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MoonLake Immunotherapeutics

Investor Day

February 23rd, 2026

Welcome to our Investor Day

Date: February 23rd, 2026
Time: 8.00 am EST

Agenda

Topic	Sub-topics	Speaker	Timing
Introduction	Welcome MLTX & SLK summary Key points for the session	Matthias	10 mins
axSpA update	axSpA market update S-OLARIS program overview Efficacy & safety overview	Kristian	20 mins
HS and FDA update	FDA update on Phase 3 VELA program VELA and VELA-TEEN clinical update	Jorge	15 mins
Overall guidance on other trials	Update on Phase 3 program in PPP PsA market update Timeline for IZAR program	Kristian Jorge	15 mins
Financial update		Matthias	10 mins
Closing remarks & Q&A		Jorge	

Source: MoonLake Corporate

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Source: MoonLake Corporate

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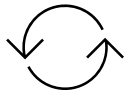

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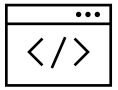

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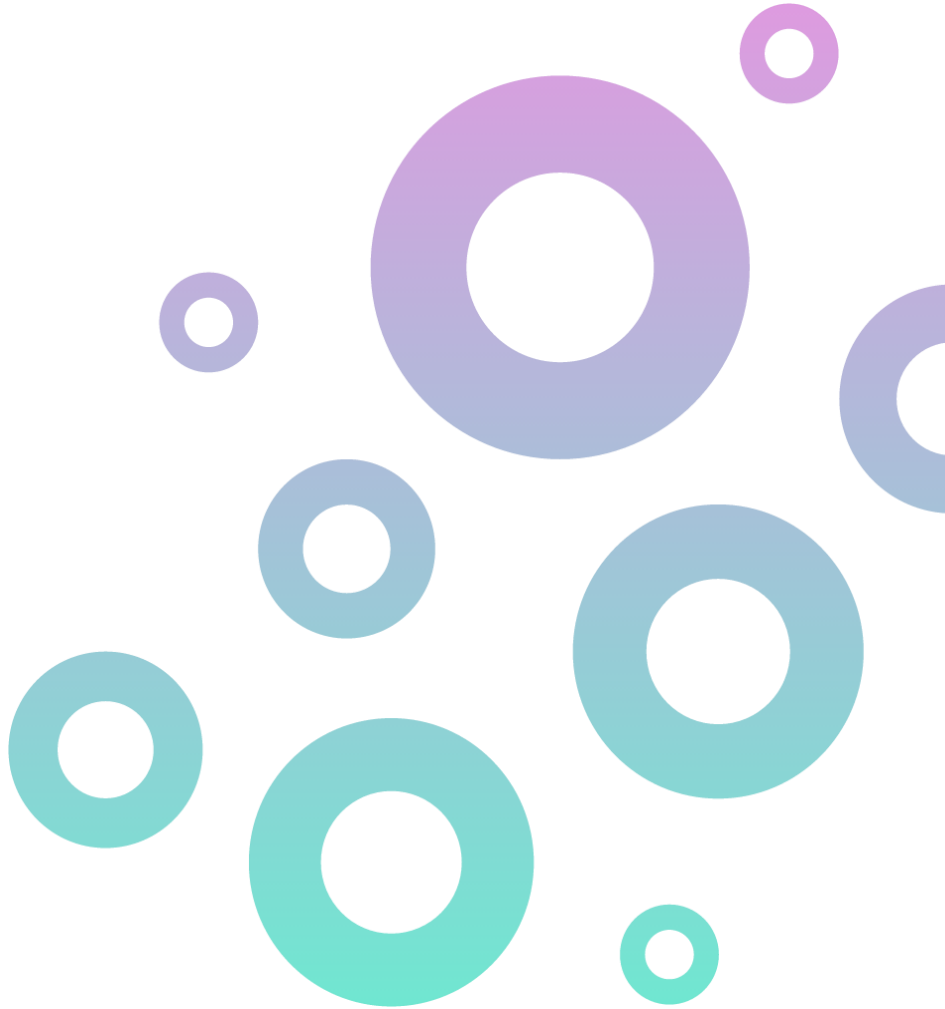

Source: MoonLake Corporate

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- **Founded in 2021** in Switzerland
- **Unique molecule with sonelokimab**, tri-specific IL-17A & F Nanobody® to elevate treatment in inflammation in a **$40bn+ market**
- **Public on Nasdaq** since April 2022 and **~$800m** raised through equity to date, plus up to **$500m** non-dilutive facility, with current cash runway to **end of 2027**
- **Clinical phase company** with clinical trials including Phase 3 in HS, Phase 2 in PsA, PPP, axSpA and PsO – Phase 3 in PsA expected to be concluded in coming months
- **First BLA submission** for sonelokimab in HS expected for second half of this year
- Driven by a top-tier team, aim is to unlock a **pipeline-in-a-product across indications** (estimated ~$3bn peak sales in HS & PsA in the US)

Source: MoonLake Corporate

A differentiated IL-17A and F molecule: Do you still Antibody?

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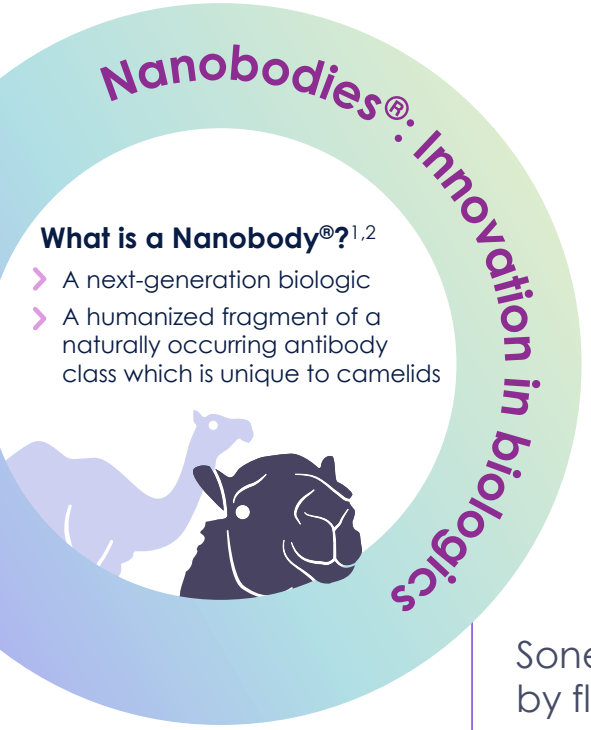
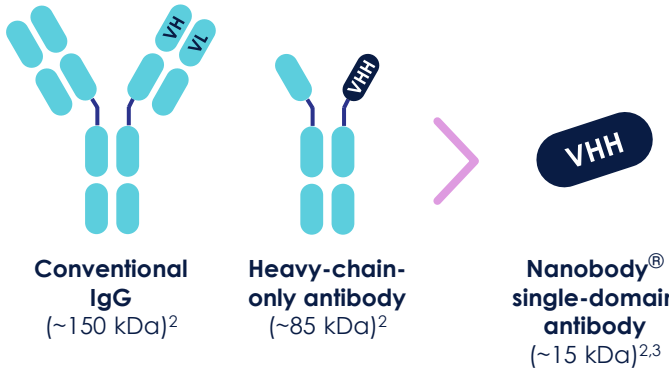
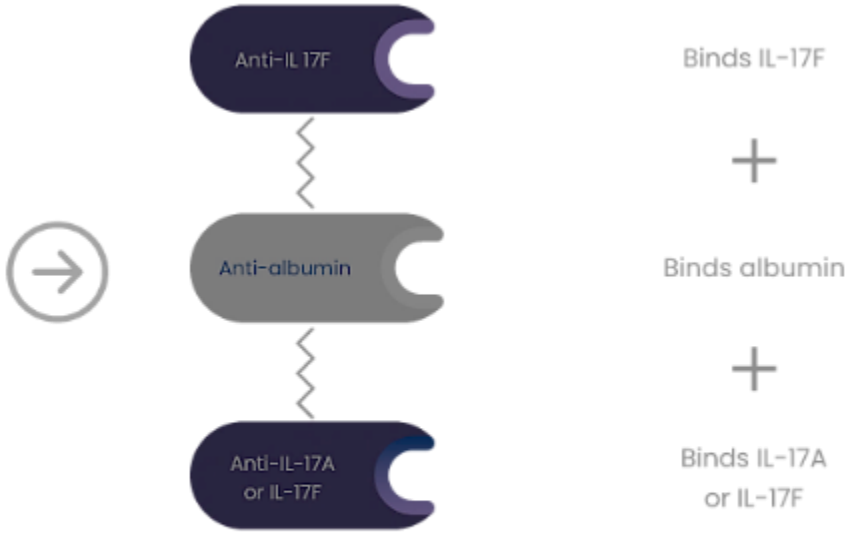


Nanobodies® are much smaller than traditional antibodies



They can be designed to have multiple and different binding domains



Sonelokimab

Sonelokimab is a ~40kDa humanized Nanobody® consisting of three VHH domains covalently linked by flexible spacers - around a **third/quarter of the size of traditional antibodies**

With 2 domains, it binds with high affinity to **IL-17A and IL-17F** – a third domain binds human **albumin**

Subcutaneous administration, **Q4W**

SLK is the only asset that binds **all IL-17A and F dimers with leading and similar affinity** (shown in 2023)

Note: Ig, immunoglobulin; VH, heavy chain variable domain; VHH, variable heavy domain of heavy chain; VL, light chain variable domain; 1 Hamers-Casterman, C., et al. Nature. 1993; 363:446–448; 2 Jovčevska I, Muyldermans S. BioDrugs. 2020;34:11–26; 3 Tijink BM, et al. Mol Cancer Ther. 2008;7:2288–2297; For reference in this presentation: the terms Nanobody® and Nanobodies® are registered trademarks of Ablynx, a Sanofi company.

Source: MoonLake Medical Affairs & Research

SLK consistently shows **a leading profile** across multiple indications

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	Dermatology			Rheumatology	
	HS (incl. Adol)	**PPP**	**PsO**	**PsA**	**axSpA**
Estimated Market size ($, 2035)	**10-15bn** (11-15% growth from '22)	**3-4bn** (12% growth from '22)	**20-25bn** (8% growth from '25)	**10-15bn** (4% growth from '25)	**10-15bn** (7% growth from '25)
Key primary endpoint responses	*Phase 2 and 3* **34-43%** **HiSCR75** response at Week 12/16[1]	*Phase 2* *(Phase 3 to start soon)* **40%+** **PPPGA0/1** response at Week 16[2]	*Phase 2* **70%+** **PASI90** response at Week 12[3]	*Phase 2* *(Phase 3 ongoing)* **46%** **ACR50** response at Week 12[4]	*Phase 2* **81%** **ASAS40** response at Week 12[4]
How MLTX elevates responses	**HiSCR75, HiSQol**	**PPPGA0/1** and **PPPASI75**	**PASI90-100**	**ACR70 + PASI100, MDA**	**ASDAS-CRP, MRI/PET**

Leading benefit-risk profile – absence of signals of events of interest

Patient convenience – fewer injections, shorter injection time, lower volumes vs mAbs

Note: Approx response, Selected data subject to change until clinical study reports are issued. 1 mNRI 120mg (VELA), NRI 120mg (MIRA), AO 120mg (VELA-TEEN): 34.4% for VELA-1 at Week 16, 34.1% for VELA-2 at Week 16, 43.3% for MIRA at Week 12, 67% for VELA-TEEN at Week 16 (interim data); 2 mNRI 120mg; 3 ITT-NRI 120mg; 4 ITT-NRI, 60mg

Source: MoonLake Corporate

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Source: MoonLake Corporate

An active **catalyst flow** for MLTX expected in 2026

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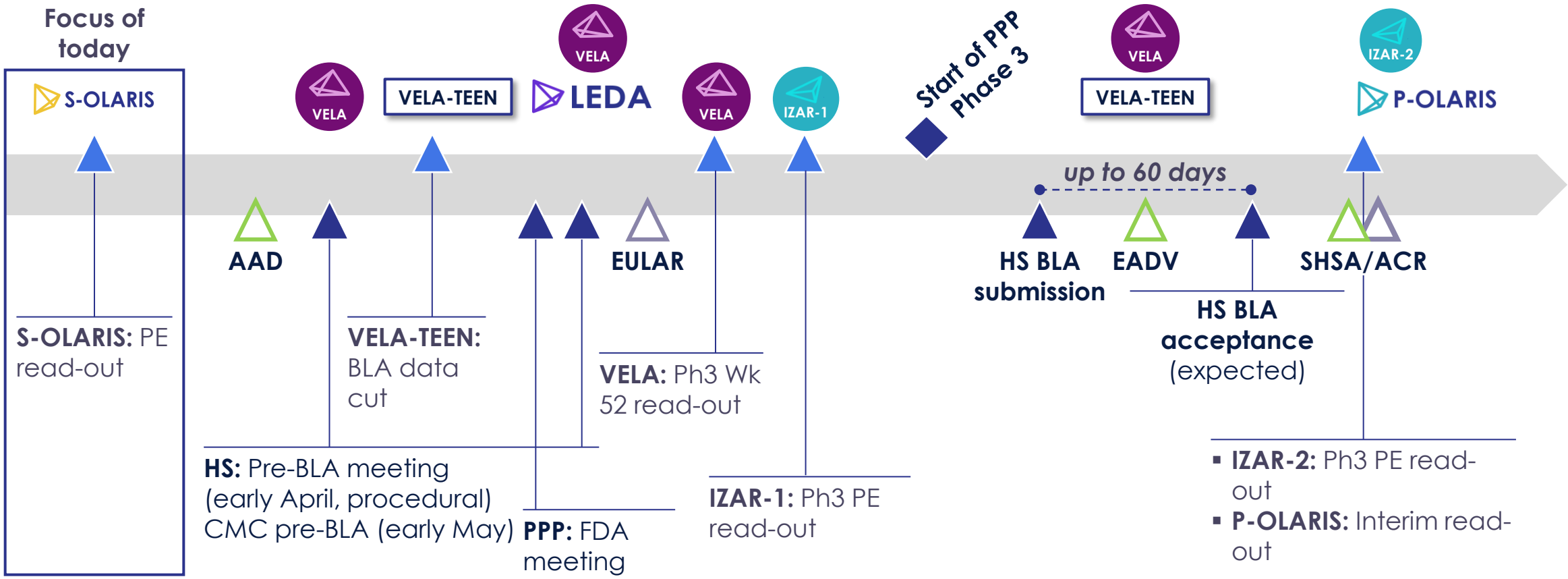
Timeline not scaled

FDA interaction | Trial data | Derm event | Rheum event



All future milestones are anticipated dates

Source: MoonLake Corporate

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S-OLARIS

axSpA Phase 2 readout

axSpA is an **attractive opportunity** in a ~$10-15bn market in 2035

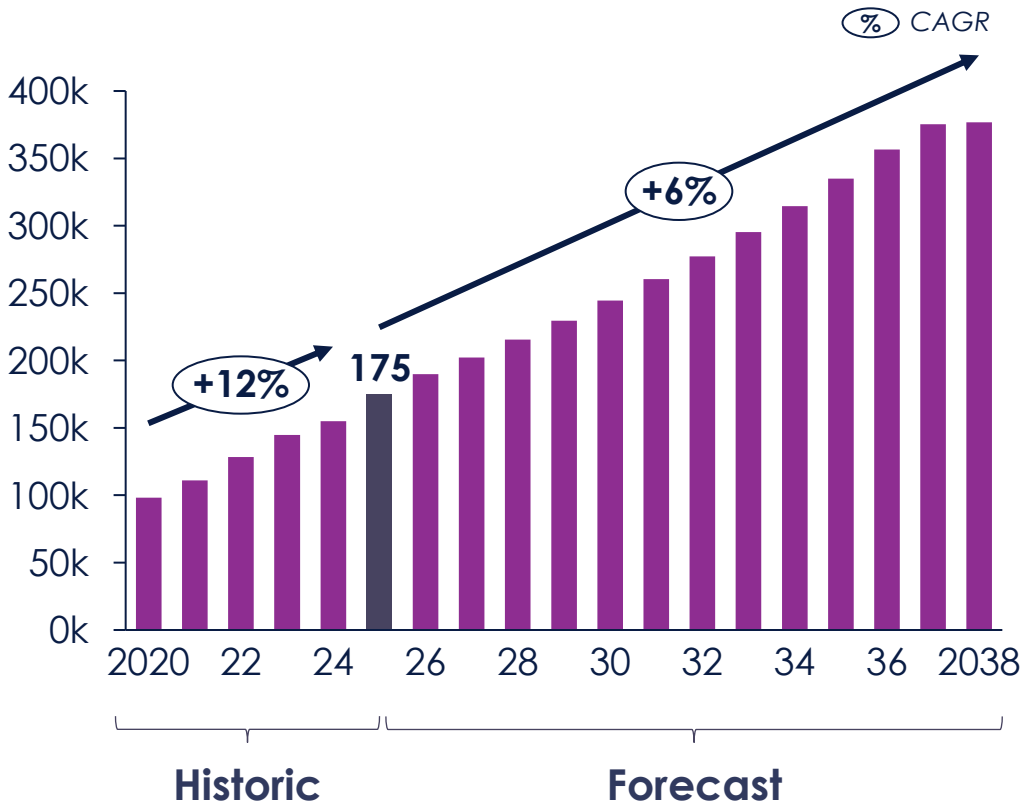
Axial Spondyloarthritis (axSpA) at a glance

What real-world data shows:

- **~1.2m unique patients** with positive diagnosis for axSpA (M45X) in 2015-2025 in US
- **~120k net new patients diagnosed** per year on average since 2016
- **~14% of axSpA patients** (175k patients today) **receive advanced treatments** like biologics
- Current therapies achieving <50% symptom improvement – **with none of them truly being disease modifying**

Literature estimates **prevalence of around 1.4%**[3,4]

Biologics patients (2020-2038 in US)[1]



Projected market size (2038)

$10-15bn[2]

1 Based on Real-World Claims as per Komodo PRISM data pull from December 2025 – extrapolating from 75% coverage to 100% patient population; 2 Assumptions include prevalence, annually treated patients shares. Bx shares, HS pricing, adherence rates; 3 Poddubnyy et al. Axial spondyloarthritis by region: PROOF study. Rheumatology (Oxford) 2021; 61:3299–30; 4 Siebert, Raj & Tsoukas. Epidemiology of axial spondyloarthritis. In: Axial Spondyloarthritis (Oxford Univ. Press), 2016.

Source: MoonLake Commercial,

Elevating the bar with biomarker control and imaging at depth

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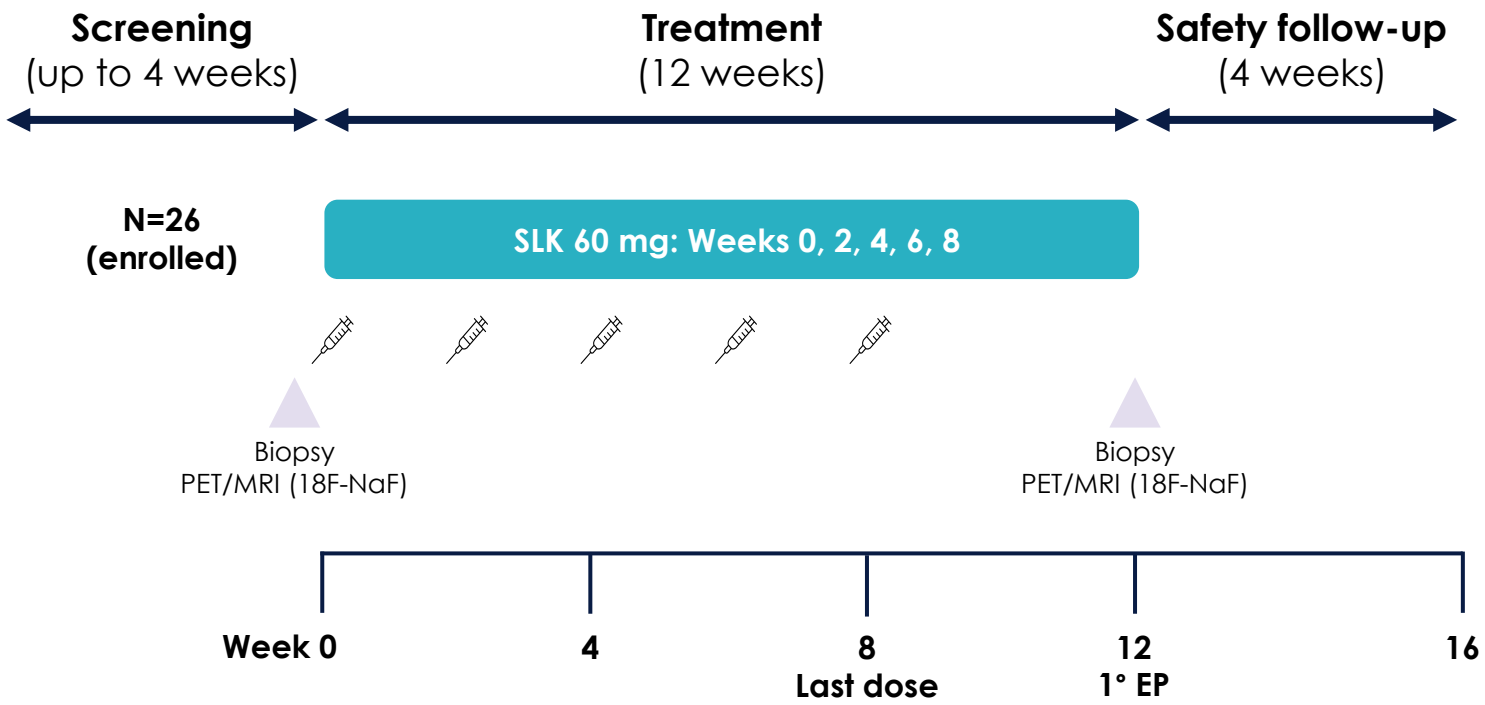
S-OLARIS

SLK administration

A Phase 2 open-label imaging study to explore the effects of sonelokimab in patients with active axial spondyloarthritis



Assessments and major milestones

Assessments (as shown on next pages):

- ASAS40 score
- ASDAS-CRP score
- Structural lesions in SIJs as measured by SPARCC MRI
- Osteoblast activity in SIJs as measured by 18F-NaF signalling
- Biomarker-control (peripheral blood)

Major milestones:

- EU CTR approval: Nov 2024
- FPI: Dec 2024
- LPI: Sep 2025
- PE read-out: Feb 2026

CfB, Change from Baseline; axSpA, Axial Spondyloarthritis; SUV, Standardized Uptake Value; SIJ, Sacroiliac Joints; NaF, Sodium Fluoride; PROs, Patient-Reported Outcomes; EU CTR = European Union Clinical Trials Regulation; PET, Positron Emission Tomography; MRI, Magnetic Resonance Imaging

Source: MoonLake Clinical

Competition: What have other axSpA trials shown?

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⚠ Black box warning

Overview of comparable biologics approved in axSpA *(not based on H2H trials)*

Bolded = primary endpoint

	HUMIRA® adalimumab	Bimzelx® (bimekizumab)	Cosentyx® (secukinumab)	RINVOQ® upadacitinib	taltz® (ixekizumab)
Patients achieving ASAS40 in %	45%[7] Week 12	**48%[1] Week 16**	**42%[3-4] Week 16**	**52%[5-6] Week 14**	**48%[9] Week 16**
Patients achieving ASDAS-CII (%)	n/a	~62%[2] Week 12	48%[4] Week 16	53%[8] Week 14	62%[11] Week 16
PET imaging	✗	✓[13]	✓[14]	✗	✗
			Not part of pivotal trial		
Safety warnings on US label[10]	⚠ *Serious infections, Malignancy, …*	*SIB, Infections, IBD, Liver abnormalities, …[12]*	*Infections, IBD, …*	⚠ *Serious infections, Mortality, Malignancy, MACE, Thrombosis, …*	*Infections, IBD, …*

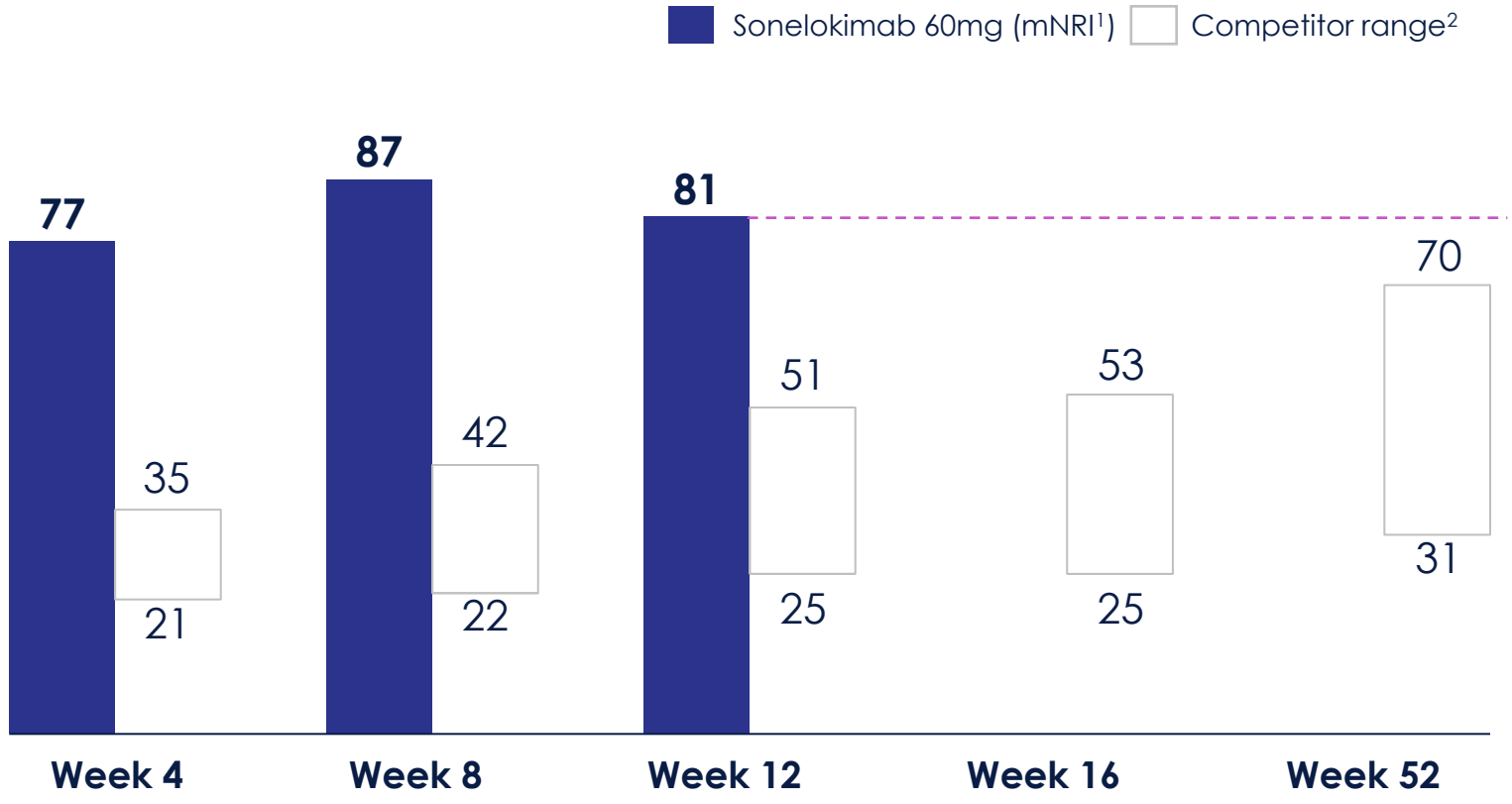
- Several biologics are approved for axSpA, yet a **substantial unmet need persists**
- Only **~40–50%** of patients achieve **ASAS40 –** Humira leads the market but **used the less stringent ASAS20** as its primary endpoint
- Even more elevated scores, such as ASDAS currently show much **space for improvement**

1 van der Heijde D. Ann Rheum Dis 2023;82:515 (naïve and IR population); 2 Deodhar A. RMD Open 2025;11:e005081. 3 Baeten D. New Eng J Med 2015;373:26 (naïve and IR population). 4 Deodhar A. Arthritis Rheumatol. 2021 Jan;73(1):110-120 (naïve and IR population). 5 van der Heijde D. Lancet 2019; 394: 2108–17 (naïve population). 6 van der Heijde D. Ann Rheum Dis 2022;81:1515 (IR population). 7 van der Heijde et al. Ann Rheum Dis. 2008 Aug 12;68(6):922–929. 8 Van der Heijde D. RMD Open 2022;8:e0002280 (supplement). 9 van der Heijde D. Lancet 2018;392:2441-51 (naïve population). 10 Safety concerns (non exhaustive) as per US PI, including warnings and precautions and Black box warnings; Suicidal Ideation Behavior, IBD, Irritable Bowel Disease, MACE, Major adverse cardiovascular events. 11 Dougados M. Ann Rheum Dis 2020;79:176-185. 12. Liver biochemical abnormalities. 13 Baraliakos X. Ther Adv Musculoskelet Dis. 2024 Nov 28;16:1759720X241293944. 14 Groothuizen S. Ann Rheum Dis 2025;84:421–422.
Note: For illustrative purposes only. Efficacy data are derived from different clinical trials conducted at different times, with differences in trial design and patient populations. As a result, cross-trial comparisons cannot be made, and no head-to-head (H2H) clinical trials have been conducted. Humira only approved in r-axSpA. Select data points not explicitly stated in publications have been derived through software-based extraction. Highest reference value across radiographic- and non-radiographic axSpA trials taken.

Source: MoonLake Medical Affairs & Research

80+% ASAS40 responders at Week 12 with SLK

ASAS40 responders, % of patients



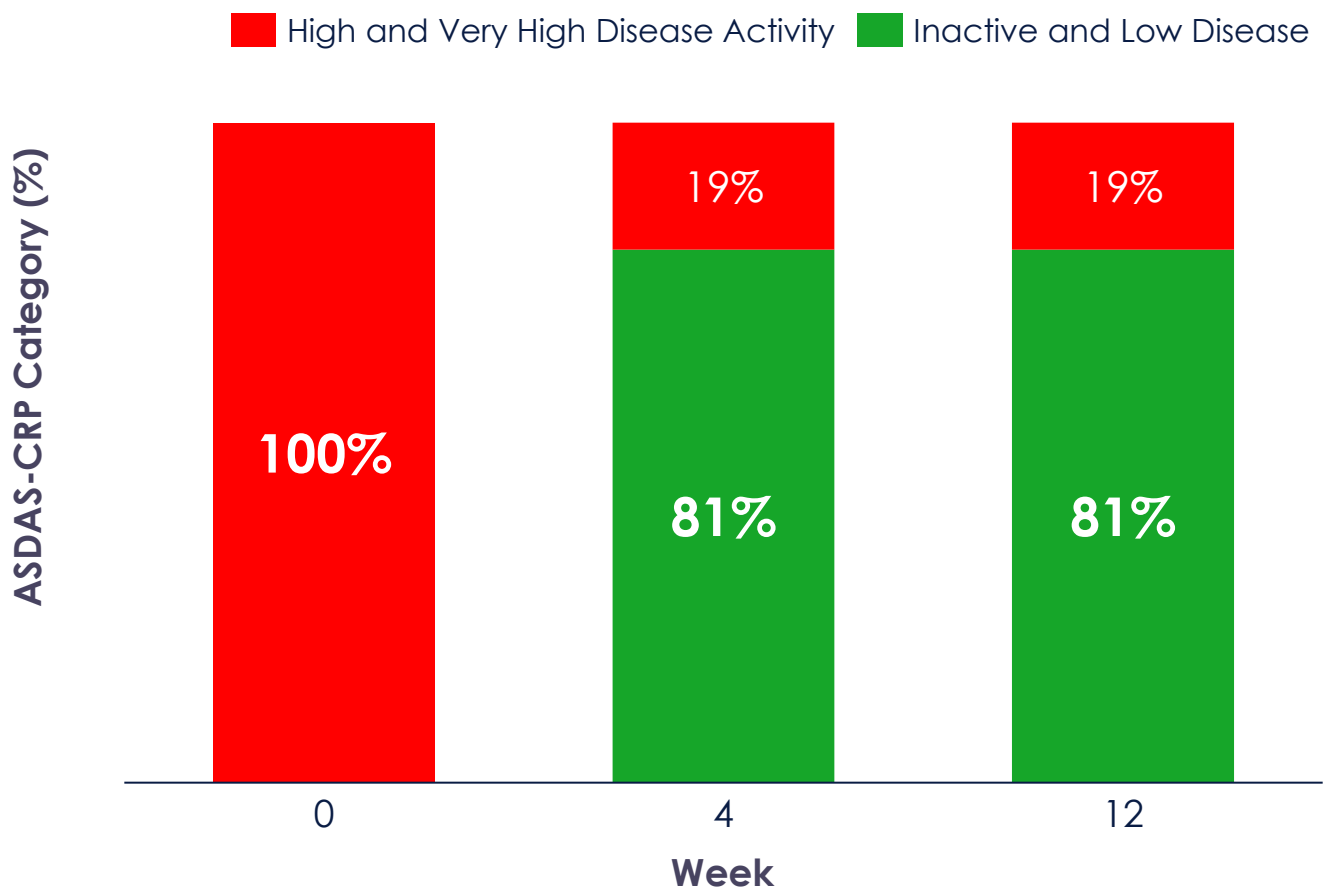
- S-OLARIS data show unprecedented **speed of onset –** with **77% of patients achieving ASAS40** by Week 4
- Response rises to **over 80% by Week 12 –** outperforming competitor long-term data through all time points, including 1 year data
- **Baseline characteristics** of S-OLARIS are aligned with expectations

For illustrative purposes only. Efficacy data are derived from different newer clinical trials conducted at different times, with differences in trial design and patient populations. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted. Select data points not explicitly stated in publications have been derived through software-based extraction. Extrapolated kinetics from baseline to primary endpoint in selected cases; Competitor data based on NRI methodology excl. one competitor with post wk 16 1° EP data and one competitor with nr-axSpA data at wk 52 (both as observed). 1 Early withdrawal data imputed as non-responders for sonelokimab; other missing data imputed using multiple imputation (modified NRI); Data subject to change until clinical study reports are issued. Total participants in S-OLARIS: n=26 at Weeks 4 and 12; n=24 at Week 8; 35% nr-axSpA and 65% r-axSpA; 2 Competitor data shows disclosed competitor data inclusive of r-axSpA and nr-axSpA. Approximate range due to use of software-based extraction for select data points and variations in methodology

Source: MoonLake Biometrics

80+% show a shift to **inactive or low disease activity** by Week 12

ASDAS-CRP Categories[1] (As Observed)



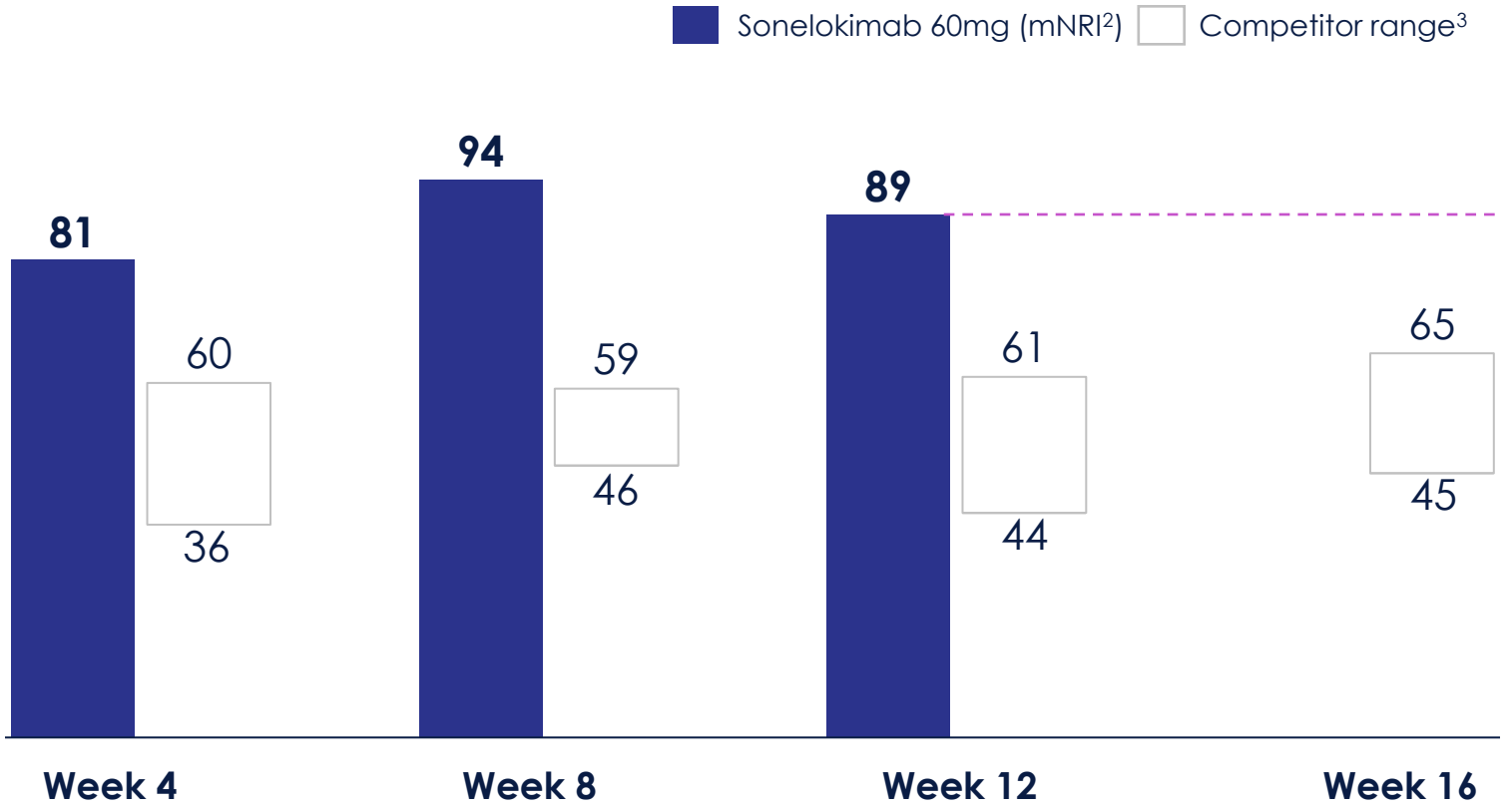
- SLK shows **rapid onset of effect in ASDAS-CRP –** with **over 80%** of patients reaching **inactive or low disease activity** already by Week 4
- This response is sustained through Week 12 – underscoring **strong durability of effect**
- **ASDAS-CRP inactive and low disease response ~20 ppt. higher** vs. >1-year open-label data from competitors in the same MoA

Total participants in S-OLARIS: n=26 at Weeks 0, 4 and 12; 35% nr-axSpA and 65% r-axSpA; 1 The ASDAS-CRP formula is: 0.12 × Back Pain + 0.06 × Morning Stiffness + 0.11 × Patient Global + 0.07 × Peripheral Pain/Swelling + 0.58 × ln (CRP + 1), All symptom scores are rated on a scale from 0 to 10. Data subject to change until clinical study reports are issued.

Source: MoonLake Biometrics

~90% experience **clinically important improvement** by Week 12

ASDAS-CRP[4] Clinically Important Improvement[1] (%)



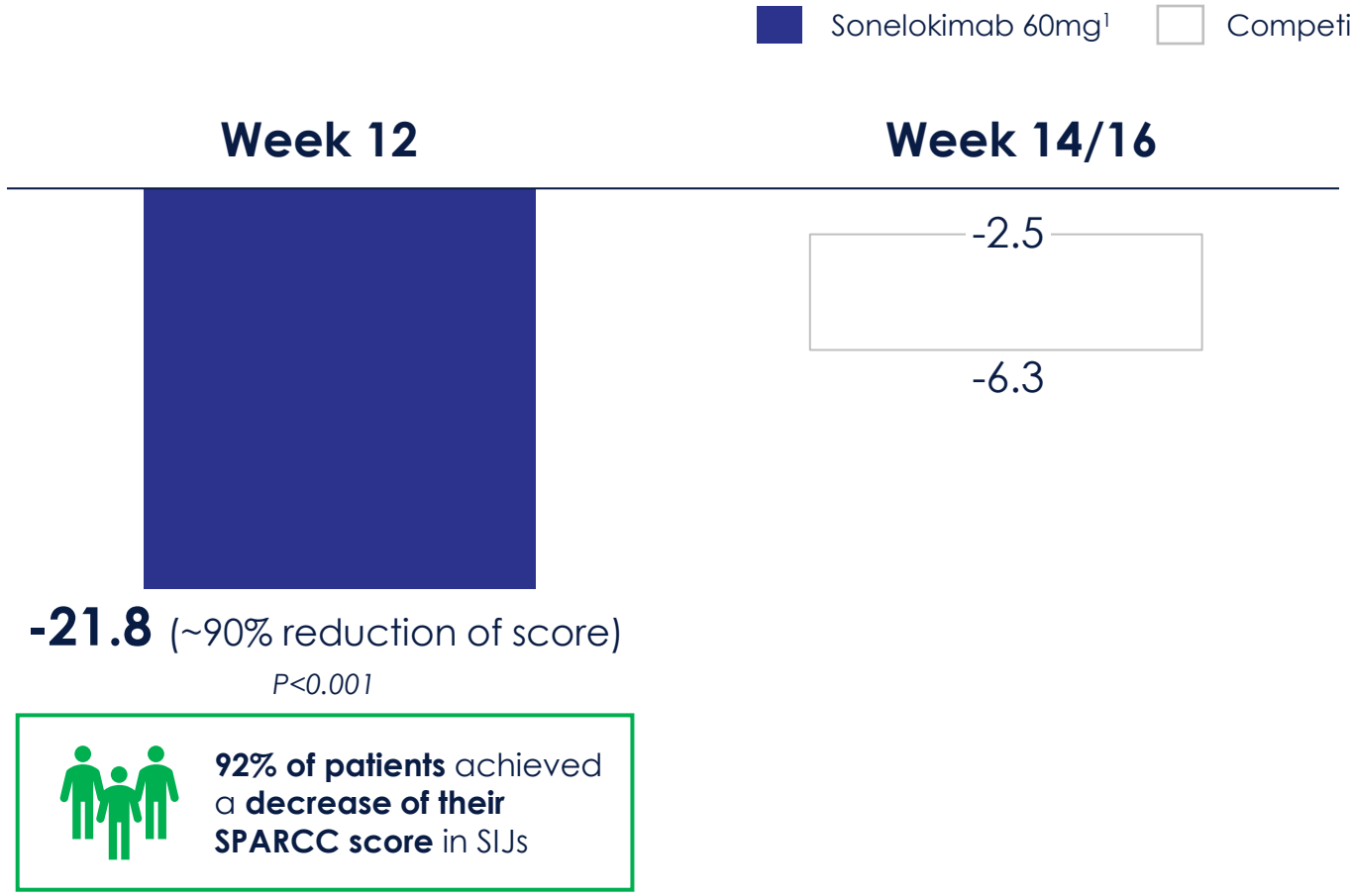
- **~90% of patients achieved a clinically important improvement** as per ASDAS-CRP score at **Week 12**
- Additionally, **58%** of patients achieve a **major improvement** – versus highest competitor score of **33%** at Week 12/16
- **ASDAS-CRP CII response at Week 12 also higher vs. >1-year open-label data** from competitors in the same MoA

For illustrative purposes only. Efficacy data are derived from newer different clinical trials conducted at different times, with differences in trial design and patient populations. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted
1 A clinically important improvement is a reduction of at least 1.1 points; 2 Early withdrawal data imputed as non-responders for sonelokimab; other missing data imputed using multiple imputation (modified NRI). Total participants in S-OLARIS: n=26 at Weeks 4 and 12; n=23 at Week 8; 35% nr-axSpA and 65% r-axSpA. 3 Competitor data shows disclosed competitor data inclusive of r-axSpA and nr-axSpA. Approximate range due to use of software-based extraction for select data points and variations in methodology; 4 ASDAS-CRP measured as 5 components: Back pain (last week), duration of morning stiffness, patient global assessment of disease activity, peripheral pain / swelling, and C-reactive protein level. Data subject to change until clinical study reports are issued.

Source: MoonLake Biometrics

SLK shows strong **reduction of structural damage**

Mean change from baseline in SPARCC MRI score in SIJs at primary endpoint vs baseline



SLK achieved a 21.8-point reduction **in inflammatory lesions in the SIJ as measured by SPARCC MRI –** outperforming other competitor data

For illustrative purposes only. Efficacy data are derived from different clinical trials conducted at different times, with differences in trial design and patient populations and different baseline scores. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted. Data subject to change until clinical study reports are issued. 1 Change from baseline in SPARCC MRI score in SIJ at Week 12 (n=25); 2 Competitor mean SIJ change-from-baseline (CfB) SPARCC inflammation score ranges are based on disclosed competitor data, inclusive of r-axSpA and nr-axSpA

Source: MoonLake Biometrics

SLK shows **disease modifying effects** deep in joints as early as week 12

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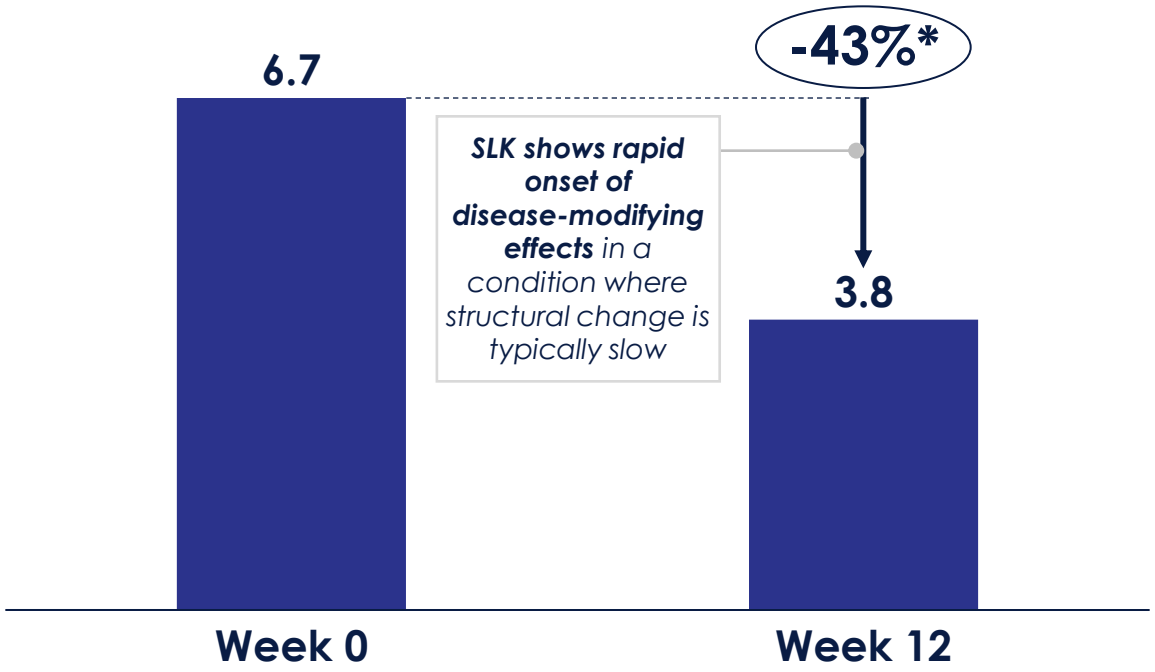
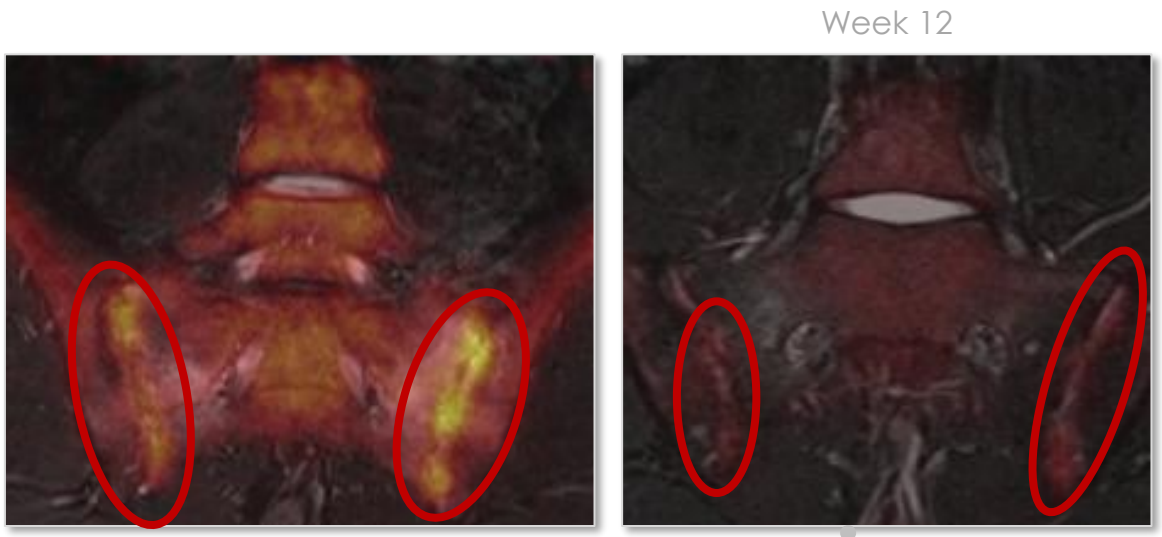
Change in mean SUVmax score (SIJ) – corresponding to disease modification[1] by reduction of bone re-modeling



Example PET image of patient participating in S-OLARIS



Levels remain above zero *due to the baseline osteoblastic activity needed for joint maintenance*

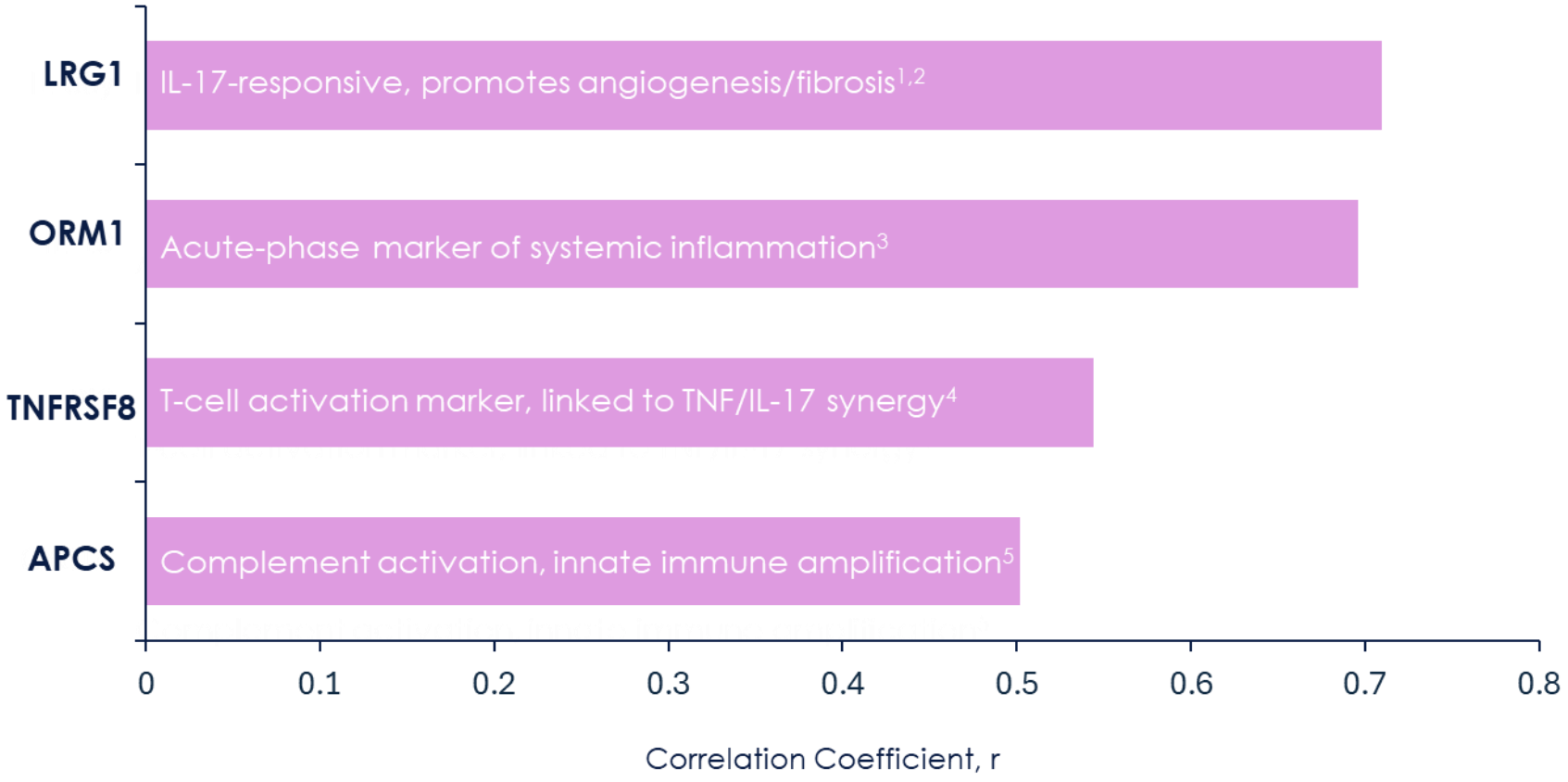
Already at week 12, SLK dramatically reduces the levels of bone re-modeling (i.e., osteoblastic activity) that lead to **irreversible ossification** over time – **signal for true disease modification**

1 Change from baseline in 18F-NaF SUVmax signals at Week 12 in the SIJ as detected by PET scan (n=24). Analysis shows participant-level mean SIJ SUVmax scores; p-value from a paired t-test comparing Week 12 with Baseline. Scores reflect inflammatory activity with physiological background removed (each patient's imaging response is evaluated relative to their own healthy reference at baseline and Week 12). Data subject to change until clinical study reports are issued.; *p=<0.001

Source: MoonLake Biometrics

Distinct axSpA serum biomarker signature **modulated by SLK**

Correlation of Key Biomarkers with SLK ASDAS-CRP response, Week 12



- Modulation of these markers shows that **SLK attenuates chronic inflammatory signalling** and **interrupts the disease cascade implicated in structural progression in axSpA**
- Response pattern validates clinical response to SLK as it **rules out natural disease activity fluctuation**

Pearson correlation analysis for the association between change from baseline in ASDAS-CRP and change from baseline in biomarker levels at Week 12 (raw p-value < 0.05). Interim analysis (n=17). Data subject to change until clinical study reports are issued. 1 Bechara et al. JEM, 2021, 218 (5): e20202191 2 Yang et al. J Mol Medicine 2025, 1317–1332; 3 Hochepied et al. Cytokine Growth FR, 2003;14(1),25-34; 4 Croft et al, 2009; Nat Rev Immunol; 9(4), 271-285; 5 Ma et al., Front Immunol, 2018;9:3046

Source: MoonLake Medical Affairs and Research

Safety profile of sonelokimab was favorable throughout entire study

Treatment-emergent adverse events (TEAE), n (%)	**S-OLARIS** to Week 12	**ARGO** to Week 12
	Sonelokimab 60 mg N=26	**Sonelokimab** 60 mg N=41
Any TEAE	14 (53.8)	14 (34.1)
Any Serious TEAE	1 (3.8)[c]	1 (2.4)
Any TEAE leading to discontinuation	1 (3.8)[c]	0
Most frequent TEAEs of SLK in S-OLARIS		
Influenza	3 (11.5)	0
Fatigue	2 (7.7)	1 (2.4)
Blood creatine phosphokinase increased	2 (7.7)	0
TEAEs of interest		
Oral candidiasis	**1 (3.8)**	**1 (2.4)**
Dermatitis and eczema[a]	**0**	**0**
Serious infection	0	1 (2.4)[b]
Diarrhea (non-infectious)	0	1 (2.4)
Hepatic event	0	0
Inflammatory bowel disease (IBD)	**0**	**0**
Suicidal ideation and behavior (SIB)	0	0
Major adverse cardiovascular event (MACE)	0	0

Sonelokimab demonstrated a clean safety profile throughout the S-OLARIS study – with notable emerging areas of potential differentiation including a favorable hepatic / liver profile, no signals related to suicidality, and potentially improved skin tolerability

Adjudication is ongoing. **a** Patients with events assigned to either of the preferred terms 'dermatitis' and 'eczema'. **b** Appendicitis. **c** Generalised urticaria in a single patient, Grade 2 severity, assessed as not related. Data subject to change until clinical study reports are issued.

Source: MoonLake Medical & Safety

Conclusions

axSpA is an attractive opportunity in a **~$10-15bn market** in 2035

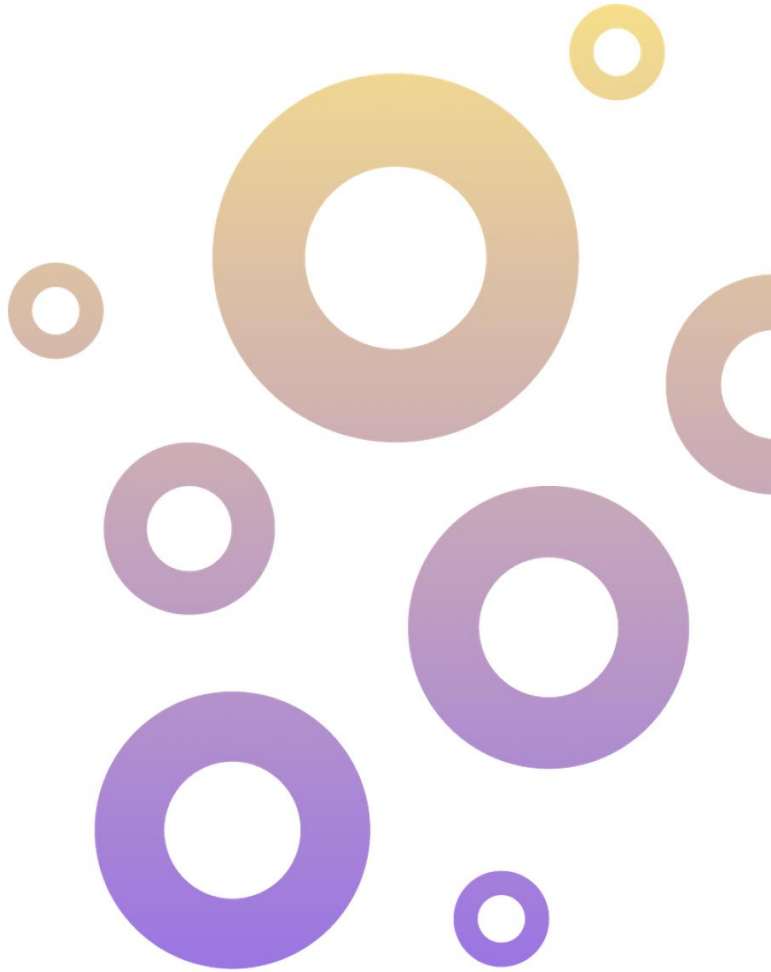
Current therapeutic options show **limited efficacy**, with **only ~40–50%** of patients achieving ASAS40

SLK raises the efficacy bar, with S-OLARIS showing patients with **80+% ASAS40** and **~90% clinically important improvement** by Week 12

Imaging, biomarker, and tissue data confirm **rapid, durable deep-tissue effects –** underlining sonelokimab's potential to change the treatment paradigm in axSpA (reduction of inflammation, reduction of ossification/bone re-modeling)

Safety was in line with other trials and **no new signals** were detected

Next steps: Begin the regulatory process with relevant agencies in parallel with the upcoming PsA readout



Source: MoonLake Corporate

MoonLake

HS BLA update

Recent FDA feedback provided regulatory **clarity for BLA process**

Preparation for FDA meeting

Following **VELA read-out** on September 29th, 2025

- **Briefing book submitted** on November 5th, 2025, with **~100s of pages** of supporting VELA data analysis (incl. VELA-2 placebo data) – FDA reviewed all data ahead of the meeting
- **Final minutes of the Type B in December 2025** already shared with MoonLake

Next steps for MLTX

- **No additional clinical trials** needed in HS, as two well-controlled trials are required to establish **substantial evidence of effectiveness (SEE)** and MLTX can submit three such trials
- **VELA-1 and MIRA –** to be submitted to establish SEE and to support safety
- **VELA-2 to be submitted for safety –** its use in establishing SEE to be discussed
- Submission of VELA-1 trial alone for establishment of SEE **excluded**
- Submission of VELA-1 and VELA-2 for establishment of SEE, without MIRA, **excluded**
- *Note: establishing SEE is a specific element the BLA process including Sec 14. – all preclinical & clinical data (incl. all VELA-2 data) will be included with the full BLA submission*
- **BLA timelines as planned –** with submission planned for Q3 2026

SEE, Substantial evidence of effectiveness

Source: MoonLake Regulatory

Why does **MIRA matter**?

MoonLake

	MIRA *Phase 2*	**VELA-1/2** *Phase 3*	**Bimekizumab** *Phase 2*	**Secukinumab** *Phase 2*
Regulatory considerations	**One adequate & well controlled trial** Large RCT with similar study design to Phase 3	**Two adequate & well controlled trials**	**Proof-of-concept** Small POC study integrating historical placebo data	**No Phase 2 trial** Progress to Ph3 relied on investigator-initiated trial
Patients	**234** *133 SLK, 68 PBO, 33 SOC*	**838** *559 SLK, 279 PBO*	**90** *46 BKZ, 22 PBO, 22 SOC*	N/A
Investigational product	SLK 120mg Q4W WI (proposed **commercial dose**)		BKZ 320mg Q2W+640mg LD (**NOT** commercial dose)	N/A
Treatment duration	**24** weeks	**52** weeks	**12** weeks	

All three MLTX HS trials are adequately and well controlled

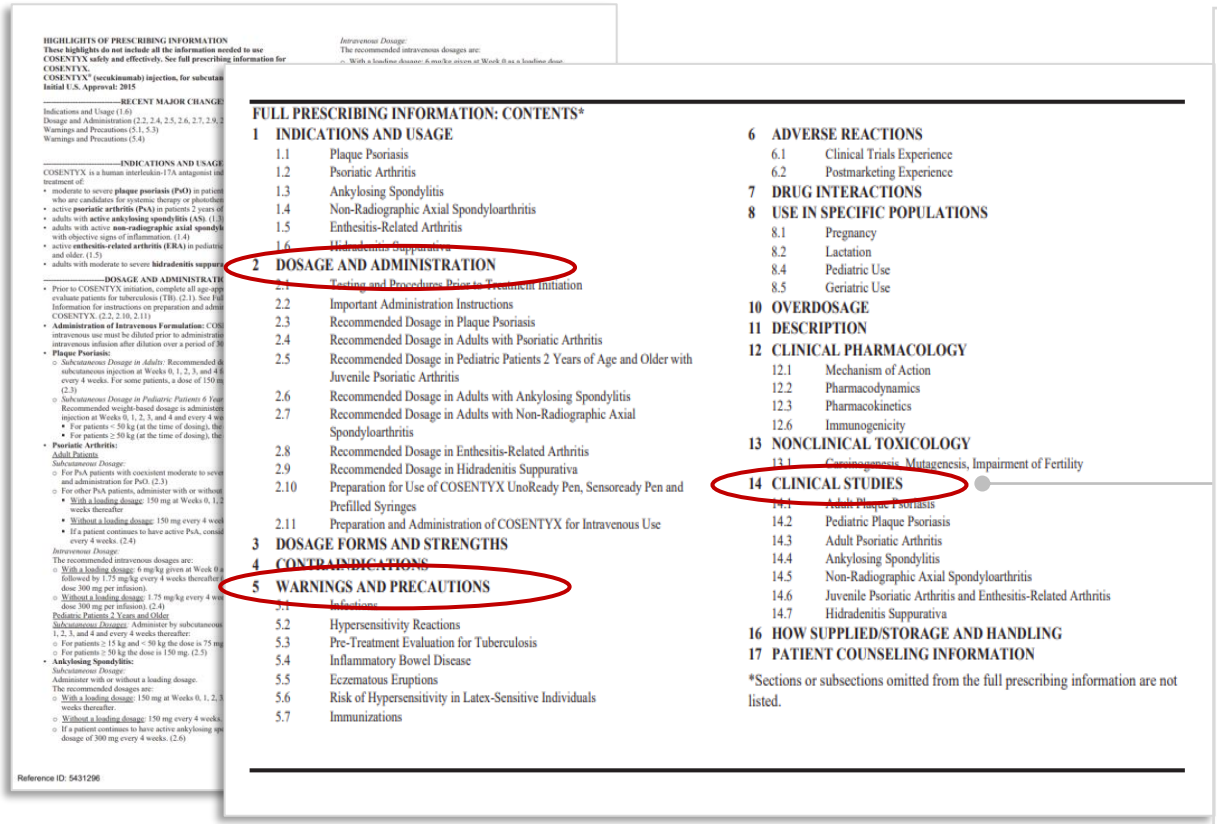
Competitors likely not able to use Phase 2 trials as pivotal (different dose to approval, few patients, IIT etc.)

PBO = Placebo arm, REF = Reference arm, LD = Loading Dose, WI = With Induction, SOC = Standard of Care
Sources: Jemec et al Presented at EHSF 2000 - and - Glatt et al JAMA Dermatol 2021;157:1279; Kimball et al Exp Dermatol 2022;31:1522

Source: MoonLake Regulatory

What matters in a label: Sections 14, 5 and 2

FDA label example, *secukinumab example*



FULL PRESCRIBING INFORMATION: CONTENTS*

1 INDICATIONS AND USAGE
- 1.1 Plaque Psoriasis
- 1.2 Psoriatic Arthritis
- 1.3 Ankylosing Spondylitis
- 1.4 Non-Radiographic Axial Spondyloarthritis
- 1.5 Enthesitis-Related Arthritis
- 1.6 Hidradenitis Suppurativa

2 DOSAGE AND ADMINISTRATION
- 2.1 Testing and Procedures Prior to Treatment Initiation
- 2.2 Important Administration Instructions
- 2.3 Recommended Dosage in Plaque Psoriasis
- 2.4 Recommended Dosage in Adults with Psoriatic Arthritis
- 2.5 Recommended Dosage in Pediatric Patients 2 Years of Age and Older with Juvenile Psoriatic Arthritis
- 2.6 Recommended Dosage in Adults with Ankylosing Spondylitis
- 2.7 Recommended Dosage in Adults with Non-Radiographic Axial Spondyloarthritis
- 2.8 Recommended Dosage in Enthesitis-Related Arthritis
- 2.9 Recommended Dosage in Hidradenitis Suppurativa
- 2.10 Preparation for Use of COSENTYX UnoReady Pen, Sensoready Pen and Prefilled Syringes
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4 CONTRAINDICATIONS

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- 5.1 Infections
- 5.2 Hypersensitivity Reactions
- 5.3 Pre-Treatment Evaluation for Tuberculosis
- 5.4 Inflammatory Bowel Disease
- 5.5 Eczematous Eruptions
- 5.6 Risk of Hypersensitivity in Latex-Sensitive Individuals
- 5.7 Immunizations

6 ADVERSE REACTIONS
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- 6.2 Postmarketing Experience

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8 USE IN SPECIFIC POPULATIONS
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- 8.2 Lactation
- 8.4 Pediatric Use
- 8.5 Geriatric Use

10 OVERDOSAGE

11 DESCRIPTION

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- 12.2 Pharmacodynamics
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- 14.1 Adult Plaque Psoriasis
- 14.2 Pediatric Plaque Psoriasis
- 14.3 Adult Psoriatic Arthritis
- 14.4 Ankylosing Spondylitis
- 14.5 Non-Radiographic Axial Spondyloarthritis
- 14.6 Juvenile Psoriatic Arthritis and Enthesitis-Related Arthritis
- 14.7 Hidradenitis Suppurativa

16 HOW SUPPLIED/STORAGE AND HANDLING

17 PATIENT COUNSELING INFORMATION

*Sections or subsections omitted from the full prescribing information are not listed.

Potential areas of differentiation

Section 14 — **Clinical response of trials incl. supplementary text, figures and additional clinical data –** enabling potential differentiation on efficacy and PROs (where SEE is primarily reflected)

Section 5 — **Warnings and precautions –** enabling potential differentiation of safety-benefit ratio

Section 2 — **Required dosing scheme –** enabling potential differentiation number, time and volume of injections

Source: MoonLake Regulatory

What matters in a label: The information you should expect

Section 14

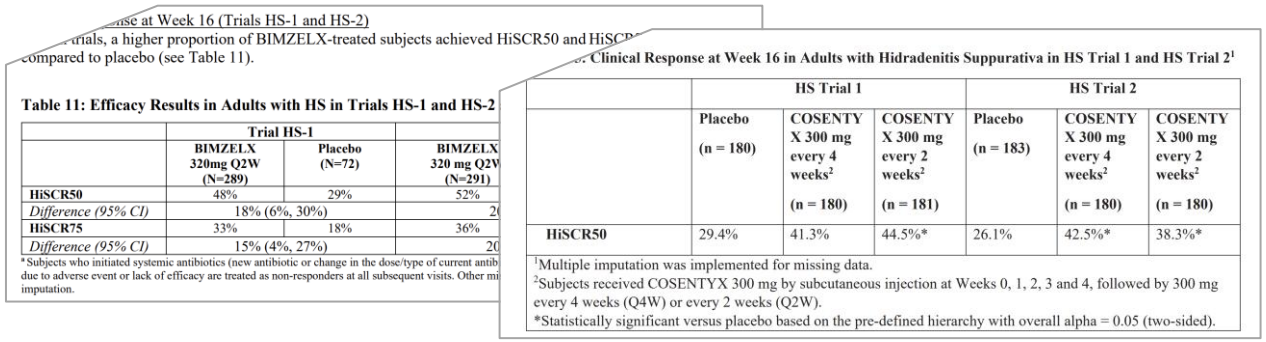


Table 11: Efficacy Results in Adults with HS in Trials HS-1 and HS-2

	Trial HS-1		
	BIMZELX 320mg Q2W (N=289)	Placebo (N=72)	BIMZELX 320 mg Q2W (N=291)
HiSCR50	48%	29%	52%
Difference (95% CI)	18% (6%, 30%)		2
HiSCR75	33%	18%	36%
Difference (95% CI)	15% (4%, 27%)		20

*Subjects who initiated systemic antibiotics (new antibiotic or change in the dose/type of current antib due to adverse event or lack of efficacy are treated as non-responders at all subsequent visits. Other mi imputation.

Clinical Response at Week 16 in Adults with Hidradenitis Suppurativa in HS Trial 1 and HS Trial 2[1]

	HS Trial 1			HS Trial 2		
	Placebo (n = 180)	COSENTYX 300 mg every 4 weeks[2] (n = 180)	COSENTYX 300 mg every 2 weeks[2] (n = 181)	Placebo (n = 183)	COSENTYX 300 mg every 4 weeks[2] (n = 180)	COSENTYX 300 mg every 2 weeks[2] (n = 180)
HiSCR50	29.4%	41.3%	44.5%*	26.1%	42.5%*	38.3%*

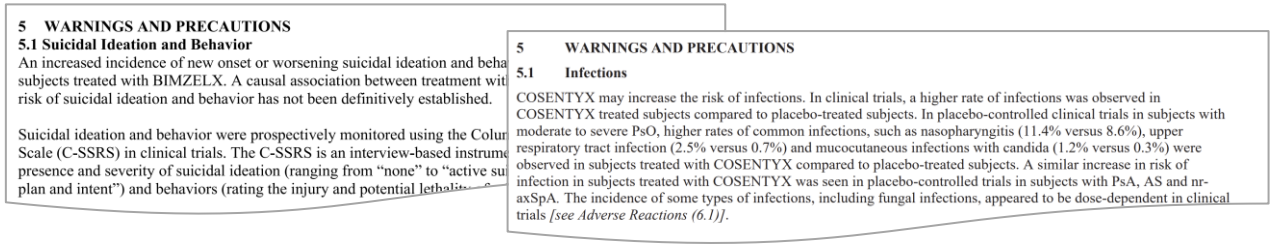
[1]Multiple imputation was implemented for missing data.
[2]Subjects received COSENTYX 300 mg by subcutaneous injection at Weeks 0, 1, 2, 3 and 4, followed by 300 mg every 4 weeks (Q4W) or every 2 weeks (Q2W).
*Statistically significant versus placebo based on the pre-defined hierarchy with overall alpha = 0.05 (two-sided).

Bimekizumab label — Bimzelx (bimekizumab)

Secukinumab — Cosentyx (secukinumab)

Clinical response of trials incl. supplementary text, figures and additional clinical data – enabling potential differentiation on efficacy and PROs (where SEE is primarily reflected) – competitors only have HiSCR

Section 5



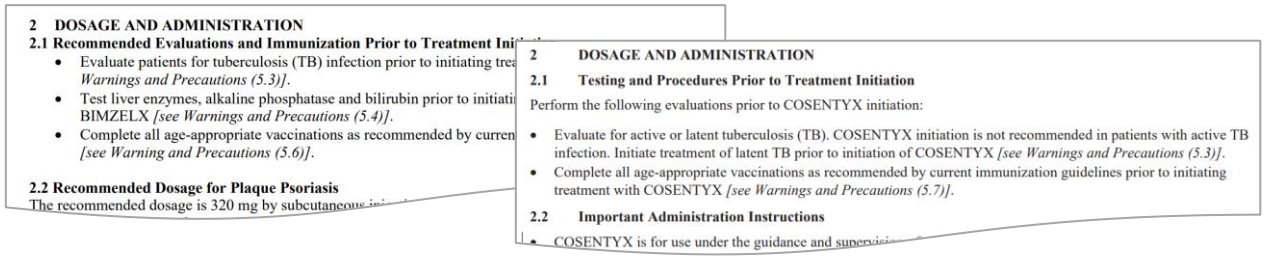
5 WARNINGS AND PRECAUTIONS
5.1 Suicidal Ideation and Behavior
An increased incidence of new onset or worsening suicidal ideation and beha subjects treated with BIMZELX. A causal association between treatment wit risk of suicidal ideation and behavior has not been definitively established.

Suicidal ideation and behavior were prospectively monitored using the Colur Scale (C-SSRS) in clinical trials. The C-SSRS is an interview-based instrume presence and severity of suicidal ideation (ranging from "none" to "active su plan and intent") and behaviors (rating the injury and potential lethali

5 WARNINGS AND PRECAUTIONS
5.1 Infections
COSENTYX may increase the risk of infections. In clinical trials, a higher rate of infections was observed in COSENTYX treated subjects compared to placebo-treated subjects. In placebo-controlled clinical trials in subjects with moderate to severe PsO, higher rates of common infections, such as nasopharyngitis (11.4% versus 8.6%), upper respiratory tract infection (2.5% versus 0.7%) and mucocutaneous infections with candida (1.2% versus 0.3%) were observed in subjects treated with COSENTYX compared to placebo-treated subjects. A similar increase in risk of infection in subjects treated with COSENTYX was seen in placebo-controlled trials in subjects with PsA, AS and nr-axSpA. The incidence of some types of infections, including fungal infections, appeared to be dose-dependent in clinical trials *[see Adverse Reactions (6.1)]*.

Warnings and precautions – enabling potential differentiation on safety-benefit ratio

Section 2



2 DOSAGE AND ADMINISTRATION
2.1 Recommended Evaluations and Immunization Prior to Treatment Ini
- Evaluate patients for tuberculosis (TB) infection prior to initiating trea *Warnings and Precautions (5.3)]*.
- Test liver enzymes, alkaline phosphatase and bilirubin prior to initiati BIMZELX *[see Warnings and Precautions (5.4)]*.
- Complete all age-appropriate vaccinations as recommended by curren *[see Warning and Precautions (5.6)]*.

2.2 Recommended Dosage for Plaque Psoriasis
The recommended dosage is 320 mg by subcutaneous in

2 DOSAGE AND ADMINISTRATION
2.1 Testing and Procedures Prior to Treatment Initiation
Perform the following evaluations prior to COSENTYX initiation:
- Evaluate for active or latent tuberculosis (TB). COSENTYX initiation is not recommended in patients with active TB infection. Initiate treatment of latent TB prior to initiation of COSENTYX *[see Warnings and Precautions (5.3)]*.
- Complete all age-appropriate vaccinations as recommended by current immunization guidelines prior to initiating treatment with COSENTYX *[see Warnings and Precautions (5.7)]*.

2.2 Important Administration Instructions
- COSENTYX is for use under the guidance and supervisi

Required dosing scheme – enabling potential differentiation on less or lower volume injections

Source: MoonLake Regulatory

Building on feedback, this is our **base scenario** for Sec. 14

Absolute response *(Delta-to-placebo); VELA data reflects composite strategy analysis (ITT-mNRI)*
Potential label options for sonelokimab reflecting MLTX's current views based on data and prior regulatory correspondence

Sonelokimab, *week 16 and week 12*

Efficacy data relevant for potential label	**HS trial 1** *(Corresponds to VELA-1)*	**HS trial 2** *(Corresponds to MIRA)*
HiSCR75, %	**34.4** (16.9)	**43.3** (28.6)
HiSCR50, %	**51.0** (20.7)	**65.7** (37.8)
Pain NRS-3, %	*Text on Pain NRS-3*	
HiSQOL, CfB[1]	*Text on HiSQOL*	
IHS4-55, %	*Text on IHS4-55*	

IL-17A and F mAb
Week 16

HS trial 1	**HS trial 2**
33 (15)	**36** (20)
48 (18)	**52** (20)

Note on improvement in patient-reported worst skin pain (lesion pain) compared to placebo at Week 16 (despite not meeting stat sign in BH1 and for one dose in BH2)

No HiSQoL, no IHS4 notes

This would result in a leading Sec 14 versus the expected competitors

Note: Absolute responses shown, delta to placebo in brackets, VELA-1 and VELA-2 results for Week 16, MIRA results for Week 12; Bimekizumab data as per FDA label for HS (Section 14) and approved dose. IHS4-55, Pain NRS-3, HiSQOL were not ranked endpoints in MIRA. Prespecified analysis method has been used for all outcome in VELA and MIRA. For illustrative purposes only. Efficacy data are derived from different clinical trials conducted at different times, with differences in trial design and patient populations. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted. Data subject to change until clinical study reports are issued.
1 Baseline numbers would be included

Source: MoonLake Clinical

An **"upside case"** also includes other responses in the Sec. 14 table

MoonLake

Absolute response *(Delta-to-placebo); VELA data reflects composite strategy analysis (ITT-mNRI)*
Potential label options for sonelokimab reflecting MLTX's current views based on data and prior regulatory correspondence

Sonelokimab, *week 16 and week 12*

Efficacy data relevant for potential label	**HS trial 1** *(Corresponds to VELA-1)*	**HS trial 2** *(Corresponds to MIRA)*
HiSCR75, %	**34.4** (16.9)	**43.3** (28.6)
HiSCR50, %	**51.0** (20.7)	**65.7** (37.8)
Pain NRS-3, %	**28.4** (16.9)	**22.0** (19.9)
HiSQOL, CfB[1]	**-8.8** (-5.7)	**-9.4** (-4.4)
IHS4-55, %	**53.2** (19.3)	**62.7** (33.3)

*Text on **Pain NRS-3, HiSQOL and IHS4-55** (see previous option) could be included as numbers*

IL-17A and F mAb
Week 16

HS trial 1	**HS trial 2**
33 (15)	**36** (20)
48 (18)	**52** (20)

Note on improvement in patient-reported worst skin pain (lesion pain) compared to placebo at Week 16 (despite not meeting stat sign in BH1 and for one dose in BH2)

No HiSQoL, no IHS4 notes

This would result in a leading Sec 14 versus the expected competitors

Note: Absolute responses shown, delta to placebo in brackets, VELA-1 and VELA-2 results for Week 16, MIRA results for Week 12; Bimekizumab data as per FDA label for HS (Section 14) and approved dose. IHS4-55, Pain NRS-3, HiSQOL were not ranked endpoints in MIRA. Prespecified analysis method has been used for all outcome in VELA and MIRA. For illustrative purposes only. Efficacy data are derived from different clinical trials conducted at different times, with differences in trial design and patient populations. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted. Data subject to change until clinical study reports are issued.
1 Baseline numbers would be included

Source: MoonLake Clinical

Potential inclusion of VELA-2 data for SEE **only supports Sec.14 further**

MoonLake

Absolute response *(Delta-to-placebo); VELA data reflects composite strategy analysis (ITT-mNRI)*
Potential label options for sonelokimab reflecting MLTX's current views based on data and prior regulatory correspondence

Sonelokimab, *week 16 and week 12*

Efficacy data relevant for potential label	**HS trial 1** *(Corresponds to VELA-1)*	**HS trial 2** *(Corresponds to MIRA)*	**HS trial 3** *(would correspond to VELA-2)*
HiSCR75, %	**34.4** (16.9)	**43.3** (28.6)	If VELA-2 is included in SEE: Data might be in table or referenced as text – some or only one score might be used
HiSCR50, %	**51.0** (20.7)	**65.7** (37.8)	
Pain NRS-3, %	**28.4** (16.9)	**22.0** (19.9)	
HiSQOL, CfB[1]	**-8.8** (-5.7)	**-9.4** (-4.4)	
IHS4-55, %	**53.2** (19.3)	**62.7** (33.3)	

*Text on **Pain NRS-3, HiSQOL and IHS4-55** (see previous option) could be included as numbers*

IL-17A and F mAb *Week 16*

HS trial 1	**HS trial 2**
33 (15)	**36** (20)
48 (18)	**52** (20)

Note on improvement in patient-reported worst skin pain (lesion pain) compared to placebo at Week 16 (despite not meeting stat sign in BH1 and for one dose in BH2)

No HiSQoL, no IHS4 notes

This would result in a leading Sec 14 versus the expected competitors

Note: Absolute responses shown, delta to placebo in brackets, VELA-1 and VELA-2 results for Week 16, MIRA results for Week 12; Bimekizumab data as per FDA label for HS (Section 14) and approved dose. IHS4-55, Pain NRS-3, HiSQOL were not ranked endpoints in MIRA. Prespecified analysis method has been used for all outcome in VELA and MIRA. For illustrative purposes only. Efficacy data are derived from different clinical trials conducted at different times, with differences in trial design and patient populations. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted. Data subject to change until clinical study reports are issued.
1 Baseline numbers would be included

Source: MoonLake Clinical

Warnings & Precautions + Dosage: SLK has differentiation potential

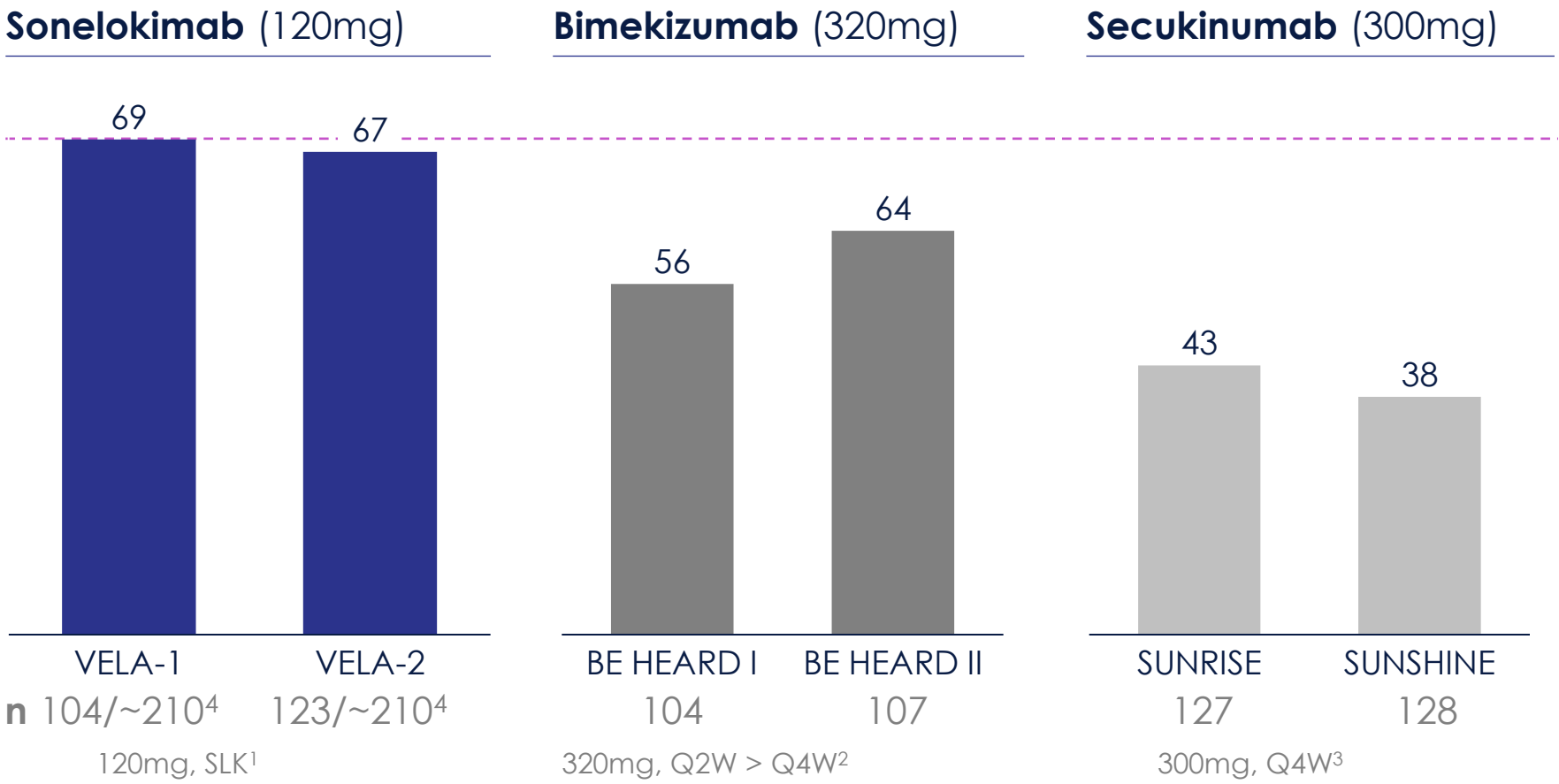
MoonLake

	Bimzelx® (bimekizumab)	Cosentyx® (secukinumab)	SLK differentiation potential
Section 5 Warnings and Precautions	▪ *Suicidal Ideation and Behavior* ▪ *Infections* ▪ *Tuberculosis* ▪ *Liver Biochemical Abnormalities* ▪ *Inflammatory Bowel Disease* ▪ *Immunization*	▪ *Infections* ▪ *Hypersensitivity Reactions* ▪ *Pre-Treatment Evaluation for Tuberculosis* ▪ *Inflammatory Bowel Disease* ▪ *Eczematous Eruptions* ▪ *Risk of Hypersensitivity in Latex-Sensitive Individuals* ▪ *Immunization*	✓ No TEAEs of SIB reported in Phase 3 trials. C-SSRS validated for risk identification and monitoring treatment response ✓ No signal for hepatic events or elevated transaminases in SLK clinical trials ✓ No evidence of association between IL-17 inhibition and TB reactivation. Clinical trials and post-marketing data show no increased TB risk
Section 2 Dosage and Administration	▪ *320 mg by subcutaneous injection* ▪ *Weeks 0, 2, 4, 6, 8, 10, 12, 14, and 16, then every 4 weeks thereafter*	▪ *300 mg by subcutaneous injection* ▪ *Weeks 0, 1, 2, 3 and 4 and every 4 weeks thereafter* ▪ *If patient does not adequately respond, consider increasing the dosage to 300 mg every 2 weeks*	✓ Low injection volume: 120mg subcutaneous injection ✓ Few induction injections: 5 injections for induction period ✓ Short induction duration: 8 weeks induction period
Additional differentiation points			✓ *Low eczema and dermatitis signals long-term as another potential commercial differentiation opportunity (not in label)*

Source: MoonLake Regulatory

Long-term data: HiSCR75 response of SLK increases over time

Long-term HiSCR75 response rates at end of parental trial (OC), in % of patients

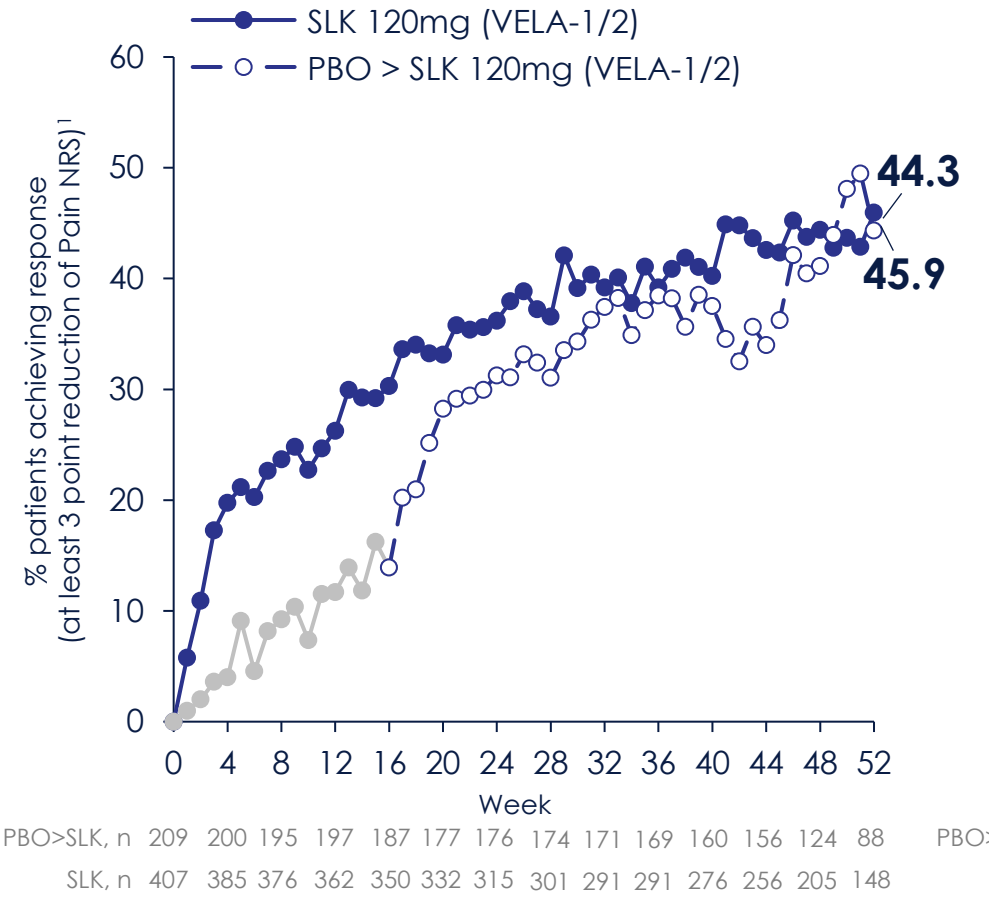


Strong long-term efficacy data establishes **potential beneficial commercial positioning for SLK** – also when compared to other available clinical data

Note: Note differences in long-term response times given different study durations. Data are as observed. VELA-1 and VELA-2 trials are ongoing with the number participants reaching W52 expected to increase over time.
Data for Bimekizumab include all patients receiving Q2W until Week 16, and patients randomized to the Q2W>Q4W dosing scheme from Week 16 to Week 48. The Bimekizumab studies were 48-week studies, hence no Week 52 data are available.
For illustrative purposes only. Efficacy data are derived from different clinical trials conducted at different times, with differences in trial design and patient populations. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted. Sources: Kimball et al. Lancet 2024;403:2504; Kimball et al. Lancet 2023;401:747. 1 SLK arm only, no PBO-to-SLK switch-over patients; 2 Approved dose of Bimekizumab 320mg Q2W until Week 16 and Q4W after. 3 Approved dose for secukinumab 300mg, Q4W from Week 4 onwards; 4 Assumed number of patients achieving W52. Data subject to change until clinical study reports are issued.
Source: MoonLake Clinical

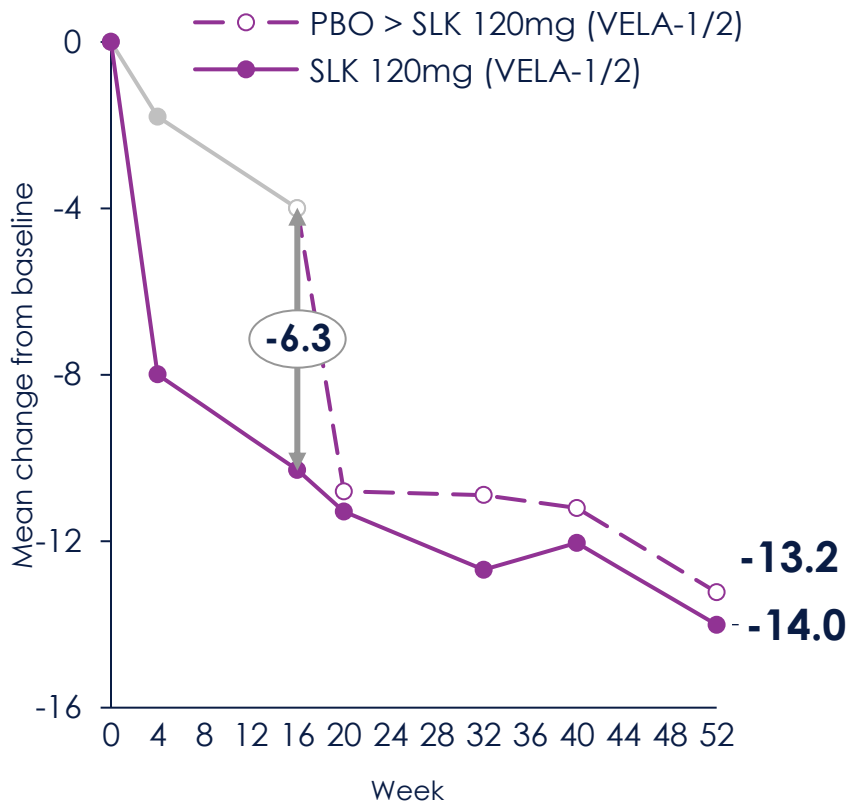
Long-term data: Pain and HiSQoL continue to improve over time

Pain response (OC)



PBO>SLK, n	209	200	195	197	187	177	176	174	171	169	160	156	124	88
SLK, n	407	385	376	362	350	332	315	301	291	291	276	256	205	148

HiSQOL improvement (OC)



PBO>SLK, n	279	270	259	249	240	231	126
SLK, n	558	537	509	485	445	411	226

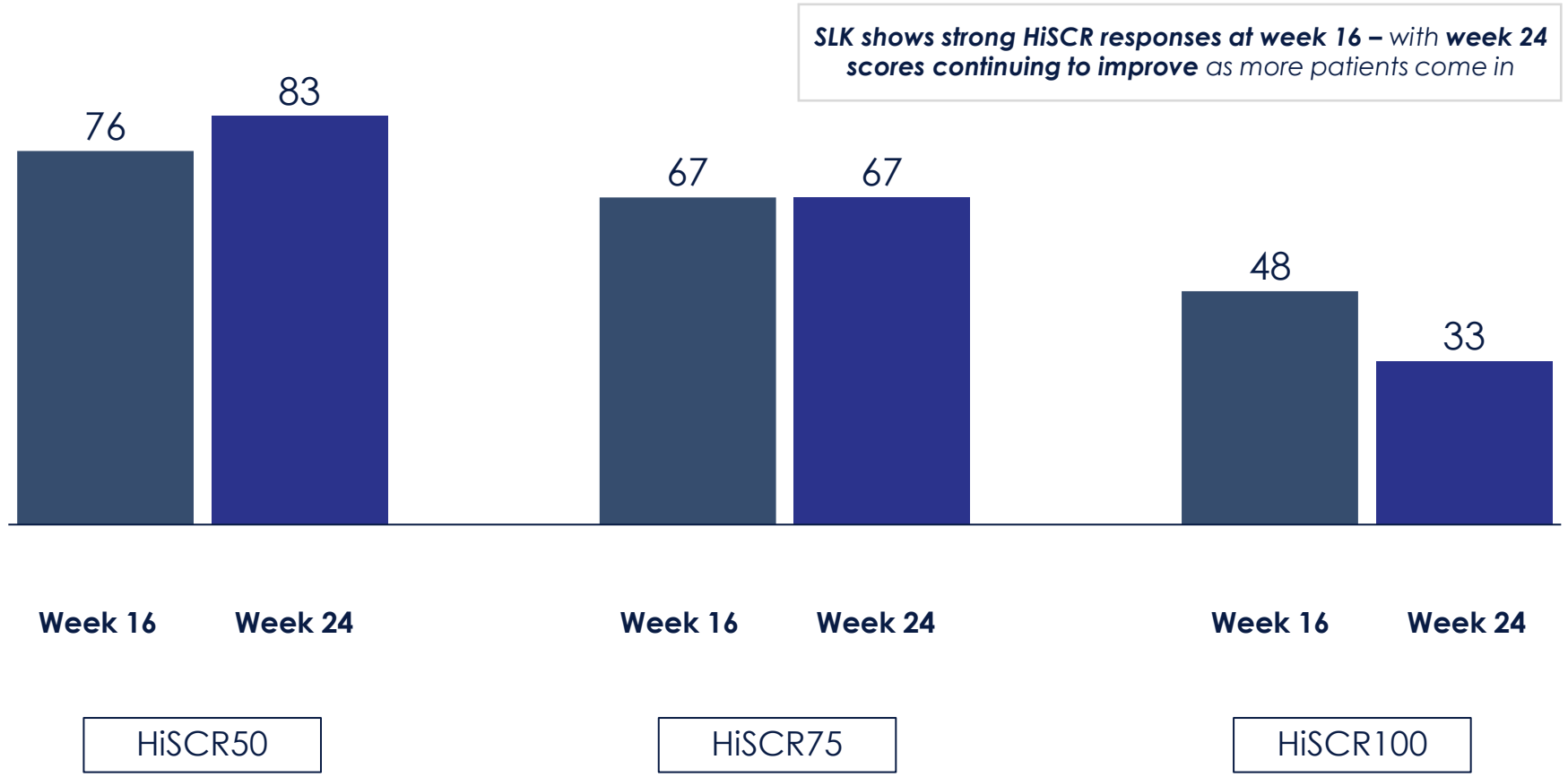
- **Continuous improvement of relevant quality of life scores** beyond Week 16 for sonelokimab
- **Substantial and rapid improvement in pain and HiSQOL** observed in placebo-switch group

Data are as observed. Data subject to change until clinical study reports are issued. BKZ data from marketing materials. Pain NRS was assessed weekly, HiSQOL was assessed at specific timepoints. HiSQOL baseline values: 27.2 for SLK, 25.7 for PBO. Pain NRS data based on worst skin pain.
1 Only includes participants with a baseline Pain NRS score ≥3

Source: MoonLake Clinical

VELA-TEEN: SLK also shows rapid onset of effect in adolescent patients

HiSCR response rates (As observed), in % of patients



We are aiming for **further differentiation** in our label through our **strong adolescent HS efficacy data –** interim Week-24 data showing **80+%** achieving **HiSCR50**, **~65+%** achieving **HiSCR75**, and **30+%** achieving **HiSCR100**

Total participants at each timepoint: Week 16 (n=21), Week 24 (n=12). Data subject to change until clinical study reports are issued. VELA-TEEN trials are ongoing with the number participants reaching W16 and W24 expected to increase over time.

Source: MoonLake Clinical

Clean safety profile signals leading benefit risk ratio across program

Treatment-emergent adverse events (TEAE), n (%)	**VELA-TEEN** to Week 28[1]
	Sonelokimab 120 mg N=27
Any TEAE	13 (48.1)
Any Serious TEAE	0
Any TEAE leading to discontinuation	1 (3.7)[2]
Most frequent TEAEs of SLK (≥5% with active treatment)	
Nasopharyngitis	3 (11.1)
Oral candidiasis	1 (3.7)
TEAEs of interest	
Oral candidiasis	1 (3.7)
Dermatitis	0
Eczema	0
Serious infection	0
Diarrhea (non-infectious)	0
Hepatic event	0
Inflammatory bowel disease (IBD)	0
Suicidal ideation and behavior (SIB)	0
Serious hypersensitivity	0
Major adverse cardiovascular event (MACE)	0

Sonelokimab is also showing a clean safety profile in the VELA-TEEN program, suggesting a favorable benefit-risk ratio in the adolescent population, consistent with VELA-1 and VELA-2

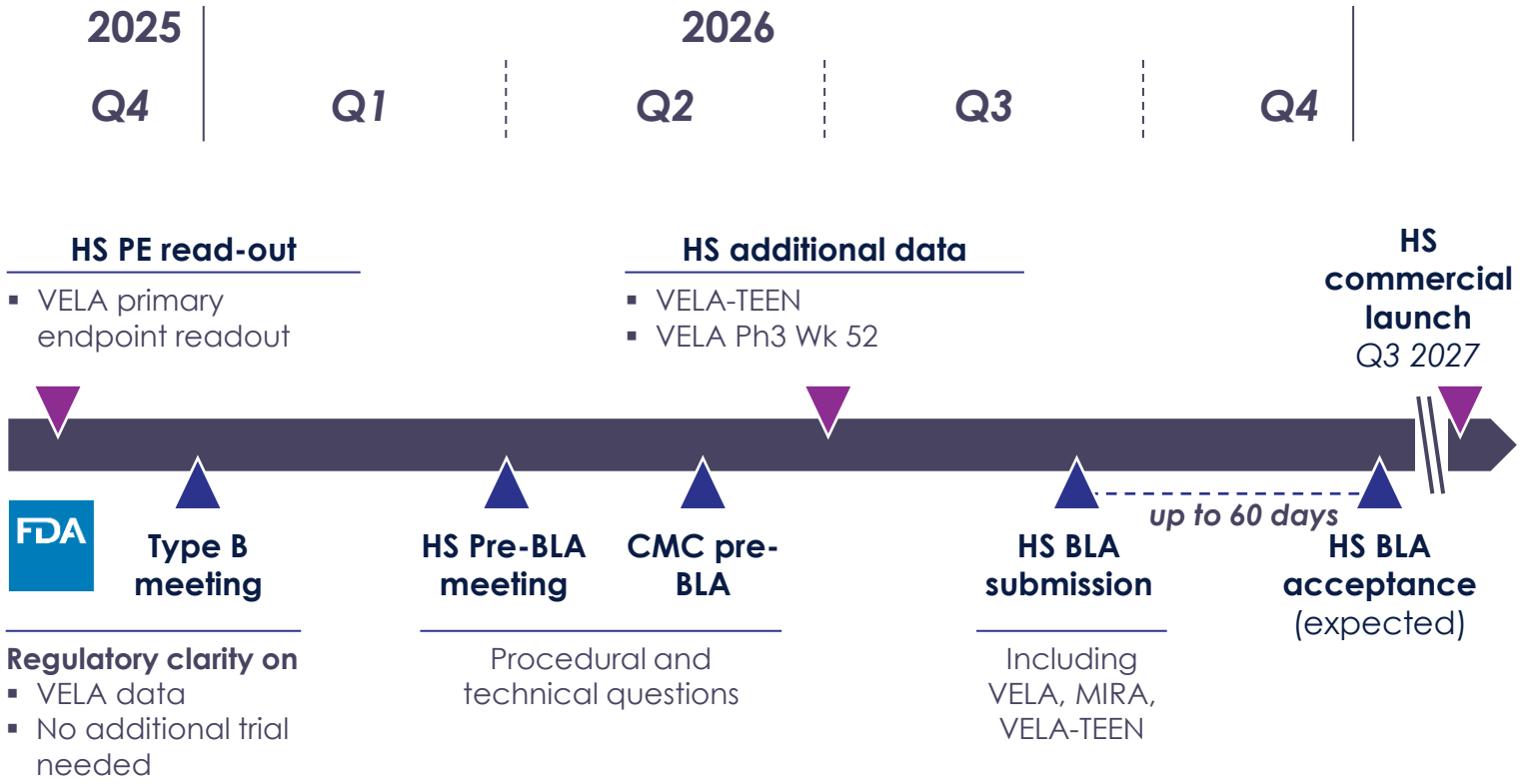
Adjudication is ongoing. 1 Different patients are at different time points as the trials are still running – indicated week is the maximum week to be reached; 2 Discontinuation due to Dysuria

Source: MoonLake Clinical

BLA submission **timeline remains as planned**

Timeline not scaled

- **Regulatory clarity obtained** at a stage where other companies typically do not get it
- Clear **guidance to complete a BLA**, with the full preclinical and clinical packages (incl. MIRA, VELA-1, VELA-2)
- Clear consideration of what data is considered to **establish SEE and safety**
- The true chance to be **numerically leading in efficacy** data incl. HiSCR
- **A strong profile on metrics that truly matter** for physicians and patients (i.e., HiSQOL, pain, DLQI, safety)



BLA submission expected to be on time and without any adjustments post VELA read-out – planned for Q3 2026 with planned commercial launch of SLK in Q3 2027

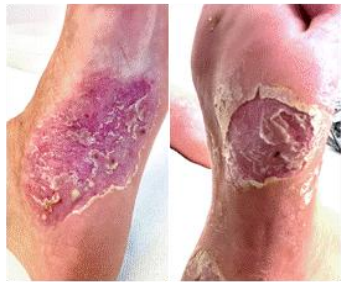
Source: MoonLake Corporate

MoonLake

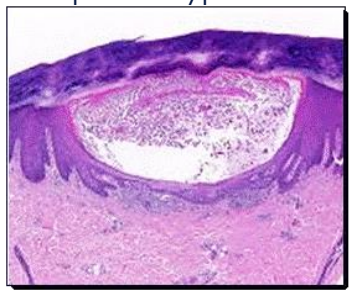
Other updates & guidance

PPP: A fast-growing disease with a continued unmet need

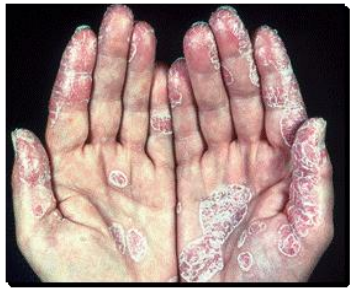
Palmoplantar pustulosis (PPP) at a glance



PPP phenotype



Micro-anatomy



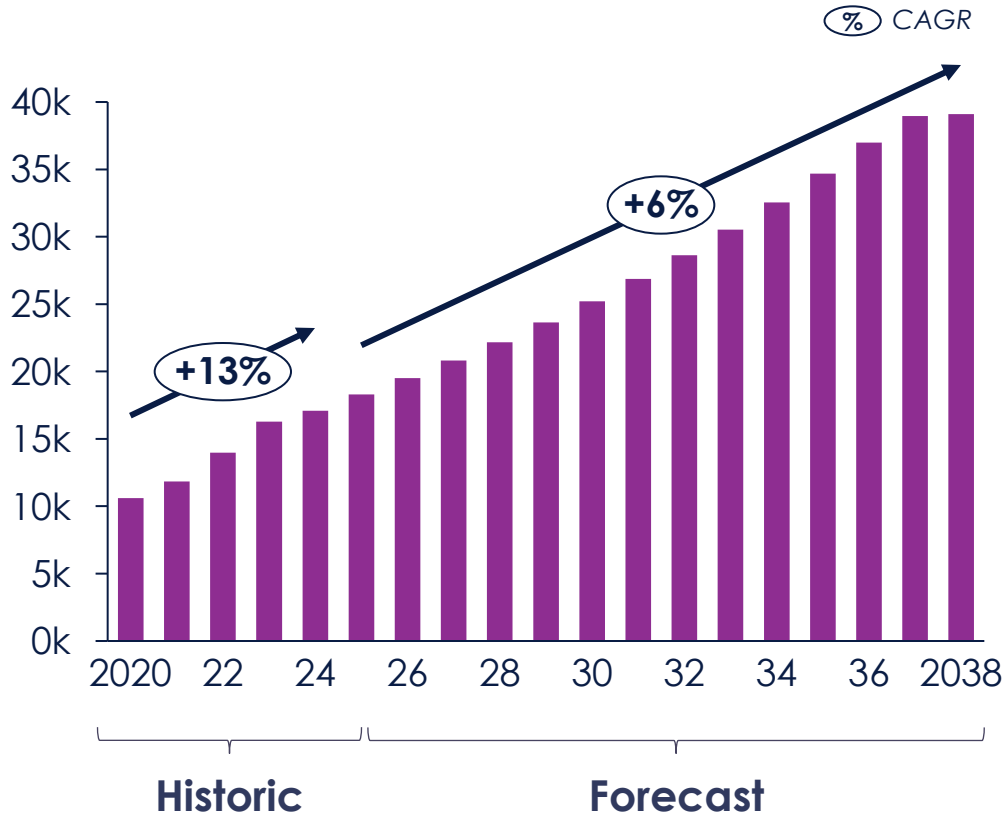
PP phenotype (palmoplantar (plaque-type) psoriasis)

What real-world data shows:

- **~185k unique patients** with positive diagnosis for PPP (L40.3) in 2015-2025 in US
- **~20k net new patients diagnosed** p.a. on average since 2016
- **~450k+ patients with PPP in 2038** assuming growth continues at same rate as observed in prior years

Estimated prevalence of target population 0.3%[1,2,3]

Biologics patients (2020-2038 in US)[3]



Projected market size (2038)

$4-5bn[4]

No approved or effective therapy in U.S. and Europe

Even without approvals several thousand patients already treated with biologics – in an attempt to control the disease

1 Ramcharran et al. Adv Ther. 2023;40:5090-5101; 2 Brunasso AMG, Massone C, Faculty Reviews. 2021; 10:62; 3 Based on Real-World Claims as per Komodo PRISM data pull from December 2025 – extrapolating from 75% coverage to 100% patient population; 4 Assumptions include prevalence, annually treated patients shares. Bx shares, HS pricing, adherence rates

Source: MoonLake Commercial, © 2025 Komodo Health, Inc. All rights reserved. Reprinted with permission.

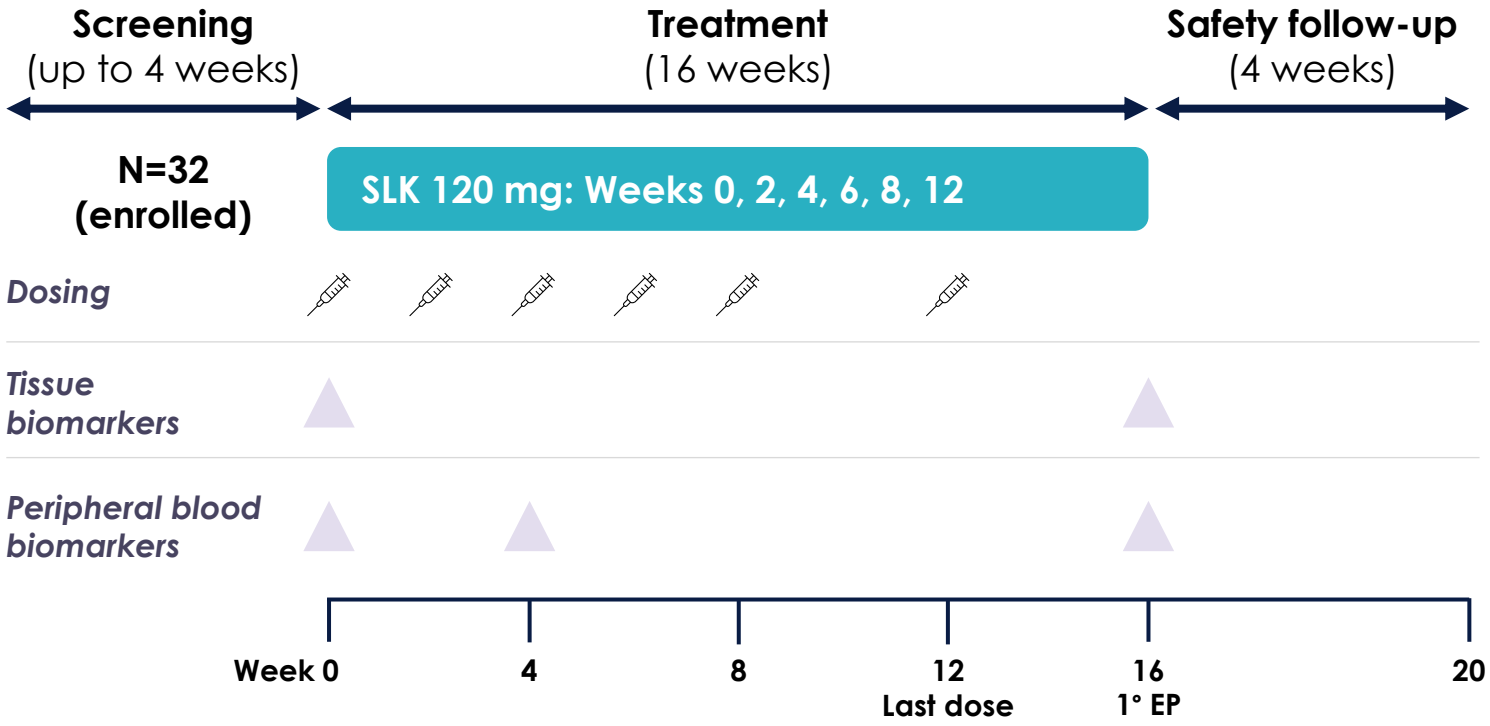
PPP: The Phase 2 LEDA trial read-out in Q4 2025

MoonLake

LEDA

SLK administration

A Phase 2, multi-center, open-label study to explore the effects of sonelokimab in patients with moderate-to-severe PPP



Endpoints and major milestones

Primary clinical endpoint:

- % CfB of PPPASI at week 16

Key secondary clinical endpoints

- PPPASI50 at week 16
- PPPASI75 at week 16
- PPPGA 0/1 + 2pts

Objective endpoints (biomarker-controlled study):

- Tissue biomarkers (IL-17A&F) – objective outcome control)
- Peripheral blood biomarkers (e.g., IL-19)
- AI-image analysis

Major milestones:

- FPI: Jan 2025
- LPI: Q2 2025
- PE read-out: Q4 2025

PPPASI, palmoplantar Psoriasis Area and Severity Index; CfB, Change from Baseline

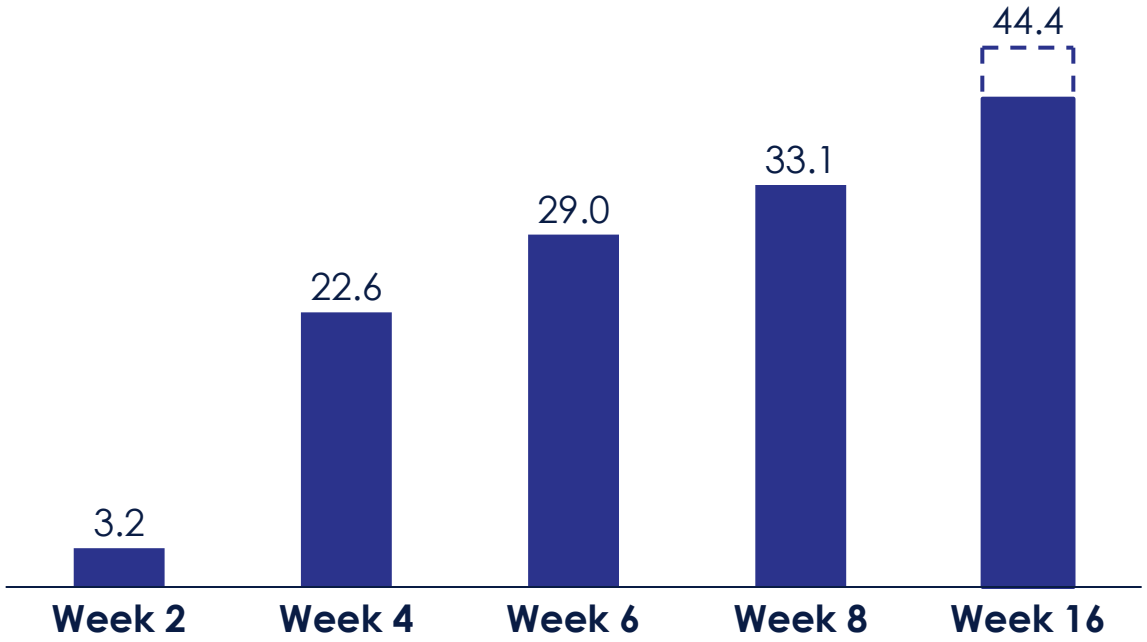
Source: MoonLake Clinical

PPP: SLK shows strong results in the key endpoints for Phase 3

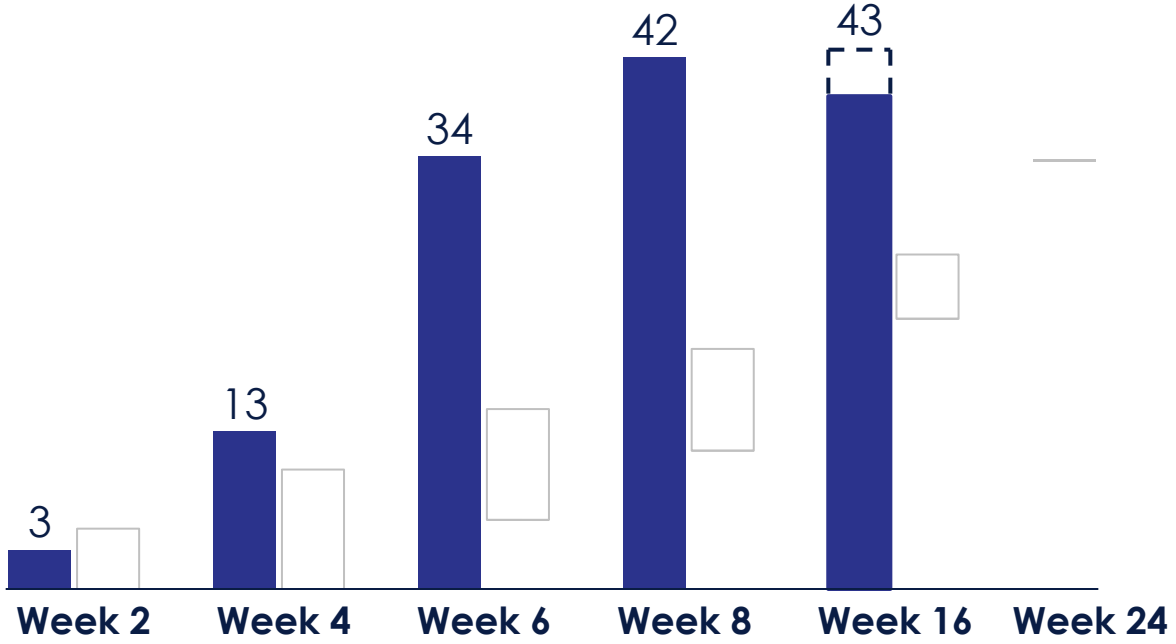
MoonLake

Sonelokimab 120mg (mNRI) | Sonelokimab 120mg (OC) | Competitor range[2]

PPPGA 0/1+2 pts (BL > 2) response rate, in % of patients



PPPASI75 response rate, in % of patients



+40% of patients with SLK achieved a PPPGA score of 0 (clear) or 1 (almost clear) and a reduction of at least 2 points from baseline[1]

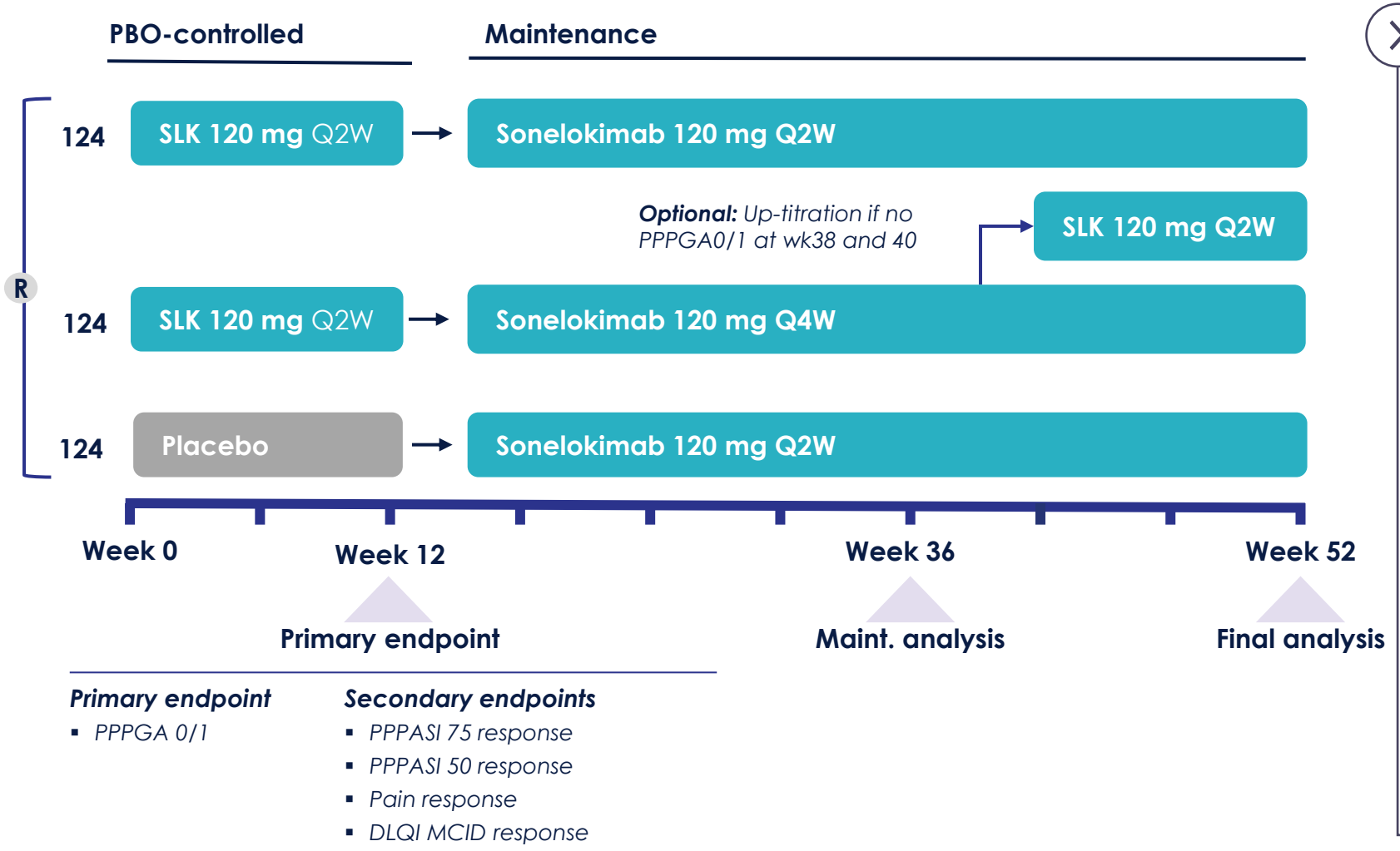
SLK outperforms benchmarks – Week 16 PPPASI75 results more than 10 pp above (also compared to week 24 benchmarks)

For illustrative purposes only. Efficacy data are derived from different clinical trials conducted at different times, with differences in trial design and patient populations. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted. Select data points not explicitly stated in publications have been derived through software-based extraction. Extrapolated kinetics from baseline to primary endpoint in selected cases. PPPGA scores based on physician assessment across categories 0 (clear) to 4 (severe); PPP-IGA and PPPGA represent the same score. Total participants for sonelokimab at each timepoint: wk 2 (n=31), wk 4 (n=31), wk 6 (n=31), wk 8 (n=30), wk 16 (n=27). 1 Baseline score higher than two; 2 Pooled competitor data includes data from Spesolimab combined, non-Asian (Burden A D et al. Dermatol Ther (Heidelb). 2023 Sep 20;13(10):2279–2297), Apremilast 30mg (Wilsmann-Theis D. J Eur Acad Dermatol Venereol. 2021;35:2045-2050), Guselkumab 100mg (Wilsmann-Theis D et al. JAAD Int. 2025;18:69-78), Secukinumab 300mg (Mrowietz et al. J Am Acad Dermatol. 2019;80:1344-52). Patients enrolled for SPEVIGO IIb in 300 and 600mg arm (non-Asian), for 2Precise in 300mg Secukinumab arm. Data subject to change until clinical study reports are issued.

Source: MoonLake Biometrics

PPP: Phase 3 design aims for an expedited read-out

As per current MoonLake plan – subject to FDA interactions



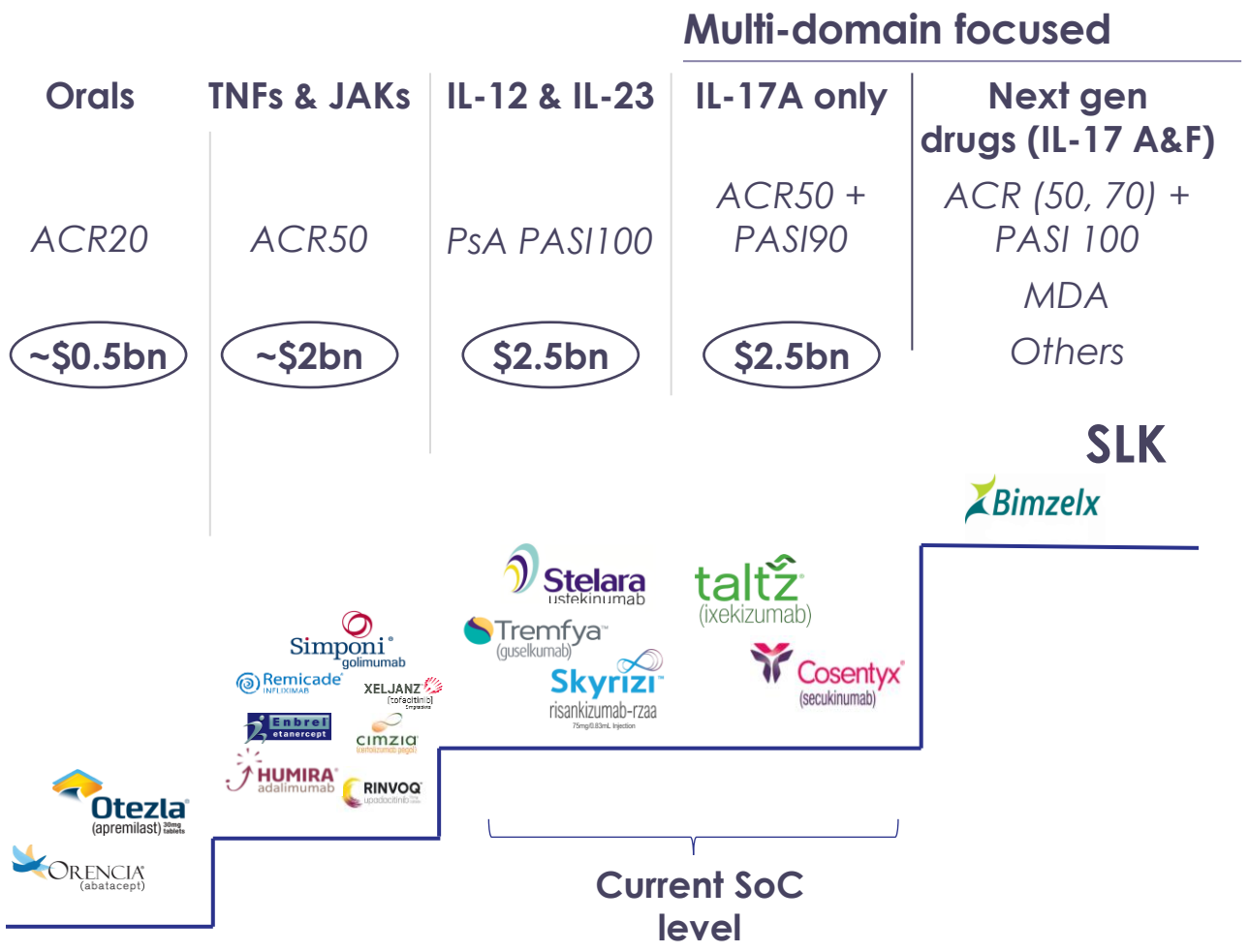
- Phase 3 program backed by **Phase 2 data** and an **optimized dosing regimen** – with **Week 12** primary endpoint enabling a **faster readout**
- **Competitive study design** for sites and patients; **FPI** expected in **Q3 2026**
- Further, FDA **Fast Track designation** allowing more **frequent FDA interactions**
- In contrast, BKZ entering Phase 3 **without Phase 2 data** and using a **later Week 16** primary endpoint

Source: MoonLake Clinical

PsA: Breaking the treatment level – SLK is the next-gen treatment

Treatment levels and positioning for existing products in PsA[1]

(xx) 2025 revenue ($bn)[2]



- **PsA prevalence continues to grow –** ~20% between Q4 2023 and Q4 2025 (1.8mn to 2.1mn patients)[3]
- Historically, **PsA treatments were single-domain focused** – different products used for distinct patients (e.g., IBD, skin-mainly) and by different HCPs (e.g., IL-23 by derms)
- Given large PsA market size, **most undifferentiated products reach $1bn+ p.a.**
- **IL-17 A&F is developed to elevate the treatment ceiling across domains,** well-positioned for leadership across entire PsA
- Hence, **SLK not directly competing with most PsA drugs** (12+) that remain single-domain focused (more like 3-5 competitors)

1 Based on clinical efficacy and Commercial product positioning; 2 Class revenue based on MoonLake estimate of 2024 total market sales and 2024 patient share by class; 3 Increase of uniquely diagnosed and treated patients between data cut-off in Q4 2023 (Q4 2015-Q4 2023) and Q4 2025 (Q4 2015-Q4 2025) – diagnosed and treated patients ≥18 years with PsA diagnosis (ICD-10 L40.5), applied ~75% coverage rate of U.S. claims, applied claims collection lag extrapolation for last 12 months

Source: Unique U.S. patients from prescription data– MoonLake Commercial, © 2023 Komodo Health, Inc. All rights reserved.; Market research

PsA: The IZAR program is a key potential catalyst for MoonLake in 2026

MoonLake

IZAR

	IZAR-1	IZAR-2
	*Phase 3 clinical trial in **bio-naïve** and **radiographic** patients with PsA*	*Phase 3 clinical trial in **bio-experienced** patients with PsA, with a **Risankizumab** reference arm*
Recruitment status	Recruitment **completed**	**Recruitment ongoing**
Timeline	Primary endpoint readout expected in **Q2/Q3 2026**	Primary endpoint readout expected in **Q4 2026**
Expected upcoming read-outs	**In alignment with regulatory guidance to avoid unblinding, the primary endpoint read-out is expected to include:** 1. Meeting/not meeting of statistical significance (for primary endpoint & hierarchy) 2. SLK response levels for primary and key secondary endpoints for 60mg[1,2] & 120mg[2]	

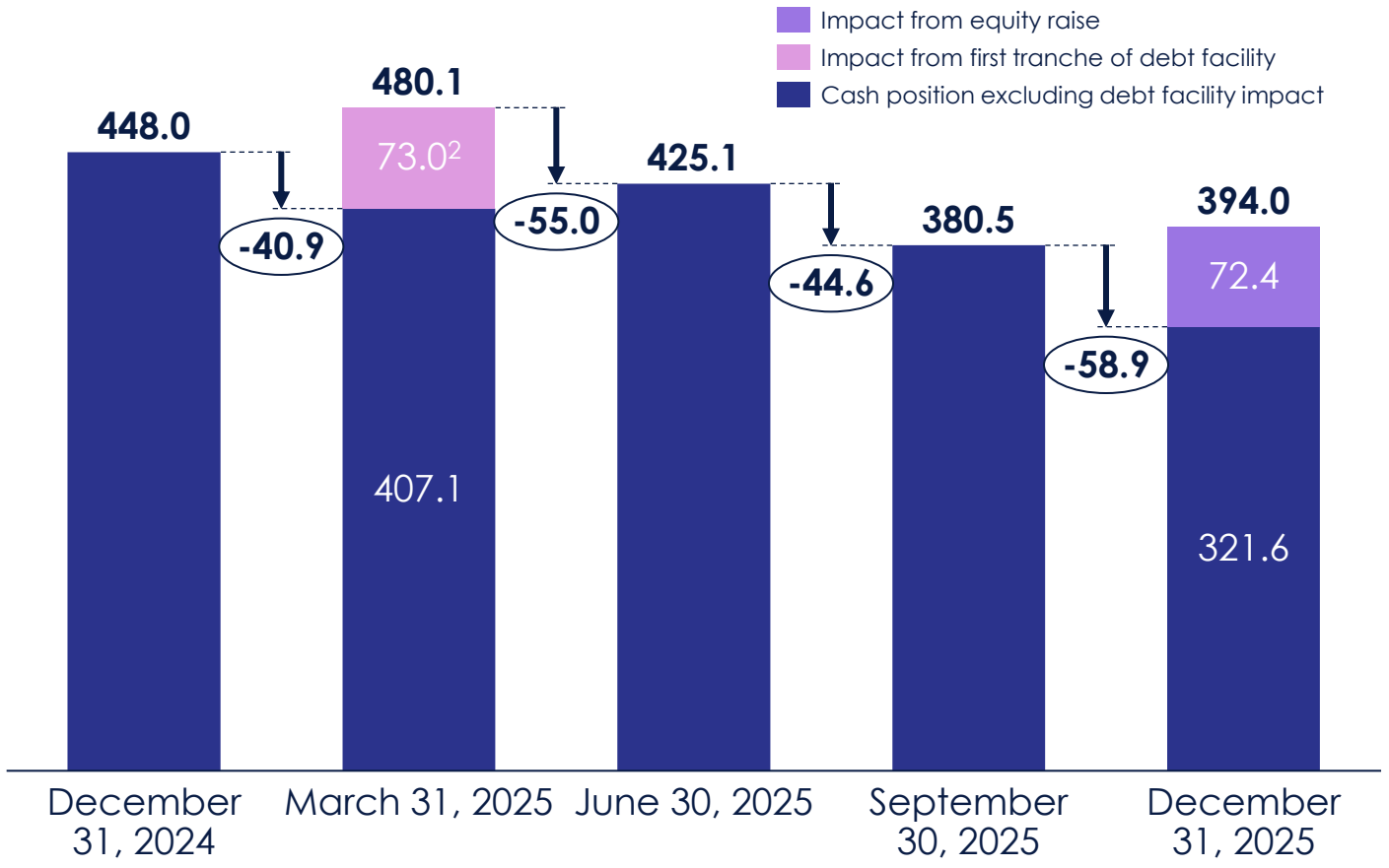
1 For IZAR-1 2 For IZAR-1 and for IZAR-2

Source: MoonLake Clinical

Finance: Additional funding further strengthened our balance sheet

Cash position by quarter, in USD m

Cash position[1], USD m



MLTX continues to operate at a **cash burn well below peers** whilst **delivering with speed and quality**

Current cash, cash equivalents and short-term marketable debt securities expected to provide **cash runway into the second half of 2027**

Amended Hercules facility, *adding another* ***$25m to the balance sheet*** *and providing* ***up to $400m in additional non-dilutive funds****, i.e. supporting cash needs well into commercialization (see next page)*

1 Including Cash, Cash Equivalents and Short-term Marketable Debt Securities; 2 USD 75m less Legal and Accounting fees, as well as underwriting commissions

Source: MoonLake Corporate

Finance: OpEx stabilized at ~$65m/quarter (incl. non-cash expense)

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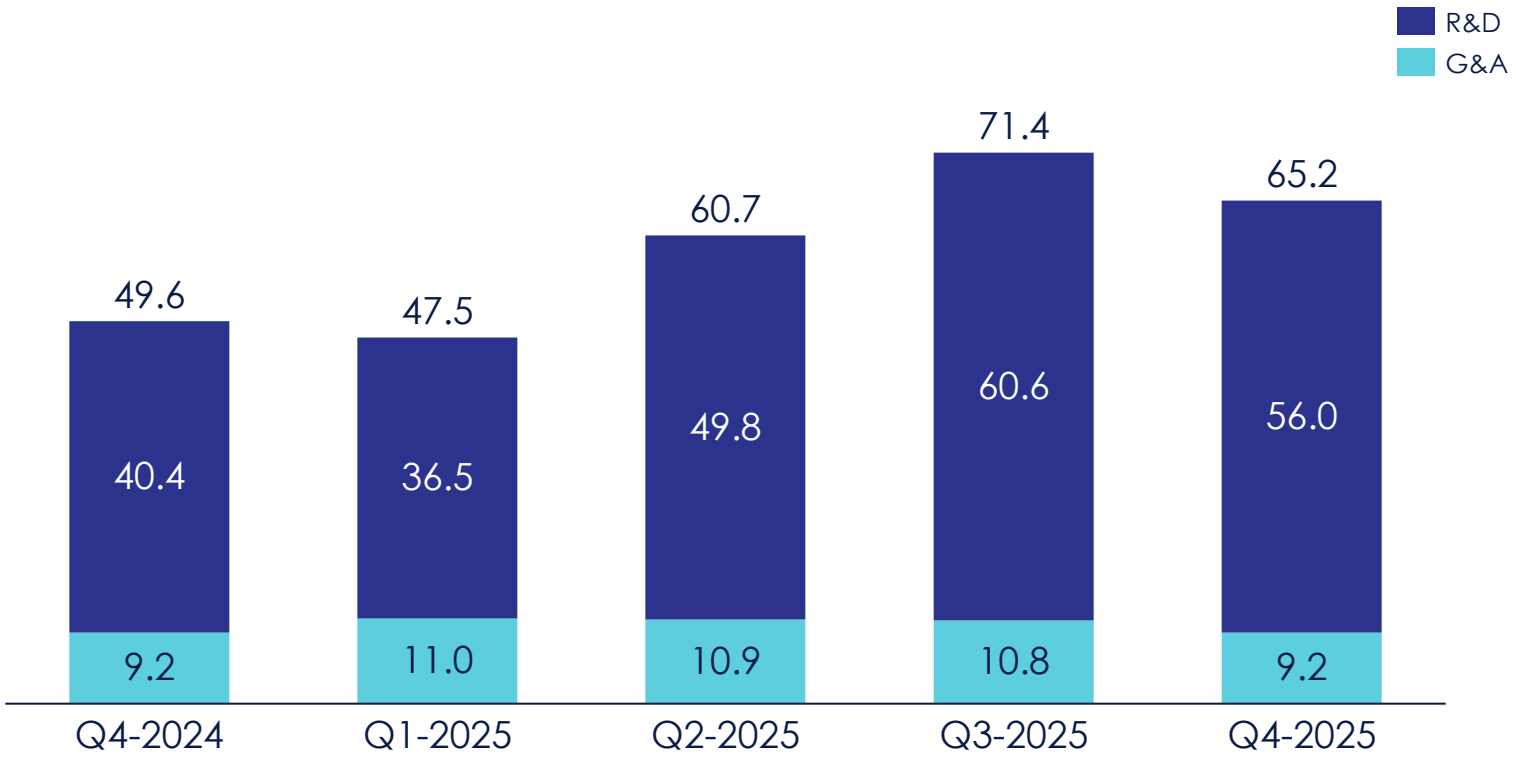
Operating expense by quarter, in USD m



Operating expenses stabilized at around $65m per quarter which includes non-cash expense such as share-based compensation

R&D expense now beyond the peak: VELA-I and VELA-II concluding soon; LEDA and S-OLARIS completed; PPP Phase 3 to be initiated but significantly smaller than VELA

G&A expense reduced in Q4 due to implemented efficiency measures; increases expected for pre-commercial activities

Source: MoonLake Corporate

Finance: We amended the debt facility to fund future growth

MoonLake x Hercules CAPITAL

Original facility terms (Mar 2025)

$75m	Closing of loan facility *Drawn March 2025*
$125m	Primary endpoint of VELA-1 and VELA-2 Phase 3 studies
$50m	Primary endpoint of IZAR-1 and IZAR-2 Phase 3 studies
$50m	FDA accepted the BLA submission
$200m	Additional capital that can be drawn [1]

Updated facility terms (Feb 2026)

$75m	Closing of loan facility *Drawn March 2025*
$25m	Closing of amendment *Feb 2026*
$50m	Clinically meaningful improvement of VELA-1 and VELA-2 at W52, minimum market cap $1.5B
$50m	Primary endpoint of IZAR-1 and IZAR-2 Phase 3 studies
$100m	FDA approved the BLA application
$200m	Additional capital that can be drawn [1]

Updated Cost of capital

8.45% cash interest rate[2,3]

0.25% reduction upon BLA acceptance by FDA

Full flexibility
No obligation to future tranches

Commercial readiness
Adjustment of tranches for same cost of capital allowing MLTX to start commercialization through debt facility

1 Subject to approval by Hercules Capital in alignment with MLTX; 2 WSJ Prime rate + 1.45%, with 8.45% as floor; 3 facility, end-of-term and prepayment charges apply as disclosed in 8-K filing, prepayment charge timeline renewed following amendment.

Source: MoonLake Corporate

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Closing Remarks

Recap: An active **catalyst flow** for MLTX is expected in 2026

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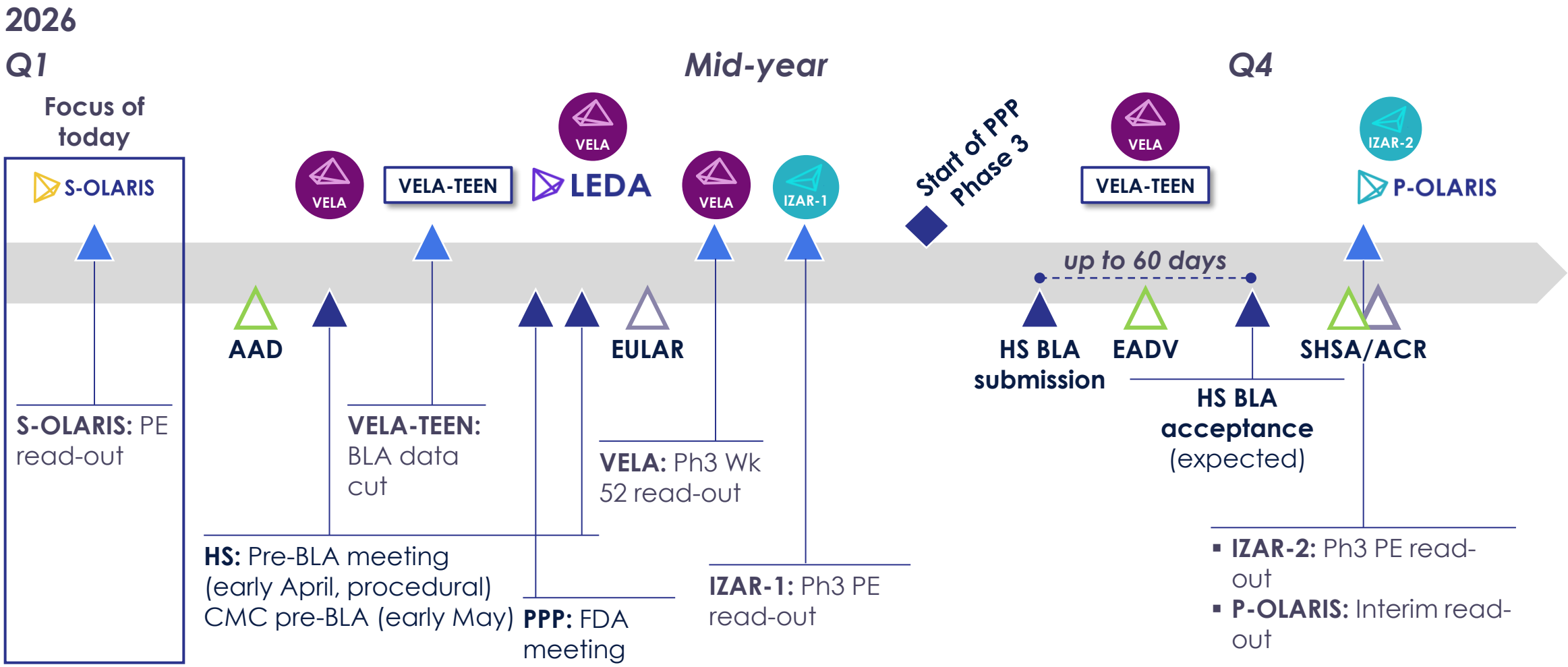
Timeline not scaled

FDA interaction | Trial data | Derm event | Rheum event



All future milestones are anticipated dates

Source: MoonLake Corporate

MoonLake

Q & A

MoonLake