MoonLake

SLK PPP Phase 2 data & Plan Forward

Proprietary

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Summary

PPP is an untapped market – Patients number continues to increase – 15-20k/year, a market size of ~$4-5bn is projected by 2038

Phase 2 LEDA data suggests high potential for SLK in PPP

Biomarker-controlled, multi-center trial in Germany with high responses at wk16 – incl. PPPASI, PPPGA, QoL & Pain

No new safety signals detected for SLK and a very favourable benefit-risk ratio

Compelling mechanistic evidence provides key information for FDA

SLK reduces IL-17A & F in lesions and normalizes the inflammatory drivers underlying pustule formation & skin disruption

Reduction of pustule count & increase of healthy skin confirmed in automated image analysis at patient-level

MLTX plans to advance PPP into the next phase – Design for Ph 3 in place (400 pts) and FDA meeting plan agreed – upcoming Bime trial with Q4 2025 start and expected time of launch similar to SLK

Broader MLTX Strategy

HS BLA process continues as planned with FDA Type B meeting December 15th to provide clarity on potential approval

Interim adolescent HS data shows responses similar to VELA and no new safety signals, and is expected to support BLA

The Rheum programs in PsA (Ph 3) and axSpA (Ph 2) are currently proceeding as planned with readouts anticipated in 2026

Source: MoonLake Corporate

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The PPP opportunity

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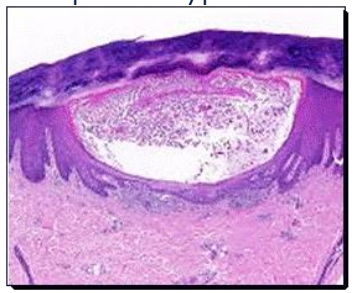
A fast-growing disease with a continued unmet need

Palmoplantar pustulosis (PPP) at a glance

PPP phenotype



Micro-anatomy

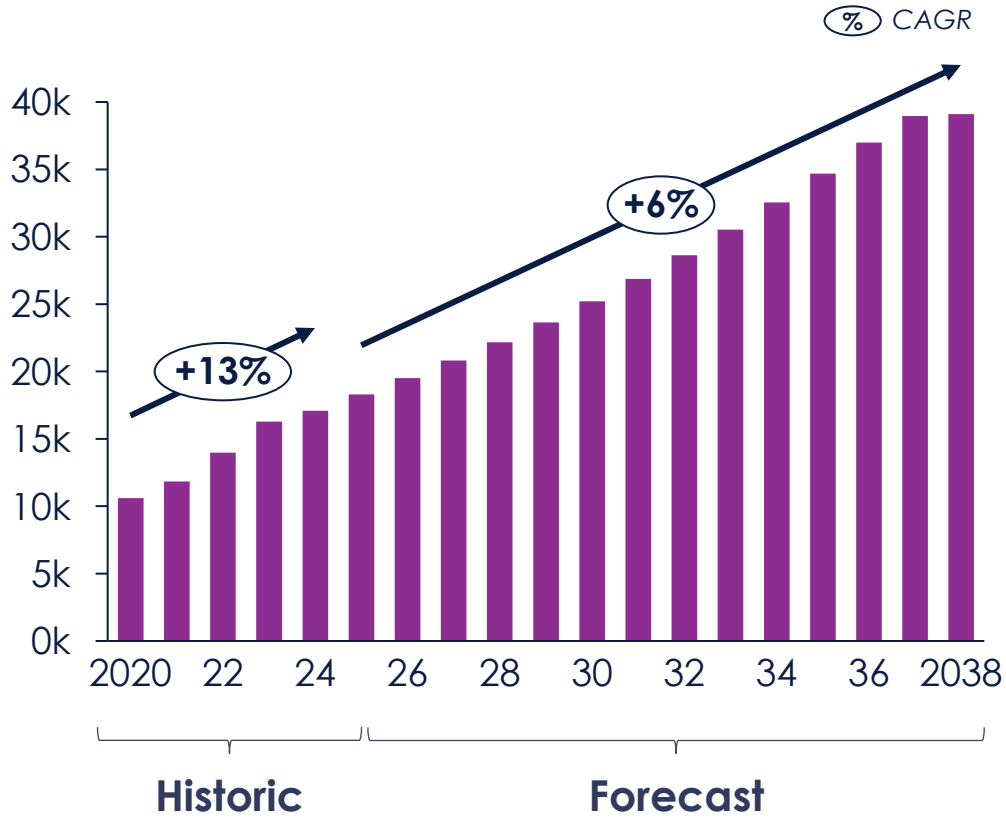
PP phenotype (palmoplantar (plaque-type) psoriasis)

What real-world data shows:

- **~170k unique patients** with positive diagnosis for PPP (L40.3) in 2016-2025 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 (2016-2038 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 November 2025; 4 Assumptions include prevalence, annually treated patients shares. Bx shares, HS pricing, adherence rates

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A barren landscape in terms of drug approvals to date for PPP

Overview of comparable PPP biologics trials *(not based on Head-to Head trials)*

Bolded = primary endpoint

Clinical trials	*APLANTUS Phase 2*[1]	*BI 1368-0016 Phase 2b*	*2PRECISE Phase 3b*	*GAP Phase 2*[1]
PPPASI change from baseline in %	**-57%**[2] **(Wk20)** *Median*	**-48%**[3] * **(Wk16)**	-30%[4] (Wk16)	**-60%**[5] **(Wk24)** *Median*
Patients achieving PPPASI75 in %	14%[2] (Wk20)	21%[3] ** (Wk16)	**27%**[4] **(Wk16)**	34%[5] (Wk24)
1° endpoint met	✓ *vs baseline*	✗ *vs placebo*	✗ *vs placebo*	✓ *vs baseline*
US or European approval	✗	✗	✗	✗

Small molecules and mAbs have shown limited efficacy in PPP

- Otezla: Phase 2 trial showed **modest** efficacy
- Tremfya: Approved in Japan – however, **no successful phase 3** has ever been conducted outside JPN
- TNF, IL-12/23, IL-36, IL-17A, IL-1, CxCR2, G-CSF **failed**

Overall, **no approved treatments** exist for PPP in US and EU

Results of other biologics to-date provide target space for clinical response of SLK

1 Investigator-initiated trials, non-industry study; 2 Wilsmann-Theis D. J Eur Acad Dermatol Venereol. 2021;35:2045-2050; 3 Burden A D et al. Dermatol Ther (Heidelb). 2023;13(10):2279–2297; 4 Mrowietz et al. J Am Acad Dermatol. 2019;80:1344-52; data shown for 300mg arm; 5 Wilsmann-Theis D et al. JAAD Int. 2025;18:69-78; * Only considered non-Asian patients (n = 67); ** Highest reported PPPASI75 results, relating to full population (Asian and non-Asian) within 'high spesolimab' dose group, source: NCT04015518. 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 clinical trials have been conducted.

Source: MoonLake Medical Affairs & Research

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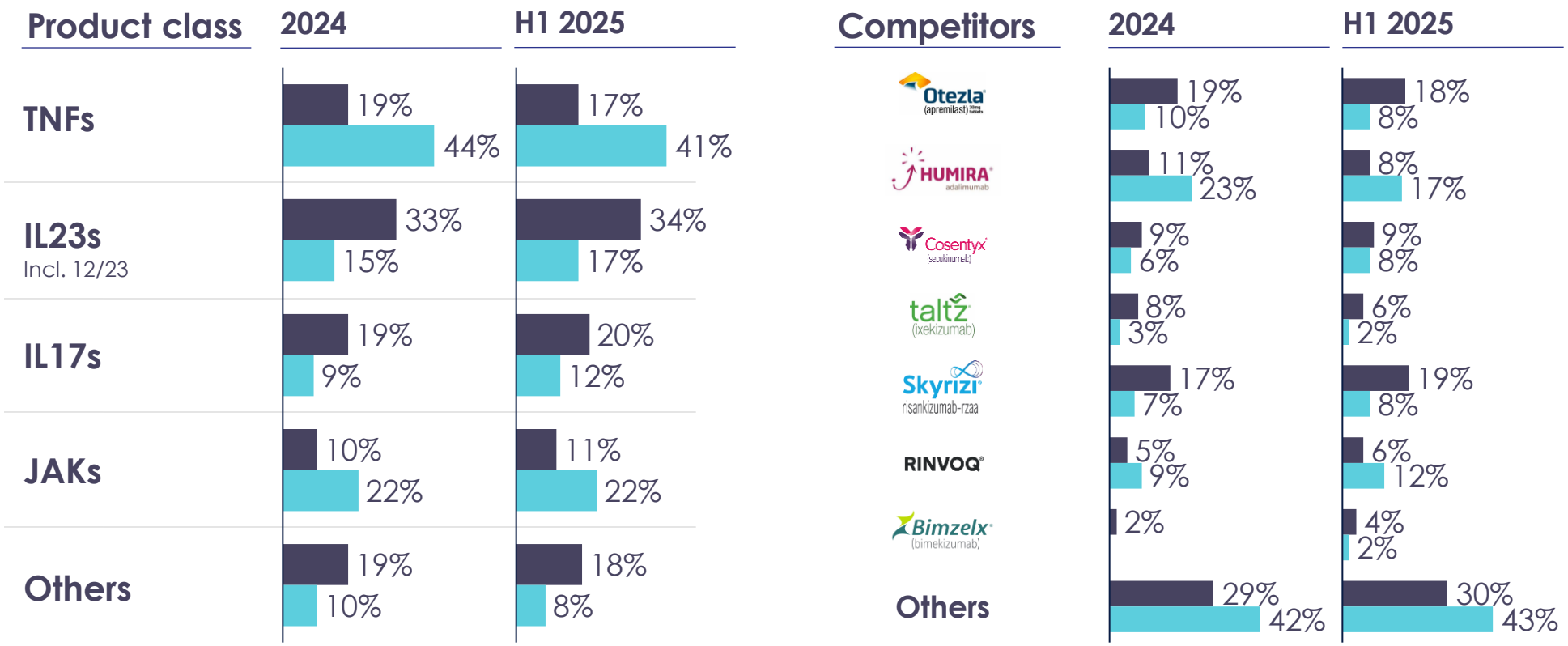
Significant Biologics use off-label incl. in pts without concomitant PsO

PPP: Total Patients in 2024: 14.5k; Total Patients in H1 2025: 7.1k /
PPP w/o PsO: Total Patients in 2024: 6.3k; Total Patients in H1 2025: 2.9k

Prescription market share[1]



1 Based on PRISM claims data: Includes patients with a prescription of the respective drug in 2020/2024/H1 2025 AND a prior PPP (ICD10 L40.3) diagnosis in 2015-2020/2024/H1 2025 2 Humira includes adalimumab biosimilars

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

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LEDA Phase 2 PPP trial data

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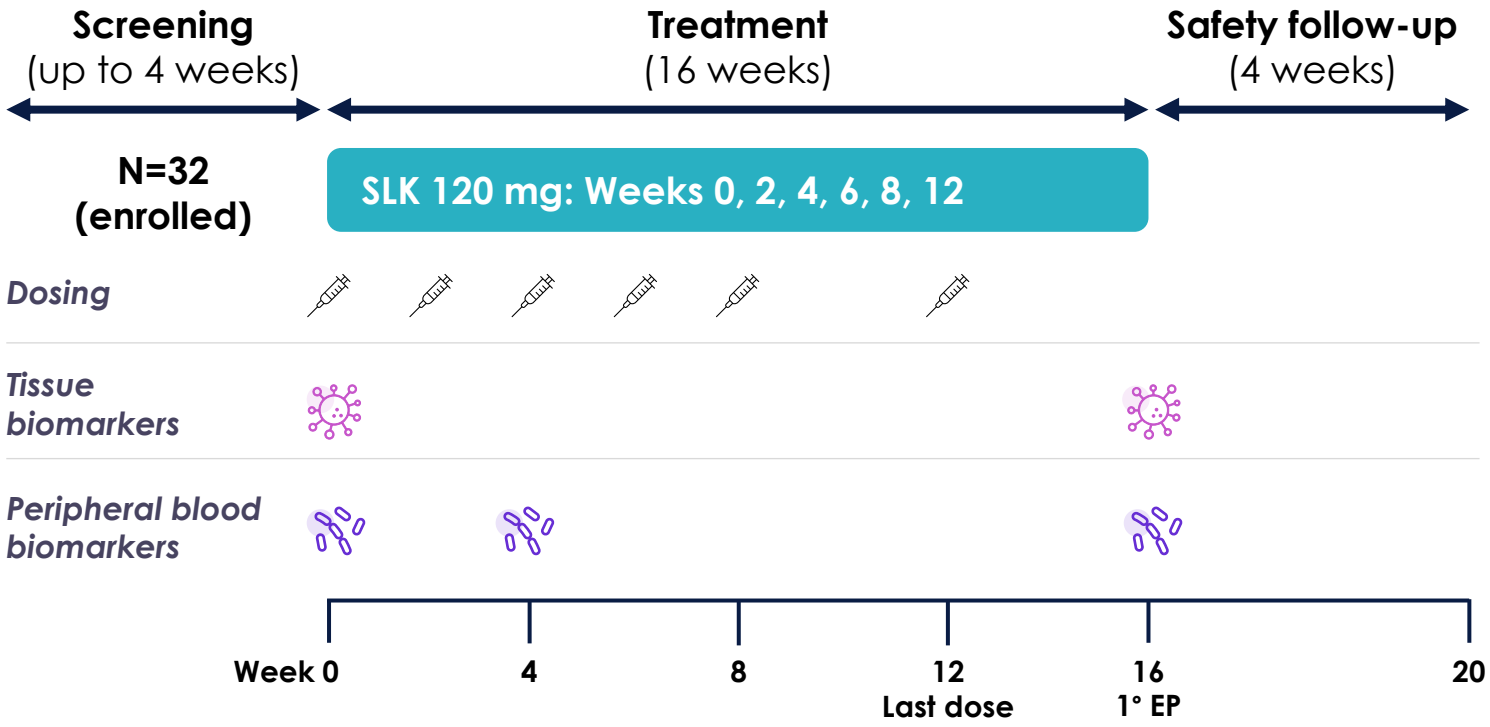
The ongoing Phase 2 LEDA trial

LEDA

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



SLK administration Biopsy

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

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

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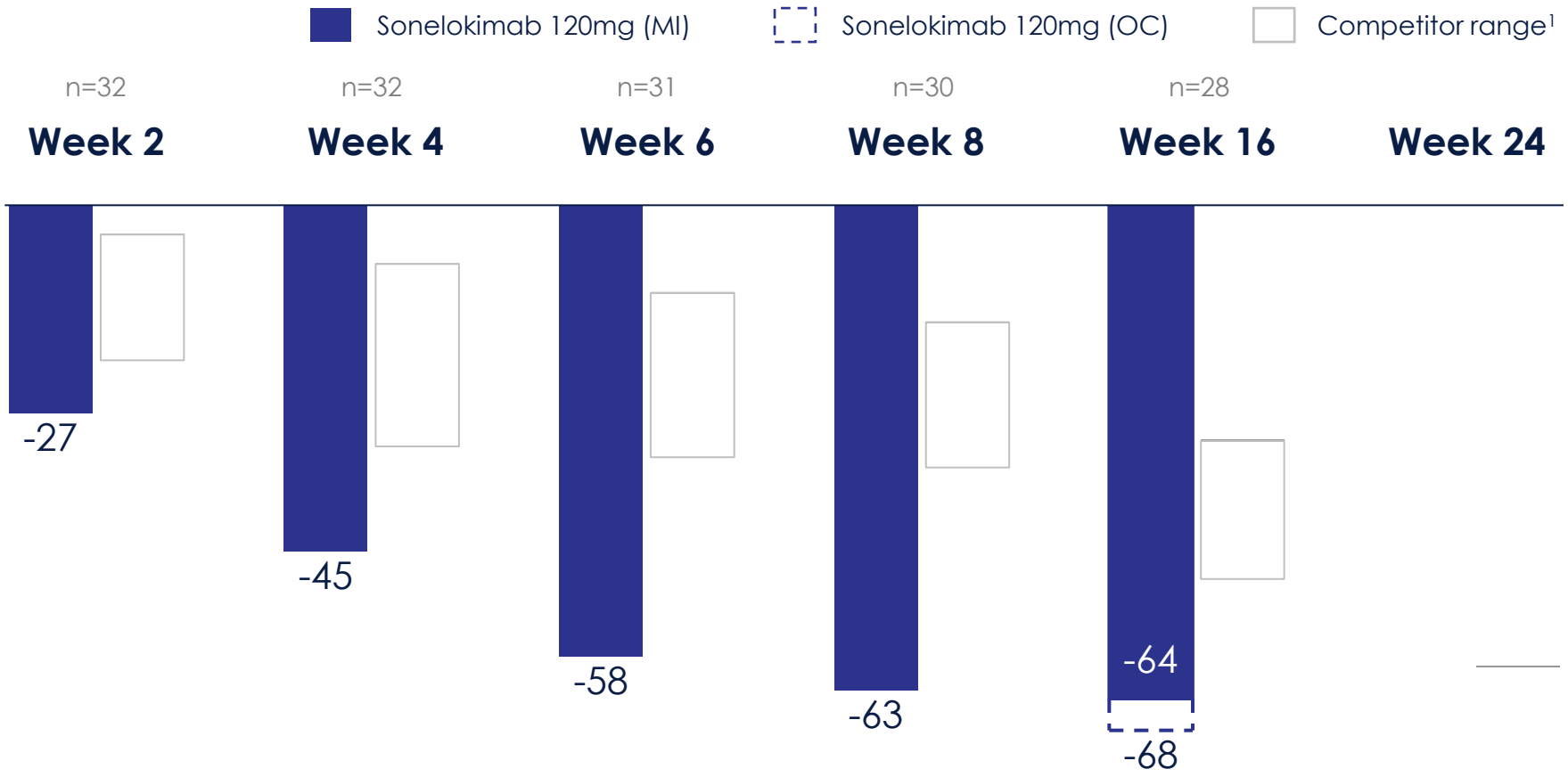
Over 60% reduction in mean PPPASI score from baseline at week 16

MI, Multiple Imputation. OC, Observed Cases

PPPASI mean percent change from baseline, in % reduction



SLK demonstrates a strong reduction of the **PPPASI mean percent change from baseline as soon as week 4**

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 Patients enrolled (for SPEVIGO IIb in 300 and 600mg arm (non-Asian), for 2Precise in 300mg Secukinumab arm); 1 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). Data subject to change until clinical study reports are issued.

Source: MoonLake Biometrics

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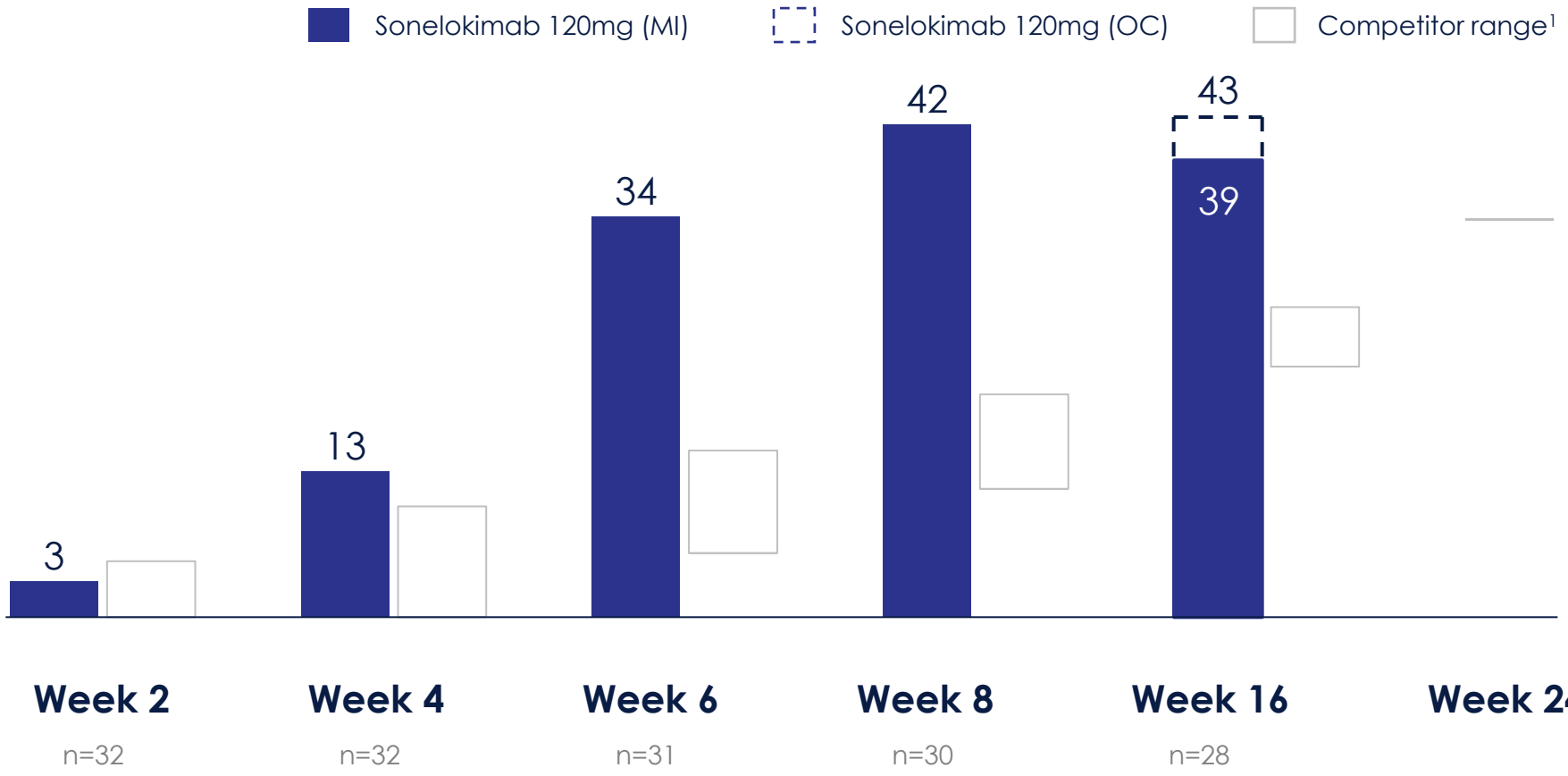
Around 40% of patients achieve PPPASI75 as soon as week 8

PPPASI75 response rate, in % of patients



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 Patients enrolled (for SPEVIGO IIb in 300 and 600mg arm (non-Asian), for 2Precise in 300mg Secukinumab arm); 1 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). Data subject to change until clinical study reports are issued.

Source: MoonLake Biometrics

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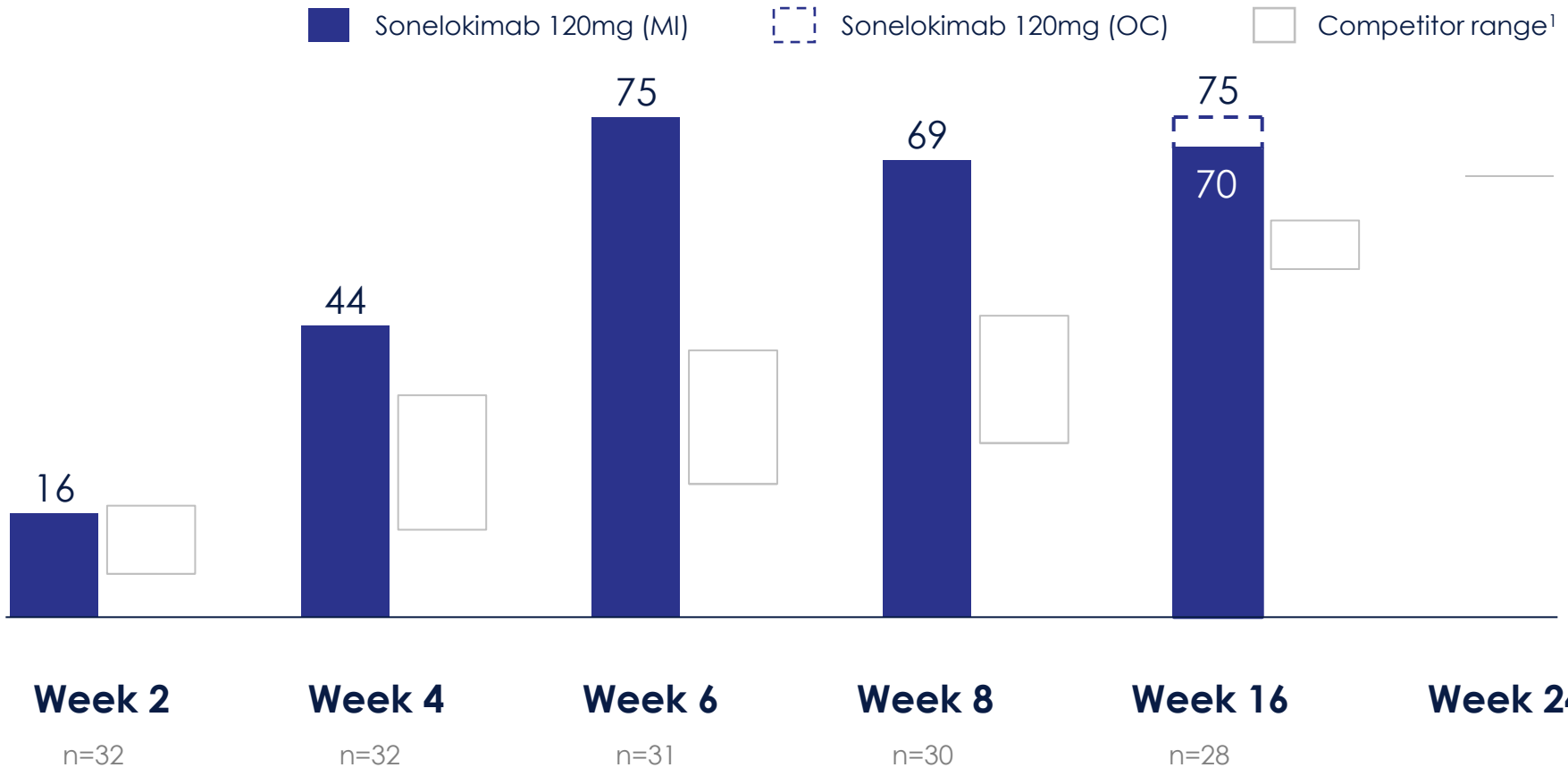
70% + of patients achieve PPPASI50 as soon as week 8

PPPASI50 response rate, in % of patients



SLK also outperforms benchmarks – week 16 PPPASI50 results also outperforming week 24 benchmark by up to 10 pp

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 Patients enrolled (for SPEVIGO IIb in 300 and 600mg arm (non-Asian), for 2Precise in 300mg Secukinumab arm); 1 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). Data subject to change until clinical study reports are issued.

Source: MoonLake Biometrics

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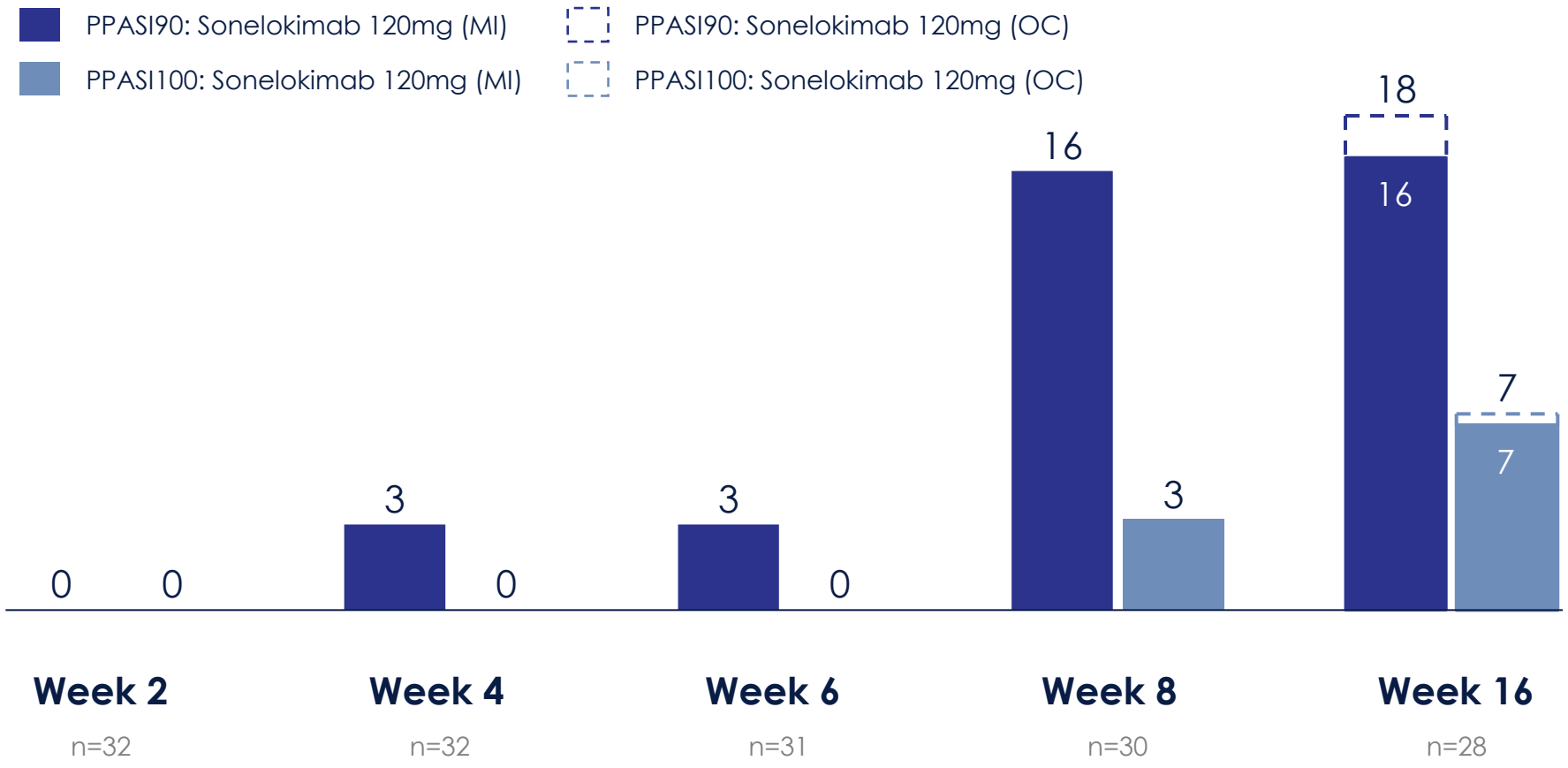
15% + of patients achieve PPPASI90 as soon as week 8

PPPASI90/100 response rate, in % of patients



SLK reaches PPPASI90/100 results for more than 15% patients at week 8 – no benchmark data available for these high endpoints

Data subject to change until clinical study reports are issued.

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SLK shows strong results in UCB's selected primary endpoint

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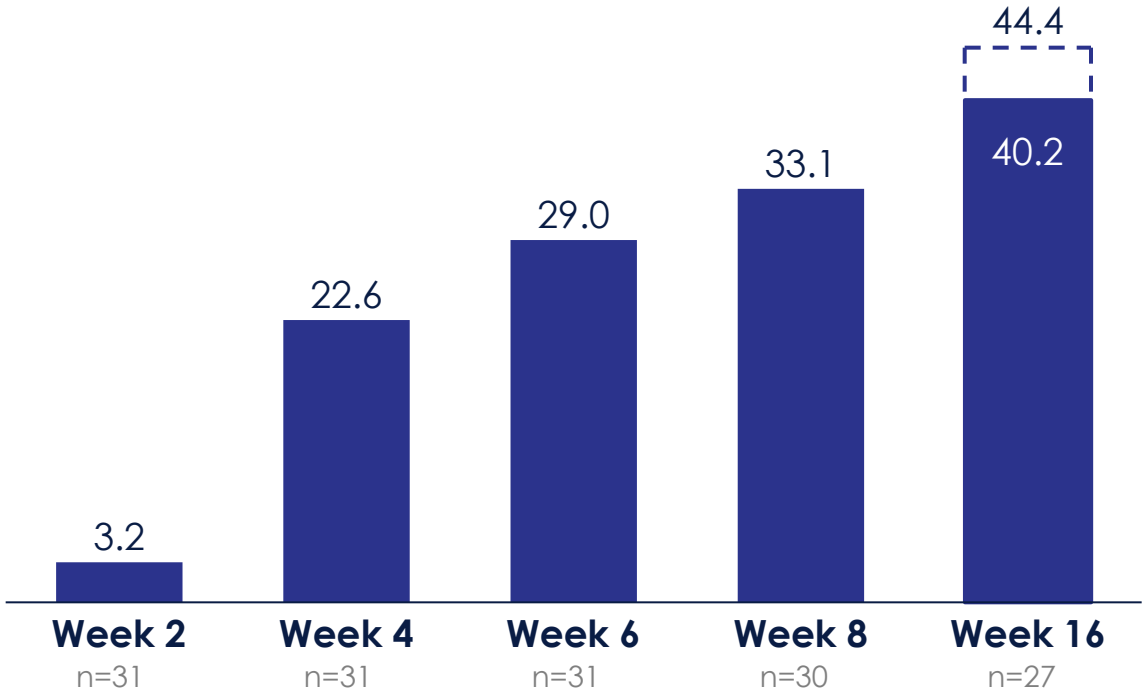
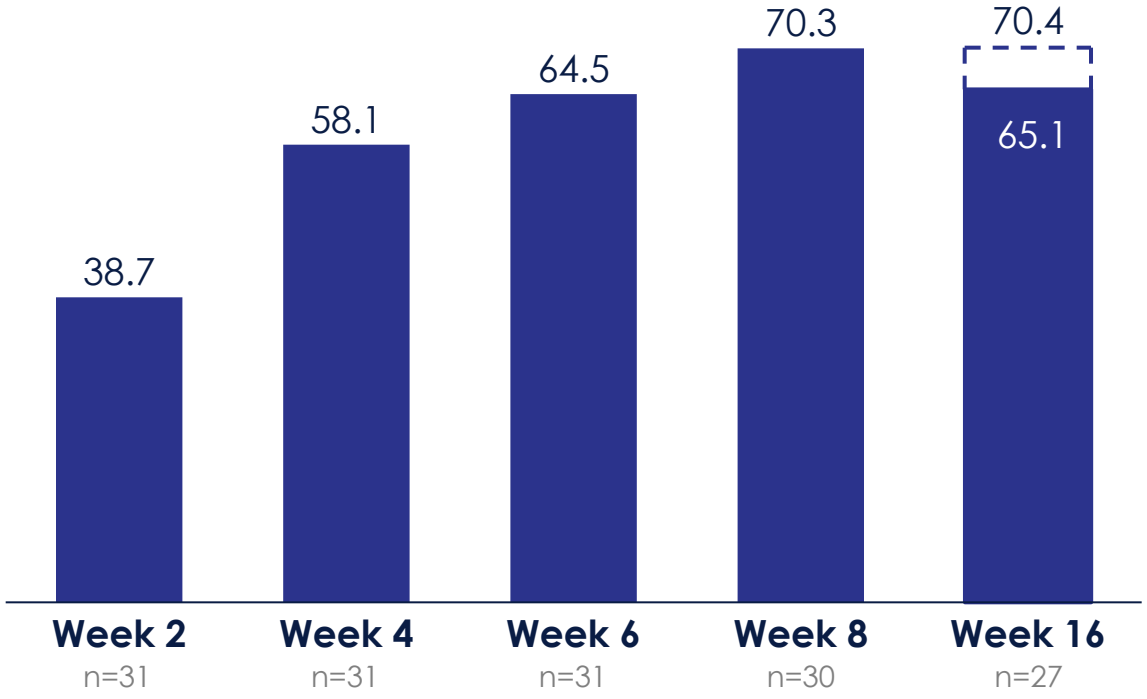
Sonelokimab 120mg (MI) Sonelokimab 120mg (OC)

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



Reflects proportion of patients who **achieved a PPPGA score of 0 (clear) or 1 (almost clear) and a reduction of at least 2 points from baseline** with a baseline score higher than 1

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



Reflects proportion of patients who **achieved a PPPGA score of 0 (clear), 1 (almost clear) or 2 (mild)** with a baseline score higher than 2

Note: PPPGA scores based on physician assessment across categories 0 (clear) to 4 (severe); PPP-IGA and PPPGA represent the same score. Data subject to change until clinical study reports are issued.

Source: MoonLake Biometrics

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Quality of life improves for PPP patients with SLK treatment

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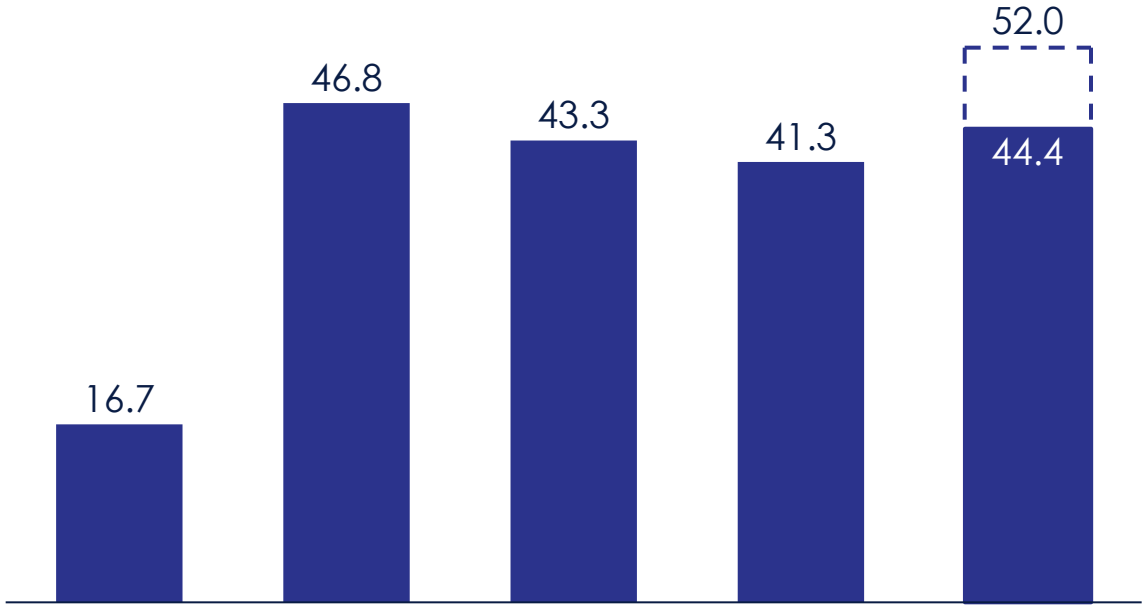
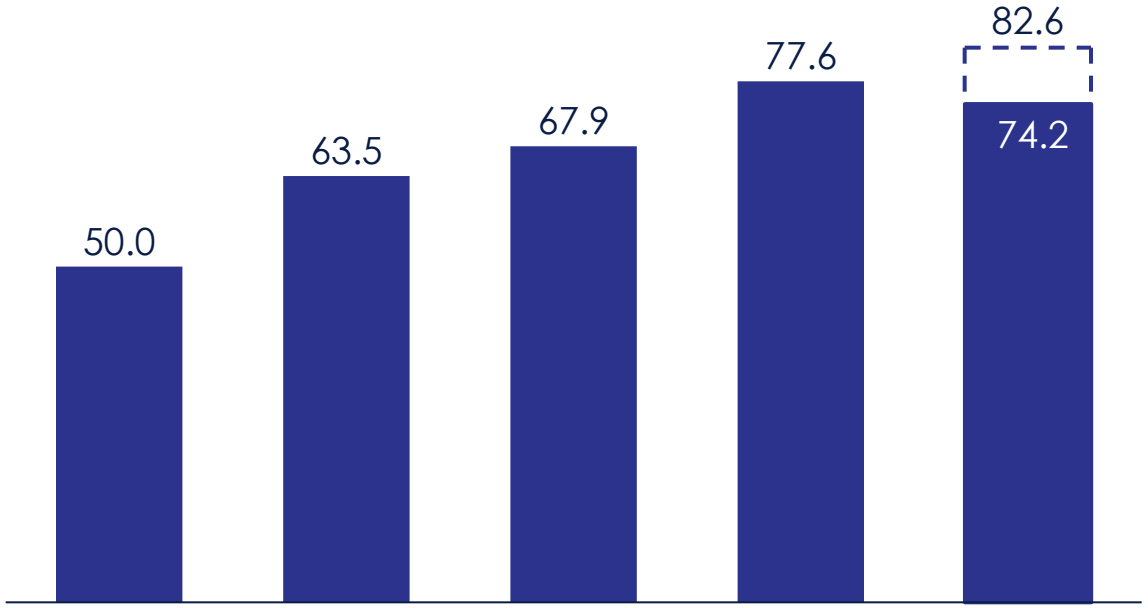
Sonelokimab 120mg (MI) Sonelokimab 120mg (OC)

DLQI 0/1 (BL>1) response rate, in % of patients



Reflects proportion of patients who indicate a DLQI score of 0/1 with a baseline score higher than 1

DLQI MCID-4 (BL≥4) response rate, in % of patients



Reflects proportion of patients who achieved minimally clinically important difference (MCID, i.e., a decrease of at least 4 points in the DLQI) with a baseline score of ≥ 4

Note: DLQI scale ranges from "no effect on patient's life" (0-1 score) to "extremely large effect on the patient's life" (21-30 score). Data subject to change until clinical study reports are issued.

Source: MoonLake Biometrics

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Skin pain is rapidly reduced in PPP patients treated with SLK

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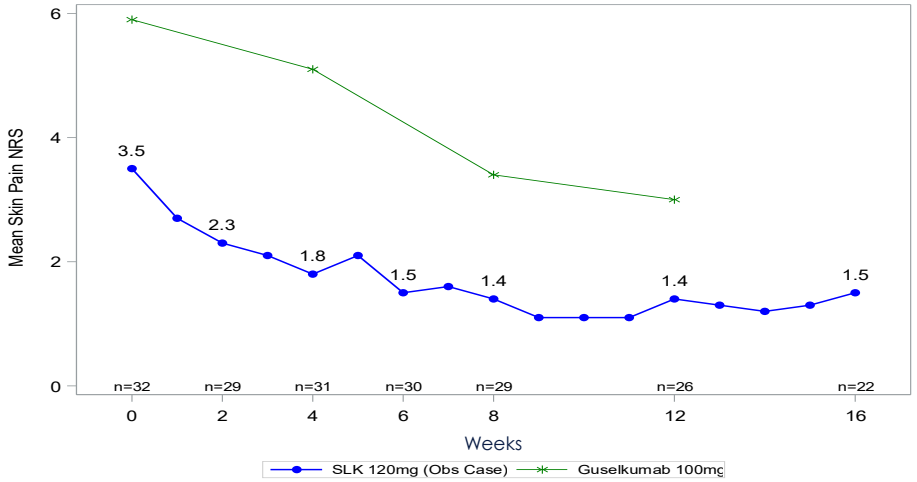
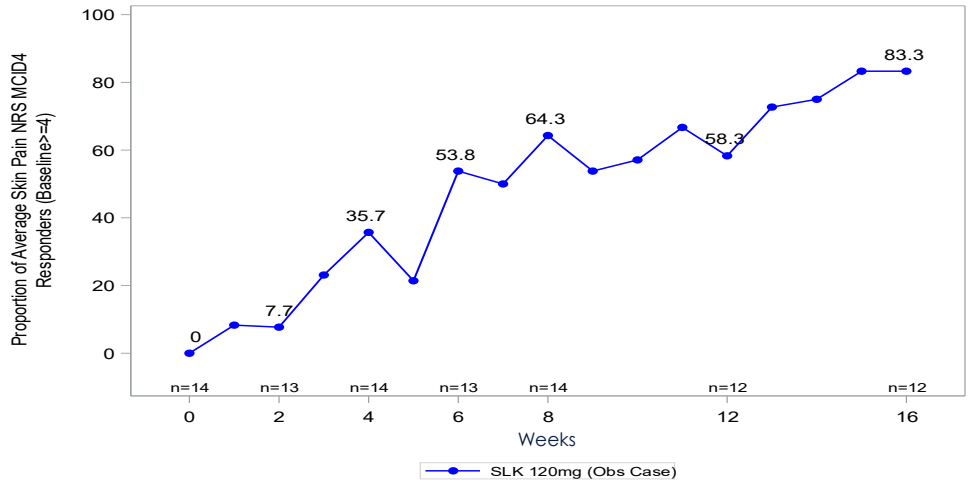
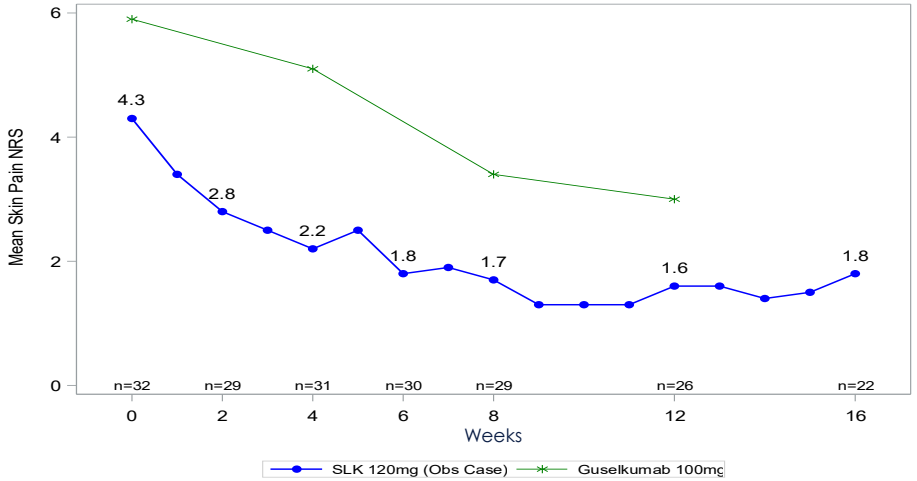
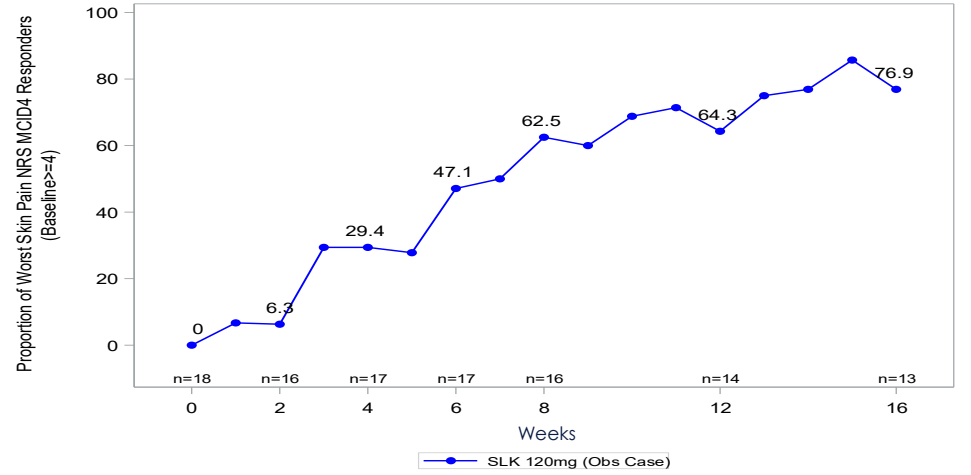
Average 24h Skin Pain





Worst 24h Skin Pain





Average and worst daily skin pain improves rapidly and substantially over 16 weeks of SLK treatment

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 clinical trials have been conducted. Guselkumab (green line, where data is available, Wilsmann-Theis, D et al. JAAD Int., 2024; 18:69-78) did not specify whether it collected average or worst pain scores. Data subject to change until clinical study reports are issued.

Source: MoonLake Biometrics

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LEDA trial with favourable safety profile over 20 weeks

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Treatment-emergent adverse events (TEAE), n (%)	**LEDA** to Week 20	**VELA-1 and VELA-2 Combined** to Week 16	**BE HEARD I/II** to Week 16
	Sonelokimab 120 mg N=32	**Sonelokimab** 120 mg N=559	**Bimekizumab** 320 mg Q2W N=576[1]
Any TEAE	30 (93.8)	376 (67.3)	379 (65.8)
Any Serious TEAE	0	14 (2.5)	15 (2.6)
Any TEAE leading to discontinuation	1 (3.1)	16 (2.9)	22 (3.8)
Most frequent TEAEs of SLK (≥5% with active treatment)			
Nasopharyngitis	13 (40.6)	48 (8.6)	23 (4.0)[2]
Oral candidiasis	6 (18.8)	41 (7.3)	41 (7.1)
TEAEs of interest			
Oral candidiasis	**6 (18.8)**	**41 (7.3)[a]**	**41 (7.1)**
Dermatitis and eczema	**4 (12.5)[3]**	**20 (3.6)[b]**	**35 (6.1)**
Serious infection	0	4 (0.7)	1 (<1)
Diarrhea (non-infectious)	0	2 (0.4)	NR
Hepatic event	1 (3.1)	1 (0.2)[c]	14 (2.4)[f]
Inflammatory bowel disease (IBD)	**0**	**0[d]**	**1 (<1)**
Suicidal ideation and behavior (SIB)	0	0	1 (<1)
Serious hypersensitivity	0	0	0
Major adverse cardiovascular event (MACE)[e]	0	0[f]	0

For illustrative purposes only. Cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted. Trials are still ongoing, and treatment assignment remains blinded to patients and trial site staff; the table only includes events where blinding can still be maintained. Adjudication is ongoing. **a** 3 events of esophageal and 2 of oropharyngeal candidiasis were reported in the sonelokimab group. **b** Patients with events assigned to either of the preferred terms 'dermatitis' and 'eczema'. **c** Of eight patients (2.9%) in the placebo group and 9 patients (1.6%) in the sonelokimab group sent for adjudication for reported hepatic events or lab elevations, three (1.1%) in the placebo group and 1 (0.2%) in the sonelokimab group were adjudicated as potential DILI . **d** 1 event recorded as Crohn's disease in the placebo group was adjudicated as not IBD. **e** Both VELA and BE HEARD programs use Extended MACE definitions. **f** 1 event of transient ischemic attack in the sonelokimab group was adjudicated as not MACE. 1 Data from Kimball A et al. Lancet 2024; 403:2504-2519, EPAR variations for HS (unless otherwise stated); 2 Data from CT.gov listing; 3 Also includes intertrigo, perioral dermatitis. Data subject to change until clinical study reports are issued.

Source: MoonLake Medical & Safety

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Compelling mechanistic data supports the favorable clinical findings

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Regulatory requirements for mechanistic data

- The **FDA has signaled the need for "compelling mechanistic evidence"** in defining trial designs, endpoints and placebo controls, and as part of potential BLA submissions
- **PPP is a disease which is not well understood –** especially in terms of mechanistic aspects and most relevant clinical trial metrics
- **One symptom of this is the unclear results so far in trials –** lack of consistency across scores in same trial and across trials, variable placebos and responses on PPASI
- We now know that **IL-17F is critical in lesions** – incl. through **self-sustaining loops with IL-19** – but this target has not been addressed in trials until now with LEDA

Strong biomarker and mechanistic rationale

1. **Peripheral tissue and blood biomarkers –** showing directly & unequivocally that the SLK targets IL-17A and F[1] in tissue – and that specific biomarkers are modulated in circulation

TISSUE IMMUNE

Olink

2. **Automated analysis of clinical images –** Objective analysis to determine that SLK impacts individual lesions in individual patients, and makes skin healthier – also to control that clinical metrics are valid

scarletred

3. **Concordance between efficacy scores and patient-reported outcomes –** to control that SLK clinical metrics are accompanied by improvement in patient pain and quality of life to match lesion counting with true impact

1 Interleukin 17 A and F are the forms targeted by sonelokimab (SLK)

Source: MoonLake Clinical

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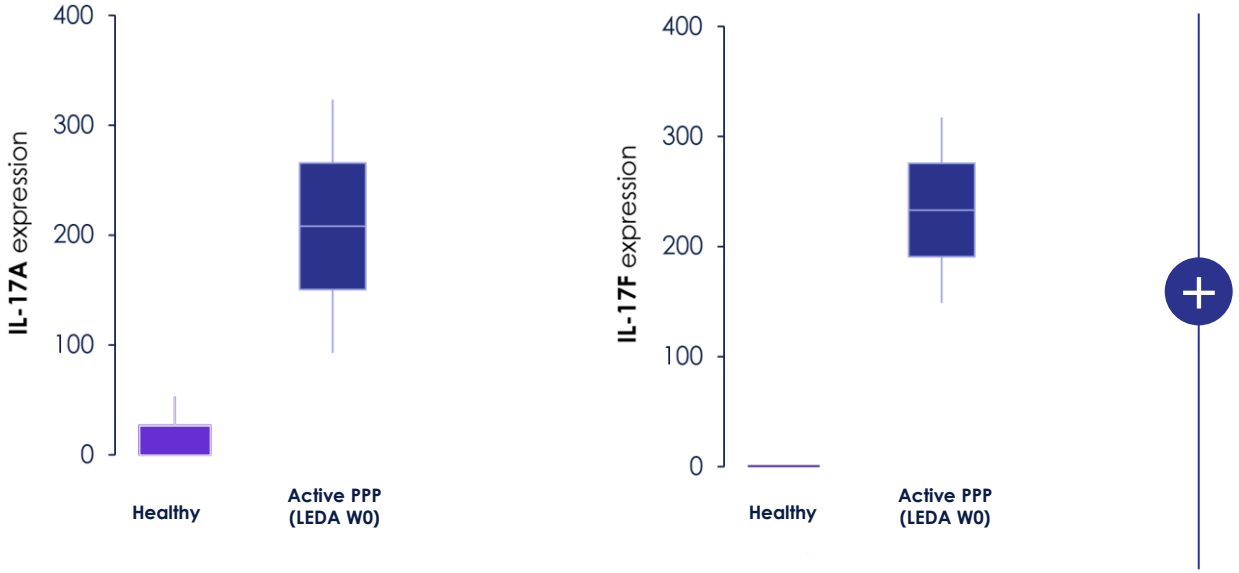
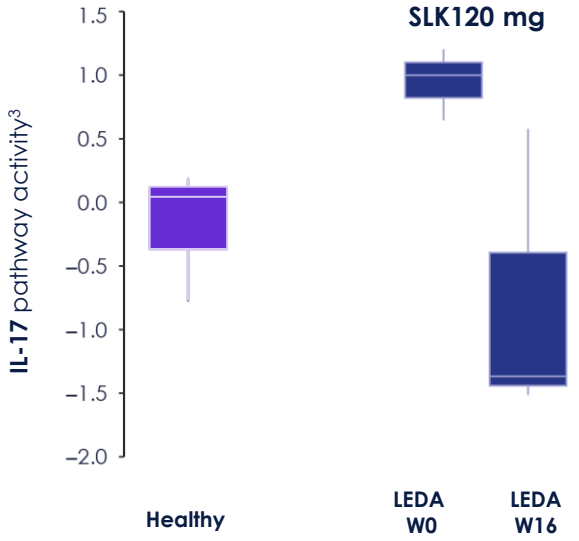
1 Biopsies confirm **IL-17 upregulation in PPP** – with **countereffect by SLK**

Tissue levels of IL-17A and IL-17F[1,2]



Downregulation of IL-17 tissue activity in response to SLK[2,3]



- **IL-17A and IL-17F are upregulated** in lesional PPP compared to healthy skin and identified as key drivers of PPP
- **Treatment with SLK downregulates IL-17 tissue activity –** reflecting clinical response

1 Pseudobulk RNA expression (scRNA-seq); 2 Confirmatory analysis in progress; 3 Activity of the IL-17 pathway (KEGG hsa04657) depicted on y-axis; 4 Paired t-test (*** FDR P<0.001), Healthy n=50, Data represent median (horizontal line), interquartile range (box), and minimum/maximum (vertical lines; outliers are presented as individual data points); 5. NPX arbitrary unit on Log2 scale. Data subject to change until clinical study reports are issued.

Source: MoonLake Medical Affairs & Research in collaboration with *TissueImmune (using tissue collected during the LEDA trial)*

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2 SLK normalizes key systemic biomarkers as early as Week 4

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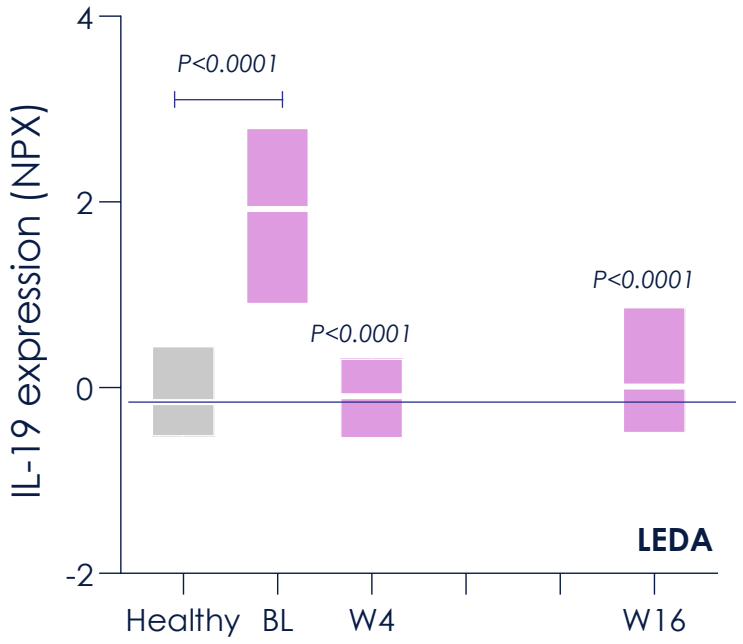
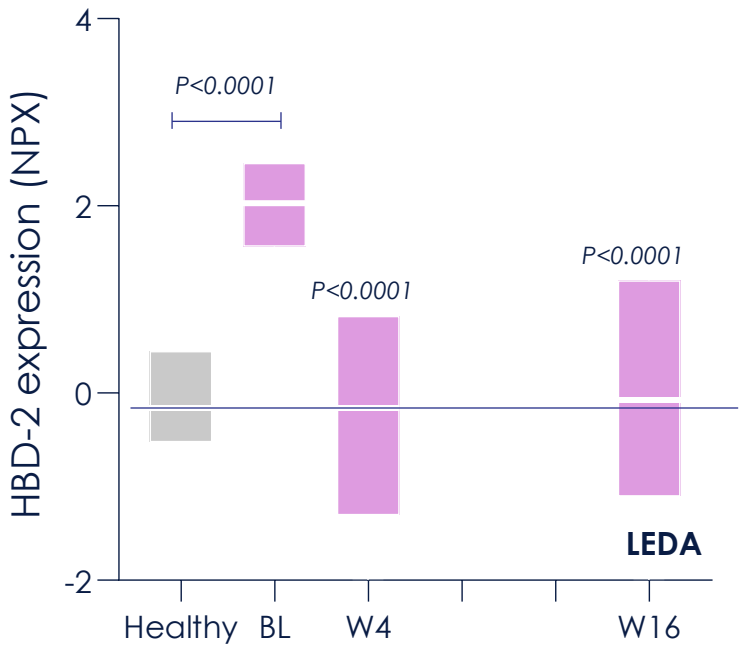
Healthy controls SLK 120mg

IL-19 expression



IL-19 amplifies local IL-17-immune responses[1,2]

HBD-2 expression



HBD2, an antimicrobial peptide, triggers further cell activation and immune cell recruitment[3,4]

IL-19 + hBD-2: **Key strategic biomarkers** in Th17-driven inflammatory skin diseases

- **IL-19 and hBD-2** are significantly upregulated in PPP vs. Healthy controls *(P<0.0001)*
- They identify a **self-sustaining inflammatory loop** that underpins pustule formation and skin barrier disruption – hallmarks of PPP clinical presentation and burden

Protein concentrations are expressed on a log2 scale and presented as the relative concentration unit, NPX. Healthy vs BL: independent t-test. BL vs W4 and BL vs W16: paired t-test. Data represent as median (horizontal line), interquartile range (box). Healthy (healthy controls), n=43; W0 (baseline), n=32; W4 (Week 4, SLK), n=31; W16 (Week 16, SLK), n=32; 1. Wolk K et al. Int J Mol Sci, 2023; 24(2):1276; 2. Kingo K et al. Br J Dermatol, 2007; 156(4):646-52; 3. Kolbinger F et al. J Allergy Clin Immunol, 2017; 139(3):923-932; 4. Prasad S et al. Int J Mol Sci, 2020; 21(1),104. Data subject to change until clinical study reports are issued.

Source: MoonLake Medical Affairs & Research in collaboration with *OLINK*

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2 PPPASI change from baseline – a mirror of SLKs deep molecular impact

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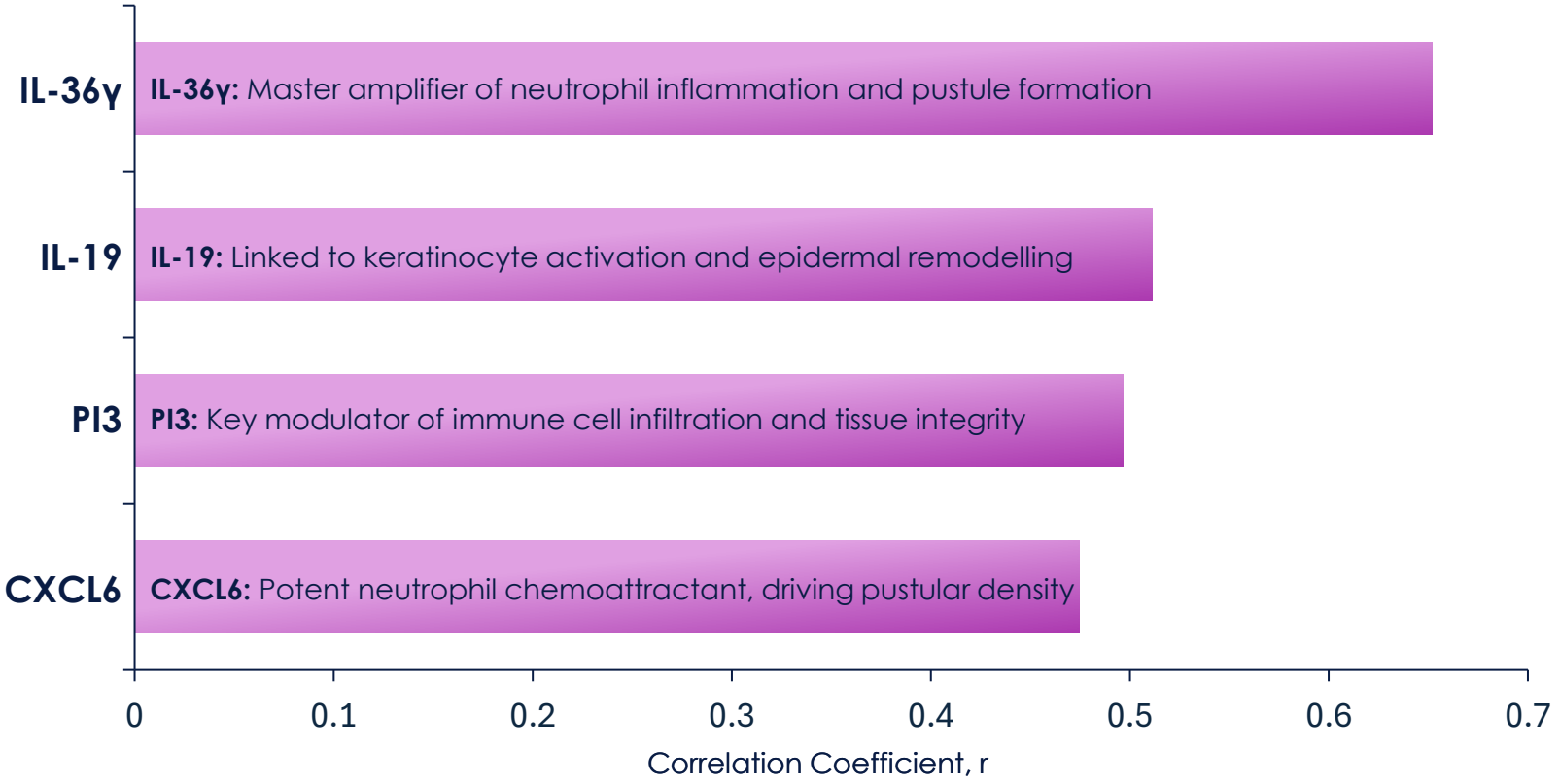
Correlation of Key Biomarkers with SLK PPPASI response, Week 16



- Patients responding to **SLK show modulation of a distinct molecular quartet –** IL-36γ, IL-19, CXCL6, and PI3
- The observed **strong correlation indicates predictive potential for SLK treatment** outcomes

Pearson correlation of change from baseline in PPPASI and biomarker levels after 16 weeks of Tx with SLK; Proteins with p-values < 0.05 (not adjusted for multiplicity). Data subject to change until clinical study reports are issued.

Source: MoonLake Medical Affairs & Research

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2 Automated imaging analysis shows significant SLK effect in PPP

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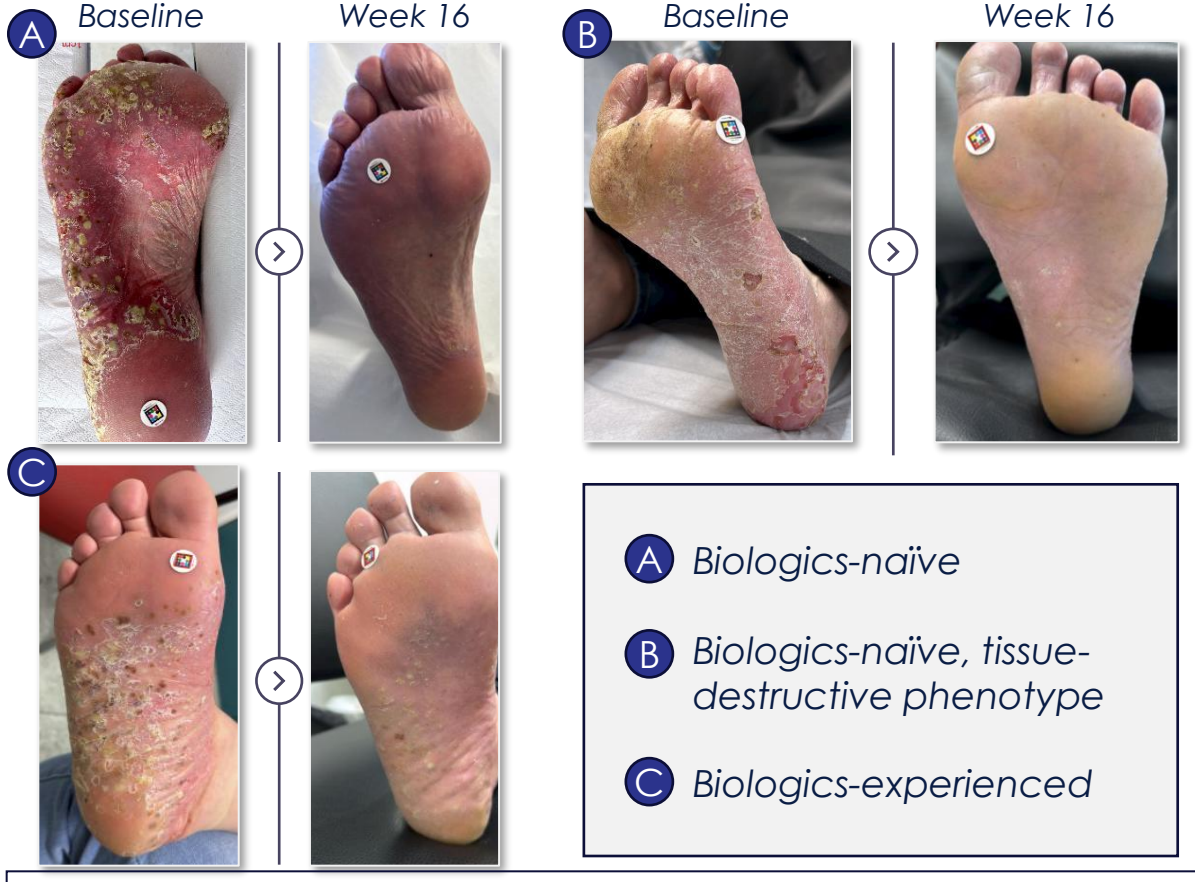
Clinical Effects of SLK in PPP at Wk 16 vs. Baseline



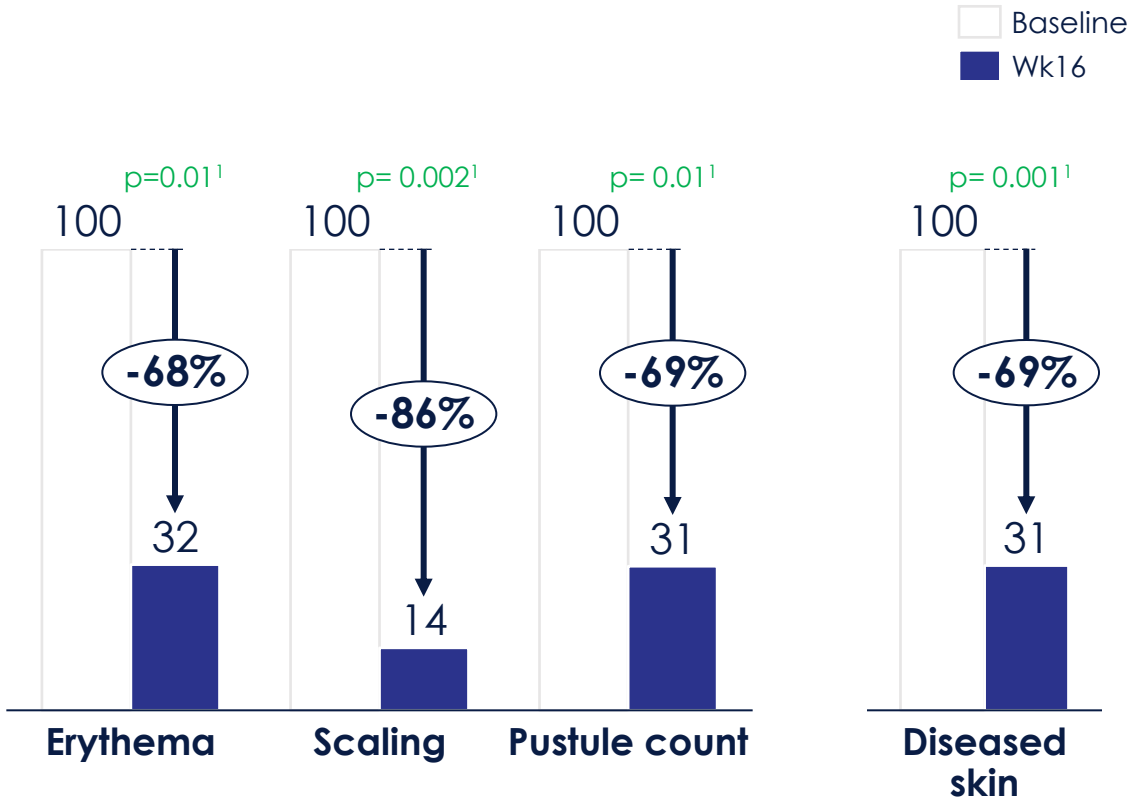
A *Biologics-naïve*

B *Biologics-naïve, tissue-destructive phenotype*

C *Biologics-experienced*

Automated imaging analysis of SLK at Week 16 vs baseline (n=24), in % change relative to baseline

both feet (left and right, per patient) represented



Automated imaging analysis confirms physician's assessment – significant improvements across hallmarks of PPP

1 p-value (t-test), all assessments also significant when applying p-value (Wilcoxon-test). Data subject to change until clinical study reports are issued.

Source: MoonLake Clinical in collaboration with *Scarletred*

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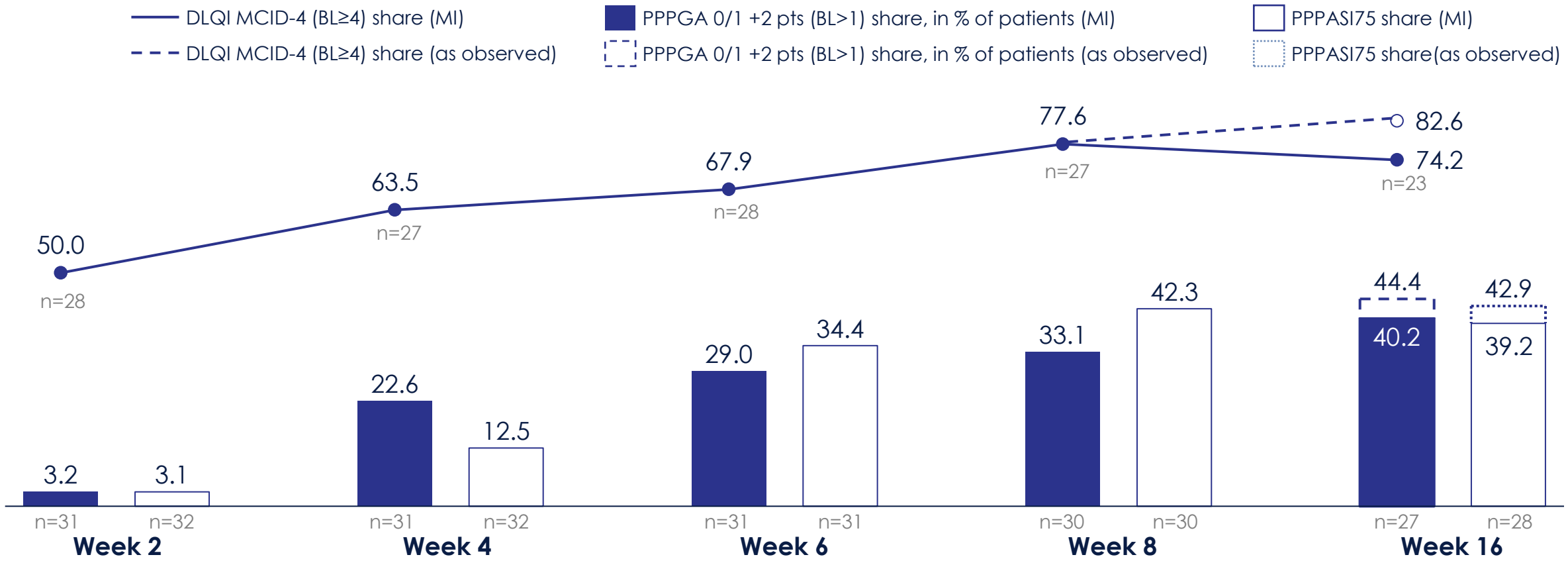
3 SLK shows concordance between efficacy and PRO endpoints

The DLQI improves in lock-step with the constant improvement of SLK's efficacy in PPP



Data subject to change until clinical study reports are issued.

Source: MoonLake Biometrics

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The broader Derm view

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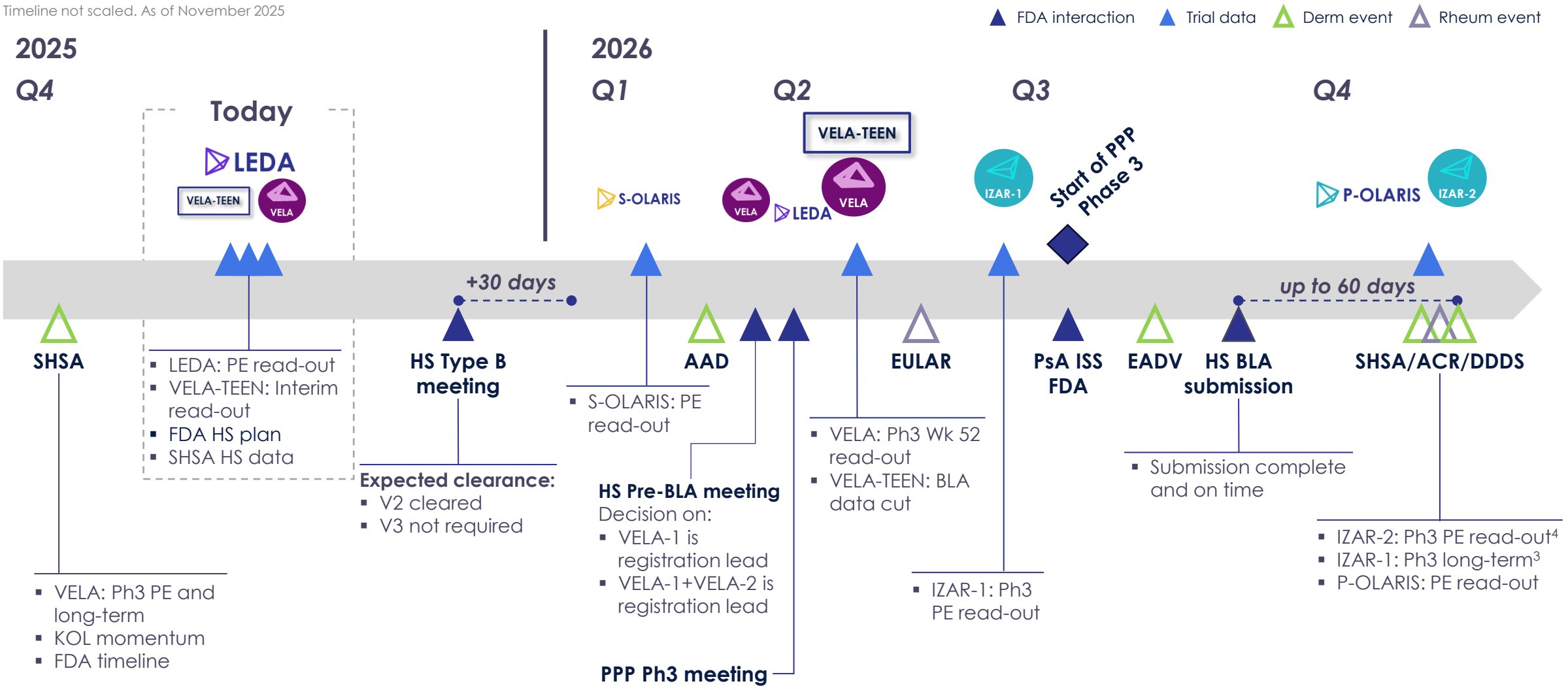
PPP data in the context of a **busy news flow for MLTX**[1]

Timeline not scaled. As of November 2025



1 All future milestones are anticipated dates

Source: MoonLake Corporate

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VELA: Regulatory pathway and new data insights clear and proximal

Regulatory pathway

1

FDA interactions post primary endpoint readout planned – Type B meeting on Dec 15, briefing book sent, and questions for discussion clear

Additional clinical trial data

2

Additional clinical data analyses supporting the differentiation potential for SLK in HS

High level data shown at **SHSA conference from October 31-November 2**

Source: MoonLake Corporate

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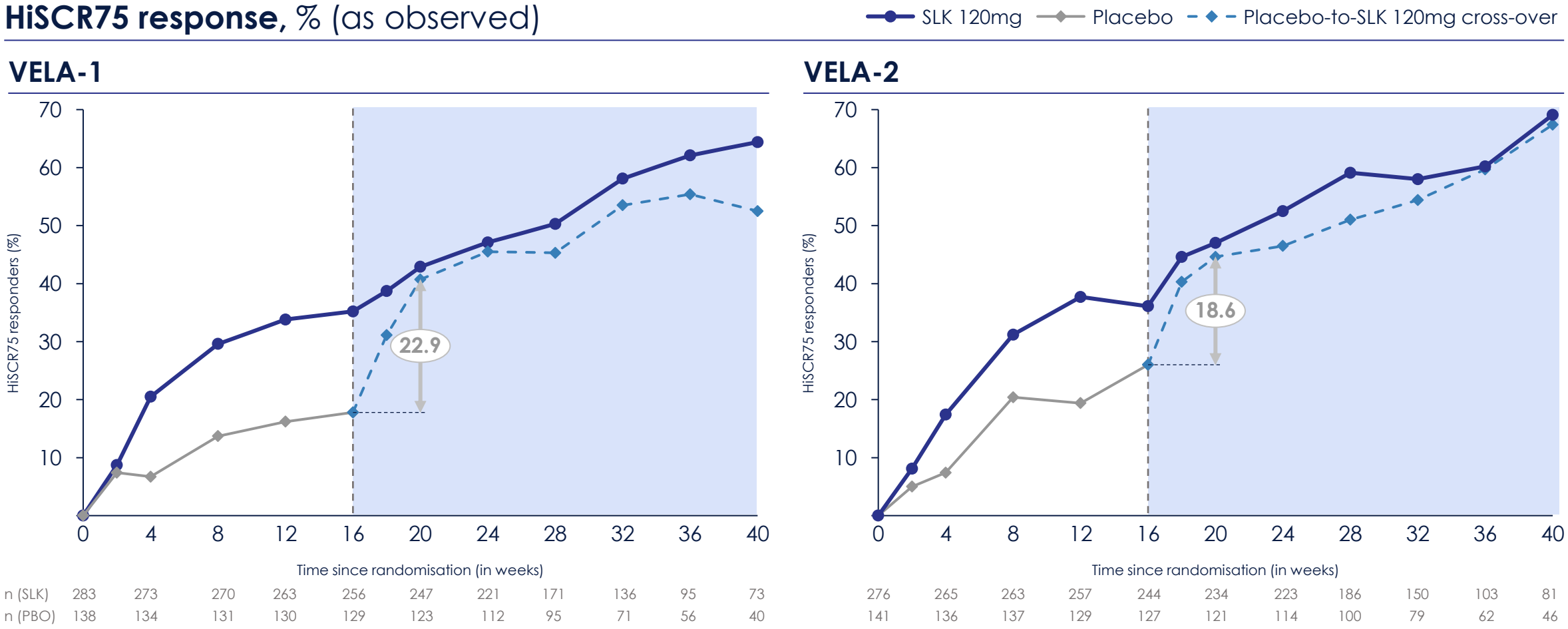
VELA: SLK continues to improve its long-term response profile

HiSCR75 response, % (as observed)



HiSCR75 rate for SLK patients continues to increase in lock-step with placebo cross-over group

Note: Preliminary, pre-specified analysis suggests continued improvement beyond week 16, subject to week 52 database lock. Not multiplicity-controlled. Beyond week 16 n-numbers reflect incomplete data due to trial ongoing. Data subject to change until clinical study reports are issued.

Source: MoonLake Clinical

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VELA: Several competitive label options potentially exist for SLK

Delta to placebo in brackets

Label options for SLK, SLK 120mg at primary endpoint

BKZ label, 320mg at primary endpoint

	VELA-1 W16	**VELA-2** W16	**VELA-1/-2**[3] W16	**MIRA** W12	**VELA-1 & MIRA**[4] W16/W12	**Label**[5,6] W16
HiSCR50[1]	51.0 *(20.7)*	55.6 *(13.4)*	53.3 *(17.0)*	65.7 *(37.8)*	53.8 *(24.3)*	49.9 *(19.5)*
HiSCR75[1]	34.4 *(16.9)*	34.1 *(9.2)*	34.3 *(13.1)*	43.3 *(28.6)*	36.1 *(19.5)*	34.6 *(17.6)*
HiSQOL, mean CfB[2]	-9.6	-11.0	-10.3	-10.6	-9.8	NR
DLQI MCID-4, %[2]	59.7	58.2	59.0	61.4	60.0	NR
Pain, NRS, %[2,7]	28.9	31.8	30.3	NR	NR	NR *(Pain in label but with different metric, HSSQ)*

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 clinical trials have been conducted. 1 Primary Estimand Method (mNRI) for VELA-1 and VELA-2, ITT-NRI for MIRA,, mNRI for BKZ; 2 As observed; 3 Pooled VELA-1 and VELA-2 data; 4 Weighted average of VELA-1 and MIRA, for delta to placebo difference of weighted average SLK and placebo response was taken; 5 Weighted average of BE HEARD I and II – do not exactly match published pooled analysis; 6 Q2W until Week 16 data (BE HEARD I N=289, BE HEARD II N=291) from Kimball A et al. Lancet 2024; 403:2504-2519; 7 Worst skin pain NRS ≥ 3. Data subject to change until clinical study reports are issued.

Source: MoonLake Clinical

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VELA-TEEN: Why did MLTX start a program in adolescent HS?

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Why HS in adolescents matters …

Devastating impact on QoL	Pain, malodour, scarring, emotional strain and social challenges undermine self-esteem, education, and social growth[1]
Early intervention crucial	Timely access to treatment is essential to prevent disease progression and lasting permanent damage
Large patient population	Often underrecognized but claims data show 80k+ total adolescent HS patients in the U.S. in 2025 with 15-20k net new adolescent HS patients each year

… and why MoonLake started the VELA-TEEN program

Parallel development: Running VELA-TEEN alongside adult Phase 3 enabling differentiation in HS from day 1 via label

Category leadership: Positioning MLTX as the HS innovation leader with broad strategic upside across regulatory, commercial, and societal domains

Cross-age coverage: Establishing SLK as the go-to therapy across ages, driving loyalty and preference

Reputation building: Creating goodwill with patient associations, derm societies, and regulators – ultimately boosting brand equity

Payer appeal: Boosting early intervention to potentially cut long-term costs – fewer surgeries, ER visits, and mental health burdens

1. Erin Collier, Vivian Y. Shi & Jennifer L. Hsiao (2021) Management of adolescents with hidradenitis suppurativa, Journal of Dermatological Treatment, 32:8, 1035-1038, DOI: 10.1080/09546634.2020.1716933; 2 Komodo claims data, cut-off date June 30, 2025, extrapolated to full U.S. population, total patients refers to number of patients that are <18 years in a given year that had a previous HS diagnosis, with or without existing claims in that year; net new adolescent patients refers to number of patients with their first HS diagnosis in a given year and that are <18 years old at the time of the claim

Source: MoonLake Medical Affairs & Research

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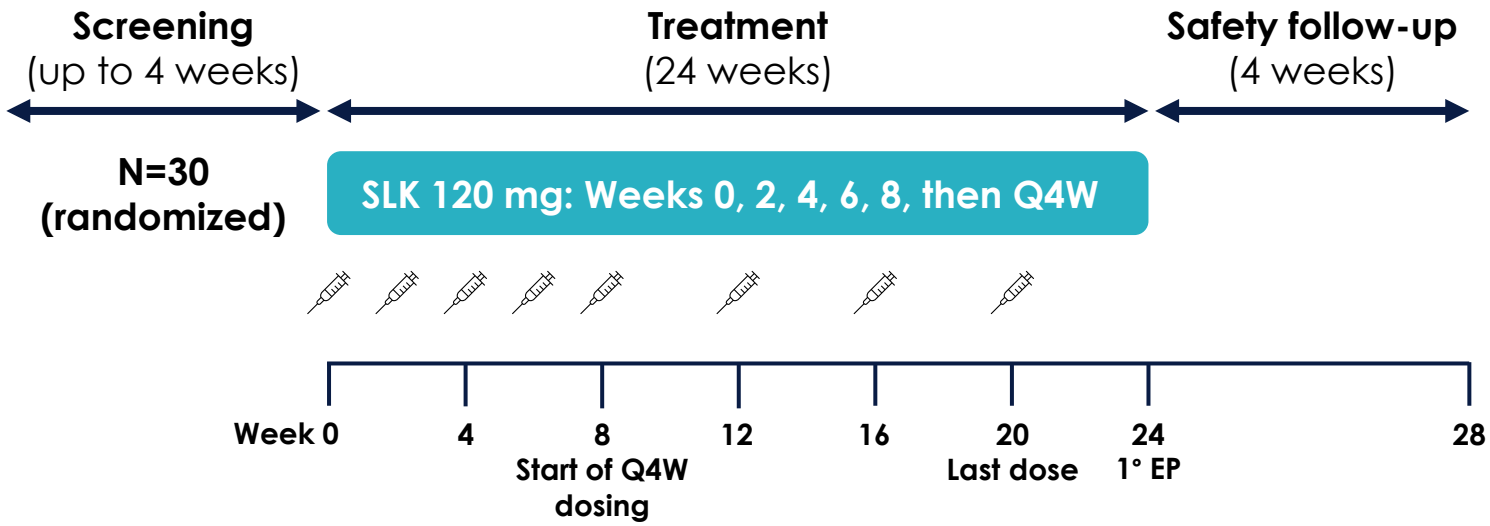
VELA-TEEN: The ongoing adolescent HS Phase 3 trial

MoonLake

VELA-TEEN

Completed SLK administration

An open-label, single-arm study to evaluate the pharmacokinetics and safety of subcutaneous (SC) sonelokimab in adolescents aged ≥12 to ≤17 years at the time of study inclusion with active moderate to severe hidradenitis suppurativa



Endpoints and major milestones

Primary endpoint – pharmacokinetics, safety and tolerability over 24 weeks to allow extrapolation to adult data

Key secondary endpoints (efficacy):

- HiSCR50/75, IHS4 over time
- CDLQI total reduction of ≥2.5 over time – among participants with baseline of DLQI ≥4
- ≥30% reduction and ≥2-unit reduction over time in the NRS30 for pain in PGA – among participants with baseline of NRS ≥3

Major anticipated milestones:

- FPI: Jan 2025
- LPI: Q1 2026
- BLA data cut: Q2 2026

Q4W, every 4 weeks; HiSCR, Hidradenitis Suppurativa Clinical Response; IHS4, International Hidradenitis Suppurativa Severity Score System; CDLQI, Children's Dermatology Life Quality Index; NRS30, Numerical Rating Scale; PGA, Physician Global Assessment

Source: MoonLake Clinical

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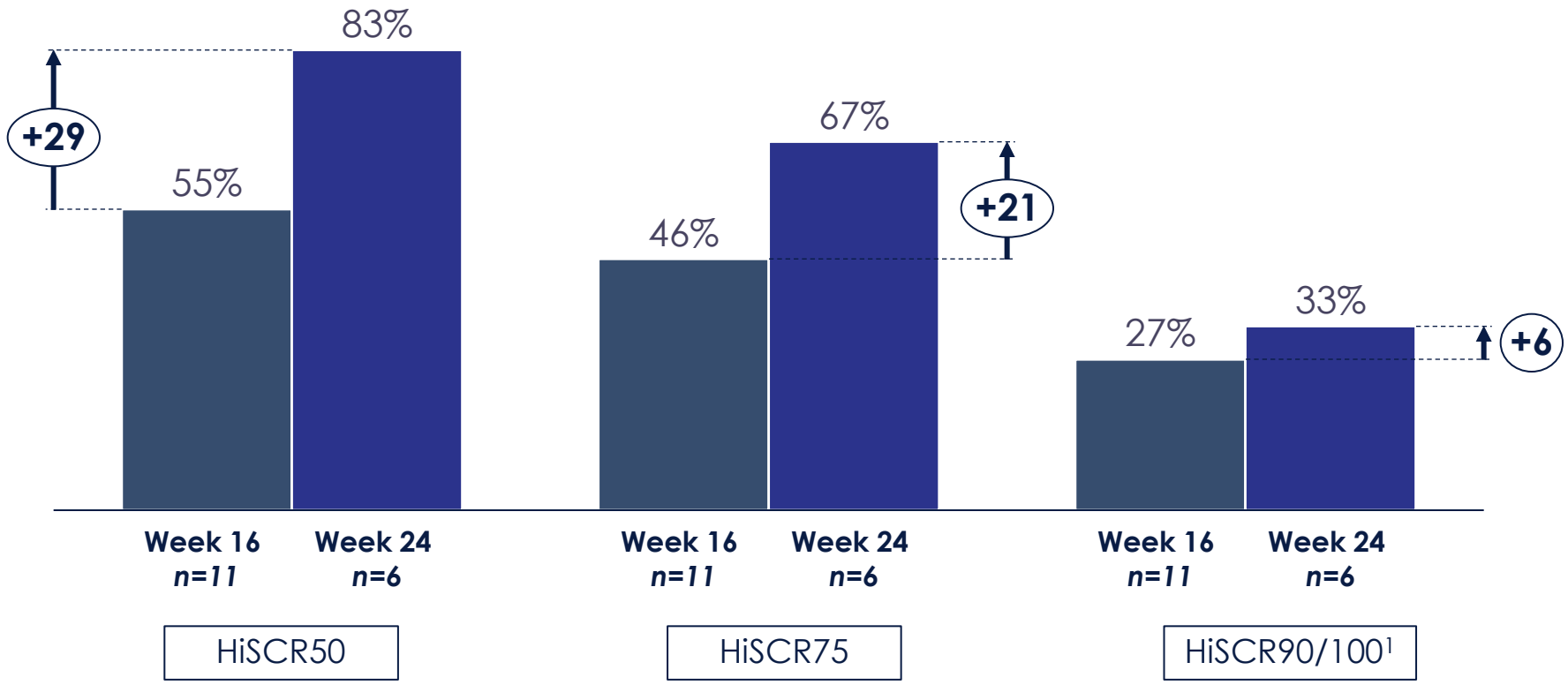
VELA-TEEN: Strong interim efficacy results across HiSCRs in adolescents

HiSCR response rates (mNRI & NRI), in % of patients



Strong results in VELA-TEEN

- **As soon as Week 16, more than 45% of patients achieved HiSCR75 –** with 25%+ achieving HiSCR90
- Data from the first six patients reaching week 24 indicate a strong further **improvement at Week 24 –** e.g., 21 pp for HiSCR75

1 HiSCR90/100 with same results. Data subject to change until clinical study reports are issued.

Source: MoonLake Biometrics

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VELA-TEEN: Favourable safety profile over 28 weeks

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Treatment-emergent adverse events (TEAE), n (%)	**VELA-TEEN** to Week 28	**VELA-1 and VELA-2 Combined** to Week 16	**BE HEARD I/II** to Week 16
	Sonelokimab 120 mg N=20	**Sonelokimab** 120 mg N=559	**Bimekizumab** 320 mg Q2W N=576[1]
Any TEAE	8 (40.0)	376 (67.3)	379 (65.8)
Any Serious TEAE	0	14 (2.5)	15 (2.6)
Any TEAE leading to discontinuation	1 (5.0)	16 (2.9)	22 (3.8)
Most frequent TEAEs of SLK (≥5% with active treatment)			
Nasopharyngitis	0	48 (8.6)	23 (4.0)[2]
Oral candidiasis	1 (5.0)	41 (7.3)	41 (7.1)
TEAEs of interest			
Oral candidiasis	**1 (5.0)**	**41 (7.3)[a]**	**41 (7.1)**
Dermatitis and eczema	**1 (5.0)**	**20 (3.6)[b]**	**35 (6.1)**
Serious infection	0	4 (0.7)	1 (<1)
Diarrhea (non-infectious)	0	2 (0.4)	NR
Hepatic event	0	1 (0.2)[c]	14 (2.4)[f]
Inflammatory bowel disease (IBD)	**0**	**0[d]**	**1 (<1)**
Suicidal ideation and behavior (SIB)	0	0	1 (<1)
Serious hypersensitivity	0	0	0
Major adverse cardiovascular event (MACE)[e]	0	0[f]	0

For illustrative purposes only. Cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted. Trials are still ongoing, and treatment assignment remains blinded to patients and trial site staff; the table only includes events where blinding can still be maintained. Adjudication is ongoing. **a** 3 events of esophageal and 2 of oropharyngeal candidiasis were reported in the sonelokimab group. **b** Patients with events assigned to either of the preferred terms 'dermatitis' and 'eczema'. **c** Of eight patients (2.9%) in the placebo group and 9 patients (1.6%) in the sonelokimab group sent for adjudication for reported hepatic events or lab elevations, three (1.1%) in the placebo group and 1 (0.2%) in the sonelokimab group were adjudicated as potential DILI . **d** 1 event recorded as Crohn's disease in the placebo group was adjudicated as not IBD. **e** Both VELA and BE HEARD programs use Extended MACE definitions. **f** 1 event of transient ischemic attack in the sonelokimab group was adjudicated as not MACE. 1 Data from Kimball A et al. Lancet 2024; 403:2504-2519, EPAR variations for HS (unless otherwise stated); 2 Data from CT.gov listing. Data subject to change until clinical study reports are issued.

Source: MoonLake Medical & Safety

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How dermatology indications drive value for SLK

MoonLake

Derm

		Market size ($, 2035)
 **HS** *(Phase 3)*	▪ **High unmet need persistent despite** multiple approved therapies ▪ **Phase 3 trial completed** to evaluate efficacy and safety in adults with moderate-to-severe HS ▪ **SLK results showing strong efficacy results,** in line with competitors and **clean safety profile**, with **better convenience**	**10-15bn** (11-15% growth from '22)
 **PPP** *(Phase 2)*	▪ **"HS-like" disease,** key priority for Derms with large unmet need ▪ **~450k+ patients** anticipated by 2038, **with no approved drug** available[1] ▪ **SLK interim data demonstrating dramatical improvement** across all outcomes and compared to any existing trials	**3-4bn** (12% growth from '22)
 **Adol HS** *(Phase 3)*	▪ **First clinical trial in adol. HS,** addressing critical gap for derms ▪ **Opportunity** to control progressive disease pre-irreversible damage ▪ **Parallel to adult HS Ph 3,** allowing further differentiation as "HS leader"	**1-2bn** (9% growth from '22)

1 Outside of Japan; 2 Limited disease control – even at lower levels: ~40% of Humira pts do not reach ASAS20 at w12 based on ATLAS trial data

Source: MoonLake Corporate

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