ASAVARA

Corporate Overview

Developing New Therapies for Rare Respiratory Diseases May 2025

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Executive Leadership Team



Autoimmune Pulmonary Alveolar Proteinosis (aPAP)

Overview and Burden of Disease



Autoimmune PAP: Disease of Alveolar Macrophage Dysfunction



Rare lung disease caused by GM-CSF autoantibodies which block GM-CSF signaling and reduce surfactant clearance

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

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



NORMAL vs ABNORMAL ALVEOLUS

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



Autoimmune PAP is a Rare, Long-Term, Chronic Lung Disease

No approved drugs in the U.S. or Europe for aPAP, only treatment option is an invasive procedure

Progressive Shortness of Breath

- With impaired gas exchange, 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



Increased Risk of Infection

 Serious infections, the most common and threatening complications of aPAP, occur in 5–13% of patients and account for 18–20% of deaths¹⁻⁴



Fibrosis and Lung Transplant

 Over time, aPAP can lead to pulmonary fibrosis and respiratory failure which can be fatal and may require lung transplantation



1. Trapnell Nat Rev Dis Primers 2019; 2. Seymour AJRCCM 2002; 3. Inoue AJRCCM 2008; 4. Jouneau Respirology 2020

Whole Lung Lavage (WLL):

Requires insertion of double-

lumen endobronchial tube for

lung separation

- Performed under anesthesia and requires hospitalization, a team of experienced HCPs, and surgical resources
- Does not correct underlying pathophysiology of the disease or prevent abnormal surfactant accumulation and often needs to be repeated
- Patients describe WLL as burdensome and emotionally taxing
- Long-term negative impact (potential lung damage) of repeated WLL procedures is unknown



Treated lung is repeatedly filled

with up to 15-50L of saline and

then drained by gravity

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



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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sediment

Disease Burden: Autoimmune PAP Patients Have Significantly Higher Rates of Healthcare Utilization and Comorbidities¹



1. Lee, et al. Orphanet J Rare Dis. 2025; 20:73.

Patient Perspectives on Living with aPAP

With whole lung lavage being the only treatment option, it's terrifying. The best way to describe it in layman's terms, it's like a car wash for your lungs. Having an alternative treatment from whole lung lavage would mean the world to me, it would give me the opportunity to get my life back. To give me the freedom of what I had before aPAP.

- Kelsea

Overall, when the surfactant builds up, I notice how much more tired I get, walking from the basement to the first floor will wind me, I'll get chest congestion and cough up yellow mucus. So, every 8 months surfactant builds up and I'll need the whole lung lavage, and it causes a lot of anxiety knowing I will need to keep having them. Having had multiple lung lavages over the years; there needs to be more options when it comes to managing aPAP."

- Eric

TO HEAR THESE PATIENTS' STORIES, PLEASE VISIT WWW.SAVARAPHARMA.COM

Disease Burden: Journey of an aPAP Patient¹

		CURRENT JOURNEY			POTENTIAL FUTURE JOURNEY
S	ymptoms and Experience Before Diagnosis	Diagnosis with aPAP		Treatment	
	12 MONTHS	18 MONTHS			
	FROM FIRST EXPERIENCING SYMPTOMS TO SEEING A PHYSICIAN	AVERAGE TIME FROM FIRST SEEING A PHYSICIAN TO DIAGNOSIS			 • Non-invasive, no-cost, simple auto-antibody blood test to help decrease time-to-
	Insidious development	aPAP diagnosis	b	 Whole lung lavage 	diagnosis
	 Battery of diagnostic tests 		(VVLL)	(VVLL)	MOLBREEVI*
	 Typically misdiagnosed as pneumonia coupled with incorrect treatment 			 Potential off-label therapies 	 Clinically meaningful positive Phase 3 results that suggest MOLBREEVI may address the
	 Cycles of misdiagnosis for 				pathophysiology of aPAP
	months to years				 Favorable benefit/risk profile
	 Eventual referral to a 				 Well tolerated
	pulmonologist for full pulmonary work-up				 March 2025: Submitted BLA

1. Ataya, et al. J.R.Med.2025 Feb.11:107990

*MOLBREEVI is the FDA and EMA conditionally accepted trade name for molgramostim inhalation solution. It is not approved in any indication.

MOLBREEVI*

(molgramostim inhalation solution)

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ASAVARA

Savara Investigational Drug-Device Treatment for aPAP

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

Nebulization Time: ~5 minutes



Summary of IMPALA-2 Results

PRIMARY ENDPOINT (MOLBREEVI vs placebo)

Change from baseline to Week 24 in DLco% (p=0.0007)¹

SECONDARY ENDPOINTS (MOLBREEVI vs placebo)

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Change from baseline to Week 48 in DLCO% (p=0.0008)¹ Change from baseline to Week 24 in SGRQ Total Score (p=0.0072)¹

- CI
 - Change from baseline to Week 24 in SGRQ Activity Score (p=0.0149)²

Change from baseline to Week 48 in Exercise Capacity (p=0.0234)²

SAFETY and TOLERABILITY

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Well-tolerated; low treatment discontinuation rate (3%), none due to drug-related adverse events

- \odot
- 100% of patients who completed the double-blind period enrolled into the open-label period

DLco%, hemoglobin-adjusted percent predicted diffusing capacity of the lungs for carbon monoxide; SGRQ, St. Georges Respiratory Questionnaire. ¹Statistically significant.²Nominally significant.

Phase 3 IMPALA-2 Trial Design



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

Discontinuations in Double-Blind Period Were Low: 3%

Participation in Open Label Period Was High: 100% of Double-Blind Period Completers



*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 in IMPALA-2 Were Well-Balanced Across Treatment Groups

		MOLBREEVI 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)

IMPALA-2: MOLBREEVI Superior to PBO on Change from Baseline in DLCO at W24 (primary endpoint) and W48 (secondary endpoint)



	LSM Change from Baseline	Between- Group LSM Difference*	P-value
Week 24	Mol: 9.8 Pbo: 3.8	6.00	0.0007
Week 48	Mol: 11.6 Pbo: 4.7	6.90	0.0008

The minimal clinically important difference (MCID) in change in DLCO is 10% in progressive pulmonary fibrosis and 11% in severe COPD.¹ MOLBREEVI in aPAP showed a ~10% increase from baseline at W24 and ~12% increase from baseline at W48.

1 Raghu G, Remy-Jardin M, Richeldi L, et al. Idiopathic Pulmonary Fibrosis (an Update) and Progressive Pulmonary Fibrosis in Adults: An Official ATS/ERS/JRS/ALAT Clinical Practice Guideline. Am J Respir Crit Care Med 2022;205:e18-e47; Horita N, Miyazawa N, Kojima R, Inoue M, Ishigatsubo Y, Kaneko T. Minimum clinically important difference in diffusing capacity of the lungs for carbon monoxide among patients with severe and very severe chronic obstructive pulmonary disease. COPD 2015;12:31-7.

*Mean change from baseline compared with placebo. P-values are for difference in LSM compared with placebo and met the threshold required in the pre-specified hierarchical testing procedure to control the overall Type 1 error rate at 0.05. DLco%, hemoglobin-adjusted percent predicted diffusing capacity of the lungs for carbon monoxide; LSM, least squares mean; Mol, MOLBREEVI; Pbo, placebo; SE, standard error.

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IMPALA-2: MOLBREEVI Superior to PBO on Change From Baseline in SGRQ Total Score at W24, Favorability Continues Through W48



	LSM Change from Baseline	Between- Group LSM Difference*	P-value
Week 24	Mol: -11.5 Pbo: -4.9	-6.59	0.0072†
Week 48	Mol: -10.7 Pbo: -5.9	-4.87	0.1046

*Mean change from baseline compared with placebo. P-values are for difference in LSM compared with placebo. [†]Statistically significant: met the threshold required in pre-specified hierarchical testing procedure to control the overall Type 1 error rate at 0.05. HRQoL, health-related quality of life; LSM, least squares mean; Mol, MOLBREEVI; Pbo, placebo; SE, standard error; SGRQ, St. George's Respiratory Questionnaire.

IMPALA-2: MOLBREEVI Nominally Significant on Change From Baseline in SGRQ Activity Score at W24, Favorability Continues Through W48



	LSM Change from Baseline	Between- Group LSM Difference*	P-value
Week 24	Mol: -13.0 Pbo: -5.2	-7.81	0.0149†
Week 48	Mol: -13.4 Pbo: -7.4	-5.99	0.1216

*Mean change from baseline compared with placebo. P-values are for difference in LSM compared with placebo. †P-value nominally significant: P-value ≤0.05 but did not meet the p-value threshold required in the pre-specified hierarchical testing procedure. HRQoL, health-related quality of life; LSM, least squares mean; Mol, MOLBREEVI; Pbo, placebo; SE, standard error; SGRQ, St. George's Respiratory Questionnaire.

IMPALA-2: MOLBREEVI Nominally Significant on Change From Baseline in Exercise Capacity (Peak METs) at W48



	LSM Change from Baseline	Between- Group LSM Difference*	P-value
Week 24	Mol: 1.11 Pbo: 0.70	0.41	0.0845
Week 48	Mol: 1.13 Pbo: 0.58	0.55	0.0234†

*Mean change from baseline compared with placebo. P-values are for difference in LSM compared with placebo. †P-value nominally significant: P-value ≤0.05 but did not meet the p-value threshold required in pre-specified hierarchical testing procedure. LSM, least squares mean; MET, metabolic equivalent; Mol, MOLBREEVI; Pbo, placebo; SE, standard error.

IMPALA-2 Demonstrated That MOLBREEVI Reduces Pulmonary Surfactant Burden: Ground Glass Opacity Score at W24





Baseline



After 24 weeks on MOLBREEVI

*P-value based on post-hoc analysis. GGO, ground glass opacity.

Whole Lung Lavage (WLL) was Permitted as a Rescue Therapy During the IMPALA-2 Trial



17 (~10%) patients underwent at least one lung lavage

IMPALA-2 Safety Summary: **MOLBREEVI** Was Well-Tolerated

Treatment Emergent Adverse Events	MOLBREEVI 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)

¹SAE of delusions resulting in psychiatric hospitalization in patient with a past medical history of seizure disorder treated with levetiracetam; the event was assessed as possibly related to study drug by the investigator.

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	MOLBREEVI (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)	

Overview of IMPALA-2 Results: Top Line, DSS, Responder Analyses, and GGO Data

	Measure	Timeframe	P-Value / Results
	DLCO%	Week 24 Week 48	0.0007 0.0008
Pulmonary gas exchange	Disease Severity Score (DSS)	Week 24 Week 48	0.0239* 0.0006*
	Responder Analysis - DLco%	Weeks 24 and 48	Significantly higher proportions of patients achieved each responder threshold (5%, 7%,10%) with MOLBREEVI compared to placebo
	SGRQ Total Score	Week 24 Week 48	0.0072 0.1046
Respiratory health-related	SGRQ Activity Score	Week 24 Week 48	0.0149 [†] 0.1216
quality of life	Responder Analysis – SGRQ Total	Week 24 Week 48	Numerically (W24) & significantly (W48) higher proportions of patients achieved each responder threshold (-4, -8, -12-points) with MOLBREEVI compared to placebo
Patient functionality	Exercise Capacity (Peak METs)	Week 24 Week 48	0.0845 0.0234 †
	Chest Computed Tomography – GGO	Week 24	0.0004*
Surfactant burden	Whole Lung Lavage	Over 48 Weeks	Numerically favorable to MOLBREEVI compared to placebo

*Post-hoc analysis. *P-value nominally significant: P-value < 0.0500 but did not meet the p-value threshold required in the pre-specified hierarchical testing procedure.

DLco%, hemoglobin-adjusted percent predicted diffusing capacity of the lungs for carbon monoxide; GGO, ground glass opacification; METs, metabolic equivalents; SGRQ, St. George's Respiratory Questionnaire.

Real-World, Retrospective Outcomes Data Suggest MOLBREEVI Addresses Underlying Pathophysiology of aPAP

Prior to Treatment

All 5 patients had

- CT tomography scan patterns
- Bronchoalveolar lavage findings
- Characteristic PAP symptoms
- Positive GM-CSF antibody test
- Mean duration of therapy: 4.2 years
- 4 patients had ≥ 1 WLL prior to taking MOLBREEVI

Post Treatment

- MOLBREEVI treatment led to
 - Improved lung function
 - Decreased disease burden
 - · Restored patient functionality
 - Reduced clinical symptoms
- 0 patients required WLL after >1 year on MOLBREEVI
- Treatment was well tolerated, no reported SAEs

Montaño C, Bendstrup E, Rønnov-Jessen I, et al. ERJ Open Res 2025;11:00567-2024

Case Series Evaluated 5 aPAP Patients Who Received MOLBREEVI Through Single Patient Access

	Patient 1	Patient 2	Patient 3	Patient 4	Patient 5
Clinical outcome	Overall improvement Decrease in oxygen demand Improved PFTs and radiological findings	Rapid clinical improvement Improved PFTs and radiological findings	Improved No longer needed O ₂ supplementation Improved PFTs and radiological findings	Improved, without further need for O ₂ supplementation Improved PFTs and radiological findings	Improved, without need for O ₂ at rest Improved PFTs and radiological findings
HRCT before treatment with molgramostim inhalation solution	Jan 2019	March 2020	Jan 2018	Aug 2018	Dec 2022*
HRCT after treatment with molgramostim inhalation solution	June 2020, after 1 year on molgramostim	Jan 2021, after 10 months on molgramostim	June 2023, after 3.5 years on molgramostim	Aug 2022, after 4 years on molgramostim	Feb 2024, after 14 months on molgramostim

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Regulatory and Intellectual Property



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U.S. and European Regulatory Timeline



*Assumes Priority Review is granted by the FDA

MOLBREEVI in aPAP Regulatory and IP Summary

REGULATORY DESIGNATIONS

US

- Orphan Drug Designation (eligible for 7 years exclusivity)
- Fast Track Designation
- Breakthrough Therapy Designation

EUROPE

Orphan Drug Designation (eligible for 10 years exclusivity)

UK

- Innovation Passport Designation
- Promising Innovative Medicine Designation

BIOLOGIC EXCLUSIVITY

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

INTELLECTUAL PROPERTY

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

Commercial Update



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Commercial Launch Planning Advancing Against Near-Term Objectives

AWARENESS	INFRASTRUCTURE	PERSONNEL	TESTING
Expand awareness of autoimmune PAP among targeted health care professionals and patients	Build critical capabilities to facilitate access to MOLBREEVI post approval	Hire and onboard key commercial roles to expand core activities	Evolve diagnostic platform to scale testing efforts
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Autoimmune PAP Disease State Awareness Campaign

Multi-channel effort across healthcare professionals and patients



Patient DSA Campaign



Exclusive Specialty Pharmacy with Integrated Patient Services

Right-sized model for first-to-market solution for orphan condition

SPECIALTY PHARMACY



- Smaller patient population is best served by a single specialty pharmacy
 - Consistency
 - Seamless provision of services
 - Clear visibility to all patient data to inform key performance indicators
- Currently evaluating partners
 - Relevant pulmonary experience
 - Demonstrated track record of exceptional patient and provider services

Single source pharmacy will service all patients with direct shipments and ongoing support

MyMolbreevi: Best in Class Support Program in Development

Program aims to reduce access barriers for appropriate MOLBREEVI patients post approval

PATIENT SERVICES

- Case management approach
 - Dedicated care navigator
 - Single point of contact

Financial assistance

- Commercial co-pay program
- Free drug for eligible patients
- **PRESCRIBER SERVICES**
- Streamlined prescribing
- Prior authorization checklist

- Clinical education
 - Pharmacist calls
 - Device training
 - Nurse educators
 - Adherence support

- Insurance services
 - Prior authorization
 - Appeals

- Sample letter of medical necessity
- Sample letter of appeal

Studies on aPAP Epidemiology Range From 6-26 Patients P/Million

Published aPAP Epidemiology Studies

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)		~2,077	~2,027	~775	~4,879
McCarthy 2018	US insurance claims data, 2008-2012	Not reported	6.3 (5.2-7.6)		~2,111	~2,060	~788	~4,959
Kimura 2025	Japanese insurance claims data, 2014-2020	Avg: 1.57 (1.4-1.8)	8.5 (7.1-9.7)		~2,848	~2,778	~1,063	~6,689
				_				
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)		~8,911	~8,698	~3,325	~20,934

*EU = France, German, Italy, Spain + UK

Inoue, et al Am J Respir Crit Care Med Vol 177. pp 752–762, 2008; McCarthy, et al. Orphanet Journal of Rare Diseases (2018) 13:129; Kimura, et al. ERJ Open Res 2025; 11: 00666-2024; Kitamura, et al. ERJ Open Res 2019; 5: 00190-2018

Significant U.S. Opportunity with ~3,600 Identified aPAP Patients



1. Analysis of 2023 U.S. claims dataset adjusted for aPAP and accounting for claims data coverage gaps

U.S. Centers Prioritized Based on aPAP Experience

Goal: Line of Sight to 1,000 Patients at Launch to Maximize Early Launch Phase



*†PAP Center of Excellence (COE) includes healthcare organizations listed on PAP Foundation website, IMPALA-2 clinical trial sites, and other sites of expertise *ILD clinics are dedicated to the management of patients with a wide variety of interstitial lung diseases that can range from pulmonary fibrosis to rare lung diseases*

Overwhelming Support for MOLBREEVI Across Stakeholders

U.S. PULMONOLOGISTS

83%

Likely to prescribe **MOLBREEVI** regardless of severity of disease

Perceived MOLBREEVI as superior to current options based on:

- Overall efficacy
- Simple, standard nebulizer
- Favorable safety profile
- FDA approval

Savara 2024 Qualitative Research: N=10 US KOLs and highvolume pulmonologists; Quantitative research: N=78 HCPs U.S. PAYERS

87%

Intend to cover MOLBREEVI with typical Prior Authorization criteria when priced between \$300-500K annually

Not concerned about impact on pharmacy budget

Recognize the significant disease burden associated with aPAP

Savara 2024 U.S. payer pricing and reimbursement research: N=10 representing ~88M covered lives

U.S. PATIENTS

100%

Think new, non-invasive PAP treatments are needed

WOULD ask their doctor to prescribe MOLBREEVI

WOULD take MOLBREEVI if their doctor recommended it

Savara 2024 Patient Advisory Board meetings: N = 7 aPAP patients

Market Development Team

Broadens market reach and accelerates pre-launch activities



- Projected market development team of ~25 people (including leadership)
- Target list of accounts expanded beyond current field medical list to broaden reach
- Territory managers will be added in waves gated to key milestones
- Key activities include:
 - Profiling accounts to gain line of sight into currently diagnosed patients
 - aPAP disease awareness and education
 - Dry blood spot (DBS) antibody testing education

Claims Data Analysis Suggests U.S. Market May Be 2x Larger

HIGHLY LIKELY AND LIKELY aPAP ~3,600 +1,400(U.S. Claims Data Analysis) +2,300Analysis of comprehensive claims dataset Based on PAP ICD9/10 diagnosis codes from 300M+ Estimate for additional +3,700 undiagnosed patients was based on a custom PAP machine Physicians managing the patients are located across learning model applied to same U.S. claims dataset ~1.100 centers aPAP ClearPath Ab testing to help confirm or rule

1. Analysis of 2023 U.S. claims dataset adjusted for aPAP and accounting for claims data coverage gaps

Highly likely

Likelv

out aPAP diagnosis

aPAP-ClearPath

aPAP ClearPath Testing Platform in the U.S.

No cost antibody testing to help confirm or rule out aPAP among undiagnosed patients



•			
	+ +	+	
NAME			
DATE OF BIRTH			



- Launched March 2025
- Simple finger prick performed in a physician's office
- Removes logistical challenges to serum testing
- ILD program to be expanded, leveraging DBS test

Europe (EU4+UK) Market Development is Underway

TREATMENT CENTER MAPPING¹



Country	Key Centers ¹	Est. TAM ²
Germany	11	~1,100
UK	25	~900
France	24	~900
Italy	16	~700
Spain	12	~600
Total	88	~5,000

- aPAP Centers of Excellence identified (8)
- 62 patients in Europe enrolled in IMPALA-2 trial open-label extension³

¹ Savara 2024 EU4+ UK Primary (N= 6 EU4+ UK Principal Investigators, 5 EU4+UK Lab Directors) and Secondary Market Research

² Data from 2023 U.S. Insurance Claims Analysis conducted by Savara and extrapolated based on geographic population; TAM, Total addressable market ³ Enrolled across 15 IMPALA-2 sites in the EU, UK, and Turkey

MOLBREEVI: U.S. Commercial Opportunity

MOLBREEVI

- Clinically meaningful benefit
- Strong stakeholder interest
- Orphan drug pricing potential
- Chronic dosing

Long Term Exclusivity

- 12-year biologic exclusivity (U.S.)
- Biosimilar competition unlikely



Opportunity

Efficient Rare Disease Model

- Small customer facing footprint
- Exclusive pharmacy network

Financials



Cash runway into 2H 2027

- ~\$172.5M in cash and short-term investments as of 3/31/25
- Non-dilutive debt financing for up to \$200M*
- Strong investor support with coverage from 8 equity research analysts

ANALYST COVERAGE

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

Financial Highlights

*Included \$30M at close to refinance existing debt facility

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Near- and Long-Term U.S. Market Opportunity in aPAP is Sizeable

- ~3,600 Current U.S. TAM of identified aPAP patients
- **\$300K-\$500K** Orphan rare disease potential pricing power
 - ~3,700 Large pool of likely patients that are currently undiagnosed
 - Multiple Patents currently being prosecuted
 - **12-years** Biologic exclusivity in U.S. upon approval
 - **Long-term** Durable revenue stream with biosimilar competition unlikely





TAM = Total addressable market



THANK YOU

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