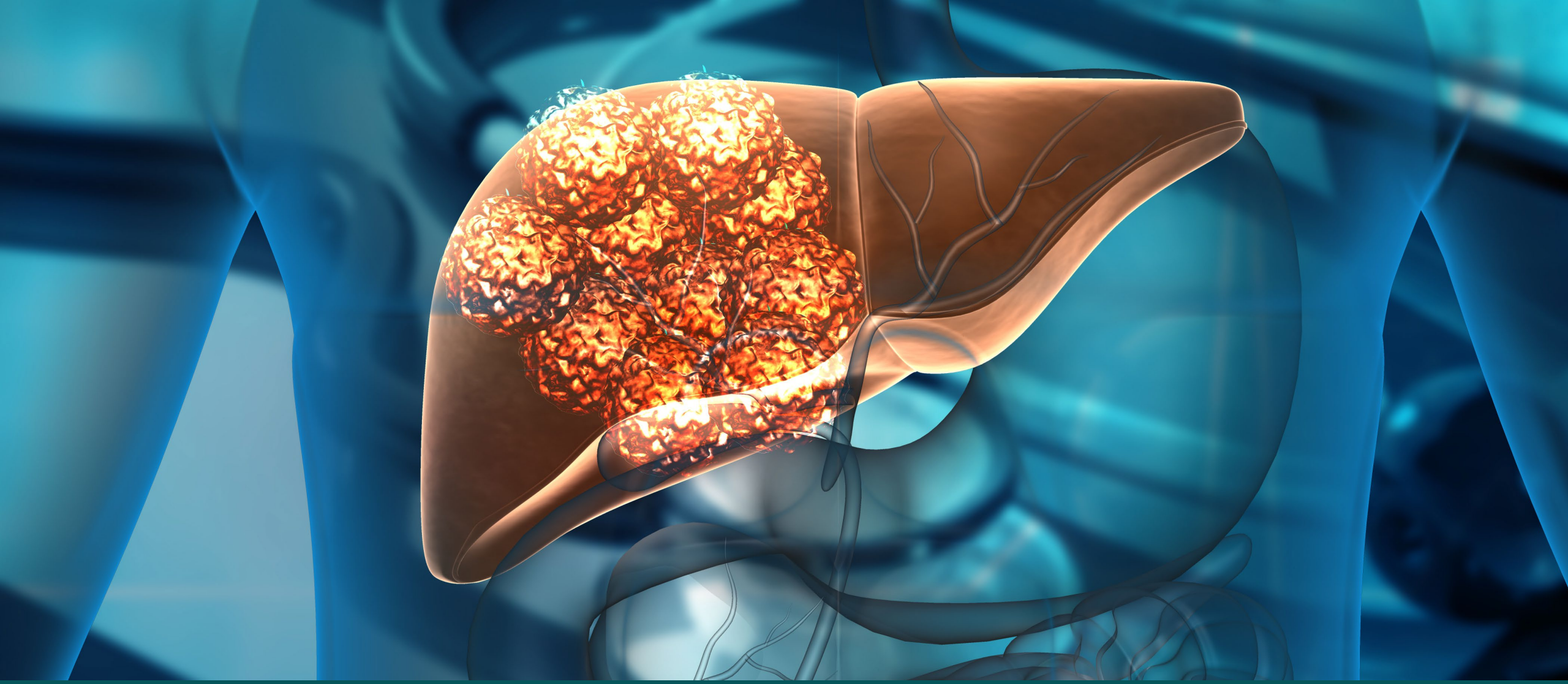


Improving life for advanced liver cancer (HCC) patients

Fostrox – The first oral, liver-targeted treatment for advanced HCC

MEDIVIR

Important notice

You must read the following before continuing. The following applies to this document and the information provided in this presentation by Medivir AB (publ) (the "Company") or any person on behalf of the Company and any other material distributed or statements made in connection with such presentation (the "Information"), and you are therefore advised to carefully read the statements below before reading, accessing or making any other use of the Information. In accessing the Information, you agree to be bound by the following terms and conditions.

The Information does not constitute or form part of, and should not be construed as, an offer of invitation to subscribe for, underwrite or otherwise acquire, any securities of the Company or a successor entity or any existing or future subsidiary or affiliate of the Company, nor should it or any part of it form the basis of, or be relied on in connection with, any contract to purchase or subscribe for any securities of the Company or any of such subsidiaries or affiliates nor shall it or any part of it form the basis of or be relied on in connection with any contract or commitment whatsoever. Specifically, this presentation does not constitute a "prospectus" within the meaning of the U.S. Securities Act of 1933, as amended.

The Information may not be reproduced, redistributed, published or passed on to any other person, directly or in directly, in whole or in part, for any purpose. The Information is not directed to, or intended for distribution to or use by, any person or entity that is a citizen or resident of, or located in, any locality, state, country or other jurisdiction where such distribution or use would be contrary to law or regulation or which would require any registration or licensing within such jurisdiction. The Information is not for publication, release or distribution in the United States, Australia, Canada or Japan, or any other jurisdiction in which the distribution or release would be unlawful.

All of the Information herein has been prepared by the Company solely for use in this presentation. The Information contained in this presentation has not been independently verified. No representation, warranty or undertaking, express or implied, is made as to, and no reliance should be placed on, the fairness, accuracy, completeness or correctness of the Information or the opinions contained herein. The Information contained in this presentation should be considered in the context of the circumstances prevailing at that time and will not be updated to reflect material developments which may occur after the date of the presentation. The Company may alter, modify or otherwise change in any manner the content of this presentation, without obligation to notify any person of such revision or changes.

This presentation may contain certain forward-looking statements and forecasts which relate to events and depend on circumstances that will occur in the future and which, by their nature, will have an impact on the Company's operations, financial position and earnings. The terms "anticipates", "assumes", "believes", "can", "could", "estimates", "expects", "forecasts", "intends", "may", "might", "plans", "should", "projects", "will", "would" or, in each case, their negative, or other variations or comparable terminology are used to identify forward-looking statements. There are a number of factors that could cause actual results and developments to differ materially from those expressed or implied in a forward-looking statement or affect the extent to which a particular projection is realized. Factors that could cause these differences include, but are not limited to, implementation of the Company's strategy and its ability to further grow, risks associated with the development and/or approval of the Company's products candidates, ongoing clinical trials and expected trial results, the ability to commercialize existing and any future products, technology changes and new products in the Company's potential market and industry, the ability to develop new products, the impact of competition, changes in general economy and industry conditions and legislative, regulatory and political factors. While the Company always intends to express its best judgment when making statements about what it believes will occur in the future, and although the Company bases these statements on assumptions that it believe to be reasonable when made, these forward-looking statements are not a guarantee of its performance, and you should not place undue reliance on such statements. Forward-looking statements are subject to many risks, uncertainties and other variable circumstances. Many of these risks are outside of the Company's control and could cause its actual results to differ materially from those it thought would occur. The forward-looking statements included in this presentation are made only as of the date hereof. The Company does not undertake, and specifically decline, any obligation to update any such statements or to publicly announce the results of any revisions to any of such statements to reflect future events or developments.

MEDIVIR

Fostrox (fostroxacitabine bralpamide)
The first oral, liver-targeted treatment tailored for HCC

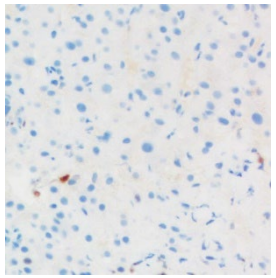
Oral, liver-activated small molecule inducing DNA damage in tumor cells, sparing healthy liver cells[3]

Unique, liver-targeted approach in HCC

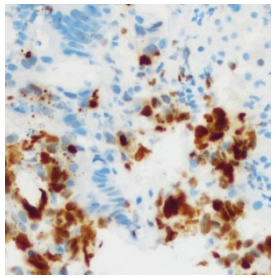
Liver-guided delivery – prodrug

Tumor-selective payload – troxacitabine

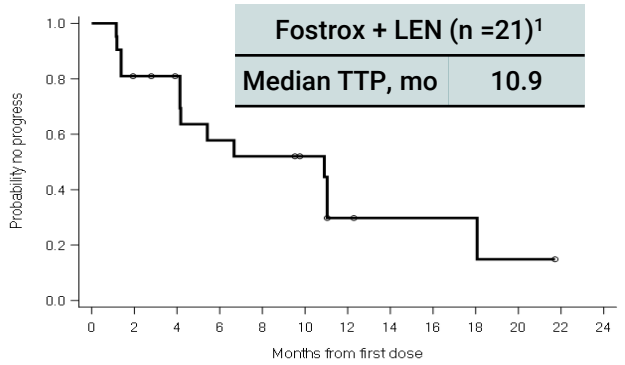
No DNA damage in healthy liver tissue



DNA damage in tumor tissue



10.9 months time to progression, substantially better than SoC[1,2]



*see slide 20 for details regarding individual study data

Absence of effective treatment options in 2nd line enables first-to-market opportunity for fostrox + Lenvima

- No 2nd line treatments approved in advanced HCC
- Global phase 2b start H1 '25
- Designed to enable breakthrough designation and support accelerated approval process

Market opportunity in 2nd line HCC >$2.5bn, with significant upside potential

>$2.5bn

2nd line HCC market by 2030, fastest growing cause of cancer death in US[4]

Significant upside in liver metastasis from other solid tumors

[1]Chon et al., ESMO, 2024, Poster 986
[2]Based on data from previous 2L phase 3 HCC studies with Stivarga, Cyramza & Cabometyx and investigator initiated prospective & retrospective 2L studies with Lenvatinib
[3]Evans et al ASCO GI, 2021
[4]Ma et al., Cancer, June 15, 2019; 2089-2098

MEDIVIR

Medivir management team

CEO
Jens Lindberg

- > 25 years of experience from pharmaceutical industry with focus on late-stage development & commercialization in Oncology of drugs like Tagrisso, Lynparza, Imfinzi and Iressa
- Other experience includes interim CEO for Sedana Medical AB and Director Investor Relations at AstraZeneca.
- Member of the Board of Braincool AB.

CMO
Dr. Pia Baumann

- MD PhD with a specialist degree in medical & radiation oncology at Karolinska Institute/University hospital.
- Substantial experience in drug development in the cancer field.
- > 25 years of clinical work at Karolinska and pharmaceutical/ biotech companies, including AstraZeneca, BMS, Takeda, Incyte and ARIAD

CFO
Magnus Christensen

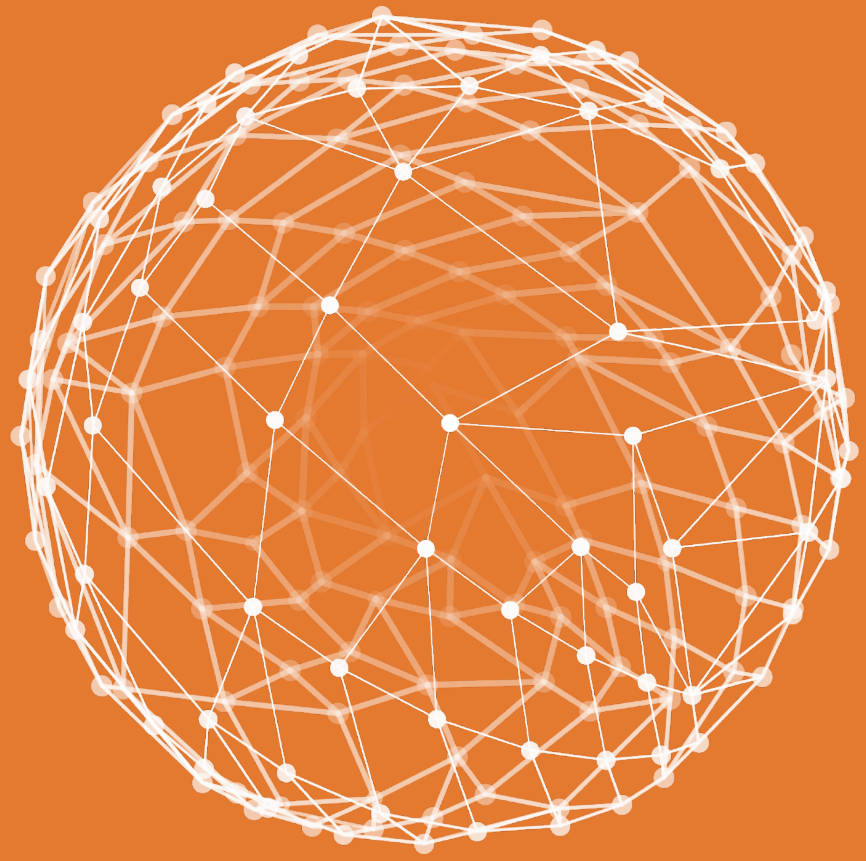
- > 25 years of experience in finance.
- Interim CEO at Medivir, May 2021-January 2022.
- Former CFO at O'Learys Trademark AB.
- Experience of working in listed-, private equity- and private companies.
- Member of the Board of PMD Device Solutions AB.

CSO
Fredrik Öberg

- PhD in Medical Science & Adjunct professor at the Medical Faculty of Uppsala University.
- > 25 years of experience in cancer research.
- During the last 10 years focused on industrial drug discovery and development projects in oncology.
- He has published more than 50 scientific articles and holds several patents.

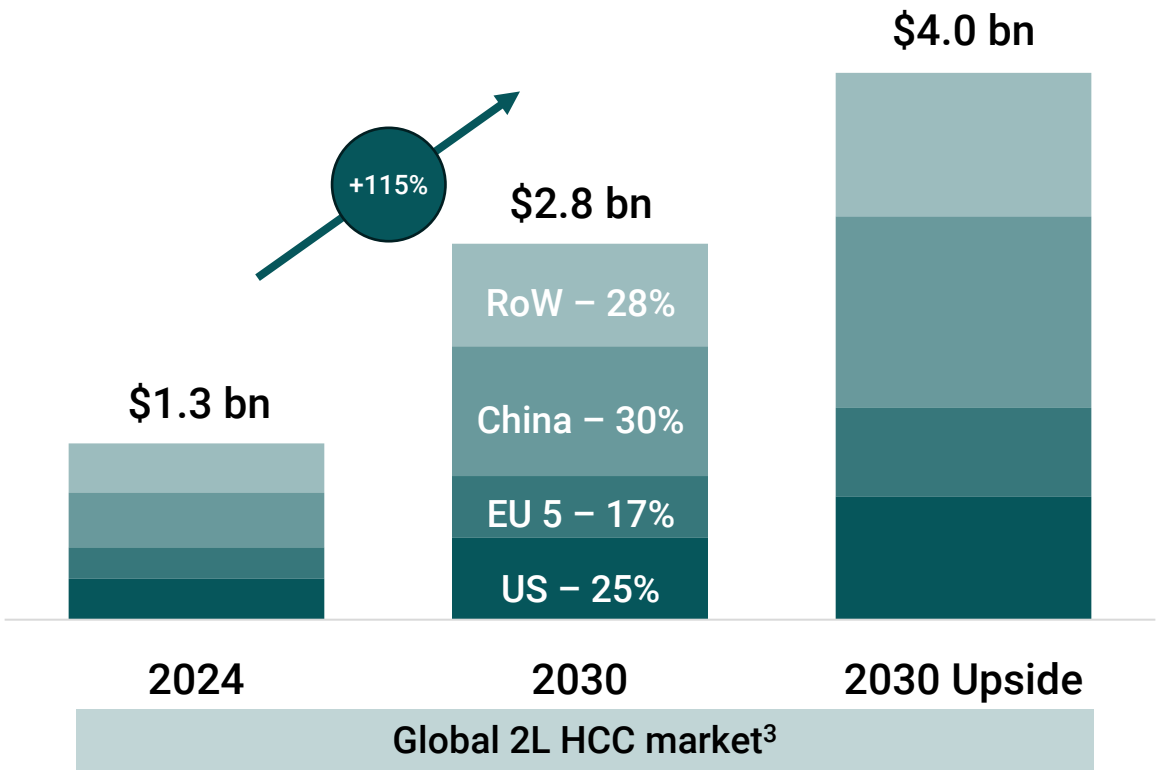
MEDIVIR

First-to-market opportunity in 2nd line HCC market valued >$2.5bn



MEDIVIR

2nd line HCC – a large and growing commercial opportunity with significant need for new treatment options[3]



Growth driven by:

- HCC to increase **+122% in the US** and +**82% in China**[2] by 2030, caused by fatty liver disease
- With improved 1L treatment, more patients will be **fit enough for 2L, 50% → 70%**
- New, approved treatment options increase average **treatment duration to 7 months** by 2030

2030 Upside:

- Average treatment duration increases to 10 months based on fostrox + Lenvima® study

[1]Rumguy et al. Journal of Hepatology 2022
[2]Huang et al., Nature Reviews, Gastroenterology & Hepatology, Vol 18, 2021
[3]GlobalData 2021 and internal analysis

Absence of effective treatment options in 2nd line HCC

Treatment algorithm – major need for new 2nd line options

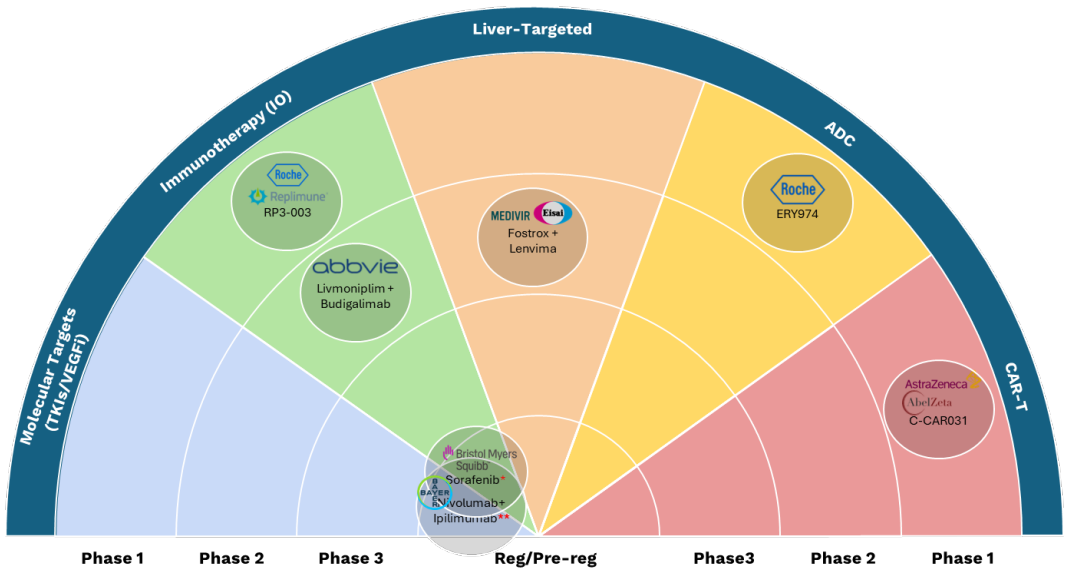
1st line treatment

- **IO combinations Standard of Care** – Tecentriq + Avastin
- Numerous studies ongoing evaluating various other IO combinations

2nd line treatment

- **No approvals or scientific evidence** to support treatment choice in 2nd line
- Few ongoing studies in 2nd line

Competitive landscape in 2nd line HCC highlights lack of novel mechanisms in development with fostrox + Lenvima at the forefront



"We are becoming greedy, trying to have 8 different regimens in the 1L setting and none of us know what to do after.

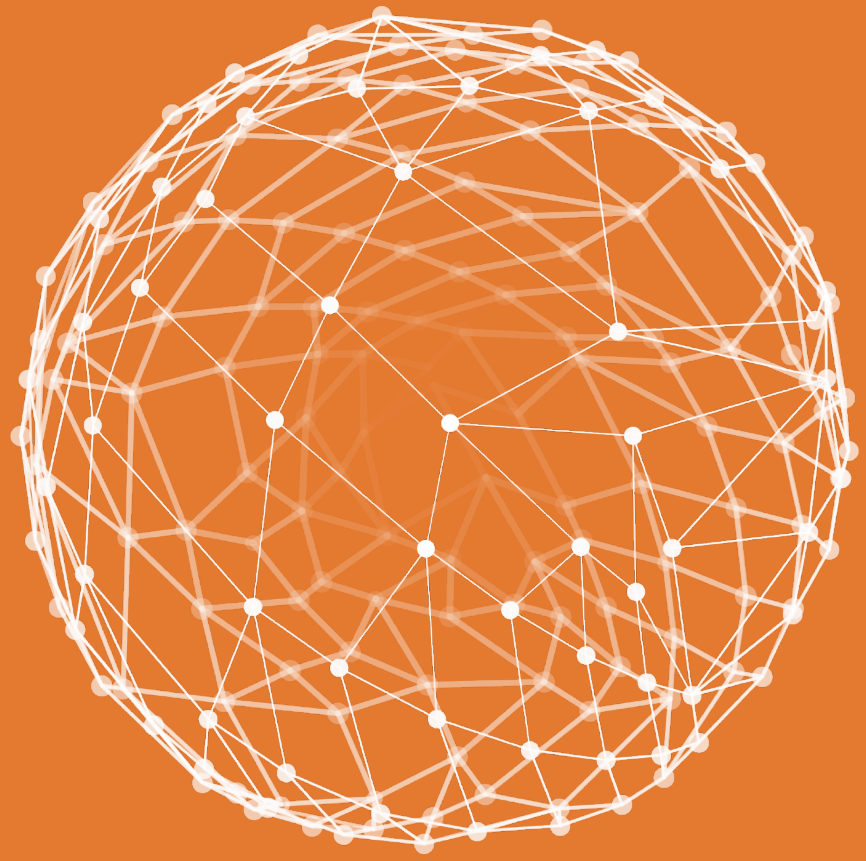
If I had my way, the focus should really be on 2L treatment and beyond"

Rachna T Schroff, University of Arizona Cancer Center
Late Breaking Abstract session at ESMO, September 2024

MEDIVIR

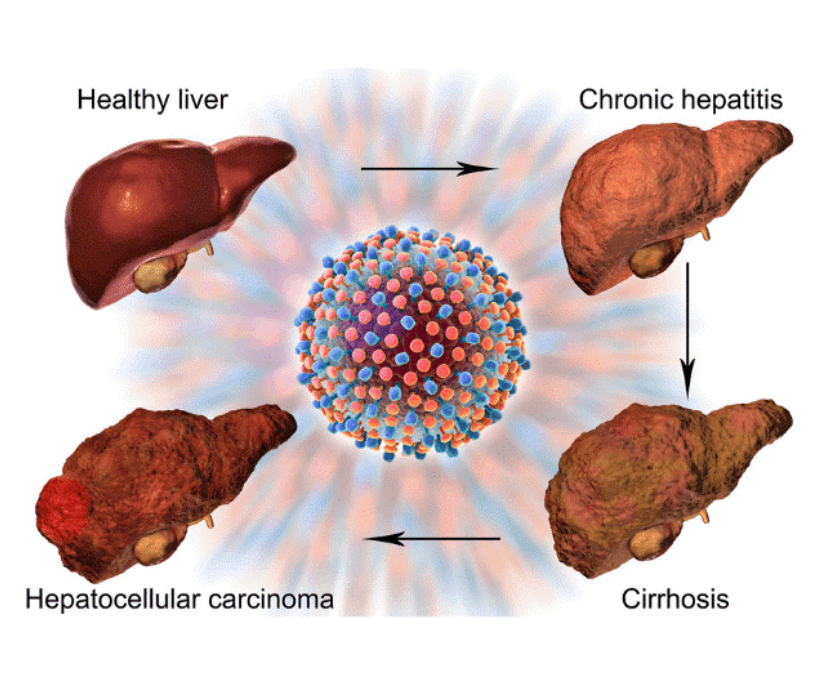
*Sorafenib was the first approved 1st-line treatment for HCC. Although approved for 2nd-line use, guidelines recommend against it due to a lack of evidence showing efficacy after immunotherapy combinations.
**Nivolumab + Ipilimumab were approved for patients post-sorafenib but are now moving into 1st line HCC treatment (positive phase III, awaiting approval (source)).

Fostrox – tailored for the specific needs of HCC



MEDIVIR

Targeted treatment approach critical in liver cancer (HCC)



~80% of patients have impaired liver function due to underlying liver disease[1,2]

Key objective – target cancer cells, minimize effects on healthy cells

Tumor growth primarily occurs locally in the liver[1]

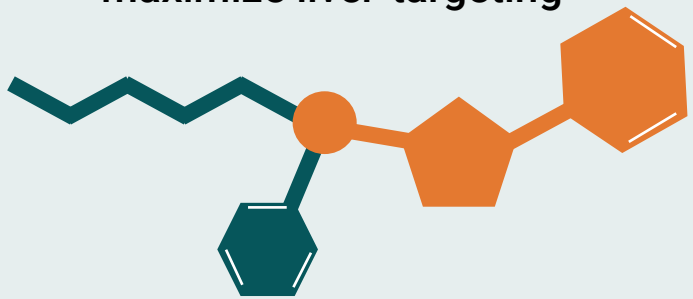
Critical to achieve selective targeting of tumor cells while sparing healthy cells

[1] Senthilnathan et al., Hepatology, 2012 May; 55(5): 1432-1442
[2] Llovet et al., Nature Reviews Gastroenterology & Hepatology, Vol 20, Aug 2023, 487-503

MEDIVIR

Fostrox – tailored for HCC to achieve targeted DNA damage in liver tumor cells with minimal impact on healthy liver cells

The same, proven & highly successful approach used in HCV to maximize liver-targeting[2]



Liver-guided delivery – prodrug

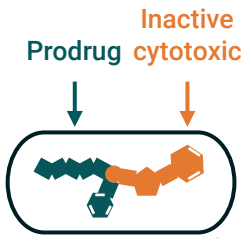
Tumor-selective payload – troxacitabine

- **Combining prodrug & payload enables oral administration & targeted (>100-fold) liver exposure vs IV chemotherapy[1]**
- **Molecule stable in GI tract & in blood, rapidly activated by enzymes in the liver[2]**
- **Payload selected as it causes DNA damage selectively in liver tumor cells, sparing healthy liver cells[3,4,5]**

[1]Bethell, R. et al , SAT-123, EASL 2017
[2]Bethell, R. et al P-035, ILCA 2016
[3]Kukhanova, M et al J Biol Chem 1995
[4]Albertella, M. et al EASL Summit P01-05, 2018
[5]Öberg F. et al, EASL PO-221, 2022

MEDIVIR

Fostrox MoA – tailored for HCC to achieve targeted DNA damage in liver tumor cells with minimal impact on healthy liver cells



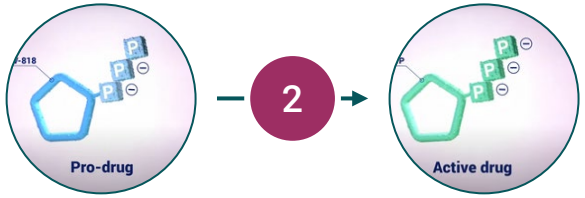
Fostrox taken as oral tablet

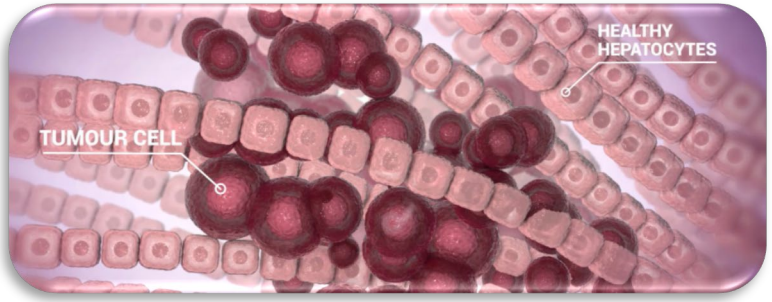
Prodrug transports inactive payload via first-pass metabolism to the liver[1]

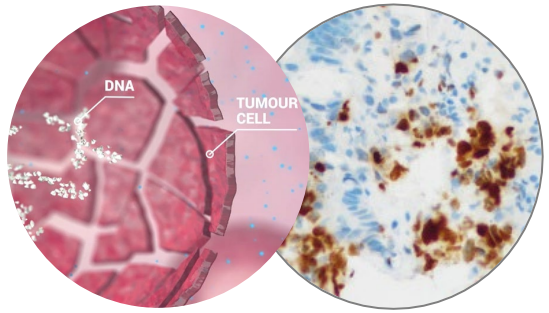
Mechanism of Action video

Rapidly activated by liver enzymes

Trapped inside liver cells for maximum liver exposure and minimal systemic spread[2,3,4]

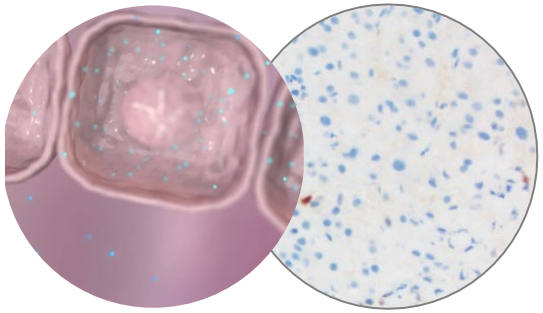






Cell death in tumor cells

Causes selective cell killing effect in tumor cells, sparing healthy liver cells as they very rarely divide[2,3,4]



No impact on healthy cells

[1]Bethell, R. et al P-035, ILCA 2016
[2]Kukhanova, M et al J Biol Chem 1995
[3]Albertella, M. et al EASL Summit P01-05, 2018
[4]Öberg F. et al, EASL PO-221, 2022

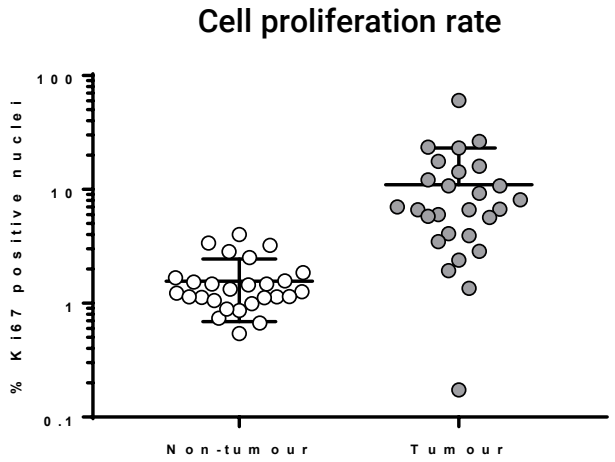
MEDIVIR

100-fold higher liver targeting vs IV administration & selective DNA damage in tumor cells enabling highly targeted mechanism

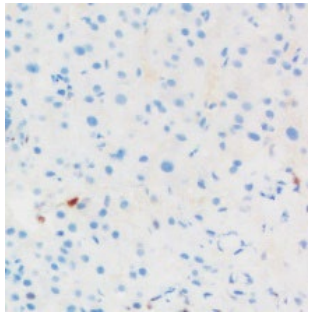
>100-fold higher liver targeting with fostrox than iv troxacitabine in rats

Compound	Route	Dose (µmol/kg)	AUC_{Liver} (nmol*h/g)	AUC_{Plasma} (µmol*h/L)	AUC ratio (Liver/ Plasma)
Troxa-citabine	*iv*	80	<1.2	80	**<0.016**
Fostrox	*oral*	80	10	5.4	**1.9**

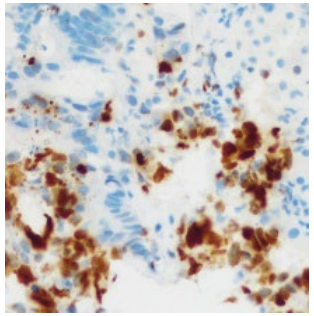
Liver tumor cells divide significantly more often than non-tumor cells[1]



Fostrox induces DNA damage in tumor cells, sparing normal liver tissue[2]



Normal liver tissue*



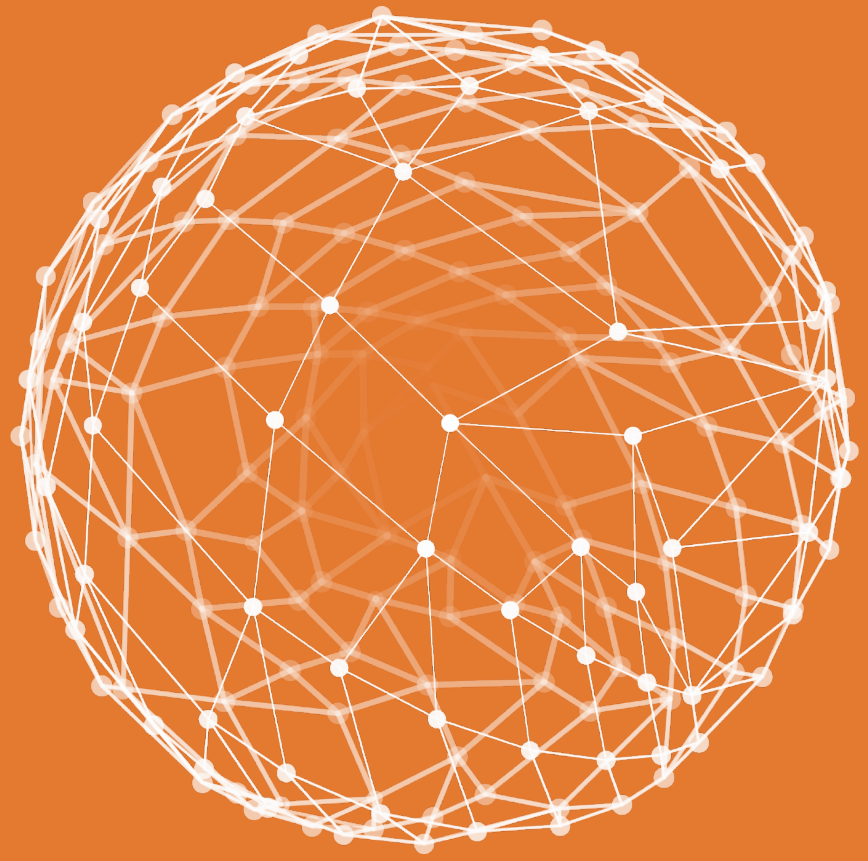
Tumor tissue*

Fostrox-induced DNA-damage indicated by pH2AX immuno-histochemistry (IHC) staining of liver biopsy from phase 1b monotherapy

[1]Albertella, M. et al EASL Summit P01-05, 2017
[2]Öberg F. et al, EASL PO-221, 2022
*Induced DNA damage indicated by pH2AX IHC staining (brown color) in patient biopsies

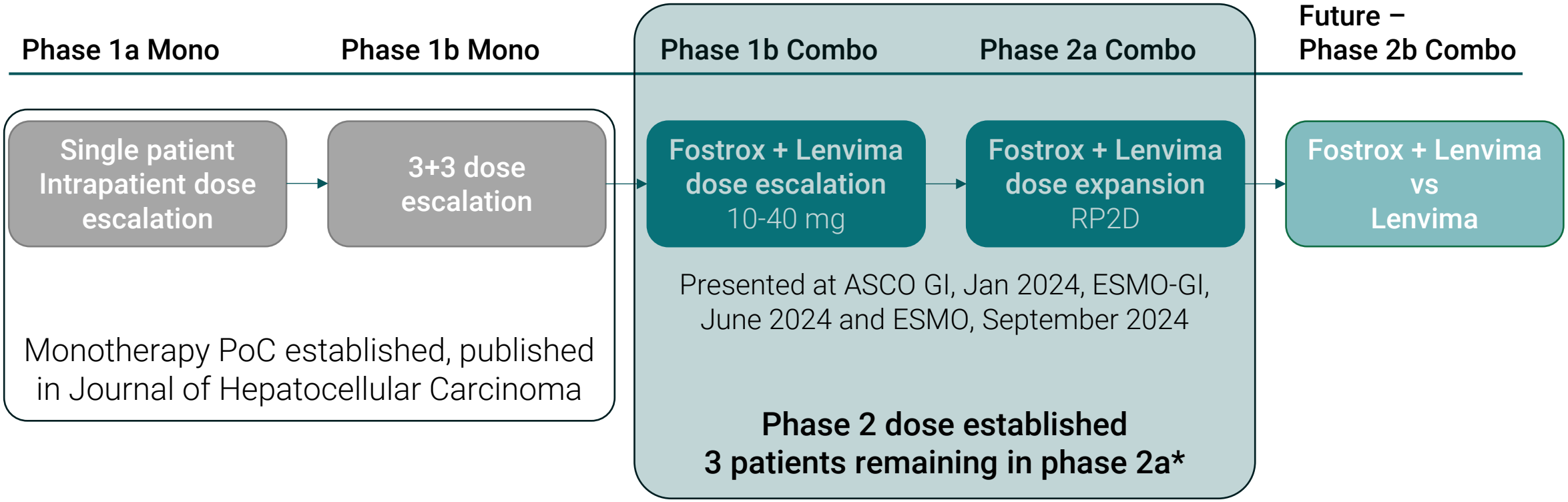
MEDIVIR

Fostrox + Lenvima shows promise of improved outcomes in 2L HCC



MEDIVIR

Fostrox Clinical Development Program; monotherapy PoC established, focus on combination approach in 2L HCC



MEDIVIR

*Data-cut August 19, 2024

Fostrox + Lenvima phase 1b/2a study design

- Adv/inop HCC
- 2L/3L
- ≥ 18 y
- ECOG ≤ 1
- Child-Pugh A

Fostrox + LEN* 20 mg (n=3)

Fostrox + LEN 30 mg (n=3)

Fostrox + LEN RP2D – 30 mg (n=15)

Treatment until PD

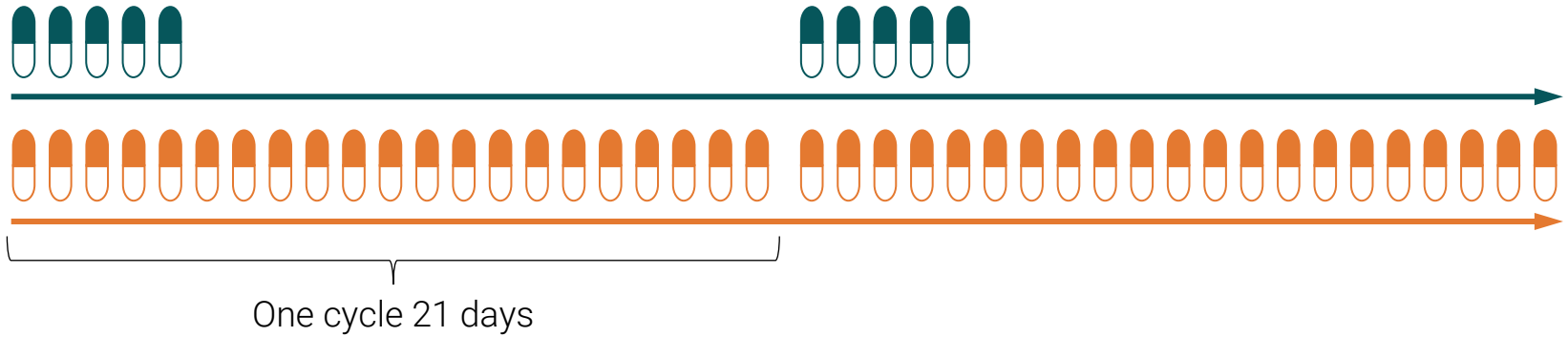
Primary Endpoint: Safety

Key Secondary Endpoints: ORR, DCR, TTP/PFS

Patients were enrolled at 15 sites in the UK, Spain and South Korea. Imaging assessments (CT & MRI) every 6 weeks.

Fostrox: Oral QD
5 days in 21 days cycles

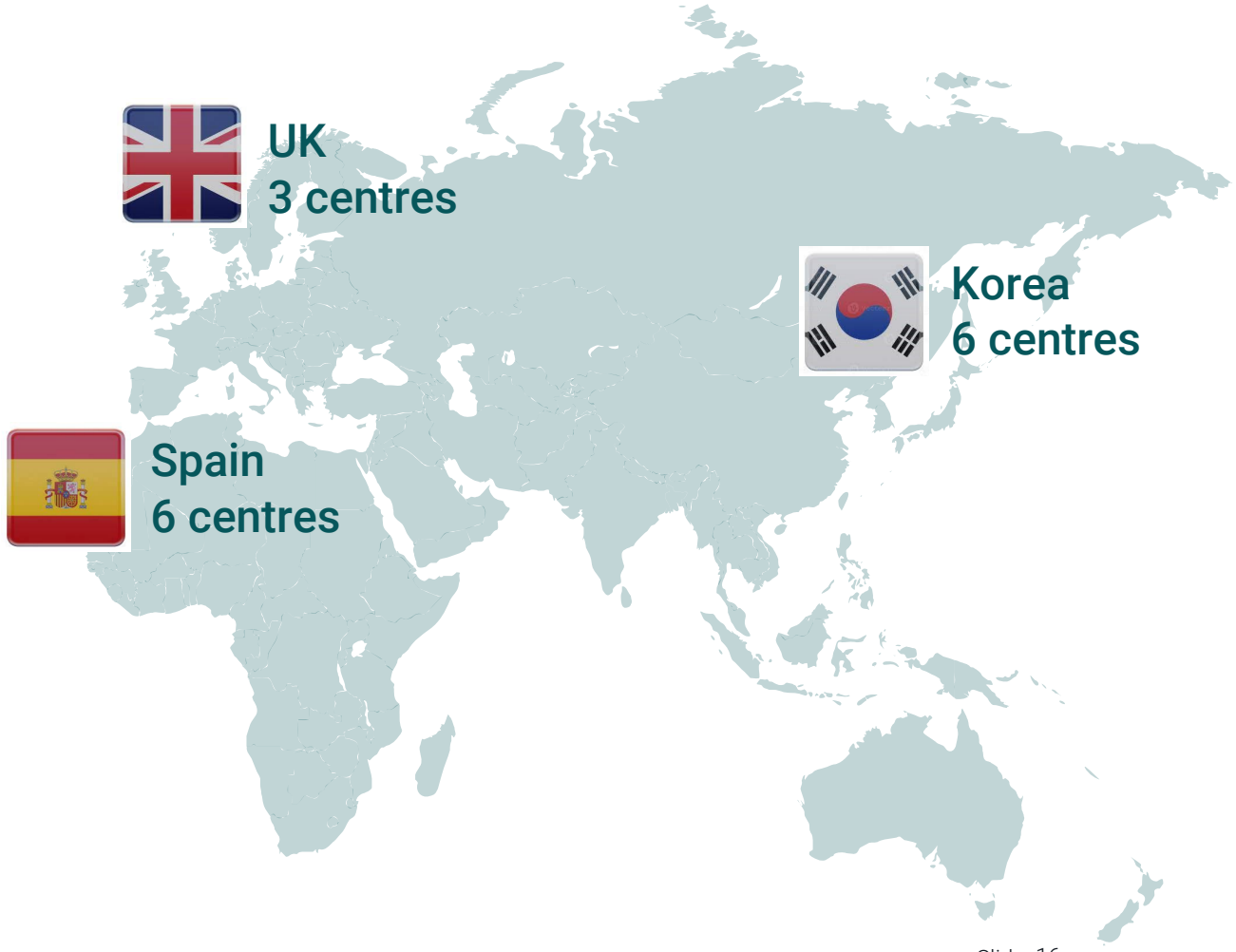
LEN: Oral QD continuous
(8 or 12 mg)



MEDIVIR

*LEN = lenvatinib

Global phase 1b/2a study with fostrox + Lenvima (TKI)



Key study features

- Fostrox + Lenvima in second and third line advanced HCC
- 15 sites in South Korea, Spain and UK
- Rapid recruitment speed, phase 2a dose expansion fully recruited in <5 months
- Median follow-up 10.5 months

MEDIVIR

Patient characteristics reflecting generous inclusion criteria

Patient characteristics[1]	N = 21
Mean age (range)	62 yrs (42 - 82)
Gender, Female / Male (%)	24 / 76
ECOG Performance status 0/1 (%)	71 / 29
Child-Pugh A (%)	100
Viral/Non-viral (%)	76* / 24
Extra hepatic lesion(s) Y/N (%)	67 / 33
AFP ≥400 ng/mL at baseline Y/N (%)**	45 / 55
Region, Asia / Europ (%)	67 / 33
Prior treatment lines; 2nd line/3rd line (%)	81 /19
Prior atezolizumab/bevacizumab in 1L (%)	86
Prior local therapy (TACE, RFA etc)	70
PD on prior treatment (%)	100
Primary refractory on prior therapy (%)***	24
Starting dose fostrox, 20mg / 30mg (%)	14 / 86

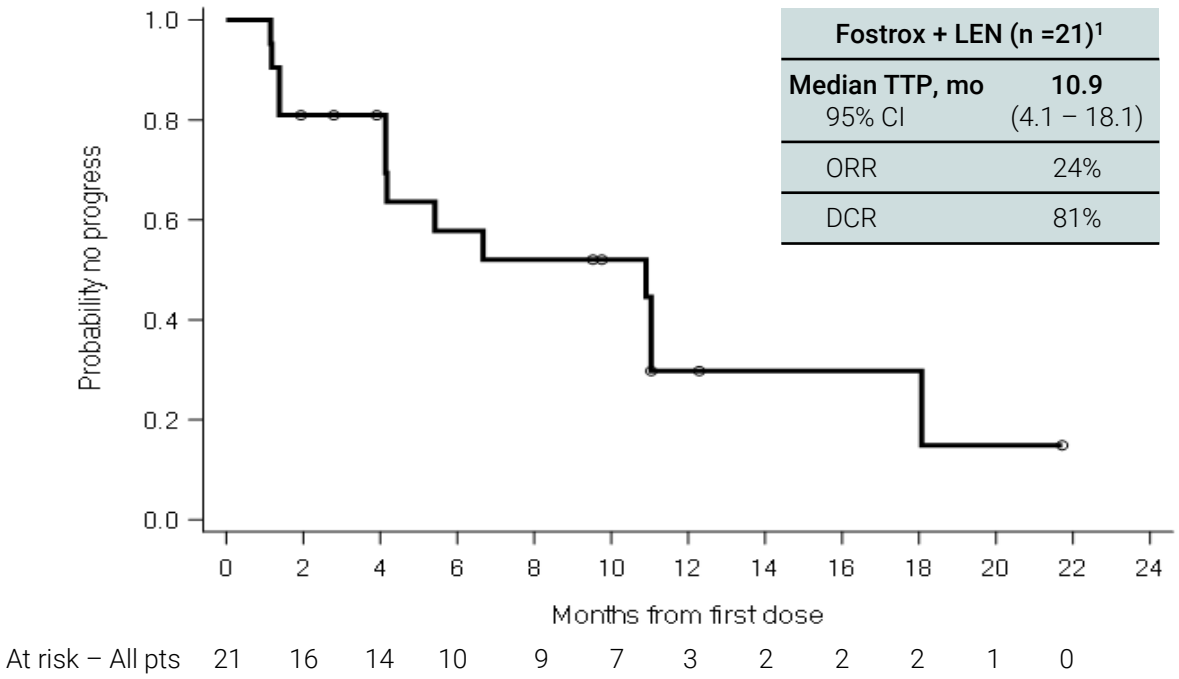
*HepB-81% and HepC-19%; **AFP- NA for 1 pt; ***Active treatment ≤ 12 weeks. Data NA for 3 patients

MEDIVIR

[1]Chon et al., ESMO 2024, Poster 986.

Median TTP 10.9 months, indicating substantially improved efficacy compared with Lenvima alone[1]

Median time to progression (TTP) with fostrox + LEN – investigator review, RECISTv1.1



Fostrox + LEN (n =21)[1]	
Median TTP, mo 95% CI	**10.9** (4.1 – 18.1)
ORR	24%
DCR	81%

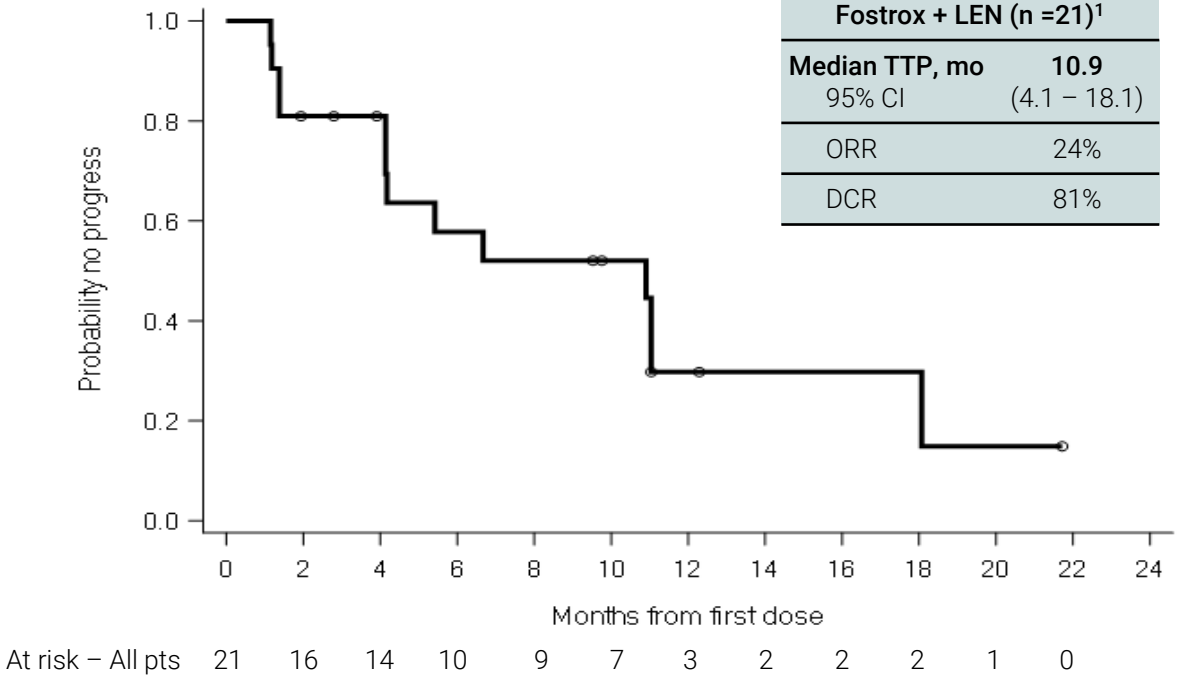
- Median time to progression 10.9 months
- Median follow-up of 10.5 months
- Longest running patient still on treatment > 2 years
- 3 patients remaining on treatment at time of data cut (Aug 19, 2024)

MEDIVIR

[1]Chon et al., ESMO 2024, Poster 986.

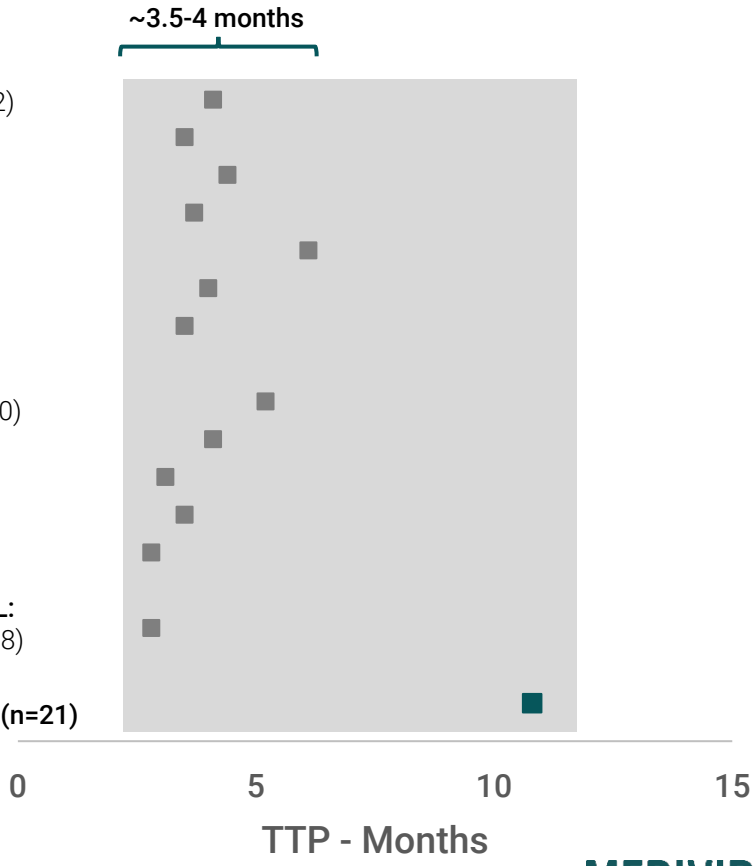
Median time to progression (TTP) 10.9 months, remarkably longer than Lenvima monotherapy and other 2L HCC treatments

Median TTP (Kaplan-Meier) with fostrox + Lenvima



Fostrox + LEN (n =21)[1]	
Median TTP, mo	**10.9**
95% CI	(4.1 – 18.1)
ORR	24%
DCR	81%

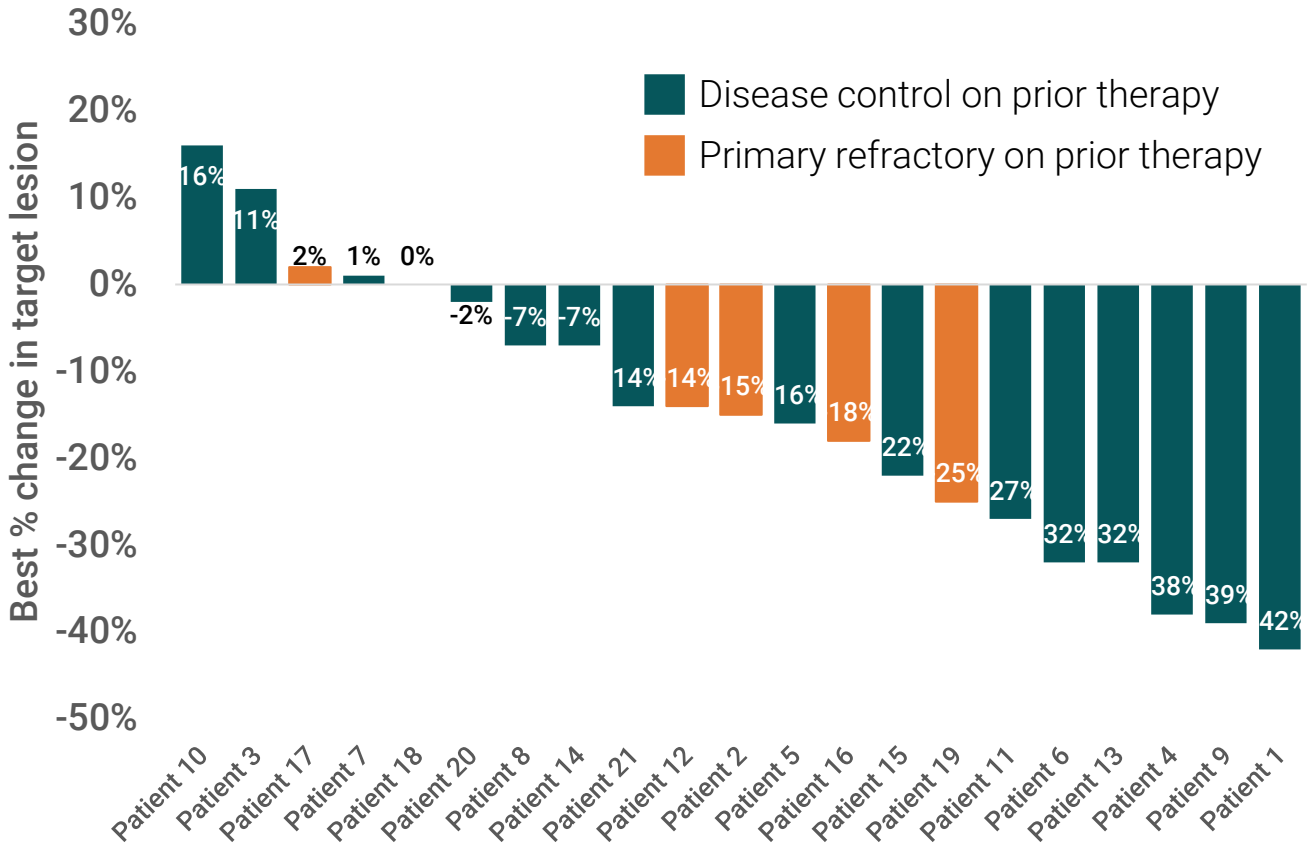
Median TTP/PFS vs previous studies in 2L HCC



[1]Chon et al., ESMO 2024, Poster 986.

More than 75% of patients experiencing tumor shrinkage[1]

Best percentage change in target lesion size related to treatment response in first line



- Median duration of response 7.0 months
- Longest duration of response still ongoing at 19.5 months
- Patients benefitted from treatment independent of outcome in previous line of therapy

MEDIVIR

[1]Chon et al., ESMO 2024, Poster 986.

Fostrox + Lenvima data signals superiority compared with Lenvima monotherapy or IO combo treatments in 2nd line HCC

	Lenvima in 2L HCC[1] – Korea	Lenvima in 2L HCC[2] – Japan	Keytruda + TKI in 2L HCC[3]	Fostrox + Lenvima[4]
Median PFS/TTP	3.5 mo	4.4 mo	2.8 mo	**10.9 mo**
Overall Response Rate	7.5%	15.4%	5.9%	**24%**
Disease Control Rate	67.5%	66.2%	54.4%	**81%**

"The response rate of 24% is higher than historical data of Lenvima alone in 2L, which is 10% or less.

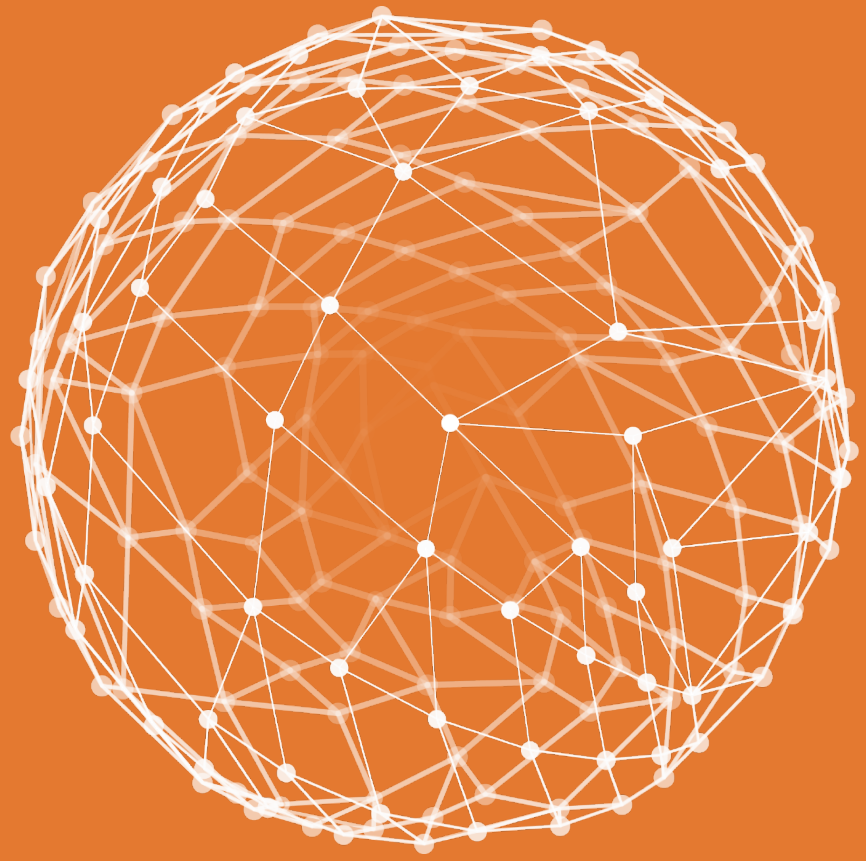
10.9 months TTP is very impressive. In our local data and in clinical trials, we have seen that Lenvima after Tecentriq + Avastin shows 4 months time to progression and around 8 months overall survival."

Dr. Hong Jae Chon, CHA Bundang Hospital, Seoul, Korea
Investigator in Fostrox + Lenvatinib phase 1b/2a

[1]Chon et al. Clinical and Molecular Hepatology 2024 Mar 12
[2]Hiraoka et al., Oncology 2023; 101:624-633
[3]El-Khoueiry et al. ASCO 2024, Abstract 4007
[4]Chon et al, ESMO 2024, Poster 986

MEDIVIR

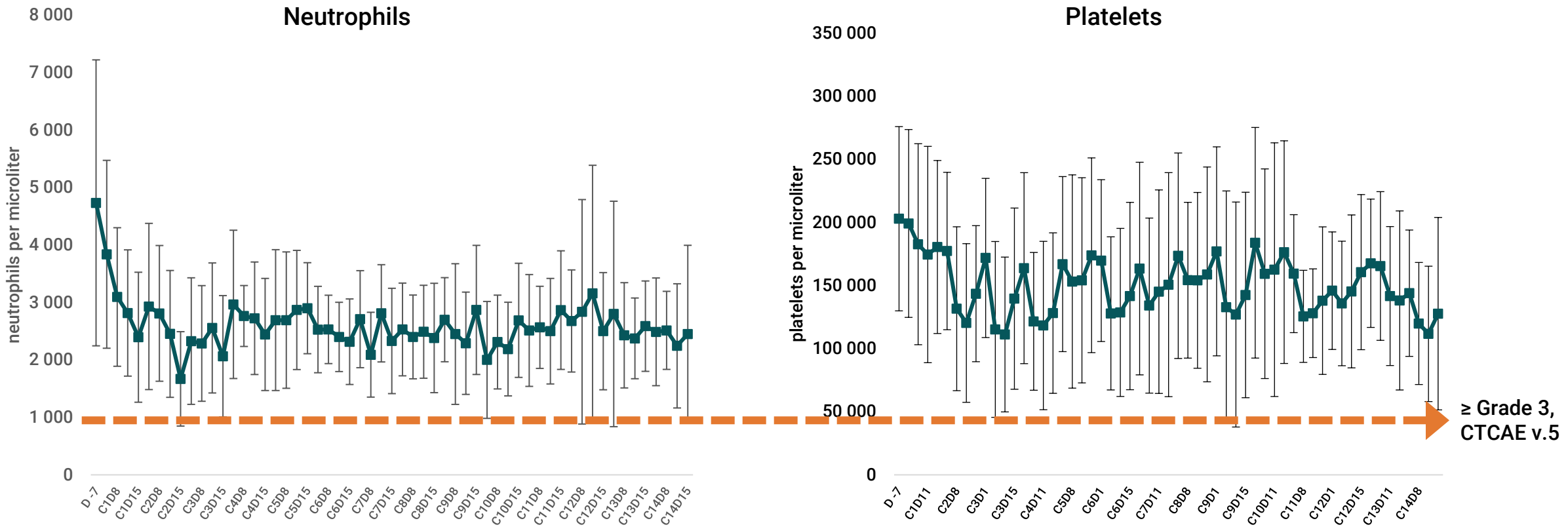
Fostrox + Lenvima shows encouraging tolerability enabling patients to remain on treatment long-term



MEDIVIR

Absolute neutrophile and platelet counts were stable over the course of treatment, enabling long-term use[1]

Longitudinal neutrophil & platelet counts, at all time points measured over first 10 months of treatment



MEDIVIR

[1]Chon et al., ESMO 2024, Poster 986.

Liver targeting properties supports encouraging tolerability profile, enabling patients to remain on treatment long-term

Adverse Events*	Treatment emergent AEs any grade No of pts (%)	Treatment emergent AEs Grade ≥ 3 No of pts (%)	Fostrox Treatment-related Grade ≥ 3 No of pts (%)	LEN Treatment-related Grade ≥ 3 No of pts (%)
Any AE	**21 (100)**	**17 (81)**	**11 (52)**	**14 (67)**
Hematologic AE				
Thrombocytopenia	13 (62)	6 (29)	5 (24)	6 (29)
Neutropenia (no febrile)	10 (48)	8 (38)	8 (38)	6 (29)
Anaemia	7 (33)	3 (14)	3 (14)	3 (14)
Leukocyte decrease	5 (24)	1 (5)	1 (5)	1 (5)
Other AE				
Hypothyroidism	12 (57)			
Diarrhoea	10 (48)	1 (5)		1 (5)
Hand-foot syndrome	10 (48)	1 (5)		1 (5)
Fatigue	9 (43)			
Asthenia	8 (38)	3 (14)	1 (5)	2 (10)
Decreased appetite	8 (38)			
Proteinuria	7 (33)	1 (5)		1 (5)
Hypertension	6 (29)	2 (10)		2 (10)
Cough	5 (24)			
Pruritus	5 (24)			

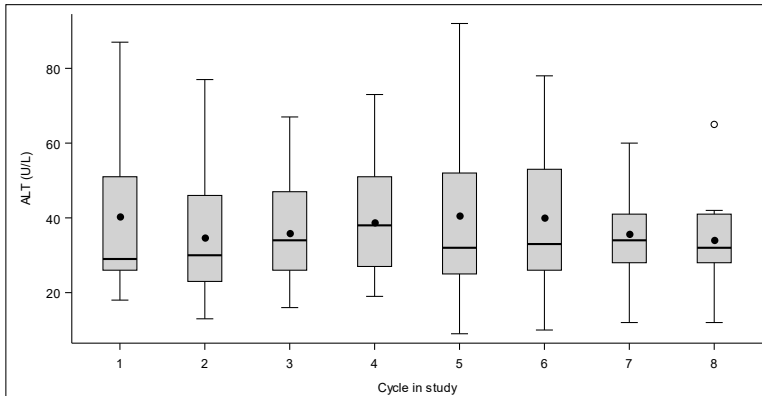
- No unexpected adverse events
- Hematological AEs were transient and manageable in nature
- Grade ≥ 3 events in 11 patients (52%) with only 7 events resulting in dose delay or discontinuation
- No patients with febrile neutropenia or low platelet count with bleeding
- No fostrox related deaths or SAEs

MEDIVIR

[1]Chon et al., ESMO 2024, Poster 986.

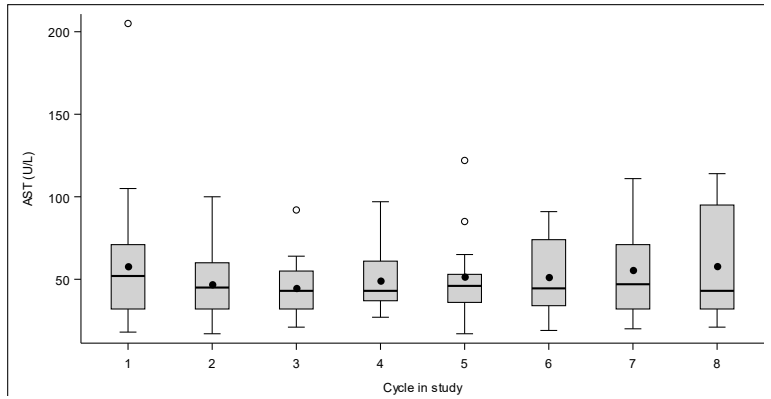
Stable liver function during treatment with fostrox + Lenvima – no deterioration in liver enzymes or change in ALBI score

ALT change over duration of treatment



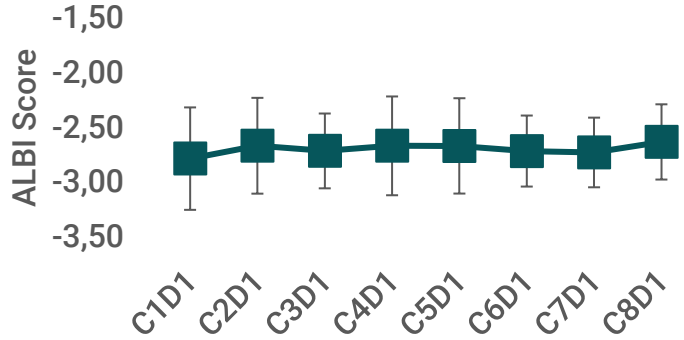
Patients At risk	21	21	16	15	14	14	11	10

AST change over duration of treatment



Patients At risk	21	21	16	15	14	14	11	10

ALBI score change over duration of treatment

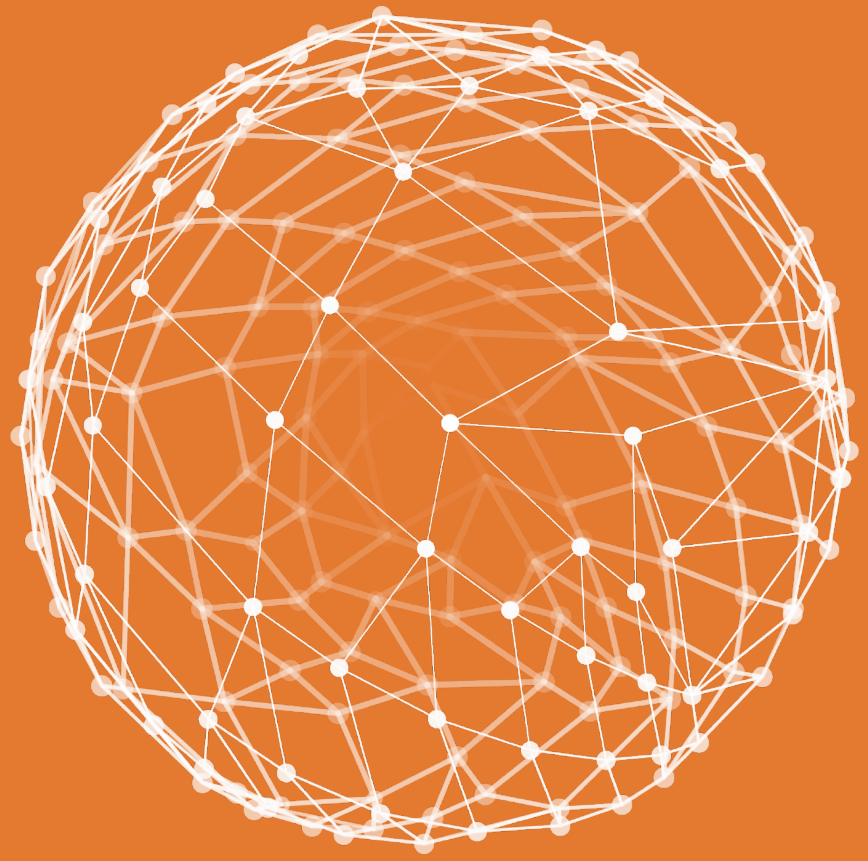


Patients At risk	21	21	16	15	14	14	11	10

MEDIVIR

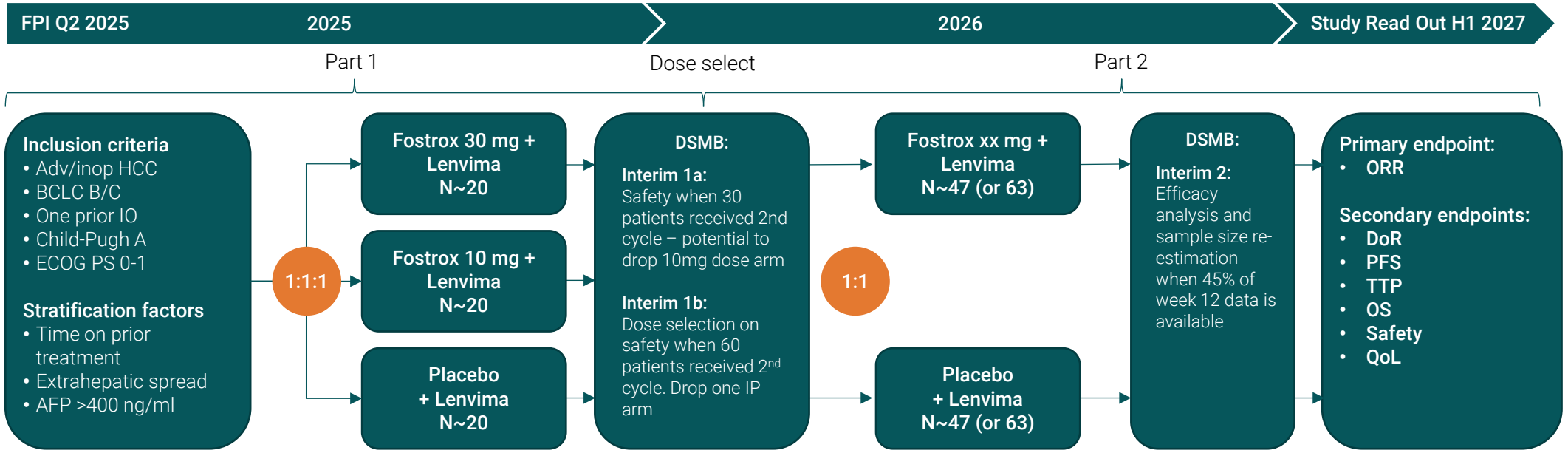
[1]Chon et al., ESMO GI 2024, Poster 176.

Randomized phase 2b to enable breakthrough designation & accelerated approval



MEDIVIR

Phase 2b; dose optimization run in & adaptive design to enable breakthrough therapy designation & accelerated approval filing



Statistics

- **Total sample size = 154**
- Interim 1a/1b (safety): dose selection based on safety (descriptive)
- Interim 2 (efficacy) with possible adaptations, when 45% of pts been treated for >12-week
  - Stop and claim efficacy using O'Brian Flemming boundary
  - Continue as planned (final analysis on 154 subjects (20 + 67 + 67)
  - Increase sample size with 25% to gain power if promising results in IA (promising zone: 0.3<CP<0.8) (Final analysis on 186 subjects (20 + 83 + 83))
  - Non-binding stop for futility if conditional power (CP) <2.5%
- Power >80% to detect difference in ORR 10% in control group and 25% in IP group using a one-sided test at significance level 10%. 10% dropouts are assumed

Time estimate and sites:

- Enrolment: 16 months (may be extended to ~62 weeks if decision to increase sample size in interim 2)
- Primary endpoint FU: 6 months
- Active study duration: ~22 months
- Total survival FU: 24 months
- 40 sites in 8 countries in the US, Europe and Asia

MEDIVIR

Coordinating PI and US PI for fostrox + Lenvima phase 2b study among the most well renowned global HCC thought leaders

Dr. Maria Reig – Coordinating PI

- Head of the BCLC (Barcelona Clinic for Liver Cancer), who authors the globally renowned BCLC treatment guidelines for liver cancer
- Head of Liver Oncology Unit at Hospital Clinic of Barcelona in Spain.
- Her expertise and area of interest is the development of prognostic models for patients with liver cancer and evaluation of treatment options as well as new research about immune modulation and cancer emergence after antiviral treatment.

Dr. Anthony B. El-Khoueiry, MD – US PI

- Associate Director for Clinical Research at USC Norris and Associate Professor of Clinical Medicine at the Keck School of Medicine of USC.
- He has led several multicenter trials in HCC, including checkmate 040 with nivolumab (PD-1) in patients with HCC which resulted in accelerated approval by the FDA.
- He also served on the steering committee of international studies such as the randomized phase 3 study of cabozantinib, which culminated in the approval of cabozantinib inHCC.

MEDIVIR

Highly distinguished steering committee
Phase 2b fostrox + Lenvima vs Lenvima

Dr. Maria Reig – Coordinating PI

- Head of the BCLC and Liver Oncology Unit at Hospital Clinic of Barcelona in Spain.
- Her expertise and area of interest is the development of prognostic models for patients with liver cancer and evaluation of treatment options as well as new research about immune modulation and cancer emergence after antiviral treatment.

Dr. Jeff Evans

- Professor of Translational Cancer Research in the School of Cancer Sciences, Univ. of Glasgow & honorary Consultant in Medical Oncology at Beatson West of Scotland Cancer Centre
- He is the Lead of the Glasgow Experimental Cancer Medicine Centre (ECMC) and National Clinical Lead of the NHS Scotland Cancer Research Network.

Dr. Arndt Vogel

- Managing senior consultant and Prof. in the Department of Gastroenterology, Hepatology and Endocrinology at Hannover Medical School.
- Member of the ESMO Guidelines Steering Committee and coordinator of the ESMO clinical practice guideline on the management of HCC and BTC.

Dr. Anthony B. El-Khoueiry, MD – US PI

- Associate Director for Clinical Research at USC Norris and Associate Professor of Clinical Medicine at the Keck School of Medicine of USC.
- Member of the National Cancer Institute Hepatobiliary Cancers Task Force and chair of the Southwest Oncology Group hepatobiliary cancers subcommittee.

Dr. Hong Jae Chon

- Professor, Medical Oncology, CHA Bundang Medical Center, CHA University, Korea
- Professor Chon has held a number of academic positions, university & hospital appointments and has extensive experience from phase I-IV clinical trials in HCC.

Dr. Lorenza Rimassa

- Associate Professor of Medical Oncology, Humanitas Research Hospital, Milan, Italy & Head of HepatoPancreatoBiliary at IRCCS Humanitas Research Hospital
- Treasurer, member of the Executive Committee and Governing Board of the International Liver Cancer Association (ILCA)

MEDIVIR

Fostrox – The first oral, liver-targeted treatment tailored for HCC

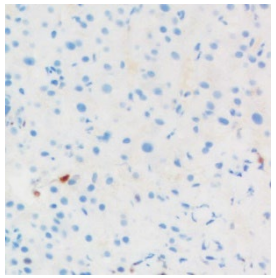
Oral, liver-activated small molecule inducing DNA damage in tumor cells, sparing healthy liver cells[3]

Unique, liver-targeted approach in HCC

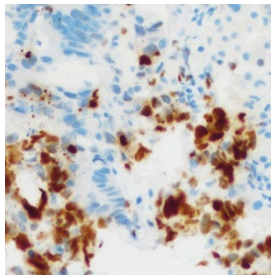
Liver-guided delivery – prodrug

Tumor-selective payload – troxacitabine

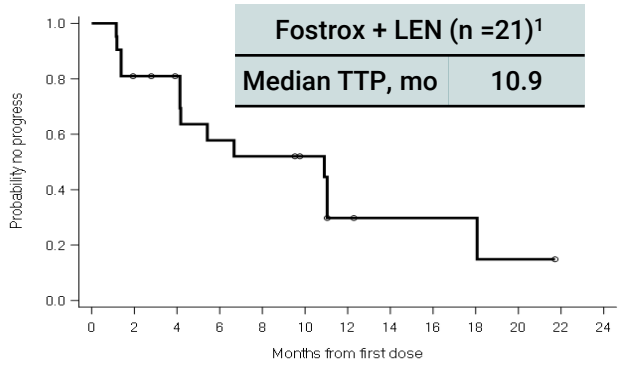
No DNA damage in healthy liver tissue



DNA damage in tumor tissue



10.9 months time to progression, substantially better than SoC[1,2]



*see slide 20 for details regarding individual study data

Absence of effective treatment options in 2nd line enables first-to-market opportunity for fostrox + Lenvima

- No 2nd line treatments approved in advanced HCC
- Global phase 2b start H1 '25
- Designed to enable breakthrough designation and support accelerated approval process

Market opportunity in 2nd line HCC >$2.5bn, with significant upside potential

>$2.5bn

2nd line HCC market by 2030, fastest growing cause of cancer death in US[4]

Significant upside in liver metastasis from other solid tumors

[1]Chon et al., ESMO, 2024, Poster 986
[2]Based on data from previous 2L phase 3 HCC studies with Stivarga, Cyramza & Cabometyx and investigator initiated prospective & retrospective 2L studies with Lenvatinib
[3]Evans et al ASCO GI, 2021
[4]Ma et al., Cancer, June 15, 2019; 2089-2098

MEDIVIR

Board with extensive early & late stage drug development experience

- **Chairman of the Board – Dr. Uli Hacksell**
- Member since 2018, Chairman since 2021
- Over 30 years pharma & biotech experience, including 10 years' experience as CEO of publicly owned companies

- **Dr. Bengt Westermark, Prof Tumor Biology**
- Member since 2017
- Published >300 papers in scientific journals, primarily on the mechanisms of uncontrolled growth of cancer cells.

- **Dr. Anna Törner, Ph D Statistics, MScs Pharmacy**
- Broad experience from drug development, especially regulatory affairs
- Founder consulting company SDS Life Science within drug development and statistics.

- **Dr. Lennart Hansson, Ph D Genetics**
- Member since 2018
- Extensive experience of pharmaceutical & commercial development in biotech & pharma companies.

- **Dr. Yilmaz Mashid, Ph D Medical Sciences**
- CFO at Egetis Therapeutics AB with prior experience at at Industrifonden and Pareto Securities.
- Previous experience from Biolipox and Orexo.

- **Dr. Angelica Loskog, Ph D, Clin. Immunology**
- CEO Lokon Pharma & scientific advisor at venture cap Nexttobe
- More than 25 year's academic drug development experience within immune oncology

MEDIVIR

Thank You!