

FDA Virtual Townhall

Moderator: Ivory Howard
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Coordinator: Welcome and thank you for standing by. At this time all participants are on listen-only mode until the question-and-answer session. At that time if you would like to ask a question over the phone please press star then 1. Today's conference is being recorded. If you have any objections you may disconnect at this time. And now I would like to turn the meeting over to Ms. Ivory Howard. You may begin.

Ivory Howard: Thank you. Hello. I'm Ivory Howard of CDRH's Office of Communication and Education. Welcome to the FDA's 54th webinar in a series of virtual town hall meetings to answer technical questions about the development and validation of tests for COVID-19.

Today Dr. Timothy Stenzel, Director of the Office of In Vitro Diagnostics and Radiological Health in the Office of Product Evaluation and Quality and Toby Lowe, Associate Director for Regulatory Programs, will provide a brief update.

Following opening remarks, we will open the line for your questions. Please remember that during this town hall we are not able to respond to questions

about specific submissions that might be under review. Now please welcome Dr. Timothy Stenzel.

Dr. Timothy Stenzel: Welcome again to this week's call. We look forward to engaging you.

We did receive some prior questions which Toby will go through first. There aren't that many so we'll go through all of them first and then go to live questions.

I did want to make one comment and that is we still recommend that any molecular comparator for any submission be of high sensitivity with an extraction step and that it be EUA authorized as used in the developer's, in the sponsor study.

If it is not EUA authorized or if there is an alteration to the authorized method it will cause a significant delay in our review because then we'll be required to bring in a molecular review group to look at the method that you use.

So if you want to streamline your submission we recommend you use an EUA authorized test. We also recommend that you check with us first to make sure it's an appropriate molecular comparator. And if there is some requirement by what - for whatever reason for your product, to make an alteration to an EUA authorized product or not use an EUA authorized product, we do recommend you reach out to the FDA and explain that and let's have a discussion, to make sure that, you know, that is the most efficient and best way to go forward.

So yes, that's just going to help you, the developer group, to have an efficient review by our teams. And we have seen issues come up. We've seen issues come up that - aware that sponsors did not do this and in both different cases, and it has caused significant delays in the review and so we recommend we together, try to avoid that. Okay. Thanks. Over to Toby.

Toby Lowe: Thanks Tim. Thanks everyone for joining us again this week. I'll go through the questions that we received through the mailbox prior to today's call. So the first one is about validating changes in the volume of collection media, specifically they're noting that they've validated their assays for specific volumes and are considering increasing or decreasing the volume of collection media.

And since the LOD is defined in terms of concentration it doesn't reflect the change of sensitivity of the assay when changing the volume. So we do recommend that you validate your test with the transport media identified in your intended use.

Media is provided in a range of volumes and you should specify in your LOD testing what volume you tested and note that that's the average or expected fill volume in the VTM provided by the vendor. If you're trying to change the transport media or the volume for your test, we would recommend performing a matrix equivalency study to evaluate the LOD.

And you can start with a swab spiked with known concentrations placed in different volumes of the same collection medium and follow the testing instructions for your test. That should take into account the dilution factor there. You can also, if your test uses an appropriate extraction step, you could perform a clinical evaluation with samples collected in a larger volume to test the worst case scenario.

The next question that we have is asking about pre-submissions for non-COVID projects. As we've discussed previously, the volume of submissions for COVID tests has impacted our non-COVID work. And we did put out

some information, I believe it was last week, about - through a Voices blog about that workload.

And we, generally unless an IVD pre-submission is related to COVID-19 companion diagnostics, a breakthrough designation request, or has a significant public health impact, we have been unable to review them and we are using all of the tools at our disposal and we expect at this point, for the remainder of this year, to be declining IVD pre-submission requests that don't fall into those categories.

The next question is about a serology assay developer for looking to seek FDA clearance rather than an EUA and asking whether that would be through a de novo or a 510k. Since we have not yet authorized a serology assay for SARS-CoV-2 outside of the EUA provisions, we would expect that the first submission would be a de novo request. After we get the first one and are able to classify them through the de novo process, so subsequent tests would be able to come through the 510k pathway.

Our next question is about the use of serology tests after vaccination. And related to comments that Tim has made in previous town halls about, you know, certain tests coming back negative because they don't detect the antibodies that are created by the vaccine.

And so this is asking whether FDA's position is that site S1 antigen-based serology tests are the most appropriate serology tests if a clinician decides to look for immune response from the current vaccines. So we generally don't have formal guidance on this topic. We can, you know, point out that the antibody testing guidelines from the CDC states that antibody testing is not currently recommended to assess for immunity to COVID-19 following COVID-19 vaccination.

We don't yet know whether the cutoff for available serology tests would be the same as a protective antibody concentration threshold. That has not yet been established for SARS-CoV-2. And further studies would be needed to establish a relationship between the detection or measure of antibodies and protection from infection.

So that continues to be a topic of conversation as more scientific and clinical information becomes available.

Dr. Timothy Stenzel: Thank you Toby. Yes. This is definitely a very active area of review for the FDA. We simply don't have the data and we've checked with our federal government partners to support such immunity claims at this moment. As we have authorized for non-COVID, for certain non-COVID infections where monitoring antibodies and antibody levels have been authorized.

So there certainly isn't necessarily any prohibition about moving in this area. We simply wait enough data to understand. It's quite likely that a quantitative test is - a truly quantitative test may be the best answer ultimately, as we have - as those have been primarily if not exclusively, the ones that we've authorized for other amenable infections and the vaccinations for them.

Okay Toby. Back over to you.

Toby Lowe: Thanks Tim. Our next question is about multi-analyte panels and noting that there is a discussion for a multi-analyte panel in the main molecular diagnostic template but not in the non-laboratory template for tests for home use. And the question is asking whether FDA would consider a home use multi-test SARS-CoV-2 and influenza test to be eligible for EUA consideration.

The sort of overarching answer is yes, the templates are not necessarily meant to be exclusive. There are definitely cases where some of the templates include some crossover where, you know, we would expect you to consider whether certain parts of different templates might be applicable for your situation and use the parts that are relevant there.

So generally, we are open to multiplexing flu and SARS-CoV-2 in a prescription home use test. At this point we're not prepared to comment on multiplexing SARS-CoV-2 with other respiratory viruses but we are open to receiving submissions that propose that approach and having those discussions.

We would, you know, we would suggest that you take a look at those templates and complete them as much as possible. And, you know, with taking the parts that apply and submit as a pre-EUA for further discussion. We would note that any multiplexed test should be simple and easy to interpret.

And as a general recommendation we suggest that the results not be interpreted via a visual read but rather that a reader or a device to facilitate the correct display and interpretation of the results, is used for assays that have more than one analyte.

All right. Our next question is asking about the supplemental template for developers of molecular and antigen diagnostic COVID-19 tests for screening with serial testing that we issued back in March I believe, specifically asking about if a new, not previously authorized at home, over the counter test, could be authorized for screening with serial testing based on studies testing only symptomatic individuals as long as there's a post authorization commitment to provide data from testing asymptomatic individuals.

Yes. The answer yes. That is the - the intent of that template is to leverage the strong performance in symptomatic individuals to authorize for asymptomatic screening. So if all of the other requirements or recommendations are met including especially for at home, over the counter, including, you know, simple to use, appropriate lay labeling and validation with lay users, we would consider that, you know, that asymptomatic screening claim with a post authorization, condition of authorization in the letter of authorization, for the developer to conduct a study to establish performance with asymptomatic individuals.

Our next question is about a prospective clinical study supporting 510k submission of a SARS-CoV-2, influenza, and RSV multi-analyte molecular RTPCR test, asking whether FDA has any expectation on the percentage of specimens tested fresh versus frozen. And if using frozen specimens asking about fresh versus frozen and frozen stability studies, asking about the requirements for that - for frozen specimen stability.

So to support a 510k we would recommend that your prospective clinical study not exceed 50% frozen prospective specimens. We typically recommend that sponsors retest any frozen specimens with the comparator method prior to testing with the candidate method. And a fresh versus frozen study would establish that the test has similar performance with both sample types.

And we've mentioned previously in these town halls as well, that if you're intending to pursue a 510k pathway we recommend that you submit a pre-submission to discuss your clinical validation for review.

Dr. Timothy Stenzel: Thank you Toby for your comments.

Toby Lowe: Great. And our last question on the ones that were sent in ahead of time, is about at home over the counter lateral flow neutralizing antibody assay using finger stick, asking about a clarification for the study design for clinical agreement and matrix equivalency studies.

Whether the clinical agreement for the clinical agreement study protocol, asking whether they need to run both serum obtained from vena-puncture whole blood as well as finger prick whole blood against the gold standard comparator guarantee.

So first, we would note that we would watch out further discussions about this home use test and particularly whether prescription home use or over the counter home use would be appropriate. So we would recommend you coming in to talk about that with us.

For the clinical agreement study we would recommend that you evaluate, excuse me, finger stick samples in a clinical agreement study and that you collect paired venipuncture samples from subjects so that you're able to run the neutralization comparator method.

Finger stick whole blood claims should be evaluated in the clinical agreement and not in a matrix equivalency study. And that is consistent with the recommendations in the serology template regarding finger stick evaluations.

Dr. Timothy Stenzel: Thank you Toby. I think that's the last submitted question. Correct?

Toby Lowe: Yes. Yes, it is.

Dr. Timothy Stenzel: Okay. And so I think we can go open up the line and take live questions.

Thank you Toby. Well done.

Coordinator: As a reminder, if you would like to ask a question over the phone, please press star then 1, record your name clearly when prompted. Be sure that your phone is not muted when you're recording your name. And our first question comes from (Richard Mantegna). Your line is now open.

(Richard Mantegna): Yes. Thank you. This is (Richard Mantegna) from (Reanix). Like I'm sure all of the other authorized manufacturers we've been continually monitoring these areas of emerging variants. Initially we were using in silica analysis to establish whether our tests would, you know, pick up these variants.

And recently, we've managed to get our hands on some actual variants that we could do wet lab testing. So based on that I have two questions. The first one is and I'm sure everyone else is getting these same questions from their customers, as to how our tests would stack up against these emerging variants.

Assuming we were able to provide to FDA in the form of an amendment to our EUA, the data that we've accumulated would FDA permit labeling changes to allow us to make those claims? And a second related question is has FDA considered or would FDA consider providing a blinded panel of samples that would contain the various variants of concern at various titers so that, you know, people could compare head to head in a very unbiased head to head manner, the relative performance of these various tests? Thanks.

Dr. Timothy Stenzel: Thank you, (Richard). Interesting question. I think we'll take that back for dialog within the FDA. We're not - unfortunately we're still staying incredibly busy and we're not looking for additional work to do. On the other

hand, variants indications are extremely important. We have been updating labeling when there is a potential issue. And if there's data around a potential issue just the magnitude of that.

And we've got guidance out there. we've also got a new Web site. You know, and our pledge to the community is that as soon as we know something that could be an issue of significance in the United States, we will reach out to the developer or developers and assess that.

And we're also looking at - ahead to variants that are either extremely low volume in the US or are not here yet but are present in other countries. So we are looking at - in the important variants in other countries that may in fact spread to the US and become dominant enough to affect test performance if there's an issue.

You know, I understand your desire here. You know, probably and I'm not - this is not a definitive answer but probably, we'll want to restrict our activities to addressing potential issues with specific tests. And, you know, part of this is we don't want to make work for developers either. You know? And we certainly remain swamped with work at the FDA; by not just COVID related work but non-COVID work as well.

So hopefully your understanding of the potential, you know, response here that may come next week on this town hall to your question.

(Richard Mantegna): Well thank you very much. I appreciate it.

Coordinator: Thank you. And our next question comes from (Elizabeth Brunelli). Your line is now open.

(Elizabeth Brunelli): Hi. This is (Elizabeth Brunelli) from (unintelligible) Diagnostics. For the purpose - and this is a three part question. So for the purposes of home collection kit EUA request, we notice that the template includes entries for both a proprietary and established name. What is the difference between the two?

Dr. Timothy Stenzel: Toby, do you think you can respond to this question?

Toby Lowe: Yes. I'll pull up the template right now, to see. I think that is, you know, generally referring to if you have a specific name for your device and there is also a more generic name for it. But why don't you go ahead with your - the rest of your question and I'll pull that up and take a look?

(Elizabeth Brunelli): Okay. This is just really quick on those - on the oral swabs that are used in the home collection kit. Does the brand of oral swab need to be specified at this point? And if so, is FDA registration of the swab necessary for each type of swab you might use?

Dr. Timothy Stenzel: I'm thinking Toby might be answering that. Can you repeat that question?
Sorry.

(Elizabeth Brunelli): Does the brand of oral swab need to be specified on a home collection kit EUA request? And if so, is FDA registration of the swab necessary or required?

Dr. Timothy Stenzel: It's preferred that it be registered. If it's not, I would have a dialog with our staff. And if - and in the submission I would state all the details of the swab used in the study. Now when it comes down to it, if there are a need for a developer pre-authorization, to switch swabs, we'd want to know about it in our review.

But also post authorization in order to keep supplies on market, we're going to, you know, expect that if it's otherwise the same exact swab, i.e. the same material, the same type of swab, that that validation can be done internal to the developer. And as long as everything looks good it does not require a review by the FDA.

And I'm not sure if Toby...

(Elizabeth Brunelli): Okay.

Dr. Timothy Stenzel: ...has gone to the template and been able to address your question yet.
Toby?

(Elizabeth Brunelli): Okay. So what I'm getting from that is that initially on the EUA we should use the FDA registration for the original swab. If we need to substitute that then we can do probably a validation in house for the new swab as long as it's the same material. Correct?

Dr. Timothy Stenzel: Yes. Yes. And at this point, we're not hearing about wide scale swab shortages so we - again, we would prefer you using an FDA registered swab. If you're not I think that's the time. If you need to switch to something that's not FDA-registered due to supply issues, I would request that you reach out to the FDA and get some input on that before you do the work.

(Elizabeth Brunelli): Okay.

((Crosstalk))

Dr. Timothy Stenzel: Perhaps we can, you know, find an alternative source that's FDA registered for you. Go ahead Toby.

(Elizabeth Brunelli): Okay.

Toby Lowe: Yes. I think, you know, we also - since the home collection kit is something that you will be distributing, we would want to know specifically what the components are in there. And so we would want to see, you know, we would want to know the brand of the swab and, you know, especially if it's not something that you intend to manufacture yourself we would want to know - to make sure that it is a listed, registered and listed device so that, you know, if there was a recall or anything we'd know who's responsible for that.

(Elizabeth Brunelli): Okay.

Toby Lowe: And for the question about the proprietary name versus the established name, you know, I can try and get some more information for that to get back to you on it. But I believe that it's referring to the legal name of the device. The, you know, proprietary name from your company and the established name would be, you know, sort of if there's a more generic common name that you use for the device.

(Elizabeth Brunelli): Okay. And if you don't have one you don't need to include it?

Toby Lowe: Yes. You can use the same thing in both fields.

(Elizabeth Brunelli): Okay.

Toby Lowe: If that's the situation for your test, for your device.

(Elizabeth Brunelli): Okay.

Toby Lowe: Yes.

(Elizabeth Brunelli): And the last part is in the non-prescription home collection molecular PCR model combination, can two separate EUA request documents be submitted at once or do they need to be combined into a single document?

Toby Lowe: sorry? Can you say that again? For what type of...

Dr. Timothy Stenzel: Yes?

Toby Lowe: ...device?

Dr. Timothy Stenzel: Yes. I didn't catch it either.

(Elizabeth Brunelli): Non-prescription home collection combined with molecular PCR at the laboratory. There are obviously two separate EUA requests. Can those be set, like submitted together in one email or do they need to be combined into a single document?

Toby Lowe: So it can - they can be separate or together in terms of a single EUA versus two EUA requests, depending on your situation. So if you have a home collection kit that you intend to only use with one single assay and they're both under the same EUA sponsor, you can submit that as a single EUA request for the system as a whole, the home collection plus the assay.

If you instead intend for the home collection kit to be used with multiple assays and/or you intend for the assay to be able to use multiple home

collection kits, then we would want to see two EUA requests so that they can be labeled appropriately.

And in that case you could submit them in one email or two, although it is probably a little bit cleaner if you submit them in two emails.

Dr. Timothy Stenzel: Yes. And if it's different developers for the collection kit and the central lab test then it will be two EUAs or two amendments and it's probably best to keep them separate so, you know, so we can clearly delineate each submission in our record keeping.

And we're going to need to move onto the next caller. Thank you.

Coordinator: And as a reminder, if you would like to ask a question over the phone, please press star 1 and please limit all of your comments to one comment and question per caller. One moment as we wait for the next question.

Dr. Timothy Stenzel: You may be muted.

Coordinator: And one moment for our next question. Okay. And our next question comes from (Arianne Erickson). Your line is now open.

(Arianne Erickson): Hello. This is (Arianne Erickson). I'm from (unintelligible). So I have a question regarding our point of care antigen IVD. So for the evaluation for EUA submission for point of care antigen IVD, can all aspects of patient endpoints and operation for our investigational device be conducted by the typical point of care personnel? So this would be nonlaboratory personnel and medical personnel.

But we would like to connect this study on a CLIA site, but in a separate demarcated area where our personnel would have no contact with the laboratory personnel.

Dr. Timothy Stenzel: You were breaking up a little bit at least for me. You have a point of care antigen test that you want to evaluate. And typically, we recommend - we do recommend that it be performed in actual CLIA-waived settings in the US with typically, you know, non-laboratorians actually. These are healthcare workers but not trained laboratorians, in order to evaluate the performance.

But there as a twist I think you introduced and I - and it - you were breaking up so I didn't understand the twist.

(Arianne Erickson): Sorry. I apologize. Can you hear me now?

Dr. Timothy Stenzel: Yes.

(Arianne Erickson): Perfect. So we're looking to do the testing in basically a simulated point of care environment. This would be because sites where they're running PCR is a CLIA site and we would like to do it in a similar location for sample collection, for ease of sample collection for our operators.

Dr. Timothy Stenzel: We continue to recommend that you use typical point of care sites. You can also use - there's a whole lot more CLIA-waived certificate labs out there including at schools and workplaces. The reason to recommend that these types of settings be used is if they're doing this kind of work, you know, they're a busy situation and they're running a lot - they're doing lots of things all at once.

In a typical point of care clinic they're seeing patients for a lot of other issues other than COVID. And they then intersperse work for you or a point of care device if it's already authorized, in all their other work. So we want to see in a busy clinic situation for example, that they still can follow the directions. It's robust enough that they can get the accurate results.

So simulated situations for point of care are not something that we would recommend. And if you absolutely have to go that route and I can't dissuade you on this call, then I recommend you reach out to our FDA staff and discuss this with us.

We are allowing simulated home environments. That's a different situation. Because a home user isn't - they're dedicating their attention to running this test. And rather than require developers to use it in home now we're making it easier to get access to home testing.

We're bringing those home users into a simulated home environment but they get no assistance. You know? They're handed the kit and that's it. There's not training or anything. So I hope I addressed your question.

Coordinator: And our next question comes from (Laura D'Angelo). Your line is now open.

(Laura D'Angelo): Great. Thank you. Hi Tim and Toby. I was hoping to follow up on something that we talked about briefly last week, which is difficulty accessing VSL-3 sites. And I think Dr. Stenzel, you mentioned that there are some like workarounds and I did not write them down. So could you just briefly go over those again, quickly?

Dr. Timothy Stenzel: Yes. And I just want to remind everybody that the transcripts from these calls are posted. Toby, do you know if the transcript from last week has

already been posted? So I'm not sure if I'm going to go through all of this quickly. But I'll just go through it quickly because there may be new callers on the line today. But yes, we do not require VSL-3 facilities for any type of validation.

It's only if a developer wants to use live virus that they would have to do that. But there are inactivated viruses. There are heat inactivated, there's - and these are for analytical studies, not for clinical studies. Heat inactivated or radiated virus that can be obtained from VEI and potentially other sources.

And then actual patient, residual patients samples can be used. And for analytical studies sometimes you can dilute that down in negative patient matrix to an appropriate level for the given analytical study. So again, VSL-3 level labs are not required to be used by the FDA for any test validation.

And it's only the developer at this point who may want to use a live virus that would do that, but that would be in their own court or anything that's specific for their device that requires that. And then please do check my comments on the transcripts that are posted for last week. Thank you.

(Laura D'Angelo): Thank you.

Toby Lowe: And just to clarify, last week I don't believe it's posted yet. But it will - it should be posted very shortly.

Coordinator: All right. And the next question I believe the caller's name is (Whitney Dell). Your line is now open.

(Whitney Dell): Hello? Did you say me?

Dr. Timothy Stenzel: Hello?

Coordinator: Your line is open.

(Whitney Dell): Hello. Is that for me? (Whitney Dell)?

Dr. Timothy Stenzel: We can hear you. Go ahead.

(Whitney Dell): Yes. Okay. Yes, I have a question regarding the home collection kit for multiple molecular assay. So must all the assays be EUA? Can the home collection kit be used for LDT as long as it has the RP in there?

Toby Lowe: So tests that are used for home collection do need to be authorized. So we would expect that the - both the assay and the home collection kit be authorized and be authorized specifically for that indication.

(Whitney Dell): I see. So they have to - okay, so okay, useful for LDT how is it going to - if we want to use the authorized home collection without LDT assay, how should we follow or should we follow the CLIA, CLIA regulation at CMS? Or we cannot even do that?

Toby Lowe: I'm not quite sure I'm following. The test needs - would need to be authorized through an EUA so we would expect an EUA request to be submitted to FDA.

Dr. Timothy Stenzel: If there are kit developers out there who are thinking about, you know, having a lab use it as an LDT but they've provided a kit with complete instructions and it's built for use for clinical purposes, that would not be a good thing to do.

I, you know, and we don't recommend that. And if we do find a kit manufacturer who's doing that it would be important for us to reach out to them and at least have a discussion about what's going on. So, and that's intended for - anything intended for clinical purposes. So it's not a recommended way to get into the United States.

Toby Lowe: Right. And to clarify, a test that is intended to be used at a clinical lab, a test kit that is intended to be used at a clinical lab for clinical testing, does not meet the definition of RUO or research use only. So the, you know, there should not be RUO test kits being sent to clinical labs for clinical testing, you know, to be "called an LDT."

Dr. Timothy Stenzel: Yes. And I'll just say I found another warning letter yesterday about the marketing of an unauthorized test in the United States, so - kit. So this is, you know, something that the FDA takes a serious look at. All right. if there is another caller we'll take that call.

Coordinator: And as a reminder, to ask a question over the phone, please press star 1. Our next question comes from (Anna Powell). Your line is now open.

(Anna Powell): Hi. This is (Anna Powell). I have a question regarding rapid antigen POC EUA definition. So far we have conducted a clinical study with prospective samples. We have very good performance but only have 22 symptomatic and ten asymptomatic. Now we know that the EUA submission requires the 30 positives and more. I'm talking about positive sample here.

Would ten asymptomatic be sufficient to make the total number more than 30?
Or you need us to obtain additional symptomatic positive sample?

Dr. Timothy Stenzel: That's an interesting question. I think typically we want to see a full set of symptomatic samples so that we can see. Is this a molecular test or an antigen test?

Coordinator: Her line was removed. Please press star 1 again and I'll reopen your line.

Toby Lowe: It was antigen Tim. She said it was a rapid antigen point of care.

Dr. Timothy Stenzel: Yes. The challenge with an antigen test is we really do want to record the days since symptom onset. So we know how many days that a test is going to be performing well. And so purchasers and users of that test know the window after symptoms for symptomatic patients in which the test performs.

So if you include a non-symptomatic patient who legitimately can be COVID positive we're not going to collect that information. And with only 20 or 22 cases our confidence interval of around the sensitivity and the days after symptom onset that it is sensitive enough for authorization, are more limited. So fortunately, you know, it is easier to enroll symptomatic patients in clinical studies and identify them and get them - and get positives that way, than it is asymptomatic.

The fact that you have ten asymptomatics and perhaps performance is good in them, is encouraging because it means that once you get those additional symptomatic subjects enrolled and your performance remains good in the symptomatic population, when you submit the data all looks good, you have the opportunity if you wish, to apply not only for symptomatic claims but also asymptomatic screening.

Coordinator: Thank you. And our next question comes from Alexis Sauer-Budge. Your line is now open.

Alexis Sauer-Budge: Hi. This is Alexis Sauer-Budge from Exponent. I had a question with regards to a study design for a breath analyzer which is based on antigen detection. Would an appropriate comparator still be recommended as a high sensitivity molecular test or should we also consider antigen tests as a comparator?

Dr. Timothy Stenzel: Antigens are typically not a good comparator because they're not as sensitive as high sensitivity molecular central lab tests with an extraction step. You have a breath test that looks for antigens?

Alexis Sauer-Budge: That's right. Yes.

Dr. Timothy Stenzel: Okay. Well the comparator would still be at least a - actually I don't know what a true comparator is here but what swab type it is. But if you email our template email address we can give you some feedback for a breath test recommendation. We're still working on a template for these sorts of tests and we'll post them as soon as we can. But we can provide some feedback now if you email our Templates email address.

Alexis Sauer-Budge: Yes, thanks. We actually already did that and we're working on a pre-EUA submission to have a further discussion. But I just wanted to get some early feedback. Thank you very much.

Coordinator: Thank you. As a reminder, to ask a question please press star 1. Our next question comes from (Albia Lane). Your line is now open.

(Albia Lane): Hi. My name is (Albia Lane). And I have a question about the clinical evaluation study for a molecular test we're developing. So it's been really difficult to recruit positive - COVID positive patients and we're just

wondering what if we have some intended users run the tests on COVID positive saliva samples collected elsewhere?

Is that a, you know, okay study design given the limitations these days? And if that's okay, you know, would you prefer to have let's say 30 intended users perform a test on each of the saliva samples we have collected elsewhere? Or would they be okay to have let's say five intended users to perform all 30 of these tests on the saliva samples we have so far?

Toby Lowe: Tim, are you taking this one? You might be on mute if you're talking.

Dr. Timothy Stenzel: I was. I was talking away. I have some of the best conversations with myself that way. So molecular tests targeting the detection of virus in saliva, is this a point of care test?

(Albia Lane): It's going to be a take home test that's going to be over the counter use.

Dr. Timothy Stenzel: Okay. So I recommend you come in with a pre-sub, pre-EUA requesting this. That's going to be really, really challenging for a new test that hasn't even received authorizations say for a point of care or for a central lab environment.

If you have a central lab test, moderate or high complexity, you can use banked samples for a molecular test. But they do need, or matched banked saliva samples that you need a matched NP swab for that sample. And you do need to also have some fresh samples, fresh positives.

This is going to be extremely challenging. We understand that viral positivity rates in the United States fortunately are going down. Hopefully they stay down. And that there's a challenge for new test developers coming into the

market now. And especially challenging subtype, substrates like saliva to get positives.

So, you know, I don't think our recommendations for validation are going to change yet, at this time. But do reach out to our staff, to the Templates email address or primarily I think through a pre-EUA. And if you want to suggest alternatives we will review them.

(Albia Lane): Okay. Thank you so much. Can I ask one additional question, or does everyone only get to ask one?

Dr. Timothy Stenzel: Well go ahead. Hopefully it's quick.

(Albia Lane): Right. So this is - so that was about clinical evaluation so this is about usability. Do we - does FDA require or recommend us to have the usability study conducted on positive patients as well? So it's not really clear from the template.

Dr. Timothy Stenzel: Yes. So usability study is more making sure that home users in this case, can follow the directions and perform the test accurately. So we have potential alternatives there to actually having positive patients. So again, I would propose something in a pre-EUA and send it to our team.

(Albia Lane): All right. Thank you so much.

Coordinator: As a reminder, to ask a question please press star 1. One moment as we wait for any additional questions. I'm not showing any additional questions at this time.

Dr. Timothy Stenzel: We can hold on for a minute or two to see if there's anybody else that wants to ask a question. If not, we can close the call.

Coordinator: Absolutely. As a reminder, to ask a question please press star 1. One moment as we wait for any additional questions.

Dr. Timothy Stenzel: Okay. I don't think we're going to get any other questions. So we can turn it back over to Ivory, to close out. Hello, Ivory?

Ivory Howard: Okay. I'm here. Thank you. This is Ivory Howard. We appreciate your participation and thoughtful questions during today's town hall. Today's presentation and transcript will be made available on the CDRH Learn Web page at www.FDA.gov/Training/CDRHLearn. If you have any additional questions about today's presentation, please email CDRH-EUA-Templates@FDA.HHS.gov.

As we continue to hold these virtual town halls, we would appreciate your feedback. Following the conclusion of this webinar, please complete a short, 13 question survey about your FDA CDRH virtual town hall experience. The survey link can be found in the chat box or online at www.FDA.gov/CDRHWebinar.

Thank you again, for participating. This concludes today's virtual town hall.

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