



ZEALAND PHARMA

Pioneering next-generation peptide therapeutics.

Zealand Pharma A/S

January 2025

Forward-looking Statements

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

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

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

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

About Zealand Pharma

Corporate Presentation



We are an international biotech company headquartered in Denmark



Headquarters and labs outside Copenhagen, Denmark

Founded in 1998

- Peptide platform validated through two approved products marketed by Sanofi and Novo Nordisk
- ~370 employees globally as of January 2, 2025

Listed on NASDAQ CPH (ZEAL.CO)

- Market cap on January 3, 2025: USD ~7.0B (DKK ~51B)
- 71.0M Shares Outstanding as of January 3, 2025

Cash position^a

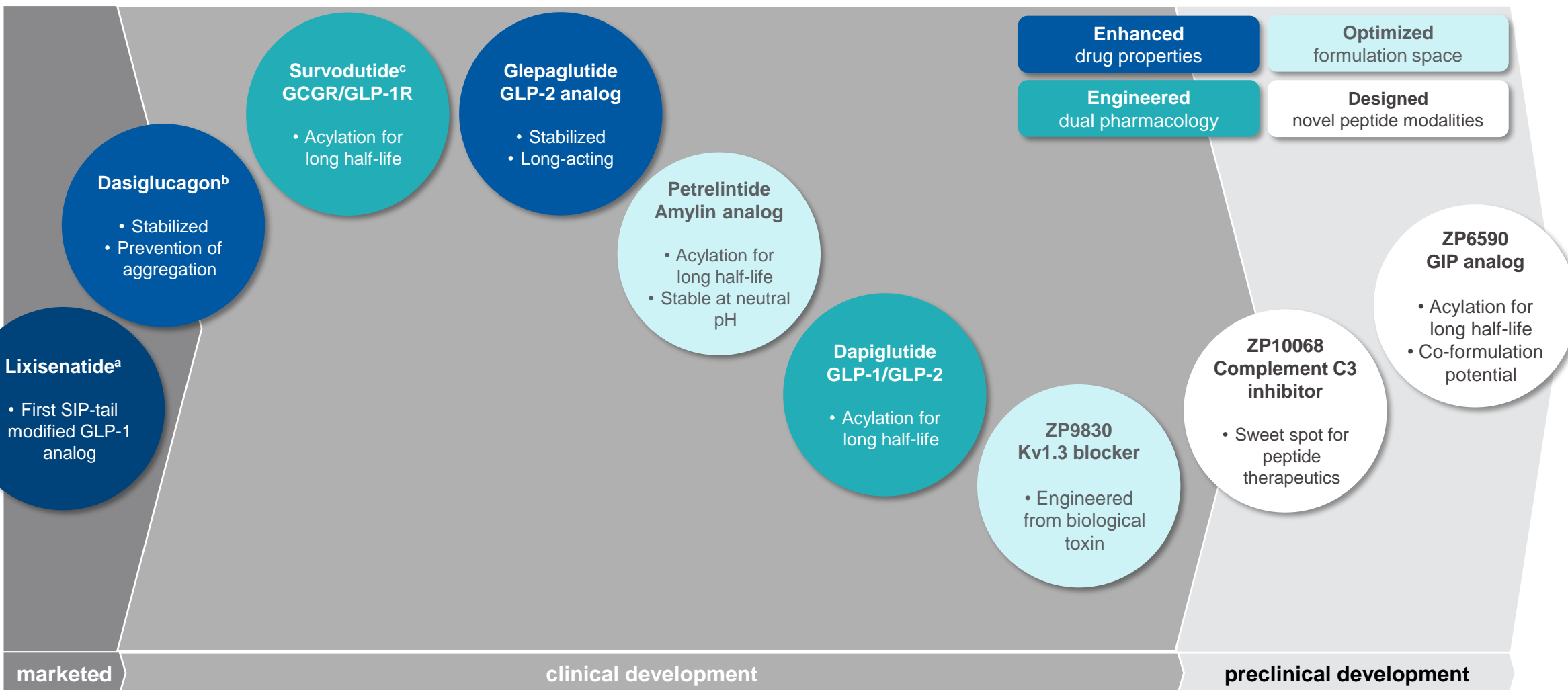
- USD ~1.3B (DKK ~9.2B) as of September 30, 2024

OPEX guidance for 2025

- Guidance on Net operating expenses to be communicated on February 20, 2025

^aCash position includes cash, cash equivalents and marketable securities. Zealand also has a Loan facility with the European Investment Bank (EIB) of EUR 90 million in three tranches (Tranche A of EUR 50 million was disbursed in Q1 2024; Tranches B and C are subject to pre-specified milestones being met).
Based on foreign exchange rates as of January 3, 2025 (DKK 7.24 = USD \$1).
OPEX=Operating Expenses.

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



^aMarketed globally by Sanofi.

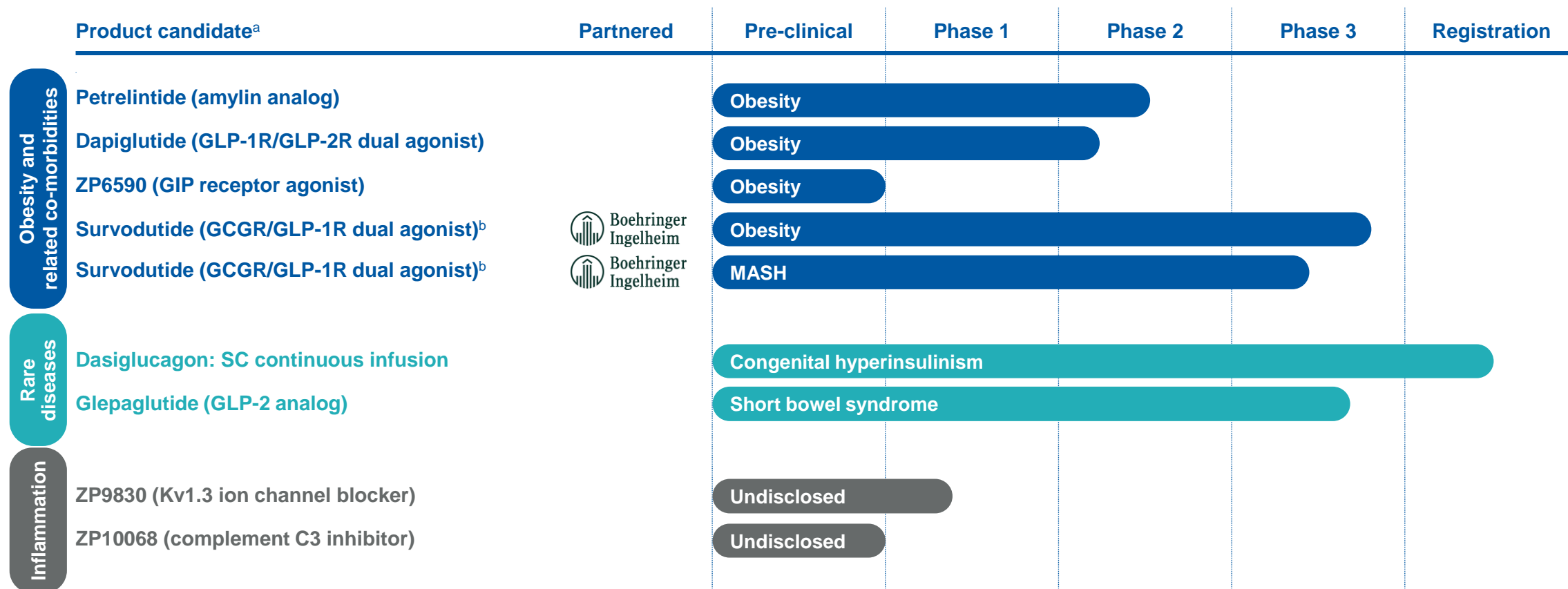
^bZegalogue[®] (dasiglucagon) for injection licensed to Novo Nordisk: DKK 227.5 million outstanding potential development, regulatory, manufacturing and sales milestones + high single to low double digit % royalties on global sales; Zealand is responsible for certain activities to support approval outside the U.S., reimbursed by Novo Nordisk; Zealand retains all non-licensed intellectual property rights to the company's other dasiglucagon development programs.

^cSurvodutide is licensed to Boehringer Ingelheim from Zealand Pharma, with Boehringer solely responsible for development and commercialization globally (subject to Zealand's co-promotion rights in the Nordic countries);

EUR 315 million outstanding potential development, regulatory and commercial milestones + high single to low double digit % royalties on global sales.

GCGR=glucagon receptor; GIP=gastric inhibitory polypeptide; GLP-1=glucagon-like peptide-1; GLP-1R=glucagon-like peptide-1 receptor; GLP-2=glucagon-like peptide-2; SIP=structure-inducing probe.

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



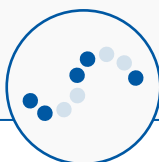
^aInvestigational compounds whose safety and efficacy have not been evaluated or approved by the U.S. Food and Drug Administration (FDA) or any other regulatory authority.

^bSurvodutide is licensed to Boehringer Ingelheim from Zealand Pharma, with Boehringer solely responsible for development and commercialization globally (subject to Zealand's co-promotion rights in the Nordic countries); EUR 315 million outstanding potential development, regulatory and commercial milestones + high single to low double digit % royalties on global sales.
 GCGR=glucagon receptor; GIP=gastric inhibitory polypeptide; GLP-1R=glucagon-like peptide-1 receptor; GLP-2=glucagon-like peptide-2; GLP-2R=glucagon-like peptide-2 receptor; MASH=metabolic dysfunction-associated steatohepatitis (formerly NASH, or nonalcoholic steatohepatitis); SC=subcutaneous.

We have a strong focus in 2025 on advancing our differentiated obesity programs in Phase 2 and 3

Petrelintide (amylin analog)

- Complete Ph2b obesity trial^a
(ZUPREME-1)
- Initiate Ph2b T2D obesity trial
(ZUPREME-2)
- Initiate Ph1b combination trial
w. GLP-1RA



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

- Report topline data from
28-week Ph1b trial
- Present detailed results from
Ph1b trial
- Initiate Ph2b obesity trial



Survodutide^b (GCGR/GLP-1R)



- Complete Ph3 obesity trials^c
(SYNCHRONIZE™-1 and 2)
- Progress Ph3 MASH trials
(LIVERAGE and LIVERAGE-Cirrhosis)



Rare diseases

Dasiglucagon (CHI)

- U.S. FDA approval

Glepaglutide (SBS)

- Initiate EASE-5 (Ph3 trial)
- Submit MAA to the EMA

Advance next-generation inflammation pipeline

ZP9830 (Kv1.3 Ion Channel Blocker)

- Complete Ph1a trial

ZP10068 (Complement C3 Inhibitor)

- Evaluate initiation of
Ph1a trial

^aPrimary completion of ZUPREME-1 is at clinicaltrials.gov estimated to be in November 2025 (NCT06662539).

^bSurvodutide is licensed to Boehringer Ingelheim from Zealand Pharma, with Boehringer solely responsible for development and commercialization globally (subject to Zealand's co-promotion rights in the Nordic countries).

^cPrimary completion of SYNCHRONIZE™-1 and 2 is at clinicaltrials.gov estimated to be in December 2025 (NCT06066515; NCT06066528).

T2D=type 2 diabetes; GLP-1R=glucagon-like peptide-1 receptor; GLP-2R=glucagon-like peptide-2 receptor; GLP-1RA=glucagon-like peptide-1 receptor agonist; GCGR=glucagon receptor; MASH=metabolic dysfunction-associated steatohepatitis; CHI=congenital hyperinsulinism; SBS=short bowel syndrome; SAD=single ascending dose; MAA=marketing authorization application; EMA=European Medicines Agency.

Exciting news flow with many potential catalysts in 2025

NON-EXHAUSTIVE

H1 2025

Petrelintide

Complete enrollment in Ph2b trial (overweight/obesity without T2D)

Petrelintide

Initiate Ph2b trial (overweight/obesity with T2D)

Dapiglutide

Report topline results from Part 2 of Ph1b dose-titration trial (28wks)

Dapiglutide

Present results from Ph1b dose-titration trial

Dapiglutide

Initiate Ph2b trial (overweight/obesity)

Dasiglucagon (CHI)

Resubmit Part 1 (acute use) of NDA to US FDA and potential approval

Dasiglucagon (CHI)

Submit analyses supporting chronic use (Part 2) to US FDA

H2 2025

Petrelintide

Initiate Ph1b combination trial with GLP-1RA

Survodutide^a

Complete Ph3 obesity trials^b (SYNCHRONIZE™-1 and 2)

ZP9830 (Kv1.3 Ion Channel Blocker)

Complete Ph1 SAD trial

ZP10068 (Complement C3 Inhibitor)

Evaluate potential initiation of Ph1 SAD trial

Dasiglucagon (CHI)

Potential approval by US FDA of chronic use (Part 2)

Glepaglutide (SBS)

Initiate additional Ph3 trial (EASE-5)

Glepaglutide (SBS)

Submit MAA to the European Medicines Agency

Legend:

Obesity

Rare diseases

Inflammation

Potential partnership agreements across therapeutic areas

^aSurvodutide is licensed to Boehringer Ingelheim from Zealand Pharma, with Boehringer solely responsible for development and commercialization globally (subject to Zealand's co-promotion rights in the Nordic countries).^b

^bPrimary completion of SYNCHRONIZE™-1 and 2 is at clinicaltrials.gov estimated to be in December 2025 (NCT06066515; NCT06066528).

T2D=Type 2 diabetes; SAD=single ascending dose; NDA=new drug application; FDA=Food and Drug Administration; GLP-1RA=glucagon-like peptide-1 receptor agonist; MAA=marketing authorization application.

Obesity

Corporate Presentation



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



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



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

50% of adults globally are expected to have **overweight or obesity** by 2030¹



Today, more than **5 million deaths** globally are **ascribed to overweight and obesity** every single year¹

Early days in the evolution of this market...

~2%

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

>220

Complications and co-morbidities associated with obesity

Including CVD, liver disease, type 2 diabetes, kidney disease, neuro-inflammation and some cancers³

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

Sources: 1. World Obesity Atlas 2024; 2. Almandoz et al. (2024) Nutritional considerations with antiobesity medications, Obesity (Silver Spring), 32(9): 1613-1631; 3. American Medical Association 2024: <https://www.ama-assn.org/topics/obesity>.

BMI=body mass index; CVD=cardiovascular disease.

We believe in a shift from maximizing weight loss towards improved tolerability and effects on co-morbidities...

Segment characteristics and key focus areas



Prescriber-driven

High-risk obesity

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

Focus on:

1. Co-morbidity risk reduction
2. Health outcomes
3. Relative weight loss
4. Tolerability and convenience of treatment



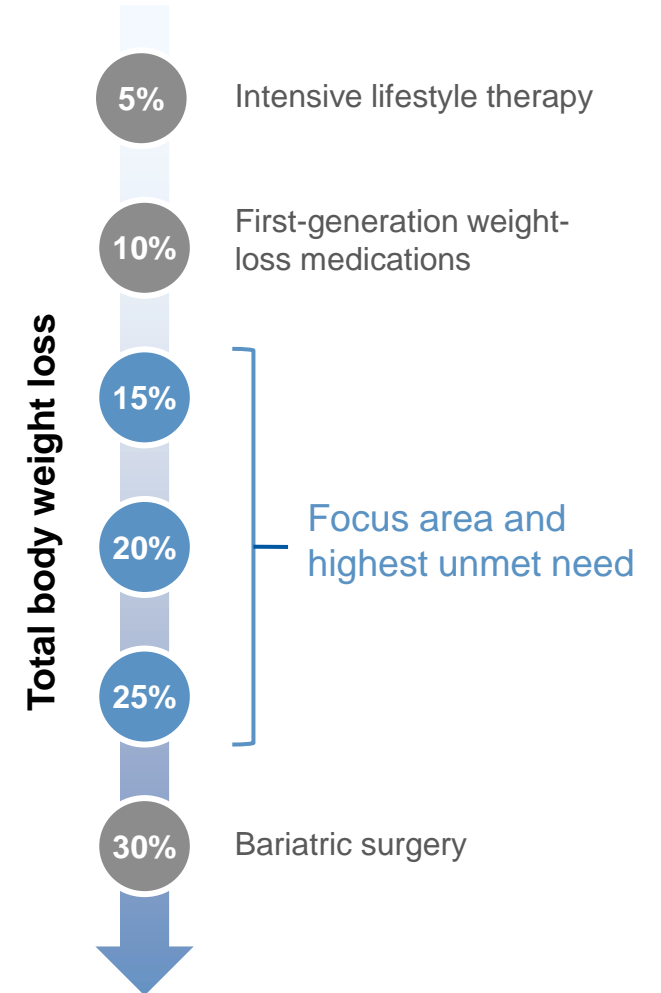
Patient-driven

Moderate-risk obesity

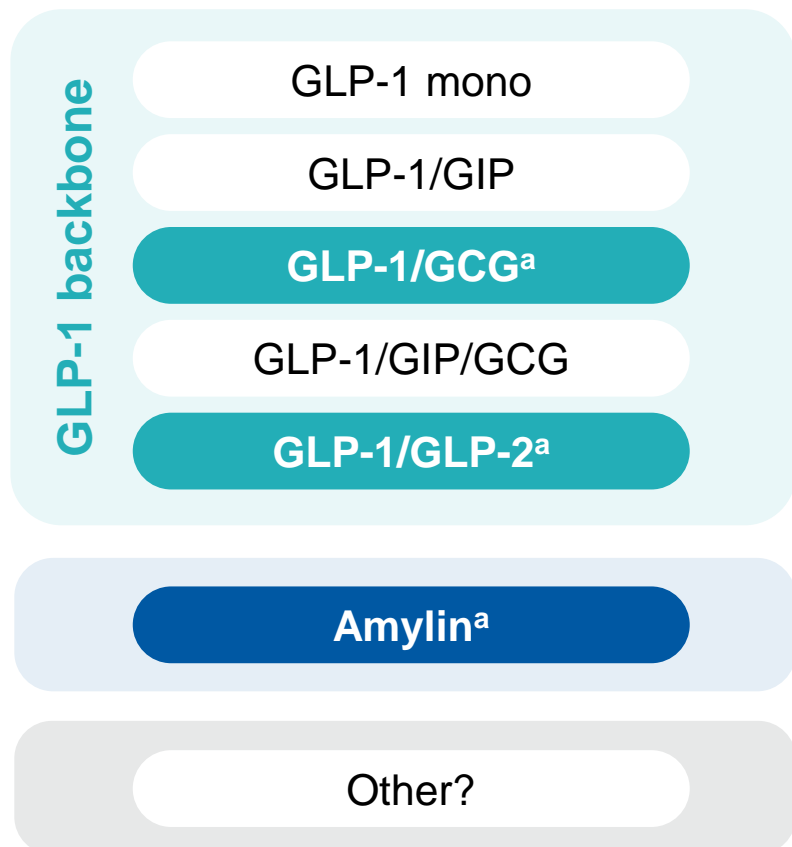
Patient-driven primary care prescriptions with focus on quality of weight loss and convenience of treatment.

Focus on:






1. Desired weight loss
2. Tolerability and convenience of treatment
3. Quality of weight loss, incl. muscle preservation
4. Health outcomes



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



Examples of differentiation factors

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

^aZealand Pharma clinical development pipeline.
GCG=glucagon; GI=gastrointestinal; GIP=gastric inhibitory polypeptide; GLP-1=glucagon-like peptide-1; GLP-2=glucagon-like peptide-2.

Zealand Pharma has a rich clinical-stage pipeline of differentiated product candidates for obesity

Developed as alternative to GLP-1RA-based therapies

Long-term potential as the future foundational therapy for weight management

Amylin

- Restore leptin sensitivity
- Increase satiety
- Increase energy expenditure



Petrelintide
long-acting amylin analog

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

Developed with added pharmacology to GLP-1 receptor agonism

GLP-1

- Increase insulin sensitivity
- Delay gastric emptying
- Decrease appetite

+ GLP-2

- Improve intestinal barrier function
- Reduce inflammation
- Delay gastric emptying



Dapiglutide
dual GLP-1/GLP-2 receptor agonist

First-in-class potential, targeting obesity and co-morbidities associated with low-grade inflammation, including liver disease and neuro-inflammation

+ Glucagon

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



Survodutide^a
dual GCG/GLP-1 receptor agonist

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



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GLP-1=glucagon-like peptide-1; GLP-1RA=glucagon-like peptide-1 receptor agonist; GCG=glucagon; MASH=metabolic dysfunction-associated steatohepatitis (formerly, non-alcoholic steatohepatitis, or NASH); MoA=mechanism of action.

GLP-1RA-based therapies are effective at reducing weight but are associated with GI tolerability issues¹

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

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



GLP-1RAs are commonly associated with GI side effects, including constipation, nausea, vomiting and diarrhea^{4,5}



Up to **30%** of patients with obesity **discontinue GLP-1RA treatment within 1 month**⁶



Up to **60–70%** of patients **discontinue GLP-1RA treatment within 12 months**⁷



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



15–20% mean weight loss and high-quality weight loss with potential for preservation of lean mass



Reduced food intake via a **non-incretin mechanism** that increases satiety and restores leptin sensitivity



Significantly improved GI tolerability with both lower frequency and severity of adverse events

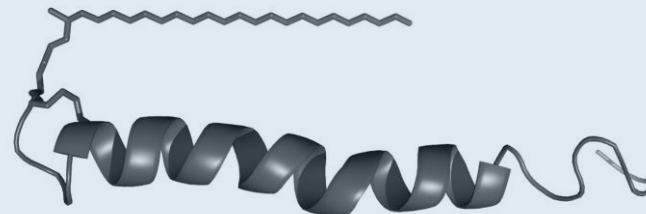
^aFor chronic weight management: Wegovy and Zepbound.

Sources: 1. Wang et al. Front Endocrinol (Lausanne) 2023;14:1085799; 2. Wegovy (semaglutide) US PI. Available from: https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/215256s011lbl.pdf, accessed July 2024; 3. Zepbound (tirzepatide) US PI. Available from: https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/217806s003lbl.pdf, accessed July 2024; 4. Wilding et al. N Engl J Med 2021;384(11):989–1002; 5. Jastreboff et al. N Engl J Med 2022;387(3):205–216; 6. Blue Health Intelligence. Real-world trends in GLP-1 treatment persistence and prescribing for weight management. May 2024; 7. Gasoyan et al. Obesity (Silver Spring) 2024;32(3):486–493. GI=gastrointestinal; GLP-1RA=glucagon-like peptide-1 receptor agonist; QW=once-weekly.

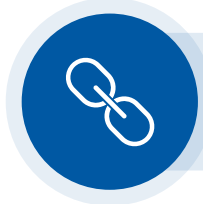
Intellectual property: Composition of matter, patent expiry in 2037. Patent-term extension up to 5 years, i.e. 2042. Potential rights beyond 2042 based on patent applications and additional elements.

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

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



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



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



Potent balanced agonist effect on **amylin and calcitonin receptors**^{1,5}

Sources: 1. Data on file; 2. Brændholt Olsen et al. Poster 92-LB. Presented at ADA 83rd Scientific Sessions, June 23–26, 2023, San Diego, CA; 3. Skarbaliene et al. Poster 1406-P. Presented at ADA 82nd Scientific Sessions, June 3–7, 2022, New Orleans, LA; 4. Eriksson et al. Poster 532. Presented at ObesityWeek, November 1–4, 2022, San Diego, CA; 5. Eriksson et al. Presentation at ObesityWeek, November 1–4, 2022, San Diego, CA.

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

Native amylin is a non-incretin hormone¹ that increases satiety, in contrast to GLP-1, which reduces appetite

Proposed physiological effects of amylin receptor activation²

Pancreas (indirect)^a

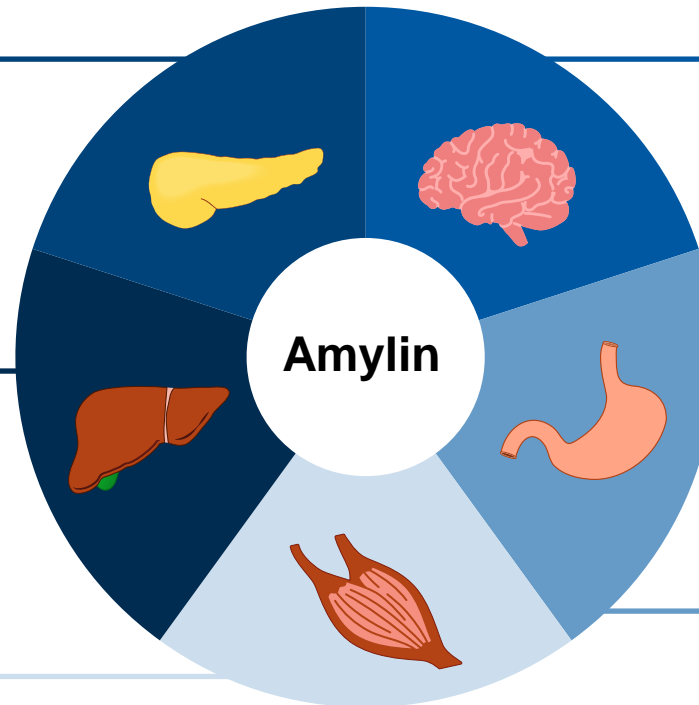
- ↓ Insulin secretion (improving glucose metabolism)
- ↓ Glucagon secretion

Liver and adipose tissue

- ↑ Insulin sensitivity
- ↓ Fat accumulation

Muscle

- ↔ Preserves lean mass^{b,4}



CNS

- ↑ Leptin sensitivity³
- ↑ Satiety
- ↑ Energy expenditure
- ↓ Body weight

⋮
Via the vagal nerve

GI tract

- ↓ Gastric emptying

^aMediated by the effect of amylin on the CNS.

^bDemonstrated pharmacologically with several amylin analogs in pre-clinical studies, including with petrelintide.

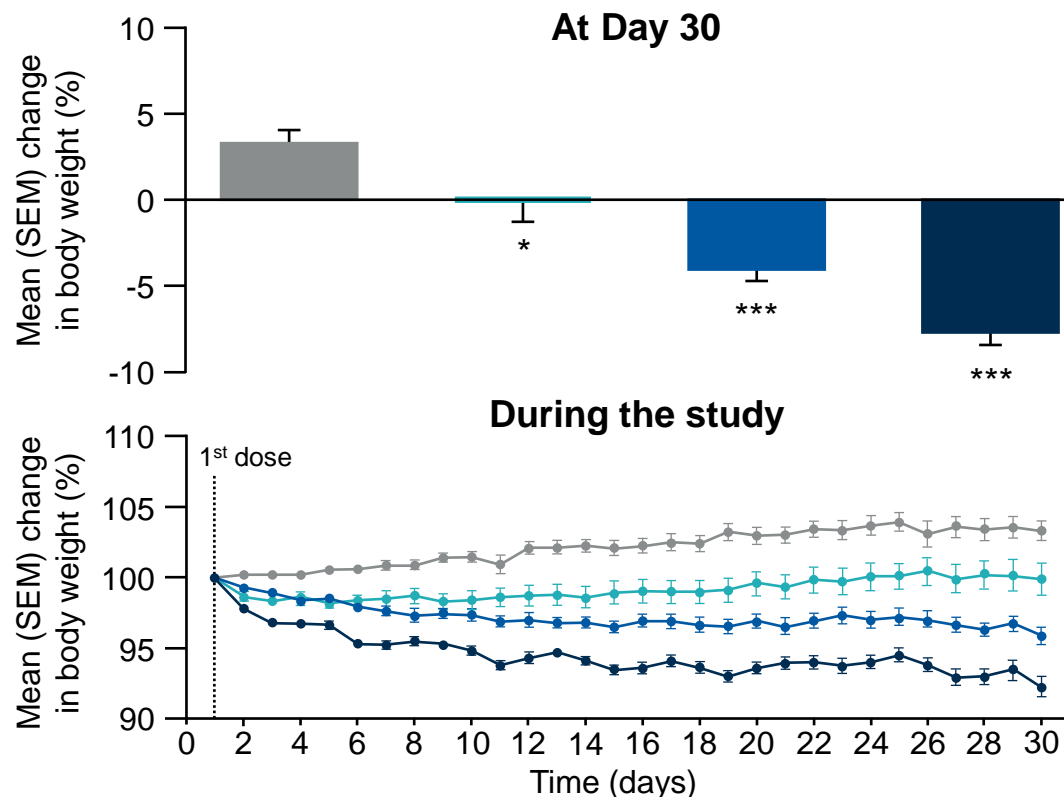
Sources: 1. Hayes et al. Annu Rev Nutr 2014;34:237–260; 2. Figure adapted from Mathiesen et al. Eur J Endocrinol 2022;186(6):R93–R111; 3. Roth et al. Proc Natl Acad Sci U S A 2008;105(20):7257–7262;

4. Vestergaard et al. Poster presented at ADA 84th Scientific Sessions, June 21–24, 2024, Orlando, FL. [1662-P].

CNS=central nervous system; GI=gastrointestinal; GLP-1=glucagon-like peptide-1.

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

Change in body weight in DIO rats^{1,2}



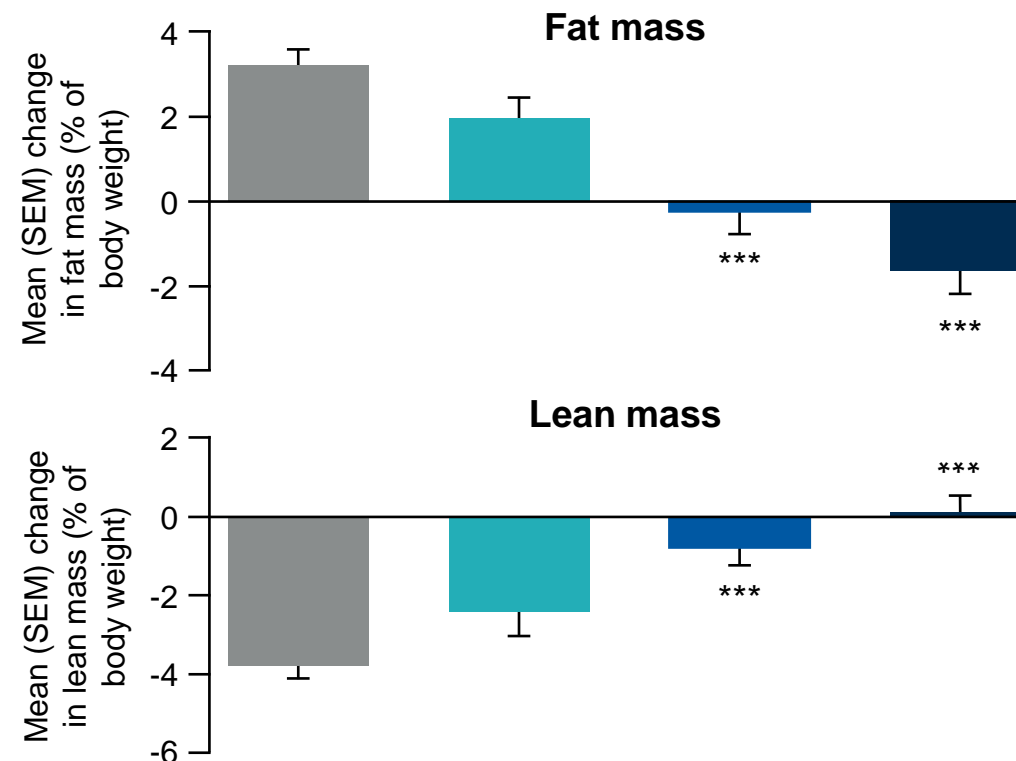
■ Vehicle

■ Liraglutide 5 nmol/kg BID

■ Petrelintide 2 nmol/kg QOD

■ Petrelintide 10 nmol/kg Q4D

Change in body composition at Day 30 in DIO rats¹



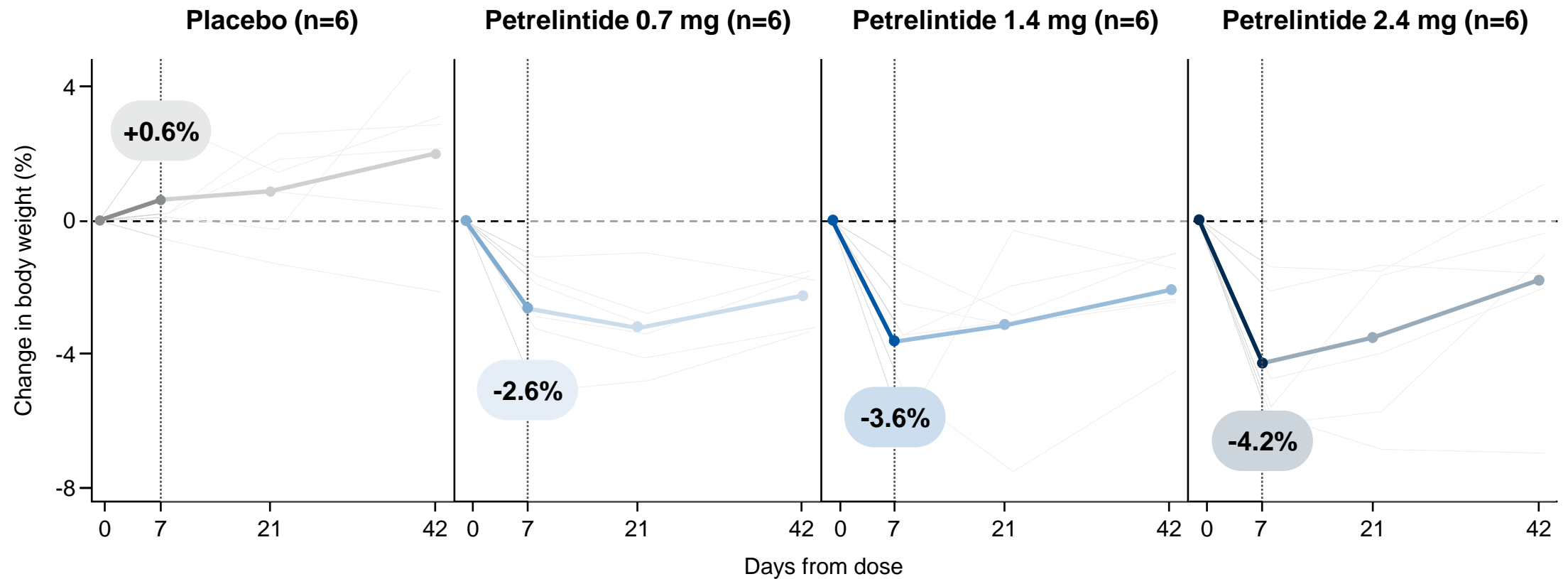
*p<0.05, ***p<0.001 vs vehicle.²

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

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

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

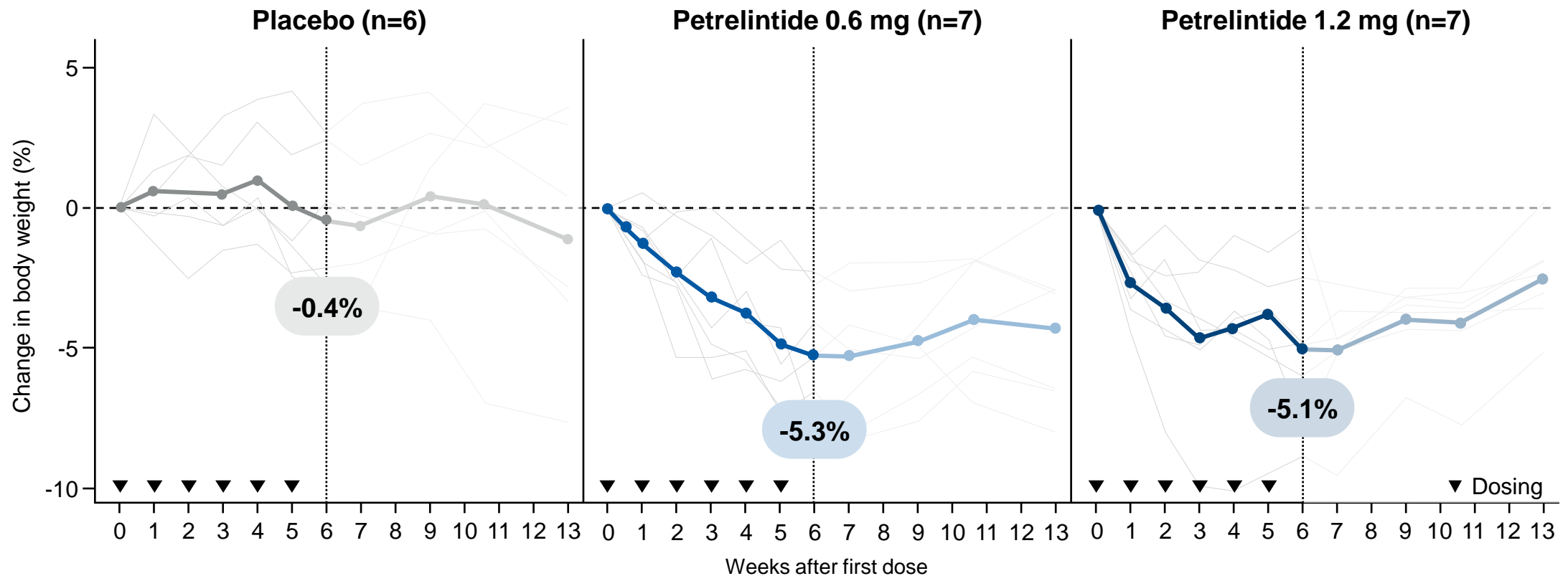
Petrelintide Phase 1a SAD trial: change in bodyweight



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

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

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



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

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

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

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

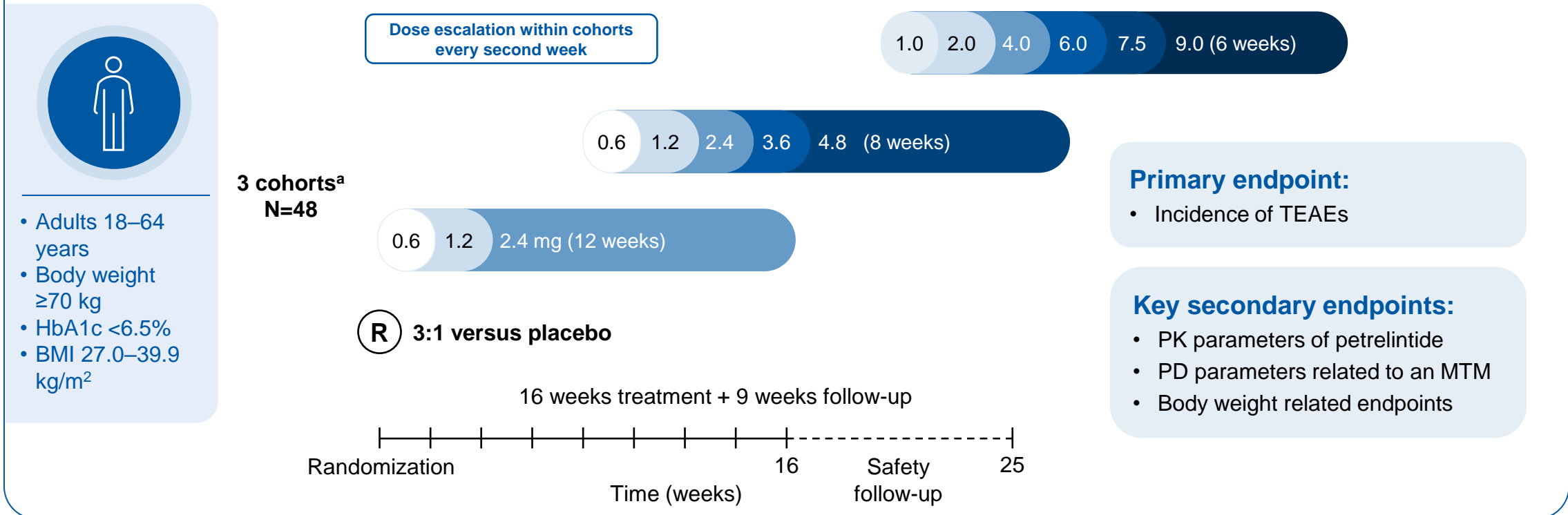
- All drug-related TEAEs were **mild and transient**, and most had an onset **within two days** of the first dose
- Nausea occurred in **three participants** on petrelintide, with one also reporting vomiting; no other participants reported vomiting
- **No injection-site reactions** were reported, and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

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

Trial design: Petrelintide Phase 1b MAD Part 2

A randomized, double-blind, placebo-controlled, Phase 1b, MAD trial of petrelintide – Part 2^{1,2}

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



^aSafety evaluation occurred after 4 weeks of treatment at the target dose for each cohort.² Initiation of the next, higher dose cohort only occurred following safety evaluation for the previous cohort.²

Sources: 1. ClinicalTrials.gov (NCT05613387), accessed October 2024; 2. Data on file.

BMI=body mass index; HbA1c=glycated hemoglobin; MAD=multiple ascending dose; MTM=mixed test meal; PD=pharmacodynamics; PK=pharmacokinetics; SC=subcutaneous; TEAE=treatment-emergent adverse event.

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

Petrelintide Phase 1b MAD trial Part 2: baseline characteristics^{1,2}



Gender

79% of participants were **male**



Age

Median **49 years**



Weight

Median **92.4 kg**



BMI

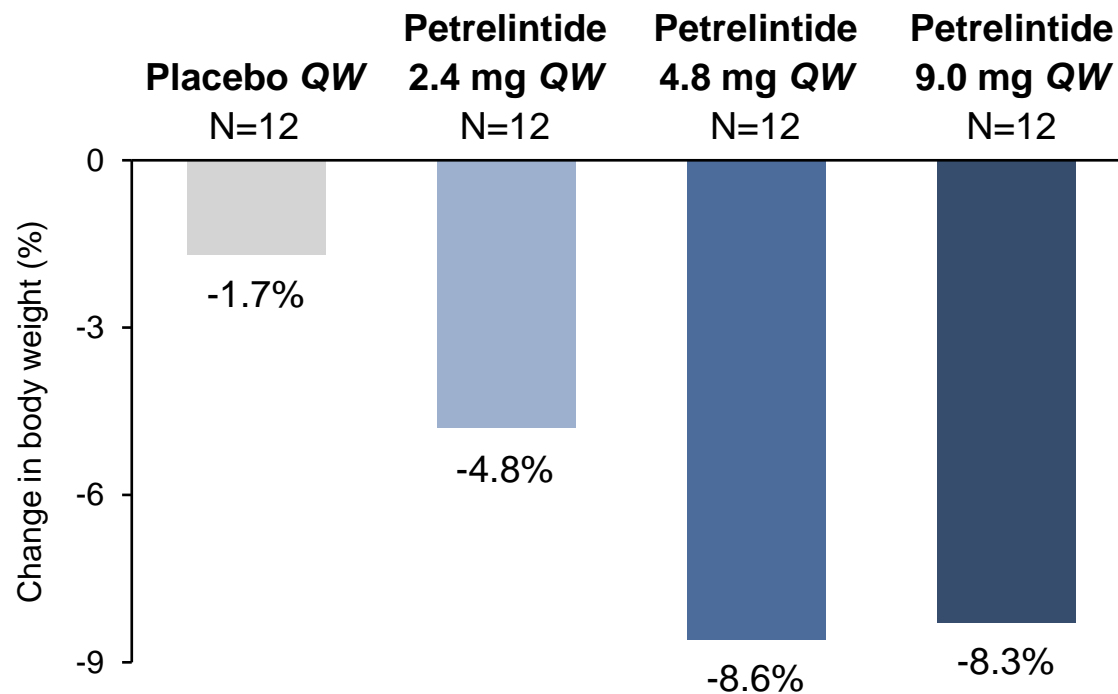
Median **29.2 kg/m²**
(eligible range: 27.0–39.9 kg/m²)

Baseline characteristics were **balanced** across the dose cohorts²

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

Substantial weight loss was observed at 16 weeks...

Petrelintide Phase 1b MAD trial Part 2: change from baseline in body weight at Week 16^{1,2}



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



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



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

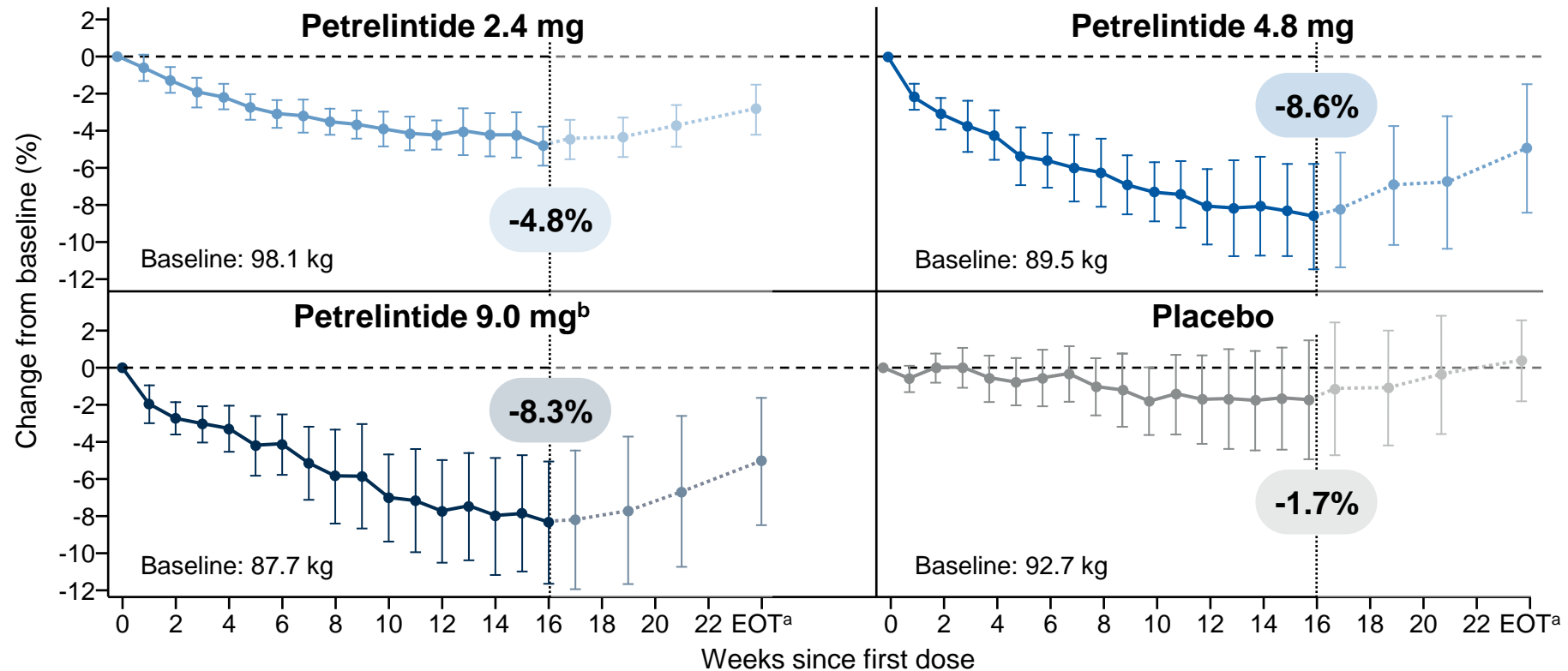
N represents cohort size at randomization.

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

DG=dose group; MAD=multiple ascending dose; QW=once-weekly.

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

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



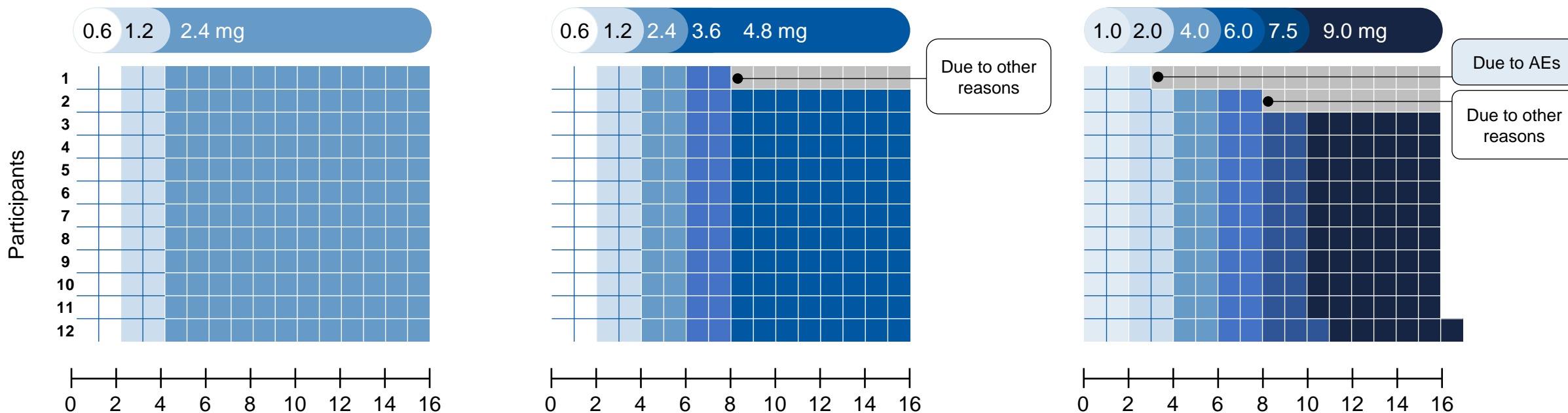
^aEOT includes measurements at the EOT visit, performed at 24 or 25 weeks after dosing, and also performed for participants discontinuing treatment early.

^bOne participant had one extra week at 7.5 mg, and thereby only five weeks on maintenance dose at Week 16. After Week 16, this participant is included with weeks after last dosing.

Source: Data on file. Data presented at ObesityWeek 2024 in San Antonio, Texas.

CI=confidence interval; EOT=end of trial; MAD=multiple ascending dose.

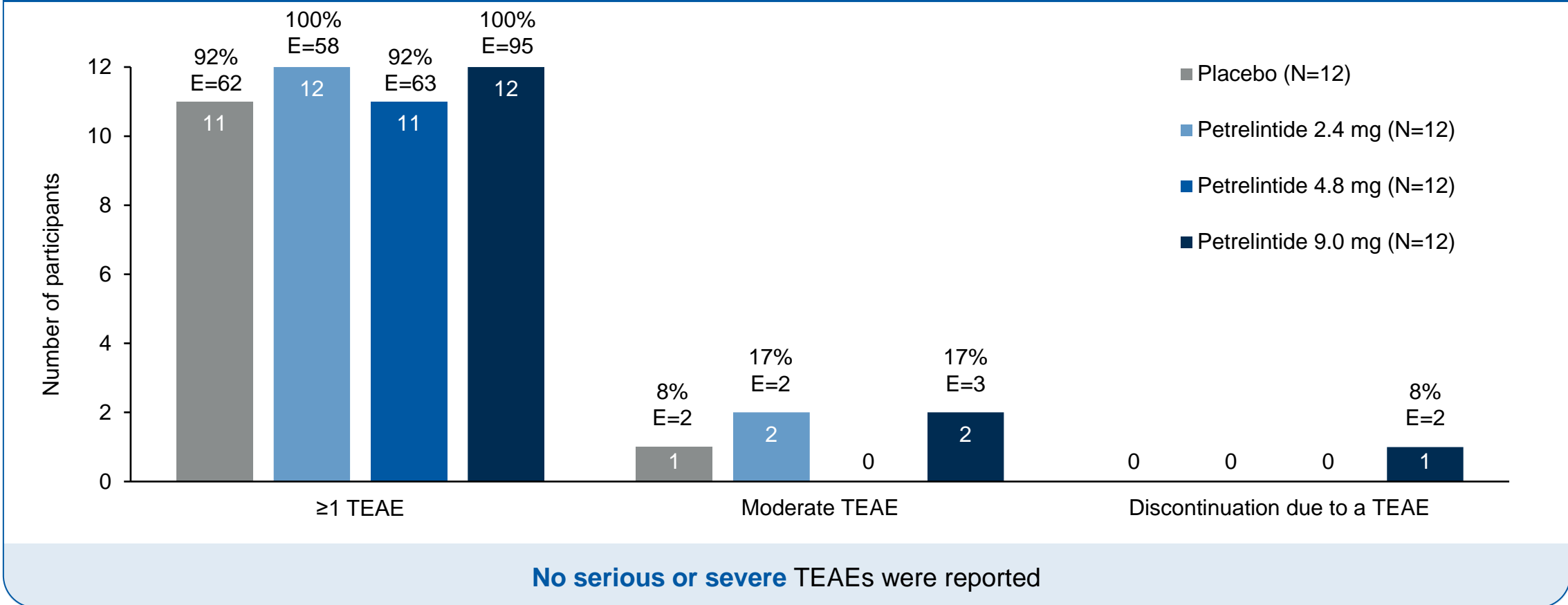
High rates of study treatment completion and adherence to dose escalation within cohorts



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

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

Only one petrelintide-treated participant discontinued treatment due to TEAEs

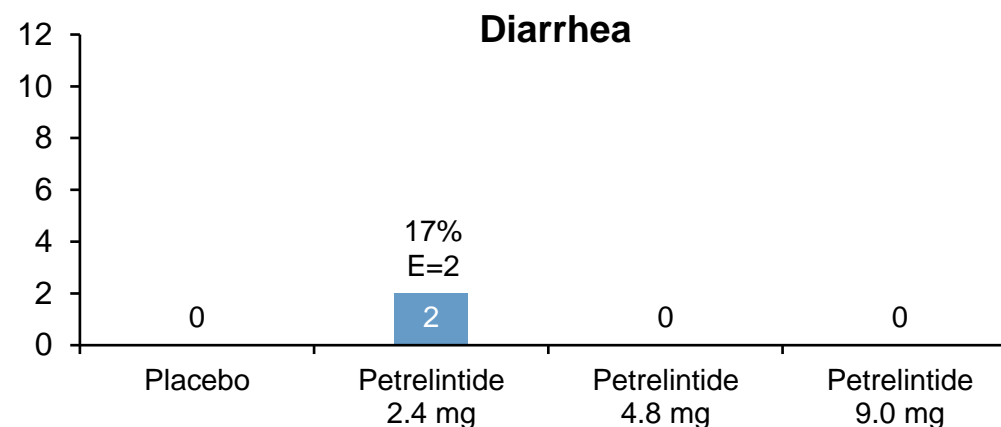
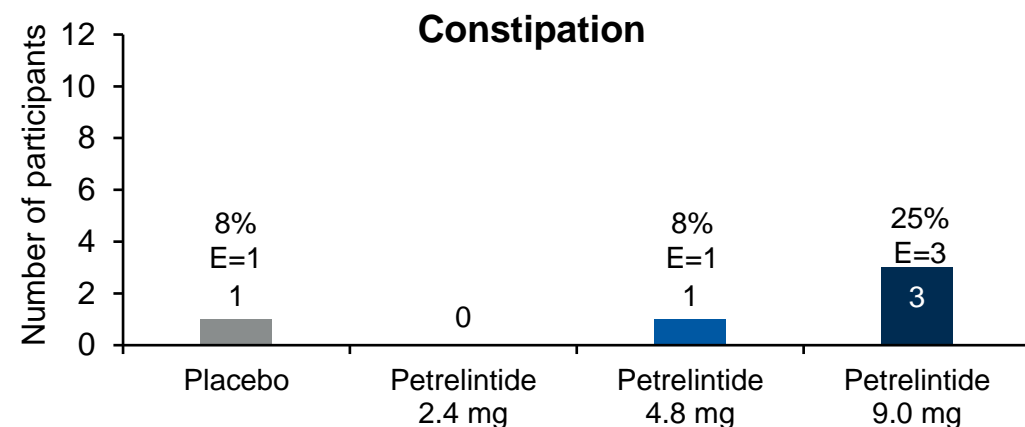
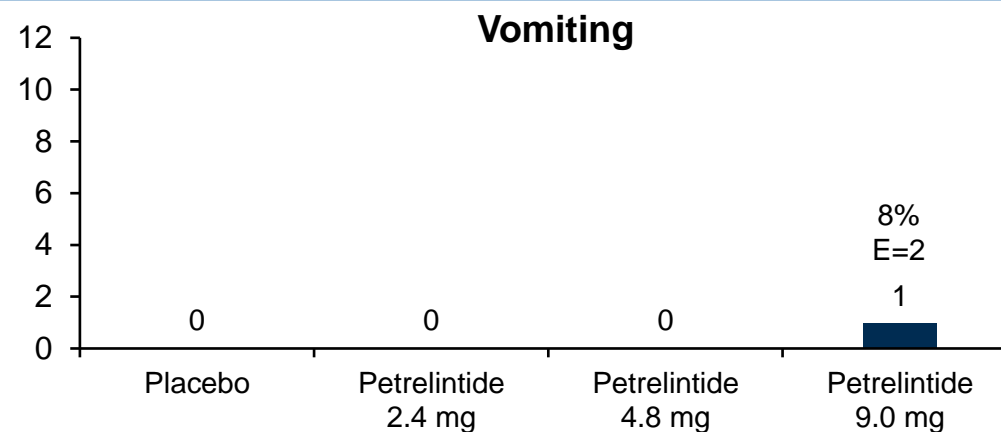
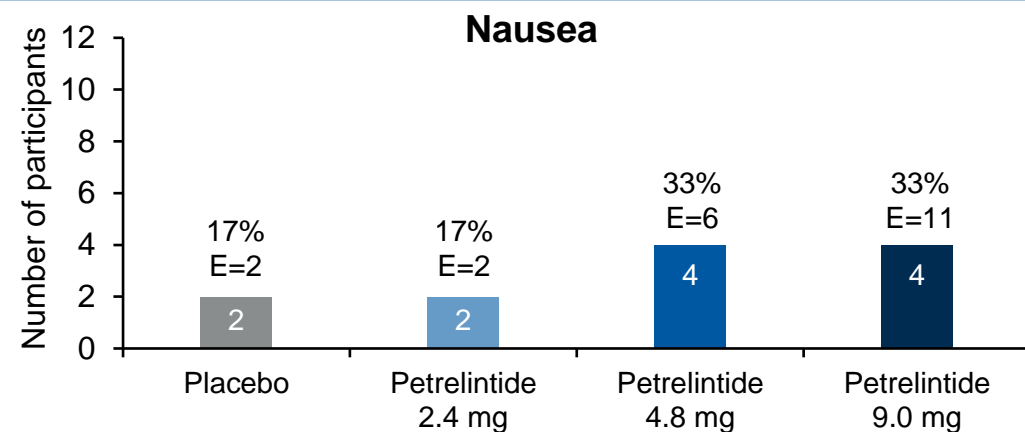


Source: Data on file. Data presented at ObesityWeek 2024 in San Antonio, Texas.

5 moderate AEs reported by petrelintide exposed participants: nausea, vomiting, nasopharyngitis, acute sinusitis, back pain
E=number of events; N=number of participants; TEAE=treatment-emergent adverse event.

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

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

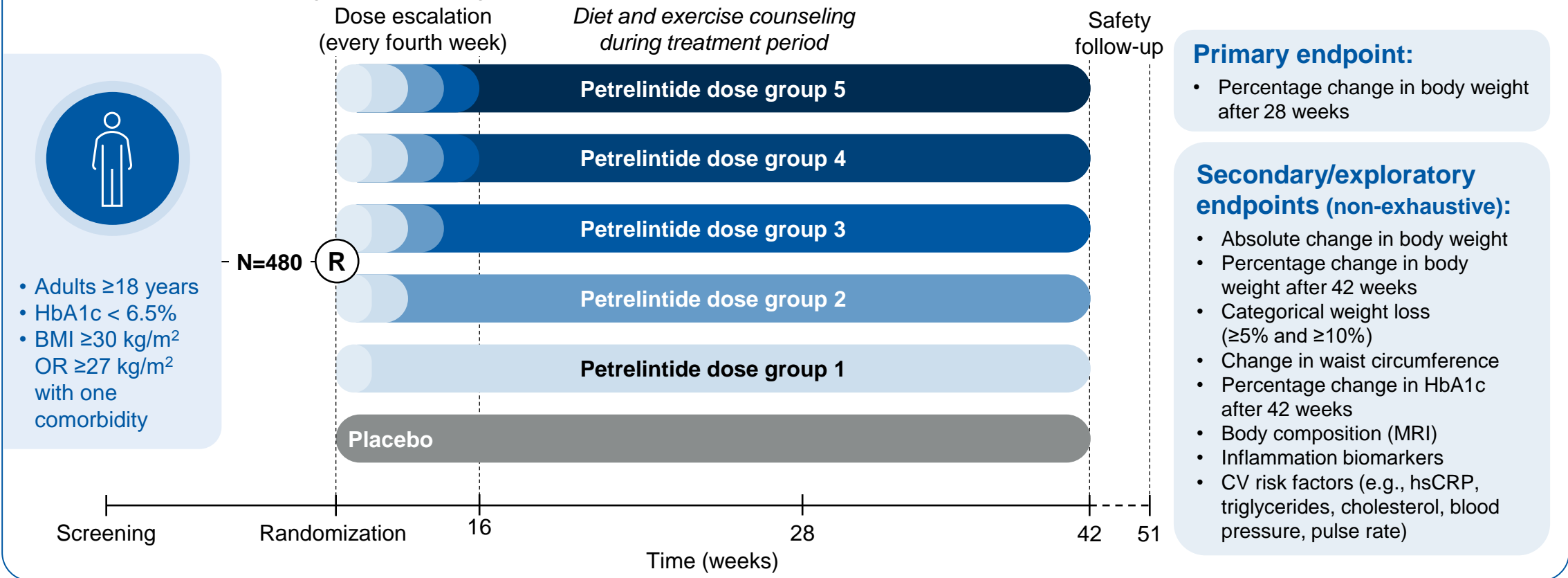


Source: Data on file. Data presented at ObesityWeek 2024 in San Antonio, Texas.
 N=12 in each treatment group.
 E=number of events; TEAE=treatment-emergent adverse event; GI=Gastrointestinal

Continuing development of petrelintide as monotherapy through a comprehensive Phase 2b trial

A randomized, double-blind, placebo-controlled, Phase 2b trial with petrelintide was initiated in Dec-2024^{1,2}

Aim: to evaluate change in body weight with multiple doses of petrelintide versus placebo



Sources: 1. ClinicalTrials.gov (NCT06662539), accessed December 2024; 2. Data on file.
 BMI=body mass index; HbA1c=glycated hemoglobin; MRI=magnetic resonance imaging; hsCRP=high-sensitivity C-reactive protein.

Target product profile of petrelintide holds potential to address the needs of patients and physicians

Establishing petrelintide as the future foundational therapy for weight management

Target product profile:

- 1 GLP-1RA-like weight loss (~15-20%)
- 2 Significantly improved GI tolerability profile
- 3 Potential for higher quality of weight loss¹
- 4 Unique MoA (satiety)
- 5 Simplicity

Potential market benefit:

- Vast majority of patients seek weight loss of 10-20%²
- Lower frequency and severity of GI AEs
- Potential to preserve lean muscle mass
- Potential for better patient experience (“feeling better”) with ability to eat but feel full (less “food aversion”)
- Sweet spot for PCPs (fewer call-backs)

Sources: 1. Vestergaard et al. Poster presented at ADA 84th Scientific Sessions, June 21–24, 2024, Orlando, FL. [1662-P]; 2. LifeSci Capital Survey May 2024 (N=4,995).
GLP-1RA=glucagon-like peptide-1 receptor agonist; GI=gastrointestinal; MoA=mechanism of action; AE=adverse event; PCP=primary care physician.

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

Design of molecule

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



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



Designed with **higher potency towards the GLP-1R** while retaining activity on the GLP-2R²



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

Positioning opportunities and differentiation



Obesity – pursuing $\geq 20\%$ weight loss



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



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



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

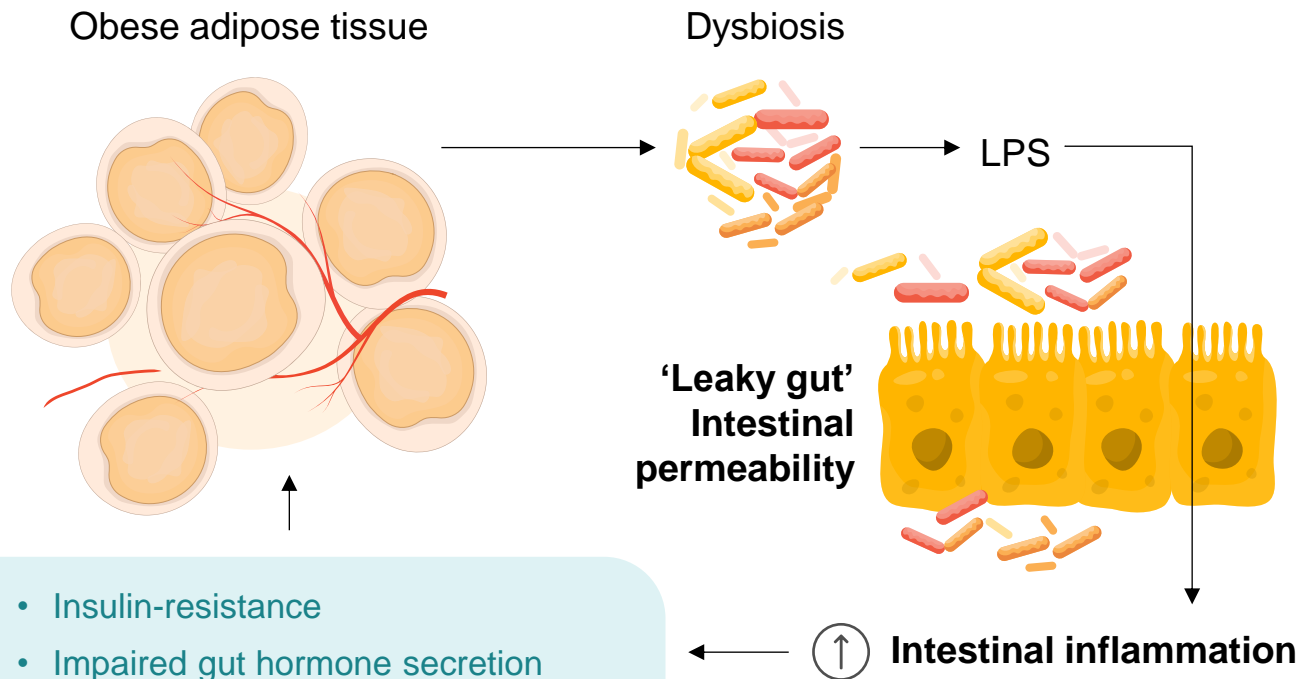
Sources: 1. Drucker & Yusta. Annu Rev Physiol 2014;76:561–583; 2. Reiner et al. JPEN J Parenter Enteral Nutr 2022;46(5):1107–1118; 3. Data presented by Agersnap at the 82nd ADA Scientific Sessions, June 3–7, 2022.

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

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

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

Excess fat storage can trigger low-grade systemic inflammation through reduced intestinal barrier integrity¹

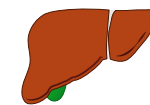


- Insulin-resistance
- Impaired gut hormone secretion
- Dysregulation of gut–brain–fat axis

Obesity-related low-grade inflammation can result in:



CVD as increased inflammation drives residual risk in people with CVD²



Liver disease due to abnormal accumulation of triglycerides in the liver³

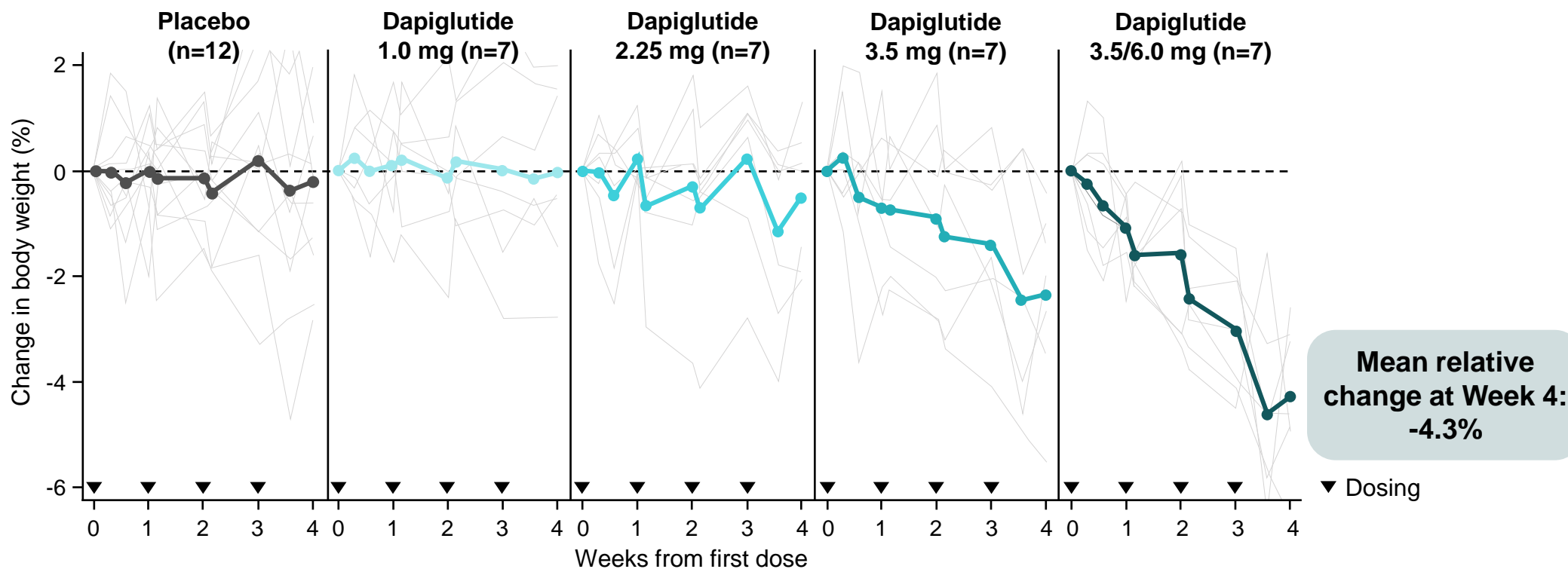


Neuro-inflammation due to excess circulating proinflammatory cytokines and changes in the integrity of the blood–brain barrier⁴

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

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

Phase 1 multiple ascending dose trial (n=40)



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

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

Investigator-led trial DREAM evaluating effects on body weight, gut permeability and inflammation¹

Trial design

- N=54, men and women aged 18-75 years (BMI ≥ 30 kg/m²)
- Duration = 12 weeks
- Dose strengths = up to 6.0 mg (similar to 4-week MAD)²
- No lifestyle interventions, such as diet or exercise

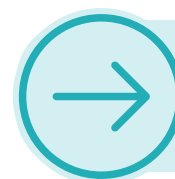
Purpose of trial

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

Low doses investigated at the lower end of the therapeutic window in obesity setting

Topline data

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



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

We expect to report topline results with dapiglutide from the 28-week Phase 1b trial in H1 2025

The 13-week Phase 1b trial¹ evaluated higher doses of dapiglutide than prior clinical trials^a



Mean **placebo-adjusted weight loss** of up to **8.3% after 13 weeks**



- Total of 54 participants, **85% male** with a median baseline **BMI of 30.0 kg/m²**
- **No lifestyle modifications**, such as diet or exercise, were included in trial



- Dapiglutide up to 13 mg assessed to be **safe and well-tolerated** with GI AEs consistent with profile of incretin-based therapies
- **Two participants** out of 54 **discontinued treatment due to GI AEs**

Next steps include topline results from 28-week trial² and initiation of Phase 2b trial



- Part 2 of the Phase 1b trial includes a **higher dose cohort (up to 26 mg)** with **28 weeks treatment**
- Monthly dose escalation
- Topline results expected in H1 2025



Large, comprehensive **Phase 2b trial** to be initiated in H1 2025

^aDREAM, an investigator-led mechanistic trial with dapiglutide: ClinicalTrials.gov (NCT05788601), and the 4-week Phase 1a clinical trial: ClinicalTrials.gov (NCT04612517).

Sources: 1. Zealand Pharma company announcement No. 44/2024, September 9, 2024; 2. ClinicalTrials.gov (NCT06000891), accessed December 2024.

BMI=body mass index; GI=gastrointestinal; AE=adverse event.

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

Design of molecule

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



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



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



Extended half-life for **once-weekly administration** achieved by amino acid substitutions²

Positioning opportunities and differentiation



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



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



Cardiovascular benefits – potential benefits driven by GLP-1RA



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

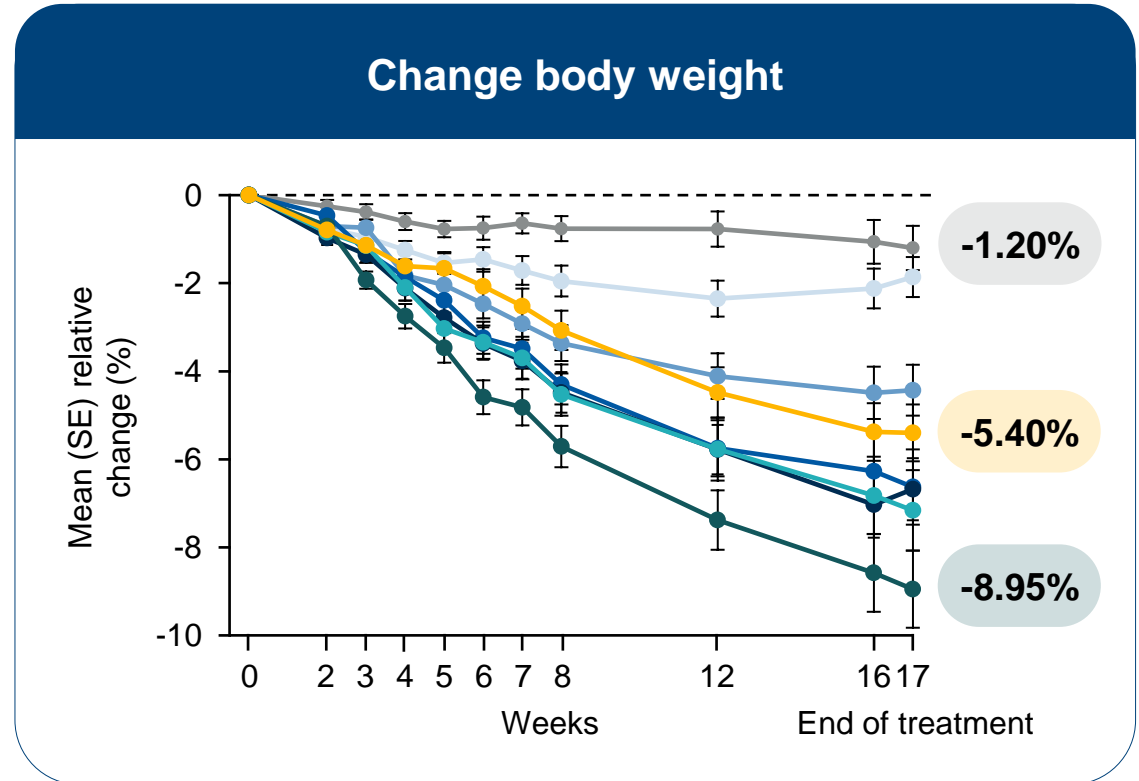
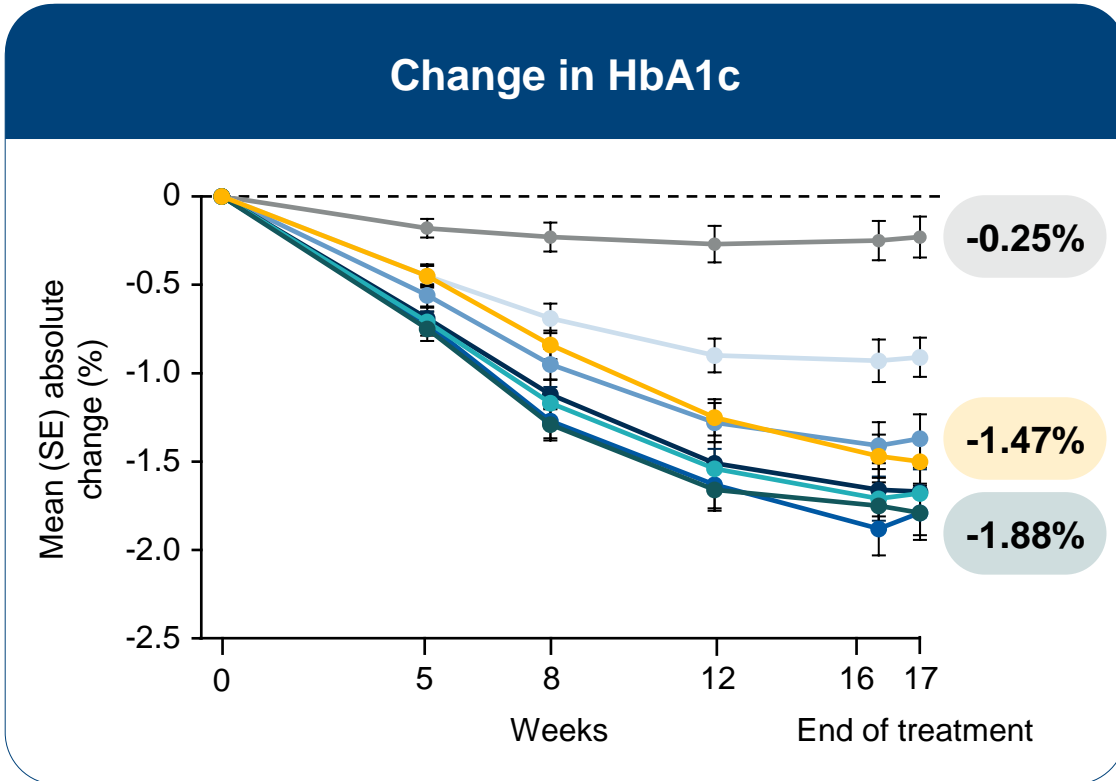
^aSurvodutide is licensed to Boehringer Ingelheim from Zealand Pharma, with Boehringer solely responsible for development and commercialization globally (subject to Zealand's co-promotion rights in the Nordic countries).

Sources: 1. Wynne et al. Int J Obes (Lond) 2006;30(12):1729–1736; 2. Zimmermann et al. Mol Metab 2022;66:101633.

GCG=glucagon; GLP-1=glucagon-like peptide-1; GLP-1RA=glucagon-like peptide-1 receptor agonist; MoA=mechanism of action; MASH=metabolic dysfunction-associated steatohepatitis (formerly, non-alcoholic steatohepatitis, or NASH).

Intellectual property: Composition of matter, patent expiry in 2034. Patent-term extension up to 5 years, i.e. 2039. Potential rights beyond 2039 based on patent applications and additional elements.

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



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

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

^aThe semaglutide arm was open-label.

Body weight at baseline was 93.0–100.1 kg and HbA1c at baseline was 7.9–8.2%.

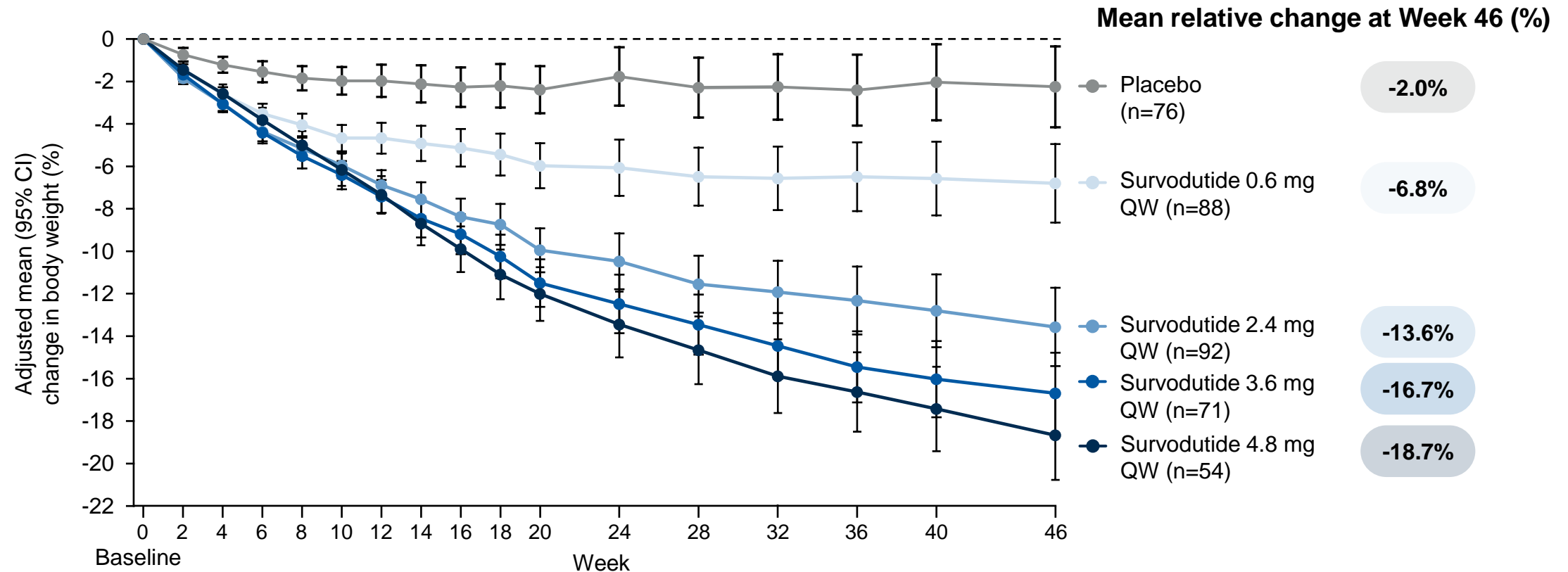
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Sources: Figures adapted from Rosenstock. Presentation at ObesityWeek, November 1–4, 2022, San Diego, CA.

BIW=twice-weekly; GLP-1R=glucagon-like peptide-1 receptor; HbA1c=hemoglobin A1c; QW=once-weekly; SE=standard error; T2DM=type 2 diabetes mellitus.

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

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



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Source: Figure adapted from Le Roux et al. Oral presentation (51-OR) at ADA 83rd Scientific Sessions, June 23–26, 2023, San Diego, CA.

Analysis based on dose reached at the end of treatment regardless of the dose assigned at randomization.

CI=confidence interval; QW=once-weekly.

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

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

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

^aBased on the treated set and presented according to planned treatment; ^bTEAEs listed according to preferred term and occurred in ≥15% patients in any treatment arm.

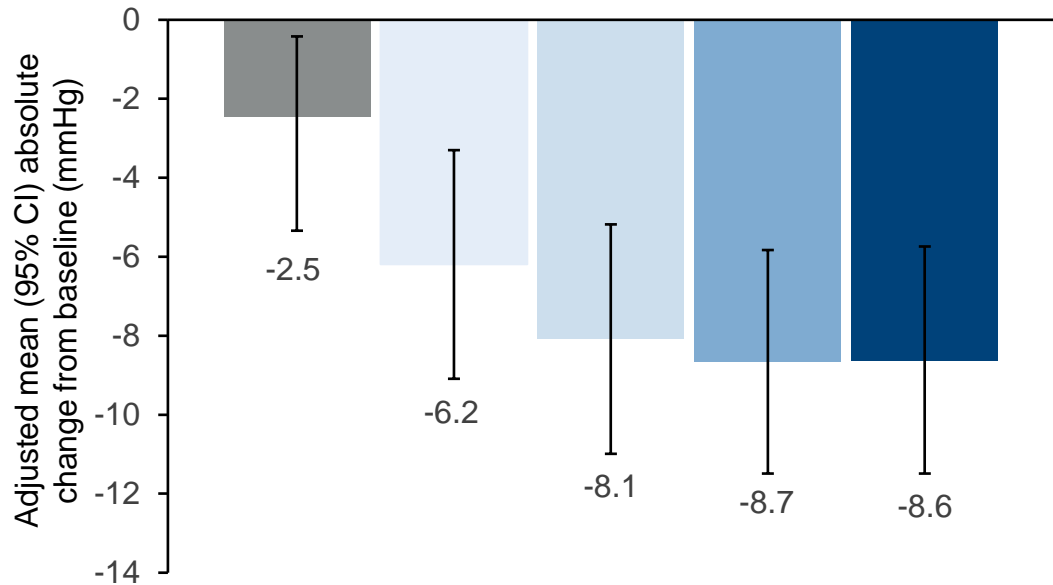
Survodutide is licensed to Boehringer Ingelheim from Zealand Pharma, with Boehringer solely responsible for development and commercialization globally (subject to Zealand's co-promotion rights in the Nordic countries).

Source: Table adapted from Le Roux et al. Oral presentation (51-OR) at ADA 83rd Scientific Sessions, San Diego, June 23–26, 2023.

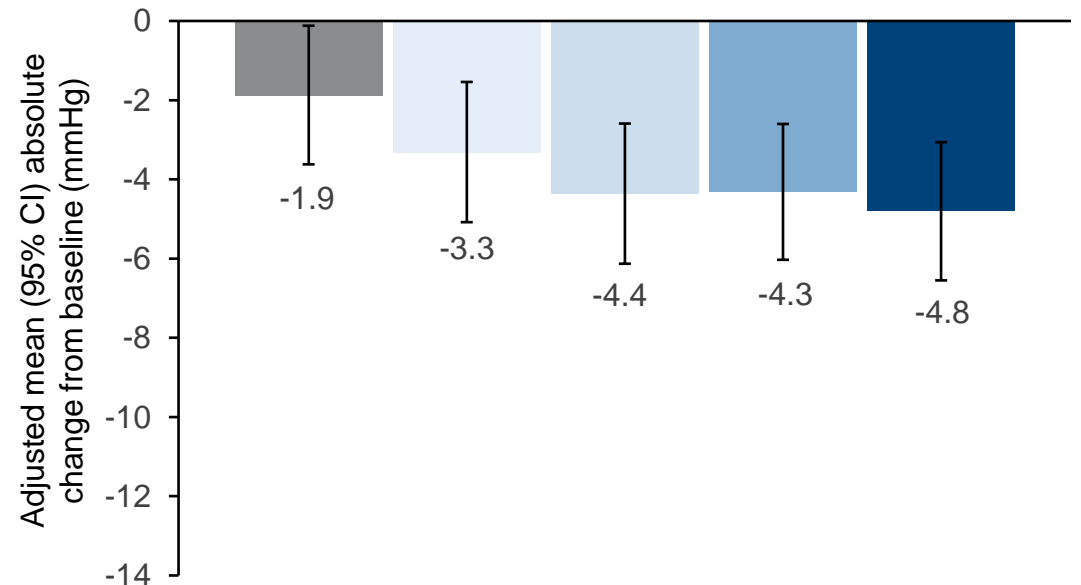
AE=adverse event; GI=gastrointestinal; TEAE=treatment-emergent adverse event.

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

Systolic blood pressure



Diastolic blood pressure



■ Placebo

■ Survodutide 0.6 mg QW

■ Survodutide 2.4 mg QW

■ Survodutide 3.6 mg QW

■ Survodutide 4.8 mg QW

Mean blood pressure at baseline across cohorts: 122.6–127.5 mmHg for systolic blood pressure; 80.5–82.4 mmHg for diastolic blood pressure.

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Source: Figures adapted from Le Roux. Presentation at the 59th EASD Annual Meeting, October 2–6, 2023, Hamburg, Germany.

CI=confidence interval; QW=once-weekly.

The Phase 3 program with survodutide in obesity is ongoing



	Inclusion criteria	Study design	Primary endpoint
SYNCHRONIZE™-1¹ Efficacy and safety in patients with obesity without T2DM	<ul style="list-style-type: none"> HbA1c <6.5% (no history of diabetes) BMI ≥30 or BMI ≥27 with co-morbidities^a 	<ul style="list-style-type: none"> N=600 1:1:1 ratio (3.6 mg, 6.0 mg, or placebo) Trial duration: 76 weeks 	<ul style="list-style-type: none"> Percentage change in body weight from baseline to Week 76 Achievement of body weight reduction ≥5% from baseline to Week 76
SYNCHRONIZE™-2² Efficacy and safety in patients with obesity and T2DM	<ul style="list-style-type: none"> HbA1c ≥6.5% and <10% BMI ≥27 T2DM managed with diet and exercise alone or with stable pharmacological treatment 	<ul style="list-style-type: none"> N=600 1:1:1 ratio (3.6 mg, 6.0 mg or placebo) Trial duration: 76 weeks 	<ul style="list-style-type: none"> Percentage change in body weight from baseline to Week 76 Achievement of body weight reduction ≥5% from baseline to Week 76
SYNCHRONIZE™-CVOT³ Long-term CV safety in patients with obesity and established CVD/CKD or risk factors for CVD	<ul style="list-style-type: none"> BMI ≥27 with CVD and/or at least two weight-related risk factors for CVD, or BMI ≥30 with CVD/CKD and/or at least two weight-related factors for CVD 	<ul style="list-style-type: none"> N=4,935 1:1:1 ratio (3.6 mg, 6.0 mg or placebo) Trial duration: up to 114 weeks 	<ul style="list-style-type: none"> Time to first occurrence of any of five major adverse cardiac events (5P-MACE) to demonstrate non-inferiority

^aCo-morbidities comprise dyslipidemia, hypertension, obstructive sleep apnea, and others.

Inclusion criteria for all three trials include age ≥18 years. 5P-MACE includes cardiovascular death, non-fatal stroke, non-fatal myocardial infarction, ischemia-related coronary revascularization or heart failure.

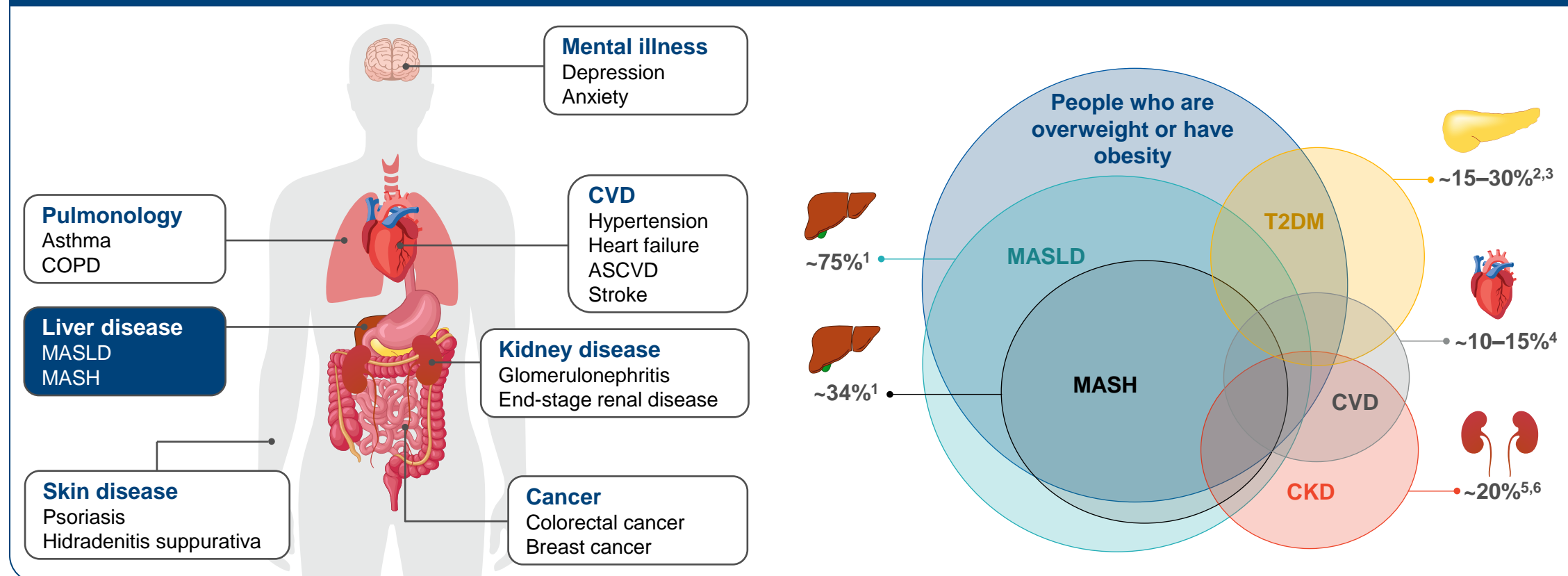
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Sources: 1. SYNCHRONIZE-1. ClinicalTrials.gov (NCT06066515), accessed November 2023; 2. SYNCHRONIZE-2. ClinicalTrials.gov (NCT06066528), accessed November 2023; 3. SYNCHRONIZE-CVOT. ClinicalTrials.gov (NCT06077864), accessed November 2023.

BMI=body mass index; CKD=chronic kidney disease; CV=cardiovascular; CVD=cardiovascular disease; CVOT=cardiovascular outcomes trial; HbA1c=hemoglobin A1c; T2DM=type 2 diabetes mellitus.

There is a significant overlap between obesity and liver disease

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



Estimates of overlap of co-morbidities are not available in literature; approximation in figure is based on individual prevalence estimates.

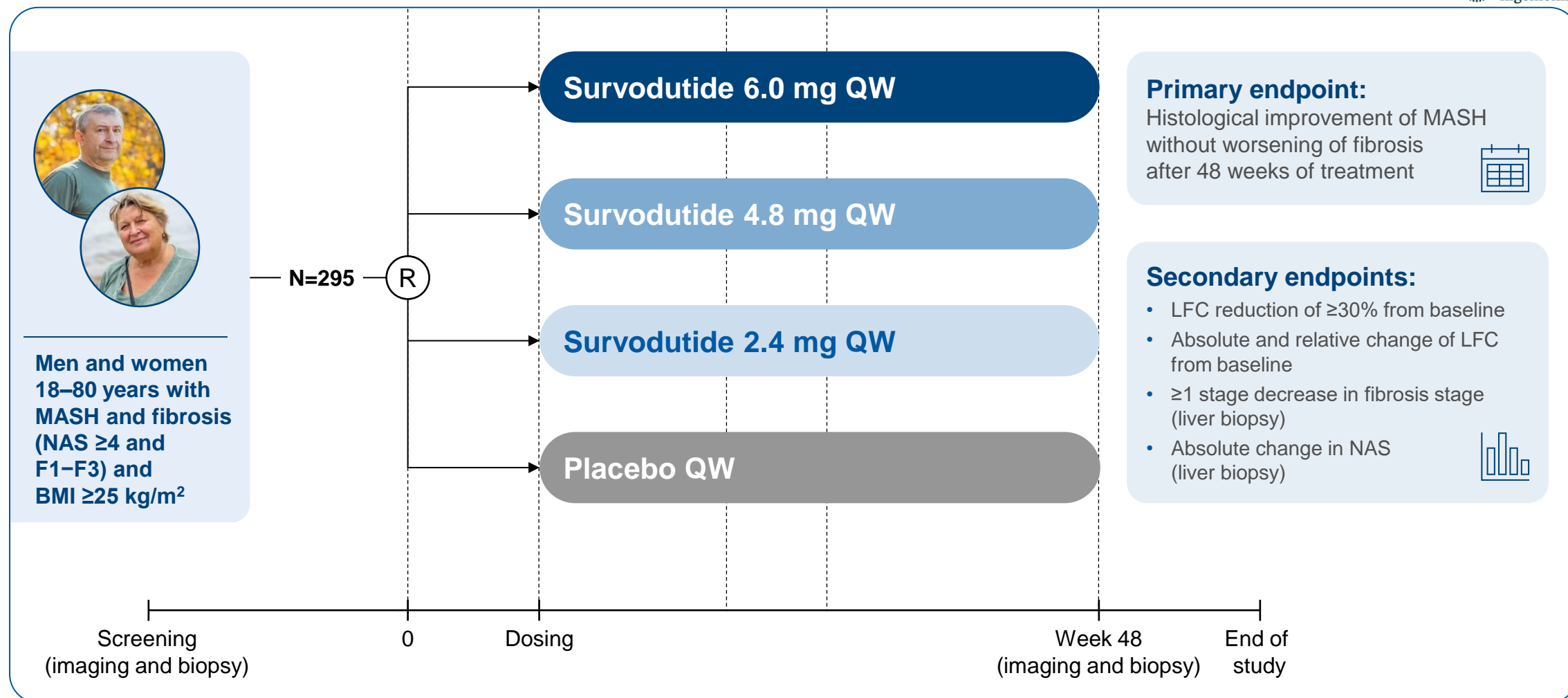
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Sources: 1. Quek et al. Lancet Gastroenterol Hepatol 2023;8(1):20–30; 2. Vinciguerra et al. Acta Diabetol 2013;50(3):443–449; 3. Pantalone et al. BMJ Open 2017;7(11):e017583; 4. Schienkiewitz et al. BMC Public Health 2012;12:658;

5. Arinsoy et al. J Ren Nutr 2016;26(6):373–379; 6. Yim & Yoo. Clin Exp Pediatr 2021;64(10):511–518.

ASCVD=atherosclerotic cardiovascular disease; CKD=chronic kidney disease; COPD=chronic obstructive pulmonary disease; CVD=cardiovascular disease; MASLD=metabolic dysfunction-associated steatotic liver disease (formerly, NAFLD, or non-alcoholic fatty liver disease); MASH=metabolic dysfunction-associated steatohepatitis (formerly, non-alcoholic steatohepatitis, or NASH); T2DM=type 2 diabetes mellitus.

Survodutide has been evaluated in a Phase 2 trial in MASH



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Source: ClinicalTrials.gov (NCT04771273), accessed February 2024.

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

Survodutide^a shows best-in-class potential in MASH Phase 2 trial



48-week biopsy-driven Phase 2 MASH trial¹



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



Participants showing **improvement in liver fibrosis** with no worsening of MASH (stages F2-F3): **64.5% with survodutide** vs 25.9% with placebo (p=0.0007)

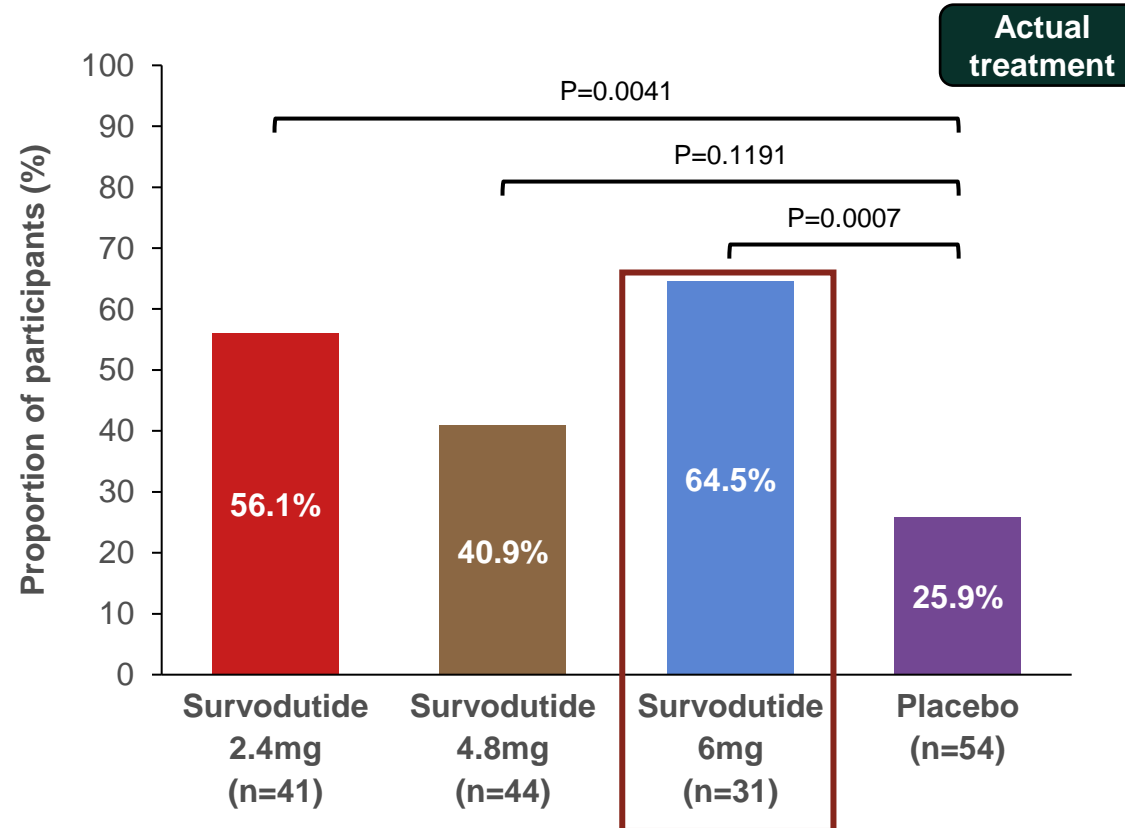


Survodutide treatment **did not show unexpected safety or tolerability issues**, including at the higher dose of 6.0 mg



Boehringer received **U.S. FDA BTD for survodutide** in MASH and fibrosis (stages F2-F3), and **launched two Phase 3 trials³** in MASH for survodutide

Improvement in liver fibrosis with no worsening of MASH Paired biopsy results (F2/F3)²



^aSurvodutide is licensed to Boehringer Ingelheim from Zealand Pharma, with Boehringer solely responsible for development and commercialization globally (subject to Zealand's co-promotion rights in the Nordic countries).

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

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

The Phase 3 program with survodutide in MASH has been initiated in October 2024



	Inclusion criteria	Study design	Primary endpoint
<p>LIVERAGE¹</p> <p>Efficacy and safety in patients with MASH and fibrosis (F2/F3)</p>	<ul style="list-style-type: none"> Diagnosis of MASH^a and biopsy-proven fibrosis stage F2-F3 <p><i>Granted Breakthrough Therapy Designation by the U.S. FDA²</i></p>	<ul style="list-style-type: none"> N=1,800 1:1 ratio (6.0 mg or placebo) Trial duration <ul style="list-style-type: none"> - Part 1: 52 weeks - Part 2: Up to 7 years 	<p>Part 1: 52 weeks</p> <ul style="list-style-type: none"> MASH resolution without worsening of liver fibrosis, and Improvement in fibrosis stage with no worsening of MASH <p>Part 2: Time to first occurrence of liver-related events or all-cause mortality</p>
<p>LIVERAGE-Cirrhosis³</p> <p>Efficacy and safety in patients with MASH and cirrhosis (F4)</p>	<ul style="list-style-type: none"> Diagnosed compensated MASH cirrhosis^b 	<ul style="list-style-type: none"> N=1,590 1:1 ratio (6.0 mg or placebo) Trial duration: Up to 4.5 years 	<ul style="list-style-type: none"> Time to first occurrence of liver-related events or all-cause mortality

^aMASH diagnosis defined by a NAS score ≥ 4 , with at least 1 point in inflammation and ballooning each. ^bDiagnosed according to modified Liver Forum criteria (Noureddin et al, Gastroenterology 2020;159:422-427)

Inclusion criteria for both trials include age ≥ 18 years. Further inclusion criteria apply.

Liver-related events include progression to cirrhosis (LIVERAGE), liver transplant, hepatic decompensation event(s), worsening of MELD score to ≥ 15 , and progression to CSPH

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Sources: 1. LIVERAGE. ClinicalTrials.gov (NCT06632444), accessed October 2024; 2. Boehringer Ingelheim press release October 8, 2024; 3. LIVERAGE-Cirrhosis. ClinicalTrials.gov (NCT06632457), accessed October 2024;

N=number of participants; BMI=body mass index; MASH = metabolic-associated steatohepatitis; MELD = Model for End-stage Liver Disease; CSPH = clinically significant portal hypertension

Rare Diseases

Corporate Presentation

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

There is a significant unmet need for an effective treatment



CHI is an ultra-rare disease in newborns and children

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



Persistent episodes of hypoglycemia may result in brain damage

- Hypoglycemia can cause seizures in ~50% of the patients⁴
- Lack of proper management within days can lead to permanent brain injury and neurocognitive impairment^{3,4}



Significant impact on the patient and caregivers' quality of life

- Complex care requirements can cause lengthy and frequent hospitalizations and make daily social activities difficult^{4,5}
- Severe CHI requires continuous enteral feeding, making transfer to other caregivers difficult (e.g., school)⁴
- More than 50% of CHI patients may be unresponsive to current medical treatment options⁶



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

QoL=quality of life

Dasiglucagon has potential to address shortcomings of current management of CHI

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

Cited by healthcare providers as greatest limitations⁵

- Lack of responsiveness or incomplete response
- Adverse effects or intolerable side effects

Treatment	Current usage (availability varies by country)	Clinical barriers
Diazoxide	<ul style="list-style-type: none"> • Approved for hyperinsulinism due to various underlying conditions in the US and certain ex-US regions² 	<ul style="list-style-type: none"> • FDA-issued warning on pulmonary hypertension in infants in 2015^{2,3} • Lack of adequate response¹ • Hypertrichosis² • Fluid retention, acute heart failure, pulmonary hypertension²
Glucagon	<ul style="list-style-type: none"> • Used off-label in CHI¹ 	<ul style="list-style-type: none"> • Requires daily reconstitution of lyophilized glucagon • Precipitates in the infusion tube (cannot use long-term)¹
Somatostatin analogs (octreotide)	<ul style="list-style-type: none"> • Used off-label in CHI¹ • Short acting: 3-4 daily s.c. injections/continuous infusion^{1,4} • Long-acting: intramuscular injection every 28 days⁵ 	<ul style="list-style-type: none"> • Hepatotoxicity^{1,4} • Tachyphylaxis, QT prolongation⁴ • Necrotizing enterocolitis (can be fatal in children with CHI)^{1,4}
Pancreatic surgery	<ul style="list-style-type: none"> • Total/near-total pancreatectomy in diffuse CHI if medical management fails¹ 	<ul style="list-style-type: none"> • Patients develop lifelong insulin dependent diabetes mellitus⁵ • Patients develop lifelong severe exocrine insufficiency⁵

Dasiglucagon for subcutaneous infusion*

Wearable s.c. infusion pump system⁶

- Glucagon analog designed to allow for continuous subcutaneous (s.c.) infusion via pump



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



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



Zealand expects to resubmit Part 1 of NDA related to dosing of up to three weeks in H1 2025⁷



Zealand expects to submit Part 2 of NDA related to dosing beyond three weeks in H1 2025⁷

IP exclusivity: compound patent US 2035 and EU 2039

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

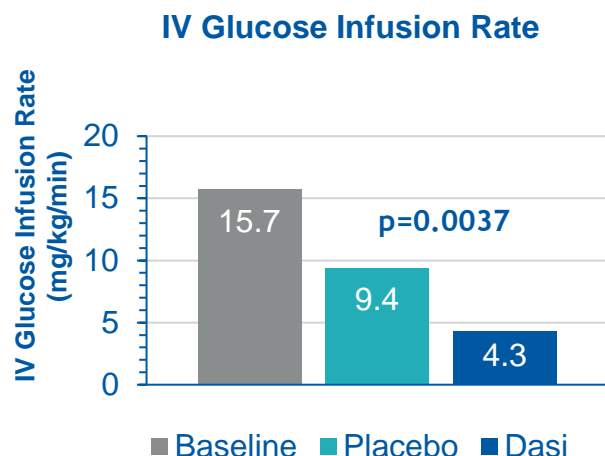
*Investigational compound and device whose safety and efficacy have not been evaluated or approved by the FDA or any other regulatory authority

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



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

Part 1: Placebo control, crossover x 48 hours¹

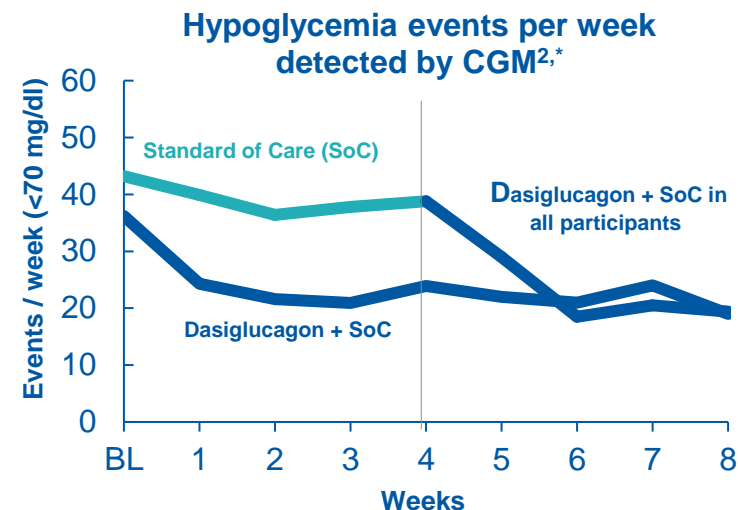


Part 2: 21-days open-label treatment¹

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



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



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

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

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

17103 Phase 3 clinical trial enrolled patients aged 7 days to 12 months, who were newly diagnosed and dependent on IV glucose in hospital setting: <https://clinicaltrials.gov/ct2/show/NCT04172441>

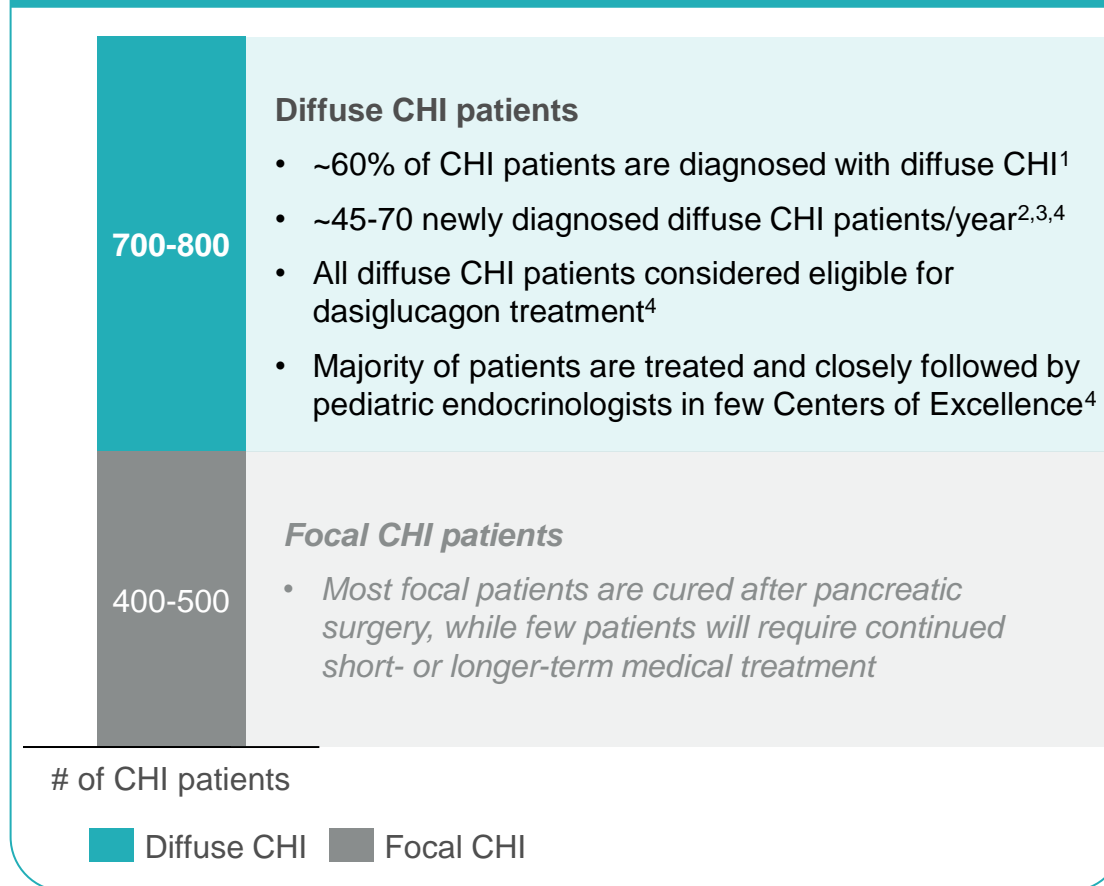
17106 is an open label long-term safety study that enrolled 17109 and 17103 participants with ongoing positive benefit / risk aged >1 month: <https://clinicaltrials.gov/ct2/show/NCT03941236>

17109 Phase 3 clinical trial enrolled children aged 3 months to 12 years being treated with standard of care (+/- surgery) with persistent hypoglycemia: <https://clinicaltrials.gov/ct2/show/NCT03777176>

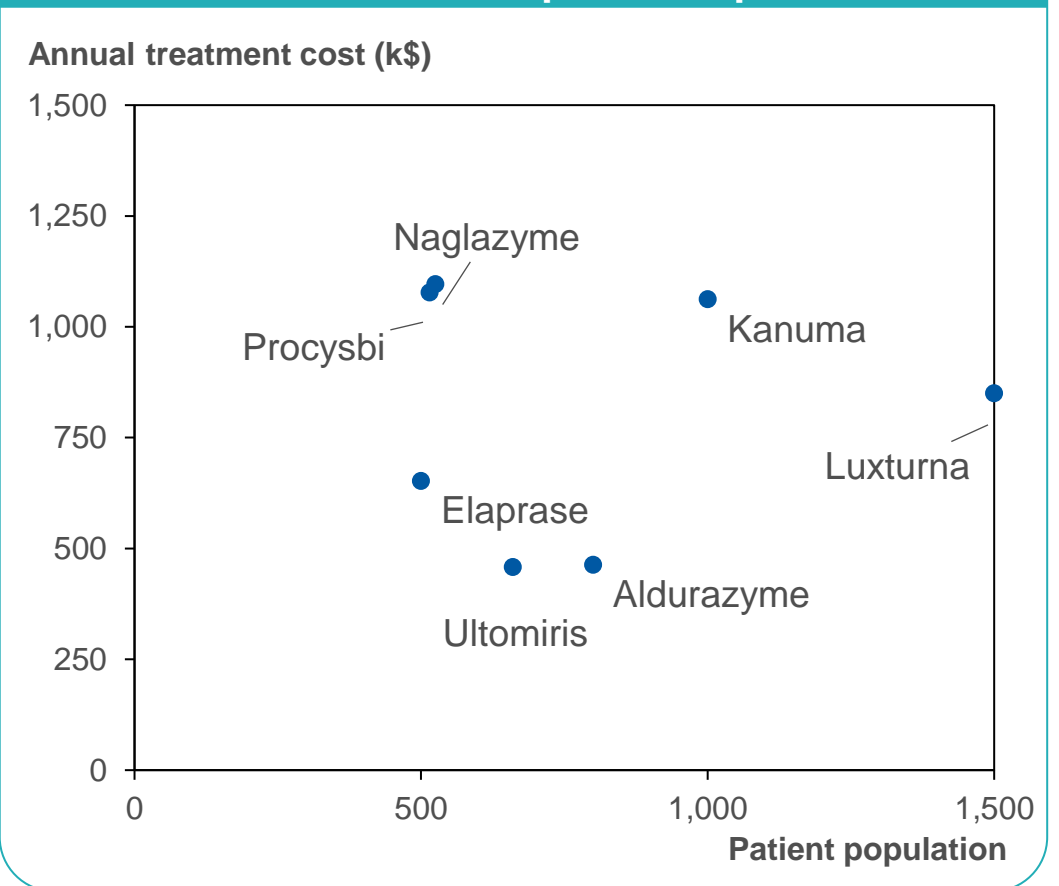
Sources: 1. De Leon et al. J Clin Endocrinol Metab, November 2024 (published online ahead of print); 2. Thornton et al. J Clin Endocrinol Metab. 2023 Nov 1;109(4):1071–1079.

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

Patients eligible for dasiglucagon treatment in the US



Ultra-rare disease therapy analogues with clear clinical value command premium prices in US⁵



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

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

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

High unmet need

- SBS is a rare, chronic and debilitating condition resulting in impaired intestinal absorptive capacity^{1, 2}
- SBS is associated with significant medical complications including liver and renal failure, metabolic complications, chronic fatigue, and life-threatening infections³

Life-long dependency on parenteral support (PS)

- SBS patients experience chronic dependence on complex PS to provide necessary nutrition and fluid intake and balance³
- PS management is associated with a significant burden on health care systems and reduction in the patients' and caregivers' quality of life^{4,5}

Need for improved treatment options

- More effective and convenient treatments to further reduce PS is needed, with the ultimate goal of enteral autonomy³



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

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



Effective half-life of 1.3 hours at steady state



0.05 mg/kg daily subcutaneous dosing via vial/syringe



Multi-step reconstitution process¹



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



Effective half-life of ~88 hours at steady state²



Expected 10 mg twice-weekly subcutaneous dosing



Ready-to-use auto-injector with needle protection

- Forms depot at the injection site



Type-A meeting with the U.S. FDA expected Q1 2025³



Second Phase 3 trial to be initiated in 2025 (EASE-5)

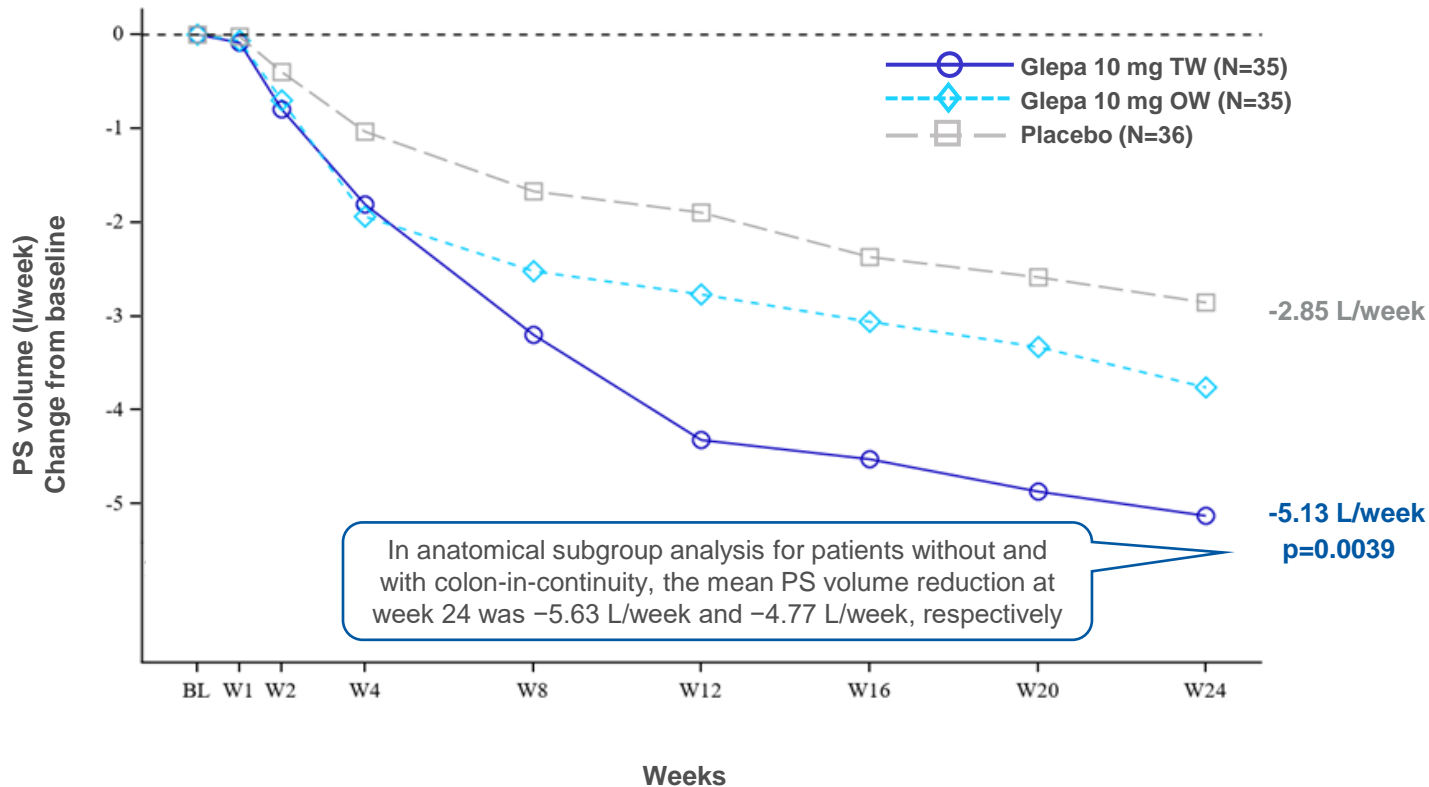
- Further confirmatory evidence for US resubmission
- Support regulatory submissions outside US and EU

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

Sources: 1. <https://www.gattex.com/resources-and-support/>; 2. Agersnap M. et al, 2022, Clin Drug Investigation; 42(12):1093-1100; 3. The U.S. FDA issued a Complete Response Letter for the glepaglutide New Drug Application for the treatment of short bowel syndrome

Glepaglutide significantly reduced weekly PS volume at Week 24 versus placebo in the EASE SBS-1 trial¹

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



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

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

9 patients treated with glepaglutide discontinued PS during the trial

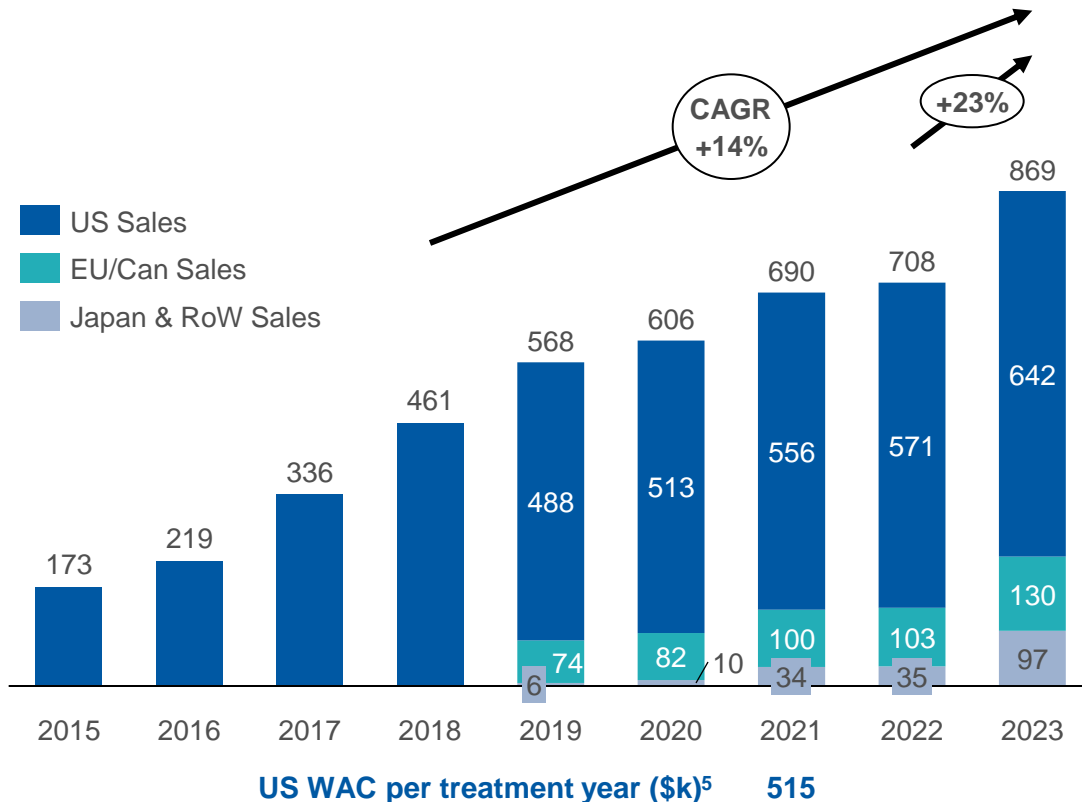
- 14% (n=5) twice weekly glepaglutide
- 11% (n=4) once weekly glepaglutide
- No patients receiving placebo

Glepaglutide appeared to be well-tolerated in the trial

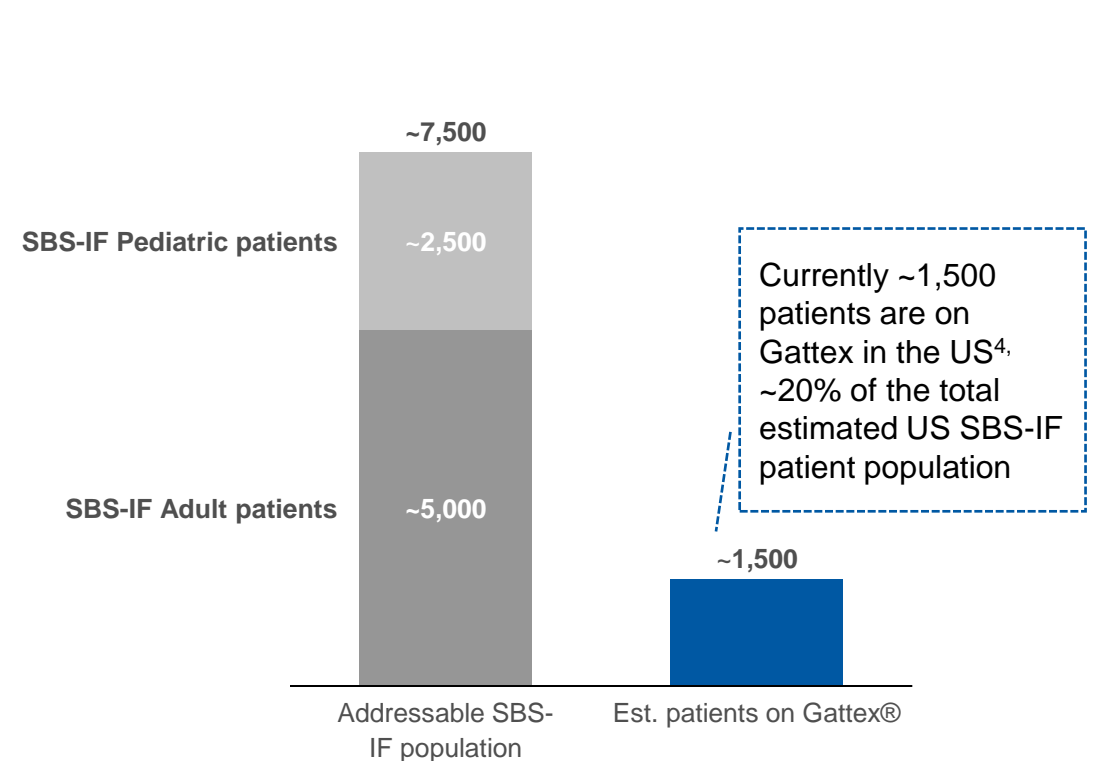
- Most frequently reported adverse events were injection site reactions and gastrointestinal events

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

Global Teduglutide Sales^{1,2} (USD Million)



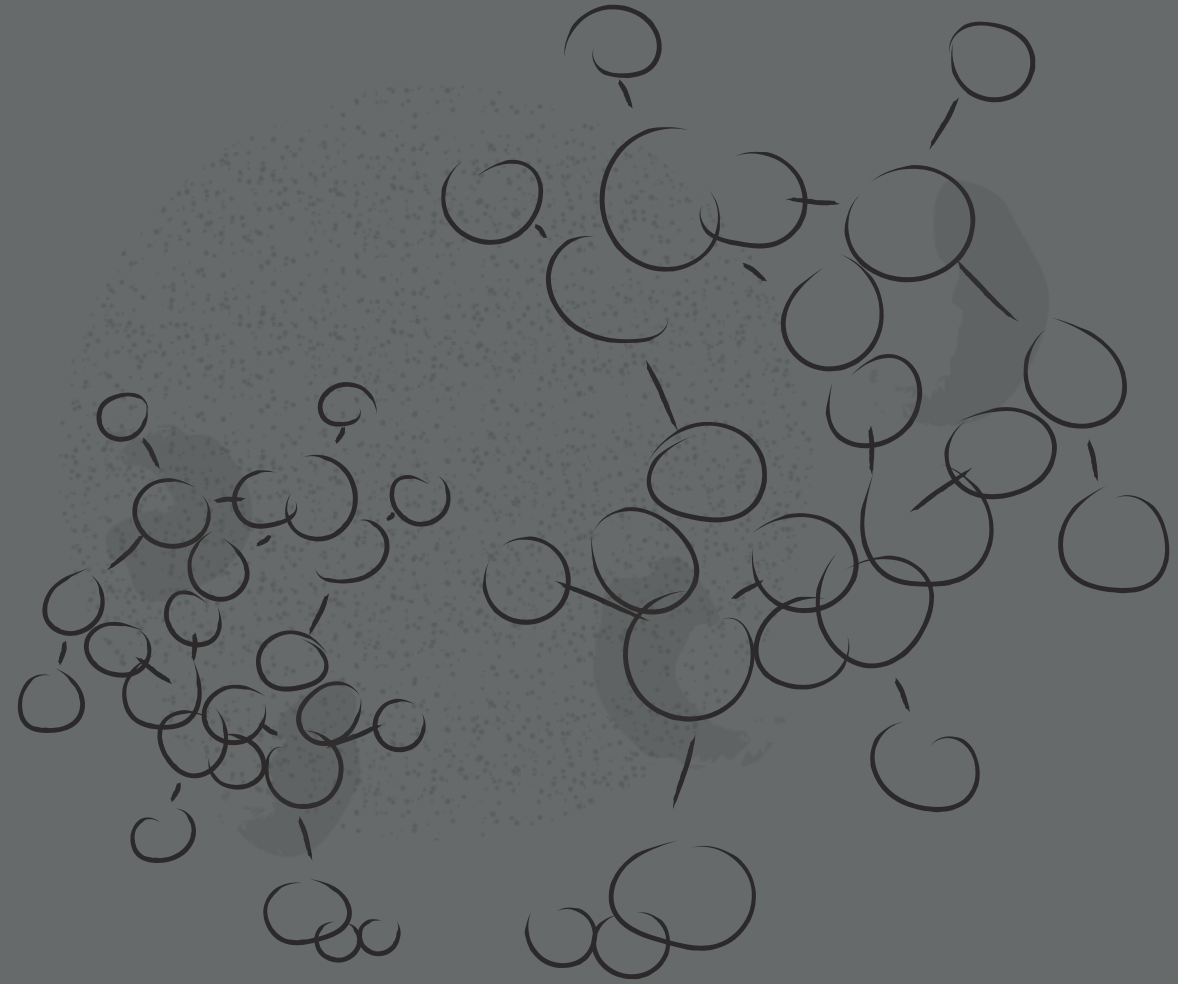
Estimated US SBS-IF Patients³



Sources: 1. 2015-2018: Carnegie ZEAL research report, 24 February 2020; 2. 2019-23: Gattex/Revestive sales data as reported in Takeda SEC filings, following fiscal financial year April to Mar. Converted to USD per Yearly Average Currency Exchange Rates, IRS.gov; 3. SBS Intestinal Failure patient estimates based on Zealand Pharma claims analysis, 2020 and Mundi et al, Characteristics of Chronic Intestinal Failure in the USA Based on Analysis of Claims Data, JPEN in Press 2022. 4. ZP estimate based on US Gattex sales and net price estimate; 5. WAC at end of year, <https://app.prospectorx.com>. WAC=wholesaler acquisition cost; SBS=short bowel syndrome; IF=intestinal failure

Chronic Inflammation

Corporate Presentation



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

Kv1.3 blocker (ZP9830)

- Potent and selective inhibitor of Kv1.3 with the potential to treat a broad range of cell-mediated autoimmune diseases¹
- Concentration-dependent inhibition of pro-inflammatory cytokine release (including IFN-g, IL-2 and IL17A) from stimulated human whole blood¹
- First-in-human clinical trial investigating the safety and tolerability of ZP9830 has been initiated²

Complement C3 inhibitor (ZP10068)

- Investigational, long-acting inhibitor of Complement C3, which has the potential to treat a broad range of complement-mediated diseases
- In 2023, Zealand completed activities to support advancing ZP10068 into the first-in-human clinical trials
- Zealand will assess the potential next steps for ZP10068³

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

ZP9830 inhibits Kv1.3, the main K⁺ channel of leukocytes from the innate and adaptive immune system¹



Kv1.3 channels are essential for the **activation, proliferation, migration and cytokine production** of leukocytes²



T effector memory and class-switched memory B cells play a **key role in autoimmunity and chronic inflammation** and are **dependent on Kv1.3** for function³



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

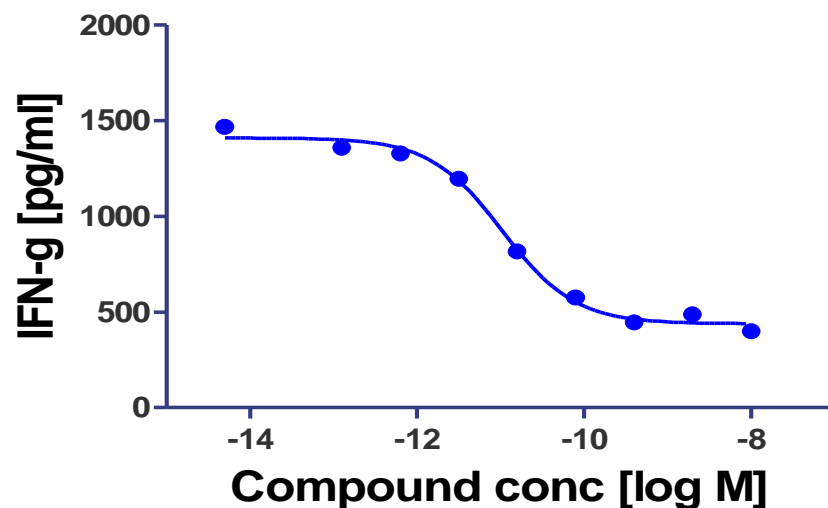


ZP9830 is a **potent and selective Kv1.3 inhibitor** with potential to treat a **broad range of cell-mediated autoimmune diseases**. First-in-human clinical trial initiated in Q4 2024⁴

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

Anti-inflammatory effects of Kv1.3 ion channel inhibition

Concentration-dependent inhibition of pro-inflammatory cytokine release (including IFN-g, IL-2 and IL17A) from stimulated human whole blood¹



First-in-human SAD clinical trial²

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

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

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

Cohort 10 (IV): Assess safety and PK

The trial will investigate:

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

Additional company information

Corporate Presentation

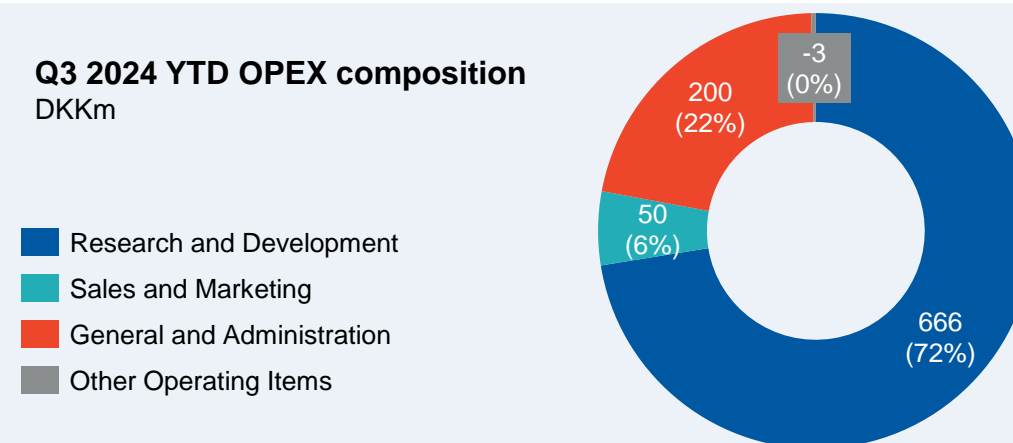
Q3 2024 YTD Profit & Loss

DKK million	Q3-24 YTD	Q3-23 YTD
Revenue	53.6	319.6
Cost of goods sold	-7.5	-5.2
Gross profit	46.2	314.4
Research and development expenses	-665.9	-494.7
Sales and marketing expenses	-50.2	-17.8
General and administrative expenses	-199.8	-134.4
Other operating Items	-3.1	13.8
Net operating expenses	-919.1	-633.2
Operating result	-872.9	-318.8
Net financial items	81.1	-124.8
Result before tax	-791.8	-443.5
Tax	4.0	4.6
Net result for the period	-787.8	-439.0

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

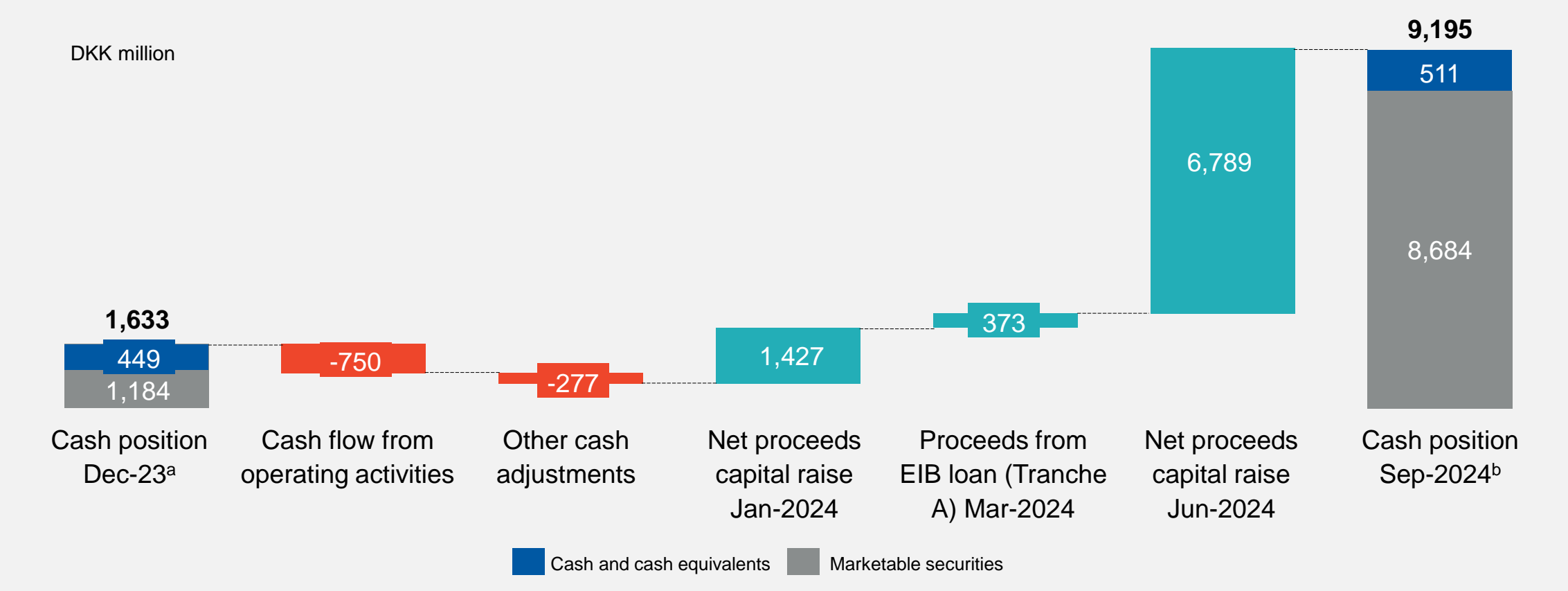
- Revenue of DKK 54 million is mainly driven by the license and development agreement with Novo Nordisk for Zegalogue®.
- Total operating expenses of DKK 919 million are higher than last year, primarily driven by the increase in R&D expenses due to clinical advancement of the obesity pipeline and activities supporting the regulatory review by the US FDA of the late-stage rare disease assets. S&M expenses are mainly driven by pre-commercial activities for the rare disease assets while the increase in G&A expenses reflect additional legal expenses related to our patent portfolio and strengthening of organizational capabilities.
- Net financial items of DKK 81 million are mainly driven by interest income from marketable securities.

Q3 2024 YTD OPEX composition DKKm



Strong cash position of DKK 9.2 billion enables significant investments in our obesity programs

Secured cash of DKK 8.6 billion in 2024 through capital raises and the EIB loan facility^a



^aThe EUR 50 million Tranche A of the EIB loan facility was disbursed in March 2024. ^bCash position includes cash, cash equivalents and marketable securities. EIB loan Tranches B and C (EUR 20 million each) are excluded from this chart. The two tranches are subject to pre-specified milestones being met. EIB = European Investment Bank

2024 financial guidance

DKK million	2024 Guidance	2023 Actuals
Revenue anticipated from existing and new license and partnership agreements	No guidance due to uncertain size and timing	343
Net operating expenses ^a	1,250 – 1,350	896

^aNet operating expenses consist of R&D, S&M, G&A and other operating items. Financial guidance based on foreign exchange rates as of November 7, 2024.

Experienced management team

Adam Steensberg



Chief Executive Officer



Henriette Wennicke



**Finance & Legal
Chief Financial Officer**



David Kendall



**Research & Development
Chief Medical Officer**



Eric Cox



**Commercial & BD
Chief Commercial Officer**



Ivan M. Møller



**Operations
Chief Operating Officer**



Christina S. Bredal



**People & Organization
Chief People Officer**

