# Corporate Overview

Developing New Therapies for Rare Respiratory Diseases

March 2025

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**MOLBREEVI (molgramostim inhalation solution) 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.**

# 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*

**Kate McCabe**
*Chief Legal Officer*

**Braden Parker, M.B.A.**
*Chief Commercial Officer*

**Ray Pratt, M.D. FACP**
*Chief Medical Officer*

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

**Charles LaPree**
*EVP, Global Regulatory Affairs*

**Brian Robinson, M.D.**
*EVP, Global Medical Affairs*

**Yasmine Wasfi, M.D., Ph.D.**
*EVP, Clinical Operations/Development*

# Autoimmune Pulmonary Alveolar Proteinosis (aPAP)

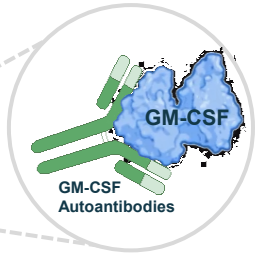
*Overview and Burden of Disease*



SAVARA

# Autoimmune PAP: Disease of Alveolar Macrophage Dysfunction

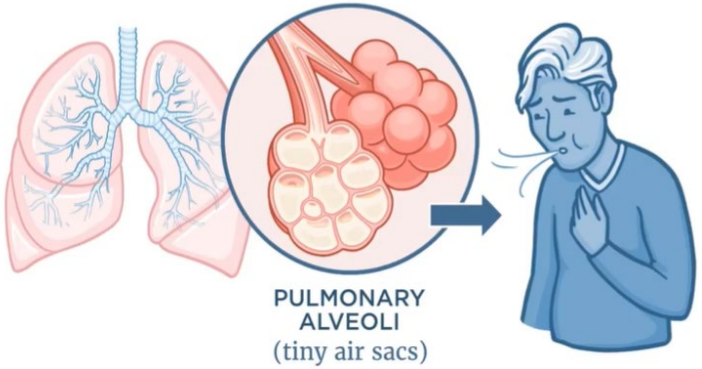
## aPAP




**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

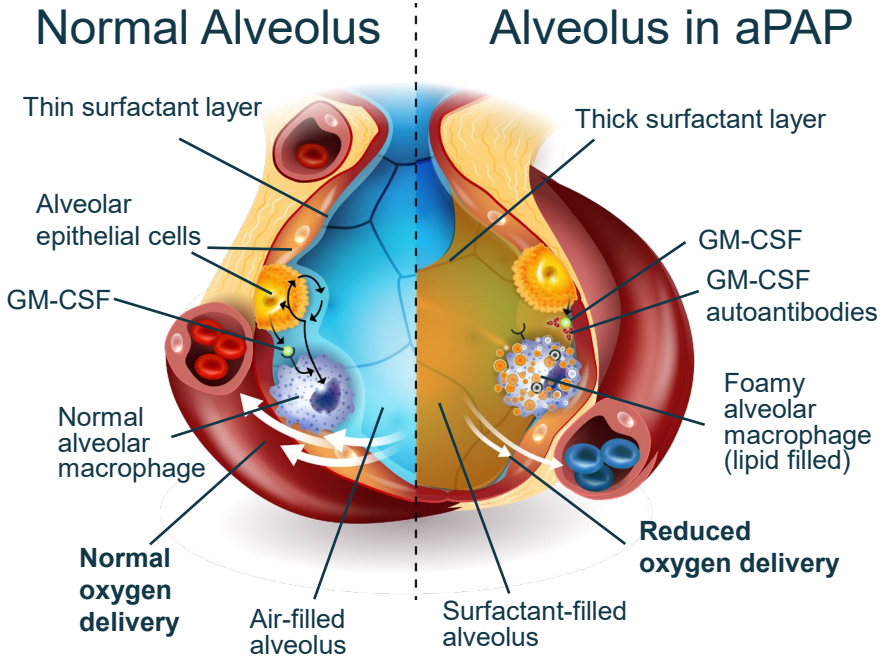
**Reduced blood oxygenation** results in difficulty breathing and, ultimately, hypoxemic respiratory failure




## 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

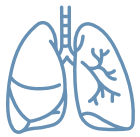
- Fatigue and significantly reduced exercise capacity can dramatically impact the simplest of daily activities, e.g., getting winded walking up a flight of stairs

## 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 deaths[1-4]



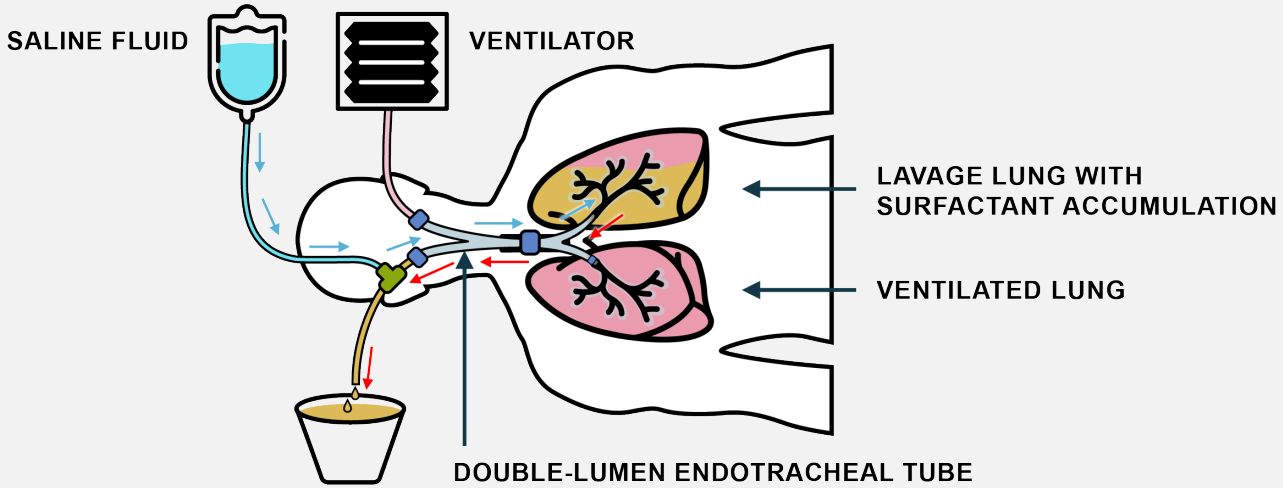
## Fibrosis and Lung Transplant

- 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):

- 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




# 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.*

# Disease Burden: Autoimmune PAP Patients Have Significantly Higher Rates of Healthcare Utilization and Comorbidities[1]

## Charlson Comorbidity Index (CCI)*

**3.5x** Vs. matched controls

**PAP:** 1.44 ± 1.96
**Age, Gender, Geography Matched Controls:** 0.41 ± 1.11
**P value:** <0.05

*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/Inpatient visits

(~11 outpatient/~2 inpatient per year)

**+167% outpatient +505% inpatient** Vs. matched controls

**PAP:** 10.7 ± 10.9 outpatient/ 2.3 ± 7.8 inpatient
**Age, Gender, Geography Matched Controls:** 4.0 ± 7.0 outpatient/ 0.38 ± 2.5 inpatient
**P value:** <0.001 outpatient/0.001 inpatient

## Emergency Room Visits

(~1 per year)

**+245%** Vs. matched controls

**PAP:** 1.0 ± 2.3
**Age, Gender, Geography Matched Controls:** 0.29 ± 1.0
**P value:** <0.001

## Longer hospital stays

(~3 days per year)

**5.0x** Vs. matched controls

**PAP:** 2.8 ± 7.6
**Age, Gender, Geography Matched Controls:** 0.56 ± 2.9
**P value:** <0.001

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 Patient[1]

## CURRENT JOURNEY

### Symptoms and Experience Before Diagnosis

**12 MONTHS**

**FROM FIRST EXPERIENCING SYMPTOMS TO SEEING A PHYSICIAN**

- Insidious development
- Battery of diagnostic tests
- Typically misdiagnosed as pneumonia coupled with incorrect treatment
- Cycles of misdiagnosis for months to years
- Eventual referral to a pulmonologist for full pulmonary work-up

### Diagnosis with aPAP

**18 MONTHS**

**AVERAGE TIME FROM FIRST SEEING A PHYSICIAN TO DIAGNOSIS**

- aPAP diagnosis

### Treatment

- Whole lung lavage (WLL)
- Potential off-label therapies

## POTENTIAL FUTURE JOURNEY

**aPAP ClearPath**

- Non-invasive, no-cost, simple auto-antibody blood test to help decrease time-to-diagnosis

**MOLBREEVI***

- Clinically meaningful positive Phase 3 results that suggest MOLBREEVI may address the pathophysiology of aPAP
- Favorable benefit/risk profile
- Well tolerated
- Rolling BLA initiated

*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)*

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

# 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)

- 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]
- 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**

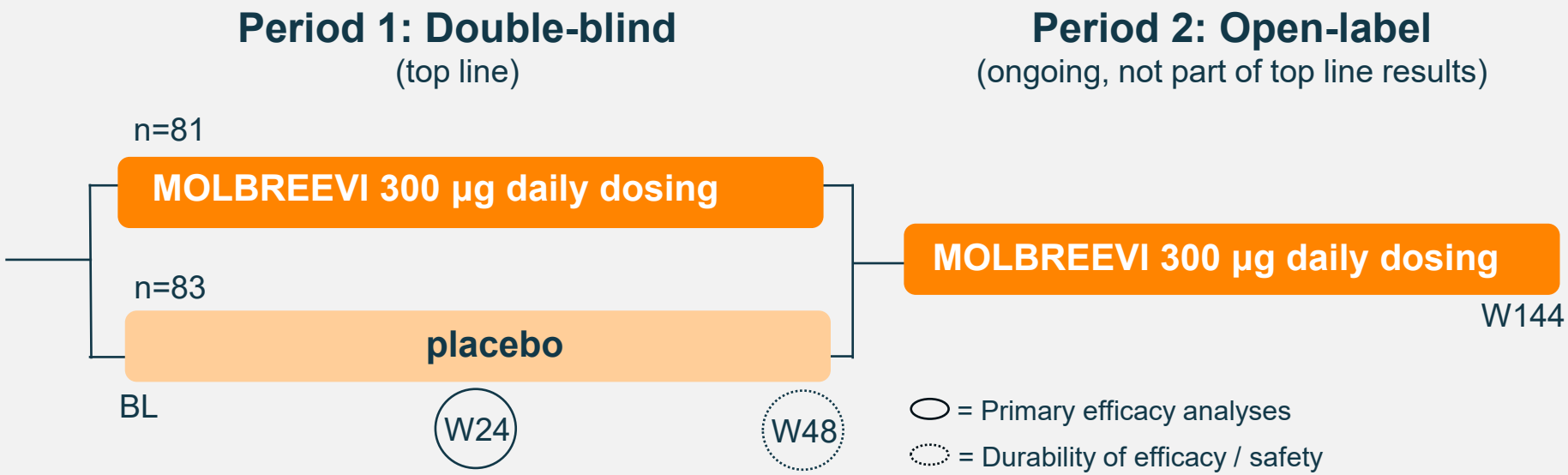
- Well-tolerated; low treatment discontinuation rate (3%), none due to drug-related adverse events
- 100% of patients who completed the double-blind period enrolled into the open-label period

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

# 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

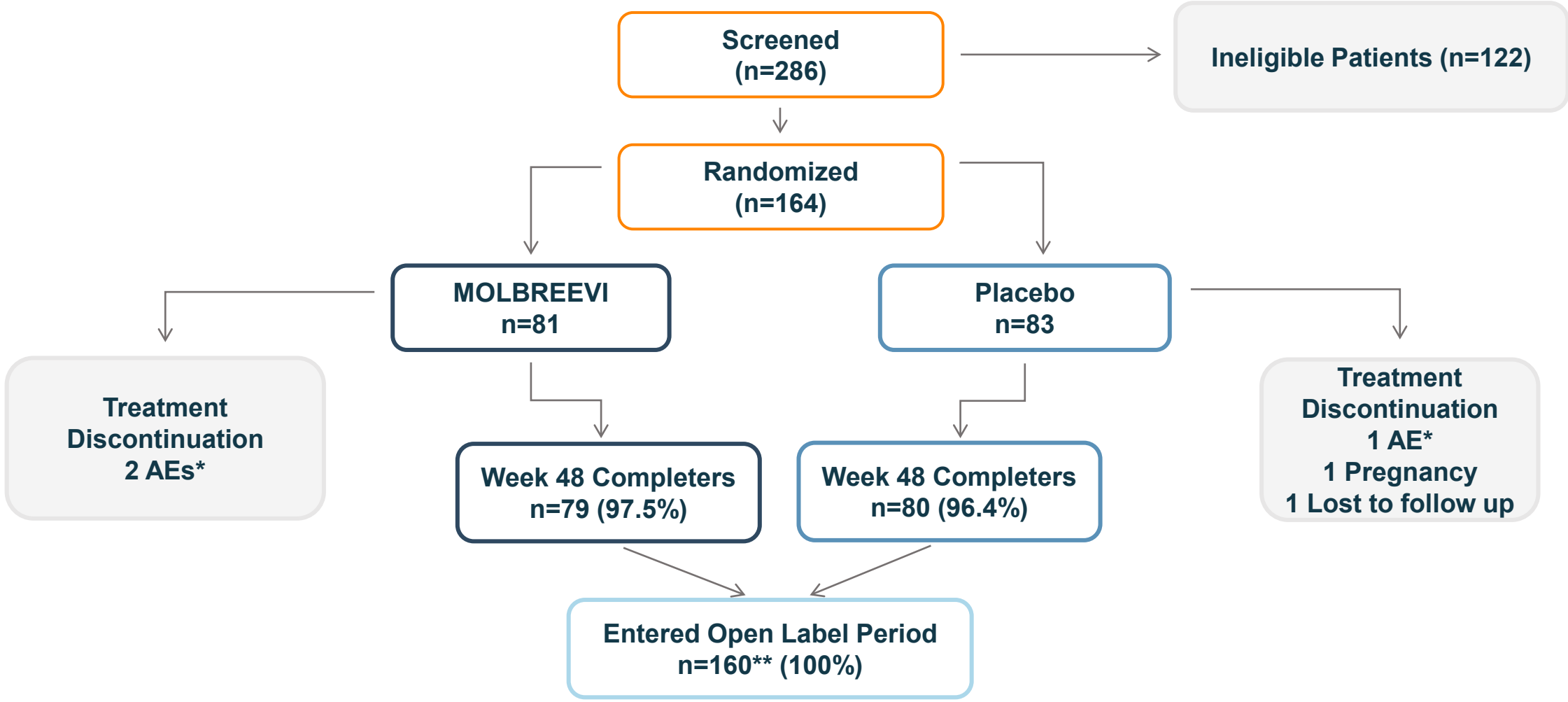
Change from baseline in:

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

# 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



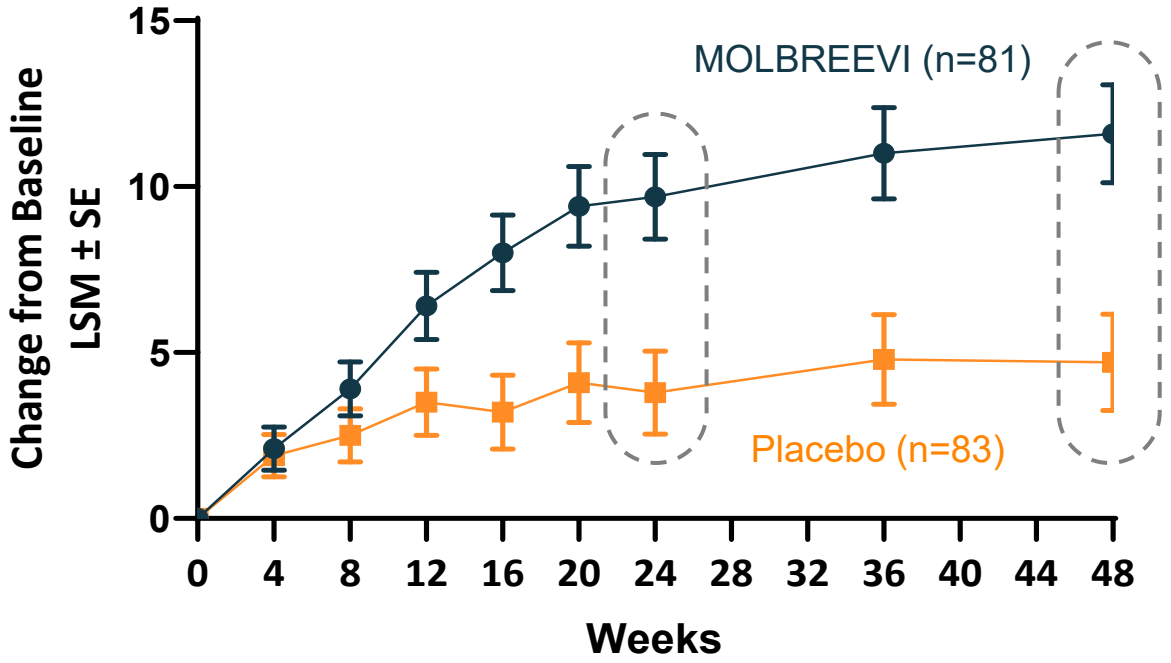

*Not considered trial drug related

**One placebo patient stopped blinded trial drug but continued trial participation through Week 48 and entered the open label period

# Demographics 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<br>Female | 44 (54.3)<br>37 (45.7) | 54 (65.1)<br>29 (34.9) |
| **Race n (%)** | White<br>Asian<br>Black or African American<br>Other | 38 (46.9)<br>36 (44.4)<br>3 (3.7)<br>4 (4.9) | 40 (48.2)<br>37 (44.6)<br>2 (2.4)<br>4 (4.8) |
| **DLCO at baseline** | Mean (SD) | 52.6 (11.71) | 52.6 (10.39) |
| **DLCO stratification group** | ≤ 50%<br>> 50% | 31 (38.3)<br>50 (61.7) | 32 (38.6)<br>51 (61.4) |

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



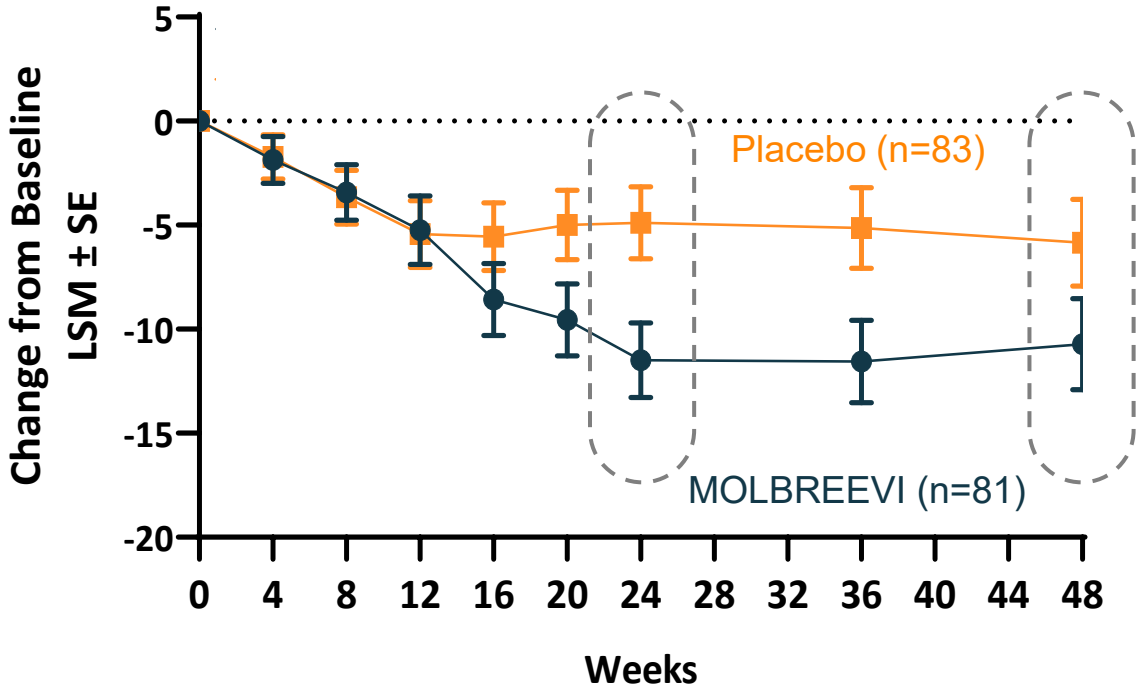

| | LSM Change from Baseline | Between-Group LSM Difference* | P-value |
|---|---|---|---|
| Week 24 | Mol: 9.8<br>Pbo: 3.8 | 6.00 | 0.0007 |
| Week 48 | Mol: 11.6<br>Pbo: 4.7 | 6.90 | 0.0008 |

**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.*

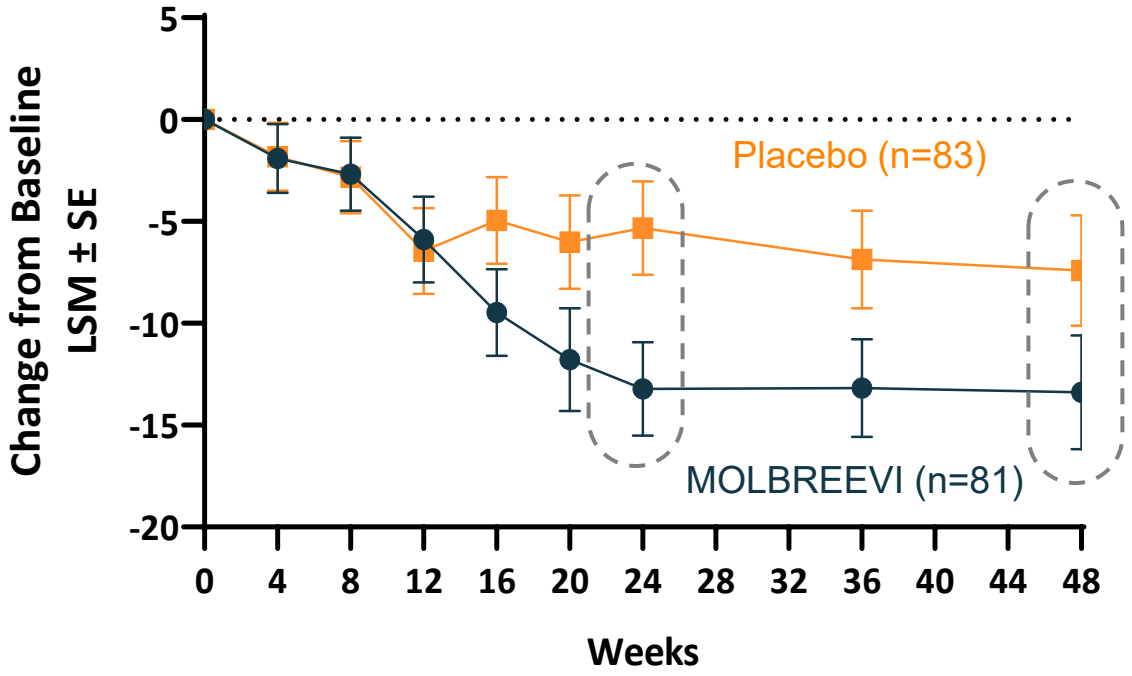
# IMPALA-2: MOLBREEVI Superior to PBO on Change From Baseline in SGRQ Total Score at W24, Favorability Continues Through W48




| | LSM Change from Baseline | Between-Group LSM Difference* | P-value |
|---|---|---|---|
| Week 24 | Mol: -11.5<br>Pbo: -4.9 | -6.59 | 0.0072† |
| Week 48 | Mol: -10.7<br>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.*

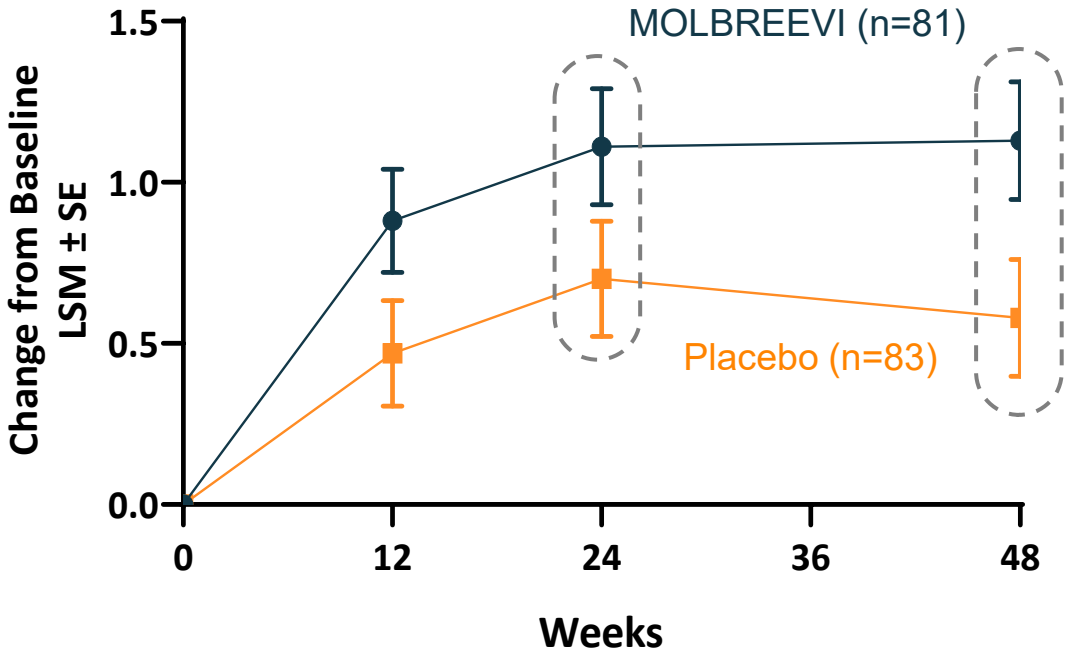
# IMPALA-2: MOLBREEVI Nominally Significant on Change From Baseline in SGRQ Activity Score at W24, Favorability Continues Through W48




| | LSM Change from Baseline | Between-Group LSM Difference* | P-value |
|---|---|---|---|
| Week 24 | Mol: -13.0<br>Pbo: -5.2 | -7.81 | 0.0149† |
| Week 48 | Mol: -13.4<br>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.*

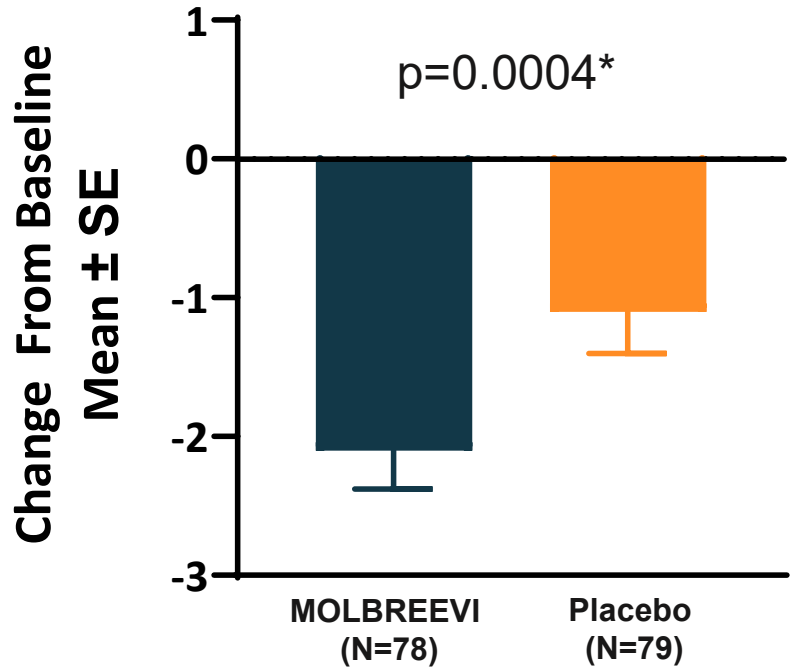
# IMPALA-2: MOLBREEVI Nominally Significant on Change From Baseline in Exercise Capacity (Peak METs) at W48

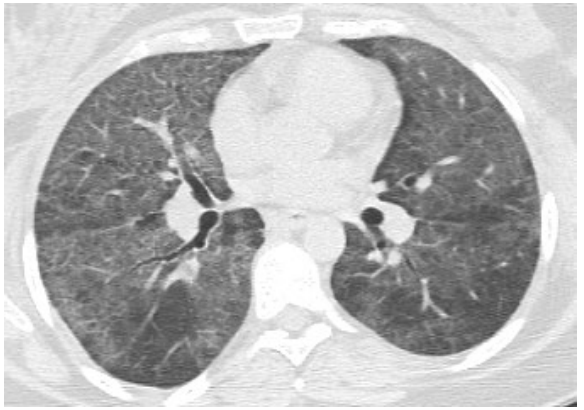



| | LSM Change from Baseline | Between-Group LSM Difference* | P-value |
|---|---|---|---|
| Week 24 | Mol: 1.11<br>Pbo: 0.70 | 0.41 | 0.0845 |
| Week 48 | Mol: 1.13<br>Pbo: 0.58 | 0.55 | 0.0234† |

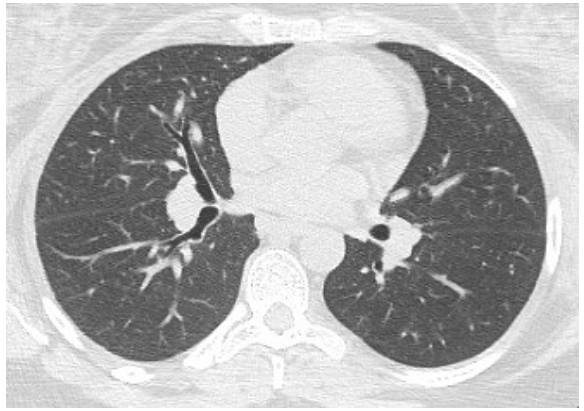
**Mean change from baseline compared with placebo. P-values are for difference in LSM compared with placebo. †P-value nominally significant: P-value ≤0.05 but did not meet the p-value threshold required in pre-specified hierarchical testing procedure. LSM, least squares mean; MET, metabolic equivalent;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

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



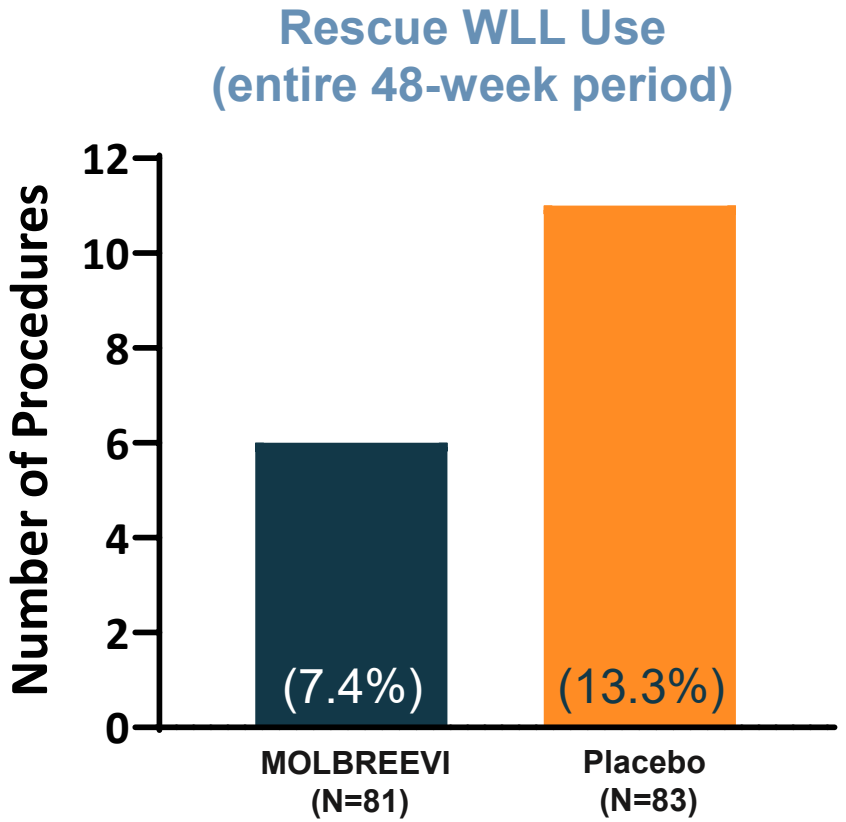
Baseline



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) |

[1]SAE 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 |
|---|---|---|---|
| **Pulmonary gas exchange** | DLCO% | Week 24<br>Week 48 | **0.0007**<br>**0.0008** |
| | Disease Severity Score (DSS) | Week 24<br>Week 48 | **0.0239***<br>**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 |
| **Respiratory health-related quality of life** | SGRQ Total Score | Week 24<br>Week 48 | **0.0072**<br>0.1046 |
| | SGRQ Activity Score | Week 24<br>Week 48 | **0.0149†**<br>0.1216 |
| | Responder Analysis – SGRQ Total | Week 24<br>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<br>Week 48 | 0.0845<br>**0.0234†** |
| **Surfactant burden** | Chest Computed Tomography – GGO | Week 24 | **0.0004*** |
| | 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

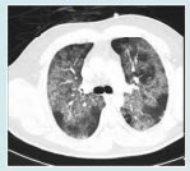
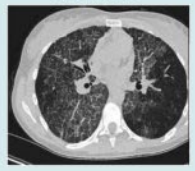
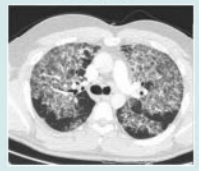
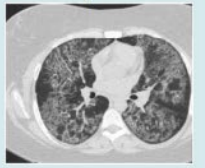
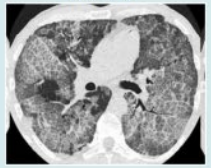
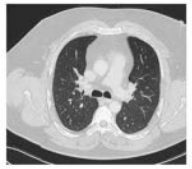
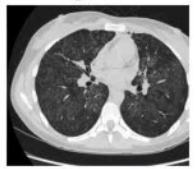
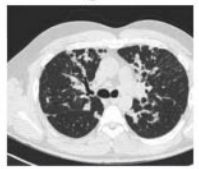
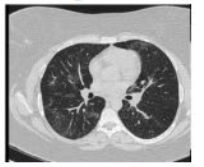
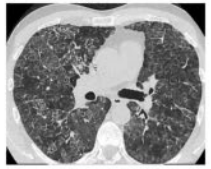
- All 5 patients had
  - CT tomography scan patterns
  - Bronchoalveolar lavage findings
  - Characteristic PAP symptoms
  - Positive GM-CSF antibody test
- Mean duration of therapy: 4.2 years
- 4 patients had ≥ 1 WLL prior to taking MOLBREEVI

## 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

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

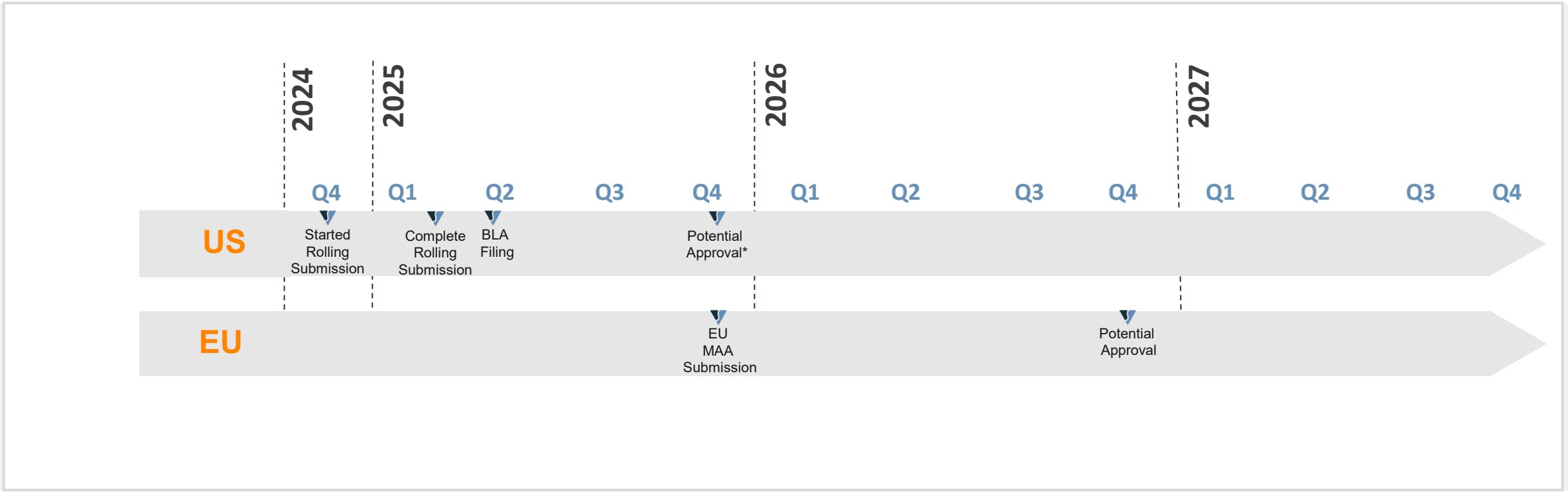
TABLE 1 Continued

| | Patient 1 | Patient 2 | Patient 3 | Patient 4 | Patient 5 |
|---|---|---|---|---|---|
| **Clinical outcome** | Overall improvement<br>Decrease in oxygen demand<br>Improved PFTs and radiological findings | Rapid clinical improvement<br>Improved PFTs and radiological findings | Improved<br>No longer needed $O_2$ supplementation<br>Improved PFTs and radiological findings | Improved, without further need for $O_2$ supplementation<br>Improved PFTs and radiological findings | Improved, without need for $O_2$ at rest<br>Improved PFTs and radiological findings |
| **HRCT before treatment with molgramostim inhalation solution** | Jan 2019  | March 2020  | Jan 2018  | Aug 2018  | Dec 2022[1]  |
| **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  |

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

# Regulatory and Intellectual Property

# 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

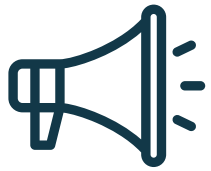
- Pending patent applications for drug formulation and methods of use including treating aPAP with MOLBREEVI
- Worldwide exclusive license to proprietary eFlow® Nebulizer System (PARI) for MOLBREEVI in aPAP and pending joint patent application with PARI for the drug/device combination
- Proprietary cell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

# Commercial Update

# Commercial Launch Planning Advancing Against Near-Term Objectives

## AWARENESS

Expand awareness of autoimmune PAP among targeted health care professionals and patients



## INFRASTRUCTURE

Build critical capabilities to facilitate access to MOLBREEVI post approval

## PERSONNEL

Hire and onboard key commercial roles to expand core activities

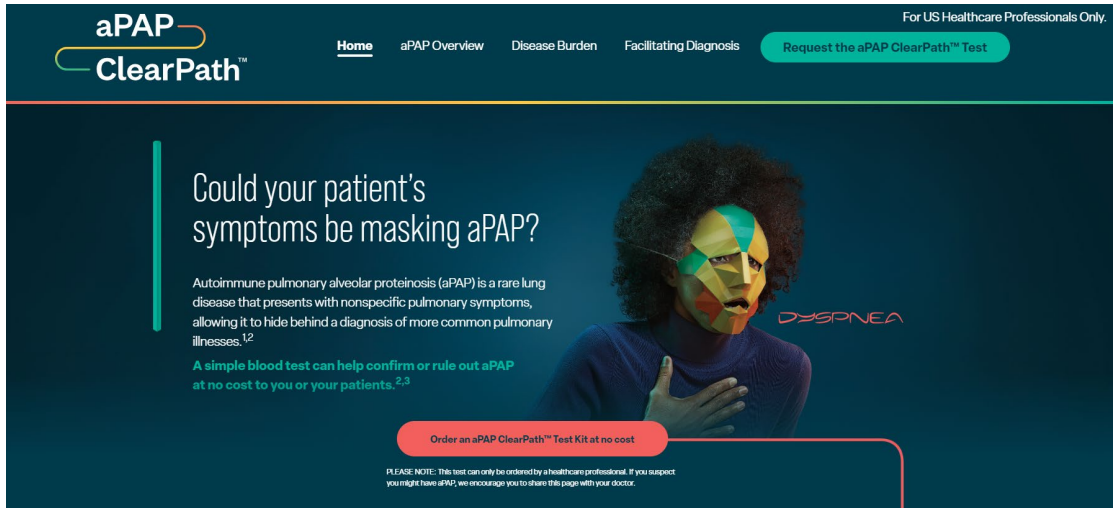
## TESTING

Evolve diagnostic platform to scale testing efforts

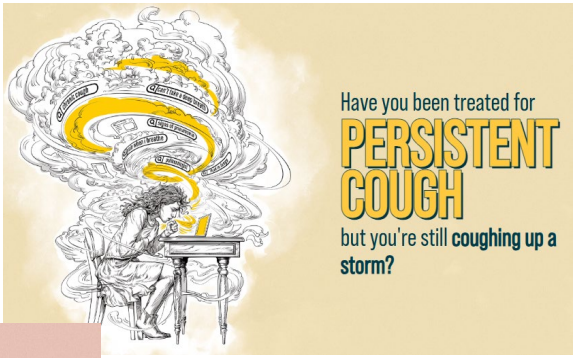
# Autoimmune PAP Disease State Awareness Campaign

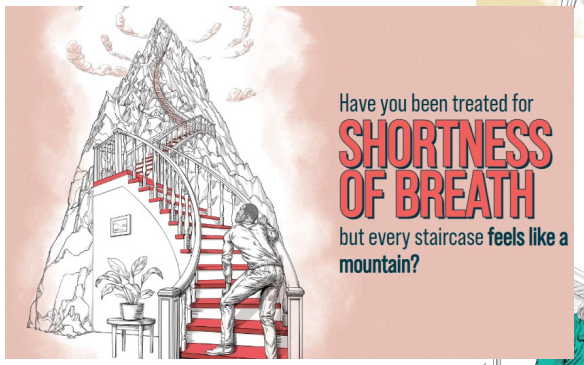
*Multi-channel effort across healthcare professionals and patients*

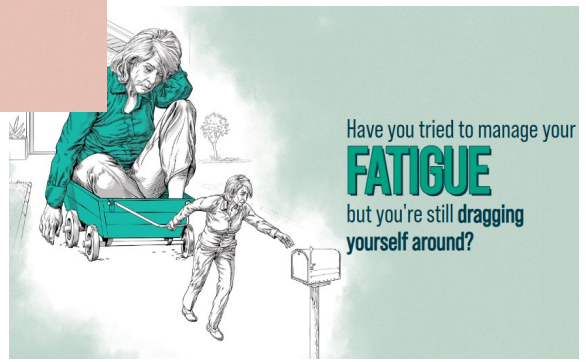
## HCP DSA Campaign




## Patient DSA Campaign



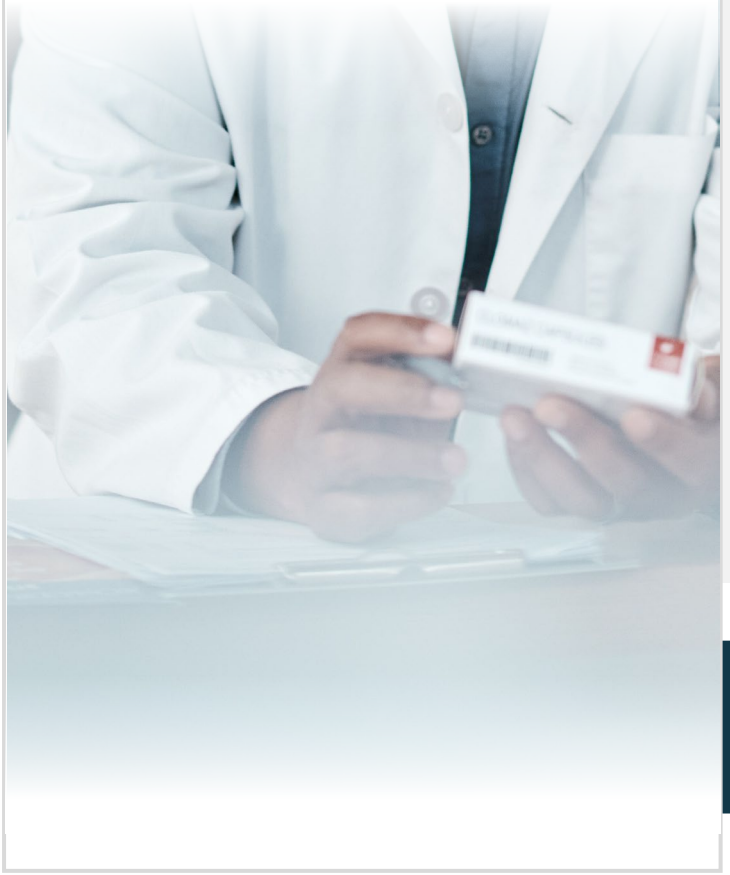



# Exclusive Specialty Pharmacy with Integrated Patient Services

*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
- Clinical education
  - Pharmacist calls
  - Device training
  - Nurse educators
  - Adherence support
- Insurance services
  - Prior authorization
  - Appeals

## PRESCRIBER SERVICES

- Streamlined prescribing
- Prior authorization checklist
- 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

## IDENTIFIED aPAP PATIENTS[1]

**~3,600**

(U.S. Claims Data Analysis)

**Analysis of comprehensive claims dataset**

- Based on PAP ICD9/10 diagnosis codes from 300M+ lives
- Physicians managing the patients are located across ~1,100 centers

## HIGHLY LIKELY AND LIKELY aPAP

**+1,400** Highly likely

**+2,300** Likely

- Estimate for additional +3,700 undiagnosed patients was based on a custom PAP machine learning model applied to same U.S. claims dataset

aPAP ClearPath™

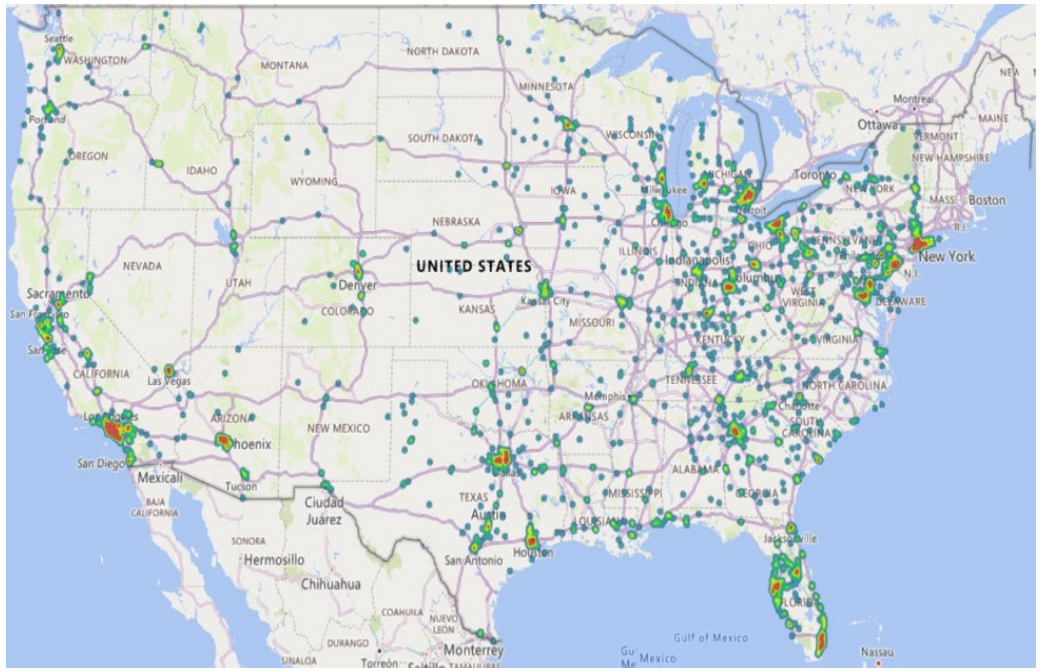
**aPAP ClearPath Ab testing to confirm diagnosis**

*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*

## U.S. PATIENTS / HCP HEATMAP[1]




[1] Data from 2023 U.S. Insurance Claims Analysis conducted by Savara

**COEs†**

**ILD Centers***

**General Pulmonary Centers**

**Currently have line of sight to ~450 patients**

- Confirmed location
- Treating physician
- Patient management

*†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 high-volume 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**

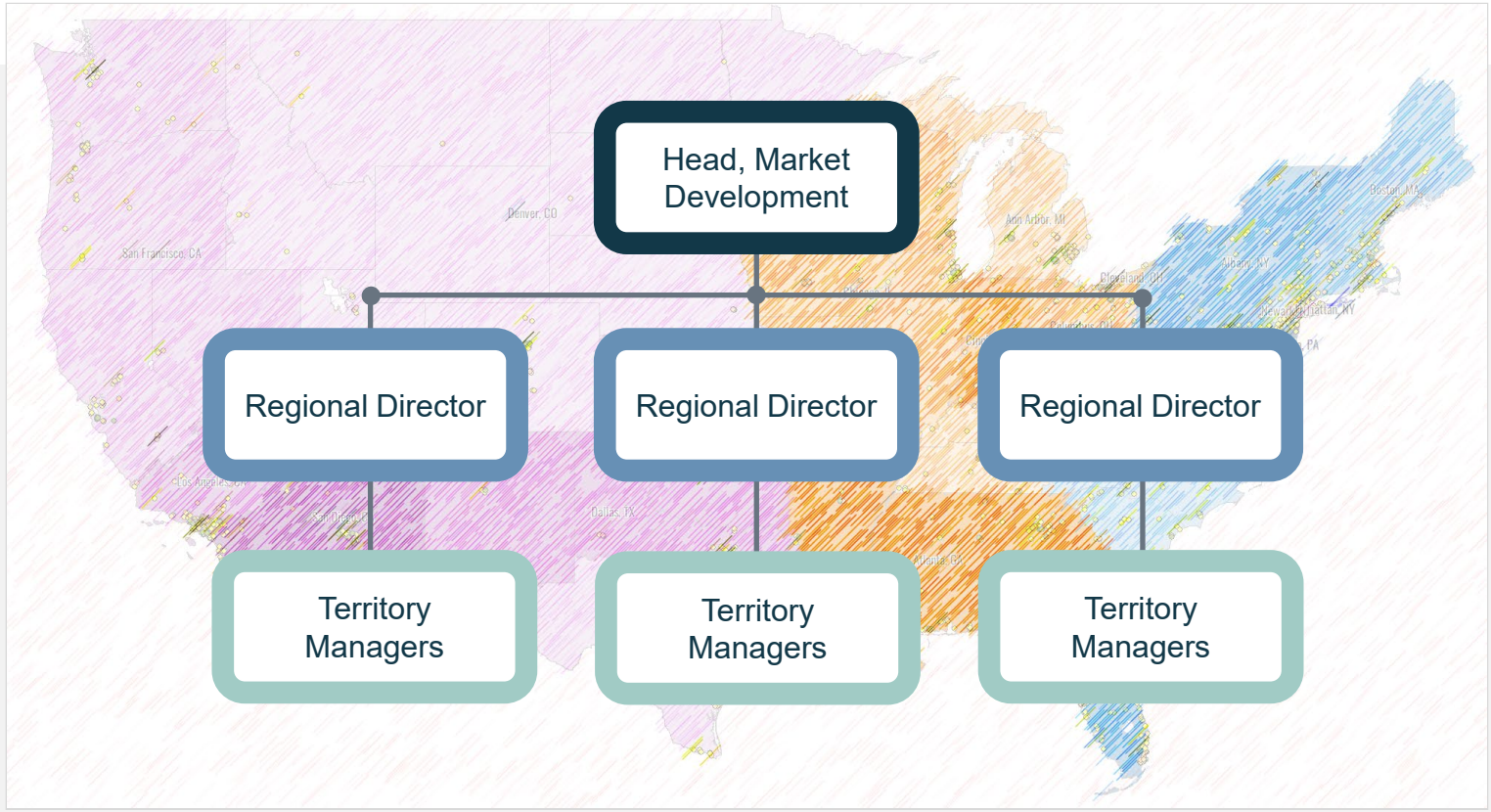
**WOULD ask their doctor to prescribe** MOLBREEVI

**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

## IDENTIFIED aPAP PATIENTS[1]

~3,600

(U.S. Claims Data Analysis)

**Analysis of comprehensive claims dataset**

- Based on PAP ICD9/10 diagnosis codes from 300M+ lives
- Physicians managing the patients are located across ~1,100 centers

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- Estimate for additional +3,700 undiagnosed patients was based on a custom PAP machine learning model applied to same U.S. claims dataset

aPAP ClearPath™

**aPAP ClearPath Ab testing to confirm diagnosis**

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

# aPAP ClearPath Testing Platform in the U.S.

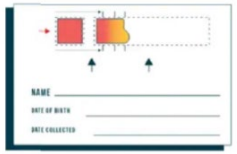
*No cost antibody testing to identify aPAP among undiagnosed patients*

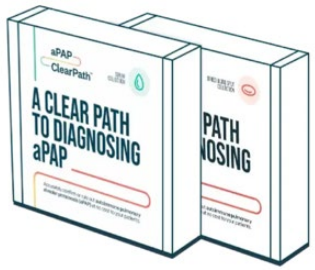
## SERUM TEST

aPAP ClearPath™

- Launched December 2023
- Platform used in Interstitial Lung Disease (ILD) Clinic Pilot Program

## DRIED BLOOD SPOT (DBS) TEST






- 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 MAPPING[1]

| 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 extension[3]

[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

## Significant Unmet Need

- High disease burden
- No FDA approved therapies
- Whole lung lavage is invasive and not standardized


## Efficient Rare Disease Model

- Small customer facing footprint
- Exclusive pharmacy network

# Financials

- **Cash runway through 2Q 2027**
  - ~$219M in cash, cash equivalents and short-term investments*
- **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 |
| JMP | Jonathan Wolleben |
| H.C. Wainwright | Andrew Fein |
| Evercore ISI | Liisa Bayko, MSC, MBA |
| Wells Fargo | Tiago Fauth |

**As of 9/30/24*

# Financial Highlights

# 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 |

**>$1B**

Potential
U.S. Opportunity

*TAM = Total addressable market*


# THANK YOU