FDA Virtual Town Hall Series – Immediately in Effect Guidance on Coronavirus (COVID-19) Diagnostic Tests Moderator: Irene Aihie December 16, 2020 12:15 pm ET

Coordinator: Welcome everyone to today's conference call. At this time your lines have been placed on listen only for today's conference until the question-and-answer portion of our call, at which time you will be prompted to press star 1 on your touchtone phone. Please ensure that your line is unmuted and please record your name when prompted so that I may introduce you to ask your question. Our conference is being recorded and if you have any objections, you may disconnect at this time. I will now turn the conference over to our host, Ms. Irene Aihie. Ma'am, you may proceed.

Irene Aihie: Thank you. Hello. I am Irene Aihie of CDRH's Office of Communications and Education. Welcome to the FDA's 37th 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 Diagnostics and Radiological Health in the Office of Product Evaluation and Quality from 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 submissions that might be under review. Now I give you Timothy.

Dr. Timothy Stenzel: Hello everyone. Welcome again. We look forward to interacting with you today on these important topics. And we're doing everything that we can do at the FDA, to greatly expand access to testing so that we can be more and more able to battle this deadly virus.

So I did want to start off by reminding everyone that the FDA is allowing tests, diagnostic tests to be used, antigen and molecular tests that are authorized, to be used off label in testing asymptomatic patients. So that is completely legitimate to do. We're encouraging it because we only have a small number of tests right now that are authorized for asymptomatic screening.

So off label use as directed by the prescriber for prescription tests is completely acceptable and encouraged. In particular, direct antigen tests, it's, you know, that have been authorized, all of them that have been authorized can be used for this purpose.

The only - there is a rare - there are rare examples where we've seen asymptomatic data that is not sufficient for authorization. And we make a very rare and unusual statement in the IFU, in the instructions for use. Otherwise, we just categorically say that all the authorized tests for direct antigen testing, can be used off label by prescription in the asymptomatic population.

Again, the, you know, we don't know the actual performance and that should, you know, be understood by the prescribers. But we, you know, if there's something that's positive then that's great. But even in that situation, you want

to make sure and look at, you know, the spread of the virus in that particular area.

If the incidents of positive results is low then it's important to strongly consider a confirmatory test. We typically say use a high sensitivity molecular test. Hopefully you have arrangements that you can get that result back in 24 to 48 hours. That would be ideal obviously.

You know, another antigen - different antigen test potential could be used as well. You know, whatever you have access to that's important to be sure and confirm that result. But again, I think the highest sensitivity molecular test. A different antigen test may have slightly lower performance than a centralized high sensitivity molecular test and could return potentially a false negative on the repeat testing.

So all that should be taken into account. But we don't know unless we see data on a particular submission, we don't know the performance in the asymptomatic population. as I said, we are looking and encouraging more and more submissions for asymptomatic claims for screening plans and we welcome those.

But in the interim, we've made this very clear and CMS and HHS have made this very clear as well. They have removed any potential roadblocks at the federal level. If there's anything else that we can do to assist in deploying the test in that manner if you have questions, please email us at the template email address and we'll do our very best.

We have FAQs on this, CMS has FAQs on this, as does HHS. I did want to also state that starting in the new year, we will continue these town halls. Look for announcements. We will try something a little bit different in the

new year. I want to make sure that those developers of antigen and molecular point of care tests and home tests, have the ability to get their questions asked and potentially answered, to the best of my ability and our abilities.

You know, there's typically a number of callers and sometimes we don't know if callers don't get their questions answered. So we are looking at different ways of doing this. I anticipate that after - we may do this by topic alternating weeks. And - but I anticipate that in all cases, by the end of the hour, we will accept all questions.

So that I just want to sort of make sure that every different development group out there gets a chance to ask some key questions so that we can clarify, explain, stimulate, encourage all test development. So of course, if you were paying attention to our announcement, we've had more authorizations in the intervening week.

Of note is one very important authorization and that was an antigen - it happened to be an antigen test. But it is an antigen test that has been authorized as the first home based over the counter test. And so we are extremely excited about that here at the agency. And look forward to more and more home testing authorizations, not just for antigen tests; not just for - and molecular, but also for serology tests as well.

And of course, we had a prior prescription based molecular test and we look forward to more authorizations both by prescription and OTC in the home. Of course, you know, molecular is great if it can be done in the home environment. There is a challenge though in that it is more difficult to manufacture molecular tests in quite the same volume as direct antigen lateral flow tests. And that - and also there may be cost differentials too.

But because of the manufacturing capacity of these so-called paper strip tests or lateral flow tests, the authorization yesterday for the first home OTC test is - was such a paper strip test. It - those - the capacity of making those tests is in the potentially tens of millions per month, if not even to the 100 million mark, even from a single manufacturer.

So obviously, deploying such testing that has been EUA authorized, by which we've had a chance to look at the test and authorize it and get a good initial feel at least under the EUA framework, of its performance, so that the public can - and users of these tests can have assurances that the FDA believes they are accurate for the intended purpose.

So I mean that kind of explains why it's so important. Because right now there is a desire I believe out there, to have a lot more testing. There's a willingness to do this. And so we're looking at - and we're looking at, you know, how we can make that testing as widely available as possible so that consumers even can - and home users, can get a fast, accurate result that they can use to make the very best decisions about their lives and those of their loved ones and other situations that are important for doing that.

Okay. We will move into the Q&A portion now. And I look forward to your questions. Thank you.

Coordinator: Thank you. At this time if you would like to ask a question please press star 1 on your touchtone phone. Please ensure that your line is unmuted. Please record your name when prompted so that you may be introduced. Our first question is from (Melissa Grusajia). Your line is open.

(Melissa Grusajia): Hi. Good afternoon. Thank you Dr. Stenzel, again, for continuing these town halls. They're very much appreciated. I have a question concerning at

home over the counter tests going forward, since we now have a baseline with the Ellume test that was just authorized yesterday.

I noticed that the letter of authorization states that the Ellume app is able to automatically report to the relevant public health authorities. And I was just wondering that is this a function or feature that you would expect all over the counter COVID tests to be able to do going forward, as in have the capability to generate reports of test results and send them to public health authorities?

And if that's not the case, and an over the counter test does not have a corresponding app, how would you expect this reporting to happen? And then last thing as a side note, the letter of authorization states that the QuickStart guide and the Ellume FAQs are available on the FDA's COVID IVD EUA Web page and I haven't been able to find them.

Right now there's just a blank spot where the authorized labeling and authorized settings are located. And I wasn't sure if that was on purpose or if it was as glitch. But I just wanted to let you know.

Dr. Timothy Stenzel: Yes. There's a number of questions. Stay on so I can make sure that I noted all of them. I'm just making notes right here. So yes, I noticed the posting was not complete yesterday when I checked it. And I'm not sure why, but we'll double check on that today.

It sometimes takes, you know, a day or so to get the posting up, post-authorization. So I will look into that. Because I saw the letter of authorization but I didn't see anything else. So I will check on that. And maybe by the end of the hour I can report back on that situation.

In regards to reporting, it's obviously strongly encouraged that developers of all tests consider that, in particular, point of care tests and home tests where it's maybe a little bit more challenging because it's not being done in a moderate or a high complexity lab which has established or it's easier at least, relatively easier for them. Not that it's easy. Relatively easy for those labs to have reporting features to the public health authorities.

It's obviously, you know, critical that the US government has; public health authorities have data on where virus is going up and where virus is going down. We are constantly looking at the effectiveness of programs and testing and that's just one good measure of how the program, the amount of testing in areas is being - whether it's being effective or not.

And the more we have that sort of information in real time the faster we can make assessments of the importance. And so while it's not what I would call a decision requirement for an EUA, we encourage it. We encourage developers to think about this. We look forward to those developers who don't have one at authorization.

I believe the first home test was that situation and we asked them as part of a post-market commitment, to come up with a plan to be able to provide home users, in that case it was RX, and/or their prescribers to be able to report that information back.

There is a, you know, US government app-a-thon that has just concluded. The goal of that app-a-thon is to identify reporting technologies that could be used not just for a specific test but - I'm sorry, it's called a design-a-thon, not just for a particular test but that's fine for developers to do that and proprietary reporting is fine.

But to find designs and apps and reporting functions that can be used independent of the tests performed, so that this is - this eases the desire we have for all developers to make some sort of reporting feature available. If a given, particularly a small developer of a test who doesn't have the full capabilities to really think about this, than having a, you know, off the shelf app that could be used for them, that would be awesome.

So we are pushing that forward. And I don't know all the current up to date details on that, but we got - I know we got a lot of submissions and I know they're moving towards, if they haven't already, designated who are the winners in this round of the design-a-thon.

Okay. I think that I've answered your questions, all right? All right?

(Melissa Grusajia): Yes. Thank you so much.

Dr. Timothy Stenzel: Next - next question?

Coordinator: Next question is from (Wendy Strongen). Your line is open, ma'am.

(Wendy Strongen): Thank you. I have several questions. In - our test is a rapid lateral flow antigen test for home use and for point of care use. In our clinical trial, does the comparator PCR test need to be collected using a nasal pharyngeal swab or is an anterior nasal or mid-turbinate swab sufficient?

Dr. Timothy Stenzel: So it's - for your application are - what's the sample type again? Was it an anterior nasal swab?

(Wendy Strongen): It's an anterior nasal swab for the lateral flow test. So does the PCR - the swab for the PCR test, does that need to be a NP swab or can it be an anterior swab?

Dr. Timothy Stenzel: Well it can be as long as the molecular test is authorized for an anterior nasal swab. So we don't - we prefer - recommend that you use tests that are used on label. Also, we do recommend that you check with us about the comparator method, to make sure that we believe it's a good comparator. We have asked for the comparator to be a high sensitivity molecular test that uses an extraction procedure to concentrate the virus. And then - go ahead.

(Wendy Strongen): I was just going to say I believe there's a list that FDA has. Is there a list we can look at to see which ones are recommended? Or do you prefer that we directly contact you?

Dr. Timothy Stenzel: I don't believe we've posted a recommended list. We have the results that have been posted already for the RNA reference panel testing. We do use that testing in part, to assess whether it's a comparator. And we try to - the reference data is important. Some - reference data for some tests have not yet been posted. But we have that information.

And if you were to, you know, want to use that molecular test there'd be no reason not to. But you don't - you - it's not visible to the public what the RNA - what the reference panel results are. So you wouldn't necessarily know. So there could be molecular tests not on that list for example.

We tend to want to look at, you know, the more sensitive tests. So you can look at that list and look at the relative analytical sensitivities and then double check with us. That would be great. Okay?

(Wendy Strongen): Okay. Thank you. And my other question is about retrospective samples. We want to augment our data using retrospective samples. And the samples that we've been able to obtain, which are purchased remnant samples, are diluted ten times compared to how we would be actually running them, because these were samples that were put into viral transport medium.

So we'd like to be able to take into account that dilutional effect in two ways. We want to limit the retrospective samples to being below a certain PCR value, for example, a CT 29. And we'd also like to be able to present a calculated CT value that we believe can be reached based on the fact that there is this dilutional effect.

Dr. Timothy Stenzel: So, you know, we certainly understand that it's in some ways, easier to get these bank samples and sometimes they're not ideal for - especially for direct antigen tests where you'd want to use a direct swab. So we are open to the use of those samples but - and we understand that it could put your device at a relative disadvantage by using them.

We look for and recommend actual data and actual samples so there have been some direct antigen tests that have included say UTM, VTM in their authorizations, at least initially. The first antigen test was that way. And their sensitivity in that substrate, was enough to - for us to go ahead and authorize. So that's our recommendation.

If you are going to propose something different than that, you know, I would recommend that you come in and seek, you know, our concurrence before you actually spend money and do the study. We'll endeavor to get back to you as soon as possible given that point of care tests are a priority. But wherever possible, it is our recommendation that actual direct swabs be used.

They can be frozen direct swabs if there are banks out there that use - that have been banking frozen direct swabs for an antigen test for example, or for molecular tests that want to use. We'll accept that as supplements for fresh samples but we have some evidence that freezing could actually increase the sensitive of testing, surprisingly enough.

And we don't want to limit an authorization to any test that says you have to freeze a sample before you test. That wouldn't make any sense. So we do ask for a minimum of five positive - for point of care testing at least, five positive prospectively collected, fresh samples for us to make an authorization decision. And then there is usually a post-market commitment to finish that study.

Given that, you know, approximately over a week we have over 200,000 new cases of PCR, of test positive patients in the United States, we do understand there are challenges in standing up testing studies. But there really is - unfortunately, there shouldn't be any trouble of getting the few number of fresh positives that we want to see prior to authorization.

Coordinator: Thank you so much for your question. Moving onto our next question. And as a reminder, please press star 1 and record your name if you'd like to ask a question. And we do ask that you limit yourself to one question. Our next question will come from (Mark Hackman). Your line is open, sir.

(Mark Hackman): Yes, good morning, Tim. One of my questions has been answered. It was regarding the documentation associated with the new antigen test that was approved yesterday. So thanks for checking into that for us. And then my second is just to say thank you very much for bringing out some OTC products, you know, for the public to use.

And I'm just wondering, are there a lot more in the pipeline coming down the way? And that's it. Thanks very much.

Dr. Timothy Stenzel: You're welcome and give me an update you mentioned that there is some editing going on with the IFU for the Ellume test that's - so that it's - have arrived back at the FDA and so that should be posted hopefully pretty soon once they've been authorized. So the - so just keep checking. So obviously, this also displays the flexibility we have in - that we have given to companies.

I do want to make another late breaking announcement. I've just been informed that another home test has been authorized and the authorization has been acknowledged by the sponsor. And I just got a text instead, confirmation of this. So we - it's not an OTC test but it is another home antigen test.

And the avid BinaxNOW has been authorized for home prescription use. So to answer your question, we're very encouraging in both the home prescription tests and home OTC tests. For the - for Ellume they showed a really good performance in even asymptomatic patients. And we have - yes, we have more developers that I think can meet our recommendations for OTC.

We have substantial interest and I would expect to see more authorizations. I can't predict exactly when of all sorts of home diagnostic tests. And whether it's prescription and OTC. But certainly, this is, you know, a FDA flag in the ground that says yes, we are going to authorize OTC tests.

Coordinator: Thank you for your question. Our next question is from (Steve Gonzales). Your line is open, sir.

(Steve Gonzales): Yes, hi. Thank you very much for taking my call. I had a question about FDA's policy with regard to reviewing laboratory developed tests. And if not

within 14 days NCI's assistance with this. I have a few questions related to that. So first, has FDA implemented this new policy? And second, is there a mechanism by which a lab should submit directly to NCI if it does not hear within FDA within 14 days?

And finally, for labs that were previously informed their LDT would not be reviewed according to FDA's previous prioritization scheme, is there any particular manner in which these labs should resubmit their EUAs to FDA or directly to NCI? Thanks.

Dr. Timothy Stenzel: Well the - let's start with the last one first. So we welcome emails and questions at our template email address. And the - I would - what I can say now is that we are still in discussions with HHS on this topic. And as soon as more details can be given they will be. Okay.

We'll open for another question if we have another question in the queue.

Coordinator: Our next question is from (Pierre Politikio). Your line is open.

(Pierre Politikio): Thank you for taking my call. I would like to ask if the actual submission of the tests that have been approved, are available to us to read and preen information off of? I think it would be very valuable for us as developers - it would cut through a lot of our red tape to - trial and error, to send in our pre-EUAs. And it would dot the I's and take care of our development timeframe if those EUA actual submissions that have been approved already, not the ones that are pending approval, are available to developers. Thank you.

Dr. Timothy Stenzel: Yes. I'm not an expert on this particular topic. I'll just say that we don't have any plan of posting that information. In almost all cases, if not all cases, there is proprietary information in those applications. That is not - that is

unlikely to ever be made public. And sponsors, test developers appreciate that.

You understand that in order for us to make the very best assessments, we ask for this kind of - some of this kind of information. And that would be a proprietary formulation so that we can understand. I'll also say that this maybe the first time that I'm mentioning this on the town hall call, so we do ask for all developers to provide us as much detail about their test design and designs.

And so we do ask for say for molecular assays, primary and probe designs. Our office, on a monthly basis, is looking at the database of mutations, at least that are linked to the US. We are - since we have those primary and probe sequences, our bio-pharmaticians are scanning the mutation data and flagging anything that could be of concern.

We have already initiated reaching out to some developers. And we are, you know, in dialog with them. If there is something that is existent that would potentially lower the performance of the test we will work with those developers in every situation and make that information public as soon as possible.

We probably are looking at communicating this program more formally in the not too distant future. So we are doing this as a service. It's not something that we normally do. But in this pandemic we feel it's important. We would encourage all developers, of course when a molecular developer say comes in with primary probe sequences, we are asking for both inclusivity testing even if in only in silico as well as cross-reactivity testing at least in silico for some things.

But we do really want that test developer's post authorization to be surveying. We would encourage them and recommend to them that they survey indication standards and for any prevalent mutations that might exist in the population at least for the US, that might affect the performance in their assay. So more to come on that later.

We, in our office, have traditionally even from before the pandemic, have made decision summaries available for all of the authorized tests, whether at the PMA, whether at the 510(k) or de novo. We do this after it's been scrubbed for confidential information from the developers, to provide just the sort of information that you're asking about that's most relevant.

And we believe in our - in the IFUs and the letters of authorization and some of them post-market commitments, that we are providing this same sort of clarity to the development community. And if you have questions about designing something or something about your test that - even after you've reviewed previous authorizations, you're always welcome to come into our templates email box and ask those questions.

And we'll be as forthcoming about, you know, answering your question as we can. Again, we treat others - a significant amount of company confidential information that we guard and we protect because that's part of our duties and it's also the law.

All right. Thank you. And I think we can go to the next question.

Coordinator: Our next question is from (Jessica). Your line is open, ma'am.

(Jessica): My question has been answered. Thank you.

Coordinator: Thank you. Our next question will be from (Russell Ivanhoe). Your line is open, sir.

(Russell Ivanhoe): Thank you. I just have a quick clarification, Dr. Stenzel. Something you mentioned on a previous call regarding the prospective fresh sample. You say you recommend a minimum of five fresh samples and that you're providing a huge amount of flexibility in allowing the completion of the fresh sample studies post-market.

I just wanted to know if that meant that we could submit our EUA and then do those five fresh samples in the post-market.

Dr. Timothy Stenzel: So for point of care studies, home studies, we want to see samples as they would be used in real life. The flexibility that we're allowing is to - five fresh positives is not meeting our recommended number of fresh positives for point of care testing.

What - the flexibility is, is that only five of the recommended fresh positives and, you know, getting fresh negatives is pretty easy. There's no reason not to have fresh positives in - fresh negatives in sufficient numbers to meet our recommendations.

But if the positives that have say, our recommendation is 30 fresh positives that are requiring all of those - recommending all of those pre-market and pre-market for authorization or allowing just five positives, not just five fresh samples, it's five positive samples, until we get a read on the performance on fresh samples.

Coordinator: Thank you. Our next question is from (Peter Sansonio). Your line is open, sir.

(Peter Sansonio): Yes. There has been a number of statements about improving the - or compensating for potential sensitivity shortfalls for home testing and/or point of care testing, by serially administering a test. And in the last call you mentioned, you know, that the two tests had to be, you know, in effect, orthogonal different manufacturers.

And my question is, is that the only serial testing mechanism that one could invoke to address that, you know, potential shortfall? Or is there, you know, timing of serial tests of the same, you know, assay that could be used?

Dr. Timothy Stenzel: So as Dr. Shuren and I announced in our - the Hill piece in September, we are open to tests that fall below the recommended sensitivity if there are mitigations. One mitigation is serial testing. If that's something that you want to pursue you would do a study with the particular serial testing format that you want to follow with your device.

I'm lost a little bit on the orthogonal. I think that was confirmation post-authorization for actual use of an authorized test in low prevalent populations, where you might discover an asymptomatic positive and you want to know if it's a true positive. Then we're asking for an orthogonal method. We're recommending an orthogonal method that's post-authorization. That's just normal clinical use.

If you were to take molecular antigen results in a low incidence population, a positive as absolute truth, that potentially can have untoward consequences. And we're recommending, the CDC recommends that you test with an orthogonal.

But pre-market for authorization purposes, the serial testing suggestion recommendation is one way to mitigate a test that on a single test say, single test result in a given person, may not meet the recommended bars that we have for authorization.

And by testing on a set schedule, you know, say it's every day, every other day, every - you know, every day, every once, you know, day one/day three, day one/day four, day one/day five depending on whatever serial testing program you'll want to have for your device, it would be with your device, to bring that sensitivity level up to our recommended level, that's - we're totally open with that.

There are potential other mitigations. You mentioned orthogonal tests. That can be useful in the tests that orthogonal method has to be authorized for the setting in which you are going to deploy that. And we want you to come in with data that shows that whatever testing schemes, serial testing schemes, orthogonal testing schemes you want to use, in order to mitigate a lower sensitivity, we're open to that.

We just want to see the data. And we would authorize based on the data and sort of the study design that was used. So if you came in and you say we tested with our tests, you know, two tests - one from day one, one from day three combined with sensitivity that our threshold, recommended threshold for sensibility for point of care, or a home test, then that's how we would authorize it.

We would say okay, this test is authorized if you perform it on day one and day three. And this is how you interpret the results. So hopefully that's helpful.

Coordinator: Thank you. Our next question is from (Richard Darren). Your line is open.

(Richard Darren): Hello. I wanted to ask you more of a policy question on compliance standards. Does the CDRH still requiring full compliance with ISO 1345 and will it eventually require compliance with the IVDR?

Dr. Timothy Stenzel: So we are - the - currently - obviously as public plans to merge our 820 quality system requirements with 1345. That - to my knowledge, that hasn't been implemented yet. We are heading in that direction. That has been publicly announced. I can't say exactly when that would be. We're obviously in discussions with worldwide regulatory authorities including Europe and Asia and all parts of the world, who want to participate in those dialogs.

I think our center has been very clear and forward thinking that we would love to see worldwide harmonization around quality system requirements. Our willingness to conform and move towards 1345 signals that also the single audit program, the single review program which has not been stood up yet, but we're obviously - it's publicly known that we're very in for- in favor of that.

Now let me be clear. So we're talking about non-EUA situations here. Okay? On full compliance with quality system regulations which currently for the FDA is 820. In the EUA we have waived most of those quality system requirements. And those are - those that still need to be adhered to, are highlighted in our various communications and in the letters of authorization.

So we're, you know, under an emergency use authorization situation. We're waiving the vast majority. We've seen a huge influx of developers which we welcome, who have never submitted anything to the FDA before. And obviously, it's not going to be an overnight situation where they're going to be fully compliant with 820.

So that's the current situation in EUA. When it comes time for us to transition, once the emergency is no longer declared, and there's going to be a time or period which we're going to finally issue a guidance around that transition period and the amount of time to convert EUA applications to full authorizations then that would also, in all likelihood include recommendations about how to move from what we allow under an EUA situation for quality systems, into - in a time period, a timeline to become compliant with - at the time that occurs with whatever quality system that we are recognizing and asking for.

So hopefully I addressed that question and also made it crystal clear about the differences between non-EUA and EUA situations.

Coordinator: Our next question is from (Louis Ferland). Your line is open, sir.

(Louis Ferland): Yes, hello. Thank you for taking my call. My question is a follow up to a previous one that we had earlier today for the developer. Indicated that she had an assay she was developing that was to be carried out on anterior nasal nares samples. And she was asking if the comparator would have to be done with NP swabs or if doing this with anterior nasal nares samples would have been okay.

I'm a little puzzled by your answer that it would have to be done with a test that is authorized on whatever sample they choose to use for that comparator assay, because the template indicates that categories of anatomical sites divide between upper respiratory and lower respiratory and others, such as saliva, were such that NP swab was a repreparation for NP, OP, mid-turbinate, and anterior nares.

So if we follow with that it would seem that any assay that is authorized for NP would be allowed for nasal nares and would be authorized for nasal nares or did I understand this incorrectly?

Dr. Timothy Stenzel: So I think it - the question earlier was a little bit different. They were asking if they could use an anterior nasal sample for the comparator test. It's just much more well-tolerated and they can enroll patients more easily than if they were to require an NP swab. Of course, if somebody - a developer wants to use an NP swab for the comparator test and an anterior nasal swab for their test, that's fine.

I would caution that that could be putting your test at a disadvantage because the NP swab may be more sensitive than the anterior nasal swab. If you want to use a comparator that is only authorized for an NP swab and you want to use that comparator, then whatever anatomic site you're looking for, you know, as far as doing the clinical study, your finding is the NP swab. I mean that's the preferred swab for all of our work.

I was just giving flexibility to this developer and other developers, if their molecular comparator is authorized for anterior nasal and NP. They can choose whatever authorized swab for the comparator testing, that they want. And so it, you know, but if the test is coming in only for NP swab which is probably, you know, unlikely these days, in order to show the best concordance, you want to probably use the same anatomic site; you'd want to do NP to NP.

These are just practicalities that go beyond our specific recommendations and go into, you know, what is a fair comparator for your test; what's going to put your test in the best possible allowable light? I'm looking to authorize tests. I'm not looking to deny tests. And I'm giving the feedback to be able to give

you and other developers the best feedback, to make that the most likely possibility.

There is one subset of tests where we are asking for either an NP swab or a mid-turbinate swab. And again, it has to be - the comparator test has to be authorized for one or the other of them. And that is for saliva or fluid. We still are asking and recommending that the comparator swab bet at least a mid-turbinate swab and - which is much more tolerable than an NP swab. Hopefully I clarified that.

Coordinator: Our next question is from (Kathleen Kennedy). Your line is open, ma'am.

(Kathleen Kennedy): Hello. Thank you for taking my call. I was wondering if we are submitting an EUA for an antigen test, for lab use only, do we need to include the five fresh samples that you've been talking about, this week and last week?

Dr. Timothy Stenzel: Okay. Antigen tests, initial EUA submission, can you include, you know, can you just submit it with the five fresh positives and not the full 30 or so…

(Kathleen Kennedy): No. No.

Dr. Timothy Stenzel: …fresh positive? Go ahead. Clarify.

Coordinator: One moment. Let me open her line back up. One moment.

Dr. Timothy Stenzel: Hopefully she's still there.

(Kathleen Kennedy): I am still here.

Coordinator: Your line is reopened, ma'am. Go ahead.

(Kathleen Kennedy): Hello. We - we have all the clinical…

Dr. Timothy Stenzel: Please clarify - yes, go ahead. I'm sorry. I'm having a hard time hearing this caller.

Coordinator: Unfortunately she…

Dr. Timothy Stenzel: Am I being heard?

Coordinator: Unfortunately - no, unfortunately she just disconnected.

Dr. Timothy Stenzel: Okay. Please call back in and ask your question and we'll try to sneak you in. If not, please just email the templates email address, asking that I, Dr. Stenzel, Tim Stenzel - I go by Tim, get through Tim to making sure that you get a response. Sorry about that disconnect. I guess we can take the next caller if there is a next caller.

Coordinator: It's from (Wendy Cho). Your line is open.

(Wendy Cho): Thank you for taking the call. Hello? Can you hear me?

Dr. Timothy Stenzel: Yes. Yes. I can hear you.

(Wendy Cho): Yes. Yes. So here is - so I just want to clarify one thing. So we know the oral throatswab, that's - we can use that once we validate against the NP swab and beyond the one category. So I have a question about the oral swab. Does oral swab belong the saliva category or how does that work? Because we run it as a saliva test.

Dr. Timothy Stenzel: Yes. Is it - so there's a difference between an oral swab that's collecting saliva or oral fluid. And between that and oral pharyngeal swab which is in the back of the throat.

(Wendy Cho): Right.

Dr. Timothy Stenzel: Okay. If you're going for, you know, collecting oral fluid then that's - oral fluid or saliva and those - and more and more developers are seeing the benefit and we see the benefit of saliva, to make sure it's not a coughed up lower respiratory sample but just saliva and there are different methods just to collect that. And so we urge that.

So if you're talking about an oral pharyngeal sample, that doesn't mean an NP comparator. I would still say that an anterior nasal swab or a mid-turbinate swab may be better received than an oral pharyngeal swab. And for home use we are recommending against the use of oral pharyngeal swabs. And obviously, against the use of NP swabs in the home situation.

Mid-turbinate swabs can be used if they're intended to be used in the pediatric population we're recommending a safety feature on the mid-turbinate swabs so that they're safe to use in kids. And obviously if the test is going to be authorized for all ages or at least down to a certain age, we want to see data - we want to see that the study does perform testing on kids. Okay?

(Wendy Cho): Yes. So for oral swab we were treated as saliva. That category? We don't do the oral pharyngeal just the oral swab?

Dr. Timothy Stenzel: Yes. Then we want to see a mid-turbinate or a nasal pharyngeal comparator in that situation.

(Wendy Cho): Okay. So even though we validated the saliva which will still validate the oral swab for that?

Dr. Timothy Stenzel: Well that might be something to come into. But in general, we don't - the best comparator - sorry for the phone in the background. The best comparator is, for any oral fluid or saliva, is an NP swab or a nasal pharyngeal swab.

(Wendy Cho): Okay.

Dr. Timothy Stenzel: I mean I'm saying that nasal pharyngeal or a mid-turbinate swab. Sorry.

(Wendy Cho): Yes. Yes. So we did validate our saliva with the NP swab so we just want to see if we can use the oral swab.

Dr. Timothy Stenzel: Yes. We're not recommending that saliva be used or oral fluid be used, as a comparator for the opposite. We're not recommending that. We're recommending a mid-turbinate or a nasal pharyngeal even if you already have saliva authorized. We've seen some quite variable data with oral fluid and saliva. And so for that, those particular claims for those that come in for EUA authorization, that's what we're asking for.

(Wendy Cho): So even the LDT is okay? Say we use the oral swab for…

Dr. Timothy Stenzel: So, you know, I'm - my focus is directing right now to recommendations for…

(Wendy Cho): For manufacturing.

Dr. Timothy Stenzel: For tests that come in for EUA authorization. That at the moment, until we finish our discussions with HHS, it's our recommendation. I mean

certainly other test developers can take and use our recommendations, but, you know, I'm - these recommendations for now, are largely directed towards, completely towards, kit developers.

Coordinator: (Kathleen Kennedy) has returned to ask her question. Your line is open, ma'am.

(Kathleen Kennedy): Hello. Thank you. My question is…

Dr. Timothy Stenzel: Hi.

(Kathleen Kennedy): …if we are submitting - hi. My question is if we're submitting an EUA for an antigen test for lab use only and we have all - everything that's recommended in the template, do we now also need to include five fresh samples?

Dr. Timothy Stenzel: So you're doing a - you're submitting a moderately or - and/or high complexity - moderate or high complexity test. Not a point of care.

(Kathleen Kennedy): Correct.

Dr. Timothy Stenzel: Oh. That's a little bit unusual situation. The - for molecular tests we do allow frozen bank samples and we haven't been asking for fresh samples always. But, you know, that kind of changes too. So I'd look to the template. But in this particular question, you know, about antigen I think is best to approach your reviewer or if you don't have a reviewer yet, the template's email box if you haven't submitted yet, the templates email box to ask that specific question.

In fact, I just got a Skype from our lead antigen person saying yes, direct her towards the template email box and we will address your question as quickly as we can.

(Kathleen Kennedy): Okay. Thank you very much.

Dr. Timothy Stenzel: Thanks for your call.

Coordinator: We have a follow up question from (Richard Darren). Your line is open.

(Richard Darren): Yes. With regard to EUAs and compliance, can you specify what quality system provisions will be required for non-EUA tests versus EUA tests?

Dr. Timothy Stenzel: For non-EUA it's our standard recommendation for quality system and compliance activities. It's only for EUA tests that we are offering standardly - I will give a caveat to that. To - it's only typically, for the lion's share situation, we're offering for EUAs and most of the requirements are waived.

There are situations where non-EUA tests and testing are impacted by the pandemic. For example, shortages of certain key supplies - plastic tips, tubes, plates, where a given manufacturer for - of testing outside of an EUA, so there's platforms used for EUA testing and non-EUA testing.

We are requesting basically, you know, pre-sub and Q-sub for those situations. And we will take a look at that. We have also waived some of the requirements for say non-SARS respiratory panels and tests that - and we have guidance out on that, immediately in effect guidance that waives some of the quality system requirements. Not all of them. Very specific elements.

So it's going to be very specific direct feedback on particular issues. So for our guidance for say VTM already, we have immediately in effect guidance for VTM, immediately in effect guidance for various consumables for non-SARS respiratory tests for example. Look to those guidances for where we're giving, you know, the ability to not follow everything under the quality system.

But it's very specific categories. So - and then if there's any questions about those or anything else that's not covered by an immediately in effect guidance, do come to us. You can use our template email address for that as well. Or you can go to whoever was your branch chief or reviewer for your non-COVID submission.

Coordinator: Thank you. This does conclude the question-and-answer portion of our call. I will turn our call back to over to our host, Ms. Irene Aihie.

Irene Aihie: Thank you. 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, by Tuesday, December 22.

If you have additional questions about today's presentation please email CDRH-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, immediately following the conclusion of today's live discussion. Again, thank you for participating and this concludes today's discussion.

Coordinator: We thank you all for participating in today's conference call. You may now disconnect. And have a great rest of your day.

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