



QuickVue®
Influenza TEST

CLIA Complexity: WAIVED



INTENDED USE

The QuickVue Influenza Test allows for the rapid, qualitative detection of influenza type A and type B antigens directly from nasal swab, nasal aspirate, and nasal wash specimens. The test is intended for use as an aid in the rapid diagnosis of acute influenza virus infection. The test is not intended to detect influenza C antigens. Negative test results should be confirmed by cell culture; they do not preclude influenza virus infection and should not be used as the sole basis for treatment or other management decisions. This test is intended for professional and laboratory use.

SUMMARY AND EXPLANATION

Influenza is a highly contagious, acute, viral infection of the respiratory tract. The causative agents of the disease are immunologically diverse, single-strand RNA viruses known as influenza viruses. There are three types of influenza viruses: A, B, and C. Type A viruses are the most prevalent and are associated with most serious epidemics. Type B viruses produce a disease that is generally milder than that caused by type A. Type C viruses have never been connected with a large epidemic of human disease. Both type A and B viruses can circulate simultaneously, but usually one type is dominant during a given season.¹

Influenza antigens may be detected in clinical specimens by immunoassay. The QuickVue Influenza Test is a lateral-flow immunoassay using highly sensitive monoclonal antibodies that are specific for influenza antigens. The test is specific to influenza types A and B antigens with no known cross-reactivity to normal flora or other known respiratory pathogens.

PRINCIPLE OF THE TEST

The QuickVue Influenza Test involves the extraction of influenza A and B viral antigens. The patient specimen is placed in the Reagent Tube, during which time the virus particles in the specimen are disrupted, exposing internal viral nucleoproteins. After extraction, the Test Strip is placed in the Reagent Tube where nucleoproteins in the specimen will react with the reagents in the Test Strip.

If the extracted specimen contains influenza antigens, a pink-to-red Test Line along with a blue procedural Control Line will appear on the Test Strip indicating a positive result. If influenza type A or type B antigens are not present, or are present at very low levels, only a blue procedural Control Line will appear.

REAGENTS AND MATERIALS SUPPLIED

25-Test Kit: Catalog Number 00317 and 00317IN

- Individually Packaged Test Strips (25): Mouse monoclonal anti-influenza A and anti-influenza B antibodies
- Reagent Solution (25): Vials with 340 µL of salt solution
- Reagent Tubes (25): Lyophilized buffer with detergents and reducing agents
- Disposable Pipettes (25)
- Sterile Nasal Swabs (25)
- Positive Influenza Type A Control Swab (1): Swab is coated with non-infectious recombinant influenza A antigen
- Positive Influenza Type B Control Swab (1): Swab is coated with non-infectious recombinant influenza B antigen
- Negative Control Swab (1): Swab is coated with heat-inactivated, non-infectious Streptococcus C antigen
- Package Insert (1)
- Procedure Card (1)

MATERIALS NOT SUPPLIED

- Specimen containers
- Timer or watch

WARNINGS AND PRECAUTIONS

- For *in vitro* diagnostic use.
- Do not use the kit contents beyond the expiration date printed on the outside of the box.
- Use appropriate precautions in the collection, handling, storage, and disposal of patient samples and used kit contents.²
- Use of Nitrile or Latex gloves is recommended when handling patient samples.²
- Dispose of containers and used contents in accordance with Federal, State and Local requirements.
- The Test Strip must remain sealed in the protective foil pouch until use.
- The Reagent Solution contains a salt solution. If the solution contacts the skin or eye, flush with copious amounts of water.
- To obtain accurate results, you must follow the Package Insert.
- Inadequate or inappropriate specimen collection, storage, and transport may yield false negative test results.
- Seek specific training or guidance if you are not experienced with specimen collection and handling procedures.³
- If infection with a novel influenza A virus is suspected based on current clinical and epidemiological screening criteria recommended by public health authorities, specimens should be collected with appropriate infection control precautions for novel virulent influenza viruses and sent to State or Local health departments for testing. Viral culture should not be attempted in these cases unless a BSL 3+ facility is available to receive and culture specimens.

KIT STORAGE AND STABILITY

Store the kit at room temperature, 59°F to 86°F (15°C to 30°C), out of direct sunlight. Kit contents are stable until the expiration date printed on the outer box. Do not freeze.

SPECIMEN COLLECTION AND HANDLING

Proper specimen collection and handling is critical to the performance of this Test.^{3, 4}

SPECIMEN COLLECTION

Nasal Swab Sample:

For proper test performance, use the Swabs supplied in the kit.

To collect a nasal swab sample, insert the sterile Swab into the nostril that presents the most secretion under visual inspection. Using gentle rotation, push the Swab until resistance is met at the level of the turbinates (less than one inch into the nostril). Rotate the Swab a few times against the nasal wall.

Nasal Wash or Aspirate Sample:

Follow your Institution's Protocol for obtaining wash specimens. **Use the minimal amount of saline that your procedure allows**, as excess volume will dilute the amount of antigen in the specimen. The following are examples of procedures used by clinicians:

For Older Children and Adults:

With the patient's head hyper-extended, instill sterile, normal saline (not supplied in the kit) into one nostril with a syringe. To collect the wash, place a clean, dry specimen container directly under the nose with slight pressure on the upper lip. Tilt the head forward and allow the fluid to run out of the nostril into the specimen container. Repeat for the other nostril and collect the fluid into the same specimen container.

For Younger Children:

The child should sit in the parent's lap facing forward, with the child's head against the parent's chest. Fill the syringe or aspiration bulb with the minimal volume of saline required per the subject's size and age. Instill the saline into one nostril while the head is tilted back. Aspirate the wash specimen back into the syringe or bulb. The aspirated wash sample will likely be at least 1 cc in volume.

Alternatively, following instillation of the saline, tilt the child's head forward and let the saline drain out into a clean collection cup.

SPECIMEN TRANSPORT AND STORAGE

Specimens should be tested as soon as possible after collection. Do not use any kind of transport media to store or transport samples. Samples may be stored refrigerated (2°C to 8°C), or at room temperature (15°C to 30°C), in a clean, dry, closed container for up to 8 hours prior to testing.

QUALITY CONTROL

Built-in Control Features

The QuickVue Influenza Test contains built-in procedural control features. The manufacturer's recommendation for daily control is to document these built-in procedural controls for the first sample tested each day.

The two-color result format provides a simple interpretation for positive and negative results. The appearance of a blue procedural Control Line provides two forms of positive internal control by demonstrating the following: (1) sufficient capillary flow has occurred; and (2) the functional integrity of the Test Strip was maintained. **If the blue procedural Control Line does not develop at 10 minutes, the test result is considered invalid.**

A built-in negative control is provided by the clearing of red background color, verifying that the test has been performed correctly. Within 10 minutes, the result area should be white to light pink and allow the clear interpretation of the test result. **If background color appears and interferes with interpretation of the test result, the result is considered invalid.** Should this occur, review the procedure and repeat the test with a new Test Strip.

External Quality Control

External controls may also be used to demonstrate that the reagents and assay procedure perform properly.

Quidel recommends that positive and negative controls be run once for each untrained operator, once for each new shipment of kits – provided that each different lot received in the shipment is tested – and as deemed additionally necessary by your internal quality control procedures, and in accordance with Local, State, and Federal regulations or accreditation requirements.

If the controls do not perform as expected, repeat the test or contact Quidel Technical Support before testing patient specimens.

External Positive and Negative Control Swabs are supplied in the kit and should be tested using the Nasal Swab Test Procedure provided in this Package Insert or in the Procedure Card.

TEST PROCEDURE

Expiration date: check expiration on each individual test package (tray or outer box) before using. *Do not use any test past the expiration date on the label.*

Nasal Swab Procedure

1. Dispense all of the Reagent Solution into the Reagent Tube. Gently swirl the Tube to dissolve its contents.



2. Place the patient Swab sample into the Reagent Tube. Roll the Swab at least 3 times while pressing the head against the bottom and side of the Reagent Tube.



3. Roll the Swab head against the inside of the Reagent Tube as you remove it. Dispose of the used Swab in accordance with your biohazard waste disposal protocol.



4. Place the Test Strip into the Reagent Tube with the arrows on the Test Strip pointing down. Do not handle or move the Test Strip until the test is complete and ready for reading.

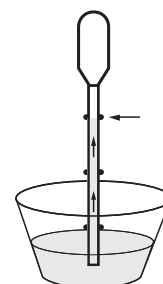


5. Read result at 10 minutes. Some positive results may appear sooner.



Nasal Wash/Nasal Aspirate Procedure

1. Fill the Pipette to the top/uppermost notch with nasal wash or nasal aspirate sample.



2. Add entire contents of the Pipette to the Reagent Tube. Swirl the Tube gently to dissolve its contents.



3. Place the Test Strip into the Reagent Tube with the arrows on the Test Strip pointing down. Do not handle or move the Test Strip until the test is complete and ready for reading.



4. Read result at 10 minutes. Some positive results may appear sooner.



CLIA Considerations

This is a waived test under the Clinical Laboratory Improvement Amendments of 1988 (CLIA) so long as it is used according to the instructions set in this Package Insert.

Any modification by the laboratory to the test system or the test system instructions will result in this test no longer meeting the requirements for waived categorization. A modified test is considered to be high complexity and is subject to all applicable CLIA requirements. Further, the laboratory should notify Quidel Corporation of any performance, perceived or validated, that does not meet the performance specifications as outlined in the instructions.

Under CLIA, several Consumer Precision Studies and a Consumer Accuracy Study was conducted to demonstrate that lay users with no formal laboratory training could read the Package Insert and perform the test with a high level of concordance with trained laboratorians. Consumer Precision Study testing was conducted using proficiency panels consisting of three hundred sixty (360) negative, low positive and moderate positive nasal wash and nasal swab samples. Consumer Accuracy Study testing was conducted using over three hundred nasal wash samples ranging from negative through low positive samples. A similar study using nasal swab samples was not conducted.

No significant differences were observed between the lay user and the laboratorian (Consumer Accuracy Study) or between the lay user and expected results (Consumer Precision Study).

Lay User and Laboratorian Results Compared and versus Expected Results

Participant	Location	Negative % negative	High Neg Level 1 % positive	High Neg Level 2 % positive	Low Pos* Level 1 % weak pos	Low Pos* Level 1 % positive	Low Pos* Level 2 % positive
Lay User	Total 4 Sites	50/50 (100%)	0/24 (0%)	11/94 (12%)	NA	83/127 (65%)	47/50 (94%)
Trained Laboratorian	Total 1 Site	49/50 (98%)	1/25 (4%)	5/98** (5%)	32/123 (26%)	84/123*** (68%)	48/50 (96%)

NA = not applicable

* Low Positive Level 1 below assay threshold

** One sample called invalid (eliminated from result calculation)

*** One sample strip used upside down and correctly called invalid (eliminated from result calculation)

INTERPRETATION OF RESULTS

Positive Result*:

At 10 minutes, the appearance of **ANY** shade of a pink-to-red Test Line **AND** the appearance of a blue procedural Control Line indicates a positive result for the presence of influenza A and/or B viral antigen.

**A positive result does not rule out co-infections with other pathogens or identify any specific influenza A virus subtype.*

Negative Result**:

At 10 minutes, the appearance of **ONLY** the blue procedural Control Line indicates influenza A and B viral antigen were not detected. A negative result should be reported as a presumptive negative for the presence of influenza antigen.

***A negative result does not exclude influenza viral infection. Negative results should be confirmed by cell culture.*

Invalid Result:

If at 10 minutes, the blue procedural Control Line does not appear, even if any shade of a pink-to-red Test Line appears, the result is considered invalid. If at 10 minutes, the background color does not clear and it interferes with the reading of the test, the result is considered invalid. If the test is invalid, a new test should be performed with a new patient sample and a new Test Strip.

LIMITATIONS

- The contents of this kit are to be used for the qualitative detection of influenza A and B antigen from nasal swab, nasal wash and nasal aspirate specimens. This test does not differentiate between influenza types A and B.
- A negative test result may occur if the level of antigen in a sample is below the detection limit of the test.
- Failure to follow the Test Procedure and Interpretations of Test Results may adversely affect test performance and/or invalidate the test result.
- Test results must be evaluated in conjunction with other clinical data available to the physician.
- Negative test results do not rule out possible other non-influenza viral infections.
- Positive test results do not rule out co-infections with other pathogens.
- Positive test results do not identify specific influenza A virus subtypes.
- Children tend to shed virus more abundantly and for longer periods of time than adults. Therefore, testing specimens from adults will often yield lower sensitivity than testing specimens from children.
- Positive and negative predictive values are highly dependent on prevalence. False negative test results are more likely during peak activity when prevalence of disease is high. False positive test results are more likely during periods of low influenza activity when prevalence is moderate to low.
- Individuals who received nasally administered influenza A vaccine may have positive test results for up to 3 days after vaccination.
- Monoclonal antibodies may fail to detect, or detect with less sensitivity, influenza A viruses that have undergone minor amino acid changes in the target epitope region.
- If differentiation of influenza type A and B virus is needed, additional testing is required. The use of the QuickVue Influenza A+B Test is recommended to differentiate influenza types A and B.
- If differentiation of specific influenza A subtypes and strains is needed, additional testing, in consultation with the State or Local public health department, is required.

EXPECTED VALUES

Seasonal outbreaks of influenza occur worldwide in both the northern and southern hemispheres causing widespread illness each winter. The average attack rate of influenza is 26-33 cases per 100 people per year. The risk of hospitalization is roughly 1/300 of those infected among the very young and elderly. Approximately 36,000 deaths in the United States are attributed to influenza or its complications each year. Ninety percent (90%) of deaths occur in those 65 years of age and older. During each of three major epidemics occurring in 1957 and 1968, more than 40,000 people died of influenza in the United States alone. In the 1918 pandemic, at least 20 million deaths resulted worldwide. In the multi-center clinical study conducted by Quidel during the 1998/1999 influenza season in North America, an illness prevalence of 24% for type A and 15% for type B influenza was observed.

PERFORMANCE CHARACTERISTICS

The performance characteristics for influenza A were established when influenza A/H3 and A/H1 were the predominant influenza A viruses in circulation. When other influenza A virus subtypes are emerging as human pathogens, the performance characteristics described below could vary. During this particular influenza season, 99% of the type A influenza viruses isolated from culture were H3N2 and 1% was H1N1.

In the winter of 1998/1999, the performance of the QuickVue Influenza Test was compared to cell culture methods in a multi-center field clinical study. This study was conducted in pediatric, adult and geriatric patient populations at physician offices located in the Northwest, Midwest, Northeast, Mid-Atlantic, Southeast and Western regions of the United States. In this multi-center, point-of-care (POC) field trial, a combination of nasal swabs and nasal wash/aspirate specimens were collected from a total of two hundred seventy-five (275) patients.

On-site testing of the nasal swab and nasal wash or nasal aspirate specimens in the QuickVue Influenza Test was performed by physician office personnel within 1 hour of collection; viral transport media was added to all nasal swab specimens intended for culture transport. Swab specimens in viral transport media and nasal wash/aspirate specimens were stored at 2°C to 8°C for up to 24 hours prior to culture. Rhesus Monkey Kidney (RKM) cells or Madin-Darby Canine Kidney (MDCK) cells were inoculated with a portion of the nasal swab specimen and nasal wash/aspirate and tested for the appearance of cytopathic effects (CPE). Infected cells were recovered from tissue culture and confirmed for influenza A or B by direct fluorescent antibody (DFA) staining.

A total of three hundred seventy-one (371) specimens were tested from two hundred seventy-five (275) patients (275 nasal swabs and 96 nasal wash/aspirate specimens). All clinical samples were collected from symptomatic patients. Twenty-two percent (22%) of the population tested were <18 years of age and 78% were ≥18 years of age. The following tables summarize the results:

For Nasal Swab Specimens:

Results for All Age Groups:

- Compared to culture and confirmed for influenza A or B by DFA, the QuickVue Influenza Test correctly identified 73% (79/108) positive specimens and 96% (160/167) negative specimens, with an overall accuracy of 87% (239/275). The results with nasal swabs are shown in Table 1.

Table 1
QuickVue Influenza Nasal Swab Results versus Culture (All Age Groups)

		Culture Result	
		Positive	Negative
QuickVue Influenza Test Results	Pos	79	7
	Neg	29	160

Sensitivity: 79/108 = 73% (95% C.I. 64%-81%)

Specificity: 160/167 = 96% (95% C.I. 91%-98%)

Accuracy: 239/275 = 87% (95% C.I. 82%-90%)

Pred. Value (+): 79/86 = 92%

Pred. Value (-): 160/189 = 85%

Results Stratified by Age Group:

The results obtained with nasal swab specimens for each age group are shown in Table 2.

Table 2
QuickVue Influenza Nasal Swab Results versus Culture (by Age Group)

<18 years of age N=61			≥18 years of age N=214		
Sensitivity	Specificity	Accuracy	Sensitivity	Specificity	Accuracy
96% (24/25)	92% (33/36)	93% (57/61)	66% (55/83)	97% (127/131)	85% (182/214)

For Nasal Wash or Nasal Aspirate Specimens:

Results for All Age Groups:

- Compared to culture and confirmed for influenza A or B by DFA, the QuickVue Influenza Test correctly identified 81% (22/27) positive specimens and 99% (68/69) negative specimens, with an overall accuracy of 94% (90/96). The results with nasal wash/nasal aspirate are shown in Table 3.

Table 3
QuickVue Influenza Nasal Wash/Nasal Aspirate Results versus Culture (All Age Groups)

		Culture Result	
		Positive	Negative
QuickVue Influenza Test Results	Pos	22	1
	Neg	5	68

Sensitivity: $22/27 = 81\%$ (95% C.I. 63%-92%)

Specificity: $68/69 = 99\%$ (95% C.I. 91%-100%)

Accuracy: $90/96 = 94\%$ (95% C.I. 87%-97%)

Pred. Value (+): $22/23 = 96\%$

Pred. Value (-): $68/73 = 93\%$

Results Stratified by Age Group:

The results obtained with nasal wash/nasal aspirate specimens for each age group are shown in Table 4.

Table 4
QuickVue Influenza Nasal Wash/Nasal Aspirate Results versus Culture (by Age Group)

<18 years of age N=22			≥18 years of age N=74		
Sensitivity	Specificity	Accuracy	Sensitivity	Specificity	Accuracy
80% (4/5)	94% (16/17)	91% (20/22)	82% (18/22)	100% (52/52)	95% (70/74)

Analytical Specificity and Cross-Reactivity

The QuickVue Influenza Test was evaluated with a total of 62 bacterial and viral isolates. Bacterial isolates were evaluated at a concentration between 10^7 and 10^9 org/mL. Viral isolates were evaluated at a concentration of at least 10^4 - 10^8 TCID₅₀/mL. Adenovirus 18 and Parainfluenza virus 3 were tested at 10^2 TCID₅₀/mL. None of the organisms or viruses listed below in Table 5 gave a positive result in the QuickVue Influenza Test.

Table 5
Analytical Specificity and Cross-Reactivity

Bacterial Panel:	Viral Panel:
<i>Acinetobacter calcoaceticus</i>	Adenovirus 5 (Ad. 75)
<i>Bacteroides fragilis</i>	Adenovirus 7 (Gomen)
<i>Bordetella pertussis</i>	Adenovirus 10 (J.J.)
<i>Branhamella catarrhalis</i>	Adenovirus 18 (D.C.)
<i>Candida albicans</i>	Coronavirus OC43
<i>Corynebacterium diphtheriae</i>	Coxsackievirus A9 (Bozek)
<i>Enterococcus faecalis</i>	Coxsackievirus B5 (Faulkner)
<i>Escherichia coli</i>	Cytomegalovirus (Towne)
<i>Gardnerella vaginalis</i>	Echovirus 2 (Cornelis)
<i>Haemophilus influenzae</i>	Echovirus 3 (Morrissey)
<i>Klebsiella pneumoniae</i>	Echovirus 6 (D'Amori)
<i>Lactobacillus casei</i>	Herpes simplex virus 1
<i>Lactobacillus plantarum</i>	Herpes simplex virus 2
<i>Legionella pneumophila</i>	Human Rhinovirus 2 (HGP)
<i>Listeria monocytogenes</i>	Human Rhinovirus 14 (1059)
<i>Mycobacterium avium</i>	Human Rhinovirus 16 (11757)
<i>Mycobacterium intracellulare</i>	Measles (Edmonston)
<i>Mycobacterium tuberculosis</i>	Mumps (Enders)
<i>Mycoplasma orale</i>	Parainfluenza virus 1 (Sendai)
<i>Mycoplasma pneumoniae</i>	Parainfluenza virus 2 (CA/Greer)
<i>Neisseria gonorrhoeae</i>	Parainfluenza virus 3 (C243)
<i>Neisseria meningitidis</i>	Respiratory Syncytial virus (A-2)
<i>Neisseria sicca</i>	Respiratory Syncytial virus
<i>Neisseria subflava</i>	(Subgroup A, Long chain)
<i>Proteus vulgaris</i>	Rubella (RA 27/3)
<i>Pseudomonas aeruginosa</i>	Varicella-Zoster (Ellen)
<i>Serratia marcescens</i>	
<i>Staphylococcus aureus</i>	
<i>Staphylococcus epidermidis</i>	
<i>Streptococcus mutans</i>	
<i>Streptococcus pneumoniae</i>	
<i>Streptococcus pyogenes</i>	
<i>Streptococcus sanguis</i>	
<i>Streptococcus</i> sp. Gp. B	
<i>Streptococcus</i> sp. Gp. C	
<i>Streptococcus</i> sp. Gp. F	
<i>Streptococcus</i> sp. Gp. G	

Analytical Sensitivity

Analytical sensitivity was demonstrated using a total of fifty-one (51) human epidemic strains of influenza viruses: thirty-eight (38) influenza A and thirteen (13) influenza B (Table 6).

Table 6
Analytical Sensitivity with Isolates of Influenza A and B

Viral Strain*	Viral Type	Sub-Type	Minimum Detectable Level (pfu/mL)	Viral Strain*	Viral Type	Sub-Type	Minimum Detectable Level (pfu/mL)
Hong Kong	A	H3N2	6.60×10^{-1}	Maryland/91	A	H1N1	1.00×10^4
Beijing/32/92	A	H3N2	3.30×10^0	Japan/305/57	A	H2N2	1.30×10^4
Duck/England	A	H11N6	6.70×10^0	Johannesburg/94	A	H3N2	1.44×10^4
Shanghai/11	A	H3N2	6.70×10^0	Brazil	A	H1N1	1.70×10^4
Shanghai/16	A	H3N2	1.00×10^1	Sydney	A	H3N2	2.00×10^4
Duck/Alberta	A	H1N1	3.30×10^1	Bangkok	A	H3N2	3.30×10^4
Victoria	A	H3N2	3.30×10^1	Wuhan	A	H3N2	3.30×10^4
Singapore/1/57	A	H2N2	6.70×10^1	Equine/Miami	A	H3N8	1.70×10^5
Port Chalmers	A	H3N2	1.24×10^2	Beijing/353/89	A	H3N2	3.30×10^5
Gull/Maryland	A	H13N6	1.30×10^2	Singapore/86	A	H1N1	6.60×10^5
USSR	A	H1N1	2.00×10^2	Texas/91	A	H1N1	1.60×10^7
Puerto Rico/8/34	A	H1N1	2.60×10^2	A/Anhui/1/2013**	A	H7N9	$1.98 \times 10^{7**}$
New Jersey	A	H1N1	2.70×10^2	Victoria	B		1.40×10^4
Taiwan	A	H1N1	3.30×10^2	Taiwan	B		1.10×10^2
Tokyo/3/67	A	H2N2	3.40×10^2	Panama	B		1.00×10^0
Bayern	A	H1N1	6.60×10^2	Ann Arbor	B		3.30×10^2
Sichuan	A	H3N2	6.60×10^2	Singapore	B		3.30×10^2
Beijing/352/89	A	H3N2	7.70×10^2	Lee	B		6.60×10^2
NWS/33	A	H1N1	1.00×10^3	Hong Kong	B		7.00×10^2
Fort Warren/1/50	A	H1N1	1.70×10^3	Beijing/184/93	B		1.66×10^3
Mississippi	A	H3N2	1.70×10^3	California	B		3.30×10^3
Texas/77	A	H1N1	3.30×10^3	Maryland	B		6.60×10^3
Fort Monmouth/1/47	A	H1N1	6.70×10^3	Yamagata/16/88	B		6.70×10^3
Duck/Ukraine	A	H3N8	3.30×10^1	Harbin	B		1.40×10^4
Aichi	A	H3N2	3.20×10^3	Stockholm	B		3.30×10^5
Shangdong	A	H3N2	8.40×10^3				

* These viral strains were obtained from American Type Culture Collection (ATCC) with titer information, and the titers were not verified by Quidel. The performance characteristics for influenza A virus subtypes emerging as human pathogens have not been established.

** Although this test has been shown to detect the H7N9 virus cultured from a positive human respiratory specimen, the performance characteristics of this device with clinical specimens that are positive for the H7N9 influenza viruses have not been established. The QuickVue Influenza Test cannot differentiate influenza subtypes. The minimum detectable level for the A/Anhui/1/2013 virus tested was in **EID₅₀/mL** (50% egg infective dose).

Interfering Substances

Whole blood, and several over-the-counter (OTC) products and common chemicals were evaluated and did not interfere with the QuickVue Influenza Test at the levels tested: whole blood (2%); three OTC mouthwashes (25%); three OTC throat drops (25%); three OTC nasal sprays (10%); 4-Acetamidophenol (10 mg/mL); Acetylsalicylic Acid (20 mg/mL); Chlorpheniramine (5 mg/mL); Dextromethorphan (10 mg/mL); Diphenhydramine (5 mg/mL); Ephedrine (20 mg/mL); Guaiacol glyceryl ether (20 mg/mL); Oxymetazoline (10 mg/mL); Phenylephrine (100 mg/mL); and Phenylpropanolamine (20 mg/mL).

Precision Studies

The total, within-run, and between-run performance of the QuickVue Influenza Test was evaluated for precision. A panel consisting of two different levels of influenza A antigen (Johannesburg/82/96; weak positive and strong positive) and two different levels of influenza B antigen (Harbin/7/94; weak positive and strong positive) were repeated five times with a single lot of QuickVue Influenza Test on three different days. One hundred percent (100%) accuracy was obtained for all specimens tested.

Physician Office Laboratory (POL) Studies

An evaluation of the QuickVue Influenza Test was conducted at three physicians' offices using a panel of coded specimens. Testing was performed by physician office personnel with diverse educational backgrounds and work experiences at three different locations. The proficiency panel contained negative, low positive and moderate positive specimens. Each specimen level was tested at each site in replicates of at least six over a period of 3 days.

The results obtained at each site agreed >99% with the expected results. No significant differences were observed within run (6 replicates), between runs (3 different days) or between sites (3 POL sites).

ASSISTANCE

If you have any questions regarding the use of this product, please call Quidel's Technical Support Number 800.874.1517 (in the U.S.) or 858.552.1100, Monday through Friday, from 7:00 a.m. to 5:00 p.m., Pacific Time. If outside the U.S., contact your local distributor or technicalsupport@quidel.com.

REFERENCES

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REF 00317 - QuickVue Influenza - 25 Test Kit
00317IN - QuickVue Influenza - 25 Test Kit

IVD



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1011808EN00 (10/14)

REF

Catalogue number



CE mark of conformity

EC REP

Authorized Representative in
the European Community

LOT

Batch code



Use by



Manufacturer

STERILE EO

Method of sterilization
using ethylene oxide



Temperature limitation



Intended use



Consult instructions for use

IVD

For *In Vitro* diagnostic use



Contains sufficient for 25 determinations

CONT

Contents/Contains

CONTROL +

Positive control

CONTROL -

Negative control