Corporate Overview

Developing New Therapies for Rare Respiratory Diseases

January 2025

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 potential health benefits and risks and projected development timeline of MOLBREEVI; the timing of regulatory submissions; the potential for and impact of regulatory approval; the potential addressable patient population, market size, commercial opportunity, and competitive landscape for MOLBREEVI; Savara’s commercial launch planning activities, including disease awareness campaign, GM-CSF autoantibody testing, planned infrastructure, and anticipated hiring and the potential impact of those activities; and the sufficiency of our resources to fund the advancement of our development program and potential sources of additional capital. Savara may not actually achieve any of its plans or product development goals in a timely manner, if at all, or otherwise carry out its current intentions or meet the expectations or projections disclosed in its forward-looking statements, and you should not place undue reliance on these forward-looking statements. These forward-looking statements are based upon Savara's current expectations and involve assumptions that may never materialize or may prove to be incorrect. Actual results and the timing of events could differ materially from those anticipated in such forward-looking statements as a result of various risks and uncertainties, which include, without limitation, the risks associated with our ability to successfully develop, obtain regulatory approval for and commercialize MOLBREEVI for aPAP; the risks and uncertainties related to the impact of widespread health concerns and geopolitical conditions on our business and operations; risks and uncertainties associated with the ability to project future cash utilization and reserves needed for contingent future liabilities and business operations; the ability to successfully conduct clinical trials for our product candidate; the availability of sufficient resources and the timing and ability of Savara to raise additional capital as needed to fund continued operations. The risks and uncertainties facing Savara are described more fully in Savara's filings with the Securities and Exchange Commission including our filings on Form 8-K, our Annual Report on Form 10-K for the fiscal year ended December 31, 2023, and our Quarterly Report on Form 10-Q for the quarter ended Sept. 30, 2024.

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

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

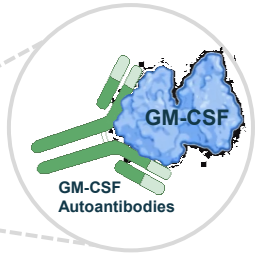
Autoimmune Pulmonary Alveolar Proteinosis (aPAP)

Overview and Burden of Disease

SAVARA

Autoimmune PAP: Disease of Alveolar Macrophage Dysfunction

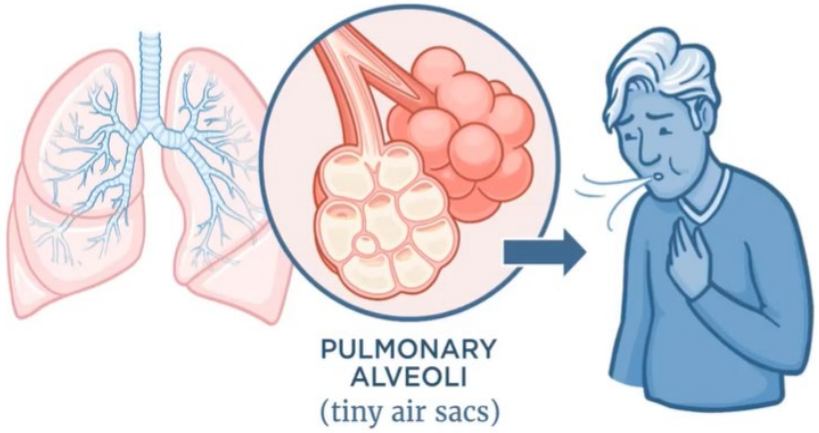
aPAP



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

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

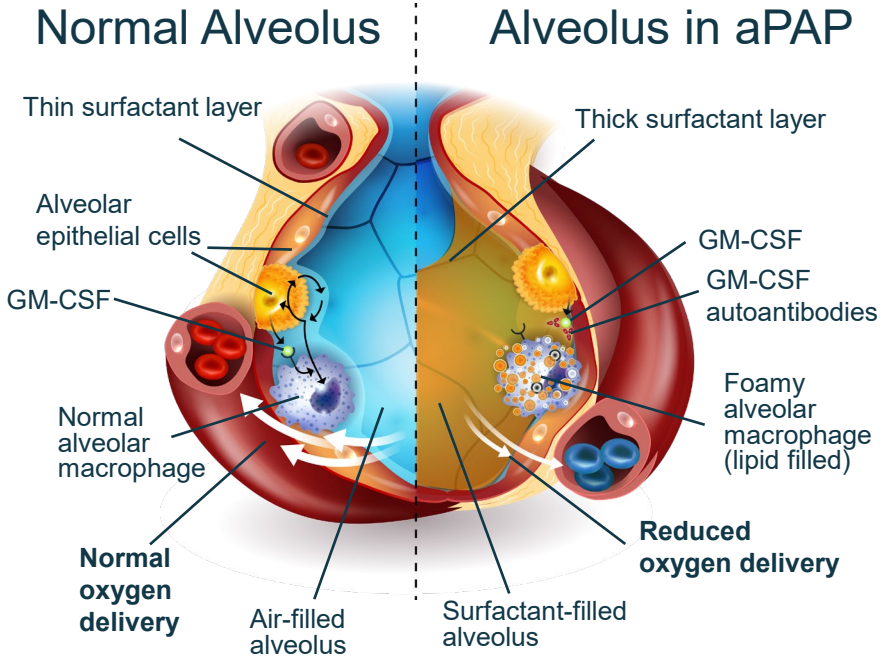
Reduced blood oxygenation results in difficulty breathing and, ultimately, hypoxemic respiratory failure



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

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

Fatigue, Decreased Exercise Tolerance

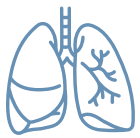
- Fatigue and significantly reduced exercise capacity can dramatically impact the simplest of daily activities, e.g., getting winded walking up a flight of stairs

Cough and Episodes of Fever

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

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]



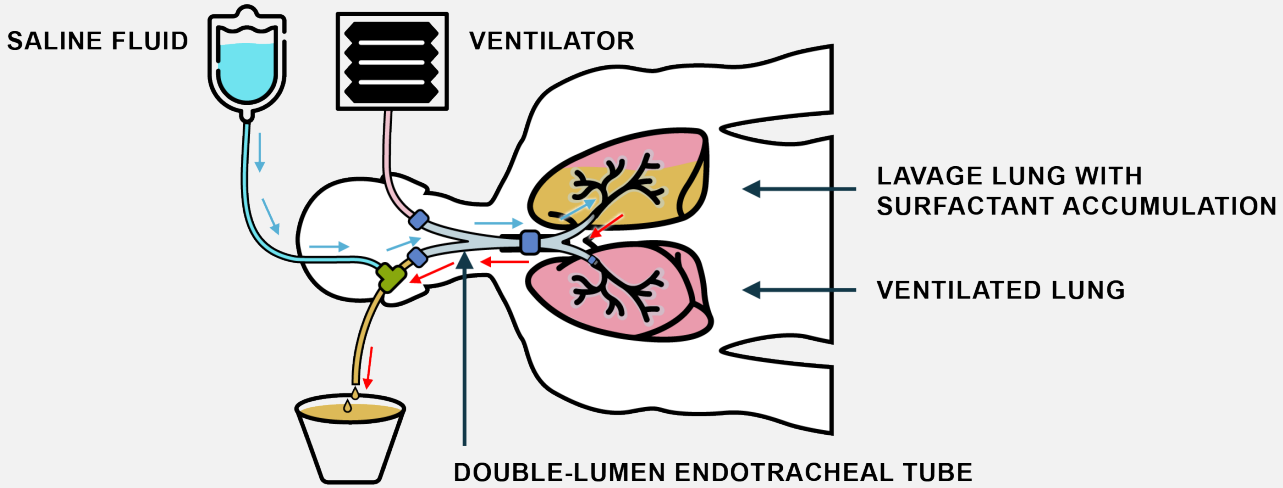
Fibrosis and Lung Transplant

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

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

Outpatient visits (~17 per year)

+66% Vs. matched controls

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

Emergency Room Visits (~1.5 per year)

+38% Vs. matched controls

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

Longer hospital stays (~16 days per year)

3.0x Vs. matched controls

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

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

Patient Perspective 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

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

**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

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 DL_{CO}% (p=0.0007)[1]

SECONDARY ENDPOINTS (MOLBREEVI vs placebo)

- Change from baseline to Week 48 in DL_{CO}% (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

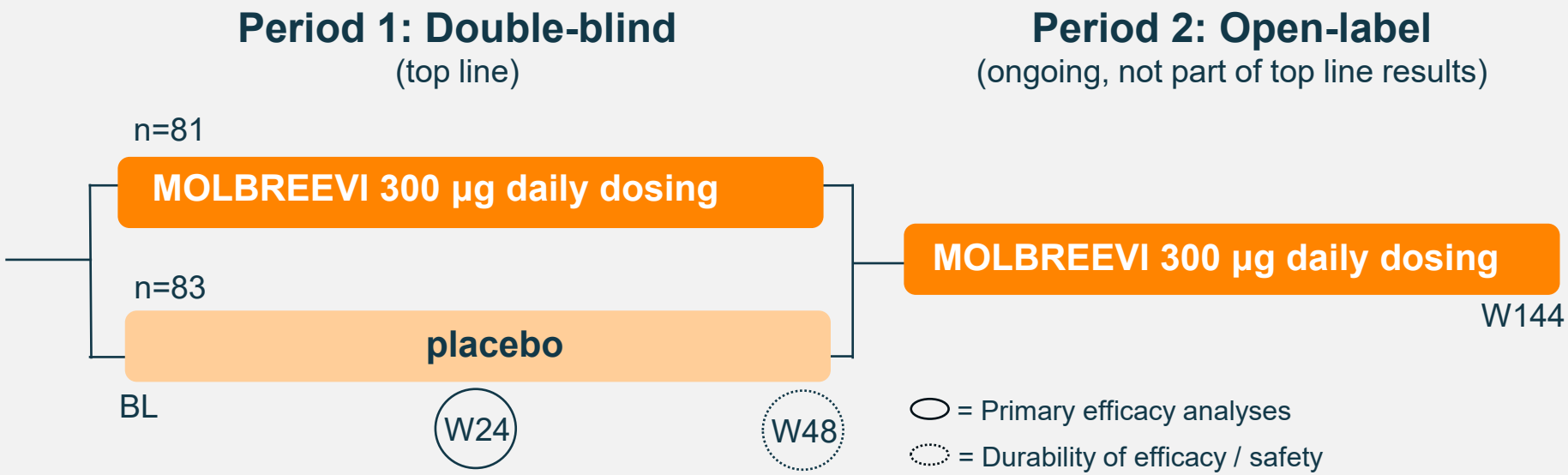
- Well-tolerated; low treatment discontinuation rate (3%), none due to drug-related adverse events
- 100% of patients who completed the double-blind period enrolled into the open-label period

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

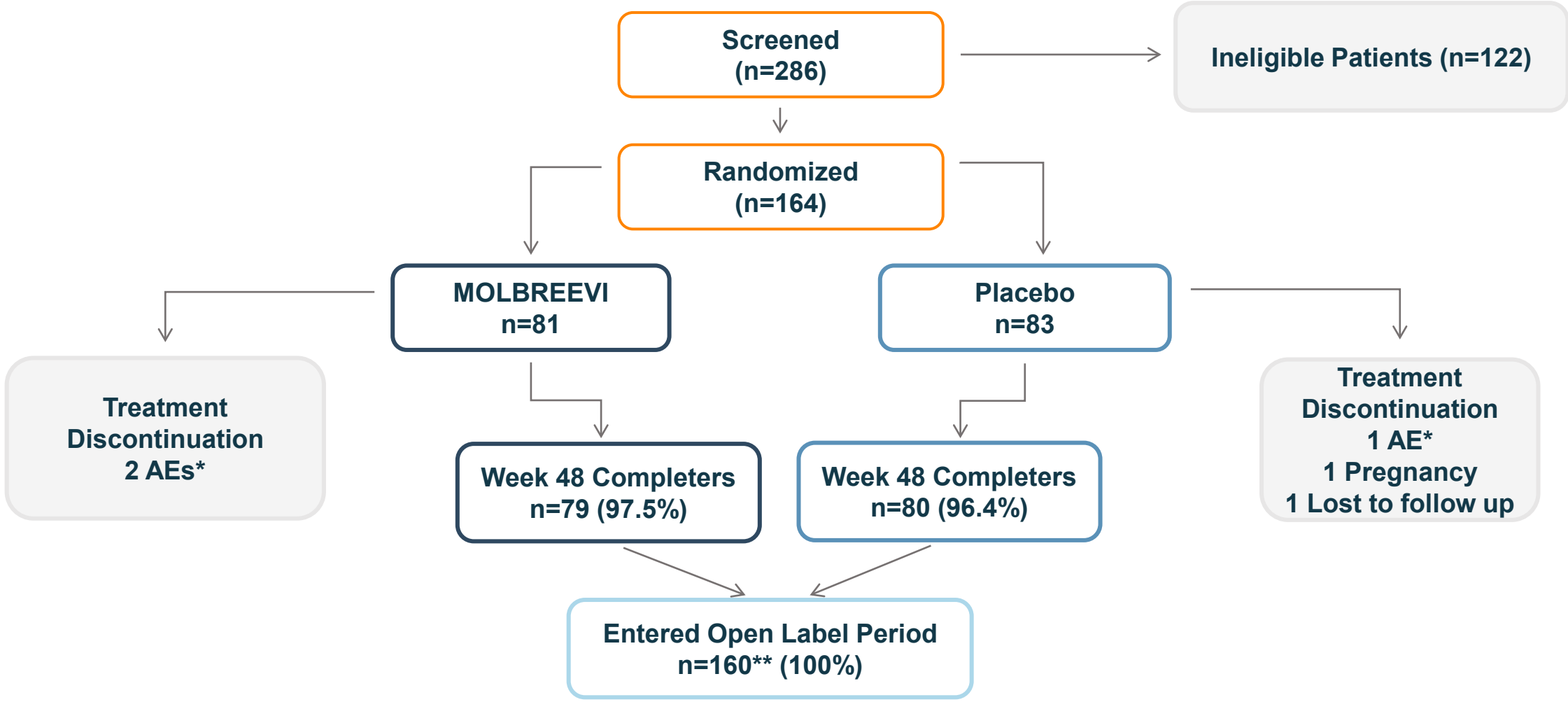
Change from baseline in:

- 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

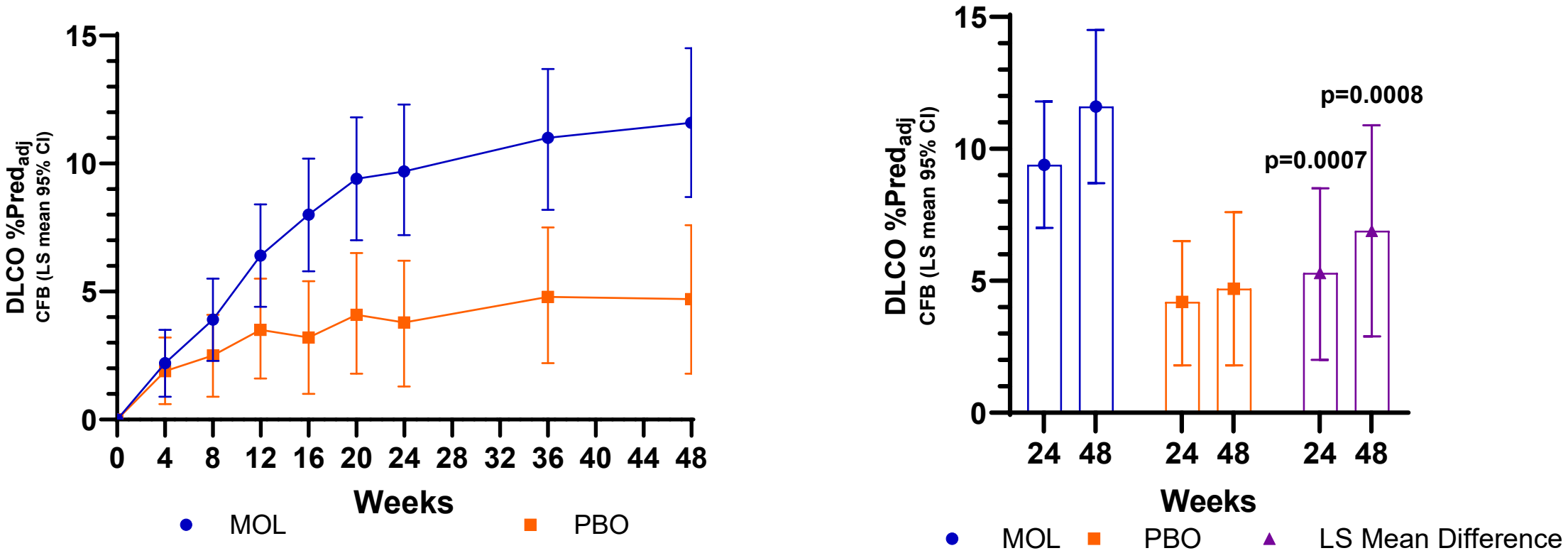
**One placebo patient stopped blinded trial drug but continued trial participation through Week 48 and entered the open label period

Demographics 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)

Primary Endpoint Met (DLCO): Achieved Statistical Significance

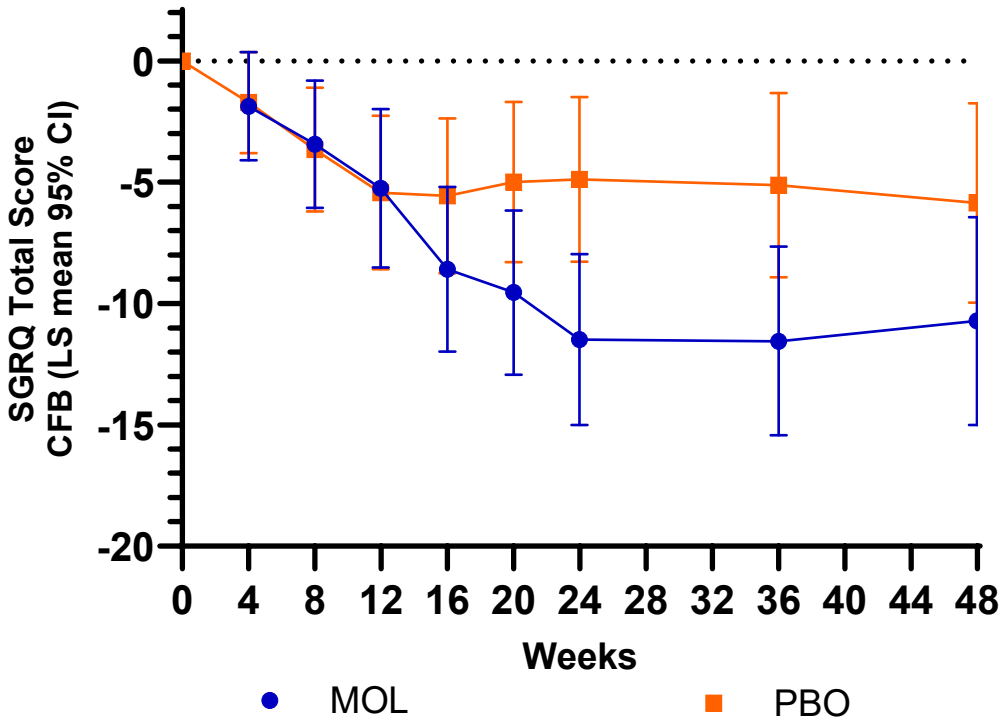
MOLBREEVI Superior to Placebo on Change From Baseline in DLCO at W24 (Primary Endpoint) and W48 (Secondary Endpoint)

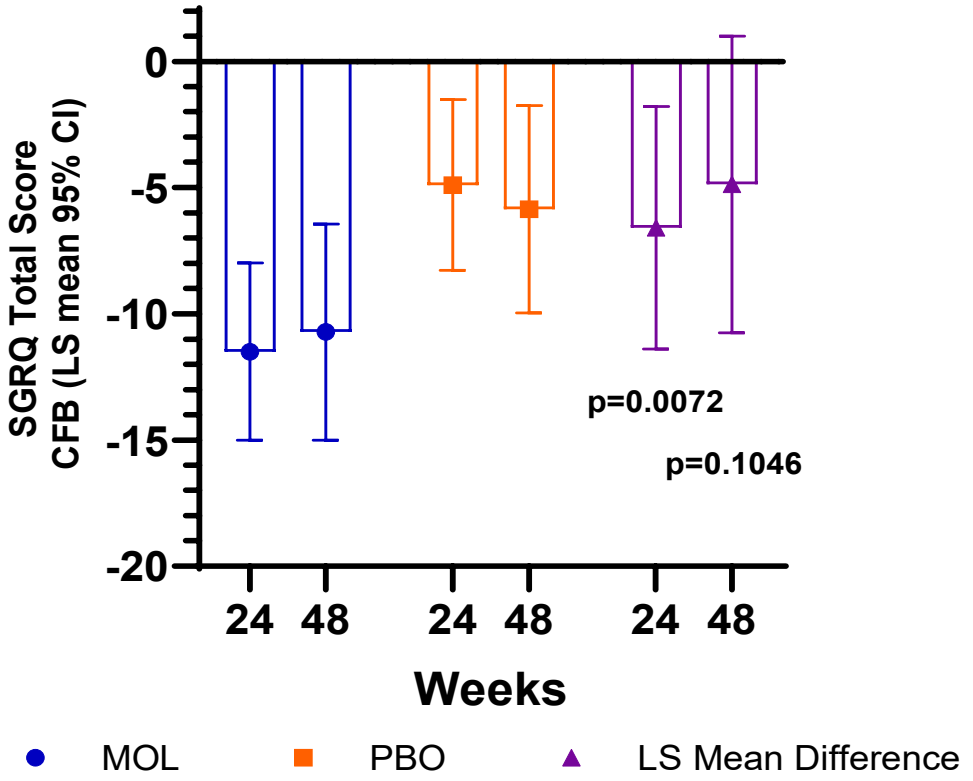


P-values are for difference in LS Mean CFB between MOLBREEVI and placebo

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

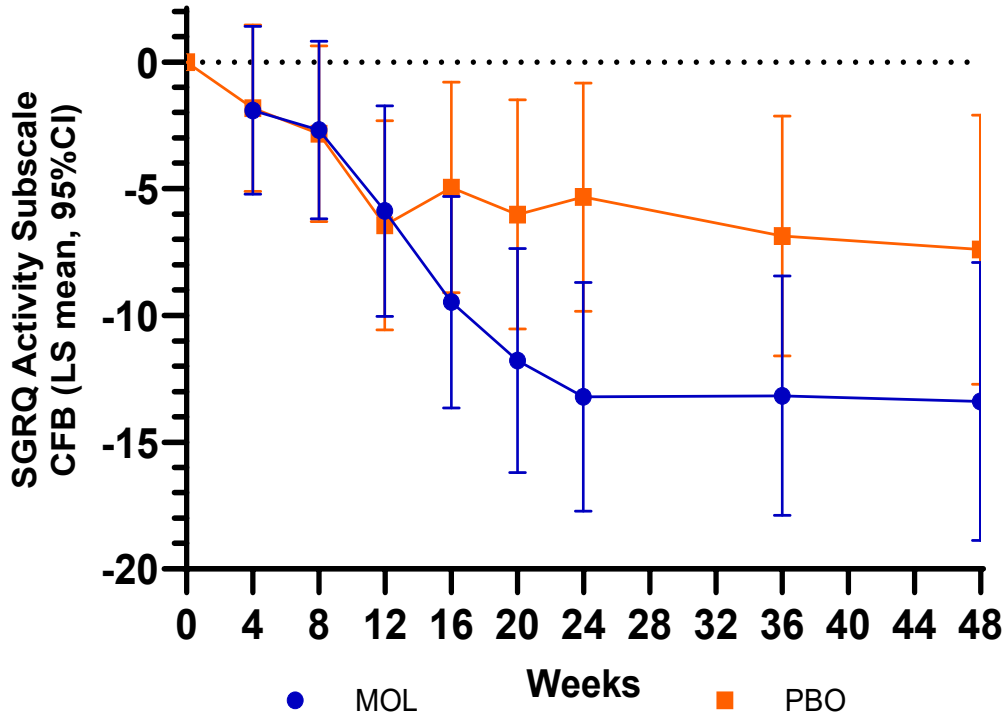
MOLBREEVI Superior to Placebo on Change From Baseline in SGRQ Total Score at W24, Favorability Continues Through W48

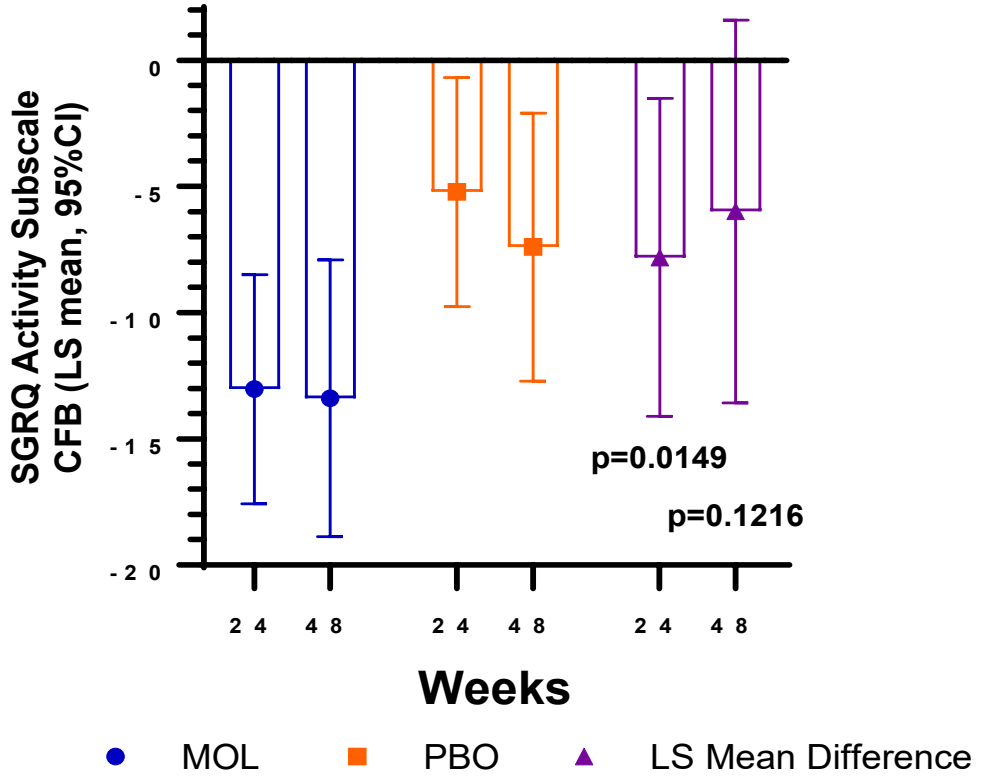




P-values are for difference in LS Mean CFB between MOLBREEVI and placebo

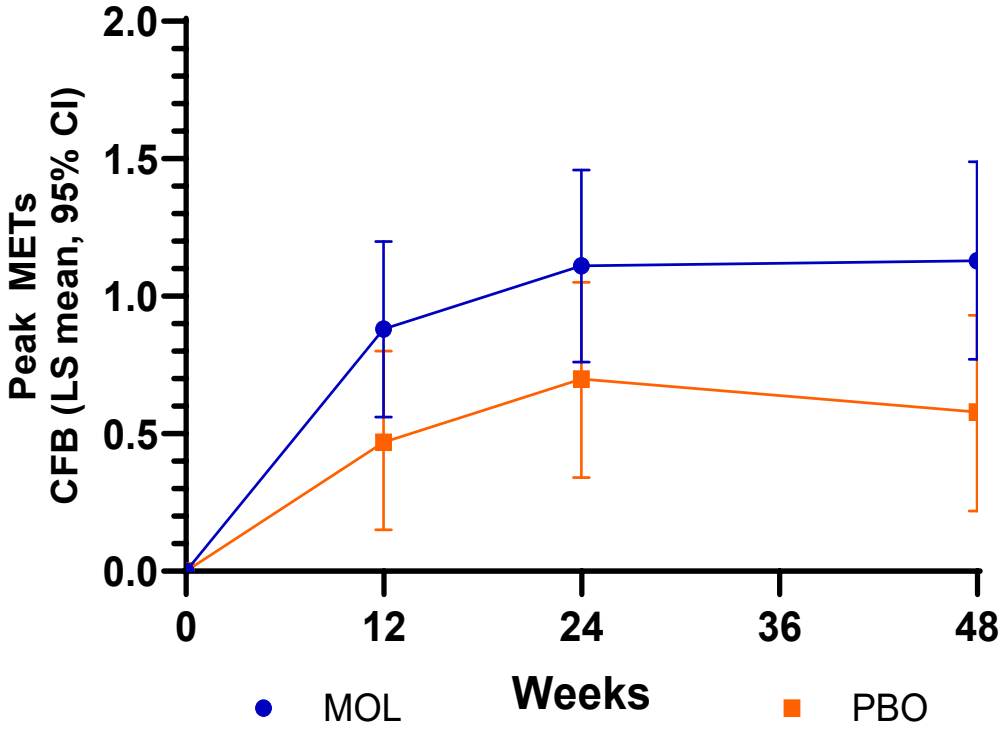
MOLBREEVI Nominally Significant on Change From Baseline in SGRQ Activity Score at W24, Favorability Continues Through W48

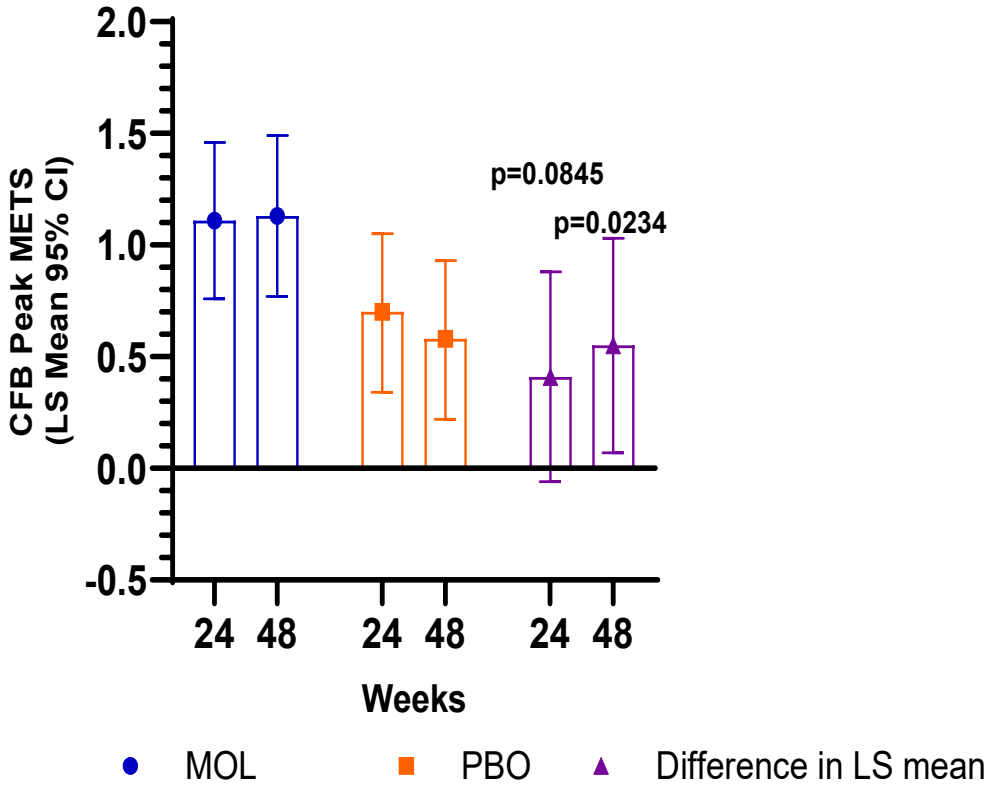




P-values are for difference in LS Mean CFB between MOLBREEVI and placebo

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





P-values are for difference in LS Mean CFB between MOLBREEVI and placebo

Lung Lavage Was Permitted as a Rescue Therapy During the Trial

During 48-week double-blind period
• 17 (~10%) patients underwent at least one lung lavage — MOLBREEVI: n=6 (7.4%) — Placebo: n=11 (13.3%)

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, which is labeled for psychiatric side effects, including delusions; 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

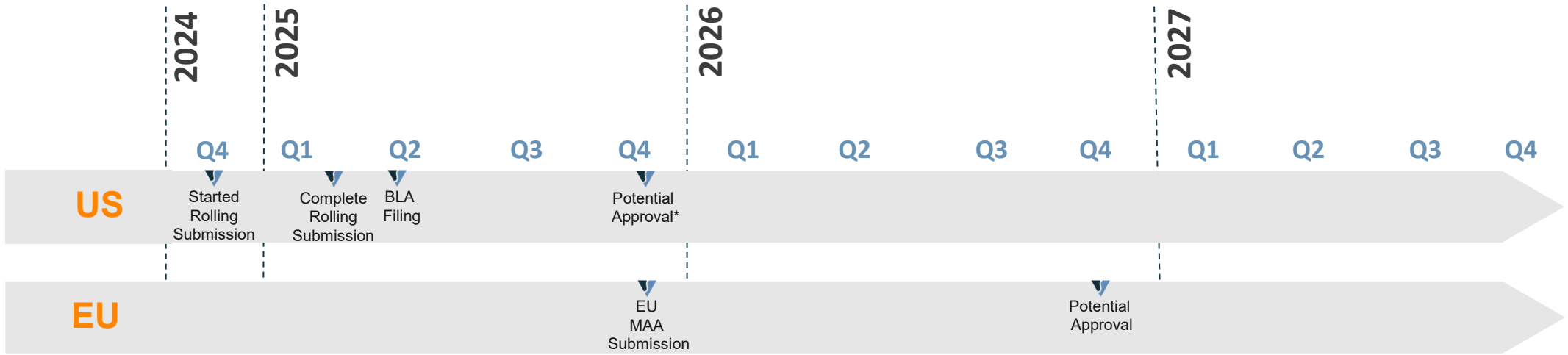
	Measure	Timeframe	P-Value / Results
Pulmonary gas exchange	DLco%	Week 24 Week 48	**0.0007** **0.0008**
	Disease Severity Score (DSS)	Week 24 Week 48	**0.0239*** **0.0006***
	Responder Analysis - DLco%	Weeks 24 and 48	Significantly higher proportions of patients achieved each responder threshold (5%, 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.

Regulatory and Intellectual Property

U.S. and European Regulatory Timeline



**Assumes Priority Review is granted by the FDA*

Regulatory and IP Summary

MOLBREEVI 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.

BIOLOGIC EXCLUSIVITY

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

INTELLECTUAL PROPERTY

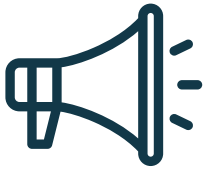
- Pending patent applications for MOLBREEVI drug formulation and methods of use including treating aPAP with MOLBREEVI
- Worldwide exclusive license to proprietary eFlow® Nebulizer System (PARI) for MOLBREEVI in aPAP and pending joint patent application with PARI for the drug/device combination
- Proprietary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

Commercial Update

Commercial Launch Planning Advancing Against Near Term Objectives

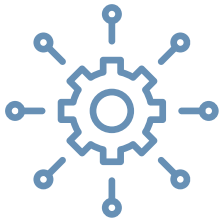
AWARENESS

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



INFRASTRUCTURE

Build critical capabilities to facilitate access to MOLBREEVI post approval



PERSONNEL

Hire and onboard key commercial roles to expand core activities

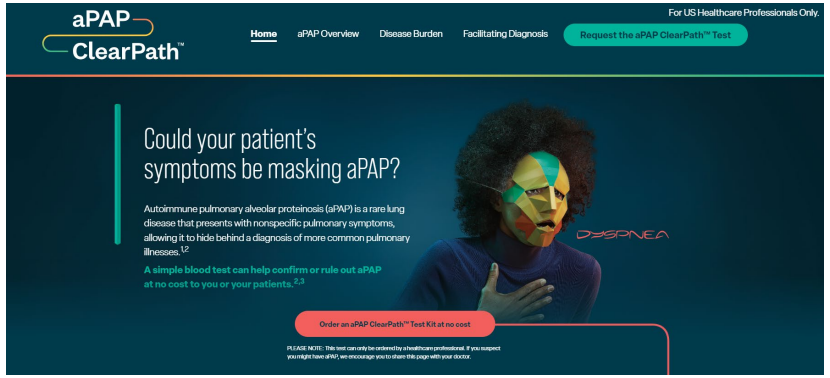
TESTING

Evolve antibody testing platform with an eye toward long term market expansion

Autoimmune PAP Disease State Awareness Campaign

Multi-channel effort across healthcare professionals and patients

HCP DSA Campaign



Conferences

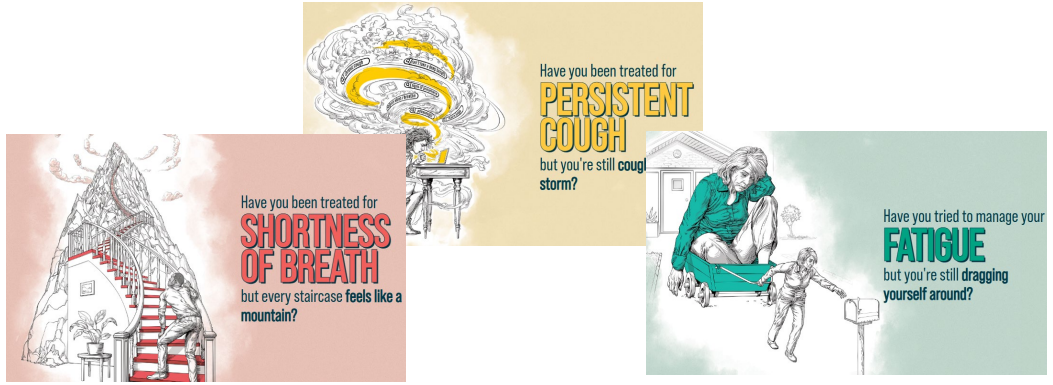
Tele-Educators

DSA Brochure

3rd Party Email

Paid Media

Patient DSA Campaign



Advocacy

Social Media

Paid Media

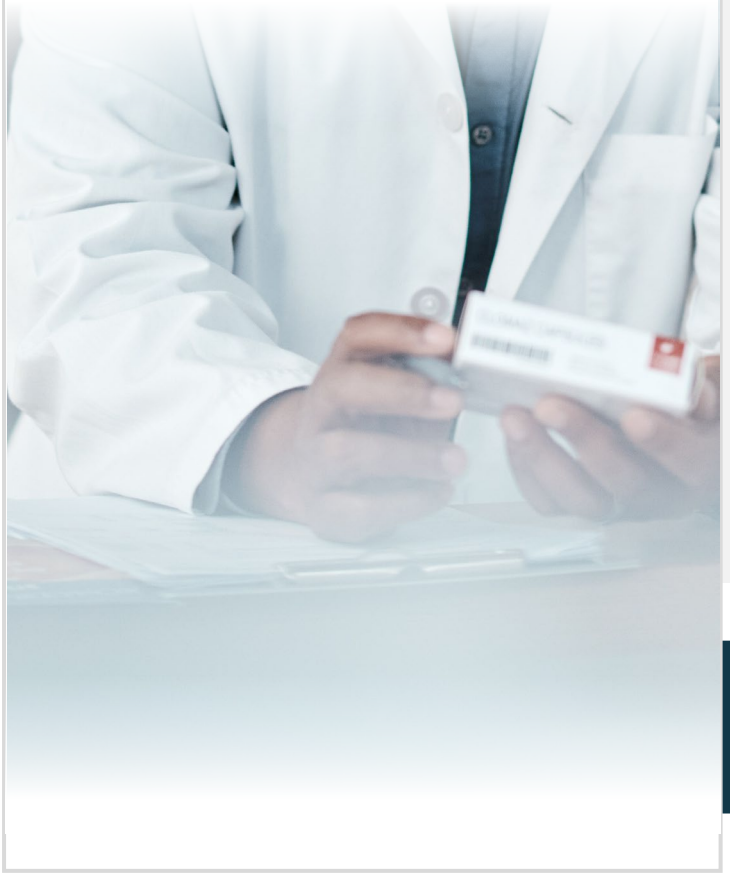
TV/YouTube

The Balancing Act

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

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

CONFIRMED DIAGNOSED aPAP PATIENTS[1]

~3,600

(U.S. Claims Data Analysis)

Analysis of comprehensive claims dataset

- Counted PAP ICD9/10 diagnosis codes from 300M+ lives*
- Physicians managing the patients are located across ~1,100 centers
- ~3,600 unique aPAP patients identified

*Adjusted for autoimmune PAP (aPAP)

UNCONFIRMED HIGHLY LIKELY AND LIKELY aPAP[1]

+1,400 Highly likely

+2,300 Likely

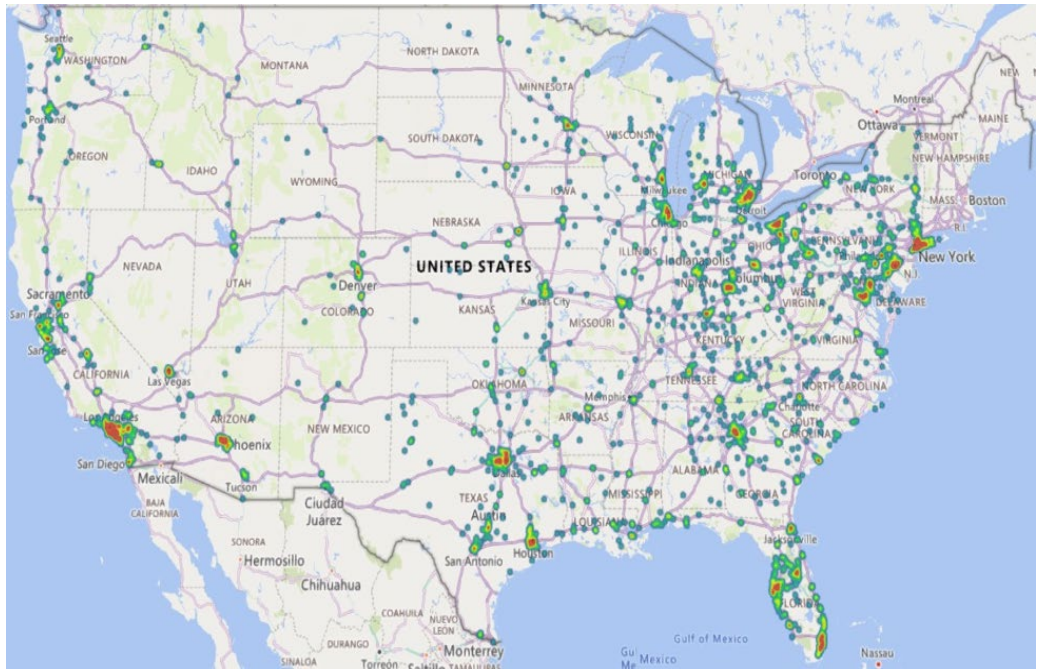
aPAP ClearPath™

aPAP ClearPath Ab testing to confirm diagnosis

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

U.S. Centers Prioritized Based on Experience Treating aPAP Patients

U.S. PATIENTS / HCP HEATMAP[1]



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

GOAL: Line of Sight to 1,000 Patients at Launch

COEs†

ILD Centers*

General Pulmonary Centers

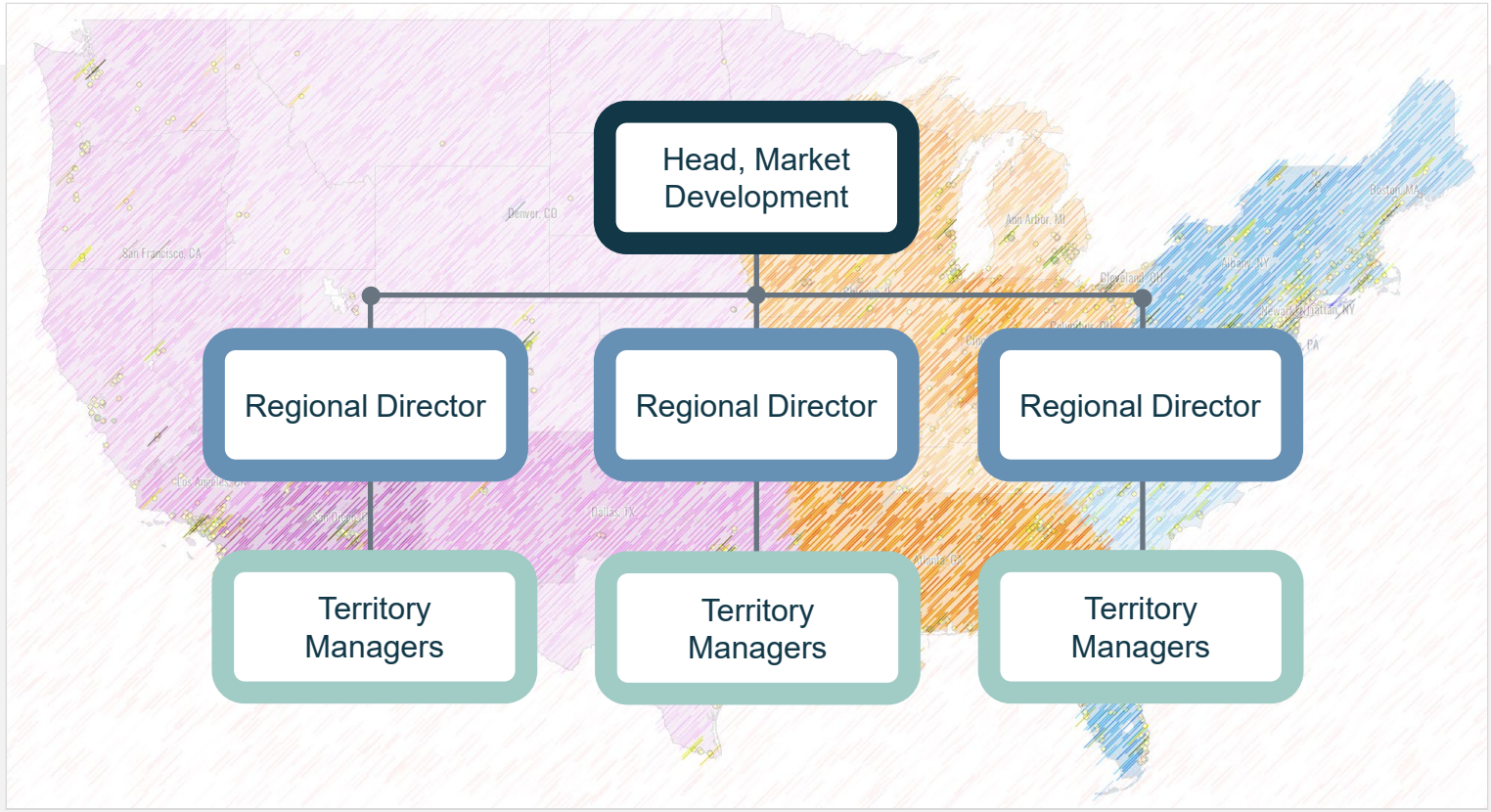
Currently have line of sight to ~450 patients

- 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*

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

CONFIRMED DIAGNOSED aPAP PATIENTS[1]

~3,600

(U.S. Claims Data Analysis)

Analysis of comprehensive claims dataset

- Counted PAP ICD9/10 diagnosis codes from 300M+ lives*
- Physicians managing the patients are located across ~1,100 centers
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UNCONFIRMED HIGHLY LIKELY AND LIKELY aPAP[1]

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aPAP ClearPath™

aPAP ClearPath Ab testing to confirm diagnosis

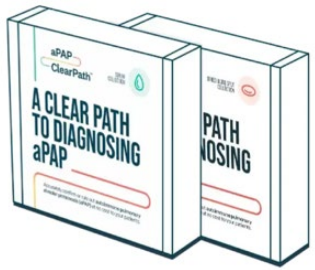
1) Data from 2023 U.S. Insurance Claims Analysis conducted by Savara

aPAP ClearPath Testing Platform

No cost antibody testing to identify aPAP among undiagnosed patients

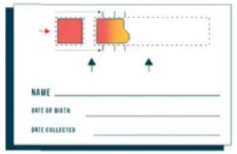
CURRENTLY AVAILABLE: SERUM

aPAP ClearPath™



- Launched in the U.S. and Europe
- Platform used in Interstitial Lung Disease (ILD) Clinic Pilot Program

COMING SOON: DRIED BLOOD SPOT (DBS)



- Simple finger prick performed in a physician's office
- Removes logistical challenges to serum testing
- **Target launch end of 1Q 2025**

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)
- aPAP ClearPath antibody test launched in Europe
- 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*
[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 confirmed diagnosed 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