UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, D.C. 20549

FORM 6-K

REPORT OF FOREIGN PRIVATE ISSUER
PURSUANT TO RULE 13A-16 OR 15D-16 UNDER
THE SECURITIES EXCHANGE ACT OF 1934

For the month of January 2025
Commission File Number: 001-40010

Pharvaris N.V.

(Translation of registrant's name into English)

Emmy Noetherweg 2
2333 BK Leiden
The Netherlands
(Address of principal executive office)

Indicate by check mark whether the registrant files or will file annual reports under cover of Form 20-F or Form 40-F.
Form 20-F ☒ Form 40-F ☐

Indicate by check mark if the registrant is submitting the Form 6-K in paper as permitted by Regulation S-T Rule 101(b)(1): ☐

Note: Regulation S-T Rule 101(b)(1) only permits the submission in paper of a Form 6-K if submitted solely to provide an attached annual report to security holders.

Indicate by check mark if the registrant is submitting the Form 6-K in paper as permitted by Regulation S-T Rule 101(b)(7): ☐

Note: Regulation S-T Rule 101(b)(7) only permits the submission in paper of a Form 6-K if submitted to furnish a report or other document that the registrant foreign private issuer must furnish and make public under the laws of the jurisdiction in which the registrant is incorporated, domiciled or legally organized (the registrant's "home country"), or under the rules of the home country exchange on which the registrant's securities are traded, as long as the report or other document is not a press release, is not required to be and has not been distributed to the registrant's security holders, and, if discussing a material event, has already been the subject of a Form 6-K submission or other Commission filing on EDGAR.

PHARVARIS N.V.

On January 13, 2025, Pharvaris N.V. (the "Company") issued a press release. The press release is attached as Exhibit 99.1 hereto and is incorporated by reference herein. Also on January 13, 2025, the Company made available an investor presentation on its website. A copy of the investor presentation is attached hereto as Exhibit 99.2.

Exhibit 99.1 to this Report on Form 6-K shall be deemed to be incorporated by reference into the registration statements on Form F-3 (Registration Number 333-273757, 333-277705 and 333-278650) and Form S-8 (Registration Number 333-252897). Exhibit 99.2 to this Report on Form 6-K shall not be deemed "filed" for purposes of Section 18 of the Securities Exchange Act of 1934, as amended (the "Exchange Act") or otherwise subject to the liabilities of that section, nor shall it be deemed incorporated by reference in any filing under the Securities Act of 1933, as amended or the Exchange Act.

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

PHARVARIS N.V.

Date: January 13, 2025

By: /s/ Berndt Modig
Name: Berndt Modig
Title: Chief Executive Officer

EXHIBIT INDEX

Exhibit No.	Description
99.1	Press release, dated January 13, 2025.
99.2	Investor Presentation, dated January 13, 2025.

Exhibit 99.1

Pharvaris Outlines 2025 Strategic Priorities

- Initiated CHAPTER-3, the pivotal Phase 3 study of deucrictibant for prophylaxis against hereditary angioedema (HAE) attacks in 2024; topline data anticipated in 2H2026
- Enrollment in RAPIDe-3, the pivotal Phase 3 study of deucrictibant for the on-demand treatment of HAE attacks, continuing as planned; topline data anticipated in 1Q2026
- Study initiation of deucrictibant for the treatment of acquired angioedema due to C1-INH deficiency (AAE-C1INH) anticipated in 2025
- Operating from a strong financial position with estimated cash runway into 3Q2026
- Company presentation at the J.P. Morgan Healthcare Conference

ZUG, Switzerland, January 13, 2025 – Pharvaris (Nasdaq: PHVS), a late-stage biopharmaceutical company developing novel, oral bradykinin B2 receptor antagonists to help address unmet needs of those living with bradykinin-mediated diseases such as hereditary angioedema (HAE) and acquired angioedema (AAE), today outlined its strategic priorities for 2025.

“This year is paramount to Pharvaris as we continue clinical development of deucrictibant to help address unmet needs for those living with bradykinin-mediated angioedema,” said Berndt Modig, Chief Executive Officer of Pharvaris. “Pharvaris is committed to generating robust clinical data to build a compelling package supporting deucrictibant’s efficacy and safety profile. Our team is focused on the execution of two Phase 3 clinical studies in HAE, the expansion of our pipeline into AAE, and preparations for commercialization of deucrictibant pending regulatory submission and approval; we have significant resources in place to support these strategic investments and provide value for our shareholders.”

2025 Strategic Priorities

Long-term Prophylaxis of HAE Attacks

- **Initiated CHAPTER-3 (NCT06669754), a global pivotal Phase 3 study, evaluating deucrictibant for the prophylactic treatment of HAE attacks; topline data anticipated 2H2026.** CHAPTER-3 is a randomized, double-blind, placebo-controlled Phase 3 study of orally administered deucrictibant extended-release tablet for the prophylaxis against angioedema attacks in adults and adolescents (12 years and older) with HAE. The study aims to enroll approximately 81 participants with HAE and randomize them in a 2:1 ratio to receive deucrictibant extended-release tablet (40 mg/day), which is currently the intended commercial dosage, or placebo, once

daily for 24 weeks. The primary endpoint of the study is to evaluate the efficacy of deucrictibant compared to placebo for prophylaxis against angioedema attacks as measured by the time-normalized number of investigator-confirmed HAE attacks during the 24-week treatment period. Other objectives of the study include evaluating additional clinically relevant outcomes, deucrictibant's safety and tolerability, pharmacokinetics and its impact on health-related quality of life measures in the prophylactic setting. Pharvaris anticipates announcing topline data of CHAPTER-3 in the second half of 2026.

- **Prophylactic open-label extension study CHAPTER-4 (NCT06679881) on track to initiate in 1Q2025.** CHAPTER-4 is a long-term, open-label extension study of orally administered deucrictibant extended-release tablet (40 mg/day) for the prophylactic treatment of HAE attacks. Participants in the open-label extension study are 12 years or older, have been diagnosed with HAE, and may either have rolled over from the CHAPTER-3 randomized clinical study, may transition to CHAPTER-4 after participating in the long-term extension study of Phase 2 prophylactic study using the twice-daily deucrictibant immediate-release capsule (CHAPTER-1 Part 2, NCT05047185), or may qualify following an eligibility confirmation via screening period. The intention of the study is to evaluate the tolerability and efficacy of deucrictibant extended-release tablet in the prophylactic treatment of HAE attacks.

On-demand Treatment of HAE Attacks

- **Topline data from RAPIDe-3 (NCT06343779), a global Phase 3 study evaluating deucrictibant for the treatment of HAE attacks, anticipated 1Q2026.** Advancement of RAPIDe-3, a global pivotal Phase 3 study of deucrictibant immediate-release capsule (20 mg) for the on-demand treatment of HAE attacks in adults and adolescents (12 years and older), is progressing as planned with a target enrollment of approximately 120 participants. The primary efficacy endpoint is time to onset of symptom relief, as measured by Patient Global Impression of Change (PGI-C) rating of at least "a little better" for two consecutive timepoints within 12 hours post-treatment. Other efficacy endpoints include time to End of Progression (EoP) in attack symptoms, substantial symptom relief, complete attack resolution and proportion of attacks achieving symptom resolution with one dose of deucrictibant as measured by Patient Global Impression of Severity (PGI-S) and by Angioedema Symptom Rating Scale (AMRA). Pharvaris anticipates announcing topline data of RAPIDe-3 in the first quarter of 2026.
- **Phase 2/3 open-label extension, RAPIDe-2 (NCT05396105), of deucrictibant immediate-release capsule for the treatment of HAE attacks ongoing.** All participants from RAPIDe-2 Part A, the dose-blinded open-label extension study of RAPIDe-1 (NCT04618211), as well as

participants who have completed RAPIDe-3, have or will be offered to enter Part B, the open-label extension study of deucrictibant immediate-release capsule (20 mg), which is the dose being used in RAPIDe-3 and currently the intended commercial dosage. The intention of the study is to evaluate the tolerability and efficacy of deucrictibant immediate-release capsule in the on-demand treatment of HAE attacks.

Clinical Development of Deucrictibant in AAE-C1 INH

- **Clinical development plans of deucrictibant in acquired angioedema due to C1-INH deficiency (AAE-C1INH) underway.** Currently, there are no approved therapies to address AAE-C1INH[1]. Pharvaris has engaged stakeholders, including the U.S. Food and Drug Administration (FDA), for feedback on a clinical development plan designed to evaluate the potential of deucrictibant to address an unmet medical need for therapies for the treatment of AAE-C1INH; Pharvaris intends to initiate a clinical study in 2025 pending feedback from regulators.

Business Updates

Corporate

- **Expansion of Pharvaris team to support deucrictibant launch preparedness, as well as business growth and planning.** Chris Wilson joined Pharvaris as the Vice President of Sales & Marketing, North America, bringing a wealth of expertise in HAE product commercialization and executing strategic sales and marketing initiatives. Christa Milley joined Pharvaris as the Vice President, Head of Business Development, bringing an extensive deal sheet that demonstrates her track record of identifying, evaluating, structuring, negotiating, and executing deals to support our corporate development strategy.
- **HAE treatment experience and burden of disease data presented at recent medical congresses.** Data from the Adelphi Disease Specific Programme™, a real-world cross-sectional survey of physicians and people living with HAE, were presented in two oral presentations at the Spanish Society of Allergology and Clinical Immunology (SEAIC) International Symposium and a poster at the BSI Clinical Immunology Network (BSI-CIPN) Conference. One oral presentation characterized the treatment of HAE airway attacks, detailing the considerable pain, fatigue, and emotional distress experienced; despite the potential consequences, approximately one-third of HAE airway attacks were not treated, underscoring the importance for people with HAE to align

[1] Petersen et al. *J Allergy Clin Immunol* July 2024.

with clinical guidelines to carry on-demand therapy, as well as highlighting the need for portable therapies. The second oral presentation investigated the burden of disease in people living with HAE and their caregivers in Europe, concluding that people with HAE who reported a greater need for caregiver support—driven by the support for medication management—experienced significant impairment in activity and a reduced quality of life. The poster presented at BSI-CIPN characterized the experience of people living with HAE in the United Kingdom with current treatments, all of whom were prescribed injectable on-demand medications. The most common unmet need associated with currently prescribed long-term prophylactic and on-demand medications was a desire for a different route of administration. This analysis highlights the unmet need for novel oral options.

Upcoming Participation at Investor Conferences

- **43rd Annual J.P. Morgan Healthcare Conference.** San Francisco, CA, January 13-16, 2025.
    - **Format:** Company Presentation
      Presenter: Berndt Modig, CEO
      Date, time: Wednesday, January 15, 2025, 5:15-5:55 p.m. PST (8:15-8:55 p.m. EST)
- **Oppenheimer 35th Annual Healthcare Life Sciences Conference.** Virtual, February 11-12, 2025.
    - **Format:** Fireside Chat
      Presenters: Berndt Modig, CEO; Wim Souverijns, Ph.D., CCO; Peng Lu, M.D., Ph.D., CMO
      Date, time: Wednesday, February 12, 2025, 9:20-9:50 a.m. EST

Live audio webcasts of the J.P. Morgan and Oppenheimer presentations will be available on the Investors section of the Pharvaris website at: https://ir.pharvaris.com/news-events/events-presentations. The audio replays will be available on Pharvaris' website for 30 days following the presentation.

Upcoming Presentations at Medical Congresses

- **American Academy of Allergy, Asthma & Immunology (AAAAI) 2025 Annual Meeting.** San Diego, CA, February 28-March 4, 2025. Details for the accepted poster presentations at AAAAI are as follows:
    - **Title:** Long-Term Safety and Efficacy of Oral Deucrictibant for Prophylaxis in Hereditary Angioedema: Results of the CHAPTER-1 Open-Label Extension Study

Presenter: Marc A. Riedl, M.D., M.S.
Date, time: Sunday, March 2, 2025, 9:45-10:45 a.m. PST (12:45-1:45 p.m. EST)

- **Title:** Long-Term Prophylactic Treatment with Oral Deucrictibant Improves Health-Related Quality of Life of Patients with Hereditary Angioedema: CHAPTER-1 Open-Label Extension Study
  Presenter: John Anderson, M.D.
  Date, time: Sunday, March 2, 2025, 9:45-10:45 a.m. PST (12:45-1:45 p.m. EST)
- **Title:** Long-Term Safety and Efficacy of Oral Deucrictibant for Treatment of Hereditary Angioedema Attacks: Results of the RAPIDe-2 Extension Study
  Presenter: Michael E. Manning, M.D.
  Date, time: Sunday, March 2, 2025, 9:45-10:45 a.m. PST (12:45-1:45 p.m. EST)

The posters will be available on the Investors section of the Pharvaris website at: https://ir.pharvaris.com/news-events/events-presentations.

About Deucrictibant
Deucrictibant is a novel, potent, oral small-molecule bradykinin B2 receptor antagonist currently in clinical development. By inhibiting bradykinin signaling through the bradykinin B2 receptor, deucrictibant has the potential to prevent the occurrence of HAE attacks and to treat the manifestations of an attack if/when they occur. Based on its chemical properties, Pharvaris is developing two formulations of deucrictibant for oral administration: an extended-release tablet to enable sustained absorption and efficacy in prophylactic treatment, and an immediate-release capsule to enable rapid onset of activity for on-demand treatment.

About Pharvaris
Pharvaris is a late-stage biopharmaceutical company developing novel, oral bradykinin B2 receptor antagonists to potentially address all types of bradykinin-mediated angioedema. Pharvaris has the ambition to provide injectable-like efficacy and placebo-like tolerability with the convenience of an oral therapy to prevent and treat HAE attacks. With positive data in both Phase 2 prophylaxis and on-demand studies in HAE, Pharvaris is currently evaluating the efficacy and tolerability of deucrictibant in a pivotal Phase 3 study for the prevention of HAE attacks (CHAPTER-3) and a pivotal Phase 3 study for the on-demand treatment of HAE attacks (RAPIDe-3). For more information, visit https://pharvaris.com/.

Forward Looking Statements

This press release contains certain forward-looking statements that involve substantial risks and uncertainties. All statements contained in this press release that do not relate to matters of historical fact should be considered forward-looking statements, including, without limitation, statements relating to our future plans, studies and trials, and any statements containing the words “believe,” “anticipate,” “expect,” “estimate,” “may,” “could,” “should,” “would,” “will,” “intend” and similar expressions. These forward-looking statements are based on management’s current expectations, are neither promises nor guarantees, and involve known and unknown risks, uncertainties and other important factors that may cause Pharvaris’ actual results, performance or achievements to be materially different from its expectations expressed or implied by the forward-looking statements. Such risks include but are not limited to the following: uncertainty in the outcome of our interactions with regulatory authorities, including the FDA; the expected timing, progress, or success of our clinical development programs, especially for deucrictibant immediate-release capsules and deucrictibant extended-release tablets, which are in late-stage global clinical trials; our ability to replicate the efficacy and safety demonstrated in the RAPIDe-1, RAPIDe-2, and CHAPTER-1 Phase 2 studies in ongoing and future nonclinical studies and clinical trials; risks arising from epidemic diseases, such as the COVID-19 pandemic, which may adversely impact our business, nonclinical studies, and clinical trials; our ability to potentially use deucrictibant for alternative purposes, for example to treat C1-INH deficiency (AAE-C1INH); the outcome and timing of regulatory approvals; the value of our ordinary shares; the timing, costs and other limitations involved in obtaining regulatory approval for our product candidates, or any other product candidate that we may develop in the future; our ability to establish commercial capabilities or enter into agreements with third parties to market, sell, and distribute our product candidates; our ability to compete in the pharmaceutical industry, including with respect to existing therapies, emerging potentially competitive therapies and with competitive generic products; our ability to market, commercialize and achieve market acceptance for our product candidates; our ability to produce sufficient amounts of drug product candidates for commercialization; our ability to raise capital when needed and on acceptable terms; regulatory developments in the United States, the European Union and other jurisdictions; our ability to protect our intellectual property and know-how and operate our business without infringing the intellectual property rights or regulatory exclusivity of others; our ability to manage negative consequences from changes in applicable laws and regulations, including tax laws (including the Biosecure Act), our ability to successfully remediate the material weaknesses in our internal control over financial reporting and to maintain an effective system of internal control over financial reporting; changes and uncertainty in general market, political and economic conditions, including as a result of inflation and the current conflict between Russia and Ukraine and the Hamas attack against Israel and the ensuing war; and the other factors described under the headings “Cautionary Statement Regarding Forward-Looking

Statements" and "Item 3. Key Information—D. Risk Factors" in our Annual Report on Form 20-F and other periodic filings with the U.S. Securities and Exchange Commission. These and other important factors could cause actual results to differ materially from those indicated by the forward-looking statements made in this press release. Any such forward-looking statements represent management's estimates as of the date of this press release. New risks and uncertainties may emerge from time to time, and it is not possible to predict all risks and uncertainties. While Pharvaris may elect to update such forward-looking statements at some point in the future, Pharvaris disclaims any obligation to do so, even if subsequent events cause its views to change. These forward-looking statements should not be relied upon as representing Pharvaris' views as of any date subsequent to the date of this press release.

Contact
Maggie Beller
Executive Director, Head of Corporate and Investor Communications
maggie.beller@pharvaris.com

Exhibit 99.2

PHARVARIS

Corporate Presentation

Pioneering science for patient choice

January 2025

Disclaimer

This Presentation contains certain “forward-looking statements” within the meaning of the federal securities laws that involve substantial risks and uncertainties. All statements contained in this Presentation that do not relate to matters of historical fact should be considered forward-looking statements, including, without limitation, statements relating to our future plans, studies and trials, and any statements containing the words “believe,” “anticipate,” “expect,” “estimate,” “may,” “could,” “should,” “would,” “will,” “intend” and similar expressions. We have based these forward-looking statements largely on our current expectations and projections about future events and trends that we believe may affect our financial condition, results of operations, business strategy and financial needs. Such forward-looking statements are neither promises nor guarantees, and involve known and unknown risks, uncertainties and other important factors which may cause our actual results, financial condition, performance or achievements, or industry results, to be materially different from any future results, performance or achievements expressed or implied by such forward-looking statements. Factors that might cause such a difference include, but are not limited to, uncertainty in the outcome of our interactions with regulatory authorities, including the FDA, the expected timing, progress, or success of our clinical development programs, especially for deucrictibant immediate-release capsules and deucrictibant extended-release tablets, which are in late-stage global clinical trials, our ability to replicate the efficacy and safety demonstrated in the RAPIDe-1, RAPIDe-2, and CHAPTER-1 Phase 2 studies in ongoing and future nonclinical studies and clinical trials, risks arising from epidemic diseases such as the COVID-19 pandemic, which may adversely impact our business, nonclinical studies, and clinical trials, our ability to potentially use deucrictibant for alternative purposes, for example to treat C1-INH deficiency (AAE-C1INH), the outcome and timing of regulatory approvals, the value of our ordinary shares, the timing, costs and other limitations involved in obtaining regulatory approval for our product candidates, or any other product candidate that we may develop in the future, our ability to establish commercial capabilities or enter into agreements with third parties to market, sell, and distribute our product candidates, our ability to compete in the pharmaceutical industry, including with respect to existing therapies, emerging potentially competitive therapies and with competitive generic products, our ability to market, commercialize and achieve market acceptance for our product candidates, our ability to produce sufficient amounts of drug product candidates for commercialization, our ability to raise capital when needed and on acceptable terms, regulatory developments in the United States, the European Union and other jurisdictions, our ability to protect our intellectual property and know-how and operate our business without infringing the intellectual property rights or regulatory exclusivity of others, our ability to manage negative consequences from changes in applicable laws and regulations, including tax laws (including the Biosecure Act), our ability to successfully remediate the material weaknesses in our internal control over financial reporting and to maintain an effective system of internal control over financial reporting, changes and uncertainty in general market, political and economic conditions, including as a result of inflation and the current conflict between Russia and Ukraine, the Hamas attack against Israel and the ensuing war, and the other factors described under the headings "Cautionary Statement Regarding Forward-Looking Statements" and "Item 3. Key Information--D. Risk Factors" in our Annual Report on Form 20-F and other periodic filings with the Securities and Exchange Commission. New risks and uncertainties may emerge from time to time, and it is not possible to predict all risks and uncertainties. We undertake no obligation to publicly update any forward-looking statements, whether as a result of new information, future events or otherwise, except as required by law.

This presentation includes data for an investigational product not yet approved by regulatory authorities. Certain information contained in this Presentation relates to or is based on studies, publications, surveys and other data obtained from third-party sources and the Company’s own internal estimates and research. While the Company believes these third-party sources to be reliable as of the date of this presentation, it has not independently verified, and makes no representation as to the adequacy, fairness, accuracy or completeness of, any information obtained from third-party sources. In addition, all of the market data included in this Presentation involves a number of assumptions and limitations, and there can be no guarantee as to the accuracy or reliability of such assumptions. Finally, while we believe our own internal research is reliable, such research has not been verified by any independent source.

Pioneering science for patient choice for hereditary angioedema (HAE)

DEUCRICTIBANT

FDA orphan drug designation[1]

Robust IP on CoM (granted in multiple territories, initial term to 2038) and formulations[2,3]

TWO LATE-STAGE PROGRAMS

- Deucrictibant is an orally available small molecule targeting the **validated bradykinin B2 receptor**[4]
- Results from randomized Phase 2 trials [5,6] and their ongoing extensions[7,8] **demonstrate a differentiated profile** for both **preventing** and **treating** HAE attacks with **injectable-like efficacy**, **rapid onset of action**, a **favorable tolerability profile**, and **oral convenience** over current standard of care[9] for people living with HAE

LARGE GLOBAL HAE MARKET

- Predicted **$5.2B market** in 2036[10]
- While people living with HAE appear satisfied with their treatment, history has shown that the availability of a **more efficacious, better-tolerated** and/or **more convenient** alternative drives a **dynamic switch to the better product**[11]
- Internationally, the **long-term prevention** market is likely to **grow significantly**[10]

STRONG FUNDAMENTALS

- Two pivotal **Phase 3** studies **designed to differentiate** current standard of care in both prophylaxis and on-demand treatments
- Accomplished team with **track record in HAE drug development and commercialization**
- Approximately **€305M** cash and cash equivalents as of September 30, 2024

Source: [1]U.S. FDA OOPD listing. [2]World Intellectual Property Organization. [3]European Patent Office. [4]Lesage et al. *Int. Immunopharmacology*. 2022. [5]Riedl MA et al. AAAAI 2024. [6]Maurer M et al. AAAAI 2023. [7]Riedl MA et al. BKS 2024. [8]Maurer M et al. BKS 2024. [9]Riedl MA at al. BKS 2024. [10]IQVIA predictions. [11]Evaluate Pharma Uptake Curves 2008-2023.

This presentation includes data for an investigational product not yet approved by regulatory authorities.

HAE: A rare, life-long genetic condition with significant burden

Unpredictable attacks

Frequency, location, severity[1]
- Often, unknown triggers[1,2]
- If untreated, **attacks may last up to 5 days**[3]

Painful and debilitating

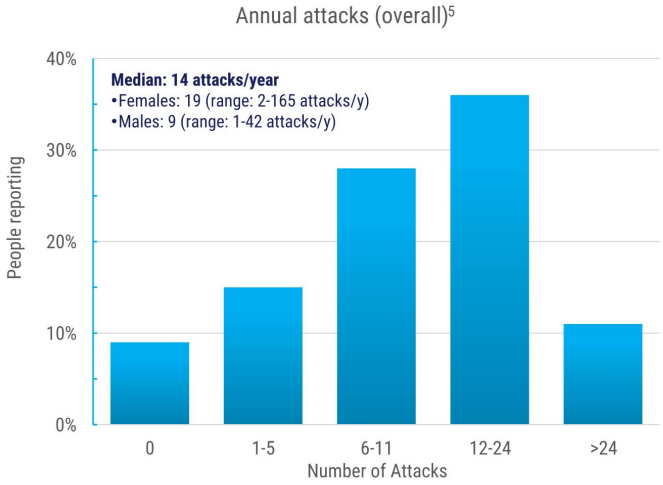
Leading to hospitalization[1]
- **Potentially life-threatening** due to asphyxiation[1]

Rare

1:30,000 to 1:80,000 individuals globally[4]

United States[4] ~7,000 individuals

Europe[4] ~15,000 individuals



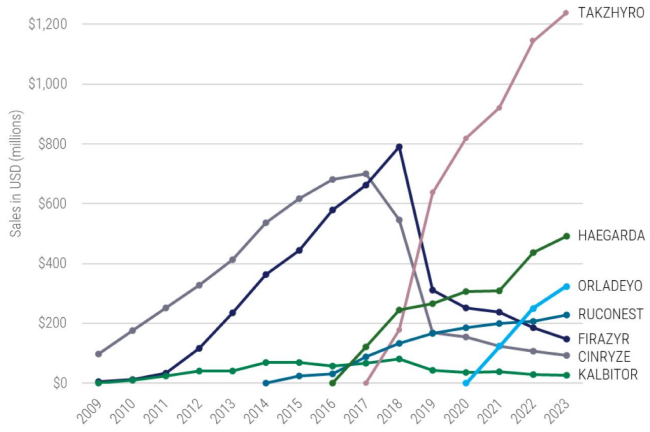
HAE: hereditary angioedema

Source: [1]Betschel SD, et al. *J Allergy Clin Immunol Pract*. 2023. [2]Christiansen SC, et al. *Ann Allergy Asthma Immunol*. 2023. [3]Bork K et al. *Allergy Asthma Clin Immunol*. 2021. [4]Lumry WR *Front. Med*. 2018. [5]Nordenfelt P et al. *Acta Derm. Venereol* 2016.

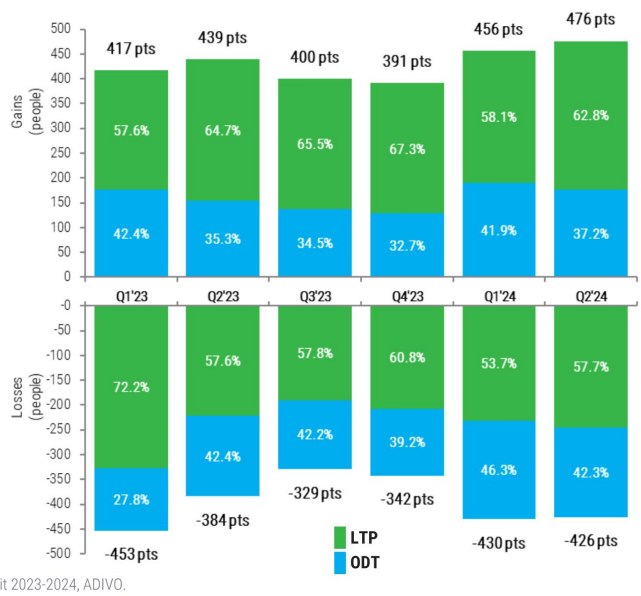
The HAE market is dynamic, with people actively seeking a better* product

People living with HAE actively switch therapies[1,2]: first-to-market is no guarantee for long-term market leadership

Evolution of HAE product sales[1,2]



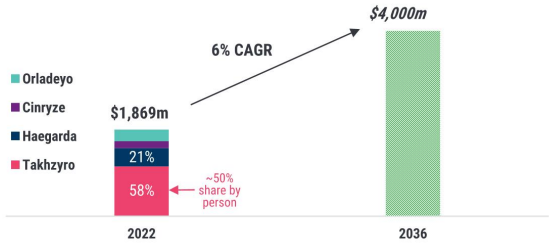
U.S. HAE switches, gains ✂ and losses 〰[3]



HAE: hereditary angioedema. *Treatment selection is driven by physicians and patient preference.
Source: [1]Evaluate Pharma uptake curves 2008-2023 [2]SEC filings (BioCryst, CSL Behring, Pharming, Takeda). [3]U.S. Chart Audit 2023-2024, ADIVO.

In the U.S., significant growth in the long-term prophylaxis (LTP) and on-demand therapy (ODT) market is expected over the next decade[1]

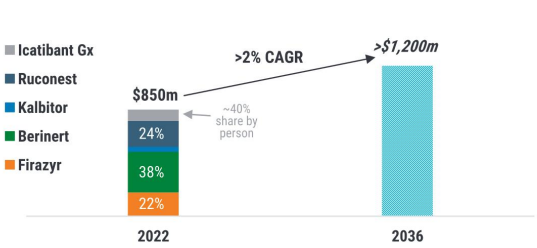
Value of prophylaxis[1-3]



Growth expected to be driven by:

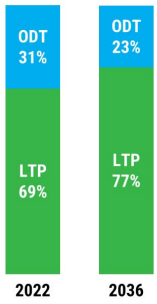
- New options
- Increased convenience
- Continued paradigm shift from ODT to LTP

Value of on-demand[1-3]



Growth expected to be driven by:

- New options
- Increased convenience
- Increased treatment rate



LTP to further grow as the dominant treatment paradigm in the U.S. market through to 2036[1]

HAE market growth will be driven by increased efficacy and convenience of new therapies

Source: [1]IQVIA market evolution and company data. [2]Evaluate Pharma uptake curves 2008-2023. [3]SEC filings (BioCryst, CSL Behring, Pharming, Takeda).

People living with HAE are seeking a life not defined by their condition nor burdened by its management[1]

Efficacy is a prime driver…

but **safety and tolerability** cause exploration of alternatives…

…while **convenience** is a key driver for overall preference[2]

People living with HAE actively switch between products[3], seeking improvement in efficacy, safety/tolerability, and convenience

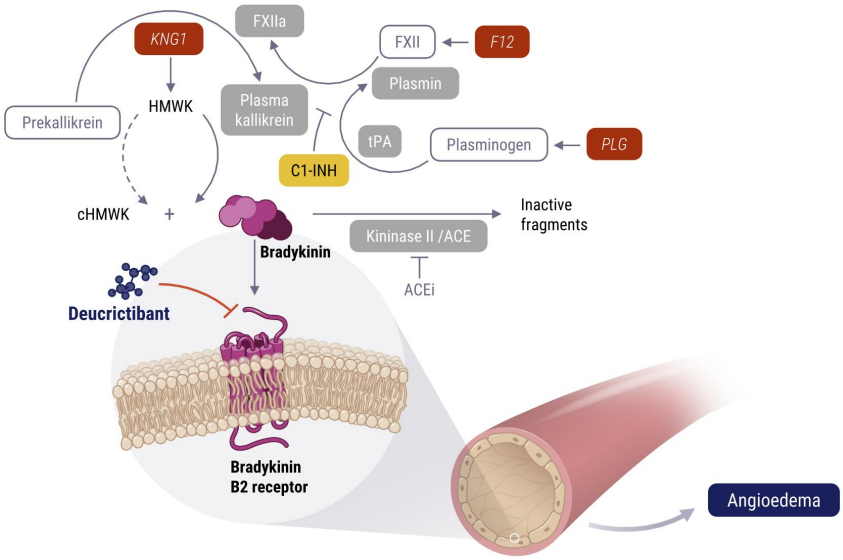
Source: [1]Lumry WR et al. *Allergy Asthma Proc*. 2020. [2]Geba et al, *J Drug Access*.2021. [3]U.S. Chart Audit 2023-2024, ADIVO.

Bradykinin B2 receptor antagonism is a foundational mechanism to treat and prevent bradykinin-mediated angioedema attacks[1,2]

Deucrictibant is a bradykinin B2 receptor antagonist in development for prevention and treatment of HAE attacks

Directly blocks the main mediator of swelling and inflammation[1,3]

Has potential to prevent or treat bradykinin-mediated angioedema **irrespective of source of bradykinin**[4-6]



Source: [1]Maurer M, et al. *Allergy*. 2022. [2]Zuraw BL *World Allergy Orphan J*. 2010. [3]Lumry WR et al. *Allergy Asthma Proc*. 2020. [4]Riedl MA et al. AAAAI 2024. [5]Maurer M et al. AAAAI 2023. [6]Petersen RS et al. *J Allergy Clin Immunol*. 2024.

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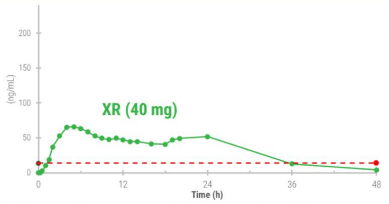
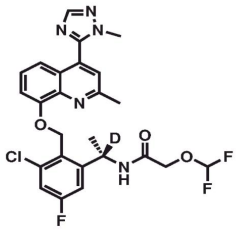
Deucrictibant has the potential to address unmet needs of people living with HAE

DEUCRICTIBANT
extended-release (XR) tablet
sustained absorption[1]

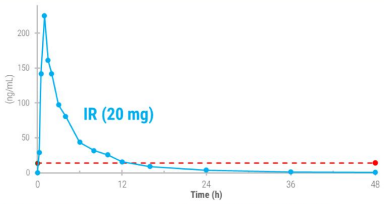


Maintains sustained therapeutic exposure over 24 hours[2] from day one, allowing for once-daily oral treatment to prevent HAE attacks*



deucrictibant

DEUCRICTIBANT
immediate-release (IR) capsule
rapid absorption[3]



Rapidly reaches therapeutic exposure within 15-30 minutes[4], making it optimal for on-demand oral treatment of HAE attacks*

Two oral products with the same active ingredient for the prevention and treatment of HAE attacks

HAE: hereditary angioedema. *To be confirmed with clinical data from Phase 3 studies
Source: [1]Company data: single-dose cross-over PK study in healthy volunteers (n=14) under fasting conditions. [2]Lesage A et al. IDDST 2024. [3]Crabbe et al. AAAAI 2021. [4]Maurer M et al. AAAAI 2023.

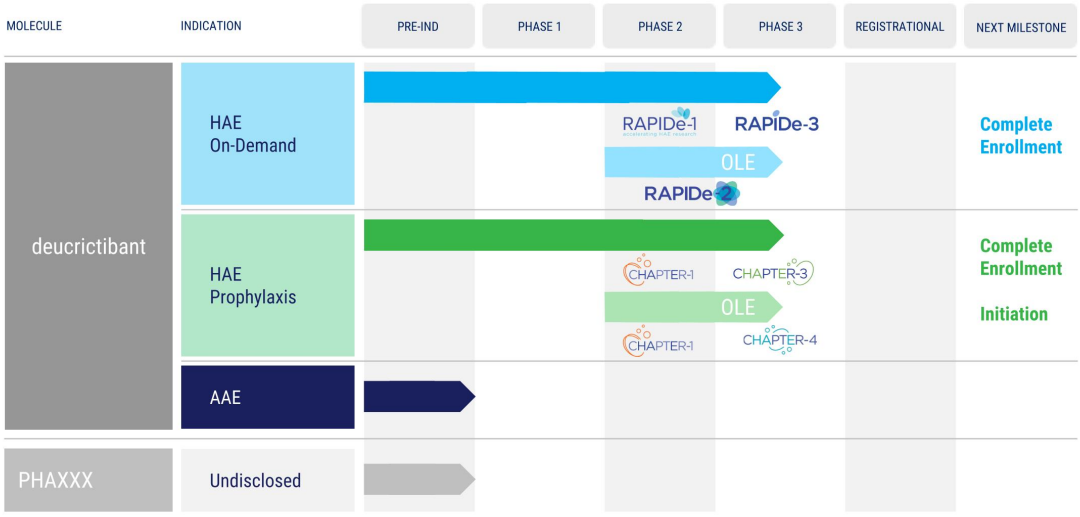
Deucrictibant differentiated profile for LTP and ODT

		LTP	ODT
Oral ODT or LTP Formulations	**Deucrictibant is the only HAE therapy**[1] in development that allows for oral administration **in both prophylaxis and on-demand**[2]	✓	✓
Single Oral Pill	**Specific formulations** allow for **once-daily dosing**[3] (XR for LTP) or **rapid, single-dose resolution**[4] of HAE attacks (IR for ODT)	✓	✓
Rapid to Steady State	Deucrictibant XR has the potential to achieve steady state within 2-3 days[5], providing **protection against HAE attacks on the initial day**[3] of LTP initiation	✓	
Rapid Absorption	Within 15-30 minutes[6], deucrictibant IR reaches therapeutic exposure resulting in the halt of attack progression within **30 minutes**[7]		✓
Longer Effective Exposure	A longer effective exposure can potentially result in a **high rate of single-dose attack resolution**[8]		✓

LTP: long-term prophylaxis. ODT: on-demand therapy. XR: extended-release tablet formulation of deucrictibant. IR: immediate-release capsule formulation of deucrictibant.
Sources: [1]Company research. [2]Leasge et al. IDDST 2024. [3]Groen K et al. ACAAI 2022. [4]Li H et al. EAC 2024. [5]Maurer M et al. HAEi Workshop, 2022. [6]Maurer M et al. AAAAI 2023. [7]Riedl et al. WSAAI 2024. [8]Maurer M et al. BKS 2024.

This presentation includes data for an investigational product not yet approved by regulatory authorities.

Wholly-owned pipeline focused on bradykinin B2 receptor mechanism



HAE: hereditary angioedema. AAE: acquired angioedema. OLE: open-label extension

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Deucrictibant clinical development program

Long-Term Prophylaxis (LTP)			On-Demand Treatment (ODT)		
CHAPTER-1	Phase 2[1]	Part 1: randomized controlled primary analysis (complete) Part 2: open-label extension (ongoing)	RAPIDe-1	Phase 2[4]	Complete
CHAPTER-3	Phase 3 pivotal[2]	Ongoing	RAPIDe-2	Phase 2/3 LTE[5]	Ongoing
CHAPTER-4	Phase 3 OLE[3]	Start-up	RAPIDe-3	Phase 3 pivotal[6]	Ongoing

OLE: open-label extension. LTE: long-term extension.
Source: [1]NCT05047185. [2]NCT06669754. [3]NCT06679881. [4]NCT04618211. [5]NCT05396105. [6]NCT06343779.

Deucrictibant shows the potential to address unmet needs of people living with HAE

Long-Term Prophylaxis (LTP)

Efficacy	Early-onset attack reduction sustained for over one year in ongoing OLE study[1]
Quality of Life	Improvement in disease control and health-related quality of life paralleled attack reduction in Phase 2[2,3]
Safety & Tolerability	Phase 2 safety and tolerability profile confirmed in ongoing OLE study[1,4]
Formulation	Intended commercial formulation for once-daily dosing ready for Phase 3

Potential preferred option for LTP

On-Demand Treatment (ODT)

Efficacy

- Onset of symptom relief with median PGI-C "a little better" ~ 1.1 hour
- Symptom resolution with PGI-S "none" ~ 11.5 hours in ongoing LTE study[5]
- 85.8% of attacks achieved complete symptom resolution within 24 hours in ongoing LTE; 90.2% of which with single dose[5]

Safety & Tolerability: Phase 2 safety and tolerability profile confirmed in ongoing LTE study[5,6]

Potential preferred option for ODT

HAE: hereditary angioedema. OLE: open-label extension. LTE: long-term extension. PGI-C: patient global impression of change. PGI-S: patient global impression of severity.
Source: [1]Riedl MA et al. BKS 2024. [2]Valerieva A et al. EAACI 2024. [3]Magerl M et al. BKS 2024. [4]Riedl MA et al. AAAAI 2024. [5]Maurer M et al. BKS 2024. [6]Maurer M et al. AAAAI 2023.

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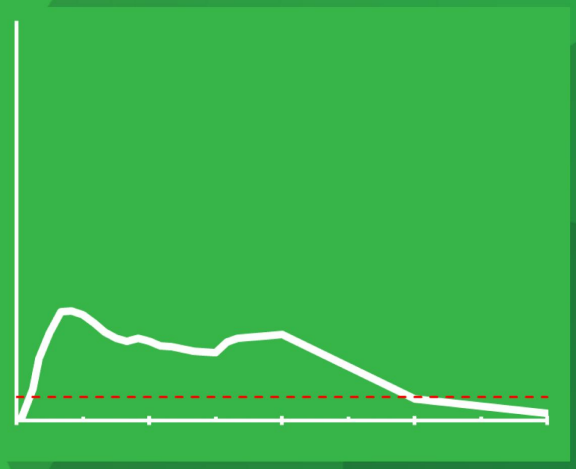
Deucrictibant extended-release tablets

Long-Term Prophylaxis



Deucrictibant clinical development for LTP and ODT

Long-Term Prophylaxis (LTP)			On-Demand Treatment (ODT)		
CHAPTER-1	Phase 2[1]	Part 1: randomized controlled primary analysis (complete) Part 2: open-label extension (ongoing)	RAPIDe-1	Phase 2[4]	Complete
CHAPTER-3	Phase 3 pivotal[2]	Ongoing	RAPIDe-2	Phase 2/3 LTE[5]	Ongoing
CHAPTER-4	Phase 3 OLE[3]	Start-up	RAPIDe-3	Phase 3 pivotal[6]	Ongoing

OLE: open-label extension. LTE: long-term extension.
Source: [1]NCT05047185. [2]NCT06669754. [3]NCT06679881. [4]NCT04618211. [5]NCT05396105. [6]NCT06343779.

Positive topline data from CHAPTER-1, a Phase 2 study of deucrictibant the for prophylaxis of HAE attacks

Primary endpoint met: **84.5%** reduction in monthly attack rate versus placebo at week 12 (p=0.0008)*

92.3%
reduction in occurrence of **moderate and severe attacks***

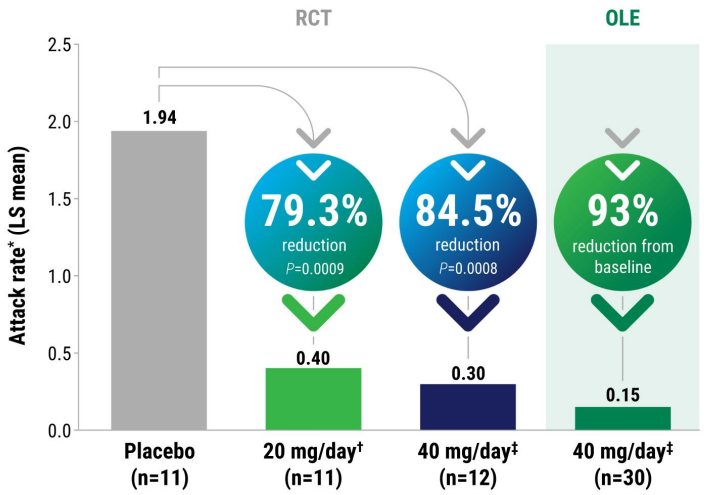
92.6%
reduction in occurrence of **attacks treated with on-demand medication***

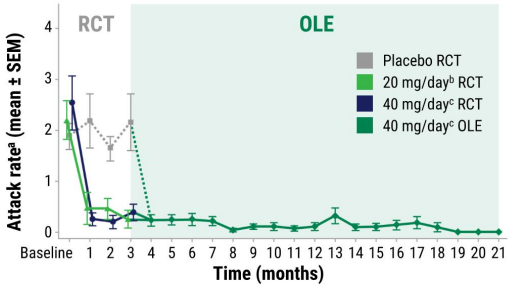
Clinically **meaningful results** across primary, secondary, and health-related quality of life endpoints

Deucrictibant **well-tolerated** at both doses

*40 mg/day deucrictibant treatment group; %reduction in monthly attack rate is based on a Poisson regression model. All attacks reported herein are investigator-confirmed; attack rate is number of attacks per month of exposure, also referred to as time-normalized number of attacks; all statistical analyses comparing deucrictibant and placebo are made without adjustment for multiplicity. HAE: hereditary angioedema.
Source: Aygören-Pürsün E et al. EAACI 2024.

Continuing deucrictibant treatment sustained the early-onset attack reduction for over one year





In the open-label extension up to 18 months:

- **93% attack rate reduction from baseline**
- Median attack rate = 0 for every month
- 99% of days symptom free

IR, immediate release; OLE, open label extension; RCT, randomized controlled trial. N = number of participants randomized in each treatment group in Part 1 of the study. N' = number of participants in the OLE. [a]1 month = 4 weeks. [b]Deucrictibant IR capsule, 10 mg twice daily. [c]Deucrictibant IR capsule, 20 mg twice daily. Source: Riedl MA et al. BKS 2024.

Deucrictibant efficacy and tolerability profile could address unmet needs in the prophylactic setting, with the convenience of a daily tablet

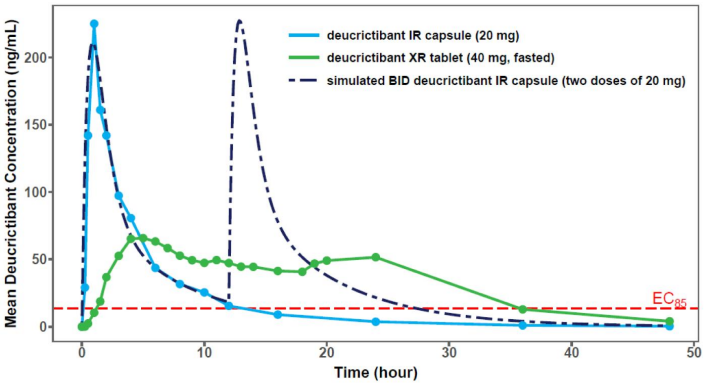
	Cinryze® (pdC1INH)	Haegarda® (pdC1INH)	Takhzyro® (lanadelumab)	Orladeyo® (berotralstat)	garadacimab	donidalorsen	deucrictibant	
Mechanism of Action	Plasma-derived C1NH	Plasma-derived C1INH	Anti-plasma kallikrein mAb	Plasma kallikrein inhibitor	Anti-FXIIa mAb	Plasma kallikrein inhibitor	Bradykinin B2 receptor antagonist	
Clinical Trial(s)	Ph 3§ (500 U, 1,000 U)	Ph 3§§ (60 IU/Kg)	Ph 3† (300mg q2w / q4w)	Ph 3†† (150mg daily)	Ph 3†	Ph 3¶ (80 mg q4w, q8w)	Ph 2‡ (40mg/day)	Ph 2/3 OLE
Mean monthly attack reduction vs. placebo	71-85%[1]	84%[2]	73-87%[4]	44%[6,7]	89%[8]	55-81%[9]	85%[10,11]	93%¤[12]
Mean reduction in use of ODT vs. placebo	-	89%[2]	74-87%[4]	54%[7]	88%[8]	67-92%¶¶[9]	93%[10,11]	pending publication
≥50% attack reduction	-	90%#[2,3]	100-100% vs. 32%[4,5]	58% vs. 25%[6,7]	95% vs. 33%[8]	83-93% vs. 27%¶¶[9]	90% vs. 18%[11]	pending publication
≥70% attack reduction	-	83%#[2,3]	76-89% vs. 10%[4,5]	50% vs. 15%[6,7]	92% vs. 17%[8]	65-92% vs. 18%¶¶[9]	80% vs. 18%[11]	pending publication
≥90% attack reduction	-	58%#[2,3]	55-67% vs. 5%[4,5]	23% vs. 8%[6,7]	74% vs. 8%[8]	48-62% vs. 9%¶¶[9]	60% vs. 0%[11]	pending publication
% patients attack-free vs. placebo	-	40% vs. 0%[2,3]	31-44% vs. 2%[4,5]	10% vs. 2.5%[6]	62% vs. 0%[8]	35-53% vs. 9%¶¶[9]	40% vs. 0%[11]	pending publication

§ Crossover, 12 weeks/treatment. §§ Crossover, 16 weeks/treatment (results reported for weeks 3-16 for each treatment arm). † Parallel-arms, 26 weeks. †† Parallel-arms, 24 weeks. ¶ Parallel-arms, 25 weeks. ‡ Parallel-arms, 12 weeks. # vs. placebo. ¶¶ Weeks 5-25. ¤ vs. RCT Part 1 baseline.

Source: [1]Cinryze® US PI, Feb 2023. [2]Longhurst H et al. *N Engl J Med*. 2017. [3]Haegarda® US PI, Jan 2022. [4]Takhzyro® US PI, Feb 2023. [5]Banerji A et al. *JAMA*. 2018. [6]Zuraw B et al. *J Allergy Clin Immunol*. 2021. [7]Orladeyo® US PI, Nov 2023. [8]Craig TJ et al. *Lancet*. 2023. [9]Riedl MA et al. *N Engl J Med*. 2024. [10]Aygören-Pürsün E et al. EAACI 2024. [11]Aygören-Pürsün E et al. BKS 2024. [12]Riedl MA et al. BKS 2024.

This presentation includes data for an investigational product not yet approved by regulatory authorities.

Commercial XR formulation maintains exposure above therapeutic level for at least 24 hours



- **Extended-release** matrix controls release and absorption of compound in small intestine as well as in colon
- Supports **once-daily** dosing while maintaining exposure more consistently versus twice-daily IR (used in proof-of-concept Phase 2 CHAPTER-1 study)
- **Formulation patent** applications filed with broad coverage of worldwide pharmaceutical markets

XR: extended-release tablet formulation of deucrictibant. IR: immediate-release capsule formulation of deucrictibant.
Source: Company data: single-dose cross-over PK study in healthy volunteers (n=14) under fasting conditions

CHAPTER-3 RCT and CHAPTER-4 OLE

Two-part, global Phase 3 study of deucrictibant for prophylaxis of HAE attacks

Enrollment

- Target enrollment of approximately 81 adolescents and adults living with HAE
- Top-line data anticipated in the second half of 2026

Objectives

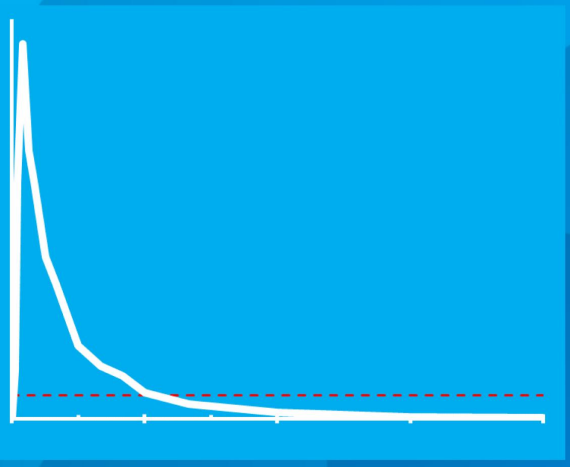
- Evaluation and characterization of investigator-confirmed HAE attacks during 24-week treatment period
- Incidence of treatment-emergent adverse events
- Evaluation of deucrictibant XR pharmacokinetics
- Measure of change in participant-reported quality of life

RCT: randomized clinical trial. OLE: open-label extension. HAE: hereditary angioedema. XR: extended-release tablet.

This presentation includes data for an investigational product not yet approved by regulatory authorities.

Deucrictibant immediate-release capsules

On-Demand



Deucrictibant clinical development for LTP and ODT

Long-Term Prophylaxis (LTP)

CHAPTER-1	Phase 2[1]	Part 1: randomized controlled primary analysis (complete) Part 2: open-label extension (ongoing)
CHAPTER-3	Phase 3 pivotal[2]	Ongoing
CHAPTER-4	Phase 3 OLE[3]	Start-up

On-Demand Treatment (ODT)

RAPIDe-1	Phase 2[4]	Complete
RAPIDe-2	Phase 2/3 LTE[5]	Ongoing
RAPIDe-3	Phase 3 pivotal[6]	Ongoing

OLE: open-label extension. LTE: long-term extension.
Source: [1]NCT05047185. [2]NCT06669754. [3]NCT06679881. [4]NCT04618211. [5]NCT05396105. [6]NCT06343779.

RAPIDe-1, a Phase 2 on-demand study of deucrictibant in HAE

RAPIDe-1

Primary endpoint met: deucrictibant IR significantly reduced attack symptoms versus placebo*[1]

Deucrictibant IR **substantially reduced** the use of **rescue medications**[1]

Deucrictibant IR **well-tolerated** at all doses[1]

Deucrictibant IR showed rapid onset of action, symptom relief, and resolution of HAE attacks

End of symptom progression in **25-26 minutes*** (based on AMRA-3)†[2]

5-fold reduction in use of rescue medication*[1]

Onset of symptom relief achieved in **2.4 hours*** (≥30% reduction in AMRA-3)[1]

HAE: hereditary angioedema. IR: immediate-release. AMRA, Angioedema Symptom Rating Scale.
*pooled 10, 20, 30 mg deucrictibant treatment group †based on post-hoc analysis.
Source: [1]Maurer M et al. AAAAI 2023. [2] Riedl MA et al. ACAAI 2023.

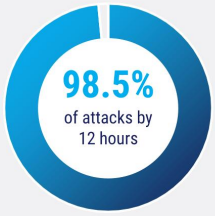
RAPIDe-2*, a long-term extension of RAPIDe-1

In the current analysis of the ongoing RAPIDe-2 Phase 2/3 extension study, **deucrictibant IR capsule was well-tolerated** for all studied doses with no new safety signals observed

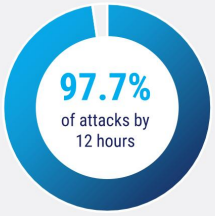
Efficacy analysis showed:

Results from the ongoing RAPIDe-2 extension are consistent with the Phase 2 RAPIDe-1 study and provide **evidence on the long-term safety and efficacy of deucrictibant IR** capsule for repeat treatment of HAE attacks

1.1 hours median time to **onset of symptom relief** by PGI-C



2.6 hours median time to **reduction in attack severity** by PGI-S



11.5 hours median time to **complete attack resolution** by PGI-S[1]

86.0%

of attacks were treated with a single dose of deucrictibant IR capsule

*A total of 265 attacks from 17 participants were included in the modified intention-to-treat efficacy analysis set (data cutoff: 1 March 2024); a total of 337 attacks from 19 participants were included in the safety analysis set (data cutoff: 10 June 2024). HAE: hereditary angioedema. IR: immediate-release capsule formulation of deucrictibant. PGI-C: Patient Global Impression of Change. PGI-S: Patient Global Impression of Severity.
Source: Maurer M et al. BKS 2024.

Deucrictibant's rapid-onset and complete symptom resolution may address unmet medical need in HAE with a single oral capsule

		sebetralstat tablet	deucrictibant IR capsule			Standard of Care Berinert® (pdC1INH), Firazyr® (icatibant), Ruconest® (rhC1INH)
Mechanism of Action		Plasma kallikrein inhibitor	Bradykinin B2 receptor antagonist			Plasma-derived C1NH (23%) - Icatibant (60%) – Recombinant hC1INH (9%) - Other (9%)
Clinical Trial(s)		Ph 3* (300mg, 600mg)	Ph 2 (10mg, 20mg, 30 mg pooled)	Ph 2/3 Ext.* (10mg, 20mg, 30mg pooled)	Ph 2/3 Ext. PSM Analysis (10mg, 20mg, 30mg pooled)	PSM Analysis of Mixed Methods Study[9]
Time to onset of symptom relief (median)	VAS/AMRA[a]	-	2.4 vs. 8.0 h[3]	-	-	-
	TOS[b]	-	2.0 vs. 7.6 h[4,5]	-	-	-
	PGI-C[c]	1.6-1.8 vs. 6.7 h[1]	-	1.1 h[7]	1.1 h[8]	2.4 h[8]
Time to ≥50% VAS reduction (median)		Not reported yet[2]	3.9 vs. 22.8 h[3]	-	-	-
Time to reduction in attack severity (median)[d]		7.7-9.3 vs. > 12 h[1]	-	2.6 h[7]	2.1 h[8]	4.0 h[8]
Time to symptom resolution (median)	VAS/AMRA[e]	-	7.5 vs. 42.0 h[3]	-	-	-
	TOS[f]	-	5.2 vs. 23.3 h[4,5]	-	-	-
	PGI-S[g]	≥24.0 vs. >24 h[1]	-	11.5 h[7]	12.3 h[8]	13.5 h[8]
% attacks resolved within 24 h with 1 dose		42.5-49.5% vs. 27.4%#[1]	75.0% vs. 15.7†[6] 81.7% vs. 22.4%‡[6]	90.2%[7]	-	-
% attacks treated with 1 dose of study drug (no additional doses of study drug and/or rescue med.)		≤60.2-≤60.9 vs. ≤44.0%[1]	pending publication	86.0%§[7]	-	-

References on following slide

This presentation includes data for an investigational product not yet approved by regulatory authorities.

ODT comparison data references

* Non-laryngeal and laryngeal attacks included for treatment with study drug. # Symptom resolution assessed by PGI-S. † Symptom resolution assessed by VAS/AMRA. ‡ Symptom resolution assessed by TOS.

a. Time to onset of symptom relief by VAS/AMRA defined as 'VAS-3 ≥30% reduction from pre-treatment score' in[3].
b. Time to onset of symptom relief by TOS defined as 'The time point when TOS PRO first reaches at least "A little better" for all symptom complexes affected at baseline, 'and no new symptom in any other symptom complex is reported. Relief is confirmed if the improvement is sustained at 2 consecutive time points' in[4,5].
c. Time to beginning (*or* onset) of symptom relief by PGI-C defined as 'beginning of symptom relief as assessed in a time-to-event analysis. The beginning of symptom relief was defined as a rating of "a little better" on the 7-point Patient Global Impression of Change (PGI-C) scale (ratings range from "much better" to "much worse") at two or more consecutive time points within 12 hours after the first administration of the trial agent' in [1] and as 'Patient Global Impression of Change (PGI-C) rating of at least "a little better" for 2 consecutive timepoints by 12 hours post-treatment' in[7,8].
d. Time to reduction in attack severity defined as 'reduction in the severity of the attack, defined as an improved rating on the 5-point Patient Global Impression of Severity (PGI-S) scale (ratings range from "none" to "very severe") at two or more consecutive time points within 12 hours after the first administration' in[1] and 'achieving ≥1 point reduction in the Patient Global Impression of Severity (PGI-S) from pretreatment for 2 consecutive timepoints by 12 hours post-treatment' in[7,8].
e. Time to symptom resolution by VAS/AMRA defined as 'all 3 individual VAS items ≤10' in[3].
f. Time to symptom resolution by TOS defined as 'The time point when TOS PRO first reaches "A lot better or resolved" for all symptom complexes affected at baseline, and no new symptom in any other symptom complex is reported' in.[4,5]
g. Time to symptom resolution by PGI-S defined as 'achieving PGI-S rating of "none" at 24 hours post-treatment' in[1] and as 'achieving PGI-S rating of "none" at 24 hours post-treatment' in [7,8] .

[1]Riedl MA et al. *N Engl J Med*. 2024. [2]EudraCT: 2021-001226-21. [3]Maurer M et al. AAAAI 2023. [4]Riedl MA et al. C1-INH Workshop 2023. [5]RAPIDe-1 Phase 2 Top-line data presentation. [6]Li HH et al. EAC 2024. [7]Maurer M et al. BKS 2024. [8]Riedl MA et al. BKS 2024. [9]Mendivil et al. GA²LEN UCARE 2023.

RAPIDe-3[1] RCT

Global Phase 3 study of deucrictibant for on-demand treatment of HAE attacks

RAPIDe-3

20 mg capsule

Double-blind crossover treatment with 2 qualifying attack treatment periods

Screening and PRO training → R → Day 1 Visit

- **Deucrictibant 20 mg/day** → **Placebo**
- **Placebo** → **Deucrictibant 20 mg/day**

→ End-of Study Visit* after second HAE attack treated with study drug → **Rollover to open-label extension**

Post-Attack-Visit after first attack treated with study drug

Enrollment

- Target enrollment of approximately 120 adolescents and adults living with HAE
- Top line data anticipated in 1Q2026

Primary Endpoints

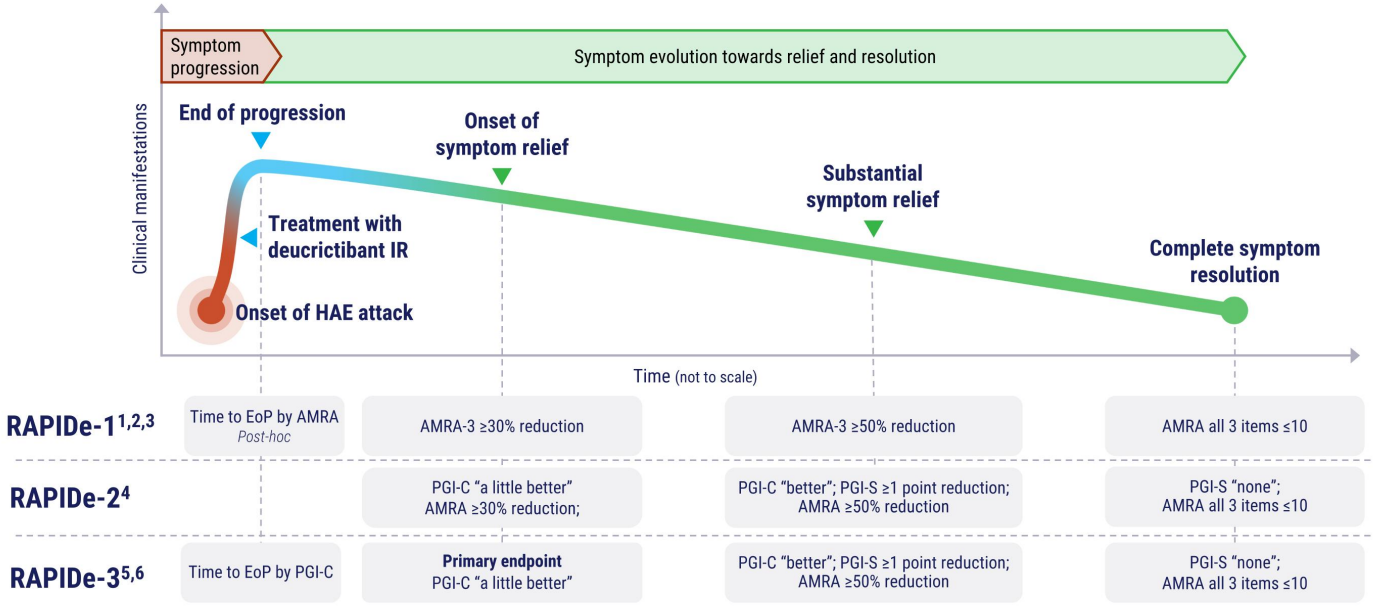
- Onset of symptom relief
- Patient Global Impression of Change (PGI-C) rating of at least "a little better" for two consecutive timepoints within 12 hours post-treatment

Secondary Endpoints

- Time to end of progression of attack symptoms, substantial symptom relief, and symptom resolution
- PGI-C, Patient Global Impression of Severity (PGI-S), Angioedema syMptom Rating scAle (AMRA)
- Use of rescue medication
- Incidence of treatment-emergent adverse events

RCT: randomized clinical trial. *Adolescent patients receive a non-attack dose for PK sampling prior to randomization.
Source: [1]Maurer M et al. EAACI 2024.

Clinical trial endpoints span the entire attack timecourse



RAPIDe-1[1,2,3]	Time to EoP by AMRA *Post-hoc*	AMRA-3 ≥30% reduction	AMRA-3 ≥50% reduction	AMRA all 3 items ≤10
RAPIDe-2[4]		PGI-C "a little better" AMRA ≥30% reduction;	PGI-C "better"; PGI-S ≥1 point reduction; AMRA ≥50% reduction	PGI-S "none"; AMRA all 3 items ≤10
RAPIDe-3[5,6]	Time to EoP by PGI-C	**Primary endpoint** PGI-C "a little better"	PGI-C "better"; PGI-S ≥1 point reduction; AMRA ≥50% reduction	PGI-S "none"; AMRA all 3 items ≤10

AMRA, Angioedema Symptom Rating Scale; EoP, end of progression; HAE, hereditary angioedema; IR, immediate release; PGI-C, Patient Global Impression of Change; PGI-S, Patient Global Impression of Severity.
Source: [1]NCT04618211. [2]Riedl et al. ACAAI 2023. [3]Medivil et al. GA²LEN UCARE 2023. [4]NCT05396105. [5]NCT06343779. [6]Maurer et al. EAACI 2024.

Patient-reported outcomes (PRO) assessments

Patient **G**lobal **I**mpression of **C**hange[1]

PGI-C

Much worse | Worse | A little worse | Same | A little better | Better | Much better

Patient **G**lobal **I**mpression of **S**everity[2]

PGI-S

Very severe | Severe | Moderate | Mild | None

Angioedema sy**M**ptom **R**ating sc**A**le[3]

AMRA

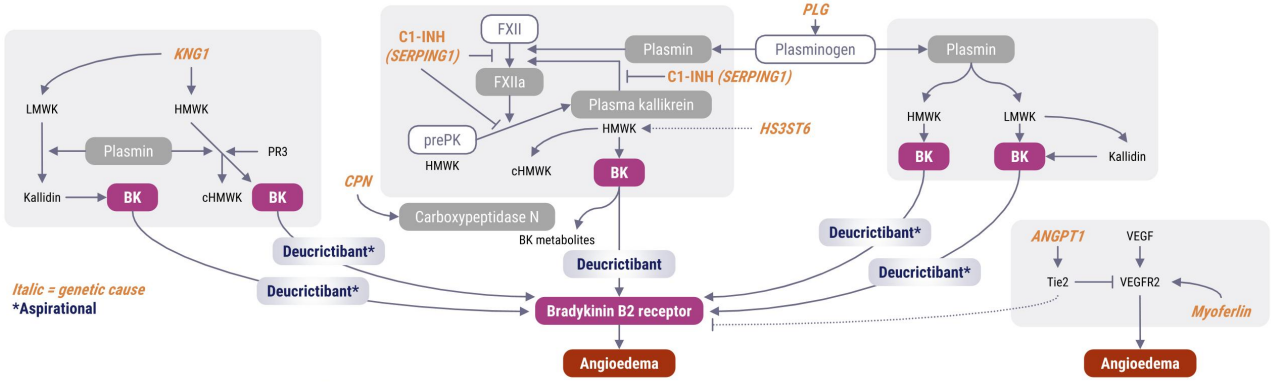
100 Worst symptoms — No symptoms 0

Source: Riedl MA et al. BKS 2024.

Acquired Angioedema

Bradykinin B2 receptor inhibition broadly applicable across angioedema

Types of angioedema	AE-MC Mast-cell mediated		AE-BK Bradykinin mediated			AE-VE Vascular endothelium	AE-DI Drug induced	AE-UNK Unknown
Mechanism	Mast cell degranulation		**Hereditary C1INH deficiency**	**Acquired C1INH deficiency**	**KKS pathway mutations**	Intrinsic vascular endothelium dysfunction	Drug adverse reactions (various mechanisms)	Unknown aetiology or mechanism
Name/ Acronym	AE-URT	AE-ANA	**HAE-C1INH (Type 1, 2)**	**AAE-C1INH**	**HAE-FXII†, HAE-PLG†, HAE-KNG†**	HAE-ANGPT†, HAE-MYOF†, HAE-HSST†, SCLS	AE-ACEI, AE-tPA, AE-DPPIV, AE-NSAID, etc.	AE-UNK, HAE-UNK†, EAE



Notes: bold = known or potential role for bradykinin involvement in disease. †also designated as Normal C1INH Angioedema (HAE-nC1INH)
HMWK: high-molecular-weight kininogen; cHMWK: cleaved high-molecular-weight kininogen; FXII(a): Factor XII(a); ACE(i): angiotensin-converting enzyme (inhibitor); tPA: tissue plasminogen activator; KNG1: gene encoding HMWK; PLG: gene encoding plasminogen; FXII: gene encoding FXII; ANGPT: gene encoding angiopoietin; MYOF: gene encoding myoferlin; HSST: gene encoding heparan sulfate sulfotransferase; SCLS: systemic capillary leak syndrome.
Source: Busse 2020 *J Allergy Clin Immunol Pract*; Bork et al 2021 *J Allergy Clin Immunol*; Zanichelli et al 2012 *Allergy*; Longhurst et al 2017 *Clin. Exp. Immunol.*; Otani, Banerji 2017 *Immunol. Allergy Clin. N. Am.*; Bova et al 2018 *Int. Arch. Allergy Immunol.*; Petersen et al 2024 *J Allergy Clin Immunol*

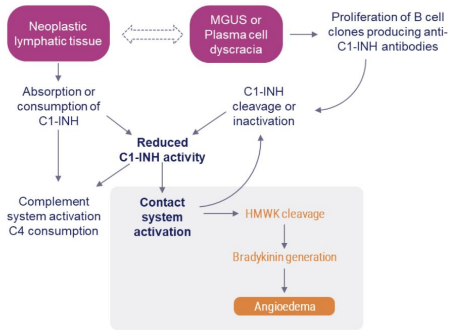
This presentation includes data for an investigational product not yet approved by regulatory authorities.

Deucrictibant proof-of-concept in acquired angioedema due to C1-INH deficiency (AAE-C1INH)[1,2]

Investigator-initiated trial (IIT) by the **Amsterdam UMC**

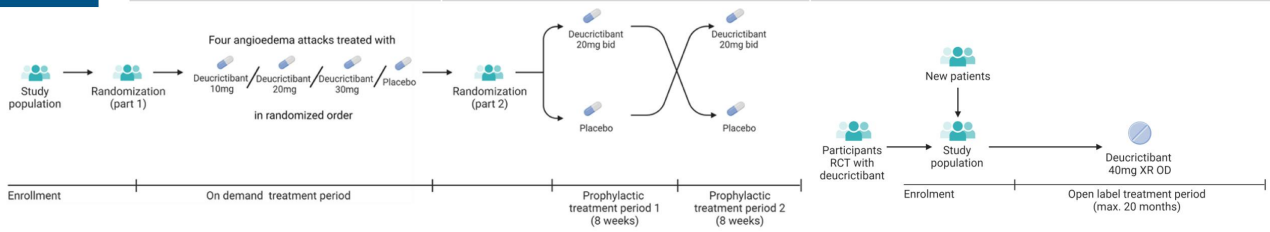
Currently, **no therapies** approved for **AAE**

Estimated prevalence of 1:100,000 to 1:500,000 or **~10% of HAE type 1/2**



JACI The Journal of Allergy and Clinical Immunology

POP-AID		ONCE-AID
Part 1: On-demand treatment	Part 2: Prophylactic treatment	Long-term extension (XR tablet)



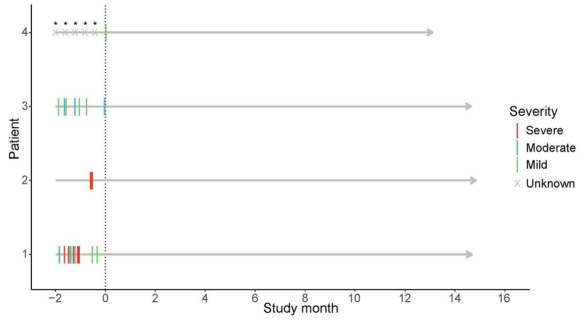
Source: [1]Petersen RS et al. *J Allergy Clin Immunol*. 2024. [2]Petersen RS et al. BKS 2024.

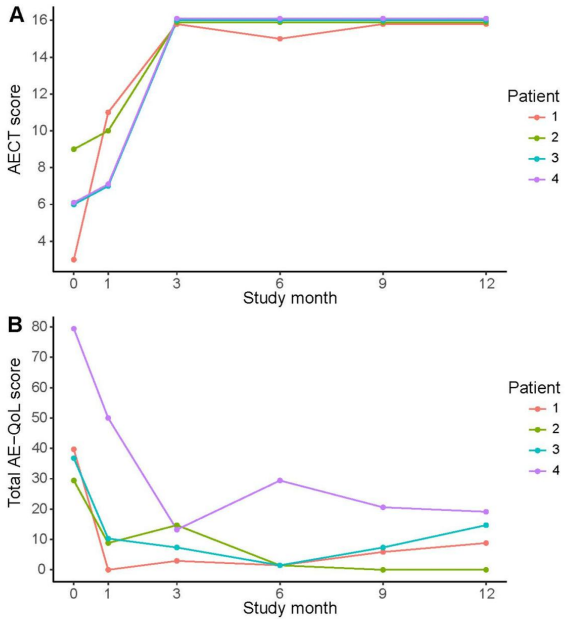
This presentation includes data for an investigational product not yet approved by regulatory authorities.

Deucrictibant XR tablet for the prevention of acquired angioedema (AAE-C1INH) attacks[1,2]

Attacks per month	Patient 1	Patient 2	Patient 3	Patient 4
Baseline	1.2	1.2	0.9	2.2
Placebo	2.0	0.6	1.0	N/A
Deucrictibant	0	0	0	0.1

Attacks before and during deucrictibant XR treatment





Notes: the baseline attack rate covers 90 days prior to randomization for prophylactic treatment in the randomized controlled trial for Patients 1,2, and 3, and 90 days prior to enrollment in the open-label portion for Patient 4. *Patient 4 reported five angioedema attacks in the two months prior to enrollment, but did not recall the exact dates on which these attacks occurred. Graph A: Angioedema Control Test (AECT) score during prophylactic treatment with deucrictibant XR tablet. Graph B: Angioedema Quality of Life (AE-QoL) score during prophylactic treatment with deucrictibant XR tablet. Source: [1]Petersen RS et al. *J Allergy Clin Immunol*. [2]Petersen RS et al. BKS 2024.

Our aspiration is to become a market leader in HAE

Rooted in a deep commitment to engage with the HAE community

Notes: Aspirational, to be confirmed with Phase 3 clinical data

This presentation includes data for an investigational product not yet approved by regulatory authorities.

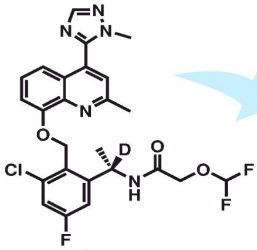
PHARVARIS

www.pharvaris.com

NASDAQ: PHVS

Appendix

Deucrictibant: Only compound today[1] with the potential to deliver injection-like efficacy orally across both LTP and ODT



Deucrictibant XR

Extended-release tablet

Sustained absorption[2]

*Maintains sustained therapeutic exposure over 24 hours[3] from initial dose, allowing for once-daily oral treatment to prevent HAE attacks**

- Highly **effective** at **preventing** attacks*,[4,5]
- **Rapid protection**[2] and elimination[6]
- **Well-tolerated**[4,5]
- **Ease of oral** administration**,[7]

Deucrictibant IR

Immediate-release capsule

Rapid absorption[6]

*Rapidly reaches therapeutic exposure within 15-30 minutes[8], making it optimal for on-demand oral treatment of HAE attacks**

- **Rapid** onset of action[9,10]
- **Single dose** resolution[10]
- **Ease of oral** administration**,[7]

*To be confirmed with clinical data from Phase 3 studies. **Patient preference varies.

Source: [1]Company research. [2]Company data: target threshold exceeded on first day in single-dose cross-over PK study in healthy volunteers (n=14) under fasting conditions. [3]Lesage A et al, IDDST 2024. [4]Riedl MA et al. AAAAI 2024. [5]Riedl MA et al. BKS 2024. [6]Maurer M et al. HAEi Workshop, 2022. [7]Lesage et al. *Int. Immunopharmacology*. 2022. [8]Crabbe et al. AAAAI 2021. [9]Maurer M et al, AAAAI 2023. [10]Maurer M et al. BKS 2024.

This presentation includes data for an investigational product not yet approved by regulatory authorities.

People living with HAE are seeking:

Highly effective, well-tolerated and less burdensome prophylactic therapies

Injectable-like **efficacy**

Well-tolerated

Easy, painless administration

Better on-demand therapies that offer rapid symptom relief with one single, oral dose

Patients want **rapid onset of symptom relief** …

…with **single dose durability**…

…in an **oral** pill

Effectively targeting the **bradykinin receptor** with a **small molecule** has the potential to deliver on their hopes

Source: Proprietary Pharvaris research, 2022 (representative sample of patients, n = 103, and doctors, n = 100)

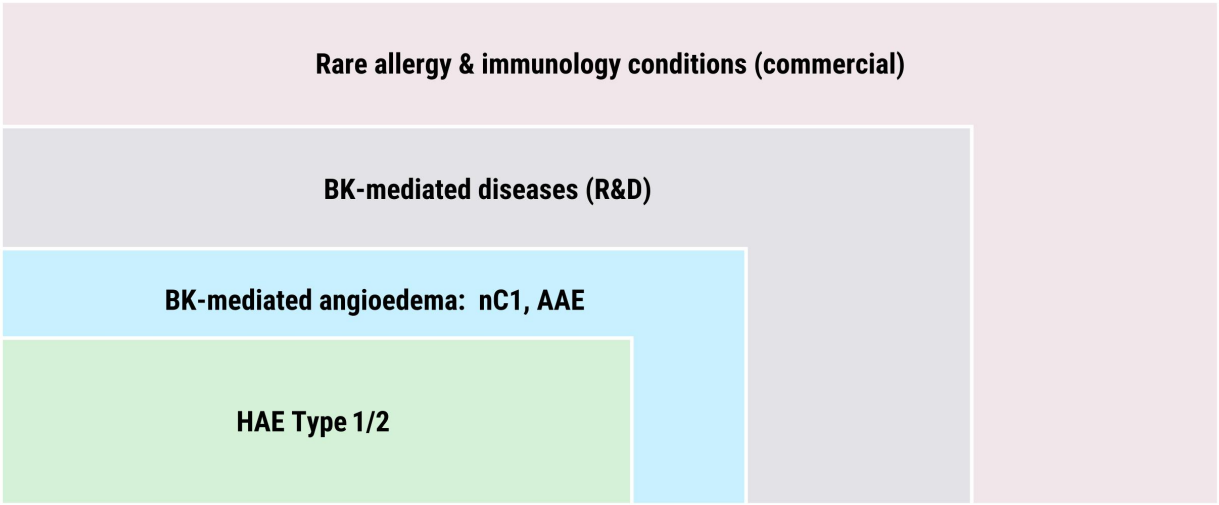
Pharvaris has the ambition to realize the potential of deucrictibant to become a preferred option for bradykinin-mediated conditions

HAE	Long-term extension data[1,2] reinforces our belief that deucrictibant has the potential to become a preferred option for the management of HAE
AAE	Based on the community's interest[3] and the initial intriguing data[4], Pharvaris plans to pursue development of deucrictibant in AAE
nC1	Leveraging B2-receptor mechanism[5], potential for application to normal C1-INH hereditary angioedema

Source: [1]Riedl MA et al. BKS 2024. [2]Maurer M et al. BKS 2024. [3]Company research. [4]Petersen RS et al. *J Allergy Clin Immunol*. 2024. [5]Lesage et al. *Int. Immunopharmacology*, 2022.

This presentation includes data for an investigational product not yet approved by regulatory authorities.

Pharvaris aspires to leverage its foundational B2R expertise to develop therapies for conditions beyond HAE



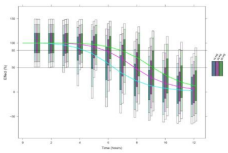
This presentation includes data for an investigational product not yet approved by regulatory authorities.

Clinical dosing is guided by prediction from a validated *in vivo* surrogate-marker model, the bradykinin challenge

Bradykinin, injected *IV* in healthy volunteers, induces a transient, limited change in cardiac parameters (heart rate ↑, blood pressure↓) which can be blocked by pre-injection of a bradykinin B2 receptor antagonist (*e.g.*, icatibant or deucrictibant)

clinical

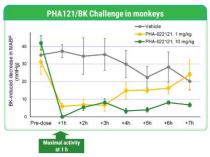
Icatibant development program (shared mechanism)



As assessed by FDA, exposure of icatibant above EC_{85} for 6 hours correlates with clinical activity[1,2,3]

nonclinical

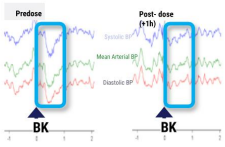
Non-human primate study



Oral deucrictibant suppresses BK effect in NHP faster than SQ icatibant; target exposures for Phase 1[4]

clinical

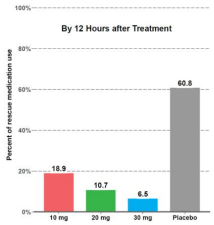
Phase 1 healthy volunteer study



EC_{85} assessed in humans at 13.8 ng/mL; target exposure for studies in people living with HAE[5]

clinical

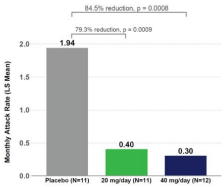
RAPIDe-1 Phase 2 on-demand



Clinical efficacy correlates with exposure exceeding and remaining above EC_{85}[6]

clinical

CHAPTER-1 Phase 2 prophylaxis



Clinical efficacy demonstrated based on dose prediction targeting exposure above EC_{85}[7]

Notes: BK: bradykinin; NHP: non-human primates; SQ: sub-cutaneous; EC_{85}: effective concentration achieving 85% inhibition of bradykinin effect Source: [1]FDA Clinical Pharmacology and Biology Review: icatibant. [2]Maurer M et al. *Clin Exp Allergy*. 2022. [3]FIRAZYR® Patient Registry. [4]Lesage et al. *Int. Immunopharmacology*. 2022. [5]Derendorf H et al. ACAAI 2020. [6]Riedl MA et al. AAAAI 2024. [7]Maurer M et al. AAAAI 2023.

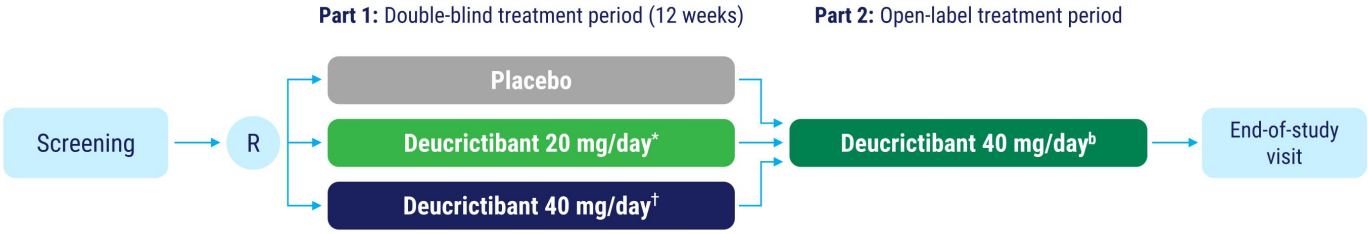
This presentation includes data for an investigational product not yet approved by regulatory authorities.

Long-term Prophylaxis Data

CHAPTER-1 Randomized Clinical Trial (RCT) Topline Data

CHAPTER-1

Two-part, Phase 2 study of deucrictibant for long-term prophylaxis of HAE attacks



Primary endpoint

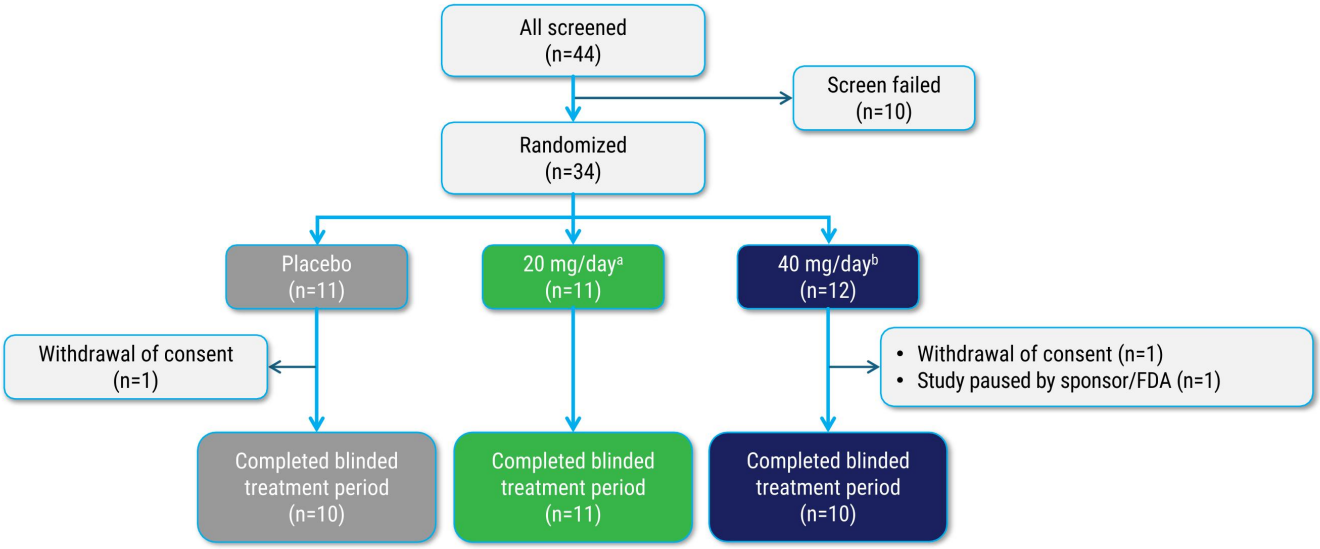
- Time-normalized number of investigator-confirmed HAE attacks (monthly[c] HAE attack rate)

Secondary endpoints

- Time-normalized number of moderate and severe HAE attacks
- Time-normalized number of HAE attacks treated with on-demand medication

HAE, hereditary angioedema; IR, immediate release; R, randomization. *Deucrictibant IR capsule, 10 mg twice daily; †Deucrictibant IR capsule, 20 mg twice daily; [c]1 month = 4 weeks.
CHAPTER-1 is a Pharvaris-sponsored clinical trial. **Source:** NCT05047185

CHAPTER-1 (RCT): Participant disposition



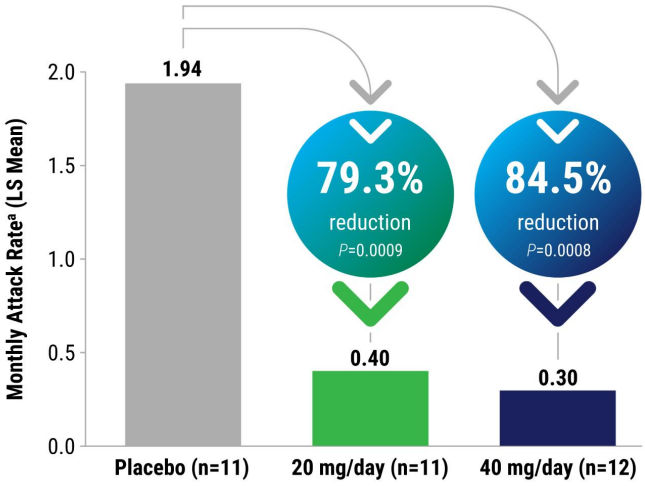
[a]Deucrictibant IR capsule, 10 mg twice daily. [b]Deucrictibant IR capsule, 20 mg twice daily. Source: Aygoren-Pursun E et al. EAACI 2024.

Balanced demographics and baseline characteristics

	Placebo n=11	20 mg/day[a] n=11	40 mg/day[b] n=12	All N=34
Age in years – Mean	41.4	38.4	40.8	40.2
Sex: M/F – n	3/8	6/5	4/8	13/21
Race: White – n (%)	11 (100)	11 (100)	12 (100)	34 (100)
BMI (kg/m2) – Mean	26.7	29.5	25.4	27.1
HAE Type – n				
Type 1	10	9	12	31
Type 2	1	2	0	3
Baseline HAE attack rate per month[c]				
Mean	1.9	2.1	2.5	2.2
Median (Min, Max)	1.7 (0.7, 3.7)	1.7 (1.0, 5.3)	1.7 (1.0, 6.7)	1.7(0.7, 6.7)
Randomized baseline HAE attack rate[c] categories – n (%)				
1 to < 2 attacks per 4 weeks	6 (54.5)	7 (63.6)	7 (58.3)	20 (58.8)
2 to < 3 attacks per 4 weeks	3 (27.3)	1 (9.1)	1 (8.3)	5 (14.7)
≥ 3 attacks per 4 weeks	2 (18.2)	3 (27.3)	4 (33.3)	9 (26.5)

BMI, body mass index; HAE, hereditary angioedema; IR, immediate-release; N = number of randomized participants. [a]Deucrictibant IR capsule, 10 mg twice daily. [b]Deucrictibant IR capsule, 20 mg twice daily. [c]1 month = 4 weeks.
Source: Aygoren-Pursun E et al. EAACI 2024.

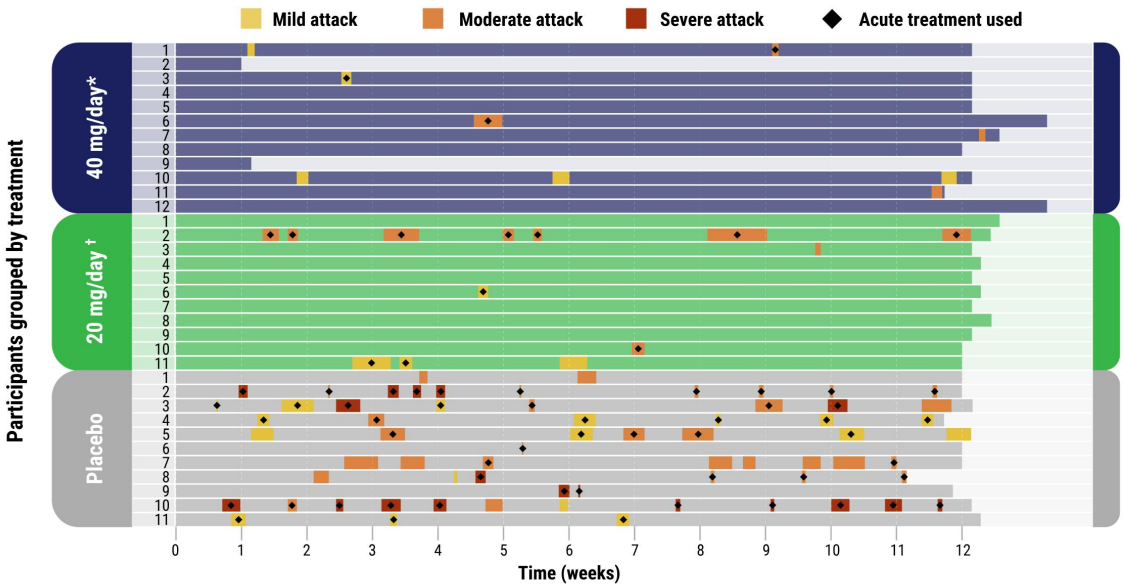
Primary endpoint met: deucrictibant significantly reduced attack rate



	Placebo n=11	20 mg/day* n=11	40 mg/day† n=12
Monthly attack rate – Median			
Baseline	1.67	1.67	1.74
On study	2.15	0	0.15
Change from baseline	0.33	-1.34	-1.59
% change from baseline	17%	-100%	-96%
Model-based inference			
LS mean	1.94	0.40	0.30
% reduction vs placebo		79.3%	84.5%
P value		0.0009	0.0008

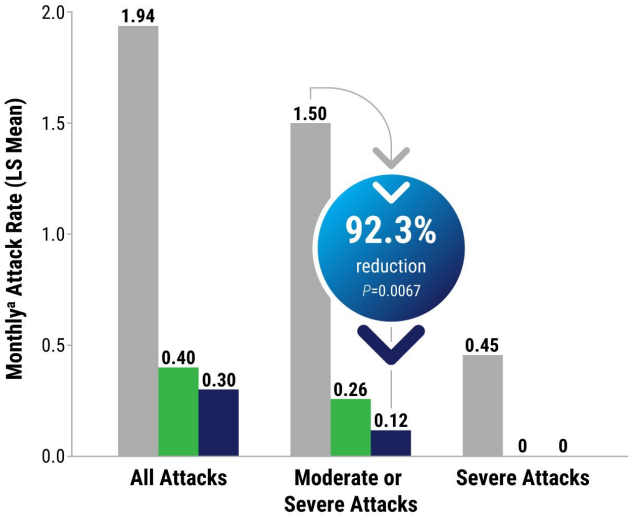
BL, baseline; IR, immediate-release; LS, least squares. N = number of randomized participants. Model-based inferences are based on a Poisson regression model adjusted for baseline attack rate and time on treatment. No multiplicity adjustment was applied. [a]Based on time normalized number of attacks per 4 weeks. [b]Deucrictibant IR capsule, 10 mg twice daily. [c]Deucrictibant IR capsule, 20 mg twice daily.
Source: Aygoren-Pursun E et al. EAACI 2024.

Significant attack reduction and no severe attacks with deucrictibant



*20 mg/day = deucrictibant immediate release (IR) capsules 10 mg twice daily; †40 mg/day = deucrictibant IR capsules 20 mg twice daily. Source: CHAPTER-1 Topline Data Presentation. December 2023.

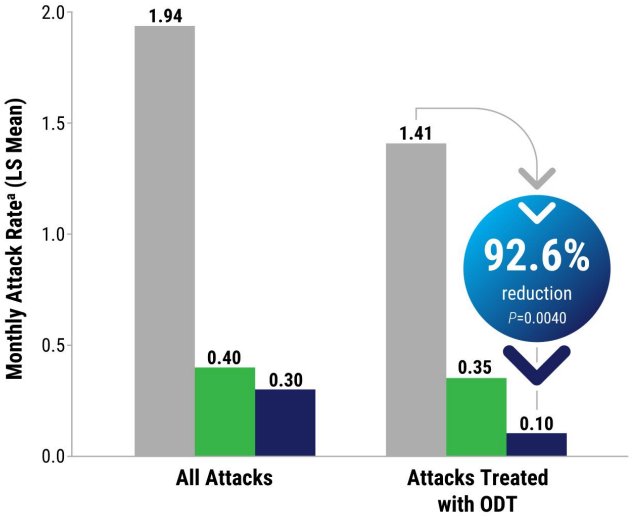
Primary endpoint met: deucrictibant significantly reduced attack rate



	Placebo n=11	20 mg/day[b] n=11	40 mg/day[c] n=12
Monthly attack rate of moderate or severe attacks			
LS mean	1.50	0.26	0.12
% reduction vs placebo		82.8%	92.3%
Nominal *P* value		0.0066	0.0067

BL, baseline; IR, immediate-release; LS, least squares. N = number of randomized participants. Model-based inferences are based on a Poisson regression model adjusted for baseline attack rate and time on treatment. No multiplicity adjustment was applied. [a]Based on time normalized number of attacks per 4 weeks. [b]Deucrictibant immediate-release (IR) capsule, 10 mg twice daily. [c]Deucrictibant IR capsule, 20 mg twice daily.
Source: Aygoren-Pursun E et al. EAACI 2024.

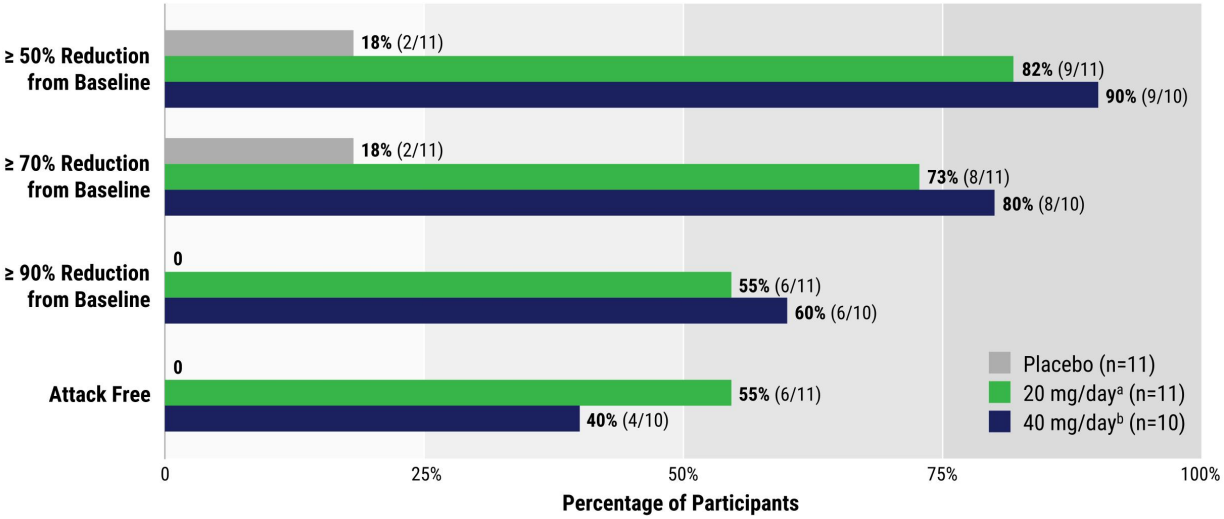
Primary endpoint met: deucrictibant significantly reduced attack rate



	Placebo n=11	20 mg/day[b] n=11	40 mg/day[c] n=12
Monthly attack rate of attacks treated with ODT			
LS mean	1.41	0.35	0.10
% reduction vs placebo		75.1%	92.6%
Nominal *P* value		0.0074	0.0040

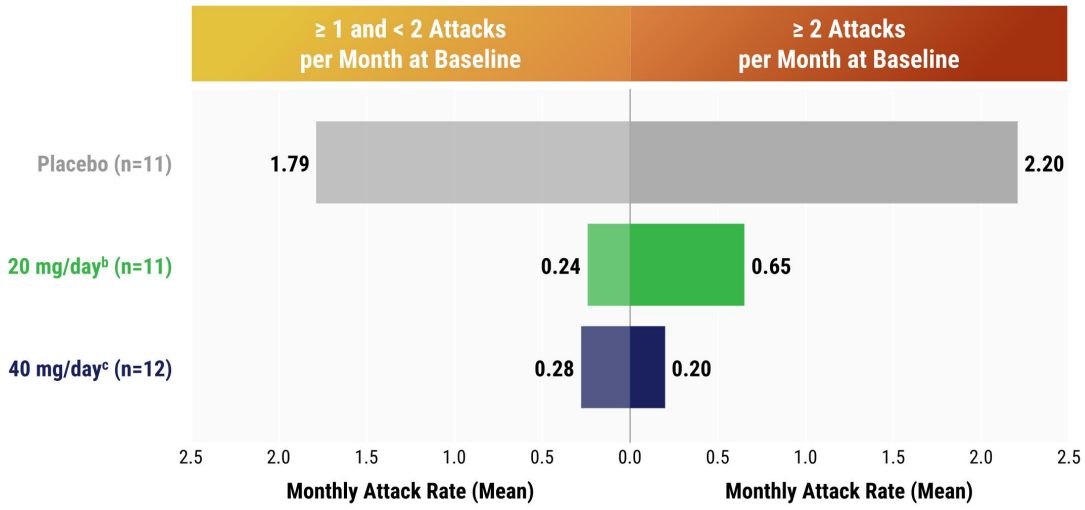
BL, baseline; IR, immediate-release; LS, least squares. N = number of randomized participants. Model-based inferences are based on a Poisson regression model adjusted for baseline attack rate and time on treatment. No multiplicity adjustment was applied. [a]Based on time normalized number of attacks per 4 weeks. [b]Deucrictibant immediate-release (IR) capsule, 10 mg twice daily. [c]Deucrictibant IR capsule, 20 mg twice daily.
Source: Aygoren-Pursun E et al. EAACI 2024.

Deucrictibant substantially reduced attack rate from baseline



IR, immediate release. N = Participants with ≥4 weeks of treatment. [a]Deucrictibant IR capsule, 10 mg twice daily. [b]Deucrictibant IR capsule, 20 mg twice daily.
Source: Wedner HJ et al. ACAAI 2024.

Deucrictibant reduced the proportion of days with symptoms, and the monthly attack rate, regardless of baseline attack rate



IR, immediate-release. N = number of randomized participants with ≥4 weeks of treatment. [a]Based on time normalized number of attacks per 4 weeks. [b]Deucrictibant IR capsule, 10 mg twice daily. [c]Deucrictibant IR capsule, 20 mg twice daily. Source: Aygoren-Pursun E et al. EAACI 2024.

Unmet need for additional HAE therapies that improve disease control and HRQoL

- International hereditary angioedema (HAE) guidelines recommend that the goals of treatment are to achieve total disease control and normalize patients' lives.[1]
- HAE negatively impacts functional and psychological domains of health-related quality of life (HRQoL).[2-6]
- Patients with well-controlled disease report lower disease burden, lower burden on daily activities, and greater HRQoL than patients with poorly-controlled disease.[7]
- Despite the availability of approved therapies for HAE, an unmet need remains for additional prophylactic treatments combining injectable-like efficacy, a well-tolerated profile, and ease of administration.[8-11]

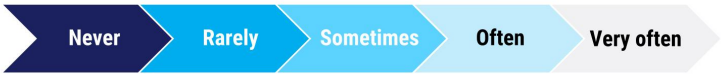
Source: [1]Maurer M et al. *Allergy*. 2022. [2]Bork K, et al. *Allergy Asthma Clin Immunol*. 2021. [3]Bygum A, et al. *Front Med*. 2017. [4]Mendivil J, et al. *Orphanet J Rare Dis*. 2021. [5]Chong-Neto HJ. *World Allergy Organ J*. 2023. [6]Lumry WR, et al. *Allergy Asthma Proc*. 2010. [7]Grumach A, et al. *J Allergy Clin Immunol*. 2024. [8]Bouillet L, et al. *Allergy Asthma Proc*. 2022. [9]Betschel SD, et al. *J Allergy Clin Immunol Pract*. 2023. [10]Center for Biologics Evaluation and Research. The voice of the patient – hereditary angioedema. US Food and Drug Administration; May 2018. [11]Covella B, et al. *Future Pharmacol*. 2024.

Measuring disease control, HRQoL, and treatment satisfaction

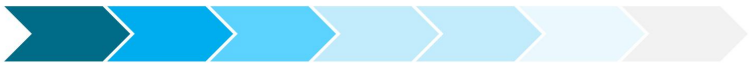
Angioedema Control Test (AECT)[1,2]**:** a four-item questionnaire with a five-point response scale developed and validated to retrospectively quantify disease control and to aid treatment decisions in patients with recurrent angioedema (AECT-4Wk – four-week recall used)

- *How often have you had angioedema in the last four weeks?*
- *How much has your quality of life been affected?*
- *How much has the unpredictability bothered you?*
- *How well has your angioedema been controlled by therapy?*

Angioedema Quality of Life Questionnaire (AE-QoL)[3-5]: A tool validated for HAE and comprising a 17-item questionnaire across four domains, 'functioning', 'fatigue/mood', 'fear/shame', and 'nutrition,' on a five-point response scale



Treatment Satisfaction Questionnaire for Medication (TSQM) Version II[6]: An 11-item questionnaire to gauge patients' satisfaction with "effectiveness", "side effects", "convenience", and "global satisfaction" of a medication



Extremely dissatisfied — *Somewhat satisfied* — *Extremely satisfied*

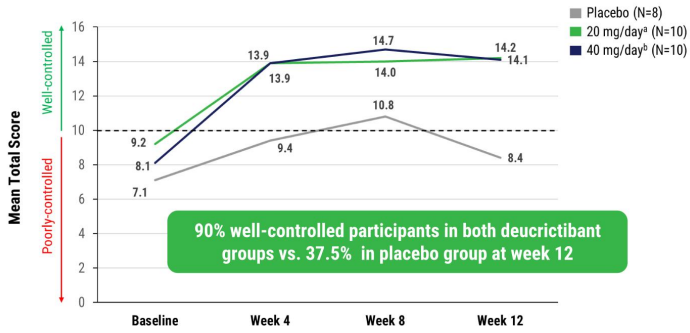
HAE, hereditary angioedema; HRQoL, health-related quality of life. **Source:** [1]Weller K, et al. *Allergy*. 2020. [2]Weller K, et al. *J Allergy Clin Immunol Pract*. 2020. [3]Weller K, et al. *Allergy*. 2012. [4]Weller K, et al. *Allergy*. 2016. [5]Vanya M, et al. *J Patient Rep Outcomes*. 2023. [6]Atkinson MJ, et al. *Value Health*. 2005.

This presentation includes data for an investigational product not yet approved by regulatory authorities.

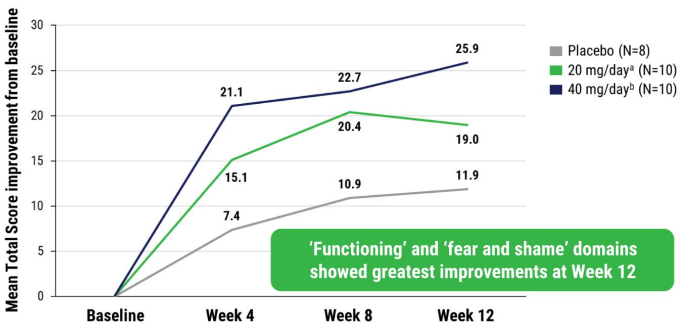
Improvements in disease control and health-related quality of life paralleled attack reduction during deucrictibant treatment[1,2]

- The goals of HAE treatment are to achieve complete control of the disease and to normalize people's lives[3]
- This can currently only be achieved by long-term prophylaxis (LTP)

AECT score[1]



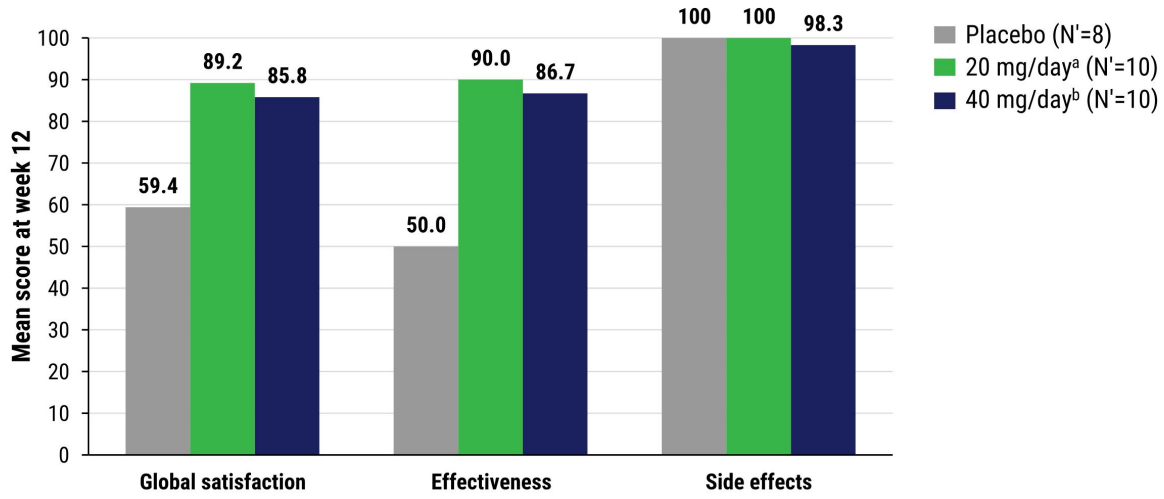
AE-QoL score[1]



AE-QoL, Angioedema Quality of Life Questionnaire; 4-week AECT, Angioedema Control Test (4-week recall period); IR, immediate-release; RCT, randomized controlled trial. N = number of participants with AECT and AE-QoL data at week 12. [a]Deucrictibant IR capsule, 10 mg twice daily. [b]Deucrictibant IR capsule, 20 mg twice daily. **Source:** [1]Magerl M et al. 2024 BKS. [2]Zanichelli A et al. ITACA 2024. [3]Maurer M et al. *Allergy*. 2022.

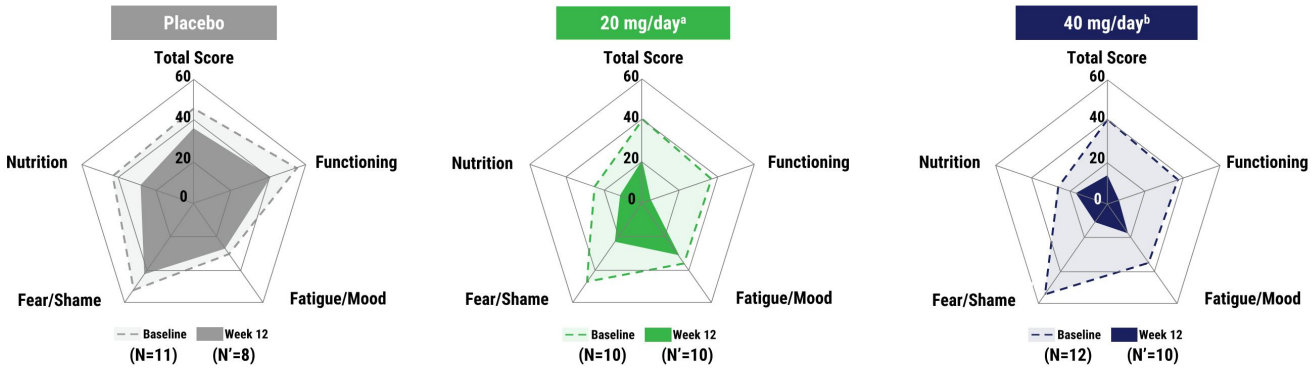
This presentation includes data for an investigational product not yet approved by regulatory authorities.

Deucrictibant shows greater patient satisfaction versus placebo across effectiveness and global satisfaction (TSQM instrument)



IR, immediate release; TSQM, Treatment Satisfaction Questionnaire for Medication. N' = number of participants with TSQM results at week 12.
[a]Deucrictibant IR capsule, 10 mg twice daily. [b]Deucrictibant IR capsule, 20 mg twice daily. Source: Magerl M et al. 2024 BKS.

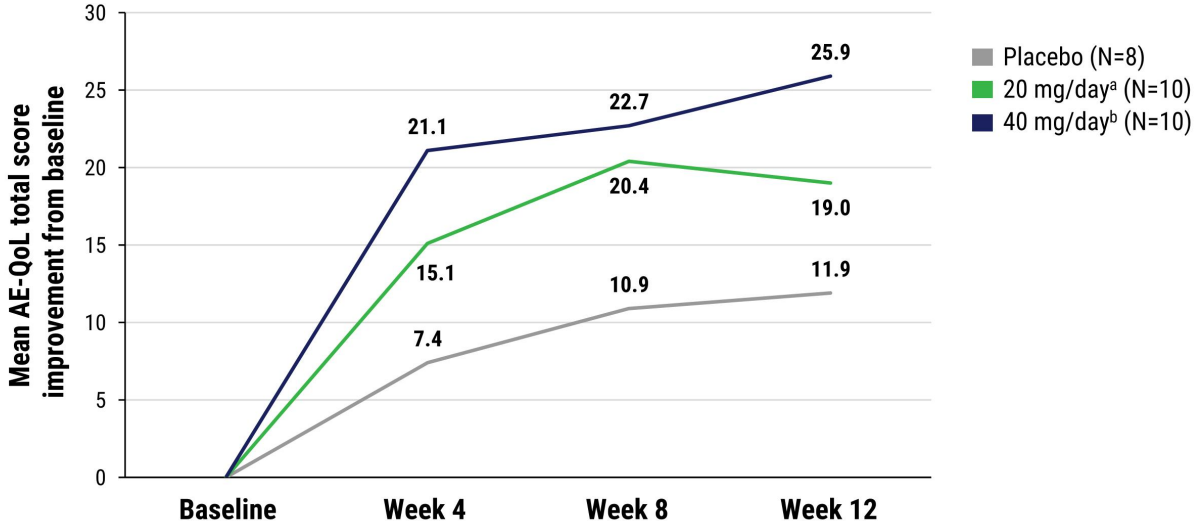
AE-QoL: HRQoL improved across all domains



		Deucrictibant	
AE-QoL Total Score	Placebo	20 mg/day[a]	40 mg/day[b]
Baseline	**N=11**	**N=10**	**N=12**
Mean (SD)	45.3 (18.5)	39.1 (22.0)	41.1 (15.5)
Median (Q1, Q3)	42.6 (29.4, 57.4)	37.5 (16.2, 55.9)	40.4 (31.6, 49.3)
Week 12	**N'=8**	**N'=10**	**N'=10**
Mean (SD)	35.7 (19.6)	20.2 (15.6)	13.2 (6.9)
Median (Q1, Q3)	37.5 (19.1, 49.3)	18.4 (7.4, 33.8)	12.5 (10.3, 17.7)

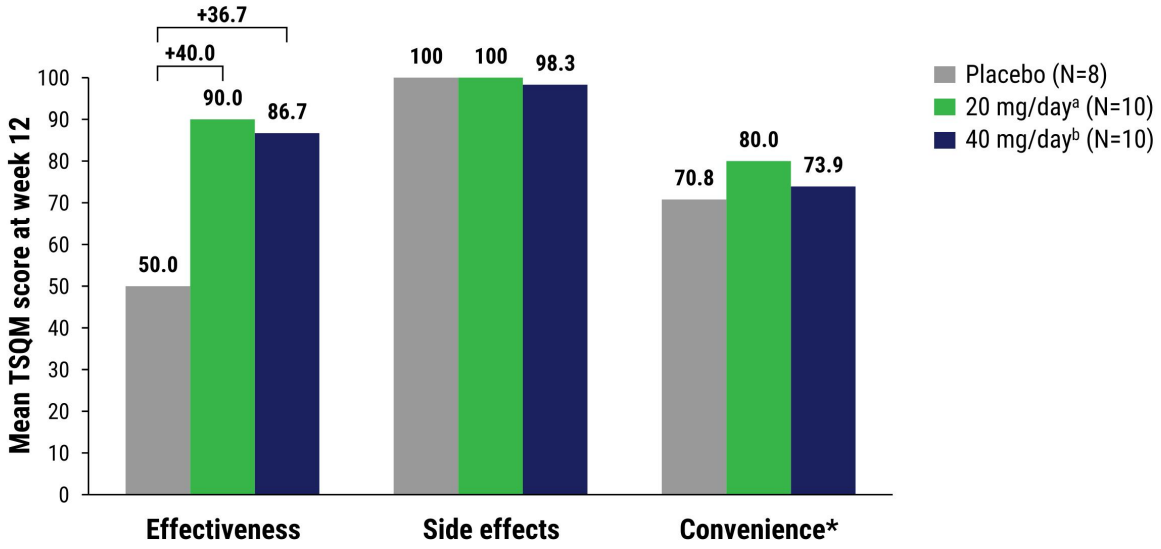
AE-QoL, Angioedema Quality of Life Questionnaire; IR, immediate-release; HRQoL, health-related quality of life. N = number of randomized participants with AE-QoL data at baseline. N' = number of participants with AE-QoL data at week 12. [a]Deucrictibant IR capsule, 10 mg twice daily. [b]Deucrictibant IR capsule, 20 mg twice daily. Source: Valerieva A et al. EAACI 2024.

AE-QoL: Total score improved from baseline by week 4 and throughout treatment



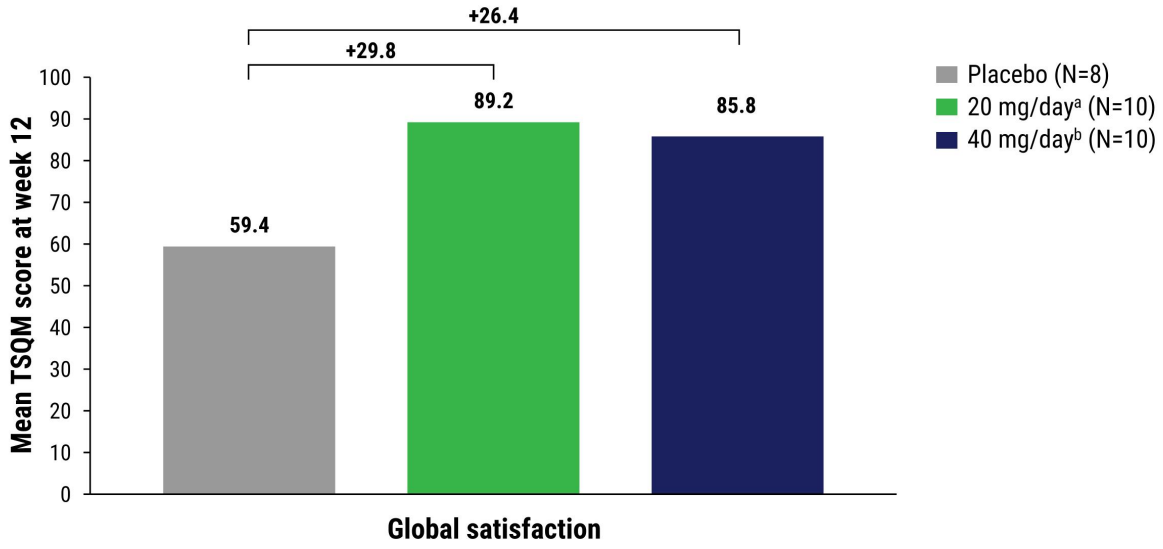
AE-QoL, Angioedema Quality of Life Questionnaire; IR, immediate-release. N = number of participants with AE-QoL data at week 12. [a]Deucrictibant IR capsule, 10 mg twice daily. [b]Deucrictibant IR capsule, 20 mg twice daily.
Source: Valerieva A et al. EAACI 2024.

TSQM: Greater patient satisfaction with effectiveness vs placebo



IR, immediate-release; TSQM, Treatment Satisfaction Questionnaire for Medication; XR, extended release. N = number of participants with TSQM results at week 12. [a]Deucrictibant IR capsule, 10 mg twice daily. [b]Deucrictibant IR capsule, 20 mg twice daily. *Dose frequency was twice daily using IR capsule; once-daily XR tablet is the intended formulation for the Phase 3 trial. Source: Valerieva A et al. EAACI 2024.

TSQM: Greater overall patient satisfaction vs placebo



IR, immediate-release; TSQM, Treatment Satisfaction Questionnaire for Medication. N = number of participants with TSQM results at week 12. [a]Deucrictibant IR capsule, 10 mg twice daily. [b]Deucrictibant IR capsule, 20 mg twice daily. Source: Valerieva A et al. EAACI 2024.

Deucrictibant was well tolerated at both doses

- Deucrictibant was well tolerated at both doses, and all reported treatment-related treatment-emergent adverse events (TEAEs) were mild in severity.
- No serious TEAEs, no severe TEAEs, and no TEAEs leading to treatment discontinuation, study withdrawal, or death were reported.

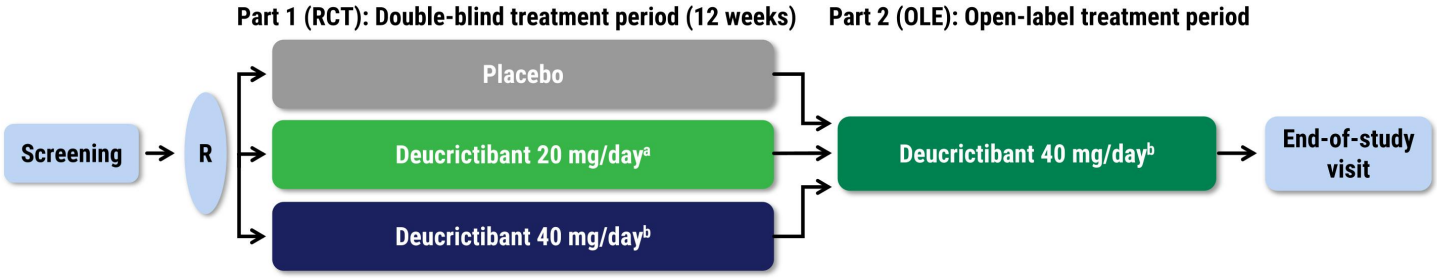
Adverse events	Placebo (N=11)		Deucrictibant 20 mg/day[a] (N=11)		Deucrictibant 40 mg/day[b] (N=12)	
	Participants, n (%)	Events, n	Participants, n (%)	Events, n	Participants, n (%)	Events, n
TEAEs	**7 (63.6)**	**16**	**6 (54.5)**	**11**	**7 (58.3)**	**12**
Treatment-related TEAEs	**1 (9.1)**	**1**	**2 (18.2)**	**2**	**1 (8.3)**	**1**
Nausea	0	0	1 (9.1)	1	0	0
Increased GGT	0	0	0	0	1 (8.3)	1
Dizziness postural	0	0	1 (9.1)	1	0	0
Headache	1 (9.1)	1	0	0	0	0
Serious TEAEs	**0**	**0**	**0**	**0**	**0**	**0**
Treatment-related serious TEAEs	**0**	**0**	**0**	**0**	**0**	**0**
TEAEs leading to study drug discontinuation, study withdrawal, or death	**0**	**0**	**0**	**0**	**0**	**0**

GGT, gamma-glutamyltransferase; IR, immediate-release; TEAE, treatment-emergent adverse event. N = number of participants who received at least one dose of blinded study treatment. [a]Deucrictibant IR capsule, 10 mg twice daily. [b]Deucrictibant IR capsule, 20 mg twice daily. Source: Wedner HJ et al. ACAAI 2024.

Long-term Prophylaxis Data

CHAPTER-1 Part 2: open-label extension

CHAPTER-1: Two-part, Phase 2 study of deucrictibant for long-term prophylaxis of HAE attacks



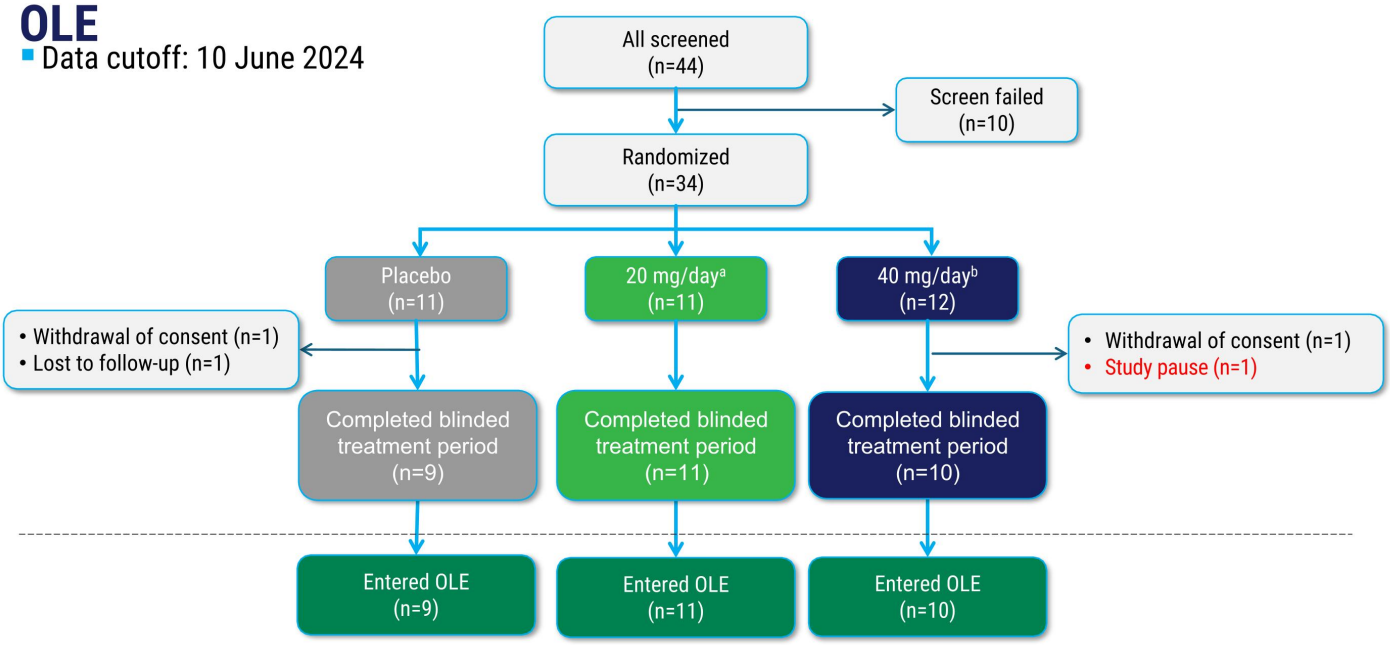
Open-Label Extension (OLE)

- Evaluate safety (primary objective) and efficacy of deucrictibant administered for long-term prophylaxis against HAE attacks
- **100% of CHAPTER-1 completers continued in OLE**
  - Data from RCT and OLE also presented for RCT completers for direct comparison

HAE, hereditary angioedema; OLE, open-label extension; IR, immediate-release; R, randomization; RCT, randomized controlled trial. [a]Deucrictibant IR capsule, 10 mg twice daily. [b]Deucrictibant IR capsule, 20 mg twice daily. CHAPTER-1 is a Pharvaris-sponsored clinical trial. **Source:** NCT05047185

CHAPTER-1: All participants who completed the RCT entered the OLE

- Data cutoff: 10 June 2024



FDA, Food and Drug Administration; IR, immediate-release; OLE, open label extension; RCT, randomized controlled trial. n = number of participants. [a]Deucrictibant IR capsule, 10 mg twice daily. [b]Deucrictibant IR capsule, 20 mg twice daily.

Balanced demographics and baseline characteristics

30 participants in the OLE received deucrictibant 40 mg/day with a mean (SD) treatment duration of 12.83 (5.03) months

	RCT			OLE
	Placebo n=11	20 mg/day[a] n=11	40 mg/day[b] n=12	40 mg/day[b] n=30
Age (years), mean (SD)	**41.4**	**38.4**	**40.8**	**39.1 (14.5)**
Sex: Male/Female, n (%)	3/8	6/5	4/8	12 (40.0) / 18 (60.0)
Race: White, n (%)	11 (100)	11 (100)	12 (100)	30 (100)
BMI (kg/m^2), mean	26.7	29.5	25.4	27.4
HAE type, n				
Type 1	10	9	12	27
Type 2	1	2	0	3
Baseline monthly‡ HAE attack rate				
Mean	1.9	2.1	2.5	2.2
Median (min, max)	1.7 (0.7, 3.7)	1.7 (1.0, 5.3)	1.7 (1.0, 6.7)	1.7 (0.7, 6.7)
Randomized baseline monthly[c] HAE attack rates, n (%)				
1 to <2 attacks	6 (54.5)	7 (63.6)	7 (58.3)	18 (60.0)
2 to <3 attacks	3 (27.3)	1 (9.1)	1 (8.3)	3 (10.0)
≥3 attacks	2 (18.2)	3 (27.3)	4 (33.3)	9 (30.0)

BMI, body mass index; HAE, hereditary angioedema; IR, immediate-release. N = number of randomized participants; RCT, randomized controlled trial. [a]Deucrictibant IR capsule, 10 mg twice daily. [b]Deucrictibant IR capsule, 20 mg twice daily. [c]1 month = 4 weeks.

Deucrictibant was well-tolerated with no new safety signals

Data snapshot (cutoff: 10 June 2024) included 30 participants in the OLE who received deucrictibant 40 mg/day with a mean (SD) treatment duration of 12.83 (5.03) months in the OLE

Deucrictibant was well-tolerated, with one treatment-related treatment-emergent adverse event (TEAE) of tooth discoloration.

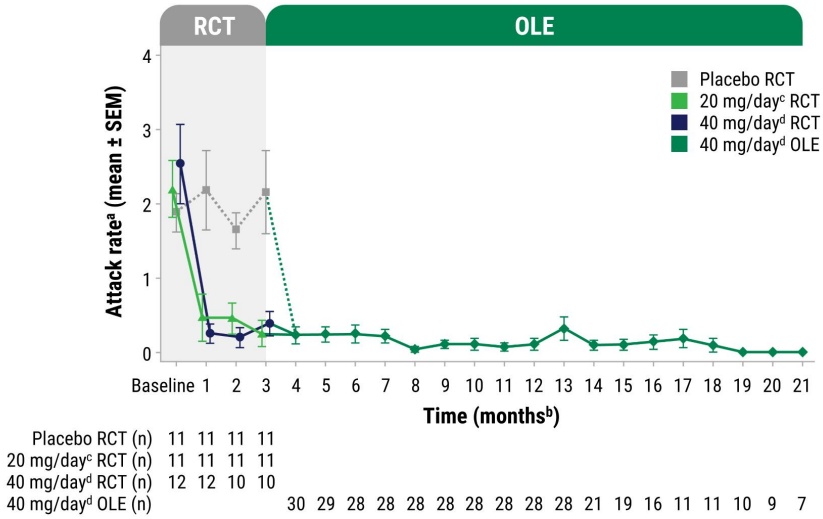
No treatment-related serious or severe TEAEs and no treatment-related TEAEs in laboratory parameters, vital signs, or ECG findings

No TEAEs leading to treatment discontinuation, study withdrawal, or death

Adverse events	Placebo to 40 mg/day[a] (n=9)		20 mg/day[b] to 40 mg/day[a] (n=11)		40 mg/day[a] to 40 mg/day[a] (n=10)		Total (N=30)	
	Participants, n (%)	Events, n	Participants, n (%)	Events, n	Participants, n (%)	Events, n	Participants, n (%)	Events, n
TEAEs	**5 (55.6)**	**25**	**7 (63.6)**	**31**	**6 (60.0)**	**16**	**18 (60.0)**	**72**
Treatment-related TEAEs	**1 (11.1)**	**1**	**0**	**0**	**0**	**0**	**1 (3.3)**	**1**
Tooth discoloration	1 (11.1)	1	0	0	0	0	1 (3.3)	1
Serious TEAEs	**0**	**0**	**1 (9.1)**	**1**	**1 (10.0)**	**1**	**2 (6.7)**	**2**
Tendon injury	0	0	0	0	1 (10.0)	1	1 (3.3)	1
Hip arthroplasty (arthritis)	0	0	1 (9.1)	1	0	0	1 (3.3)	1
Treatment-related serious TEAEs	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
TEAEs leading to study drug discontinuation, study withdrawal, or death	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Includes participants who received at least one dose of blinded study treatment in the OLE by the cutoff date of 10 June 2024. [a]Deucrictibant IR capsule, 20 mg twice daily. [b]Deucrictibant IR capsule, 10 mg twice daily. ECG: electrocardiogram. IR: immediate-release capsule formulation of deucrictibant. OLE: open-label extension. TEAE: treatment emergent adverse event. Source: Anderson J, et al. ACAAI 2024.

Reduced attack rate in the RCT remained low in the OLE

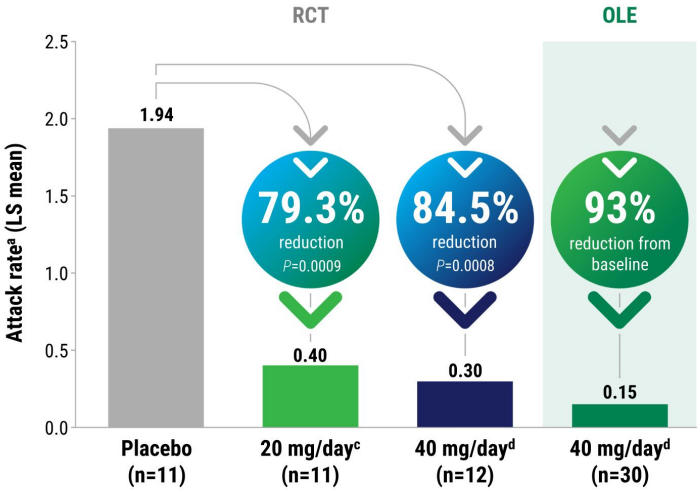


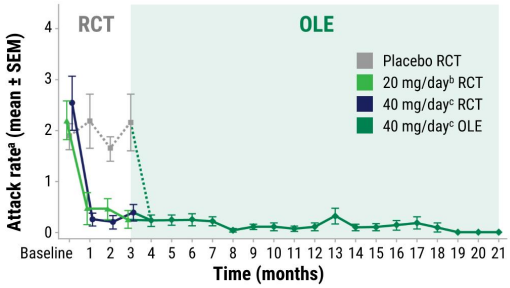
Placebo RCT (n)	11	11	11	11																	
20 mg/day[c] RCT (n)	11	11	11	11																	
40 mg/day[d] RCT (n)	12	12	10	10																	
40 mg/day[d] OLE (n)					30	29	28	28	28	28	28	28	28	28	21	19	16	11	11	10	9	7

Following early-onset reduction in attack rate with deucrictibant in the first month of the RCT, attack rate remained low during long-term (up to >1.5 years) deucrictibant 40 mg/day treatment in the OLE

IR, immediate release; OLE, open-label extension; RCT, randomized controlled trial; SEM, standard error of the mean. (n) = number of patients analyzed at each timepoint. LS mean estimates of attack rate are based on Poisson regression models adjusted for baseline attack rate and time on treatment. No multiplicity adjustment was applied. [a]Based on time normalized number of attacks per 4 weeks. [b]1 month = 4 weeks. [c]Deucrictibant IR capsule, 10 mg twice daily. [d]Deucrictibant IR capsule, 20 mg twice daily. Source: Anderson J, et al. ACAAI 2024.

Continuing deucrictibant treatment sustained the early-onset attack reduction for over one year



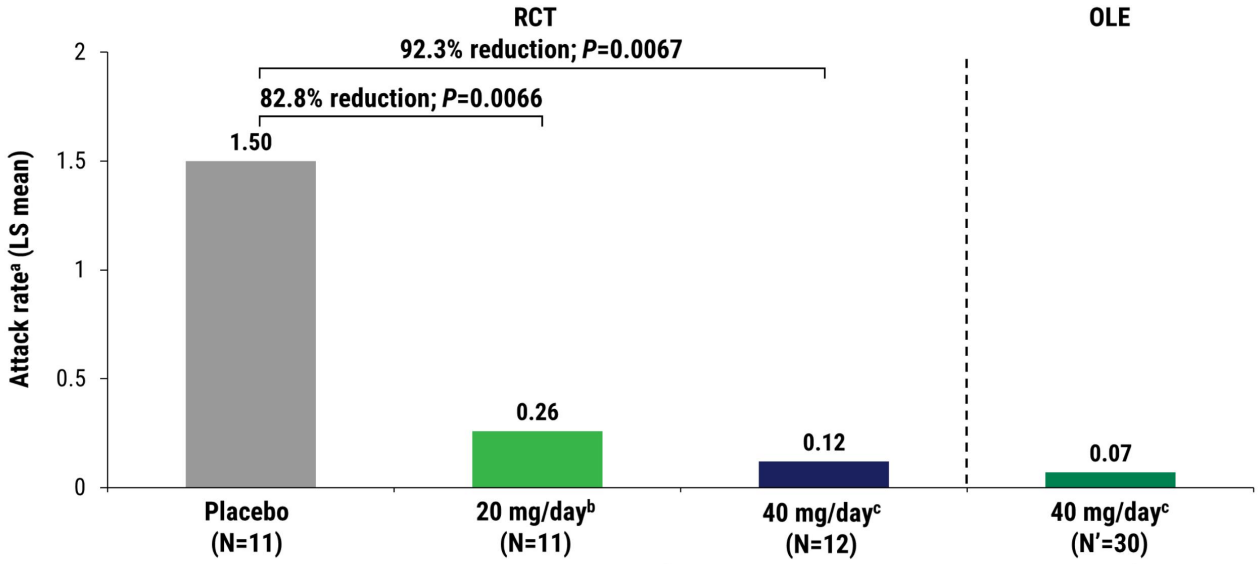


In the open-label extension up to 18 months:

- **93% attack rate reduction from baseline**
- Median attack rate = 0 for every month
- 99% of days symptom free

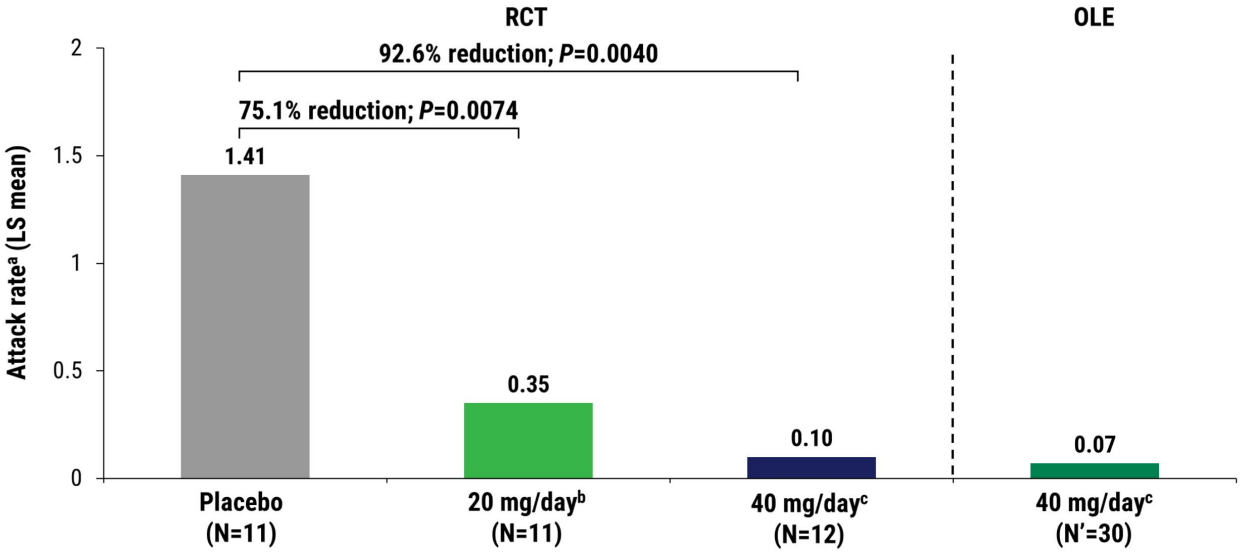
IR, immediate release; OLE, open-label extension; RCT, randomized controlled trial; SEM, standard error of the mean. (n) = number of patients analyzed at each timepoint. LS mean estimates of attack rate are based on Poisson regression models adjusted for baseline attack rate and time on treatment. No multiplicity adjustment was applied. [a]Based on time normalized number of attacks per 4 weeks. [b]1 month = 4 weeks. [c]Deucrictibant IR capsule, 10 mg twice daily. [d]Deucrictibant IR capsule, 20 mg twice daily. Source: Anderson J, et al. ACAAI 2024.

Occurrence of moderate and severe attacks remained low in the OLE treatment period



IR, immediate release; LS, least squares; OLE, open-label extension; RCT, randomized controlled trial. N = number of participants randomized in each treatment group in the RCT. N' = number of participants in the OLE. LS mean estimates of attack rate are based on Poisson regression models adjusted for baseline attack rate and time on treatment. No multiplicity adjustment was applied. The P-values in this figure are nominal. [a]Based on time-normalized number of attacks per 4 weeks. [b]Deucrictibant IR capsule, 10 mg twice daily. [c]Deucrictibant IR capsule, 20 mg twice daily. Source: Riedl MA et al. BKS 2024.

On average less than one attack per year per participant was treated with rescue medication



IR, immediate release; LS, least squares; OLE, open-label extension; RCT, randomized controlled trial. N = number of participants randomized in each treatment group in the RCT. N' = number of participants in the OLE. LS mean estimates of attack rate are based on Poisson regression models adjusted for baseline attack rate and time on treatment. No multiplicity adjustment was applied. The *P*-values in this figure are nominal. [a]Based on time normalized number of attacks per 4 weeks. [b]Deucrictibant IR capsule, 10 mg twice daily. [c]Deucrictibant IR capsule, 20 mg twice daily. Source: Riedl MA et al. BKS 2024.

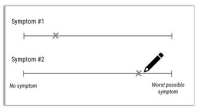
On-Demand Program

We have renamed VAS to AMRA, reflecting its evolution from a paper-based to electronic attack assessment[1]

What is a **V**isual **A**nalogue **S**cale (VAS)?

- Simple, reproducible, paper-based tool to allow patient self-assessment of symptom severity
- Analog scale with an 'X' hand-marked to reflect severity of attack

2008–2011
Jerini-Shire



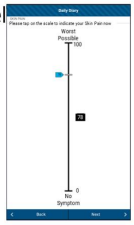
Why do we need change?

- Addressing user experience to leverage technology and accuracy of data collection[1]
- HAE ODT trials require frequent assessments to be recorded by participants; a digital tool is an accessible method for timely data input

How has Pharvaris evolved the VAS to a contemporary electronic standard?

- Electronic Clinical Outcome Assessment (eCOA)
- Presents the numeric scale vertically (e.g. from 'Worst possible' = 100 to 'No symptom' = 0)
- Participants can see in real time the exact score (between 0 and 100) sel
- Performed at home

2023
Pharvaris

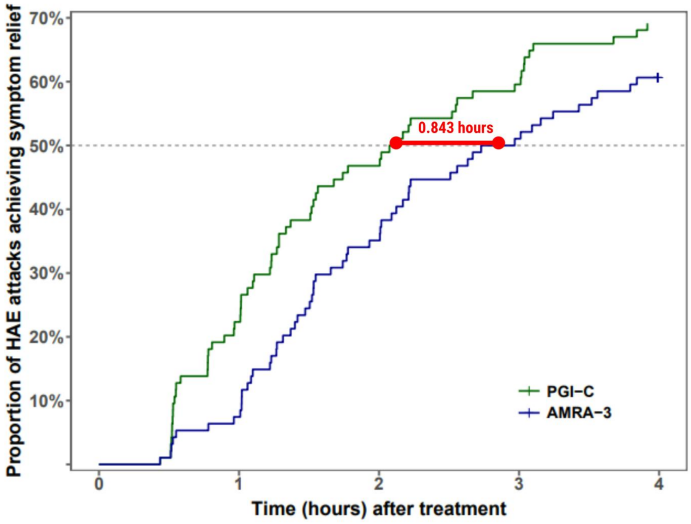


A numeric rating scale requires a self- explanatory name

Angioedema sy**m**ptom **R**ating sc**A**le (AMRA)

Source: [1] CDER. Patient-Focused Drug Development: Selecting, Developing, or Modifying Fit-for Purpose Clinical Outcome Assessments. FDA. June 2022.

In a real-world study using standard-of-care therapy, median time to symptom relief for PGI-C "a little better" is 0.8 h faster than AMRA-3 ≥30% reduction



PRO instrument	Events (n)	Median time to, h (95% CI)
PGI-C "a little better"	90	**2.147** (1.518, 3.017)
AMRA-3 30% reduction from pre-treatment	89	**2.990** (2.123, 4.011)

- **Onset of symptom relief** (AMRA-3 ≥30%) for deucrictibant (20mg) in RAPIDe-1 was **2.7 hours** (p=0.0021)

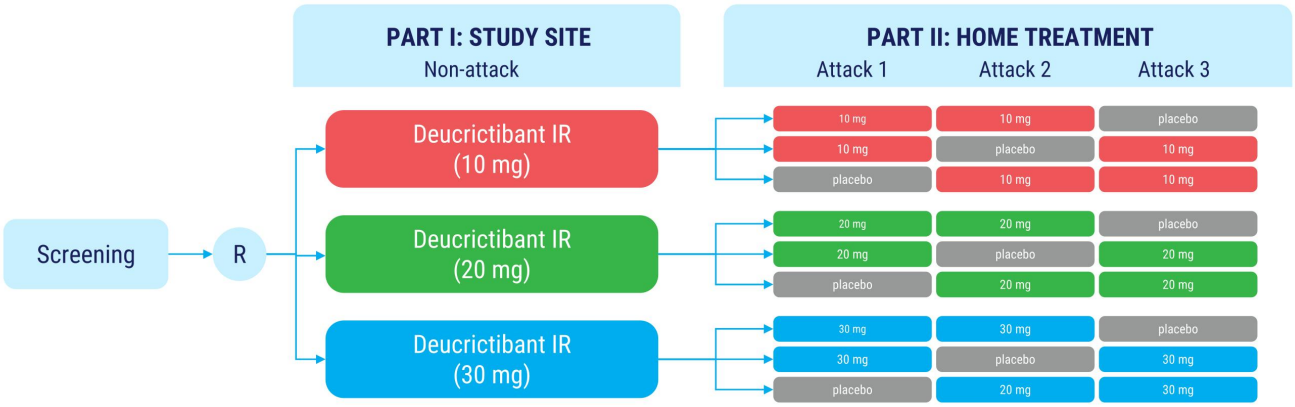
Source: Mendivil *et al.*, UCARE 2023.

On-demand Data

RAPIDe-1 Randomized Clinical Trial (RCT)
Topline Data

RAPIDe-1

Phase 2 study of on-demand treatment of attacks in patients with HAE-C1INH-Type 1/2



Primary objective

To evaluate angioedema symptom relief within four hours in acute attacks of patients with HAE-C1INH-Type 1/2

Study design

- Placebo-controlled, with three dose levels
- Before an attack was treated, one of the VAS-3 elements had to hit a score of ≥30 and be qualified by the clinician

74 HAE patients

enrolled from ~30 sites in US, Canada, Europe, Israel, and UK

HAE: hereditary angioedema; IR, immediate-release capsule formulation of deucrictibant. VAS: visual analog scale. Source: NCT04618211.

Baseline characteristics

	Deucrictibant IR dose group			
	10 mg (n=22)	20 mg (n=18)	30 mg (n=22)	Total (N=62)
Age (years), mean	42.5	44.5	41.9	42.9
Sex, n (%)				
Male	7 (31.8)	5 (27.8)	8 (36.4)	20 (32.3)
Female	15 (68.2)	13 (72.2)	14 (63.6)	42 (67.7)
Race, n (%)				
White	20 (90.9)	18 (100)	22 (100)	60 (96.8)
Other	2 (9.1)	0	0	2 (3.2)
BMI (kg/m^2), mean	27.5	27.6	27.9	27.7
Time since HAE diagnosis (years), mean	21.11	21.64	23.98	22.28
HAE type, n (%)				
HAE-1	18	15	22	55
HAE-2	4	2	0	6
HAE-1 or HAE-2	0	1	0	1

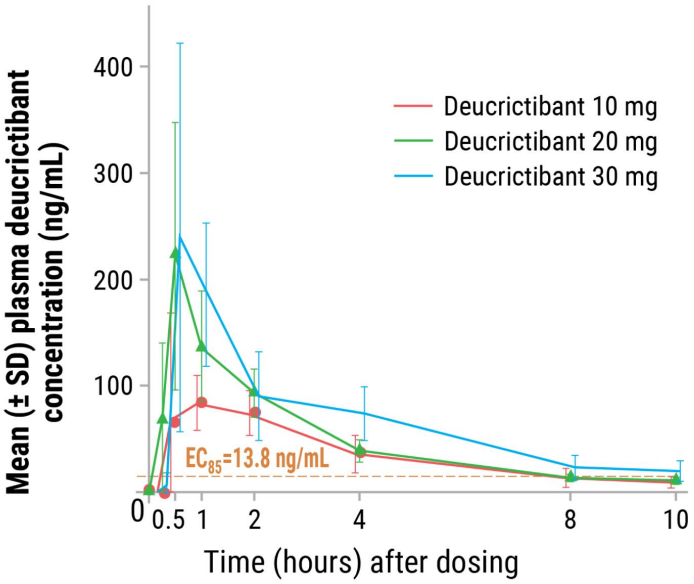
Safety analysis set:
73 patients with
156 attacks

mITT analysis set:
62 patients with
147 attacks

Demographics and baseline characteristics were generally balanced between the different dose groups

BMI, body mass index; HAE, hereditary angioedema; IR, immediate release; mITT, modified intent-to-treat; VAS, visual analog scale. Source: Misra L, et al. *Indian J Anaesth*. 2016.

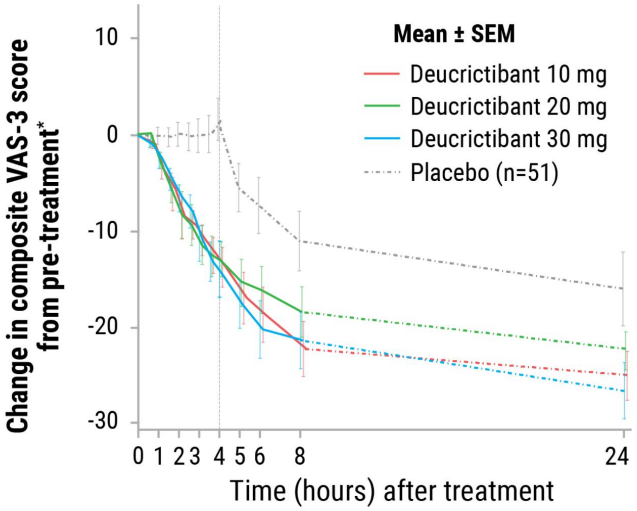
PK analysis in HAE patients confirmed rapid absorption on oral dosing, consistent with Phase 1 healthy volunteer studies



- **Rapid absorption** with mean plasma levels exceeding EC_{85} (13.8 ng/mL) within 30 min
- Mean **plasma levels maintained** >EC_{85} for approximately:
  - 8 h at 10 mg or 20 mg
  - >10 h at 30 mg dose
- **EC_{85}** levels established using **bradykinin challenge**, a human surrogate endpoint study in healthy volunteers

HAE, hereditary angioedema; PK, pharmacokinetic. Source: Jacobs JS, et al. WSAAI 2024.

Primary endpoint: deucrictibant IR significantly reduced attack symptoms by VAS-3 at 4h



Difference from placebo in change from pre-treatment to 4 h post-treatment, LS mean (95% CI)

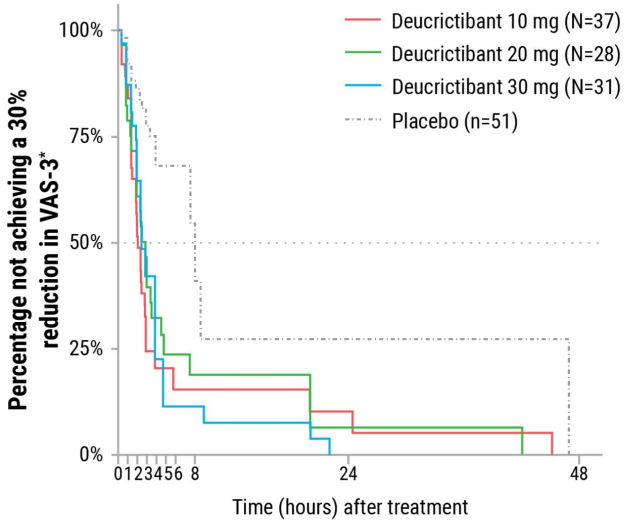
Deucrictibant 10 mg	-16.75 (-21.52, -11.97)	*P*<0.0001†
Deucrictibant 20 mg	-15.02 (-20.22, -9.81)	*P*<0.0001
Deucrictibant 30 mg	-16.28 (-21.27, -11.29)	*P*<0.0001
Combined deucrictibant	-16.08 (-19.87, -12.29)	

Median **VAS-3** at pre-treatment ranges from **24.33-27.00** across different dose levels

*VAS assessed every 30 minutes up to 4 hours post-treatment, then at 5, 6, 8, 24, 48 hours; †Nominal p-value. Note: Attacks in mITT Analysis Set refer to attacks treated with blinded study drug that had non-missing VAS result at pre-treatment and at least one non-missing VAS result post-treatment. Figure is based on descriptive summary of mean and SEM (standard error of the mean). Least-squares mean differences, CIs, and P values come from a MMRM. Data after rescue medication use is not included. Combined deucrictibant result is based on post-hoc analysis using a similar MMRM with all three active doses combined vs placebo.

IR; immediate release; LS, least squares; MRMM, mixed-effects model with repeated measures; VAS, visual analog scale. Source: Jacobs JS, et al. WSAAI 2024.

Deucrictibant IR significantly shortened time to onset of symptom relief (30% reduction in VAS-3)

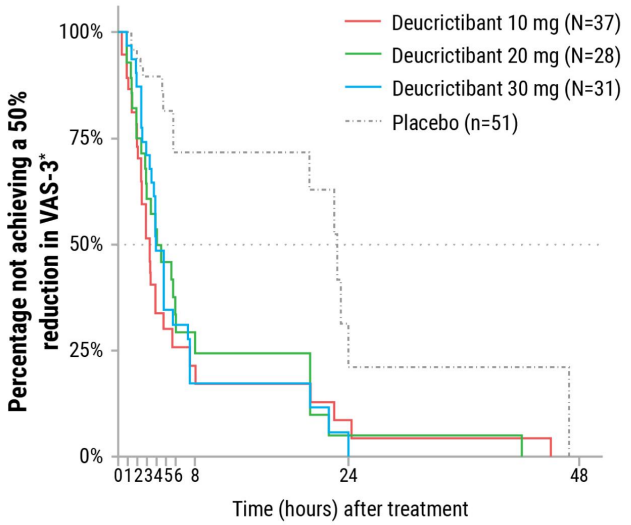


Median time in hours (95% CI)

Placebo	8.0 (7.6, 46.9)	
Deucrictibant 10 mg	2.1 (1.5, 2.9)	*P*<0.0001†
Deucrictibant 20 mg	2.7 (1.9, 3.5)	*P*=0.0021
Deucrictibant 30 mg	2.5 (1.9, 3.8)	*P*<0.0001
Combined deucrictibant	2.4 (2.0, 2.9)	

*VAS assessed every 30 minutes up to 4 hours post-treatment, then at 5, 6, 8, 24, 48 hours; †Nominal p-value. Note: N = The number of attacks in the mITT Analysis Set. Median time based on Kaplan-Meier estimates. *P* values based on a marginal Cox proportional hazards model.
The combined deucrictibant results are based on post-hoc analyses to provide a reference of the result by pooling all three active doses. CI, confidence interval; IR; immediate release; VAS, visual analog scale.
Source: Maurer M, et al. APAAACI 2023.

Deucrictibant IR significantly reduced time to 50% reduction in VAS-3

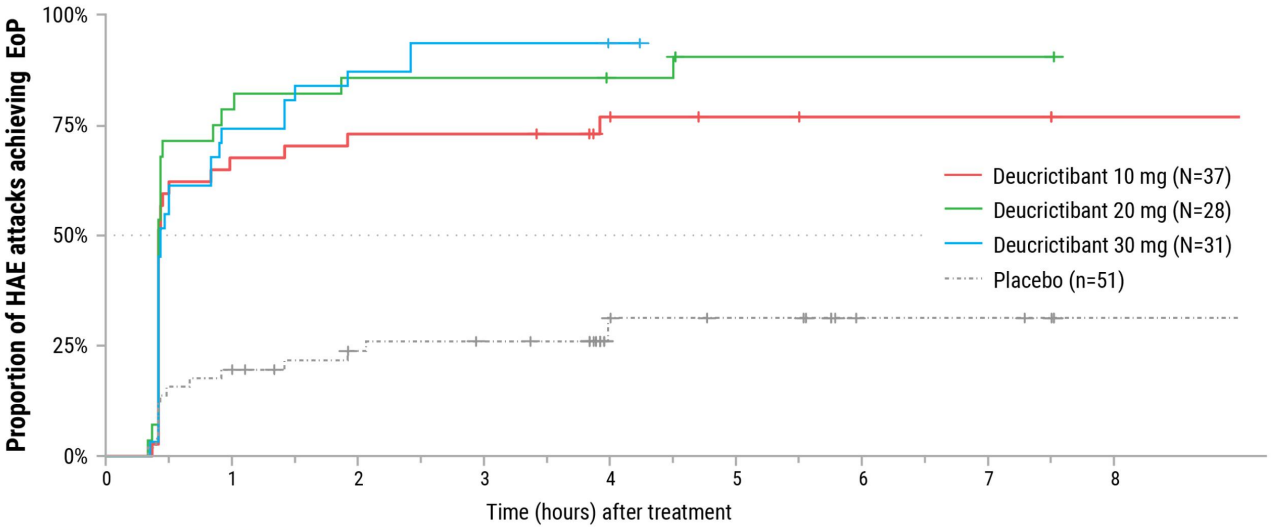


Median time in hours (95% CI)

Placebo	22.8 (20.0, 24.1)	
Deucrictibant 10 mg	3.3 (2.4, 3.9)	*P*<0.0001†
Deucrictibant 20 mg	4.0 (2.9, 6.0)	*P*=0.0003
Deucrictibant 30 mg	4.0 (3.3, 5.8)	*P*<0.0001
Combined deucrictibant	3.9 (3.0, 4.8)	

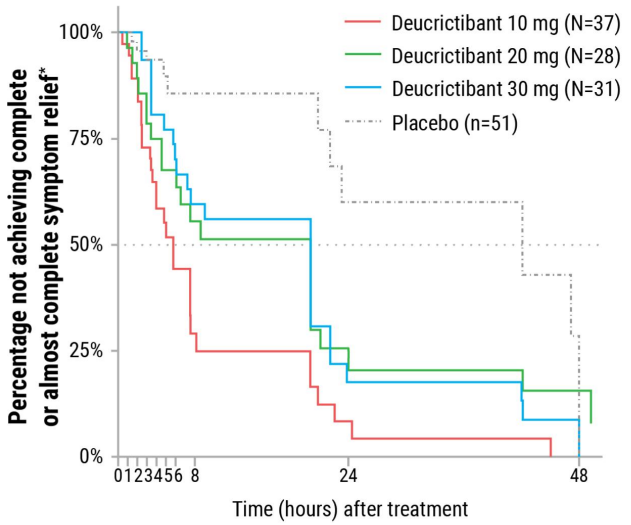
*VAS assessed every 30 minutes up to 4 hours post-treatment, then at 5, 6, 8, 24, 48 hours; †Nominal p-value. Note: N = The number of attacks in the mITT Analysis Set. Median time based on Kaplan-Meier estimates. p-values based on a marginal Cox proportional hazards model.
The combined deucrictibant results are based on post-hoc analyses to provide a reference of the result by pooling all three active doses.
CI, confidence interval; IR; immediate release; VAS, visual analog scale.

In a post-hoc analysis, patients on deucrictibant achieved end of progression by VAS-3 within 25 to 26 minutes



EoP: end of progression. HAE: hereditary angioedema. VAS: visual analog scale.
Source: Riedl MA, et al. ACAAI 2023.

Deucrictibant IR significantly reduced time to almost complete or complete symptom relief (all individual VAS ≤10)

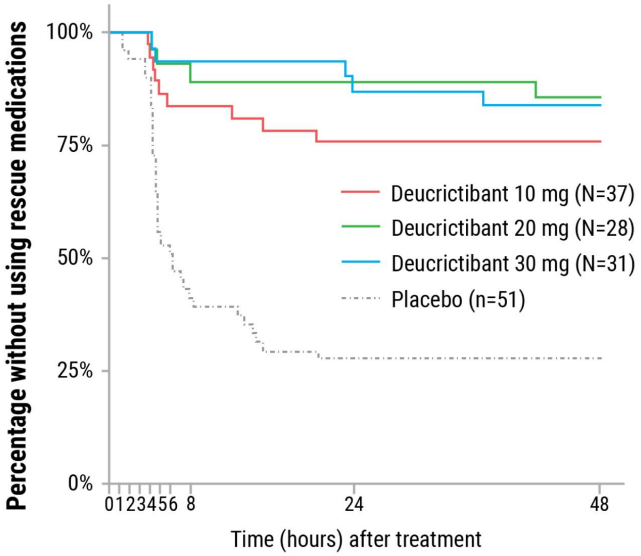


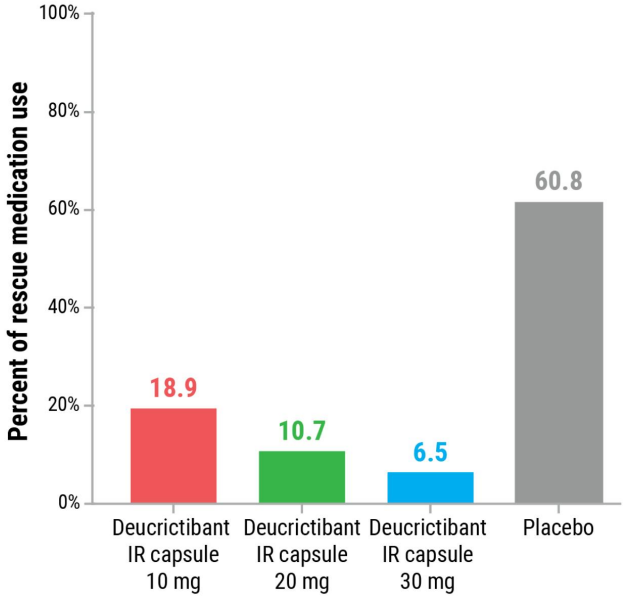
Median time in hours (95% CI)

Placebo	42.0 (22.0, 48.1)	
Deucrictibant 10 mg	5.8 (3.6, 7.5)	*P*<0.0001†
Deucrictibant 20 mg	20.0 (4.5, 20.0)	*P*=0.0127
Deucrictibant 30 mg	20.0 (6.0, 20.1)	*P*=0.0001
Combined Deucrictibant IR	7.5 (5.9, 20.0)	

*VAS assessed every 30 minutes up to 4 hours post-treatment, then at 5, 6, 8, 24, 48 hours; †Nominal p-value. Note: N = The number of attacks in the mITT Analysis Set. Median time based on Kaplan-Meier estimates. p-values based on a marginal Cox proportional hazards model. The combined PHVS416 results are based on post-hoc analyses to provide a reference of the result by pooling all three active doses.
CI, confidence interval; IR; immediate release; VAS, visual analog scale.
Source: Maurer M, et al. APAAACI 2023.

Patients treating with deucrictibant IR used substantially less rescue medication





Note: n = The number of attacks in the mITT Analysis Set.
CI, confidence interval; IR; immediate release; VAS, visual analog scale.
Source: Jacobs JS, et al. WSAAI 2024.

Deucrictibant IR was well tolerated at all doses

RAPIDe-1

- No treatment-related SAEs or AEs of severe severity
- No AEs leading to treatment discontinuation
- Few treatment-related AEs reported within 48 h after administration of study drug

	Part I (Non-Attack)			Part II (Attack 1,2,3)			
	10 mg n=23	20 mg n=24	30 mg n=25	Placebo n=53	10 mg n=23	20 mg n=24	30 mg n=25
Subjects (Part I) or attacks (Part II) with any treatment-related AEs	**1 (4.3%)**	**1 (4.2%)**	**-**	**1 (1.9%)**	**-**	**-**	**1 (2.8%)**
Headache	-	1 (4.2%)	-	-	-	-	-
Nausea	1 (4.3%)	-	-	-	-	-	1 (2.8%)
Vomiting	-	-	-	-	-	-	1 (2.8%)
Fatigue	-	-	-	-	-	-	1 (2.8%)
Blister	-	-	-	1 (1.9%)	-	-	-

Note: n = The number of subjects (Part I) and number of attacks (Part II) in the Safety Analysis Set; The Safety Analysis Set includes all randomized patients who received any dose of study drug; Treatment-related AEs within 48 h post-treatment are included.
AE, adverse event; SAE, serious adverse event.
Source: Maurer M et al. BKS 2024.

Greater improvement in MSCS and TOS with deucrictibant than placebo

	Placebo	Deucrictibant 10 mg	Deucrictibant 20 mg	Deucrictibant 30 mg	Combined deucrictibant*
Change in MSCS score at 4 hours					
n	40	32	26	27	85
LS mean (95% CI)	-0.29 (-0.51, -0.08)	-1.08 (-1.33, -0.83)	-0.91 (-1.19, -0.62)	-0.68 (-0.95, -0.40)	-0.90 (-1.06, -0.75)
Difference (Deucrictibant – Placebo) *P* value		-0.79 *P*<0.0001*	-0.61 *P*=0.0008	-0.39 *P*=0.0291	-0.61
TOS at 4 hours					
n	40	32	25	28	85
LS mean (95% CI)	-3.62 (-19.68, 12.45)	60.52 (41.74, 79.29)	59.08 (37.58, 80.57)	67.44 (47.15, 87.74)	62.57 (50.95, 74.19)
Difference (Deucrictibant – Placebo) *P* value		64.13 *P*<0.0001*	62.69 *P*<0.0001	71.06 *P*<0.0001	66.05

*Nominal p-value; Note: LS mean, LSMD, CIs, and p-values for MSCS change from pre-treatment/TOS come from mixed-effect models with repeated measures (MMRM). Data after rescue medication use is not included. The combined deucrictibant result is based on post-hoc analysis using similar MMRM with all three active doses combined vs placebo.

CI, confidence interval; LS mean, least-squares mean; LSMD, least-squares mean difference; MSCS, mean symptom complex severity; TOS, treatment outcome score.

Source: Manning ME, et al. CIIC 2023.

Time to symptom relief by TOS PRO demonstrated consistent efficacy at all doses

	Placebo	Deucrictibant 10 mg	Deucrictibant 20 mg	Deucrictibant 30 mg	Combined Deucrictibant*
Number of attacks	49	36	28	29	93
Attacks achieving "a little better" for all SCs at two consecutive time points - n (%)*	18 (**36.7%**)	32 (88.9%)	25 (89.3%)	27 (93.1%)	84 (**90.3%**)
Median (95% CI) time by KM estimate (hours)	**7.62** (3.95, NE)	1.89 (0.97, 3.97)	2.15 (1.75, 4.00)	1.98 (1.80, 3.87)	**1.98** (1.88, 3.87)
Attacks achieving "a lot better or resolved" for all SCs at any time point – n (%)*	13 (**26.5%**)	30 (83.3%)	23 (82.1%)	25 (86.2%)	78 (**83.9%**)
Median (95% CI) time by KM estimate (hours)	**23.28** (5.78, 47.17)	4.02 (3.93, 5.77)	5.93 (3.90, 8.58)	4.12 (3.92, 7.22)	**5.23** (3.98, 5.78)

*Within 48-hour assessments.

KM, Kaplan-Meier; NE, not estimable; PRO, patient reported outcome; SC, symptom complex; TOS, treatment outcome score.

Source: Manning ME, et al. CHC 2023.

On-demand Data

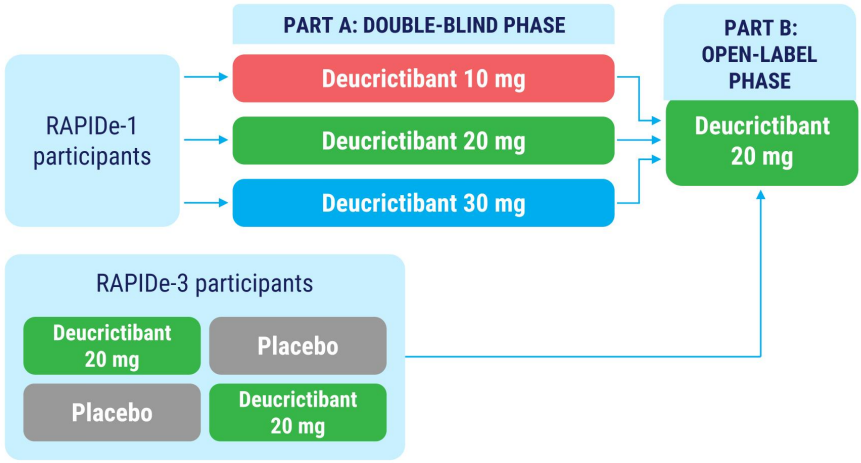
RAPIDe-2 long-term extension data

RAPIDe-2

Phase 2/3 LTE study of ODT of attacks in patients with HAE-C1INH-Type 1/2*

Part A enrolls adult (≥18 years) **participants who completed RAPIDe-1**

Participants continue self-administering the same double-blinded dose of deucrictibant IR capsule (10 mg, 20 mg, or 30 mg) **received in RAPIDe-1** to treat qualifying non-laryngeal attacks†, and laryngeal attacks presenting without breathing difficulties



Objective: To evaluate the long-term safety and efficacy of orally administered deucrictibant immediate-release capsule for the treatment of HAE attacks

IR, immediate-release. [a]Including laryngeal attacks (without breathing difficulties). *RAPIDEe-2 is an extension of RAPIDe1, a phase 2 study of on-demand treatment of attacks in patients with HAE-C1INH-Type 1/2; †≥1 symptom with VAS score ≥30.
HAE, hereditary angioedema; IR, immediate-release; VAS, visual analog scale. Source: Maurer M et al. BKS 2024.

Study endpoints

Primary endpoint: Safety, including TEAEs, clinical laboratory tests, vital signs, and ECG findings

Efficacy: Assessed using PRO tools

Key efficacy endpoints

Onset of symptom relief

PGI-C rating of at least "a little better" for 2 consecutive timepoints by 12 hours post-treatment

Time to reduction in attack severity

≥1 level reduction in PGI-S from pre-treatment for 2 consecutive timepoints by 12 hours post-treatment

Proportion of attacks achieving complete attack resolution

PGI-S rating of "none" at 24 hours post-treatment

Efficacy (PRO) assessment scales

Patient **G**lobal **I**mpression of **C**hange[1] — PGI-C: Much worse | Worse | A little worse | Same | A little better | Better | Much better

Patient **G**lobal **I**mpression of **S**everity[2] — PGI-S: Very severe | Severe | Moderate | Mild | None

ECG, electrocardiogram; PGI-C, Patient Global Impression of Change; PGI-S, Patient Global Impression of Severity; PRO, patient-reported outcome; TEAE, treatment-emergent adverse event.
Source: [1]Guy W (ed). *ECDEU Assessment Manual for Psychopharmacology*.1976. [2]Cohn DM, et al. *Clin Transl Allergy*. 2023.

Baseline characteristics

265 attacks from 17 participants included in the mITT **efficacy analysis set** (data cutoff: 01 March 2024)*

337 attacks from 19 participants included in the **safety analysis set** (data cutoff: 10 June 2024)†

7 of 337 attacks were laryngeal

Baseline characteristics consistent with the **RAPIDe-1** Phase 2 trial

	Deucrictibant IR capsule (All doses)
Number of attacks treated‡	337
Number of participants‡	19
Age in years, mean (SD)	42.7 (17.6)
Sex: Male/female, n (%)	7 (36.8) / 12 (63.2)
Race: White/other	18 / 1
BMI, mean (SD)	27.0 (3.8)
Years since HAE diagnosis, mean (SD)	21.7 (15.2)
HAE type, n (%)	
HAE-1	17 (89.5)
HAE-2	2 (10.5)

*All participants who had ≥1 attack treated with deucrictibant and non-missing PGI-C results from ≥1 post-treatment timepoint. †All participants who received any dose of deucrictibant in the study.
‡Number by the cutoff date of 10 June 2024.
BMI, body mass index; HAE, hereditary angioedema; IR, immediate-release; SD, standard deviation. [a]Number by the cutoff date of 10 June 2024.
Source: Maurer M et al. BKS 2024.

Deucrictibant was well-tolerated across all doses

- No treatment-related TEAEs
- No treatment-related serious or severe TEAEs, no treatment-related TEAEs in laboratory parameters, vital signs, or ECG findings
- No TEAEs leading to treatment discontinuation, study withdrawal, or death

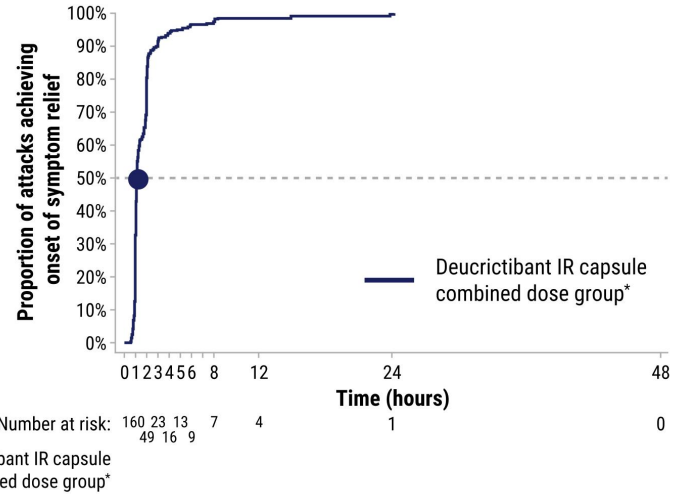
TEAEs within 5 days after administration of study drug

	Deucrictibant IR capsule (All doses)
Number of attacks treated*	337
Number of participants*	19
Attacks with any TEAE, n (%)	13 (3.9)
Treatment-related TEAEs, n	0
Serious TEAEs, n	1†
Treatment-related serious TEAEs, n	0
TEAEs leading to study drug discontinuation, study withdrawal, or death, n	0

*Number in the safety analysis set (data cutoff: 10 June 2024). †Tooth caries unrelated to treatment.ECG, electrocardiogram; IR, immediate-release; TEAE, treatment-emergent adverse event (defined as adverse event occurring during time window from first study drug administration).
Source: Maurer M et al. BKS 2024.

PGI-C “a little better” is the RAPIDe-3 primary endpoint

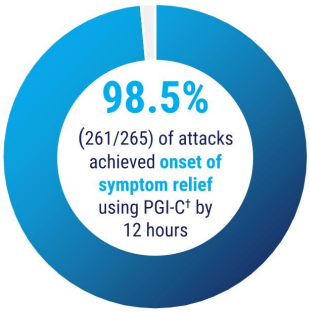
Kaplan-Meier plot of time to onset of symptom relief



Number at risk:	160	23	13	7	4	1	0
	49	16	9				

Deucrictibant IR capsule combined dose group*

1.1 hours (95% CI, 1.0, 1.2) median time to **onset of symptom relief** by PGI-C†

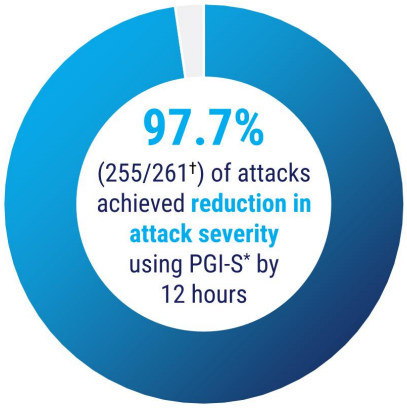


CI, confidence interval; IR, immediate-release; PGI-C, Patient Global Impression of Change. *Includes 10 mg, 20 mg, and 30 mg dose groups. †PGI-C rating of at least “a little better” for 2 consecutive timepoints by 12 hours post-treatment.

Source: Maurer M et al. BKS 2024.

Rapid median reduction in attack severity at 2.6 hours: 97.7% of attacks achieved a reduction in severity by 12 hours

2.6 hours (95% CI, 2.0, 2.9) median time to **reduction in attack severity** by PGI-S*



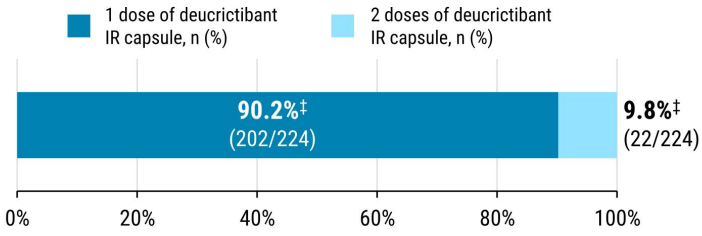
*≥1 point reduction in PGI-S from pre-treatment for 2 consecutive timepoints by 12 hours post-treatment; †261 attacks have non-missing pre-treatment PGI-S.
PGI-S, Patient Global Impression of Severity.
Source: Maurer M et al. BKS 2024.

Median attack resolution time 11.5 hours: 85.8% of attacks completely resolved within 24 hours (90.2% of which with one only dose)[1]

11.5 hours (95% CI, 11.0, 13.0) median time to **complete attack resolution** by PGI-S[1*]

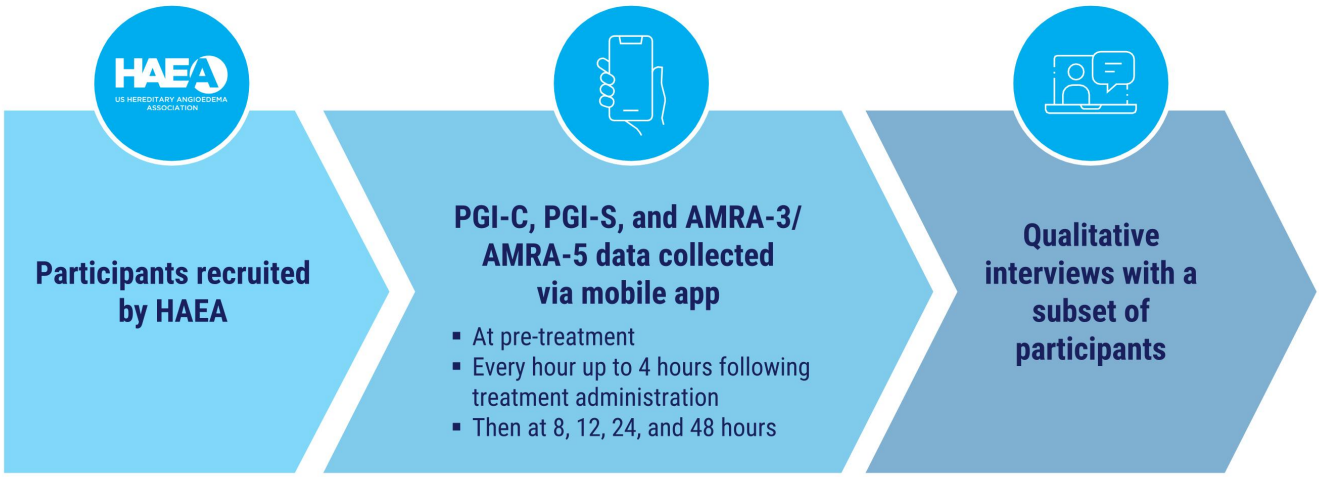
90.2% (202/224) of attacks achieved complete attack resolution with a **single dose** of deucrictibant IR capsule[2]

Attacks treated with 1 or 2 doses of deucrictibant prior to achieving complete attack resolution[2]



*PGI-S rating of "none" at 24 hours post-treatment. †261 attacks have non-missing pre-treatment PGI-S. ‡Percentage of 224 attacks achieving complete attack resolution using PGI-S within 24 hours.
IR, immediate-release; PGI-S, Patient Global Impression of Severity.
Source: [1]Maurer M et al. BKS 2024.

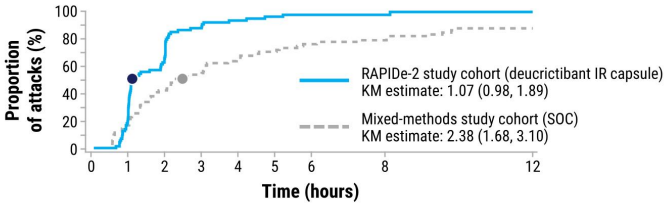
Mixed-methods study: Non-interventional collection of HAE attack symptoms assessments following treatment with standard of care



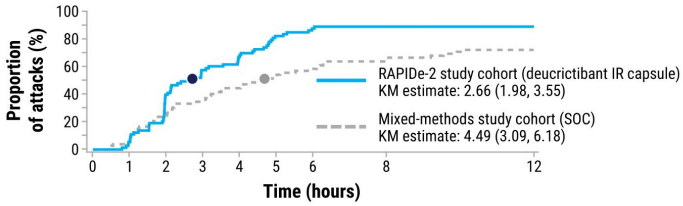
Note: Standard of care was icatibant or plasma derived/recombinant C1-Inhibitor.
AMRA, angioedema Symptom Rating Scale; HAEA, US Hereditary Angioedema Association; PGI-C, Patient Global Impression of Change; PGI-S, Patient Global Impression of Severity.
Source: Riedl MA, et al. BKS 2024.

In a propensity-score-matching analysis, deucrictibant showed favorable symptom relief outcomes versus standard of care

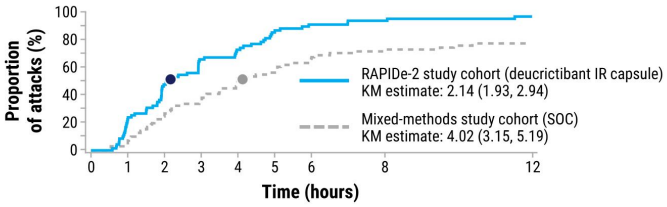
A. Time to symptom relief defined as PGI-C "A little better"



C. Time to symptom relief defined as PGI-C "Better"



B. Time to reduction in attack severity defined as PGI-S ≥1 point reduction



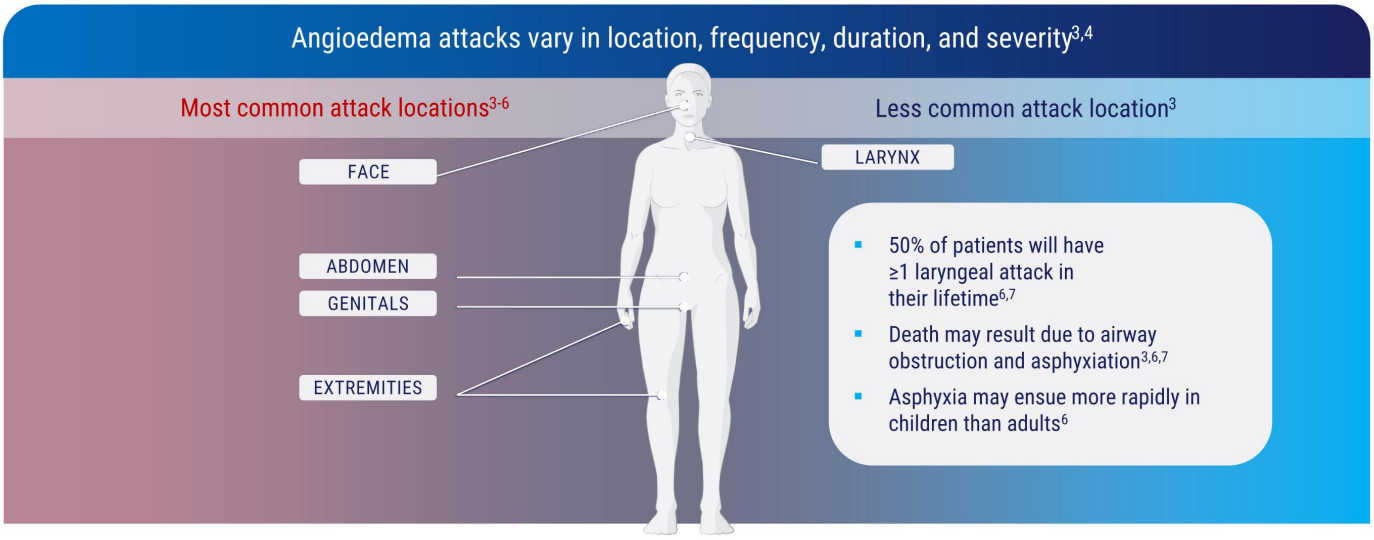
	Time to symptom relief in hours, median (95% CI)	RAPIDe-2 cohort (deucrictibant; N=73)	Mixed-methods cohort (SOC; N=73)
A	PGI-C: "A little better"	**1.07** (0.98, 1.89)	**2.38** (1.68, 3.10)
B	PGI-S: ≥1 point reduction	**2.14** (1.93, 2.94)	**4.02** (3.15, 5.19)
C	PGI-C: "Better"	**2.66** (1.98, 3.55)	**4.49** (3.09, 6.18)

AMRA, Angioedema syMptom Rating scAle; CI, confidence interval; IR, immediate-release; PGI-C, Patient Global Impression of Change; PGI-S, Patient Global Impression of Severity. N=73 for both cohorts. Parameters: The first 10 consecutive attacks were selected for each participant; Greedy Nearest Neighbor 1:1 matching was used with Caliper = 0.5; participants were matched for sex, age, baseline attack severity (defined by AMRA score), and exact attack primary location. Source: Riedl MA, et al. BKS 2024.

Introduction to HAE

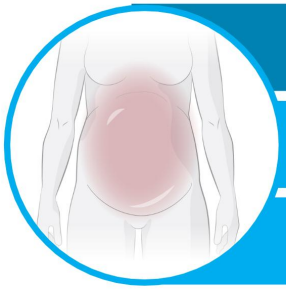
Locations of HAE attacks

HAE Type 1 and 2 are indistinguishable in their clinical presentation,[1] having identical symptoms characterized by edema of one or several organ systems[2]



HAE: hereditary angioedema. Source: [1]Zuraw BL. *N Engl J Med*. 2008. [2]Nzeako UC, et al. *Arch Intern Med*. 2001. [3]Lumry WR. *Am J Manag Care*. 2013. [4]Farkas H. *Allergy Asthma Clin Immunol*. 2010. [5]Nygren A, et al. *Acta Paediatr*. 2016. [6]Lumry WR. *Am J Manag Care*. 2013. [7]Agostoni A, et al. *J Allergy Clin Immunol*. 2004.

Characteristics of HAE attacks



Abdominal pain is caused by edema of the mucosa at any portion of the GI tract[2]; it can be severe and may lead to onerous surgeries[2,3]

Abdominal attacks are often accompanied by vomiting and/or diarrhea[4]

- Patients report needing 24-50 hours of bed rest per attack[4]
- Abdominal attacks may necessitate hospitalization[4]

Abdominal films, CT scans, ultrasonography, or endoscopy may be useful in identifying edema of the intestinal wall[1,2,5]

Patients may first notice a sensation of tingling prior to the start of skin swelling[2,39-10]

Some patients have an erythematous, nonpruritic, non-raised rash, known as erythema marginatum[2,3,9-10]

Angioedema develops over several hours[10]

Swelling can interfere with daily functioning (e.g., inability to dress or wear shoes)[11]

Facial swelling may be associated with obstruction of the upper airway[7]

Attacks are disfiguring and disabling and may result in serious loss of function (e.g., lips too swollen to eat, swollen throat resulting in difficulty breathing)[8]

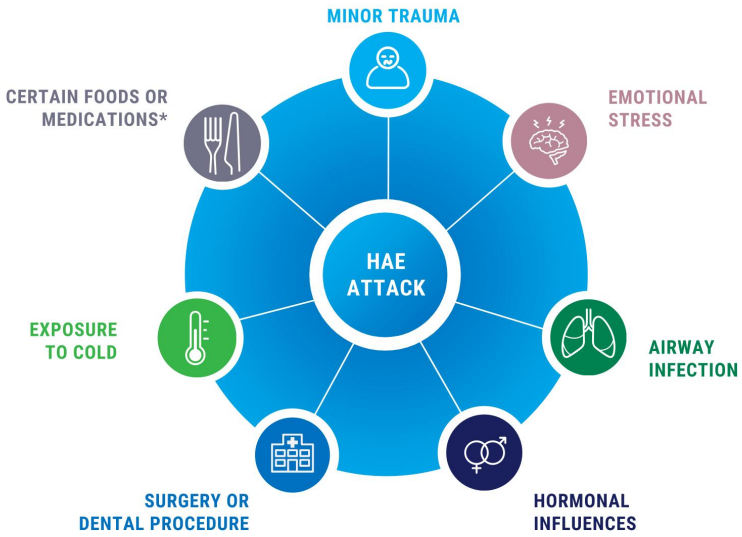
*In Chinese patients, the percentage of abdominal attacks is lower (approximately 34%).[6]
CT: computed tomography. GI: gastrointestinal. HAE: hereditary angioedema.
Source: [1]Agostoni A, et al. J Allergy Clin Immunol. 2004. [2]Frank MM. eMedicine. September 2010. [3]Frank MM. Immunol Allergy Clin North Am. 2006. [4]Bork K, et al. Am J Gastroenterol. 2006. [5]Koruth JS, et al. Gastrointest Endosc. 2005. [6]Liu S, et al. Eur J Dermatol. 2019. [7]Bork K, et al. Am J Med. 2006. [8]Lumry WR, et al. Allergy Asthma Proc. 2010. [9]MacGinnitie AJ. Pediatr Allergy Immunol. 2014. [10]Zuraw BL. N Engl J Med. 2008.

Triggers of HAE attacks

A number of possible attack triggers have been proposed for HAE[1]

- Many attacks, particularly among children, occur without a clear trigger[1,2]
- Common triggers include mechanical trauma, mental stress, and airway infection[2]
- Dental eruption is not a common trigger but can provoke an attack in some children[2]
- Menstruation and ovulation are common triggers in adolescent girls[2]
- The same trigger may not always provoke an attack[1]

Possible triggers for HAE attacks[1-4]



*Medications include estrogen-containing oral contraceptives, hormone replacement therapies, ACE inhibitors.[1,2]
ACE, angiotensin-converting enzyme; HAE, hereditary angioedema.
Source: [1]Lumry WR. *Am J Manag Care*. 2013. [2]Farkas H, et al. *Allergy*. 2017. [3]Steiner UC, et al. *Orphanet J Rare Dis*. 2018. [4]Caballero T, et al. *J Invest Allergol Clin Immunol*. 2016.

A timely and accurate diagnosis is key

Due its rarity and overlap of symptoms with other conditions, HAE is frequently under-recognized and misdiagnosed[1,2]

The most common **misdiagnoses** are **allergic angioedema** and **appendicitis**[1]

Misdiagnosis or delayed diagnosis of HAE **can result in mismanagement and incorrect treatment**, which can have serious implications for the patient[1,2]

Misdiagnosis is more likely to **occur in patients without a family history of HAE**[1]

HAE, hereditary ang[illegible]

It often takes several years to acheive an accurate diagnosis of HAE[3-5]

Many patients experience a **delay of over 10 years** from onset of symptoms to correct diagnosis[1,5,6]

Earlier onset of symptoms has been shown to be **correlated with longer delays in diagnosis**[4]

Patients **without a family history of HAE may experience longer delays** in diagnosis than patients with a family history[6,7]

Diagnostic **delays vary considerably** between **countries**[6] **and** according **to decade of birth**[6,7]

Source: [1]Zanichelli A, et al. *Ann Allergy Asthma Immunol*. 2016. [2]Greve J, et al. *Allergo J Int*. 2022. [3]Farkas H, et al. *Allergy*. 2017. [4]Christiansen SC, et al. *Clin Pediatr*. 2016. [5]Banerji A, et al. *Allergy Asthma Proc*. 2018. [6]Schöffl C, et al. *J Dtsch Dermatol Ges*. 2019. [7]Zanichelli A, et al. *Clin Trans Allergy*. 2018.

HAE treatment goals

WAO/EAACI Guidelines[1]

The goals of HAE treatment are to achieve complete control of the disease and to normalize patients' lives.

This can currently only be achieved by LTP.

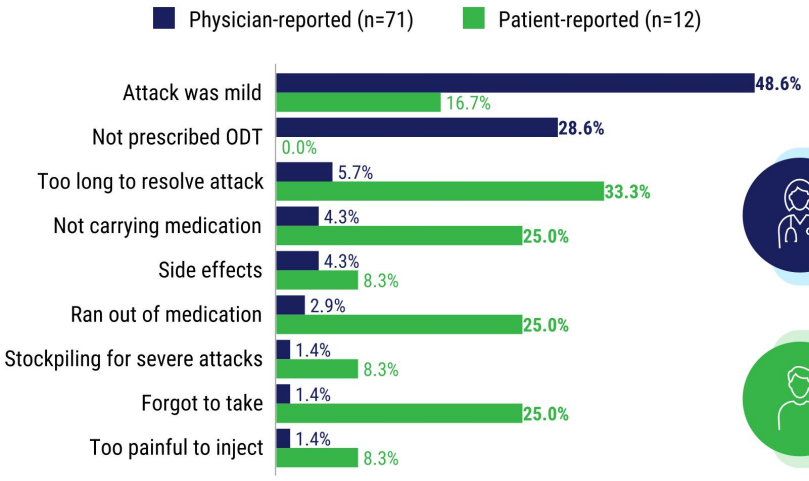
The International/ Canadian HAE Guidelines[2]

The aim of treating an attack on demand is to reduce the duration and severity of an attack, to minimize the impact of an attack on the functional ability of the patient, and reduce morbidity and potential mortality.

The aim of LTP is to reduce the frequency and/or severity of attacks and minimize the impact of HAE on QoL, thereby enabling patients to live normal lives.

EAACI, European Academy of Allergy and Clinical Immunology; HAE, hereditary angioedema; LTP, long-term prophylaxis; ODT, on-demand treatment; QoL, quality of life; WAO, World Allergy Organization.
Source: [1]Maurer M, et al. *Allergy*. 2022. [2]Betschel S, et al. *Allergy Asthma Clin Immunol*. 2019.

Not all HAE attacks are treated: physicians and patients report reasons for not treating most recent attack



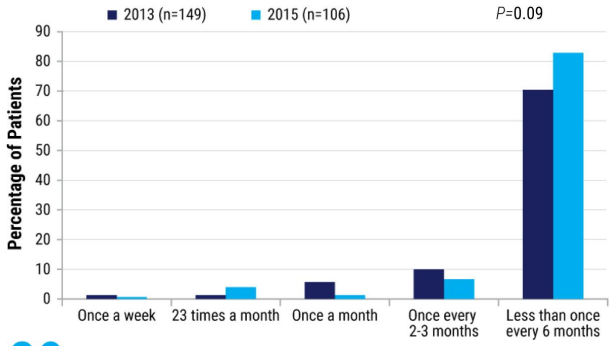
Physicians focus on attack severity and lack of a prescription

Patients raise logistics and treatment dissatisfaction as key reasons for not treating an attack

HAE, hereditary angioedema; ODT, on-demand therapy. Source: Mendivil J et al. ACAAI 2023.

Current treatments vary in efficacy, leading to the need for additional healthcare resources to fully treat attacks

Need for urgent medical care among patients with HAE-C1-INH having an attack[1]



89% of these patients had on-demand medication for HAE attacks

Some patients with on-demand treatment still require emergency care for HAE attacks

Characteristics of HAE patients utilizing on-demand treatments in 2018[2]

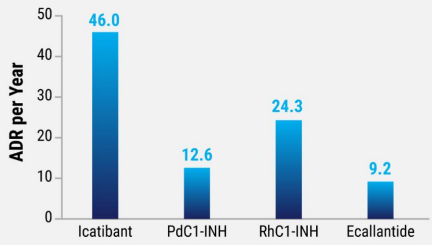
Variable = Value, Reference (Range)	rhC1-INH	Icatibant	Ecallantide	pdC1-INH
Distribution unit	2,100 U	3 mL 10 mg/mL	1 mL 10 mg/mL	500 U
Distribution unit wholesale cost, $	5,965 (5,070-6,263)	11,148 (9,475-11,705)	4,923 (4,184-5,169)	2,955 (2,512-3,103)
Dosing	50 U/kg	30 mg	30 mg	20 U/kg
Redosing rate, %	3 (2-10)	29 (7-44)	12 (6-18)	19 (8-30)
Self-administration rate, %	95 (80-98)	100	0	95 (85-98)
Time to resolution, hour	4.4 (4.0-15.0)	6.0 (2.2-24.3)	3.1 (2.8-3.8)	8.4 (6.2-21.5)

Redosing rates and time to attack resolution for current on-demand treatments are sub-optimal

HAE, hereditary angioedema; INH, inhibitor; pd, plasma-derived; rh, recombinant humanized. Source: [1]Banerji A, et al. *Allergy Asthma Proc*. 2018. [2]Bernstein JA, et al. *J Manag Care Spec Pharm*. 2020.

Current on-demand treatments for HAE approved in the U.S.

On-demand treatment	FIRAZYR (icatibant)	BERINERT (pdC1-INH)	RUCONEST (rhC1-INH)	KALBITOR (ecallantide)
Mechanism of action	Bradykinin B2R antagonist	C1-INH replacement	C1-INH replacement	Kallikrein inhibitor
Administration	Subcutaneous	Intravenous	Intravenous	Subcutaneous
Plasma half-life	1-2 hours	>30 hours	~3 hours	2 hours



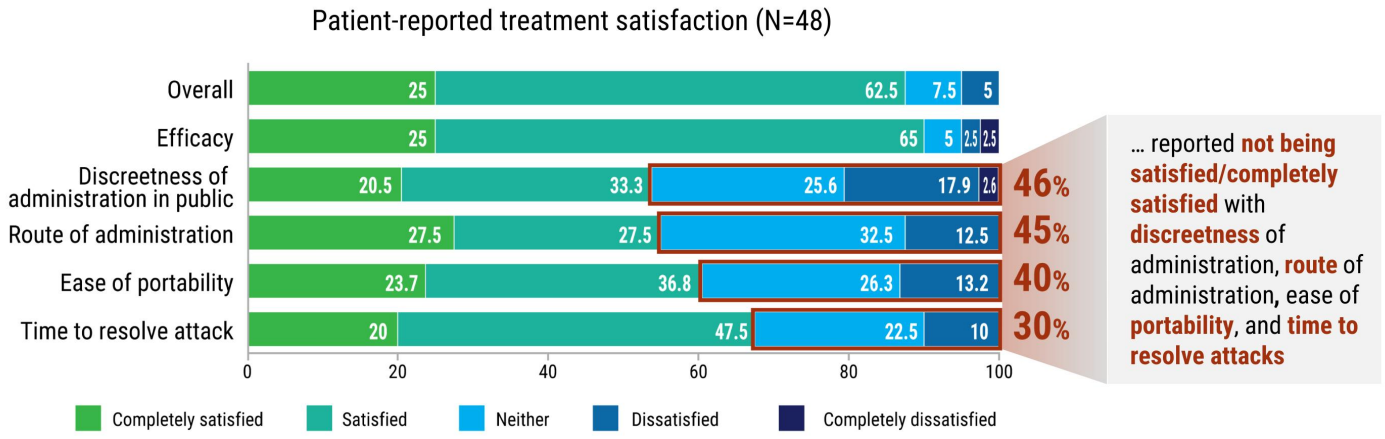
All recommended first-line ODTs are injectables[1,2]

Potential injection-associated ADRs include[3]:

- Pain
- Bruising
- Extravasation
- Rash
- Vesicles
- Urticaria
- Erythema
- Hemorrhage
- Infection
- Incorrect route of administration
- Poor venous access

ADR, adverse drug reaction; HAE, hereditary angioedema; INH, inhibitor; ODT, on-demand treatment; pd, plasma-derived; rh, recombinant humanized.
Source: [1]Maurer M, et al. *World Allergy Organ J*. 2022. [2]Riedl MA, et al. *Ann Allergy Asthma Immunol*. 2021. [3]Tachdjian R, et al. *Allergy Asthma Proc*. 2024.

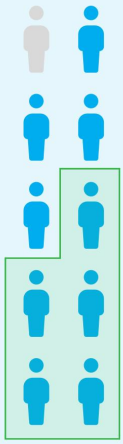
Patients are not fully satisfied with current treatment options



Patients also express a **dislike** for **injections** in general, while some with **severe needle phobia** could **benefit from other therapies**[2,3]

Source: [1]Mendivil J, et al. ACAAI 2023. [2]Tachdjian R, et al. *Allergy Asthma Proc*. 2024. [3]Kelbel T. *Ann Allergy Asthma Immunol*. 2022.

Self-administration and people's ability to always carry their on-demand medication outside their home remain important unmet needs



90% of patients (n=32)

believe it is important or very important to **recover quickly from an HAE attack**

Despite that, only

50% of patients carry their **rescue medication with them** when they leave their home[1]

Patients carrying ODT all the time[2]

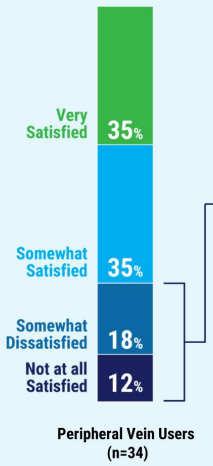
29% of patients <40yrs (n=56)

45% of patients ≥40yrs (n=51)

No patients ≤24yrs (n=14) carry ODT all the time

HAE, hereditary angioedema; ODT, on-demand treatment.
Source: [1]Radojicic C, et al. AAAAI 2023. [2]Geng B, et al. ACAAI 2023.

Current ODTs for HAE present a substantial burden for patients due to their difficult routes of administration



30%

of HAE patients

receiving intravenous C1 esterase inhibitor infusions via a peripheral vein voice some level of **dissatisfaction***

Reasons patient for dissatisfaction include **time to prepare** and **administer**

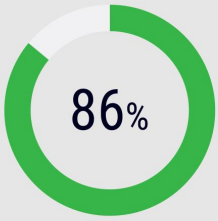
Patients' impressions about intravenous C1 esterase inhibitor use (n=34)

	Agree, %	Equally agree and disagree, %	Disagree, %
I can take it and feel confident I've administered it correctly†	79	12	3
When I take it I know I've infused all the medication	88	9	3
I worry about the long-term damage I'm doing to my veins	59	35	6
The length of time it takes often causes me to put off other more enjoyable things in my life	32	21	**47**
I often spend too much time trying to get the infusion to work while my symptoms worsen	21	21	**59**

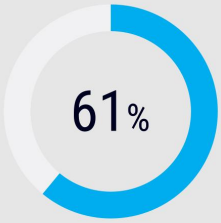
*Patients used this treatment as prophylaxis and ODT; †Six percent of respondents (n=2) reported that they did not know or that the question did not apply to them.
HAE, hereditary angioedema; ODT: on-demand therapy. Source: Riedl MA, et al. *Ann Allergy Asthma Immunol*. 2017.

Patients express a desire for alternative routes of administration, reflecting a general desire to move away from injectables

Survey of patients with HAE: Satisfaction and unmet needs (N=75)



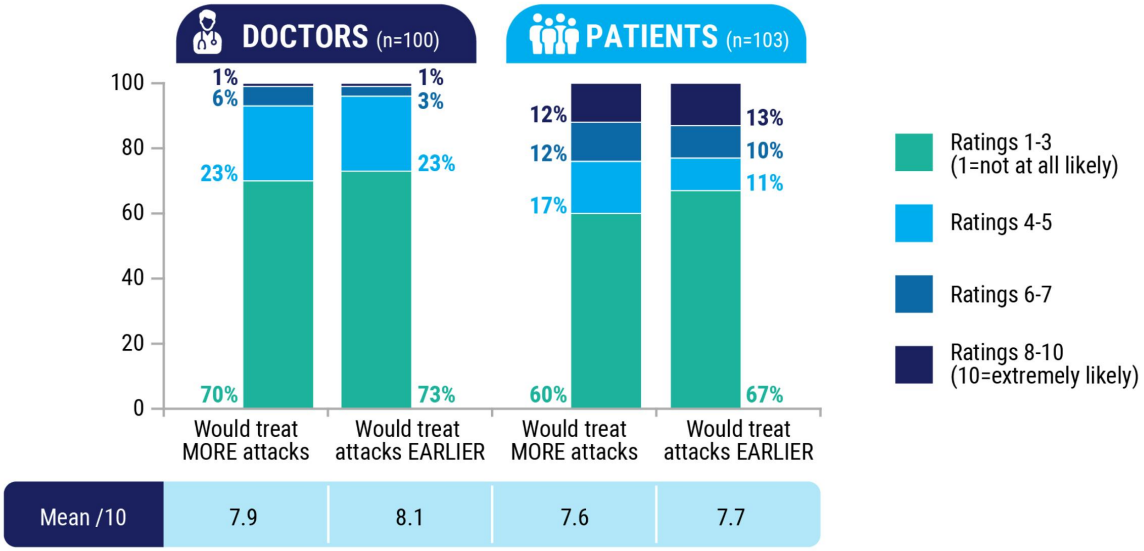
Patients who reported being **satisfied with their prophylactic treatment** but are interested in a medication that is **easier to administer**



Patients who wished they could treat their HAE **more discreetly**

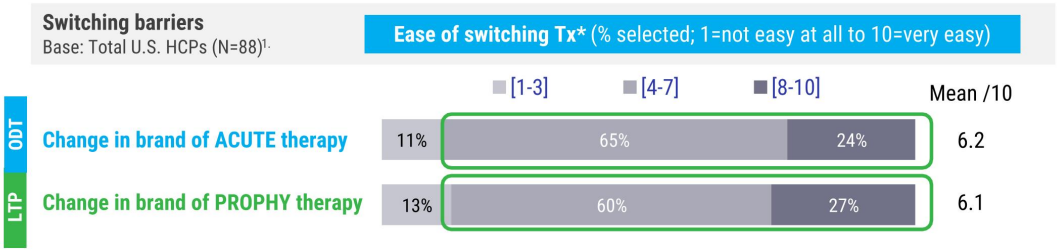
Source: Radojicic C, et al. *Allergy Asthma Proc*. 2021.

Both doctors and patients consider an oral acute therapy would increase likelihood that patients would treat more attacks, earlier



Note: Percentages may not sum to 100 due to rounding. Source: Proprietary Pharvaris research, 2022 (representative sample of patients, n=103, and doctors, n=100)

For both patients on prophylaxis or on-demand therapy, switching treatment is moderately easy for HCPs[1]



HCPs would feel comfortable switching therapy after at least 6 months on current treatment

*Based on HCPs experience, considering all the barriers there may be from an access/coverage and clinical perspective. Source: [1]Company Research (October 2024).

Efficacy is prime for HCPs, but patient preference drives choice for oral administration[1]

HCPs top reasons for selecting a therapy (current users, n = 216)	
Efficacy	**44%**
Convenience of dosing frequency	30%
Convenience of administration	28%
Insurance coverage/cost	27%
Patient's preference	27%

- **Efficacy** remains the first driver for HCP preference
- **Dosing frequency** and **route of administration** play less of decisive role in HCP preference and are at par with **patients' preference**

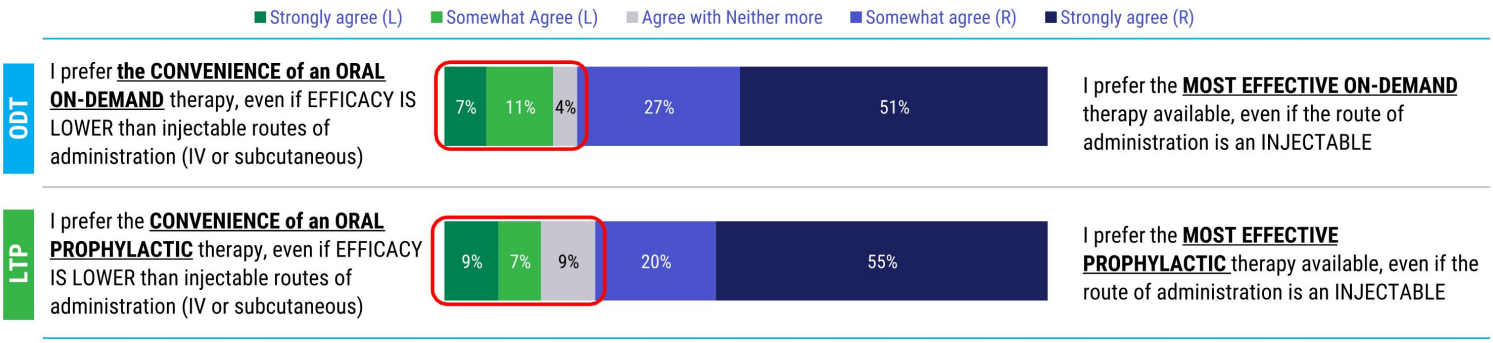
Patient preference or request for prophylactic route of administration based on HCPs experience (current users, n = 216)	
Oral (preferred over injection)	**38%**
Subcutaneous injection (preferred over oral)	18%
No preference/request	46%

- **Nearly 40% of patients** actively **request or prefer** an **oral LTP**
- Less than 20% would prefer or request an injection

Source: [1]Company Research (October 2024).

But people living with HAE are not willing to trade off efficacy for the convenience of an oral therapy[1]

Efficacy vs. Convenience trade-off
Base: Total U.S. Patients (N=94); excluding those not on prophylaxis and unlikely to start (N=87)[1]



An oral therapy with injectable-like efficacy has the potential to become the preferred option for patients

Notes: ODT: on-demand therapy. LTP: long-term prophylaxis. Source: [1]Company Research (October 2024).

Despite high compliance on novel therapies, including Orladeyo®, breakthrough attacks are still common with nearly 3 attacks per year[1]

Base: Total U.S. HCPs (N=88)[1].

	Total	TAKHZYRO®	CINRYZE®	ORLADEYO®	HAEGARDA®	DANOCRINE®
Base: current users	216	83	22	55	46	*10
Compliance						
High	65%	64%	50%	71%	70%	60%
Medium	33%	35%	50%	27%	28%	30%
Low	2%	1%	0%	2%	2%	10%
Number of attacks in the past 6 months						
Average # attacks (total treated or not)	1.4	1.6	1.6	1.7	1.4	0.9
% pts with 1+ attack (total treated or not)	66%	64%	77%	79%	59%	60%
Average # attacks resulting in ER visit	0.4	0.4	0.8	0.3	0.7	0.3
% pts with 1+ attack resulting in ER visit	34%	27%	59%	26%	58%	33%

Notes: *small base size for DANOCRINE. Source: [1]Company Research (October 2024).