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Participants

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Executive Vice President, Oncology US
Iptacopan is a first-in-class, oral, selective factor B inhibitor of the alternative complement pathway

- Dysregulation of the complement pathway is associated with a range of rare hematologic and renal diseases
- As a selective factor B inhibitor, iptacopan targets the complement system proximally via the alternative pathway, leaving classical and lectin pathway signaling intact
- Discovered in-house at NIBR
Opportunity to redefine care in multiple complement-driven conditions

<table>
<thead>
<tr>
<th>Indication</th>
<th>2021</th>
<th>2022</th>
<th>2023</th>
<th>2024</th>
<th>2025</th>
<th>2026</th>
</tr>
</thead>
<tbody>
<tr>
<td>PNH</td>
<td></td>
<td>Ph3 - APPLY</td>
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<td></td>
<td></td>
<td>Ph3 - APPOINT</td>
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<tr>
<td>IgAN</td>
<td>Ph3 - APPLAUSE</td>
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<td>*</td>
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<tr>
<td>C3G</td>
<td></td>
<td>Ph3 - APPEAR</td>
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<tr>
<td>aHUS</td>
<td></td>
<td>Ph3 - APPELHUS</td>
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<tr>
<td>IC-MPGN</td>
<td>Ph3</td>
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</tr>
</tbody>
</table>

Phase 3 studies initiated or planned; additional indications are being explored

Market potential

<table>
<thead>
<tr>
<th>Indication</th>
<th>US prevalence thousands</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hematology</strong></td>
<td></td>
</tr>
<tr>
<td>PNH</td>
<td>&lt;10</td>
</tr>
<tr>
<td><strong>Nephrology</strong></td>
<td></td>
</tr>
<tr>
<td>IgAN</td>
<td>~46-55¹</td>
</tr>
<tr>
<td>C3G</td>
<td>&lt;10</td>
</tr>
<tr>
<td>aHUS</td>
<td>&lt;10</td>
</tr>
<tr>
<td>IC-MPGN</td>
<td>&lt;10</td>
</tr>
</tbody>
</table>

PNH = paroxysmal nocturnal hemoglobinuria  IgAN = IgA nephropathy  C3G = C3 glomerulopathy  aHUS = atypical hemolytic uremic syndrome  IC-MPGN = immune complex membranoproliferative glomerulonephritis

* 9 months readout may support US submission for accelerated approval  ¹. Estimated number of patients at high risk of progression with proteinuria > 1g/day (~25-30%)
Two positive Ph3 studies in PNH are the first pivotal readouts for iptacopan

<table>
<thead>
<tr>
<th>Study</th>
<th>APPLY-PNH</th>
<th>APPOINT-PNH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient type</td>
<td>PNH patients with residual anemia despite anti-C5</td>
<td>PNH patients naive to complement inhibitor therapy</td>
</tr>
<tr>
<td>Intervention</td>
<td>Iptacopan vs. anti-C5 antibody</td>
<td>Iptacopan, single-arm study</td>
</tr>
</tbody>
</table>
Significant unmet need remains in PNH despite current standard of care anti-C5 therapy

PNH prevalence 10-20 cases/million = ~6k patients in the US

| 63% of patients treated with a terminal complement inhibitor showed signs of ongoing hemolysis |
| ~1/3 of patients reported having ≥1 RBC transfusion despite treatment with terminal complement inhibitors |
| >75% of patients treated with terminal complement inhibitors reported fatigue symptoms |

Complement regulation in PNH is impairedⁱ,²

PNH is a rare, chronic hematological disorder characterized by intravascular hemolysis (IVH), thrombophilia and bone marrow failureⁱ,²

Caused by an acquired mutation in hematopoietic stem cells, which results in a lack of complement-regulatory proteins, leading to IVH

Targeting the terminal complement pathway at C₅ can address IVH, reduce thrombosis and improve overall survival³⁻⁹

However, up to 2/3 of patients have clinically meaningful residual anemia, largely because of emerging extravascular hemolysis¹⁰

Iptacopan, a first-in-class, oral, selective factor B inhibitor, targets the complement system proximally via the alternative pathway\(^1\)

Iptacopan binds to the active site of factor B, inhibiting the activity of C3 convertase\(^1\)

Iptacopan controlled intra- and extravascular hemolysis in 10 patients with a sub-optimal response to eculizumab, leading to transfusion independence and an improved quality of life\(^2\)

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APPLY-PNH is a randomized Ph3 trial investigating iptacopan monotherapy in PNH patients with residual anemia despite SoC

**Study design**

DATA PRESENTED UP TO 24 WEEKS

<table>
<thead>
<tr>
<th>Anti-C5 antibody</th>
<th>Iptacopan 200mg BID (n= 62)</th>
<th>Continue with iptacopan 200mg BID</th>
<th>[24 weeks]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 8 weeks</td>
<td>Ant-C5 antibody (n= 35)</td>
<td>Switch to iptacopan 200mg BID</td>
<td>24 weeks</td>
</tr>
<tr>
<td>D-60</td>
<td>D1</td>
<td>D168</td>
<td>24 weeks</td>
</tr>
<tr>
<td>Screening period</td>
<td>Randomized treatment period</td>
<td>Treatment extension period</td>
<td>D336 EoS</td>
</tr>
</tbody>
</table>

**Population (n = 97)**

Adult PNH patients with residual anemia (Hb < 10g/dL) on a stable regimen of anti-C5 therapy 6 months prior to randomization

**Primary endpoints**

- Superiority for proportion of patients achieving increase in Hb ≥ 2g/dL from baseline in the absence of RBC transfusion
- Superiority for proportion of patients achieving Hb ≥ 12g/dL in the absence of RBC transfusion

PNH = Paroxysmal Nocturnal Hemoglobinuria  
Hb = Hemoglobin  
RBC = Red Blood Cell  
BID = twice a day  
EoS = End of Study
Iptacopan was superior to SoC for both primary endpoints; majority of iptacopan patients achieved more normal Hb levels vs. 0 on SoC

Increase from baseline in Hb of ≥ 2 g/dL in the absence of RBC transfusions

<table>
<thead>
<tr>
<th>Observed</th>
<th>Population estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>51/60</strong>&lt;sup&gt;1&lt;/sup&gt; patients treated with <strong>iptacopan</strong></td>
<td>Estimated proportion of patients, % (95% CI) 82.3% (95% CI 71.3, 87.6) P&lt;0.0001&lt;sup&gt;3&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>0/35</strong> patients treated with <strong>SoC</strong></td>
<td>Difference = 80.3% (95% CI 71.3, 87.6) P&lt;0.0001&lt;sup&gt;3&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

Hb ≥ 12 g/dL in the absence of RBC transfusions

<table>
<thead>
<tr>
<th>Observed</th>
<th>Population estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>42/60</strong>&lt;sup&gt;1&lt;/sup&gt; patients treated with <strong>iptacopan</strong></td>
<td>Estimated proportion of patients, % (95% CI) 68.8% (95% CI 56.3, 76.9) P&lt;0.0001&lt;sup&gt;3&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>0/35</strong> patients treated with <strong>SoC</strong></td>
<td>Difference = 67.0% (95% CI 56.3, 76.9) P&lt;0.0001&lt;sup&gt;3&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

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1. 2/62 patients in the iptacopan arm had missing data between Days 126 and 168 so were not evaluable based on observed data.
2. Marginal proportions, differences in marginal proportions and 95% CIs were calculated using a logistic regression model using the Firth correction that adjusted for baseline covariates and accounted for missing data and the possibility of no patients meeting the primary endpoint criteria in the SoC arm; consequently, the treatment effect of iptacopan is underestimated and the treatment effect of SoC is overestimated. Marginal proportions reflect the population average probability of a patient meeting the primary endpoint criteria.
3. P values are two-sided and unadjusted. CI, confidence interval.
Iptacopan monotherapy was superior to SoC for transfusion avoidance

Transfusion avoidance

<table>
<thead>
<tr>
<th>Observed</th>
<th>60/62 patients treated with iptacopan</th>
<th>14/35 patients treated with SoC</th>
</tr>
</thead>
</table>

Population estimate

- **Estimated proportion of patients, % (95% CI)**
  - **Iptacopan**: 96.4% (95% CI 52.6, 84.9)  \( P < 0.0001 \)
  - **SoC**: 26.1% (95% CI 23.1, 55.8)

Difference = 70.3% (95% CI 52.6, 84.9)  \( P < 0.0001 \)

A post hoc sensitivity analysis using a different approach for handling missing data confirmed the significance of the pre-specified analysis:

- **Iptacopan**: 96.7% (95% CI 91.3, 100.0)
- **SoC**: 38.9% (95% CI 23.1, 55.8)

Difference = 57.8% (95% CI 39.8, 74.2),  \( P < 0.0001 \)

Of the patients treated with anti-C5 therapy who received transfusions, they received on average more than double the number of transfusions vs. the few patients on iptacopan.

1. Marginal proportions, differences in marginal proportions and 95% CIs were calculated using a logistic regression model that adjusted for baseline covariates and accounted for missing data. Marginal proportions reflect the population average probability of a patient meeting the endpoint criteria.
2. \( P \) values are two-sided and unadjusted.
Iptacopan monotherapy was superior to SoC at increasing Hb level from baseline

Mean Hb (SD) over time during the 24-week randomized treatment period

Adjusted mean Hb change from baseline\(^1\) (95% CI) was +3.59 (3.32, 3.86) g/dL for iptacopan vs −0.04 (−0.42, 0.35) g/dL for SoC, with a difference of +3.63 (3.18, 4.08) g/dL (\(P<0.0001\)).

---

1. Between Days 126 and 168 (excluding values within 30 days of RBC transfusion).  
2. A repeated measures model, adjusting for covariates including baseline Hb, was used for comparisons between the treatment arms. P value is two-sided and unadjusted.  
3. Includes post-transfusion data. 2/62 patients in the iptacopan arm and 21/35 patients in the SoC arm had RBC transfusions between Days 14 and 168.  

BL = baseline  
Wk = week
Iptacopan monotherapy was superior to SoC at reducing patient-reported fatigue from baseline

Mean FACIT-Fatigue score (SD) during the 24-week randomized treatment period

![Graph showing mean FACIT-Fatigue score (SD) during the 24-week randomized treatment period.]

- **Iptacopan**: 62, 60, 57
- **Anti-C5 SoC**: 33, 27, 28

**Patients with available data**

- **Study visit**
  - Wk6: 61
  - Wk12: 57
  - Wk18: 58
  - Wk20: 59
  - Wk22: 56
  - Wk24: 60

*Adjusted mean change from baseline*¹ in FACIT-Fatigue score (95% CI) was +8.59 (6.72, 10.47) for iptacopan vs +0.31 (−2.20, 2.81) for SoC, with a difference of +8.29 (5.28, 11.29) (P<0.0001)²

---

¹ Between Days 126 and 168.
² A repeated measures model, adjusting for covariates including baseline FACIT-Fatigue score, was used for comparisons between the treatment arms. P value is two-sided and unadjusted.
Iptacopan monotherapy was superior to SoC at reducing absolute reticulocyte count from baseline

Mean absolute reticulocyte count (SD) during the 24-week randomized treatment period

![Graph showing mean absolute reticulocyte count (SD) during the 24-week randomized treatment period](image)

Patients with available data

<table>
<thead>
<tr>
<th>Iptacopan</th>
<th>Anti-C5</th>
<th>SoC</th>
</tr>
</thead>
<tbody>
<tr>
<td>62</td>
<td>35</td>
<td>61</td>
</tr>
<tr>
<td>61</td>
<td>28</td>
<td>58</td>
</tr>
<tr>
<td>58</td>
<td>27</td>
<td>35</td>
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<td>60</td>
<td>32</td>
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<td>59</td>
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<td>59</td>
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<td>59</td>
<td>31</td>
<td>59</td>
</tr>
<tr>
<td>60</td>
<td>33</td>
<td>60</td>
</tr>
</tbody>
</table>

Study visit

- BL
- Wk1
- Wk2
- Wk4
- Wk6
- Wk8
- Wk12
- Wk16
- Wk18
- Wk20
- Wk22
- Wk24

Adjusted mean change from baseline\(^1\) in absolute reticulocyte count (95% CI) was \(-115.89\) (\(-126.49, -105.30\)) \(x 10^9/L\) for iptacopan vs \(+0.37\) (\(-13.03, 13.77\)) \(x 10^9/L\) for SoC, with a difference of \(-116.26\) (\(-132.17, -100.36\)) \(x 10^9/L\) (\(P<0.0001\)\(^2\)).

---

1. Between Days 126 and 168.
2. A repeated measures model, adjusting for covariates including baseline absolute reticulocyte count, was used for comparisons between the treatment arms. P value is two-sided and unadjusted. LLN = lower limit of normal \(\text{ULN} = \) upper limit of normal.
There was no significant difference between iptacopan monotherapy and SoC for change from baseline in LDH level

Mean LDH level (SD) during the 24-week randomized treatment period

- As expected, with all patients having been treated with anti-C5s prior to entering the study, IVH was well controlled and LDH levels < 1.5x ULN in the vast majority of patients.
- No difference in LDH levels shows that iptacopan maintains IVH control.

Adjusted geometric mean ratio to baseline in log-transformed LDH (95% CI) was 0.96 (0.90, 1.03) for iptacopan vs 0.98 (0.89, 1.07) for SoC, equating to a reduction of 1.15% (95% CI −10.18, 11.32) with iptacopan vs SoC (P=0.8345).
Iptacopan monotherapy was superior to SoC for annualized rate of clinical breakthrough hemolysis¹

<table>
<thead>
<tr>
<th>Arm</th>
<th>n/N²</th>
<th>Adjusted annual rate, % (95% CI)</th>
<th>Rate ratio (95% CI)³</th>
<th>P value³</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate of clinical breakthrough hemolysis¹</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Iptacopan</td>
<td>2/62</td>
<td>0.07 (0.02, 0.31)</td>
<td>0.10 (0.02, 0.61)</td>
<td>0.0118</td>
</tr>
<tr>
<td>Anti-C5 SoC</td>
<td>6/35</td>
<td>0.67 (0.26, 1.72)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Rate ratio of 0.10 means **10-fold lower rate of annualized clinical breakthrough hemolysis**

1. Events that met the protocol-specified criteria for clinical breakthrough hemolysis. All hemolytic events were also reported as TEAEs, even if they did not meet the criteria for clinical breakthrough hemolysis.  
2. n=number of patients with at least one event. N=overall number of patients.  
3. A negative binomial model was used for the comparison between treatment arms. P value is two-sided and unadjusted. TEAE = treatment-emergent adverse event.
There was no significant difference between iptacopan monotherapy and SoC for the annualized rate of MAVEs

<table>
<thead>
<tr>
<th>Arm</th>
<th>n/N¹</th>
<th>Adjusted annual rate, % (95% CI)</th>
<th>Rate ratio (95% CI)²</th>
<th>P value²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iptacopan</td>
<td>1/62</td>
<td>0.03 (0.00, 0.25)</td>
<td>Not estimable</td>
<td>0.3173</td>
</tr>
<tr>
<td>Anti-C5 SoC</td>
<td>0/35</td>
<td>0</td>
<td></td>
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</tbody>
</table>

- Serious TEAE of **transient ischemic attack**, considered by the investigator to be **unrelated to iptacopan**
- The patient had a concomitant serious TEAE of sick sinus syndrome and is **continuing** to receive **iptacopan** treatment

MAVE = major adverse vascular event  
1. n=number of patients with at least one event, N=overall number of patients.  
2. A negative binomial model was used for the comparison between treatment arms. P value is two-sided and unadjusted.

TEAE = treatment-emergent adverse event.
Iptacopan monotherapy was well tolerated and had a favorable safety profile

Most common TEAEs (≥4 patients in either arm)¹

<table>
<thead>
<tr>
<th>TEAE</th>
<th>Iptacopan 200mg bid N=62</th>
<th>Anti-C5 SoC N=35</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any TEAE</td>
<td>51 (82.3)</td>
<td>28 (80.0)</td>
</tr>
<tr>
<td>Mild / Moderate / Severe, %</td>
<td>32.3 / 45.2 / 4.8</td>
<td>37.1 / 34.3 / 8.6</td>
</tr>
<tr>
<td>Headache</td>
<td>10 (16.1)</td>
<td>1 (2.9)</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>9 (14.5)</td>
<td>2 (5.7)</td>
</tr>
<tr>
<td>Nasopharyngitis</td>
<td>7 (11.3)</td>
<td>2 (5.7)</td>
</tr>
<tr>
<td>Nausea</td>
<td>6 (9.7)</td>
<td>1 (2.9)</td>
</tr>
<tr>
<td>COVID-19</td>
<td>5 (8.1)</td>
<td>9 (25.7)</td>
</tr>
<tr>
<td>Urinary tract infection</td>
<td>5 (8.1)</td>
<td>1 (2.9)</td>
</tr>
<tr>
<td>Arthralgia</td>
<td>5 (8.1)</td>
<td>1 (2.9)</td>
</tr>
<tr>
<td>Abdominal pain</td>
<td>4 (6.5)</td>
<td>1 (2.9)</td>
</tr>
<tr>
<td>Increased blood LDH</td>
<td>4 (6.5)</td>
<td>3 (8.6)</td>
</tr>
<tr>
<td>Dizziness</td>
<td>4 (6.5)</td>
<td>0</td>
</tr>
<tr>
<td>Breakthrough hemolysis</td>
<td>2 (3.2)</td>
<td>6 (17.1)</td>
</tr>
</tbody>
</table>

TEAE = treatment-emergent adverse event ¹. Organized by descending frequency in the iptacopan arm

No deaths

No discontinuations due to TEAEs

Serious TEAEs:
9.7% vs 14.3%

Hemolysis serious TEAEs:
- **Iptacopan:** None
- **SoC:** Breakthrough hemolysis (n=1) and extravascular hemolysis (n=1)

No serious infections caused by encapsulated bacteria
Two positive Ph3 studies in PNH first pivotal readouts for iptacopan

<table>
<thead>
<tr>
<th>Study</th>
<th>APPLY-PNH</th>
<th>APPOINT-PNH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient type</td>
<td>PNH patients with residual anemia despite anti-C5</td>
<td>PNH patients naive to complement inhibitor therapy</td>
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<tr>
<td>Intervention</td>
<td>Iptacopan vs. anti-C5 antibody</td>
<td>Iptacopan, single-arm study</td>
</tr>
</tbody>
</table>
APPOINT-PNH study is a single-arm Ph3 trial investigating iptacopan monotherapy in treatment-naive patients with PNH

Study design

Population (n = 40)
Adult PNH patients with hemolysis (LDH > 1.5x ULN) and anemia (Hb < 10g/dL) naive to complement inhibitor therapy

Primary endpoint
✓ Proportion of patients achieving a sustained increase in Hb of ≥ 2g/dL, in the absence of transfusions

BID = twice a day  EoS = End of Study  ULN = upper limit of normal
Iptacopan monotherapy achieved clinically meaningful increases in hemoglobin levels in treatment-naive patients with PNH

APPOINT-PNH met primary endpoint of proportion of patients achieving a sustained increase in Hb of ≥ 2g/dL, in the absence of transfusions, at 24 weeks

Safety profile consistent with previously reported data

Data to be presented at upcoming medical meeting
As a potent, selective factor B inhibitor, iptacopan has the potential to be practice-changing, the new standard of care in PNH

<table>
<thead>
<tr>
<th>Addresses both intravascular and extravascular hemolysis</th>
<th>Superior in PNH patients with residual anemia despite prior anti-C5 treatment (APPLY)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Normalized hemoglobin levels</td>
</tr>
<tr>
<td></td>
<td>• Reduced need for transfusions</td>
</tr>
<tr>
<td></td>
<td>• Reduced patient-reported fatigue</td>
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<tr>
<td></td>
<td>• Favorable safety with no serious breakthrough hemolysis</td>
</tr>
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<table>
<thead>
<tr>
<th>Clinically meaningful Hb increases in treatment-naive patients (APPOINT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Safety profile consistent with APPLY-PNH</td>
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</table>

<table>
<thead>
<tr>
<th>Significant QoL benefits as the first oral monotherapy</th>
</tr>
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</table>
Global regulatory filings starting in H1 2023

Selected iptacopan PNH submissions

FDA submission expected H1 2023
EMA submission expected H1 2023
PMDA submission expected H2 2023
China FDA submission expected H2 2023

Orphan Drug Designation
FDA Apr. 2020, EMA Jul. 2020

Breakthrough Therapy Designation
FDA Dec. 2020
The path to PNH diagnosis and treatment involves many steps and can take months to years

<table>
<thead>
<tr>
<th>Delays in diagnosis and treatment of PNH</th>
<th>Increase urgency to intervene earlier</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Up to 3 years to diagnose PNH (avg. 7-9 months)</td>
<td></td>
</tr>
<tr>
<td>▪ Median age at disease onset 36 years¹</td>
<td></td>
</tr>
<tr>
<td>▪ Common symptoms (e.g., fatigue, hemoglobinuria) can have multiple causes</td>
<td></td>
</tr>
<tr>
<td>▪ “Watch &amp; Wait” for disease progression before treatment is initiated</td>
<td></td>
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<tr>
<td>▪ Patients still experiencing symptoms and may be receiving transfusions</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Limited options available for treatment</th>
<th>More choice in first line and switch</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Until 2021, only anti-C5’s available for treatment</td>
<td></td>
</tr>
<tr>
<td>▪ 4-6 weeks to determine if treatment is working</td>
<td></td>
</tr>
<tr>
<td>▪ Some patients unwilling to commit to regular infusions</td>
<td></td>
</tr>
</tbody>
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<tr>
<th>Need to make treatment for life manageable</th>
<th>Unburden patients from infusions and expect more from treatments</th>
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<td>▪ Regular monitoring with stable patients every 3 months but unstable patients as often as weekly</td>
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<tr>
<td>▪ “Good enough” patient outcomes accepted</td>
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<tr>
<td>▪ Managed by hematologists</td>
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Opportunity to redefine PNH treatment paradigm

~6k
Prevalent PNH patients in US

- Treated with complement inhibitor
  - 30%
  - Current market ~USD 2bn WW (USD 1bn US)
  - Of C5-treated patients, ~80% have Hb < 12g/dL
    - Still experiencing symptoms
    - Managing life around infusion schedule
    - Some still receiving transfusions

Displace Anti-C5

- Untreated
  - 70%
  - Varying views of when treatment should be started
  - Heterogeneous presentation of symptoms
  - Some unwilling to commit to regular infusions
  - Some still receiving transfusions

Potentially increase treatment rate

~400
Incident PNH patients/year in US

- Start appropriate patients on iptacopan

2. Incidence: 1.0-1.5 per million individuals (Hill A, 2017).
3. Treated with anti-C5 or anti-C3
4. Based on C5i therapies only
5. Debureaux PE et al. Bone Marrow Transplant 2021;56:2600–2

Source: Patient journey market research 2022
Significant experience in non-malignant hematology and rare disease provides strong foundation for launch

Track record of execution in rare hematology / oncology conditions

- **Promacta** market leadership in SAA (ultra-rare) and ITP (rare) based on deep understanding of HCP insights and patient needs / motivations; also an oral option in originally infusion-driven market
- Building on rare disease playbook from Vjoice and Afinitor TSC launches, including early and critical focus on patient engagement and advocacy

Existing relationships with PNH treaters

- ~2.5k hematologists / oncologists seeing PNH patients
- Rare disease, but treated and managed not just by experts in large centers, but also community HCPs
- Strong existing customer relationships with majority of PNH treaters
- Top medical experts engaged in either clinical studies or advisory capacity
- Account profiling underway to identify individual success levers
### Patient engagement and activation
- Relationships built with key patient advocacy groups
- Focus on educating PNH patients on available therapies and activating them to seek treatment that’s right for their life

### Disease state education
- Launched PNH disease education campaign at ASH 2022 to raise awareness of high burden of disease and unmet need
- Ongoing digital engagement

### Patient support services
- Detailed mapping of patient journey to minimize friction for new and switch patients
- Leveraging experience in Rare Disease, Oncology and MS to ensure best practice

### Comprehensive evidence generation
- Ph3 program covering broad spectrum of PNH patients: treatment naïve (APPOINT) and switch (APPLY)
- Patient registries with key stakeholder organizations

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**Launch readiness to support rare disease success is on track**

Field medical and field sales teams already in place
On track to launch a potential new standard-of-care in PNH

1

Iptacopan could be practice-changing:
- Superior efficacy to anti-C5 therapy
- Significant QoL benefits
- Oral option in infusion market
- Potential new standard of care

2

On track with launch readiness:
- Playbook for rare disease launches
- Existing relationships with PNH HCPs
- Disease education campaign launched
- Medical and sales teams in place
Appendix
Iptacopan has the potential to become the new SoC in a well established and growing global PNH market

PNH complement inhibitors market size is estimated at ~USD 2bn\(^1\)

PNH market is expected to grow at 7.6% CAGR over the next 10 years in the 7 major markets\(^2\) driven by new entrants and increased penetration of complement inhibitors\(^3\)

Current total C5 inhibitor sales in PNH roughly evenly split between US and ex-US\(^1\)

**Significant opportunities ex-US**, including China, where until recently there were no complement inhibitors available

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1. Evaluate Pharma Dec 2022.  
2. 7 Major Markets: US, Germany, France, UK, Italy, Spain and Japan.  