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VELA program week 16 readout

R&D Update

Monday, 29 September 2025

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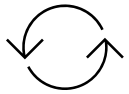

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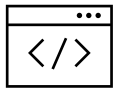

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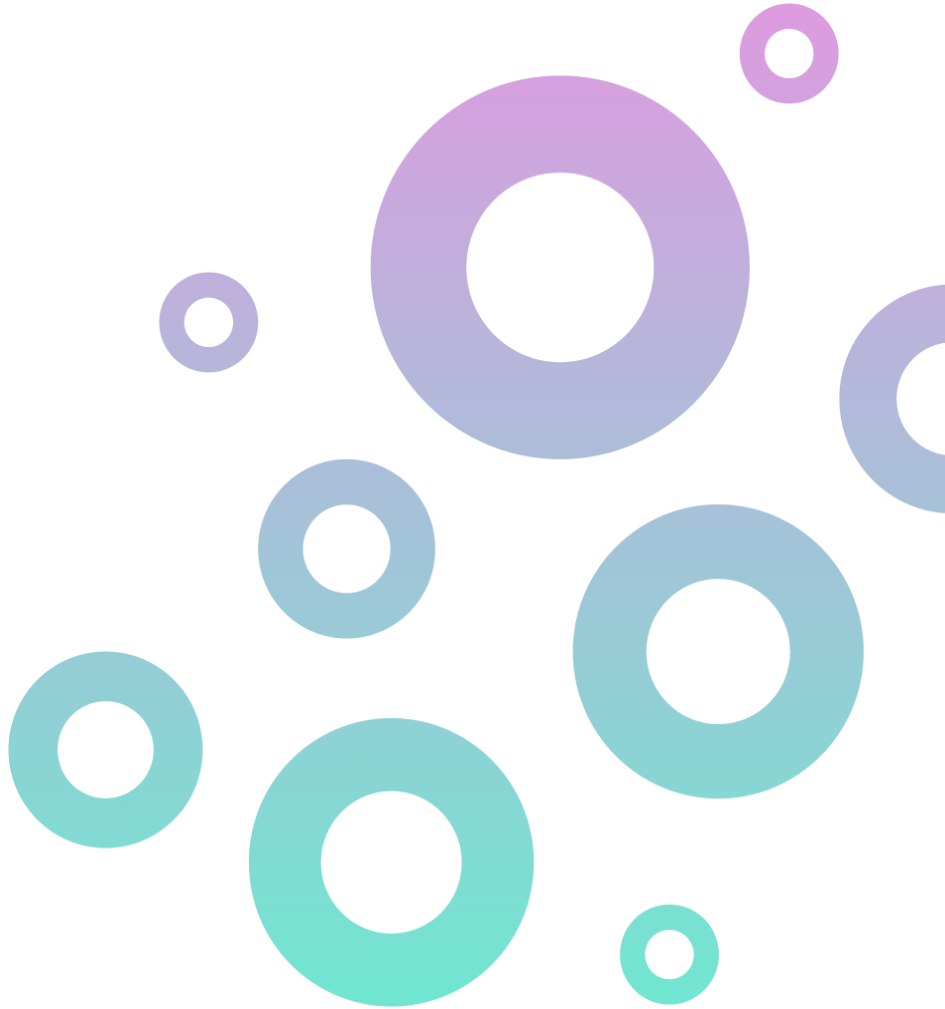


Source: MoonLake Corporate

Executive Summary

VELA-1 and VELA-2 are two identical studies to evaluate efficacy and safety of sonelokimab in adults with moderate-to-severe HS, with the primary endpoint readout at week 16

Combined VELA program demonstrated clinically meaningful and statistically significant improvement across all primary and key secondary endpoints at week 16 using both pre-specified strategies ($p<0.001$)

- VELA-1 achieved statistical significance for all primary and key secondary endpoints
- In VELA-2, intercurrent events in the higher-than-expected placebo arm precluded the study from achieving statistical significance at week 16 using composite strategy ($p=0.053$) – using the pre-specified treatment policy strategy VELA-2 also demonstrates statistically significant HiSCR75 response rates at week 16

In VELA-1 and VELA-2 the active sonelokimab arm demonstrated strong responses across endpoints, including competitive HiSCR75 response rate (35% and 36% respectively, treatment policy) and HiSCR50 response rate

Sonelokimab continues to show a differentiated profile, including:

- Leading Patient Reported Outcomes (PROs), e.g., quality-of-life and pain scores
- Favorable safety profile
- Convenient sub-cutaneous dosing scheme with fewer and lower volume injections

VELA trial progresses and will now seek to confirm the path to registration in HS with the appropriate regulatory authorities

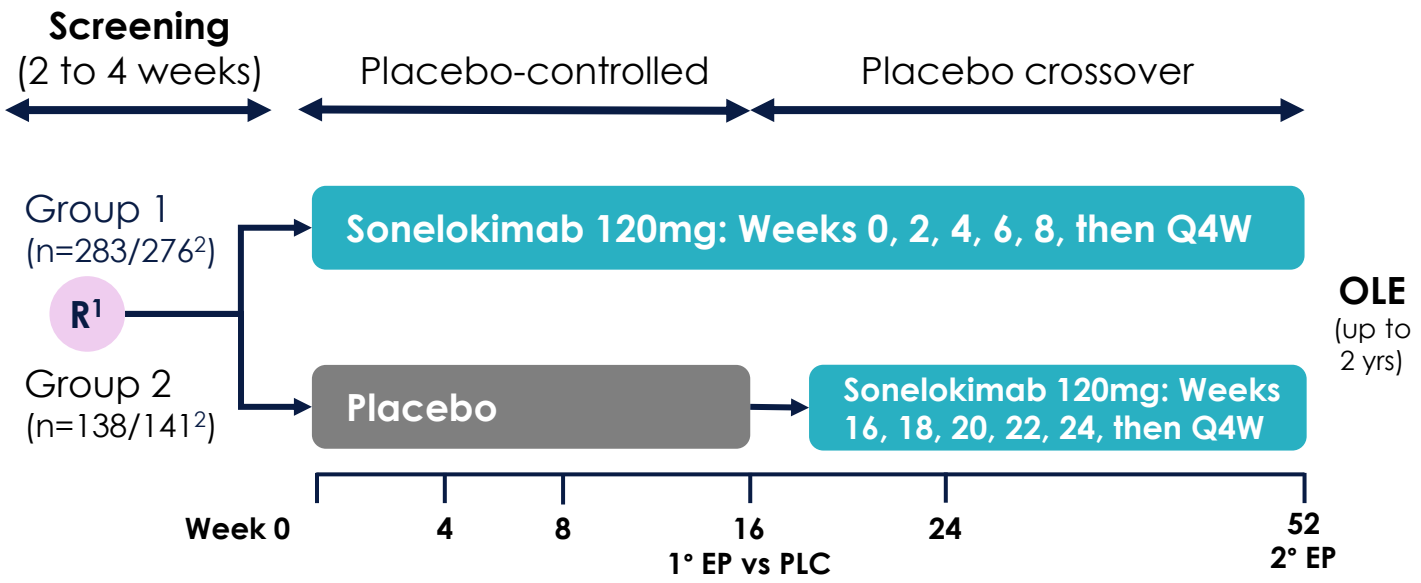
MoonLake continues to advance its pipeline with near-term catalysts approaching in PsA, PPP, and axSpA

Source: MoonLake

Recap: Phase 3 design and endpoints of VELA trials

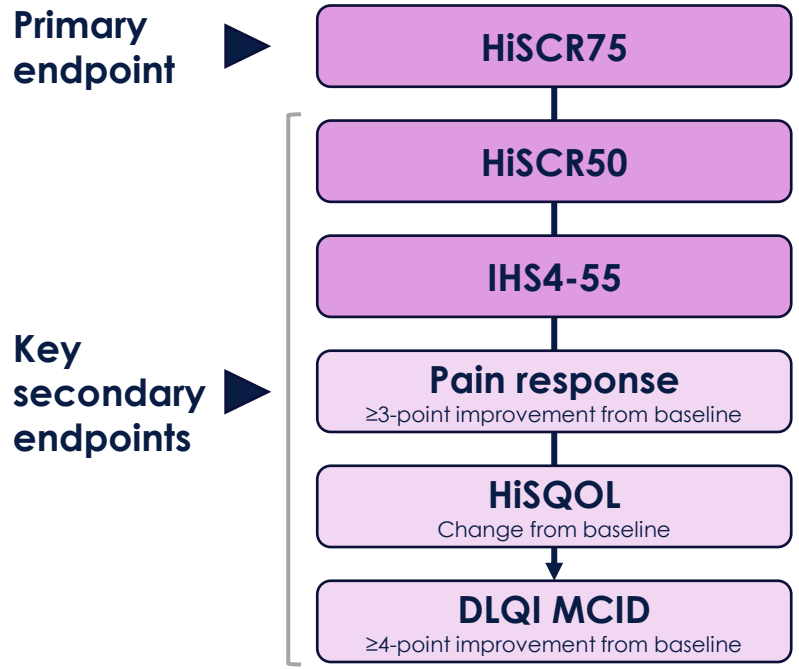
Lesions PROs

Phase 3 study design for VELA-1 and VELA-2



Protocol repeated 2x (n=838 pts) – VELA-1 and VELA-2 (both follow the same protocol)

Endpoints – SLK vs placebo W16



1 Randomization stratified by Hurley stage status (II vs. III), prior biologic use (Y/N) and geographic region (NA/EU). Patients in Hurley stage III limited to ~40% EoPh2, End of Phase 2; 2 n for VELA-1 and VELA-2 respectively

Source: MoonLake Clinical

VELA disposition: More than 90% of patients completed Week 16

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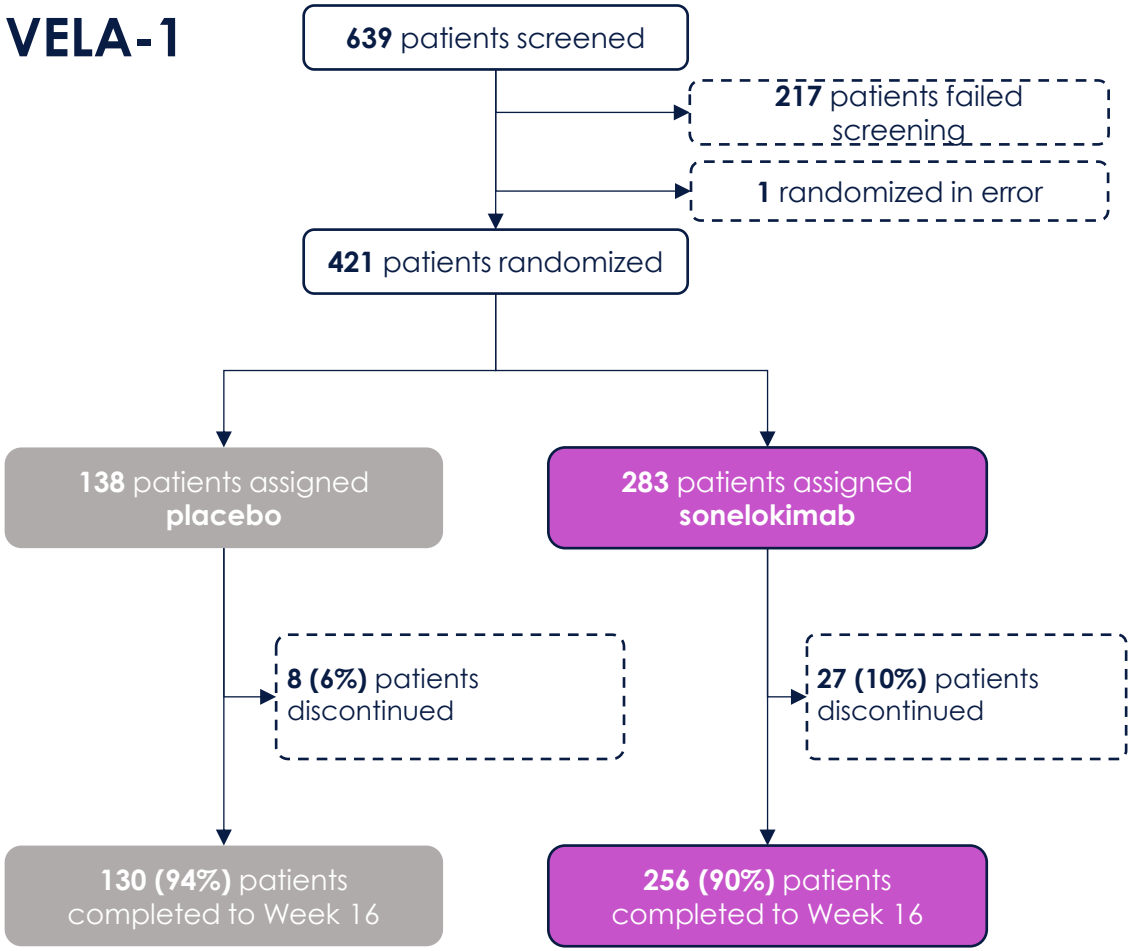
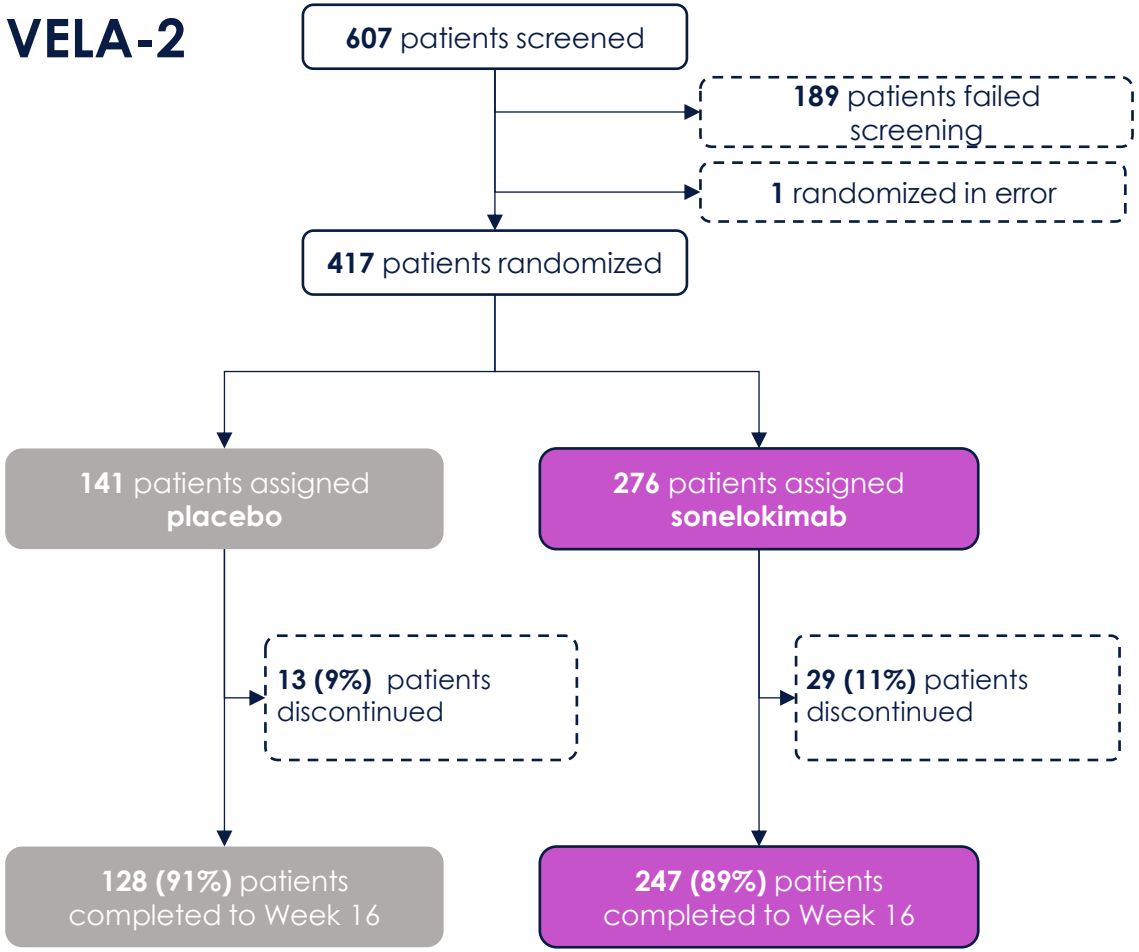
VELA-1



VELA-2



Source: MoonLake Clinical

VELA baseline: Patient characteristics balanced across trials

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Patient demographics and characteristics	VELA-1		VELA-2	
	Placebo N=138	Sonelokimab N=283	Placebo N=141	Sonelokimab N=276
Age [years], mean	36.1	37.2	38.0	37.2
Female, %	62.3	61.5	49.6	53.6
Race, %				
White	76.1	77.7	85.1	81.5
Black or African American	15.2	12.0	10.6	9.4
BMI [kg/m^2], mean	33.6	33.5	32.7	33.0
Current smoker, %	41.3	43.8	56.0	51.8
Hurley Stage, %				
II	63.8	64.0	67.4	63.0
III	36.2	36.0	32.6	37.0
Years since diagnosis, mean	8.4	8.1	7.7	7.5
Lesions, mean				
AN count	13.3	13.5	13.8	14.5
DT count	2.8	3.2	3.5	3.9
DLQI Total, mean	11.8	11.7	11.3	12.6
HiSQOL Total, mean	27.6	26.5	23.8	28.0
Patient Global Assessment of Skin Pain NRS, mean	4.9	4.7	5.0	4.9
Prior biologic use, %	15.9	15.5	22.0	19.6
Concomitant antibiotics, %	8.7	6.7	7.8	10.5

AN, abscess or inflammatory nodule; BMI, body mass index; DT, draining tunnel; DLQI, Dermatology Life Quality Index; HiSQOL, HS Quality of Life; NRS, numerical rating scale; SD, standard deviation

Source: MoonLake Clinical

Important: VELA uses two statistical strategies, as any other study

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Protocol includes two pre-specified analysis strategies in accordance with regulatory advice

Composite strategy + **Treatment policy strategy**

ITT, Intention-to-treat population

NRI, Non-responder imputation for:

- (i) patients starting rescue medication
- (ii) patients that discontinued for lack of efficacy or adverse events

All collected data irrespective of intercurrent events included (approximates a real-world setting)

Multiple imputation for missing data

Primary estimand **evaluates significance of endpoints …**

… works **to confirm robustness** of primary estimand

Both strategies are a 'must-see' for FDA and EMA in any scenario for any I&I drug

FDA U.S. FOOD & DRUG ADMINISTRATION

EMA EUROPEAN MEDICINES AGENCY

If there is **no concordance**, guidance must be obtained from the regulators

Source: MoonLake Clinical

VELA efficacy: SLK shows consistent response – high W16 pbo in VELA-2

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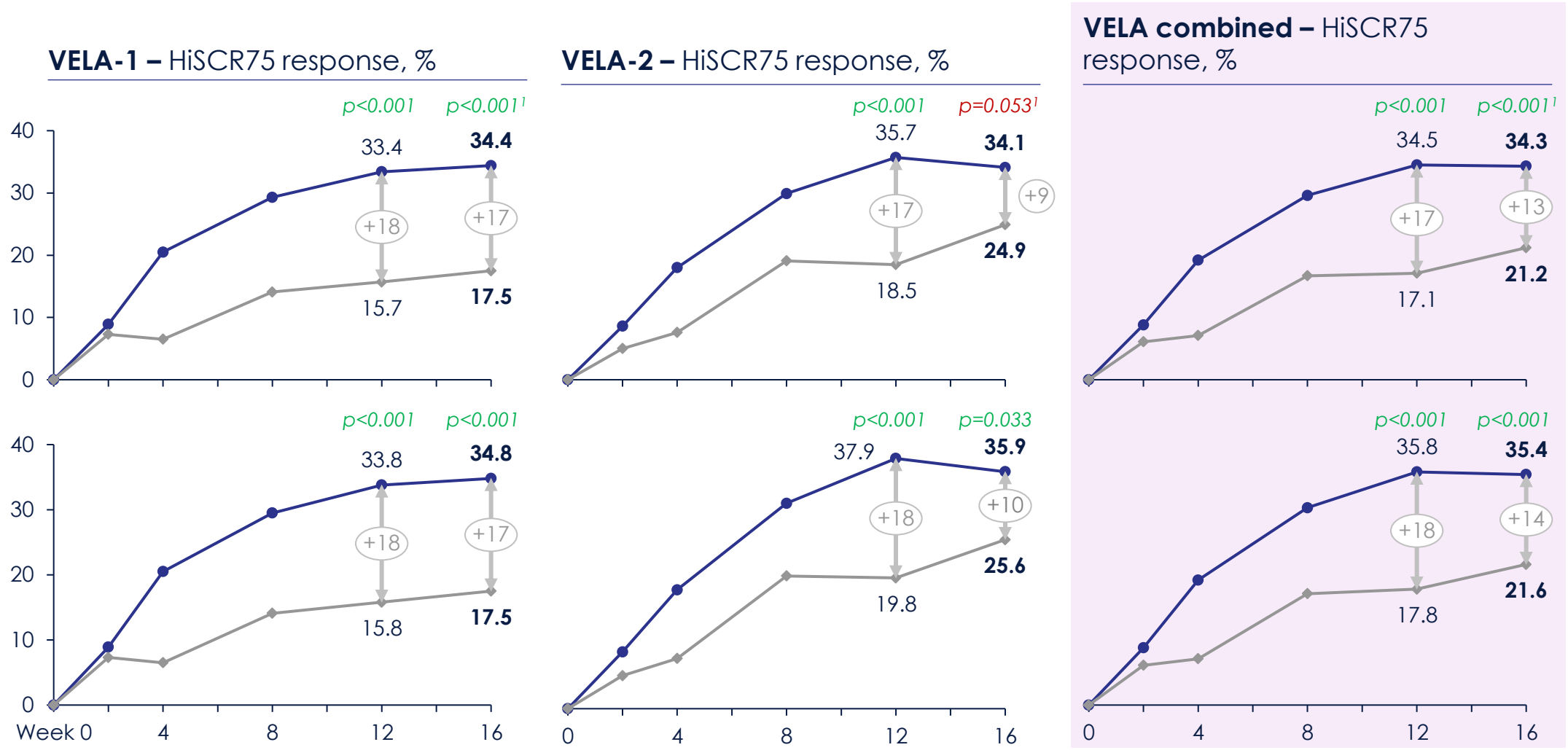
SLK 120mg — Placebo

Composite strategy analysis (ITT-mNRI)

Treatment policy analysis (ITT-MI)



Note: HiSCR75 responders, mNRI, VELA-1: SLK 120mg arm (n=283), PBO arm (n=138), VELA-2: SLK 120mg arm (n=276), PBO arm (n=141); 1 Multiplicity control was only applied for testing of the primary and key secondary endpoints at week 16 by composite strategy in VELA-1 and VELA-2 individually

Source: MoonLake Clinical

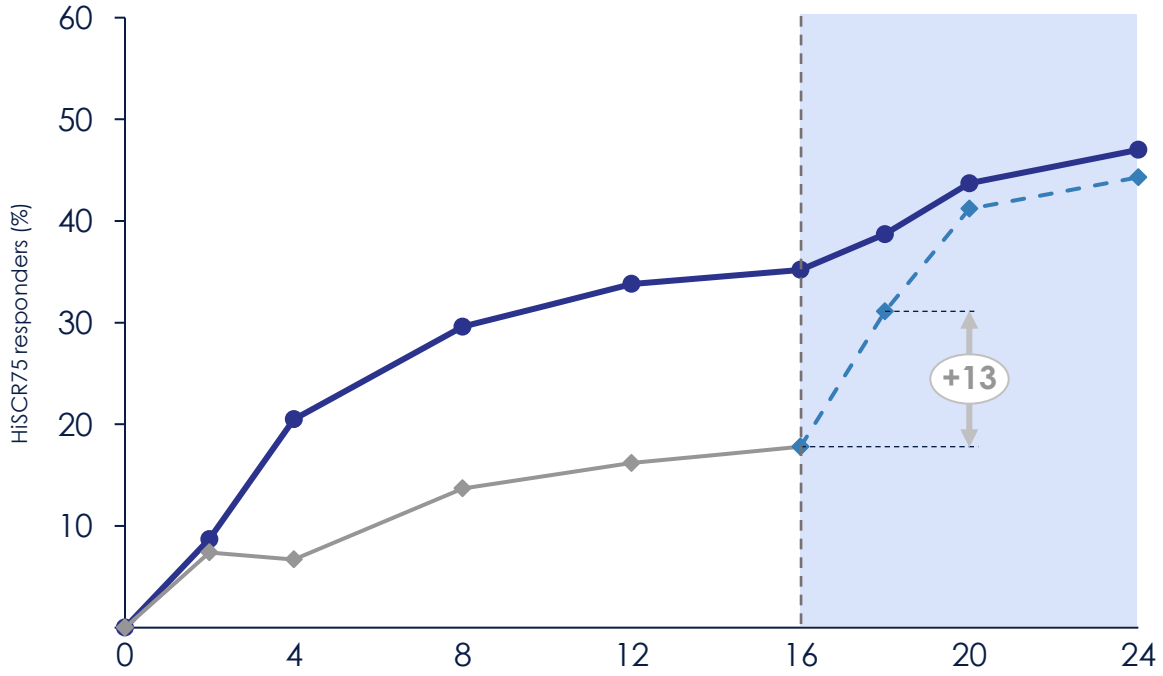
VELA efficacy: SLK demonstrates strong and lasting cross-over response

Preliminary data – subject to week 52 database lock

HiSCR75 response, % (as observed)

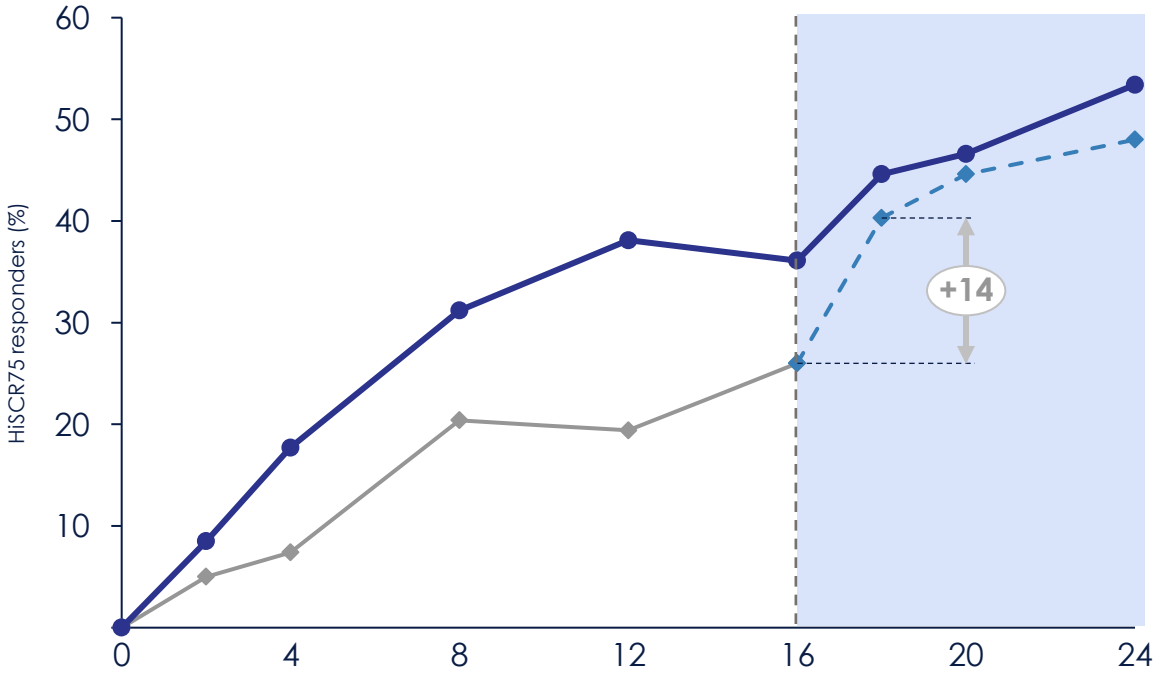
SLK 120mg | Placebo | Placebo-to-SLK 120mg cross-over

VELA-1



n (SLK)	283	273	270	263	256	229	185
n (PBO)	138	134	131	130	129	114	97

VELA-2



n (SLK)	276	265	263	257	244	232	193
n (PBO)	141	136	137	129	127	121	98

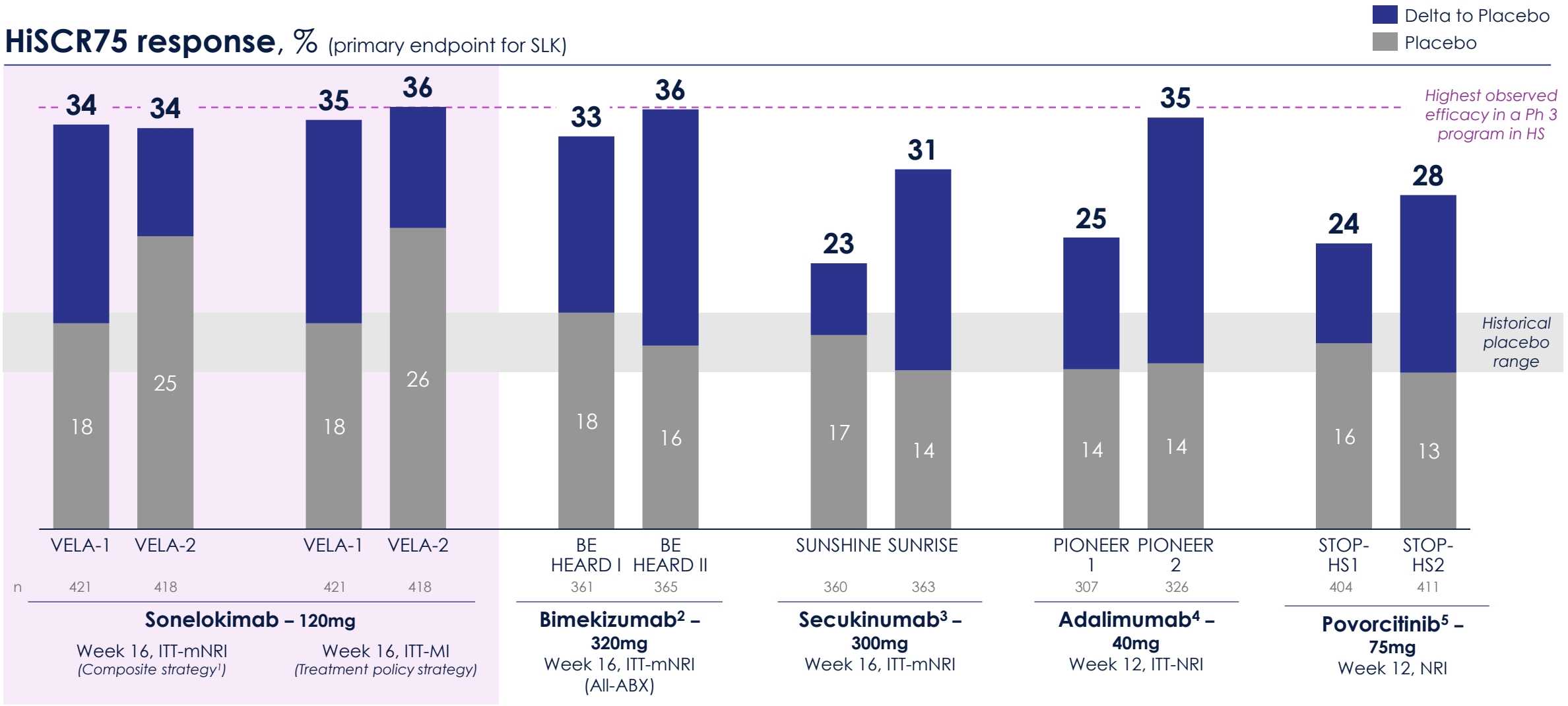
Efficacy for SLK further builds up beyond week 16, with strong placebo cross-over results

Note: Preliminary, pre-specified analysis suggests continued improvement beyond week 16, subject to week 52 database lock. Not multiplicity-controlled. Week 20 and week 24 n-numbers reflect incomplete data due to trial ongoing.

Source: MoonLake Clinical

VELA efficacy: Absolute HiSCR75 response across Ph3 HS programs

HiSCR75 response, % (primary endpoint for SLK)

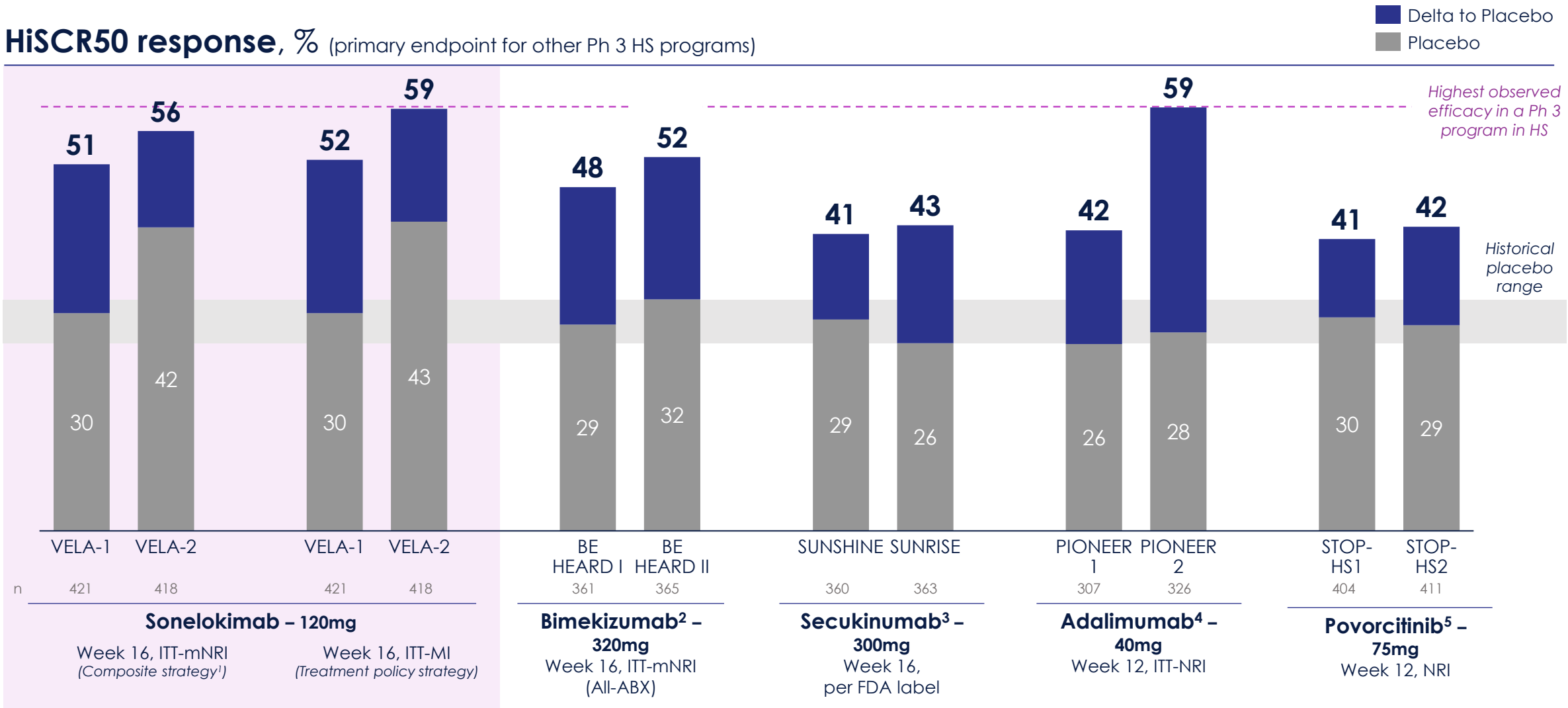


Note: These data are derived from different clinical trials at different points in time, with differences in trial design and patient populations. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted; 1 Primary estimand; 2 BE HEARD I & II (Kimball A et al. Lancet 2024; 403:2504-2519), considers all patients in Q2W arm until W16; 3 SUNSHINE & SUNRISE (Kimball A et al. EADV 2023), considers all patients in Q4W arm; 4 PIONEER I & II (Porter M, et al. SHSA 2022, P3814 (integrated post-hoc analysis of HiSCR 75 response in PIONEER I and II)), considers all patients; 5 Incyte Investor Presentation March 17, 2025, considers all patients in 75mg arm

Source: MoonLake Clinical

VELA efficacy: Absolute HiSCR50 response across Ph3 HS programs

HiSCR50 response, % (primary endpoint for other Ph 3 HS programs)

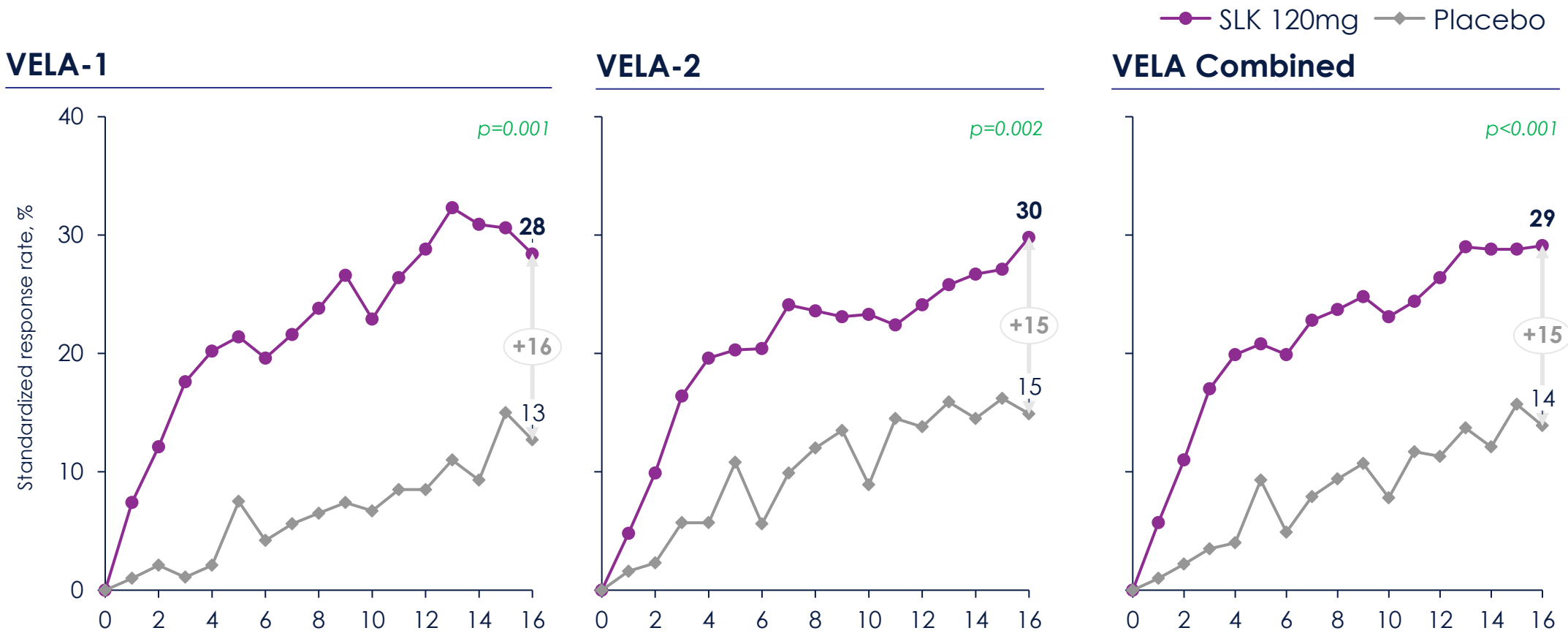


Note: These data are derived from different clinical trials at different points in time, with differences in trial design and patient populations. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted; 1 Primary estimand; 2 BE HEARD I & II (Kimball A et al. Lancet 2024; 403:2504-2519), considers all patients in Q2W arm until W16; 3 SUNSHINE & SUNRISE (FDA label), considers all patients in Q4W arm; 4 PIONEER I & II (Porter M, et al. SHSA 2022, P3814 (integrated post-hoc analysis of HiSCR 75 response in PIONEER I and II)), considers all patients; 5 Incyte Investor Presentation March 17, 2025, considers all patients in 75mg arm

Source: MoonLake Clinical

PRO: Sonelokimab significantly improves pain in HS patients

Pain NRS-3[1]



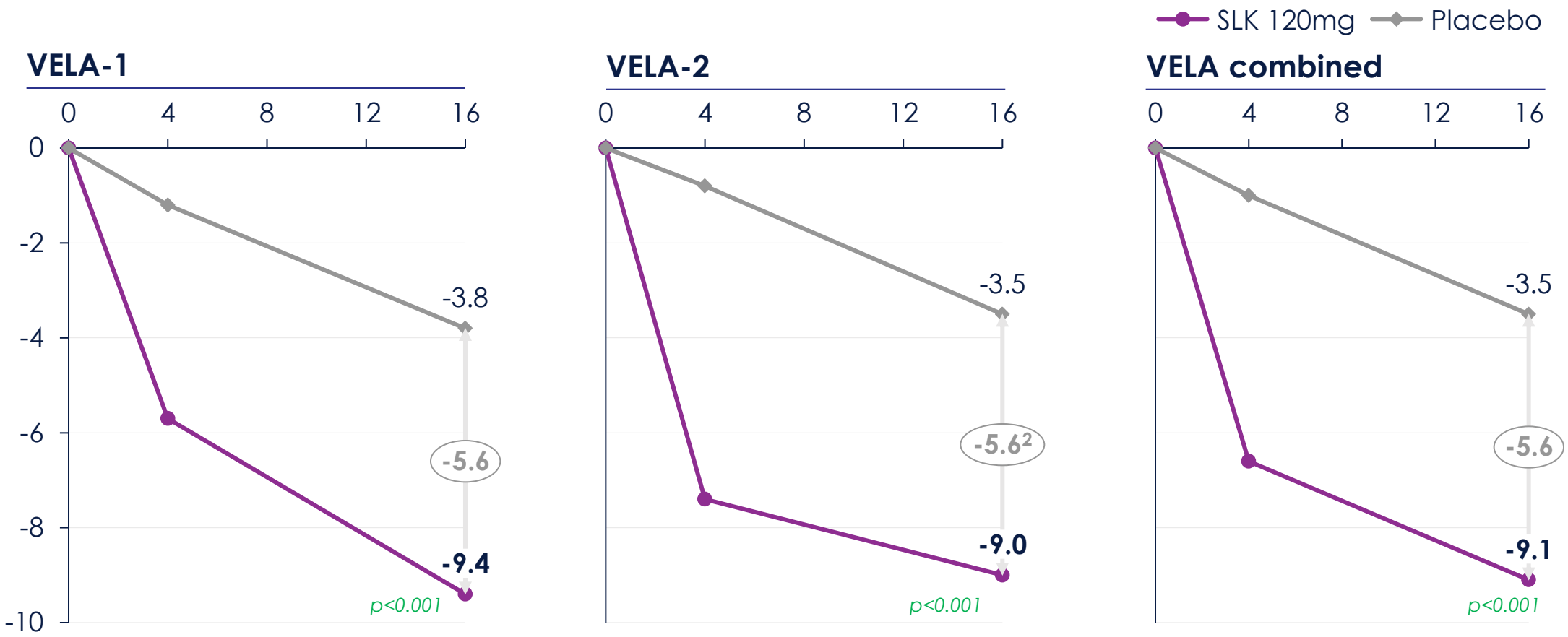
In VELA-1 and VELA-2, ~30% of patients experienced a marked reduction of pain – in line with MIRA (22% response in SLK 120mg)

Note: VELA-1: SLK 120mg arm (n=283), PBO arm (n=138), VELA-2: SLK 120mg arm (n=276), PBO arm (n=141); 1 Pain NRS-3 refers to Worst Pain NRS reduction of at least 3 points, ITT, pre-specified treatment policy strategy, deltas to placebo vary between treatment policy and composite strategy by less than 1.5 percentage points

Source: MoonLake Clinical

PRO: Sonelokimab demonstrates high HiSQOL response

HiSQOL total score CfB[1]



VELA-1 and VELA-2 show strong HiSQOL response – better than MIRA (-4.4pp delta to PBO). **Response is highly relevant for patients**, capturing unique aspects of HS burden and factors that most strongly affect QOL in real-world clinical practice[3]

Note: VELA-1: SLK 120mg arm (n=283), PBO arm (n=138), VELA-2: SLK 120mg arm (n=276), PBO arm (n=141); 1 Change from Baseline LS Mean (+/- SE), ITT, pre-specified treatment policy strategy, deltas to placebo vary between treatment policy and composite strategy by less than 0.5 percentage points; 2 Numbers do not add up due to rounding; 3 Garg et al. Br J Dermatol. 2025; 192:261-268

Source: MoonLake Clinical

PRO: Sonelokimab demonstrates high DLQI response

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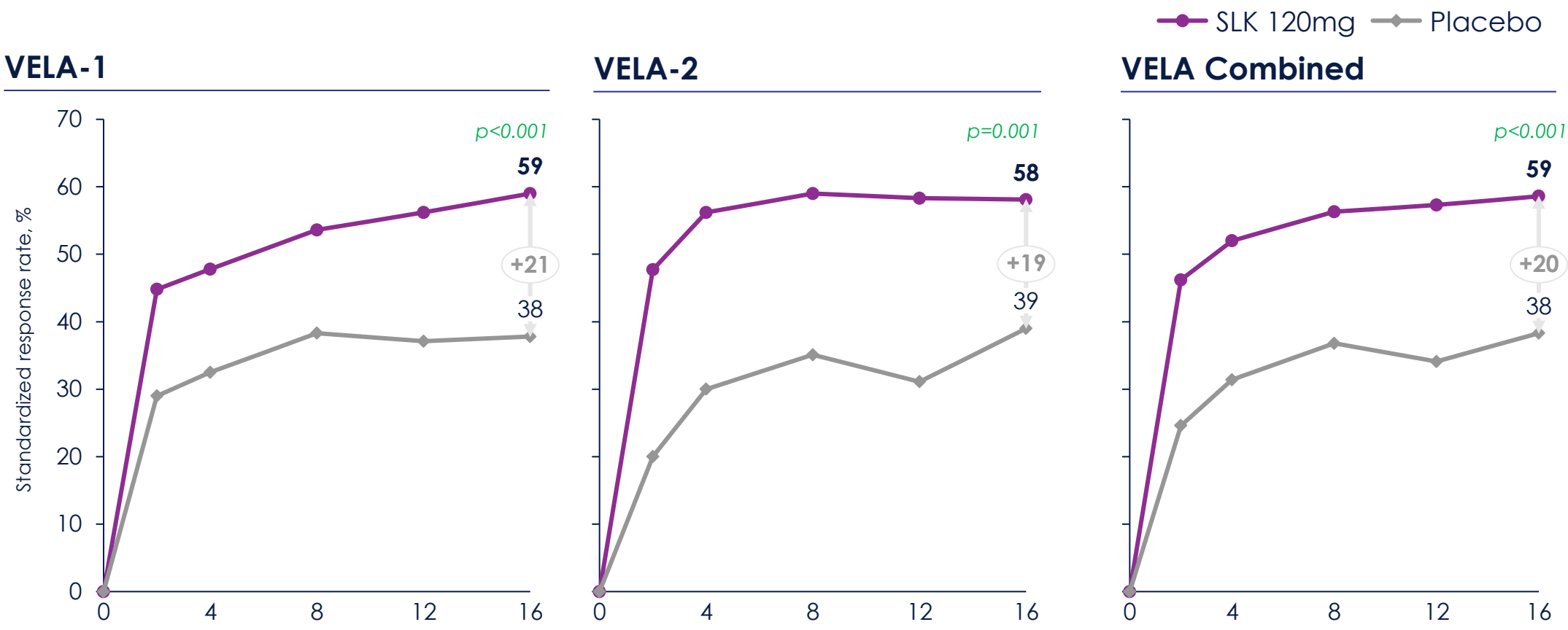
DLQI-MCID[1]



VELA-1 and VELA-2 shows beneficial DLQI-MCID response – in line with MIRA (22pp delta to PBO)

Note: VELA-1: SLK 120mg arm (n=283), PBO arm (n=138), VELA-2: SLK 120mg arm (n=276), PBO arm (n=141); 1 MCID refers to minimally clinically important difference which reflects a reduction of at least 4 points in the score, ITT, pre-specified treatment policy strategy, deltas to placebo vary between treatment policy and composite strategy by less than 1.5 percentage points

Source: MoonLake Clinical

Efficacy: Summary of primary and key secondary endpoints

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	VELA-1				VELA-2				VELA combined			
	Placebo (N=138)	SLK 120mg (N=283)	Delta	p-value	Placebo (N=141)	SLK 120mg (N=276)	Delta	p-value	Placebo (N=279)	SLK 120mg (N=559)	Delta	p-value
Composite Strategy (Primary Estimand)												
HiSCR75 (%)	**17.5**	**34.4**	**16.9**	<0.001	**24.9**	**34.1**	**9.2**	0.053	**21.2**	**34.3**	**13.1**	<0.001
HiSCR50 (%)	30.3	51.0	20.7	<0.001	42.2	55.6	13.4	0.011	36.3	53.3	17.0	<0.001
IHS4-55 (%)	33.9	53.2	19.3	<0.001	43.0	54.9	11.9	0.024	38.4	54.1	15.6	<0.001
Pain NRS-3 (%)	11.5	28.4	16.9	<0.001	14.9	29.1	14.1	0.003	11.3	26.4	15.4	<0.001
HiSQOL LSM CfB	-3.1	-8.8	-5.7	<0.001	-3.3	-8.3	-5.0	<0.001	-3.2	-8.5	-5.3	<0.001
DLQI-4 (%)	36.2	56.8	20.6	<0.001	38.1	55.1	16.9	0.002	37.1	55.9	18.9	<0.001
Treatment Policy												
HiSCR75 (%)	**17.5**	**34.8**	**17.3**	<0.001	**25.6**	**35.9**	**10.3**	0.033	**21.6**	**35.4**	**13.8**	<0.001
HiSCR50 (%)	30.3	51.6	21.3	<0.001	43.0	58.7	15.6	0.003	36.7	55.1	18.4	<0.001
IHS4-55 (%)	34.2	54.4	20.3	<0.001	44.7	56.9	12.3	0.021	39.4	55.7	16.3	<0.001
Pain NRS-3 (%)	12.7	28.4	15.8	0.001	14.9	29.8	14.9	0.002	13.9	29.1	15.2	<0.001
HiSQOL LSM CfB	-3.8	-9.4	-5.6	<0.001	-3.5	-9.0	-5.6	<0.001	-3.5	-9.1	-5.6	<0.001
DLQI-4 (%)	37.8	59.0	21.2	<0.001	39.0	58.1	19.0	0.001	38.3	58.6	20.3	<0.001

Note: Primary endpoint HiSCR75 in bold

Source: MoonLake Clinical

Safety: SLK continues favorable safety profile, with no new signals

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Participants with event, n (%)	Placebo n=279	Sonelokimab 120 mg n=559
Any TEAE	155 (55.6)	376 (67.3)
Any serious TEAE	5 (1.8)	14 (2.5)
Any TEAE leading to treatment discontinuation	4 (1.4)	16 (2.9)
Most frequent TEAEs[1]		
Nasopharyngitis	28 (10.0)	48 (8.6)
Headache	14 (5.0)	27 (4.8)
URTI	21 (7.5)	24 (4.3)
Safety topics of interest		
IBD[2]	0	0
Diarrhea (non-infectious)[3]	1 (0.4)	2 (0.4)
Oral candidiasis[4]	1 (0.4)	41 (7.3)
Serious hypersensitivity	0	0
Dermatitis & Eczema[5]	7 (2.5)	20 (3.6)
Serious infections	2 (0.7)	4 (0.7)
SI/B[6]	0	0
Hepatic events[7]	3 (1.1)	1 (0.2)
MACE[8]	0	0

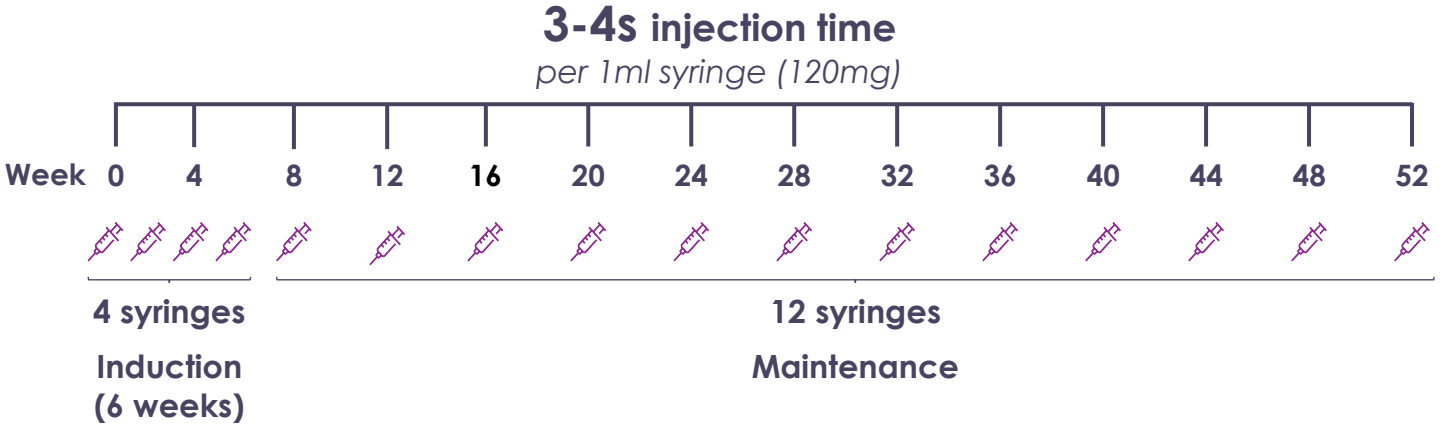
Sonelokimab continues to show a **favourable safety profile** with no new safety signals detected – including an **absence of IBD, SI/B and hepatic event signals**

1 Most frequent TEAEs exclude safety topics of interest and TEAEs with data presentation potentially unblinding the ongoing VELA studies; 2 AESI: Adverse Events of Special Interest; events in adjudication; 3 AESI; 4 Three cases of oesophageal candida and two of oropharyngeal candida reported on SLK; 5 PTs: eczema and dermatitis; 6 Reported adverse events; 7 Hepatic events include all hepatic AEs and lab investigations in adjudication to possible DILI; 8 Events in adjudication.

Source: MoonLake Clinical

Convenience: SLK offers convenience in induction and maintenance

Sonelokimab treatment scheme – as per VELA trial



Available treatment options with **up to 18 syringes in induction phase** and **longer injection time (up to 25 seconds)**

Note: These data are derived from different clinical trials at different points in time, with differences in trial design and patient populations.

Source: MoonLake Medical, BKZ Instructions for Use and FDA label

Invited expert: Alexa Kimball (MD, MPH) – disclosures

Institution receives grants: Acelyrn, AnaptysBio, Avalo, Bristol Myers Squibb, Eli Lilly, Incyte, Janssen, Moonlake, Novartis, Pfizer, Prometheus, Regeneron, Sanofi, Sonoma Bio, UCB

Consulting or Honoraria: Abbvie, Avalo, Boehringer Ingelheim, Cellarity, Citryll, Eli Lilly, Evoimmune, Janssen, Merck, Moonlake, Novartis, Nurix, Pfizer, Sanofi, Sonoma Bio, Takeda, Target RWE, UCB, Union Therapeutics, Ventyx, Zura Bio

Other: Member, Board of Directors, Almirall

Source: Alexa Kimball – MD, MPH

Invited expert

Alexa Kimball – MD, MPH

Professor of Dermatology at Harvard Medical School

CEO and President of Harvard Medical Faculty Physicians at Beth Israel Deaconess Medical Center (>2400 employees and > USD 1 bn revenue)

Internationally renowned HS and PsO researcher:

- Lead author for all three programs leading to biologics approval in HS – bimekizumab, secukinumab, adalimumab
- >385 published papers
- >150 clinical trials
- Multiple patents and licensing agreements
- Several awards incl. recent American Skin Association 2025 Research Achievement Award in Inflammatory Skin Diseases
- Book author in HS, e.g., "Hidradenitis Suppurativa: Your Questions, Expert Answers."

Source: Alexa Kimball – MD, MPH

MLTX continues to progress its development program

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	Indication	Trial	Phase	Key dates[1] – expected timings: Read-out	Filing	Approval
Base indications	**Hidradenitis suppurativa** *Dermatology*	VELA-1, VELA-2	3 *FPI May 2024*	Q3 2025 (1° EP) Q2 2026 (1-year)	Q3 2026	Mid-2027
		VELA-TEEN	3 *FPI Dec 2024*	H1 2026	Q3 2026	Mid-2027
	PsA *Rheumatology*	IZAR-1, IZAR-2	3 *FPI Nov 2024*	H1 2026 (1° EP) H1 2027 (1-year)	Q3 2027 (sBLA)	Q3 2028
		P-OLARIS	2	H2 2026 (1° EP)	Q3 2027 (sBLA)[2]	
New indications	**PPP** *Dermatology*	LEDA	2 *FPI Nov 2024*	Q2 2025 (interim) Q4 2025 (1° EP)	TBC	TBC
	axSpA *Rheumatology*	S-OLARIS	2 *FPI Dec 2024*	Q1 2026 (1° EP)	TBC	TBC

1 Based on current management plans, dates shown are for the US; 2. Filing date is only for the PsA part of the study; PPP; palmoplantar pustulosis; PsA, psoriatic arthritis; EP, end point; sBLA, supplemental BLA; axSpA, axial spondyloarthritis

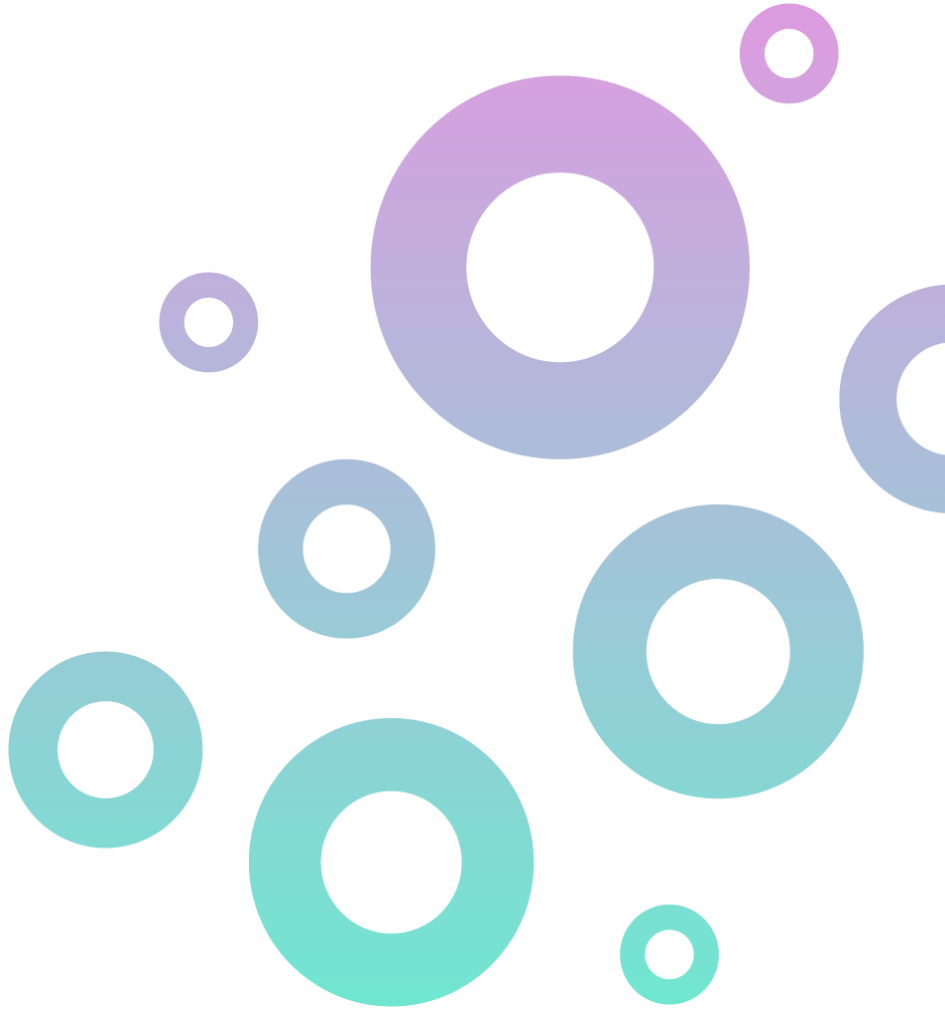
Source: MoonLake

What happens next

MLTX believes that is has a clear path forward in HS

- MLTX believes that the HS package should be approvable based on all relevant SLK data to date (incl. VELA and MIRA trial data), internal and external assessments, and precedents in HS
- Company will now seek to confirm registration path with the appropriate regulatory authorities
- To that end, guidance from the FDA is being sought in the coming weeks
- SLK continues to show a differentiated profile, matching efficacy, impact on pain and quality of life, safety and convenience

MLTX will present VELA topline data at the 10th Annual Symposium on Hidradenitis Suppurativa Advances (SHSA) in Nashville, TN (October 31 – November 2, 2025)



Source: MoonLake

MoonLake

Q & A

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