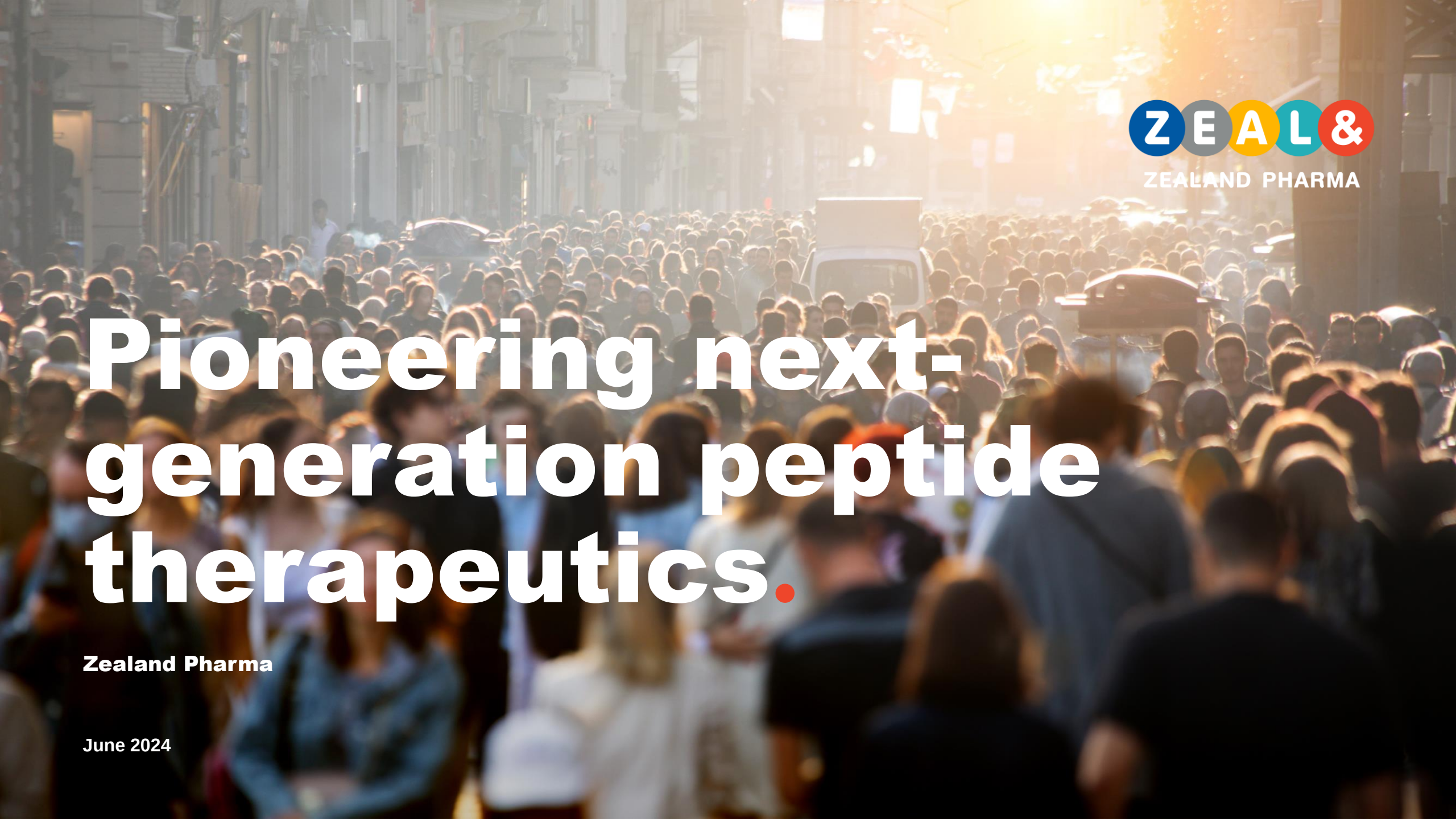


Pioneering next-generation peptide therapeutics.

Zealand Pharma

June 2024

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 2024 and Financial Guidance for 2024. These forward-looking statements may be identified by words such as “aim,” “anticipate,” “believe,” “could,” “estimate,” “expect,” “forecast,” “goal,” “intend,” “may,” “plan,” “possible,” “potential,” “will,” “would” and other words and terms of similar meaning. You should not place undue reliance on these statements, or the scientific data presented.

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

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

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

About Zealand Pharma.

We are an international biotech company headquartered in Denmark

Headquarters and labs outside Copenhagen, Denmark

Founded in 1998

- Peptide platform validated through two approved products marketed by Sanofi and Novo Nordisk
- ~280 employees globally as of May 31, 2024

Listed on NASDAQ CPH (ZEAL.CO)

- Market Cap on 5/31/2024: DKK 40B (USD ~6.0B)
- 62.6M Shares Outstanding as of May 31, 2024

Cash position*

- DKK 3.9B (~USD $560M)
- Including Jan-24 capital raise, EIB loan and RCF

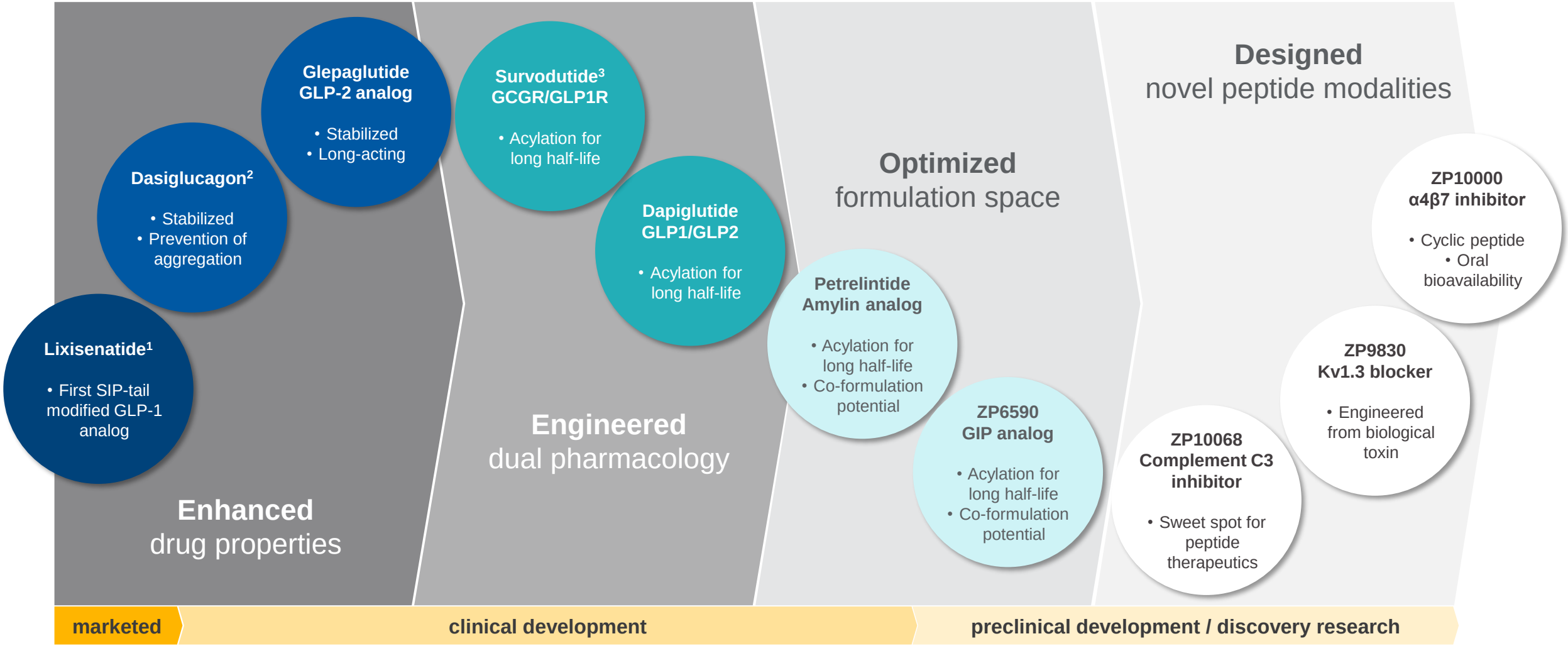
OPEX guidance for 2024

- Net operating expenses are expected to be DKK 1,100-1,200M

*Cash position includes cash, cash equivalents and marketable securities. Zealand also has a Revolving Credit Facility (RCF) with Danske Bank, off-balance sheet, of DKK 350M and a Loan facility with the European Investment Bank of EUR 90 million in three tranches (Tranche A of EUR 50 million was disbursed in Q1 2024,Tranches B and C are subject to pre-specified milestones being met).

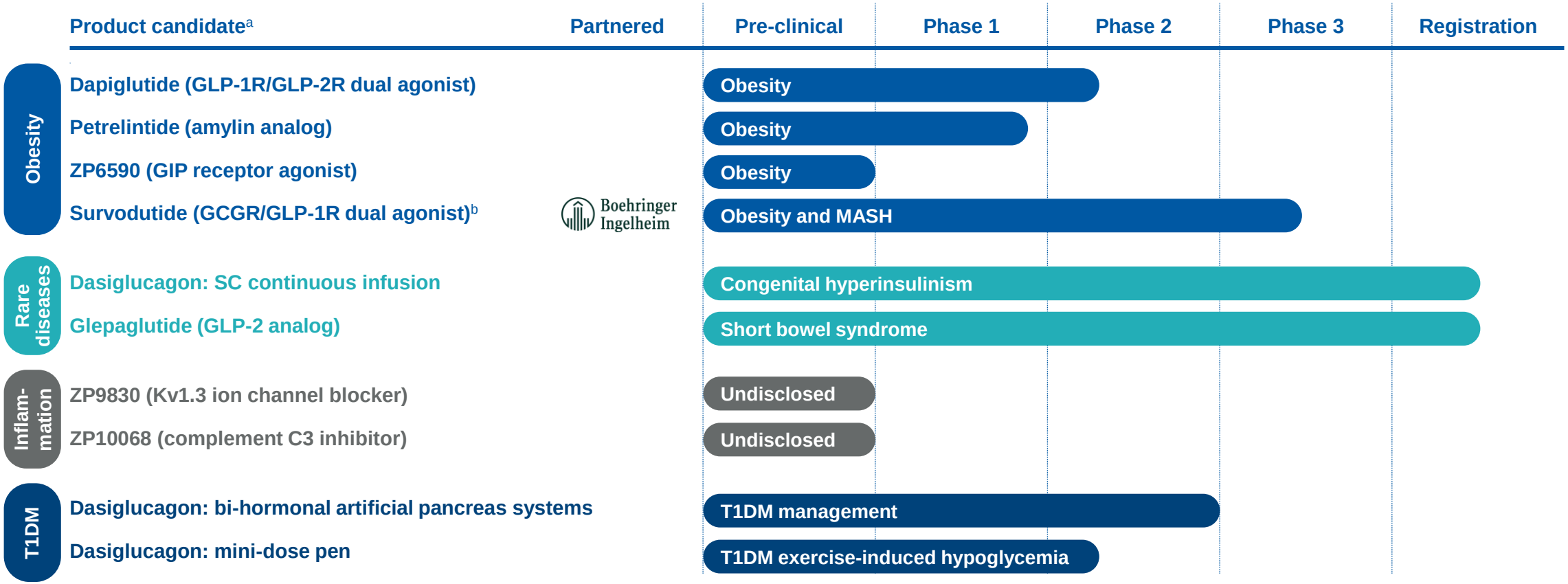
Based on foreign exchange rates as of March 31, 2024 DKK 6.943 = USD $1

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



[1] Marketed globally by Sanofi.
[2] Zegalogue® (dasiglucagon) for injection licensed to Novo Nordisk: DKK 242.5 million outstanding potential development, regulatory manufacturing and sales milestones + high single to low double digit % royalties on global sales; Zealand is responsible for certain activities to support approval outside the U.S., reimbursed by Novo Nordisk; Zealand retains all non-licensed intellectual property rights to the company's other dasiglucagon development programs
[3] Survodutide is licensed to Boehringer Ingelheim from Zealand Pharma, with Boehringer solely responsible for development and commercialization globally (subject to Zealand's co-promotion rights in the Nordic countries): EUR 315 million outstanding potential development, regulatory and commercial milestones + high single to low double digit % royalties on global sales

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



[a]**Investigational compounds whose safety and efficacy have not been evaluated or approved by the U.S. Food and Drug Administration (FDA) or any other regulatory authority.**
[b]Survodutide is licensed to Boehringer Ingelheim from Zealand Pharma, with Boehringer solely responsible for development and commercialization globally (subject to Zealand's co-promotion rights in the Nordic countries): EUR 315 million outstanding potential development, regulatory and commercial milestones + high single to low double digit % royalties on global sales.

GCGR=glucagon receptor; GIP=gastric inhibitory polypeptide; GLP-1R=glucagon-like peptide-1 receptor; GLP-2=glucagon-like peptide-2; GLP-2R=glucagon-like peptide-2 receptor; MASH=metabolic dysfunction-associated steatohepatitis (formerly NASH, or nonalcoholic steatohepatitis); SC=subcutaneous; T1DM=type 1 diabetes mellitus.

We are well on track to deliver on the most important priorities for the year 2024

Petrelintide (amylin analog)

- ☐ **Ph1b 16-week MAD clinical trial data**
- ☐ **Ph2b trial initiation**

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

- ☐ **Ph2a DREAM clinical trial data[1]**
- ☐ **Ph1b 13-week dose-titration clinical trial data**

Survodutide[2] (GCGR/GLP-1R)

Boehringer Ingelheim

- ☐ **Ph2 MASH clinical trial data**
- ☐ **Ph3 obesity trial enrollment[3]**

Deliver on rare disease and inflammation pipeline

Regulatory decisions for rare disease assets

- ☐ Dasiglucagon for CHI
- ☐ Glepaglutide for SBS

First-in-human trial initiation with inflammation assets

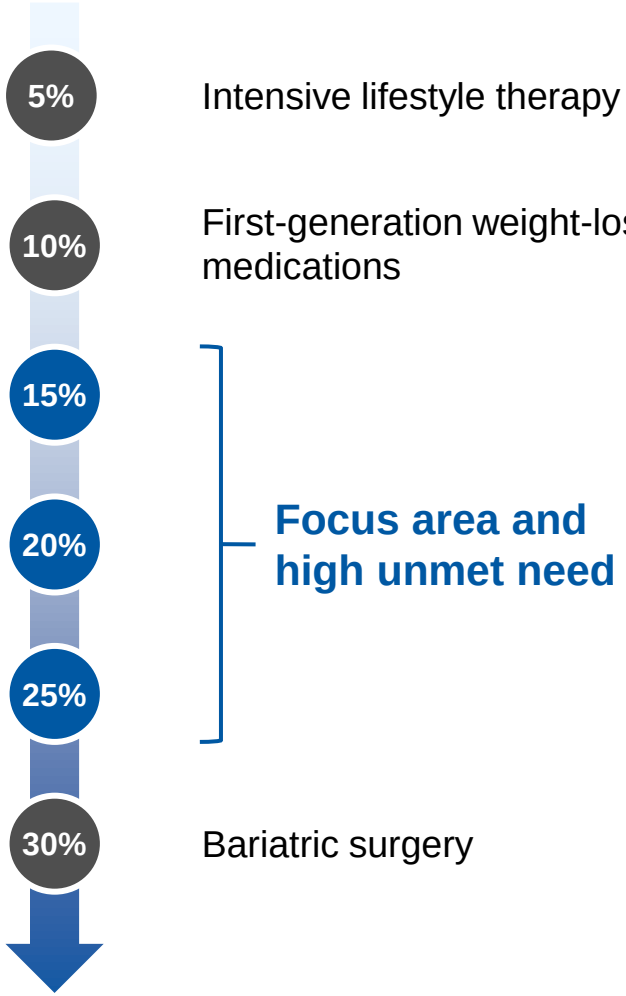
- ☐ ZP9830 (Kv1.3 Ion Channel Blocker)
- ☐ ZP10068 (Complement C3 Inhibitor)

Notes: 1. DREAM is an investigator-led trial. 2. Survodutide is licensed to Boehringer Ingelheim from Zealand Pharma, with Boehringer solely responsible for development and commercialization globally (subject to Zealand's co-promotion rights in the Nordic countries). 3. SYNCHRONIZE™.
MAD=multiple ascending dose; MASH=metabolic dysfunction-associated steatohepatitis (formerly NASH=non-alcoholic steatohepatitis); CHI=congenital hyperinsulinism; SBS=short bowel syndrome.

Obesity.

We aspire to be a key player in the fast-developing obesity treatment space, achieving meaningful weight loss and addressing long-term complications such as MASH

We believe in a shift from maximizing weight loss towards quality of weight loss and effects on comorbidities…



Segment characteristics and drivers

Payer-reimbursed segment (prescriber-driven)

Key drivers

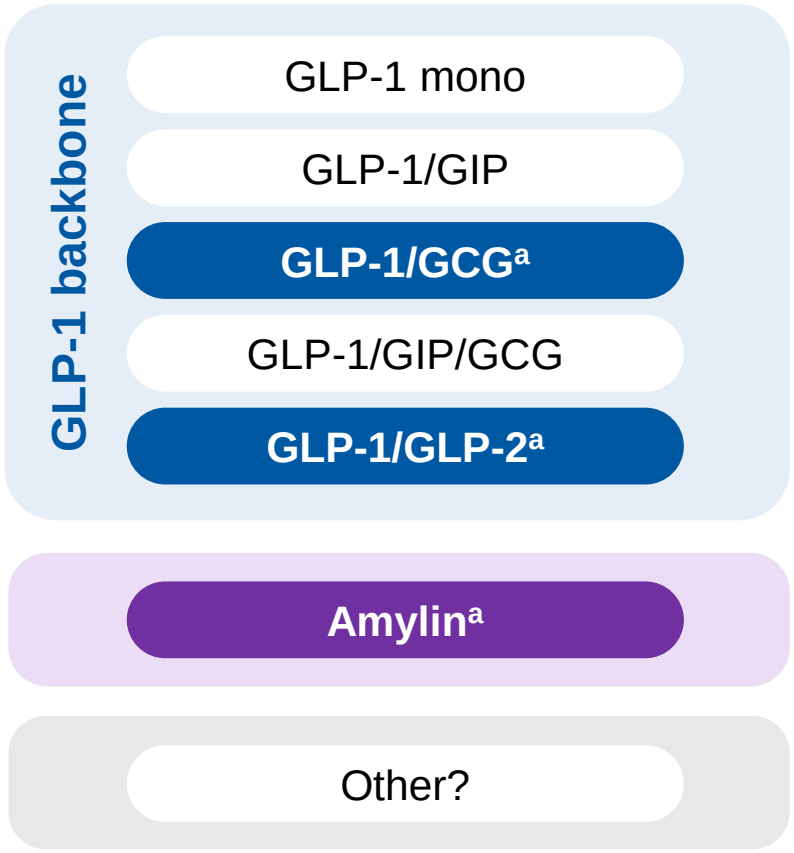
- Relative weight loss
- Comorbidity risk reduction
- Health outcomes data
- Safety
- Tolerability

Self-pay segment (consumer-driven)

Key drivers

- Desired weight loss
- Quality of weight loss, incl. muscle preservation
- Tolerability
- Convenience and administration
- Patients' willingness-to-pay

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



Examples of differentiation factors

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

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

Zealand Pharma has a rich obesity pipeline of differentiated product candidates

Developed with GLP-1 receptor agonist foundation

Initially developed as monotherapy but with potential for combination

GLP-1

- Increase insulin sensitivity
- Delay gastric emptying
- Decrease appetite

+ Glucagon

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

Survodutide
dual GCG/GLP-1 receptor agonist

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

+ GLP-2

- Improve intestinal barrier function
- Delay gastric emptying
- Improve tolerability to GLP-1

Dapiglutide
dual GLP-1/GLP-2 receptor agonist

Novel MoA with first-in-class potential, targeting obesity and co-morbidities associated with low-grade inflammation, including MASH and neuro-inflammation, such as Alzheimer's disease

Amylin

- Delay gastric emptying
- Restore leptin sensitivity
- Increase satiety

Petrelintide
amylin analog

Non-incretin MoA with best-in-class potential for obesity as monotherapy option with GLP-1RA-like weight loss but better tolerability and potential for preservation of muscle mass

GIP

- Stimulate insulin secretion
- Increase satiety
- Reduce nausea

ZP 6590
GIP receptor agonist

Targeting obesity with potential to complement GLP-1 for better effect and/or tolerability

Petrelintide is a potential best-in-class amylin analog for GLP-1RA-like weight loss with better tolerability

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Design of molecule

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

- **Long-acting** amylin analog (half-life of 10 days)[1], suitable for **once-weekly administration**
- **Chemical and physical stability** at neutral pH, allowing for **co-formulation** with other peptides[2]
- **Potent agonistic effects** on **amylin and calcitonin receptors**[3]

Positioning opportunities and differentiation

- **Obesity** – targeting GLP-1RA-like weight loss with high quality, incl. preservation of muscle mass
- **MoA** – alternative mechanism that reduces food intake by restoring leptin sensitivity and increasing satiety
- **Safety and tolerability** – potential for better tolerability vs GLP-1RAs

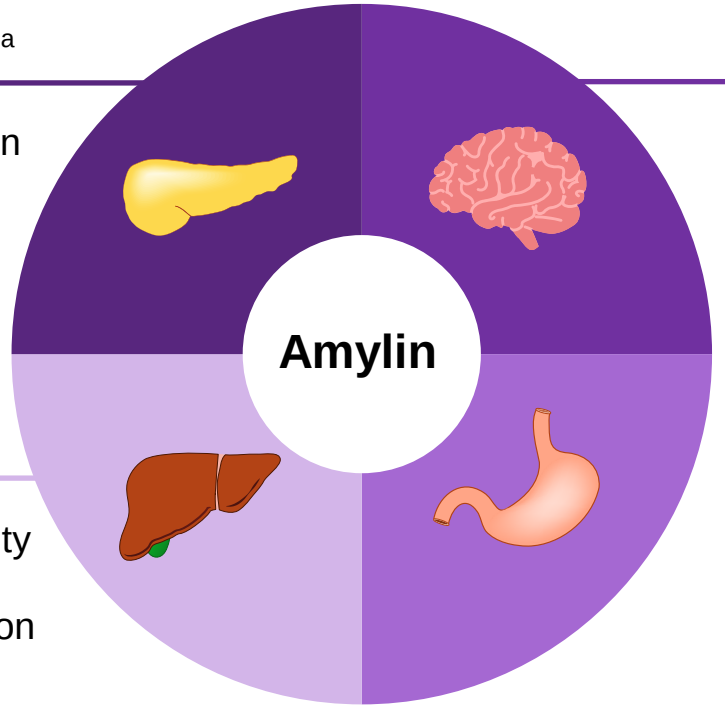
Sources: 1. Olsen et al. Poster 92-LB. Presented at ADA 83rd Scientific Sessions, June 23–26, 2023, San Diego, CA; 2. Skarbaliene et al. Poster 1406-P. Presented at ADA 82nd Scientific Sessions, June 3–7, 2022, New Orleans, LA; 3. Eriksson et al. Presentation at ObesityWeek, November 1–4, 2022, San Diego, CA.
GLP-1RA=glucagon-like peptide-1 receptor agonist; MoA=mechanism of action.
Intellectual property: Composition of matter, patent expiry in 2037. Patent-term extension up to 5 years, i.e. 2042. Potential rights beyond 2042 based on patent applications and additional elements.

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

Mechanism of action

A 37-amino acid peptide hormone, produced mainly in the pancreatic beta cells and co-secreted with insulin in response to ingested nutrients

Proposed physiological effects of amylin receptor activation[1]



Pancreas (indirect)[a]
- ↓ Insulin secretion
- ↓ Glucagon secretion

Liver and adipose tissue
- ↑ Insulin sensitivity
- ↓ Fat accumulation

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

Via the vagal nerve

GI tract
- ↓ Gastric emptying

[a]Mediated by the effect of amylin on the CNS.
Sources: 1. Figure adapted from Mathiesen et al. Eur J Endocrinol 2022;186(6):R93–R111; 2. Roth et al. Proc Natl Acad Sci U S A 2008;105(20):7257–7262.
CNS=central nervous system; GI=gastrointestinal; GLP-1=glucagon-like peptide-1.

Petrelintide significantly reduced fat mass while preserving lean mass in DIO rats

Unpublished data

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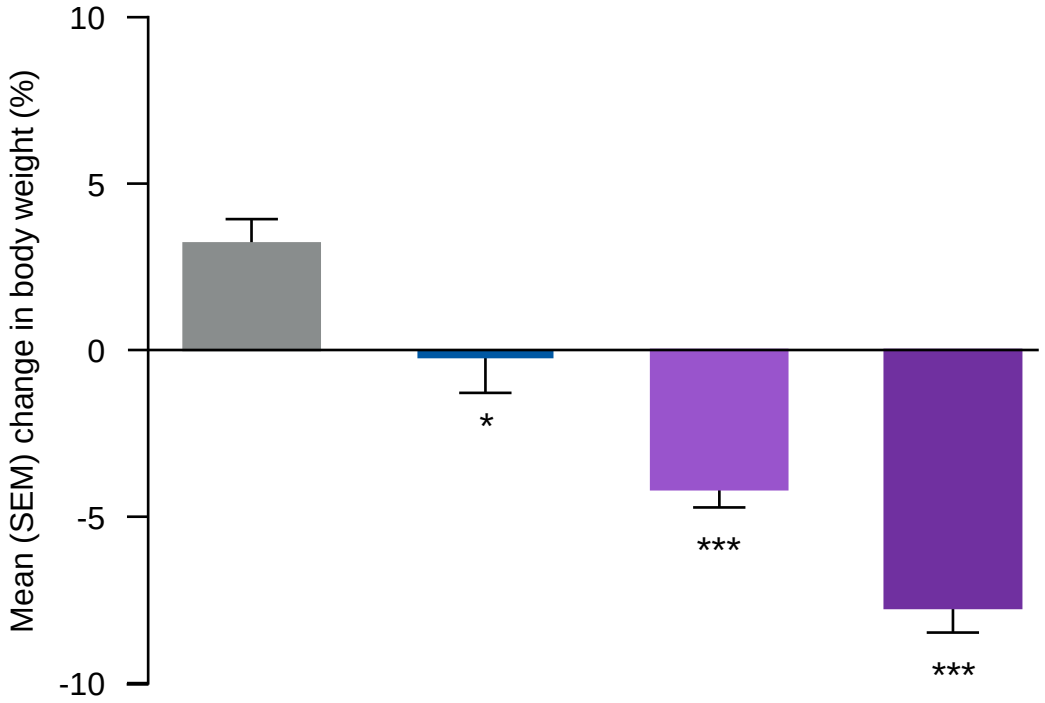
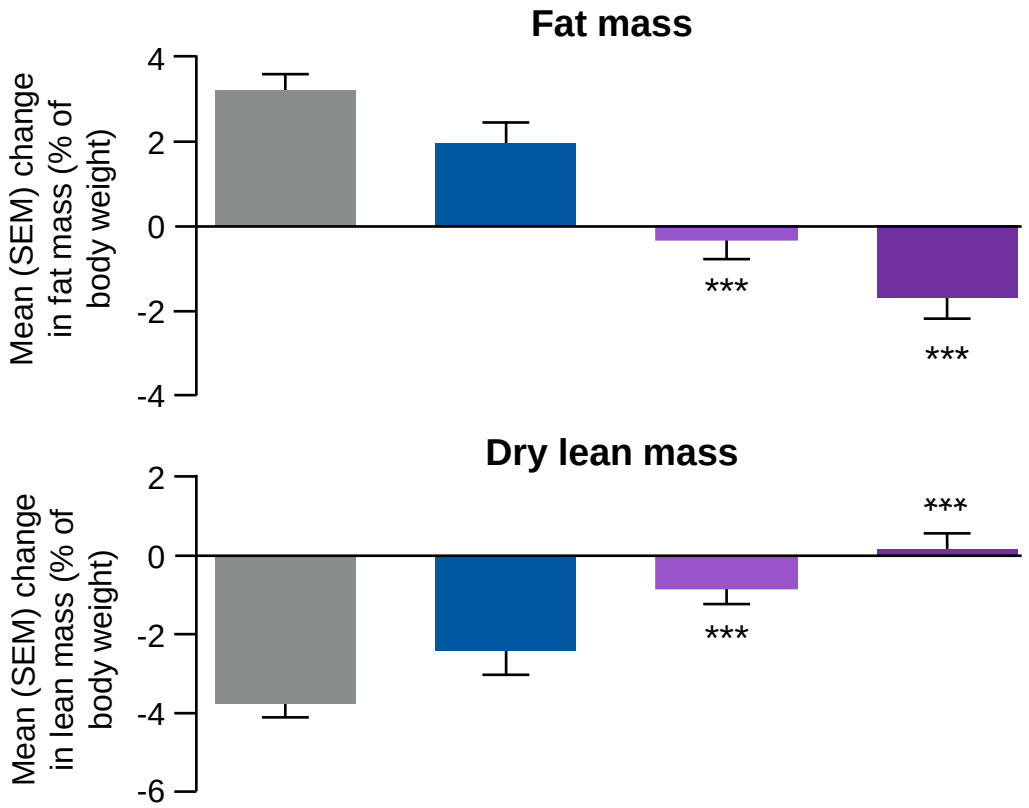
Change in body weight at Day 30



Change in body composition at Day 30

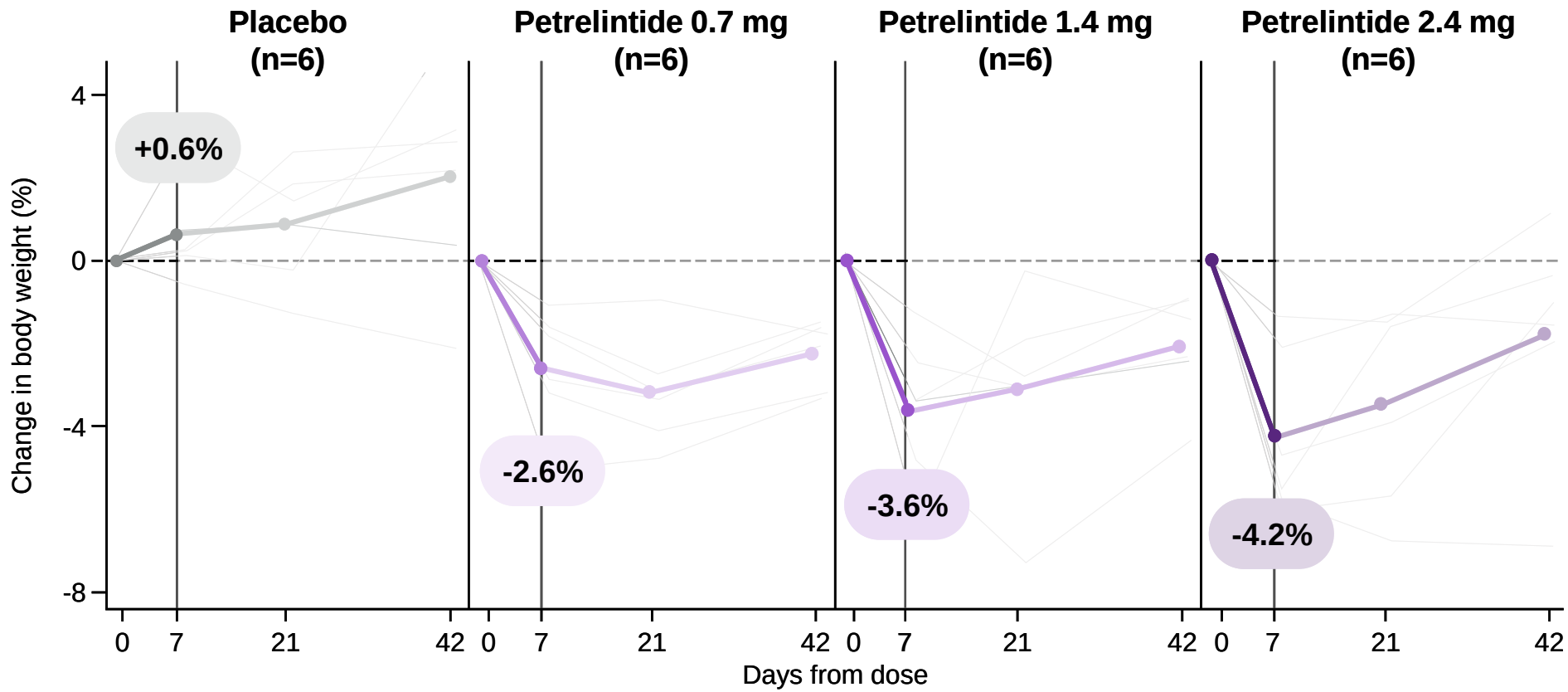


Vehicle | Liraglutide 5 nmol/kg BID | Petrelintide 2 nmol/kg Q2D | Petrelintide 10 nmol/kg Q4D

*p<0.05, ***p<0.001 vs vehicle.
Source: Figures adapted from Data on file.
BID=twice daily; DIO=diet-induced obese; Q2D=every 2 days; Q4D=every 4 days; SEM=standard error of the mean.

A single subcutaneous dose of petrelintide 2.4 mg resulted in average weight loss of 4.2% at Day 7

Change in body weight in Phase 1a SAD trial of petrelintide



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

Six, once-weekly, low doses of petrelintide resulted in average weight loss above 5%

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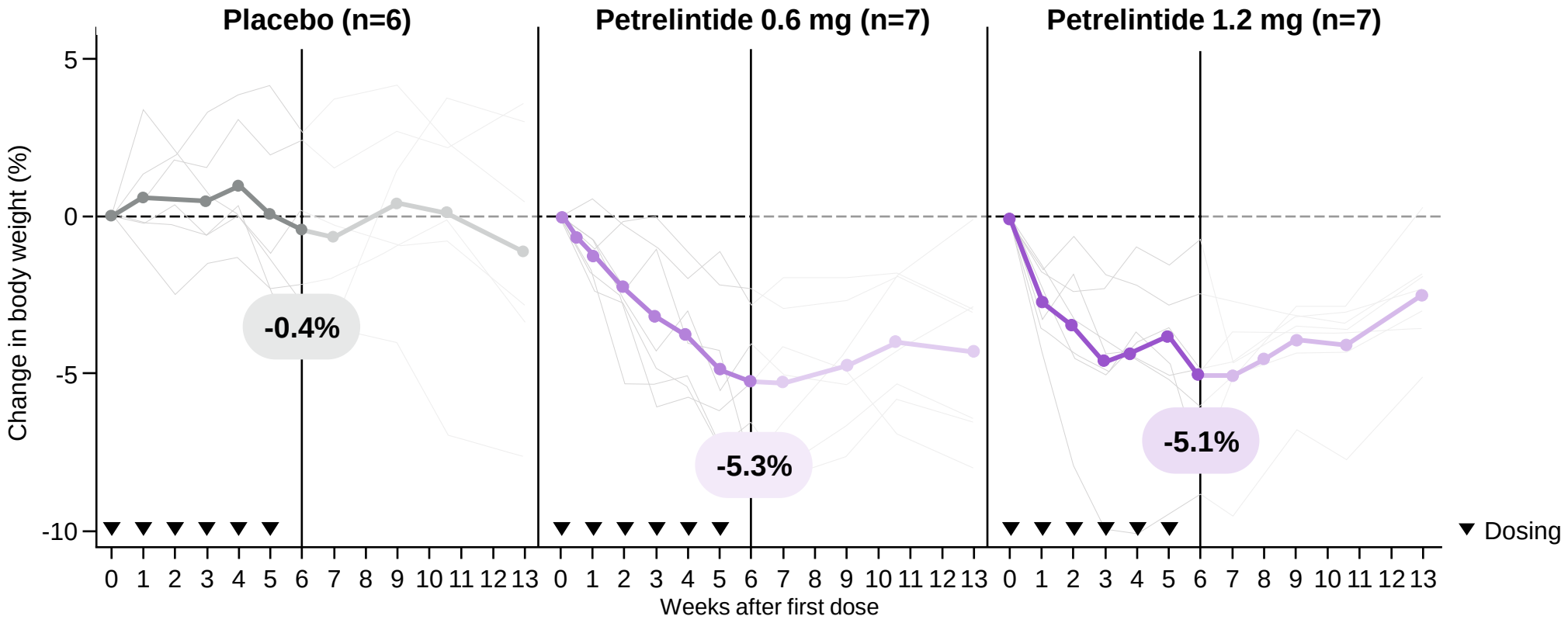
Part 1 of the Phase 1b MAD trial of petrelintide



Source: Figure adapted from Olsen et al. Poster presented at ObesityWeek, October 14–17, 2023, Dallas, TX.
MAD=multiple ascending dose.

In Part 1 of the MAD trial, petrelintide was well-tolerated with no serious or severe TEAEs and no withdrawals

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TEAEs in Part 1 of the Phase 1b MAD trial with petrelintide

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

- Nausea occurred in **three participants** on petrelintide, with one also reporting vomiting; no other participants reported vomiting
- **No injection-site reactions** were reported, and **no participants developed anti-drug antibodies**

Source: Table adapted from Olsen et al. Poster presented at ObesityWeek, October 14–17, 2023, Dallas, TX.
AE=adverse event; GI=gastrointestinal; MAD=multiple ascending dose; TEAE=treatment-emergent adverse event.

Results from Part 2 of the trial, exploring higher doses of petrelintide over 16 weeks, are expected in H1 2024

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We are investigating significantly **higher doses** of petrelintide…

…over a **longer duration** of 16 weeks…

…using a **dose-escalation** scheme…

…in **48 people** who are overweight or have obesity

The next step in the development of petrelintide will be a comprehensive Phase 2 program to be initiated in H2 2024

Source: ClinicalTrials.gov (NCT05613387), accessed November 2023.

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

Design of molecule

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

GLP-1 component reduces body weight and **GLP-2** has potential for additional **anti-inflammatory effects**[1]

Designed with **higher potency towards the GLP-1R** while retaining activity on the GLP-2R[2]

Long-acting with a half-life (123–129 hours) that is suitable for **once-weekly administration**[3]

Positioning opportunities and differentiation

Obesity – pursuing ≥20% weight loss

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

Cardiovascular benefits – potential cardioprotective benefits from GLP-1 agonism and additional anti-inflammatory effect from GLP-2 agonism

Comorbidities – potential for regenerative effects to address organ damage associated with low-grade inflammation, such as MASH and Alzheimer’s disease

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

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

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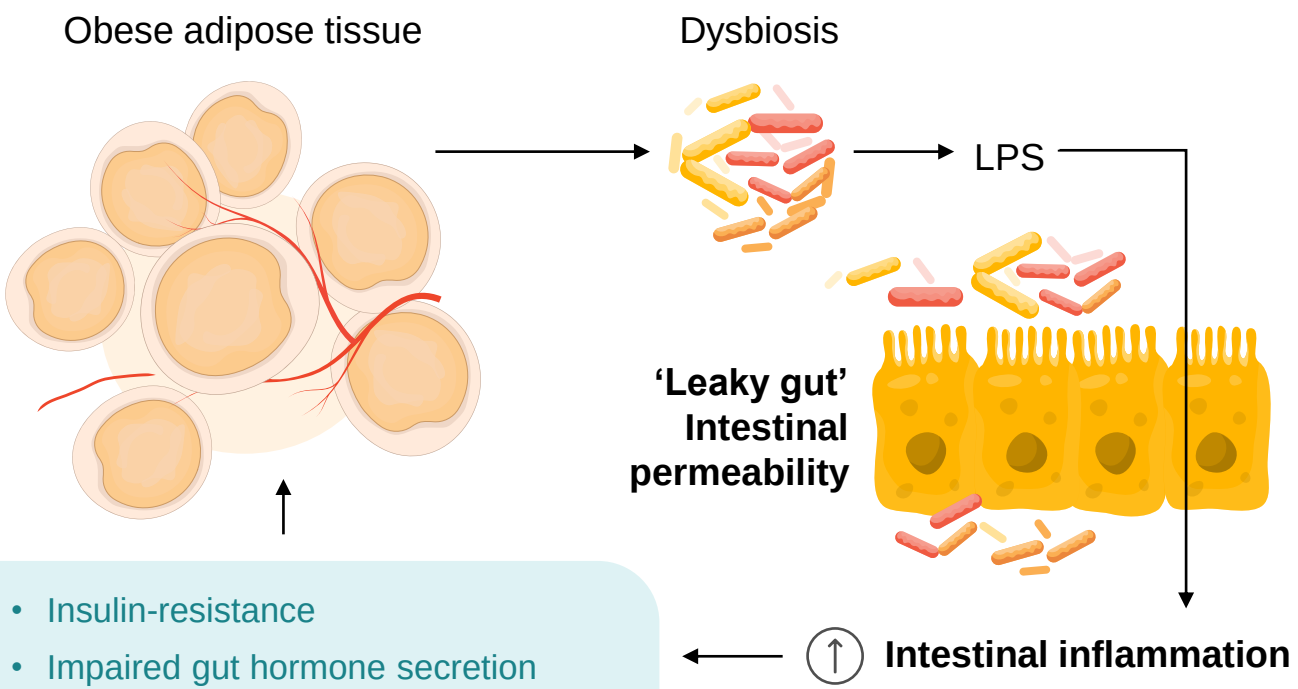
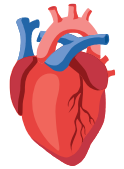
Excess fat storage can trigger low-grade systemic inflammation through reduced intestinal barrier integrity[1]

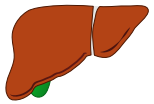


- Insulin-resistance
- Impaired gut hormone secretion
- Dysregulation of gut–brain–fat axis

Obesity-related low-grade inflammation can result in:



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



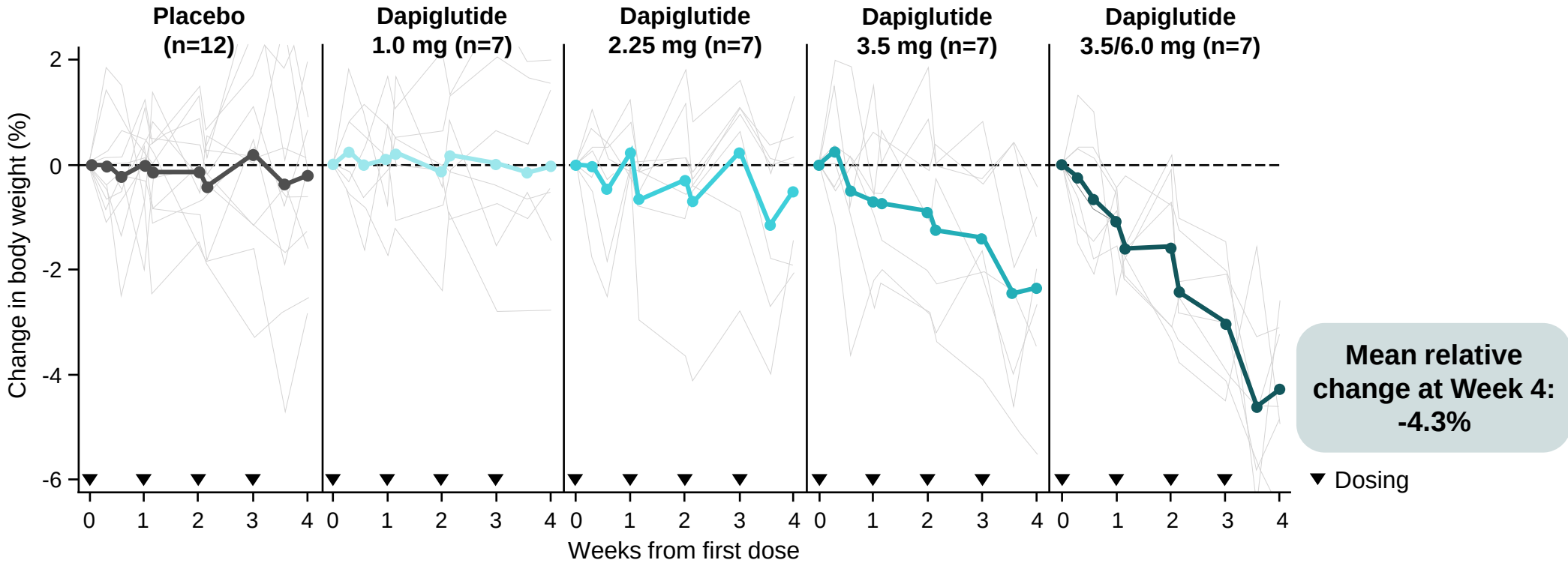
Liver disease due to abnormal accumulation of triglycerides in the liver[3]

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

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

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

Phase 1 multiple ascending dose trial (n=40)



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

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

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

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

Trial design

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

Purpose of trial

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

Low doses investigated at the low end of the therapeutic range in obesity setting

Topline data

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

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

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

In H2 2024, results for dapiglutide are expected from the 13-week Phase 1b dose-titration trial

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The Phase 1b trial is evaluating higher doses of dapiglutide than the previous 4-week MAD trial and DREAM

Population	N=54, men and women aged 18–64 years BMI 27.0–39.9 kg/m^2
Duration	13 weeks
Dose strengths	• Significantly higher doses (up to 13 mg) than the previous 4-week MAD trial and DREAM • Based on the tolerability profile observed to date, Zealand will seek to investigate even higher doses than 13 mg going forward
Endpoints	**Primary endpoint:** incidence of TEAEs **Key secondary endpoints:** pharmacokinetics endpoints related to dapiglutide exposure; absolute and percentage change in body weight from baseline to Day 92

Source: ClinicalTrials.gov (NCT06000891), accessed November 2023.
BMI=body mass index; MAD=multiple ascending dose; TEAE=treatment-emergent adverse event.

Survodutide*, targeting obesity and MASH, activates both GLP-1 and glucagon receptors

Design of molecule

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

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

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

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

Positioning opportunities and differentiation

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

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

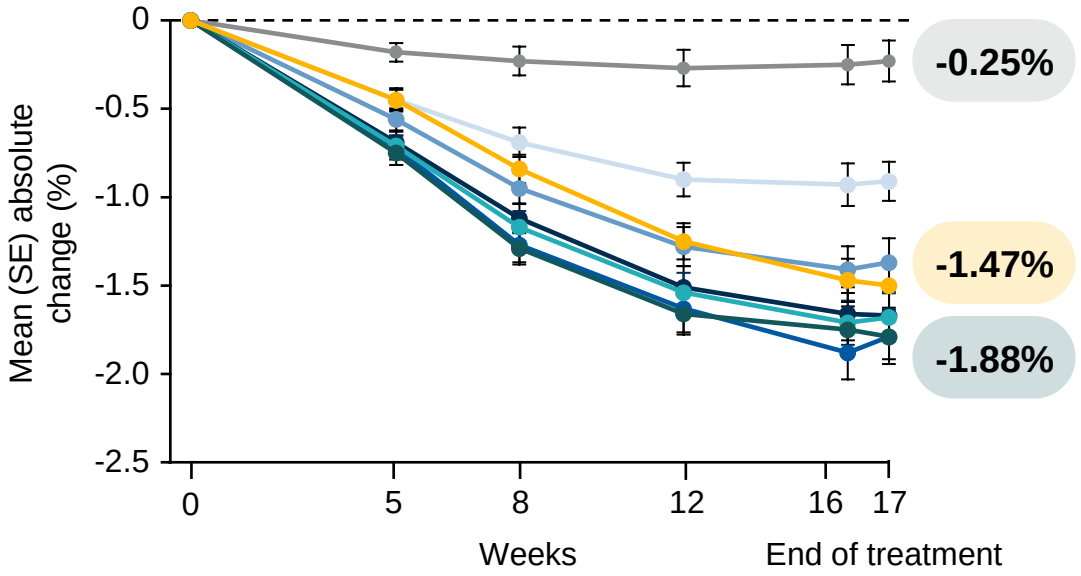
Cardiovascular benefits – potential benefits driven by GLP-1RA

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

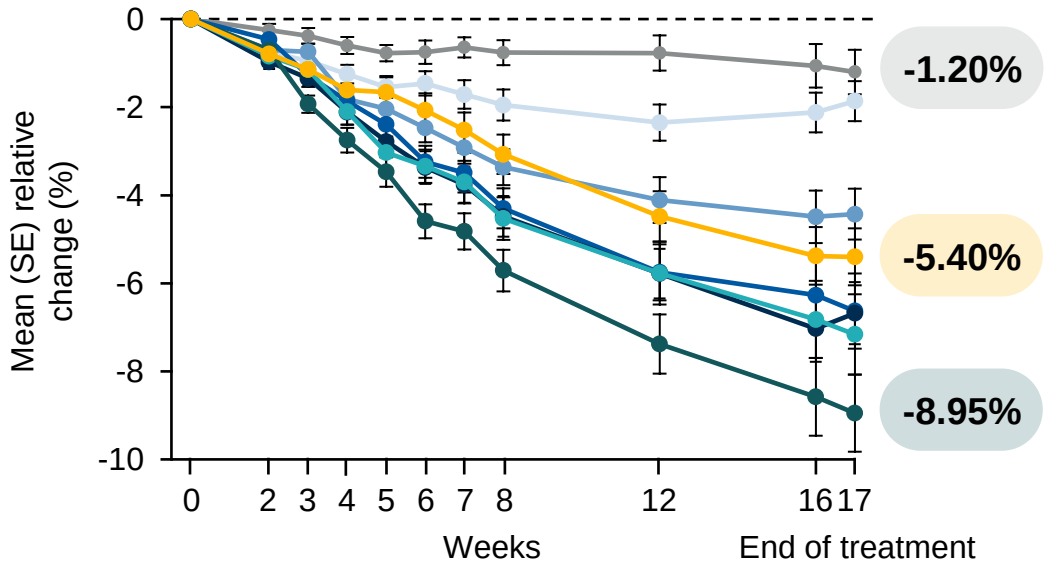
*Survodutide is licensed to Boehringer Ingelheim from Zealand Pharma, with Boehringer solely responsible for development and commercialization globally (subject to Zealand's co-promotion rights in the Nordic countries).
Sources: 1. Wynne et al. Int J Obes (Lond) 2006;30(12):1729–1736; 2. Zimmermann et al. Mol Metab 2022;66:101633.
GCG=glucagon; GLP-1=glucagon-like peptide-1; GLP-1RA=glucagon-like peptide-1 receptor agonist; MoA=mechanism of action; MASH=metabolic dysfunction-associated steatohepatitis (formerly, non-alcoholic steatohepatitis, or NASH).
Intellectual property: Composition of matter, patent expiry in 2034. Patent-term extension up to 5 years, i.e. 2039. Potential rights beyond 2039 based on patent applications and additional elements.

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

Change in HbA1c



Change body weight



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

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

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

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

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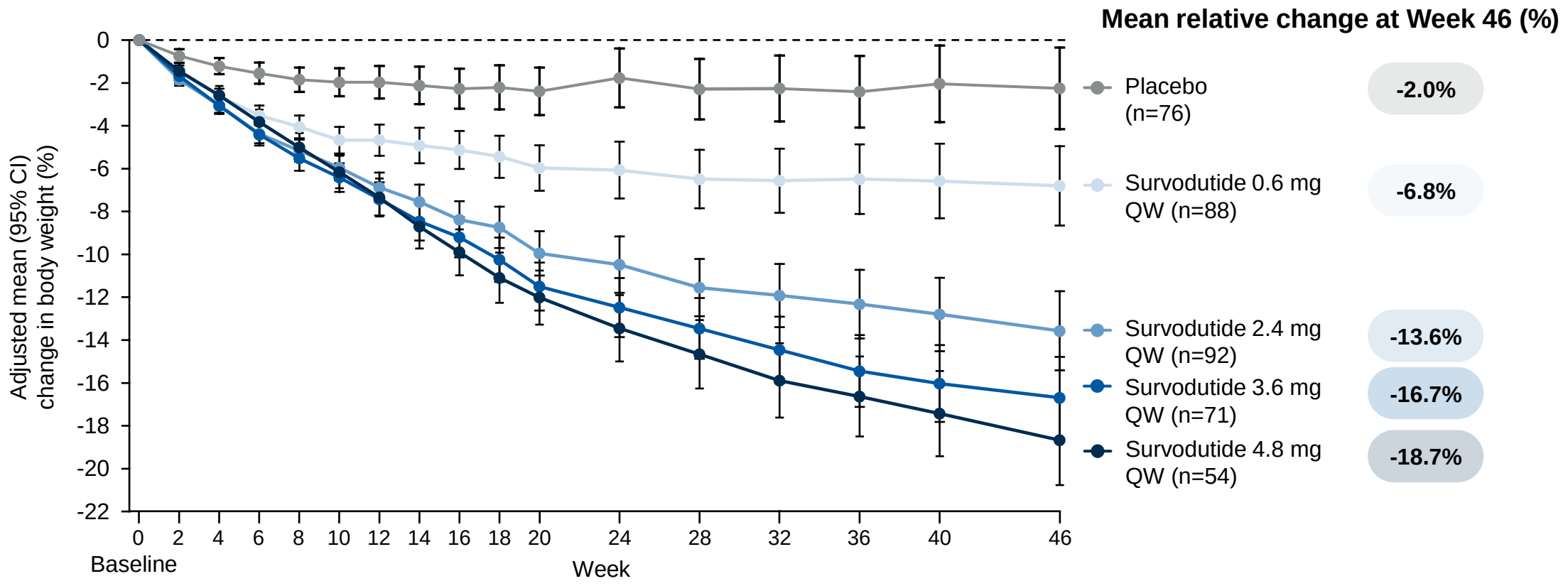
Boehringer Ingelheim

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



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

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

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

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

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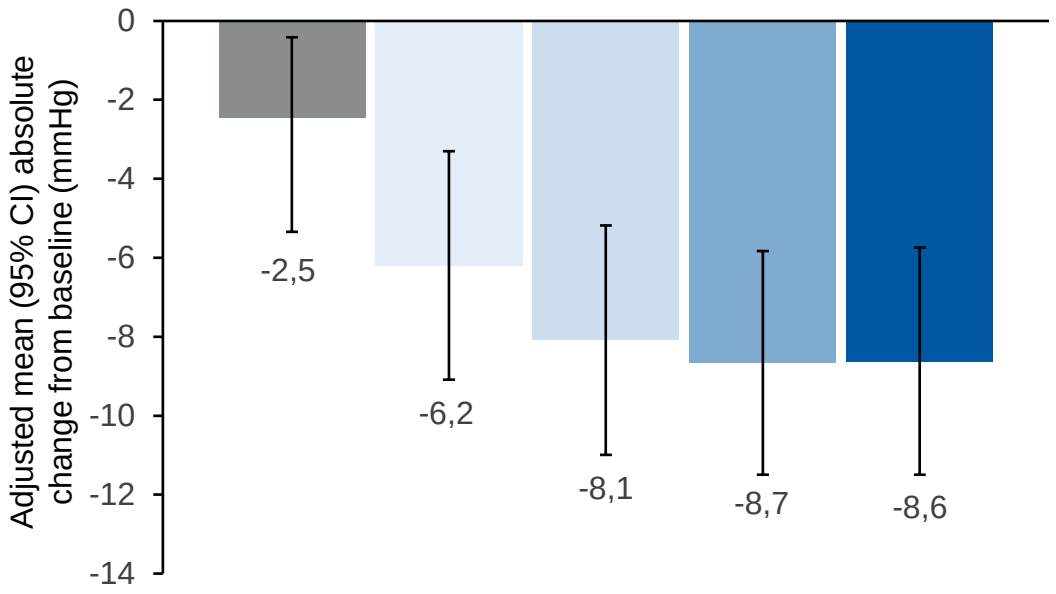
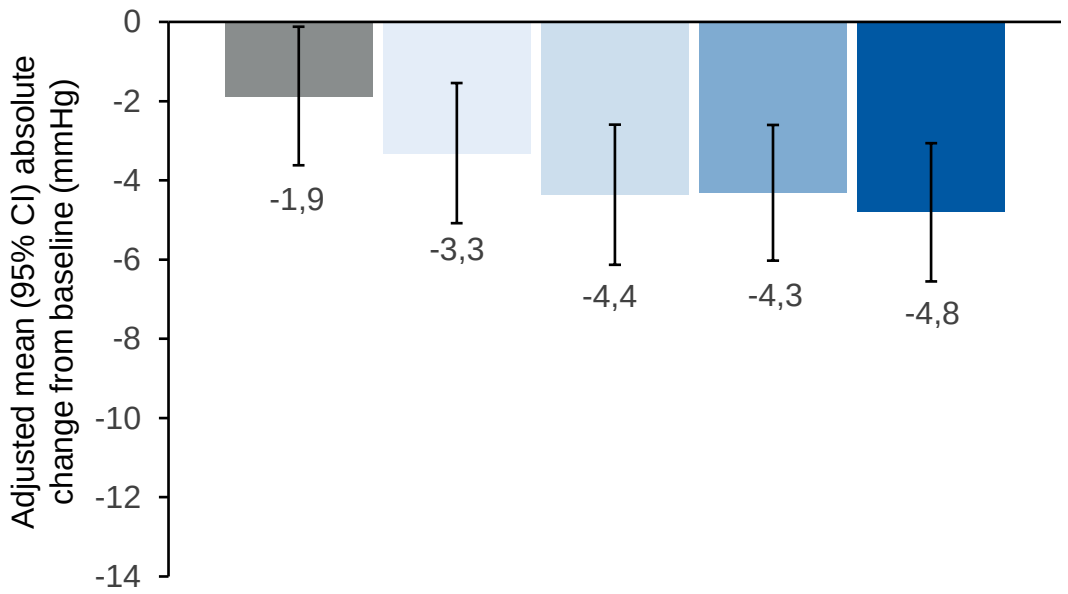
Source: Table adapted from Le Roux et al. Oral presentation (51-OR) at ADA 83rd Scientific Sessions, San Diego, June 23–26, 2023.
AE=adverse event; GI=gastrointestinal; TEAE=treatment-emergent adverse event.

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

Systolic blood pressure



Diastolic blood pressure



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

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

The Phase 3 program with survodutide in obesity, SYNCHRONIZE™, has been initiated

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

[a]Comorbidities comprise dyslipidemia, hypertension, obstructive sleep apnea, and others.
Inclusion criteria for all three trials include age ≥18 years. 5P-MACE includes cardiovascular death, non-fatal stroke, non-fatal myocardial infarction, ischemia-related coronary revascularization or heart failure.
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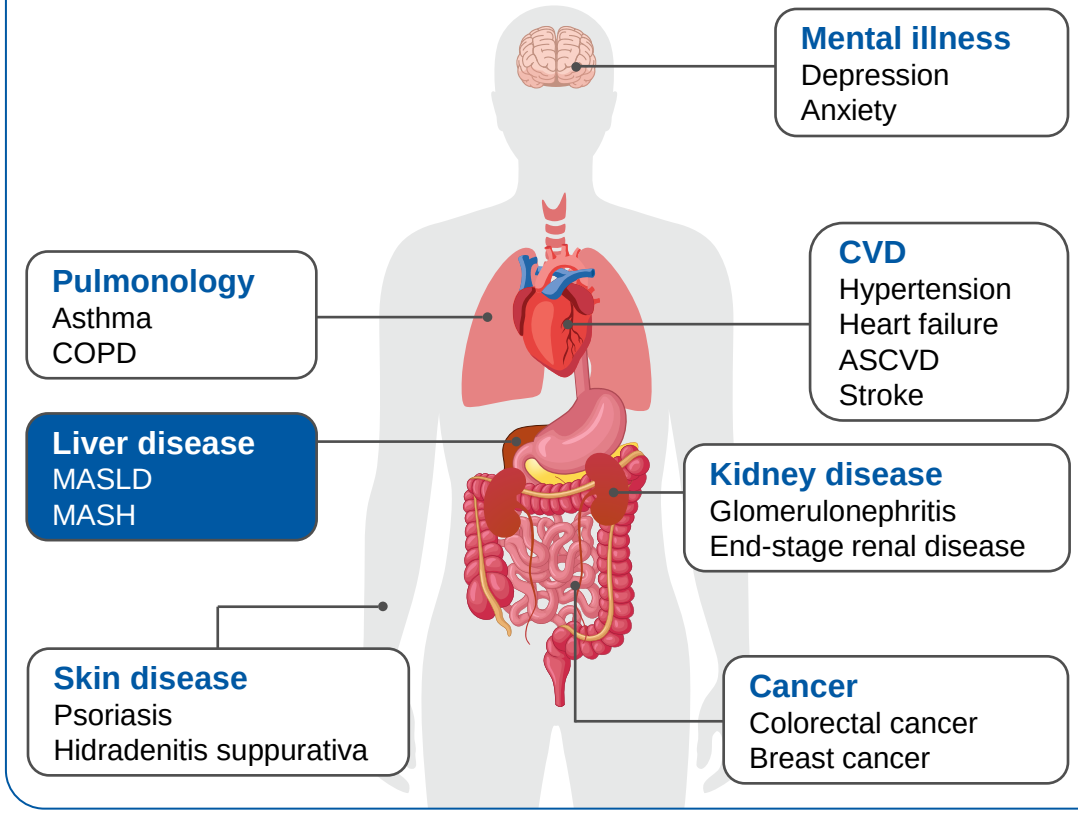
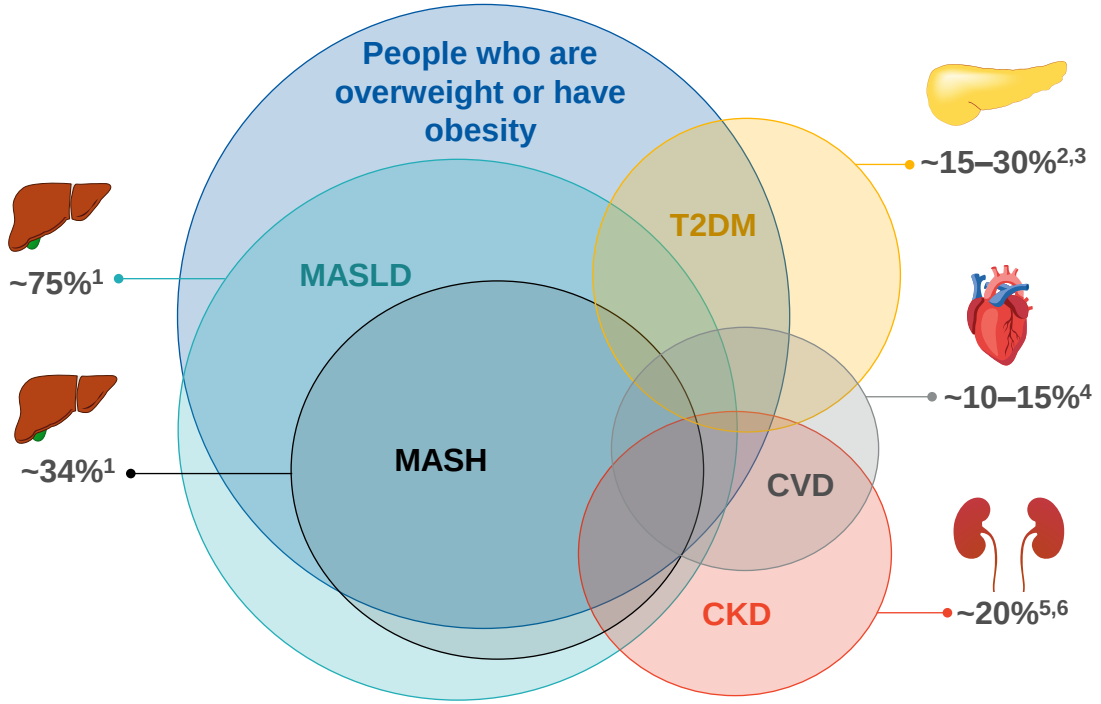
Sources: 1. SYNCHRONIZE-1. ClinicalTrials.gov (NCT06066515), accessed November 2023; 2. SYNCHRONIZE-2. ClinicalTrials.gov (NCT06066528), accessed November 2023; 3. SYNCHRONIZE-CVOT. ClinicalTrials.gov (NCT06077864), accessed November 2023.
BMI=body mass index; CKD=chronic kidney disease; CV=cardiovascular; CVD=cardiovascular disease; CVOT=cardiovascular outcomes trial; HbA1c=hemoglobin A1c; T2DM=type 2 diabetes mellitus.

There is a significant overlap between obesity and liver disease

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





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

Survodutide has been evaluated in a Phase 2 trial in MASH

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

N=295

R

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

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

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

Secondary endpoints:

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

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Source: ClinicalTrials.gov (NCT04771273), accessed February 2024.
BMI=body mass index; LFC=liver fat content; NAS=NAFLD activity score; MASH=metabolic dysfunction-associated steatohepatitis (formerly NASH, or non-alcoholic steatohepatitis); QW=once-weekly.

Survodutide* GCGR/GLP-1 receptor dual agonist shows best-in-class potential in MASH Phase 2 trial

Phase 2 biopsy-driven trial in people with MASH[1]

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

Statistically significant improvement in liver fibrosis with survodutide in secondary endpoint

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

Full data to be presented at the EASL congress in Milan, Italy on June 7, 2024

Further development in MASH planned

*Survodutide is licensed to Boehringer Ingelheim from Zealand Pharma, with Boehringer solely responsible for development and commercialization globally (subject to Zealand's co-promotion rights in the Nordic countries).
Source: 1) Boehringer Ingelheim press release February 26, 2024
MASH= metabolic dysfunction-associated steatohepatitis (formerly NASH=non-alcoholic steatohepatitis); CI=confidence interval; QW=once-weekly; GCG=glucagon; GLP-1=glucagon-like peptide-1

Rare Diseases.

We aspire to lead in SBS and CHI, and expand into intestinal rehabilitation and transient hyperinsulinism to alleviate disease burden for as many patients as possible

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

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CHI is an ultra-rare disease in newborns and children

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

Persistent episodes of hypoglycemia may result in brain damage

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

Significant impact on the patient and caregivers' quality of life

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

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

Dasiglucagon has potential to address shortcomings of current management of CHI

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

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

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

Dasiglucagon for subcutaneous infusion*

PDUFA date for Part 1 of NDA related to three weeks of dosing set by US FDA for October 8, 2024[7]

- Glucagon analog designed to allow for continuous subcutaneous (s.c.) infusion via pump
- Two Phase 3 trials in neonates and children up to 12 years of age demonstrated potential in management of CHI
- Wearable s.c. infusion pump system[6]
- Zealand expects to submit Part 2 of NDA related to dosing beyond three weeks in the second half of 2024[7]

IP exclusivity: compound patent US 2035 and EU 2039

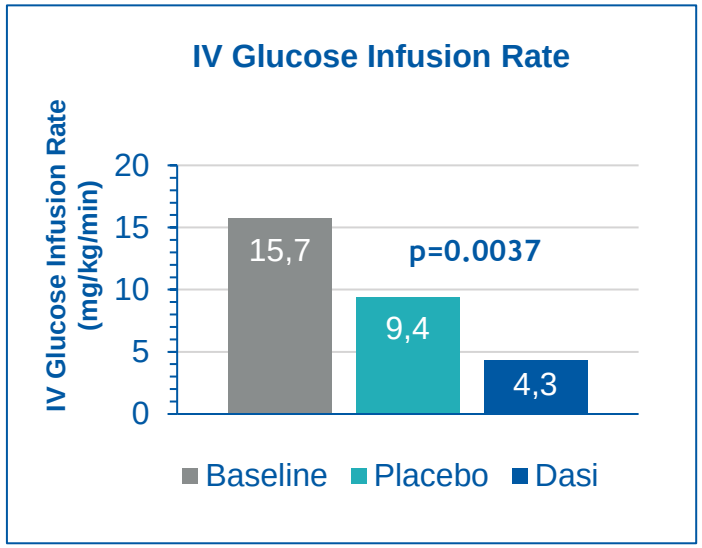
[1]Yorifuji et al. Clin Pediatr Endocrinol 2017;26(3):127-152; [2]Proglycem. Package insert. Teva Pharmaceuticals; 2015; [3]Gray KD et al. J Perinatol. 2018;38(11):1496-1502; [4]Haris et al. Therapeutic Adv Endocrinology Metabolism 2020;11:1-23; [5]Zealand Pharma, Physician Market Survey, 2020; [6]Zealand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

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

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

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

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

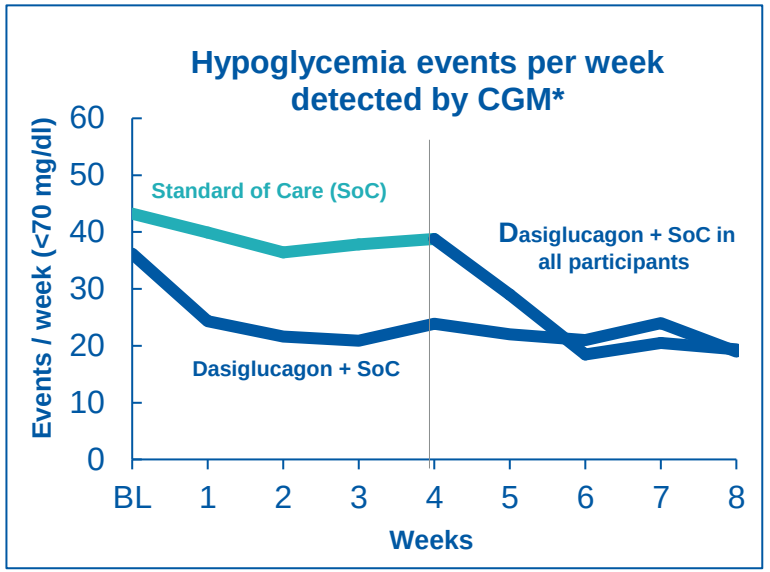


Part 2: 21-days open-label treatment[2]

10 of 12 patients weaned off IV glucose >12 hours

7 patients weaned off IV glucose without need for pancreatectomy

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



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

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

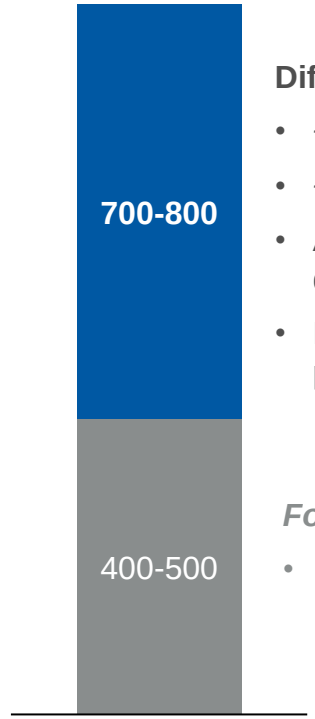
42 of 44 participants continued into long-term extension trial 17106

17103 Phase 3 clinical trial enrolled patients aged 7 days to 12 months, who were newly diagnosed and dependent on IV glucose in hospital setting: https://clinicaltrials.gov/ct2/show/NCT04172441
17109 Phase 3 clinical trial enrolled children aged 3 months to 12 years being treated with standard of care (+/- surgery) with persistent hypoglycemia: https://clinicaltrials.gov/ct2/show/NCT03777176
17106 is an open label long-term safety study that enrolled 17109 and 17103 participants with ongoing positive benefit / risk aged >1 month: https://clinicaltrials.gov/ct2/show/NCT03941236

[1] De Leon et al. European Society for Paediatric Endocrinology (ESPE), September 2022; [2] Banerjee et al. ESPE, September 2022; [3]Thornton et al. Pediatric Endocrine Society, April 2022

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

Patients eligible for dasiglucagon treatment in the US



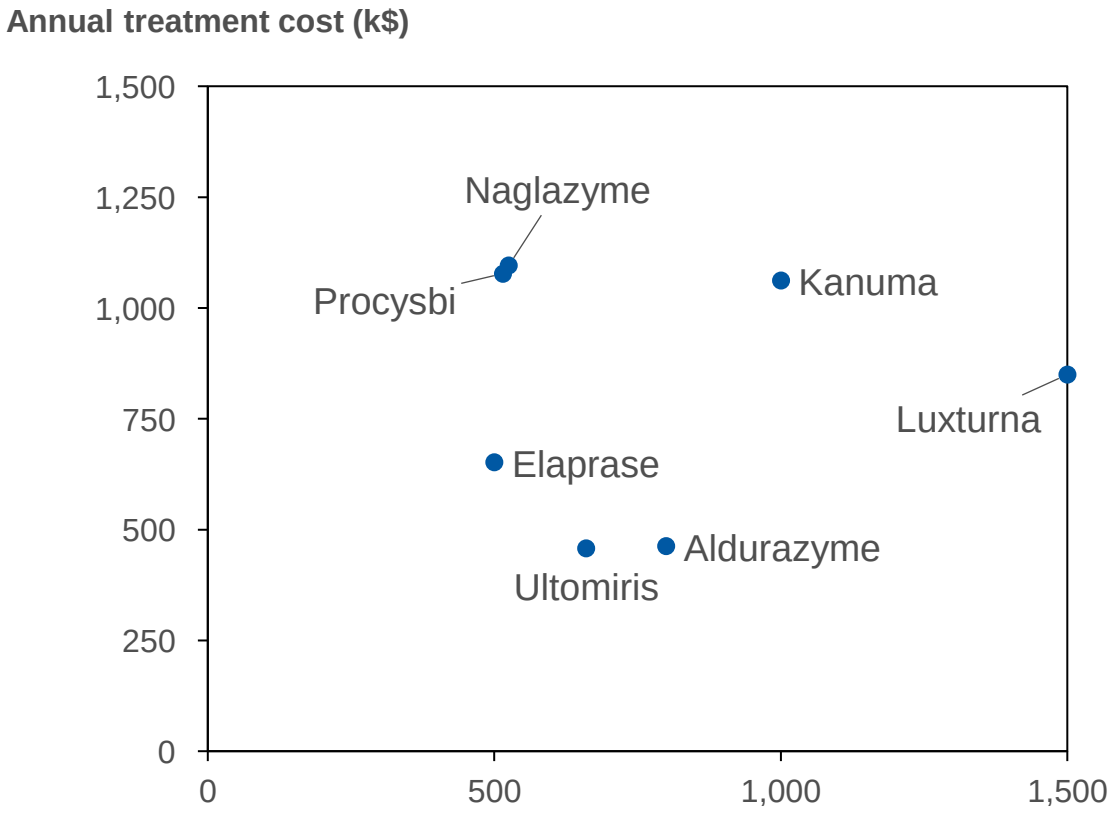
Diffuse CHI patients

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

Focal CHI patients

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

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



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

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

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

High unmet medical need

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

Life-long dependency on parenteral support (PS)

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

Need for improved treatment options

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

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

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

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

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

Source: https://www.gattex.com/resources-and-support/

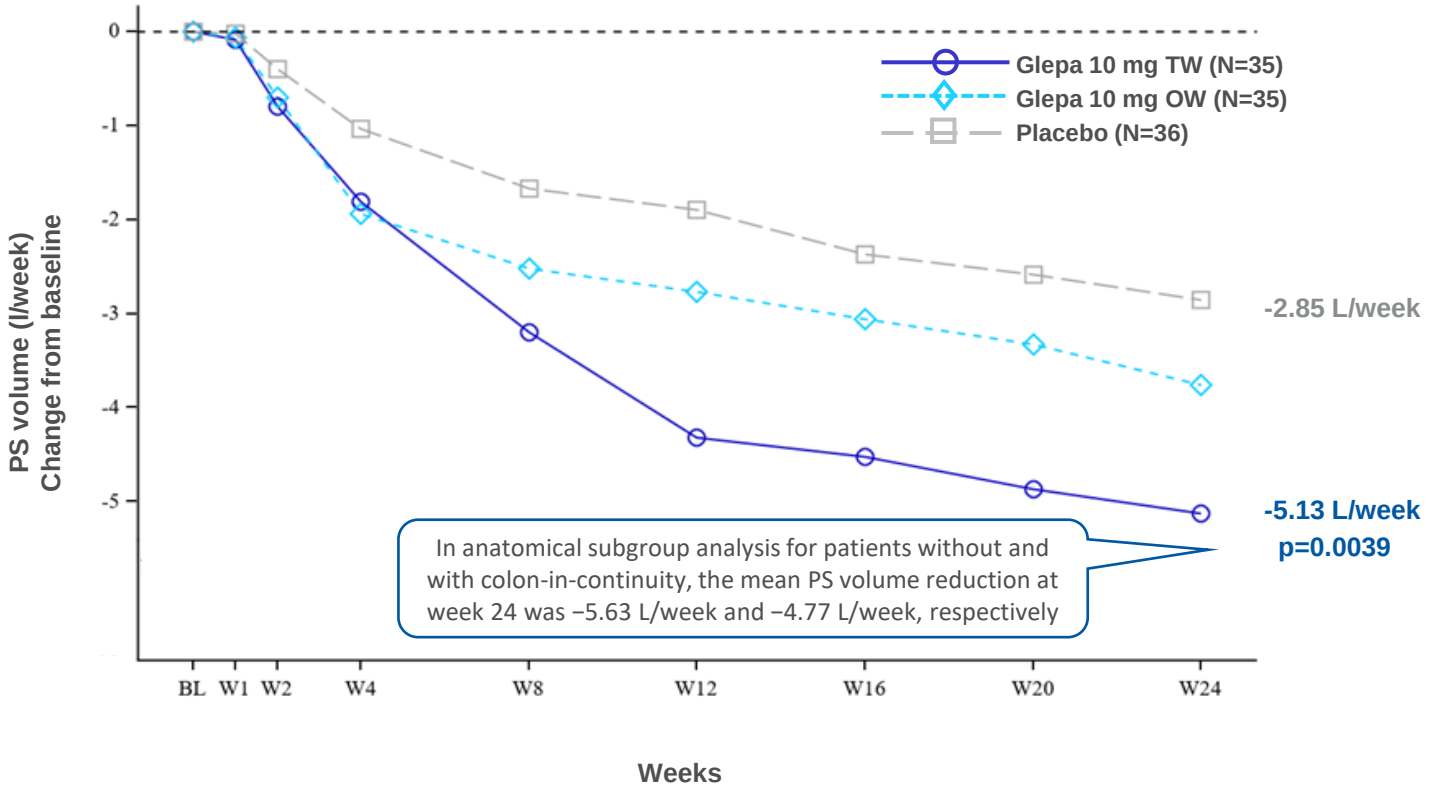
Glepaglutide: a long-acting stable GLP-2 analog*

- Forms depot at the injection site
- Effective half-life of ~88 hours at steady state[1]
- Expected 10 mg twice-weekly subcutaneous dosing
- Ready-to-use auto-injector with needle protection
- Regulatory decision (PDUFA) with US FDA in Dec-2024

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

[1] Agersnap M. et al, 2022, Clin Drug Investigation; 42(12):1093-1100

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



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

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

9 patients treated with glepaglutide discontinued PS during the trial

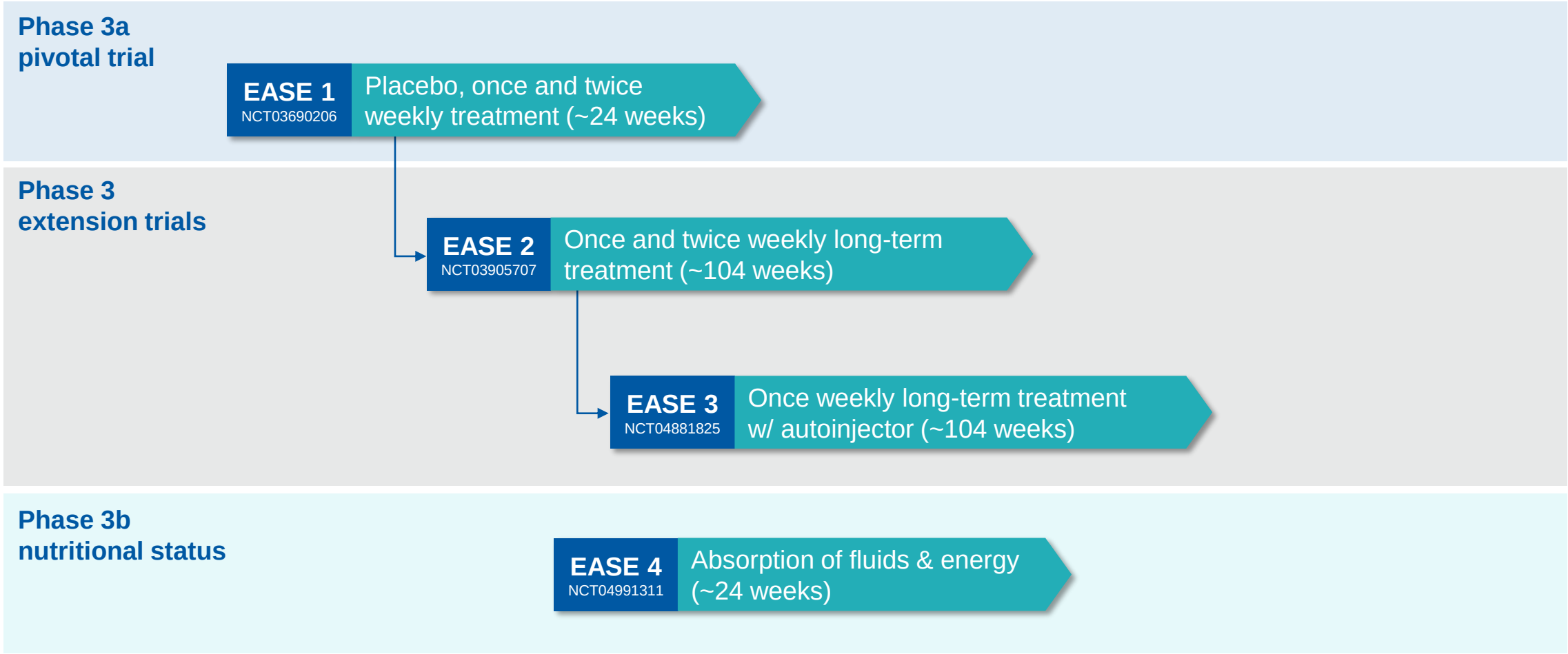
- 14% (n=5) twice weekly glepaglutide
- 11% (n=4) once weekly glepaglutide
- no patients receiving placebo

Glepaglutide appeared to be well-tolerated in the trial

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

Notes:
*) Results presented by Palle B. Jeppesen at the ASPEN 2023 Nutrition Science & Practice Conference in April 2023.

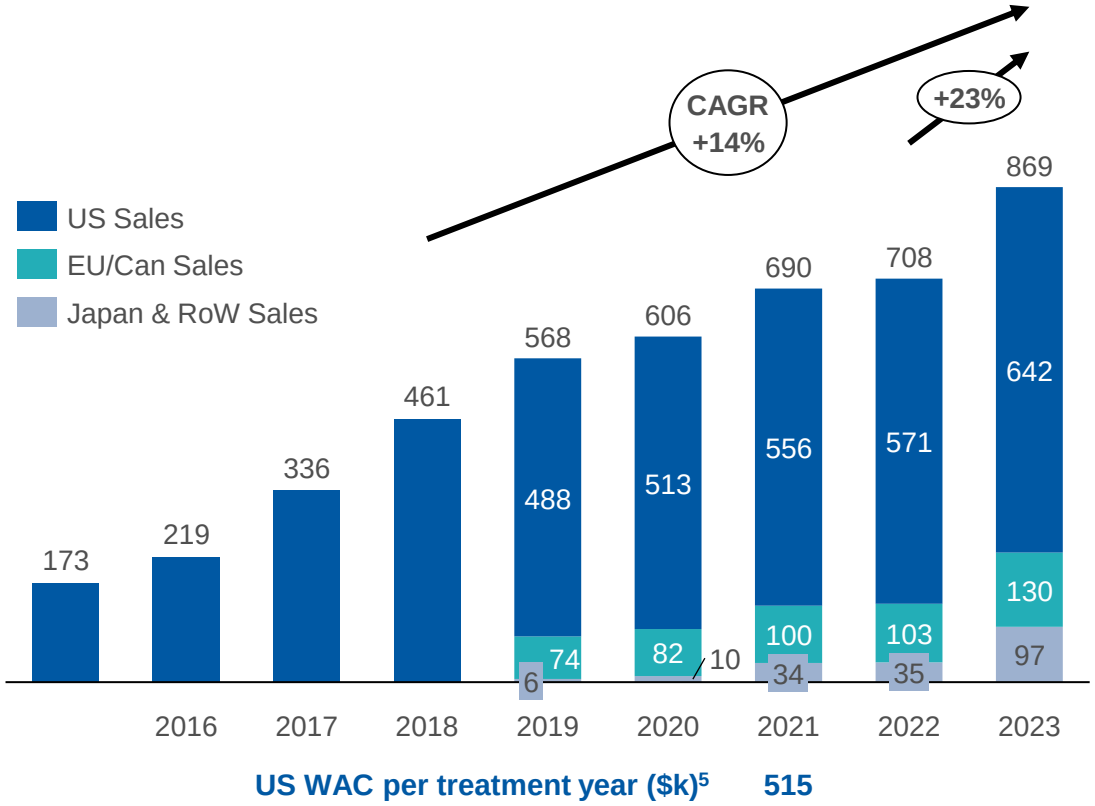
Glepaglutide Phase 3 clinical program focused on potential regulatory approval in 2024



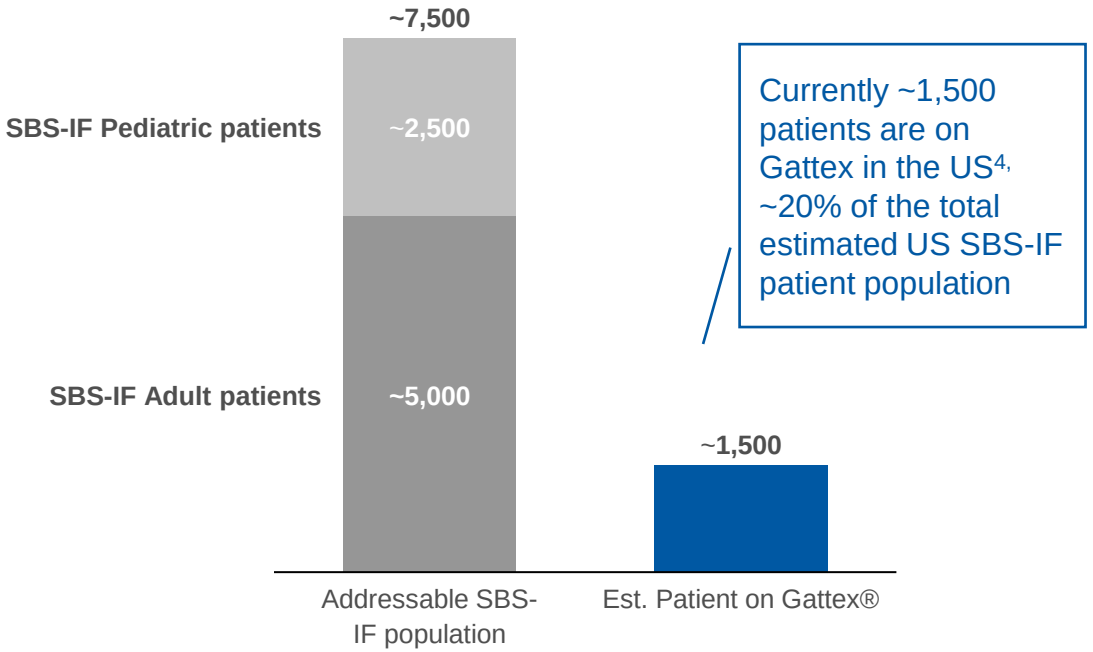
[1] https://clinicaltrials.gov/ct2/show/NCT03690206; [2] https://clinicaltrials.gov/ct2/show/NCT03905707; [3] https://clinicaltrials.gov/ct2/show/NCT04881825; [4] https://clinicaltrials.gov/ct2/show/NCT04991311

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

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



Estimated US SBS-IF Patients[3]



Currently ~1,500 patients are on Gattex in the US[4], ~20% of the total estimated US SBS-IF patient population

[1] 2014-2018: Carnegie ZEAL research report, 24 February 2020; [2] 2019-22: Gattex/Revestive sales data as reported in Takeda SEC filings, following fiscal financial year April to Mar. Converted to USD per Yearly Average Currency Exchange Rates, IRS.gov; [3] SBS Intestinal Failure patient estimates based on Zealand Pharma claims analysis, 2020 and Mundi et al, Characteristics of Chronic Intestinal Failure in the USA Based on Analysis of Claims Data, JPEN in Press 2022. [4] ZP estimate based on US Gattex sales and net price estimate; [5] WAC at end of year, https://app.prospectorx.com/

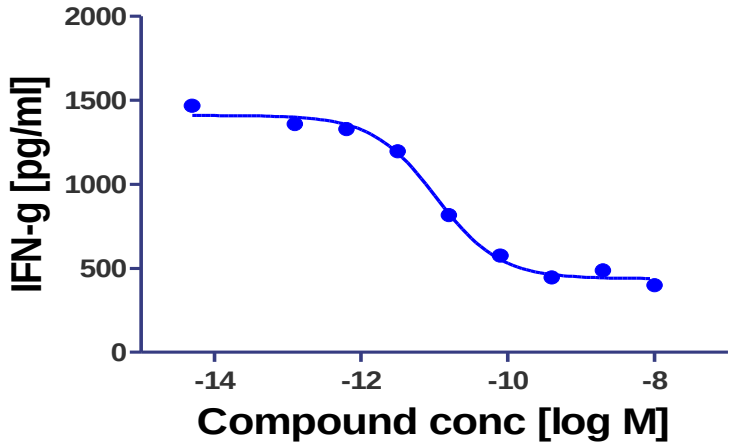
Chronic Inflammation.

Advance innovative treatments against chronic inflammatory diseases by adding clinical benefits to existing treatments: improved efficacy outcomes, better safety/tolerability or reduced treatment burden

Our pre-clinical pipeline targets chronic inflammatory diseases with significant unmet medical needs

Kv1.3 blocker (ZP9830)

- **Targeting a broad set of chronic inflammatory diseases**



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

Complement C3 inhibitor (ZP10068)

- Investigational, long-acting inhibitor of Complement C3, which has the potential to treat a broad range of complement-mediated diseases
- In 2023, Zealand has completed activities to support advancing ZP10068 into the first-in-human clinical trials
- In 2024, Zealand will assess the potential next steps for ZP10068

[1]Data on file. Concentration-dependent effect on pro-inflammatory cytokine release from Thapsigargin stimulated whole blood.

Type 1 Diabetes.

We aspire to create a paradigm shift in type 1 diabetes management by reaching higher glycemic goals and drive better outcomes and quality of life

We aim to shift the paradigm in the management of T1D by using dasiglucagon

Severe hypoglycemia

- Severe hypoglycemia associated with significant morbidity and mortality[1]
- Approved in the U.S. for pediatric and adult patients with diabetes aged >6 years
- Partnership with Novo Nordisk for commercialization and further development

Positive CHMP opinion

Exercise-induced hypoglycemia*

Mini-dose pen
(investigational device)

- Physical activity is recommended for individuals living with diabetes[2]
- Current recommendations for insulin/blood sugar management during exercise are complex[2]
- Despite innovation people with diabetes remain at significant risk of EIH

Phase 2 IITs completed

Automated glucose management*

iLet® bihormonal bionic pancreas
(investigational device)

- Only 20% of people with T1 diabetes achieve glycemic goals[3]
- 90% of subjects on Phase 2 study of BHBP achieved ADA treatment goals[4]
- A staged, phase 3 program to evaluate ~700 adults and children to begin in 2023

Ready for Phase 3

*** investigational compounds whose safety and efficacy have not been evaluated or approved by the FDA or any other regulatory authority**

[1] ADA Standards of care. Diabetes Care 2021 Jan; 44 (Supplement 1): S1-S2; [2] Colberg SR et al. Diabetes Care. 2016;39:2065-2079;; [3] Pettus et al., Diabetes Care (2019) 42(12):2220–2227;
[4] S. Russell et al. 2020. Conference. Diabetes Technology & Therapeutics. Page A-53; MAA = Marketing Authorisation Application

Additional company information

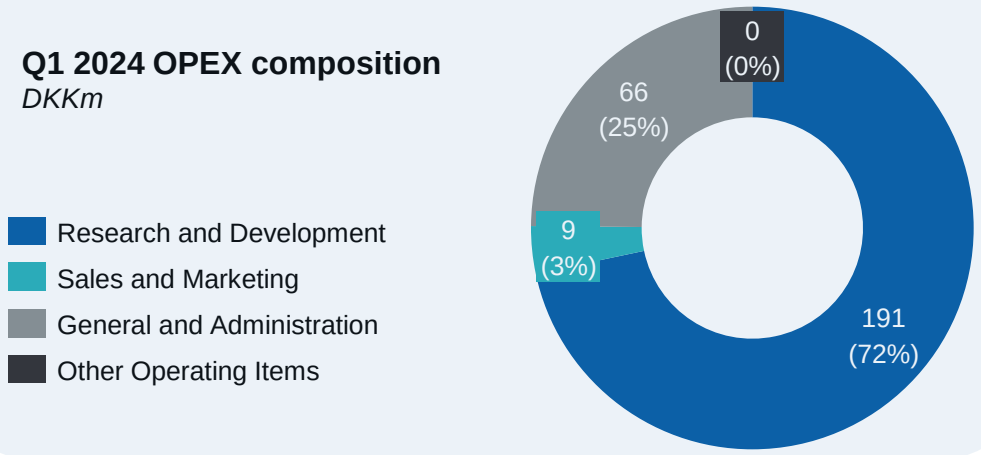
Q1 2024 Profit & Loss

DKK million	Q1 2024	Q1 2023
Revenue	15.1	13.6
Gross profit	**10.5**	**13.6**
Research and development expenses	-190.9	-142.3
Sales and marketing expenses	-9.2	-4.6
General and administrative expenses	-66.2	-42.5
Other operating Items	-	7.1
Net operating expenses	**-266.3**	**-182.3**
Operating result	**-255.8**	**-168.7**
Net financial items	25.9	-26.7
Result before tax	**-230.0**	**-195.3**
Tax	1.4	1.7
Net result for the period	**-228.6**	**-193.6**

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

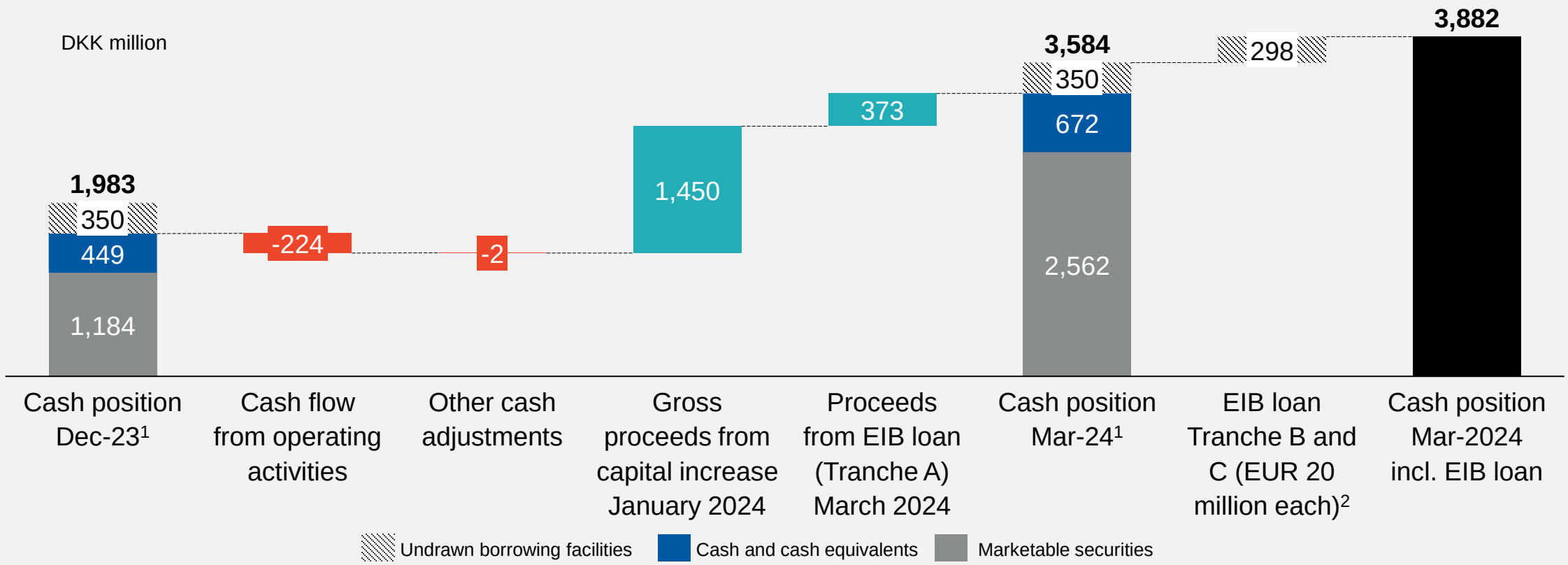
- Revenue of DKK 15 million is mainly driven by the license and development agreement with Novo Nordisk for Zegalogue®.
- Total operating expenses of DKK 266 million are higher than last year, primarily driven by the increase in R&D expenses (72% of OPEX allocated to R&D) due to the clinical advancement of the obesity pipeline and activities supporting the regulatory review by the US FDA of the late-stage rare disease assets.
- Net financial items of DKK 26 million are mainly driven by interest income from excess liquidity invested in marketable securities and favorable exchange rate adjustments, primarily related to USD deposits.

Q1 2024 OPEX composition
DKKm



Solid cash position allows for investments in R&D

DKK 3.9 billion cash position, including the EIB loan, ensures runway into 2027



Notes
1. Cash position includes cash, cash equivalents and marketable securities. Undrawn borrowing facilities comprise DKK 350 million Revolving Credit Facility provided by Danske Bank.
2. The two tranches are subject to pre-specified milestones being met.

2024 financial guidance

DKK million	2024 Guidance	2023 Actual
Revenue anticipated from existing and new license and partnership agreements	No guidance due to uncertain size and timing	343
Net operating expenses[1]	1,100 – 1,200	896

Notes:
1. Net operating expenses consist of R&D, S&M, G&A and other operating items.
Financial guidance based on foreign exchange rates as of May 16, 2024.

Experienced management team

Adam Steensberg

Chief Executive Officer

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

Henriette Wennicke

Finance and Business Development

Chief Financial Officer

Copenhagen Business School, GN, novo nordisk

David Kendall

Research & Development

Chief Medical Officer

University of Minnesota, mannkind, American Diabetes Association, Lilly

Christina S. Bredal

People & Organization

Chief People Officer

University of Copenhagen, pwc, EY

Ivan M. Møller

Operations

Chief Operating Officer

DTU, Harvard University, NOVARTIS, BCG

Ravinder S. Chahil

Legal & IP

General Counsel

King's College London, Copenhagen Business School, polpharma, Actavis

Significant events and potential catalysts in 2024

NON-EXHAUSTIVE

Q2 2024

Petrelintide
Topline results from 16-week Phase 1b MAD trial

Dapiglutide
Topline results from Phase 2a investigator-led trial DREAM

Survodutide[1]
Presentation of results from Phase 2 MASH trial at EASL congress

H2 2024

Petrelintide
Initiation of Phase 2b trial

Dapiglutide
Topline results from 13-week Phase 1b dose-titration trial

Survodutide[1]
Enrollment of Phase 3 SYNCHRONIZE program[2]

Dasiglucagon (CHI)
Submission to US FDA of analyses supporting chronic use

Dasiglucagon (CHI)
Potential US regulatory approval for Part 1 of NDA

Glepaglutide (SBS)
Potential US regulatory approval

ZP9830 (Kv1.3 Ion Channel Blocker)
Initiation of first-in-human clinical trials

Legend:

Obesity | Rare diseases | Inflammation

Potential partnership agreements across therapeutics areas

Notes: 1. Survodutide is licensed to Boehringer Ingelheim from Zealand Pharma, with Boehringer solely responsible for development and commercialization globally (subject to Zealand's co-promotion rights in the Nordic countries). 2. SYNCHRONIZE™-1 and SYNCHRONIZE™-2.
MAD=multiple ascending dose; MASH=metabolic dysfunction-associated steatohepatitis (formerly NASH=non-alcoholic steatohepatitis); EASL=European Association for the Study of the Liver; NDA=new drug application.

Strongly focused on delivering on our strategic objectives for 2024

Advance obesity portfolio

Ensure regulatory progress for rare disease assets

Initiate first-in-human trials with inflammation assets