Corporate Overview

Developing New Therapies *for* Rare Respiratory Diseases

July 2024

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Safe Harbor Statement

Savara Inc. (“Savara” or the “Company”) cautions you that statements in this presentation that are not a description of historical fact are forward-looking statements which may be identified by the use of words such as “expect,” “intend,” “plan,” “anticipate,” “believe,” and “will,” among others. Such statements include, but are not limited to, statements regarding the nature, strategy and focus of Savara; the Savara investment thesis; the safety, efficacy and projected development timeline of molgramostim; the potential health benefits of molgramostim; the likelihood and timing of regulatory submissions, including a Biologics License Application; the potential for and impact of regulatory approval of molgramostim; and the potential market size, commercial opportunity, and competitive landscape for molgramostim; Savara’s disease awareness campaign and GM-CSF autoantibody testing, and the potential impact of those programs; and the sufficiency of our resources to fund the advancement of our development program and potential sources of additional capital. Savara may not actually achieve any of its plans or product development goals in a timely manner, if at all, or otherwise carry out its current intentions or meet the expectations or projections disclosed in its forward-looking statements, and you should not place undue reliance on these forward-looking statements. These forward-looking statements are based upon Savara's current expectations and involve assumptions that may never materialize or may prove to be incorrect. Actual results and the timing of events could differ materially from those anticipated in such forward-looking statements as a result of various risks and uncertainties, which include, without limitation, the risks that analysis of the full data set from the IMPALA-2 clinical trial could result in observations not seen in the topline results; the risks associated with our ability to successfully develop, obtain regulatory approval for and commercialize molgramostim for aPAP; the risks and uncertainties related to the impact of widespread health concerns impacting healthcare providers or patients and geopolitical conditions on our business and operations; risks and uncertainties associated with the ability to project future cash utilization and reserves needed for contingent future liabilities and business operations; the ability to successfully conduct clinical trials for our product candidate; the availability of sufficient resources for our operations and to conduct or continue planned clinical development programs; and the timing and ability of Savara to raise additional capital as needed to fund continued operations. The risks and uncertainties facing Savara are described more fully in Savara's filings with the Securities and Exchange Commission including our filings on Form 8-K, our Annual Report on Form 10-K for the fiscal year ended December 31, 2023, and our Quarterly Report on Form 10-Q for the quarter ended March 31, 2024.

You are cautioned not to place undue reliance on our forward-looking statements, which speak only as of the date on which they were made. Savara undertakes no obligation to update such statements to reflect events that occur or circumstances that exist after the date on which they were made, except as may be required by law. Third-party information included herein has been obtained from sources believed to be reliable, but the accuracy or completeness of such information is not guaranteed by, and should not be construed as a representation by, the Company.

Please note that molgramostim is an investigational product that has not been approved for sale or determined to be safe or effective by the U.S. Food & Drug Administration or any regulatory authority.

The trademarks included herein are the property of the owners thereof and are used for reference purposes only. Such use should not be construed as an endorsement of such products.

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Executive Leadership Team

Matthew Pauls, J.D., M.B.A.
Chair & Chief Executive Officer

Anne Erickson
Chief Business Officer

Dave Lowrance
Chief Financial & Administrative Officer

Rob Lutz, M.B.A.
Chief Operating Officer

Ray Pratt, M.D. FACP
Chief Medical Officer

Scott Wilhoit
EVP, Global Commercial

Yasmine Wasfi, M.D., Ph.D.
SVP, Head of Clinical Development

Sid Advant, Ph.D.
EVP, Global Technical Operations

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Investment Thesis

Successful Pivotal Phase 3 Program in aPAP

- Molgramostim achieved statistical significance on primary endpoint and multiple secondary endpoints in IMPALA-2 trial
- Favorable safety profile observed from the first and second IMPALA trials
- BLA submission expected to be complete 1H 2025

Strong global commercial opportunity

- Significant unmet need
- Claims dataset estimate indicates ~5,000 U.S. patients
- Chronic dosing expected
- Assumed pricing power consistent with orphan drug analogs (i.e., in U.S. ~$300-$500K p/patient, p/year)

As a novel inhaled biologic, molgramostim has:

- 12-year biologic exclusivity in U.S. upon approval
- Potential for a long-term, durable revenue stream with biosimilar competition unlikely

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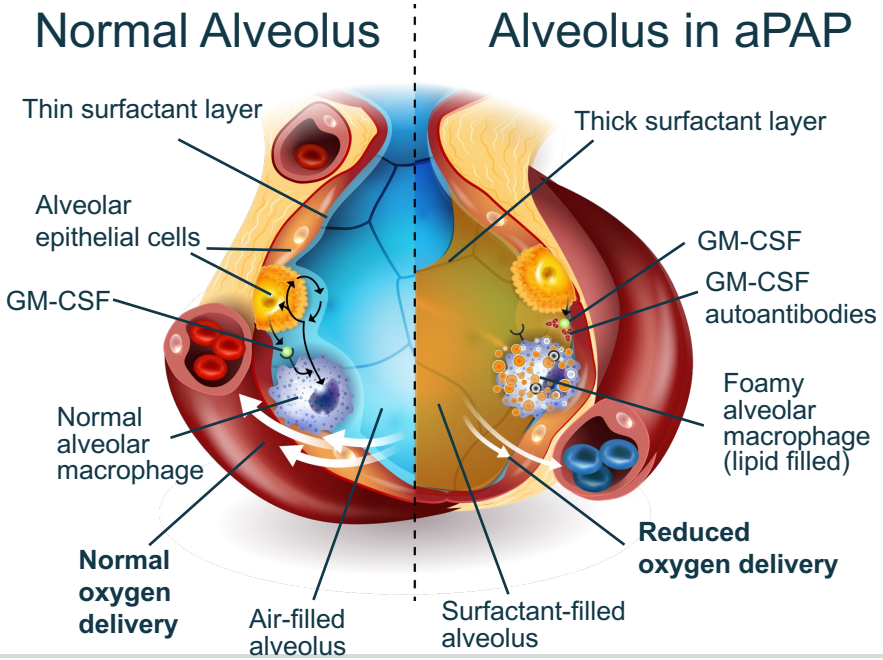
aPAP and Molgramostim

aPAP: An Autoimmune Disease of Alveolar Macrophage Dysfunction

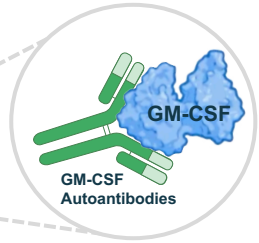
NORMAL LUNG FUNCTION

Alveoli need surfactant to keep from collapsing

GM-CSF is critical for alveolar macrophage function and allows for alveolar surfactant homeostasis, structure, function, and host defense



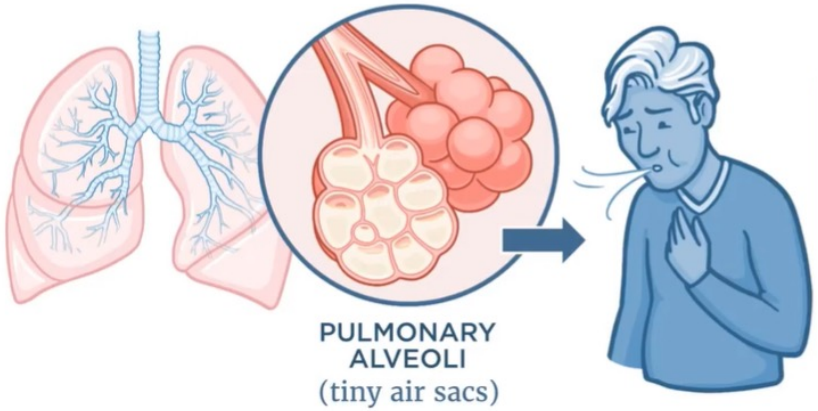
aPAP



Rare lung disease caused by GM-CSF autoantibodies which block GM-CSF signaling and reduce surfactant clearance. This results in:

Surfactant accumulation that blocks movement of oxygen from the alveoli into the blood

Reduced blood oxygenation results in difficulty breathing and, ultimately, hypoxemic respiratory failure



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aPAP is a Rare, Long-Term, Chronic Disease

Progressive Shortness of Breath

- Gas exchange in the lungs is impaired and patients may experience shortness of breath
- At first it occurs upon exertion, but as disease progresses, it can occur even when a person is at rest

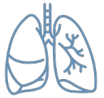
Fatigue, Decreased Exercise Tolerance

- Fatigue and significantly reduced exercise capacity can dramatically impact the simplest of daily activities, e.g., getting winded walking up a flight of stairs

Cough and Episodes of Fever

- Cough, sputum production, and episodes of fever, especially if secondary lung infection develops

Fibrosis and Lung Transplant



- In the long-term, the disease can lead to serious complications, including fibrosis, and may lead to the need for lung transplantation

There are no approved drugs for the treatment of aPAP.
Only option is a lung lavage, an invasive procedure.

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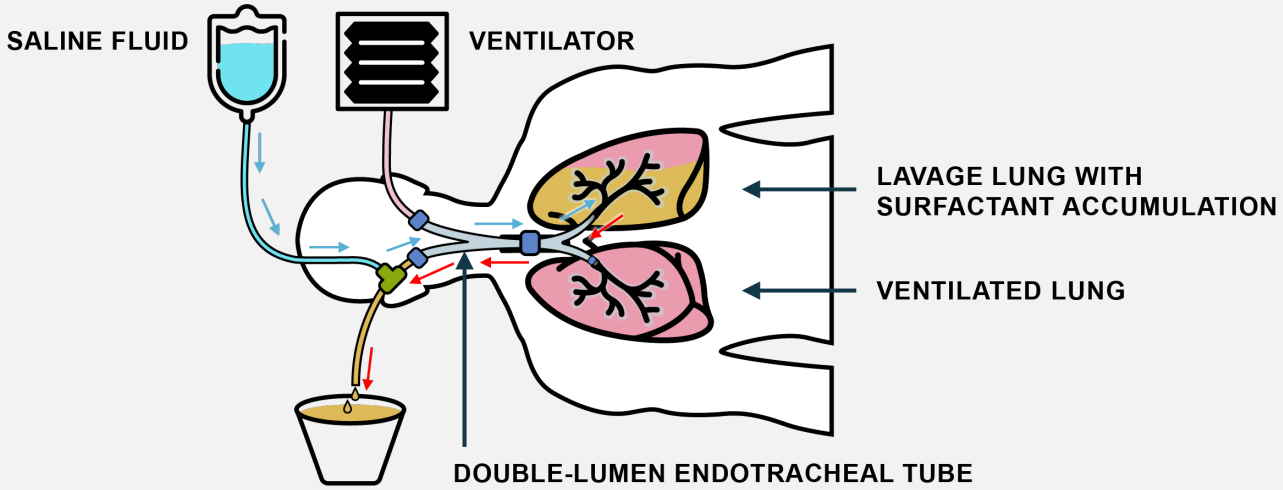
- A lung lavage physically removes excess surfactant from the lungs and requires hospitalization
- Performed under general anesthesia
- Unavailable at many medical institutions

A Lung Lavage is an Invasive Procedure Performed in a Tertiary Center and is Not Standardized



Requires insertion of double-lumen endobronchial tube for lung separation

Treated lung is repeatedly filled with up to 15-50L of saline and then drained by gravity

Patient is percussed to emulsify the surfactant sediment

Saline is drained by gravity and continued until lavage fluid becomes clear

Sources: 1: Campo, Assessment and Management of PAP in a Reference Center, Orphanet Jour. of Rare Dis., 2013; 2: Campo, Nat. History of PAP Data from Italian Nat. Reference Center, ERJ, 2019.; Seymour, J. J. Pulmonary alveolar proteinosis: Progress in the First 44 Years, Am. J. Respir Crit. Care Med, 2002. 3: Udwadia, Jain. NEJM (2007) 357:19, 4 McCarthy, Autoimmune Pulmonary Alveolar Proteinosis, Amer. Journal of Respiratory and Critical Care Med., 2022.

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Unmet Need: aPAP Patients Have Significantly Higher Rates of Healthcare Utilization and Comorbidities[1]

Charlson Comorbidity Index (CCI)*

3.5x Vs. matched controls

PAP: 1.84 ± 2.48
Age and Gender Matched Controls: 0.55 ± 1.44
P value: <0.0001

*Developed to classify comorbid conditions which may influence mortality risk. Most widely used comorbidity index used to determine survival rates in patients with multiple comorbidities.

Outpatient visits (~17 per year)

+66% Vs. matched controls

PAP: 17.30 ± 13.77
Age and Gender Matched Controls: 10.40 ± 11.38
P value: <0.01

Emergency Room Visits (~1.5 per year)

+38% Vs. matched controls

PAP: 1.49 ± 1.17
Age and Gender Matched Controls: 1.08 ± 0.27
P value: 0.014

Longer hospital stays (~16 days per year)

3.0x Vs. matched controls

PAP: 15.96 ± 20.71
Age and Gender Matched Controls: 5.40 ± 5.07
P value: 0.027

1: McCarthy et al. Orphanet Journal of Rare Diseases (2018) 13:129

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Savara Investigational Drug-Device Treatment for aPAP

- Once daily 300 μg inhaled molgramostim
- Proprietary eFlow® Nebulizer System (PARI)
  - Optimized for molgramostim administration
  - Well-established manufacturer of devices used for inhalation therapy
  - 5 FDA approved nebulizers based on eFlow® Technology

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IMPALA-2 Top Line Results

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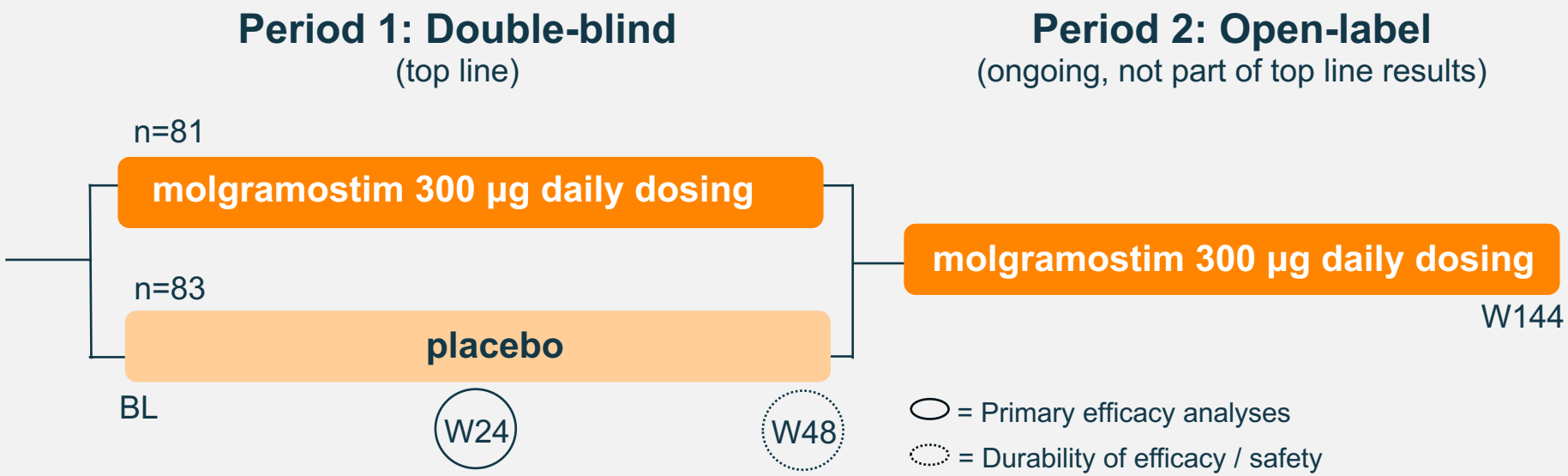
Phase 3 IMPALA-2 Trial Design

6-Week Screening

- DLCO ≤70% predicted at first screening and baseline
- Change in % predicted DLCO <15% points to ensure stably impaired patients



PRIMARY ENDPOINT

- Change from baseline in DLCO at W24

SECONDARY ENDPOINTS

Change from baseline in:

- DLCO at W48
- SGRQ Total Score at W24 and W48
- SGRQ Activity Score at W24 and W48
- Exercise Capacity at W24 and 48

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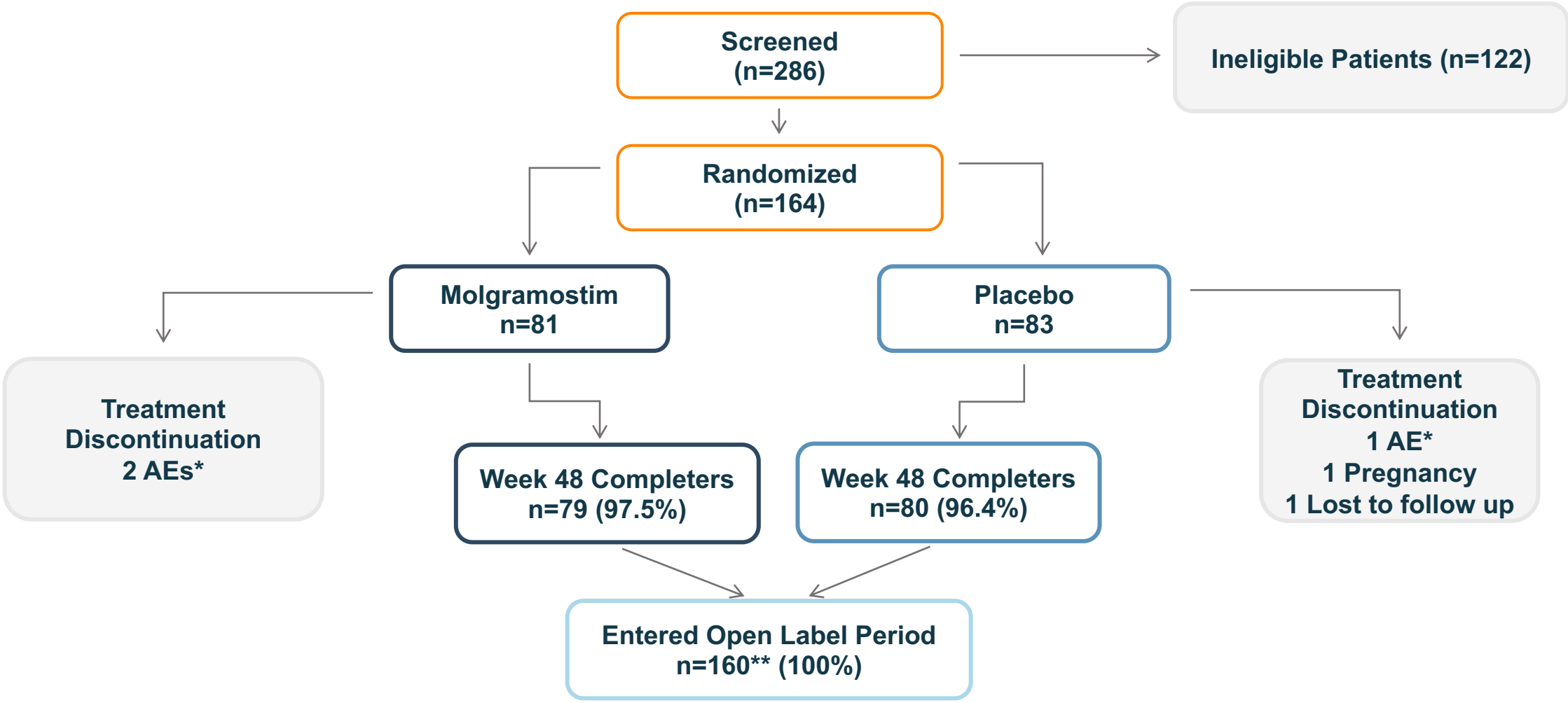
Discontinuations in Double-Blind Period Were Low: 3%
Participation in Open Label Period Was High: 100% of Double-Blind Period Completers

IMPALA-2 PATIENT DISPOSITION



*Not considered trial drug related
**One placebo patient stopped blinded trial drug but continued trial participation through Week 48 and entered the open label period

Demographics Were Well-Balanced Across Treatment Groups

		Molgramostim N=81	Placebo N=83
Age years	Mean (SD)	50.8 (13.03)	48.4 (12.69)
Sex n (%)	Male Female	44 (54.3) 37 (45.7)	54 (65.1) 29 (34.9)
Race n (%)	White Asian Black or African American Other	38 (46.9) 36 (44.4) 3 (3.7) 4 (4.9)	40 (48.2) 37 (44.6) 2 (2.4) 4 (4.8)
DLCO at baseline	Mean (SD)	52.6 (11.71)	52.6 (10.39)
DLCO stratification group	≤ 50% > 50%	31 (38.3) 50 (61.7)	32 (38.6) 51 (61.4)

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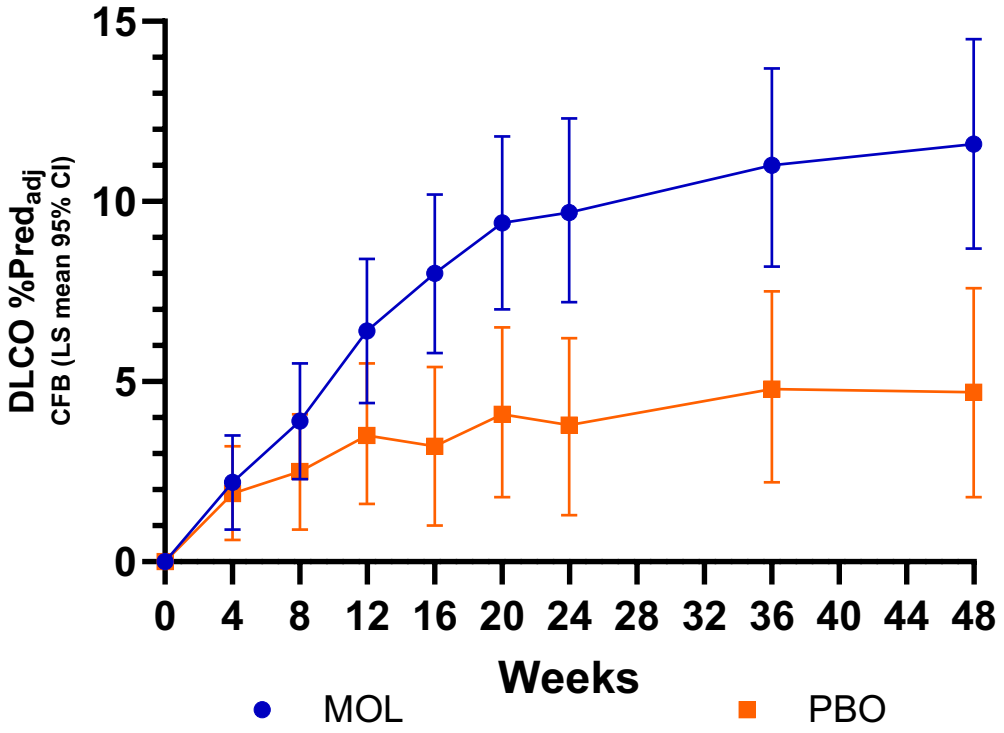
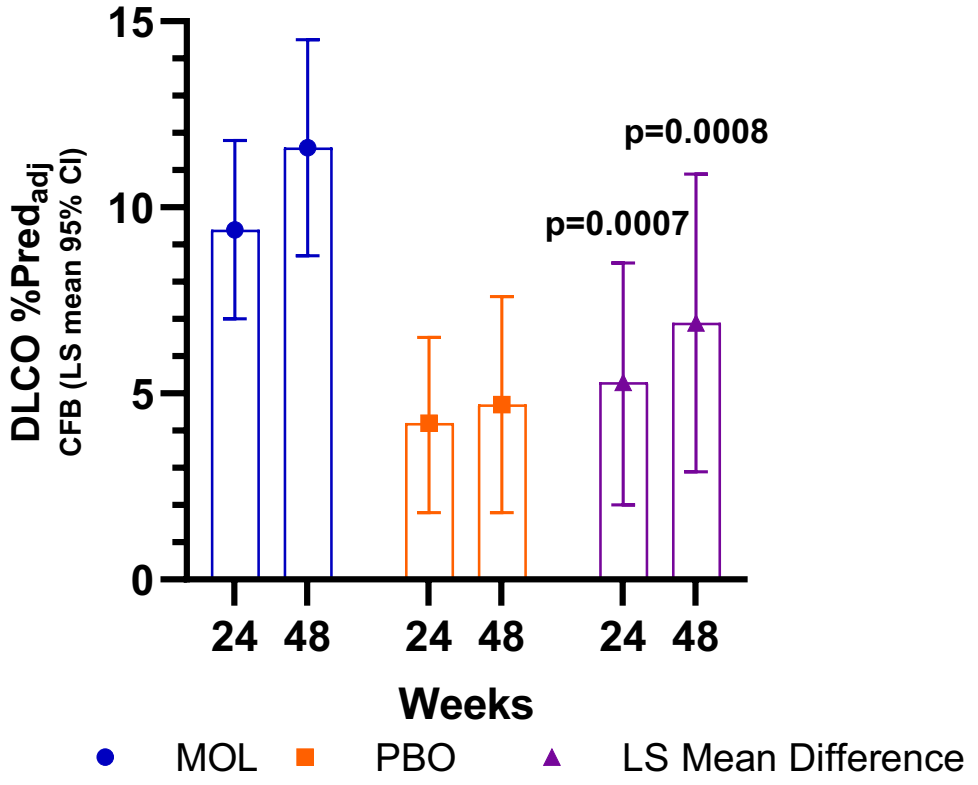
Primary Endpoint Met

Molgramostim Superior to Placebo on Change From Baseline in DLCO at W24 (Primary Endpoint) and W48 (Secondary Endpoint)





P-values are for Difference in LS Mean compared to PBO

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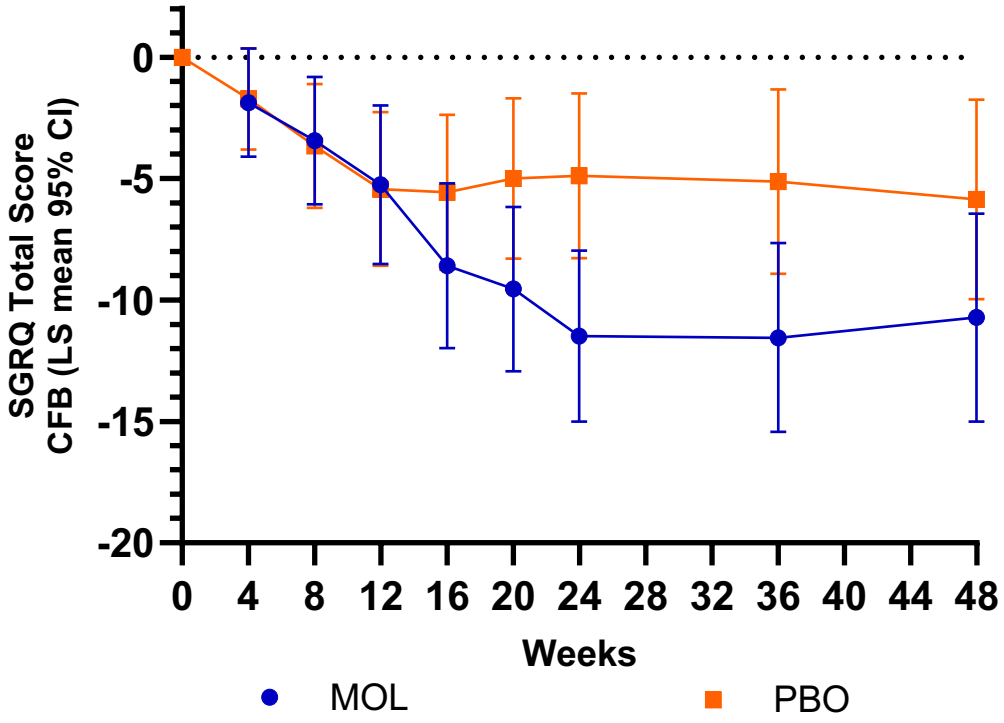
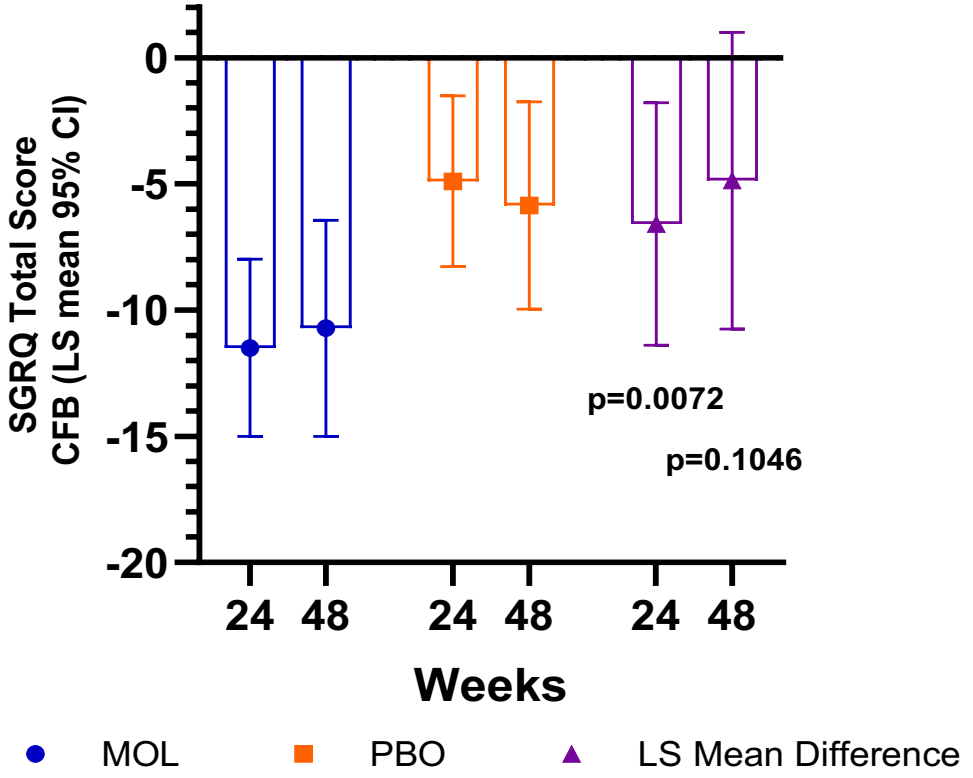
Molgramostim Superior to Placebo on Change From Baseline in SGRQ Total Score at W24, Favorability Continues Through W48





P-values are for Difference in LS Mean compared to PBO

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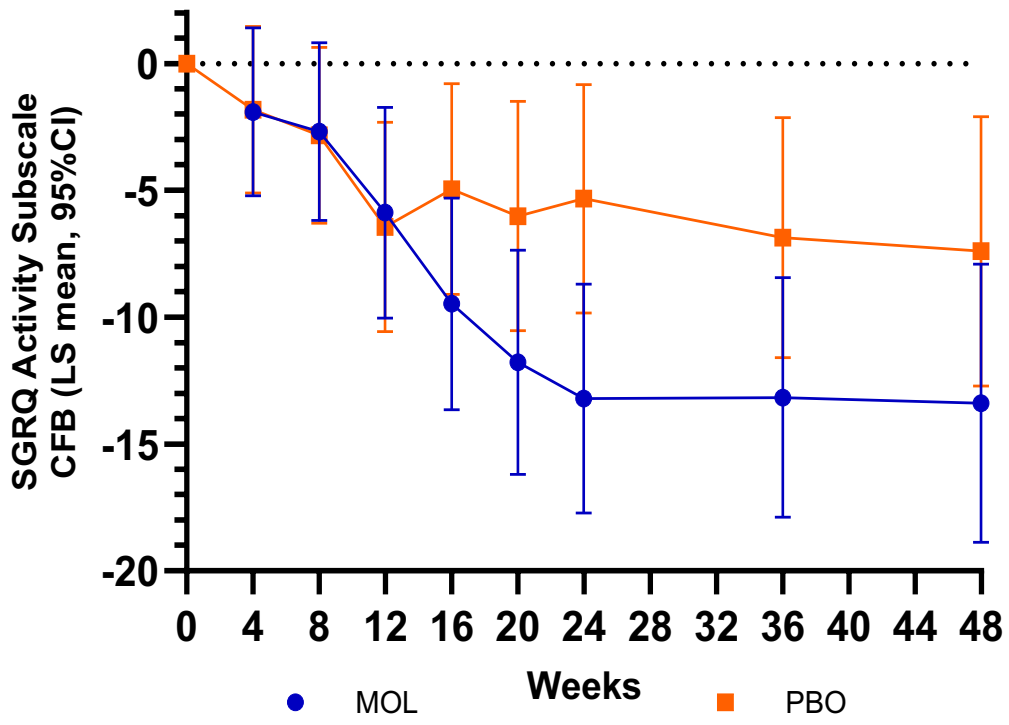
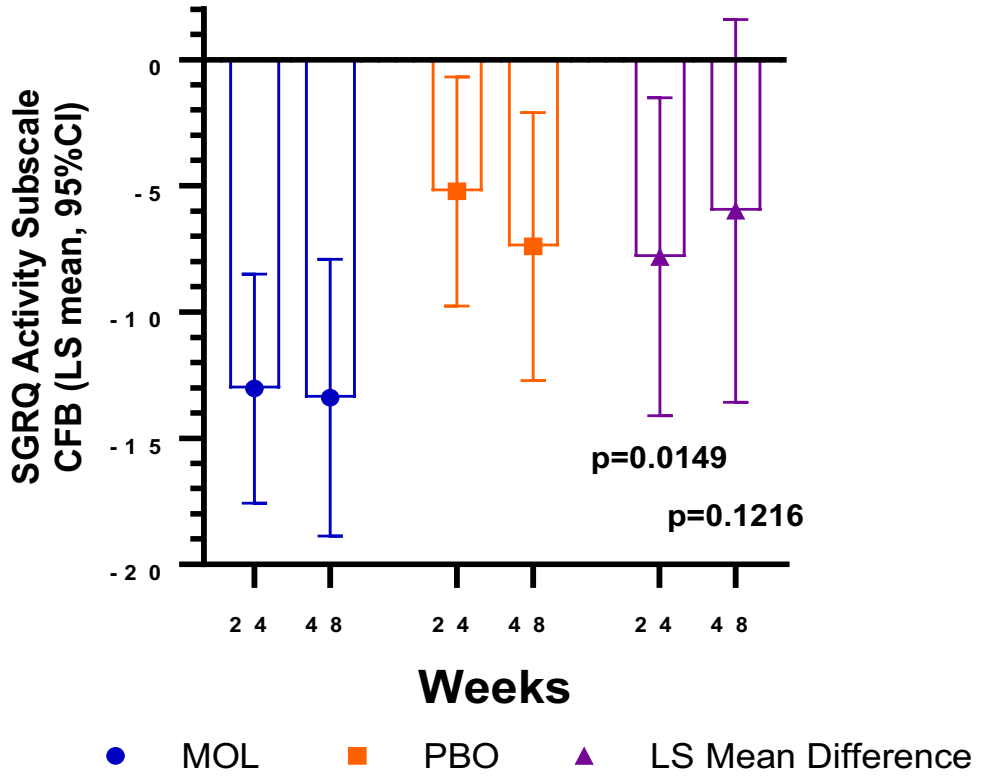
Molgramostim Nominally Significant on Change From Baseline in SGRQ Activity Score at W24, Favorability Continues Through W48





P-values are for Difference in LS Mean compared to PBO

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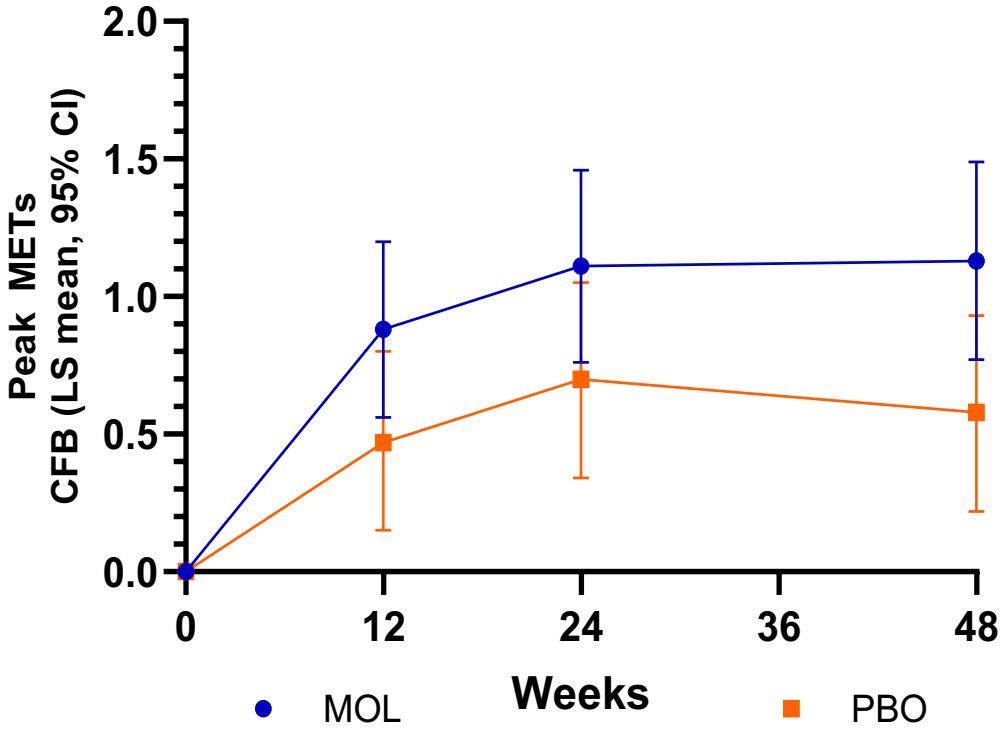
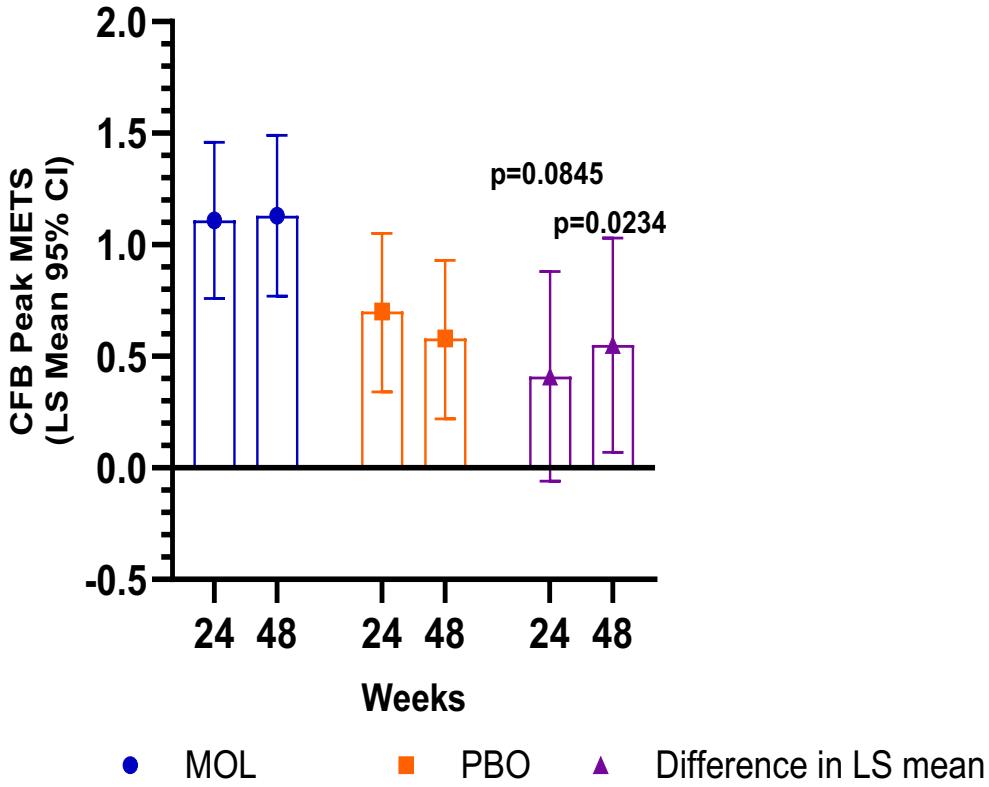
Molgramostim Nominally Significant on Change From Baseline in Exercise Capacity (Peak METs) at W48





P-values are for Difference in LS Mean compared to PBO

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Lung Lavage Was Permitted as a Rescue Therapy During the Trial

During 48-week double-blind period

- 17 (~10%) patients underwent at least one lung lavage
  - Molgramostim: n=6 (7.4%)
  - Placebo: n=11 (13.3%)

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IMPALA-2 Safety Summary: Molgramostim Was Well-Tolerated

Treatment Emergent Adverse Events	Molgramostim N=81 n (%)	Placebo N=83 n (%)
Any	**69 (85)**	**71 (86)**
Severe	13 (16)	16 (19)
Treatment related	**20 (25)**	**16 (19)**
Serious	**14 (17)**	**20 (24)**
Not treatment related	13 (16)	20 (24)
Treatment related[1]	1 (1)	0
Leading to death	**0**	**0**
Leading to trial drug discontinuation	**2 (2)**	**1 (1)**
Special interest (chest pain, hypersensitivity)	**9 (11)**	**6 (7)**
Serious and of special interest	0	1 (1)

[1]SAE of delusions resulting in psychiatric hospitalization in patient with a past medical history of seizure disorder treated with levetiracetam, which is labeled for psychiatric side effects, including delusions; the event was assessed as possibly related to study drug by the investigator.

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IMPALA-2 Safety Summary: Most Common Adverse Events

ADVERSE EVENTS IN >10% OF PATIENTS IN ANY TREATMENT ARM DURING DOUBLE-BLIND TREATMENT PERIOD

Treatment Emergent Adverse Events	Molgramostim (N=81) n (%)	Placebo (N=83) n (%)
Any	**69 (85)**	**71 (86)**
Most common		
COVID-19	18 (22)	8 (10)
Cough	17 (21)	18 (22)
Pyrexia	11 (14)	9 (11)
Nasopharyngitis	11 (14)	7 (8)
Arthralgia	9 (11)	7 (8)
Headache	9 (11)	7 (8)
Diarrhea	9 (11)	2 (2)
Alveolar proteinosis	4 (5)	12 (14)
Treatment related	**20 (25)**	**16 (19)**

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Regulatory and Intellectual Property

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1H 2025: BLA Submission Expected to be Complete

MOLGRAMOSTIM IN aPAP REGULATORY DESIGNATIONS

- Orphan Drug Designation, Europe (eligible for 10 years exclusivity)
- Orphan Drug Designation, U.S. (eligible for 7 years exclusivity)
- Fast Track Designation, U.S.
- Breakthrough Therapy Designation, U.S.
- Innovation Passport Designation, U.K.
- Promising Innovative Medicine Designation, U.K.

IMPALA-2

- Trial design endorsed by regulatory authorities in the U.S., Canada, Japan, South Korea, Australia, U.K., and countries in Europe where the trial is being conducted

BIOLOGIC EXCLUSIVITY

- Upon Biologics License Application (BLA) approval FDA would grant 12 years marketing exclusivity

INTELLECTUAL PROPERTY

- Pending patent applications for molgramostim drug formulation and methods of use including treating aPAP with molgramostim
- Worldwide exclusive license to proprietary eFlow® Nebulizer System (PARI) for molgramostim in aPAP and pending joint patent application with PARI for the drug/device combination
- Proprietary cell bank for molgramostim

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Commercial Outlook

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aPAP Diagnosed Prevalence Before and After Broad Availability of GM-CSF Autoantibody Testing

Published aPAP Epidemiology Studies

Current Diagnosed Prevalence Before Broad GM-CSF Autoantibody Testing

REFERENCE	METHODOLOGY	INCIDENCE PER MILLION	DIAGNOSED PREVALENCE PER MILLION	IMPLIED US PATIENTS	IMPLIED EU PATIENTS	IMPLIED JAPAN PATIENTS	TOTAL IMPLIED PATIENTS
DIAGNOSED PREVALENCE							
Inoue 2008	Registry based in Niigata, Japan	0.48 *(0.23-1.00)*	6.2 *(3.8-10.3)*	*~2,058*	*~2,325*	*~775*	*~5,158*
McCarthy 2018	US insurance claims data, 2008-2012	Not reported	6.3 *(5.2-7.6)*	*~2,092*	*~2,363*	*~788*	*~5,243*

Diagnosed Prevalence After Broad GM-CSF Autoantibody Testing

REFERENCE	METHODOLOGY	INCIDENCE PER MILLION	DIAGNOSED PREVALENCE PER MILLION	IMPLIED US PATIENTS	IMPLIED EU PATIENTS	IMPLIED JAPAN PATIENTS	TOTAL IMPLIED PATIENTS
DIAGNOSED PREVALENCE							
Kitamura 2019	Update of Niigata registry	1.66 *(1.2-2.2)*	26.6 *(9.0-73.0)*	*~8,831*	~9,975	~3,325	~22,131

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Re-analysis of Claims Dataset Estimates There Are ~5,000 aPAP Patients in the U.S.

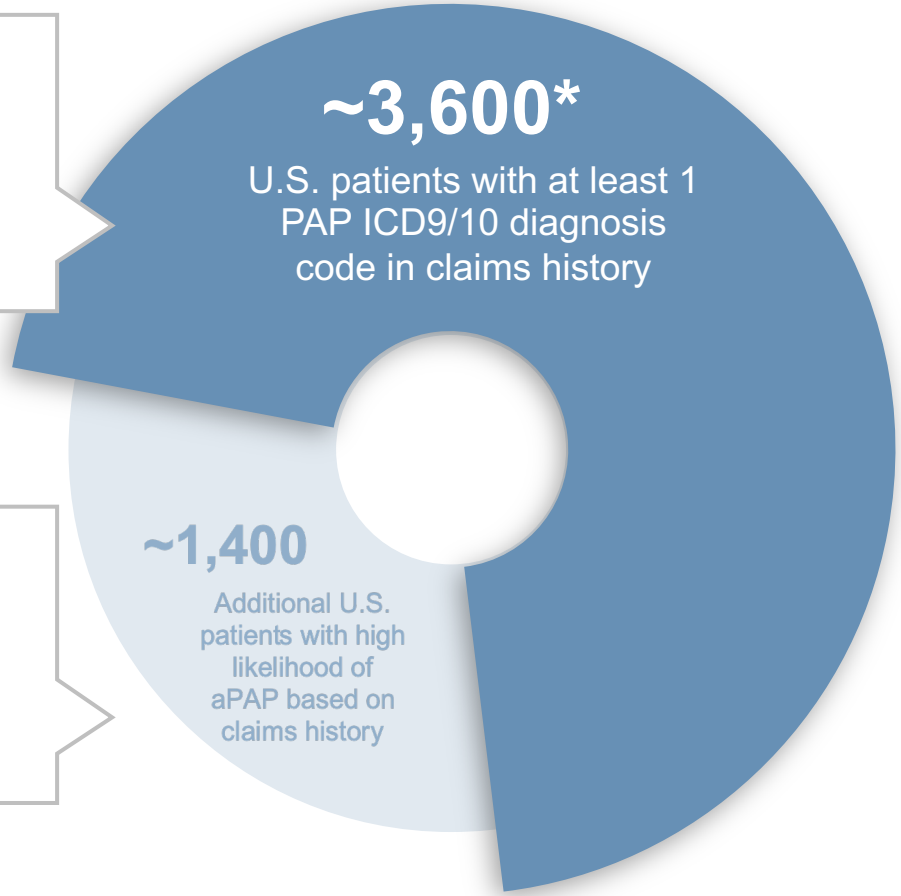
ANALYSIS OF COMPREHENSIVE CLAIMS DATASET

Real-World Claims Dataset:

- **300M+ unique, active patients**
- **89-99% providers/sites of care**
- **Counted PAP ICD9/10 diagnosis claims**

APPLIED MACHINE LEARNING (ML) MODEL TO SAME CLAIMS DATASET

ML model identified patients who have high likelihood of PAP, but are not yet diagnosed (patients were required to have either a bronchoscopy, BAL, or lung lavage in their claims history)



~5,000 estimated aPAP patients in the U.S., based on identified PAP claims history and machine learning assessment

**Data from 2023 U.S. insurance claims analysis conducted by Savara. Highly likely patients: ≥ 2 PAP diagnosis claims, likely patients: 1 PAP diagnosis claim*

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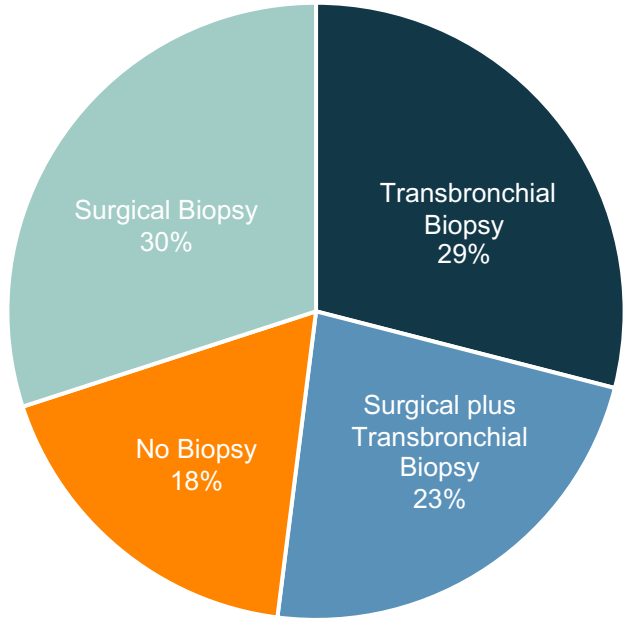
Historically, Without a Broadly Available Diagnostic for aPAP, the Journey to Diagnosis Can Be Long and Misdiagnosis Common

- **3-36 months[1]: Range for aPAP time-to-diagnosis**
- **18 months[2]: Average delay caused by misdiagnosis (e.g., pneumonia or asthma)**
- **Diagnostic workup frequently involves multiple tests and invasive procedures, including**
  - Pulmonary function tests
  - Arterial blood gas analysis
  - Chest radiographs
  - CT scans
  - Bronchoalveolar lavage (BAL) cytology and/or lung histopathology[3]
  - Transbronchial biopsy, surgical lung biopsy, or both

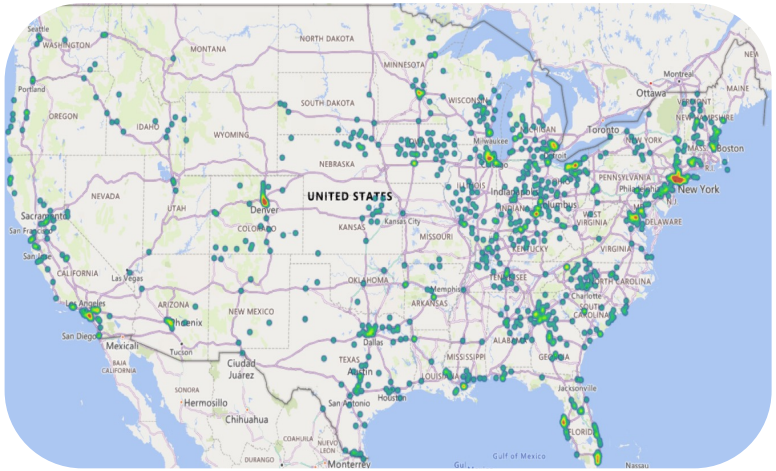
U.S. National PAP Registry[4] indicates many patients with PAP are diagnosed via an invasive transbronchial biopsy, surgical lung biopsy, or both[3]



Sources: 1: Campo Orphanet J Rare Dis 2013; 2: Trapnell Nat Rev Dis Primers 2019; 3: McCarthy Chest 2019; 4: Trapnell PAP Registry http://clinicaltrials.gov/ct2/show/

Launched HCP Disease Awareness Campaign and No-Cost GM-CSF Autoantibody Testing in U.S.

1,111 affiliated accounts* with ≥2 aPAP diagnosis claims



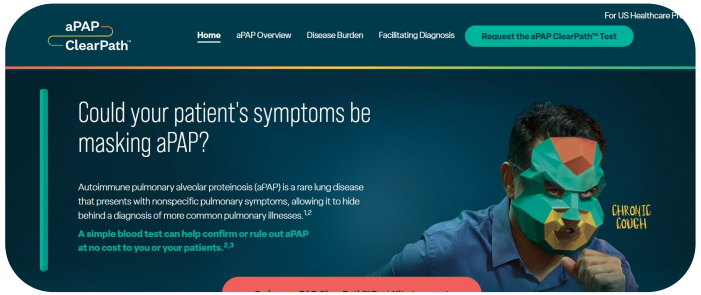
~15K
Pulmonologists in the US

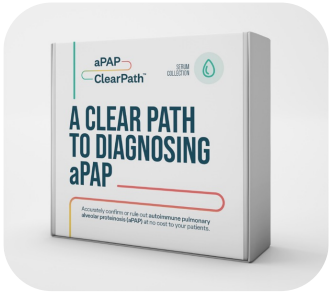
~5K
HCPs with diagnosed or machine-learning suspected PAP patients

~120
Pulmonology centers

~10
PAP clinical centers

www.apapclearpath.com





U.S. HCP Website

- Increase HCP awareness of aPAP, including hallmark symptoms of the disease
- Educate HCPs on need for routine GM-CSF autoantibody testing
- REQUEST THE TEST: Order a simple, non-invasive, no-cost GM-CSF autoantibody blood test

Patient Advocacy Group Partnerships/Memberships

NTM Info & Research, Inc.

NORD® National Organization for Rare Disorders

PAP FOUNDATION

American Lung Association.

- **Any hospital and health system the diagnosing HCP is affiliated with (within the U.S. claims database).*
- *Data on file.*

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Molgramostim: Global Commercial Opportunity

Significant Unmet Need

- **High disease burden**
- **Strong market expansion potential** via disease awareness campaign, broad access to GM-CSF autoantibody testing

Rare Disease Infrastructure

- **Orphan disease-like infrastructure in U.S.** – field-based team of ~15-30
- **OUS commercial strategy optionality** – go-it-alone, regional partnerships, etc.

Molgramostim

- **WLL (standard of care) is invasive and not standardized**
- **Dosing expected to be chronic,** providing long-term revenue stream
- **Assumed pricing power consistent with recently approved orphan drug analogs** (i.e., in U.S. ~$300-$500K p/patient, p/year)

Long Term Exclusivity

- **12-year biologic exclusivity in the U.S. and biosimilar competition unlikely**

**Compared to matched controls. Data on file*

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Financials

Financial Highlights

- **Cash runway through 2026**
  - ~$237M in cash*
- **Strong investor support with coverage from 7 equity research analysts**

ANALYST COVERAGE

Jefferies	Andrew Tsai
Piper Sandler	Yasmeen Rahimi, PhD
Guggenheim Securities	Vamil Divan, MD, MBA
Oppenheimer	Francois Brisebois
JMP	Jonathan Wolleben
H.C. Wainwright	Andrew Fein
Evercore ISI	Liisa Bayko, MSC, MBA

**Pro forma for cash, cash equivalents, and short-term investments as of 03/31/24, including July 2024 equity offering of $94M (net).*

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Investment Thesis

Successful Pivotal Phase 3 Program in aPAP

- Molgramostim achieved statistical significance on primary endpoint and multiple secondary endpoints in IMPALA-2 trial
- Favorable safety profile observed from the first and second IMPALA trials
- BLA submission expected to be complete 1H 2025

Strong global commercial opportunity

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- Potential for a long-term, durable revenue stream with biosimilar competition unlikely

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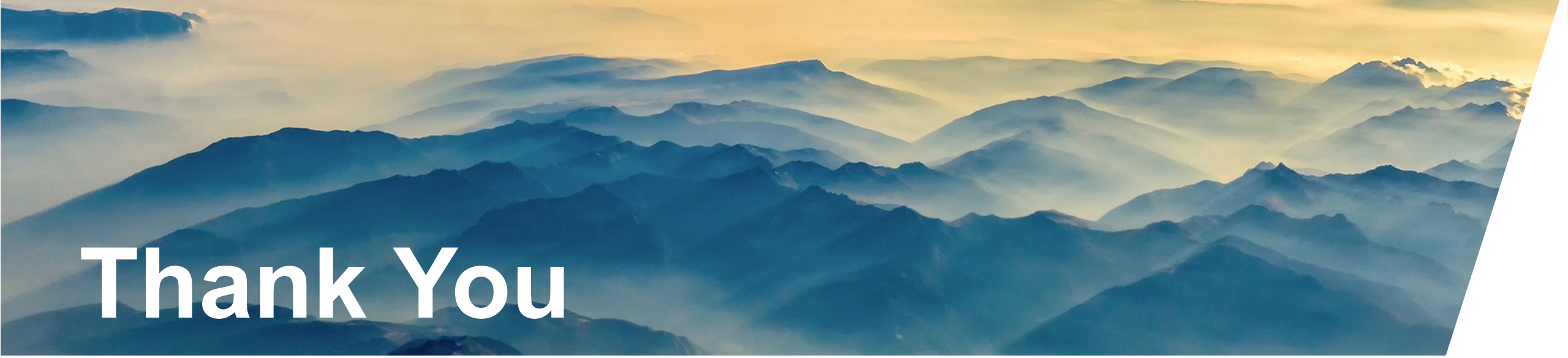

Thank You

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