

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

APPLICATION TO MARKET A NEW OR ABBREVIATED NEW DRUG OR BIOLOGIC FOR HUMAN USE

(Title 21, Code of Federal Regulations, Parts 314 & 601)

Form Approved: OMB No. 0910-0338

Expiration Date: March 31, 2020

See PRA Statement on page 3.

1. Date of Submission (mm/dd/yyyy)

APPLICANT INFORMATION

2. Name of Applicant

3. Telephone Number (Include country code if applicable and area code)

4. Facsimile (FAX) Number (Include country code if applicable and area code)

5. Applicant Address

Address 1 (Street address, P.O. box, company name c/o)

Email Address

Address 2 (Apartment, suite, unit, building, floor, etc.)

Applicant DUNS

City

State/Province/Region

U.S. License Number if previously issued

Country

ZIP or Postal Code

6. Authorized U.S. Agent (Required for non-U.S. applicants)

Authorized U.S. Agent Name

Telephone Number (Include area code)

Address 1 (Street address, P.O. box, company name c/o)

FAX Number (Include area code)

Address 2 (Apartment, suite, unit, building, floor, etc.)

Email Address

City

State

U.S. Agent DUNS

ZIP Code

PRODUCT DESCRIPTION

7. NDA, ANDA, or BLA Application Number

8. Supplement Number (If applicable)

9. Established Name (e.g., proper name, USP/USAN name)

10. Proprietary Name (Trade Name) (If any)

11. Chemical/Biochemical/Blood Product Name (If any)

12. Dosage Form

13. Strengths

14. Route of Administration

15A. Proposed Indication for Use

Is this indication for a rare disease (prevalence <200,000 in U.S.)? Yes No

Does this product have an FDA Orphan Designation for this indication?

If yes, provide the Orphan Designation number for this indication:

 Yes No

Continuation Page for #15

15B. SNOMED CT Indication Disease Term (Use continuation page for each additional indication and respective coded disease term)

APPLICATION INFORMATION16. Application Type
(Select one) New Drug Application (NDA) Biologics License Application (BLA) Abbreviated New Drug Application (ANDA)

17. If an NDA, identify the type

 505(b)(1) 505(b)(2)

18. If a BLA, identify the type

 351(a) 351(k)

19. If a 351(k), identify the biological reference product that is the basis for the submission.

Name of Biologic:

Holder of Licensed Application:

20. If an ANDA, or 505(b)(2), identify the listed drug product that is/are the basis for the submission.

Name of Drug:

Application Number of Relied Upon Product:

Indicate Patent Certification:

 P1 P2 P3 P4 Section viii - MOU Statement of no relevant patents

<p>21. Submission (See <i>instructions</i>) <input type="checkbox"/> Original <input type="checkbox"/> Labeling Supplement <input type="checkbox"/> CMC Supplement <input type="checkbox"/> Efficacy Supplement <input type="checkbox"/> Annual Report <input type="checkbox"/> Product Correspondence <input type="checkbox"/> REMS Supplement <input type="checkbox"/> Postmarketing Requirements or Commitments <input type="checkbox"/> Periodic Safety Report <input type="checkbox"/> Request for Proprietary Name Review <input type="checkbox"/> Other (<i>Specify</i>): _____</p>																																															
<p>22. Submission Sub-Type <input type="checkbox"/> Presubmission <input type="checkbox"/> Amendment <input type="checkbox"/> Initial Submission <input type="checkbox"/> Resubmission</p>				<p>23. If a supplement, identify the appropriate category. <input type="checkbox"/> CBE <input type="checkbox"/> Prior Approval (PA) <input type="checkbox"/> CBE-30</p>																																											
<p>24. For Originals and all Supplements, is the product a combination product (21 CFR 3.2(e))? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>				<p>Combination Product Type (See <i>instructions</i>)</p>		<p>Request for Designation (RFD) Number</p>																																									
<p>25. Does the submission contain: Human factors information? Only Pediatric data? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		<input type="checkbox"/> Yes <input type="checkbox"/> No		<p>26. Proposed Marketing Status (Select one) <input type="checkbox"/> Prescription Product (Rx) <input type="checkbox"/> Over-The-Counter Product (OTC)</p>																																											
<p>27. Reasons for Submission</p>																																															
<p>28. Establishment Information (Full establishment information should be provided in the body of the application.)</p>																																															
<table border="1"> <tr> <td colspan="4">Establishment Name</td> </tr> <tr> <td colspan="4">Address 1 (Street address, P.O. box, company name c/o)</td> <td colspan="3">Registration (FEI) Number</td> </tr> <tr> <td colspan="4">Address 2 (Apartment, suite, unit, building, floor, etc.)</td> <td colspan="3">MF Number</td> </tr> <tr> <td colspan="2">City</td> <td colspan="2">State/Province/Region</td> <td colspan="3">Establishment DUNS Number</td> </tr> <tr> <td colspan="2">Country</td> <td colspan="2">ZIP or Postal Code</td> <td colspan="3"></td> </tr> <tr> <td colspan="4">Is the establishment new to the application? <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td colspan="4">What is the status of the establishment? <input type="checkbox"/> Pending <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Withdrawn</td> </tr> </table>								Establishment Name				Address 1 (Street address, P.O. box, company name c/o)				Registration (FEI) Number			Address 2 (Apartment, suite, unit, building, floor, etc.)				MF Number			City		State/Province/Region		Establishment DUNS Number			Country		ZIP or Postal Code					Is the establishment new to the application? <input type="checkbox"/> Yes <input type="checkbox"/> No				What is the status of the establishment? <input type="checkbox"/> Pending <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Withdrawn			
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Continuation Page for #28																																															
<p>29. Cross References (List related BLAs, INDs, NDAs, PMAs, 510(k)s, IDEs, BMFs, MAFs, and DMFs referenced in the current application.)</p>																																															
Contin. Page for #29																																															
<p>30. This application contains the following items (Select all that apply)</p>																																															
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<i>Item 30 continued on page 3</i>																																															

30. This application contains the following items (*Continued; select all that apply*)

<input type="checkbox"/> 9. Safety update report (e.g., 21 CFR 314.50(d)(5)(vi)(b); 21 CFR 601.2)	<input type="checkbox"/> 10. Statistical section (e.g., 21 CFR 314.50(d)(6); 21 CFR 601.2)
<input type="checkbox"/> 11. Case report tabulations (e.g., 21 CFR 314.50(f)(1); 21 CFR 601.2)	<input type="checkbox"/> 12. Case report forms (e.g., 21 CFR 314.50 (f)(2); 21 CFR 601.2)
<input type="checkbox"/> 13. Patent information on any patent that claims the drug/biologic (21 U.S.C. 355(b) or (c))	<input type="checkbox"/> 14. A patent certification with respect to any patent that claims the drug/biologic (21 U.S.C. 355 (b)(2) or (j)(2)(A))
<input type="checkbox"/> 15. Establishment description (21 CFR Part 600, if applicable)	<input type="checkbox"/> 16. Debarment certification (FD&C Act 306 (k)(1))
<input type="checkbox"/> 17. Field copy certification (21 CFR 314.50 (l)(3))	<input type="checkbox"/> 18. User Fee Cover Sheet (PDUFA Form FDA 3397, GDUFA Form FDA 3794, BsUFA Form FDA 3792, or MDUFA Form FDA 3601)
<input type="checkbox"/> 19. Financial Disclosure Information (21 CFR Part 54)	
<input type="checkbox"/> 20. Other (Specify): _____	

CERTIFICATION

I agree to update this application with new safety information about the product that may reasonably affect the statement of contraindications, warnings, precautions, or adverse reactions in the draft labeling. I agree to submit safety update reports as provided for by regulation or as requested by FDA. If this application is approved, I agree to comply with all applicable laws and regulations that apply to approved applications, including, but not limited to, the following:

1. Good manufacturing practice regulations in 21 CFR Parts 210, 211 or applicable regulations, Parts 606, and/or 820.
2. Biological establishment standards in 21 CFR Part 600.
3. Labeling regulations in 21 CFR Parts 201, 606, 610, 660, and/or 809.
4. In the case of a prescription drug or biological product, prescription drug advertising regulations in 21 CFR Part 202.
5. Regulations on making changes in application in FD&C Act section 506A, 21 CFR 314.71, 314.72, 314.97, 314.99, and 601.12.
6. Regulations on Reports in 21 CFR 314.80, 314.81, 600.80, and 600.81.
7. Local, state, and Federal environmental impact laws.

If this application applies to a drug product that FDA has proposed for scheduling under the Controlled Substances Act, I agree not to market the product until the Drug Enforcement Administration makes a final scheduling decision.

The data and information in this submission have been reviewed and, to the best of my knowledge, are certified to be true and accurate.

Warning: A willfully false statement is a criminal offense, U.S. Code, title 18, section 1001.

31. Typed Name and Title of Applicant's Responsible Official		32. Date (mm/dd/yyyy)
33. Telephone Number (Include country code if applicable and area code)	34. FAX Number (Include country code if applicable and area code)	35. Email Address
36. Address of Applicant's Responsible Official		
Address 1 (Street address, P.O. box, company name c/o)		
Address 2 (Apartment, suite, unit, building, floor, etc.)		
City	State/Province/Region	
Country		ZIP or Postal Code
37. Signature of Applicant's Responsible Official or Other Authorized Official		38. Countersignature of Authorized U.S. Agent
Sign		Sign

The information below applies only to requirements of the Paperwork Reduction Act of 1995.

The burden time for this collection of information is estimated to average 24 hours per response, including the time to review instructions, search existing data sources, gather and maintain the data needed and complete and review the collection of information. Send comments regarding this burden estimate or any other aspect of this information collection, including suggestions for reducing this burden to the address to the right:

Department of Health and Human Services
Food and Drug Administration
Office of Operations
Paperwork Reduction Act (PRA) Staff
PRAStaff@fda.hhs.gov

"An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB number."

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