



Corporate Overview

Developing New Therapies
for Rare Respiratory Diseases

May 2024



Safe Harbor Statement

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

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Executive Leadership Team

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

Anne Erickson
Chief Business Officer

Dave Lowrance
Chief Financial & Administrative Officer

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

Ray Pratt, M.D. FACP
Chief Medical Officer

Scott Wilhoit
EVP, Global Commercial

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

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

Investment Thesis



Single Phase 3 program with high probability of success:

- Molgramostim nebulizer solution (molgramostim) in autoimmune pulmonary alveolar proteinosis (aPAP)
- Favorable efficacy and safety data generated from the first IMPALA trial
- Top line data from pivotal Phase 3 IMPALA-2 trial expected end of 2Q 2024
 - BLA filing anticipated 1H 2025



Strong global commercial opportunity

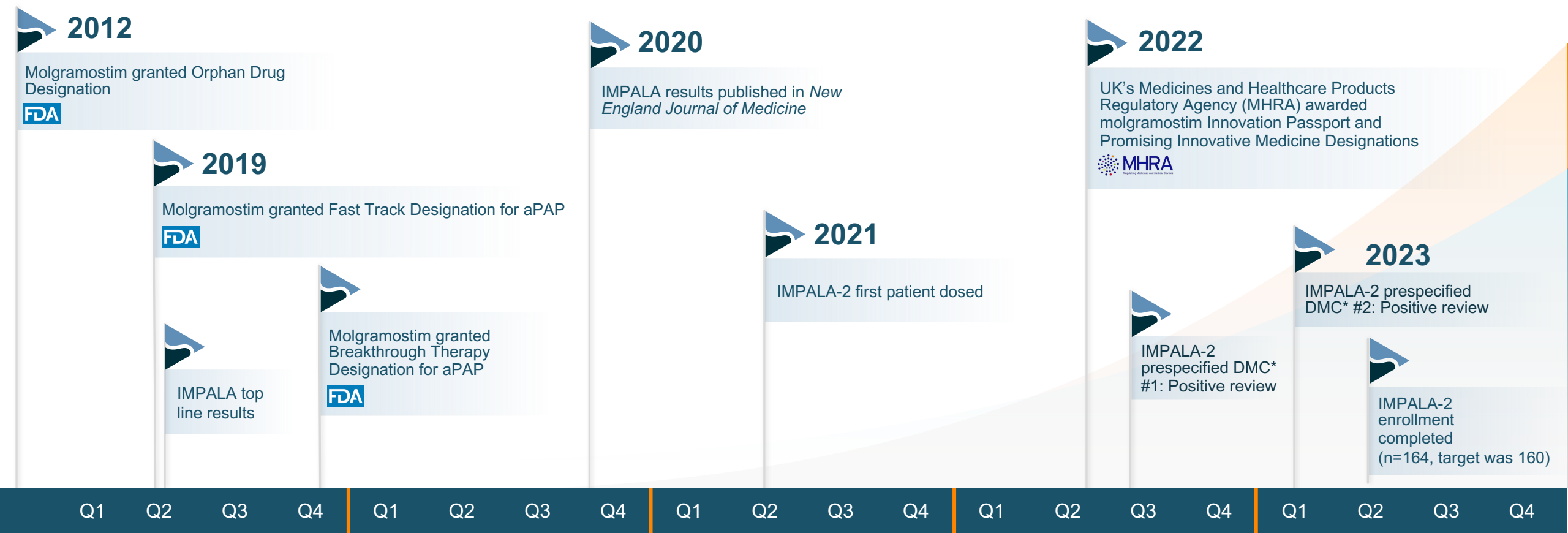
- Significant unmet need
- Claims dataset estimate indicates ~5,000 U.S. patients
- Chronic dosing expected
- Assumed pricing power consistent with orphan drug analogs (i.e., in U.S. ~\$300-\$500K p/patient, p/year)



As a novel inhaled biologic, molgramostim has:

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

Molgramostim Key Highlights



*The Data Monitoring Committee (DMC) conducted two pre-planned evaluations of IMPALA-2 to assess safety and sample size. In both cases the DMC recommended that the study continue unmodified.

Molgramostim

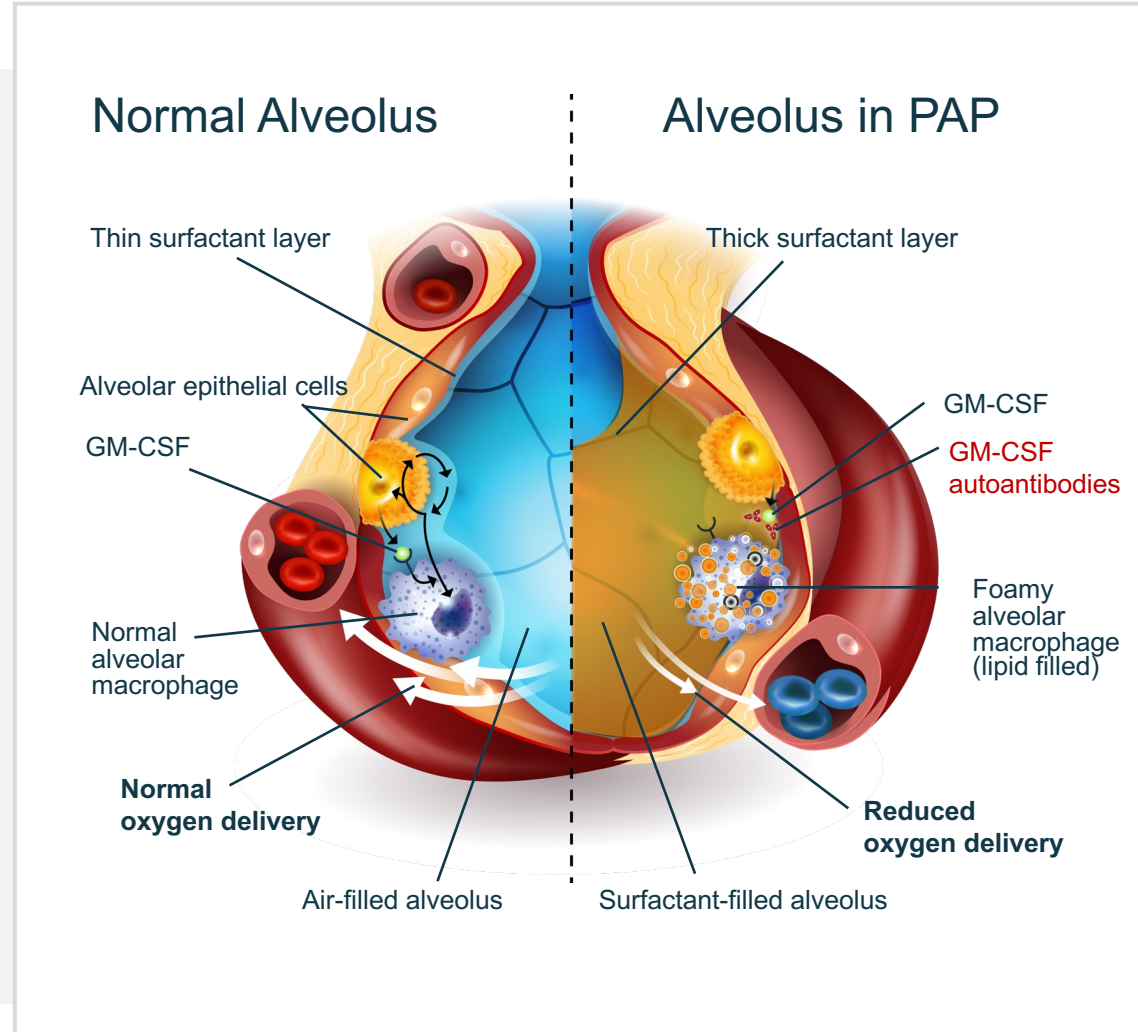
Molgramostim for Autoimmune Pulmonary
Alveolar Proteinosis (aPAP)

aPAP: An Autoimmune Disease of Alveolar Macrophage Dysfunction

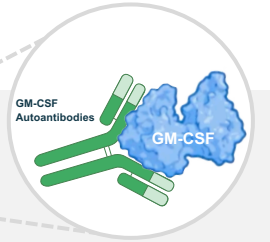
NORMAL LUNG FUNCTION

Alveoli need surfactant to keep from collapsing

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



aPAP



Rare lung disease

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

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

Reduced blood oxygenation that makes it hard to breath and, ultimately, hypoxemic respiratory failure

aPAP is a Rare, Long-Term, Chronic Disease

Progressive Shortness of Breath



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

Cough and Episodes of Fever



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

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

Fibrosis and Lung Transplant



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

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

Unmet Need: aPAP Patients Have Significantly Higher Rates of Healthcare Utilization and Comorbidities¹



Charlson Comorbidity Index (CCI)*

3.5x
Vs.
matched
controls

PAP: 1.84 ± 2.48

Age and Gender Matched Controls: 0.55 ± 1.44

P value: <0.0001

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



Outpatient visits (~17 per year)

+66%
Vs.
matched
controls

PAP: 17.30 ± 13.77

Age and Gender Matched Controls: 10.40 ± 11.38

P value: <0.01



Emergency Room Visits (~1.5 per year)

+38%
Vs.
matched
controls

PAP: 1.49 ± 1.17

Age and Gender Matched Controls: 1.08 ± 0.27

P value: 0.014



Longer hospital stays (~16 days per year)

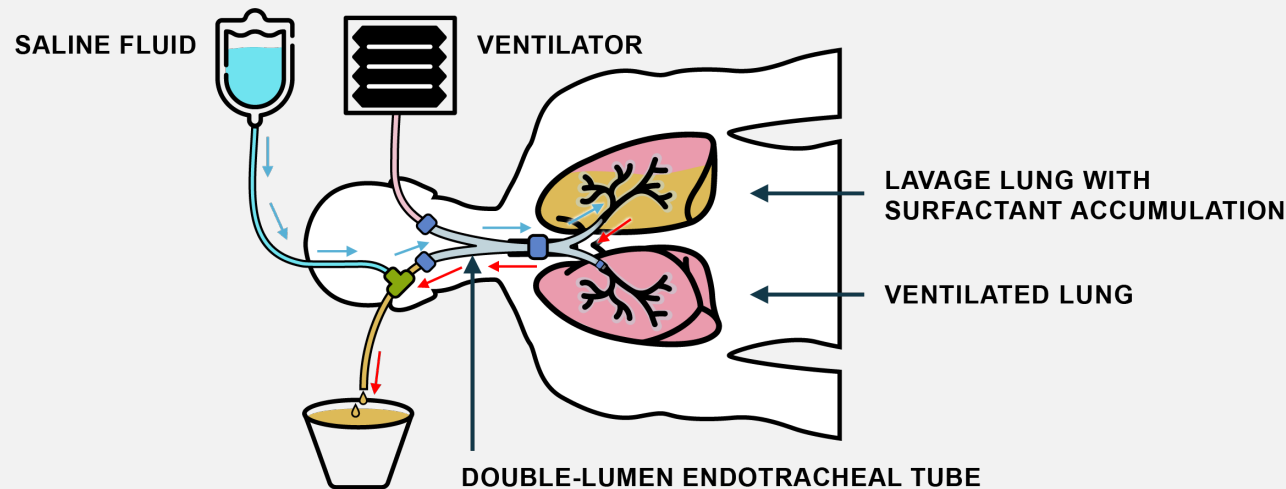
3.0x
Vs.
matched
controls

PAP: 15.96 ± 20.71

Age and Gender Matched Controls: 5.40 ± 5.07

P value: 0.027

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



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



Requires insertion of double-lumen endobronchial tube for lung separation

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

Patient is percussed to emulsify the surfactant sediment

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

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

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Complications and Short-Comings of Whole Lung Lavage



Potential Complications

- Rib fracture
- Hypoxia
- Pneumothorax (collapsed lung)
- Hydrothorax (fluid in pleural cavity)
- Superimposed infection
- Acute Respiratory Distress Syndrome (ARDS)



Short Comings

- Treatment fails to address underlying cause of the disease
- Patients continue to experience symptomatic deterioration between procedures – and can require more than one whole lung lavage
- Rollercoaster ride of improvement and decline
- The procedure, performed under general anesthesia, is not standardized (nor is requirement for WLL) and remains highly operator-dependent

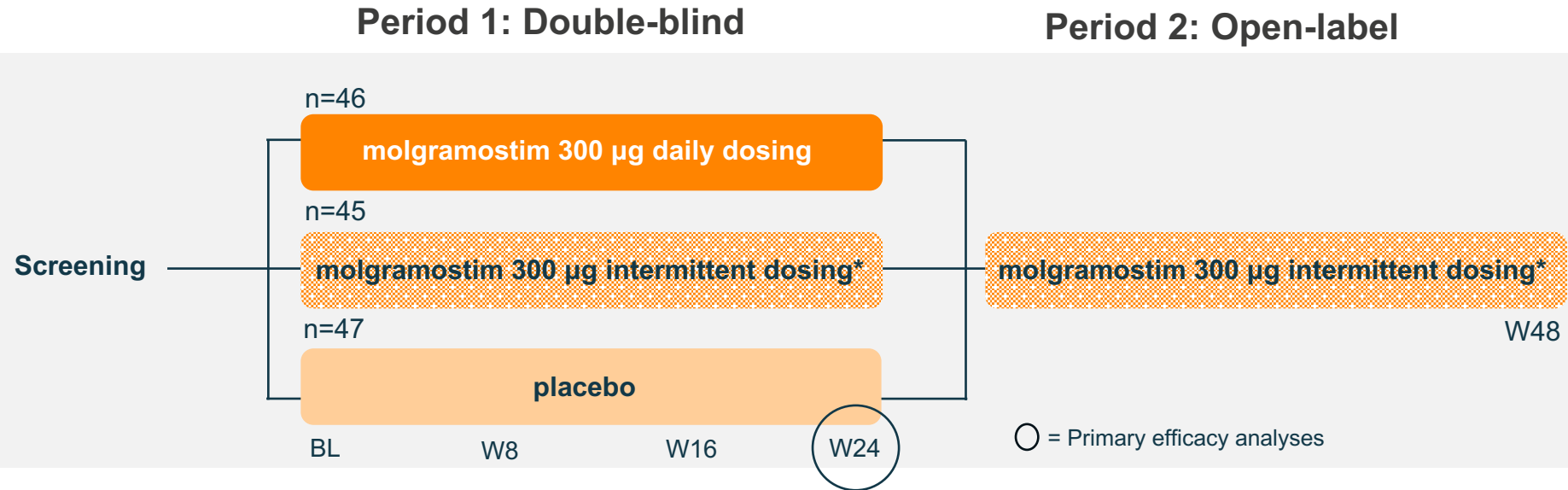
Savara Investigational Drug-Device Treatment for aPAP

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

Molgramostim nebulization time = 3-5 minutes



IMPALA Clinical Trial Design



Primary Endpoint

- Change from baseline in A-aDO₂**

Primary analysis was continuous dose vs. placebo

Key Secondary Endpoints

- 6-minute walk distance
- SGRQ***
- Time to whole lung lavage/requirement for whole lung lavage

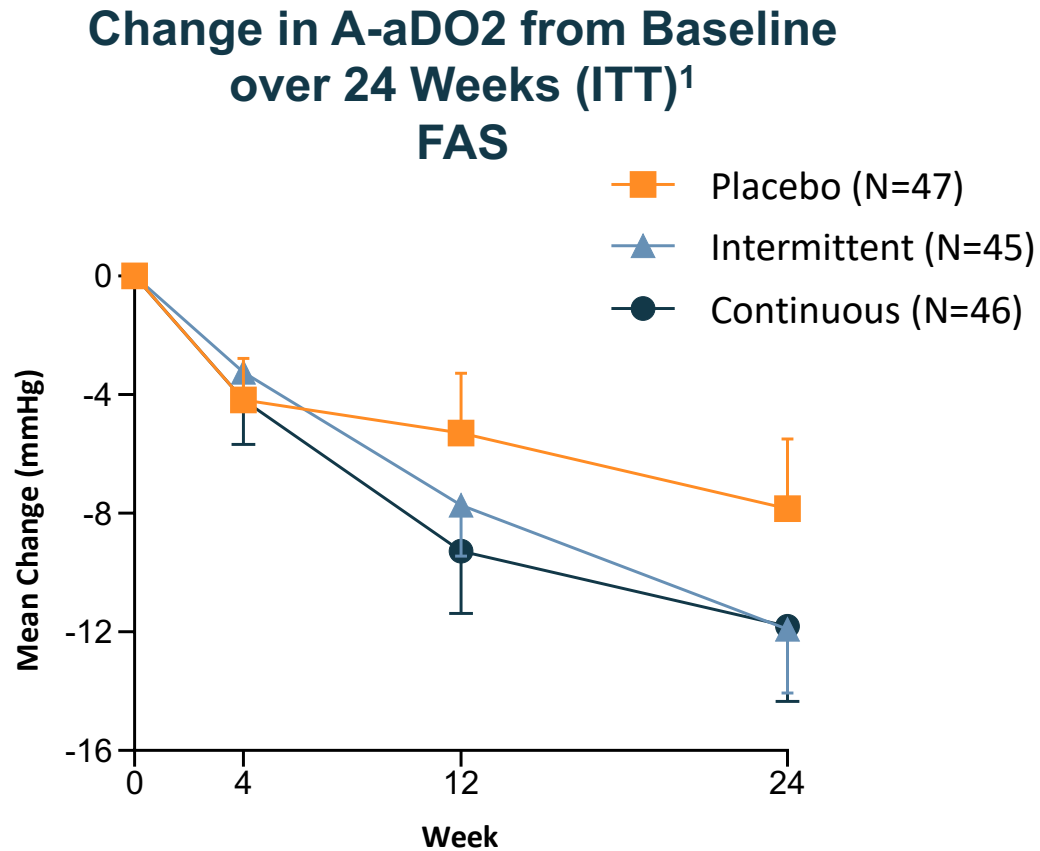
Secondary endpoints were analyzed in parallel and corrected for multiplicity

*One week on, one week off

**A-aDO₂: Gas exchange measure used to calculate difference between oxygen concentration in the alveoli and arterial system

***St. George's Respiratory Questionnaire: Patient-reported Quality of Life tool measuring impact on overall health, daily life, and perceived well being

IMPALA Trial Did Not Meet the Primary Endpoint



Continuous Once Daily (QD) Dosing Regimen

Full Analysis Set (FAS)*
Estimated treatment difference of
-4.6 mmHg (p=0.17)

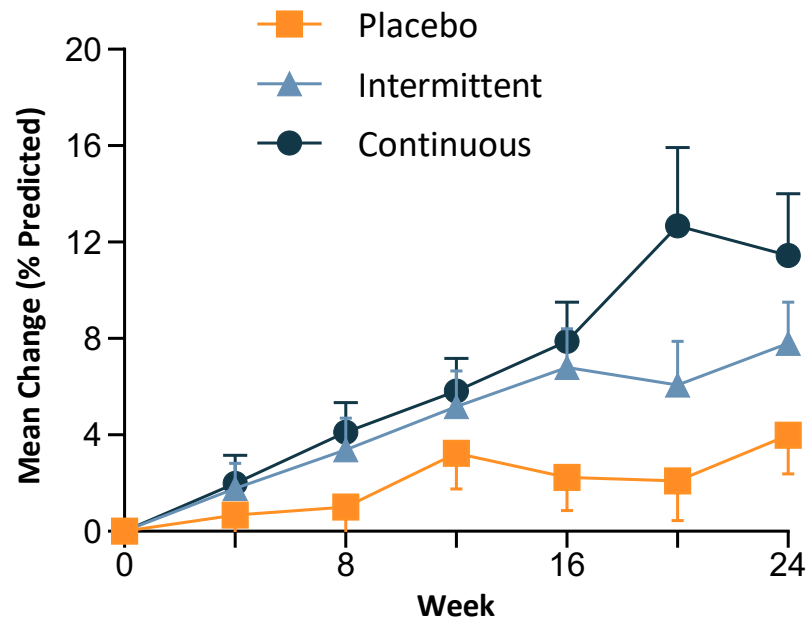
Revised FAS**
Estimated treatment difference of
-6.5 mmHG (p=0.025)

*Protocol specified analysis (ITT).

**Revised analysis excluded 4 patients using supplemental oxygen during testing (placebo: n=2, intermittent: n=1, continuous: n=1).

IMPALA: DLCO and SGRQ Showed Robust Improvement with Continuous Once Daily (QD) Dosing Regimen

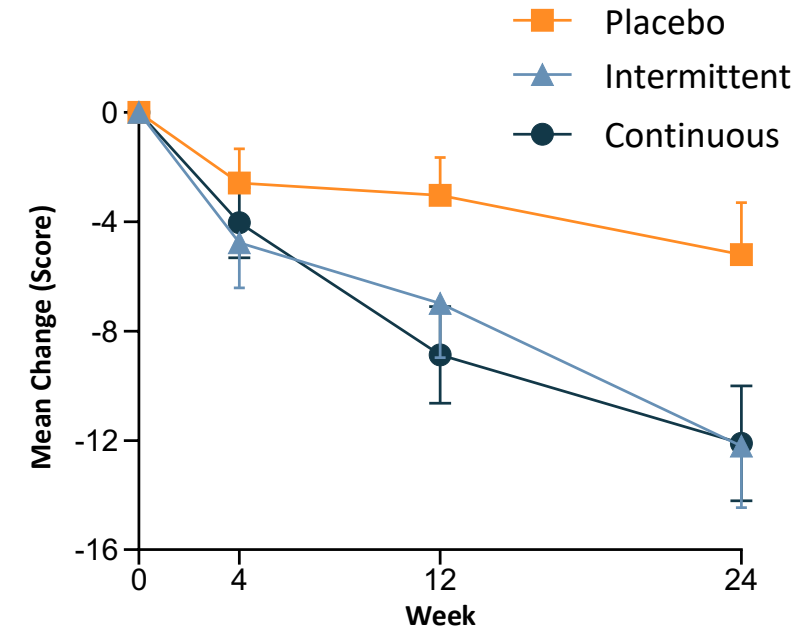
Change in Diffusion Capacity for Carbon Monoxide (DLCO) From Baseline Over 24-weeks¹ (FAS)



QD estimated treatment difference of 7.9% predicted (p=0.007)

Became Primary Endpoint in IMPALA-2

Change in St. George's Respiratory Questionnaire (SGRQ) From Baseline Over 24-weeks¹ (FAS)

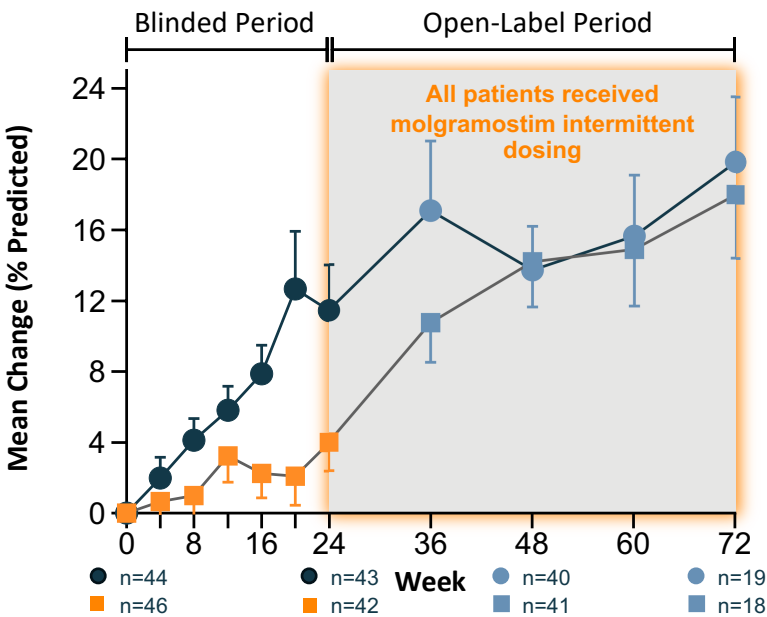


QD estimated treatment difference of 7.6 points (p=0.01)

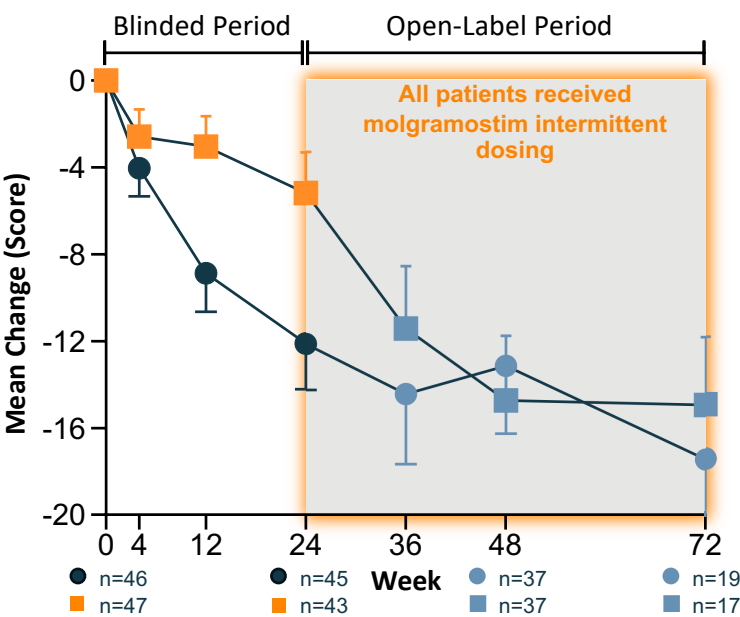
Became Key Secondary Endpoint in IMPALA-2

IMPALA Open-Label Data Showed Sustained Effect, or Continued Improvement, after Longer-Term Drug Exposure

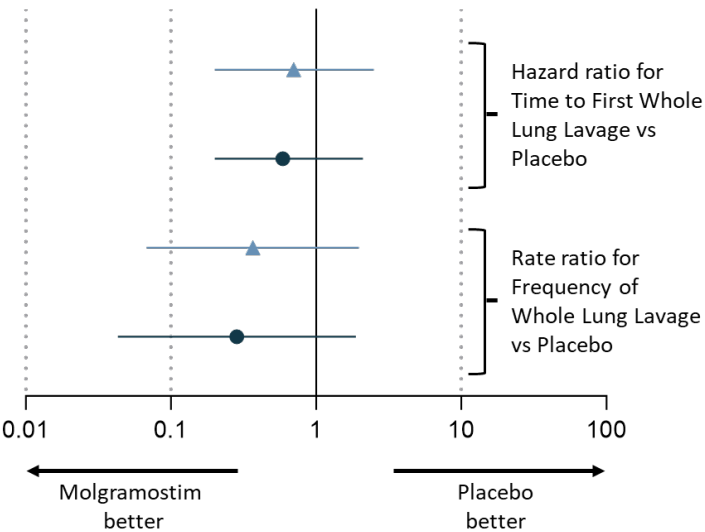
Mean Change in DLCO Over Time¹



Mean Change in SGRQ Total Score Over Time¹



Use of Whole Lung Lavage During the Blinded Treatment Period¹



■ Placebo ■ Intermittent molgramostim ● Continuous molgramostim

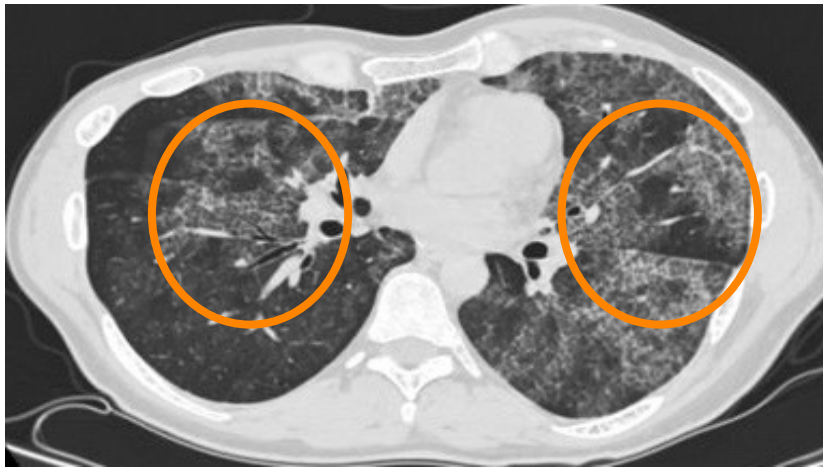
▲ Intermittent molgramostim ● Continuous molgramostim

Dosing schedules for blinded and open-label periods were different.

Molgramostim May Stimulate Alveolar Macrophages to Clear Surfactant From the Lungs

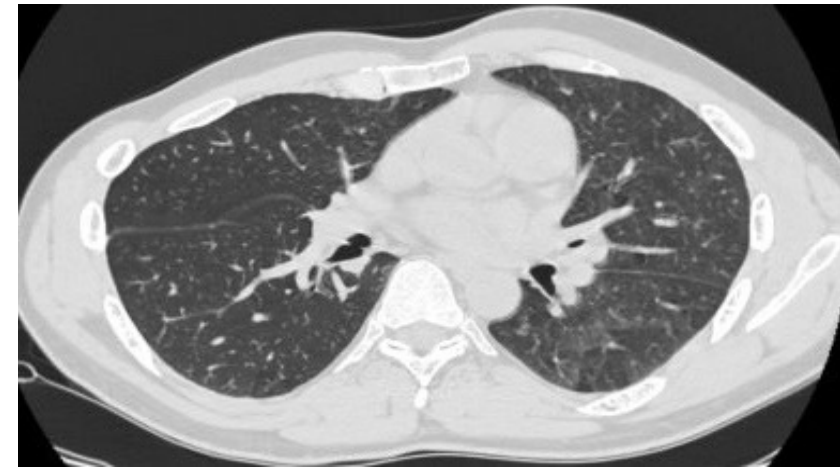
Before and After CT Scans From IMPALA Trial

White lines, called “crazy paving,” are a hallmark symptom of aPAP



High resolution chest CT scan of aPAP patient at baseline (week 0)

Following molgramostim treatment, a reduction in “crazy paving” was observed



High resolution chest CT scan of aPAP patient after treatment (week 24)

IMPALA Safety Overview

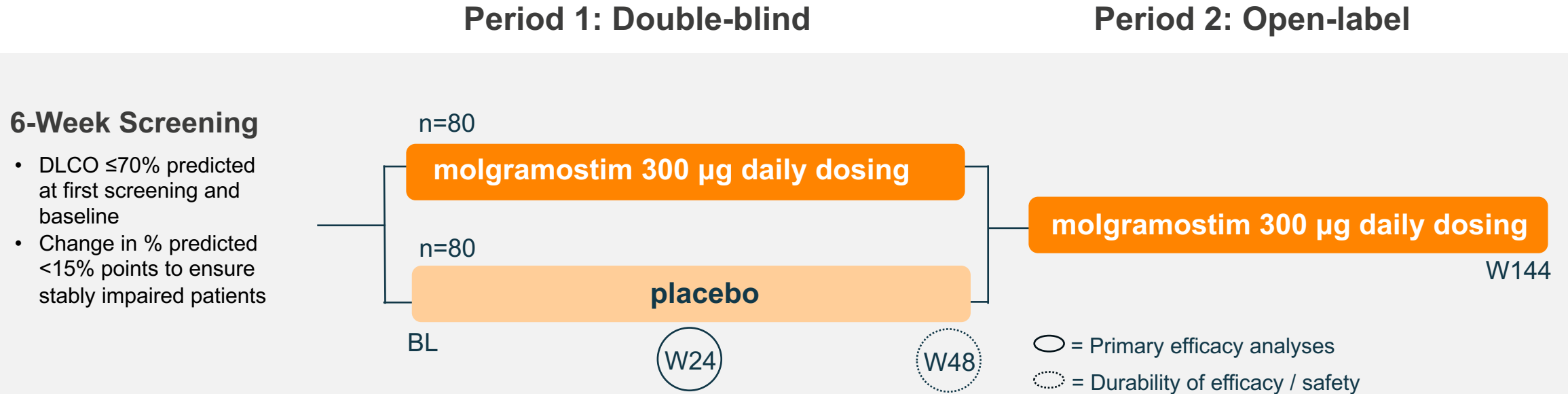
% PATIENTS WITH ADVERSE EVENTS (AEs) DURING DOUBLE-BLIND TREATMENT PERIOD*

Category	Continuous molgramostim (Patients with AEs >5% in double-blind treatment period) (n=46)	Placebo (n=47)
Any adverse event	84.8%	87.2%
Most common adverse events		
Cough	32.6%	23.4%
Chest pain	21.7%	2.1%
Nasopharyngitis	15.2%	12.8%
Headache	13.0%	14.9%
Dyspnea	10.9%	8.5%
Productive cough	8.7%	6.4%
Adverse events possibly or probably related to the intervention	32.6%	29.8%
Adverse events leading to discontinuation of the intervention	4.3%	2.1%

*Trapnell, Inhaled Molgramostim Therapy in aPAP, NEJM Supplementary Appendix, 2020

Phase 3 IMPALA-2 Trial Design Leverages IMPALA Key Learnings

Top Line Data Expected End of 2Q24



Primary Endpoint

- Change from baseline in DLCO at W24
 - 90% powered to detect 5.7% predicted difference with standard deviation of 11*

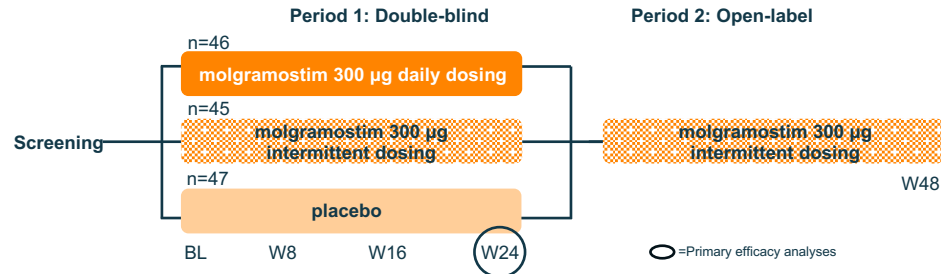
Secondary Endpoints

- SGRQ Total Score
- SGRQ Activity Score
- Exercise capacity using treadmill test

*Based on patient level data from IMPALA that best matches expected population for IMPALA-2

IMPALA-2 Study Design Leveraged Lessons from IMPALA

IMPALA



Primary Endpoint (Gas Exchange: surrogate measure): A-aDO₂

- Requires subject arterial blood draw
- Not repeatable

Supplemental Oxygen and Primary Endpoint: Supplemental oxygen not allowed during measurement of A-aDO₂

DLCO Screening Criteria: Vital capacity not improved by more than 5% and/or DLCO not improved by more than 10% as assessed by medical records

DLCO Variability Management: No standardization across sites

Key Secondary Endpoints:

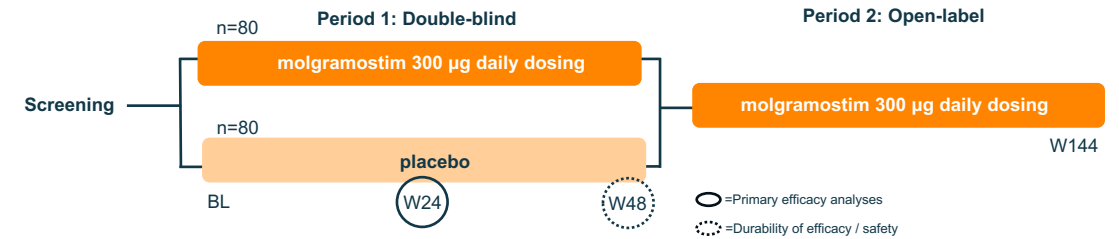
- SGRQ Total
- 6-minute walk distance
- Time-to/requirement for whole lung lavage

Patients Per Arm On Continuous Molgramostim: ~46

Double Blind Period: 24 weeks

Sites: 34

IMPALA-2



Primary Endpoint (Gas Exchange: surrogate measure): DLCO

- Requires subject to blow into a tube
- Repeatable

Supplemental Oxygen and Primary Endpoint: Not physically feasible to be on supplemental oxygen during measurement of DLCO

DLCO Screening Criteria: DLCO <70% predicted, <15-point % predicted change during screening

DLCO Variability Management: Device standardized across sites, real-time overread

Key Secondary Endpoints:

- SGRQ Total
- SGRQ Activity
- Exercise Treadmill Test

Patients Per Arm On Continuous Molgramostim: ~82

Double Blind Period: 48 weeks (Primary/key secondaries measured at W24)

Sites: 54

DLCO: Lung Function Test

- Diffusing capacity of the lungs for carbon monoxide (CO)
- Measures how well oxygen passes from the air sacs of the lungs into the blood
- Can indicate the efficiency of lung gas transfer and the presence of respiratory problems

**American Thoracic Society (ATS), European Respiratory Society (ERS)*

IMPALA-2 PROTOCOL FOR DLCO ASSESSMENT

- Conducted in accordance with ATS/ERS* guidelines
- Supplemental oxygen discontinued 15 minutes before assessment
- O₂ saturation must be stable before assessment ($\leq 2\%$ points over 5 min.)
- Up to 5 assessments allowed to obtain at least 2 acceptable/repeatable measurements
- Cloud-based, real-time overreads at the time of assessment ensure reliability and accuracy of the result

EasyOne Pro device used at all IMPALA-2 sites



Molgramostim Regulatory / Intellectual Property Landscape

MOLGRAMOSTIM IN aPAP REGULATORY DESIGNATIONS

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

IMPALA-2

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

BIOLOGIC EXCLUSIVITY

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

INTELLECTUAL PROPERTY

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

Commercial Outlook

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

Current
Diagnosed
Prevalence
Before Broad
GM-CSF
Autoantibody
Testing

Published aPAP Epidemiology Studies			
REFERENCE	METHODOLOGY	INCIDENCE PER MILLION	DIAGNOSED PREVALENCE PER MILLION
DIAGNOSED PREVALENCE			
Inoue 2008	Registry based in Niigata, Japan	0.48 (0.23-1.00)	6.2 (3.8-10.3)
McCarthy 2018	US insurance claims data, 2008-2012	Not reported	6.3 (5.2-7.6)

REFERENCE	METHODOLOGY	INCIDENCE PER MILLION	DIAGNOSED PREVALENCE PER MILLION
DIAGNOSED PREVALENCE			
Kitamura 2019	Update of Niigata registry	1.66 (1.2-2.2)	26.6 (9.0-73.0)

Diagnosed
Prevalence After
Broad GM-CSF
Autoantibody
Testing

IMPLIED US PATIENTS	IMPLIED EU PATIENTS	IMPLIED JAPAN PATIENTS	TOTAL IMPLIED PATIENTS
DIAGNOSED PREVALENCE			
~2,058	~2,325	~775	~5,158
~2,092	~2,363	~788	~5,243

IMPLIED US PATIENTS	IMPLIED EU PATIENTS	IMPLIED JAPAN PATIENTS	TOTAL IMPLIED PATIENTS
DIAGNOSED PREVALENCE			
~8,831	~9,975	~3,325	~22,131

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

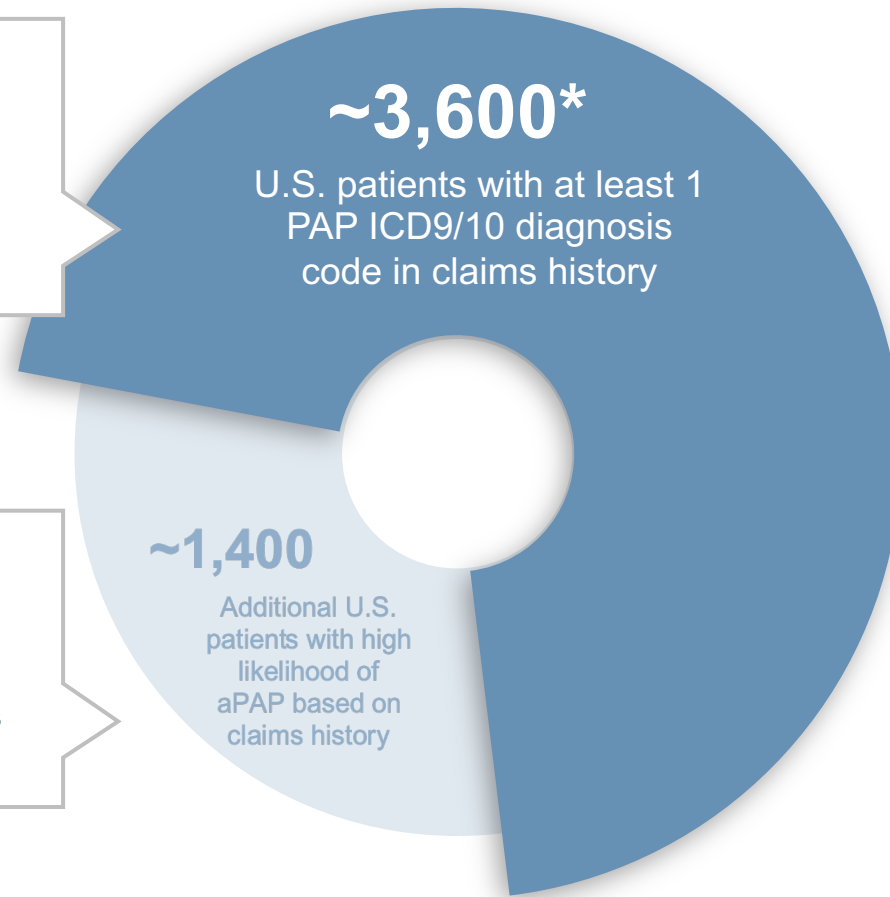
ANALYSIS OF COMPREHENSIVE CLAIMS DATASET

Real-World Claims Dataset:

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

APPLIED MACHINE LEARNING (ML) MODEL TO SAME CLAIMS DATASET

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



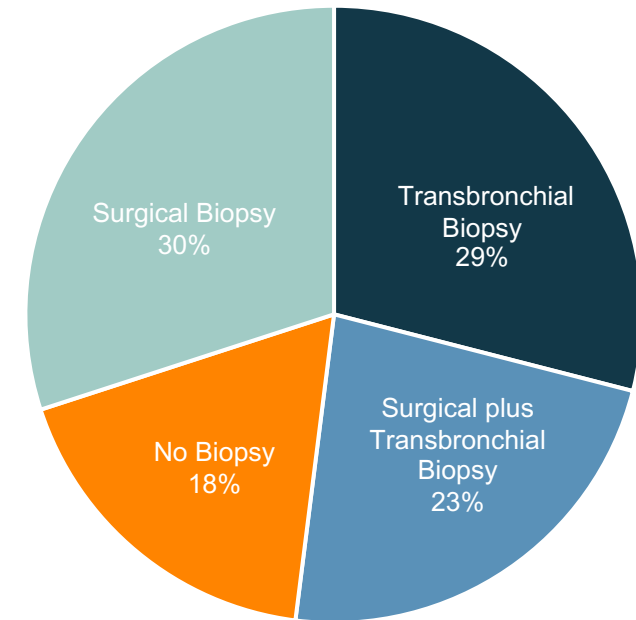
~5,000 estimated aPAP patients in the U.S., based on identified PAP claims history and machine learning assessment

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

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

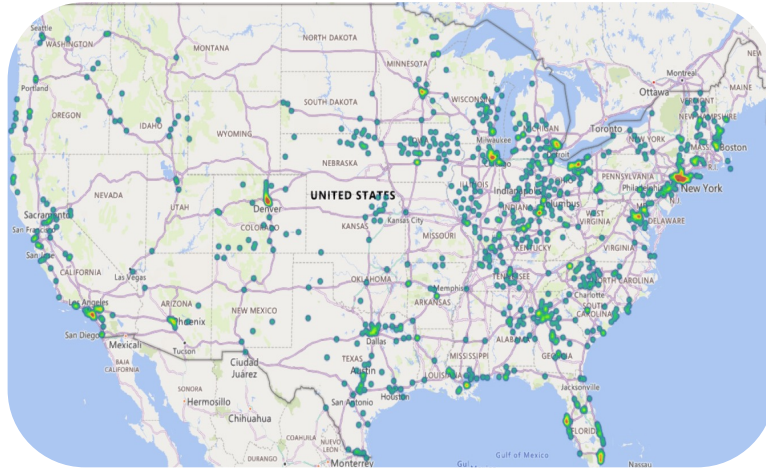
- 3-36 months¹: Range for aPAP time-to-diagnosis
- 18 months²: Average delay caused by misdiagnosis (e.g., pneumonia or asthma)
- Diagnostic workup frequently involves multiple tests and invasive procedures, including
 - Pulmonary function tests
 - Arterial blood gas analysis
 - Chest radiographs
 - CT scans
 - Bronchoalveolar lavage (BAL) cytology and/or lung histopathology³
 - Transbronchial biopsy, surgical lung biopsy, or both

U.S. National PAP Registry⁴ indicates many patients with PAP are diagnosed via an invasive transbronchial biopsy, surgical lung biopsy, or both³



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

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



~15K

Pulmonologists in the US

~5K

HCPs with diagnosed or machine-learning suspected PAP patients

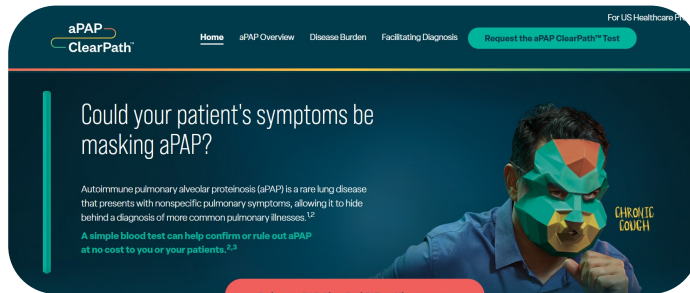
~120

Pulmonology centers

~10

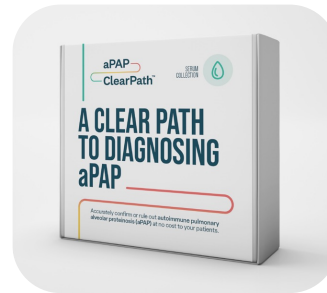
PAP clinical centers

www.apapclearpath.com



U.S. HCP Website

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



Patient Advocacy Group Partnerships/Memberships



 American Lung Association.

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

Molgramostim: Global Commercial Opportunity

Significant Unmet Need

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

Rare Disease Infrastructure

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



Molgramostim

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

Long Term Exclusivity

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

Financials

- **Well capitalized into 2026**
 - ~\$143M in cash*
- **Strong investor support with coverage from 7 equity research analysts**

ANALYST COVERAGE

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

Financial Highlights

Investment Thesis



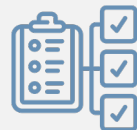
Single Phase 3 program with high probability of success:

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- Favorable efficacy and safety data generated from the first IMPALA trial
- Top line data from pivotal Phase 3 IMPALA-2 trial expected end of 2Q 2024
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- Chronic dosing expected
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- 12-year biologic exclusivity in U.S.
- Potential for a long-term, durable revenue stream with biosimilar competition unlikely



Thank You

