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MoonLake Immunotherapeutics

R&D Day

San Diego, during AAD

March 10th 2024

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Welcome to our R&D Day

Logistics

Date: March 10th, 2024
Time: 09.00-11:30 PST
Location: Westin San Diego Bayview
(Webcast also available)

Agenda

Topic	Sub-topics	Speaker	Timing
Introduction	- Welcome & session details	Matthias Bodenstedt	5 mins
PsA *Going beyond in Rheumatology*	- PsA, a multi-domain challenge - SLK in a competitive context - ARGO data read-out (24 weeks) - Next steps on Ph 3 program	Prof. Joseph Merola Kristian Reich	40 mins
HS *A franchise building indication in Derm*	- HS, a devastating disease - The MIRA data in context - Regulatory feedback & Ph 3 program - Market size & potential	Prof. Ken Gordon Kristian Reich Jorge Santos da Silva	40 mins
New frontiers for SLK and MLTX	- Unlocking the value of SLK - New Indications - Path forward catalysts 2024/2025	Jorge Santos da Silva	20 mins
Moving Forward	- Financials & next steps - Next steps for MLTX	Matthias Bodenstedt	5 mins
Q&A session			To end

Source: MoonLake Corporate

Disclaimer

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Certain information contained in this presentation relates to or is based on studies, publications, surveys and our own internal estimates and research. In this presentation, we rely on, and refer to, publicly available information and statistics regarding market participants in the sector in which we compete and other industry data. Any comparison of us to any other entity assumes the reliability of the information available to us. We obtained this information and statistics from third-party sources, including reports by market research firms and company filings. In addition, all of the market data included in this presentation involve a number of assumptions and limitations, and there can be no guarantee as to the accuracy or reliability of such assumptions. Finally, while we believe our internal research is reliable, such research has not been verified by any independent source and we have not independently verified the information.

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Source: MoonLake Corporate

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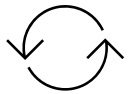
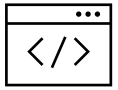
Instructions for this session

Please **take note of the disclaimer** on the previous page

You can **submit your questions** through the Q&A function – questions are only visible to the moderators – we will address **as many questions as possible** at the end of this session



The presentation and a **replay** will be made available on our IR website



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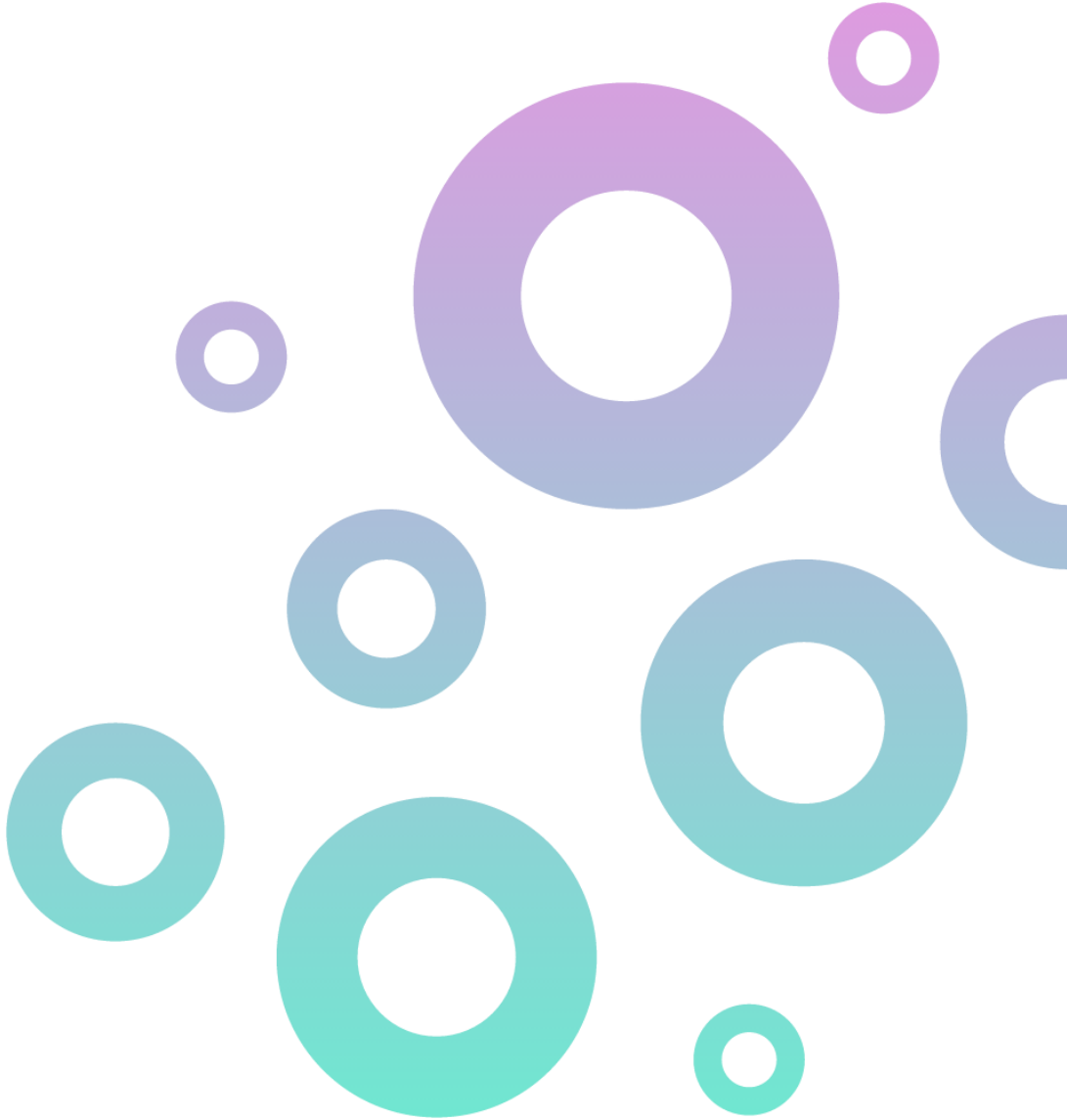

Source: MoonLake Corporate

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- **Founded in 2021** in Switzerland
- **Nanobody® technology** licensed in initial private round
- **Unique molecule with sonelokimab**, tri-specific IL-17A & IL-17F Nanobody® to elevate treatment in inflammation in a **$40bn+ market**
- **Public on Nasdaq** since April 2022 and **~$750m raised** to date
- **Clinical phase company** successfully concluded phase 2b studies in psoriasis (n=313), HS ("MIRA", n=234), and PsA ("ARGO", n=207)
- **Commencing Phase 3 programs in 2024** with first **commercial launches expected in 2027**
- Driven by a top-tier team, target is to unlock a **pipeline-in-a-product across large indications** from 2023 (>$5bn in HS & PsA alone)

Source: MoonLake Corporate

A differentiated molecule – Do you still Antibody?

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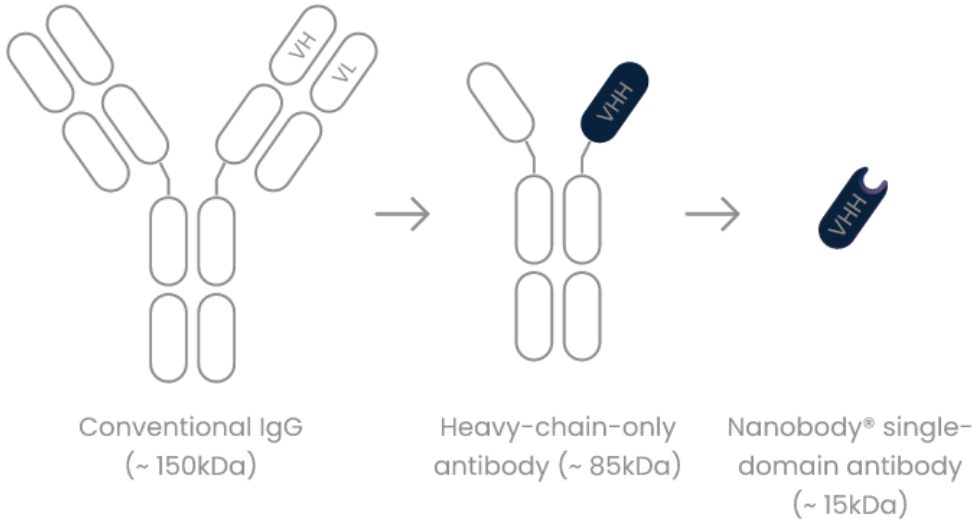
Nanobodies® are much smaller than traditional antibodies



They can be designed to have multiple and different binding domains

IL-17A & IL-17F

Sonelokimab is a ~40kDa humanized Nanobody® consisting of three VHH domains covalently linked by flexible spacers - around a 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

Source: MoonLake Research

It's all about the dimers

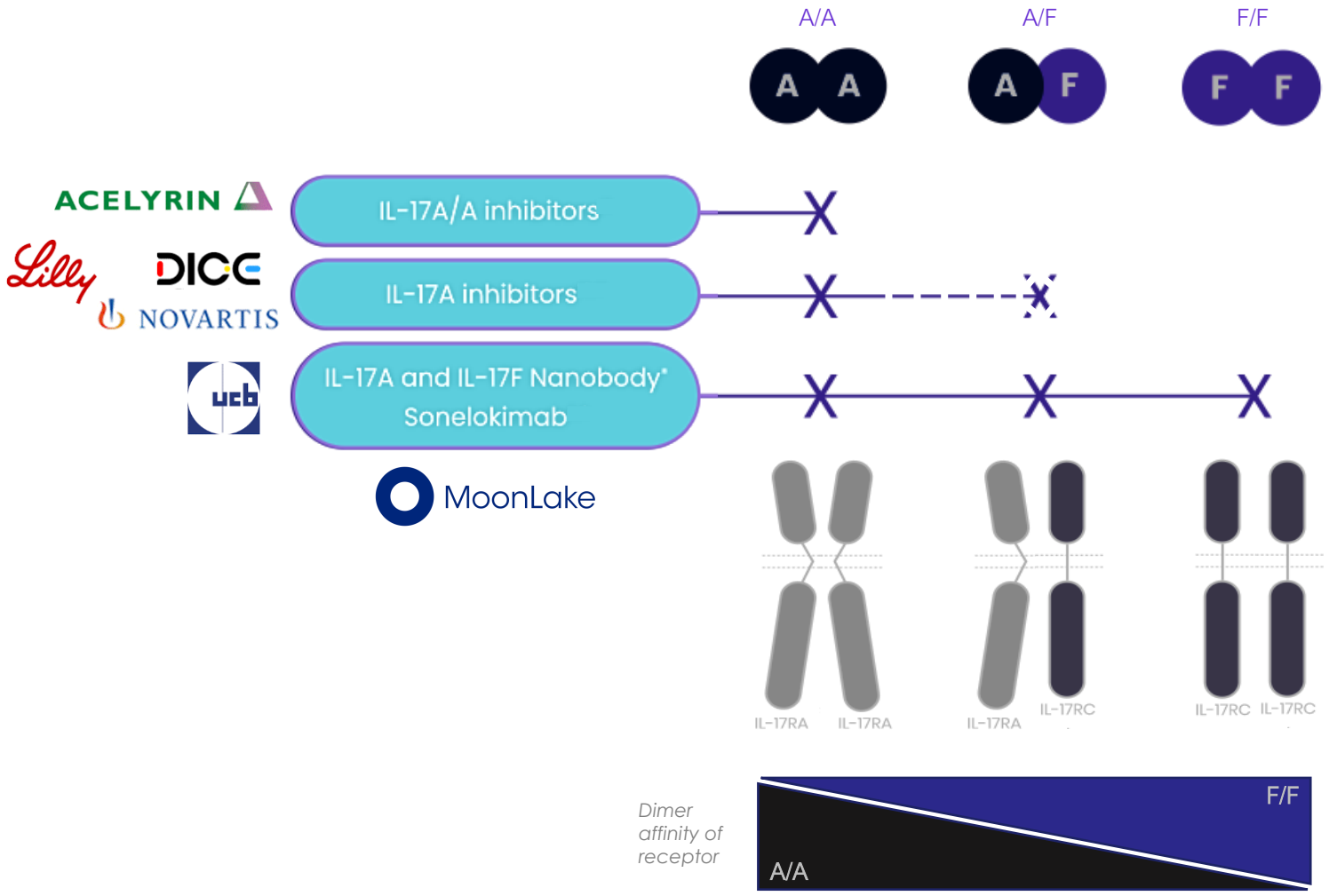
Illustrative

IL-17A and IL-17F function as dimers to drive inflammation, through activation of IL-17RA & RC receptor complexes

Different IL-17RA & RC chains combine to form complexes, and those have different affinity for different dimers[1,2]

Not all IL-17-targeting therapeutics can inhibit IL-17A/A, IL-17A/F and IL-17F/F dimers

SLK is the only asset that binds all dimers and with similar affinity



1 Liu S, et al. Nat Commun. 2013;4:1888; 2 Goepfert A, et al. Immunity. 2020 Mar 17;52(3):499-512

Source: MoonLake Research

SLK rapidly becoming a leader in large inflammatory diseases

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	Trial	Patients (n)	Leading MoA	SLK leading asset
 **HS**	Phase 2b (MIRA) *Placebo-controlled with Humira™*	234	IL-17A & F TNF & IL-17A	✓ **Highest** ever primary endpoint (HiSCR75), **largest** deltas to placebo, depth of responses
 **PsA**	Phase 2b (ARGO) *Placebo-controlled with Humira™*	207	IL-17A & F TNF & IL-17A	✓ **Highest responses** in skin/joints, incl. critical composite scores
 **PsO**	Phase 2b *Placebo-controlled with Cosentyx™*	313	IL-17A & F IL-23 & IL-17A	✓ **Largest** delta vs market leader Cosentyx™ at PASI100, compared to BKZ, IL-23, etc.
 *Other Rheum & Derm*	TBA	TBA	IL-17A & F Other	○ IL-17A & F inhibition **best** data in AS, nr-AxSpA, PPP…

PsA ARGO 24 -eek data presented today, also information on other indications

Source: MoonLake Corporate

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PsA

Going beyond in Rheumatology

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PsA – A multidomain challenge

Prof. Joseph F. Merola

Disclosures

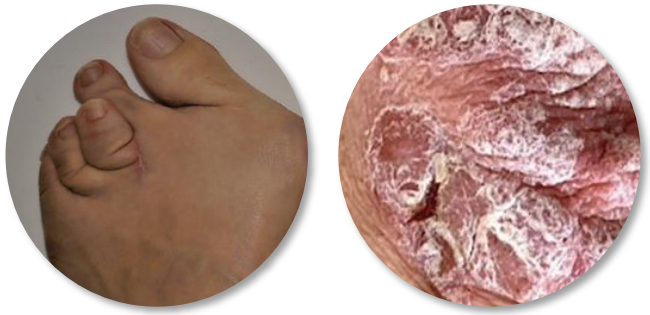
Prof. Merola is a consultant and/or investigator for Amgen, Boehringer Ingelheim, Bristol-Myers Squibb, AbbVie, Eli Lilly, Novartis, Janssen, UCB, Sanofi, Regeneron, Sun Pharma, Biogen, Pfizer, MoonLake Immunotherapeutics

PsA is a multidomain disease, involving joints and skin

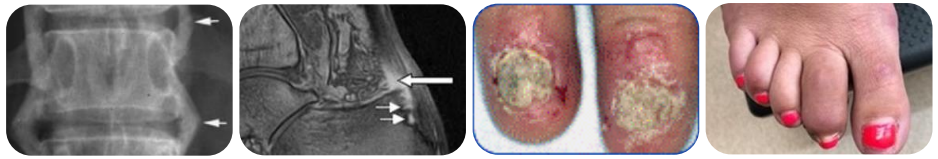
PsA is a multidomain disease

Treatments are assessed using clinical and patient-reported outcomes across domains

Key clinical endpoints
Joints and skin[1]



Other clinical domains[1]



Axial | Enthesitis | Nail | Dactylitis

Patient-reported outcomes[2]

Function e.g. HAQ

Pain e.g. VAS

Disease severity e.g. PGA

Multidomain composite outcomes[2]

Multidomain composite outcomes are used with increasing prominence in clinical trials to assess treatment impact simultaneously across domains

MDA **Minimal Disease Activity**

= ≥5 out of 7 stringent multidomain outcomes

Tender joints | Swollen joints | Skin lesions | Tender entheses | HAQ | Pain | PGA

ACR + PASI **Response in joints + skin**

ACR50 + PASI100

Can we elevate to ACR70 + PASI 100?

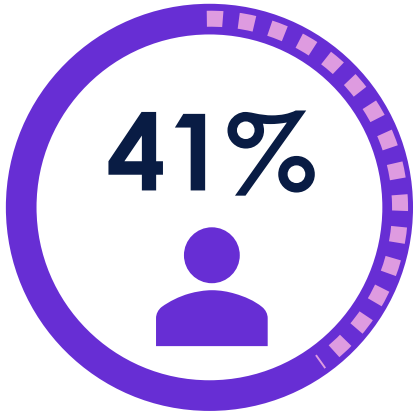
1 Coates et al Nat Rev Rheumatol 2022;18:465–479 | Dactylitis and nai/skin images courtesy of Prof. Joseph F. Merola and Prof. Kristian Reich, respectively (please do not reproduce) | Other images reproduced (CC-BY licenses) from Mochizuki et al Case Rep Rheumatol 2018:2018:4216938, Jurik Insights Imaging 2011;2:177–191, McQueen et al Arthritis Res Ther 2006;8:207 2 Gossec et al J Rheumatol 2018;45:6–13

PsA is common and often underdiagnosed — and undertreated

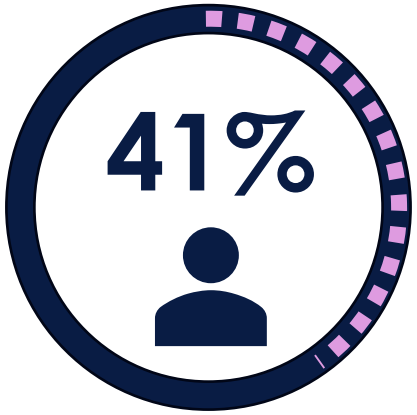
PsA is common

- **1.5 million Americans are thought to be living with PsA**[1]
  30% of patients with PSO progress to a PsA diagnosis[2]
- **47% of patients already have musculoskeletal symptoms** at PSO diagnosis[3]

However, PsA is **often underdiagnosed** or **undertreated**



~2 in 5 patients with PsA were underdiagnosed
in the PREPARE non-interventional study[4]



~2 in 5 patients diagnosed with PsA are not on biologics
in a recent international survey[5]

★ **New research at AAD 2024**

Among surveyed US patients with PSO:

41% already had joint symptoms, but in most cases had not discussed treating these symptoms with their doctor[6]

1 Johns Hopkins Medicine [https://www.hopkinsarthritis.org/arthritis-info/psoriatic-arthritis] Accessed Mar 2024 2 National Psoriasis Foundation [https://www.psoriasis.org/psoriasis-statistics] Accessed Mar 2024 3 Merola et al Dermatol Ther 2023;13:2635–2648 4 Mease et al. J Am Acad Dermatol. 2013;69:729–35 5 Tillett et al Rheumatol Ther 2020;7:617–37 6 Luce et al AAD 2024;Poster 50361

The symptom burden of PsA leads to substantial work impairment

Functional impairment

44%

Work impairment

among patients with PsA in the COPPAR registry (N=113)[1]

A **>30%** and **>25%** prevalence in PsA of anxiety and depression[2]

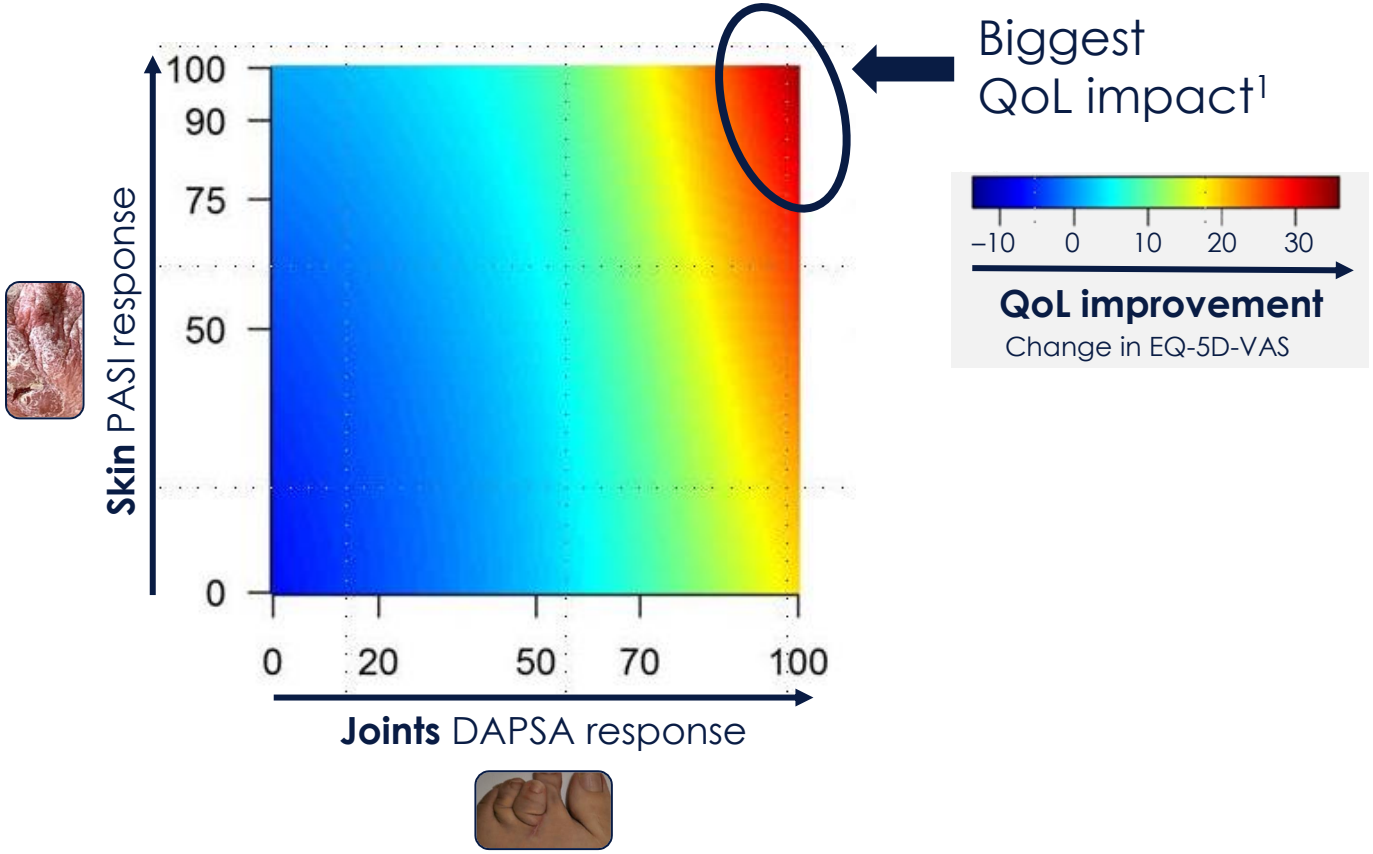
4 in 5 patients report fatigue,[3] with a major impact on physical activity

- **Fatigue**, **pain**, **anxiety**, **depression** and **disturbed sleep** are interconnected symptoms linked to work impairment[1,4–6]
- **Multidomain** disease[7] is also associated with work impairment, including **skin**, **polyarticular**, and **entheseal** involvement

Using treatments that better resolve symptoms will have wide-ranging benefits for patients and society

1 Shadick et al ACR 2023;Poster 0488 Rheum Dis 2020;79 (suppl 1):AB0821
2 Vestergaard et al RMD Open 2024;10:e003412
3 Gossec et al J Rheumatol 2022;49:1221–8
4 Haugeberg et al Arthritis Res Ther 2020;22:198
5 Gossec et al Ann
6 Spindler et al J Am Acad Dermatol 2021;85:910–922
7 Walsh et al Joint Bone Spine 2023;90:105534

High clinical response in skin, in addition to joints, is critical for patients



Multidomain PsA leads to more pronounced QoL impairment[2]

- A greater risk of **flare**
- More substantial **work impairment**
- Higher rates of **anxiety** and **depression**
- Worse overall **quality of life** scores

→ **Assess response in both joints + skin**

ACR + PASI 

It is critical to assess treatment response in both joints and skin to make the biggest difference to patients

Image credits: skin—courtesy of Prof. Kristian Reich, joints—Mochizuki et al Case Rep Rheumatol 2018:2018:4216938 1 Quality of life data from 402 patients with PsA and moderate-to-severe skin involvement (≥3% BSA) after 24 weeks on therapy/placebo in the SPIRIT Phase 3 clinical study program (heat map image reproduced with permission from Prof. Merola) | Kavanaugh et al Arthritis Rheumatol 2017;69(suppl 10);AB2539 2 Tillett et al Rheumatol Ther 2020;7:617–37

Most patients currently do not achieve MDA, even with biologics

>3 in 4 patients do not achieve MDA
within 6 months of biologic initiation[1]

% of patients who achieved MDA
in a US real-world study

Patients who do not achieve MDA may also have a higher overall disease burden, e.g.:[2]

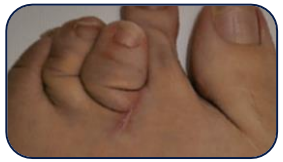
- More fatigue
- Worse physical function
- Worse mental function
- Greater quality of life impact

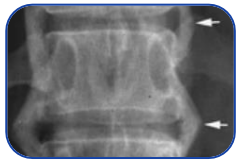
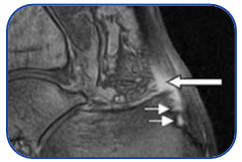
Treatment ceiling in PsA: advances in PsA treatment have led to success in some domains, but achievement of MDA with biologics remains challenging, even for newer therapies

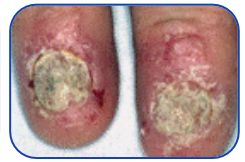
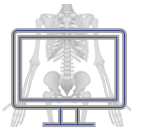
1 Data from the CorEvitas registry (N=1,251); Ogdie et al ACR 2021;abstract 1344 2 Coates et al RMD Open 2019;5:e001002.

IL-17i is the only biologic class preferred in all clinical domains of PsA

Joints | Skin | Other domains



Preferred biologic(s)[1]	Peripheral arthritis	Psoriasis	Axial	Enthesitis	Dactylitis	Nails	Radiographic progression
IL-17i	✓	✓	✓	✓	✓	✓	✓
TNFi	✓	✓	✓	✓	✓	✓	✓
IL-12/23i	✓	✓	✗	✓	✓	✓	✗
IL-23i	✓	✓	✗	✓	✓	✓	✗

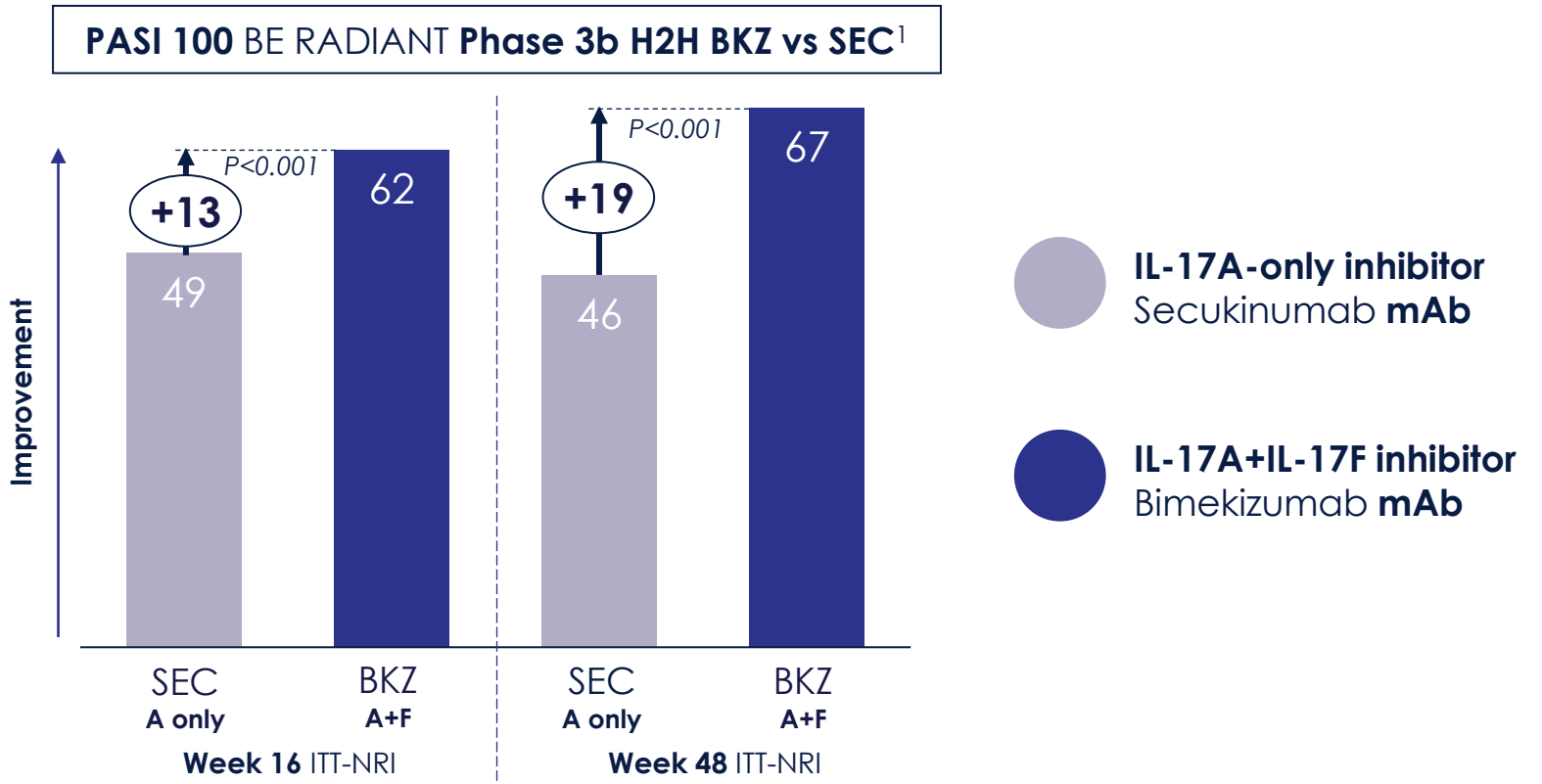
1 Preferred biologic classes are based on the expert interpretation of clinical study results by Prof. Merola, Dactylitis and nai/skin images courtesy of Prof. Joseph F. Merola and Prof. Kristian Reich, respectively (please do not reproduce) | Other images reproduced (CC-BY licenses) from Mochizuki et al Case Rep Rheumatol 2018:2018:4216938, Jurik Insights Imaging 2011;2:177–191, McQueen et al Arthritis Res Ther 2006;8:207

Can we optimize IL-17 inhibition?

As the class of choice for addressing all domains in PsA, **innovation on MOA is centered on optimizing IL-17i**, based on increasing evidence that IL-17F drives psoriatic inflammation alongside IL-17A…

Skin: Plaque psoriasis
(Moderate-to-severe)

Primary endpoint:
PASI 100 at Week 16



Inhibition of **both IL-17A+IL-17F** provides **greater benefits** in skin vs. inhibition of IL-17A only

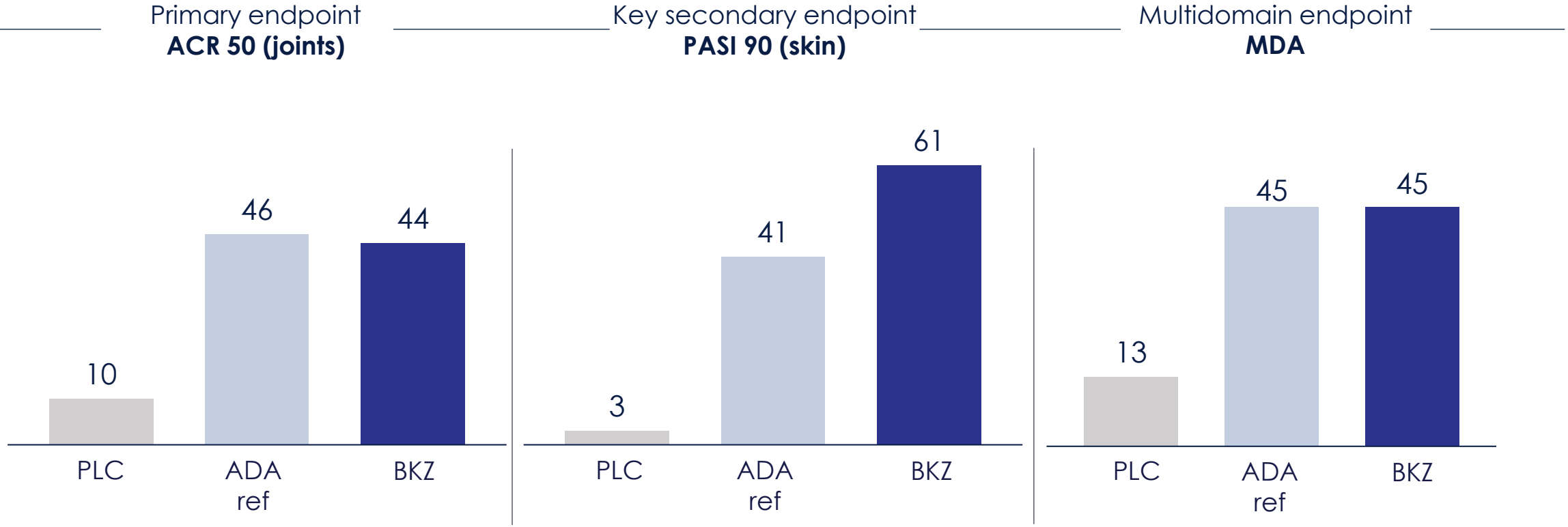
A study in patients with moderate-to-severe psoriasis; only a subset of participants had PsA and the clinical significance of the findings is unclear (there are no head-to-head studies of these two MOAs in PsA); Reich et al N Engl J Med 2021;385:142–152
Image of skin courtesy of Prof. Kristian Reich

IL-17A and IL-17F dual inhibition is a newly validated MOA in PsA

Bimekizumab IL-17A and IL-17F inhibitor (160 mg Q4W) | BE OPTIMAL (Phase 3 **PsA**)[1]

Week 16 NRI-ITT

- Patients enrolled in the study were biologic-naïve — similar results were seen in a TNF-IR study[2]



Inhibition of **both IL-17A and IL-17F** provided **high levels** of **joints + skin** responses at Week 16

1 NRI, non-responder impuation; McInnes et al Lancet 2023;401:25–37; 2 Merola et al Lancet 2023;401:38–48

Sonelokimab is a novel humanized Nanobody® targeting IL-17A+IL-17F

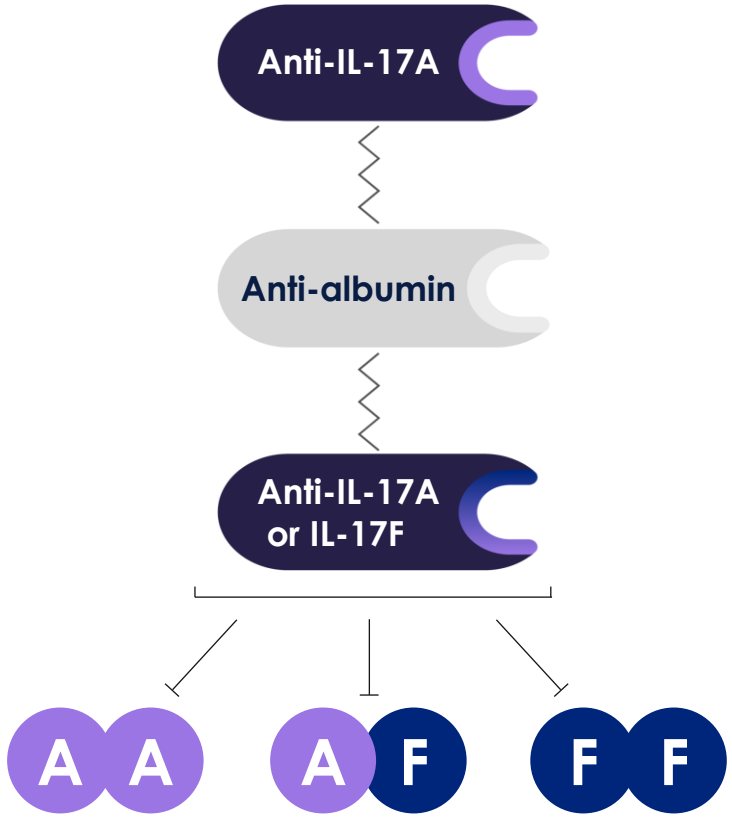
As a **Nanobody®**, **sonelokimab (SLK)** is designed to penetrate difficult-to-reach tissues and directly target sites of inflammation:[1,2]

- **Small size** (~40 kDa vs. ~150 kDa for a conventional mAb)
- **Albumin-binding domain** to extend half-life and target sites of inflammation

Sonelokimab Phase 2b in psoriasis[1]

- Rapid and durable skin clearance (PASI 100) with no unexpected safety findings

Sonelokimab Nanobody® ~40 kDa[1,2]



Inhibits IL-17A/A, IL-17A/F, and IL-17F/F dimers

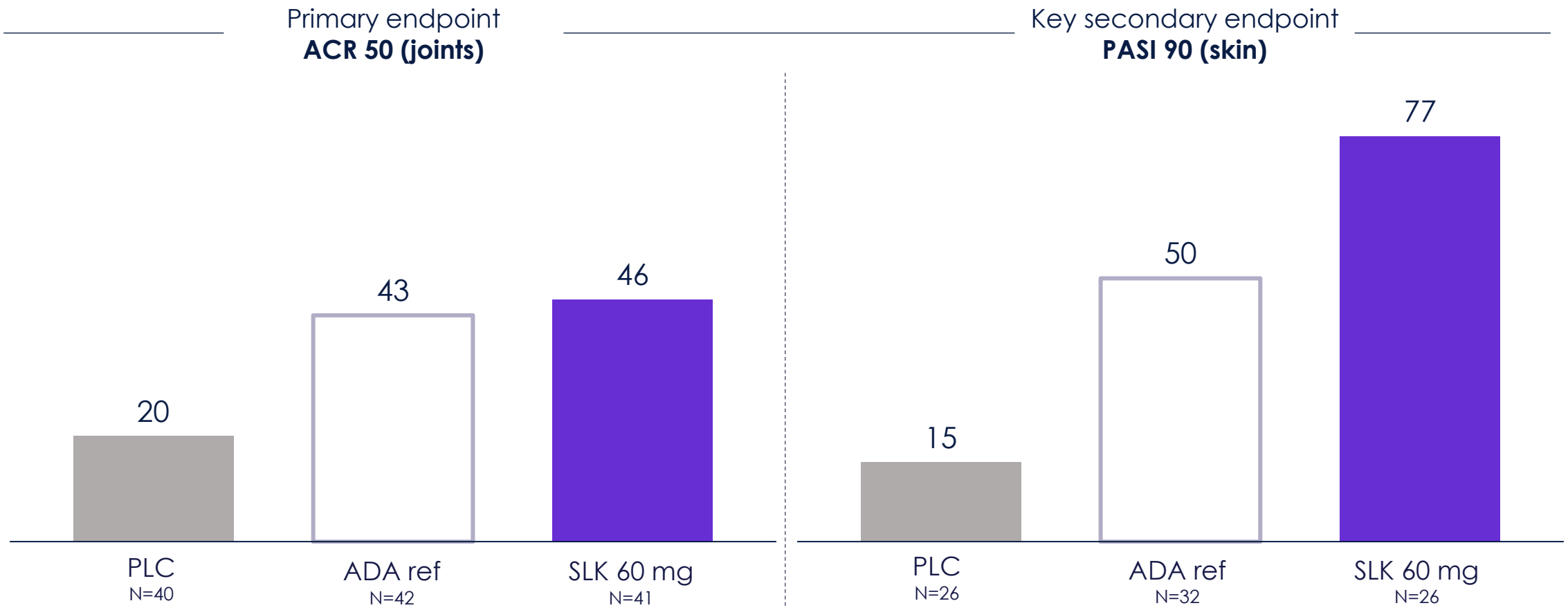
1 Papp et al Lancet 2021;397:1564–1575 2 Svecova et al J Am Acad Dermatol 2019;81:196–203

SLK achieved high levels of response in joints and skin by Week 12

Sonelokimab IL-17A and IL-17F inhibitor (Nanobody®) | ARGO (Phase 2 **PsA**)

Week 12 NRI-ITT

- Both bio-naïve and -experienced patients were enrolled in the study

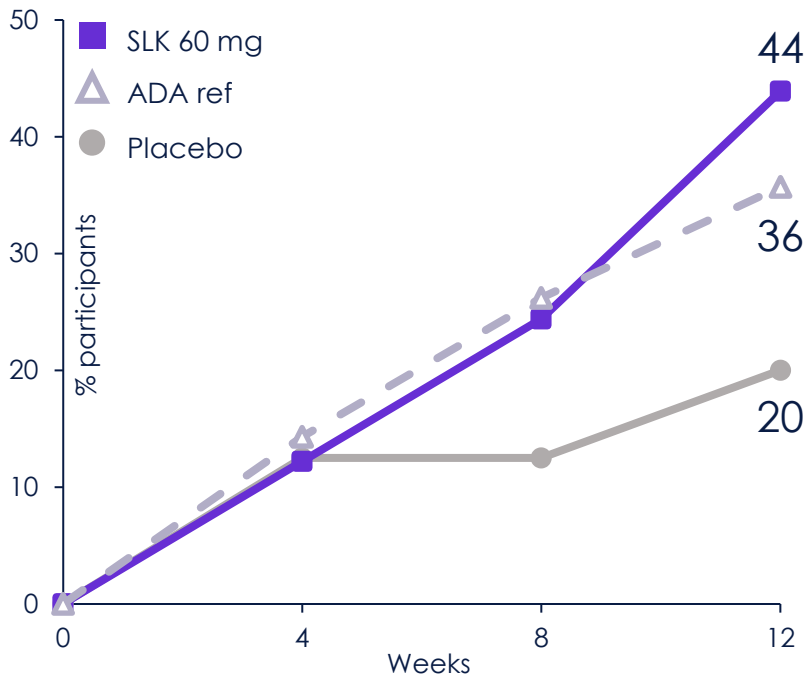


Inhibition of **IL-17A and IL-17F** with a Nanobody® **showed promising efficacy in both joints + skin**

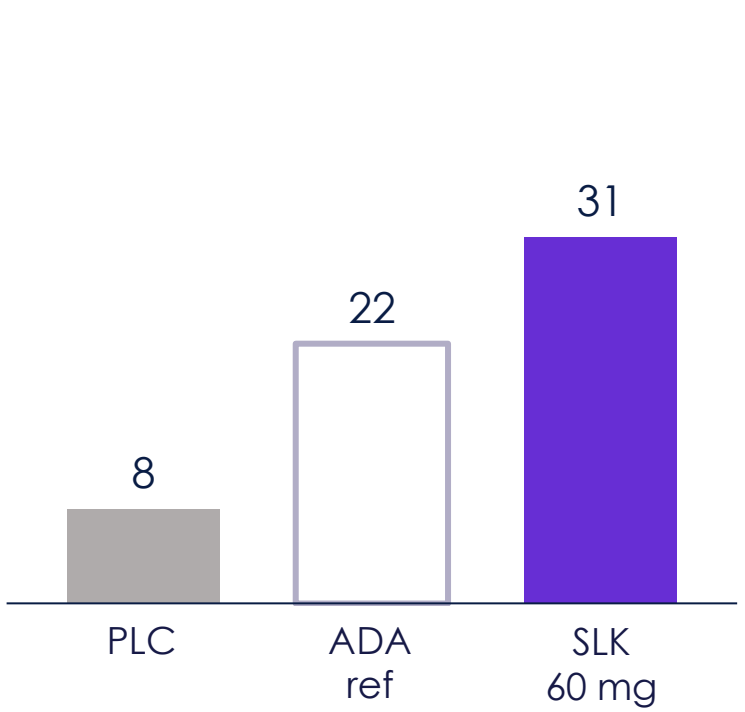
The SLK Nanobody® also showed promising responses in composite scores

Sonelokimab ARGO | **Week 12** ITT-NRI

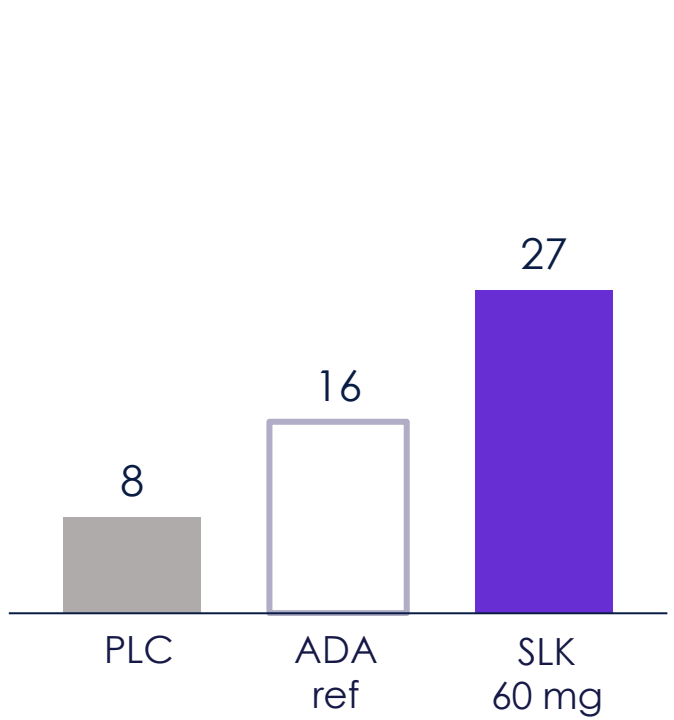
Multidomain endpoint
MDA



Joints + skin composite
ACR 50 + PASI 100



Higher threshold
ACR 70 + PASI 100



SLK treatment provided a **multidomain** response in the ARGO trial
that met stringent, high-threshold endpoints such as **MDA** and **ACR 70 + PASI 100**

Summary

- **Unmet need across multiple domains** demands novel PsA therapies
- **MDA** is a **PsA-specific**, stringent endpoint that sets **a high bar across domains**, while **ACR + PASI composites** allow simultaneous assessment of key domains
- **IL-17A + IL-17F inhibition** has the potential to optimize outcomes across PsA domains, including **MDA** and **joint + skin** composites
- **Sonelokimab** is designed to combine the '**best of both worlds**': IL-17A + IL-17F inhibition, mediated by a small, albumin-binding Nanobody®
- In the Phase 2 ARGO trial, inhibition of IL-17A + IL-17F with the Nanobody® **sonelokimab led to high levels of multidomain response** by Week 12, with no sign of plateauing

Week 12 data in the ARGO trial **set high expectations of continuing increases in key endpoints, as well as multidomain composites**, to Week 24 with SLK treatment

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ARGO trial 24 wk data

Kristian Reich

PsA: IL-17F dependent multi-domain disease in difficult-to-reach tissues

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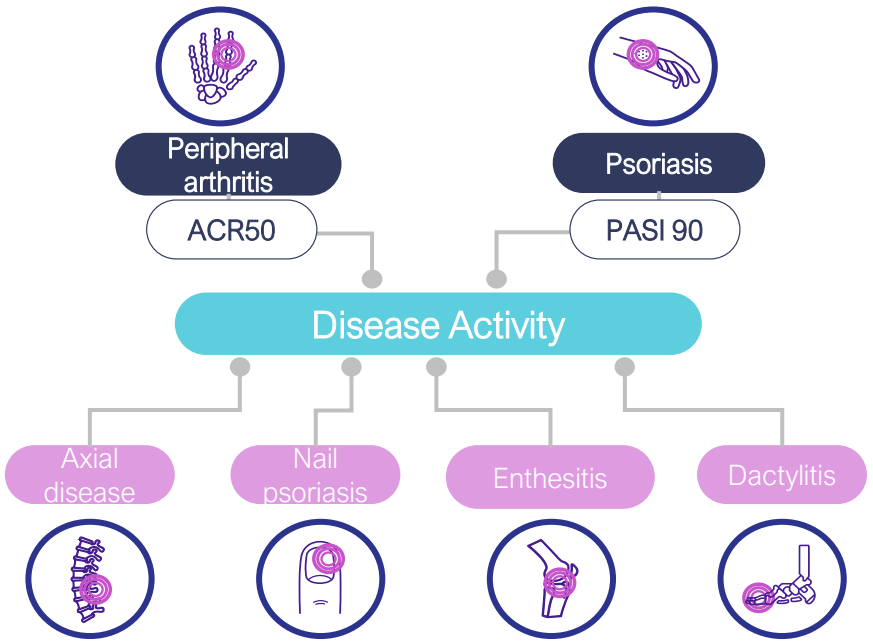
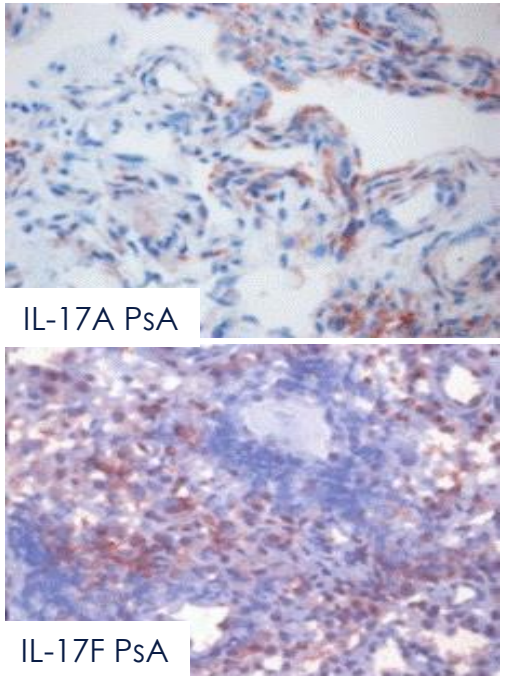
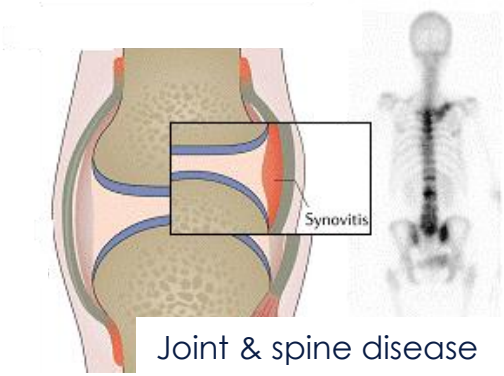
PsA is a multi-domain deep-tissue disease…



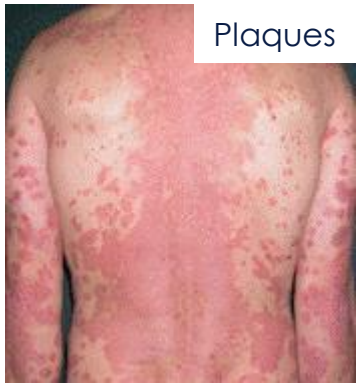
…with 3x IL-17F vs IL-17A[1]…



…and causing devastating damage

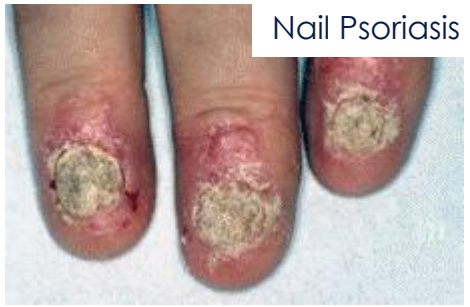


Joint & spine disease



Plaques

(PsA starts as enthesitis[2], with IL-17F producing cells in associated plaques[3] and axial disease[4-6], and with 80% of patients suffering from nail psoriasis[7])



Nail Psoriasis

Market size

0.5% Global prevalence

10+ USD bn sales beyond 2030

Unmet Needs

80% or more patients with multiple disease domains

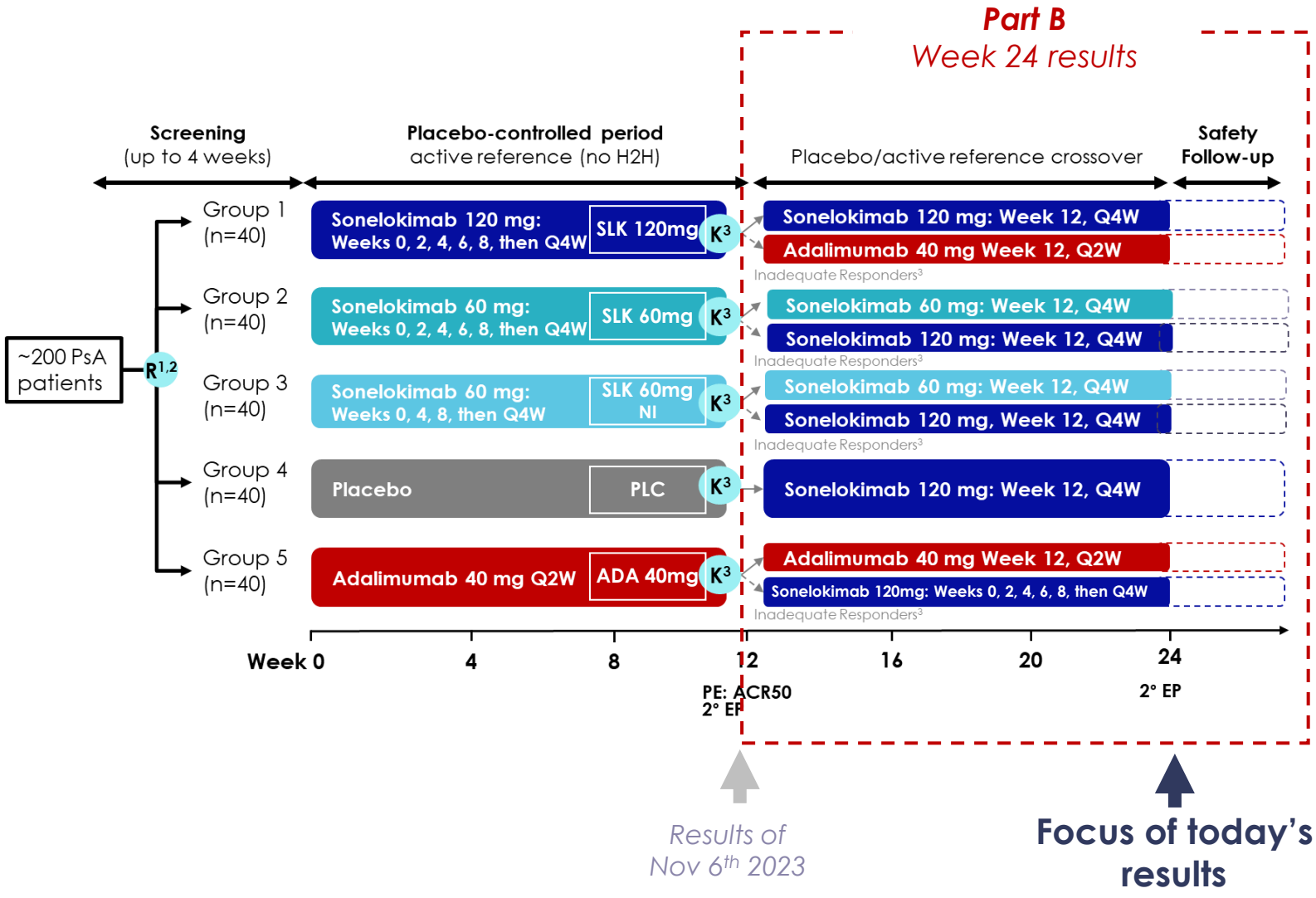
10% skin involvement in PsA patients – severe skin disease

20% is still standard ACR level of improvement

1 van Baarsen LG, et al. Arthritis Res Ther. 2014; 16:426-436; 2 Schett G, et al. Nature Reviews Rheumatology. 2017; 13:731-741; 3 Prinz JC, et al. J Exp Med. 2020 Jan 6;217(1):e20191397; 4 Sweet K, et al. RMD Open 2021;7e001679; 5 Shao M, et al. Clin Immunol 2020;213:108374; 6 Lories RJ and McInnes IB, Nature Medicine. 2012; 18:1018-1019; 7 Reich K. J Eur Acad Dermatol Venereol. 2009; 23 Suppl 1:15-21; Clinical pictures K. Reich

Source: MoonLake Medical, Clinical pictures K. Reich

ARGO: Phase 2 trial design



Key design elements of ARGO

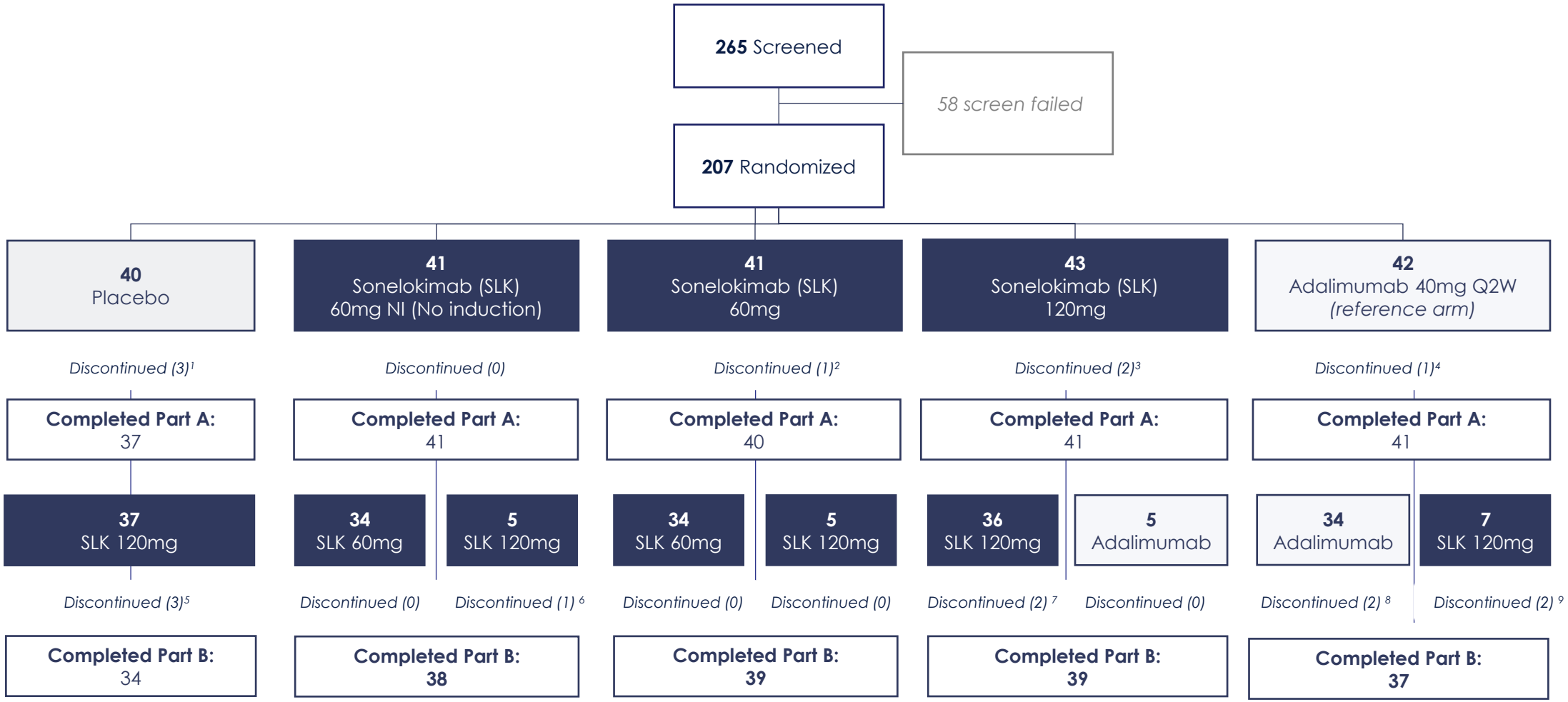
- Global study with approx. **50 sites**, with **207 patients** randomized
- **Double-blind, placebo-controlled, active reference arm**
- **Active PsA** (TJC68 ≥3, SJC≥3, current active PsO and/or confirmed PsO)
- **ACR50** as primary endpoint, **PASI90** as key secondary endpoint
- **ITT-NRI** primary analysis; Stratification by sex, previous bio use
- **SLK 120mg** and **SLK 60mg reached stat sig at wk 12**
- Group 3 ("**SLK 60mg NI**", no induction) had not reached stat sig at wk 12
- **Some crossover arms** not analyzed separately (small samples, 5-7 pts/arm)

Notes: 1 Randomization stratified by sex and prior exposure to biologics; 2 At Week 0/Day 1, all eligible participants were randomized 1:1:1:1:1; 3 In the cross-over period, starting at Week 12, participants on sonelokimab 120 mg who did not achieve an adequate response switched to adalimumab 40 mg Q2W until Week 24; participants on sonelokimab 60 mg (started at baseline Q2W or Q4W) who did not achieve an adequate response switched to sonelokimab 120 mg Q4W until week 24; participants on adalimumab who did not achieve an adequate response switched to sonelokimab 120 mg Q4W until Week 24; an adequate response is defined as a reduction of the tender and swollen joint count of ≥20%. Participants on placebo at Week 12 were switched to sonelokimab Q4W until Week 24

Source: MoonLake Clinical

Disposition: The ARGO trial had a drop-out of rate of 5% in Part B

Disposition (Part A+B)



Part B Database lock 7th February 2024. AE =Adverse Event, Wdw by S = Withdrawal by Subject; Completed Part A = completed treatment up to Week 10 and completed assessments to Week 12; 3 patients did not subsequently enter part B; 1: 1x Not Treated, 1x Wdw by S & 1 x Lack of Effect; 2: 1x Protocol withdrawal criteria; 3: 1x AE (not related to treatment) & 1x Wdw by S; 4: 1x Wdw by S; 5: 3 x AE; 6: 1 1x Wdw by S; 7: 1 x AE 1x Wdw by S; 8: 1 x PD 1 x Wdw by S; 9 1 x AE 1 x PD

Source: MoonLake Clinical

SLK efficacy **in joints continues to improve** to wk 24, with **high responses**

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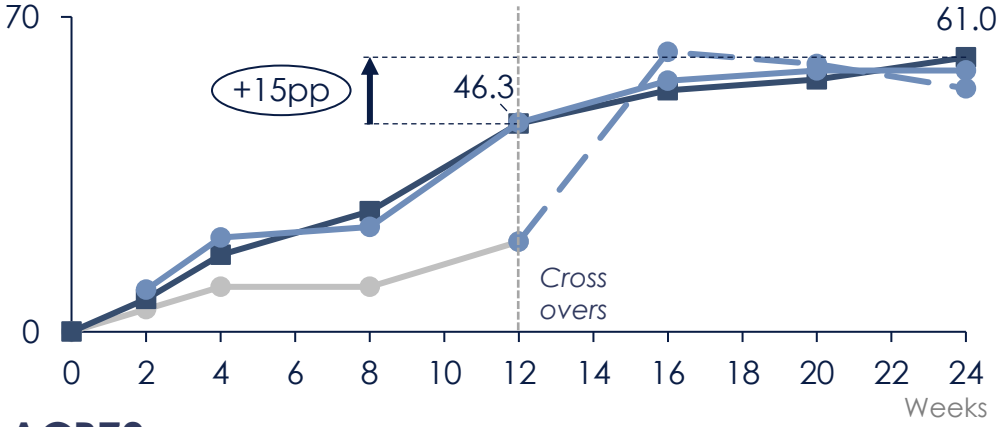
PLC | SLK 60mg | SLK 120mg | PLC->SLK 120mg

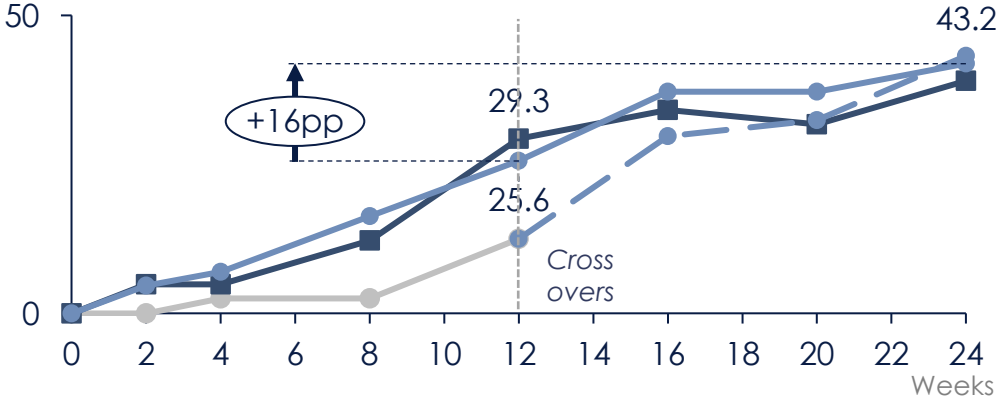
ACR50 response (Primary endpoint)

Percent (%) pts reaching score, NRI[1]

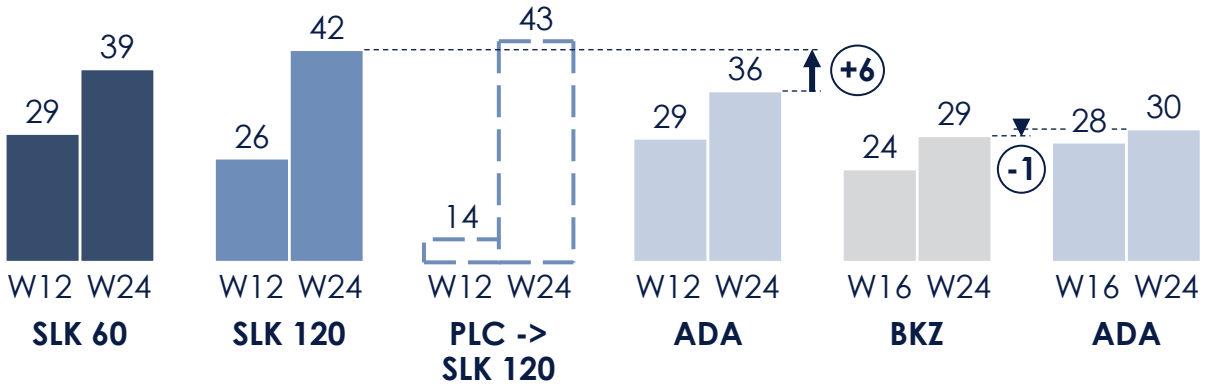


ACR70 response (Secondary endpoint)

Percent (%) pts reaching score, NRI[1]



Cross-trial comparison to BKZ



ARGO (NRI[1])

BE OPTIMAL[2] (NRI)

Note: Comparison across trials have inherent limitations. No head-to-head trials 1 ITT-NRI up to Week 24, except that participants who were re-assigned from their original treatment arm at Week 12 as per protocol had last observation carried forward from Week 12 onwards; 2 Ritchlin et al. Ann Rheum Dis 2023;82:1404–1414 BE OPTIMAL;

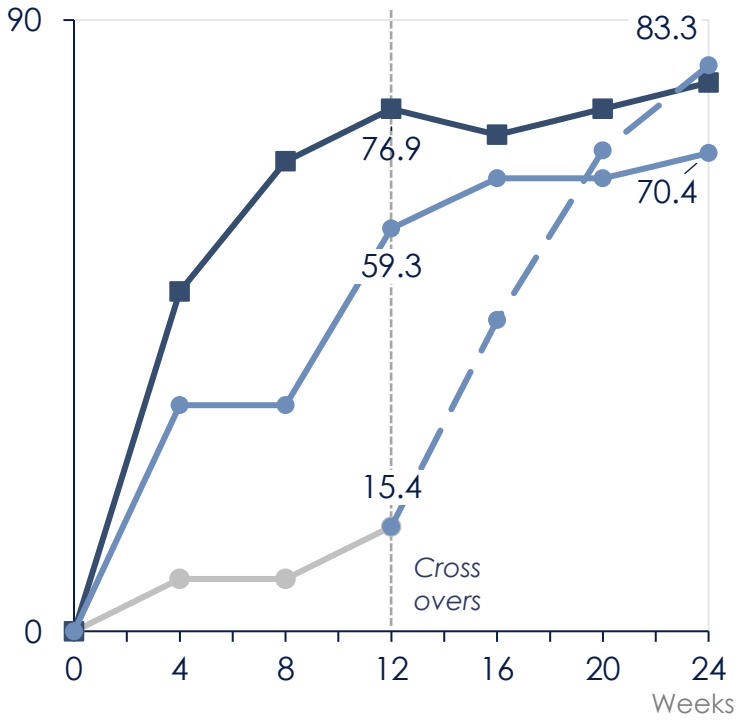
Source: MoonLake Clinical

Skin outcomes continue to improve to wk 24, beyond competitors

PLC SLK 60 SLK 120 PLC->SLK 120

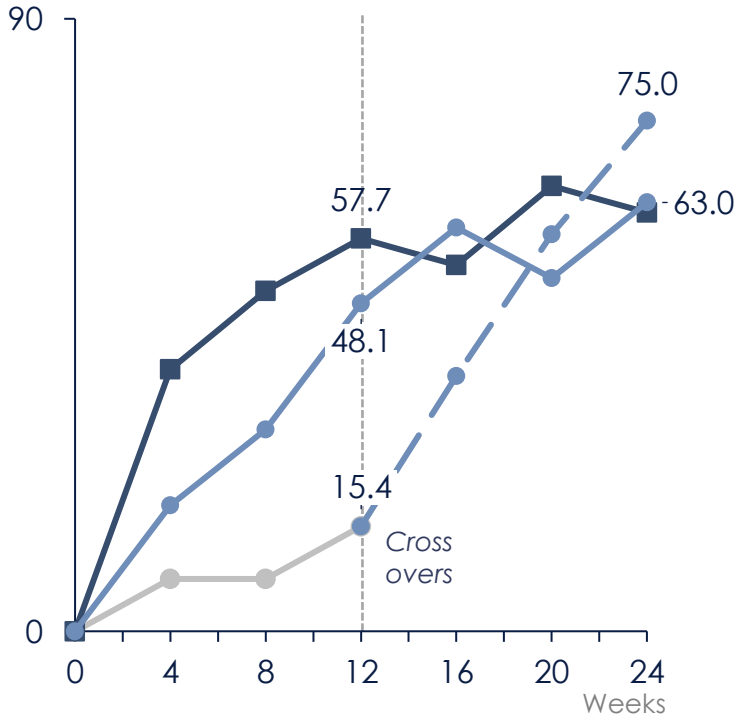
PASI90 response

Percent (%) pts reaching score, NRI[1]



PASI100 response

Percent (%) pts reaching score, NRI[1]



PASI response rates with **SLK continue to increase to week 24** - clinical response has not plateaued

Placebo crossover arms achieve **83% PASI90** and **75% PASI100** rates after just 12 weeks of SLK treatment

Deltas between SLK dose and adalimumab at wk 24 up to **27% for PASI90 and 25% for PASI100**

SLK 60mg & 120mg numerically outperform adalimumab on **every PASI score** tested at wk 24 (as well as ACR)

SLK responses are numerically higher than observed with BKZ, (73% PASI90 and 56% PASI100 in BE OPTIMAL at wk 24)[2]

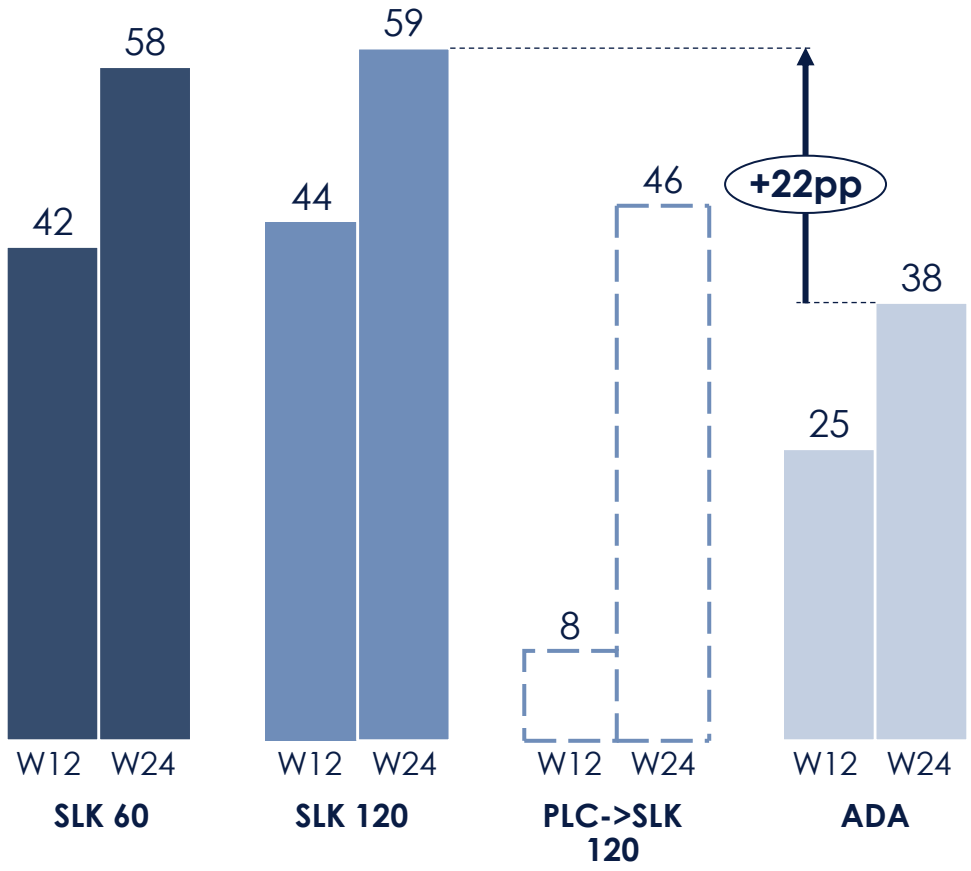
Note: Comparison across trials have inherent limitations. No head-to-head trials 1 Subset of participants with BSA >=3% at baseline, ITT-NRI up to Week 24, except that participants who were re-assigned from their original treatment arm at Week 12 as per protocol had last observation carried forward from Week 12 onwards 2 2 Ritchlin et al. Ann Rheum Dis 2023;82:1404–1414 BE OPTIMAL

Source: MoonLake Clinical

Most patients meet **both joint & skin** outcomes – **a differentiated profile**

Patients reaching both ACR50 and PASI90

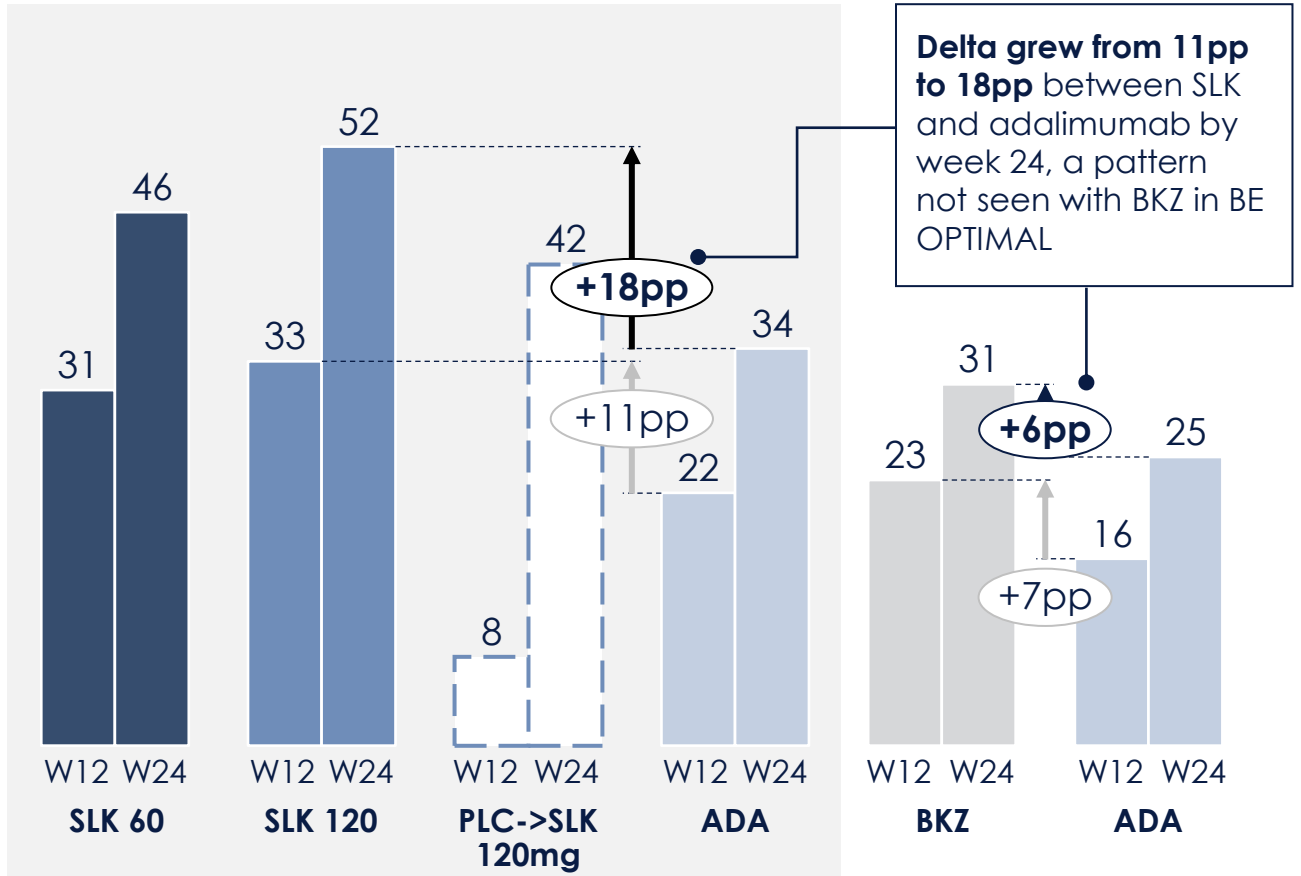
Percent (%) pts reaching score, NRI[1]



ARGO
(NRI[1])

Patients achieving both ACR50 and PASI100

Percent (%) pts reaching score



Delta grew from 11pp to 18pp between SLK and adalimumab by week 24, a pattern not seen with BKZ in BE OPTIMAL

ARGO
(NRI[1])

BE OPTIMAL[2]
(NRI)

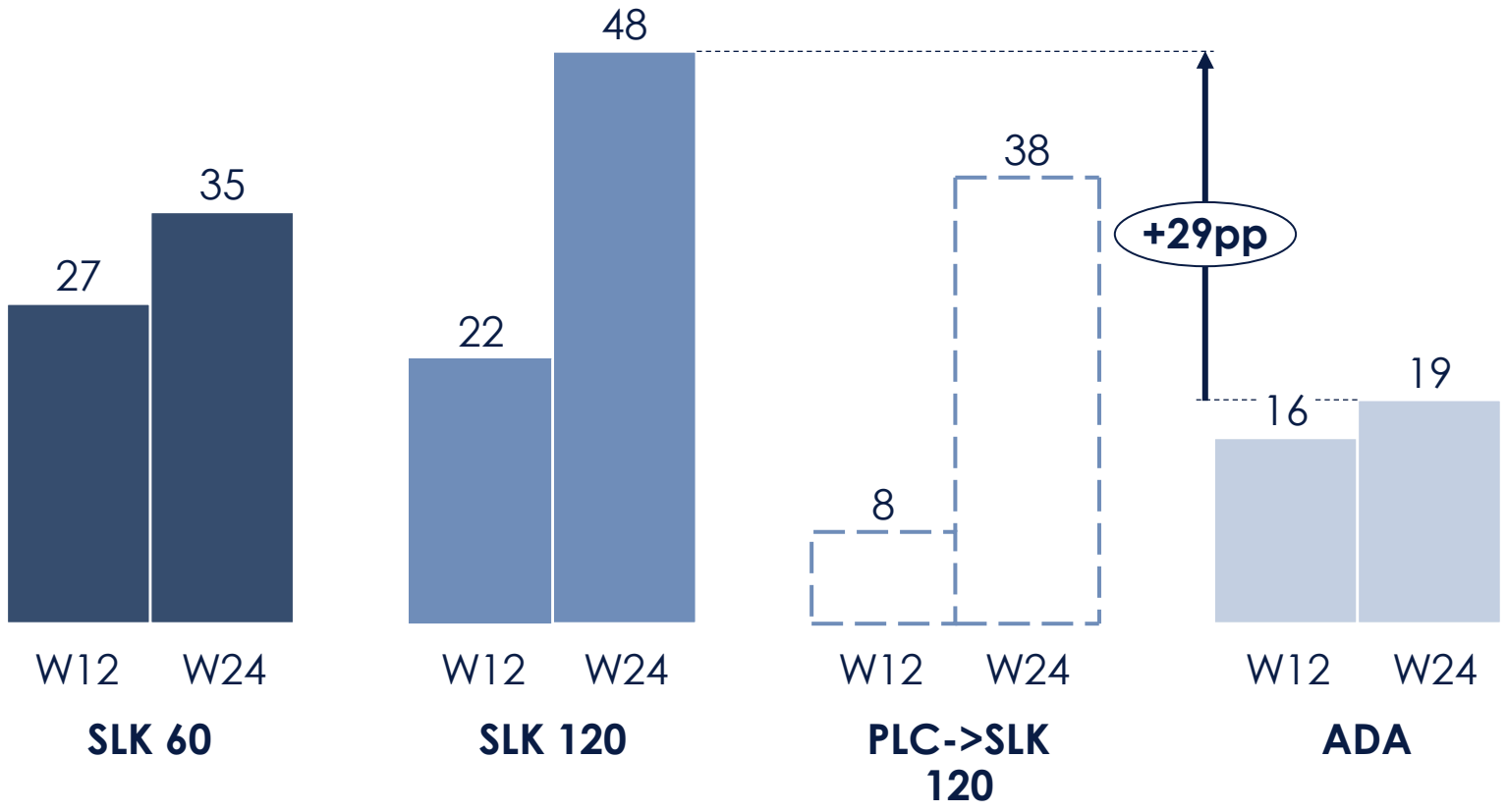
Note: Comparison across trials have inherent limitations. No head-to-head trials 1 Subset of participants with BSA >=3% at baseline, ITT-NRI up to Week 24, except that participants who were re-assigned from their original treatment arm at Week 12 as per protocol had last observation carried forward from Week 12 onwards; 2 Ritchlin et al. Ann Rheum Dis 2023;82:1404–1414 BE OPTIMAL

Source: MoonLake Clinical

SLK efficacy is **further shown with a higher the treatment goal**

Patients reaching both ACR70 and PASI100

Percent (%) pts reaching score, NRI[1]



Almost **50% of patients** reach both ACR70 & PASI100 with SLK

At week 24 delta to adalimumab in this **high bar composite score is close to 30pp**

Strong signal of **elevated efficacy vs adalimumab**[2] on this higher hurdle endpoint

1 Subset of participants with BSA >=3% at baseline, ITT-NRI up to Week 24, except that participants who were re-assigned from their original treatment arm at Week 12 as per protocol had last observation carried forward from Week 12 onwards;
2 Nominal p value, post-hoc analysis (p<0.05), study not powered for statistical comparison between SLK and ADA arms

Source: MoonLake Clinical

MDA: A composite of ambitious clinical response targets in joints & skin

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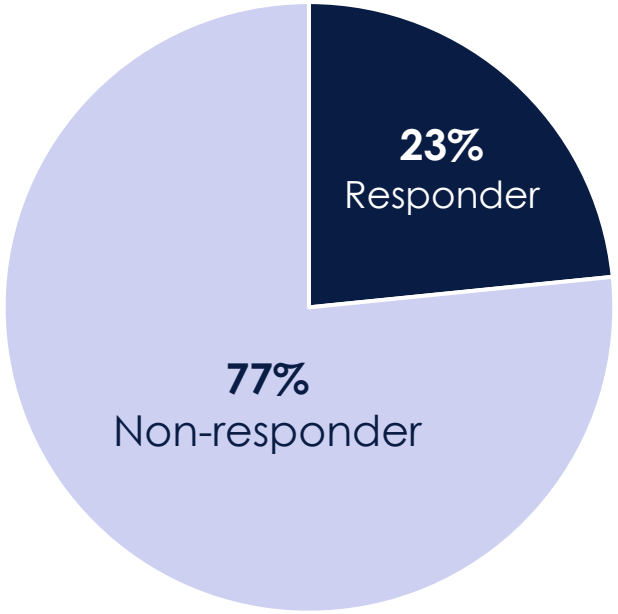
>3 in 4 patients do not achieve MDA
within 6 months of biologic initiation[1]



% of patients who were MDA responders

MDA breakdown[2]

MDA (Minimal Disease Activity) denotes a patient who has achieved **≥5 of the following 7 criteria**:

1. **Joints:** TJC ≤1
2. **Joints:** SJC ≤1
3. **Skin:** PASI ≤1 *(or BSA ≤3%)*
4. **Entheses:** Tender entheseal points ≤1
5. **PRO:** Patient pain VAS ≤15
6. **PRO:** Patient global activity VAS ≤20
7. **PRO:** HAQ-DI VAS ≤0.5

Achievement of MDA clinical responses with any biologic remains low

1 Data from the CorEvitas registry (N=1,251); Ogdie et al. ACR 2021;abstract 1344; 2 BSA, body surface area; HAQ-DI, Health Assessment Questionnaire Disability Index; PASI, Psoriasis Area and Severity Index; PRO, patient-reported outcome; S/TJC, swollen/tender joint count; VAS, visual analog scale; Gossec et al. J Rheumatol. 2018;45:6–13

Source: Prof Joseph Merola

Impact of SLK on MDA is clear: 60%+ of patients reach this high goal

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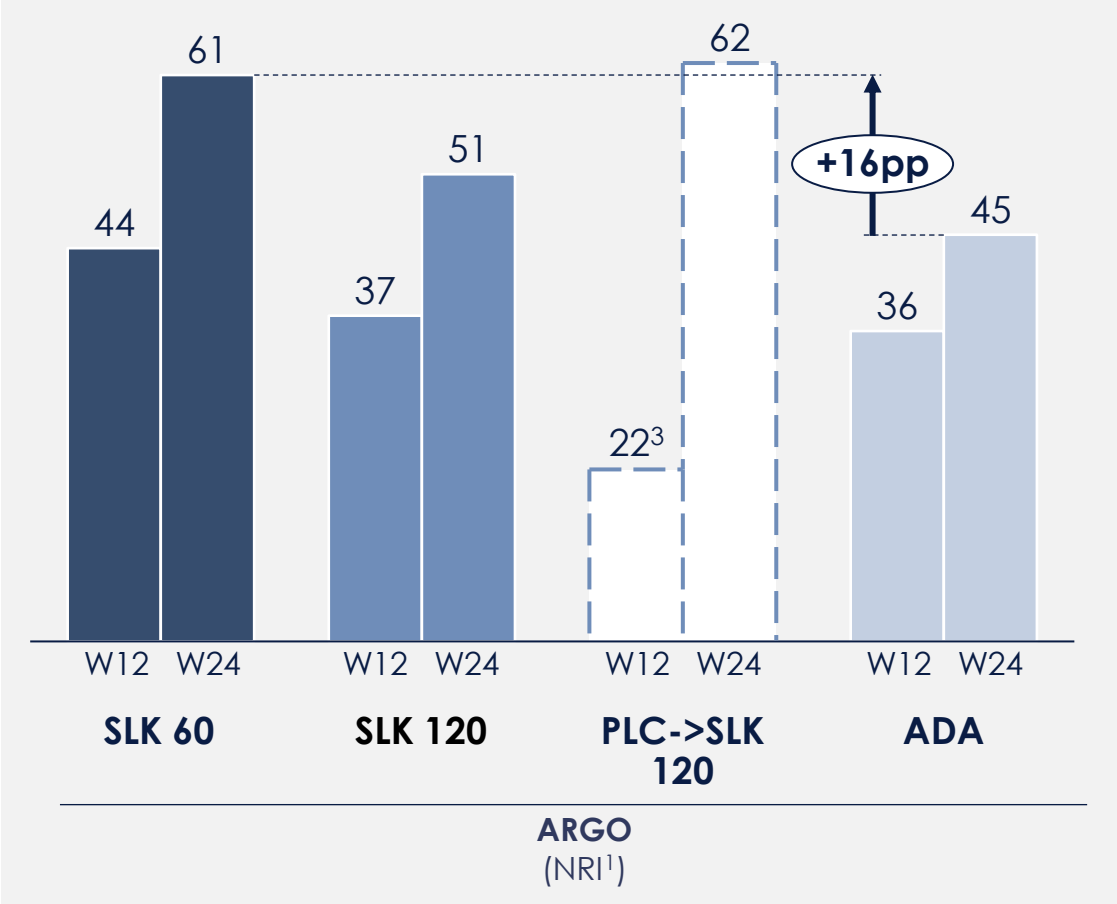
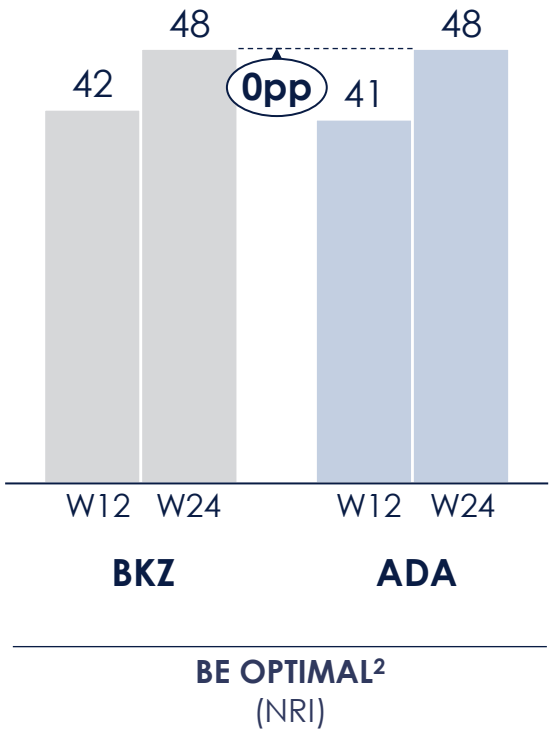
Patients reaching Minimal Disease Activity (MDA)

Percent (%) pts reaching score





SLK brought over 50% of patients to MDA response across arms, higher than has been seen in previous PsA trials

Delta to adalimumab was observed (up to 16pp) within the trial, which **has not been the case with BKZ** in the trial that incl. the same reference arm

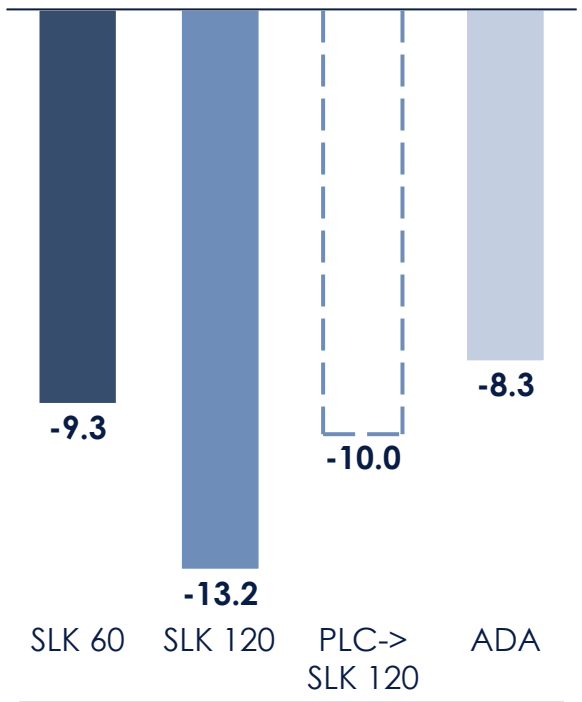
Note: Comparison across trials have inherent limitations. No head-to-head trials 1 ITT-NRI up to Week 24, except that participants who were re-assigned from their original treatment arm at Week 12 as per protocol had last observation carried forward from Week 12 onwards; 2 Ritchlin et al. Ann Rheum Dis 2023;82:1404–1414 BE OPTIMAL; 3 Differs from the overall PLC rate at Week 12 (20%) because this includes only those participants who were crossed over to SLK 120mg at W12

Source: MoonLake Clinical

SLK also shows **higher responses in deep-tissue** at wk 24

Nail PsO Severity (mNAPSI)

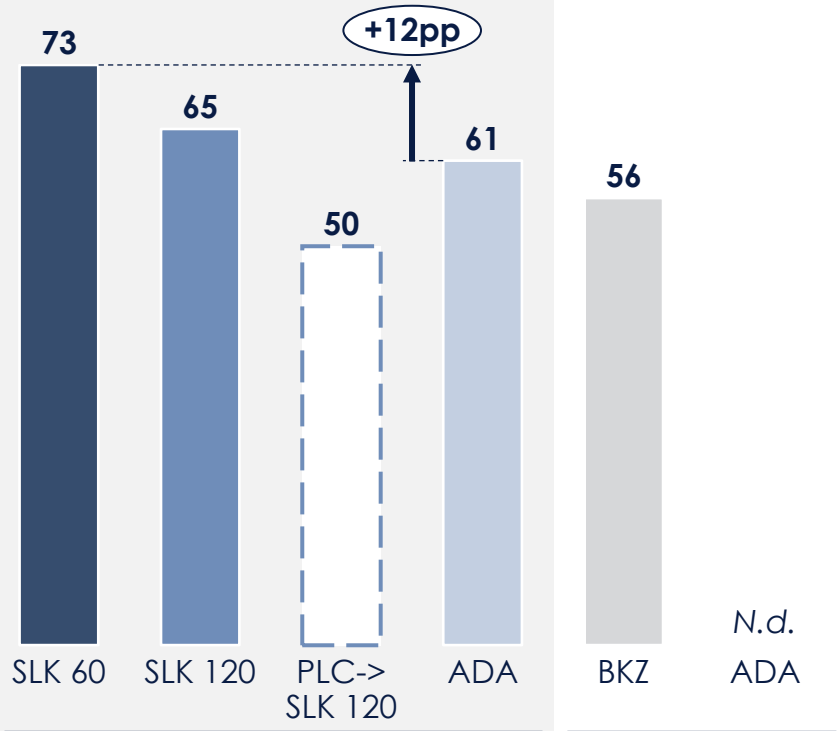
Mean change from baseline



ARGO
(Wk 24, LOCF[1])

Nail PsO Resolution (mNAPSI=0)

Percent (%) of pts with mNAPSI>0 at baseline that achieve mNAPSI=0

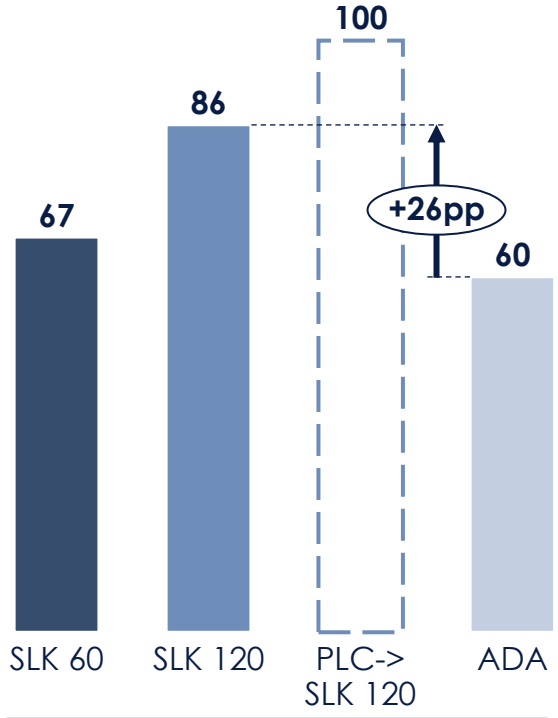


ARGO
(Wk 24, NRI[2])

BE OPTIMAL[3]
(Wk 24, NRI)

Leeds Enthesitis Index (LEI)

Percent (%) of pts with LEI 2+ at baseline that improved 2+ pt



ARGO
(Wk 24, NRI[2])

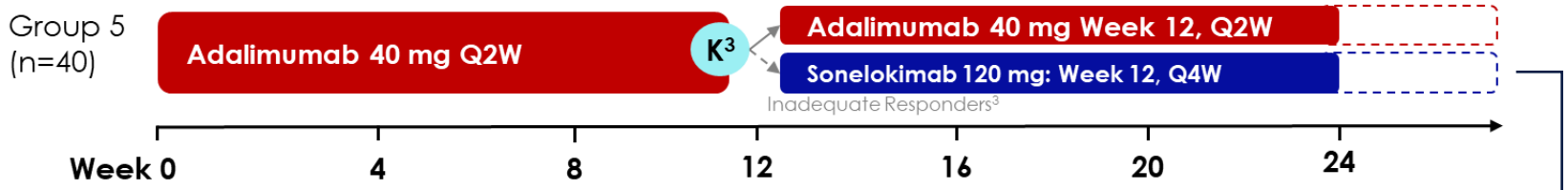
Deltas to adalimumab continue to improve from week 12 to week 24

Note: Comparison across trials have inherent limitations. No head-to-head trials. 1 Last observation carried forward for all missing values; 2 ITT-NRI up to Week 24, except that participants who were re-assigned from their original treatment arm at Week 12 as per protocol had last observation carried forward from Week 12 onwards; 3 Merola et al., ACR Convergence 2023 poster 1433, estimate from graph

Source: MoonLake Clinical

Part B crossover signals **potential of SLK in TNF non-responders**

ARGO trial design – Adalimumab group re-allocation at Week 12



Patients reaching Minimal Disease Activity (MDA)

Percent (%) pts reaching score, NRI[1]

- In the 7 participants crossed from ADA to SLK 120mg, **MDA response rates at week 24 were similar to the other SLK arms** after 12 weeks of SLK exposure
- **Similar trends were seen on other endpoints** (e.g. PASI, mNAPSI, PhGADA, PROs, etc.)
- *Due to small n numbers, the crossover arms are not sufficiently powered for definitive comparisons with the other arms*
- We will **explore SLK potential in TNF-IR patients** in Phase 3

Note: Comparison across trials have inherent limitations. No head-to-head trials 1 Subset of participants with BSA >=3% at baseline, ITT-NRI up to Week 24, except that participants who were re-assigned from their original treatment arm at Week 12 as per protocol had last observation carried forward from Week 12 onwards; 2 Total of 7 inadequate ADA responders crossed over to SLK 120mg Inadequate response was defined as <20% improvement in either SJC or TJC by Week 12

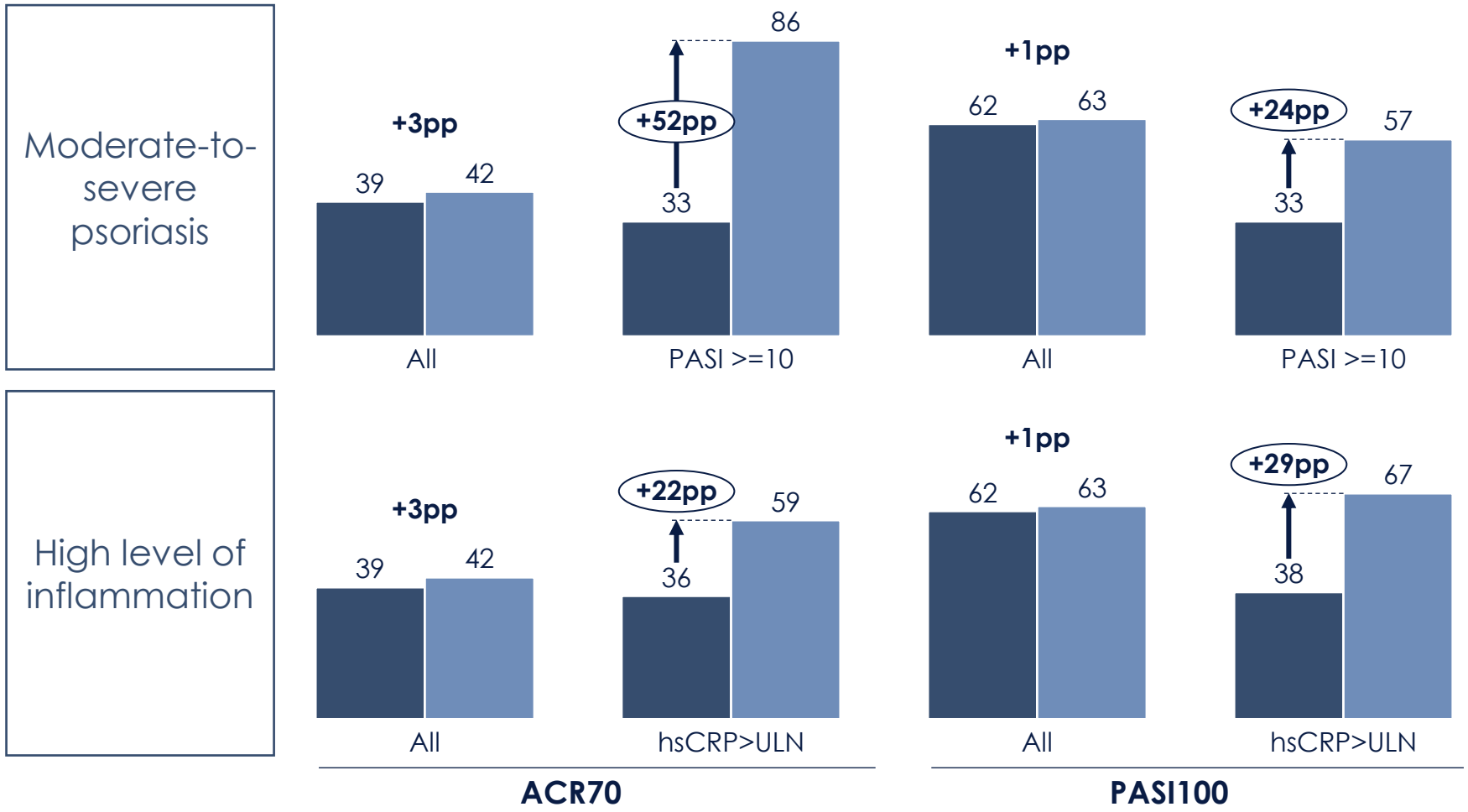
Source: MoonLake Clinical

Higher 120mg efficacy in key subgroups

Response rates at week 24 (subgroups)

SLK 60mg SLK 120mg

Percent (%) of pts, NRI[1]



- Key subgroups may further **benefit with 120mg** vs 60 mg
- Incl. those with **high level of skin involvement** (moderate-to-severe PsO) and **high level of inflammation** (high CRP)
- Or patients with **high PsA disease activity** (DAPSA≥28) and presence of **nail disease** (mNAPSI>0)
- Other subgroups benefit at wk12 but the 60mg "catches-up" in many patients at wk 24 – **up-titration likely a case-by-case decision for these patients** (e.g., high MTX use, high weight, prio Bx use)
- Patients benefiting from higher dosing (from start or up-titration) **estimated to be 20-30%** of the trial population

1 ITT-NRI up to Week 24, except that participants who were re-assigned from their original treatment arm at Week 12 as per protocol had last observation carried forward from Week 12 onwards;

Source: MoonLake Clinical

Safety: **no notable signals**, a favorable benefit-risk profile in PsA

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	Part A				Part A + B		
	Placebo	**Sonelokimab** 60mg w/induction	**Sonelokimab** 120mg w/induction	**Adalimumab** *(active reference)*	**Sonelokimab** 60mg	**Sonelokimab** 120mg	**Adalimumab** *(active reference)*
Patients with events, n	39	41	43	42	82	97	47
Any TEAE	15 (38.5%)	14 (34.1%)	17 (39.5%)	14 (33.3%)	37 (45.1%)	57 (58.8%)	22 (46.8%)
Any SAE	0	1 (2.4%)	0	0	1 (2.4%)[2]	4 (4.1%)[2]	0
Any TEAE leading to discontinuation	0	0	1 (2.3%)	0	0	6 (6.2%)[4]	0
Fatal TEAE	0	0	0	0	0	0	0
Most frequent TEAEs[1]							
Nasopharyngitis	1 (2.6%)	1 (2.4%)	0	3 (7.1%)	5 (5.6%)	5 (5.2%)	4 (8.5%)
Upper respiratory tract infection	1 (2.6%)	2 (4.9%)	1 (2.3%)	1 (2.4%)	5 (5.6%)	4 (4.1%)	2 (4.3%)
Injection site erythema (reaction)	0	2 (4.9%)	3 (7.0%)	1 (2.4%)	3 (3.7%)	3 (3.1%)	1 (2.1%)
Adverse events of special interest							
IBD	0	0	0	0	0	0	0
Diarrhea	0	1 (2.4%)	0	1 (2.4%)	1 (1.2%)	2 (2.1%)	1 (2.1%)
Candidiasis							
Oral Candidiasis	0	1 (2.4%)	0	0	2 (2.4%)	2 (2.1%)	0
Oropharyngeal Candidiasis	0	0	0	0	0	0	0
Esophageal Candidiasis	0	0	0	0	0	0	0
Vulvovaginal Candidiasis	0	0	0	0	0	0	0
Skin Candidiasis	0	0	0	0	0	0	0
Genital Candidiasis	0	0	0	0	0	0	0
Other adverse events of interest							
Serious hypersensitivity	0	0	0	0	0	0	0
Serious infection	0	1 (2.4%)	0	0	1 (2.4%)[2]	1 (1.0%)[2]	0
MACE	0	0	0	0	0	0	0
Liver AST/ALT > 5x ULN[3]	0	0	0	0	0	0	0

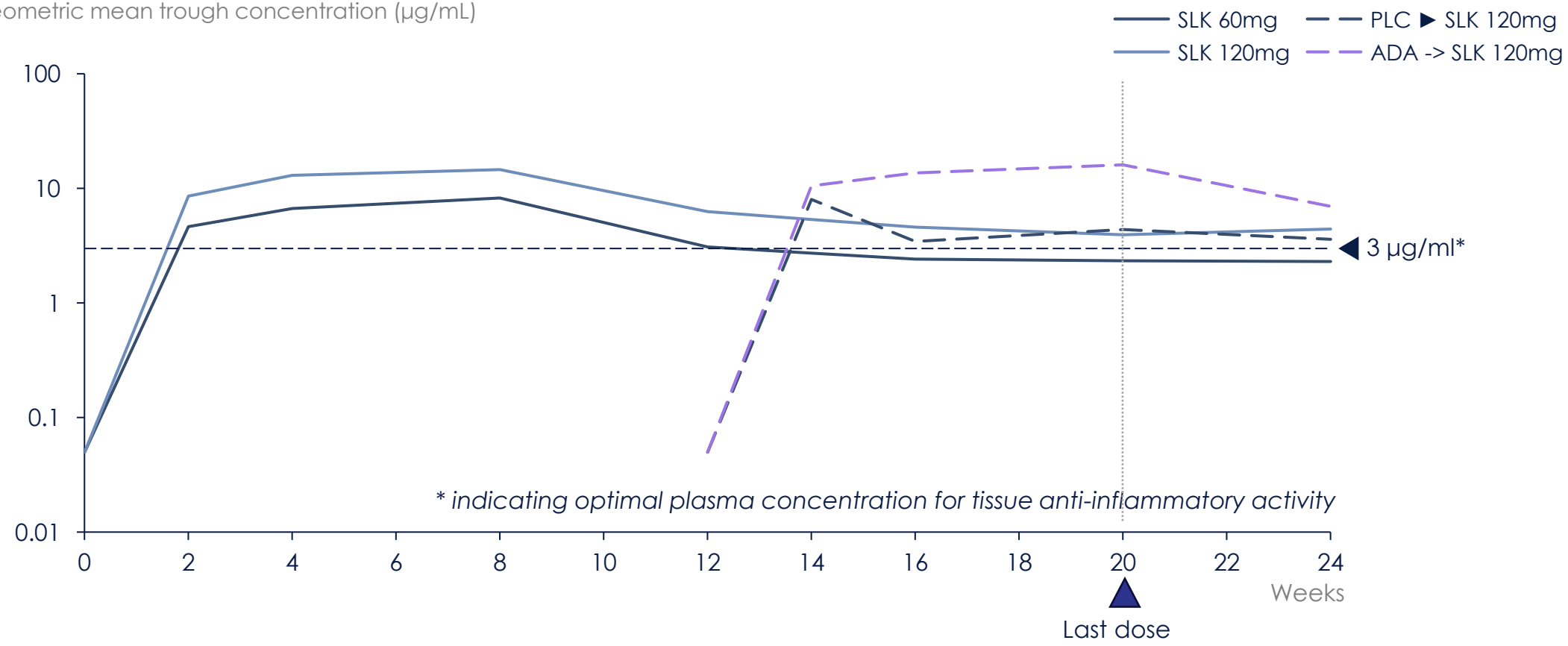
ALT, Alanine aminotransferase and AST, Aspartate transaminase; IBD, inflammatory bowel disease; MACE, major adverse cardiovascular event; SAE, serious adverse event; TEAE, treatment-emergent adverse event; ULN, upper limit of normal; 1 Top three most frequent AEs in the SLK groups. Note: The adalimumab therapy used in the MIRA trial was the originator drug (citrate-free formulation); 2 No SAEs judged to be treatment related; 3 One case with elevated transaminases >3x ULN in adalimumab arm reported as an AE; one case of transient elevated transaminases and CK concurrent with a reported event of exercise-related muscle inflammation in SLK 60 mg; 4 TEAEs leading to discontinuation included 1 x tonic-clonic seizure, 1x Furuncle, 1x Pharyngeal abscess & Subcutaneous emphysema,1 x Tonsillar inflammation, 1 x Epididymitis, 1 x Arthritis

Source: MoonLake Clinical

PK data shows ARGO PsA **doses behave as expected**

SLK trough concentrations

Sonelokimab geometric mean trough concentration (µg/mL)



Trough concentrations of crossed over arms **replicate data** from first 12 weeks, **rapidly bringing SLK above** optimal plasma concentration (to reduce large amounts of target) and **remaining above level** as patients move to maintenance dose

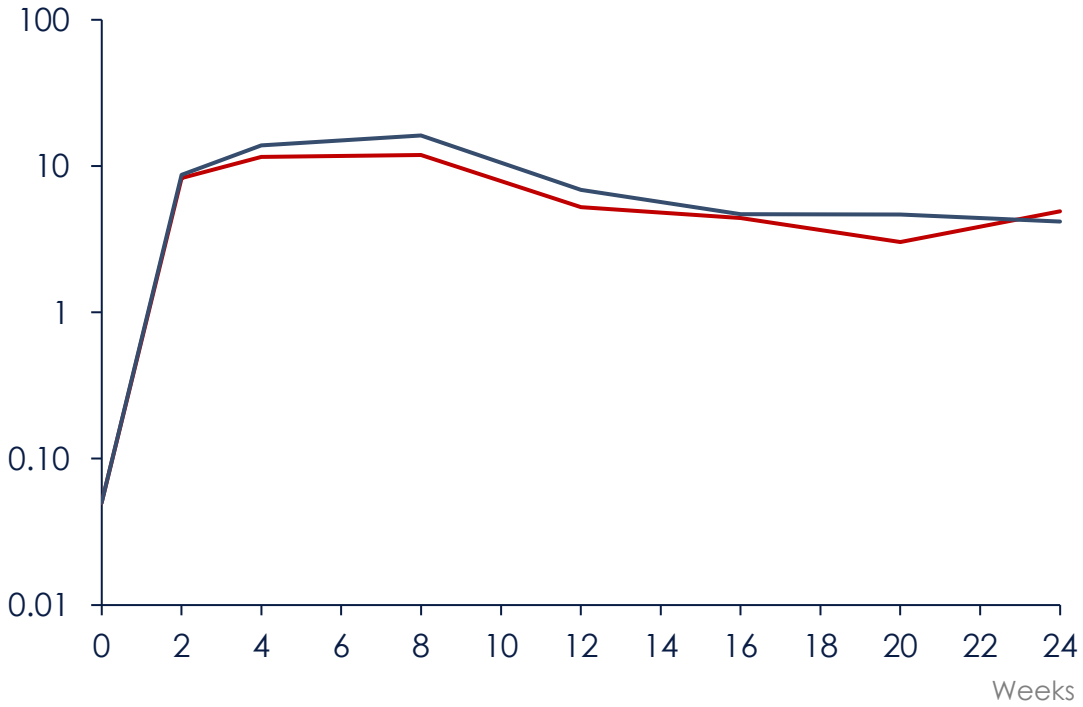
Source: MoonLake Clinical

No signs of clinically relevant immunogenicity

Treatment emergent ADA — Yes (Y) — No (N)

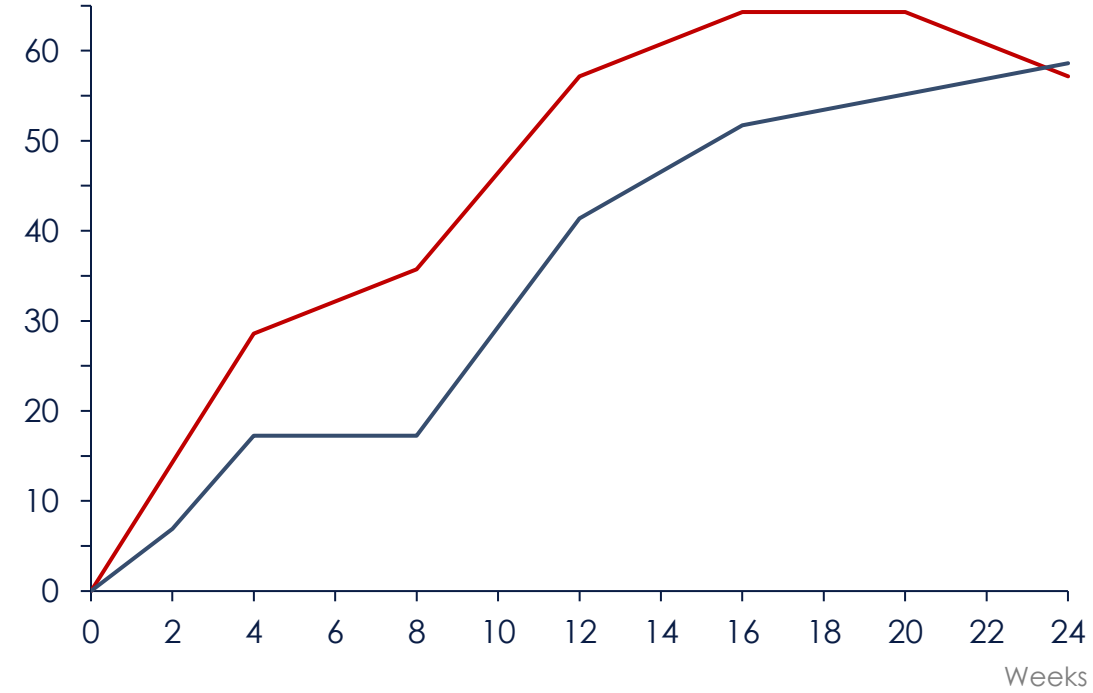
SLK trough concentrations were unaffected by treatment-emergent ADA status

SLK 120mg geometric mean trough concentration (µg/mL) by ADA status



Furthermore, clinical response was unaffected by anti-drug antibodies[1]

SLK 120mg ACR50 response rate (%) by ADA status



Similar for 60mg dose

Source: MoonLake Clinical

PsA: A clear path towards Phase 3 (current plan)

MoonLake

What know now from ARGO

- **Dose-response pattern in line with findings** in plaque-type Psoriasis (PsO, 313 patients) and Hidradenitis Suppurativa (HS, 234 patients)
- Doses with **optimal benefit-risk profile** identified for PsA – **60 mg & 120mg** (with induction)
- Support of **favorable safety profile**
- Main ARGO study design **elements will be replicated in Phase 3** design
- **Larger program size** (potentially ~1,100-1400) expected to **reduce variations** driven by small groups
- **Sub-groups** with up-titration potential identified
- **Endpoints confirmed** for Phase3 – ACR50 & PASI90 – but with expected **primary endpoint at week 16 and emphasis on composite secondaries**
- Currently planning **two trials**
  - **TNF-IR** trial
  - **Bio-naïve** trial

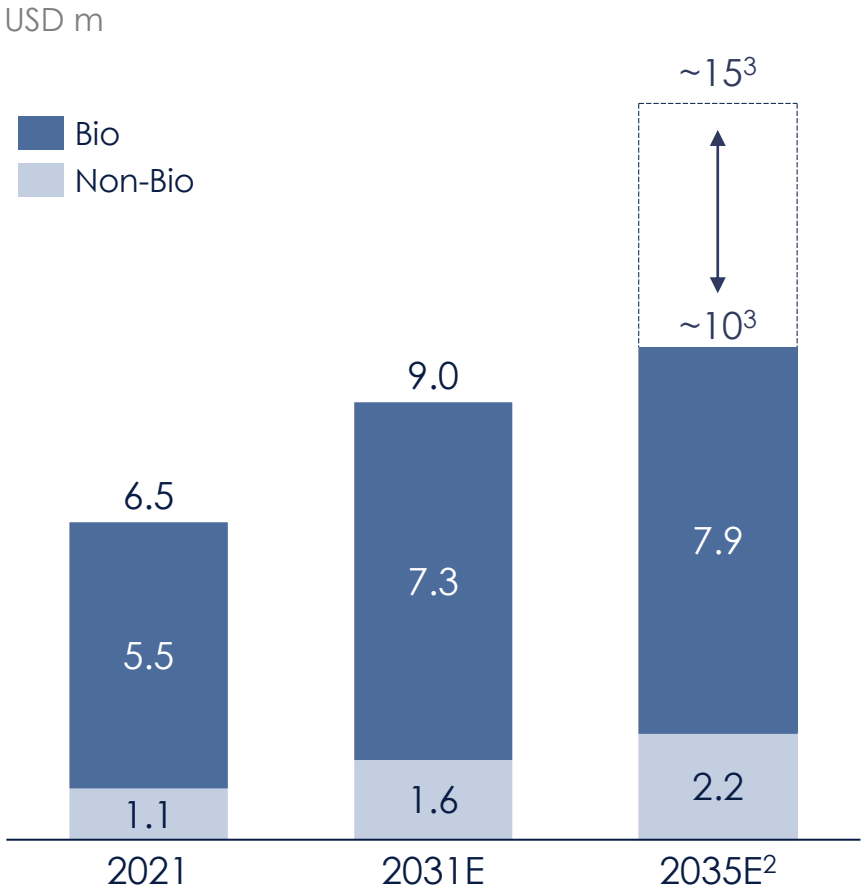
Planned FDA EoP2 timeline
(parallel with EMA):

- Submission of FDA meeting request: Q1 2024
- Submission of FDA briefing book: Q1 2024
- FDA Meeting: Expected Q2 2024
- Full TFLs from the Ph 2 PsA trial (ARGO) due by Q2 2024

Source: MoonLake Clinical

IL-17 expected to become largest MoA in PsA in the next years

PsA market size estimates[1]



Key notes

- IL-17 becomes **largest drug class** in the next years in PsA (already estimated as 35-40% of market in 2031)
- Most data sources, incl. DRG/Carivate have BKZ latest estimates performed **before BE COMPLETE** (Ph 3) results
- **SLK is not yet part** of general, publicly available estimates – although an all-analysts-average places **sales for PsA above blockbuster leve**l
- BKZ is **~18% of IL-17** class by 2031 according to DRG/Clarivate, which is **likely an underestimation** versus SEC or IXE
- Most analysts suggest a small percentage market share for SLK only (~1-15%) – likely **an underestimation** versus any biologic leading any immunology market[4]

1 Based on DRG/Clarivate data ("Bio" included TNFs, IL-12/23, IL-17 and IL-23 related assets; "Non-Bio" includes all DMARDs, JAK inhibitors and selection co-stimulation modulators); 2 Based on extending sales to 2035 using a 5-year historical CAGR (2027-2031); 3 Upper bound of range indicated in Analyst Reports that cover MLTX (where available); 4 Considering DRG data from 16 Immunology indications: PsA, RA, Asthma, Moderate adult AD, Severe adult AD, nr-axSpA, AS, CU, LN, SLE, PsO, COPD, Acute CD, Maintenance CD, Acute UC, Maintenance UC (where avg. biologic share per indication is ~13%, share of second leading biologic is ~23% and share of leading Biologic is 36%
Source: MoonLake, DRG/Clarivate, Analyst Reports

PsA: ARGO results confirm SLK as the potential leader in PsA

MoonLake

Unprecedented multi-domain response	**60%** of patients reach **MDA** and **~60%** reach **ACR50+PASI90**, at wk 24 - *confirming consistent multi-domain impact of SLK*
Greater depth of response	**40%+** reach **ACR70 and 60%+ reach PASI100 by** wk 24, with **~50%** patients reaching the **ACR70+PASI100 composite** – *long lasting effect and not yet maxed out*
More disease control	**Fast onset** (ACR50, 27% wk 8) coupled with **increasing efficacy** at wk 24 (ACR50, **61%** wk 24) – *also reflected in deep tissue (70% nail clearance) and patient reported outcomes*
Flexible dosing	**60mg confirmed as sufficient** to achieve leading results in most domains, **120mg adds benefit in specific subgroups** – *highly convenient regimens (monthly maintenance)*
Beyond current biologics	At wk 24, **patients respond better with SLK** vs. ADA in all critical scores and higher than other Bx – *a differentiated step-up*
Favorable safety profile	**No new** signals, **mAb-like ISR** rate, *Candida* (if present) **transient** and with **no discontinuations**

Source: MoonLake Corporate

MoonLake

HS

Franchise building indication

MoonLake

HS – A devastating disease

Prof Kenneth B. Gordon

Disclosures

Prof Gordon has received honoraria and/or research support from the following pharmaceutical companies: AbbVie, Amgen, Arcutis, Bristol-Myers Squibb, Boehringer Ingelheim, Dermavant, DICE, Incyte, Eli Lilly, Janssen, LEO Pharma, MoonLake Immunotherapeutics, Novartis, Pfizer, Protagonist, UCB, Union

Hidradenitis suppurativa: a challenge and an opportunity

HS is **progressive** and results in **irreversible tissue destruction** over time…[1]

…we need HS therapies that treat **all types of lesions**, with the **opportunity for inflammatory remission**

Delayed and insufficient treatment are **critical gaps** in disease management…[2]

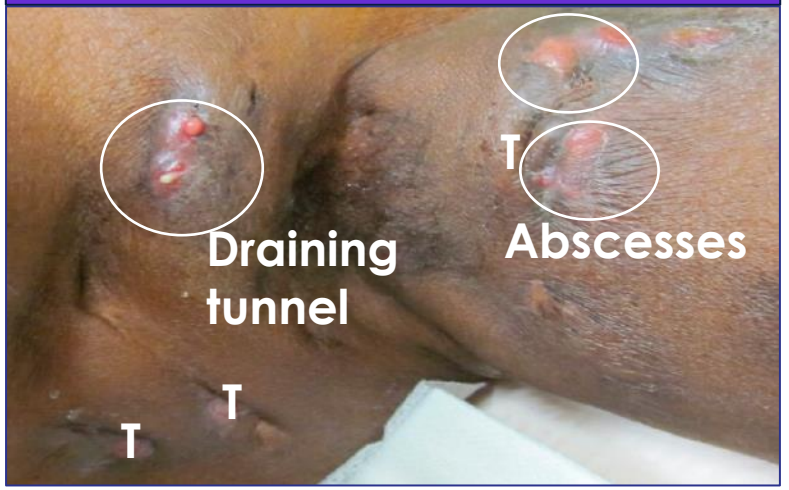
…we need HS therapies that provide **sustained and significant improvements** to patients' lives

2%
Est. global prevalence

Delayed (and **under-**) **diagnosis** drive conservative prevalence estimates…[2,3]

…we need HS therapies that are **developed with all patients in mind** — reflecting many millions of people

Advanced disease with deep abscesses and tunnels[4]



Late-stage disease with extensive scarring and ulceration[4]

1 Sabat et al Nat Rev Dis Primers 2020;6:18 2 Krueger et al Br J Dermatol 2024;190:149–162 3 Ingram et al EADV 2023;Poster P0046 4 T, tunnel | Pictures courtesy of Prof. Kenneth B. Gordon and Dr Gretchen M. Roth

HS is characterized by a profound burden for patients and society

Symptoms[1]

Key symptoms include...

- **Pain**
- **Malodorous drainage**
- **Low mood/depression**

...and may be more burdensome in patients with draining tunnels

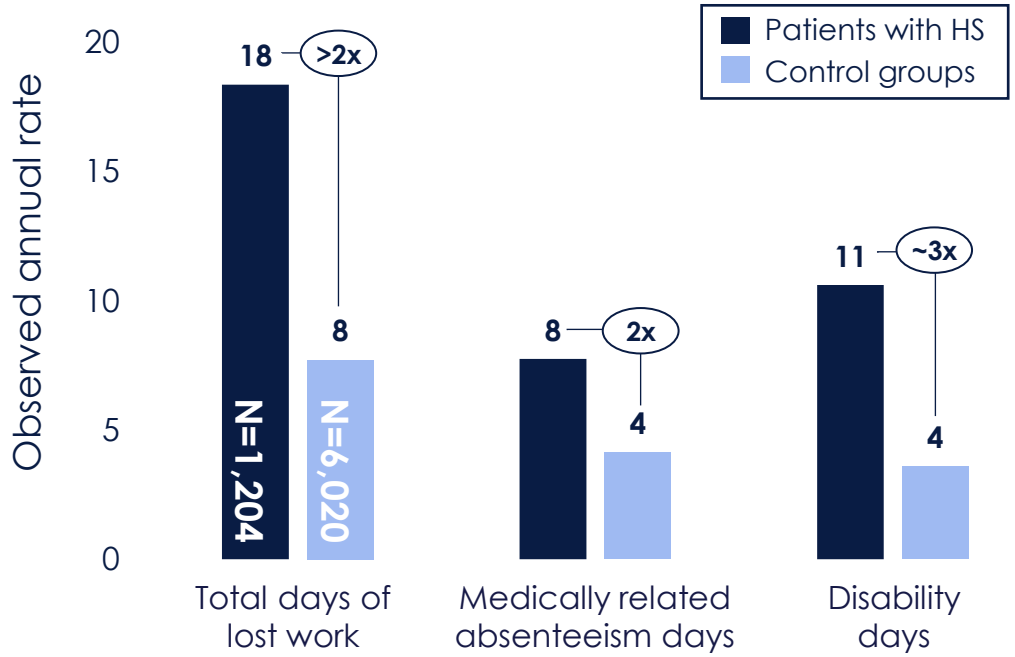
Hospitalizations

Hospitalization and ER visits are common for patients with HS[2]

- **30% of patients with HS were hospitalized** as an inpatient on ≥1 occasion, in a US claims database covering 2016–2019[2]
- **6 days in hospital** and **$33k costs** represent a typical hospitalization of a patient with HS, according to NIS data[3]

Work and employment burden

In the US, HS leads to **>2x days of lost work** and nearly **3x** disability days vs. controls[4]

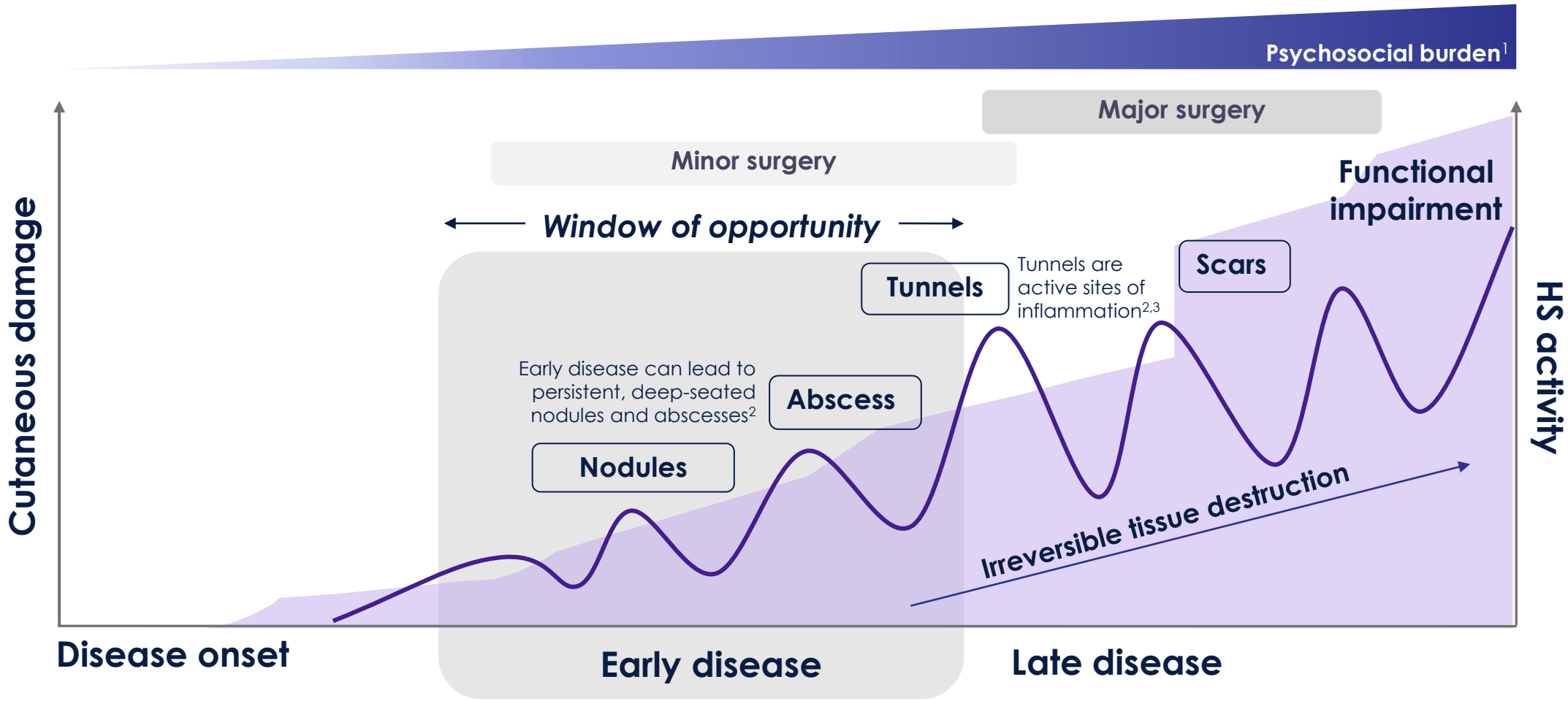


A similarly severe impact on work and employment is seen in Europe[5]

NIS, National Inpatient Sample

1 Ingram et al EHSF 2023;Poster P139 2 Chopra et al SID 2022;Poster 343 3 Bhattaru et al AAD 2023;Poster 43666 4 Tzellos et al Br J Dermatol 2019;181:147–154 5 Schneider-Burrus et al Br J Dermatol 2023;188:122–130

Chronic inflammation in HS progresses to irreversible tissue destruction



Resolution of **nodules, abscesses and tunnels** in a **'Window of Opportunity'** may offer the possibility of remission

Figure adapted from Martorell et al Actas Dermosifiliogr 2016;107(Suppl 2):32–42

1 Ooi et al JAAD Int 2023;10:89–94 2 Sabat et al Nat Rev Dis Primers 2020;6:18 3 Navrazhina et al J Allergy Clin Immunol 2021;147:2213–2224

Can we treat HS more effectively in the 'Window of Opportunity'?

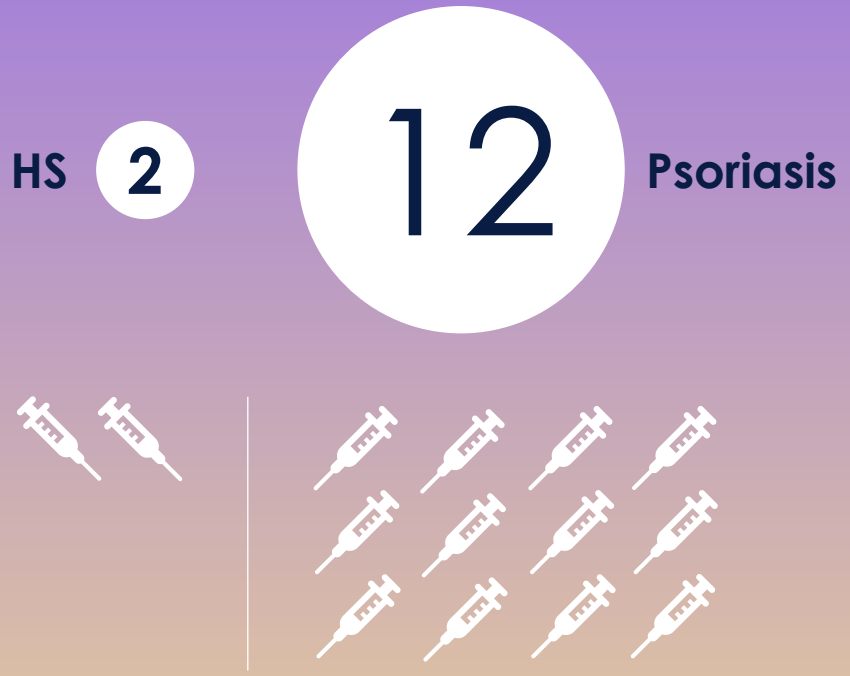
We need

- **More treatment options**
- **Better therapies**
- **Shorter time to treatment**

to allow health systems to move patients onto treatment more quickly, and to keep them there

Only 2 biologics are approved for HS

FDA-approved biologic therapies[1]



1 Drugs @ FDA: HS — adalimumab, secukinumab. Psoriasis — etanercept, infliximab, adalimumab, ustekinumab, certolizumab pegol, secukinumab, ixekizumab, brodalumab, guselkumab, tildakizumab, risankizumab, bimekizumab

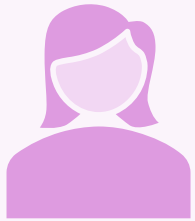
Current therapy with adalimumab has high discontinuation rates

Median drug survival
Adalimumab in US patients with HS[1]

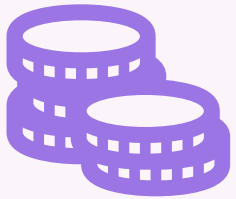
<1 year

1 in 3 US patients with HS **discontinue** adalimumab within **6 months**[1]

Patient groups with the highest burden of drug discontinuation…[1]



Women



Medicaid coverage

Younger adults

Recent surgery

→ Similar rates observed in Europe: median drug survival reported from 8–9 months (Denmark) to 18 months (Netherlands)[2]

1 Kimball et al EHSF 2024;T6-P-08

2 Data also available for Austria | Ring et al JAMA Dermatol 2022;158:184–188, Prens et al Br J Dermatol 2021;185:177–184, Wiala et al EADV 2023;P0134, Ring et al Br J Dermatol 2024;doi:10.1093/bjd/ljae042

What do we need from an effective therapy in HS?

Sustained efficacy is key for both derms and patients[1,2] and is central to other aims of treatment

Hospitalizations[3,4]
- Reduce the burden of inpatient and ER visits
- Reduce surgical interventions

Symptoms[6]
Alleviate symptom burden by resolution of all inflammatory lesion types, including tunnels

Work and employment burden[5]
- Enable employment
- Increase personal happiness and social integration

Established safety profile[1,6] — Risk of serious adverse events is another important consideration for both derms and patients

The consequences of uncontrolled HS are substantial for all aspects of patients' lives and society

1 Ingram et al EHSF 2023;T6-O-15 2 Ring et al Br J Dermatol 2024;doi:10.1093/bjd/ljae042 3 Garg et al J Am Acad Dermatol 2020;82:366–376 4 Krueger et al Br J Dermatol 2024;190:149–162
5 Schneider-Burrus et al Br J Dermatol 2023;188:122–130 6 Willems et al Patient 2023;16:153–164

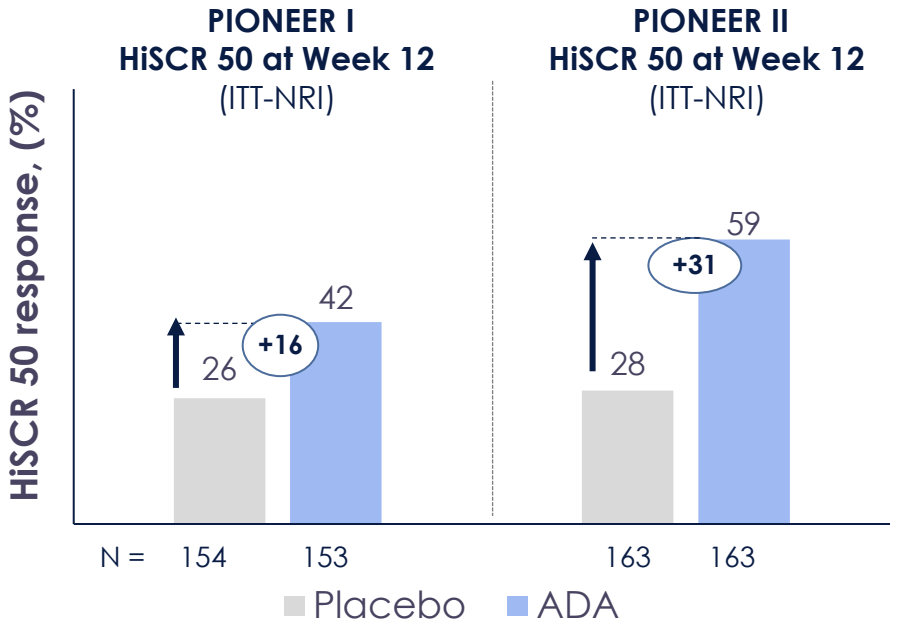
Treatment goals have not been advanced in eight years

Adalimumab (Humira®[1]) **FDA HS approval 2015**[1]

- **TNF inhibitor** Traditional mAb (~148kDa)

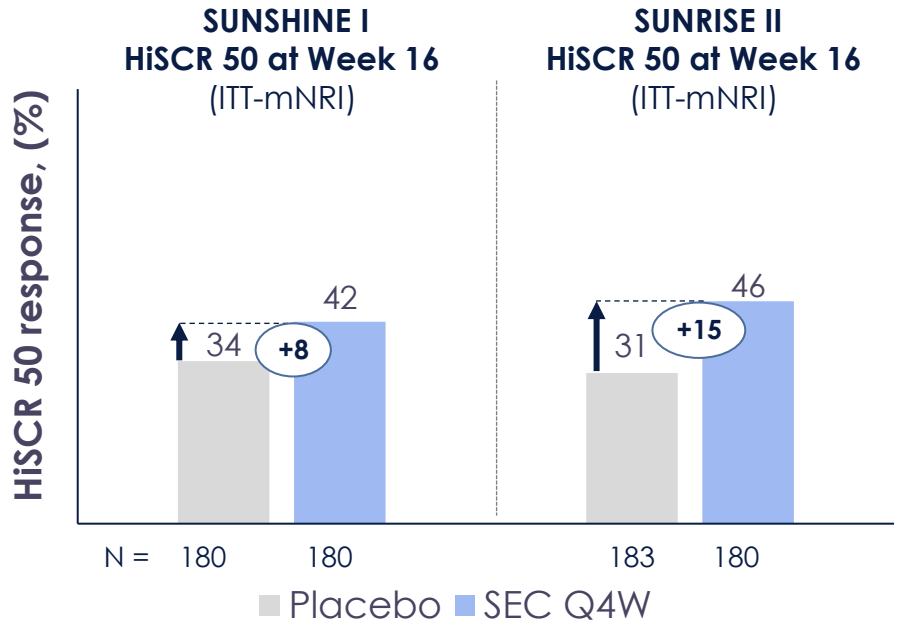
Secukinumab (Cosentyx®[3]) **FDA HS approval 2023**[2]

- **IL-17A inhibitor** Traditional mAb (~150 kDa)



50% improvement (HiSCR50) in approx. 50% of patients

8 years



50% improvement (HiSCR 50) in approx. 45% of patients

Additional therapeutic options with alternative mechanisms of action and higher levels of response are urgently needed

1 ITT-NRI, non-responder imputation in an intention-to-treat population | Humira® Prescribing Information, Kimball et al N Engl J Med 2016;375:422–434
2 ITT-mNRI, modified non-responder imputation in an intention-to-treat population | Cosentyx® Prescribing Information, Kimball et al. Lancet 2023;40:747–761

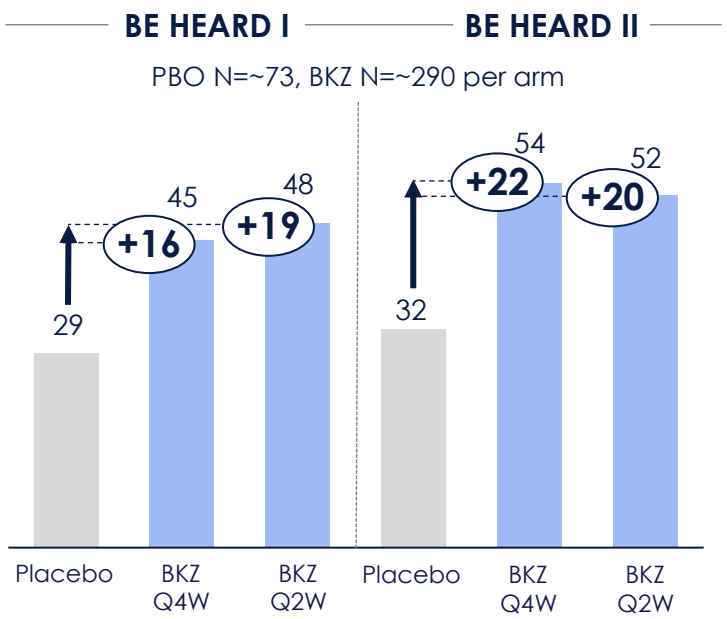
Can targeting IL-17A + IL-17F advance treatment goals in HS?

Bimekizumab (Bimzelx®)

- **IL-17A and IL-F inhibitor** Traditional mAb (~150kDa)

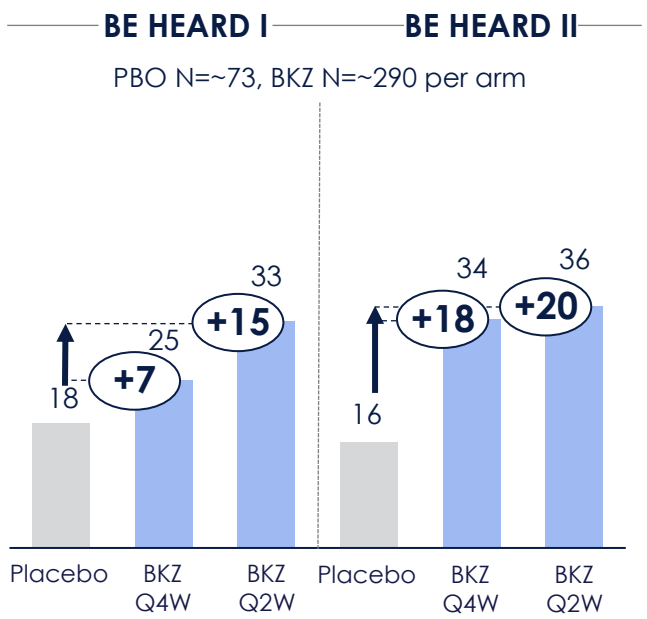
Primary endpoint

HiSCR 50 at Week 16 (ITT-mNRI)



Secondary endpoint

HiSCR 75 at Week 16 (ITT-mNRI)



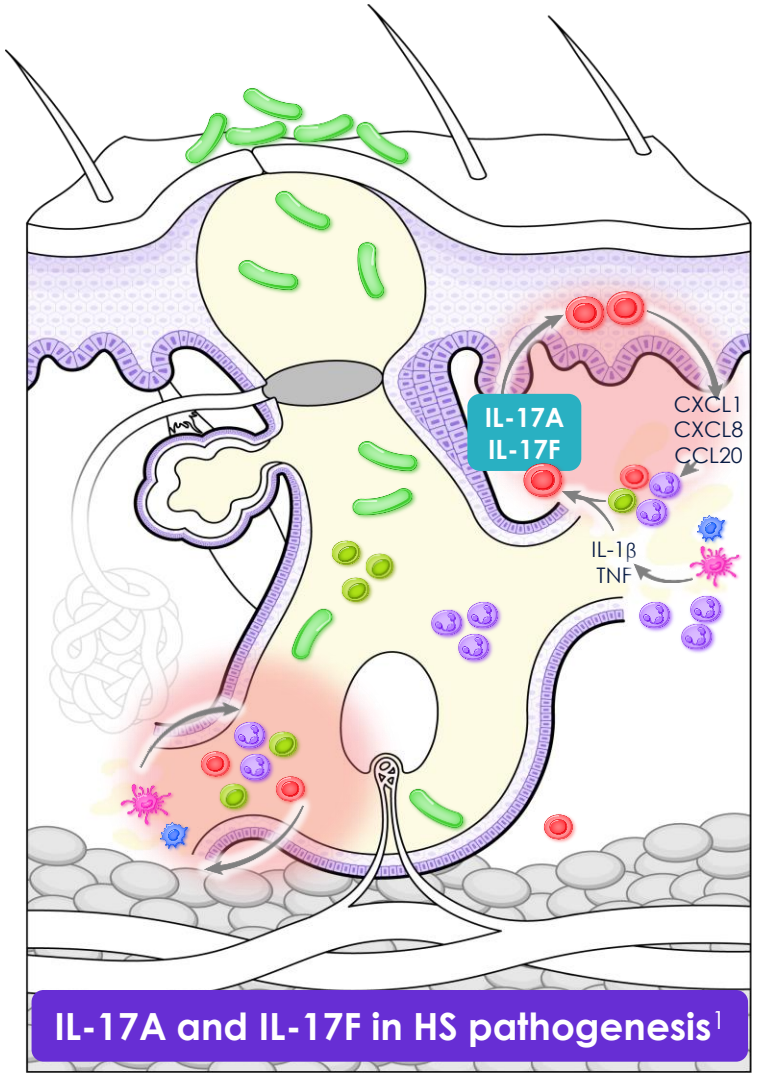
Elevating trial endpoints

- Primary endpoint response was within the range of reports from earlier HS trials
- HiSCR 75 data suggested possibility of achieving higher threshold responses in HS than HiSCR 50

- Safety profile: No unexpected findings (oral candidiasis as expected from MOA)
- Maintenance of response: Phase 3 data showed continued efficacy to Week 48

mNRI; modified non-responder imputation, with missing data due to adverse events or lack of efficacy, and systemic antibiotic initiation or intensification, imputed as non-response
Kimball et al AAD 2023;late-breaking presentation

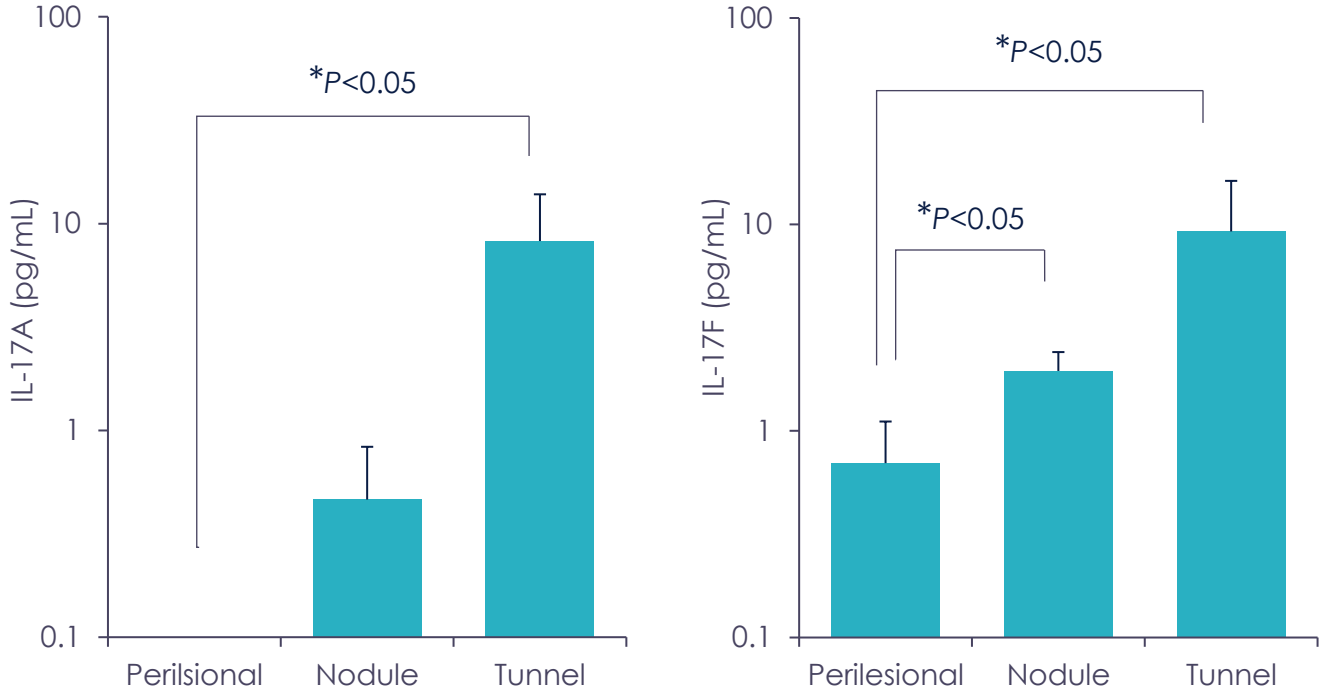
Elevated IL-17A + IL-17F in HS: rationale for targeting both cytokines



IL-17A and IL-17F in HS pathogenesis[1]

Both IL-17A and IL-17F are elevated in HS lesions, including inflammatory nodules and draining tunnels

MoonLake research[2]



IL-17A and IL-17F protein levels measured by cytokine array

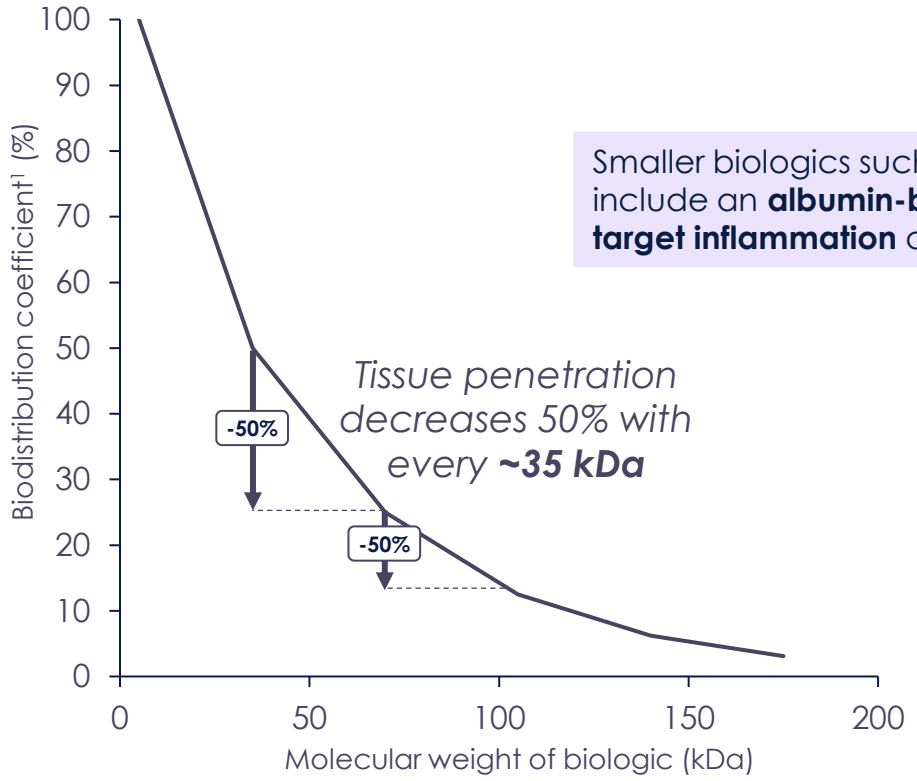
Data represent mean ± SEM. N=6 biopsy lysate samples for each tissue

1 Figure reproduced under the terms of the CC-BY license | Krueger et al Br J Dermtol 2024;190:149–162

2 SEM, standard error of the mean | Reich et al EHSF 2024;T1-P-03

Can Nanobodies® improve outcomes in HS?

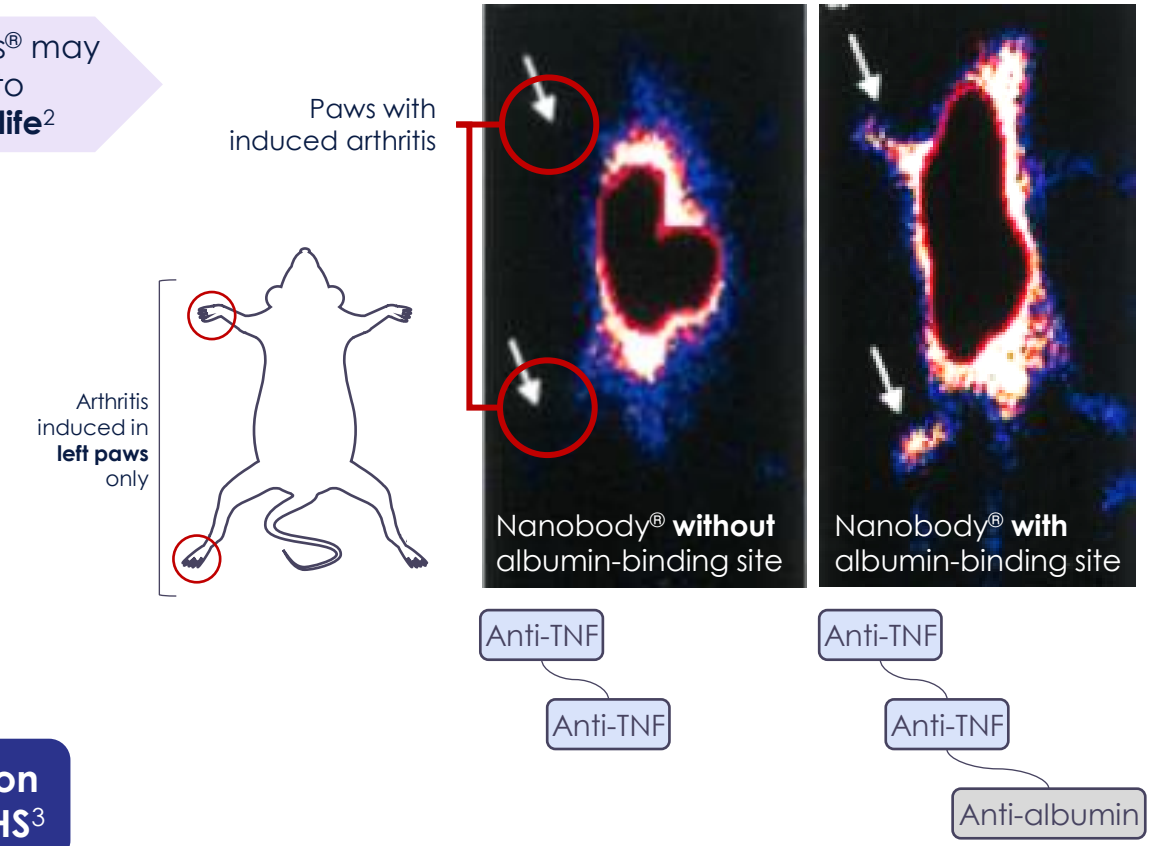
Smaller biologics → higher tissue uptake[1]



Smaller biologics such as Nanobodies® may include an **albumin-binding domain** to **target inflammation** and **extend half-life**[2]

Albumin-binding domains target inflammation

Accumulation of Nanobodies® 24 h after treatment[2]
Distribution of anti-TNF Nanobodies® +/- albumin-binding site 24h after a single injection in mice with collagen-induced arthritis



Nanobodies® are designed to directly target sites of inflammation in difficult-to-reach tissues, such as the deep dermal tunnels in HS[3]

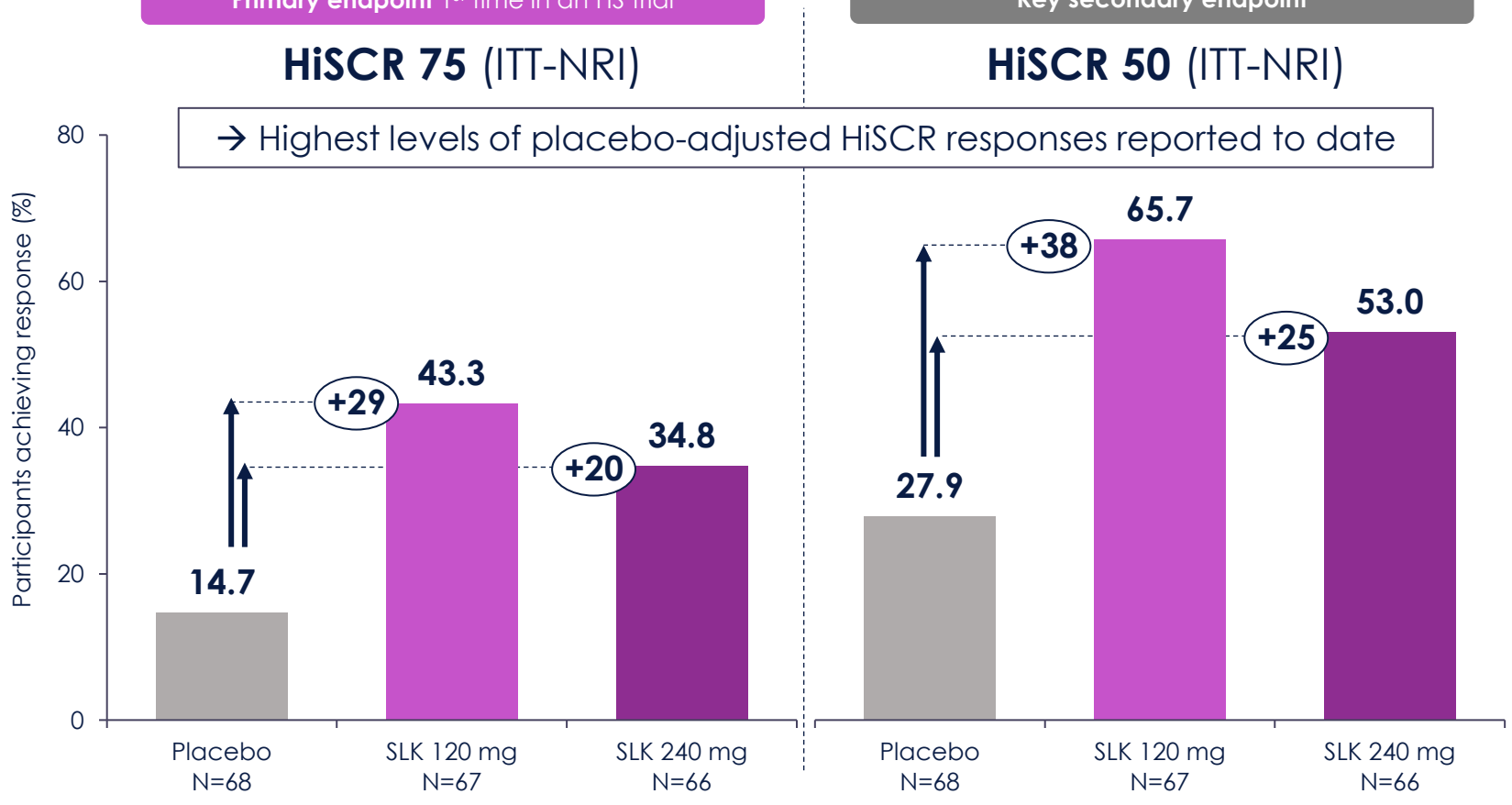
1 Biodistribution coefficient, calculated as tissue concentration/plasma concentration in muscle (other tissues ranged from 14 to 41 kDa molecular weight change required for a 50% difference in tissue penetration); Li et al mAbs 2016;8:113–9
2 Coppieters et al Arthritis Rheum 2006;54:1856–66 3 Krueger et al Br J Dermatol 2024;190:149–162

High levels of response were seen with sonelokimab in the MIRA trial

MIRA efficacy at Week 12

Primary endpoint 1st time in an HS trial

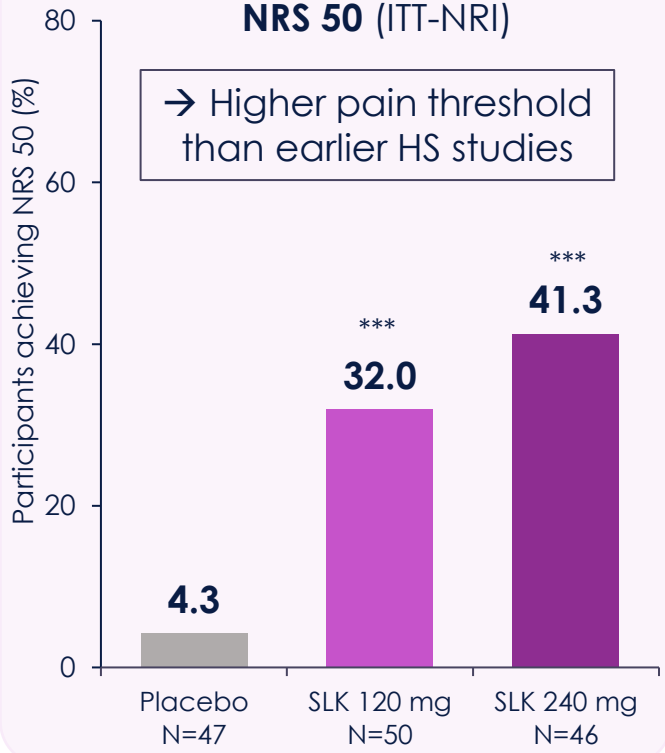
Key secondary endpoint



Sonelokimab was well tolerated with no unexpected safety findings

Pain at Week 12

SLK achieved pain responses at the high threshold of NRS 50

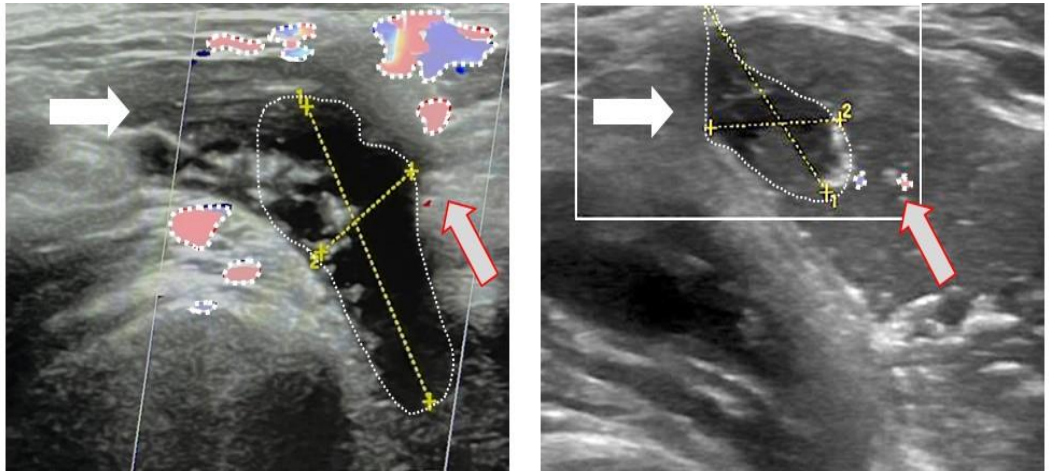


Peer-reviewed Week 24 data will be presented today at AAD Late-breaking research session, 14:00 PST

Kimball et al EADV 2023;late-breaking presentation D1T01.1H

Imaging lesions beneath the skin shows a direct effect on tunnels

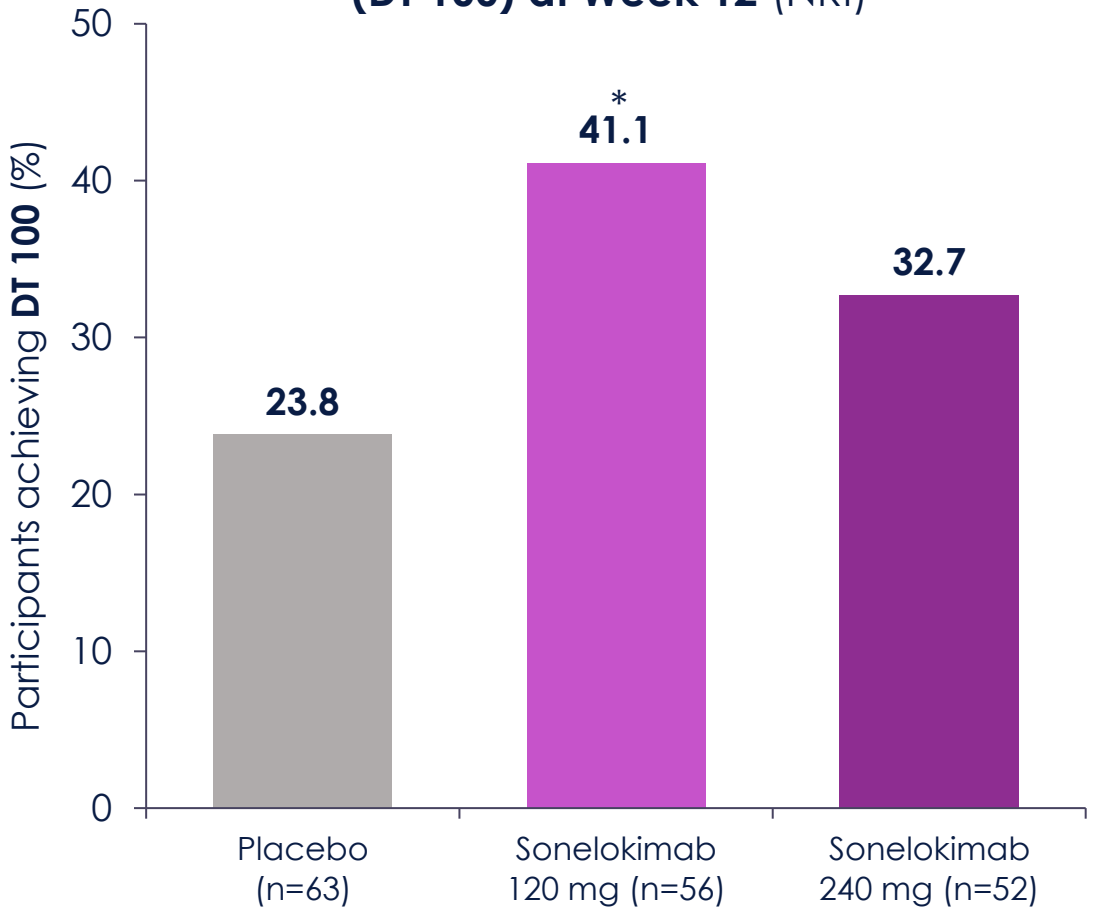
An exploratory ultrasound sub-study measured direct evidence of draining tunnel changes with SLK



Baseline Week 12

- Case study of a participant randomized to the sonelokimab 240 mg treatment arm
- Reduction in tunnel diameter and inflammatory activity observed at Week 12

Complete resolution of draining tunnels (DT 100) at Week 12 (NRI)



Phase 3 will be critical to better understand the potential of SLK as a Nanobody® to improve clinical outcomes

Ultrasound images show the same draining tunnel (white arrow) at baseline and week 12; color-shaded areas indicate active inflammation (duplex signal of increased blood flow in the peri-tunnel area; grey arrow) | Kirby et al ISDS 2023;P260

After MIRA: what I would like to see in a Phase 3 program

A key goal of Phase 3 will be to show consistency with Phase 2, while always maintaining a patient-centered focus

ENDPOINT SELECTION

High level endpoints, such as **HiSCR 75**, **DT 100**, **IHS4-100**

MAINTENANCE OF RESPONSE

Assessing the **longevity** of treatment effect is critical

PATIENT POPULATION

Baseline disease severity is key for interpreting results

Phase 3

OPTIMAL DOSE

Dose based on **risk–benefit** evidence per **regulators**

SIMPLE PROTOCOL

A protocol **consistent with MIRA**, attractive to derms

COHORT SIZE

Enroll **sufficient number of patients** to satisfy regulators

Looking at high level endpoints and including patients with severe disease reflects patients in clinical practice

Expert opinion of Prof. Kenneth B. Gordon

MoonLake

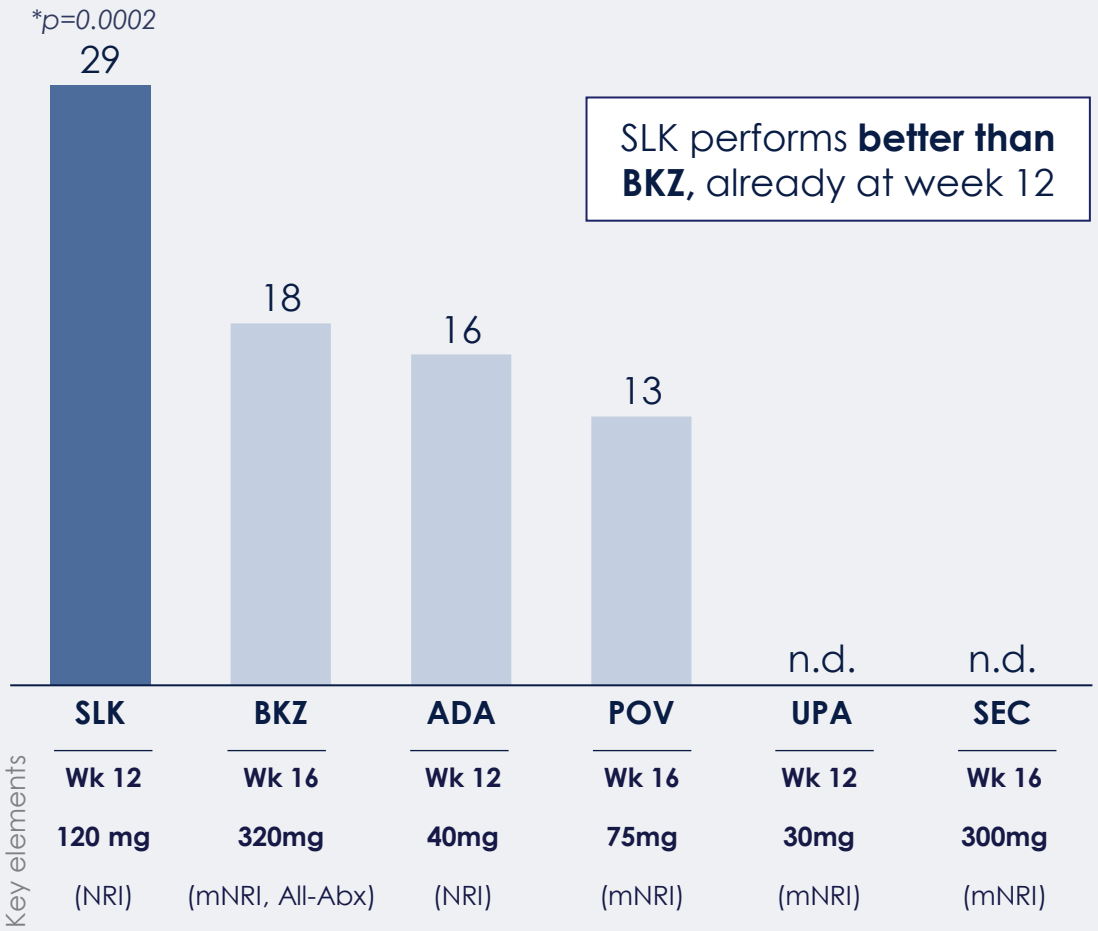
SLK differentiation & Phase 3 program

Kristian Reich

Recap: Setting a new bar in HS for primary endpoints

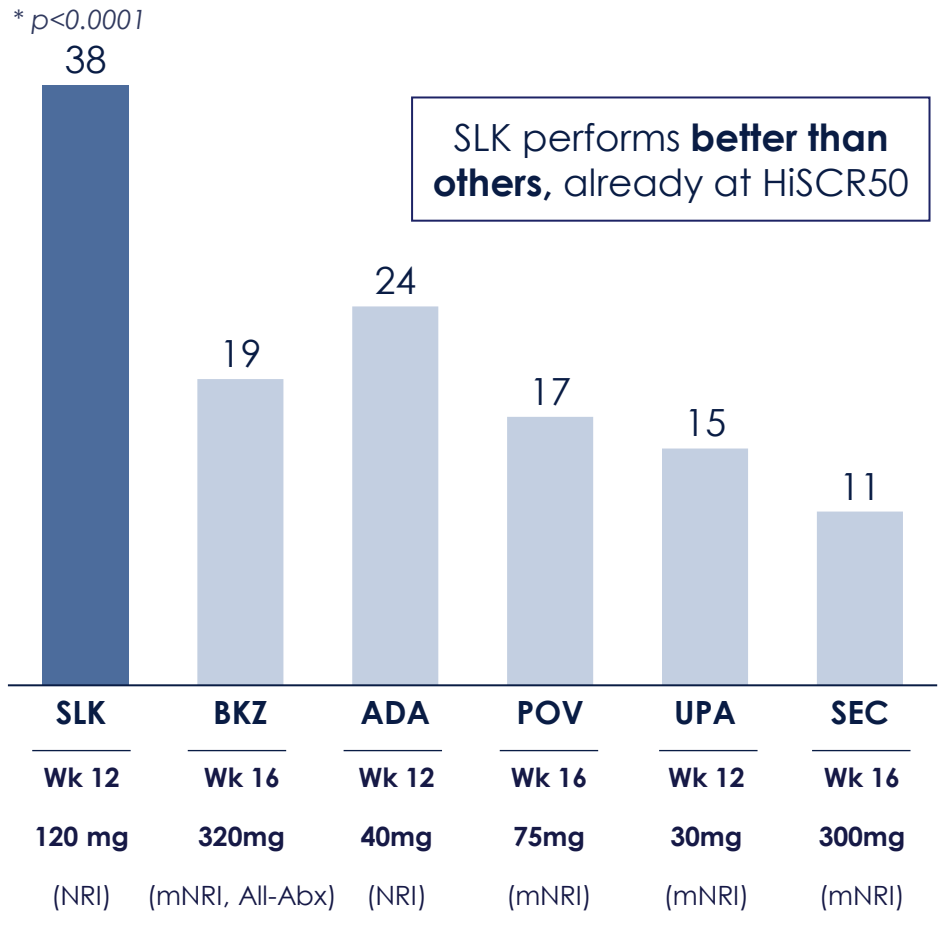
HiSCR75 delta to PLC (Primary endpoint only for SLK)

Percent delta for best doses, primary analysis



HiSCR50 delta to PLC (Primary endpoint for others[1])

Percent delta for best doses, primary analysis



Note: This is a comparison across trials, with inherent limitations. No head-to-head trials. 1 POV used mean AN count reduction as primary endpoint 2 Estimation of HiSCR75 delta to PLC at wk 16 using the avg. response of the 2 crossed-over groups from PLC to SLK doses at wk 12 (PLC plateaus already from week 8) and the wk 16 response for the 120mg arm; PLC, Placebo; SLK, Sonelokimab (MIRA study); BKZ, Bimekizumab (pooled BE HEARD I/II); ADA, Adalimumab (pooled PIONEER I/II); POV, Povorcitinhib (NCT04476043); UPA, Upadacitinib (NCT04430855); SEC, Secukinumab (pooled SUNRISE/SUNSHINE)

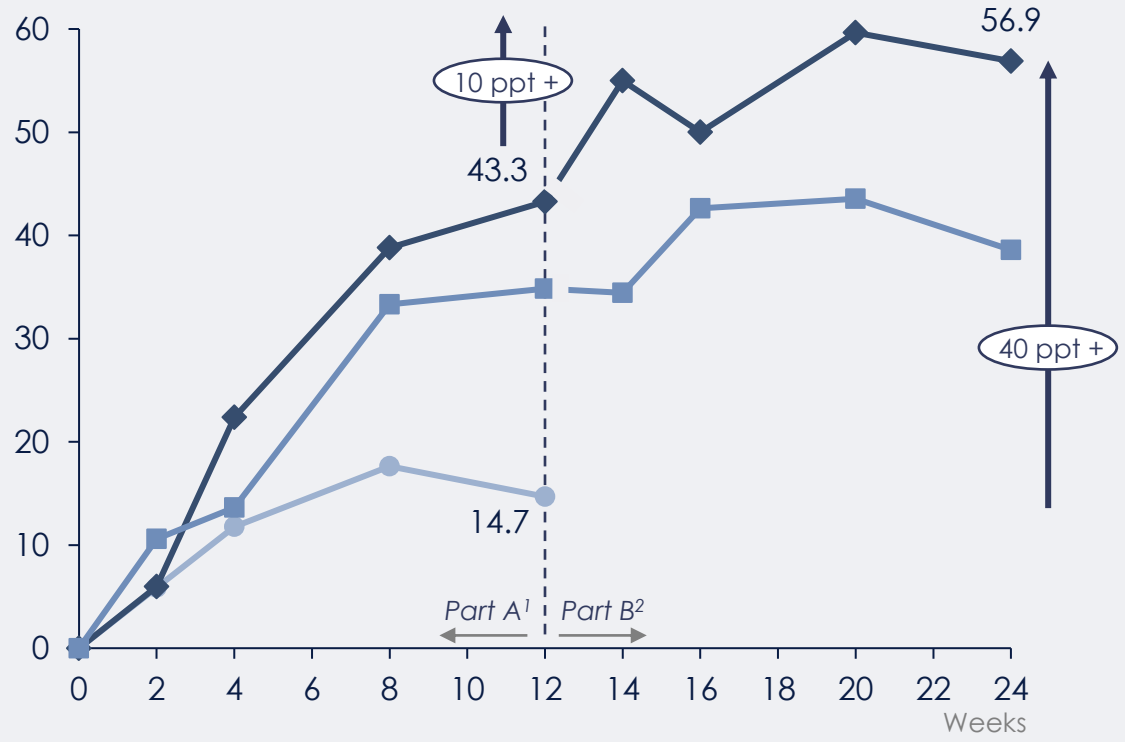
Source: MoonLake Clinical (R&D Day June 27th 2023)

HS: Response with SLK increases through week 24, with monthly dose

PLC SLK 120mg SLK 240mg

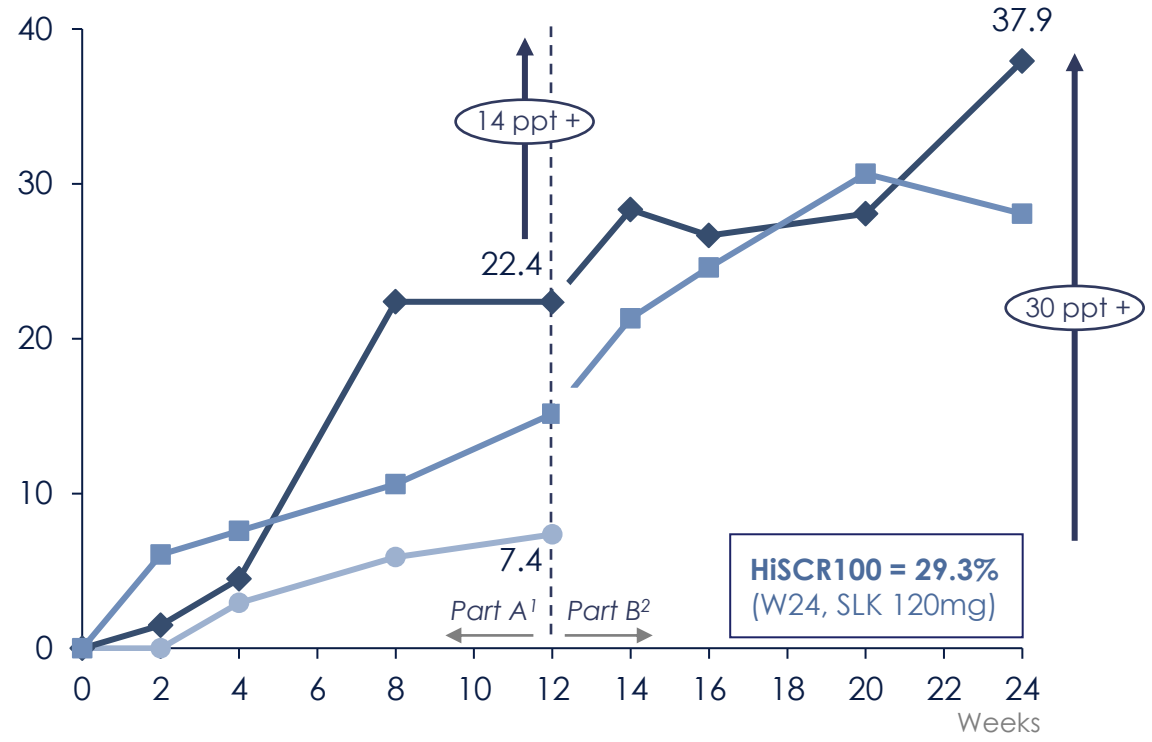
HiSCR75 response (Primary endpoint)

Percent (%) pts reaching score



HiSCR90 response

Percent (%) pts reaching score



Significant increase in number of patients **reaching HiSCR75** with convenient **monthly injection**
Deepening of responses with monthly maintenance dosing, as close to **40% of patients reach HiSCR90** by week 24

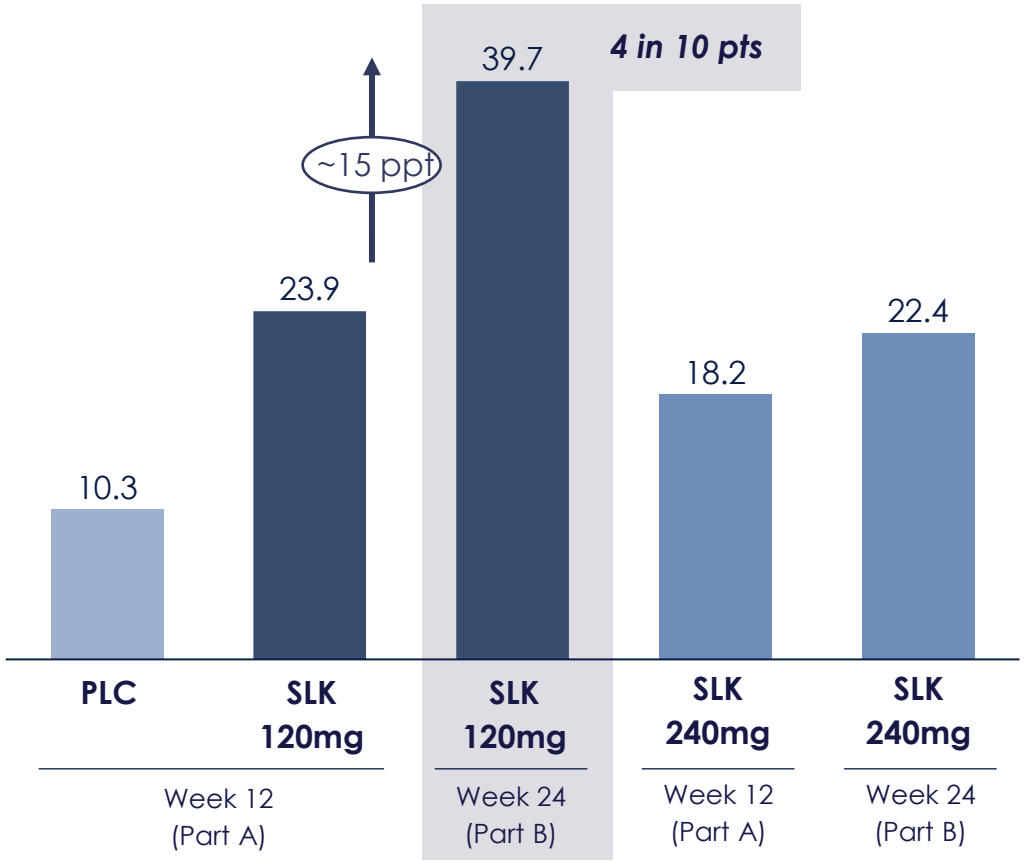
1 ITT-NRI data up to Wk 12 (Part A) 2 As observed data from Wk 14-24 (Part B)

Source: MoonLake Clinical

HS: SLK allows patients & physicians to aim for inflammatory remission

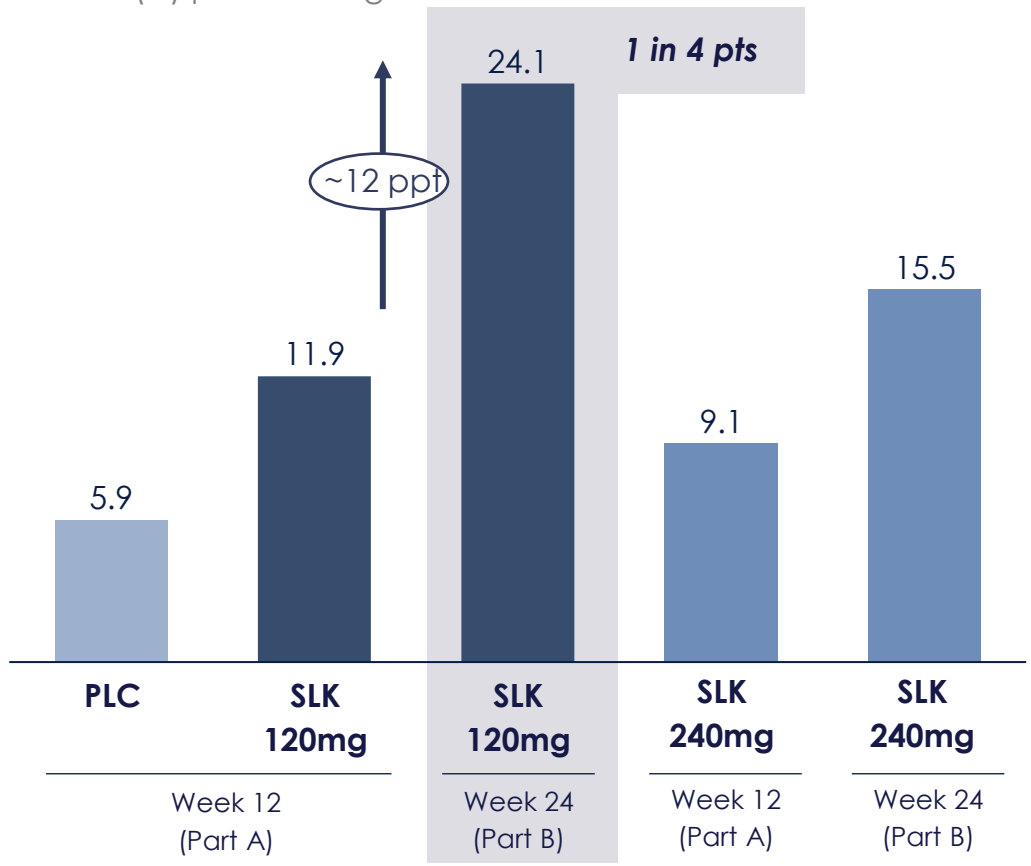
IHS4-90 response

Percent (%) pts reaching score[1]



IHS4-100 response

Percent (%) pts reaching score[1]



Monthly SLK deepens **IHS4 response** (e.g., IHS4-90 and IHS4-100)
About 1 in 4 four HS patients on monthly SLK 120mg achieve **inflammatory remission** (IHS4-100)

1 ITT-NRI data up to Wk 12; as observed data after week 12

Source: MoonLake Clinical

HS: The results are staggering and confirm SLK as the potential leader

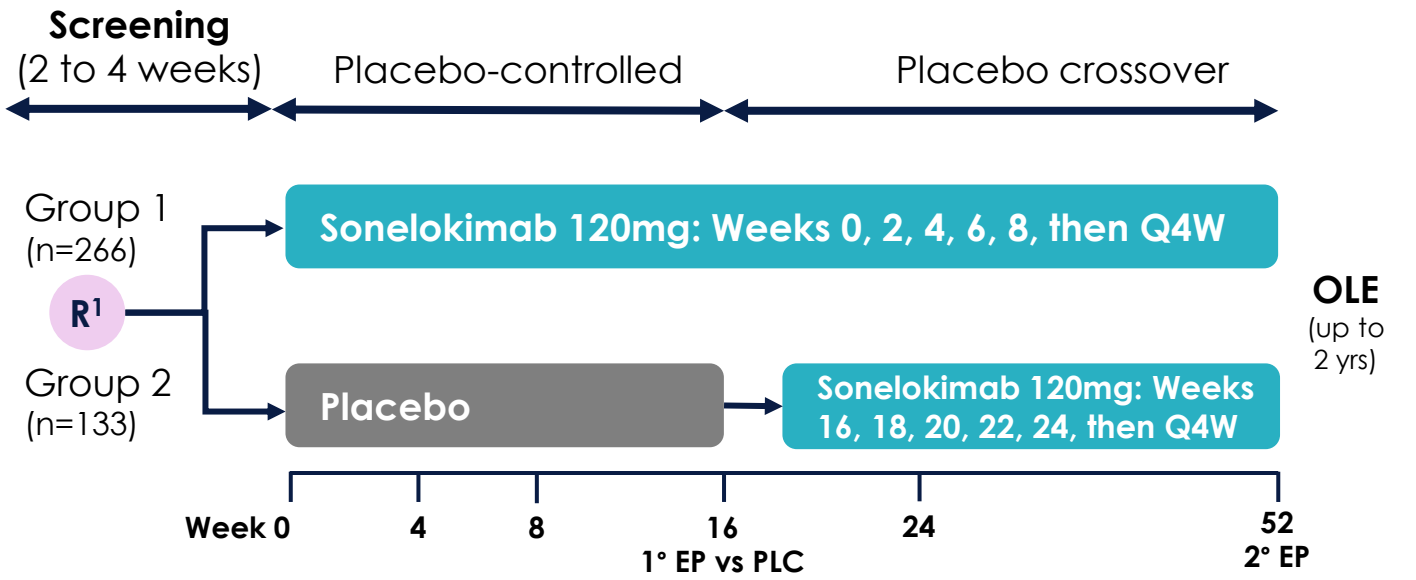
MoonLake

Higher HiSCR75 with Q4W dosing	**57%** of patients reach **HiSCR75** at week 24 with 120mg (**10ppt**+)
Greater depth of responses	**40%** patients reach **HiSCR90 and IHS4-90** by week 24 (**14ppt** +)
More disease control	**1 in every 4** patients in **inflammatory remission (IHS4-100)** & **40%+ report absent or minimal** disease activity (PGI-S)
Best dose confirmed	**120mg is best performing dose** across the board and dose **behavior replicated** from wk 12
Effect on TNF patients	At wk 24 **patients respond better with SLK** vs. ADA; **non-responders reach SLK-like responses** within 12 weeks
Favorable safety profile	**No new** signals, **no IBD,** or **malignancy**, **mAb-like ISR** rate, *Candida* (if present) **transient** and with **no discontinuations**

Source: MoonLake Corporate

HS: Very positive FDA & EMA EoP2 meeting, **HS highly de-risked**

Phase 3 protocol post FDA EoP2 meeting



Protocol repeated 2x (n=800 pts) – VELA I and II (both follow the same protocol)

Detailed interaction correspondence with FDA and EMA available
Comparable Phase 2 and 3 protocols available

- One dose phase 3 – FDA agrees HS **dosing is very clear** (120mg)
- 800 patients only (compared with Novartis, UCB, others) – FDA sees **Ph 2 as registrational** and considers patient data from other indications
- All other areas including stats, analytics etc. all **clear and low risk**
- Allows being **forward with primary endpoint** already in mid 2025, launch in 2027 (within 18-24 months of BKZ launch)
- **Cash in hand** for HS trial with no risk to other trials
- **Simpler protocol** compared to Phase 2 with stats that will likely **favor delta to PLC** (e.g., mNRI vs. NRI)

1 Randomization stratified by Hurley stage status (II vs. III) and prior biologic use (Y/N). Patients in Hurley stage III limited to ~40%; ²responder: HiSCR75 on two consecutive visits 4 weeks apart

Source: MoonLake Clinical Development

2. HS: VELA builds on the success of MIRA

Announcing Phase 3 HS program:

VELA I

VELA II

The MoonLake HS clinical trials continue to be the **only ones with HiSCR75 as the primary endpoint**

Source: MoonLake ClinDev

HS: Pivotal-like MIRA design is replicated in Ph3, in contrast to other trials

MoonLake

BKZ Ph2[1,2] n=90	**BKZ Ph3 (BH II)**[3,4] n=509	**MLTX Ph2 (MIRA)** n=234	**MLTX Ph3 (VELA)** n=800
Trial structure			
Only one dose tested	**Two doses tested**	**Two doses tested**	**One dose tested**
Loading dose	**No loading dose**	**No loading dose**	**No loading dose**
21 patients received placebo	**74 patients received placebo**	**68 patients received placebo**	**266 patients receive placebo**
Double Blinded/Placebo-controlled	**Double Blinded/Placebo-controlled**	**Double Blinded/Placebo-controlled**	**Double Blinded/Placebo-controlled**
Stats analyses			
PPS with no clear Abx Tx rules	**ITT with Abx Tx rules**	**ITT with Abx Tx rules**	**ITT with Abx Tx rules**
NRI, as observed[5]	**mNRI**	**NRI**	**mNRI**
Bayesian augmentation +40 PBO, ADA	**No Bayesian augmentation**	**No Bayesian augmentation**	**No Bayesian augmentation**
9% placebo HiSCR 75	**16% placebo** HiSCR 75	**15% placebo** HiSCR 75	**Replication of PhII expected**
12% discontinuations primary period	**~8% discontinuations** primary period	**~5% discontinuations** primary period	**Low discontinuations expected**
Cohort characteristics			
0% prior biologic use[6]	**13% prior biologic use**	**18% prior biologic use**[7] **with 30% cap**	**30% prior biologic cap**[9]
Mandatory topical antiseptic	**No mandatory antiseptic**	**No mandatory antiseptic**	**No mandatory antiseptic**
≥3 AN lesions	**≥5 AN lesions**	**≥5 AN lesions**	**≥5 AN lesions**
Mean AN # 14.5 BKZ vs **22.1** PBO	**Mean AN # 17.7** BKZ Q4W[8] vs **14.4** PBO	**Mean AN # balanced 14.6** SLK 120 vs **14.5** PBO	**Balanced mean AN expected**
49% Hurley II	**61% Hurley II**	**64% Hurley II**	**40% Hurley III cap**
No limit on concomitant Abx (% not reported)	**Concomitant Abx limit not reported** (9% at baseline in overall population)	**30% limit on concomitant Abx** (11% at baseline in overall population)	**30% limit on concomitant Abx**
1 stratification factor (Hurley)	**2 stratification factors** (Hurley, ABX)	**2 stratification factors** (Hurley, prior Bx)	**3 stratification factors** (Hurley, prior Bx, region)

1 Glatt et al. JAMA Dermatol 2021;157:1279–88; 2 NCT03248531; 3 Kimball et al. AAD 2023;oral presentation; 4 NCT04242498; 5 Sensitivity analysis presented as key data in primary publication; 6 No prior TNFi or IL-17i as per protocol — other prior biologic experience is not clarified in study publications 7 No primary failures or patients unsuitable for therapy 8 Mean AN # 17.2 for Q2W→Q4W arm and 14.7 for Q2W→Q2W arm 9 previous IL-17A/F excluded, no primary failure to IL-17i

Note: comparisons across trials, with inherent limitations. Not head-to-head trials. Not all trial details might be captured in full. VELA designs subject to final regulatory approval

Source: MoonLake Clinical

MoonLake

HS is the next large indication in Derm

Jorge Santos da Silva

Recap: The HS market is expected to growth to >10bn USD by 2035

MoonLake

U.S. HS Biologics Market estimation, examples of main MoAs

SLK as "Best of both worlds" *MoA & molecule characteristics*

- ✓ Leading HiSCR75 response
- ✓ Effect on tunnels (penetration)
- ✓ Speed and depth of response
- ✓ Inflammatory Remission
- ✓ Patient Reported outcomes
- ✓ TNF-IR switching advantageous
- ✓ Safety profile

Today

HUMIRA® adalimumab
TNF a (mAb)
AbbVie

Only ~50% of patients achieve HiSCR50 at wk 12

Limited durability of response (<11 m)

Future

Cosentyx® (secukinumab)
IL-17 A (mAb)
Novartis

Marginally lower efficacy vs. Humira but **durable response** and good safety

Key strategic focus for Novartis

Bimzelx® (bimekizumab)
IL-17 A+F (mAb)
UCB

Data supporting **IL 17A&F inhib. as best MoA** in HS

US launch expected in 2025, as key driver for UCB

SLK
IL-17A & F (small bio)
MoonLake

SLK uses **best MoA and is highly differentiated** (efficacy and likely safety)

Unique features (tunnels, convenience etc.)

JAK-inhibitors
JAKs (chem)
AbbVie / Incyte

No improvements in efficacy vs approved drugs

Focus on **later line treatments**

Note: This is a comparison across trials, with inherent limitations. No head-to-head trials. 1 POV used mean AN count reduction as primary endpoint; PLC, Placebo; SLK, Sonelokimab (MIRA study); BKZ, Bimekizumab (pooled BE HEARD I/II); ADA, Adalimumab (pooled PIONEER I/II); POV, Povorcitinhib (NCT04476043); UPA, Upadacitinib (NCT04430855); SEC, Secukinumab (pooled SUNRISE/SUNSHINE), Launch dates based on MoonLake estimate

Source: MoonLake Commercial, DRG/Clarivate, academic journals, CBO; Komodo Health

Market: Large market size is substantiated by real-world data

MoonLake

U.S. adult HS patients

Claims methodology

- **Source are unique U.S. patients** from prescription claims data
- **~250m** U.S. patient lives (~75% coverage)
- **Diagnosed & treated** patients with HS diagnosis (ICD-10 L73.2)

Key insights (extrapolated to 100% of U.S. population)

~2.0m	**Unique patients diagnosed and treated** in 2016-2023[1]	**Confirms** large existing HS population
~240k	**New diagnosed and treated patients every year** (previously undiagnosed)[2]	**Confirms** underdiagnosis & future growth potential
~40k/56k	**Adalimumab / Biologics** treated patients in 2023[3]	**Confirms** current Bx market size estimates
~30%	**Bx prescriptions are non-Adalimumab** in 2023[3]	**Confirms** high unmet need & need for new treatments
~25%	**Growth p.a. in Biologics-treated** pts in 2016-2023[4]	**Confirms** high unmet need & Bx market growth potential

1

2

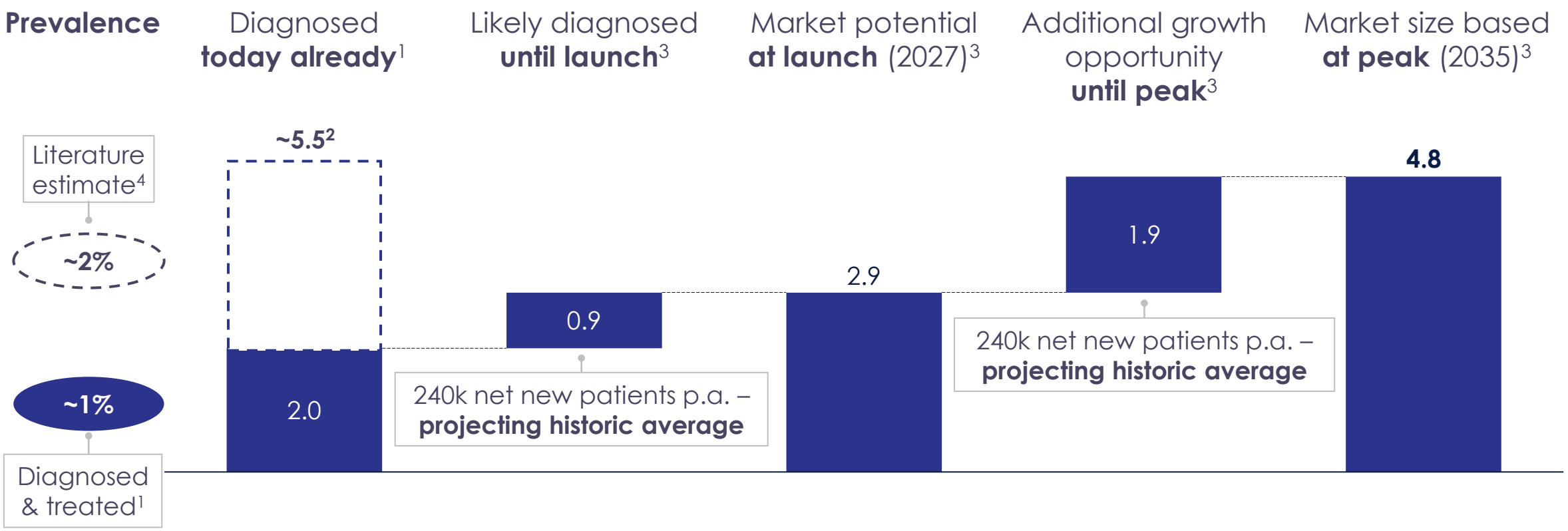
Note: Biologics (Bx) includes other targeted therapies (e.g., JAKs, PDE4i); 1. Patients ≥18 years with a HS diagnosis in 2016-2023; Extrapolated based on ~75% claims coverage rate (U.S. claims data); 2. historic average of annually net new diagnosed HS patients in 2016-2023, based on~75% coverage rate; 3. Patients with a HS-related Bx prescription in 2023 AND a HS diagnosis in 2016-2023; 4. Based on historic growth of patients with a HS-related Bx prescription in the given year and a preceding HS diagnosis

Source: MoonLake Commercial, © 2023 Komodo Health, Inc. All rights reserved.

1 **Market:** Claims alone show ~2M HS patients – not incl. undiagnosed

MoonLake

U.S. adult HS patients



Claims confirm significant HS market already today we see ~1% of the population being diagnosed & treated

1. Includes patients ≥18 years with a HS diagnosis in 2016-2023; Extrapolated based on ~75% claims coverage – showing a 0.8% of U.S. Population HS diagnosed and treated; 2. Scaling the 2M patients (0.8%) to 2.1% prevalence (as per literature – see footnote 4); 3. Based on extrapolating historic average of annually net new diagnosed HS patients from 2024-2027; based on ~75% U.S. claims coverage; 4. Prens L. et al. Br J Dermatol. 2022

Source: MoonLake Commercial, © 2023 Komodo Health, Inc. All rights reserved.

1 **Market:** HS patients face challenging journey – even years after Dx

MoonLake

U.S. adult HS patients

	Therapy post HS diagnosis	
	Year 1[1]	Year 2-3, of year 1[2]
Patients on antibiotics or steroids – most continue longer-term	**55%+**	65%+
Patients visiting an emergency room – most continue to have visits	**30%+**	55%+
Patients that undergo HS related surgery – continue to have surgeries	**15%**	20%
Patients on biologics – few remain on drug uninterruptedly[3]	**3%**	0.6%

Patients are cycling through various supportive care treatments – pre and post biologics

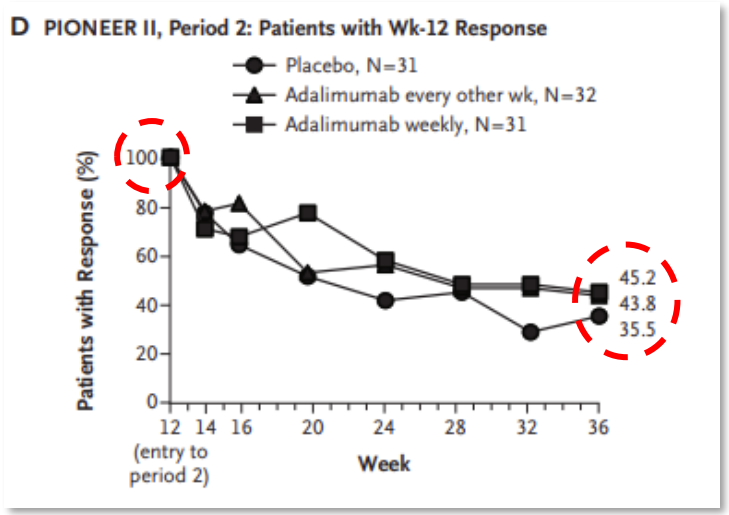
1. HS patients receiving respective care in the first year after diagnosis; 2. HS patients receiving respective care in years 2 and 3 post diagnosis, as a % of year 1 patients, 3. Consecutively on drug for >24m

Source: Market research, © 2023 Komodo Health, Inc. All rights reserved.

❶ **Market:** Adalimumab with limited duration of response in real world

MoonLake

Trial results: Maintenance of response



~55% did not maintain response after 9m

Claims: Duration of therapy (N=53k)[1]

% of patients by months on therapy (prescription fill breaks >3 months treated as new treatment)

xx Median duration (m) on therapy

~11m median duration of treatment

Not linked to U.S. access & affordability hurdles, given European studies show similar results[2]

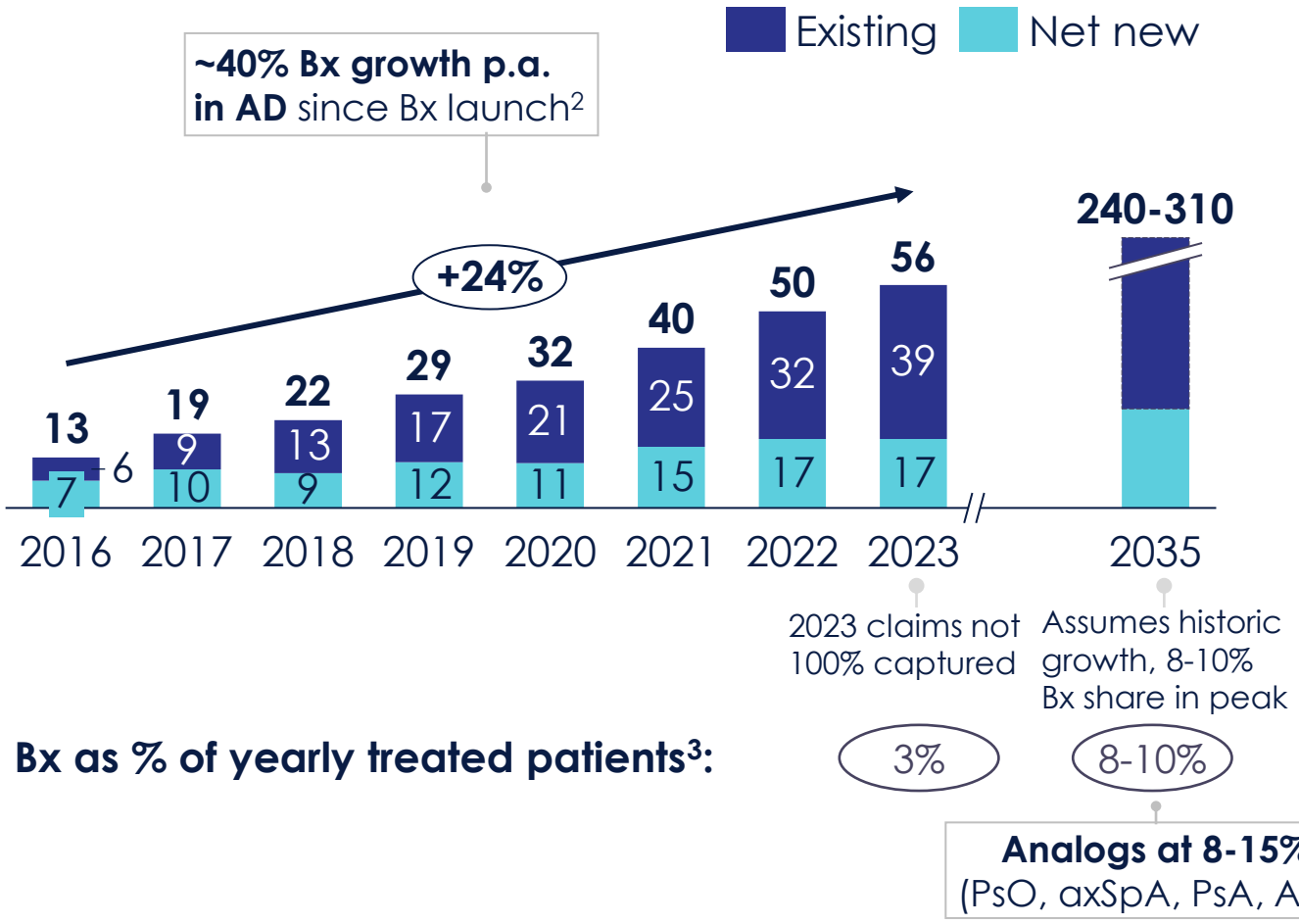
Claims data confirms limited duration of therapy (~11m median) for Adalimumab in real-world patients, leaving them without efficacious HS treatment option

1. Average duration of treatment for the period of 2016-2023 for HS-relevant Adalimumab patients with a prescription start in until 2022; 2. E.g., Prens L.M. et al. *Br J Dermatol. 2021 Jul;185(1):177-184.* doi: 10.1111/bjd.19863, Ring H.C. et al. *JAMA Dermatol. 2022 Feb 1;158(2):184-188.* doi: 10.1001/jamadermatol.2021.4805.

Source: MoonLake Commercial, © 2023 Komodo Health, Inc. All rights reserved.. N Engl J Med 2016; 375:422-434; JAMA Dermatol. 2022 Feb; 158(2): 1–5.

2 **Market:** Growth and unmet need expected to remain high

HS Biologics and targeted treatment patients in U.S. (k)[1]



- **Bx treatments with strong grows at ~25% p.a.** from 2016 to 2023
- Today's Bx share is starting from a small base due to limited **effective Bx treatments and low durability of Adalimumab** (~3% of yearly treated patients)
- **~30% of Bx treatments other than Humira** (e.g., ixekizumab), further highlighting the **need for a novel and effective treatment options in HS**

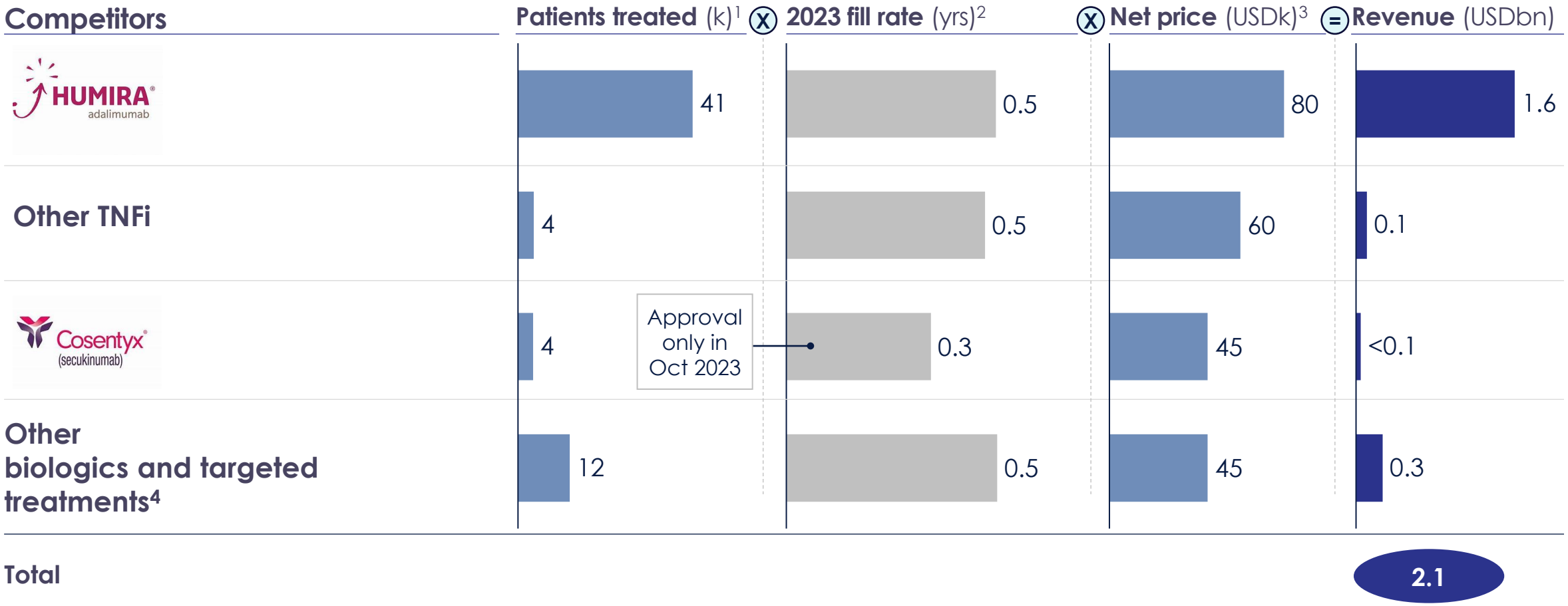
1. Patients with a HS-relevant biologics prescription in the respective year and a preceding HS diagnosis; includes JAKs and PDE4i; 2. Annual growth in Bx for patients with a preceding AD diagnosis in 2017-2023; 3. Share of patients with a HS-relevant biologics prescription in the respective year as % of the annually treated HS population (~65%); 4. Share of patients with a relevant Biologics prescription for PsO / axSpA / PsA in 2023 as % of the total patients with a PsO / axSpA / PsA diagnosis in 2016-2023

Source: MoonLake Commercial, Market research, © 2023 Komodo Health, Inc. All rights reserved.

2 **Market:** Humira accounts for most of current $2bn+ biologics market

2023 claims not 100% captured yet (time lag)

HS market (2023 – Q4 claims not fully covered)



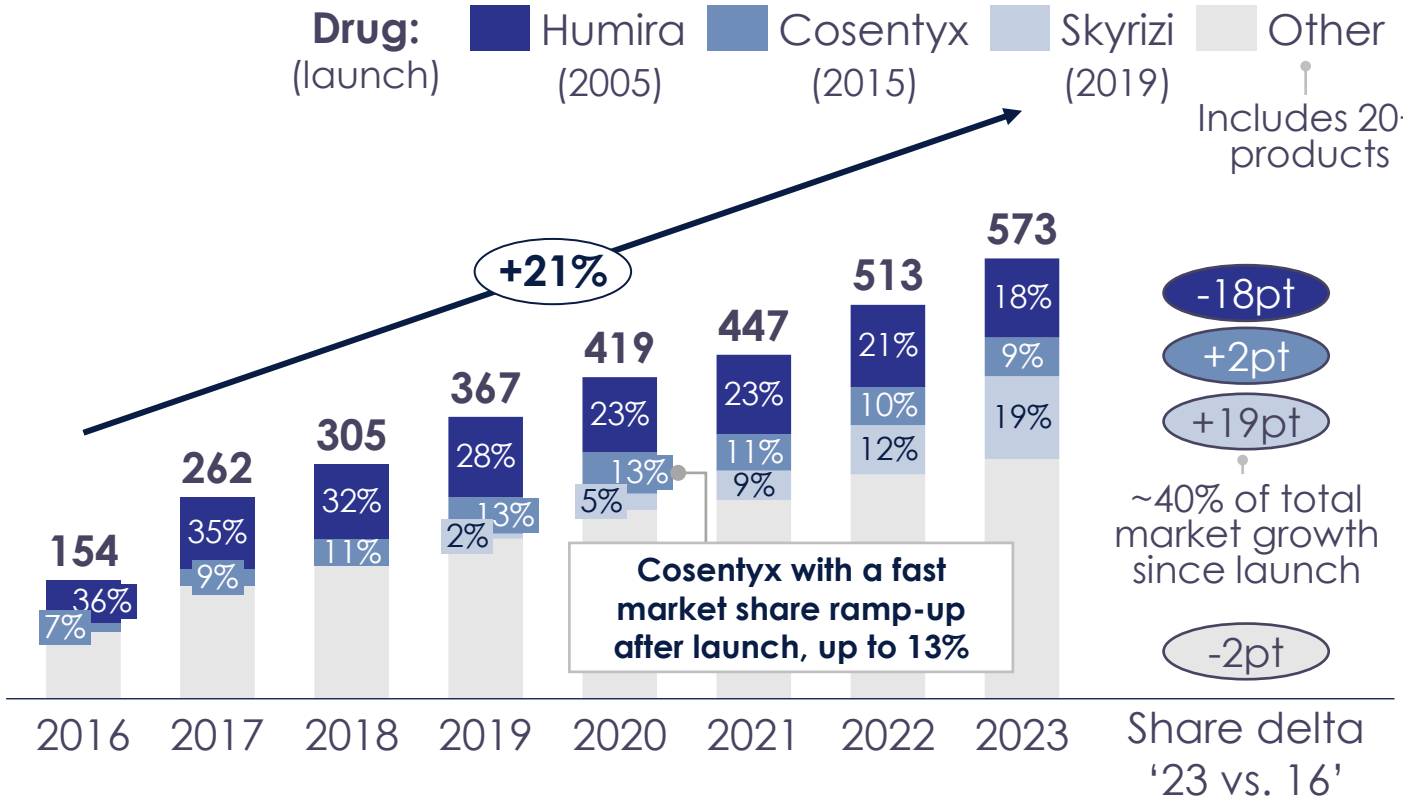
1. Includes patients with a prescription of the respective drug in 2023 AND a corresponding HS diagnosis (U.S. claims data); 2. Based on average days supplied across all patients on the respective drug in 2023 (Avg. fill rate for all patients with a prescription in 2023); 3. Calculated as annualized WAC (for maintenance therapy) net of total GTN incl. service fees, statutory & confidential discretionary rebates, etc. (based on market research); 4. *Includes JAKs and PDE4i*

Source: MoonLake Commercial, Market research, © 2023 Komodo Health, Inc. All rights reserved.

2 **Market:** PsO shows clinical differentiation wins over time-to-market

MoonLake

PsO biologics patients in U.S. (k)[1]



- **Better clinical profile matters most**: After their respective launches Cosentyx and Skyrizi are capturing a big share of the market
- **New entrants are growing the market**: Upon their launches the biologics market has grown substantially (Skyrizi accounted for 40% of market growth)
- **Disease area leadership can be built despite launching later**: Skyrizi is market leader in PsO (~19% share in 2023) among 20+ biologics competitors

New entrants capture substantial share in PsO and increase market growth rate by improving efficacy and setting a new bar for treatment outcomes (e.g., PASI100), despite not being first-to-market

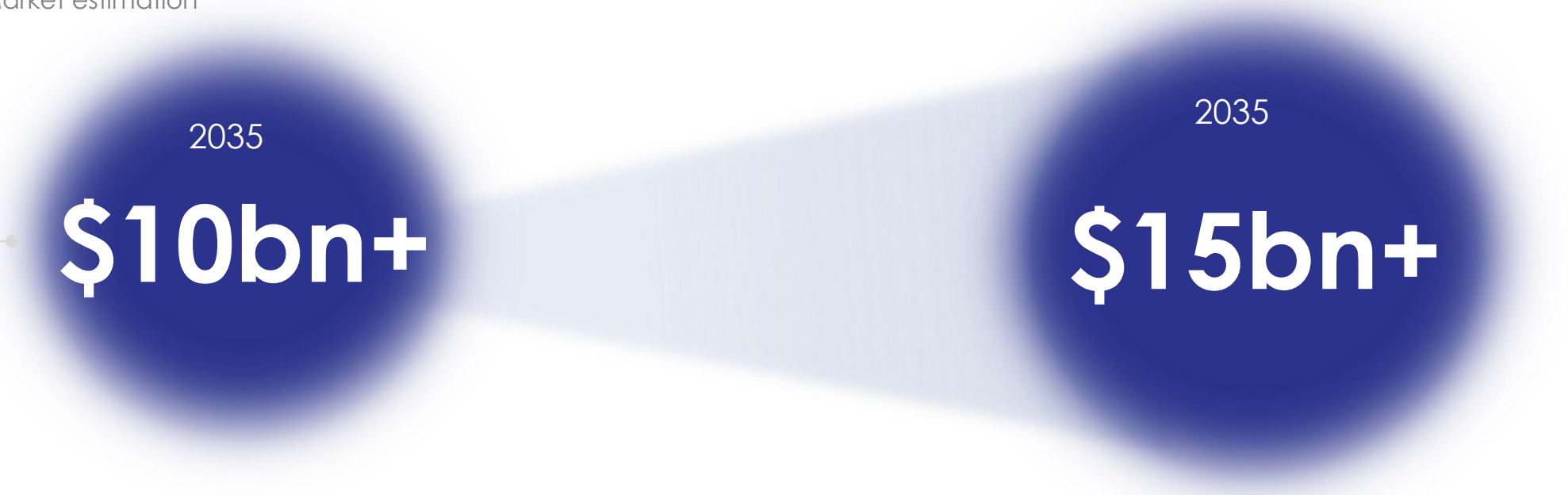
1. Patients with a biologics prescription in the respective year and a preceding PsO diagnosis;

Source: Market research, © 2023 Komodo Health, Inc. All rights reserved.

Market: The HS market might be even larger than $10bn in 2035

U.S. adults HS Biologics Market estimation

~$10bn+ U.S. market size projection based on very conversative extrapolations of historic growth



Diagnosed prevalence	**4.8m** based on claims extrapolation[1]	Higher HS awareness increases diagnosis and treatment rate	**5m+** likely given claims only capture diagnosed & treated[2]
Biologics adoption	**~8%**	More efficacious treatment options increase Bx adoption to levels of analogs	**~10%** analogs ~15% (PsA, axSpA[3])

Through recent claims analyses we cannot only substantiate the projected 2035 $10bn HS market in the U.S. but we believe the true HS market in the U.S. has potential to become $15bn+

1. Patients ≥18 years with a HS diagnosis in 2016-2023; Extrapolated based on ~75% claims coverage rate, further conservatively extrapolating historic average of annually net new diagnosed HS patients from 2024-2027 and ~70% of historic average of annually net new diagnosed HS patients from 2028-2035; Assumes based on ~75% claims coverage rate, 2. Share of patients with a relevant Bx prescription for PsO / axSpA / PsA in 2023 as % of the total patients with a PsO / axSpA / PsA diagnosis in 2016-2023; 3. extrapolated based on SLK opportunity and Humira-like prices

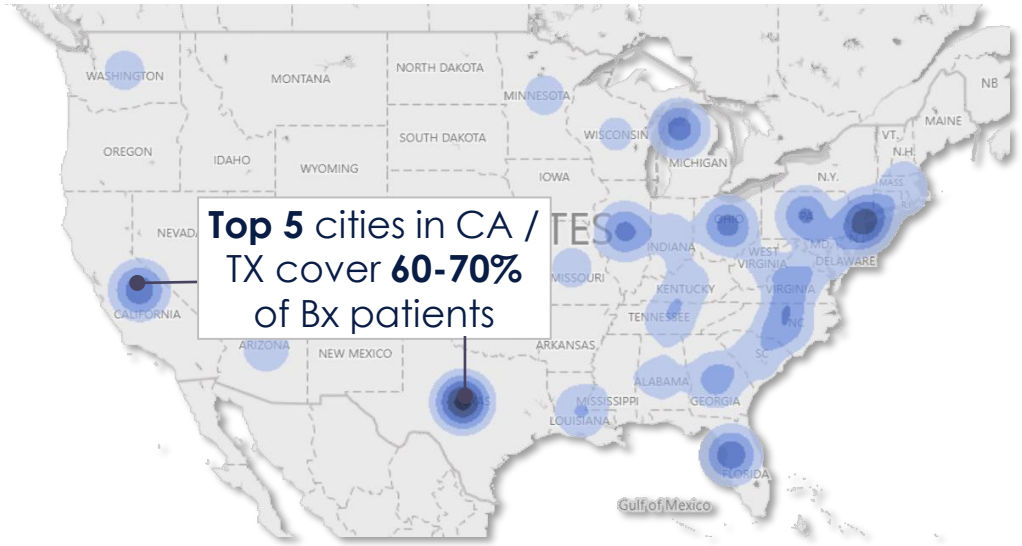
Source: MoonLake Commercial, © 2023 Komodo Health, Inc. All rights reserved.

Targeting: Achieving SLK blockbuster status in concentrated landscape

MoonLake

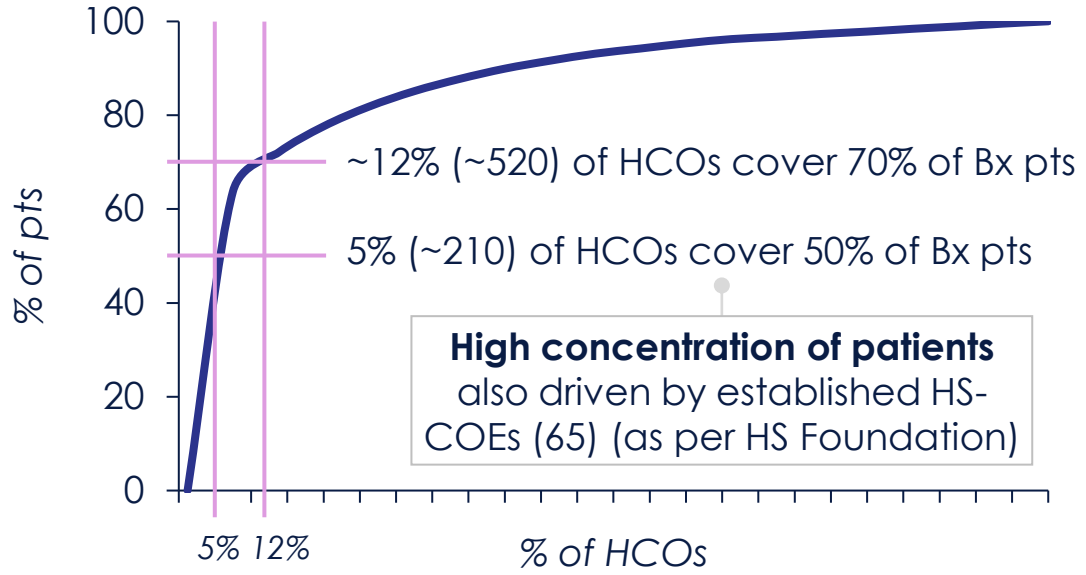
U.S. adult HS patients on biologics

Distribution by state



15 states in the U.S. cover **~70% of Biologics** treated patients[1]

Distribution by HCO in top 15 states



12% of HCOs cover **~70% of Biologics** patients[1] (within top 15 states)

Targeted Go-To-Market approach enables to unlock SLK blockbuster status in concentrated HS landscape

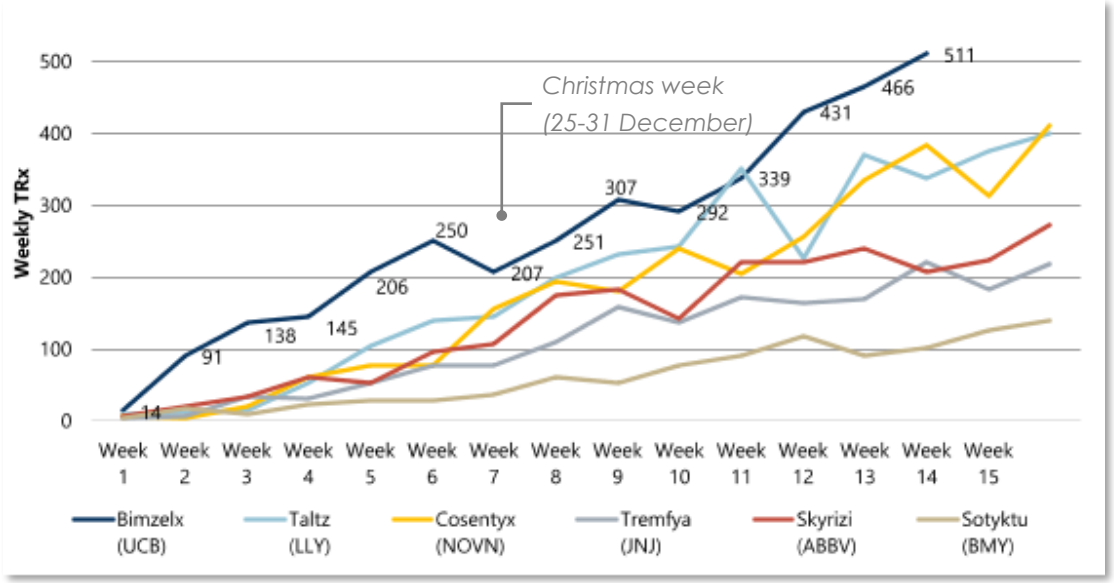
1. Based on Komodo Health claims data: Includes patients with a Bx prescription in 2022 and a HS diagnosis in 2015-2022

Source: Market research, © 2023 Komodo Health, Inc. All rights reserved., MoonLake Commercial

Competition: Bimzelx above expectations – SLK is **further differentiated**

MoonLake

Bimzelx confirms A&F as winning MoA with fast market uptake and good clinical data (in Plaque Psoriasis)



SLK shows a differentiated profile across multiple trials and clinical outcomes

- SLK has shown **leading responses** at wk 12 and week 24 in across **all relevant outcomes in HS (**MIRA trial), incl. being the **first to use HiSCR75** as primary endpoint, showing largest **deltas to placebo in different HiSCRs**, bringing **one quarter of patients to inflammatory remission**, demonstrating **impact on tunnels** etc.
- SLK shows **leading responses across all relevant outcomes in PsA** (ARGO trial) at wk 12 and wk 24, **especially in multi-domain scores** where other drugs appear to struggle
- Original data in Psoriasis (PsO) indicates that **SLK also has leading responses in skin inflammation and can sustain longer-term responses**

Bimzelx has achieved leadership in the dynamic market share of the IL-17 class, with share reaching ~40%

Note: Comparisons across trials, with inherent limitations. No head-to-head trials. 1 Warren et al., EADV 2021, P0353

Source: MoonLake Commercial, IQVIA, Barclays Research, RAPID Weekly Audit, November 2023-December 2023 (Copyright IQVIA), Company statements

HS: SLK is most convenient

MoonLake

Maintenance injection schedule

Bimzelx® (bimekizumab)

15s injection time
per 1ml syringe[1]

Cosentyx® (secukinumab)

15s injection time
per 1ml syringe[2]

SLK

3s injection time
per 1ml syringe

Substantially fewer and quicker injections
(5x faster injection)

Note: 320 mg for Bimzelx and 300mg for Cosentyx require 2 syringes per application – then every two weeks [Q2W] applied 1. Trial includes Q2W and Q4W dosing regimens (both requiring 2 injections) – TBD on actual label 2. Available as 2x 150mg (4 injections) and 300mg/2ml pens; Standard dose as Q4W, but possibility to move to 300mg Q2W

Source: Product leaflets, Company information, MoonLake Commercial

Recap: HS provides a sizable market with high unmet need

MoonLake

- **Sizeable, underdiagnosed market:** 2m patients today, >240k newly diagnosed patients every year
- **Albeit starting from a small base** (~13k in 2016) **biologics market is growing rapidly** (25% p.a.): similar trajectory to other markets such as PsO, AD etc.
- **Severe unmet need** with current options: patients cycled through with no disease control
- **HS causes a significant burden to patients and health systems** (ER visits, surgeries, medications)
- **SLK has potential to be the most differentiated:** Patients ~11m in ADA, ~4x SEC patients needed to get to SLK outcome (HiSCR50), 10-20ppt higher in key scores versus BKZ

*Market likely **among the largest across Inflammation (15bn+)** and able to accommodate different players: **SLK positioned as potential leader***

Source: MoonLake Commercial

MoonLake

New indications

New frontiers for SLK and MLTX

SLK is a unique molecule: Nanobody® that targets IL-17 A & F

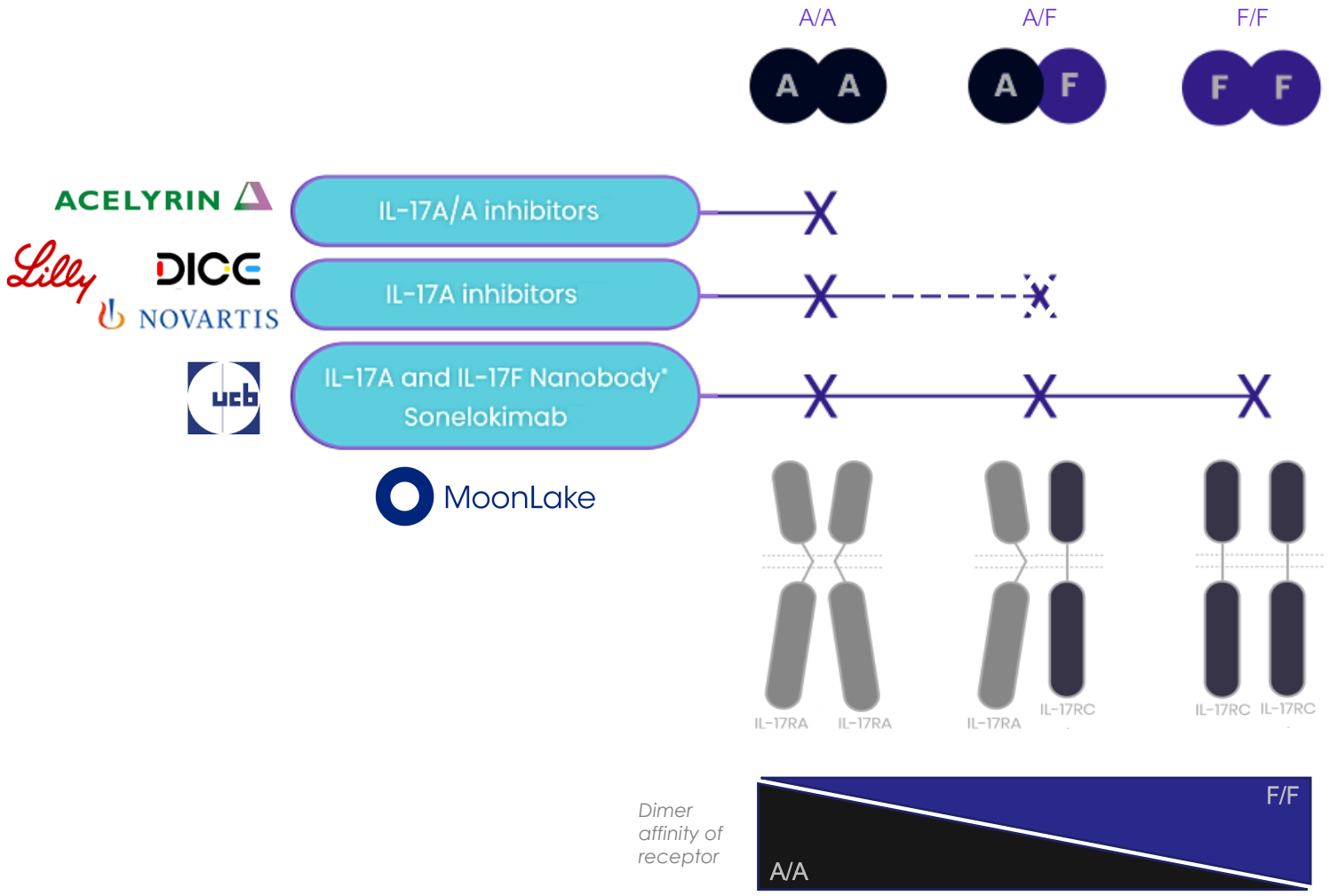
Illustrative

IL-17A and IL-17F function as dimers to drive inflammation, through activation of IL-17RA & RC receptor complexes

Different IL-17RA & RC chains combine to form complexes, and those have different affinity for different dimers[1,2]

Not all IL-17-targeting therapeutics can inhibit IL-17A/A, IL-17A/F and IL-17F/F dimers

SLK is the only asset that binds all dimers and with similar affinity



1 Liu S, et al. Nat Commun. 2013;4:1888; 2 Goepfert A, et al. Immunity. 2020 Mar 17;52(3):499-512

Source: MoonLake Research

Key MoA: IL-17A & F is at the crux of **many** inflammation pathways

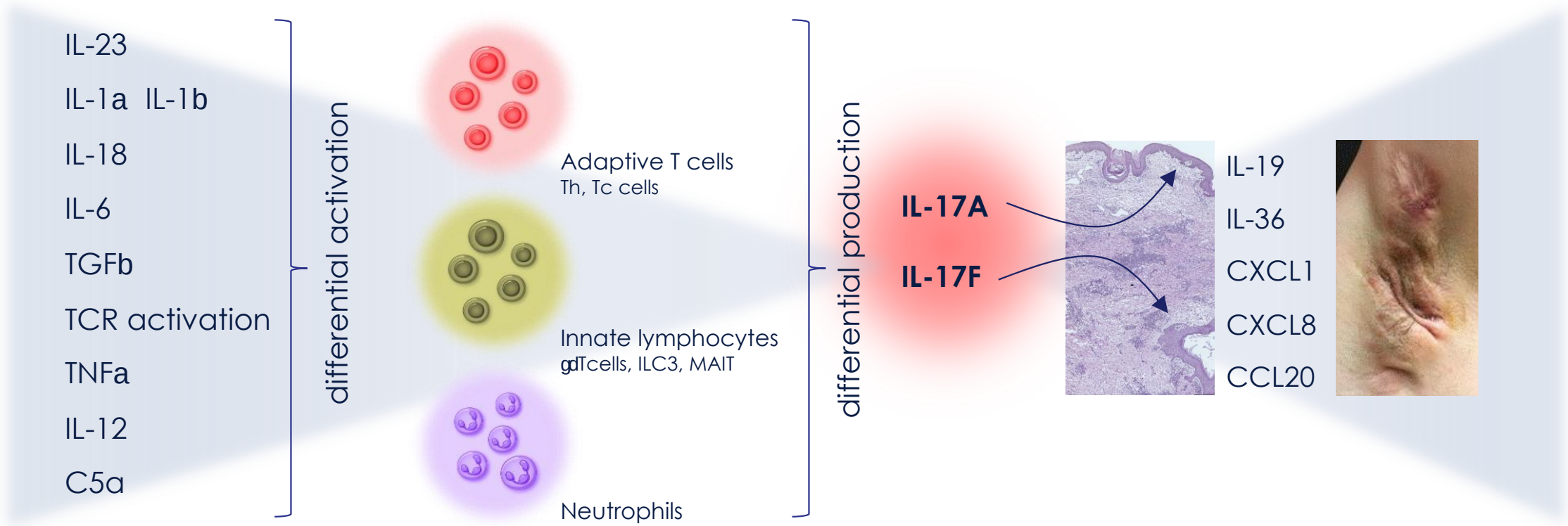
MoonLake

Multiple stimuli induce subsets of immune cells to produce IL-17A and F

Different cell types preferentially produce IL-17 A and/or F

IL-17A and F as "bottleneck" in many pathologies

IL-17A and F induce multiple pro-inflammatory effectors, e.g. activation of keratinocytes



Targeting upstream or downstream pathways to IL-17A and F has led to several failures as **pathways are redundant**

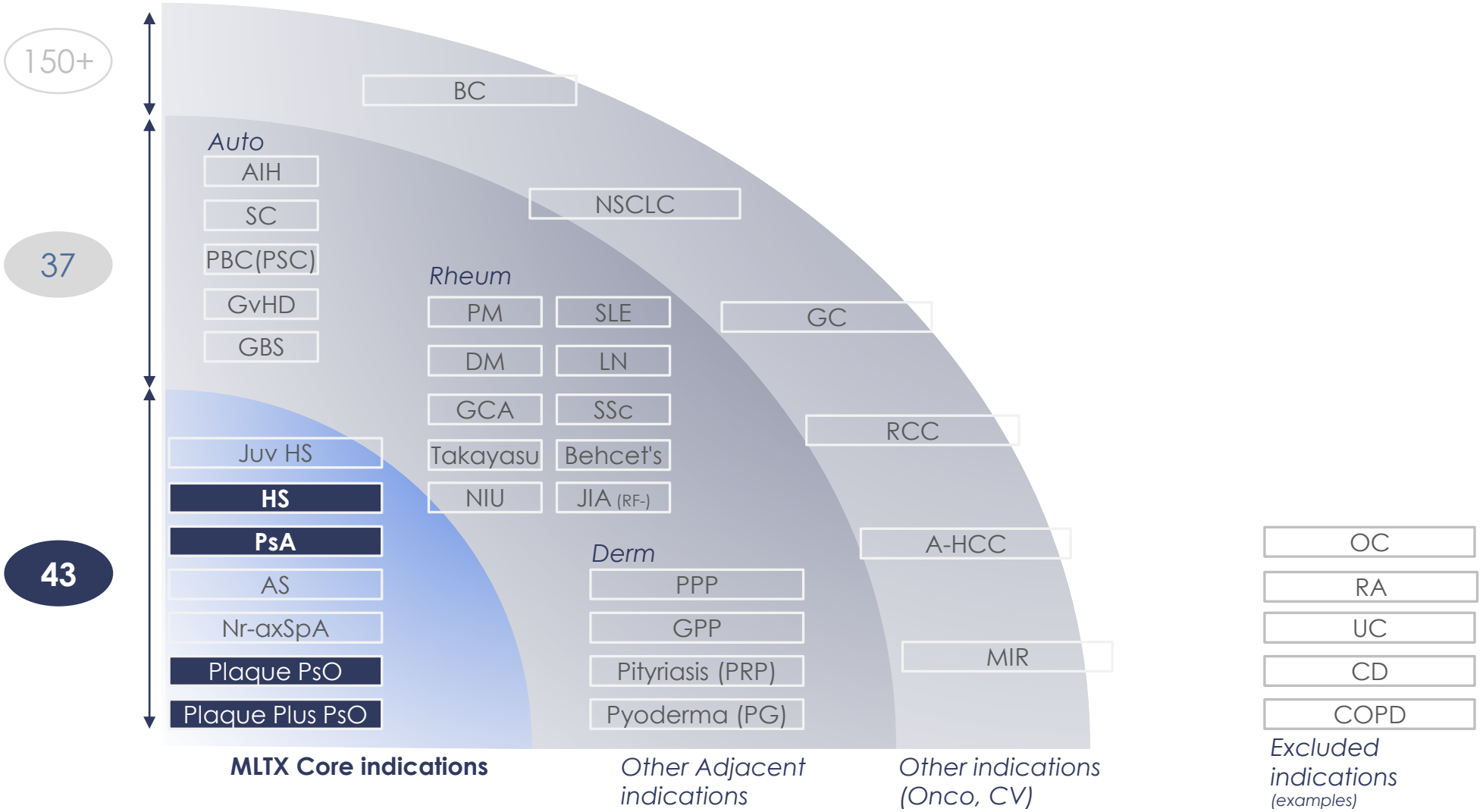
Source: MoonLake Clinical

Many diseases involve IL-17A&F as a key pathway, beyond **HS and PsA**

MoonLake

Addressable Market Size

USD bn



Abbreviations: HS (Hidradenitis suppurativa), PsA (psoriatic arthritis), AS (Ankylosing Spondylitis or adiographic axial spondyloarthritis), nr-axSpA (non-radiographic axial spondyloarthritis), PsO (Psoriasis), AIH (Autoimmune Hepatitis), PSC (Primary Sclerosing Cholangitis), PBC (Primary Biliary Cholangitis), GvHD (Graft-vs-Host disease), GBS (Guillan-Barre Syndrome), PM (Polymyositis), DM (Dermatomyositis), GCA (Giant Cell Arteritis), NIU (Non-infectious uveitis), SLE (Systemic lupus erythematosus), LN (Lupus Nephritis), SSc (Systemic Sclerosis), JIA (Juvenile Idiopathic Arthritis), PPP (Palmo-plantar pustulosis), GPP (Generalized Pustular Psoriasis), BC (Breast Cancer, NSCLC (Non-small cell lung carcinoma), GC (Gastric Cancer), RCC (Renal Cell Carcinoma), A-HCC (Alcohol-related Hepatocellular Carcinoma), MIR (Myocardial ischaemia and reperfusion)

Source: Clinical and scientific publications, MoonLake

MLTX will expand its portfolio of **SLK indications in Derm & Rheum**

MoonLake

- **MLTX has a robust late-stage development program ongoing**
  - HS Phase 3
  - PsA Phase 3
  - Commercialization-enabling data in 2025/2026

- **Portfolio expansion is driven on the strengths of MLTX**
  - Focus on building the leadership of SLK in Derm & Rheum (vs. "opening" new TAs)
  - Significant value that can be unlocked with our Nanobody® against IL-17 A&F
  - Where elevating treatment goals with stellar science can make a real difference

Derm

Palmo-Plantar pustulosis
(Phase 2)

Juvenile HS
(Phase 3)

Rheum

axSpA
(Phase 2)

PsA
(Phase 2)

Source: MoonLake

How the new indications **drive value for MLTX**

MoonLake

Derm

Rheum

PPP
(Phase 2)

- **"HS-like" disease,** key priority for Derms, large unmet need
- **Up to ~10-15% of PsO patients have palmoplantar involvement**[1]
- **IL17 A&F** relevance shown through BKZ case series[2]

New indication

1 Merola J. et al. (2018). *Dermatologic Therapy; 31:e12589*. doi.org/10.1111/dth.12589 and Chimenti et al. (2020). *Biologics;14:53-75.* doi: 10.2147/BTT; 2 Passeron et al. (2023). *JAMA Dermatol*. doi:10.1001/jamadermatol.2023.5051;
3 Limited disease control – even at lower levels: ~40% of Humira pts do not reach ASAS20 at w12 based on ATLAS trial data; 4 Based on BE MOBILE trial results

Source: MoonLake

PPP: Elevating position as the leading innovator in Derm

MoonLake

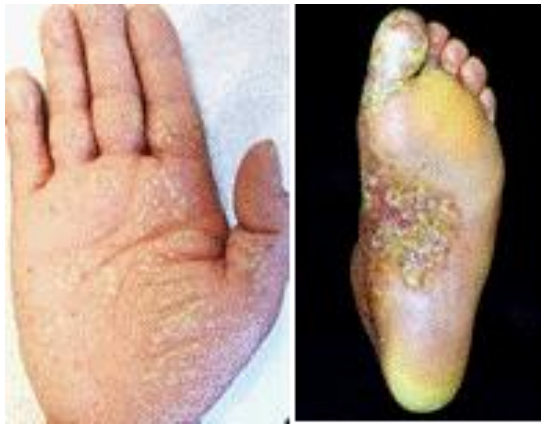
SLK can be highly differentiated…

IL-17 A&F is **most promising MoA** considering BKZ cases[1] and previously shown relative performance of SLK vs BKZ

Nanobody benefit given **deep-tissue location of lesions** (similarly to HS tunnels, pustules in deep skin)

Potential to be **first-to-market** in U.S. and US, and add yet another **distinctive therapy for Derms**

… in a severe disease without effective treatments…



Chronic inflammation: Crops of pustules causing pain & bleeding[2]

No approved therapy

Multiple MoAs failed (e.g., IL-1, IL-12/23s, IL-36, IL-17)

…by breaking new ground where others have given up

ppPASI as primary endpoint to elevate the bar vs previous attempts

Objective inflammation endpoints as additional scores to establish broader treatment goals

Competitive **number of patients** in trial, with **attractive design** for the **main PPP sites**

Deemed as sufficient to **move to Phase 3 or even approval** with successful read-outs

Market size

0.3% Global prevalence

4+ USD bn sales beyond 2037

Unmet Needs

~10-15% Of PsO patients with palmoplantar involvement[3]

0 Approved or effective treatment options

1. Passeron et al. (2023). *JAMA Dermatol*. doi:10.1001/jamadermatol.2023.5051; 2 Brunasso A. & Massone C (2021). *Fac Rev.*; Twelves et al. (2019. *J Allergy Clin Immunol, 143(3):1021-1026*. and Misiak-Galazka, M. (2020). *Am J Clin Dermatol 21, 355–370.*; 3 Merola J. et al. (2018). *Dermatologic Therapy; 31:e12589*. doi.org/10.1111/dth.12589 and Chimenti et al. (2020). *Biologics;14:53-75.* doi: 10.2147/BTT

Source: MoonLake team

How the new indications **drive value for MLTX**

MoonLake

Derm

PPP
(Phase 2)

New indication

- **"HS-like" disease,** key priority for Derms, large unmet need
- **Up to ~10-15% of PsO patients have palmoplantar involvement**[1]
- **IL17 A&F** relevance shown through BKZ case series[2]

Juv HS
(Phase 3)

Strengthen indication

- **First clinical trial in juvenile 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"

Rheum

1 Merola J. et al. (2018). *Dermatologic Therapy; 31:e12589*. doi.org/10.1111/dth.12589 and Chimenti et al. (2020). *Biologics;14:53-75.* doi: 10.2147/BTT; 2 Passeron et al. (2023). *JAMA Dermatol*. doi:10.1001/jamadermatol.2023.5051;
3 Limited disease control – even at lower levels: ~40% of Humira pts do not reach ASAS20 at w12 based on ATLAS trial data; 4 Based on BE MOBILE trial results

Source: MoonLake

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axSpA
(Phase 2)

- **Multi-bn markets** (r/nr-axSpA) with limited efficacy of current SoC[3]
- With PsA allows MLTX to further **lead in seronegative Spondylarthritis**
- **IL17 A&F** relevance shown through BKZ cases[4], small size an advantage

New indication

1 Merola J. et al. (2018). *Dermatologic Therapy; 31:e12589*. doi.org/10.1111/dth.12589 and Chimenti et al. (2020). *Biologics;14:53-75.* doi: 10.2147/BTT; 2 Passeron et al. (2023). *JAMA Dermatol*. doi:10.1001/jamadermatol.2023.5051;
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Source: MoonLake

axSpa: Broadening leadership in Rheum by elevating care in axSpA

MoonLake

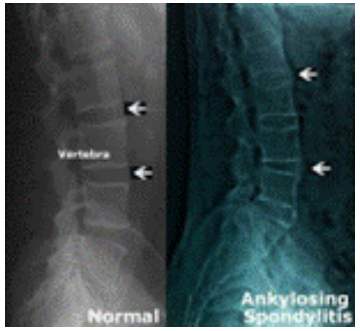
SLK to elevate care to new efficacy levels…

Strong rationale for **SLK to elevate care in axSpA**

- Winning MoA, with IL-17A&F inhibition showing most durable responses
- Strong SLK PsA data in joints and nails as proxy for spinal inflammation
- Nanobody benefit in difficult-to-treat deep inflammation and co-morbidities[1]

With PsA allows MLTX to further **lead in seronegative Spondylarthritis**

… in a disease with high unmet need…

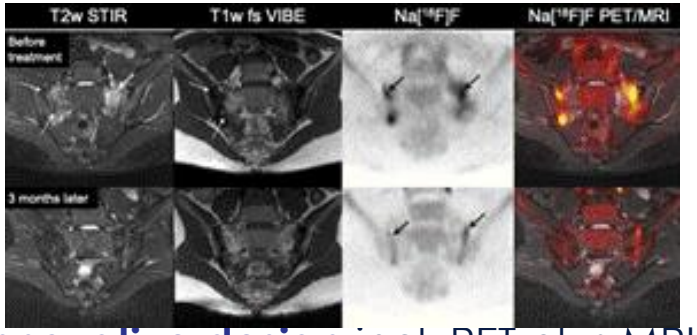


Chronic inflammation of axial skeleton

Large **unmet needs**, at least 1.5M US patients diagnosed & treated in 2015-2023[2]

Limited disease control for SoC – even at lower levels[3]

…with innovative imaging to redefine outcome measurements



Innovative design incl. PET plus MRI imaging in parallel with clinical read-outs

Accelerated path to Phase 3

Competitive **number of patients** in trial, with **attractive design** for the **specialized sites**

Market size

1.5% As current upper level of global prevalence

10+ USD bn market potential in next 10 yrs

Unmet Needs

40% Of pts do not reach relevant improvements with current therapies[3]

30% As current upper limit of nr-axSpA patients that progress to r-axSpA[4]

1. BKZ with durable response and effective in treating co-morbidities (i.e., uveitis) based on BE MOBILE trial results; 2. Based on U.S. claims data and estimations for AS: Unique patients diagnosed between 2015-2023 (ICD-10 code: M45.*) and assuming 50:50 split between AS and nr-axSpA as per literature; 3. ~40% of Humira pts do not reach ASAS20 at w12 based on ATLAS trial data; 4. Ruderman E. et al. (2013). Arthritis Rheum. 2013;65:S1052–S1053.

Source: MoonLake team; Lubrano (E.) (2018). *Clin Rev Allergy Immunol*; 9298.; Tahir H. et al. (2021). *J Exp Pharmacol*. *2;13:627-635;* MyAS;

How the new indications **drive value for MLTX**

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New indication

PsA
(Phase 2)

- **Double down on PsA** (and spondyloarthritis) by elevating bar on outcomes
- **Innovation to measure disease-modification** in joints, enthesitis, dactylitis
- **Parallel to current Ph 3,** further enabling commercial success

Strengthen indication

1 Merola J. et al. (2018). *Dermatologic Therapy; 31:e12589*. doi.org/10.1111/dth.12589 and Chimenti et al. (2020). *Biologics;14:53-75.* doi: 10.2147/BTT; 2 Passeron et al. (2023). *JAMA Dermatol*. doi:10.1001/jamadermatol.2023.5051;
3 Limited disease control – even at lower levels: ~40% of Humira pts do not reach ASAS20 at w12 based on ATLAS trial data; 4 Based on BE MOBILE trial results

Source: MoonLake

New indications provide sizeable **opportunity in multi-bn markets**

MoonLake

Derm

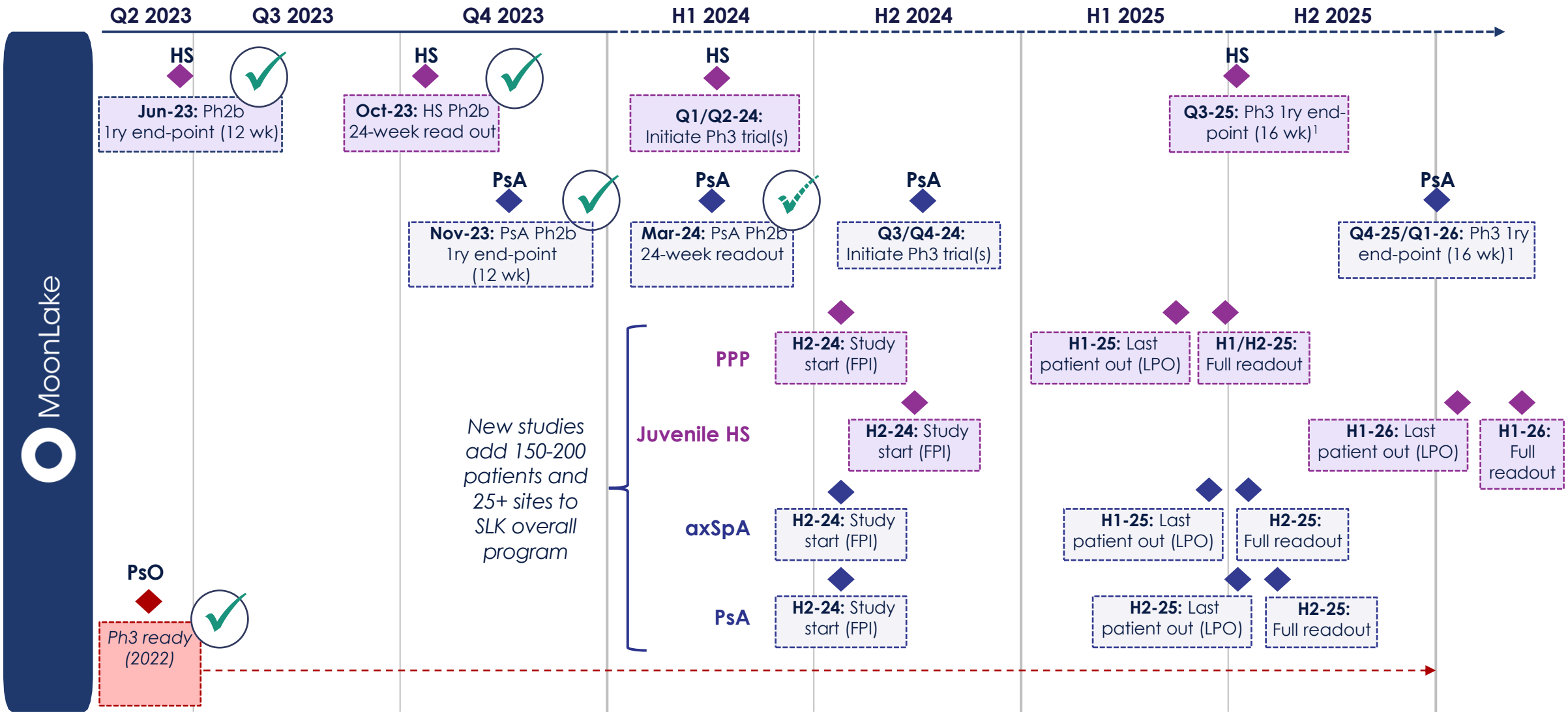
Rheum

	Leading MoA	Prevalence (%)	Mkt size ($, 2035)	Key challenge
 **PPP** *(Phase 2)*	IL-17A&F[1]	0.3%	3.5-4bn (12% growth from '22)	*No approved or effective therapy*
 **Juv HS** *(Phase 3)*	IL-17A&F TNF (no trial)	1%	USD 1-2bn (9% growth from '22)	*No clinically studied product*[4]
 **axSpA** *(Phase 2)*	IL-17A&F[2] TNF & IL-17A	1.5%	USD 10-12bn (6% growth from '22)	*Limited efficacy of SOC*[5]
 **PsA** *(Phase 2)*	IL-17A&F TNF & IL-17A	1%	USD 15bn (5% growth from '22)	*Outcomes sub-optimal (e.g., ACR)*

1 See Bimekizumab case series: Passeron et al. (2023). JAMA Dermatol. doi:10.1001/jamadermatol.2023.5051; 2 Based on BE MOBILE trial results; 3 Prevalence based on literature and U.S. claims data / Global market size estimates based on forecasting historic growth in prevalence and MLTX research on key assumptions (e.g., net prices, adherence, etc.) 4. Humira label in juvenile based on safety data from other indications; 5 ~40% of Humira pts do not reach ASAS20 at w12 based on ATLAS trial data

Source: MoonLake Internal Opportunity Model,

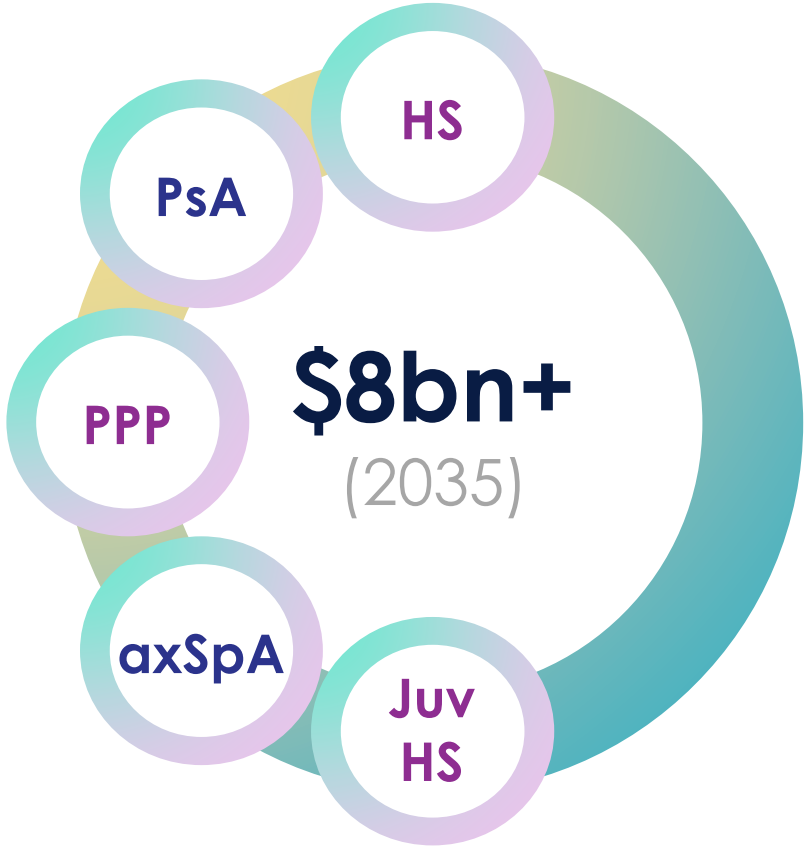
New indications further **enrich the potential catalyst calendar** in 2024-25



1 Assuming current Phase 3 planning is agreed with regulators (+/- 6 months)

Source: MoonLake team

Potential new indications could **further build out SLK's potential**



MoonLake continues to address the **most pressing unmet needs** in inflammatory diseases

The additional programs result in **USD 3Bn+**, continuing to push the potential of SLK as a leading drug in inflammation

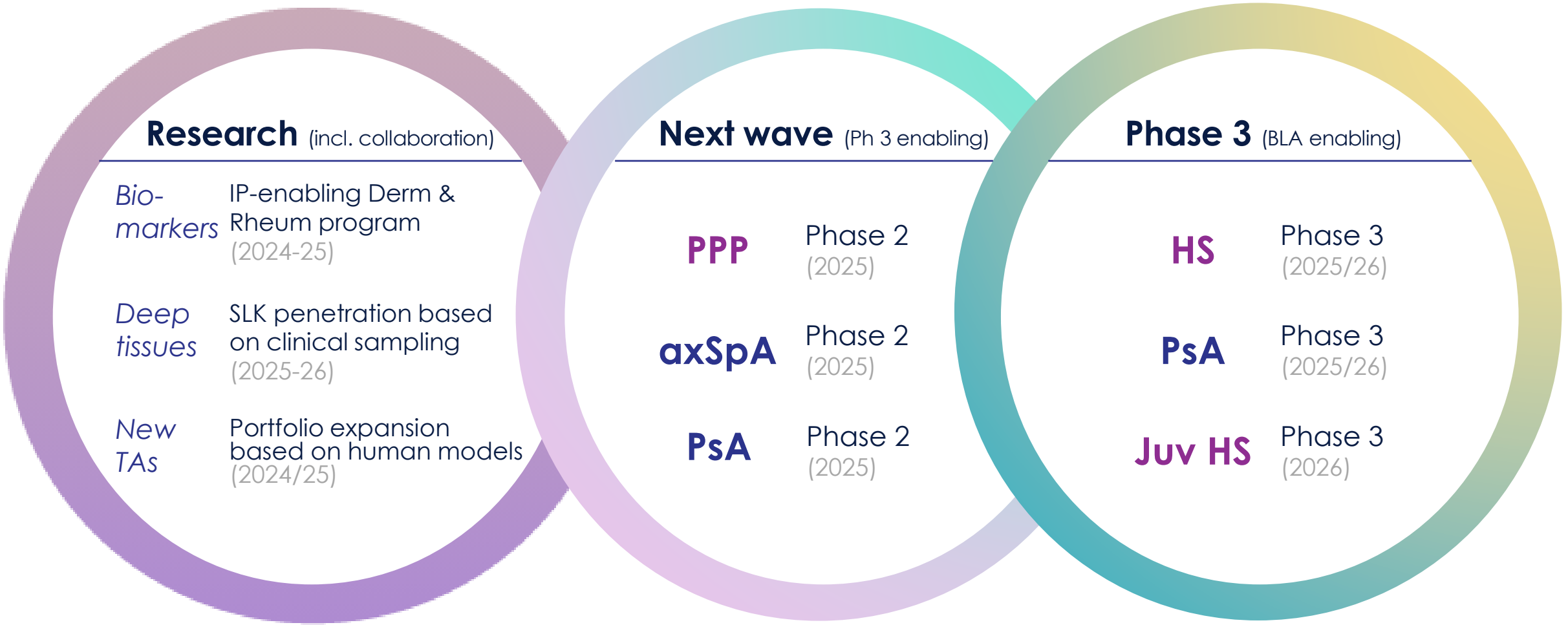
Risk profile of company remains similar as **data supports portfolio expansion** and operations can be scaled up from current structured

MLTX comfortably **financed to support development plan** and growth into market launch

Source: MoonLake Corporate

Taking a step back: Overview of R&D programs at MLTX

MoonLake



Source: Moonlake Clinical

MoonLake

Moving Forward

SLK combines properties like no other asset

MoonLake

A promising MoA…

- **Highest responses**

  IL-17A & F inhibition showed highest & most durable responses (BKZ & SLK)

- **Favorable safety profile**

  Long history of consistent safety for IL-17, where Candida ("thrush") is main adverse event – vs. TB, ISRs, cancer, infections, CV events, death… (with TNFa or JAK1)

- **Leading potential**

  Top 2 typically get 2/3 of indication bio sales (avg. $4bn+)[1]

… and a differentiated molecule

- **Elevated Performance**

  SLK shows highest responses at high treatment goals, HiSCR75, IHS4-100, PsO PASI100, PsA MDA, ACR50/70+PASI90/100 and key patient outcomes

- **Higher goals**

  Combines higher primary clinical endpoints in comparisons to gold-standards like Humira® (or Cosentyx®)

- **Improved convenience**

  Monthly 1ml maintenance injections and leading benefit-risk profile

Note: Comparisons across trials, with inherent limitations. No head-to-head trials. 1 Based on analysis of 2023 sales of 11 indications (PsO, RA, Asthma, AD, AxSpA, CU, SLE, PsA, COPD, CD, UC) – 2030 ranges are even higher

Source: DRG, MoonLake Corporate

Strategic path forward remains unchanged

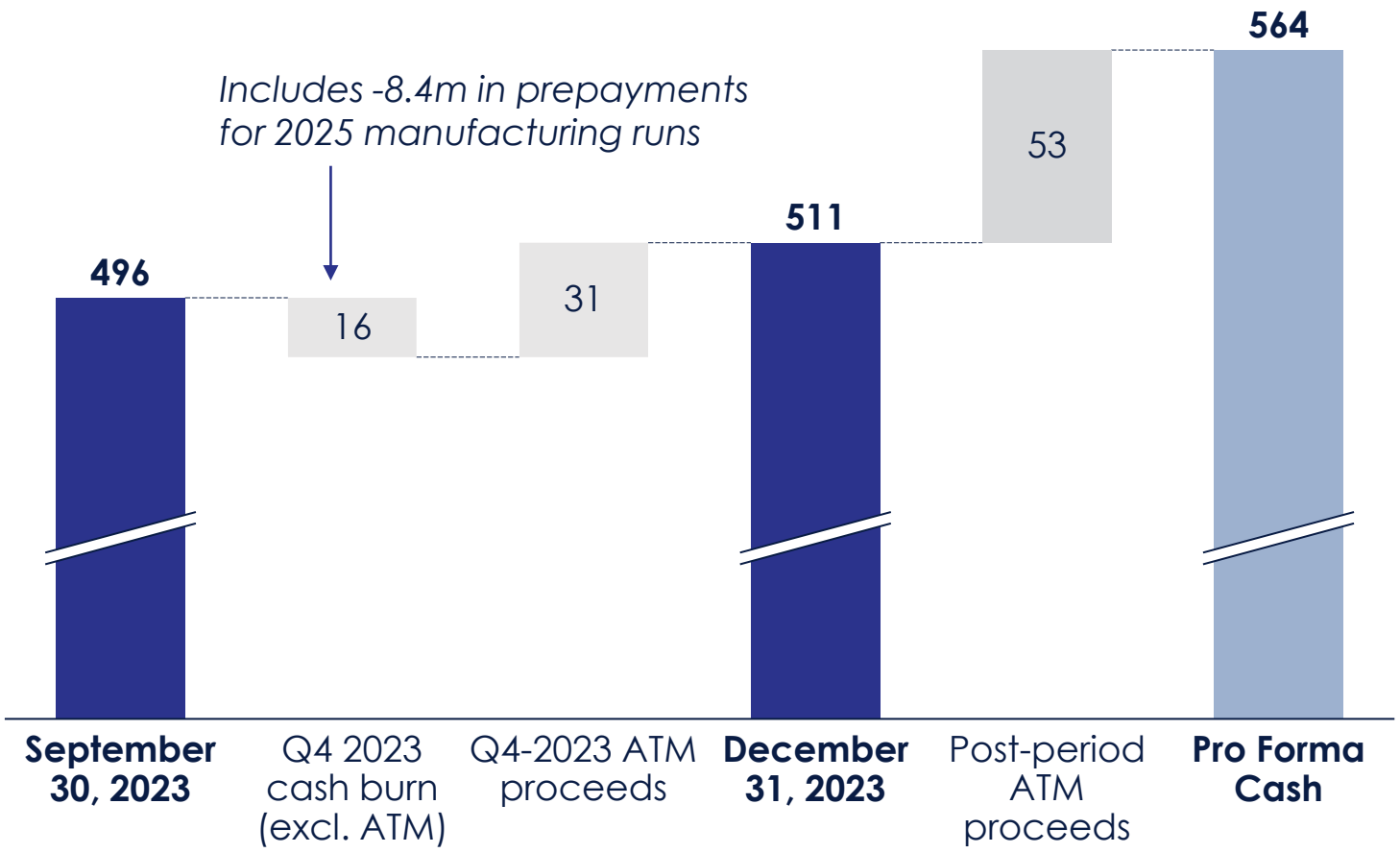
Current owner

Better owner

Source: MoonLake

Operating from a position of strength: over $500m in cash on the B/S

Cash, cash equivalents and short-term marketable debt securities
in USD M



Expected sufficient cash runway until the end of 2026, covering

- Ph3 program in HS
- Ph3 program in PsA
- Additional indication work
- Submission of BLA
- All other base spend

Low cash burn continues to demonstrate cost-efficient set up and focus of MLTX

$85.0m added via ATM at minimal dilution to double down on SLK development – no current plans for further raises

Source: MoonLake

Focus on strengthening the story of SLK as leader in Type 3 diseases

MoonLake

Inflammatory Pathway	Other	Type 1 (E.g., aTL1A)	Type 2 (E.g., Dupixent)	Type 3 (E.g., Sonelokimab)
Primary immune cells[1,2]	B cell	Macrophage; Th1, ILC1, NK	Th2 cell, ILC2, Mast cell; T_{fh}, Basophil, Eosinophil	Neutrophil; Th17, Th22, ILC3
Key cytokines[1-3]	IL-1, IL-36	IFNγ, TNF, IL-6, IL-12, IL-2	IL-4, IL-5, IL-13, IL-31	IL-17, IL-22, IL-23
Diseases related to dysregulated immunity *(examples)*[4,6]	B cell dominated: Pemphigus, ITP	UC, CD, SLE, other CTD, Rheumatoid Arthritis	Atopic dermatitis, Allergic asthma, CRSwNP, Eosinophilic esophagitis, Food allergy, **BP**	PsO, PsA, HS, NR & R Ax-SpA, GPP, PPP, PG, GCA, SSc, Myositis, AIH, Cholangitis, Glomerulosis, A-HCC etc.
	Autoinflammatory: CAPS, DIRA			

Note: Simplified depiction based on key published information, not meant to be exhaustive in nature. AD, atopic dermatitis; IFNγ, interferon gamma; IL, interleukin; ILC, innate lymphoid cell; NK, natural killer; Tfh, follicular helper; Th, T helper.

1 Kaiko GE, et al. *Immunology*. 2008;123:326-338 2 Eyerich K, Eyerich S. *J Eur Acad Dermatol Venereol*. 2018;32:692-703 3 Raphael I, et al. Cytokine. 2015;74:5-17 4 Nakayama T, et al. *Annu Rev Immunol*. 2017;35:53-84 5 Coates LC, et al. *Semin Arthritis Rheum*. 2016;46:291-304 6 Gandhi NA, et al. *Expert Rev Clin Immunol*. 2017;13(5):425-437.

Source: MoonLake Corporate

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Q & A

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