



DEPARTMENT OF HEALTH AND HUMAN SERVICES
Food and Drug Administration

Certification of Compliance

Under 42 U.S.C. § 282(j)(5)(B), with Requirements of ClinicalTrials.gov Data Bank

(For submission with an application/submission, including amendments, supplements, and resubmissions, under §§ 505, 515, 520(m), or 510(k) of the Federal Food, Drug, and Cosmetic Act or § 351 of the Public Health Service Act.)

SPONSOR / APPLICANT / SUBMITTER INFORMATION

1. Name of Sponsor/Applicant/Submitter ModernaTx, Inc		2. Date of the Application/Submission 08/25/2021	
3. Address		4. Telephone and Fax Numbers (Include country code if applicable and area code)	
Address 1 (Street address, P.O. box, company name c/o) 200 Technology Square		(Tel): 617-803-1357	
Address 2 (Apartment, suite, unit, building, floor, etc.)		(Fax):	
City Cambridge	State/Province/Region MA		
Country United States	ZIP or Postal Code 02139		

PRODUCT INFORMATION

5. **For Drugs/Biologics:** Include Any/All Available Established, Proprietary and/or Chemical/Biochemical/Blood/Cellular/Gene Therapy Product Name(s).

For Devices: Include Any/All Common or Usual Name(s), Classification, Trade or Proprietary or Model Name(s) and/or Model Number(s)

Spikevax

mRNA-1273

Moderna COVID-19 Vaccine

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APPLICATION / SUBMISSION INFORMATION

6. Type of Application/Submission Which This Certification Accompanies

☐ IND ☐ NDA ☐ ANDA ☒ BLA ☐ PMA ☐ HDE ☐ 510(k) ☐ PDP ☐ Other

7. Include IND/NDA/ANDA/BLA/PMA/HDE/510(k)/PDP/ Other Number
(If number previously assigned)

125752

If BLA was selected in item 6, provide Supplement Number

8. Serial Number Assigned to Application/Submission Which This Certification Accompanies

00003

CERTIFICATION STATEMENT / INFORMATION

9. Check only one of the following boxes (See instructions for additional information and explanation)

- ☐ A. I certify that the requirements of 42 U.S.C. § 282(j), Section 402(j) of the Public Health Service Act, including 42 CFR part 11, do not apply because the application/submission which this certification accompanies does not reference any clinical trial.
- ☐ B. I certify that the requirements of 42 U.S.C. § 282(j), Section 402(j) of the Public Health Service Act, including 42 CFR part 11, do not apply to any clinical trial referenced in the application/submission which this certification accompanies.
- ☒ C. I certify that the requirements of 42 U.S.C. § 282(j), section 402(j) of the Public Health Service Act, apply to one or more of the clinical trials referenced in the application/submission which this certification accompanies and that the requirements of 42 U.S.C. 282(j), including any applicable provisions of 42 CFR part 11, have been met.

Certification Statement / Information section continued on page 2

CERTIFICATION STATEMENT / INFORMATION (Continued)

10. If you checked box C, in number 9, provide the National Clinical Trial (NCT) Number(s) for any "applicable clinical trial(s)," for which you (the sponsor/applicant/submitter) are the "responsible party" under 42 U.S.C. § 282(j)(1)(a)(i), section 402(j)(1)(a)(i) of the Public Health Service Act referenced in the application/ submission which this Certification accompanies. (Add continuation page as necessary.)

NCT Number(s): _____

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The undersigned declares, to the best of her/his knowledge, that this is an accurate, true, and complete submission of information. I understand that the failure to submit the certification required by 42 U.S.C. § 282(j)(5)(B), section 402(j)(5)(B) of the Public Health Service Act, and the knowing submission of a false certification under such section are prohibited acts under 21 U.S.C. § 331, section 301 of the Federal Food, Drug, and Cosmetic Act.

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

11. Name and Title of the Person who Signs Number 15

Name	Title
Michelle Olsen	Associate Director Global Regulatory Affairs

12. Address

Address 1 (Street address, P.O. box, company name c/o) 200 Technology Square		13. Telephone and Fax Numbers (Include country code if applicable and area code) (Tel): 617-417-4428 (Fax): _____
Address 2 (Apartment, suite, unit, building, floor, etc.)		
City Cambridge	State/Province/Region MA	
Country United States	ZIP or Postal Code 02139	

14. Date of Certification

08/16/2021

15. Signature of Sponsor/Applicant/Submitter or an Authorized Representative (Sign)

Sign

Michelle Olsen

Digitally signed by Michelle Olsen
Date: 2021.08.16 12:42:42 -04'00'

This section applies only to requirements of the Paperwork Reduction Act of 1995.

DO NOT SEND YOUR COMPLETED FORM TO THE PRA STAFF EMAIL ADDRESS BELOW.

The burden time for this collection of information is estimated to average 15 minutes and 45 minutes (depending on the type of application/ submission) 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:

Department of Health and Human Services
Food and Drug Administration
Office of Chief Information Officer
Paperwork Reduction Act (PRA) Staff
PRASStaff@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."