EGETIS THERAPEUTICS

Corporate presentation

August 2021

A new specialised late-stage orphan drug development company

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Agenda

1. A new specialised late-stage orphan drug development company
2. Emcitate®
   - Clinical development programme
   - Commercial opportunity
3. Aladote®
   - Clinical development programme
   - Commercial opportunity
4. The Orphan drug segment and path to market
5. Summary

A. Appendix

1.

A new specialised late-stage orphan drug development company

New specialised late-stage orphan drug development company

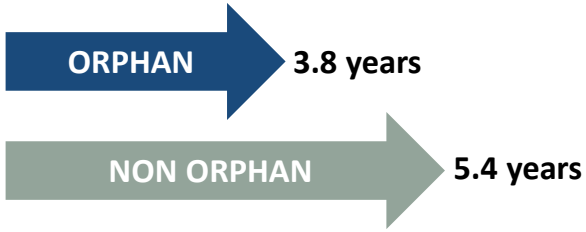
1. Dedicated orphan drug development company with two late-stage orphan drug assets: **Emcitate®** and **Aladote®**
2. Highly attractive **orphan drug segment** with potential **>$1Bn annual sales opportunity**
3. Clear path to **market approval in EU and US** within **3 years**
4. Plan to **launch** through niche inhouse commercial organization in the EU and US
5. Combined core expertise in **late-stage orphan clinical development, registration and commercialization** with experience from:

sobi Pioneer in Rare Diseases · WILSON THERAPEUTICS · Medical Need · NOVARTIS · AstraZeneca · ALEXION

Orphan drug segment – a highly attractive opportunity

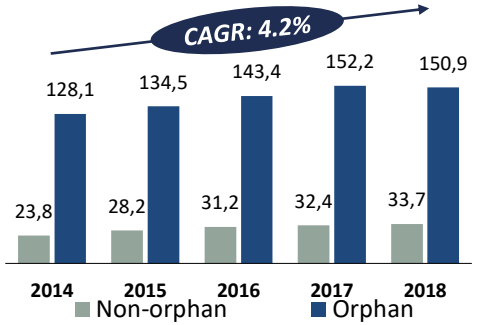
Shorter clinical development time[1]

Phase II to launch Average # of years



Higher attainable prices[2]

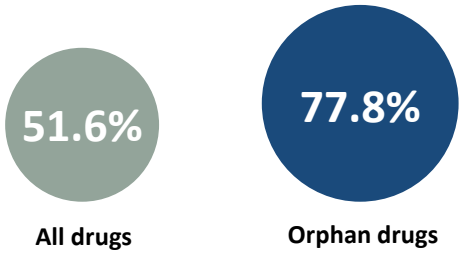
Mean cost per patient and year (USDk)



Higher probability of success[3]

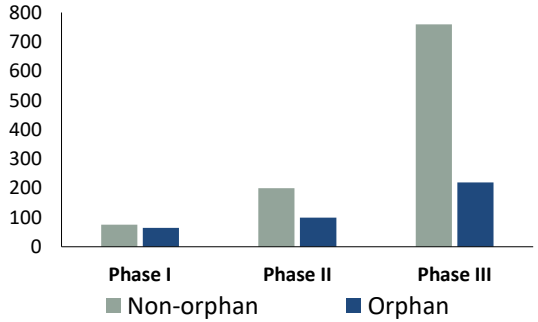
Phase III to approval

POS in metabolic/endocrinology indications

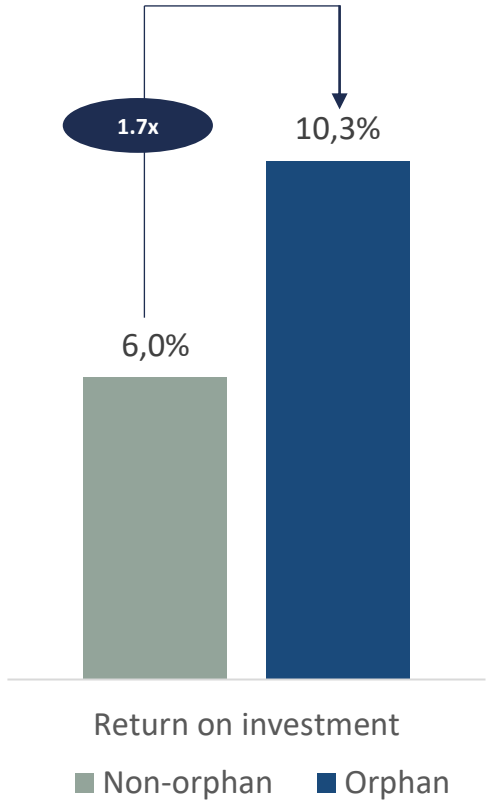


Fewer patients for clinical trials[4]

Patients per trial



Orphan drugs attractive returns[5]



Source: (1) Orphan drugdevelopment: an economically viable strategy for biopharma R&D, Meekings, Williams & Arrowsmith, 2012; (2) EvaluatePharma; (3) Estimation of clinical trial success rates and related parameters, C. Wong, K. Siah, A. Lo, Biostatistics, 2019; (4) BioMed Central; (5) EvaluatePharma Orphan Drug Report 2013 Note: Orphan Drugs: Populations of less than 5/10,000 inhabitants in the EU or <200,000 inhabitants in the US

Late-stage orphan drug pipeline addressing billion dollar markets

Candidate	Pre-clinical	Phase I	Phase II	Phase III	Approval
Emcitate®	Phase IIb/III				
Aladote®	Phase IIb/III				

Two highly promising orphan drug candidates

Emcitate® – *Therapy for genetic disturbance in thyroid hormone signalling with life-long severe disability*

- Lead candidate for addressing MCT8 deficiency, a condition with high unmet medical need and no available treatment
- Rare disease which affects ~1:70,000 males
- Obtained Orphan drug designation in the EU and US 2017 and 2019 respectively. **US Rare Paediatric Disease Designation received in November 2020**, eligible for Priority Review Voucher.
- Phase IIb clinical trial completed with significant and clinically relevant effects
- Pivotal Phase IIb/III early intervention trial in young subjects initiated with **first patient dosed in Dec 2020**. Patient recruitment progresses according to plan and expected to be completed in Q4 2021.
- No competing products in clinical development
- More than 120 patients are being **treated** with Emcitate on a **named patient basis**, following individual regulatory approval from the national regulatory agency.

Aladote® – *Prevents acute liver injury caused by paracetamol/acetaminophen poisoning*

- Paracetamol poisoning is one of the most common overdose with >175,000 hospital admissions globally per annum
- No adequate treatment for increased risk patients exists
- Orphan drug designation (ODD) granted in 2019 in the US
- Application submitted for ODD in the EU in Q1 2021
- Successful results from Phase Ib/IIa study in paracetamol overdosed patients
- Pivotal Phase IIb/III study planned for marketing authorisation application in both US and EU, targeting study start end 2021 pending the COVID-19 pandemic situation
- No competing products in clinical development

2.

Emcitate® - clinical development programme

MCT8 deficiency: a detrimental condition with significant unmet medical need

What is MCT8 deficiency?

- Genetic disorder resulting in impaired thyroid hormone trafficking across cellular membranes
- MCT8 is one of the key thyroid hormone transporters in the body
- Mutation located to the X chromosome, affecting only males
- Estimated prevalence of 1:70,000 males

Patients with MCT8 Deficiency[1)]

What does it mean?

- Absence of a functional MCT8 protein means that thyroid hormone is not able to pass into cells dependent on MCT8 and importantly cross the blood-brain-barrier, resulting in too low or no thyroid hormone levels in such tissues, including the brain
- Disrupted feedback loop mechanism results in a compensatory increase in circulating thyroid hormone
- Tissues depending on other transporters than MCT8 for thyroid hormone transport will suffer from too high thyroid hormone levels

- Simultaneous too high and too low thyroid hormone stimulation in different tissues

What are the challenges?

- Patients appear normal at birth with normal weight, length and head circumference with no evident signs of significant thyroid hormone disturbance
- Initial symptoms appear within the first months of life
- Disruption of normal neurodevelopment in childhood resulting in severe intellectual disability.
- Most patients never develop autonomy or ability to sit or walk and have limited ability to communicate
- Life-long morbidity from disturbed thyroid hormone pattern, resulting in agitation, cardiovascular symptoms, wasting and impaired life expectancy
- Heavily dependant on caregivers resulting in very high disease burden

How do you manage the disease?

- Currently no therapy available to address the root cause of the disorder
- Standard therapeutic approaches for thyroid dysfunction not effective or suitable
- Easy diagnosis once considered with readily available, low-cost laboratory test
- Large proportion of patients remain undiagnosed with significant delay to diagnosis

- Significant unmet medical need from a humanitarian, health economic and societal perspective

Quick facts from natural history[2]

Median life expectancy:	**35 years**
Median onset of symptoms:	**4 months**
Median age of diagnosis:	**24 months**
Patients surviving into adulthood:	**70%**
Severe intellectual disability:	**100%**
Global delay in myelination:	**100%**
Reduced white matter volume:	**100%**
Neurocognitive development age:	**<12m**
Ability to sit independently:	**8%**
Global hypotonia, hypertonia and persistence of primitive reflexes:	**90%**
Requires tube feeding:	**36%**
Severe underweight:	**75%**
Cardiac arrythmias (PAC):	**76%**
Life long 24-hour care:	**100%**

Note: 1) Picture from Schwarz et al; Clin Endocrinol & Met 2007; 2) Groeneweg et al, Lancet Diabetes & Endocrinology, 2020

Orphan drug candidate

with clear scientific and mechanistic rationale and established safety profile

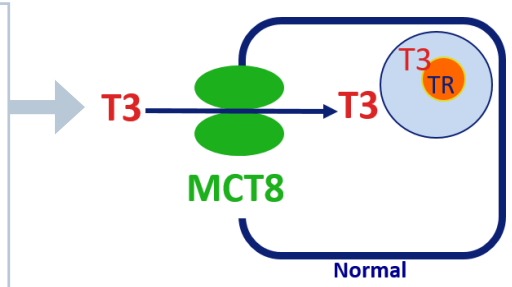
Difference normal MCT8 and deficiency of MCT8

- Thyroid hormone T3 requires transporters such as MCT8 to enter the target cells

Normal MCT8 ✔

- Functional thyroid gland producing T3
- Functioning production of MCT8

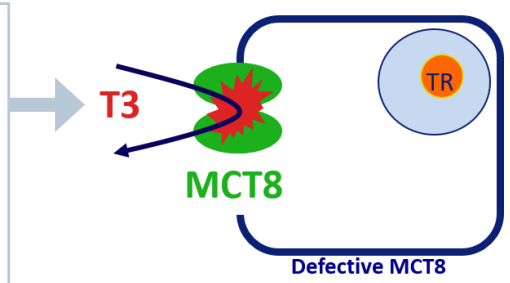
→ T3 cross the cellular membrane and enters the target cell



Mutated MCT8 ✘

- Functional thyroid gland producing T3
- MCT8 deficiency leads to absence or loss of function of MCT8 on the cell surface

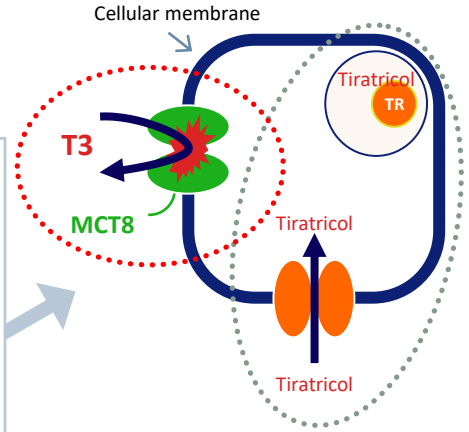
→ T3 cannot cross the cellular membrane and fails to enter the target cell



Emcitate (tiratricol) – Addressing the MCT8 deficiency

- Tiratricol is a thyroid hormone analogue with high chemical and structural similarity to T3
- Unlike T3, tiratricol can cross cellular membranes without a functional MCT8 transporter
- Tiratricol can bypass the problem in patients with MCT8 deficiency, enter MCT8 deficient cells and restore thyroid hormone signalling
- Experience from 40 years on the French market in a different indication, owned and controlled by company

Emcitate in action



Without a functioning MCT8, the T3 is unable to be transported across the cellular membrane to enter the target cell ✘

Emcitate (Tiratricol) is able to enter the cell without MCT8 and restore thyroid hormone signalling ✔

Overview of completed Phase IIb

Primary objective and results

- Evaluate the efficacy and safety of oral administration of tiratricol in male patients with MCT8 deficiency of all ages
- Highly significant primary outcome - Change in T3 serum concentrations
- Safe and tolerable
- Results published in Lancet 2019

Secondary objective and results

- Change in other thyroid hormone function tests, thyrotoxic symptoms and markers
- Significant and clinically relevant effects observed across secondary endpoints

Description

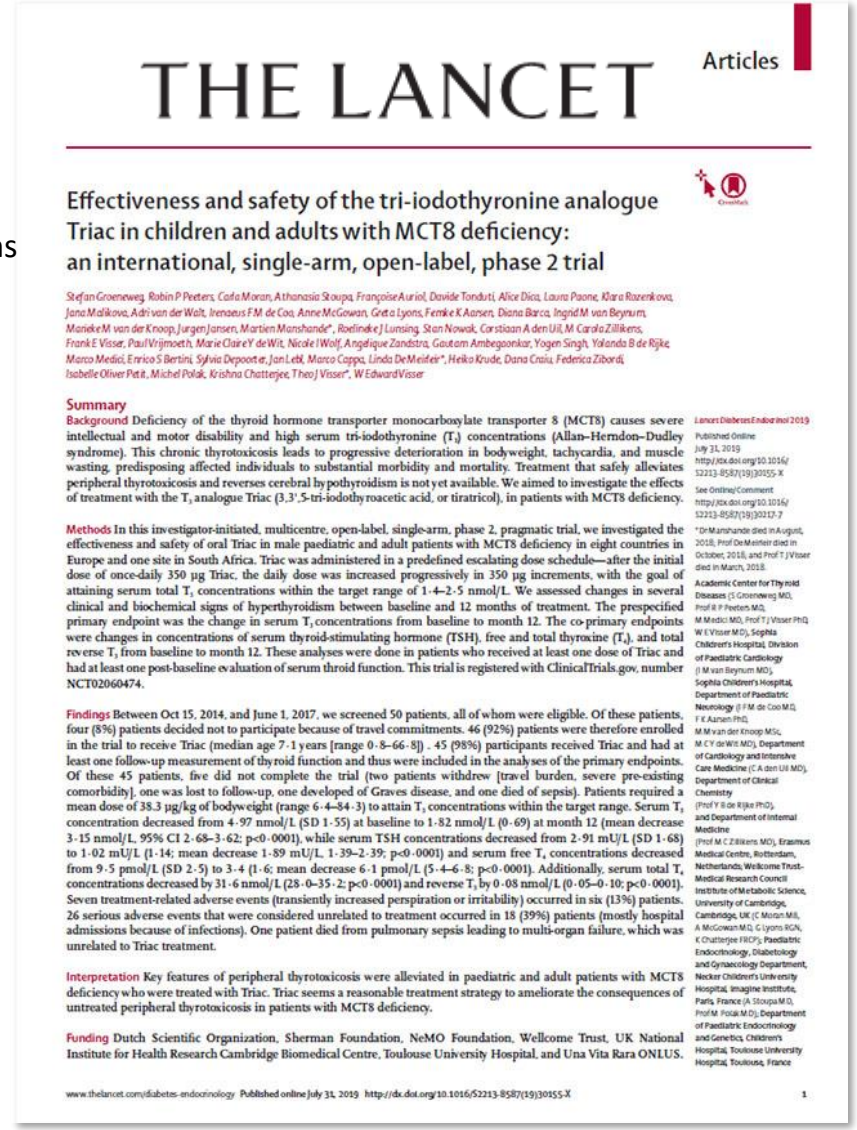
- An international, single-arm, open-label, Phase II trial
- ClinicalTrials.gov identifier: NCT02060474

# of patients

- 46 MCT8 patients in 9 countries

Timetable

- Initiated in October 2014 (first patient in)
- Completed in June 2018



THE LANCET

Articles

Effectiveness and safety of the tri-iodothyronine analogue Triac in children and adults with MCT8 deficiency: an international, single-arm, open-label, phase 2 trial

Stefan Groeneweg, Robin P Peeters, Carla Moran, Athanasia Stoupa, Françoise Auriol, Davide Tonduti, Alice Dicu, Laura Paone, Klara Rozenkova, Jana Malikova, Adri van der Walt, Irenaeus F.M. de Coo, Anne McGowan, Greta Lyons, Femke K Aansen, Diana Barca, Ingrid M. van Beynum, Marieke M. van der Knoop, Jurgen Jansen, Martien Manshande*, Roelinde J Lunsing, Stan Nowak, Corstiaan A den Uil, M Carola Zillikens, Frank E Visser, Paul Vrijmoeth, Marie Claire Y de Wit, Nicole I Wolf, Angelique Zandstra, Gautam Ambegaonkar, Yogen Singh, Yolanda B de Rijke, Marco Medici, Enrico S Bertini, Sylvia Depoorter, Jan Lebl, Marco Cappa, Linda De Meirleir*, Heiko Krude, Dana Craiu, Federica Zibordi, Isabelle Oliver Petit, Michel Polak, Krishna Chatterjee, Theo J Visser*, W Edward Visser

Summary

Background Deficiency of the thyroid hormone transporter monocarboxylate transporter 8 (MCT8) causes severe intellectual and motor disability and high serum tri-iodothyronine (T_3) concentrations (Allan–Herndon–Dudley syndrome). This chronic thyrotoxicosis leads to progressive deterioration in bodyweight, tachycardia, and muscle wasting, predisposing affected individuals to substantial morbidity and mortality. Treatment that safely alleviates peripheral thyrotoxicosis and reverses cerebral hypothyroidism is not yet available. We aimed to investigate the effects of treatment with the T_3 analogue Triac (3,3',5-tri-iodothyroacetic acid, or tiratricol), in patients with MCT8 deficiency.

Methods In this investigator-initiated, multicentre, open-label, single-arm, phase 2, pragmatic trial, we investigated the effectiveness and safety of oral Triac in male paediatric and adult patients with MCT8 deficiency in eight countries in Europe and one site in South Africa. Triac was administered in a predefined escalating dose schedule—after the initial dose of once-daily 350 µg Triac, the daily dose was increased progressively in 350 µg increments, with the goal of attaining serum total T_3 concentrations within the target range of 1·4–2·5 nmol/L. We assessed changes in several clinical and biochemical signs of hyperthyroidism between baseline and 12 months of treatment. The prespecified primary endpoint was the change in serum T_3 concentrations from baseline to month 12. The co-primary endpoints were changes in concentrations of serum thyroid-stimulating hormone (TSH), free and total thyroxine (T_4), and total reverse T_3 from baseline to month 12. These analyses were done in patients who received at least one dose of Triac and had at least one post-baseline evaluation of serum throid function. This trial is registered with ClinicalTrials.gov, number NCT02060474.

Findings Between Oct 15, 2014, and June 1, 2017, we screened 50 patients, all of whom were eligible. Of these patients, four (8%) patients decided not to participate because of travel commitments. 46 (92%) patients were therefore enrolled in the trial to receive Triac (median age 7·1 years [range 0·8–66·8]) . 45 (98%) participants received Triac and had at least one follow-up measurement of thyroid function and thus were included in the analyses of the primary endpoints. Of these 45 patients, five did not complete the trial (two patients withdrew [travel burden, severe pre-existing comorbidity], one was lost to follow-up, one developed of Graves disease, and one died of sepsis). Patients required a mean dose of 38·3 µg/kg of bodyweight (range 6·4–84·3) to attain T_3 concentrations within the target range. Serum T_3 concentration decreased from 4·97 nmol/L (SD 1·55) at baseline to 1·82 nmol/L (0·69) at month 12 (mean decrease 3·15 nmol/L, 95% CI 2·68–3·62; p<0·0001), while serum TSH concentrations decreased from 2·91 mU/L (SD 1·68) to 1·02 mU/L (1·14; mean decrease 1·89 mU/L, 1·39–2·39; p<0·0001) and serum free T_4 concentrations decreased from 9·5 pmol/L (SD 2·5) to 3·4 (1·6; mean decrease 6·1 pmol/L (5·4–6·8; p<0·0001). Additionally, serum total T_4 concentrations decreased by 31·6 nmol/L (28·0–35·2; p<0·0001) and reverse T_3 by 0·08 nmol/L (0·05–0·10; p<0·0001). Seven treatment-related adverse events (transiently increased perspiration or irritability) occurred in six (13%) patients. 26 serious adverse events that were considered unrelated to treatment occurred in 18 (39%) patients (mostly hospital admissions because of infections). One patient died from pulmonary sepsis leading to multi-organ failure, which was unrelated to Triac treatment.

Interpretation Key features of peripheral thyrotoxicosis were alleviated in paediatric and adult patients with MCT8 deficiency who were treated with Triac. Triac seems a reasonable treatment strategy to ameliorate the consequences of untreated peripheral thyrotoxicosis in patients with MCT8 deficiency.

Funding Dutch Scientific Organization, Sherman Foundation, NeMO Foundation, Wellcome Trust, UK National Institute for Health Research Cambridge Biomedical Centre, Toulouse University Hospital, and Una Vita Rara ONLUS.

Lancet Diabetes Endocrinol 2019

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See Online/Comment http://dx.doi.org/10.1016/S2213-8587(19)30217-7

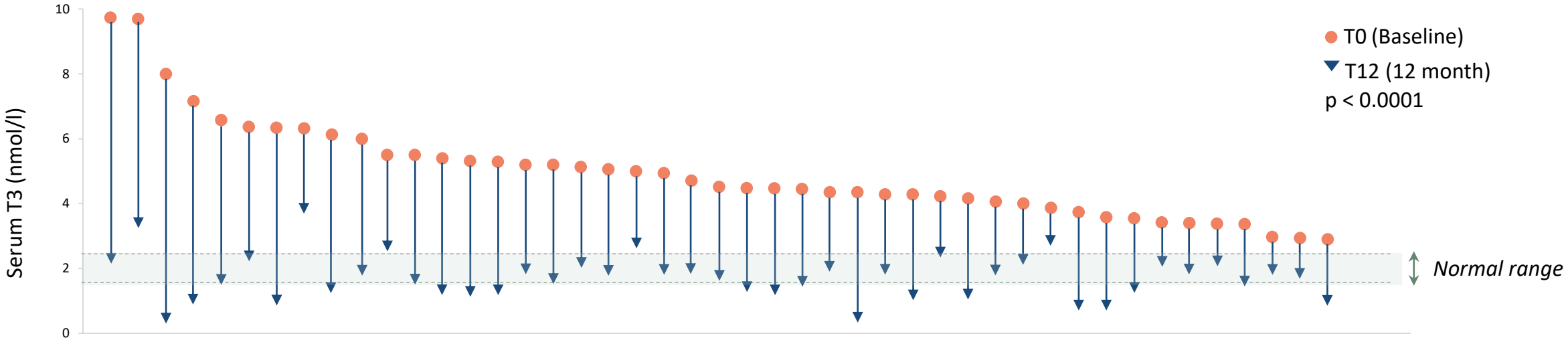
*Dr Manshande died in August, 2018, Prof De Meirleir died in October, 2018, and Prof T J Visser died in March, 2018.

Academic Center for Thyroid Diseases (S Groeneweg MD, Prof R P Peeters MD, M Medici MD, Prof T J Visser PhD, W E Visser MD), Sophia Children's Hospital, Division of Paediatric Cardiology (J M van Beynum MD), Sophia Children's Hospital, Department of Paediatric Neurology (I F M de Coo MD, F K Aansen PhD, M M van der Knoop MSc, M C Y de Wit MD), Department of Cardiology and Intensive Care Medicine (C A den Uil MD), Department of Clinical Chemistry (Prof Y B de Rijke PhD), and Department of Internal Medicine (Prof M C Zillikens MD), Erasmus Medical Centre, Rotterdam, Netherlands; Wellcome Trust-Medical Research Council Institute of Metabolic Science, University of Cambridge, Cambridge, UK (C Moran MB, A McGowan MD, G Lyons RGN, K Chatterjee FRCP); Paediatric Endocrinology, Diabetology and Gynaecology Department, Necker Children's University Hospital, Imagine Institute, Paris, France (A Stoupa M D, Prof M Polak M D); Department of Paediatric Endocrinology and Genetics, Children's Hospital, Toulouse University Hospital, Toulouse, France

Source: Groeneweg et al, Lancet D&E 2019;

Consistent, clinically relevant and highly significant results

44 out of 48 patients reached target level serum T3 in completed Phase IIb trial

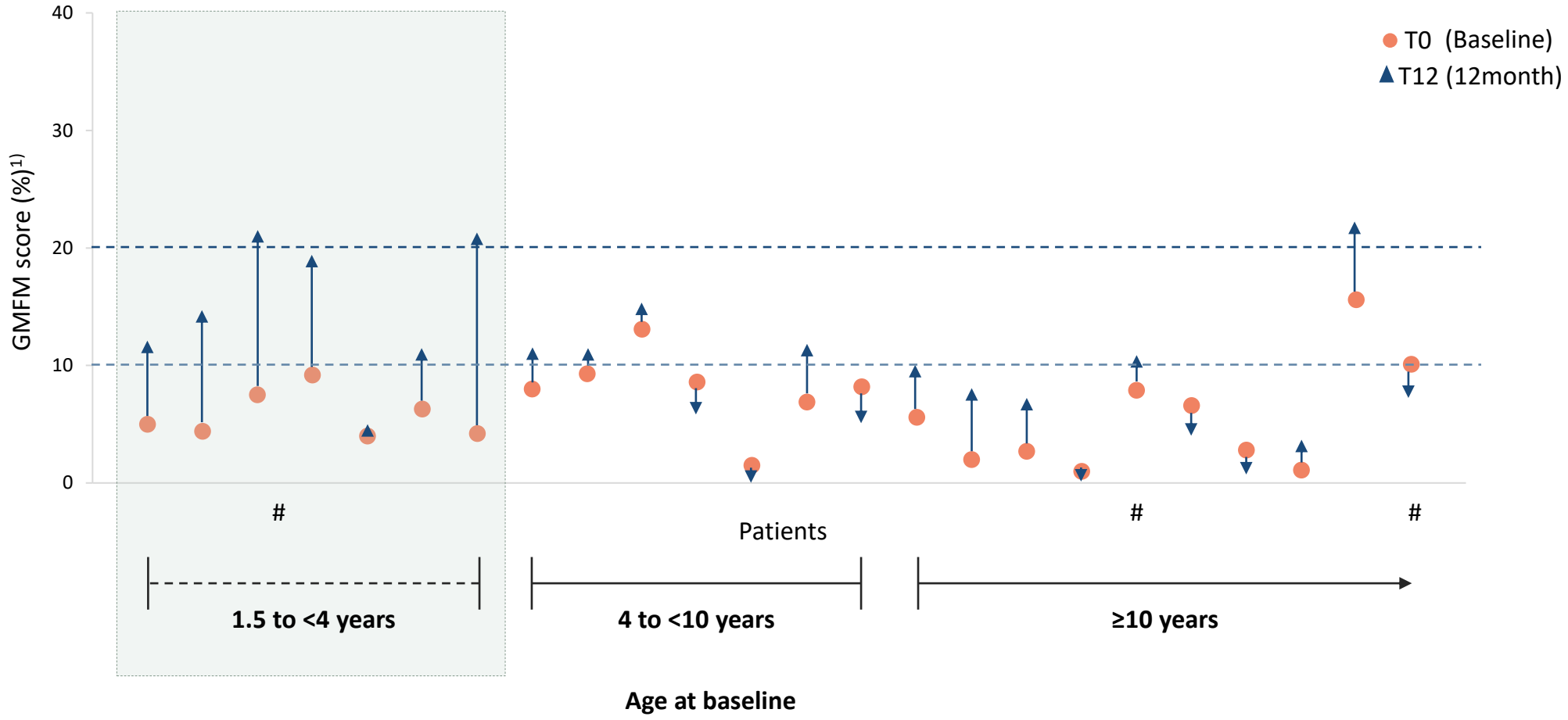


Endpoints	Baseline mean *(± SD)*	12 months mean *(± SD)*	Difference in means *(95% CI)*	p-value
Serum T3 (nmol/L)	4.97 (± 1.55)	1.82 (± 0.69)	-3.15 (-3.62, -2.68)	<0.0001
Weight to age (z score)	-2.98 *(± 1.93)*	-2.71 *(± 1.79)*	0.27 *(0.03, 0.50)*	0.025
Resting heart rate (bpm)	112 *(± 23)*	104 *(± 17)*	-9 *(-16, -2)*	0.01
Mean heart rate 24 h (bpm)	102 *(± 14)*	97 *(± 9)*	-5 *(-9, -1)*	0.012
SHBG (nmol/L)	212 *(± 91)*	178 *(± 76)*	-35 *(-55, -15)*	0.0013
Total cholesterol (mmol/L)	3.2 *(± 0.7)*	3.4 *(± 0.7)*	0.2 *(0.0, 0.3)*	0.056
CK (U/L)	108 *(± 90)*	161 *(± 117)*	53*(27, 78)*	<0.0001

Source: Groeneweg et al; Lancet D&E 2019

Indication of positive effect on neurocognitive development

in the youngest patients which is further studied in ongoing Phase IIb/III trial



Source: Groeneweg et al; Lancet D&E 2019

Ongoing Phase IIb/III early intervention trial design

Patient recruitment progresses according to plan and expected to be completed in Q4 2021

Primary objective	• Confirm findings from Triac I Trial in youngest age group • Improvement in neurocognitive development as measured by GMFM[1)] and BSID-III[2)] compared to natural history controls
Secondary objective	• Achievement of motor milestones (e.g. hold head, sit independently) • Normalisation of thyroid hormone function tests and markers of thyrotoxicosis
Description	• An open label, multi-centre trial in very young children with MCT8 deficiency • International trial with 10 centres in CZ, DE, IT, UK, FR, NL, US • Design discussed and anchored with EMA and FDA
# of patients	• 18-22 children 0-30 months of age
Timetable	• **First Patient First Visit achieved in Dec 2020**, LPFV[3] expected for Q4 2021 • Results from interim analysis at 12 months expected in Q4 2022

Note: (1) Gross motor function measure; (2) Bayley Scales of Infant Development; (3) Last patient first visit

Emcitate® clinical development timeline

2017

- ✔ Licensing of IP, data and know-how within thyroid hormone signalling disorders from Erasmus Medical Centre 1
- ✔ EU Orphan Drug Designation
- ✔ Elected for funding by EUREKA EUROSTARS

2018

- ✔ Acquisition of all rights and assets relating to Teatrois in France
- ✔ Triac I Trial completed
- ✔ EMA Protocol AssistanceEU

2019

- ✔ US Orphan Drug Designation
- ✔ Publication Triac Trial
- ✔ FDA pre-IND meeting
- ✔ CTA submissions EU

2020

- ✔ CTA approvals in EU
- ✔ IND submission
- ✔ IND open (SMP)
- ✔ FPFV2 pivotal Phase IIb/III early intervention trial

2021

- Completed recruitment (LPFV) Triac Trial II

2022/23

- Interim (12 month) analysis
- Filing EU MAA and US NDA
- Launch preparations

2023/24

- EU and US approval, pricing and launch
- US Rare Pediatric Disease Priority Review Voucher
- Publication of complete study data (24 month)

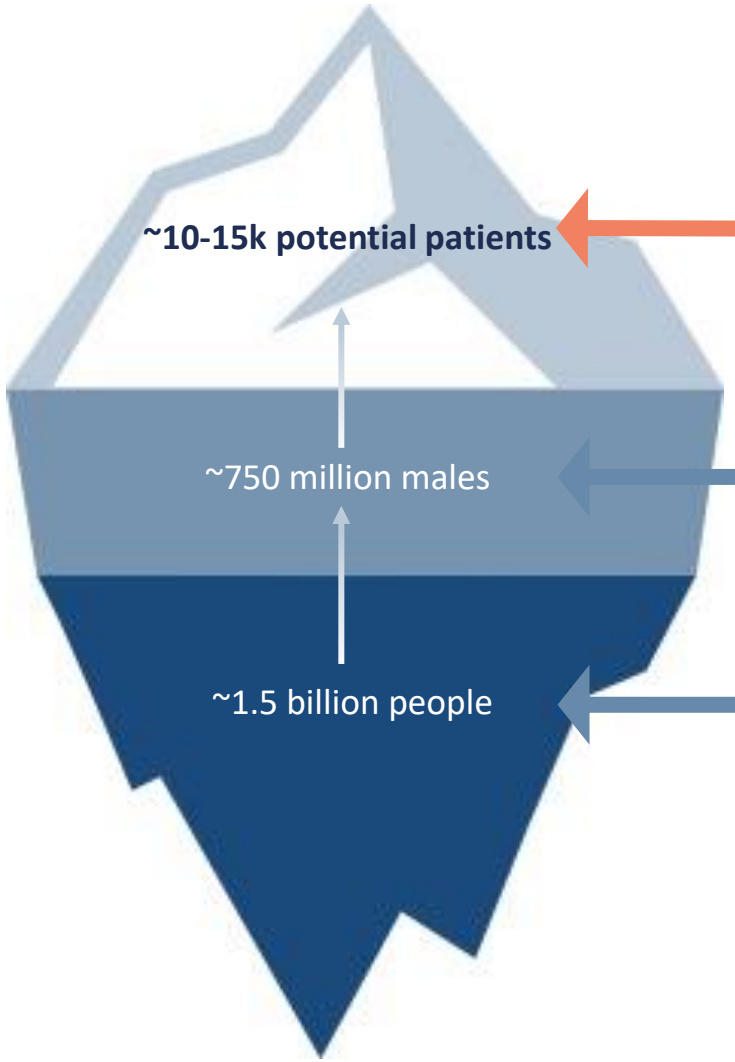
Note: (1) Erasmus Medical Centre; (2) First patient first visit; (3) Provided compelling data in 12 month interim analysis of Phase IIb/III early intervention trial

2.

Emcitate® - Commercial opportunity

Estimating 10-15k addressable patients globally

No approved treatment for MCT8 deficiency



MCT8 deficiency prevalence 1:50,000-70,000 males

Male subset of US, EU and RoW approachable population[1)]

US, EU and RoW approachable population[1)]

MCT8 deficiency epidemiology

- At least one new-born diagnosed per 140,000 live births in the Netherlands in past years, corresponding to 1:70,000 males
- Actual number of patients could be higher:
  - Screening study suggests prevalence of 1:50,000 males[2)]
  - Once treatment available, more patients tend to be diagnosed
- **Emcitate supplied on a named patient basis in several countries, in total > 100 patients treated**

Note: 1) RoW approachable population, e.g. UK, Australia, Canada, Japan, Russia, Switzerland, South Korea and Turkey, 2) Visser et al, Clinical Endocrinology 2012

Emcitate®– alleviating patient and societal burden

Aiming to provide value for both patients and society

MCT8 deficiency is a detrimental condition with significant unmet medical need and no approved therapy

Patients

- Median life-expectancy of MCT8 patients is 35 years[1]
- Patients underweight for age or without ability to hold head have an even increased risk of premature death.

Society

- All MCT8 patients have significant neurocognitive disability from early childhood and typically require constant, life-long supportive care
- A recent study in a condition with similar severity (SMA) estimated total healthcare cost (excluding treatment cost) to USD 138k per patient and year[2]

Emcitate holds potential to become the **first approved therapy** to address the cause of MCT8 deficiency, restore thyroid hormone signalling and thereby **prevent disease progression**, allieviate symptoms and **prolong lives**

Source: (1) Disease characteristics of MCT8 deficiency: an international, retrospective, multicentre cohort study, Groeneweg et al, The Lancet, 2012; (2) Economic burden of spinal muscular atrophy in the United States: a contemporary assessment, Droege et al, Journal of Medical Economics, 2020;

Analogue orphan drugs priced at > $ 250k – 400k per patient

Rapid market penetration with considerable sales already 3rd year in market

- Payers in general accept higher prices for orphan drugs compared to traditional drugs and especially if they;
  - Address an ultra **rare** disease, e.g. prevalence less than 1:50,000 people
  - Target a **severe** disease, i.e. life threatening/debilitating
  - Provide **health gain**, rather than just condition stabilization
- Emcitate fulfills these criteria and can become unique, since no other drugs available or being developed for MCT8 deficiency
- Benchmarks from analogue drugs, comparable to Emcitate in MCT8 deficiency;
  - A global average annual treatment cost of > $ 250k – 400k
  - Rapid market penetration, considerable sales already 3rd year in market

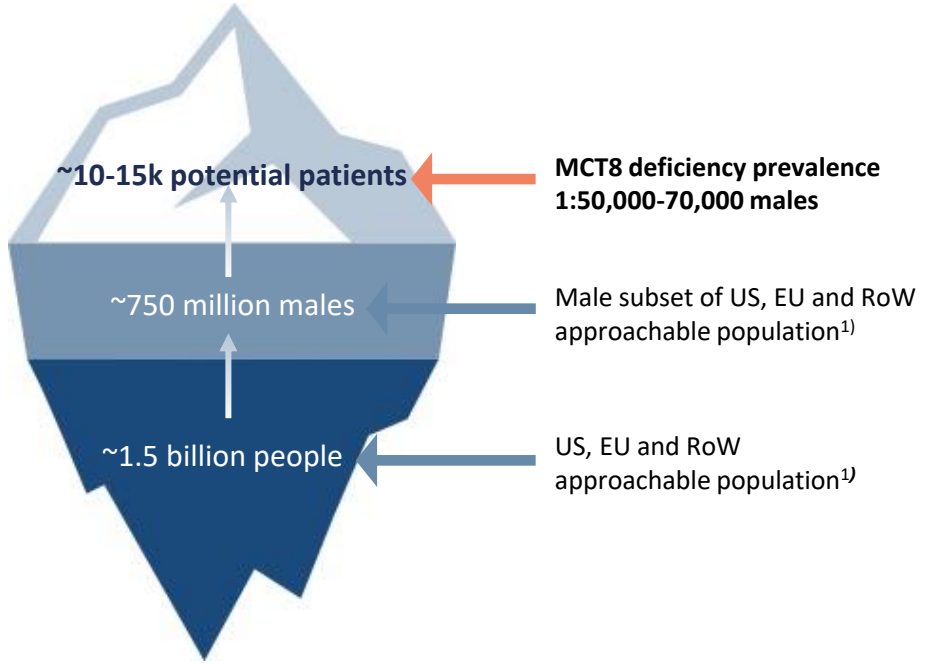
Emcitate and analogue orphan drugs

	Vimizim® *Recombinant enzyme*	**Kalydeco®** *Small molecule*	**Spinraza®** *Antisense oligonucleotide*	**Emcitate (target profile)** *Small molecule*
Disease	MPS IVA	CF with specific mutations	SMA	MCT8 deficiency
Rarity - less than 1:50,000 people	✓	✓	✓	✓
Severity – life threatening/debilitating	✓	✓	✓	✓
Health gain	✓	✓	✓	✓
Global annual treatment cost	> $400k	> $250k	> $350k	TBD
Year of 1st approval	2011	2012	2016	Expected 2023
Global sales 3rd year in market	$354mn	$464mn	$1.7bn	NA
Global sales 2019	$544mn	$991mn	$2.1bn	NA

Emcitate® commercial opportunity

– Addressing unmet needs in ultra rare diseases create substantial opportunity

- Significant unmet needs for patients suffering from MCT8 deficiency, i.e. no satisfactory treatments and heavy disease burden
- No other companies developing drugs for MCT8 deficiency
- Analogue benchmarks demonstrate that drugs providing health gains in ultra rare and severe conditions like MCT8 deficiency can achieve
  - global average annual treatment price of > $ 250k – 400k
  - rapid market penetration with considerable sales already 3rd year in market
  - substantial commercial opportunities



Analogue benchmarks indicate a market potential for Emcitate of > $1Bn:

- Global average annual treatment cost per patient: > $250k
- Addressable patients: > 10,000
- Market penetration: 50%

Note: 1) RoW approachable population, e.g. UK, Australia, Canada, Japan, Russia, Switzerland, South Korea and Turkey

FDA granted Rare Pediatric Disease designation to Emcitate®

US Rare Pediatric Disease Priority Review Voucher (PRV) provides a ~$100m opportunity

Overview PRV

- The FDA grants Rare Pediatric Disease designation (RPD) to therapies for serious or life-threatening diseases affecting fewer than 200,000 people in the USA.
- PRV program recently prolonged until FY 2026
- Sponsors holding a RPD can apply to receive a US Rare Pediatric Disease Priority Review Voucher (PRV) up on approval
- Provides accelerated FDA review of a new drug application for another drug candidate, in any indication, shortening time to market in the US
- The voucher may be sold or transferred to another sponsor.
- By end 2019 22 PRVs for rare pediatric diseases have been awarded by FDA, 12 were sold with individual voucher sale prices ranging from $67m to $350m

Examples of PRVs sold

Seller	Buyer	Value	Year
Bavarian Nordics	Undisclosed	$95M	2019
SOBI	AstraZeneca	$95M	2019
Bayer Healthcare	argenx	$100M	2020
Lumos Pharma	Merck	$100M	2020
Sarepta Therapeutics	Gilead	$125M	2020

Under the terms of the acquisition of RTT in Q3 2020, 50% of the potential net proceeds from a sale of a PRV related to Emcitate should be paid as an earnout to the sellers of RTT

3.

Aladote® - clinical development programme

Paracetamol/acetaminophen poisoning

– no adequate treatment for increased-risk patients

What is paracetamol/ acetaminophen poisoning?

- Minimum toxic dose of paracetamol/acetaminophen in adults is only **7.5g**
- Risk factors include malnutrition, alcoholism and consumption of other medications
- Paracetamol/acetaminophen poisoning can lead to **acute liver failure, liver transplant** or **death**

How many does it affect?

- **19 billion** units of paracetamol /acetaminophen packages are sold in the US alone every year
- **>175,000 patients hospitalised globally per annum** driven by 89,000 cases/year of paracetamol overdose in the US and 105,000 cases/year in the UK (~ 50% hospitalised)
- ~50% of paracetamol overdose cases are unintentional

Why is current treatment inadequate?

- Efficacy of current NAC (N-acetylcysteine) treatment decreases with time
- Approximately **25% of patients are late arrivals** to hospitals (>8h) – late arrivals are **at increased risk**
- There is **no effective treatment option for patients at increased risk**

A new standard of care is needed

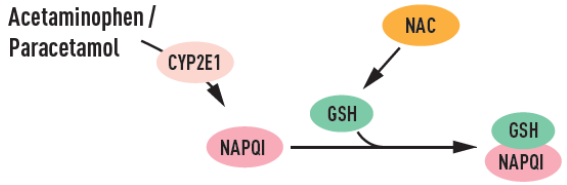
- **Aladote®** aims to become **a new standard of care** for patients with increased risk for liver injury in combination with NAC

Orphan drug candidate

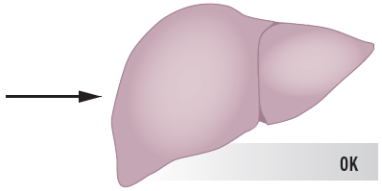
with clear scientific and mechanistic rationale

Early presenters (<8h)
NAC treatment effective against liver injury

- Liver glutathione (GSH) replenished by NAC, toxic NAPQI metabolite excreted as GSH conjugate

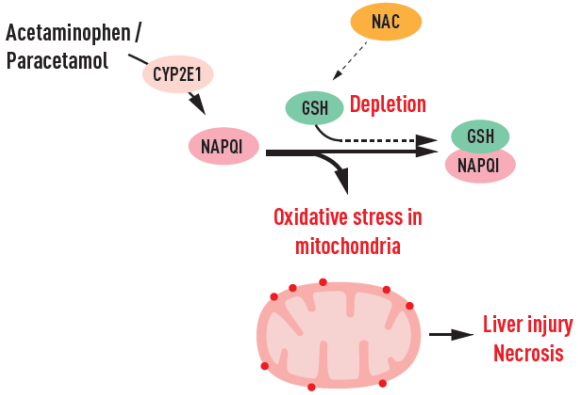


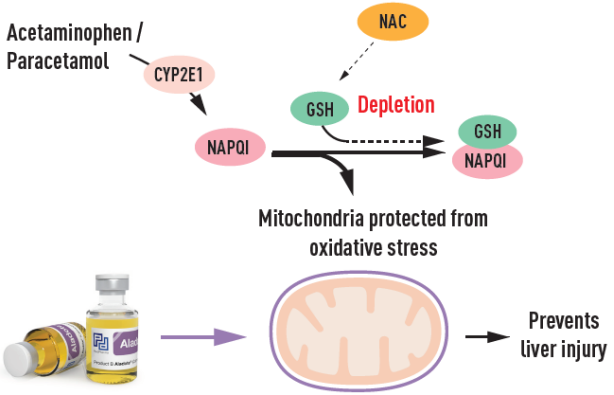
- In most cases NAC effectively prevents liver injury i.e. limited need for Aladote®



Late presenters (>8h) are at increased-risk for liver injury
NAC treatment + Aladote® to prevent liver injury

- **Under NAC treatment alone** liver GSH stores depleted by the toxic NAPQI metabolite -> **oxidative stress, mitochondrial dysfunction and liver injury (necrosis)**





- **Aladote®** (calmangafodipir) prevents ROS and RNS formation, restores mitochondrial energy production and **prevents liver injury**

Source: Akakpo et al. 2020, Burke et al. 2010.

Reactive nitrogen species (RNS), Reactive Oxygene Species (ROS)

Overview of completed Phase Ib/IIa

Primary objective and results	• Met primary endpoint of safety tolerability in the combination of Aladote® and NAC • Results presented at the 58th Annual Meeting of the Society of Toxicology, EASL ILC in April, Vienna and published in Lancet's journal EBioMedicine in 2019 • Presented at, American College of Medical Toxicology (ACMT) and Society of Toxicology (SOT), as novel emerging treatments for acetaminophen/ paracetamol toxicity in 2021
Secondary objectives and results	• Measurements of Alanine transaminase (ALT), international normalised ratio (INR), keratin-18, caspase-cleaved keratin-18 (ccK18) and microRNA-122 (mir122) and glutamate dehydrogenase (GLDH) indicates that Aladote® reduce liver injury
Description	• An open label, rising-dose, randomized study exploring safety and tolerability of Aladote® co-treatment with NAC • ClinicalTrials.gov identifier: NCT03177395
# of patients	• Single ascending dose study in 3 dosing cohorts of 8 patients (N=24) as add-on to NAC regime
Timetable	• Initiated in June 2017 (first patient in) • Completed in September 2018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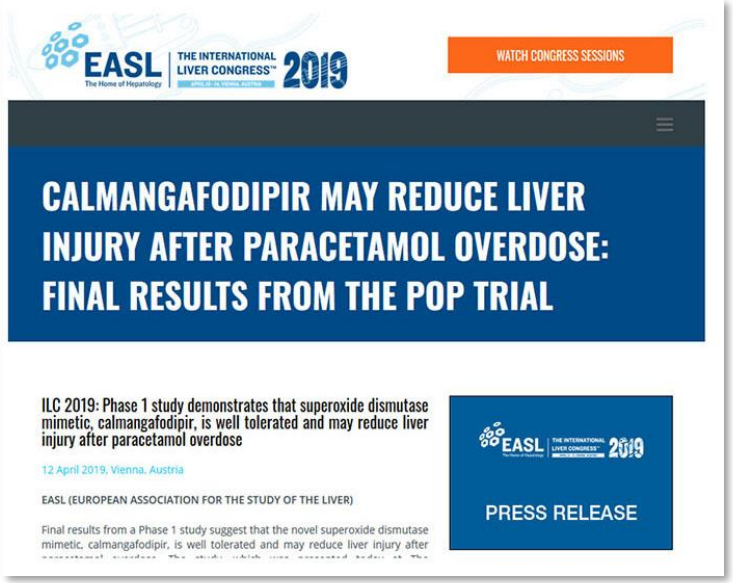
Published by THE LANCET

Principal results of a randomised open label exploratory, safety and tolerability study with calmangafodipir in patients treated with a 12 h regimen of N-acetylcysteine for paracetamol overdose (POP trial)

Emma E. Morrison [a], Katherine Oatey [b], Bernadette Gallagher [c], Julia Grahamslaw [c], Rachel O'Brien [c], Polly Black [c], Wilna Oosthuyzen [d], Robert J. Lee [b], Christopher J. Weir [b], Dennis Henriksen [d], James W. Dear [a,*], On behalf of the POP Trial Investigators [1]

[a] Pharmacology, Therapeutics and Toxicology Unit, Centre for Cardiovascular Science, University of Edinburgh, UK
[b] Edinburgh Clinical Trials Unit, UK
[c] Emergency Medicine Research Group, Royal Infirmary of Edinburgh, UK
[d] PledPharma AB, Stockholm, Sweden



Positive proof-of-principle Phase Ib/IIa results

Indicates that Aladote may reduce liver injury

Safety & tolerability

Event	NAC alone	NAC + 2 µmol/kg Aladote	NAC + 5 µmol/kg Aladote	NAC + 10 µmol/kg Aladote
Any AE	6 (100%)	6 (100%)	6 (100%)	6 (100%)
Any SAE	2 (33%)	4 (67%)	2 (33%)	3 (50%)
SAE Starting within 7 days	1 (17%)	1 (17%)	1 (17%)	2 (33%)

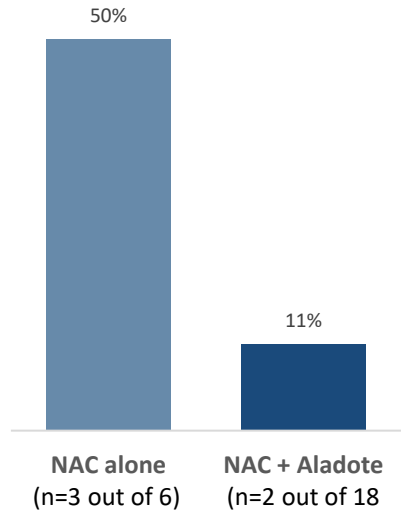
- Met primary endpoint of safety tolerability in the combination of Aladote® and NAC
- No AE or SAE probably or definitely related to Aladote®

Liver injury – ALT[1] pre-defined secondary outcome

Event	NAC alone	NAC + 2 µmol/kg Aladote	NAC + 5 µmol/kg Aladote	NAC + 10 µmol/kg Aladote
50% ALT increase	2 (33%)	0 (0%)	0 (0%)	1 (17%)
100% ALT increase	1 (17%)	0 (0%)	0 (0%)	1 (17%)
ALT >100 U/L at 10 hours	2 (33%)	0 (0%)	0 (0%)	0 (0%)
ALT >100 U/L at 20 hours	2 (33%)	0 (0%)	0 (0%)	0 (0%)

- ALT >100 U/L is the indication to stay in hospital

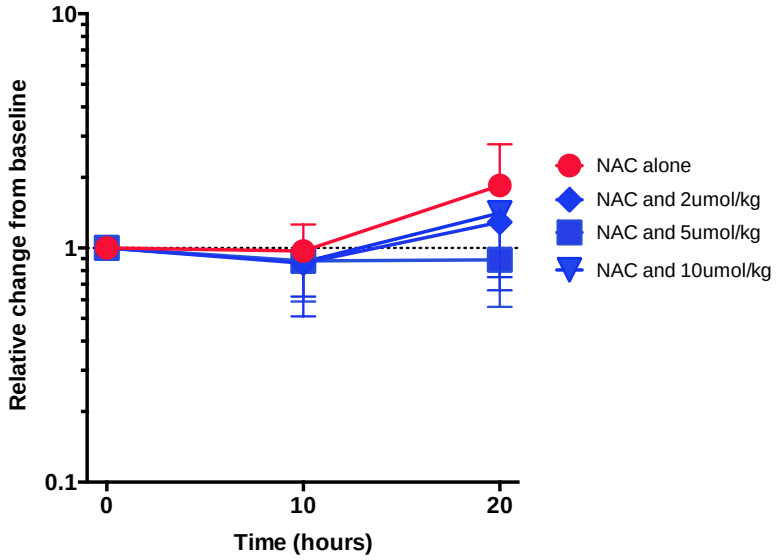
% of patients needing additional NAC infusions after planned 12h NAC infusion



Note: (1) Alanine transaminase (ALT) is a transaminase enzyme also called alanine aminotransferase (ALAT). ALT is found in plasma and in various body tissues especially the liver's hepatocytes. Serum ALT is commonly measured clinically as part of a diagnostic evaluation of hepatocellular injury, to determine liver health

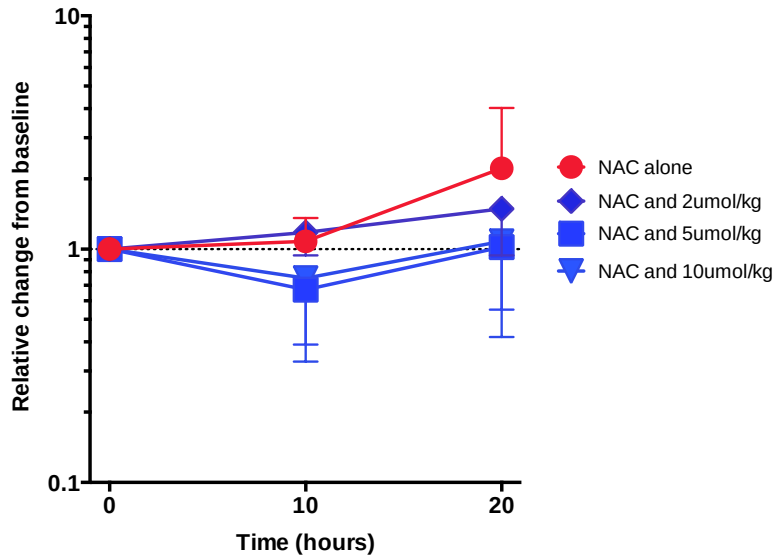
Aladote® demonstrates consistent results of reduced liver injury as measured by exploratory biomarkers

K18



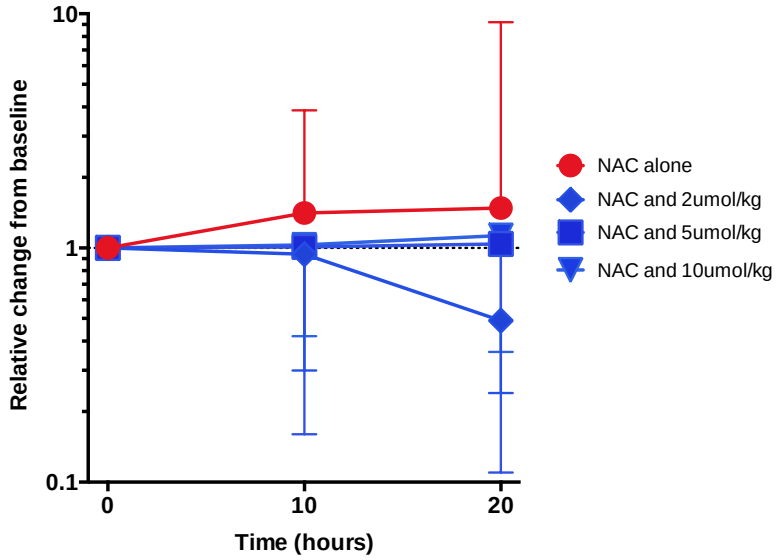
K18 is a measure of cell death and correlate with peak ALT activity during the hospital stay

ccK18



ccK18, is a measure of cell death and correlate with peak ALT activity during the hospital stay

miR-22



miR-122 is a liver specific early marker (micro-RNA) for acute liver injury which predicts a rise in ALT activity following paracetamol overdose

Pivotal Phase IIb/III study for US/EU regulatory submission[1]

Efficacy endpoints	• Primary: Composite of ALT and INR • Number (%) of patients that need further NAC after 21h • Length of hospital stay • Experimental biomarkers, K18, miR-122 and GLDH
Patient population	• Increased-risk POD patients, Late arrivals (>8h) requiring treatment with 21 hr NAC regime
Description	• International study in EU, UK and US • IV (bolus) as soon as possible after randomization and after starting NAC (but no later than 4 hours after starting NAC) • 3 arms: Aladote® high-dose; Aladote® low dose; Placebo
Sample size	• ~225 patients planned
Interim analysis	• Interim analysis after 50% of patients, that includes a futility analysis and dose selection where the most effective dose will be continued
Preliminary timetable	• Planned to be initiated end 2021. COVID situation dependent

Note: (1) Final design after completed interactions during Q2-Q3 2020 with FDA, EMA and MHRA, pending approved clinical trial applications

Aladote® clinical development timeline

2018

- ✔ Phase Ib/IIa study fully recruited
- ✔ Initial Phase Ib/IIa results
- ✔ Established Scientific Adviosry Board
- ✔ Full Phase Ib/IIa results
- ✔ Submission of ODD

2019

- ✔ US ODD granted
- ✔ Results presented at Society of Toxicology, EASL ILC and Lancet EBiomedicine
- ✔ Regulatory interactions with FDA and EMA

2020/21

- ✔ Design of pivotal study finalised
- ✔ Regulatory interactions FDA, EMA & MHRA
- Initiate pivotal Phase IIb/III study[2]
- Orphan Drug Designation EU

2022/23

- Interim analysis after 50% of patients included
- Recruitment completed

2023/24

- Regulatory submissions EU/US
- First EU/US approval and launch
- Regulatory submissions ROW

2032[1]

Note: (1) Calmangafodipir composition of matter patent expires. (2) COVID 19 situation dependent

3.

Aladote® - Commercial opportunity

Estimating at least 175k addressable patients globally

Annual number of POD (paracetamol/acetaminophen overdose) cases hospitalized and receiving i.v. antidote. (NAC currently the only option)

POD epidemiology

89,000 cases/year of paracetamol overdose in the US and 105,000 cases/year in the UK

- ~50% hospitalized and receive i.v. antidote treatment
- ~25% are late arrivals

Global paracetamol/acetaminophen exposure varies, why POD incidence different between countries

Aladote®– alleviating patient and societal burden

Aiming to provide value for both patients and society

POD is a life threatening condition with remaining medical needs

Patients

- POD (paracetamol/acetaminophen overdose) can lead to acute liver failure, liver transplant or death
- In US and UK together, yearly > 500 deaths due to POD and more people registered for liver transplantation

Society

- In the US the annual cost in 2010 was estimated at > $1bn to treat patients with POD[1]
- The POD Emergency Department and inpatient cost is approximately USD 13-40k[1]
- The average POD inpatient length of stay is 3.1 days with a variance of +4.4 days for the most severe cases[1]
- US liver transplant costs USD 125-473k[1]

With **Aladote**, the ambition is to **reduce hepatic injury** of POD and thereby contribute to **fewer hospitalization days**, **prevent need** for liver transplantation and **increase survival**

Source:; (1) Adapted from: Altyar A. Clinical and economic characteristics of emergency department visits due to acetaminophen toxicity in the USA BMJ Open 2015;5;

Analogue antidotes priced at $ 3.5k – 50k

National emergency hospital stocking guidelines - opportunity for rapid market penetration

- Various antidotes, e.g. vs. drug overdosing, metal poisoning, snake bites and reversal of anticoagulant treatment effects
- Limit morbidity/mortality when used within appropriate time
- National recommendations for stocking of antidotes at hospitals providing emergency care
  - For getting payer/formulary committee acceptance to be stocked, antidotes are in general priced lower than traditional orphan drugs, despite often having orphan status
  - Getting included provides great opportunity for rapid market penetration
    - Praxbind stocked in 3,200 US hospitals < 3 years from launch
    - Andexxa sales $112mn in US alone second year on market
- Analogue antidotes for comparable settings as Aladote have global average costs of $ 3.5k – 50k per treatment

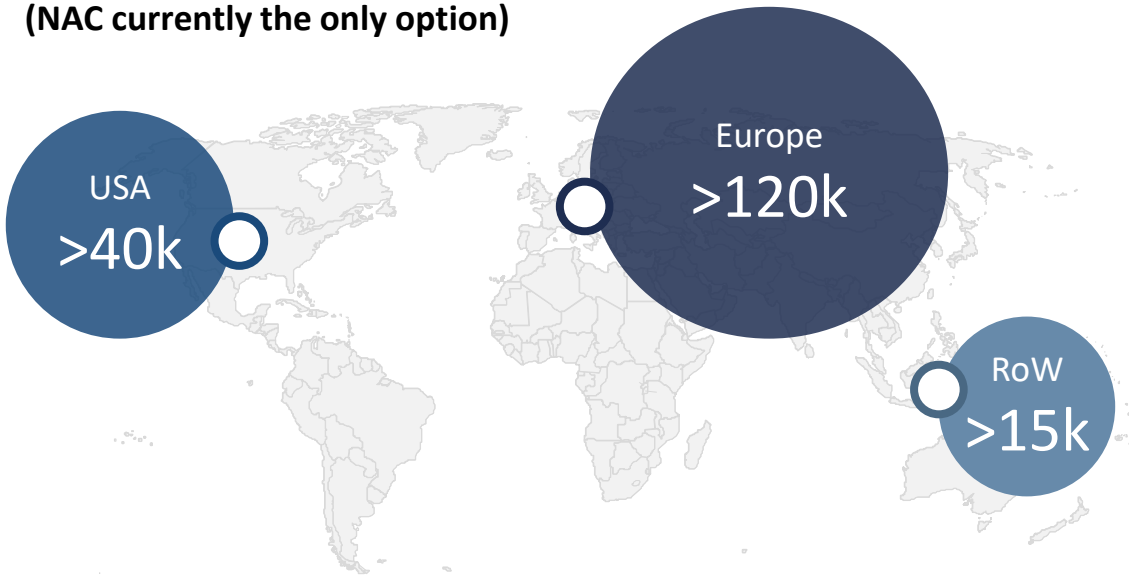
	Naloxone hydrocloride	Praxbind	Andexxa/Ondexxya	Aladote (target profile)
Year of first approval	1971	2015	2018	NA
Poisoning indication	Opioid toxicity	Reversal of anticoagulant effects of the NOAC dabigatran	Reversal of anticoagulant effects of the factor Xa inhibitors apixaban & rivaroxaban	Paracetamol/ acetaminophen toxicity
Cost per treatment	Low since generic	$ 3.5k – 4.5k	$ 25k – 50k	TBD

Aladote® commercial opportunity

– Addressing unmet needs in antidote market create substantial opportunity

- POD is a life-threatening condition with remaining medical needs
- No effective treatments for high-risk patients, e.g. patients arriving > 8h after ingestion
- No other companies developing drugs for POD
- Opportunity for rapid sales uptake due to national emergency hospital stocking guidelines
- Anologue antidotes priced at $3.5k – 50k

Annual number of POD cases hospitalized and receiving i.v. antidote (NAC currently the only option)



>$350mn annual sales opportunity assuming:

- Global average annual treatment cost per patient: $5k
- Addressable patients: >175,000
- Market penetration: 40%

4.

The orphan drug segment and path to market

Orphan drug segment – a highly attractive opportunity

1. **Orphan drug designation is awarded to products targeting limited disease populations[1]**
2. **More than 7,000 known rare diseases**
3. **Approx. 10% of the general population may be affected by a rare disease**
4. **Substantial unmet medical need for patients, only 5% of rare diseases have an approved therapy**

Development

- Less extensive clinical trials
- Agile and faster development process
- Lower costs
- Lower development risk

Registration

- Free regulatory advice
- Reduced fees
- Expedited review
- Market exclusivity

Market

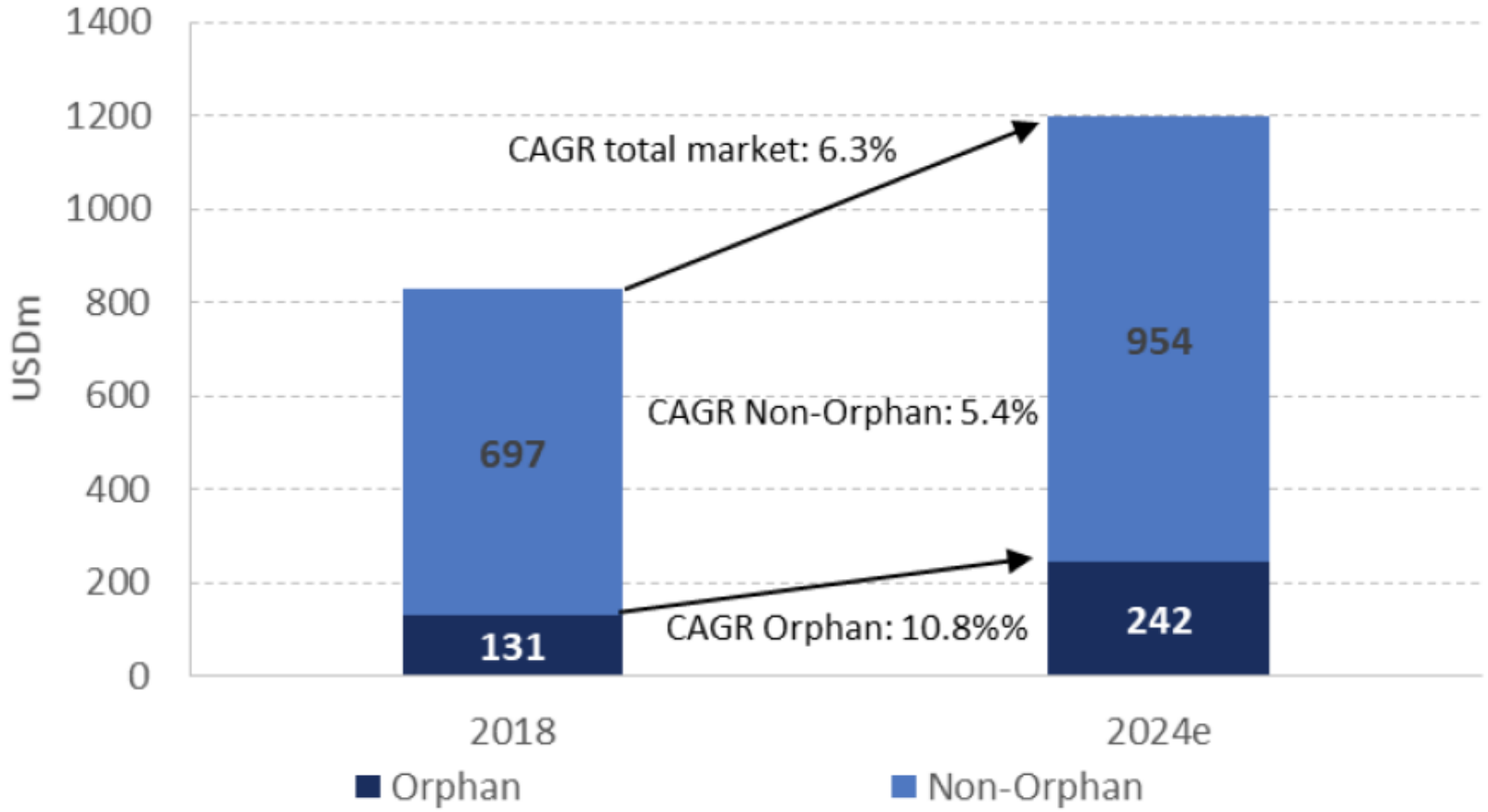
- No or few competitors
- Highly focused target groups
- Premium pricing

Well-defined patient populations with substantial unmet medical need

Note: (1) Populations of less than 5/10,000 inhabitants in the EU or <200,000 inhabitants in the US

CAGR estimates of total pharmaceutical market vs orphan

The global orphan or rare disease market size was valued at an estimated USD 140 – 150 bn and is expected to grow at 10-14% CAGR over the coming five years.



Source: EvaluatePharma, Pareto.

Commercialisation of Emcitate & Aladote

Strong success factors…

1. **High unmet medical need** without competing compounds
2. Centralized**, focused target** groups of **specialists**
3. **Top-down** scientific **sales approach**
4. **Leading KOL support**
5. Treatment algorithms **highly protocol driven**

…for sustainable, profitable & lean commercialisation

- Plan to build **inhouse commercial capabilities** for launch of Emcitate® and Aladote® in EU and US
- **Small and focused footprint** with an estimated < 50 FTEs considered sufficient for both assets
- Retain **larger share of product revenues** over time within company
- **Commercialization** in other territories through **partners**

5.

Summary

Two highly promising orphan drug candidates in one company

Emcitate® – *Therapy for genetic disturbance in thyroid hormone signalling with life-long severe disability*

- Lead candidate for addressing MCT8 deficiency, a condition with high unmet medical need and no available treatment
- Rare disease which affects ~1:70,000 males
- Obtained Orphan drug designation in the EU and US 2017 and 2019 respectively. **US Rare Paediatric Disease Designation received in November 2020**, eligible for Priority Review Voucher.
- Phase IIb clinical trial completed with significant and clinically relevant effects
- Pivotal Phase IIb/III early intervention trial in young subjects initiated with **first patient dosed in Dec 2020**. Patient recruitment progresses according to plan and expected to be completed in Q4 2021.
- No competing products in clinical development
- More than 120 patients are being **treated** with Emcitate on a **named patient basis**, following individual regulatory approval from the national regulatory agency.

Aladote® – *Prevents acute liver injury caused by paracetamol/acetaminophen poisoning*

- Paracetamol poisoning is one of the most common overdose with >175,000 hospital admissions globally per annum
- No adequate treatment for increased risk patients exists
- Orphan drug designation (ODD) granted in 2019 in the US
- Application submitted for ODD in the EU in Q1 2021
- Successful results from Phase Ib/IIa study in paracetamol overdosed patients
- Pivotal Phase IIb/III study planned for marketing authorisation application in both US and EU, targeting study start back end 2021 pending the COVID-19 pandemic situation
- No competing products in clinical development

Late-stage orphan drug pipeline, $1Bn+ annual sales opportunity

Analogue benchmarks indicate substantial market potential

Emcitate®

Addressable patients[1]

> 10,000

Estimate of addressable patients globally with access to western standard health care[2]

Analogue pricing

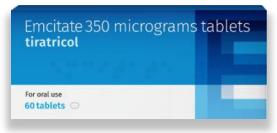
> $250,000

Global average annual treatment cost per patient

Annual sales opportunity:

> $1Bn

If market penetration 50%



Aladote®

Target population

> 175,000

Estimate of addressable patients globally with access to western standard health care[2]

Pricing assumption

$5,000

Global average annual treatment cost per patient

Annual sales opportunity:

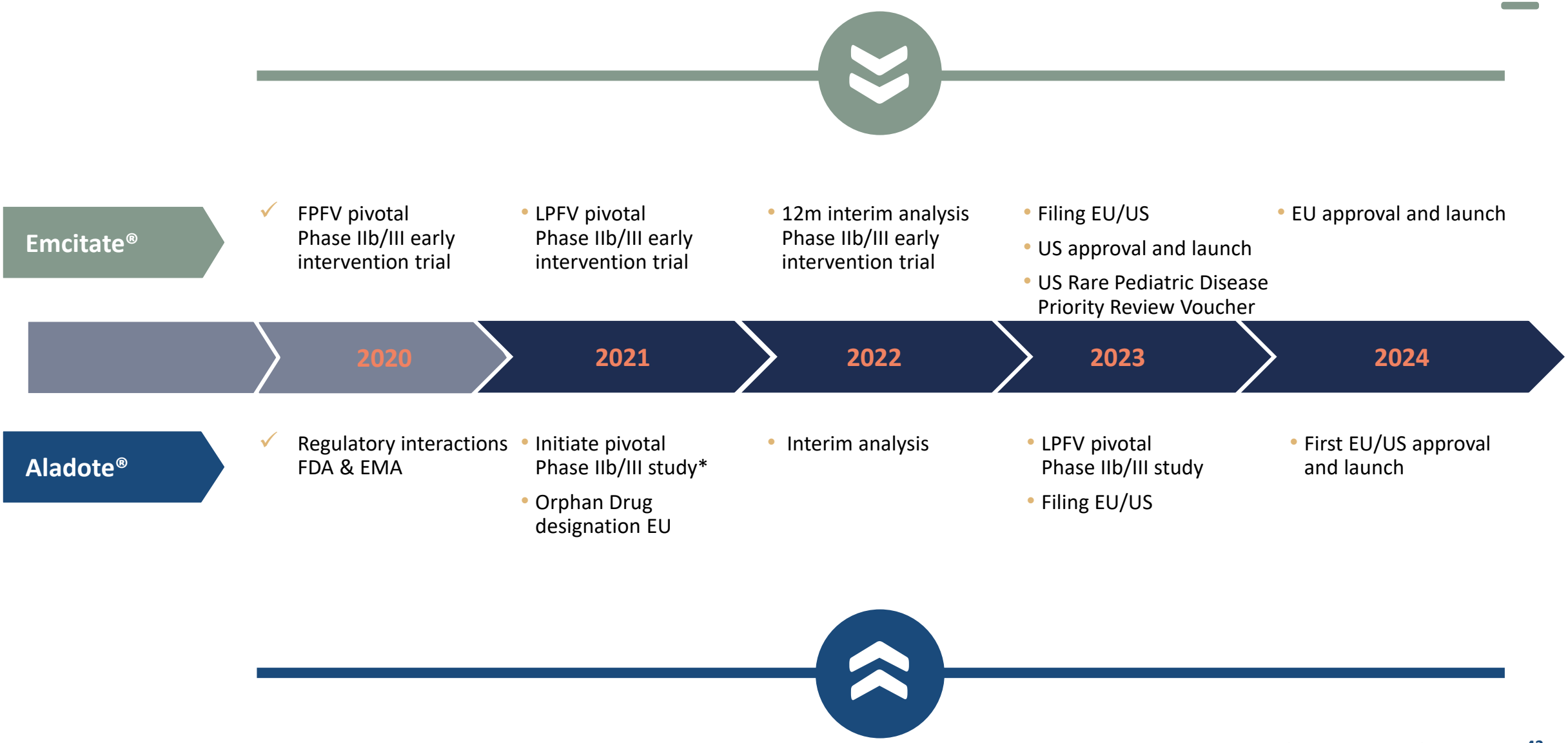
> $350mn

If market penetration 40%

COGS assumption: Low single digit percent

Source: (1) 1:70,000 males. Visser et al, Clinical Endocrinology 2012; (2) US, EU and RoW approachable population including Australia, Canada, Japan, Russia, Switzerland, South Korea and Turkey; Note: Royalties of 10% on Emcitate® net sales to Erasmus Medical Centre and Royalties of 3% on Emcitate® net sales to RTT owners

Upcoming pipeline milestones



*targeting study start end 2021 pending the COVID-19 pandemic situation

New specialised late-stage orphan drug development company

1. Dedicated orphan drug development company with two late-stage orphan drug assets: **Aladote®** and **Emcitate®**
2. Highly attractive **orphan drug segment** with potential **>$1Bn annual sales opportunity**
3. Clear path to **market approval in EU and US** within **3 years**
4. Plan to **launch** through niche inhouse commercial organization in the EU and US
5. Core expertise provides a platform potentially to be leveraged for **additional** late-stage orphan drug projects

A.

Appendix

Leadership team

Nicklas Westerholm

CEO

- Took office in June 2017 and has previously worked in the AstraZeneca Group since 1995 in several global roles in various business areas, most recently as VP Project & Portfolio Management. Prior Nicklas has held positions such as Executive Officer & VP Japan Operations, Director Investor Relations, Head of Global API Supply and Head of Development Manufacture. He has studied Analytical and Organic Chemistry at Stockholm University and Chemical Engineering at KTH, as well as studies at University of Warwick, INSEAD and Harvard Business School.
- Ownership: 58,940 shares, 193,703 warrants and 2 400 000 employee stock options

Yilmaz Mahshid

CFO

- Yilmaz has experience from different senior positions in the life science sector, including Investment Manager & Controller at Industrifonden, and CFO at PledPharma between 2017 and 2020, as well as healthcare analyst at Pareto Securities and Öhman Fondkommission. Prior to joining Egetis Therapeutics, Yilmaz was CEO of the listed biotech company Medivir. Yilmaz also has a solid academic background with a PhD from the Department of Medical Biochemistry and Biophysics at Karolinska Institutet, Stockholm.
- Ownership: 156,000 shares, 100,000 warrants and 1 150 000 employee stock options

Henrik Krook

VP Commercial Operations

- Appointed VP Commercial Operations in December 2020. He has a broad experience from over 15 years in commercial leadership settings, including both big pharma and biotechs. He has previously held senior corporate and commercial advisory roles for biotech companies such as Affibody and senior managerial positions at e g Alexion, Novartis and Roche. Henrik has a PhD in immunology from Uppsala University and an Executive MBA from Stockholm School of Economics.
- Ownership: 140 000 (through an insurance solution) and 1 150 000 employee stock options

Kristina Sjöblom Nygren

CMO

- Took office in May 2020 and has previously worked as CMO and Head of Development at Santhera, were she oversaw activities in late-stage clinical development, registration, post-approval commitments and managed access-programs within rare diseases in different therapeutic areas. Previously, Kristina spent 18 years at SOBI, Wyeth and AstraZeneca, where she held a number of senior positions. She has been involved in many different interactions with regulatory bodies such as the US FDA and the EMA including scientific advice and orphan drug applications. Before joining the industry, she worked as a licensed physician in several clinical positions. She holds a Diploma in Pharmaceutical Medicine, and an MD from the Karolinska Institute, Stockholm.
- Ownership: 6 000 shares and 650 000 employee stock options

Christian Sonesson

VP Product Strategy & Development

- Appointed VP Product Strategy & Development in August 2017 following 13 years at Astra Zeneca. He has broad experience within drug development, including successfully leading products during Phase 3 (FORXIGA® in type 1 diabetes) and of regulatory submissions and defense, bringing new drug candidates to market in different regions (e.g. FORXIGA® in type 2 diabetes, MOVANTIK®, ONGLYZA®-SAVOR, BRILINTA®-PEGASUS and QTERN®). PhD in Biostatistics from Gothenburg University and an Executive MBA from Stockholm School of Economics.
- Ownership: 58,111 warrants and 1 150 000 employee stock options

Board of directors

Thomas Lönngren

Chairman of the board

- Board member since: 2021
- MSc in social and regulatory pharmacy and a degree in Pharmacy, University of Uppsala.
- Other assignments: Board member at Compass Pathsways PLC and NDA group. Director at own company PharmaExec Consulting AB. Advisor to NDA group, Artis Venture, Baren Therapeutics, Centre for Innovation in Regulatory Science (CIRS) and ScientificMed AB. Faculty member of GLG Institute
- Ownership: 100 000 shares

Mats Blom

Board member

- Board member since: 2021
- BA, Business Administration and Economics, University of Lund and MBA, IESE University of Navarra.
- Other assignments: CFO NorthSea Therapeutics and Board member of Hansa Biopharma and Auris Medical
- Ownership: 1 988 227 shares

Peder Walberg

Board member

- Founder and CEO of Rare Thyroid Therapeutics
- MD and BSc in international economy and business administration, Uppsala University
- Other assignments: Board Member of Immedica Pharma AB,
- Previous assignments: Founder and CEO, Medical Need, Head of Business Development and Strategy, Swedish Orphan International and SOBI. BoD of Wilson Therapeutics and identified Decuprate for treatment of Wilson disease
- Ownership: 31 858 414 shares (via Cetoros AB)

Gunilla Osswald

Board member

- Board member since: 2017
- Ph.D. in biopharmacy and pharmacokinetics
- Other assignments: CEO BioArctic AB
- Ownership: -

Elisabeth Svanberg

Board member

- Board member since: 2017
- MD, Ph.D., Assoc Professor in surgery
- Other assignments: Chief Development Officer Ixaltis SA. Board member Swedish Orphan Biovitrum (SOBI)
- Ownership: -

Share Register and Market Cap

10 largest shareholders

Name	Capital	Votes	Num. of shares	Verified
Peder Walberg	19.30%	19.30%	31 858 414	2021-06-30
Avla Holding AB	10.04%	10.04%	16 572 442	2021-06-30
Fjärde AP-fonden	8.67%	8.67%	14 311 300	2021-06-30
Peter Lindell	7.71%	7.71%	12 724 820	2021-06-30
RegulaPharm AB	5.97%	5.97%	9 846 730	2021-06-30
Staffan Persson	2.88%	2.88%	4 759 234	2021-03-31
Avanza Pension	2.82%	2.82%	4 656 479	2021-06-30
Thomas Eldered	1.36%	1.36%	2 251 674	2020-12-31
Nordnet Pensionsförsäkring	1.25%	1.25%	2 070 953	2021-06-30
Mats Blom	1.20%	1.20%	1 988 227	2021-06-30
Total 10	**61.21%**	**61.21%**	**101 040 273**	
Total number of owners	6,822			2021-06-30
Total number of shares	165,068,560			2021-06-30

- Cash position: SEK 207M (~EUR 20M)*
- Number of shares: 165M
- MCap: SEK 950M**
- Listing: Nasdaq Stockholm Main Market

Source: Monitor by Modular Finance. Compiled and processed data from various sources, including Euroclear, Morningstar and the Swedish Financial Supervisory Authority (Finansinspektionen). The verification date may vary for certain shareholders
**Half-year report, **2021-09-01*

EGETIS THERAPEUTICS

Acquisition of Rare Thyroid Therapeutics on 5 November 2020

The combination will drive synergies

PledPharma and Rare Thyroid Therapeutics merged to launch a new company

PledPharma

- Team with profound late-stage drug development experience and strong track-record
- Listing on Nasdaq Stockholm provides access to public markets and capital as well as visibility
- Desired prospective partner in project collaborations. Previous major license agreement with Solasia
- Efficient internal organisation and strong corporate governance

Rare Thyroid Therapeutics

- Team with strong track-record of identifying and developing ODDs and creating shareholder value
- Strong network of external project advisors with specialist knowledge. Collaboration with Erasmus Medical Center in Rotterdam
- Founding team with experience from international launch and commercialization of orphan drugs

Synergistic orphan drug focus

- 2020 accelerated PledPharma's strategic review
- Lead asset Aladote® facilitates the new pronounced strategic focus on orphan drug segment
- Emcitate® and RTT's capabilities fit well with the new strategy
- Build critical mass, generate synergies and improve operational effectiveness for projects in the orphan segment
- Size, vicinity and complementary capabilities allow for a fast and smooth integration

The acquisition and rights issue

Institutional investor base broadened

Acquisition

- On 5 November 2020, PledPharma acquired all outstanding common shares in Rare Thyroid Therapeutics
- Consideration consisted of a combination of PledPharma common shares and cash
  - An upfront cash payment of SEK 60m
  - 63.8 million shares representing approx 39% of the total number of outstanding shares in PledPharma post rights issues
  - Owners of Rare Thyroid Therapeutics will receive a royalty of 3% of net sales generated through Emcitate®[1]
  - Owners of Rare Thyroid Therapeutics will also be granted 50% of the net proceeds from a potential sale of US Rare Pediatric Disease Priority Review Voucher related to Emcitate®

Rights issue

- Successfully raised SEK 250 million in oversubscribed rights issue (c. SEK 200m) and utilized overallotment option (c. SEK 50m)
  - Subscription price of SEK 5.25 per share corresponding to a 2.5 percent premium to close 2 October 2020
- Institutional investor base broadened
  - Overallotment Option, allocated to the Fourth Swedish National Pension Fund ("AP4"), NYIP (Nyenburgh Holding BV) and Nordic Cross
- The proceeds will be used to finance: (i) the development of Emcitate® and Aladote® to market approval in Europe and USA (60%); (ii) initial commercial preparations (20%); (iii) general corporate purposes and financial flexibility (20%)

Note: (1) Royalties of 10% on Emcitate® net sales to Erasmus Medical Centre;

EGETIS THERAPEUTICS

Thank you!

Egetis Therapeutics
egetis.com