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Capital Markets and R&D Day 2022

Camurus today and five-year vision

IVA Conference Center, Stockholm
6 September 2022

Today's presenters

Fredrik Tiberg
PhD, Assoc. Prof.
President & CEO

Jon G. Alonso
Chief Financial Officer

Richard Jameson
Chief Commercial Officer

Lenka Katila
MD, Anesthesiologist, pain physician, Uppsala University Hospital, Akademiska sjukhuset

Diego Ferone
MD, PhD, Prof. Endocrinology, Internal Medicine and Medical Specialties, University of Genoa

Samantha Nickerson
General Manager,
UK & Ireland

Peter Hjelmström
MD, PhD, Assoc. Prof
Chief Medical Officer

Markus Johnson
PhD, Senior Vice President R&D

Simron Singh
MD, MPH, Sunnybrook Health Science center, Toronto;
Assoc. Prof. University of Toronto

Lars Frick
Moderator

Forward looking statements

This presentation contains forward-looking statements that provide our expectations or forecasts of future events such as new product developments and regulatory approvals and financial performance.

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Camurus undertakes no obligation to update forward-looking statements

Today's agenda

13:00	Welcome and introductions, *Lars Frick*
13:05	Camurus today and the path forward – realizing opportunities, *Fredrik Tiberg*
13:35	Financial outlook, *Jon Garay Alonso*
13:45	Establishing market leadership in opioid dependence treatment *Richard Jameson & Samantha Nickerson*
14:15	Q&A, *Lars Frick*
14:30	Coffee break
14:45	Buvidal® life cycle management and chronic pain *Peter Hjelmström & Guest Speaker Dr. Lenka Katila*
15:25	Late-stage pipeline – bringing octreotide SC depot (CAM2029) to registration in three rare disease indications *Markus Johnsson & Guest Speakers Dr. Diego Ferone and Dr. Simron Singh*
16:30	Concluding remarks, *Fredrik Tiberg*
16:45	Q&A, *Lars Frick*
17:00	Meet the team & refreshments

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Camurus today and the path forward

Fredrik Tiberg, Ph.D., Assoc. prof.

President & CEO, Camurus

Camurus snapshot

Rapidly growing commercial stage company

With Buvidal® weekly and monthly injections

Strong financial performance

Entering profitability in 2022

Advancing late-stage pipeline with blockbuster potential

Prospects for several new approvals in coming years in CNS and rare disease indications

Unique FluidCrystal® technology platform

Commercially validated, with a broad range of applications

LISTED ON NASDAQ STOCKHOLM
TICKER **CAMX**; EMPLOYEES: **167**

Robin, social worker and
Will, Buvidal patient
Wales UK

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Medications with best-in-class potential

Focusing underserved patient groups with high unmet medical needs

Leveraging our strong development expertise and leading technologies

CNS
Addiction
Pain

Rare disease
Endocrinology
Oncology

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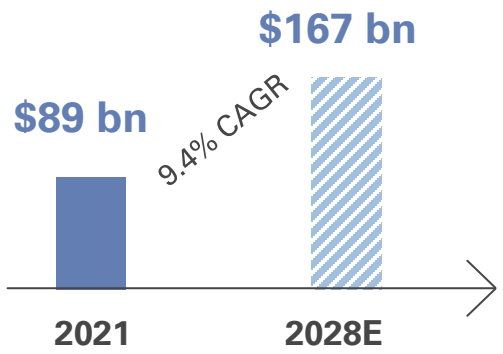
CNS and rare disease markets expected to grow

CNS

– Aging population and growing addiction and mental health issues fuels demand[1]
– 90% global market growth to 2028[1]



Rare disease

– Large treatment gap and unmet need[2]
– Shorter clinical development times[3]
– Higher probability of approval[4]
– Global market set to grow by >60% in 5 years[5]

Only 5% of rare diseases have an effective treatment[6]

> 400 million worldwide have a rare disease[6,7]

[1] www.fortunebusinessinsights.com/central-nervous-system-treatment-market-103973; [2] ec.europa.eu/research-and-innovation/en/horizon-magazine/building-blocks-make-rare-disease-treatments-more-common; [3] Orphan drug development: an economically viable strategy for biopharma R&D, Meekings, Williams & Arrowsmith, 2012; [4] Estimation of clinical trial success rates and related parameters, C. Wong, K. Siah, A. Lo, Biostatistics 2019; [5] www.globenewswire.com/en/news-release/2022/07/07/2475583/28124/en/229-7-Billion-Worldwide-Orphan-Drugs-Industry-to-2031-Identify-Growth-Segments-for-Investment.html [6] de Vrueh R, et al. Priority medicines for Europe and the world: "A public health approach to innovation." WHO Background Paper 6.19. Rare Diseases; 2013. http://www.who.int/medicines/areas/priority_medicines/BP6_19Rare.pdf. ; [7] Global Genes, RARE Disease Facts: https://globalgenes.org/rare- disease-facts/.

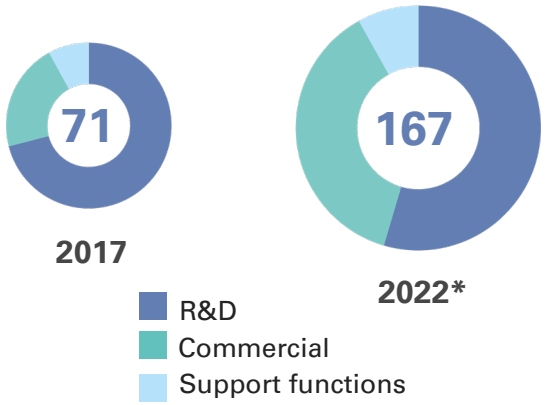
Track record of strong development and business progress

Transformation and commercial execution

Corporate development

- Transformation from R&D company to a fully integrated, pharmaceutical company
- Infrastructure across Europe and in Australía

Number of employees

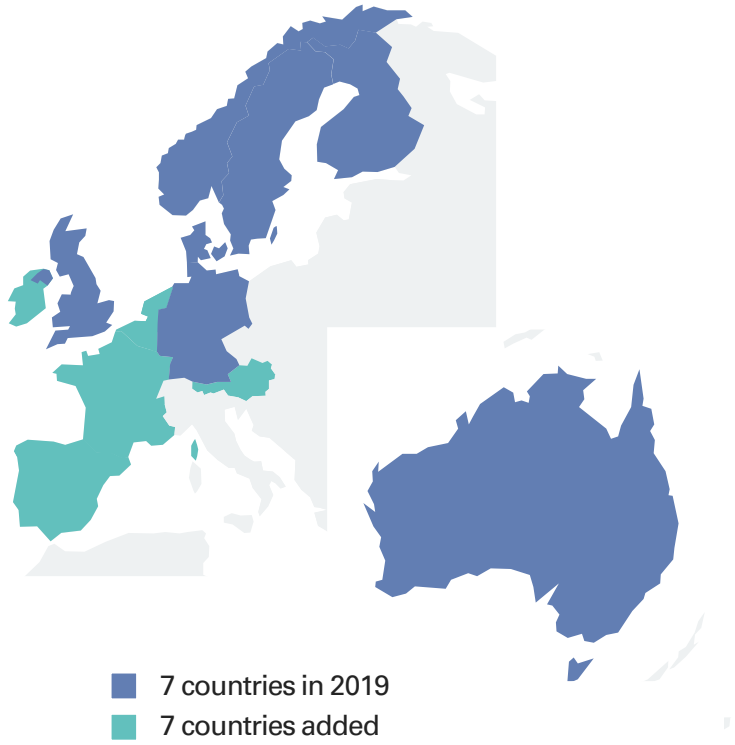


Commercial execution

- Successfully launched Buvidal in opioid dependence
- Secured access in key markets
- **Emerging leader in opioid dependence treatment**

12 quarters of double-digit sales growth

Own commercial organization*



** Coverage as of August 2022*

Solid R&D and financial performance

Pipeline progress

- Nine market approvals (centralized and national)
- Life-cycle management approvals
- Advanced four pipeline programs to Phase 3 or registration phase

Solid financial performance

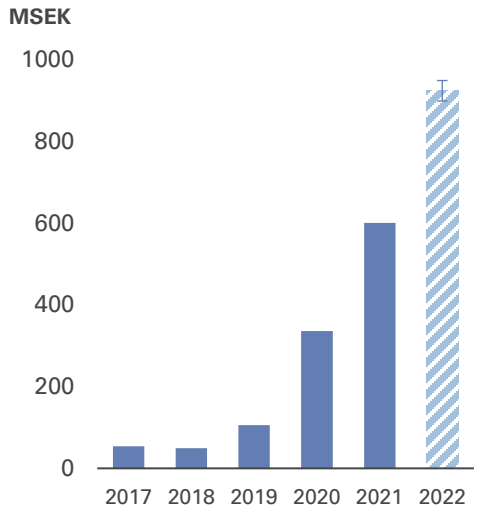
- Strong revenue growth
- Enter profitability in 2022
- Solid cash position and no debt

11 completed clinical trials

1.3 billion SEK invested in pipeline

Grew market capital from SEK 5 to 12 bn

Revenue*



** Forecasted 2022 revenue (Company outlook) excl. potential US milestone payments*

Five-year vision

5-year vision

Commercial

- 5x revenue growth
- Establish commercial infrastructure in the US

R&D pipeline

- Approvals for 4 new programs

Corporate

- ~50 percent operating margin

Sustainable value to all stakeholders

Strategic levers for realizing our vision

- Commitment to sustainable value creation
- Buvidal market penetration
- Expand to new geographies and indications
- Advance in-house pipeline to new approvals and launches
- Grow and diversify through business development

Comprehensive ESG agenda

- Sustainability materiality assessment completed
- Strategy and reporting aligned with UN SDGs
- Camurus awarded Carnegie's 2021 Sustainability Award

Focus areas

Patients

People

Planet

Responsible business

ESG – Environmental, social and governance; SASB – Sustainability Accounting Standards Board

Recent sustainability initiatives

Improving access to treatment

Collaboration with Ukraine Ministry of Health and WHO regarding request for humanitarian aid donation of Buvidal for ODT

Reducing patient stigma

Supported global campaigns around reducing stigma for patients with opioid dependence and rare diseases

Employee wellbeing

New employee survey and follow-up with positive results

Strengthening compliance framework

Appointment experienced Head of Compliance

ODT – Opioid dependence treatment

Opioid dependence – a global health crisis

Largest society burden of all drugs[1]

– 61 million opioid users worldwide[1]
– Increasing problems during COVID-19

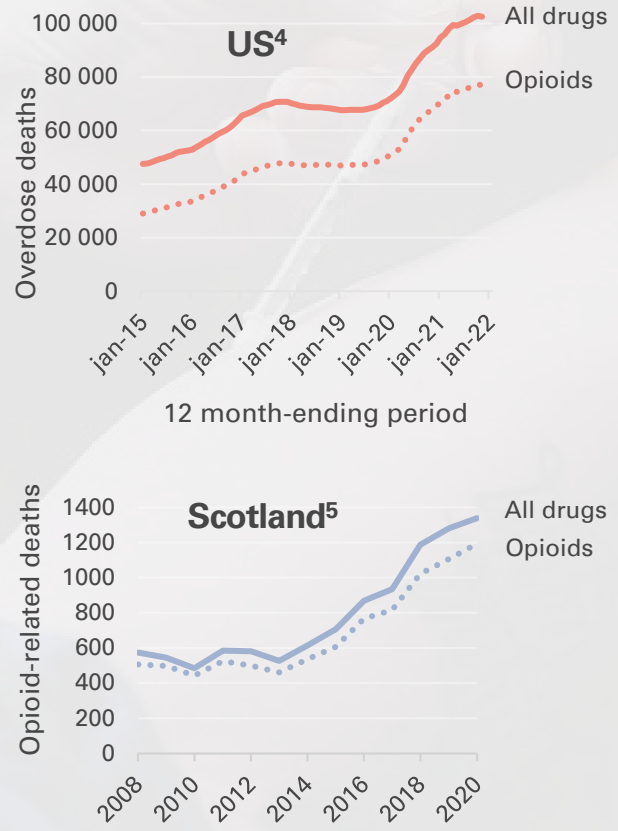
High need for access to care and new treatment alternatives

– Long-acting injections a new paradigm in opioid dependence treatment

Significant limitations with current daily medications

– Diversion, misuse, risk of overdose, poor retention, burdens and stigma of daily medications

Escalating opioid overdose deaths



[1] United Nations: World drug report 2022 [2] SAMSHA; [3] EMCDDA; [4] www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm
[5] https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/deaths/drug-related-deaths-in-scotland/2020

BUVIDAL MARKET PENETRATION IN OPIOID DEPENDENCE TREATMENT

Buvidal uptake driven by a high unmet medical need

Demonstrated benefits to patients and society

- Superior treatment outcome and patient satisfaction[1-3]
- Reduced treatment burden and improved quality of life[3,4]
- Decreased risk of diversion, misuse and pediatric exposure[5,6]
- Reduced treatment costs[7]

Expand patients' access to treatment

- Collaborations with physicians, KOL's, policy makers, patient and user groups
- Continue build the scientific evidence base
- Life cycle management and new clinical applications

[1] SmPC Buvidal Sep 2021; [2] Lofwall et al. JAMA Int. Med. 2018;178(6); 764-773; [3] Lintzeris, N., et al. JAMA Network Open. 2021;4(5):e219041. doi:10.1001/jamanetworkopen.2021.9041, [4] Barnett et al Drug and Alcohol Dependence 2021; https://doi.org/10.1016/j.drugalcdep.2021.108959 ; [5] EPAR for Buvidal; [6] Dunlop, A. J., et al. Addiction. 2021. https://doi.org/10.1111/add.15627; [7] Dunlop, A. Oral presentation at CPDD June 2020.

Substantial growth potential in MENA

Large unmet need[1]

- Large untreated populations
- Future challenging problems to MENA countries
- Estimated >3 million opioid users[2] and 0.3 – 1 million injection drug users[3]

Buvidal in MENA

- Early access programs three markets
- New approvals in Saudi Arabia and Egypt – **first approved treatment of opioid dependence**
- Significant untreated populations

MENA – Middle East and North Africa; Sources: [1]ElKashef A. et al.; J Subst Use 2019; 24: 4-7; [2]World drug report 2022; [3]Harm Reduction International Global State of Harm Reduction 2016

US remains a very significant opportunity

High unmet medical need

- Opioid use disorder remains a major issue[1]
- 10 million Americans misuse opioids
- Only 1.4 million patients in treatment[2]

Opportunity for Brixadi™ (Buvidal)[3]

- Large need for new treatment alternatives
- Long-acting injections approaching US$ 800m sales with only ~3% patient share[4]
- Brixadi peak sales estimated to US$ 600m to 1b

Path to US approval

- FDA has issued Brixadi tentative NDA approval
- Waiting for US licensee Braeburn to resubmit NDA
- 2-month or 6-month review time from submission

Brixadi well positioned against competition

LAI features	Sublocade	Vivitrol	Buvidal
Weekly dosing	–	–	✓
Monthly dosing	✓	✓	✓
Multiple doses	–	–	✓
Choice of inj. sites	–	–	✓
Smallest needle	(19G)	(20G)	✓ (23G)
Lowest dose volume	0.5–1.5mL	3.4mL	✓ 0.16–0.64mL
Room temp. storage	–	–	✓
Day one initiation	–	–	✓
Clin. data vs active control*	–	–	✓
Launched	US, CAN, AUS, IL	US	EU, UK, AUS

[1]SAHMSA; [2]Symphony health and Company estimates; [3]Brixadi™ is the US trade name for Buvidal®; [4]Company estimates based on Indivior and Alkermes sales data

EXPANSION TO NEW GEOGRAPHIES AND INDICATIONS

Buvidal indication expansion

Label extension to include chronic pain

- Potential first long-acting injection for treatment of chronic pain
- High unmet medical need, especially in opioid dependent patients
- The pivotal Phase 3 trial sponsored by Braeburn was completed in 2020 with positive results
- Registration processes ongoing in the EU and Australia
- Preparing for launch in 2023

33-55% diagnosed with OD are also affected by chronic pain[1,2]

Estimated Buvidal EU/AUS peak sales €150 million[3]

[1]Delorme J, et al. 2021;12:641430.; [2]Latif ZH, et al. Am J Addict. 2021;30(4):366-75; [3]Company estimate;

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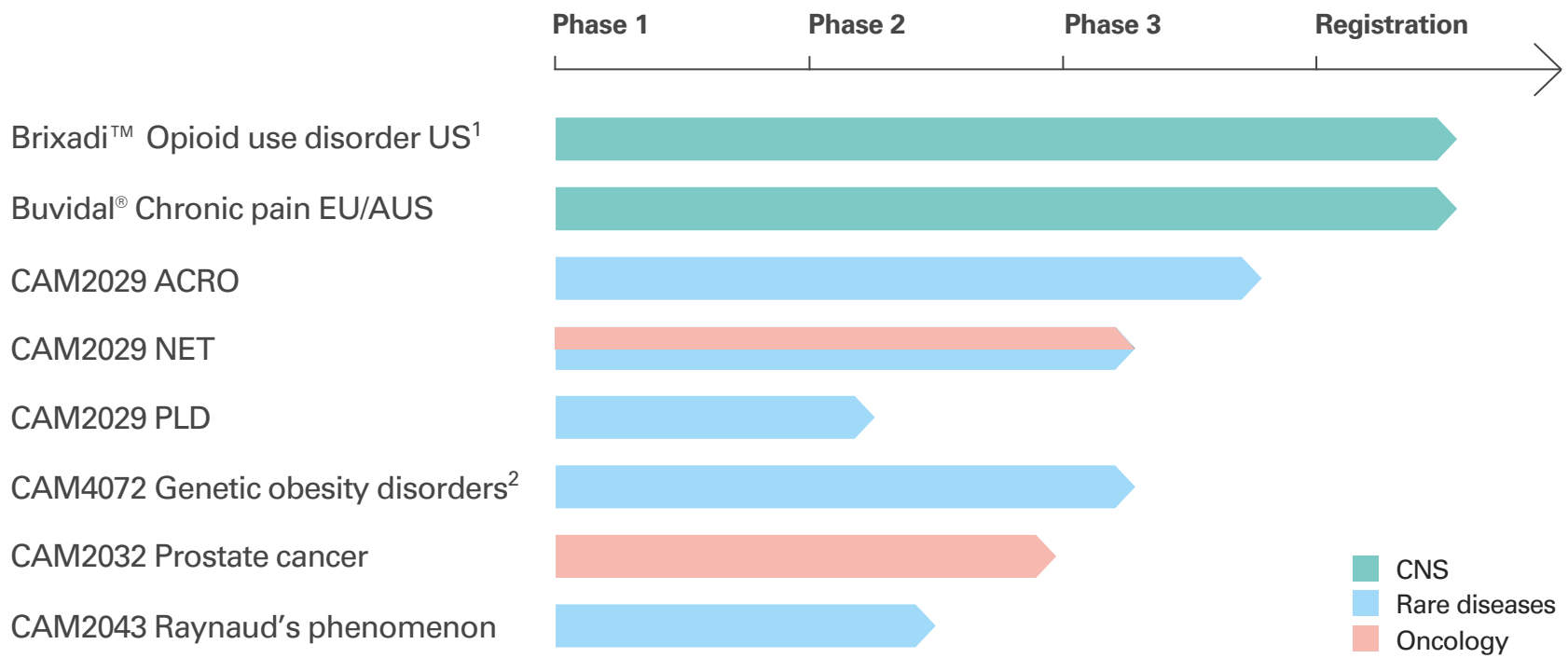
ADVANCE IN-HOUSE PIPELINE TO NEW APPROVALS AND LAUNCHES

Advancing late-stage pipeline



[1]Licensed to Braeburn in North America; [2]Licensed to Rhythm Pharmaceuticals worldwide

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ADVANCE IN-HOUSE PIPELINE TO NEW APPROVALS AND LAUNCHES

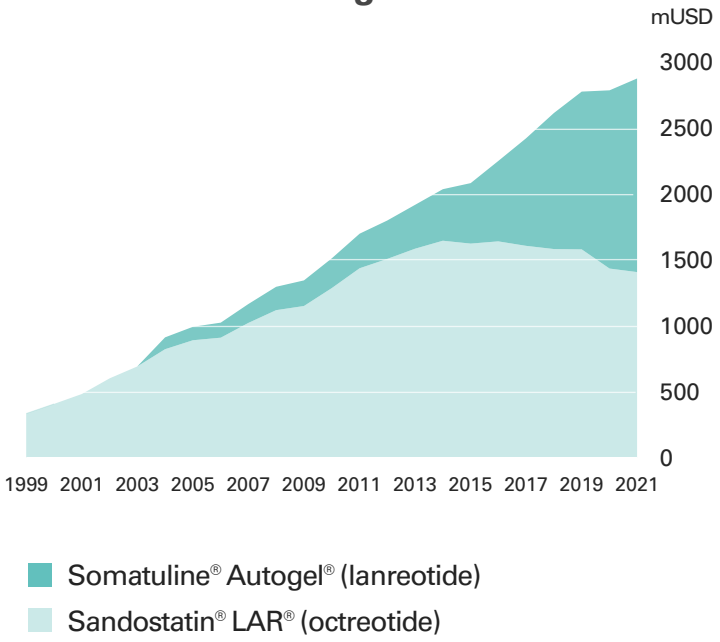
CAM2029 targeting 3-billion-dollar SSA market

Established treatment, with limitations

- Somatostatin analogs (SSAs) widely used with favorable safety profile
- First-line treatment of acromegaly and neuroendocrine tumors (NET)
- Limitations incl., plasma exposure, disease control and patient convenience

Octreotide SC depot, CAM2029, designed to address key limitations

Annual sales of first-generation SSAs[1]



[1] *GlobalData 2022*

ADVANCE IN-HOUSE PIPELINE TO NEW APPROVALS AND LAUNCHES

CAM2029 developed in three rare diseases

Targeting key limitations of first generation SSAs

- Improved patient experience and enhanced exposure for disease control in **acromegaly**
- Superiority in progression free survival and improved symptom control in **neuroendocrine tumors (NET)**
- Potential first approved treatment for **symptomatic polycystic liver disease (PLD)**

Risk mitigated registration programs

State-of-the-art device

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"I do not want to have to live my life circled around my disease"

Laura, patient, acromegaly, US

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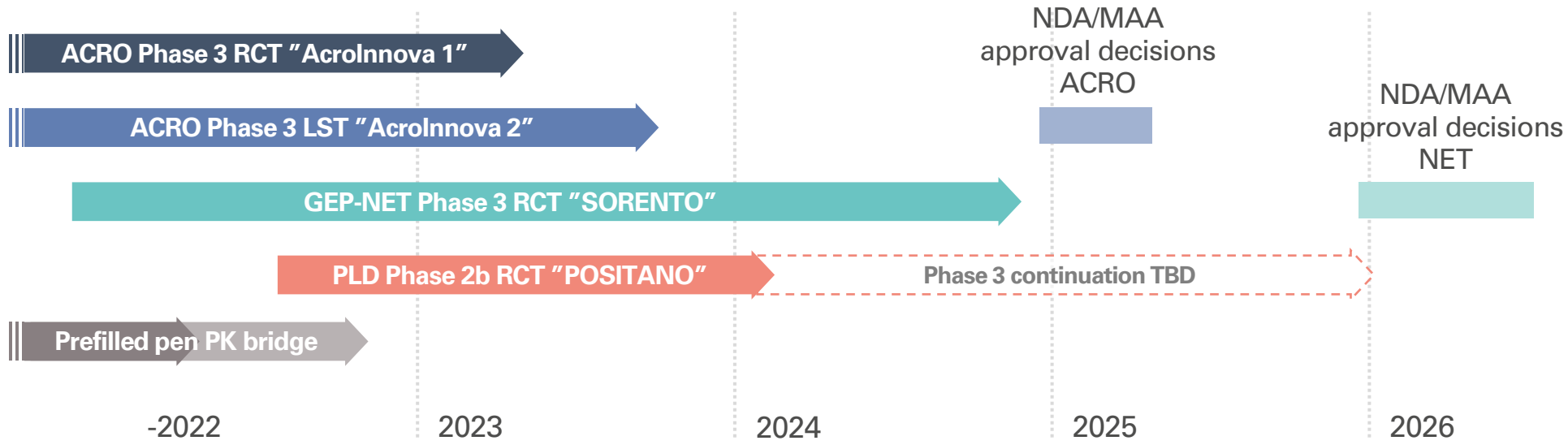
ADVANCE IN-HOUSE PIPELINE TO NEW APPROVALS AND LAUNCHES

CAM2029 extensive clinical program



ACRO Phase 3 RCT
Randomized, double-blind, placebo-controlled trial in SSA responders

ACRO Phase 3 LST
Open label, long-term safety trial in partial and full SSA responders

GEP-NET Phase 3 RCT
Active controlled Phase 3 trial in patients with metastatic/unresectable GEP-NET

PLD Phase 2b RCT
Randomized, double-blind, placebo-controlled Phase 2b study in patients with PLD

Prefilled pen PK
PK bridging study prefilled syringe and prefilled pen devices

Timelines are indicative. PK – pharmacokinetic; PD – pharmacodynamic; RCT – Randomized control trial; LST – Long-term safety trial; ACRO – acromegaly, GEP-NET – gastroenteropancreatic neuroendocrine tumors; PLD – polycystic liver disease; OLE – open label extension

Significant market potential for CAM2029

Attractive opportunity

- Highly concentrated target audiences
- Differentiated product properties
- Switch opportunity from established first-line treatments

CAM2029 peak sales estimates from third party market research[1-4]

	TERRITORY	PATIENT POPULATION	EST. PEAK PATIENT SHARE	EST. PEAK SALES (BILLION SEK)
ACRO[1]	EU/AUS	16,500[4]	20 – 35%	0.3 – 0.65
	US	10,000	25 – 40%	1.5 – 2.8
NET[1]	EU/AUS	68,000[4]	30%	3 – 4
	US	37,000	40%	12 – 15
PLD[1]	EU/AUS	15-18,000[4]	30 – 40%	0.8 – 1
	US	12-13,000	30 – 40%	2 – 3

GlobalData report[5]

"Top selling drug to enter the market will be Camurus' Octreotide LA"

Estimates CAM2029 sales of **US$210m** US+EU5 sales in 2029 in acromegaly

[1]Globe Life Science Aug 2022, data on file; [2]Globe Life Science 2020, data on file; [3]Assuming €10-12.5k (EU/AUS) and $60-70K (US) per year net pricing in acromegaly, €15-20k (EU/AUS) and $80-100K (US) per year net pricing in NET, and €17.5k (EU/AUS) and $60K (US) per year net pricing in PLD; [4]Patient numbers extrapolated from 5EU estimates by assuming same prevalence across European countries and Australia

Preparing for CAM2029 commercialization

Using existing infrastructure in Europe and Australia

– Focused audience and significant market potential >4 billion SEK across indications[1,2]
– Established scalable commercial infrastructure

Establishing own US commercial infrastructure

– Single largest market with high market potential >15 billion SEK across indications[1,2]
– Positive payor response to CAM2029 with recognition of benefits and likelihood to be on formularies
– Commercial organisation can be built stepwise as new indications are approved
– Medical science and market access functions in 2023
– Full commercial team in 2024 ready for launch

[1]Globe Life Science Aug 2022, data on file; [2]Globe Life Science 2020, data on file

GROW AND DIVERSIFY THROUGH BUSINESS DEVELOPMENT

Diversifying business through licensing and M&A

Key objectives

– US commercial organization
– Diversify product portfolio in CNS or rare disease areas
– New technology platforms

Opportunity for significant value creation

1.

Key priorities going forward

- Grow Buvidal
- Expand to new markets and indications
- Advance our R&D Pipeline
- Grow and diversify through business development
- Fully implement our sustainability strategy

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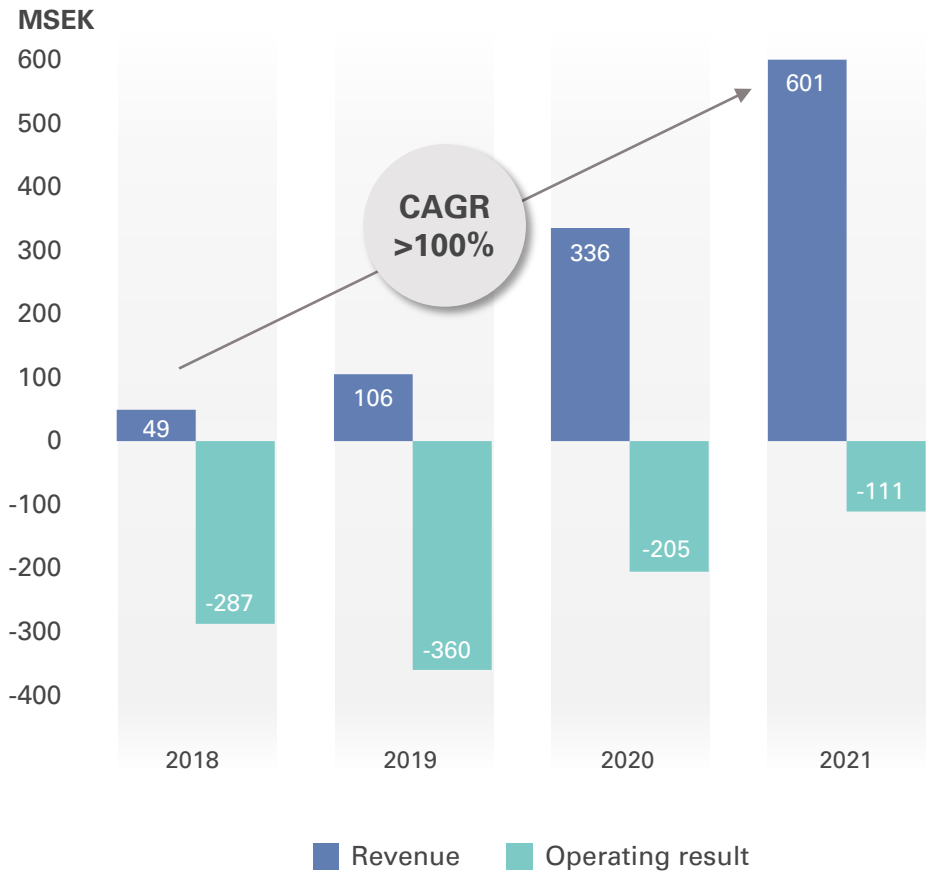
Financial outlook

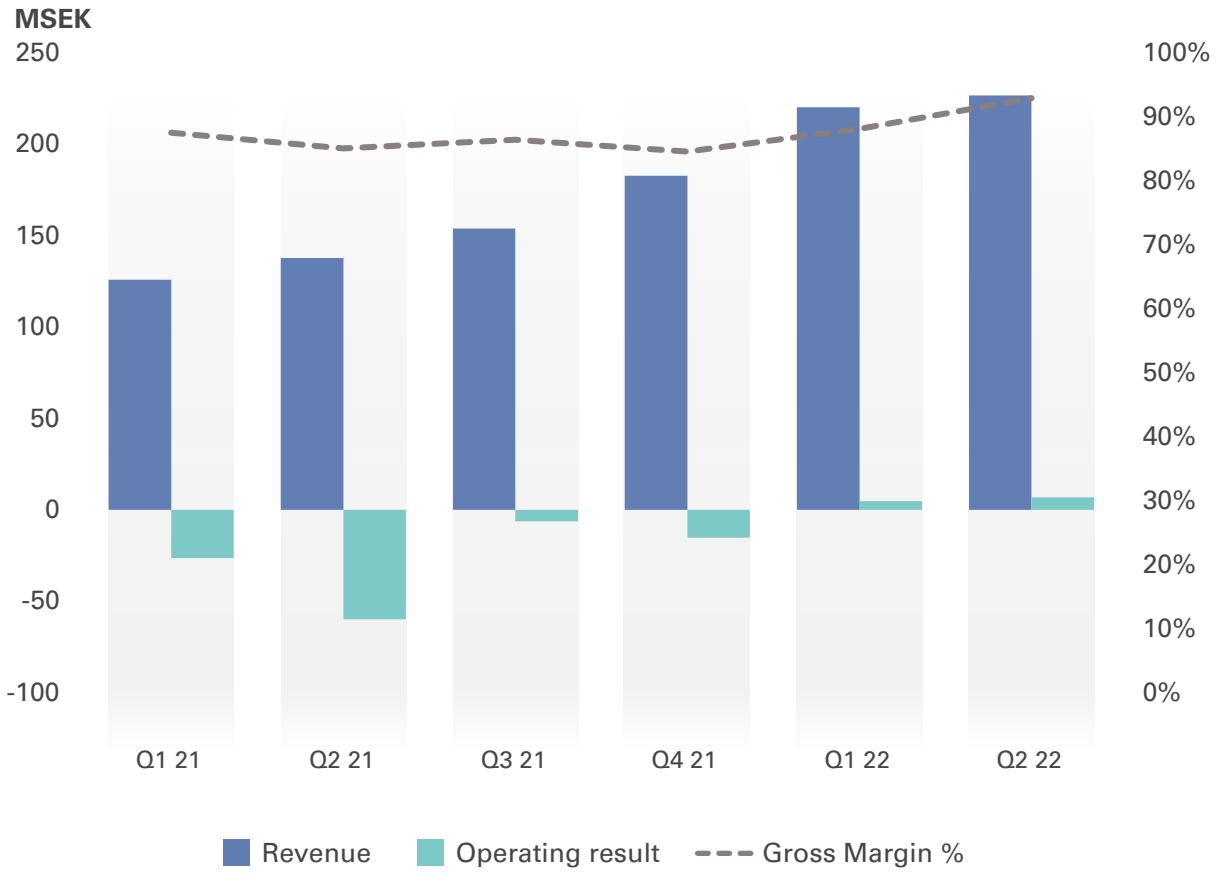
Jon Garay Alonso
Chief Financial Officer

Fast growth following Buvidal launch



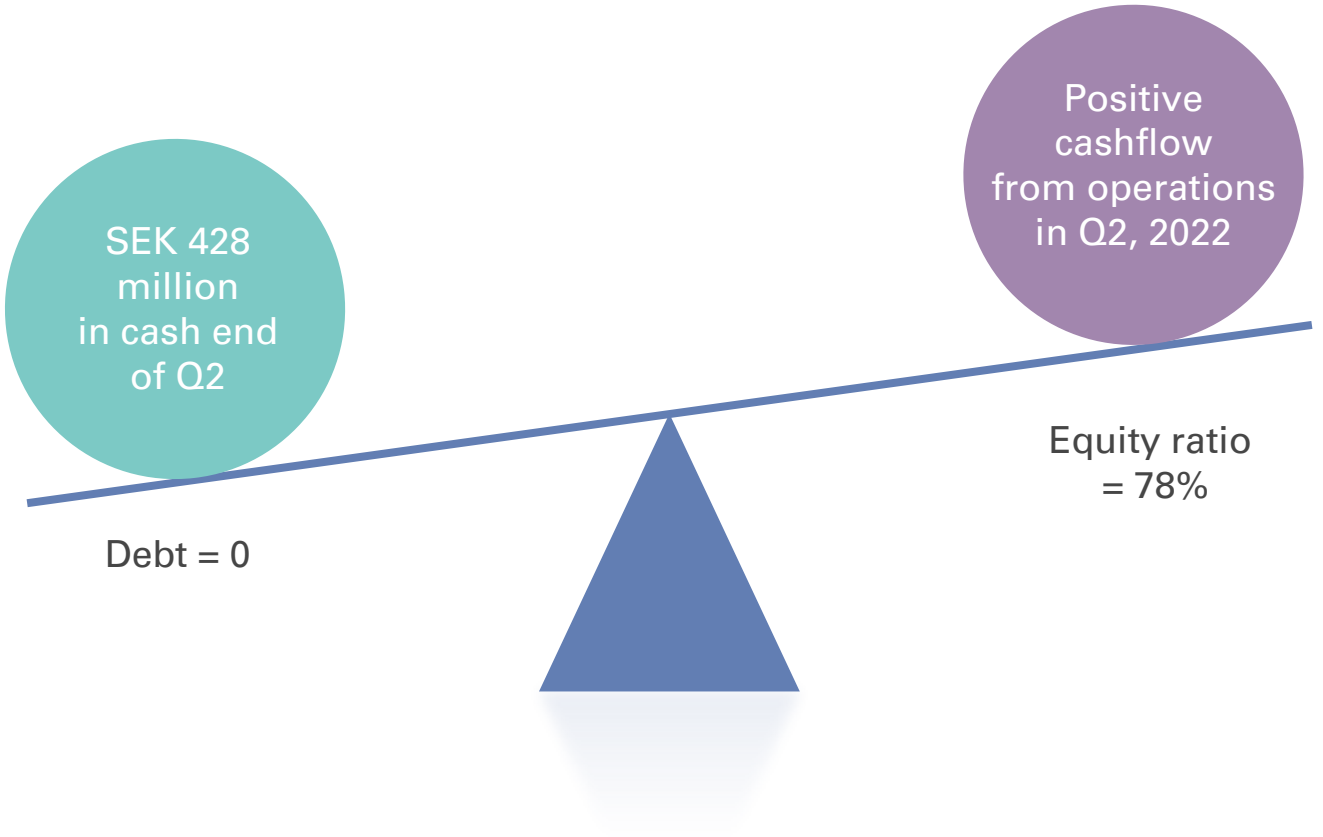
- Maintain high growth in opioid dependance trough market penetration and geographical expansion
- SEK 1.3 billion R&D invested 2017-2021 to bring late-stage product candidates to market

Achieving profitability in H2



- Profitability achieved in Q2 2022 “best quarter result ever”
- Driven by strong sales growth and margins improvement
- Committed to a SEK 0.5 billion R&D investment in 2022

A strong balance sheet



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Well positioned to create shareholder value to 2027

2022–2027 Sales CAGR 37%

- SEK 4.5 billion sales 2027

Operating Margin ~50%

- SEK ~2 billion 2027

Equity Ratio > 30%

Partnering and M&A agenda

- Value creation through commercialization, pipeline, and technology platforms synergies

Value creation drivers

Strong balance sheet to support M&A

Continued growth

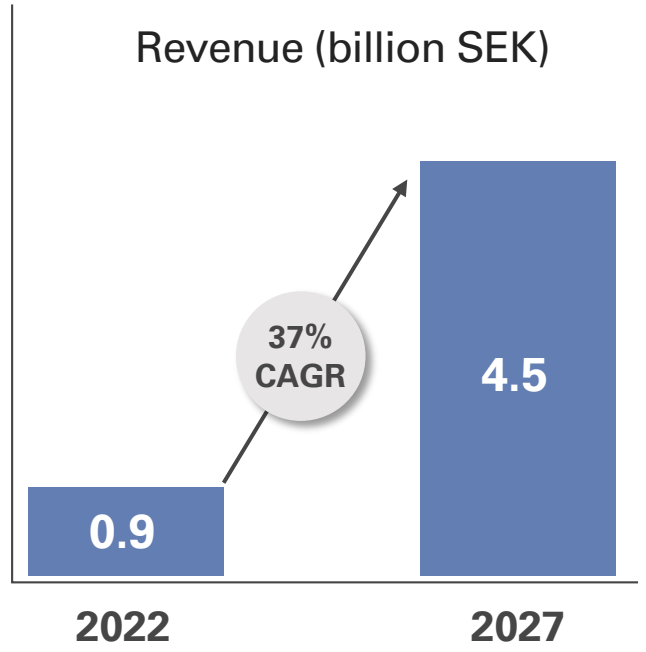
Cash generation

Profitable business

CONTINUED GROWTH

Pipeline accelerating growth

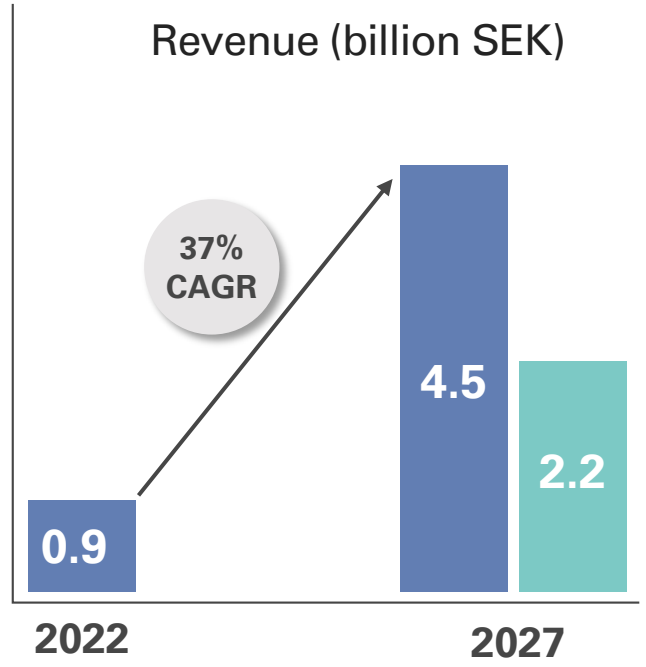
- Buvidal market penetration and geographical expansion SEK 3.0 billion
- Innovation: late-stage product candidates will contribute SEK 1.5 billion by 2027
- Targets via M&A contributing to additional growth



PROFITABLE BUSINESS

Buvidal success funds for future investments

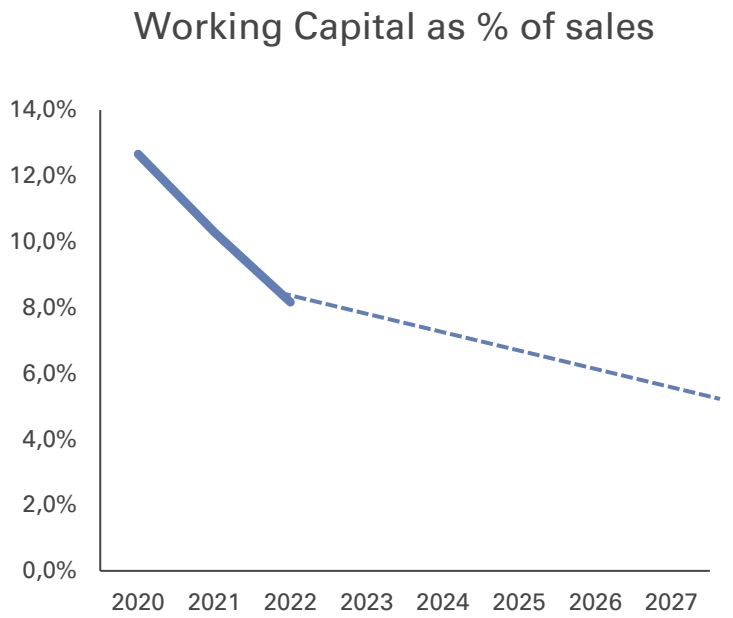
- Late-stage product candidates (SEK ~0.5 billion) already funded via current Buvidal sales
- New product launches will be fully accretive to our Earning Per Share (EPS) and fund additional required structure
- Disciplined OPEX Investment
- Operating Margin % ~ 50%



CASH GENERATION

Improving cash generation

- Working Capital efficient management of days to collect, days of sales in inventory and days to pay
- Limited recurring Capital Expenditures and below depreciation. Pursued Material projects with positive return of Investment and short/mid term execution.



STRONG BALANCE SHEET TO SUPPORT M&A

A strong foundation for growth

Key indicators Q2 2022

>400
MILLION SEK
IN CASH

0
DEBT NET

78%
EQUITY RATIO

Foundation for growth

- Late-stage program launches self-financed by current Buvidal business growth
- Operating margin improvement from 2022 onwards thanks to volume growth
- Strong balance sheet allows to access to external funding for Strategic M&A transaction

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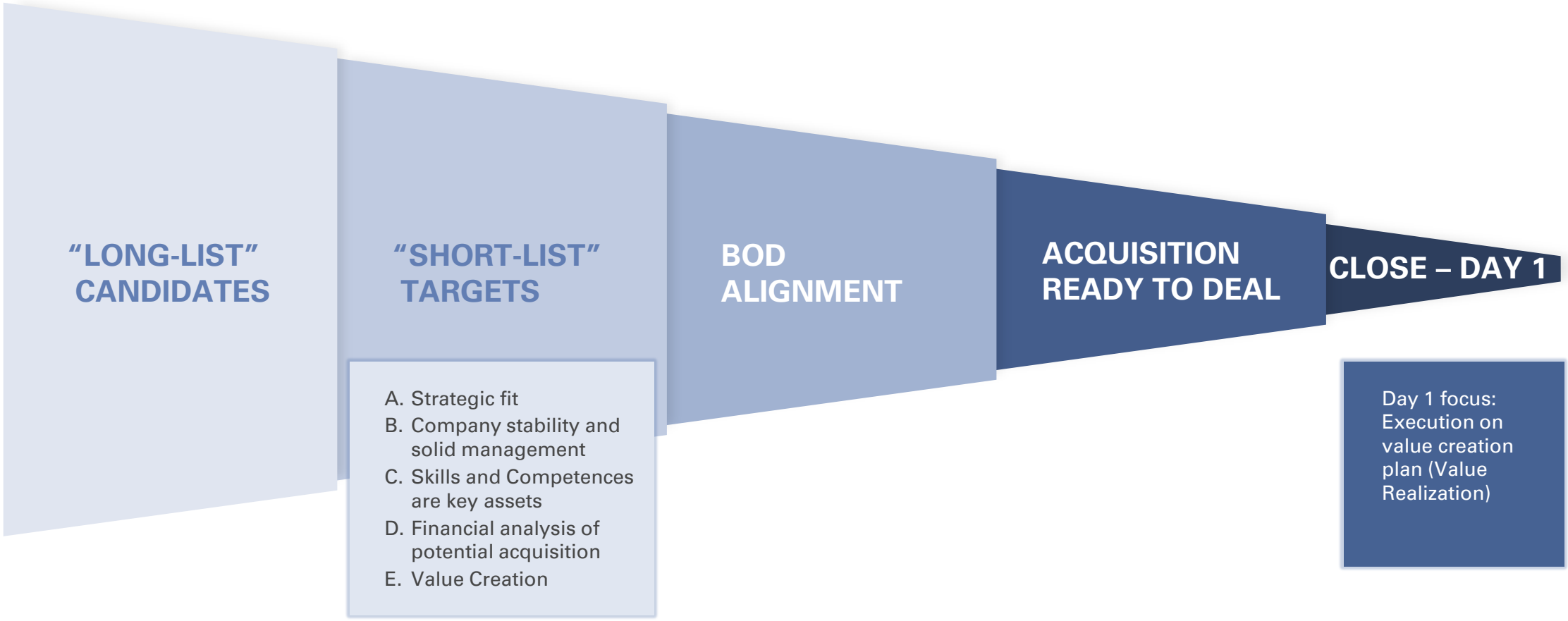
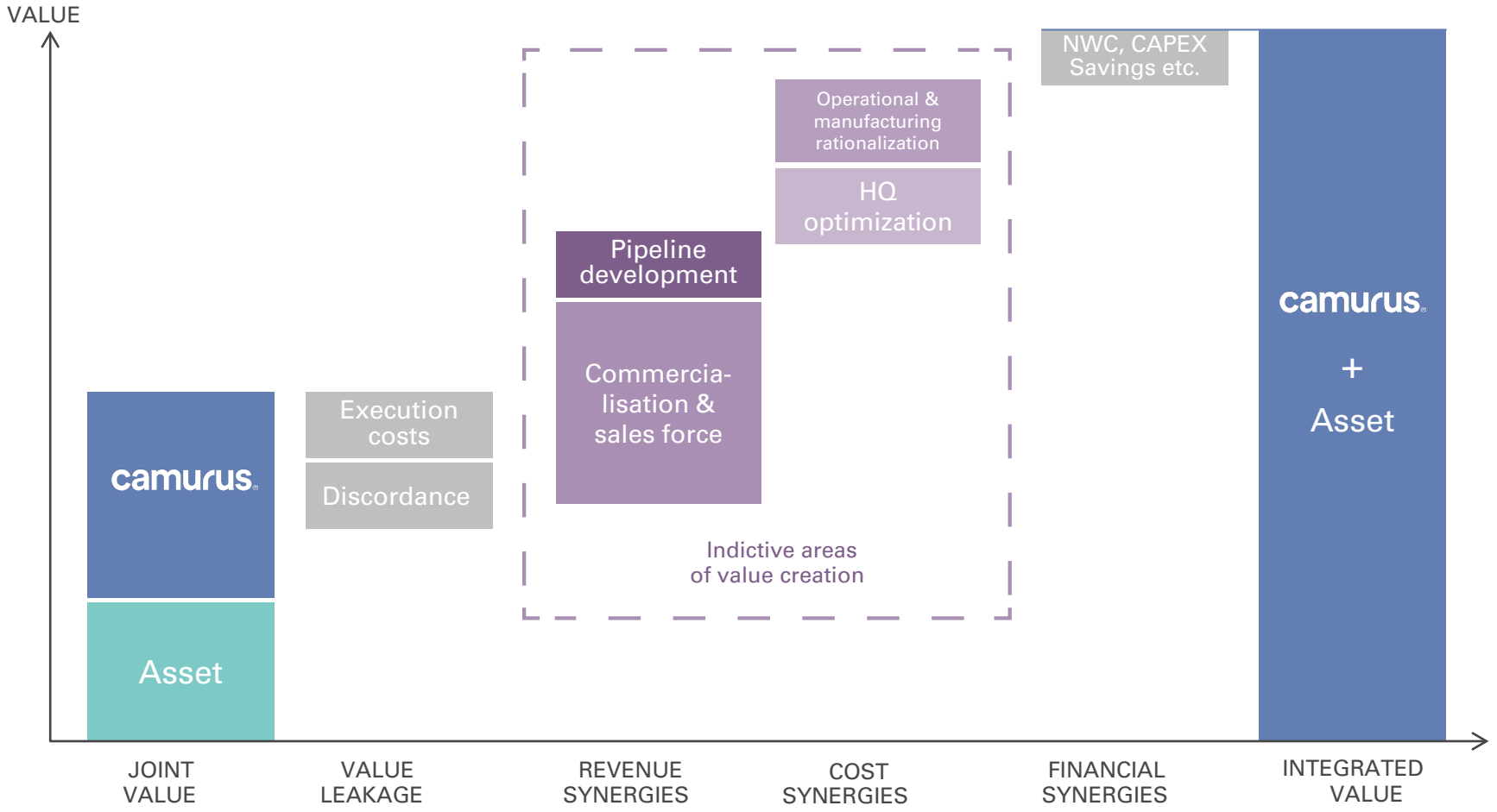
Value creation through Transaction



Value creation through transaction



2027 Financial outlook summary

- Deliver 37% sales CAGR = SEK 4.5 Bn revenue
- Operating Margin ~50%
- Equity ratio > 30%
- Creating value for our shareholders organically and inorganically

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Establishing market leadership in opioid dependence

Richard Jameson
Chief Commercial Officer

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Buvidal

Innovation in treatment of opioid dependence

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Opioid dependence – escalating global health crisis

- Largest society burden of all drugs
- Prevalent disease and with serious consequences for individuals, families and society
- Significant limitations with current daily medications
- High need for better access to care and new treatment alternatives

EU and Australia

– 1.4 million problem opioid users
– ~750,000 in treatment[2,3]
– Estimated > 400,000 patients dependent on Rx opioids and not in ODT[4-8]
– ~12,000 overdose deaths in EU 2020/21[1]

MENA

– Overdose deaths unknown
– Estimated 300,000 to 1.1m injecting drug users[9]
– Estimated <100,000 in treatment

[1]https://www.emcdda.europa.eu/topics/drug-related-deaths [2]EMCDDA 2022 Drug report [3]NOPSAD data Australia
[4]www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/deaths/drug-related-deaths-in-scotland/2020; [5]Chenaf C, et al., Eur J Pain. 2019 Jan;23(1):124-13 [6]Marschall U, et al., Eur J Pain. 2016 May;20(5):767-76 [7]De Sola H, et al., Front Pharmacol. 2020 Nov 18;11:564412 [8]Delevinsight Chronic pain Report 2020 [9]Harm Reduction International Global State of Harm Reduction 2016

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Buvidal is an innovation in treatment addressing the limitations of SoC

	Addressed by Buvidal
Limited treatment adherence[1] – Increased risk of relapse/overdose	✓
Significant burdens and stigma for patients[2] – Strict controls and supervised administration – Limited access and stringent entry criteria	✓
Public health impact – Medication misuse, abuse and diversion – Huge healthcare and societal costs[3]	✓
High relapse rates and repeated treatment journeys[4] – 40–50% of patients terminate treatment with buprenorphine in the first 6 months[1]	✓
Many uses do not come into treatment due to rules and regulations – Increased risk of relapse/overdose	✓

1. Kaur AK, et al. 2008, Journal of Managed Care Pharmacy; 2. Benyamina et al 2013 Heroin Addiction and Related Clinical Problems 14 (4): 65-80; 3. Public Health England https://www.gov.uk/government/publications/alcohol-and-drug-prevention-treatment-and-recovery-why-invest/alcohol-and-drug-prevention-treatment-and-recovery-why-invest; 4. Fischer G et al Heroin Addict Relat Clin Probl 2012; 14(4): 39-50

Buvidal

A meaningful product… changing the treatment paradigm

"You don't have to stand in lines, and you're not reminded every day that you're in treatment for heroin addiction. **It's revolutionary**"

Patient, Australia

"I'm much better off. **It's magic**, it's amazing that it exists, and I think it will help a lot of people"

Patient, France

"It's given me a **fresh outlook on life** and it really works. I wish other people could have the chance"

Patient, UK

"You can go on holiday, meet your friends, find a job – everything is possible with Buvidal. **It is freedom**"

Patient, Germany

"Now I get treatment once a month, walk away and I'm free. **It's absolutely amazing**. Almost everything is as before"

Patient, Sweden

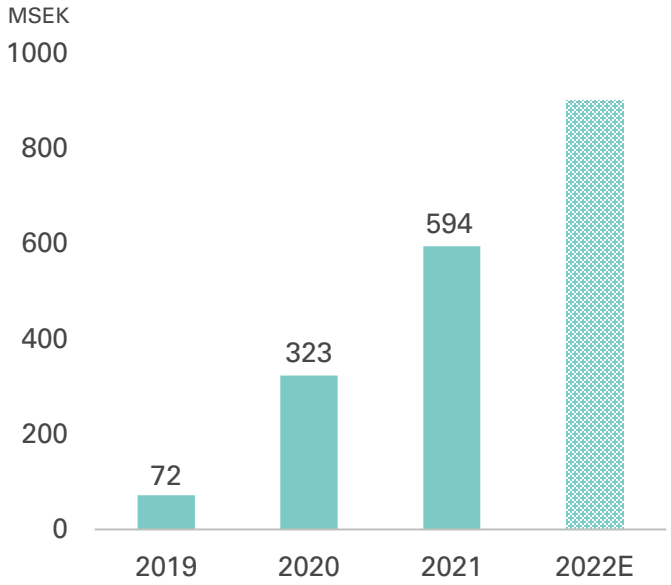
Buvidal launch

Excellence in regulatory & commercial execution

Buvidal has delivered significant growth and value

Market leadership across EU/AUS within 4 years of our first ever commercial launch

Product sales development



Market share development in first launch countries

Country	Patient share	Est. cash share 2022
Finland	>60%	>70%[1]
Australia, Norway, Sweden	>20%	>35%[2,3,4]
UK	>4%	>15%[4]
Germany	~2%	~10%[5]

1. IQVIA Finland sell in data July 2022 2. IIQVIA July 2022 country sales reports Sweden, 3. Pharmastat Norway July 2022 4. Camurus data on File July 2022 5. IQVIA Germany July 2022 sales report

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Strong commercial launch execution

Building market leadership within 4 years of first launch

82% of patients in EU/AUS live in a country where Buvidal is available

~ 1 million injections given

9 regulatory approvals

10 HTA approvals
6 Pending

Successful, expert commercial team recruited and onboarded, N=>70

>30,000 patients in treatment

Buvidal available in 17 countries

Positive patient feedback[1]

"I think Buvidal is a wonder drug. Treatment is better as a monthly injection. It takes away your liquid handcuffs. I've got my life back, I feel free and can make my own choices."

Clear value creation
Pricing up to 10x that of daily treatment

Distribution and supply network delivers Buvidal with 24 hours

Compelling evidence base

69 articles published in scientific journals

Distribution partnerships in 8 non-core countries

1. Male, 35-44, Swansea Bay UHB. Was prescribed methadone and had spend time in prison.

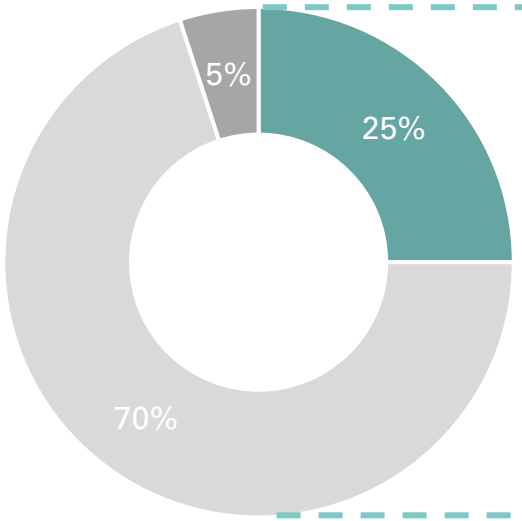
Launch success

A platform to deliver durable Buvidal growth

Opioid dependence

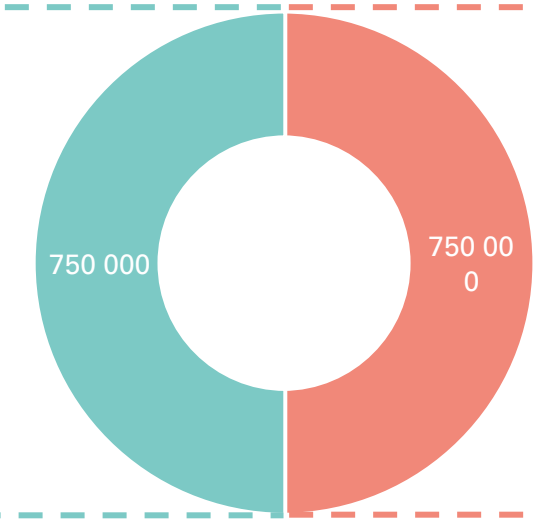
Prevalence and treatment in EU/AUS

Patients in ODT[2]



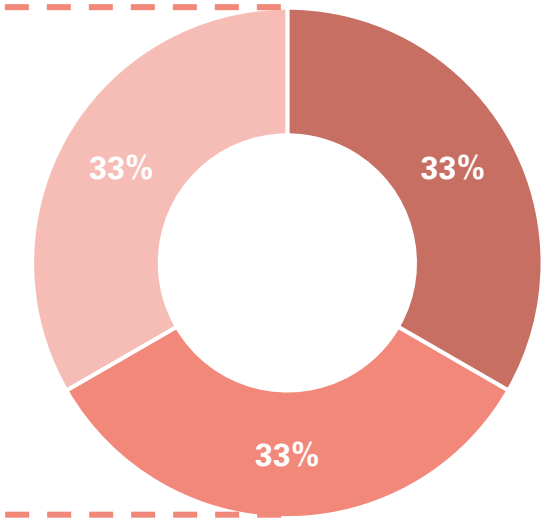
Buprenorphine
Methadone
Other

1.4m problem opioid users[1]



In treatment
Out of treatment

Why users do not enter treatment[3,4]



Don’t want to
Cannot access
Cannot cope with rules and regulations

1. EMCDDA 2022 Drug report 2. ECMDDA country drug reports 3. Benyamina et al 2013 Heroin Addiction and Related Clinical Problems 14 (4): 65-80; 4. Camurus data on file 2018 Patient qualitative study

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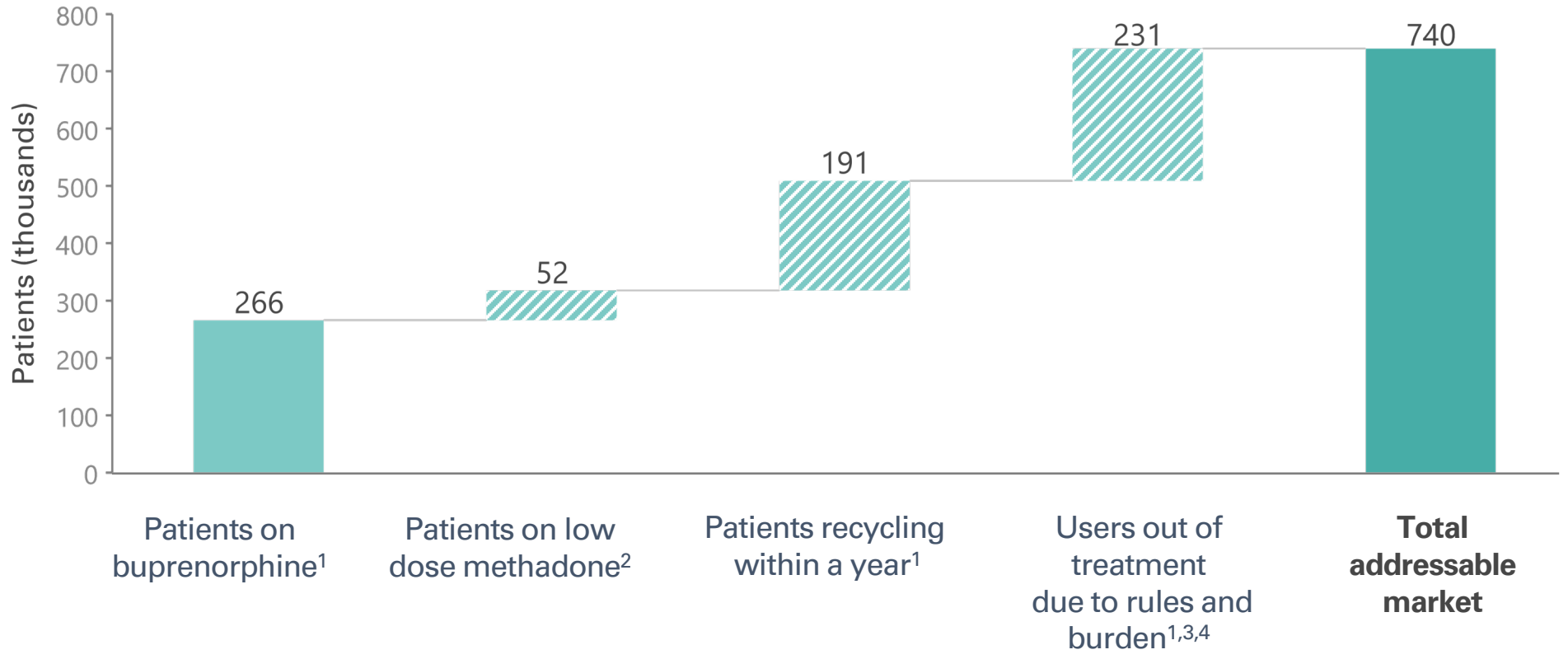
Addressable market of ~740,000 patients in EU/AUS



1. EMCDDA 2022 Drug report; 2. Camurus estimate; 3. Benyamina et al 2013 Heroin Addiction and Related Clinical Problems 14 (4): 65-80; 4. Camurus data on file 2018 Patient qualitative study

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Opportunities to expand the patient pool for Buvidal

Methadone

– Growing patient demand to transfer to Buvidal
– New methods for transfer being developed and researched

Opioid dependence patients with chronic pain not in treatment

– Estimated 400,000 pain patients with OD not in treatment
– Resistance to attend 'addiction' clinics

New geographies RoW

– Potentially 300k to 1 million injecting drug users in MENA[1]
– Growing recognition of the need for treatment
– Buvidal the first approved product for opioid dependence treatment in some markets
– Concerns on risk of misuse and diversion if introduced daily treatment

1. Harm Reduction International Global State of Harm Reduction 2016

Delivering our ambition

To exceed 100,000 patients in treatment

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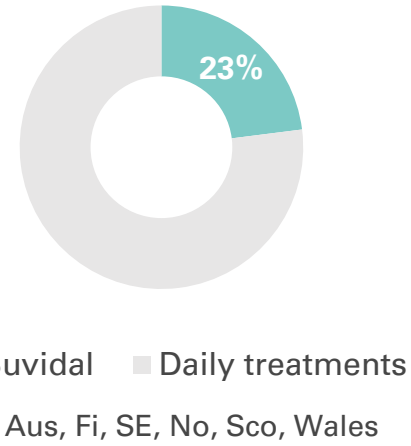
Why we are confident…

Buvidal is a game-changing product

- Robust clinical and real-world evidence and experience
- Highly positive patient and HCP experience
- Growing patient awareness & demand
  - >40% patients suitable and would try[1,2]
  - New patients are entering treatment due to Buvidal
- Wide stakeholder recognition of value
- Access and funding hurdles being addressed

Where access hurdles addressed uptake is high

Average patient share (all ODT patients) in markets with resolved access*: launch + 3 years



[1] Rolland B, et al. Drug Alcohol Depend. 2021; 220:108492. [2] Pascual FS, et al. Eur Addict Res. 2022; 28: 143-154.

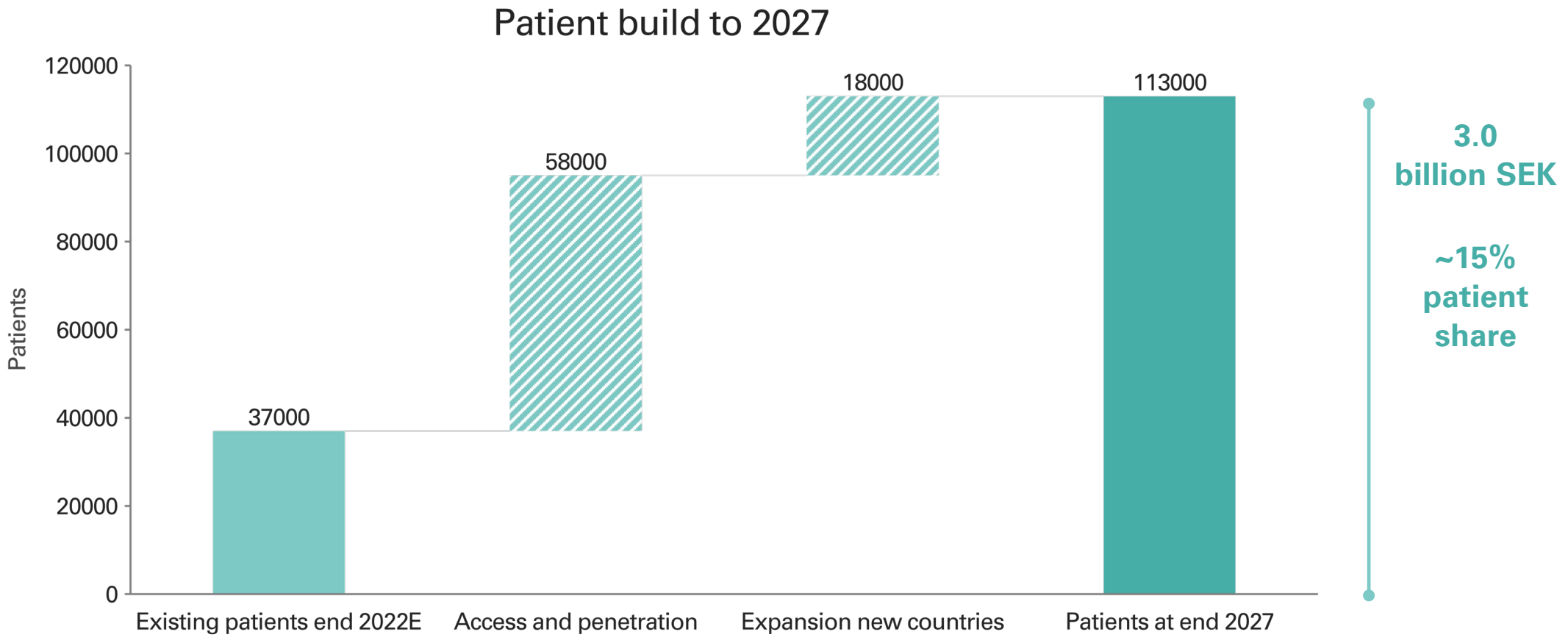
Three key pillars for sustained growth

Access and penetration – addressing hurdles and accelerating patient uptake

Geographical expansion – complete regulatory & PMA processes and drive successful launches

Indication expansion – to include chronic pain

Delivering our ambition for 2027



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UK Case history

Accelerating patient uptake now funding challenge addressed

Samantha Nickerson
GM UK & Ireland

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UK has most patients in treatment in EU/AUS and high numbers of drug related deaths

Drug misuse: prevalence, overdose deaths and treatment

	Problematic drug use[1]	Patients in ODT[2]	Drug-related deaths (per million)[2]
England	280,000	141,000	48
Wales	25,000	8,000	52
Scotland	56,000	29,000	234
N Ireland	2,200	1,150	87
Total	**363,200**	**179,150**	**65**

6,225 drug-related deaths in the UK in 2021[3]

1. Internal Camurus estimate. No official data source available; 2. European Drug Report 2021 , EMCCDA

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Scotland & Wales have redefined drug treatment strategies to address the crisis

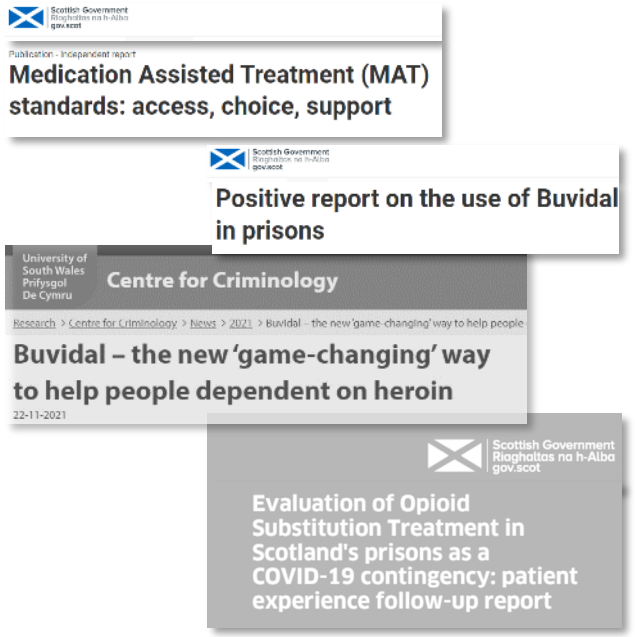
- High level Government commitment to address
  - Drug-related deaths & management opioid dependence in pandemic lead to accelerated uptake of innovations
  - Strong Government support

> "A commitment to increasing funding for and **access to long-acting buprenorphine** as this has better outcomes for some people"

Angela Constance
Drugs Policy Minister
Scottish Government

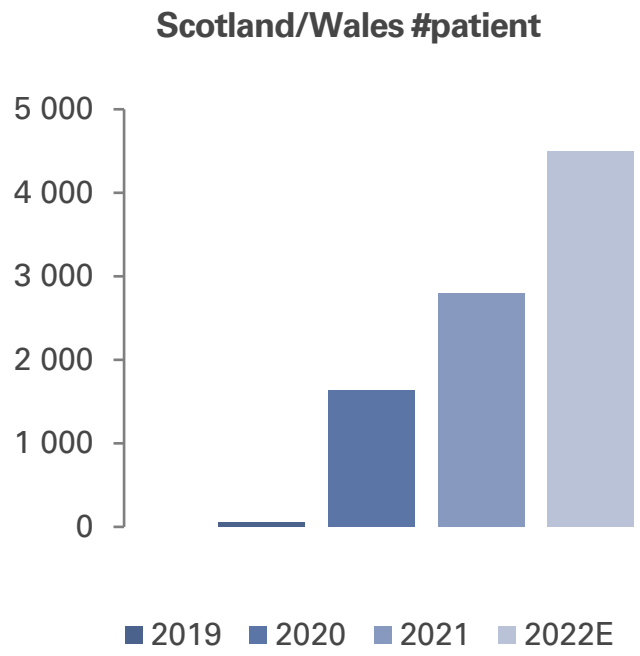
- Created accelerated access for Buvidal
- Very positive response from patients and physicians
- Guidelines on LAIB access

Guidelines and real-world experience

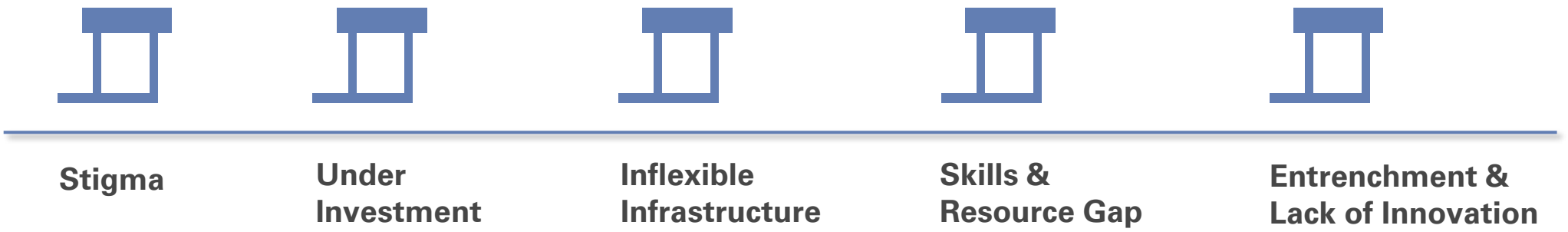


Rapid uptake in Scotland and Wales

- > 4,000 patients in Scotland & Wales treated with Buvidal
- 10% penetration of all patients
- Continuing rapid growth
- High performing team driving growth
  - Commercial and therapy specialists with broad knowledge and expertise
- Wide stakeholder engagement across disciplines



England momentum building as hurdles addressed



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England momentum building as hurdles addressed

Stigma

Under Investment

Inflexible Infrastructure

Skills & Resource Gap

Entrenchment & Lack of Innovation

"The capacity of the treatment system is insufficient to meet the need for support and half of people with an addiction to the most harmful drugs – opiate and crack cocaine – are not engaged in treatment"[1]

- Independent Review of Drugs commissioned by Government gave clear direction…
- Makes clear recommendation for significant investment …
- Overall, 32 recommendations setting out whole system approach to tackling drug misuse

[1] *Boris Johnson. Prime Minister UK*

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A new strategy

Opening the door to a new landscape

- Delivering a **world-class treatment** and recovery system
- **£553 million** over 3 years to rebuild treatment services
- Support local areas to expand and improve range of treatment
- Funding for Ministry of Justice so offenders fully engage with treatment services
- Consistency through a new national commissioning quality standard

> *We will work with local area to secure… system is responding to new and promising innovations, **such as forms of long-acting buprenorphine.***

> *We are exploring the benefit of **making long-acting buprenorphine available** to prisoners in treatment for an opiate problem, to see how this impacts engagement with treatment, protection from overdose and relapse after release*

Payer hurdles now addressed

Treatment clinics experienced and seeing patient successes

- 100% payer coverage in Scotland, Wales and Northern Ireland
- 74% payer coverage in local authorities in England
- 84% of top 50 regions
- 76% of 141,000 patients in England in region with Buvidal coverage[1]
- 75% active clinics
- Driving increase in prescribers and depth of prescribing

1. Based on analysis from NDTMS 2020/21 www.NDTMS.net

Payer hurdles now addressed

Treatment clinics experienced and seeing patient successes

- 100% payer coverage in Scotland, Wales and Northern Ireland
- 74% payer coverage in local authorities in England
- 84% of top 50 regions
- 76% of 141,000 patients in England in region with Buvidal coverage[1]
- 75% active clinics
- Driving increase in prescribers and depth of prescribing

UK scenario

If **23% patient penetration** level reached, as current in Australia and Nordics, this corresponds to **~40,000 patients** on Buvidal in the UK

1. Based on analysis from NDTMS 2020/21 www.NDTMS.net

Accelerating our growth

Capitalizing on the new drugs strategy

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UK is a significant opportunity

Build on policy direction from drug strategy to include Buvidal as treatment option in community and criminal justice

Drive funding and access with focus on top 50 regions

Deliver medical education to support upskilling of the workforce

Build informed choice for patients

Capture real-world-evidence and share best practice

Unlock criminal justice opportunity

Patient views

Kevin and Jim from Scotland

The following video features excerpts from a conversation between Kevin, a Buvidal patient and Jim, a support worker from a Glasgow based homeless charity, the Simon Community.

Q&A

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Buvidal life cycle management and chronic pain

Peter Hjelmström
Chief Medical Officer

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Evidence base for Buvidal at time of launch in EU/AUS

- Pharmacokinetic profiles for weekly and monthly dosing[1]
- Blockade of opioid effects[2]
- Suppression of withdrawal and cravings[2,3,4]
- Non-inferior and superior efficacy for illicit opioid use demonstrated in pivotal double-blind Phase 3 study versus standard daily SL BPN/NX in new-to-treatment patients[3]
- Retention in treatment and illicit opioid use comparable to or better than historic study results[3,4,5]
- Safety profile comparable to SL BPN except for mild to moderate injection site reactions[2,3,4]

SL BPN/NX, sublingual buprenorphine/naloxone

References: 1. Albayaty M et al. Adv Ther. 2017 34:560-575;2.. Walsh et al. JAMA Psychiatry 2017;74:894-902 ; 3. Lofwall et al. JAMA Int. Med. 2018;178; 764-773;4. Frost M et al. Addiction. 2019;114:1416-1426;5. Hjelmstrom P et al. Drug Dev Ind Pharm. 2020; 46: 1-7.

Extended evidence base since launch of Buvidal

MEDICAL AFFAIRS METRICS

Scientific publications	**69**
Presentations at scientific conferences	**131** (78 oral; 53 posters)
Investigator sponsored studies supported	**17** (12 EU/AUS; 5 US)
Patients in investigator sponsored studies	**>2500**
Grant requests approved	**98**
Medical information enquires answered	**1751**

References: Camurus data on file

Life-cycle management of Buvidal registration

DEBUT and UNLOC-T studies have enabled updates to the Buvidal registration:

EU (2021)

– Addition of 160 mg Buvidal monthly

AUS (2021)

– Addition of 160 mg Buvidal Monthly
– Possibility to initiate patients on Buvidal directly instead of initiation on SL BPN
– Removal of pregnancy and lactation as contraindications, allowing additional patients to receive treatment with Buvidal


JAMA Network Open.

Patient-Reported Outcomes of Treatment of Opioid Dependence With Weekly and Monthly Subcutaneous Depot vs Daily Sublingual Buprenorphine
A Randomized Clinical Trial

ADDICTION

RESEARCH REPORT

Treatment of opioid dependence with depot buprenorphine (CAM2038) in custodial settings

References: Lintzeris N et al. JAMA Netw Open. 2021; 4:e219041. https://doi.org/10.1001/jamanetworkopen.2021.9041 (ANZCTR12618001759280); Dunlop A et al. Addiction 2022;117: 382-391. https://doi.org/10.1111/add.15627 (ACTRN12618000942257)

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Investigator Sponsored Studies ongoing with Buvidal

STUDY	PATIENTS	PROTOCOL PUBLICATION
Addiction recovery of opioid dependent patients treated with injectable subcutaneous depot buprenorphine (Buvidal®) (**ARIDE**, DRKS00020797)	426 (Buvidal 213)	Schulte et al. Front Psychiatry. 2020; 11: 580863. https://doi.org/10.3389/fpsyt.2020.580863
Medication Treatment for OUD in Expectant Mothers (**MOMs**): A Pragmatic RT Comparing Two BUP Formulations (CTN-0080; NCT03918850**)**	200 (Buvidal 100)	Winhusen et al. Contemp Clin Trials. 2020; 93:106014. (https://doi.org/10.1016/j.cct.2020.106014)
Emergency Department-INitiated bupreNOrphine and Validation Network Trial (**ED-INNOVATION**, CTN-0099; NCT04225598)	2000 (Buvidal 1000)	D'Onofrio et al. Contemp Clin Trials. 2021; 104:106359. (https://doi.org/10.1016/j.cct.2021.106359)
Optimizing Retention, Duration and Discontinuation Strategies for Opioid Use Disorder Pharmacotherapy (**RDD**; CTN-0100; NCT04464980)	2630 (Buvidal 650)	Schulman et al. Addict Sci Clin Pract. 2021; 16: 15. (https://doi.org/10.1186/s13722-021-00223-z)
A comparative effectiveness trial of XR Naltrexone vs XR-BUP with individuals leaving jail (NCT04408313**)**	240 (Buvidal120)	Gordon et al. J Subst Abuse Treat. 2021; 128:108241. (https://doi.org/10.1016/j.jsat.2020.108241)
Exemplar Hospital Initiation Trial to Enhance Treatment Engagement - Comparative Effectiveness Trial of XR BPN Vs TAU for Hospitalized Patients With OUD (**EXHIT ENTRE**, CTN-0098; NCT04345718)	314 (Buvidal 157)	Not published
Characterizing withdrawal from depot buprenorphine: an observational case series (ACTRN12621001011875)	30 (Buvidal 15)	Not published
Case series examining the use of depot buprenorphine formulation Buvidal in the management of patients with co-occurring opioid dependence and chronic pain (ACTRN12622000511730)	30 (Buvidal 30	Not published

Chronic pain Phase 3 trial with CAM2038

Randomized, double-blind, placebo-controlled, enriched-enrollment withdrawal (EEW) trial

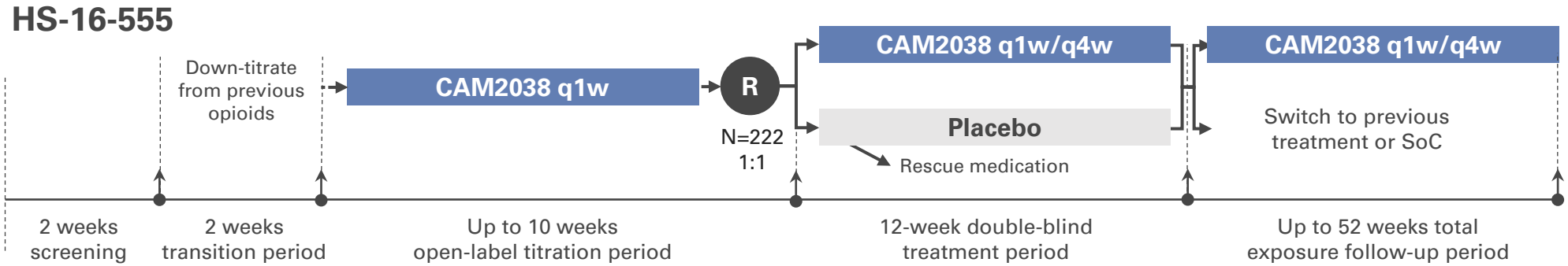
- US study sponsored by Braeburn Pharmaceuticals

Opioid-experienced subjects

- Subjects with moderate to severe Chronic Low Back Pain (CLBP)
- Treated with daily opioids for ≥3 months and on stable dose of ≥40 mg/day of oral morphine equivalents

Primary and secondary endpoints

- Primary endpoint: Change from baseline in Weekly Average of (Daily) Average Pain Intensity (WAAPI)
- Secondary endpoints include: Worst pain intensity, responder analysis, time to loss of efficacy, patient-reported outcomes and quality of life (PGI-I,WPAI, EQ-5D-5L), rescue medication use
- Safety evaluated in titration, double-blind treatment and open-label extension parts of trial



Reference: Buprenorphine (CAM2038) in Subjects With a Recent History of Moderate to Severe Chronic Low Back Pain https://clinicaltrials.gov/ct2/show/NCT02946073 (NCT02946073)

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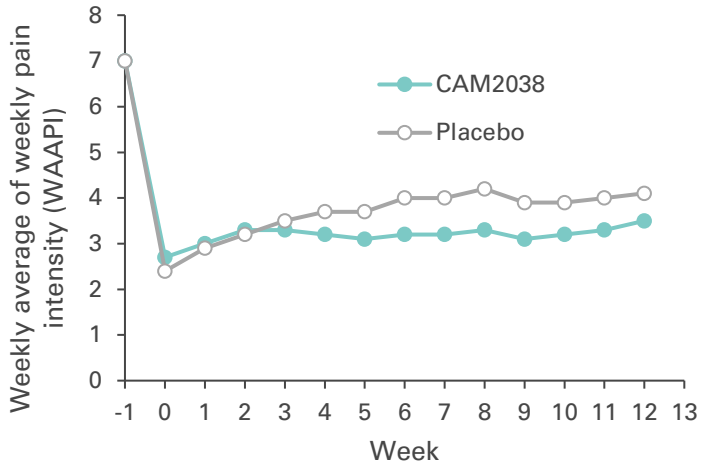
Positive results in Phase 3 trial

Primary and key secondary endpoints met

– Significant reduction in baseline adjusted average pain at week 12 versus placebo, p<.001
– Significant reduction in worst pain, p<.001

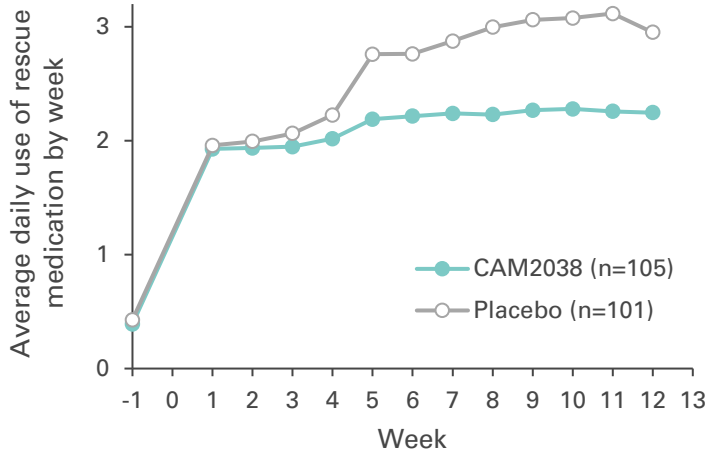
WAAPI scores over time



Improvement in additional endpoints

– Time to loss of efficacy, p=.002; patient global impression of improvement, p<.001, and activity impairment, p=0.005

Rescue medication use over time



Safety profile

– Safety profile consistent with the known safety profile of buprenorphine and Buvidal

Reference: Buprenorphine (CAM2038) in Subjects With a Recent History of Moderate to Severe Chronic Low Back Pain https://clinicaltrials.gov/ct2/show/NCT02946073 (NCT02946073)

Regulatory applications to extend indication for Buvidal to include chronic pain

Regulatory status EU

- ✓ Pre-submission meeting held with EU Rapporteur
- ✓ Regulatory submission accepted by EMA and requests for supplementary information received from CHMP

Regulatory status AUS

- ✓ Regulatory submission in Australia accepted by TGA and s31 request for information received

CHMP – Committee for Medicinal Products for Human; EMA – European Medicines Agency TGA – Therapeutic Goods Administration; Reference: 1. *Buprenorphine (CAM2038) in Subjects With a Recent History of Moderate to Severe Chronic Low Back Pain* https://clinicaltrials.gov/ct2/show/NCT02946073 *(NCT02946073)*

Medical need for Buvidal in chronic pain

- >35% of patients with non-cancer pain at specialty pain clinics have a problematic use of opioids[1]
- 33% to 55% of patients being treated for opioid dependence report chronic pain[2,3]
- >20% of patients with opioid dependence and chronic pain use illicit drugs for pain management[2]

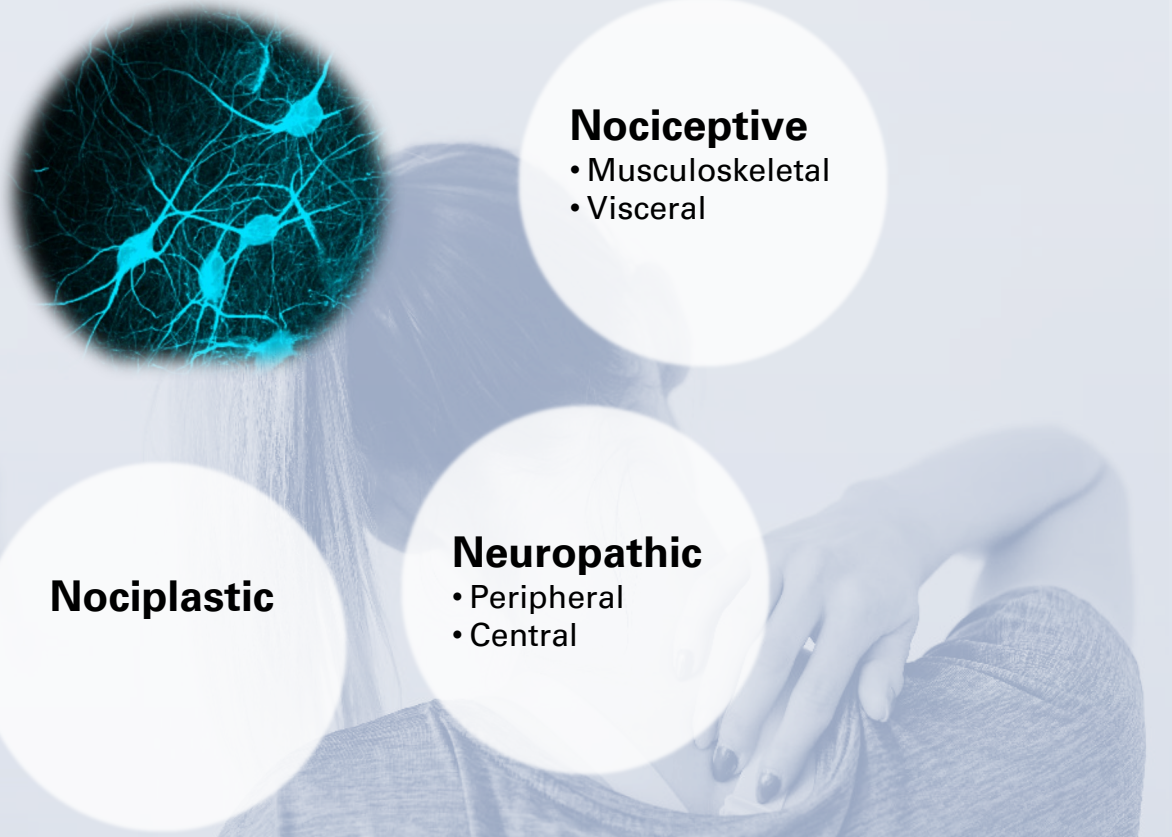
There is currently no medicinal product approved for treatment of both chronic pain and opioid dependence

References: 1. Jantarada C et al. Pain Pract. 2021; 21: 715-29. 2. Delorme J, et al. Front Psychiatry. 2021;12: 641430.; 3. Latif ZH, Am J Addict. 2021; 30: 366-75; 4.

Pain, opioids and addiction

Lenka Katila, MD, NEAPM
Pain Consultant, Multidiciplinary Pain centre & Addiction program for Pain Patients
Uppsala University Hospital

Acute versus Chronic pain

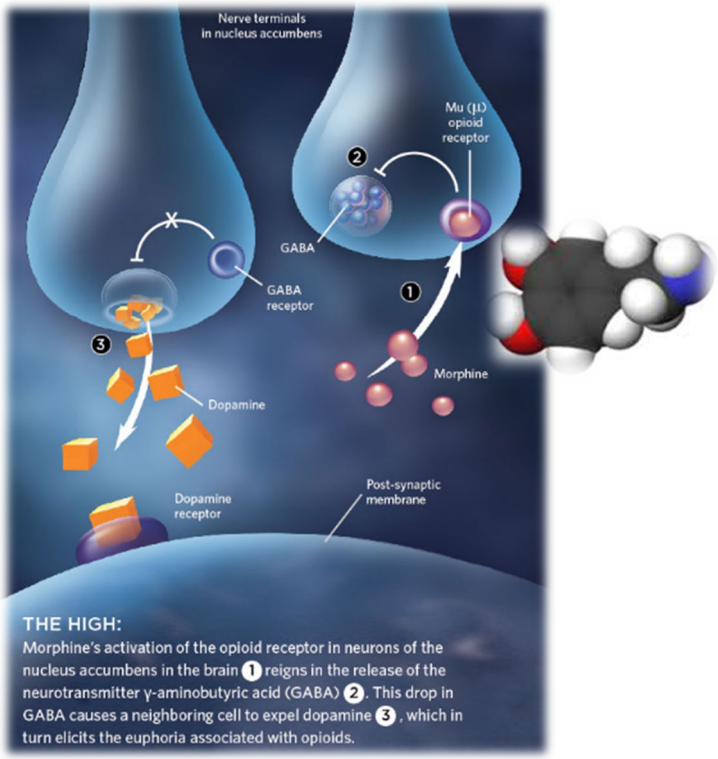


Acute pain	Chronic pain
…is caused by external or internal injury or damage	…is uncoupled from the causative event
…its intensity correlates with the triggering stimulus	…its intensity no longer correlates with the causal stimulus
…can be clearly located	…becomes a disease in its own right
…has a distinct warning and protective function	…has lost its warning and protective function
	…is a special therapeutic challenge

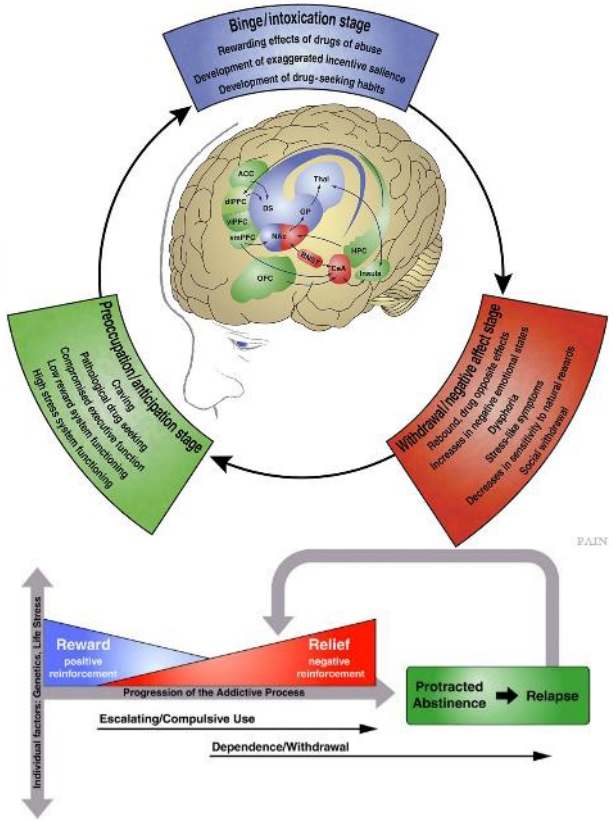
References: 1) Turk DC, Okifuji A. Interdisciplinary Approach to Pain Management: Philosophy, Operations and Efficacy. In: Ashburn MA, Rice LJ, editors. The Management of Pain. New York: Churchill Livingstone; 1998. p. 235-48; 2) Galer BS, Dworkin RH. A Clinical Guide to Neuropathic Pain. Minneapolis, MN: McGraw-Hill; 2000.; 3) Woolf CJ, Mannion RJ. Neuropathic pain: aetiology, symptoms, mechanisms, and management. Lancet. 1999;353:1959-64; 4) Ashburn MA, Staats PS. Management of chronic pain. Lancet. 1999;353:1865-9; 5) Portenoy RK, Kanner RM. Pain Management: Theory and Practice. Philadelphia PA: FA.

Refractory opioid use syndrome in chronic pain

Opioids and dopamine release in Nucleus Accumbens



Neurobiological basis of substance use disorders



- Opioids are effective in acute pain
- Chronic use of opioids causes adaptation of the dopamine release system in Nucleus Accumbens and can lead to development of tolerance and addiction
- While the positive reinforcement/relief of pain diminishes, the negative reinforcement ("hyperkatifeia") increases in a three-stage cycle of addiction

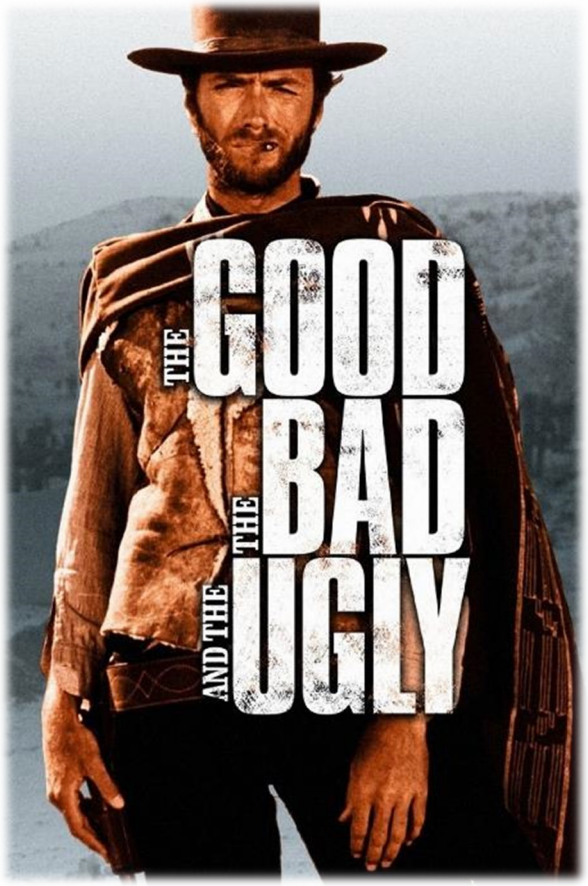
References: 1) Ballantyne JC, Sullivan MD, Koob GF. Refractory dependence on opioid analgesics. Pain 2019; 160: 2655–2660; 2) Koob GF. Drug addiction: Hyperkatifeia/negative reinforcement as a framework for medications development. Pharmacol Rev. 2021;73: 163-201; 3) Grens K. Is it possible to make a nonaddictive opioid painkiller? The Scientist, 2014

IASP statement on opioids for pain management

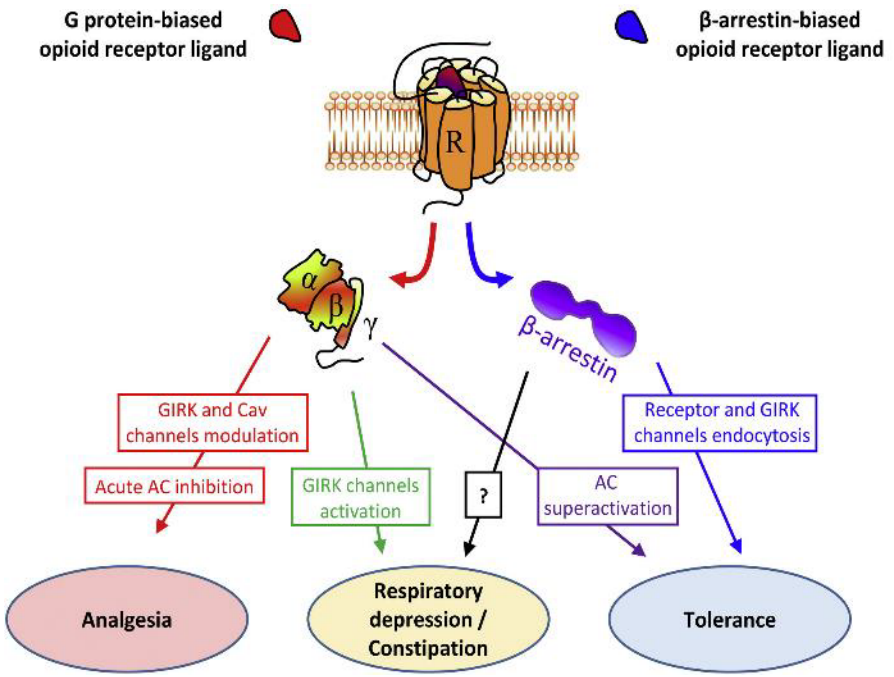
- IASP strongly advocates for access to opioids for the humane treatment of severe short-lived pain, using reasonable precautions to avoid misuse, diversion, and other adverse outcomes.
- At the same time, IASP recommends caution when prescribing opioids for chronic pain. There may be a role for medium-term, low-dose opioid therapy in carefully selected patients with chronic pain who can be managed in a monitored setting. However, with continuous longer-term use, tolerance, dependence, and other neuroadaptations compromise both efficacy and safety.

IASP
INTERNATIONAL ASSOCIATION FOR THE STUDY OF PAIN

Does it matter which opioid we use?



- Opioids differ in the ability to help, harm and kill
- Differences due to pharmacological characteristics in binding to opioid receptors and in particular the mu-opioid receptor



References: Pineyro G, Nagi K. Signaling diversity of mu- and delta- opioid receptor ligands: Re-evaluating the benefits of β-arrestin/G protein signaling bias. Cell Signal. 2021; 80:109906.

Guidelines for chronic/persistent pain treatment

Moderate to severe nociceptive pain

- Codeine with paracetamol (acetaminophen)
- Tramadol
- Buprenorphine (patch)

Severe nociceptive pain

- Morphine
- Oxycodone
- Ketobemidon
- Tapentadol

Introduced by pain specialist:

- Fentanyl
- Buprenorphine (sublingual)
- Methadone

Neuropathic pain

- III: tramadol
- IV: strong opioids

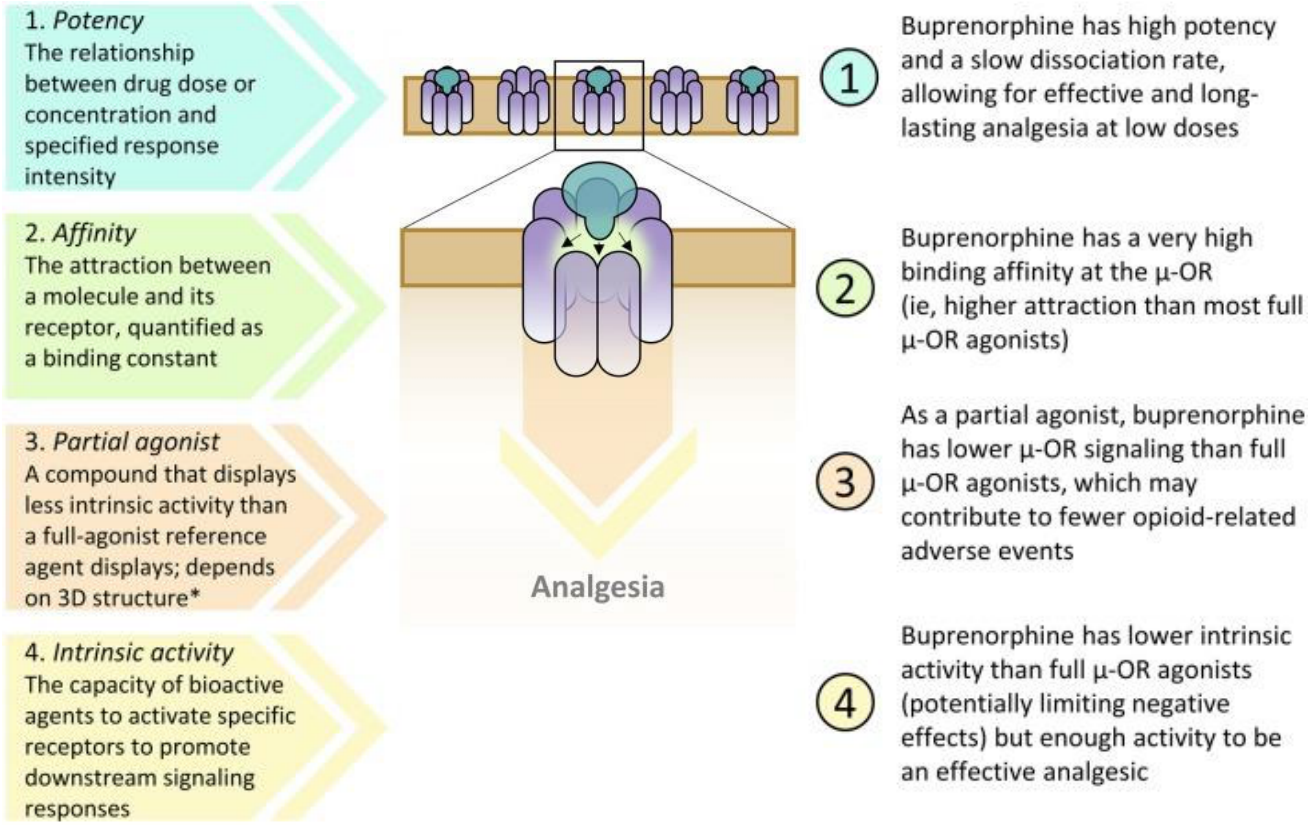
Nociplastic pain – NO!

- Exception: Fibromyalgia – tramadol Gr IV

Comparison of commonly used opioids

	Codeine	Morphine	Oxycodone	Fentanyl	Methadone	Buprenorphine
Analgesia	+	+ +	+ +	+ + +	+ + +	+ + +
Respiratory depression	+ +	+ + +	+ + +	+ + +	+ + +	-
Obstipation	+	+ + +	+ + +	+ + +	++	+
Opioid-induced endocrinopathy	+	+ +	+ +	+ + +	+ + +	+
Addiction	+	+ + +	+ + +	+ + +	+ +	+
Renal clearence dependent	+	+ + +	+	-	+ + +	-
Dysphoria	+	+	+ + +	+ +	+	- - -

Buprenorphine pharmacology



- Buprenorphine has a high potency and effect at low doses and a long-lasting effect through slow receptor dissociation
- It has a higher receptor affinity and can block the effects of other opioids
- As a partial mu-receptor agonist through a different modulation of beta arrestin it has a different side effect profile than other opioids

Can buprenorphine be used to manage withdrawal during opioid tapering in chronic pain patients?

References: Webster L, Gudin J, Raffa RB, Kuchera J, Rauck R, Fudin J, Adler J, Mallick-Searle T. Understanding buprenorphine for use in chronic pain: expert opinion. Pain Med. 2020 ; 21: 714-723.

Multidiciplinary pain centre & addiction program

Multidisciplinary & multiprofessional care

Typical patients at program in Uppsala

Characteristics of the patients

- Age (years): 52 (26-74)
- Pain duration (years): 20 (2-59)
- Opioid treatment (years): 15.6 (2-40)
- Psychiatric comorbidity: 80%
- Primary opioid: 41% oxycodone; 18% fentanyl
- Injection treatments: 13%

Outcomes of treatment

- Perception of treatment: Very good 75%; Quite good 25%
- Global quality of life (QoL) score: 50 (0-100)

Global QoL score of Swedish chronic pain patients: 33 (0-100)

References: Eberstein & Rhodin 2014

Patient experiences

Qualitative results from program

"Um, of course, it would have been wonderful to be completely medicine-free. I have eaten tons of medicines of all kinds, but at the same time, and then I had no choice, so to survive and then I chose it because I didn't want to just lie in bed and be in a lot of pain."

Buvidal testimony

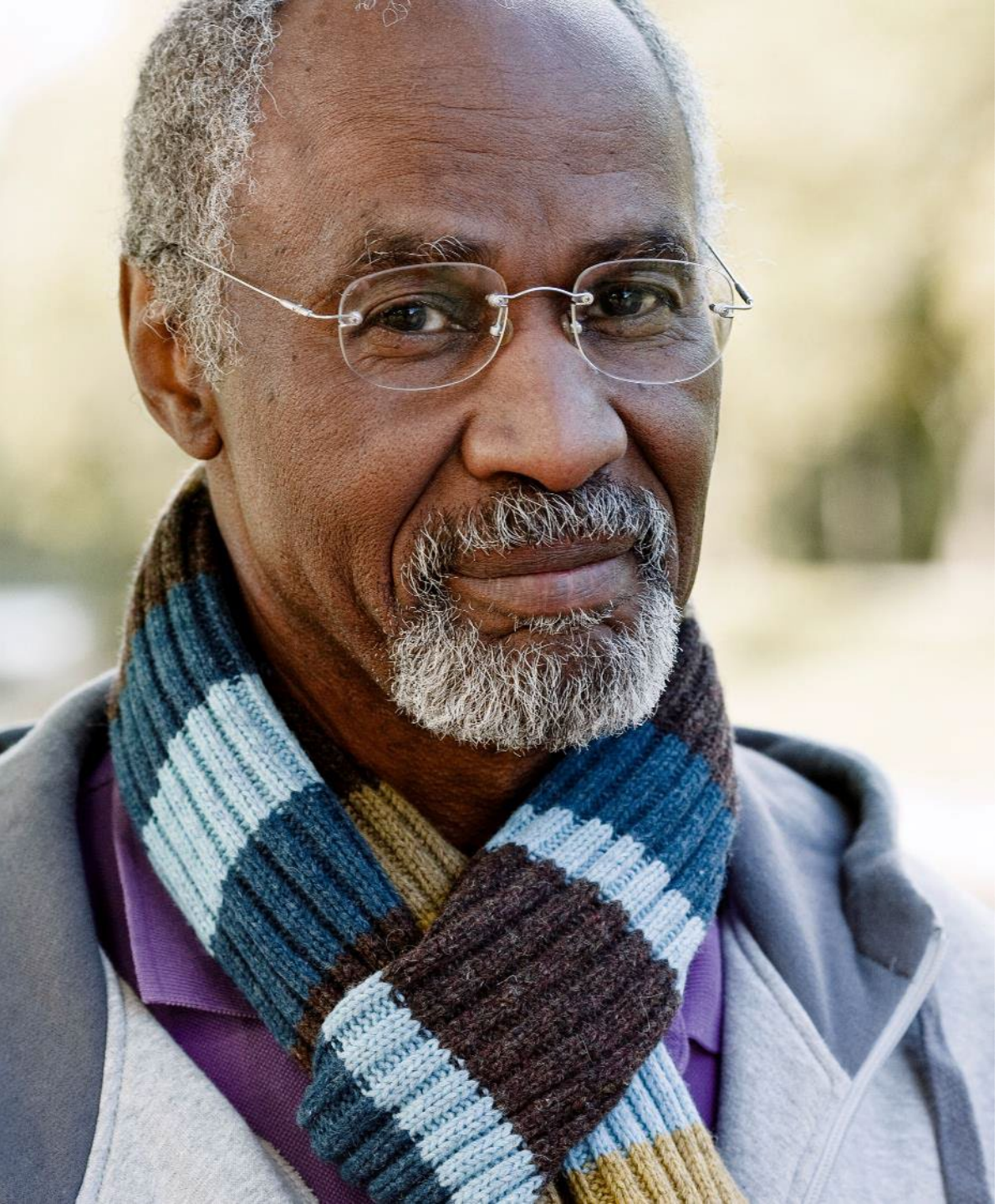
"It is wonderful to skip thinking about taking the pills all day and still be pain-free"

References: Ljungvall H, Rhodin A, Wagner S, Zetterberg H, Åsenlöf P."My life is under control with these medications": an interpretative phenomenological analysis of managing chronic pain with opioids. BMC Musculoskelet Disord. 2020; 21: 61.

camurus®

Bringing CAM2029 to registration in three rare disease indications

Markus Johnsson
Senior VP R&D



CAM2029 – octreotide subcutaneous depot in Phase 3 development

Investigational treatment of three, serious, rare diseases with high unmet medical needs

- Acromegaly
- Gastroenteropancreatic neuroendocrine tumors (GEP-NET)
- Polycystic liver disease (PLD)

Designed for enhanced efficacy and patient convenience

camurus.

Somatostatin analogs established treatment

Wide use of somatostatin analogs (SSAs)

- Antisecretory, antiproliferative, and immunomodulatory activity
- First-line medical treatment of acromegaly (ACRO) and neuroendocrine tumors (NET)[1]
- SSAs also used in other fields of endocrinology and oncology, as well as in gastrointestinal, kidney and liver diseases[2]

SSA market dominated by long-acting injectables

- Key products: Sandostatin® LAR® (octreotide LAR) and Somatuline® Autogel® (lanreotide ATG)

Source: 1. Pavel, M. et al. Cancer Chemotherapy and Pharmacology. 2019; 83:375–385. doi: 10.1007/s00280-018-3734-1; 2. Gomes-Porras, M. et al. Int J Mol Sci. 2020 Mar; 21(5): 1682.

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Key limitations of current SSA therapies

Sandostatin® LAR®

First approved 1998

POSOLOGY	Monthly intramuscular injection
DOSAGE FORM	19-gauge 38mm needle
DOSE	10-40mg per month, 2.5mL

Limitations:
- Complex reconstitution
- Refrigerated storage
- Large injection needle
- IM injection
- Dosing by trained HCP
- Limited exposure, and efficacy with incomplete symptom control[1,2]

Somatuline® Autogel®

First approved 2007

POSOLOGY	Monthly deep subcutaneous injection
DOSAGE FORM	18-gauge 20mm needle
DOSE	60-120mg per month, 0.2-0.5mL

Limitations:
- Refrigerated storage
- Large injection needle
- Deep SC injection
- Dosing by HCP (US)
- Limited efficacy with incomplete symptom control[1,2]

Mycapssa®

First approved 2020

POSOLOGY	Twice daily (BID)
DOSAGE FORM	Oral capsule
DOSE	40-80mg per day

Limitations[3,4]:
- Significant food effect requiring dosing under fasting conditions twice daily
- Multiple DDIs
- Modest efficacy – 42% of patients in pivotal trial lost biochemical control (IGF-1) after switch from injectable SSAs
- Not approved in NET

Source: 1. Colao A, et al. Pituitary 2016; 19:235–247.; 2. Anthony LB, et al., Oncologist 2021; Jul;26(7): e1171-e1178; 3. Mycapssa US label; 4. Samson SL, et al., J. Clin. Endocrinol. Metab. 2020, 105(10): e3785–e3797

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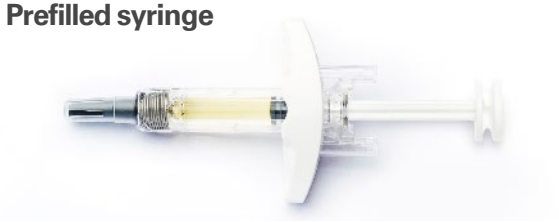
CAM2029 designed to address key limitations

Differentiating features

- ✓ Ready-for-use FluidCrystal® technology
- ✓ Rapid onset and long-acting octreotide release[1]
- ✓ 500% increased plasma exposure vs Sandostatin LAR with potential for improved efficacy[1,2,3]
- ✓ State-of-the-art, pre-filled syringe or pen devices enabling convenient patient self-administration
- ✓ Subcutaneous administration with thin needle (22-gauge, 12.5mm)
- ✓ Room temperature storage

State-of-the-art product designs

Prefilled syringe



Prefilled pen

Attributes ranked most important by nurses: fast administration, no clogging, and no product losses[4]

Source: 1. Tiberg F, et al., Br J Clin Pharmacol. 2015; 80(3): 460-472; 2. Constant dose; 3. Pavel M , et al., Cancer Chemotherapy and Pharmacology 2019; 83: 375-383; 4. Adelman D et al. Adv Ther. 2020;37(4):1608-19.

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CAM2029 potential improvements over current SSA treatments

Patients

- Self-administration – reduced treatment burden of dosing visits
- Improved symptom control
- Improved Quality of Life (QoL)

Healthcare system

- No need for complex reconstitution and temperature conditioning – time saving
- No incomplete dosing or product waste due to needle clogging
- Improved efficacy and overall treatment outcomes

"A real challenge with the current therapies is that you are tethered to your medical center, to needing to be someplace that can give you your shot every 28 days."

Patient - US, NET

"I think everybody would take it or would swap to it. Why would they take this horse needle I call it, over something new and different like this?"

KOL - US, acromegaly

"The high bioavailability [of CAM2029] is a good one, because I think from former studies, the antiproliferative effect is to some extent dose related, so it makes sense."

KOL - EU, NET

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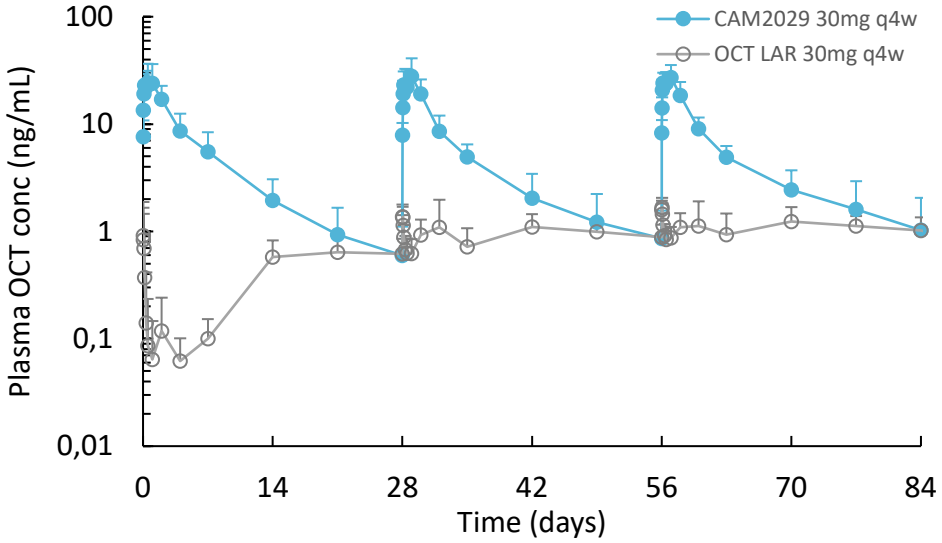
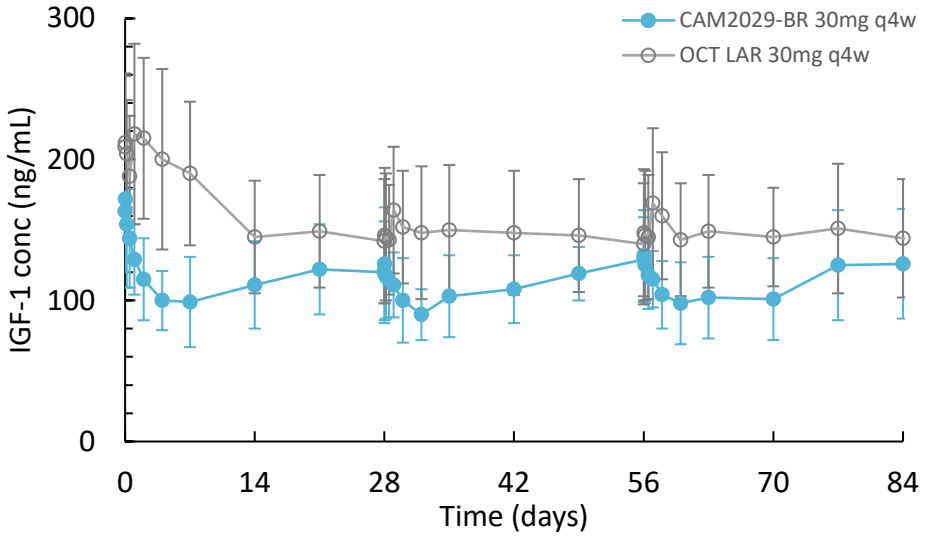
CAM2029 provides enhanced octreotide exposure

Octreotide plasma concentrations



IGF-1 concentrations



Source: Tiberg F, et al. Br J Clin Pharmacol. 2015 Sep;80(3):460-72.
OCT, octreotide; IGF-1, insulin-like growth factor 1

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Positive results from 5 completed clinical trials

- Dose proportional long-acting octreotide release suitable for once monthly dosing[1]
- Enhanced octreotide exposure with ~500% increase of octreotide bioavailbility[1]
- Rapid and sustained suppression of IGF-1 in healthy volunteers[1]
- Biochemical control (IGF-1 and GH) indicated in acromegaly patients[2]
- Symptom control indicated in NET patients[2]
- Bridging PK to pre-filled pen device
- Safety and local tolerability profile supporting confirmatory Phase 3 trials[1,2]

Source: 1. Tiberg F, et al., Br J Clin Pharmacol 2015; 2. Pavel M, et al., Cancer Chemother Pharmacol 2019 .

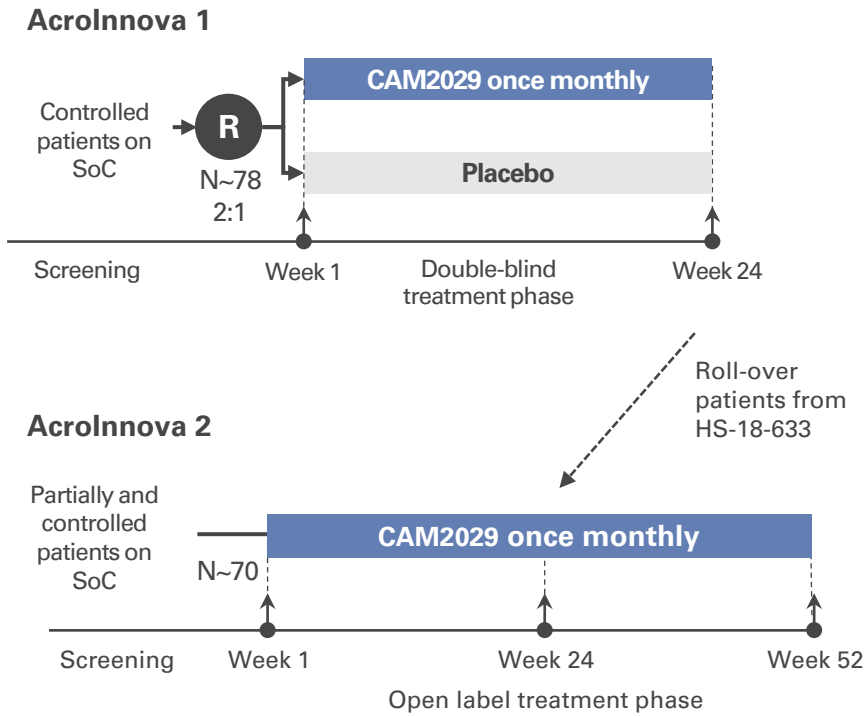
AcroInnova Phase 3 program based on two parallel trials to meet regulatory requirements

Pivotal randomized, placebo-controlled Phase 3 trial

- Rigorous, 24-week, randomized, double-blind, placebo-controlled trial
- Biomarker response (IGF-1≤1xULN) primary endpoint
- **Filling regulatory requirement for efficacy**
- CAM2029 PK–PD modelling and simulations used to predict result

Long-term safety Phase 3 trial

- 52-week long-term safety, switch and extension trial
- **Filling regulatory requirements for safety exposure**
- Effective and easy for patients to continue CAM2029
- Broad study population of partially and fully controlled patients

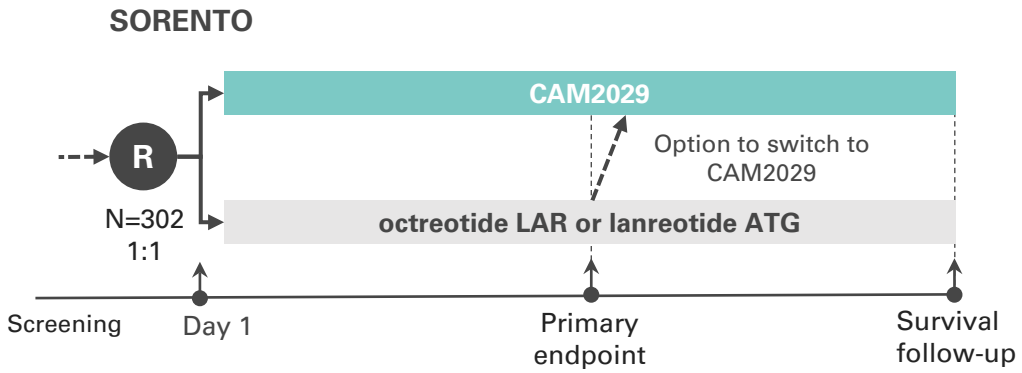


PK – pharmacokinetics of octreotide; PD- pharmacodynamics (IGF-1 concentrations)

SORENTO Phase 3 trial assesses superiority versus standard of care

Pivotal randomized, active-controlled Phase 3 trial

- Primary endpoint is superiority in progression free survival, PFS, versus octreotide LAR and lanreotide ATG
- Assessed after 194 progression events
- Multiple patient reported outcomes included in study
- **Single, large trial fills regulatory requirements for safety and efficacy**
- Broad GEP-NET population of grade 1 to grade 3 tumors

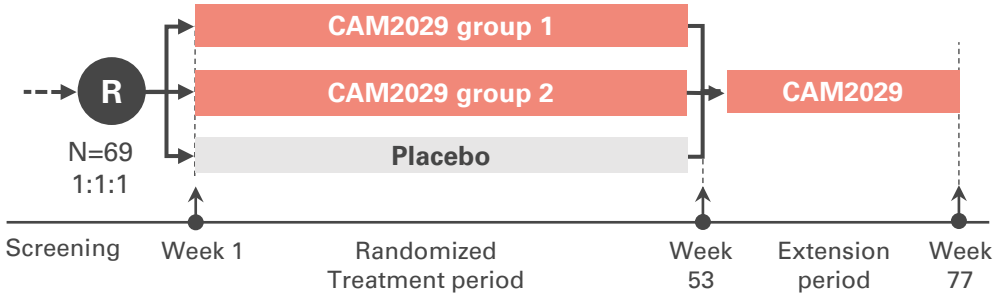


PFS – progression free survival; LAR – long-acting release; GEP-NET – gastroenteropancreatic neuroendocrine tumors

Clinical Phase 2b trial, POSITANO, started in PLD

Significant unmet need with no approved treatment

- PLD is a rare, genetic and chronic disorder
- Progressive growth of cysts in the liver
- Can cause severe symptoms and impaired quality of life
- Estimated ~30,000 patients with symptomatic PLD[1]
- No approved pharmacological treatment available
- Increased scientific evidence for SSA's



POSITANO trial to assess efficacy and safety

- 52-week randomized, placebo-controlled, three-arm trial
- Primary endpoint is liver volume change
- Key secondary endpoint Camurus' developed PROs, PLD-S

PLD – polycystic liver disease, SSAs – somatostatin analogues ; PRO – patient reported outcome ; PLD-S – PLD symptoms
[1]*Globe Life Science 2020,*

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CAM2029 recent and upcoming milestones

ACRO

- ❑ Completed enrollment H2 2022
- ❑ Topline Phase 3 efficacy results H1 2023
- ❑ NDA and MAA submissions 2023/24

AcroInnova™

NET

- ✓ Start SORENTO Phase 3 trial
- ❑ Est. enrollment completion H1 2023
- ❑ Completion SORENTO efficacy part after 194 PFS events
- ❑ Est. NDA/MAA submissions 2025

SORENTO™

Subcutaneous Octreotide Randomized Efficacy in Neuroendocrine TumOrs

PLD

- ✓ Orphan drug designation (US)
- ✓ New PROs developed and aligned with FDA
- ✓ Phase 2b trial started June 2022
- ❑ Target enrollment completion H1 2023
- ❑ Topline results H1 2024

positano™

POlycystic liver Safety and efficacy TriAl with subcutaNeous Octreotide

AcroInnova

Ocreotide SC depot (CAM2029) in treatment of acromegaly

Diego Ferone

Unit of Endocrinology (DiMI), IRCCS Policlinico San Martino, University of Genova, Italy

Center of Excellence for Biomedical Research
- University of Genoa -

Università di Genova

OSPEDALE POLICLINICO SAN MARTINO
Sistema Sanitario Regione Liguria

Acromegaly

- Rare pituitary disorder caused by a benign tumor and excess of growth hormone
- Slowly developing chronic disease with progressive physical changes or disability, often unrecognized, leading to late diagnosis
- Incidence: 2-11 cases per million/population/year
- Prevalence: 50-70 cases per million population (underestimated by late diagnosis ~ 7-10 years)
- Uncontrolled acromegaly increases the risk of significant morbidity and mortality

Maurice Tillet
French actor

Shrek

Robert Pershing Wadlow
2.71 m, 450 kg

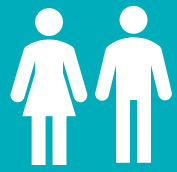
Pierre Marie's patient (1891)

Rare disease diagnosed late

- 75% of patients present with a macroadenoma, which could be explained by delayed diagnosis[1]
- >85% patients with microadenomas and 40–50% with macroadenomas enter disease remission following TSS[2]
- Factors associated with disease recurrence include large tumor size, tumor invasiveness, high GH secretion[3]
- Recurrence rate of 2–8% within 5 years of surgery[2]

2–11 cases per million people/year[4]

40 years at diagnosis[5]



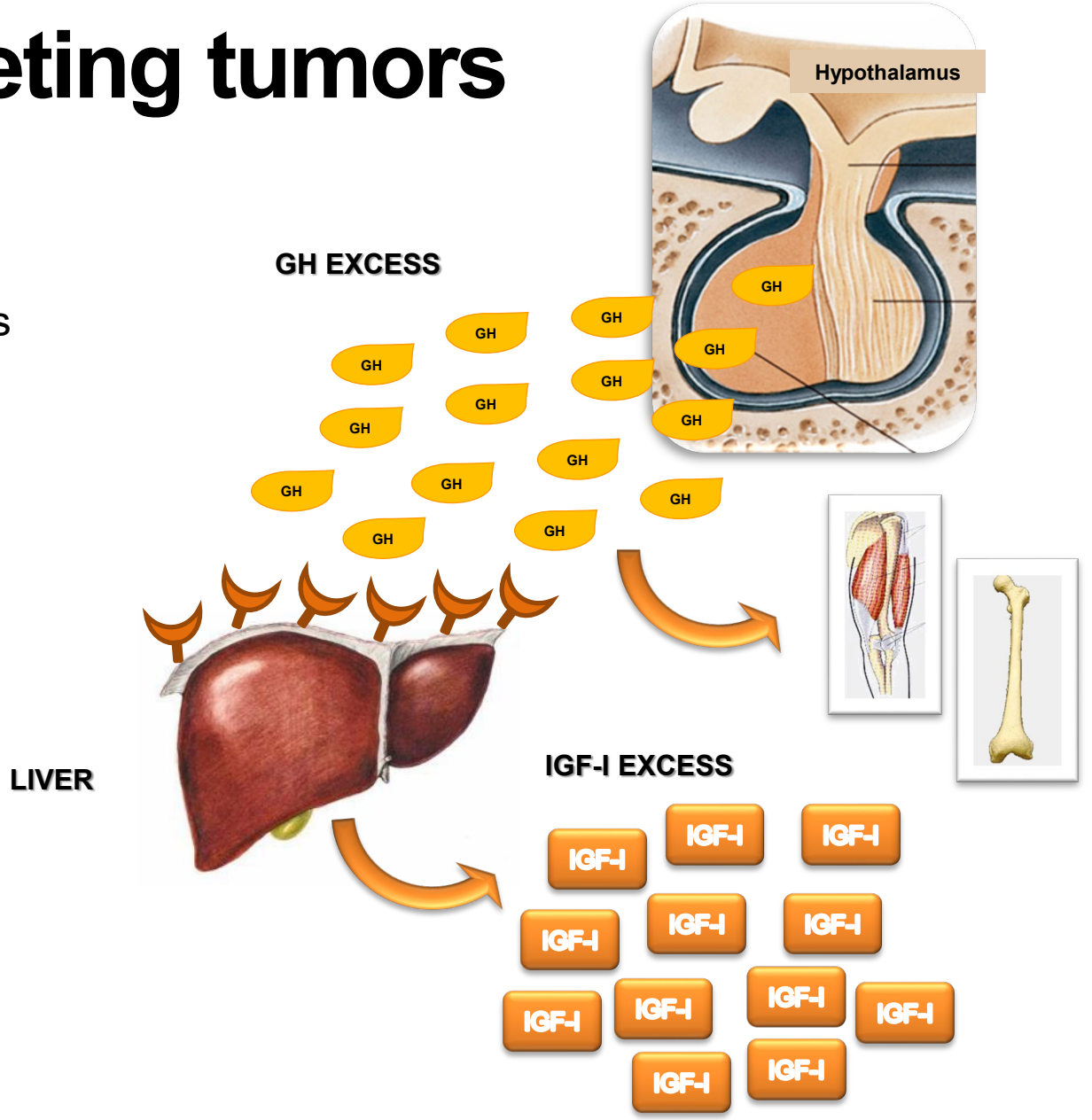
Affects men and women equally[5]

GH, growth hormone; TSS, transsphenoidal surgery

Source: 1. Cuevas-Ramos D et al. JCEM 2015; 2. Katznelson L et al. JCEM 2014; 3. Carrasco CA et al. Pituitary 2014; 4. Crisafillu S, et al. Eur. J. Endocrinol, 185(2), 251-263, 2021.; 5. Chanson P, Sylvie S. Orphanet J Rare Dis 2008.

Caused by GH secreting tumors

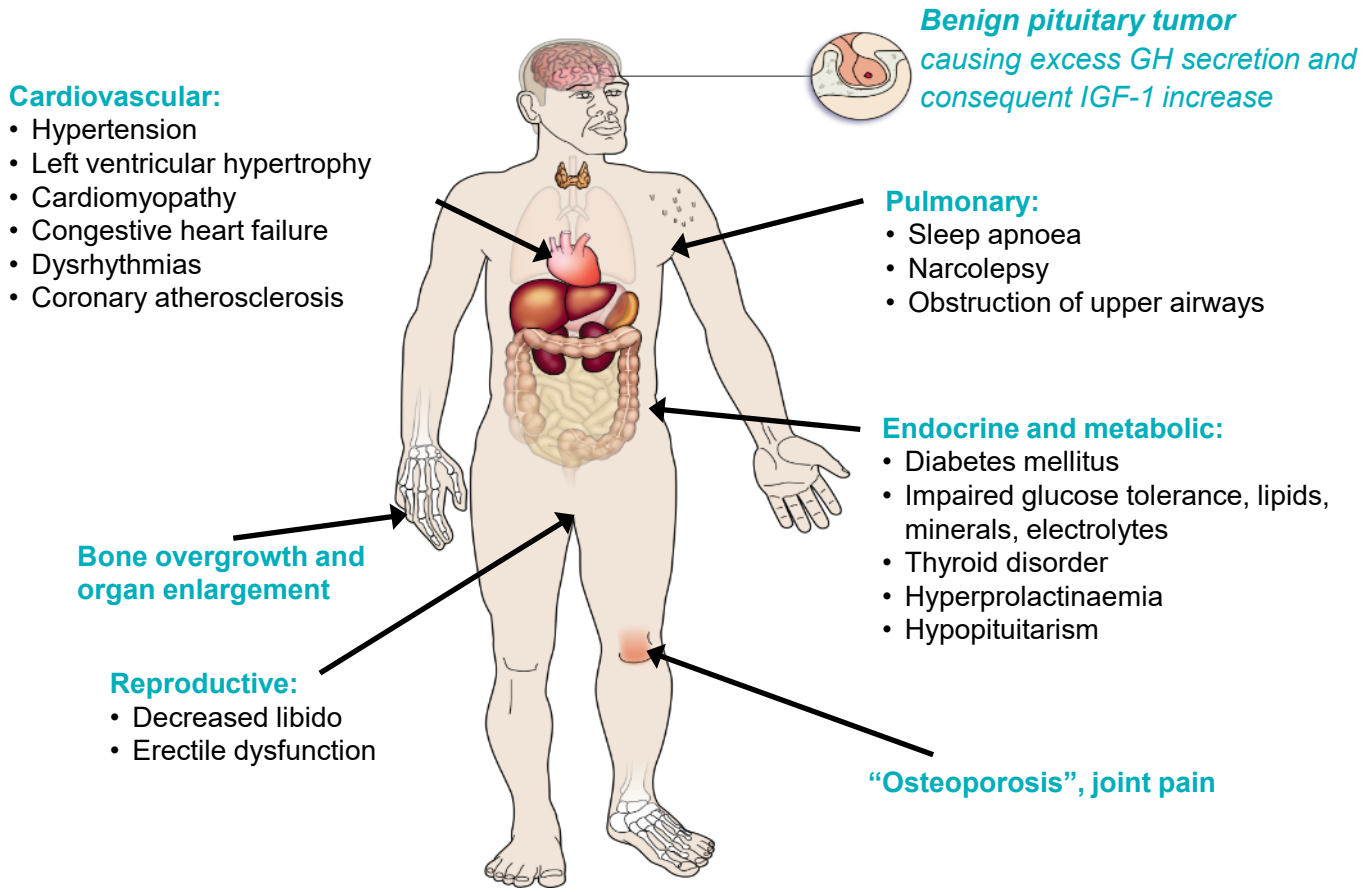
- Vast majority of cases is caused by a growth hormone (GH) secreting adenomas
- More rarely by ectopic tumors secreting GH or its releasing factor (GHRH)



IGF-1, insulin-like growth factor-1

Disease symptoms and morbidity

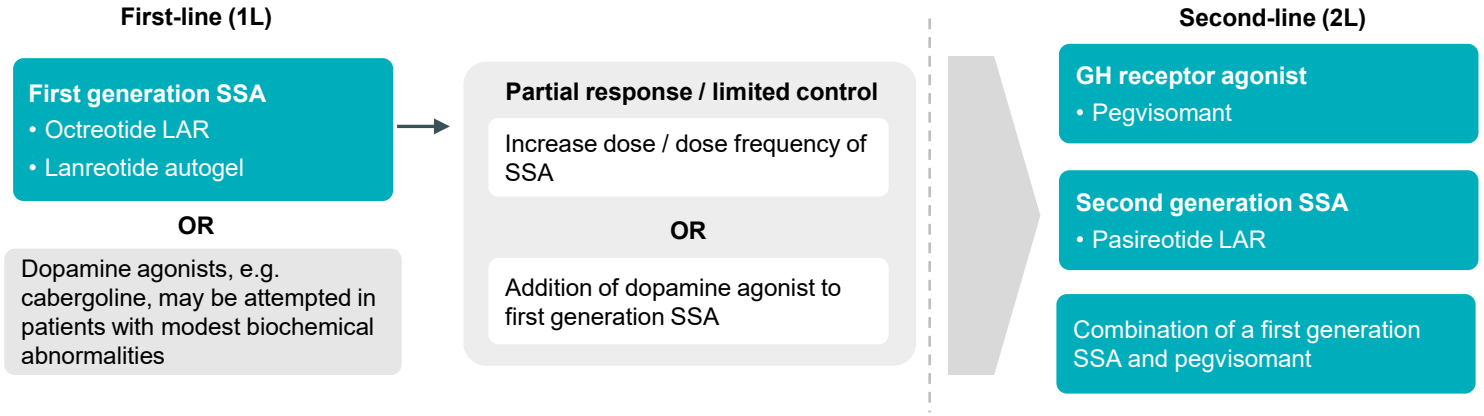
Significant morbidity can develop in patients between disease onset and diagnosis



GH, growth hormone; IGF-1, insulin-like growth factor-1
Source: Melmed S. J Clin 2009; Kyriakakis N et al. Endocrinol Diabetes Metab; Gadelha MR et al. Endocr Rev 2019

SSAs are first-line medical treatment

- Transsphenoidal surgery of micro- and macro-adenomas
- First-line medical treatment is first-generation, long-acting somatostatin analogs (SSAs) – octreotide LAR and lanreotide Autogel (rarely dopamine agonist)
- For partial responders, dose and dose frequency of the SSAs may be increased, or cabergoline may be added to SSA treatment
- Second line therapy often includes pegvisomant and pasireotide



SSAs, somatostatin analogues; LAR, long-acting release

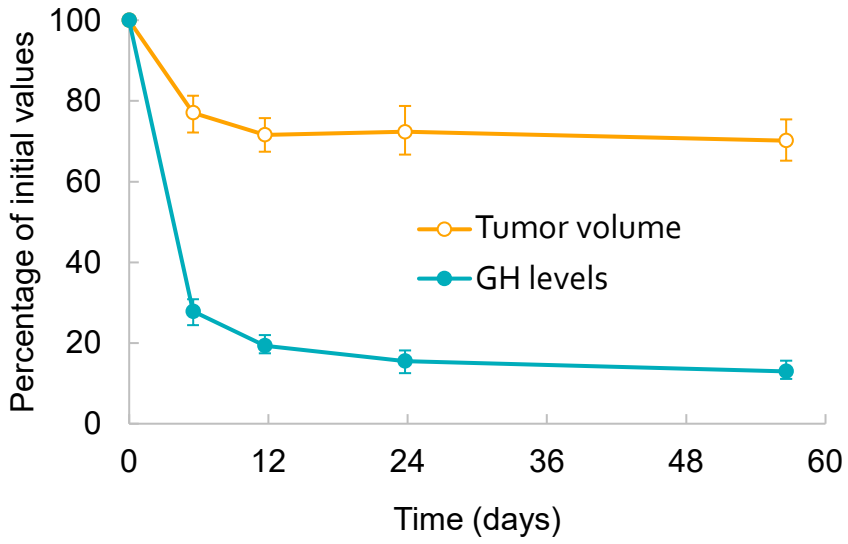
Source: Melmed S, et al., Nat Rev Endocrinol. 2018 Sep;14(9):552-561

Tumor shrinkage and GH suppression on exposure to octreotide

SSA treatment in acromegaly

- Treatment objectives
  - Normalize GH and IGF-1 levels
  - Control or reduce tumor size
  - Improve comorbidities
- Alternative to surgery in patients with controlled GH and IGF-1
- Long-acting octreotide and lanreotide constitutes first line treatment
- Potential for improved response rate by optimizing plasma exposure

Pituitary tumor volume and serum GH levels[1]



The effects of octreotide total pituitary volume and serum GH levels during treatment of 18 patients with acromegaly, expressed as percentages of the pre-treatment values (mean 6 SEM).
Redrawn from [1]Lundin P et al, AJNR Am J Neuroradiol 1997:18:765–772

GH, growth hormone; IGF-1, insulin-like growth factor-1; SSA, somatostatin analogs

Treatment limitations of current therapies

Injectable treatments - standard of care

- IM or deep SC injections with large needles[1,2]
- Lack of self- or partner administration impacts patient's sense of autonomy[1,2]
- Frequent dosing visits at specialist clinics
- Modest biochemical and disease control
  - Less than half of acromegaly patients biochemically controlled

Oral treatment

- Twice daily dosing (up to three monthly doses 80mg) under fasting conditions[3]
- Very low bioavailability <1% and food effects
- Limited efficacy and utility to stable patients

IM, intramuscular; SC, subcutaneous; LAR, long-acting release

Source: 1. Somatuline® Depot Prescribing information, Ipsen Biopharmaceuticals; 2. Sandostatin LAR® Depot Prescribing information, Novartis Pharmaceuticals; 3. MYCAPSSA® Prescribing information, Chiasma.

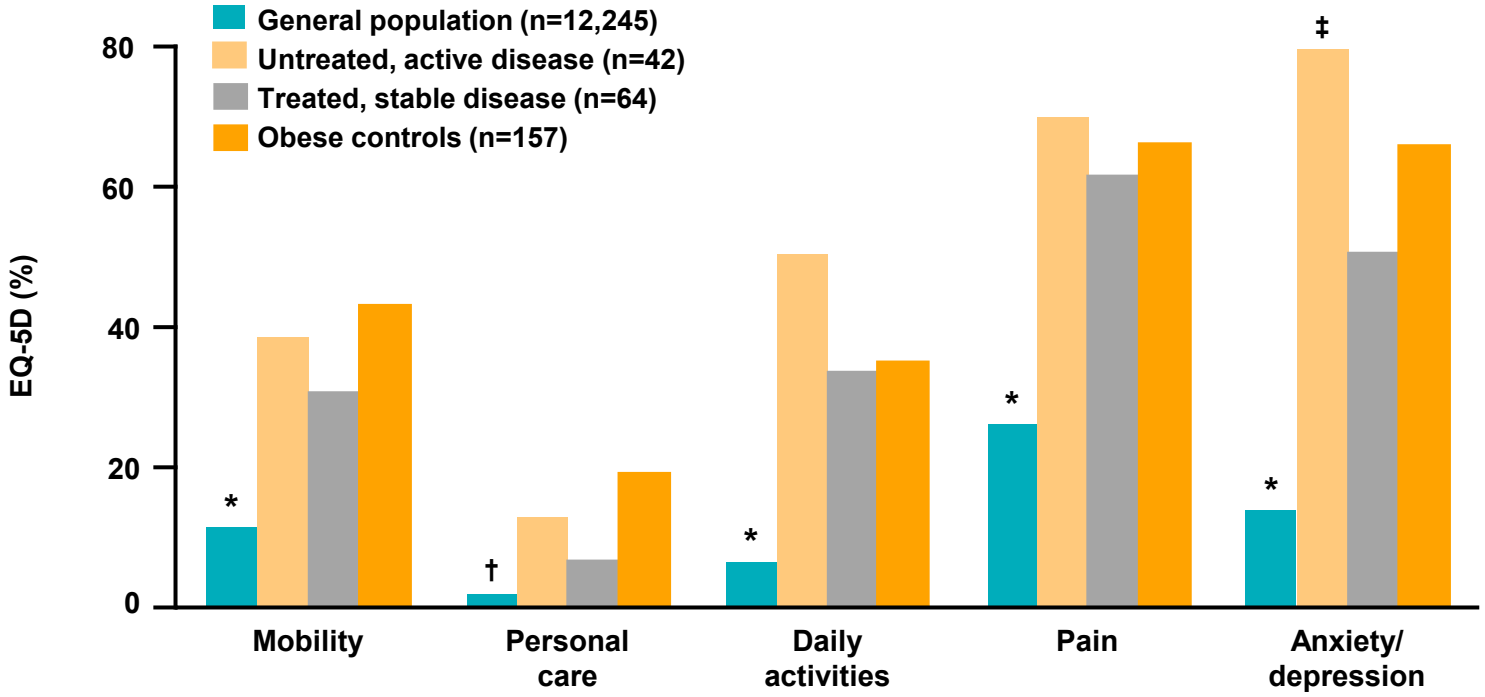
Impaired quality of life of patients

- Patients **report impaired health-related quality of life (QoL)**[1]
- Disease control, treatment satisfaction and convenience improves QoL
- Symptoms and comorbidities, impaired appearance and physical status decreases QoL
- Even biochemically stable patients reported compromised QoL, incl.:
  - 65% of patients being bothered by need to schedule injections
  - 74% had issues with need to travel

Source: 1. Geer EB, Sisco J, Adelman DT, Ludlam WH, Haviv A, Liu S, et al. Patient reported outcome data from acromegaly patients treated with injectable somatostatin receptor ligands (SRLs) in routine clinical practice. BMC Endocr Disord. 2020;20(1):117.

HRQoL impairment is greatest in patients with untreated, active disease

In this prospective, observational study, 106 adults with acromegaly were included from 16 centres throughout Spain



*P<0.01 versus all study groups
†P<0.05 versus untreated and not significant versus treated group
‡P<0.01 untreated versus treated

Treated, stable disease included patients with active or controlled acromegaly clinically stable for >1 year prior to inclusion
Obese controls, BMI >30 kg/m^2

BMI, body mass index
Source: Webb S et al. Eur J Endocrinol 2006

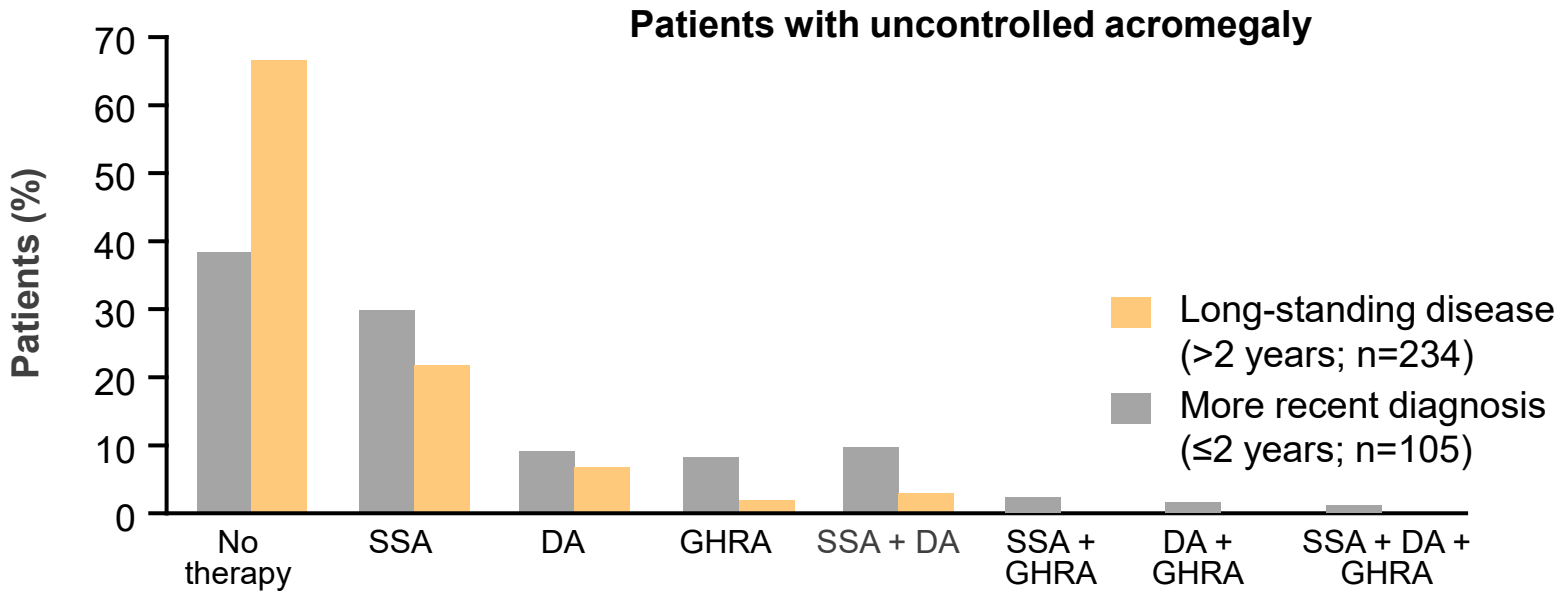
Many uncontrolled patients do not receive appropriate medical therapy

Results from the German acromegaly registry (n=1344)

- Patients could have had ≥1 pituitary surgery and/or received radiotherapy

72% (917/1275) of patients with available IGF-1 values at last follow-up had normalized IGF-1

- IGF-1 remained elevated in 358 patients



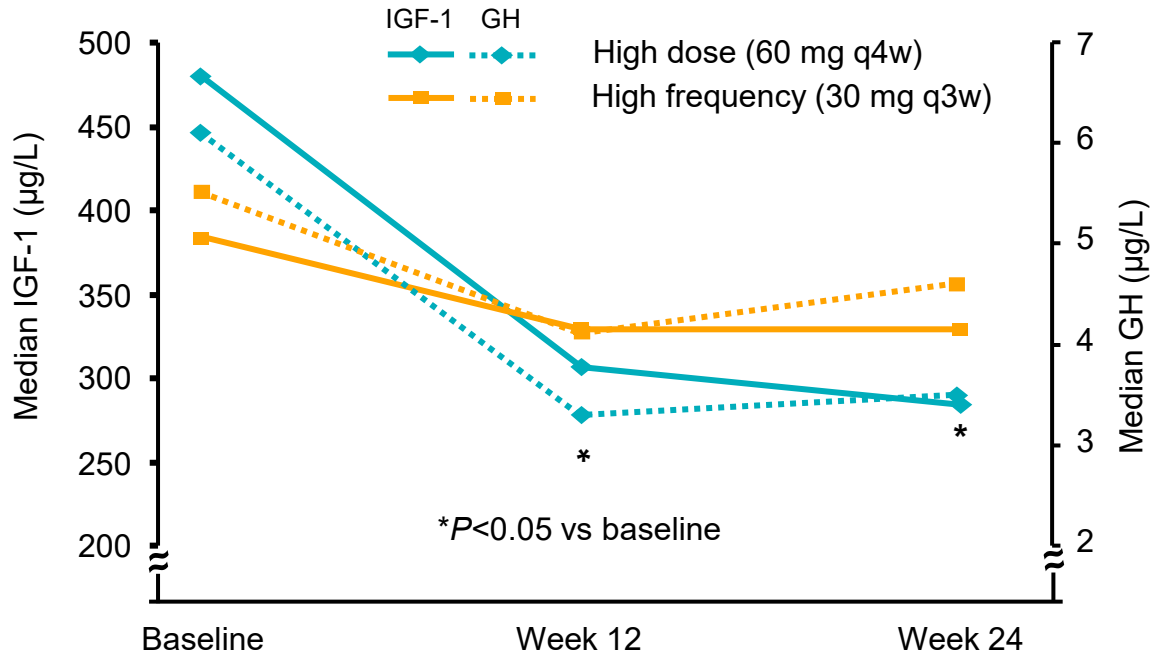
47.2% (169/358) of patients with uncontrolled acromegaly (IGF-1 >ULN for age and sex) were not receiving medical therapy at last follow-up

ULN, upper limit of normal; DA, dopamine agonist; GHRA, GH receptor antagonist; SSA, somatostatin analog; IGF-1, Insulin-like growth factor-1
Schöfl C et al. Eur J Endocrinol 2012;168(1):39–47

Improved biochemical response with high-dose octreotide

At Week 24, median IGF-1 and GH levels were improved in patients treated with high-dose and high-frequency octreotide LAR:

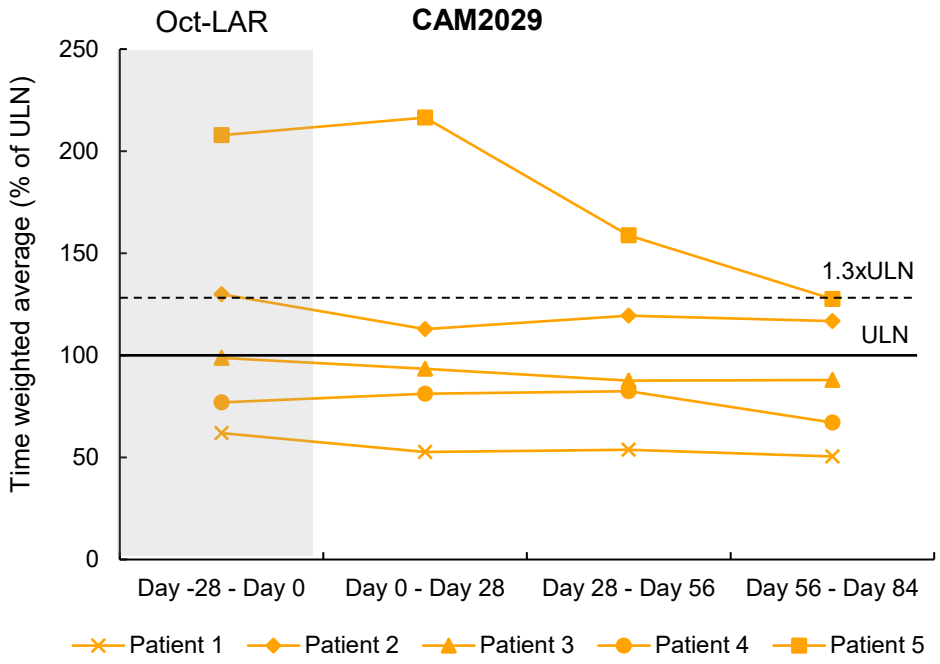
- Significant IGF-1 and GH-level reduction when increasing to unconventional octreotide dose
- Trend of improved efficacy with increased frequency
- Effects related to increased octreotide plasma exposure



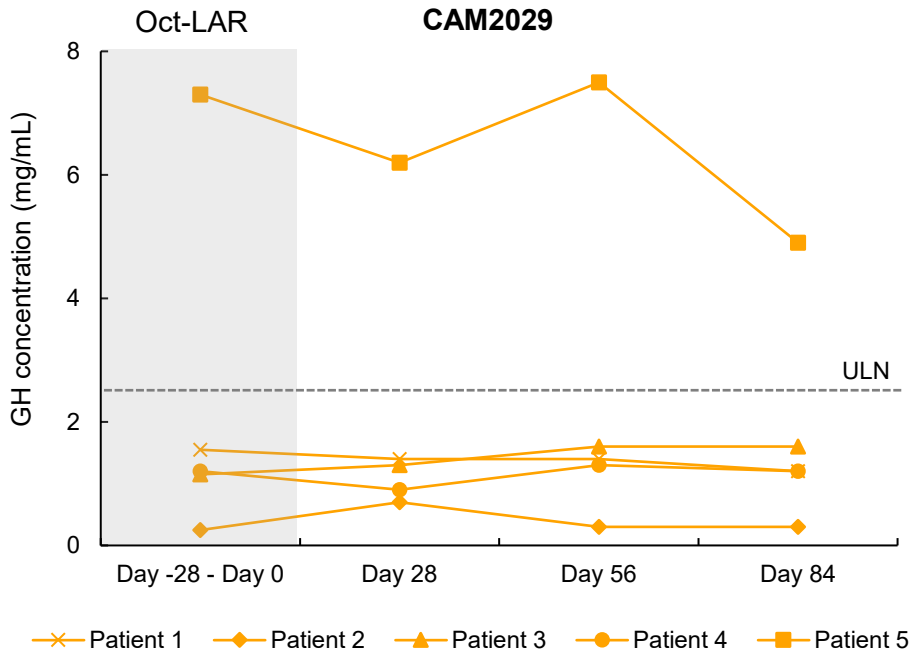
LAR, long-acting release; GH, growth hormone; IGF-1, insulin-like growth factor-1
Source: Giustina A, et al. .Eur J Endocrinol. 2009

Well-maintained or improved biochemical control indicated with CAM2029

Insulin-like growth factor-1, IGF-1



Growth hormone, GH



Analysis of data from Pavel M et al. Cancer Chemotherapy and Pharmacology 2019

Oct-LAR, ocreotide long-acting release

Pivotal Phase 3 RCT to determine efficacy

Phase 3, randomized, double-blind, placebo-controlled, multi-center trial to assess efficacy and safety of CAM2029

Primary objective:

- To assess the superiority of CAM2029 compared to placebo in biochemical response for insulin-like growth factor-1 (IGF-1)

Primary endpoint

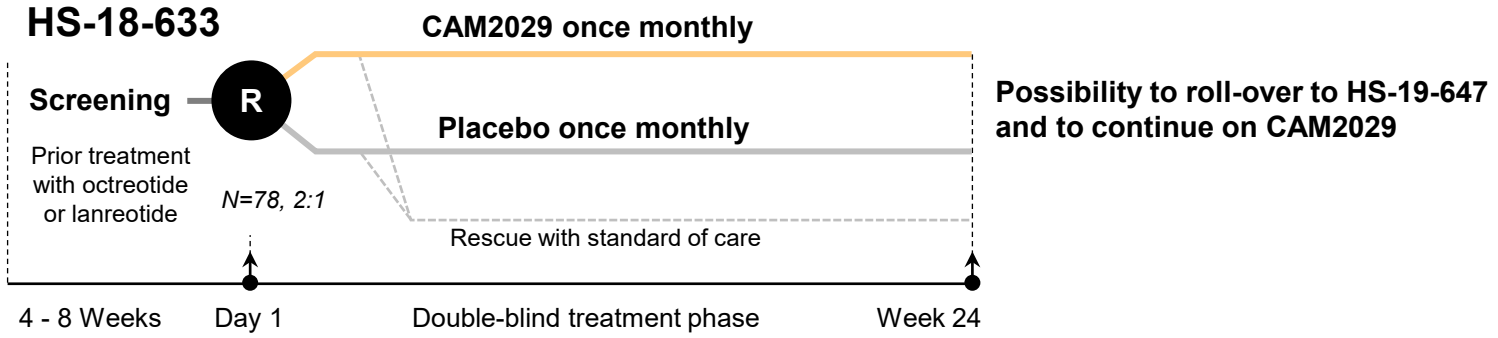
- Proportion of patients with mean IGF-1 levels ≤1x upper limit of normal (ULN) at Week 22 and Week 24 (average of the 2 measurements)

Main secondary endpoints:

- Biochemical response (IGF-1, GH)
- Tumor size
- Patient satisfaction and quality of life
- Self- or partner administration
- Plasma concentrations of octreotide
- Safety

Stable patient population:

- Patients (n~78) with confirmed acromegaly on treatment with a stable dose of octreotide long-acting release or lanreotide autogel for at least 3 months and with IGF-1 levels ≤1xULN and mean GH cycle levels <2.5 µg/L at screening



Auxiliary Phase 3 long-term safety trial

12-month, open-label, single arm, multi-center Phase 3 trial to assess safety of CAM2029

Primary objective:

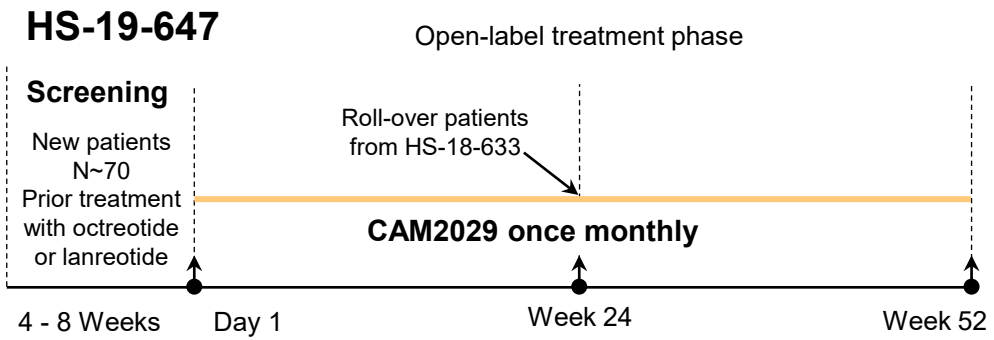
- To assess long-term safety and tolerability of CAM2029

Main secondary endpoint

- **Biochemical response (IGF-1, GH)**
- **Patient satisfaction and quality of life**
- Self- or partner-administration
- Plasma concentrations of octreotide

Broad patient population, including:

- Patients who are inadequately controlled by previous treatment
- Patients who have received prior pituitary radiotherapy (3 years cut-off)
- Patients from study HS-18-633



Phase 3 program progress

Screening and enrollment under finalization

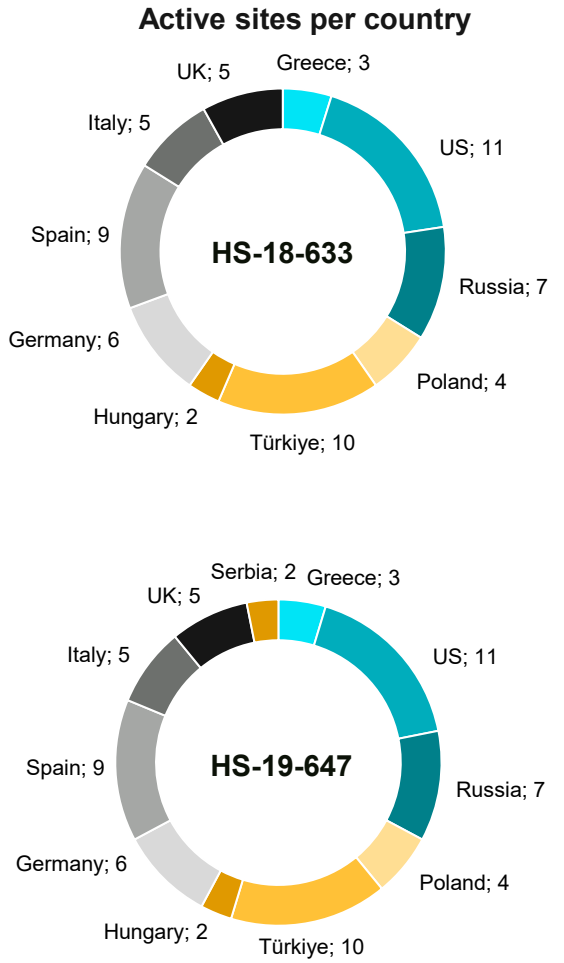
- Final phase of patient recruitment
- Patient satisfaction
- Quality of life (QoL)
- Self-administration

Phase 3 efficacy study results expected in H1 2023

- **Biochemical control (IGF-1 and GH)**
- Patient satisfaction
- Quality of life (QoL)
- Self-administration

Phase 3 long-term safety study results

- **Safety and tolerability**
- Biochemical control rates (IGF-1 and GH)
- Patient satisfaction and QoL
- Self-administration



GH, growth hormone; IGF-1, insulin-like growth factor-1

Continued need to improve treatment of acromegaly

Underestimated disease

- Slow development and late diagnosis
- High disease burden

Improvement potential

- Dosing and treatment experience
- Easy self-administration
- Increased plasma exposure
- Better biochemical and symptom control

Unmet medical need

- Reduced treatment burden
- Increased compliance
- Modest disease control

CAM2029 strong candidate

- Answers in ongoing Phase 3 studies

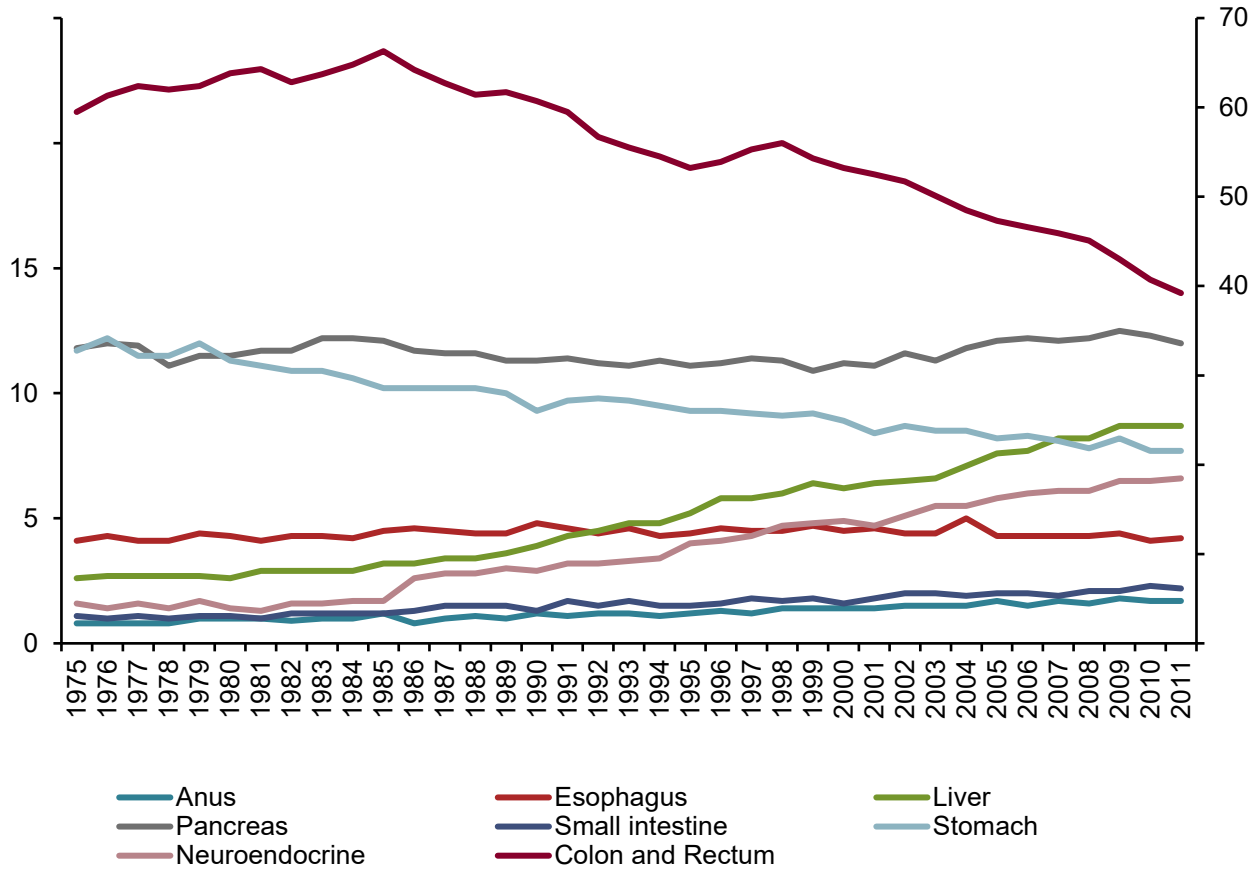
Neuroendocrine Cancers:

Unmet Medical Needs and Opportunities

Simron Singh, MD. MPH. FRCPC.

Associate Professor, University of Toronto
Co-head, Susan Leslie Clinic for Neuroendocrine Cancers
Provincial Lead, Cancer Care Ontario, Person Centered Care
Scientist – Institute for Clinical Evaluative Sciences, Sunnybrook Research Institute

Incidence Rates of GI Malignancies From SEER Registries: Age-Adjusted Rates per 100,000



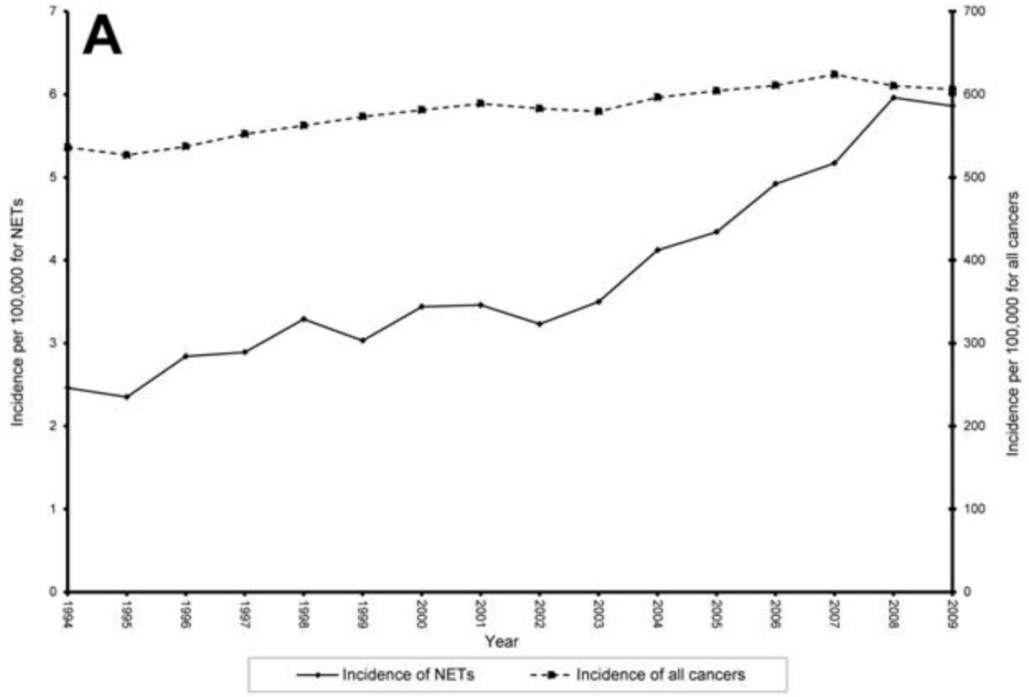
Slide Courtesy of Dr. J Yao

GI, gastrointestinal.

*Surveillance, Epidemiology, and End Results (SEER) Program (www.seer.cancer.gov) SEER*Stat Database. National Cancer Institute, DCCPS, Surveillance Research Program, Surveillance Systems Branch, released April 2014, based on the November 2013 submission.*

NETs epidemiology: More common than thought

Incidence NETs, Ontario, CANADA 1994-2009 (n=5,619)



2.4X increase in incidence over 15 y

2.48 (95%CI 2.13-2.83) to **5.86** (95%CI 5.40-6.35) cases per 100 000 per year

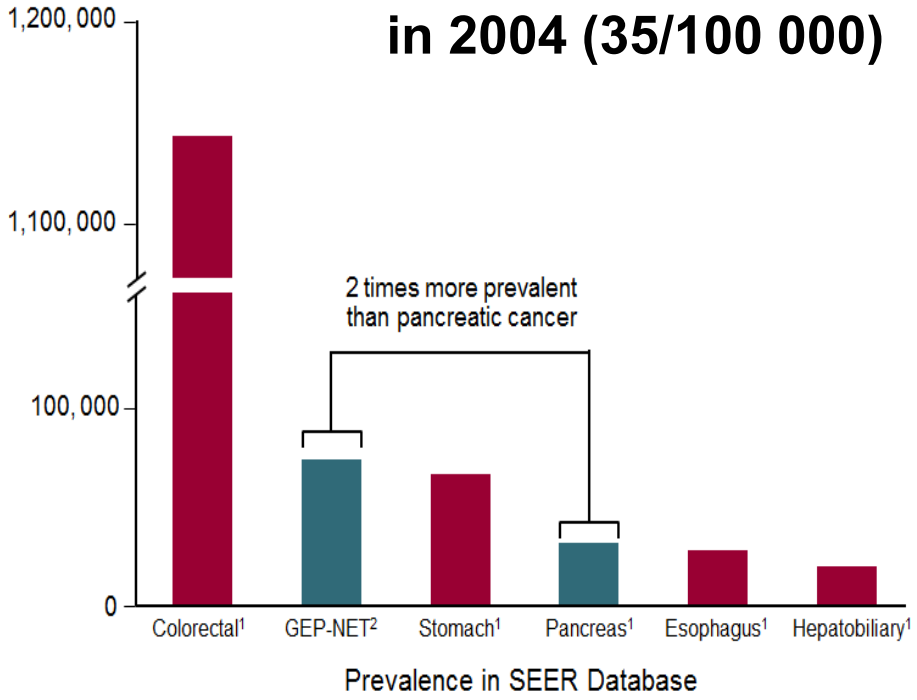
Source: Hallet J et al, Cancer. 2015

NET Prevalence

[1] SEER Estimated 29-year limited-duration prevalence

103,312

in 2004 (35/100 000)



GEP = gastroenteropancreatic

[1]National Cancer Institute. SEER Cancer Statistics Review, 1975-2004. http://seer.cancer.gov/csr/1975_2004;
[2]Modlin IM, Lye KD, Kidd M. *Cancer*. 2003;97(4):934-959.

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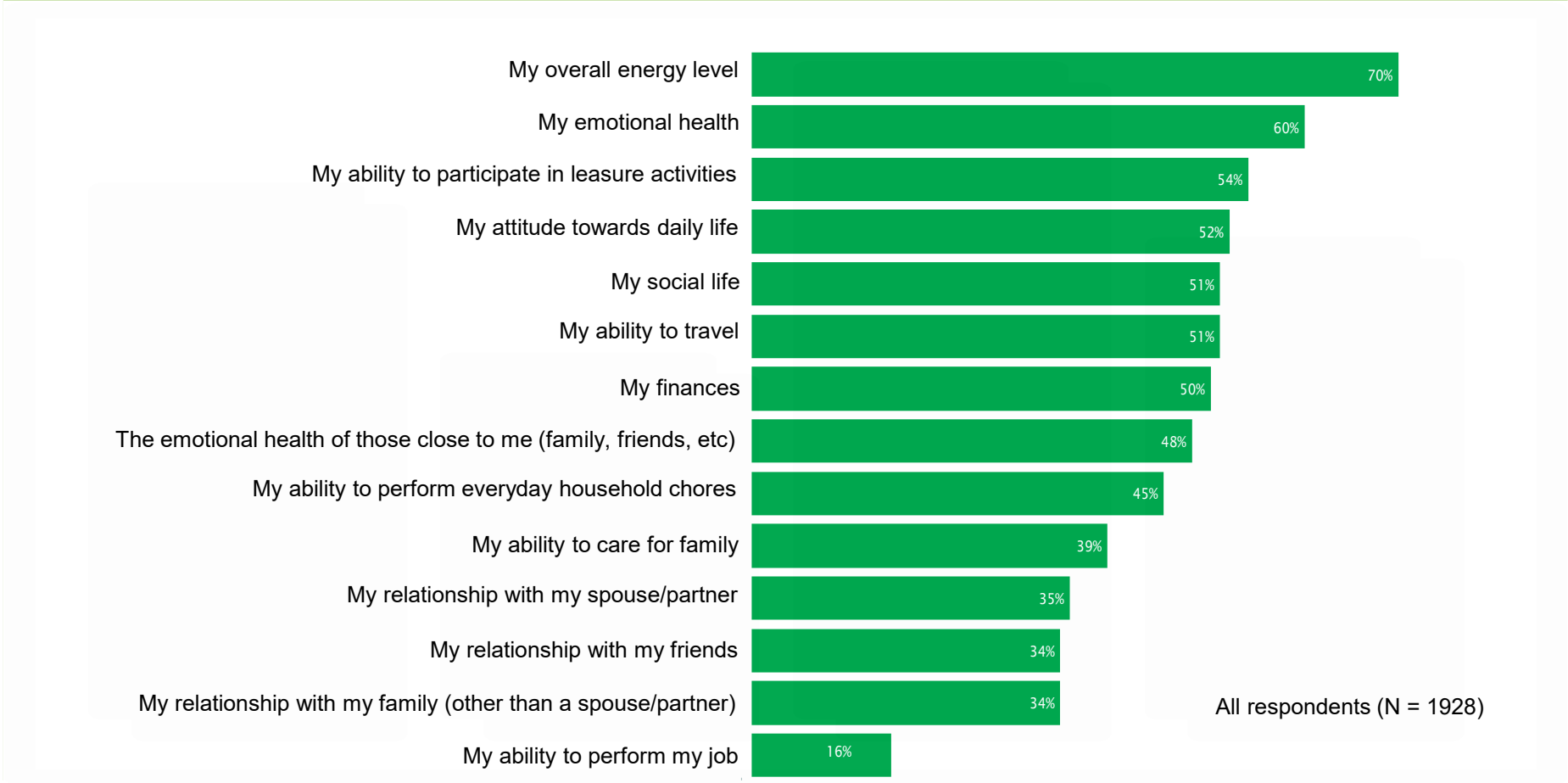
72% overall reported a negative impact of NET on their lives



Source: Singh, et al. JGO.

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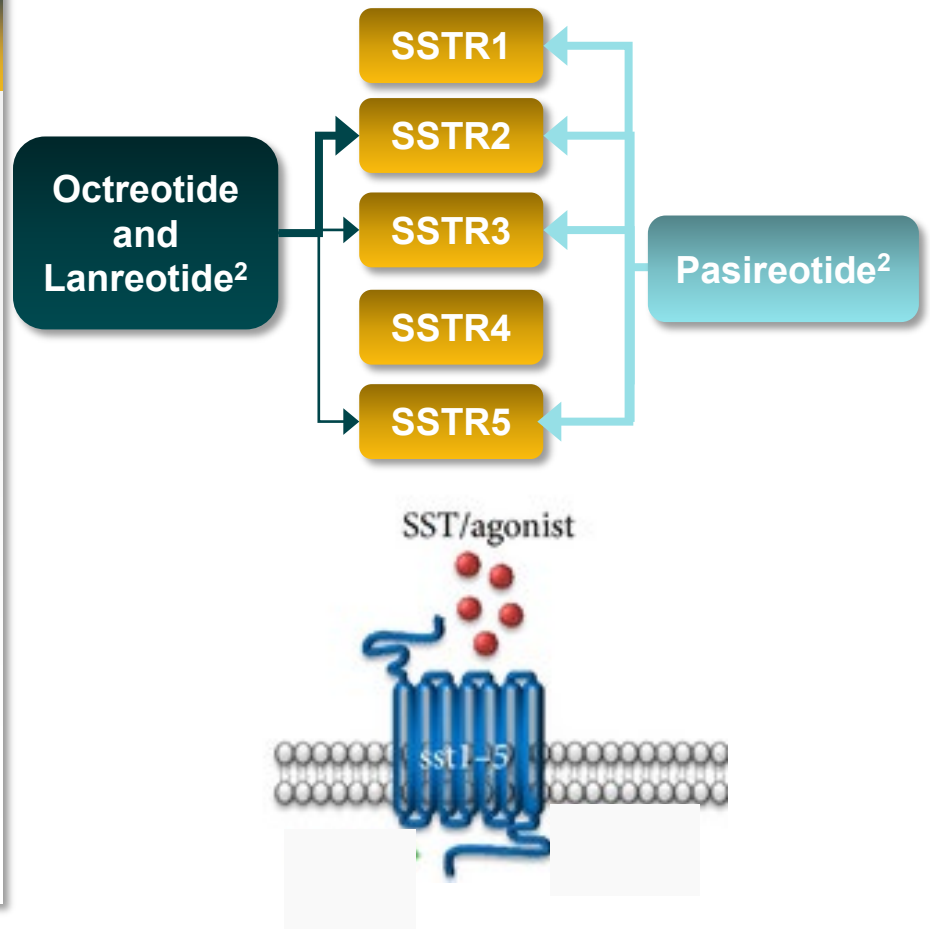
Somatostatin Analogs (SSAs)

Overview

- Synthetic derivatives of somatostatin[1]
- Bind to somatostatin receptors (SSTRs)[1]
- Similar to endogenous somatostatins but with[1]:
  - Increased affinity for specific SSTRs
  - Longer half-life and greater stability
  - Longer duration of action in the body
- Have different SSTR affinity profiles[2]
  - Octreotide and lanreotide have high affinity for SSTR2 and lower affinities for SSTR3 and 5
  - Pasireotide has high affinity for SSTR1-3, and 5



1. Susini C, Buscail L. Ann Oncol. 2006;17:1733-1742.
2. Öberg KE et al. Gastroenterology. 2010;139:742-753.

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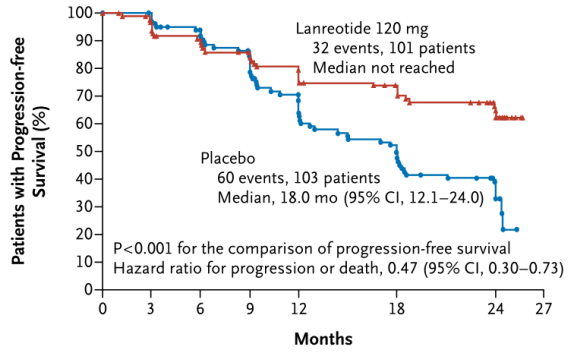
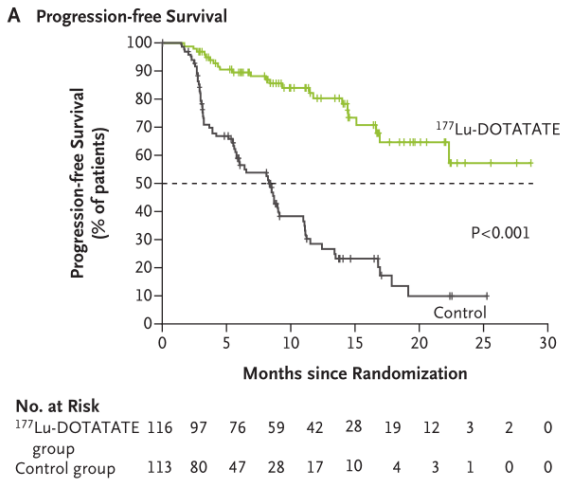
Background

- **SSAs are the cornerstone of treatment strategies for G1-2 GEP-NETs**
  - PROMID (Rinke JCO 2009), CLARINET (Caplin NEJM 2014) trials
  - However, responses may not be long-lasting
- **The escalated SSA arm of NETTER-1 (Strosberg NEJM 2017, 60 mg octreotide/4 wk) demonstrated a PFS of 8 months in patients progressing on standard dose**
  - Escalated SSA may still have effect in patients with NET refractory to standard SSA





GEP-NET: gastroenteropancreatic neuroendocrine tumors; PFS: progression-free survival; SSA: somatostatin analog

Source: Rinke A, et al. J Clin Oncol 2009;27:4656–4663 ; Caplin ME, et al. N Engl J Med. 2014;371:224-33; Strosberg J, et al. N Engl J Med. 2017;376:125-35.

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Research question

Does long-acting SSA **above** the standard dose/exposure and/or increased dosing frequency improve progression-free survival compared to standard dose SSA?

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Clinical data

Table 1A Characteristics of included studies—prospective studies

Prospective trials	Primary/ number	Prior SSA?	Intervention	Reason for dose escalation	Symptoms	DCR	ORR	Biochemical response	Toxicity
Strosberg 2017	Metastatic SBNET (230)	Y	Octreotide LAR 60 mg (115)	Tumour progression	NR	65%	3%	NR	34% any adverse event related to treatment, 1% G3–4
Albertelli 2016	Metastatic NET (35)	Y	Lanreotide ATG 180 mg/4 weeks	Tumour progression	NR	NR	NR	NR	21% any SAE; 3% SAE related to treatment (cholelithiasis/cholecystitis)
Wolin 2015	Metastatic GEPNET (57)	Y	Octreotide LAR 40 mg/28 days ($n = 57$) vs. Pasireotide LAR 60 mg/28 days ($n = 53$)	Carcinoid symptoms	12/45	75%	2%	NR	Hyperglycaemia (5%), fatigue (3%), cholelithiasis (5%), injection site pain, LFT derangement, diarrhoea (2% each)
Ferolla 2012	Metastatic NET (28)	Y	Octreotide LAR 30 mg/21 days	Flushing 25%, diarrhoea 36%, bronchoconstriction 7%, pain 21%, weakness 14%, no symptoms 32%	100%	100%	7%	CgA 30%, u5HIAA 57%, Gastrin 100%	Diarrhoea (4%), abdominal pain (4%), cholelithiasis (8%), pyrexia (4%)
Welin 2004	Midgut NET (12)	Y	Octreotide 160 mg/ 2 weeks for 2 months, then monthly	NR	NR	75%	0%	CgA 33%, u5HIAA 16%	Gallstone (8%), fever (50%)
Faiss 1999	Foregut NET (30)	Y (or prior interferon)	Lanreotide 5 mg tds	Tumour progression	Diarrhoea significantly improved as a group	43%	6%	Decreased (CgA/ u5HIAA)	Fatigue (30%), steatorrhoea (6%), cholelithiasis (3%)
Eriksson 1997	SBNET/PNET (19)	N	Lanreotide 750 mcg qid to 3 mg qid	NR	Flushing better ($p = 0.06$)	NR	NR	58% (u5HIAA/ CgA)	4 ceased due to AE (gallstone, diarrhoea)
Imam 1997	Metastatic NET (8)	N	Lanreotide 12 mg/day	NR	NR	100%	0%	71% (CgA/ u5HIAA)	NR
Arnold 1996	Metastatic GEPNET (52)	Y	Octreotide 500 mcg tid	Tumour progression	NR	37%	0%	NR	NR
Di Bartolomeo 1996	SBNET/PNET (58)	N	Octreotide 500 mcg tid ($N = 23$) or 1000 mcg tid ($N = 35$)	NR	Diarrhoea improved in 40%, flushing in 50%	50%	3%	77% (u5HIAA)	Gallstones (4%), Steatorrhoea (4%)
Anthony 1993	NET (28)	Y	Octreotide 500–2000 mcg tid, Lanreotide 3000 mcg tid	NR	Flushing "significantly reduced" with octreotide, $p < 0.05$ on VAS	42% (6/13 octreotide, 5/13 lanreotide)	31% (4/13 octreotide, 4/13 lanreotide)	NA	Steatorrhoea with octreotide; injection site discomfort, mild abdominal cramping and gallstones (1) with lanreotide

PFS

- 8.4 months (NETTER-1)
- 6.8 months
- 30 months

PFS: progression-free survival
Source: Chan DL, et al. Endocrine. 2017;57:366-75.

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CLARINET FORTE study design

Prospective, single-arm, open-label, exploratory, international phase II study (NCT02651987)

Inclusion criteria

Patients with a metastatic or locally advanced unresectable panNET or midgut NET:

- SSTR2+
- Progression, within 24 months prior to enrollment as assessed by an independent reviewer via RECIST v1.0, while receiving first-line treatment (LAN 120 mg every 28 days) for ≥24 weeks
- Ki-67 ≤20%
- ECOG PS ≤2
- With or without hormonal-related syndromes

Planned enrollment
N=50 per cohort

panNET cohort

LAN 120 mg q2w × 24 cycles*

Midgut NET cohort

LAN 120 mg q2w × 48 cycles*

Primary endpoint
- Median PFS (centrally assessed by RECIST v1.0)

Secondary endpoints
- Disease control rate
- Duration of stable disease
- Occurrence of adverse events

Post-hoc analysis
- Median PFS by Ki-67 index

QoL endpoints:
- EQ-5D-5L v1.0†
- EORTC QLQ-C30 v3.0[1]
- QLQ-GINET.21[2]

*or until centrally assessed progressive disease, unacceptable toxicity or tolerability, or death (events); or longer if <25 events per cohort had occurred.
†which assesses the severity of problems associated with mobility, self-care, usual activities, pain/discomfort, and anxiety/depression.[3]

ECOG PS, Eastern Cooperative Oncology Group performance status; EORTC QLQ-C30, European Organisation into the Research and Treatment of Cancer QoL Questionnaire Core 30; EQ-5D-5L, EuroQoL 5 dimensions, 5 levels; Ki-67, proliferation index; LAN, lanreotide autogel; panNET, pancreatic NET; PFS, progression-free survival; NET, neuroendocrine tumor; q2w, every 2 weeks; QLQ GI.NET21, Quality of Life Questionnaire Gastrointestinal Neuroendocrine Tumor 21; QoL, quality of life; RECIST, Response Evaluation Criteria in Solid Tumors; SSTR2+, somatostatin receptor type 2 positive.

Source: 1.Cocks K et al. J Clin Oncol 2011;29(1):89–96. 2. Davies AHG et al. Eur J Cancer 2006;42(4):477–84. 3. Herdman M et al. Qual Life Res 2011;20(10):1727–36.

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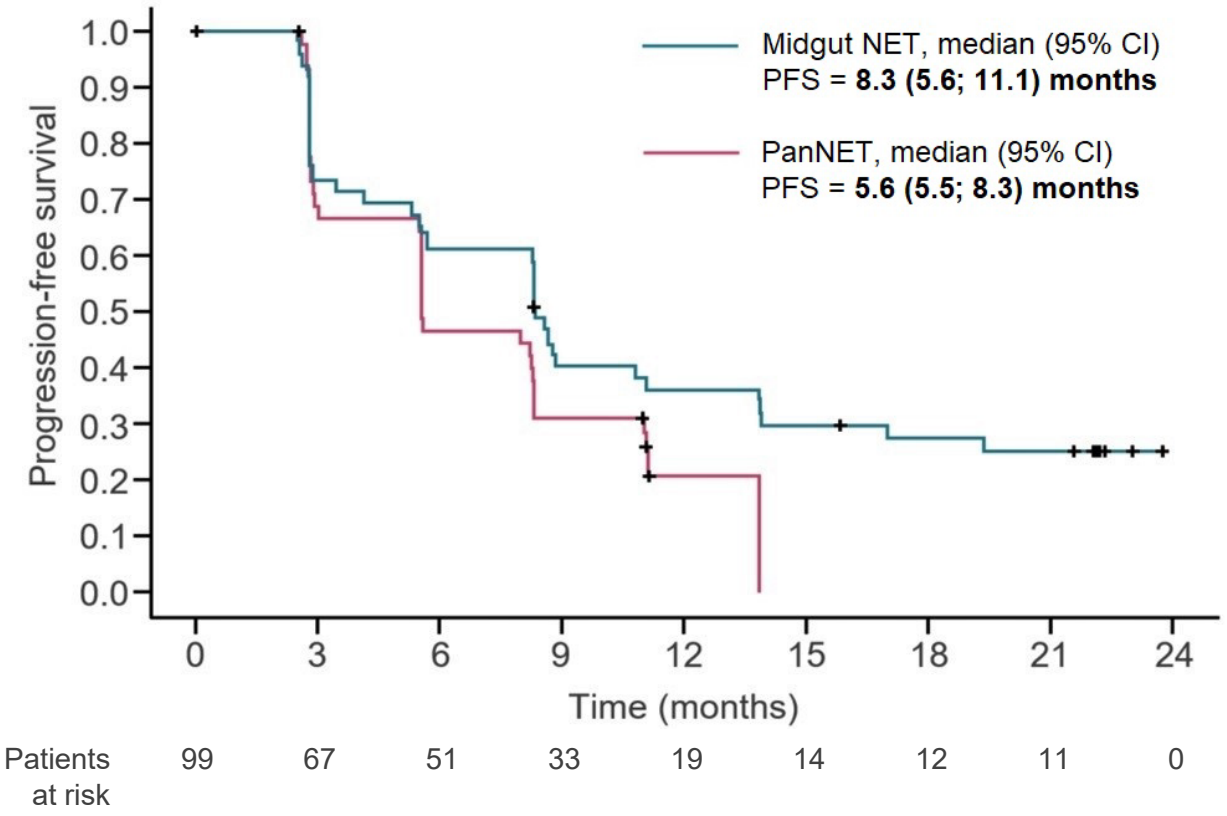
Results – Progression free survival (primary endpoint)



Efficacy endpoint	panNET, n=48	Midgut NET, n=51
PFS by Ki-67 index, median (95% CI), months		
Ki-67 ≤10%* (n=43; n=47)	8.0 (5.6; 8.3)	8.6 (5.6; 13.8)
Ki-67 >10%* (n=5; n=4)	2.8 (2.8; 2.9)	5.5 (2.6; NE)

Data are presented for the FAS, defined as all patients who received at least one dose of LAN 120 mg during the study. *Post-hoc analysis; Ki-67 categories are not exclusive. These data are outside of the approved product information for lanreotide.

CI, confidence interval; FAS, full analysis set; Ki-67, proliferation index; LAN, lanreotide autogel; NE, not estimable; NET, neuroendocrine tumor; panNET, pancreatic NET; PFS, progression-free survival.

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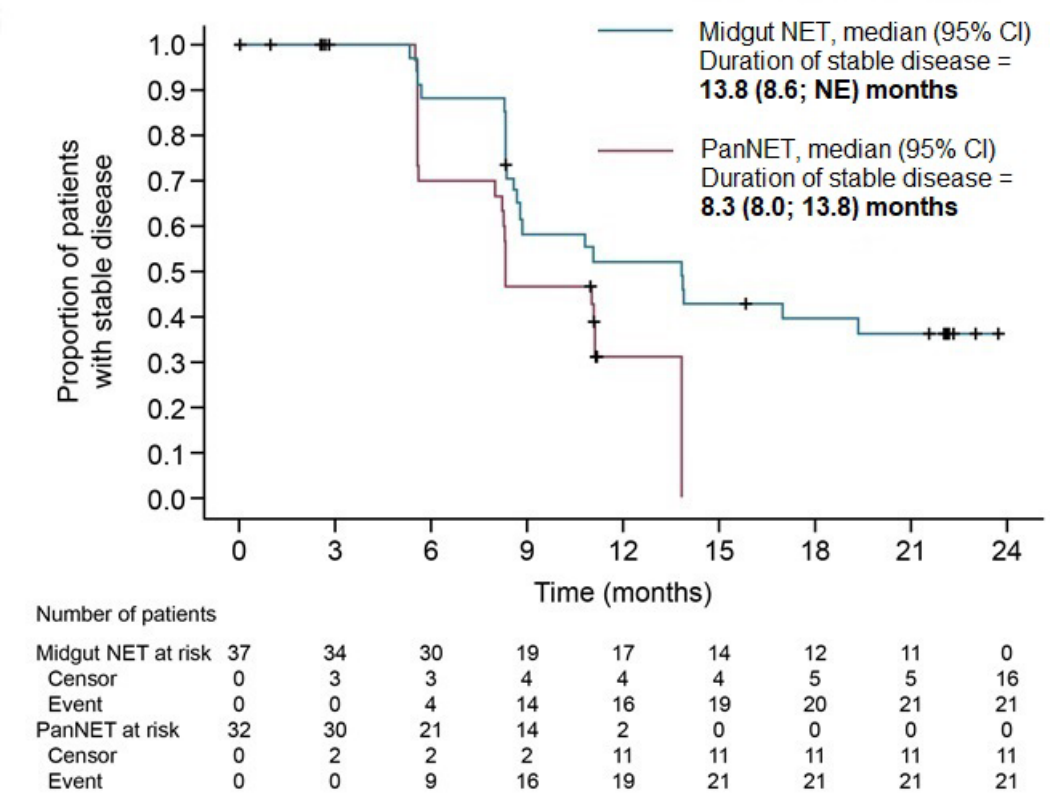
Results – Duration of stable disease and disease control rate



Efficacy endpoint	panNET, n=48	Midgut NET, n=51
Disease control rate, % (95% CI)†		
Week 24	43.8% (29.5; 58.8)	58.8% (44.2; 72.4)
Week 48	22.9% (12.0; 37.3)	33.3% (20.8; 47.9)

Data are presented for the FAS, defined as all patients who received at least one dose of LAN 120 mg during the study. †Disease control rate was defined as the proportion of patients with complete response, partial response or stable disease. These data are outside of the approved product information for lanreotide.

CI, confidence interval; FAS, full analysis set; LAN, lanreotide autogel; NE, not estimable; NET, neuroendocrine tumor; panNET, pancreatic NET; PFS, progression-free survival.

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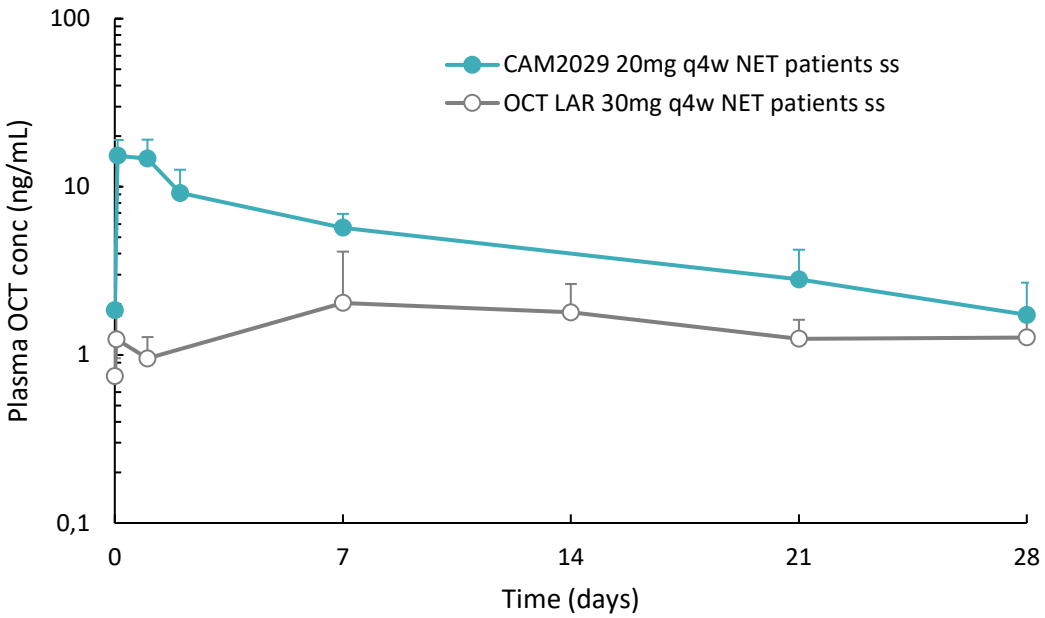
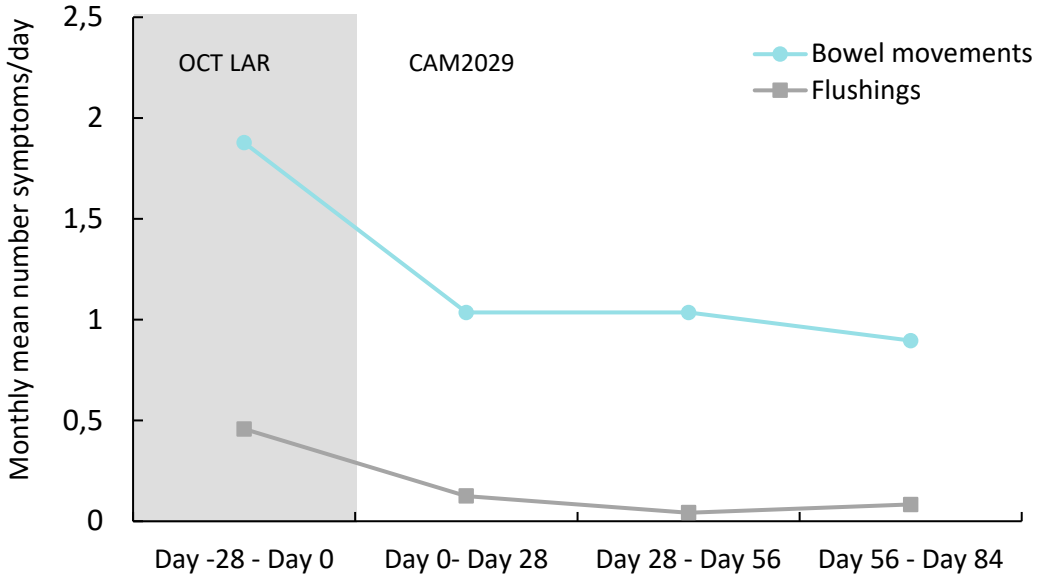
Enhanced octreotide exposure with CAM2029

Pharmacokinetics in GEP-NET patients



GEP-NET symptoms



Source: Analysis of data from Pavel M et al, Cancer Chemotherapy and Pharmacology 2019.

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SORENTO Trial Rationale and Purpose

SORENTO

A randomized, multi-center, open-label, active-controlled Phase 3 trial to assess the efficacy and safety of octreotide subcutaneous depot (CAM2029) versus octreotide LAR or lanreotide ATG in patients with gastroenteropancreatic neuroendocrine tumors

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Rational for SORENTO

- Higher doses or shorter intervals between SSA injections is a common “empirical” approach in patients with metastatic NET and suboptimal control of functional syndrome or tumor growth.
- Retrospective data support escalating the standard dose of SSAs.
- Increased dose density or intensity is a proposed option in patients with progressive and well-differentiated GEP-NET.
- No increased toxicity compared to conventional dose therapy has been reported in early phase studies.
- Due to the nature of these trials (retrospective, limited number of patients, short follow up) no definitive conclusions made.
- Prospective trials are needed to assess the safety and efficacy of high-dose SSA on disease progression and survival.

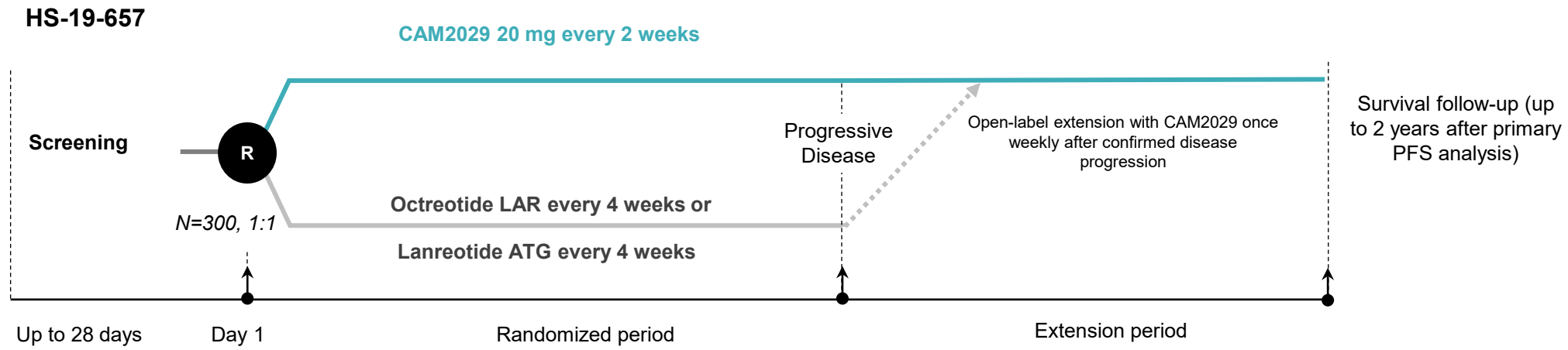
GEP: gastroenteropancreatic; NET: neuroendocrine tumors; SSA: somatostatin analog
Source: Strosberg J, et al. N Engl J Med. 2017;376:125-35; Broder MS, et al. World J Gastroenterol. 2015;21:1945-55; Eriksson B, et al. Ann Oncol. 1997;8:1041-4; Faiss S, et al. Digestion. 1999;60:469-76; Welin S, et al. Eur J Endocrinol. 2004;151:107-12; Carmona-Bayonas A, et al. Curr Oncol Rep. 2017;19:72; Lamberti G, et al. J Clin Endocrinol Metab. 2020;105(1):dgz035; Sharp AJ, et al. Eur Endocrinol. 2020;16:93-5; Pavel M, et al. CLARINET FORTE study results. 2020. [Internet: annalsofoncology.org/action/showPdf?pii=S0923-7534%2820%2941371-7]; Diamantopoulos L, et al. Neuroendocrinology. 2021;111:650-659.

SORENTO – Superiority Trial Design

Primary objective

To determine whether treatment with **CAM2029** prolongs the progression free survival (**PFS**), determined by Blinded Independent Review Committee (**BIRC**), compared to **octreotide LAR or lanreotide ATG** in patients with **metastatic/inoperable well differentiated gastroenteropancreatic neuroendocrine tumors (GEP-NET)**

Patients with advanced, well-differentiated GEP-NET



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SORENTO – Trial Design, cont.

Comparing the efficacy of treatment with CAM2029 20 mg every 2 weeks to treatment with the Investigator's choice of comparator, i.e., octreotide LAR 30 mg or lanreotide ATG 120 mg every 4 weeks

CAM2029

20 mg every other week

- SC injection in abdomen, thigh or buttock
- Patient and partner administration allowed after training
- ***Home administration***

Comparators

Investigator choice of:

- Octreotide LAR 30 mg per month - IM injection in gluteus – by a trained HCP
- Lanreotide ATG 120 mg per month – deep SC injection in gluteus or thigh – by a trained HCP

HCP: healthcare professional; IM: intramuscular; SC: subcutaneous

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SORENTO Main Inclusion Criteria

- Male or female patient ≥18 years old
- Histologically confirmed, advanced (unresectable and/or metastatic), and well-differentiated NET of GEP or presumed GEP origin
- **At least 1 measurable, somatostatin receptor-positive, lesion according to RECIST 1.1 determined by multiphasic CT or MRI (performed within 28 days before randomization)**
- **Expression of somatostatin receptors on lesions documented by CT/MRI scans, assessed by somatostatin-receptor imaging modalities within 3 months before randomization**
- Results from FDG-PET CT for patients with well-differentiated Grade 3 NET (if performed) must show that FDG avid areas of disease also are avid on somatostatin-receptor imaging
- ECOG performance status of 0 to 2

CT: computed tomography; ECOG: Eastern Cooperative Oncology Group; FDG: fluorodeoxyglucose; GEP: gastroenteropancreatic; NET: neuroendocrine tumors; PET: positron emission tomography

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SORENTO Main Exclusion Criteria

- Documented evidence of disease progression while on treatment (including SSAs) for locally advanced unresectable or metastatic disease
- Known central nervous system metastases
- **Consecutive treatment with long-acting SSAs for more than 6 months before randomization**
- Carcinoid symptoms that are refractory to treatment (according to the Investigator's judgement) with conventional doses of octreotide LAR or lanreotide ATG and/or to treatment with daily doses of ≤600 µg of octreotide IR
- Previous treatment with more than 1 cycle of targeted therapies such as mTOR inhibitors or vascular endothelial growth factor inhibitors, or more than 1 cycle of chemotherapy or interferon for GEP-NET
- Treatment of GEP-NET with trans-arterial chemoembolization or trans-arterial embolization within 12 months before screening
- Previously received radioligand therapy (PRRT) at any time

GEP: gastroenteropancreatic; mTOR: mammalian target of rapamycin; NET: neuroendocrine tumors; PRRT: peptide receptor radionuclide therapy; SSA: somatostatin analog

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SORENTO Steering Committee

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Diego Ferone
Genoa, Italy

Daniel Halperin
Houston, USA

Wouter De Herder
Rotterdam, The Netherlands

Josh Mailman (Patient Advocate)
Oakland, USA

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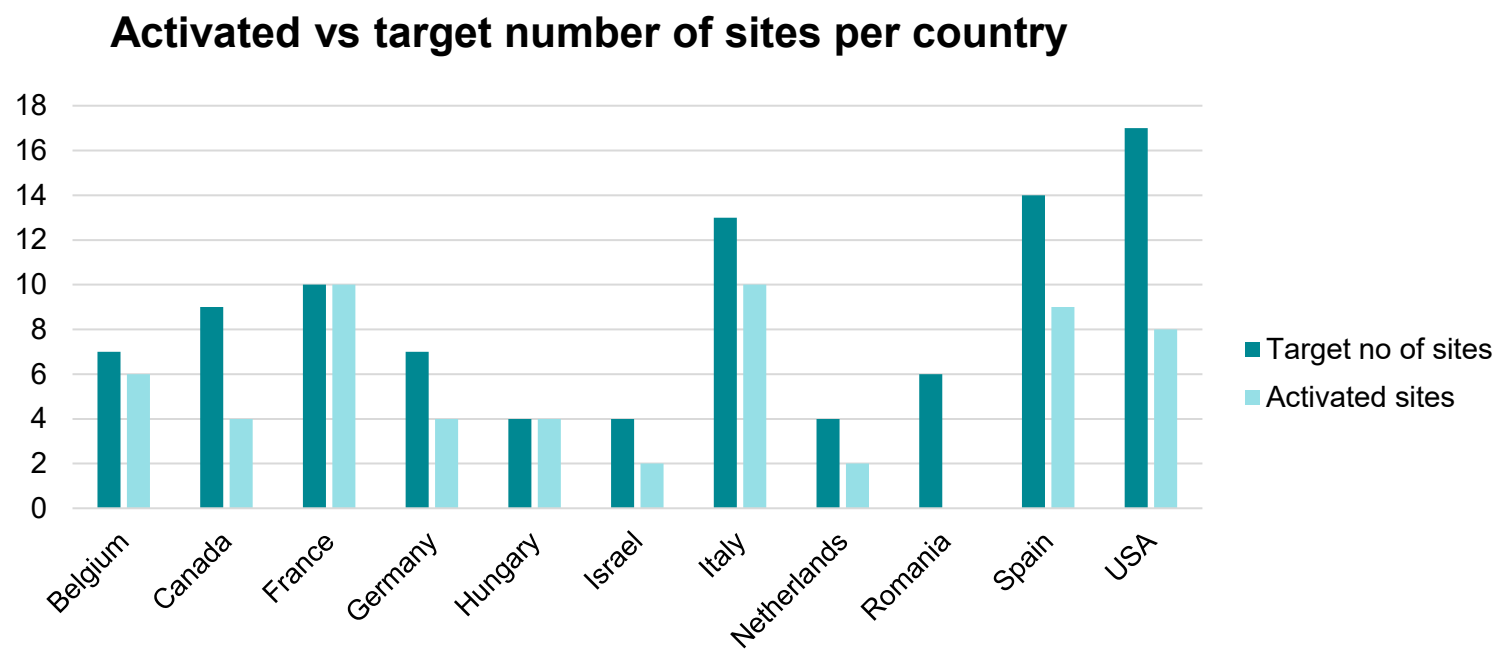
SORENTO Site Start-up Status

- 10/11 countries open for recruitment
  - Romania pending response from Regulatory Agency, expected Sep 2022
- 59/95 selected sites (clinics) activated
  - ~20 sites to be activated during September



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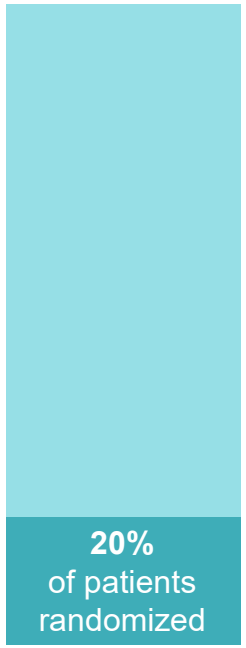
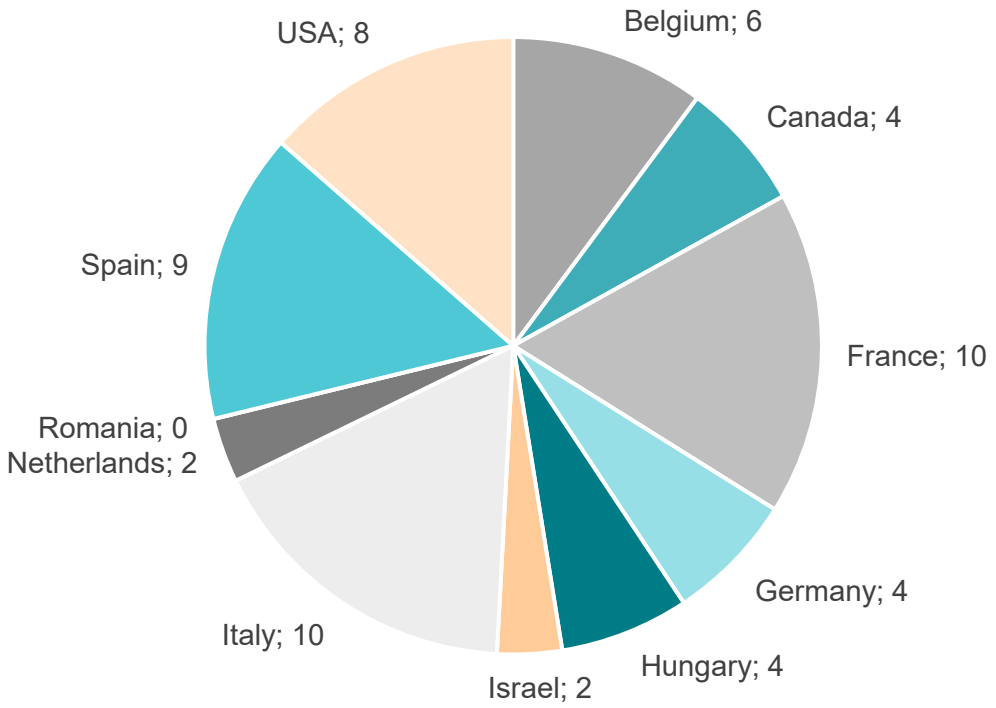
Current status of SORENTO trial

Target:
302 patients



 # Activated sites per country



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Outlook for CAM2029 and advanced SSA treatment

Patient Preferences

- For many of our patients this is a ***continuous journey***
  - Patients don’t see cancer as a series of episodic care events
- Many patients will live with this disease for a long time
  - Chronic cancer
- Need to determine what is **important** to your patient
  - What are they hoping to achieve? What tools do we have to achieve that

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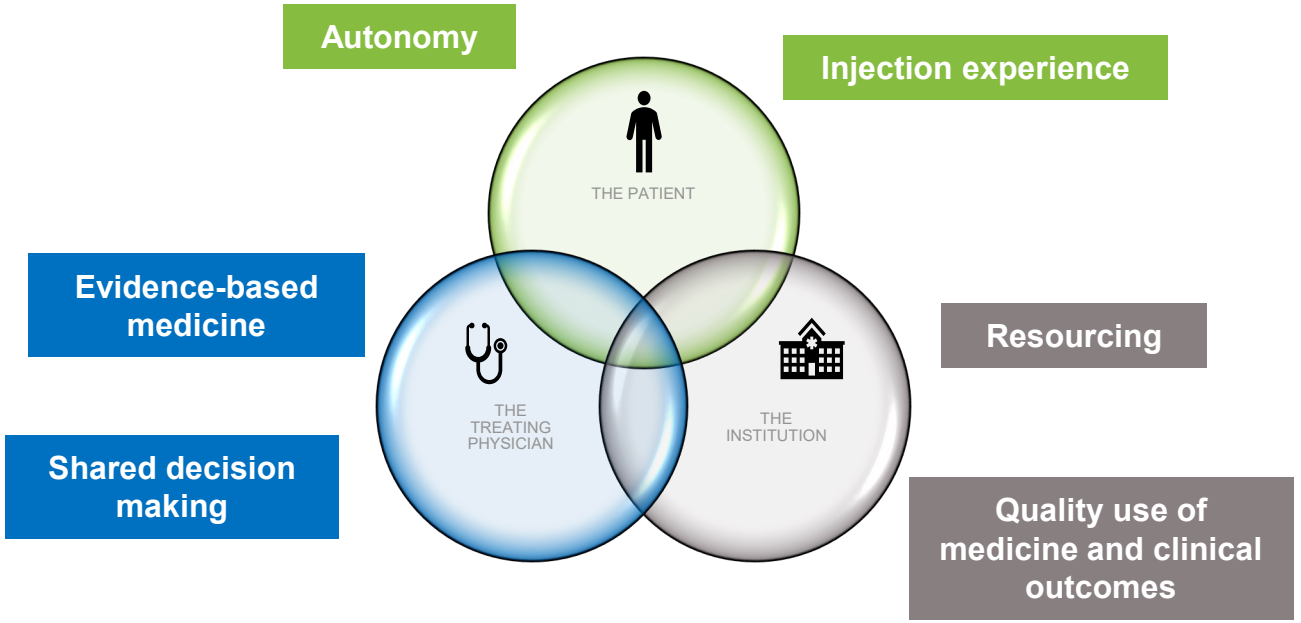
What influences treatment decision making?

Goals of long-term systemic treatment for GEP-NET are symptom management and tumor suppression,[1] which may be influenced by: [2-8]



Source: 1. Uri I, et al. Clin Diabetes Endocrinol 2018;4:16; 2. Pavel M, et al. Ann Oncol. 2020;31:844-60; 3. Shah MH, et al. J Natl Compr Canc Netw. 2018;16:693-702; 4. Caplin ME, et al. N Engl J Med. 2014;371:224-33; 5. White BE, et al. Endocr Relat Cancer. 2020;27:R267–R280; 6. Singh S, et al. J Glob Oncol. 2017;3:43–53; 7. Ryan P, et al. J Oncol Pharm Practice. 2019;25:1425–33; 8. Strom T, et al. Patient Prefer Adherence. 2019;13:1799-1807.

CAM2029 and SORENTO

- Largest SSA trial to date
- High level of interest with
  - Health care providers
  - Patients
- Potential to be **Standard of Care**
  - first line therapy for almost all NETs patients
- From system perspective it is “resource friendly”

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Truly individualized patient centered therapy that allows the patient to live life with cancer

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camurus®

Concluding remarks

Fredrik Tiberg, Ph.D., Assoc. prof.

President & CEO, Camurus

camurus

Diversified business with multiple growth levers

5x
revenue growth

Mid-term
– Late-stage pipeline launches
– Partnerships and M&A

2027

Short-term
– Buvidal market penetration and expansion

2022

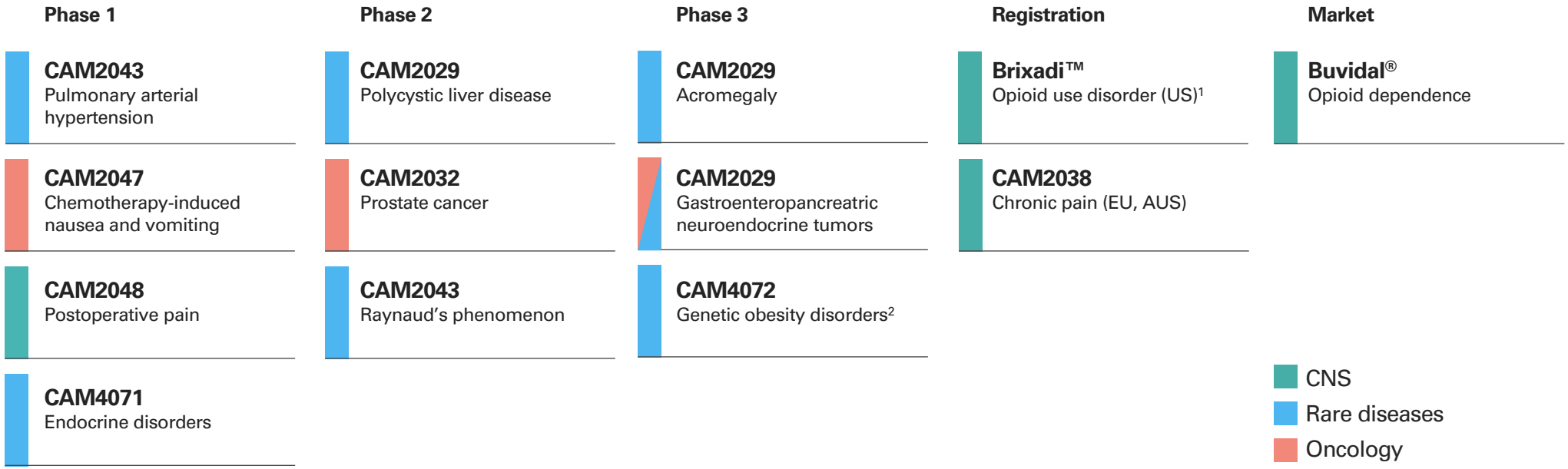
Long-term
– Early-stage pipeline
– Technology innovation
– Early-stage partnerships

Q&A

Appendix

camurus.

Broad and diversified pipeline and approved products



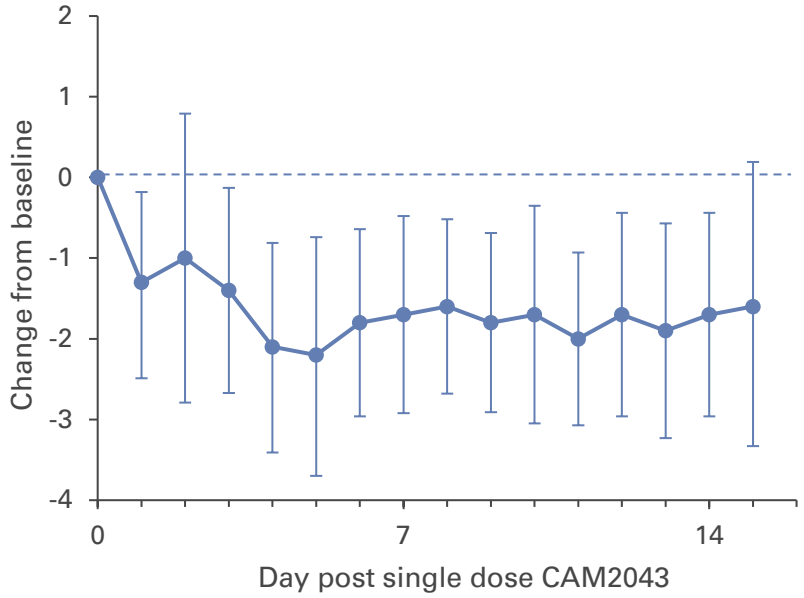
[1]Licensed to Braeburn in North America; [2]Licensed to Rhythm Pharmaceuticals worldwide

Other rare disease pipeline opportunities

Treprostinil SC depot (CAM2043)

- Targeting high medical need in treating Reynaud's Phenomenon and PAH*
- Recent Phase 2a results indicate efficacy in Raynaud's Phenomenon[1]
  - Primary endpoint not met, 6h post dose
  - Several secondary endpoints met, including primary measure at 24h[2]
  - Improvement of Raynaud's condition score up to 15 days post single dose[2]
  - Safety and tolerability with expected systemic and local reactions to treprostinil
  - No serious adverse events
- Evaluations of next steps ongoing

Significant change in Raynaud's condition score (95% CI)



[1]Camurus' Interim Report Second Quarter 2022. [2]Clinical Trial Report HS-18-638, September 2022. PAH – Pulmonary Arterial Hypertension

Early phase and partner projects

Pasireotide SC depot, CAM4071

- Positive PK and PD results in Phase 1 MAD study
- Ready for Phase 2 study
- Differentiated profile versus competitor
- Improved understanding of role of pasireotide in treatment of acromegaly and other rare disease

Weekly setmelanotide depot, CAM4072

- Licensed Rhythm
- Camurus eligible to milestones and royalty payments
- Positive PK and PD results in Phase 2a MAD study
- Phase 3 trial ongoing in patients with genetic obesity disease, e.g. Bardet Biedl Syndrome (BBS)
- Second Phase 3 trial in BBS planned to start in H2 2022

Experienced and committed management team

Fredrik Tiberg, PhD
President & CEO, Head R&D
In Company since: *2002*
Holdings*: 1,672,788 shares, 90,000 warrants & 60,000 employee options*

Education: M.Sc. in Chemical Engineering, Lund Institute of Technology, PhD and Assoc. Prof. Physical Chemistry, Lund University.
Previous experience: More than 20 years leadership experience from the pharmaceutical industry. Professor Physical Chemistry at Lund University, Sect. Head Institute for Surface Chemistry, Visiting Professor at Oxford University

Maria Lundqvist
Head of Global HR
In Company since: *2021*
Holdings*: 22,500 employee options*

Education: B.Sc: in Business and Economics, Uppsala University
Previous experience: More than 20 years of experience of leadership roles within Human Resources, including HR Director Nordics at Teva Pharmaceuticals and HR positions at Tetra Pak, Vestas and AstraZeneca.

Peter Hjelmström, MD, PhD
Chief Medical Officer
In Company since: *2016*
Holdings*: 22,500 employee options*

Education: MD, PhD and Assoc. Prof. Karolinska Institutet, Postdoc.Yale University
Previous experience: More than 15 years of experience from the pharmaceutical industry, including as Medical Director at Orexo and Head of Clinical Science at Sobi

Torsten Malmström, PhD
Chief Technical Officer
In Company since: *2013*
Holdings*: 46,858 shares & 22,500 employee options*

Education: M.Sc. in Chemistry, PhD in Inorganic Chemistry, Lund University
Previous experience: More than 20 years of experience from pharmaceutical R&D including Director Pharmaceutical Development at Zealand Pharma, Director of Development at Polypeptide, Team Manager at AstraZeneca.

Agneta Svedberg
VP Clinical & Regulatory Dev.
In Company since: *2015*
Holdings*: 17,987 shares, 37,500 subscription warrants & 22,500 employee options*

Education: M.Sc. In Radiophysics and B.Sc. In Medicine from Lund University, Executive MBA from Executive Foundation Lund
Previous experience: More than 25 years of experience in drug development, incl. as COO at Zealand Pharma, CEO of Cantargia, Senior VP Clinical Development at Genmab.

Jon Garay Alonso
Chief Financial Officer
In Company since: *2022*
Holdings*: 1,450 shares & 33,750 employee options*

Education: Bachelor in Business Administration by Universidad Comercial de Deusto. Executive MBA by IESE Business School.
Previous experience: More than 20 years experience from Finance within pharmaceutical and medtech companies, incl. Baxter, Gambro, Convatec, Bristol Myers Squibb.

Richard Jameson
Chief Commercial Officer
In Company since: *2016*
Holdings*: 25,193 shares, 58,000 warrants and 33,750 employee options*

Education: B.Sc. in Applied Biological Sciences from University West of England
Previous experience: General Manager, UK & Nordics for Reckitt Benckiser (2010 – 2013) and Area Director Europe, Middle East and Africa for Indivior (2013 – 2016).

Fredrik Joabsson, PhD
Chief Business Dev. Officer
In Company since: *2001*
Holdings*: 49,170 shares , 15,000 subscription warrants & 22,500 employee options*

Education: M.Sc. in Chemistry, PhD in Physical Chemistry, Lund University
Previous experience: More than 20 years of experience in pharmaceutical R&D, business development and alliance management.

Annette Mattsson
VP Regulatory Affairs
In Company since: *2017*
Holdings*: 1,504 shares, 7,000 subscription warrants & 22,500 employee options*

Education: Bachelor of Pharmacy, Uppsala University and Business Economics, Lund University
Previous experience: More than 25 years of experience within regulatory affairs, including European RA Director/Global RA Lead at AstraZeneca and Global RA Lead at LEO Pharma.

Markus Johnsson
Senior VP R&D
In Company since: *2003-2017, 2019-*
Holdings*: 21,000 shares & 23,500 employee options*

Education: Ph.D. in physical chemistry and M.Sc. in chemistry from Uppsala University.
Previous experience: More than 20 years of experience from pharmaceutical development and project management