Medicines Australia

Better health through research & innovation

IVD Reforms
Medical Devices Branch
Therapeutic Goods Administration
PO Box 100
WODEN ACT 2606
DUE DATE: 14 December 2018

Dear Sir/Madam

Consultation: Proposal for the regulation of IVD companion diagnostics

Medicines Australia welcomes the opportunity to provide comment on the Therapeutic Goods Administration (TGA) consultation paper '*Proposal for the regulation of IVD companion diagnostics*'.

Our submission has been prepared with the expert input of Medicines Australia's Regulatory Affairs Working Group (RAWG). Members are selected for their regulatory and experience and industry knowledge, and bring a whole-of-industry perspective to the consideration of regulatory issues that stand to impact our sector.

In addition, the input of Medicines Australia's Health Economics Working Group (HEWG) has also been sought. The reimbursement of companion diagnostics and associated medicines/biologics is coordinated via a co-dependent technology process that includes sequential evaluation and consideration of individual and combined evidence by the Medical Services Advisory Committee (MSAC) and the Pharmaceutical Benefits Advisory Committee (PBAC). A positive recommendation is required by both Committees before proceeding to simultaneous listing of the test on the MBS and the drug on the PBS. Learnings from HEWG experiences with this system have been included as part of the attached response. Alignment of regulatory and reimbursement processes is important to avoid delays for patients to access innovative new treatments and associated companion diagnostics.

Our detailed feedback on the guidance, are contained in Attachment 1 including answers to the specific questions included in the consultation paper. Key points include:

- Overall Medicines Australia support the TGA initiative. However, any new process should not impede the timely access to medicines as per the principles of the National Medicines Policy
- To ensure harmonisation any guidance needs to align with requirements in the EU
- Further clarity is required around the timing/pre-requisite of IVD CDx and alignment of the drug evaluation processes
- Clearer guidance on demonstration of concordance between tests is required
- Avoiding reference to specific products in Product Information, Consumer Medicines

Information and Information For Use documents is critical to simplify life cycle management
- Reference in labelling documents to CDx must allow use of both commercial and 'in-house developed' tests.
- Learnings from the Australian codependent technologies reimbursement process should be applied to assure consistency of definitions and levels of evidence to streamline assessments
- Any framework should be developed to accommodate ongoing technology developments

Our response includes suggestions for changes to provide better clarity on requirements which will support practical implementation as well as identifying key areas of concern.

We would be happy to discuss or provide further comment on any aspect of our response and we appreciate being kept up to date on further developments. Please feel free to contact Betsy Anderson-Smith if you would like further clarification on any aspect of our submission (banderson-smith@medaus.com.au).

Yours sincerely

Elizabeth de Somer
CEO

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-	**General Comments**	• In the spirit of MMDR Recommendation #20, the interpretation of the definition of IVD CDx, as well as related guidance materials should be aligned with other major jurisdictions, so that the requirements for regulatory approval are consistent. There should be no Australia-specific interpretation or requirements. EU CDx guidance are expected to be released in Q4 2018 for industry consultation. TGA should consider the EU guidance in developing AU guidance and processes for CDx applications, to ensure there is no inadvertent divergence. • TGA guidance for managing the "corresponding prescription medicine" are required, specifically in terms of coordination and relationship between evaluations, impact on timing of registrations. Importantly, specific guidance should be developed concurrently for Product Information (PI), Consumer Medicines Information (CMI) and Instructions For Use (IFU) wording. • The terminology used should be clearly defined and consistent. For example, indication and label mean different things between jurisdictions and co-dependent and companion appear to be used differently between TGA & MSAC. • The Regulations and associated Guidance should make it explicit that the process of coordination between TGA medicine evaluation and a corresponding TGA device registration today is Sponsor driven. An option would be to introduce at the Pre-Submission stage as smaller companies and/or medical device Sponsors who are not as familiar with the registration process may not appreciate the need for proactive coordination of processes. • Learnings and the appropriateness of alignment across TGA and PBAC processes for codependent technologies should be considered. There are complexities in the reimbursement processes of codependent test and drug technologies that should be mitigated against in the regulatory process. Learnings from streamlining the TGA process could be applied to the PBAC process in terms of how the evaluations of both the test and drug are conducted. • This proposal focuses on the market authorization of CDx and an associated targeted therapy. Clarification is required if this will also impact the conduct of drug clinical trials that are using potentially investigational assays (non-approved) to select patients for trial enrollment.

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Proposal 1	**A definition of an 'IVD Companion Diagnostic'**	
Q1	**Is the proposed definition of IVD CDx clear enough?**	There is a need to specify clearly how to interpret "*safe and effective use of corresponding medicinal product*". • "*Safe and effective use*" is not a term specifically defined in TGA medicine guidance or legislation today. Therefore, introducing this term in the CDx guidance without an interpretation, and/or requirements for medicinal product, may lead to confusion and likelihood of inconsistent TGA application of 'essential for safe and effective use' decisions across evaluation units. • TGA should confirm that if an IVD CDx is essential to the use of the medicine as registered under S.25 of the TGA Act, then it is essential for the "safe and effective" use of that medicine for the relevant population, as established holistically by the clinical data underpinning the registration. • There is a need to ensure that 'in-house' genomic profiling is adequately captured by the changes to the regulations, given these tests do not strictly fall under the 'genetic' test definition. It is important to clarify that these tests will be captured by the companion diagnostic definition, even if they are not used in the development of the therapy but happen to identify a relevant biomarker in the array of genes analysed • The proposed definition includes the statement "*IVD companion diagnostics are essential for defining patients' eligibility for specific treatment*". The word '*eligibility*', suggests the use of the IVD CDx in patient selection, that is, "… to identify ***before*** …." Use of the medicine in both parts a) and b) of the definition. Therefore, it is necessary for TGA to provide specific examples of where the criteria 'a) …. benefit' and 'b) …. serious adverse reactions' would apply '***during treatment***', and how this relates to the safe and effective use of the medicine as defined under S.25 of the TG Act. This clarity would be especially useful as the proposal rules out therapeutic monitoring as a caveat to the definition of IVD CDx. • Consistency in interpretation of the definition will be critical across evaluation streams. In cases where individual medicines have multiple indications across different streams Medicines Australia member experience has been that different Delegates have different interpretations that can result in Sponsors being asked to reword already approved indications. Adequate guidance is required to avoid the situation described for CDx in relation to information on 'eligibility' in PI/CMI.

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		An option would be to include further details around eligibility for use in the Dosage and Usage section of the PI/CMI so there is alignment of where information is located. • The statement "*The IFU of the device shall stipulate the corresponding medicine or biological therapeutic good for which it is an IVD companion diagnostic."* is not helpful in a definition because it appears to describe a requirement, rather that provide definition. Further, it only describes half of the requirement, as the Proposal document also describes that the PI/CMI should contain information about the IVD CDx. • A process to evaluate codependent technologies for reimbursement has been in place within the Department of Health since 2011. Applicants seeking to apply for funding for a codependent technology must address the PBAC and MSAC guidelines for codependent technologies as set out in the PBAC Product type 4 – Codependent technologies and Appendix 7 of the full MSAC Investigative Guidelines and present an integrated codependent submission which will be reviewed separately at meetings of the MSAC and PBAC. To date, assessments conducted have predominantly involved codependent medicines and pathology tests. The definition used in this context is '*Health technologies are codependent if their use needs to be combined (either sequentially or simultaneously) to achieve or enhance the intended clinical effect of either technology*'. This is not as definitive as that used by the FDA, EU and proposed by TGA with the term 'essential' for safe and effective use and inclusion in product labelling. • TGA should collaborate with relevant Department of Health areas to ensure there are no unintended consequences of differences in definitions to prevent a streamlined regulatory and reimbursement approach. This is important after recent experience with changes to orphan designations had unintended consequences on fee waivers for reimbursement submissions. • The use of *'identify, before and/or during treatment'* can be considered broader than that intended by the current reimbursement process. Clarification of the intended meaning of 'during treatment' is required eg measurement of blood glucose to monitor diabetes to ensure a streamlined regulatory and reimbursement approach.
Q2	**Is the proposed definition appropriately aligned with the EU and US FDA definitions?**	• Australia Device assessment is currently closely aligned with the EU CE marking process which covers the Analytical Validity. It is critical to keep alignment with EU so that demonstrating the

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		Clinical Validity and Clinical Utility is based on the EU definitions especially if using companies are already developing EU dossiers. • In the US, the creation of the CDx definitions and guidance documents created a 1-test/1-drug/1-indication paradigm. This has had the unforeseen consequence of raising unnecessary hurdles to patient access and some confusion in both the market place and the healthcare community. In response, FDA has needed to issue multiple guidance documents. The most recent of which (FDA Draft Guidance: Developing and Labeling In vitro Companion Diagnostic Devices for a Specific Group or Class of Oncology Therapeutic Products) attempts to outline a plan to allow CDx claims to a class of therapeutic drugs with the best example being TKI drugs targeting EGFR mutations. Clarification is sought on whether the TGA plans to consider a class approach in the proposed regulation. • The proposed definition would seem to be appropriately aligned with the EU and US FDA definitions, noting the EU guidance is still under development, and considering the requirement to account for the definitions of a medicine and a biological therapeutic as currently specified in the Therapeutic Goods Act. • Clarity of TGA interpretation and application in the guidance will be critical for Australian sponsors who may not be familiar with the US guidance or its application.
Q3	**Do you have any other comments or suggestions about the proposed definition?**	• No comments
Q4	**Do you have any other comments or suggestions for alternative or additional strategies?**	• Examples of CDx intended to be covered in each scenario specified by agreed TGA definition and examples of the caveats (exceptions) to the definition of IVD CDx would be very useful in the guidance to provide clarity for industry. The model of the Australian Regulatory Guidance for Medical Devices (ARGMD, pp 20, 81, 84,88) listing specific examples of medical devices, application of classification rules, and examples of invasive/non-invasive devices are especially useful. • It is proposed the format for this wording would be general, without naming a specific brand IVD so as to simplify the process for updating and maintaining the documents. Not referring to a specific brand is also aligned with the approach taken for the funding of IVDs on the Medicare Benefits Scheme.

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		• Future proofing of the regulations and guidance to ensure that as technology develops the process of "delinking" to a specific test is manageable. For example, FISH tests are still on MBS for some specific genes but FISH has been superseded by newer technologies. • Alternative approaches are necessary to specifically address the needs of patients with rare diseases. In the US even rare diseases with targeted therapeutics require the approval of a specific CDx. This can lead to delays in patient access while the therapeutic drug sponsor tries to contract with a diagnostic partner. This is often difficult because there is little evidence business case for a CDx sponsor to go through the time and expense of developing and seeking market authorisations for a CDx claim for a rare indication. An alternative approach would be to allow additional rare disease indications for the CDx if it is already approved for the specific marker for that targeted therapy in 1 or more indications.
Proposal 2	**The meaning of 'essential for the safe and effective use'**	
Q5	**Is the meaning of 'essential for the safe and effective use' as used in the definition of IVD CDx clear enough?**	• No. More precise guidance concerning how product labelling will describe the concept of essential for the safe and effective use is required. • In addition to clarifying the meaning of 'safe and effective' (Q1 above), TGA should also provide clear guidance of when a device would be considered to be 'required in the labelling' of a medicine (reference to the US FDA approach and interpretation of the term 'essential' as being limited to diagnostic tests that are required in the (medicine) labelling ….", p.13). The guidance should reflect sufficient flexibility in where text may appear in the Product Information, e.g. in Indication, or Dosage and Administration, other sections, as appropriate. • It may be helpful to use the concept described in the definition of the IVD CDx, i.e. for a Delegate to consider if a device is essential to the 'safe and effective' use of a medicine, as per S.25 of the TGA Act. • The introduction of the term 'required' in the context of the medicine evaluation adds another layer of subjectivity and complexity to the determination of 'essentiality' of the CDx. For example, what "level" of Clinical Validity or Utility is required to fit this definition.

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		• Clarity around what is a non- essential IVD and how this aligns with those of other jurisdictions, for example the FDA term 'complimentary diagnostic' which is when the use of the diagnostic provides a guide but does not dictate a specific treatment. • Additionally, omic tests are often not clear as these depend on penetrance, PPV, NPV, specificity. A combination of several tests may provide clinical utility, and hence be complementary and not companion diagnostics. If so, where would such tests fit into the regulatory process.
Q6	**Do you have any other comments or suggestions about the proposal to include references to approved IVD CDx in the PI and CMI of corresponding medicines and biologicals?**	• The proposal that "... expectations in relation to wording in the PI and CMI for the medicine/biological would be negotiated on a case-by-case basis" should be supported with clearer guidance for TGA Delegates, to promote consistency in application (as per comments on 'definition' above.) • This specific guidance should be developed concurrently for PI, CMI and IFU requirements. • Only general reference should be included in the PI/CMI to product information about the CDx and vice versa to simplify the updating and maintenance of both CDx & medicine PI, as per the example in the Proposal document (p.13). A risk is that if the reference is too specific, in-house IVDs will be excluded. Commercial Kits are transparently listed on the ARTG, whereas Class 1-3 in-house IVDs are included on a TGA notification database which is not publically accessible. • Medicines Australia draws attention to the standard wording used in USPIs for medicines in relation to directing users to further information on CDxs, as follows, under the "Dosage and Administration" section: *"Information on FDA approved tests for the detection of XXXX is available at http://www.fda.gov/companiondiagnostics"* This could be a useful model for consideration, utilising the proposed comprehensive ARTG list, per proposal 5 "Amendments to allow for the identification of individual IVD CDx in the ARTG or other Database"
Q7	**Do you have any other comments or suggestions about the proposal for the IFU of approved IVD CDx to include**	• As above and suggest that the TGA to ensure that naming of therapeutic goods in product labelling is sufficiently broad, so as not to introduce additional regulatory burden into the proposed regulatory framework. • The consultation acknowledges that many IVD CDx are developed overseas, and therefore device

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	references to the corresponding medicine or biological?	instructions for use (IFUs) are not necessarily specific for Australia. Alignment with the proposed EU IVD regulations, that the IFU for the device must contain the International Non-proprietary Name (INN) of the corresponding medicinal product, should be considered by TGA as in the event of revisions to product names, the corresponding device IFU is unlikely to require major revision.
Proposal 3	**Amendment to clarify the classification of IVD CDx**	
Q8	**Do you have any comments or suggestions about the proposal to classify all companion diagnostics as Class 3 IVDs to ensure appropriate and consistent regulation of IVD CDx in future?**	• Medicines Australia supports this proposal, however clarity is required to ensure that existing devices do not full under the umbrella of a CDx per the suggested definition. For example, a blood pressure monitor could be deemed "essential" to initiating and monitoring treatment; or glucose testing etc for insulin use. The caveats to the definition provided on page 12, still do introduce the possibility that blood glucose testing may fall under the definition of being essential to the safe and effective use of the medicine during treatment. • Specific consideration should be given to current tests which would fall outside the scope of the definition provided.
Q9	**Is the proposed amendment to Rule 1.3 clear enough?**	• Yes
Proposal 4	**Amendments to allow for compulsory audits of ARTG inclusion applications for IVD CDx**	
Q10	**Do you have any comments or suggestions about the proposal to require a compulsory audit of all IVD CDx prior to inclusion on the ARTG?**	• The TGA should consider the potential impact of a compulsory audit of the IVD CDx on the timelines for review and approval of both a medicine/biological and an accompanying IVD CDx, where applications are made in parallel for approval of both.
Q11	**Is the proposed amendment to Regulation 5.3 clear enough?**	• Yes
Proposal 5	**Amendments to allow for the identification of individual IVD CDx in the ARTG or other Database**	

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Q12	**Do you have any comments or suggestions about the proposal to amend Regulation 1.6 to require a unique product identifier as a characteristic for identification of all IVD companion diagnostics in applications for inclusion on the ARTG?**	• Medicines Australia supports the identification of individual IVD CDx included in the ARTG and encourages alignment with overseas regulators to avoid imposition of additional regulatory burden upon Sponsors.
Q13	**Do you have any other suggestions for the effective identification of IVD companion diagnostics that are included on the ARTG?**	• No comments
Q14	**Do you have any comments or suggestions regarding the publishing of a list of approved IVD companion diagnostics on the TGA website (similar to the US FDA approach)?**	• Agree (see Q6 above) and suggest the system introduced has no ongoing manual components.
Proposal 6	**Assessment fees for initial applications and changes to existing entries on the ARTG**	
Q15	**As discussed under proposal 4, a compulsory audit to ensure the safety and performance of all IVD CDx could become a requirement. It is therefore proposed that an application audit fee should apply to all IVD CDx to ensure full cost recovery by the TGA for the assessments required. Do you have any comments or suggestions about the proposal that an application audit fee should apply to all IVD CDx**	• Agree and request TGA to ensure that the proposed compulsory audit does not introduce unnecessary regulatory burden, particularly for devices with a history of safe and effective use in Australia. • A reduced fee is also appropriate for evaluation of a CDx test for use with subsequent medicines that require use of an existing TGA approved test to determine eligibility (eg subsequent BRAF inhibitors approved that require use of a BRAF test). A streamlined 'fit for purpose' evaluation process is currently undertaken by MSAC in these situations.

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	applications for inclusion (subject to any fee reductions that may be applicable for abridged assessments)?	
Q16	**Do you have any other comments or suggestions about the proposal that an assessment fee should apply to applications to vary an ARTG inclusion of an IVD CDx where an assessment is required for a new intended purpose for the device?**	• No comments
Proposal 7	**Transition arrangements for IVD CDx already included on the ARTG**	
Q17	**Do you have any comments on the proposal for transitioning of IVD CDx under existing ARTG entries to meet the proposed new requirements as outlined in this paper?**	• There are many IVD CDx already included on the ARTG with an intended purpose that meets the proposed definition of an IVD CDx. For many, appropriate clinical evidence to support transitioning existing ARTG entries may not be available and require collection. We suggest a grandfathering clause be considered for certain low risk, well established CDx.
Q18	**In particular, do you have any comments on options a,b and c for the auditing of existing IVD CDx transitioning to the new framework?**	• Potential risks should be considered for transitions where multiple laboratories are involved and/or "in-House" testing done due to different analytical validation methodologies.
Proposal 8	**Timeframe for transition**	
Q19	**Do you have any comments on the transition timeframe proposed for existing IVD CDx to meet the requirements of the new framework?**	• The EU guidance proposes a 5-year transition period and, given the likely volume of work required by Sponsors, in particular where laboratory accreditation is required, the feasibility of a 2-year transition timeframe should be considered.
Proposal 9	**IVD CDx that are in-house IVDs**	

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Q20	**Do you have any comments or suggestions on the proposal that in-house IVD CDx should comply with the clinical evidence and analytical performance requirements applicable to all IVD CDx?**	• Equivalent standards of evidence and compliance should be applied to all IVD CDx, whether they are commercial or in-house devices. • The current situation whereby Class 3 in-house IVDs are not required to be included in the ARTG is potentially inconsistent with the goals of this consultation paper concerning identification of IVD CDx and precludes identification of in-house IVD CDx from the ARTG entry details. • The Regulatory Requirements for In-house IVDs Class 1-3 (September 2018, version 2.2), appears to limit access to the Class 1-3 in-house IVD notification database to the TGA and NATA. Sponsor companies of medicines may require information for the purposes of MSAC and PBAC co-dependent submissions. Direction on how to request relevant information from the TGA should be included in guidance materials • We welcome the development of guidelines for clinical evidence and analytical performance requirements for IVD CDx, including in-house IVD
Q21	**Do you have any comments or suggestions regarding the compliance of in-house IVD CDx with the proposals outlined in this paper?**	• In-house developed IVD CDx tests should be included and treated in the same way as commercial kits.
Proposal 10	**Coordinated Premarket Assessment of an IVD CDx and its Corresponding medicine/Biological**	
Q22	**To provide assurance of the safety and efficacy of targeted therapies, an IVD CDx and its corresponding medicine or biological should ideally be evaluated and approved concurrently. Do you have any comments or suggestions regarding the ways in which concurrent evaluation may be facilitated?**	• Medicines Australia fully supports the TGA proposal to review an application for an IVD CDx within the context of, and in conjunction with, its corresponding therapeutic good in a coordinated review. The learnings from the reimbursement process for codependent test and drug applications is that it can be lengthy, given the requirement for separate sequential evaluations. The drug evaluation is initiated by the PBAC, this is then followed by the test evaluation by MSAC and then another assessment by the PBAC that brings the two recommendations together. Concurrent assessment of the test and medicine by the regulatory authority would therefore avoid delays in patient access to medicines. • Where an application for reimbursement runs in parallel with an application to register a new therapeutic good, the availability of a Delegates Overview/Summary from the TGA Delegate is required to support a decision by the PBAC on reimbursement.

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		• Application for a medicine should be able to be submitted prior to, or after the device application. The completion of medicine registration should not necessarily be delayed due to the time to completion of a IVD CDx registration, depending on the nature of outstanding issues in the IVD CDx evaluation, e.g. technical issues vs. clinical utility.
Q23	**Do you have any comments on the proposal under a) above that a change in intended purpose of an IVD CDx would require an application to vary the ARTG entry and submission of evidence which supports the new intended purpose?**	• Variation requirements and timing should be clear and, where possible, not impede access to innovative treatments. • Aligned with the MSAC process, it is appropriate for a streamlined/abbreviated evaluation of a CDx test for use with subsequent medicines that require use of an existing TGA approved test to determine eligibility (eg subsequent BRAF inhibitors approved that require use of a BRAF test). • As noted above may need special consideration for rare diseases and an alternative approach.
Q24	**Do you have any comments on the proposal under b) above that any IVD CDx that was not used in the clinical trials of a targeted therapy must demonstrate equivalent performance to the reference test in concordance studies?**	• Medicines Australia supports the development of guidance for sponsors on the requirements for clinical evidence and analytical performance requirements that would be applicable to IVD CDx, including in house IVDs. • In a given development program, initial clinical studies (phase 1/phase 2) may commence using an in-house IVD to make clinical decisions such as stratifying patients for inclusion/exclusion in a trial. Traditional phase 3 registrational studies may subsequently be conducted using alternative in-house or commercial IVD CDx solutions, in line with current clinical practice. In such instances, the availability of guidance documentation to clearly address how to meet the requirement for demonstrating equivalent performance to the reference test in concordance studies will be of benefit to sponsors. • Concordance of the reference or evidentiary test (meaning the test used in the clinical trials) with tests used in clinical practice is a current requirement of MSAC applications to support funding. Any regulatory framework and guidance should support alignment of TGA and MSAC processes to avoid delays in patient access. •
Other		
Other	• **Suggested improvements** • **Impact of proposed changes on industry**	• There are learnings to be had from the reimbursement process for tests and drugs that could be considered for the regulatory process. Aligned with the MSAC process, it is appropriate for a streamlined/abbreviated evaluation of a CDx test for use with subsequent medicines that require

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	• **Likely benefits – financial and non-financial (quantify if possible)** **Costs – financial and non-financial (quantify if possible)**	use of an existing TGA approved test to determine eligibility (eg subsequent BRAF inhibitors approved that require use of a BRAF test). • It is assumed that the appropriate stakeholders within the PBAC and MSAC have also been approached for this consultation.
		• The Regulatory Requirements for In-house IVDs Class 1-3 (September 2018, version 2.2), appears to limit access to the Class 1-3 in-house IVD notification database to the TGA and NATA. Sponsor companies of medicines may require information for the purposes of MSAC and PBAC co-dependent submissions. Direction on how to request relevant information from the TGA should be included in guidance materials • The transition arrangements for CDx only are described. For medicines, PI/CMI updates will/may be required. TGA guidance is required for affected corresponding medicines as there is potential for impact on sponsors of medicines due to a historically inconsistent approach to inclusion of information concerning IVDs essential for the safe and effective use within the Product Information of medicines. • Clarification is required if there be any specific requirements for Post-Market data collection to demonstrate safe and effective use.
	TGA will develop guidance materials	• Medicines Australia welcomes TGA developing guidance material to assist sponsors of therapeutic goods, whether medicines, biologicals or IVDs, impacted by this proposed change and expects that such guidance material will undergo consultation with relevant parties.
	ARTG entries vs available in the market	• There is a distinction between registration and inclusion of a medicine and device in the ARTG and their ready availability to healthcare practitioners and consumers, which is largely driven by the reimbursement processes for medicines and medical services.
	Potential unintended consequences of proposal	• The reimbursement co-dependent technology process was introduced to amend the scenario where an unsubsidised test was required to access a subsidised drug. Often the gap between reimbursement was years and impacted patient access. TGA should give consideration to untended creation of situations where there may be inconsistency between the ARTG and the availability of therapeutic goods and their associated IVD CDx. • Introduction of compulsory audit of all IVD CDx presently included in the ARTG, and associated costs, could potentially lead to withdrawal of IVDs from the Australian market.

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		• TGA should ensure that it is adequately resourced in order that the intended concomitant evaluation occurs in a timely manner for both the medicine/biological and device evaluations. This could be particularly impactful during the proposed 2-year transition period for IVD CDx.