Corporate Overview

Developing New Therapies for Rare Respiratory Diseases

March 2025

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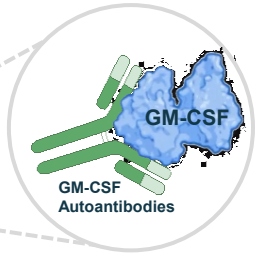
Autoimmune Pulmonary Alveolar Proteinosis (aPAP)

Overview and Burden of Disease

SAVARA

Autoimmune PAP: Disease of Alveolar Macrophage Dysfunction

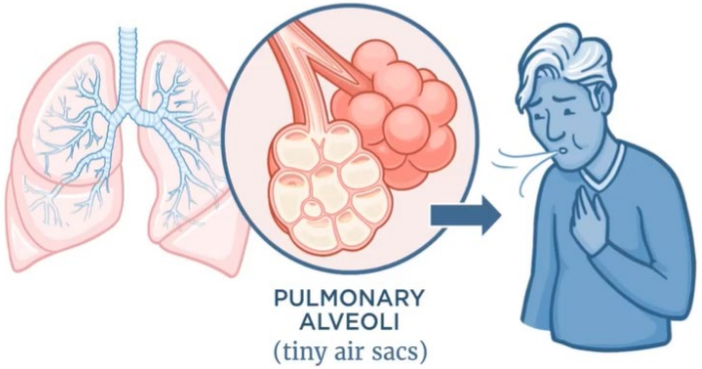
aPAP



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

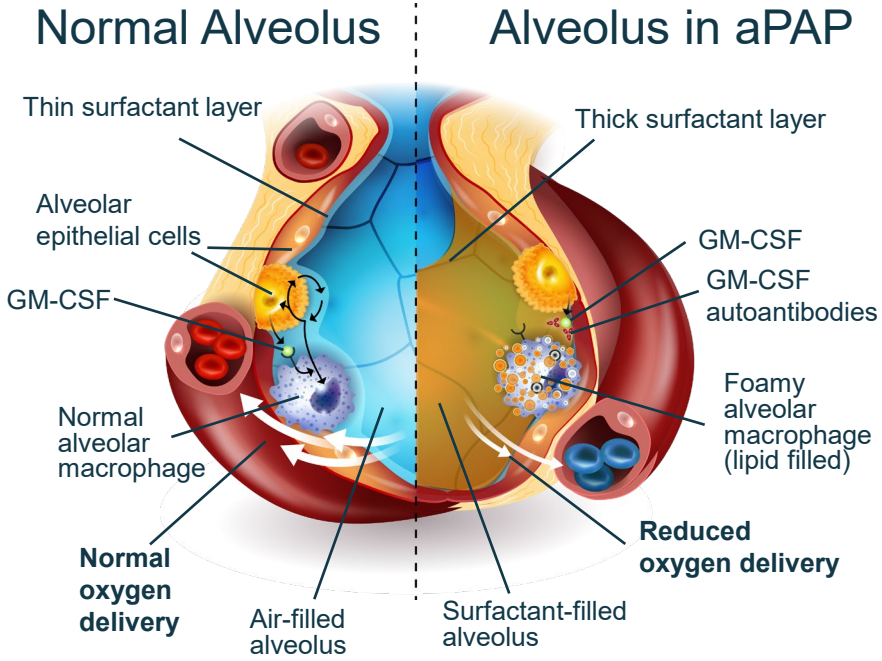
Reduced blood oxygenation results in difficulty breathing and, ultimately, hypoxemic respiratory failure



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

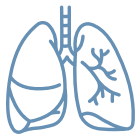
- Fatigue and significantly reduced exercise capacity can dramatically impact the simplest of daily activities, e.g., getting winded walking up a flight of stairs

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]



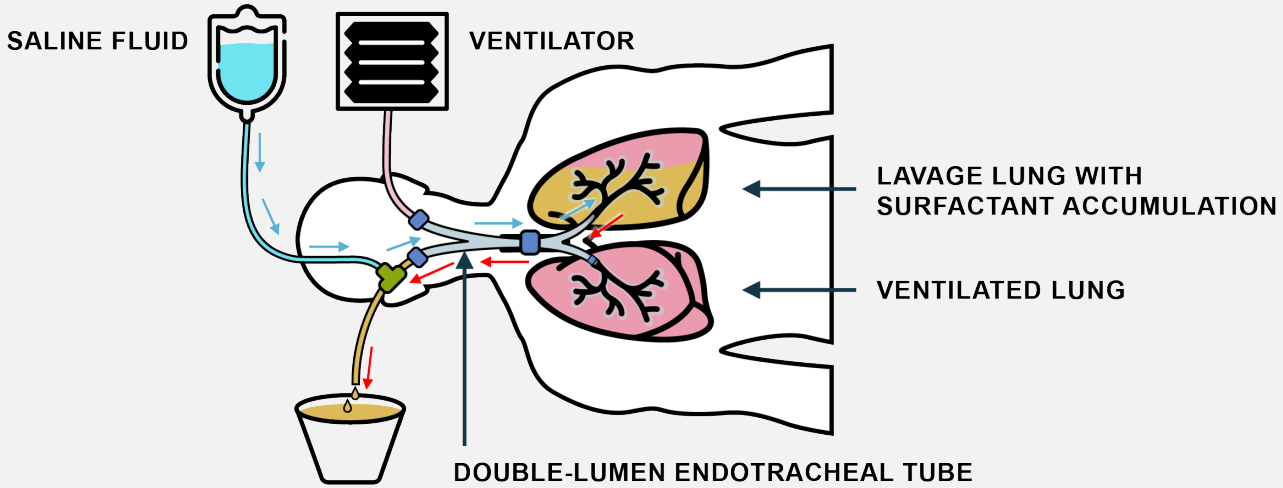
Fibrosis and Lung Transplant

- 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

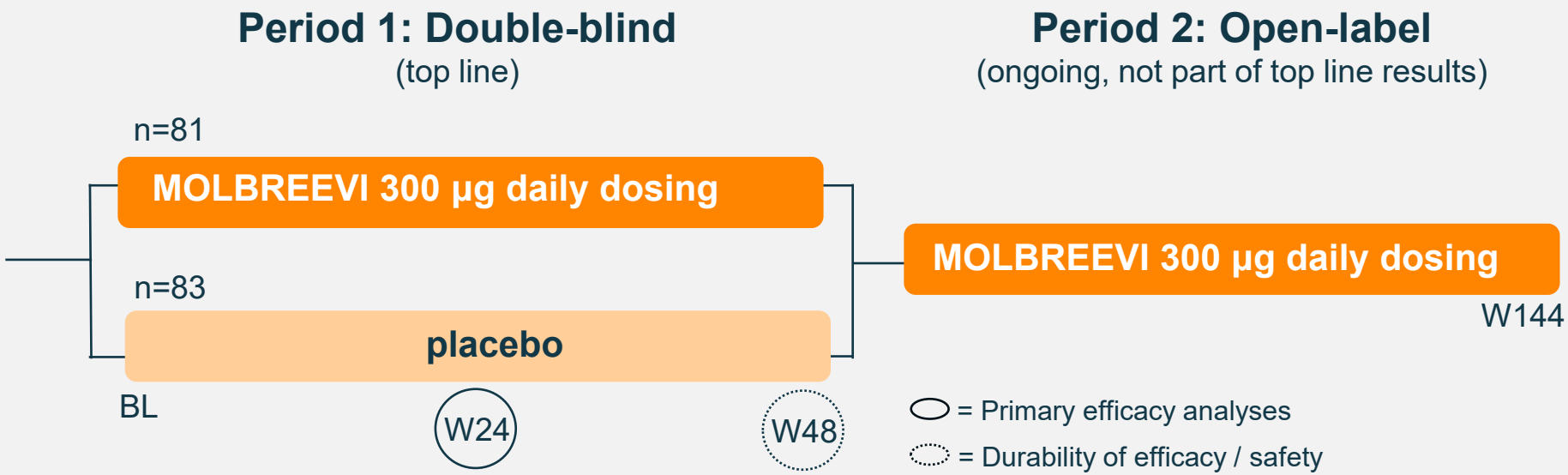
- Well-tolerated; low treatment discontinuation rate (3%), none due to drug-related adverse events
- 100% of patients who completed the double-blind period enrolled into the open-label period

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

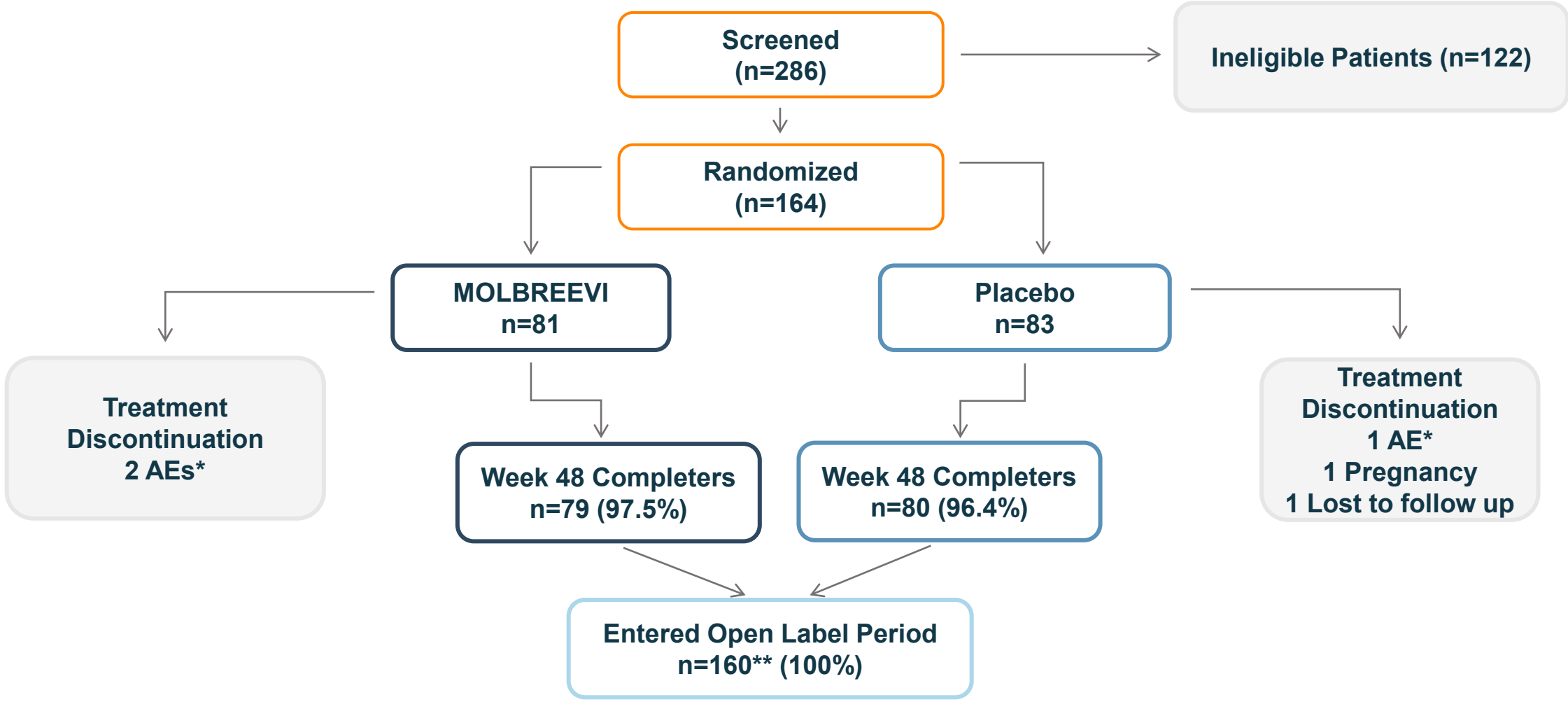
Change from baseline in:

- 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



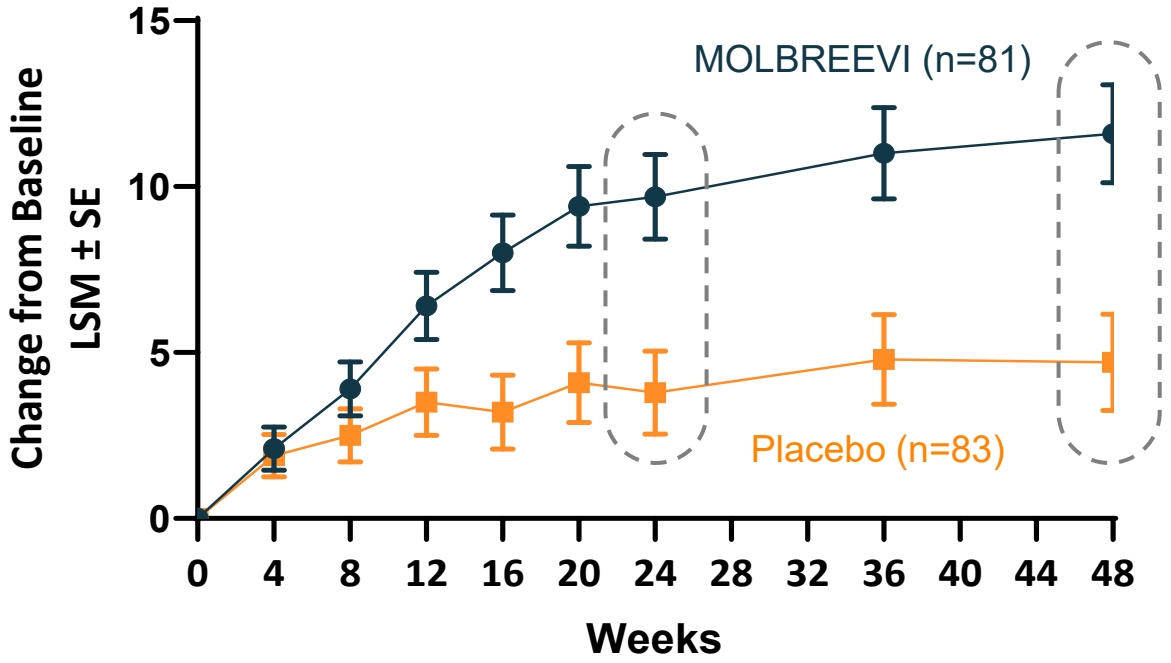
*Not considered trial drug related

**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 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)



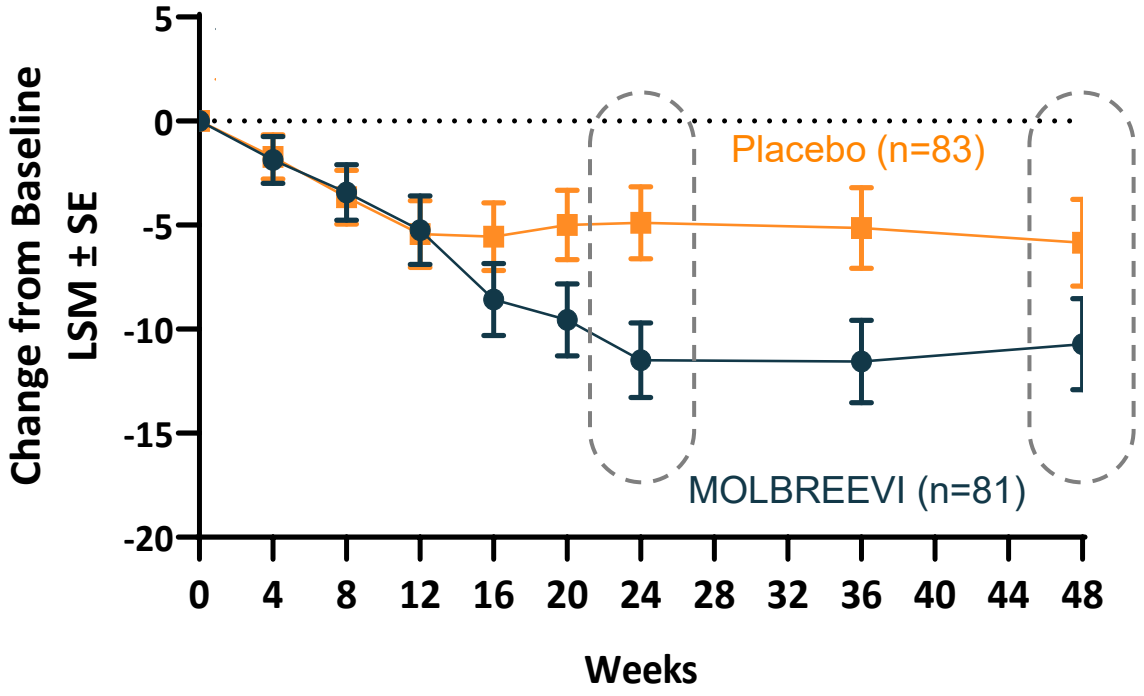
	LSM Change from Baseline	Between-Group LSM Difference*	P-value
Week 24	Mol: 9.8 Pbo: 3.8	6.00	0.0007
Week 48	Mol: 11.6 Pbo: 4.7	6.90	0.0008

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.*

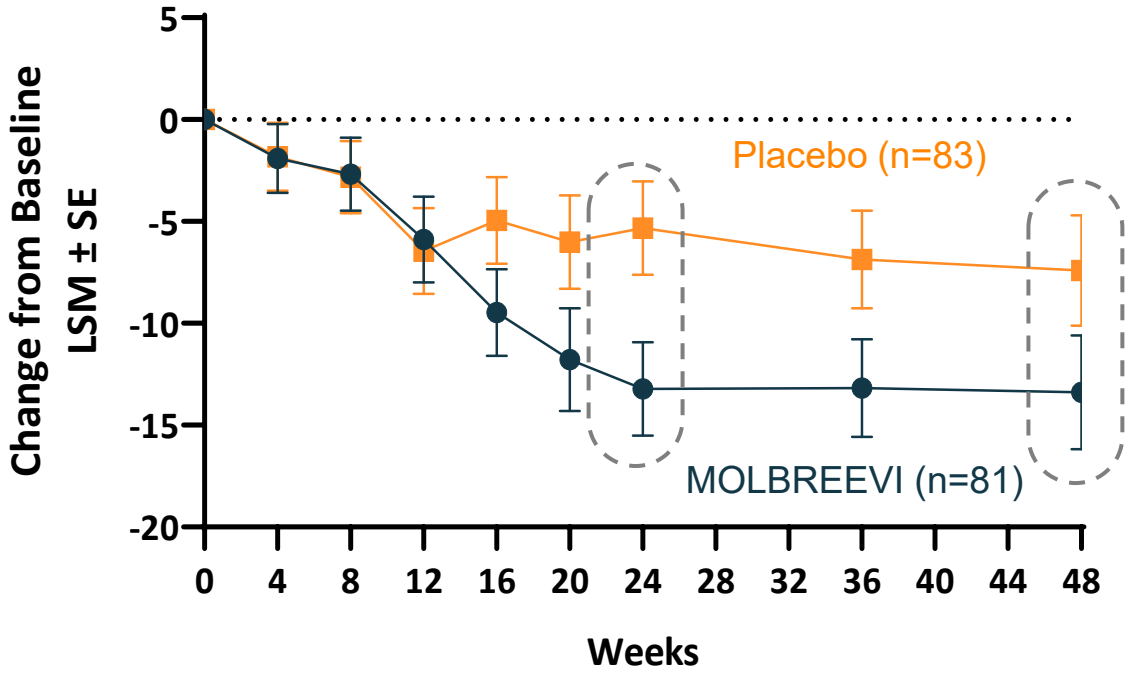
IMPALA-2: MOLBREEVI Superior to PBO on Change From Baseline in SGRQ Total Score at W24, Favorability Continues Through W48



	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.*

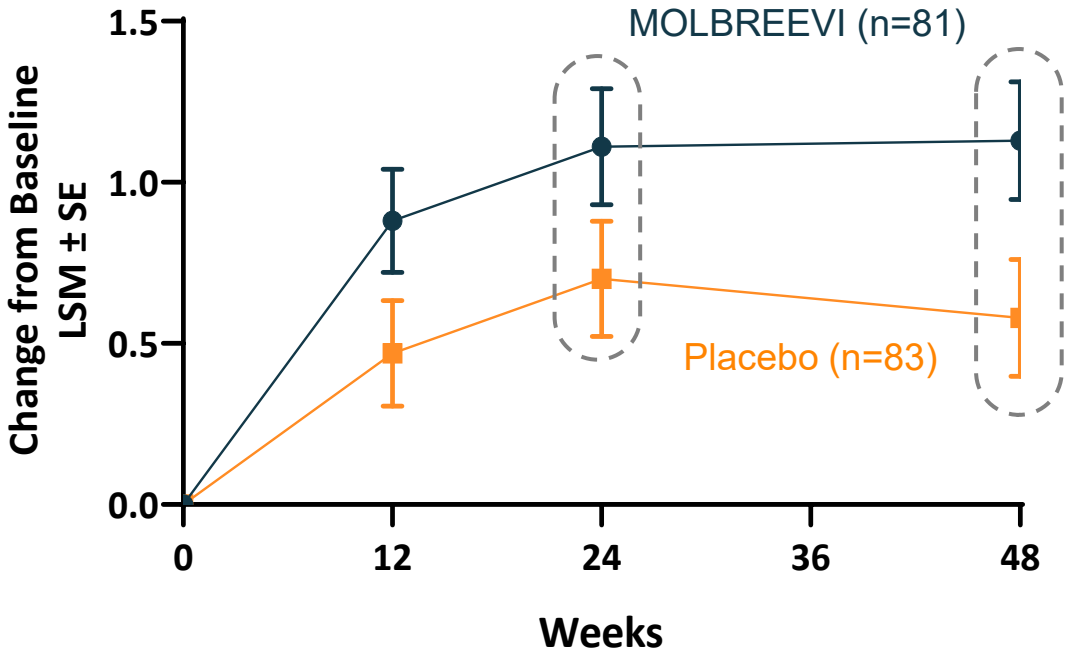
IMPALA-2: MOLBREEVI Nominally Significant on Change From Baseline in SGRQ Activity Score at W24, Favorability Continues Through W48



	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.*

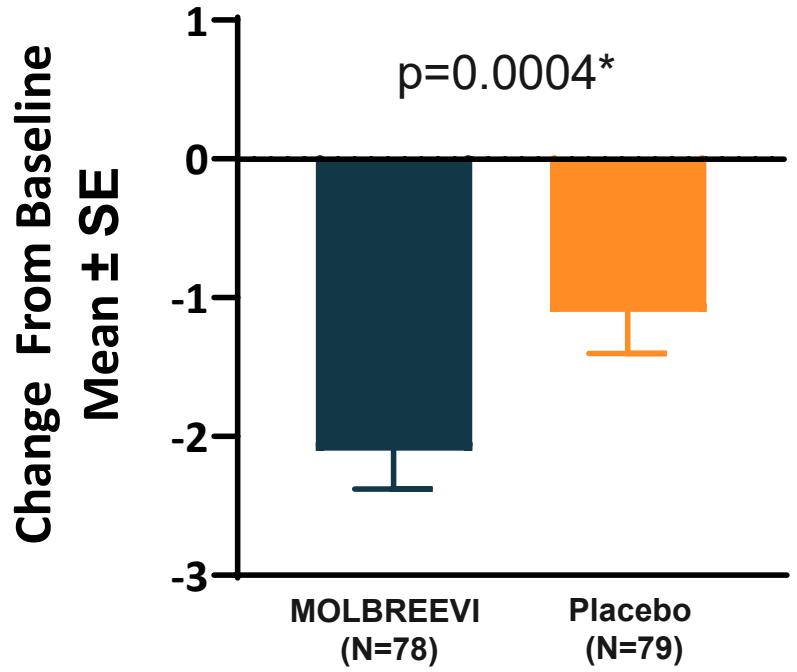
IMPALA-2: MOLBREEVI Nominally Significant on Change From Baseline in Exercise Capacity (Peak METs) at W48

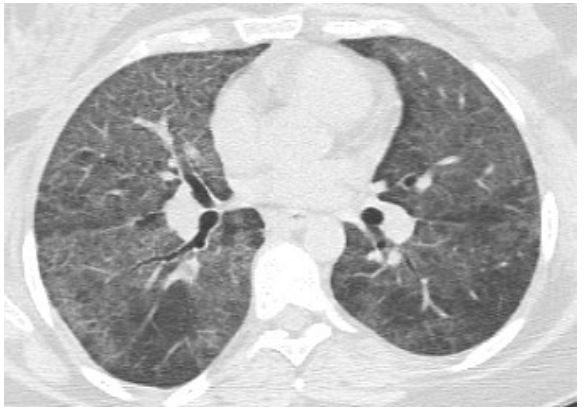


	LSM Change from Baseline	Between-Group LSM Difference*	P-value
Week 24	Mol: 1.11 Pbo: 0.70	0.41	0.0845
Week 48	Mol: 1.13 Pbo: 0.58	0.55	0.0234†

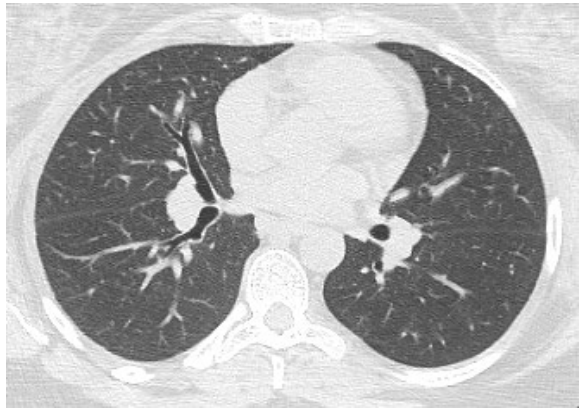
**Mean change from baseline compared with placebo. P-values are for difference in LSM compared with placebo. †P-value nominally significant: P-value ≤0.05 but did not meet the p-value threshold required in pre-specified hierarchical testing procedure. LSM, least squares mean; MET, metabolic equivalent;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

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





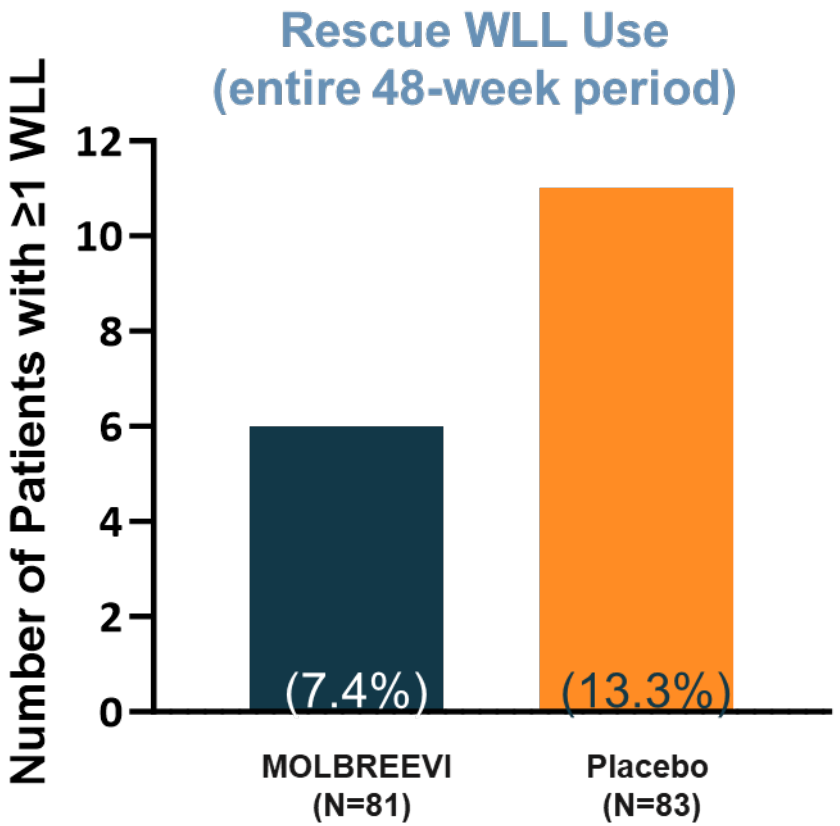
Baseline



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)

[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 Week 48	**0.0007** **0.0008**
	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
Respiratory health-related quality of life	SGRQ Total Score	Week 24 Week 48	**0.0072** 0.1046
	SGRQ Activity Score	Week 24 Week 48	**0.0149†** 0.1216
	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†**
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

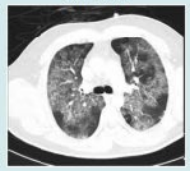
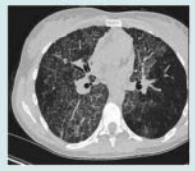
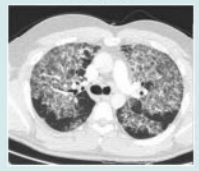
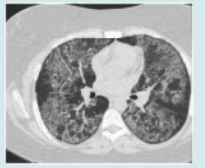
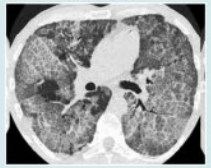
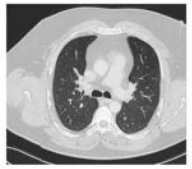
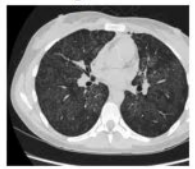
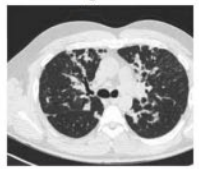
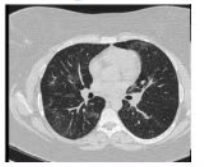
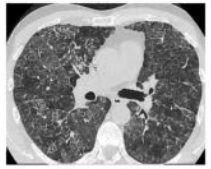
- All 5 patients had
  - CT tomography scan patterns
  - Bronchoalveolar lavage findings
  - Characteristic PAP symptoms
  - Positive GM-CSF antibody test
- Mean duration of therapy: 4.2 years
- 4 patients had ≥ 1 WLL prior to taking MOLBREEVI

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

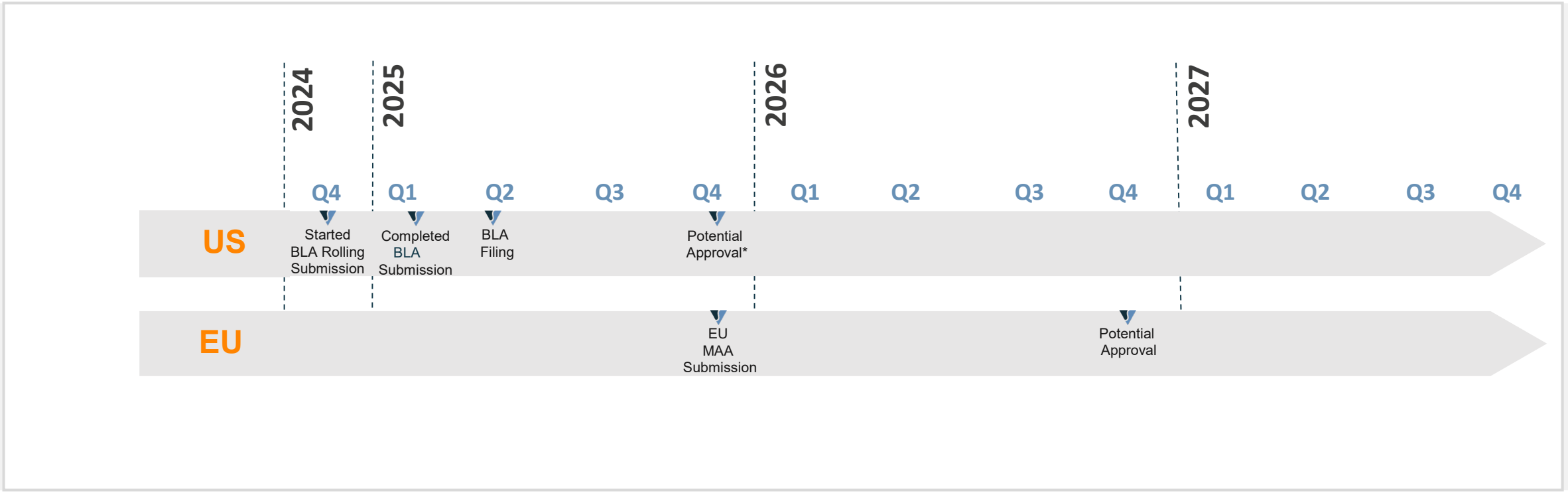
TABLE 1 Continued

	Patient 1	Patient 2	Patient 3	Patient 4	Patient 5
Clinical outcome	Overall improvement 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[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

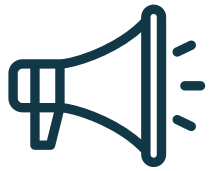
- Pending patent applications for drug formulation and methods of use including treating aPAP with MOLBREEVI
- Worldwide exclusive license to proprietary eFlow® Nebulizer System (PARI) for MOLBREEVI in aPAP and pending joint patent application with PARI for the drug/device combination
- Proprietary cell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

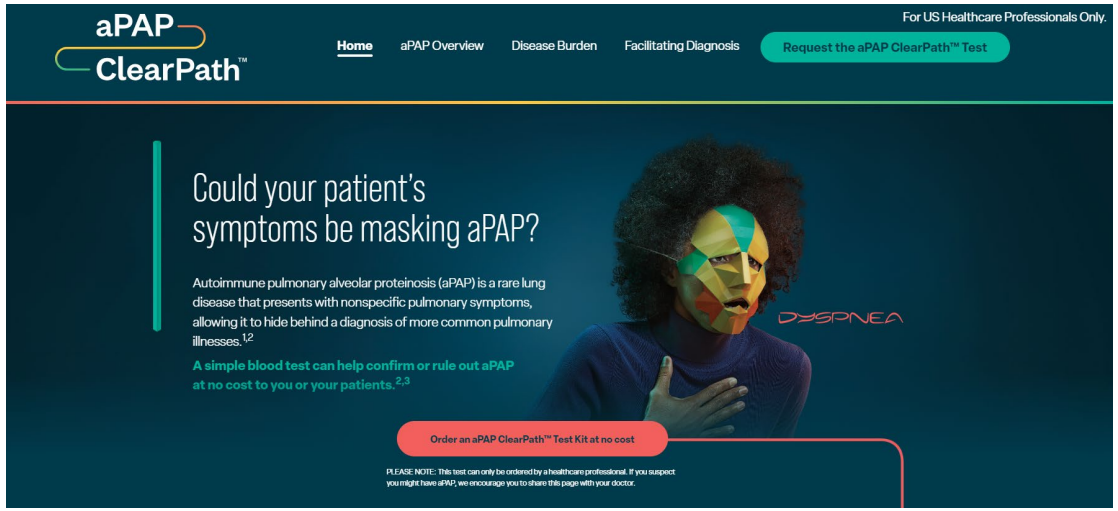
TESTING

Evolve diagnostic platform to scale testing efforts

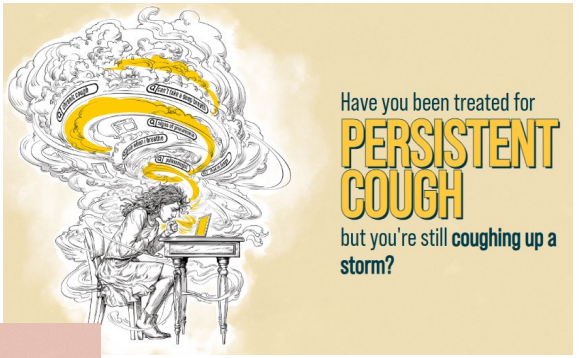
Autoimmune PAP Disease State Awareness Campaign

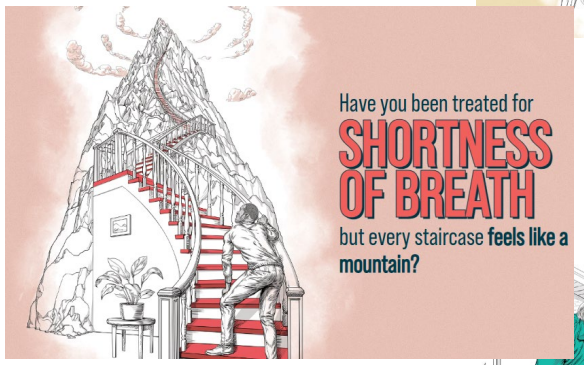
Multi-channel effort across healthcare professionals and patients

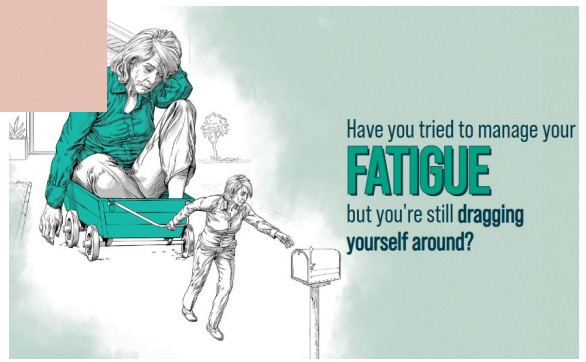
HCP DSA Campaign



Patient DSA Campaign



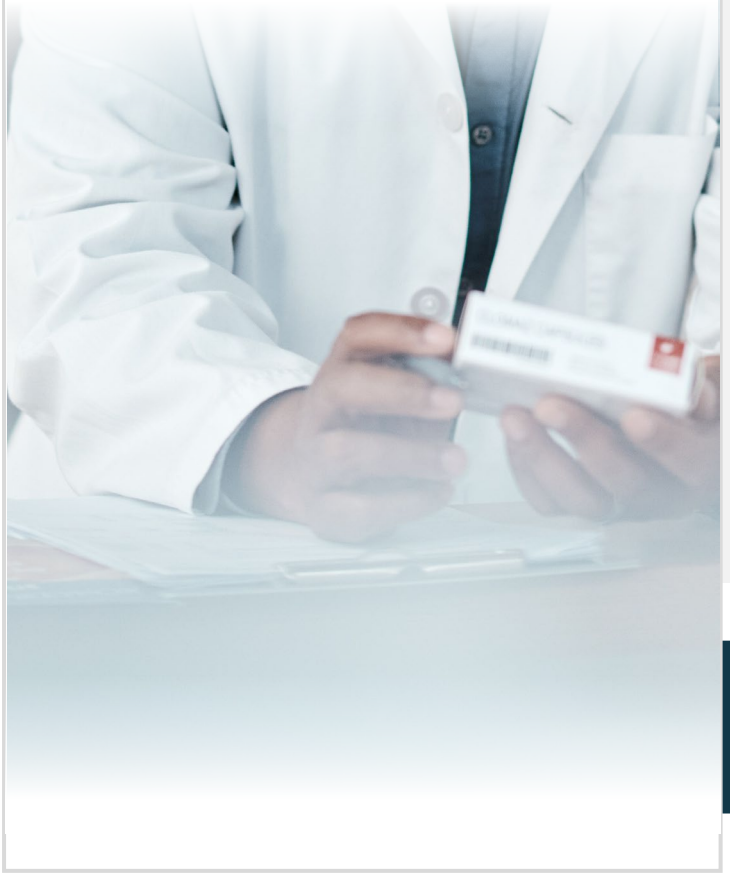




Exclusive Specialty Pharmacy with Integrated Patient Services

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™

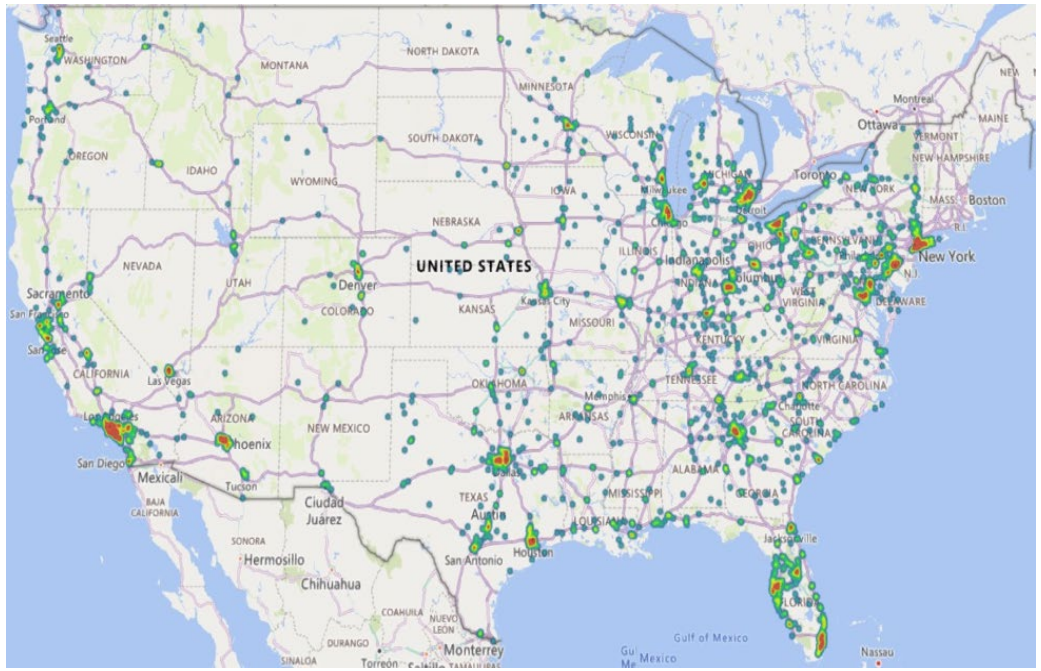
aPAP ClearPath Ab testing to confirm diagnosis

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

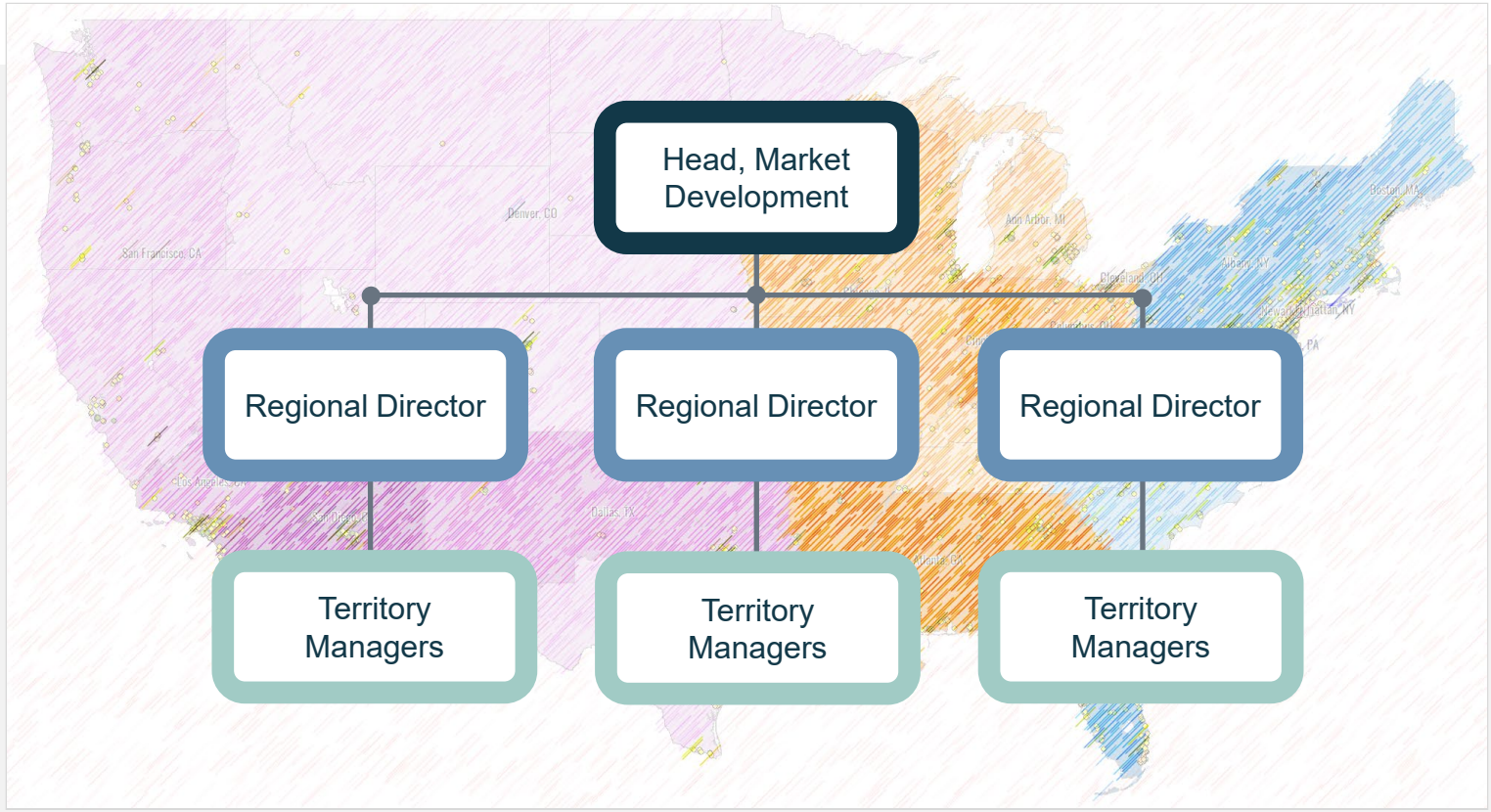
WOULD ask their doctor to prescribe MOLBREEVI

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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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.

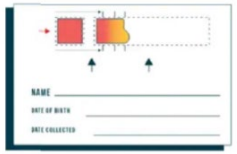
No cost antibody testing to identify aPAP among undiagnosed patients

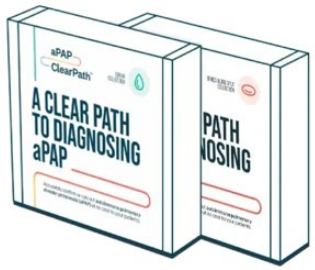
SERUM TEST

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***
  - ~$196M in cash and short-term investments as of 12/31/24
- **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

**Excluding the potential impact of the March 2025 debt financing of up to $200M.*

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