FARON

ACTIVATE YOUR BODY TO DEACTIVATE CANCER

Faron's Capital Markets Day, 22 October 2024

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Today's agenda and presenters

Faron's role now and in the future in the development of *bexmarilimab*

Juho Jalkanen, CEO, Faron

BEXMAB r/r MDS follow-up data on previously reported patients

Mika Kontro, Principal Investigator of the BEXMAB trial, HUS

Results of MDS Market Research

Ralph Hughes, PharmaVentures

Establishing *bexmarilimab* as a cornerstone treatment for solid tumors

Petri Bono, CMO, Faron

Who benefits from *bexmarilimab* and why?

Maija Hollmén, CSO, Faron

Closing remarks

+ final Q&A session

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Leadership focused on delivering value to patients and investors

The key people working for you 24/7

Juho Jalkanen
CEO

Maija Hollmén
CSO

Yrjö Wichmann
CFO

Petri Bono
CMO

Turku, Finland
Global Headquarters

24
Employees

2007
Year Founded

TYKS Turku University Hospital · frontiers · University of Turku · ETH zürich · FibroGen · BIOTIE THERAPIES · CapMan · BIOHIT · Massachusetts Institute of Technology · HUS Helsinki University Hospital · Terveystalo

What have we delivered in the past 6 months

- We've raised > €30 million and become a financial healthy and well traded stock
- We've continued to produce exceptional Phase 2 clinical results in r/r MDS and are on track to complete Phase 2 enrolment
- We've obtained excellent regulatory (FDA) feedback concerning our registrational study plans with Fast Track Designation and accelerated approval possibilities in both r/r and frontline HR MDS with one single Phase 3 study
- We've delivered the option to partner at this stage
- We've become the leading macrophage re-programming agent in the industry

And you thought that we would stop here…

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Faron’s role now and in the future in the development of *bexmarilimab*

Juho Jalkanen
CEO, Faron

A leading cause of death

CANCER

Why does cancer kill?

TREATMENT RESISTANCE

A leading cause of treatment resistance

MACROPHAGES

A master regulator of macrophages

CLEVER-1

The best drug candidate for CLEVER-1

BEXMARILIMAB (BEX)

What do we aim to achieve?

Our purpose is to establish Bex as a cornerstone drug for cancer, in ALL indications where CLEVER-1 macrophages are a source of treatment resistance and cancer progression.

What does this mean?

This means possibly being able to help

20-30%

of all cancer patients.

How do we aim to achieve this?

1.

Best achieved with a series of smart and cost-effective Phase 2 proof-of-concept (PoC) studies.

2.

Phase 3 studies are done in partnership with commercial big pharma companies.

3.

Faron is ideally suited to accomplish this with its knowhow, people and resources.

4.

The more proof-of-concept data Faron generates, the higher the return is to shareholders.

Faron's strategy

A balance of de-risking the made investments and retaining future value of *bexmarilimab*

Become revenue generating with data from MDS

- Partnership(s) and first approvals

Expand by generating PoC Phase 2 data in new indications

- Both in blood cancers and solid tumors

New Phase 2 studies will be primarily ran using funds obtained through deals and partnerships

- A tiered approach until resources enable parallel development in multiple indications and settings at the same time

New Phase 2 studies will commence depending on available resources, clinical importance and market opportunity, i.e. non-competitive areas with clear unmet need

The next business decisions we make will be crucial in how the value and future of *bexmarilimab* is divided

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Q&A

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BEXMAB r/r MDS follow-up data on previously reported patients

Mika Kontro
Principal Investigator of the BEXMAB trial, HUS

The prognosis of myelodysplastic syndrome (MDS) that has not responded or has relapsed on standard care (r/r MDS) is poor

Large population of patients[1)]

~180-510K people globally live with MDS

New diagnoses are growing as the population ages

No viable treatment options for r/r MDS[2)]

50% of patients will not respond to hypometylating agent (HMA)

Of the 50% who respond, 80% will relapse within 1-2 years

r/r MDS patients are symptomatic and have a poor prognosis for survival

Patients suffer from and need…

- anemia
- infections
- frequent hospitalizations
- transfusions

r/r MDS patients have…

5.6 months to live (median overall survival)[3)]
10-15% 2-year survival rate[2)]

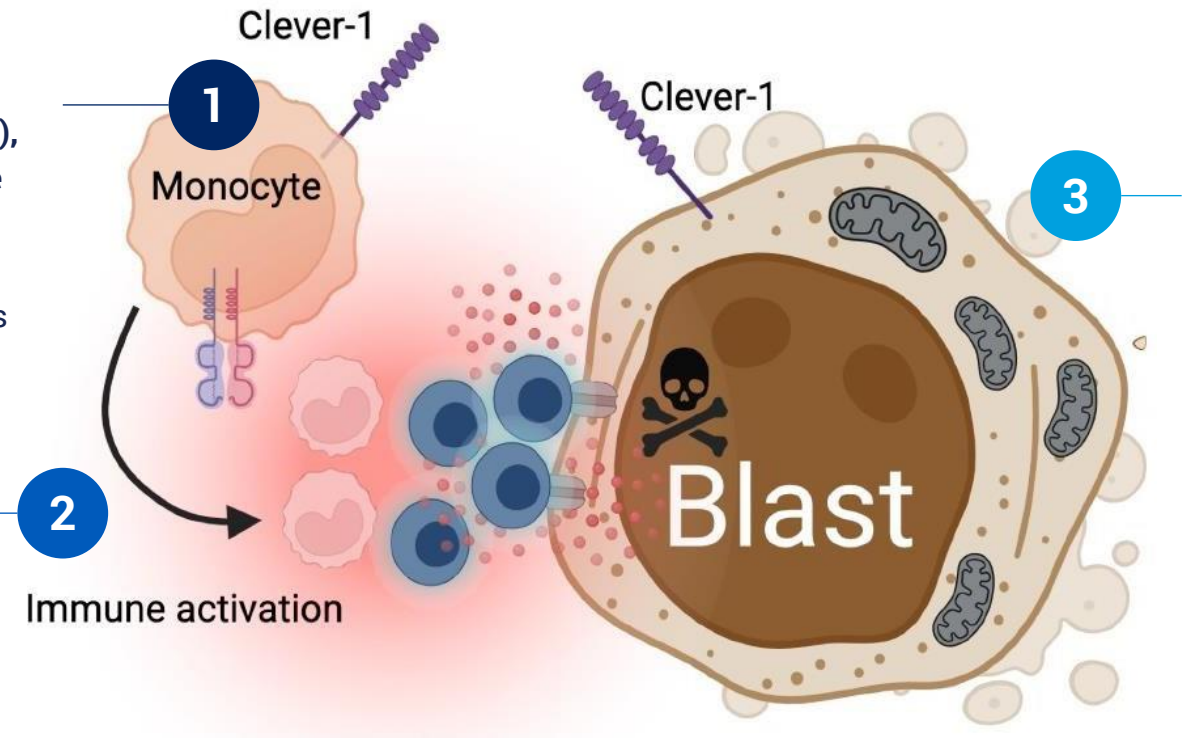
Source: 1) GlobalData® report "Myelodysplastic Syndromes: Opportunity Analysis 2018-2028" (May 2020 2) Fenaux et al. 2021 Myelodysplastic syndromes: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up 3) Prébet, et al. 2011 Outcome of high-risk myelodysplastic syndrome after azacitidine treatment failure

Bexmarilimab's (anti-CLEVER-1 mAb) mechanism of action to treat r/r MDS

A novel dual mechanism of action that activates your cells to deactivate cancer

● ***Bexmarilimab*** **targets the CLEVER-1 receptor on immune cells (monocytes), reprogramming them from an immune suppressive to an immune activating state.** Monocytes are responsible for eliminating infected or cancerous cells

● **Change in the state of monocytes activates the immune system, which enables the immune system to find and destroy cancer cells**



● ***Bexmarilimab*** **deactivates the energy production of the cancer cells.** This enables existing therapies, which previously did not work, to destroy cancer cells

Source: Hirayama, Iida & Nakase 2017 The Phagocytic Function of Macrophage-Enforcing Innate Immunity and Tissue Homeostasis; Gonzalez, Hagerling & Werb 2018 Roles of the immune system in cancer: from tumor initiation to metastatic progression; Kim & Cho 2022 The Evasion Mechanisms of Cancer Immunity and Drug Intervention in the Tumor Microenvironment; Mantovani & Bonecchi 2019 One Clever Macrophage Checkpoint; Hollmen et al. 2022 Nonclinical Characterization of Bexmarilimab, a Clever-1-Targeting Antibody for Supporting Immune Defense Against Cancers. Molecular cancer therapeutics

BEXMAB trial design

BEXMAB Doublet

Study design: Phase I/II Study Evaluating *Bexmarilimab* with Standard of Care

Dose Finding (Phase I) → **Efficacy Evaluation (Phase II)**

POPULATION

Frontline HR MDS / CMML

r/r AML

MDS / CMML failed HMA-based therapy

DOUBLET

azacitidine
+ *bexmarilimab*

1st line MDS

Expansion chort (n=20)

Phase 2 doses

r/r MDS (n=32)

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BEXMAB Study Sites

Clinical Investigators (Finland)

Mika Kontro, MD/PhD (Associate Professor, Department of Hematology, Helsinki University Hospital Comprehensive Cancer Center, Helsinki, Finland)

Marja Pyörälä, MD/PhD (Department of Medicine, Kuopio University Hospital, Kuopio, Finland)

Johanna Rimpiläinen, MD (Department of Internal Medicine, Tampere University Hospital, Tampere, Finland)

Timo Siitonen, MD/PhD (Department of Medicine, Oulu University Hospital, Oulu, Finland)

Clinical Investigators (US)

Naval Daver, MD (Professor, Department of Leukemia, Division of Cancer Medicine, MDACC)

Antony Stein, MD (Professor, Division of Leukemia, Department of Hematology & Hematopoietic Cell Transplantation, CoH)

Amer Zeidan, MD (Associate Professor, Yale)

Joshua Zeidner, MD (Associate Professor, Chief Leukemia Research, UNC)

↗ **Two additional UK sites to open in Nov24**

BEXMAB Study
Emerging Biomarker Data

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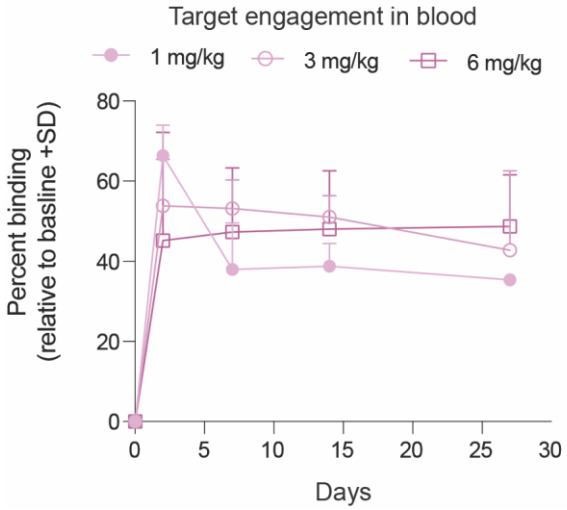
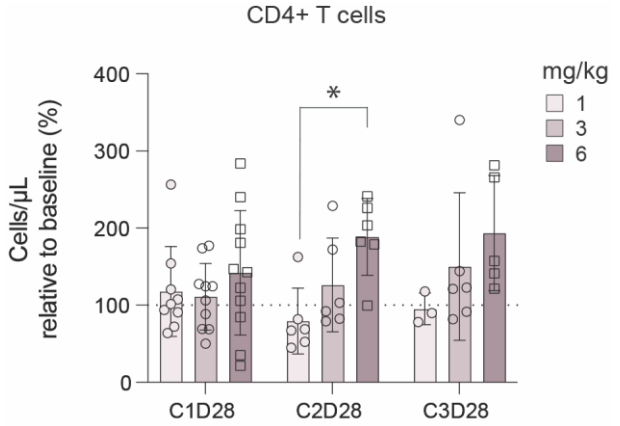
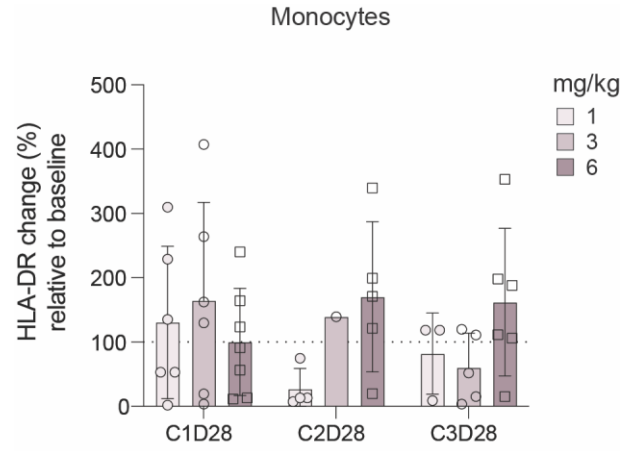
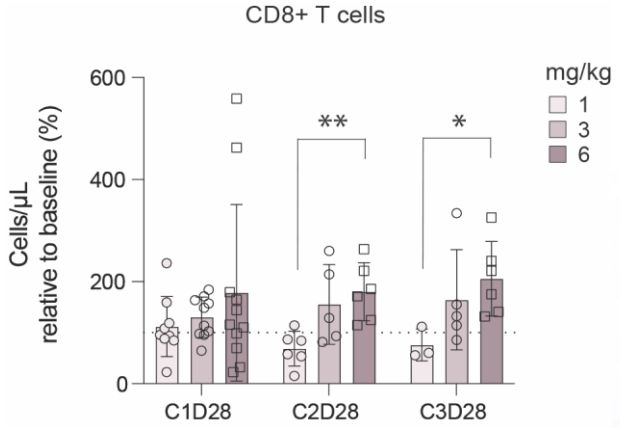
Bexmarilimab increases antigen presentation and lymphocyte numbers in the bone marrow









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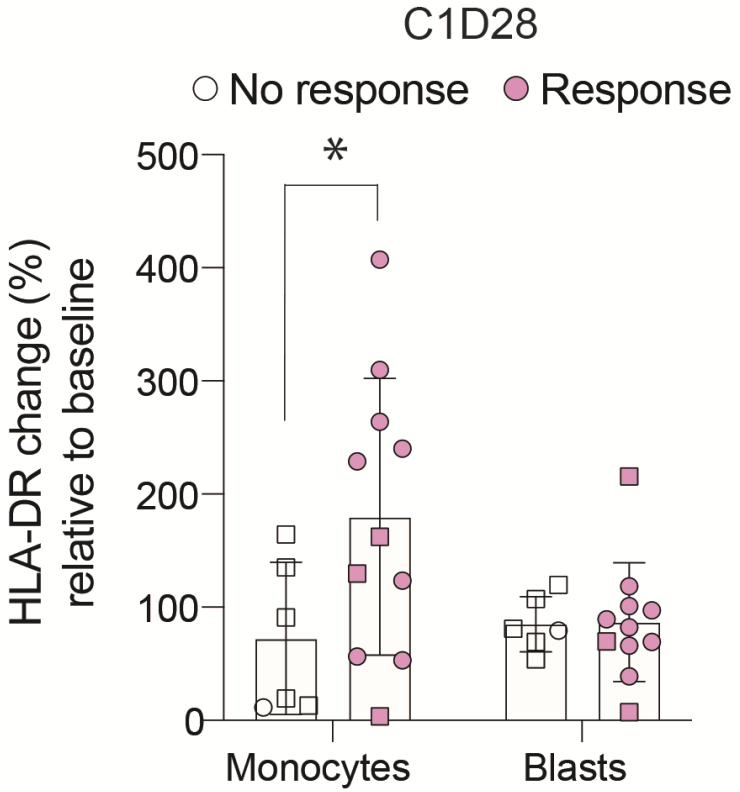
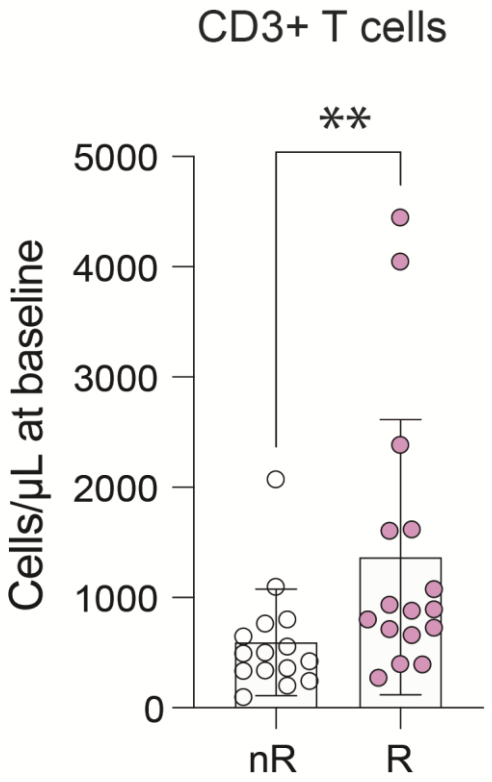
Biomarkers for patient selection and efficacy





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BEXMAB Study
Emerging Safety and Efficacy Data

Bexmarilimab-related adverse events were rare and all Grade 1-2
Data Cut-off Oct 4, 2024

- Only 4 *bexmarilimab*-related adverse events in 3 patients
  - Nausea (1), peripheral oedema, limb (1), pyrexia (1), infusion-related reaction (1)
- All AEs of Grade 1 and 2; none of Grade 3-5
- These patients had also 21 serious adverse events (SAEs) but none of them were considered *bexmarilimab*-related.

Primary System Organ Class	Dictionary-Derived Term	Total (N=14) n (%) f RELATED ALL AEs	Total (N=14) n (%) f RELATED GRADE 3-5
ANY AE	ANY AE	3 (21.4) 4	0 (0.0) 0
Gastrointestinal disorders	Nausea	1 (7.1) 1	0
General disorders and administration site conditions	Oedema peripheral	1 (7.1) 1	0
	Pyrexia	1 (7.1) 1	0
Injury, poisoning and procedural complications	Infusion related reaction	1 (7.1) 1	0

Positive r/r MDS results in on-going Phase 2 trial

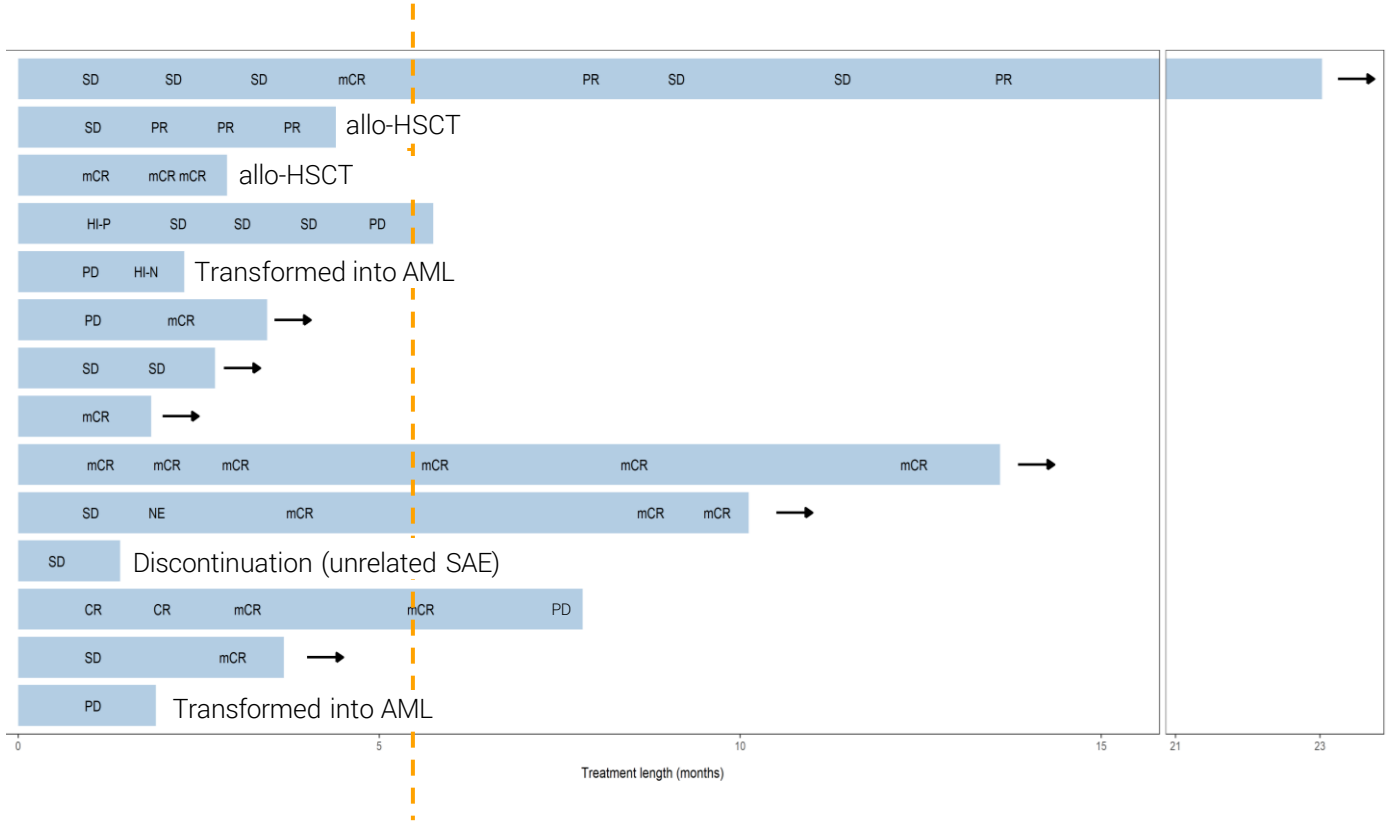
May '24 update

☑ **Majority of responses are deep and durable[1)]**

9 out of 14 r/r MDS patients have achieved treatment response allowing two patients to undergo a stem cell transplant[1)]

☑ **Extended survival**

For Phase 1 patients with adequate follow-up the estimated median overall survival (mOS) at the moment is 13.4 months (subject to still change)[1)]



Source: 1) Faron press release titled "Faron Reports Initial Positive Phase 2 Read-out in HMA-resistant MDS" (2024)

Positive survival results continue in Oct '24 update

Median follow-up of r/r MDS patients increased (from 135 to 275 days)

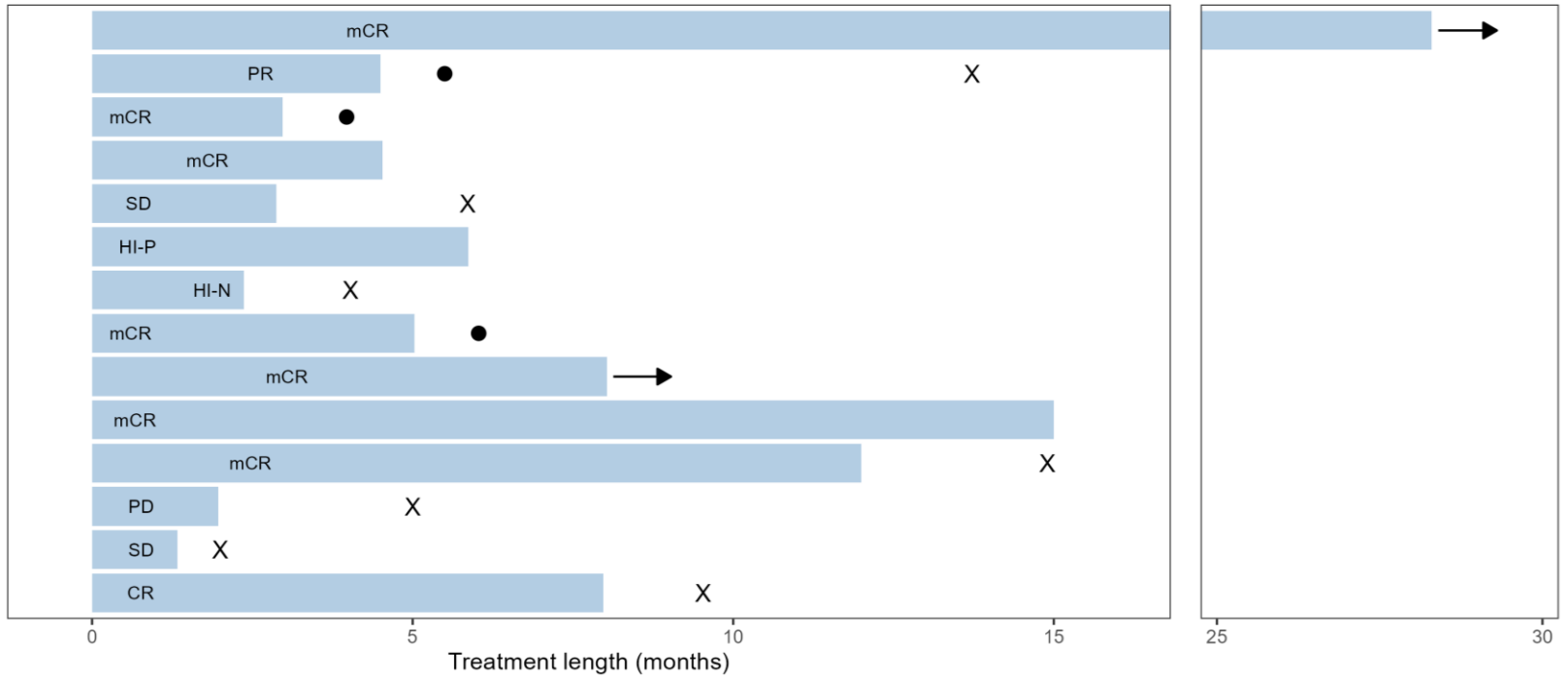
☑ **Majority of responses are still deep and durable[1)]**

8 out of 14 achieved marrow responses (CR or mCR)

Altogether 11 out of 14 r/r MDS patients have achieved treatment response allowing three patients to undergo a stem cell transplant[1)]

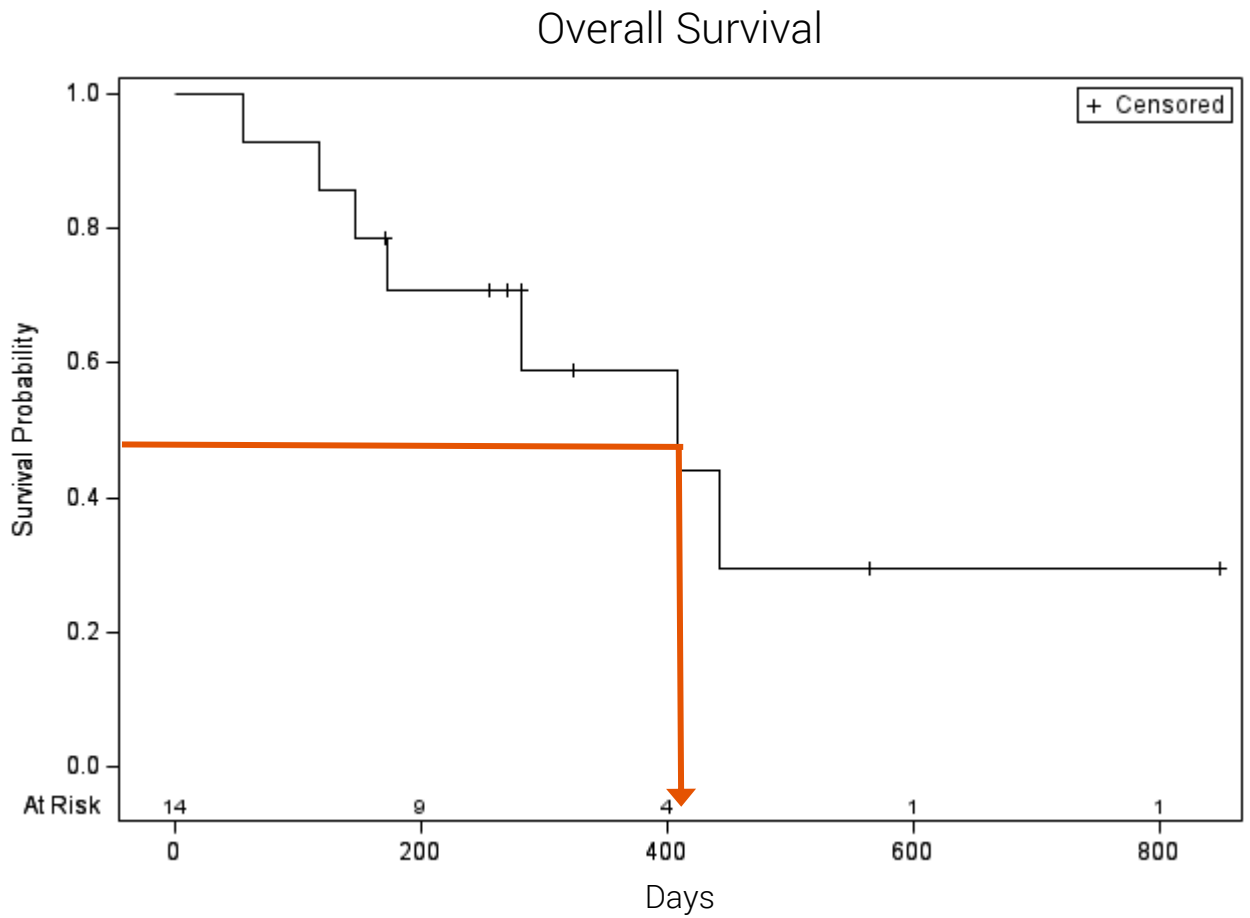
☑ **Extended survival after median 9.1 month follow-up**

Estimated median overall survival (mOS) unchanged 13.4 months [2)]



Source: 1) Faron press release titled "Faron Reports Initial Positive Phase 2 Read-out in HMA-resistant MDS" (2024) 2) Faron press release titled "Faron's Capital Markets Day 2024 – BEXMAB follow-up data and update on drug development pipeline" (2024)

Long overall survival for BEXMAB r/r MDS patients, N=14



- Median OS 13.4 months (historical for r/r MDS 5-6 months)
- Median time on *bexmarilimab* treatment for r/r MDS 7.9 months


Q&A

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Results of MDS Market Research

Ralph Hughes
PharmaVentures

FARON

PharmaVentures

KOL and Payer Insights on *Bexmarilimab*

October 2024

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We operate across all therapy areas and life science sector. We have transacted assets with a wide variety of modalities and stages of development. Our flexibility is enabled by many of our senior colleagues coming from industry and bringing decades of experience.

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We operate globally and have a wide network of pharma and biotech worldwide. We frequently communicate with all the leading pharmaceutical companies as well as many of the medium and smaller players. Our network covers not only global and regional BD teams, but also key decision makers in R&D and management.

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Indication Prioritisation

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Valuation & Deal Strategy

Pricing & Market Access

Payer Landscape

Expert Consultation

Price Modelling

Asset Positioning

M&A

Company Sales & Divestments

Product & Company Acquisitions

Sell Side Due Diligence

Buy side Due Diligence

PharmaVenture's Task

PV were commissioned to review the TPP for *Bexmarilimab* with KOLs and payers to determine the likely uptake and price and access.

We also developed an epi model to understand the likely patient numbers and market size.

The information provided here is not investment or financial product advice and is not intended to be used as the basis for making an investment decision.

Scope

In this report, PharmaVentures assessed the market access landscape and pricing potential for *bexmarilimab* with payers in US, Germany (DE) and France (FR).

Views on *bexmarilimab*'s Target Product Profile (TPP), clinical results to date, potential positioning in the treatment pathways and likely adoption rates were also explored with KOLs from US, DE and Spain.

KOLs

We engaged with 4 hematologists based in the US, Germany, and Spain.

These specialists have extensive experience in both patient care and research. They actively manage a high volume of patients with MDS and AML and have been involved in clinical trials for drugs targeting these conditions.

All of them are affiliated with large university hospitals.

Payers

We engaged with 8 payers across the US, France, and Germany.

In the US, payers included a mix of Pharmacy and Medical Directors from major PBMs, insurance companies, and healthcare providers.

In Germany and France, we primarily engaged national payers with prior involvement in formulary approval and policy development for AML and MDS.

Epidemiology

We developed an epidemiology based patient forecast based on global data projected forward using incindence data and population statistics.

The model additionally layers in eligibility criteria, diagnosis and treatment rates so that we can determine the patient numbers likely to receive *bexmarilimab*

PBMs: Pharmacy Benefit Managers.

Market Overview

Epidemiology based patient flow for MDS is highly complex due to multiple lines of therapy and cannibalisation of second line by first line and anaemia status

Patient Flow Dynamics

The epidemiology model identifies incident patients only in US and EU5.

The target patient population are patients that are diagnosed, symptomatic and treated 1L. Then patients are moving to a 2L setting. LR MDS patients also progress to HR MDS.

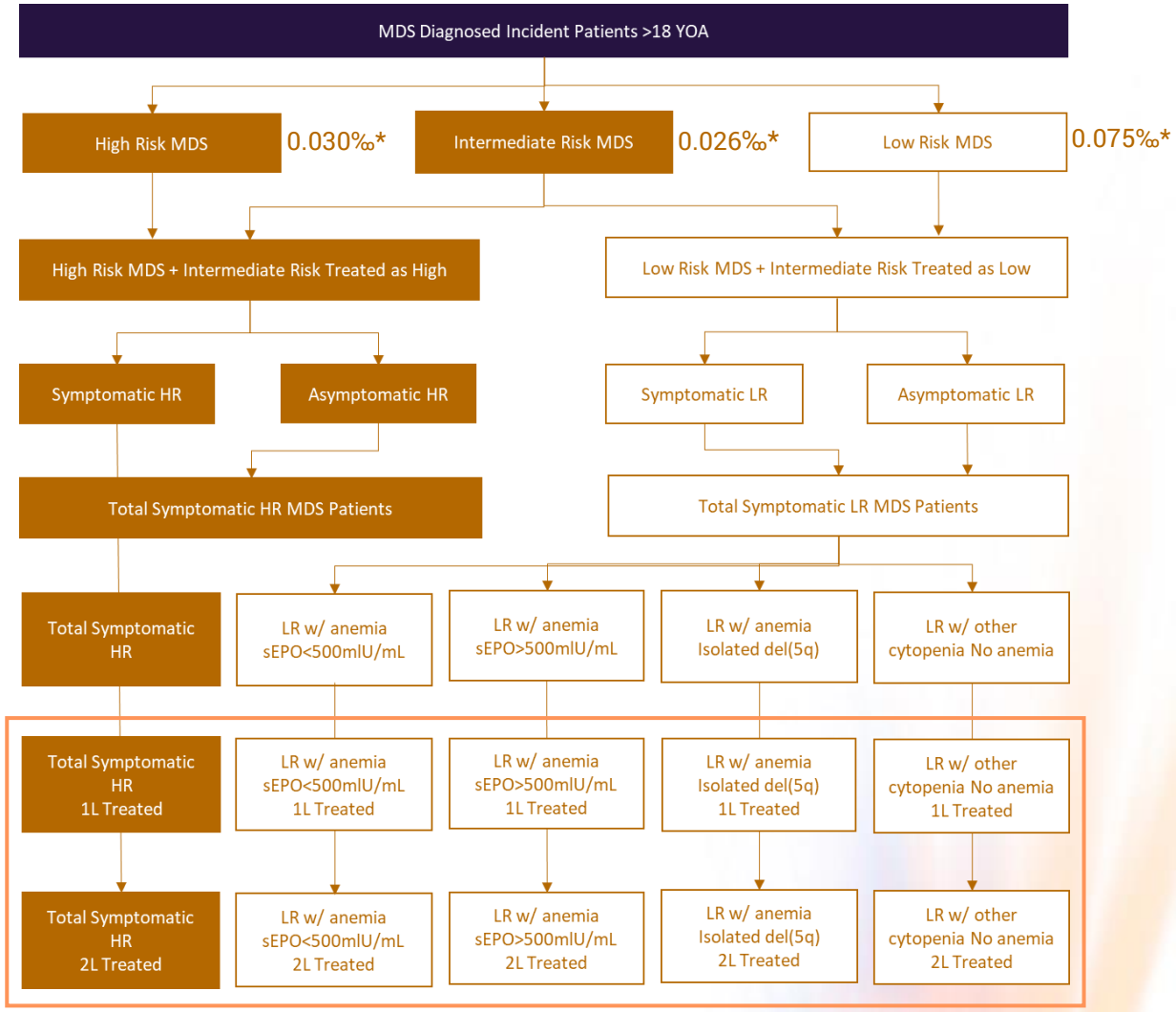
The model is therefore capturing 4 MDS sub indications as well as maintenance and induction therapy and cannibalisation between 1st and 2nd lines of treatment as *bexmarilimab.*

Patients that are receiving all types of treatments are included in the target patient population.

- HMA, low-intensity therapy, high-intensity therapy for HR MDS.
- ESA, HMA, low-intensity therapy, anti-anemia therapy for LR MDS.

For LR MDS, all subtypes of LR MDS are included regardless of anemia status, sEPO, cytopenia or presence of del(5q).

The source of the epidemiology model is GlobalData® report "*Myelodysplastic Syndromes: Opportunity Analysis 2018-2028"* (May 2020).



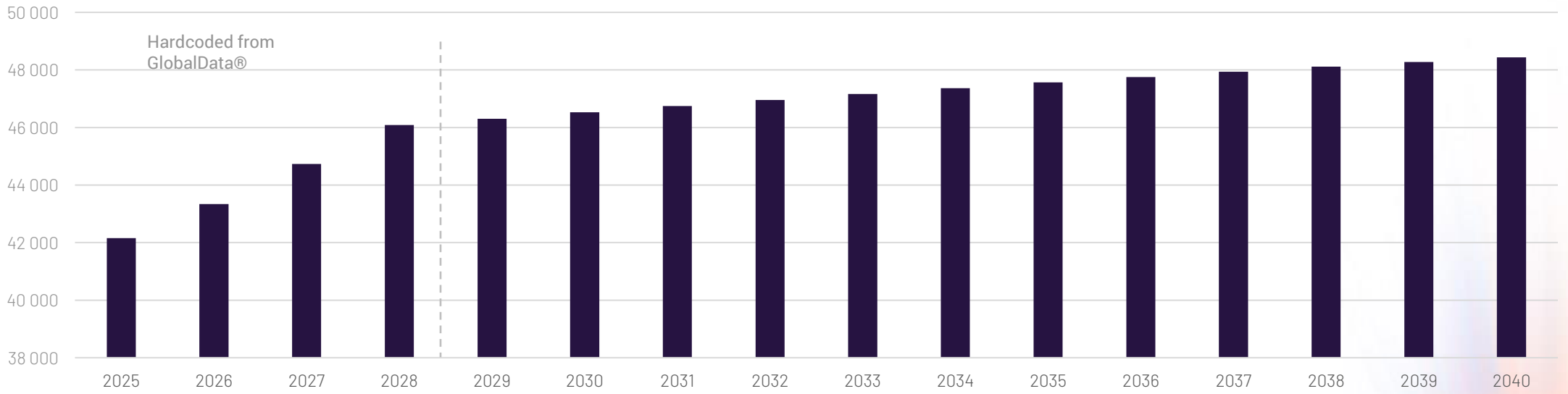
*2028 diagnosed MDS incident patients based on IPSS-R risk category in the USA (Globaldata®) per 1000s.

GlobalData® MDS Epidemiology

- PharmaVentures used the GlobalData® report on MDS which is a patient-based analysis with data from primary sources, KOL insights and prescribers' surveys.
- The epidemiology period is limited to 2028. After 2028, the forecasted incidence is based on 2028 incident ratios to each region total population.

- PV's patient-based model is dynamic i.e. in year and incident patients are being treated and moving from a 1L setting to a 2L treatment.
- Because of prolonged survival, LR MDS patients are likely to be underestimated in the model as prevalent patients are not included.

MDS Diagnosed Incident Cases in the USA



Generic HMAs are typically low-cost. Expensive MDS drugs include oral medications and targeted therapies. Treatments for LR MDS, such as Rytelo and Reblozyl, also come with high monthly expenses.

Category	Intervention type	US Price Anchors	US Monthly Costs*	EU Monthly cost*
All MDS	HMA	Price of generic HMA (per month)	$158	€444
		ONUREG™ (azacitidine) tablets 300 mg • 200 mg	$25,885	€17,859
		Vidaza®	$2,000	€2,000
	Venetoclax	VENCLEXTA® venetoclax tablets 10mg, 50mg, 100mg	$11,000	€5,000
	Targeted therapies (MDS specific)	Ivosidenib	$20,672	NA
Low-Risk MDS	Rytelo	RYTELO™ (imetelstat) for Injection 47 mg 188 mg	$25,000	NA
		ICER estimated RYTELO price	$10,000	NA
	Reblozyl	Pr Reblozyl® luspatercept for injection	$23,000	NA
	Erythropoietin stimulating agents	Epogen (epoetin alfa)	$7,000 – $11,000	€1320 - €2000
Resource costs	Transfusions	Monthly cost of transfusions	~$4,000	~€2,000
	HSCT	hematopoietic stem cell transplantation	~$300,000	~€100,000

Sources and calculations available upon request

KOLs

Although most patients receive treatment, half fail to respond to 1st line treatment and most stop responding within 2 years. Therefore, improved response rates, duration of response and overall survival were seen as the biggest unmet needs in HR MDS

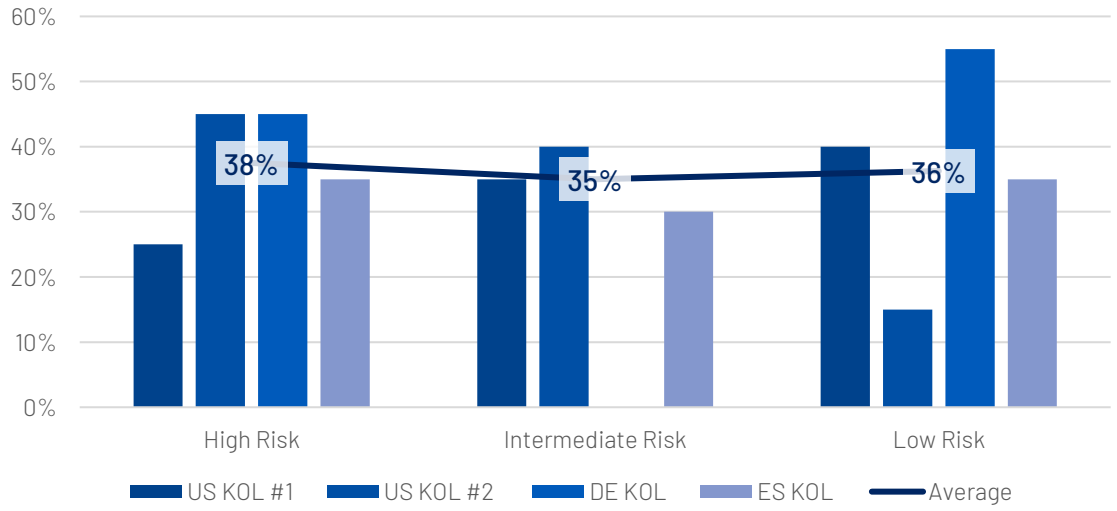
"overall responses [to 1st line treatment in HR patients] with standard treatment of about 40 to 50% and a CR, complete remission rate of about 20, 30%. So there are 50% of patients who will be refractory to treatment."

US KOL #1

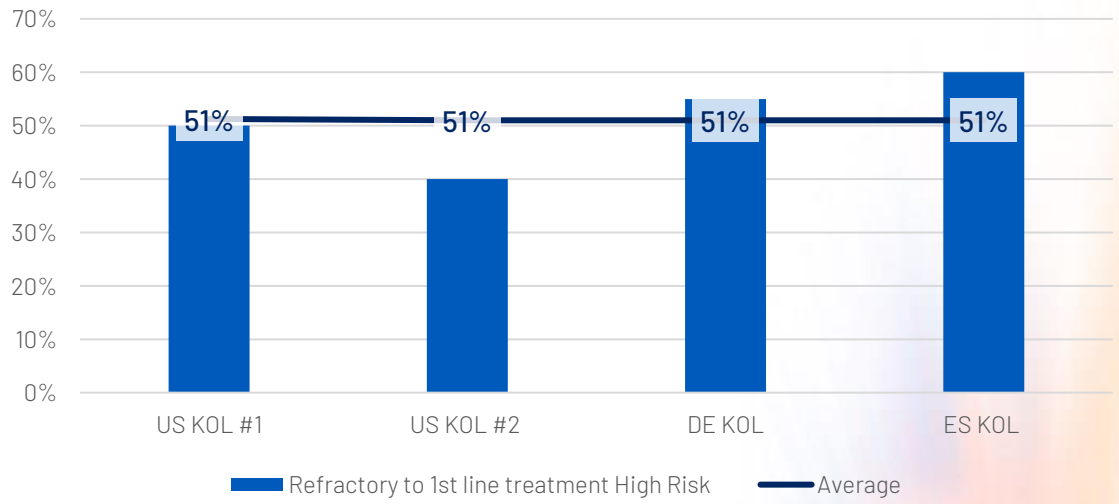
"there are a lot of limitations in MDS because for intensive chemotherapy, for example, it's that the CR rate in general for intensive chemotherapy is very low in MDS compared to AML…..The response rate to HMAs alone and the duration of response are not great. And after HMAs, it seems really that the response rates to anything are very low to non-existent."

DE KOL

KOL defined distribution of populations



KOL estimates of patients refractory to first line



Source: KOL responses

All KOLs agreed that meeting the CR rates in the TPP for *bexmarilimab* in both 1st line and r/r HR patients would represent a significant improvement on current SoC.

> *"Those are very high numbers. It's very promising. The sample size is just a little bit small…..So I would favour expanding this to more patients and seeing if that response rate is still there. But, you know, it looks very good so far based on how this slide is looking.*
>
> US KOL #2

> *"the new standard of care will be the combination of azacitidine plus [Product] X, with these results".*
>
> ES KOL

> *"objectively they are impressive response rates and my hope is that it would improve survival.*
>
> US KOL #1

KOL	80% CR rate in 1st line HR	CR rate of 20% in r/r HR	4 month improvement in OS	Other comments
US KOL #1	*"Very impressive endpoint depending on how CR is defined"*	*"Good target"*	*"Reasonable and hopefully achievable"*	*"HMA venetoclax combination in the Phase 1 studies, the composite CR rates are around 80%"*
US KOL #2	*"High number"*	*"High number"*	Did not comment	*"Achieving an improvement in overall survival compared to **current standards is one of the most important clinical endpoints"***
DE KOL	*"80% of course is very high"*	*"20% is not a poor rate because it's very difficult to achieve CRs in this patient population"*	Did not comment	*None*
ES KOL	*"80% would be amazing, has never seen 80% response in 1st line"*	*"Good, as very low% currently respond to 2nd line"*	*"4 months improvement over azacitidine alone is reasonable"*	*"Would need to be very well tolerated with no added toxicity and no impairment to quality of life."*

Bexmarilimab was viewed as having most potential benefit as 1st line treatment in high risk MDS, where the majority of patients could be eligible, depending on comparison to venetoclax.

KOLs expressed the opinion that although it may be easier to demonstrate a benefit in clinical trials in r/r MDS as the current response rate is so low, from a patient perspective the combination of *bexmarilimab* + azacitidine would be best positioned in 1st line, as once patients had relapsed on HMA therapy, they were generally very unresponsive to subsequent therapies.

All KOLs mentioned the need to demonstrate superiority over venetoclax, otherwise use would be limited to patients not suitable for, or had failed, venetoclax.

One KOL mentioned patient populations where venetoclax doesn't probably add much includes patients with p53 disease, complex karyotypes, HMA refractory or HMA pre-exposed.

	Potential Percentage of Eligible Patients		
KOL	1st line HR	r/r HR	Other comments
US KOL #1	80-90% transplant eligible 50-60% transplant ineligible	Same % as in 1st line	Until more data is available, may use only in venetoclax unsuitable pts.
US KOL #2	70-80%	90% pts who haven't received frontline	Positioning vs venetoclax depends on toxicity profile
DE KOL	Most patients if it is superior to venetoclax	Most patients	Comparison to venetoclax: If no better, would only be used in the approx. 20% of patients where venetoclax combo is not tolerated
ES KOL	85-90%	80-90%	Needs venetoclax and azacitidine comparator, not azacitidine alone
Average	**~75%**	**~84%**	Rough calculations based on midpoints and estimates of "most patients"

All KOLs agreed that *bexmarilimab*'s Mechanism of Action was encouraging and that immune modulation was a promising approach in MDS.

The KOLs were not familiar with Clever-1 as a target and had questions on selectively for leukemia stem cells or blasts over normal hematopoietic stem cells, and the mechanistic explanation for synergy with HMA, but in general viewed immune modulation as a promising approach.

The novel MoA aspect of impairing mitochondrial respiration and ability to resensitise patients to HMA were viewed very positively.

Both US KOLs mentioned that although CD47 inhibitors have shown promise in early trials, magrolimab has recently failed Phase 3 trials. The toxicity profile of magrolimab was also mentioned as causing severe anemia so some concern was expressed over the potential for checkpoint inhibitors to damage erythroid cells or erythroid progenitors.

> *"My first impression of this product profile is quite favourable. In general, it seems to be a macrophage checkpoint inhibitor similar to CD47 antibodies like magrolimab and the equivalent antibodies. And those have shown fairly good efficacy in MDS and also AML for certain mutational subsets. So I would be in favour of moving this product forward in the pipeline.*
>
> US KOL #2

> *"It sounds interesting and the experience from checkpoint inhibitors in solid tumours and also in lymphomas, in some of the lymphomas is very good, so why not? It's definitely an interesting mode of action."*
>
> DE KOL

> *"Obviously the appeal of these [immune checkpoint inhibitor] drugs without adding a lot of cytotoxicity or mild suppression is very appealing. So, I think they'll continue to get studied. And I don't think we've seen enough negative trials, I guess, to completely get rid of this mechanism of action. So, I would say like cautious optimism, you know, for the MOA".*
>
> US KOL #1

> *"Immunotherapy also in combination with azacitidine, it could be also interesting, because if the patient is resistant, perhaps with this anti-Clever-1 product, the resistance can be disappeared and could be again sensitive to the patient. I think it's a very interesting product,"*
>
> ES KOL

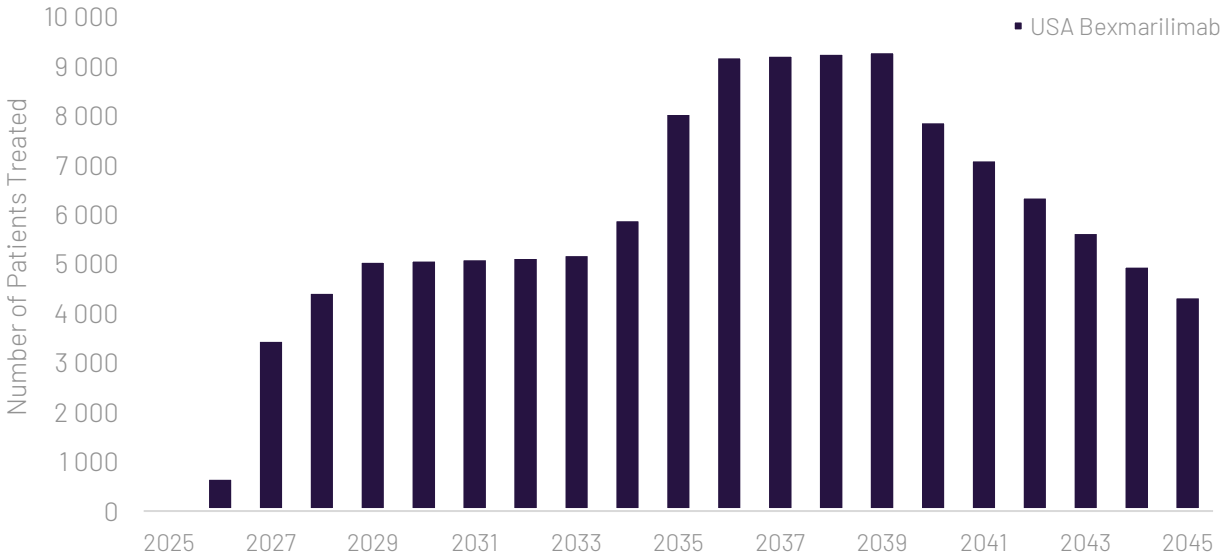
Patient Population

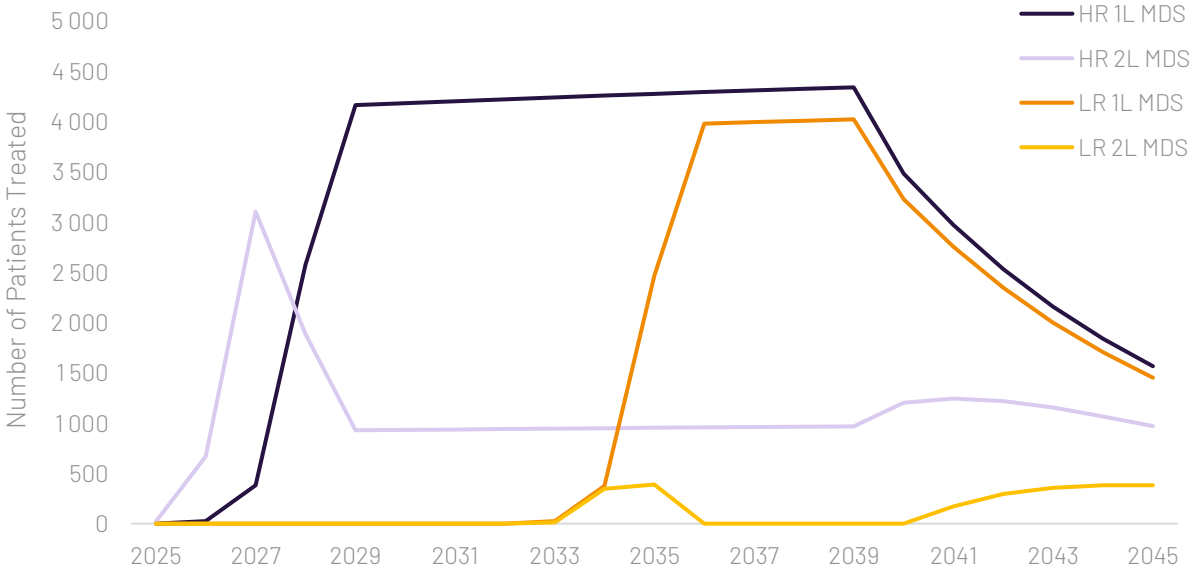
When high and low risk MDS in 1st and 2nd lines are combined, the number of patients treated by *bexmarilimab* peaks at just over 9,000 patients in the US alone in our projections

- The number of patients treated by *bexmarilimab* peaks at just over 9,000 patients in our projections.
- For 1L HR MDS, the number of patients flattens after 2032 apart from slight population growth of <1% per year as this is the year in which we have estimated peak uptake.

- The same situation can be observed with the 2L HR MDS, although the curve look different due to the cannibalisation by lines of treatment and risk status.
- The patient numbers are adjusted for compliance.
- An additional study is ongoing to confirm the uptake and market share assumptions.

Bexmarilimab patients treated (adjusted for compliance) by line of treatment over whole forecast period





Payers

Bexmarilimab can be priced similarly to Rytelo without significant hurdles in the US. However some more plans might look to reduce the price to a lower level through rebates. Prices $18k – $25k per month are realistic.

In the US, oncology drugs are typically covered by insurers. However, utilization management practices vary among insurance companies. Some apply stricter prior authorization to ensure appropriate use (#1, #4) at a high price, while others rely on verbal persuasion or value-based arrangements to guide physicians towards cost-effective options (#2, #3).

R/R MDS	US #1	US #2	US #3	US #4
$10,000/month	○	○	○	○
$14,000/month	○	○	○	○
$18,000/month	○	○	○	○
$22,000/month	○	○	○	◯
$25,000/month	◯	○	○	◯
$20,000/month	◯	○	○	◯
$30,000/month	◯	○	○	◯

Rytelo

HR MDS 1st line	US #1	US #2	US #3	US #4
$10,000/month	○	○	○	○
$14,000/month	○	○	○	○
$18,000/month	○	○	○	○
$22,000/month	◯	○	○	◯
$25,000/month	◯	○	○	◯
$20,000/month	◯	○	○	◯
$30,000/month	◯	○	○	◯

Rytelo

Legend:

○ Likely to cover

◯ Cover with higher restrictions

◯ Too expensive, unlikely to cover

NB: US payers #2 and #3 confirmed that their health plans do not impose pricing-based restrictions on drugs like *bexmarilimab*. Despite considering Rytelo's price high, they have covered it without formal restrictions. Therefore, we recommend using Rytelo as a price benchmark.

Some health plans (2/4) may use prior authorisation (PA) as a utilization tool, but it is not always employed to restrict high-cost drugs.

US #1

Prior authorization (PA) is required regardless of pricing to ensure proper diagnosis and appropriate use of *bexmarilimab* as per the label.

If priced above $22,000/month, payers will closely review patient criteria on a case-by-case basis, potentially requiring medical necessity demonstration and peer-to-peer discussions.

At $25,000, payers may also consider a value-based arrangements.

At lower prices, physicians' decisions will primarily drive utilization, with less payer interference.

Same pricing assumption can be applied to all 3 indications.

Recommended price:

$22,000/month

For all 3 indications

Management tool:

PA, value-based arrangements

"There'd be a diagnostic PA, whatever the age restrictions are, like would this be patient that has a use of other induction [or] intense therapy...frankly speaking, up to probably $22,000 category, it probably be the same for all of them [i.e. indications]. But after that, we would probably get into more case-by-case approval with appeals."

US Payer #1

US #2

The payer's health plan does not use restrictions like PA or step therapy. The decision to use *bexmarilimab* will be made by the clinician.

The payer would not restrict clinician's prescription based on the price. Coinsurance is also not used for the patients.

Regarding Rytelo, which costs $25,000/month, the payer noted it is expensive but not uncommon in the US and would consider this as the price benchmark.

The payer said they are generally confident that it will be effective if used according to the label.

Recommended price:

$25,000/month

For all 3 indications

"When we anticipate price prior to launch, it is to use a comparative bench price benchmark...and I use that to guide in my plan both actuary and finance as new products come to market...so that $25,000 price, whether I like it or not, is going to be the price that we use for a price benchmark."

US Payer #2

Most US payers (3/4) cited Rytelo and Reblozyl as good price benchmarks. Therefore, *bexmarilimab* can be priced similarly (~$25,000). Offering discounts (price at $18,000) could further reduce coverage hurdles.

US #3

Regardless of pricing, the payer would cover *bexmarilimab* as per its label.

However, they would incentivize clinicians to use lower-cost therapies if the data is similar among options. This can be achieved through value-based arrangements between health providers and the health plan.

Health plans also employ oncology benefit managers, who are oncologists monitoring the use of expensive drugs and may have peer-to-peer conversations with doctors if the chosen therapy is deemed inappropriate.

The payer mentioned potential price analogues, including Rytelo ($25,000), Reblozyl ($23,000), and Onureg ($25,885).

Recommended price:

$25,000/month

For all 3 indications

Management tool:

Value-based arrangements, benefit manager monitoring

> *"We have oncology benefit managers that review our PA requests and these are oncologists. If they see that the physician chose a drug that is a very high-cost drug, where the data doesn't look remarkably different than other treatment options, they'll pick up the phone and have a peer-to-peer discussion with the provider and ask why they chose what they chose and try to persuade them to use the more cost-effective option."*
>
> US Payer #3

US #4

Higher price for *bexmarilimab* would mean heavier PA restrictions.

Given the small patient population and numerous health plans in the US, pricing *bexmarilimab* below $18,000 would avoid heavy restrictions.

For prices above $18,000, the payer will manage usage more aggressively, restricting based on label, guidelines, clinical trial criteria, comparative data, and KOL consultations.

Rytelo and Reblozyl are good price benchmarks, and up to 10% higher pricing is acceptable according to the payer.

Recommended price:

$18,000/month

For all 3 indications

Management tool:

PA

> *"We tend to cover drugs in oncology. It's kind of rare where we say we don't cover something, but maybe just more of an onerous process to justify why you want to go to that very expensive drug...it probably starts 18 [thousand] and beyond, we start to add more ands"*
>
> US Payer #4

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the deal experts


Q&A

FARON

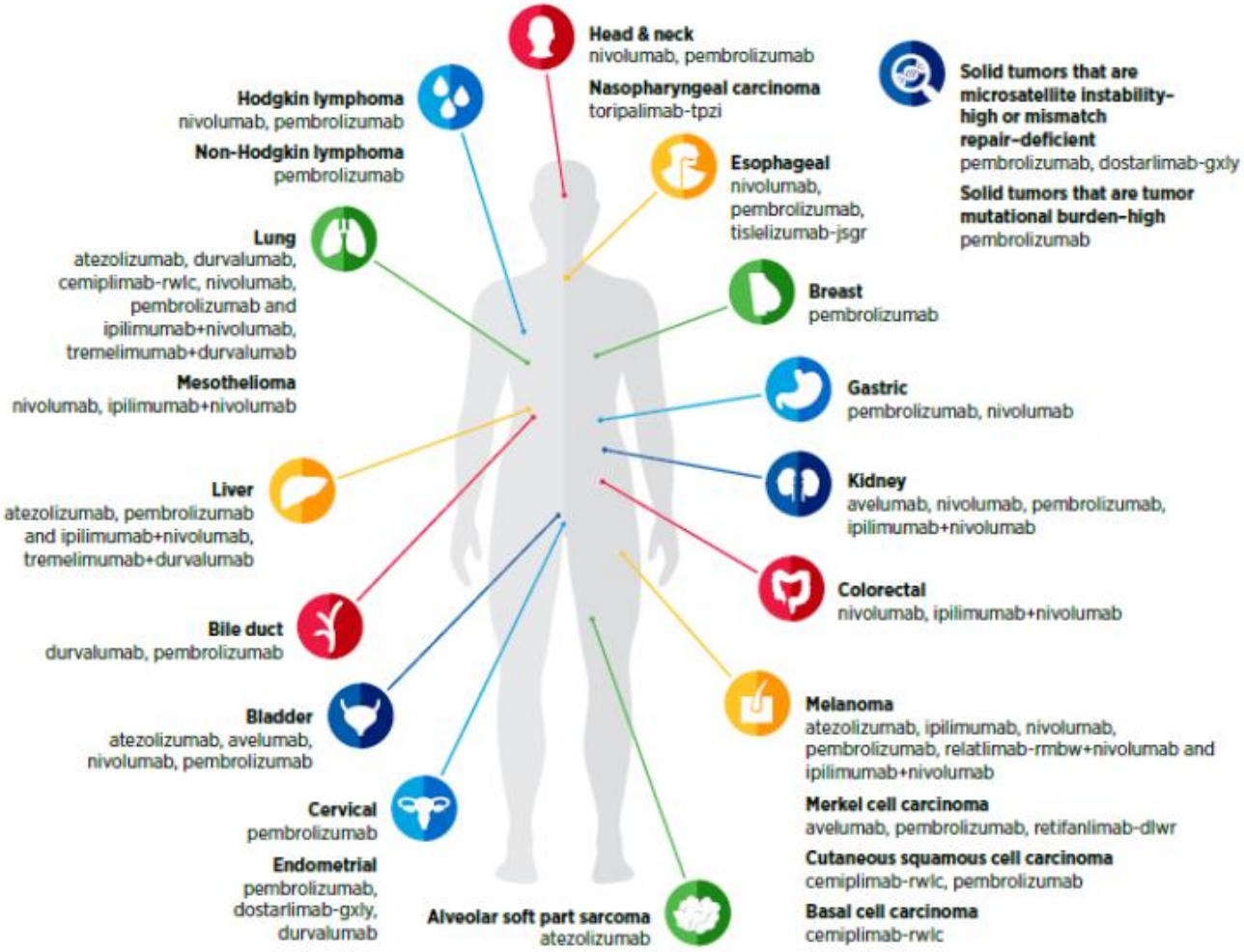
Establishing *bexmarilimab* as a cornerstone treatment for solid tumors

Petri Bono
CMO, Faron

Immunotherapy as evolving cancer treatment option

FDA has approved 13 immune checkpoint inhibitors to treat 20 different cancer types [1)]

- While immune checkpoint inhibitors have advanced cancer immunotherapy, more effective and personalized treatments are still needed
- Diversity, or heterogeneity, among cancer cells within and between tumors is a major cause of treatment resistance
- Targeting resistance mechanisms related to non-responsiveness of approved immunotherapies form the basis of improving outcome



Source: 1) AACR cancer progress report 2024

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Most patients do not derive benefit from current immunotherapies

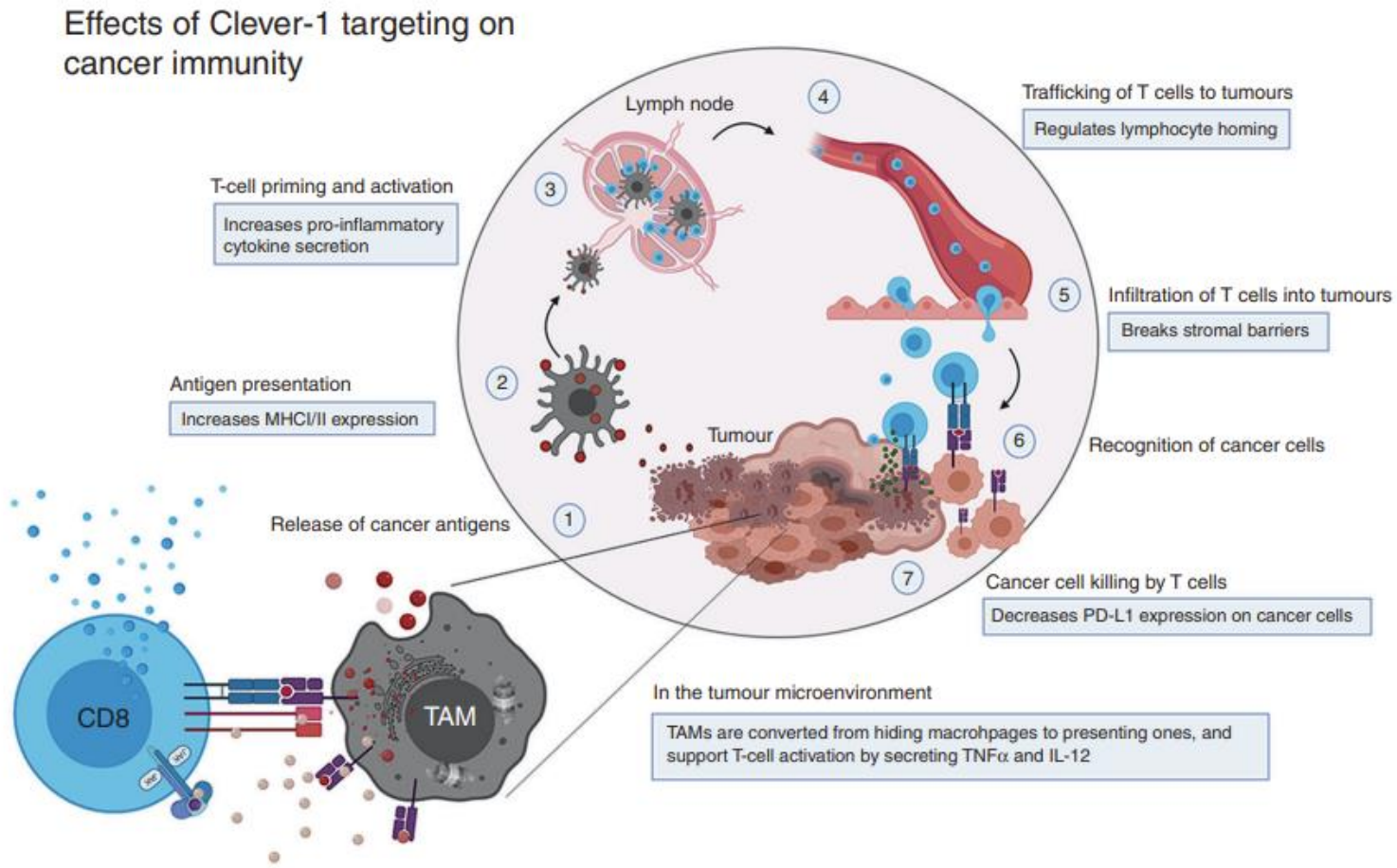
Expanding Scope of Immune Checkpoint Inhibitors

- Primary resistance is common- immunotherapies do not work in tumors with low immune activity and T-cell infiltration. Pharmaceutical companies are looking for solutions for turning cold tumors immunologically hot.
- The complexity of cancer immunity and the tumor microenvironment and the diversity of cancer types make it challenging to develop universal therapies. A more personalized approach is required.
- Macrophages are key players involved in the primary and secondary treatment resistance.
- Clever-1 is a major regulator of macrophage function and therefore targeting with anti-Clever-1 antibody *bexmarilimab* represents a novel way to overcome immune evasion mechanisms linked to non-responsiveness of cold tumors to approved immune checkpoint inhibitors (anti- PD-1 inhibitors).

Source: 1) Revisiting checkpoint blockade. Nat Biotechnol 40, 981 (2022)

Clever-1 Targeting Has Profound Effects on Boosting Cancer Immunity

Activation of the Innate as well as Adaptive Immune System



Source: 1) Karikoski et al. Eur J Immunol 2009; Hollmen et al. Br J Cancer 2020

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Clever-1 Targeting Has Profound Effects on Boosting Cancer Immunity

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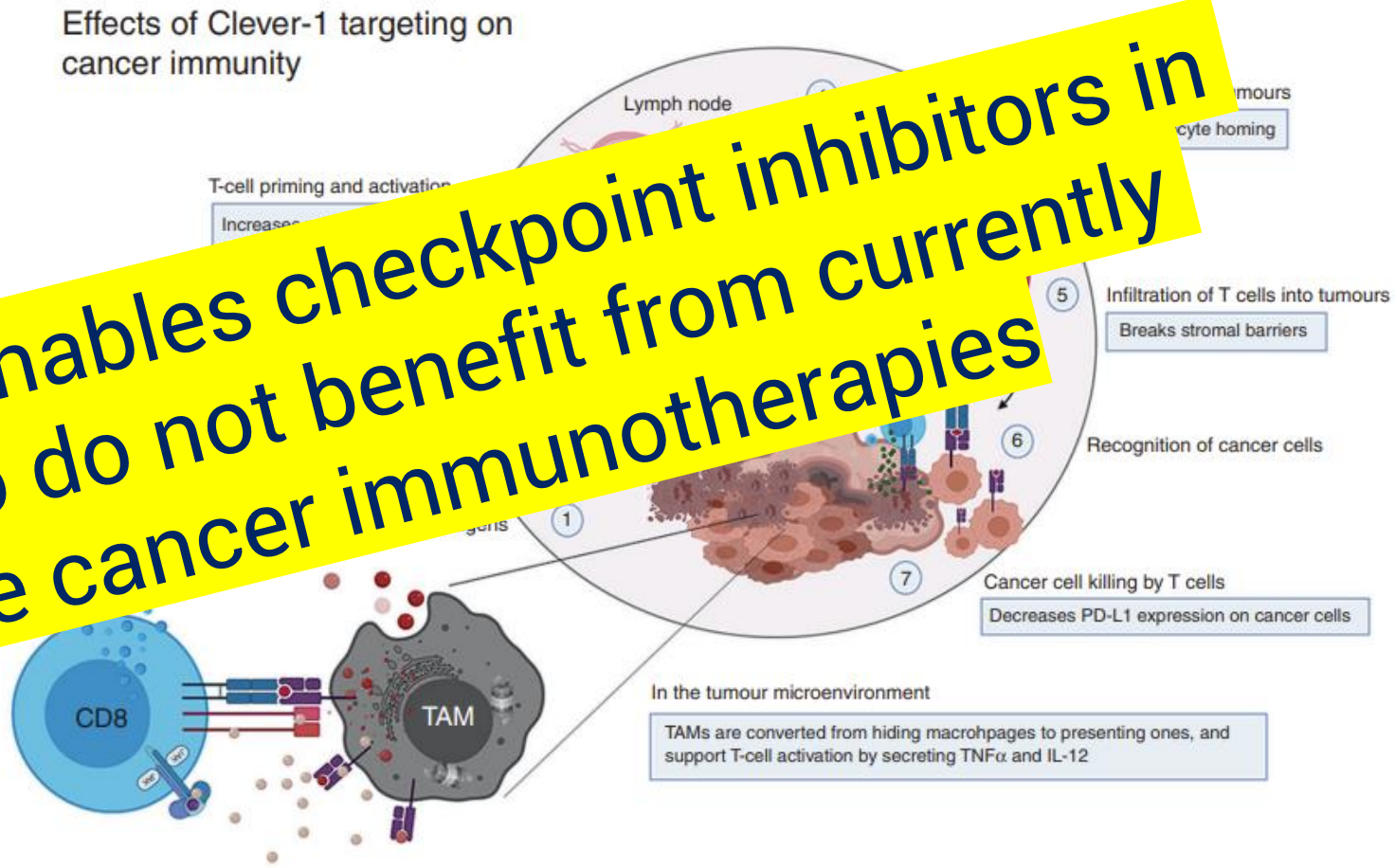

Bexmarilimab enables checkpoint inhibitors in patients who do not benefit from currently available cancer immunotherapies

Source: 1) Karikoski et al. Eur J Immunol 2009; Hollmen et al. Br J Cancer 2020

Current *bexmarilimab* Data in Solid Tumours

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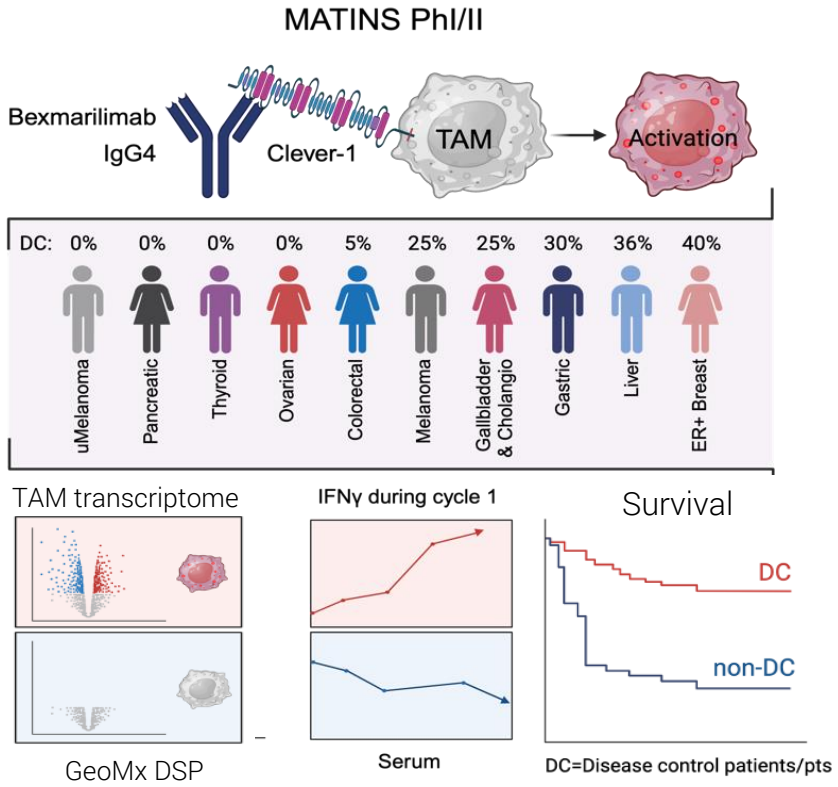
Proof of Principle of Modulating the Tumor Microenvironment (TME)

Phase 1/2 First-in-Human MATINS Trial



Highlights

216 patients treated across 10 different cancer types

Targeting Clever-1 with bex is well tolerated, RP2D 1mg/kg Q3W supported by the FDA

Bex converts intratumoral macrophages to support adaptive immune responses and IFNg signaling

Bex monotherapy modified the TME, which led to increased survival in late-stage cancer patients

Low baseline immune activation associates with clinical benefit from Bex

Source: 1) MoA: Mechanism of Action, TME: Tumor Microenvironment
Source: 2) Rannikko et al. (2023) Cell Reports Medicine, 4, 101307, available in open access. See Faron release on December 7th, 2023

MATINS Updated Safety and Efficacy Part I and II

Well tolerated therapy with clear clinical indications of efficacy and immune activation

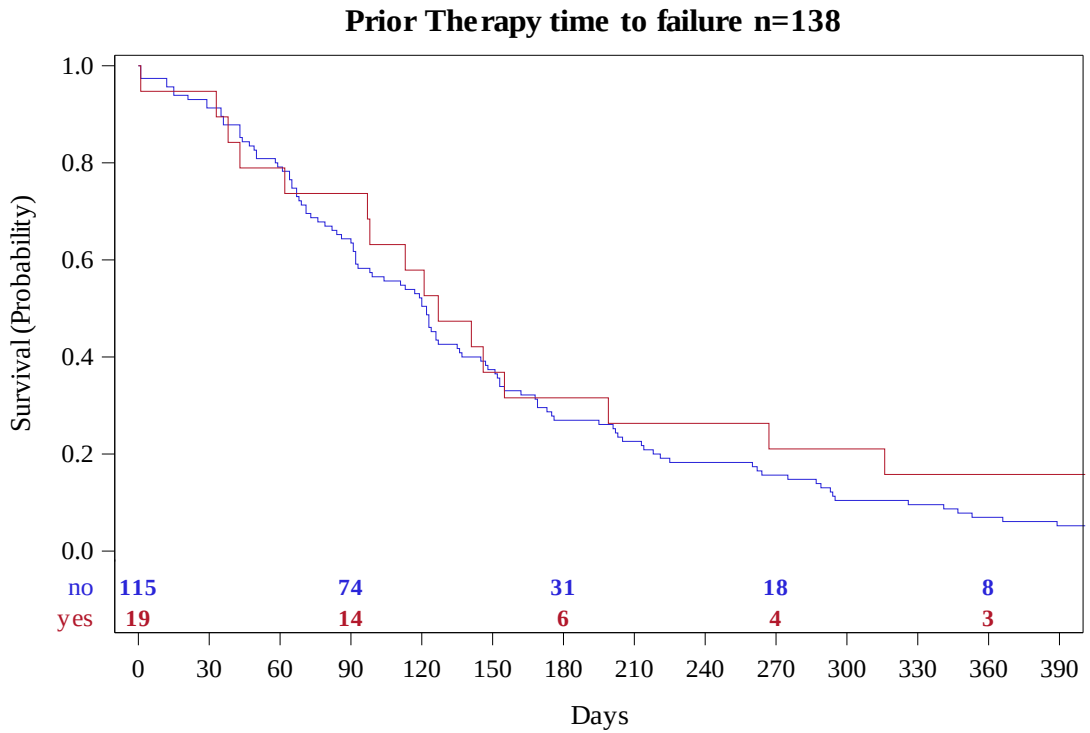
Treatment Related Adverse Events	Patients (%)
Any grade	94 (45)
Grade 3	11 (5)
Grade 4	4 (2)

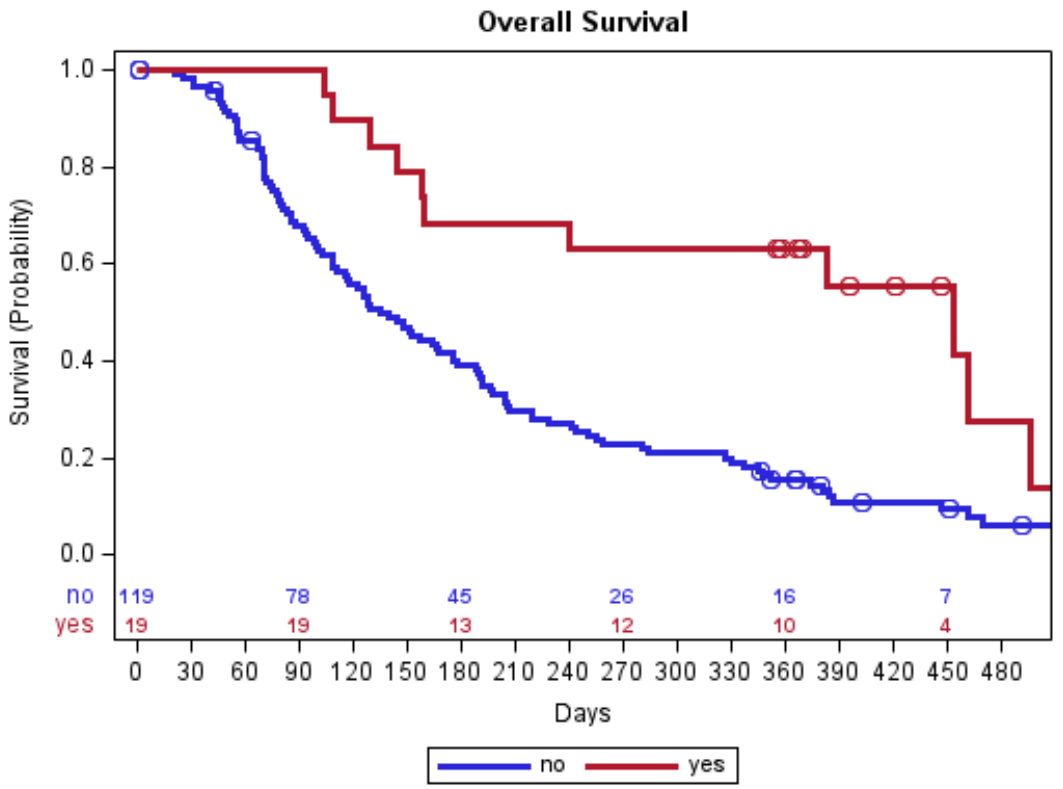
Most Frequent TRAEs	Grade 1/2	Grade 3	Grade 4/5
Fatigue	34 (16)	1 (<1)	0
Pyrexia	12 (6)	0	0
Nausea	10 (5)	1 (<1)	0
Anemia	9 (4)	2 (<1)	0
Blood ALP increased	9 (4)	0	0
Decreased appetite	8 (4)	0	0
AST increased	7 (3)	1 (<1)	0

Confirmed Responses (RECIST)	n (%)
Complete response (CR)	0 (0)
Partial Response (PR)	1 (0.5)
Stable Disease (SD)	26 (13)
Progressive Disease (PD)	178 (87)
Disease control (SD+PR) per cohort	27 (13)
Colorectal cancer	2 (4)
Cutaneous melanoma	**5 (22)**
Cholangiocarcinoma	**5 (23)**
Gastric adenocarcinoma	**6 (21)**
Hepatocellular cancer	**4 (36)**
Ovarian cancer	1 (7)
ER+ Breast cancer	**4 (33)**
Pancreatic cancer	0 (0)
Uveal melanoma	0 (0)

More Than 3 Times Longer Survival for Patients Achieving Disease Control

Attributed to *bexmarilimab* therapy





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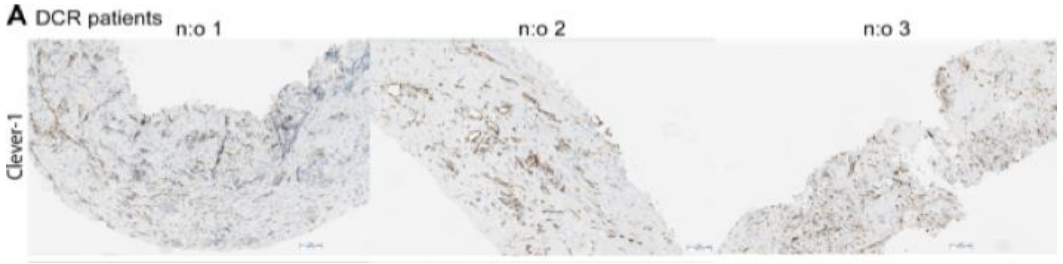
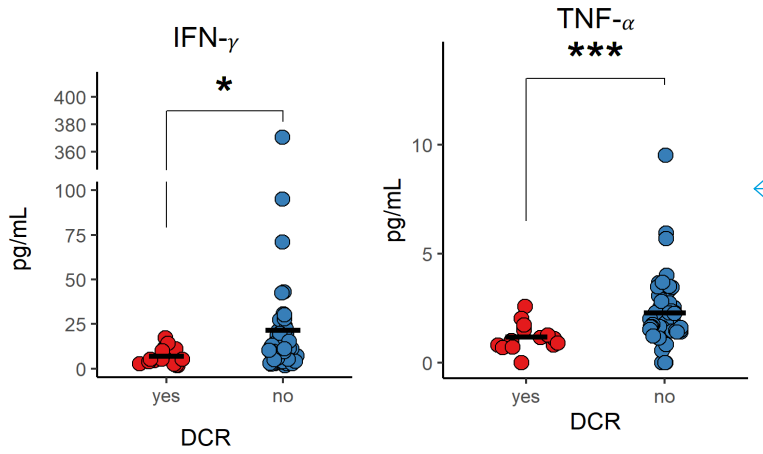
Patients With Cold Tumors Responded to Treatment

As single agents *bexmarilimab* and anti-PD-1s benefit opposite melanoma populations

	n (%)	median % (range)	p-value
Clever-1	78 (100)		
Whole tumor	78 (100)	15 (1-55)	
non-DCR	71 (91)	15 (1-55)	NS
DCR	7 (9)	20 (13-35)	
Stroma	78 (100)	20 (0-75)	
non-DCR	71 (91)	20 (0-75)	NS
DCR	7 (9)	20 (5-40)	
Intratumoral	78 (100)	5 (0-85)	
non-DCR	71 (91)	3 (0-85)	0.038
DCR	7 (9)	15 (0-25)	





Patients achieving disease control have significantly lower levels of pro-inflammatory markers prior to treatment.

Clever-1/PD-L1 (CPS) ratio was even more significant (P = 0.01), i.e. high Clever-1 and low PD-L1 combined could be even better in identifying patients that benefit from Bex

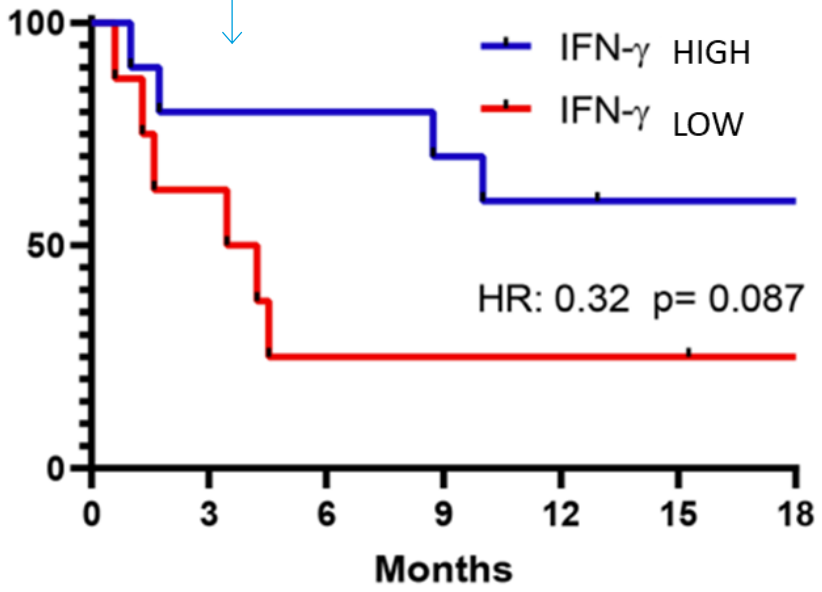
This highlights a level of immunosuppression from the tumour and unlikeliness to respond to currently available IO drugs within the responding patients (Yamazaki et al Cancer Sci. 2017). In ROC analyses the AUC for IFNg and TNFa was 0.8

Source: 1) Clever-1 Score: percentage of CLEVER-1 positive cells over all viable cells, mimicking CPS for PD-L1 staining. Biopsies stained using anti-Clever-1 antibody clone 4G9 by Abnova (presented at ASCO Annual Meeting 2022).

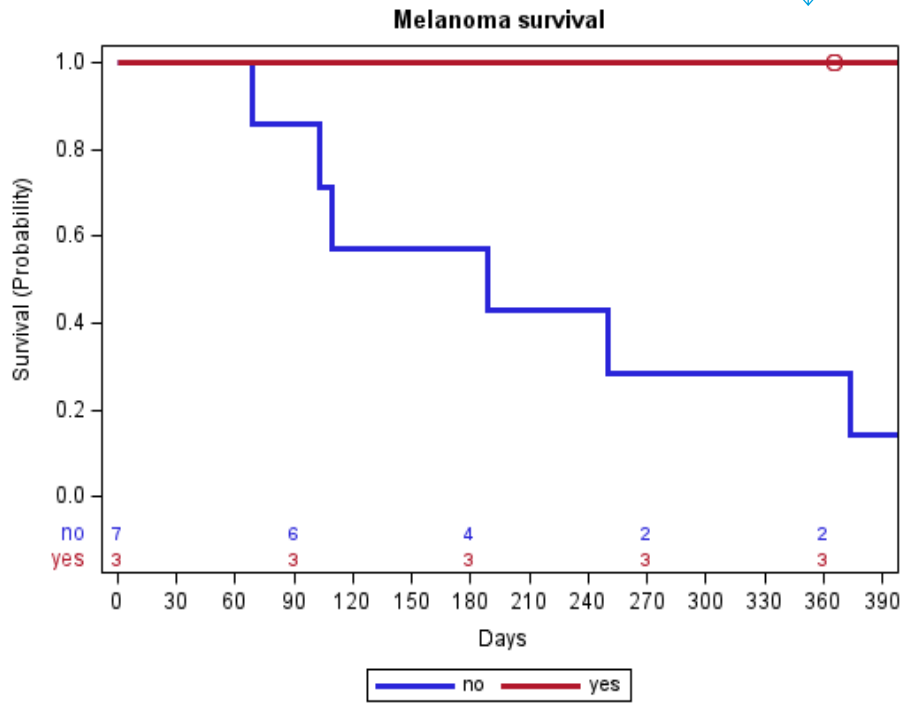
Bexmarilimab – a drug for the IFN gamma low population

As single agents *bexmarilimab* and anti-PD-1s benefit opposite melanoma populations

Anti-PD1 treated melanoma patients according to IFN gamma status[1,2]



Bex treated melanoma patients according to IFN gamma status[3]



↗ **Faron's *bexmarilimab* aims to tackle the immunosuppressive microenvironment characterized by low IFNy, inactive T-Cells and a high amount of immunosuppressive tumor associated macrophages that are CLEVER-1 positive.**

Source: 1) 1) Giunta et al. Scientific Reports 2020. 2) Ayers et al. J Clin Invest. 2017 3) MATINS Phase I/II first-in-human trial with bexmarilimab in advanced solid tumors

Bexmarilimab
Solid Tumors Pipeline

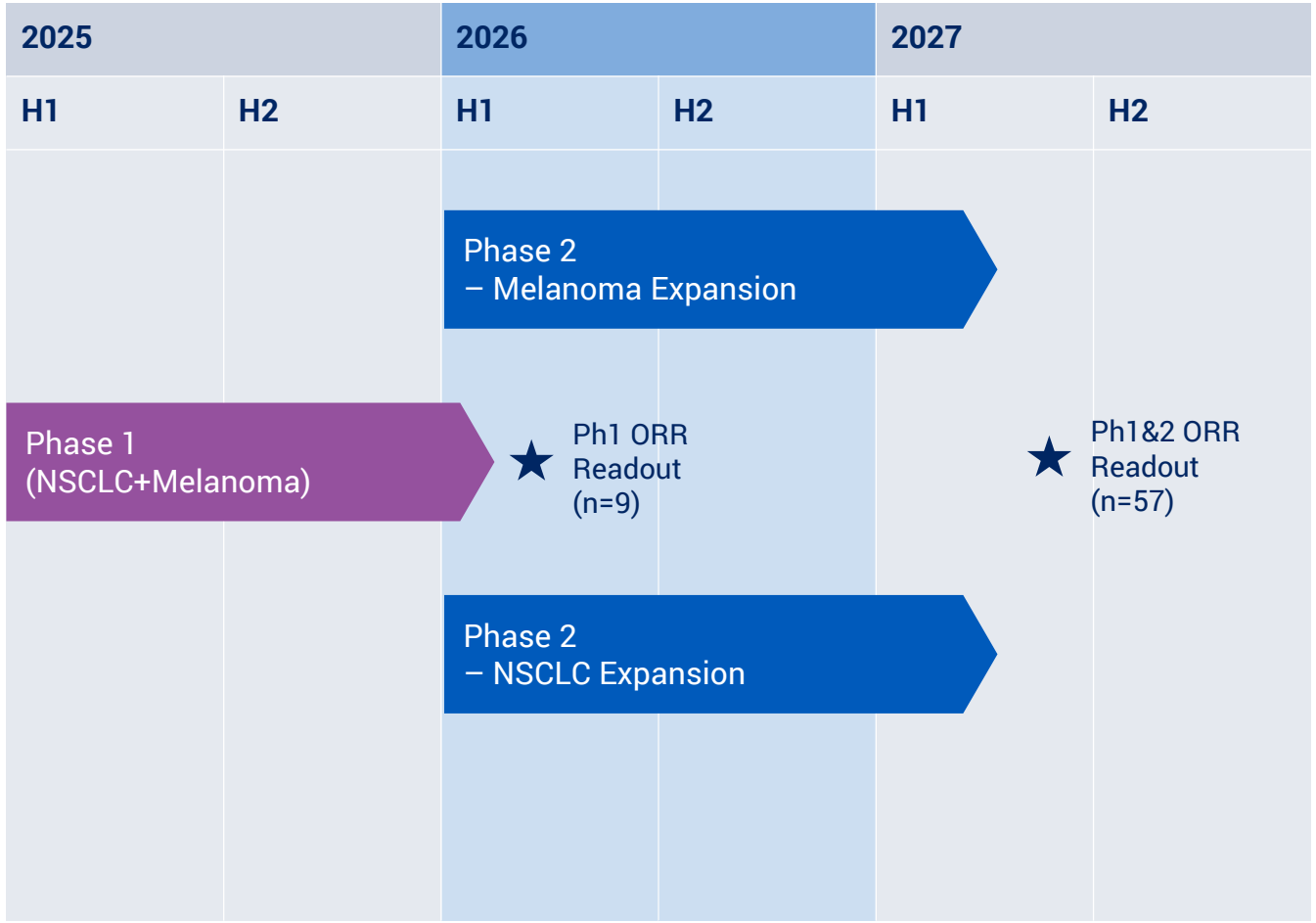
Faron Solid Tumours

Treatment	Indication(s)	Phase of Development				Anticipated Key Milestones
		Preclinical	Phase 1	Phase 2	Phase 3	
Single-Agent ***Bexmarilimab***	Advanced solid tumors **FARON SPONSORED**	MATINS (First in Human, single agent)				▪ Completed
Bexmarilimab **+ PD-1**	PD-1 Blockade Basket trial in Solid Tumors **FARON SPONSORED**	MATINS-02				▪ First-patient-in expected in Q4 '25
	PD-1 resistant NSCLC and Melanoma **INVESTIGATOR INITIATED**	BLAZE				▪ First-patient-in expected in Q2 '25
	Soft Tissue Sarcomas **INVESTIGATOR INITIATED**	BEXAR				▪ First patient in expected in Q4'25
TBC	Lymphomas (DLBCL and TCL) **FARON SPONSORED**	MATINS-03				▪ Preclinical expected to complete Q2'25

BLAZE: Investigator Initiated

Can *bexmarilimab* overcome PD-1 resistance?

- Resistance to first-line immunotherapy in NSCLC and melanoma is very common. Targeting of tumour associated macrophages may overcome resistance.
- Response to *bexmarilimab* + anti-PD-1 in this setting will represent proof-of-concept of reversal of resistance
- Initial priming with bex 7 days prior to bex + PD1 combo
- Biomarker intense to provide translational correlates of phenotypic macrophage switch and immune activation.

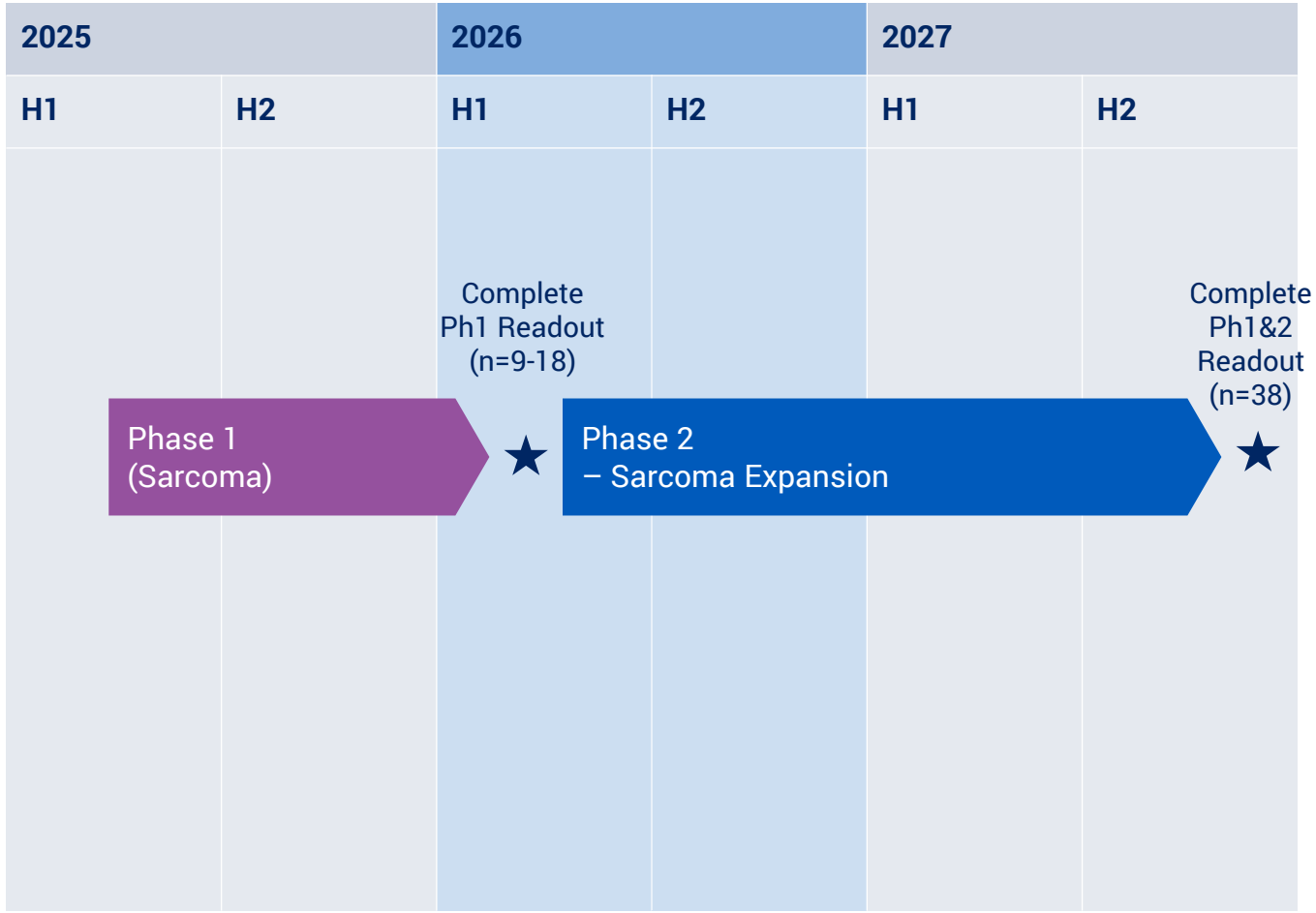


FARON

BEXAR: Investigator Initiated

Can we turn cold tumors hot in soft-tissue sarcomas?

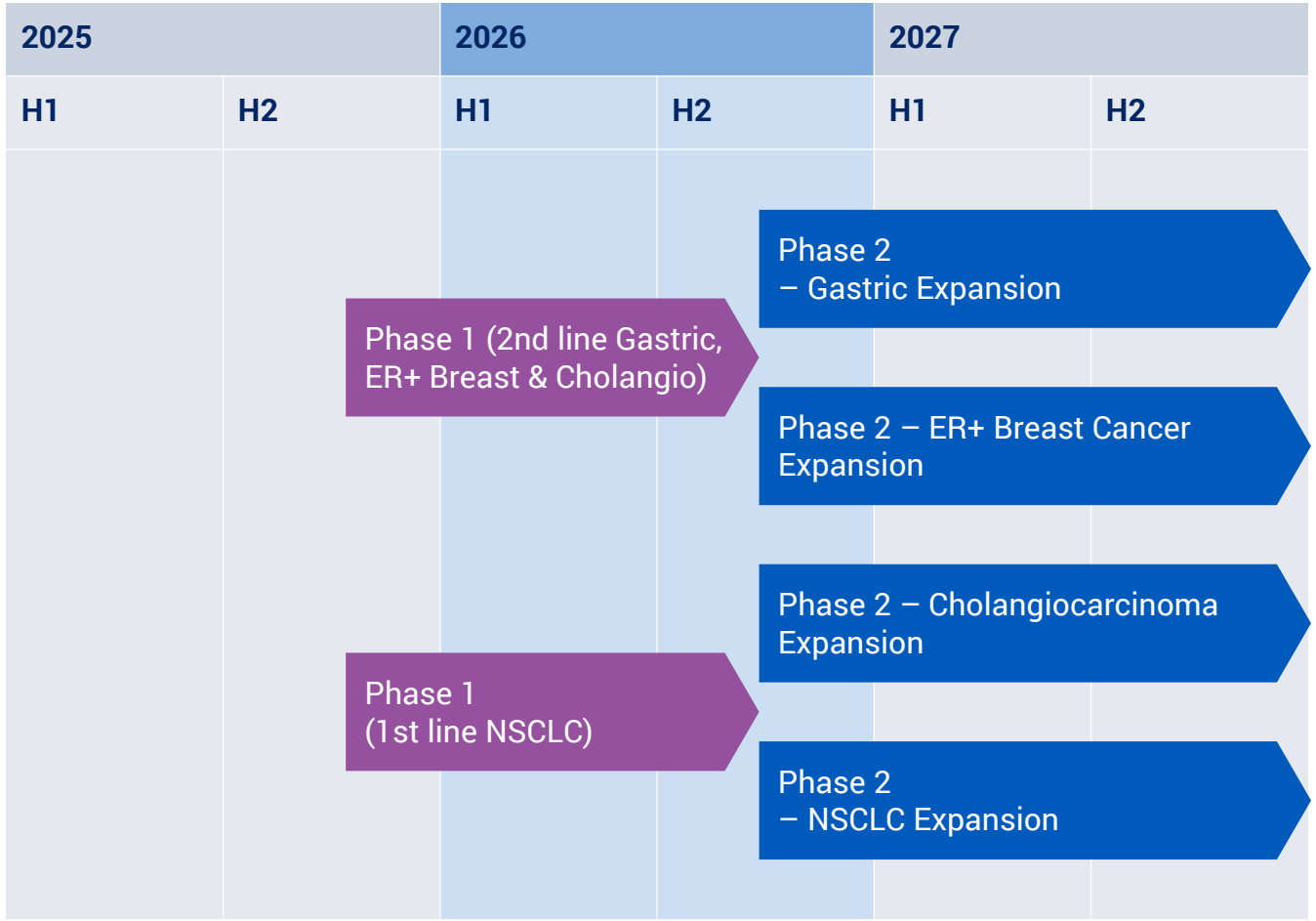
- Early experiences with immune checkpoint inhibitors (ICIs) in clinical soft tissue sarcoma (STS) trials have been disappointing so far
- These tumors are commonly regarded as “cold” owing to an immunosuppressive tumor microenvironment (TME) rich in M2-like macrophages as well as frequent expression of Clever-1
- *Bexmarilimab* 1st line treatment may turn primary refractory STS tumors sensitive to anti-PD-1 treatment = turn cold tumors hot



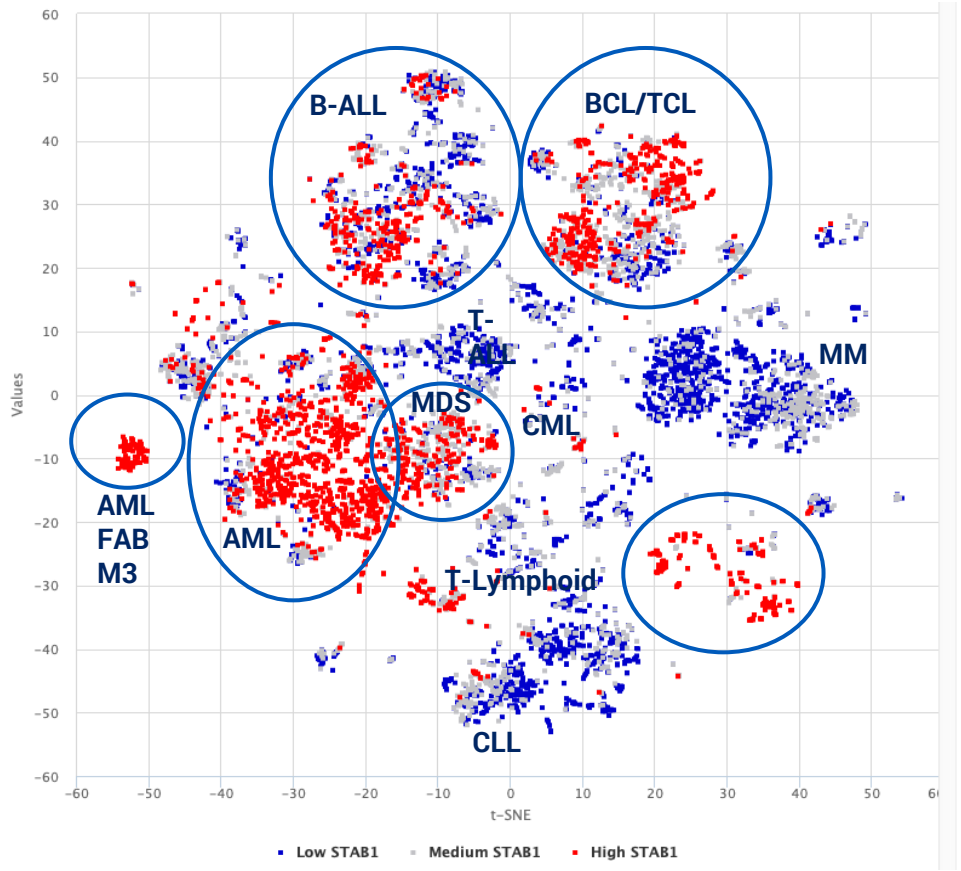
MATINS-02: Faron Sponsored basket trial in solid tumors

Can *bexmarilimab* overcome PD-1 resistance?

- Results with PD-1 inhibitors have been disappointing in immunologically cold tumors (such as gastric, ER+ breast cancer)
- *Bexmarilimab* can potentially turn primary refractory (cold) tumors sensitive to PD-1
- Can we add efficacy of PD-1 inhibitors in hot tumor type (NCSLC)?
- Could Clever-1/IFN-γ signature act as a predictive biomarker for patient selection?



Clever-1 is highly expressed by malignant cells in AML, MDS, and also lymphomas



Source: 1) HEMAP dataset: Microarray data of 9,544 samples (Pölönen et al. Cancer Research 2019) http://hemap.uta.fi
Clin Lymphoma Myeloma Leuk. 2013 Dec;13(6):711-5. doi: 10.1016/j.clml.2013.07.007. Epub 2013 Sep 17..

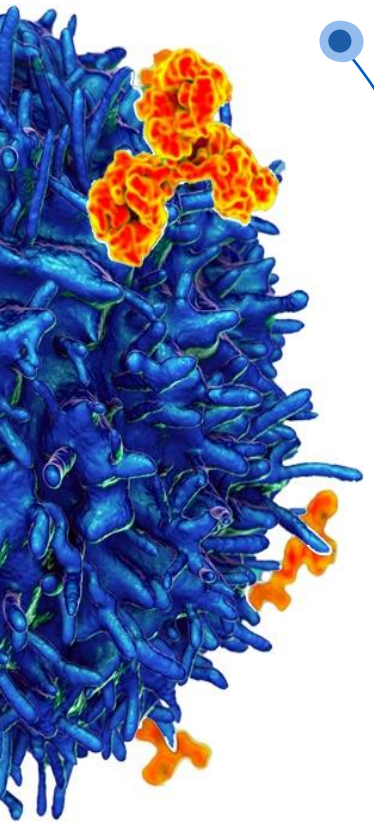
Clever-1 is also expressed in B-cell and T-cell lymphomas- can we increase the efficacy of SoC agents or sensitize after failure?

85-90% of non-Hodgkin lymphomas are B cell lymphomas! 4-5x more common than MDS

FARON

Our *bexmarilimab* solid tumor mission

A Unique Approach to Fight Cancer via Re-programming Macrophages and Myeloid Cells



Our purpose is to establish *bexmarilimab* as a cornerstone drug for cancer in indications where Clever-1 macrophages are a source of treatment resistance and cancer progression

Bexmarilimab is a 1st in class humanized anti-Clever-1 antibody.
It primes the immune system to attack tumors by a novel mode of action.

Bex is potentially applicable to a wide range of hematologic diseases and solid tumors in combination with traditional therapies, or as maintenance therapy

In Clever-1+ haematological cancers, dual mode of action. Very encouraging activity.
In solid tumors, Bex will be first-in-class targeted macrophage re-programmer in combination of PD-1 inhibitors based on tumor agnostic biomarker (Clever-1)

Scientific Advisory Board
further depth and experience

Scientific Advisors

Toni Choueiri, MD, FASCO

Professor
Harvard, USA

Naval G. Daver, MD

Professor
MD Anderson, CCC

Tom Powles, MBBS, MRCP, MD

Professor
Barts Cancer Center, London

Mika Kontro, MD, PhD

Adjunct Professor
HUS, CCC

Amer Zeidan, MD, MBBS, MHS

Associate Professor
Yale, USA

Cristophe Massard, MD, PhD

Professor
Gustave Roussy CCC, Paris

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Scientific Advisory Board

Toni Choueiri, MD, FASCO

Toni Choueiri[1)]**,** MD is the Jerome and Nancy Kohlberg Chair and Professor of Medicine at Harvard Medical School, Boston, MA, the Director of the Lank Center for Genitourinary (GU) Oncology at Dana-Farber Cancer Institute and co-leader of the Kidney Cancer Program at Dana-Farber/Harvard Cancer Center. He serves at the US National comprehensive cancer network (NCCN) panel. He has over 800 PubMed indexed publications and is the lead investigator in multiple international phase 1-3 trials. In a series of NEJM articles on which Dr Choueiri was either first or last author, he has made seminal observations leading to multiple FDA and EMA approvals.

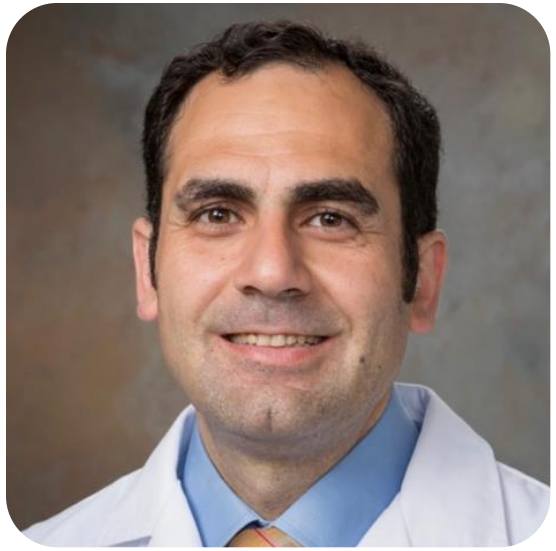
1) Written approval, contract under revision

Scientific Advisory Board

Tom Powles, MBBS, MRCP, MD

Tom Powles, MBBS, MRCP, MD is a professor of urology cancer at the University of London and the Director of Barts Cancer Centre which is one of the UKs largest Cancer Centres. Prof Powles is also editor-in-chief of Annals of Oncology, the leading European oncology scientific journal. He has had a major role in the development of biomarkers and new drug strategies leading to multiple FDA and EMA approvals. He has authored 10 NEJM or Lancet publications with two first author NEJM publications and two first author Nature publications. He was named in December 2023 in TIME's list among the most influential people in global health.

Scientific Advisory Board



Amer Zeidan, MD, MBBS, MHS

Amer Zeidan, MD, MBBS, MHS is a Associate Professor of Medicine, Chief of Hematologic Malignancies Division, Director of Hematology Early Therapeutics Research, and leader of the clinical program and the Clinical Research Team for Leukemia and Myeloid Malignancies at Yale Cancer Center. Dr. Zeidan specializes in the management of myeloid malignancies especially MDS and acute myeloid leukemia (AML). His research and clinical care focus on targeting therapies to a patient's diagnosis and working with their own immune system to counter the malignancies. He has published over 330 peer-reviewed publications and is the principal investigator on numerous phase 2 and 3 clinical trials in the areas of acute myeloid leukemia and myelodysplastic syndromes.

Scientific Advisory Board

Naval G. Daver, MD

Naval G. Daver, MD is a Professor and Director of the Leukemia Research Alliance Program in the Department of Leukemia at MD Anderson Cancer Center (MDACC) in Houston, TX. He is a clinical investigator with a focus on molecular and immune therapies in acute myeloid leukemia (AML) and myeloid disease and is principal investigator on more than 25 ongoing institutional, national, and international clinical trials in these diseases, including multiple registration and label enabling trials. Prof Daver has published over 400 peer-reviewed manuscripts and is on the editorial board of numerous hemalotology journals.

Scientific Advisory Board

Mika Kontro, MD, PhD

Mika Kontro, MD, PhD is an adjunct professor and a consultant in clinical hematology at the Helsinki University Hospital Comprehensive Cancer Center. Dr. Mika currently works as K. Albin Johannson Cancer Research Fellow (Finnish Cancer Institute) and as a group leader in Finnish Institute of molecular medicine, FIMM. He has a strong background in running clinical trials and was selected at 2017 for European Hematology Association Clinical Research Training program (CRTH).he currently chairs the Finnish AML group and is a board member of the Nordic AML Group.

Scientific Advisory Board

Christophe Massard, MD, PhD

Christophe Massard, MD, PhD is professor and a Head of Cancer Research at Gustave-Roussy, the first leading cancer hospital in Europe and in the top five of the world. Eugène Marquis Cancer Centre in Rennes, France. Dr. Christophe is a member of ESMO, ASCO and AACR and has participated in over 130 trials in the past five years. He has been the principal investigator over the last 10 years of 50 phase 1 trials and co-investigator in more than 100 trialsHis research focuses on early clinical trials and, precision medicine. . , GU cancers (prostate, bladder and testis) and glioblastoma. He has published over 100 peer-reviewed publications.


Q&A

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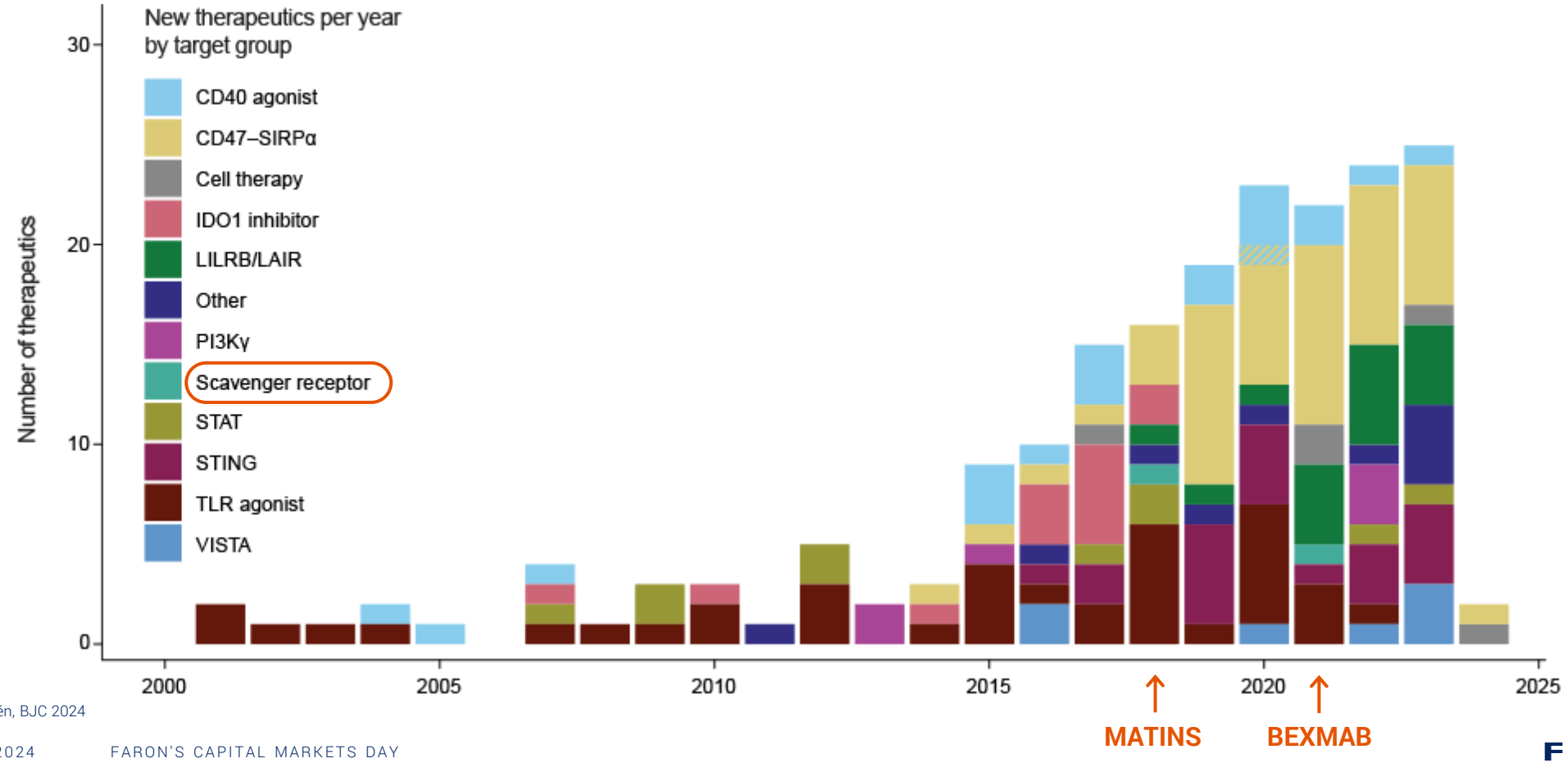
Who benefits from *bexmarilimab* and why?

Maija Hollmén
CSO, Faron

Timeline of clinically evaluated macrophage-reprogramming therapeutics

Problems: overlapping strategies, safety issues, low efficacy as monotherapy



Rannikko and Hollmén, BJC 2024

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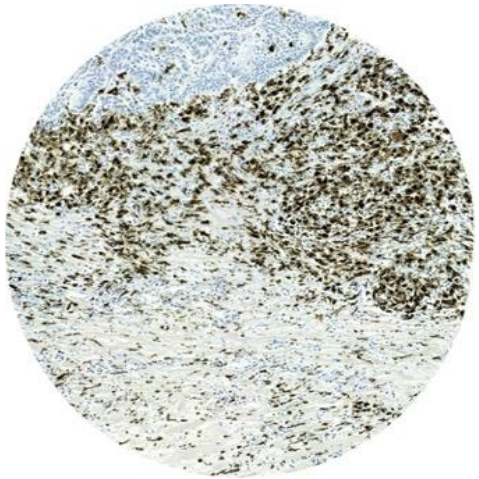
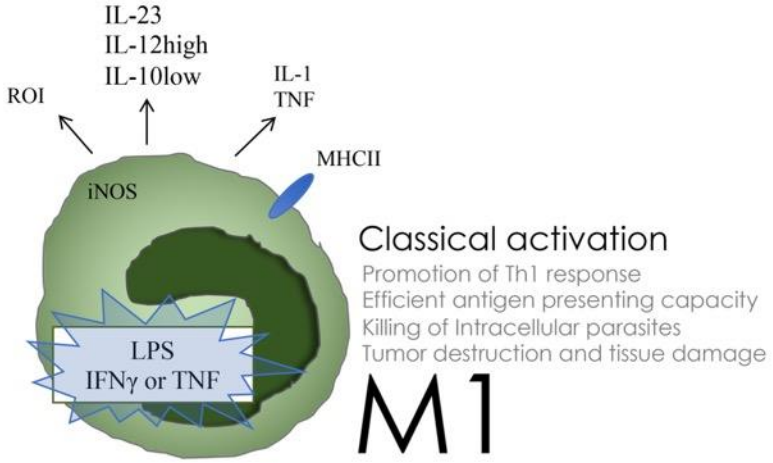
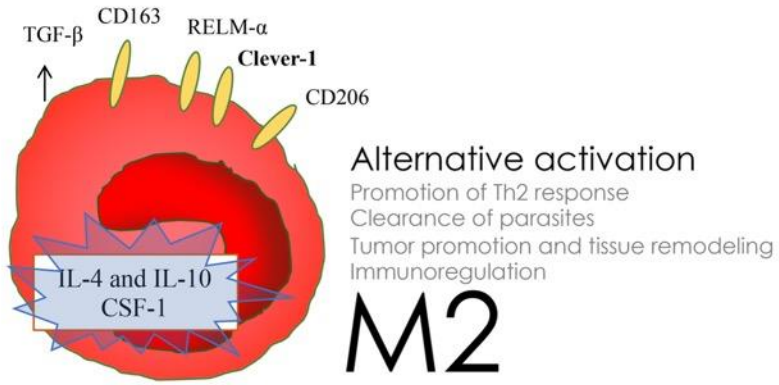
Diversity of tumor-associated macrophages (TAM)

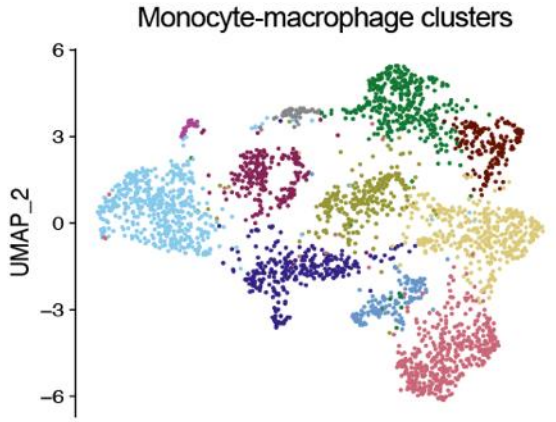
Finding the right population to target within heterogenous populations across tumors

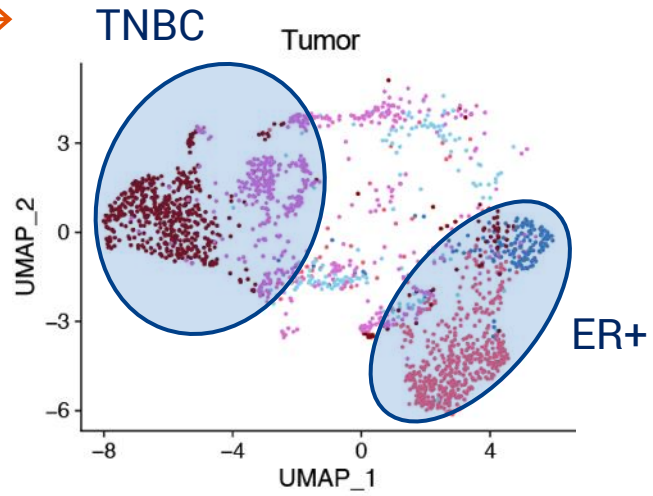


In vitro









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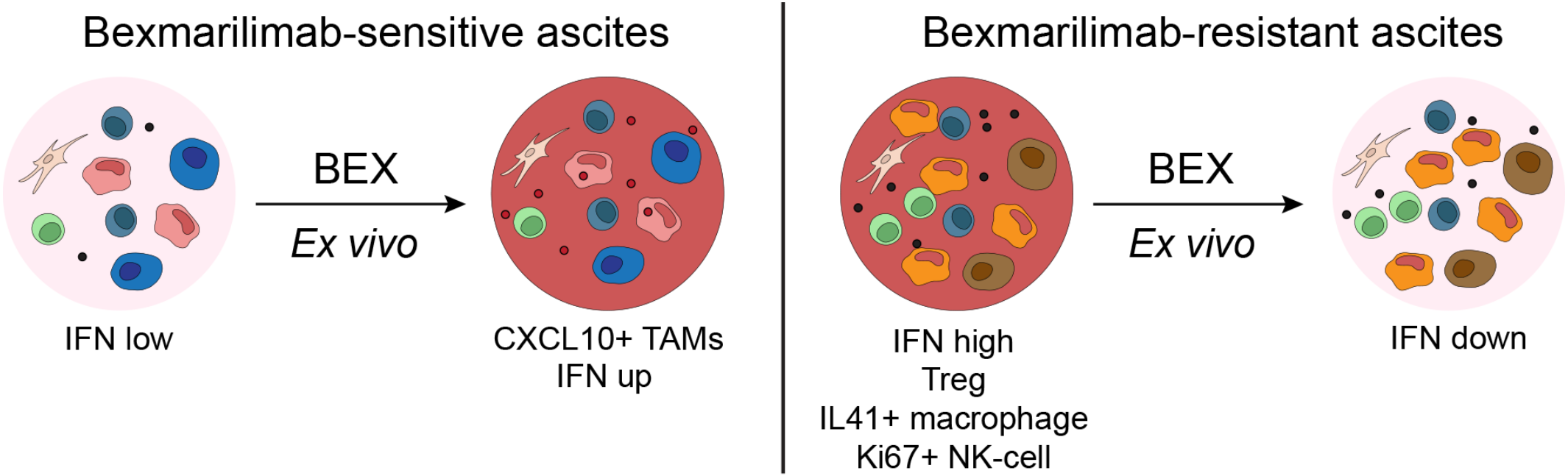
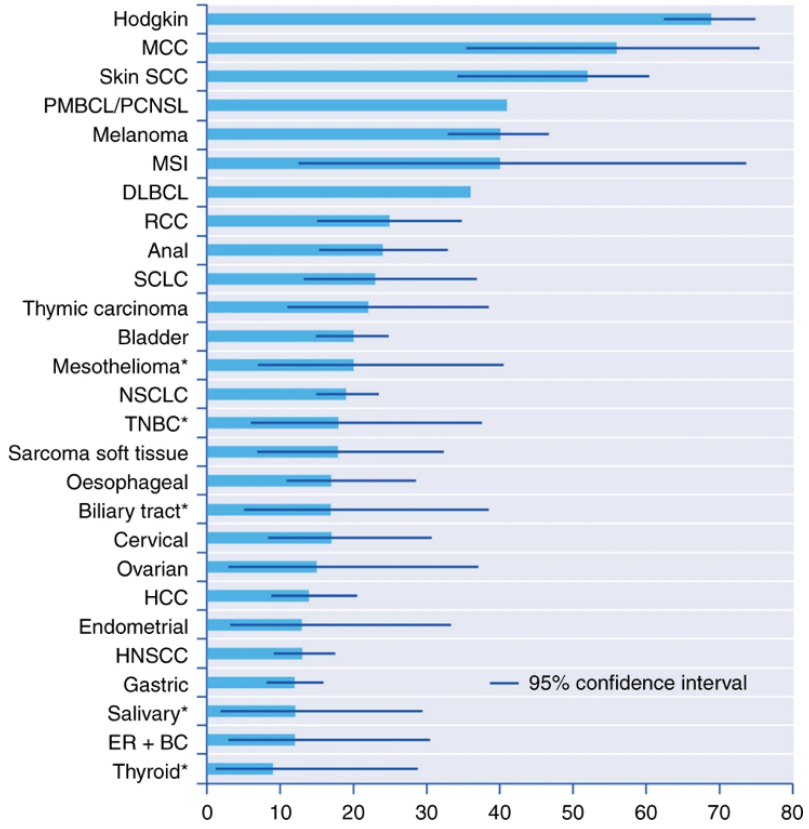
Bexmarilimab activates TAMs to support adaptive immune responses in interferon-poor immune microenvironments



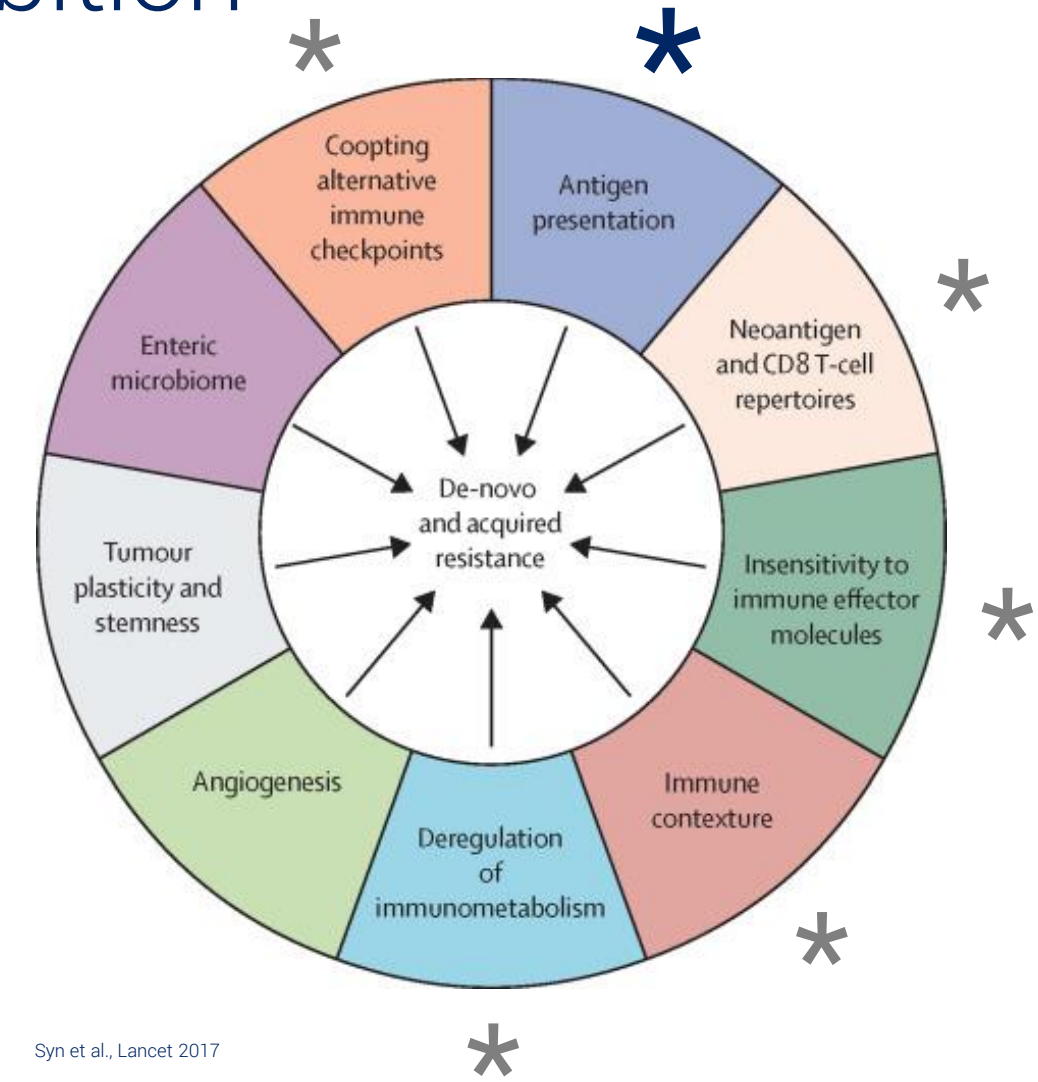
Rannikko et al., CIR 2024

The majority of cancers do not respond to immune checkpoint inhibition

Overcoming resistance with *bexmarilimab*



Hirsch et al., BJC 2019



Syn et al., Lancet 2017

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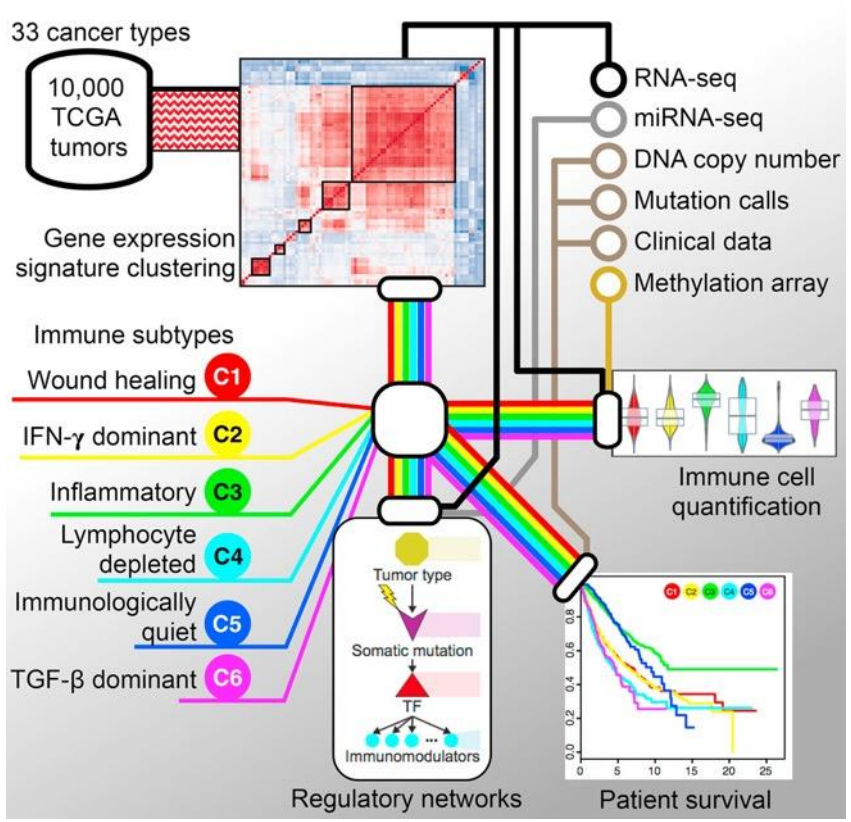
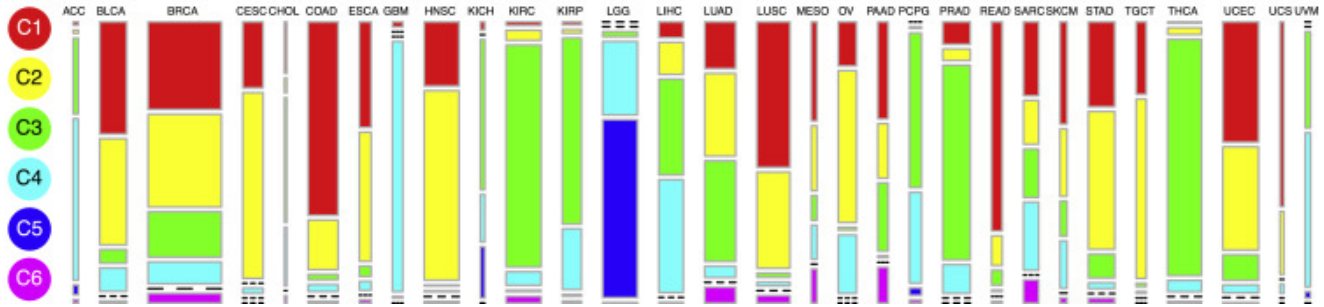
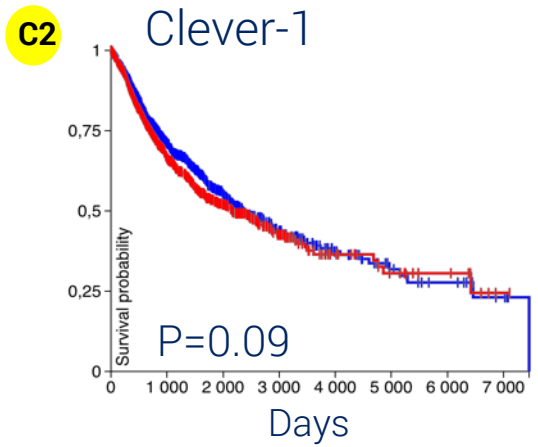
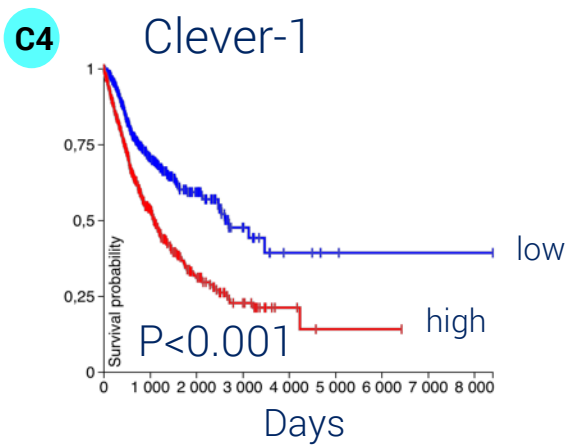
Potential of *bexmarilimab* use in immunologically cold tumors

Rethinking of immune phenotype rather than organ of origin as an indication









Thorsson et al., Immunity 2018

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Solving the problems of macrophage-targeted therapies

Patient selection is as important as knowing your drug, who to treat and when?

- **Overlapping strategies:** Targeting Clever-1 with *bexmarilimab* is a novel approach and presents a completely new way of re-programming macrophages
- **Safety issues:** *Bexmarilimab* has a very good safety profile
- **Low efficacy as monotherapy:** *Bexmarilimab* has shown efficacy in 30-40% in various solid tumors as monotherapy, however, improvements include
  - Treatment at earlier lines of therapy due to good safety profile
  - Patient selection in solid tumors according to immune phenotype
  - Broad use in sensitizing tumors to immune checkpoint inhibitors
  - Broad use in therapies where antigen presentation and immune activation is desired

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Closing remarks

Juho Jalkanen
CEO, Faron

Outlook

Potential to become cornerstone in cancer treatment

Indication	Patients (8MM)	Market size*	
		2024	2030
Sarcoma	85 801	0.20	1.5
DLBCL and TCL	125 903	5.652	12.088
ER+/HER-	789 367	24.29	41.748
NSCLC	1 523 899	35.84	59.86
Melanoma	214 301	9.38	12.91
Gastric/stomach	240 350	1.66	4.01

Source: Evaluate, Worldwide Indication Sales by Year ($B), 8MM = 8 major markets

Outlook

Value creation opportunity with full Phase 2 read-outs (response rate, duration of response and survival), regulatory interactions, partnering and combination data with anti-PD-1

Outlook

- Dec 2024 Phase II Interim readout at ASH
- Phase II enrollment completed by Jan 2025
- End of Q1 2025 full Phase 2 response rate readout
- End of Q2 2025 FDA EOP2 meeting and Breakthrough Designation possibility
- End of Q3 2025 Phase 2 duration of response and survival data
- Q4 2025 Regulatory feedback on accelerated approval possibility
- Q4 2025 First combination data with anti-PD1

Faron as an investment opportunity

- Clear market opportunity with limited competition
- Current treatment options have low efficacy and the need for new treatments is high, enabling Accelerated Approval application
- Highly promising Phase 1 data, with further validation from initial Phase 2 read-out and streamlined development plan by the FDA
- Strong safety foundation with over 250 treated patients

Q&A session


Thank You.