The InflaRx Commitment Program for GOHIBIC® (vilobelimab)

PHYSICIAN ATTESTATION FORM

(TO BE COMPLETED BY TREATING PHYICIAN)

Please email the **completed** forms to inflarxcommitment@inflarx.com or fax 1-734-249-5300.
For questions, please call 1 (888) 618-7445. The information you provide will be used by InflaRx's administrator to determine eligibility and administer program claims.

Prescribing Physician

Prescribing Physician Information	
Name (First/m/Last)	
NPI#	
State License #	
E-mail	
Office Phone	

Site of Care

Site of Care Information	
Hospital Name	
Specify Intensive Care Ward	
Address, City, State, Zip	
E-mail	

Important Questions*:

YES	**NO**	
		Did the patient receive (either prior or concomitantly) another approved immunomodulator treatment for the COVID-19 disease (e.g. tocilizumab or baricitinib): If yes, please specify here: ______________________
		To my professional assessment, COVID-19 disease was a contributing factor in the death for the patient who received GOHIBIC.

***Please note these questions are not mandatory, but would be helpful in our ongoing development of GOHIBIC**

I certify the following*:

***Important to note, *all four boxes* need to be checked to validate your claim under the InflaRx Commitment Program.**

	Patient had a positive COVID-19 diagnosis.
	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 have read and acknowledge the following (which is stated in the GOHIBIC Letter of Authorization which was provided upon receipt of GOHIBIC to our institution): Healthcare facilities and healthcare providers receiving GOHIBIC will track all serious adverse events and medication errors that are considered to be potentially related to GOHIBIC use and must report these to FDA in accordance with the Fact Sheet for Healthcare Providers. Complete and submit a MedWatch form (www.fda.gov/medwatch/report.htm), or complete and submit FDA Form 3500 (health professional) by fax (1-800-FDA-0178). Call 1-800-FDA-1088 for questions. Submitted reports must state, “GOHIBIC use for COVID-19 under Emergency Use Authorization” at the beginning of the question “Describe Event” for further analysis. A copy of the completed FDA Form 3500 must also be provided to InflaRx per the instructions in the authorized labeling.

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.

Healthcare Provider Consent
I understand that completing this attestation form does not guarantee that a warranty remedy will be provided to the hospital. I will comply with and abide by my State Practitioner Dispensing Laws for authorized Prescribers, when applicable. I understand that the information provided on this attestation form is subject to random audits and verification. 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 remained in effect.

Telephone Consumer Protection Act (TCPA) Attestation
I also give my permission to receive calls related to these services from InflaRx, and parties acting on their behalf, including calls made with an auto dialer or prerecorded voice at the phone number(s) provided regarding the purposes described above. I consent to providing my information to InflaRx as it relates to the InflaRx Commitment Program.

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.

Physician Signature	
Date	
Physician Contact Information (Email)	