The InflaRx Commitment Program for GOHIBIC® (vilobelimab)

PROGRAM CLAIM FORM

(TO BE COMPLETED BY AN AUTHORIZED HOSPITAL REPRESENTATIVE)

IMPORTANT NOTE:
Please complete ALL sections of this form.
An incomplete form may cause a delay in our assessment of your claim. Please either type your responses or print clearly.

Documents Required:

- **Signed and completed Program Claim Form with proof of purchase evidence.**
- **Signed and completed Hospital Declarations and Authorizations Form.**
- **Signed and completed Physician Attestation Form.**

To enable InflaRx to process your claim expeditiously, please return the completed claim form with supporting documents as listed in the subsequent section. Please direct the claim form and all correspondence to:

The InflaRx Commitment Program Administrator
Email: inflarxcommitment@inflarx.com
Fax: 1-734-249-5300
For Questions, please call 1(888) 618-7445

All benefits are paid in accordance with the terms and conditions of the Program. The acceptance of this claim form is NOT an admission of liability on the part of InflaRx Pharmaceuticals Inc, including its affiliates. Any documentary proof or report required to process this claim shall be furnished at the expense of the Hospital. This program and benefits are provided to you as part of the InflaRx Commitment Program.

PATIENT INFORMATION (FOR PHARMACOVIGILANCE REPORTING PURPOSES)		
Patient Initials:	Gender:	Date of Birth (MM/DD/YYYY):
HOSPITAL INFORMATION		
Hospital Name:	Mailing Address (Street, City, State, Zip):	
Tax ID Number (TIN):	Hospital ID Number (HIN):	

The inflaRx Commitment

AUTHORIZED HOSPITAL REPRESENTATIVE INFORMATION	
Hospital Representative Name (First, Middle, Last)	Title:
Department:	Mailing Address, If different than hospital (Street, City, State, Zip):
Email Address: All communication regarding claims status update will be sent via email.	Email:
Phone Number:	Fax Number:

By requesting for us to communicate with you electronically, you consent to electronic delivery of notices, disclosures, documents, and other communications InflaRx via the communications method indicated above in relation to your claim, including leaving voicemails on the phone number indicated above. If applicable, you also agree to check your messages and/or email accounts and to inform InflaRx of any changes to the above information. You agree that all notices, disclosures, and other communications that we provide to you electronically satisfy any legal requirements that such communications should be in writing.

TREATING PHYSICIAN INFORMATION
Treating Physician Name (First, Middle, Last)
Business Mailing Address, if different than hospital (Street, City, State, Zip):

PRODUCT INFORMATION	
Product Name:	
Product LOT Number:	**Product Dosage:**

GOHIBIC CLAIM REASON
Please confirm the reason and condition for your CLAIM

☐	• **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.**

GOHIBIC CLAIM DETAILS		
Date of Hospital Admission:		
Date of first GOHIBIC treatment initiation:		Date of Patient Death
Number of GOHIBIC i.v. treatments (doses) administered (maximum = 6)		

Date of GOHIBIC Administration
Please specify the date of GOHIBIC dose infusion

Dose 1 [Date]:	**Dose 2 [Date]:**	**Dose 3 [Date]:**
Dose 4 [Date]:	**Dose 5 [Date]:**	**Dose 6 [Date]:**