CDRH Virtual Town Hall #102
Mpox and COVID-19 Test Development and Validation
March 22, 2023

Joseph Tartal: Welcome, everyone, to today's Virtual Town Hall number 102 for mpox and SARS-CoV-2 test developers. It has been a little more than three years since this series began in March of 2020. Today will be the last of these recurring town halls, and we will discuss and answer your questions about diagnostic tests in response to the mpox and COVID-19 public health emergencies.

I am Joe Tartal, Deputy Director within the Division of Industry and Consumer Education in CDRH's Office of Communication and Education, and I will be your moderator for today's virtual town hall. Our panelists for today's program are Dr. Timothy Stenzel, Director of the Office of In Vitro Diagnostics, which is also referred to as the Office of Health Technology number 7, or OHT7, in CDRH's Office of Product Evaluation and Quality, or OPEQ; Toby Lowe, Associate Director for Regulatory Programs, also in OHT7; Dr. Kristian Roth, Deputy Director of the Division of Microbiology Devices in OHT7; and Dr. Noel Gerald, Branch Chief for Bacterial, Respiratory, and Medical Countermeasures in OHT7 as well.

For today's virtual town hall, we'll begin with opening remarks. Then we'll answer your previously-emailed questions. And then we'll address your live questions. As a friendly reminder for those of you participating live in today's virtual town hall, please be sure you have joined us by the Zoom app , and not through a web browser, to avoid any technical issues.

The presentation and transcript for our last virtual town hall, which was held on February 15, 2023, have been posted to CDRH Learn. A screenshot has been provided on this slide where you can find those materials within CDRH Learn. Please use this valuable resource.

I'd now like to welcome Tim, Toby, and Kris, who will provide today's opening remarks on the town hall program in general, and mpox and COVID-19. Tim, the floor is yours.

Timothy Stenzel: Thank you, Joe. Hello and welcome, everyone. We have reached another milestone. Based on current public health trends, we have decided that today will be the last regular recurring virtual town hall on mpox and COVID-19 test development and validation. As we have discussed on previous town halls, we are encouraging stakeholders to move towards a traditional marketing submission. Developers are encouraged to submit a Q-Sub or a Pre-Sub to address questions they have for these conversions from EUA tests to fully authorize tests.

We will, in general, allow use of the EUA data to decrease the validation needed. And this can be worked out through the Q-Sub, Pre-Sub process. We can also provide, through this process, our standard validation recommendations for your device type upon request.

This full authorization pathway is also open to developers who did not have an EUA authorization but want to develop a test. While the 564 declaration for both COVID-19 and mpox IVDs remain in effect, 564, again, is a section of the Food, Drug, and Cosmetic Act. We are focusing on only a very limited set of priorities for both COVID-19 and mpox EUA reviews at this time. The COVID-19 transition plan guidance, issued in draft in December of 2021, will be finalized soon and will include additional information on the transition back to normal operations. We will host a town hall/webinar on the final guidance for IVD developers following the final guidance release, so be on the lookout for that announcement.

Over the last three years, we have hosted more than 100 virtual town halls and have really enjoyed having this time to connect with all of you, learn more about your development activities and pain points, and answer your questions. While we won't be holding these sessions regularly, we will still be available for questions. You can always reach out to us by email at COVID19Dx@fda.hhs.gov, or for mpox, the MPXDx@fda.hhs.gov. Additionally, we may schedule ad hoc webinars on special topics for IVDs in the future, as this format seems to be helpful to many developers and other stakeholders.

I'll move into general updates for this call. FDA recommendations in general, that is things like recommendations made in the COVID and mpox templates, and the standards ways of evaluating both EUAs for emergency response and traditional marketing IVD submissions are just that, recommendations. They are not hard and fast requirements. Through the COVID response and into the mpox response, the FDA has displayed a high degree of flexibility to meet the needs to match the situation currently on the ground. This is very much our standard operating procedure.

So if our recommendations present significant challenges, reach out to us via either a pre-EUA for emergency response submissions or Q-Subs for full submissions, and discuss it with us. Present the issue, the challenge that you face, and a suggested way to overcome it. And we will review it and let you know through those either of those formal processes. We will consider changes to our recommendation when it makes sense for a specific given situation. We have demonstrated that we have done this, and will continue to demonstrate it going forward.

Next I'd like to give a brief mpox update, IVD update. We have had questions about screening tests for mpox. The FDA is open to such screening tests. And if interested, please submit a pre-EUA. There are various US government-sponsored studies that are looking at this and may help inform both the sample type and/or appropriateness of a specific screening method. For the moment, though, lesion-based testing remains the most reliable method of detecting mpox. With that, I will turn it over to Toby next for some COVID-19 updates.

Toby Lowe: Thanks, Tim. Hey, everyone. Thanks again for joining us this week and for this whole series. So we're going to talk a little bit about the transition. As we've discussed previously on the town halls and mentioned in the last town hall, the administration has announced that the public health emergency under 319 will expire on May 11 and will not be renewed. We've also discussed on previous town halls and in our FAQs on our website that the 319 and the 564 declarations are independent, and the 319 public health emergency expiration does not impact the 564 declaration, which is what gives us the authority to issue emergency use authorizations.

The COVID-19 EUA declaration under Section 564 of the FD&C Act will continue until the Secretary of HHS terminates it. And as is discussed in the draft transition plan guidance, we do expect 180 days notice before that 564 EUA declaration is terminated. We don't plan to take any action that would leave Americans without the tests that they need, and we recognize the need for manufacturers of tests that were issued EUAs to have an appropriate period of transition time to move to normal operations when the declaration under 564 is no longer in effect.

The draft transition plan guidance discusses that FDA intends to implement policies for continued distribution of tests previously issued an EUA while the manufacturer's traditional marketing submission is under review. And the final details for that will be described in the final transition plan guidance when

issued. And you may have seen on the OMB website that OMB has completed their review of the final transition plan guidances, so we do expect them to publish very soon. So keep an eye out for that. And as always, if you have specific questions about how to manage your current plans for your COVID-19 test, you can always send an email to COVID19Dx@fda.hhs.gov or submit a pre-submission, as Tim was discussing, if you're considering submitting a De Novo or a 510(k). And now I can hand it over to Kris to give a couple other COVID-19 updates.

Kristian Roth: OK, great. Thank you, Toby. I just want to talk about comparator methods a little bit. So we have received several questions regarding appropriate COVID-19 comparator methods to support a De Novo or 510(k) premarket submission. And as we have discussed in previous town halls, we have some expectations that I'd like to highlight today.

The top choice for comparator methods for COVID-19 is an FDA-cleared RT-PCR test. As there are a variety of factors to consider for alternate comparator methods, we recommend that you submit a Q-Sub or Pre-Sub, and we will provide additional information on appropriate comparators for your particular situation. To support a multi-analyte respiratory panel, we recommend that the comparative method for flu be a highly-sensitive, FDA-cleared, RT-PCR test, and typically we recommend that this is cleared within the past five years. However, we may consider a comparator that has been cleared previous to that time frame if you can demonstrate that the test performance is expected to remain unchanged with currently circulating flu strains; for example, providing an in silico analysis of the primers and probes, including contemporary strains.

Again, a Q-Sub will be beneficial in assuring that you use an appropriate comparator, and really just want to highlight that this is an issue that we are glad to discuss with you all, and it really is an important decision to make sure that your clinical trial or your clinical study really is designed appropriately. We similarly recommend using a high-sensitivity FDA cleared test, cleared within the past 5 to 10 years for other analytes in your respiratory panel. And again, bring us a Q-Sub and make these proposals to us in writing, and we can reply to you very quickly.

For questions related to specific submissions, including regarding special potential comparators-- sorry, excuse me, specific potential comparators and study designs, we recommend that you submit a Pre-Sub, also known as a Q-Sub, with information about your device, validation plans, and specific questions so that we can provide appropriate feedback and answers to your questions after considering your test-specific issues.

Next, I'd like to cover a couple of topics regarding flu B, influenza B. We have received several questions regarding flu B validation due to the low prevalence of flu B in the US. We recognize the need for additional tests for influenza, particularly over-the-counter tests and point-of-care tests, including respiratory panels with COVID-19. We will continue to tailor our validation recommendations to best serve public health needs. We have provided recommendations in our EUA templates, pre-EUA, and Pre-Submission responses, and it is important to note that these are recommendations provided at a single point in time based on the available information at that time. They are not requirements, as Tim has mentioned, and we are open to alternate approaches to demonstrate performance of your test.

We encourage discussion of flu test validation as part of a Pre-Submission and with your lead reviewer, since this is an evolving issue. The recently-issued EUA for the OTC Lucira COVID-19 and flu home test included data from 94 subjects determined positive for influenza A by the comparator method and 0

subjects positive for flu B from the prospectively collected clinical samples. Banked patient samples collected in transfer media were used to establish test performance with flu B due to the low prevalence in the clinical study population and across the US, as reported by CDC.

As part of the conditions for authorization, the clinical performance of this test must be further evaluated in an FDA agreed-upon clinical study. The goal of such a study will be to establish performance for flu B in a clinical study with prospective samples. Due to the low levels of flu B in the past few seasons, we are adjusting our general recommendations for developers to target at least 30 influenza-B-positive subjects in a prospective clinical study to support CLIA waiver or over-the-counter IVD indications. This differs from feedback developers may have previously received, such as in Q-Submissions.

These previous recommendations for testing included a target of 120 subjects positive by the comparator method for flu B to support CLIA waiver and OTC IVD indications. Again, we encourage developers to continue engaging with us on this topic. And with that, I will turn it back to Joe. Thank you.

Joseph Tartal: Thank you, everyone, for those opening remarks. We'll now answer your previously-emailed questions about mpox and COVID-19 test development and validation. Please note, we do receive some emailed questions that are too detailed or test case-specific that we will not address during today's town hall. For those questions, we will try to send a response in writing within a few days.

If you have submitted a question and do not hear it addressed today, please look for a written response. If you do not receive a written response in a few days, please feel free to reach back out to us at MPXDx@fda.hhs.gov email box or to COVID19Dx@fda.hhs.gov mailbox for an update.

Also, we have received some specific questions as a follow-up to FDA feedback from the pre-emergency-use authorization or pre-submission requests that we will not address during today's virtual town hall. For these questions, we encourage you to contact your assigned lead reviewer to discuss or submit a supplemental request. So with that, let's talk about these questions.

So first, we have received no previously-emailed questions about mpox test development that we will address today. So we will move on directly to the COVID questions. So the first question, I will direct to you, Toby, which is, FDA recently granted a De Novo for Quidel's Sofia 2 test antigen for use in point-of-care setting. Can an over-the-counter COVID-19 antigen test be submitted through the 510(k) pathway now using the Quidel's Sofia 2 test as the predicate device?

Toby Lowe: Thanks, Joe. No, the Quidel Sofia 2 test is cleared only for point-of-care use, not over-the-counter. And the regulation and special controls were drafted for point-of-care use. While we have not yet granted full marketing authorization for an at-home over-the-counter COVID-19 antigen test, we are interested in doing so, and the first such test would need to be granted through the De Novo pathway.

Joseph Tartal: OK, thank you for that response. We'll move on to our next question. We are developing an at-home SARS-CoV-2 test. The sealed cartridge will contain guanidine hydrochloride. Is this acceptable for an at-home test?

Toby Lowe: Hazardous or irritating materials, such as guanidinium salts, should not be used for at-home devices unless the device has specific safety features to mitigate the risk of patient exposure. That might be, for example, releasing the preservative only when the container's lid is closed. We recommend that you provide the FDA with detailed design information, including images and a list of all reagents and concentrations, for an assessment of the toxicology profile of the components of your assay. We also recommend that your proposed assay labeling inform users of the risks associated with the use of your device as well as any recommendations for personal protective equipment. We recommend that you specify the volumes and concentrations of each reagent included in your test kit, and FDA will conduct an independent risk assessment to determine if the proposed mitigations are appropriate.

Joseph Tartal: Thank you for that answer. We'll move on to our next question. At the current time, code QMN, COVID-19 multi-analyte antigen device in the FDA product classification database states emergency use authorization for regulation and classification. Will this be updated on the basis that the new COVID-19 test manufacturers are now encouraged not to use the emergency use authorization route?

Toby Lowe: The product codes that are existing will not be changed. They will remain as EUA product codes, and product codes will be added as new premarket submissions are granted or FDA cleared. You can also see on the molecular EUA web page and the antigen EUA web page, there's a blue box above the table of EUA tests, and that blue box points to the De Novo and 510(k) databases and lists the procodes for the tests that have received authorization through the traditional premarket authorization pathways, De Novo and 510(k).

Joseph Tartal: OK, good information to know. Onto our next question. There have been several EUA-authorized SARS-CoV-2 molecular tests that amplify and detect a single highly-conserved region of the SARS-CoV-2 genome. Can the FDA comment on the current thinking regarding single-target COVID tests for emergency use authorization now that there is a large database of genomic information available for manufacturers to utilize in the design of IVD tests? Would it be acceptable to use this approach for future premarket submissions?

Toby Lowe: As the COVID pandemic has progressed, we've observed changes in EUA test performance as new variants emerge. We have a good deal of information on our website about that. And there is a risk to public health if test performance changes as new variants harboring mutations in regions targeted by a molecular test emerge.

In general, tests that detect multiple SARS-CoV-2 targets have a lower probability of being impacted by mutations when compared with tests capable of detecting only one target region. It's likely appropriate that users of single-target tests be made aware of this risk through additional mitigations. So we would likely require additional labeling mitigations, so information in the product labeling about the risk of impact by mutations. And multiple target tests likely would not need these additional labeling mitigations.

Joseph Tartal: OK, thank you, Toby. Thank you for that response and your previous responses. This wraps up the previously-emailed questions for both mpox and COVID-19 test development. We'll now move on to the live question portion of the town hall.

To ask a live question, please select the Raise Hand icon at the bottom of your Zoom screen. When you're called on, please follow the prompt in Zoom and select the blue button to unmute your line. Then identify yourself and ask your question. Please remember to limit yourself to asking one question only. If you have additional questions, you may raise your hand again to get back into the queue, and I'll call on you as time permits.

Our first live question is from Kal Mansoor. I'm unmuting your line. Please unmute yourself and ask your question.

Kal Mansoor: Hi, Thanks for taking my question. My question is about flu B. So as prevalence has been low, so enrichment won't help, and if a sponsor does not have any retrospective samples to demonstrate flu B performance, what recommendations do you have?

Timothy Stenzel: So this is Tim. So first of all, the flu season is picking up in the Southern hemisphere. And very frequently, flu B is more prevalent in the Southern hemisphere. So that is one pathway to collect flu B samples.

If we're talking about an EUA-- so that would be an EUA that's combined with COVID-- we will be relatively flexible about how we do this by alternate means. But we do need to understand flu performance in some way. An alternate approach is to potentially turn off the flu B signal in some way. If it's an antigen test, it can be masked with a change to the cover. Or if it's a molecular test, sometimes that can be done by electronic means, if it's an electronic readout. So come in with a proposal about how we can-- how you can validate this for discussion. I want to pause in case Kris has anything else to add.

Kristian Roth: No, I don't. Thank you.

Joseph Tartal: OK. Thank you for that question. Our next question is from Mary. Mary, I'm unmuting your line. Please unmute yourself and ask your question.

Mary V: Thank you. My name is Mary, and this is regarding COVID. It's my understanding that it's acceptable to consistently collect the comparator method test swab sample prior to the candidate test swab sample in clinical studies for an at-home antigen test. So my question is, if the standard of care at the clinical site where clinical trials are taking place is to first test with an FDA EUA at-home antigen test as their standard of care, then a comparator method test swab is collected, then the candidate test's lab sample is collected, I just want to confirm that this order is acceptable. That's my question.

Timothy Stenzel: Yes. You do need to follow standard of care procedures per IRB recommendations, when appropriate. That can be a molecular rather than, necessarily, an antigen test. But obviously, it takes longer to get that molecular result back than an on-site antigen test.

You can pause between collections, particularly between the molecular comparator collection and the candidate test collection, to allow what we call a washout period. Or we've seen in developers, sponsors of studies wait 15 minutes in between collections, and to date I'm not aware of any challenges that put any of the comparisons at a disadvantage. And you can also address this, if you wish, through, if it's an EUA submission, through the pre-EUA process or a Q-Sub if it's for a full authorization process. I'll pause here in case Kris has anything else to add.

Kristian Roth: I guess the only thing that I would add is, at the beginning, or earlier in the pandemic, we were concerned with users being taught how to collect a nasal swab by that health care provider prior to self-collecting. And so I think now that we have half-- excuse me-- a billion tests distributed and more on the way, I think that concern is a little bit less. So as Tim mentioned, come in with a Pre-Sub and let us know how you plan to collect those samples. But I think that information has influenced our study recommendations.

Timothy Stenzel: So traditionally, we've been concerned about bias introduced from a health care professional collecting the sample prior to a self test. And now for home respiratory testing, at least, it's hard to imagine that there's any person left in the United States who can perform the testing on themselves or on somebody else, hasn't done a home test yet. So that pool of unbiased candidate test subjects is not available any longer, and I think people are pretty well-trained on collection and running a test. And so we're then, at this point, focused on the actual performance of the test. Thank you.

Mary V: Thank you.

Joseph Tartal: Thank you for your question, Mary. Our next person up is Ray. Ray, I'm unmuting your line. Please unmute yourself and ask your question.

Ray Bandziulis: Hello, this is Ray Bandziulis from LGC Bio Search Technologies. My question is whether FDA plans to issue any specific guidance directed towards clinical laboratories who would wish to pursue a 510(k) or a path to clearance for their own institution. And I'm thinking this would be triggered in circumstances where the manufacturer of a SARS-CoV-2 test is not pursuing clearance themselves, but a key customer, key clinical laboratory may wish to continue using that test. Thank you.

Timothy Stenzel: The FDA has always welcomed lab-developed tests and labs to participate in FDA submissions, and we routinely have been authorizing such tests, even outside of an emergency response. Your specific situation has some inherent challenges, because I take it that it would still be a manufactured test. But you're not the manufacturer, unless you take on the manufacturing role for your own situation.

So this is, I think, a perfect example of submitting your plans. And you can do that briefly, and if it's not enough detail, we can ask more questions. You can ask your questions and then submit that as a Pre-Submission or a Q-Submission, and there's no charge for that submission. There is a guidance out there. If you just submit “google FDA Q-Submission process,” it'll explain in detail how you do that and how you make that submission.

It's just a formal way of the FDA receiving a submission electronically and logging it in and opening a file so that we have a record of our responses to you. We endeavor to hold ourselves to the words that we provide in that response to you, to your questions, for when you come back in. So it's all a matter of formal record that we can refer to, and you'll have a formal response that you can refer to as well.

Ray Bandziulis: So just for clarification, that would mean being able to present a Pre-Submission that does reflect a unique situation where the clinical laboratory is the sponsor or the manufacturer, and somehow the manufacturer is the supplier? Is that a valid—

Timothy Stenzel: Yeah, that's a very unique situation. And I think it's worthy of discussion with the FDA to find a way that we can do that.

Ray Bandziulis: Great. Thank you very much.

Joseph Tartal: Thank you, Ray. Our next question is coming from Deb. Deb, I'm unmuting you. Unmute yourself and please ask your question.

Debs Payne: Hey, Deb, last name Payne and the Promega Clinical Laboratory. We had notified the FDA, and we're in the EUA review process, but I'm not seeing that the Promega Clinical Lab is listed in the lab notification list on the FDA website. I sent several emails to the webinars and the EUA reviewer, and several other people, trying to get an idea of, who do I need a contact to see the PCL get listed in the lab notification list?

Timothy Stenzel: Yeah. Hey, Deb. So go ahead and send an email to the COVID email box, and ask this be submitted to Kris, Toby, and Tim.

Debs Payne: Yeah. I had sent it to Toby, just to follow up, because I seem to just not have the right email. So it's the COVID-19--

Timothy Stenzel: Dx, yeah, at fda.hhs.gov.

Toby Lowe: Hi, Deb. I see your email from a few days ago. We'll take a look and get back to you.

Debs Payne: OK. I just want to make sure that there's not any confusion. Thank you.

Timothy Stenzel: And Toby may be able to expand why or why not something, in general, may not be posted. I think some of our processes have changed over time.

Debs Payne: Yeah. I'm not sure if my reviewer is still assigned to me. But that's maybe a different topic, because I'm not getting a response from her either.

Timothy Stenzel: OK, well, Toby's on top of it. Go ahead, Toby.

Toby Lowe: Yeah, we can look at that. And there is a difference between having submitted an EUA request and having notified, and so we can look into whether that's part of the issue. An applicant doesn't get listed on the notification list based on an EUA request being submitted. It's only if a notification was submitted earlier in the emergency, when we were accepting notifications through the previous policy.

Debs Payne: OK. So appreciate your work. I'm going to miss hearing your voices. Talk to you later.

Toby Lowe: Thank you. Bye.

Joseph Tartal: OK, thank you, Debs. Our next call is from Eileen. Eileen, I'm unmuting your line. Please unmute yourself.

Eileen McCafferty: Hi, this is Eileen McCafferty, and thank you for taking the time to answer our questions today. I had a question requesting clarification to a FDA draft transition guidance, specifically on the discontinuation of distribution of IVDs after the EUA termination date. The FDA has stated they don't intend to request a market removal, but does the FDA intend to require the authorized distributors list under the EUAs to also stop distribution of product already in their control and out of the manufacturer's control?

Timothy Stenzel: OK, Toby is going to take this. But Eileen, you broke up for me. I'm not sure if you broke up for Toby.

Toby Lowe: Yeah, a little bit, but I think I understand the gist of your question. And the main answer really is to keep an eye out for the final guidances. We do expect them to post very soon based on the public notice that OMB has completed their review. So keep an eye out for those, and I think that they will provide more of the clarity that you're looking for. And then if you still have questions after the final guidances are posted, please send those in, and also keep an eye out for the webinars that will be focused specifically on those final guidances.

Eileen McCafferty: OK, thank you.

Joseph Tartal: Thank you. Our next question is from Alexandra. Alexandra, I'm unmuting your line. Please unmute yourself and ask your question.

Alexandra Hubenko: Hi, this is Alex Hubenko I'm from the Radx-rad DCC at UC San Diego. My question is regarding the EUA templates. I've been working with teams on pre-EUA and EUA submissions, and there are still molecular and antigen templates posted on the COVID-19 EUA page. And I know that you've done one EUA for the InspectIR breath test, and I'm wondering if there will be a breath test EUA-published template.

Timothy Stenzel: No, there will not be a breath test template published. We're just not seeing a ton of those to justify the process that we have to go to clear a template and post it. But you can send a pre-EUA in requesting our standard recommendations for a breath test. That will go to the breath test team, and they will respond with their current recommendations for breath test validations.

Alexandra Hubenko: OK, great. Thanks.

Joseph Tartal: Our next question is from Stacey. Stacey, I'm unmuting your line. Please unmute yourself and ask your question.

Stacey Moltchanoff: Hi, this is Stacey Moltchanoff from Thermo Fisher Scientific. I know that in the opening remarks, it was mentioned that there would be a certain amount of notice before the end of the declaration for either COVID or mpox. Is there any plans at this time for those EUAs to go away? And if so, how would that be communicated?

Timothy Stenzel: Toby, do you want to handle this one again?

Toby Lowe: Yeah, sure. So again, we are working on getting the final COVID transition guidances posted. That should be done very soon. That said, the guidances do not trigger that 180 days. We do not have

any timeline on that at the moment. That would be an announcement, I believe, from the Secretary of HHS giving that advanced notice of terminating the 564 declaration.

Stacey Moltchanoff: Great. Thank you.

Joseph Tartal: Our next person up is Ling. Ling, I'm unmuting your line. Please unmute yourself and then ask your question.

Ling Koh: Thanks for taking my question. This is Ling calling from BD. I have a question about multiplex COVID and flu assays. In the past, we've heard FDA consistently say that their preference is for assays that differentiate between flu A and flu B. But when I was looking through the town hall transcripts, I see someone asked a question in January about a pan flu assay, and there seemed to be some openness in the response. So I was just wondering if you could comment on that, and whether, as we move forward into 510(k)s, if there's a preference between a COVID and flu-A-only assay versus a COVID and pan flu assay. Thanks.

Timothy Stenzel: I'll start this and then see if Kris has anything to add. So there are some technologies that just don't have enough channels to report all of the, say, flu A and B, and maybe only can report one result and not two. And so we are, again, open to alterations in the pathways, to authorizations of tests that are of public health importance. So we would recommend that you come in with your technology and explain how you would control any potential risks from not differentiating flu A and B and discuss that option with us. Kris, anything else to add to that?

Kristian Roth: The only thing I'd like to highlight is just the risks. Come in, let us know if you've got expert opinion in differentiating flu A and B. We'd love to hear that opinion. Certainly, physicians that are in your organization, outside your organization, so that's something that we'd like to know more about.

Ling Koh: Great. Thank you so much.

Joseph Tartal: Thank you for your question. Up next is Homer. Homer, I'm unmuting your line. Unmute yourself and please ask your question.

Homer Wu: Hi. This is Homer Wu from Hopkins MedTech Compliance. Thanks for taking my call. Regarding to the final transition plan, my question is, we still have a couple EUA submissions still pending approval. So whether FDA is still going to approve any new EUA or go to the-- once the final transition plan comes out, we're going to change to 510(k) or something else.

Toby Lowe: Thanks for that question. So the guidance document does not terminate the 564 declaration, as we mentioned. So as we've talked about, we are recommending that developers move toward traditional marketing submissions. We are continuing to review EUA requests for a small number of submissions that meet our current priorities based on the public health needs.

But we are, the 564 is still open, and the guidance document does not change that. And so we'll continue to work through the priority submissions that we are reviewing. And every developer with an EUA request that is in-house and still open will receive a response either that we are declining to review

or declining to issue, or that we are authorizing it, depending on how everything goes. So you will get a response. We just can't say what that response will be at this time.

Homer Wu: OK. Just for this question, for the final transition, if that happens for existing EUA, they have to change to the full pathway. But since there's no De Novo, so there's only choice to do De Novo? If the final test comes out--

Toby Lowe: So we do have-- there are De Novos granted for a couple of device types. If there is not an appropriate predicate for your particular device, then yes, it would need to go through De Novo.

Homer Wu: OK, for antigen, because we only have the PLC antigen. But for the at-home use OTC, there's no De Novo, right?. So that's the only choice.

Toby Lowe: That's correct.

Homer Wu: OK, thank you.

Toby Lowe: Yep.

Joseph Tartal: Thank you, Homer, for your question. Our next question is from Mary. Mary, please unmute yourself and ask your question.

Mary: Yes, hello. Actually, my question was already addressed in a previous caller's question, so I no longer have a question. Thank you very much.

Joseph Tartal: OK, thank you. And next will be our last question of the day. Stacey, I'm unmuting yourself. Please unmute yourself and ask your question.

Stacey Moltchanoff: Hello, this is Stacey Moltchanoff from Thermo Fisher Scientific again. I know that there is a COVID transition draft guidance. Will there be any plans to have a similar one for mpox?

Timothy Stenzel: I'll take this. So mpox is a whole lot different than COVID-19. There continue to be, in the last few days, 30,000 new cases known in the US, and may underestimate it. And we anticipate that COVID-19 will be with us probably for much longer than we hope.

With mpox, there are very few cases. The last time I checked, there was 1.7 cases a day in the United States. That's probably a week-old data. And it would be super, super challenging to try to do a prospective clinical study anywhere in the world right now for mpox in order to transition EUAs to full authorization in an acceptable manner.

So this is the perfect situation for the EUA authorities, where we can keep the 564 declaration in place, if we wish, in order that there is still access to testing for mpox. And we do believe that there is a continued need for mpox, and we want to have tests continue to be available. And in fact, there still are some priority categories for EUAs for mpox, and that doesn't include-- the primary category now for mpox is really a multi-analyte point-of-care mpox test that includes other commonly-seen and potentially overlapping with symptoms and presentation with mpox, STDs. But it is fairly focused and limited.

But the US government is interested in continuing to have a test availability to keep pressure on keeping any sort of potential resurgence mitigated and addressed. So there isn't really a need for transition guidance, and we didn't do it for others that are still-- 564 that are open. That includes things like Zika and Ebola. And in fact, this year, we've already used the Ebola authorities to make sure that our nation-- and last year-- that our nation has appropriate countermeasures, IVD countermeasures for Ebola because of the outbreak that, fortunately, never reached our shores, but needed to be dealt with exterior to the US.

But we needed to be prepared in the US for anything that might happen here. We do a lot of those things behind the scenes on a regular basis. And Marburg is up right now, and we're focused on making sure that we can deal with Marburg. Hopefully it never hits our shores, but it doesn't hurt to be prepared.

So I think that was our last question, and I do want to thank everybody. I do want to give an opportunity to all of our experts who are on the call today to say thanks to all of you. So from my heart to yours, thank you for all the work that developers had done, and for the positive feedback for this series, and for your continued attendance. And it's not goodbye, it's until we meet again. Toby?

Toby Lowe: Thanks, Tim. I just want to thank everyone for making these town halls so successful. Engaging with you all is really the highlight of this experience for me, and this is why I like this job. So thank you all for engaging with us and for all of the collaboration that we've been able to have over the past three years. We know that will continue even without these town halls, and we look forward to continuing to work with all of you as we move forward.

Joseph Tartal: Thank you, Toby. And thank you, everyone, for your participation today. Thanks again to our panelists, Tim, Toby, Kris, and Noel. Today's virtual town hall presentation and transcript will be posted to the CDRH Learn under the section titled In Vitro Diagnostics and the subsection titled Virtual Town Hall Series.

Remember, if you have additional questions about mpox test development, you may send an email to MPXDx@fda.hhs.gov. And for additional questions about COVID-19 test development, you may send an email to COVID19Dx@fda.hhs.gov. This concludes today's virtual town hall. Thank you all for joining us. Have a great day.

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