Generating Hope for Rare Disease & Oncology Patients

October 2023
Non-Confidential
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The Spexis Proposition:
Life-changing macrocycle therapeutics for rare disease and oncology patients

**Macrocycle focus:**
- Extensive macrocycle platform with both peptidic & non-peptidic libraries
- 3 clinical-stage products discovered in-house thus far
- Lead asset ColiFin®: approved (in EU), US Phase 3-ready, also a macrocycle
- Significant molecular glue & protein degrader potential

**Early & late-stage cystic fibrosis (CF) pipeline:**
Funded and supported by the CF Foundation & IMI

1. **Inhaled Murepavadin:**
   - Novel OMPTA-antibiotic
   - 9 i.v. clinical trials in ~290 subjects to date
   - Phase 1 CF trial data reported in Jan 2023

2. **Balixafortide:**
   - Best-in-class CXCR4i
   - 8 clinical trials in >500 subjects to date
   - Now under development for pancreatic cancer

3. **ColiFin®:**
   - Lead candidate for CF
   - EU approved; U.S. Phase 3 ready

**Excellent value growth potential:**
- Lead asset highly de-risked
- Multiple other clinical shots-on-goal
- Cutting-edge macrocycle platform

**Lonodelestat:**
- Best-in-class neutrophil elastase inhibitor
- Phase 2 ready
- Out-licensed to Santhera

IMI – Innovative Medicines Initiative (EU research initiative)
Spexis’ Focus on Macrocycles

Broadly Applicable, Large Clinical Data Set, Partner Validated

**Macrocycles**
- Can target difficult-to-drug extra- and intracellular structures
- **Offer unique drug-like profiles** incl. favorable PK/PD parameters, improved oral bioavailability, enhanced metabolic stability and cell permeability
- Since 2014, **19 macrocyclic structures approved by FDA**

**Extensive peptidic & non-peptidic libraries, databases & IP**
Will fuel pipeline and generate partnering opportunities
- 2 in-house candidates progressed through P3 thus far; additional 1 (ColiFin®) in-licensed & P3-ready
- Additional candidate out-partnered & entering P2
- Validated by multiple prior **pharma collaborations**

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1 https://doi.org/10.3390/molecules27031012
# Spexis Pipeline: Multiple “Shots-On-Goal”

## Potential for Significant Value Generation

<table>
<thead>
<tr>
<th>Program</th>
<th>Research</th>
<th>Preclinical</th>
<th>Phase 1</th>
<th>Phase 2</th>
<th>Phase 3</th>
<th>Partnership / Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cystic Fibrosis</td>
<td>ColiFin®</td>
<td>Chronic CF infections</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Inhaled Murepavadin</td>
<td>Chronic CF infections</td>
<td>Non-CF bronchiectasis</td>
<td></td>
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<tr>
<td>Oncology/Rare Disease</td>
<td>Balixafortide</td>
<td>Pancreatic ductal adenocarcinoma (PDAC)</td>
<td></td>
<td></td>
<td></td>
<td>FOSUN PHARMA</td>
</tr>
<tr>
<td>Neutrophil Elastase Inhibition</td>
<td>Lonodelestat</td>
<td>CF, AATD, PCD</td>
<td></td>
<td></td>
<td></td>
<td>Product out-licensed to santhera</td>
</tr>
<tr>
<td>Macrocycle platform</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CARB-X (OMPTA)</td>
</tr>
</tbody>
</table>

CF – cystic fibrosis; AATD – alpha-1 antitrypsin deficiency; PCD – primary ciliary dyskinesia
OMPTA – Outer Membrane Protein Targeted Antibiotics
Indications according to https://www.santhera.com/health-care-professionals/lonodelestat

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<table>
<thead>
<tr>
<th>Pipeline Today</th>
<th>Readiness if/when initiated</th>
</tr>
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</table>
ColiFin®:
As Approved In Europe
ColiFin®

Significantly De-risked Via EU Approval, FDA Interactions & CF Foundation (“CFF”) Support

Approved in EU (DE, AT, CH, FR, SP, IT, UK, NE): 2010 – 2018 via decentralized process

U.S. Phase 3 Program (“COPA”):

- FDA “Study May Proceed Letter”: 1 Phase 3 trial sufficient
- QD dosing favored due to high treatment burden in CF patients
- Continuous use therapy (not 28d on, 28 off): same as ColiFin® EU label, also significant compliance factor
- COPA developed with CFF equity investment & sig design input & endorsement from CFF’s Therapeutics Development Network – a “must have” for doing CF trials in U.S. and Canada

Multiple P3 “COPA” study value-inflection points:

1st Interim Analysis (“IA”):
- 1x/day dosing safety/PK/efficacy readout after ~80 subjects

2nd Interim Analysis
- after 60% of subjects have completed COPA Part A
- if positive, could file early NDA

Commercial:

QIDP + Orphan Drug designation = 12 yrs U.S. market exclusivity

Concentrated N. American market: ~130 CF care centers

Small commercial structure sufficient to “go-it-alone”
Future ColiFin® Patients

Already Use Inhaled Colistin

Current EU Usage

- EU inhaled colistin revenues (all products) est. €75M/yr
- Average EU price per course: €800-1.5K

Current US Usage

- ~2200 CF patients used unapproved colistin in 2019
- Those patients will convert to ColiFin® upon approval

EU vs. US

- US pricing 3-5x EU (e.g. TOBI®, Cayston®, generics)
- EU29 & US CF patient population comparable (~40K vs 30K)

[1] Confidential market information shared.
85% of eligible population receive CFTR modulators – slowing disease progression & improving mucus clearance\(^1\)

5yr data show reduced load BUT chronic infections persist – will remain major issue\(^2\)

> Ageing CF patient population – a longer, but not healthier life\(^1\)

> Chronic lung infections – increased likelihood as patient ages; *P. aeruginosa* predominant > age 33\(^1\)

> Increasing need for long-term inhaled antibiotics\(^1\)

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2) Finke et al.; Lenhan et al.; Quinn et al.
ColiFin®: Potential to be More Effective, Safer Therapy
Current Treatments in U.S. Not Fully Addressing Need

<table>
<thead>
<tr>
<th>Mechanism of Action</th>
<th>TOBI®/Cayston®</th>
<th>ColiFin®</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Leads to resistance development</td>
<td>Difficult for <em>P. aeruginosa</em> to mutate around</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Resistance Development</th>
<th>Increasing, up to 40% in some regions(^1,2)</th>
<th>Rarely exceeding ~5%(^1,2)</th>
</tr>
</thead>
</table>

| Safety                    | TOBI has significant ototoxicity concerns     | Validated in EU:            |
|---------------------------|-----------------------------------------------| Strong efficacy, minimal serious adverse events in >15K patients dosed to date |

<table>
<thead>
<tr>
<th>Efficacy</th>
<th>Decreased efficacy over time</th>
<th>Continuous (i.e., no CAT) b.i.d. dosing with P3 plans for q.d. dosing</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Dosing</th>
<th>Continuous b.i.d./t.i.d. alternating therapy (&quot;CAT&quot;) (rotation of 28d cycles)</th>
<th>Colistin available as I.V. formulation – inhalation unapproved (U.S.) → not reimbursed, most patients must pay-out-of-pocket</th>
</tr>
</thead>
</table>

1) doi: 10.1128/AAC.01541-19
2) doi: 10.1128/AAC.02483-20
ColiFin® Life Cycle Management:

Expansion into Non-CFBE, COPD

1) McShane et. al. 2013, DOI: 10.1164/rcrim.201303-0411CI
2) Finch S et. al. 2015 DOI: 10.1513/AnnalsATS.201506-333OC.
3) Chen et. al. 2018, DOI: 10.1080/13543784.2018.1439919
4) Planquette et. al. 2015, DOI: 10.2147/COPD.S71413

Non-CF Bronchiectasis & COPD patients also suffer chronic P. aeruginosa infections, no proven inhaled standard-of-care

An effective QD ColiFin® would be an attractive therapeutic in both these additional indications

LCM Expands Treatable Patients to >30M Worldwide

1) Cystic Fibrosis ~10K Treatable US Patients
   • Primary indication w/ front-line label
   • Very accessible patient population
   • Established usage in U.S. & RoW

2) Non-CF Bronchiectasis 15x U.S. CF Market
   • 1/3rd of patients have 3+ exacerbations/yr
   • Most of these have chronic lung infections
   • ~30% culture P aeru, have worse outcomes

3) COPD 50x U.S. CF Market
   • 15M US Patients, >250M globally
   • 5-15% infected with P aeru
   • Infections drive exacerbations, deaths

1) McShane et. al. 2013, DOI: 10.1164/rcrim.201303-0411CI
2) Finch S et. al. 2015 DOI: 10.1513/AnnalsATS.201506-333OC.
3) Chen et. al. 2018, DOI: 10.1080/13543784.2018.1439919
4) Planquette et. al. 2015, DOI: 10.2147/COPD.S71413
# Potential ColiFin® Peak Revenues

<table>
<thead>
<tr>
<th>Product</th>
<th>Indication</th>
<th>Territory</th>
<th>Target Patient Population</th>
<th>Peak Penetration</th>
<th>Revenue per Patient/Yr</th>
<th>Projected Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>ColiFin®</td>
<td>CF</td>
<td>US</td>
<td>12,000&lt;sup&gt;1&lt;/sup&gt;</td>
<td>45%</td>
<td>$36K</td>
<td>$210M</td>
</tr>
<tr>
<td>nCFB</td>
<td>US</td>
<td>50,000&lt;sup&gt;2&lt;/sup&gt;</td>
<td>30%</td>
<td>$30K</td>
<td></td>
<td>$450M</td>
</tr>
<tr>
<td>Asia Pacific</td>
<td></td>
<td></td>
<td>250,000&lt;sup&gt;3&lt;/sup&gt;</td>
<td>20%</td>
<td>$10K</td>
<td>$500M</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>$1,160M</strong></td>
</tr>
</tbody>
</table>

[1] Adult US patients with moderate to advanced disease, per CFF registry report  
[2] 450K nCFB patients, 37% exacerbate 3+ times/yr, ~30% of those culture P aeruginosa (Chalmers 2018)  
### ColiFin® Target Patient Populations & Value Generation

**Compares Well to Insmed’s ARIKAYCE®**

<table>
<thead>
<tr>
<th>ARIYAKCE®</th>
<th>ColiFin®</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indication</strong></td>
<td>MAC NTM (Refractory)</td>
</tr>
<tr>
<td>Regulatory Status</td>
<td>Approved</td>
</tr>
<tr>
<td>Target Patient Population (US)</td>
<td>10-15K (Insmed est.)</td>
</tr>
<tr>
<td></td>
<td>-12K eligible</td>
</tr>
<tr>
<td>Other Markets</td>
<td>JP: 15-18K (Insmed est.)</td>
</tr>
<tr>
<td></td>
<td>EU: -1K (Insmed est.)</td>
</tr>
<tr>
<td>Net Revenues</td>
<td>-$300M (2023 est)</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Company Mkt Cap:</td>
<td>$1.5B (post-2018 approval)</td>
</tr>
</tbody>
</table>
Insmed Mkt Cap Peaked at $4.2B
With 2\textsuperscript{nd} Line NTM Approval

- \textbf{2015: mkt cap hits $1.3B}: on positive P2 NTM readout & ongoing P3 in CF (which later failed)
- \textbf{Early 2021: mkt cap hits >$4B}: announcement of ~$110M first yr ARIKAYCE® sales; next most advanced pipeline asset nCFB P2
<table>
<thead>
<tr>
<th>Historical Spexis Stock Prices Illustrate Significant Growth Potential</th>
</tr>
</thead>
</table>
| **CHF 2.20**  
(mkt cap - CHF 90M) | Share price all-time high  
(Jan 3, 2022) |
| **CHF 0.988** | 52-wk share price high  
(May 23, 2022) |
| **CHF 0.30** | 52 wk share price low  
(Apr 5, 2023) |
| **CHF 0.30** | 60d VWAP (volume weighted average price) as of Oct 23, 2023 |
ColiFin® Phase 3 Program: COPILOT Trial

QD vs BID dosing, open label

**Primary Objective:**
- Tolerability and safety of ColiFin®, once-daily (QD) vs twice-daily (BID)
- Interim analysis (Day 42) to support switch from BID to QD dosing in COPA
- Important short-term value inflection point: QD approval could grant USP...

**Secondary Objectives:**
- Assessment of pulmonary function (ppFEV1)
- Clinical events (number/severity of pulmonary exacerbations, hospitalizations)
- Additional antibacterial therapy

To be conducted in Europe; enrollment expected to initiate 2H2023

**Screening:**
Patients on stable inhaled antibiotic treatment

<table>
<thead>
<tr>
<th>Treatment</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>ColiFin®</td>
<td>4 MIU QD, n=19</td>
</tr>
<tr>
<td>ColiFin®</td>
<td>2 MIU BID, n=19</td>
</tr>
</tbody>
</table>

**Timeline:**
- D1: 1:1 randomization QD vs. BID*
- D 28: End of treatment
- D 42: Interim analysis
- D 169: End of trial

* Stratification by current use of oral corticosteroids > or <= 10 mg QD or 20 mg QOD (prednisone or prednisolone equivalents)
ColiFin® Phase 3 Program: COPA Pivotal Trial

28d double blind efficacy + 20w open-label safety

Eligible: Adults/adolescents with CF + chronic *P. aeruginosa* (Pae) lung infection

Therapy: Continuous ColiFin® for 6 months vs. placebo + usual inhaled antibiotics

Primary endpoint: Mean absolute diff. in ppFEV1 (of ≥3 %) in change from baseline to Day 28

Key secondary endpoints throughout 6 months: Difference in CFQ-R respiratory symptom score; exacerbation severity/duration; consistency of treatment response; sputum microbiology: Pae density, resistance development (MIC)

Independent Data Monitoring Committee: Interim efficacy analysis after 288 patients complete 28d days of treatment (~12 mos from FPI)

Screening: Patients on tobramycin, aztreonam or levofloxacin

Part A: 28d double-blind efficacy

<table>
<thead>
<tr>
<th></th>
<th>ColiFin®</th>
<th>Placebo</th>
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</thead>
<tbody>
<tr>
<td>n</td>
<td>360</td>
<td>120</td>
</tr>
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</table>

D 1: 3:1 randomization

Part B: 20wk open label safety

<table>
<thead>
<tr>
<th></th>
<th>ColiFin® QD</th>
<th>Active Control (“usual care”)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rollover from ColiFin group; total n=300 completed</td>
<td>Rollover from placebo group; total n=100 completed</td>
<td></td>
</tr>
</tbody>
</table>

D 28: Roll over

D 199: Safety follow-up (tel.); End of trial

D 169: End of trial

1) ppFEV1: Percent Predicted Forced Expiratory Volume in 1 second
2) Stratification of randomization by age (<18, >18 yrs, pp FEV 1 (<70%;>70%), prior PEx treated with systemic antibacterials in last 12 months, stable baseline use of CFTR modulators
# Inhaled Murepavadin ("iMPV") for Cystic Fibrosis

**Novel Class Therapeutic For a Rare Disease**

## Attractive market
- Peak CF sales 200-400m USD
- Label expansion potential to nCFBE: >$1B market

## In Phase 1
- Potent & selective activity against resistant *P. aeruginosa*

## Externally validated & partially funded
- Substantial funding from: EU Innovative Medicines Initiative (IMI) for Ph. 1a & CF Foundation for Ph. 2

## High safety margin
- 9 clinical trials of IV MPV totaling 290 subjects have informed & de-risked the inhalation route
- Low systemic exposure upon inhalation mitigates nephrotoxicity risk
- High safety margin (5- to 10-fold above IV) in GLP tox studies

## IP protected
- Market exclusivity through about 2036 via COM/additional IP
- Eligible for QIDP & orphan drug status

## Timeline
<table>
<thead>
<tr>
<th>2021</th>
<th>2022</th>
<th>2023</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ph 1a: SAD in HVs</td>
<td>Ph 1b: SAD in CF</td>
<td>Ph 2: CF patients</td>
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</tbody>
</table>
**Balixafortide**

- Potent, highly selective blocker of CXCR4
- CXCR4 is involved in tumor growth and metastasis and is also implicated in a variety of primary immune deficiency and other rare diseases

**Clinical proof of concept established**

- >500 patients in 8 clinical trials
- Phase 3 study in advanced HER-2 negative breast cancer did not achieve primary endpoint; data analyses ongoing

**Good safety and tolerability profile**

- Well tolerated by i.v. route of administration
- No limiting safety events identified at top dose given (5.5mg/kg)
- Shown to overcome SoC drug resistance
- Compatible with combination therapies

**Evaluating potential new indications**

- Extensively profiled in animal models of stem cell mobilization, cancer, inflammatory and rare disease indications
- **Encouraging results of BLX + anti-PD1 in multiple animal models of pancreatic ductal adenocarcinoma (PDAC)**
Pancreatic Cancer

Multi-Billion $ Indication w/ High Unmet Need

3rd leading cancer death (US)
Projected 2nd by 2030¹

~500k annual diagnoses ww²

~470k annual deaths ww²

6% 5-yr survival for pancreatic ductal adenocarcinoma (PDAC)⁴
Poor prognosis due largely to late diagnosis

USD 6.85 Billion
projected market by 2029³

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¹ Rahib L et. al, Estimated Projection of US Cancer Incidence and Death to 2040. JAMA Netw Open. 2021;
² World J Gastroenterol., Irena Ilic et al., 2022 Aug 28; 28(32): 4696–4715
⁴ Yushifumi Noda et al., Medical Imaging, 22, Article number: 23 (2022)
• Pancreatic Ductal Adenocarcinoma accounts for ~90% of all pancreatic cancers\textsuperscript{1}, but:
  • Survival rates are the lowest of all common cancers
  • Only ~15% have operable disease at diagnosis
• Global incidence highest in Europe, North America\textsuperscript{2}

\textsuperscript{1} doi: 10.4103/eus.eus_60_17
\textsuperscript{2} doi: 10.3748/wjg.v24.i43.4846
In last 40 years, 10yr survival rates have dramatically improved for every cancer except pancreatic.

Recently approved therapies (e.g. Abraxane) have increased 5-year survival only slightly (~12%).

[1] pancreaticcanceraction.org
Incidence of Pancreatic Cancer in China Has Increased Significantly Over The Years

Increasing incidence of pancreatic cancer in China¹:

- In 2019, the number of pancreatic cancer cases in China was estimated to be 114,964 and the incidence was estimated to be 5.78/100,000, an increase of 329.40% and 82.11% compared with 1990, respectively.

- Whether in 1990 or 2019, the incidence of pancreatic cancer was low before the age of 50, and it substantially increased with age, starting from the 50–54 age group, and reaching its peak in the 85-and-over age group.

- The incidence for males is greater than that for females.

There were 124,994 new cases of pancreatic cancer and 121,853 deaths in China in 2020²

[1] Yuan He et al., China CDC weekly, 2022, 4(24): 527-531
[2] IARC Global Cancer Observatory
Potential for Anti-PD1 in PDAC

- PD-1 inhibitors have been most successful class of immuno-oncology agents
- Blocks mechanism by which many cancer cells suppress immune response

<table>
<thead>
<tr>
<th>Anti-PD1</th>
<th>2022 Revenues:</th>
<th>Approvals in melanoma, NSCLC, HNSCC, cHL, PMBCL, others</th>
</tr>
</thead>
<tbody>
<tr>
<td>KEYTRUDA (pembrolizumab)</td>
<td>~$20.9B</td>
<td></td>
</tr>
<tr>
<td>OPDIVO (nivolumab)</td>
<td>~$8.2</td>
<td></td>
</tr>
<tr>
<td>LIBTAYO (cemiplimab-rwlc)</td>
<td>~$445M</td>
<td></td>
</tr>
</tbody>
</table>

- However, PD-1 inhibitors alone have not shown significant survival benefits in PDAC


2022 Revenues: ~$20.9B
Approvals in melanoma, NSCLC, HNSCC, cHL, PMBCL, others

2022 Revenues: ~$8.2
Approvals in melanoma, NSCLC, KC, LC, CRC, melanoma, others

2022 Revenues: ~$445M
Approvals in NSCLC, CSCC, BCC, others
Immune Checkpoint Inhibitors (ICIs) Bring Survival Benefits, But Much Less Effective in PDAC to Date

↔ PDAC has:
• Lower PD-1/PDL-1 expression (green)
• Lower CD8 expression (yellow)
• More FOXP3+ Treg cells (red)

Additional Issues with ICIs in PDAC¹:
• PDAC is immunologically “cold” cancer: less T-cell infiltration, which ICI needs
• PDAC creates highly immunosuppressive tumor microenvironment (TME)
• PDAC often has dense stromal tissue barrier, acts as physical barrier

Potential for Anti-PD1 in PDAC

• However, recent studies suggest PDAC mutates to use PD-1 in response to chemotherapy

SWOG S1505: Results of Perioperative Chemotherapy with mFOLFIRINOX vs Gemcitabine/nab-Paclitaxel for Resectable Pancreatic Ductal Adenocarcinoma

• PD-L1 induction observed on tumor epithelium following neoadjuvant chemotherapy

Multiplex immunofluorescence staining of PDACs following neoadjuvant geme/abrax. CD 8 Yellow; FOXP3 Red; CD68 Magenta; PD-1 Cyan; PD-L1 Green; Keratin Orange; DAPI. Note that PD-L1 expression (in green) on tumor epithelium was induced following neoadjuvant chemotherapy

• CXCR4 is an alpha-chemokine receptor specific for stromal-derived-factor-1 (SDF-1)
• CXC4 overexpressed in 23 different solid tumor types, including pancreas

Data to date shows:
• PDAC patient CXCR4 expression negatively correlates with overall survival
• Exceptional responders to PDAC chemotherapy have lower CXCR4 expression
• CXCR4 inhibition potentiates Anti-PD-1 therapies in animal models

• CXCR4 could enable ICI treatment in PDAC

CXCR4 Inhibition Results in:

1. Reduced Metastasis:
   - Fewer tumor cells into the circulation, fewer metastases
   - Inhibition of epithelial-to-mesenchymal transition
   - Reduction of tumor stemness

2. Immune suppression \rightarrow Immune cell activation:
   - Reduction of immunosuppressive cells (e.g., Treg, MDSC, cancer-associated fibroblasts)
   - Increase of tumor-eliminating cytotoxic T cells

3. Inhibited angiogenesis:
   - Smaller and less blood vessels in the tumor leading to reduction of tumor blood supply
   - Preventing entry of endothelial progenitor cells and differentiation
# Spexis Executive Management & Board of Directors

## Highly Experienced Team

<table>
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<tr>
<th>Name</th>
<th>Position</th>
<th>Experience Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jeff Wager, MD</td>
<td>CEO &amp; Chairman</td>
<td>30 yrs VC &amp; CEO leadership; $2.5B in value created since 2000</td>
</tr>
<tr>
<td>Hernan Levett</td>
<td>CFO</td>
<td>25+ yrs financial leadership in pharma / biotech</td>
</tr>
<tr>
<td>Juergen Froehlich, MD</td>
<td>Consulting CMO</td>
<td>30+ yrs Chief Medical Officer &amp; senior reg affairs experience</td>
</tr>
<tr>
<td>Dennis Ausiello, MD</td>
<td>Vice Chair of the Board</td>
<td>17yrs Physician-in-Chief, MGH 8 yrs lead director of the Pfizer board</td>
</tr>
<tr>
<td>Kuno Sommer, PhD</td>
<td>Director</td>
<td>Former CEO, Berna Biotech (acq. by J&amp;J) Chairman Bachem, Sunstar, Targimmune, more</td>
</tr>
<tr>
<td>Robert Clarke, PhD</td>
<td>Director</td>
<td>20+ yrs inhaled R &amp; D and CEO experience</td>
</tr>
<tr>
<td>Dan Hartman, MD</td>
<td>Director</td>
<td>25+yrs R &amp; D leadership; Head of $2B Gates malaria R &amp; D portfolio</td>
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<tr>
<td>Bernard Bollag, MBA</td>
<td>Director</td>
<td>Senior finance executive across corporate finance &amp; capital markets</td>
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Near-term and multiple value inflection points

CF therapeutic proposition addresses important and growing need

Two CF/nCFBE clinical candidates
- ColiFin® – starting Phase 3 2H2023 contingent on next financing or corporate partnership
- Inhaled murepavadin (iMPV) – positive Phase 1 data reported in Jan 23

Balixafortide (BLX)
- 8 clinical trials to date; >500 subjects dosed; under evaluation for additional oncology & rare disease indications
- Pancreatic ductal adenocarcinoma (PDAC) now selected as next clinical development priority

Proprietary macrocycle platform poised to build pipeline and fuel corporate partnerships
- Result of >$400M prior investment & multiple alliances
- iMPV, BLX & lonodelestat generated by our macrocycle platform; ColiFin® (in-licensed from PARI) also a macrocycle
- Highly leverageable towards other extracellular, intracellular & protein-protein interaction targets
- Ideal for targeting protein-protein interactions, molecular glues and targeted therapies
**Hegenheimermattweg 125**  
CH-4123 Allschwil, Switzerland

### Key Contact Information:

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