Sobi KOL investor event

The journey for Vonjo®

19 July 2023

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Agenda and presenters

Opening remarks		Guido Oelkers, Chief Executive Officer Swedish Orphan Biovitrum
Overview of Myelofibrosis and Vonjo		John Mascarenhas, Professor of Medicine Icahn School of Medicine at Mount Sinai
Emerging Insights & Future Potential of Pacritinib		Sarah Buckley, Medicine Development Lead Swedish Orphan Biovitrum
Summary and Q&A		

Vonjo is part of our journey to build the leading rare haematology portfolio

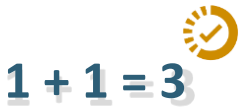
Leading products in Haemophilia A and B	*Only oral TPO-RA with no food restrictions and clean safety profile*	*First in class C3 inhibitor and only sub-cutaneous therapy in PNH*	*Safe and efficacious CD-19 ADC in severe DLBCL*	**First and only JAK1-sparing inhibitor that targets both JAK2 and IRAK1***
ELOCTA® efmoroctocog alfa (recombinant human coagulation factor VIII, Fc fusion protein) ALPROLIX™ [Coagulation Factor IX (Recombinant), Fc Fusion Protein] **Efanesoctocog alfa**	Doptelet® (avatrombopag) tablets	ASPAVELI® (pegcetacoplan)	Zynlonta	VONJO® (pacritinib) capsules

* Approved under accelerated approval in the US for the treatment of adults with intermediate or high-risk primary or secondary (post-polycythaemia vera or post-essential thrombocythemia) myelofibrosis with a platelet count below 50 x 10^9/L.

Well-prepared CTI integration capturing Vonjo's value

Positive and smooth first two weeks focused on seamless continuation of Vonjo operations

Life-cycle management planning initiated for geographic expansion and extended indications



Thoughtful strategy to maximize Vonjo's potential and synergies beyond cost savings

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Myelofibrosis is a blood cancer with clinical features including splenomegaly and abnormal blood counts

Abnormal haematopoiesis:
driven by mutations
affecting the JAK/STAT pathway[1]

Splenomegaly: resulting from
bone marrow fibrosis and
extramedullary hematopoiesis[2]

Myelofibrosis symptoms:
resulting from aberrant cytokine
production and splenomegaly[2]

References: 1. O'Sullivan JM, Harrison CN. Mol Cell Endocrinol. 2017;451:71-79. **2.** Mascarenhas J, et al. Leukaemia. 2023;37:255-264.

Symptoms and associated disease complications impact QoL and prognosis of myelofibrosis patients

Symptoms

Symptoms of MF may go unrecognized in early disease, but with **progression** they can lead to **reduced QoL**, **functional status**, and **activities of daily living**[1-3]

Haematology-Driven Symptoms
e.g., fatigue/inactivity experienced by nearly all patients[4]

Cytokine-Driven Constitutional Symptoms
e.g., night sweats, itching, bone pain, fever, weight loss, and cough[4]

Splenomegaly-Related Symptoms
e.g., early satiety and abdominal pain/discomfort[4]

Complications

20% risk of leukemic transformation within 10 years[5]

30% have thrombosis or thromboembolism, and 10% have bleeding events[6,7]

5-6 years median overall survival[8]

QoL=quality of life.

References: 1. Anderson LA, et al. Am J Hematol. 2015;90(19):864-870. **2.** Mesa R, et al. BMC Cancer. 2016;16:167. **3.** Harrison CN, et al. Ann Hematol. 2017;96(10):1653-1665. **4.** Emanuel RM, et al. J Clin Oncol. 2012;30(33):4098-4103. **5.** Gangat N, et al. J Clin Oncol. 2011;29(4):392-397. **6.** Kaifie A, et al. J Hematol Oncol. 2016;9:18. **7.** Devendra KC, Falchi L and Verstovsek S. Ann Hematol. 2017;96(10):1595-1604. **8.** Masarova L, et al. Cancer. 2022;128(8):1658-1665.

Myelofibrosis is characterised by activated JAK-STAT signalling and inflammation

Different pathways involved in myelofibrosis

JAK-STAT Pathway[1-5]

Myddosome/IRAK1 Pathway[5-6]

Proinflammatory cytokines

Haematopoiesis (dysregulated in MPNs)

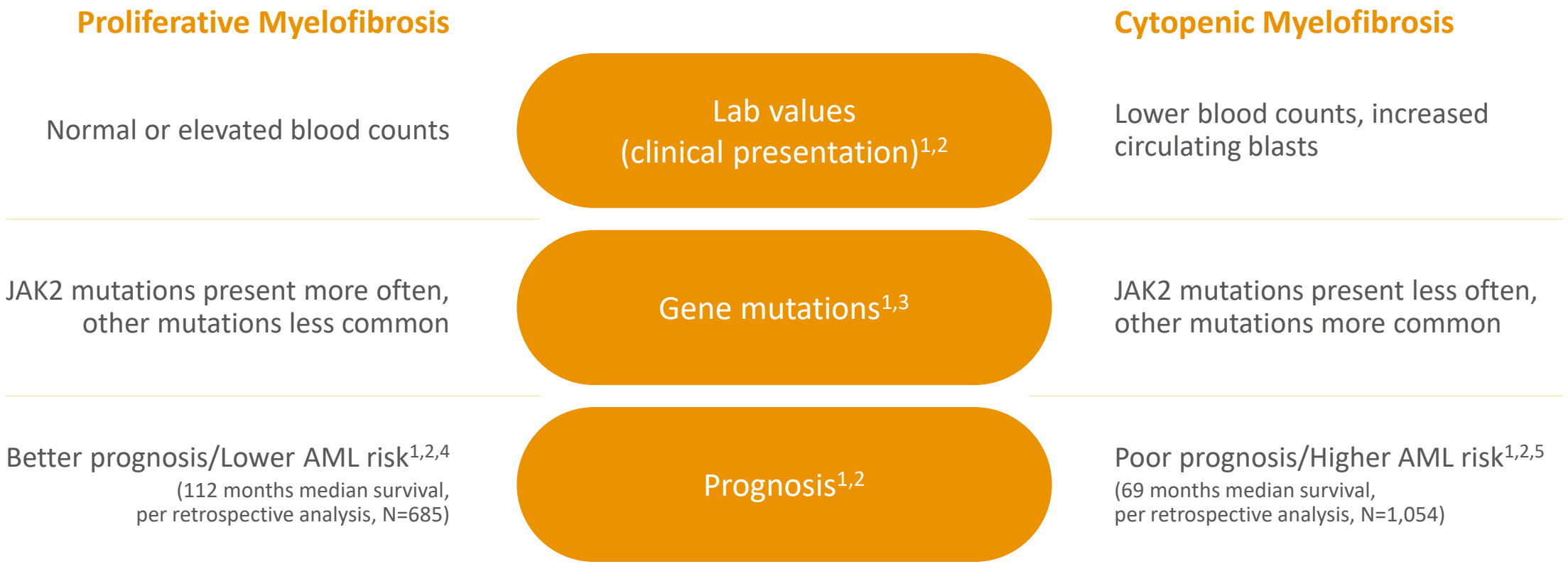
Proinflammatory cytokines, Haematopoiesis, Inflammation

IRAK1=interleukin 1 receptor-associated kinase; JAK=Janus kinase; MPN=myeloproliferative neoplasms; NFκB=Nuclear factor kappa-light-chain-enhancer of activated B cells; STAT=signal transducer and activator of transcription.

References: 1. O'Sullivan JM, Harrison CN. Mol Cell Endocrinol. 2017;451:71-79. **2.** Tefferi A. Am J Hematol. 2021;96(1):145-162. **3.** Tefferi A, et al. Am J Hematol. 2018;93(3):348-355. **4.** Kleppe M, et al. Cell Stem Cell. 2017;5:21(4):489-501. **5**. Mascarenhas J, et al. Leukaemia. 2023;37:255-264. **6.** Singer JW, et al. Oncotarget. 2018;9(70):33416-33439.

Proliferative and cytopenic MF are clinically and biologically different and present across a spectrum

The Phenotypic Spectrum of Myelofibrosis[1,2]



AML=acute myeloid leukaemia; JAK2=Janus kinase 2; MF=myelofibrosis.

References: 1. Mascarenhas J, et al. Leukaemia. 2023;37:255-264. **2.** Marcellino BK, et al. Clin Lymphoma Myeloma Leuk. 2020;20(7):415-421. **3.** Vainchenker W and Kralovics R. Blood. 2017;129(6):667-669. **4.** Passamonti F, et al. Leukaemia. 2017;31:2726-2731. **5.** Cervantes F, et al. Blood. 2009;113(13):2895-2901.

Cytopenias are a common feature of MF progression and a frequent side effect of JAK1/2 inhibitors

Thrombocytopenia

Prevalence of moderate-to-severe thrombocytopenia[a] in patients with MF rises over time[1-3†]

Anaemia

Prevalence of anaemia[b] in patients with MF rises over time and is often an anticipated downside of current therapies[4-6‡]

[a] Moderate-and-severe thrombocytopenia is defined as platelet counts <100 x 10^9/L. [b] Anaemia is defined as haemoglobin <10 g/dL. † Prevalence at presentation from a retrospective cohort analysis of 1281 patients with thrombocytopenia presented at a single centre between Jan 1984 and Dec 2015; prevalence at 1-year post-diagnosis from TriNetX; prevalence any time during course of the disease from a recent survey of >800 haematologists/oncologists from 12 countries. ‡ Prevalence at diagnosis and within 1 year of diagnosis among 1000 Mayo Clinic patients with primary MF. JAK=Janus associated kinase; MF=myelofibrosis

References: 1. Masarova L, et al. Leuk Res. 2020;91:106338. **2.** Masarova L, et al. Eur J Haematol. 2018;100(3):257-263. **3.** TriNetX. Dataworks US EMR Database. Accessed March 2021. https://trinetx.com/. **4.** Tefferi A, et al. Mayo Clin Proc. 2012;87(1):25-33. **5.** Naymagon L, et al. HemaSphere. 2017;1(1):e1. **6.** Tefferi A, et al. Clin Ther. 2014;36(4):560-566.

Myelofibrosis patients with severe cytopenias have significantly shorter overall survival

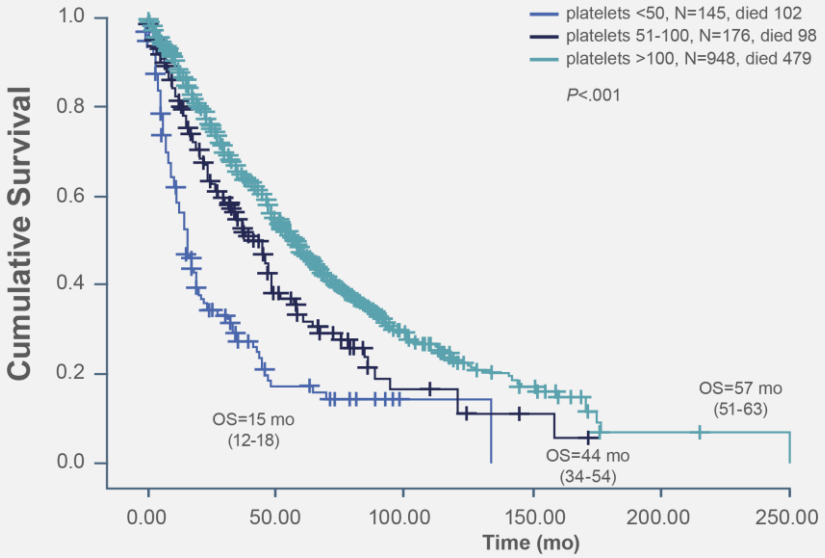
Worst survival in cytopenic myelofibrosis patients[1,2]

Patients frequently have more than one cytopenia

~70% of thrombocytopenic patients also have anaemia[3,4]

Thrombocytopenia

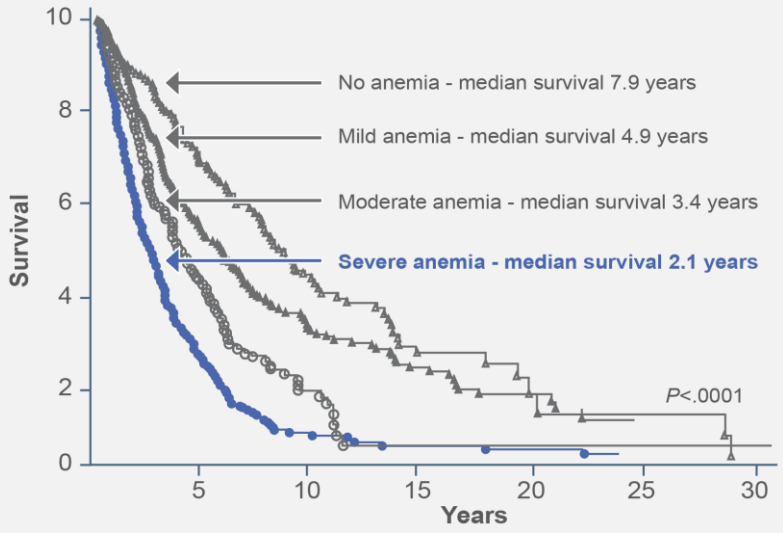
OS in patients with MF by platelet count[1]



1.25 years **Median OS (PLT<50 x 10^9/L)**

Anaemia

OS in patients with MF by degree of anaemia[2]



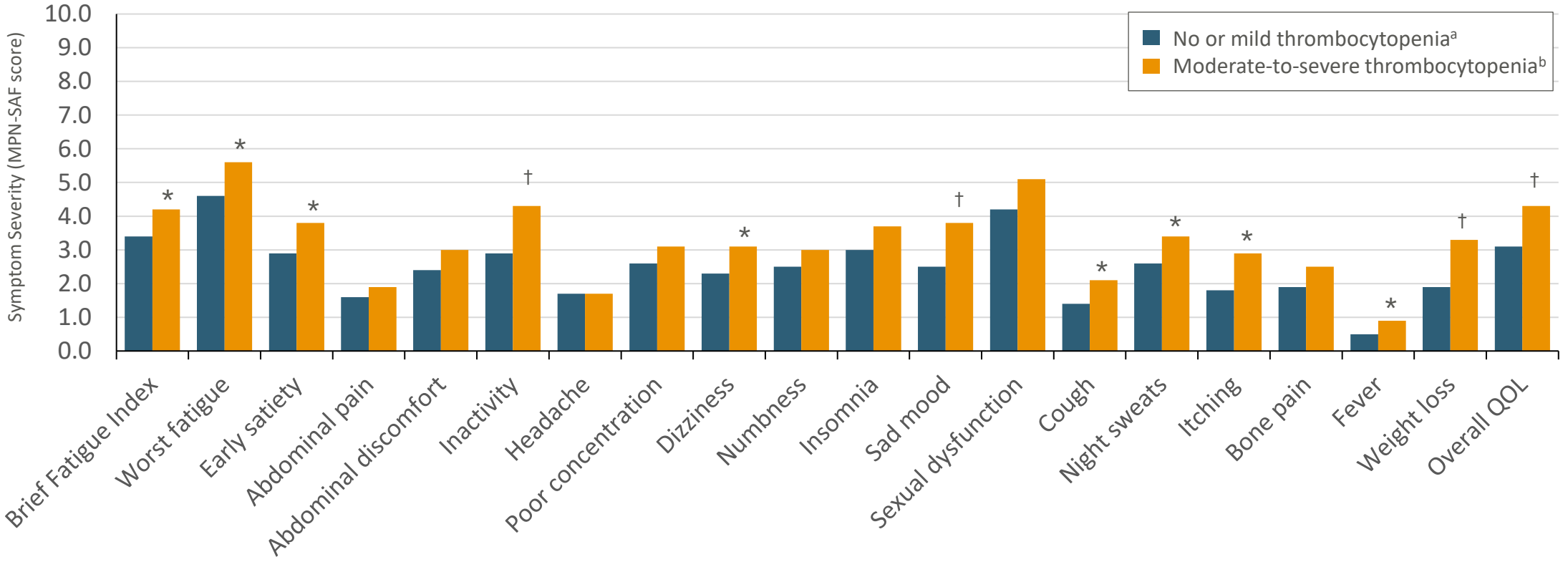
2.1 years **Median OS (HB <8 g/dL or TD)**

HB=haemoglobin; MF=myelofibrosis; mo=months; OS=overall survival; PLT=platelet count; TD=transfusion dependent, Gale criteria.

References: 1. Masarova L, et al. Eur J Haematol. 2018;100(3):257-263. **2.** Nicolosi M, et al. Leukemia. 2018;32(5):1254-1258. **3.** Scotch AH, et al. Leuk Res. 2017;63:34-40. **4.** Hernandez-Boluda JC, et al. Br J Haematol. 2018;181(3):397-400

Symptom burden is also worse in myelofibrosis patients with thrombocytopenia

Symptom burden in myelofibrosis patients with thrombocytopenia[1]

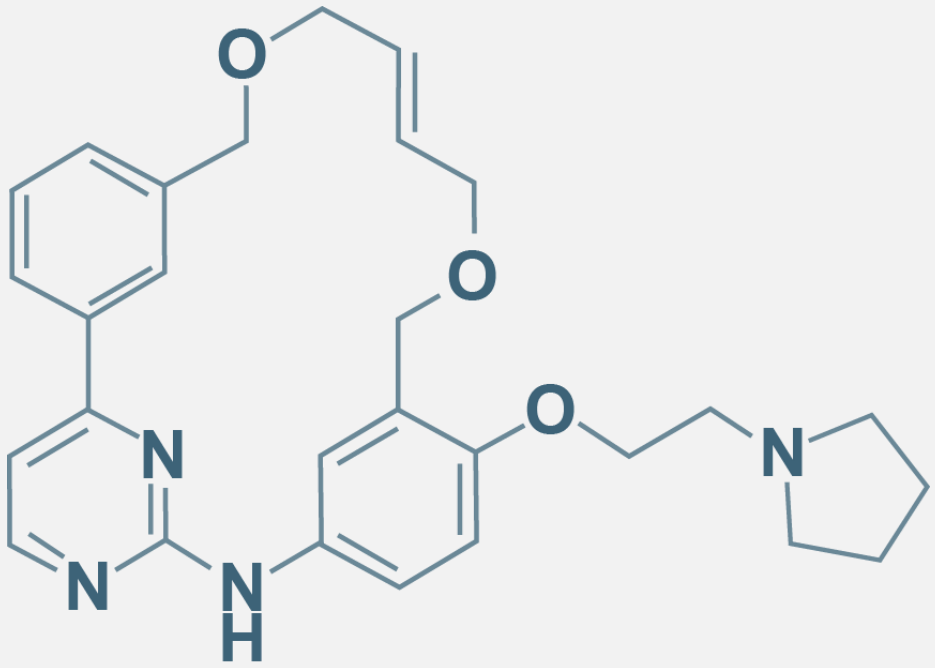


[a] No or mild thrombocytopenia is defined as platelet counts >100 x 10^9/L. [b] Moderate-to-severe thrombocytopenia is defined as platelet counts ≤100 x 10^9/L. * P<0.05. † P<0.001.
MPN-SAF=Myeloproliferative Neoplasm Symptom Assessment Form; QOL=Quality of life.

Reference: 1. Scotch A, et al. Leuk Res. 2017;63:34-40.

Pacritinib is the only approved JAK inhibitor studied in MF patients with platelet counts <50 x 10^9/L at baseline

Pacritinib



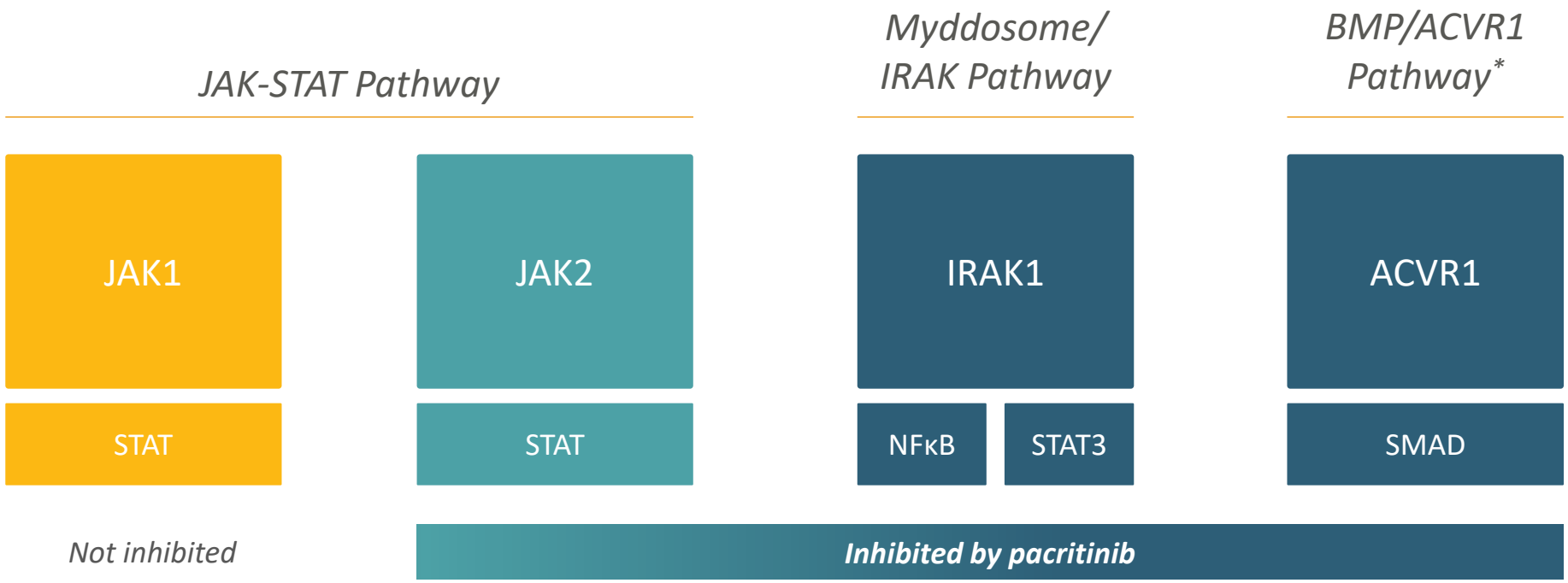
Pacritinib is indicated in the US for the treatment of adults with intermediate or high-risk primary or secondary (post-polycythaemia vera or post-essential thrombocythemia) **myelofibrosis with severe thrombocytopenia (platelet counts <50 x 10^9/L)**.[1]

This indication is approved under accelerated approval based on spleen volume reduction. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial(s).

Note: Pacritinib is currently only approved in the US. JAK=Janus associated kinase; MF=myelofibrosis.

References: 1. VONJO®. Prescribing information. CTI BioPharma Corp.; 2022.

Pacritinib is a JAK1-sparing JAK2 inhibitor that acts on multiple pathways involved in myelofibrosis



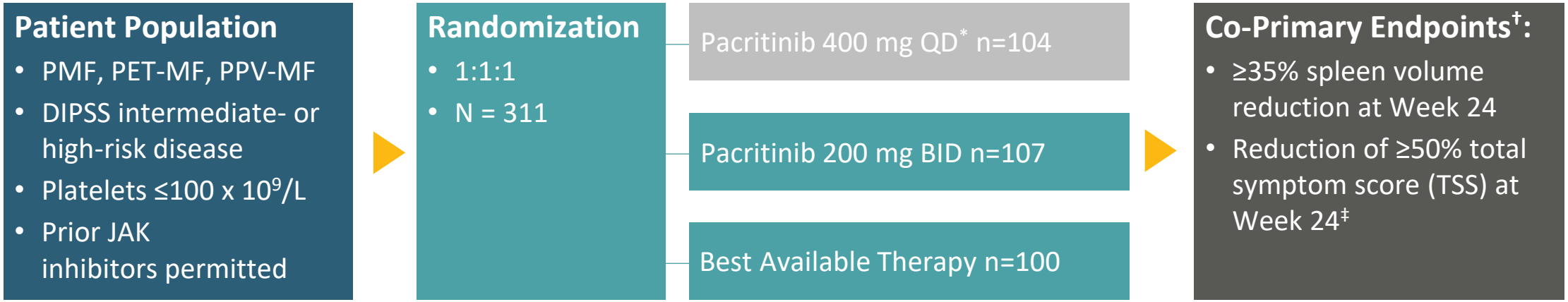
* Published data on file. This pathway is not currently referenced in the USPI.

ACVR1=activin receptor-like kinase-2; IRAK1=interleukin 1 receptor–associated kinase; JAK=Janus associated kinase; NFκB=nuclear factor kappa light chain enhancer of activated B cells; STAT=signal transducer and activator of transcription.

References: 1. Mascarenhas et al. Leukemia. 2023:37:255-264. **2.** O'Sullivan JM, Harrison CN. Mol Cell Endocrinol. 2017;451:71-79. **3.** Singer JW, et al. Oncotarget. 2018;9(70):33416-33439.

Pacritinib received accelerated FDA approval in February 2022 based on data from PERSIST-2

PERSIST-2 study design[1]



Efficacy was established on spleen volume reduction in patients who received pacritinib 200 mg twice daily and had a platelet count <50 x 10^9 (N=31)[2]

Safety data are based off the 106 patients who were treated with pacritinib 200 mg twice daily[2]

Note: Accelerated approval is based on efficacy data from PERSIST-2 and safety data from PERSIST-2 and PAC203 (a phase 2 dose-finding study). Continued approval may be contingent upon verification and description of clinical benefit in Phase 3 PACIFICA confirmatory study. * The 400 mg once daily dose could not be established to be safe, so further information on this arm is not provided. † The efficacy population included patients who received pacritinib 200 mg BID (n=31) or BAT (n=32) and had baseline platelet counts <50 x 10^9/L. ‡ Limitation: No conclusions regarding the benefits or risks of pacritinib can be established based on the TSS data from PERSIST-2. These data are not included in the VONJO® Prescribing Information. BID=twice daily; DIPSS=Dynamic International Prognostic Scoring System; MF=myelofibrosis; PET-MF=post-essential thrombocythemia MF; PMF=primary MF; PPV-MF=post-polycythaemia vera MF; QD=once daily.

References: 1. Mascarenhas J, et al., JAMA Oncol. 2018;4(5):652-659. **2.** VONJO®. Prescribing information. CTI BioPharma Corp.; 2022.

Baseline demographics

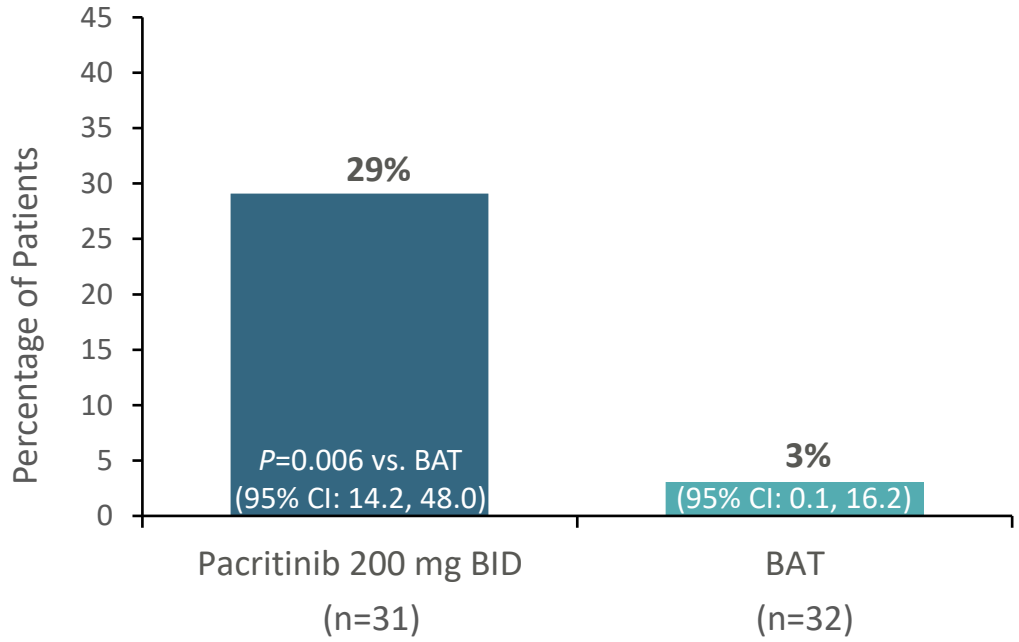
Characteristics	**PERSIST-2 patient demographics** (ITT population; N=311)[1]		
Median age	68 years (range 32 to 91)		
Gender	55% male, 45% female		
Ethnicity	86% Caucasian, 14% non-Caucasian		
Median baseline platelet count	55 x 10^9/L • 45% of patients had Grade ≥3 thrombocytopenia (platelet count <50 x 10^9/L)		
Median baseline haemoglobin	9.5 g/dL • 23% of patients were red blood cell transfusion dependent at study entry		
Prior ruxolitinib therapy	Vonjo arm (n=211): 46%	BAT arm (n=100): 51%	
Disease history	Primary MF: 68%	PPV-MF: 20%	PET-MF: 12%
Baseline median spleen length	14 cm assessed by magnetic resonance imaging or computerized axial tomography		

BAT=best available therapy; ITT=intent-to-treat; MF=myelofibrosis; PET-MF=post-essential thrombocythemia MF; PPV-MF=post-polycythaemia vera MF.

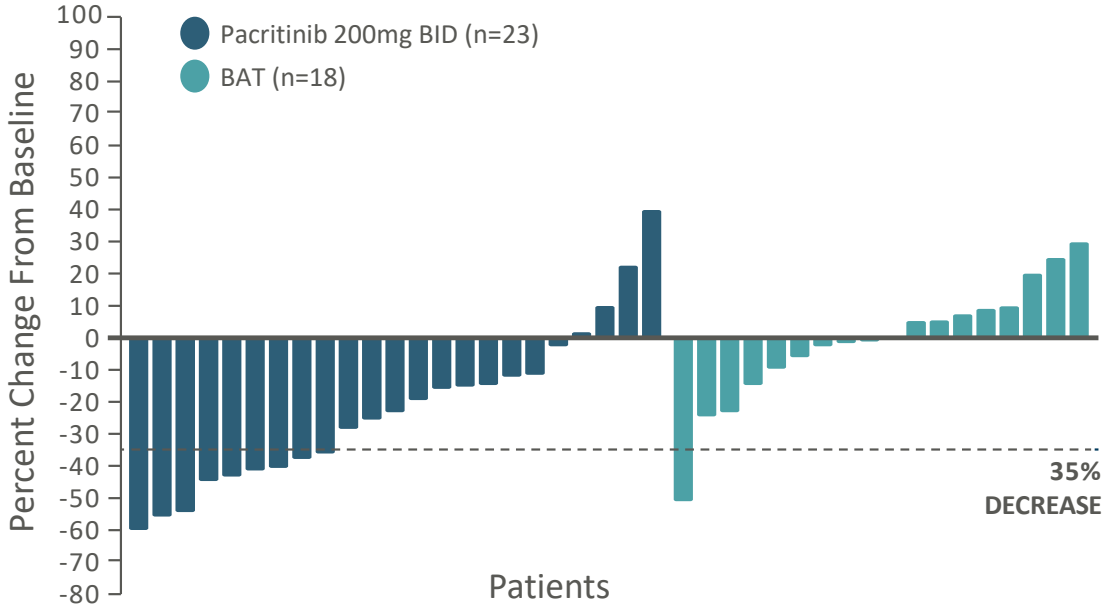
References: 1. VONJO®. Prescribing information. CTI BioPharma Corp.; 2022.

Pacritinib approval was based on spleen volume reduction in severely thrombocytopenic MF patients

Percentage of patients with platelet counts <50 x 10^9/L achieving ≥35% SVR from baseline to Week 24 (ITT Efficacy Population)[1]



Median percent change from baseline in spleen volume at Week 24 in patients with platelet counts <50 x 10^9/L (ITT Efficacy Population)[1*†]



* Dropout rates in pacritinib and BAT arms were 26% and 44%, respectively.
† Only patients with an available SVR percent change value at Week 24 were included in the waterfall plot.

Patients on pacritinib were ~10x more likely to achieve ≥35% SVR vs BAT (29% vs 3%)

83% of patients on pacritinib experienced any SVR compared to 56% of patients on BAT in the efficacy population (platelet count <50 x 10^9/L)†

BAT=best available therapy; BID=twice daily; CI=confidence interval, ITT=intent-to-treat; MF=myelofibrosis; SVR=spleen volume reduction.

References: 1. VONJO®. Prescribing information. CTI BioPharma Corp.; 2022

Pacritinib was observed to be generally well tolerated

Key safety overview from PERSIST-2[1]

Most common adverse events of any grade occurring in ≥20% of patients (N=106) treated with PAC 200mg BID were diarrhoea (45%), thrombocytopenia (32%), nausea (30%), anaemia (23%) and peripheral oedema (19%)

- Most cases of **diarrhoea** were low-grade, manageable with loperamide and resolved within 1-2 weeks[1,2]

Serious adverse reactions occurred in 47% of patients treated with PAC 200 mg BID and in 31% of patients treated with BAT

- The most frequent serious adverse reactions occurring ≥3% in patients receiving PAC 200 mg BID were anaemia (8%), thrombocytopenia (6%), pneumonia (6%), cardiac failure (4%), disease progression (3%), pyrexia (3%), and squamous cell carcinoma of skin (3%)

Fatal adverse reactions occurred in 8% of patients receiving PAC 200 mg BID and in 9% of patients treated with BAT

BID=twice daily; PAC=pacritinib.

References: 1. VONJO®. Prescribing information. CTI BioPharma Corp.; 2022. **2.** Mascarenhas J, et al. JAMA Oncol. 2018;4(5):652-659.

A post hoc risk-adjusted safety analysis showed favourable safety profile for pacritinib 200 mg BID

Events per 100 patient-years are calculated as 100 times the number of patients with an event divided by the cumulative time on treatment for each patient until the first adverse event for patients with an event otherwise the last dose of treatment

Patients with Events Per 100 Patient-Years at Risk[1]

	Pooled PAC (PERSIST-2/PAC203*) (n=160)	BAT (n=98)	BAT=RUX (n=44)
Cardiac event[a]	62	81	67
Bleeding event[a]	98	129	127
Thrombosis[b]	4	2	6
Non-melanoma skin cancer events[c]	5	7	11
Infection event[d]	116	88	80
Zoster reactivation[e]	0	2	6
Fungal infection[f]	6	12	6
Deaths	12	22	27

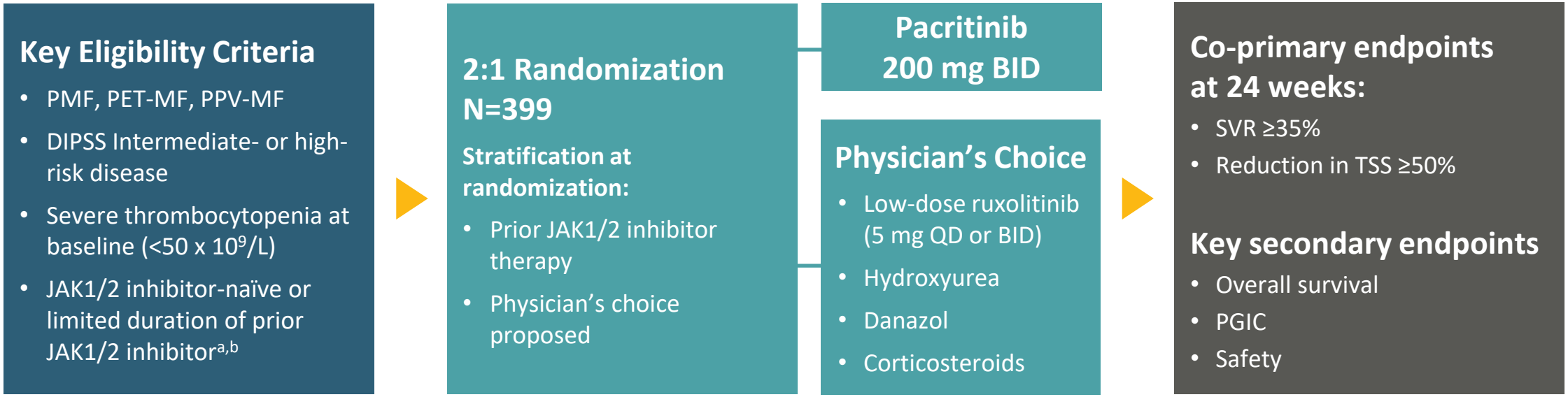
- Rates of fatal events, thrombosis, major adverse cardiac events, non-melanoma skin cancer numerically higher on ruxolitinib than pacritinib[1]
- No excess risk of bleeding, on pacritinib, including in patients with severe thrombocytopenia[1]
- Infection more frequent on pacritinib vs BAT but no increased risk of zoster or fungal infection[1]

Limitation: These data are not included in the Pacritinib Prescribing Information. Results should be interpreted with caution. * PAC203 study: a phase 2, open-label, randomized, dose-finding study of pacritinib in adult patients with intermediate or high-risk primary or secondary myelofibrosis who were intolerant of, or failed to benefit from ruxolitinib. [a] Cardiac and bleeding events determined by Standardised MedDRA Query. [b] Includes arterial thrombosis, venous thrombosis, thromboembolism, ischemic stroke, and type 1 myocardial infarction. [c] Includes basal cell and squamous cell carcinoma of the skin, as determined by medical review. [d] Includes all events within the Systems Order Class 'Infection'. [e] Includes any infection with the term 'zoster' or 'shingles'. [f] Determined by medical review. BAT=best available therapy; BID=twice daily; PAC=pacritinib; RUX=ruxolitinib

Reference: 1. Pemmaraju N, et al. EJHaem. 2022;3(4):1346-1351.

The confirmatory Phase 3 PACIFICA trial is ongoing

PACIFICA Study Design[1-3]



Recruitment is currently ongoing across 83 sites and 16 countries.

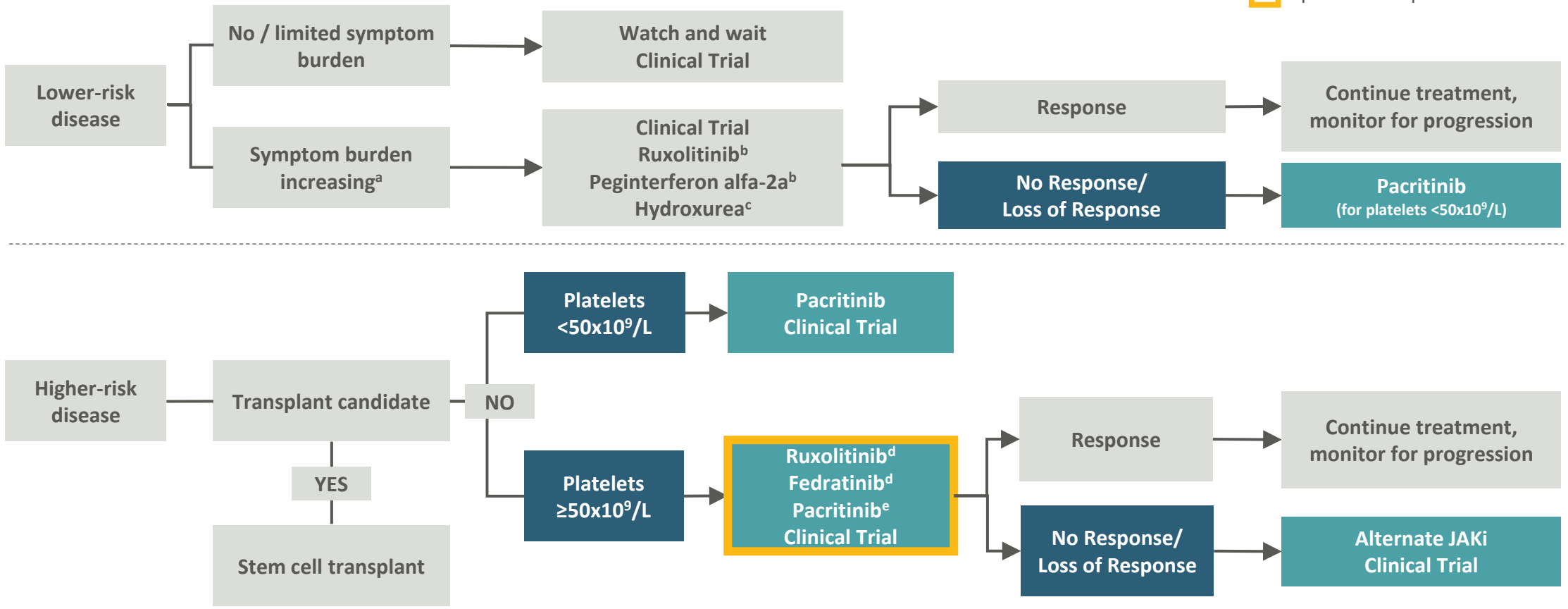
BID=twice daily; DIPSS=Dynamic International Prognostic Scoring System; JAK=Janus associated kinase; MF=myelofibrosis; PET-MF=post-essential thrombocythemia MF; PGIC=patient's global impression of change; PMF=primary MF; PPV-MF=post-polycythaemia vera MF; QD=once daily; SVR=spleen volume reduction; TSS=total symptom score.

[a] Up to 270 days of low-dose ruxolitinib or up to 90 days of higher dose ruxolitinib. [b] A 2-week washout will be required for MF directed therapy and at least 28 days for experimental MF therapies.

References: 1. Harrison CN, et al. Blood. 2019;134(suppl 1):4175. **2.** PACIFICA trial: https://www.clinicaltrials.gov/ct2/show/NCT03165734. **3.** Data on file. PAC303 Protocol (amendment 9). CTI BioPharma Corp. 2022.

The NCCN guidelines have been recently updated to include pacritinib as a first and second line treatment

Update since previous version



Disclaimer: The recommendations provided by the NCCN Guidelines are not contained in the FDA-approved pacritinib (VONJO®) US Prescribing Information and were not part of FDA's evaluation to grant accelerated approval for pacritinib.

[a] Supportive Care. [b] Useful in certain circumstances. [c] Hydroxyurea, if cytoreduction would be symptomatically beneficial. [d] Category 1. [e] Category 2B, all other recommendations are category 2A.

Reference: NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Myeloproliferative Neoplasms. V1.2023

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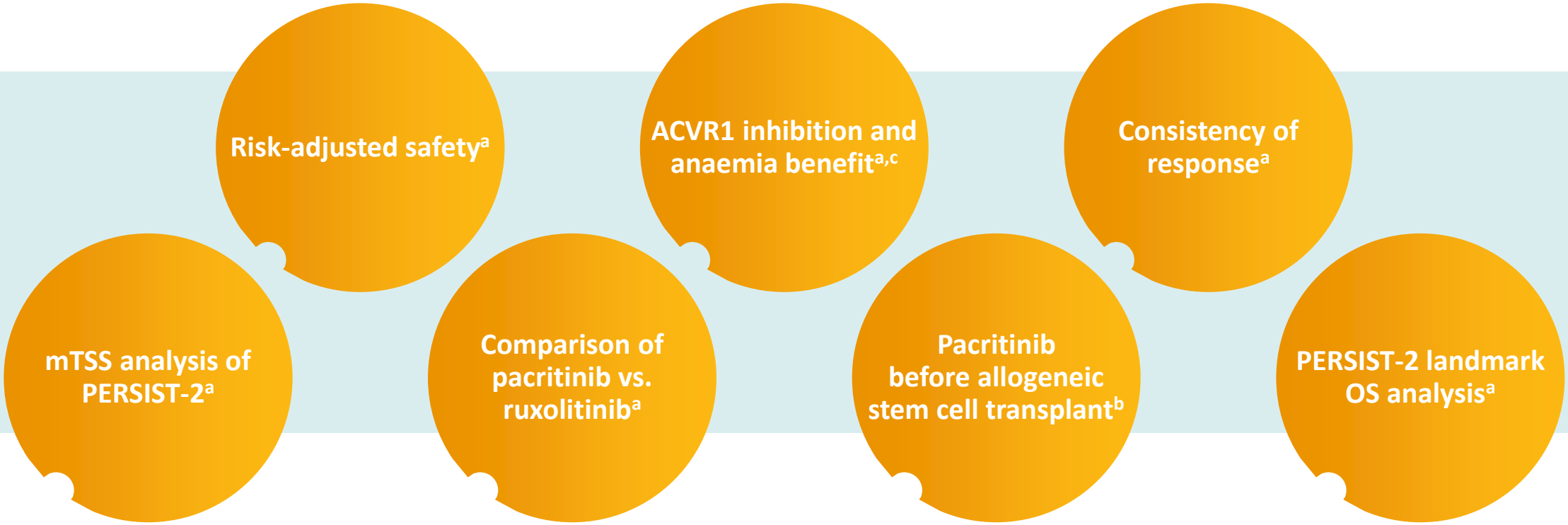
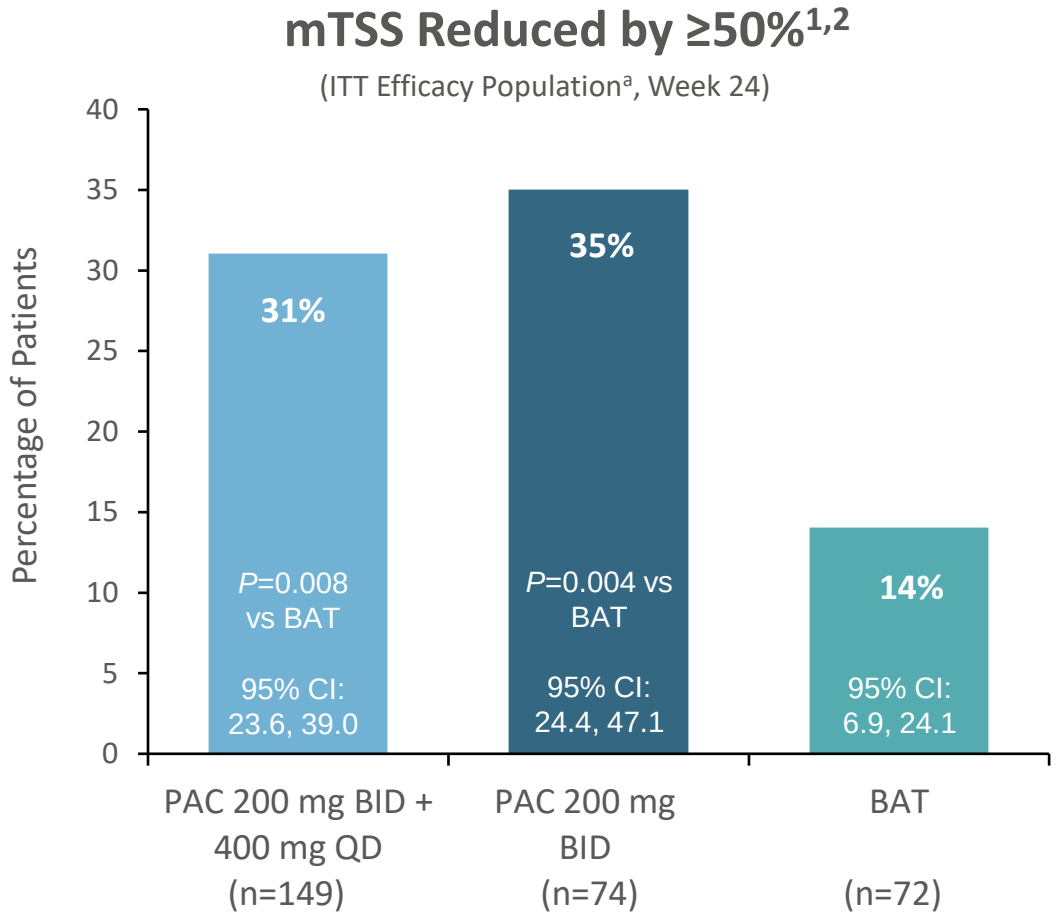
Additional insights have been emerging on the benefit of pacritinib for myelofibrosis patients



[a] Retrospective analysis. [b] Investigator sponsored study (HOVON-134) by Van Dijck, R et al. Oral session (S249) presented at EHA 2023, Frankfurt, Germany. [c] *In vitro* data.
ACVR1=activin receptor-like kinase-2; mTSS=modified total symptom score; OS=overall survival.

mTSS: A retrospective analysis based on mTSS shows PERSIST-2 would have met the primary endpoint



PERSIST-2 included tiredness as part of the total symptom score (TSS) endpoint.

A retrospective analysis of PERSIST-2 based on modified TSS[b], which excludes tiredness, found PERSIST-2 would have achieved the primary endpoint with symptom benefit seen with pacritinib vs. BAT.

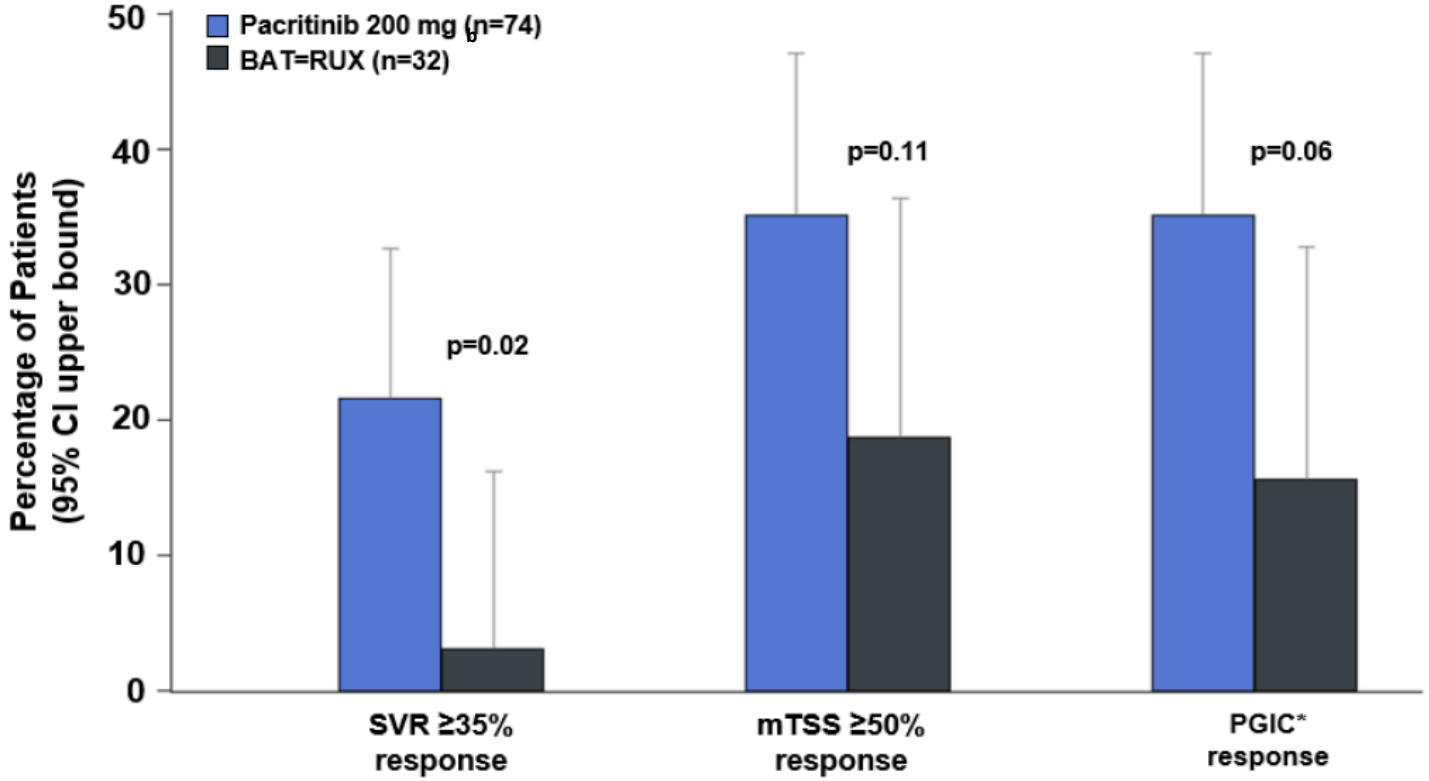
Limitation: No conclusions regarding the benefits or risks of PAC can be established based on the TSS data from PERSIST-2. These data are not included in the Pacritinib Prescribing Information. Results should be interpreted with caution. [a] ITT-efficacy population includes those patients who were randomized ≥22 weeks prior to study termination. [b] mTSS was used for regulatory approval by other JAK inhibitors in myelofibrosis. BAT=best available therapy; BID=twice daily; CI=confidence interval; ITT=intention-to-treat; MF=myelofibrosis; mTSS=modified total symptom score; PAC=pacritinib; QD=once daily.

References: 1. Palmer J, et al. Poster (#3628) presented at ASH 2021, Atlanta, GA. **2.** FDA Integrated Review. Pacritinib. Version 2.0 (04/23/2020). Reference ID: 4944832.

PAC vs. RUX: Pacritinib 200 mg BID showed larger response compared to ruxolitinib in PERSIST-2

Retrospective Analysis - Efficacy endpoints[1]

(ITT Efficacy Population[a], Week 24)



Patients treated with pacritinib versus ruxolitinib achieved higher rates of spleen volume reduction and total symptom score (v2.0, excluding tiredness) at Week 24

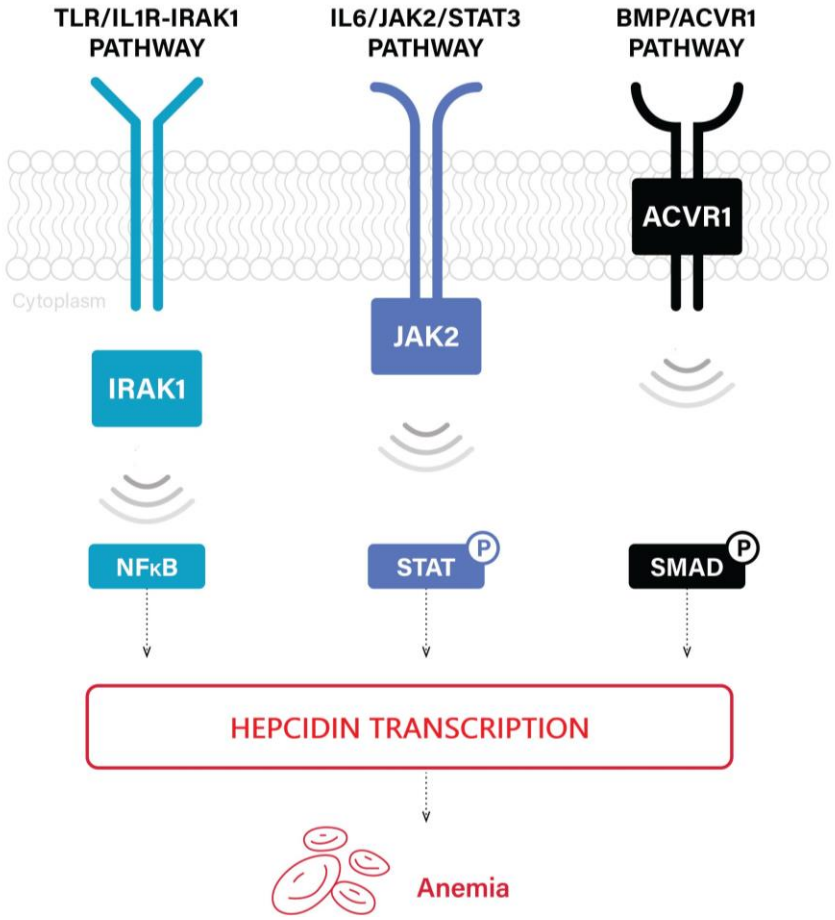
PGIC response including “very much improved” and “much improved” was higher with pacritinib than ruxolitinib

Limitation: These data are not included in the Pacritinib Prescribing Information. Results should be interpreted with caution.

[a] ITT-efficacy population includes those patients who were randomized ≥22 weeks prior to study termination. [b] RUX dose was variable with median dose of 5 mg twice daily. BAT=best available therapy; BID=twice daily; CI=confidence interval; ITT=intent-to-treat; mTSS=modified total symptom score; PAC=pacritinib; PGIC=patient global impression of change; RUX=ruxolitinib; SVR=spleen volume reduction.

Reference: 1. Harrison C, et al. Poster (P1069) presented at EHA 2022. Vienna, Austria.

ACVR1: Multiple pathways in myelofibrosis can contribute to anaemia



ACVR1 is a receptor kinase that controls the expression of the peptide hormone hepcidin

Inhibition of ACVR1 reduces production of hepcidin, which leads to increased iron availability for erythropoiesis

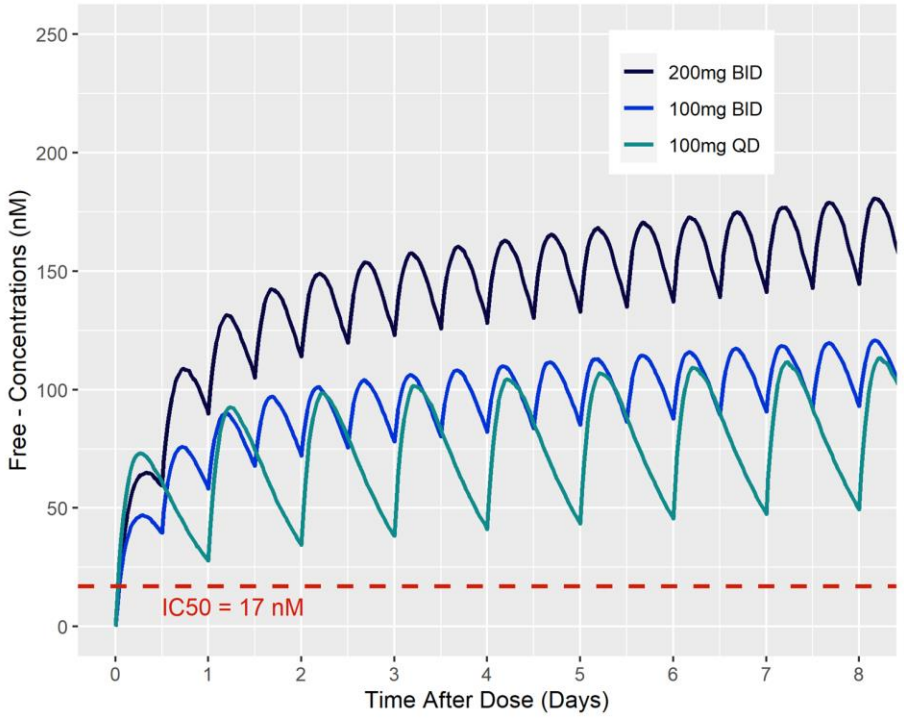
In parallel, inhibition of IRAK1 contributes to the reduction of downstream cytokines, particularly interleukin-6, which also impacts hepcidin expression

ACVR1=activin receptor-like kinase-2; BMP=bone morphogenetic protein; IRAK1=interleukin 1 receptor–associated kinase; JAK2=Janus associated kinase 2; IL1R=interleukin-1 receptor; IL6=interleukin-6; NFκB=nuclear factor kappa light chain enhancer of activated B cells; P=phosphorylation; STAT=signal transducer and activator of transcription; TLR=toll-like receptor.

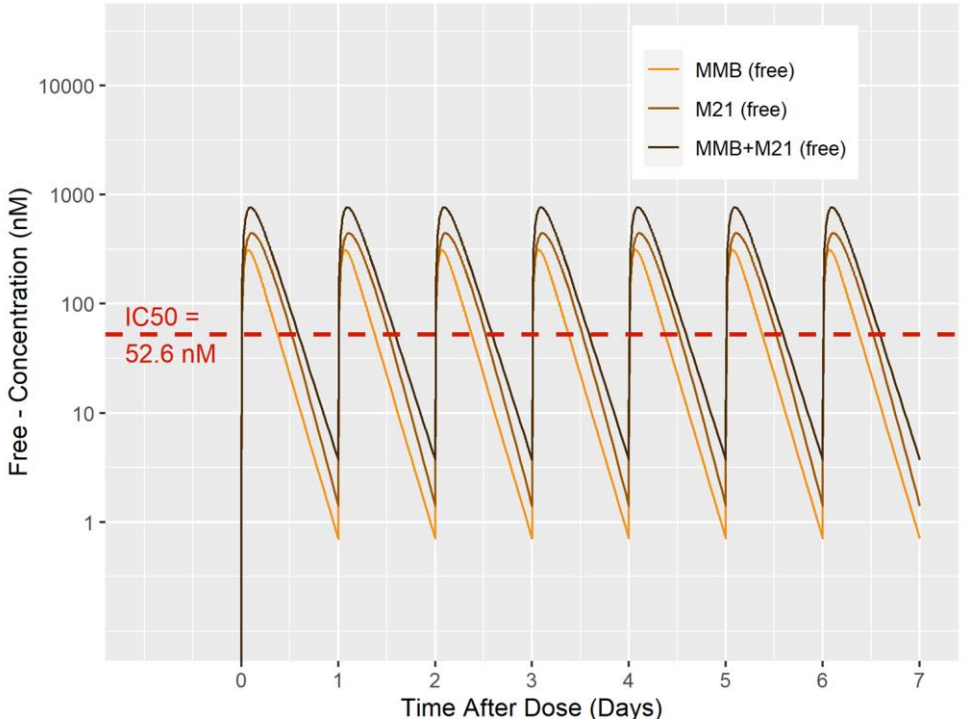
Reference: Oh et al . Poster (MPN-145) presented at SOHO 2022. Houston TX. **2.** Oh S, et al. Oral Presentation (#628) presented at ASH 2022. New Orleans, LA.

ACVR1: Pacritinib is a potent ACVR1 inhibitor *in vitro*, with predicted 24-hour on-target inhibition

Pacritinib Concentration-Time Curve[1]



Momelotinib Concentration-Time Curve[1]



Pacritinib is a highly potent, 24-hour inhibitor of ACVR1

Limitation: These data are not included in the Pacritinib Prescribing Information. Results should be interpreted with caution.
ACVR1=Activin A receptor type 1; BID=twice daily; IC_{50}=half maximal inhibitory concentration; MMB=momelotinib; M21=metabolite of momelotinib; QD=once daily.
Reference: 1. Oh S, et al. Oral Presentation (#628) presented at ASH 2022. New Orleans, LA.

Anaemia: Pacritinib increases transfusion independence (PERSIST-2 retrospective analysis)

TI conversion rate (Gale criteria*)[1]

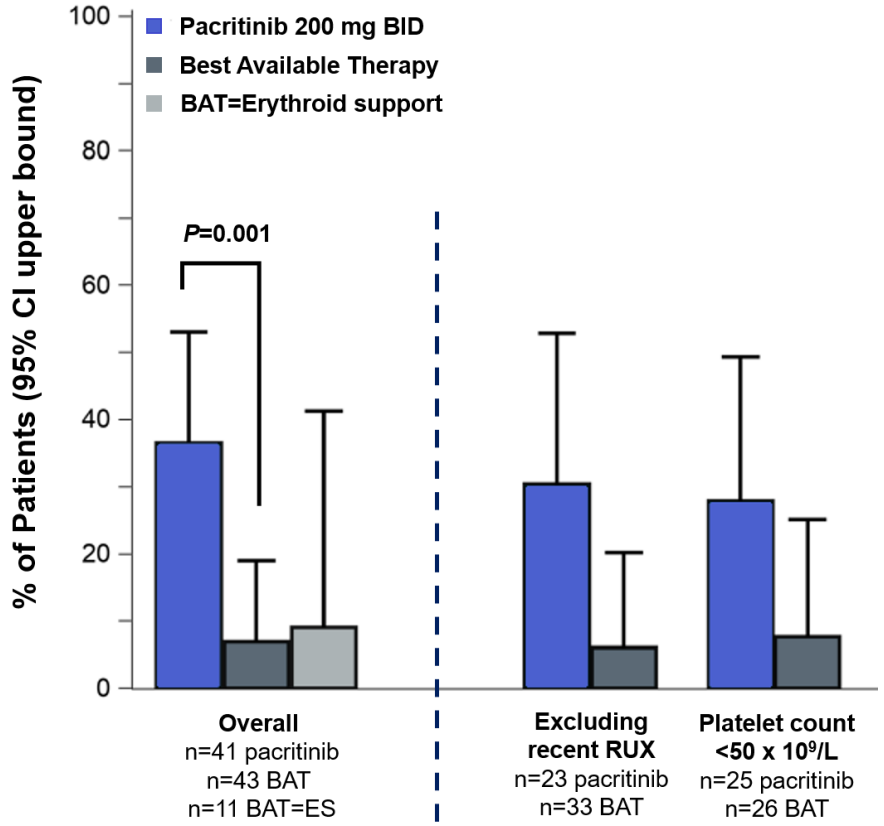
Among patients requiring RBC transfusion at baseline

PAC 200 mg BID N=41	BAT N=43	*P*-value
37%	7%	0.001

TI conversion was more common on pacritinib than BAT

Rate of Transfusion Independence[1]

Over 12-week interval through Week 24 (Gale criteria)



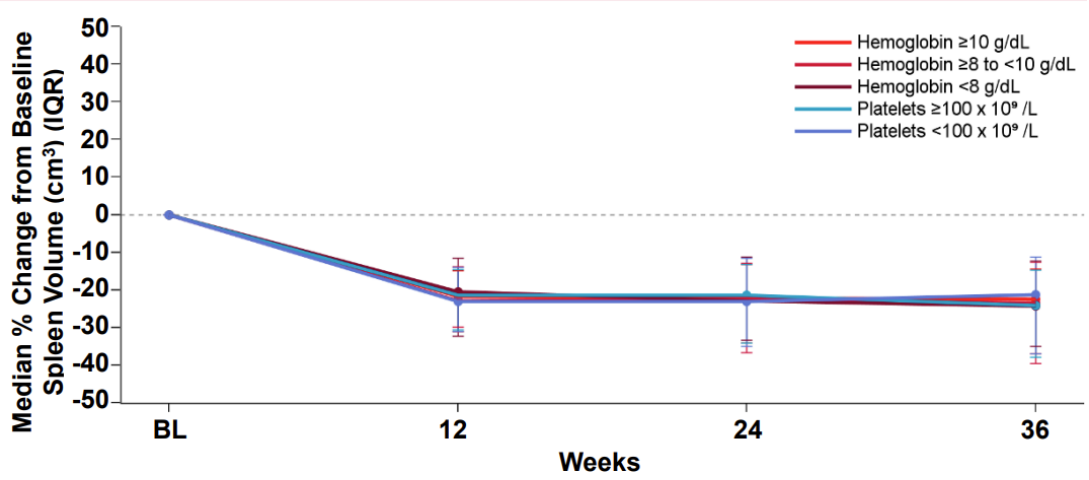
Limitation: These data are not included in the Pacritinib Prescribing Information. Results should be interpreted with caution.
Note: Retrospective analysis based on PERSIST-2 data in population not TI at baseline and who were randomized ≥12 weeks prior to study termination.
*Gale criteria: no red blood cell transfusions over any 12 weeks. BAT=best available therapy; BID=twice daily; ES=erythroid support; PAC=pacritinib; recent RUX=no ruxolitinib in prior 30 days; TI=transfusion independence.
Reference: 1. Oh S, et al. Oral Presentation (#628) presented at ASH 2022. New Orleans, LA.

Consistency of response: Pacritinib has similar efficacy regardless of baseline cytopenias

Retrospective Analysis

Spleen Reduction Over Time by Subgroups[1]

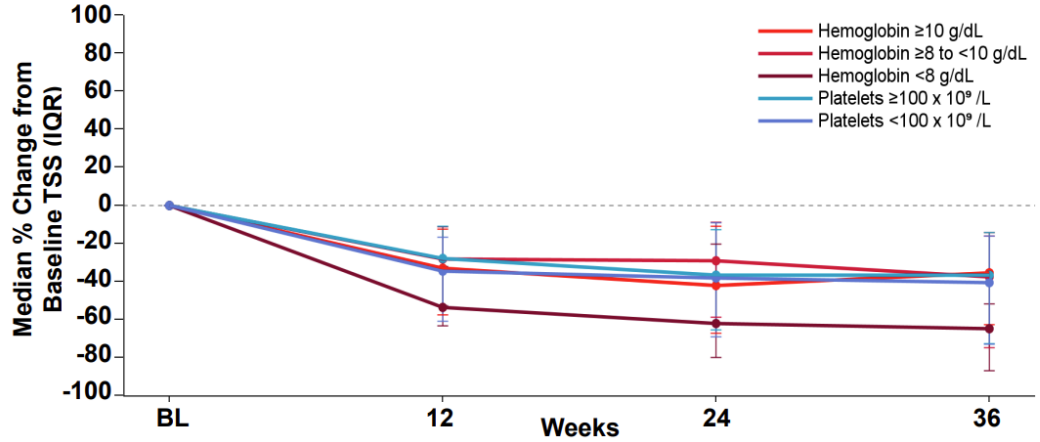
Evaluable population (PERSIST-1 and PERSIST-2)



- **The depth of Week 24 spleen reduction was consistent across all analysed platelet and haemoglobin subgroups**
- Spleen reduction occurred by Week 12 across all subgroups and remained consistent over time

TSS Reduction Over Time by Subgroups[1]

Evaluable population (PERSIST-1 and PERSIST-2)



- **Symptom improvement occurred consistently across subgroups**, with greatest improvement in patients with baseline haemoglobin <8 g/dL
- Some ongoing improvement seen beyond Week 12

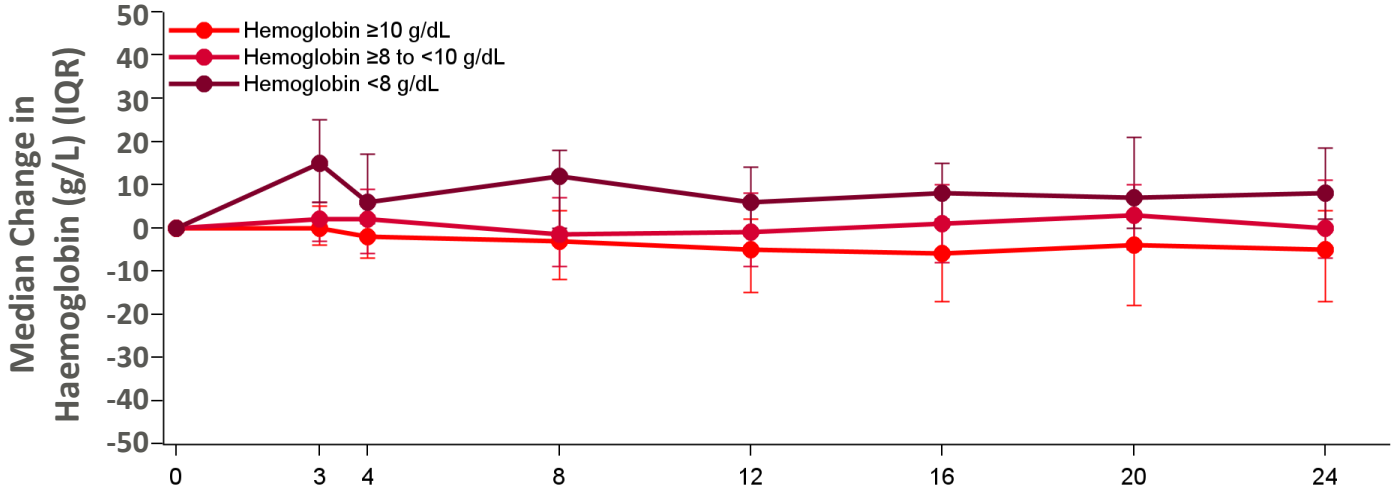
Limitation: These data are not included in the Pacritinib Prescribing Information. Results should be interpreted with caution. IQR=interquartile range; TSS=total symptom score.

Reference: 1. Bose P, et al. Poster (#7068) presented at ASCO 2023. Chicago, Illinois.

Consistency of response: Haemoglobin stability/ improvement with pacritinib

Median Change in Haemoglobin Over Time by Baseline Haemoglobin Subgroups[1]

Evaluable population (PERSIST-1 and PERSIST-2); retrospective analysis



N	Weeks							
HB≥10 g/dL	153	141	144	148	147	150	150	143
HB≥8 to <10 g/dL	94	85	83	90	91	91	93	82
HB<8 g/dL	29	26	26	26	27	29	27	24

Median haemoglobin remains stable through Week 24

Improvements in haemoglobin observed in subgroup with baseline haemoglobin <8 g/dL

Limitation: These data are not included in the Pacritinib Prescribing Information. Results should be interpreted with caution. HB=haemoglobin; IQR=interquartile range; TSS=total symptom score.

Reference: 1. Bose P, et al. Poster (#7068) presented at ASCO 2023. Chicago, Illinois.

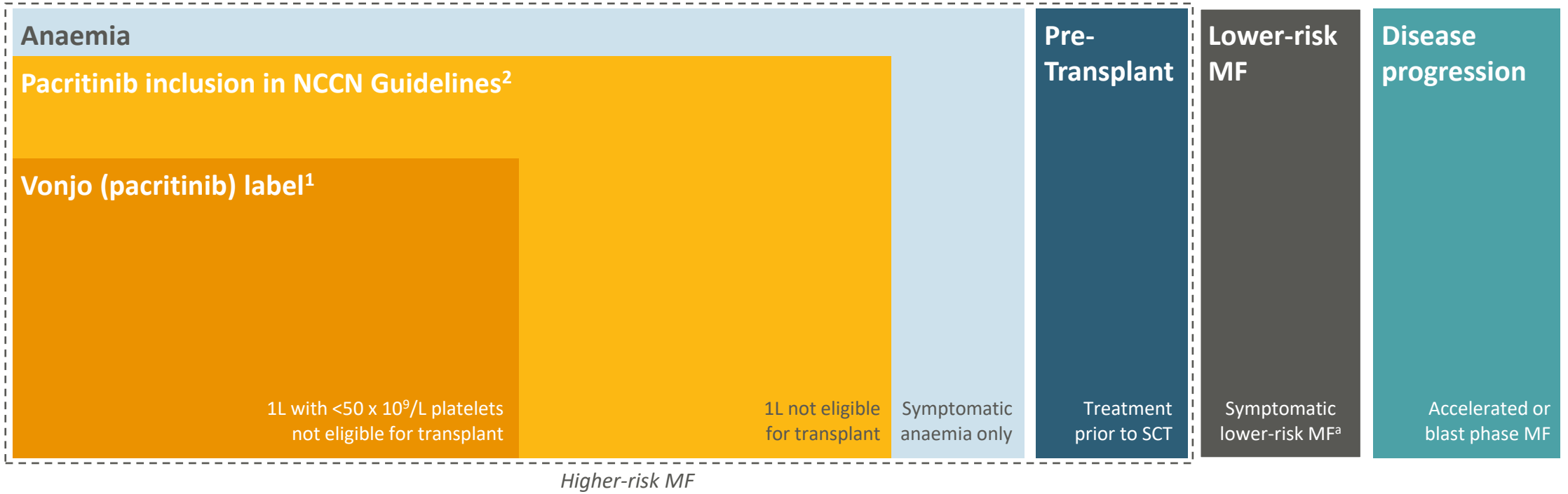
The future potential of pacritinib

We are committed to exploring the potential of pacritinib to benefit patients in myelofibrosis and beyond

Pacritinib has the potential to address unmet needs in additional patient populations in myelofibrosis

Illustration of myelofibrosis patient populations

Approx. 20k myelofibrosis patients in the US



Pacritinib alone or combination with novel agents currently in development may be able to address unmet needs in myelofibrosis patient populations beyond its current label

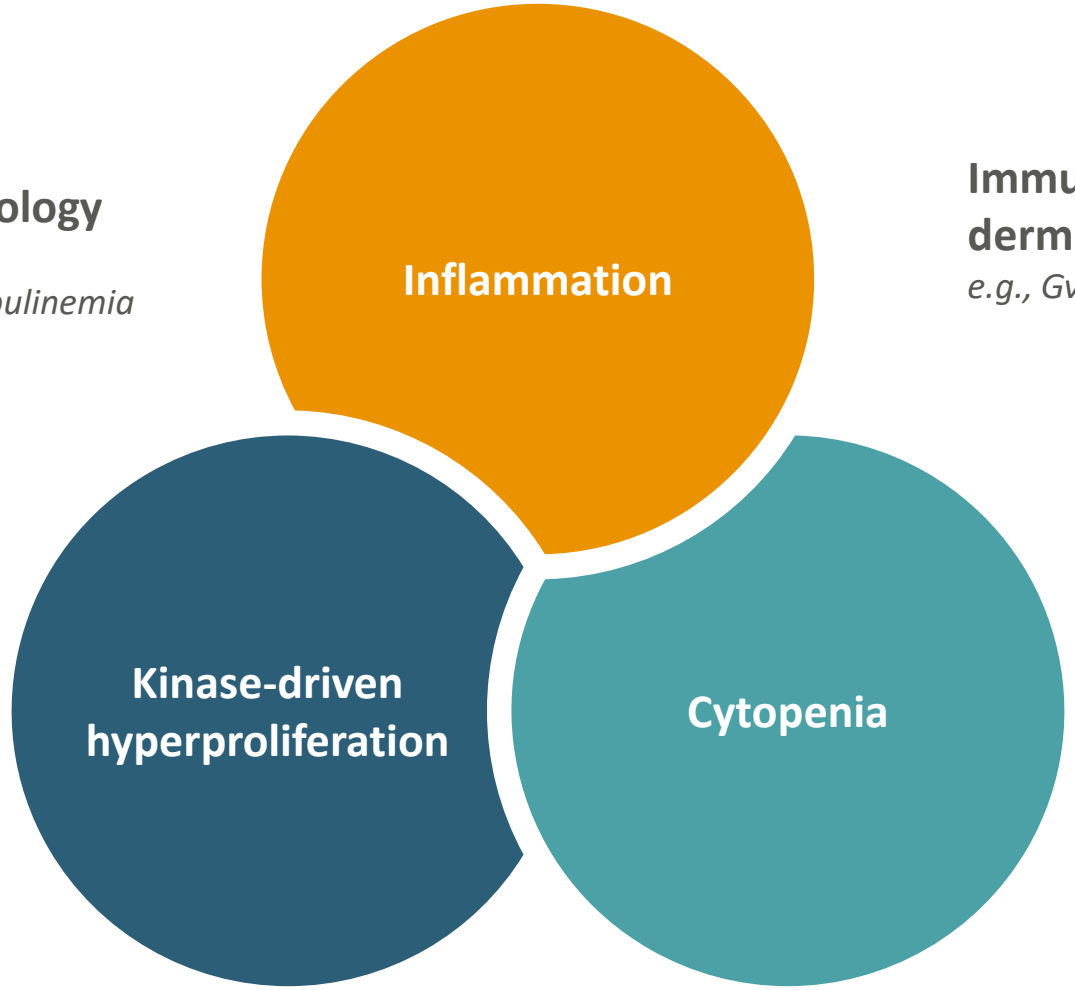
Note: Graphic shows indicative sizes of myelofibrosis subpopulations based on literature[3-6]. MF=myelofibrosis; SCT=stem cell transplant. [a] NCCN guidelines include pacritinib as a consideration in 2L symptomatic lower-risk MF.

References: 1. VONJO® [package insert]. Seattle, WA; CTI Biopharma; February 2022. **2.** NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Myeloproliferative Neoplasms. V1.2023. **3.** Tefferi A, et al. Mayo Clin Proc. 2012;87(1):25-33. **4.** Slot S, et al. Hemasphere. 2021;5(7):e595 **5.** 6. Mead AJ, et al. Ther Adv Hematol. 2022;13:20406207221084487. **6.** Tefferi A, et al. Blood. 2014;124(16):2507-2513.

Treatment with pacritinib could be beneficial in other indications based on its mechanism of action

Malignant haematology
e.g., AML, CMML, MDS, Waldenström macroglobulinemia

Immunology, rheumatology, dermatology
e.g., GvHD, SLE, VEXAS syndrome



Solid tumours
e.g., glioblastoma, prostate cancer

Benign haematology
e.g., Castleman disease, HLH, aplastic anaemia

AML=acute myeloid leukaemia; CMML=chronic myelomonocytic leukaemia; GvHD=Graft-versus-host disease; HLH=hemophagocytic lymphohistiocytosis; MDS=myelodysplastic syndromes; SLE=systemic lupus erythematosus.

Pacritinib is well positioned for further exploration of its benefits in myelofibrosis and beyond

Real world insights

Additional data generation into the benefit of pacritinib in different patient populations to understand its potential and enable wider patient access

New indications

Strong scientific rationale for benefit of pacritinib as combination partner of choice in myelofibrosis as well as in other diseases with underlying inflammation-driven pathophysiology

Geographic expansion

Regulatory submissions in international markets based on current label and supported by additional data from PACIFICA trial

Agenda and presenters

Opening remarks		Guido Oelkers, Chief Executive Officer Swedish Orphan Biovitrum
Overview of Myelofibrosis and Vonjo		John Mascarenhas, Professor of Medicine Icahn School of Medicine at Mount Sinai
Emerging Insights & Future Potential of Pacritinib		Sarah Buckley, Medicine Development Lead Swedish Orphan Biovitrum
Summary and Q&A		

Combined leadership in haematology

Vonjo has a **differentiated profile** in myelofibrosis

Severe thrombocytopenic MF represents an **unmet clinical need**

Complementary haematology reach and expertise

Expectation: **highly accretive** to Sobi's revenue and margins

Thank you

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