FSN Ref: 2021-05

Date: 2021-10-22

Urgent Field Safety Notice
Olerup QTYPE 11 E049

For Attention of: Users of product Olerup QTYPE 11 lot E049

Contact details (name, e-mail, telephone, address etc.)
Maria Ilar regulatory-se@caredx.com +46 8 508 939 00 Franzéngatan 5 112 51 Stockholm Sweden

1. Information on Affected Devices*	
1.	1. Device Type(s)
	Olerup QTYPE 11 kits consist of qPCR plates containing pre-aliquoted and dried reaction mixes in each well, together with Master Mix provided in separate vials.
1.	2. Commercial name(s)
	Olerup QTYPE 11
1.	3. Unique Device Identifier(s) (UDI-DI)
	0 7340035 52500 4
1.	4. Primary clinical purpose of device(s)
	Olerup QTYPE 11 HLA Typing Kits are qualitative in vitro diagnostic tests for the DNA typing of HLA Class I and Class II alleles. The kits are to be used as an aid in determining HLA-A, B, C, DRB1, DRB3, DRB4, DRB5, DQA1, DQB1, DPA1 and/or DPB1 alleles with low to intermediate resolution in human genomic DNA samples extracted from anticoagulated blood, to aid in transfusion and transplantation donor and recipient matching. Olerup QTYPE 11 kits are for professional use only and must not be used as the sole basis for making clinical decisions.
1.	5. Device Model/Catalogue/part number(s)
	201.701-10
1.	6. Software version
	N/A
1.	7. Affected serial or lot number range
	Lot E049
1.	8. Associated devices
	N/A

2. Reason for Field Safety Corrective Action (FSCA)	
2.	1. Description of the product problem
	Increased potential risk for not getting valid DPB1 results due to qPCR false negative reactions stemming from the reaction mix in well B21 O560. This applies to all instruments, including Light Cycler 480, ThermoFisher Viia7 and QuantStudio 6 Flex, QuantStudio 7 Flex and QuantStudio DX systems.

2.	2. Hazard giving rise to the FSCA
	No or incorrect DPB1 result generated due to false negative results from well B21 O560 when testing samples with the allele DPB1*02:01:04
2.	3. Probability of problem arising
	Low
2.	4. Predicted risk to patient/users
	The issue is rare in that a specific allele needs to be present in the tested sample, and manifests in such way that will likely be evident for a trained professional that the test is not performing as expected. This issue will manifest as a false negative (FN) result for well B21 when testing DPB1*02:01:04 samples, with the outcome that no result, or no CWD result, or wrong result for DPB1 is generated (depending on which other HLA-DPB1 allele is present in the sample). There is low risk to patient safety or health deterioration, due to the role that the generated results play in the context of clinical transplant decision making and the intended use of the product. There is no risk to users. The risk will be mitigated by updating the specificity of the B21 O560 reaction in the QTYPE kit file.
2.	5. Further information to help characterise the problem
	N/A
2.	6. Background on Issue
	One complaint has been received from customers for lot E049 where the assay reported an incorrect, but rare, result. Increasing the Score 6 tolerance to 1 revealed the correct result of a well-documented allele. The correct result was confirmed by NGS typing. The root cause investigation has been performed regarding the B21 O560 reaction mix in E049. DPB1*02:01:04 has a distal mismatch on the reverse primer. No DNA with this motif was available during development, and it was presumed that this mismatch would not be enough to make the reaction negative if samples containing this motif were tested. This is a known limitation of SSP-based assays for HLA genotyping. On testing the customer sample, the reaction B21 O560 was in fact negative with this motif.
2.	7. Other information relevant to FSCA
	This issue will affect all lots from E037 when analysed with a kit file older than Typingkit_QTYPE_20210920.

	3. Type of Action to mitigate the risk	
3.	**1. Action To Be Taken by the User*** ☒ Identify Device ☐ Quarantine Device ☐ Return Device ☐ Destroy Device ☐ On-site device modification/inspection ☐ Follow patient management recommendations ☐ Take note of amendment/reinforcement of Instructions For Use (IFU) ☒ Other ☐ None Describe: Update to typingkit_QTYPE_20211022.vda file. The Olerup QTYPE 11 kit and SCORE 6 are indicated for use by clinicians trained in molecular biology techniques, working in histocompatibility and immunogenetics laboratories. Regardless of the lot used, any suspected false negative/false positive reactions (e.g. as highlighted by a tolerance display in SCORE 6) should be manually inspected and evaluated by the user. If called for, the reaction can be excluded, as instructed by the SCORE 6 IFU	
3.	2. By when should the action be completed?	Customer Reply Form to be returned by 2021-11-05.
3.	3. Particular considerations for: IVD No	
3.	4. Is customer Reply Required? (If yes, form attached specifying deadline for return)	Yes
3.	**5. Action Being Taken by the Manufacturer** ☐ Product Removal ☐ On-site device modification/inspection ☐ Software upgrade ☐ IFU or labelling change ☒ Other ☐ None The Olerup QTYPE 11 kit file has been updated and reaction B21 O560 has received a specificity change in typing kit file Typingkit_QTYPE_20211022.vda	
3	6. By when should the action be completed?	2021-10-22
3.	7. Is the FSN required to be communicated to the patient /lay user?	No
~~3~~	8. If yes, has manufacturer provided additional information suitable for the patient/lay user in a patient/lay or non-professional user information letter/sheet?	
	N/A	

	4. General Information	
4.	1. FSN Type	New
4.	2. For updated FSN, reference number and date of previous FSN	N/A
4.	3. Further advice or information already expected in follow-up FSN?	No
4.	4. Manufacturer information (For contact details refer to page 1 of this FSN)	
	a. Company Name	CareDx AB
	b. Address	Franzéngatan 5, 112 51 Stockholm, Sweden
	c. Website address	www.caredx.com
4.	5. The Competent (Regulatory) Authority of your country has been informed about this communication to customers.	
4.	6. List of attachments/appendices:	Customer/Distributor Reply Form
4.	7. Name/Signature	Maria Ilar Head of Regulatory Affairs 

	Transmission of this Field Safety Notice
	This notice needs to be passed on all those who need to be aware within your organisation or to any organisation where the potentially affected devices have been transferred. (As appropriate) Please transfer this notice to other organisations on which this action has an impact. (As appropriate) Please maintain awareness on this notice and resulting action for an appropriate period to ensure effectiveness of the corrective action. Please report all device-related incidents to the manufacturer, distributor or local representative, and the national Competent Authority if appropriate, as this provides important feedback.