LEADER IN HDV
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, whether the FDA minutes confirm the understanding that existing data will support an NDA filing for lonafarnib in Progeria; our ability to meet the quality and documentation requirements for potential approval of an NDA; and the timing for filing of an NDA; our ongoing and planned clinical development, including whether the D-LIVR study will be supported by the FDA as a single, pivotal study to support registration; the timing of and our ability to initiate or enroll clinical trials, including whether our D-LIVR study can be advanced by the end of this year; whether PREVENT Phase 2 study results will support further development of avexitide; our ability to make timely regulatory filings and obtain and maintain regulatory approvals for lonafarnib as a single agent or in combination, PEG IFN lambda, avexitide and our other product candidates; our intellectual property position; and the potential safety, efficacy, reimbursement, convenience clinical and pharmaco-economic benefits of our product candidates as well as the commercial opportunities, including potential market sizes and segments; our ability to finance the continued advancement of our development pipeline products, including our results of operations, cash available, financial condition, liquidity, prospects, growth and strategies; and the potential for success of any of our product candidates.

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.

This presentation concerns products that have not yet been approved for marketing by the FDA. No representation is made as to their safety or effectiveness for the purposes for which they are being investigated.

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EIGER is a late stage biopharmaceutical company focused on the development and commercialization of well-characterized drugs for life-threatening, rare and ultra-rare diseases with high unmet medical needs and no approved therapies.

EIGER has reported positive proof-of concept clinical results in all programs, all with first-in-class drugs, now advancing toward NDA or Phase 3 clinical development.
Portfolio of Clinical Programs
Targeting Diverse Rare Indications

HEPATITIS
DELTA VIRUS

PROGERIA

POST-BARIATRIC HYPOGLYCEMIA

Multiple Programs Positioned for Success
# FIRST-IN-CLASS THERAPIES IN DEVELOPMENT

## Targeting Rare and Ultra-Rare Diseases with No Approved Treatments

<table>
<thead>
<tr>
<th>Indication</th>
<th>Drug</th>
<th>Regulatory Status</th>
<th>Clinical Status</th>
</tr>
</thead>
</table>
| Hepatitis Delta Virus | Lonafarnib + Ritonavir | • Orphan Designation US & EU  
• Breakthrough Designation FDA  
• PRIME Designation EMA | Phase 3 |
| Hepatitis Delta Virus | Peginterferon Lambda | • Orphan Designation US  
• Fast Track Designation FDA | Phase 2 |
| Progeria* and Progeroid Laminopathies | Lonafarnib | • Orphan Designation US* & EU  
• Breakthrough Designation FDA  
• Rare Disease Designation FDA | NDA & MAA Prep |
| Post-Bariatric Hypoglycemia | Avexitide | • Orphan Designation US & EU | Phase 2 |
# ROBUST PIPELINE ADVANCING IN 2019

Value Creating Catalysts Expected in 2019

<table>
<thead>
<tr>
<th></th>
<th>Q1 2019</th>
<th>Q2 2019</th>
<th>Q3 2019</th>
<th>Q4 2019</th>
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<tbody>
<tr>
<td><strong>HDV</strong></td>
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<tr>
<td>Lonafarnib</td>
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<tr>
<td>+ Ritonavir</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>HDV</strong></td>
<td></td>
<td></td>
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<tr>
<td>Peginterferon Lambda</td>
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<tr>
<td><strong>Progeria &amp; Progeroid Laminopathies</strong></td>
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<tr>
<td>Lonafarnib</td>
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<tr>
<td><strong>PBH</strong></td>
<td></td>
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<tr>
<td>Avexitide</td>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>

**Q1 2019**
- Phase 3 Study Enrolling and Dosing Ongoing

**Q2 2019**
- Phase 2 LIFT Combo Study Dosing Ongoing
- LIFT Study EOT Data

**Q3 2019**
- Phase 2 LIMT End of Study Data

**Q4 2019**
- NDA & MAA Filing Planned in 2019
- Expanded Access Program Ongoing

- Oral Presentation
- Regulatory Guidance

*Note: The table and diagram illustrate the progress and upcoming events for each pipeline item.*
HEPATITIS DELTA VIRUS (HDV)

OVERVIEW

• HDV is the most severe form of human viral hepatitis
• HDV is always a co-infection with HBV
  - HBsAg acquired through protein prenylation
• 4-6% of HBV infected patients co-infected with HDV
• HDV causes more rapid disease progression
  - Compared to HBV mono-infection
• No FDA approved Rx
• 15-20 M HDV infected patients worldwide
  - > 100K HDV patients in US; > 200K HDV patients in EU
  - > 2 Million HDV patients in China

HDV consists of a single stranded, circular RNA virus, with an envelope made up of HBsAg.

• HDV requires HBsAg to complete virus assembly
• HBsAg acquired through PROTEIN PRENYLATION
**HDV: MOST RAPID PROGRESSION OF VIRAL HEPATITIS**

50% of HDV-Infected Patients are Cirrhotic at Diagnosis

<table>
<thead>
<tr>
<th>Progression to Cirrhosis</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>HCV</td>
<td>10-20% within 20 Years</td>
</tr>
<tr>
<td>HBV</td>
<td>20% within 5 Years</td>
</tr>
<tr>
<td>HDV</td>
<td>70% within 5-10 Years</td>
</tr>
</tbody>
</table>

Westbrook et al, *J Hepatology* 2014
Fattovich et al, *Seminars in Liver Diseases* 2003
HDV CAUSES MORE RAPID DISEASE PROGRESSION

Compared to HBV Mono-infection

At diagnosis, > 50% of HDV patients are cirrhotic

**HDV LEADS TO POOR SURVIVAL**

Risk of Hepatocellular Carcinoma, Decompensation, Mortality Increase

![Graph showing survival rates for HBV and HBV + HDV over years.](image)

- **HBV and HDV**
  - Survival rates decrease over time.
  - HBV + HDV shows a more rapid decline in survival compared to HBV alone.
  - **P = 0.0002**

---

1Serrano et al, EASL 2011
**SURVIVAL: HDV VS CANCER**

**HBV and HDV**

- Survival vs Years
- **HBV**
- **HBV + HDV**
- $P = 0.0002$

**Colorectal Cancer**

- Survival vs Years
- Stage I, Stage II, Stage III, Stage IV

**Resected NSCLC**

- Survival vs Years

---

HBV INVESTIGATIONAL THERAPIES DO NOT ERADICATE HDV

Targeting Functional Cure vs Sterilizing Cure

- Approved HBV nucleos(t)ide treatments only suppress HBV DNA
  - Do not affect HBsAg and have no impact on HDV

- Investigational HBV treatments target functional cure
  - Not expected to eliminate extra-hepatic reservoirs of HBsAg

HBV Functional Cure (If Achieved) Will Not Eradicate HDV
# HBV Rx FDA APPROVALS

Registration Endpoints: Viral Load Reduction, ALT Normalization, Histology

<table>
<thead>
<tr>
<th>Brand (generic)</th>
<th>Approved</th>
<th>Primary Endpoint(s)</th>
<th>Secondary Endpoint(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intron A® (interferon alfa-2b)</td>
<td>1991</td>
<td>• HBeAg + HBV DNA</td>
<td>• HBsAg + ALT + Histology</td>
</tr>
<tr>
<td>Epivir HBV® (lamivudine)</td>
<td>1998</td>
<td>• Histology*</td>
<td>• ALT</td>
</tr>
<tr>
<td>Hepsera® (adefovir dipivoxil)</td>
<td>2002</td>
<td>• Histology*</td>
<td>• HBV DNA + ALT + HBeAg</td>
</tr>
<tr>
<td>Baraclude® (entecavir)</td>
<td>2005</td>
<td>• Histology*</td>
<td>• HBV DNA + ALT</td>
</tr>
<tr>
<td>Pegasys® (peginterferon alfa-2a)</td>
<td>2005</td>
<td>• HBeAg</td>
<td>• Histology</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• HBV DNA</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• ALT</td>
<td></td>
</tr>
<tr>
<td>Tyzeka® (telbivudine)</td>
<td>2006</td>
<td>• HBV DNA + HBeAg or ALT</td>
<td>• Histology + ALT</td>
</tr>
<tr>
<td>Viread® (tenofovir disoproxil fumurate)</td>
<td>2008</td>
<td>• HBV DNA + Histology</td>
<td>• ALT</td>
</tr>
<tr>
<td>Vemlidy® (tenofovir alafenamide)</td>
<td>2016</td>
<td>• HBV DNA</td>
<td>• ALT + HBsAg + HBeAg</td>
</tr>
</tbody>
</table>
PEG IFN-ALFA REDUCED HDV RNA IN PATIENTS

Not Approved for HDV (Approved for HBV)

Mean Change in Log HDV-RNA

HIDIT-2: PEG IFNα 180 mcg QW + tenofovir (N=91)

Hepatitis Delta International Network

HIDIT – 2 Study

Wobse et al, Hepatology 2014

Wedemeyer et al, Hepatology 2014
Reducing HDV-RNA with IFN-α improves survival

Improved Clinical Benefit without Clearance of HDV-RNA

Interferon-α for 48 weeks with 15 year Follow Up

Farci et al, Gastroenterology 2004: Long-Term Benefit of Interferon-α Therapy of Chronic HDV: Regression of Advanced Hepatic Fibrosis
HDV WORLDWIDE PREVALENCE: 15-20 MILLION

6% of HBV Population Co-Infected with HDV

“If you look for Hepatitis Delta, you will find it.”
MIGRATION AND VIRAL HEPATITIS

Globalization of Disease

Foreign-born individuals now comprise majority of HDV population in North America and Western Europe
MIGRATION INTO WESTERN EUROPE

Known Claims for Asylum in 2015 > 1 Million
INCREASE IN HDV TESTING IN THE U.S.

Increasing % of Chronic HBV Patients Tested for HDV

* Koh, C. et al, AASLD 2014, “Prenylation inhibition with lonafarnib decreases hepatitis D levels in humans”
INCREASED HDV PATIENT DIAGNOSIS

Estimated ~110,000 Individuals Co-Infected with HBV / HDV in the U.S.
QUEST DIAGNOSTICS LAUNCHES COMMERCIAL HDV RNA TEST

HDV RNA Quantification is Gold Standard in HDV Diagnosis and Management

• Leading provider of diagnostic services
• Over 2,200 patient service centers across the U.S.
• Highly targeted patient and physician outreach
• HDV testing program for HBV+ patients
• HDV RNA quantification and HBV/HDV reflex testing
BUILDING THE U.S. HDV MARKET

- 600,000 Dx HBV patients provide readily identifiable HDV market
- Claims data produces a known geographic HDV patient footprint in major metros of the US
- Key partners facilitate education and identification of HDV patients

- Highly targeted patient and physician outreach
- HDV testing program for HBV+ patients
- HDV RNA quantification and HBV/HDV reflex test for commercial testing
- HDV Connect Program: Global outreach to 111 countries
- Strong presence among ex-US and foreign-born HBV patients
- Patient and physician outreach supporting Eiger HDV testing initiative
U.S. MAJOR METRO HOTSPOTS IDENTIFIED

HDV Geographic Footprint is Growing

Top 10 U.S. Cities in 2016

1. Chicago, Illinois
2. Berwyn, Illinois
3. Brooklyn, New York
4. Corona, New York
5. Waukegan, Illinois
6. New York, New York
7. Bronx, New York
8. Jamaica, New York
9. Lombard, New York
10. Aurora, Illinois
MONGOLIA: 60% HDV CO-INFECTION IN HBV PATIENTS

Highest Rate in the World of Hepatocellular Carcinoma

- Mongolia Population of ~3,000,000
  - > 300,000 (11%) is infected with HBV
- 60% of HBsAg positive patients are coinfected with HDV
  - >180,000 HDV infected patients in Mongolia

Chen et al, Hepatology, 2017
• HBV is Endemic in China
• > 400,000 Cases of Liver Cancer Per Year
• 50% of All New Liver Cancer Cases in China
• Migration Into and Within China Spreads HBV

>100 MILLION HBV-INFECTED IN MAINLAND CHINA

Distribution of HBV in 31 Provinces in China

6.5% HDV / HBV CO-INFECTION IN GUANGDONG, CHINA

HBsAg (+) Patients Screened for HDV Antibody at Guangzhou People’s Hospital (2005-2011)

- 6.5% HDV / HBV Co-Infection Identified
- HDV Screening in HBsAg (+) Patients Needed
- Validated and Reliable HDV Assay Needed
- Large Commercial Opportunity in China
LONAFARNIB FOR HDV

Well-characterized Clinical Stage Lead Compound

- Small molecule, first-in-class, 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)
- Over 120 HDV patients dosed across international sites
- US & EU Orphan Designation, FDA Breakthrough Designation, EMA PRIME Designation
- Patent cover broad range of lonafarnib + ritonavir doses and durations
ALL-ORAL REGIMEN: 29% ACHIEVE COMPOSITE ENDPOINT

Lonafarnib 50 mg BID + Ritonavir 100 mg BID

- 33% (6 of 18) patients ≥ 2 log decline or BLQ
- 47% (7 of 15) patients normalized ALT
- Composite endpoint: 29% (4 of 14)

Yurdaydin et al, J Hepatology 2018, Abstract #PS-161
**ALL-ORAL REGIMEN**

Comparable Antiviral Activity vs PEG IFN-alfa-2a

Yurdaydin et al, *J Hepatology* 2018, Abstract #PS-161
COMBO REGIMEN: 63% ACHIEVE COMPOSITE ENDPOINT

Lonafarnib 50 mg BID + Ritonavir 100 mg BID + PEG IFN-alfa-2a 180 mcg QW

Yurdaydin et al, J Hepatology 2018, Abstract #PS-161

78% (7 of 9) patients ≥ 2 log decline or BLQ
88% (7 of 8) patients normalized ALT
Composite endpoint: 63% (5 of 8)
LONAFARNIB TREATMENT OPTIONS

Guided by Baseline HDV Viral Loads

High Baseline Viral Load

65% of HDV population

Lonafarnib / Ritonavir + PEG IFN-alfa-2a

Low Baseline Viral Load

35% of HDV population

Lonafarnib / Ritonavir

Baseline Viral Load
**Primary Endpoint at Week 48**
- $\geq 2$ log decline in HDV RNA + Normalization of ALT

**Secondary Endpoint at Week 48**
- Histologic improvement
  - $> 2$ point improvement in HAI inflammatory score
  - No progression in fibrosis
- Improvement of fibrosis

All patients will be run-in and maintained on background HBV nucleoside therapy. Superiority over PEG IFN-alfa-2a not required.
PHASE 3 D-LIVR GLOBAL FOOTPRINT

United States
Canada

United Kingdom
France
Spain

Belgium
Germany
Sweden

Italy
Greece

Bulgaria
Romania
Moldova

Israel
Turkey
Pakistan

Taiwan
Vietnam
New Zealand
**PEGINTERFERON LAMBDA**

A Better Tolerated Interferon

- A novel first-in-class Type III interferon
- 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 17 clinical trials (HCV / HBV)
- Less of the typical IFN alfa related side effects*

*Chan, HLY et al, J Hepatology 2016*
**LIMT: PHASE 2 LAMBDA MONOTHERAPY STUDY**

**Lambda Interferon Monotherapy Study**

<table>
<thead>
<tr>
<th>Arm 1</th>
<th>N = 19</th>
</tr>
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<tbody>
<tr>
<td>Mono</td>
<td>Lambda 120 mcg QW</td>
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</table>

<table>
<thead>
<tr>
<th>Arm 2</th>
<th>N = 14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mono</td>
<td>Lambda 180 mcg QW</td>
</tr>
</tbody>
</table>

Goals:
- Demonstrate comparable activity to historical PEG IFN-alfa-2a
- Demonstrate better tolerability to historical PEG IFN-alfa-2a
Dose Response Demonstrated

<table>
<thead>
<tr>
<th>Week 48</th>
<th>N</th>
<th>Mean VL Decline</th>
<th>≥ 2 Log Decline or BLQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>120 mcg*</td>
<td>13/19</td>
<td>-1.1 log</td>
<td>7 of 13 (53.8%)</td>
</tr>
<tr>
<td>180 mcg*</td>
<td>11/14</td>
<td>-2.3 log</td>
<td>10 of 11 (90.1%)</td>
</tr>
</tbody>
</table>


Limit of quantification = 14 IU/mL

* Randomization Dose
Lambda demonstrated comparable anti-HDV activity to historical PEG IFN-alfa-2a

Lambda was well tolerated in the majority of patients

Lambda is a promising investigational agent, alone or in combination Rx in HDV

EASL 2019 Late Breaker Oral Presentation Granted

“End of Study Results from LIMT HDV Study: 36% Durable Virologic Response
At 24 Weeks Post-treatment with Pegylated Interferon Lambda Monotherapy in Patients with Chronic HDV”
**Primary Endpoint:**
- \( \geq 2 \) Log HDV RNA reduction at EOT

**Secondary Endpoint:**
- Histological Improvement (biopsy confirmed)

**Dosing**
- Lambda 180 mcg QW
- Lonafarnib 50 mg BID
- Ritonavir 100 mg BID

**Follow Up**
- 24 Weeks Post-treatment

**N=26**

* biopsy

**LIFT: PHASE 2 LAMBDA COMBO WITH LONAFARNIB STUDY**

Lambda InterFeron combination Therapy
FIRST-IN-CLASS TREATMENTS IN DEVELOPMENT FOR HDV

Leader in HDV

Lonafarnib

Lonafarnib + Ritonavir
All Oral Rx

Lonafarnib + Ritonavir + PEG IFN Lambda
Combination Rx

PEG IFN Lambda

PEG IFN Lambda
Sub Q Rx
WORKING TO CHANGE THE FACE OF HEPATITIS DELTA VIRUS (HDV)

- US Investigator Meeting, November 29
- First Site Initiated, December 10
- EU Investigator Meeting, January 16
- Activated Sites Now Screening
HDV DISEASE AWARENESS

Rare Disease Supplement September 2018

HDV

... the most severe form of human viral hepatitis

... over 15 million people are infected worldwide

... no approved treatment

COMMITTED TO RARE DISEASES

For more information visit www.eigerbio.com
HUTCHINSON-GILFORD PROGERIA SYNDROME (PROGERIA)

OVERVIEW

• Ultra-rare, fatal, premature aging pediatric disease
• Point mutation in the Lamin A gene
  - Results in a farnesylated aberrant protein, Progerin
  - Disruption of scaffold structure of the nuclear membrane
• Accelerated atherosclerosis with cardiovascular decline
• Average lifespan = 14.5 years
• Prevalence of 1 in 20 million (~400 worldwide)
  - 1 child born each year in the US
• No FDA approved Rx
• >80 Children treated with lonafarnib
Berns Family
Founders of The Progeria Research Foundation (PRF)
ACCUMULATION OF PROGERIN
Disrupts Cell Scaffold, Leads to Disfigurement of Nucleus

Normal Lamin A Generation

Progerin Generation

Lonafarnib blocks production of Progerin
**W/W PREVALENCE ~ 400 CHILDREN WITH PROGERIA**

147 Identified Across 47 Countries Worldwide with Progeria and Progeroid Laminopathies

147 Patients Identified Worldwide

- Progeria* W/W = 114
- Progeroid Laminopathies** W/W = 33

43 Patients Identified in US/EU

- Progeria* US/EU = 32
- Progeroid Laminopathies** US/EU = 11

* Progeria (HGPS) patients have a progerin-producing mutation in the LMNA gene
** Progeroid Laminopathies have a mutation in the lamin pathway but do not produce progerin
SURVIVAL OF UNTREATED PROGERIA CHILDREN

Average Lifespan = 14.5 Years

Gordon, L et al, JAMA, 2018, 319(16): 1687
LONAFARNIB IMPROVES SURVIVAL IN PROGERIA

77% Reduction in Risk of Mortality Compared to No Treatment

Average follow-up period of 2.2 years

Hazard Ratio = 0.23, p = 0.04

Gordon, L et al. JAMA, 2018, 319(16): 1687
NEXT STEPS FOR PROGERIA

LATE 2018

Launch
Expanded Access Program

2019

File NDA in the U.S.
and
MAA in Europe

EIGER’S COMMITMENT IS TO PROVIDE ACCESS TO LONAFARNIB TO EVERY CHILD IN THE WORLD WITH PROGERIA
PROGERIA AND HDV

Distinct Diseases, Distinct Treatment Regimens, Distinct Commercial Strategies

PROGERIA
Lonafarnib Monotherapy (weight-based)

HDV
Lonafarnib Boosted with Ritonavir ± Peginterferon-Alfa
EXPANDED ACCESS PROGRAM (EAP)

• EAP supplies unlicensed drugs to patients with life threatening diseases

• A non-negotiable, global reference price will be set

• Reimbursement status is determined country by country

• Reimbursement sought through a treating physician (investigator), paid by various payers

• CLINIGEN is a global leader in expanded access execution
EXPANDED ACCESS PROGRAM: OBJECTIVES

For Progeria and Progeroid Laminopathies (PL)

• Provides global access of lonafarnib to children with Progeria and PL in 37 countries
  - Both treatment naïve and patients ending study participation are eligible

• Seek reimbursement where available

• Prepare for commercialization
**EAP: COUNTRY REIMBURSEMENT BUCKETS**

Determined by Country Regulatory Guidelines & Availability of Reimbursement

<table>
<thead>
<tr>
<th>Bucket 1</th>
<th>Bucket 2</th>
<th>Bucket 3</th>
<th>Bucket 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States: Will Not Seek Reimbursement; Filing NDA</td>
<td>EAP Reimbursement Does Not Require Prior Approval in US</td>
<td>EAP Reimbursement Post-US approval</td>
<td>No EAP</td>
</tr>
</tbody>
</table>

| # Countries: | 1 | 25 | 11 | 9 |
| # Children: | 16 | 64 | 24 | 9 |
POST-BARIATRIC HYPOGLYCEMIA (PBH)

OVERVIEW

• Bariatric Surgery Increasing due to Morbid Obesity
  - ~200K US / ~100K EU in 2015*
  - Significant Impact: Weight Loss, Glycemic Control
  - Roux-en-Y Gastric Bypass ~35% of all procedures

• Postprandial Hypoglycemia: Serious Complication
  - Dangerously low blood sugar after meals
  - Impacts 5-10% of Roux-en-Y patients

• PBH estimated prevalence ~70K in US / EU

• No approved therapy

* American Society for Metabolic and Bariatric Surgery 2015
TARGETED BLOCKADE OF GLP-1
Normalizes Insulin Secretion

ALTERED NUTRIENT TRANSIT
POST ROUX-EN-Y GASTRIC BYPASS

HYPER-SECRETION
OF GLP-1

HYPER-SECRETION
OF INSULIN

NORMALIZED INSULIN SECRETION

SYMPTOMATIC
HYPOGLYCEMIA

Craig et al. Diabetes, Obesity and Metabolism 2017

Autonomic
- Sweating
- Shaking
- Palpitations
- Hunger

Neuroglycopenic
- Blurred vision
- Confusion
- Drowsiness
- Odd behavior
- Speech difficulty
- Incoordination
- Dizziness
- Inability to concentrate

TARGETED BLOCKADE OF GLP-1
Normalizes Insulin Secretion

ALTERED NUTRIENT TRANSIT
POST ROUX-EN-Y GASTRIC BYPASS

HYPER-SECRETION
OF GLP-1

HYPER-SECRETION
OF INSULIN

NORMALIZED INSULIN SECRETION

SYMPTOMATIC
HYPOGLYCEMIA

Craig et al. Diabetes, Obesity and Metabolism 2017

Autonomic
- Sweating
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Neuroglycopenic
- Blurred vision
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- Speech difficulty
- Incoordination
- Dizziness
- Inability to concentrate
**AVEXITIDE: A GLP-1 ANTAGONIST**

31 Amino Acid Fragment of Byetta (exenatide), a GLP-1 Agonist

- Phase 2 Activity and Safety Demonstrated in 54 PBH Patients
  - Four clinical studies completed (POC, SAD, MAD, 28-day)

- Previous experience as investigational agent
  - >300 patients reported dosed worldwide*

- Proprietary Liquid Formulation Developed

- Orphan Designation Granted in US and EU

* www.clinicaltrials.gov
## AVEXITIDE: PHASE 2 PROOF OF CONCEPT DEMONSTRATED

54 Patients Dosed in 4 Completed Clinical Studies with Avexitide

<table>
<thead>
<tr>
<th>Study</th>
<th># Patients</th>
<th>Duration of Dosing</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>IV Infusion</td>
<td>8</td>
<td>Single dose</td>
<td>Published Diabetologia</td>
</tr>
<tr>
<td>Sub Q Injection SAD</td>
<td>8</td>
<td>Single dose</td>
<td>Presented at 2016 ADA, Published Diabetes, Obesity and Metabolism</td>
</tr>
<tr>
<td>Sub Q Injection MAD</td>
<td>20</td>
<td>Up to 3 days BID</td>
<td>Presented at 2017 ADA</td>
</tr>
<tr>
<td>Sub Q Injection; Durability of Effect</td>
<td>18</td>
<td>28 days QD / BID</td>
<td>Presented at 2019 ENDO</td>
</tr>
</tbody>
</table>
AVEXITIDE REDUCES PBH

Single Ascending Dose Study Results

- All subjects required rescue
- Rapid decline
- Rate of glucose decline reduced
- No patient became hypoglycemic
- Increase in glucose nadir
- Improvement in patient reported outcomes

* P<0.05, ** P<0.01
Craig C et al, Diabetes, Obesity and Metabolism 2017.
28-DAY, PHASE 2 STUDY

Goal: Demonstrate Durability of Effect, Define Dose, Safety, Tolerability

Primary Endpoint: Magnitude of postprandial hypoglycemia defined as the plasma glucose nadir during MMTT provocation
**IMPROVED POSTPRANDIAL GLUCOSE NADIR**

Primary Endpoint Achieved

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Glucose Nadir (mg/dL)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placebo</td>
<td>47.1</td>
<td>0.0011</td>
</tr>
<tr>
<td>30 mg BID</td>
<td>57.1</td>
<td>0.0002</td>
</tr>
<tr>
<td>60 mg QD</td>
<td>59.2</td>
<td></td>
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</tbody>
</table>

The chart shows the glucose nadir levels for Placebo, 30 mg BID, and 60 mg QD treatments. The p-values indicate statistical significance.
REDUCED POSTPRANDIAL INSULIN PEAK

Secondary Endpoint Achieved

![Graph showing reduced postprandial insulin peak with statistical analysis]
## METABOLIC AND CLINICAL IMPROVEMENTS

Reduction in Rates\(^1\) of Hypoglycemia, Severe Hypoglycemia and Rescue by eDiary

<table>
<thead>
<tr>
<th></th>
<th>Number of Episodes in 14 Day Period</th>
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<tbody>
<tr>
<td></td>
<td>Placebo</td>
</tr>
<tr>
<td>Rate of Hypoglycemia(^2)</td>
<td>4.03</td>
</tr>
<tr>
<td>Change from Placebo</td>
<td>NA</td>
</tr>
<tr>
<td>Rate of Severe Hypoglycemia(^3)</td>
<td>2.36</td>
</tr>
<tr>
<td>Change from Placebo</td>
<td>NA</td>
</tr>
<tr>
<td>Rate of Rescue</td>
<td>4.87</td>
</tr>
<tr>
<td>Change from Placebo</td>
<td>N/A</td>
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</tbody>
</table>

\(^1\) Rate is defined as number of episodes in a 14 day period
\(^2\) Hypoglycemia is defined as hypoglycemia symptoms confirmed by SBGM concentrations of <70 mg/dL
\(^3\) Severe hypoglycemia is defined as neuroglycopenic symptoms confirmed by SBGM concentrations <55 mg/dL
SAFETY AND TOLERABILITY

- Avexitide was well-tolerated
- No treatment-related SAEs and no participant withdrawals
- AEs were typically mild to moderate in severity and transient
- Most common AEs were injection site bruising, nausea, headache
  - All occurred with higher frequency during placebo than active treatment
- Low occurrence of development of anti-drug antibodies (ADA)
  - 1 of 18 participants showed low positive titers for ADA
  - No associated AEs and no apparent effect on efficacy
SUMMARY AND NEXT STEPS

• PBH is a rare but growing disease with unmet medical need
• GLP-1 plays a critical role in mediating hyperinsulinemic hypoglycemia in PBH
• Avexitide is a targeted therapeutic approach with POC demonstrated in 4 clinical trials
• 28-days of treatment in outpatient setting demonstrated clinically meaningful improvements
  o Reductions in the magnitude of postprandial hyperinsulinemic hypoglycemia
  o Reductions in rates of hypoglycemia and severe hypoglycemia
  o Reductions in rate of rescue
• Avexitide has been well tolerated and has shown no significant safety concerns
• Regulatory guidance in 2019
# FIRST-IN-CLASS THERAPIES IN DEVELOPMENT

Targeting Rare and Ultra-Rare Diseases with No Approved Treatments

<table>
<thead>
<tr>
<th>Indication</th>
<th>Drug</th>
<th>Regulatory Status</th>
<th>Clinical Status</th>
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</thead>
</table>
| Hepatitis Delta Virus             | Lonafarnib + Ritonavir | • Orphan Designation US & EU  
• Breakthrough Designation FDA  
• PRIME Designation EMA       | Phase 3              |
| Hepatitis Delta Virus             | Peginterferon Lambda | • Orphan Designation US  
• Fast Track Designation FDA | Phase 2              |
| Progeria* and Progeroid Laminopathies | Lonafarnib        | • Orphan Designation US* & EU  
• Breakthrough Designation FDA  
• Rare Disease Designation FDA | NDA & MAA Prep       |
| Post-Bariatric Hypoglycemia       | Avexitide           | • Orphan Designation US & EU                                                   | Phase 2           |
## ROBUST PIPELINE ADVANCING IN 2019

### Value Creating Catalysts Expected in 2019

<table>
<thead>
<tr>
<th></th>
<th>Q1 2019</th>
<th>Q2 2019</th>
<th>Q3 2019</th>
<th>Q4 2019</th>
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<tr>
<td>HDV</td>
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<td>Lonafarnib + Ritonavir</td>
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<tr>
<td>HDV</td>
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<tr>
<td>Peginterferon Lambda</td>
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<td>Progeria &amp; Progeroid</td>
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<tr>
<td>Avexitide</td>
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</tbody>
</table>

**HDV**
- **Lonafarnib + Ritonavir**: Phase 3 Study Enrolling and Dosing Ongoing
- **Peginterferon Lambda**: Phase 2 LIFT Combo Study Dosing Ongoing
- **Progeria & Progeroid Laminopathies**: NDA & MAA Filing Planned in 2019
- **Lonafarnib**: Expanded Access Program Ongoing

**PBH**
- **Avexitide**: Oral Presentation

**Regulatory Guidance**
- EASL Late Breaker Oral
- Endo 2019
- Orally Presented

**LIFT Study**
- End of Study Data
- Ongoing

**LIFT Study**
- End of Study Data
- Ongoing
**FINANCIAL SUMMARY**

**Public**
- Nasdaq: EIGR

**Cash**
- ~$100 M to begin 2019

**Shares outstanding**
- 19.2 million

**Market cap**
- $282 million as of April 4, 2019
# EXPERIENCED MANAGEMENT

<table>
<thead>
<tr>
<th>Name</th>
<th>Position and Department</th>
<th>Company Logos</th>
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</thead>
<tbody>
<tr>
<td>DAVID CORY, RPH, MBA</td>
<td>Business Founder, President, Chief Executive Officer</td>
<td></td>
</tr>
<tr>
<td>DAVID APELIAN, MD, PHD, MBA</td>
<td>Chief Operating Officer, Executive Medical Officer</td>
<td></td>
</tr>
<tr>
<td>SRI RYALI, MBA</td>
<td>Chief Financial Officer</td>
<td></td>
</tr>
<tr>
<td>STEPHANA PATTON, PHD, JD</td>
<td>General Counsel, Corporate Secretary, Chief Compliance Officer</td>
<td></td>
</tr>
<tr>
<td>LISA PORTER, MD</td>
<td>Chief Medical Officer, Metabolic Diseases</td>
<td></td>
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<tr>
<td>JIM SHAFFER, MBA</td>
<td>Chief Business Officer</td>
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</tr>
<tr>
<td>INGRID CHOONG, PHD</td>
<td>Vice President, Investor Relations, Corporate Development</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Title</td>
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<tr>
<td>THOMAS DIETZ, PHD</td>
<td>Chairman</td>
<td></td>
</tr>
<tr>
<td>EVAN LOH, MD</td>
<td>Independent Director</td>
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</tr>
<tr>
<td>ELDON MAYER, MBA</td>
<td>Independent Director</td>
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<tr>
<td>CHRISTINE MURRAY, MS, RAC</td>
<td>Independent Director</td>
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<tr>
<td>JEFFREY GLENN, MD, PHD</td>
<td>Independent Director</td>
<td></td>
</tr>
<tr>
<td>DAVID CORY, RPH, MBA</td>
<td>President and CEO</td>
<td></td>
</tr>
<tr>
<td>DAVID APELIAN, MD, PHD, MBA</td>
<td>COO and EMO</td>
<td></td>
</tr>
</tbody>
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