Pioneering next-generation peptide therapeutics.

Zealand Pharma A/S

November 2025

Forward-looking Statements

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

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

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

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

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About Zealand Pharma

Corporate Presentation

We are an international biotech company headquartered in Denmark

Headquarters and labs outside Copenhagen, Denmark

Founded in 1998

- Peptide platform validated through two approved products marketed by Sanofi and Novo Nordisk
- ~460 employees globally as of November 1, 2025

Listed on NASDAQ CPH (ZEAL.CO)

- Market cap on November 20, 2025: USD ~5.9B (DKK ~38.4B)
- 71.4M Shares Outstanding as of September 30, 2025

Cash position[a]

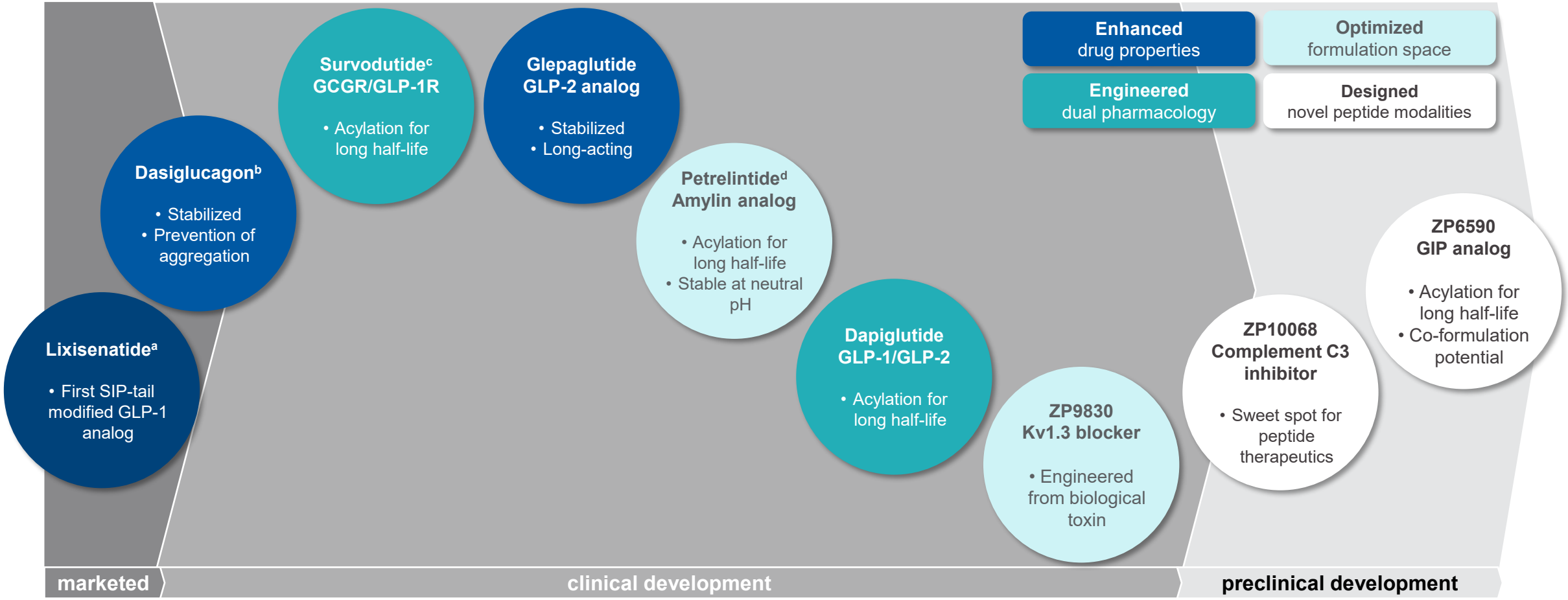
- USD ~2.5B (DKK ~16.2B) as of September 30, 2025

OPEX guidance for 2025[b]

- Net operating expenses are expected to be DKK 2,000-2,300M

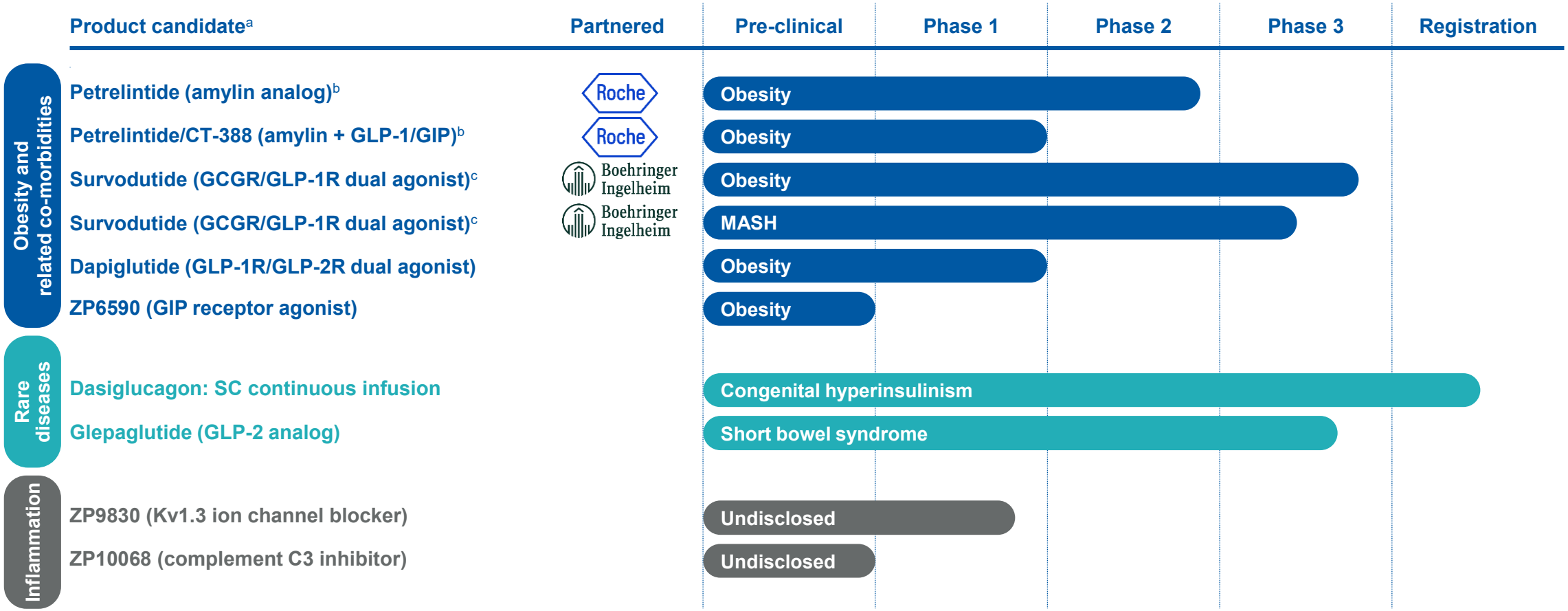
[a]Cash position includes cash, cash equivalents and marketable securities. Zealand also has a loan facility with the European Investment Bank (EIB) of EUR 90 million in three tranches (Tranche A of EUR 50 million was disbursed in Q1 2024; Tranches B and C are subject to pre-specified milestones being met).
[b]Financial guidance for 2025 excludes Other operating items.
Based on foreign exchange rates as of November 20, 2025 (DKK 6.48 = USD $1).
OPEX=Operating Expenses.

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



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

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



[a]**Investigational compounds whose safety and efficacy have not been evaluated or approved by the U.S. Food and Drug Administration (FDA) or any other regulatory authority.**
[b]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.

Exciting news flow with major catalysts across the portfolio rapidly approaching

NON-EXHAUSTIVE

Q4 2025

Glepaglutide (SBS)
Initiation of additional Ph3 trial (EASE-5)

Zealand Pharma Capital Markets Day

H1 2026

Petrelintide[a]
Topline results from Ph2 ZUPREME-1 trial

Petrelintide/CT-388[a]
Initiation of Ph2

Survodutide[b]
Topline results from Ph3 obesity trials

Glepaglutide (SBS)
Potential approval in Europe

ZP9830 (Kv1.3 Ion Channel Blocker)
Topline results from Ph1 SAD trial

H2 2026

Petrelintide[a]
Expected initiation of Ph3 program

Petrelintide[a]
Topline results from Ph2 ZUPREME-2 trial

Survodutide[b]
Topline results from Ph3 obesity trials

Legend:

Obesity | Rare diseases | Inflammation

Potential partnership agreements across therapeutic areas

[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, with Boehringer solely responsible for development and commercialization globally. Primary completion of SYNCHRONIZE™-1 and 2 is expected in H2 2025, ClinicalTrials.gov (NCT06066515; NCT06066528), accessed November 2025.
SAD=single ascending dose; SBS=short bowel syndrome.

Obesity

Corporate Presentation

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

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

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

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

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

Early days in the evolution of this market…

~3%

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

>220

Complications and comorbidities associated with obesity
Including CVD, liver disease, type 2 diabetes, kidney disease, neuro-inflammation and some cancers[3]

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

Sources: [1]World Obesity Atlas 2024; [2]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]American Medical Association 2024: https://www.ama-assn.org/topics/obesity.
BMI=body mass index; CVD=cardiovascular disease.

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

Segment characteristics and key focus areas

Prescriber-driven

High-risk obesity

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

Focus on:

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

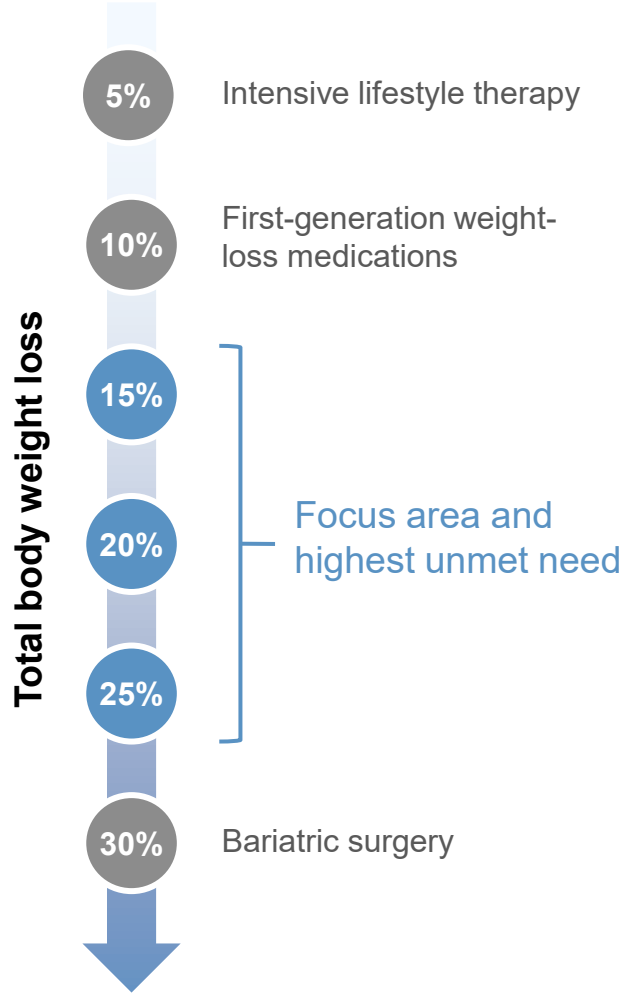
Patient-driven

Moderate-risk obesity

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

Focus on:

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



...and that success of future weight-loss medications relies on differentiation on multiple fronts

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GLP-1-based

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

Amylin-based

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

Other drug classes

Examples of differentiation factors

- **Improved tolerability** by addressing GI side effects
- Unique **non-incretin mechanisms**, addressing the lack of food enjoyment and/or improving quality of weight loss
- Better effects on obesity-related **comorbidities**
- Develop loose 'flexible-use' or **fixed-dose combinations** for patient segments who need the highest weight loss
- Offer **greater convenience** through dosing regimen and/or delivery method

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

Our rich clinical-stage pipeline hold potential to redefine the near-term future of obesity management

Petrelintide[a]	Petrelintide/CT-388[a]	Survodutide[b]
Long-acting amylin analog	Amylin + GLP-1/GIP fixed-dose combination	Glucagon/GLP-1 receptor dual agonist
Ph2 trials in obesity ongoing	Ph2 initiation in obesity expected in H1 2026	Ph3 programs in obesity and MASH ongoing
Potential best-in-class alternative to GLP-1RA-based therapy	Potential best-in-disease weight loss efficacy and glycemic control	Potential best-in-class therapy for obesity and MASH
Roche	Roche	Boehringer Ingelheim

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[b]Survodutide is licensed to Boehringer Ingelheim from Zealand Pharma, with Boehringer solely responsible for development and commercialization globally. EUR 315 million outstanding potential development, regulatory and commercial milestones + high single to low double digit % royalties on global sales.
GLP-1RA=glucagon-like peptide-1 receptor agonist; GLP-1=glucagon-like peptide-1; GIP=gastric inhibitory polypeptide; GLP-2=glucagon-like peptide-2; MASH=metabolic dysfunction-associated steatohepatitis.

GLP-1RA-based therapies effectively reduce body weight but are associated with GI tolerability issues[1]

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

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

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

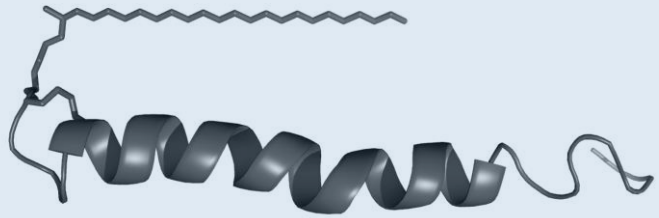
Petrelintide[b] is a long-acting amylin analog with the following target product profile:

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

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

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

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



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

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

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

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]Brændholt Olsen et al. Poster 92-LB. Presented at ADA 83rd Scientific Sessions, June 23–26, 2023, San Diego, CA; [3]Skarbaliene et al. Poster 1406-P. Presented at ADA 82nd Scientific Sessions, June 3–7, 2022, New Orleans, LA; [4]Eriksson et al. Poster 532. Presented at ObesityWeek, November 1–4, 2022, San Diego, CA; [5]Eriksson et al. Presentation at ObesityWeek, November 1–4, 2022, San Diego, CA.
Intellectual property: Composition of matter, patent expiry in 2037. Patent-term extension up to 5 years, i.e. 2042. Potential rights beyond 2042 based on patent applications and additional elements.

Native amylin, a non-incretin hormone[1], increases satiety, unlike GLP-1, which reduces appetite

Proposed physiological effects of amylin receptor activation[2]

Pancreas (indirect)[a]

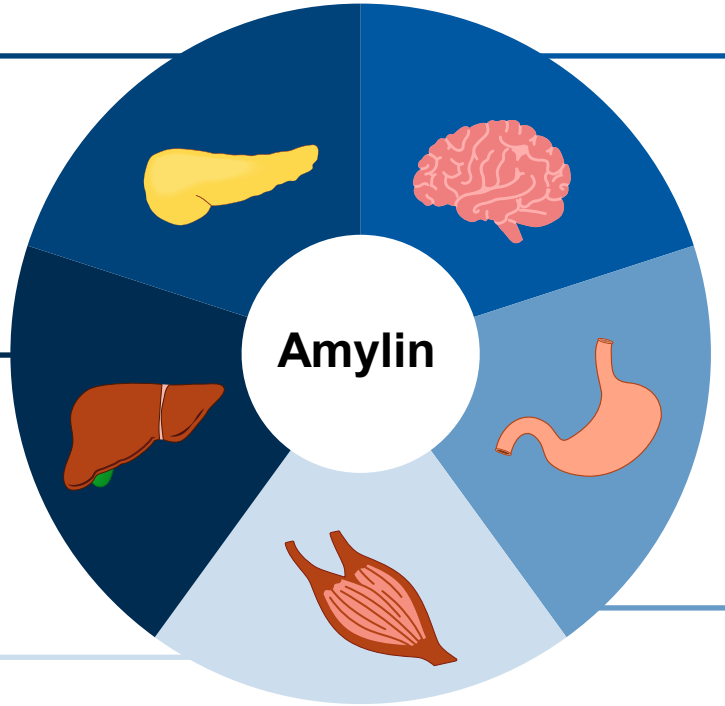
- ↓ Insulin secretion (improving glucose metabolism)
- ↓ Glucagon secretion

Liver and adipose tissue

- ↑ Insulin sensitivity
- ↓ Fat accumulation

Muscle

- ⇆ Preserves lean mass[b,4]



CNS

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

Via the vagal nerve

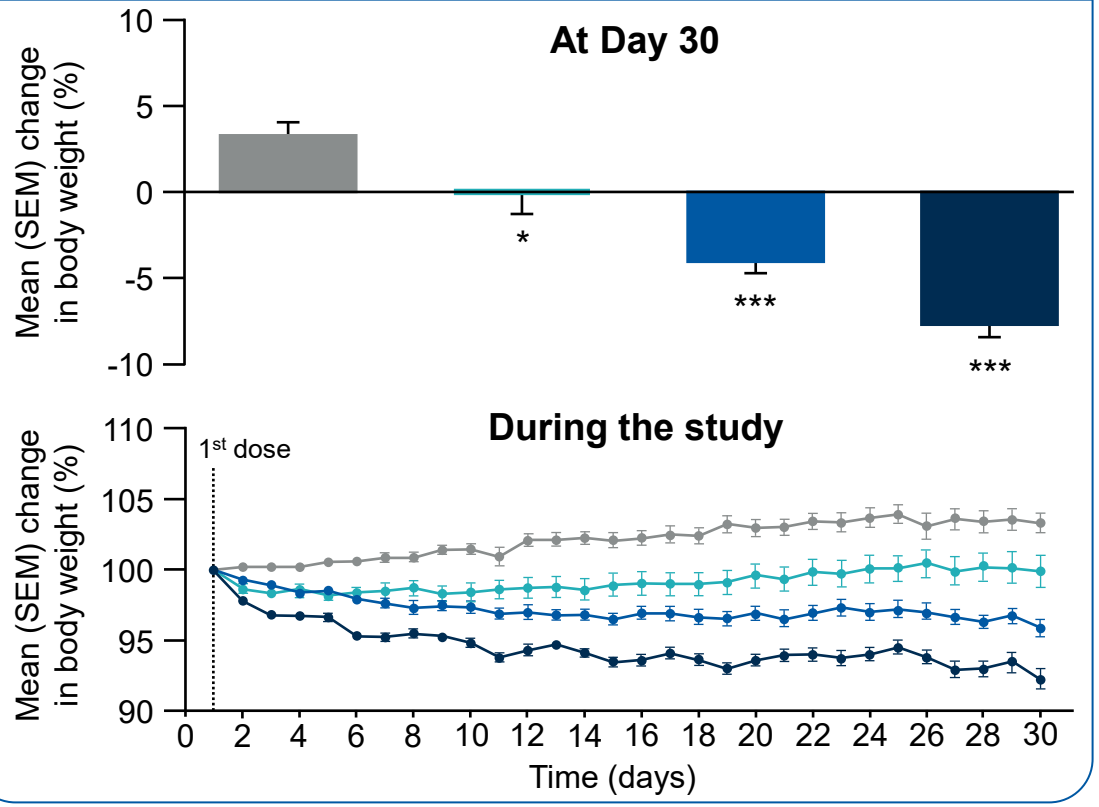
GI tract

- ↓ Gastric emptying

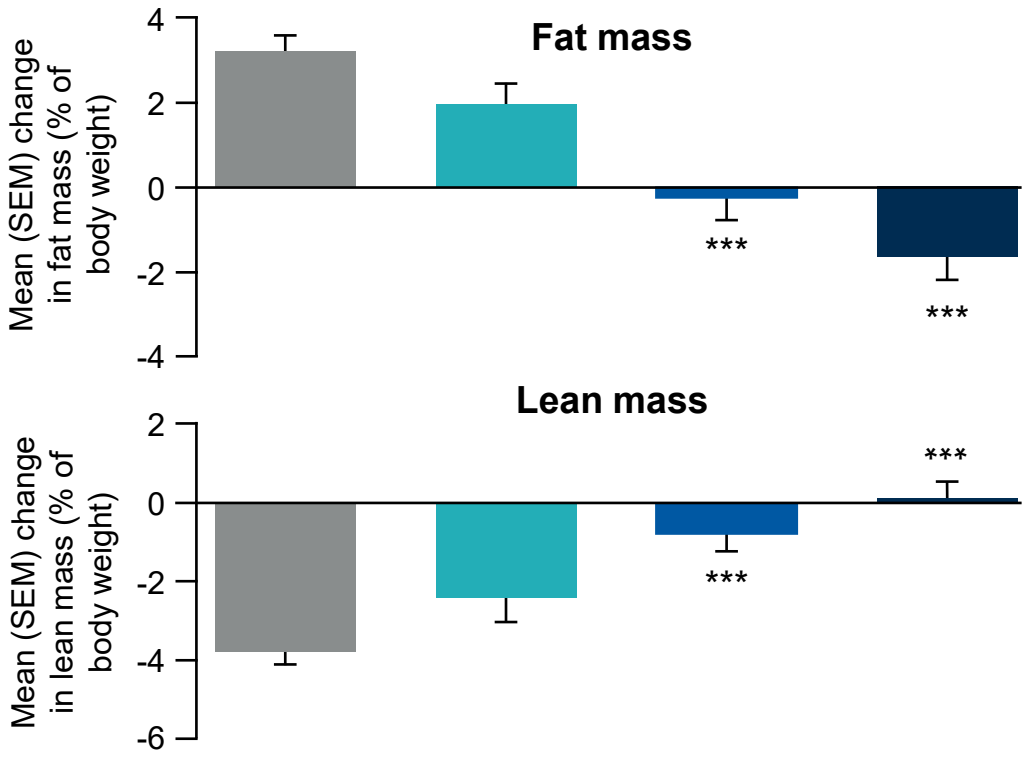
[a]Mediated by the effect of amylin on the CNS; [b]Demonstrated pharmacologically with several amylin analogs in pre-clinical studies, including with petrelintide.
Sources: [1]Hayes et al. Annu Rev Nutr 2014;34:237–260; [2]Figure adapted from Mathiesen et al. Eur J Endocrinol 2022;186(6):R93–R111; [3]Roth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

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

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



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



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

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

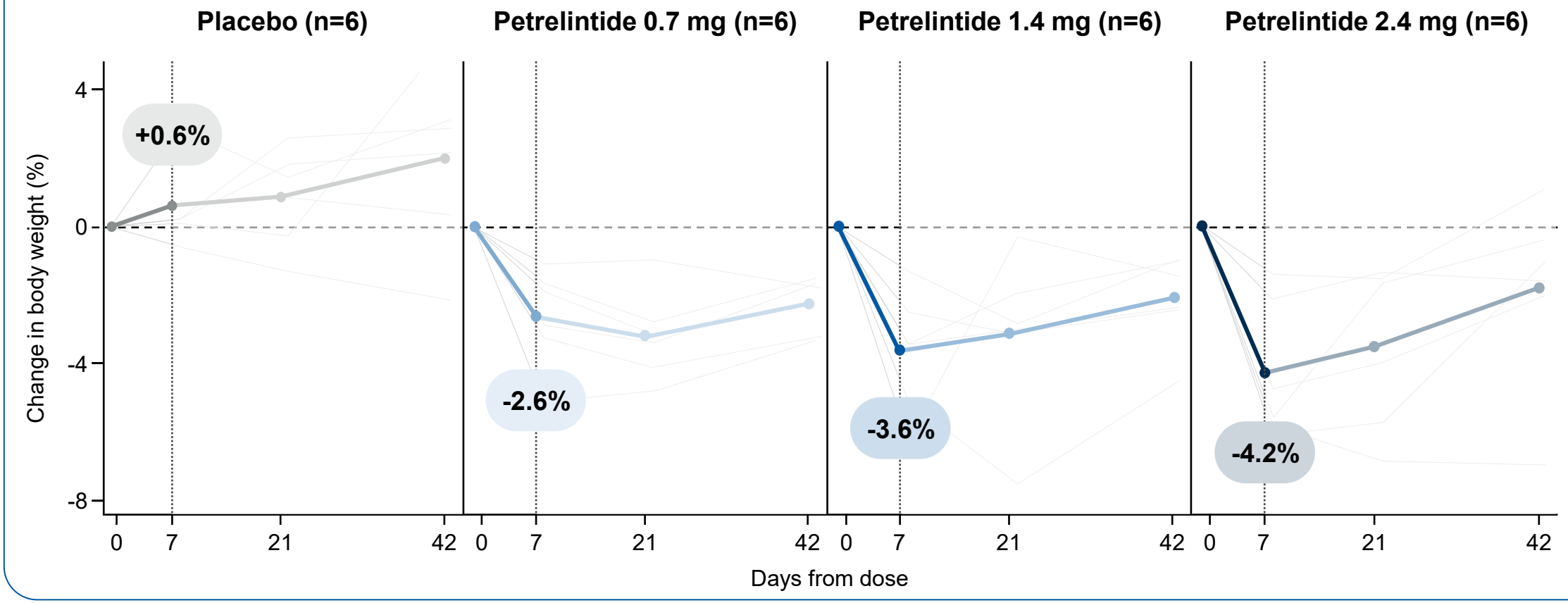
Zealand Pharma has a collaboration and license agreement with Roche for petrelintide, including co-development and co-commercialization in the U.S. and Europe.

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

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

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

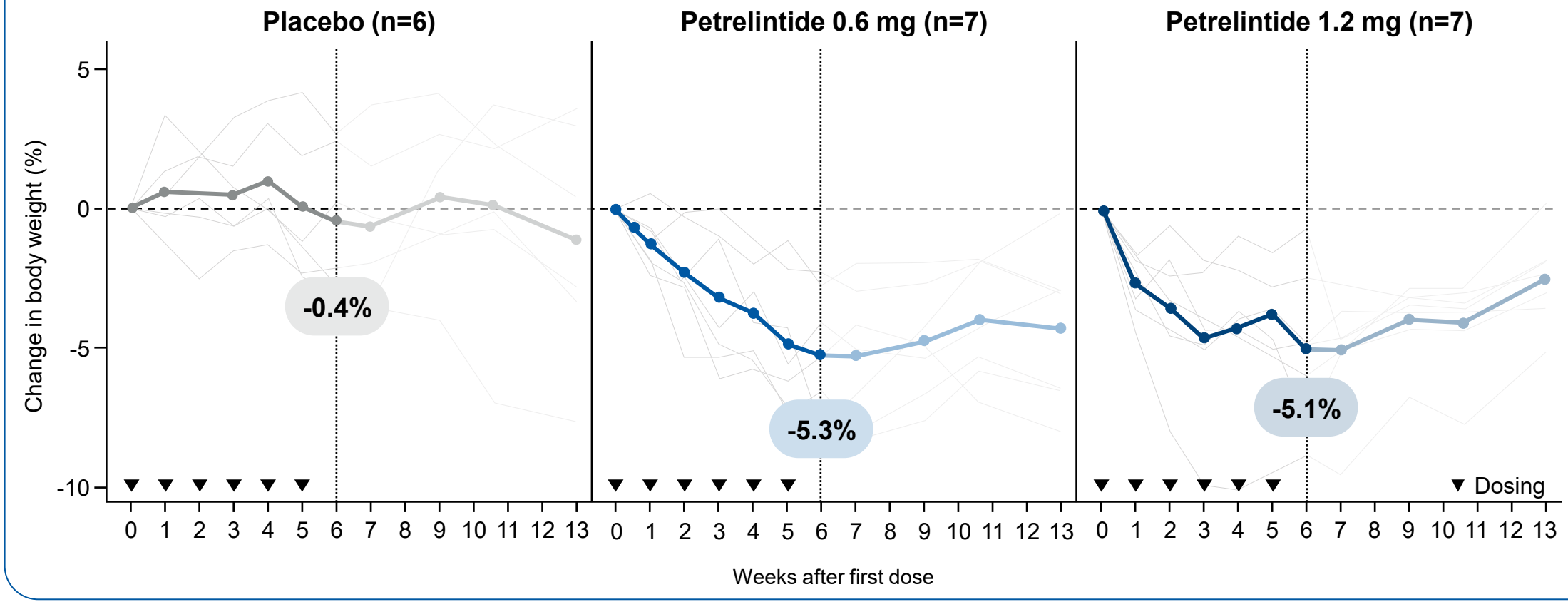
Petrelintide Phase 1a SAD trial: change in bodyweight



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



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 presented at ObesityWeek, October 14–17, 2023, Dallas, TX.
MAD=multiple ascending dose.

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

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

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

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

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

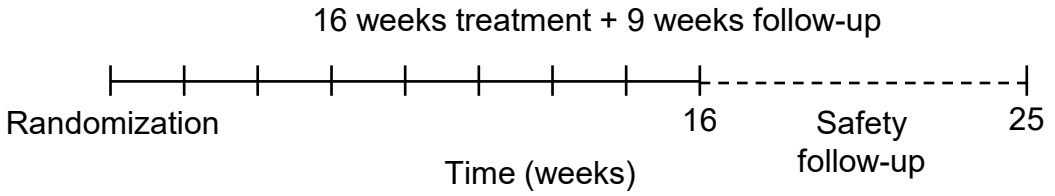
- Adults 18–64 years
- Body weight ≥70 kg
- HbA1c <6.5%
- BMI 27.0–39.9 kg/m^2

Dose escalation within cohorts every second week

3 cohorts[a]
N=48

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

R **3:1 versus placebo**



Primary endpoint:
- Incidence of TEAEs

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

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

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

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

Gender

79% of participants were **male**

Age

Median **49 years**

Weight

Median **92.4 kg**

BMI

Median **29.2 kg/m^2**

(eligible range: 27.0–39.9 kg/m^2)

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

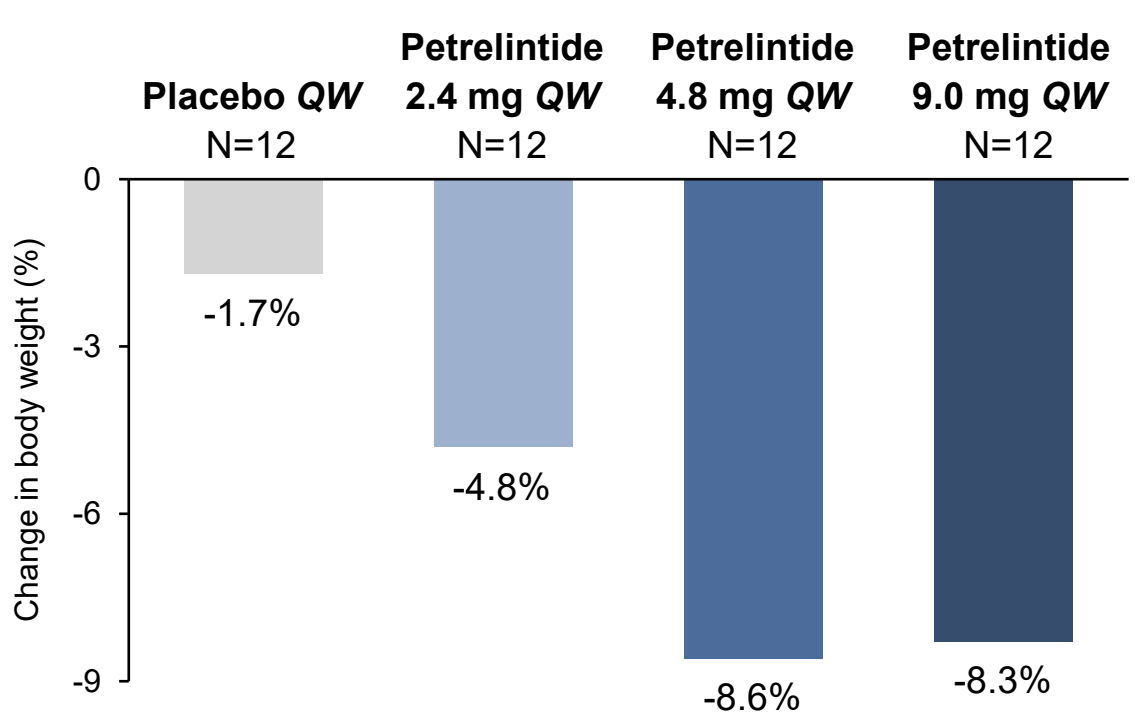
Zealand Pharma has a collaboration and license agreement with Roche for petrelintide, including co-development and co-commercialization in the U.S. and Europe.

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.

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]

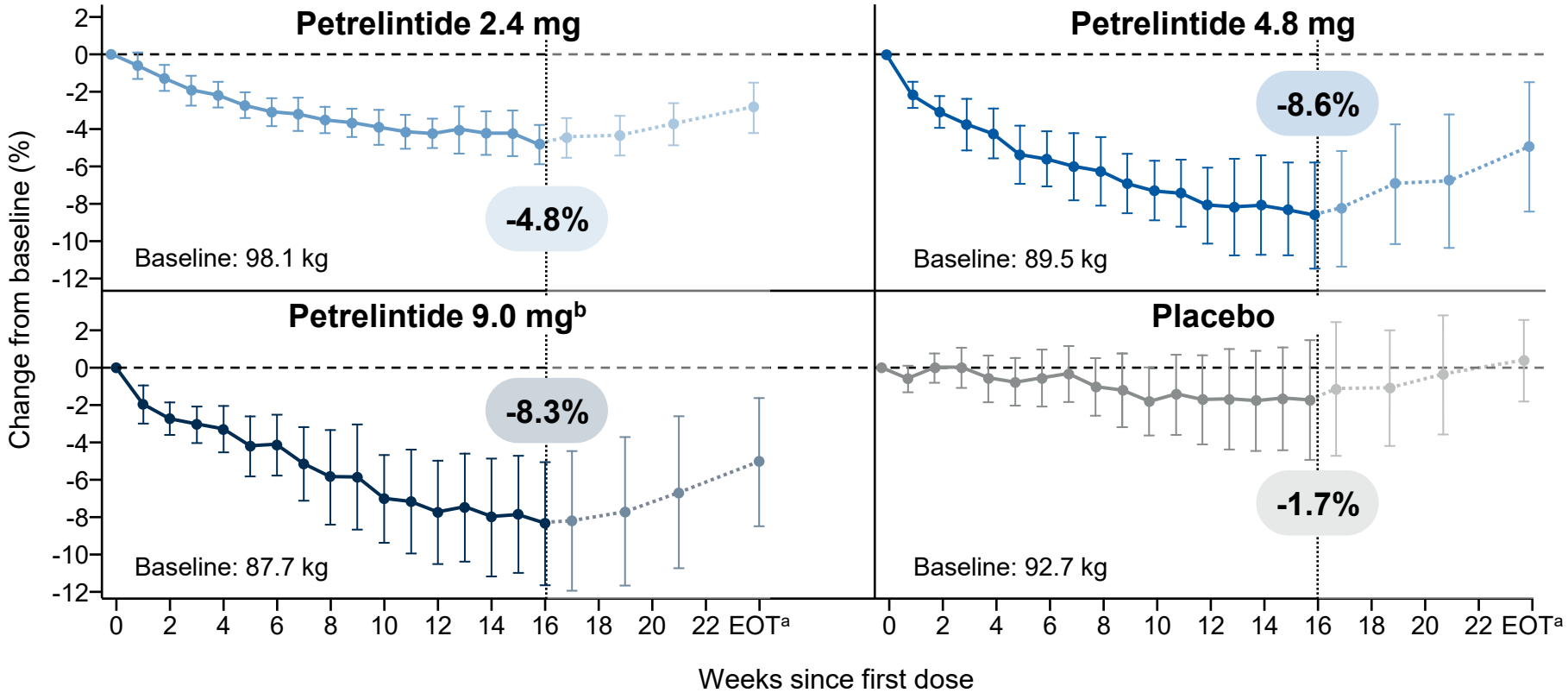


- Petrelintide treatment resulted in a **mean weight loss** of **up to 8.6%** from baseline after 16 weeks
- **All participants** treated with petrelintide **lost weight** during the trial
- Review of data from individual participants supports that **separation at the higher doses is possible**

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.

...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.

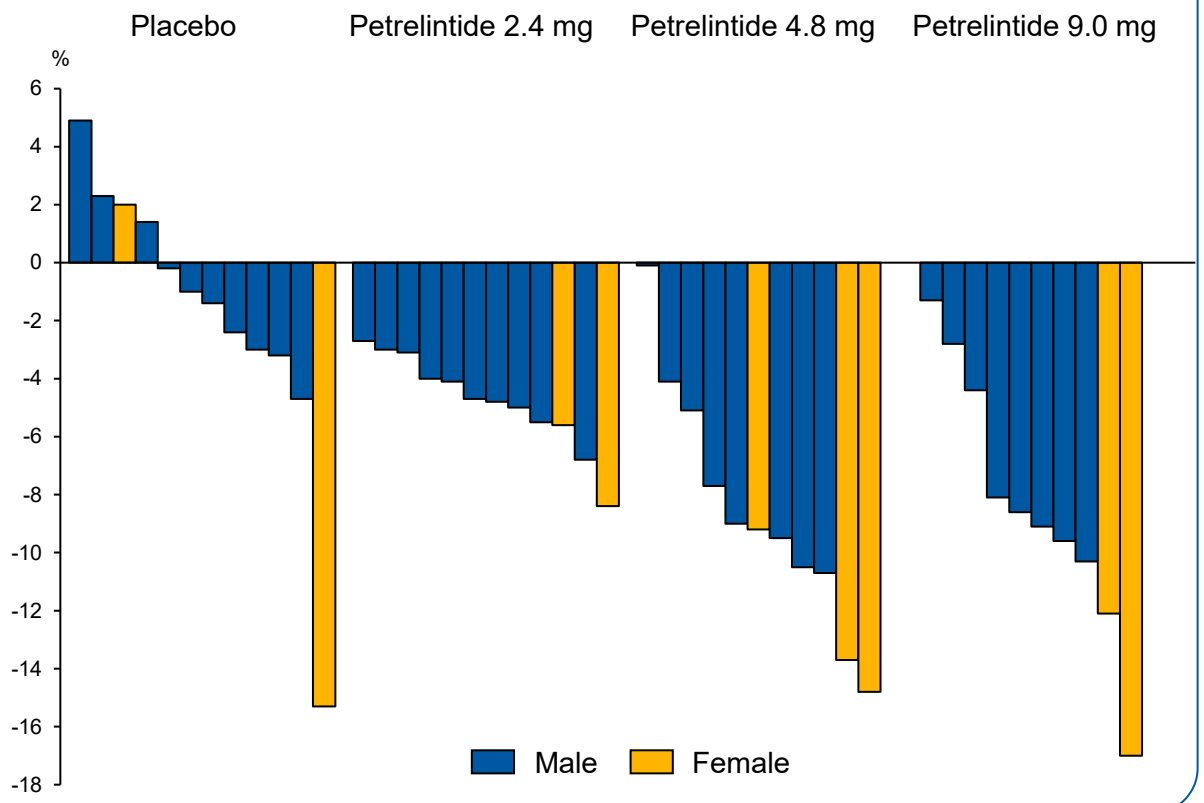
Female participants in the 16-week Phase 1b trial generally lost more weight than the males

Individual change in body weight (%) by gender presented in June at ADA 2025

21% (10/48) of trial participants in Part 2 of the Phase 1b MAD trial were **female**

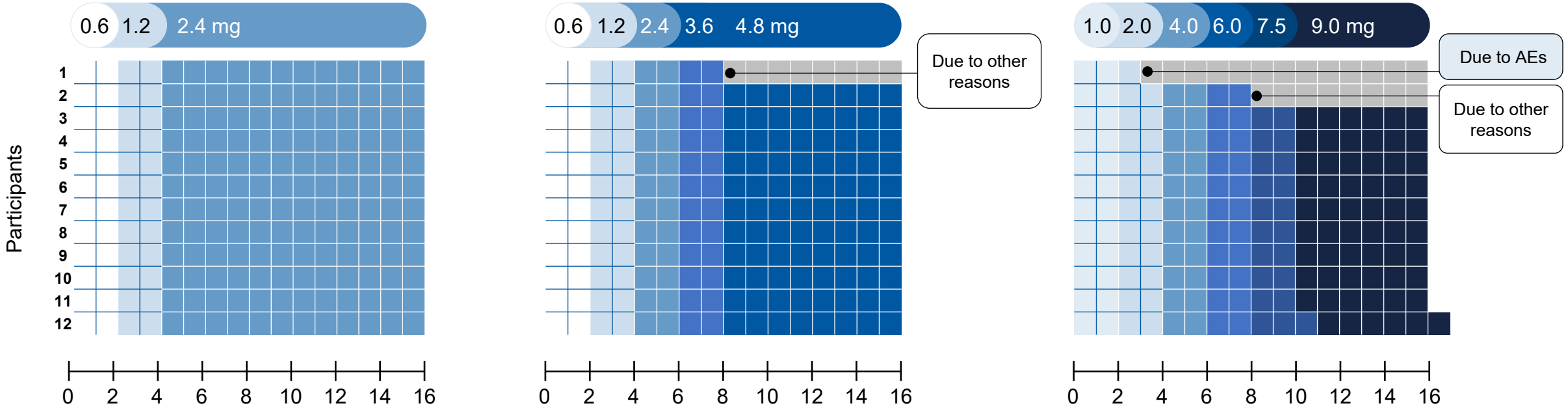
A **greater treatment response** was observed **in women** across the three petrelintide treated cohorts

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. (2025) Effects of the novel long-acting amylin analogue petrelintide on body weight and waist circumference by sex in a Phase 1 trial. ADA 2025.
ADA=American Diabetes Association; GI=gastrointestinal; AE=adverse event

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

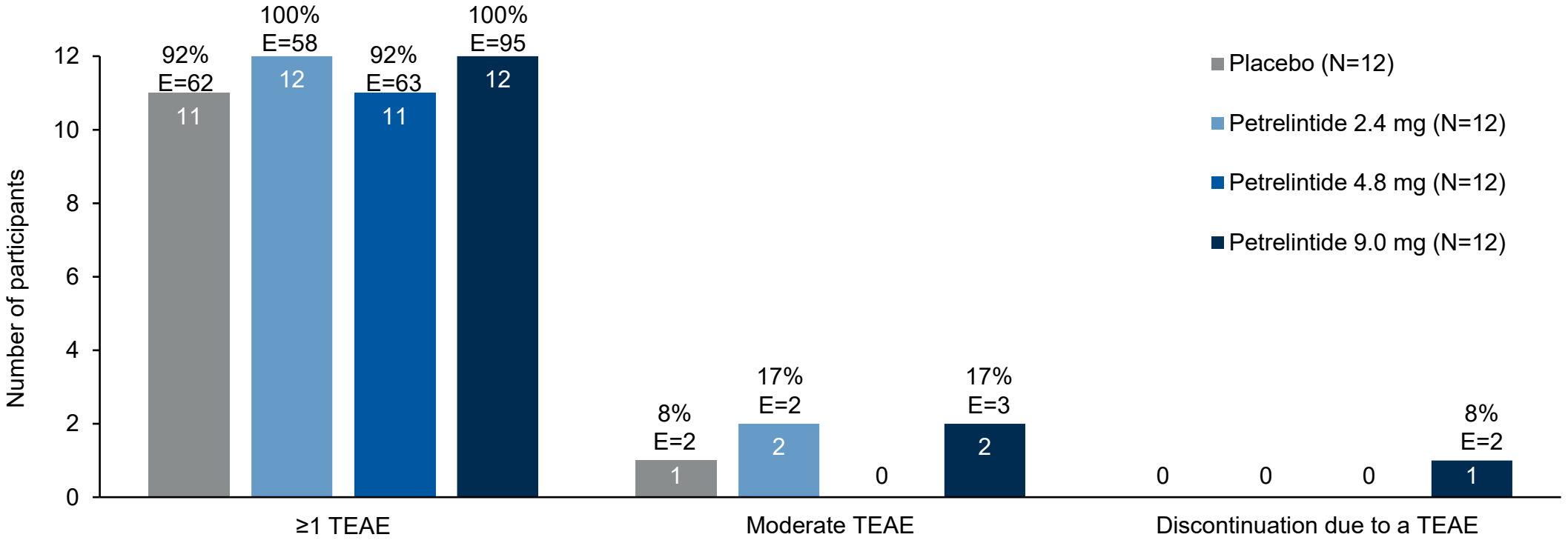


- **Three participants discontinued** petrelintide: one due to AEs, one to focus on recovery from a cold, and one due to personal reasons
- One participant in the 9.0 mg arm had **an extra week at 7.5 mg** (due to tolerability)
- The remaining participants followed dose escalation steps within cohorts

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

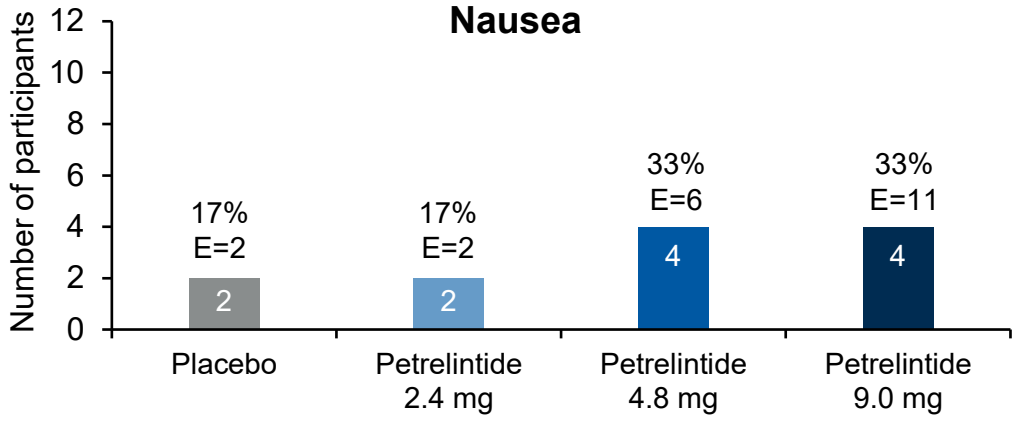


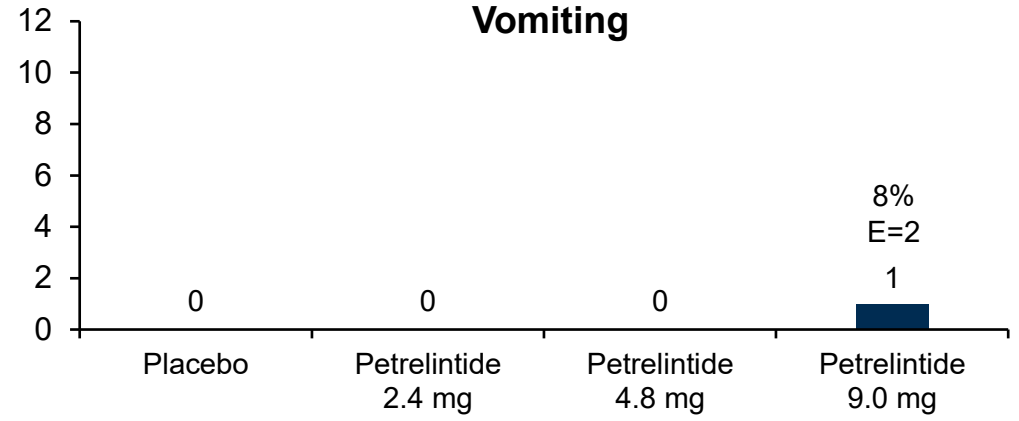
No serious or severe TEAEs were reported

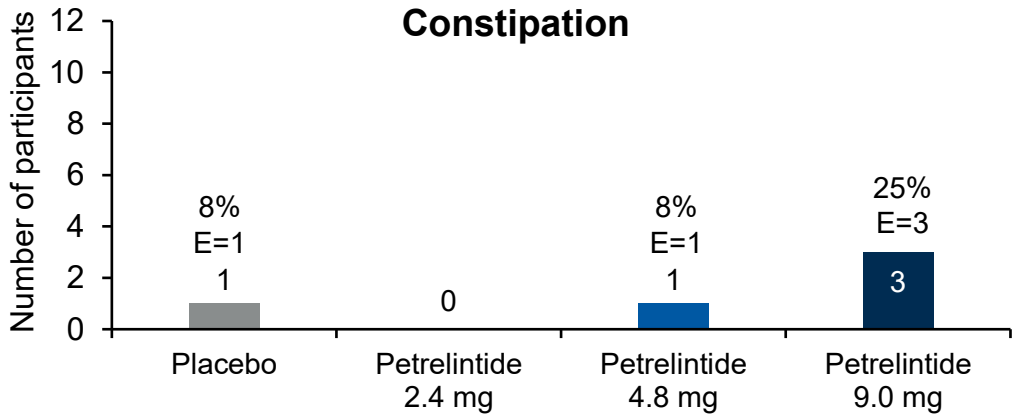
Zealand Pharma has a collaboration and license agreement with Roche for petrelintide, including co-development and co-commercialization in the U.S. and Europe.
Source: Data on file. Data presented at ObesityWeek 2024 in San Antonio, Texas.
5 moderate AEs reported by petrelintide exposed participants: nausea, vomiting, nasopharyngitis, acute sinusitis, back pain
E=number of events; N=number of participants; TEAE=treatment-emergent adverse event.

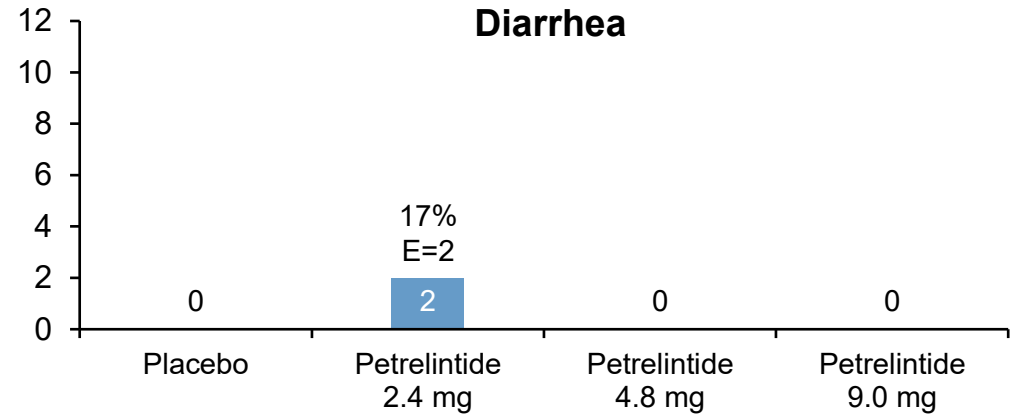
Petrelintide treatment appeared safe and was well-tolerated at all dose levels in the 16-week trial

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









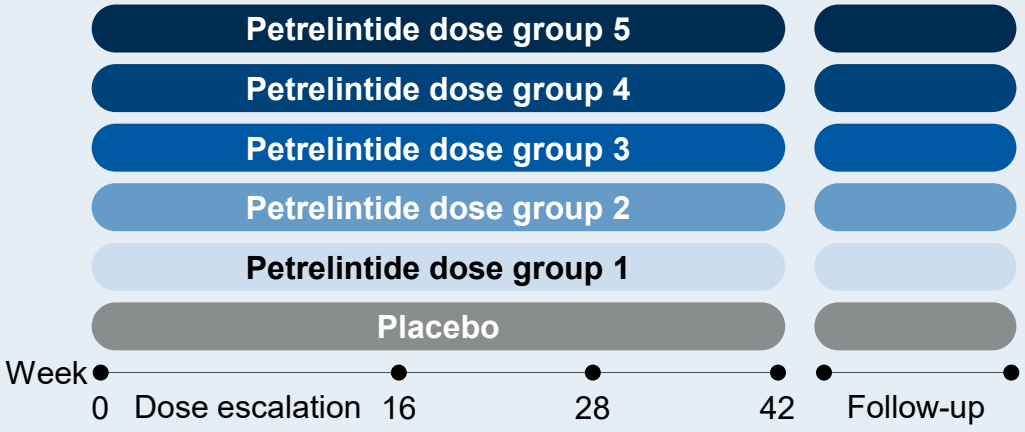
Zealand Pharma has a collaboration and license agreement with Roche for petrelintide, including co-development and co-commercialization in the U.S. and Europe.
Source: Data on file. Data presented at ObesityWeek 2024 in San Antonio, Texas.
N=12 in each treatment group.
E=number of events; TEAE=treatment-emergent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

ZUPREME-1 Phase 2 results expected in H1 2026, with Phase 3 initiation anticipated in H2 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 H1 2026



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

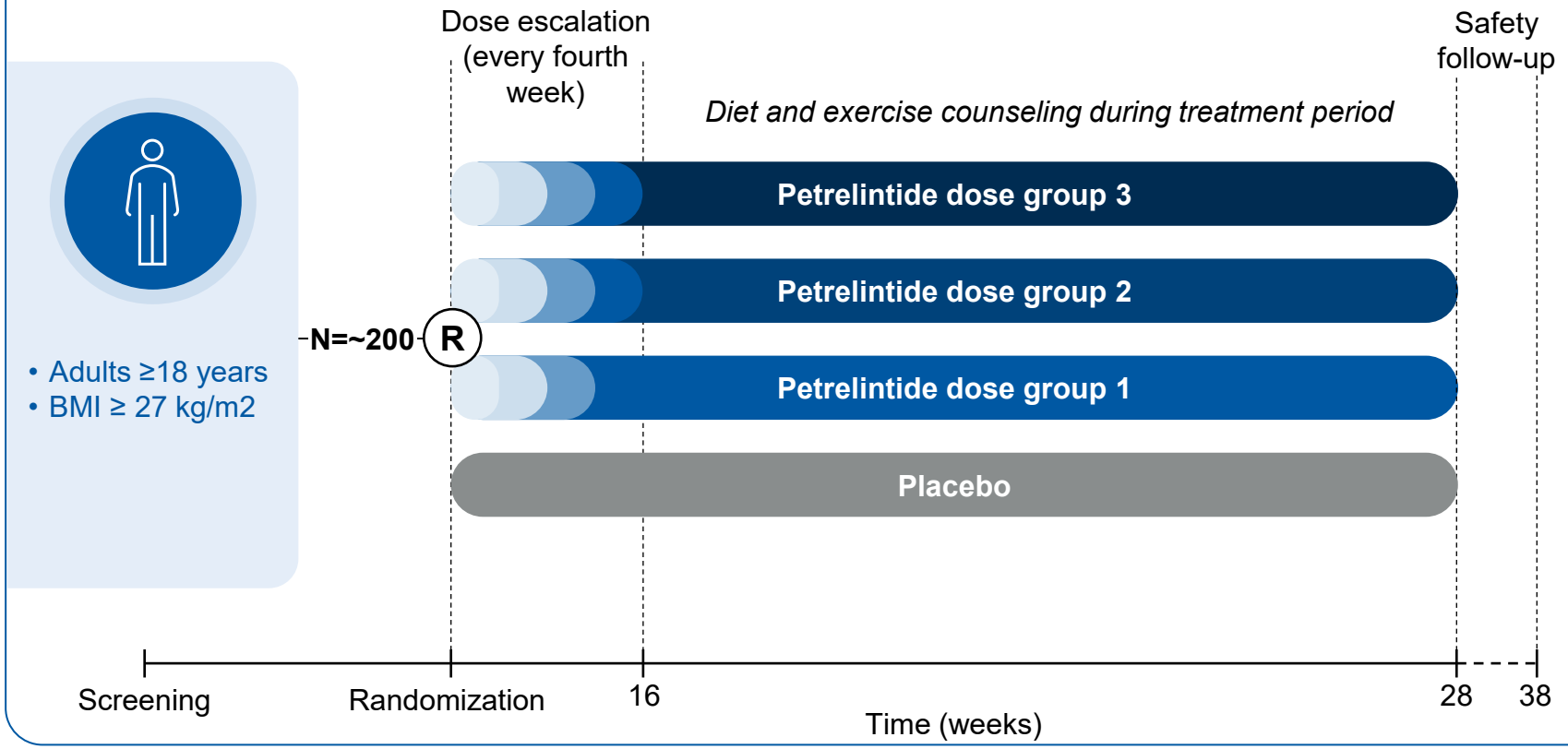
	ZUPREME-1[2,a] >480 trial participants enrolled	16-week Phase 1b[3] N=48
Weight (kg)	~107	92
BMI (kg/m^2)	~37	30
Age (years)	~48	47
Female (%)	~53	21

Zealand Pharma has a collaboration and license agreement with Roche for petrelintide, including co-development and co-commercialization in the U.S. and Europe.
[a]Preliminary baseline data. Weight, BMI and Age represent mean values.
Sources: [1]ClinicalTrials.gov (NCT06662539); [2]Data on file; [3]Data presented at ObesityWeek 2024 in San Antonio, Texas.
T2D=type 2 diabetes; MRI=magnetic resonance imaging; CV=cardiovascular; HbA1c=glycated hemoglobin; hsCRP=high-sensitivity C-reactive protein.

… and topline results from ZUPREME-2 is expected in H2 2026

A randomized, double-blind, placebo-controlled, Phase 2 trial with petrelintide was initiated in April 2025[1]

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



Primary endpoint:

- Percentage change in body weight from baseline to week 28

Secondary endpoints (non-exhaustive):

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

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: [1]ClinicalTrials.gov (NCT06926842), accessed August 2025
T2D=type 2 diabetes; BMI=body mass index; QW=once-weekly; HbA1c=hemoglobin A1C (glycated hemoglobin); TEAE=treatment emergent adverse event.

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

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

Unmet medical needs…

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

…being targeted with petrelintide

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

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

Petrelintide in **combinations**:

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

Rapidly expanding into related indications

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

Petrelintide is backed by a partner that is committed to becoming a top 3 obesity company

Roche

- Global footprint with >100,000 employees in >150 markets[1]
- CHF 60.5 billion net sales in 2024[1]
- Establishing next-generation obesity portfolio with petrelintide as a cornerstone[2]

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

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]Roche's Annual Report 2024; [2]Roche Pharma Day 2025.

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.

Survodutide[a] is in Phase 3 development for obesity and MASH with first- and best-in-class potential

Design of molecule

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

- MoA reduces body weight by **increasing energy expenditure** and **regulating appetite**[1]
- Deliberately designed with **strong bias towards GLP-1** receptor (8:1 receptor bias vs glucagon)[2]
- Extended half-life for **once-weekly administration** achieved by amino acid substitutions[2]

Positioning opportunities and differentiation

- **Obesity** – potential for ~20–25% weight loss and improved glycemic control
- **Safety and tolerability** – similar to other GLP-1RA-based weight-loss medications
- **Cardiovascular benefits** – potential benefits driven by GLP-1RA
- **MASH** – potential for important benefit in MASH with direct effect of glucagon on the liver

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

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

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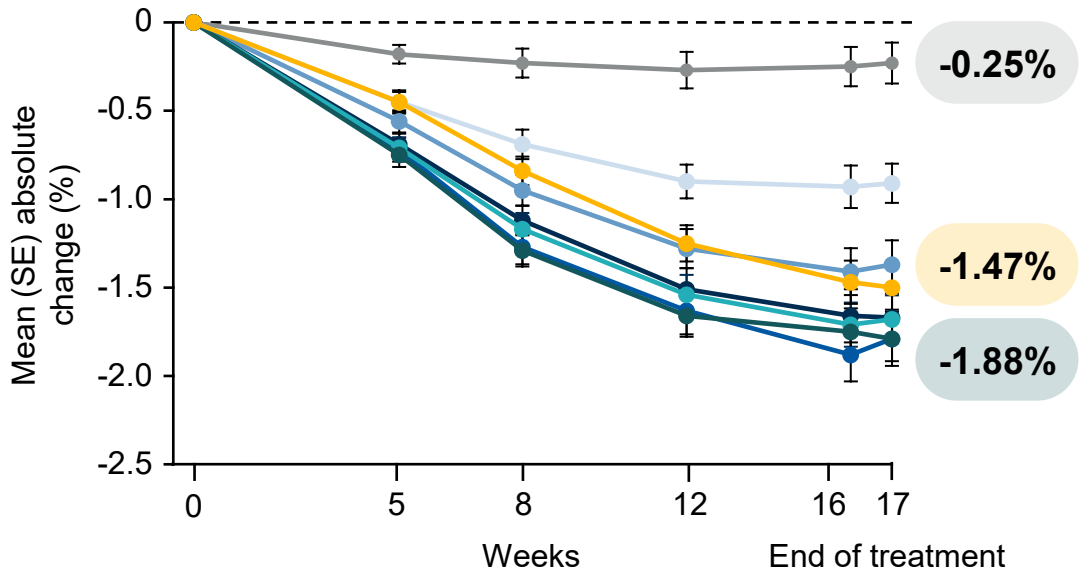
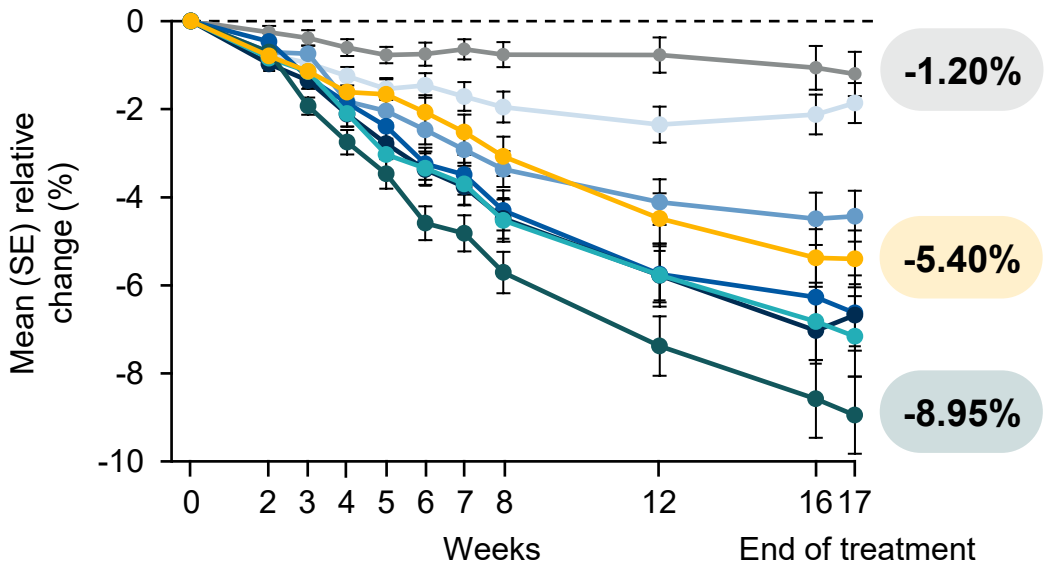
Change in HbA1c



Change body weight



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

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

[a]The semaglutide arm was open-label.
Body weight at baseline was 93.0–100.1 kg and HbA1c at baseline was 7.9–8.2%.
Survodutide is licensed to Boehringer Ingelheim from Zealand Pharma, with Boehringer solely responsible for development and commercialization globally.
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; T2DM=type 2 diabetes mellitus.

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

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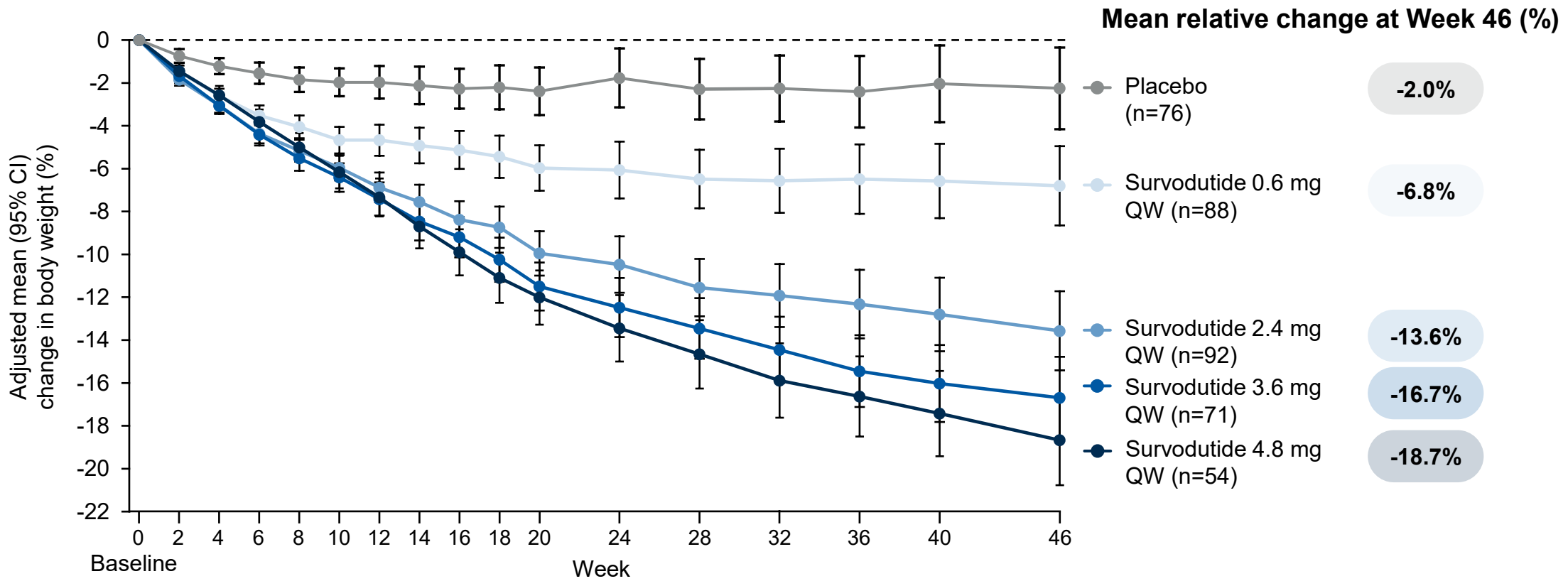
Phase 2 trial of survodutide in people with overweight or obesity



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.
Analysis based on dose reached at the end of treatment regardless of the dose assigned at randomization.
CI=confidence interval; QW=once-weekly.

No unexpected safety findings in the Phase 2 obesity trial with survodutide

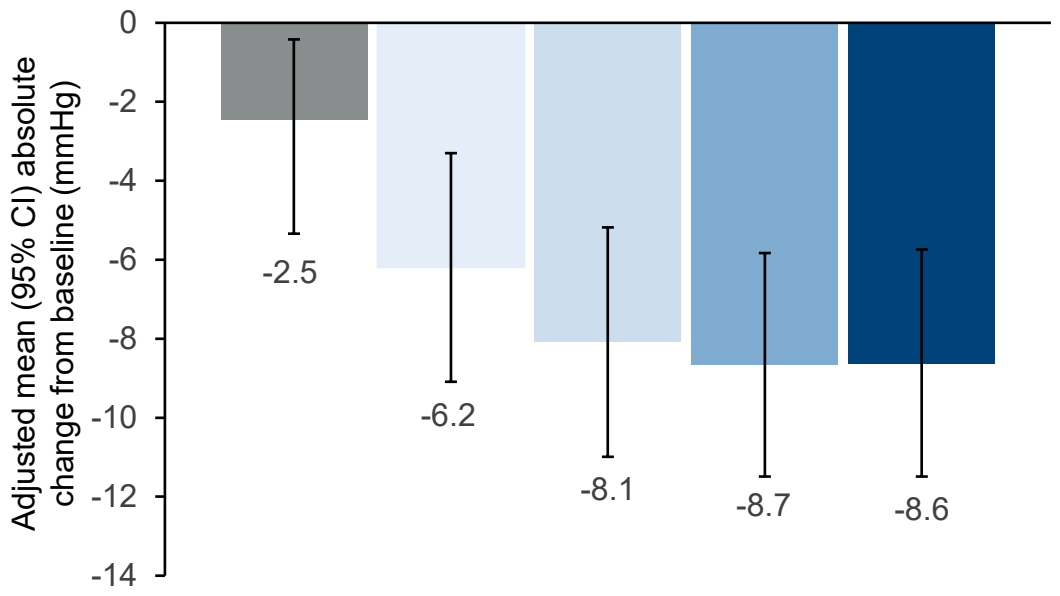
- As expected, **GI disorders were the most frequent drug-related AEs**
- Most treatment discontinuations occurred during the **rapid dose escalation** phase (up to Week 20) and may be **mitigated with more gradual dose-escalation**

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

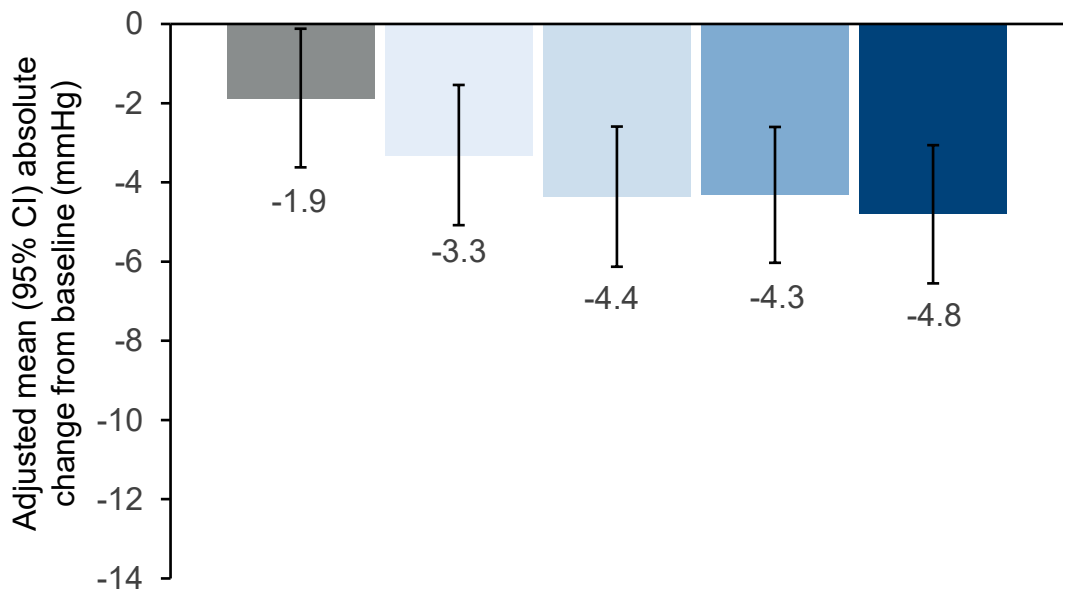
Survodutide is licensed to Boehringer Ingelheim from Zealand Pharma, with Boehringer solely responsible for development and commercialization globally.
[b]Based on the treated set and presented according to planned treatment. TEAEs listed according to preferred term and occurred in ≥20% patients in any treatment arm.
Source: Table adapted from Le Roux et al. Oral presentation (51-OR) at ADA 83rd Scientific Sessions, San Diego, June 23–26, 2023.
AE=adverse event; GI=gastrointestinal; TEAE=treatment-emergent adverse event.

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

Change in systolic blood pressure at Week 46



Change in diastolic blood pressure at Week 46



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

Mean blood pressure at baseline across cohorts: 122.6–127.5 mmHg for systolic blood pressure; 80.5–82.4 mmHg for diastolic blood pressure.
Survodutide is licensed to Boehringer Ingelheim from Zealand Pharma, with Boehringer solely responsible for development and commercialization globally.
Source: Figures adapted from Le Roux. Presentation at the 59th EASD Annual Meeting, October 2–6, 2023, Hamburg, Germany.
CI=confidence interval; QW=once-weekly.

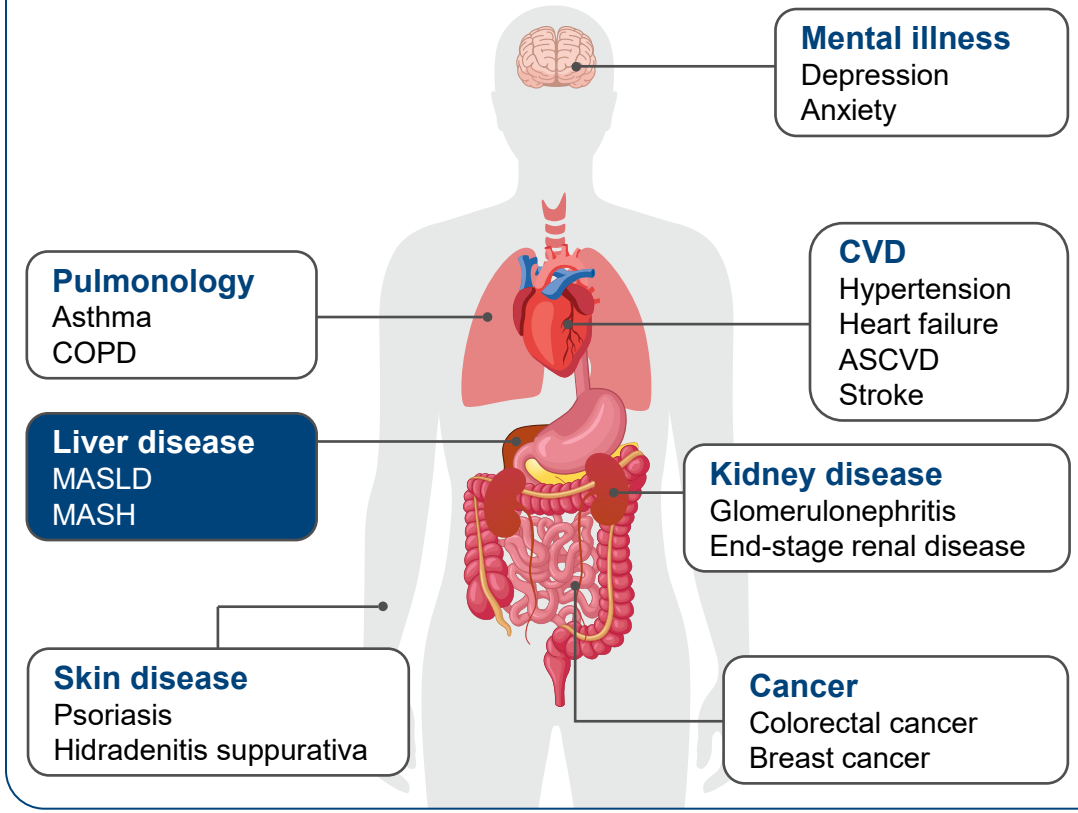
Results from first Phase 3 obesity trials with survodutide[a] expected in H1 2026

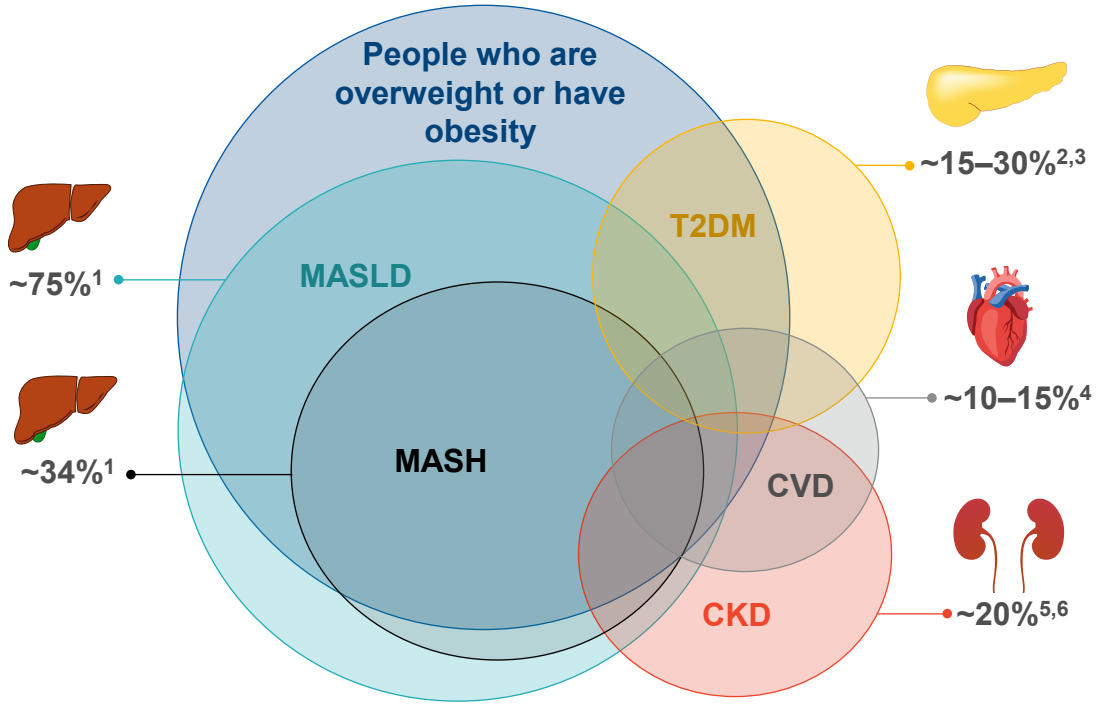
	Inclusion criteria	Study design	Primary endpoint
SYNCHRONIZE™-1[1] Efficacy and safety in patients with obesity without T2DM	• HbA1c <6.5% (no history of diabetes) • BMI ≥30 or BMI ≥27 with comorbidities[b]	• N=727 • 1:1:1 ratio (3.6 mg, 6.0 mg, or placebo) • Trial duration: 76 weeks	• Percentage change in body weight from baseline to Week 76 • Achievement of body weight reduction ≥5% from baseline to Week 76
SYNCHRONIZE™-2[2] Efficacy and safety in patients with obesity and T2DM	• HbA1c ≥6.5% and <10% • BMI ≥27 • T2DM managed with diet and exercise alone or with stable pharmacological treatment	• N=756 • 1:1:1 ratio (3.6 mg, 6.0 mg or placebo) • Trial duration: 76 weeks	• Percentage change in body weight from baseline to Week 76 • Achievement of body weight reduction ≥5% from baseline to Week 76
SYNCHRONIZE™-CVOT[3] Long-term CV safety in patients with obesity and established CVD/CKD or risk factors for CVD	• BMI ≥27 with CVD and/or at least two weight-related risk factors for CVD, or • BMI ≥30 with CVD/CKD and/or at least two weight-related factors for CVD	• N=5,550 • 1:1:1 ratio (3.6 mg, 6.0 mg or placebo) • Trial duration: up to 114 weeks	• Time to first occurrence of any of five major adverse cardiac events (5P-MACE) to demonstrate non-inferiority

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

There is a significant overlap between obesity and liver disease

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





Estimates of overlap of co-morbidities are not available in literature; approximation in figure is based on individual prevalence estimates.
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.
ASCVD=atherosclerotic cardiovascular disease; CKD=chronic kidney disease; COPD=chronic obstructive pulmonary disease; CVD=cardiovascular disease; MASLD=metabolic dysfunction-associated steatotic liver disease (formerly, NAFLD, or non-alcoholic fatty liver disease); MASH=metabolic dysfunction-associated steatohepatitis (formerly, non-alcoholic steatohepatitis, or NASH); T2DM=type 2 diabetes mellitus.

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

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

N=295

R

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

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

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

Secondary endpoints:

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

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

In the Phase 2 MASH trial, survodutide[a] showed best-in-class potential

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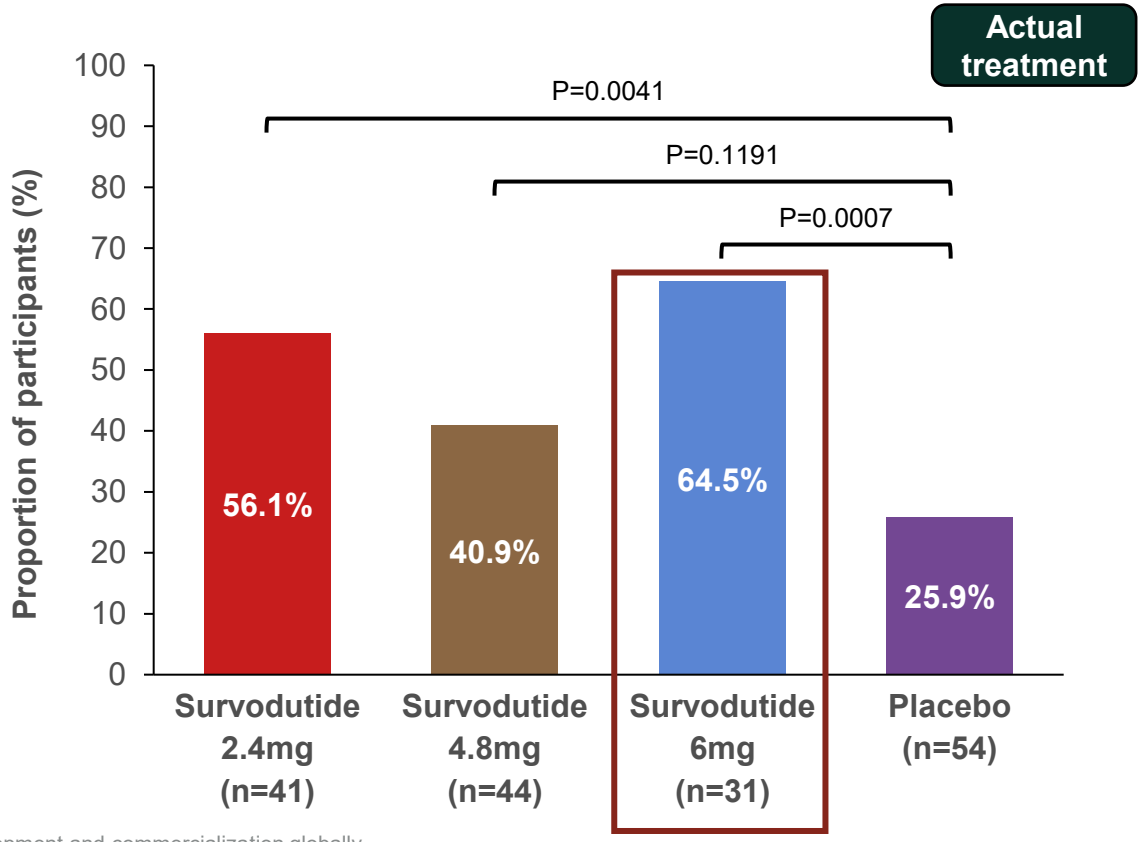
48-week biopsy-driven Phase 2 MASH trial[1]

- Participants showing **improvement in MASH** without worsening of fibrosis (stages F1-F3): **83.0% with survodutide** vs 18.2% with placebo (p<0.0001)
- Participants showing **improvement in liver fibrosis** with no worsening of MASH (stages F2-F3): **64.5% with survodutide** vs 25.9% with placebo (p=0.0007)
- Survodutide treatment **did not show unexpected safety or tolerability issues**, including at the higher dose of 6.0 mg
- Boehringer received **U.S. FDA BTD for survodutide** in MASH and fibrosis (stages F2-F3), and **launched two Phase 3 trials**[3] in MASH with survodutide

Improvement in liver fibrosis with no worsening of MASH

Paired biopsy results (F2/F3)[2]



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

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

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

The largest Phase 3 program in MASH with an incretin-based therapy is ongoing

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

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

Survodutide is backed by a global leader in CVRM R&D, manufacturing and commercial execution

ZEALAND PHARMA

Boehringer Ingelheim

Boehringer Ingelheim

Global footprint with ~54,500 employees in **130 markets**[1]

66 million patients reached in 2024[2]

EUR 26.8 billion net sales in 2024[2]

Innovation and leadership in CVRM

Jardiance: World's best selling SGLT-2 inhibitor[2,4,b]

- EUR 8.3 billion net sales in 2024[2]
- First to show CV safety and cardioprotective benefits in CVOT with glucose-lowering agent[3,b]

Key terms of survodutide licensing agreement

- BI 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

Boehringer Ingelheim

Survodutide is licensed to Boehringer Ingelheim from Zealand Pharma, with Boehringer solely responsible for development and commercialization globally.
[a]Jardiance is approved for the treatment of T2D, symptomatic chronic heart failure, and chronic kidney disease: https://www.accessdata.fda.gov/drugsatfda_docs/label/2023/204629s040lbl.pdf; [b]Based on FY 2024 sales (vs. Farxiga).
Sources: [1]Boehringer Ingelheim – Who we are (https://www.boehringer-ingelheim.com/about-us/who-we-are), accessed August 2025; [2]Boehringer Ingelheim 2024 Highlights (https://www.boehringer-ingelheim.com/annualreport/2024/facts-and-figures/), accessed August 2025; [3]Davies et al. (2022), Cardiovasc Diabetol. 2022 Aug 4;21:144; [4]AstraZeneca 2024 FY Report, accessed August 2025;
CVRM=cardiovascular, renal and metabolic disease; R&D=research and development; T2D=type 2 diabetes; CVOT=cardiovascular outcomes trial; SGLT-2=sodium-glucose cotransporter-2.

Development of dapiglutide paused due to 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 grater 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

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

A potential GLP-1R/GLP-2R dual agonist for obesity and low-grade inflammation

ZEALAND PHARMA

Design of molecule

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

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

Demonstrated competitive weight loss[4]

- Mean **placebo-adjusted weight loss** of **11.4%** after **28 weeks** with doses up to 26 mg
- N=30, **93% male**, median baseline **BMI 28.8 kg/m²**
- **No lifestyle modifications** included in trial
- **Safety** and **tolerability** in line with other incretin-based therapies
- Two **treatment discontinuations** due to TEAEs, **one related to GI events**

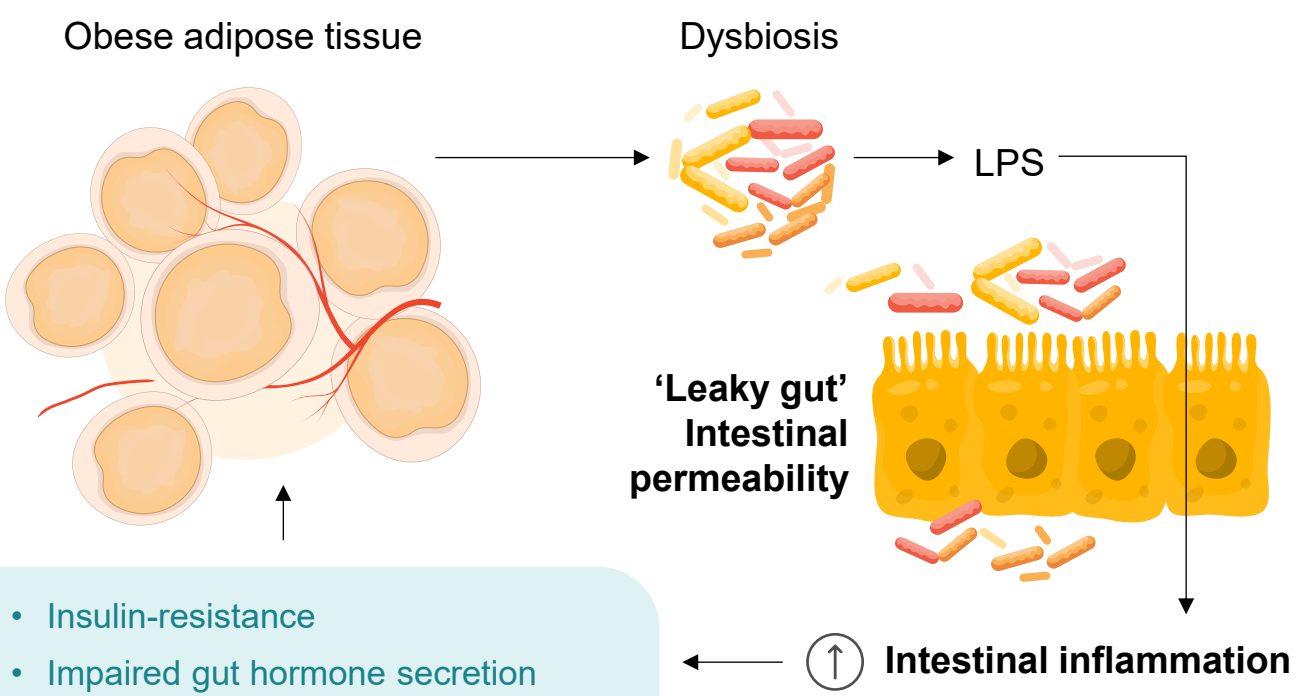
Sources: [1]Drucker & Yusta. Annu Rev Physiol 2014;76:561–583; [2]Reiner et al. JPEN J Parenter Enteral Nutr 2022;46(5):1107–1118; [3]Data presented by Agersnap at the 82nd ADA Scientific Sessions, June 3–7, 2022; [4]Zealand Pharma company announcement No. 15/2025, June 18, 2025

GLP-1=glucagon-like peptide-1; GLP-1R=glucagon-like peptide-1 receptor; GLP-2=glucagon-like peptide-2; GLP-2R=glucagon-like peptide-2 receptor; MASH=metabolic dysfunction-associated steatohepatitis (formerly, non-alcoholic steatohepatitis, or NASH); IBD=inflammatory bowel disease

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

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

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

Zealand is prepared to resubmit Part 1 of the original NDA related to dosing of up to three weeks[7]

Submission of Part 2 of the original NDA related to dosing beyond three weeks is planned for after Part 1 resubmission[7]

IP exclusivity: compound patent US 2035 and EU 2039

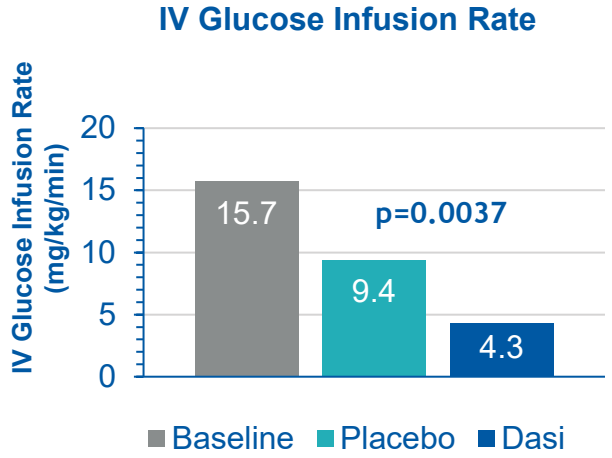
Sources: [1]Yorifuji et al. Clin Pediatr Endocrinol 2017;26(3):127-152; [2]Proglycem. Package insert. Teva Pharmaceuticals; 2015; [3]Gray KD et al. J Perinatol. 2018;38(11):1496-1502; [4]Haris et al. Therapeutic Adv Endocrinology Metabolism 2020;11:1-23; [5]Zealand Pharma, Physician Market Survey, 2020; [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

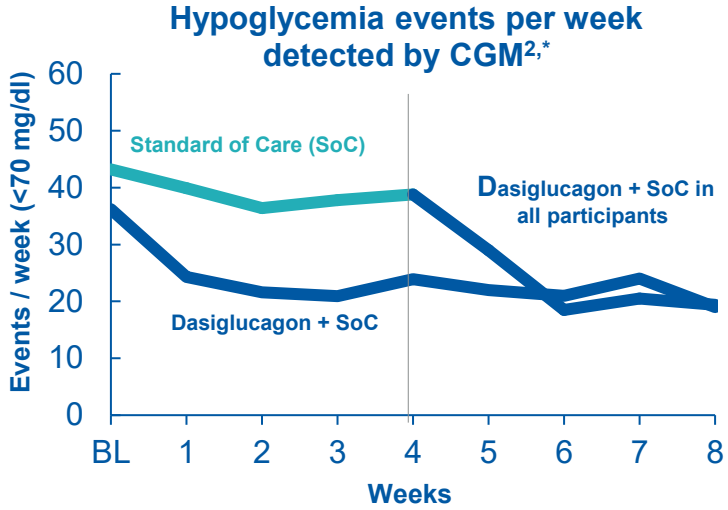
Part 1: Placebo control, crossover x 48 hours[1]



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

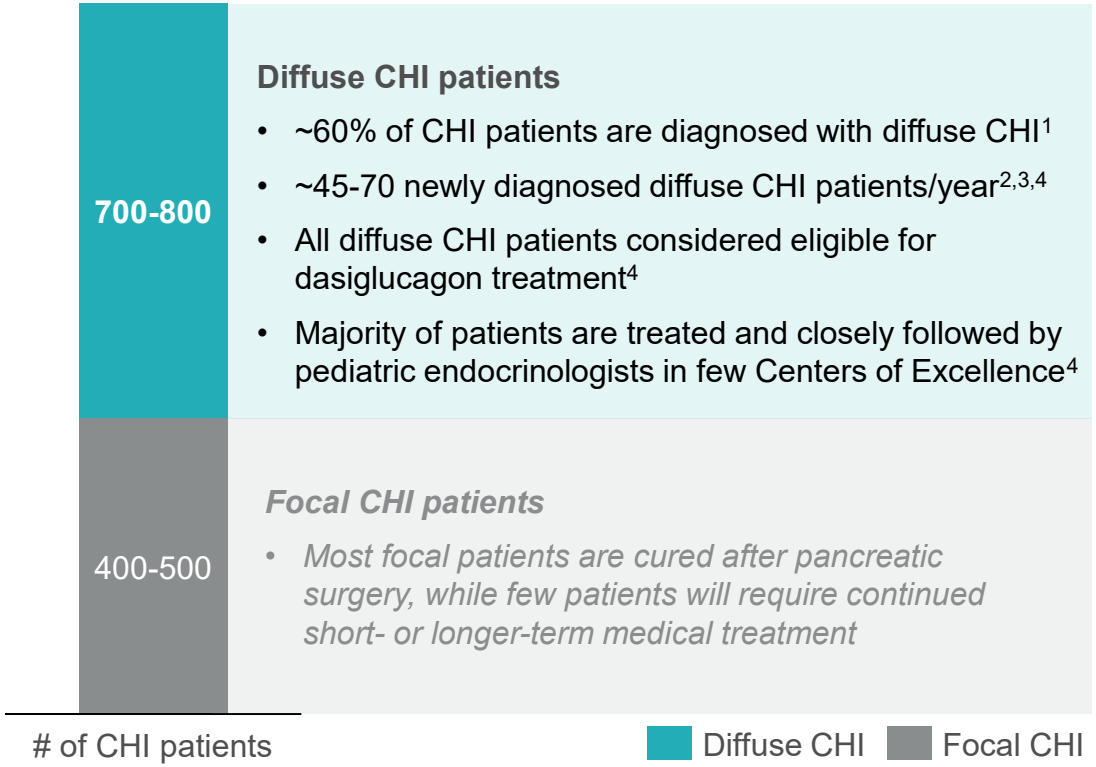
- Assessed as generally well tolerated in both trials
- Skin reactions and gastrointestinal disturbances most frequently reported adverse events

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



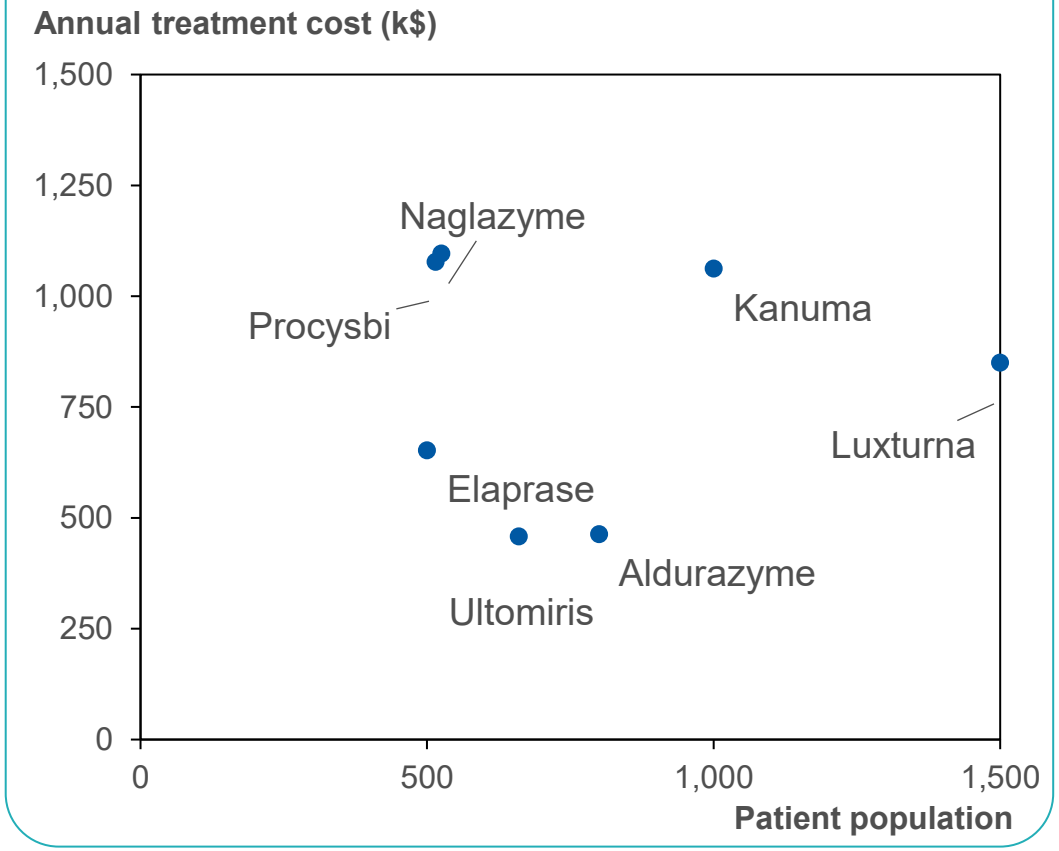
Diffuse CHI patients

- ~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]

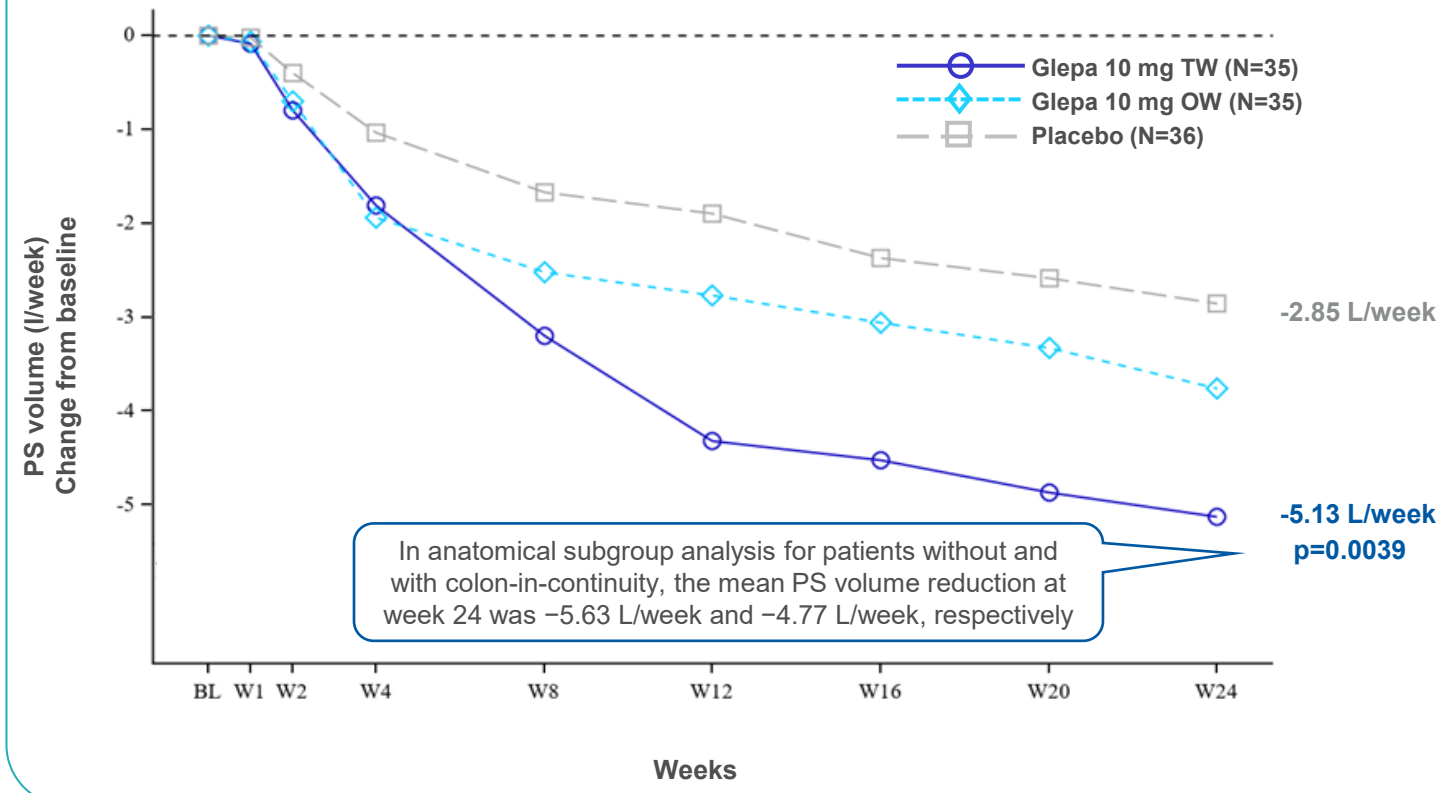
Glepaglutide: a long-acting stable GLP-2 analog[a]

- 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
- An MAA to the EMA was submitted in June 2025
- Second Phase 3 trial to be initiated in 2025 (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
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

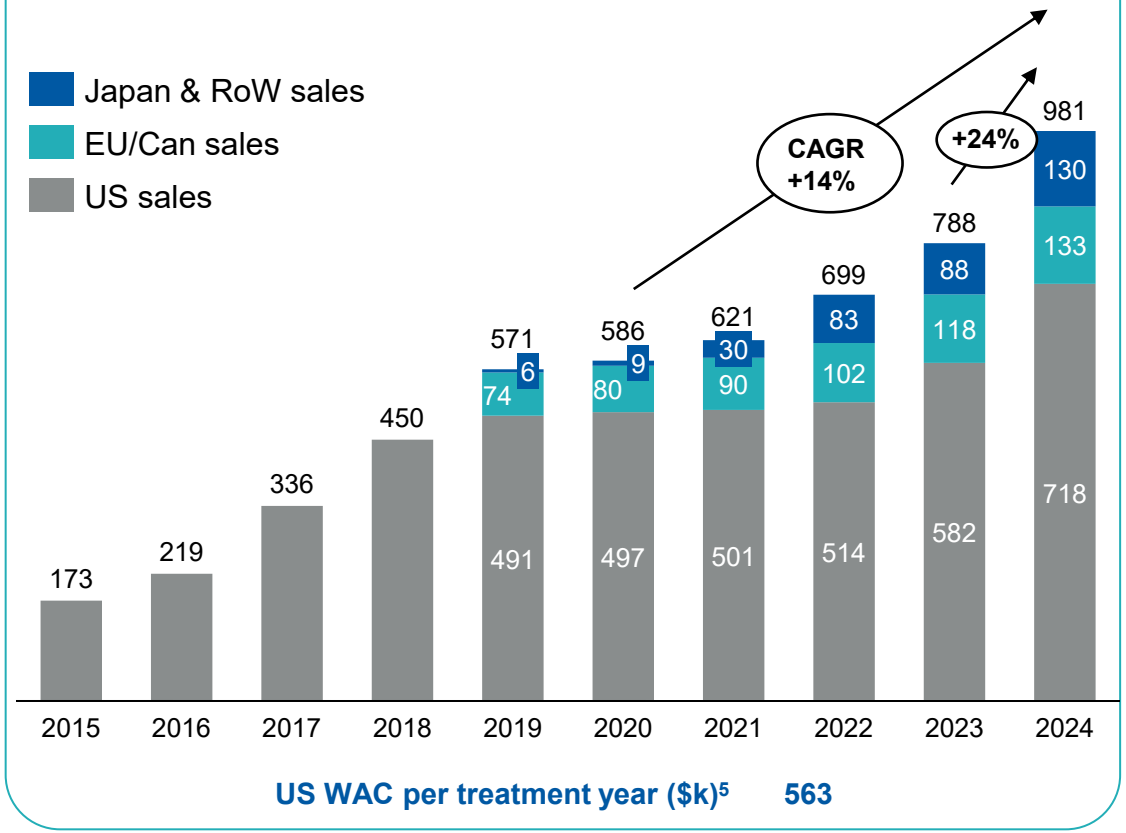
Glepaglutide appeared to be well-tolerated in the trial

- 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

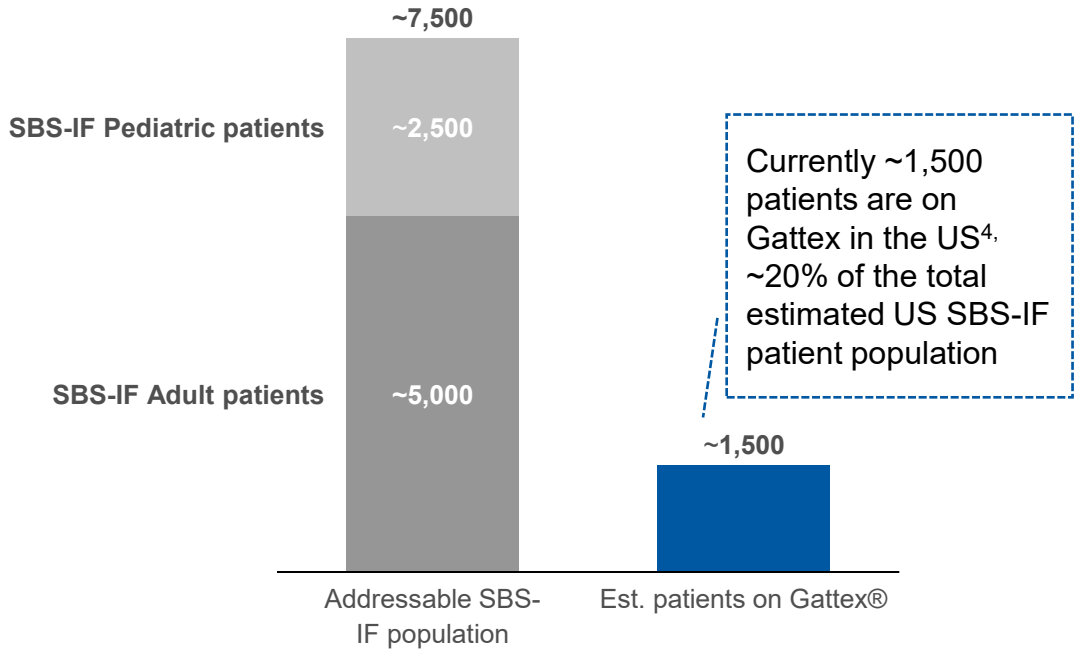
Global teduglutide sales approaching USD 1 billion with significant room for market expansion

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



US WAC per treatment year ($k)[5] 563

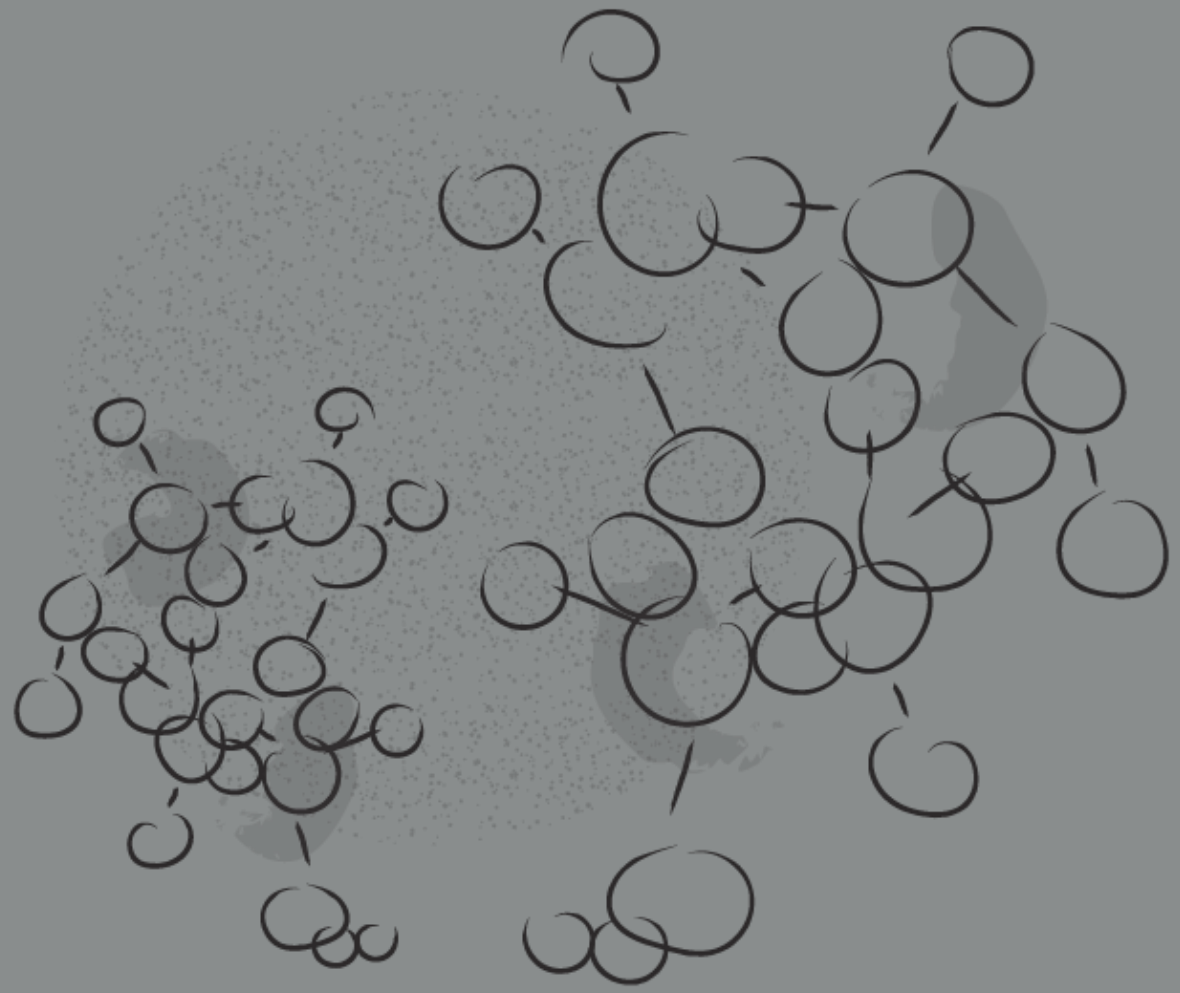
Estimated US SBS-IF Patients[3]



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



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

Kv1.3 blocker (ZP9830)

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

Complement C3 inhibitor (ZP10068)

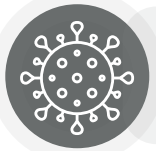
- Investigational, long-acting inhibitor of Complement C3, which has the potential to treat a broad range of complement-mediated diseases
- In 2023, Zealand completed activities to support advancing ZP10068 into the first-in-human clinical trials
- Zealand will assess the potential next steps for ZP10068[3]

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

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**

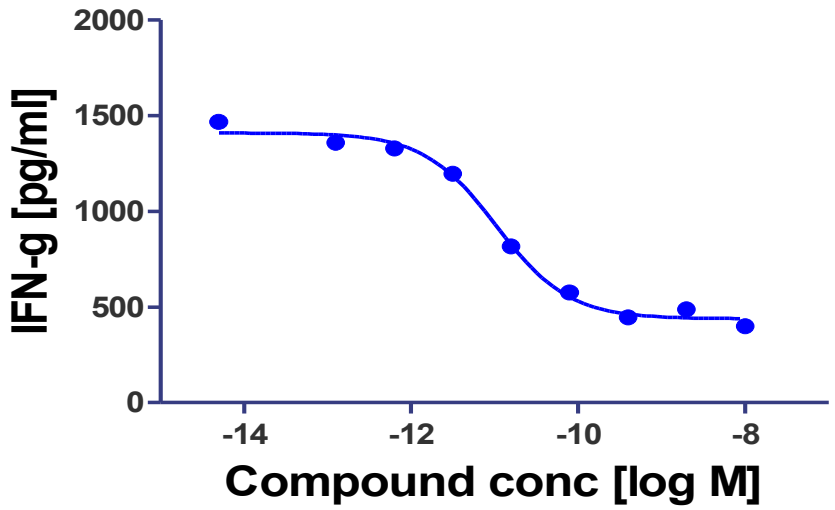
ZP9830 is a **potent** and **selective Kv1.3 inhibitor** with potential to treat a **broad range** of **cell-mediated autoimmune diseases**. First-in-human clinical trial initiated in Q4 2024[4]

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.

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

Anti-inflammatory effects of Kv1.3 ion channel inhibition

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



First-in-human SAD clinical trial[2]

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

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

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

Cohort 10 (IV): Assess safety and PK

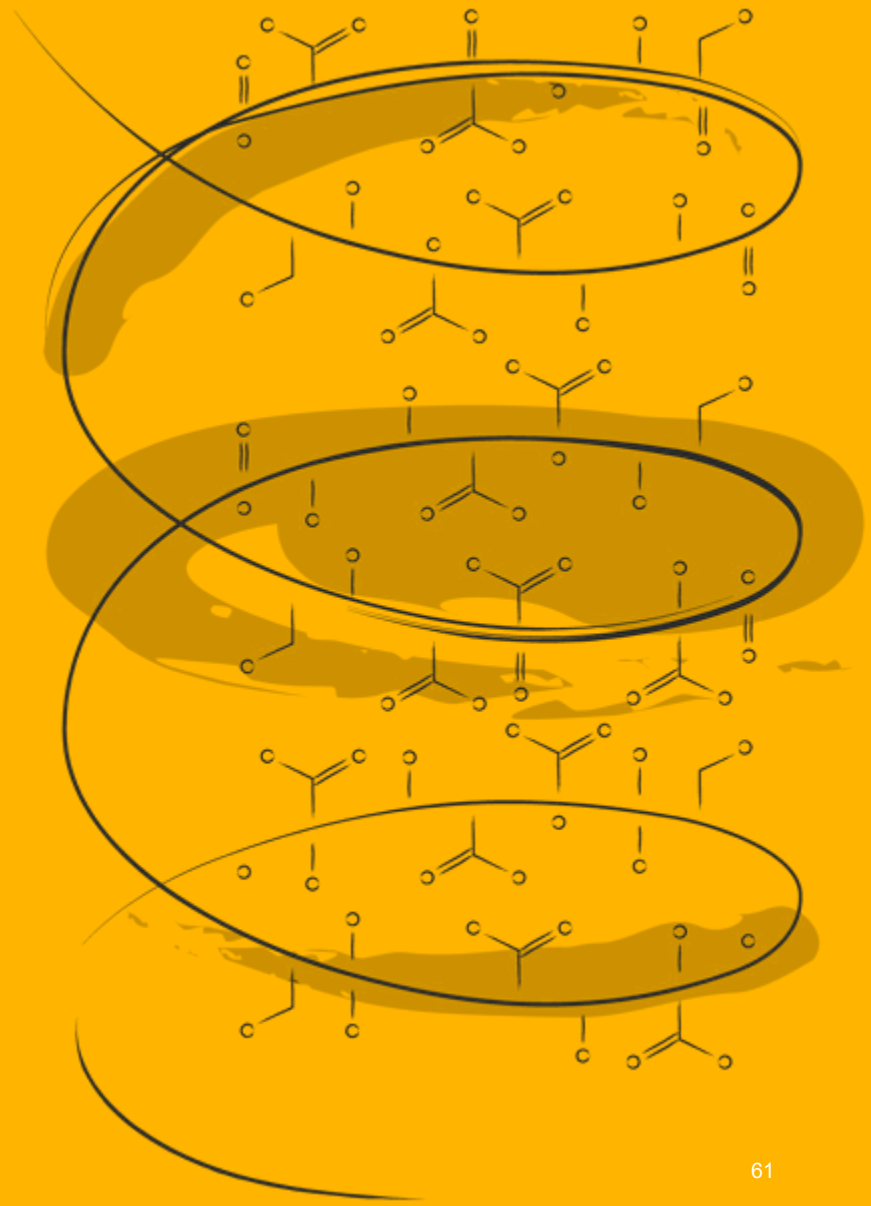
The trial will investigate:

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

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

Additional company information

Corporate Presentation



Q3 2025 YTD Profit & Loss

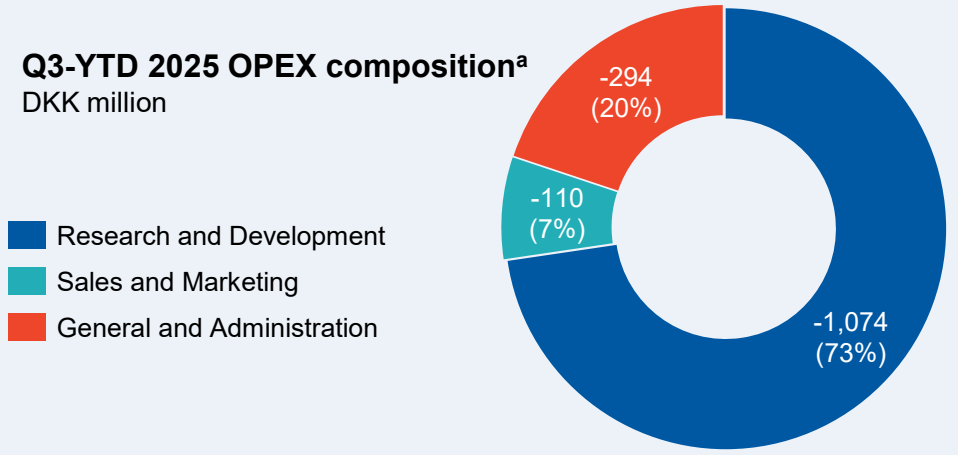
DKK million	Q3-25 YTD	Q3-24 YTD
Revenue	9,145.9	53.6
Gross profit	**9,145.1**	**46.2**
Research and development expenses	-1,074.5	-665.9
Sales and marketing expenses	-110.3	-50.2
General and administrative expenses	-293.9	-199.8
Other operating items[a]	-	-3.1
Net operating expenses[a]	**-1,478.6**	**-919.1**
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**

[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.

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

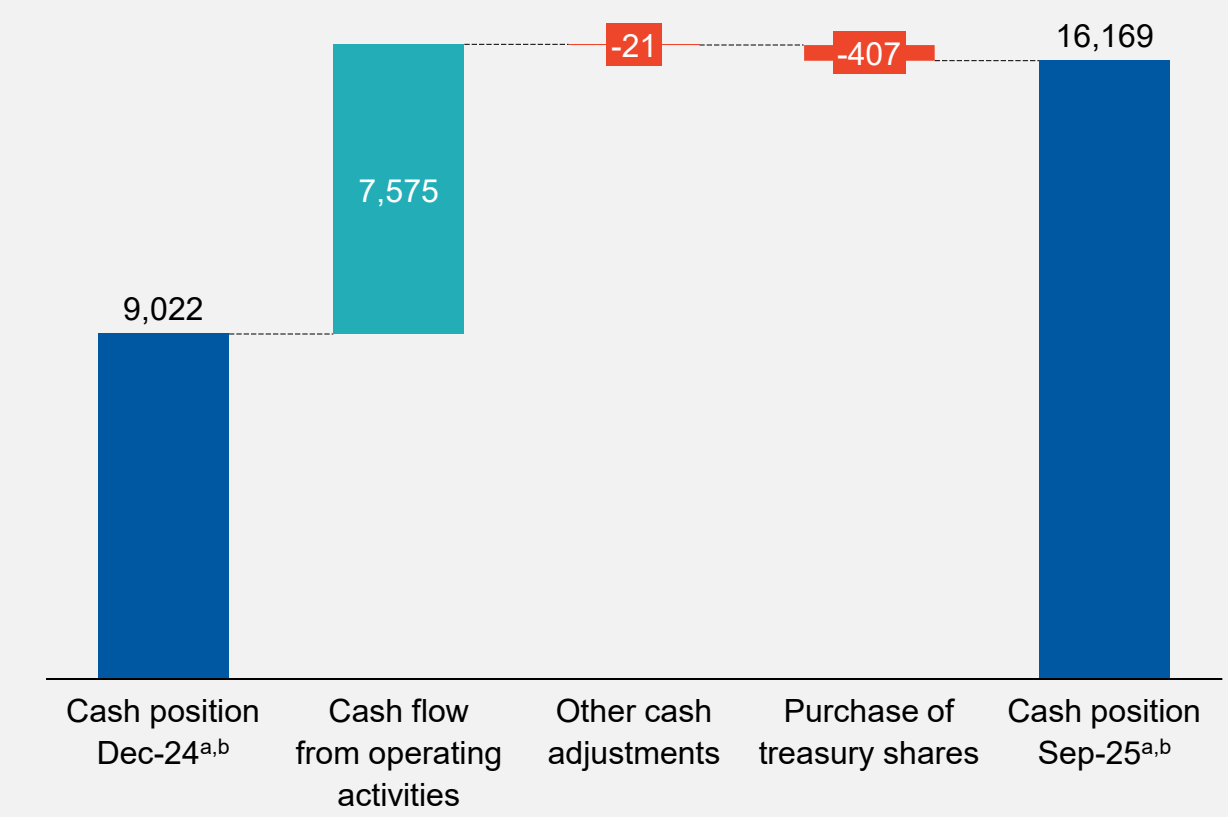
- Revenue of DKK 9,146 million is driven by the initial upfront payment under the partnership agreement with Roche for petrelintide.
- R&D expenses of DKK 1,074 million, representing 73% of the cost base, are mainly driven by development costs for the mid-stage obesity assets, whereas S&M expenses of 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



Zealand Pharma is very well-funded, providing a strong foundation ahead of major upcoming catalysts

Solid financial position with ample room for investments in the R&D pipeline



Potential near-term cash inflows

- USD 250 million in anniversary payments
- USD 1.2 billion in potential development milestones, mainly linked to initiation of Ph3 trials with petrelintide monotherapy[c]

Strong capital preparedness

- Honor cost obligations under Roche partnership for petrelintide
- Invest significantly in early-stage research pipeline
- Zealand Pharma has no costs associated with the development and commercialization of survodutide

[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]Zealand Pharma will pay Roche USD 350 million for the contribution of CT-388 in the first combination product arising from the collaboration.
EIB=European Investment Bank.

2025 financial guidance

DKK million	2025 Guidance as of November 13, 2025	2025 Guidance as of February 20, 2025	2024 Actuals
Revenue anticipated from existing and new license and partnership agreements	No guidance	No guidance	63
Net operating expenses[a]	2,000 – 2,300	2,000-2,500	1,327

[a]Net operating expenses consist of R&D, S&M, and G&A, and excludes Other operating items.
Financial guidance based on foreign exchange rates as of November 12, 2025.

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