ZEALAND PHARMA

Zealand Pharma

Capital Markets Day 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 financial guidance for 2025. 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 audience and readers of this presentation are 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.

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 unless required by law.

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

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Not a faster horse

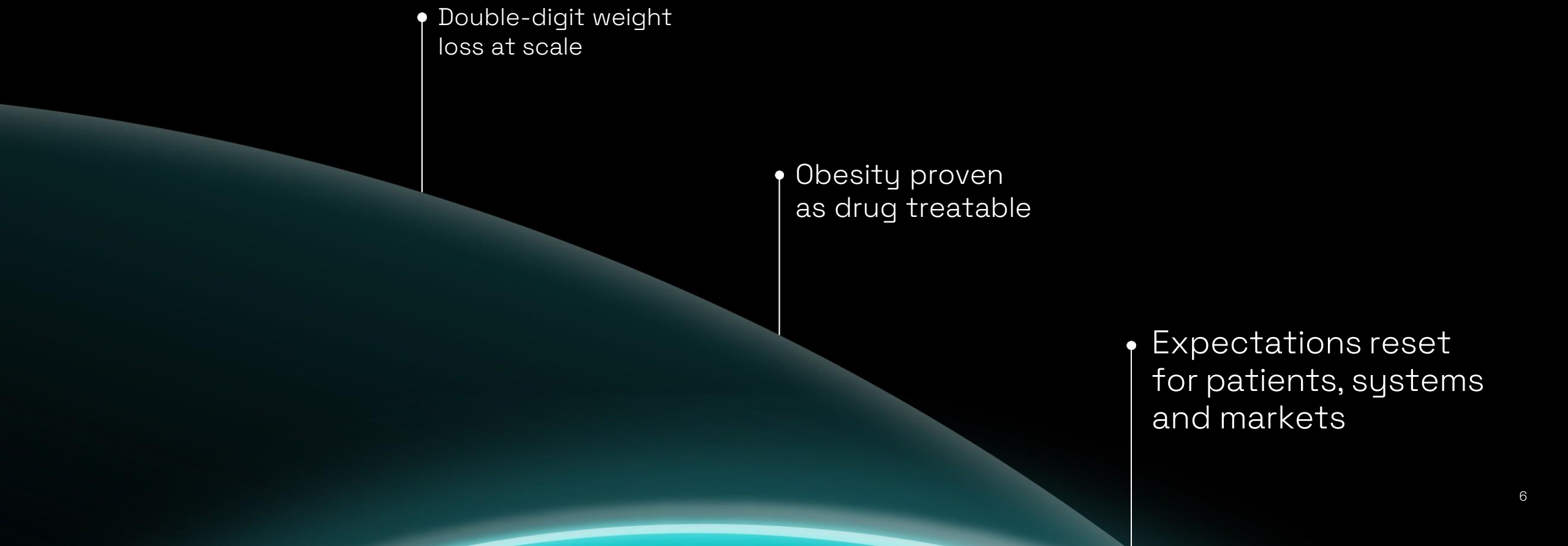
Redefining obesity for a new era

Building a generational biotech company in metabolic health.

Obesity: requires a civilization-scale health shift

- >1 billion people living with obesity today
- Rising for decades without decisive action
- Obesity is not an individual failure

The GLP-1 revolution changed expectations



Petrelintide

A potential foundational therapy

- Feel full faster
- Designed for high-quality, durable weight loss
- Stand-alone and in combo with CT-388 (GLP-1/GIP)

Zealand Pharma has a collaboration and license agreement with Roche for petrelintide, including co-development and co-commercialization in the U.S. and Europe.

Teresa Graham, CEO, Roche Pharmaceuticals and Adam Steensberg, CEO, Zealand Pharma. October 2025

Biotech speed, pharma strength

- Equal partnership with a shared commitment to redefine obesity care
- Unites Zealand Pharma's metabolic heritage with Roche's manufacturing and commercial infrastructure
- Zealand Pharma to build U.S. launchpad for petrelintide and future metabolic health medicines

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Roche

A generational biotech in metabolic health

By ‘generational’ we mean:

- We will shape obesity care for decades, not cycles
- Through a platform and exceptional pipeline, not a single product
- With multiple waves of innovation in metabolic health

An engine built on peptides, data and AI

Our unfair advantage in metabolic health

Unmatched expertise in peptides and metabolic health

+

>25 years of rich proprietary data

+

Unique opportunity to leverage AI/ML

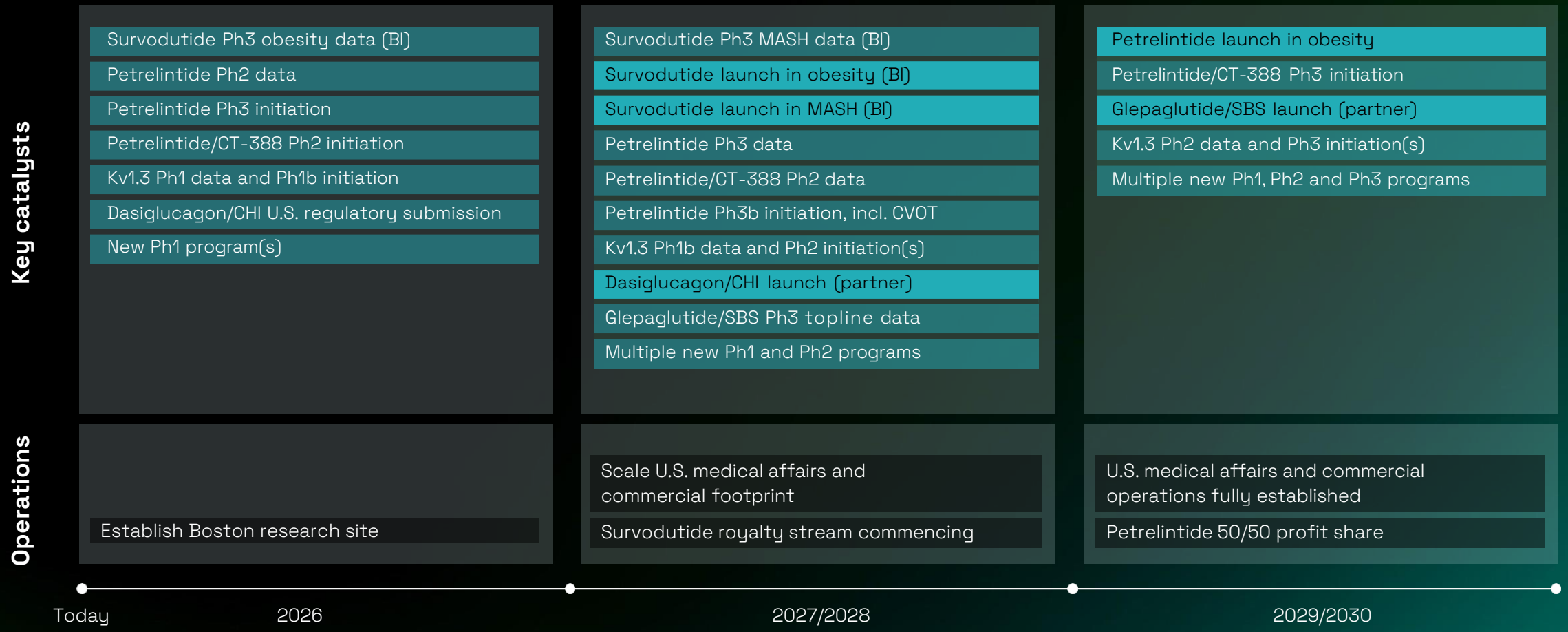
METABOLIC FRONTIER 2030

By 2030:

- 5 launches in 5 years
- 10+ clinical programs in metabolic health
- Industry-leading cycle times from idea to clinic

Clear path to long-term value creation with transformational milestones ahead

NON-EXHAUSTIVE



Disclaimer: All follow-on activities and events are subject to final decision and contingent upon outcomes from ongoing and prior trials and other activities. Progression, sequencing, and timing are dependent on successful completion and evaluation of earlier activities, some of which have not yet been initiated.

CHI=congenital hyperinsulinism; MASH=metabolic dysfunction-associated steatohepatitis; SBS=short bowel syndrome; BI=Boehringer Ingelheim; CVOT=cardiovascular outcomes trial.

The culture that delivers generational biotech for patients

Patient-driven & science-first:

Every decision anchored in metabolic biology & patient impact

Small, accountable, owner mindset:

Lean teams, clear ownership, no passengers

Data-native & collaborative:

Turning >25 years of data into better solutions with partners


Move Like
a Biotech,
Hit Like a
Pharma

Today's journey: how the story unfolds

1.

The opportunity & our ambition

Adam Steensberg
1:05-1:25

2.

The future of weight management

Eric Cox
1:25-1:50

3.

Survodutide: the next frontier in obesity & MASH (GCG/GLP-1)

Carel Le Roux & David Kendall - including Q&A
1:50-2:25

4.

Amylin: an emerging therapeutic class

Jonathan D. Roth & Louis J. Aronne
2:25-3:05

Break
3:05-3:45

5.

Petrelintide: building the leading amylin franchise

David Kendall - including Q&A
3:45-4:20

6.

Our engine: world's most valuable metabolic health pipeline

Utpal Singh
4:20-4:50

7.

How we fund and scale this

Henriette Wennicke
4:50-5:00

8.

Q&A and closing remarks

Adam Steensberg & team
5:00-5:30

Maximize this metabolic moment

Obesity will define the next decades of healthcare

Catalyst-rich 2026 igniting transformational journey toward 2030 and beyond

We will become a generational biotech by building the world's most valuable metabolic health pipeline

The opportunity now: Zealand Pharma on the cusp of transforming the game for patients and HCPs

2.

The future of weight management

Eric Cox – 1:25-1:50

1. The opportunity & our ambition
Adam Steensberg
1:05-1:25

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Five launches in the next five years

Obesity and related comorbidities

Product candidate[a]			
Petrelintide (amylin analog)[b]	Obesity	ZEALAND PHARMA, Roche	Phase 2
Petrelintide/CT-388 (amylin + GLP-1/GIP)[b]	Obesity	ZEALAND PHARMA, Roche	Phase 2-ready
Survodutide (GCGR/GLP-1R dual agonist)[c]	Obesity	Boehringer Ingelheim	Phase 3
Survodutide (GCGR/GLP-1R dual agonist)[c]	MASH	Boehringer Ingelheim	Phase 3
ZP6590 (GIP receptor agonist)	Obesity		Phase 1-ready
Dapiglutide (GLP-1R/GLP-2R dual agonist)	Obesity		Paused (Phase 2-ready)

Rare disease

Product candidate[a]		
Dasiglucagon: SC continuous infusion	Congenital hyperinsulinism	Registration
Glepaglutide (GLP-2 analog)	Short bowel syndrome	Phase 3

Inflammation

Product candidate[a]		
ZP9830 (Kv1.3 ion channel blocker)	Undisclosed	Phase 1
ZP10068 (complement C3 inhibitor)	Undisclosed	Pre-clinical

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[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]Zealand Pharma has a collaboration and license agreement with Roche for petrelintide, including co-development and co-commercialization in the U.S. and Europe.
[c]Survodutide is licensed to Boehringer Ingelheim from Zealand Pharma, with Boehringer solely responsible for development and commercialization globally.
GCGR=glucagon receptor; GIP=gastric inhibitory polypeptide; GLP-1R=glucagon-like peptide-1 receptor; GLP-2R=glucagon-like peptide-2 receptor; MASH=metabolic dysfunction-associated steatohepatitis; SC=subcutaneous.

Obesity: greatest healthcare challenge of our time

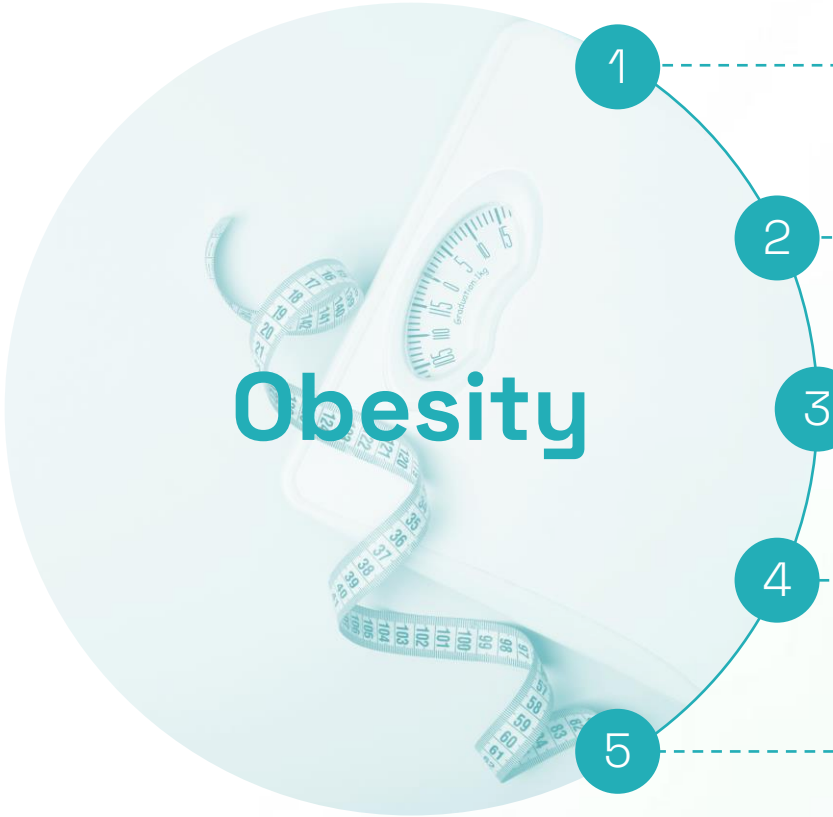
The obesity epidemic has **surged over the past decades,** with **50% of adults** globally expected to live with **overweight or obesity** by 2030[1]

>200 complications and comorbidities associated with obesity[2]

Today, **~35% of U.S. children and adolescents aged 2–19 years** live with overweight or obesity[3]

Sources: [1]World Obesity Atlas 2024; [2]American Medical Association 2024: https://www.ama-assn.org/topics/obesity; [3]CDC Childhood Obesity Facts (April 2024).

Unique disease area

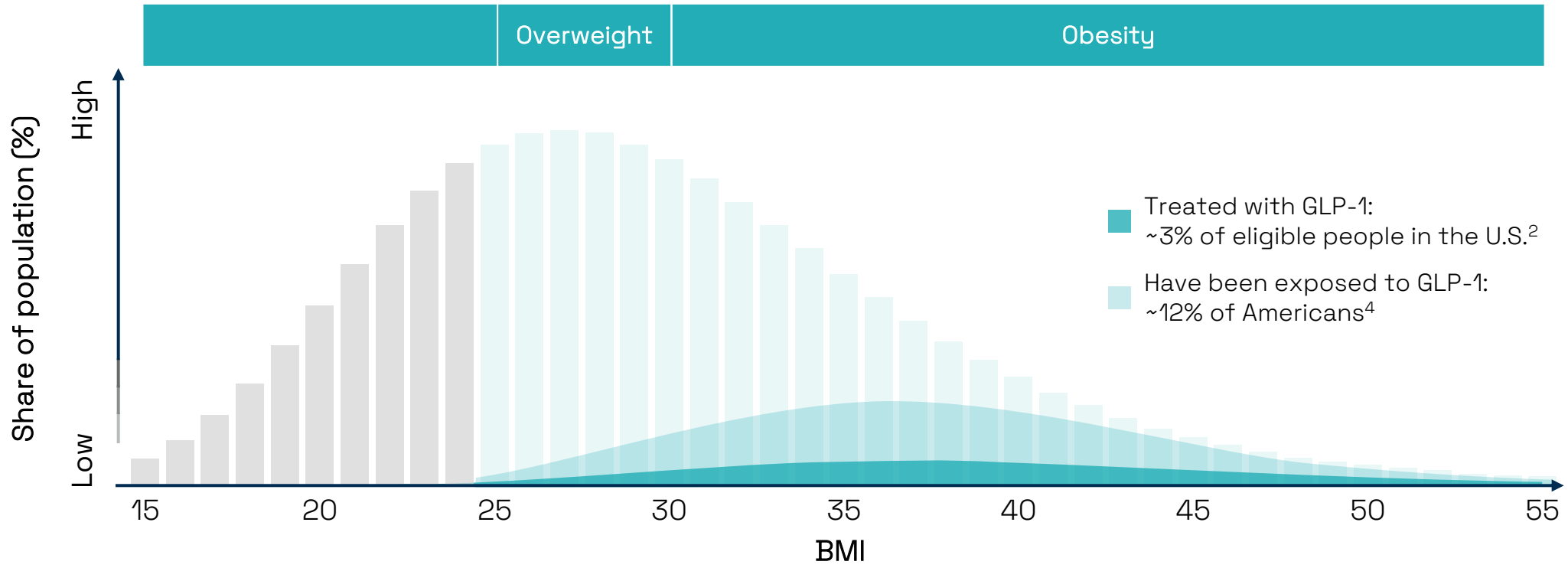


1. The consumer as key decision driver[a]
2. Unprecedented size and scale
3. Two key healthcare providers: Primary care and specialty care
4. Heterogeneity and fragmentation
5. Linked to many comorbidities

[a]Medicinal products remain prescription only. Ultimate decision maker remains the treating physician.

Public health challenge:
We must improve treatment penetration and maintenance

BMI distribution and GLP-1 usage today[a,1-3]



[a]Chart is illustrative. The general population BMI is modeled based on national public health statistics from a large, developed market.

Sources: [1]Distribution of Body Mass Index Among Adults (2024), https://www.kff.org/state-health-policy-data/state-indicator/distribution-of-body-mass-index-among-adults, accessed November 2024; [2]Kim et al. (2025) Uptake of and Disparities in Semaglutide and Tirzepatide Prescribing for Obesity in the US, JAMA. Published online April 29, 2025; [3]World Obesity Atlas 2025. World Obesity. https://data.worldobesity.org/publications/world-obesity-atlas-2025-v7.pdf. Accessed November 2025; [4]Bozick et al (2025) GLP-1 agonist use and side effects in the United States. RAND. Published August 5, 2025.

BMI=body mass index; GLP-1=glucagon-like peptide-1.

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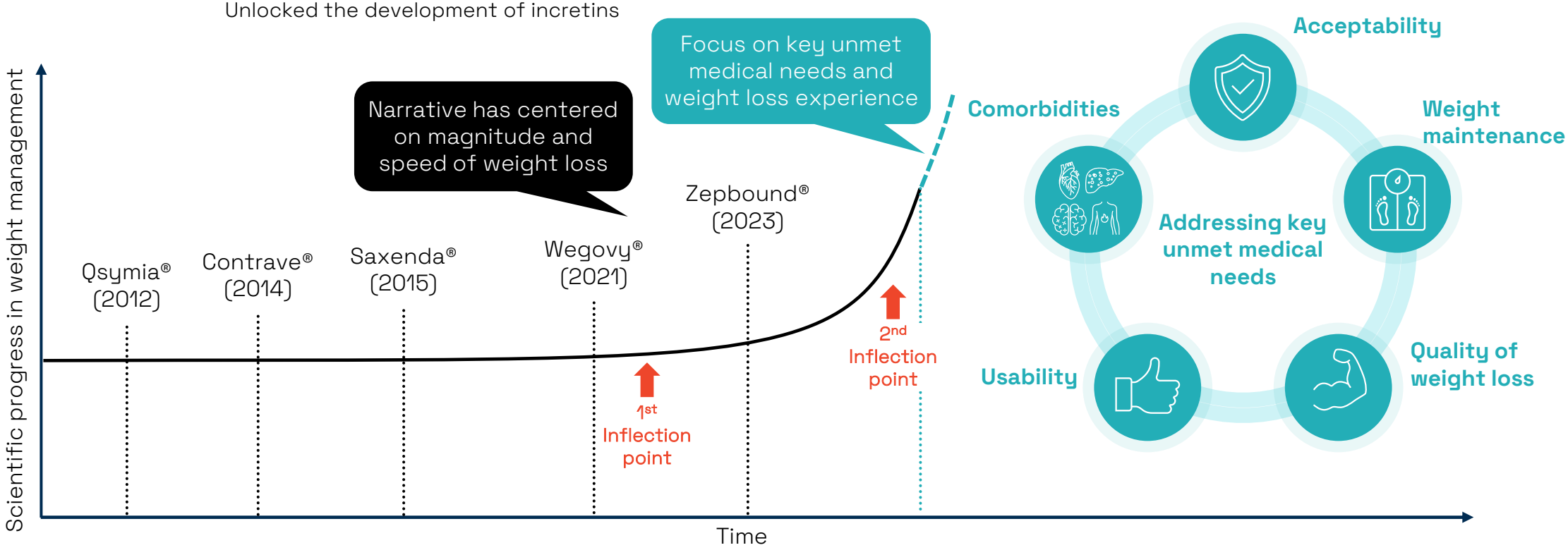
Beyond Weight loss Olympics: key unmet needs

First wave of incretins | **New mechanisms and next-gen incretins**

Better understanding of gut–brain axis biology
Unlocked the development of incretins



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Obesity demands new classes of drugs

Hypertension
- Diuretics
- Beta-blockers
- ACE inhibitors
- ARBs
- Calcium channel blockers
- Direct renin inhibitors
- Vasodilators
- Centrally acting agents

Dyslipidemia
- Statins
- Cholesterol absorption inhibitors
- PCSK9 inhibitors
- Bile acid sequestrants
- PPAR-α agonists
- Nicotinic acid
- Omega-3 fatty acids
- ANGPTL3 inhibitors

Type 2 diabetes
- Metformin
- Sulfonylureas
- Meglitinides
- DPP-4 inhibitors
- SGLT-2 inhibitors
- GLP-1 receptor agonists
- Insulin
- Amylin (short-acting)

Obesity
- GLP-1RA-based therapies (GLP-1 and GLP-1/GIP)

+8 classes of drugs in other chronic disease areas with more mature and saturated markets

One class of drugs available today

Treatment options shown are not exhaustive.
ACE=angiotensin-converting-enzyme; ANGPTL3=angiopoietin-like protein 3; ARB=angiotensin receptor blocker; DPP-4=dipeptidyl peptidase 4; GLP-1=glucagon-like peptide-1; GIP=glucose-dependent insulinotropic polypeptide; GLP-1RA=glucagon-like peptide-1 receptor agonist; PCSK9=proprotein convertase subtilisin/kexin type 9; PPAR-α=peroxisome proliferator-activated receptor alpha; SGLT-2=sodium-glucose cotransporter-2; MoA=mechanism of action.

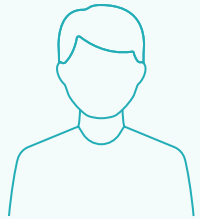
Two distinct segments, two focus areas

Prescriber-driven

Specialist-driven prescriptions focusing on benefits of treating **comorbidities** and **health impact** of weight loss

Objectives:

1. Comorbidity risk reduction and health outcomes
2. Relative weight loss
3. Tolerability and user experience (to improve persistence)
4. Convenience of treatment



Consumer-driven

Consumer-driven **primary care** prescriptions focusing on **desired weight loss** and **user experience**

Objectives:

1. Desired weight loss
2. Tolerability and user experience
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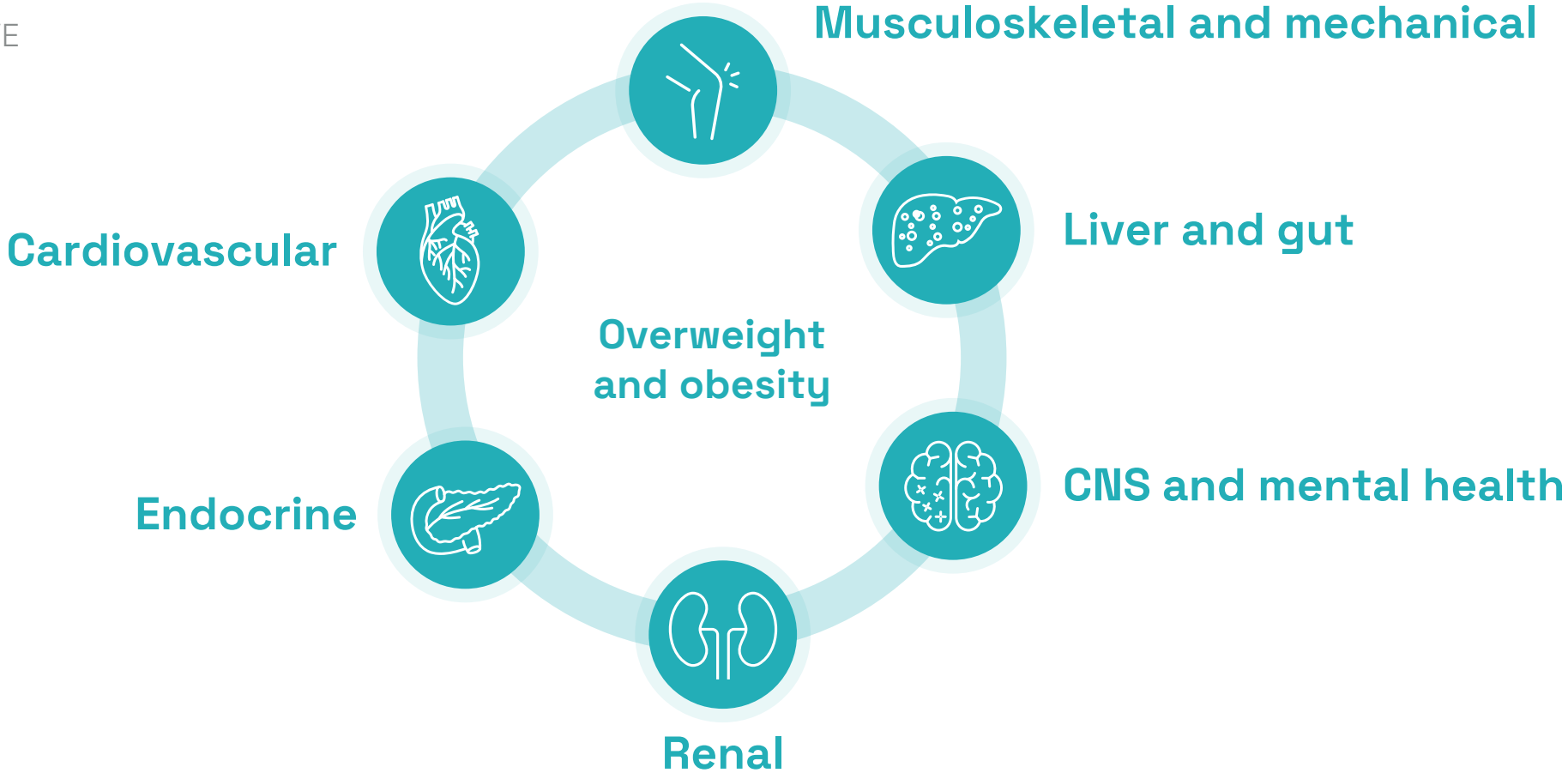
Obesity impacts several organ systems

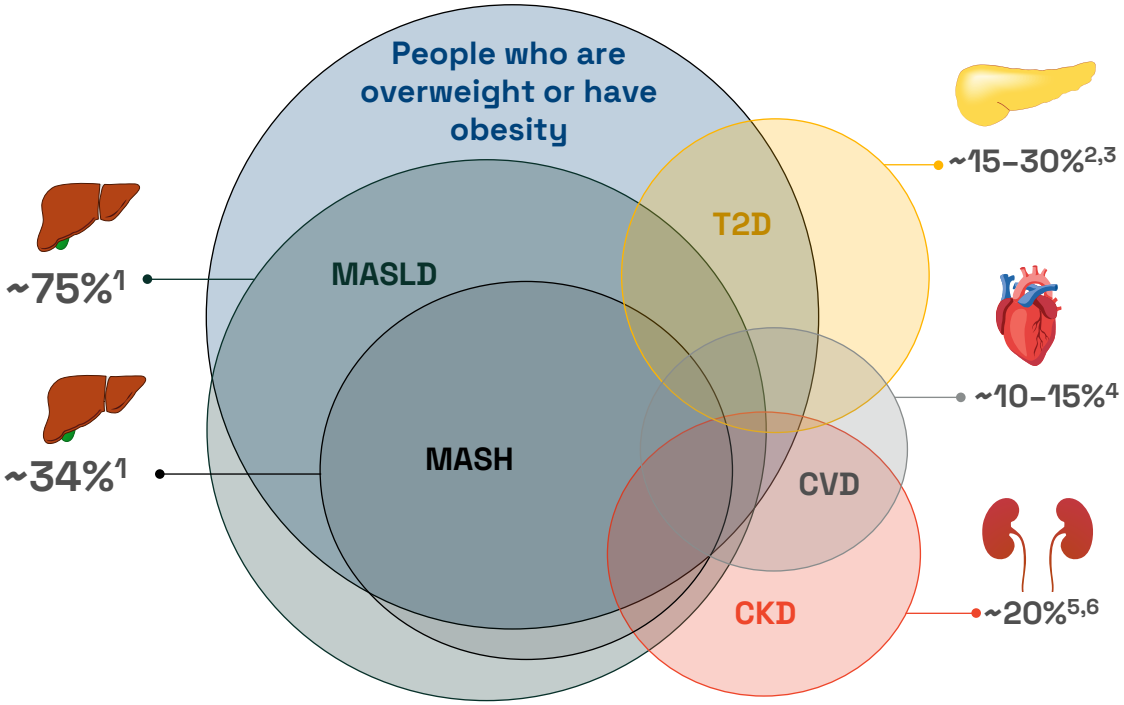
NON-EXHAUSTIVE



Source: American Medical Association 2024: https://www.ama-assn.org/topics/obesity.
CNS=central nervous system.

Urgent need for better treatment options in MASH

Survodutide[a] holds potential to revolutionize treatment of MASH and establish a strong foothold in the prescriber-driven segment



"See Obesity, Think Liver"

Boehringer Ingelheim at ObesityWeek 2025.

[a]Survodutide is licensed to Boehringer Ingelheim from Zealand Pharma, with Boehringer solely responsible for development and commercialization globally.
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.
CKD=chronic kidney disease; CVD=cardiovascular disease; MASH=metabolic dysfunction-associated steatohepatitis; MASLD=metabolic dysfunction-associated steatotic liver disease; T2D=type 2 diabetes.

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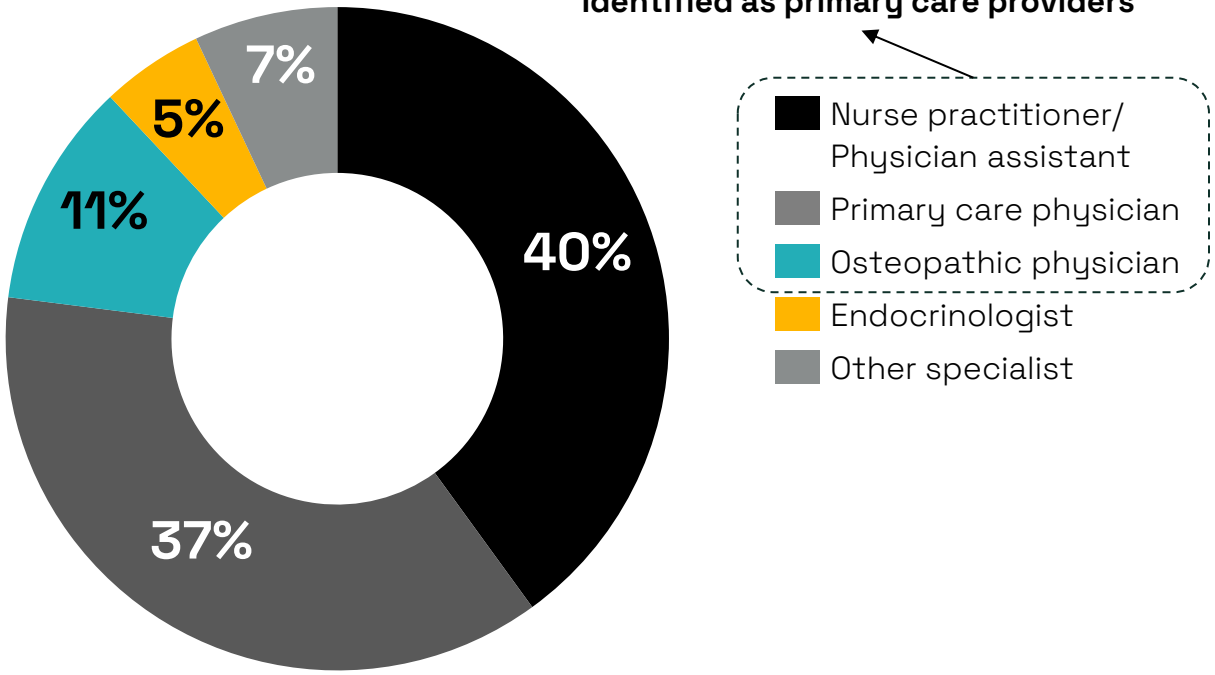
Primary care leads; specialty still emerging

~90% of GLP-1 prescriptions for weight management are driven by primary care providers[1,a]



Identified as primary care providers

- Nurse practitioner/ Physician assistant
- Primary care physician
- Osteopathic physician
- Endocrinologist
- Other specialist

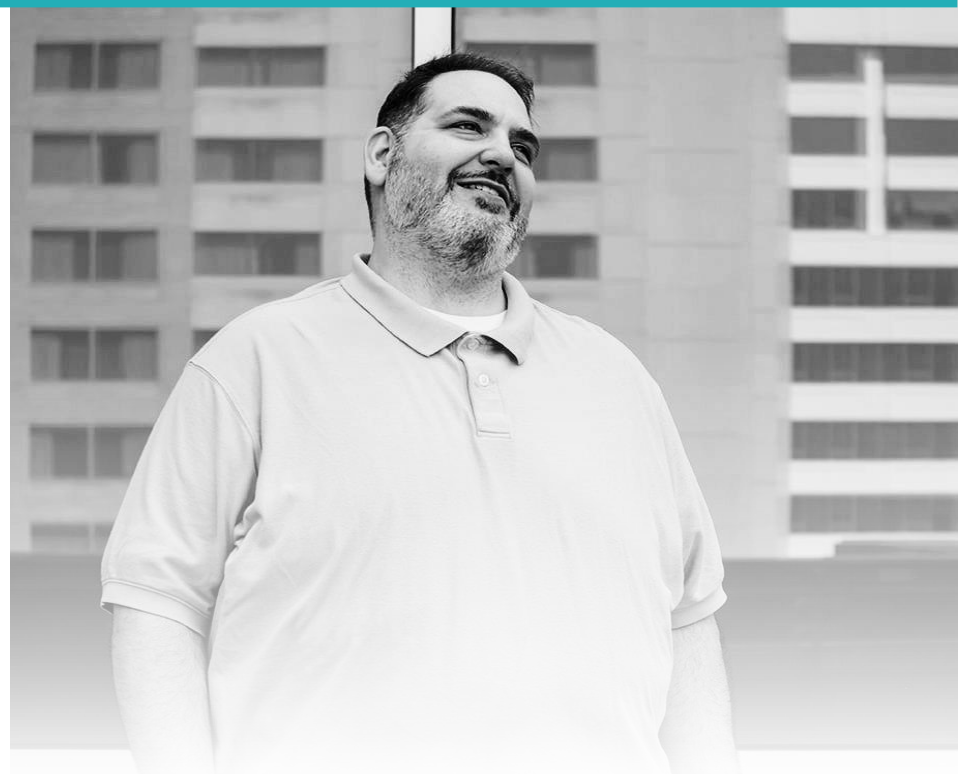


Image is illustrative, no associations implied.
[a]Primary care physicians include internal medicine, general practice, and family practice. Other specialists include cardiology, obstetrics/gynecology, general surgery, emergency medicine, geriatrics, and pediatrics.
Sources: [1]IQVIA National Prescription Audit, MAT October 2025.
GLP-1=glucagon-like peptide-1.

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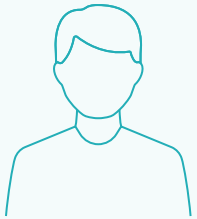

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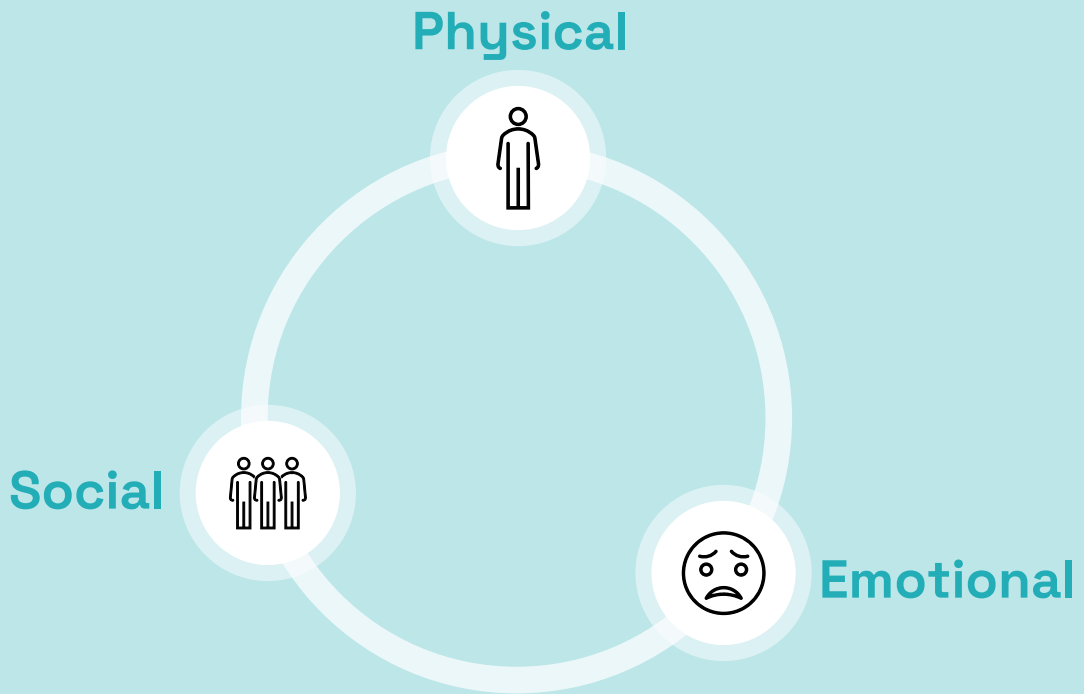
Healthier version of themselves, not healthiest

Decisions driven by more than clinical needs



61% of users in the U.S. self-refer[1]

Unprecedented willingness to pay out of pocket

Highly **individualized** and **cyclical journeys**

Source: [1]Ipsos Obesity and Cardiometabolic Therapy Monitor Q2 2025.

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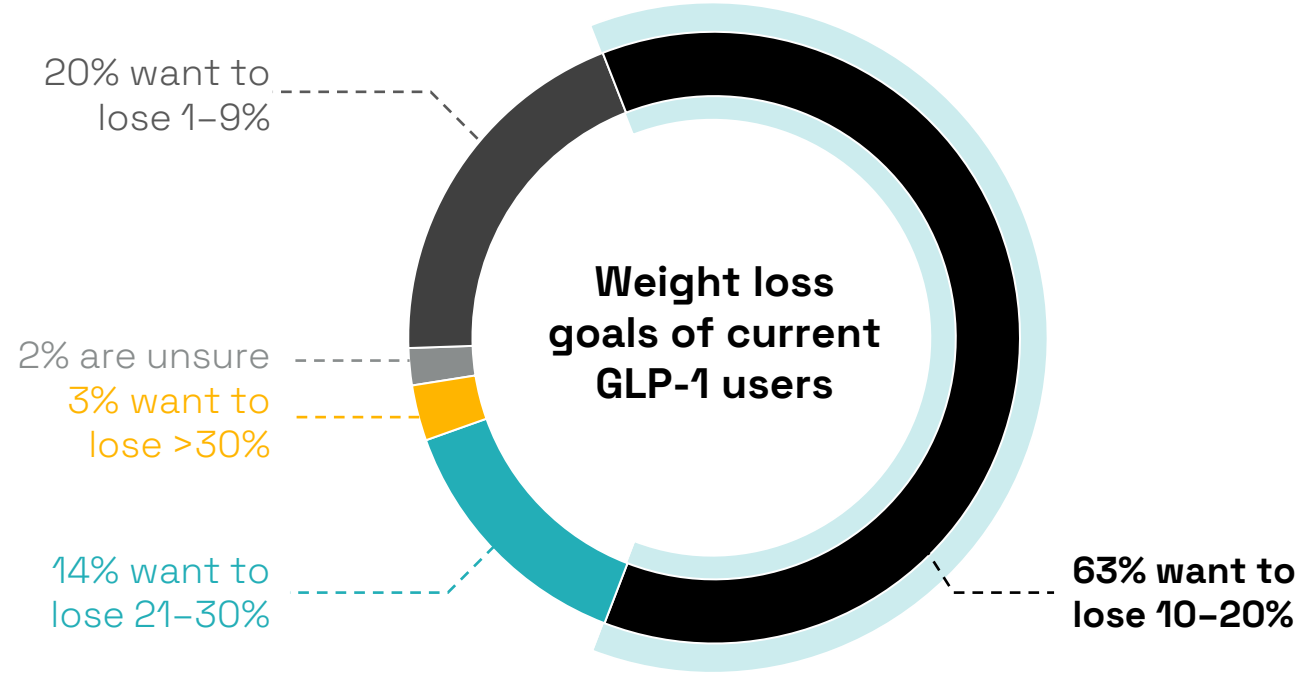
Desired weight loss contradicts *Weight loss Olympics*

>80% of GLP-1 users want to lose up to 20% of their body weight

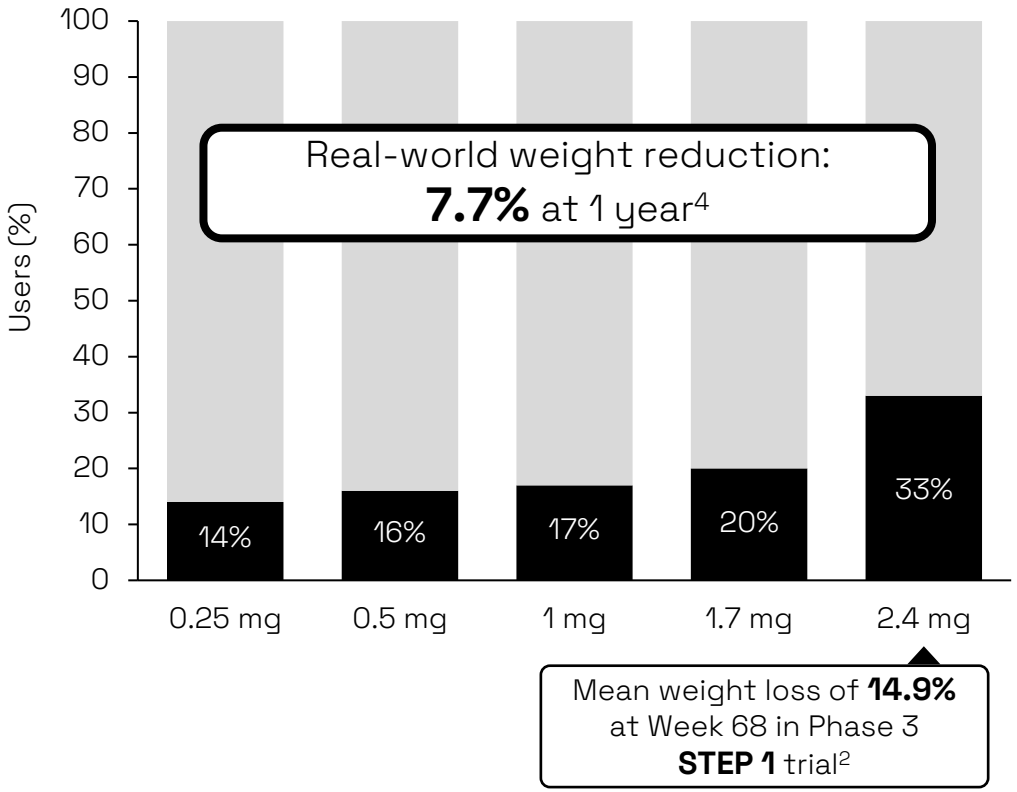


Source: LifeSci Capital Survey May 2024 (N=819).
GLP-1=glucagon-like peptide-1.

GLP-1 efficacy: real world vs. clinical trials

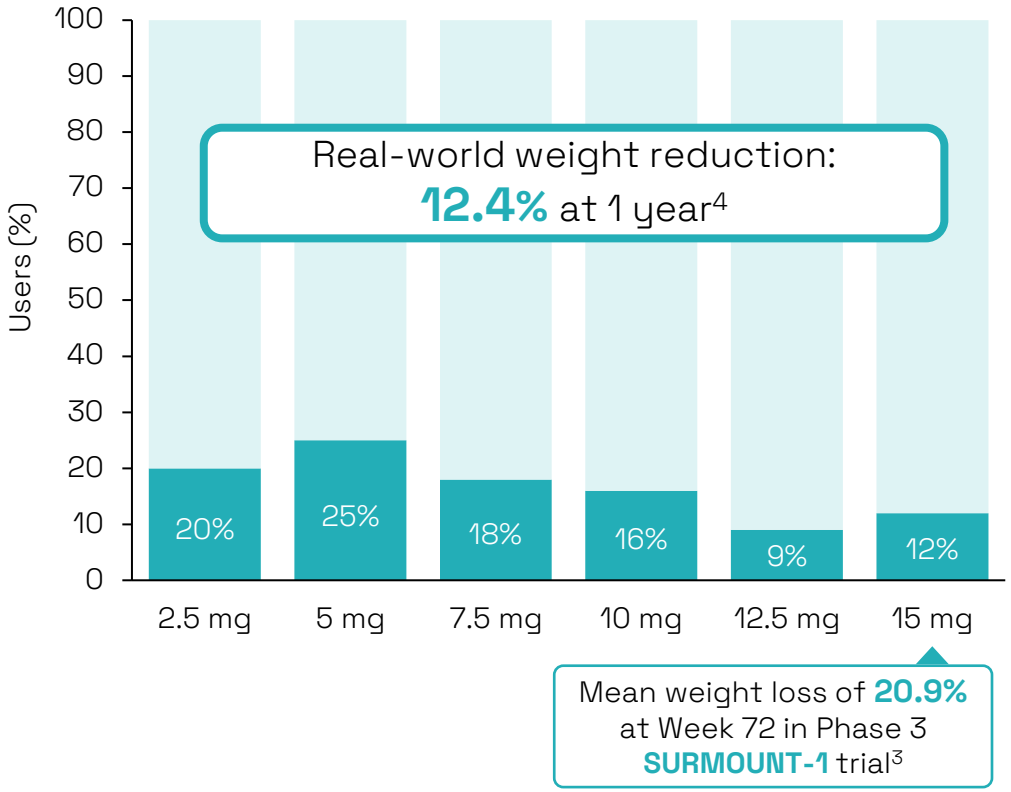
ONCE-WEEKLY wegovy® semaglutide injection 2.4 mg

Real-world use of Wegovy by dose[1]



zepbound™ (tirzepatide) injection

Real-world use of Zepbound by dose[1]



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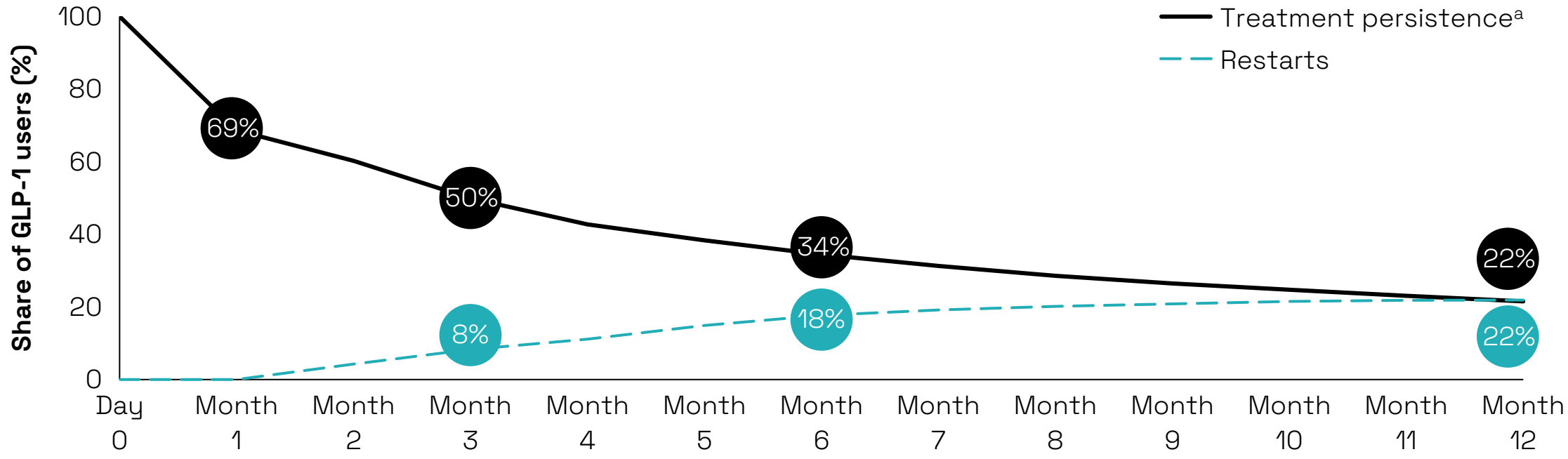
Sources: [1]IQVIA National Prescription Audit, MAT October 2025; [2]Wilding et al. N Engl J Med 2021;384(11):989–1002; [3]Jastreboff et al. N Engl J Med 2022;387(3):205–216; [4]Real-World GLP-1 Weight-Loss Results Differ From Trials - Medscape - June 10, 2025.
GLP-1RA=glucagon-like peptide-1 receptor agonist.

Poor treatment persistence and frequent restarts in the real world



Enhancing weight loss **experience** is critical to improve long-term treatment persistence and change the trajectory of the obesity epidemic

[a]Includes a 30-day grace period. A grace period is an allowed number of days after a prescription runs out during which a patient is still considered on therapy.
Source: IQVIA LAAD DATA Q4 2023–Q4 2024.
GLP-1RA=glucagon-like peptide-1 receptor agonist.

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Gastrointestinal adverse effects primary reason for discontinuation

Reasons given by GLP-1 users for negative experience with current treatments for obesity[1]

49%: Adverse effects

32%: Cost concerns

19%: Access

Top five adverse effects prompting discontinuation[2]

- **Nausea**
- **Vomiting**
- **Diarrhea**
- **Fatigue**
- **Headache**

Sources: [1]IQVIA Social Intelligence Report June 2025, US/UK (N=11,431); [2]Ipsos Obesity Consumer Monitor. 4,200 consumers in US providing perceptions online in Q4 2024. Data are © Ipsos 2025, all rights reserved.
GLP-1=glucagon-like peptide-1; GLP-1RA=glucagon-like peptide-1 receptor agonist.

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Zealand Pharma poised to lead in highest unmet needs

Enhanced weight loss experience to **improve treatment persistence**	**Petrelintide[a]**
New foundational MoA, **redefining the standard of care** in weight management	**Petrelintide[a]**
Targeted effects on obesity-related **comorbidities**	**Survodutide[b], petrelintide[a], petrelintide/CT-388 FDC[a]**
Fixed-dose combinations for specific segments needing additional benefits beyond monotherapy	**Petrelintide/CT-388 FDC[a]**
Expand **usability** through less frequent dosing and/or route of administration	**Next wave of innovation**

[a]Zealand Pharma has a collaboration and license agreement with Roche for petrelintide, including co-development and co-commercialization in the U.S. and Europe.
[b]Survodutide is licensed to Boehringer Ingelheim from Zealand Pharma, with Boehringer solely responsible for development and commercialization globally.
MoA=mechanism of action; FDC=fixed-dose combination.

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Strategic roadmap toward becoming a fully-integrated biotech company

2024-2025

- Established core commercial capabilities
- Petrelintide partnership with Roche
  Co-development and co-commercialization, incl. strategic optionality and flexibility (geographies, products)

Roche is responsible for commercial manufacturing and supply

~2026-2028

Scaling alongside Roche, to build customer-centric commercial and medical affairs footprint

2029 and beyond

Harness launchpad for petrelintide as force multiplier for future medicines

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Zealand Pharma has collaboration and license with Roche for petrelintide, including co-development and co-commercialization in the U.S. and Europe.

3.

Survodutide: the next frontier in obesity & MASH (GCG/GLP-1)

Carel Le Roux & David Kendall - including Q&A – 1:50-2:25

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Survodutide: the next frontier in obesity & MASH (GCG/GLP-1)

Carel Le Roux, MBChB, MSC, FRCP, FRCPath, PhD
Professor of Experimental Pathology

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Treatment of obesity extends far beyond weight loss

Source: Joseph Wright of Derby. The Alchemist Discovering Phosphorus. 1771. Derby Museum and Art Gallery.

Oxyntomodulin is the scientific foundation for the investigation of survodutide

Oxyntomodulin

- Hormone with dual agonism at GCG and GLP-1 receptors that **reduces body weight by increasing energy expenditure and regulating appetite**[1]
- Clinical application is limited due to a short half-life[2]

Survodutide is a 29-amino-acid peptide **derived from oxyntomodulin** and **effectively binds to GCG and GLP-1 receptors**[3]

Deliberately designed with strong bias toward GLP-1 receptor[3]
(8:1 receptor bias vs. glucagon)

Extended half-life for once-weekly administration achieved by amino acid substitutions[3]

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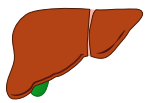
Sources: [1]Wynne et al. Int J Obes (Lond) 2006;30(12):1729–1736; [2]Schjoldageret al. Eur J Clin Invest 1988;18(5):499–503; [3]Zimmermann et al. Mol Metab 2022;66:101633.
GCG=glucagon; GLP-1=glucagon-like peptide-1.

Glucagon/GLP-1 dual agonism offers coordinated regulation of energy expenditure and energy intake

GCG/GCGR

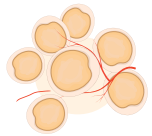
↑ Energy expenditure (metabolic rate)

Liver (direct)



Fatty acid oxidation[1]
Glycogenolysis[2]
Gluconeogenesis[2]

Adipose tissue (indirect)

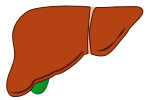


Lipolysis[3]

+ GLP-1/GLP-1R[4]

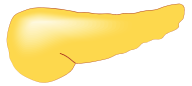
↑ Insulin secretion ↓ Food intake

Liver (indirect)



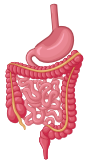
Steatosis[5]

Pancreas



Glucose-dependent insulin secretion

GI tract



Gastric emptying

Brain

Food intake/appetite

GLP-1 has a glucagon-suppressive effect[4]

Glucagon and GLP-1 receptor dual agonism may achieve **superior body weight reduction** relative to GLP-1 mono agonists, with **equivalent glycemic control** and **direct, enhanced effects on the liver**

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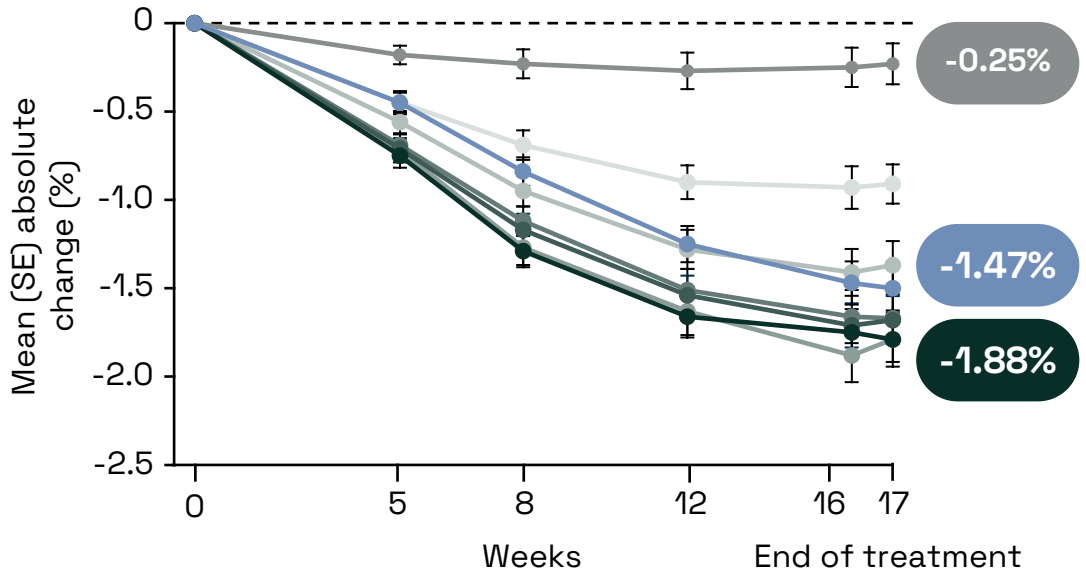
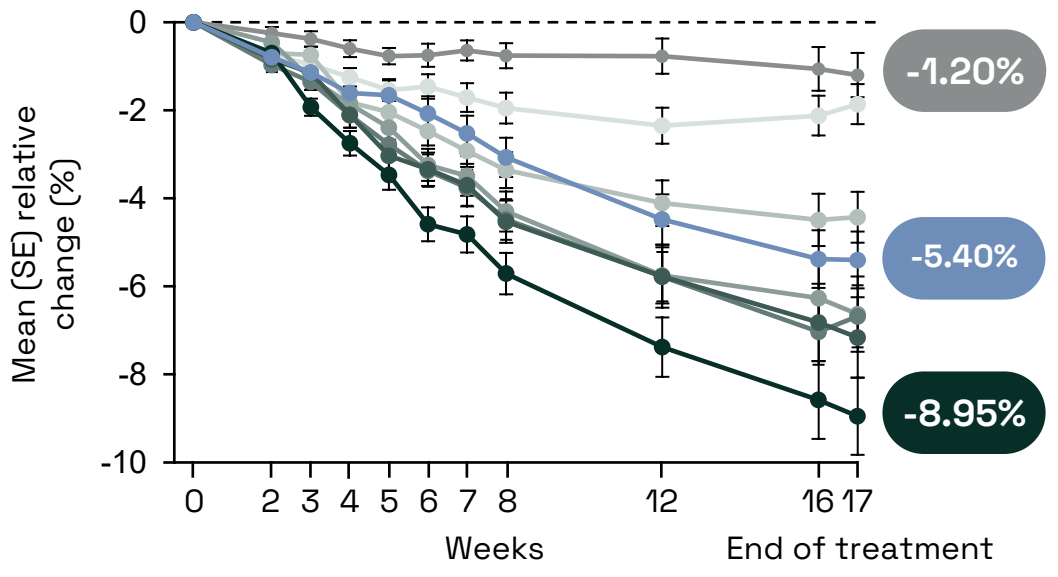
Sources: [1]Pégorier et al. Biochem J 1989;264(1):93–100; [2]Cherrington. Diabetes 1999;48(5):1198–1214;
[3]Del Prato et al. Obes Rev 2022;23(2):e13372; [4]Flint et al. J Clin Invest 1998;101(3):515–520; [5]Nevola et al. Int J Mol Sci 2023;24(2):1703.
GCG=glucagon; GCGR=glucagon receptor; GI=gastrointestinal; GLP-1=glucagon-like peptide-1; GLP-1R=glucagon-like peptide-1 receptor.

In a 16-week Phase 2 trial in T2D, survodutide effectively reduced HbA1c and body weight

Change in HbA1c



Change in 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

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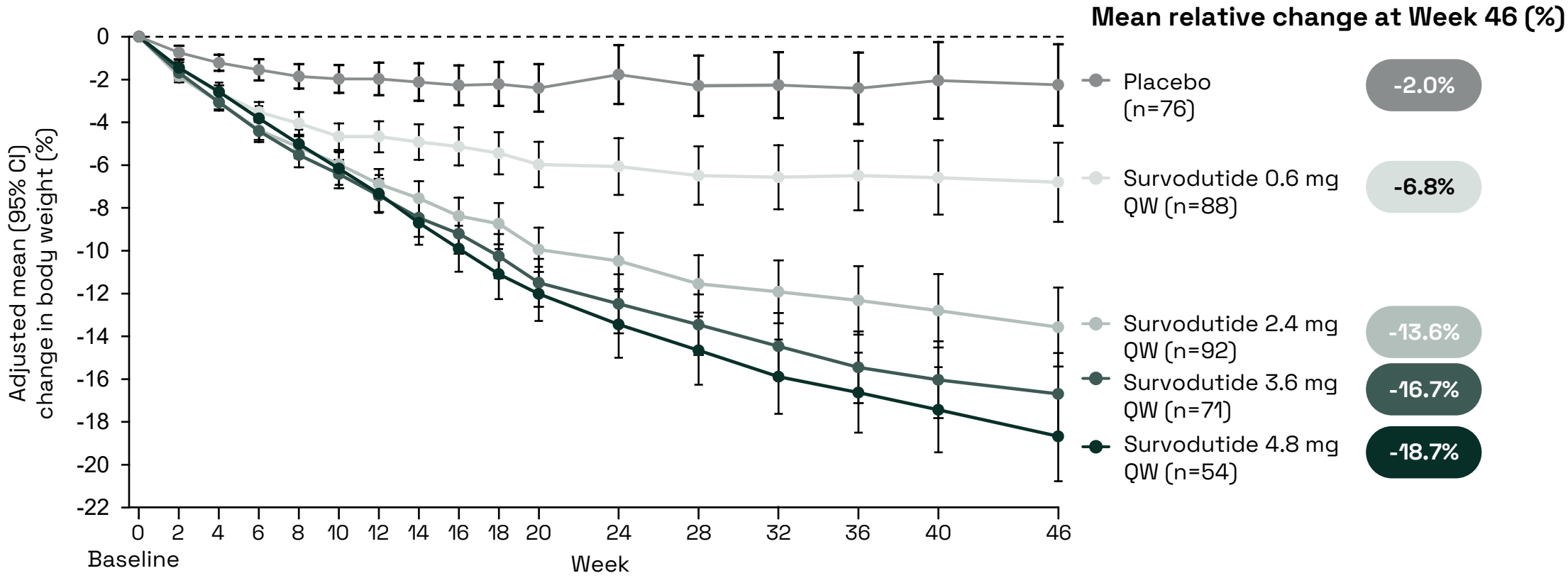
[a]The semaglutide arm was open-label.
Source: Figures adapted from Rosenstock. Presentation at ObesityWeek, November 1–4, 2022, San Diego, CA.
BIW=twice-weekly; GLP-1R=glucagon-like peptide-1 receptor; HbA1c=hemoglobin A1c; QW=once-weekly; SE=standard error; T2D=type 2 diabetes.

ZEALAND PHARMA

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

Randomized, double-blind, placebo-controlled Phase 2 trial of survodutide in people with overweight or obesity

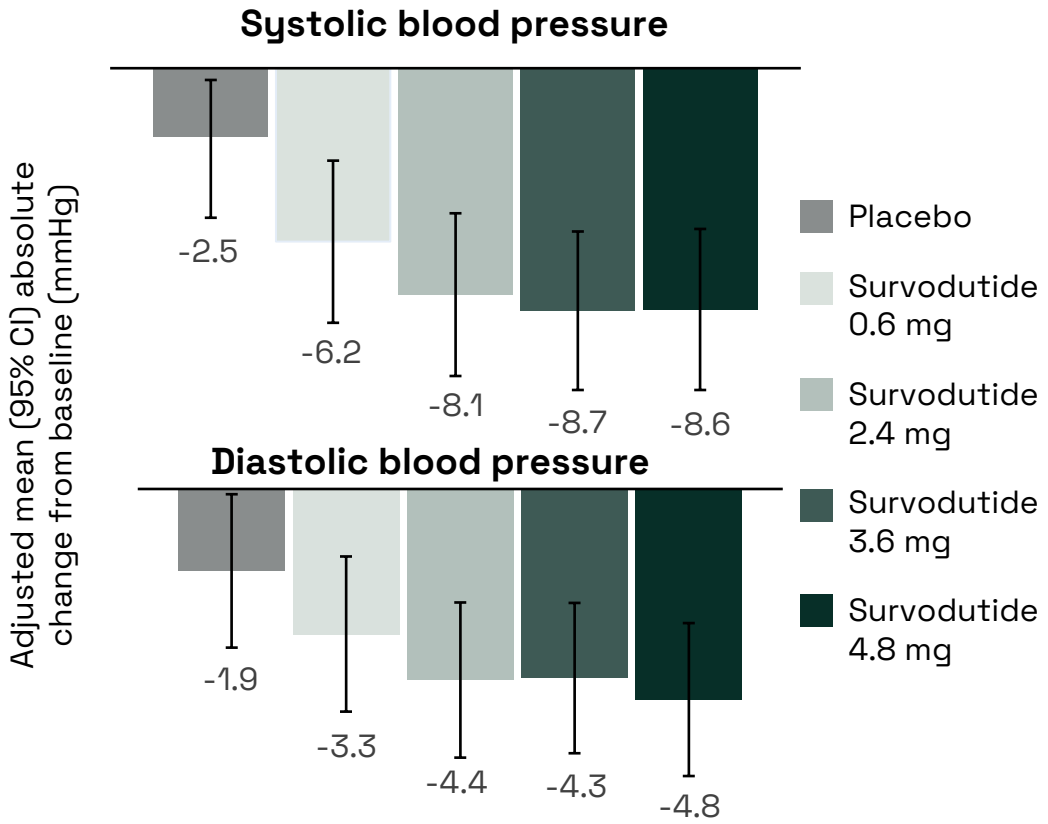


Survodutide is licensed to Boehringer Ingelheim from Zealand Pharma, with Boehringer solely responsible for development and commercialization globally.
Source: Figure adapted from Le Roux et al. Oral presentation (51-OR) at ADA 83rd Scientific Sessions, June 23–26, 2023, San Diego, CA.
Actual treatment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

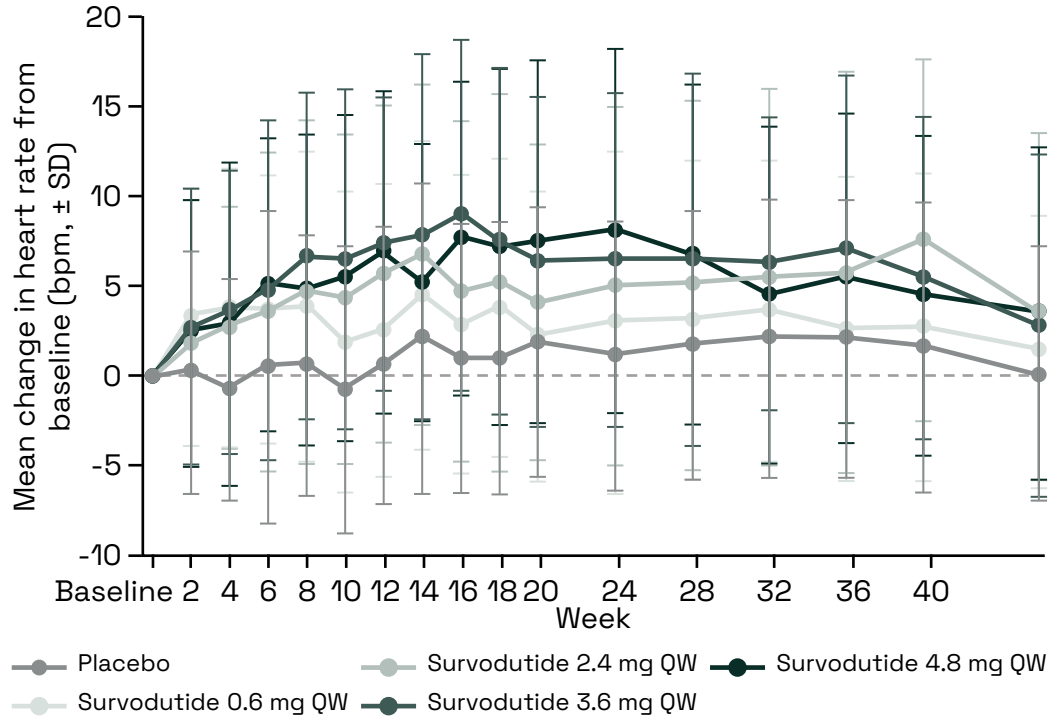
ZEALAND PHARMA

Survodutide substantially reduced blood pressure, with heart rate effects consistent with GLP-1RAs

Absolute change in blood pressure at Week 46[1]



Absolute change in heart rate (bpm)[2]



Week 46: +2.7 bpm with survodutide (pooled) vs +0.1 bpm placebo

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Sources: [1]Figures adapted from Le Roux. Presentation at the 59th EASD Annual Meeting, October 2–6, 2023, Hamburg, Germany; [2]Supplement to Le Roux et al. Lancet Diabetes Endocrinol 2024;12(3):162–173 (reprinted with permission from Elsevier, copyright 2024).

bpm=beats per minute; CI=confidence interval; GLP-1RA=glucagon-like peptide-1 receptor agonist; QW=once weekly; SD=standard deviation.

ZEALAND PHARMA

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

TEAE, n (%)[a]	Survodutide 3.6 mg (n=77)	Survodutide 4.8 mg (n=77)	Placebo (n=77)
GI TEAE			
Nausea[b]	48 (62.3)	49 (63.6)	15 (19.5)
Vomiting[b]	26 (33.8)	27 (35.1)	4 (5.2)
Diarrhea[b]	18 (23.4)	15 (19.5)	8 (10.4)
Constipation[b]	19 (24.7)	20 (26.0)	4 (5.2)
Leading to treatment discontinuation	19 (24.7)	22 (28.6)	3 (3.9)
GI-related	13 (16.9)	20 (26.0)	1 (1.3)
Serious	6 (7.8)	4 (5.2)	5 (6.5)
Investigator defined, drug-related TEAE	62 (80.5)	62 (80.5)	29 (37.7)
Serious, drug-related TEAE	2 (2.6)	0 (0.0)	0 (0.0)

As expected, **GI AEs** were the **most frequent TEAEs**

Most treatment discontinuations occurred during the **rapid dose escalation phase**

More **flexible and gradual dose escalation** (every 4 weeks) implemented in **Phase 3** trials

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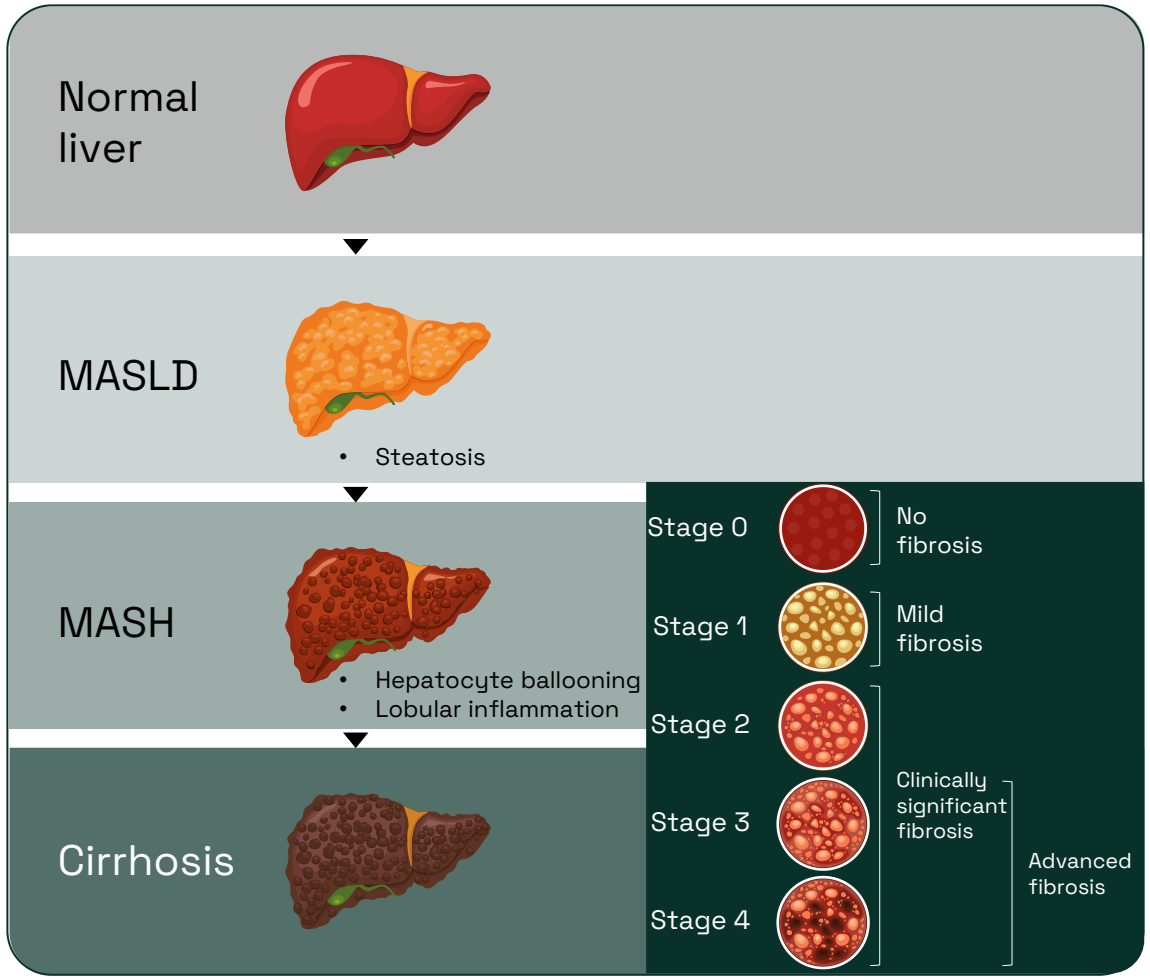
[a]Table includes only the two highest dose cohorts and is based on the treated set and presented according to planned treatment; [b]TEAEs listed according to preferred term and occurred in ≥15% participants in any treatment arm.
Source: Table adapted from Le Roux et al. Oral presentation (51-OR) at ADA 83rd Scientific Sessions, San Diego, June 23–26, 2023.
AE=adverse event; GI=gastrointestinal; TEAE=treatment-emergent adverse event.

ZEALAND PHARMA

MASH is among the most serious obesity-related comorbidities with urgent need for better treatments



Need for more and better treatment options for people with overweight/obesity and MASH

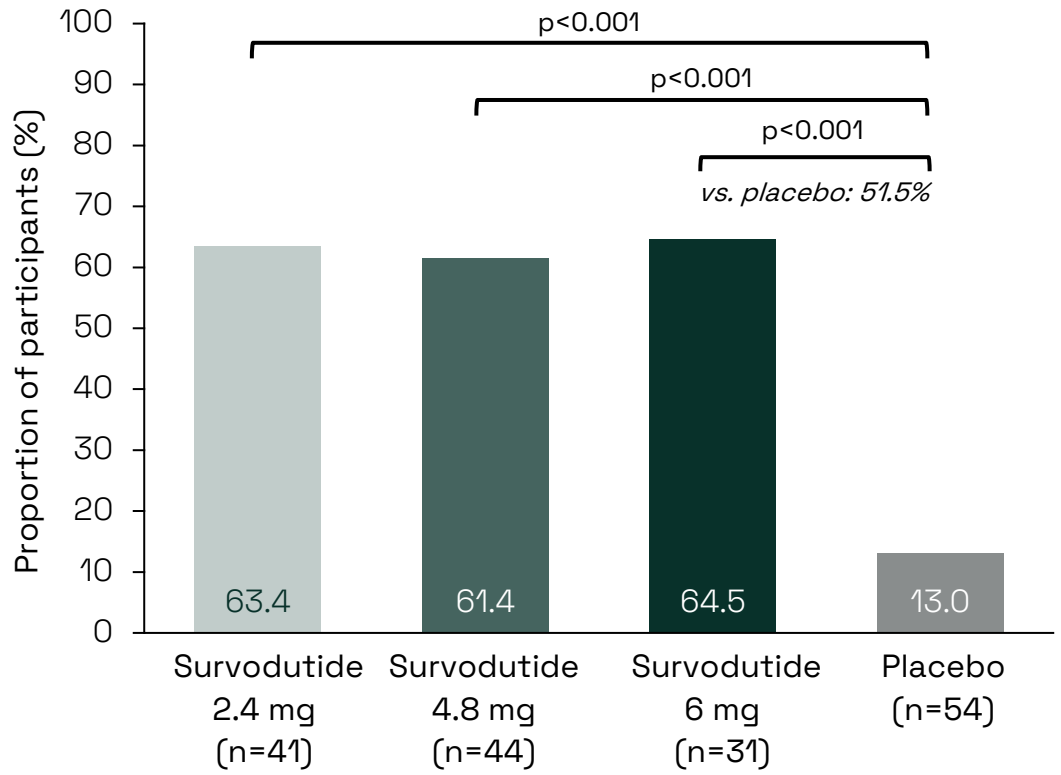
- One of the most **prevalent obesity-related comorbidities** (**75%** of people with overweight and obesity have **MASLD** and **34%** have **MASH**)[1]
- Expected to soon become the **leading cause** for **liver transplantation in the U.S.**[2]
- Increased risk of **serious complications**, incl. hepatocellular carcinoma and liver-related and all-cause mortality[3,4]
- **Two therapies approved** in the U.S. today with relatively **modest treatment effect** in Phase 3 on fibrosis improvement

Sources: Figure adapted from 1–4: [1]Rinella et al. Hepatology 2023;77(5):1797–1835; [2]Younossi & Henry. JHEP Rep 2021;3(4):100305; [3]Targher et al. Gut 2020;69(9):1691–1705; [4]Ng et al. Clin Gastroenterol Hepatol 2023;21(4):931–939; [5]Quek et al. Lancet Gastroenterol Hepatol 2023;8(1):20–30; [6]Rinella et al. BMC Gastroenterol 2022;22(1):335.
MASH=metabolic dysfunction-associated steatohepatitis; MASLD=metabolic dysfunction-associated steatotic liver disease.

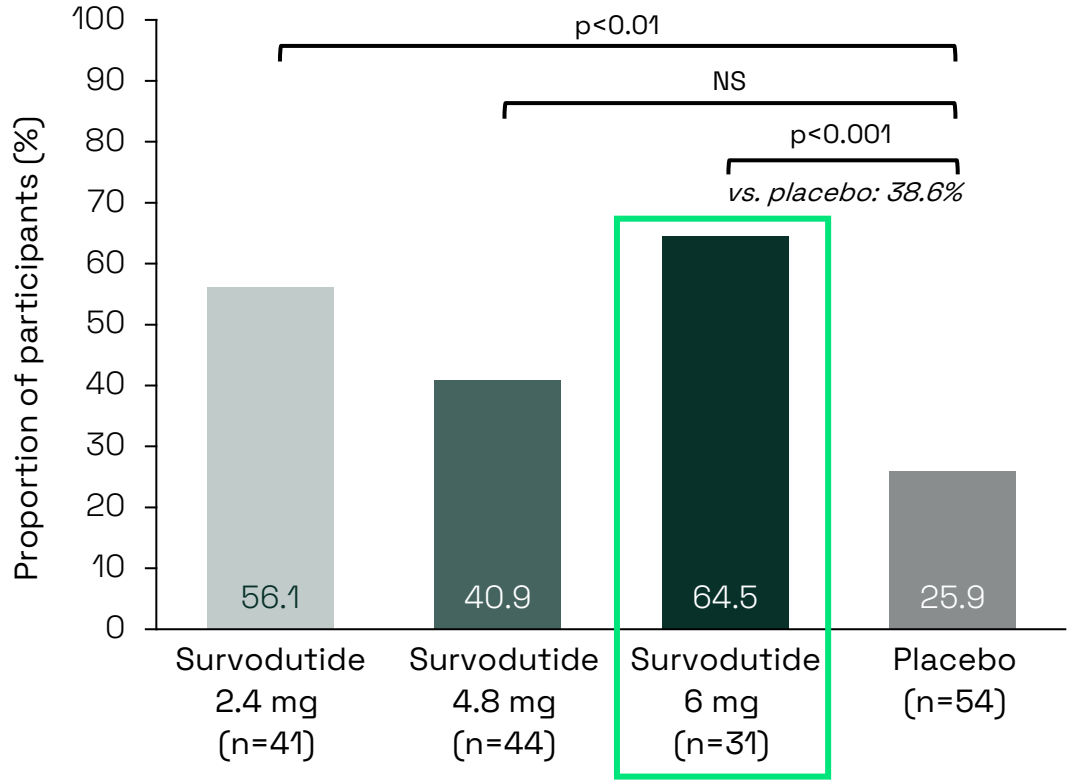
ZEALAND PHARMA

Survodutide demonstrated best-in-disease potential in the 48-week Phase 2 trial in people with MASH[a]

MASH resolution with no worsening in fibrosis
Paired biopsy results (F2/F3)



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



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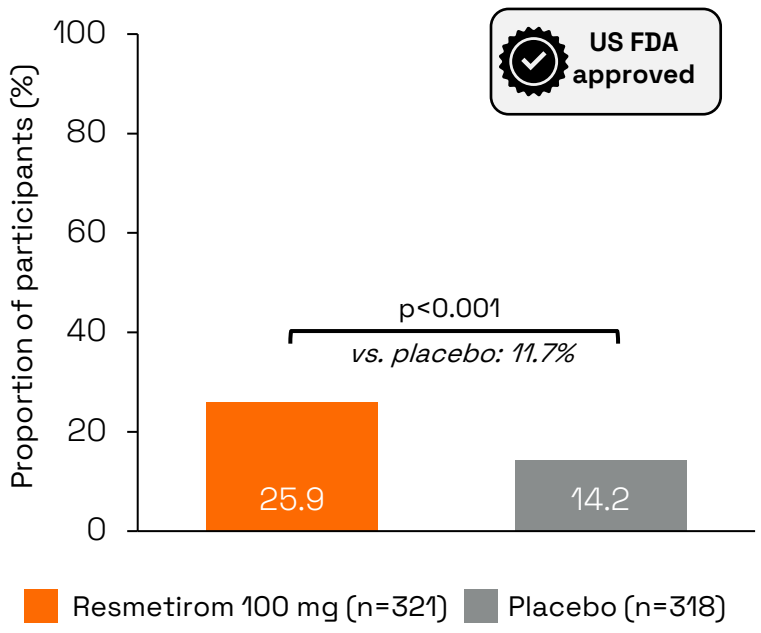
[a]Post hoc analysis in people with fibrosis Stage F2–F3 after 48 weeks of actual treatment.
Sources: Figures adapted from Sanyal et al. N Engl J Med 2024;391(4):311–319 (reprinted with permission from Massachusetts Medical Society); Sanyal et al. Oral presentation at EASL Congress, June 5–8, 2024, Milan, Italy.
MASH=metabolic dysfunction-associated steatohepatitis; NS=not significant.

ZEALAND PHARMA

There are currently two therapies approved in the U.S. for the treatment of MASH with liver fibrosis

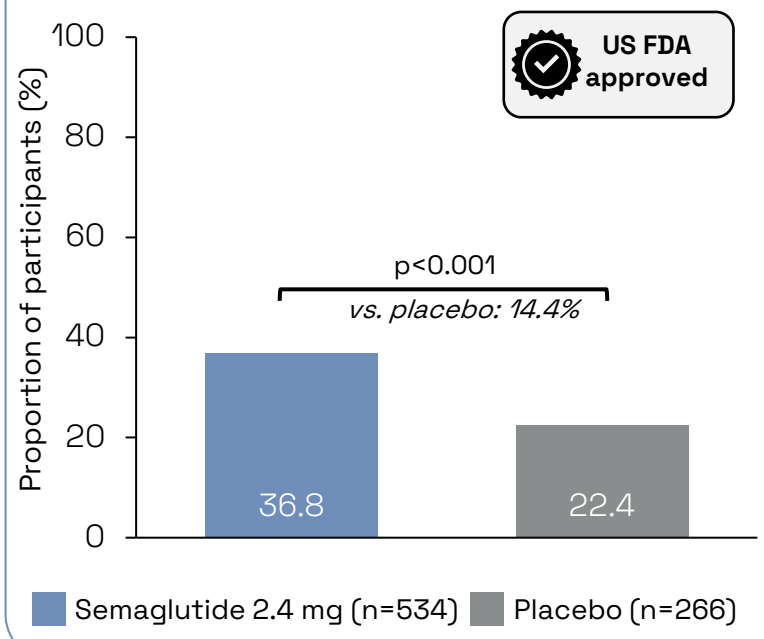
Phase 3 trial (MAESTRO-NASH) with resmetirom in people with MASH (F1B-F3)[1,a]

Improvement in liver fibrosis with no worsening of MASH at Week 52



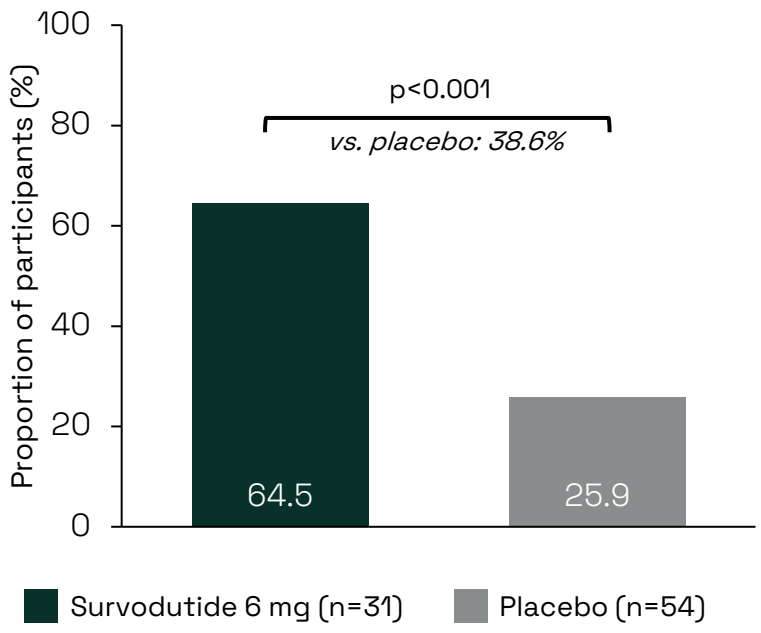
Phase 3 (ESSENCE) trial with semaglutide in people with MASH (F2/F3)[2,b]

Improvement in liver fibrosis with no worsening of MASH at Week 72



Phase 2 trial with survodutide in people with MASH (F2/F3)[3,c]

Improvement in liver fibrosis with no worsening of MASH at Week 48



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No head-to-head trial has been conducted with survodutide against the other products. Differences exist in trial designs and conditions, and caution should be exercised when comparing data across trials.

[a]5% of participants enrolled in the MAESTRO-NASH trial were stage F1B at baseline. Paired biopsy results only; Modified intention-to-treat analysis; [b]Missing data imputed as placebo responders; Treatment policy estimand; [c]Paired biopsy results only; Actual treatment analysis.

Sources: Figures adapted from [1]Harrison et al. N Engl J Med 2024;390:497–509 (reprinted with permission from Massachusetts Medical Society); [2]Sanyal et al. N Engl J Med 2025;392:2089–2099 (reprinted with permission from Massachusetts Medical Society); [3]Sanyal et al. N Engl J Med 2024;391(4):311–319 (reprinted with permission from Massachusetts Medical Society).

MASH=metabolic dysfunction-associated steatohepatitis; FDA=Food and Drug Administration.

ZEALAND PHARMA

Glucagon/GLP-1: Holistic approach to metabolic health and potential next frontier in obesity and MASH

Key takeaways

Coordinated regulation of energy intake (GLP-1) and energy expenditure (glucagon)

Robust clinical data with survodutide across comprehensive Phase 2 program with separate trials in type 2 diabetes, obesity, and MASH

- Delivers powerful, clinically meaningful weight reduction
- Demonstrates strong glucose-lowering effects
- Improves key cardiovascular risk factors
- Achieves breakthrough liver fibrosis improvement in MASH
- Safety profile in line with GLP-1RA-based therapies, and no unexpected findings

Potential for competitive body weight reduction and direct, enhanced effects on the liver

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GLP-1=glucagon-like peptide-1; GLP-1RA=glucagon-like peptide-1 receptor agonist; MASH=metabolic dysfunction-associated steatohepatitis.

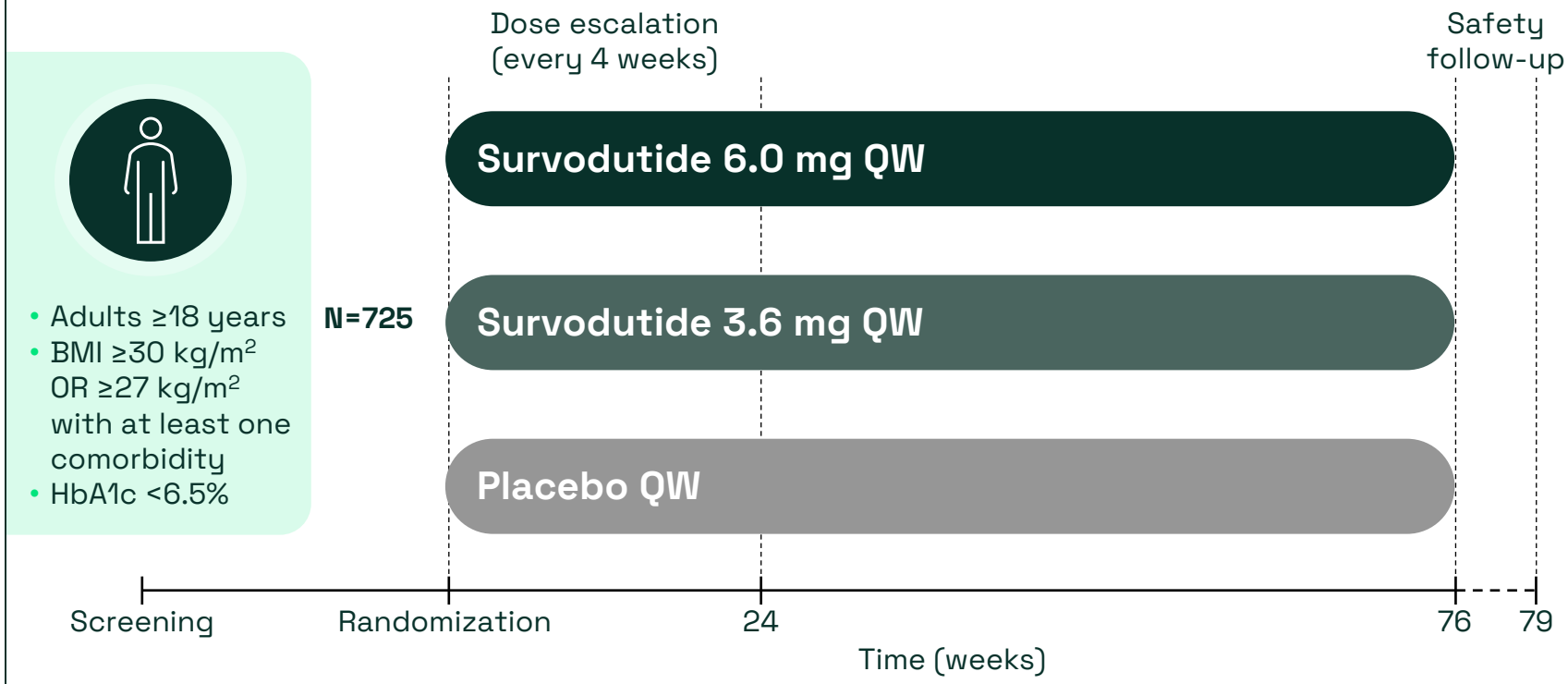
Survodutide in Phase 3 for obesity and MASH

David Kendall
Chief Medical Officer

ZEALAND PHARMA

We expect topline results from the Phase 3 SYNCHRONIZE™-1 trial with survodutide in H1 2026

Randomized, double-blind, placebo-controlled Phase 3 trial in people with overweight or obesity without T2D[1]



Primary endpoint:

- Percentage change in body weight from baseline to week 76
- Body weight reduction ≥5% from baseline to week 76

Baseline characteristics[2]:

Age	47.1
Female, %	59.4
Body weight, kg	108.8
BMI, kg/m²	37.9

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Sources: [1]Wharton et. al, Obesity Silver Spring 2024;33(1):67–77 (adapted with permission from Wiley); [2]Le Roux et al. Diabetes Obes Metab 2025; doi: 10.1111/dom.70196.
BMI=body mass index; HbA1c=hemoglobin A1c; QW=once weekly; T2D=type 2 diabetes.

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Results from the Phase 3 SYNCHRONIZE™ program may pave the way for regulatory submissions in 2026

Large, global Phase 3 program in obesity

- **SYNCHRONIZE™-1[1]:** Overweight/obesity w/o T2D (N=~720)
- **SYNCHRONIZE™-2[2]:** Overweight/obesity with T2D (N=~750)
- **SYNCHRONIZE™-CVOT[3]:** Long-term CV safety in patients with obesity and established CVD/CKD or risk factors for CVD (N=~5,500)
- **SYNCHRONIZE™-MASLD[4]:** Overweight/obesity with confirmed or presumed MASH (N=~250)
- **SYNCHRONIZE™-JP[5]:** In Japanese participants (N=~270)
- **SYNCHRONIZE™-CN[6]:** In Chinese participants (N=~300)

We expect Phase 3 data from key trials in the SYNCHRONIZE™ program to be reported and presented in detail at scientific meetings throughout 2026

Boehringer Ingelheim could be the third company to market in the U.S. and Europe in this new era of weight-loss therapies – with a first-in-class glucagon/GLP-1 receptor dual agonist

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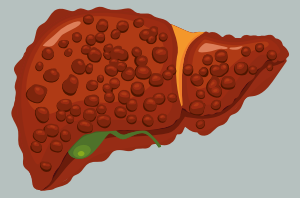
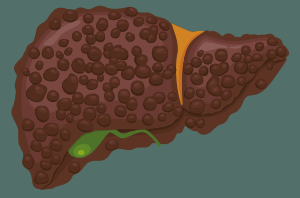
Sources: [1]ClinicalTrials.gov (NCT06066515); [2]ClinicalTrials.gov (NCT06066528); [3]ClinicalTrials.gov (NCT06077864); [4]ClinicalTrials.gov (NCT06309992); [5]ClinicalTrials.gov (NCT06176365); [6]ClinicalTrials.gov (NCT06214741).
CKD=chronic kidney disease; CV=cardiovascular; CVD=cardiovascular disease; GLP-1=glucagon-like peptide-1; MASLD=metabolic dysfunction-associated liver disease; MASH=metabolic dysfunction-associated steatohepatitis; T2D=type 2 diabetes.

ZEALAND PHARMA

Largest ever Phase 3 program in MASH with an incretin-based therapy was initiated in October 2024

	Inclusion criteria	Study design	Primary endpoint
LIVERAGE[1] Efficacy and safety in participants with MASH and fibrosis (F2/F3) 	• Diagnosis of MASH[a] and biopsy-proven fibrosis stage F2–F3 **Granted Breakthrough Therapy Designation by the US FDA**[2]	• N=1,800 • 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 participants with MASH and cirrhosis (F4) 	• Diagnosed compensated MASH cirrhosis[b]	• N=1,590 • 6.0 mg or placebo • Trial duration: Up to 4.5 years	• Time to first occurrence of liver-related events or all-cause mortality

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[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(2):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.
Sources: [1]LIVERAGE, ClinicalTrials.gov (NCT06632444), accessed November 2025; [2]Boehringer Ingelheim press release October 8, 2024; [3]LIVERAGE-Cirrhosis, ClinicalTrials.gov (NCT06632457), accessed November 2025.
BMI=body mass index; CSPH=clinically significant portal hypertension; FDA=Food and Drug Administration; MASH=metabolic dysfunction-associated steatohepatitis; MELD=Model for End-stage Liver Disease.

ZEALAND PHARMA

Survodutide holds potential as a leading therapy for people with overweight/obesity and MASH

MoA – Dual agonism leveraging GCGR and GLP-1R to achieve effective body weight reduction and direct liver effects	**Registrational trials**
Obesity – potential for competitive weight loss and improved glycemic control	**SYNCHRONIZE™ -1, 2, CN & JP**
MASH – potential best-in-disease therapy with direct effect of glucagon on the liver, supported by groundbreaking Phase 2 data[1]	**LIVERAGE & LIVERAGE-Cirrhosis**
Cardiovascular disease – potential for improvement in key CV risk factors, supported by solid BP reductions in Phase 2 trials[1,2]	**SYNCHRONIZE™ -CVOT**

SYNCHRONIZE™ -MASLD

In people with overweight/obesity, expected to read out in 2026

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Sources: [1]Sanyal et al. N Engl J Med 2024;391(4):311–319; [2]Le Roux et al. Lancet Diabetes Endocrinol 2024;12(3):162–173.
BP=blood pressure; CN=China; CV=cardiovascular; CVOT=cardiovascular outcomes trial; GCGR=glucagon receptor; GLP-1R=glucagon-like peptide-1 receptor; GLP-1RA=glucagon-like peptide-1 receptor agonist; JP=Japan; MoA=mechanism of action; MASH=metabolic dysfunction-associated steatohepatitis; MASLD=metabolic dysfunction-associated steatotic liver disease.

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Q&A

Survodutide

Adam Steensberg
David Kendall
Carel Le Roux

ZEALAND PHARMA

4.

Amylin: an emerging therapeutic class

Jonathan D. Roth & Louis J. Aronne – 2:25-3:05

1. The opportunity & our ambition
Adam Steensberg
1:05-1:25

2. The future of weight management
Eric Cox
1:25-1:50

3. Survodutide: the next frontier in obesity & MASH (GCG/GLP-1)
Carel Le Roux & David Kendall - including Q&A
1:50-2:25

4. Amylin: an emerging therapeutic class
Jonathan D. Roth & Louis J. Aronne
2:25-3:05

Break
3:05-3:45

5. Petrelintide: building the leading amylin franchise
David Kendall - including Q&A
3:45-4:20

6. Our engine: world's most valuable metabolic health pipeline
Utpal Singh
4:20-4:50

7. How we fund and scale this
Henriette Wennicke
4:50-5:00

8. Q&A and closing remarks
Adam Steensberg & team
5:00-5:30

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Amylin: an emerging class for weight management

Jonathan D. Roth, PhD
Metabolic researcher

Louis J. Aronne, MD, FACP, DABOM
Weill Professor of Medical Research at Weill Cornell Medicine

ZEALAND PHARMA

Amylin biology and mechanism of action

Jonathan D. Roth, PhD
Metabolic researcher

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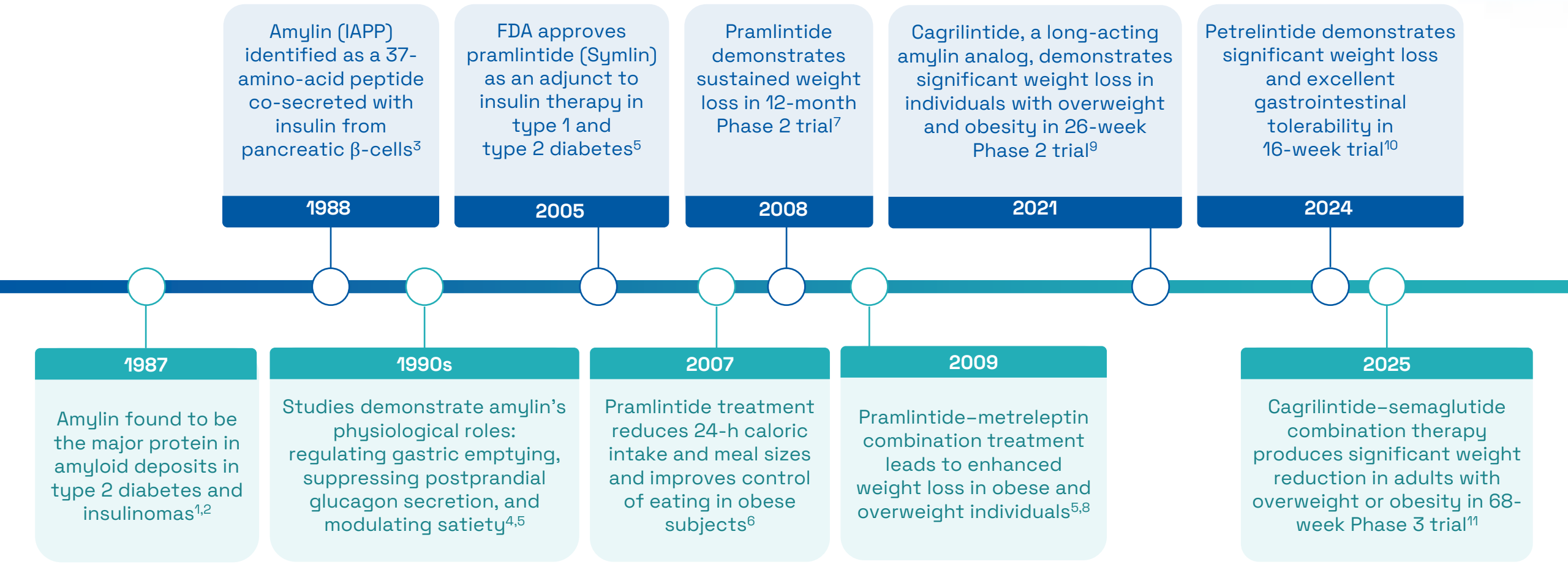
The discovery and development of amylin



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Sources: [1]Westermark et al. Proc Natl Acad Sci USA 1987;84(11):3881–3885; [2]Cooper et al. Proc Natl Acad Sci USA 1987;84(23):8628–8632; [3]Moore & Cooper. Biochem Biophys Res Commun 1991;179(1):1–9; [4]Lutz. Appetite 2022;172:105965; [5]Hay et al. Pharmacol Rev 2015;67(3):564–600; [6]Johnson et al. Diabetes 1991;40(3):310–314; [7]Smith et al. Am J Physiol Endocrinol Metab 2007;293(2):E620–E627; [8]Smith et al. Diabetes Care 2008;31(9):1816–1823; [9]Ravussin et al. Obesity (Silver Spring) 2009;17(9):1736–1743; [10]Lau et al. Lancet 2021;398(10317):2160–2172; [11]Heise et al. Presentation at ObesityWeek, November 3–6 2024; San Antonio, TX; [12]Garvey et al. N Engl J Med 2025;393(7):635–647.
IAPP=islet amyloid polypeptide.

What is amylin?

Amylin is a 37-amino acid neuroendocrine peptide hormone[1,2]

Co-secreted with **insulin** by pancreatic **β-cells** in response to ingested food[2]

Native amylin has **strong fibrillating properties**[3]

The **$t_{1/2}$** of native amylin is approximately **12 minutes** in humans[4,5]

Amylin has a **disulfide bridge** at the **N-terminal**, which is important for **receptor activation**[6,7]

The amylin receptor is part of the **calcitonin receptor family**, which consists of **different receptors** and their **subunits**, including:[6,7]

- Calcitonin receptor (CTR)
- Calcitonin receptor-like receptor (CLR)
- Receptor activity-modifying protein (RAMP) (1–3)
- Amylin receptor (AMY-R) (1–3)
- Adrenomedullin receptor (ADM-R) (1–2)
- Calcitonin gene-related peptide receptor (CGRP-R)

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Sources: [1]Hay et al. Pharmacol Rev 2015;67(3):564–600 (adapted with permission from Wiley); [2]Lorenzo et al. Nature 1994;368(6473):756–760; [3]Bretherton-Watt et al. Diabetologia 1990;33(2):115–117; [4]Clodi et al. Am J Physiol 1998;274(5):E903–E908; [5]Bower & Hay. Br J Pharmacol 2016;173(12):1883–1898; [6]Barwell et al. Br J Pharmacol 2012;166(1):51–65.
$t_{1/2}$=half-life.

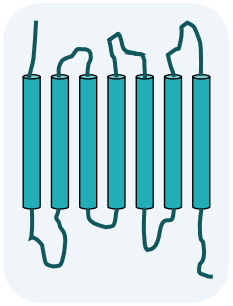
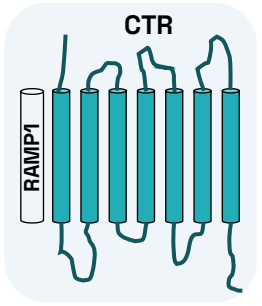
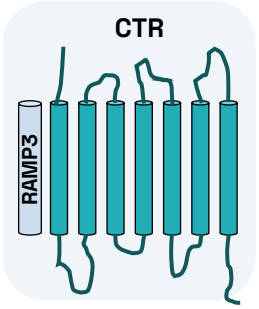
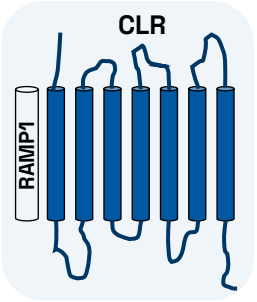
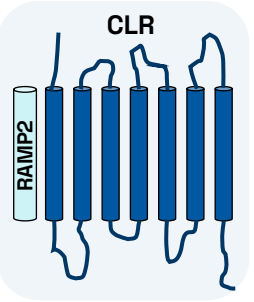
Amylin receptor biology is complex

Amylin receptors are members of the calcitonin receptor family[1]

Amylin receptors are heterodimeric – RAMPs alter CTR pharmacology from calcitonin-preferring to amylin-preferring receptors[2]

Different calcitonin family receptor subtypes – according to the RAMP combined with the CTR or CLR[3,4]

Receptors from the calcitonin family (non-exhaustive)[3,4]

	CTR	AMY1-R	AMY3-R	CGRP-R	ADM1-R
					
	Considered important for weight loss[5]	Considered important for weight loss[5]	Considered important for weight loss[5]	Potentially involved in migraine attacks[6]	Potentially associated with increased risk of cancer[7]
EC50[a] (pM)[5]					
Human calcitonin	33	140	1,110	>1,000-fold less potent than their endogenous agonists[5,8]	
Human amylin	1,780	301	197		

[a]Receptor potencies are based on the CTRa isoform.

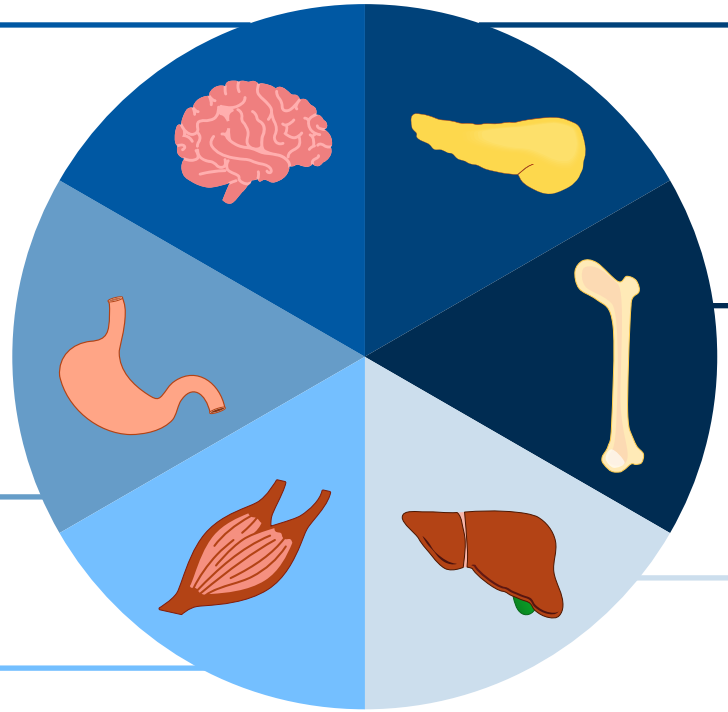
Sources: [1]Mathiesen et al. Eur J Endocrinol 2022;186(6):R93–R111; [2]Hay et al. Pharmacol Rev 2015;67(3):564–600; [3]Hay et al. Br J Pharmacol 2018;175(1):3–17; [4]Bower & Hay. Br J Pharmacol 2016;173(12):1883–1898; [5]Data on file; [6]Ghanizada et al. Neurology 2021;96(20):e2488–e2499; [7]Zhang et al. Oncol Lett. 2020;20(5):253; [8]Garelja et al. Br J Pharmacol 2022;179(3):416–434.

ADM1-R=adrenomedullin 1 receptor; AMY1-R=amylin 1 receptor; AMY3-R=amylin 3 receptor; CGRP-R=calcitonin gene-related peptide receptor; CLR=calcitonin receptor-like receptor; CTR=calcitonin receptor; EC50=half maximal effective concentration; RAMP=receptor activity-modifying protein.

ZEALAND PHARMA

Amylin exerts beneficial metabolic effects on multiple organ systems

Physiological and pharmacological effects of amylin receptor activation[1-5]



CNS

- ↑ Leptin sensitivity[2]
- ↑ Satiety[3]
- ↑ Energy expenditure[3]
- ↓ Body weight[3]

Via the vagal nerve

GI tract

- ↓ Gastric emptying[3]

Muscle

- ⇄ Preserves lean mass[a,4]

Pancreas (indirect)[b]

- ↓ Insulin secretion (improving glucose metabolism)[3]
- ↓ Glucagon secretion[3]

Bone

- ↓ Osteoclast activity[5]
- ↑ Osteoblast activity[5]

Liver and adipose tissue

- ↑ Insulin sensitivity[3]
- ↓ Fat accumulation[3]

[a]Demonstrated pharmacologically with several amylin analogs in pre-clinical studies, including with petrelintide; [b]Mediated by the effect of amylin on the CNS.

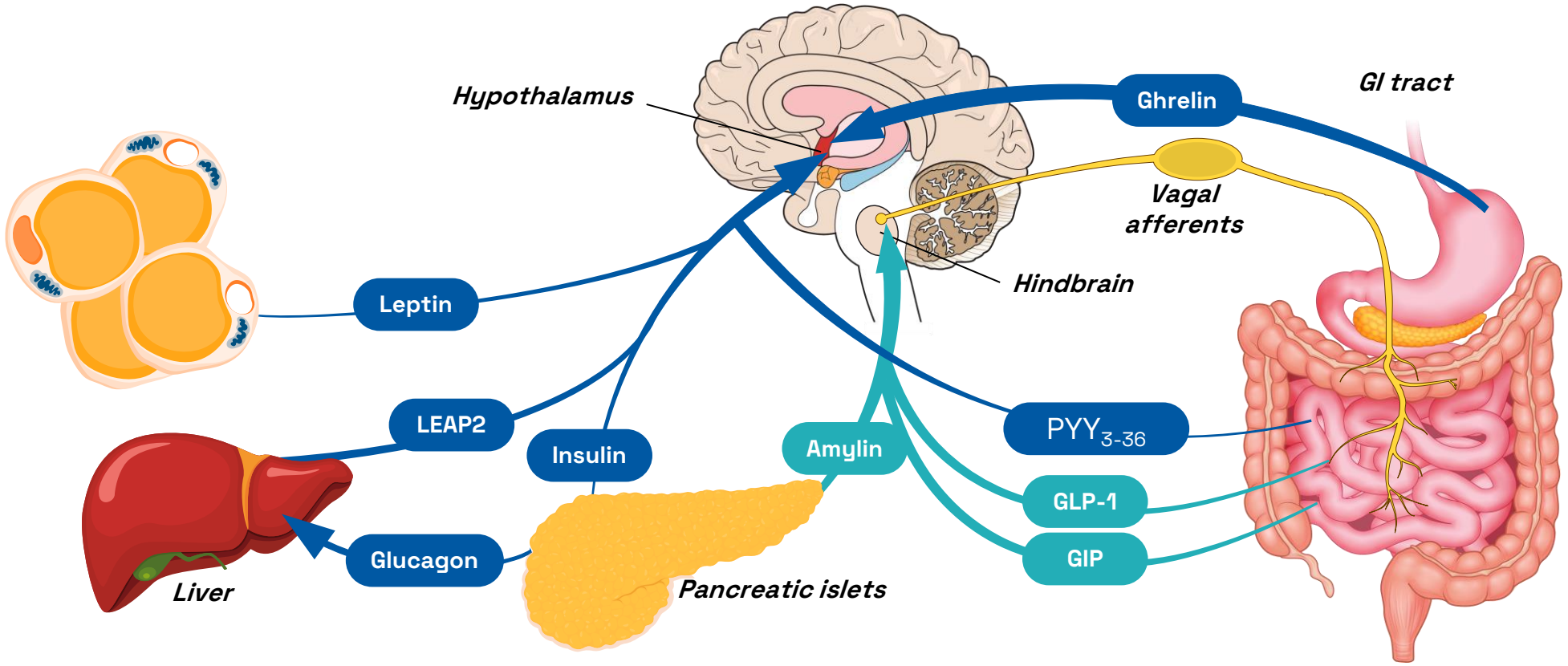
Sources: [1]Hayes et al. Annu Rev Nutr 2014;34:237–260; [2]Roth et al. Proc Natl Acad Sci U S A 2008;105(20):7257–7262; [3]Figure adapted from Mathiesen et al. Eur J Endocrinol 2022;186(6):R93–R111; [4]Vestergaard et al. Poster presented at ADA 84th Scientific Sessions, June 21–24, 2024, Orlando, FL. [1662-P]; [5]Naot et al. Chapter 33 – Calcitonin peptides. In: Principles of Bone Biology, 4th edition. 2020.

CNS=central nervous system; GI=gastrointestinal.

ZEALAND PHARMA

Leptin acts as a long-term signal of adiposity and energy balance to the brain

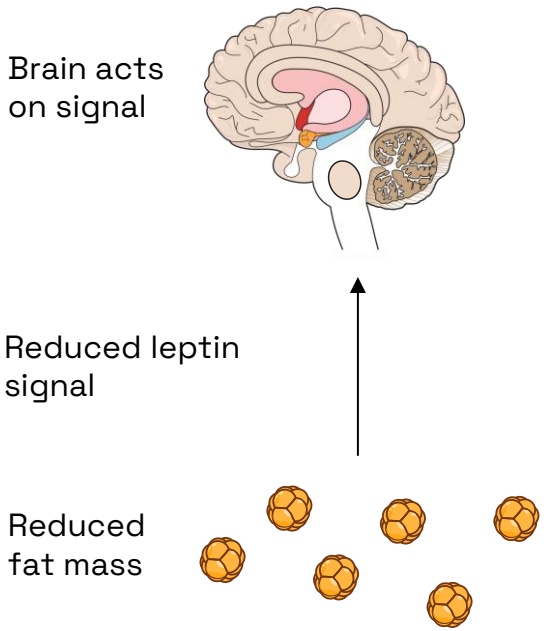
Multi-hormonal control of body weight: long-term adiposity signals, short-term satiety signals



Source: Figure adapted from Badman & Flier. Science 2005;307(5717):1909–1914.
GI=gastrointestinal; GIP=glucose-dependent insulinotropic polypeptide; GLP-1=glucagon-like peptide-1; LEAP2=liver-expressed antimicrobial peptide 2; PYY_{3-36}=Peptide YY residues 3–36.

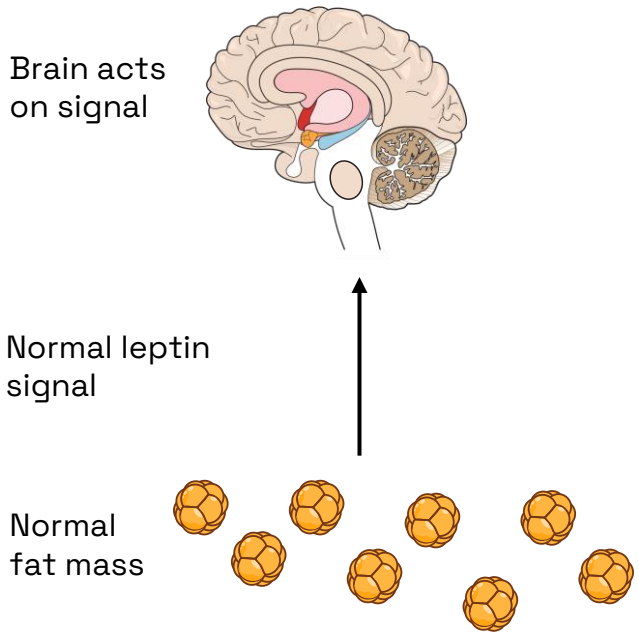
Circulating leptin levels differentially influence metabolism and leptin sensitivity

Low leptin[1]



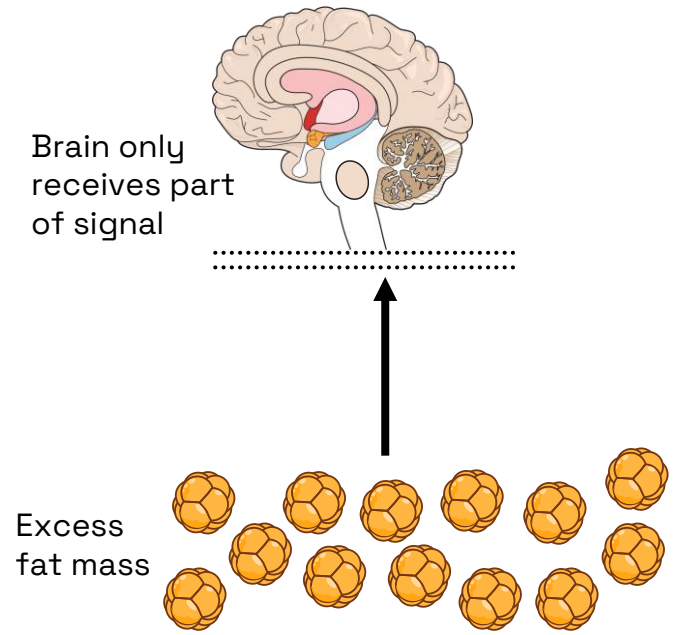
- **"True"** starvation mode (e.g., dieting or genetic deficiency)
- Increased appetite
- Decreased metabolism

Normal leptin[1]



- Normal appetite
- Increased metabolism
- Weight normal

Leptin resistance[1,2]



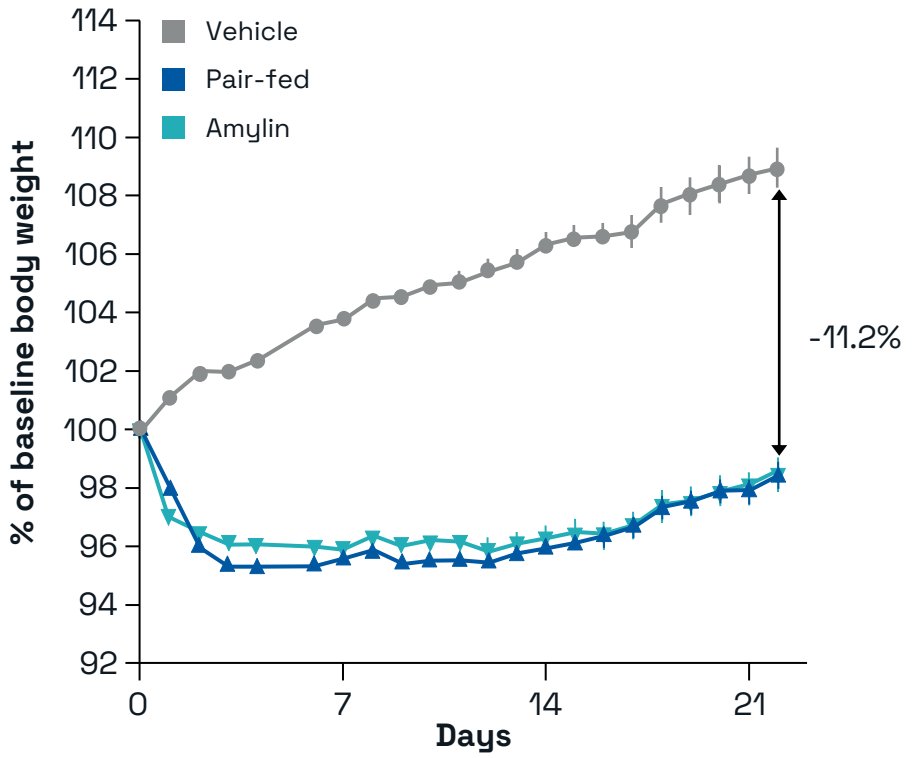
- **"False"** starvation mode
- Increased appetite
- Decreased metabolism
- Leptin receptors downregulated
- Leptin signaling impaired
- Obesity, diabetes, MASH

Sources: [1]https://www.geneticlifehacks.com/weight-loss-genetics-leptin-receptor-polymorphisms, accessed November 2025; [2]Martin et al. Metabolism 2000;49(11):1479–1484.
MASH=metabolic dysfunction-associated steatohepatitis.

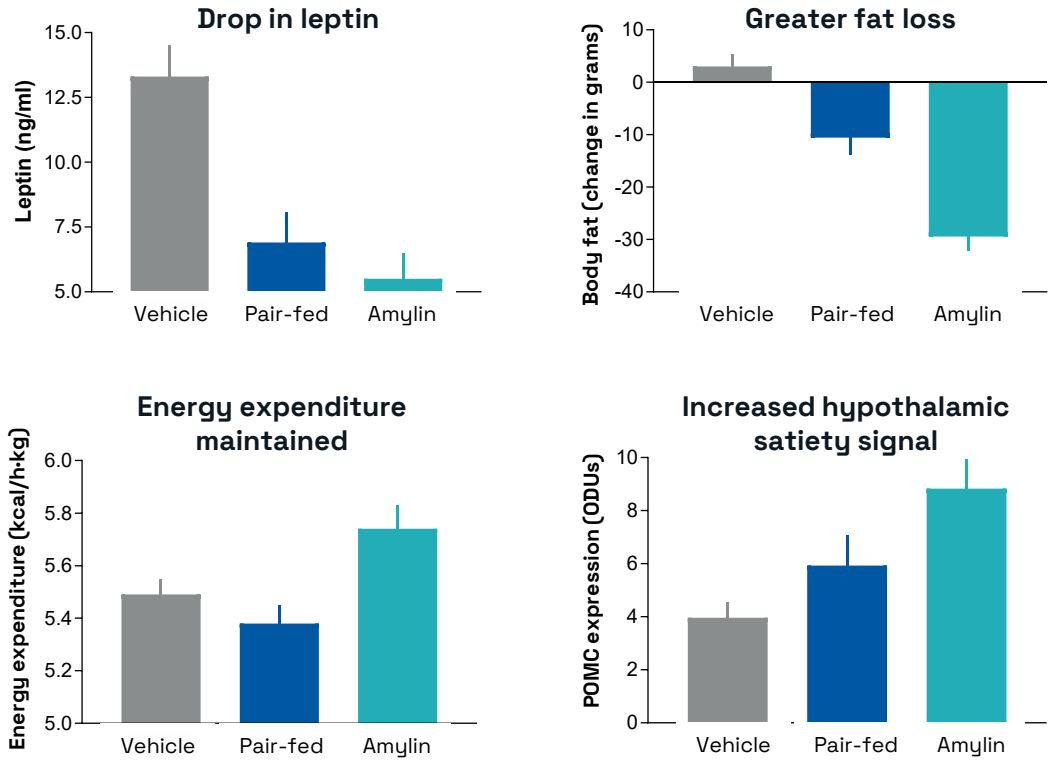
ZEALAND PHARMA

Pre-clinical mechanistic studies in DIO rats suggested that amylin could be a leptin sensitizer

Similar weight loss in amylin-treated DIO rats and their pair-fed controls



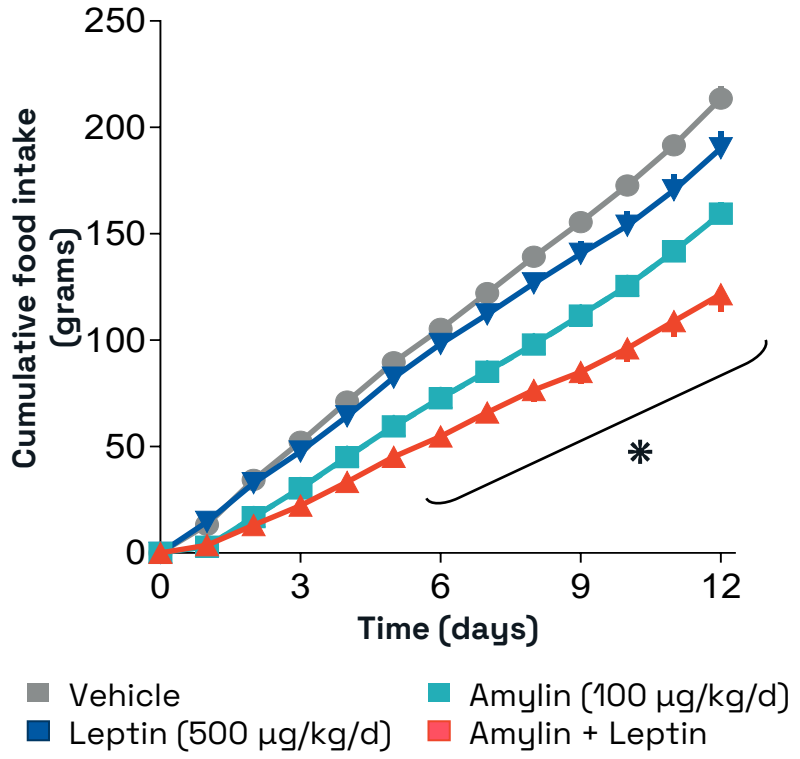
Amylin maintains leptin levels and energy expenditure while promoting fat loss and satiety



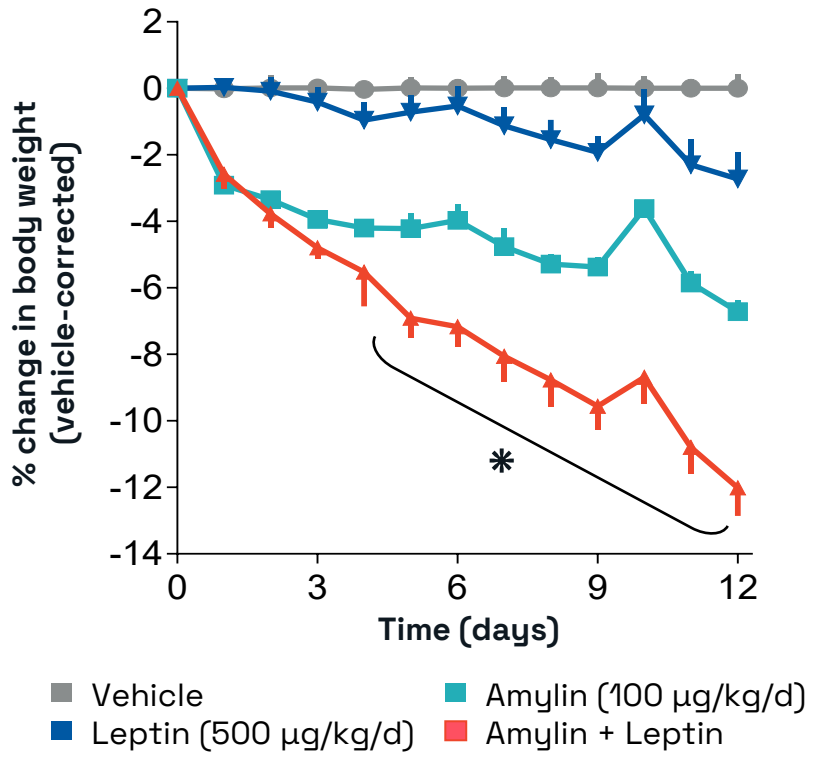
Source: Roth et al. Endocrinology 2006;147(12):5855–5864 (with permission of The Endocrine Society).
DIO=diet-induced obese; ODU=optical density unit; POMC=pro-opiomelanocortin

Amylin and leptin induce synergistic weight loss that is not explained by the anorexigenic effect of amylin

Food intake



Body weight



*p<0.05 compared to all groups.
Diet-induced obesity prone rats (Charles River Laboratories: N=7/group).
Source: Adapted from Roth et al. Proc Natl Acad Sci USA 2008;105(20):7257–7262 (with permission from Wiley).

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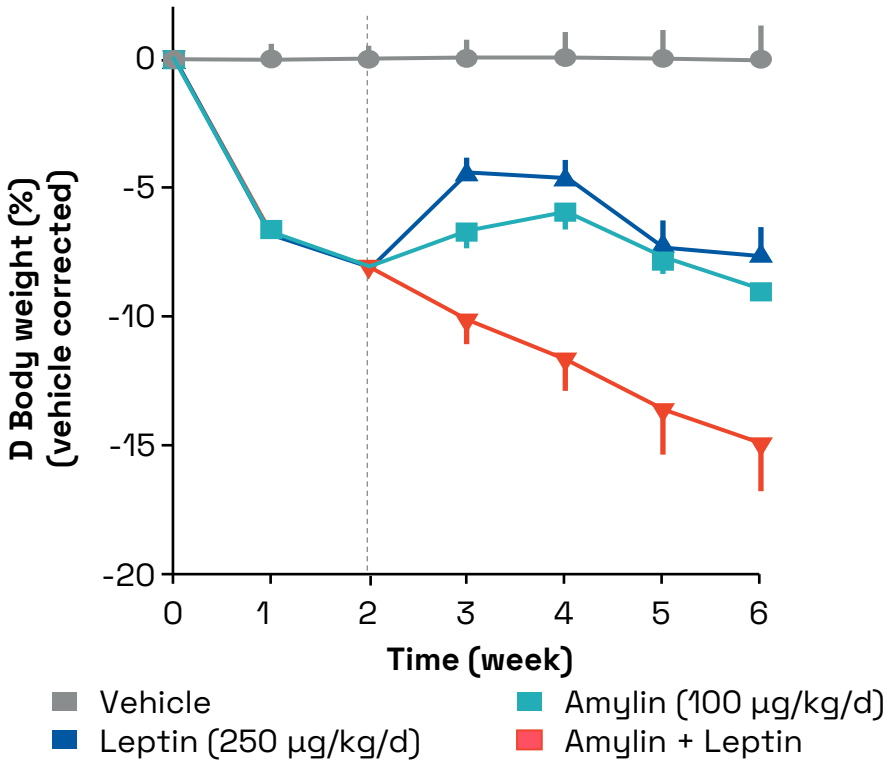
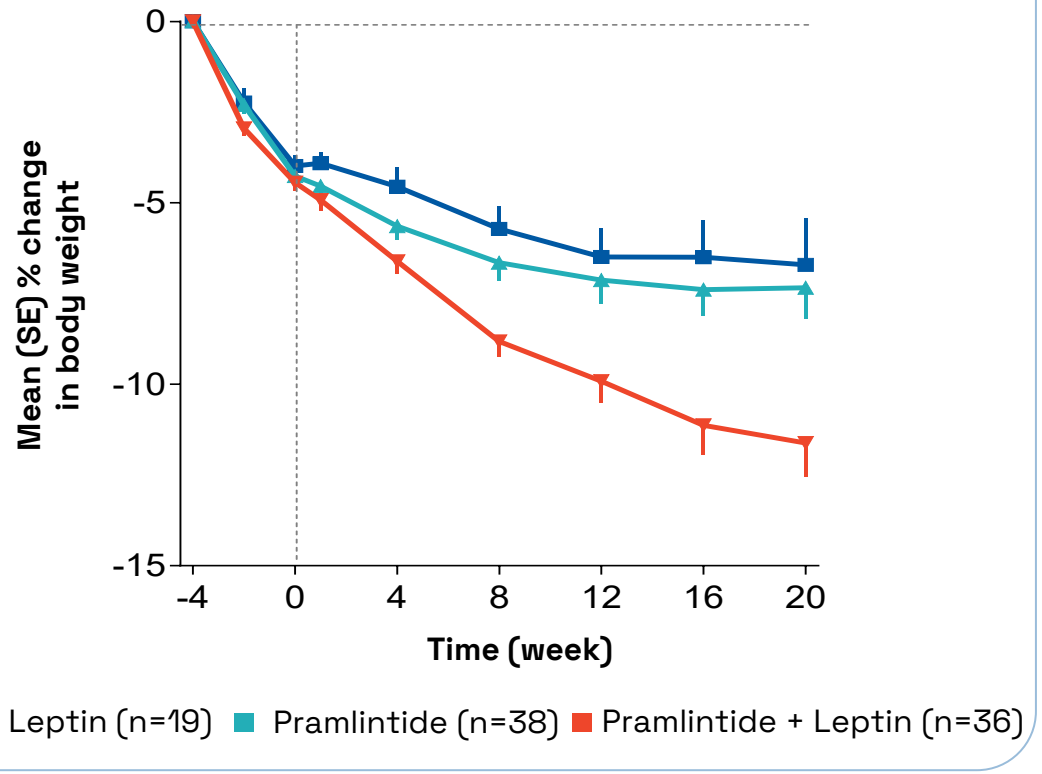
Amylin agonism restores leptin responsiveness in DIO rats… and in humans

DIO rats[1]



Overweight and obese humans[2]



Source: [1]Roth et al. Proc Natl Acad Sci USA 2008;105(20):7257–7262 (with permission from Wiley); [2]Ravussin et al. Obesity (Silver Spring) 2009;17(9):1736–1743 (with permission from Wiley).
DIO=diet-induced obese; SE=standard error.

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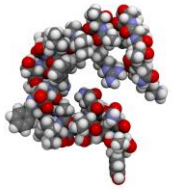
Amylin and GLP-1 exert distinct physiological and potentially distinct pharmacological effects

	Amylin	GLP-1
		
Effect on food intake	**Increases satiety**[1,2] Smaller meals, prolonged fullness[6]	**Reduces appetite**[7] Fewer meals, less food-seeking[7]
Leptin sensitivity	Restores leptin responsiveness[1,2]	Minimal or no effect on leptin sensitivity[7]
Pancreatic β-cell function	Improves insulin sensitivity[3]	Stimulates insulin secretion[7]
Effects on brain pathways	Area postrema, hypothalamus, amygdala; interacts with leptin pathways[2,4,5]	Hypothalamic arcuate nucleus, vagal afferents; appetite-suppressing circuits[7,8]
Clinical implications	May provide durable weight loss via leptin pathway restoration	Many treated individuals plateau or discontinue due to adverse events

Sources: [1]Roth. Curr Opin Endocrinol Diabetes Obes 2013;20(1):8–13; [2]Trevaskis et al. Endocrinology 2008;149(11) 5679–5687; [3]Smith et al. Diabetes Care 2008;31(9):1816–1823; [4]Mathiesen et al. Eur J Endocrinol 2022;186(6):R93–R111;[5]Lutz. Appetite 2022;172:105965;[6]Byun et al. iScience 2025;28(3):112040;[7]Müller et al. Mol Metab 2019;30:72–130; [8]Holst. Physiol Rev 2007;87(4):1409–1439.
GLP-1=glucagon-like peptide-1.

ZEALAND PHARMA

Key takeaways

Amylin is a pancreatic hormone that **helps regulate meal size** and promote fullness

Its **receptor system is complex** but enables broad and coordinated physiological effects

Amylin can help **restore sensitivity to leptin**, a key satiety pathway, supporting the potential for healthier long-term energy balance

Amylin works differently from GLP-1, increasing satiety and **driving earlier fullness** rather than primarily suppressing appetite

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GLP-1=glucagon-like peptide-1.

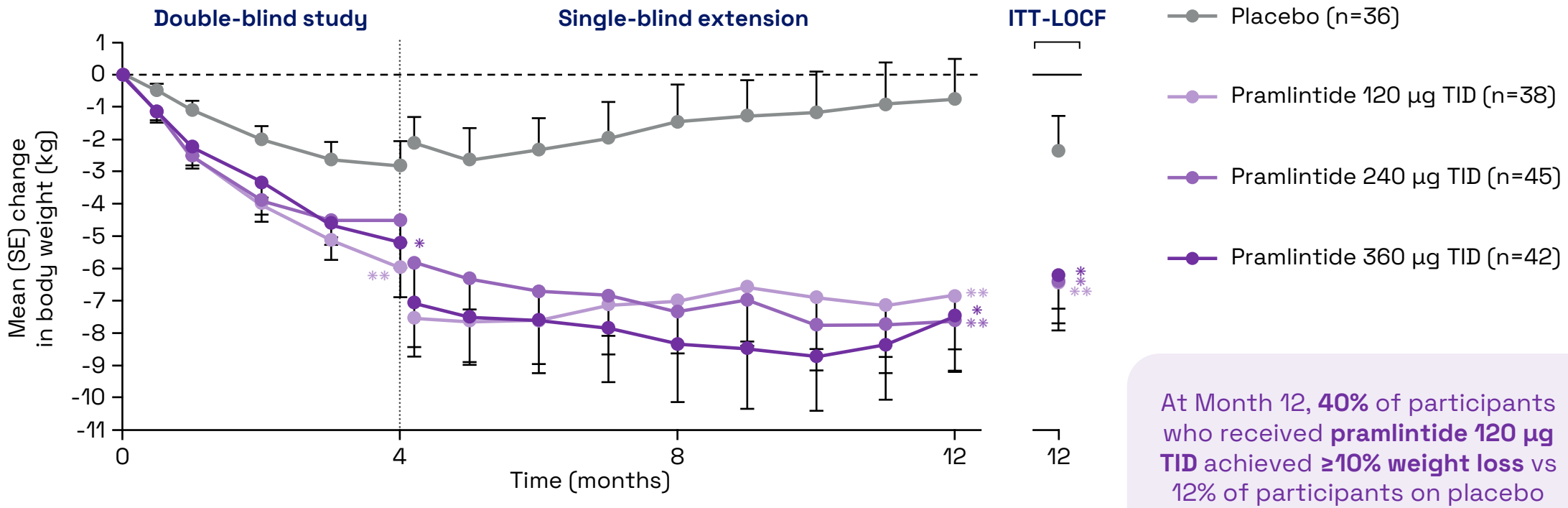
Clinical evidence of amylin analogs for weight management

Louis J. Aronne, MD, FACP, DABOM
Weill Professor of Medical Research at Weill Cornell Medicine

ZEALAND PHARMA

Short-acting amylin analog pramlintide showed weight loss potential in people with obesity

Phase 2b trial with pramlintide in people with obesity



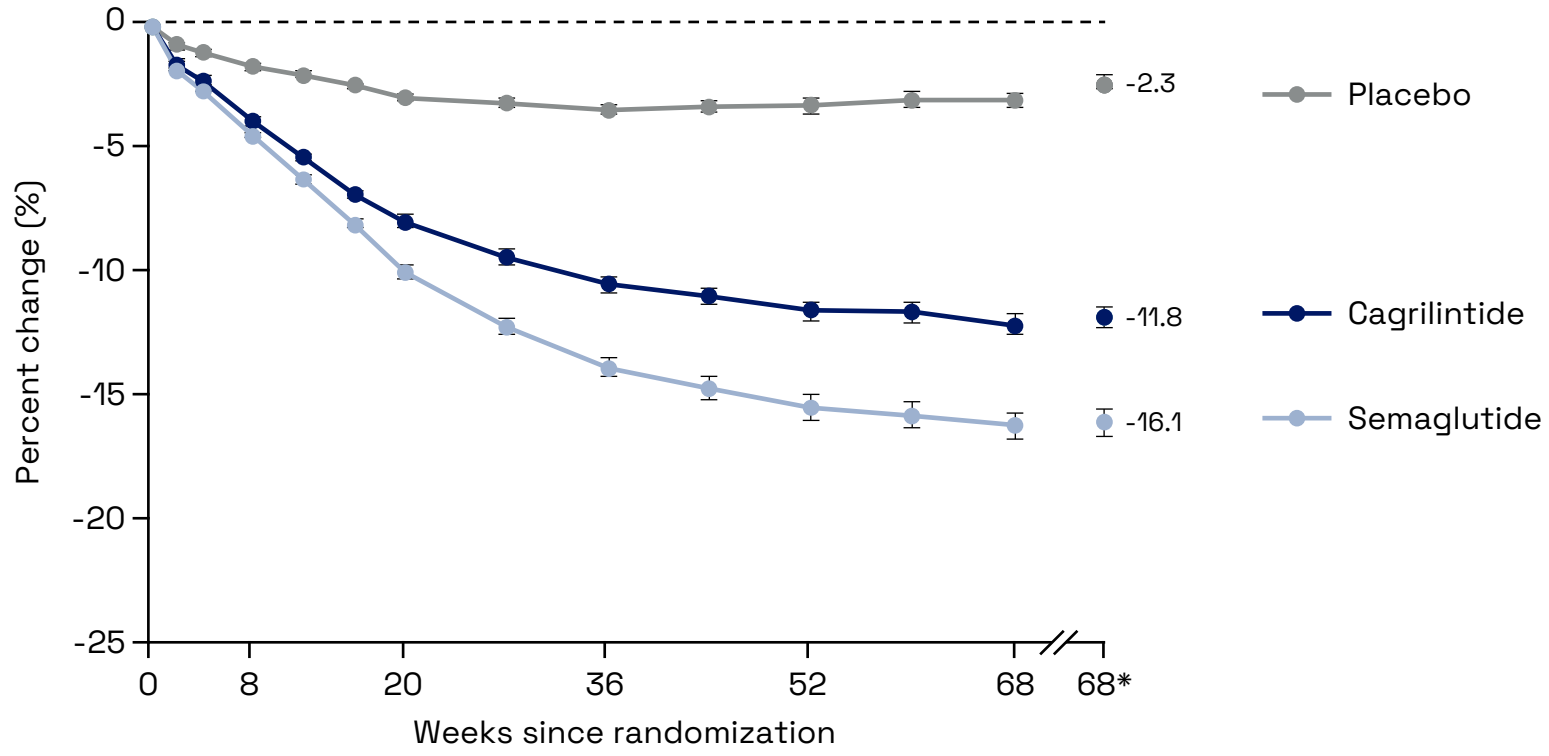
At Month 12, **40%** of participants who received **pramlintide 120 µg TID** achieved **≥10% weight loss** vs 12% of participants on placebo

*p<0.05, **p<0.01 vs placebo.
N-values are at baseline.
Mean body weight at baseline was ~106 kg.
Source: Figure adapted from Smith et al. Diabetes Care 2008;31(9):1816–1823 (with permission from Wiley)
ITT=intention-to-treat; LOCF=last observation carried forward; SE=standard error; TID=three times daily.

ZEALAND PHARMA

Long-acting amylin analog cagrilintide showed 11.8% weight loss in the Phase 3 REDEFINE-1 trial

Effects of cagrilintide and semaglutide on body weight in REDEFINE-1 trial



- This study used a flexible dosing regimen with a maximum dose of 2.4 mg for each drug[1]
- This was a potentially inferior dose of cagrilintide:
  - In a prior Phase 2 trial, cagrilintide 4.5 mg showed greater weight loss than cagrilintide 2.4 mg[2]
- In terms of efficacy, the lower dose of cagrilintide may not have maximized amylin-associated physiological effects

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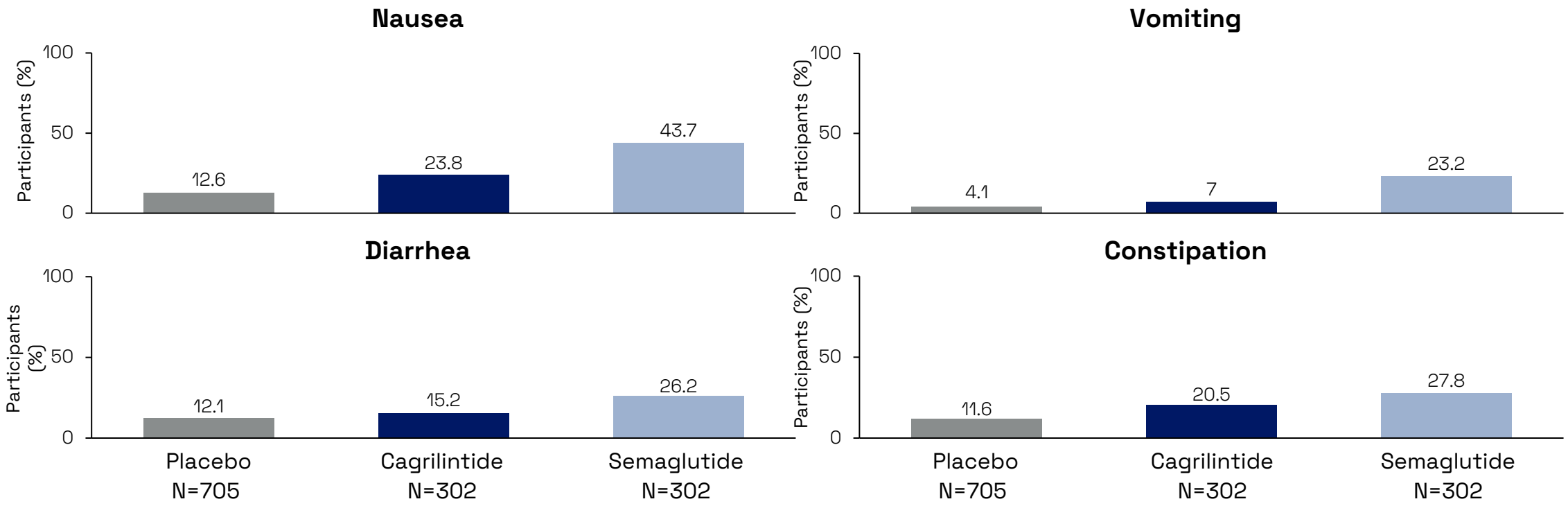
Source: Adapted from [1]Garvey et al. N Engl J Med 2025;393(7):635–647 (with permission from Massachusetts Medical Society); [2]Lau et al. Lancet 2021;398(10317):2160–2172.

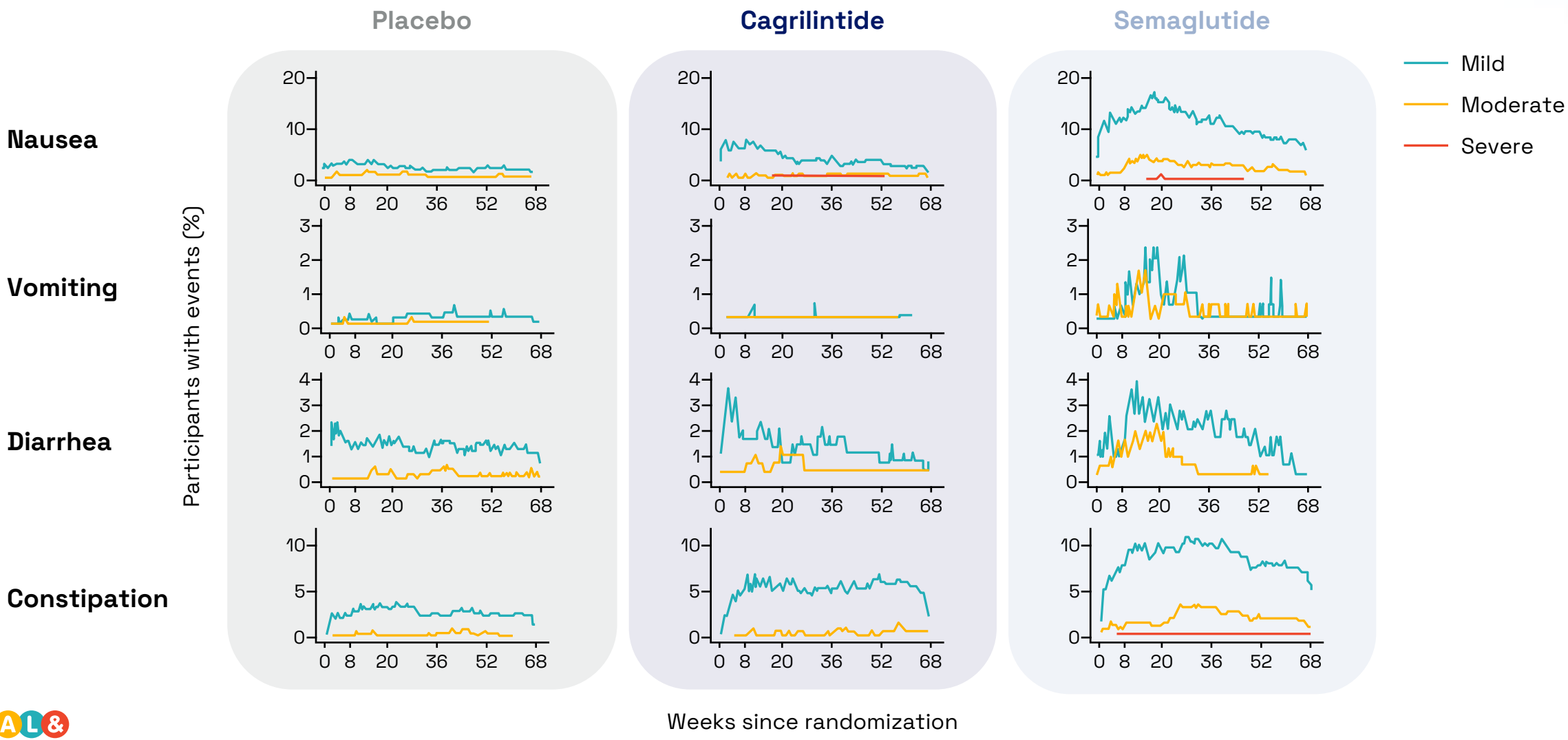
Cagrilintide showed excellent gastrointestinal tolerability in the Phase 3 REDEFINE-1 trial

Proportion of participants experiencing adverse events



Source: Adapted from Garvey et al. N Engl J Med 2025;393(7):635–647 (with permission from Massachusetts Medical Society).

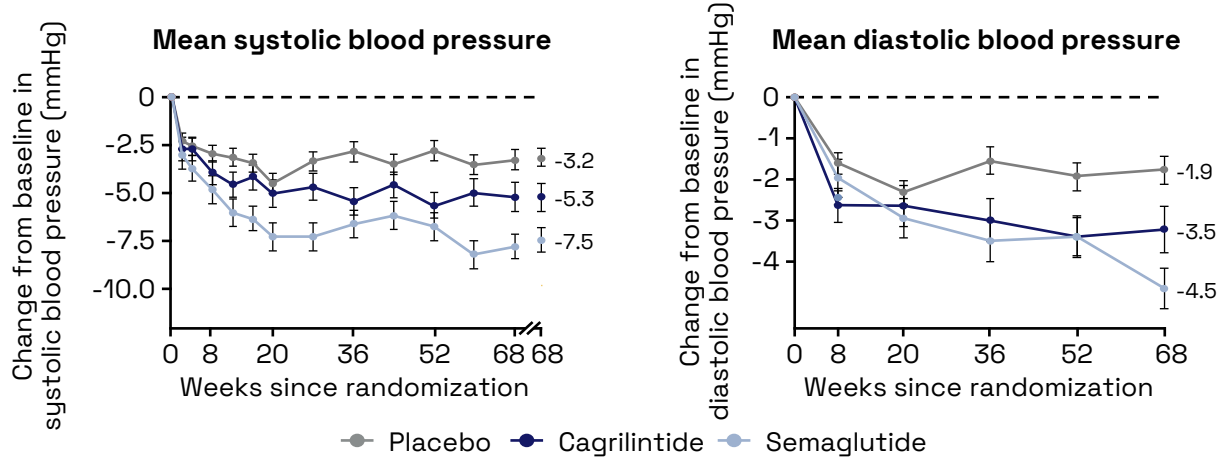
Gastrointestinal AEs with cagrilintide were not only less frequent but also considerably less severe



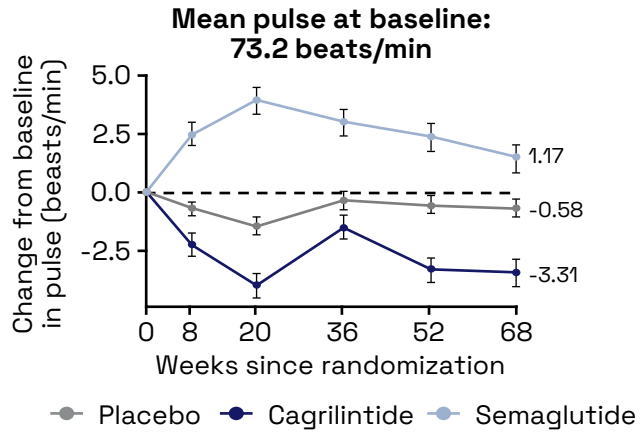
Source: Adapted from Garvey et al. N Engl J Med 2025;393(7):635–647 (with permission from Massachusetts Medical Society).
AE=adverse event.

All risk factors for cardiovascular disease were improved with cagrilintide

Changes in blood pressure over 68 weeks



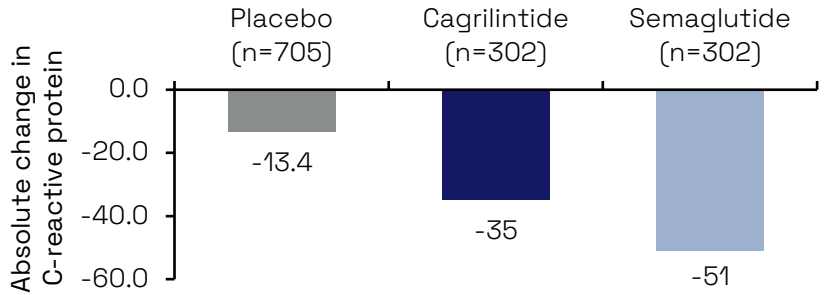
Changes in pulse over 68 weeks



Change from baseline in lipid profile

Ratio to baseline in lipids	Placebo (n=705)	Cagrilintide (n=302)	Semaglutide (n=302)	Significance
Total cholesterol	0.99	0.99	0.94	NS
HDL cholesterol	1.01	1.06	1.07	NS
LDL cholesterol	0.99	0.99	0.93	NS
VLDL cholesterol	0.96	0.86	0.78	NS
Non-HDL cholesterol	0.98	0.96	0.90	NS
Triglycerides	0.96	0.86	0.78	NS
Free fatty acids	1.02	1.02	0.94	NS

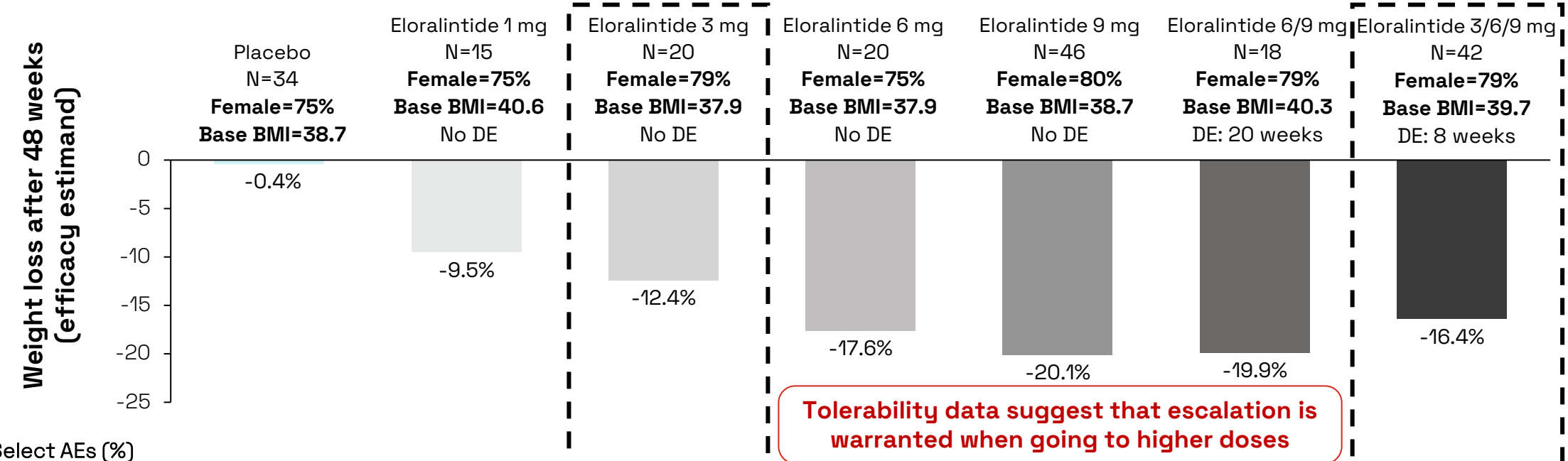
Absolute reduction in hsCRP



Source: Adapted from Garvey et al. N Engl J Med 2025;393(7):635–647 (with permission from Massachusetts Medical Society).
BPM=beats per minute; HDL=high-density lipoprotein; hsCRP=high-sensitivity C-reactive protein; LDL=low-density lipoprotein; NS=no significant difference; VLDL=very low-density lipoprotein.

ZEALAND PHARMA

Eloralintide Phase 2 data reinforced the potential of amylin as stand-alone therapy for weight management



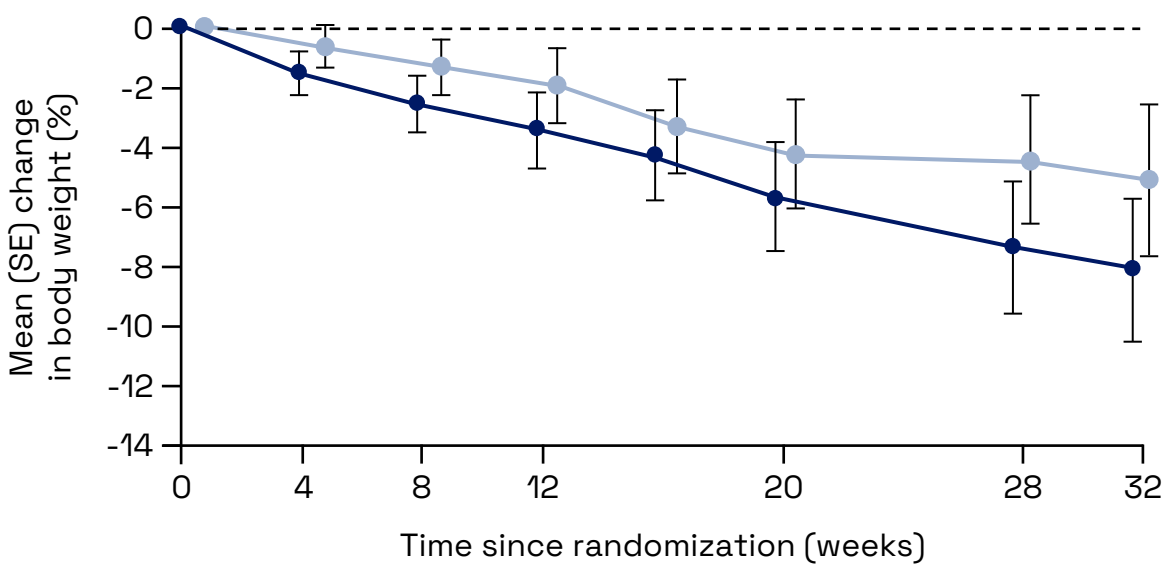
Select AEs (%)	Placebo N=34 Female=75% Base BMI=38.7	Eloralintide 1 mg N=15 Female=75% Base BMI=40.6 No DE	Eloralintide 3 mg N=20 Female=79% Base BMI=37.9 No DE	Eloralintide 6 mg N=20 Female=75% Base BMI=37.9 No DE	Eloralintide 9 mg N=46 Female=80% Base BMI=38.7 No DE	Eloralintide 6/9 mg N=18 Female=79% Base BMI=40.3 DE: 20 weeks	Eloralintide 3/6/9 mg N=42 Female=79% Base BMI=39.7 DE: 8 weeks
Nausea	13.5%	11.1%	13.0%	64.3%	33.3%	54.2%	25.0%
Vomiting	0%	0%	0%	25.0%	11.1%	12.5%	1.9%
Diarrhea	9.6%	3.7%	8.7%	35.7%	11.1%	12.5%	17.3%
Constipation	5.8%	14.8%	17.4%	7.1%	24.1%	16.7%	7.7%
Fatigue	11.5%	0%	13.0%	28.6%	42.6%	45.8%	21.2%
Alopecia	0%	3.7%	0%	3.6%	9.3%	8.3%	9.6%

Source: Billings et al. Lancet 2025. doi: 10.1016/S0140-6736(25)02155-5 (reprinted with permission from Elsevier, copyright 2025).
AE=adverse event; BMI=body mass index (mean values, kg/m2); DE=dose escalation.

ZEALAND PHARMA

Amylin has potential to deliver comparable weight loss in people with type 2 diabetes

Phase 2 trial in people with type 2 diabetes



Mean relative change at Week 32

-5.1%

-8.1%

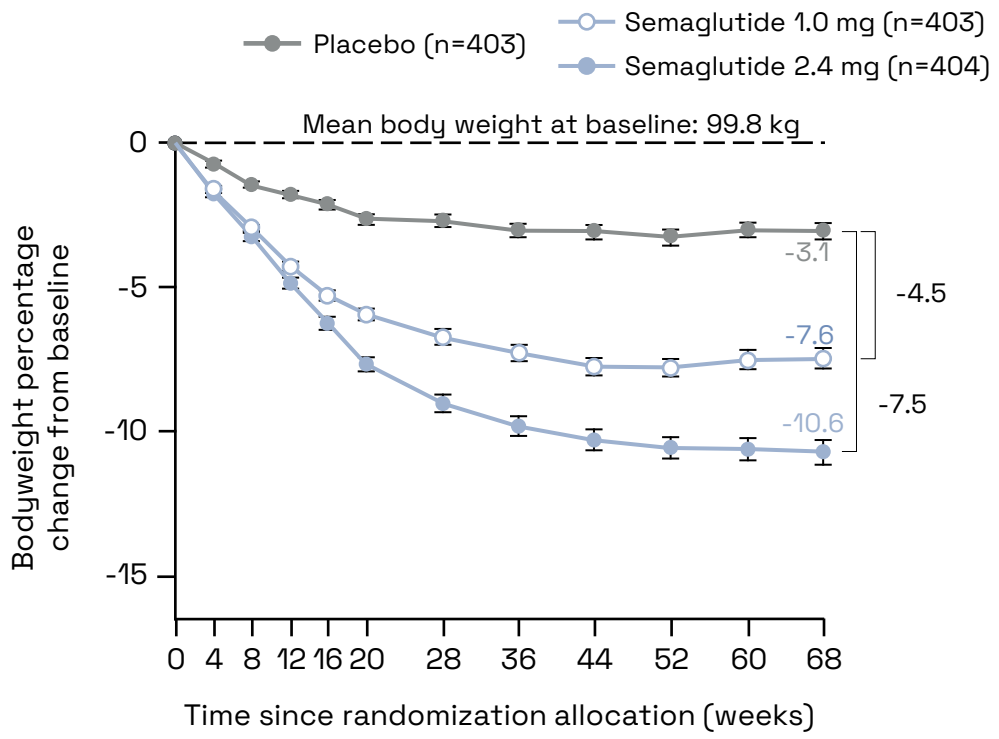
Semaglutide 2.4 mg (n=31)

Cagrilintide 2.4 mg (n=30)

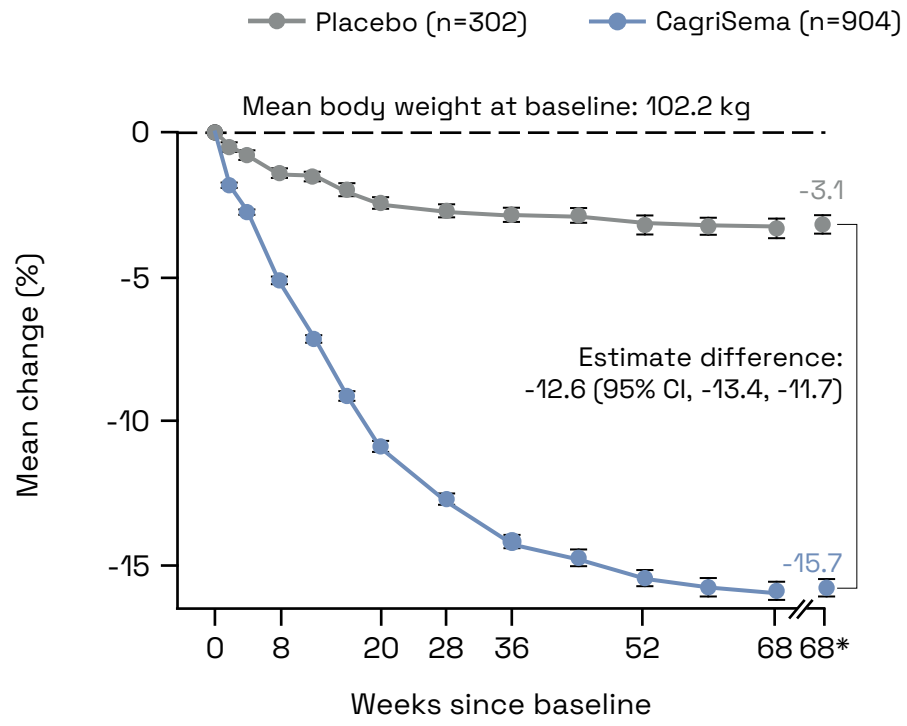
Treatment efficacy was evaluated using the trial product estimand.
Source: Figure adapted from Frias et al. Lancet 2023;402(10403):720–730720–730 (reprinted with permission from Elsevier, copyright 2023).
SE=standard error.

Amylin has potential to enhance weight loss in people with type 2 diabetes when added to GLP-1

Weight loss with semaglutide in STEP-2[1]



Weight loss with CagriSema in REDEFINE-2[2]



Sources: [1]Davies et al. Lancet 2021;397(10278):971–984 (reprinted with permission from Elsevier, copyright 2021); [2]Davies et al. N Engl J Med 2025;393(7):648–659 (adapted with permission from Massachusetts Medical Society).
CI=confidence interval; GLP-1=glucagon-like peptide-1.

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Amylin holds transformative potential for chronic weight management

We need a toolbox to address one of the greatest healthcare challenges of our time, not just a hammer

Amylin represents a distinct new modality that can **expand the chronic weight management toolbox**

Potential to deliver the **weight loss that most people with overweight and obesity desire**, with considerably improved **GI tolerability**

For specific segments, **combining amylin** with incretin-based therapy offers strong potential for additional therapeutic benefits

Using the **maximum dose of the better-tolerated agent** and **optimizing the less tolerable agent** may boost efficacy without compromising GI tolerability

GI=GI=gastrointestinal.

Break

The meeting commences at 3:45 pm GMT

1. The opportunity & our ambition
   Adam Steensberg
   1:05-1:25
2. The future of weight management
   Eric Cox
   1:25-1:50
3. Survodutide: the next frontier in obesity & MASH (GCG/GLP-1)
   Carel Le Roux & David Kendall - including Q&A
   1:50-2:25
4. Amylin: an emerging therapeutic class
   Jonathan D. Roth & Louis J. Aronne
   2:25-3:05

Break
3:05-3:45

5. Petrelintide: building the leading amylin franchise
   David Kendall - including Q&A
   3:45-4:20
6. Our engine: world's most valuable metabolic health pipeline
   Utpal Singh
   4:20-4:50
7. How we fund and scale this
   Henriette Wennicke
   4:50-5:00
8. Q&A and closing remarks
   Adam Steensberg & team
   5:00-5:30

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5.

Petrelintide: building the leading amylin franchise

David Kendall - including Q&A – 3:45-4:20

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Petrelintide

LEAD

in amylin-based therapies

DELIVER

on efficacy and improved experience

WIN

in establishing a new foundational therapy for weight management

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Petrelintide is a long-acting, potential best-in-class amylin analog

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

- **Human amylin backbone** (intentionally avoiding sCT due to potential safety and tolerability concerns)[1]
- Potent **balanced agonistic effects** on **AMY-1R**, **AMY-3R**, and **CTR** (motivated by extensive screening)[1,3]
- Chemical and physical **stability** around **neutral pH** (allowing for co-formulation and co-administration with other peptides, and reducing the risk of injection site reactions and immunogenicity)[2,3]
- Consistent **half-life of 10 days**, suitable for once-weekly administration and potentially important for tolerability[4,5]
- **~85% bioavailability**[1,5], potentially important for efficacy and COGS

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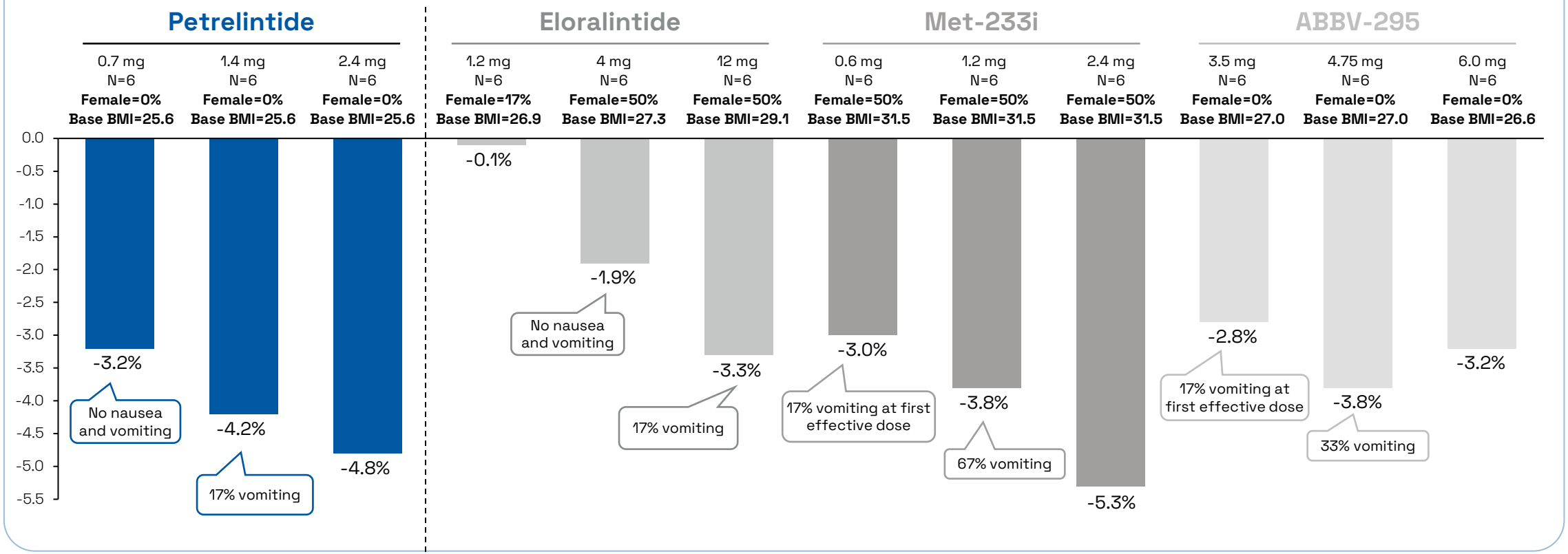
Zealand Pharma has a collaboration and license agreement with Roche for petrelintide, including co-development and co-commercialization in the U.S. and Europe.
Sources: [1]Data on file; [2]Eriksson et al. Poster 532. Presented at ObesityWeek, November 1–4, 2022, San Diego, CA; [3]Skarbaliene et al. Poster 1406-P. Presented at ADA 82nd Scientific Sessions, June 3–7, 2022, New Orleans, LA; [4]Brændholt Olsen et al. Poster 92-LB. Presented at ADA 83rd Scientific Sessions, June 23–26, 2023, San Diego, CA; [5]Data presented at ObesityWeek 2024 in San Antonio, TX.
AMY-1R=amylin-1 receptor; AMY-3R=amylin-3 receptor; COGS=cost of goods sold; CTR=calcitonin receptor; sCT=salmon calcitonin.

Early clinical data support a favorable balance between weight loss and GI AEs with petrelintide

Indirect comparison of SAD trials: Placebo-adjusted weight loss one week after a single dose[1-5]



No head-to-head trial has been conducted with petrelintide against the other product candidates. Differences exist in trial designs and conditions, and caution should be exercised when comparing data across trials.

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]Briere et al. Mol Metab 2025. doi: 10.1016/j.molmet.2025.102271 (reprinted with permission from Elsevier, copyright 2025); [4]Metsera conference call presentation June 2025, https://investors.metsera.com/static-files/3e514c6b-fdba-49e5-84f8-aa3168936b8e; [5]ABBV-295/GUBamy SAD data conference call presentation, November 2024, https://www.gubra.dk/wp-content/uploads/2024/11/GUBamy-Phase-1a-study-results.pdf.

AE=adverse event; BMI=body mass index (mean values, kg/m^2); GI=gastrointestinal; N=number of trial participants; SAD=single ascending dose.

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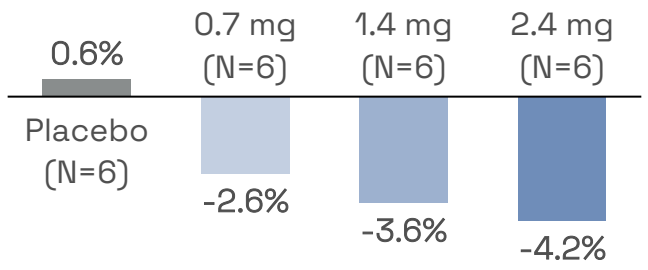
Totality and consistency of clinical data to date reinforce the best-in-class potential of petrelintide

SAD trial[1]

% change in body weight from baseline at Day 7

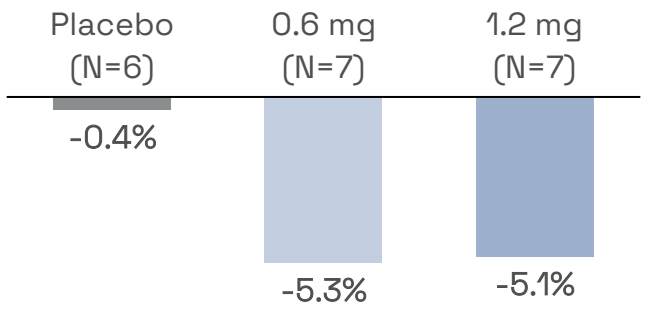


Tolerability

- Well tolerated
- No serious or severe TEAEs
- No withdrawals

MAD trial Part 1 (6-week study)[2]

% change in body weight from baseline at week 6

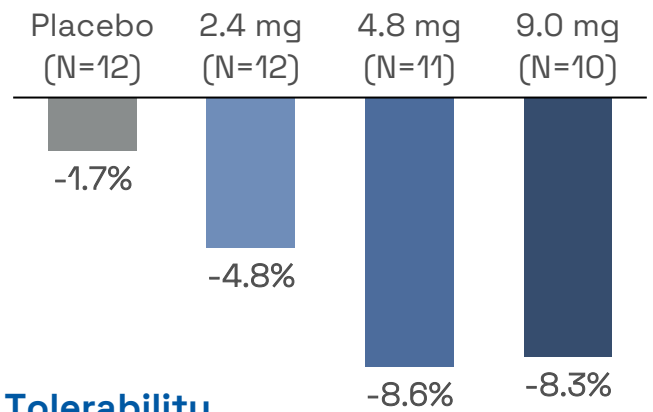


Tolerability

- All drug-related TEAEs were mild
- Less GI AEs with petrelintide than placebo
- No withdrawals

MAD trial Part 2 (16-week study)[3]

% change in body weight from baseline at week 16



Tolerability

- All GI AEs mild except for two moderate events reported by one participant (nausea, vomiting)
- This participant was the only one discontinuing treatment due to AEs

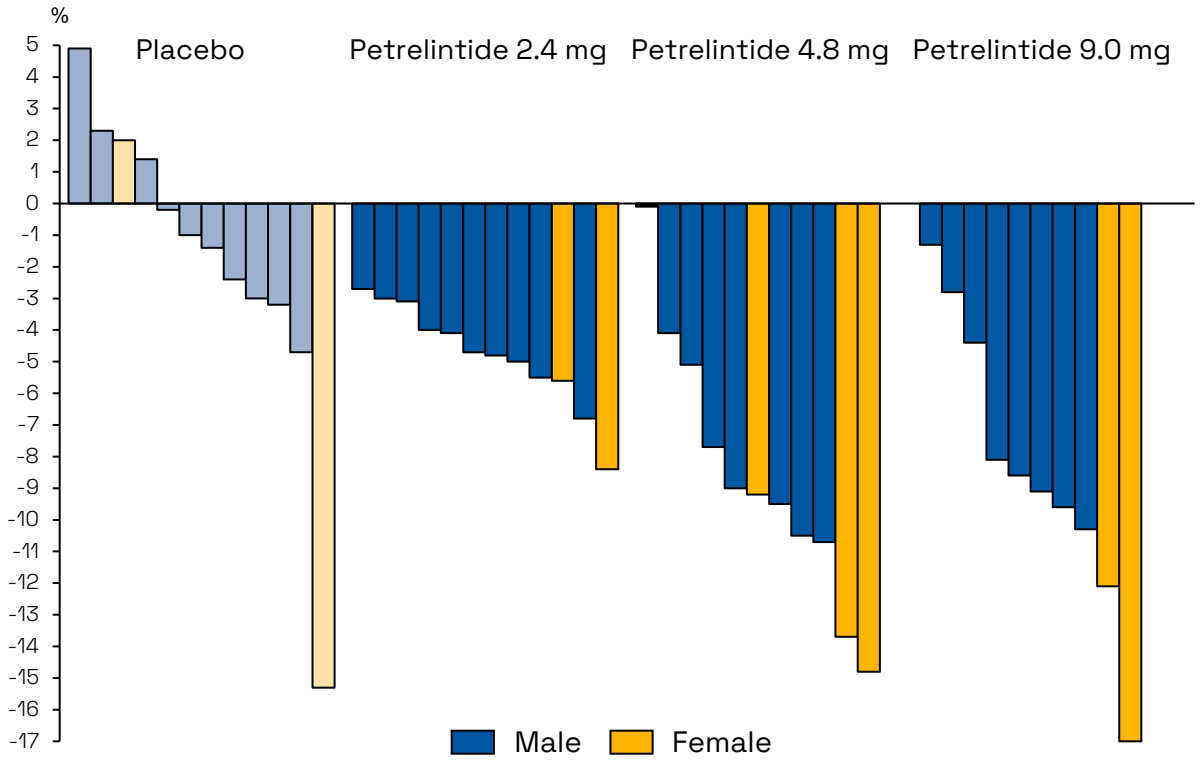
Zealand Pharma has a collaboration and license agreement with Roche for petrelintide, including co-development and co-commercialization in the U.S. and Europe

Sources: [1]Brændholt Olsen et al. Poster 92-LB. Presented at ADA 83rd Scientific Sessions, June 23–26, 2023, San Diego, CA; [2]Brændholt Olsen et al. Poster presented at ObesityWeek, October 14–17, 2023, Dallas, TX; [3]Heise et al. Presentation at ObesityWeek, November 3–6 2024; San Antonio, TX.

AE=adverse event; GI=gastrointestinal; MAD=multiple ascending dose; N=number of participants; SAD=single ascending dose; TEAE=treatment-emergent adverse event.

Females in the petrelintide 16-week Phase 1b trial generally lost more weight than the males

Weight loss from baseline after 16 weeks by gender



21% of trial participants in the trial were **female**

A **greater treatment response** was observed **in females** across the three petrelintide treated cohorts

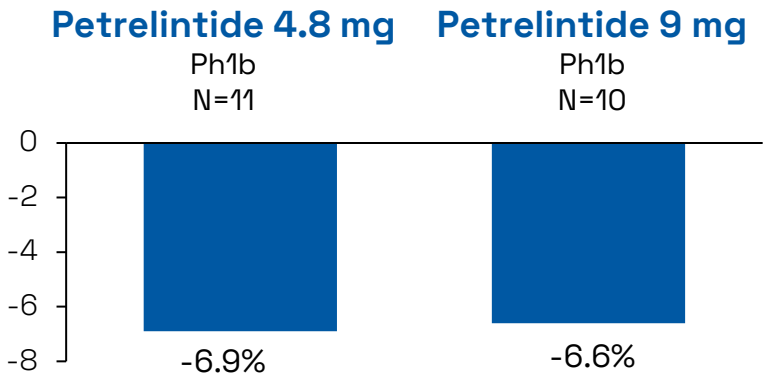
No pattern of differences between males and females were observed for **GI AEs** or any other AEs

Zealand Pharma has a collaboration and license agreement with Roche for petrelintide, including co-development and co-commercialization in the U.S. and Europe.
Source: Hesse et al. Poster 1773-P. Presented at ADA 85th Scientific Sessions, June 20–23, 2025, Chicago, IL.
ADA=American Diabetes Association; AE=adverse event; GI=gastrointestinal.

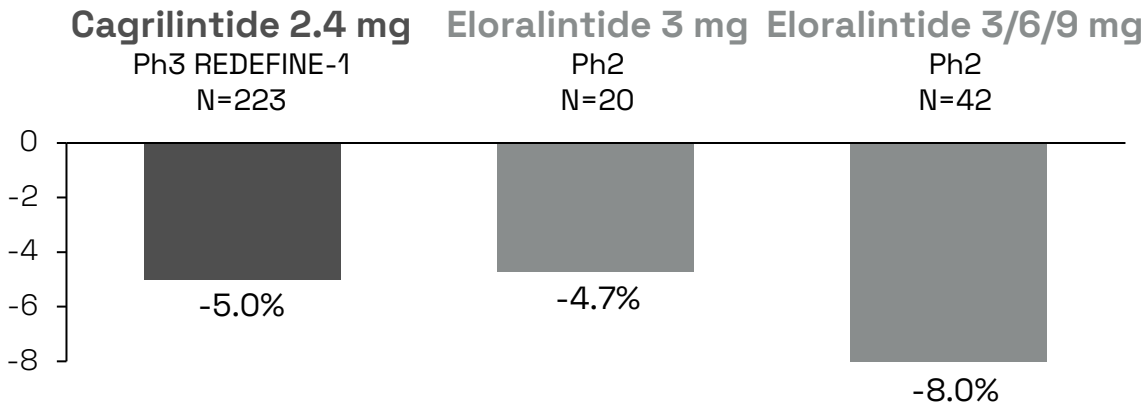
Petrelintide holds potential to deliver ~15–20% weight loss with a benign tolerability profile

Indirect comparison: Placebo-adjusted weight loss at Week 16 by efficacy estimand[1-4]

Phase 1 trial with ~20% female participants and baseline BMI <30 kg/m² [1,2]



Phase 2/3 trials with up to 80% female participants and baseline BMI >38 kg/m² [1,3,4]



Select AEs, placebo-adjusted (%)[1-3]

Nausea	17%	17%	11%	0%	12%
Vomiting	0%	8%	3%	0%	2%
Diarrhea	0%	0%	3%	<0%	7%
Constipation	0%	17%	9%	11%	2%
Fatigue	<0%	0%	8%	1%	9%
Alopecia	0%	0%	4%	4%	10%

No head-to-head trial has been conducted with petrelintide against the other product candidates. Differences exist in trial designs and conditions, and caution should be exercised when comparing data across trials.

Sources: [1]Data on file; [2]Heise et al. Presentation at ObesityWeek, November 3–6 2024; San Antonio, TX; [3]Garvey et al. N Engl J Med 2025;393(7):635–647; [4]Billings et al. Lancet 2025, doi: 10.1016/S0140-6736(25)02155-5.

AE=adverse event; BMI=body mass index (mean values, kg/m²); N=number of trial participants.

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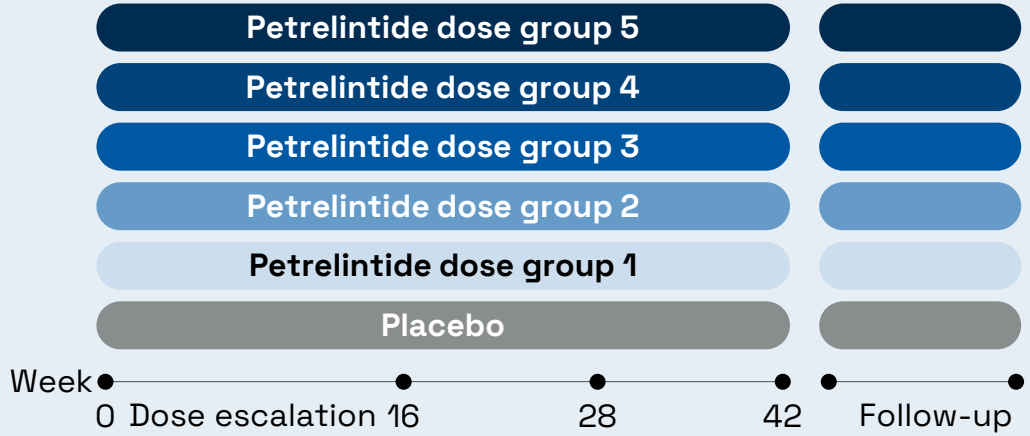
We expect to report topline results from the ZUPREME-1 Phase 2 trial in Q1 2026

ZUPREME-1 features a balanced gender distribution and a higher BMI at baseline compared to Phase 1

ZUPREME-1: Overweight/obesity without T2D[1]

Initiated in December 2024
Enrollment completed in March 2025
Topline data expected in Q1 2026



Primary endpoint: Body weight change (%) at week 28
Secondary endpoints (non-exhaustive): Body composition (MRI), inflammation biomarkers, CV risk factors

	ZUPREME-1[2,a] N=494	16-week Phase 1b[3] N=48
Weight (kg)	~107	92
BMI (kg/m²)	~37	30
Age (years)	~48	47
Female (%)	~53	21

Zealand Pharma has a collaboration and license agreement with Roche for petrelintide, including co-development and co-commercialization in the U.S. and Europe.
[a]Preliminary baseline data. Weight, BMI, and age represent mean values.
Sources: [1]ClinicalTrials.gov (NCT06662539); [2]Data on file; [3]Heise et al. Presentation at ObesityWeek, November 3–6 2024; San Antonio, TX.
BMI=body mass index; CV=cardiovascular; MRI=magnetic resonance imaging; T2D=type 2 diabetes.

The petrelintide monotherapy program is progressing rapidly towards Phase 3 initiation in H2 2026

Robust Phase 2 program

ZUPREME-1 (obesity w/o T2D)[1]
42-week topline data expected in Q1 2026

ZUPREME-2 (obesity w. T2D)[2]
28-week topline data expected in H2 2026

Comprehensive Phase 3 program

Phase 3a: Focus on accelerated launch
Expected initiation in H2 2026

Phase 3b: Unlock full value potential
Rapid expansion into related comorbidities and further value-creation opportunities, including anticipated initiation of CVOT[a]

Image is illustrative, no associations implied.
Zealand Pharma has a collaboration and license agreement with Roche for petrelintide, including co-development and co-commercialization in the US and Europe.
[a]Pending Phase 2 data in 2026.
Sources: [1]ClinicalTrials.gov (NCT06662539); [2]ClinicalTrials.gov (NCT06926842).
CVOT=cardiovascular outcomes trial; T2D=type 2 diabetes.

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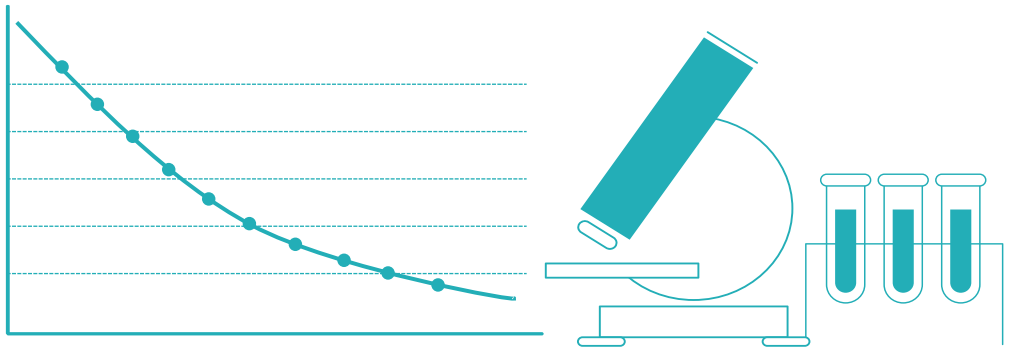
Phase 2 trial with petrelintide/CT-388 planned for initiation in H1 2026

Zealand Pharma and Roche aim to maximize the dose of petrelintide[a] and optimize the dose of CT-388

Petrelintide as the foundation[a]



Placebo-controlled trial with inclusion of **active comparator arms** (petrelintide and CT-388 monotherapy)

Strategic objectives of the Phase 2 trial

Identify the doses that **maximize weight loss** efficacy whilst **optimizing the experience**

Identify and **select optimal dose(s)** to move forward to Phase 3

Zealand Pharma has a collaboration and license agreement with Roche for petrelintide, including co-development and co-commercialization in the U.S. and Europe.
[a]Pending ZUPREME-1 Phase 2 monotherapy data with petrelintide.

Petrelintide holds potential as a future foundational therapy for weight management

Weight loss – Potential for ~15–20% reduction in body weight as monotherapy[1-3]

Safety and tolerability – Potential for better tolerability compared to incretins, including less frequent and less severe GI AEs, leading to overall better patient experience and improved treatment persistence[1-3]

Mechanism of action – Reduces food intake by restoring leptin sensitivity and enhancing satiety, making people feel full faster, rather than suppressing appetite[4]

Cardiovascular disease – Potential to reduce CVD risk (e.g., through effects on blood pressure, heart rate, lipids, and hsCRP)[1-3]

Potential of petrelintide to meet most needs as monotherapy and serve as the backbone in combination with CT-388 for added weight loss and/or improved glycemic control

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Zealand Pharma has a collaboration and license agreement with Roche for petrelintide, including co-development and co-commercialization in the U.S. and Europe

Sources: [1]Brændholt Olsen et al. Data presented at ObesityWeek 2023 in San Antonio, TX; [2]Garvey et al. N Engl J Med 2025;393(7):635–647; [3]Billings et al. Lancet 2025 doi: 10.1016/S0140-6736(25)02155-5; [4]Roth et al. Proc Natl Acad Sci U S A 2008;105(20):7257–7262.

AE=adverse event; CVD=cardiovascular disease; GI=gastrointestinal; GLP-1RA=glucagon-like peptide-1 receptor agonist; hsCRP=high-sensitivity C-reactive protein; MoA=mechanism of action.

Q&A

Petrelintide

Adam Steensberg
David Kendall
Louis J. Aronne

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6.

Our engine: world's most valuable metabolic health pipeline

Utpal Singh – 4:20-4:50

1. The opportunity & our ambition
Adam Steensberg
1:05-1:25

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5:00-5:30

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Zealand is built to lead in metabolic health

Idea

Insights modulating multi-hormonal circuits

Discovery

>25 years of data to build ML models

Medical

Led by experts and pioneers in amylin therapeutics

Patients

Potential for 5 launches in 5 years[a]

Utpal Singh
Chief Scientific Officer

David Kendall
Chief Medical Officer

Steven Johnson
Chief Development Officer

Steven Smith
Senior Global Medical Advisor

Our expertise across the value chain will harness human physiology to develop breakthrough medicines

[a]Potential mid-term product approvals include dasiglucagon for congenital hyperinsulinism, glepaglutide for short bowel syndrome, survodutide for chronic weight management, survodutide for metabolic dysfunction-associated steatohepatitis, and petrelintide for chronic weight management.
ML=machine learning.

Defined by firsts in complex peptide engineering

25+ years of expertise in peptide R&D

Strong track record in stabilizing and developing the most challenging peptides

Lixisenatide
First SIP-tail modified **GLP-1** analog

Dasiglucagon
First glucagon analog with stability in aqueous solution

Survodutide
First glucagon/GLP-1 receptor dual agonist[a]

Glepaglutide
First GLP-2 analog in a ready-to-use autoinjector

Petrelintide
First long-acting human amylin-derived **amylin** analog with stability around neutral pH

Dapiglutide
First GLP-1/GLP-2 receptor dual agonist

ZP9830
Potential **first** specific inhibitor of the **Kv1.3** ion channel

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[a]U.S. and Europe.
R&D=research and development; SIP=structure inducing probe; GLP-1=glucagon-like peptide-1; GLP-2=glucagon-like peptide-2.

Metabolic health: Hidden epidemic beyond obesity

>1 billion people worldwide with metabolic imbalance

NON-EXHAUSTIVE

The Visible Epidemic

>120 million people in the U.S. are living with obesity[1,2]

The Hidden Epidemic

~20 million people in the U.S. with BMI <25 are **metabolically unhealthy**[3]

Consequences of metabolic imbalance

- Cardiovascular disease
- T2D and beta cell failure
- MASH
- CKD / DKD

Increased mortality and shorter healthspan

Healthspan is the period of a person's life during which they are in good health free from disease, disability, and age-related ailments.

Sources: [1]CDC - Obesity and Severe Obesity Prevalence in Adults: United States, August 2021–August 2023, NCHS Data Brief No. 508, September 2024; [2]CDC – Childhood Obesity Facts, Public Health, April 2, 2024; [3]Anand, Seerat et al. (2025) BMJ Open Diabetes Res Care, 2025 May 28;13(3).
BMI=body mass index; T2D=type 2 diabetes; MASH=metabolic dysfunction-associated steatohepatitis; CKD=chronic kidney disease; DKD=diabetic kidney disease.

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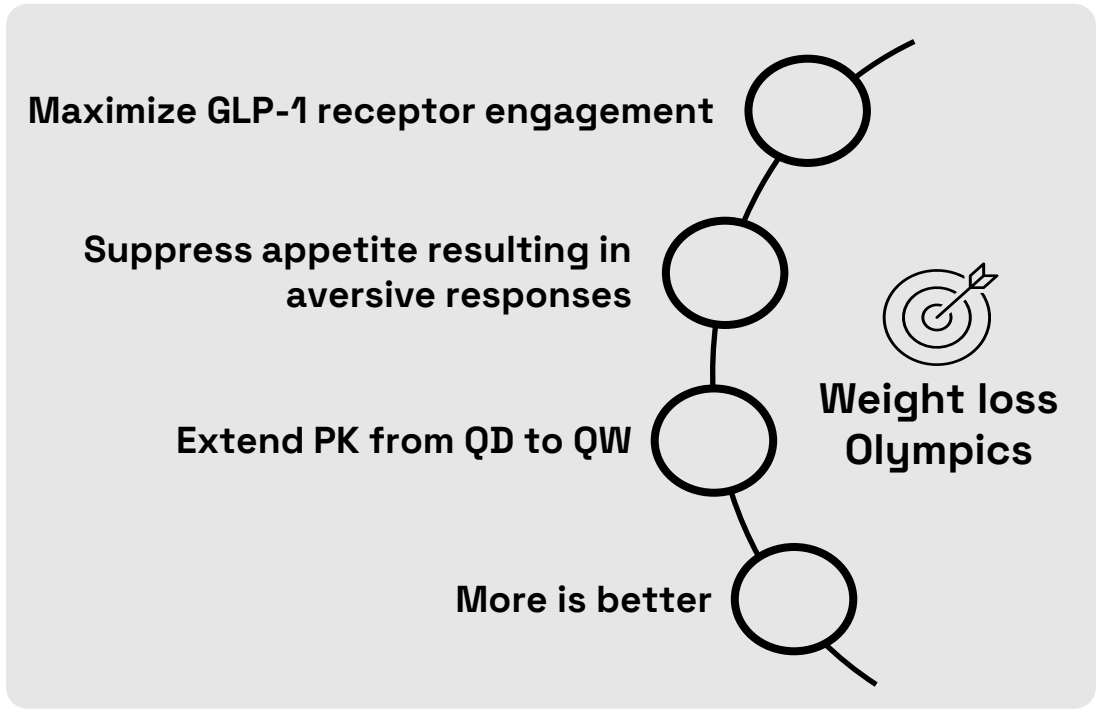
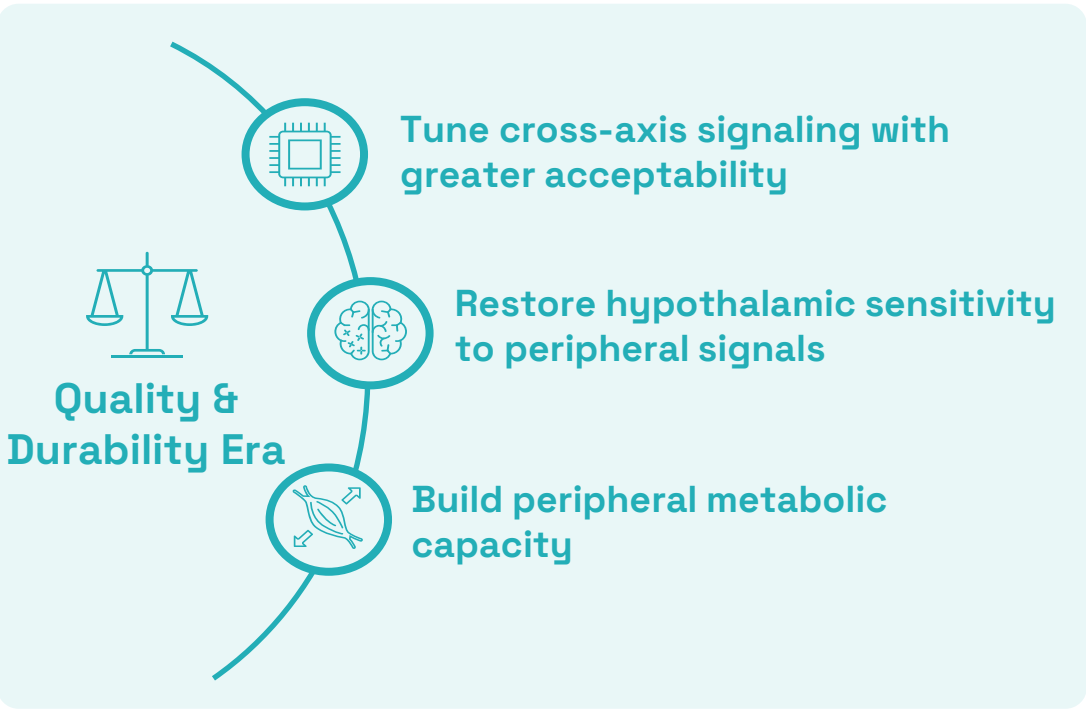
Designing to treat root causes and enhance experience

Weight loss Olympics (2005-2025)
Weight loss through appetite suppression (gut–brain axis)

Quality & Durability Era (Now → Future)
Systemic rebalancing across brain–gut–periphery

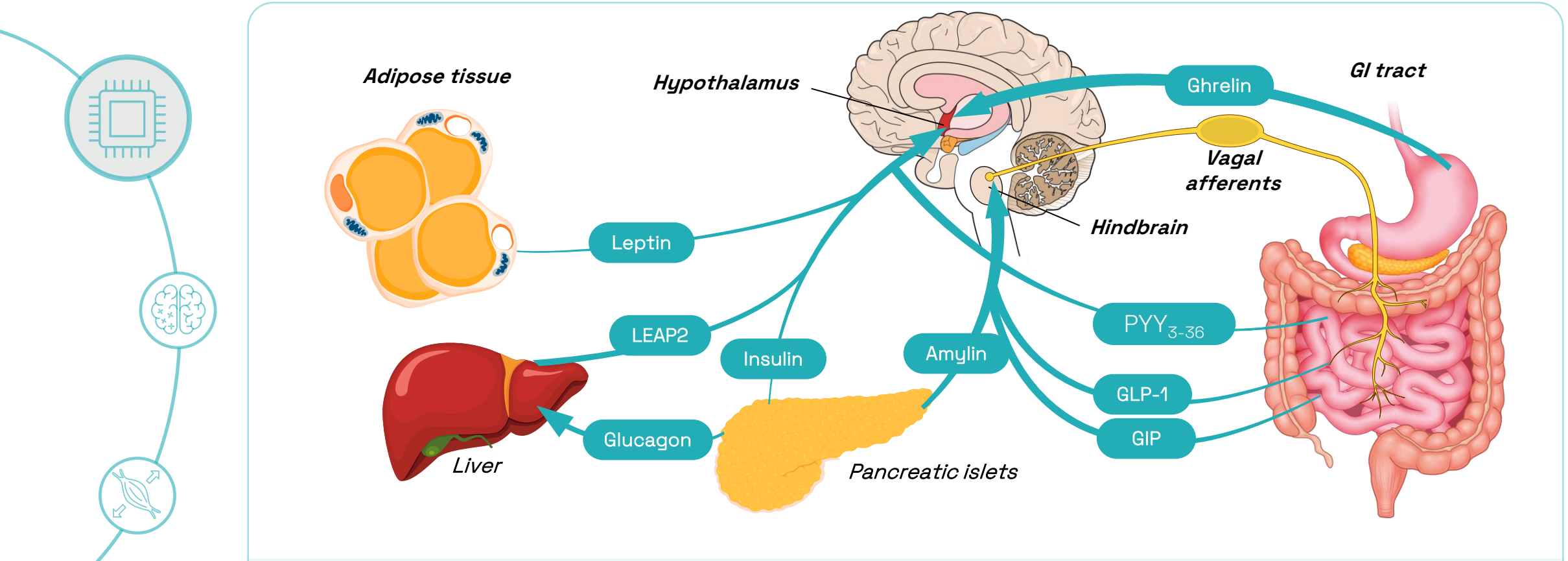
Liraglutide *Semaglutide* *Tirzepatide* *Survodutide* *Petrelintide* *Tuned Multi-hormone combinations*





GLP-1=glucagon-like peptide-1; PK=pharmacokinetics; QD=once daily; QW=once weekly.

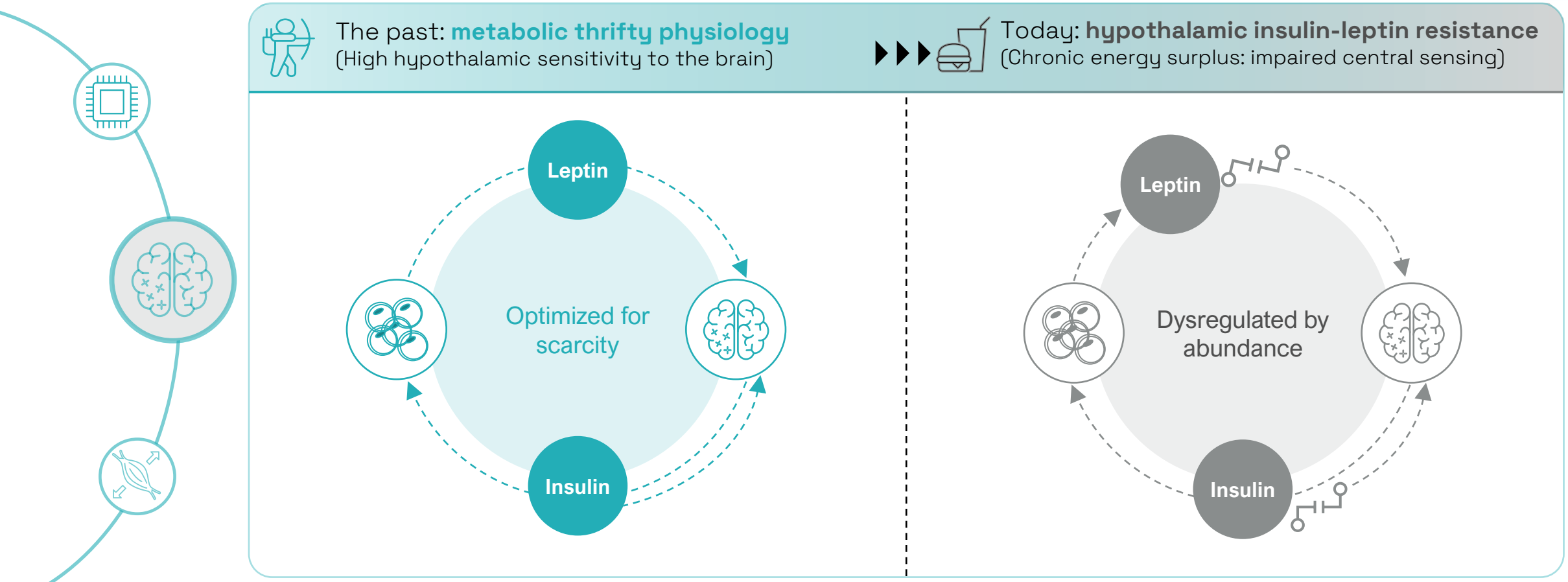
Tune cross axis signaling to rebalance the system



Leveraging human physiology with multi-hormone combinations to dial in efficacy and dial out adverse effects

Source: Figure adapted from Badman & Flier. Science 2005;307:1909–1914.
GI=gastrointestinal; GIP=glucose-dependent insulinotropic polypeptide; GLP-1=glucagon-like peptide-1; LEAP2=liver enriched antimicrobial peptide 2; PYY_{3-36}=Peptide YY residues 3–36.

Targeting the brain to restore hypothalamic sensitivity



Restoring the insulin–leptin axis restores the brain's ability to sense energy status providing deeper metabolic control beyond what peripheral therapies alone can achieve

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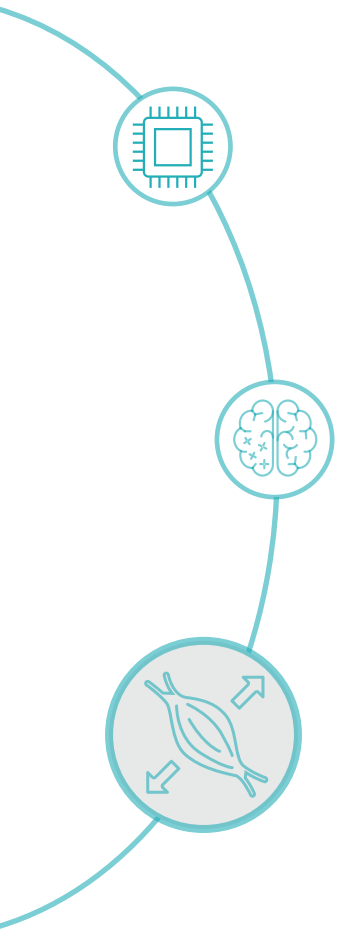
Increase peripheral metabolic capacity and flexibility



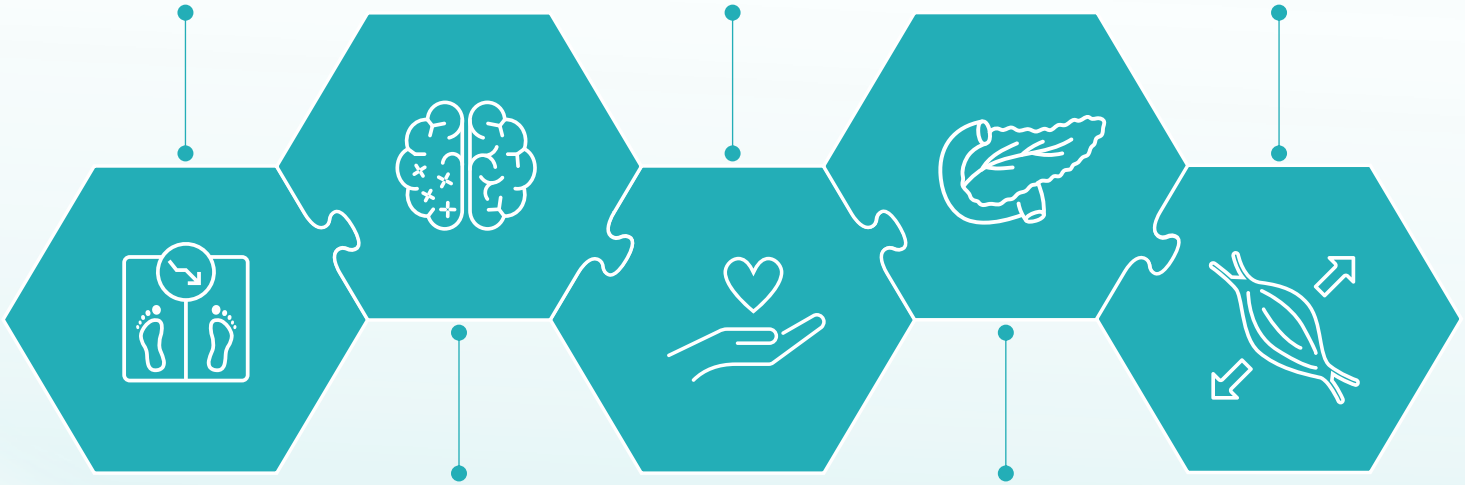
	The future: metabolic fitness
Skeletal muscle	**Build / preserve functional muscle**
Adipose tissue	**Enable adipose remodeling and flexibility**
Beta cell	**Protect, rest, and restore function**
Liver	**Restore HGP to normal physiological control**

Weight-independent insulin sensitization will drive metabolic flexibility required for durable outcomes

HGP=hepatic glucose production.

Delivering outcomes that will increase human health span

Quality & Durability Era



Weight loss with higher acceptability to shatter adherence ceiling

Convenience and durability

Improved bone and muscle health

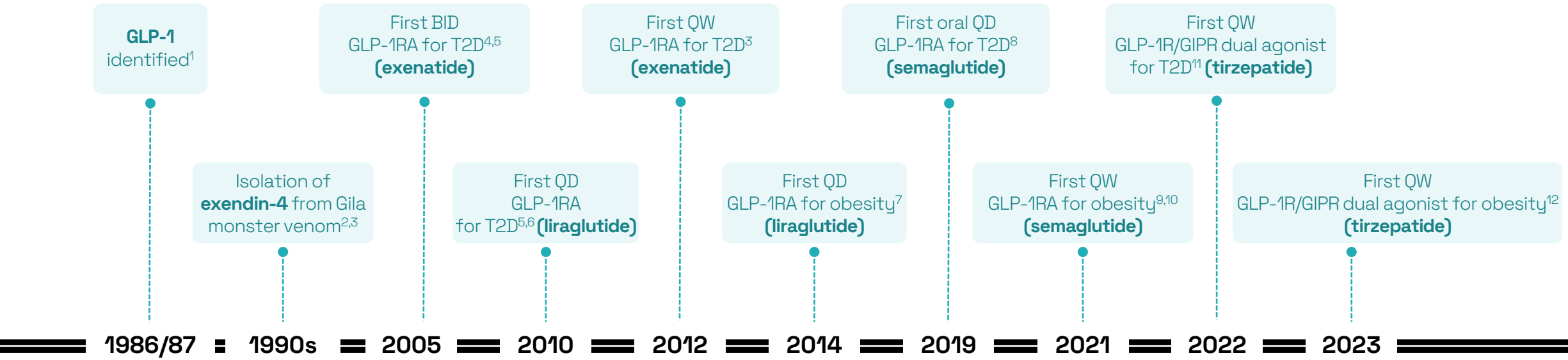
Leptin sensitivity to restore brain's regulatory baseline

Improved beta-cell function for T2D and T1D remission

T1D=type 1 diabetes; T2D=type 2 diabetes.

GLP-1 story shows that persistence and innovation redefine what's possible

Stability & DPP-4 resistance | **Half-life extension technologies** | **Oral peptide delivery** | **Signaling engineering**



Sources: [1]Friedman. Proc Natl Acad Sci USA 2024;121(39):e2415550121; [2]Eng et al. J Biol Chem 1992;267(11):7402–7405; [3]Prasad-Reddy & Isaacs D. Drugs Context 2015;4:212283; [4]Drucker et al. J Clin Invest 2017;127(12):
4217–4227; [5]Nauck et al. Mol Metab 2021;46:101102; [6]Jackson et al. P T 2010;35(9):498–529; [7]Tilinca et al. Medicina (Kaunas) 2021;57(7):669; [8]Isaacs et al. Diabetes Spectr 2021;34(1):7–19; [9]Fornes et al. J Pharm Technol 2022;38(4):239–246; [10]Moiz et al. Am J Cardiol 2024;222:121–130; [11]Gallwitz. Front Endocrinol (Lausanne) 2022;13:1004044; [12]Liu. Front Endocrinol (Lausanne) 2024;15:1431292.
BID=twice daily; DPP-4=Dipeptidyl peptidase-4; QD=once daily; QW=once weekly; FDA=US Food and Drug Administration; GIPR=glucose-dependent insulinotropic polypeptide receptor; GLP-1R=glucagon-like peptide-1 receptor; GLP-1RA=glucagon-like peptide-1 receptor agonist; T1D=type 1 diabetes; T2D=type 2 diabetes.

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Amylin renaissance through peptide design

1988 — **Amylin** (IAPP) identified[1]

1990s — Studies demonstrate amylin's physiological **roles in satiety**[2,3]

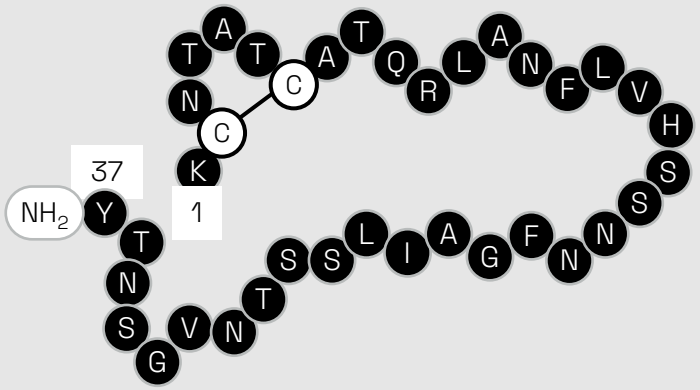
2005 — FDA **approves pramlintide** as an adjunct to insulin therapy in T1D and T2D[3,4]

Key challenges for pramlintide

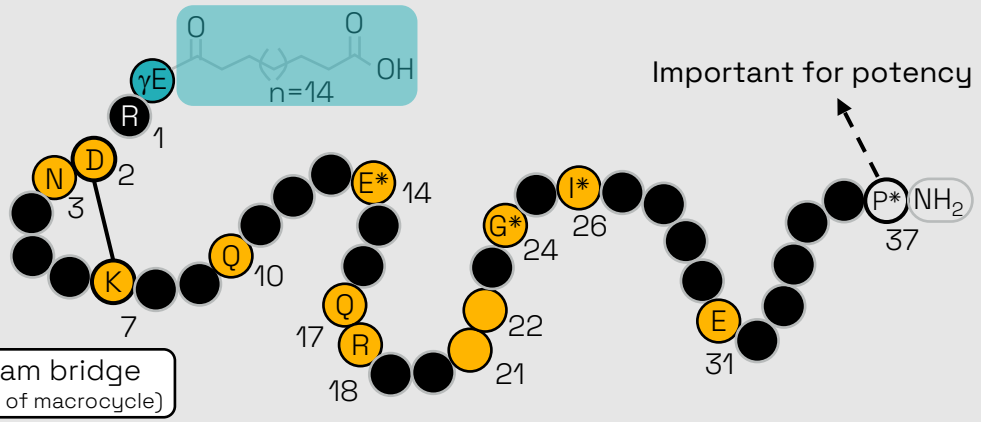
- Amyloidogenic instability[5]
- Inconvenient dosing and injection burden due to short half-life[6,7]
- Limited market uptake led to perception that biology was not commercially viable
- Technology gap[4,8,9] (e.g., the era before lipidation, albumin fusion)

2028/29 — Potential approval of **first long-acting amylin** analogs (monotherapy) for obesity

Human amylin[10]



Petrelintide: Key modifications to human amylin[11,12]



Disulfide to lactam bridge (3-atom ring-expansion of macrocycle)

- Modifications important for physical and chemical stability
- Acylation important for half-life

Sources: [1]Moore CX, Cooper GJ. Biochem Biophys Res Commun. 1991 Aug 30;179(1):1-9; [2]Lutz. Appetite 2022;172:105965; [3]Hay et al. Pharmacol Rev 2015;67(3):564–600; [4]Symlin® (pramlintide) US Prescribing Information. AstraZeneca, December 2019; [5]da Silva et al. Biophys Chem 2016;219:1–8; [6]Kruse et al. J Med Chem 2021;64(15):11183–11194; [7]Maikawa et al. Adv Sci (Weinh) 2021;8(21):e2101575; [8]Deng et al. Diabetes Metab Syndr Obes 2024;17:343-362; [9]Koh et al. Nat Rev Bioengineering 2025; http://doi.org/10.1038/s44222-025-00349-8; [10]Adapted from Alghrably et al. J Inorg Biochem 2019;191:69–76; [11]Munch, Henrik Fischer (2024) Presentation on The discovery of petrelintide, a potent, stable, long-acting human amylin analog, 19th Annual Peptide Therapeutics Symposium, October 2024, San Diego, US; [12]Data on file.

IAPP=islet amyloid polypeptide; FDA=US Food and Drug Administration; T1D=type 1 diabetes; T2D=type 2 diabetes.

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Prioritizing and accelerating early-stage programs

ZP9830: Highly potent and specific Kv1.3 inhibitor

Kv1.3 overexpression in memory T cells drives chronic inflammation and autoimmune disease[1]

PK and safety data from SAD trial[2] expected in Q1 2026

Pending SAD data, we will progress to Phase 1b/2a PoC trials, pursuing multi-indication strategy

Pipeline in a product potential

ZP6590: Progressing GIP analog to clinical testing

Improve tolerability and adipose insulin sensitivity, reducing ectopic fat and enhancing metabolic flexibility

Phase 1 start in 2026

Pending Phase 1 data, we will progress to evaluate the potential in combination with other assets

Enhance weight loss and insulin sensitivity

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Sources: [1]Chandy and Norton (2017) Peptide blockers of Kv1.3 channels in T cells as therapeutics for autoimmune diseases, Curr Opin Chem Biol, 38:97-107; [2]ClinicalTrials.gov ID: NCT06682975.
GIP=glucose-dependent insulinotropic polypeptide; PK=pharmacokinetics; PoC=proof of concept; SAD=single ascending dose.

Expanding platform reach through partnerships to reimagine medicine creation

Expand toolbox

Build multi-asset amylin franchise and expand toolbox to enable tissue-selective targeting

Strengthen platform

Access technologies (AI/ML) to develop predictive models leveraging our legacy data and expertise for challenging targets

Fuel clinical pipeline

Partnerships for assets that are at or near clinical readiness

AI=artificial intelligence; ML=machine learning.

Building a multi-asset amylin franchise to expand treatment options

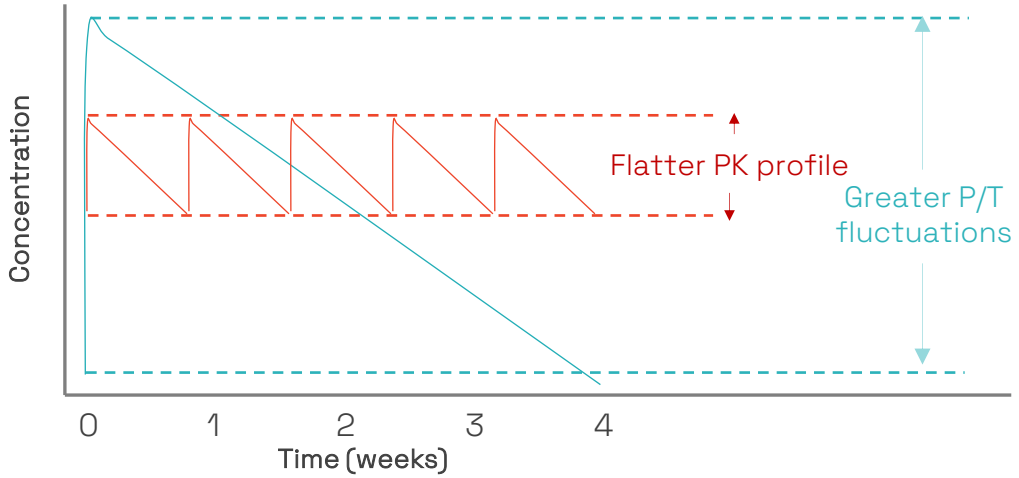
Oral small-molecule amylin

- ✓ Broader accessibility
- ✓ Greater flexibility in treatment options
- ✓ Supply chain resilience

True once-monthly injectable amylin

- ✓ Specifically designed for less frequent dosing
- ✓ Maintain favorable tolerability profile

Force-fitting QW profile into QM may lead to poor tolerability and/or lower efficacy



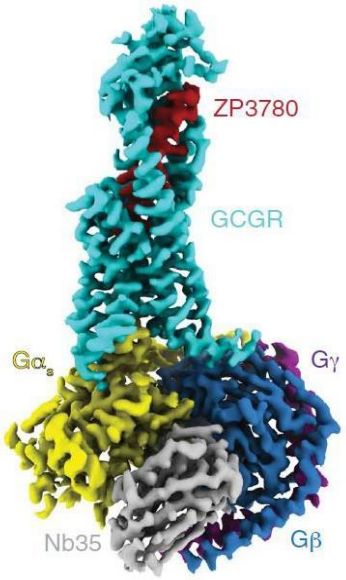
QW=once weekly; QM=once monthly; PK=pharmacokinetics; P/T=peak-to-trough.

Investing in advanced computational methods for medicine creation

Structural dynamics and legacy data will enable precise molecule design and pivot from empirical sequence screening

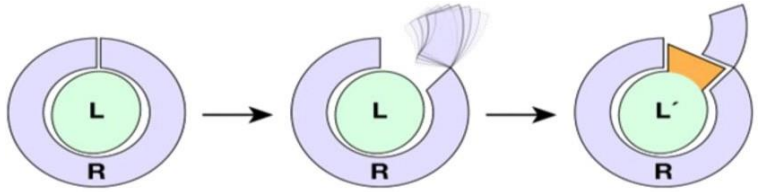
Static model

Static views constrain design:



Dynamic model

Molecular dynamics can reveal novel design:



3D structure:
Static binding site

MD simulation:
Dynamic binding sites

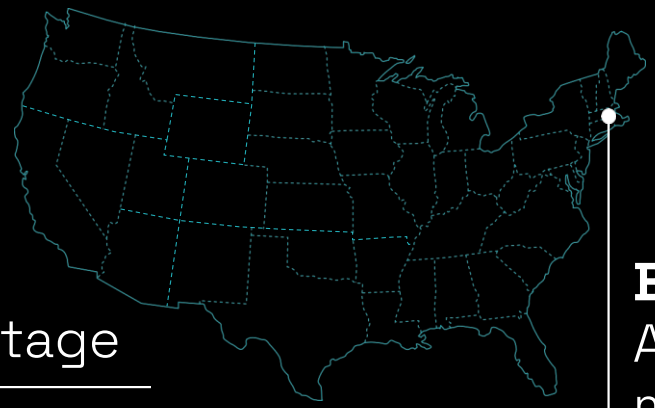
Alternative ligands:
Optimized interactions

Develop predictive ML models leveraging our legacy data

Source: Hilger et al. Science. 2020 Jul 31;369(6503) (with author permission).
MD=molecular dynamics. ML=machine learning L=ligand; L'=different ligand; R=receptor.

Integrating two biotech powerhouses in metabolic health

Expand the reach of our platform



Copenhagen:
Build on our heritage

- Peptide engineering
- Structural biology
- Deep preclinical MoA studies
- 150 FTEs in Research by 2026

Boston:
Accelerate medicine creation

- AI-ML driven peptide discovery with legacy data
- Automation to accelerate idea to clinic
- Hybrid modalities for tissue-selective targeting
- Ramp to 100 FTEs from 2026

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MoA=mechanism of action; FTE=full time employee; AI=artificial intelligence; ML=machine learning.

We will build the world's most valuable metabolic health pipeline

Focus on our expertise

Partner to evolve our platform

Accelerate our research engine

Deliver valued medicines

#1
idea → clinic cycle times

+10
clinical programs by 2030

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7.

How we fund and scale this

Henriette Wennicke – 4:50-5:00

1.
The opportunity & our ambition
Adam Steensberg
1:05-1:25

2.
The future of weight management
Eric Cox
1:25-1:50

3.
Survodutide: the next frontier in obesity & MASH (GCG/GLP-1)
Carel Le Roux & David Kendall - including Q&A
1:50-2:25

4.
Amylin: an emerging therapeutic class
Jonathan D. Roth & Louis J. Aronne
2:25-3:05

Break
3:05-3:45

5.
Petrelintide: building the leading amylin franchise
David Kendall - including Q&A
3:45-4:20

6.
Our engine: world's most valuable metabolic health pipeline
Utpal Singh
4:20-4:50

7.
How we fund and scale this
Henriette Wennicke
4:50-5:00

8.
Q&A and closing remarks
Adam Steensberg & team
5:00-5:30

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Uniquely positioned to maximize the value of petrelintide and build a leading metabolic health pipeline

Capital Allocation Strategy

1. Establish leading multi-asset amylin-based franchise
2. Accelerate and strengthen research engine
3. Inorganic investments to enhance R&D capabilities and pipeline

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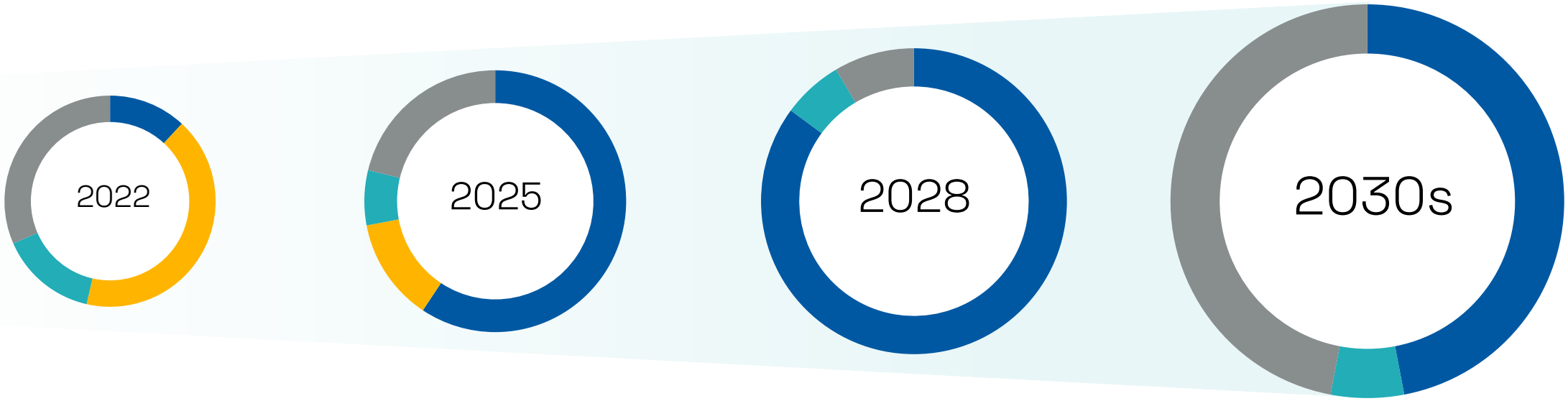
Allocating resources to lead in obesity and metabolic health

ILLUSTRATIVE[a]



R&D

- Obesity & inflammation
- Rare diseases
- Research

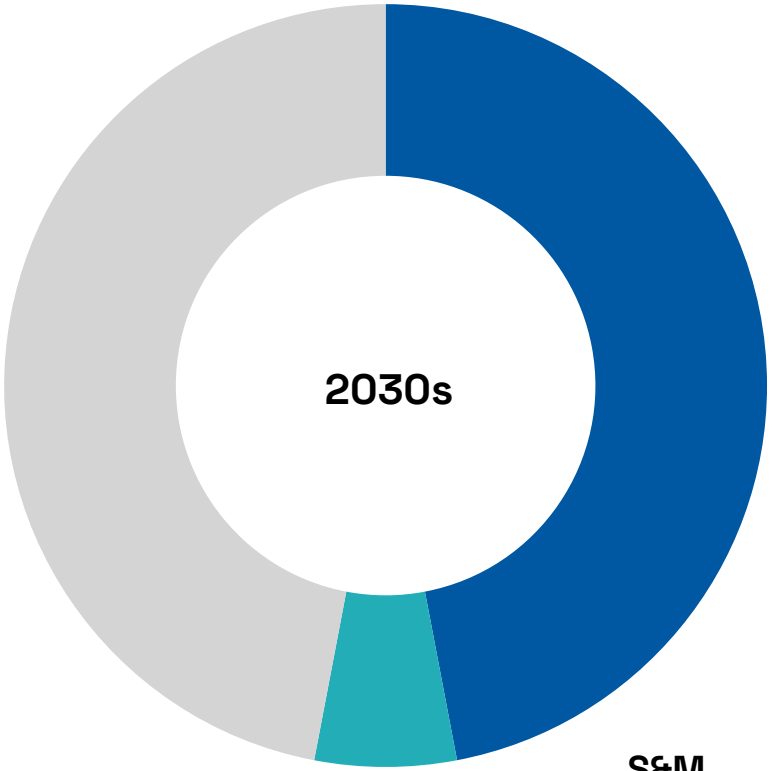
S&M

- Commercial

[a]The anticipated 2028 and 2030 resource allocation is subject to the "Forward-Looking Statements" disclaimer and should not be relied upon as a prediction of future performance; actual outcomes may differ materially and adversely from those anticipated or implied.

The route to becoming a generational biotech

ILLUSTRATIVE[a]



Obesity & Inflammation

- Petrelintide development costs peaked late 2020s
- New programs drive development expenses

Research

- Step change in absolute investments
- From DKK 1 billion past 5 years to DKK ~5 billion in the coming 5 years

Commercial

- Significant petrelintide S&M expenses around monotherapy launch

S&M

Commercial

R&D

Obesity & Inflammation

Research

[a]The anticipated 2030 resource allocation is subject to the "Forward-Looking Statements" disclaimer and should not be relied upon as a prediction of future performance; actual outcomes may differ materially and adversely from those anticipated or implied.

Strong financial terms and commitments

Petrelintide and petrelintide/CT-388

Roche

50% profit share in U.S. and Europe

Tiered **double-digit %** royalties on net sales in RoW ranging up to high-teens

Up to **USD 1.2bn**[a] in outstanding development milestones
- Incl. USD 575m for Phase 3a initiation and USD 575m for Phase 3b initiation with petrelintide monotherapy

USD 125m (x2) in anniversary payments (2026+2027)

Up to **USD 2.4bn** in sales-based milestones

No CAPEX by Zealand Pharma related to commercial supply

Survodutide

Boehringer Ingelheim

Solely responsible for development and commercialization globally

High single-digit to low double-digit % royalties on global sales

EUR 315 million outstanding in potential milestone payments

[a]Zealand Pharma will pay Roche USD 350 million for the contribution of CT-388 in the first combination product arising from the collaboration. The payment will become due in four installments throughout 2026-27.
CAPEX=capital expenditure; RoW=rest of world (outside U.S. and Europe).

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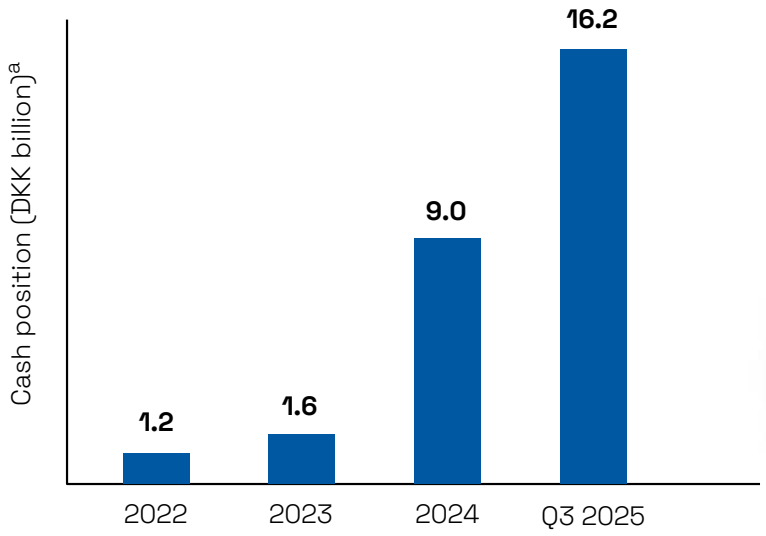
Financial muscle for accelerated growth

ILLUSTRATIVE

Robust capital position more than sufficient to deliver on key strategic priorities



Mid-term profitability drivers

- **Today**: Potential partnerships across pipeline assets
- **2026**: USD 125 million in anniversary payments from Roche in Q2 2026 and Q2 2027, respectively; USD 1.2 billion[b] in development milestones
- **2027/2028**: Survodutide royalty stream and milestones commencing[c]
- **2029/2030**: Significant petrelintide economics: 50/50 profit share, royalty stream, commercial milestones[d]

[a]Cash position includes cash, cash equivalents and marketable securities; [b]Including USD 575m for Phase 3a initiation and Phase 3b initiation, respectively, with petrelintide monotherapy. Zealand Pharma will pay Roche USD 350 million for the contribution of CT-388 in the first combination product arising from the collaboration; [c]EUR 315 million outstanding potential development, regulatory and commercial milestones + high single to low double digit % royalties on global sales; [d]Zealand Pharma and Roche will share profits in the U.S. and Europe on 50/50 basis, and Zealand Pharma is entitled to royalties on net sales in the rest of the world, and up to USD 2.4 billion in sales-based milestones.

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And that's how we will build a **pharma pipeline with biotech financial discipline**

ZEAL&
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Today's speakers from Zealand Pharma

Q&A

Adam Steensberg
Chief Executive Officer

Henriette Wennicke
Chief Financial Officer

David Kendall
Chief Medical Officer

Eric Cox
Chief Commercial Officer

Utpal Singh
Chief Scientific Officer

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What today's journey adds up to

1. Opportunity & ambition: Zealand Pharma a generational biotech.
2. Weight management must shift to long-term treatments.
3. Survodutide – Next frontier in obesity & MASH.
4. Amylin: Emerging class.
5. Petrelintide – Foundational therapy, anchoring a best-in-class franchise.
6. Our engine and unfair advantage: Powering the world's most valuable metabolic health pipeline.
7. How we fund and scale: Pharma pipeline with biotech financial discipline.

Maximize this metabolic moment

Join the disciplined outsider in metabolic health – and be part of the moment that changes the game for patients and healthcare providers.