The InflaRx Commitment Program for GOHIBIC® (vilobelimab)

HOSPITAL DECLARATIONS AND AUTHORIZATIONS FORM

(TO BE COMPLETED BY AN AUTHORIZED HOSPITAL REPRESENTATIVE)

PLEASE READ THE FOLLOWING AND PROVIDE THE APPROPRIATE INFORMATION INCLUDING THE REQUIRED SIGNATURE REQUESTED ON PAGE 2. FAILURE TO COMPLETE THIS FORM WILL DELAY THE PROCESSING OF YOUR CLAIM.

Please complete all sections of this form.

The information you provide will be used by the InflaRx administrator to determine eligibility, to administer program claims, to manage and improve the Program and to communicate with you about the Program.

By signing this form, I agree to the following: Completing the Claim Form, Physician Attestation Form, and the Hospital Declarations and Authorizations Form does not guarantee that the Hospital will qualify for the Program. InflaRx may contact the Hospital to administer the Program. InflaRx may verify the accuracy of the information I have provided and may ask for more information. InflaRx reserves the right to change or cancel the Program at any time. Should InflaRx change or cancel the program, it will continue to honor valid warranty claims related to qualifying doses of GOHIBIC dispensed during the period in which the program was in effect as long as a claim is brought forward within 90 days following the date of the related patient's death. Any benefits provided under the Program are not contingent on any future purchase.

I certify and attest to the following:

☐	I am an authorized representative to file the claim on behalf of the Hospital.
☐	Hospital has purchased the product through the InflaRx authorized distributor.
☐	Hospital has not requested reimbursement from any third party (e.g., insurance company, Medicaid, Medicare, patient, etc.) for the acquisition cost of GOHIBIC treatment subject to the Program.
☐	Hospital will fully and accurately report the amount refunded to it as part of the Program in the applicable cost reporting mechanism or claim for payment filed with the Department of Health and Human Services or a state Medicaid agency. Furthermore, Hospital will provide, upon request by the Secretary of the Department of Health and Human Services or a state Medicaid agency, information provided to Hospital regarding the amount returned to you under the Program.
☐	This is the <u>only</u> program claim for this patient per the Physician Attestation Form.
☐	GOHIBIC was administered to the patient in accordance with its FDA emergency use authorization (EUA) and related fact sheet information for prescribers.
☐	Patient died in the Intensive Care Unit (ICU), where GOHIBIC treatment was administered, either during active treatment with GOHIBIC or following the administration of all 6 doses, due to complications from COVID-19 disease.

I declare that, to the best of my knowledge and belief, all the information provided in support of this claim is complete, true and accurate. I understand that if I made or shall make any false or fraudulent statements or withhold material facts relating to this claim, this could result in Hospital disqualification of the benefits.

Acknowledgement of Federal and State Fraud Laws:

WARNING: Any person who knowingly and with the intent to injure, defraud, or deceive person or entity, who files a statement of claim containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act, which may be a crime and may be subject to criminal prosecution and civil penalties under federal and state laws.

Consent to Receive Electronic Communications

I agree to receive electronic communications from InflaRx to determine eligibility and administer program claims. I agree to be contacted by InflaRx for these purposes, including using an autodialer or prerecorded voice at the telephone number(s) provided. By requesting for InflaRx to communicate with me electronically, I consent to electronic delivery of notices, disclosures, documents, and other communications from InflaRx via the communications method indicated in this form in relation to this claim, including leaving voicemails on the phone number indicated below. I agree to check my messages and/or email accounts and to inform InflaRx of any changes to the information below. I agree that all notices, disclosures, and other communications that InflaRx provides to me electronically satisfies any legal requirements that such communications should be in writing. I understand that I can opt out of these communications at any time by contacting InflaRx at 1-888-618-7445.

Hospital Name	
Mailing Address (Street, City, State, Zip)	
Hospital Representative Name (Print)	
Hospital Representative Email	
Hospital Representative Fax (if applicable)	
Hospital Representative Phone	

Hospital Representative Signature	
Hospital Representative Title	
Date	