An Orphan Disease Company by Design

September 8, 2016
Forward-Looking Statements

This presentation and the oral commentary contain “forward-looking” statements that involve substantial risks and uncertainties. All statements other than statements of historical facts, including statements regarding our future financial condition, timing for and outcomes of clinical results, business strategy and plans and objectives for future operations, are forward looking statements. These forward-looking statements include terminology such as “believe,” “will,” “may,” “estimate,” “continue,” “anticipate,” “contemplate,” “intend,” “target,” “project,” “should,” “plan,” “expect,” “predict,” “could,” “potentially” or the negative of these terms Forward looking statements are our current statements regarding our intentions, beliefs, projections, outlook, analyses or current expectations concerning, among other things, our ongoing and planned clinical development, the timing of and our ability to initiate or enroll clinical trials, and our ability to make regulatory filings and obtain and maintain regulatory approvals for Sarasar, Bestatin, PEG IFN Lambda and our other product candidates, our intellectual property position, the potential safety, efficacy, reimbursement, convenience clinical and pharmaco-economic benefits of our product candidates, commercial opportunities, including potential market sizes and segments, our ability to commercialize, expectations regarding clinical trial data and FDA outcomes, our results of operations, cash needs, spending of the proceeds from this offering, financial condition, liquidity, prospects, growth and strategies, the industry in which we operate and the trends that may affect the industry or us.

Forward-looking statements involve known and unknown risks, uncertainties, assumptions and other factors that may cause our actual results, performance or achievements to be materially different from any future results, performance or achievements expressed or implied by the forward-looking statements. Forward-looking statements represent our beliefs and assumptions only as of the date of this presentation. Except as required by law, we assume no obligation to update these forward-looking statements publicly, or to update the reasons why actual results could differ materially from those anticipated in the forward-looking statements, even if new information becomes available in the future.

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Sarasar is a registered trademark of Merck Sharp & Dohme Corp. Bestatin is a trademark of Nippon Kayaku Co., Ltd. All other trademarks belong to their respective owners.
Corporate Overview

Background
- Founded in 2008
- Public in March 2016

Pipeline
- Phase 2, clinical stage
- Novel targets in multiple orphan diseases

Experienced Team
- Key roles in Commercial, R&D in biotech and pharma
- Members of team have worked together since 90’s

Solid Financials
- $45M cash as of June 30, 2016
- Raised $18M net in August 2016
- Resources expected to fund operations through 2017
Investment Highlights

- 5 - Phase 2 programs in the clinic and dosing patients
- 4 - Well characterized, clinical stage compounds
- Therapeutically diverse set of orphan disease programs
- Multiple large commercial market opportunities
- Multiple shots on goal for clinical & regulatory success
- Data from all 5 programs over the next 18 months
## Development Pipeline

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<th>Phase II</th>
<th>Approved Treatments</th>
<th>Phase 2 Data</th>
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<td>Sarasar® (lonafarnib)</td>
<td>Hepatitis Delta</td>
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<tr>
<td>PEG IFN Lambda</td>
<td>Hepatitis Delta</td>
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<td>Pulmonary Arterial Hypertension</td>
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<td>Bestatin™ (ubenimex)</td>
<td>Lymphedema</td>
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<td>2017</td>
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Hepatitis Delta Virus
The Most Severe Form of Viral Hepatitis

- **HDV is the most severe form of viral hepatitis**
  - More rapid progression to liver cirrhosis and liver cancer
  - 5-7x more likely to develop cirrhosis and HCC vs HBV

- **HDV is always associated with HBV Infection**
  - HDV steals HBsAg to complete its envelope

- **Final step in replication involves prenylation**
  - HDV hijacks prenylation, a host process

- **No FDA approved Rx for HDV**
  - PEG IFN α demonstrates modest benefit

- **HDV worldwide prevalence is 15 - 20 million**
  - Approximately 4-6% of HBV worldwide population is infected with HDV
  - Orphan status in US and EU
Complications of Hepatitis D
At the time of diagnosis, >50% of HDV patients are cirrhotic

Risk of hepatocellular carcinoma, decompensation, mortality increased…

Evolution from Chronic Active Hepatitis to Cirrhosis¹

Survival Curves²

HDV Worldwide Prevalence: 15 - 20 Million

6% of HBV Population Infected with HDV

Anti-HD (HBsAg+)

(Range 0 - > 60%)
**PEG IFN-α in HDV: Activity Over 48 Weeks**

*Poor Tolerability, Retreatment Not an Option for Rebound*

Mean Viral Decline (---) versus Cumulative Viral Clearance (-----)

**Mean Change in Log HDV RNA**

**Week**

PEG IFN-α 180 mcg QW +/- tenofovir (N = 91)

*Wobse 2014: AASLD Wedemeyer 2014: AASLD*
Reducing HDV RNA Improves Survival
Improved Clinical Benefit without Clearance of HDV RNA

Interferon Alfa for 48 weeks with 15 year Follow Up

Change in HDV RNA

![Change in HDV RNA Chart]

Survival

![Survival Chart]

Fari et al, Gastroenterology 2004: Long-Term Benefit of Interferon α Therapy of Chronic HDV: Regression of Advanced Hepatic Fibrosis
Fewer Clinical Events following IFN-α
HDV RNA Loss Improves Long-term Clinical Outcomes

Interferon Alfa for 48 weeks with up to 18.8 Year Follow Up

- Long term clinical outcomes
  - IFN alfa treatment in HDV

- Retrospective analysis
  - single cohort study

- 136 anti-HDV positive patients

- Median follow-up: 5.2 years
  - Range 0.6 -18.8 years

Wranke et al. J Hepatology 2016: Does Antiviral Treatment Affect the Clinical Long-term Outcome of Hepatitis Delta?
The HDV Life Cycle

Uncoating of Virus

Transport to Nucleus

Assembly

Replication

Release of Progeny

Cytoplasm

HDV genome

small delta antigen

large delta antigen

Prenylation

HDV genome

small HDAg

large HDAg

prenylated LHDAg

prenyl moiety

HBsAg
Sarasar® (lonafarnib) for HDV
Well-Characterized Clinical Stage Lead Compound

• Small molecule, oral, prenylation inhibitor

• Well-characterized through Phase 3
  - >2,000 patients dosed in oncology program by Merck (Schering)
  - Dose limiting toxicity is GI (class effect)

• Prenylation is a host target; confers high barrier to resistance

• Over 100 HDV patients dosed across international sites
  - NIH Phase 2 study results published in Lancet Infectious Diseases 2015*

• Orphan Designation in US & EU, Fast Track in US

Sarasar® (Lonafarnib) Phase 2 HDV Program
106 HDV Infected Patients Dosed

- **Proof of Concept**
  - Monotherapy  \( N = 14 \) Complete

- **LOWR HDV – 1**
  - Combinations +/- PEG IFN \( \alpha \)  \( N = 15 \) Complete

- **LOWR HDV – 2**
  - Dose Finding +/- PEG IFN \( \alpha \)  \( N = 41 \) Dosing

- **LOWR HDV – 3**
  - QD  \( N = 21 \) Last Patient Out

- **LOWR HDV – 4**
  - Titration  \( N = 15 \) Last Patient Out

LOWR HDV = **Lo**nafarnib **W**ith Ritonavir in HDV
Week 4 Reduction in HDV RNA with Lonafarnib

National Institutes of Health
NIH POC (Lancet Infect. Dis. 2015)

Lonafarnib 100 mg BID

Mean △ - 0.74 Log
N = 4

Lonafarnib 200 mg BID

Mean △ - 1.6 Log
N = 6

Placebo

Mean △ - 0.2 Log
N = 6
### Week 4 Reduction in HDV RNA with Lonafarnib

#### National Institutes of Health
**NIH POC (Lancet Infect. Dis. 2015)**

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Mean $\Delta$</th>
<th>N</th>
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<tbody>
<tr>
<td>Placebo</td>
<td>- 0.2 Log</td>
<td>4</td>
</tr>
<tr>
<td>Lonafarnib 100 mg BID</td>
<td>- 0.74 Log</td>
<td>6</td>
</tr>
<tr>
<td>Lonafarnib 200 mg BID</td>
<td>- 1.6 Log</td>
<td>6</td>
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#### Ankara University
**LOWR HDV -1 (EASL 2015)**

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<th>Mean $\Delta$</th>
<th>N</th>
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<tbody>
<tr>
<td>Lonafarnib 100 mg BID</td>
<td>- 1.6 Log</td>
<td>3</td>
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<tr>
<td>Lonafarnib 100 mg BID + Ritonavir 100 mg QD</td>
<td>- 2.4 Log</td>
<td>3</td>
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<tr>
<td>Lonafarnib 100 mg BID + PEG IFN $\alpha$ 180 mcg QW</td>
<td>- 1.8 Log</td>
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<tr>
<td>Lonafarnib 200 mg BID</td>
<td>- 1.2 Log</td>
<td>3</td>
</tr>
<tr>
<td>Lonafarnib 300 mg BID</td>
<td>- 2.0 Log</td>
<td>3</td>
</tr>
<tr>
<td>Lonafarnib 100 mg TID</td>
<td>- 1.6 Log</td>
<td>3</td>
</tr>
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<td>Lonafarnib 200 mg BID</td>
<td>- 1.6 Log</td>
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**Ankara University**

**LOWR HDV -1 (EASL 2015)**

- Lonafarnib 100 mg BID
- Lonafarnib 100 mg BID + Ritonavir 100 mg QD
- Lonafarnib 100 mg BID + PEG IFN $\alpha$ 180 mcg QW

**National Institutes of Health**

- Placebo
- Lonafarnib 100 mg BID
- Lonafarnib 200 mg BID
Faster Decline with Lonafarnib Combinations

Mean Change in Log HDV RNA

-4 -3.5 -3 -2.5 -2 -1.5 -1 -0.5 0

0 4 8 12 16 20 24 28 32 36 40 44 48

Week

LOWR HDV – 1

- LNF 100 mg BID + PEG IFN \( \alpha \) 180 mcg QW (N=3)
- LNF 100 mg BID + RTV 100 mg QD (N=3)
Faster Decline with Lonafarnib Combinations

Larger Declines in HDV RNA at Week 8 versus PEG IFN α at Week 48

Mean Change in Log HDV RNA

Week

PEG IFN α 180 mcg QW ± tenofovir QD (N=91)

LNF 100 mg BID + PEG IFN α 180 mcg QW (N=3)

LNF 100 mg BID + RTV 100 mg QD (N=3)

HIDIT – 2

Hepatitis Delta International Network

LOWR HDV – 1

Larger Declines in HDV RNA at Week 8 versus PEG IFN α at Week 48

Faster Decline with Lonafarnib Combinations
LOWR HDV – 2: “Dose Finding” Study
Tolerability, Longer Dosing, and Triple Combination

High Dose
- Months 1-3: LNF 50 mg BID or LNF 25 mg BID
- Months 4-6: LNF ≥ 75 mg BID + RTV

Lower Dose
- N=13: LNF 50 mg BID or LNF 25 mg BID + RTV 100 mg BID

Lower Dose: Triple Combination
- N=12: LNF 50 mg BID or LNF 25 mg BID + RTV 100 mg BID + PEG IFN α 180 mcg QW

N=41

N=16

N=13
LOWR HDV – 2: Week 4 Reduction in HDV RNA

Comparable Viral Load Decline: High Dose vs Lower Dose
LOWR HDV – 2: Week 8 Reduction in HDV RNA

Comparable Viral Load Decline: High Dose vs Lower Dose

Mean Change in Log HDV RNA
LOWR HDV – 2: ALT Normalization

In 65% of Patients at Week 12*

Number of Patients

0 5 10 15 20

Elevated ALT at Baseline

N = 17

Elevated ALT at Week 12

N = 6

Normal ALT
Male < 45
Female < 34

* 23 of 37 patients have Week 12 data
LOWR HDV – 2
Interim Observations & Conclusions

- Activity demonstrated in all patients with all doses of LNF
- Lower doses identified that improve GI tolerability
- Longer dosing durations now possible with tolerability
- HDV RNA negativity achieved with low dose LNF
- ALT normalization in 65% of patients at Week 12
- Addition of PEG IFN offers promising treatment options
- Data at AASLD 2016
LOWR HDV – 3: “QD” Study

Dosing Completed

N=4
LNF 100 mg QD + RTV 100 mg QD

N=4
LNF 75 mg QD + RTV 100 mg QD

N=4
LNF 50 mg QD + RTV 100 mg QD

N=3
Placebo

N=3
Placebo

N=3
Placebo

N=3
LNF 50 mg QD + RTV 100 mg QD

N=21
Placebo

LNF 100 mg QD + RTV 100 mg QD

LNF 75 mg QD + RTV 100 mg QD

LNF 50 mg QD + RTV 100 mg QD

Weeks 1-12

Weeks 13-24

EOT
LOWR HDV – 4: “Dose Titration” Study

Dosing Completed

N=15

≥ 2 Weeks

18 Weeks

≥ 4 Weeks

24 Weeks

LNF 50 mg BID + RTV 100 mg BID

LNF 75 mg BID + RTV 100 mg BID

LNF 100 mg BID + RTV 100 mg BID

MHH Hannover Medical School

LOWR HDV – 4: “Dose Titration” Study

Dosing Completed

N=15

≥ 2 Weeks

18 Weeks

≥ 4 Weeks

24 Weeks

LNF 50 mg BID + RTV 100 mg BID

LNF 75 mg BID + RTV 100 mg BID

LNF 100 mg BID + RTV 100 mg BID

MHH Hannover Medical School

LOWR HDV – 4: “Dose Titration” Study

Dosing Completed

N=15

≥ 2 Weeks

18 Weeks

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LNF 50 mg BID + RTV 100 mg BID

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LNF 100 mg BID + RTV 100 mg BID

MHH Hannover Medical School

LOWR HDV – 4: “Dose Titration” Study

Dosing Completed

N=15

≥ 2 Weeks

18 Weeks

≥ 4 Weeks

24 Weeks

LNF 50 mg BID + RTV 100 mg BID

LNF 75 mg BID + RTV 100 mg BID

LNF 100 mg BID + RTV 100 mg BID

MHH Hannover Medical School
LOWR HDV Program Data at AASLD 2016
Targeting End of Phase 2 Meeting in mid-2017

Phase 2 LOWR HDV – 2
N = 41

Phase 2 LOWR HDV – 3
N = 21

Phase 2 LOWR HDV – 4
N = 15

Interim Data
Data
Post TRx Data

2016
2016
2017

End of Phase 2 Meeting
**HDV Phase 3 Registration Options**

*Plans to Initiate Second Half 2017*

---

**End of Treatment Outcome**

- **HDV RNA Negative**
  - **Cure Rx***

- **HDV RNA Reduction + ALT Normalization**
  - **Chronic Rx****

- **Non / Partial Responder**
  - + PEG IFN λ

---

* Patients remain HDV RNA negative 3-6 months post cessation of therapy

** HDV RNA reduction, ALT normalization, 2 point improvement in inflammatory score without worsening in fibrosis score
Eiger BioPharmaceuticals Announces License of Worldwide Rights to Pegylated Interferon Lambda-1a from Bristol-Myers Squibb
Including Rights for All Indications and Associated Patents

PALO ALTO, CALIF, April 20, 2016 /PRNewswire/ -- Eiger BioPharmaceuticals, Inc. (NASDAQ: EIGR) announced today that it has licensed Pegylated Interferon Lambda-1a (“Lambda”), a novel, well-characterized, first in class Type III interferon to be studied as an investigational therapy for hepatitis delta virus (HDV) infection, from Bristol-Myers Squibb. Lambda has been administered in clinical trials involving over 3,000 subjects. It has not been approved for any indication. Eiger plans to evaluate Lambda as a potential monotherapy and combination treatment for chronic HDV infection, the most aggressive and deadly form of human viral hepatitis.
PEG IFN Lambda
A targeted interferon for HDV

• A novel, first in class Type III interferon
  - Native Lambda is generated by human immune system in viral infections

• Binds to a unique receptor versus Type I interferons
  - Highly expressed on hepatocytes
  - Limited expression on hematopoietic cells and CNS cells

• Uses similar downstream signaling pathway as Type I interferons

• Greater than 3,000 patients in 18 clinical trials (HCV / HBV)

• Antiviral activity with less of the typical IFN alfa related side effects

• Anti HDV activity demonstrated in humanized liver mouse model
Potential Impact of Lambda Receptor Distribution

IFN alfa receptors **widely** distributed throughout body.

Lambda receptors **NOT widely** distributed throughout body.

Potential for **MORE** IFN-associated abnormalities:

- ↑ Neutropenia
- ↑ Thrombocytopenia
- ↑ Flu-like Symptoms
- ↑ Musculoskeletal Symptoms

Potential for **LESS** IFN-associated abnormalities:

- ↓ Neutropenia
- ↓ Thrombocytopenia
- ↓ Flu-like Symptoms
- ↓ Musculoskeletal Symptoms
Eiger HDV Program

PEG IFN Lambda Results to Expand Franchise

<table>
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<tr>
<th>2015</th>
<th>2016</th>
<th>2017</th>
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Phase 2 LOWR HDV – 2
N = 41

Interim Data

Phase 2 LOWR HDV – 3
N = 21

Data 2016

Phase 2 LOWR HDV – 4
N = 15

Data 2016

Phase 2 LIMT HDV
N = 20

Post TRx Data 2017

Phase 2 CLIRIT – λ HDV
N = 20

Post TRx Data 2017
Bariatric Surgery increasing worldwide
- 200,000 bariatric surgeries in the US in 2014 and growing*

- Post-prandial hyperinsulinemia and hypoglycemia
  - Neuroglycopenia – seizures, loss of consciousness, and even death
  - Disability – impaired ability to work, drive, perform daily activities

- Impacts 5-10% of Roux-en-Y patients: Orphan Disease
  - ~ 60,000 Roux-en-Y procedures in the US in 2015
  - ~ Up to 3,000 new patients presenting annually in US (incidence)
  - ~ 30,000 current patients in US (prevalence)

- No approved therapy; high unmet medical need

* Angrisani et al., Obes Surg, 2015
Exendin (9-39) is a GLP-1 Antagonist

- 31 AA fragment of exenatide, a GLP-1 agonist
- Decreases insulin secretion
SC Exendin (9-39)
Phase 2: SC SAD Study

Baseline OGGT  SC Ex (9-39) with OGGT

Inclusion Criteria:
1) Whipple’s triad
   - Hypoglycemic sx post-prandially
   - Plasma glucose <50 mg/dL
   - Resolution w/ CHO intake
2) Documented hyperinsulinemia (>2 uU/mL)

Endpoints:
1°: Prevention of hypoglycemia <50 mg/dL
2°: Improvement in hypoglycemia score
3°: PK, Safety, Tolerability
SC Exendin (9-39) Mean SAD Study Results

SC Exendin (9-39) - All Doses Therapeutic

All subjects required rescue

Rapid decline

Rate of glucose decline reduced

No patient became hypoglycemic

* * P < 0.05
** P < 0.01

Glucose (mg/dL) vs. Time (minutes)

SC Ex (9-39) (N=8)
Baseline (N=8)

American Diabetes Association
June 2016
**Exendin (9-39)**

**Development Status**

**2015**

- **IV Infusion Study**
  - N=10
  - Manuscript Submitted

- **SC Injection SAD Study**
  - N=8
  - IND for SC Formulation by Stanford

**2016**

- **SC Injection MAD Study**
  - N=16
  - Dosing Now

- **Oral Presentation**

- **IND Enabling Studies**
  - Pre IND Meeting
  - Orphan Application
• **PAH is a $4 Billion+ Orphan Disease market**
  - Approved agents for PAH are all Vasodilators (palliative)

• **Inflammation now recognized as major component in PAH**
  - \( \text{LTB}_4 \) identified as an inflammatory mediator in PAH

• **\( \text{LTB}_4 \) is elevated in PAH animals and human PAH disease**
  - Targeted inhibition of \( \text{LTB}_4 \) reverses PAH in animal models

• **Ubenimex is a targeted inhibitor of \( \text{LTA}_4 \text{H} \)**
  - Approved in Japan for a different indication; well characterized

• **Potential for PAH Disease Modification & Reversal**
PAH and Inflammation

LTB₄ Induces Pulmonary Endothelial Cell Death

LTB₄ Induces Pulmonary Arterial Smooth Muscle Proliferation

* Sci Transl Med, 2013: “Blocking Macrophage Leukotriene B₄ Prevents Endothelial Injury and Reverses Pulmonary Hypertension”
**Bestatin™ (ubenimex)**

*Partner: Nippon Kayaku, Japan*

- Orally active, small molecule, marketed in Japan since 1987
- Approved as an adjuvant to chemotherapy for non-lymphocytic leukemia
- LTA$_4$H inhibitor
- Marketed in 30 mg QD capsules
- Well-characterized, safe and well-tolerated
- Never introduced in the US or EU – NCE
- PAH IND Approved: US Sites Ramping
- Granted: Orphan Designation in PAH in US and EU
- US Patent Allowance for Claims in PAH
LIBERTY: Phase 2 Study

A Randomized, Double-Blind, Placebo-Controlled Study of UBenimex in Patients with Pulmonary ARTerial Hypertension*

- **Months 1-6**

- **N=30**
  - Standard of Care¹ + Ubenimex 150 mg TID

- **N=15**
  - Standard of Care¹ + PBO

**Primary Endpoint:** Pulmonary Vascular Resistance

**Secondary Endpoint:** Six Minute Walk Distance (6MWD)

Efficacy Evaluation

¹ On at least one of PDE5 inhibitor/sGC inhibitor and/or endothelin receptor antagonist and/or prostacyclin
* Enrolling Functional Class 2 and 3
Ubenimex in PAH Timeline
Estimated

- IND Approved ✓
- US Patent Allowance ✓
- US Orphan Designation Granted ✓
- EU Orphan Designation Granted ✓

Enrollment | Dose
---|---
LIBERTY
Phase 2 Study
N=45

Topline Data

EOP2

Fast Track / Breakthrough Designation

Enrollment | Dose
---|---
Phase 3 Study
N=300

Topline Data
NDA Filing
Lymphedema
A Disabling Disorder with Significant Impact on Quality of Life
No Approved Rx Therapy

• Lymphedema is a state of vascular insufficiency
  - Decreased clearance of interstitial fluid through lymphatics
  - Debilitating architectural alterations in skin & supporting tissues

• Primary Lymphedema – hereditary (Orphan)

• Secondary Lymphedema – due to a causative event

• Elevated LTB$_4$ in animal models and human lymphedema
  - Targeted blockade of LTB$_4$ improves preclinical lymphedema

• Potential for Disease Modification & Reversal

* Rockson et al Provisional Patent Filing: LTB$_4$ inhibition to prevent and treat lymphedema; 2015
A Randomized, Placebo-Controlled Trial to Evaluate Efficacy, Safety, and Tolerability of Ubenimex in Patients with Lymphedema

Entry Criteria:
Secondary lymphedema of the lower limbs

Primary Endpoint:
Skin Thickness

Secondary Endpoint:
Histology, Limb Volume, Symptom Measures

Enrolling

Ulta X Lymphedema Trial Restoring Activity

Months 1-6

N=20

Ubenimex 150 mg TID

N=20

Placebo
Ubenimex in Lymphedema Timeline

Estimated

IND Approved

Enroll

Phase 2 Study
N≈40

2016

Dose

Data

2017

If Positive Results

Type B FDA

Fast Track Designation

Breakthrough Designation
Clinical Data and News Flow
Phase 2 Results Across All Programs

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Sarasar®: LOWR HDV – 2 Interim Data
Exendin (9-39): SC SAD Study
Sarasar®: LOWR HDV – 2 Data
Sarasar®: LOWR HDV – 3 Data
Sarasar®: LOWR HDV – 4 Data
Exendin (9-39): SC MAD Study
Bestatin™: Lymphedema ULTRA Study
Bestatin™: PAH LIBERTY Study
Experienced Management

David Cory, RPh, MBA
President and CEO

Jim Welch, MBA
Chief Financial Officer

Joanne Quan, MD
Chief Medical Officer

Eduardo Martins, MD, PhD
Senior Vice President, Liver & Infectious Diseases

Jim Shaffer, MBA
Chief Business Officer

Shelly Xiong, PhD, RAC
Vice President, Regulatory Affairs

Debra Odink, PhD
Senior Vice President, Manufacturing
## Indication

<table>
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<tr>
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<tr>
<td>Hepatitis Delta</td>
<td>Jeffrey Glenn, MD, PhD</td>
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<tr>
<td>Post-Bariatric Hypoglycemia</td>
<td>Tracey McLaughlin, MD, MPH</td>
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<tr>
<td>Pulmonary Arterial Hypertension</td>
<td>Mark Nicolls, MD</td>
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