Zealand Pharma

Transforming the future of metabolic health.

Corporate Presentation
March 2026

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 2026 and financial guidance for 2026. 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 and geopolitical 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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Zealand Pharma is transforming the future of metabolic health

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 ~2.3B
(DKK ~15.1B)[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 December 31, 2025. Based on foreign exchange rate as of March 8, 2026 (USD/DKK 6.45).

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.

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 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.

Building the world's most valuable metabolic health pipeline

METABOLIC FRONTIER 2030

ACCELERATE
Progress pre-clinical programs at speed

PARTNER
Evolve and fuel our platform

EXPAND
Establish Boston site to strengthen research engine

5 launches in **5** years

+10 clinical programs

Industry-leading cycle times from idea to clinic

Unmatched expertise in peptides and metabolic health

>25 years of rich proprietary data

Unique opportunity to leverage AI/ML

2026: Most defining and catalyst-rich year yet

NON-EXHAUSTIVE

Petrelintide[a] (amylin analog)

- ✓ **Results from Ph2 ZUPREME-1**
- ☐ **Results from Ph2 ZUPREME-2**
- ☐ **Initiation of Phase 3a program**
- ☐ **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

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**

Executing on rare disease programs

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

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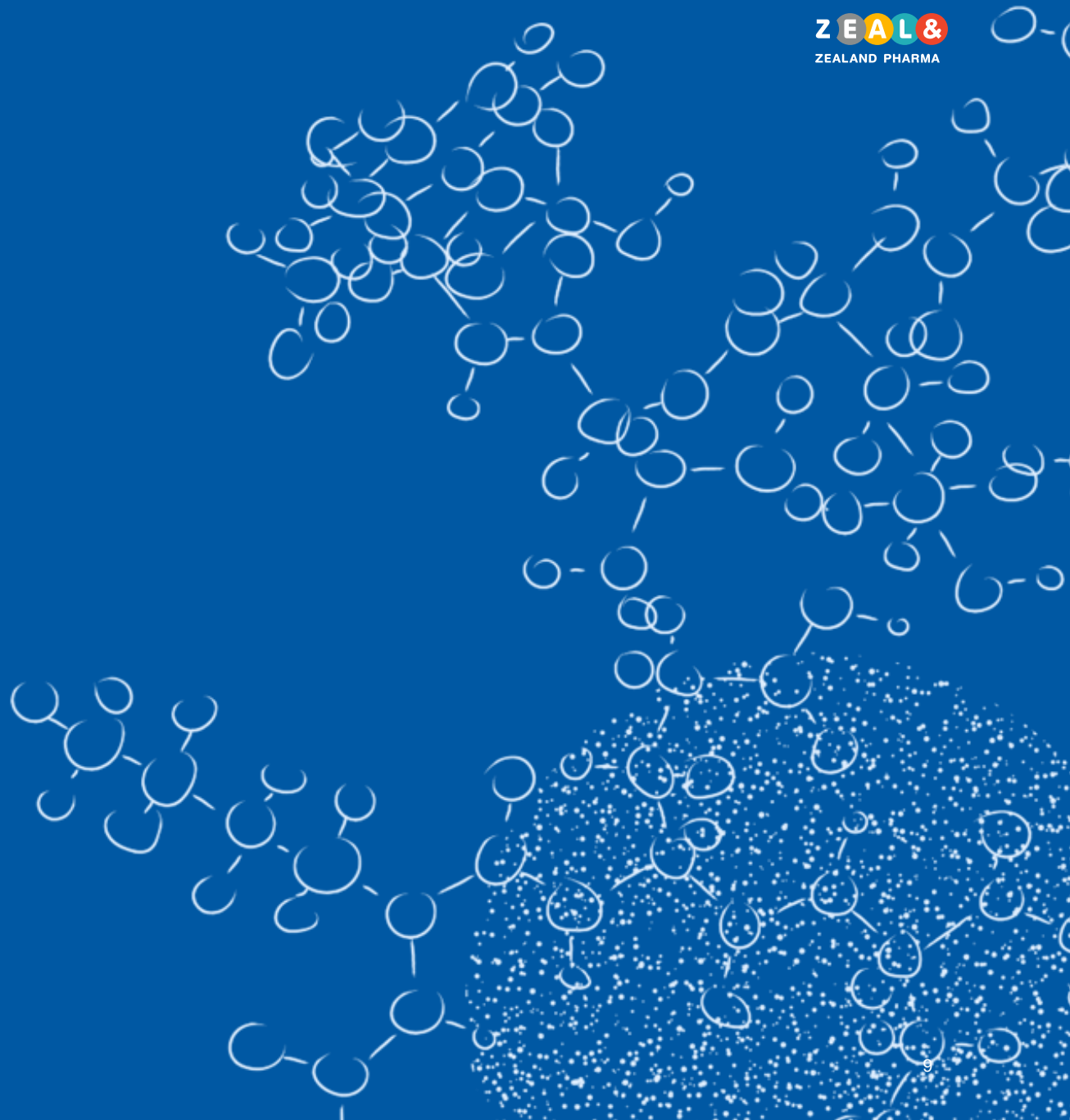
[b]Survodutide is licensed to Boehringer Ingelheim from Zealand Pharma, with Boehringer solely responsible for development and commercialization globally.
CGCR=glucagon receptor; GLP-1R=glucagon-like peptide-1 receptor; CVOT=cardiovascular outcomes trial; MASLD=metabolic dysfunction-associated steatotic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

Obesity

Corporate Presentation



Obesity: greatest healthcare challenge of our time

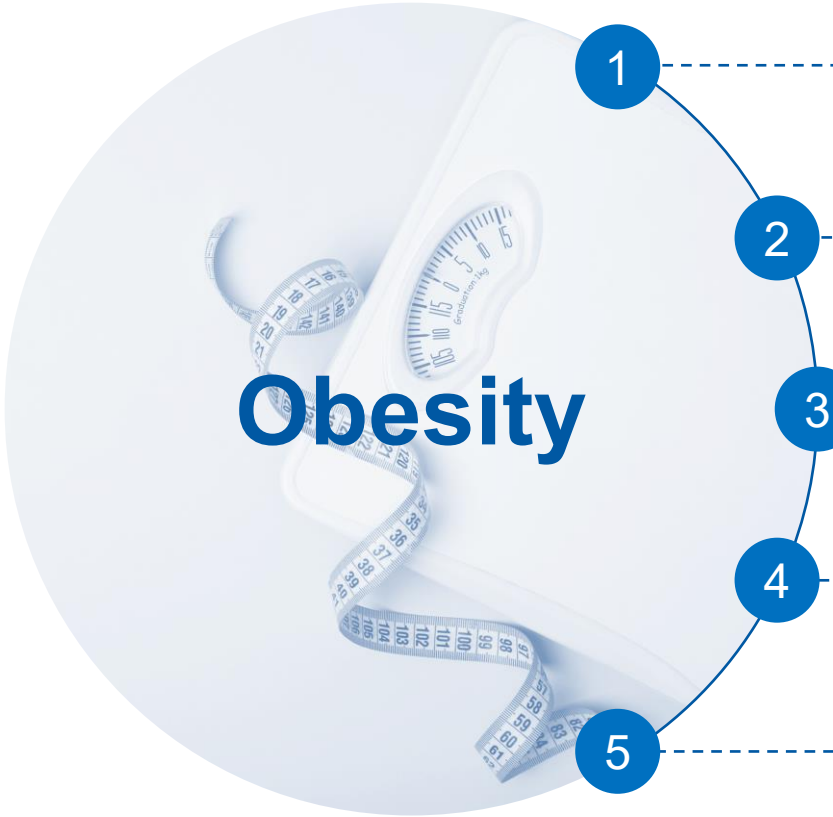
The obesity epidemic has **surged over the past decades,** with **50% of adults** globally expected to live with **overweight or obesity** by 2030[1]

>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

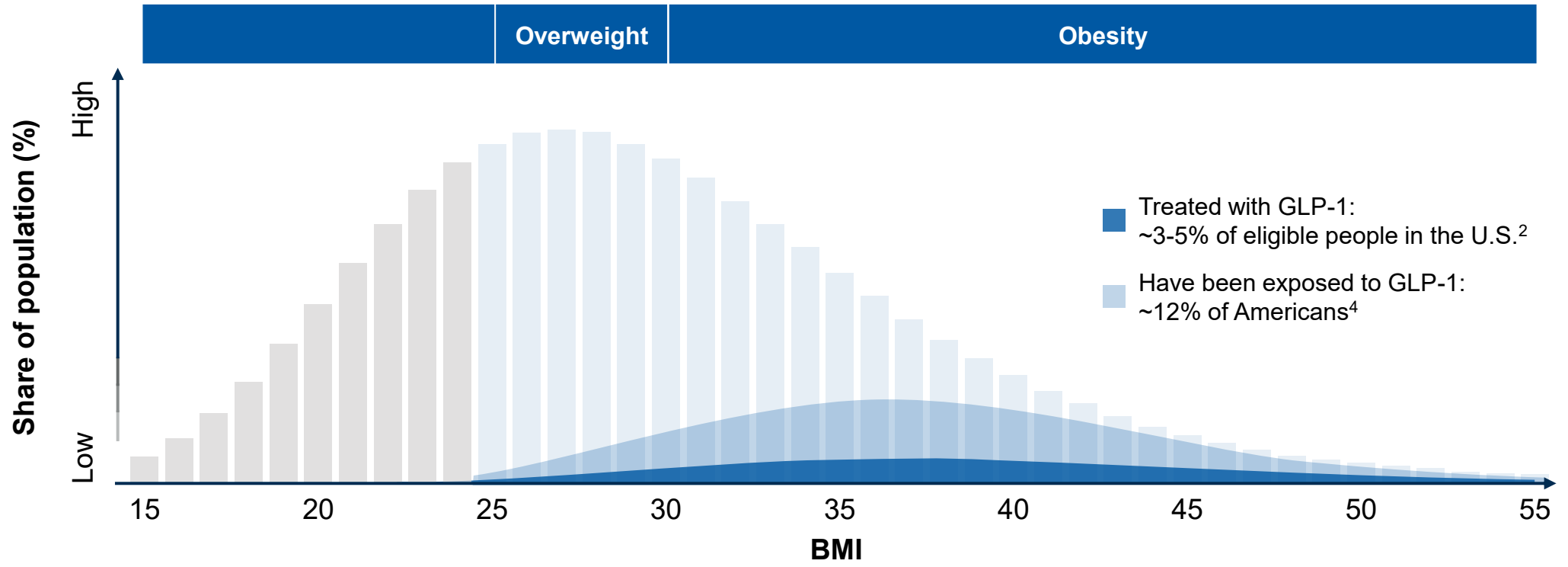


1. The consumer as key decision driver[a]
2. Unprecedented size and scale
3. Two key healthcare providers: Primary care and specialty care
4. Heterogeneity and fragmentation
5. Linked to many comorbidities

[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.

Beyond Weight loss Olympics: key unmet needs

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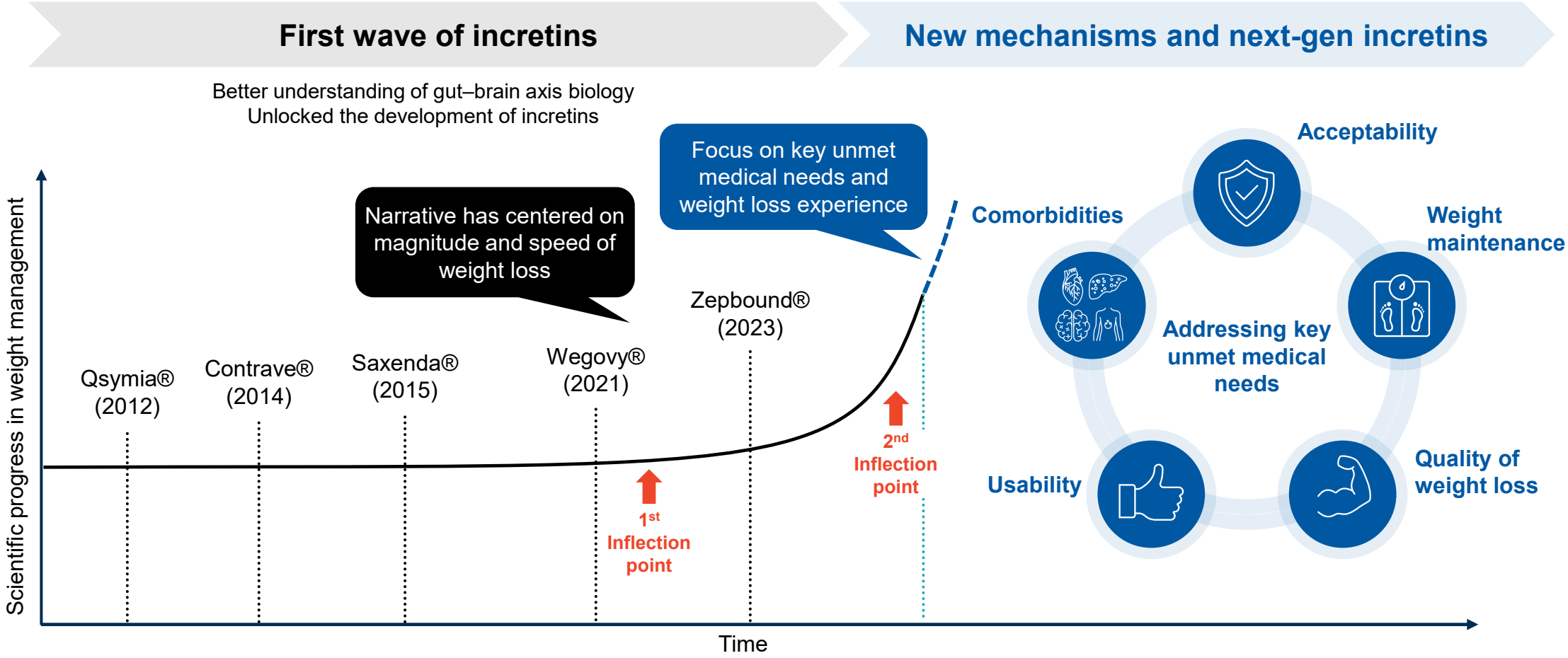


Obesity demands new classes of drugs

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

+8

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

+8

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

+8

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

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

Only 1

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.

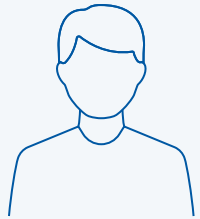
Two distinct segments, two focus areas

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

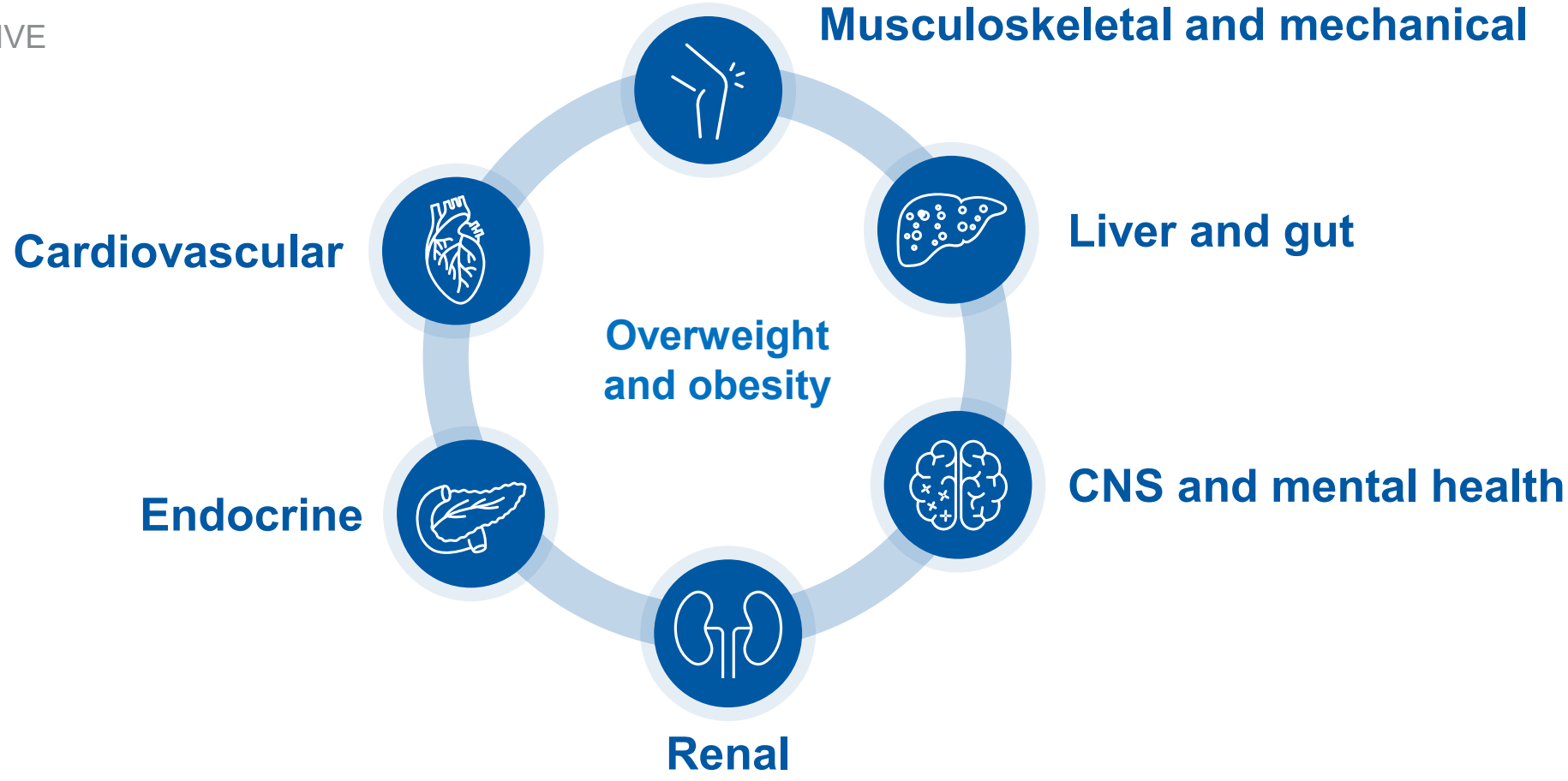
Consumer-driven **primary care** prescriptions focusing on **desired weight loss** and **user experience**

Objectives:

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

Obesity impacts several organ systems

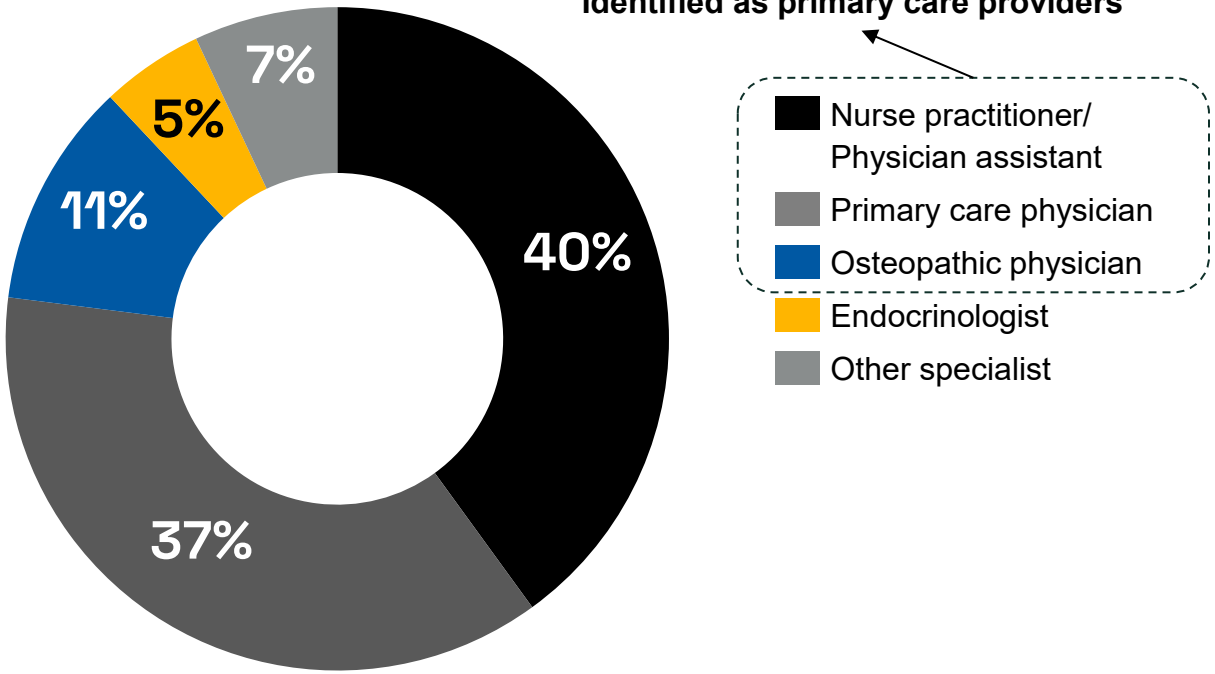
NON-EXHAUSTIVE



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]



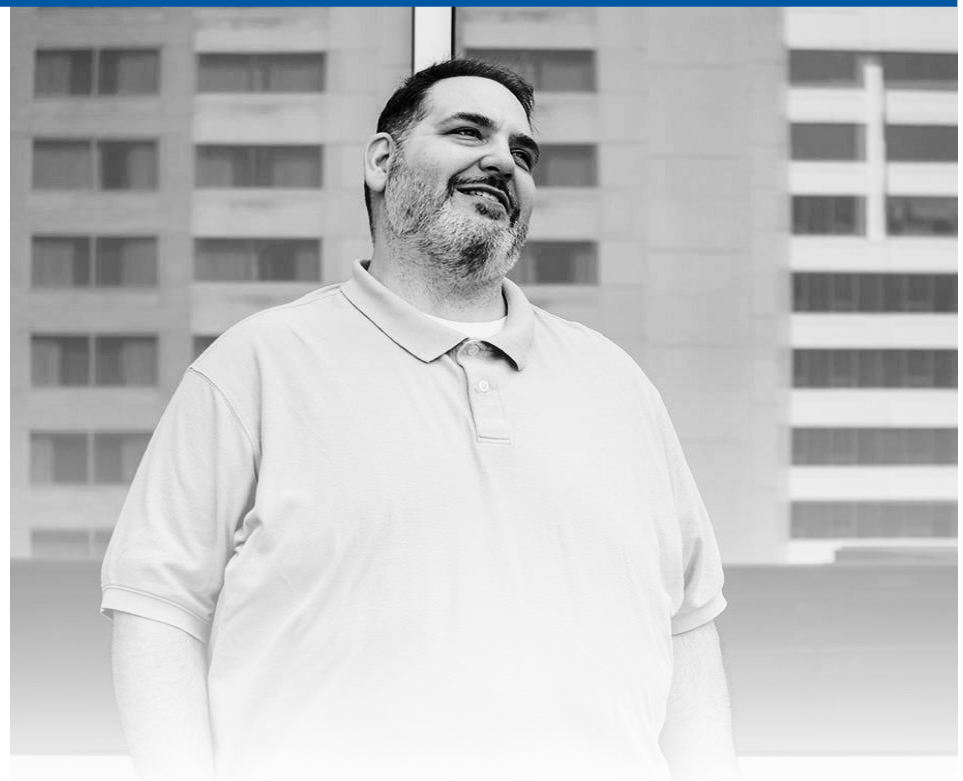
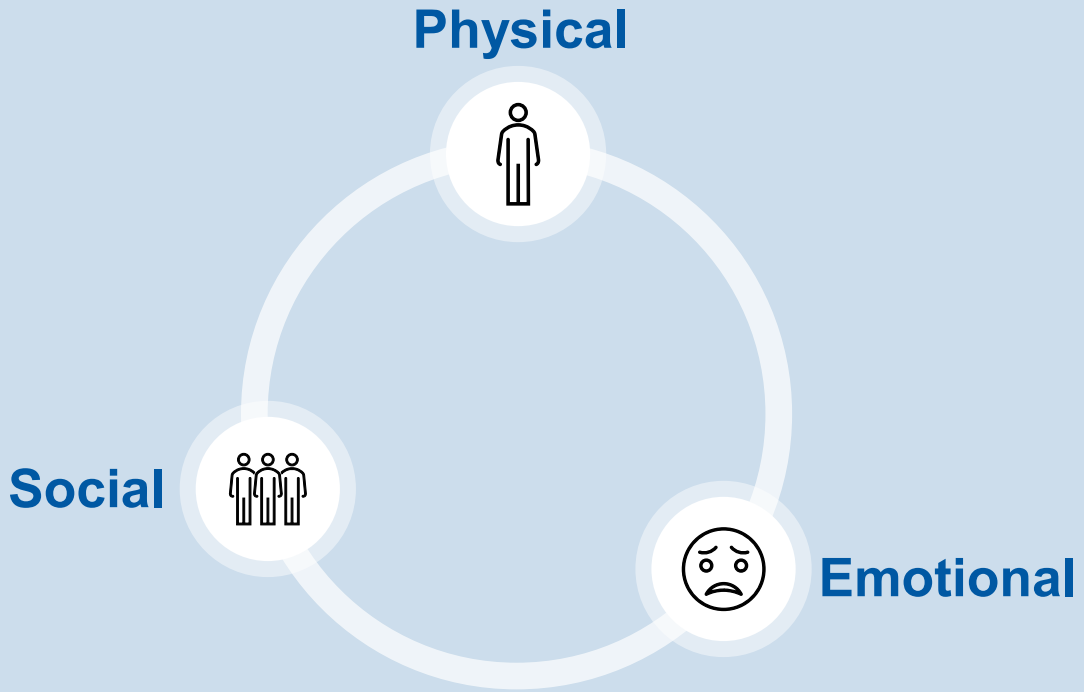


Image is illustrative, no associations implied.
[a]Primary care physicians include internal medicine, general practice, and family practice. Other specialists include cardiology, obstetrics/gynecology, general surgery, emergency medicine, geriatrics, and pediatrics.
Sources: [1]IQVIA National Prescription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

Healthier version of themselves, not healthiest

Decisions driven by more than clinical needs



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

Unprecedented willingness to pay out of pocket

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

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

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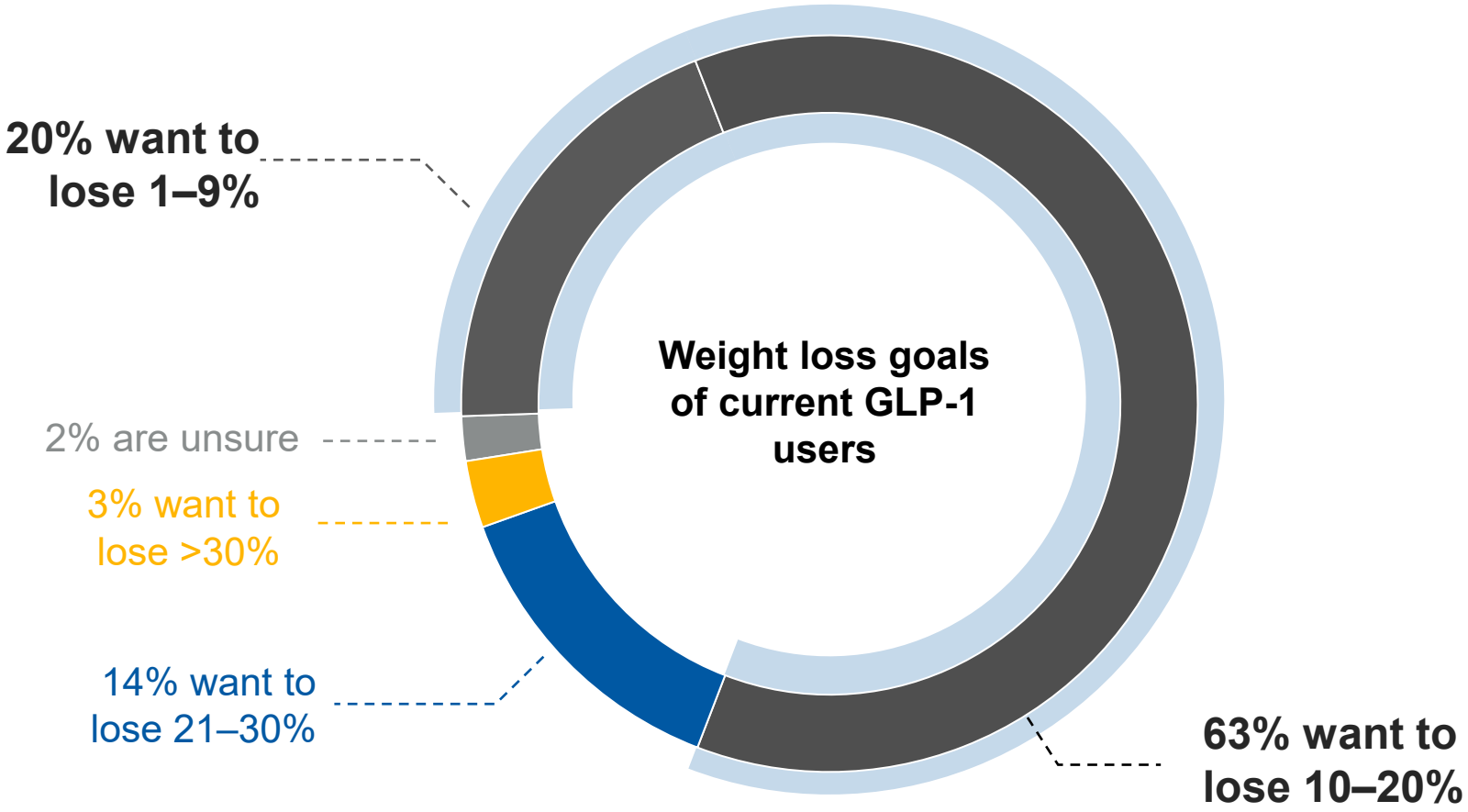
Desired weight loss contradicts *Weight loss Olympics*

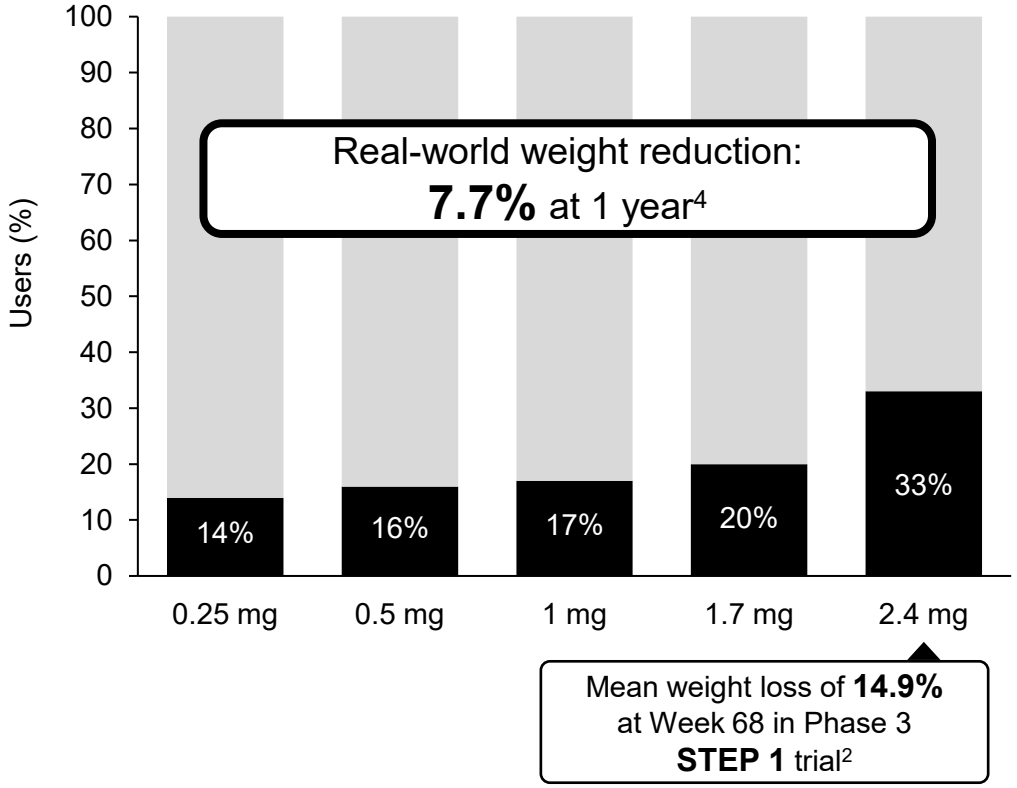


Source: LifeSci Capital Survey May 2024 (N=819).
GLP-1=glucagon-like peptide-1.

GLP-1 efficacy: real world vs. clinical trials

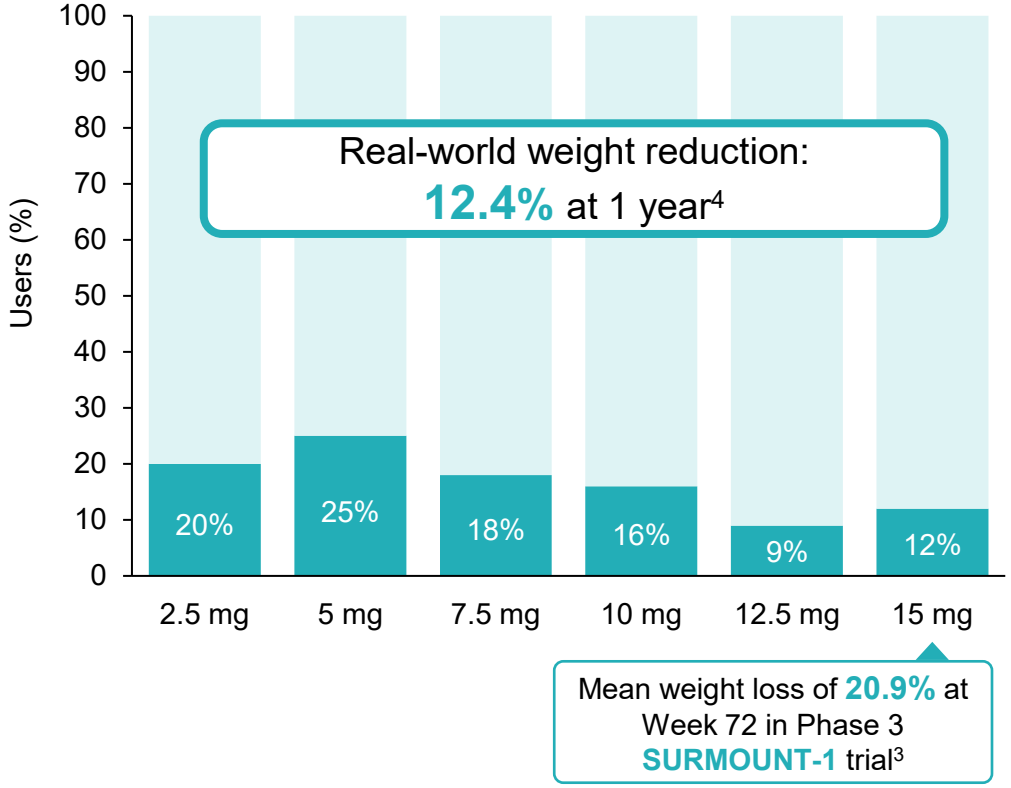
ONCE-WEEKLY wegovy® semaglutide injection 2.4 mg

Real-world use of Wegovy by dose[1]



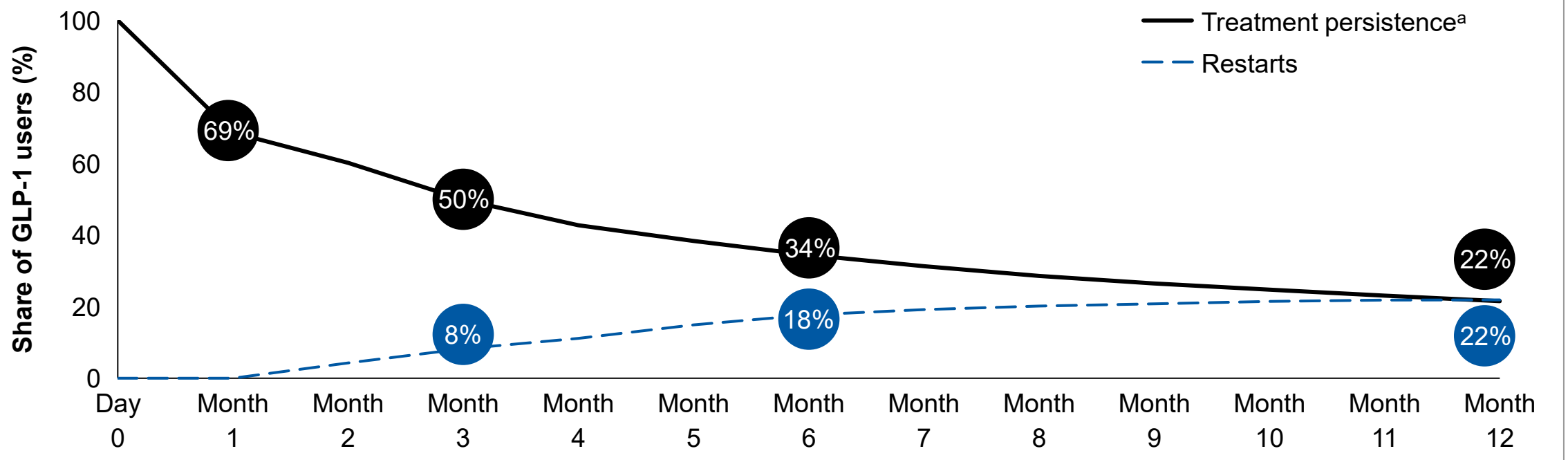
zepbound™ (tirzepatide) injection

Real-world use of Zepbound by dose[1]



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.

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.

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

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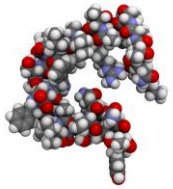
- Potent **balanced agonistic effects** on **AMY-1R**, **AMY-3R**, and **CTR** (motivated by extensive screening)[1,3]
- Chemical and physical **stability** around **neutral pH** (allowing for co-formulation and co-administration with other peptides)[2,3]
- Consistent **half-life of 10 days**, suitable for once-weekly administration[4,5]
- **~85% bioavailability**[1,5]

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

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

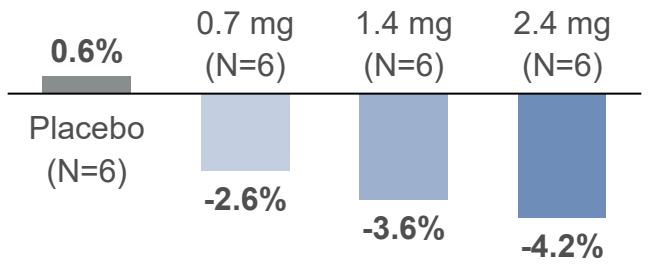
	Amylin	GLP-1
		
Effect on food intake	**Increases satiety**[1,2] Smaller meals, prolonged fullness[6]	**Reduces appetite**[7] Fewer meals, less food-seeking[7]
Leptin sensitivity	Restores leptin responsiveness[1,2]	Minimal or no effect on leptin sensitivity[7]
Pancreatic β-cell function	Improves insulin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

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

We remain encouraged by the consistency of the results from the Phase 1 program with petrelintide

SAD trial[1]

% change in body weight from baseline at Day 7

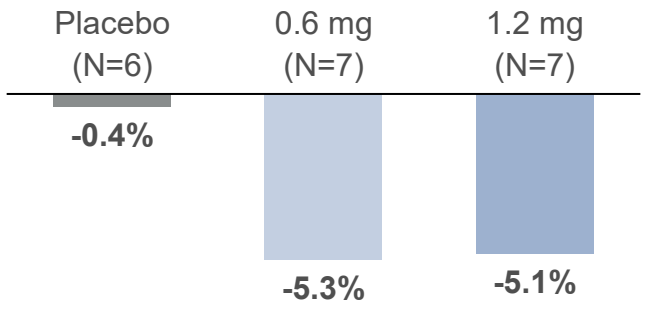


Tolerability

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

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

% change in body weight from baseline at week 6

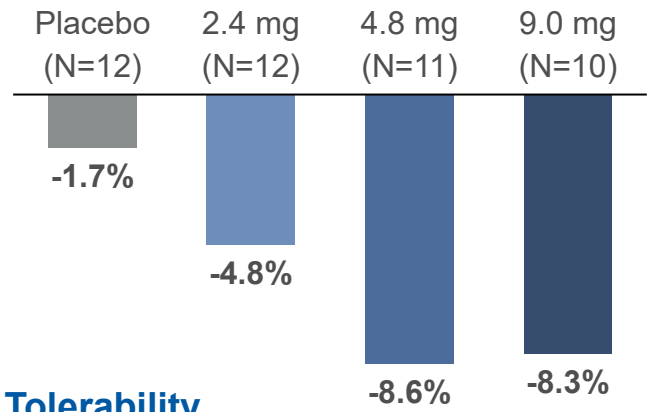


Tolerability

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

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

% change in body weight from baseline at week 16



Tolerability

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

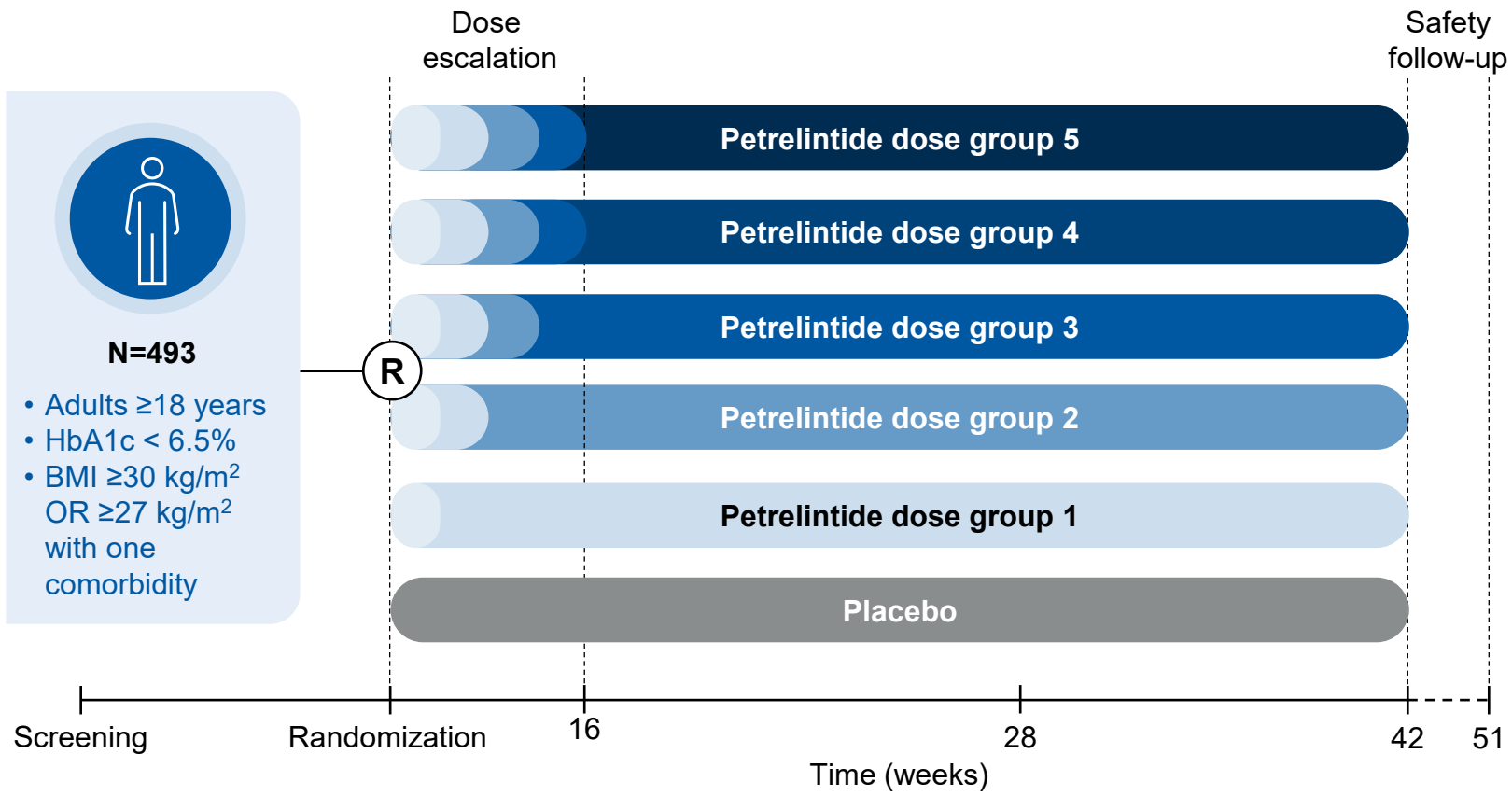
Zealand Pharma has a collaboration and license agreement with Roche for petrelintide, including co-development and co-commercialization in the U.S. and Europe

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

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

In Q1 2026, we reported positive topline results from the Phase 2 ZUPREME-1 trial

A randomized, double-blind, placebo-controlled, Phase 2 dose-finding trial with petrelintide



Primary endpoint:

- Percentage change in body weight from baseline to Week 28

Secondary/exploratory endpoints (non-exhaustive):

- Percentage change in body weight from baseline to Week 42
- Absolute change in body weight from baseline to end of treatment
- Categorical weight loss (≥5% and ≥10%)
- Change in waist circumference
- Body composition (MRI)
- CV risk factors (e.g. hsCRP, triglycerides, cholesterol, blood pressure, pulse rate)

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: ClinicalTrials.gov (NCT06662539);
BMI=body mass index; HbA1c=glycated hemoglobin; MRI=magnetic resonance imaging; hsCRP=high-sensitivity C-reactive protein.

Baseline characteristics were balanced across dose cohorts

Gender

53% of participants were **female**

Weight

Mean **107 kg**

Body Mass Index

Mean **37 kg/m^2**

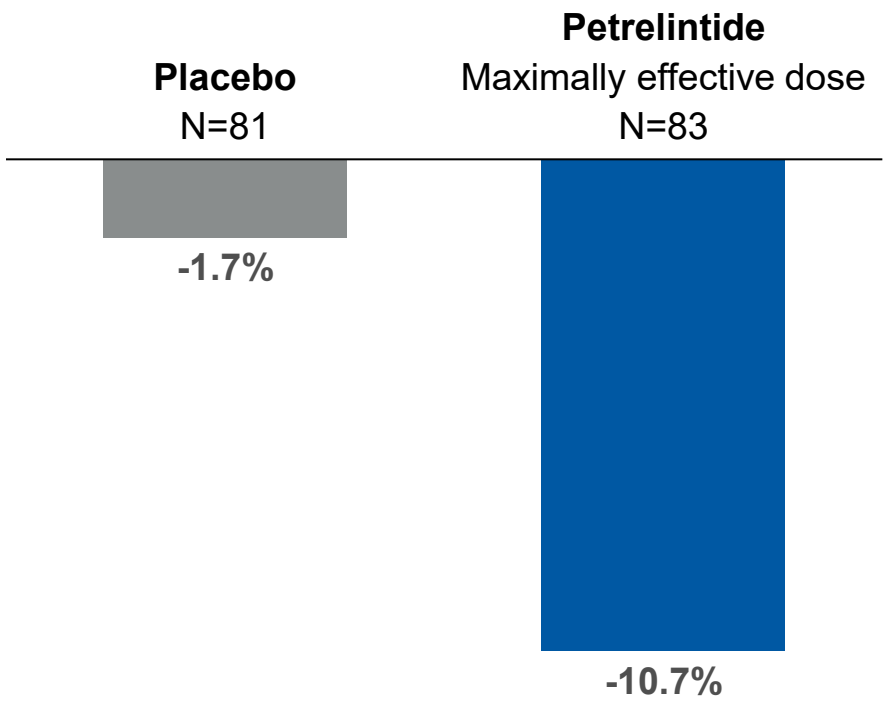
Age

Mean **47 years**

Source: Data on file.

Sustained double-digit weight loss with multiple levers to optimize trial conditions for greater efficacy

Change in body weight (%) from baseline at week 42, efficacy estimand



- Body weight reduction continued through week 42, suggesting the potential for continued weight loss with longer treatment duration
- Efficacy by treatment regimen estimand largely consistent with efficacy estimand, driven by high retention rate and exceptional tolerability
- Nearly 100% of participants receiving petrelintide achieved a body weight reduction

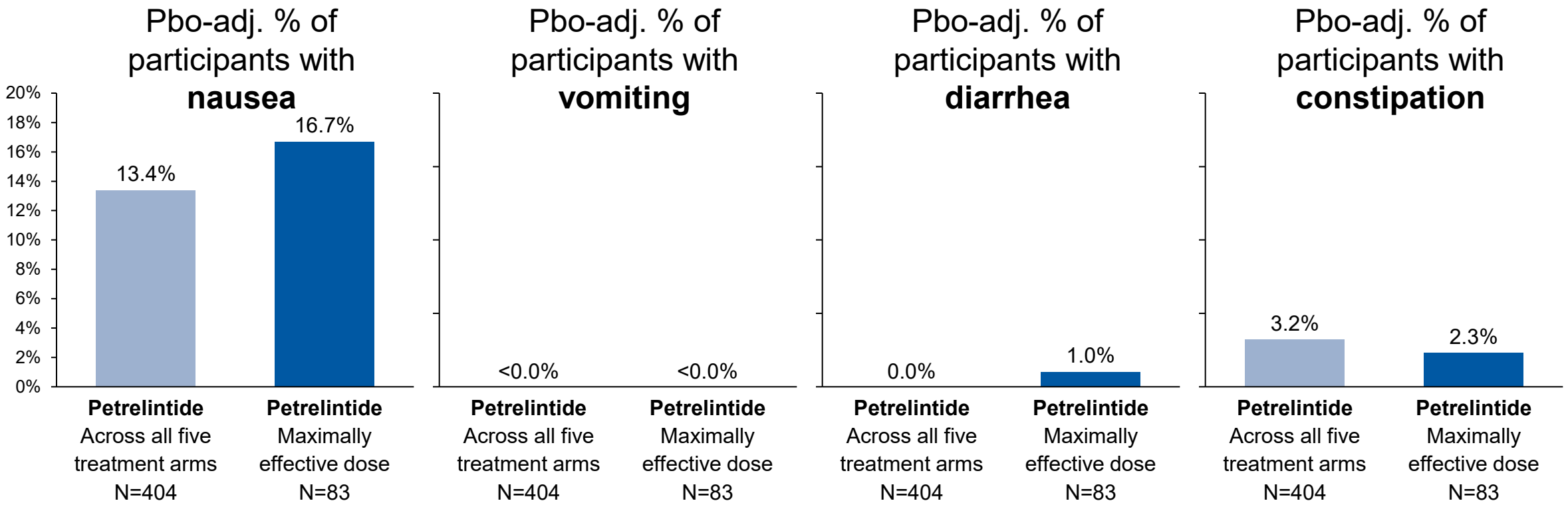
Trial-specific conditions influencing efficacy[a]

- Females achieved ~6%-point greater weight loss vs males
- EU participants achieved ~3%-point greater weight loss vs. U.S. participants

[a]Placebo-adjusted change in body weight by subgroups.for maximially effective dose vs. placebo. The pattern was similar across dose groups but slightly more pronounced in some than others.
GLP-1=glucagon-like peptide-1; BMI=body mass index; GLP-1RA=glucagon-like 1 receptor agonist.

Petrelintide demonstrated a potential best-in-class gastrointestinal tolerability profile

GI AEs largely comparable to placebo

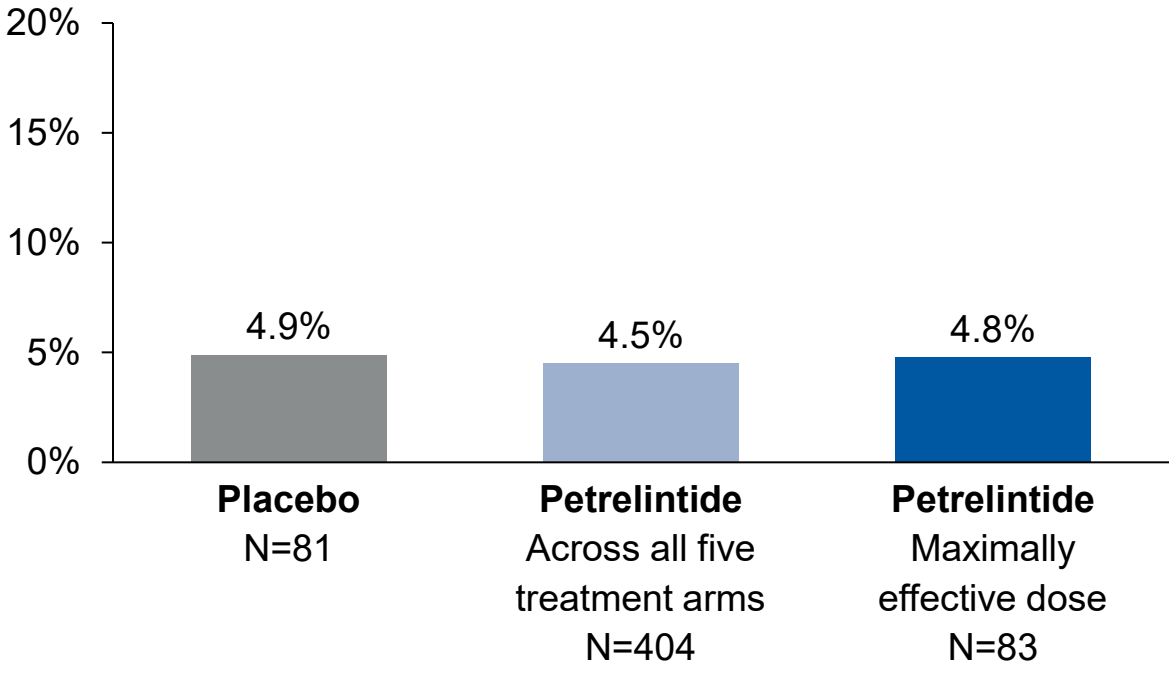


- ~70% of participants on the maximally effective dose reported no gastrointestinal AEs at any time during the trial
- 80% of nausea events were mild; remaining events moderate, with only one severe event in the highest petrelintide dose arm (DG5)
- Almost no nausea events occurred after reaching target dose

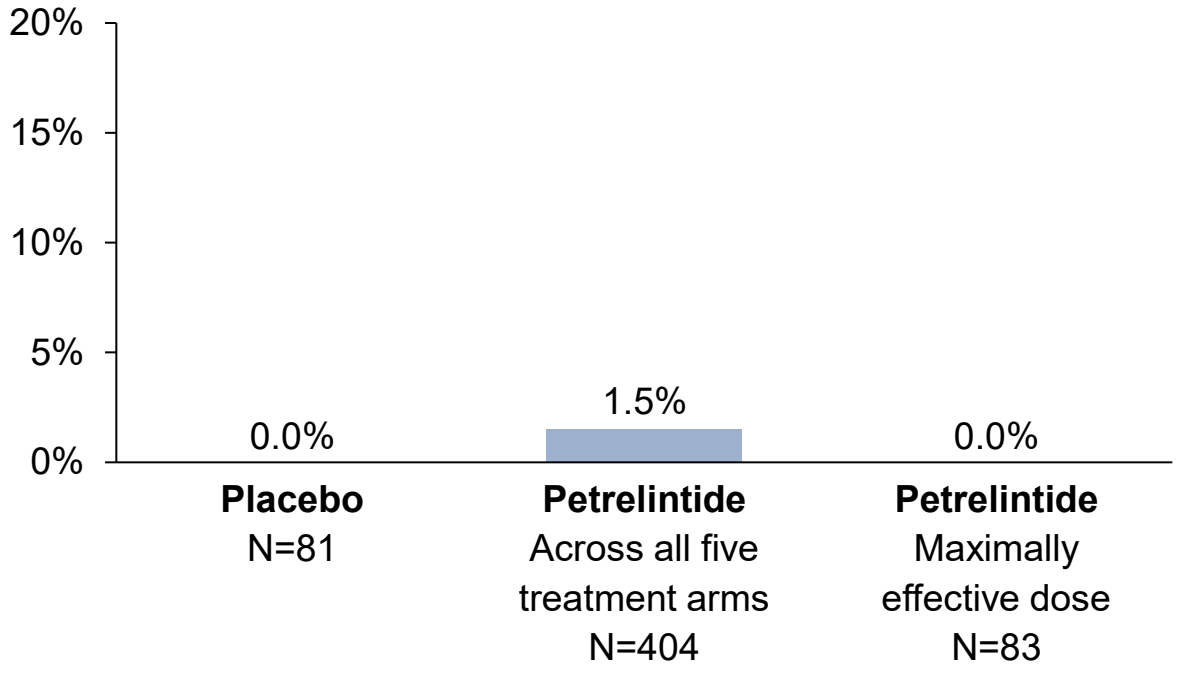
GI=gastrointestinal; AE=adverse events

Treatment persistence supported by placebo-like discontinuation rates

Treatment discontinuation rate due to AEs



Treatment discontinuation rate due to GI AEs



98% in the maximally effective dose group successfully escalated to the target maintenance dose

AE=adverse event; GI=gastrointestinal.

Sustained, double-digit weight loss with a tolerability profile comparable to placebo

Efficacy

- Up to **10.7% mean weight loss at week 42** versus 1.7% for placebo; further weight loss expected over time
- Nearly 100% of participants on petrelintide achieved weight reduction
- Efficacy influenced by trial-specific conditions, including female-to-male ratio and geography (Europe vs. U.S.)
- Petrelintide treatment was associated with favorable improvements in CV risk factors

Safety and tolerability

- **Exceptional tolerability profile**, consistent with placebo
- No unexpected safety signals, including for alopecia, fatigue, and neuropsychiatric AEs
- No discontinuations due to GI AEs and no vomiting in maximally effective dose group
- Very low rate of injection site reactions and consistent with placebo

Next steps

- ZUPREME-1 data to be presented in detail at an upcoming scientific meeting in 2026
- **Phase 3 initiation expected in the second half of 2026**, with trial conditions optimized to maximize body weight loss while maintaining a differentiated tolerability profile

CV=cardiovascular; AE=adverse event; GI=gastrointestinal; PK=pharmacokinetics.

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

Robust Phase 2 program

ZUPREME-1 (obesity w/o T2D)[1]
42-week topline data reported 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

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.
Sources: [1]Zealand Pharma company announcement No. 3/2026, March 5, 2026; [2]ClinicalTrials.gov (NCT06926842).
CVOT=cardiovascular outcomes trial; T2D=type 2 diabetes.

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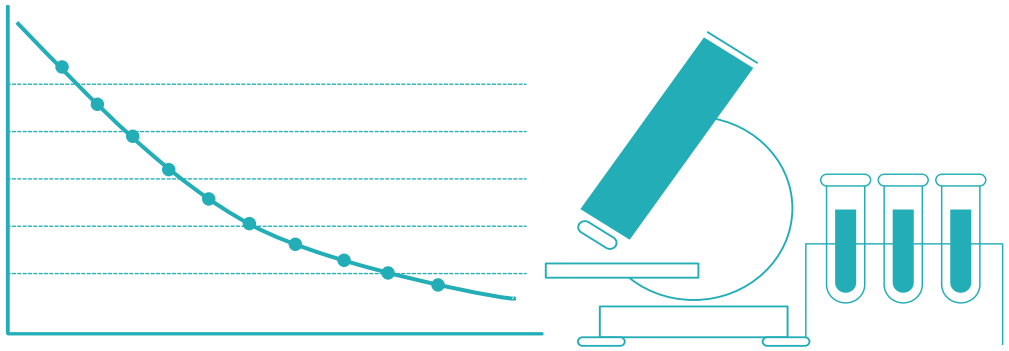
Phase 2 trial with petrelintide/CT-388 planned for initiation in H1 2026

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

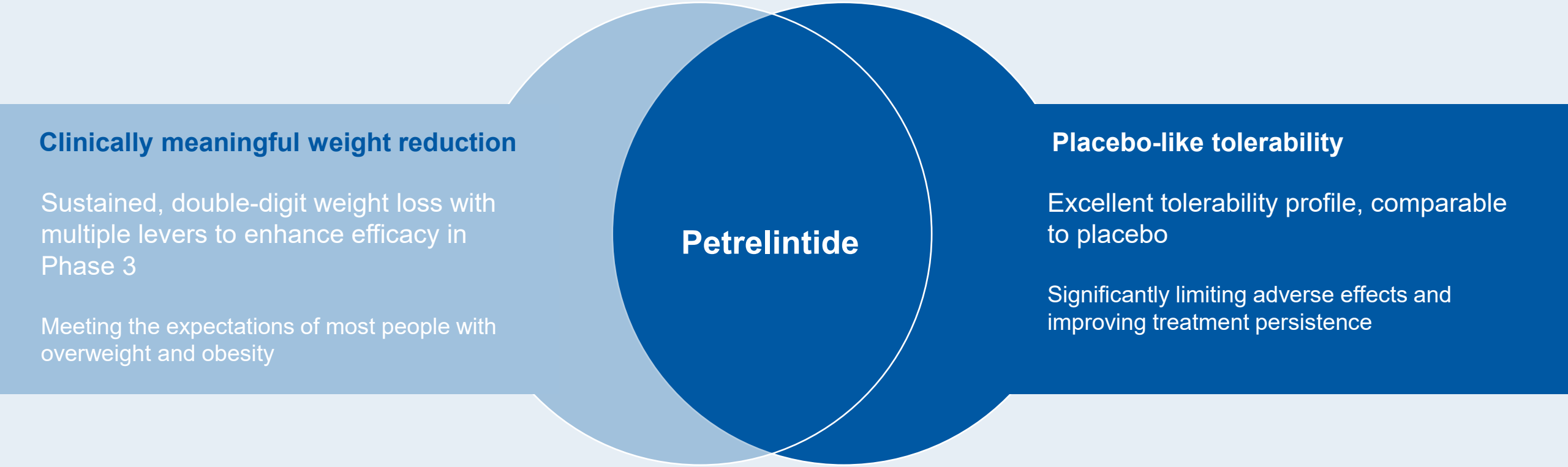
Identify the doses that **maximize weight loss** efficacy whilst **optimizing the experience**

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 has the potential to establish a new treatment paradigm for chronic weight management

ILLUSTRATIVE



Petrelintide in the sweet spot

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

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Roche

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 received in Q2 2025 and $250 million due 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

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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.

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

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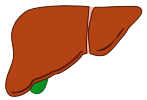
GCG/GCGR

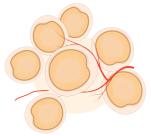
↑ Energy expenditure (metabolic rate)

Liver (direct)



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

Adipose tissue (indirect)

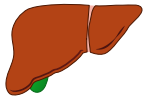


Lipolysis[3]

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

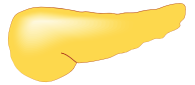
↑ Insulin secretion ↓ Food intake

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.

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

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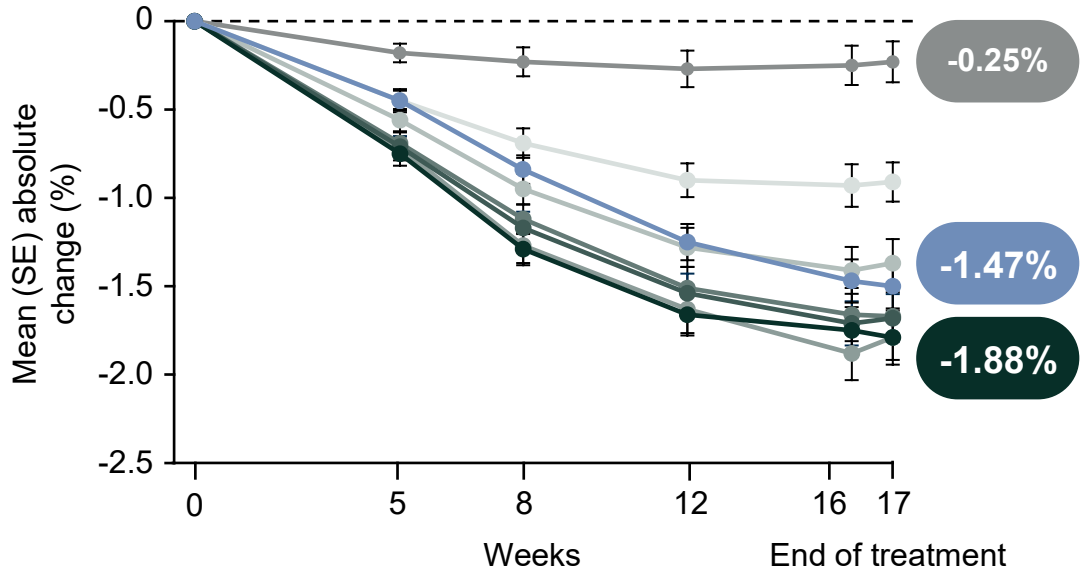
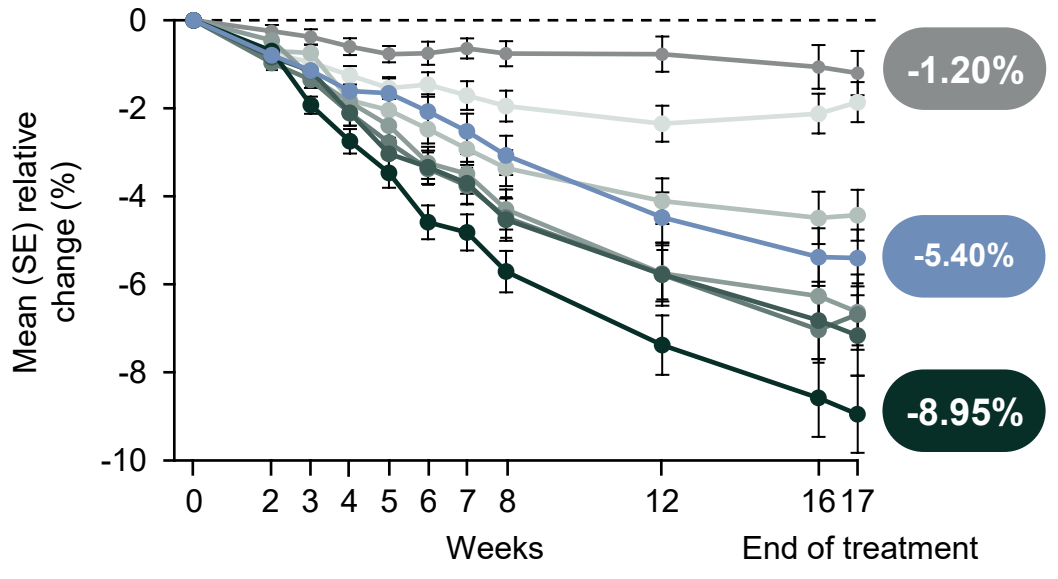
Change in HbA1c



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.

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

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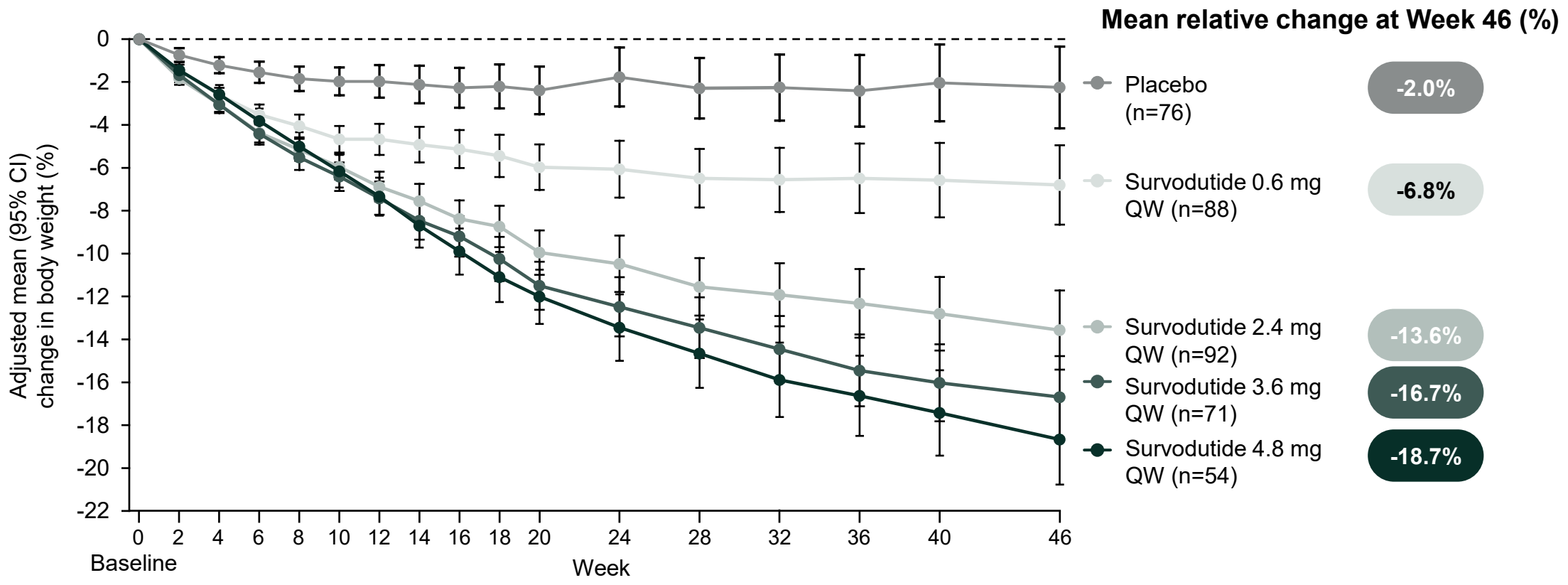
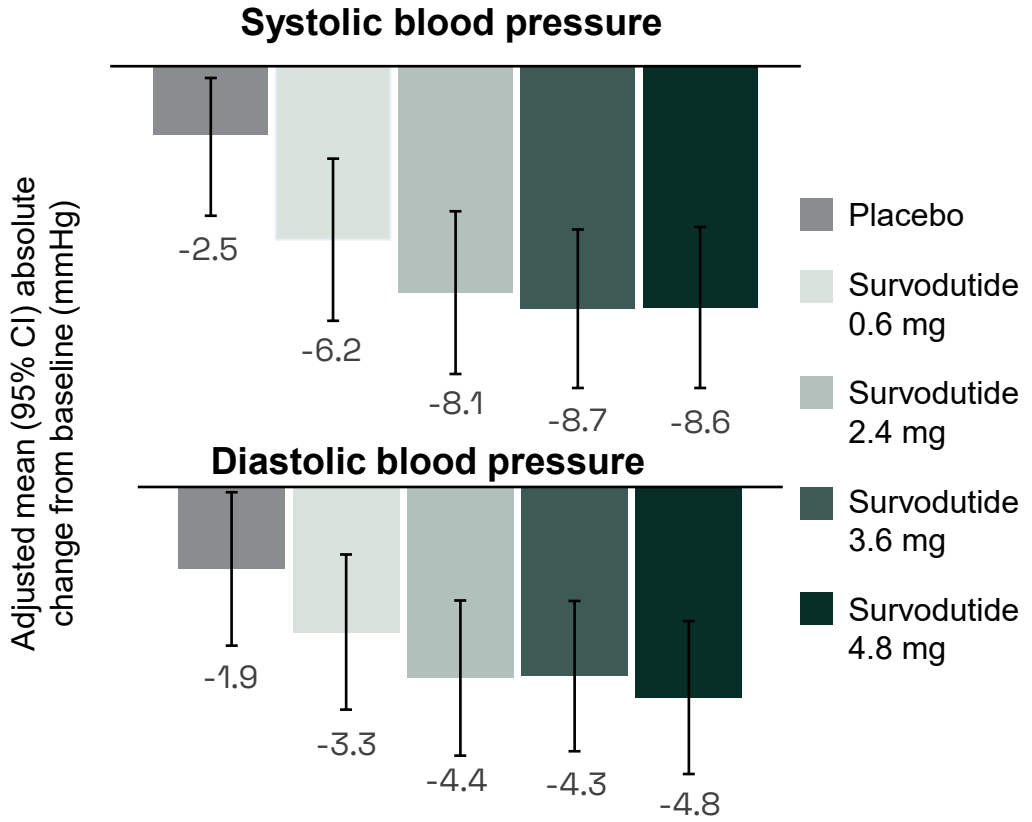
Randomized, double-blind, placebo-controlled Phase 2 trial of survodutide in people with overweight or obesity



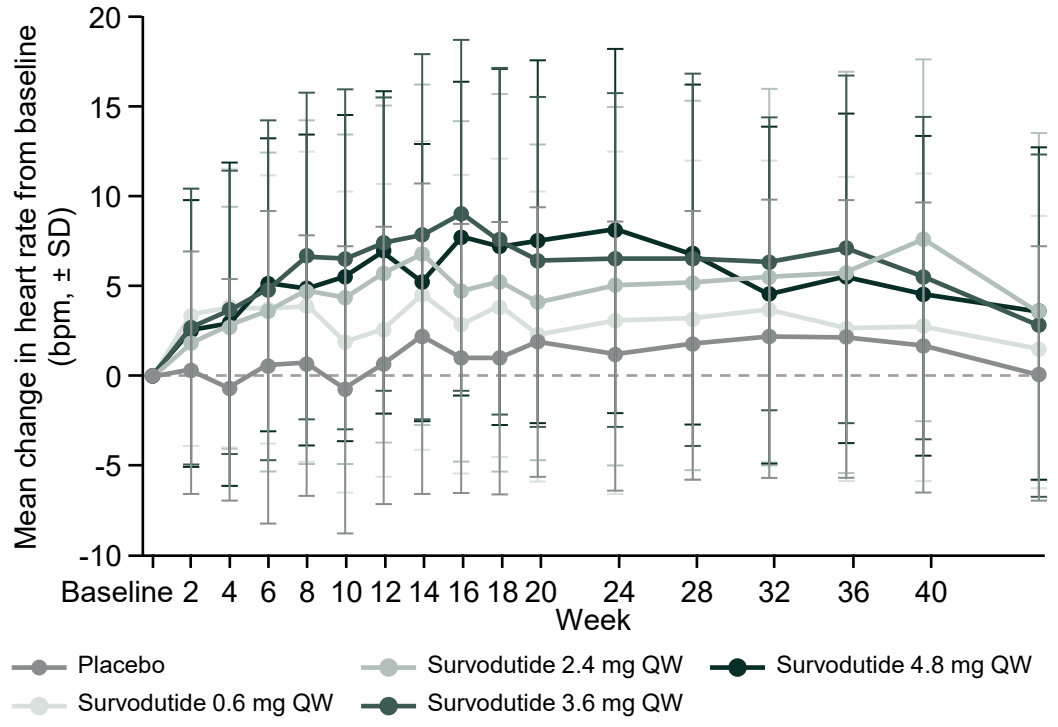
Survodutide is licensed to Boehringer Ingelheim from Zealand Pharma, with Boehringer solely responsible for development and commercialization globally.
Source: Figure adapted from Le Roux et al. Oral presentation (51-OR) at ADA 83rd Scientific Sessions, June 23–26, 2023, San Diego, CA.
Actual treatment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

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.

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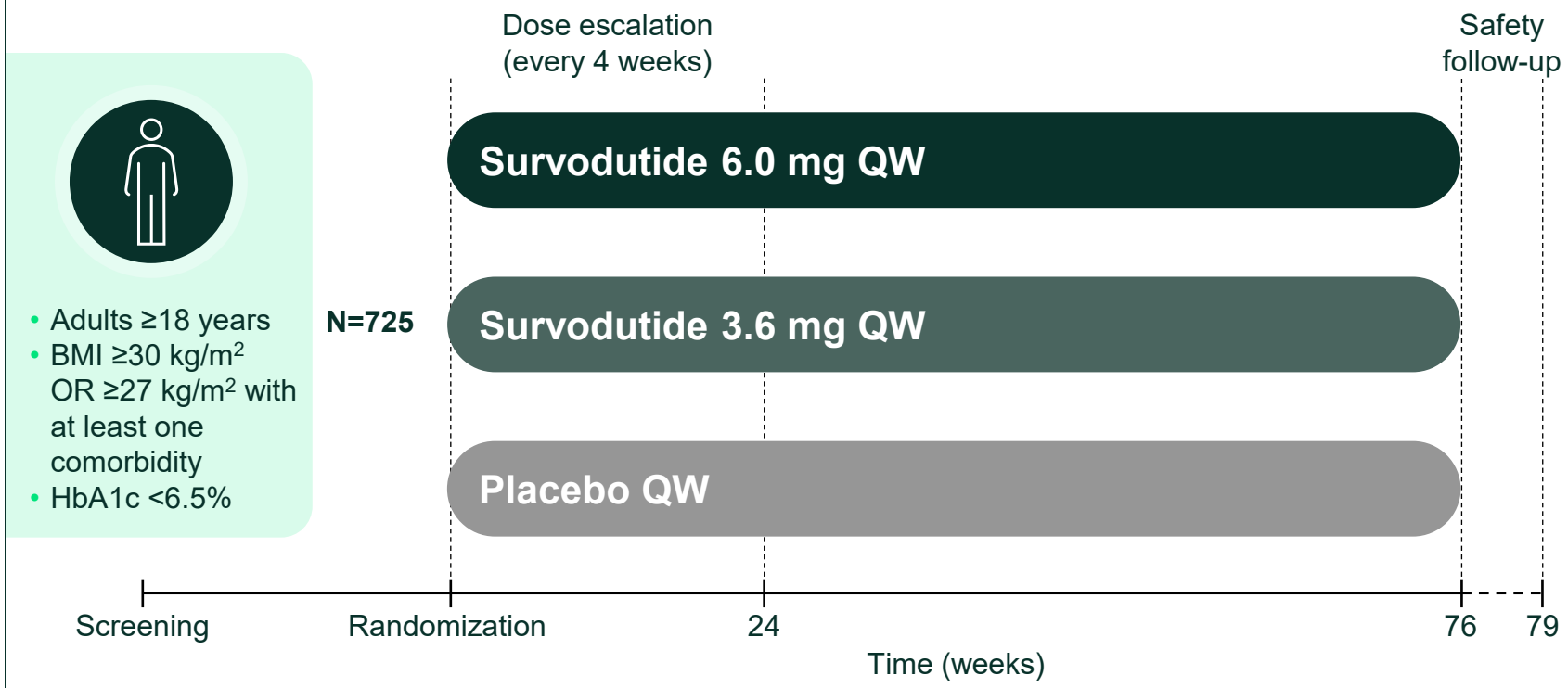
[a]Table includes only the two highest dose cohorts and is based on the treated set and presented according to planned treatment; [b]TEAEs listed according to preferred term and occurred in ≥15% participants in any treatment arm.
Source: Table adapted from Le Roux et al. Oral presentation (51-OR) at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

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]



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

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/m^2	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.

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

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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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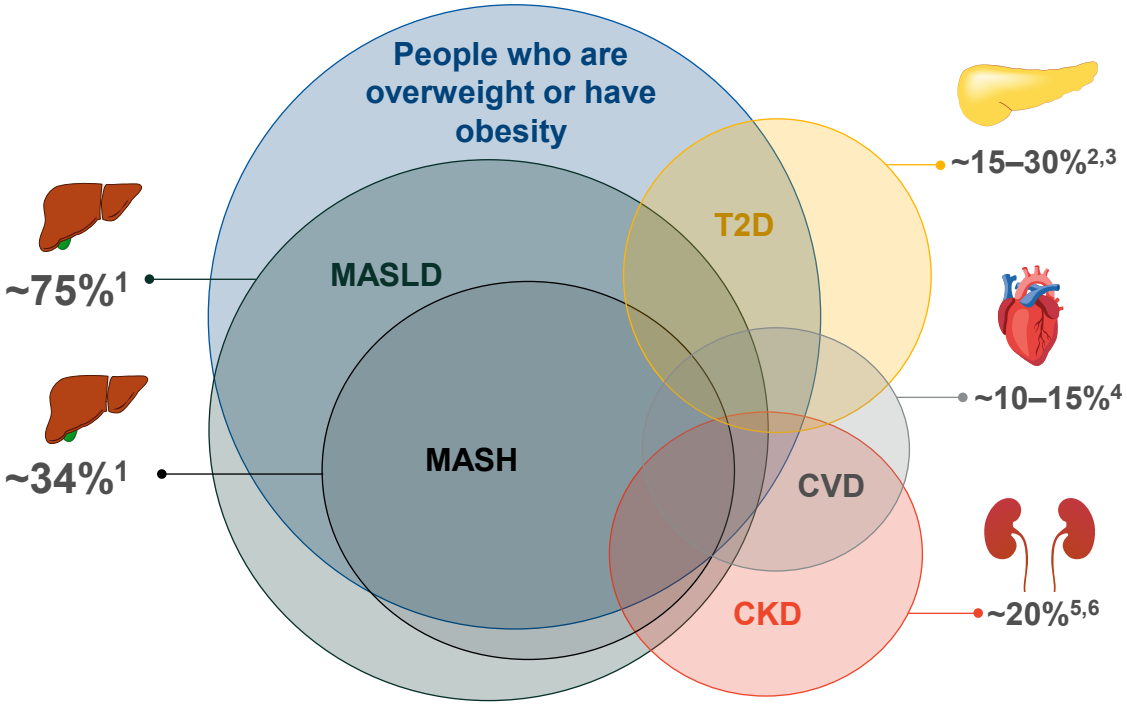
Sources: [1]ClinicalTrials.gov (NCT06066515); [2]ClinicalTrials.gov (NCT06066528); [3]ClinicalTrials.gov (NCT06077864); [4]ClinicalTrials.gov (NCT06309992); [5]ClinicalTrials.gov (NCT06176365); [6]ClinicalTrials.gov (NCT06214741).
CKD=chronic kidney disease; CV=cardiovascular; CVD=cardiovascular disease; 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.

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

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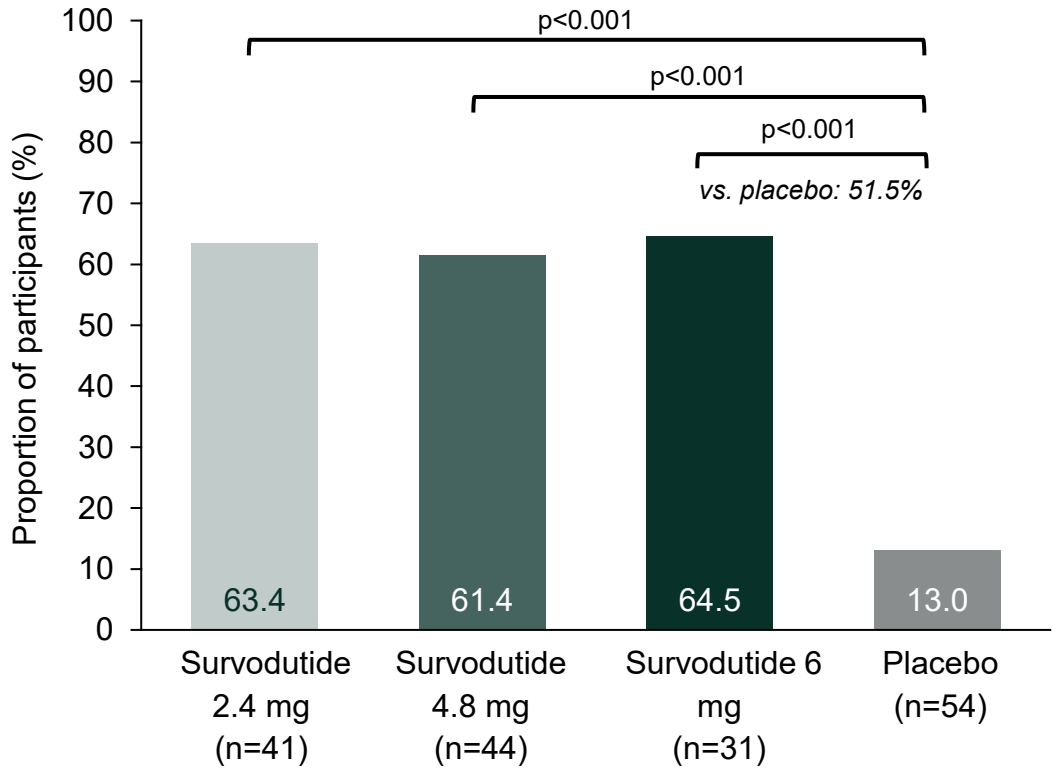
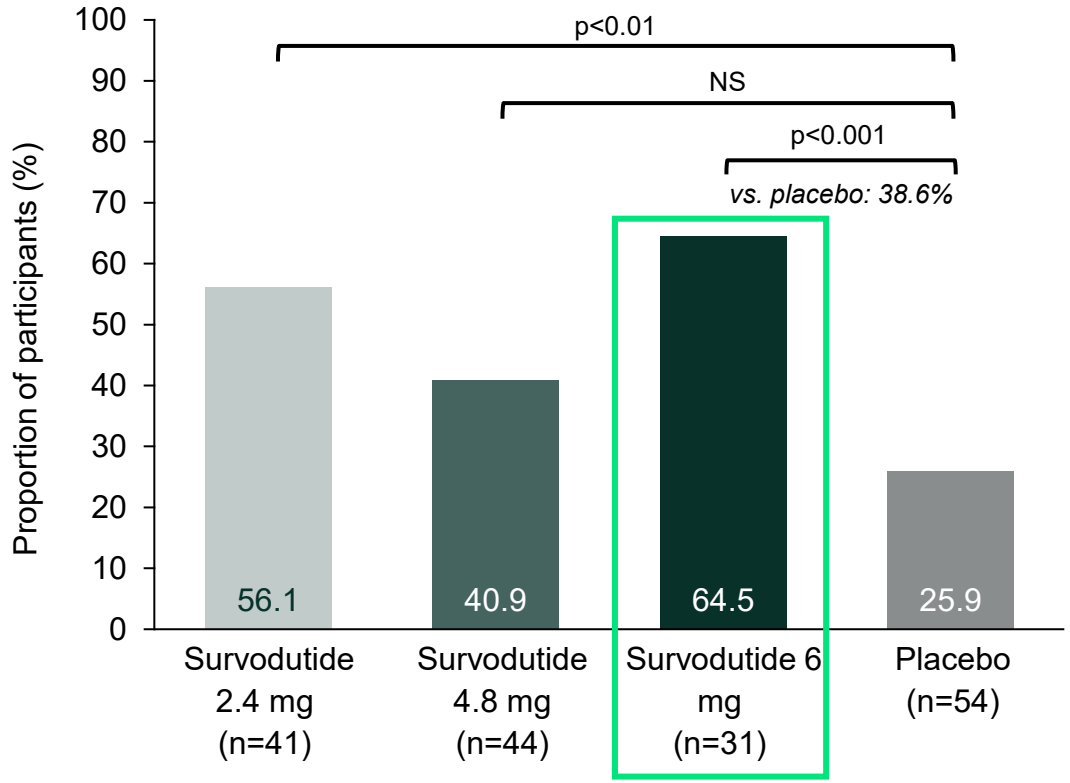
MASH resolution with no worsening in fibrosis
Paired biopsy results (F2/F3)



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



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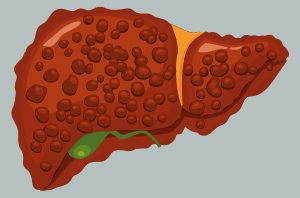
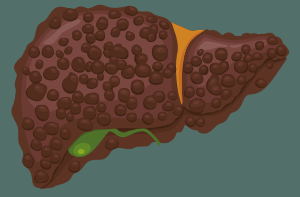
[a]Post hoc analysis in people with fibrosis Stage F2–F3 after 48 weeks of actual treatment.
Sources: Figures adapted from Sanyal et al. N Engl J Med 2024;391(4):311–319 (reprinted with permission from Massachusetts Medical Society); Sanyal et al. Oral presentation at EASL Congress, June 5–8, 2024, Milan,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

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

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

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

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

Rare diseases

Corporate Presentation

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

There is a significant unmet need for an effective treatment

CHI is an ultra-rare disease in newborns and children

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

Persistent episodes of hypoglycemia may result in brain damage

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

Significant impact on the patient and caregivers' quality of life

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

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

We expect to resubmit Part 1 and Part 2 of the original NDA to the U.S. FDA in H2 2026[7]

IP exclusivity: compound patent US 2035 and EU 2039

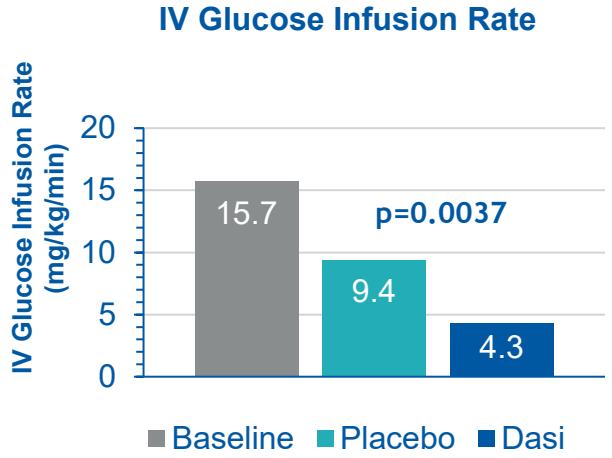
Sources: [1]Yorifuji et al. Clin Pediatr Endocrinol 2017;26(3):127-152; [2]Proglycem. Package insert. Teva Pharmaceuticals; 2015; [3]Gray KD et al. J Perinatol. 2018;38(11):1496-1502; [4]Haris et al. Therapeutic Adv Endocrinology Metabolism 2020;11:1-23; [5]Zealand Pharma, Physician Market Survey, 2020;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

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

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

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

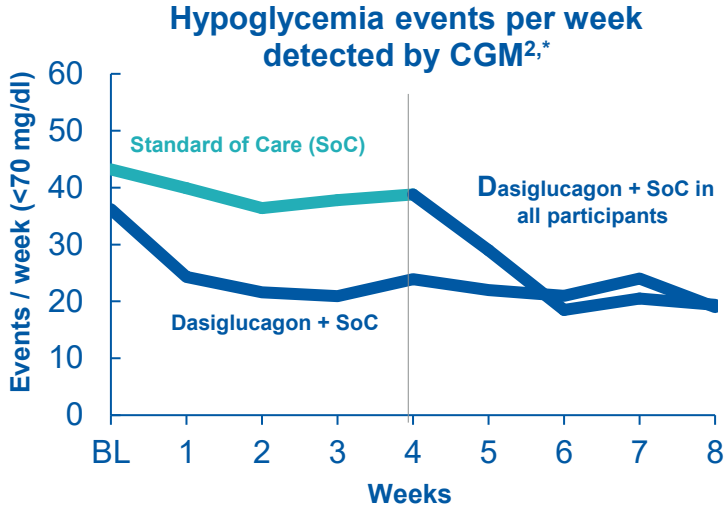
Part 1: Placebo control, crossover x 48 hours[1]



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

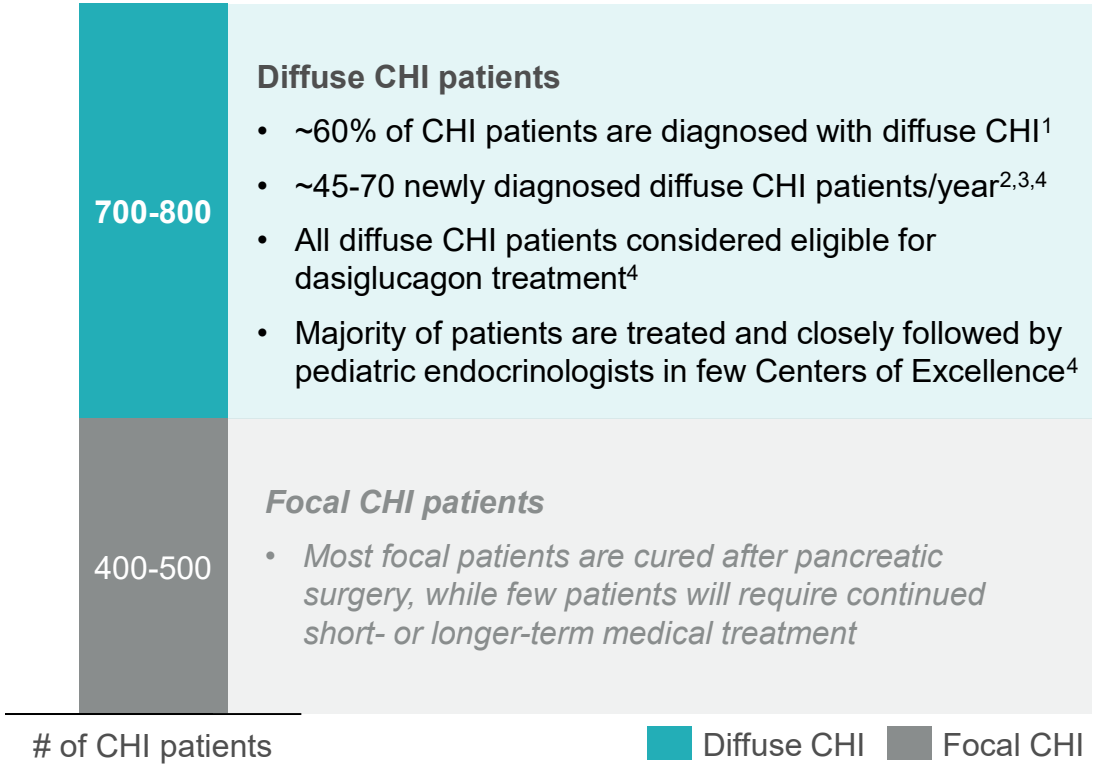
- Assessed as generally well tolerated in both trials
- Skin reactions and gastrointestinal disturbances most frequently reported adverse events

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.

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



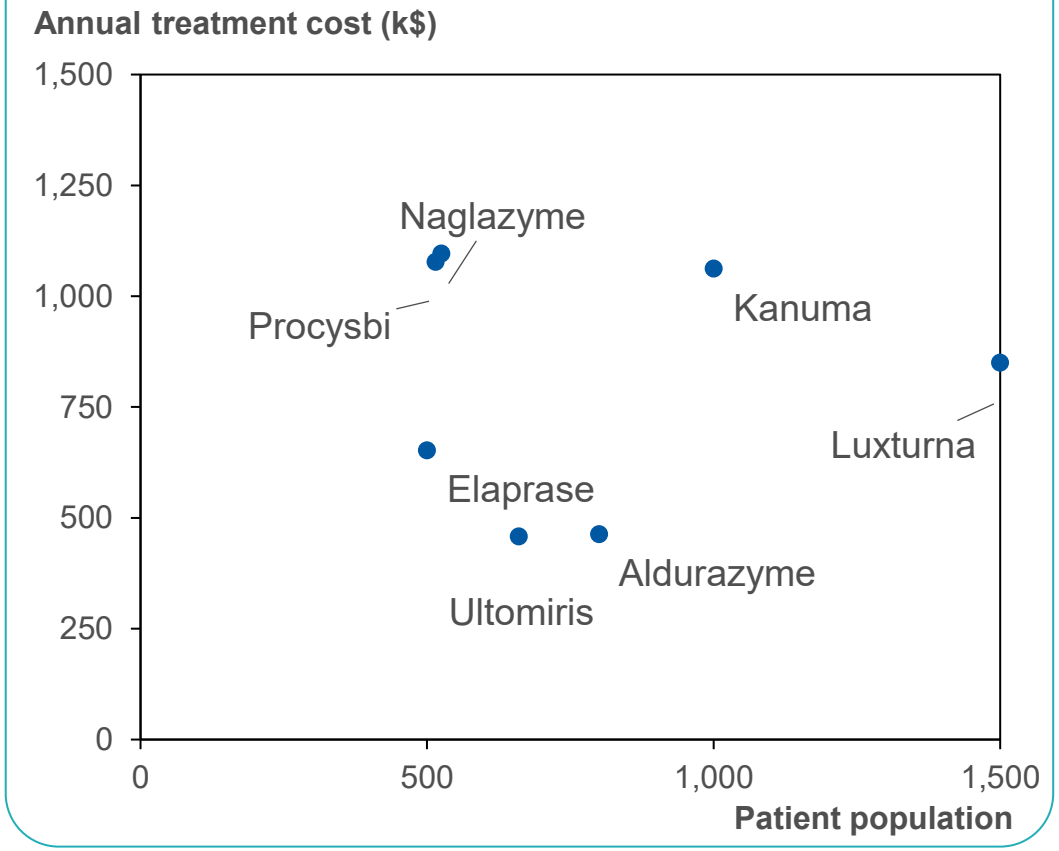
Diffuse CHI patients

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

Focal CHI patients

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

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



Sources: [1]Arya et al. Plos One 2014;9:e98054; [2]Arnoux JB et al. 2011 Orphanet J Rare Dis;6:63; [3]Yau et al. Plos One 2020;15(2); [4]Based on KOL interviews (2022); [5]Zealand Pharma Payer & Pricing Research, December 2022
Indications by product: Procysbi (nephropathic cystinosis); Naglazyme (Maratolamy syndrome); Ultomoris (atypical hemolytic uremic syndrome); Kanuma (lysosomal acid lipase deficiency); Luxturna (biallelic RPE65 mutation-associated retinal dystrophy); Elaprase (Hunter syndrome); Aldurazyme (Hurler and Hurler-Scheie forms of Mucopolysaccharidosis I).

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

High unmet need

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

Life-long dependency on parenteral support (PS)

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

Need for improved treatment options

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

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

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

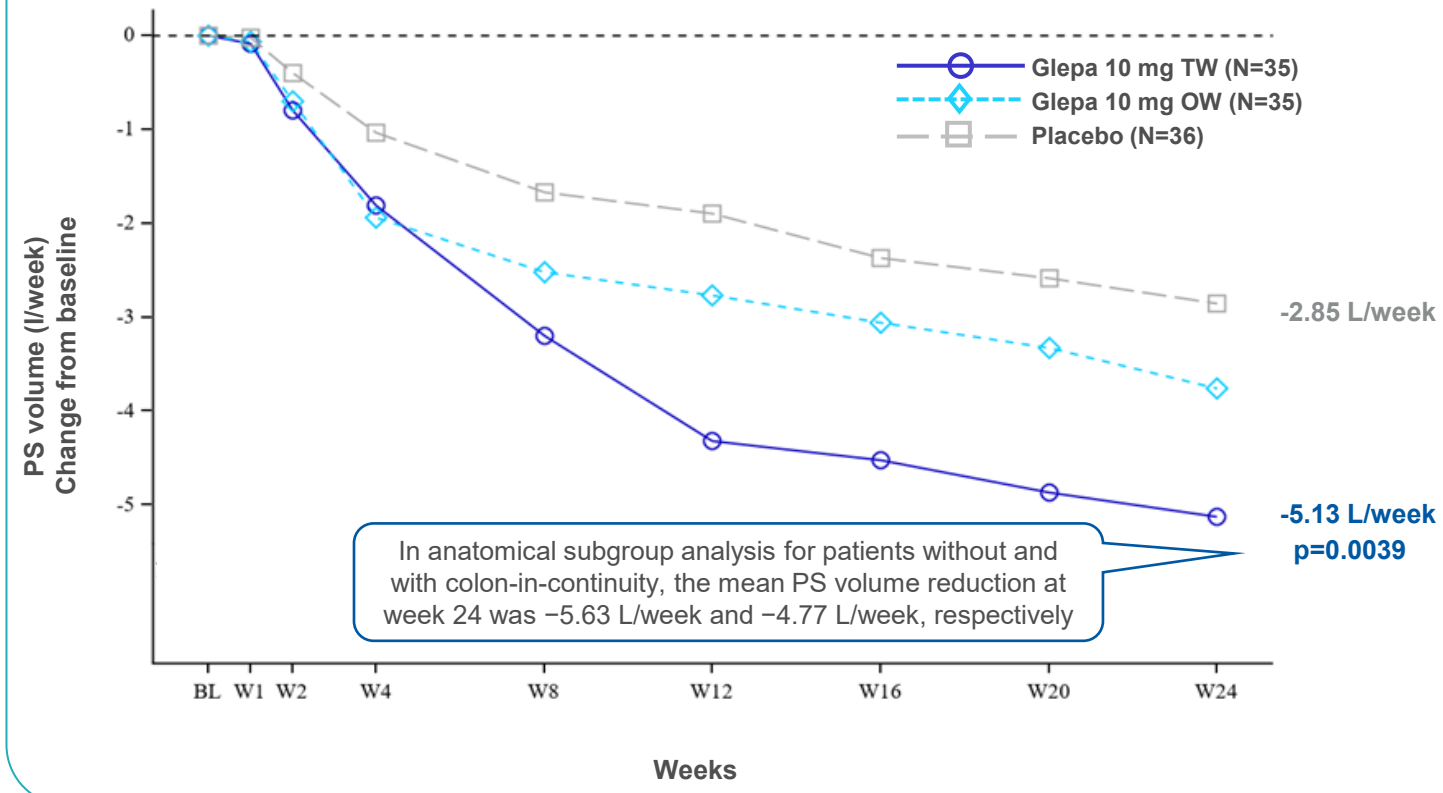
Glepaglutide: a long-acting stable GLP-2 analog[a]

- 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
- Second Phase 3 trial is ongoing (EASE-5), to provide further confirmatory evidence for U.S. resubmission[3,4]

[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; [4]clinicaltrials.gov (NCT07197944)
MAA=marketing authorization application; EMA=european medicines association

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

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



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

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

9 patients treated with glepaglutide discontinued PS during the trial

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

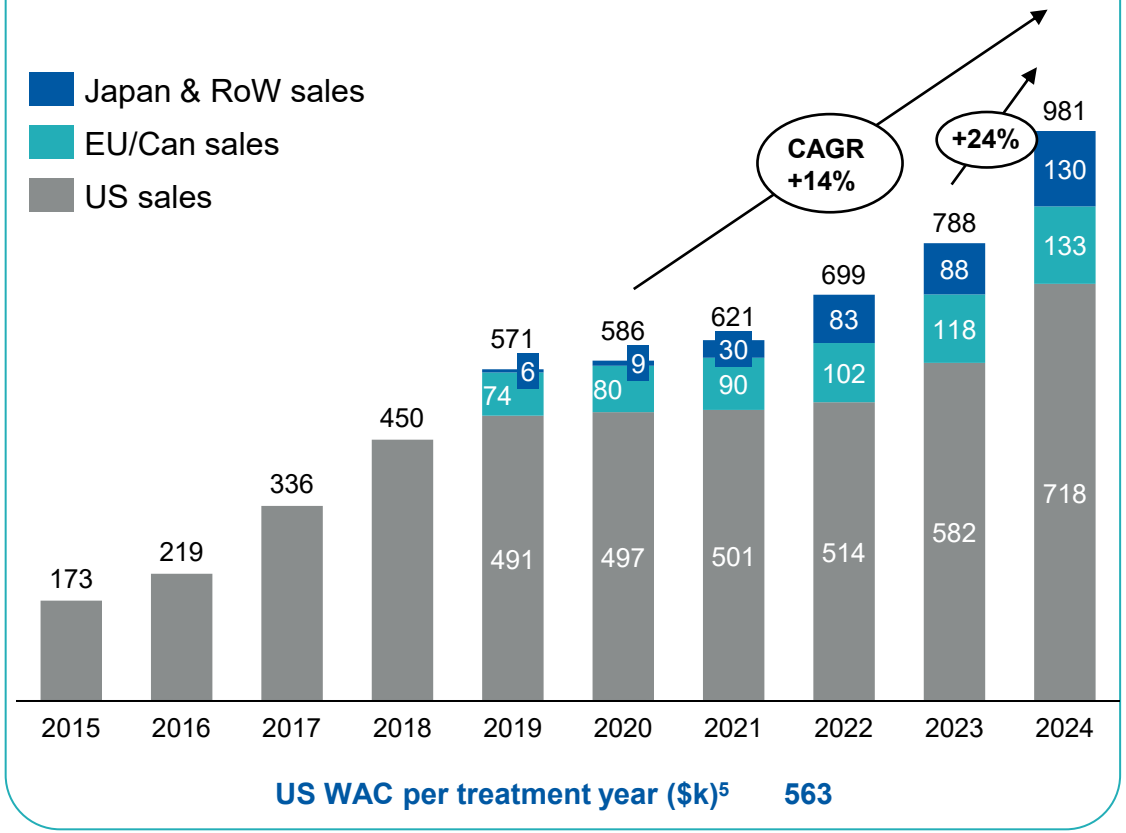
Glepaglutide appeared to be well-tolerated in the trial

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

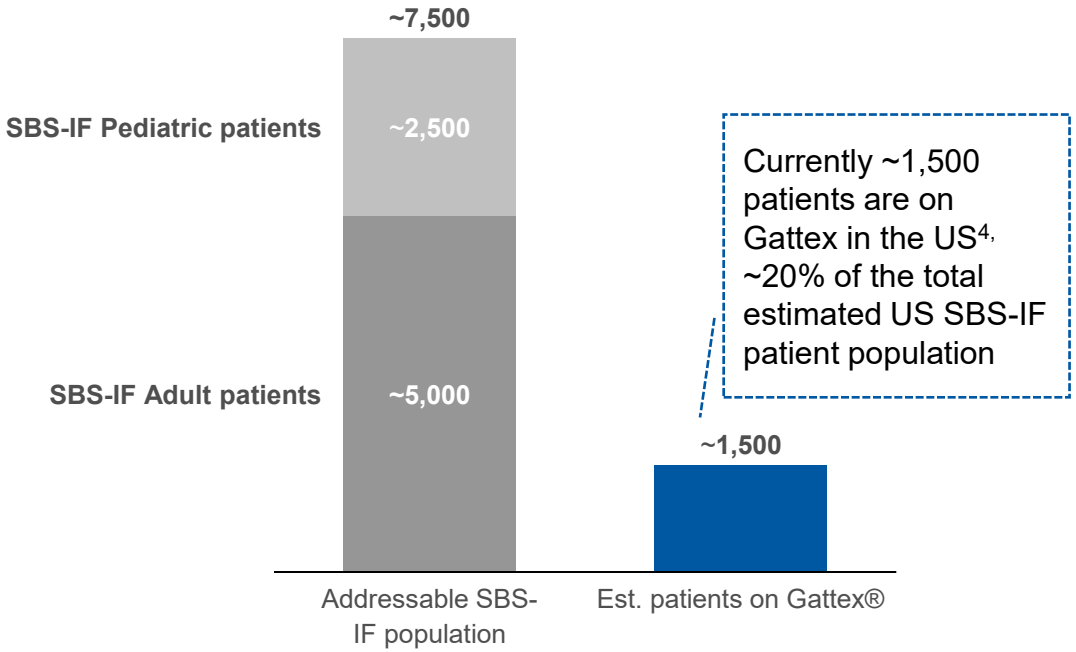
Source: [1]Jeppesen, et al, Gastroenterology, December 2024 (published online ahead of print).
SBS=short bowel syndrome; PS=parenteral support; N=number of participants; TW=twice weekly; OW=once weekly

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

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



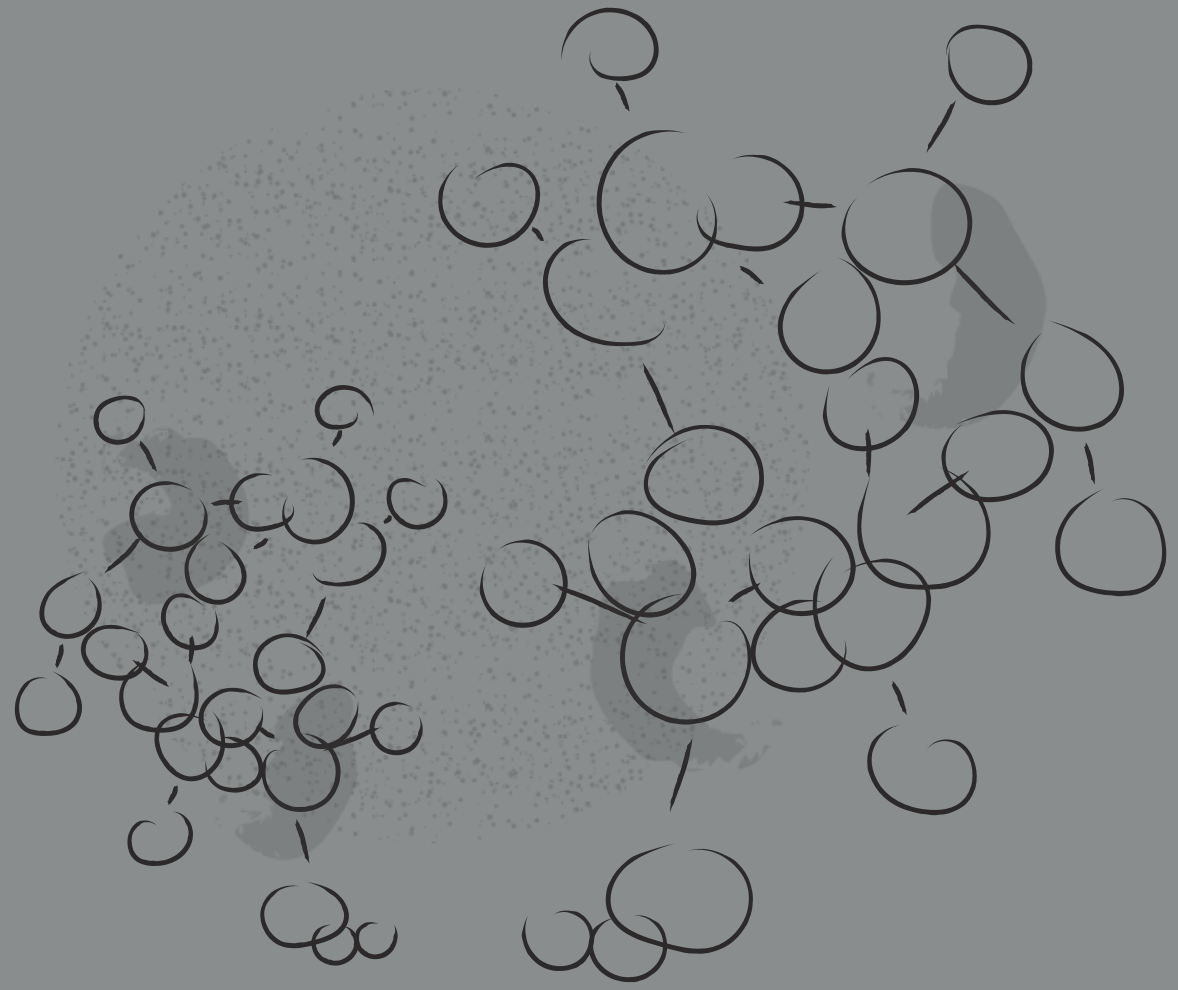
Estimated US SBS-IF Patients[3]



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

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]

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.

In H2 2026, we expect to topline results from MAD part of Phase 1a trial and Phase 1b/2a initiation

Positive results from Phase 1a SAD trial

- ✓ Well tolerated, with no serious or severe AEs or dose-limiting safety findings at any dose level
- ✓ PK profile in line with predictions based on preclinical data
- ✓ Exploratory PD biomarkers showing robust, dose-dependent activity consistent with Kv1.3 target engagement
- ✓ High bioavailability of subcutaneous formulation

Development program progressing at full speed

- ➢ Topline data from MAD part of Phase 1a trial expected in H2 2026
- ➢ Phase 1b/2a initiation expected in H2 2026

Pipeline-in-a-product potential

FIH=first in human; SAD=single ascending dose; AE=adverse event; PK=pharmacokinetics; PD=pharmacodynamics; MAD=multiple ascending dose.

Research strategy

Company Presentation

Zealand Pharma 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

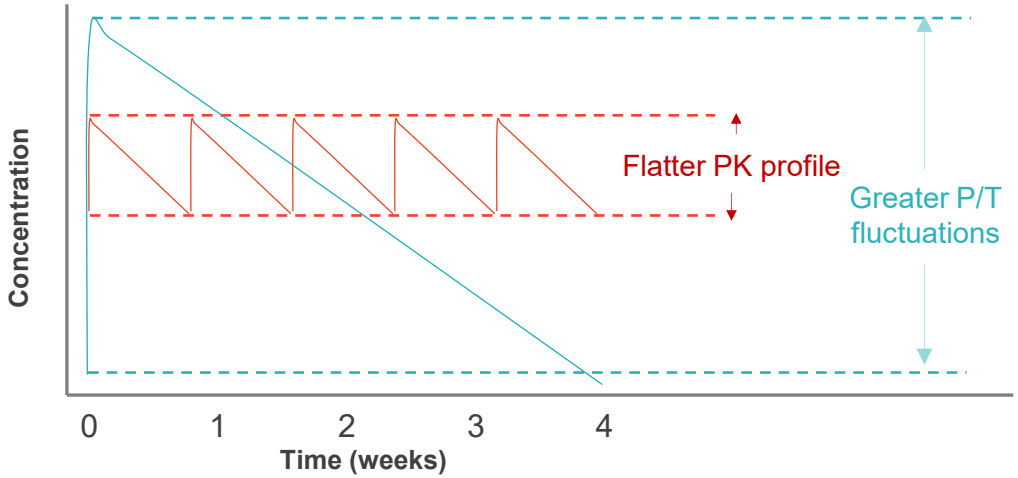
Oral small-molecule amylin

- ✓ 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



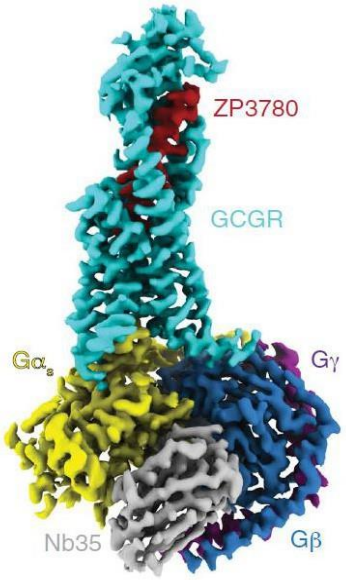
QW=once weekly; QM=once monthly; PK=pharmacokinetics; P/T=peak-to-trough.

Investing in advanced computational methods for medicine creation

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

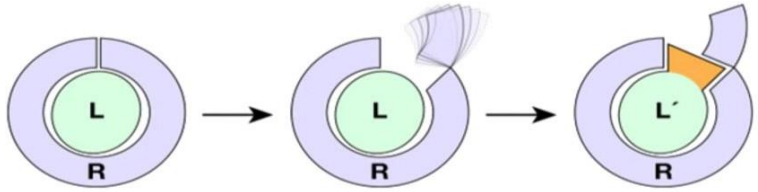
Static model

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

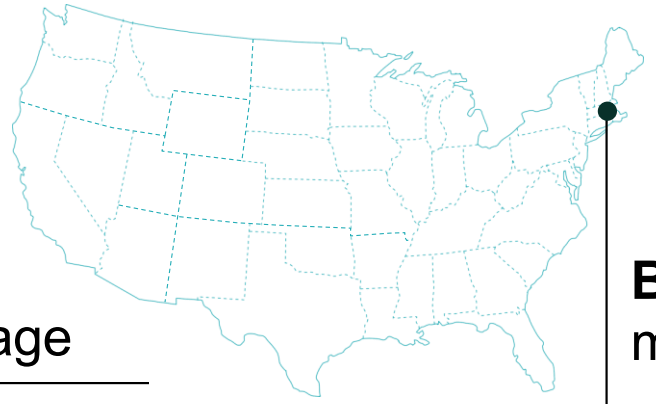
Source: Hilger et al. Science. 2020 Jul 31;369(6503) (with author permission).
MD=molecular dynamics. ML=machine learning L=ligand; L'=different ligand; R=receptor.

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



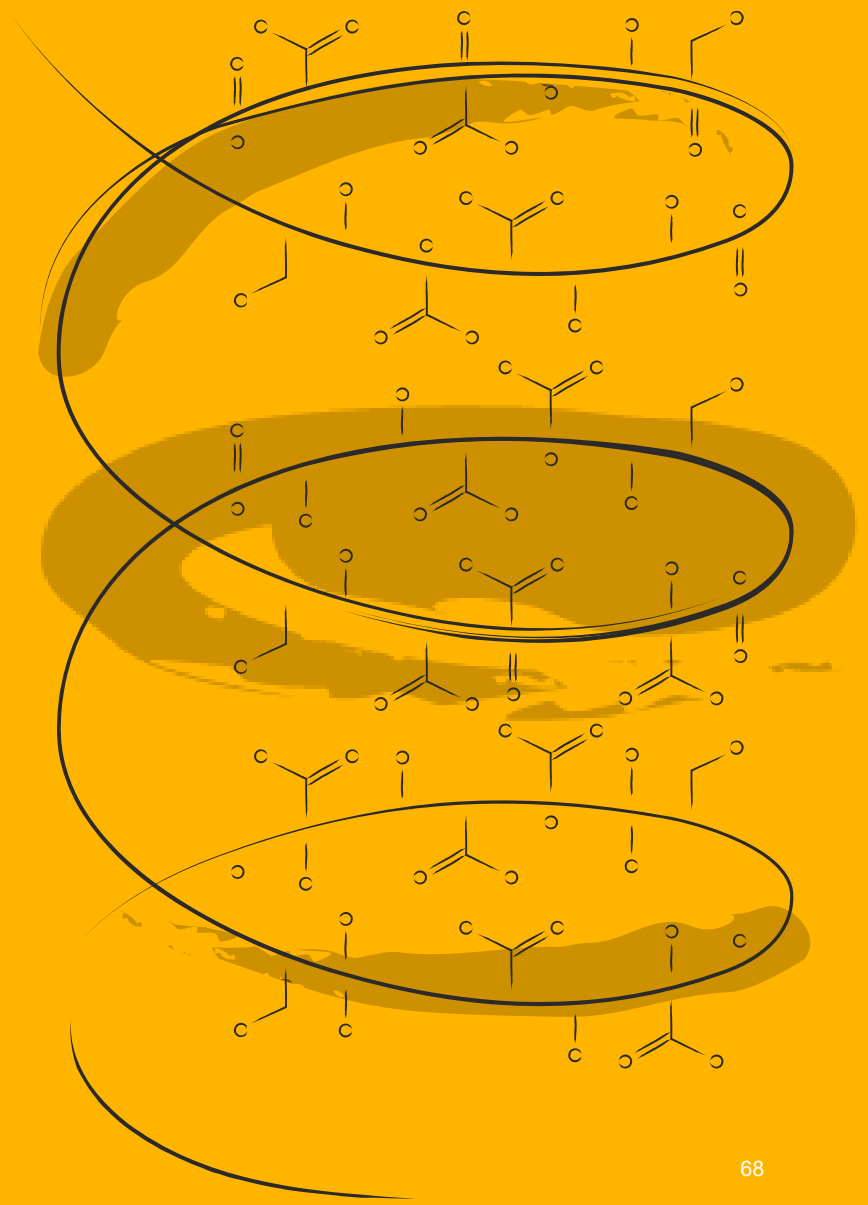
Boston: Accelerate medicine creation

- 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

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

Additional company information

Corporate Presentation

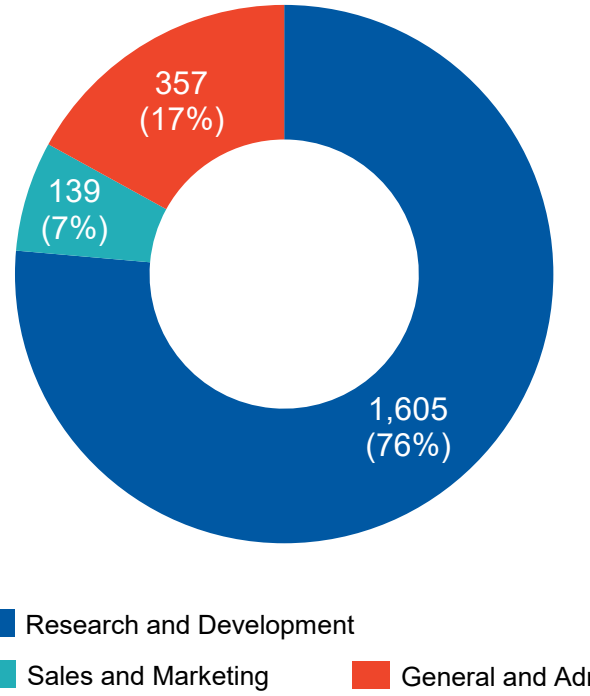


In 2025, we delivered a net positive result of DKK 6.5 billion

DKK million	FY 2025	FY 2024
Revenue	9,215	63
Gross profit	**9,214**	**55**
Research and development expenses	-1,605	-920
Sales and marketing expenses	-139	-88
General and administrative expenses	-357	-316
Other operating items	-154[a]	-3
Net operating expenses	**-2,255[a]**	**-1,327**
Operating result	**6,959**	**-1,272**
Net financial items	42	189
Result before tax	**7,001**	**-1,083**
Tax	-546	5
Net result for the period	**6,455**	**-1,079**

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

FY 2025 OPEX composition[a]
DKK million



[a]Net operating expenses excluding Other operating items amounted to DKK 2.1 billion in 2025, compared to guidance of DKK 2.0-2.3 billion.

Strong financial terms and commitments from partners

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

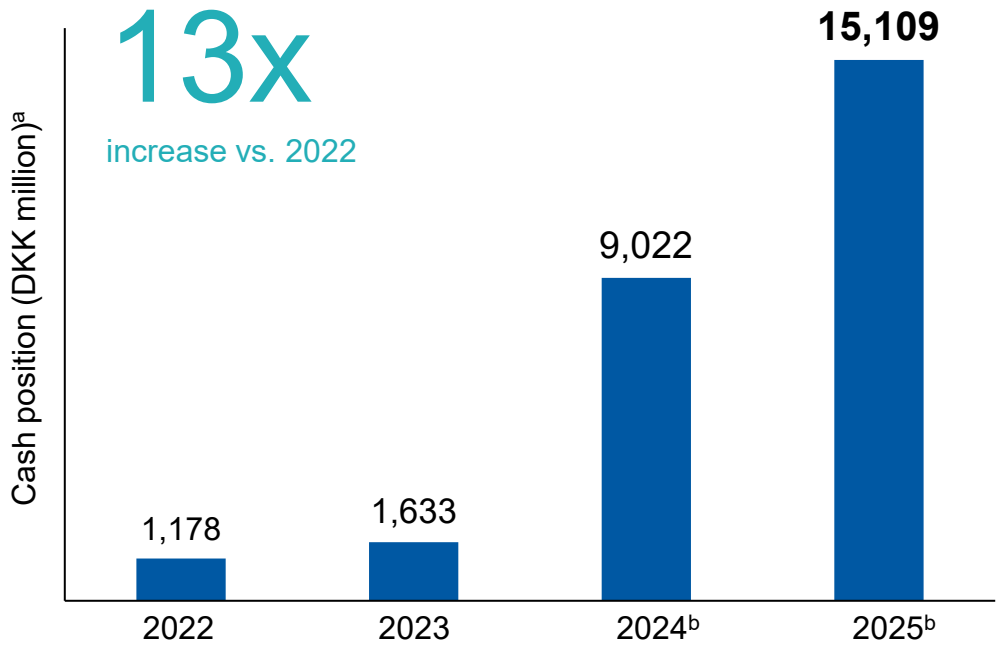
EUR 315 million outstanding in potential milestone payments

[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).

Strong financial muscle to bridge the path to profitability

ILLUSTRATIVE

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



Short- to mid-term topline drivers

2026
- USD 125 million - anniversary payment (Roche)
- USD 575 million - development milestone (Roche)[c]

2027
- USD 125 million - anniversary payment (Roche)
- USD 575 million - development milestone (Roche)[d]

2027/28
- Survodutide royalty stream and milestones commencing[e]

[a]Cash position includes cash, cash equivalents and marketable securities; [b]EIB loan Tranches B and C (EUR 20 million each) are excluded from this chart. The two tranches are subject to pre-specified milestones being met; [c]Subject to the initiation of a Phase 3a program with petrelintide monotherapy; [d]Subject to the initiation of a Phase 3b program with petrelintide monotherapy; [e]EUR 315 million outstanding in potential development, regulatory and commercial milestones + high single to low double digit % royalties on global sales.

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Zealand Management Team

Adam Steensberg

Chief Executive Officer

Henriette Wennicke

Chief Financial Officer

Utpal Singh

Chief Scientific Officer

Steven Johnson

Chief Development Officer

David Kendall

Chief Medical Officer

Eric Cox

Chief Commercial Officer

Ivan M. Møller

Chief Operating Officer

Christina S. Bredal

Chief People Officer