

Fill in this information to identify the case:

Debtor 1 Eiger BioPharmaceuticals, Inc.

Debtor 2
(Spouse, if filing) _____

United States Bankruptcy Court for the: Northern District of Texas

Case number 24-80040-sgj

Official Form 410**Proof of Claim**

04/16

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Do not use this form to make a request for payment of an administrative expense. Make such a request according to 11 U.S.C. § 503.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies of any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. **Do not send original documents;** they may be destroyed after scanning. If the documents are not available, explain in an attachment.

A person who files a fraudulent claim could be fined up to \$500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

Fill in all the information about the claim as of the date the case was filed. That date is on the notice of bankruptcy (Form 309) that you received.

Part 1: Identify the Claim

1. Who is the current creditor?	<u>State of Wisconsin Department of Health Services</u> Name of the current creditor (the person or entity to be paid for this claim)	
	Other names the creditor used with the debtor _____	
2. Has this claim been acquired from someone else?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. From whom? _____	
3. Where should notices and payments to the creditor be sent? Federal Rule of Bankruptcy Procedure (FRBP) 2002(g)	Where should notices to the creditor be sent? <u>Michael D. Morris</u> Name <u>P. O. Box 7857</u> Number Street <u>Madison WI 53707</u> City State ZIP Code Contact phone <u>608-266-3936</u> Contact email <u>morrismd@doj.state.wi.us</u>	Where should payments to the creditor be sent? (if different) <u>Anthony Davenport</u> Name <u>1 West Wilson Street</u> Number Street <u>Madison WI 53703</u> City State ZIP Code Contact phone <u>608 267 7724</u> Contact email _____
Uniform claim identifier for electronic payments in chapter 13 (if you use one): _____		
4. Does this claim amend one already filed?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Claim number on court claims registry (if known) _____ Filed on _____ MM / DD / YYYY	
5. Do you know if anyone else has filed a proof of claim for this claim?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Who made the earlier filing? _____	



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Part 2: Give Information About the Claim as of the Date the Case Was Filed

6. Do you have any number you use to identify the debtor? ☒ No
☐ Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor: ____

7. How much is the claim? \$ 246,094.00 Does this amount include interest or other charges?
☒ No
☐ Yes. Attach statement itemizing interest, fees, expenses, or other charges required by Bankruptcy Rule 3001(c)(2)(A).

8. What is the basis of the claim? Examples: Goods sold, money loaned, lease, services performed, personal injury or wrongful death, or credit card.
Attach redacted copies of any documents supporting the claim required by Bankruptcy Rule 3001(c).
Limit disclosing information that is entitled to privacy, such as health care information.

Medicaid Drug Rebate Program - see attachment

9. Is all or part of the claim secured? ☒ No
☐ Yes. The claim is secured by a lien on property.

Nature of property:
☐ Real estate. If the claim is secured by the debtor's principal residence, file a *Mortgage Proof of Claim Attachment* (Official Form 410-A) with this *Proof of Claim*.
☐ Motor vehicle
☐ Other. Describe: _____

Basis for perfection: _____
Attach redacted copies of documents, if any, that show evidence of perfection of a security interest (for example, a mortgage, lien, certificate of title, financing statement, or other document that shows the lien has been filed or recorded.)

Value of property: \$ _____
Amount of the claim that is secured: \$ _____
Amount of the claim that is unsecured: \$ _____ (The sum of the secured and unsecured amounts should match the amount in line 7.)

Amount necessary to cure any default as of the date of the petition: \$ _____

Annual Interest Rate (when case was filed) _____ %
☐ Fixed
☐ Variable

10. Is this claim based on a lease? ☒ No
☐ Yes. Amount necessary to cure any default as of the date of the petition. \$ _____

11. Is this claim subject to a right of setoff? ☒ No
☐ Yes. Identify the property: _____

12. Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?

☒ No

☐ Yes. Check one:

☐ Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).

☐ Up to \$2,850* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(7).

☐ Wages, salaries, or commissions (up to \$12,850*) earned within 180 days before the bankruptcy petition is filed or the debtor's business ends, whichever is earlier. 11 U.S.C. § 507(a)(4).

☐ Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).

☐ Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).

☐ Other. Specify subsection of 11 U.S.C. § 507(a)() that applies.

Amount entitled to priority

\$ _____

\$ _____

\$ _____

\$ _____

\$ _____

\$ _____

* Amounts are subject to adjustment on 4/01/19 and every 3 years after that for cases begun on or after the date of adjustment.

Part 3: Sign Below

The person completing this proof of claim must sign and date it. FRBP 9011(b).

If you file this claim electronically, FRBP 5005(a)(2) authorizes courts to establish local rules specifying what a signature is.

A person who files a fraudulent claim could be fined up to \$500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

Check the appropriate box:

☒ I am the creditor.

☐ I am the creditor's attorney or authorized agent.

☐ I am the trustee, or the debtor, or their authorized agent. Bankruptcy Rule 3004.

☐ I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

I understand that an authorized signature on this *Proof of Claim* serves as an acknowledgment that when calculating the amount of the claim, the creditor gave the debtor credit for any payments received toward the debt.

I have examined the information in this *Proof of Claim* and have a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 04/22/2024
MM / DD / YYYY

Anthony P. Davenport
Signature

Print the name of the person who is completing and signing this claim:

Name Anthony P. Davenport
First name Middle name Last name

Title Attorney

Company Wisconsin Department of Health Services
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address 1 West Wilson Street
Number Street

Madison WI 53707
City State ZIP Code

Contact phone 608 264 7724 Email anthony.p.davenport@dhs.wisconsin.

**STATE OF WISCONSIN DEPARTMENT OF HEALTH SERVICES
ATTACHMENT TO PROOF OF CLAIM**

This claim is a contingent and unliquidated claim for debts owed to the Department under the Federal Medicaid Drug Rebate Program in the event the debtor ceases to participate in the program. The debtor has the following labeler codes active in the rebate program.

Labeler Code	Labeler Name
73079	Eiger Biopharmaceuticals Inc.

As long as the debtor continues to participate in the program, the Department will continue to adjust balances according to the program. Should the debtor cease participation in the rebate program, the Department will file an amended claim for the balance owed based upon the last quarterly adjustment.

Labeler Code	Labeler Name	Invoice Period	Invoice Type	Mail Date	Total Rebate Amt Claimed	Total Rebate Amt Paid	Total Writeoff Amt	Rebate Amt Balance Due	Total Dispute Amt	Total Interest Amt Billed	Total Interest Amt Paid	Interest Amt Written Off	Interest Amt Due	Total Balance Due
73079	Eiger Biopharmaceuticals Inc.	4Q2023	Medicaid	2/28/2024	\$67,673.95	\$0.00	\$0.00	\$67,673.95	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$67,673.95
73079	Eiger Biopharmaceuticals Inc.	3Q2023	Medicaid	11/21/2023	\$67,673.95	\$0.00	\$0.00	\$67,673.95	\$0.00	\$929.11	\$0.00	\$0.00	\$929.11	\$68,603.06
73079	Eiger Biopharmaceuticals Inc.	2Q2023	Medicaid	8/22/2023	\$63,845.68	\$0.00	\$0.00	\$63,845.68	\$0.00	\$1,719.97	\$0.00	\$0.00	\$1,719.97	\$65,565.65
73079	Eiger Biopharmaceuticals Inc.	1Q2023	Medicaid	5/24/2023	\$21,281.89	\$0.00	\$0.00	\$21,281.89	\$0.00	\$850.41	\$0.00	\$0.00	\$850.41	\$22,132.30
73079	Eiger Biopharmaceuticals Inc.	1Q2022	Medicaid	5/25/2022	\$20,463.18	\$0.00	\$0.00	\$20,463.18	\$0.00	\$1,655.86	\$0.00	\$0.00	\$1,655.86	\$22,119.04
Total													Interest	Grand Total
\$240,938.65													\$5,155.35	\$246,094.00