PHARVARIS

Corporate Presentation

Pioneering science for patient choice

November 2024

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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]

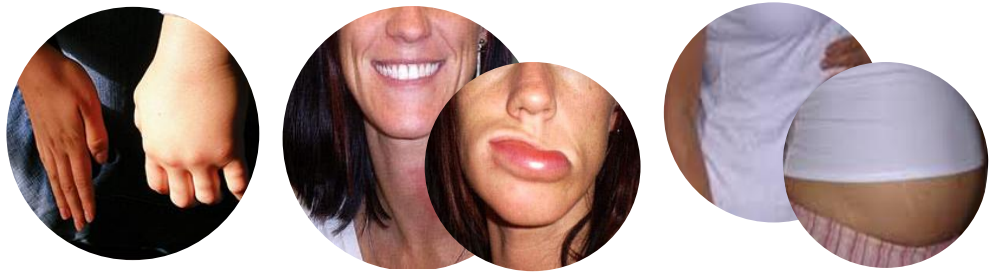
STRONG FUNDAMENTALS

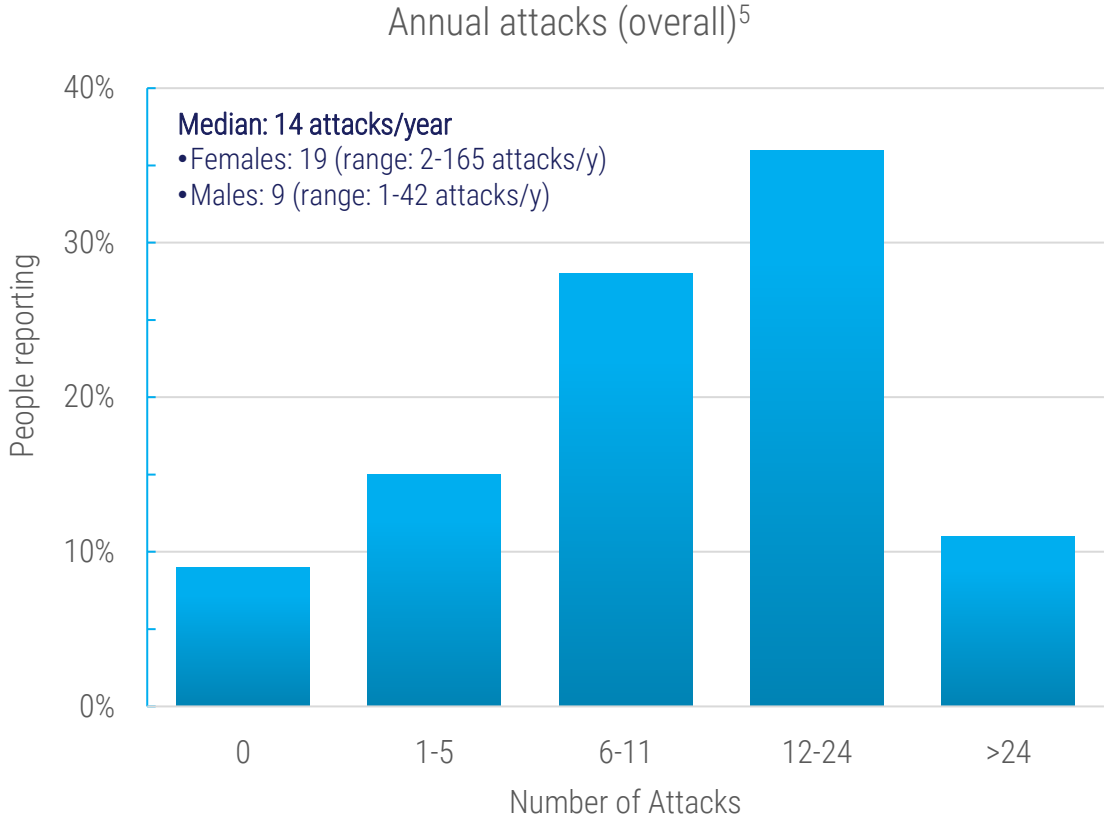
- Two pivotal **Phase 3** studies **designed to differentiate** current standard of care in both prophylaxis and on-demand treatments
- Accomplished team with **track record in HAE drug development and commercialization**
- Approximately **€305M** cash and cash equivalents as of September 30, 2024

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.

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]
  - Approximately 8,000 people living with HAE in the U.S. [4]
  - Approximately 15,000 people living with HAE in Europe[4]

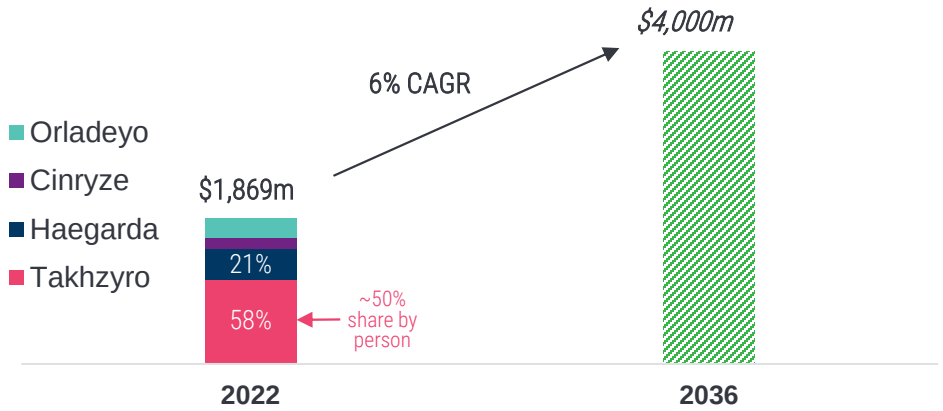




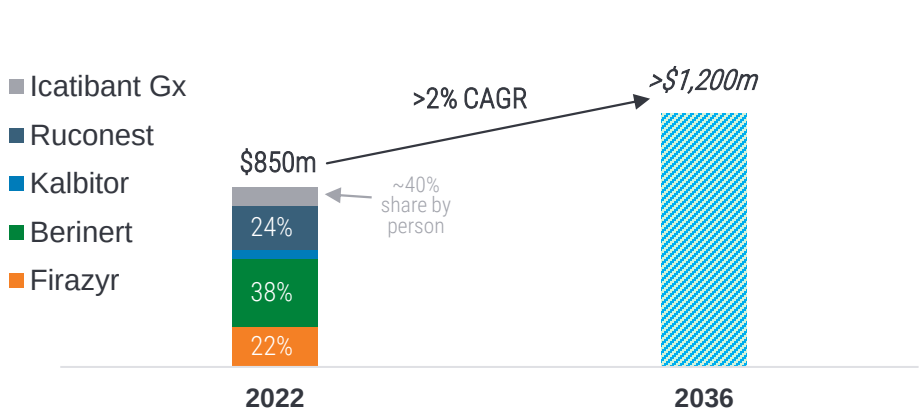
Source: [1]Betschel SD, et al. *J Allergy Clin Immunol Pract*. 2023. [2]Christiansen SC, et al. *Ann Allergy Asthma Immunol*. 2023. [3]Bork K et al. *Allergy Asthma Clin Immunol*. 2021. [4]Lumry WR *Front. Med*. 2018. [5]Nordenfelt P et al. *Acta Derm. Venereol* 2016.

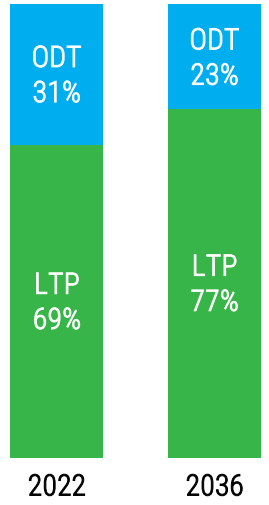
In the U.S., significant growth in the long-term prophylaxis (LTP) and on-demand therapy (ODT) market is expected over the next decade[1]

Value of prophylaxis[1-3]



Value of on-demand[1-3]





Growth expected to be driven by:

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

Growth expected to be driven by:

- New options
- Increased convenience
- Increased treatment rate

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

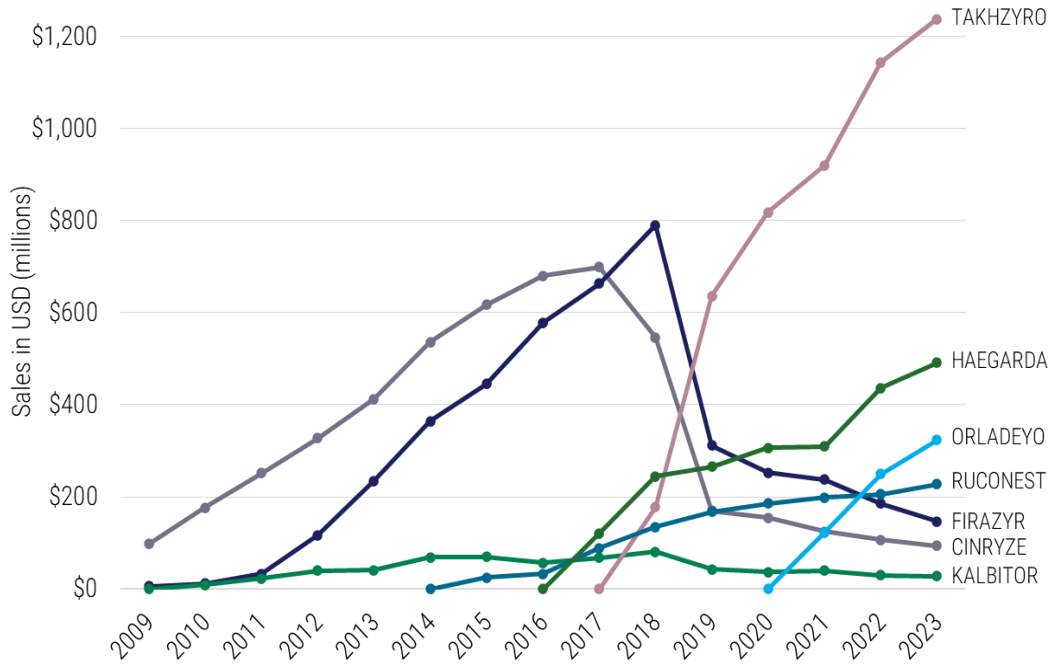
HAE market growth will be driven by increased efficacy and convenience of new therapies

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

Despite treatment satisfaction, the U.S. HAE market is dynamic, with people actively seeking a better[1] product

People actively switch therapies[2,3]: first-to-market is no guarantee for long-term market leadership

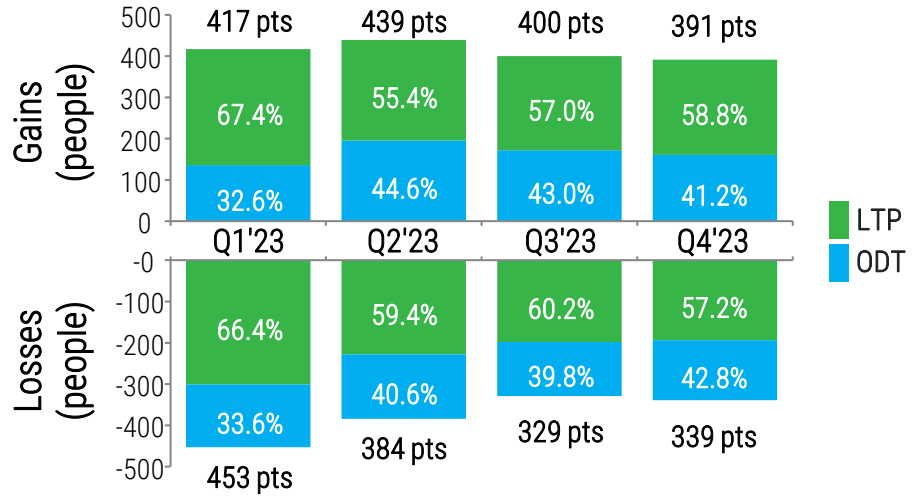
Evolution of HAE product sales[1,2]



Across ~7,000 people with HAE, there were over >1,500 unique counts of treatment initiation in 2023[4]

- Preference for convenient administration
- ODT-only to LTP switches dominate
- Most LTP gains went to Takhzyro and Orladeyo

U.S. HAE switches, gains ↑ and losses ↓[3]



# of new Rx	-36	+55	+70	+52

[1]Treatment selection is driven by physicians and patient preference.
Source: [2]Evaluate Pharma uptake curves 2008-2023 [3]SEC filings (BioCryst, CSL Behring, Pharming, Takeda). [4]U.S. Chart Audit 2023.

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…

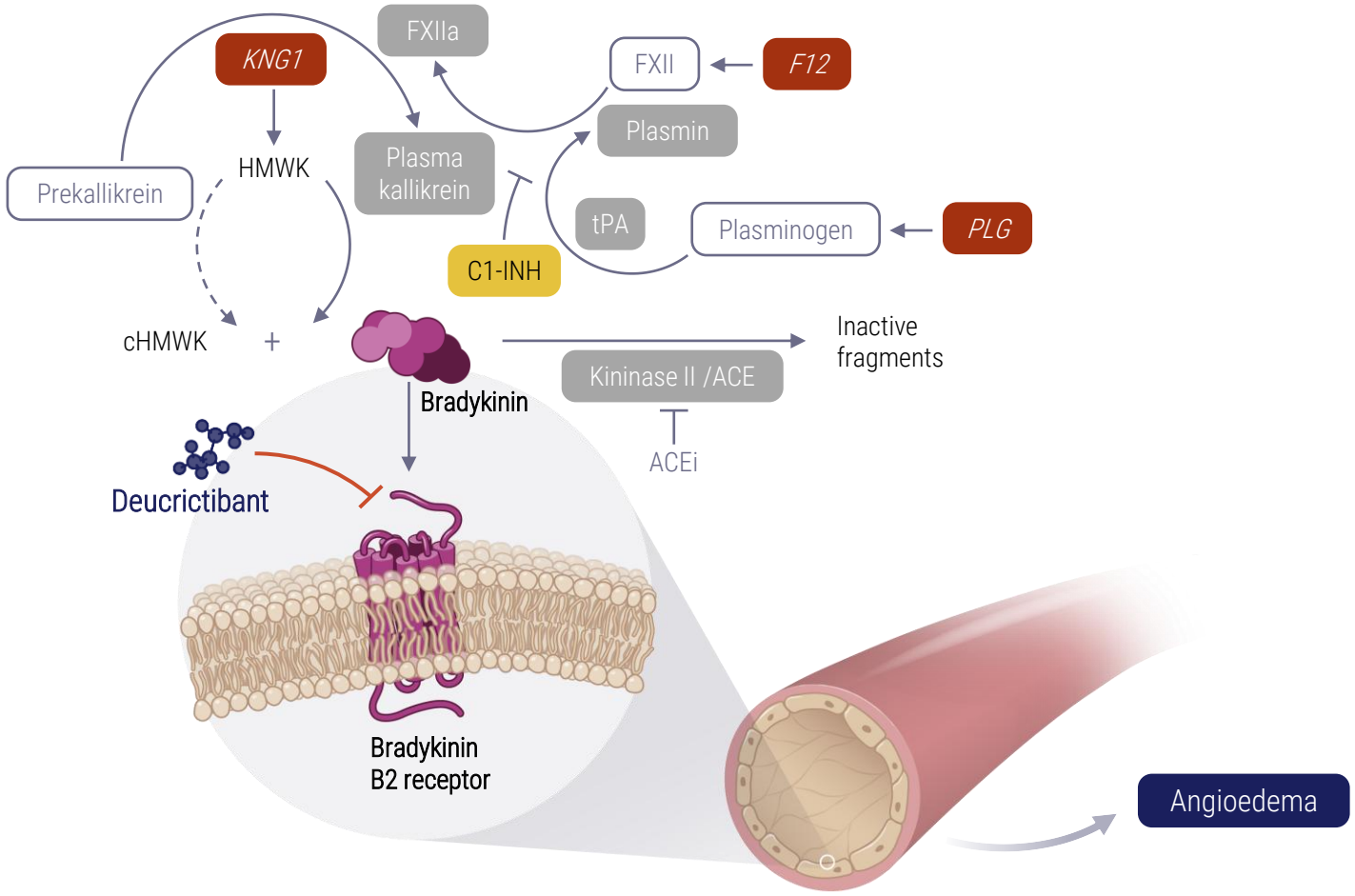
…while **convenience** is a key driver for overall preference[2]

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

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

- **Directly blocks the main mediator** of swelling and inflammation[1,3]
- Has the potential to prevent or treat bradykinin-mediated angioedema **irrespective of the source of bradykinin**[4-6]

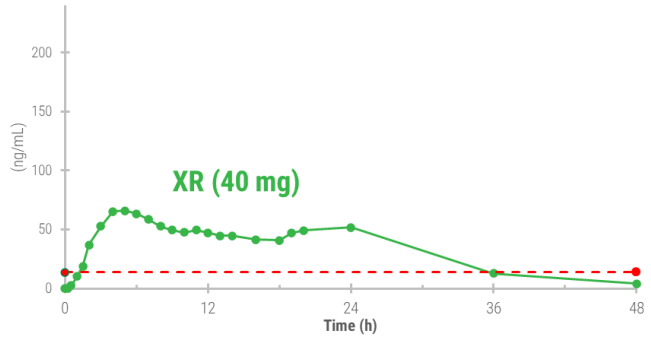


Source: [1]Maurer M, et al. *Allergy*. 2022. [2]Zuraw BL *World Allergy Orphan J*. 2010. [3]Lumry WR et al. *Allergy Asthma Proc*. 2020. [4]Riedl MA et al. AAAAI 2024. [5]Maurer M et al. AAAAI 2023. [6]Petersen RS et al. *J Allergy Clin Immunol*. 2024.

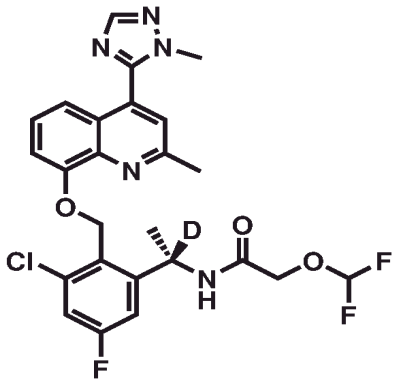
Deucrictibant has the potential to become a preferred therapy for people living with HAE

DEUCRICTIBANT extended-release (XR) tablet

sustained absorption[1]



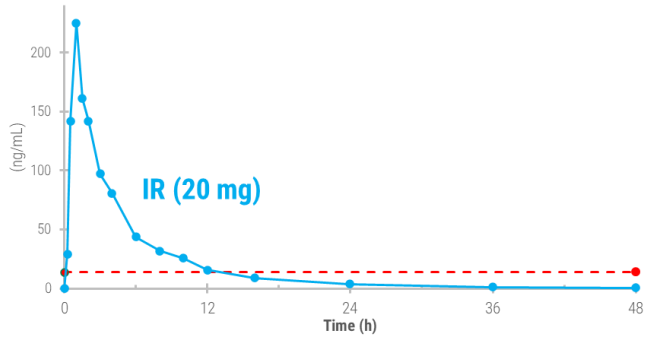
Maintains sustained therapeutic exposure over 24 hours[2] from day one, allowing for once-daily oral treatment to prevent HAE attacks*



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

*To be confirmed with clinical data from Phase 3 studies

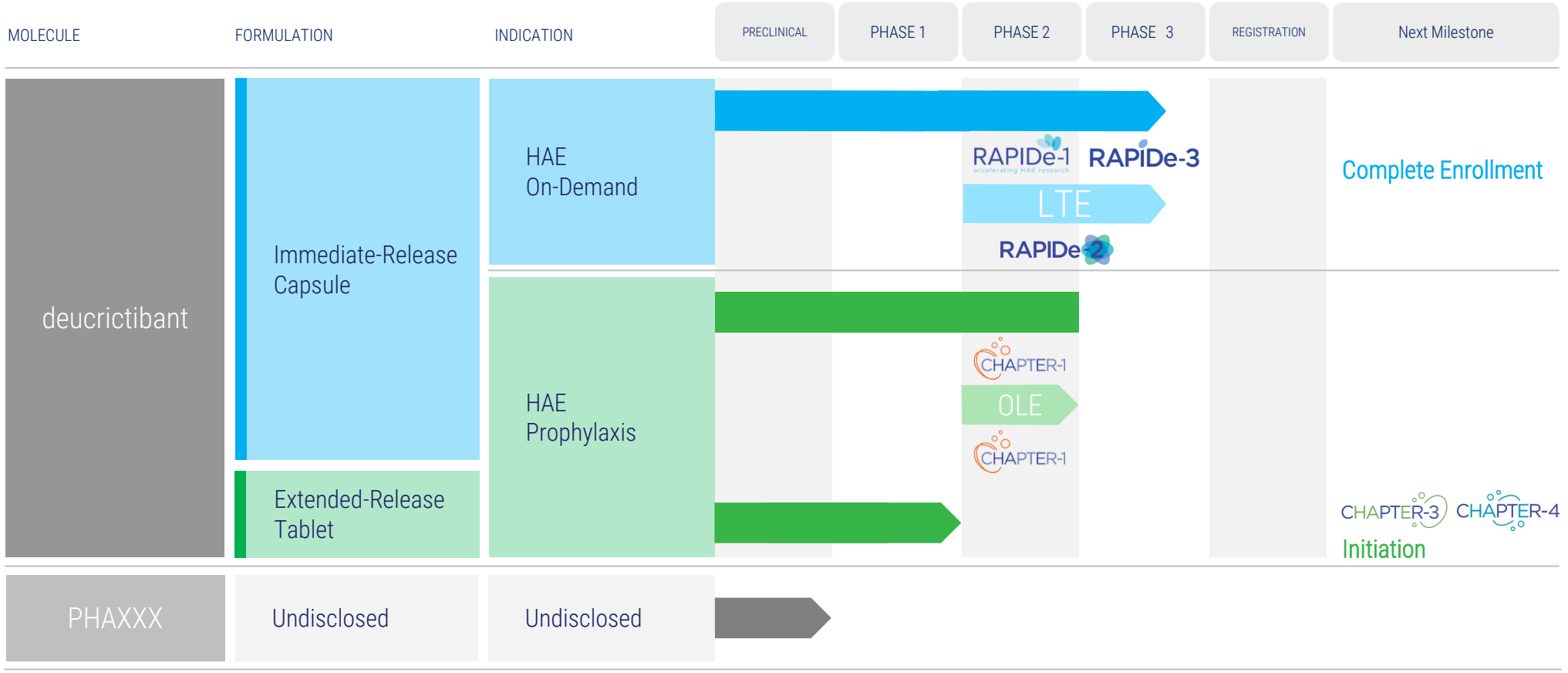
Source: [1]Company data: single-dose cross-over PK study in healthy volunteers (n=14) under fasting conditions. [2]Lesage A et al. IDDST 2024. [3]Crabbe et al. AAAAI 2021. [4]Maurer M et al. AAAAI 2023.

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 results in a **high rate of single-dose attack resolution**[8]		✓

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.

Wholly-owned pipeline focused on bradykinin B2 receptor mechanism



LTE: long-term extension, OLE: open-label extension

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]	Start-up
CHAPTER-4	Phase 3 OLE	Start-up

On-Demand Treatment (ODT)

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

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

With injectable-like efficacy and oral convenience, deucrictibant shows potential to become a preferred therapy to manage 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	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]

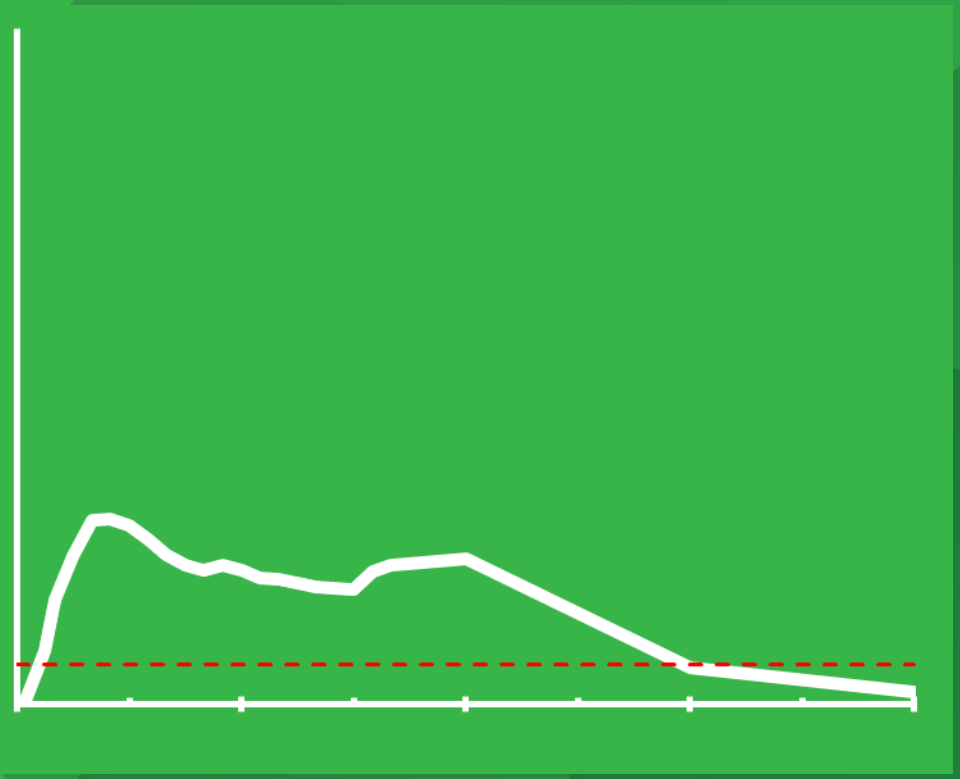
Potential preferred option for ODT

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.

Deucrictibant extended-release tablets

Long-Term Prophylaxis



Deucrictibant clinical development for LTP and ODT

Long-Term Prophylaxis (LTP)

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

Positive top-line data from CHAPTER-1, a Phase 2 prophylactic study of deucrictibant in HAE, announced in December 2023[1]

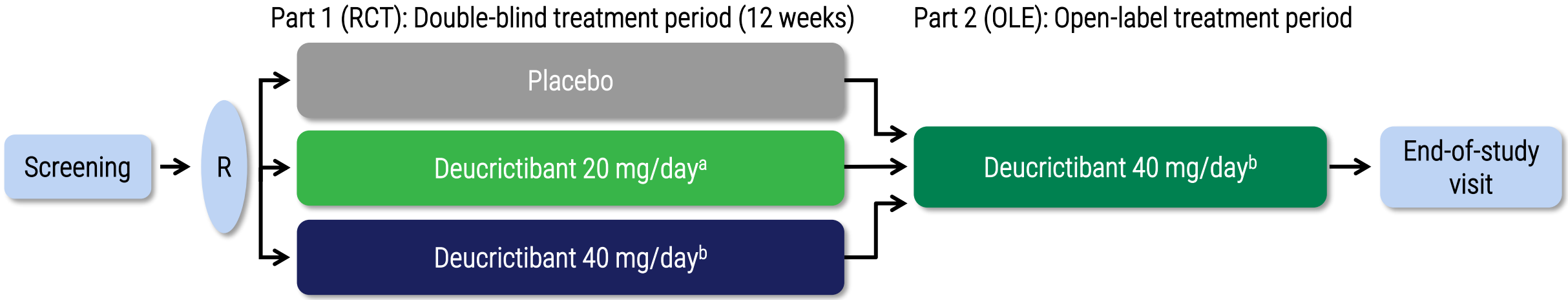
Primary endpoint met: 84.5% (p=0.0008) reduction in monthly attack rate versus placebo*

- 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.

Source: [1]Aygören-Pürsün E et al. EAACI 2024.

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

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[c] 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 rate categories, 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.

Summary of safety data in LTP ongoing open-label extension

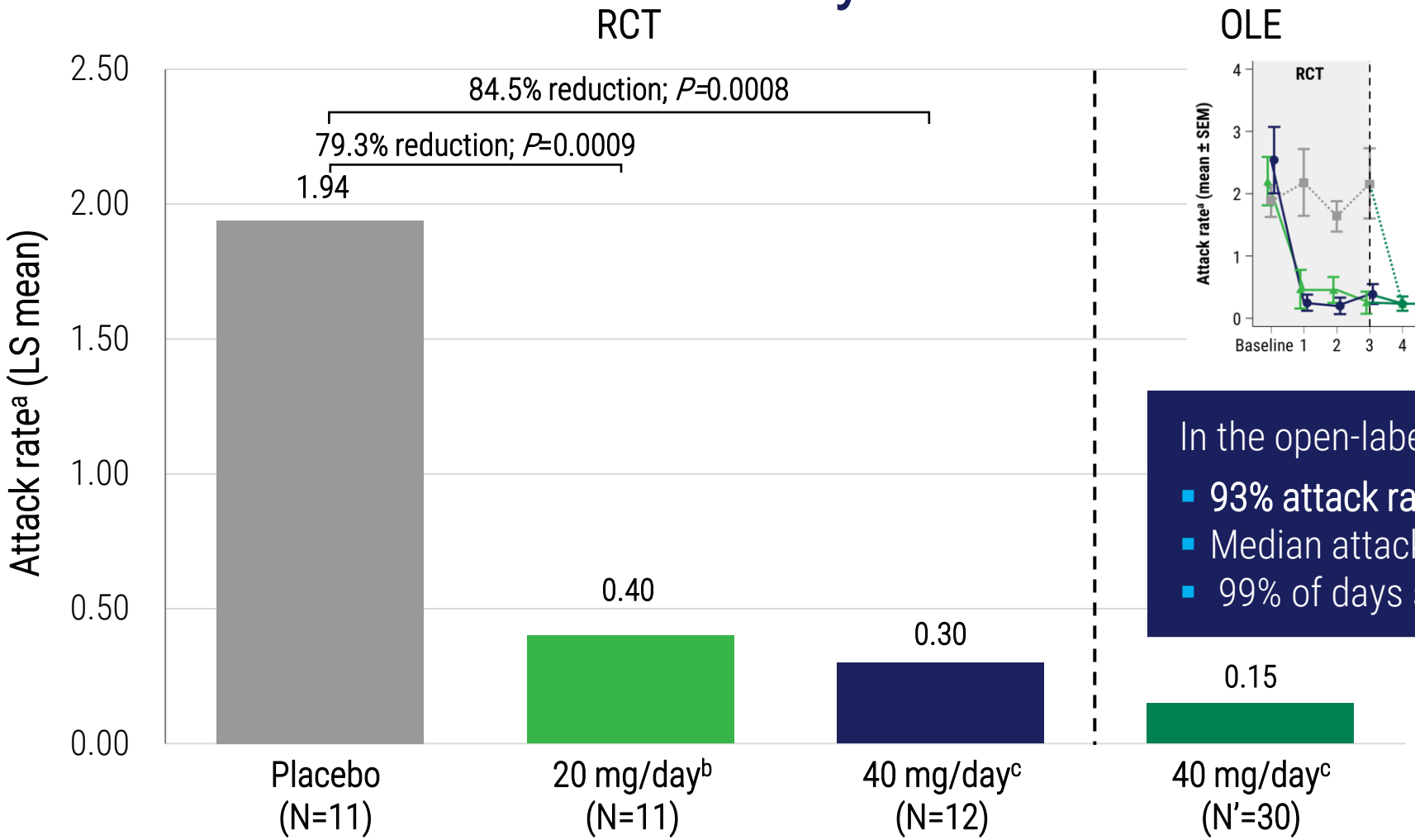
Adverse events	Placebo to 40 mg/day[a] (N=9)		20 mg/day[b] to 40 mg/day[a] (N=11)		40 mg/day[a] to 40 mg/day[a] (N=10)		Total (N=30)	
	Participants, n (%)	Events, n	Participants, n (%)	Events, n	Participants, n (%)	Events, n	Participants, n (%)	Events, n
TEAEs	5 (55.6)	25	7 (63.6)	31	6 (60.0)	16	18 (60.0)	72
Treatment-related TEAEs	1 (11.1)	1*	0	0	0	0	1 (3.3)	1
Serious TEAEs	0	0	1 (9.1)	1	1 (10.0)	1	2 (6.7)	2
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

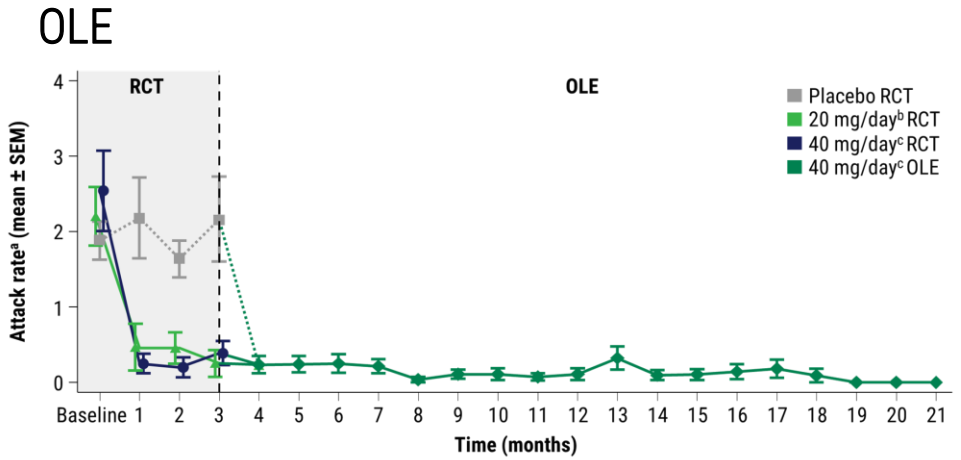
* One event of tooth discoloration is reported as treatment-related TEAEs

- 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

IR, immediate-release; TEAE, treatment emergent adverse event. N = number of participants who received at least 1 dose of blinded study treatment. [a]Deucrictibant IR capsule, 20 mg twice daily. [b]Deucrictibant IR capsule, 10 mg twice daily.

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



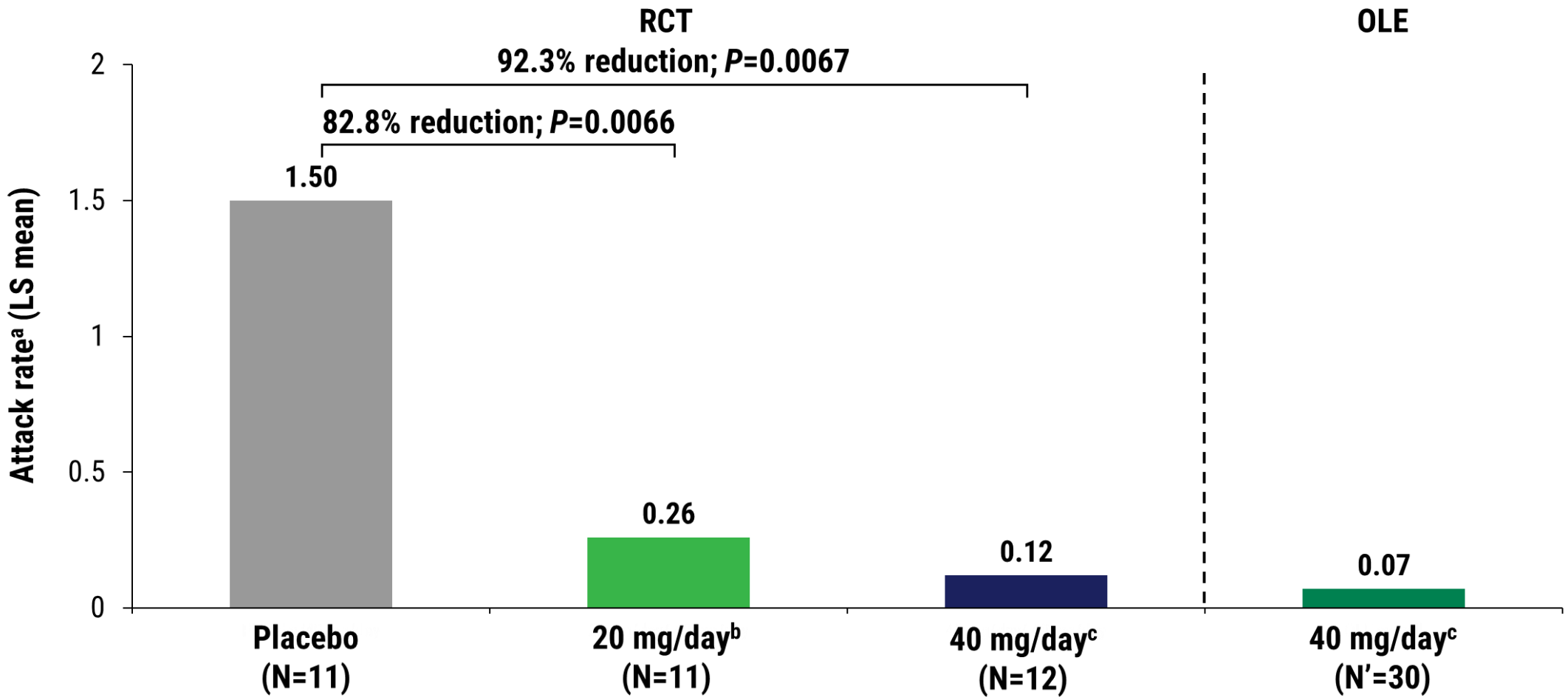


In the open-label extension up to 18 months:

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

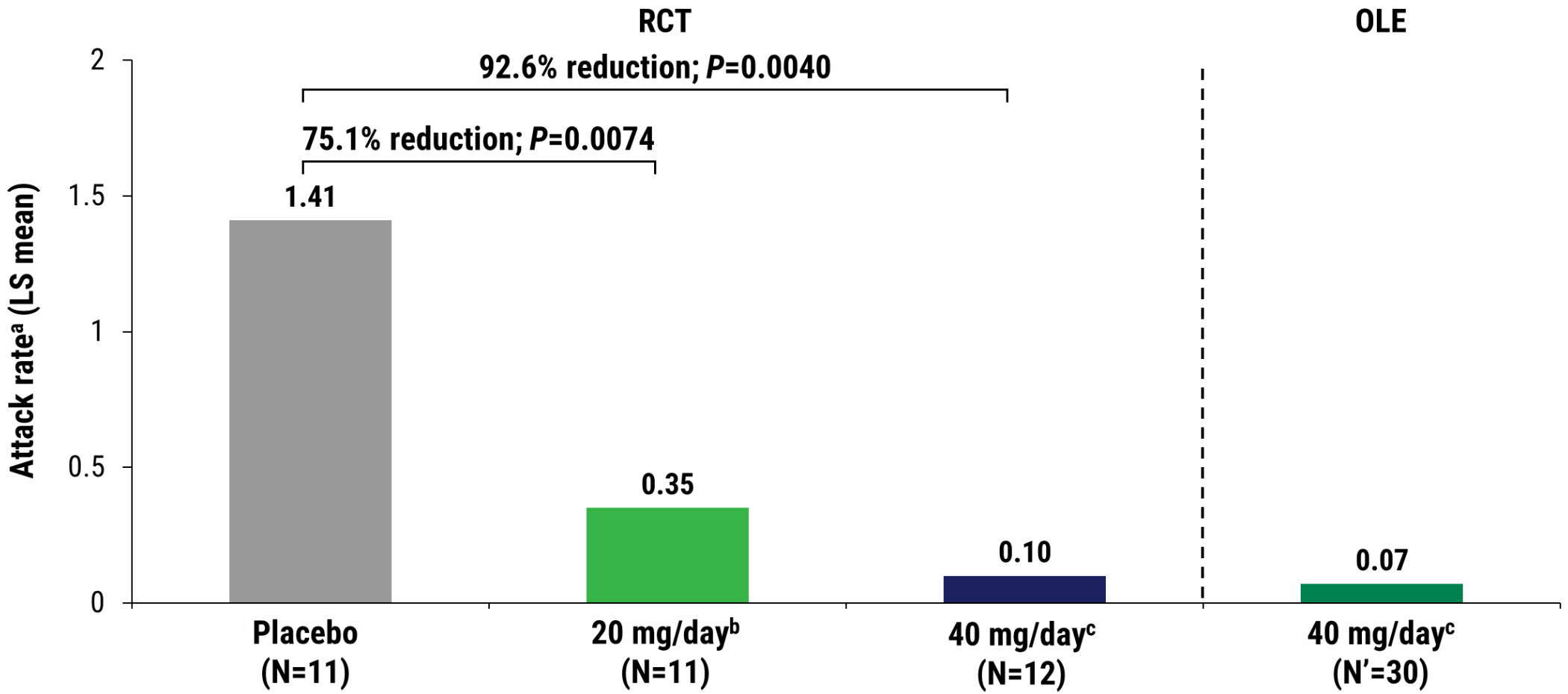
IR, immediate release; OLE, open label extension; RCT, randomized controlled trial. N = number of participants randomized in each treatment group in Part 1 of the study. N' = number of participants in the OLE. [a]1 month = 4 weeks. [b]Deucrictibant IR capsule, 10 mg twice daily. [c]Deucrictibant IR capsule,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

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

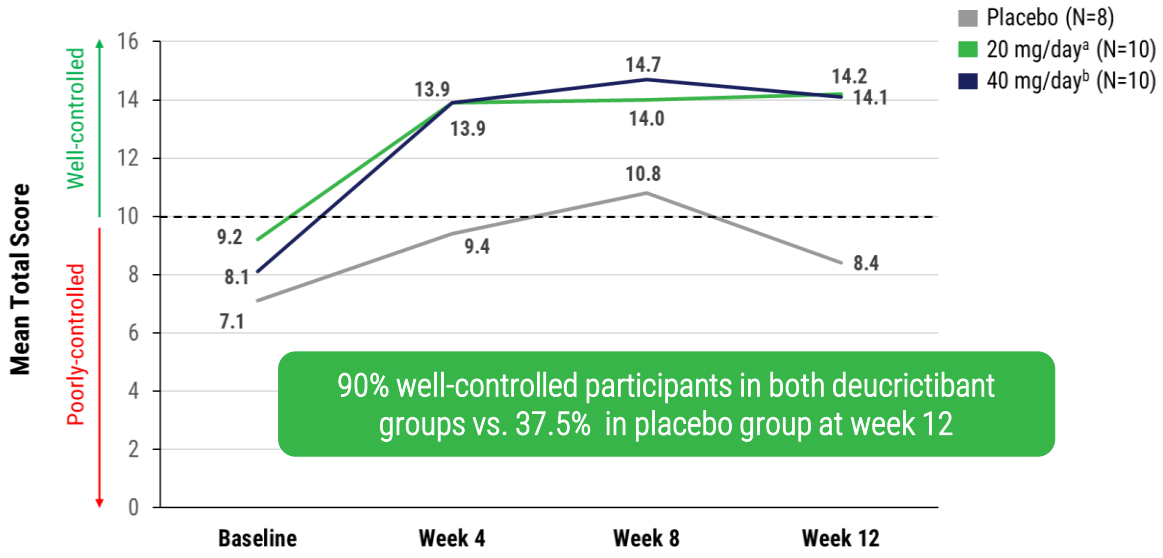


IR, immediate release; LS, least squares; OLE, open-label extension; RCT, randomized controlled trial. N = number of participants randomized in each treatment group in the RCT. N' = number of participants in the OLE. LS mean estimates of attack rate are based on Poisson regression models adjusted for 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.

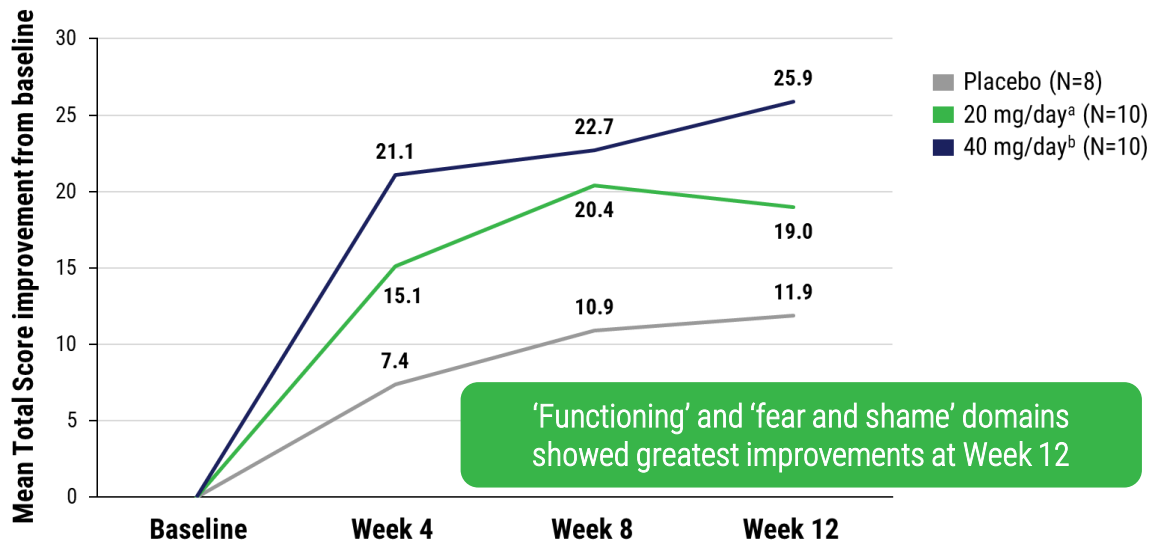
Improvements in disease control and health-related quality of life paralleled attack reduction during deucrictibant treatment[1,2]

- 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]

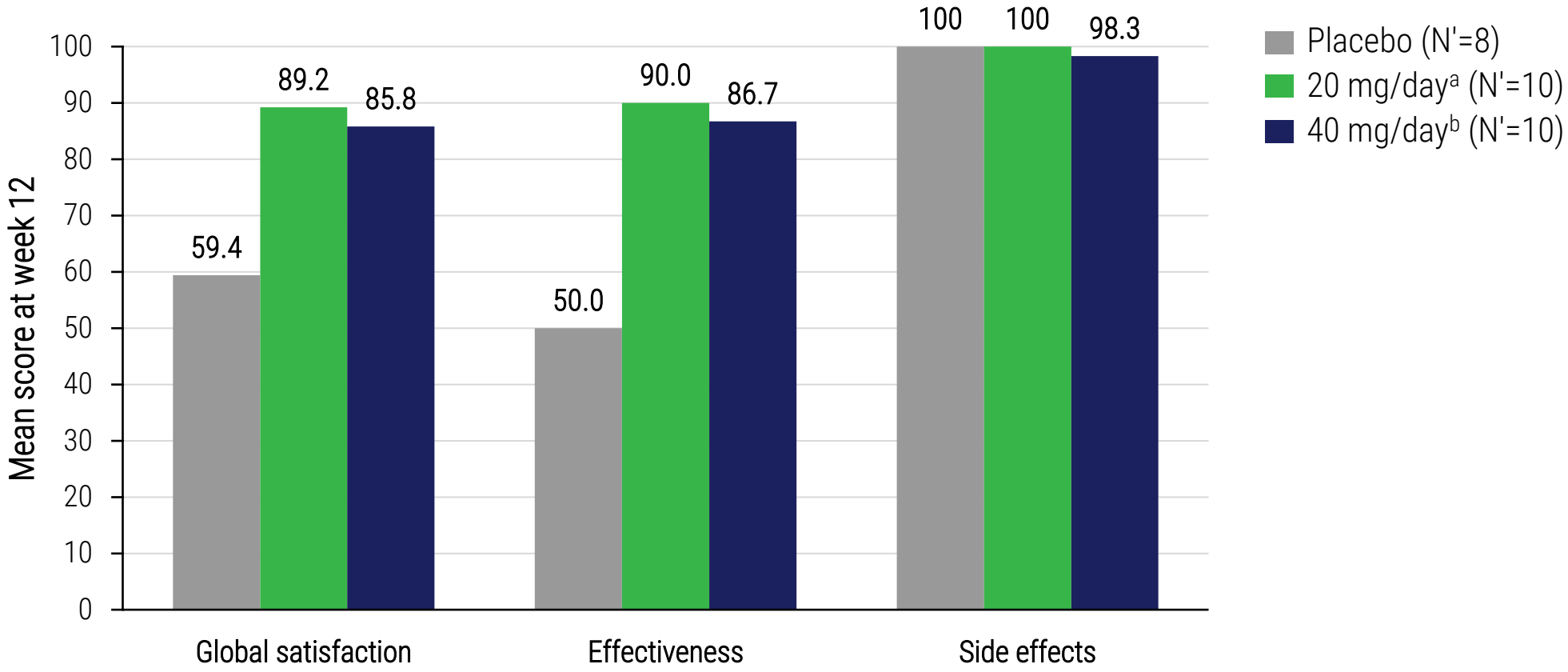


AE-QoL score[1]



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.

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.

Positive Phase 3 data could position deucrictibant to become a preferred LTP with injectable-like efficacy and the oral convenience of a daily tablet

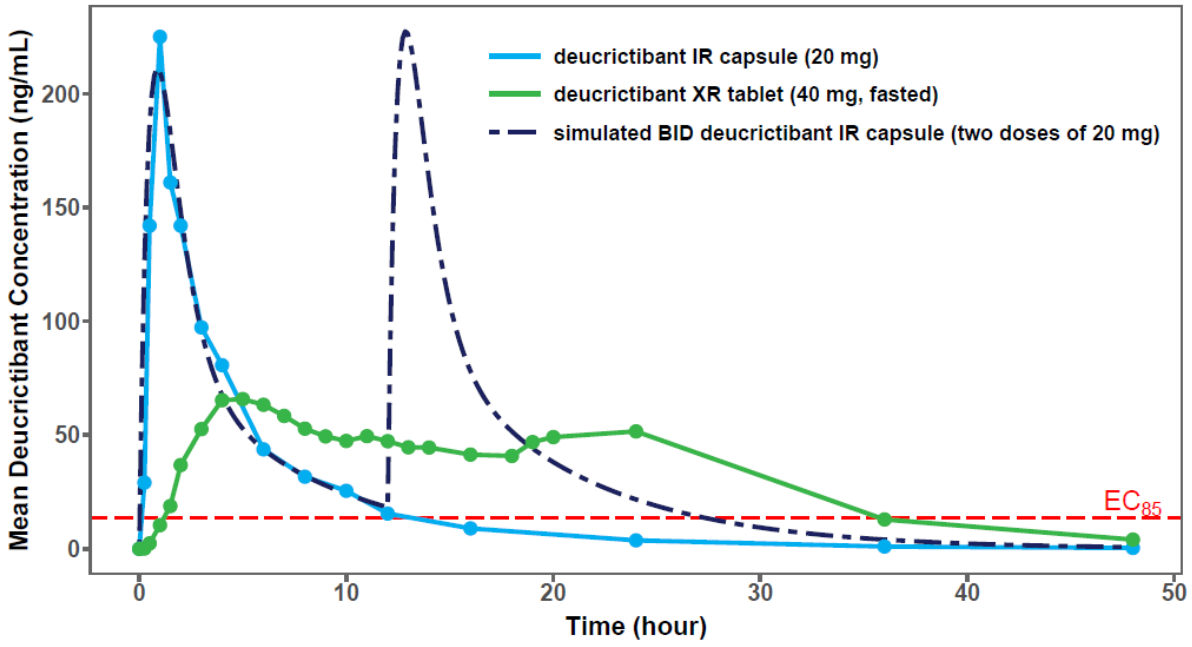
	Cinryze® (pdC1INH)	Haegarda® (pdC1INH)	Takhzyro® (lanadelumab)	Orladeyo® (berotralstat)	garadacimab	donidalorsen	deucrictibant	
Mechanism of Action	Plasma-derived C1NH	Plasma-derived C1INH	Anti-plasma kallikrein mAb	Plasma kallikrein inhibitor	Anti-FXIIa mAb	Plasma kallikrein inhibitor	Bradykinin B2 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 LTE
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.

CHAPTER-3 and CHAPTER-4
Clinical Studies

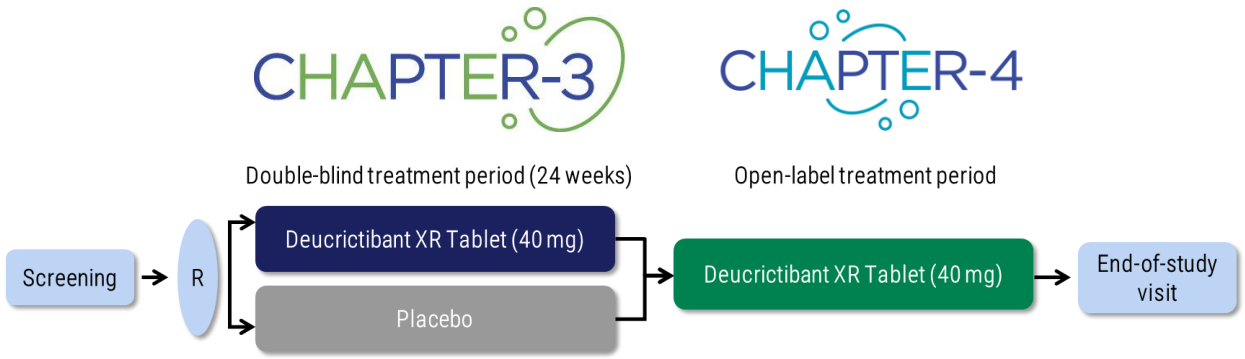
Commercial XR formulation maintains exposure above therapeutic level for at least 24 hours



- **Extended-release** matrix controls release and absorption of compound in small intestine as well as in colon
- Supports **once-daily** dosing while maintain 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

Source: Company data: single-dose cross-over PK study in healthy volunteers (n=14) under fasting conditions

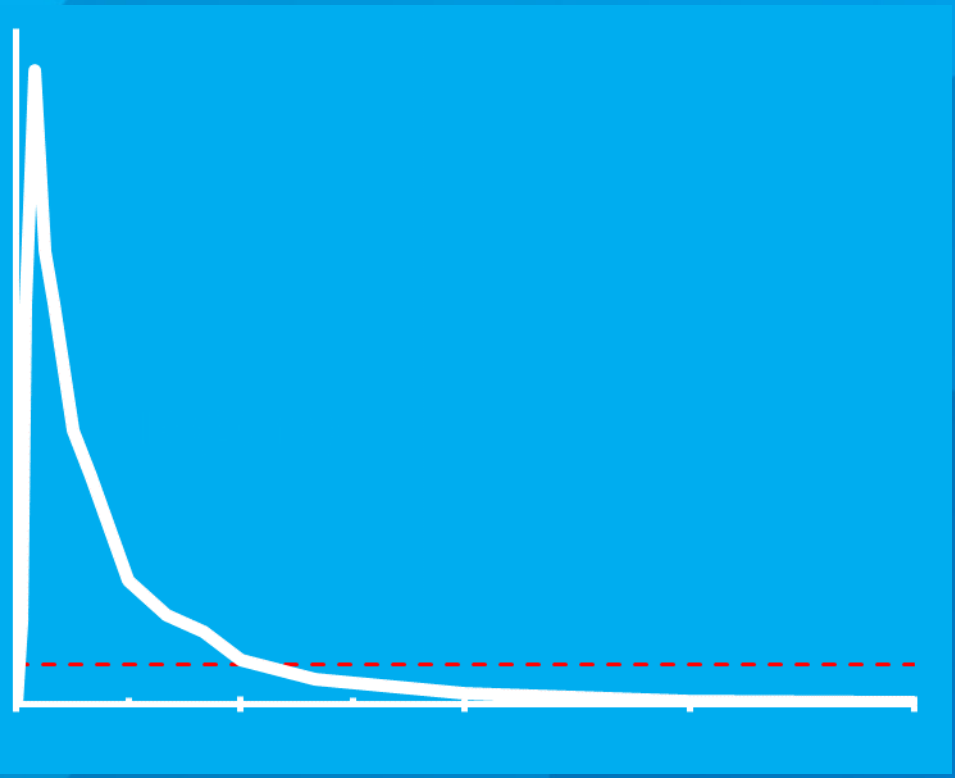
CHAPTER-3 study: A global Phase 3 study of prophylactic treatment of angioedema attacks in people with HAE



- Target enrollment of approximately 81 adolescents and adults living with HAE; 2:1 randomization
- Initiating by year-end 2024
- **Study 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
- Rollover to open-label extension

Deucrictibant immediate-release capsules

On-Demand



Deucrictibant clinical development for LTP and ODT

Long-Term Prophylaxis (LTP)

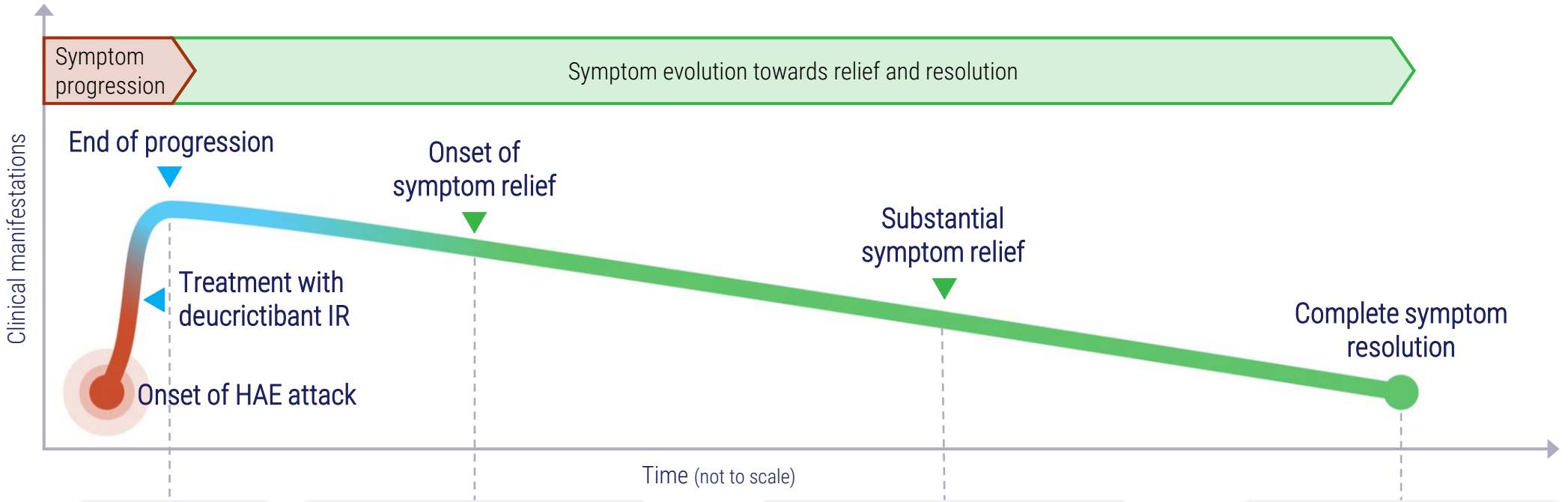
CHAPTER-1	Phase 2[1]	Part 1: randomized controlled primary analysis (complete) Part 2: open-label extension (ongoing)
CHAPTER-3	Phase 3 pivotal[2]	Start-up
CHAPTER-4	Phase 3 OLE	Start-up

On-Demand Treatment (ODT)

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

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

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

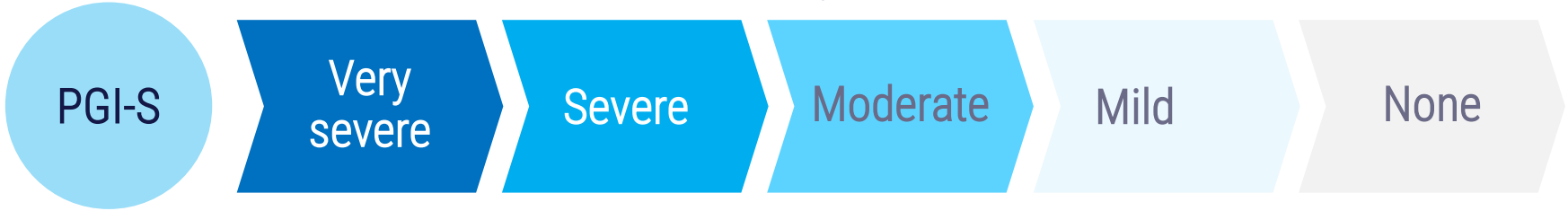
AMRA, Angioedema Symptom Rating Scale; EoP, end of progression; HAE, hereditary angioedema; IR, immediate release; PGI-C, Patient Global Impression of Change; PGI-S, Patient Global Impression of Severity.

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 Global Impression of Change

Patient Global Impression of Severity



Angioedema syMptom Rating scAle (AMRA)

Source: Riedl MA et al. BKS 2024.

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

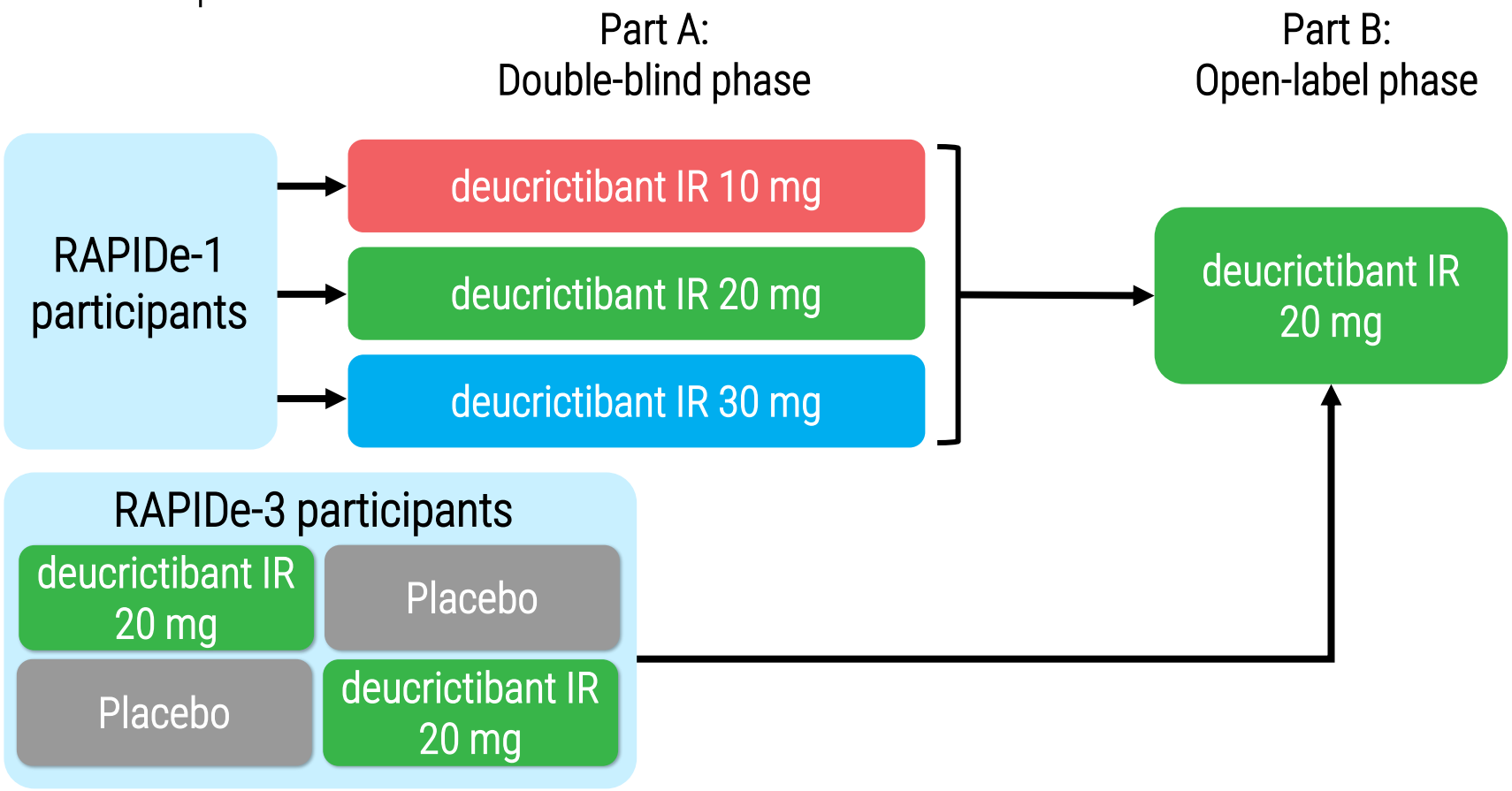
Primary endpoint met: deucrictibant IR significantly reduced attack symptoms versus placebo*[1]

- End of symptom progression in 25-26 minutes* (based on AMRA-3)[†2]
- Onset of symptom relief occurs in 2.4 hours* (≥30% reduction in AMRA-3)[1]
- 5-fold reduction in rescue medication use*[1]
- 81.7% of attacks achieved symptom resolution in 24 hours* (TOS PRO of "a lot better or resolved" in all symptom complexes) [†3]
- Deucrictibant well-tolerated at all doses[1]

*pooled 10, 20, 30 mg deucrictibant treatment group †based on post-hoc analysis
Source: [1]Maurer M et al. ACAAI 2023. [2] Riedl MA et al. ACAAI 2023. [3]Li H et al. EAC 2024.

RAPIDe-2 study design and objective[1]

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



IR, immediate-release. [a]Including laryngeal attacks (without breathing difficulties). **Source:** [1]Maurer M et al. BKS 2024.

Baseline characteristics[1]

- 265 attacks from 17 patients included in the mITT efficacy analysis set (data cutoff: 01 March 2024)
- 337 attacks from 19 patients included in the safety analysis set (data cutoff: 10 June 2024)
  - 7 of 337 attacks were laryngeal

	Deucrictibant IR capsule (All doses)
Number of attacks treated[a]	337
Number of participants[a]	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)

BMI, body mass index; HAE, hereditary angioedema; IR, immediate-release; SD, standard deviation. [a]Number by the cutoff date of 10 June 2024.
Source: [1]Maurer M et al. BKS 2024.

Summary of safety profile from ongoing RAPIDe-2 study[1]

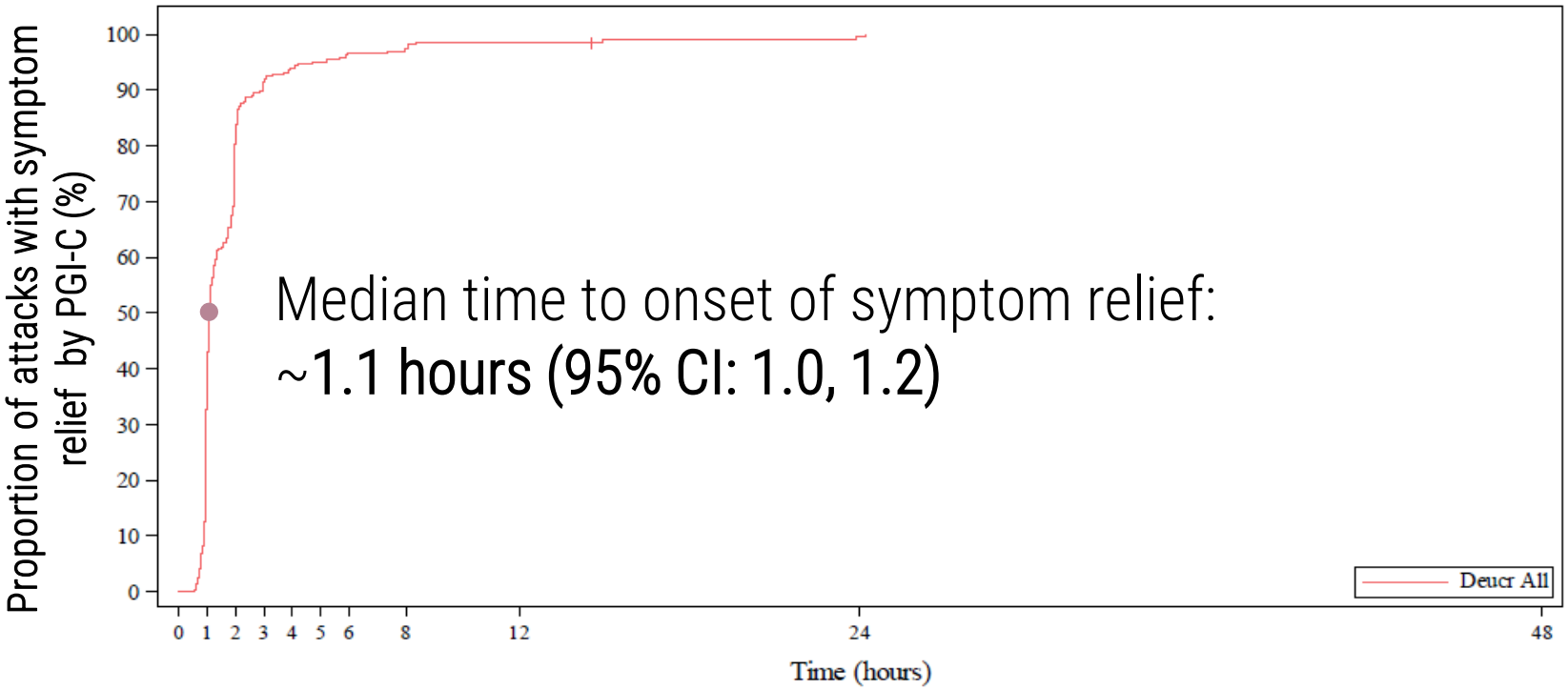
Adverse events	Deucrictibant IR capsule (All doses)
Number of patients (safety analysis population)	N=19
Number of attacks treated	N'=337
Attacks with any TEAE, n (%)	13 (3.9)
Treatment-related TEAEs, n	0
Serious TEAEs, n	1
Treatment-related serious TEAEs, n	0
TEAEs leading to study drug discontinuation, study withdrawal, or death, n	0

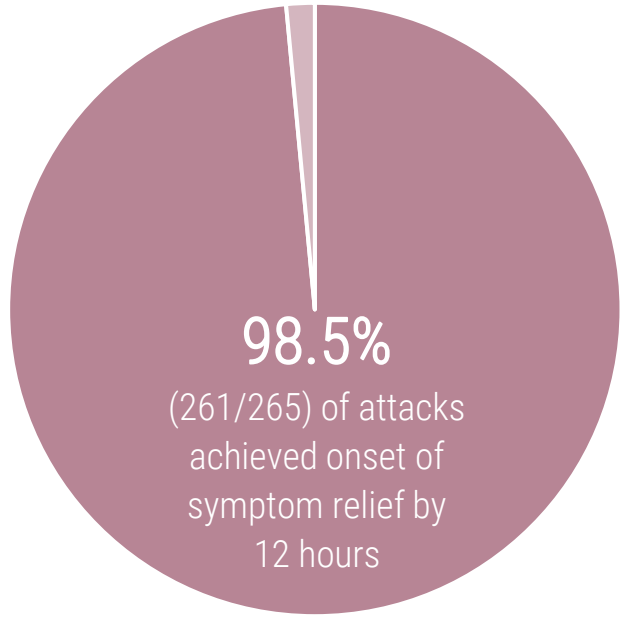
- No treatment-related serious or severe TEAEs
- No treatment-related TEAEs in laboratory parameters, vital signs, or ECG findings were reported
- No TEAEs leading to treatment discontinuation, study withdrawal, or death

IR, immediate-release; TEAE, treatment-emergent adverse event (defined as AE occurring during time window from first study drug administration; TEAEs within 5 days post-treatment were analyzed); N= Number of participants treated with study drug, N' = Number of attacks treated with study drug. Data snapshot for safety analysis population: 10 June 2024. **Source:** [1]Maurer M et al. BKS 2024.

Rapid median onset of symptom relief at ~1.1 hours: 98.5% of attacks achieved onset of symptom relief by 12 hours[1]

- Time to onset of symptom relief is defined as PGI-C rating of at least 'a little better' for two consecutive timepoints post-treatment[a]



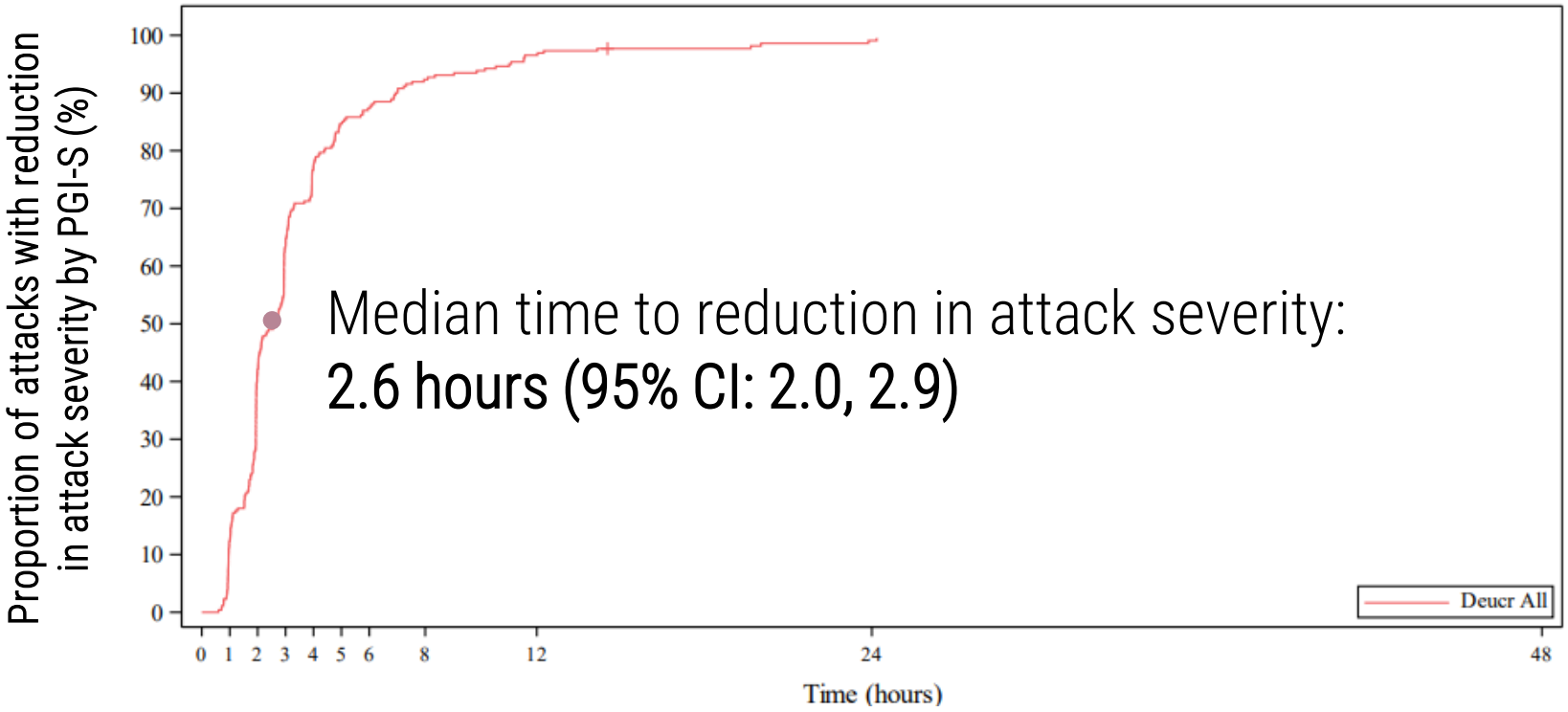


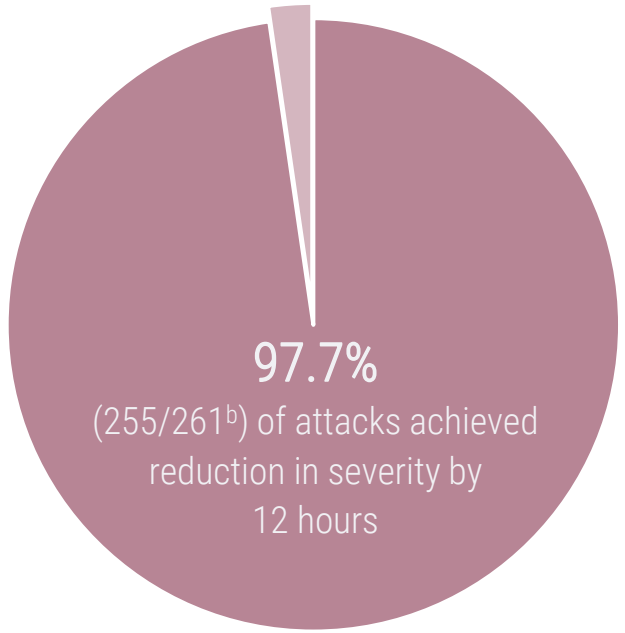
PGI-C, Patient Global Impression of Change. [a]Symptom relief is also considered as achieved if PGI-C rating reached at least a 'little better' at the last scheduled time point (48 h) provided no rescue medication used within 48h after the last time point. The time is censored at the time of the last post-treatment PGI-C assessment prior to intake of HAE rescue medication, or a medication not allowed for treating an attack.

Source: [1]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[1]

- Reduction in attack severity is defined as achieving ≥1 point reduction in PGI-S from pre-treatment for two consecutive time points[a]



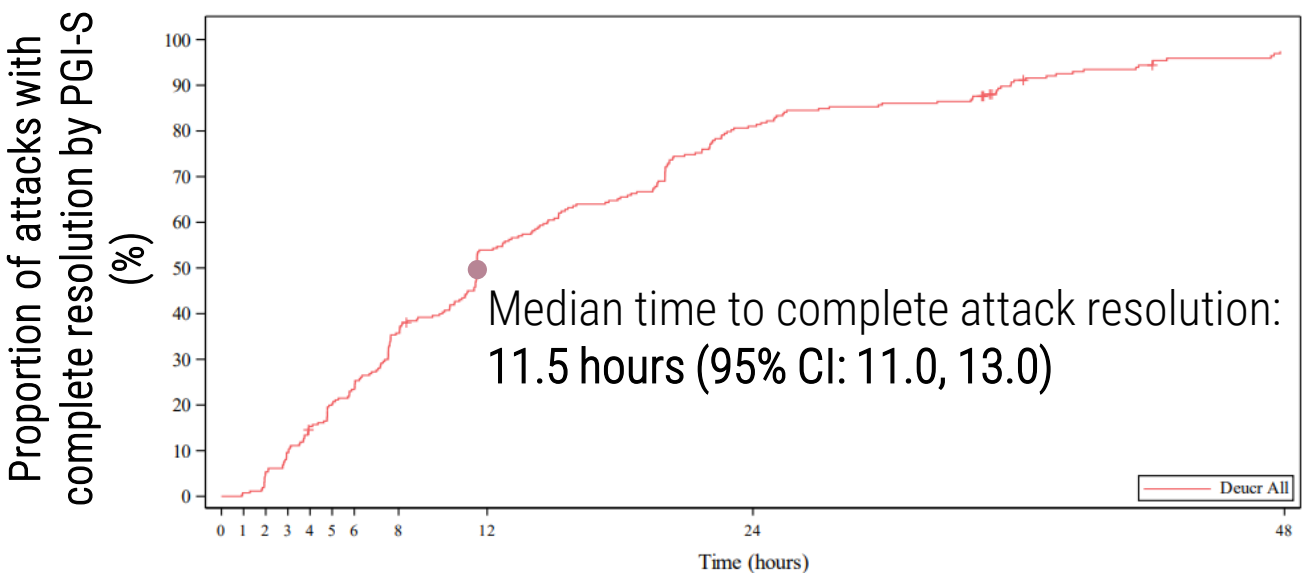


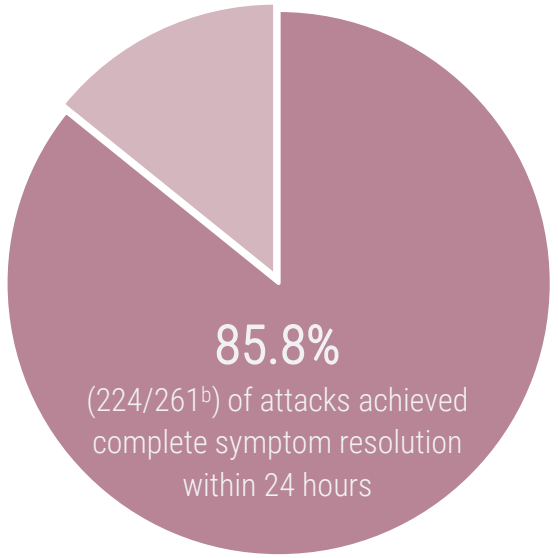
PGI-S, Patient Global Impression of Severity. [a]Reduction in attack severity is also considered as achieved if ≥ 1 point reduction in PGI-S from pre-treatment at the last scheduled time point (48 h) provided no rescue medication used within 48h after the last time point. [b]261 attacks have non-missing pre-treatment PGI-S.

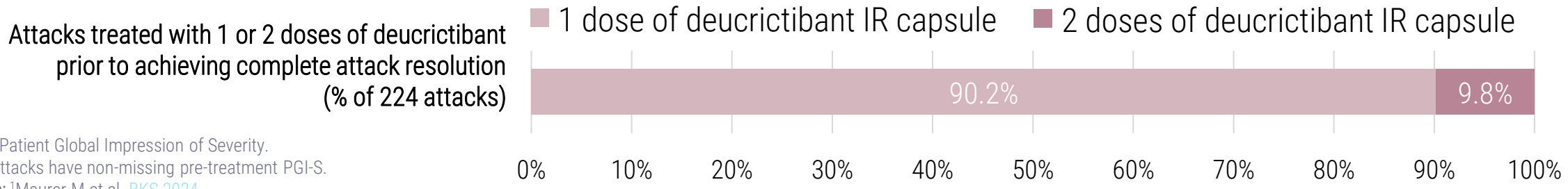
Source: [1]Maurer M et al. BKS 2024.

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]

- Time to complete attack resolution is defined as the time to post-treatment PGI-S rating achieving 'none'







PGI-S, Patient Global Impression of Severity.
[a]261 attacks have non-missing pre-treatment PGI-S.
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

Participants recruited by HAEA

PGI-C, PGI-S, and AMRA-3/ AMRA-5 data collected via mobile app

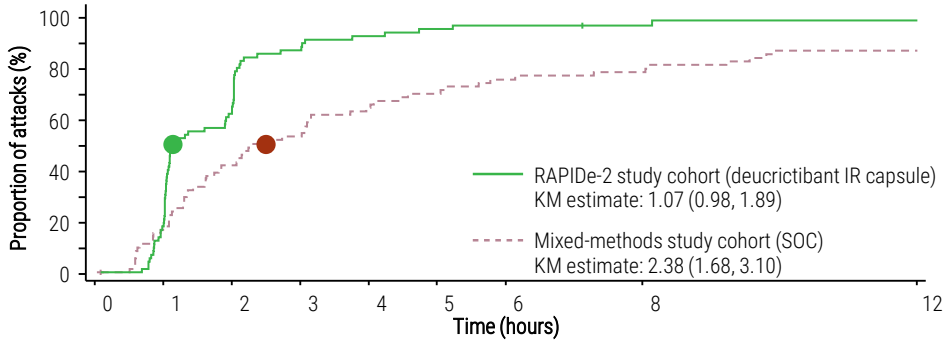
- At pre-treatment
- Every hour up to 4 hours following treatment administration
- Then at 8, 12, 24, and 48 hours

Qualitative interviews with a subset of participants

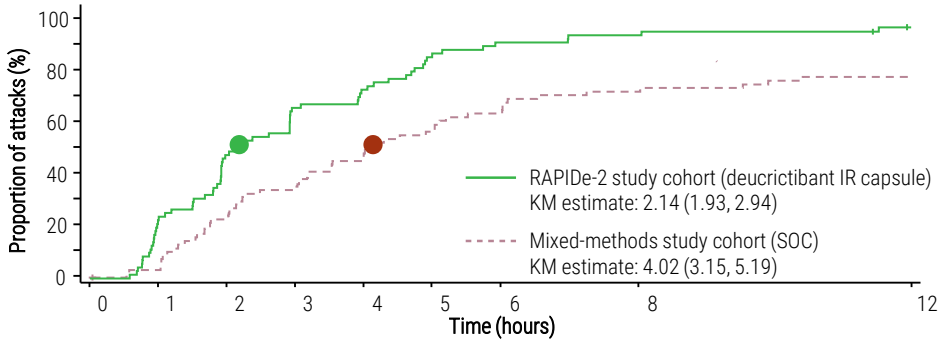
Note: Standard of care was icatibant or plasma derived/recombinant C1-Inhibiitor

In a propensity-score-matching analysis, deucrictibant showed favorable symptom relief outcomes versus standard of care[1]

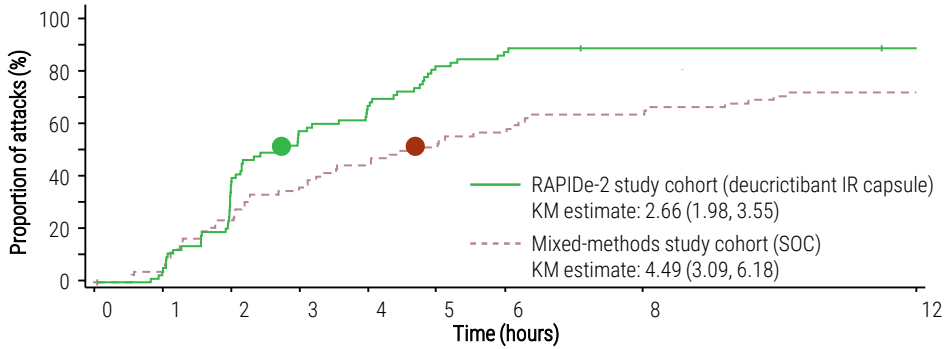
A. Time to symptom relief defined as PGI-C "A little better"



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



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



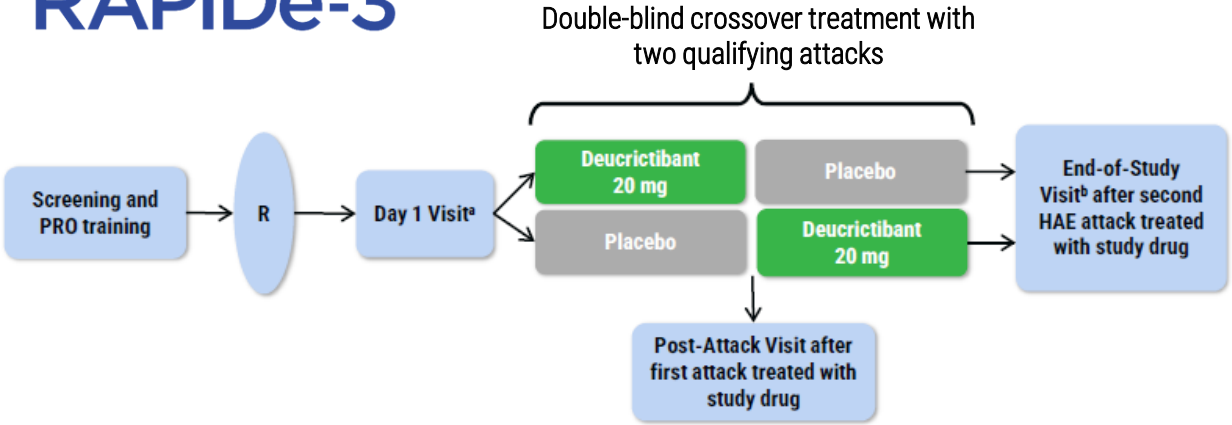
Time to symptom relief in hours, median (95% CI)		RAPIDe-2 cohort (deucrictibant; N=73)	Mixed-methods cohort (SOC; N=73)
A	PGI-C – "A little better"	1.07 (0.98, 1.89)	2.38 (1.68, 3.10)
B	PGI-S – ≥1 point reduction	2.14 (1.93, 2.94)	4.02 (3.15, 5.19)
C	PGI-C – "Better"	2.66 (1.98, 3.55)	4.49 (3.09, 6.18)

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:** [1]Riedl MA et al. BKS 2024.

RAPIDe-3 Clinical Study

HAE RAPIDe-3[1] study enrolling: A global Phase 3 study of on-demand treatment of angioedema attacks in people with HAE-1/2

RAPIDe-3



- Target enrollment of approximately 120 adolescents and adults (between 12 and 75 years old)
- **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
    - 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
- Rollover to open-label extension

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

Positive Phase 3 data could position deucrictibant to become a preferred ODT with rapid-onset and complete symptom resolution 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 2023. [8]Riedl MA et al. 2024 BKS. [9]Mendivil et al. GA²LEN UCARE 2023.

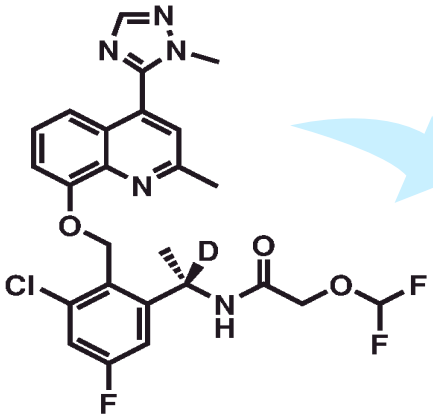
Our strategy is to become a market leader in HAE

Rooted in a deep commitment to engage with the HAE community

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

Going Beyond HAE

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**

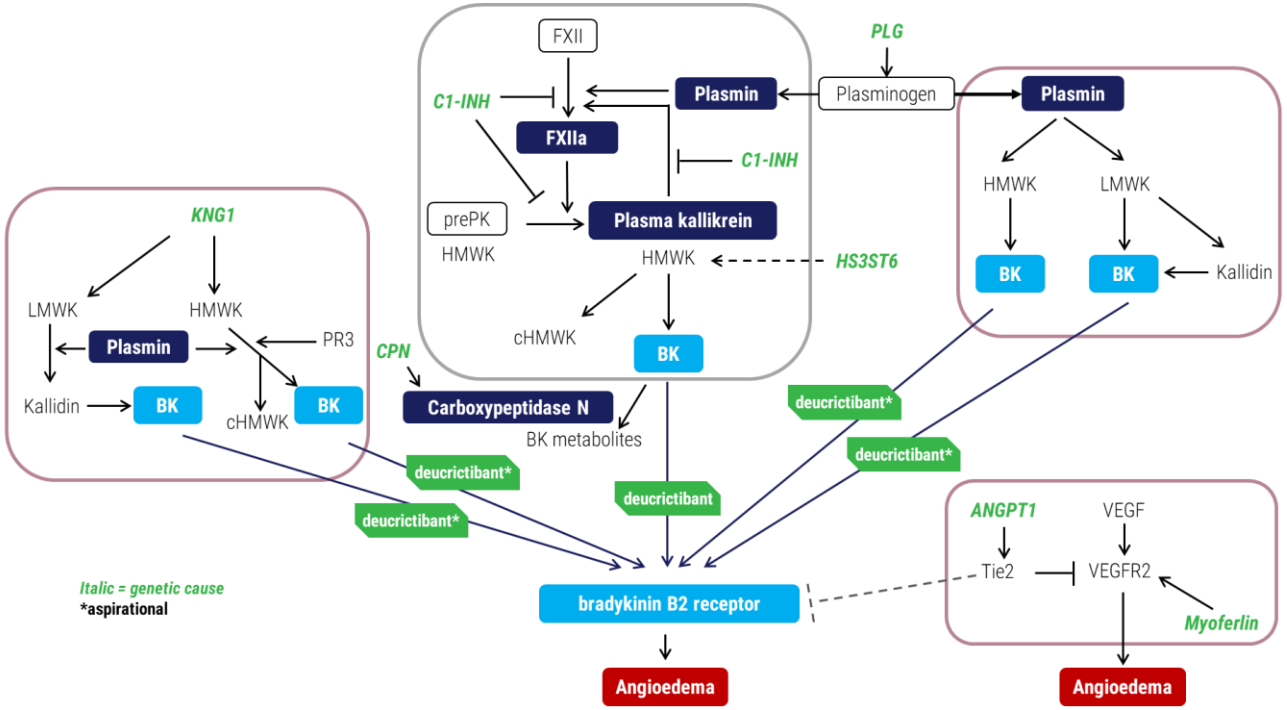
- **Rapid** onset of action[9,10]
- **Single dose** resolution[10]
- **Ease of oral** administration**[,7]

*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.

Bradykinin B2 receptor inhibition is broadly applicable across angioedema

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

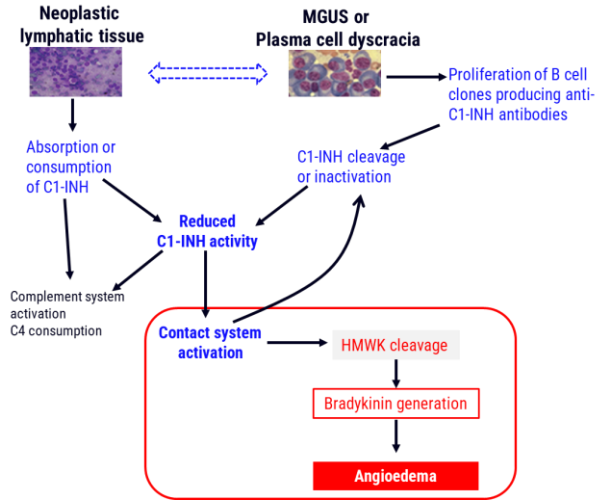


Notes: bold = known or potential role for bradykinin involvement in disease. *also designated as Normal C1INH Angioedema (HAE-nC1INH); HMWK: high-molecular-weight kininogen; cHMWK: cleaved high-molecular-weight kininogen; FXII(a): Factor XII(a); ACE(i): angiotensin-converting enzyme (inhibitor); tPA: 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.

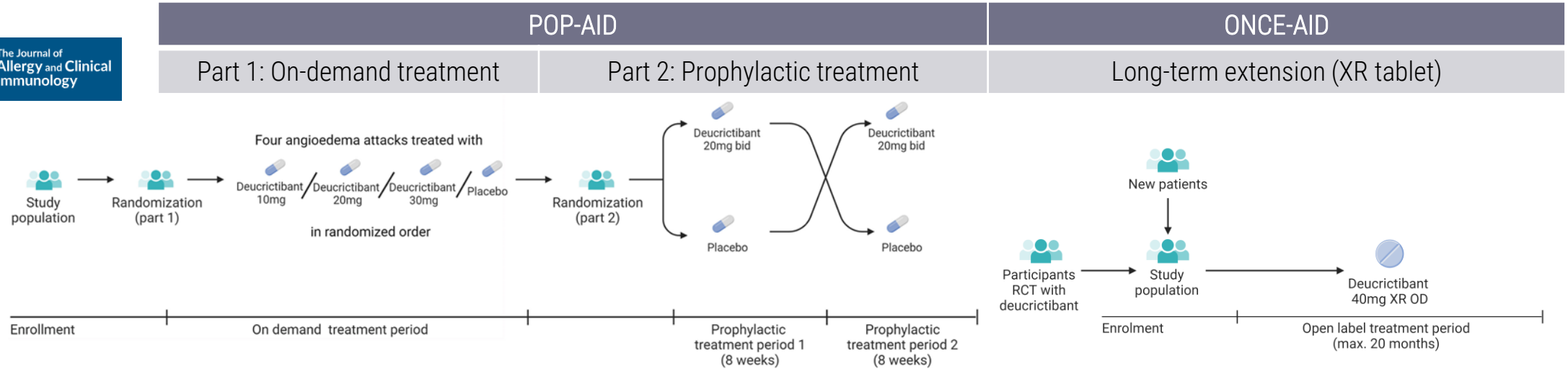
Source: Busse 2020 J Allergy Clin Immunol Pract; Bork et al 2021 J Allergy Clin Immunol; Zanichelli et al 2012 Allergy; Longhurst et al 2017 Clin. Exp. Immunol.; Otani, Banerji 2017 Immunol. Allergy Clin. N. Am.; Bova et al 2018 Int. Arch. Allergy Immunol.; Petersen et al 2024 J Allergy Clin Immunol

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

- Estimated prevalence of 1:100,000 to 1:500,000
  - ~ 10% of HAE type 1/2
- Currently, no therapies approved for AAE
- Investigator-initiated trial (IIT) by the Amsterdam UMC



JACI The Journal of Allergy and Clinical Immunology

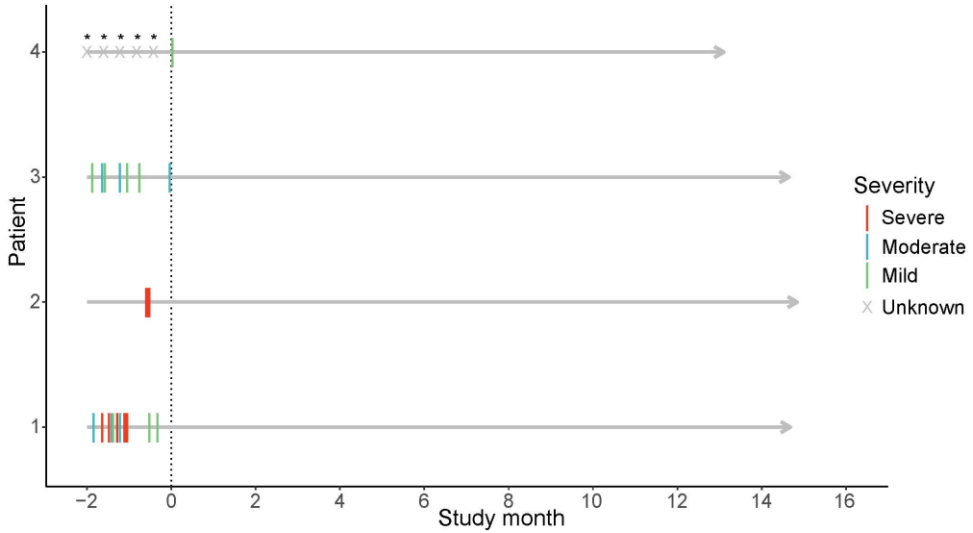


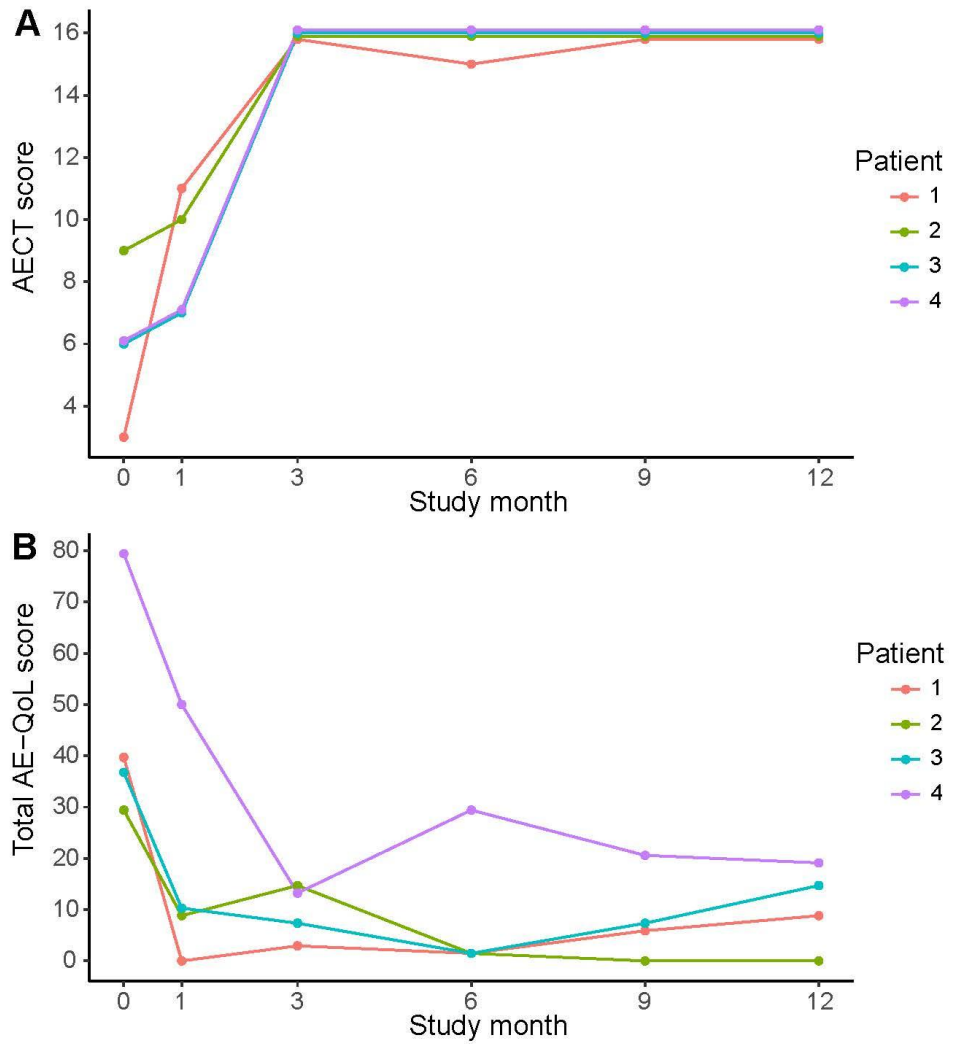
Source: [1]Petersen RS et al. *J Allergy Clin Immunol*. 2024. [2]Petersen RS et al. BKS 2024.

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

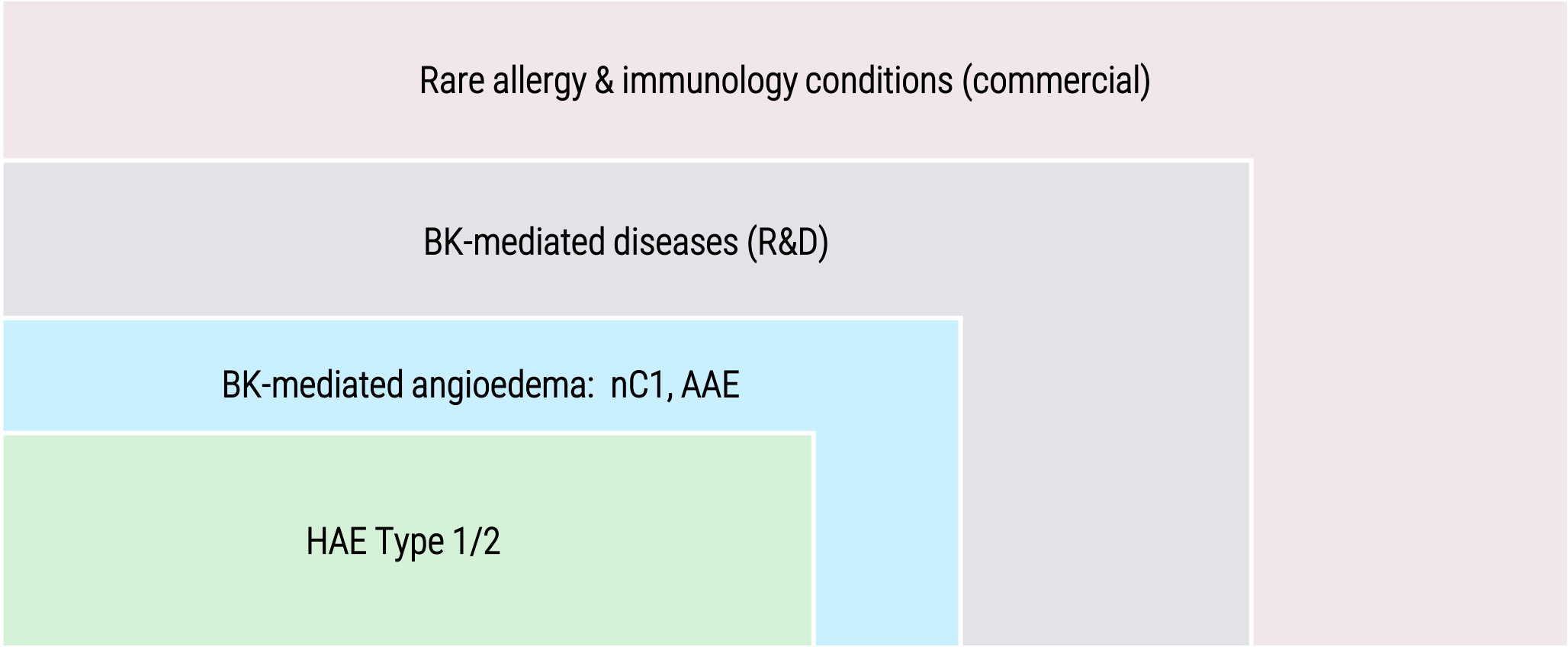
Attacks before and during deucrictibant XR treatment





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.

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



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PHARVARIS

www.pharvaris.com

NASDAQ: PHVS

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

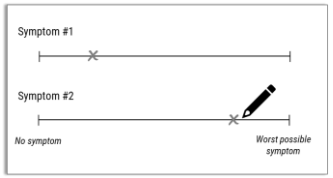
Appendix

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

What is a Visual Analogue Scale (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



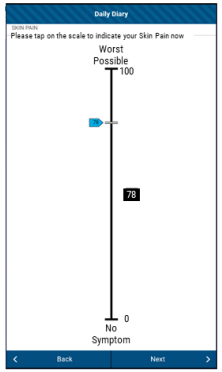
Why do we need change?

- 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) selected
- Performed at home

2023
Pharvaris



A numeric rating scale requires a self- explanatory name

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

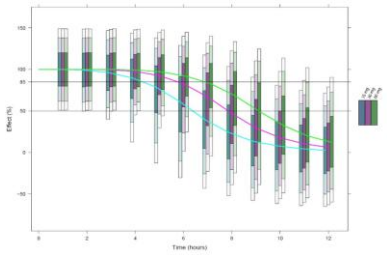
Source: [1] CDER. Patient-Focused Drug Development: Selecting, Developing, or Modifying Fit-for Purpose Clinical Outcome Assessments. FDA. June 2022.

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

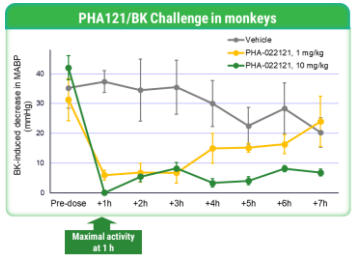
Icatibant development program (shared mechanism)



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

nonclinical

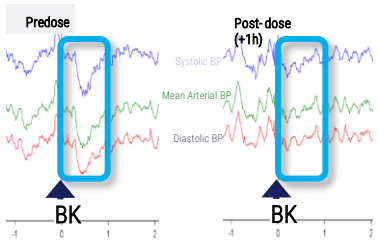
Non-human primate study



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

clinical

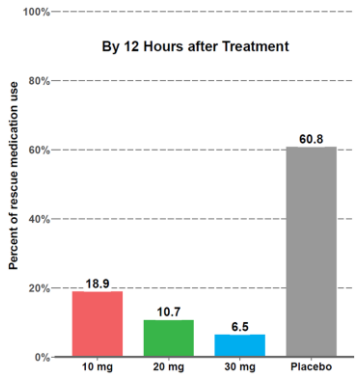
Phase 1 healthy volunteer study



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

clinical

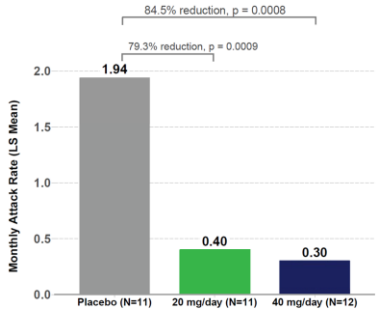
RAPIDe-1 Phase 2 on-demand



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

clinical

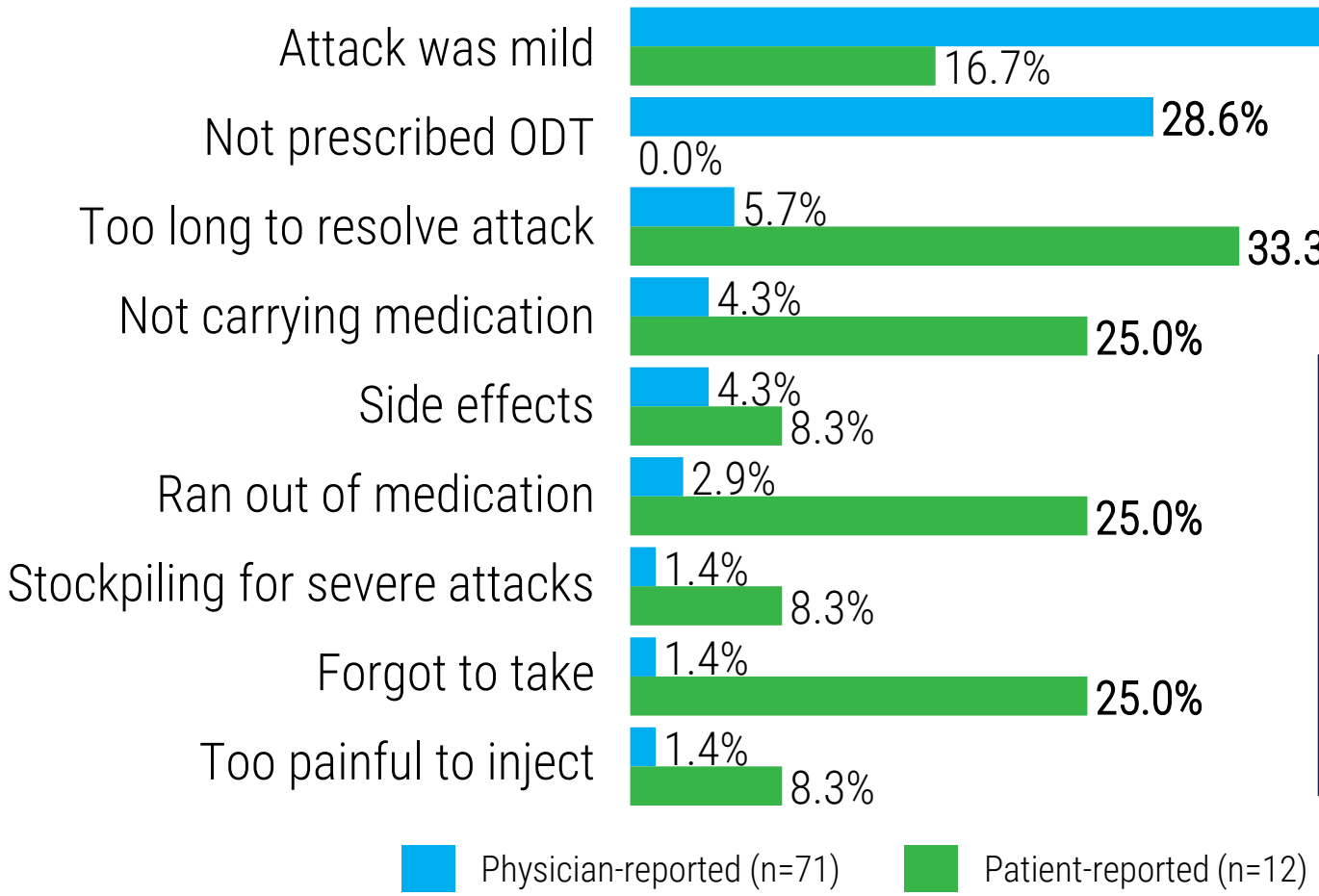
CHAPTER-1 Phase 2 prophylaxis



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.

Not all attacks are treated: Physicians and patients report reasons for not treating most recent attack[1]



- Physicians focus on attack severity and lack of a prescription
- Patients raise logistics and treatment dissatisfaction as key reasons for not treating an attack

Source: [1]Mendivil et al., ACAAI 2023.

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

	Doctors (n=100)		Patients (n=103)	
	Would treat MORE attacks	Would treat attacks EARLIER	Would treat MORE attacks	Would treat attacks EARLIER
Mean /10	7.9	8.1	7.6	7.7
Ratings 8-10 (10=extremely likely)	70%	73%	60%	67%
Ratings 6-7	23%	23%	17%	11%
Ratings 4-5	6%	3%	12%	10%
Ratings 1-3 (1=not at all likely)			12%	13%

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