And those labs that are designated by Yale will receive the authorized instructions for use from Yale directly. And they would be responsible for acquiring all of the components that are specified in the authorized instructions for use and performing the test according to the authorized instructions for use in order to be performing the test as an EUA authorized test.

(Daniel Marcus): So how does one become deputized like Yale to be the one that basically sub-authorizes other labs to perform the tests, you know, is there a specific case made in their EUA because that seems pretty unique to me?

Toby Lowe: Okay. Yes, I think there is a misconception there that they're, you know, somehow deputized or anything like that. This is a test that is authorized for distribution to high complexity certified laboratories.

So just like any other authorized test that is distributed by a EUA holder, Yale is responsible for determining who they distribute that test to as long as the labs that are - that they're distributing it to are high complexity CLIA certified laboratories since that is what the test is authorized for.

So that's no different than any other EUA holder distributing their authorized test to the labs that purchase it from them. The - this difference is that Yale is not requiring payment for the distribution of their test.

Dr. Timothy Stenzel: Oh and Yale doesn't distribute kit components to labs. They acquire them on their own. So it is unique in that sense. It's not a cookie-cutter kit developer model precisely. And we welcome this kind of creativity that will hopefully be able to spread more "open source type" tests to labs.

Jason Robotham: Okay so to clarify there is no separate method pathway. It's just because their school is doing this open-source as opposed to a traditional commercial test manufacturer that would otherwise sell into high complexity labs? That's...

((Crosstalk))

(Toby Lowe): So any new test developer would be able to come in with a submission similar to Yale. It doesn't have to be in university. It could be any test developer. And we would expect to see that complete test included in the submission and validated as a complete test. But absolutely any developer could come in with a similar situation where all of the components would be commercially available and acquired by the downstream labs that would be performing the test.

(Jason Robotham: Okay all right well thank you. That clears - I appreciate it and I will send you an email about the other evidence.

Toby Lowe: Great. Thank you.

Operator: And our next question is from (Griffin Soriano). You may go ahead.

(Griffin Soriano): Yes my question was actually answered. Thank you very much though.

Operator: And our next question is from (Jeff Keriberry). You may go ahead.

(Jeff Keriberry): Thank you. Good afternoon and appreciate all the good information you guys deliver. I have a question also related to finger stick samples and the use of the correct templates. We plan to - we're validating our test with the venous, the plasma and want to do a serum equivalence with capillary plasma with the eventual goal of having patients or subjects, mail their capillary plasma to a high complexity lab for testing.

So does that require a EUA for collection the kit which is a commercially available product for finger stick? And or is that captured in the updated serology EUA where we would just put the capillary data in there as a serum equivalent study?

Dr. Timothy Stenzel: It sounds like you're a kit developer and you want to have the option of a home collection and a home collection device. And that's definitely something that we would want to talk to you about how that can be validated. And totally open to that and working with you on how to figure that out so that any labs you sell your test to can utilize that pathway.

(Jeff Keriberry): Right so it would require discussion not necessarily a separate EUA for the collection if it's a commercially available collection kit that we're just recommending they use to send to high complexity lab?

Dr. Timothy Stenzel: Yes and some of the details are important here and so I would urge you to reach out which you already have a lead developer and discuss that with them. And if they have any questions have them bring it up with me. Of if you haven't submitted anything yet on this, right. And it sounds like you already have a EUA or have one EUA submission so we could add this to that.

(Jeff Keriberry): Well we're getting it prepared. We're trying to prepare the EUA and I'm just trying to clarify whether we need one submission or two. But I guess we'll need it...

((Crosstalk))

Dr. Timothy Stenzel: That can be all done within one submission, absolutely...

(Jeff Keriberry): Oh okay.

Dr. Timothy Stenzel: ...in this. And we don't...

(Jeff Keriberry): Okay.

Dr. Timothy Stenzel: ...we don't have a template yet for home collection for serology. We're working on it. We have a template for home testing for serology. So I would urge you to reach out through the, you know, probably through the pre-EUA method to get any guidance that you feel you'd like on how to validate that home collection.

(Jeff Keriberry): Okay perfect. Thank you.

Operator: And our next question is from (Steve Scalise). You may go ahead.

(Steve Scalise): Hi. Thanks for taking my call. I heard the question posed, a similar question asked last week. My company's preparing an EUA for a serology test. And then we're planning on following it up with an additional, I guess I would say amendment, like for point of care testing.

Last week you seemed to advise the lack of need for two separate EUAs, that it would just be an amendment to your initial - to my company's initial EUA application. I just wanted to follow through and make sure that my understanding of what was said last week was correct. Can you help me on that one?

Dr. Timothy Stenzel: Yes for serology point of care, we do have templates information and recommendations about that. You can simply follow that with - along with all the other recommendations for the tests you want to develop and submit it as one EUA. I think what I meant it'll take longer for you to complete the point of care study, you know, then a standard EUA for say high complexity laboratory situation.

You can go ahead and submit what you have to get the initial authorization going. And if you want to market that, the notification pathway is there as well. And that gets all those balls rolling and then you can complete your point of care studies and submit that along. You know, and if the primary application is still in process that can be added prior to authorization or there may be timing where you want the first authorization.

So we'll just work with you whether it's all in one package or staged in two different packages. It would be great to be - if it's two packages it should be an amendment to the first one.

(Jeff Keriberry): Yes and that is very much along the lines of what you said last week. I just wanted to make sure I understood that correctly. Thank you very much for your help. I appreciate that.

Dr. Timothy Stenzel: You're welcome.

(Jeff Keriberry): Take care.

Operator: And our next question is from (Eric Lepart). You may go ahead. And again



(Eric Lepart) your line is open.

Dr. Timothy Stenzel: We're not hearing and should we move on if there's another call?

Operator: (Eric Lepart) you may go ahead.

Irene Aihie: Operator can we go to the next call and come back to him if he is able to connect again?

Operator: Our next question is from (Laura D'Angelo). You may go ahead.

(Laura D'Angelo): Hi. Thanks again for holding these calls. I have a question about kind of following trends from recent weeks. It's about quant assays. So from my record. From my recollection, there aren't any currently authorized fully quant assays. And my question kind of goes to the EUA for convalescent plasma over the weekend which cites an assay that according to the instructions for use is qualitative.

So I was just wondering on an update, is they're going to be an update to kind of the guidance or is that in the works? Obviously you can't say anything specific to kind of the standards for convalescent plasma or quantitative assays?

Dr. Timothy Stenzel: Yes we're working on an updated template that will cover broadly those topics including semi-quant, quant titering. And what - you know, what we think the pathway forward is to, you know, for some of those claims that you mentioned. So if you're interested in development of that we would urge you to reach out to our templates email address and ask your questions about what's to be done and we'll take that offline.

(Laura D'Angelo): Great. Thank you so much and thank you for your work during this time.

Dr. Timothy Stenzel: You're welcome. Thank you. You're welcome.

Operator: And the next question is from (Cecelia Hutchins). You may go ahead.

(Cecelia Hutchins): Hi. Thank you. It's been really good to have –access to all of this information is - seemed to have been provided by for us. My question is about this surveillance testing for surveillance purpose. So when district or meat packing facility or some specific community wants to do the surveillance if they - the concept is that they are going to be testing and the FAQ says that they can test and if it's not - it doesn't have to be under CLIA lab test site labs but it has to be followed by test of the positive with the CLIA certified labs.

So my question is does surveillance on this study apply to school districts or specific communities like meat packing facility or something and they could use the EUA authorized PCR for the molecular testing regularly that's managed by a laboratory not exactly under a CLIA certified lab? So is that my understanding...

((Crosstalk))

(Cecelia Hutchins): ...correct?

Toby Lowe: So for surveillance testing, we do have some information on our FAQs about surveillance testing and the difference between surveillance screening and diagnostic testing. Generally, FDA does not regulate surveillance testing and surveillance is really intended - they're generally intended for ongoing systematic activity is looking for occurrences outbreaks, et cetera. And surveillance testing is primarily used to obtain information at the population level, not to make individual decisions.

So if that is what you're looking to do, then that would be something that falls under surveillance testing. And in terms of the laboratory requirements, the CLIA requirements, I would encourage you to reach out to CMS for, you know, to make sure that you're clear on their requirements under CLIA. And CDC has also put out some information on surveillance testing including around recording results from surveillance testing. So those would be other resources for you.

And their Web site that I mentioned at the beginning of the call today about pooling and screening does also include a little bit of discussion about surveillance testing and so it is another place to take a look.

(Cecelia Hutchins): Yes just because the FAQ besides the definition of surveillance is claiming it also has the questions that can an EUA authorized test be used for surveillance. And if it says that the FDA doesn't really regulate the surveillance. But it says that all in vivo positives should be have a confirmatory test that's processed by a CLIA test site laboratory.

So my question would be would the district that is looking for a school district that is actually looking for a school district that's not exactly looking for diagnosing this but just looking or monitor or so do a surveillance of the spread of COVID on their district, would that be the surveillance because the school districts have done the analysis. There's no description for that. But the school district is monitoring to make decisions on control of the spread or...

Toby Lowe: Right.

(Cecelia Hutchins): ...the quantity.

Toby Lowe: So if the school district is looking for information about infection at the community level then that would likely fall under surveillance. And if you're looking for and as you state, FDA does not generally regulate surveillance testing. So then if what you're doing - if you believe what you're doing does fall under surveillance then I would encourage you to reach out to CMS to determine the CLIA requirements there.

(Cecelia Hutchins): Okay thank you.

Toby Lowe: Sure.

Operator: Our next question is from (Sean Ward). You may go ahead.

(Sean Ward): Thank you for hosting the session. So following off of the EUA for Saliva Direct. Does the FDA still consider saliva an alternative sample matrix or would we consider a EUA application where saliva is the primary sample matrix?

Dr. Timothy Stenzel: Yes we absolutely will consider EUAs for saliva, as the primary sample type. You know, with our intermittent test swab shortages and transport media shortages we see the attractiveness of saliva. We've just known that it's - it can be a problematic sample type. Not infrequently we see performance that's subpar and in some cases haven't been able to authorize.

So we do recommend because it is a challenging sample type that the comparator validation be done with preferably an NP swab but a mid-turbinate swab will also be allowed. That's not in the template but just saying that we have that flexibility.

We've seen some very variable and difficult to interpret results when a nasal swab is used. So our recommendation is mid-turbinate or NP swab. But absolutely know when we validate but absolutely saliva is an important sample type because of some of the supply issues in the US.

(Sean Ward): Yes but also continuing on to that point given prevalence rates in certain areas it can be challenging to talk about having the proper paired studies on a large scale especially when we have had studies like Japan's 1.7000 paired NP and saliva studies from airport testing that, you know, generally showing that equivalence as well as the studies taking place in the UK. So would it be considered, on a study which doesn't have that paired NP swab, as an example?

Dr. Timothy Stenzel: Well...

(Sean Ward): Does our system compare say RTCCR comparator on the saliva sample?

Dr. Timothy Stenzel: Here if you're submitting the exact test that was used in Japan and where

there's data we can include real-world data and may be sufficient depending on how it was put together. But we've definitely seen what we think to be test to test differences and we still don't understand the variability.

And so in order to EUA authorize saliva that is our recommendation that the paired swabs be attained. We're allowing the mid-turbinate because NP swabs are more challenging to obtain. Sometimes patients are less likely to want to volunteer for it but the mid-turbinate is not so bad. It also is lower risk to the healthcare providers who's getting a mid-turbinate swab...

(Sean Ward): Yes.

Dr. Timothy Stenzel: ...to use a mid-turbinate versus the NP.

(Sean Ward): Okay thank you very much.

Operator: And our next question is from (Jessica Wasserman). You may go ahead.

(Jessica Wasserman): Hello my question is about if the test fails the NCI process and serology tests does the developer still wants to work on the test and resubmit it, is that permissible? And if so how do you treat that in terms of notification and in terms of EU authorization? I understand that I believe your policy is that it cannot be notified but is there any reason it couldn't be EUA authorized?

Dr. Timothy Stenzel: So we - we'll work with all developers in solving whatever issues that may be existing there and there was no prohibition to getting the subsequent EUA if the test is - if improvements are made so that it can meet our expectation. And the specifics of notification, I would address with the lead reviewer or the EUA templates email to figure out what's appropriate for you.

But obviously, if someone has - if a developer has failed, you know, to hit that bar there are concerns and we want to make sure that before something again is marketed the US that where we know the performance is going to be adequate. So we'd ask that you'd work with us.

We would in reworking the test we want to understand what changes were made and see data that shows comparative performance between the original version and subsequent version that demonstrates say an increased sensitivity that would be sufficient to support the new - the EUA.

(Jessica Wasserman): Well we did - first of all the temple folks told us that it's your absolute policy that you can't be notified if you failed the NCI. So that's one thing. But then second of all with regard to resubmitting, so we resubmitted it immediately with everything that you're saying in terms of how it's different and how it's improved and so forth. And that's like a month ago and still no lead reviewer.

There is somebody that gives an update from a different seeming office once a week but there's no forward movement or assigned and so forth. And these folks know, have been involved in this, you know, months and months and months ago. And I think there some ways in which those that get engaged in the whole process earlier are kind of penalized because they didn't know what the NCI validation would be.

So they validated against serum because plasma was harder to get then. And then the NCI turns out to be 1/3, 2/3 on serum plasma. So anyway they're just trying to keep at it and improve it and resubmit it. It seems like there is just no pathway for that anymore.

Dr. Timothy Stenzel: Yes so what I would say is it sounds like there are some details of this submission and this product. We have dealt with some situations where tests were perhaps not developed for both sample types that we tested NCI and we do endeavor to try to find a way forward.

If performance though on enough samples of the given sample types still fall short you're only allowed so many misses overall. And if the preferred sample types you already hit that - you already missed more than that. For example, I don't know the specifics of the situation.

(Jessica Wasserman): Yes Tim I don't want you to waste time reconsidering all of that. But just on the question of whether they can move through the process with a totally revised test is just a...

((Crosstalk))

Dr. Timothy Stenzel: Yes.

(Jessica Wasserman): ... of that.

Dr. Timothy Stenzel: ...so the fairness is really really hard to deal with here because there's a lot of people in the queue...

(Jessica Wasserman): Yes.

Dr. Timothy Stenzel: ...if someone hasn't had the first shot yet. And it would seem fair to make sure that they get a fair shot in a EUA authorization. So it's a really challenging time so given the volume of submissions that we have.

(Jessica Wasserman): Thank you.

Operator: And our last question is from (Jonathan Cohen). Go ahead.

(Jonathan Cohen): Thank you. I was pleased to hear Dr. Stenzel's views on the rapid antigen tests, namely that the benefits of convenience and cost may help mitigate some of the loss of sensitivity. My question is, is why doesn't that same enthusiasm extend for rapid antibody tests?

To the best of my knowledge, the half dozen or so authorized tests are all limited to performance in a high complexity CLIA lab. I'm not aware of any that are yet authorized for point of care or for home use. And in particular, as we know that there are typically two antibodies that these tests, these rapid tests detect IgG and IgM whereas IgG tends to look at longer-term immunity, a topic that's still - there's still a bit of questions around, IgM tends to identify the

presence of a virus sometime around seven days from symptom onset just when the PCR, the RNA detection tends to drop off.

So it seems to me that if one sees a world where there's lot of rapid antigen tests either at the point of care or at home you would want to have next, you know, side by side rapid antibody tests since they seem to for lack of a better term pick up where the antigen tests leave off.

Dr. Timothy Stenzel: Yes I think the CDC has discussed the serology, different types of serology tests and how they might be used and that later in the course of an infection if it's important to establish for a diagnosis that someone has COVID-19 that antibody test may be useful in that situation though they - I think they recommend that molecular testing is the preferred way to diagnose.

And this week I think if I'm quoting or, you know, paraphrasing what the CDC recommendations are that, you know, being those patients use as an aid to diagnoses for the patient where the diagnosis is critical to figure out, you know, in a critically ill person what to do. But in general, that's not the utility of antibody tests in a pandemic.

We're very open to point of care serology tests. We - that's why we put up serology point of care template information about how to go ahead and validate for that. But we do need to see those point of care validation studies to know that the tests will perform at the point of care in the hands of non-lab, non-laboratory health care professionals.

So I'll just refer you and any other developers to that template. And of course, if someone has completed all those studies and the studies look good, you know, I do want to hear about that. It is important that we understand the performance of the test.

And currently, the NCI testing program is a very important part of our assessment of - can really aid in our assessment of the performance of the serology tests that are amenable for testing in the NCI program. So yes send



in data and we will - if the test performs we'll authorize it for the point of care.

(Jonathan Cohen): Do you see any authorizations for point of care serology tests over the next few weeks?

Dr. Timothy Stenzel: Yes unfortunately I can't answer that kind of question. It would be somewhat privileged information. As I said we welcome all developers who want to pursue this pathway to work with us to achieve that end.

(Jonathan Cohen): Thank you.

Irene Aihie: Thank you.

Operator:

Irene Aihie: This is Irene Aihie. We appreciate your participation and thoughtful questions. Today's presentation and transcript will be made available on the CDRH Learn Web page at [www.fda.gov/training/cdrhlearn](http://www.fda.gov/training/cdrhlearn) by Tuesday, September 1. If you have additional questions about today's presentation please email [cdhr-eua-templates@fda.hhs.gov](mailto:cdhr-eua-templates@fda.hhs.gov).

As always we appreciate your feedback. Following the conclusion of today's presentation, please complete a short 13 question survey about your FDA CDRH virtual town hall experience. The survey can be found at [www.fda.gov/cdrhwebinar](http://www.fda.gov/cdrhwebinar) immediately following the conclusion of today's live discussion. Again thank you for participating and this concludes today's discussion.

Operator: And this concludes today's conference. Thank you for participating. You may disconnect at this time. Speakers, please stand by for post-conference.

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