Zealand Pharma

Transforming the future of metabolic health

Corporate Presentation
January 2026

ZEALAND PHARMA

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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About Zealand Pharma

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On the cusp of transforming into a generational biotech

Redefining the near-term future of weight management

Differentiated obesity pipeline with mid- to late-stage candidates

Petrelintide[a]

Survodutide[b]

Leading programs backed by strong partners

Roche

Boehringer Ingelheim

Building the world's most valuable metabolic health pipeline

Our unfair advantage

>25 years of unmatched peptide R&D expertise

+10 clinical programs by 2030 and industry-leading cycle times from idea to clinic

Boston research site

Partnerships for external innovation

Solid cash position

USD ~2.5B
(DKK ~16.2B)[c]

[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.
[c]Cash position (cash, cash equivalents, and marketable securities) as of September 30, 2025. Based on foreign exchange rate as of January 6, 2026 (USD/DKK 6.38).

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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

[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.

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

2026: Most defining and catalyst-rich year yet

NON-EXHAUSTIVE

Petrelintide[a] (amylin analog)

- **Results from Ph2 ZUPREME-1**
- **Initiation of Ph3 program**
- **Results from Ph2 ZUPREME-2**
- **Initiation of Ph2 with petrelintide/CT-388**

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

- **Results from Ph3 obesity program**
  - SYNCHRONIZE™-1
  - SYNCHRONIZE™-2
  - SYNCHRONIZE™-CVOT
  - SYNCHRONIZE™-MASLD

Executing on rare disease programs

- **Dasiglucagon for CHI:** U.S. regulatory submission
- **Glepaglutide for SBS:** Progression of Ph3 EASE-5 trial

Building the pipeline of the future

- **ZP9830 (Kv1.3)** Results from Ph1a SAD and MAD, and clinical advancement
- **Progress pre-clinical programs at accelerated speed**
- **Establish Boston research site**
- **Partnerships to evolve and fuel platform**

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[b]Survodutide is licensed to Boehringer Ingelheim from Zealand Pharma, with Boehringer solely responsible for development and commercialization globally.
CGCR=glucagon receptor; GLP-1R=glucagon-like peptide-1 receptor; CVOT=cardiovascular outcomes trial; MASLD=metabolic dysfunction-associated steatotic liver disease; SAD=single ascending dose; MAD=multiple ascending dose; CHI=congenital hyperinsulinism; SBS=short bowel syndrome.

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Clinical pipeline: 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

[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.

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2026 transformational milestones shaping long-term value creation

NON-EXHAUSTIVE

H1 2026

Petrelintide
Topline results from Phase 2 ZUPREME-1

Petrelintide/CT-388
Initiation of Phase 2

Survodutide
Topline results from key trials in Phase 3 obesity program (SYNCHRONIZE™-1, -2, -MASLD, -CVOT)

ZP9830 (Kv1.3 ion channel blocker)
Topline results from Phase 1a trial (SAD)

H2 2026

Petrelintide
Topline results from Phase 2 ZUPREME-2

Petrelintide
Initiation of Phase 3 program

ZP9830 (Kv1.3 ion channel blocker)
Topline results from Phase 1a trial (MAD)

ZP9830 (Kv1.3 ion channel blocker)
Initiation of Phase 1b trial

Dasiglucagon for CHI
U.S. regulatory submission

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Obesity

Corporate Presentation

Obesity: greatest healthcare challenge of our time

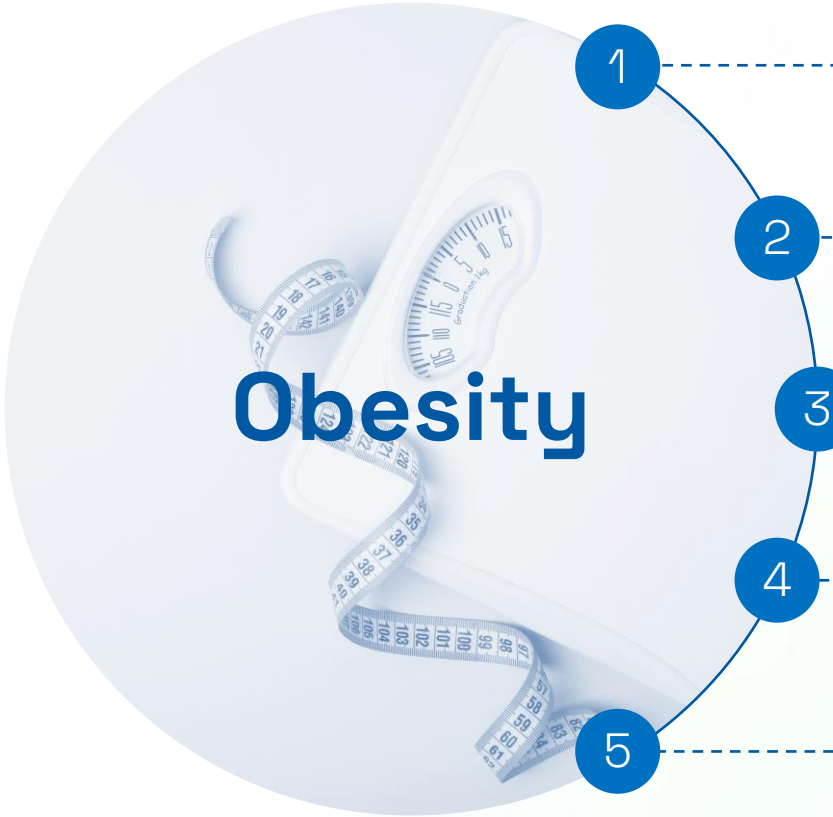
The obesity epidemic has **surged over the past decades,** with **50% of adults** globally expected to live with **overweight or obesity** by 2030[1]

>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

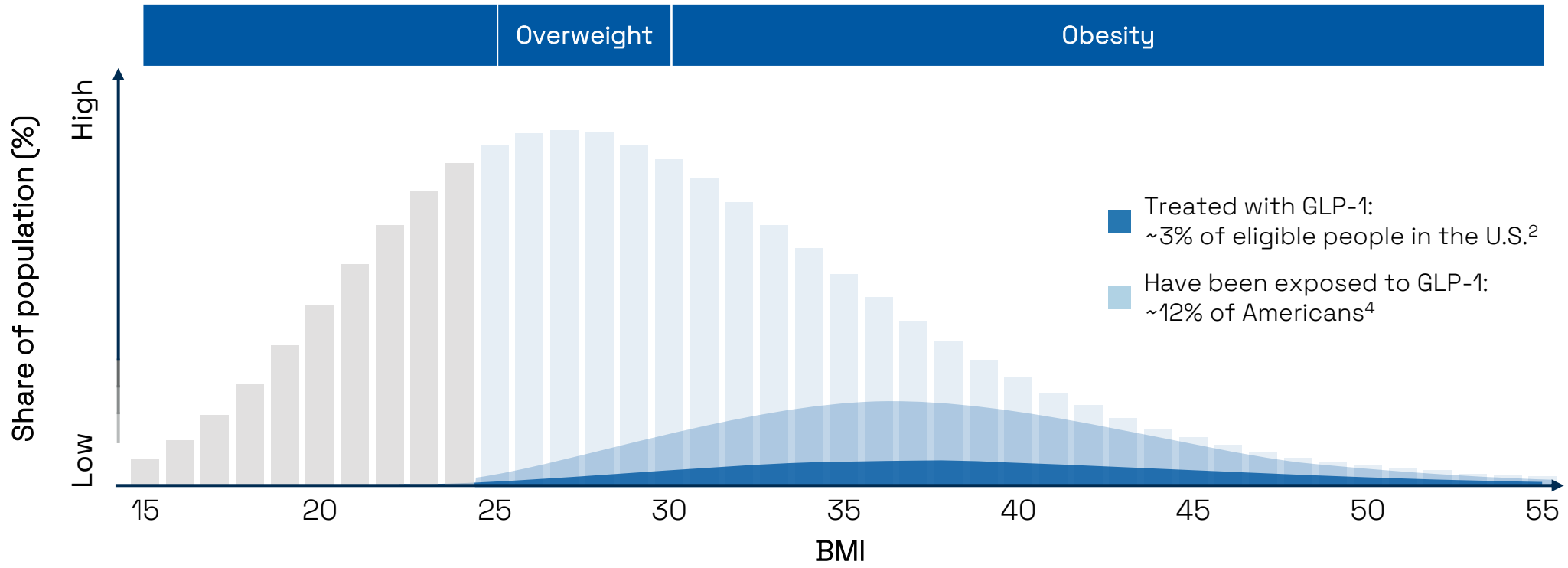


1. The consumer as key decision driver[a]
2. Unprecedented size and scale
3. Two key healthcare providers: Primary care and specialty care
4. Heterogeneity and fragmentation
5. Linked to many comorbidities

[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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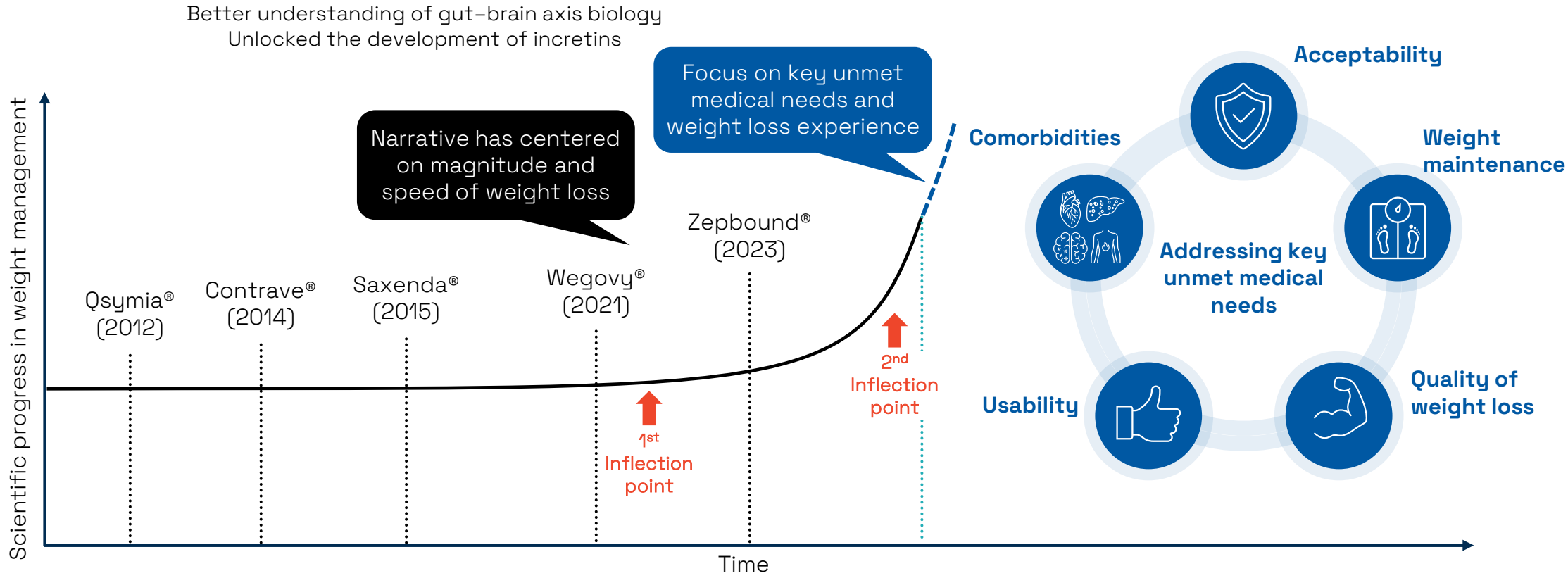
Beyond Weight loss Olympics: key unmet needs

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



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.

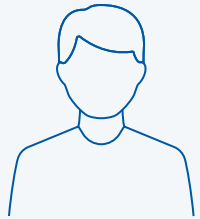
Two distinct segments, two focus areas

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

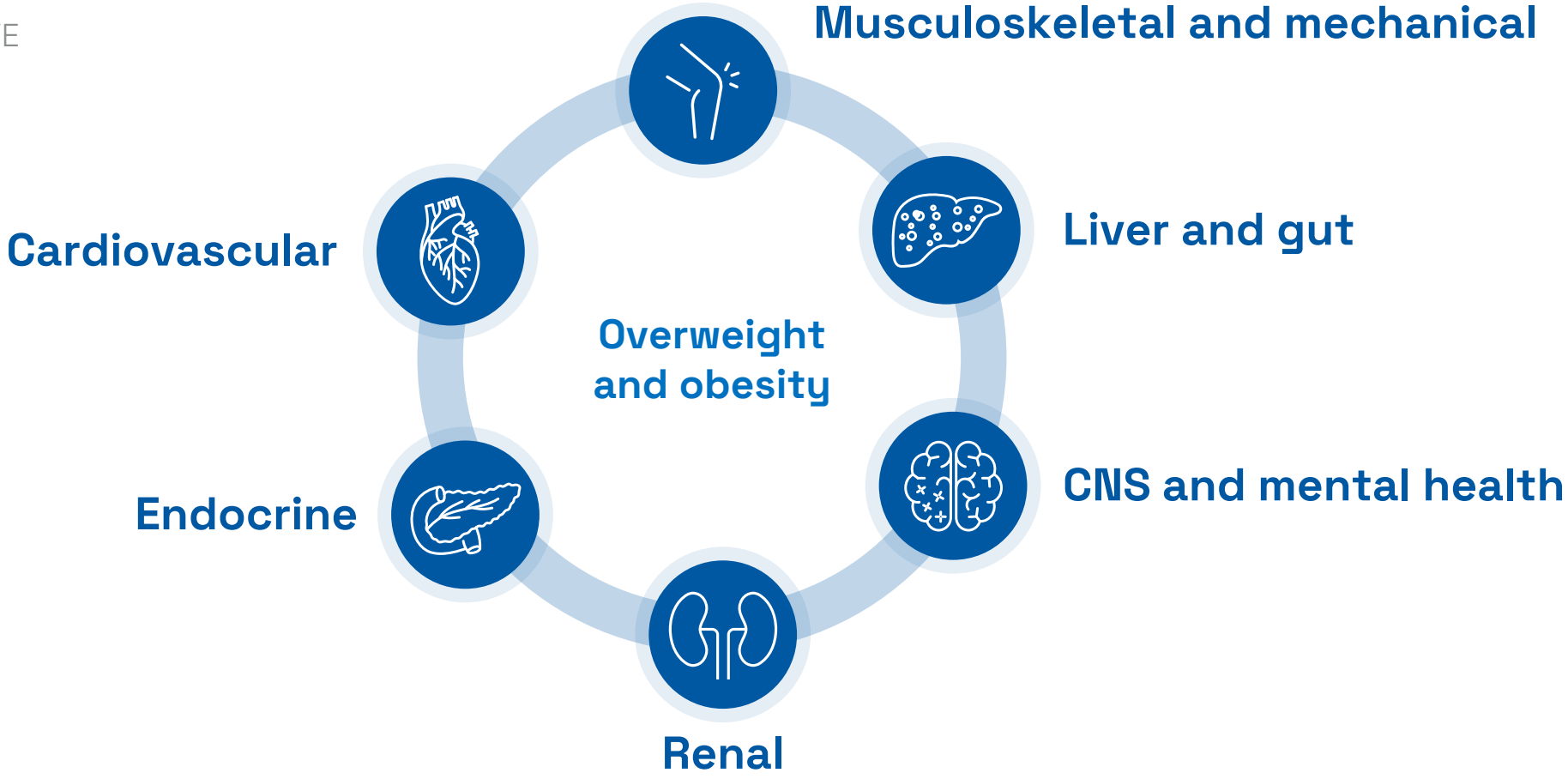
Consumer-driven **primary care** prescriptions focusing on **desired weight loss** and **user experience**

Objectives:

1. Desired weight loss
2. Tolerability and user experience
3. Health outcomes
4. Convenience of treatment

Obesity impacts several organ systems

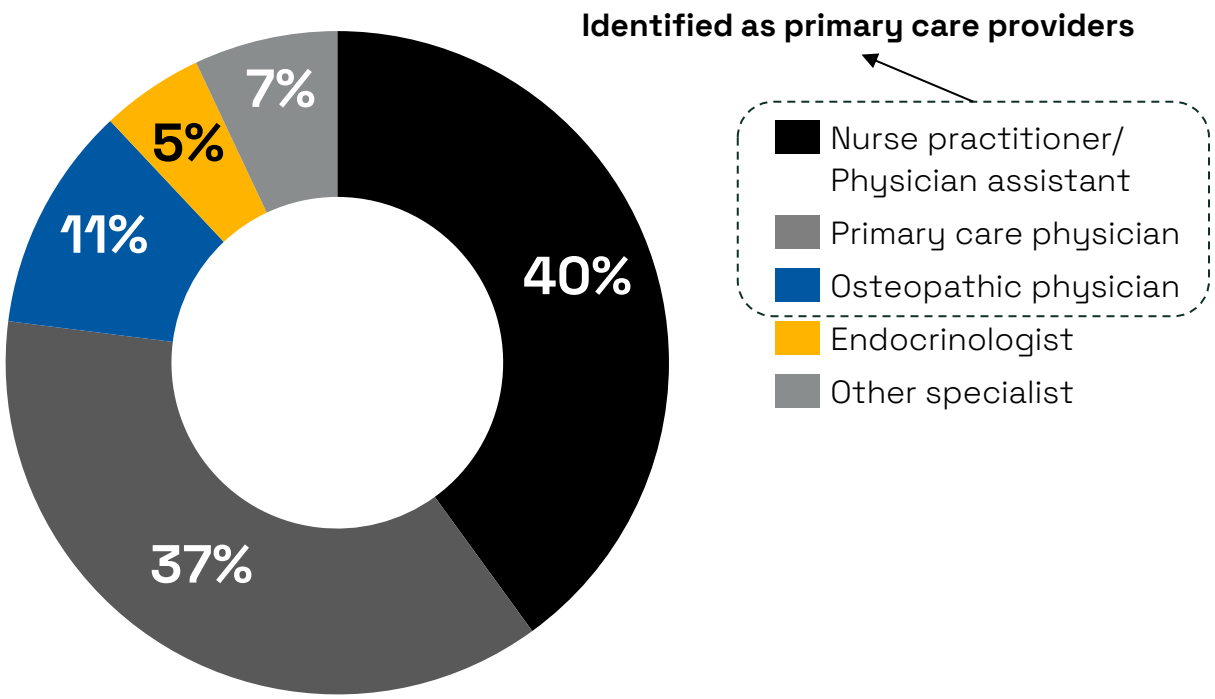
NON-EXHAUSTIVE



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

Primary care leads; specialty still emerging

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



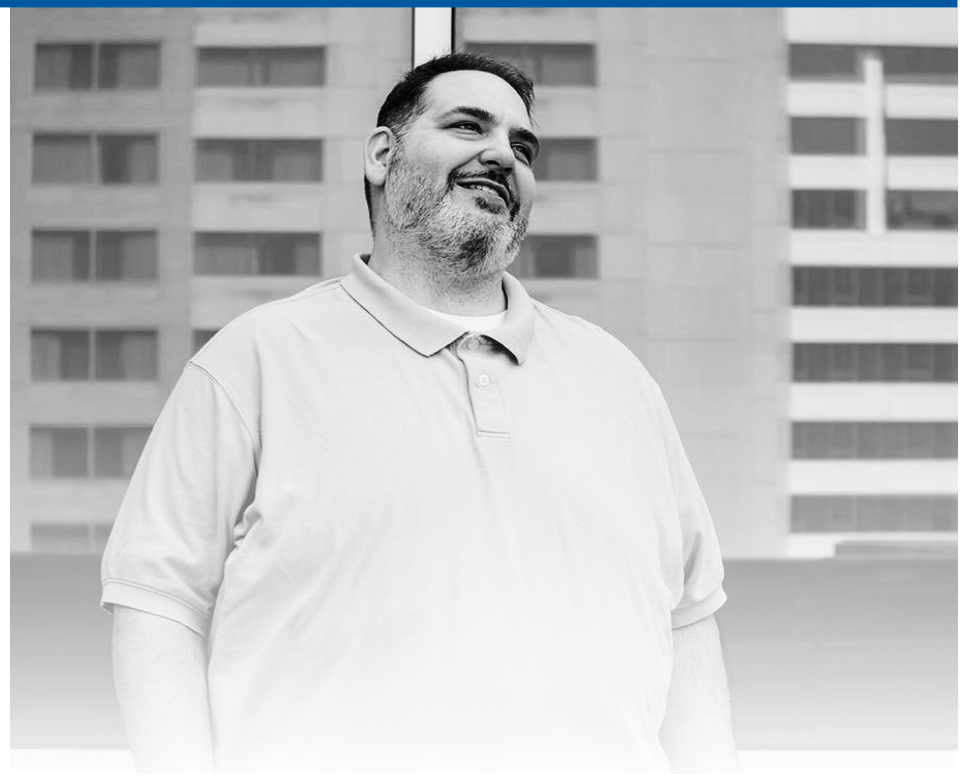


Image is illustrative, no associations implied.

[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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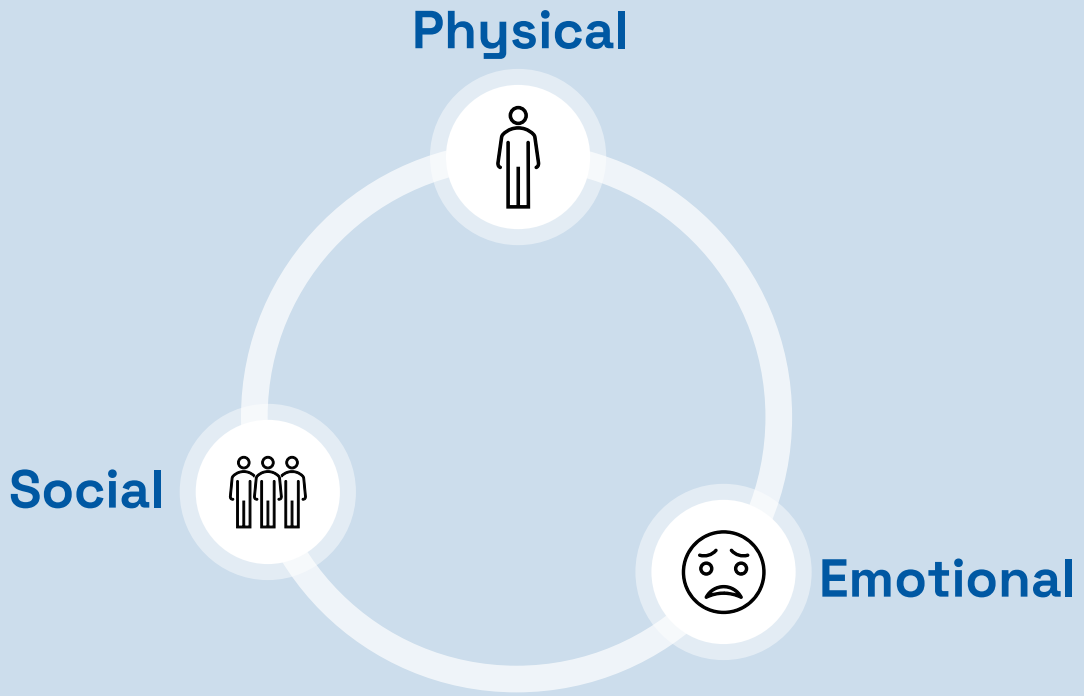
Healthier version of themselves, not healthiest

Decisions driven by more than clinical needs



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

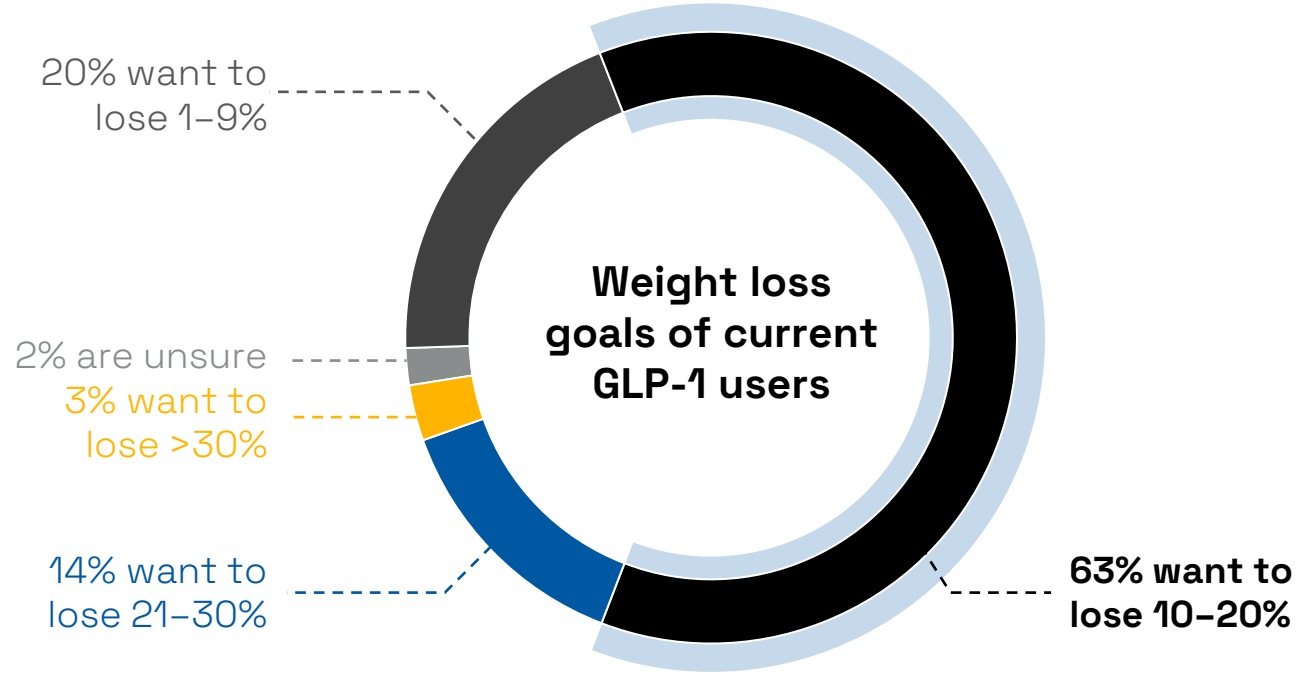
Unprecedented willingness to pay out of pocket

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

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

Desired weight loss contradicts *Weight loss Olympics*

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

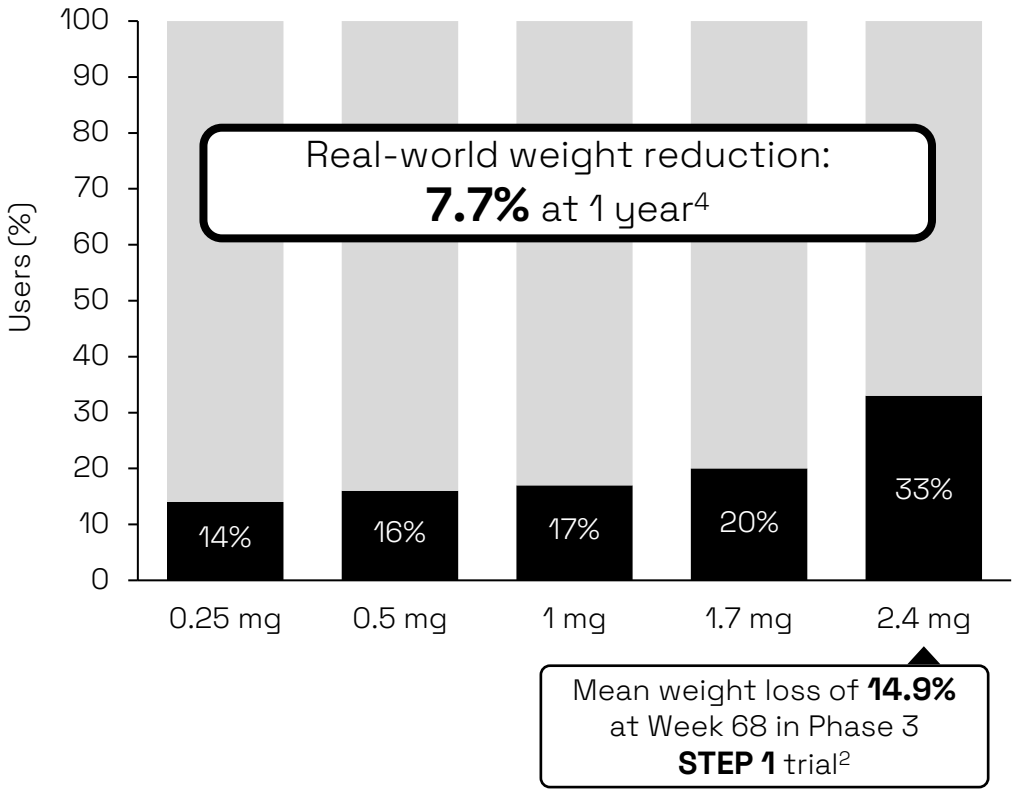


Source: LifeSci Capital Survey May 2024 (N=819).
GLP-1=glucagon-like peptide-1.

GLP-1 efficacy: real world vs. clinical trials

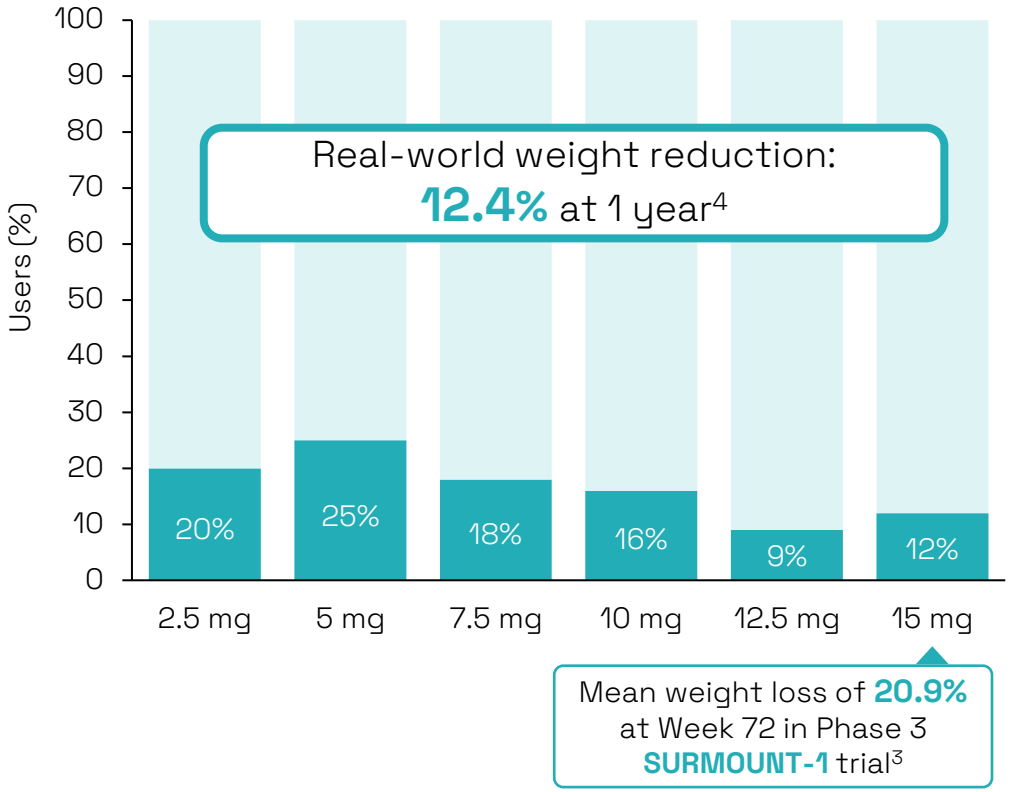
ONCE-WEEKLY wegovy® semaglutide injection 2.4 mg

Real-world use of Wegovy by dose[1]



zepbound™ (tirzepatide) injection

Real-world use of Zepbound by dose[1]



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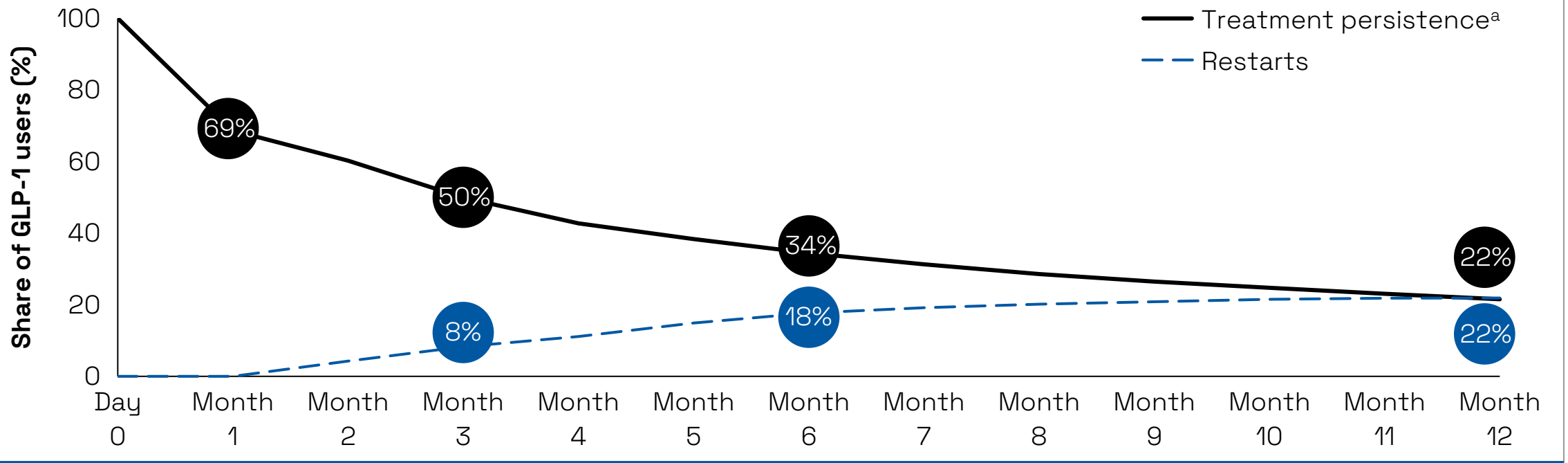
Sources: [1]IQVIA National Prescription Audit, MAT October 2025; [2]Wilding et al. N Engl J Med 2021;384(11):989–1002; [3]Jastreboff et al. N Engl J Med 2022;387(3):205–216; [4]Real-World GLP-1 Weight-Loss Results Differ From Trials - Medscape - June 10, 2025.
GLP-1RA=glucagon-like peptide-1 receptor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

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MoA=mechanism of action; FDC=fixed-dose combination.

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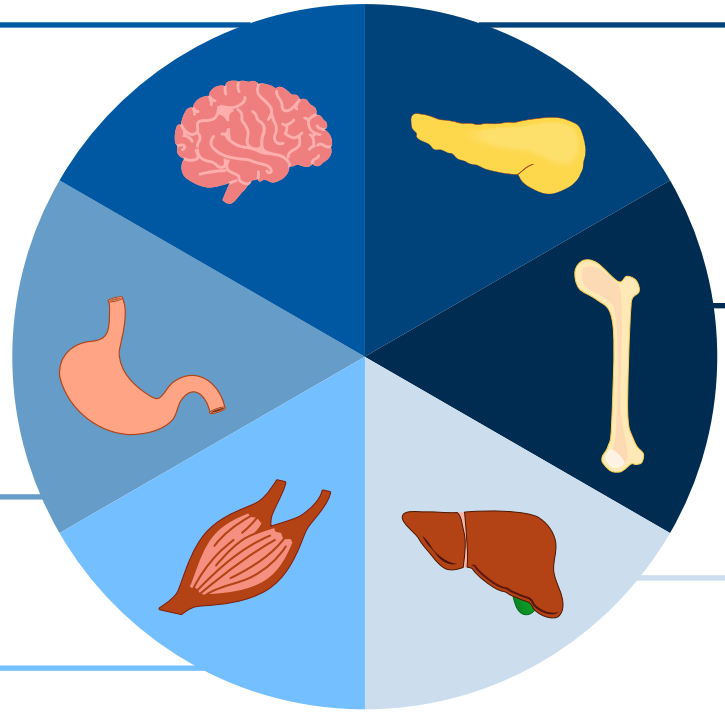
Sources: [1]Data on file; [2]Eriksson et al. Poster 532. Presented at ObesityWeek, November 1–4, 2022, San Diego, CA; [3]Skarbaliene et al. Poster 1406-P. Presented at ADA 82nd Scientific Sessions, June 3–7, 2022, New Orleans, LA; [4]Brændholt Olsen et al. Poster 92-LB. Presented at ADA 83rd Scientific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

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.

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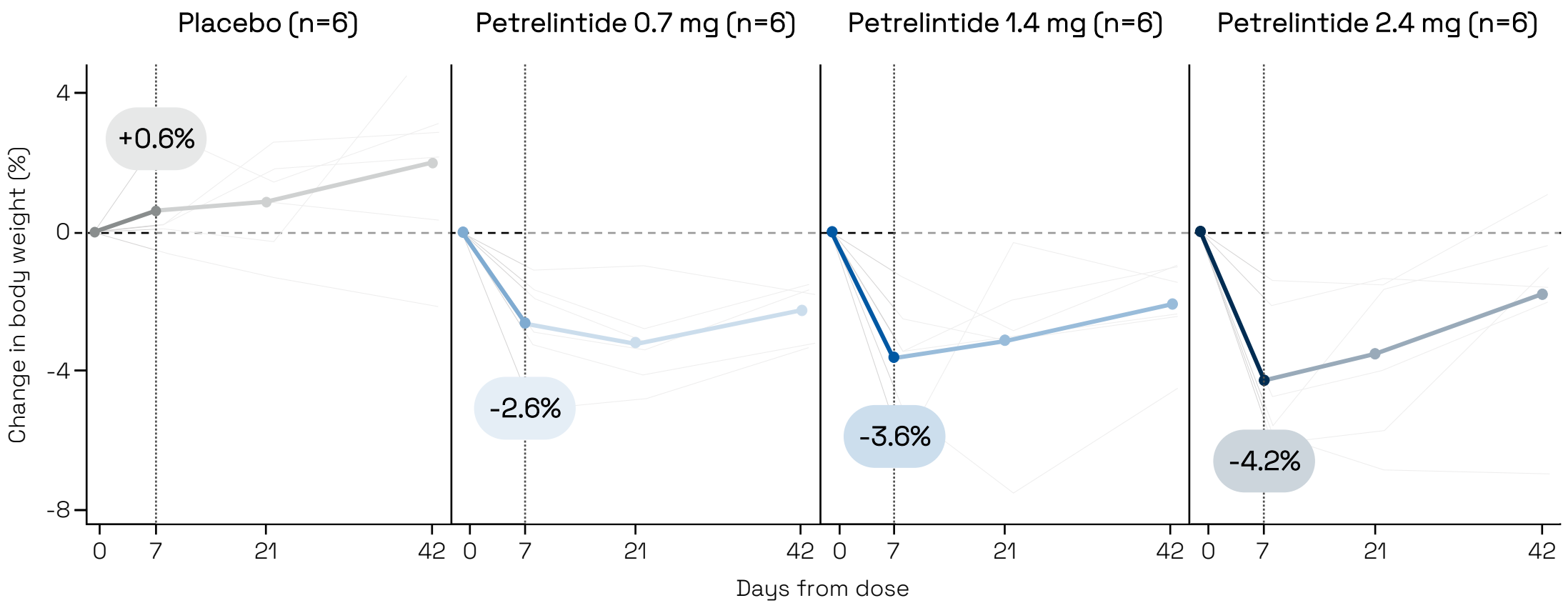
Dose-dependent weight loss was observed with single doses of petrelintide

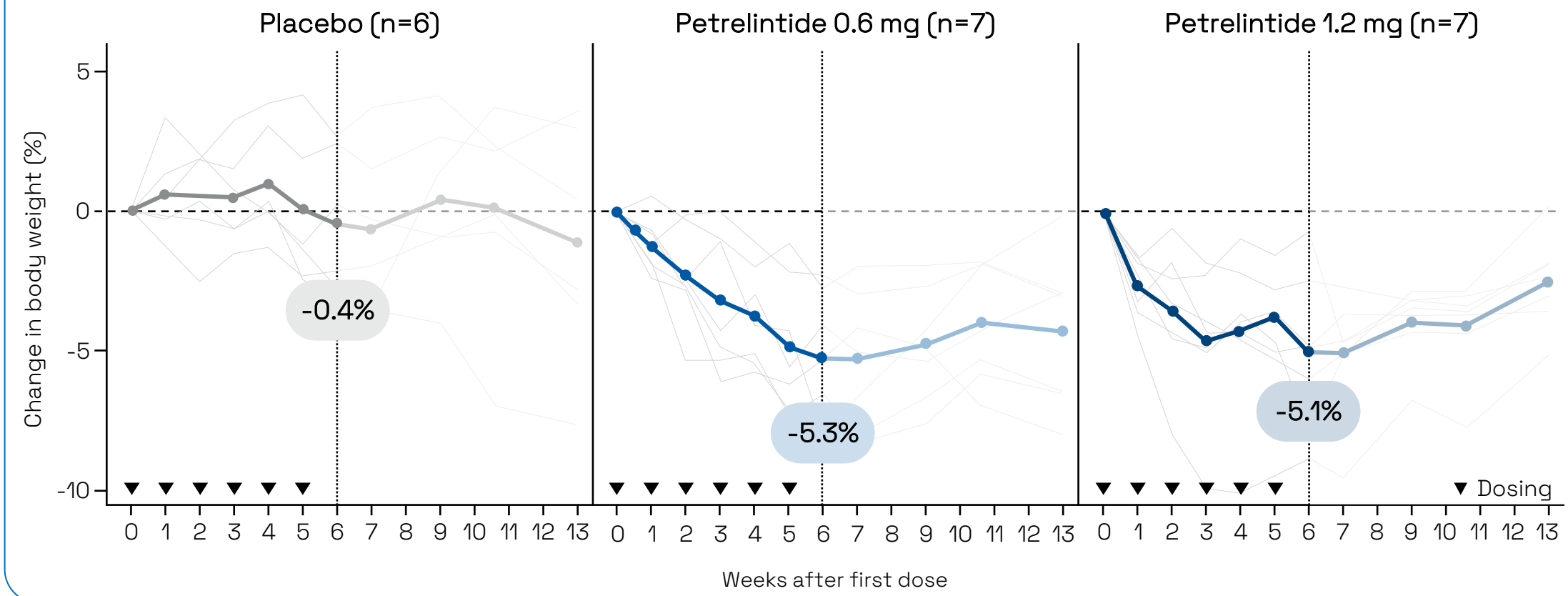
Petrelintide Phase 1a SAD trial: change in bodyweight



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

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

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



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

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

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

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

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

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

Trial design: Petrelintide Phase 1b MAD Part 2

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

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

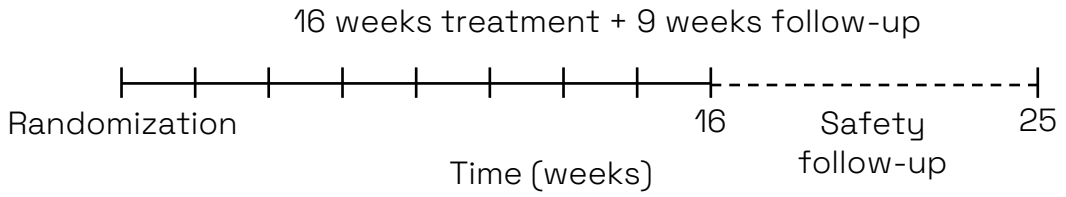
- Adults 18–64 years
- Body weight ≥70 kg
- HbA1c <6.5%
- BMI 27.0–39.9 kg/m^2

3 cohorts[a]
N=48

Dose escalation within cohorts every second week

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

R 3:1 versus placebo



Primary endpoint:
- Incidence of TEAEs

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

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[a]Safety evaluation occurred after 4 weeks of treatment at the target dose for each cohort. Initiation of the next, higher dose cohort only occurred following safety evaluation for the previous cohort.
Sources: [1]ClinicalTrials.gov (NCT05613387), accessed October 2024; [2]Data on file.
BMI=body mass index; HbA1c=glycated hemoglobin; MAD=multiple ascending dose; MTM=mixed test meal; PD=pharmacodynamics; PK=pharmacokinetics; SC=subcutaneous; TEAE=treatment-emergent adverse event.

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

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

Gender

79% of participants were male

Age

Median 49 years

Weight

Median 92.4 kg

BMI

Median 29.2 kg/m^2

(eligible range: 27.0–39.9 kg/m^2)

Baseline characteristics were balanced across the dose cohorts[2]

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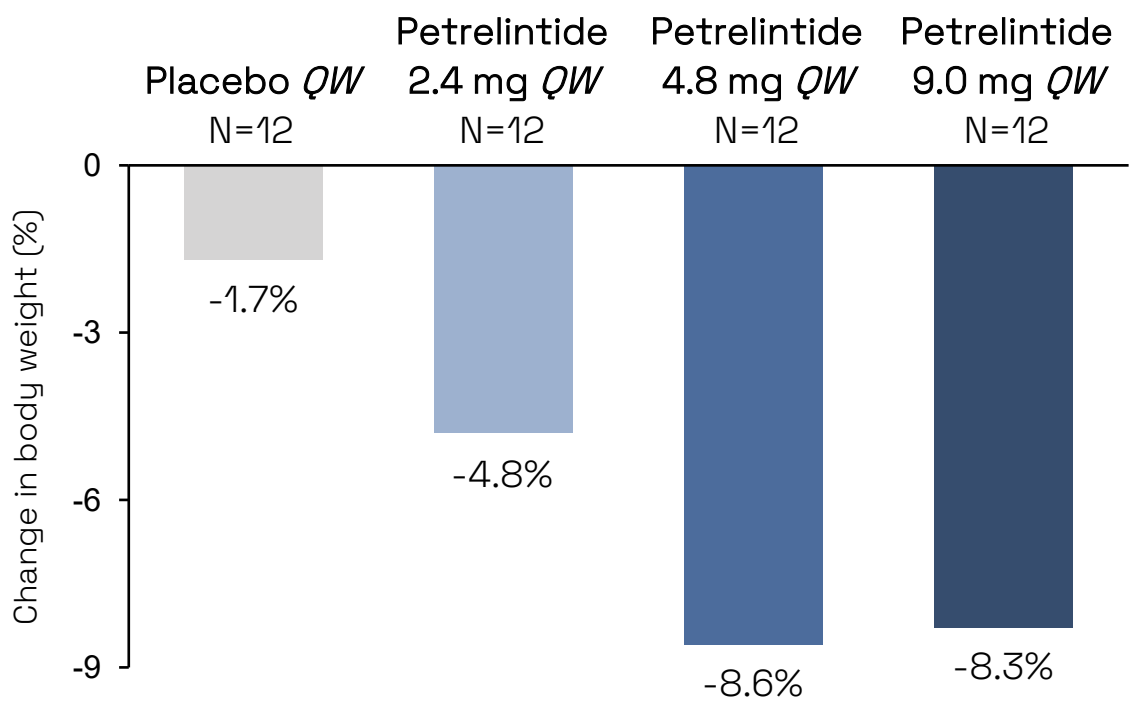
Sources: [1]Zealand Pharma. Press release 20 June 2024. Available from: https://www.globenewswire.com/news-release/2024/06/20/2901879/0/en/Zealand-Pharma-announces-positive-topline-results-from-the-Phase-1b-16-week-multiple-ascending-dose-clinical-trial-with-long-acting-amylin-analog-petrelintide.html,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

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

Substantial weight loss was observed at 16 weeks…

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



Petrelintide treatment resulted in a **mean weight loss** of **up to 8.6%** from baseline after 16 weeks

All participants treated with petrelintide **lost weight** during the trial

Review of data from individual participants supports that **separation at the higher doses is possible**

N represents cohort size at randomization.
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]Zealand Pharma. Press release 20 June 2024. Available from: https://www.globenewswire.com/news-release/2024/06/20/2901879/0/en/Zealand-Pharma-announces-positive-topline-results-from-the-Phase-1b-16-week-multiple-ascending-dose-clinical-trial-with-long-acting-amylin-analog-petrelintide.html, accessed July 2024; [2]Data on file.
DG=dose group; MAD=multiple ascending dose; QW=once-weekly.

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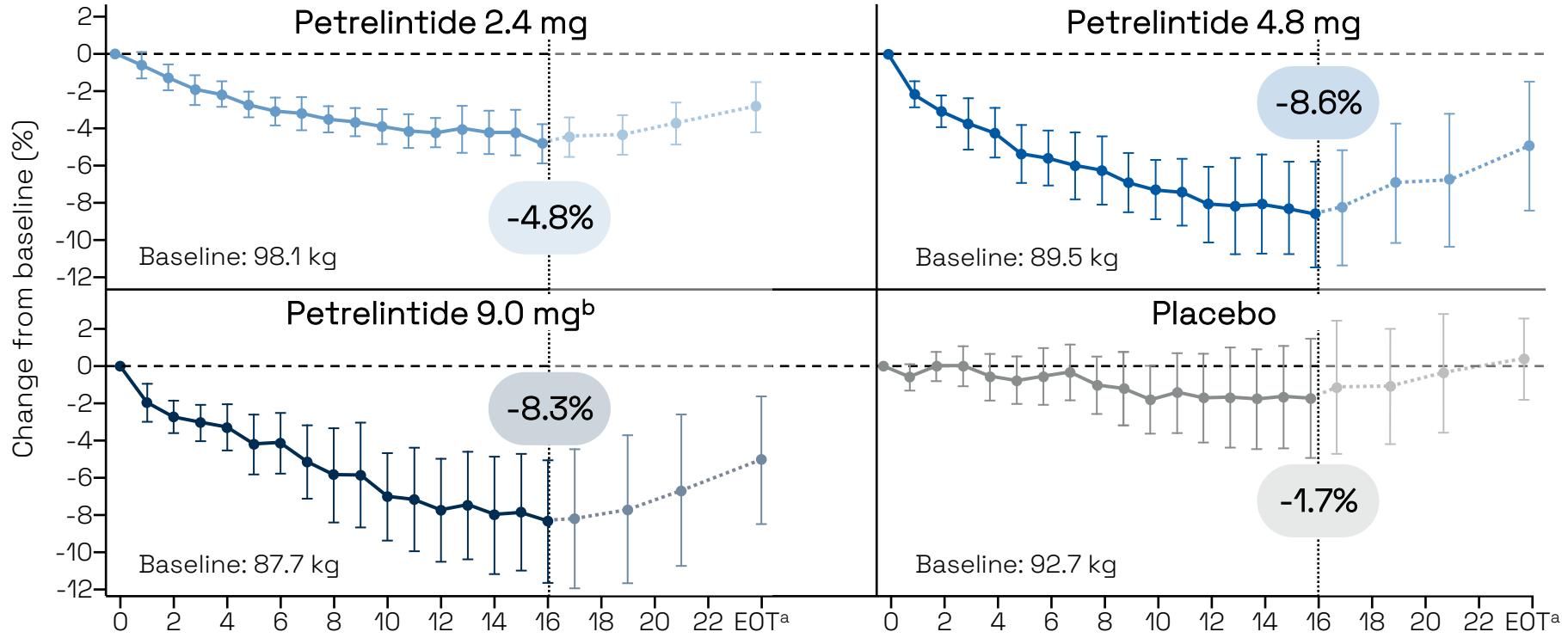
...with continued body weight loss expected with longer treatment duration

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



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]EOT includes measurements at the EOT visit, performed at 24 or 25 weeks after dosing, and also performed for participants discontinuing treatment early; [b]One participant had one extra week at 7.5 mg, and thereby only five weeks on maintenance dose at Week 16. After Week 16, this participant is included with weeks after last dosing.
Source: Data on file. Data presented at ObesityWeek 2024 in San Antonio, Texas.
CI=confidence interval; EOT=end of trial; MAD=multiple ascending dose.

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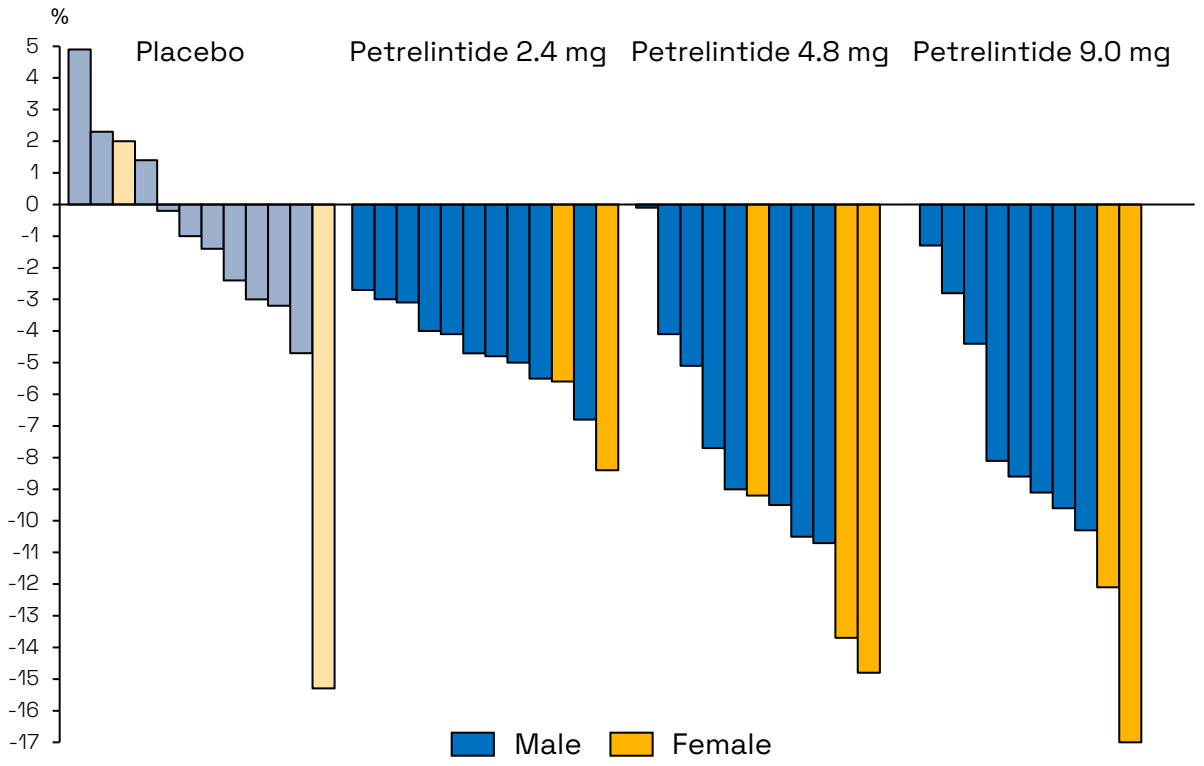
Females in the petrelintide 16-week Phase 1b trial generally lost more weight than the males

Weight loss from baseline after 16 weeks by gender



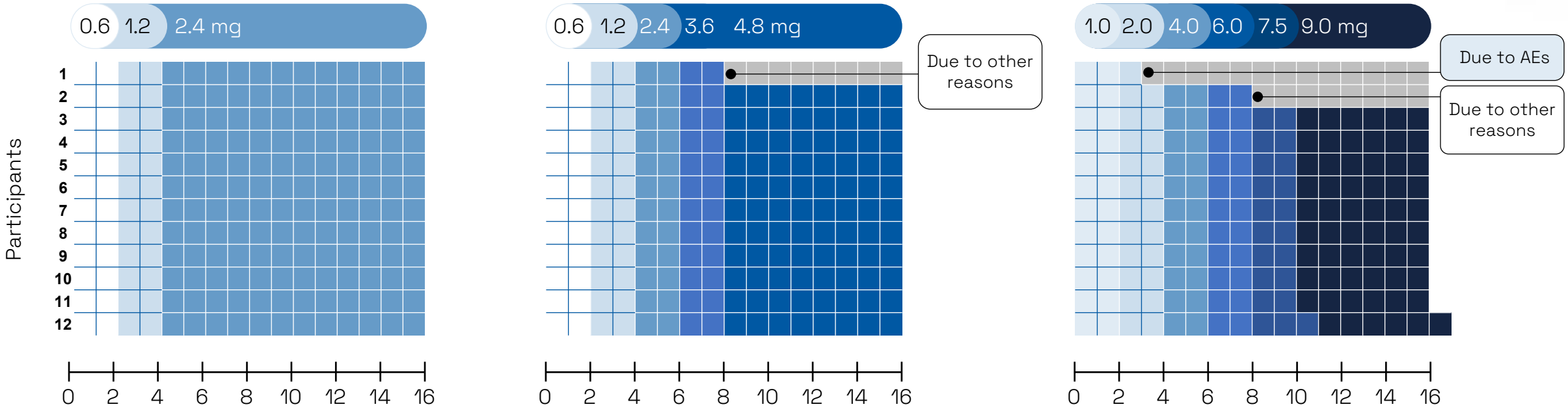
21% of trial participants in the trial were **female**

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.

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

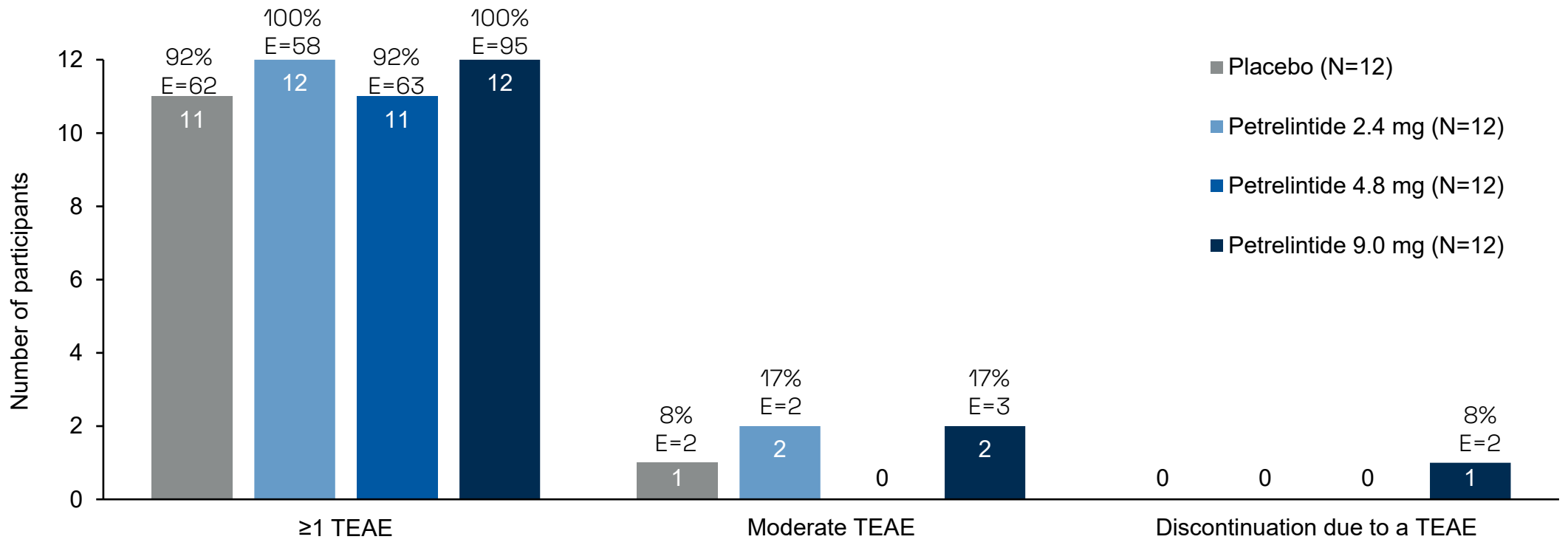


- Three participants discontinued petrelintide: one due to AEs, one to recover from a cold, and one due to personal reasons
- One participant in the 9.0 mg arm had an extra week at 7.5 mg (due to tolerability)
- The remaining participants followed dose escalation steps within cohorts

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: Data on file. Data presented at ObesityWeek 2024 in San Antonio, Texas.
AE=adverse event.

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

Only one petrelintide-treated participant discontinued treatment due to TEAEs



No serious or severe TEAEs were reported

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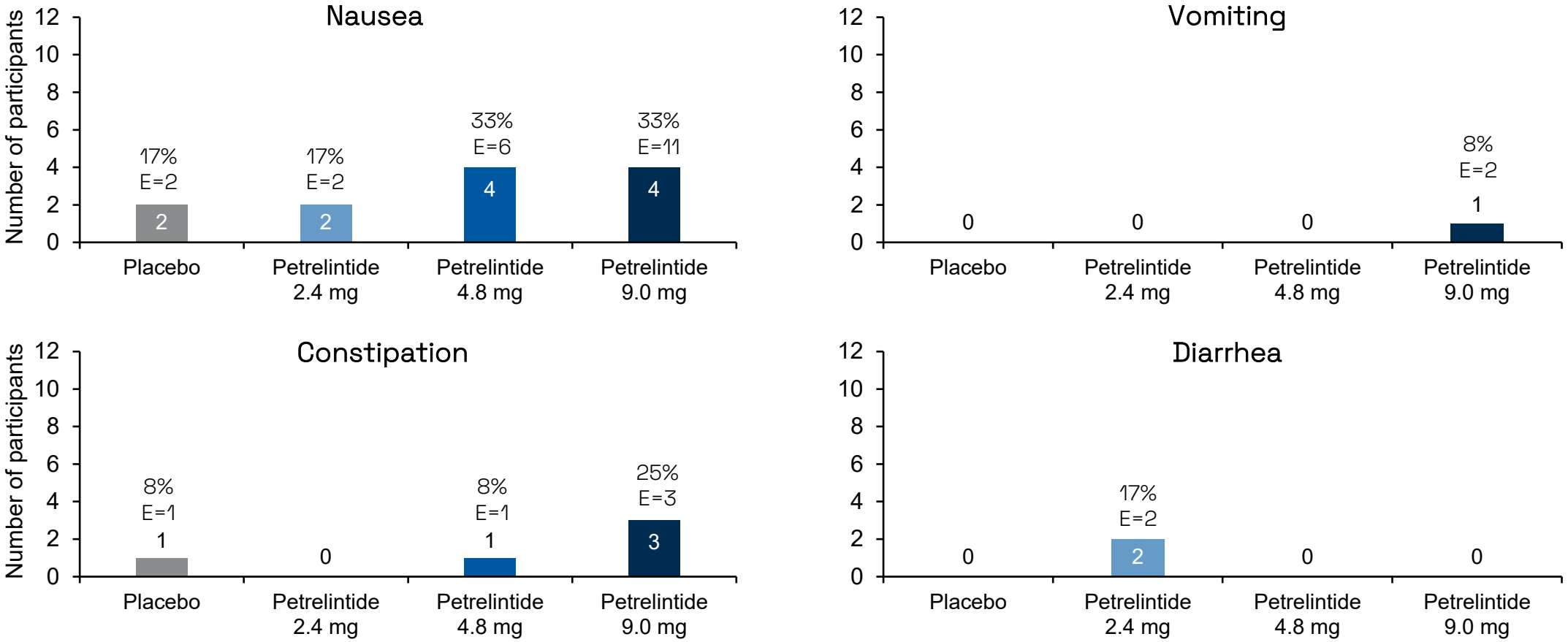
Source: Data on file. Data presented at ObesityWeek 2024 in San Antonio, Texas.
5 moderate AEs reported by petrelintide exposed participants: nausea, vomiting, nasopharyngitis, acute sinusitis, back pain
E=number of events; N=number of participants; TEAE=treatment-emergent adverse event.

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

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



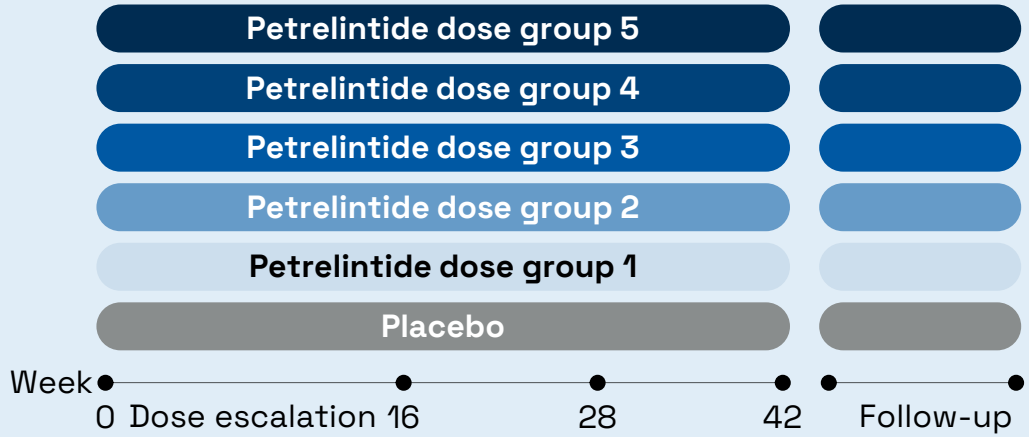
Zealand Pharma has a collaboration and license agreement with Roche for petrelintide, including co-development and co-commercialization in the U.S. and Europe.
Source: Data on file. Data presented at ObesityWeek 2024 in San Antonio, Texas.
N=12 in each treatment group.
E=number of events; TEAE=treatment-emergent adverse event; GI=Gastrointestinal.

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

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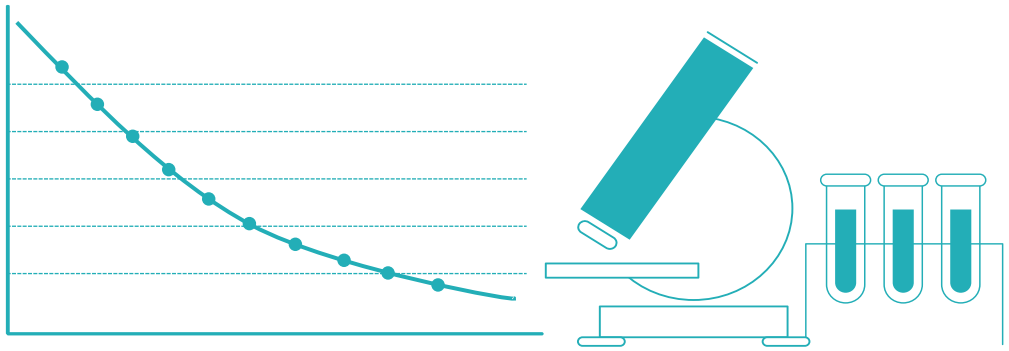
Phase 2 trial with petrelintide/CT-388 planned for initiation in H1 2026

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.

Shared commitment to redefine obesity care

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

- Equal partnership with co-development and co-commercialization
- Strong financials, including 50/50 profit sharing in U.S. and Europe
- Zealand Pharma scaling alongside Roche, to build customer-centric commercial and medical affairs footprint

ZEAL&
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Roche

A transformative collaboration and license agreement to unlock the full potential of petrelintide

True partnership agreement	✓ Shared vision for petrelintide as a future foundational therapy for weight management ✓ Co-development and co-commercialization (up to 50% in U.S. and Europe)
Important synergies and complementary capabilities	✓ Combining Zealand's >25 years of peptide expertise with Roche's global R&D, manufacturing, and commercial capabilities
Maximizing the full value potential of petrelintide	✓ Addressing different high unmet medical needs, both as monotherapy and in combination with other agents (e.g., CT-388), to reach as many patients as possible ✓ Accelerating and expanding the opportunities with petrelintide in weight management and related indications
Up to $5.3 billion in total consideration to Zealand	✓ $1.65 billion in upfront (of which $1.4 billion due in Q2 2025 and $250 million in anniversary payments over two years) ✓ Up to $1.2 billion in development milestone payments ✓ Up to $2.4 billion in sales-based milestone payments
Economics and upside further enhanced	✓ 50/50 profit sharing in U.S. and Europe ✓ Royalties on net sales in the rest of the world ✓ $350 million to Roche from Zealand Pharma for CT-388 in the first combination product

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

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]

Survodutide is licensed to Boehringer Ingelheim from Zealand Pharma, with Boehringer solely responsible for development and commercialization globally.
Sources: [1]Wynne et al. Int J Obes (Lond) 2006;30(12):1729–1736; [2]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.

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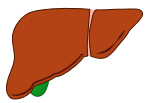
Glucagon/GLP-1 dual agonism offers coordinated regulation of energy expenditure and energy intake

GCG/GCGR

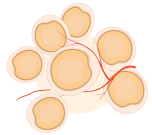
↑ Energy expenditure (metabolic rate)

Liver (direct)



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

Adipose tissue (indirect)



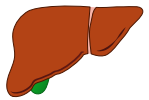
Lipolysis[3]

+

GLP-1/GLP-1R[4]

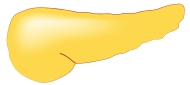
↑ Insulin secretion ↓ Food intake

Liver (indirect)



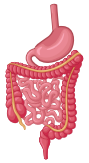
Steatosis[5]

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**

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.

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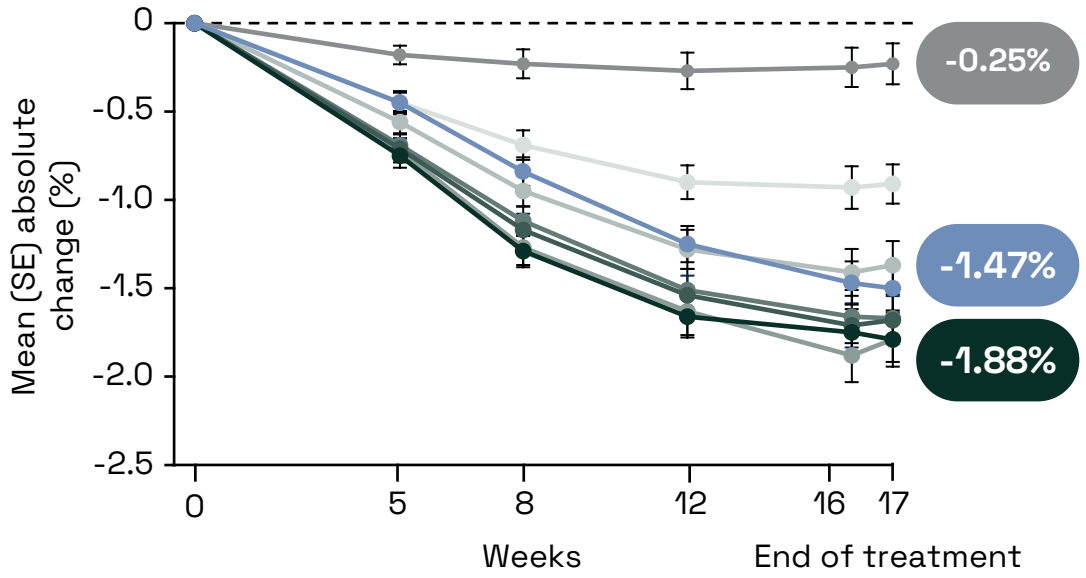
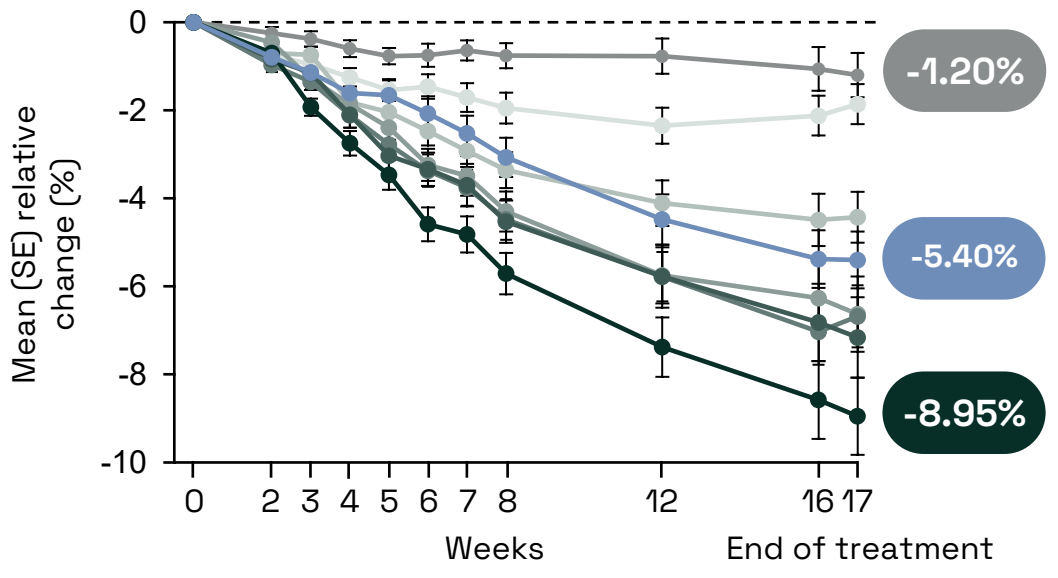
In a 16-week Phase 2 trial in T2D, survodutide effectively reduced HbA1c and body weight

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.

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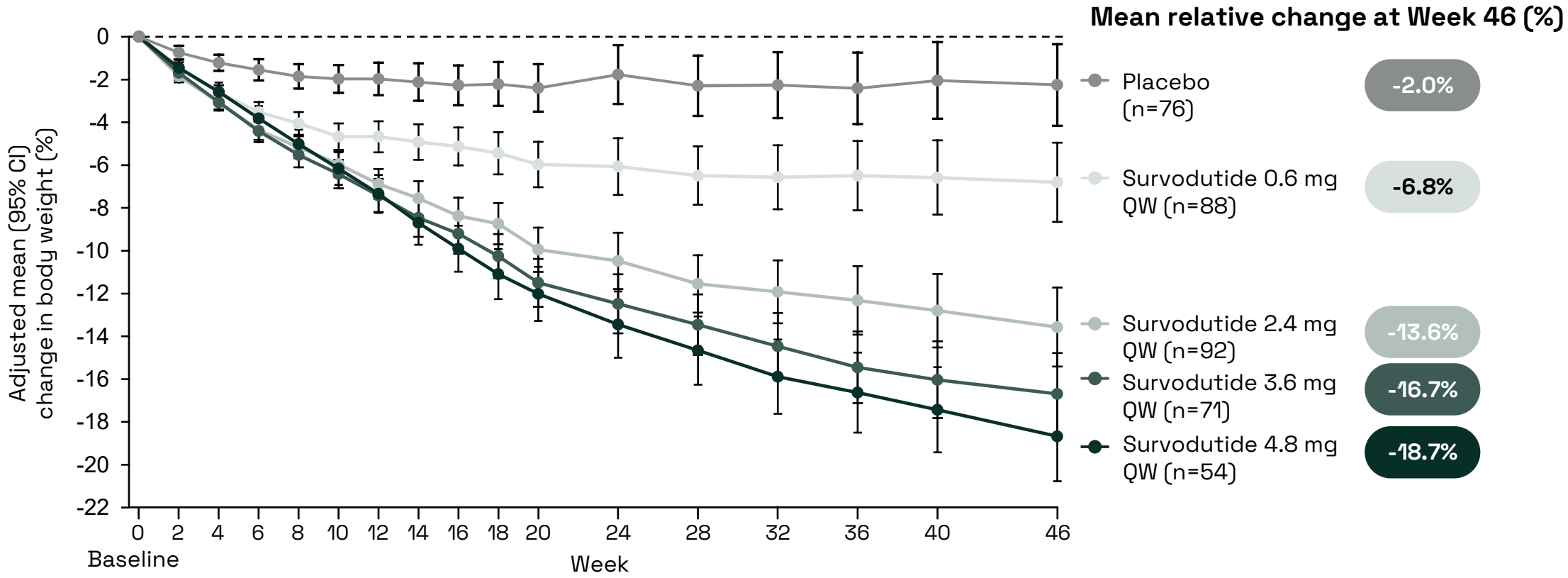
In a 46-week Phase 2 trial in obesity, survodutide dose-dependently reduced body weight by up to 18.7%

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



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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.

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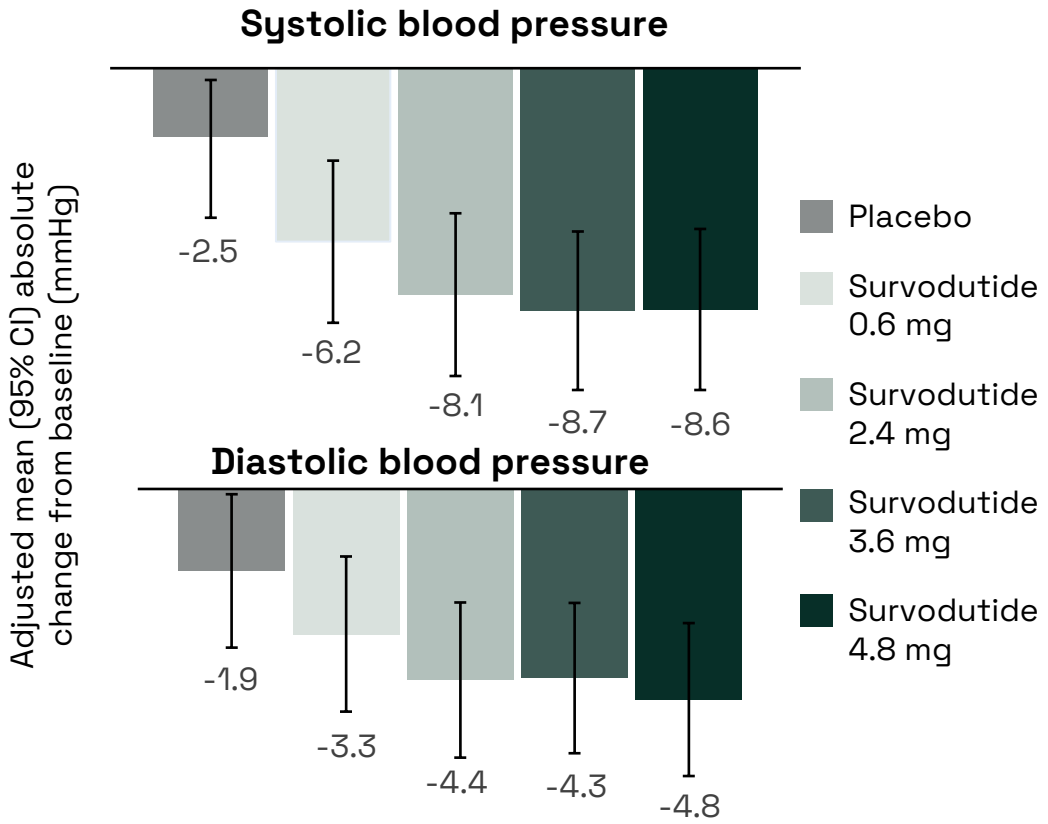
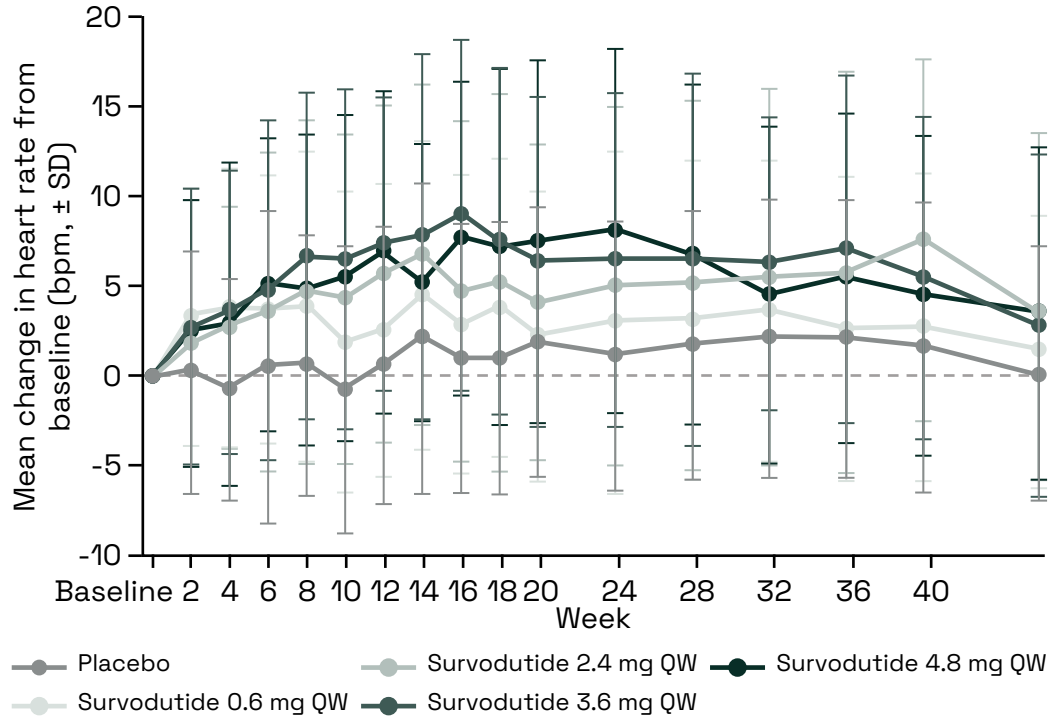
Survodutide substantially reduced blood pressure, with heart rate effects consistent with GLP-1RAs

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.

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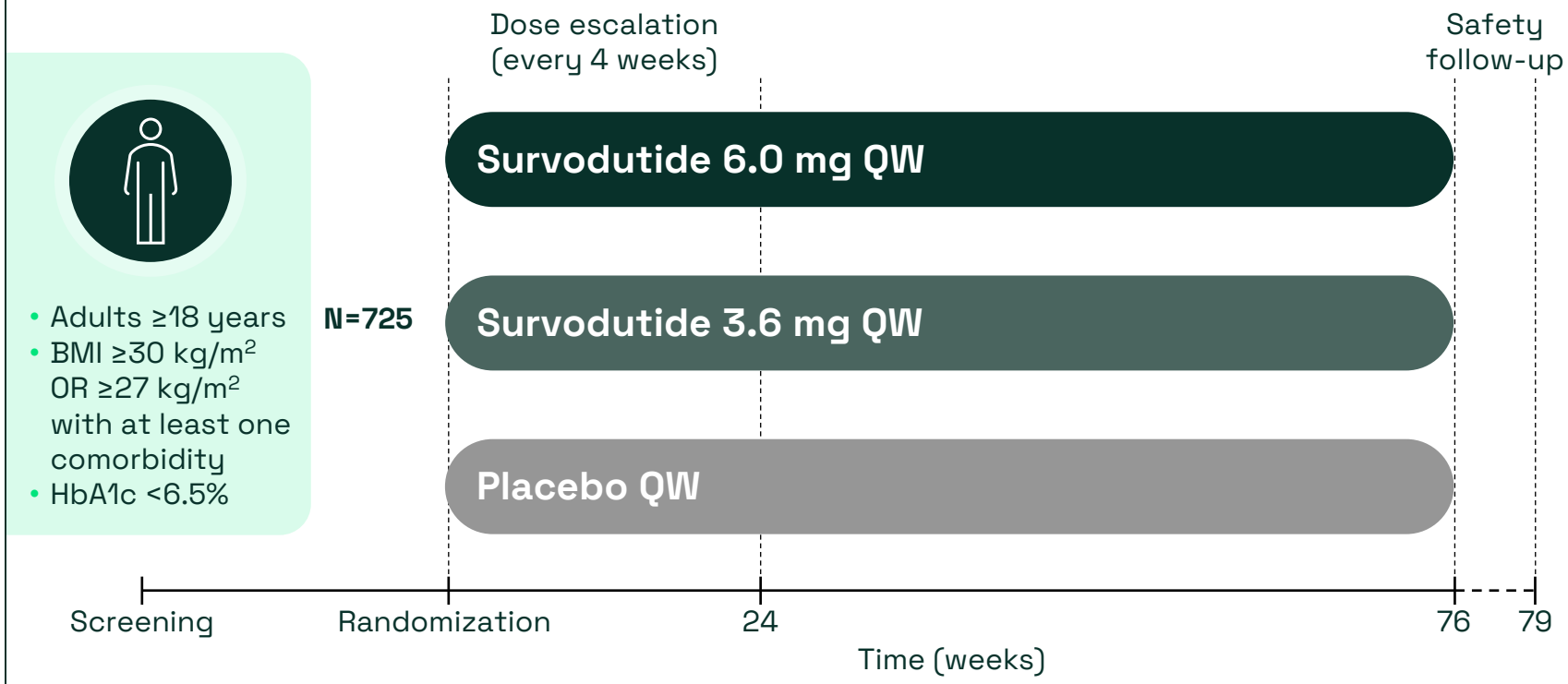
[a]Table includes only the two highest dose cohorts and is based on the treated set and presented according to planned treatment; [b]TEAEs listed according to preferred term and occurred in ≥15% participants in any treatment arm.
Source: Table adapted from Le Roux et al. Oral presentation (51-OR) at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

ZEALAND PHARMA

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.

ZEALAND PHARMA

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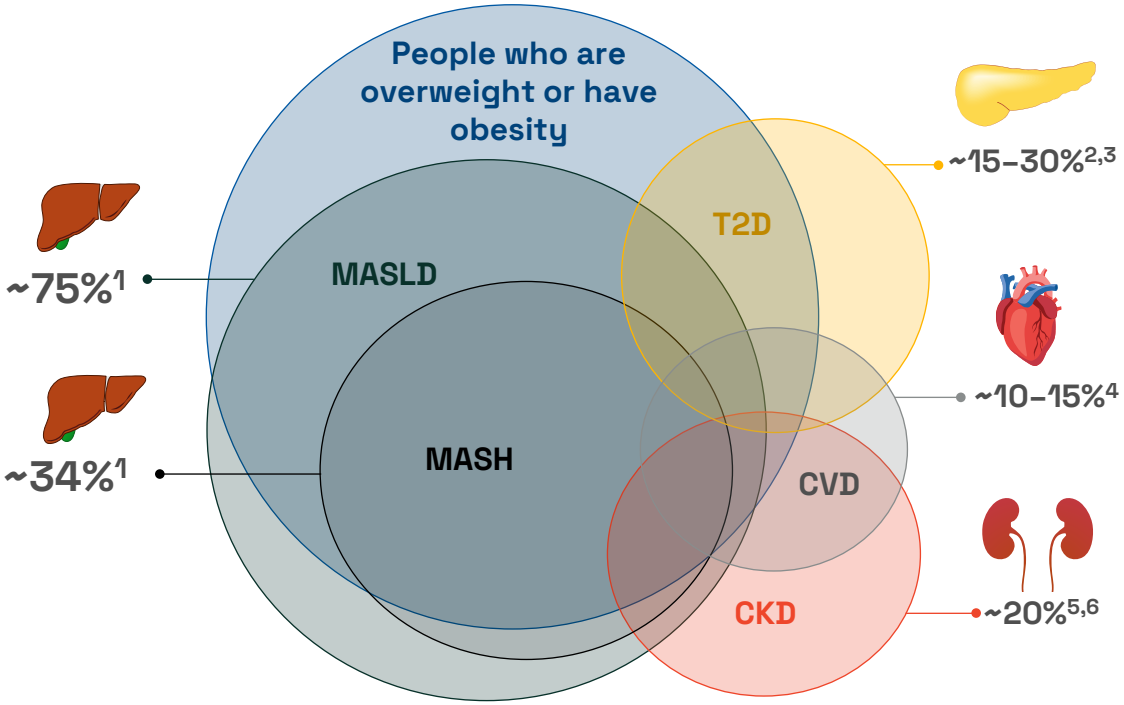
Sources: [1]ClinicalTrials.gov (NCT06066515); [2]ClinicalTrials.gov (NCT06066528); [3]ClinicalTrials.gov (NCT06077864); [4]ClinicalTrials.gov (NCT06309992); [5]ClinicalTrials.gov (NCT06176365); [6]ClinicalTrials.gov (NCT06214741).
CKD=chronic kidney disease; CV=cardiovascular; CVD=cardiovascular disease;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

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.

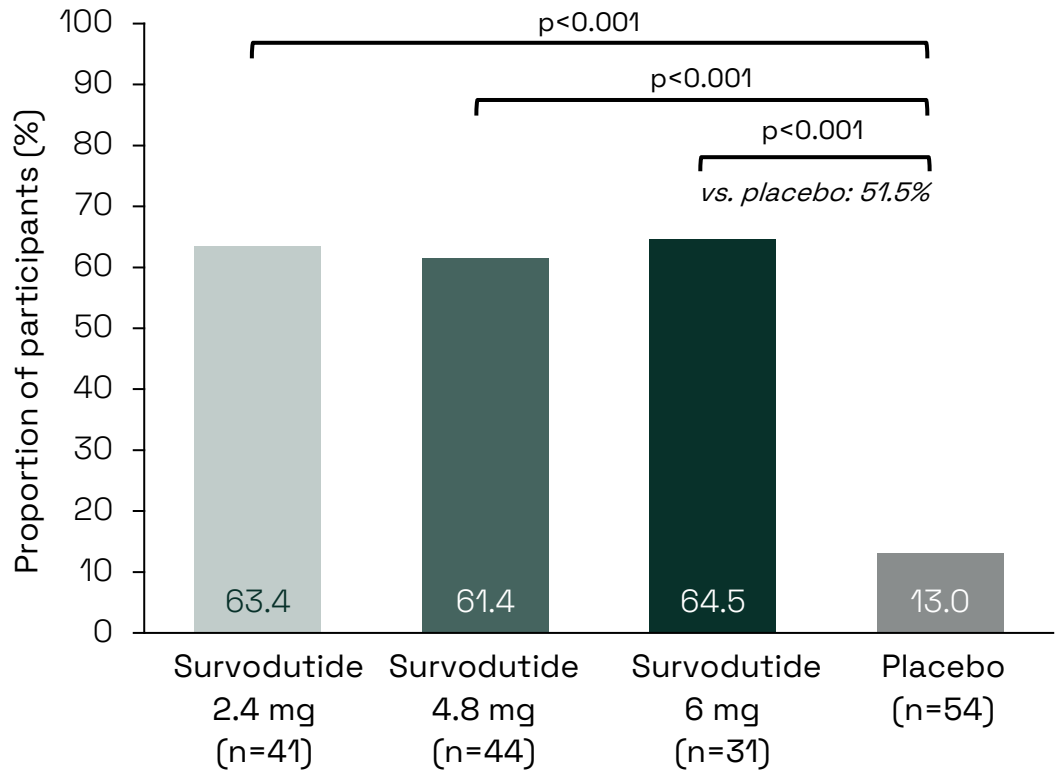
Sources: [1]Quek et al. Lancet Gastroenterol Hepatol 2023;8(1):20–30; [2]Vinciguerra et al. Acta Diabetol 2013;50(3):443–449; [3]Pantalone et al. BMJ Open 2017;7(11):e017583; [4]Schienkiewitz et al. BMC Public Health 2012;12:658; [5]Arinsoy et al. J Ren Nutr 2016;26(6):373–379; [6]Yim & Yoo. Clin Exp 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.

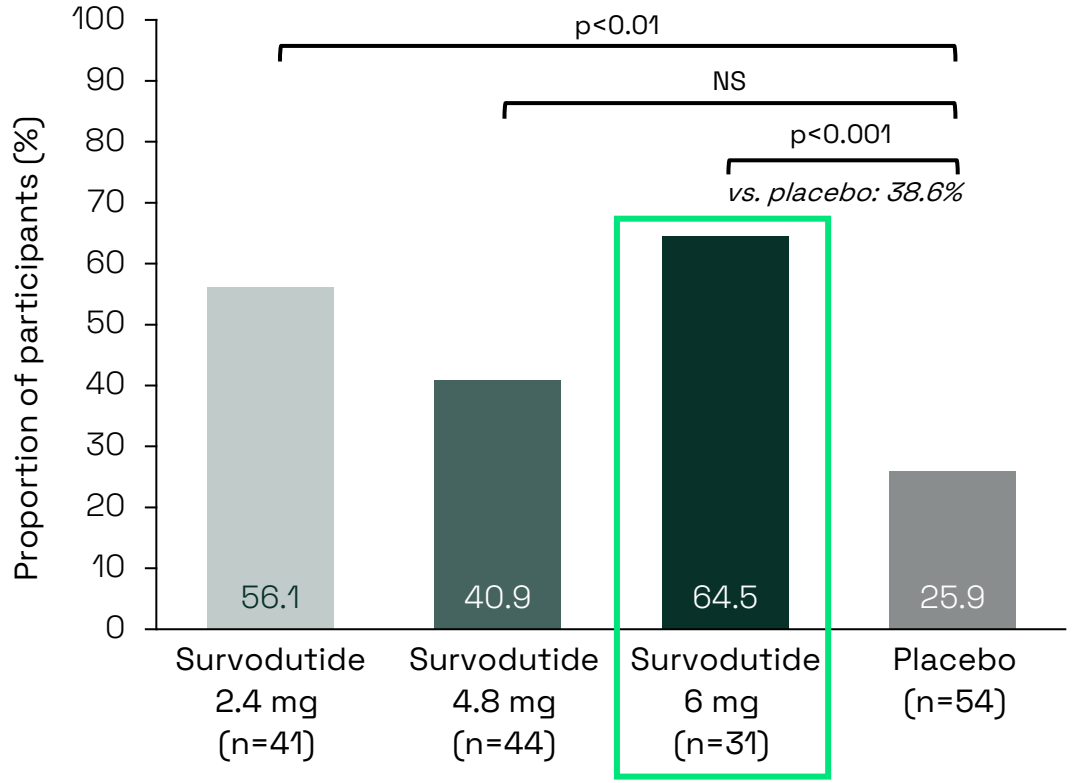
ZEALAND PHARMA

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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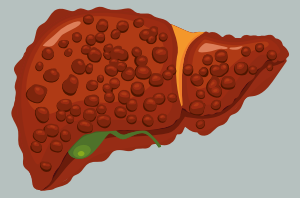
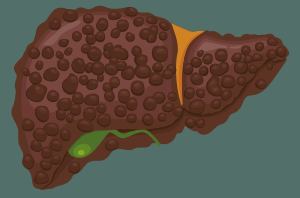
[a]Post hoc analysis in people with fibrosis Stage F2–F3 after 48 weeks of actual treatment.

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

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.

Development of dapiglutide paused as a result of active portfolio management

As part of our active portfolio management, we have decided to pause further investment in dapiglutide

Dapiglutide has demonstrated potential for competitive weight loss in clinical trials to date, and there is a strong scientific rationale for GLP-1R/GLP-2R dual agonism

The GLP-1 space is becoming increasingly crowded, emphasizing the need for even greater and clinically meaningful differentiation for another GLP-1RA-based therapy

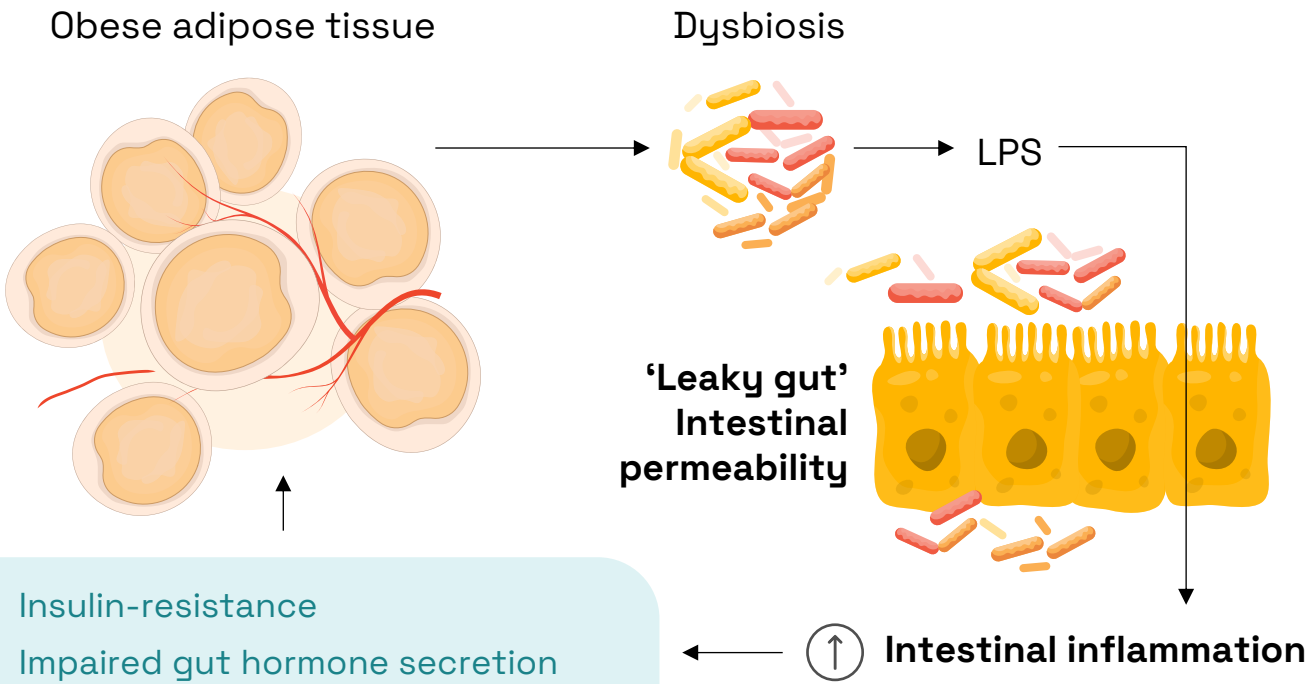
Demonstrating the potential of dapiglutide to modulate low-grade inflammation more effectively than GLP-1R agonist alone would require long and complex clinical trials

ZEALAND PHARMA

Source: Zealand Pharma company announcement No. 23/2025, November 13, 2025.
GLP-1R=glucagon-like peptide-1 receptor; GLP-1RA=glucagon-like peptide-1 receptor agonist; GLP-2R=glucagon-like peptide-2 receptor.

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

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



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

Obesity-related low-grade inflammation can result in:

IBD as increased inflammation impairs the intestinal lining, promoting tissue damage and flare-ups[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]Chang et al. Gastroenterology 2017; 153(3):723–731; [3]Luo & Lin. Immun Inflamm Dis 2021;9(1):59–73; [4]Salas-Venegas et al. Front Integr Neurosci 2022;16:798995.
IBD=inflammatory bowel disease; LPS=lipopolysaccharides.

ZEALAND PHARMA

Rare diseases

Corporate Presentation

CHI is a severe, ultra-rare genetic disorder with significant impact on patients' quality of life

There is a significant unmet need for an effective treatment

CHI is an ultra-rare disease in newborns and children

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

Persistent episodes of hypoglycemia may result in brain damage

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

Significant impact on quality of life

- Complex care requirements 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]

ZEALAND PHARMA

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

Dasiglucagon has potential to address shortcomings of current management of CHI

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

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

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

Dasiglucagon for subcutaneous infusion*

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

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

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

Zealand Pharma is expected to resubmit the NDA to the U.S. FDA in the second half of 2026
- Including both Part 1 (three weeks of dosing) and Part 2 (dosing beyond three weeks) from the original NDA[7]

IP exclusivity: compound patent US 2035 and EU 2039

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

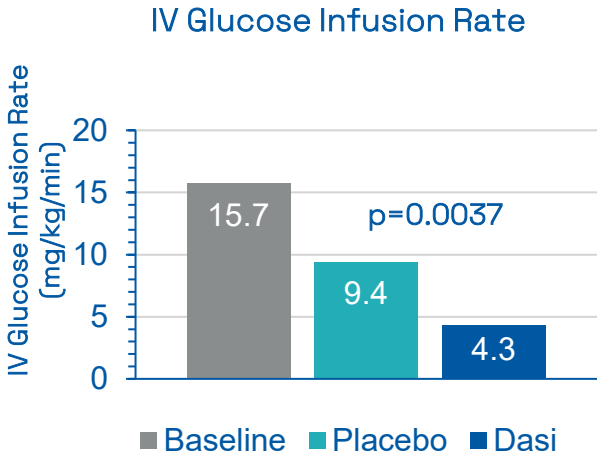
*Investigational compound and device whose safety and efficacy have not been evaluated or approved by the FDA or any other regulatory authority

ZEALAND PHARMA

Three Phase 3 trials form the basis of our NDA submission to the U.S. FDA

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

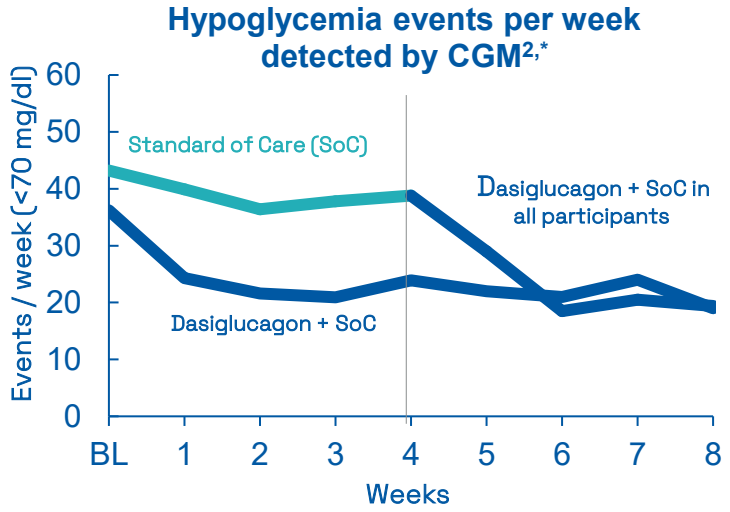
Part 1: Placebo control, crossover x 48 hours[1]



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

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

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



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

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

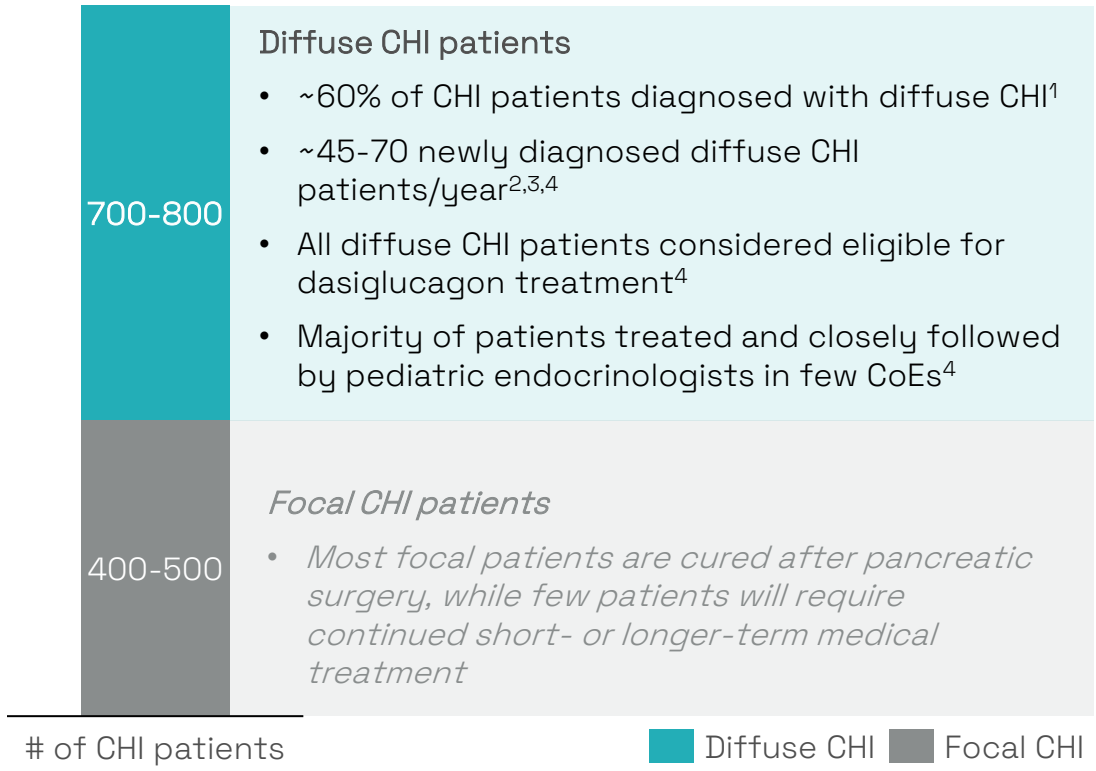
42 of 44 participants continued into long-term extension trial 17106

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

ZEALAND PHARMA

Opportunity to treat up to 800 patients at ultra-rare disease price levels in the U.S.

Patients eligible for dasiglucagon treatment in the US



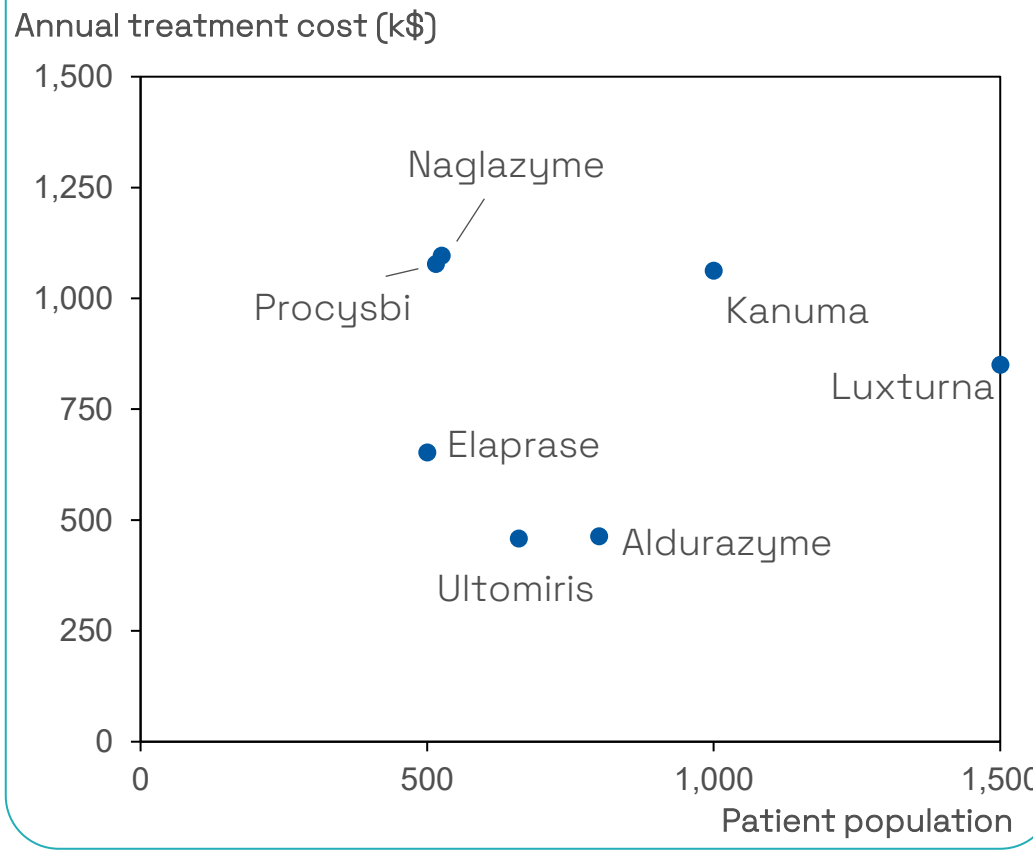
Diffuse CHI patients

- ~60% of CHI patients 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 treated and closely followed by pediatric endocrinologists in few CoEs[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 therapies with clear clinical value command premium prices in US[5]



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

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

ZEALAND PHARMA

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

High unmet need

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

Life-long dependency on parenteral support (PS)

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

Need for improved treatment options

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

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

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

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

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

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

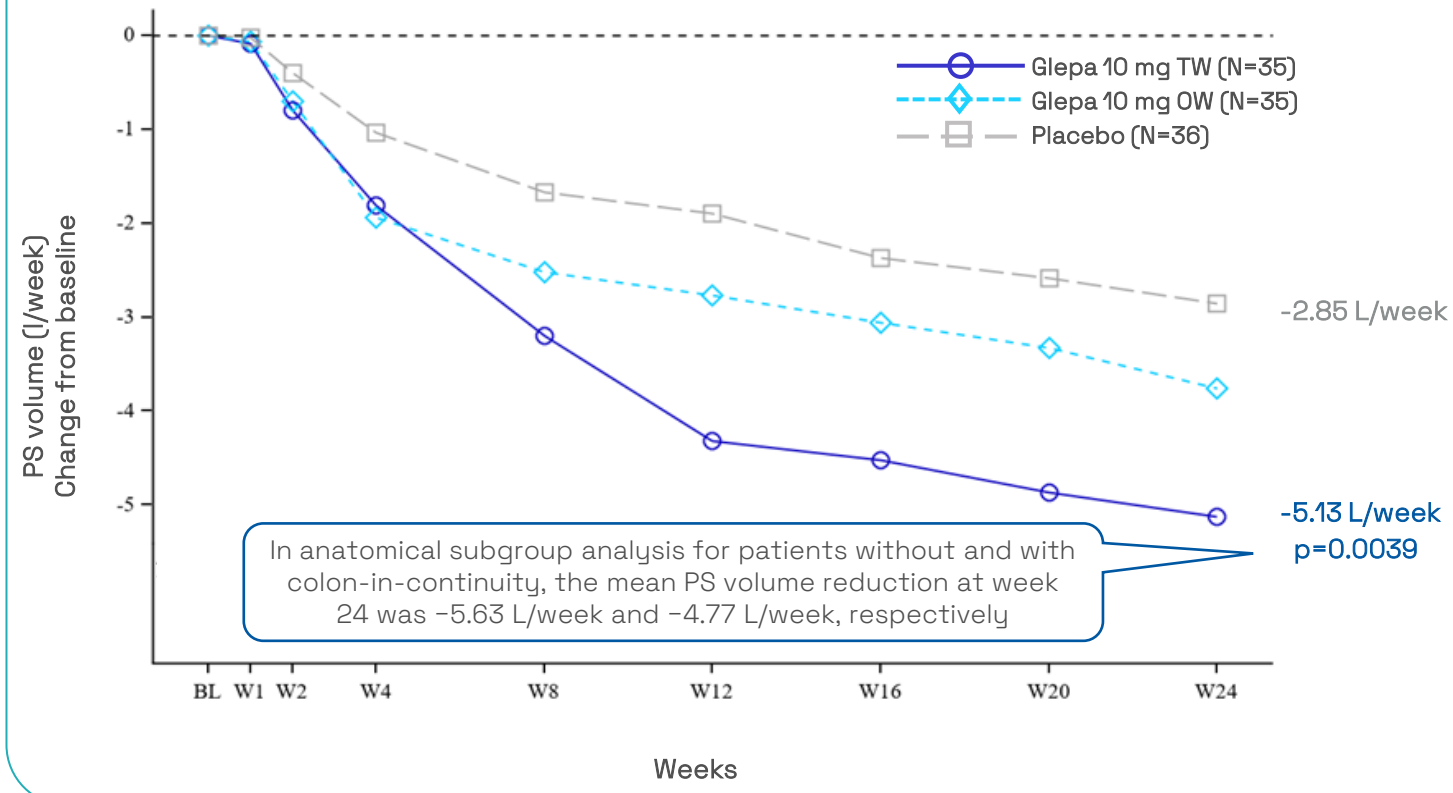
- Effective half-life of ~88 hours at steady state[2]
- Expected 10 mg twice-weekly subcutaneous dosing
- Ready-to-use auto-injector with needle protection
  - Forms depot at the injection site
- An MAA to the EMA was submitted in June 2025
- Second Phase 3 trial initiated (EASE-5)
  - Further confirmatory evidence for U.S. resubmission

[a]Investigational product, not approved for distribution; IP exclusivity: Compound patent 2026 + 5 years PTE; Dosing regime (pending) 2038, Clinical formulation (pending) 2039
Sources: [1]https://www.gattex.com/resources-and-support/; [2]Agersnap M. et al, 2022, Clin Drug Investigation; 42(12):1093-1100; [3]The U.S. FDA issued a Complete Response Letter for the glepaglutide New Drug Application for the treatment of short bowel syndrome.
SBS=short bowel syndrome; MAA=marketing authorization application; EMA=european medicines association.

ZEALAND PHARMA

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

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



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

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

9 patients treated with glepaglutide discontinued PS during the trial

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

Glepaglutide appeared to be well-tolerated in the trial

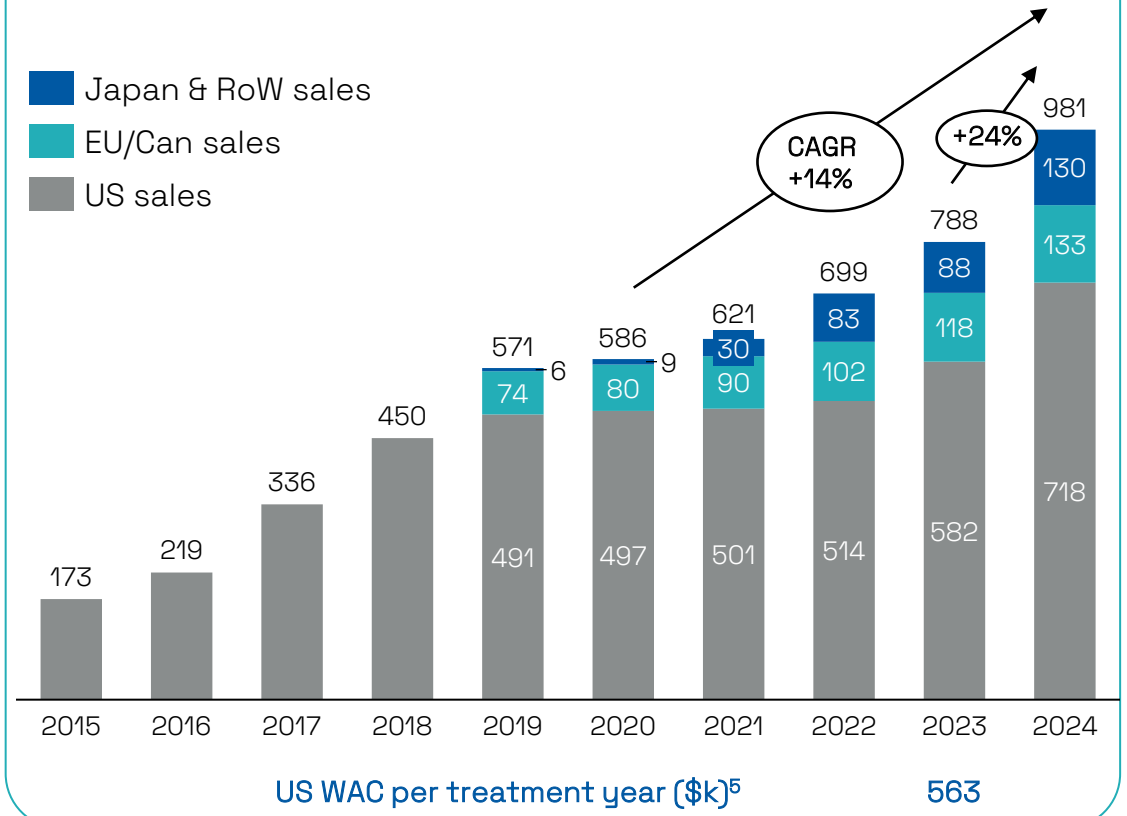
- Most frequently reported adverse events were injection site reactions and gastrointestinal events

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

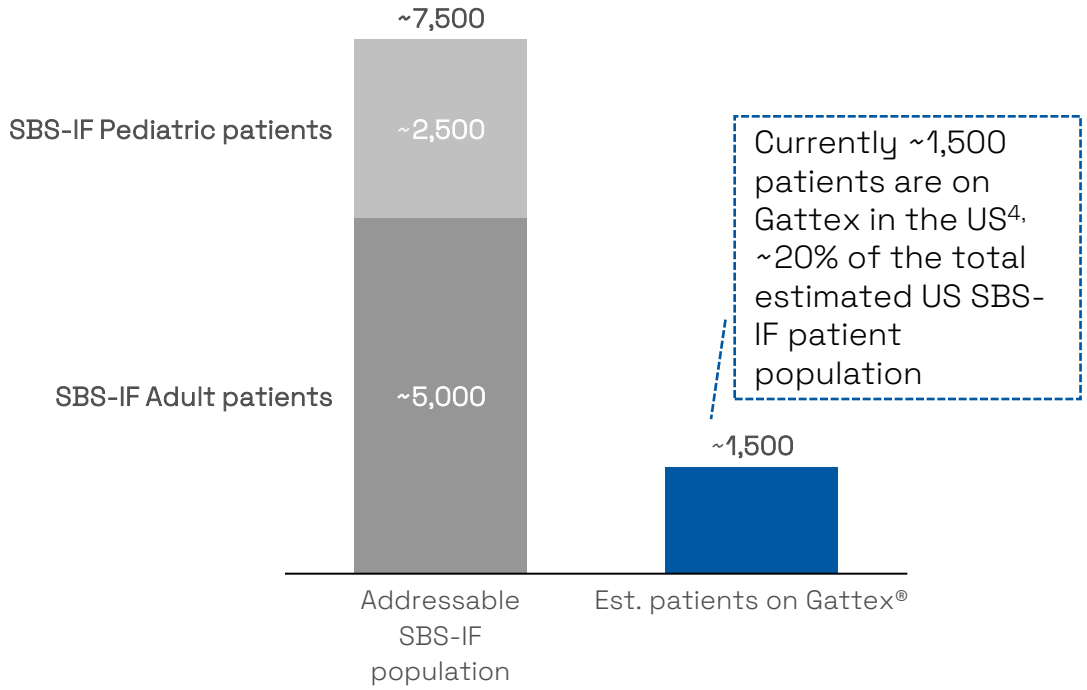
ZEALAND PHARMA

Global teduglutide sales approaching USD 1 billion with significant room for market expansion

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



Estimated US SBS-IF Patients[3]



Sources: [1]2015-2018: Carnegie ZEAL research report, 24 February 2020; [2]2019-24: 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, PriceRx.
WAC=wholesaler acquisition cost; SBS=short bowel syndrome; IF=intestinal failure.

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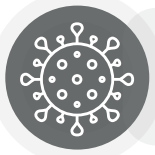
Chronic inflammation

Corporate Presentation

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

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

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



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

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

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

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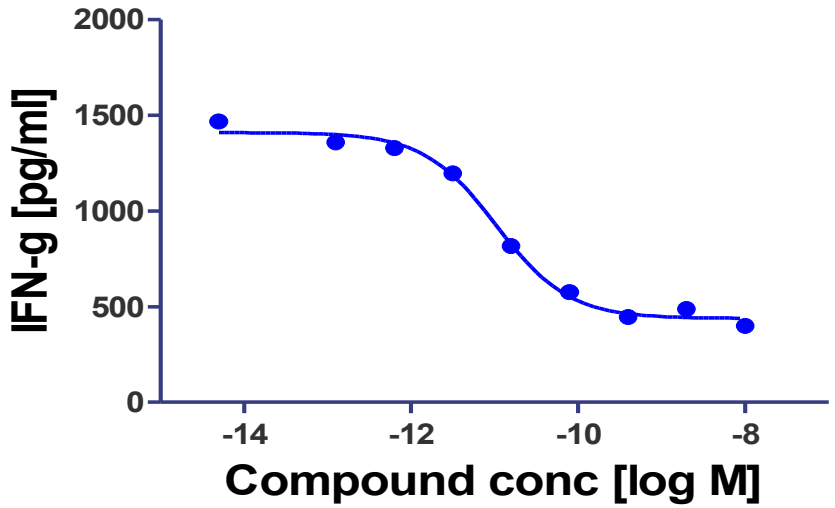
Sources: [1]Navarro-Pérez, Expert Opinion on Therapeutic Targets 2024, 28(1-2):67-82; [2]Markakis, Frontiers in Pharmacology 2021,12: 714841; [3]Chandy and Norton, Current Opinion in Chemical Biology 2017, 38:97–107; [4]ClinicalTrials.gov (NCT06682975), accessed December 2024.

Topline results from the first-in-human clinical trial with ZP9830 is expected in H1 2026

Anti-inflammatory effects of Kv1.3 ion channel inhibition

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



First-in-human SAD clinical trial[2]

The first-in-human Phase 1 single ascending dose trial includes 10 dose cohorts:

- Cohorts 1-3 (SC): Assess safety and PK
- Cohorts 4-9 (SC): Assess safety, PK, and PD
- Cohort 10 (IV): Assess safety and PK

The trial will investigate:

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

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

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.

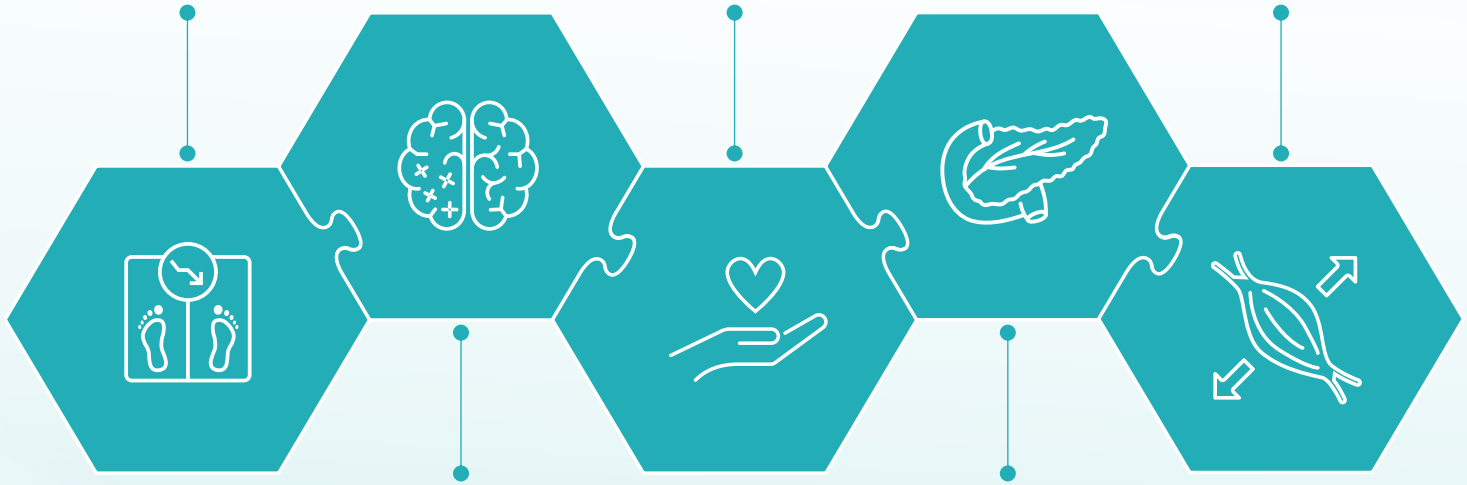
Delivering outcomes that will increase human health span

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.

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

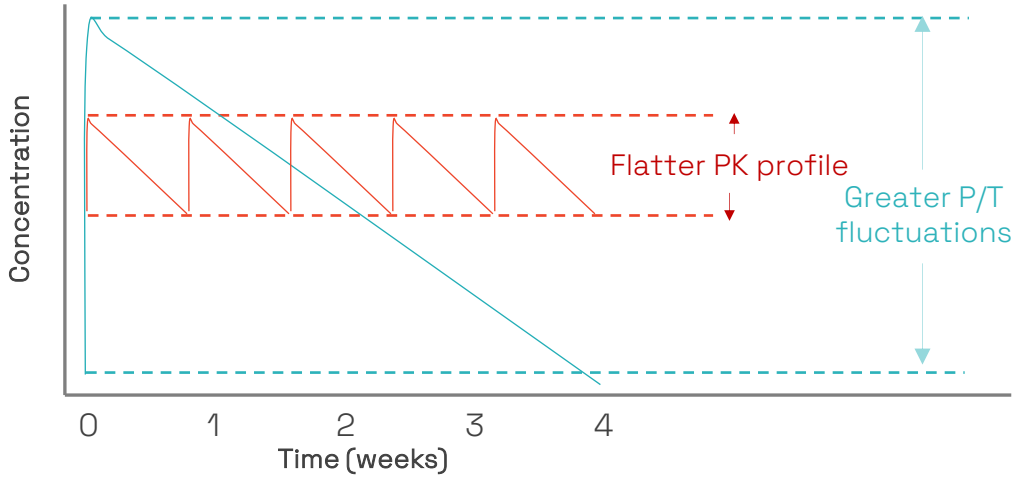
Oral small-molecule amylin

- ✓ 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



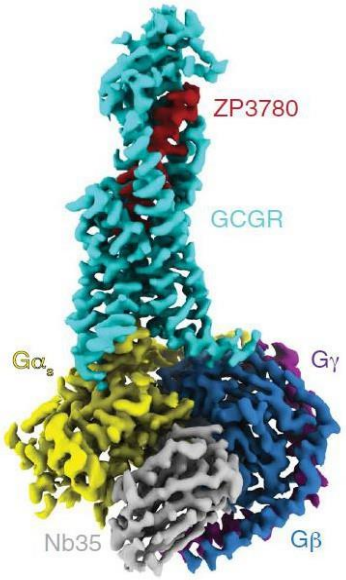
QW=once weekly; QM=once monthly; PK=pharmacokinetics; P/T=peak-to-trough.

Investing in advanced computational methods for medicine creation

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

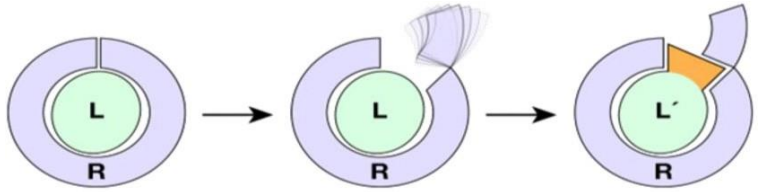
Static model

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

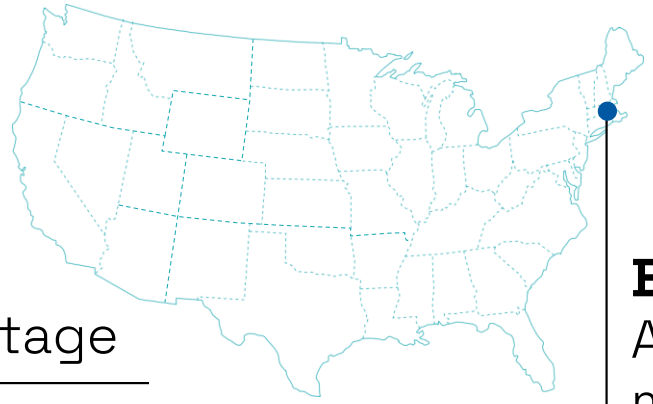
Source: Hilger et al. Science. 2020 Jul 31;369(6503) (with author permission).
MD=molecular dynamics. ML=machine learning L=ligand; L'=different ligand; R=receptor.

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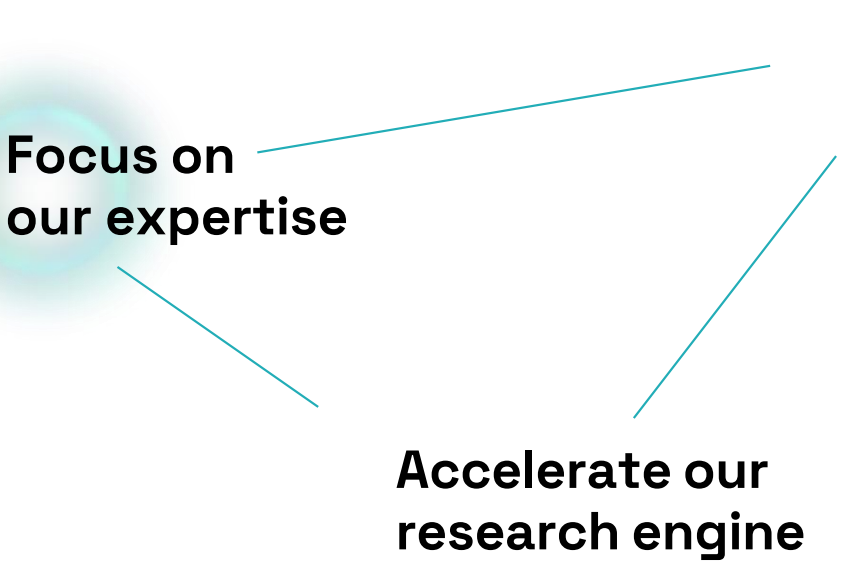
MoA=mechanism of action; FTE=full time employee; AI=artificial intelligence; ML=machine learning.

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



Deliver valued medicines

#1
idea → clinic cycle times

+10
clinical programs by 2030

Additional company information

Corporate Presentation

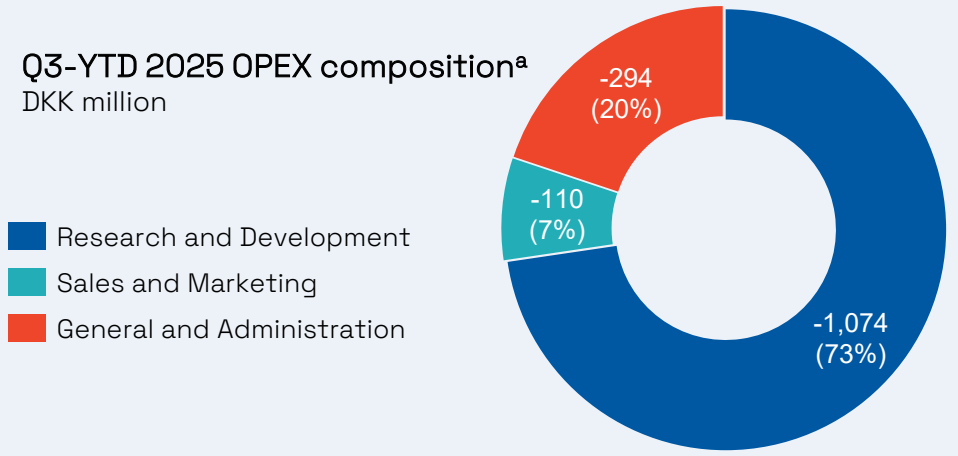
Q3 2025 YTD Profit & Loss

DKK million	Q3-25 YTD	Q3-24 YTD
Revenue	9,145.9	53.6
Gross profit	**9,145.1**	**46.2**
Research and development expenses	-1,074.5	-665.9
Sales and marketing expenses	-110.3	-50.2
General and administrative expenses	-293.9	-199.8
Other operating items[a]	-	-3.1
Net operating expenses[a]	**-1,478.6**	**-919.1**
Operating result[a]	**7,666.5**	**-872.9**
Net financial items	-62.5	81.1
Result before tax[a]	**7,604.0**	**-791.8**
Tax	-573.4	4.0
Net result for the period[a]	**7,030.5**	**-787.8**

P&L reflecting strategic investments in differentiated R&D assets and organization

- Revenue of DKK 9,146 million driven by the initial upfront payment under the partnership agreement with Roche for petrelintide.
- R&D expenses of DKK 1,074 million, representing 73% of the cost base, are mainly driven by development costs for the mid-stage obesity assets, whereas S&M expenses of DKK 110 million are driven by pre-commercial activities associated with petrelintide and the rare disease assets. G&A expenses of DKK 294 million reflect strengthening of organizational capabilities, investments in IT infrastructure and legal expenses related to the patent portfolio.
- Net financial items of DKK -62 million are driven by exchange rate adjustments, partly offset by interest income from the excess liquidity invested in marketable securities.

Q3-YTD 2025 OPEX composition[a]
DKK million



[a]Excluding transaction-related costs of DKK 196.4 million associated with the Roche partnership agreement. Net operating expenses including transaction-related costs amount to DKK 1,675.1 million in Q3-25 YTD.

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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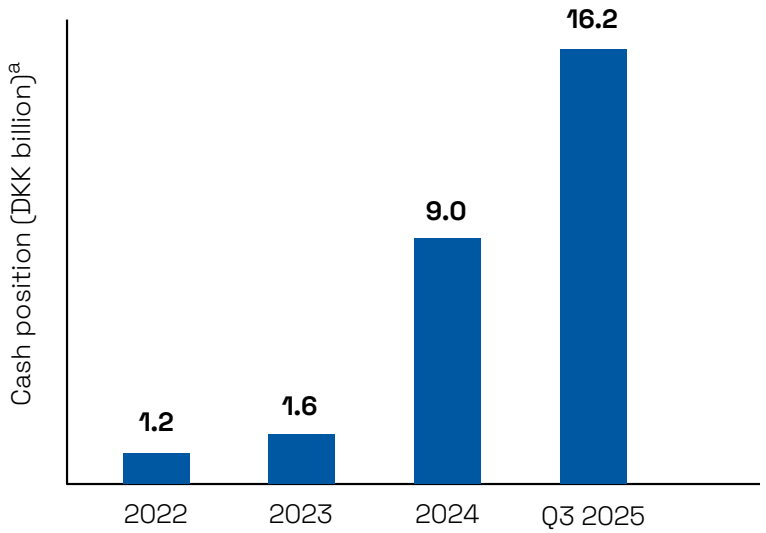
Financial muscle for accelerated growth

ILLUSTRATIVE

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



Mid-term profitability drivers

- **Today**: USD 125 million in anniversary payments from Roche in Q2 2026 and Q2 2027, respectively
- **2026**: Potential partnerships across pipeline assets; 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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