Pioneering next-generation peptide therapeutics

Zealand Pharma A/S

March 2025

Forward-looking Statements

This presentation contains “forward-looking statements”, as that term is defined in the Private Securities Litigation Reform Act of 1995 in the United States, as amended, even though no longer listed in the United States this is used as a definition to provide Zealand Pharma’s expectations or forecasts of future events regarding the research, development and commercialization of pharmaceutical products, the timing of the company’s pre-clinical and clinical trials and the reporting of data therefrom and the company’s significant events and potential catalysts in 2025 and any financial guidance published by the company, as applicable. These forward-looking statements may be identified by words such as “aim,” “anticipate,” “believe,” “could,” “estimate,” “expect,” “forecast,” “goal,” “intend,” “may,” “plan,” “possible,” “potential,” “will,” “would” and other words and terms of similar meaning. You should not place undue reliance on these statements, or the scientific data presented.

The reader is cautioned not to rely on these forward-looking statements. Such forward-looking statements are subject to risks, uncertainties and inaccurate assumptions, which may cause actual results to differ materially from expectations set forth herein and may cause any or all of such forward-looking statements to be incorrect, and which include, but are not limited to, unexpected costs or delays in clinical trials and other development activities due to adverse safety events, patient recruitment or otherwise; unexpected concerns that may arise from additional data, analysis or results obtained during clinical trials; our ability to successfully market both new and existing products; changes in reimbursement rules and governmental laws and related interpretation thereof; government-mandated or market-driven price decreases for our products; introduction of competing products; production problems at third party manufacturers; dependency on third parties, for instance contract research or development organizations; unexpected growth in costs and expenses; our ability to effect the strategic reorganization of our businesses in the manner planned; failure to protect and enforce our data, intellectual property and other proprietary rights and uncertainties relating to intellectual property claims and challenges; regulatory authorities may require additional information or further studies, or may reject, fail to approve or may delay approval of our drug candidates or expansion of product labeling; failure to obtain regulatory approvals in other jurisdictions; exposure to product liability and other claims; interest rate and currency exchange rate fluctuations; unexpected contract breaches or terminations; inflationary pressures on the global economy; and political uncertainty, including the ongoing military conflict in Ukraine.

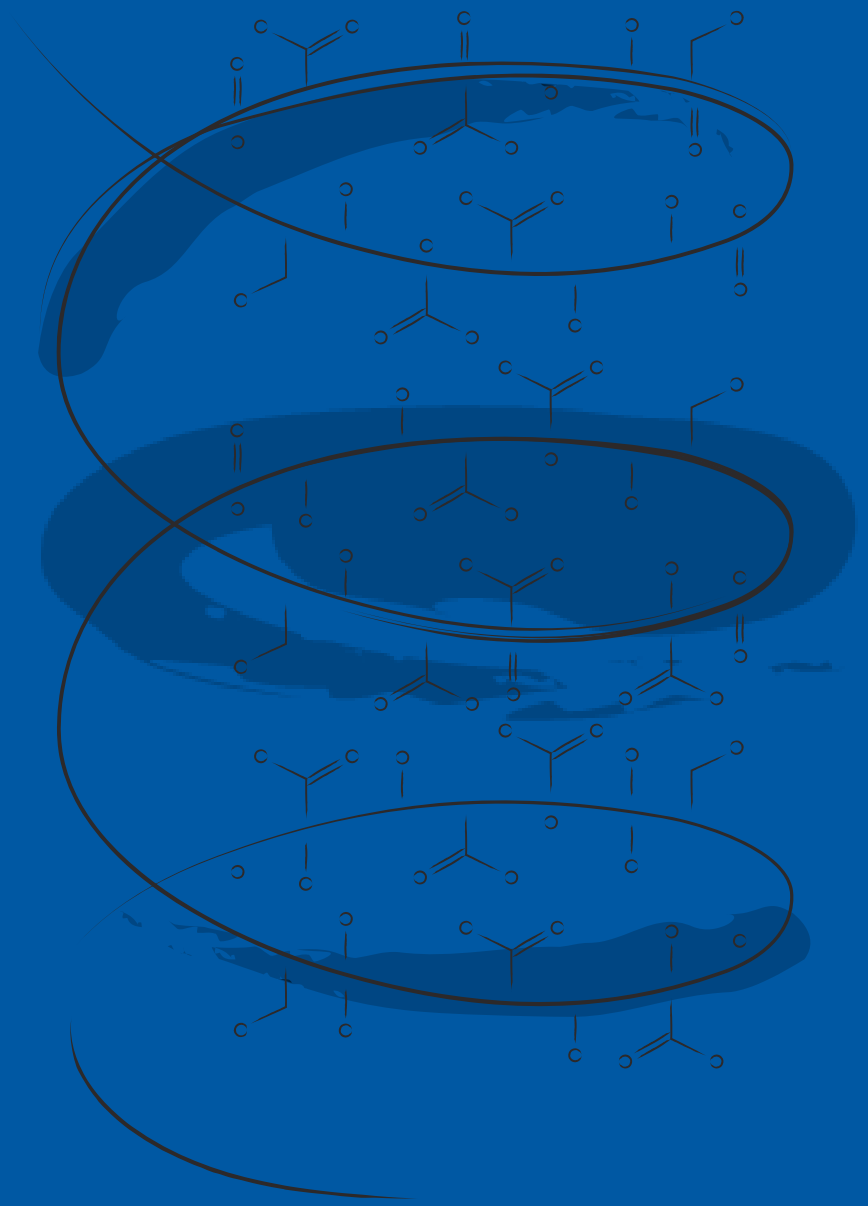
If any or all of such forward-looking statements prove to be incorrect, our actual results could differ materially and adversely from those anticipated or implied by such statements. The foregoing sets forth many, but not all, of the factors that could cause actual results to differ from our expectations in any forward-looking statement. All such forward-looking statements speak only as of the date of this presentation and are based on information available to Zealand Pharma as of the date of this presentation. We do not undertake to update any of these forward-looking statements to reflect events or circumstances that occur after the date hereof.

Information concerning pharmaceuticals (including compounds under development) contained within this material is not intended as advertising or medical advice.

ZEALAND PHARMA

About Zealand Pharma

Corporate Presentation



We are an international biotech company headquartered in Denmark

Headquarters and labs outside Copenhagen, Denmark

Founded in 1998

- Peptide platform validated through two approved products marketed by Sanofi and Novo Nordisk
- ~400 employees globally as of March 21, 2025

Listed on NASDAQ CPH (ZEAL.CO)

- Market cap on March 21, 2025: USD ~5.9B (DKK ~40.5B)
- 71.0M Shares Outstanding as of March 21, 2025

Cash position[a]

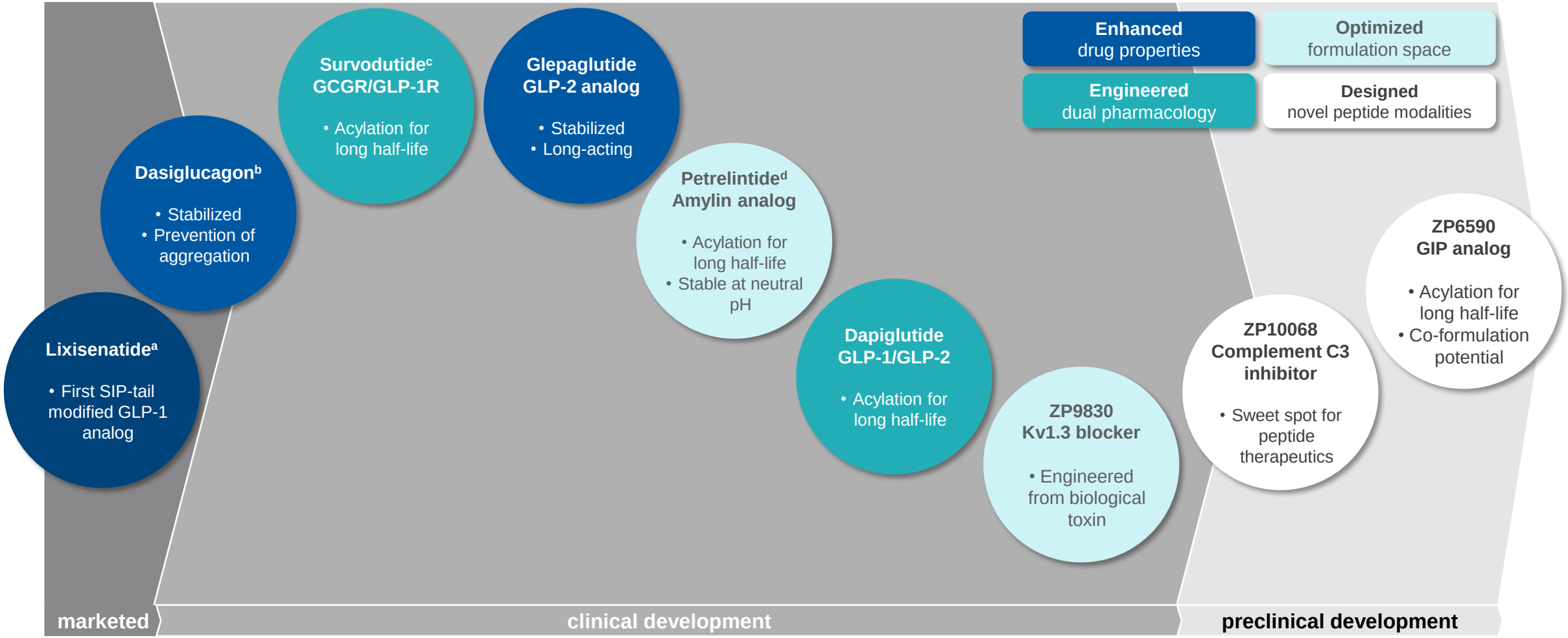
- USD ~1.3B (DKK ~9.0B) as of December 31, 2024

OPEX guidance for 2025

- Net operating expenses are expected to be DKK 2,000-2,500M

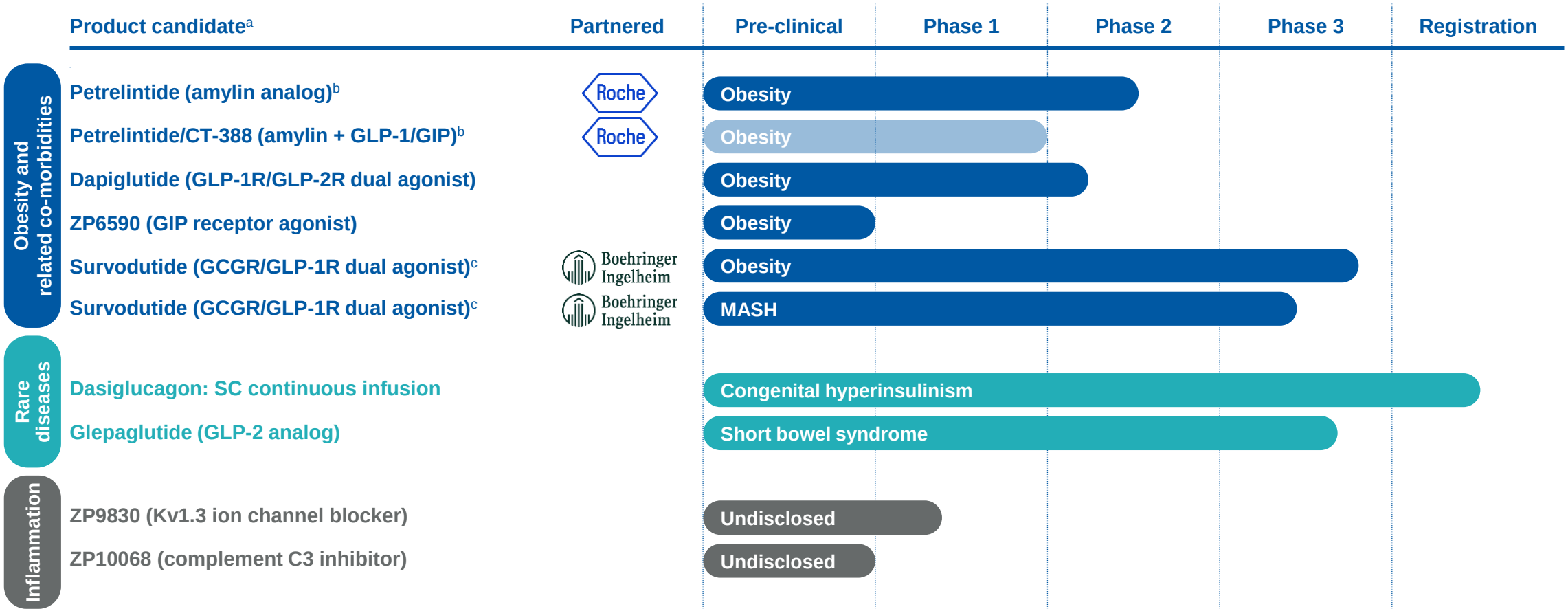
[a]Cash position includes cash, cash equivalents and marketable securities. Zealand also has a Loan facility with the European Investment Bank (EIB) of EUR 90 million in three tranches (Tranche A of EUR 50 million was disbursed in Q1 2024; Tranches B and C are subject to pre-specified milestones being met). Financial considerations from the collaboration and licensing agreement with Roche, entered in March 2025, is not included in these figures.
Based on foreign exchange rates as of March 21, 2025 (DKK 6.88 = USD $1).
OPEX=Operating Expenses.

We strive to be the world's best peptide drug discovery and development company



[a]Marketed globally by Sanofi.
[b]Licensed to Novo Nordisk: DKK 227.5 million outstanding in potential development, regulatory, manufacturing and sales milestones + high single to low double digit % royalties on global sales.
[c]Licensed to Boehringer Ingelheim: Boehringer solely responsible for development and commercialization globally. EUR 315 million outstanding potential development, regulatory and commercial milestones + high single to low double digit % royalties on global sales.
[d]Collaboration and license agreement with Roche, including co-development and co-commercialization in the U.S. and Europe. The closing of the transaction is subject to regulatory approvals and other customary closing conditions.
GCGR=glucagon receptor; GIP=gastric inhibitory polypeptide; GLP-1=glucagon-like peptide-1; GLP-1R=glucagon-like peptide-1 receptor; GLP-2=glucagon-like peptide-2; SIP=structure-inducing probe.

Our R&D pipeline addresses unmet medical needs across several therapeutic areas



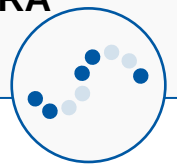
[a]**Investigational compounds whose safety and efficacy have not been evaluated or approved by the U.S. Food and Drug Administration (FDA) or any other regulatory authority.**
[b]Collaboration and license agreement with Roche, including co-development and co-commercialization in the U.S. and Europe. The closing of the transaction is subject to regulatory approvals and other customary closing conditions.
[c]Survodutide is licensed to Boehringer Ingelheim from Zealand Pharma, with Boehringer solely responsible for development and commercialization globally. EUR 315 million outstanding in potential development, regulatory and commercial milestones + high single to low double digit % royalties on global sales.
GCGR=glucagon receptor; GIP=gastric inhibitory polypeptide; GLP-1R=glucagon-like peptide-1 receptor; GLP-2=glucagon-like peptide-2; GLP-2R=glucagon-like peptide-2 receptor; MASH=metabolic dysfunction-associated steatohepatitis (formerly NASH, or nonalcoholic steatohepatitis); SC=subcutaneous.

We have a strong focus in 2025 on advancing our differentiated obesity programs in Phase 2 and 3

Petrelintide[a] (amylin analog)

Roche

- ☐ **Complete Ph2b obesity trial[b]** (ZUPREME-1)
- ☐ **Initiate Ph2b T2D obesity trial** (ZUPREME-2)
- ☐ **Initiate Ph1b combination trial w. GLP-1RA**



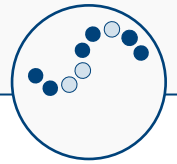
Dapiglutide (GLP-1R/GLP-2R)

- ☐ **Report topline data from 28-week Ph1b trial**
- ☐ **Present detailed results from Ph1b trial**
- ☐ **Initiate Ph2b obesity trial**

Survodutide[c] (GCGR/GLP-1R)

Boehringer Ingelheim

- ☐ **Complete Ph3 obesity trials[d]** (SYNCHRONIZE™-1 and 2)
- ☐ **Progress Ph3 MASH trials** (LIVERAGE and LIVERAGE-Cirrhosis)



Rare diseases

Dasiglucagon (CHI)

- ☐ U.S. FDA approval

Glepaglutide (SBS)

- ☐ Initiate EASE-5 (Ph3 trial)
- ☐ Submit MAA to the EMA

Advance next-generation inflammation pipeline

ZP9830 (Kv1.3 Ion Channel Blocker)

- ☐ Complete Ph1a trial

ZP10068 (Complement C3 Inhibitor)

- ☐ Evaluate initiation of Ph1a trial

[a]Collaboration and license agreement with Roche, including co-development and co-commercialization in the U.S. and Europe. The closing of the transaction is subject to regulatory approvals and other customary closing conditions.
[b]Primary completion of ZUPREME-1 is at clinicaltrials.gov estimated to be in November 2025 (NCT06662539).
[c]Survodutide is licensed to Boehringer Ingelheim from Zealand Pharma, with Boehringer solely responsible for development and commercialization globally.
[d]Primary completion of SYNCHRONIZE™-1 and 2 is at clinicaltrials.gov estimated to be in October 2025 and December 2025, respectively (NCT06066515; NCT06066528).
T2D=type 2 diabetes; GLP-1R=glucagon-like peptide-1 receptor; GLP-2R=glucagon-like peptide-2 receptor; GLP-1RA=glucagon-like peptide-1 receptor agonist; GCGR=glucagon receptor; MASH=metabolic dysfunction-associated steatohepatitis; CHI=congenital hyperinsulinism; SBS=short bowel syndrome; SAD=single ascending dose; MAA=marketing authorization application; EMA=European Medicines Agency.

Exciting news flow with many potential catalysts in 2025

NON-EXHAUSTIVE

H1 2025

Petrelintide[a]
Initiate Ph2b trial (overweight/obesity with T2D)

Dapiglutide
Report topline results from Part 2 of Ph1b dose-titration trial (28wks)

Dapiglutide
Present results from Ph1b dose-titration trial (13wks)

Dapiglutide
Initiate Ph2b trial (overweight/obesity)

Dasiglucagon (CHI)
Resubmit Part 1 (acute use) of NDA to US FDA and potential approval

Dasiglucagon (CHI)
Submit analyses supporting chronic use (Part 2) to US FDA

H2 2025

Petrelintide[a]
Initiate Ph1b combination trial with GLP-1RA

Survodutide[b]
Complete Ph3 obesity trials (SYNCHRONIZE™-1 and 2)

ZP9830 (Kv1.3 Ion Channel Blocker)
Complete Ph1 SAD trial

ZP10068 (Complement C3 Inhibitor)
Evaluate potential initiation of Ph1 SAD trial

Dasiglucagon (CHI)
Potential approval by US FDA of chronic use (Part 2)

Glepaglutide (SBS)
Initiate additional Ph3 trial (EASE-5)

Glepaglutide (SBS)
Submit MAA to the European Medicines Agency

Legend:

Obesity | Rare diseases | Inflammation

Potential partnership agreements across therapeutic areas

[a]Collaboration and license agreement with Roche, including co-development and co-commercialization in the U.S. and Europe. The closing of the transaction is subject to regulatory approvals and other customary closing conditions.
[b]Survodutide is licensed to Boehringer Ingelheim from Zealand Pharma, with Boehringer solely responsible for development and commercialization globally. Primary completion of SYNCHRONIZE™-1 and 2 is expected in H2 2025, ClinicalTrials.gov (NCT06066515; NCT06066528), accessed February 2025.
T2D=Type 2 diabetes; SAD=single ascending dose; NDA=new drug application; FDA=Food and Drug Administration; GLP-1RA=glucagon-like peptide-1 receptor agonist; MAA=marketing authorization application.

Obesity

Corporate Presentation

The obesity pandemic represents one of the greatest healthcare challenges of our time

For **300,000 years**, human beings maintained a relatively **stable BMI**…

The obesity pandemic has **evolved in only 50 years**

50% of adults globally are expected to have **overweight or obesity** by 2030[1]

Today, more than **5 million deaths** globally are **ascribed to overweight and obesity** every single year[1]

Early days in the evolution of this market…

~2%

Eligible patients in the US receiving **prescriptions** for **weight loss therapy**[2]

>220

Complications and comorbidities associated with obesity

Including CVD, liver disease, type 2 diabetes, kidney disease, neuro-inflammation and some cancers[3]

There is a significant **unmet medical need** for **more and better treatment options**

Sources: 1. World Obesity Atlas 2024; 2. Almandoz et al. (2024) Nutritional considerations with antiobesity medications, Obesity (Silver Spring), 32(9): 1613-1631; 3. American Medical Association 2024: https://www.ama-assn.org/topics/obesity.
BMI=body mass index; CVD=cardiovascular disease.

We believe in a shift from maximizing weight loss towards improved tolerability and effects on comorbidities…

Segment characteristics and key focus areas

Prescriber-driven

High-risk obesity

Specialist-driven prescriptions with focus on benefits on co-morbidities and health impact of weight loss.

Focus on:

1. Comorbidity risk reduction
2. Health outcomes
3. Relative weight loss
4. Tolerability and convenience of treatment

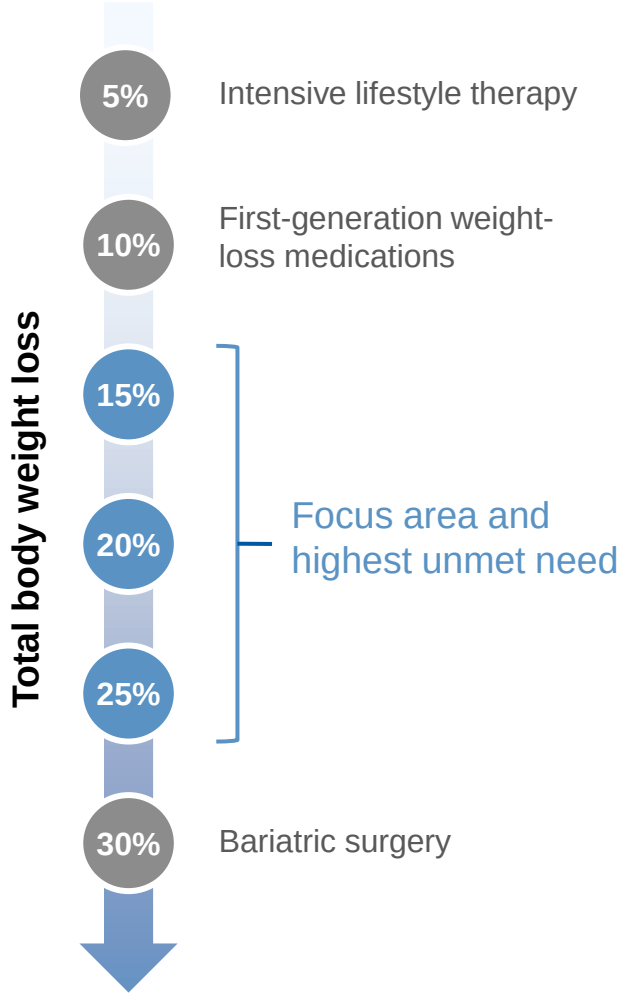
Patient-driven

Moderate-risk obesity

Patient-driven primary care prescriptions with focus on quality of weight loss and convenience of treatment.

Focus on:

1. Desired weight loss
2. Tolerability and convenience of treatment
3. Quality of weight loss, incl. muscle preservation
4. Health outcomes



...and that success of future weight-loss medications will be determined by differentiation on multiple fronts

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GLP-1-based

- GLP-1 mono
- GLP-1/GIP
- **GLP-1/GCG[a]**
- GLP-1/amylin
- **GLP-1/GLP-2[a]**

Amylin-based

- **Amylin mono[a]**
- **Amylin/GLP-1/GIP[a]**
- **Amylin/other**

Other drug classes

Examples of differentiation factors

- Unique **non-incretin mechanisms**, addressing quality of weight loss for weight maintenance (incl. preservation of muscle mass)
- **Improved tolerability** by addressing GI side effects
- Effects on obesity-related **comorbidities**
- Offer **greater convenience** through dosing regimen and/or delivery method
- Develop loose ‘flexible-use’ or **fixed-dose combinations** for patient segments who need the highest weight loss

[a]Zealand Pharma clinical development pipeline.
GCG=glucagon; GI=gastrointestinal; GIP=gastric inhibitory polypeptide; GLP-1=glucagon-like peptide-1; GLP-2=glucagon-like peptide-2.

Zealand Pharma has a rich clinical-stage pipeline of differentiated product candidates for obesity

Developed as alternative to GLP-1RA-based therapies and potential future foundational therapy

Amylin

- Restore leptin sensitivity
- Increase satiety
- Increase energy expenditure

Amylin mono

- Non-incretin mechanism
- Restore leptin sensitivity
- Increase satiety

Petrelintide[a]
long-acting amylin analog

Best-in-class potential for weight management with GLP-1RA-like weight loss but better tolerability with potential for muscle preservation

+GLP-1/GIP

- Increase insulin sensitivity
- Increase energy expenditure
- Delay gastric emptying

Petrelintide/CT-388[a]
amylin+GLP-1/GIP fixed-dose combination

GLP-1/GIP pharmacology added to amylin agonism for potential best-in-disease weight loss efficacy

Developed with added pharmacology to GLP-1 receptor agonism

GLP-1

- Increase insulin sensitivity
- Delay gastric emptying
- Decrease appetite

+ GLP-2

- Improve intestinal barrier function
- Reduce inflammation
- Delay gastric emptying

Dapiglutide
dual GLP-1/GLP-2 receptor agonist

First-in-class potential, targeting obesity and comorbidities associated with low-grade inflammation, including liver disease and neuro-inflammation

+ Glucagon

- Reduce hepatic fat content
- Stimulate lipolysis in fat tissue
- Increase energy expenditure

Survodutide[b]
dual GCG/GLP-1 receptor agonist

First-in-class potential, targeting obesity and the large sub-population with fatty liver disease and MASH

[a]Collaboration and license agreement with Roche, including co-development and co-commercialization in the U.S. and Europe. The closing of the transaction is subject to regulatory approvals and other customary closing conditions.
[b]Survodutide is licensed to Boehringer Ingelheim from Zealand Pharma, with Boehringer solely responsible for development and commercialization globally.
EUR 315 million in outstanding potential development, regulatory and commercial milestones + high single to low double digit % royalties on global sales.
GLP-1=glucagon-like peptide-1; GLP-1RA=glucagon-like peptide-1 receptor agonist; GIP=gastric inhibitory polypeptide; GCG=glucagon; MASH=metabolic dysfunction-associated steatohepatitis (formerly, non-alcoholic steatohepatitis, or NASH); MoA=mechanism of action.

GLP-1RA-based therapies are effective at reducing weight but are associated with GI tolerability issues[1]

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There is a significant unmet need for alternative treatment options with different mechanisms of action

Today, **two QW GLP-1RA-based therapies are approved**,[a,2,3] offering ~15–21% mean weight loss[4,5]

- **GLP-1RAs are commonly associated with GI side effects**, including constipation, nausea, vomiting and diarrhea[4,5]
- Up to **30%** of patients with obesity **discontinue GLP-1RA treatment** within **1 month**[6]
- Up to **60–70%** of patients **discontinue GLP-1RA treatment** within **12 months**[7]

>

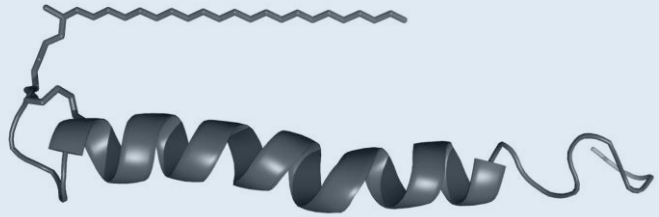
Petrelintide[b] is a long-acting amylin analog with the following target product profile:

- **15–20% mean weight loss** and high-quality weight loss with potential for preservation of lean mass
- Reduced food intake via a **non-incretin mechanism** that increases satiety and restores leptin sensitivity
- **Significantly improved GI tolerability** with both lower frequency and severity of adverse events

[a]For chronic weight management: Wegovy and Zepbound.
[b]Collaboration and license agreement with Roche, including co-development and co-commercialization in the U.S. and Europe. The closing of the transaction is subject to regulatory approvals and other customary closing conditions.
Sources: 1. Wang et al. Front Endocrinol (Lausanne) 2023;14:1085799; 2. Wegovy (semaglutide) US PI. Available from: https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/215256s011lbl.pdf, accessed July 2024; 3. Zepbound (tirzepatide) US PI. Available from: https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/217806s003lbl.pdf, accessed July 2024; 4. Wilding et al. N Engl J Med 2021;384(11):989–1002; 5. Jastreboff et al. N Engl J Med 2022;387(3):205–216; 6. Blue Health Intelligence. Real-world trends in GLP-1 treatment persistence and prescribing for weight management. May 2024; 7. Gasoyan et al. Obesity (Silver Spring) 2024;32(3):486–493.
GI=gastrointestinal; GLP-1RA=glucagon-like peptide-1 receptor agonist; QW=once-weekly.
Intellectual property: Composition of matter, patent expiry in 2037. Patent-term extension up to 5 years, i.e. 2042. Potential rights beyond 2042 based on patent applications and additional elements.

Petrelintide is a long-acting, potential best-in-class amylin analog designed with stability at neutral pH

Petrelintide (ZP8396) is a 36-amino-acid acylated peptide, based on the peptide sequence of **human amylin**[1]



Long-acting amylin analog due to acylation (half-life of 10 days), suitable for **once-weekly administration**[1,2]

Chemical and physical stability with no fibrillation around **neutral pH**, allowing for **co-formulation** and co-administration with other peptides[3,4]

Potent balanced agonist effect on **amylin and calcitonin receptors**[1,5]

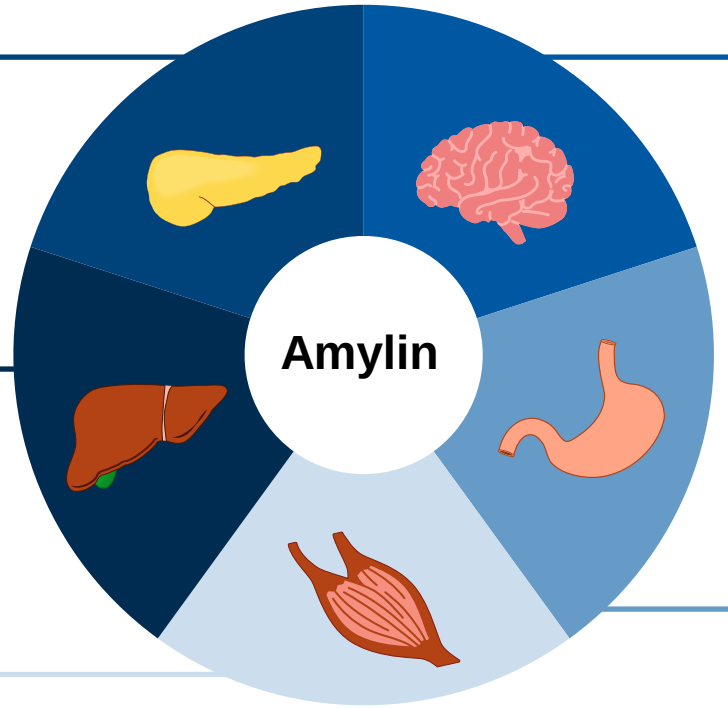
Collaboration and license agreement with Roche for petrelintide, including co-development and co-commercialization in the U.S. and Europe. The closing of the transaction is subject to regulatory approvals and other customary closing conditions.

Sources: 1. Data on file; 2. Brændholt Olsen et al. Poster 92-LB. Presented at ADA 83rd Scientific Sessions, June 23–26, 2023, San Diego, CA; 3. Skarbaliene et al. Poster 1406-P. Presented at ADA 82nd Scientific Sessions, June 3–7, 2022, New Orleans, LA; 4. Eriksson et al. Poster 532. Presented at ObesityWeek, November 1–4, 2022, San Diego, CA; 5. Eriksson et al. Presentation at ObesityWeek, November 1–4, 2022, San Diego, CA.

Intellectual property: Composition of matter, patent expiry in 2037. Patent-term extension up to 5 years, i.e. 2042. Potential rights beyond 2042 based on patent applications and additional elements.

Native amylin is a non-incretin hormone[1] that increases satiety, in contrast to GLP-1, which reduces appetite

Proposed physiological effects of amylin receptor activation[2]



Pancreas (indirect)[a]

- ↓ Insulin secretion (improving glucose metabolism)
- ↓ Glucagon secretion

Liver and adipose tissue

- ↑ Insulin sensitivity
- ↓ Fat accumulation

Muscle

- ⇆ Preserves lean mass[b,4]

CNS

- ↑ Leptin sensitivity[3]
- ↑ Satiety
- ↑ Energy expenditure
- ↓ Body weight

Via the vagal nerve

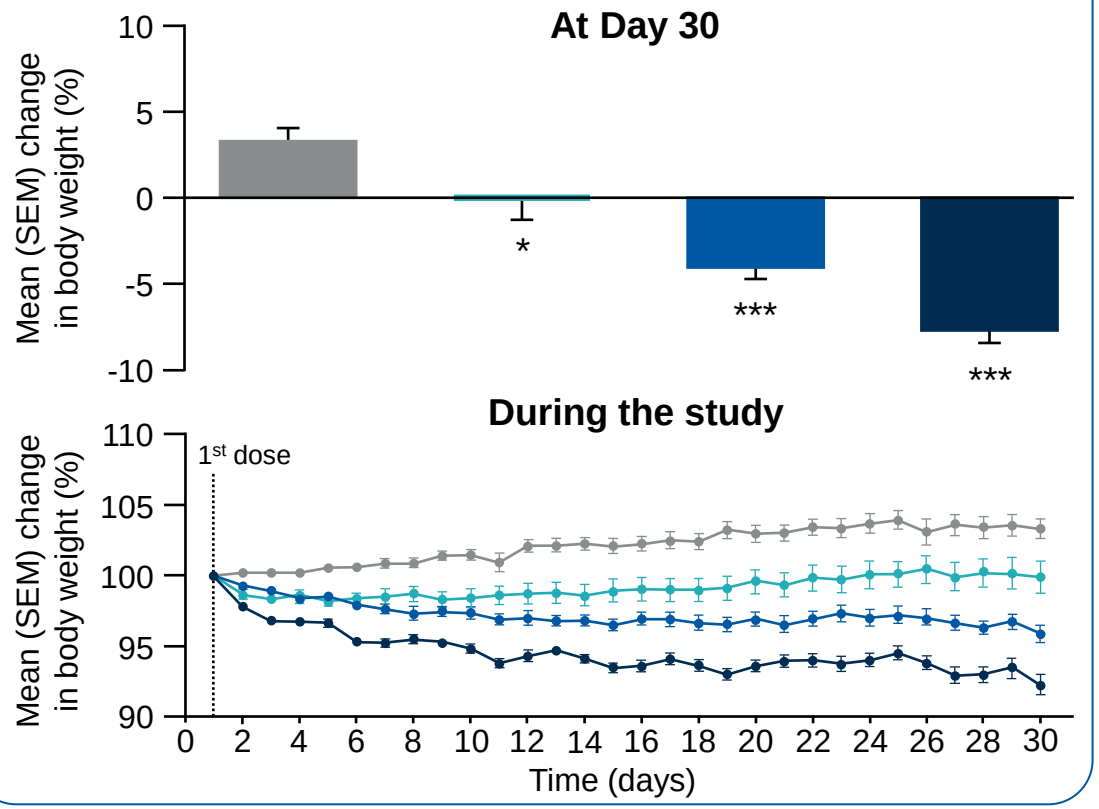
GI tract

- ↓ Gastric emptying

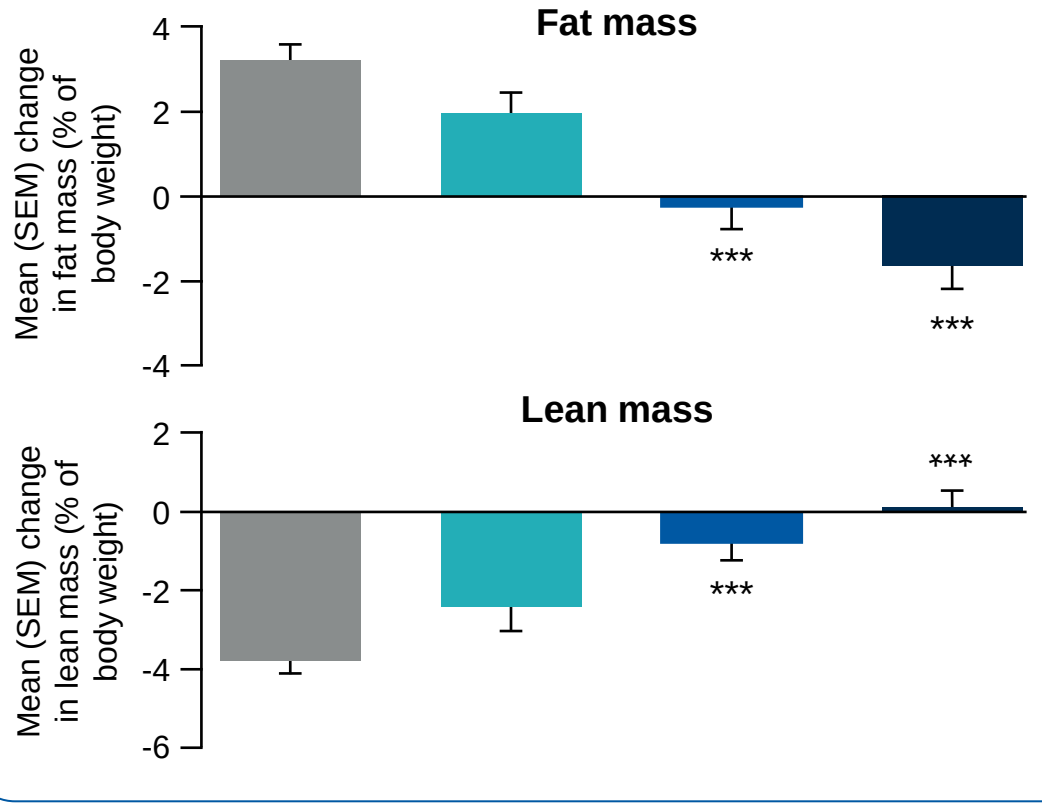
[a]Mediated by the effect of amylin on the CNS.
[b]Demonstrated pharmacologically with several amylin analogs in pre-clinical studies, including with petrelintide.
Sources: 1. Hayes et al. Annu Rev Nutr 2014;34:237–260; 2. Figure adapted from Mathiesen et al. Eur J Endocrinol 2022;186(6):R93–R111; 3. Roth et al. Proc Natl Acad Sci U S A 2008;105(20):7257–7262; 4. Vestergaard et al. Poster presented at ADA 84th Scientific Sessions, June 21–24, 2024, Orlando, FL. [1662-P].
CNS=central nervous system; GI=gastrointestinal; GLP-1=glucagon-like peptide-1.

In DIO rats, petrelintide reduced fat mass and preserved lean mass vs vehicle and a GLP-1RA

Change in body weight in DIO rats[1,2]



Change in body composition at Day 30 in DIO rats[1]



Vehicle | Liraglutide 5 nmol/kg BID | Petrelintide 2 nmol/kg QOD | Petrelintide 10 nmol/kg Q4D

*p<0.05, ***p<0.001 vs vehicle.

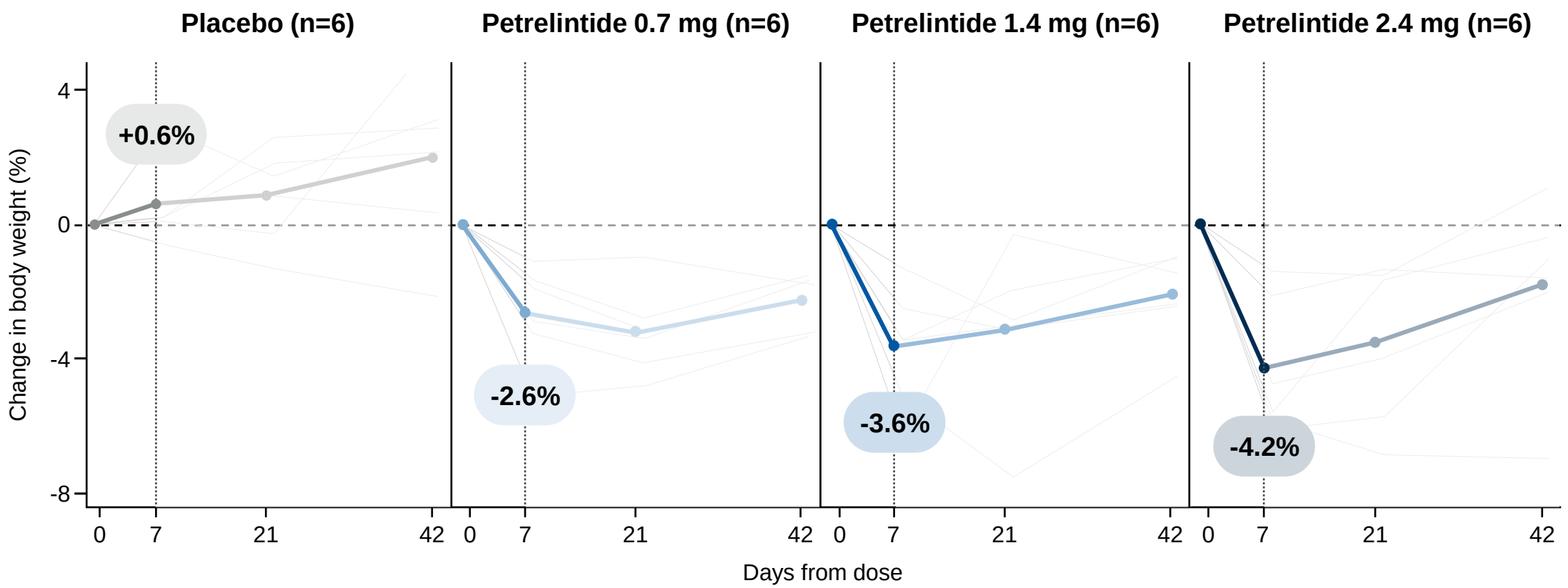
Collaboration and license agreement with Roche for petrelintide, including co-development and co-commercialization in the U.S. and Europe. The closing of the transaction is subject to regulatory approvals and other customary closing conditions.

Sources: 1. Vestergaard et al. Poster presented at ADA 84th Scientific Sessions, June 21–24, 2024, Orlando, FL. [1662-P]; 2. Data on file.

BID=twice daily; DIO=diet-induced obese; GLP-1RA=glucagon-like peptide-1 receptor agonist; Q4D=every 4 days; QOD=every other day; SEM=standard error of the mean.

Dose-dependent weight loss was observed with single doses of petrelintide

Petrelintide Phase 1a SAD trial: change in bodyweight



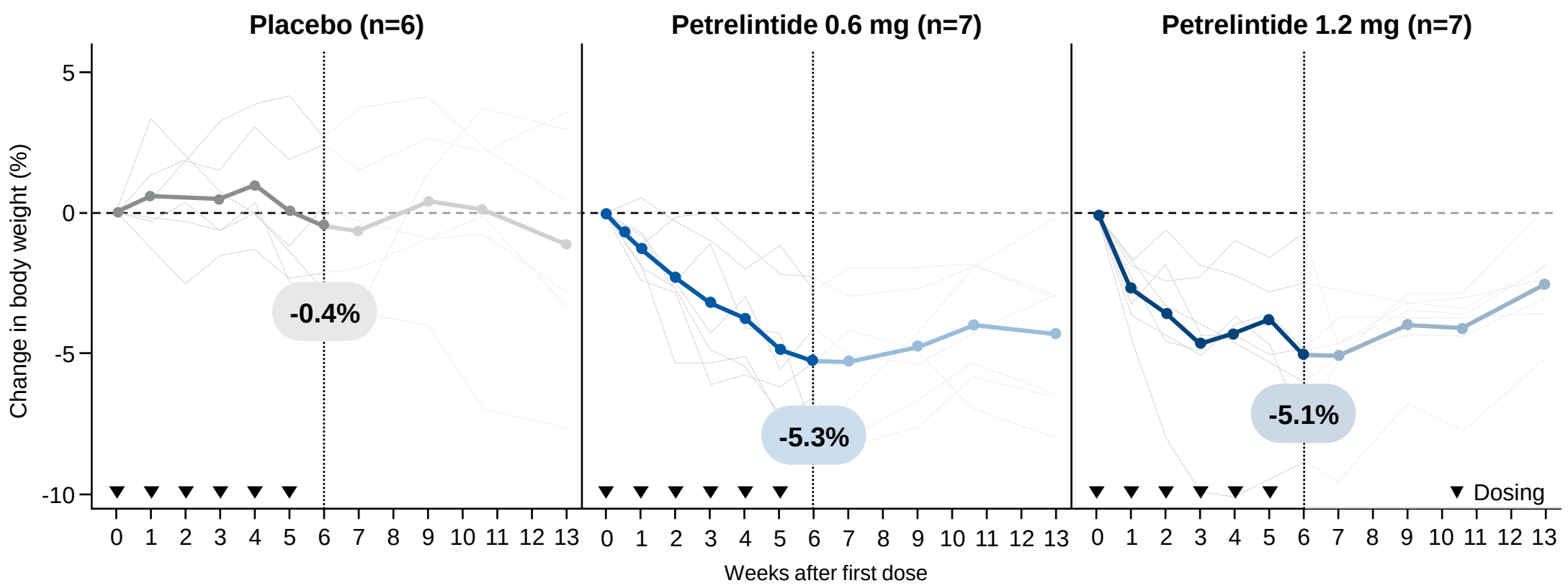
Collaboration and license agreement with Roche for petrelintide, including co-development and co-commercialization in the U.S. and Europe. The closing of the transaction is subject to regulatory approvals and other customary closing conditions.

Source: Figure adapted from Brændholt Olsen et al. Poster 92-LB. Presented at ADA 83rd Scientific Sessions, June 23–26, 2023, San Diego, CA.

SAD=single ascending dose.

Consistent weight loss was observed after 6 weeks of treatment with petrelintide, with no dose escalation

Petrelintide Phase 1b MAD trial Part 1: change in body weight



Collaboration and license agreement with Roche for petrelintide, including co-development and co-commercialization in the U.S. and Europe. The closing of the transaction is subject to regulatory approvals and other customary closing conditions.

Source: Figure adapted from Brændholt Olsen et al. Poster presented at ObesityWeek, October 14–17, 2023, Dallas, TX.

MAD=multiple ascending dose.

Petrelintide was well tolerated with no serious or severe TEAEs and no withdrawals from the trial

Phase 1b MAD trial Part 1: TEAEs reported with petrelintide and placebo

Number of participants (events)	Placebo (n=6)	Petrelintide 0.6 mg (n=7)	Petrelintide 1.2 mg (n=7)
Total AEs	**5 (28)**	**6 (23)**	**7 (29)**
Mild	5 (24)	6 (23)	7 (27)
Moderate	3 (4)	0	1 (2)
Severe	0	0	0
Serious	**0**	**0**	**0**
Metabolism and nutrition disorders	**1 (1)**	**6 (9)**	**6 (8)**
GI disorders	**3 (7)**	**2 (6)**	**5 (9)**

- All drug-related TEAEs were **mild and transient**, and most had an onset **within two days** of the first dose
- Nausea occurred in **three participants** on petrelintide, with one also reporting vomiting; no other participants reported vomiting
- **No injection-site reactions** were reported, and **no participants developed anti-drug antibodies**

Collaboration and license agreement with Roche for petrelintide, including co-development and co-commercialization in the U.S. and Europe. The closing of the transaction is subject to regulatory approvals and other customary closing conditions.
Source: Table adapted from Brændholt Olsen et al. Poster presented at ObesityWeek, October 14–17, 2023, Dallas, TX.
AE=adverse event; GI=gastrointestinal; MAD=multiple ascending dose; TEAE=treatment-emergent adverse event.

Trial design: Petrelintide Phase 1b MAD Part 2

A randomized, double-blind, placebo-controlled, Phase 1b, MAD trial of petrelintide – Part 2[1,2]

Aim: to evaluate the safety, tolerability, PK and PD of multiple SC doses of petrelintide, with dose escalation

- Adults 18–64 years
- Body weight ≥70 kg
- HbA1c <6.5%
- BMI 27.0–39.9 kg/m^2

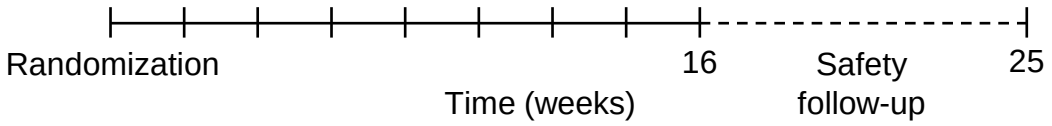
Dose escalation within cohorts every second week

3 cohorts[b]
N=48

- 1.0 2.0 4.0 6.0 7.5 9.0 (6 weeks)
- 0.6 1.2 2.4 3.6 4.8 (8 weeks)
- 0.6 1.2 2.4 mg (12 weeks)

R **3:1 versus placebo**

16 weeks treatment + 9 weeks follow-up



Primary endpoint:
- Incidence of TEAEs

Key secondary endpoints:
- PK parameters of petrelintide
- PD parameters related to an MTM
- Body weight related endpoints

Collaboration and license agreement with Roche for petrelintide, including co-development and co-commercialization in the U.S. and Europe. The closing of the transaction is subject to regulatory approvals and other customary closing conditions.

[b]Safety evaluation occurred after 4 weeks of treatment at the target dose for each cohort. Initiation of the next, higher dose cohort only occurred following safety evaluation for the previous cohort.

Sources: 1. ClinicalTrials.gov (NCT05613387), accessed October 2024; 2. Data on file.

BMI=body mass index; HbA1c=glycated hemoglobin; MAD=multiple ascending dose; MTM=mixed test meal; PD=pharmacodynamics; PK=pharmacokinetics; SC=subcutaneous; TEAE=treatment-emergent adverse event.

Most participants were male and had a BMI at the lower end of the eligible range

Petrelintide Phase 1b MAD trial Part 2: baseline characteristics[1,2]

Gender

79% of participants were **male**

Age

Median **49 years**

Weight

Median **92.4 kg**

BMI

Median **29.2 kg/m^2**

(eligible range: 27.0–39.9 kg/m^2)

Baseline characteristics were **balanced** across the dose cohorts[2]

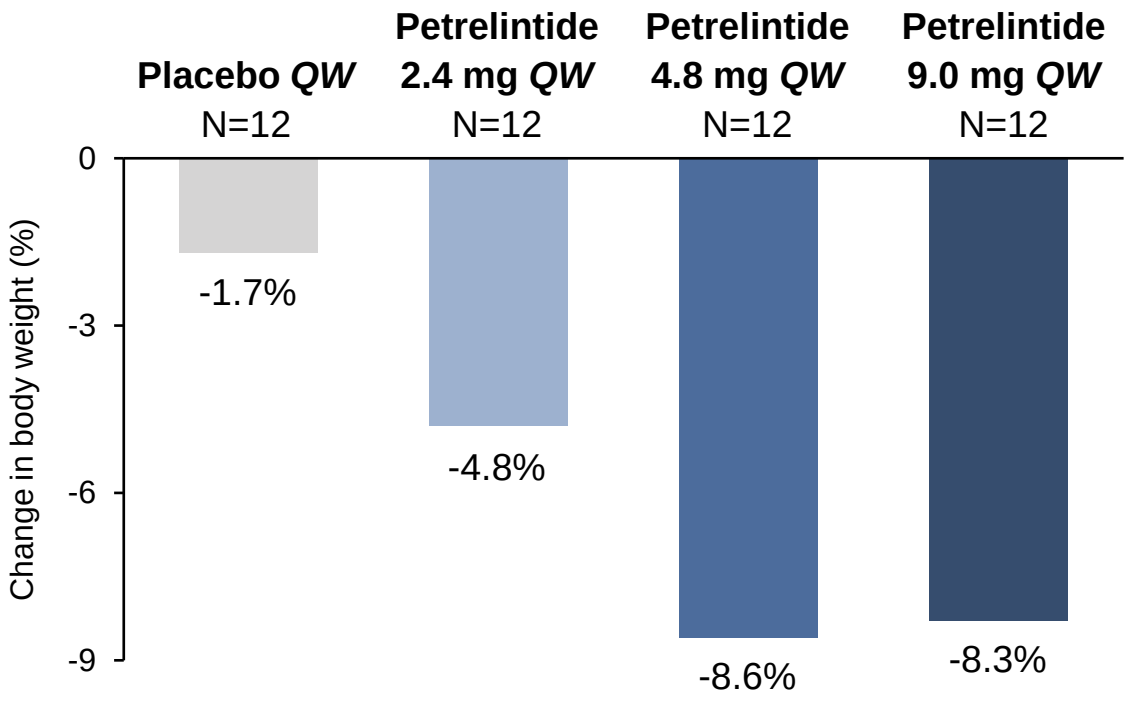
Collaboration and license agreement with Roche for petrelintide, including co-development and co-commercialization in the U.S. and Europe. The closing of the transaction is subject to regulatory approvals and other customary closing conditions.

Sources: 1. Zealand Pharma. Press release 20 June 2024. Available from: https://www.globenewswire.com/news-release/2024/06/20/2901879/0/en/Zealand-Pharma-announces-positive-topline-results-from-the-Phase-1b-16-week-multiple-ascending-dose-clinical-trial-with-long-acting-amylin-analog-petrelintide.html, accessed July 2024; 2. Data on file.

BMI=body mass index; MAD=multiple ascending dose.

Substantial weight loss was observed at 16 weeks…

Petrelintide Phase 1b MAD trial Part 2: change from baseline in body weight at Week 16[1,2]

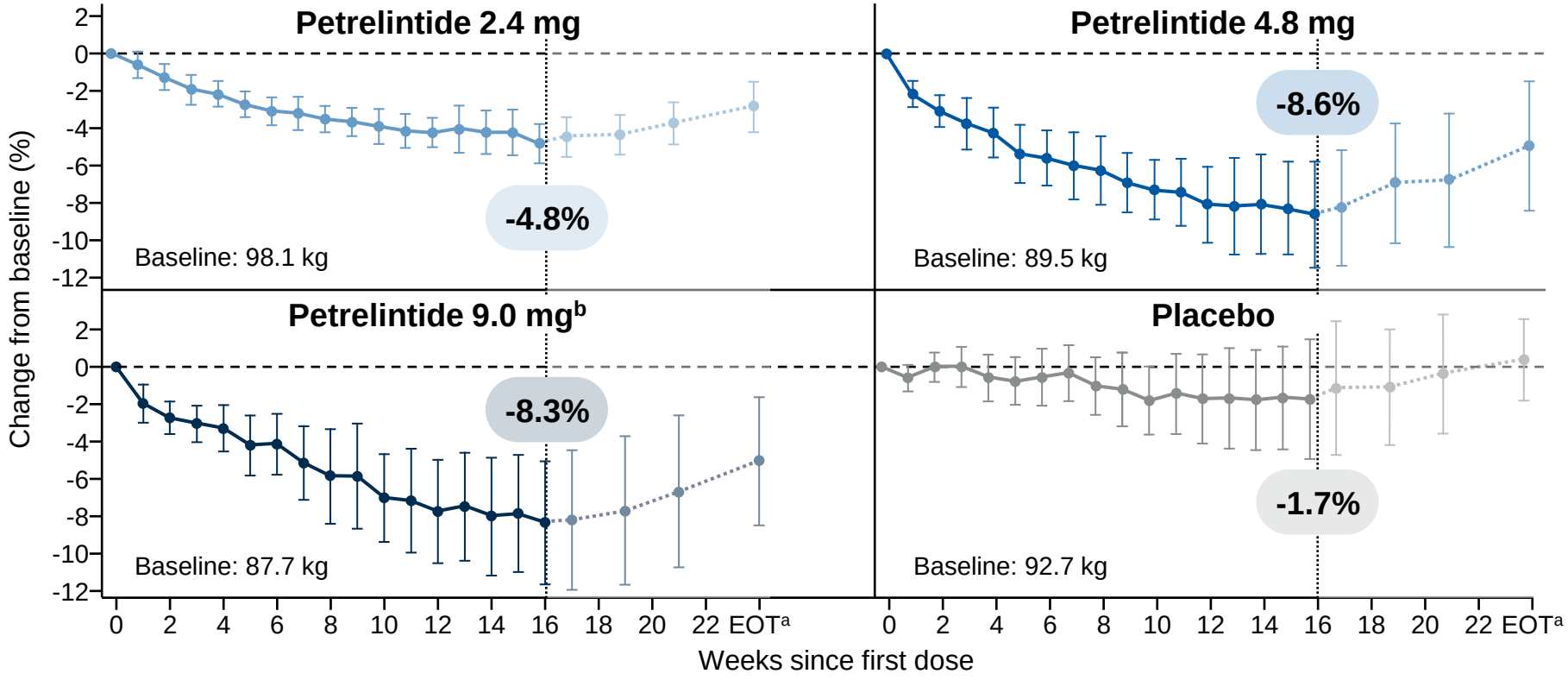


- Petrelintide treatment resulted in a **mean weight loss** of **up to 8.6%** from baseline after 16 weeks
- **All participants** treated with petrelintide **lost weight** during the trial
- Review of data from individual participants supports that **separation at the higher doses is possible**

N represents cohort size at randomization.
Collaboration and license agreement with Roche for petrelintide, including co-development and co-commercialization in the U.S. and Europe. The closing of the transaction is subject to regulatory approvals and other customary closing conditions.
Sources: 1. Zealand Pharma. Press release 20 June 2024. Available from: https://www.globenewswire.com/news-release/2024/06/20/2901879/0/en/Zealand-Pharma-announces-positive-topline-results-from-the-Phase-1b-16-week-multiple-ascending-dose-clinical-trial-with-long-acting-amylin-analog-petrelintide.html, accessed July 2024; 2. Data on file.
DG=dose group; MAD=multiple ascending dose; QW=once-weekly.

...with continued body weight loss expected with longer treatment duration

Observed mean (95% CI) percent change from baseline in body weight



Collaboration and license agreement with Roche for petrelintide, including co-development and co-commercialization in the U.S. and Europe. The closing of the transaction is subject to regulatory approvals and other customary closing conditions.

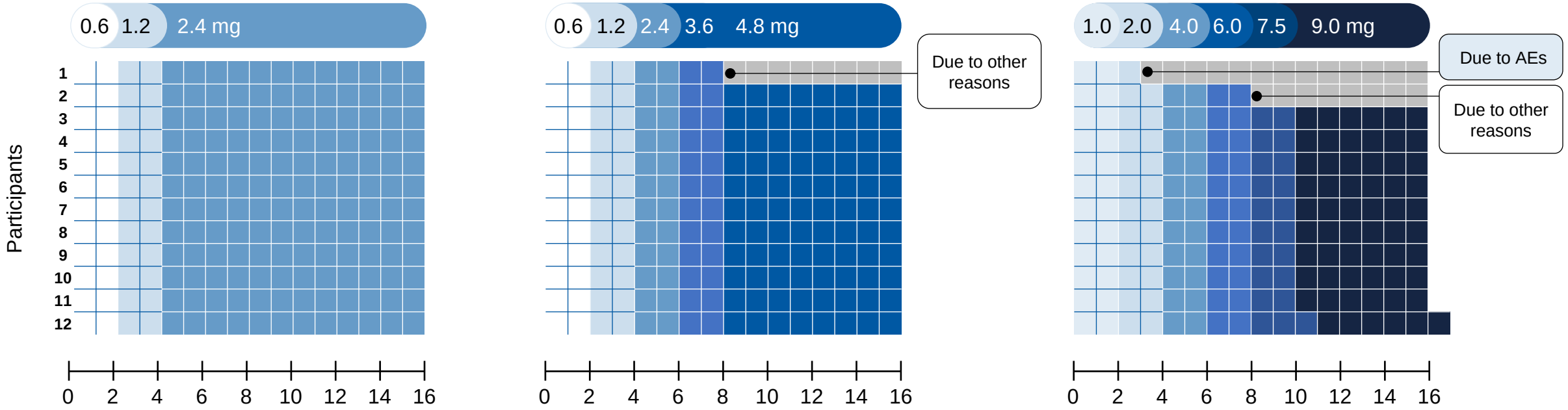
[a]EOT includes measurements at the EOT visit, performed at 24 or 25 weeks after dosing, and also performed for participants discontinuing treatment early.

[b]One participant had one extra week at 7.5 mg, and thereby only five weeks on maintenance dose at Week 16. After Week 16, this participant is included with weeks after last dosing.

Source: Data on file. Data presented at ObesityWeek 2024 in San Antonio, Texas.

CI=confidence interval; EOT=end of trial; MAD=multiple ascending dose.

High rates of study treatment completion and adherence to dose escalation within cohorts

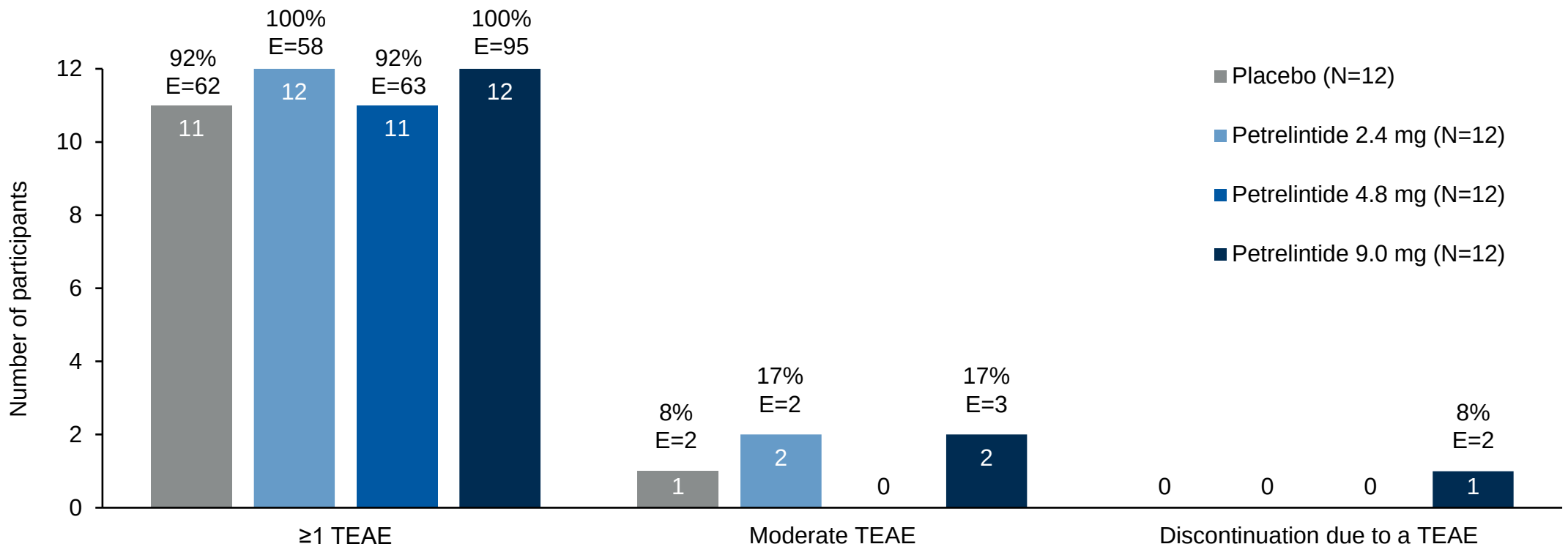


- **Three participants discontinued** petrelintide: one due to AEs, one to focus on recovery from a cold, and one due to personal reasons
- One participant in the 9.0 mg arm had **an extra week at 7.5 mg** (due to tolerability)
- The remaining participants followed dose escalation steps within cohorts

Collaboration and license agreement with Roche for petrelintide, including co-development and co-commercialization in the U.S. and Europe. The closing of the transaction is subject to regulatory approvals and other customary closing conditions.
Source: Data on file. Data presented at ObesityWeek 2024 in San Antonio, Texas.
AE=adverse event.

Vast majority of TEAEs reported by petrelintide-treated patients were mild

Only one petrelintide-treated participant discontinued treatment due to TEAEs



No serious or severe TEAEs were reported

Collaboration and license agreement with Roche for petrelintide, including co-development and co-commercialization in the U.S. and Europe. The closing of the transaction is subject to regulatory approvals and other customary closing conditions.

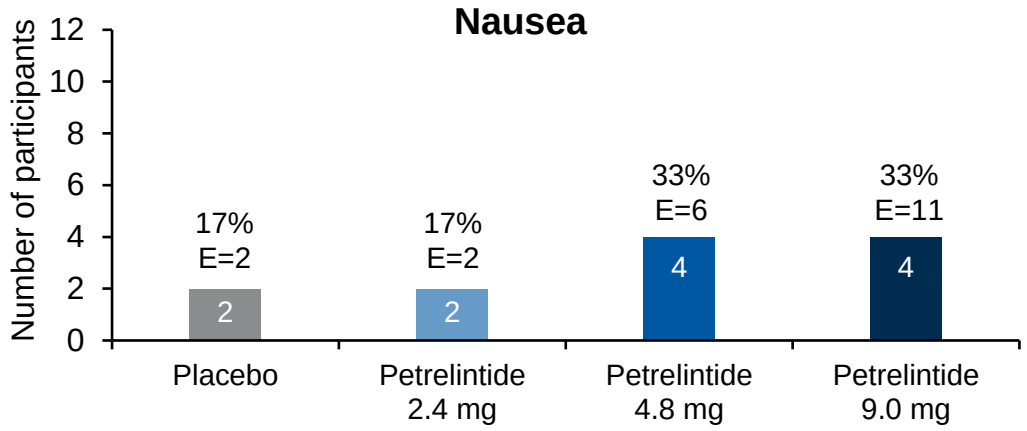
Source: Data on file. Data presented at ObesityWeek 2024 in San Antonio, Texas.

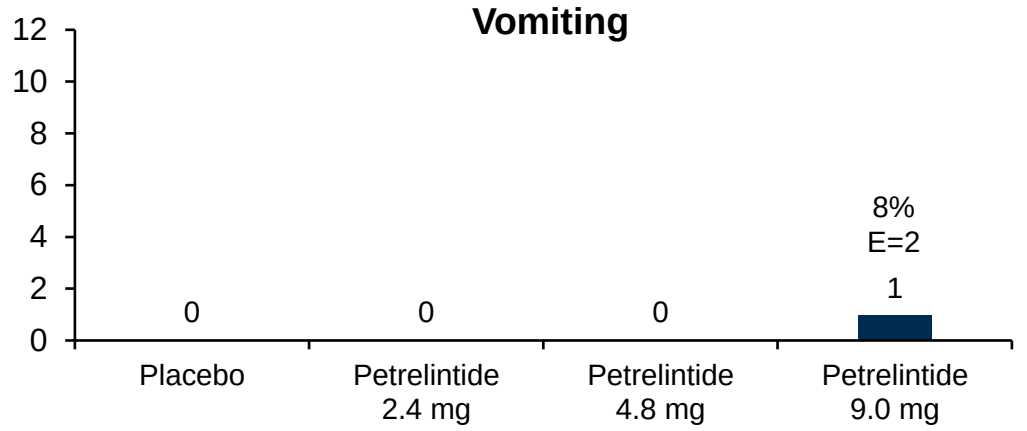
5 moderate AEs reported by petrelintide exposed participants: nausea, vomiting, nasopharyngitis, acute sinusitis, back pain

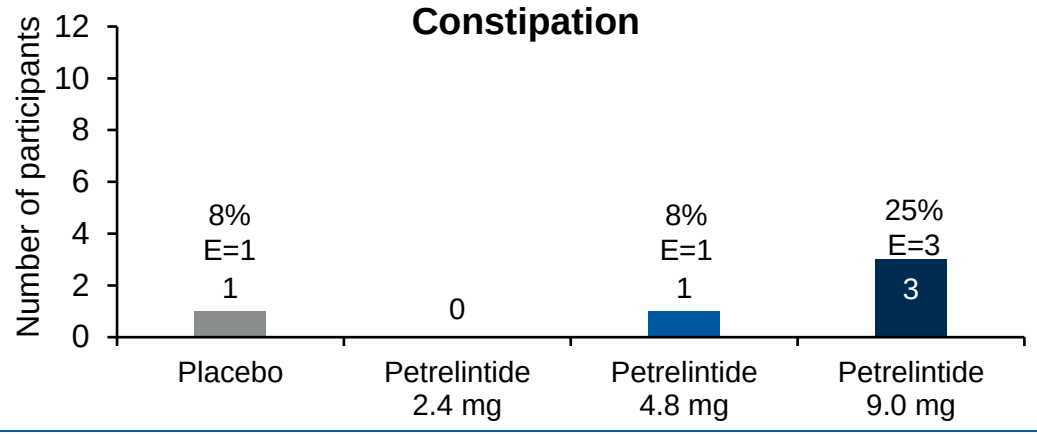
E=number of events; N=number of participants; TEAE=treatment-emergent adverse event.

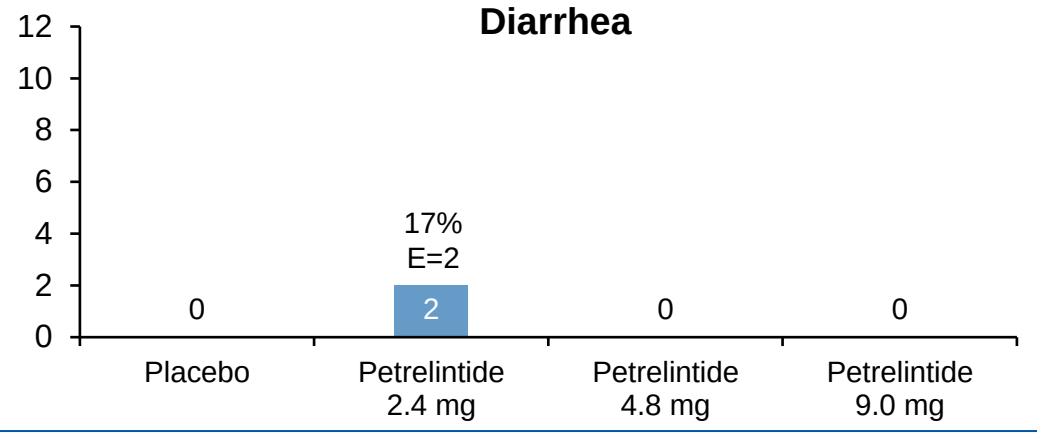
Petrelintide treatment appeared safe and was well-tolerated at all dose levels in the 16-week trial

All GI TEAEs were mild, except for one event of moderate nausea and moderate vomiting in one participant







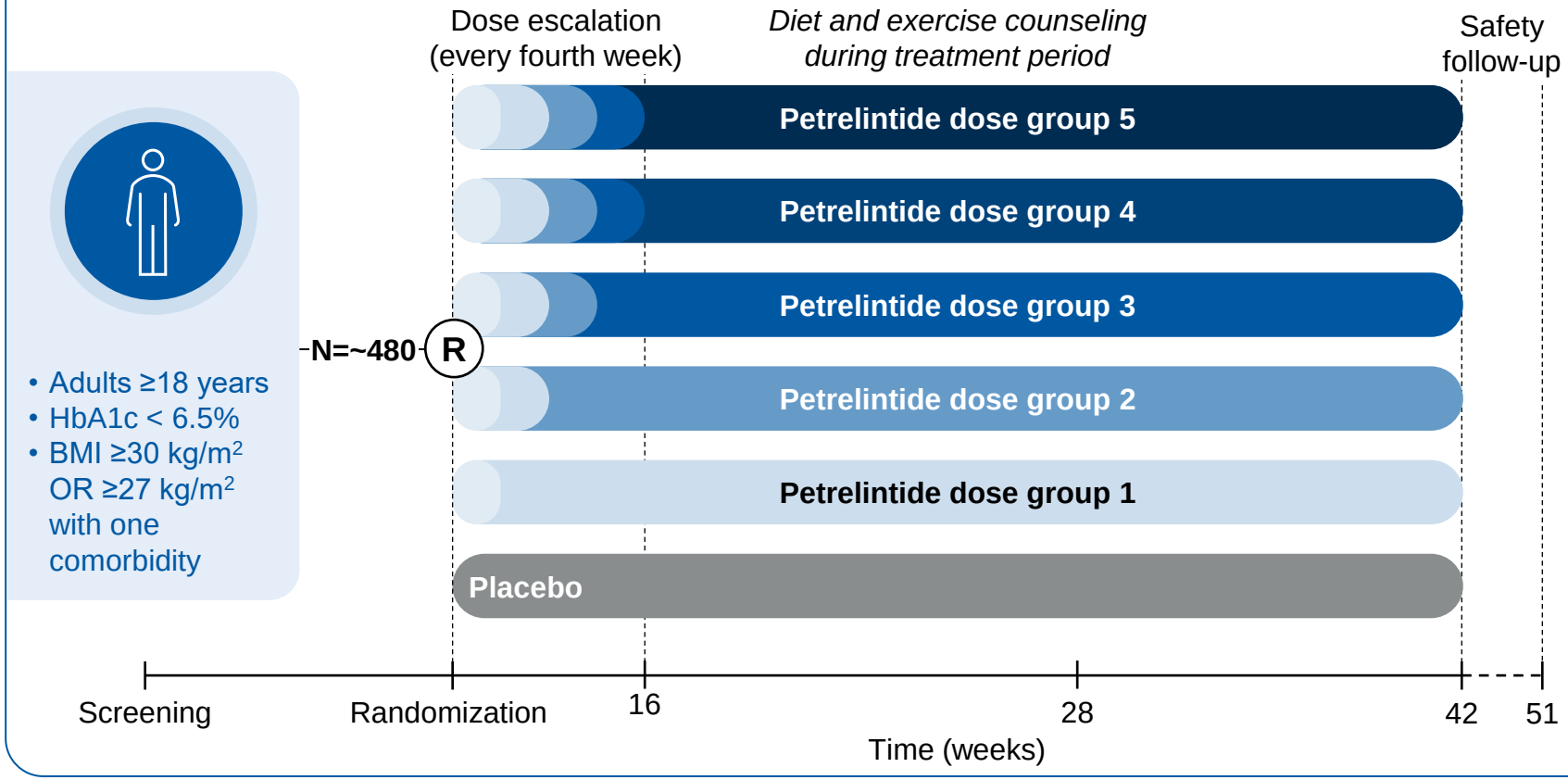


Collaboration and license agreement with Roche for petrelintide, including co-development and co-commercialization in the U.S. and Europe. The closing of the transaction is subject to regulatory approvals and other customary closing conditions.
Source: Data on file. Data presented at ObesityWeek 2024 in San Antonio, Texas.
N=12 in each treatment group.
E=number of events; TEAE=treatment-emergent adverse event; GI=Gastrointestinal

Continuing development of petrelintide as monotherapy through a comprehensive Phase 2b trial (ZUPREME-1)

A randomized, double-blind, placebo-controlled, Phase 2b trial with petrelintide was initiated in Dec-2024[1,2]

Aim: to evaluate change in body weight with multiple doses of petrelintide versus placebo



- Adults ≥18 years
- HbA1c < 6.5%
- BMI ≥30 kg/m^2 OR ≥27 kg/m^2 with one comorbidity

Primary endpoint:

- Percentage change in body weight after 28 weeks

Secondary/exploratory endpoints (non-exhaustive):

- Absolute change in body weight
- Percentage change in body weight after 42 weeks
- Categorical weight loss (≥5% and ≥10%)
- Change in waist circumference
- Percentage change in HbA1c after 42 weeks
- Body composition (MRI)
- Inflammation biomarkers
- CV risk factors (e.g., hsCRP, triglycerides, cholesterol, blood pressure, pulse rate)

Collaboration and license agreement with Roche for petrelintide, including co-development and co-commercialization in the U.S. and Europe. The closing of the transaction is subject to regulatory approvals and other customary closing conditions.

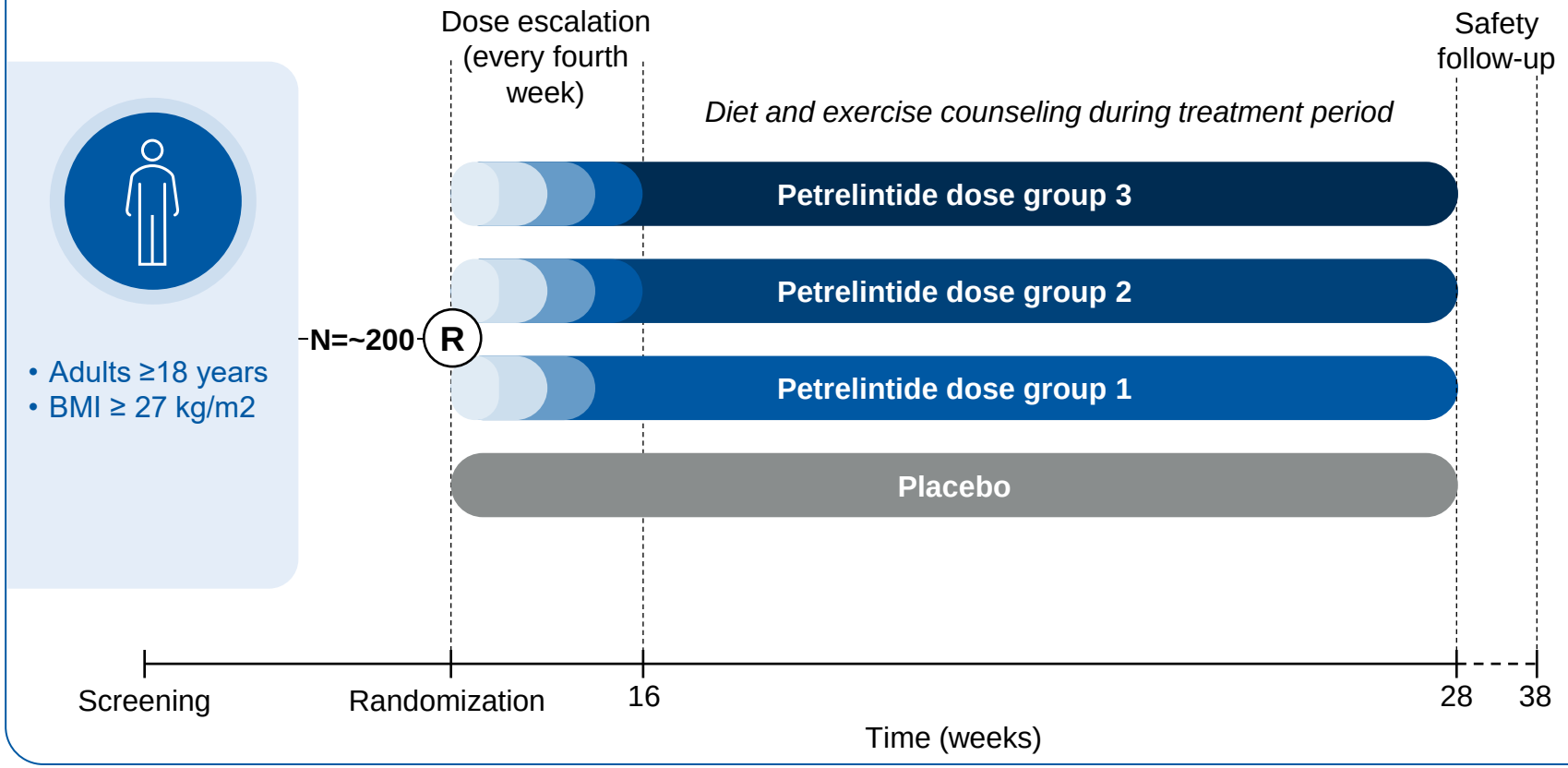
Sources: 1. ClinicalTrials.gov (NCT06662539), accessed March 2025; 2. Data on file.

BMI=body mass index; HbA1c=glycated hemoglobin; MRI=magnetic resonance imaging; hsCRP=high-sensitivity C-reactive protein.

Expanding the development program with Phase 2b trial in people with overweight/obesity and T2D (ZUPREME-2)

A randomized, double-blind, placebo-controlled, Phase 2b trial with petrelintide to be initiated in H1 2025[1]

Aim: Demonstrate superior weight loss for petrelintide vs. placebo in people with T2D and overweight or obesity



Primary endpoint:

- Percentage change in body weight from baseline to week 28

Secondary endpoints (non-exhaustive):

- Categorical weight loss (≥5% and ≥10%)
- HbA1c
- Blood pressure
- Fasting lipids
- TEAEs
- Hypoglycemia

Collaboration and license agreement with Roche for petrelintide, including co-development and co-commercialization in the U.S. and Europe. The closing of the transaction is subject to regulatory approvals and other customary closing conditions.

Source: 1. Data on file.

T2D=type 2 diabetes; BMI=body mass index; QW=once-weekly; HbA1c=hemoglobin A1C (glycated hemoglobin); TEAE=treatment emergent adverse event.

Our vision is to establish the leading amylin-based weight management franchise with petrelintide

Potential to address the unmet medical needs of the majority of people with overweight and obesity

Unmet medical needs…

- **Alternative mechanisms of action** to provide new treatment options
- **Improved GI tolerability** for a better patient experience and treatment persistence
- Improved **effect on obesity-related comorbidities**
- **Greater** weight loss **efficacy** for the segment of patients who need most weight loss

…being targeted with petrelintide

Petrelintide **monotherapy** as a foundational therapy targeting:

- **~15-20% weight loss**
- **non-incretin** mechanism
- substantially improved **GI tolerability**
- **muscle preservation**

Petrelintide in **combinations**:

- with **CT-388** for people who need **more weight loss** and/or **better glycemic control**

Rapidly expanding into related indications

Collaboration and license agreement with Roche for petrelintide, including co-development and co-commercialization in the U.S. and Europe. The closing of the transaction is subject to regulatory approvals and other customary closing conditions.
GI=gastrointestinal.

Entered a transformative collaboration and license agreement[1] to unlock the full potential of petrelintide

True partnership agreement	✓ Shared vision for petrelintide as a future foundational therapy for weight management ✓ Co-development and co-commercialization (up to 50% in U.S. and Europe)
Important synergies and complementary capabilities	✓ Combining Zealand's >25 years of peptide expertise with Roche's global R&D, manufacturing, and commercial capabilities
Maximizing the full value potential of petrelintide	✓ Addressing different high unmet medical needs, both as monotherapy and in combination with other agents (e.g., CT-388), to reach as many patients as possible ✓ Accelerating and expanding the opportunities with petrelintide in weight management and related indications
Up to $5.3 billion in total consideration to Zealand	✓ $1.65 billion in upfront (of which $1.4 billion due at closing and $250 million in anniversary payments over two years) ✓ Up to $1.2 billion in development milestone payments ✓ Up to $2.4 billion in sales-based milestone payments
Economics and upside further enhanced	✓ 50/50 profit sharing in U.S. and Europe ✓ Royalties on net sales in the rest of the world ✓ $350 million to Roche from Zealand Pharma for CT-388 in the first combination product

Source: 1. Zealand Pharma. Press release 12 March 2025. Available from: Zealand Pharma and Roche enter collaboration and license, accessed March 2025.

Dapiglutide is a potential first-in-class GLP-1R/GLP-2R dual agonist for obesity and low-grade inflammation

Design of molecule

Dapiglutide is derived from a GLP-2 peptide backbone with amino acid substitutions to ‘dial in’ GLP-1R activity

- GLP-1 component reduces body weight and **GLP-2** has potential for additional **anti-inflammatory effects**[1]
- Designed with **higher potency towards the GLP-1R** while retaining activity on the GLP-2R[2]
- **Long-acting** with a half-life (123–129 hours) that is suitable for **once-weekly administration**[3]

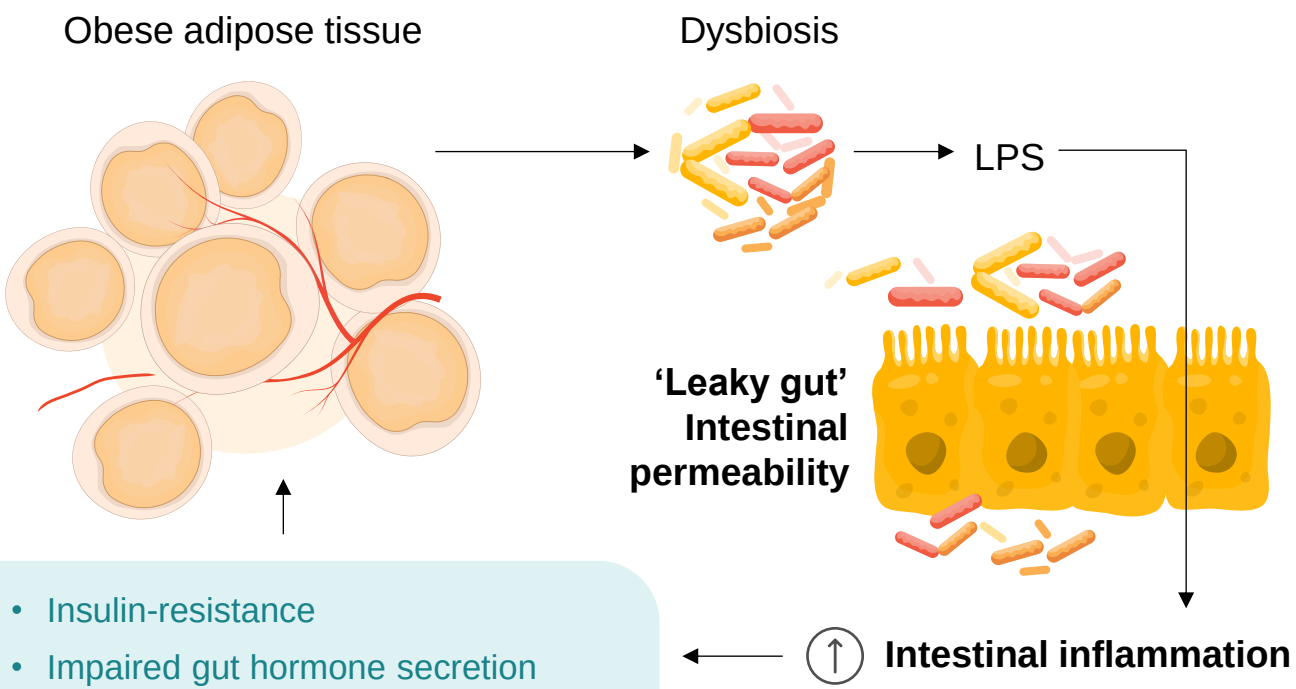
Positioning opportunities and differentiation

- **Obesity** – pursuing ≥20% weight loss
- **Safety and tolerability** – similar to other GLP-1RA-based weight-loss medications
- **Cardiovascular benefits** – potential cardioprotective benefits from GLP-1 agonism and additional anti-inflammatory effect from GLP-2 agonism
- **Comorbidities** – potential for regenerative effects to address organ damage associated with low-grade inflammation, such as MASH and Alzheimer’s disease

Sources: 1. Drucker & Yusta. Annu Rev Physiol 2014;76:561–583; 2. Reiner et al. JPEN J Parenter Enteral Nutr 2022;46(5):1107–1118; 3. Data presented by Agersnap at the 82nd ADA Scientific Sessions, June 3–7, 2022.
GLP-1=glucagon-like peptide-1; GLP-1R=glucagon-like peptide-1 receptor; GLP-2=glucagon-like peptide-2; GLP-2R=glucagon-like peptide-2 receptor; MASH=metabolic dysfunction-associated steatohepatitis (formerly, non-alcoholic steatohepatitis, or NASH).
Intellectual property: Composition of matter, patent expiry in 2037. Patent-term extension up to 5 years, i.e. 2042. Potential rights beyond 2042 based on patent applications and additional elements.

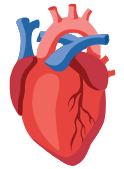
People with obesity have increased low-grade inflammation, which drives several related comorbidities

Excess fat storage can trigger low-grade systemic inflammation through reduced intestinal barrier integrity[1]

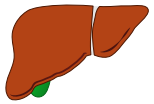


- Insulin-resistance
- Impaired gut hormone secretion
- Dysregulation of gut–brain–fat axis

Obesity-related low-grade inflammation can result in:



CVD as increased inflammation drives residual risk in people with CVD[2]



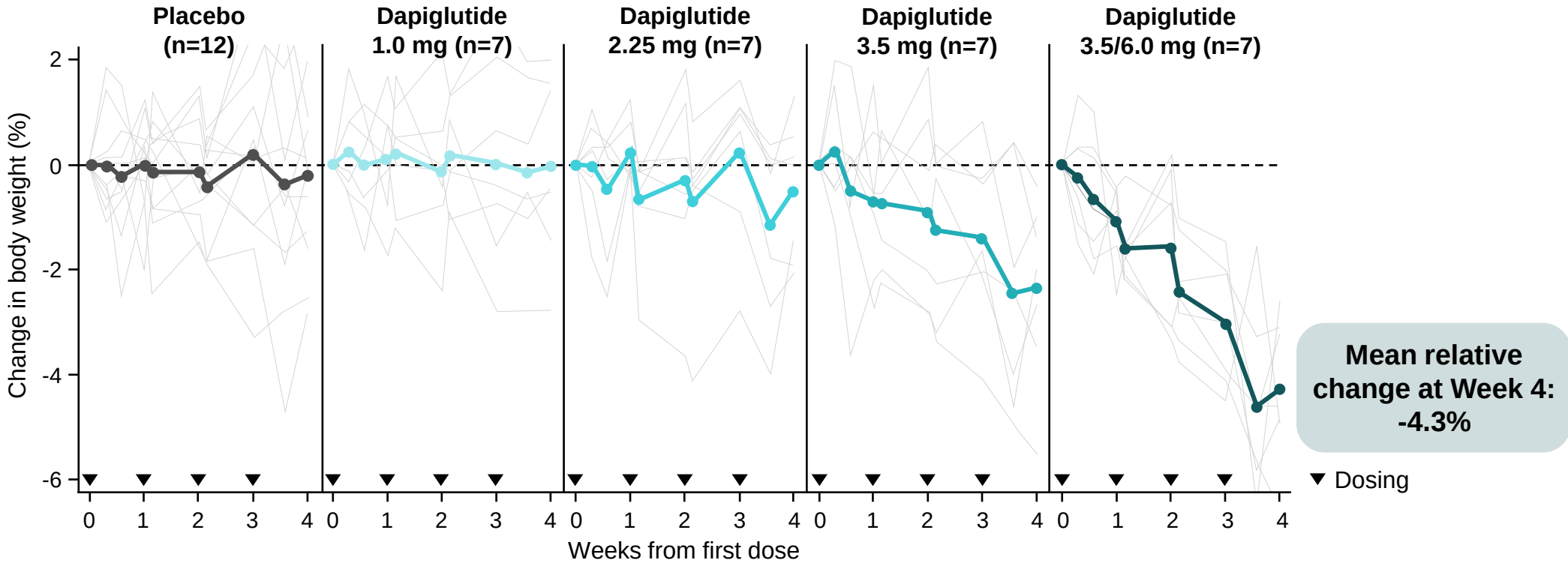
Liver disease due to abnormal accumulation of triglycerides in the liver[3]

Neuro-inflammation due to excess circulating proinflammatory cytokines and changes in the integrity of the blood–brain barrier[4]

Sources: 1. Figure adapted from Vetrani et al. Nutrients 2022;14(10):2103, used under the Creative Commons Attribution (CC BY 4.0) license (https://creativecommons.org/licenses/by/4.0/). The figure has been reformatted. The publication is available at https://doi.org/10.3390/nu14102103; 2. Ridker et al. Lancet 2023;401(10384):1293–1301; 3. Luo & Lin. Immun Inflamm Dis 2021;9(1):59–73; 4. Salas-Venegas et al. Front Integr Neurosci 2022;16:798995.
CVD=cardiovascular disease; LPS=lipopolysaccharides.

Dapiglutide showed dose-dependent mean weight loss of up to 4.3% over 4 weeks in healthy participants

Phase 1 multiple ascending dose trial (n=40)



Dapiglutide was generally well-tolerated with no severe or serious AEs, no withdrawals due to AEs, and no observation of anti-drug antibodies

Source: Figures adapted from data presented by Agersnap at the 82nd ADA Scientific Sessions, June 3–7, 2022, New Orleans, LA.
AE=adverse event.

Topline data from DREAM trial confirmed that doses investigated were at lower end of therapeutic range

ZEALAND PHARMA

Investigator-led trial DREAM evaluating effects on body weight, gut permeability and inflammation[1]

Trial design

- N=54, men and women aged 18-75 years (BMI ≥30 kg/m^2)
- Duration = 12 weeks
- Dose strengths = up to 6.0 mg (similar to 4-week MAD)[2]
- No lifestyle interventions, such as diet or exercise

Purpose of trial

- Gain key mechanistic insights into the effects of low doses of GLP-1/GLP-2 receptor dual agonist dapiglutide
- Evaluate the potential for weight loss and assess the safety and tolerability profile of dapiglutide

Low doses investigated at the lower end of the therapeutic window in obesity setting

Topline data

- Mean weight loss of up to 4.3% with dapiglutide treatment
- Results in line with outcomes observed with shorter term treatment using lower doses of incretin-based therapies
- Dapiglutide assessed to be well-tolerated with fewer TEAEs related to the GI system compared to what have been reported from other trials with incretin-based therapies
- No TEAEs related to the GI system led to treatment discontinuation

Data on inflammatory markers, as well as data from gut biopsies, to be presented at future scientific meeting

Sources: 1. ClinicalTrials.gov (NCT05788601). 2. Data presented by Agersnap at the 82nd ADA Scientific Sessions, June 3–7, 2022, New Orleans, LA.
BMI=body mass index; MAD=multiple ascending dose; GLP-1=glucagon-like peptide-1; GLP-2=glucagon-like peptide-2; TEAE=treatment-emergent adverse event; GI=gastrointestinal.

We expect to report topline results with dapiglutide from the 28-week Phase 1b trial in H1 2025…

The 13-week Phase 1b trial[1] evaluated higher doses of dapiglutide than prior clinical trials[a]

Mean **placebo-adjusted weight loss** of up to **8.3% after 13 weeks**

- Total of 54 participants, **85% male** with a median baseline **BMI of 30.0 kg/m²**
- **No lifestyle modifications**, such as diet or exercise, were included in trial

- Dapiglutide up to 13 mg assessed to be **safe and well-tolerated** with GI AEs consistent with profile of incretin-based therapies
- **Two participants** out of 54 **discontinued treatment due to GI AEs**

Next steps include topline results from 28-week trial[2] and initiation of Phase 2b trial

- Part 2 of the Phase 1b trial includes a **higher dose cohort (up to 26 mg)** with **28 weeks treatment**
- Monthly dose escalation
- Topline results expected in H1 2025

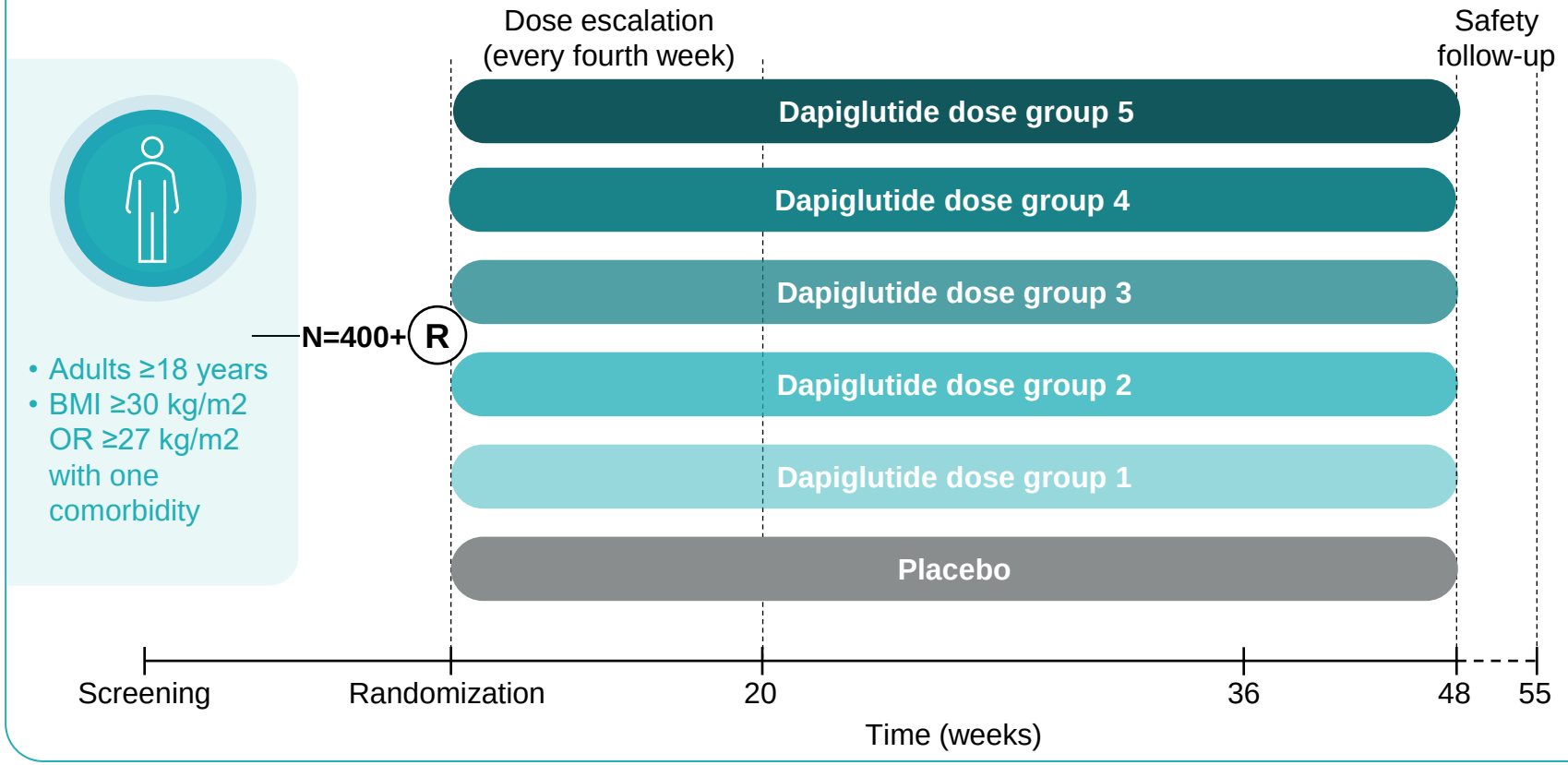
Large, comprehensive **Phase 2b trial** to be initiated in H1 2025

[a]DREAM, an investigator-led mechanistic trial with dapiglutide: ClinicalTrials.gov (NCT05788601), and the 4-week Phase 1a clinical trial: ClinicalTrials.gov (NCT04612517).
Sources: 1. Zealand Pharma company announcement No. 44/2024, September 9, 2024; 2. ClinicalTrials.gov (NCT06000891), accessed March 2025.
BMI=body mass index; GI=gastrointestinal; AE=adverse event.

...and initiate a comprehensive Phase 2b trial with dapiglutide in people with overweight/obesity in H1 2025

A randomized, double-blind, placebo-controlled, Phase 2b trial with dapiglutide to be initiated in H1 2025[1]

Aim: To evaluate change in body weight with multiple doses of dapiglutide versus placebo



Primary endpoint:

- Percentage change in body weight from baseline to week 36

Secondary/explorative endpoints (non-exhaustive):

- Categorical weight loss (≥5% and ≥10%)
- Body composition
- Inflammation biomarkers

Source: 1. Data on file.
BMI=body mass index; EOT=end of treatment

Survodutide[a], targeting obesity and MASH, activates both GLP-1 and glucagon receptors

Design of molecule

Survodutide is a 29-amino-acid peptide, based on the hormone **oxyntomodulin** with dual agonism at GCG and GLP-1 receptors

MoA reduces body weight by **increasing energy expenditure** and **regulating appetite**[1]

Deliberately designed with **strong bias towards GLP-1** receptor (8:1 receptor bias vs glucagon)[2]

Extended half-life for **once-weekly administration** achieved by amino acid substitutions[2]

Positioning opportunities and differentiation

Obesity – potential for ~20–25% weight loss and improved glycemic control

Safety and tolerability – similar to other GLP-1RA-based weight-loss medications

Cardiovascular benefits – potential benefits driven by GLP-1RA

MASH – potential for important benefit in MASH with direct effect of glucagon on the liver

[a]Survodutide is licensed to Boehringer Ingelheim from Zealand Pharma, with Boehringer solely responsible for development and commercialization globally.

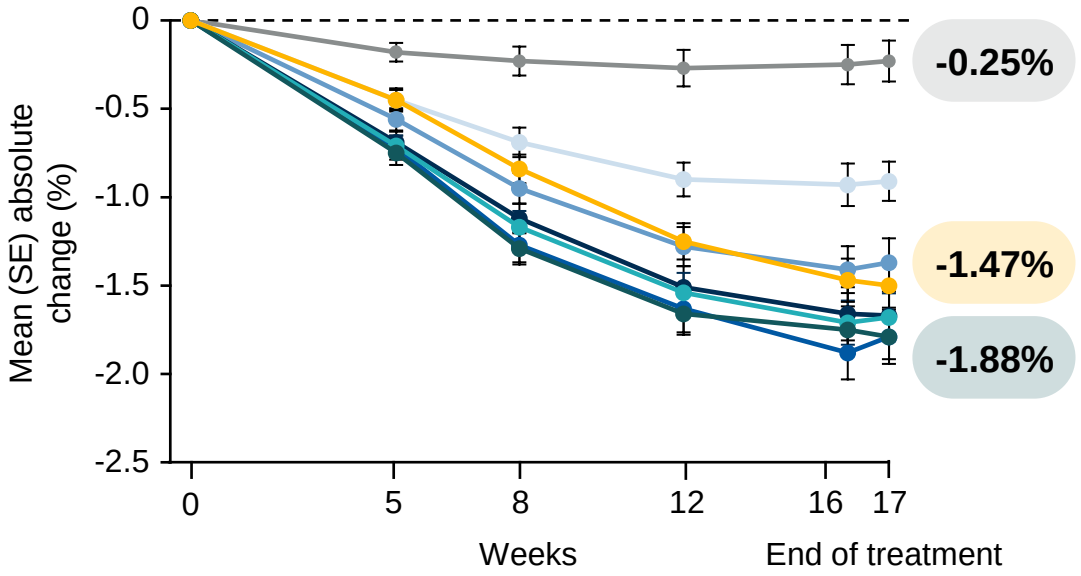
Sources: 1. Wynne et al. Int J Obes (Lond) 2006;30(12):1729–1736; 2. Zimmermann et al. Mol Metab 2022;66:101633.

GCG=glucagon; GLP-1=glucagon-like peptide-1; GLP-1RA=glucagon-like peptide-1 receptor agonist; MoA=mechanism of action; MASH=metabolic dysfunction-associated steatohepatitis (formerly, non-alcoholic steatohepatitis, or NASH).

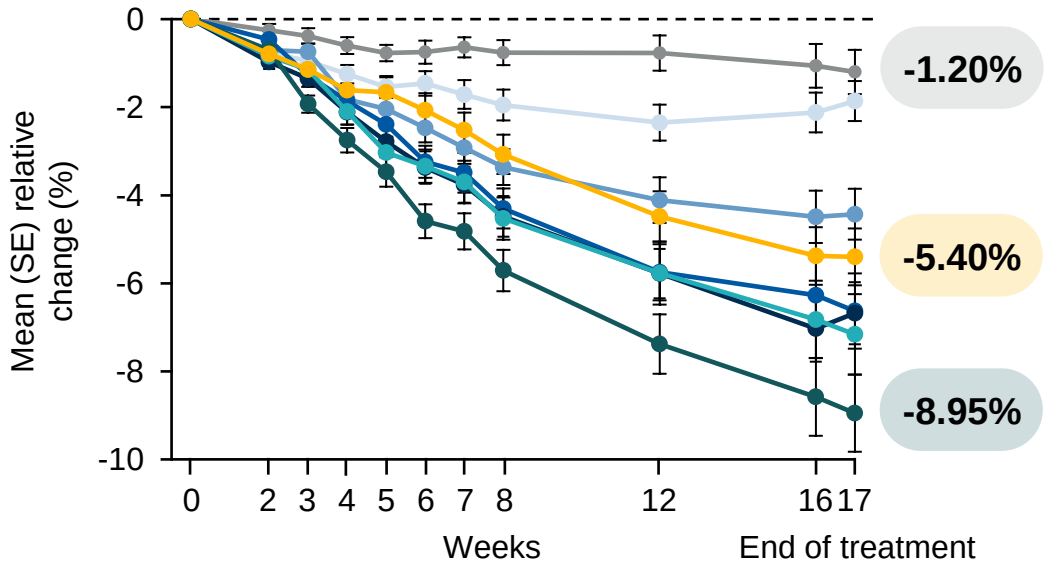
Intellectual property: Composition of matter, patent expiry in 2034. Patent-term extension up to 5 years, i.e. 2039. Potential rights beyond 2039 based on patent applications and additional elements.

In a 16-week Phase 2 trial in T2DM, survodutide effectively reduced HbA1c and body weight

Change in HbA1c



Change body weight



- Placebo
- Survodutide 0.3 mg QW
- Survodutide 0.9 mg QW
- Survodutide 1.8 mg QW
- Survodutide 2.7 mg QW
- Survodutide 1.2 mg BIW
- Survodutide 1.8 mg BIW
- Semaglutide[a] 1.0 mg QW

The safety and tolerability profile was as expected and in line with increasing doses of GLP-1R agonists

[a]The semaglutide arm was open-label.
Body weight at baseline was 93.0–100.1 kg and HbA1c at baseline was 7.9–8.2%.
Survodutide is licensed to Boehringer Ingelheim from Zealand Pharma, with Boehringer solely responsible for development and commercialization globally.
Sources: Figures adapted from Rosenstock. Presentation at ObesityWeek, November 1–4, 2022, San Diego, CA.
BIW=twice-weekly; GLP-1R=glucagon-like peptide-1 receptor; HbA1c=hemoglobin A1c; QW=once-weekly; SE=standard error; T2DM=type 2 diabetes mellitus.

In a 46-week Phase 2 trial in obesity, survodutide dose-dependently reduced body weight by up to 18.7%

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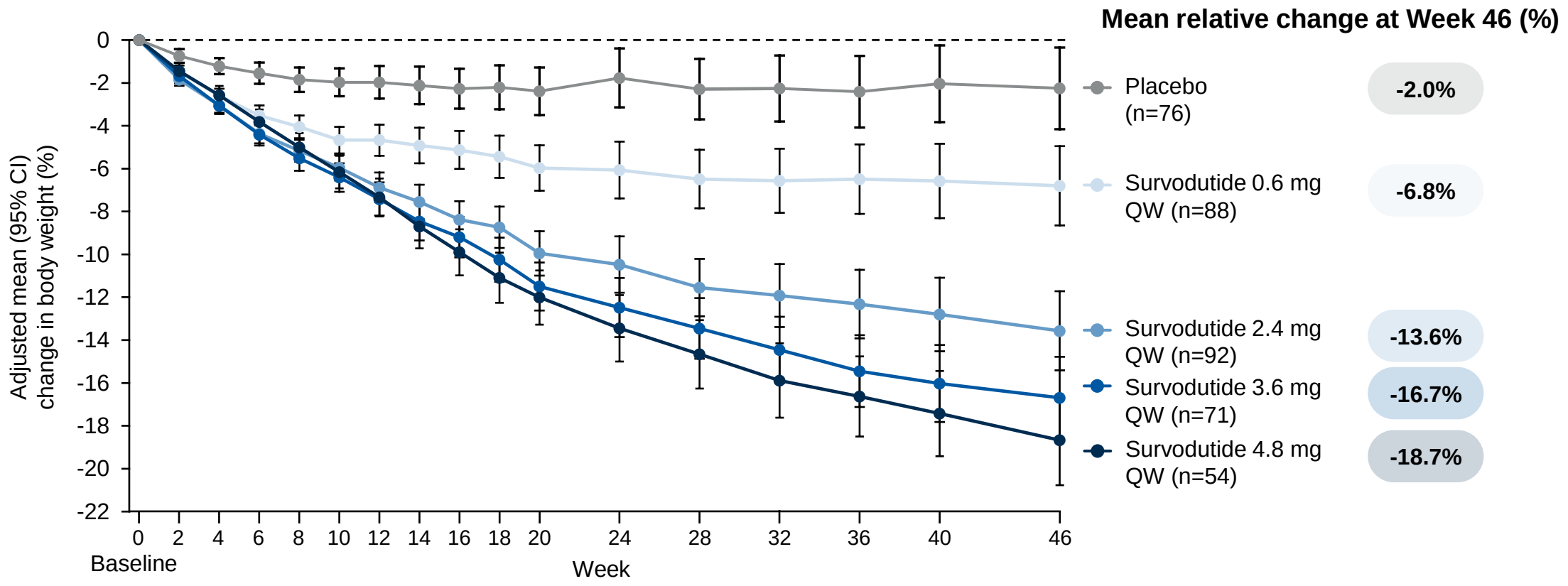
Phase 2 trial of survodutide in people who were overweight or had obesity



Survodutide is licensed to Boehringer Ingelheim from Zealand Pharma, with Boehringer solely responsible for development and commercialization globally.
Source: Figure adapted from Le Roux et al. Oral presentation (51-OR) at ADA 83rd Scientific Sessions, June 23–26, 2023, San Diego, CA.
Analysis based on dose reached at the end of treatment regardless of the dose assigned at randomization.
CI=confidence interval; QW=once-weekly.

Treatment with survodutide[a] in the Phase 2 obesity trial showed no unexpected safety findings

- As expected, **GI disorders were the most frequent drug-related AEs**
- Most treatment discontinuations occurred during the **rapid dose escalation** phase (up to Week 20) and may be **mitigated with more gradual dose-escalation**

TEAE, n (%)[a]	Survodutide 0.6 mg (n=77)	Survodutide 2.4 mg (n=78)	Survodutide 3.6 mg (n=77)	Survodutide 4.8 mg (n=77)	Survodutide total (n=309)	Placebo (n=77)
Any TEAE	70 (90.9)	70 (89.7)	71 (92.2)	70 (90.9)	281 (90.9)	58 (75.3)
Nausea[b]	26 (33.8)	51 (65.4)	48 (62.3)	49 (63.6)	174 (56.3)	15 (19.5)
Vomiting[b]	7 (9.1)	23 (29.5)	26 (33.8)	27 (35.1)	83 (26.9)	4 (5.2)
Diarrhea[b]	14 (18.2)	22 (28.2)	18 (23.4)	15 (19.5)	69 (22.3)	8 (10.4)
Constipation[b]	9 (11.7)	17 (21.8)	19 (24.7)	20 (26.0)	65 (21.0)	4 (5.2)
Leading to treatment discontinuation	15 (19.5)	20 (25.6)	19 (24.7)	22 (28.6)	76 (24.6)	3 (3.9)
GI-related	5 (6.5)	13 (16.7)	13 (16.9)	20 (26.0)	51 (16.5)	1 (1.3)
Serious	1 (1.3)	2 (2.6)	6 (7.8)	4 (5.2)	13 (4.2)	5 (6.5)
Investigator defined, drug-related TEAE	47 (61.0)	66 (84.6)	62 (80.5)	62 (80.5)	237 (76.7)	29 (37.7)
Serious, drug-related TEAE	0 (0.0)	0 (0.0)	2 (2.6)	0 (0.0)	2 (0.6)	0 (0.0)

[a]Survodutide is licensed to Boehringer Ingelheim from Zealand Pharma, with Boehringer solely responsible for development and commercialization globally.
[b]Based on the treated set and presented according to planned treatment; [b]TEAEs listed according to preferred term and occurred in ≥15% patients in any treatment arm.
Source: Table adapted from Le Roux et al. Oral presentation (51-OR) at ADA 83rd Scientific Sessions, San Diego, June 23–26, 2023.
AE=adverse event; GI=gastrointestinal; TEAE=treatment-emergent adverse event.

Survodutide reduced blood pressure by up to 8.6 mmHg (systolic) and up to 4.8 mmHg (diastolic) at Week 46

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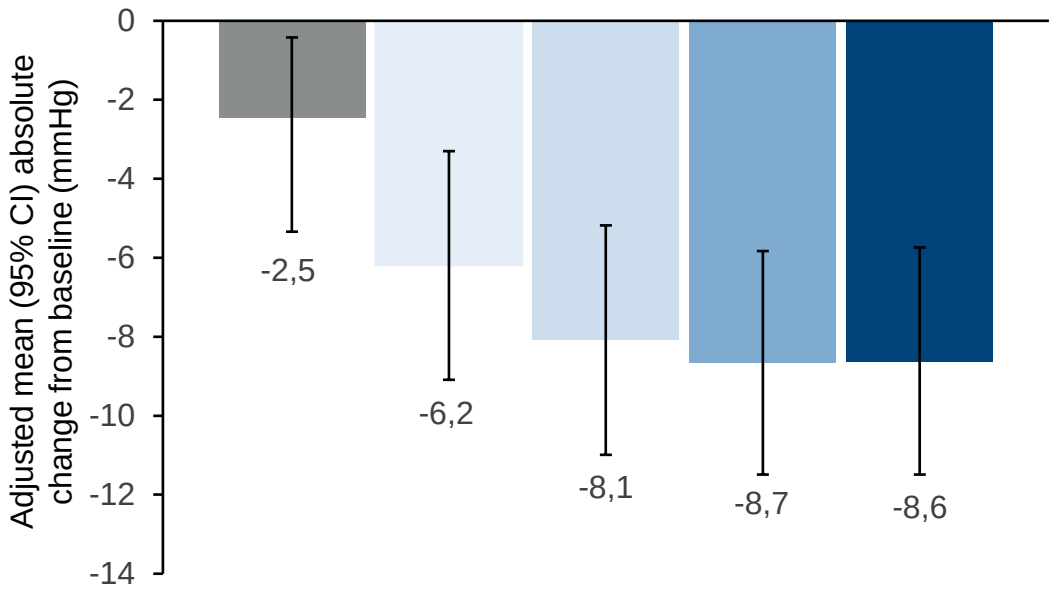
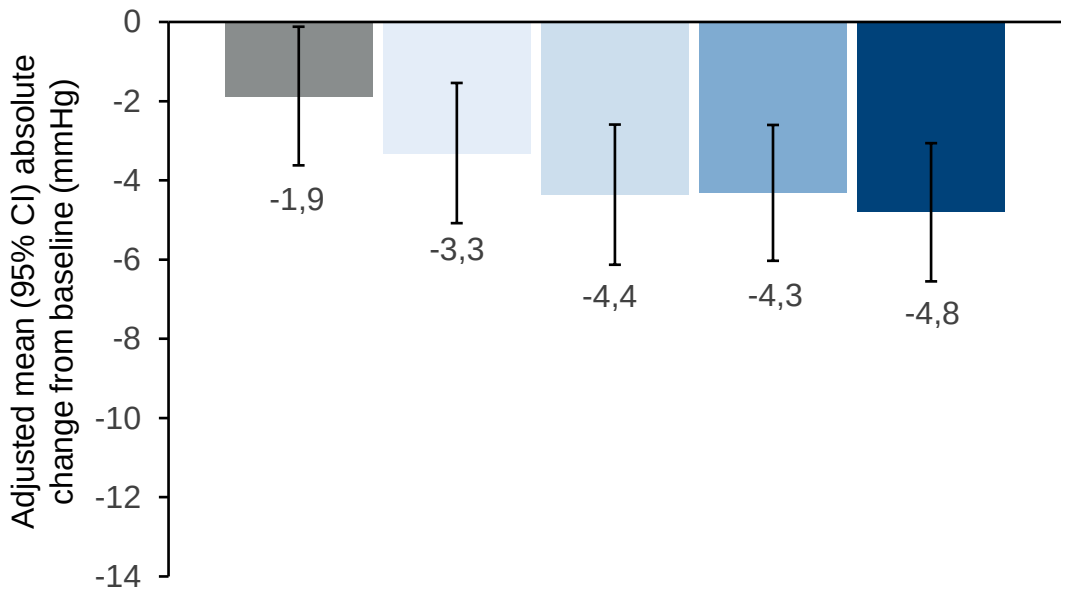
Systolic blood pressure



Diastolic blood pressure



Placebo | Survodutide 0.6 mg QW | Survodutide 2.4 mg QW | Survodutide 3.6 mg QW | Survodutide 4.8 mg QW

Mean blood pressure at baseline across cohorts: 122.6–127.5 mmHg for systolic blood pressure; 80.5–82.4 mmHg for diastolic blood pressure.
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Source: Figures adapted from Le Roux. Presentation at the 59th EASD Annual Meeting, October 2–6, 2023, Hamburg, Germany.
CI=confidence interval; QW=once-weekly.

The Phase 3 program with survodutide in obesity is ongoing and is fully enrolled

	Inclusion criteria	Study design	Primary endpoint
SYNCHRONIZE™-1[1] Efficacy and safety in patients with obesity without T2DM	• HbA1c <6.5% (no history of diabetes) • BMI ≥30 or BMI ≥27 with comorbidities[a]	• N=600 • 1:1:1 ratio (3.6 mg, 6.0 mg, or placebo) • Trial duration: 76 weeks	• Percentage change in body weight from baseline to Week 76 • Achievement of body weight reduction ≥5% from baseline to Week 76
SYNCHRONIZE™-2[2] Efficacy and safety in patients with obesity and T2DM	• HbA1c ≥6.5% and <10% • BMI ≥27 • T2DM managed with diet and exercise alone or with stable pharmacological treatment	• N=600 • 1:1:1 ratio (3.6 mg, 6.0 mg or placebo) • Trial duration: 76 weeks	• Percentage change in body weight from baseline to Week 76 • Achievement of body weight reduction ≥5% from baseline to Week 76
SYNCHRONIZE™-CVOT[3] Long-term CV safety in patients with obesity and established CVD/CKD or risk factors for CVD	• BMI ≥27 with CVD and/or at least two weight-related risk factors for CVD, or • BMI ≥30 with CVD/CKD and/or at least two weight-related factors for CVD	• N=4,935 • 1:1:1 ratio (3.6 mg, 6.0 mg or placebo) • Trial duration: up to 114 weeks	• Time to first occurrence of any of five major adverse cardiac events (5P-MACE) to demonstrate non-inferiority

[a]Comorbidities comprise dyslipidemia, hypertension, obstructive sleep apnea, and others.
Inclusion criteria for all three trials include age ≥18 years. 5P-MACE includes cardiovascular death, non-fatal stroke, non-fatal myocardial infarction, ischemia-related coronary revascularization or heart failure.
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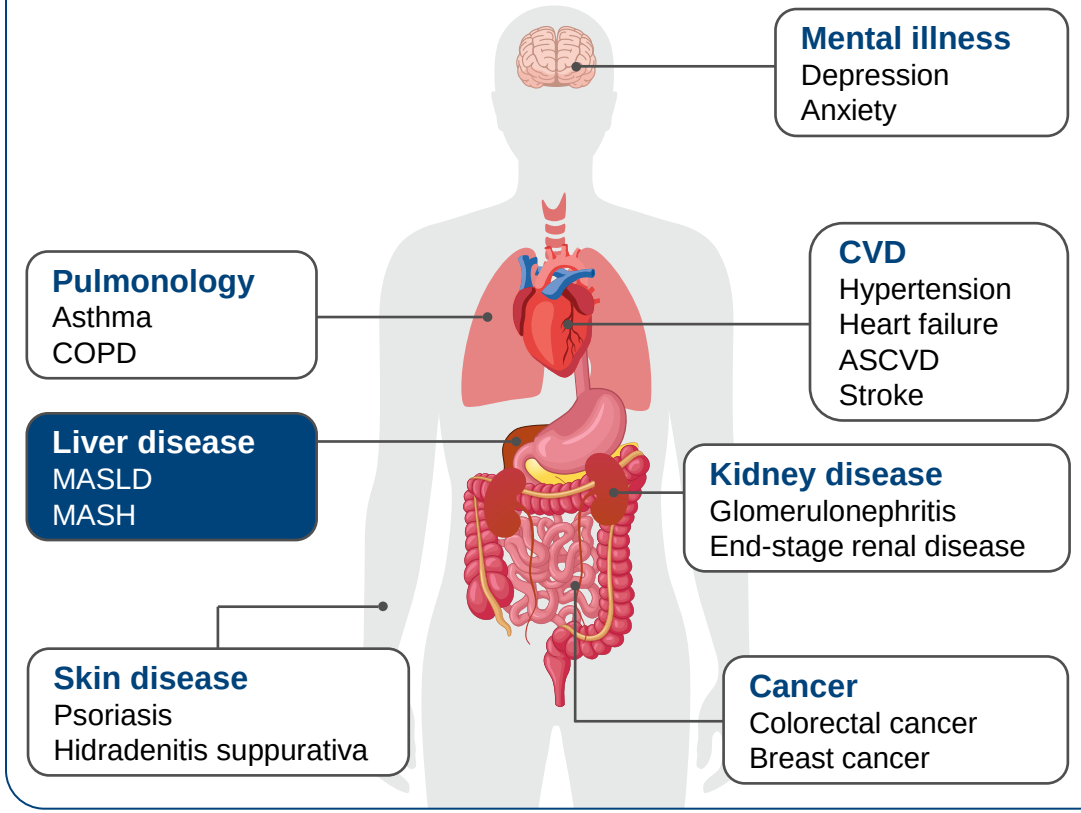
Sources: 1. SYNCHRONIZE-1. ClinicalTrials.gov (NCT06066515), accessed March 2025; 2. SYNCHRONIZE-2. ClinicalTrials.gov (NCT06066528), accessed March 2025; 3. SYNCHRONIZE-CVOT. ClinicalTrials.gov (NCT06077864), accessed March 2025.
BMI=body mass index; CKD=chronic kidney disease; CV=cardiovascular; CVD=cardiovascular disease; CVOT=cardiovascular outcomes trial; HbA1c=hemoglobin A1c; T2DM=type 2 diabetes mellitus.

There is a significant overlap between obesity and liver disease

Obesity is associated with severe comorbidities, for which there are significant unmet medical needs



Mental illness
Depression
Anxiety

Pulmonology
Asthma
COPD

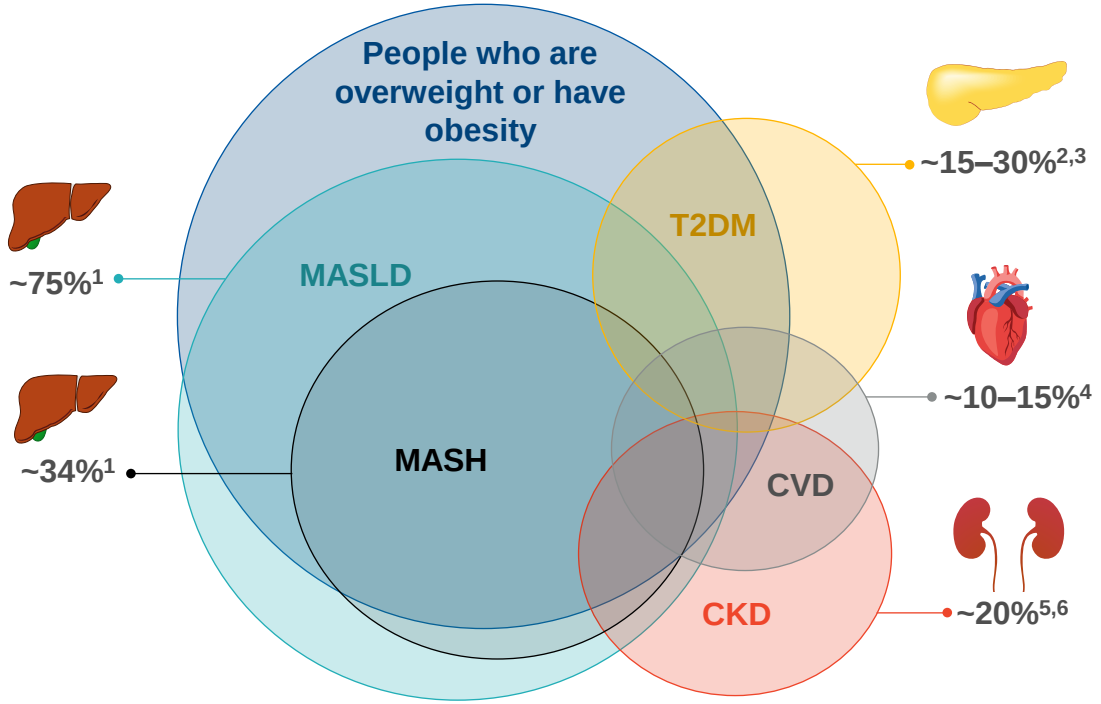
CVD
Hypertension
Heart failure
ASCVD
Stroke

Liver disease
MASLD
MASH

Kidney disease
Glomerulonephritis
End-stage renal disease

Skin disease
Psoriasis
Hidradenitis suppurativa

Cancer
Colorectal cancer
Breast cancer



Estimates of overlap of co-morbidities are not available in literature; approximation in figure is based on individual prevalence estimates.
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Sources: 1. Quek et al. Lancet Gastroenterol Hepatol 2023;8(1):20–30; 2. Vinciguerra et al. Acta Diabetol 2013;50(3):443–449; 3. Pantalone et al. BMJ Open 2017;7(11):e017583; 4. Schienkiewitz et al. BMC Public Health 2012;12:658; 5. Arinsoy et al. J Ren Nutr 2016;26(6):373–379; 6. Yim & Yoo. Clin Exp Pediatr 2021;64(10):511–518.
ASCVD=atherosclerotic cardiovascular disease; CKD=chronic kidney disease; COPD=chronic obstructive pulmonary disease; CVD=cardiovascular disease; MASLD=metabolic dysfunction-associated steatotic liver disease (formerly, NAFLD, or non-alcoholic fatty liver disease); MASH=metabolic dysfunction-associated steatohepatitis (formerly, non-alcoholic steatohepatitis, or NASH); T2DM=type 2 diabetes mellitus.

Survodutide[a] has been evaluated in a Phase 2 trial in MASH

Men and women 18–80 years with MASH and fibrosis (NAS ≥4 and F1−F3) and BMI ≥25 kg/m²

N=295

R

- Survodutide 6.0 mg QW
- Survodutide 4.8 mg QW
- Survodutide 2.4 mg QW
- Placebo QW

Screening (imaging and biopsy) — 0 — Dosing — Week 48 (imaging and biopsy) — End of study

Primary endpoint:
Histological improvement of MASH without worsening of fibrosis after 48 weeks of treatment

Secondary endpoints:

- LFC reduction of ≥30% from baseline
- Absolute and relative change of LFC from baseline
- ≥1 stage decrease in fibrosis stage (liver biopsy)
- Absolute change in NAS (liver biopsy)

[a]Survodutide is licensed to Boehringer Ingelheim from Zealand Pharma, with Boehringer solely responsible for development and commercialization globally.
Source: ClinicalTrials.gov (NCT04771273), accessed February 2024.
BMI=body mass index; LFC=liver fat content; NAS=NAFLD activity score; MASH=metabolic dysfunction-associated steatohepatitis (formerly NASH, or non-alcoholic steatohepatitis); QW=once-weekly.

Survodutide[a] shows best-in-class potential in MASH Phase 2 trial

48-week biopsy-driven Phase 2 MASH trial[1]

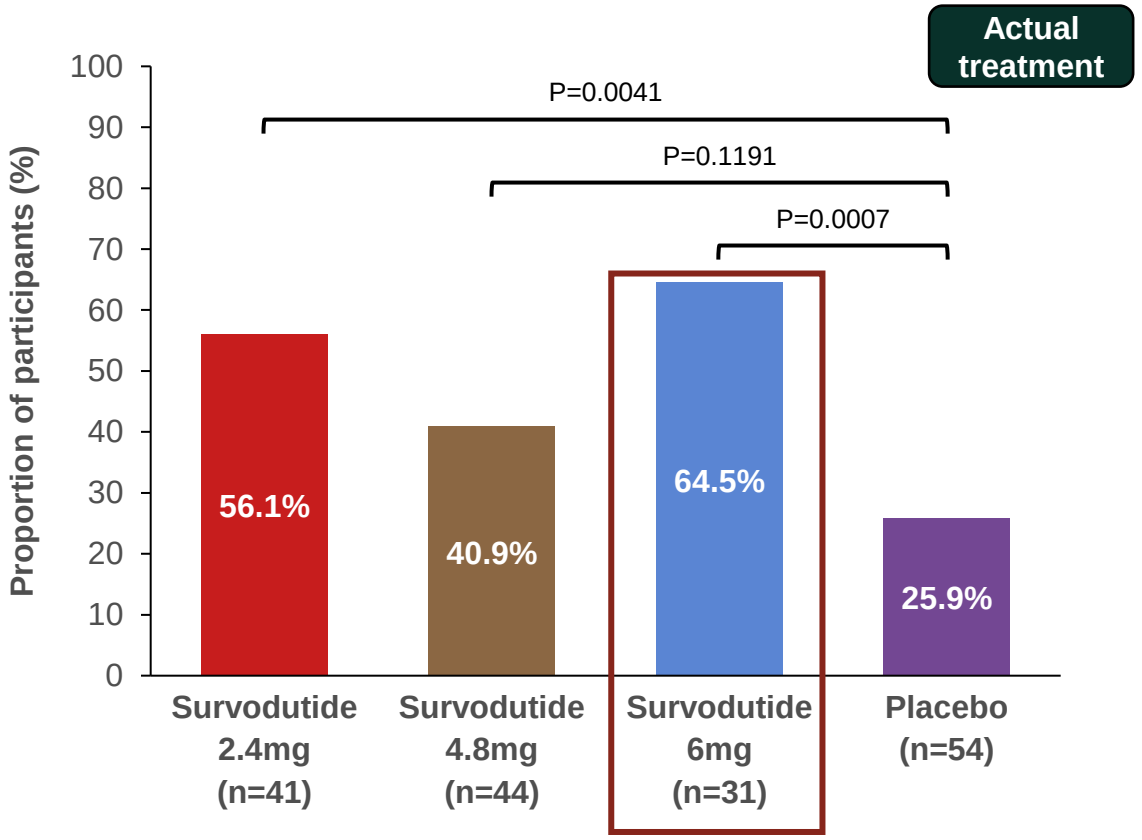
Participants showing **improvement in MASH** without worsening of fibrosis (stages F1-F3): **83.0% with survodutide** vs 18.2% with placebo (p<0.0001)

Participants showing **improvement in liver fibrosis** with no worsening of MASH (stages F2-F3): **64.5% with survodutide** vs 25.9% with placebo (p=0.0007)

Survodutide treatment **did not show unexpected safety or tolerability issues**, including at the higher dose of 6.0 mg

Boehringer received **U.S. FDA BTD for survodutide** in MASH and fibrosis (stages F2-F3), and **launched two Phase 3 trials**[3] in MASH for survodutide

Improvement in liver fibrosis with no worsening of MASH
Paired biopsy results (F2/F3)[2]



[a]Survodutide is licensed to Boehringer Ingelheim from Zealand Pharma, with Boehringer solely responsible for development and commercialization globally.

Sources: 1. Boehringer Ingelheim press release June 7, 2024. Data presented at the EASL Congress 2024 in Milan, Italy. 2. A sensitivity analysis based on participants with paired biopsy results at baseline and end of treatment. 3. Boehringer Ingelheim press release October 8, 2024.

MASH= metabolic dysfunction-associated steatohepatitis (formerly NASH=non-alcoholic steatohepatitis); CI=confidence interval; QW=once-weekly; GCG=glucagon; GLP-1=glucagon-like peptide-1; BTD= Breakthrough Therapy Designation

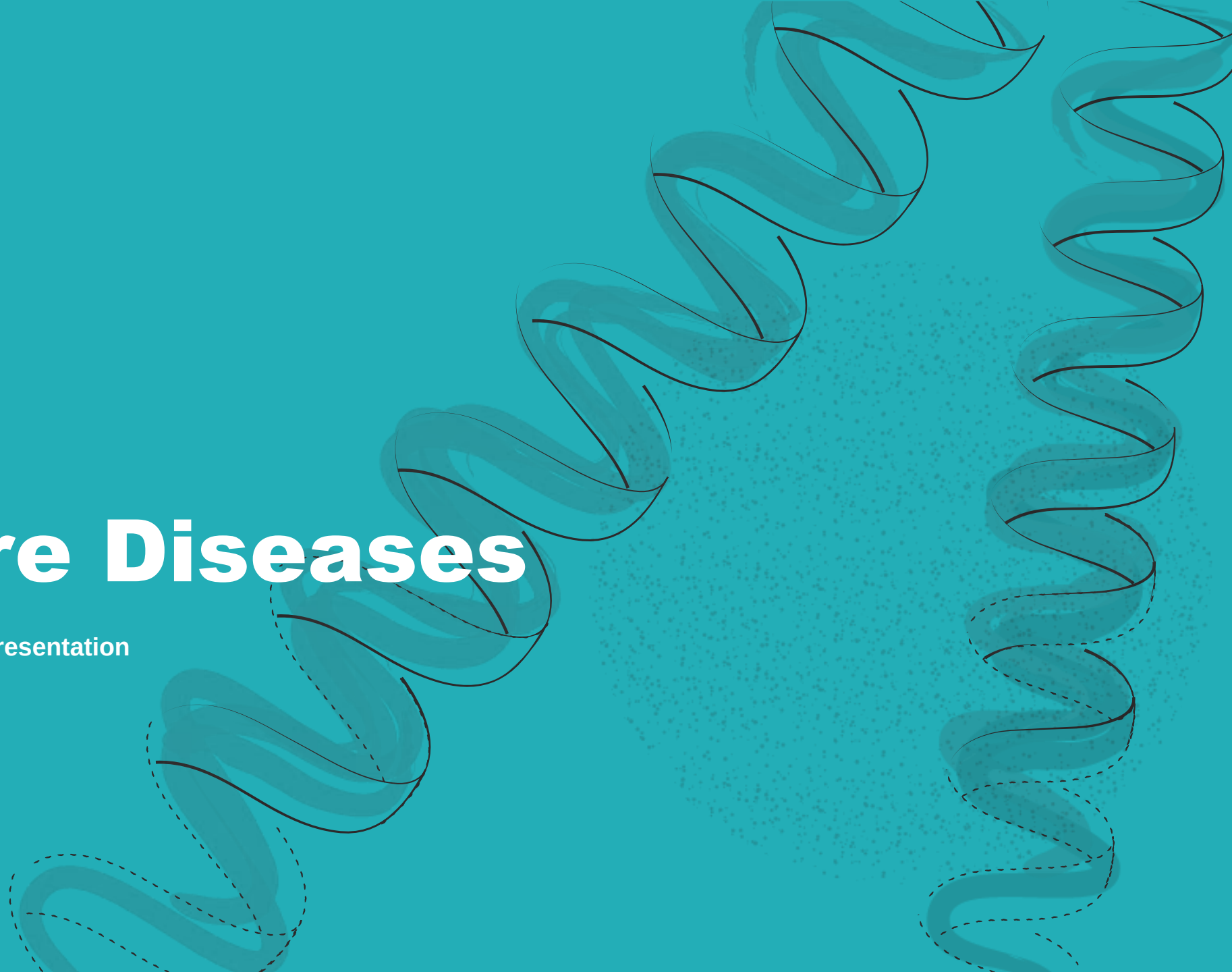
The Phase 3 program with survodutide in MASH has been initiated in October 2024

	Inclusion criteria	Study design	Primary endpoint
LIVERAGE[1] Efficacy and safety in patients with MASH and fibrosis (F2/F3)	• Diagnosis of MASH[a] and biopsy-proven fibrosis stage F2-F3 ***Granted Breakthrough Therapy Designation by the U.S. FDA***[2]	• N=1,800 • 1:1 ratio (6.0 mg or placebo) • Trial duration - Part 1: 52 weeks - Part 2: Up to 7 years	Part 1: 52 weeks • MASH resolution without worsening of liver fibrosis, and • Improvement in fibrosis stage with no worsening of MASH Part 2: Time to first occurrence of liver-related events or all-cause mortality
LIVERAGE-Cirrhosis[3] Efficacy and safety in patients with MASH and cirrhosis (F4)	• Diagnosed compensated MASH cirrhosis[b]	• N=1,590 • 1:1 ratio (6.0 mg or placebo) • Trial duration: Up to 4.5 years	• Time to first occurrence of liver-related events or all-cause mortality

[a]MASH diagnosis defined by a NAS score≥4, with at least 1 point in inflammation and ballooning each. [b]Diagnosed according to modified Liver Forum criteria (Noureddin et al, Gastroenterology 2020;159:422-427)
Inclusion criteria for both trials include age ≥18 years. Further inclusion criteria apply.
Liver-related events include progression to cirrhosis (LIVERAGE), liver transplant, hepatic decompensation event(s), worsening of MELD score to ≥15, and progression to CSPH
Survodutide is licensed to Boehringer Ingelheim from Zealand Pharma, with Boehringer solely responsible for development and commercialization globally.
Sources: 1. LIVERAGE. ClinicalTrials.gov (NCT06632444), accessed March 2025; 2 Boehringer Ingelheim press release October 8, 2024; 3. LIVERAGE-Cirrhosis. ClinicalTrials.gov (NCT06632457), accessed March 2025;
N=number of participants; BMI=body mass index; MASH = metabolic-associated steatohepatitis; MELD = Model for End-stage Liver Disease; CSPH = clinically significant portal hypertension

Rare Diseases

Corporate Presentation



Congenital Hyperinsulinism (CHI) is a severe, ultra-rare genetic disorder with significant impact on patients' QoL

There is a significant unmet need for an effective treatment

CHI is an ultra-rare disease in newborns and children

- 1 in 28-50,000 newborns per year are diagnosed with genetically determined CHI in the US and EU[1,2]
- CHI can cause serious episodes of hypoglycemia during childhood[2,3]

Persistent episodes of hypoglycemia may result in brain damage

- Hypoglycemia can cause seizures in ~50% of the patients[4]
- Lack of proper management within days can lead to permanent brain injury and neurocognitive impairment[3,4]

Significant impact on the patient and caregivers' quality of life

- Complex care requirements can cause lengthy and frequent hospitalizations and make daily social activities difficult[4,5]
- Severe CHI requires continuous enteral feeding, making transfer to other caregivers difficult (e.g., school)[4]
- More than 50% of CHI patients may be unresponsive to current medical treatment options[6]

Sources: 1. Arnoux JB et al. 2011 Orphanet J Rare Dis;6:63; 2. Yau et al. Plos One 2020;15(2):e0228417; 3.Thornton PS et al., J Pediatr. 2015;167(2):238-45. 4, Banerjee I et al., Orphanet J Rare Dis. 2022;17:61; 5. Pasquini TLS et al. Front Endocrinol 2022:13;876903; 6. Yorifuji et al. Clin Pediatr Endocrinol 2017;26(3):127-152.

QoL=quality of life

Dasiglucagon has potential to address shortcomings of current management of CHI

Current treatments for CHI are associated with significant limitations and clinical barriers

Cited by healthcare providers as greatest limitations[5]
- Lack of responsiveness or incomplete response
- Adverse effects or intolerable side effects

Treatment	Current usage (availability varies by country)	Clinical barriers
Diazoxide	• Approved for hyperinsulinism due to various underlying conditions in the US and certain ex-US regions[2]	• FDA-issued warning on pulmonary hypertension in infants in 2015[2,3] • Lack of adequate response[1] • Hypertrichosis[2] • Fluid retention, acute heart failure, pulmonary hypertension[2]
Glucagon	• Used off-label in CHI[1]	• Requires daily reconstitution of lyophilized glucagon • Precipitates in the infusion tube (cannot use long-term)[1]
Somatostatin analogs (octreotide)	• Used off-label in CHI[1] • Short acting: 3-4 daily s.c. injections/continuous infusion[1,4] • Long-acting: intramuscular injection every 28 days[5]	• Hepatotoxicity[1,4] • Tachyphylaxis, QT prolongation[4] • Necrotizing enterocolitis (can be fatal in children with CHI)[1,4]
Pancreatic surgery	• Total/near-total pancreatectomy in diffuse CHI if medical management fails[1]	• Patients develop lifelong insulin dependent diabetes mellitus[5] • Patients develop lifelong severe exocrine insufficiency[5]

Dasiglucagon for subcutaneous infusion*

Wearable s.c. infusion pump system[6]
- Glucagon analog designed to allow for continuous subcutaneous (s.c.) infusion via pump

Dasiglucagon is a glucagon receptor agonist that works by causing the liver to release stored sugar to the blood

Two Phase 3 trials in neonates and children up to 12 years of age demonstrated potential in management of CHI

Zealand expects to resubmit Part 1 of NDA related to dosing of up to three weeks in H1 2025[7]

Zealand expects to submit Part 2 of NDA related to dosing beyond three weeks in H1 2025[7]

IP exclusivity: compound patent US 2035 and EU 2039

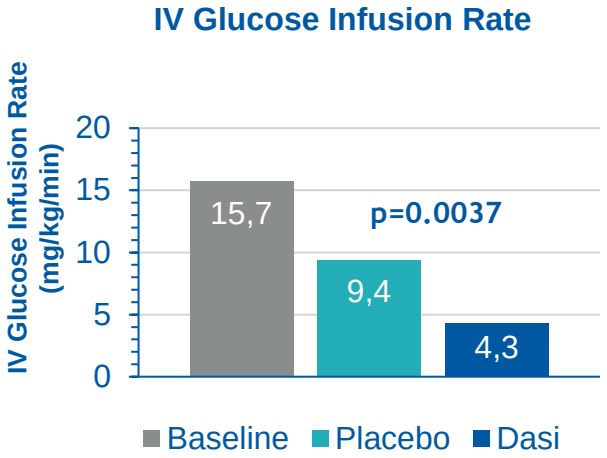
Sources: 1. Yorifuji et al. Clin Pediatr Endocrinol 2017;26(3):127-152; 2. Proglycem. Package insert. Teva Pharmaceuticals; 2015; 3. Gray KD et al. J Perinatol. 2018;38(11):1496-1502; 4. Haris et al. Therapeutic Adv Endocrinology Metabolism 2020;11:1-23; 5. Zealand Pharma, Physician Market Survey, 2020; 6. Zealand Pharma has entered a collaborative development and supply agreement with DEKA Research & Development Corporation and affiliates for infusion pump system; 7. FDA issued a Complete Response Letter (CRL) to Part 1 of the NDA due to inspection findings at a third-party manufacturing facility that were not specific to dasiglucagon; Part 2 to be supported by additional analyses from existing CGM datasets included as a secondary outcome measure in the Phase 3 program.

***Investigational compound and device whose safety and efficacy have not been evaluated or approved by the FDA or any other regulatory authority**

Three Phase 3 trials form the basis of our NDA submission to the US FDA for dasiglucagon in CHI

Trial 17103: Dasiglucagon significantly reduced the requirement for IV glucose in a hospital setting

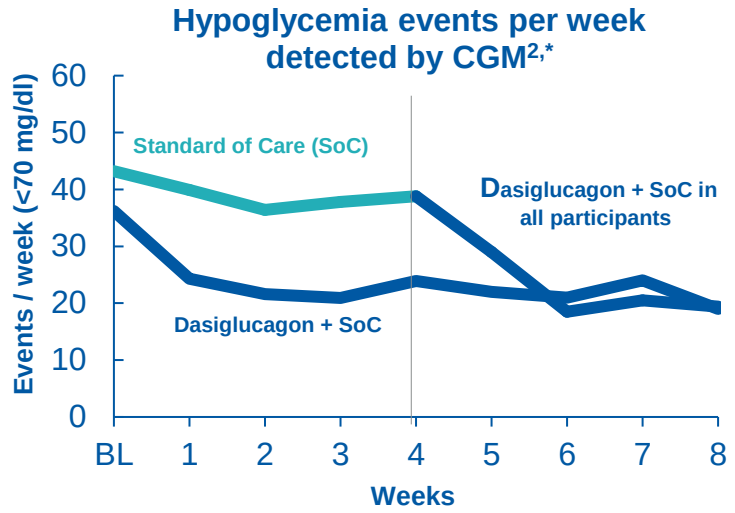
Part 1: Placebo control, crossover x 48 hours[1]



Part 2: 21-days open-label treatmentc[1]

- 10 of 12 patients weaned off IV glucose >12 hours
- 7 patients weaned off IV glucose without need for pancreatectomy

Trial 17109: Dasiglucagon reduced time in hypoglycemia by ~50% and hypoglycemic events by 37-40% in a homecare setting



*Primary endpoint comparing rates of hypoglycemia detected by SMPG demonstrated no difference between dasiglucagon and SoC
CGM = continuous glucose monitoring; SMPG = self-measured plasma glucose

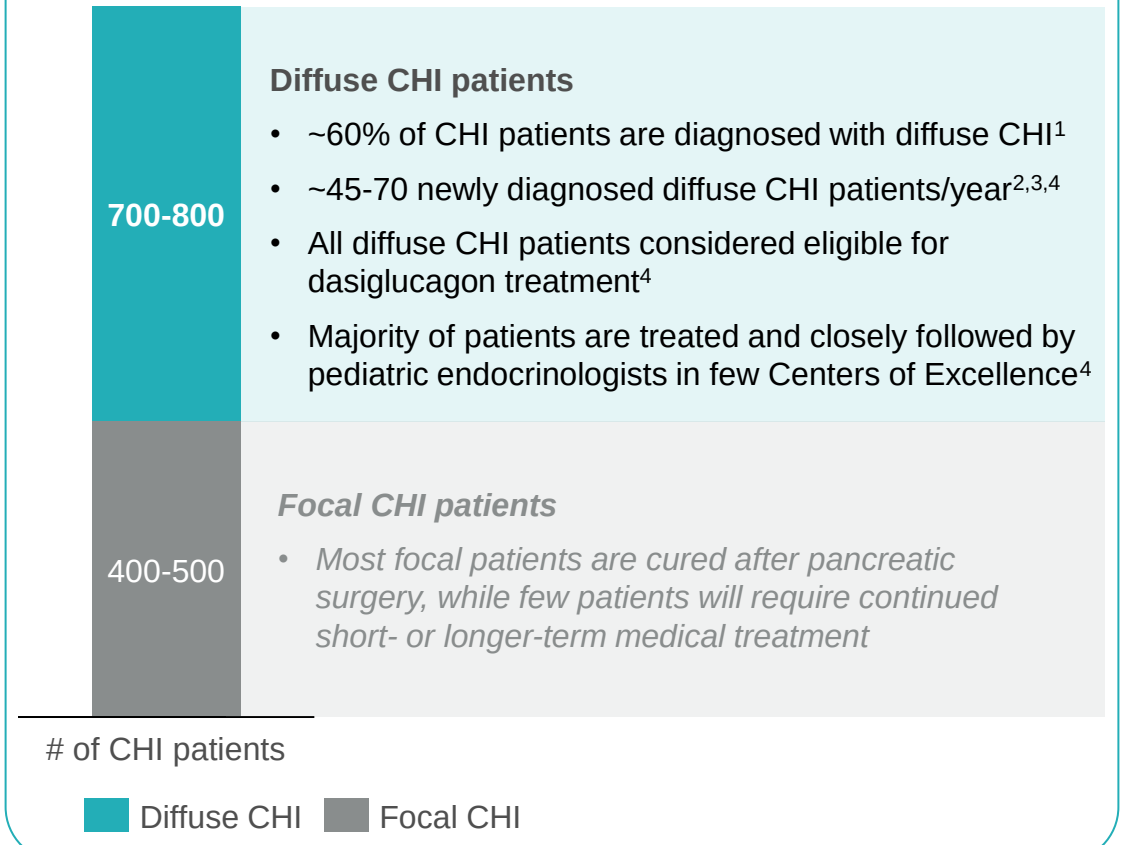
- Assessed as generally well tolerated in both trials
- Skin reactions and gastrointestinal disturbances most frequently reported adverse events

42 of 44 participants continued into long-term extension trial 17106

17103 Phase 3 clinical trial enrolled patients aged 7 days to 12 months, who were newly diagnosed and dependent on IV glucose in hospital setting: https://clinicaltrials.gov/ct2/show/NCT04172441
17106 is an open label long-term safety study that enrolled 17109 and 17103 participants with ongoing positive benefit / risk aged >1 month: https://clinicaltrials.gov/ct2/show/NCT03941236
17109 Phase 3 clinical trial enrolled children aged 3 months to 12 years being treated with standard of care (+/- surgery) with persistent hypoglycemia: https://clinicaltrials.gov/ct2/show/NCT03777176
Sources: 1. De Leon et al. J Clin Endocrinol Metab, November 2024 (published online ahead of print); 2. Thornton et al. J Clin Endocrinol Metab. 2023 Nov 1;109(4):1071–1079.

Opportunity to treat up to 800 patients with diffuse CHI at ultra-rare disease price levels in the US

Patients eligible for dasiglucagon treatment in the US



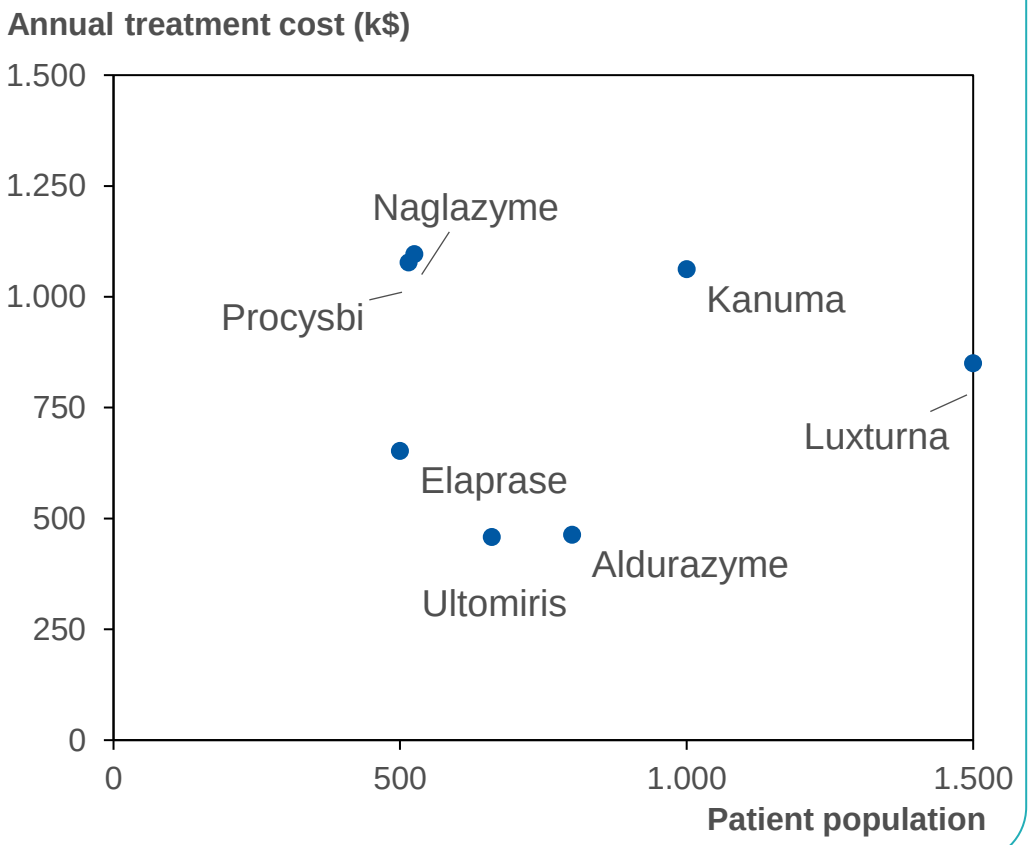
Diffuse CHI patients

- ~60% of CHI patients are diagnosed with diffuse CHI[1]
- ~45-70 newly diagnosed diffuse CHI patients/year[2,3,4]
- All diffuse CHI patients considered eligible for dasiglucagon treatment[4]
- Majority of patients are treated and closely followed by pediatric endocrinologists in few Centers of Excellence[4]

Focal CHI patients

- *Most focal patients are cured after pancreatic surgery, while few patients will require continued short- or longer-term medical treatment*

Ultra-rare disease therapy analogues with clear clinical value command premium prices in US[5]



Sources: 1. Arya et al. Plos One 2014;9:e98054; 2. Arnoux JB et al. 2011 Orphanet J Rare Dis;6:63; 3. Yau et al. Plos One 2020;15(2); 4. Based on KOL interviews (2022); 5. Zealand Pharma Payer & Pricing Research, December 2022

Indications by product: Procysbi (nephropathic cystinosis); Naglazyme (Maratolamy syndrome); Ultomoris (atypical hemolytic uremic syndrome); Kanuma (lysosomal acid lipase deficiency); Luxturna (biallelic RPE65 mutation-associated retinal dystrophy); Elaprase (Hunter syndrome); Aldurazyme (Hurler and Hurler-Scheie forms of Mucopolysaccharidosis I).

Short Bowel Syndrome (SBS) is a rare, chronic and debilitating condition

High unmet need

- SBS is a rare, chronic and debilitating condition resulting in impaired intestinal absorptive capacity[1, 2]
- SBS is associated with significant medical complications including liver and renal failure, metabolic complications, chronic fatigue, and life-threatening infections[3]

Life-long dependency on parenteral support (PS)

- SBS patients experience chronic dependence on complex PS to provide necessary nutrition and fluid intake and balance[3]
- PS management is associated with a significant burden on health care systems and reduction in the patients' and caregivers' quality of life[4,5]

Need for improved treatment options

- More effective and convenient treatments to further reduce PS is needed, with the ultimate goal of enteral autonomy[3]

Sources: 1. Jeppesen P., Expert Opinion on Orphan Drugs; 1:515-25, 2013; 2. Pironi, L, et al. Definitions of intestinal failure and the short bowel syndrome. Best Practice & Research Clinical Gastroenterology. 30(2), 173-185 (2016); 3. Cueda C et al. ESPEN Practical Guideline: clinical nutrition in chronic intestinal failure. Clin Nutrition 40; 5196-5120 (2021); 4. Belza et al. Stress, Anxiety, Depression and Health-Related Quality of Life in Caregivers of Children with Intestinal Failure on Parenteral Nutrition: A Cross-sectional Survey Study. JPEN J Parenter Enteral Nutr. 2022 Nov 6. doi: 10.1002/jpen.2461; 5. Winkler et al. Clinical, social, and economic impacts of home parenteral nutrition dependence in short bowel syndrome.

Glepaglutide has best-in-class potential as a next-generation GLP-2 therapy for patients with SBS

Gattex® (teduglutide): only currently available GLP-2 treatment

- Effective half-life of 1.3 hours at steady state
- 0.05 mg/kg daily subcutaneous dosing via vial/syringe
- Multi-step reconstitution process[1]

Glepaglutide: a long-acting stable GLP-2 analog[a]

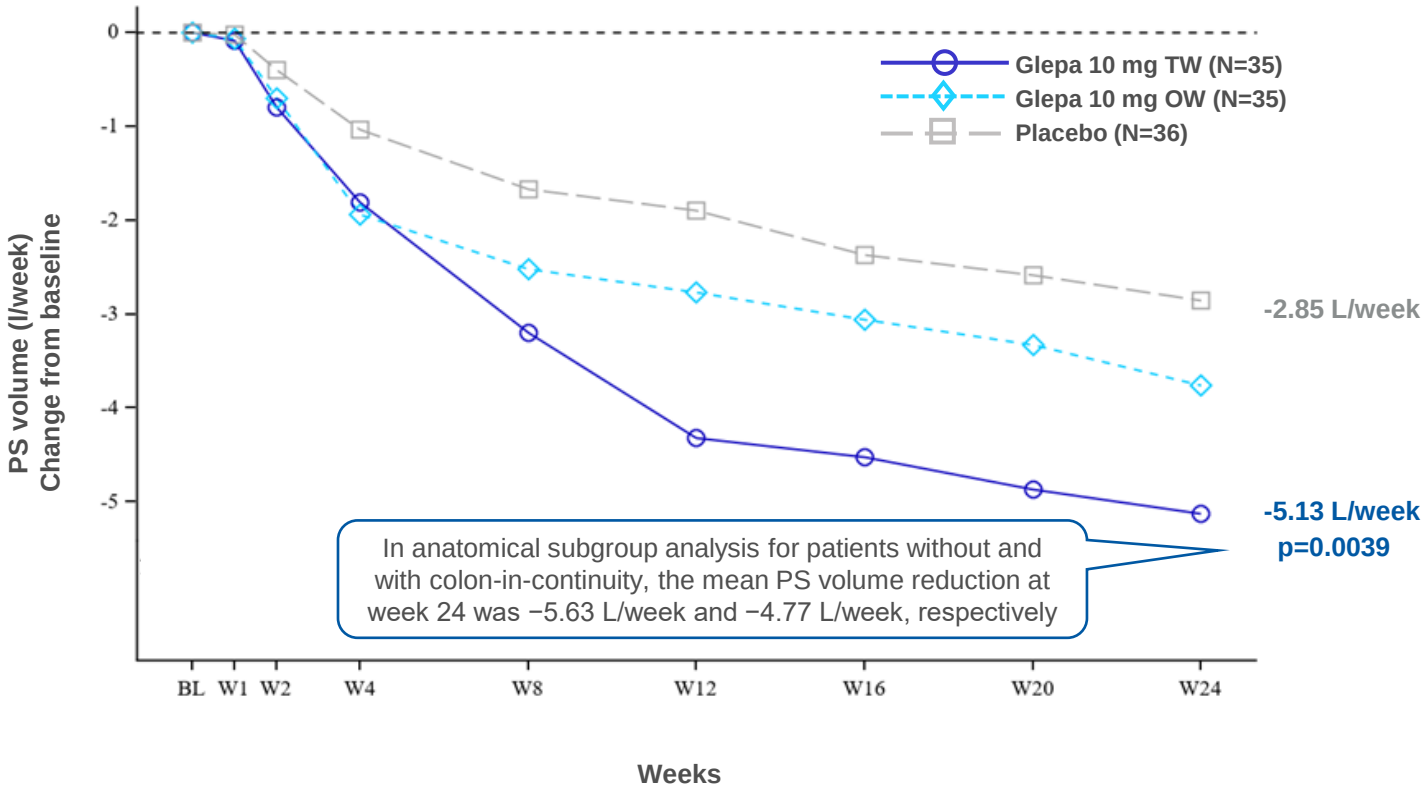
- Effective half-life of ~88 hours at steady state[2]
- Expected 10 mg twice-weekly subcutaneous dosing
- Ready-to-use auto-injector with needle protection
  - Forms depot at the injection site
- Second Phase 3 trial to be initiated in 2025 (EASE-5)
  - Further confirmatory evidence for US resubmission
  - Support regulatory submissions outside US and EU

[a]Investigational product, not approved for distribution; IP exclusivity: Compound patent 2026 + 5 years PTE; Dosing regime (pending) 2038, Clinical formulation (pending) 2039

Sources: 1. https://www.gattex.com/resources-and-support/; 2. Agersnap M. et al, 2022, Clin Drug Investigation; 42(12):1093-1100; 3. The U.S. FDA issued a Complete Response Letter for the glepaglutide New Drug Application for the treatment of short bowel syndrome

Glepaglutide significantly reduced weekly PS volume at Week 24 versus placebo in the EASE SBS-1 trial[1]

Phase 3 trial of glepaglutide in people with SBS (EASE-1)



Clinical response was significantly higher with twice weekly glepaglutide compared to placebo (p=0.0243)

- 65.7% twice weekly glepaglutide
- 45.7% once weekly glepaglutide
- 38.9% placebo group

9 patients treated with glepaglutide discontinued PS during the trial

- 14% (n=5) twice weekly glepaglutide
- 11% (n=4) once weekly glepaglutide
- No patients receiving placebo

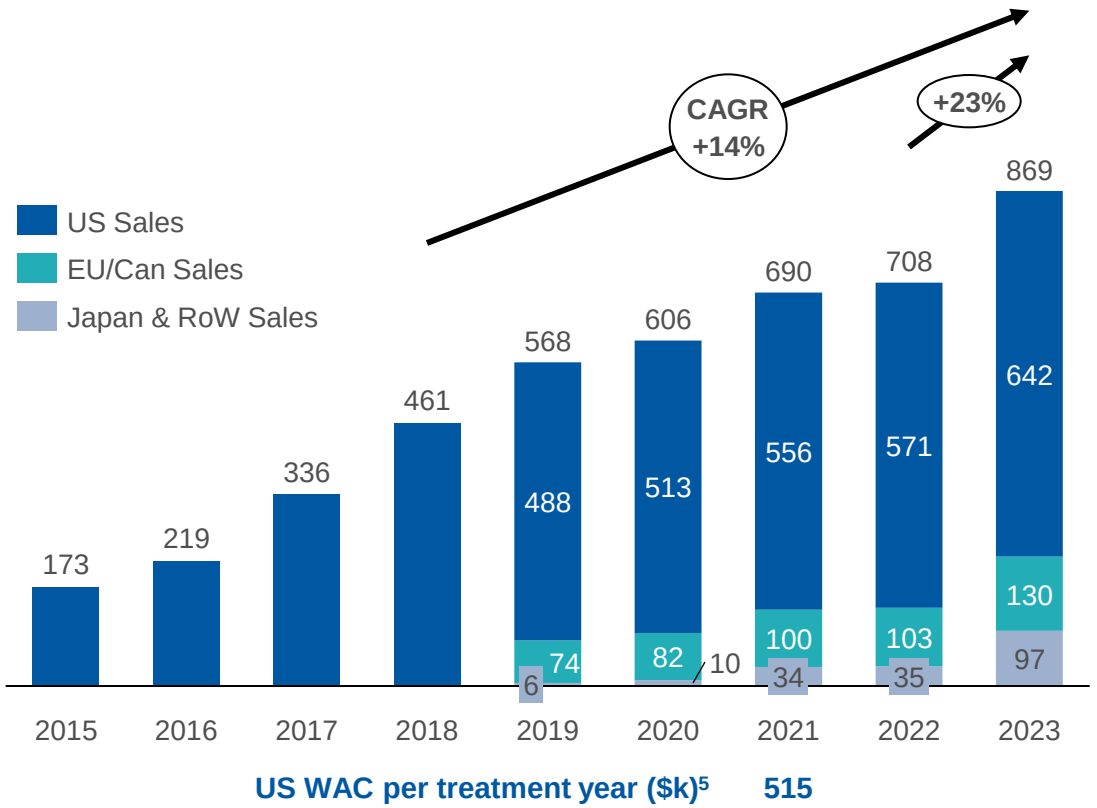
Glepaglutide appeared to be well-tolerated in the trial

- Most frequently reported adverse events were injection site reactions and gastrointestinal events

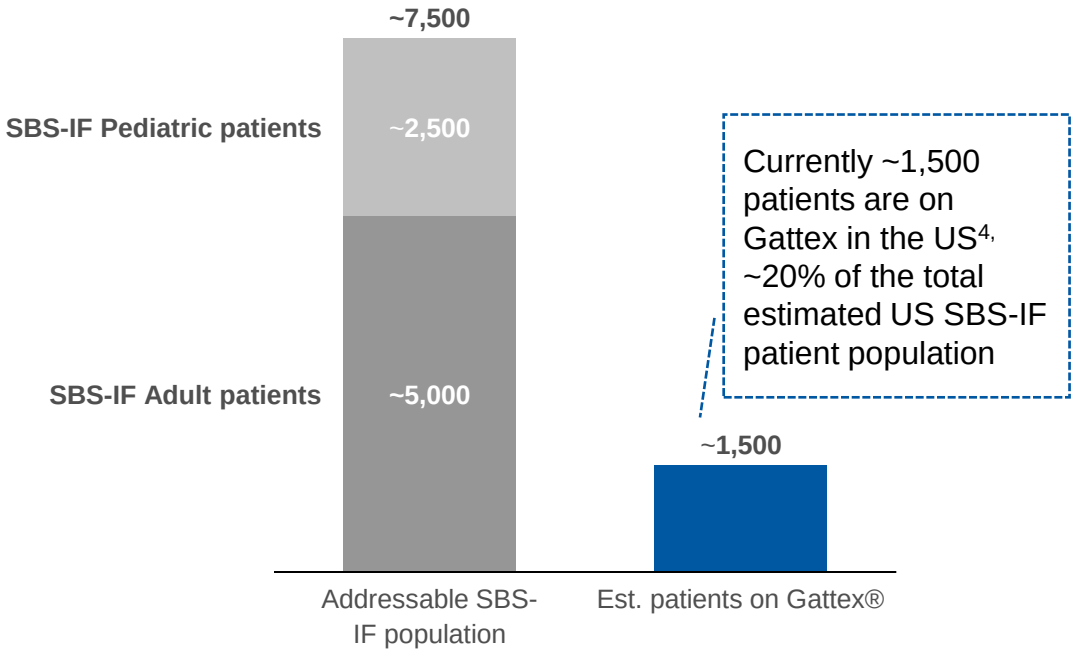
Sources: 1. Jeppesen, et al, Gastroenterology, December 2024 (published online ahead of print).
SBS=short bowel syndrome; PS=parenteral support; N=number of participants; TW=twice weekly; OW=once weekly

Global teduglutide sales of >$850M, with US price of $515k/year and significant room for patient expansion

Global Teduglutide Sales[1,2] (USD Million)



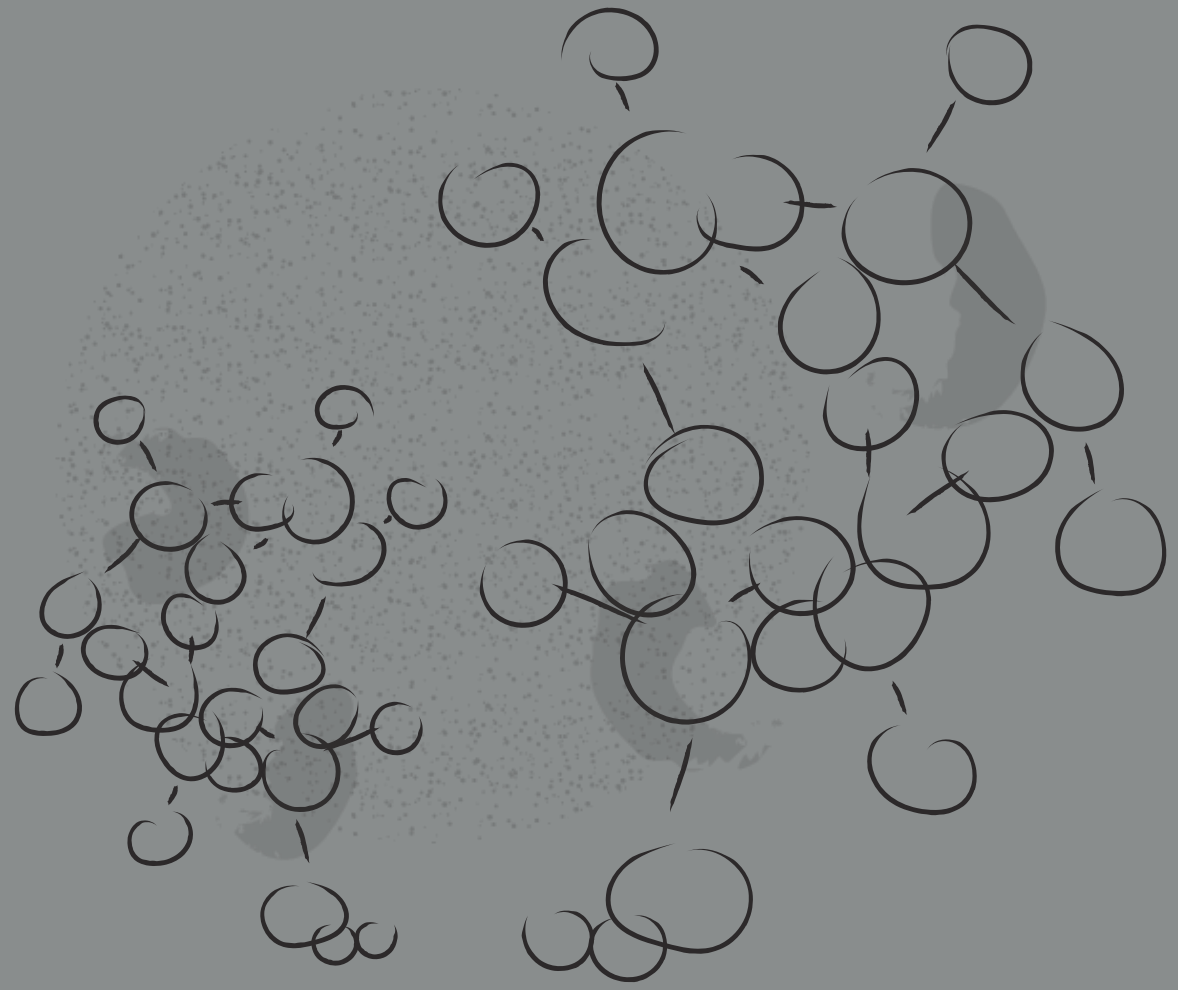
Estimated US SBS-IF Patients[3]



Sources: 1. 2015-2018: Carnegie ZEAL research report, 24 February 2020; 2. 2019-23: Gattex/Revestive sales data as reported in Takeda SEC filings, following fiscal financial year April to Mar. Converted to USD per Yearly Average Currency Exchange Rates, IRS.gov; 3. SBS Intestinal Failure patient estimates based on Zealand Pharma claims analysis, 2020 and Mundi et al, Characteristics of Chronic Intestinal Failure in the USA Based on Analysis of Claims Data, JPEN in Press 2022. 4. ZP estimate based on US Gattex sales and net price estimate; 5. WAC at end of year, https://app.prospectorx.com.
WAC=wholesaler acquisition cost; SBS=short bowel syndrome; IF=intestinal failure

Chronic Inflammation

Corporate Presentation



Early-stage pipeline targets chronic inflammatory diseases with significant unmet medical needs

ZEALAND PHARMA

Kv1.3 blocker (ZP9830)

- Potent and selective inhibitor of Kv1.3 with the potential to treat a broad range of cell-mediated autoimmune diseases[1]
- Concentration-dependent inhibition of pro-inflammatory cytokine release (including IFN-g, IL-2 and IL17A) from stimulated human whole blood[1]
- First-in-human clinical trial investigating the safety and tolerability of ZP9830 has been initiated[2]

Complement C3 inhibitor (ZP10068)

- Investigational, long-acting inhibitor of Complement C3, which has the potential to treat a broad range of complement-mediated diseases
- In 2023, Zealand completed activities to support advancing ZP10068 into the first-in-human clinical trials
- Zealand will assess the potential next steps for ZP10068[3]

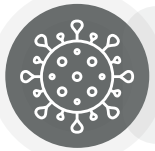
Sources: 1. Data on file. Concentration-dependent effect on pro-inflammatory cytokine release from Thapsigargin stimulated whole blood; 2. ClinicalTrials.gov (NCT06682975), accessed December 2024; 3: In the first quarter of 2024, Alexion Pharmaceuticals discontinued development of ZP10068 citing business reasons and is in the process of transferring the asset to Zealand

ZP9830 is a Kv1.3 inhibitor designed to treat cell-mediated immune disorders

ZEALAND PHARMA

ZP9830 inhibits Kv1.3, the main K^+ channel of leukocytes from the innate and adaptive immune system[1]

Kv1.3. channels are essential for the **activation**, **proliferation**, **migration** and **cytokine production** of leukocytes[2]



T effector memory and class-switched memory B cells play a **key role** in **autoimmunity** and **chronic inflammation** and are **dependent** on Kv1.3 for function[3]

Inhibition of Kv1.3 channels **preserves** the **protective effects** of the rest of the immune system, making it an **attractive pharmaceutical target**

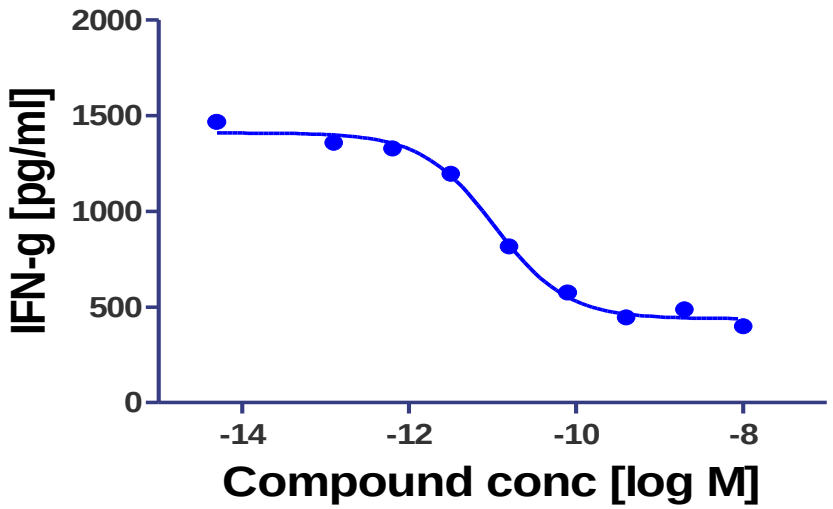
ZP9830 is a **potent** and **selective Kv1.3 inhibitor** with potential to treat a **broad range** of **cell-mediated autoimmune diseases**. First-in-human clinical trial initiated in Q4 2024[4]

Sources: 1. Navarro-Pérez, Expert Opinion on Therapeutic Targets 2024, 28(1-2):67-82; 2. Markakis, Frontiers in Pharmacology 2021,12: 714841; 3. Chandy and Norton, Current Opinion in Chemical Biology 2017, 38:97–107; 4. ClinicalTrials.gov (NCT06682975), accessed December 2024.

First-in-human clinical trial investigating safety and tolerability of ZP9830 is ongoing

Anti-inflammatory effects of Kv1.3 ion channel inhibition

Concentration-dependent inhibition of pro-inflammatory cytokine release (including IFN-g, IL-2 and IL17A) from stimulated human whole blood[1]



First-in-human SAD clinical trial[2]

The first-in-human Phase 1 single ascending dose trial include 10 dose cohorts and is expected to enroll 92 healthy men.

Cohorts 1-3 (SC): Assess safety and PK

Cohorts 4-9 (SC): Assess safety, PK, and PD

Cohort 10 (IV): Assess safety and PK

The trial will investigate:

- Safety and tolerability profile with single ascending doses
- PK profile to determine the appropriate dose level(s)
- Effect of ZP9830 on the body's immune system

Sources:1. Data on file. Concentration-dependent effect on pro-inflammatory cytokine release from Thapsigargin stimulated; 2. ClinicalTrials.gov (NCT06682975), accessed December 2024.
PK=pharmacokinetic; PD=pharmacodynamic; SAD=single ascending dose trial; SC=subcutaneous; IV=intravenous.

Additional company information

Corporate Presentation

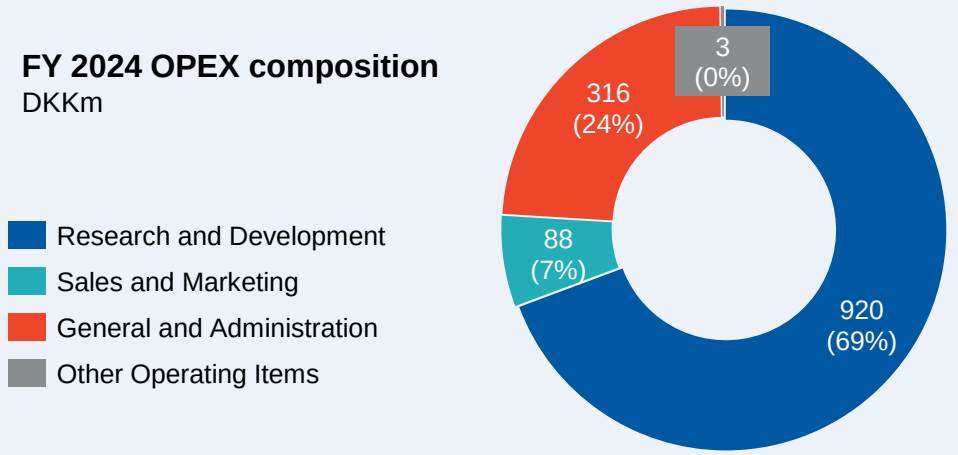
FY 2024 Profit & Loss

DKK million	FY 2024	FY 2023
Revenue	63	343
Gross profit	**55**	**324**
Research and development expenses	-920	-685
Sales and marketing expenses	-88	-31
General and administrative expenses	-316	-185
Other operating Items	-3	5
Net operating expenses	**-1,327**	**-896**
Operating result	**-1,272**	**-572**
Net financial items	189	-137
Result before tax	**-1,083**	**-709**
Tax	5	5
Net result for the period	**-1,079**	**-704**

P&L reflecting Zealand's investments in its differentiated assets targeting obesity

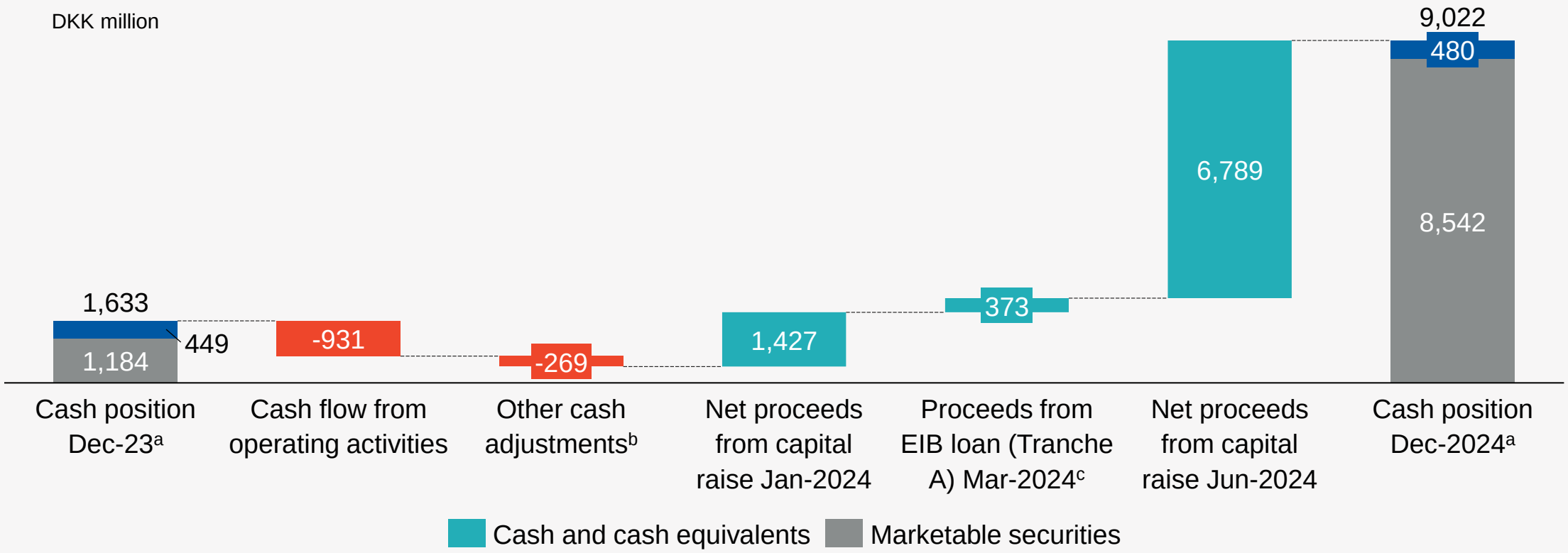
- Revenue of DKK 63 million is mainly driven by the license and development agreement with Novo Nordisk for Zegalogue®.
- Total operating expenses of DKK 1,327 million are higher than last year, primarily driven by the increase in R&D expenses due to clinical advancement of the obesity pipeline, including preparations for large Phase 2b trials for the wholly-owned obesity assets. S&M expenses are mainly driven by pre-commercial activities for the rare disease assets, whereas the increase in G&A expenses reflects legal expenses related to our patent portfolio and strengthening of organizational capabilities.
- Net financial items of DKK 189 million are mainly driven by interest income from the excess liquidity invested in marketable securities.

FY 2024 OPEX composition
DKKm



Strong cash position of DKK 9.0 billion enables significant investments in our obesity programs

Secured cash of DKK 8.6 billion in 2024 through capital raises and the EIB loan facility[a]



[a]Cash position includes cash, cash equivalents and marketable securities. EIB loan Tranches B and C (EUR 20 million each) are excluded from this chart. The two tranches are subject to pre-specified milestones being met.
[b]Other cash adjustments include purchase of treasury shares to cover LTI programs.
[c]The EUR 50 million Tranche A of the EIB loan facility was disbursed in March 2024.
EIB = European Investment Bank

2025 financial guidance

2025 operating expenses anticipated to be in the range of DKK 2,000-2,500 million

Anticipated increase in OPEX is mainly to support mid-stage obesity pipeline and further enhance research efforts

- Development: Accelerate investments in obesity pipeline, which in 2025 will include three large Phase 2b trials. In addition to the clinical costs associated with conducting these trials, the guidance also includes CMC investments in activities mainly related to API and Drug Product, as well as preparations for Phase 3
- Research: Enhance investments in next-generation peptide research, including early-stage portfolio of novel peptides targeting obesity and inflammation

DKK million	2025 Guidance	2024 Actuals
Revenue anticipated from existing and new license and partnership agreements	No guidance	63
Net operating expenses[a]	2,000 – 2,500	1,327

[a]Net operating expenses consist of R&D, S&M, G&A and other operating items.
Financial guidance based on foreign exchange rates as of February 19, 2025.

Experienced management team

Adam Steensberg

Chief Executive Officer

University of Copenhagen · IMD · DANISHBIO · cessatech · novo nordisk

Henriette Wennicke

Finance & Legal
Chief Financial Officer

Copenhagen Business School · GN · novo nordisk

David Kendall

Research & Development
Chief Medical Officer

University of Minnesota · AMYLIN · American Diabetes Association · Lilly

Eric Cox

Commercial & BD
Chief Commercial Officer

Missouri State University · KU The University of Kansas · AstraZeneca · MERCK · BAYER · Johnson & Johnson · CARMOT THERAPEUTICS · Roche

Ivan M. Møller

Operations
Chief Operating Officer

DTU · HARVARD UNIVERSITY · NOVARTIS · BCG

Christina S. Bredal

People & Organization
Chief People Officer

University of Copenhagen · Copenhagen Business School · pwc · EY