# Welcome to Investor Day

August 5, 2026

NewAmsterdam Pharma

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This presentation and the accompanying oral statements made in connection herewith (collectively, this "Presentation") contains forward-looking statements within the meaning of the United States Private Securities Litigation Reform Act of 1995 and are subject to the "safe harbor" provisions created thereunder. All statements that are not historical facts are hereby identified as forwarding-looking statements for this purposes and include, among others, statements by NewAmsterdam Pharma Company N.V. ("NewAmsterdam", the "Company", "we" or "our") regarding: estimates and forecasts of financial and performance metrics and projections of market opportunity; the Company's business and strategic plans; expectations and timing related to the success, cost and timing of product development activities, including timing of initiation, completion and data readouts for clinical trials and the potential approval of the Company's product candidate; the timing for enrolling patients; the Company's intention to conduct the PREVAIL interim analysis and expectations regarding the timing of the interim analysis, when the result of the interim analysis may be announced and the potential of PREVAIL to be stopped early for efficacy as a result of the interim analysis; the design and predictive ability of clinical trials; potential predictors of MACE benefit; potential drivers of the blinded event rates observed in PREVAIL; the timing and forums for announcing data; the size and growth potential of the markets for the Company's product candidate; the Company's ability to achieve the broad degree of physician adoption and use and market acceptance necessary for commercial success; the therapeutic and curative potential of the Company's product candidate; financing and other business milestones; the Company's expected cash runway; and the Company's plans for commercialization.

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# Agenda

## Date: August 5, 2026

**Corporate Update**: Michael Davidson, MD, CEO, NewAmsterdam

- Introduction
- General Corporate Update

**Science Update:** John Kastelein, MD, PhD, FESC, CSO, NewAmsterdam

- Biomarker predictors of MACE and REVEAL
- Potential Benefits of HDL
- REMBRANDT
- RUBENS
- CETP and Alzheimer's Disease

**PREVAIL Update:** Michael Davidson, MD, CEO, NewAmsterdam

- PREVAIL: Improving Probability of Success
- Alzheimer's Update

**Commercial Update:** BJ Jones, CCO, NewAmsterdam

- Market Momentum
- Product Differentiation
- US Launch Readiness
- Prelaunch Activities
- European Launch overview

**Closing:** Michael Davidson, MD, CEO, NewAmsterdam

**Q&A**

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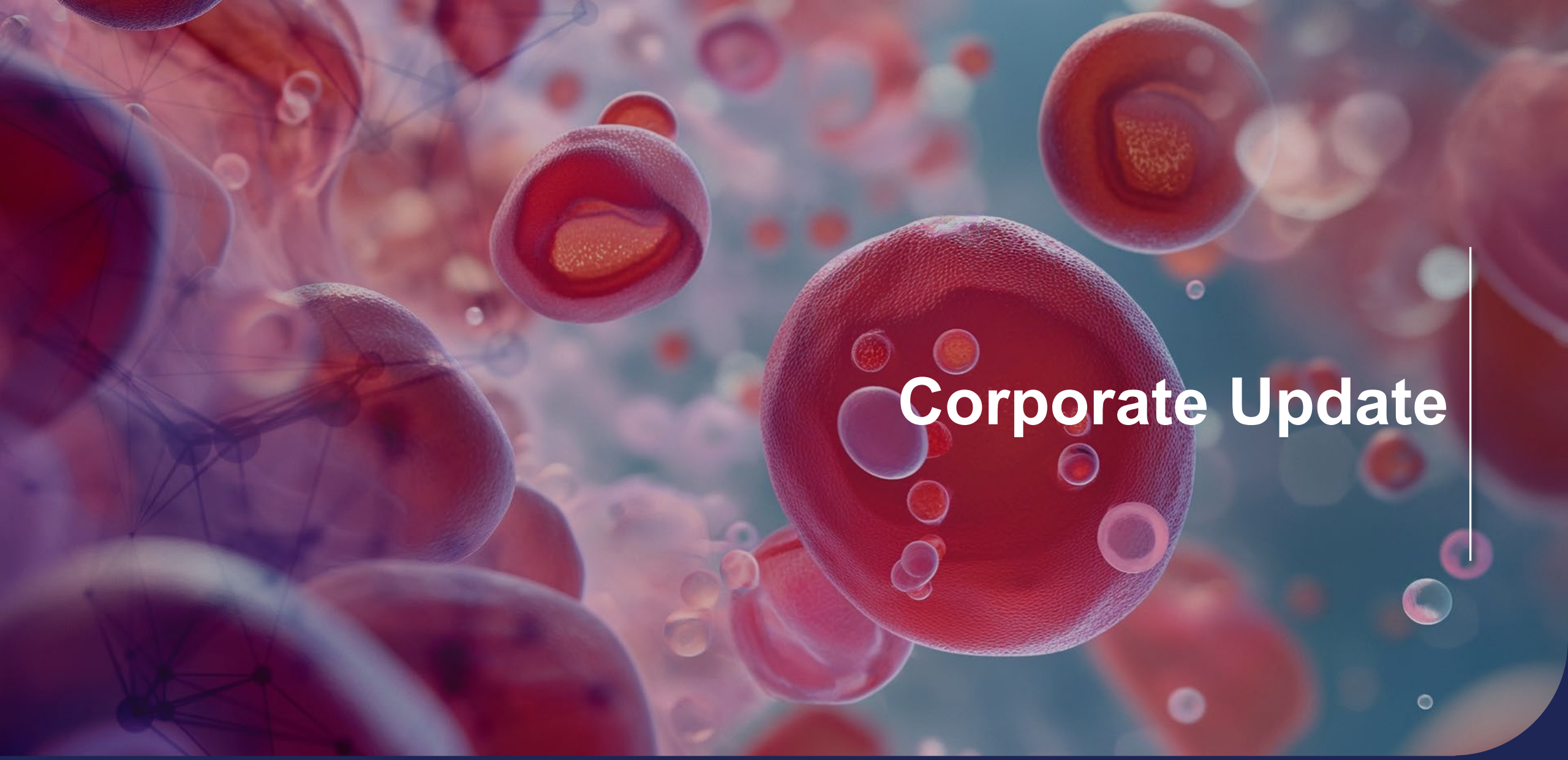

# Corporate Update

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# Our Mission is Clear and Simple

Our mission is to build **a new standard of care** for people living with cardiometabolic disease by challenging convention with courage, translating deep biological insight into meaningful patient impact, and delivering with rigor, precision and purpose. This is how NewAmsterdam is **built to go beyond**.

# Moving Forward, Still Looking Ahead

“

I got a wake-up call early in life that I needed to take better care of myself. My family history didn’t do me any favors, so, I try to stay as diligent as possible to live a long, healthy life. I’m grateful to my wife, Mary, and my doctors who have helped me change the trajectory of my life. High cholesterol doesn’t simply go away, but with the support of my care team and a willingness to consider medication options that may help me, I feel motivated to keep moving forward.

**Frank L.**
*Committed to Prevention, Open to What’s to Come*

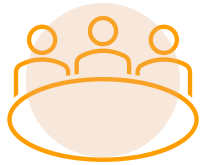
AGE 76 • MALE • CVD, DIABETES & HYPERTENSION • FHx CVD & DIABETES
MEDICATIONS: STATIN, EZE •
SWIMMER AND BIKER •
RETIRED ENTERTAINER

# The NewAmsterdam Value Proposition

- **Clinical Expertise:** Data driven clinical development increases probability of success
- **Differentiated Target Product Profile:** Phase 3 data demonstrates obicetrapib's potential impact on multiple CVD risk factors
- **Unmet Need:** Significant need for a potent, convenient, well-tolerated low-dose oral therapy
- **Experienced Leadership and Team:** Expanding team comprised of accomplished industry executives
- **KOL Support:** Physician community aware of unmet need and eager to leverage obicetrapib's differentiated profile to achieve desired clinical benefit, if approved
- **CMC Expertise and Manufacturing Capacity:** Preparing to meet anticipated demand for obicetrapib and the fixed dose combination, creating redundancy, expanding capacity and building inventory
- **Commercial Excellence:** Growing team with track record of blockbuster launch success and innovative go-to-market model
- **Strong Balance Sheet:** Cash runway expected to be sufficient to support U.S. commercial launch

# Previous Years Were a Time of Groundwork, Goals and Growth

Completed and announced results for BROOKLYN, BROADWAY, and TANDEM Phase 3 studies



Building world-class commercial and MSL functions

Doubled in size (>100) with new hires and offices in Amsterdam, NL, Miami, FL, and Philadelphia metro area

Secured funding to support US commercial launch, if approved, with cash at end of 2Q 2026 of ~$678M*

## 2024

- Composition of matter IP granted
- Announced topline results for BROOKLYN Phase 3 trial
- Announced topline results for TANDEM Phase 3 trial
- Announced topline results for BROADWAY Phase 3 trial

## 2025

- Announced Alzheimer's topline
- Full AD data was presented at AAIC on July 30
- EMA submission

## 2026

- CHMP Positive Opinion
- European Approvals

* Includes cash and cash equivalents and marketable securities



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# Lipid Lowering Market Primed for Commercial Success

## Observations[1-4]

1. We have seen LLT market growth each year for the last 5 years
2. Non-statin growth continues in the high double digits
3. Guidelines have shifted to recommend more intense and earlier intervention not only with statins, but with ezetimibe, PCSK9's and bempedoic acid
4. Access to PCSK9's has been increasing, and utilization controls have been decreasing
5. PCSK9 growth continues to accelerate 10 years post launch with 45%+ growth in net sales in each of the last 2 years
6. FDA labeling changes continue to support broad access and earlier treatment

## Key Takeaways

- Very large opportunity – even small amounts of penetration can result in significant financial success
- Shift towards more aggressive treatment using alternatives / adding to statins
- Governing bodies and KOL's are prioritizing the importance of treating to goal
- Payers are willing to cover medications in LLT space if priced appropriately
- Commercial success is being demonstrated and is accelerating
- Labels are less restrictive and support broad usage

1. Based on third party prescription data on file
2. Grundy SM, et al. J Am Coll Cardiol. 2019;73(24):3168-3209.
3. Lloyd-Jones DM, et al. J Am Coll Cardiol. 2022;80(14):1366-1418
4. 2025 ACC/AHA/ACEP/NAEMSP/SCAI Guideline for the Management of Patients With Acute Coronary Syndromes: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines | Circulation

# Positive CHMP Opinion Supports Potential Approval in Europe

- Committee for Medicinal Products for Human Use ("CHMP") of the European Medicines Agency (“EMA”) adopted positive opinion recommending marketing authorization for **Ubeslo® (obicetrapib 10 mg monotherapy)** and **Evlarco® (10 mg obicetrapib plus 10 mg ezetimibe FDC)** for patients with primary hypercholesterolemia, both HeFH and non-familial or mixed dyslipidemia
- Final decision by European Commission (“EC”) has authority to grant centralized marketing authorization applicable across all **27 EU member states**, and **Iceland, Liechtenstein and Norway**

Positive CHMP opinion received in July 2026 based on robust data from the Phase 3 BROADWAY, BROOKLYN and TANDEM trials

European Commission decision expected in 2H26

Partnership with Menarini provides commercial and regulatory infrastructure in EU→ under licensing agreement Menarini holds rights for obicetrapib in Europe

NewAmsterdam entitled to tiered double-digit % royalties on net sales and up to an additional €833 million with achievement of various milestones

# Science Update



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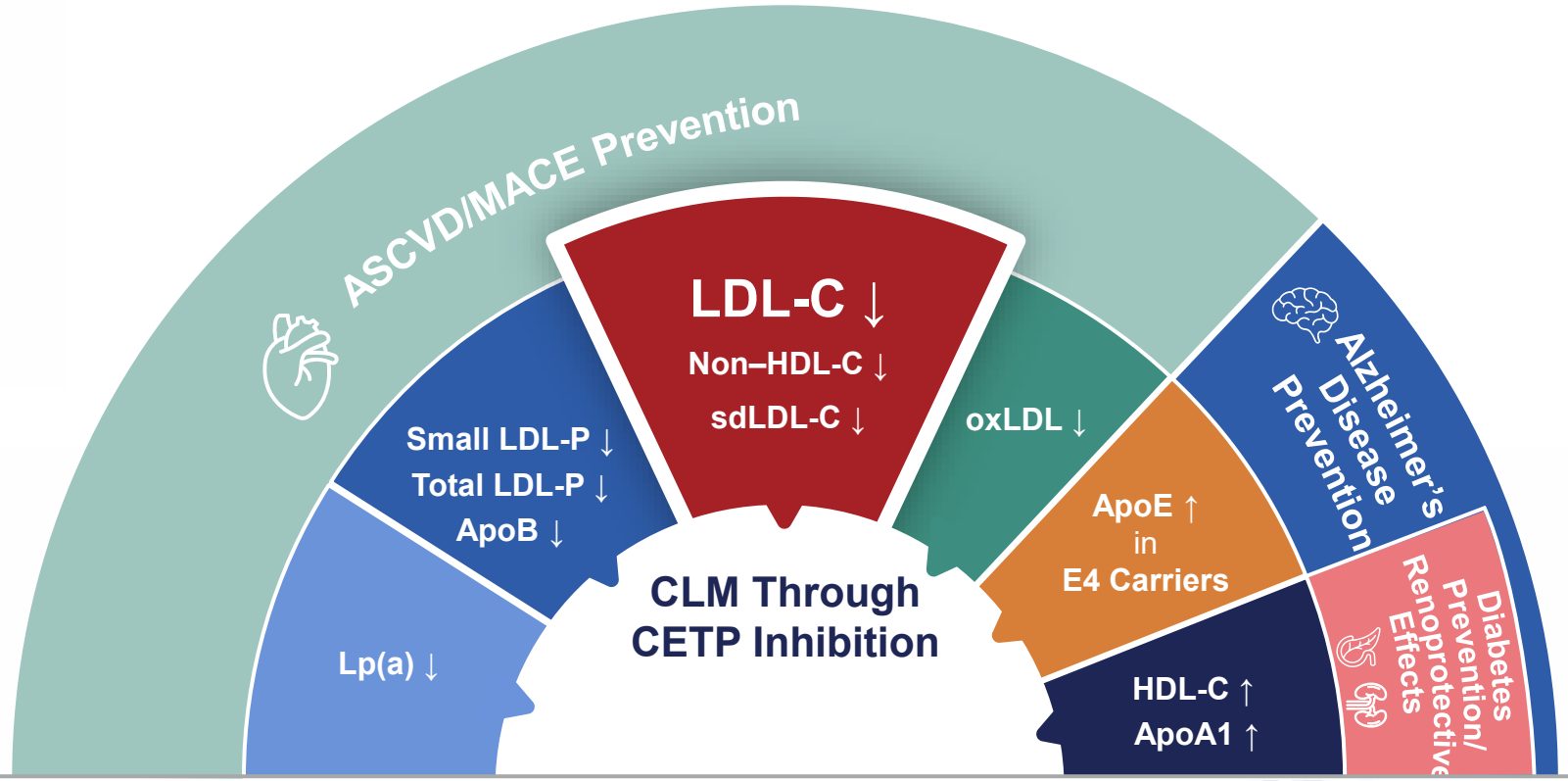
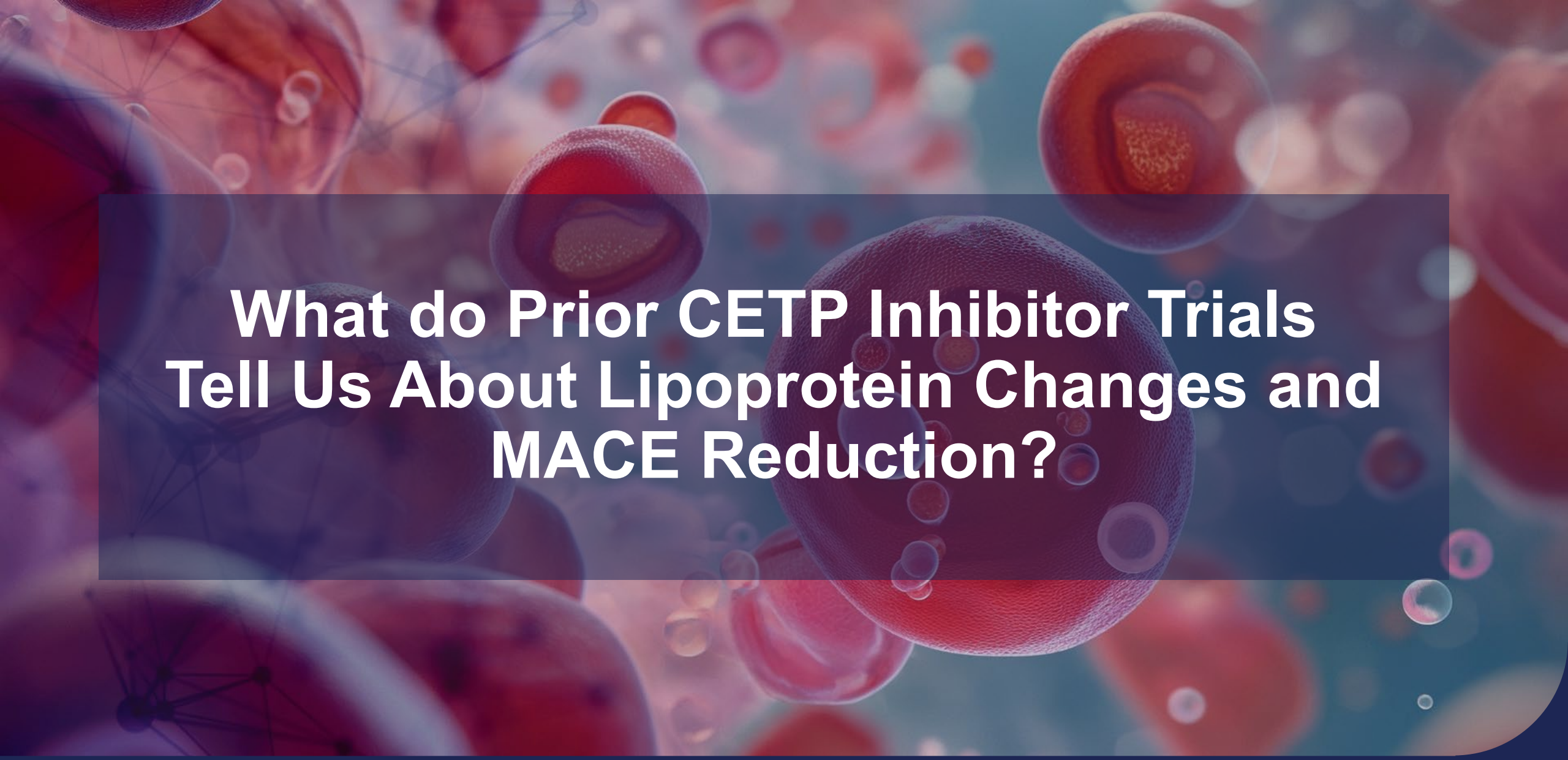
# Observed Effects of Obicetrapib on MACE Biomarkers

# Obicetrapib Delivers Comprehensive Lipid Modulation Through CETP Inhibition




ApoA1, apolipoprotein A1; ApoE, apolipoprotein E; ASCVD, atherosclerotic cardiovascular disease; CETP, cholesterol ester transfer protein; CVD, cardiovascular disease; LDL-P, low-density lipoprotein particle; MACE, major adverse cardiovascular events; oxLDL, oxidized low-density lipoprotein; sdLDL-C, small dense low-density lipoprotein cholesterol.



# What do Prior CETP Inhibitor Trials Tell Us About Lipoprotein Changes and MACE Reduction?

# Limitations of Prior CETP Inhibitor CVOTs

| | SAFETY | LDL-LOWERING POTENCY | CVOT DESIGN (DURATION & BASELINE LDL) | COMMERCIAL VIABILITY |
|---|---|---|---|---|
| **TORCETRAPIB[1]**<br>Suffered from drug-specific toxicity issue (Pfizer) | OFF-TARGET TOXICITY, INCREASED BLOOD PRESSURE, ALDOSTERONE *(seen early in Phase 2)* | NO LDL-LOWERING<br>*~40% CETP inhibition at CVOT dose* | INSUFFICIENT TRIAL DURATION *(only 2 years)* | COMMERCIALLY UNVIABLE<br>*High lipophilicity and fat tissue accumulation led to 4+ year half-life* |
| **DALCETRAPIB[2]**<br>Drug showed no LDL-lowering efficacy (Roche) | Safe & well-tolerated | | | |
| **EVACETRAPIB[3]**<br>*Overall mortality benefit (P =.04)* – but CVOT was too short to demonstrate MACE benefit (Lilly) | Safe & well-tolerated | Modest LDL-lowering (~17-36%)<br>*~80% CETP inhibition at CVOT dose* | Sufficient duration<br>*(4.1 years, with 6.3 year follow up)* | |
| **ANACETRAPIB[4]**<br>*Meaningful MACE benefit observed* - but drug accumulated in fat tissue (Merck) | Safe & well-tolerated | Modest LDL-lowering (17%)<br>*~80% CETP inhibition at CVOT dose* | Baseline LDL too low<br>*(60 mg/dL)* | |

*Strong safety profile across ~59k patients*

We believe that all prior CETPi were developed with a **misguided focus on HDL increase** (rather than LDL decrease) as the primary MoA for CVD risk reduction, leading to **inappropriate compound selection or inappropriate CVOT design.**

## OBICETRAPIB[5]

- ✓ **Tolerability profile observed in >4000 patients through Phase 3**
- ✓ **No concerns seen in biomarker safety data, including blood pressure-associated biomarkers**

- ✓ **35-40%** LDL lowering observed in phase 3
- ✓ **~50%** LDL-lowering observed in fdc phase 3

*~97% target coverage*

- ✓ **Longer trial duration** *(4 yrs)*
- **+**
- ✓ **High baseline LDL** *(100 mg/dL)*[(1)]

- ✓ **Favorable PK/PD profile**
- ✓ **No accumulation in fat tissue observed**

Note: The above trials and data do not represent head-to-head comparisons. Obicetrapib has not been approved for marketing by any regulatory authority. Represents estimated average baseline LDL to be enrolled, not entry criteria. Evacetrapib measured using direct LDL-C assay.

Sources: 1. Barter PJ, et al. N Engl J Med 2007;357:2109-2122; 2. Schwartz GG, et al. N Engl J Med 2012;367:2089-2099; 3. Lincoff AM, et al. N Engl J Med 2017;376:1933-1942; 4. The HPS3/TIMI55–REVEAL Collaborative Group. N Engl J Med 2017;377:1217-1227; 5. Data on file

# REVEAL: The Largest CETP Inhibitor Outcomes Trial

**30,449**[1]

**patients with ASCVD**

**Largest CVOT** ever conducted[1]

(1 tertile is ~PREVAIL-sized)

**17%**[1]

**LDL-C reduction**

With anacetrapib 100 mg/day on top of intensive statin therapy led to **9% MACE reduction**[1]

**75-80%**

**CETP inhibition**

with 100 mg dose[2]

(Obicetrapib demonstrates 98% inhibition)

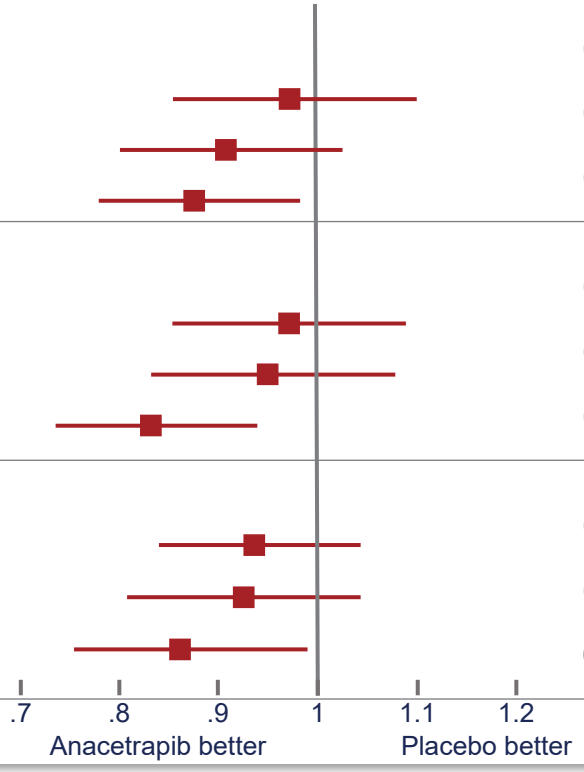
**Although anacetrapib is a much weaker CETP inhibitor with only modest LDL-C lowering, REVEAL still achieved a statistically significant reduction in MACE validating CETP inhibition on top of statins as a potential route to cardiovascular risk reduction[1]**

ASCVD, atherosclerotic cardiovascular disease; CETP, cholesteryl ester transfer protein; CVOT, cardiovascular outcomes trial; LDL-C, low-density lipoprotein cholesterol; MACE, major adverse coronary events.

1. HPS3/TIMI55–REVEAL Collaborative Group. *N Engl J Med*. 2017;377(13):1217-1227. 2. Krishna R, et al. *Br J Clin Pharmacol*. 2009;68(4):535-545.

# What Did We Observe In REVEAL?

| Baseline characteristic | Mean Lipid Difference (mg/dL) | | Anacetrapib (N=15,225) | Placebo (N=15,224) | Rate ratio (95%CI) | Nominal *P* Value | *Trend P* Value |
|---|---|---|---|---|---|---|---|
| | HDL-C | Non-HDL-C | Number of participants with events (%) | | | | |
| **LDL-C (mg/dL)** | | | | | | | |
| <54 | 43 | -11 | 527 (10.5) | 558 (11.0) | 0.96 (0.85-1.08) | 0.504 | |
| ≥54<66 | 44 | -17 | 492 (10.6) | 553 (11.8) | 0.90 (0.80-1.01) | 0.076 | |
| ≥66 | 44 | -24 | 621 (11.2) | 692 (12.7) | 0.87 (0.78-0.97) | 0.012 | 0.230 |
| **Non-HDL-C (mg/dL)** | | | | | | | |
| <85 | 42 | -11 | 561 (9.9) | 592 (10.4) | 0.96 (0.85-1.07) | 0.487 | |
| ≥85<101 | 44 | -18 | 534 (10.9) | 564 (11.6) | 0.94 (0.83-1.06) | 0.321 | |
| ≥101 | 45 | -23 | 545 (11.6) | 647 (13.9) | 0.83 (0.74-0.93) | 0.001 | 0.080 |
| **ApoB (mg/dL)** | | | | | | | |
| <60 | 44 | -12 | 693 (9.7) | 752 (10.4) | 0.93 (0.84-1.03) | 0.163 | |
| ≥60<70 | 43 | -19 | 505 (11.3) | 548 (12.3) | 0.92 (0.81-1.03) | 0.174 | |
| ≥70 | 43 | -26 | 442 (12.3) | 503 (14.1) | 0.86 (0.76-0.98) | 0.020 | 0.390 |




**Patients with the highest baseline non-HDL-C showed a ~17% reduction in rate of MACE**

ApoB, apolipoprotein B; HDL-C, high-density lipoprotein cholesterol; LDL-C, low-density lipoprotein cholesterol.
*Major coronary event was defined as a composite of coronary death, myocardial infarction, or coronary revascularization.
HPS3/TIMI55–REVEAL Collaborative Group. *N Engl J Med*. 2017;377(13):1217-1227.



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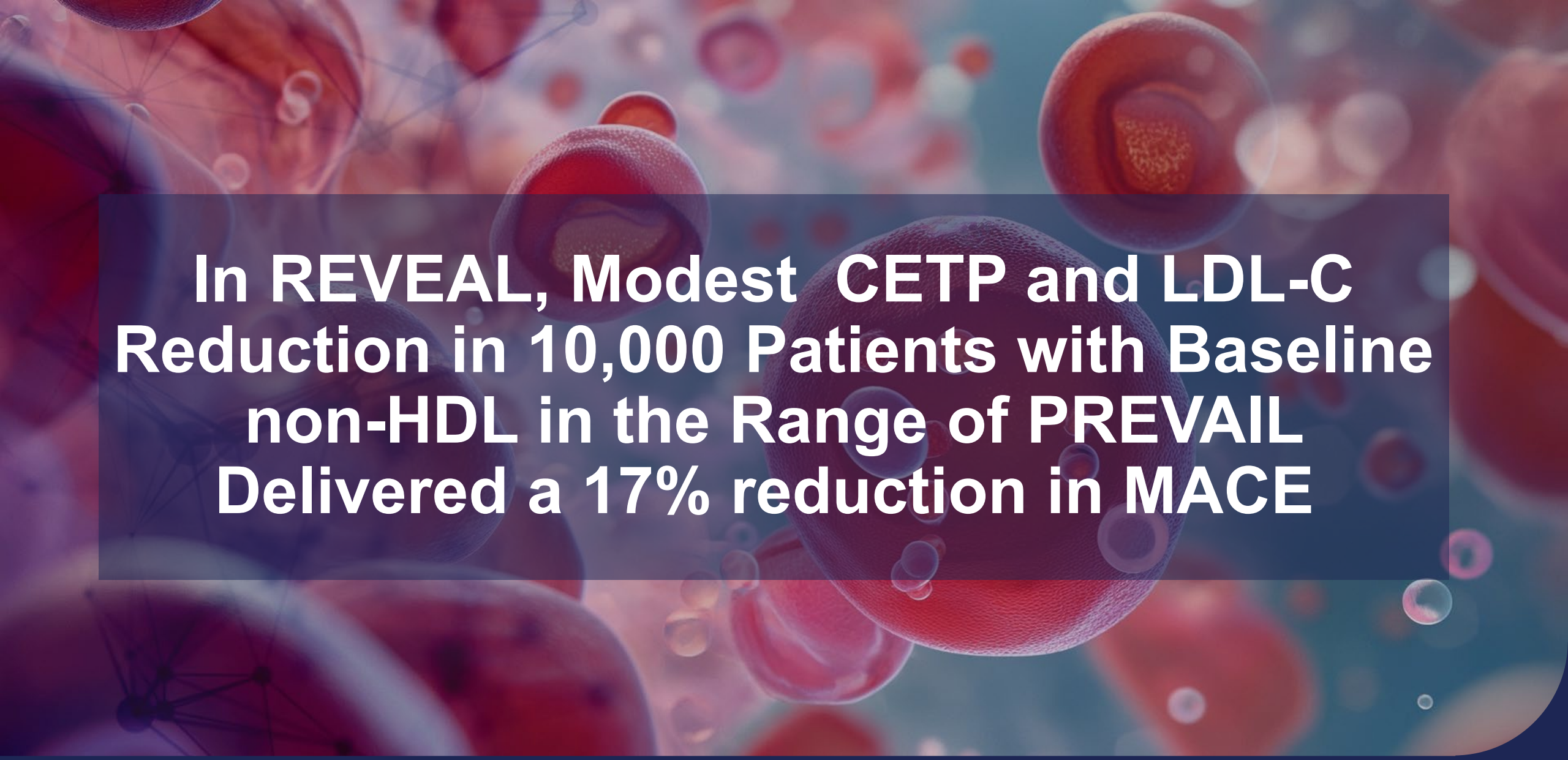
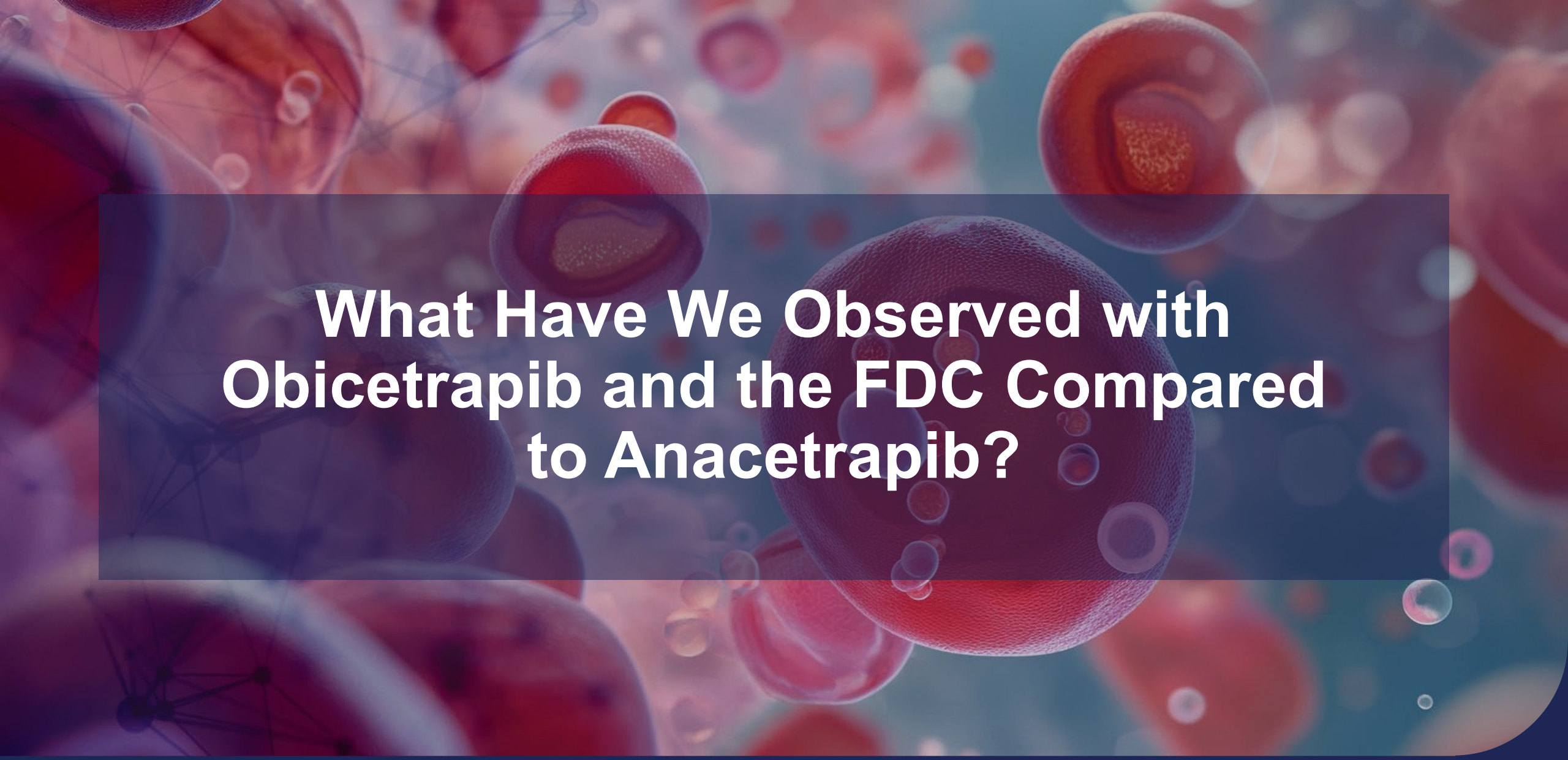
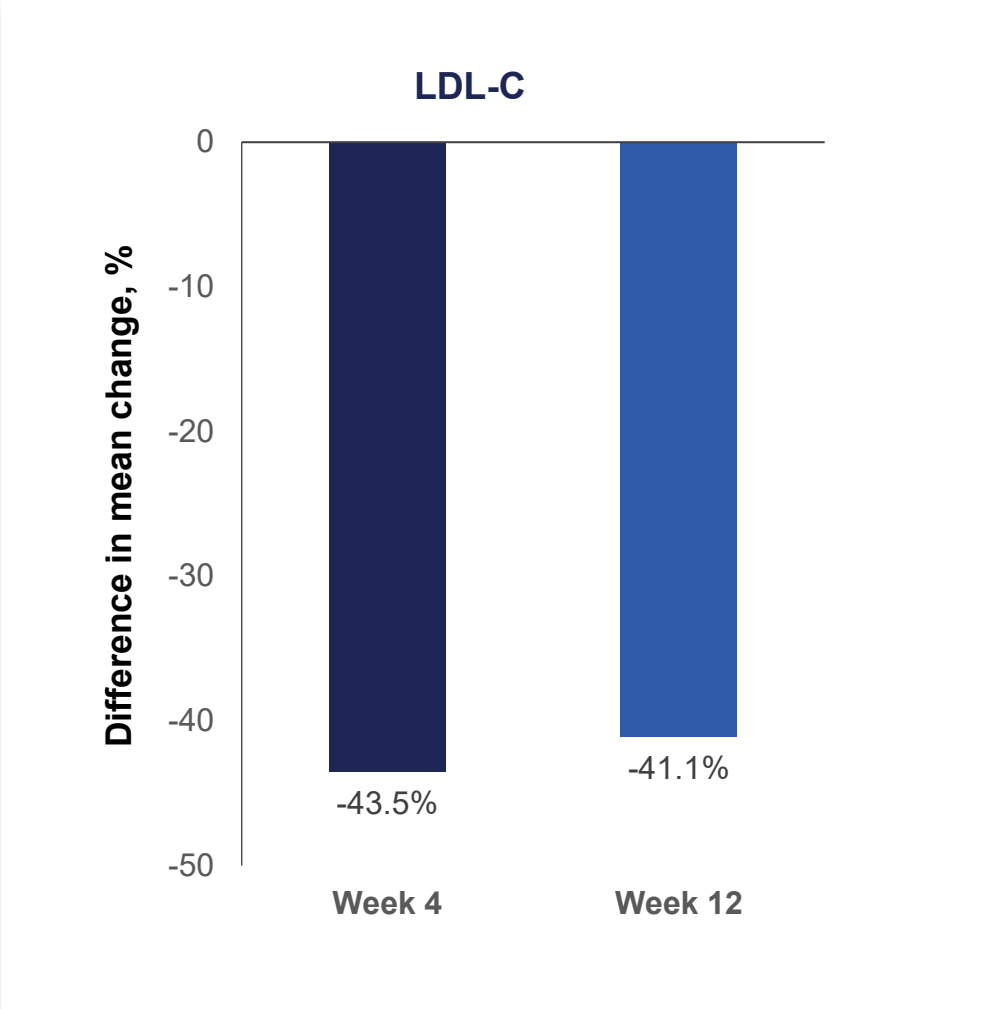

In REVEAL, Modest CETP and LDL-C Reduction in 10,000 Patients with Baseline non-HDL in the Range of PREVAIL Delivered a 17% reduction in MACE

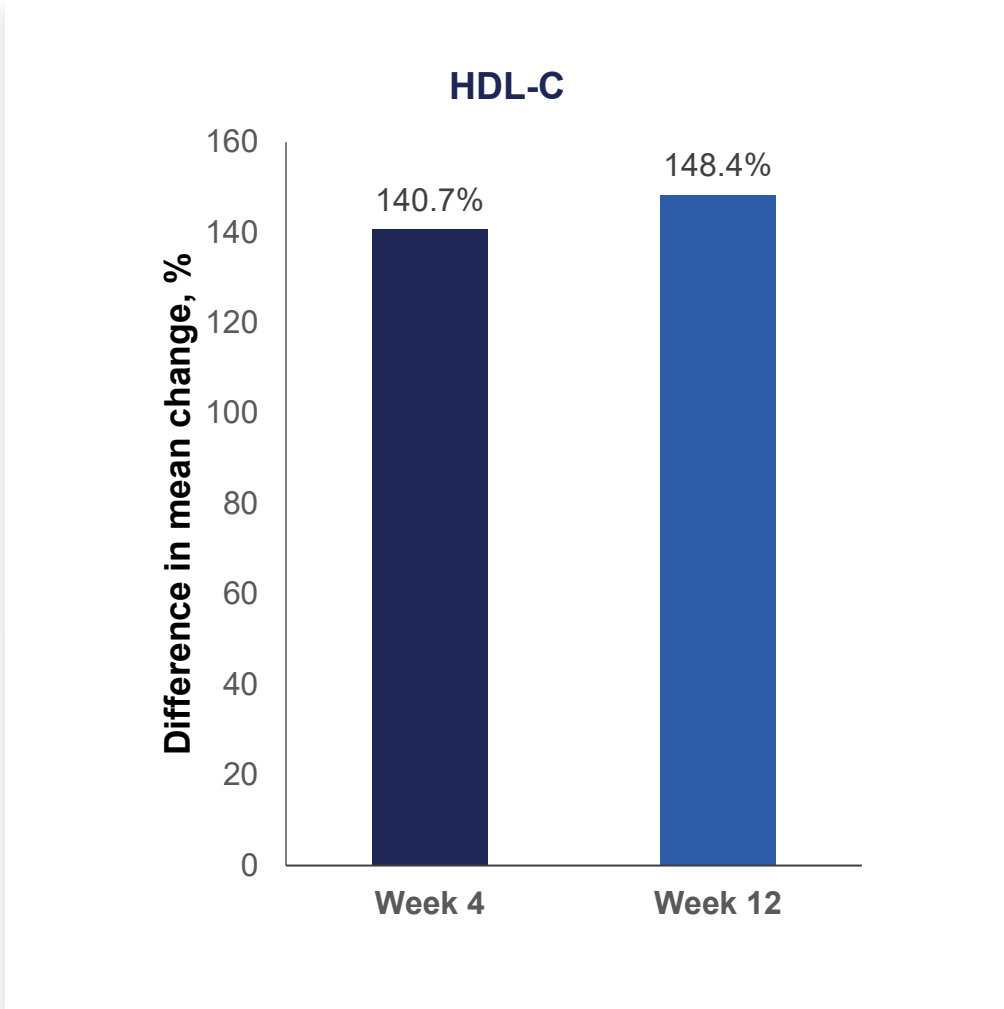


# What Have We Observed with Obicetrapib and the FDC Compared to Anacetrapib?

# Most Recent Analysis of Obicetrapib Phase 3 Data

# PK-Confirmed, Placebo Controlled, On-Treatment Effectiveness of Obicetrapib in Pooled Analysis of BROOKLYN, BROADWAY, and TANDEM




De Kleer et al. ESC 2026. Abstract 89477.



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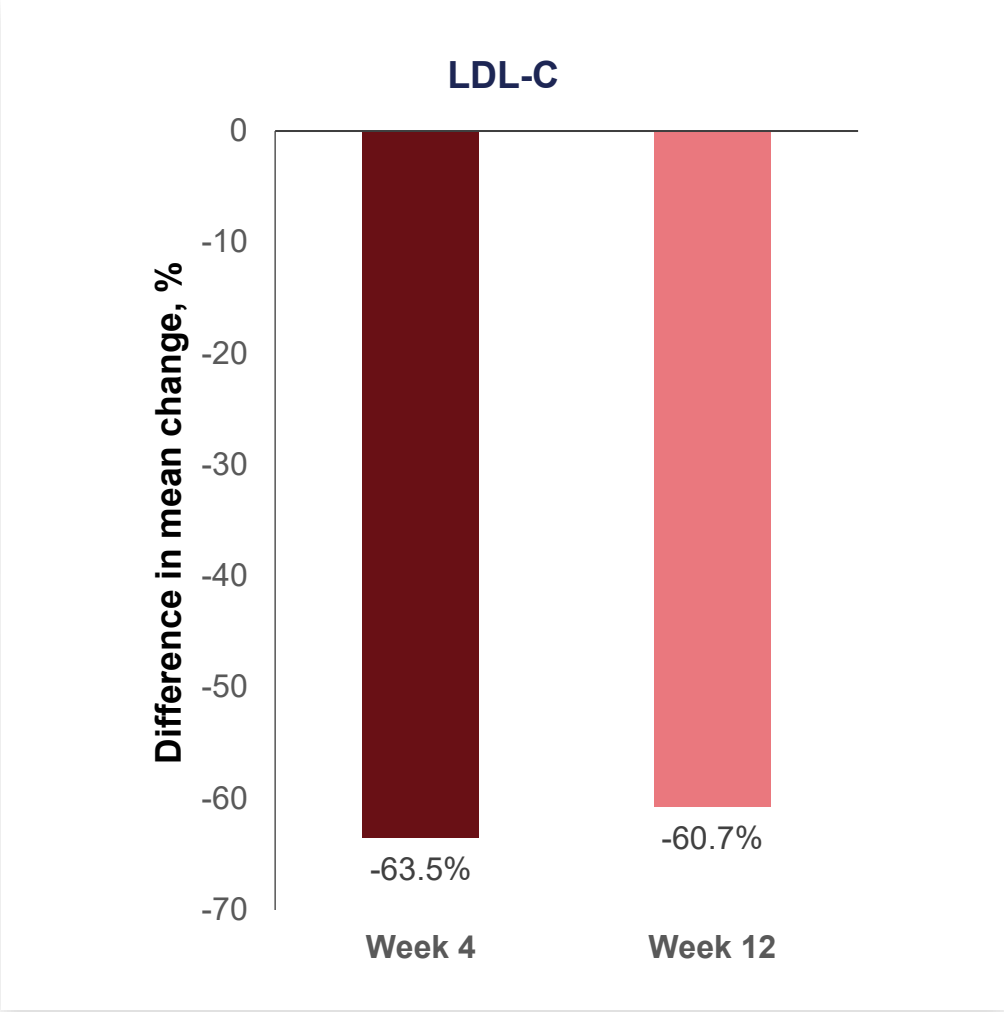
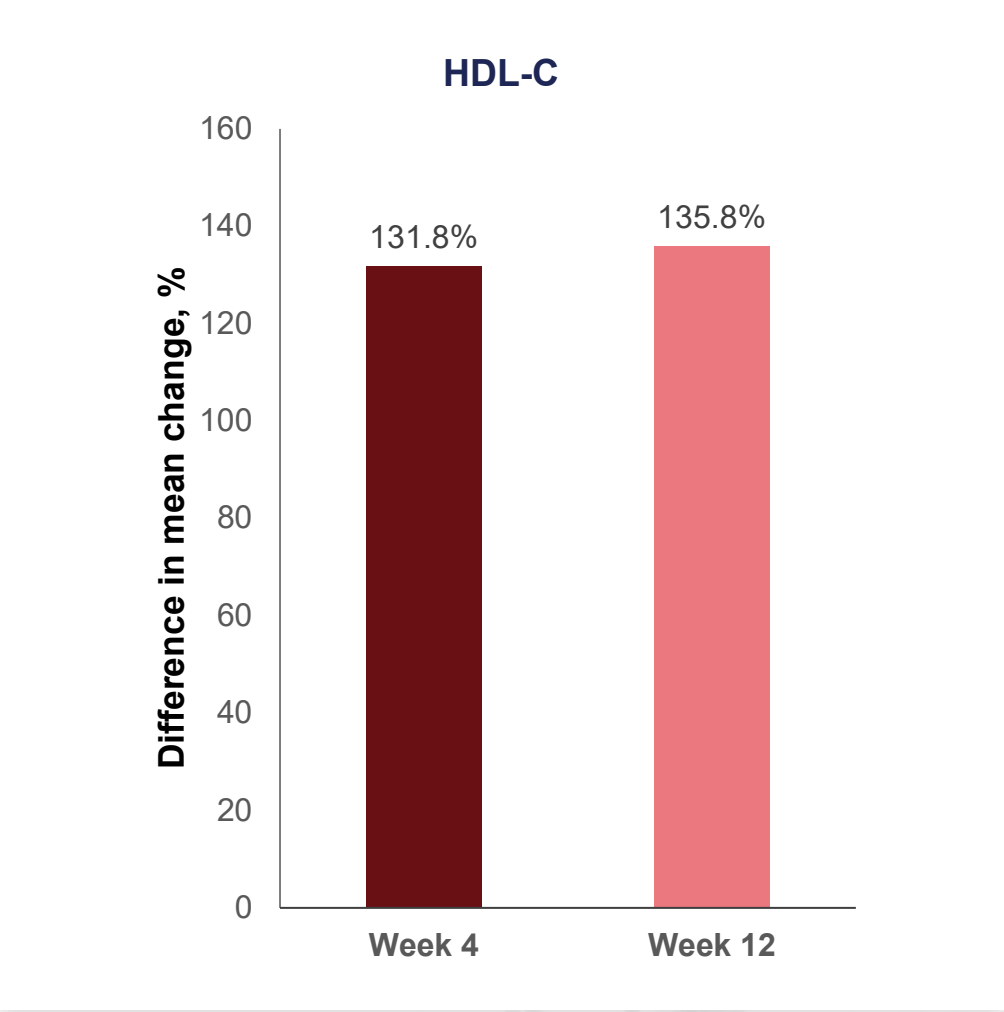
# PK-Confirmed, Placebo Controlled, On-Treatment Effectiveness of the Obicetrapib-Ezetimibe Fixed-Dose Combination in Analysis of TANDEM




De Kleer et al. ESC 2026. Abstract 89477.

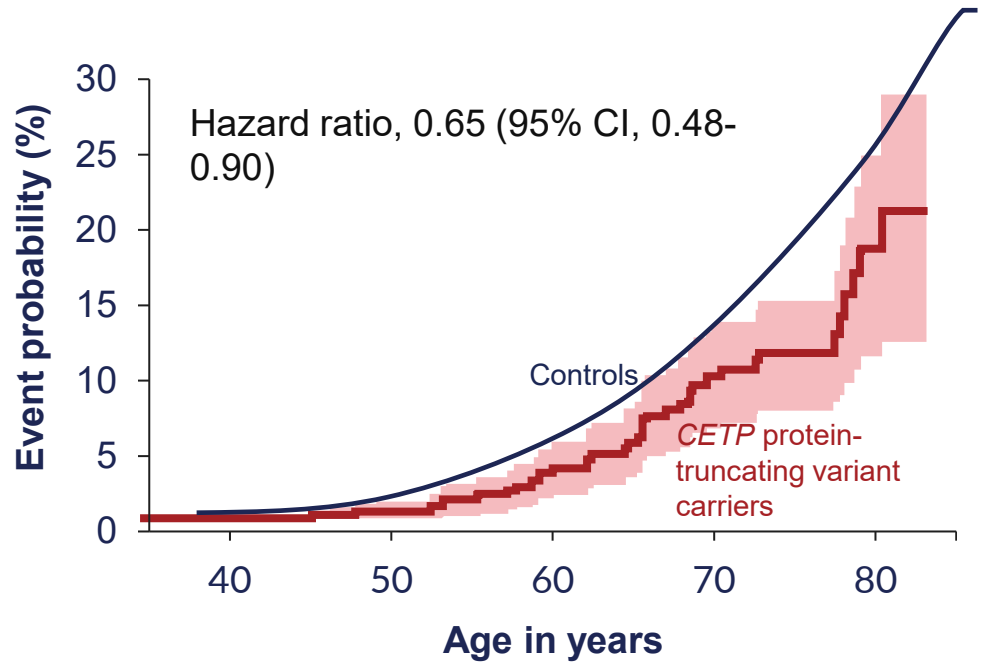
# Obicetrapib Observed to Lower LDL-C More Than Twice as much as Anacetrapib

Note: This comparison is based on an indirect treatment comparison; no head-to-head clinical trials were conducted. Results should be interpreted with caution due to inherent limitations in cross-trial comparisons.

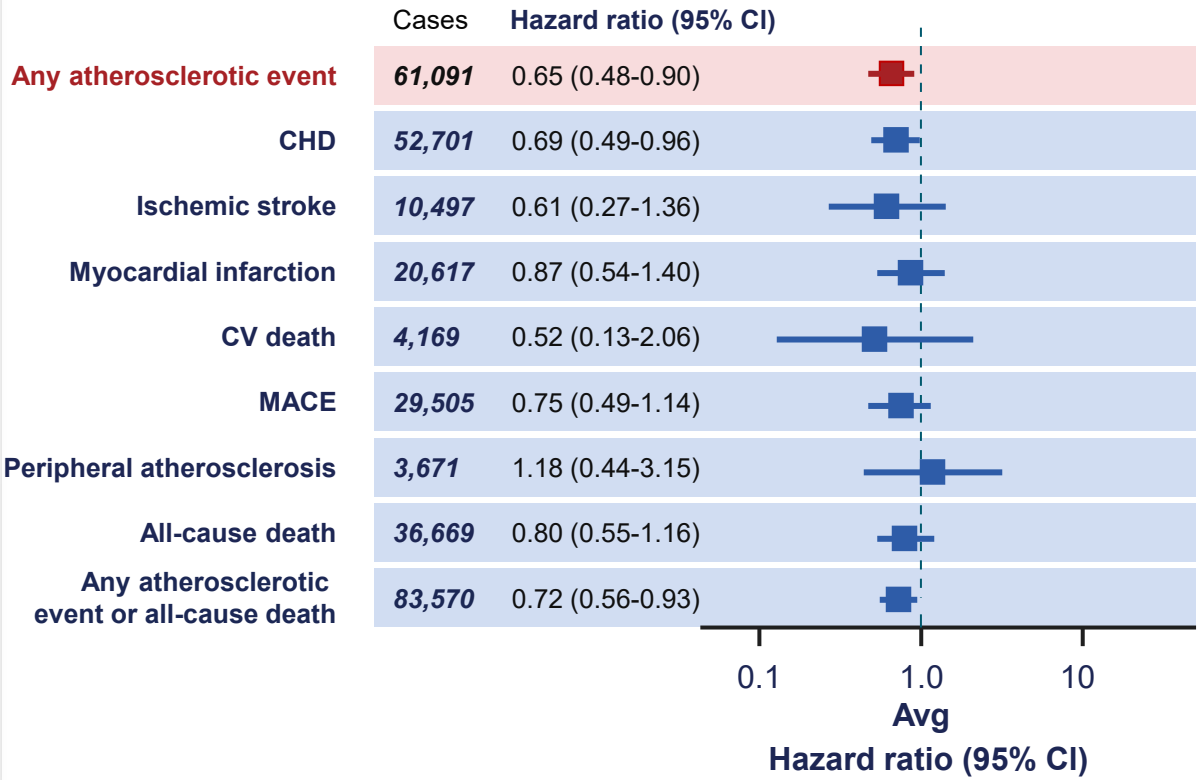
# Besides the REVEAL Study, What Is the Additional Evidence for CETP as a Target for Reduction of ASCVD Risk?

# In Press: Individuals with 50% Lower CETP Activity Show Lower Risk of CV Events

## *CETP* protein-truncating variant carriers had a lower probability of cumulative CV events compared with controls*




## *CETP* protein-truncating variants were associated with lower risk of any atherosclerotic event†




*In a study of individuals from the UK Biobank, the effects of CETP protein-truncating variants on ASCVD risk were determined by analyzing ASCVD events in individuals with CETP protein-truncating variant carriers (n=385) and noncarriers (n=409,253). Shaded areas around each curve represent 95% confidence intervals.
†In this analysis, the primary endpoint was any atherosclerotic disease event. All other endpoints were considered secondary endpoints.
ASCVD, atherosclerotic cardiovascular disease; CETP, cholesteryl ester transfer protein; CHD, coronary heart disease; CI, confidence interval; CV, cardiovascular; MACE, major adverse cardiovascular events.
Landfors F et al. *medRxiv*. 2024. 12.02.24318306



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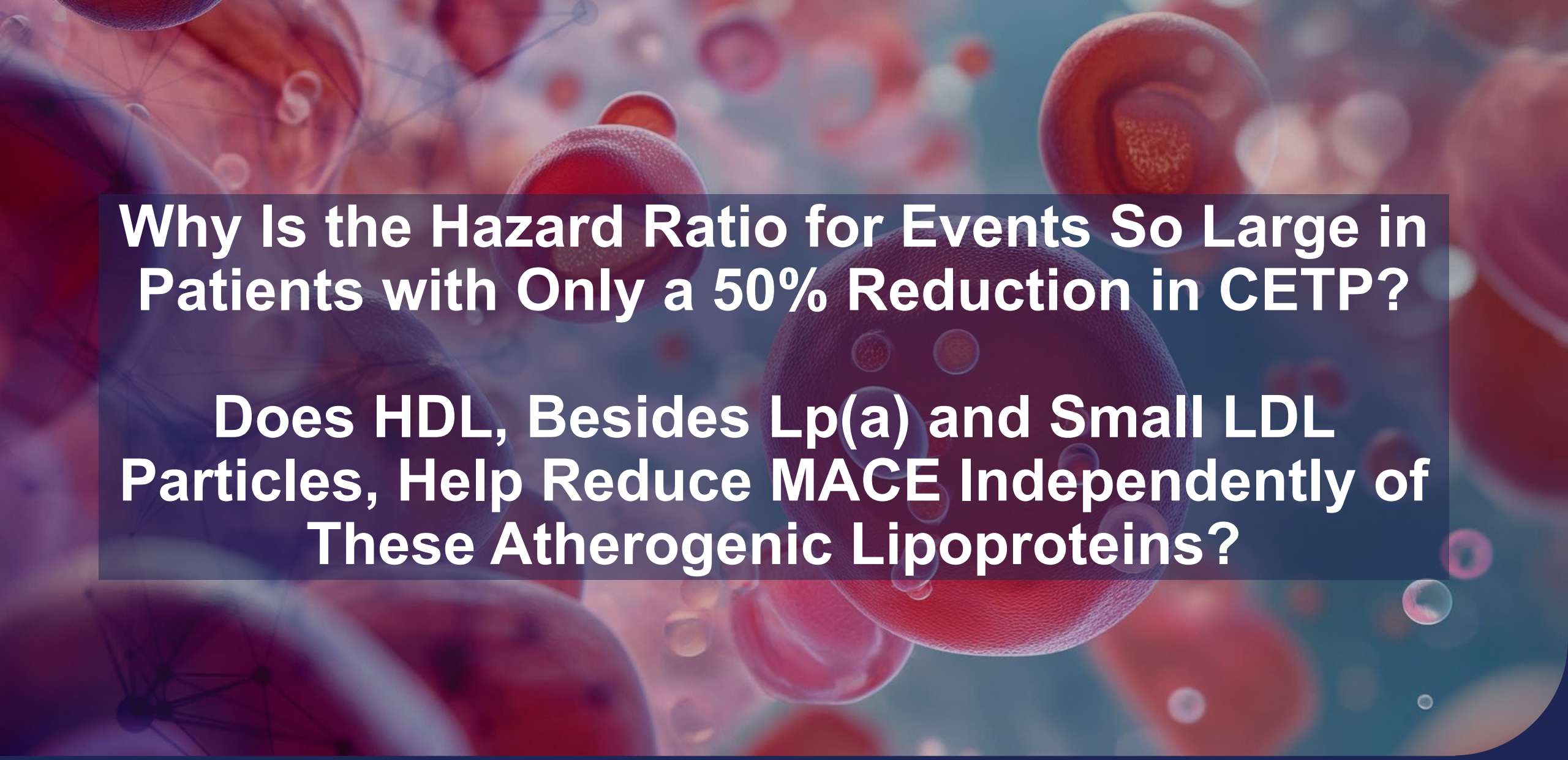


# Why Is the Hazard Ratio for Events So Large in Patients with Only a 50% Reduction in CETP?

# Does HDL, Besides Lp(a) and Small LDL Particles, Help Reduce MACE Independently of These Atherogenic Lipoproteins?

# Let's Look at Genetic Background First: Are Genetics Supportive of Clinical Data?

# When Did We Discover That Humans with Low CETP Activity Do Better Than The Rest of Us?

# CETP Loss of Function and the Ashkenazi Jewish Longevity Project

## Louise Levy, 'supercentenarian' subject of longevity study among Ashkenazi Jews, dies at 112

BY ANDREW SILOW-CARROLL JULY 28, 2023 3:22 PM

Louise Levy was born in 1910 and grew up in Cleveland and New York City; Levy often ascribed her longevity to a daily glass of red wine and a low-cholesterol diet.

CETP, cholesteryl ester transfer protein.

# The Low CETP Activity Gene Variant Is Associated with Exceptional Longevity and the Healthy Aging Phenotype

**CETP I405V genotype and lipoprotein characteristic and plasma CETP levels in families with exceptional longevity vs control**

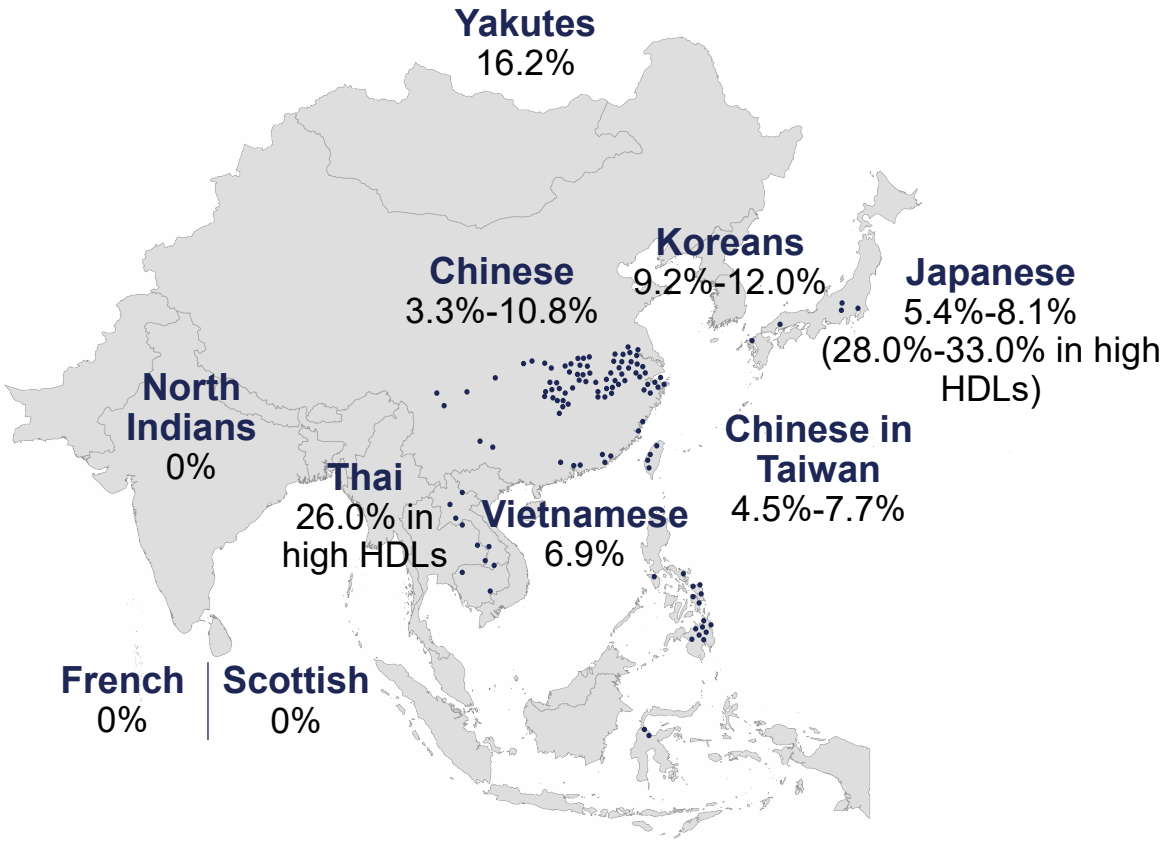
| Variable | CETP I405V Genotype VV | CETP I405V Genotype II | *P* value (VV vs II Genotypes) |
|---|---|---|---|
| HDL | | | |
| Concentration, mg/dL | 57 | 55 | 0.53 |
| Large particle size, % of total | 56 | 60 | 0.10 |
| Particle size, nm | 9.28 | 9.07 | 0.02 |
| LDL | | | |
| Concentration, mg/dL | 114 | 123 | 0.16 |
| Large particle size, % of total | 67 | 56 | 0.02 |
| Particle size, nm | 21.29 | 20.88 | 0.002 |
| CETP concentration, mg/mL | 1.65 | 1.99 | <0.001 |

**Individuals with exceptional longevity had significantly higher frequency of low CETP activity mutations**

CETP, cholesteryl ester transfer protein; HDL, high-density lipoprotein; LDL, low-density lipoprotein.
Barzilai N et al. *JAMA*. 2003;290(15):2030-2040.

# Where Do We Find Individuals with No CETP Activity at All and Do They Live Longer Too?

# CETP Deficiency Resulting in High HDL-C Levels Is Common in Regions With Endemic Schistosomiasis and May Confer Protection




CETP deficiency,* resulting in high HDL-C levels, is common in populations from regions with endemic schistosomiasis

Egg embryonation of *Schistosoma japonicum* in the liver requires plasma HDL, and this process is impaired with CETP deficiency

CETP inhibition is hypothesized to be a viable treatment strategy in schistosomiasis

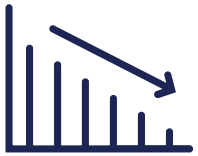
CETP, cholesteryl ester transfer protein; HDL, high-density lipoprotein; HDL-C, high-density lipoprotein cholesterol.
*D442G mutation prevalence listed as percentage in each ethnic general population.
Yokoyama S et al. *J Biomed Res*. 2015;29(3):176-188.

# What Do These Individuals Look Like Besides Having Protection Against Parasites?

# Characteristics of Individuals With CETP Deficiency

## Lipid Profiles[1]

- >100% increase in HDL
- 40% decreases in LDL-C and ApoB
- 40% decrease in Lp(a)
- No small LDL particles



## Exceptional Longevity[2]

in individuals homozygous for the I405V allele (associated with lower CETP protein levels)

## Lower ASCVD Risk[3]

CETP protein-truncating variant carriers have a lower probability of cumulative CV events

## Lower AD Risk[4]

Individuals with 1 or 2 LoF CETP genes have decreased risk of dementia and AD

## Lower Risk of AMD[5,6]

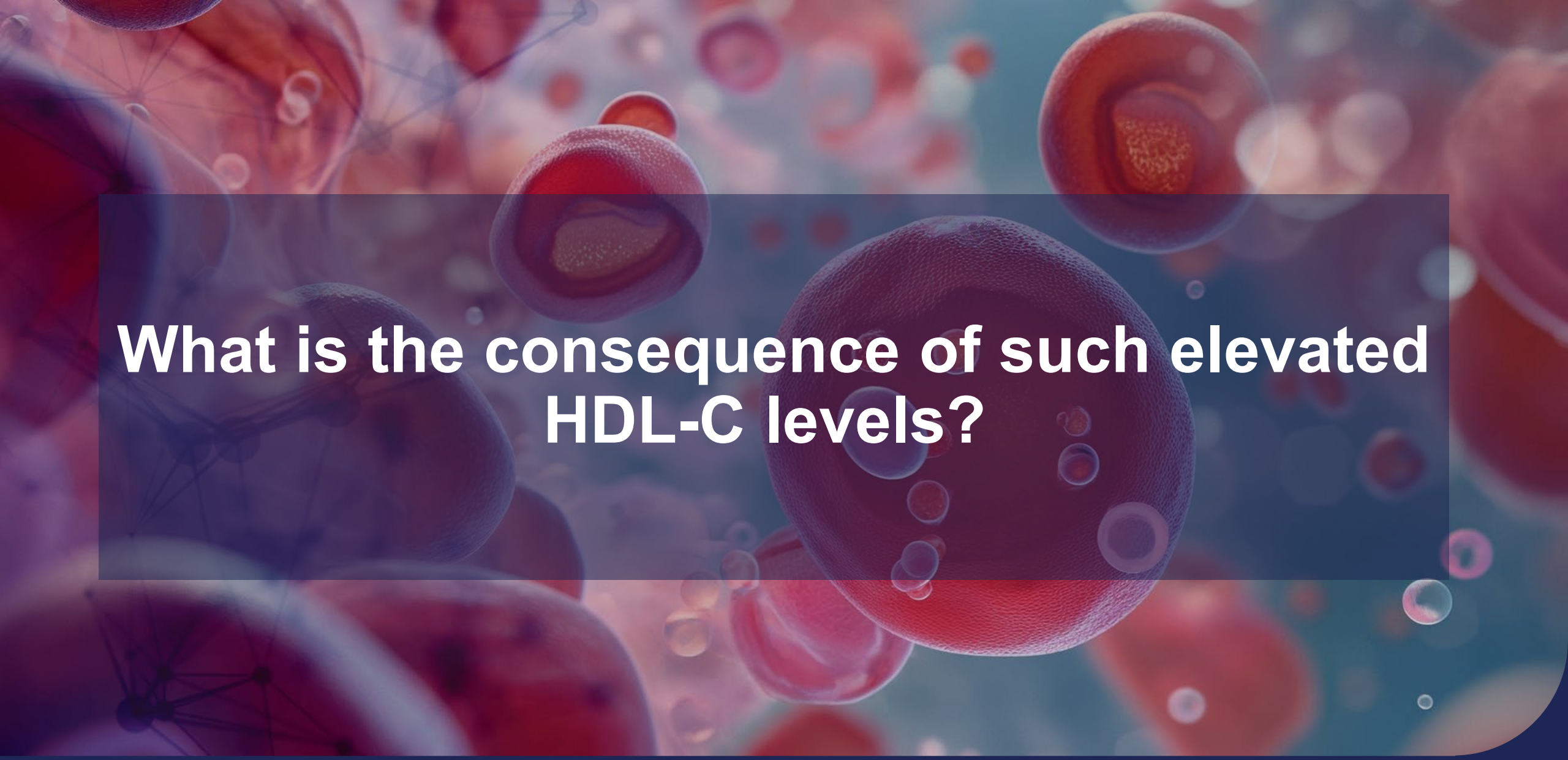
- No AMD in patients with CETP deficiency

## Lower Risk of Sepsis Mortality[7]

Genetically proxied CETP inhibition was associated with lower risk of sepsis-related critical care admission and death

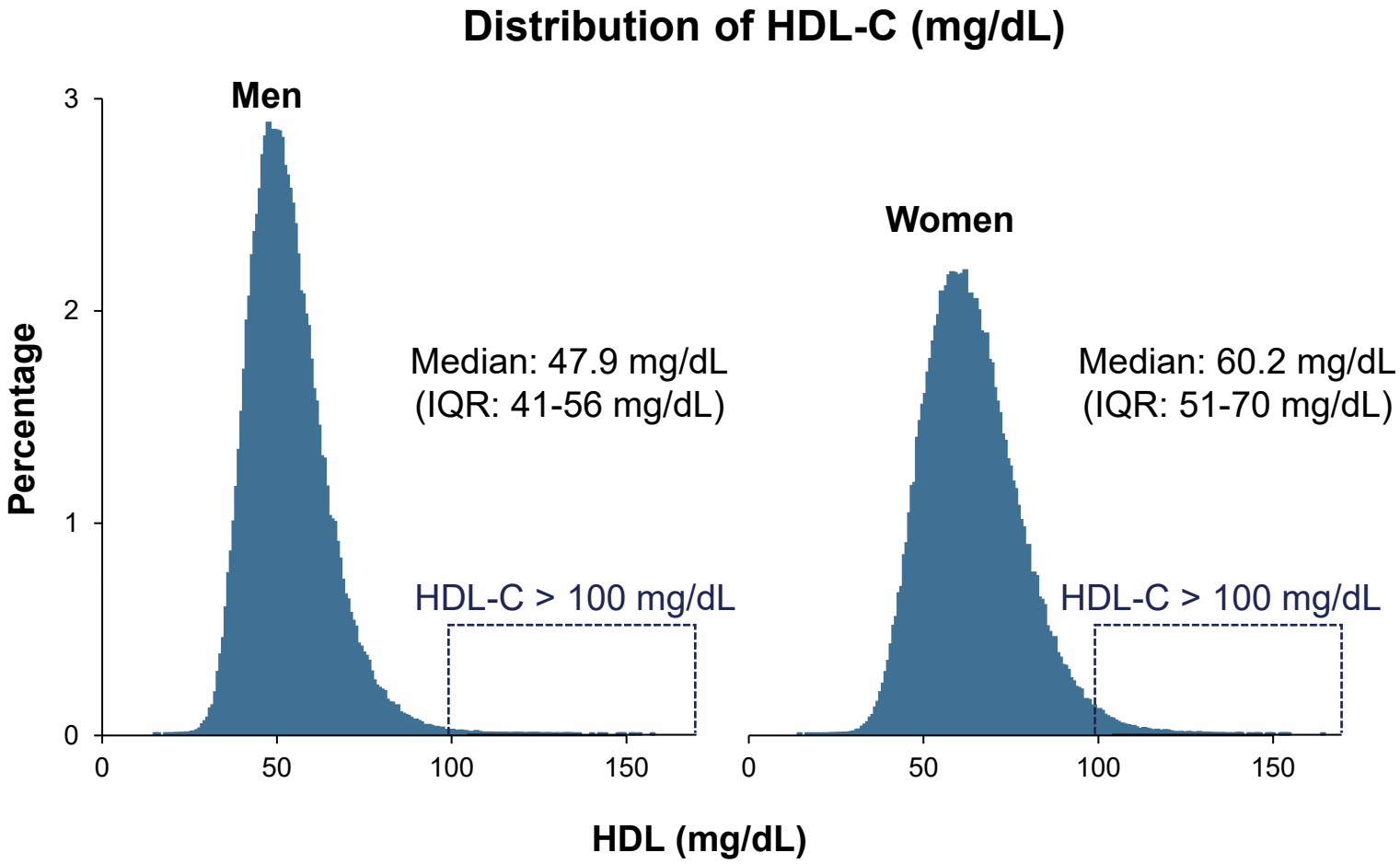
AD, Alzheimer's disease; AMD, age-related macular degeneration; ApoB, apolipoprotein B; ASCVD, atherosclerotic cardiovascular disease; CETP, cholesteryl ester transfer protein; CV, cardiovascular; HDL, high-density lipoprotein; LoF, loss of function; Lp(a), lipoprotein (a).

1. Tall AR et al. *Arterioscler Thromb Vasc Biol*. 2007;27(2):257-260. 2. Barzilai N et al. *JAMA*. 2003;290(15):2030-2040. 3. Landfors F et al. *medRxiv*. 2024. 12.02.24318306. 4. Sanders AE et al. *JAMA*. 2010;303(2):150-158. 5. Yu C et al. *J Am Heart Assoc*. 2023;12(21):e031459. 6. Mehta N et al. *Pharmacol Res*. 2023;197:106972. 7. Li Q et al. *World J Emerg Med*. 2025;16(3):256-261.



# What is the consequence of such elevated HDL-C levels?

# Extremely High Levels of HDL-C* Are Very Uncommon in the General Population



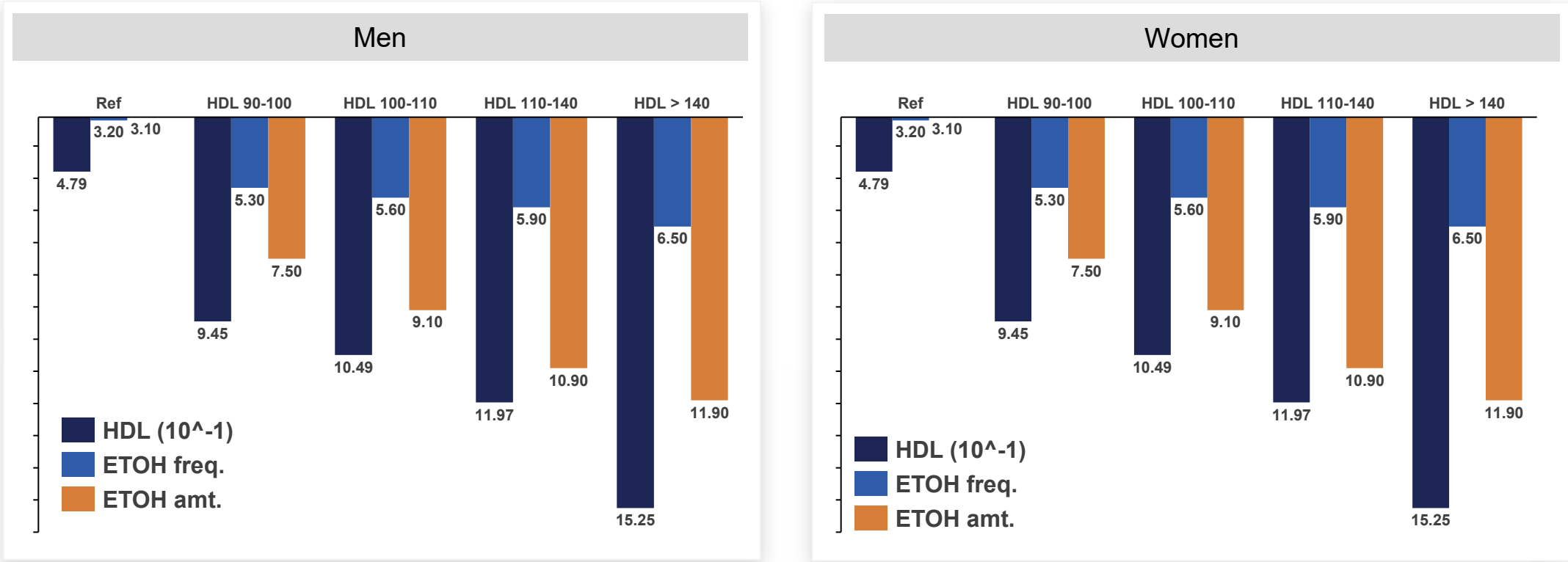

**Among 207,741 men in the UK Biobank, 428 (0.5%) had HDL-C levels >100 mg/dL**

**Among 239,129 women, 3,295 (2%) had HDL-C levels >100 mg/dL**

*Reference groups were participants with HDL-C levels between the 25th and 75th percentiles: median (IQR) HDL-C was 47.9 (41-56) mg/dL for men, and 60.2 (51-70) mg/dL for women.
IQR, interquartile range; UK, United Kingdom.
Ference BA et al. ESC 2026. Abstract 86367.

# Participants With Extremely High HDL-C Had Progressively Higher Alcohol Use

**There Is a Stepwise Increase in Alcohol Consumption and Alcohol-Related Comorbidities Among Participants Who Have HDL-C Levels Above 90 mg/dL**




**Participants with high HDL-C had higher alcohol use, alcohol frequency, GGT, SBP, and heart rate; and lower BMI, weight, and ApoB. Characteristics of severe alcohol-induced multisystem morbidity.**

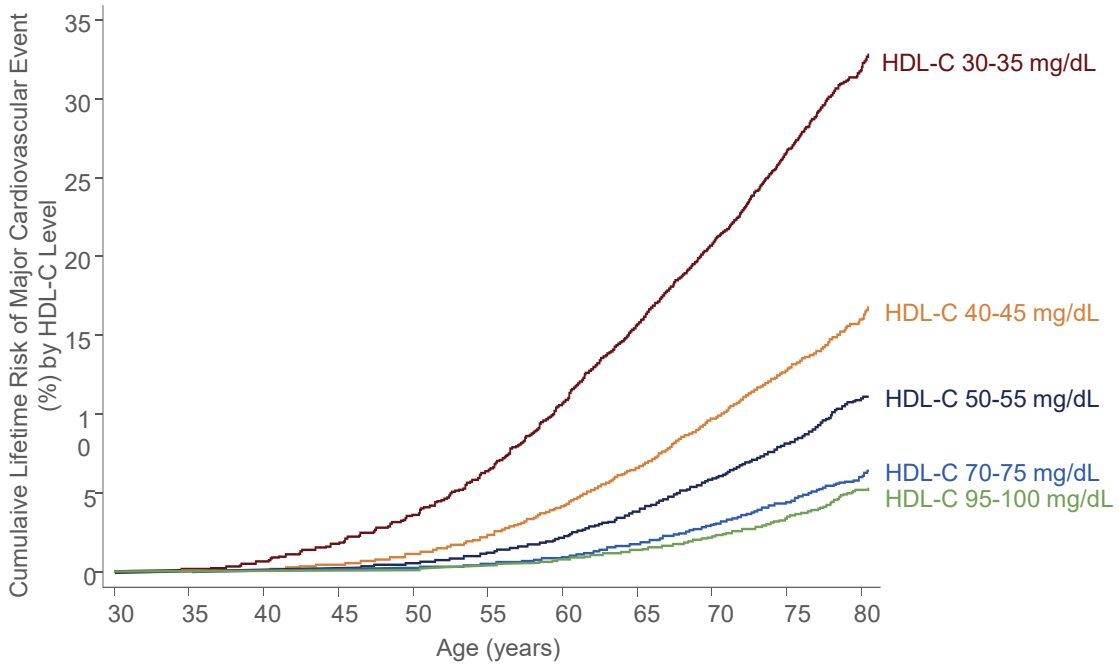
*Reference groups were participants with HDL-C levels between the 25th and 75th percentiles: median (IQR) HDL-C was 47.9 (41-56) mg/dL for men, and 60.2 (51-70) mg/dL for women.
Individual participant data from a study of 429,892 participants enrolled in UK Biobank who had HDL-C measured at baseline.
ApoB, apolipoprotein B; BMI, body mass index; ETOH, alcohol; freq, frequency; GGT, gamma-glutamyl transferase; ref, reference group; SBP, systolic blood pressure.
Ference BA et al. ESC 2026. Abstract 86367.

# The Mortality Associated with High HDL-C in Observational Studies May Be Explained by Alcohol-Induced Multisystem Disease

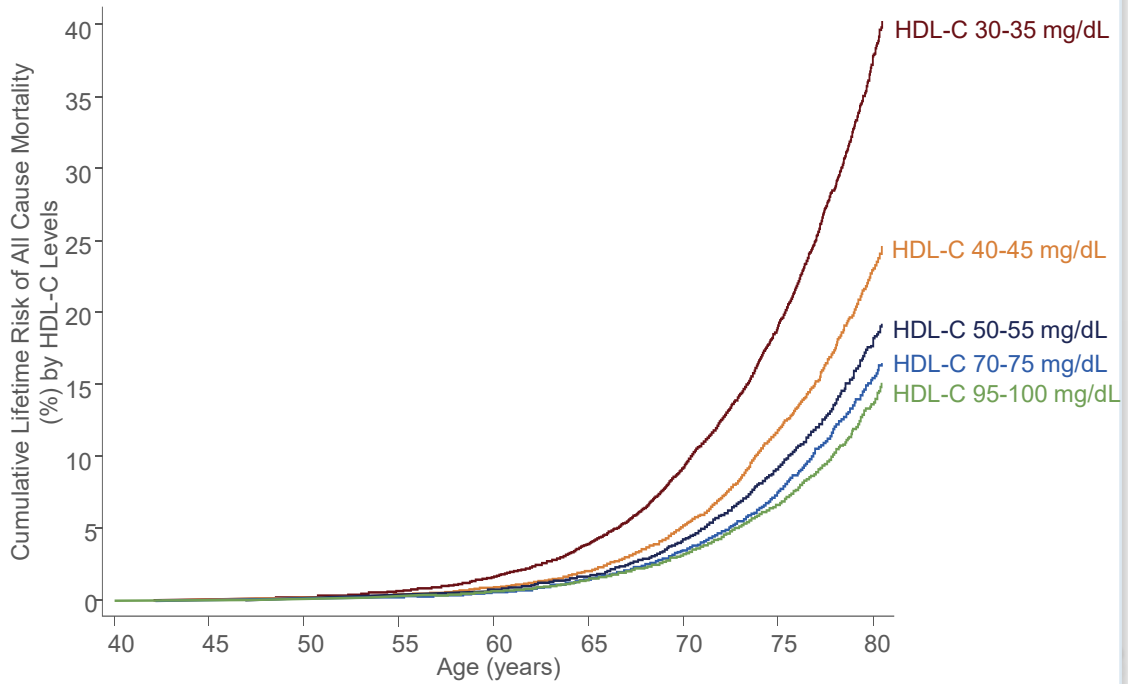
# In Fact: HDL-C Levels May be Associated With Decreased Cumulative Lifetime Risk for MACE and All Cause Mortality

ESC CONGRESS 2026 MUNICH

**UK Biobank Participants:** N=447,651; 29,876 **Major Cardiovascular Events**; includes both events (and age at event) occurring before and after enrolment to estimate lifetime risk of major coronary events by HDL-c level




**UK Biobank Participants:** N=447,651; 31,215 Deaths (any fatal event); Median follow-Up 12.5 years




HDL-C, high-density lipoprotein cholesterol;



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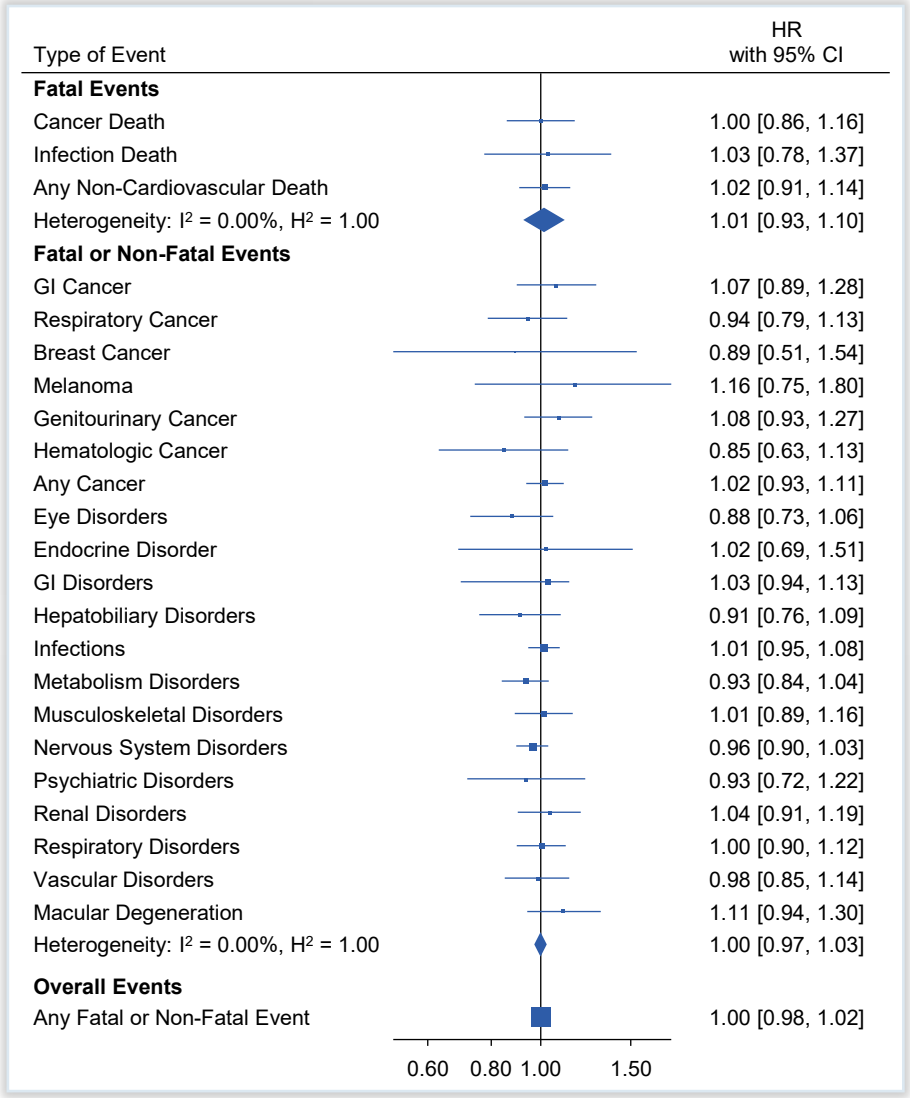
# What is the Safety of a 100% Increase in HDL-C ?

# Safety of HDL Increases With CETP Inhibition Were Observed With Anacetrapib in the REVEAL Trial




HPS3/TIMI55–REVEAL Collaborative Group. *N Engl J Med.* 2017;377:1217–1227.

**In REVEAL, anacetrapib increased HDL-C by 104% relative to placebo**

**This led to no increase in any fatal or non-fatal event in over 30,000 patients**



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# Obicetrapib Clinical Trials Update: Going with the Evidence

# Obicetrapib Clinical Pipeline Update

**Obicetrapib is being studied in three clinical trials that are designed to demonstrate benefits beyond LDL-C lowering**

**RUBENS**

Phase 3 study to evaluate the effect of obicetrapib + ezetimibe FDC on LDL-C lowering in patients with **metabolic syndrome and/or T2D**

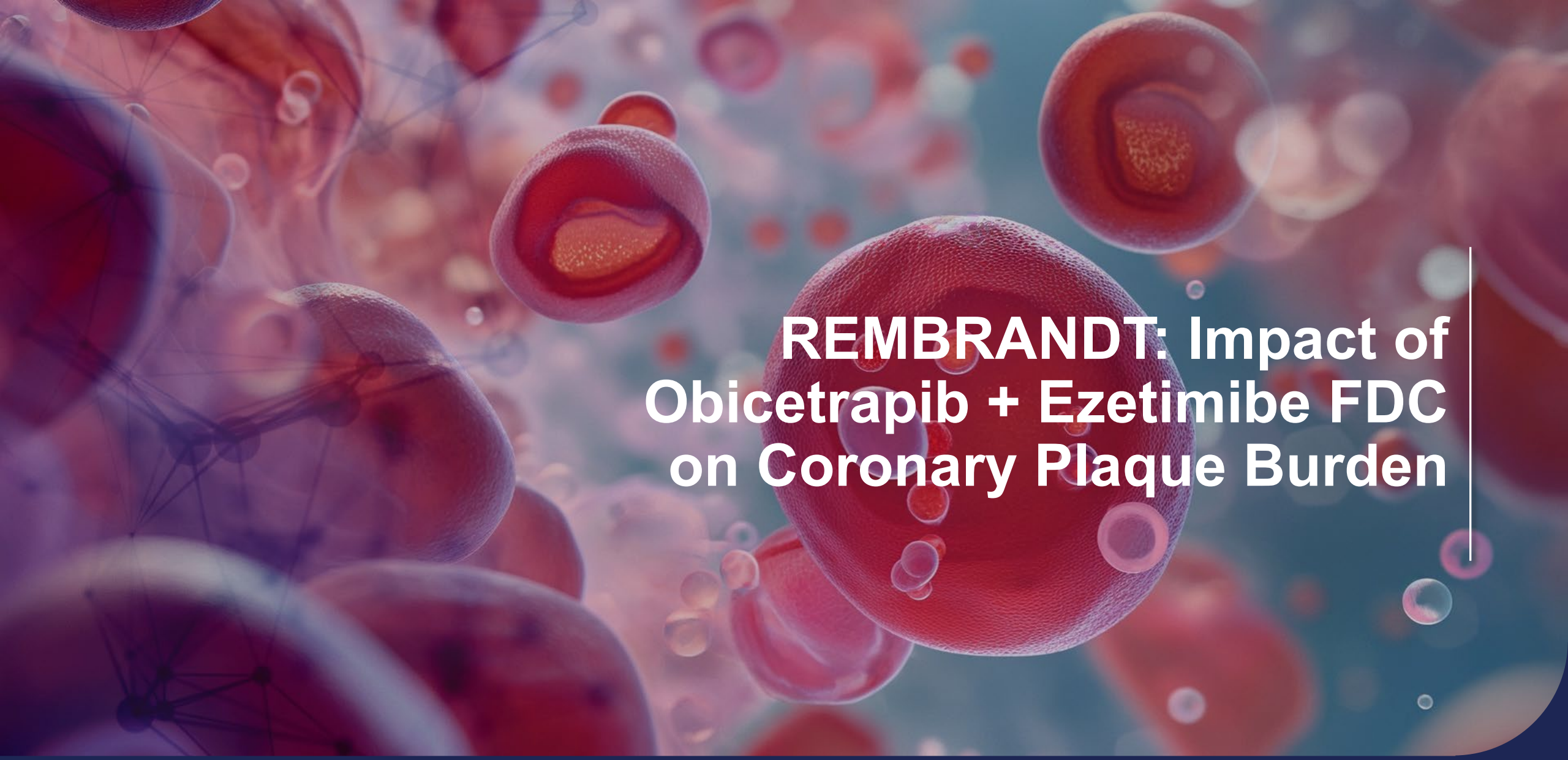
**REMBRANDT**

Phase 3 CCTA study to evaluate the effect of obicetrapib + ezetimibe FDC on **coronary plaque burden** in patients with **ASCVD**

**SPINOZA STUDY**

Phase 2b study to evaluate the effect of obicetrapib on Alzheimer's disease biomarkers in high-risk APOE4 carriers with **preclinical AD**

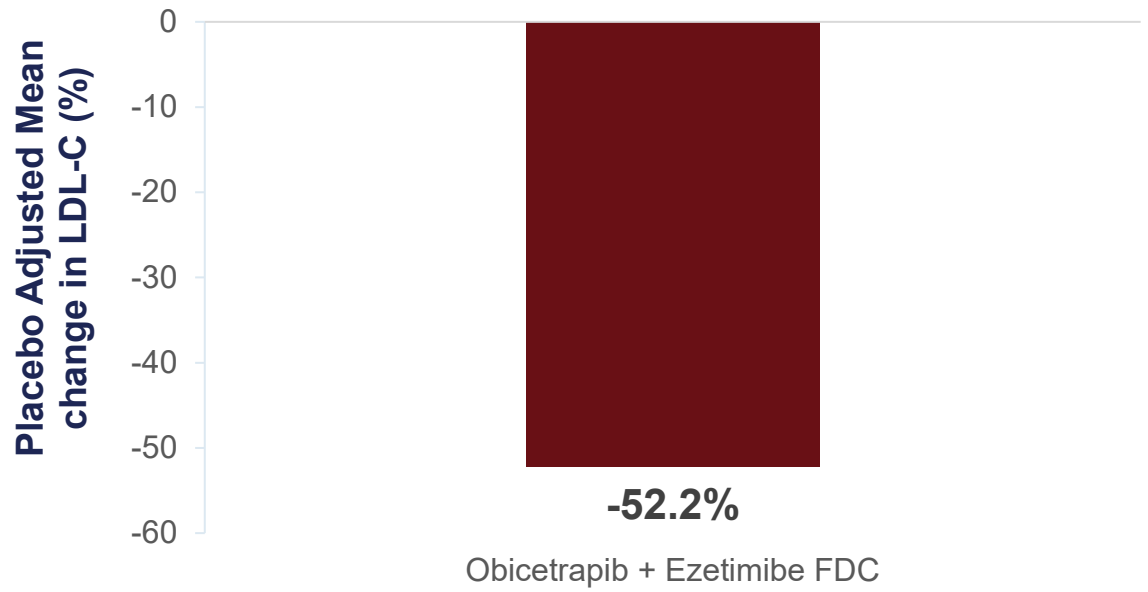
AD, Alzheimer's disease; APOE, apolipoprotein E; ASCVD, atherosclerotic cardiovascular disease; CCTA, coronary computed tomography angiography; FDC, fixed-dose combination; LDL-C, low-density lipoprotein cholesterol; T2D, type 2 diabetes.



# REMBRANDT: Impact of Obicetrapib + Ezetimibe FDC on Coronary Plaque Burden

# Obicetrapib + Ezetimibe FDC Delivers PCSK9i – Like* LDL-C Lowering Without Compromising Safety

## Obicetrapib + Ezetimibe FDC Demonstrates Robust Reductions in LDL-C




## Obicetrapib + Ezetimibe FDC Is Well Tolerated

| | Any AE | Serious AE |
|---|---|---|
| **FDC: Obi + Eze** | 51% | 3% |
| Obicetrapib (mono) | 54% | 6% |
| Ezetimibe (mono) | 53% | 7% |
| Placebo | 37% | 4% |

FDC, fixed-dose combination; LDL-C low-density lipoprotein cholesterol; PCSK9, proprotein convertase subtilisin/kexin type 9.

*-PCSK9 label efficacy of 50-60%

Sarraju A, et al. *Lancet.* 2025;405(10491):1757-1768.



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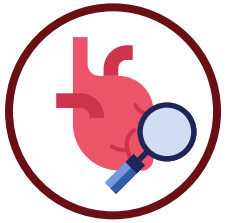
# PREVAIL Will Settle Efficacy and Safety — But What About the Plaque?

PREVAIL

The decisive efficacy & safety read-out

**OBICETRAPIB MONOTHERAPY**

?



## The Plaque Question

How do atherosclerotic plaques behave following treatment with obicetrapib + ezetimibe FDC?

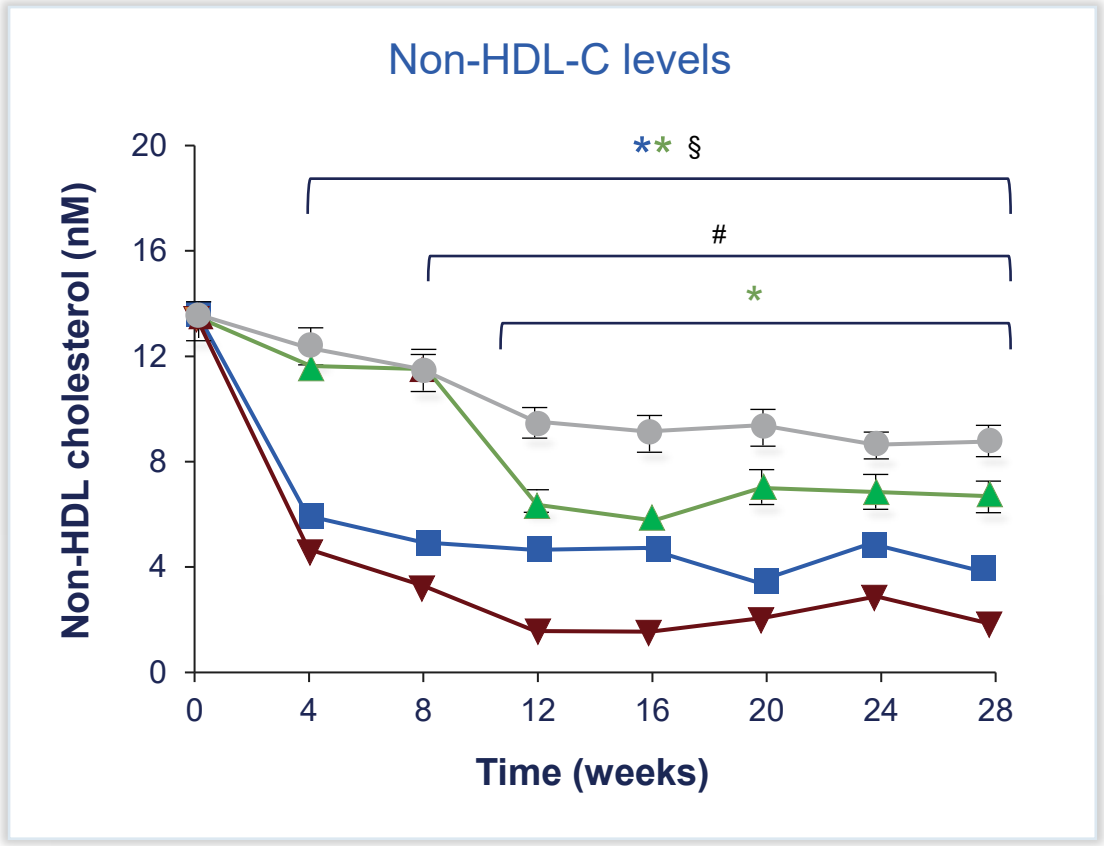
**OBICETRAPIB + EZETIMIBE FDC**

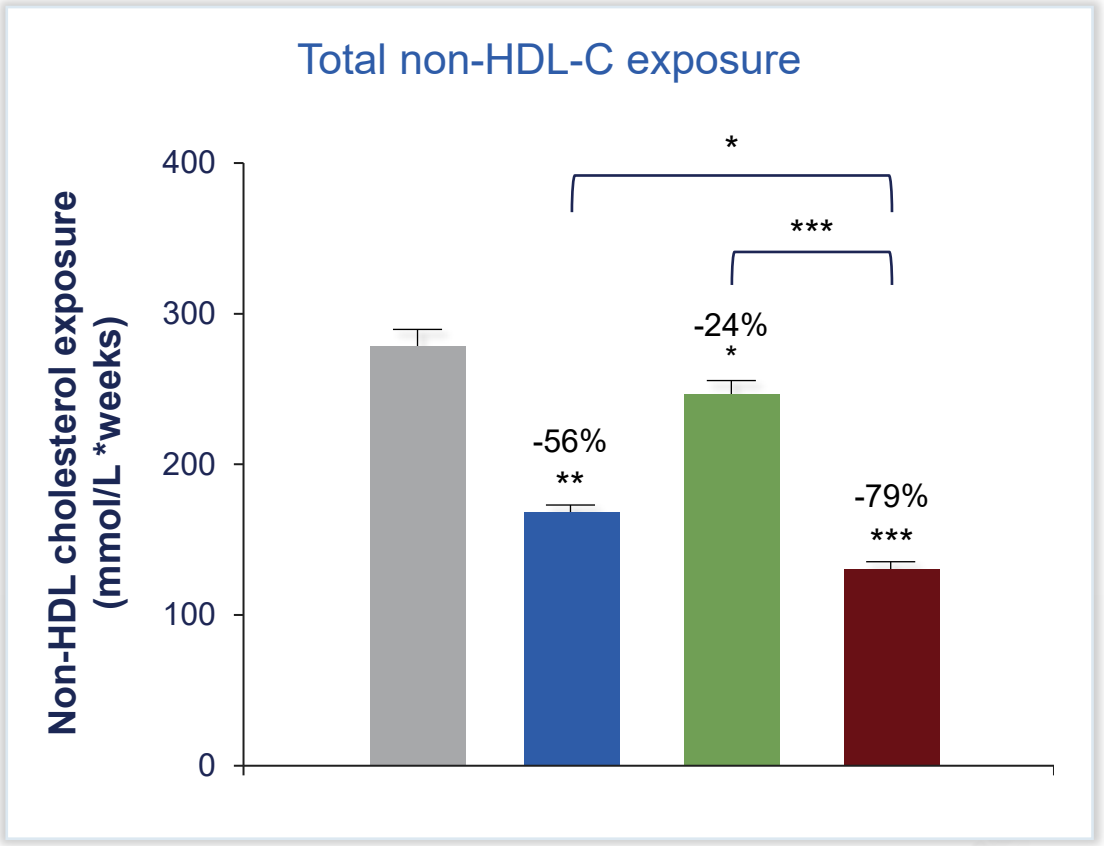
**PREVAIL delivers the decisive read-out — but atherosclerotic plaque behavior under the fixed-dose combination remains to be shown.**

FDC, fixed-dose combination.

# How Does Obicetrapib + Ezetimibe Perform in a Humanized Mouse Model?

# Obicetrapib plus Ezetimibe Robustly Decreases Non-HDL Cholesterol in Humanized Mouse Model



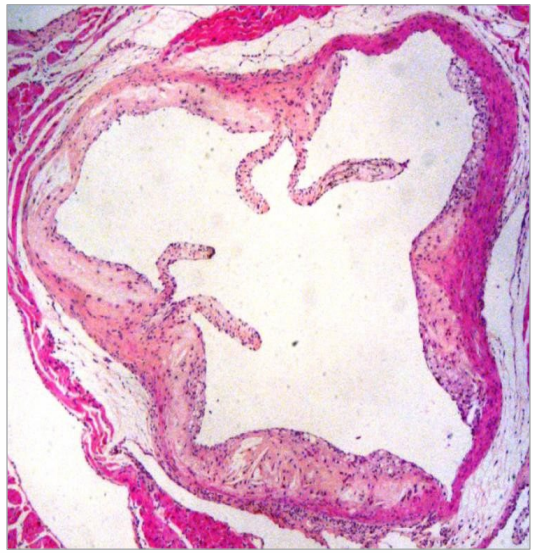



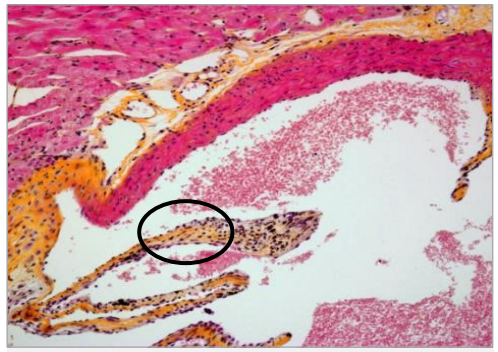

Control Obicetrapib Ezetimibe Obicetrapib + Ezetimibe

*(blue) *P*<0.05 Obicetrapib vs control. *(red) *P*<0.05 ezetimibe vs control. *(yellow) *P*<0.05 ezetimibe vs control. **P*<0.05. ***P*<0.01. ****P*<0.001.
#*P*<0.05 obicetrapib vs obicetrapib + ezetimibe. §*P*<0.05 ezetimibe vs obicetrapib + ezetimibe.
Apo, apolipoprotein; CETP, cholesteryl ester transfer protein; HDL, high-density lipoprotein; HDL-C, high-density lipoprotein cholesterol; LDL, low-density lipoprotein; VLDL, very-low-density lipoprotein.
Inia JA et al. *J Clin Lipidol.* 2025;19(3S):e111.

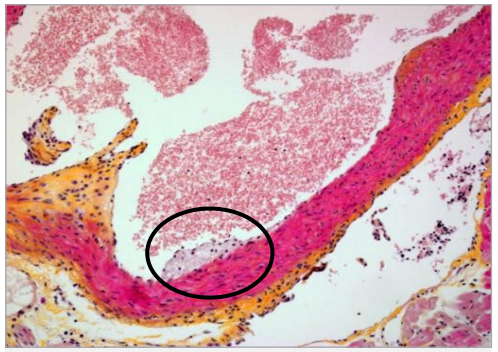
# How Did Atherosclerotic Plaques Respond to These Changes in Lipids?

# Atherosclerotic Lesions Remain Main Contributor to Risk for Heart Attack and Stroke

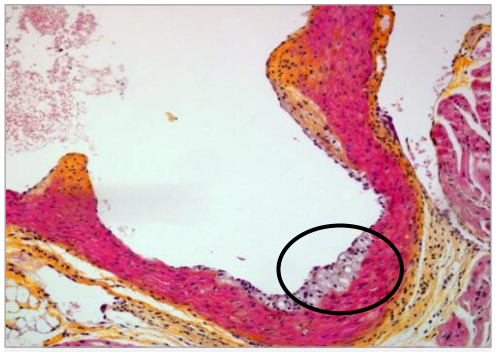




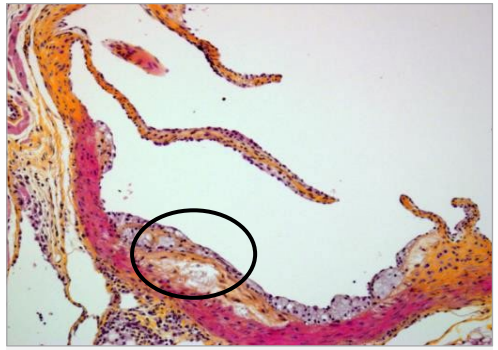
**Type I – Early fatty streak**
Up to 10 foam cells in the intima



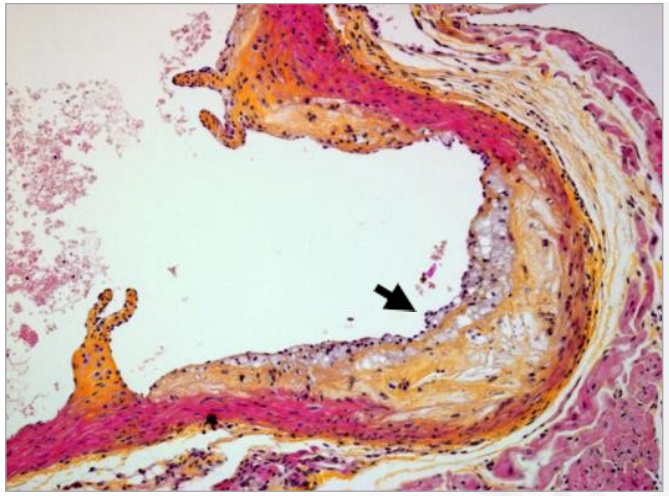
**Type II – Regular fatty streak**
Over 10 foam cells present in the intima



**Type III – Mild plaque**
Extension of foam cells into the media with presence of a fibrotic cap



**Type IV – Moderate plaque**
A more progressive lesion with affected media, without loss of architecture and fibrosis of the media

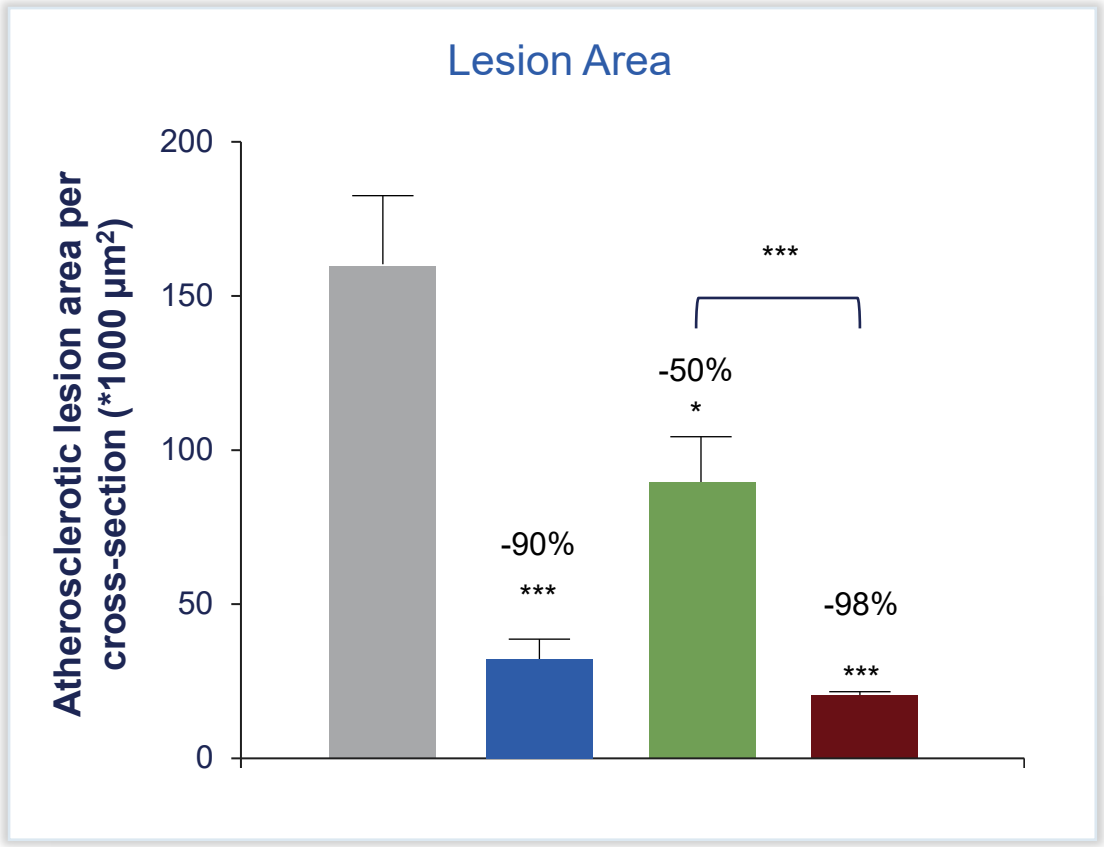


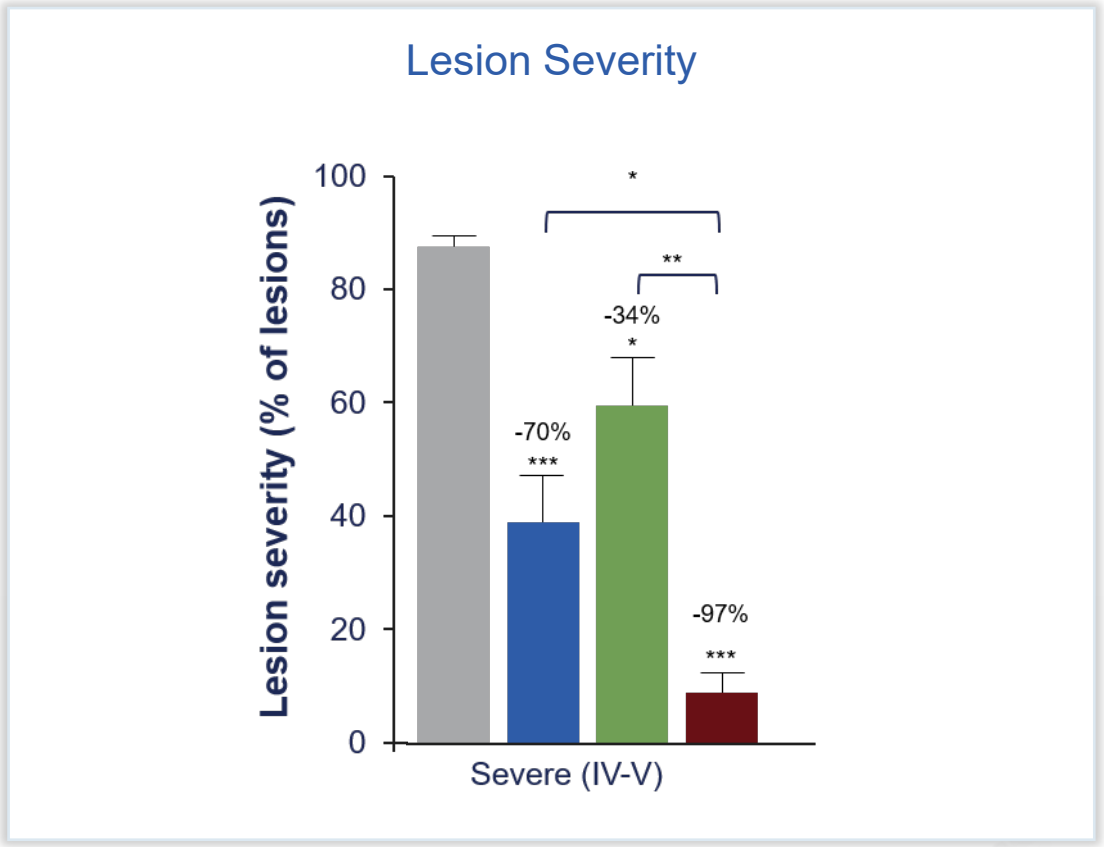
**Type V – Severe plaque**

- Media is severely damaged with broken internal elastic lamina
- Cholesterol clefts and/or crystals, calcium mineralization and necrosis are often visible

Source: Data on File. NewAmsterdam Pharma.
Atherosclerotic Lesion Typing According to AHA Classification

# Obicetrapib plus Ezetimibe Decreased Surface Area of Severe Lesions in the Aortic Root by 98%




Control | Obicetrapib | Ezetimibe | Obicetrapib + Ezetimibe

*$P$<0.05. **$P$<0.01. ***$P$<0.001.
Inia JA et al. *J Clin Lipidol.* 2025;19(3S):e111.



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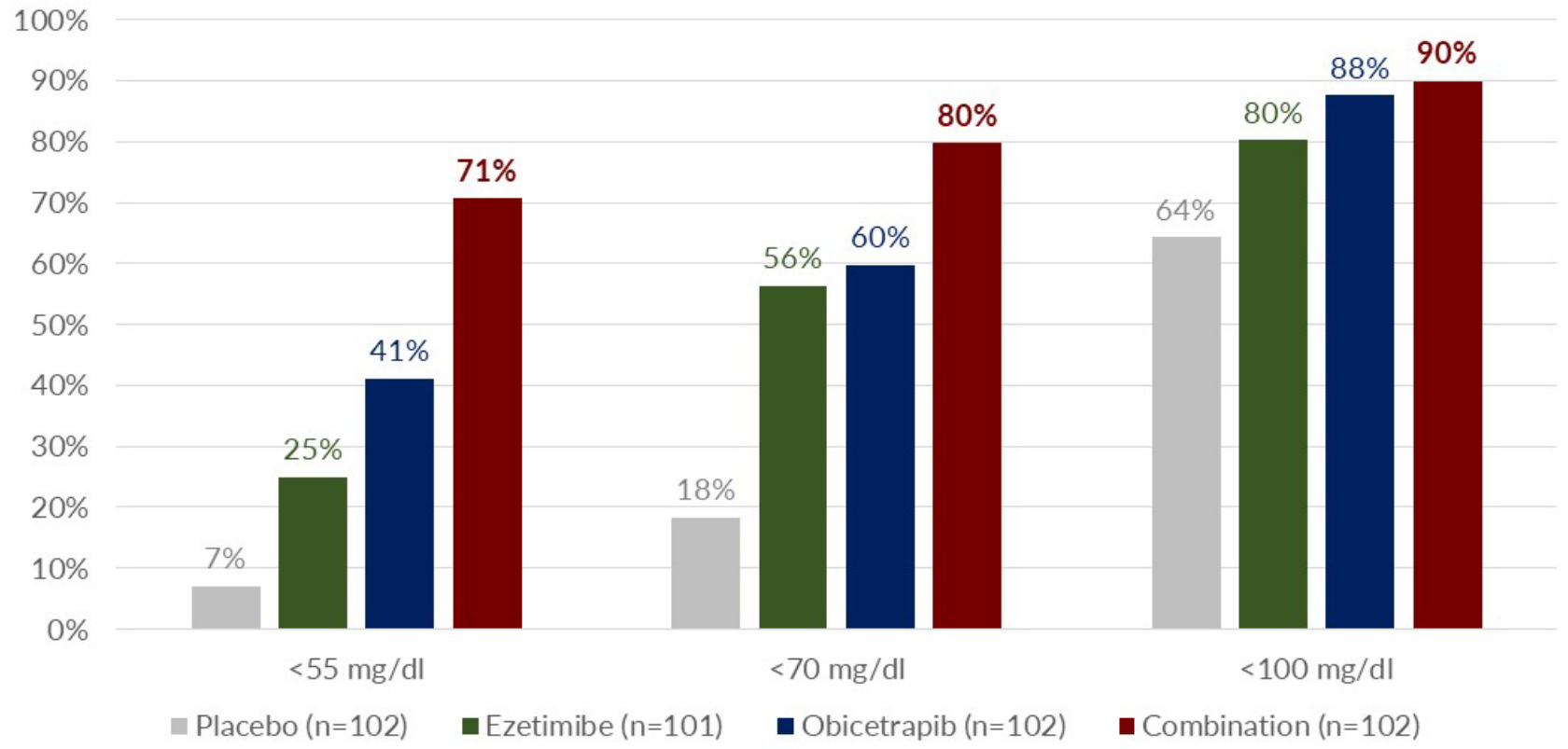
# Now Back to Humans ….

# Over 70% of Patients on Obicetrapib + Ezetimbe Achieved LDL-C <55 mg/dL

TANDEM

**% of patients achieving LDL-C thresholds at Day 84**




Source: Data on file. LDL-C, low-density lipoprotein cholesterol.



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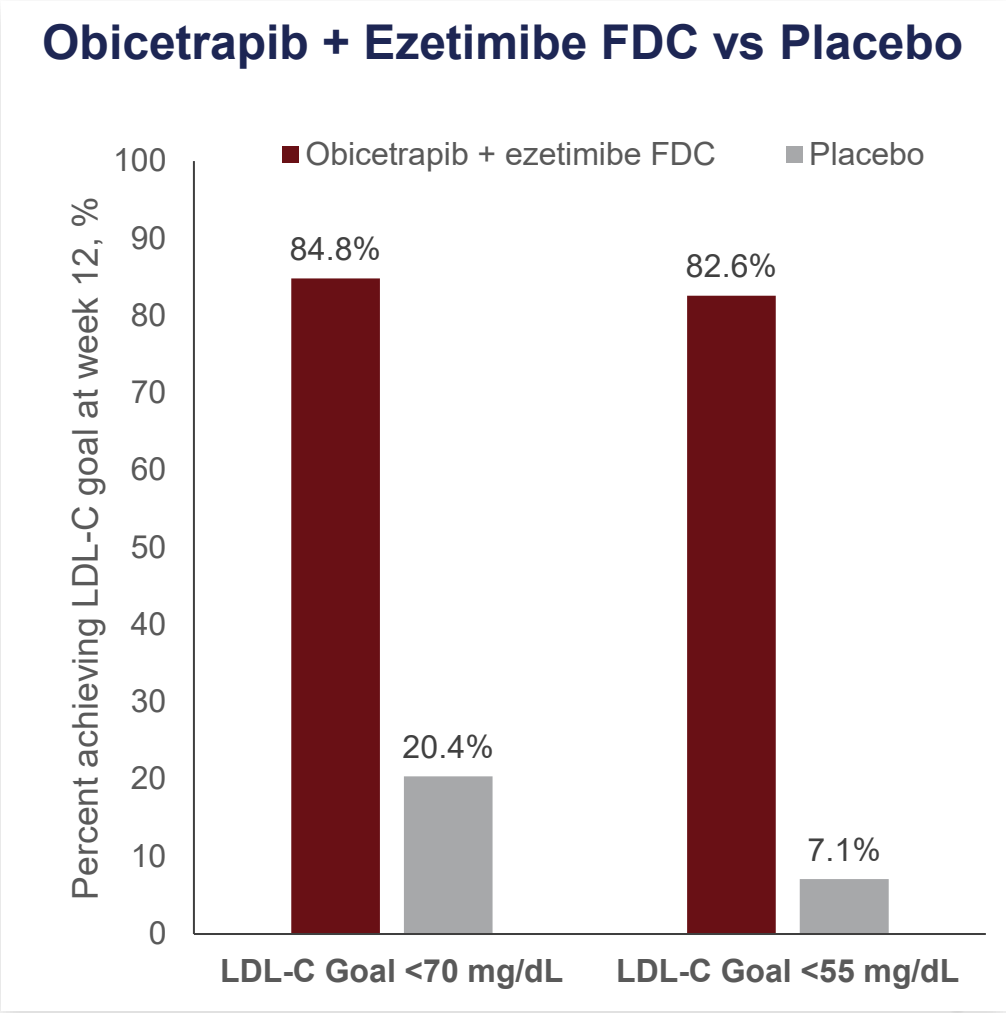
# PK-Confirmed On-Treatment LDL-C Goal Attainment Was High For Obicetrapib Monotherapy and Obicetrapib + Ezetimibe FDC




Source: De Kleer et al. ESC 2026. Abstract 89477.

# REMBRANDT

# Effect of FDC Obicetrapib/Ezetimibe on Top of Maximally Tolerated Lipid-Modifying Therapy on Coronary Plaque Characteristics in Participants with or at High Risk for ASCVD

REMBRANDT

## Main inclusion criteria

- Age > 45 years
- ASCVD
  - Imaging evidence (CTA / Angio) of vascular disease.
  - Having established ASCVD (MI, Stroke, revasc, PAD)
- Non calcified total plaque volume >75mm$^3$
- Screening LDL-C level ≥ 70 mg/dL
- On maximally tolerated lipid-modifying therapy

## Main exclusion criteria

- Poorly controlled diabetes (HbA1c >10%)
- Hypertension
- Congestive heart failure
- PCI/stroke/MI within 3 months
- eGFR < 45mL/min
- Ezetimibe use within 30 days

## Primary endpoint

- % Change total NCPV in ALL major coronary arteries

## Secondary endpoint

- Absolute change NCPV in ALL major coronary arteries
- % change in LDL-C
- % change NCPVMD
- Absolute change NCPVMD
- Change in FAI

**Rationale:** Despite reducing the progression of coronary atherosclerosis, statin therapy does not fully address residual CV risk. Adding the FDC obicetrapib/ezetimibe to statin therapy will further reduce the progression of coronary atherosclerosis in ASCVD patients with high residually risk

**Objective:** To evaluate the effect of FDC obicetrapib/ezetimibe 10 mg FDC daily on total non-calcified coronary atherosclerotic plaque volume at 18 months

**Study design:** Randomized, double-blind, placebo-controlled

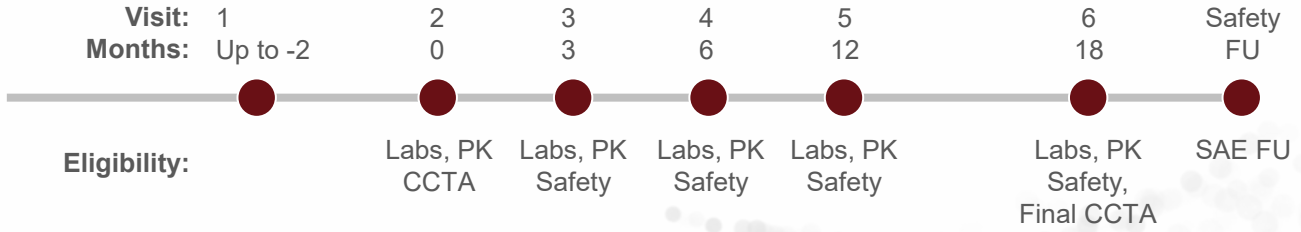
**Screening Phase**

- Patients (n=~300)
- Patients with sufficient non-calcified plaque

**Double-blind**

**FDC Obicetrapib/ezetimibe** (n=150) → Safety FU

Placebo (n=150) → Safety FU




ASCVD, atherosclerotic cardiovascular disease; CCTA, coronary computed tomography angiography; CV, cardiovascular disease; FDC, fixed-dose combination; FU, follow-up; LDL-C, LDL-C, low-density lipoprotein cholesterol; MI, myocardial infarction; PK, pharmacokinetics; SAE, serious adverse events.

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# REMBRANDT: CT Angiography Study Designed to Demonstrate Obicetrapib + Ezetimibe FDC's Anti-Atherosclerotic

REMBRANDT

1. Show LDL-C reduction yields benefit on underlying atherosclerosis
2. Demonstrate FDC regresses coronary plaque volume
3. Link FDC benefit directly to plaque improvement
4. Confirm efficacy and safety in high-risk patients

**Increased utilization of CTA for diagnosis of cardiovascular disease**

**Positive traction with practicing cardiologists**

**Designed to demonstrate clinical benefit of FDC**

**May support labeling and promotion**

FDC, fixed-dose combination; FU, follow-up; LDL-C, LDL-C, low-density lipoprotein cholesterol.



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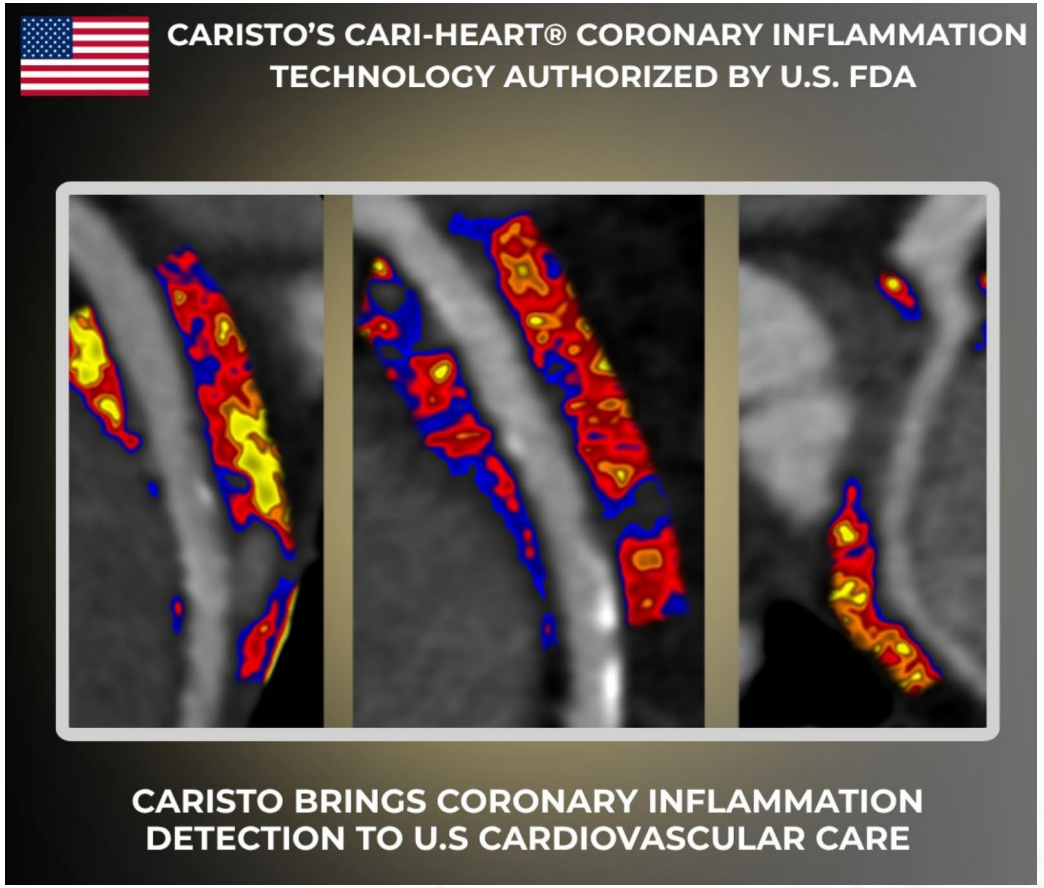
# Recent FDA Approval of New CCTA Imaging Technology

*"CaRi-Heart has received U.S. FDA De Novo authorization, becoming the first and only technology authorized in the U.S. to detect and quantify coronary inflammation from routine coronary CT angiography (CCTA)."*



# REMBRANDT Is Fully Enrolled and Tracking to a Readout[1,2]

REMBRANDT

ENROLLMENT COMPLETE

**323**
patients enrolled (vs. ~300 target)

**50**
sites across 7 countries

**18 mo**
double-blind treatment period per patient

**2027**
estimated trial completion

**First Patient Randomized**
May 2024

**Last Patient Randomized**
March 2026

**Trial Completion**
YE2027 Est.

***Fully enrolled, on schedule, and on track to deliver the next major proof point for the FDC franchise***

1. NewAmsterdam Pharma corporate updates (Jan & May 2026); 2.ClinicalTrials.gov NCT06305559.



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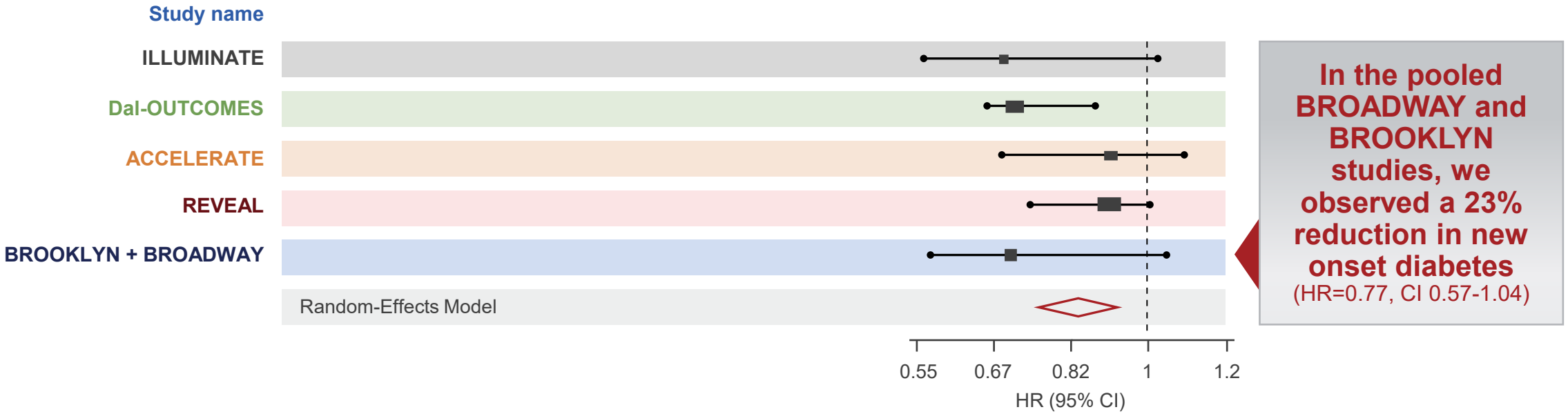
# From Plaque to Small LDL Particles and Diabetes

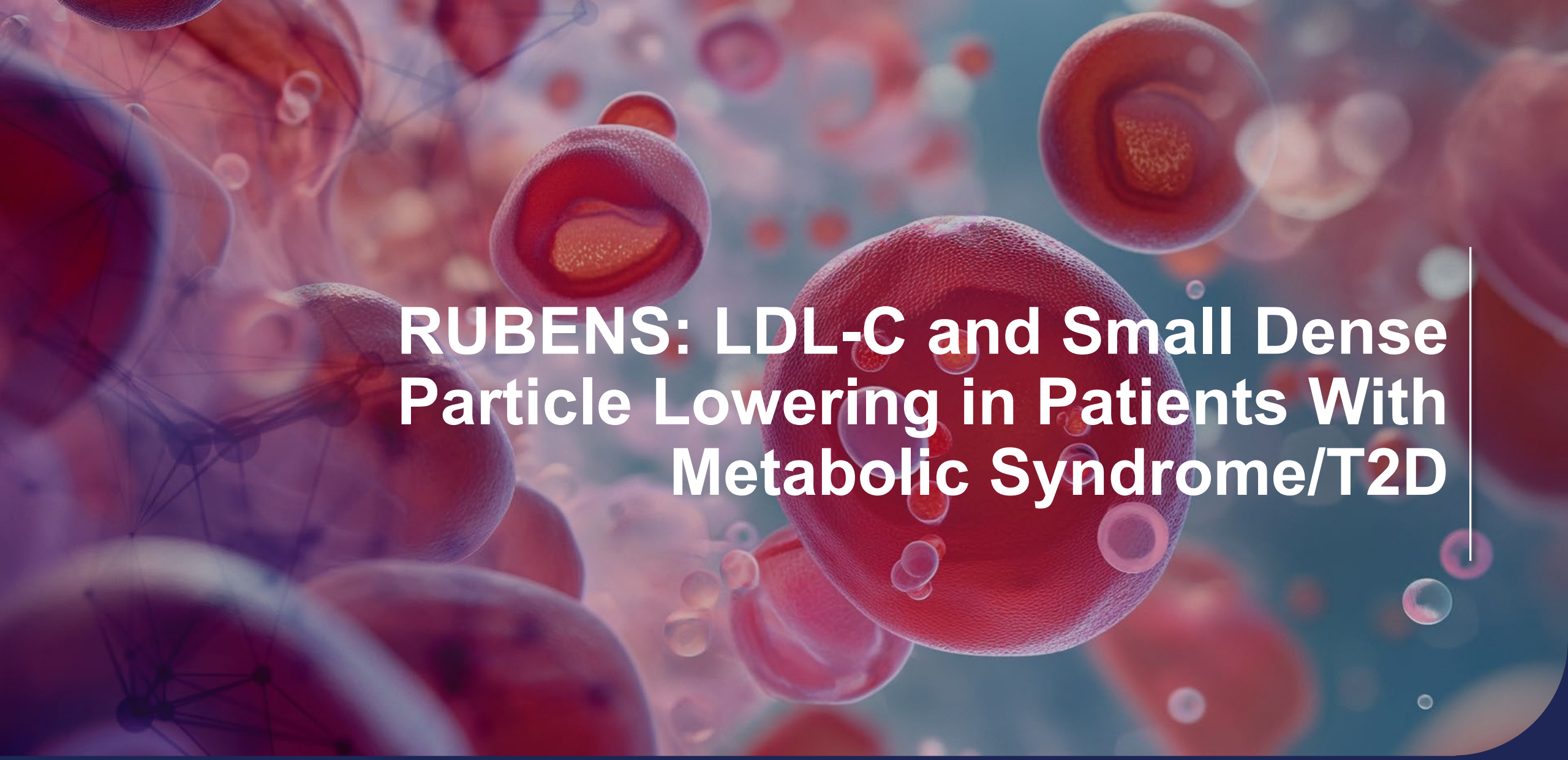
# CETP Inhibition Has the Potential to Reverse Diabetes Risk, Potentially Addressing Patient Concerns About High Dose Statins

This is consistent with the benefits observed in other CETP trials that have shown 17% reduction in new onset diabetes (HR=0.83, CI 0.77-0.90)




**In the pooled BROADWAY and BROOKLYN studies, we observed a 23% reduction in new onset diabetes** (HR=0.77, CI 0.57-1.04)

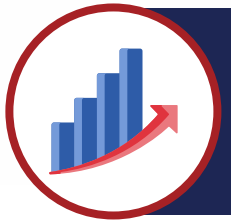
CETP, cholesteryl ester transfer protein; CI, confidence interval; HR, hazard ratio. Data from CVOT trials not designed to demonstrate diabetes benefits
National Lipid Association Conference 2025 (data on file).



# RUBENS: LDL-C and Small Dense Particle Lowering in Patients With Metabolic Syndrome/T2D

# LDL-C Lowering in Patients with Obesity, Metabolic Syndrome, and Type 2 Diabetes: The Sweet Spot for Obicetrapib

**Shared patient population:** patients with obesity, metabolic syndrome, and T2D are frequently prescribed statins



**Statins cut both ways:** statins increase diabetes risk and preferentially reduce large LDL particles, leaving relatively more small LDL-Ps

**Obicetrapib fills the gap:** obicetrapib lowers the NoD risk and dramatically reduces small LDL-Ps, potentially being the ideal complement to statin therapy

1. Laakso M, Silva LF. *Front Endocrinol (Lausanne)*. 2023;14:1239335. 2. Dugani SB et al. *JAMA Cardiol*. 2016;1(2):136-145. 3. Toth PP et al. *Am J Cardiol*. 2018;121(3):308-314. 4. Ray KK et al. *J Clin Lipidol*. 2025;19(3S):e116-e117. 5. Data on File. NewAmsterdam Pharma. 6. Ballantyne CM et al. *J Clin Lipidol*. 2023;17(4):491-503. 7. Kastelein JJP et al. *Curr Atheroscler Rep*. 2024;26(2):35-44. 8. Nicholls SJ et al. Safety and efficacy of obicetrapib in patients with heterozygous familial hypercholesterolemia: the BROOKLYN trial [manuscript in preparation]. 9. Sarraju A et al. Fixed-dose combination of obicetrapib and ezetimibe for LDL cholesterol reduction [manuscript in preparation].

# How Might Obicetrapib Reduce Diabetes Risk?

# Increase in HDL-C Observed to Reduce Risk of Developing Type 2 Diabetes

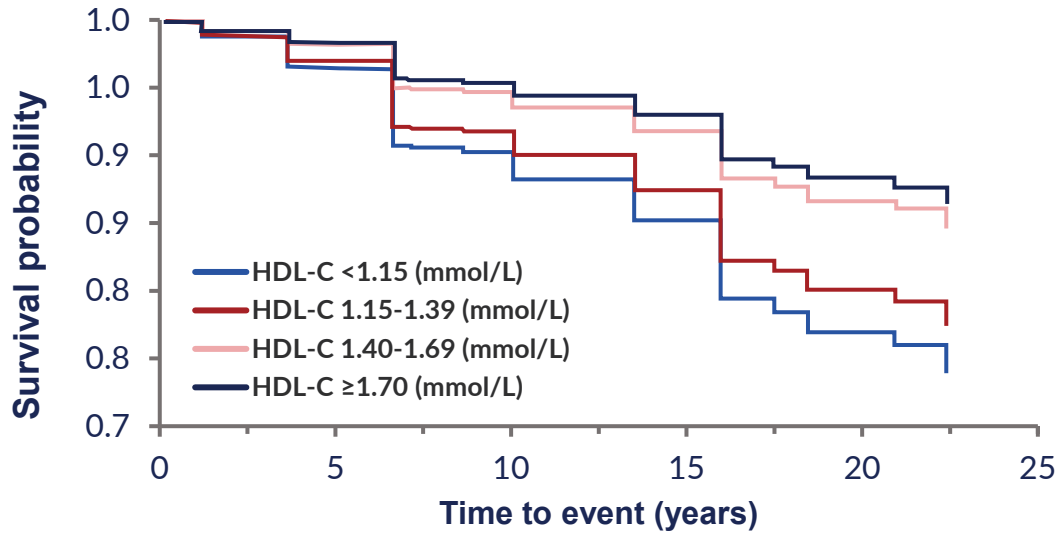
- Dose-response relationship observed between HDL-C and the risk of new-onset diabetes
- Multivariate predictive models show robust negative correlation between HDL-C and risk of future T2DM incidence
- 25-year follow-up data also show that increased HDL-C correlates with diminished T2DM risk, suggesting that HDL-C levels may influence glucose metabolism

## Association Between HDL-C Levels and T2DM Risk for Baseline Levels of HDL-C* (mmol/L)

| **HDL-C,** Cox model | **HR** (95% CI) | *P*=0.003 |
|---|---|---|
| **<1.15** | **1.00** (1.00-1.00) | |
| **1.15 – 1.39** | **0.96** (0.60-1.52) | |
| **1.40 – 1.69** | **0.48** (0.27-0.86) | |
| **>1.69** | **0.45** (0.25-0.81) | |

Increasing HDL-C levels across these four quartiles was associated with considerable differences in survival probabilities

## Reduced Risk of Diabetes Incidence With Increased HDL-C Levels




*1 mmol/L HDL=38.67 mg/dL.
CI, confidence interval; HDL-C, high-density lipoprotein cholesterol; HR, hazard ratio; T2DM, type 2 diabetes mellitus.
Cao X et al. *Lipids Health Dis.* 2021;20(1):71.



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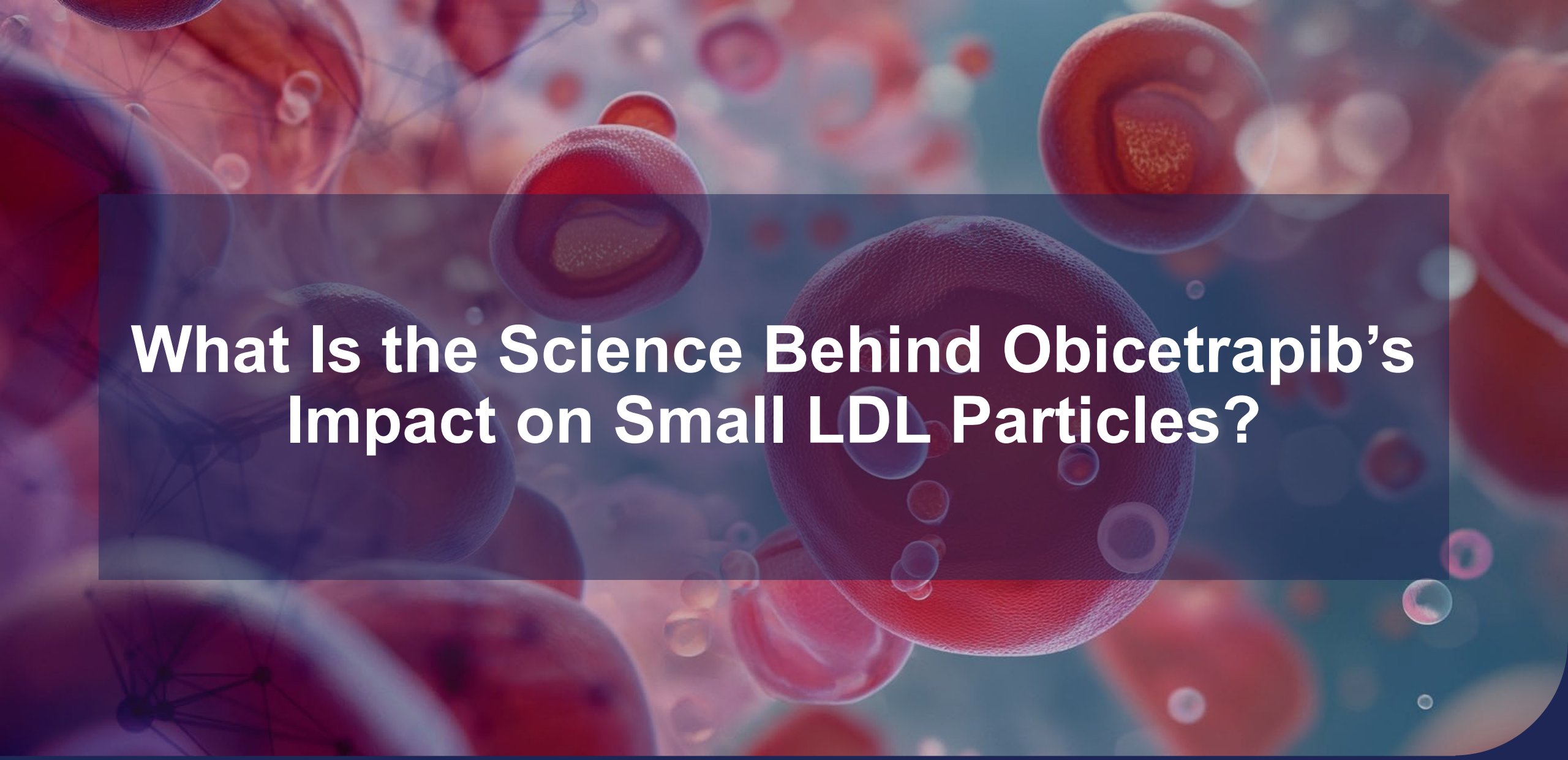
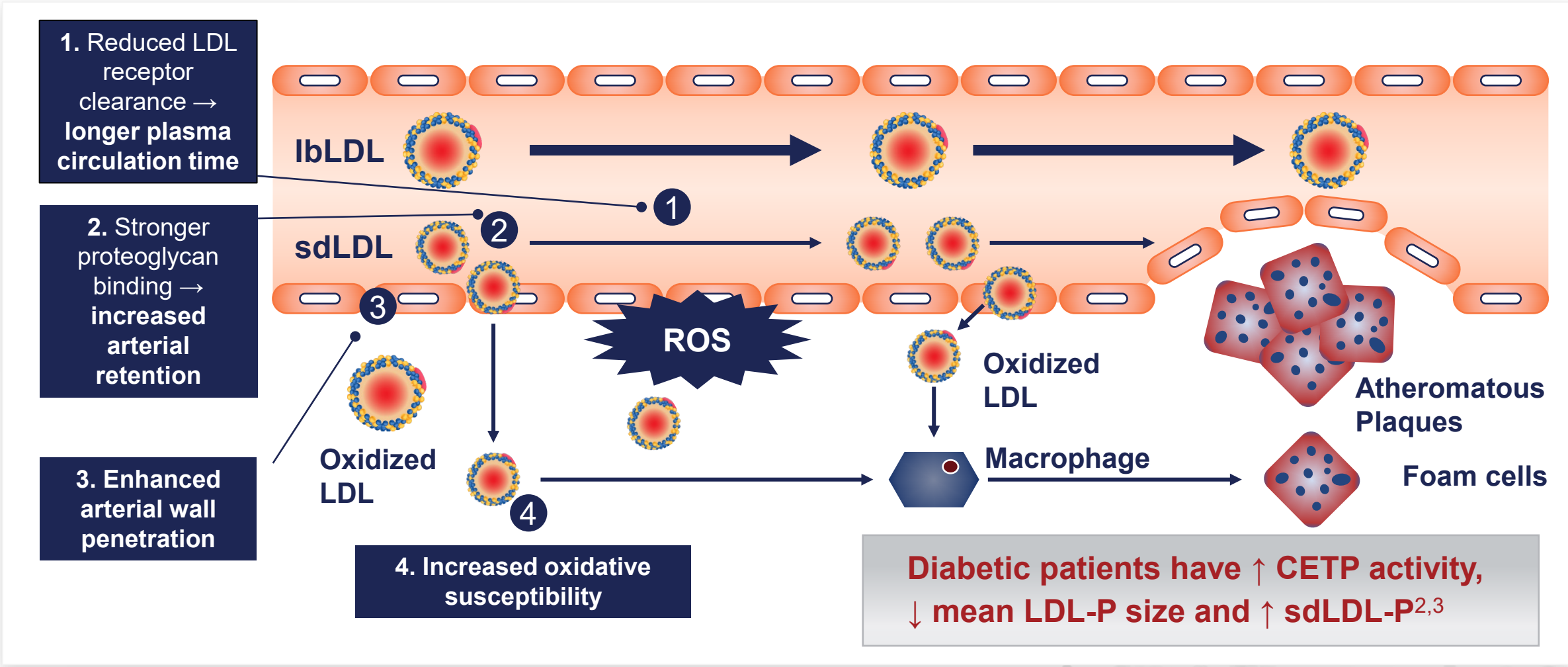


# What Is the Science Behind Obicetrapib's Impact on Small LDL Particles?

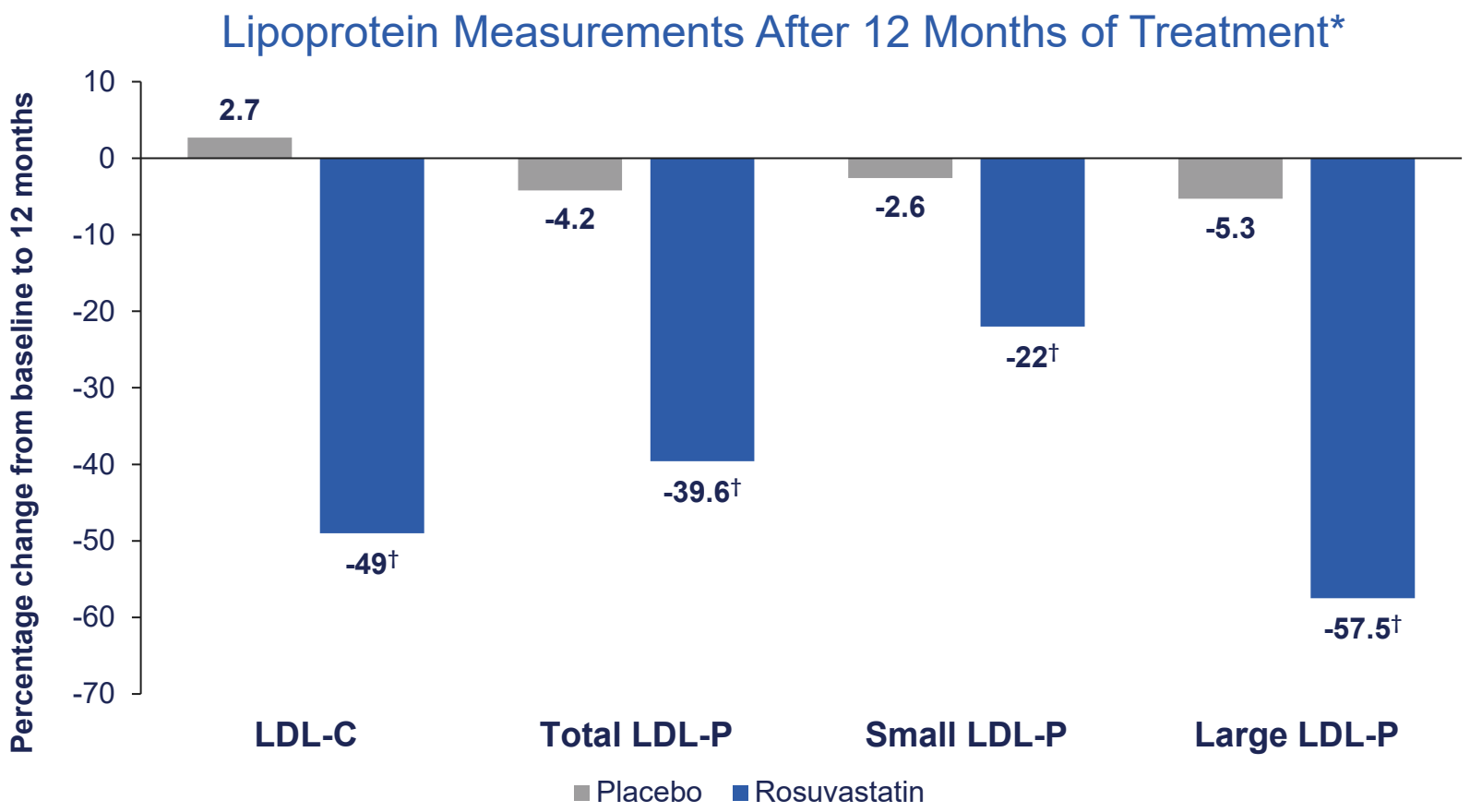
# Insulin Resistance-Induced Dyslipidemia is Characterized by Increased sdLDL, Which are More Atherogenic Due to Multiple Mechanisms




lbLDL, large buoyant LDL; LDL-P, LDL particle; ROS, reactive oxygen species.

1. Hirano T. *J Diabetes Investig*. 2025;16(3):370-383. 2. He Q et al. *Sci Rep*. 2025;15(1):19500. 3. Siewert S et al. *J Diabetes Investig*. 2015;6(1):67-77.

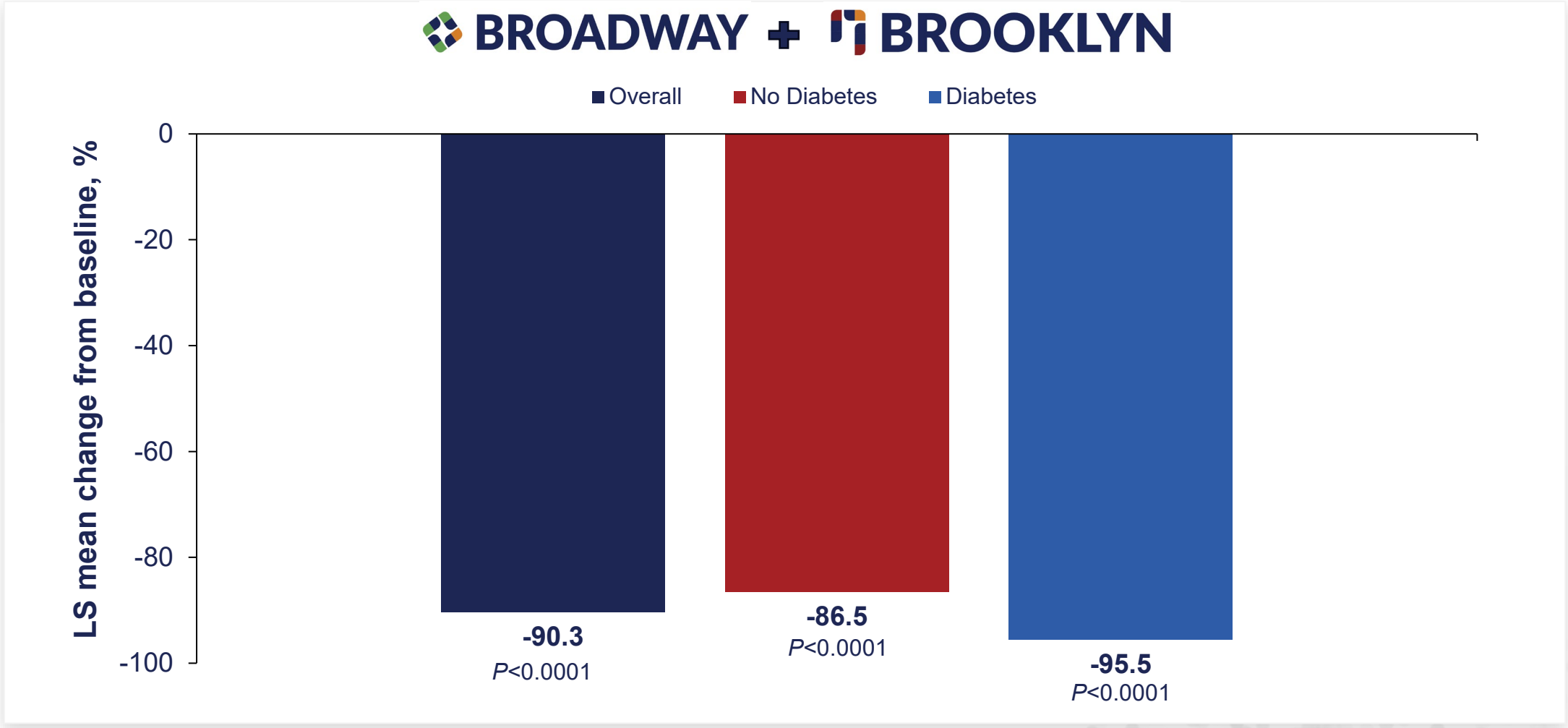
# Statins Decrease Large LDL-P Concentration to a Greater Extent Than Small LDL-P




**Rosuvastatin treatment altered the LDL lipoprotein subclass distribution, resulting in smaller mean sizes (-1.5%; 95% CI, -3.7% to 0.5%)**

*Includes 9180 individuals with baseline and 12-month measurements.
†Differences in change between groups were $P<0.001$ for all (calculated using the Wilcoxon rank sum test).
CI, confidence interval; LDL, low-density lipoprotein; LDL-P, low-density lipoprotein particle concentration.
Dugani SB et al. *JAMA Cardiol.* 2016;1(2):136-145.

# Consistent ~90% Reduction in Small LDL Particles Observed with Obicetrapib in a Pooled Analysis




LDL, low-density lipoprotein; LS, least squares.
Davidson MH et al. *Circulation.* 2025;152(Suppl 3):Abstract 4368890.

# RUBENS Designed to Test the LDL-C Lowering Effects of Obicetrapib and Obicetrapib + Ezetimibe FDC in Diabetic Patient Population

# T2D/Metabolic Syndrome Study

**Objective:** To evaluate the effect of obicetrapib and the FDC on LDL-C in patients with T2D / Met Syn

**Study design:** Randomized, double-blind, placebo-controlled

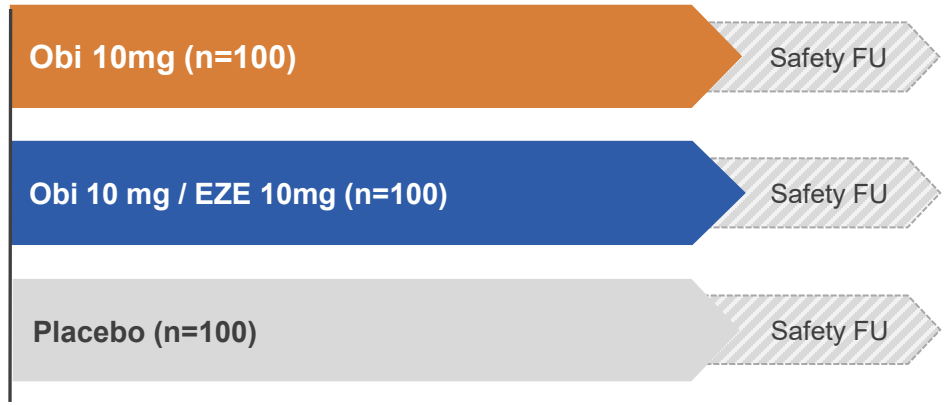
### Main Inclusion Criteria:

- ≥ 18 years
- T2D / Metabolic Syndrome
- LDL ≥ 100 mg/dL
- TG ≥ 150 < 400 mg/dL
- Guideline recommended LLT

### Main Exclusion Criteria:

- Clinical ASCVD
- HoFH
- Uncontrolled hypertension

- Patients (n=300)
- T2D / Met Syn
- Guideline recommended LLT

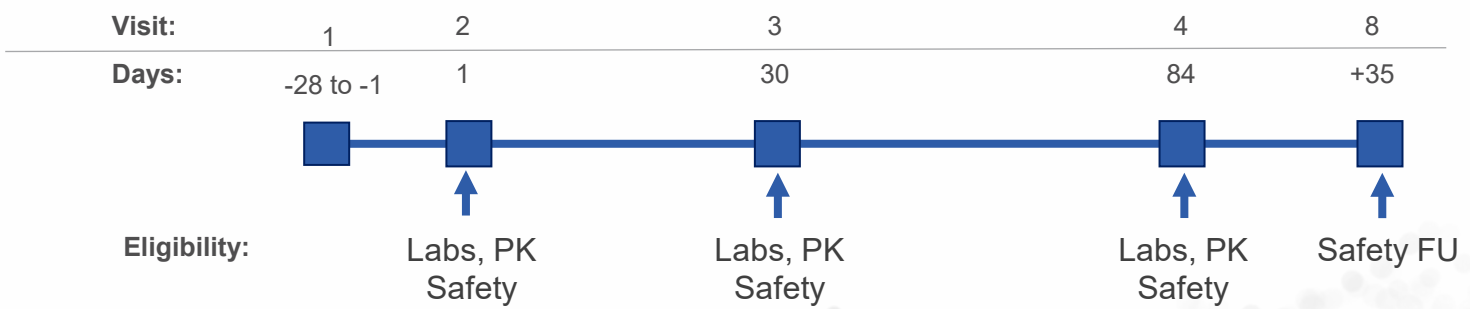



### Primary efficacy endpoint

- % LS mean change from BL to Day 84 in LDL-C for obicetrapib & FDC using Martin-Hopkins

### Key secondary efficacy endpoint

- LDL-C Goal attainment
- Lp(a), LDL-P, sdLDL




ASCVD, atherosclerotic cardiovascular disease; BL, baseline; eze, ezetimibe; FDC, fixed-dose combination; FU, follow-up; LDL, low-density lipoprotein; LDL-C, low-density lipoprotein cholesterol; LDL-P, low-density lipoprotein particles; LS, least squares; PK, pharmacokinetics; T2D, type 2 diabetes; TG, triglycerides.

# RUBENS Is Designed to Provide Insight into LDL-C and Small Particle Lowering in the Diabetic Population without ASCVD

RUBENS

1. Show obicetrapib and FDC robustly lower LDL-C in T2D/metabolic syndrome patients
2. Demonstrate reduction of atherogenic sdLDL particles and Lp(a)
3. Establish CETP inhibition preserves glycemic control in patients on statin therapy
4. Confirm efficacy and safety in high-risk patients without ASCVD

**Large, underserved population: T2D/metabolic syndrome patients not at LDL-C goal despite statin therapy**

**Positive traction with endocrinologists and diabetes specialists**

**Designed to evaluate changes in LDL-C, sdLDL & Lp(a)**

**May support LDL-C lowering in a T2D/metabolic syndrome population in the label**

ASCVD, atherosclerotic cardiovascular disease; CETP, cholesteryl ester transfer protein; FDC, fixed-dose combination; LDL-C, low-density lipoprotein cholesterol.

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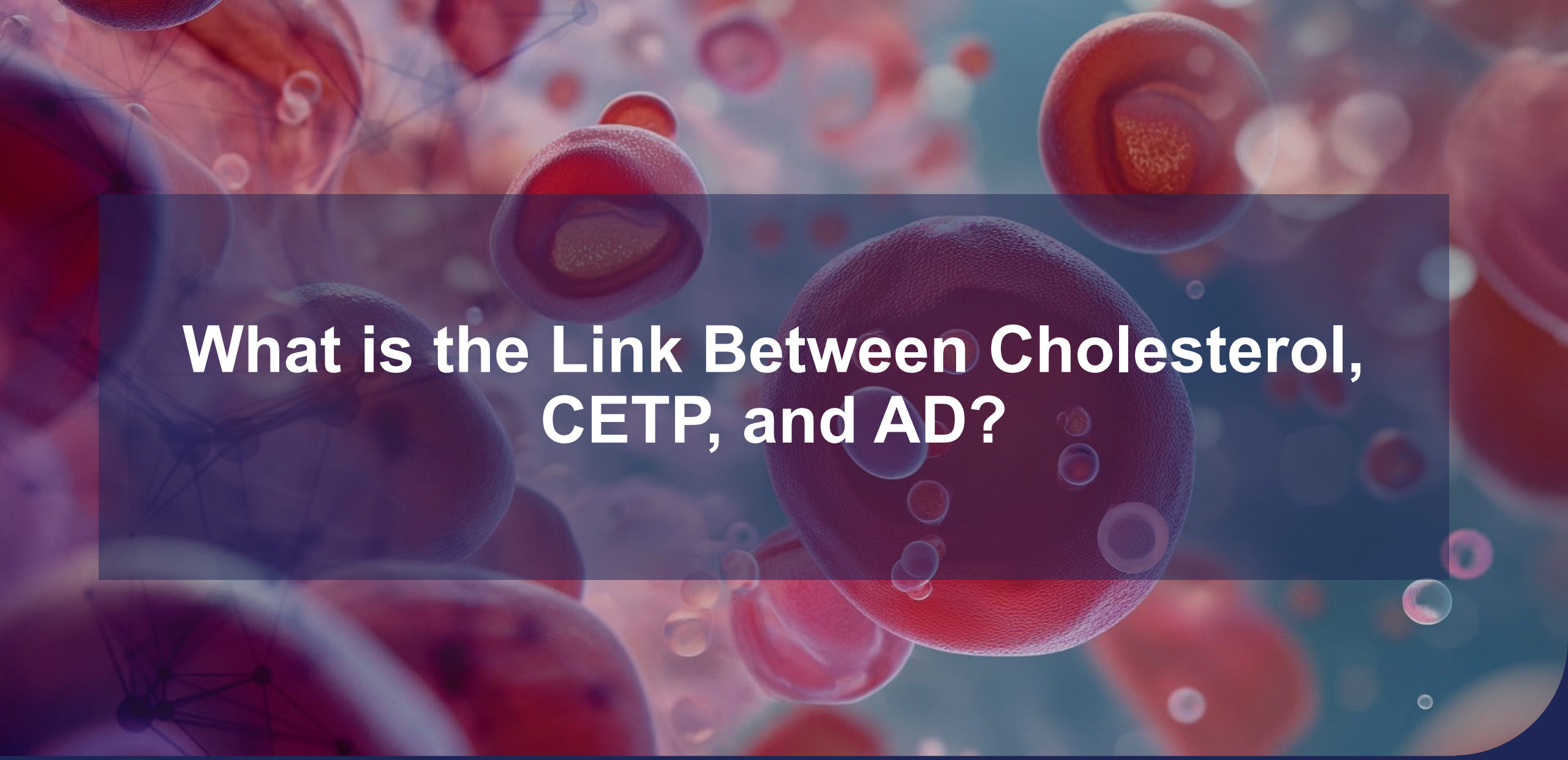
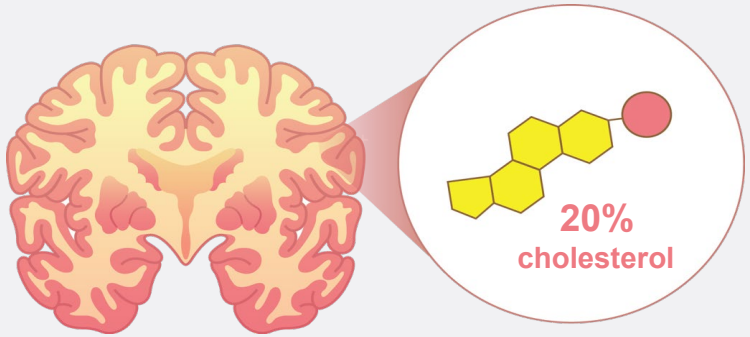
# Moving from the Heart to the Brain…



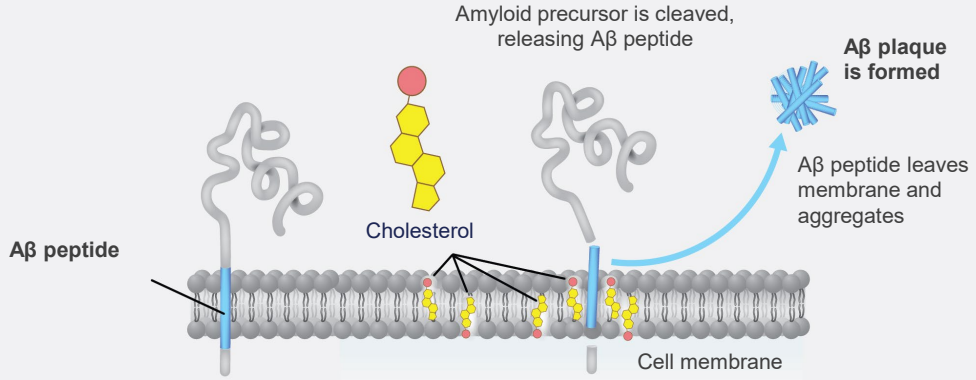
# What is the Link Between Cholesterol, CETP, and AD?

# Elevated Cholesterol Levels in the Brain Precede Formation of Amyloid-Beta (Aβ) Plaques

**The brain is the most cholesterol-rich organ; it contains only 2% body mass but has 20% of the body's cholesterol**




**Aβ plaque formation inside AD brain cells**




**During early development,** oligodendrocytes synthesize large quantities of cholesterol for myelination

**In adults,** when myelination is complete, glial cells and, to a lesser extent, neurons account for the steady-state production of cholesterol

**The brain uses a unique mechanism** for cholesterol recycling and redistribution

- Involves an ApoE-mediated lipoprotein pathway unique to the CNS whereby cholesterol is turned over
- Excess oxysterols are ultimately delivered to the liver for secretion into the bile

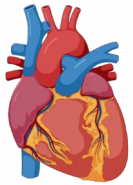
**Cholesterol itself does not exit the brain** but instead is converted to a metabolite, 24S-hydroxycholesterol

- 24S-hydroxycholesterol is a proxy for excess cholesterol that will be measured in our phase 2a clinical trial

APOE, apolipoprotein E; CNS, central nervous system.
Mahley RW. *Arterioscler Thromb Vasc Biol*. 2016;36(7):1305-1315.

# ApoE4 is a Risk Factor for Both CVD and Alzheimer's Disease[1-5]

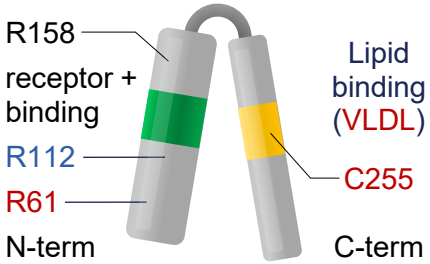
## CVD



## CVD Risk Factors

- ▲ Risk for CVD by 22-45%
- ▲ LDL-C
- ▼ HDL-C
- ▲ ApoC
- ▲ Lp(a)

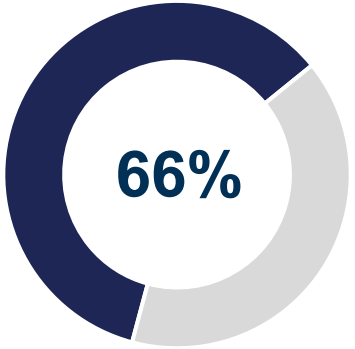
## APOE4




## AD Risk Factors

- ▼ Cholesterol transport and clearance
- ▲ Lipid accumulation in brain
- ▲ Aβ aggregation
- ▲ Total cholesterol
- ▼ HDL-C

## Prevalence of APOE4 in AD




**Elevated risk is mediated by the profound effect of APOE4 on lipid metabolism**

| APOE2/E2 | APOE2/E3 | APOE3/E3 |
|---|---|---|
| **0.5%** | **11%** | **61%** |

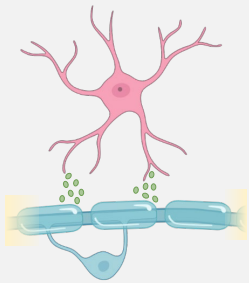
% of population with this genotype

**>25% of population at increased risk**

APOE4/E2 = **2%**
APOE4/E3 = **24%**
APOE4/E4 = **2%**

**ApoE4-induced cholesterol dysregulation has cell-specific effects in the brain that all contribute to AD pathogenesis**

- Disruption of neuronal synaptic function
- Altered astrocytic glucose metabolism
- Promotion of microglial inflammatory responses
- Impaired oligodendrocyte remyelination



Aβ, amyloid β; AD, Alzheimer's disease; Apo, apolipoprotein; CVD, cardiovascular disese; HDL-C, high density lipoprotein cholesterol; LDL-C, low density lipoprotein cholesterol; Lp(a), lipoprotein(a). 1. Abondio P et al. *Genes (Basel)*. 2019;10(3):222. 2. Feringa FM et al. *Front Aging Neurosci*. 2021;13:690372. 3. Hottman DA et al. *Neurobiol Dis*. 2014;72(A):22-36. 4. Jeong W et al. *Mol Cells*. 2019;42(11):739-746. 5. Williams HC et al. *Neurobiol Dis*. 2020;136:104742. 6. Li Y et al. *BMC Cardiovasc Disord*. 2024;24(1):353. 7. Fernandez CG et al. *Front Aging Neurosci*. 2019;11:14. 8. Moriarty PM et al. *Arterioscler Thromb Vasc Biol*. 2017;37(3):580-588. 9. Xu M et al. *Biomed Res Int*. 2016;2016:3912175. 10. Mattsson N et al. *Alzheimers Dement*. 2018;14(7):913-924.



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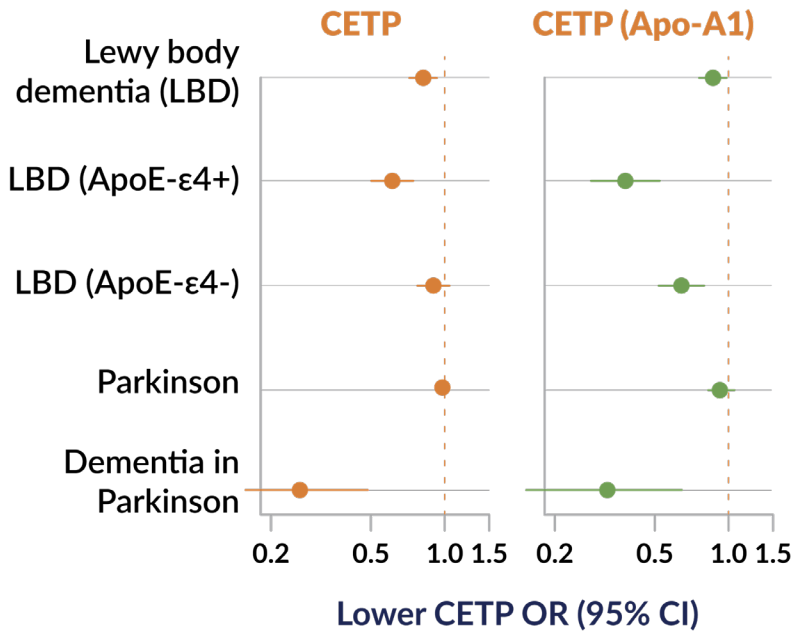
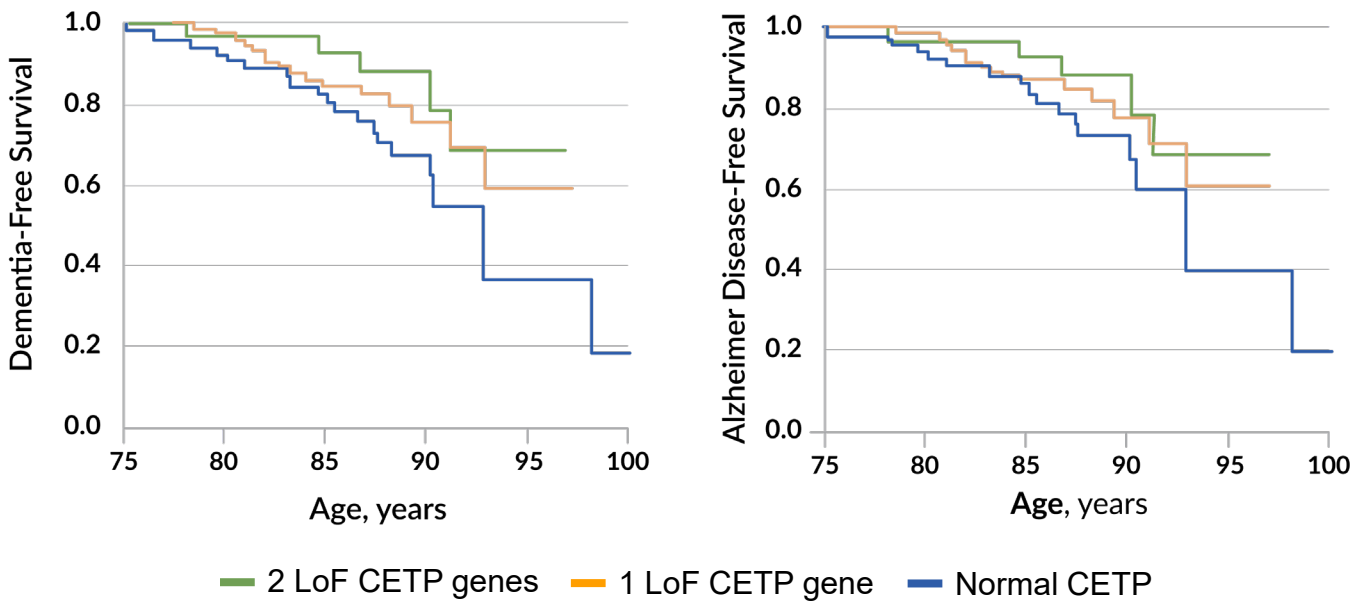
# CETP Loss-of-Function (LoF) Genotype May be Associated with Slower Memory Decline and Lower AD Risk

**CETP's potential involvement in CNS cholesterol homeostasis is supported by genomic data[1]**

**CETP LoF may be associated with lower CETP activity & a corresponding increase in HDL levels[2]**

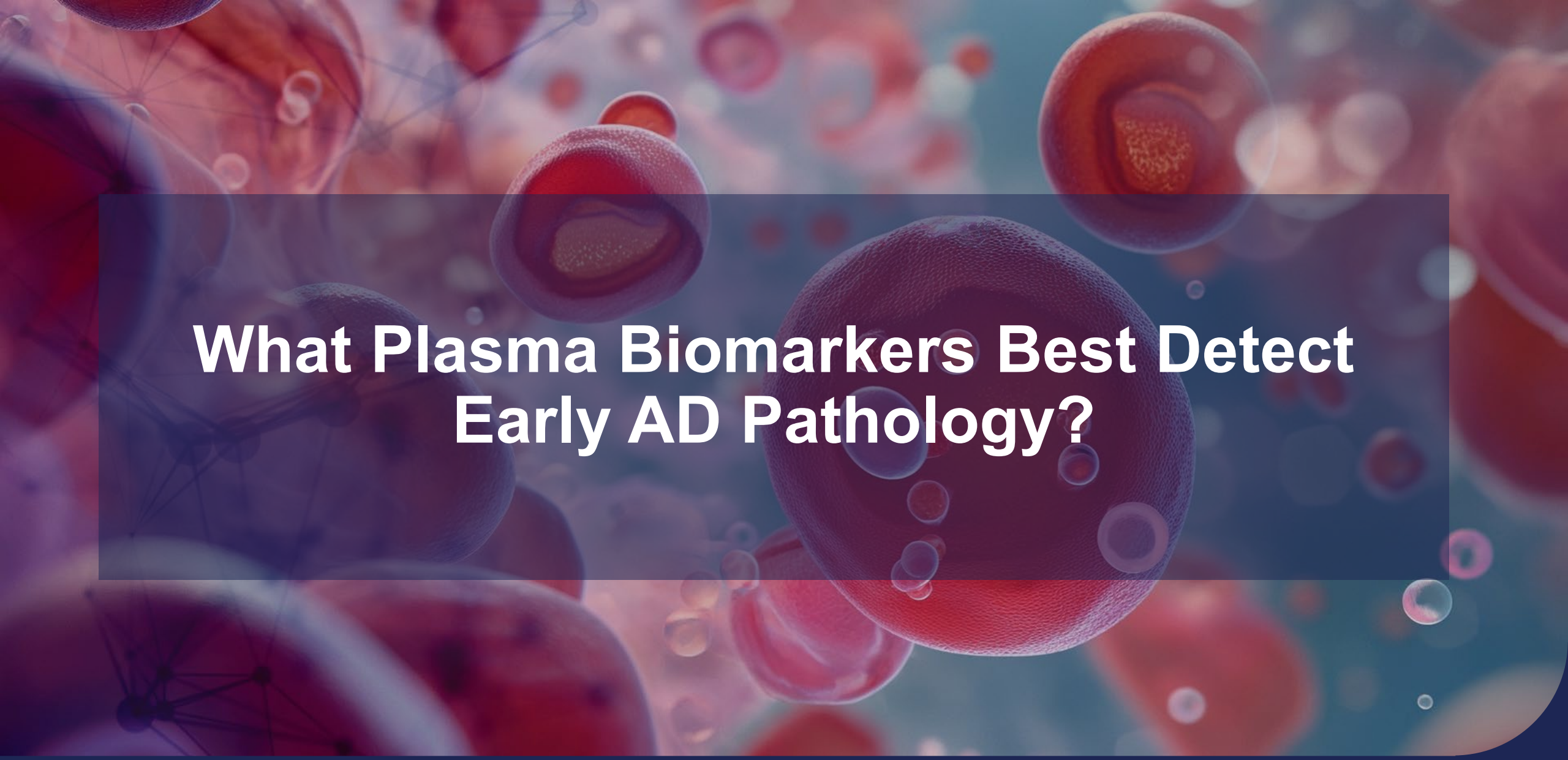



## Incidence of Dementia and Alzheimer's Disease by *CETP* Genotype Group[2]



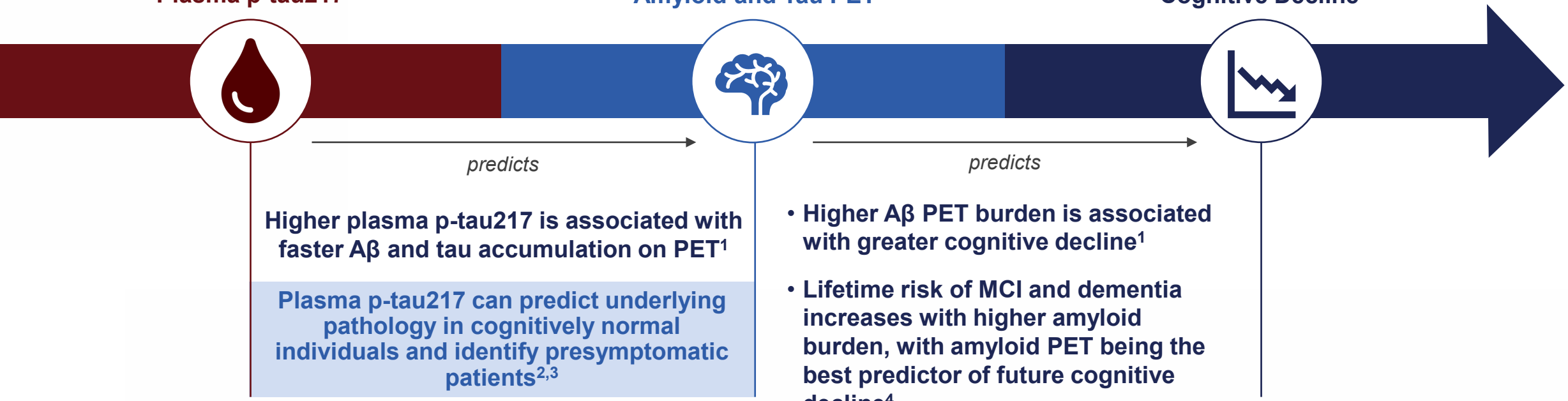

AD, Alzheimer's disease; CETP, cholesteryl ester transfer protein; CNS, central nervous system; HDL, high-density lipoprotein.

1. Schmidt AF et al. *Alzheimers Res Ther*. 2024;16(1):228. 2. Sanders AE et al. *JAMA*. 2010;303(2):150-158.



# What Plasma Biomarkers Best Detect Early AD Pathology?

# Evidence Supports Plasma p-tau217 as a Predictive Biomarker of Amyloid PET, Which Is Predictive of Cognitive Decline




**Higher plasma p-tau217 is associated with faster Aβ and tau accumulation on PET[1]**

**Plasma p-tau217 can predict underlying pathology in cognitively normal individuals and identify presymptomatic patients[2,3]**

- **Higher Aβ PET burden is associated with greater cognitive decline[1]**
- **Lifetime risk of MCI and dementia increases with higher amyloid burden, with amyloid PET being the best predictor of future cognitive decline[4]**

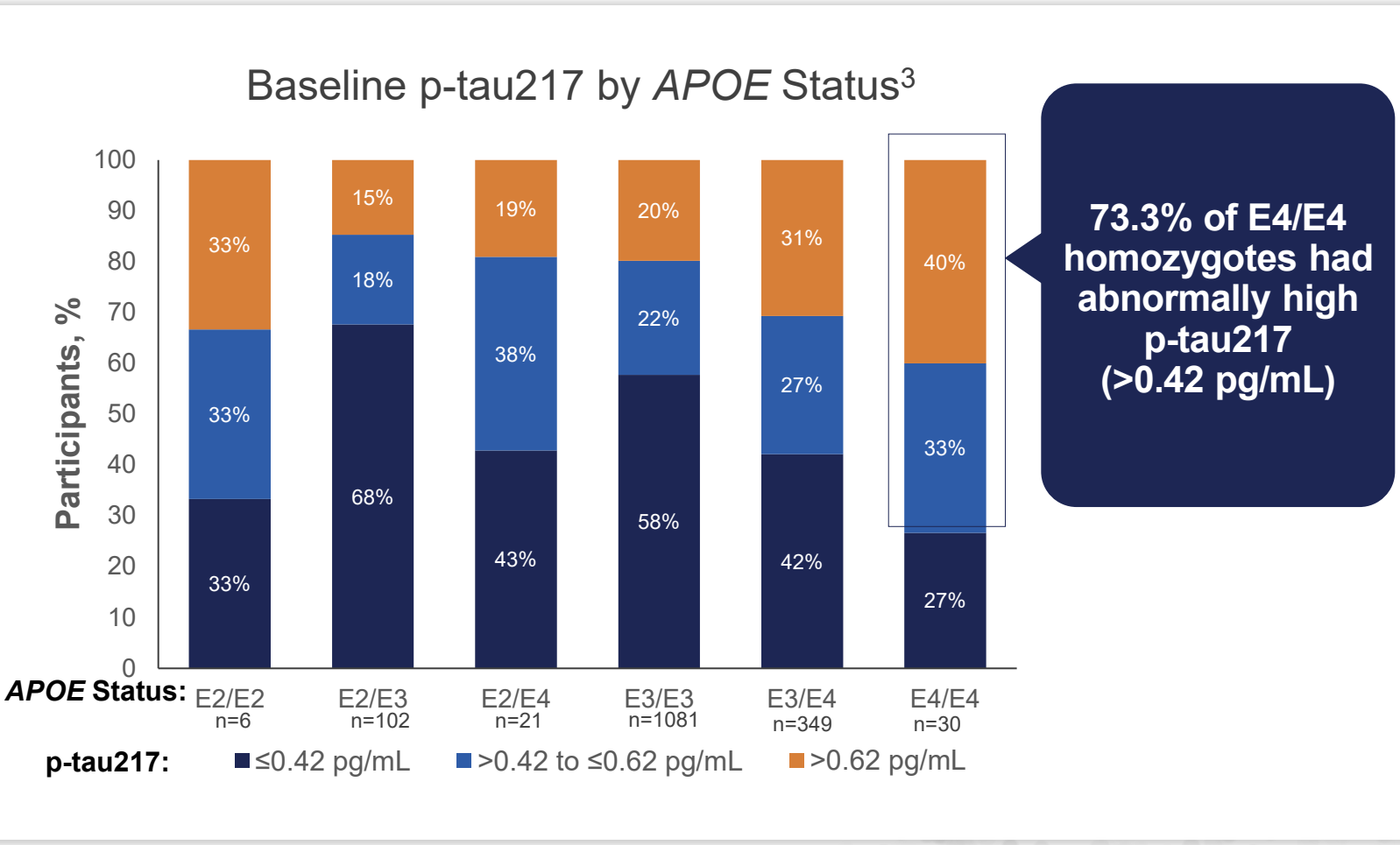
MCI, mild cognitive impairment; PET, positron emission tomography.

1. Yang HS et al. *Nat Commun.* 2026;17(1):3188. 2. Jonaitis EM et al. *Brain Commun.* 2023;5(2):fcad057. 3. Schindler SE et al. *Alzheimers Dement.* 2024;20(11):8074-8096.
4. Jack CR et al. *Lancet Neurol.* 2025;24(12).

# What Did we Discover in the BROADWAY Data?

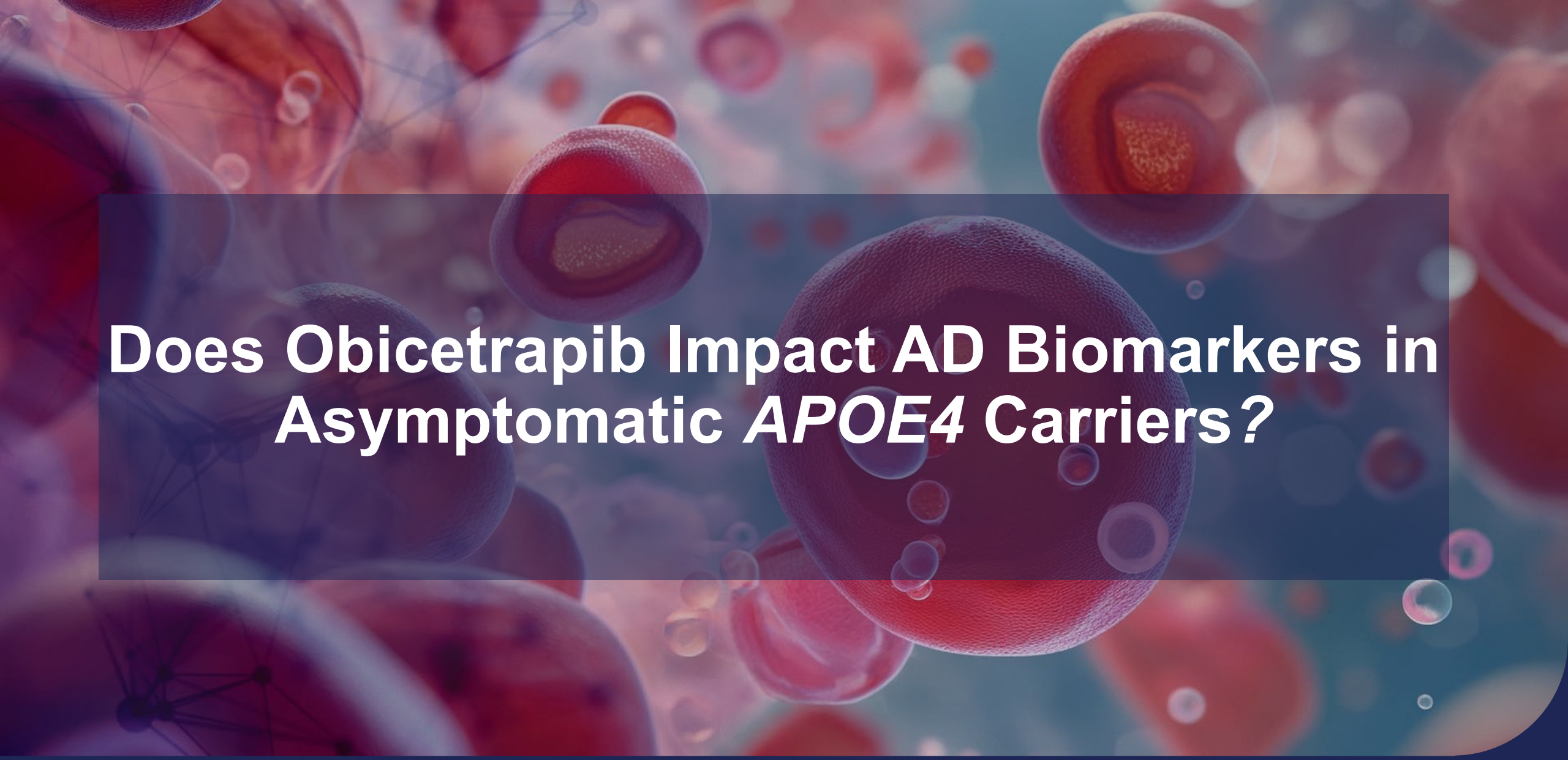
# Patients With ASCVD Carry Undiagnosed AD Pathology, as Measured by p-tau217 Levels[1-3]

In the BROADWAY AD Biomarker Substudy of 1535 **adults with ASCVD, nearly half** (45.9%, n=730) had **abnormally high p-tau217 levels** (>0.42 pg/mL), indicating preclinical AD pathology[3]




AD, Alzheimer's disease; APOE, apolipoprotein E; ASCVD, atherosclerotic cardiovascular disease.

1. van Nieuwkerk AC et al. *Stroke*. 2023;54(8):2181-2191. 2. French SR et al. *Alzheimers Dement*. 2025;21(8):e70565. 3. Kastelein JJP et al. Poster presented at the Alzheimer's Association International Conference 2026. July 12-15, 2026. London, UK.



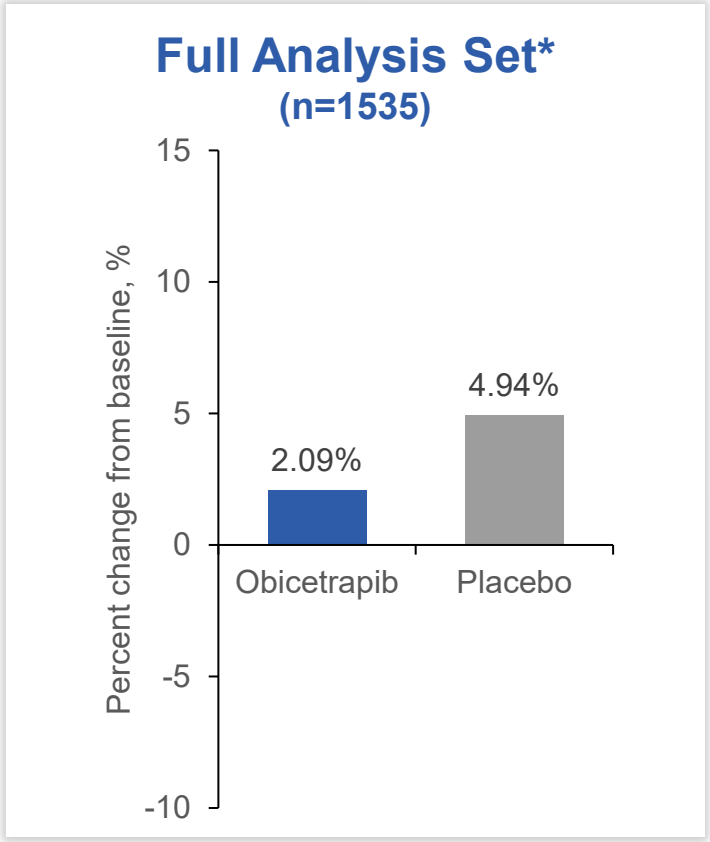
# Does Obicetrapib Impact AD Biomarkers in Asymptomatic *APOE4* Carriers?

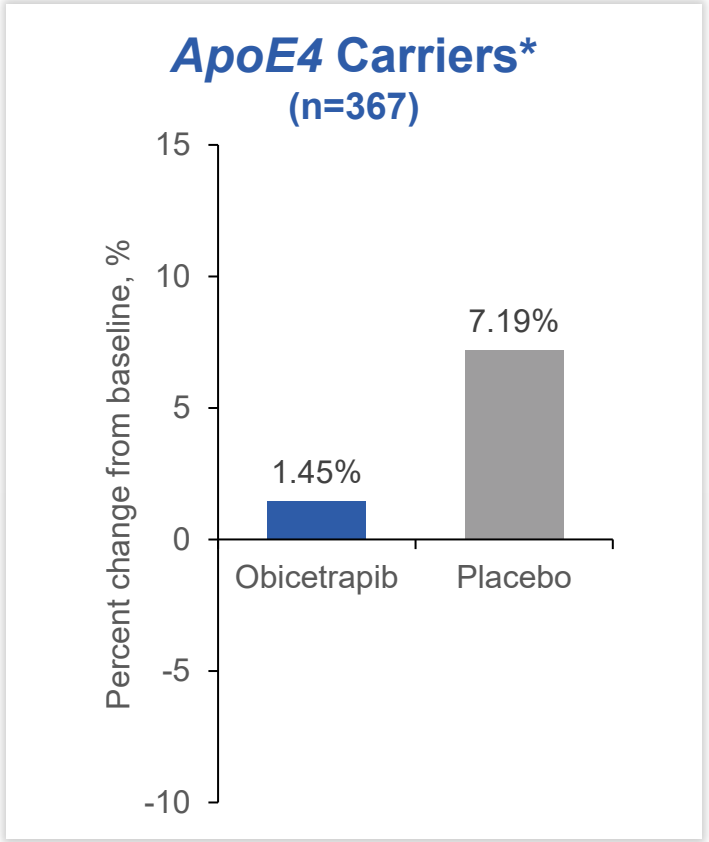
# Significant Reduction in p-tau217 Progression Over 12 Months Observed with Greater Reductions as ApoE4 Risk Factors Increase

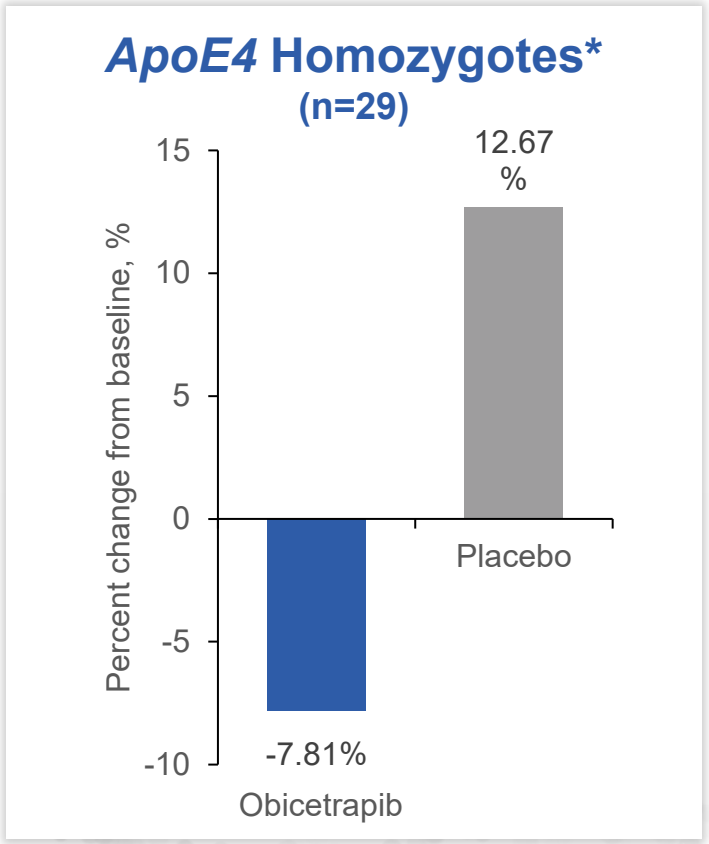
**2.84% benefit between obicetrapib and placebo (*P*=0.025)**

**5.74% treatment benefit in *ApoE4* carriers (*P*=0.022)**

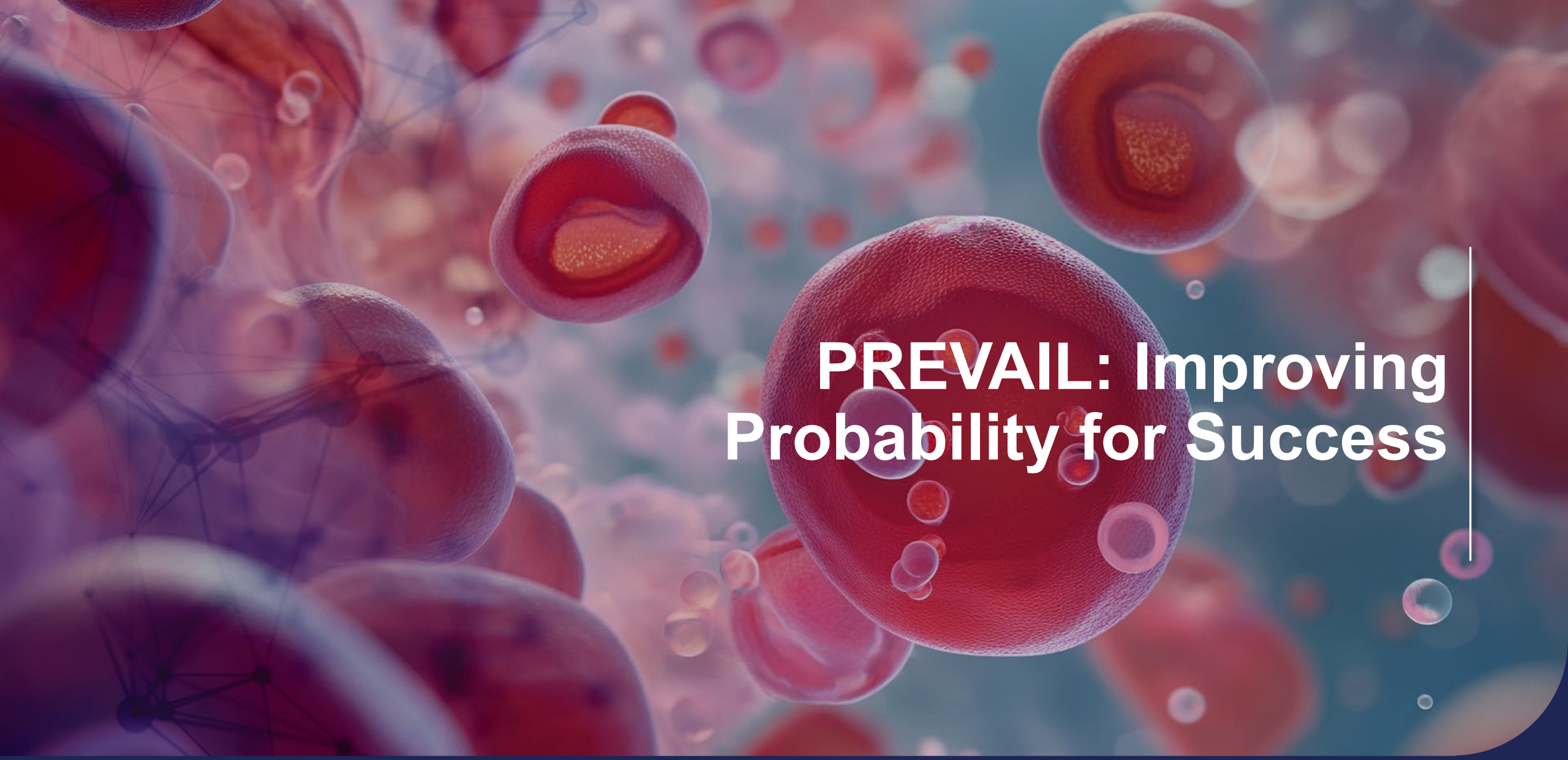
**20.5% treatment benefit in *ApoE4* homozygotes (*P*=0.010)**




*Results reflect adjustment for mean-centered baseline p-tau217 and mean-centered age. Participants with known ApoE status (based on phenotypic analysis), baseline p-tau217 above the lower limit of quantification (LLQ), and available end-of-study p-tau217 were included in the current analyses.
ApoE, apolipoprotein E; p-tau, phosphorylated tau. ApoE4 carriers defined as ApoE3/E4 or ApoE4/E4, based on phenotypic analysis
Davidson MH et al. 2025. Journal of Prevention of Alzheimer's Disease



# PREVAIL: Improving Probability for Success

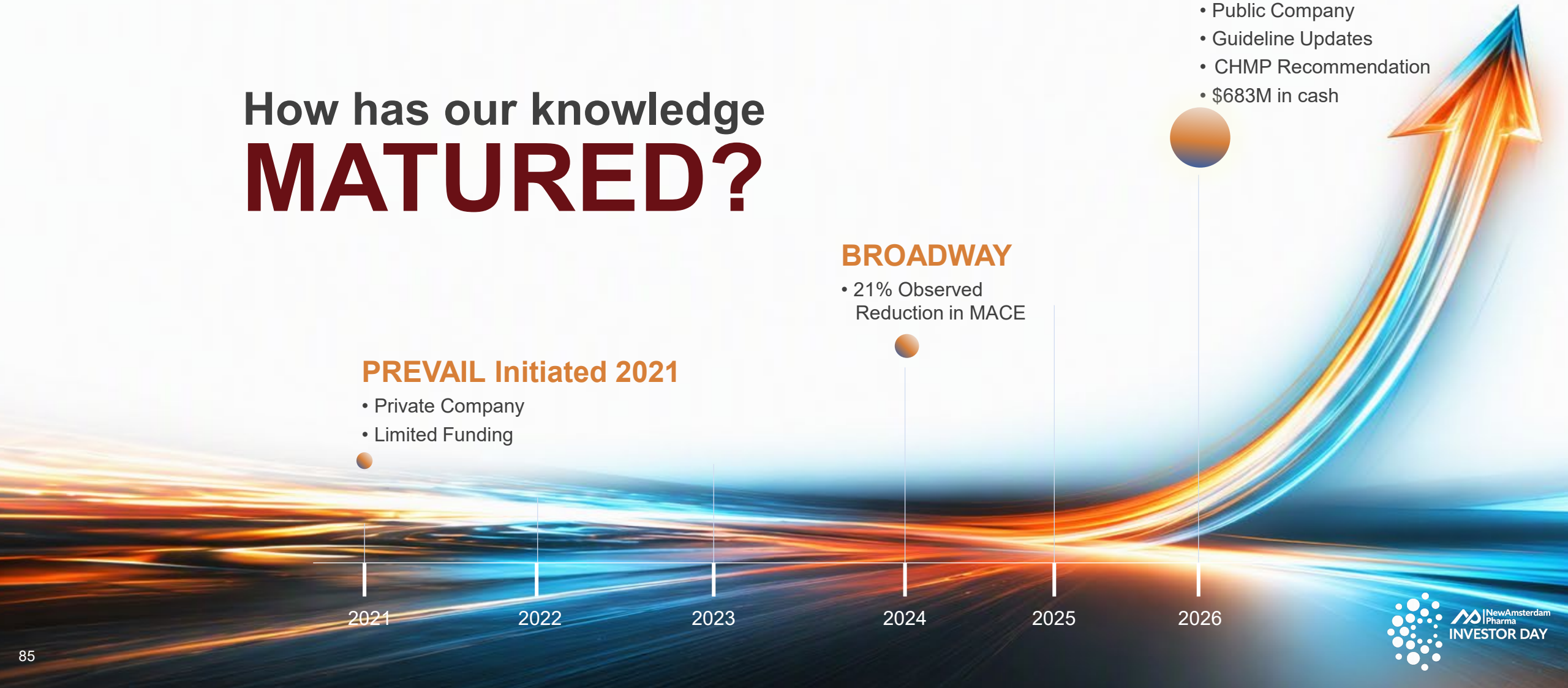
# Setting Up PREVAIL for Success

## How has our knowledge MATURED?

### PREVAIL Initiated 2021
- Private Company
- Limited Funding

### BROADWAY
- 21% Observed Reduction in MACE

### TODAY
- Public Company
- Guideline Updates
- CHMP Recommendation
- $683M in cash



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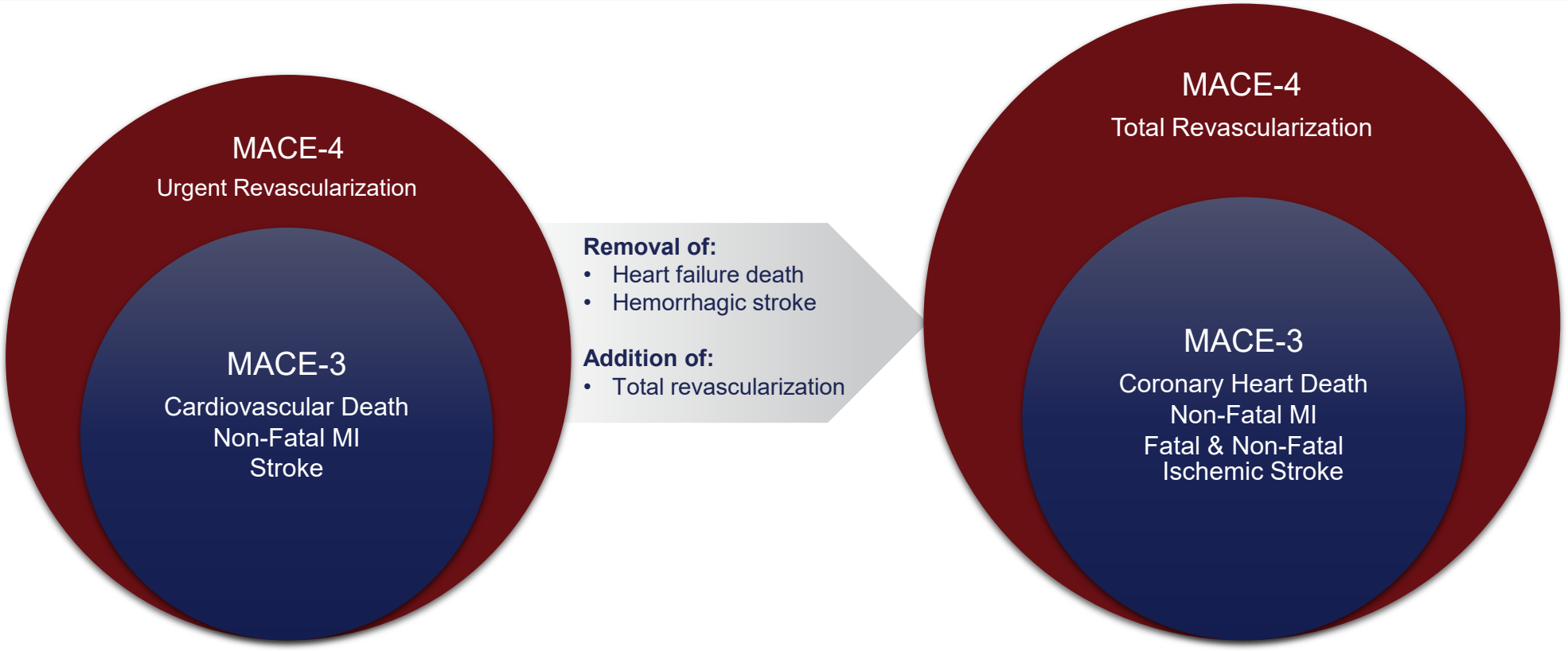
# PREVAIL Designed to Apply Lessons Learned from Previous CVOTs to Demonstrate Obicetrapib's Full Benefit

| | |
|---|---|
| Greater LDL-C lowering activity anticipated<br>Targeting higher baseline LDL-C patients | Higher *absolute* LDL-C reduction expected to lead to greater MACE benefit |
| Longer duration of follow up<br>Targeting higher-risk patient population | Maximizes opportunity for MACE reduction |
| Differentiated secondary endpoints | Potentially enhanced commercial profile vs. other LDL-C lowering agents |

**Primary endpoint selection**

Coronary heart disease (CHD) death, non-fatal MI, fatal and non-fatal ischemic stroke, coronary revascularization

# Changes in MACE-3/MACE-4 in-line with CTT Definition and Focused on LDL-C Modifiable Endpoints




**MACE-4: Urgent/non-elective coronary revascularization updated to total coronary revascularization, given minimal difference in MACE reduction between the two definitions; but by utilizing total coronary revascularization the event number and overall study power increases**

# PREVAIL Probability of Success and Study Power Increased

| | PREVAIL at Initiation | At Interim Analysis | At end of 2027 |
|---|---|---|---|
| Estimated Study Completion | YE 2026/1Q 2027 | YE 2026/1Q 2027 | YE 2027 |
| Primary Event Number | ~950 | >950 | >>950 |
| Median Follow Up | ~3.5 years | ~3.5 years | ~4.5 years |
| Minimum Follow Up | ~2.5 years | ~2.5 years | ~3.5 years |
| Expected Time to Majority of MACE benefit (1) | 2.0-2.5 years | 2.0-2.5 years | 2.0-2.5 years |

**PREVAIL study extension to the end of 2027 driven by slowing event rates plus desire to power the primary MACE-4 endpoint down to 15% through the addition of an additional one year of event accrual**

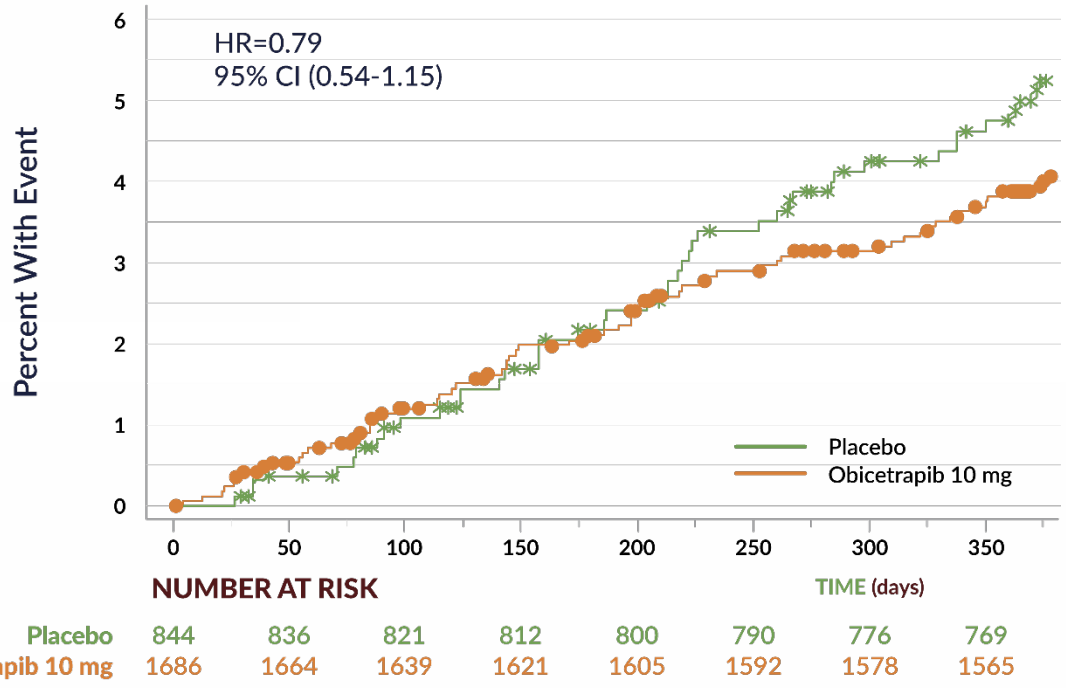
**Interim analysis allows the opportunity to enter the market a year earlier, without jeopardizing efficacy or needed alpha for primary endpoint**

1. Based on internal analysis

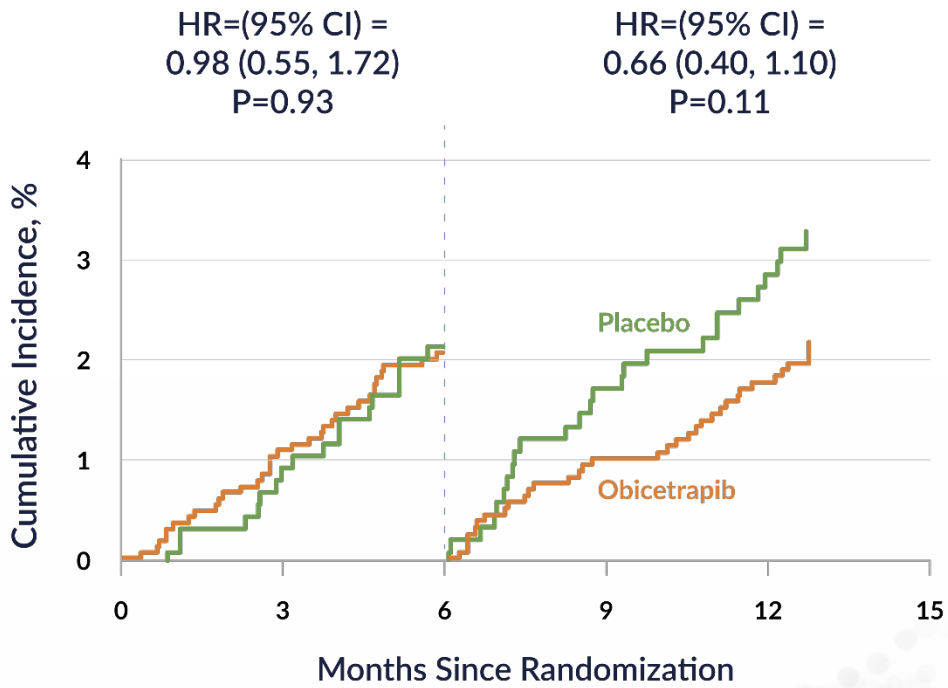
# Kaplan-Meier Curve Separates at Day 200 Driven by Attenuation of MACE-4 Events in the Obicetrapib Arm

BROADWAY

## Kaplan Meier Curve




## Landmark Analysis: Censored at 6 months




4-point MACE: CHD death, Non-fatal myocardial infarction, non-fatal stroke, coronary revascularization
While not powered to detect a MACE-4 benefit, we observed positive MACE-4 data as part of our review of the exploratory endpoint. BROADWAY was not powered to measure MACE-4 benefit and the MACE-4 data presented below may not be predictive of the MACE data we observe in PREVAIL, which has been designed to measure MACE benefit.

# MACE Benefit Observed Across Multiple Components After 1 Year of Treatment

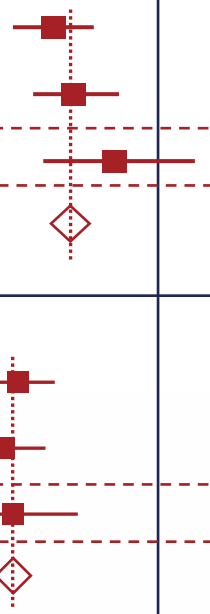
## BROADWAY MACE Data[1]

| | Placebo N = 844 | Obicetrapib N = 1686 | Hazard Ratio | 95% CI |
|---|---|---|---|---|
| All-cause mortality – no. (%) | 12 (1.4) | 19 (1.1) | 0.83 | (0.40-1.71) |
| First 4-point MACE – no. (%) | 44 (5.2) | 70 (4.2) | 0.79 | (0.54-1.15) |
| Coronary heart death – no. (%) | 5 (0.6) | 8 (0.5) | 0.80 | (0.26-2.44) |
| Nonfatal MI – no. (%) | 11 (1.3) | 20 (1.2) | 0.91 | (0.44-1.90) |
| Stroke – no. (%) | 5 (0.6) | 14 (0.8) | 1.39 | (0.50-3.86) |
| Coronary revascularization – no. (%) | 34 (4.0) | 49 (2.9) | 0.72 | (0.46-1.11) |

4-point MACE: CHD death, Non-fatal myocardial infarction, non-fatal stroke, coronary revascularization
(1) MACE was evaluated in BROADWAY as an exploratory endpoint. There are limitations on the interpretation of MACE data derived from both BROOKLYN and BROADWAY studies given they were not designed or powered to assess MACE. MACE data presented above may not be predictive of the MACE data we observe in PREVAIL, which has been designed to measure MACE benefit.

# Stroke Benefit Typically Delayed; Contributing in Later Years

| Year/Outcome | Events (% p.a.) Statin / more | Events (% p.a.) Control / less | RR (CI) per 1 mmol/L reduction in LDL–C |
|---|---|---|---|
| **YEAR 0–1** | | | |
| Major coronary event | 1441 (1.7) | 1727 (2.1) | 0.84 (0.76 – 0.92) |
| Coronary revascularization | 1886 (2.3) | 2150 (2.6) | 0.88 (0.80 – 0.97) |
| Stroke | 557 (0.7) | 588 (0.7) | 0.96 (0.82 – 1.12) |
| **Major vascular event** | **3497 (4.3)** | **3952 (4.8)** | **0.88 (0.84 – 0.93)** p<0.0001 |
| **YEAR 1–2** | | | |
| Major coronary event | 1009 (1.3) | 1256 (1.6) | 0.78 (0.70 – 0.86) |
| Coronary revascularization | 997 (1.3) | 1282 (1.7) | 0.75 (0.67 – 0.84) |
| Stroke | 445 (0.6) | 573 (0.7) | 0.77 (0.66 – 0.91) |
| **Major vascular event** | **2112 (2.8)** | **2645 (3.6)** | **0.77 (0.73 – 0.82)** p<0.0001 |



**Meta-analysis of 21 CVOTs demonstrate delayed stroke benefit through LDL-C reductions**

Source: Cholesterol Treatment Trialists Collaboration. Lancet. 2010

# LDL-C Studies: Generally Shown to be Predictive of CVOT Outcomes

## Concordance results for lipid lowering drugs evaluated

| Drug | Sample Size | | MACE EVENTS (1st occurrence) | | | | CVOT[1] MACE HR (95% CI) Non-CVOT MACE RR (95% CI) | Concordance |
|---|---|---|---|---|---|---|---|---|
| | N-active drug | N-comparator | Events-Drug | Events-Comparator | % Event Rate-Drug | % Event Rate-Comparator | | |
| **Bempedoic Acid-CVOT** | 6992 | 6978 | 819 | 927 | 11.71 | 13.28 | 0.87 (0.79–0.96) | Concordant |
| **Non-CVOT** | 2424 | 1197 | 117 | 75 | 4.83 | 6.27 | 0.77 (0.58–1.02) | |
| **Evolocumab-CVOT** | 13,784 | 13,780 | 1344 | 1563 | 9.75 | 11.34 | 0.85 (0.79–0.92) | Concordant |
| **Non-CVOT** | 2976 | 1489 | 28 | 30 | 0.94 | 2.01 | 0.47 (0.28–0.78) | |
| **Alirocumab-CVOT** | 9462 | 9462 | 903 | 1052 | 9.54 | 11.12 | 0.85 (0.78–0.93) | Concordant |
| **Non-CVOT** | 3182 | 1792 | 52 | 33 | 1.63 | 1.84 | 0.89 (0.57–1.37) | |
| **Bococizumab-CVOT** | 13,720 | 13,718 | 352 | 397 | 3.16 | 3.59 | 0.88 (0.76–1.02) | Concordant |
| **Non-CVOT** | 2377 | 2058 | 57 | 55 | 2.5 | 2.7 | 0.90 (0.62–1.29) | |

**100% of Non-CVOT studies results were concordant with the CVOT outcome***

Source: Shear et al, *American Heart Journal Plus: Cardiology Research and Practice* 63 (2026) 100728.
* Excludes CETP studies that were based on HDL-C raising, where only one was not concordant

# BROADWAY Designed to be a Predictor of PREVAIL

## BROADWAY

1º endpoint – week 12

N = 2532

**Obicetrapib 10 mg (2:1 randomization)**

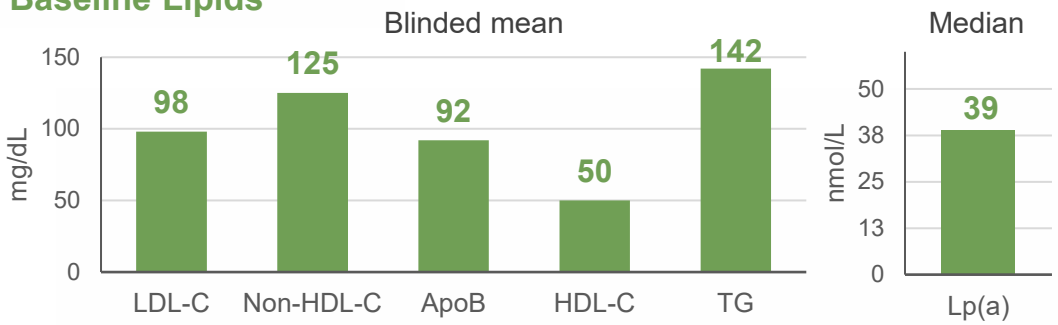
Placebo

13-months

### Key Inclusion Criteria

- ASCVD or HeFH
- LDL-C ≥55 mg/dL w/risk factors, or
- LDL-C≥ 100 mg/dL
- Maximally tolerated lipid lowering therapy

### Baseline Lipids




### Baseline Lipid Modifying Therapy

- Any statin: 91%
- High intensity statin: 65%
- Ezetimibe: 26%
- PCSK9i: 4%
- SGLT2i: 11%
- GLP-1: 6%

## PREVAIL

LDL-C endpoint

N = 9541

**Obicetrapib 10 mg (1:1 randomization)**

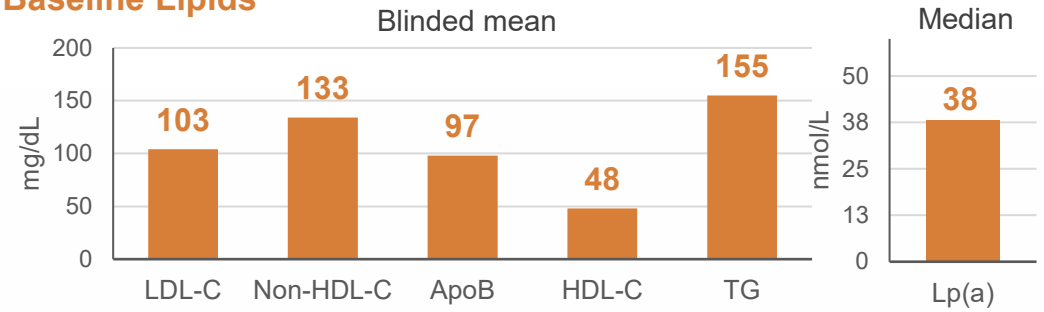
Placebo

54-months

### Key Inclusion Criteria

- ASCVD
- LDL-C ≥55 mg/dL w/risk factors, or
- LDL-C≥ 100 mg/dL
- Maximally tolerated lipid lowering therapy

### Baseline Lipids

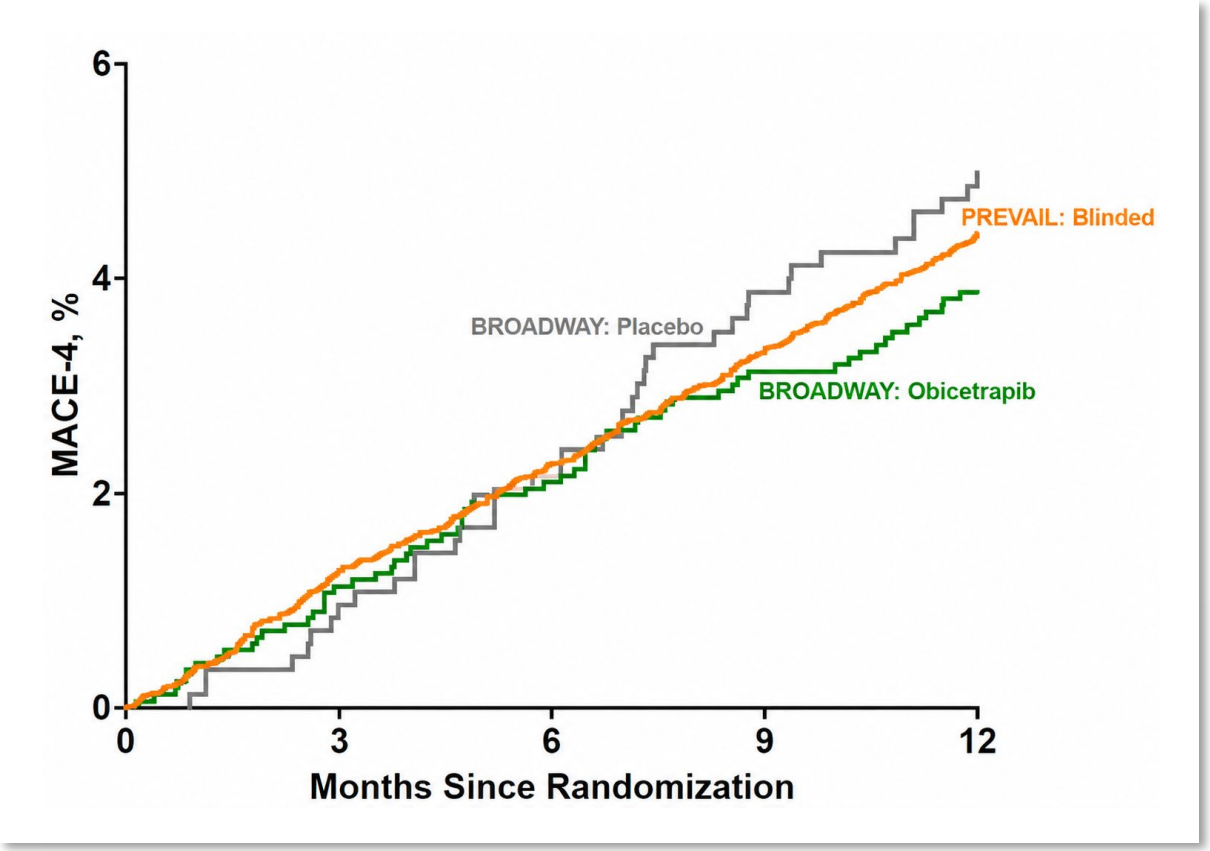


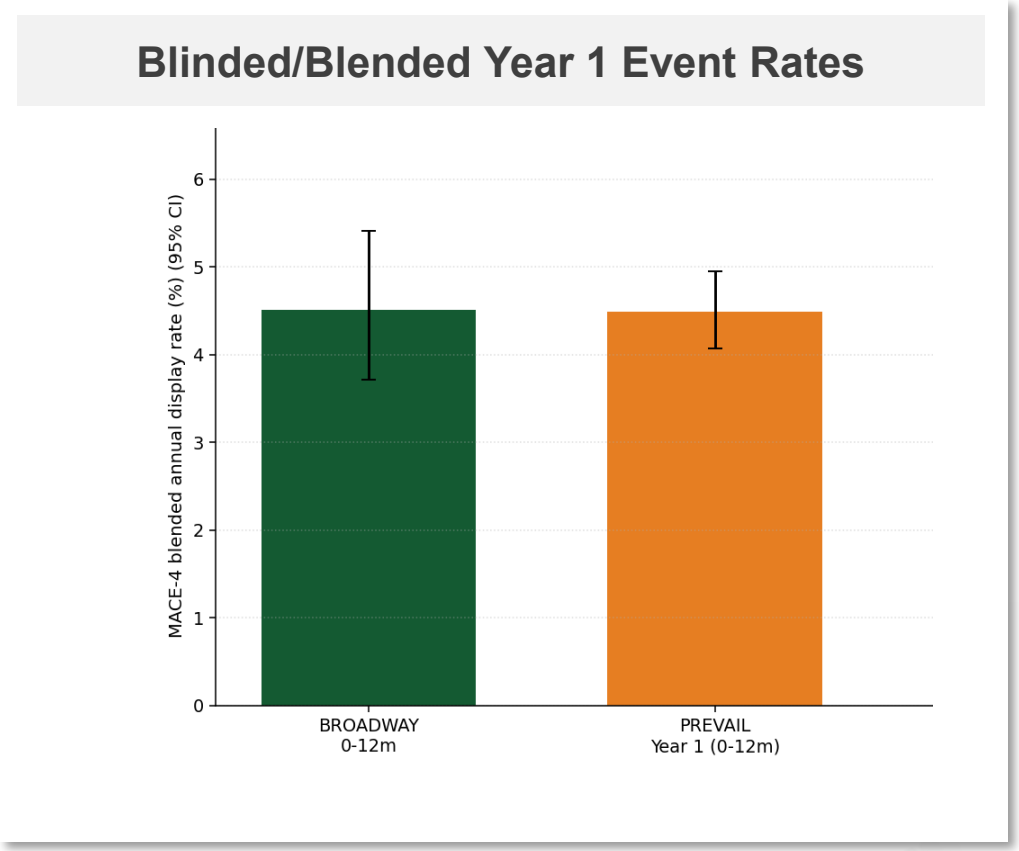

### Baseline Lipid Modifying Therapy

- Any statin: >90%
- High intensity statin: 74%
- Ezetimibe: 26%
- PCSK9i: 2%
- SGLT2i: 14%
- GLP-1: 6%

Source: Data on file

# BROADWAY and PREVAIL Year 1 Event Rates - Showing Similar MACE Rates in the Study Populations




4-point MACE: CHD death, Non-fatal myocardial infarction, non-fatal stroke, coronary revascularization
(1) While not powered to detect a MACE benefit, we observed positive MACE-4 data as part of our review of the exploratory endpoint. BROADWAY was not powered to measure MACE benefit and the MACE data presented below may not be predictive of the MACE data we observe in PREVAIL, which has been designed to measure MACE benefit. PREVAIL data is preliminary and subject to change as MACE events continue to be identified and adjudicated (including with respect to periods presented above). Additionally, Year 1 and Year 2 MACE event trends may not be indicative of future trends.

# PREVAIL has a higher or comparable baseline risk vs comparator trials but blinded event rates are trending lower

**PREVAIL Blinded Rates vs Contemporary Secondary Prevention CVOT Placebo Rates (2017–2025)**

| Trial | Year | Median Follow Up (Yr)[2] | Age | LDL (mg/dL)[3] | Diabetes | Prior MI | Calc. MACE-4 Event Rates[1] | Calc. MACE-3 Event Rates[1] |
|---|---|---|---|---|---|---|---|---|
| **CLEAR SP Cohort** | 2023 | 3.4 | 65 | 139 | 46% | 30% | 4.60% | 3.20% |
| **SOUL** | 2025 | 4.1 | 66 | 72 | 100% | 100% | 3.90% | 3.35% |
| **SELECT** | 2023 | 3.3[3] | 62 | 78 | 0% | 68% | 3.68% | 2.41% |
| **FOURIER** | 2017 | 2.2 | 63 | 92 | 37% | 81% | 5.14% | 3.36% |
| **ODYSSEY** | 2018 | 2.8 | 59 | 87 | 29% | 19% | 5.57% | 3.74% |
| **Average** | | 3.2 | 63 | 88 | 42% | 60% | 4.58% | 3.21% |
| **PREVAIL** | **2026** | 2.78 | **65** | **103** | **49%** | **50%** | | |
| **BROADWAY** | 2023 | 1 | 66 | 97 | 38% | 57% | 5.20% | 2.50% |

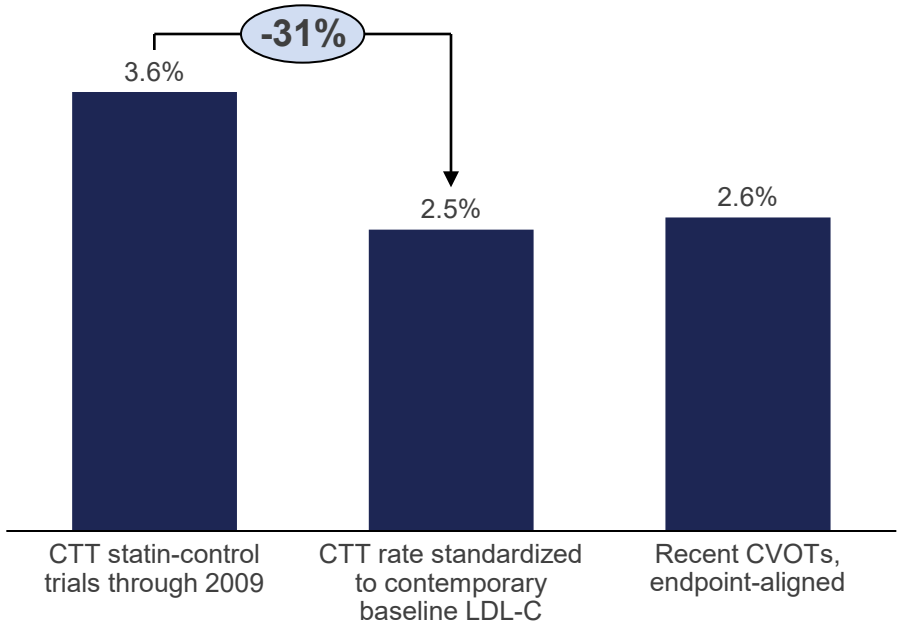
Source: Internal analysis | 1. Sayed et al. International Journal of Cardiology 406 (2024) 132074 2.McGuire et al. N Engl J Med 2025;392:2001-12. 3.Lincoff et al. N Engl J Med 2023;389:2221-32. 4. Sabatine et al. N Engl J Med 2017;376:1713-22. 5. Schwartz et al. N Engl J Med 2018;379:2097-107.

Note: 1. Internal analysis based on annualized placebo rates for comparator trials calculated based on available data; MACE-4 was 4 pt CTT (3pt MACE + total coronary revasc; if not available: then 3 pt + ischemic driven revasc (IDR) or 3 pt + coronary/cerebral revasc (CCR) . 2. Approximate 3. Median values except for PREVAIL, BROADWAY, CLEAR

Results should be interpreted with caution due to inherent limitations in cross-trial comparisons.

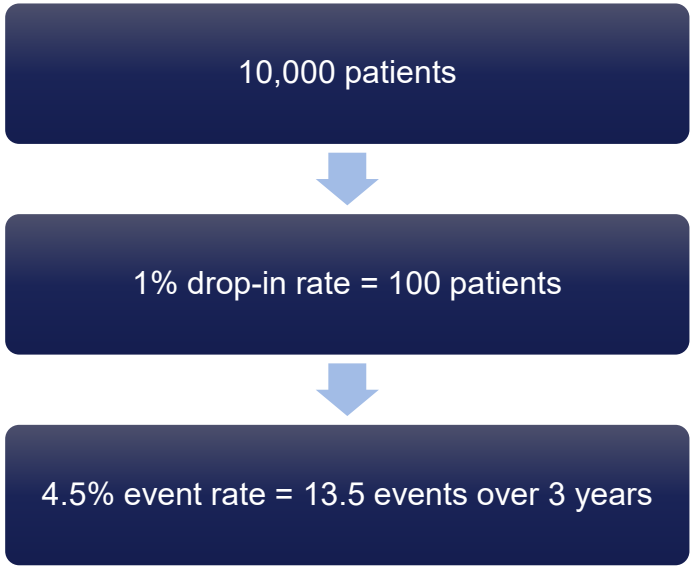
# Analysis Suggests Event Rates in CVOT Trials Have Remained Stable When Adjusting for Baseline LDL-C; Impact of Drop-In's Minimal

## Has standard of care been reducing event rates?




**Although novel drug usage is increasing (GLP1, SGLT2, PCSK9, etc.) lower event rates in LDL-C based CVOTs are explainable by lower baseline LDL-C**

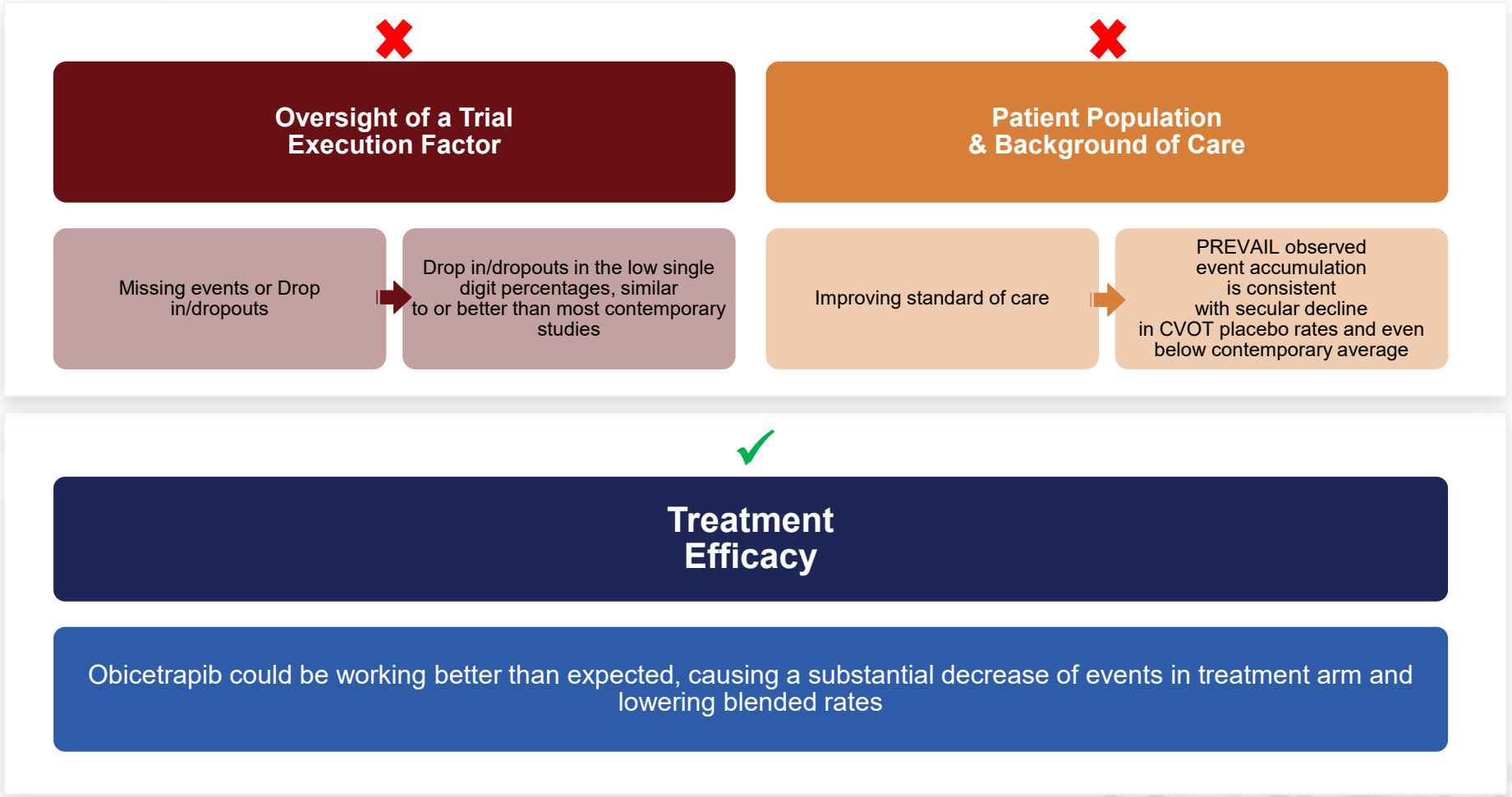
## What effect could drops-in have?




**A 1% drop-in rate of a therapy that provides a 20% MACE benefit would only impact event rates by 0.009%, from 4.500% to 4.491%**

Source: Internal analysis; 1. Sayed et al. International Journal of Cardiology 406 (2024) 132074; 2.McGuire et al. N Engl J Med 2025;392:2001-12; 3.Lincoff et al. N Engl J Med 2023;389:2221-32; 4. Sabatine et al. N Engl J Med 2017;376:1713-22; 5. Schwartz et al. N Engl J Med 2018;379:2097-107; 6. Cholesterol Treatment Trialists Collaboration. Lancet. 2010.

# Treatment Effect Believed to be Likely Explanation for Lower Event Rates

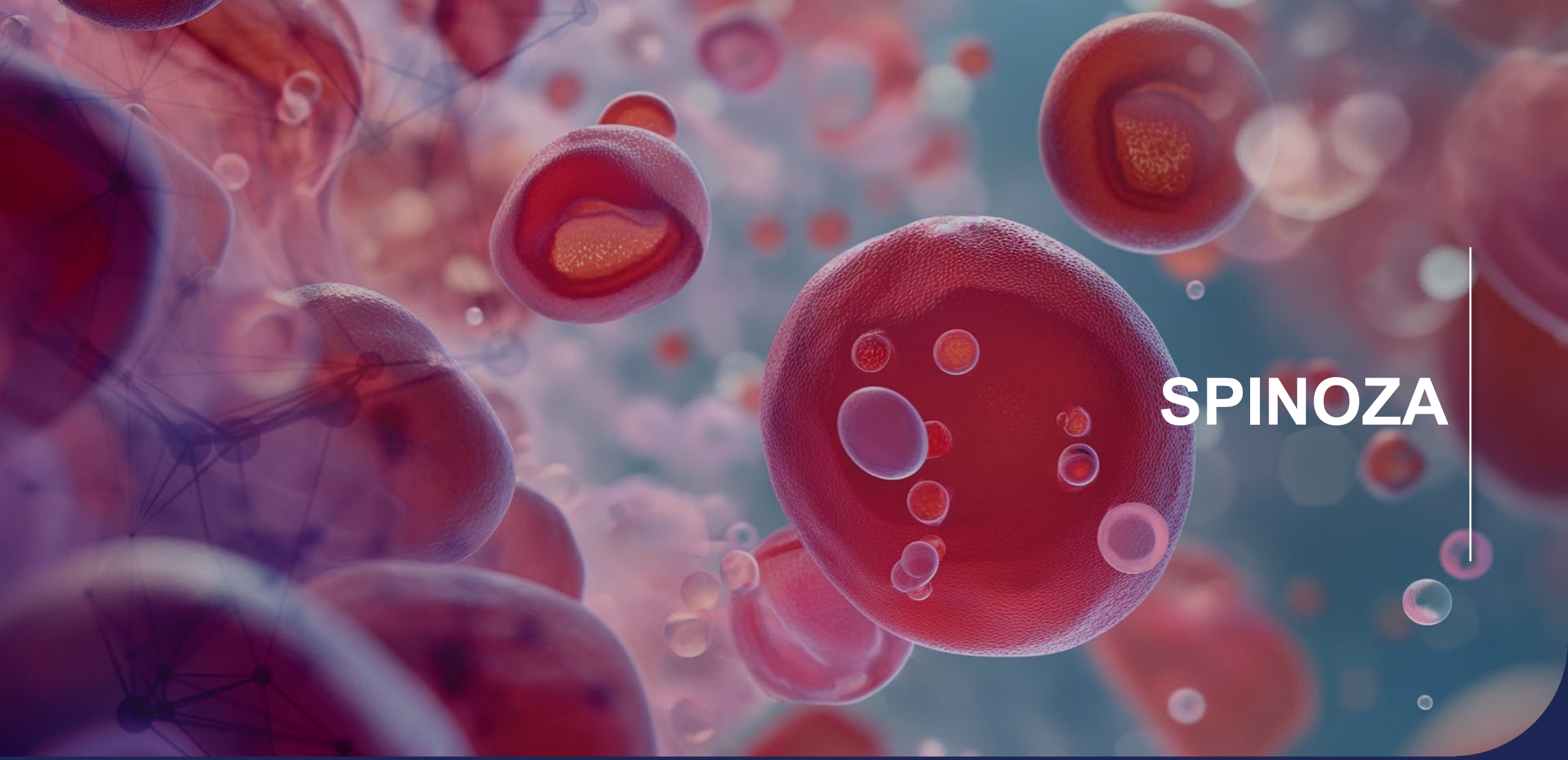


# PREVAIL Design Changes Increase Probability of Success

PREVAIL

The Study Should Not Fail the Drug

- Increased number of events at interim and end of study
- Encouraging blinded event trends believed to be driven by treatment effect, and not explained by standard of care or drop-ins
- CVOT precedents and blinded data suggest a potential benefit consistent with BROADWAY, providing margin to the powering assumptions and commercial hurdle
- Success is more important than the ultimate MACE value, driven by guideline updates, prescribing behavior, and differentiated product profile
- Optimistic around a successful study outcome, interim provides option to enter market earlier



# SPINOZA

# A Future Worth Getting Ahead Of

**AGE 55 • FEMALE • APOE4 HOMOZYGOTE • FHx ALZHEIMER'S**
**MEDICATIONS: STATIN • TRIATHLETE & MOUNTAINEER •**
**PhD, BIOTECH EXECUTIVE**


ADVOCATE

“

I watched Alzheimer’s take so much from both my mother and now my father. Living with two copies of APOE4, I can’t help but fear that my daughters or I will face the same future. I’m healthy today, but waiting for symptoms is not enough. We need treatment options that enable earlier intervention.

**Wendy N.**
*Living Fully, Still Waiting for Prevention*

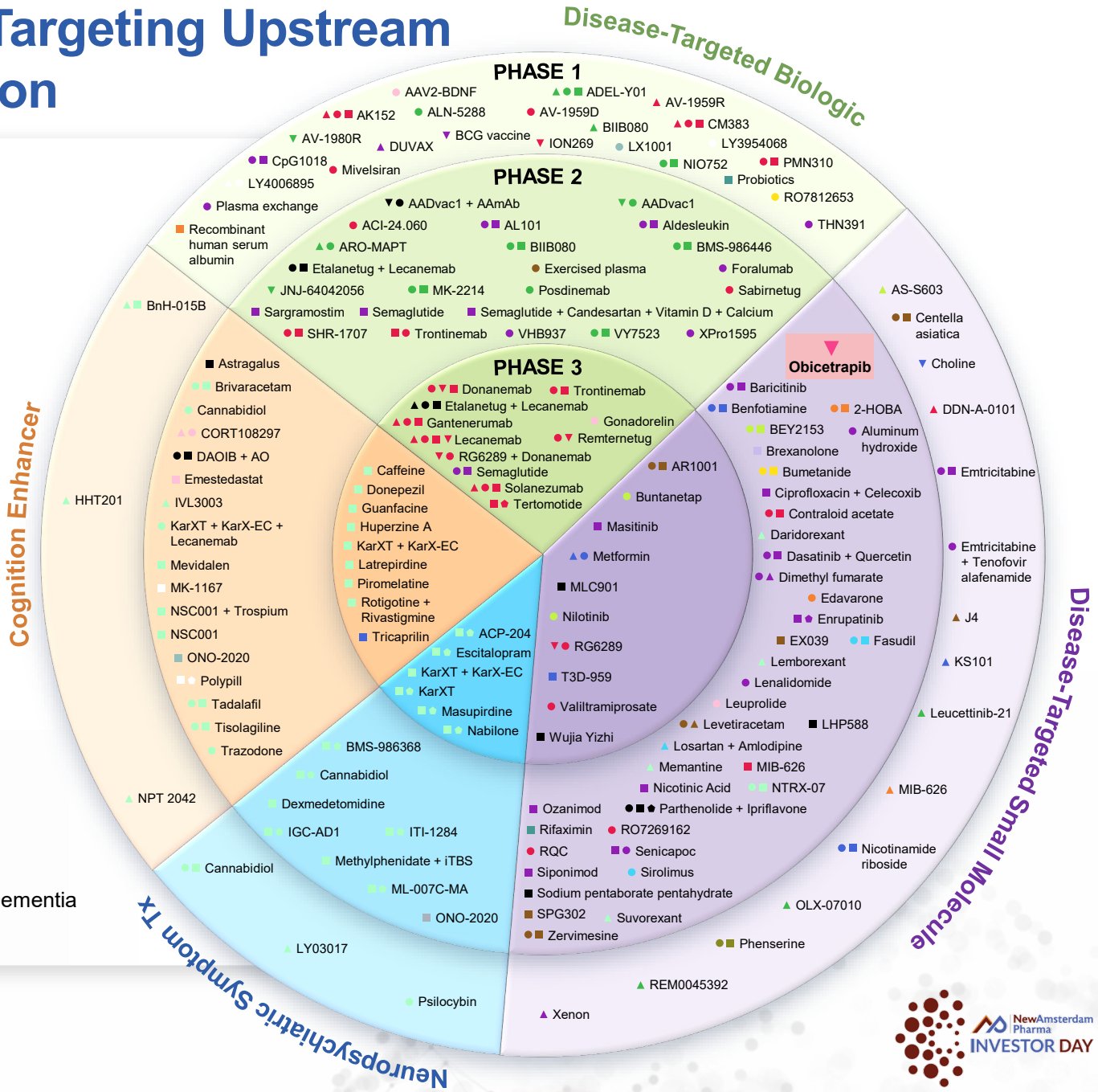
# Obicetrapib Is the Only Therapy Targeting Upstream Lipid Metabolism for AD Prevention

## Targeted Pathophysiological Process

- Amyloid
- Tau
- APOE, Lipids and Lipoprotein Receptors
- Neurotransmitter Receptors
- Neurogenesis
- Inflammation
- Oxidative Stress
- Cell Death
- Proteostasis/Proteinopathies
- Metabolism and Bioenergetics
- Vasculature
- Growth Factors and Hormones
- Synaptic Plasticity/Neuroprotection
- Gut-Brain Axis
- Circadian Rhythm
- Epigenetic Regulators
- Multi-Target
- Undisclosed
- **Lipid Metabolism** (with downstream effects on inflammation and oxidative stress)

## Trial Population

- ▲ Healthy Volunteers
- ● MCI (Prodromal) and MCI-Mild AD Dementia
- ▼ Preclinical AD
- ■ Mild-Moderate AD Dementia
- ⬟ Severe AD Dementia




Source: Cummings et al. Alzheimer's Dement. 2026;12:e70251



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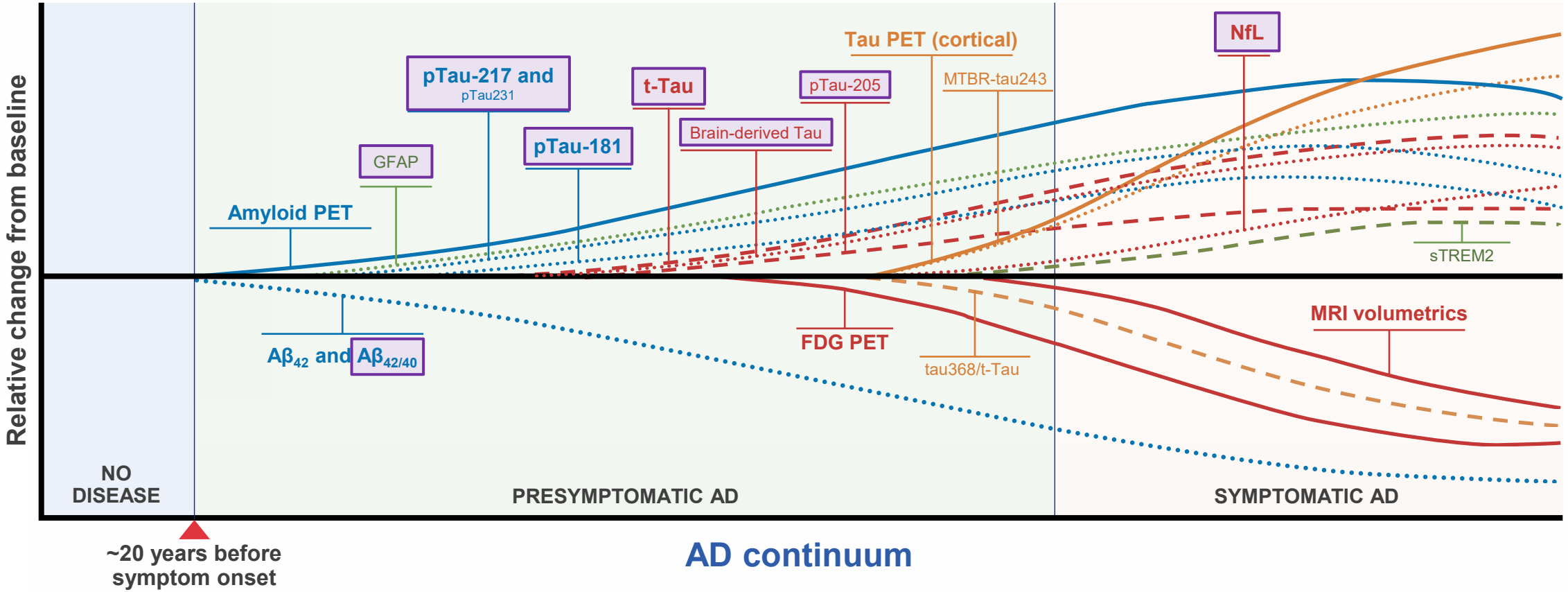
# Alzheimer's Disease is Being Redefined as a Biological Process That Begins 20 Years Before Cognitive Decline




| TYPES OF BIOMARKER | CLOSEST PATHOLOGIC CORRELATION | STAGE OF DEVELOPMENT | |
|---|---|---|---|
| Imaging | Amyloid plaques | CLINICALLY APPROVED | Biomarkers measured as endpoints in obicetrapib AD studies |
| CSF | Neurofibrillary tangles | Investigational | |
| CSF and plasma | Neuroinflammation | | |
| | Neurodegeneration | | |



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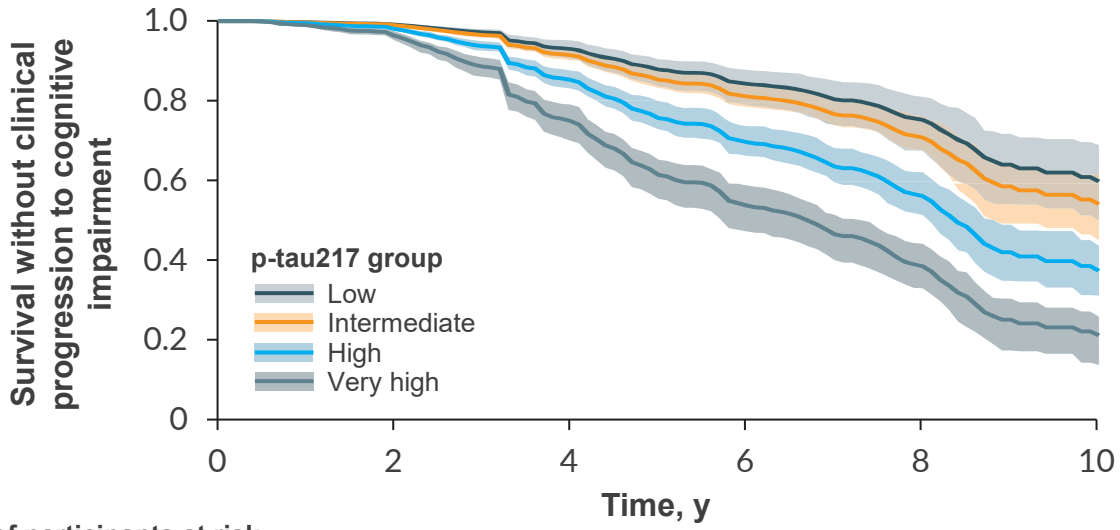
# Higher Plasma p-tau217 Levels Are Associated With Greater Risk of Progression to Cognitive Impairment in Unimpaired Adults*

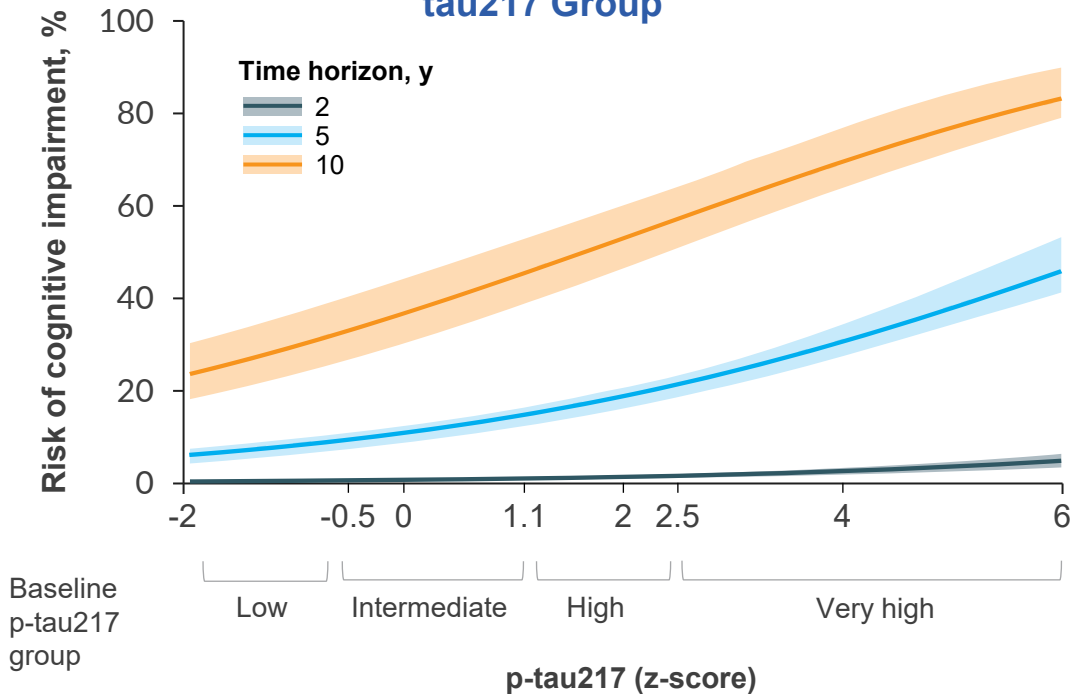
## Survival Free of Cognitive Impairment Over Time, by Baseline Plasma p-tau217 Group




**No. of participants at risk**

| | | | | | | |
|---|---|---|---|---|---|---|
| Low | 516 | 451 | 296 | 197 | 53 | 19 |
| Intermediate | 1087 | 983 | 625 | 404 | 139 | 65 |
| High | 598 | 520 | 358 | 195 | 49 | 16 |
| Very high | 483 | 425 | 285 | 143 | 27 | 11 |

## High and Very High Levels of p-tau217 Are Associated With the Greatest Risk of Progression Relative to the Low p-tau217 Group




An increase of 1 SD in p-tau217 was associated with an
**HR for progression to cognitive impairment of 1.38 (95% CI, 1.30-1.46; *P*<0.001)**

*Study included 2684 cognitively unimpaired older adults with baseline plasma p-tau217 and Aβ PET imaging and longitudinal clinical follow-up from multiple well-characterized observational and clinical trial cohorts. Cognitive impairment was defined as a within-cohort diagnosis of mild cognitive impairment, dementia, or 2 consecutive global Clinical Dementia Rating scores of 0.5 or greater.
Aβ, amyloid beta; CI, confidence interval; HR, hazard ratio; PET, positron emission tomography; SD, standard deviation; y, years.
Buckley RF et al. *JAMA*. 2026:e2612556. Epub ahead of print. doi:10.1001/jama.2026.12556



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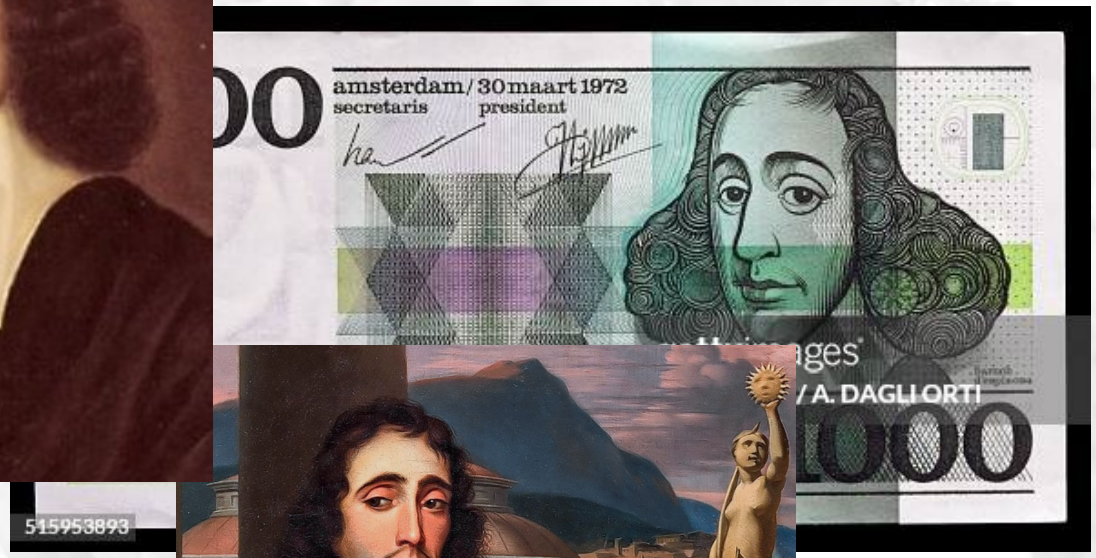
# SPINOZA



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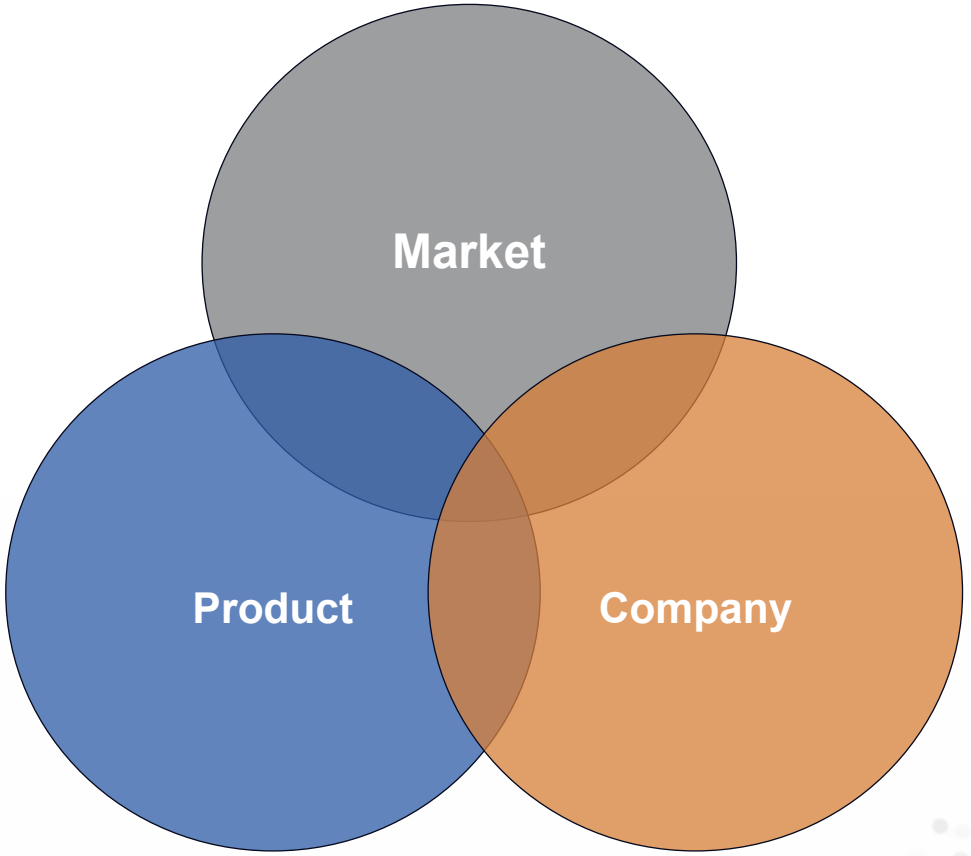
# Commercial Update

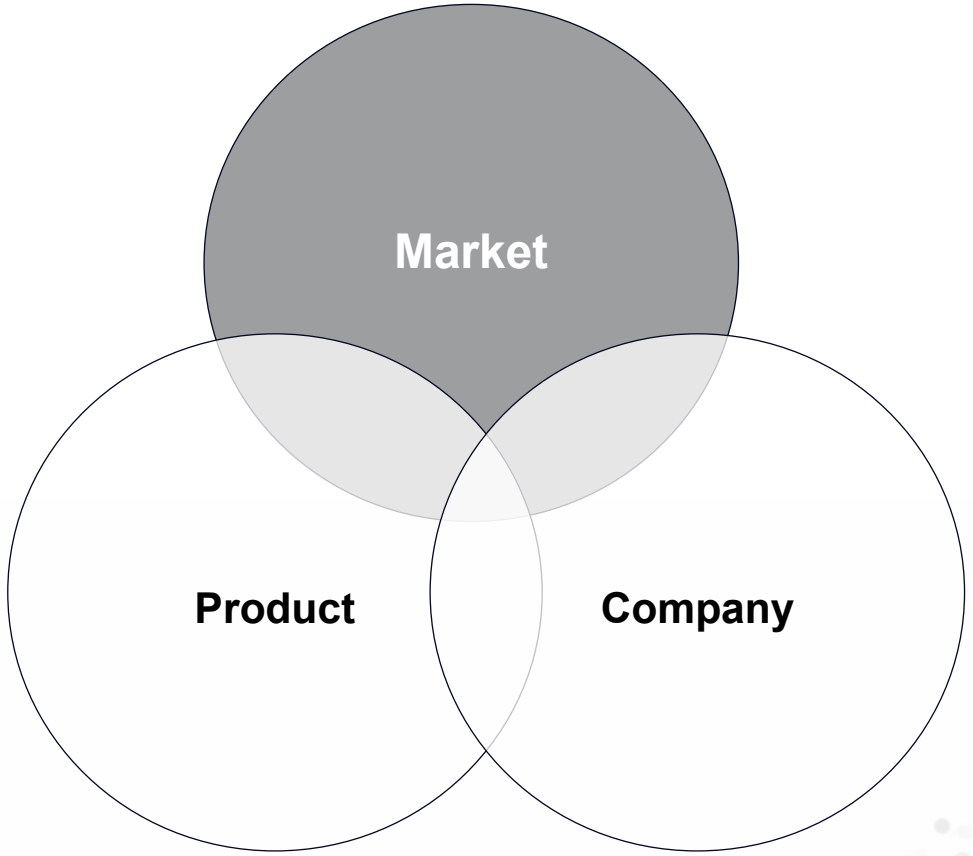
# Agenda

- **US Launch Preparations**
- **European Launch Update**

# US Launch Preparations



# Preparing The Market

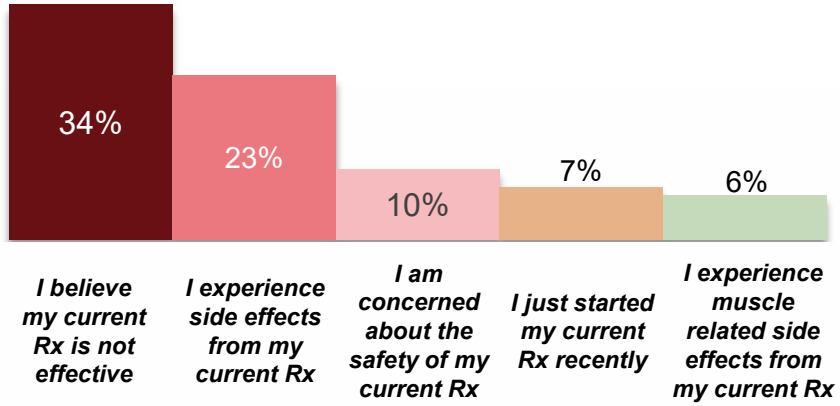


# Patient Satisfaction With Current Therapies Is Low

**2 out of 3 Patients**
are not fully satisfied with their hypercholesterolemia treatment

What is the main reason you were not fully satisfied with your treatments for high cholesterol (hypercholesterolemia)?

## Top 5 Reasons




## Lack of Efficacy

**"Frustration. Because some of the best advice I would give someone to lower their cholesterol, I follow. And my cholesterol, is still very high."**
**- Patient**

## Safety/Tolerability

***"Every statin I've ever tried makes muscles in your body just ache."***
***- Patient***

Source(s): 1) Magnolia March 2024 Patient Quant Research, N=276 Patient Quantitative Respondents 2) Klick Patient Ethnography Research, Jan 2026 3) Always Future Patient Physician Disconnect Study, April 2026

# Unmet Need Is Driving Increased Innovation

Multiple companies are advancing LDL-C, Lp(a), and combination programs, reinforcing broad recognition that the LLT market continues to need new patient solutions

**VISIBLE INDUSTRY COMMITMENT**

**7** companies with listed LLT programs in the competitor timeline

Merck | AstraZeneca | Novartis | Amgen | Lilly | Esperion | LIB Ther.

**LDL-C / PCSK9**

- Enlicitide
- Laroprovstat
- Lerodalcibep

**Lp(a)**

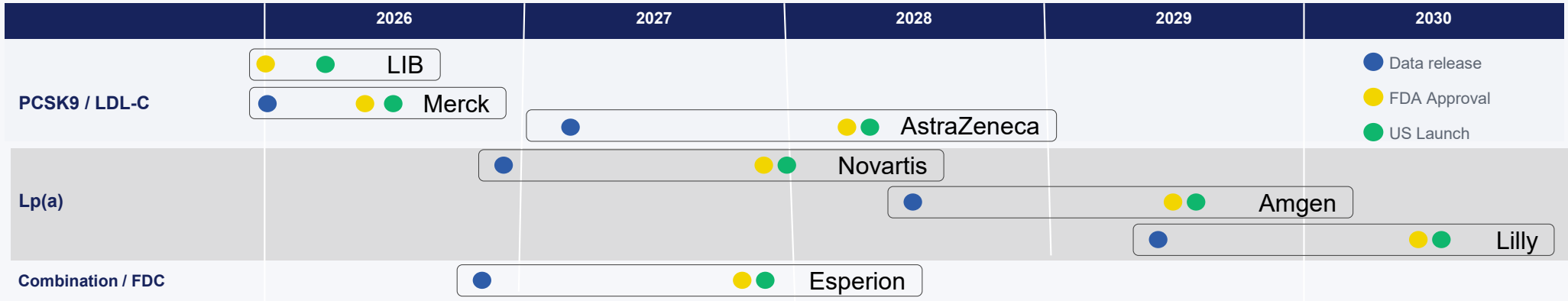
- Pelacarsen
- Olpasiran
- Lepodisiran
- Muvalaplin

**Combination / FDC**

- BPA + EZE + Statin
- Oral PCSK9i + Statin

## Lipid management pipeline momentum, 2026–2030

Visible timelines include launch, filing, approval, data release, and outcomes readout activity across multiple mechanisms




**Industry investment across LDL-C, Lp(a), and combination approaches reinforces broad conviction that lipid management remains a large, active, and underpenetrated cardiovascular market**

Source: Timeline estimated based on publicly available sources

# Market Dynamics: Growth of Non-Statin (+19%) and Branded (+31%) Volume Continue to Grow Rapidly Year Over Year

Market

## 1 Patient Population[1]

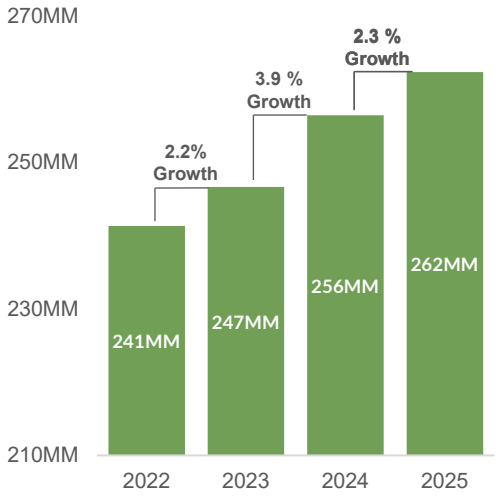
**84 million**
Adults in US diagnosed with hyperlipidemia

**~21 million**
Diagnosed patients not treated with statin or LLT

**~40 million**
Not at goal

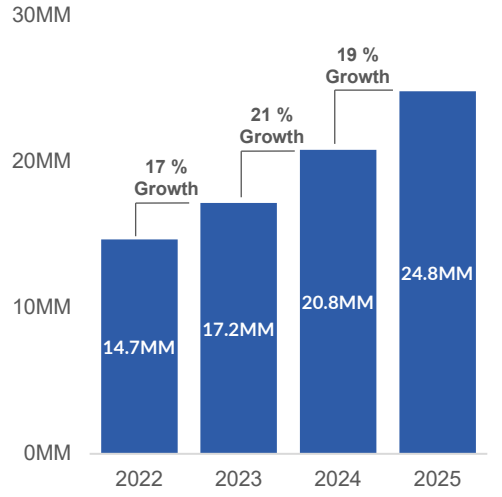
Over 60 million patients undertreated/ not treated

## 2 Lipid lowering Therapy TRx[2]



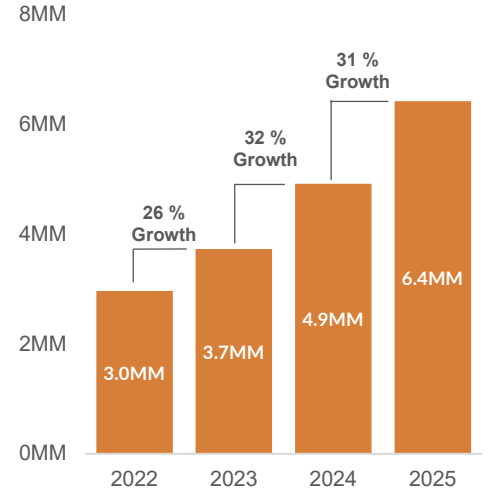

6 years of consecutive growth

## 3 Non-Statins[3] TRx




Non-statins growing at high double digits

## 4 Branded[4] TRx




Branded agents grew 31% matching last year's growth

**Market Growth of 2.3% in 2025, adds 6 million additional TRx's, of which 1.5 million are branded TRx's**

Source: Based on third party prescription data on file
1. Forian Healthcare Closed Claims and EHR Data (2022-2024)
2. All Lipid Lowering therapies: Statins, Ezetimibe and combinations; PCSK9 and BPA;
3. Non-Statins : Ezetimibe and combinations; PCSK9 and BPA;
4. Branded: PCSK9 and BPA;



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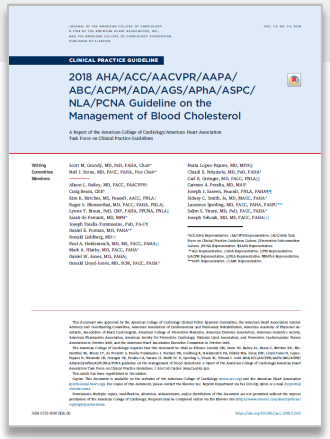
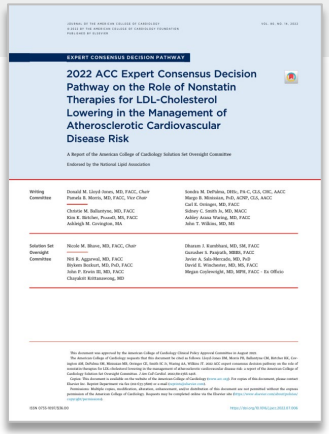
# Recent Updates to Guidelines Advocate for More Aggressive Intervention

## Guidance for patients with very high-risk ASCVD receiving maximally tolerated statin therapy

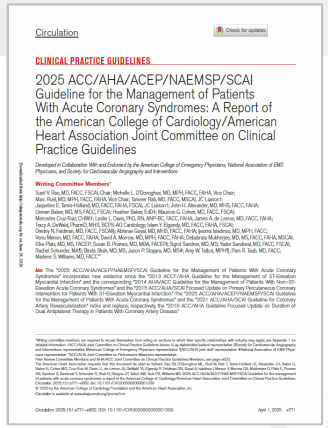
**2018** — LDL-C threshold of **70 mg/dL** for the addition of nonstatin therapy[1]




**2022** — LDL-C threshold of **55 mg/dL** for the addition of nonstatin therapy [2]

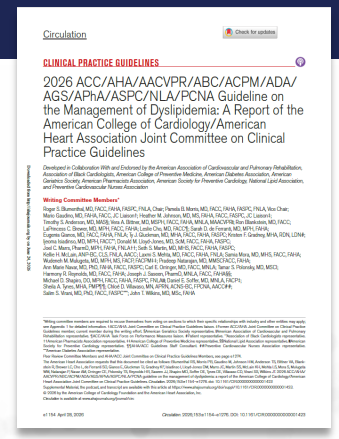



**2024** — LDL-C threshold of **55 mg/dL** for the addition of nonstatin therapy among hospitalized patients with ACS [3]




**2026** — **Formal LDL-C goal of <55 mg/dL** to guide the addition and intensification of nonstatin therapy[4]

NEW!

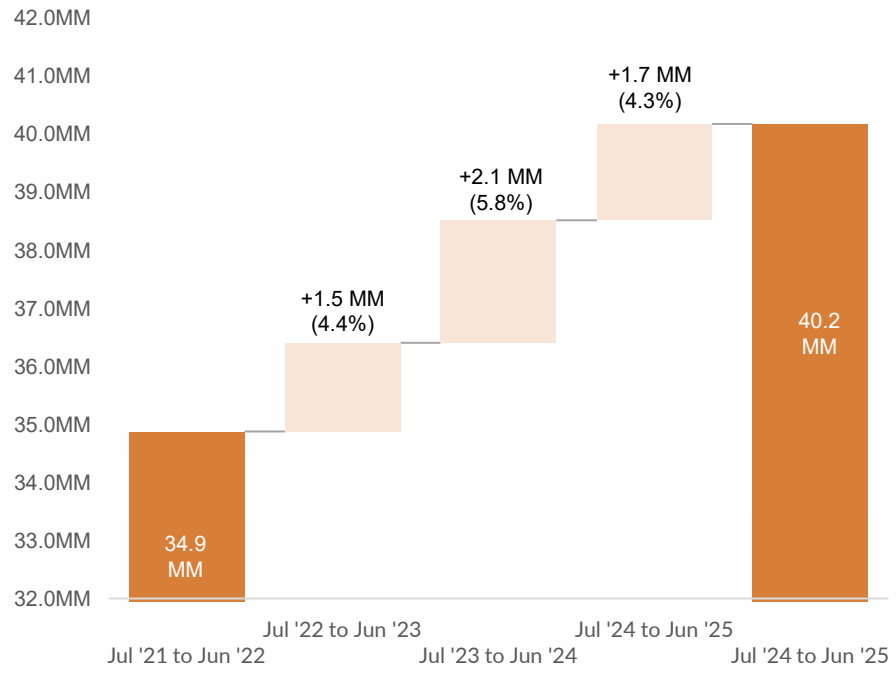



1. Grundy SM et al. *J Am Coll Cardiol*. 2019;73(24):e285-e350. 2. Lloyd-Jones DM et al. *J Am Coll Cardiol*. 2022;80(14):1366-1418. 3. Rao SV et al. *Circulation*. 2025; 151(13):e771-e862.
4. Blumenthal RS et al. *Circulation*. 2026;153(17):e1154-e1276.

# Resulting In More Patients Treated and Greater Focus On Goal Attainment

1

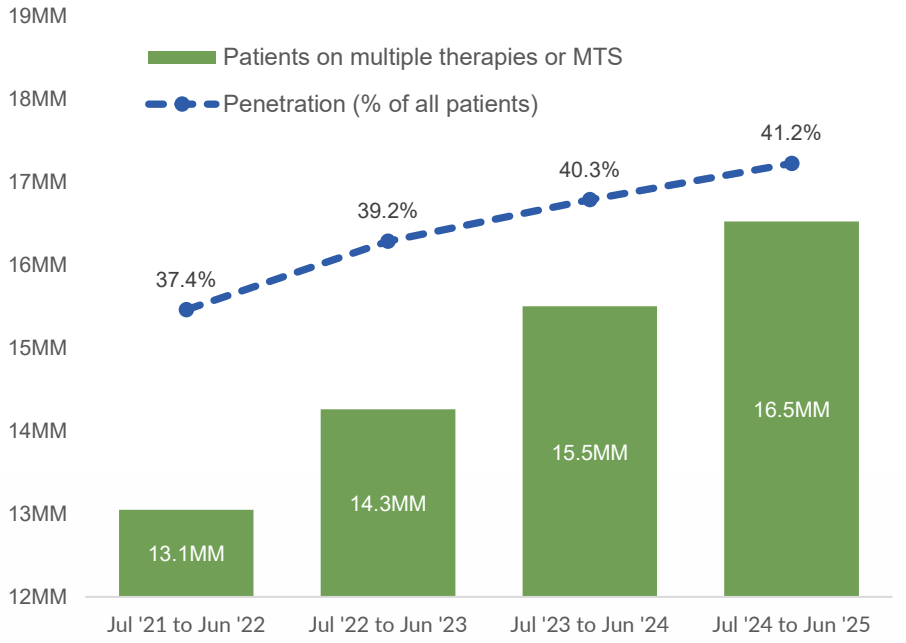
## Patients on Lipid lowering Therapy[1]




**Greater than 5 MM treated patients added in the last 3 years**

2

## Patients on high intensity[2] or add-on therapies




**More aggressive treatment over time**

Source: Forian data from Jul '21 to Jun '25

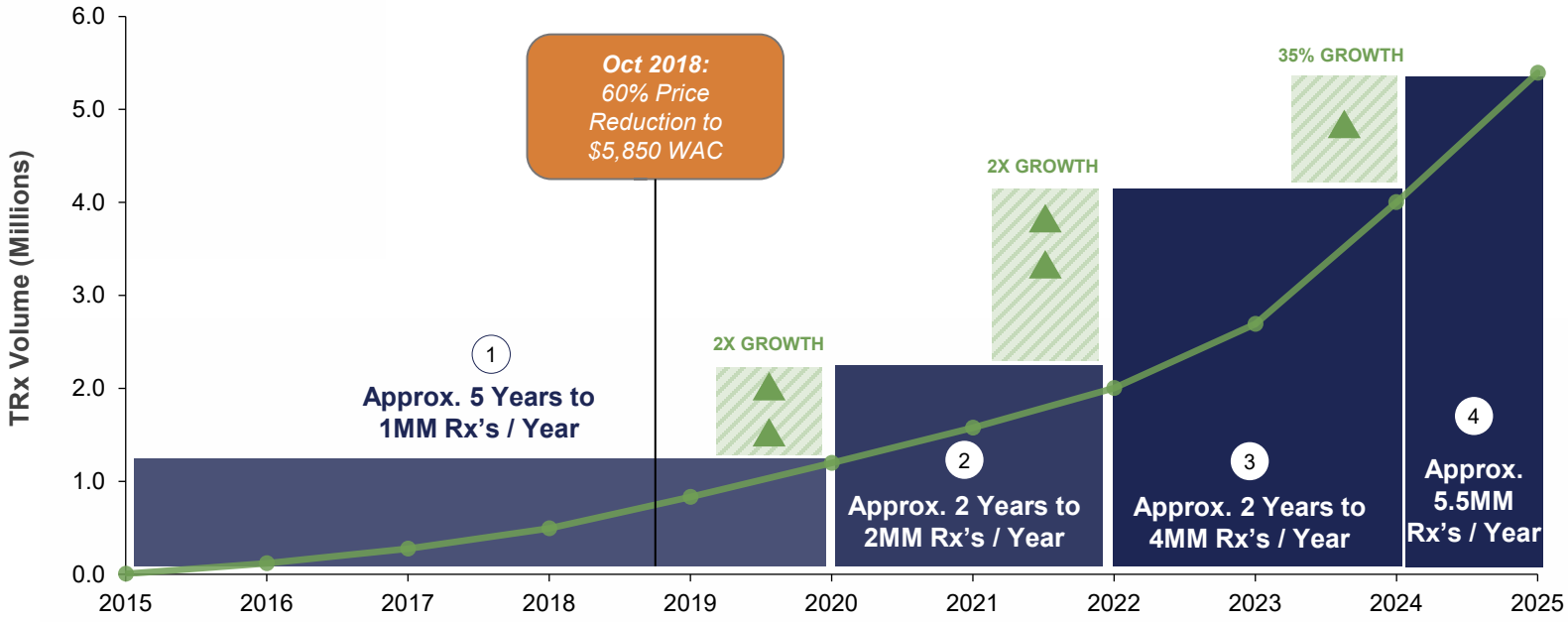
[1]All Lipid Lowering therapies: Statins, Ezetimibe and combinations; PCSK9 and BPA

[2]Atorvastatin 40 & 80 mg, Simvastatin 80 mg, Rosuvastatin 20 & 40 mg

# … Leading to Accelerated Brand Growth

**Accelerating growth is evidence of the demand for additional options in the LLT space**

## Repatha® volume continues to be on track to double every 2 years



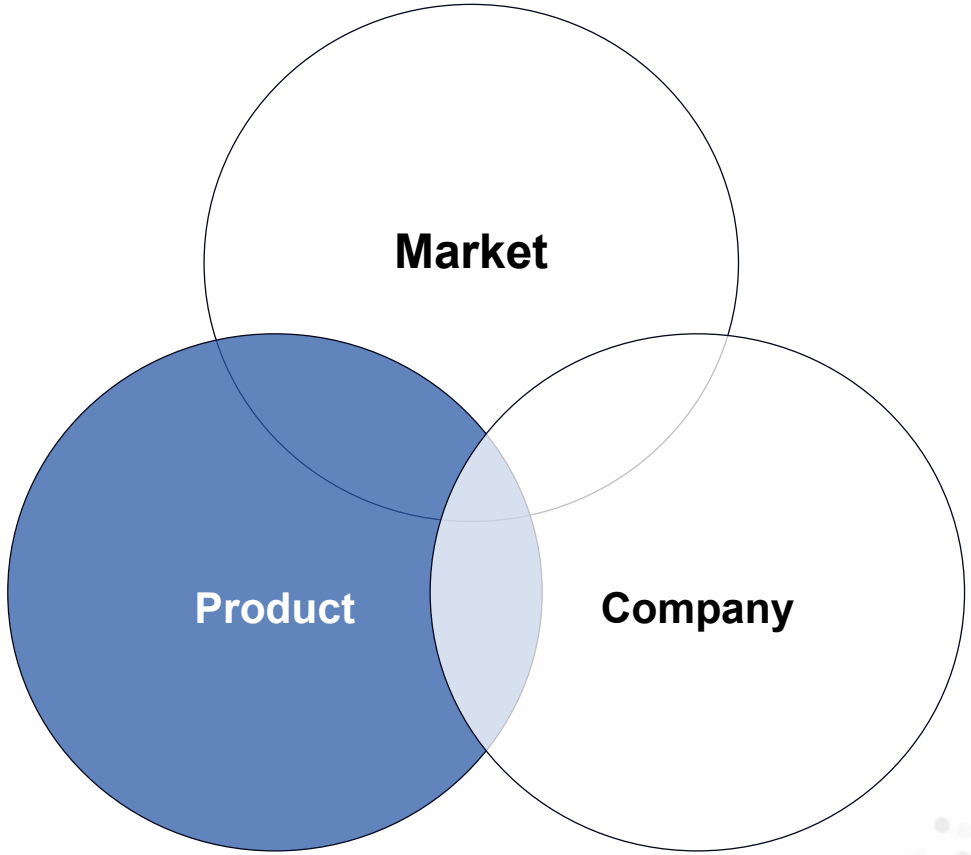

2025 worldwide revenue of
**$3 Billion**

US revenues of
**$1.7 Billion**

WW PCSK9 class is approaching
**$5 Billion**

Source: Based on third party prescription data and competitive intelligence on file

# Preparing The Product

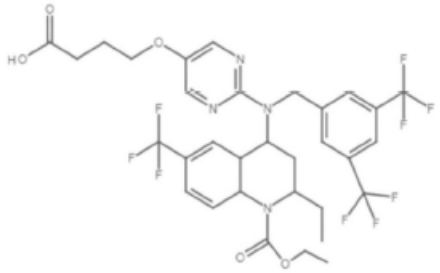


# Evidence Supporting the Potential of Obicetrapib's Portfolio is Grounded in Comprehensive, Outcomes-Driven Clinical Program

Product

1

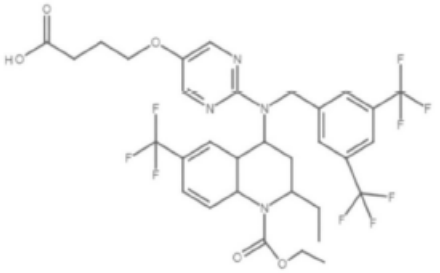
## Obicetrapib

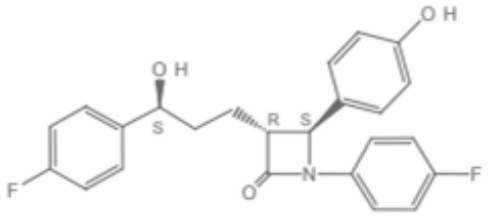


&

2

## Obicetrapib + Ezetimibe





PHASE 2

- TULIP
- ROSE
- ROSE2
- JAPAN

PHASE 3

- BROOKLYN
- BROADWAY
- TANDEM
- PREVAIL*
- REMBRANDT*
- VINCENT*
- RUBENS*

*In Progress



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# Obi Delivers What LDL-Only Therapies Were Never Designed to Offer

## Obi/ Obi-Eze redefines what physicians expect by addressing a broader set of lipid risk markers beyond LDL-C alone

### CURRENT LLT PARADIGM

**Statins, Ezetimibe, PCSK9i/oral PCSK9i, Bempedoic acid**

**Atherogenic particle burden**

- LDL-C
- ApoB
- Non-HDL
- LDL-P

**Obi Changes the Frame**

**Lipid Risk Remains**

### FUTURE LLT PARADIGM

**Obi: Has the potential to impact LDL-C, Lp(a), and multiple biomarkers in one product to address broad cardiometabolic risk**

**Atherogenic particle burden**

- LDL-C
- ApoB
- Non-HDL
- LDL-P

**Residual lipid risk**

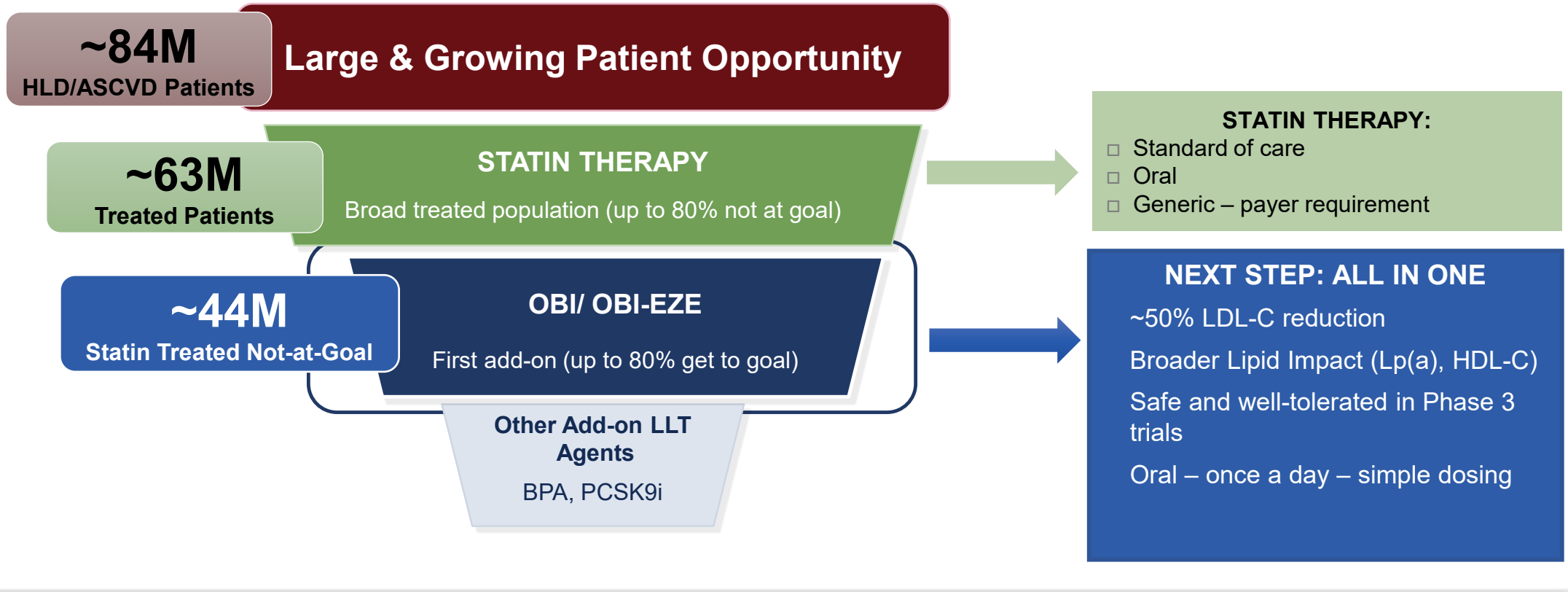
- Lp(a)
- Small LDL-P
- NODM

**Functional lipid biology**

- ApoA1
- HDL-C
- HDL function

Oral, safe & well tolerated, once daily, simple dosing

# Obi Redefines Post-Statin Therapy For >60 Million Patients Not At Goal, Supported by a Differentiated LDL-C+ Profile

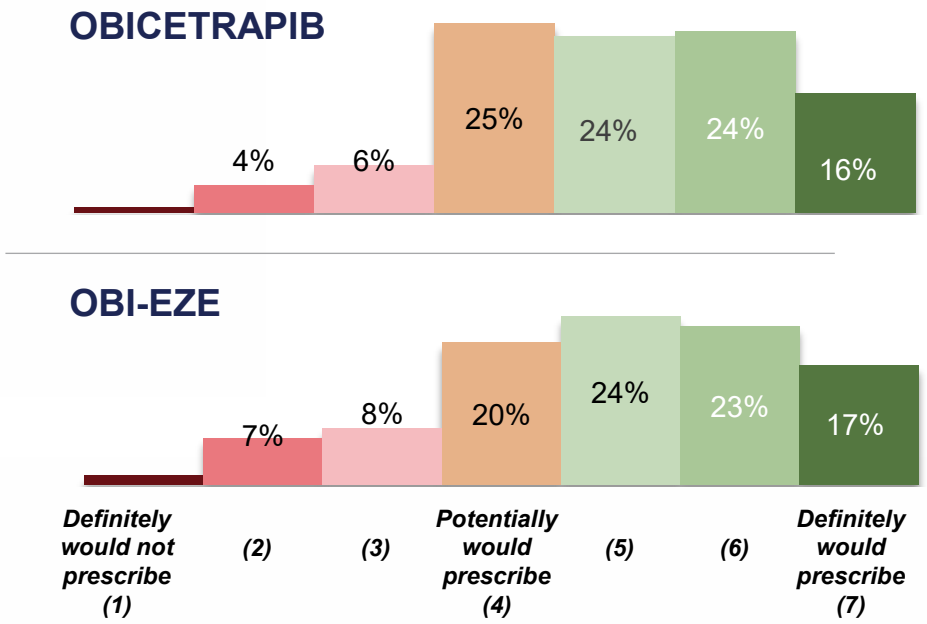



**Obicetrapib and Obicetrapib-Ezetimibe: the ideal choice after a statin —**
powerful LDL-C efficacy with broader lipid impact get up to 80% of patients to LDL-C goal

Conceptual visual; not intended to represent quantified patient counts.

# What Are Customers Saying About Obi and Obi-Eze?

How likely are you to Rx **obi and obi-eze** in the first 6 months after they become available?




**2 out of 3 HCP's**
indicate a propensity to prescribe Obi & Obi-Eze within the first 6 months

## Broad Efficacy*

## Safety/Tolerability

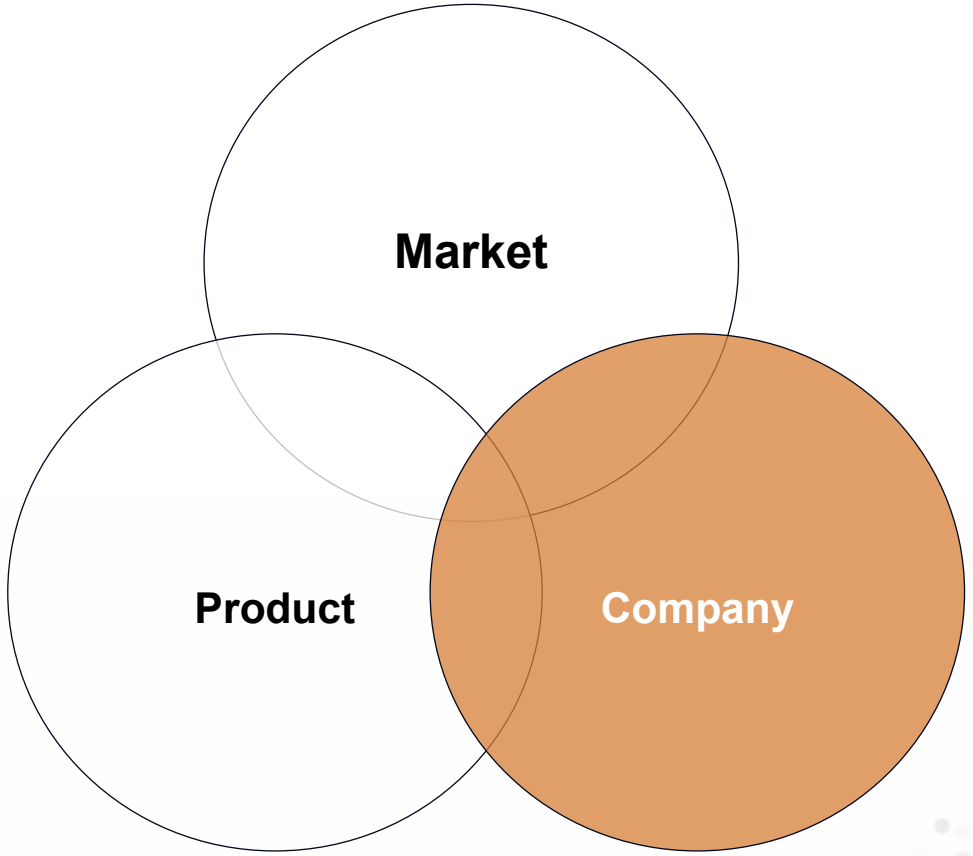
***"Now we have something that is even more effective at getting you to goal with minimal side effects, and it's safe to take with your current medications and, you know, just reducing your overall risk."***
**- PCP**

## Convenience / Oral RoA

**"I would just say it's a novel product, you know, once daily, oral, easy to use that targets those harder to fix types of cholesterol, like the Lp(a) and ApoB and boost the HDL, which leads to better cardiovascular outcomes."**
**- PCP**

Magnolia June 2026 HCP Quant Research, N=250 HCP Quantitative Respondents.
Obicetrapib and obi-eze target product profile described as a once daily tablet for a small molecule CETP inhibitor (or CETP + Ezetimibe for FDC) taken with or without food; with safety and efficacy profile reflecting BROADWAY, TANDEM and BROOKLYN Phase 3 results (including LDL-C, ApoB, Non-HDL-C, HDL-C, Lp(a), 4-point MACE).
*Source: Patient Physician Disconnect Research, April 2026.

# Preparing The Company



# Launch Success Requires A Great Asset, But Talent Is the Key To Unlocking Market Opportunity

Company

## NewAmsterdam Pharma Launch Leadership Team

**BJ Jones**
Chief Commercial Officer

**Steven Albers**
Executive Vice President, Market Access & Public Affairs

**Michael Austwick**
Executive Vice President, Global Commercial

**Chris Deluzio**
Executive Vice President, Sales & Enterprise Operations

**Serina Fischer**
Executive Vice President, Global Marketing

**Debra Horner**
Executive Director, Operational Excellence

**Andy Hsieh**
Vice President, Medical Affairs

**Sanjay Keshav**
Vice President, Insights & Analytics

Apogee Therapeutics · biohaven pharmaceuticals · AstraZeneca

novo nordisk · MERCK SERONO · Takeda

Verona Pharma · AstraZeneca · NOVARTIS

biohaven pharmaceuticals · Takeda · Bristol Myers Squibb

Takeda · Lilly

biohaven pharmaceuticals · novo nordisk · Takeda

FORUM PHARMACEUTICALS · AKCEA THERAPEUTICS · Biogen

biohaven pharmaceuticals · Boehringer Ingelheim · ZS



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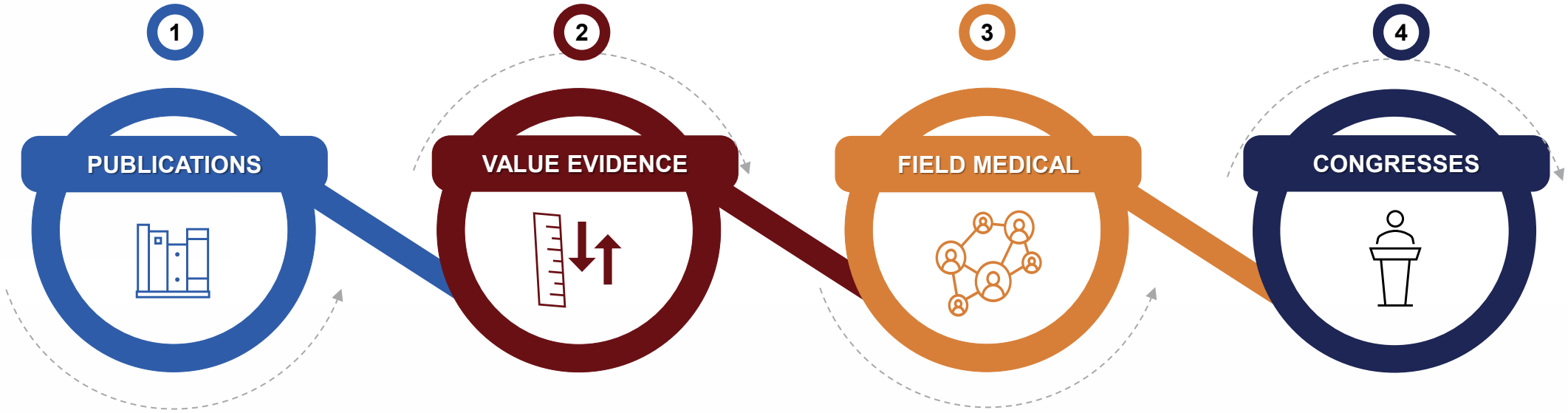
Company

# Already Deployed: Medical Affairs Education

**Investment in Obicetrapib's scientific platform, engagement with the clinical community, and building value evidence are underway**



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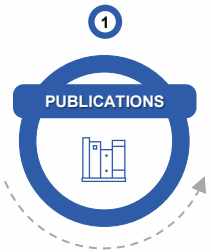
# In Market | Publications

## Most Influential Journals in Cardiovascular Medicine, Reaching Hundreds of Millions of Readers




**# of Peer Reviewed Publications**

**26**

**BROOKLYN (*Nature Med*)**
**>25 million** downloads/year

**BROADWAY AD Biomarker Substudy (*JPAD*)**
**9** citations
**>600,000** downloads/year

**Pooled MACE (*JACC*)**
**26** citations
**>2.1 million** downloads/year

**BROADWAY (*NEJM*)**
**80** citations;
Readership of **>600,000**

**TANDEM (*Lancet*)**
**47** citations
**>155 million** downloads/year

**356**
**Total Citations**

**88.5**
**Top Publication Impact Factor**

**>220M**
**Total Annual Readership/ Download Reach**

Company

# In Market | Value Evidence

## Health economic value narrative grounded in clinical benefit and economic value


**Milestones completed**

Phase 3 (BROADWAY/TANDEM) and Phase 2 (ROSE) CEAs **ISPOR 2024 and 2026 posters**

US value dossier

RWE unmet need and resource use **2026 NLA posters and *JME* publication**



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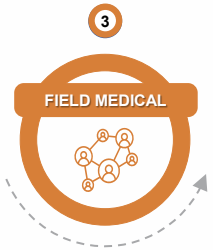
# In Market | Field Medical

## Built to engage institutions, leaders, and decision-makers shaping cardiovascular practice




**Deployed MSL team has over 260 years of combined medical affairs experience!**

### AT THE INSTITUTION

**1,700+**
*Institutions engaged*

**Engaged with the academic medical centers and health systems that shape practice**

### WITH PAYER MEDICAL

**12**
*payer organizations*

**Pre-launch scientific engagement with the medical teams to inform and educate on unmet need**

### WITH SCIENTIFIC LEADERS

**6000+**
*Engagements*

**Sustained scientific dialogue with leading cardiovascular and lipidology KOLs**

### AT CONGRESSES

**95+**
*Scientific presentations*

**Active scientific presence at every major cardiovascular and lipid society meeting**

# In Market | Congress Presence

## Scientific dialogue spanning North America, Europe, and Asia


### CARDIOVASCULAR SOCIETIES

**ACC**
American College of Cardiology
*United States*

**AHA**
American Heart Association
*United States*

**ESC**
European Society of Cardiology
*Europe*

**ASPC**
American Society for Preventive Cardiology
*United States*

### LIPID AND ATHEROSCLEROSIS SOCIETIES

**NLA**
National Lipid Association
*United States*

**EAS**
European Atherosclerosis Society
*Europe*

**JAS**
Japan Atherosclerosis Society
*Japan*

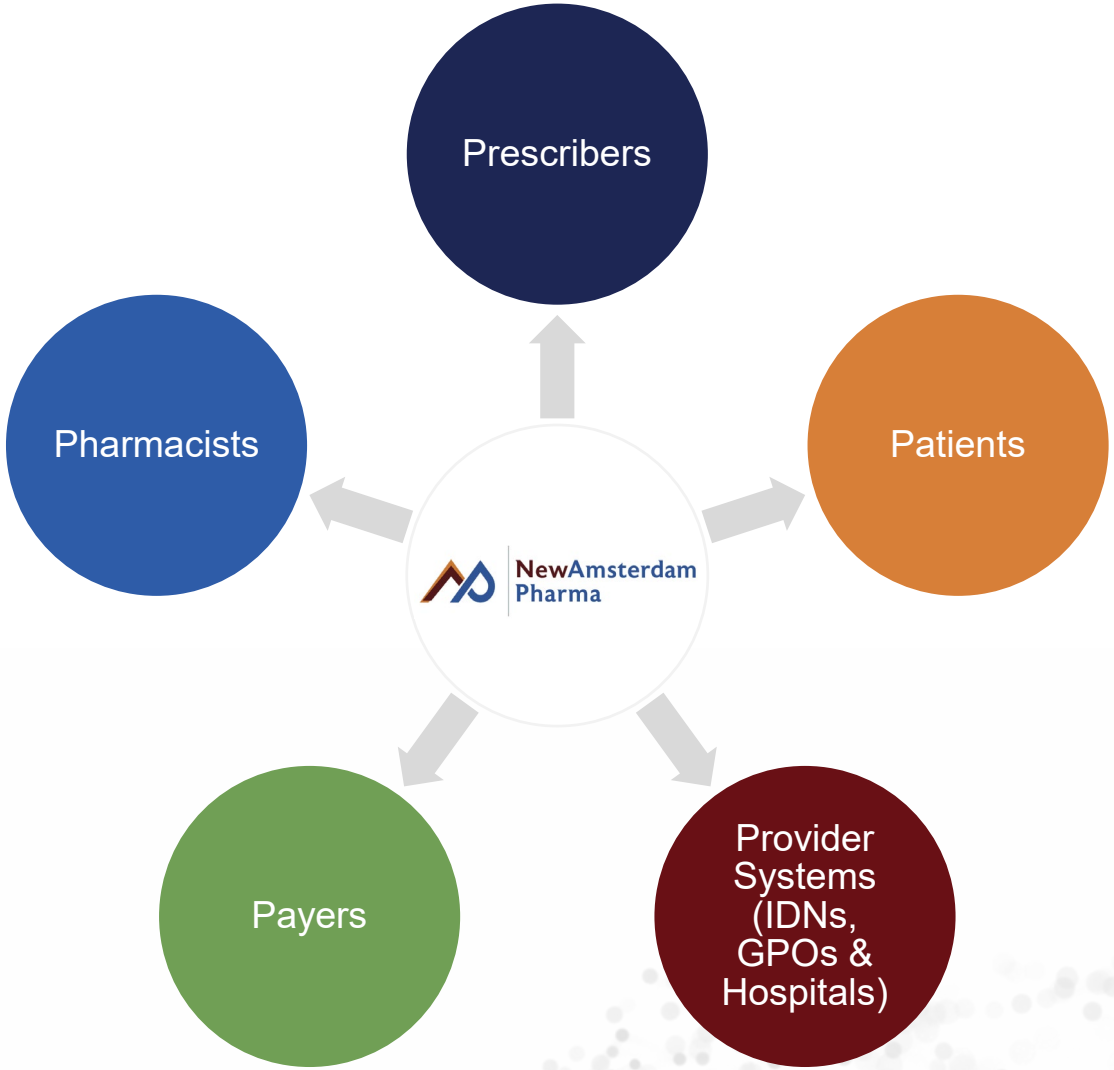
**2024**
17 presentations

**2025**
40 presentations

**2026**
39 presentations & counting

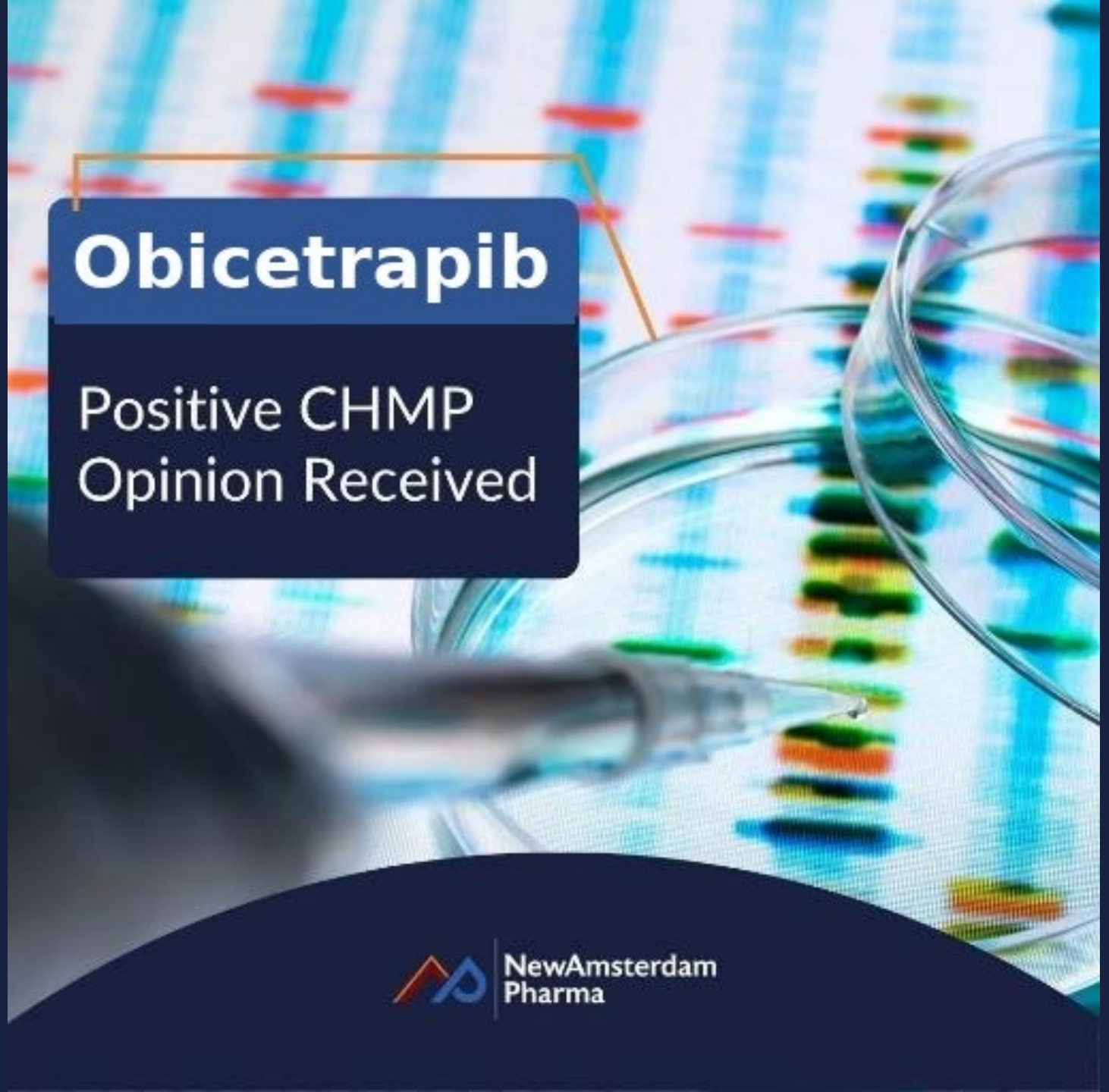
# Coming Soon | Branded Launch!

**NAMS is a customer-centric organization focused on bringing transformational therapy and a seamless experience to each of its key customer groups**



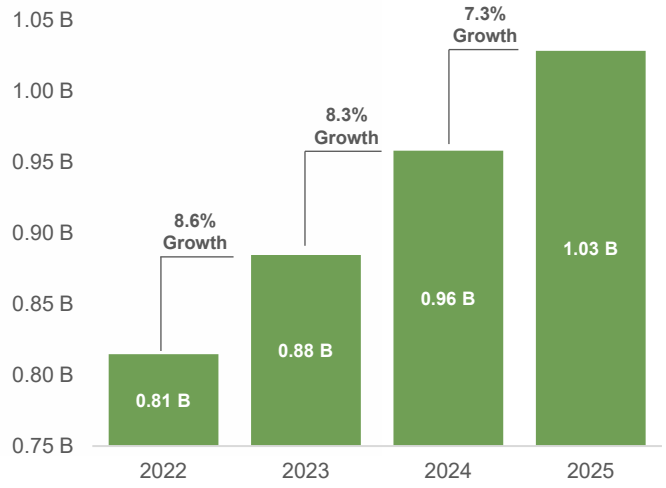
# Agenda

- US Launch Preparations
- European Launch Update


Obicetrapib
Positive CHMP
Opinion Received
NewAmsterdam
Pharma

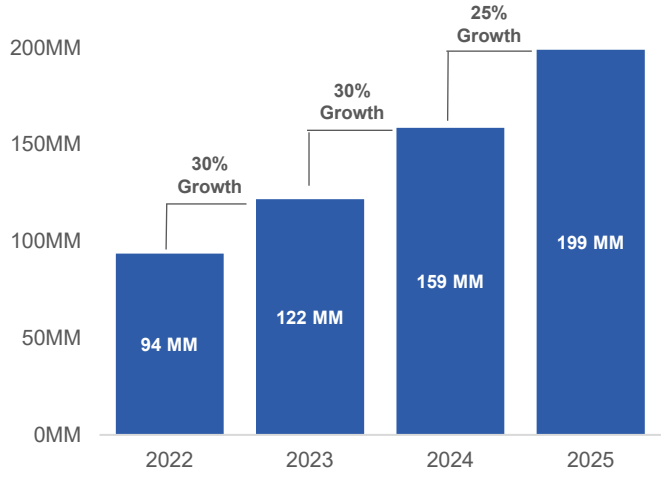
# EU Lipid Lowering Therapy Market is Large and Growing Rapidly

## 1 Lipid lowering Therapy[2]: 30-Day TRx[1]



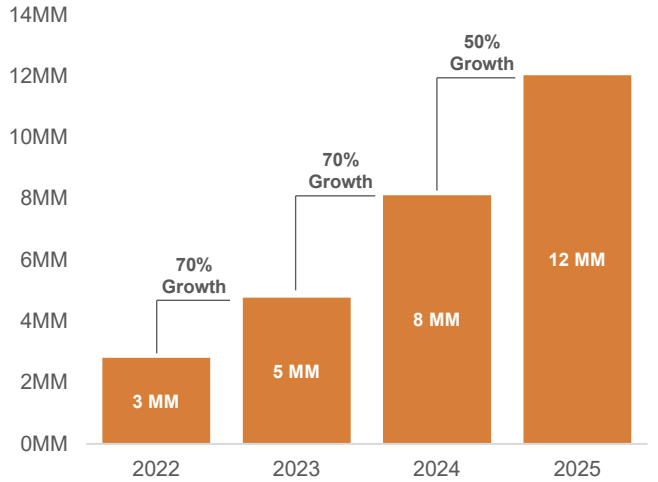

Consecutive Years of
7% to 8% Market growth

## 2 Non-Statins[3] : 30-Day TRx[1]




Non-statins growing
at high double digits

## 3 Branded[4] : 30-Day TRx[1]



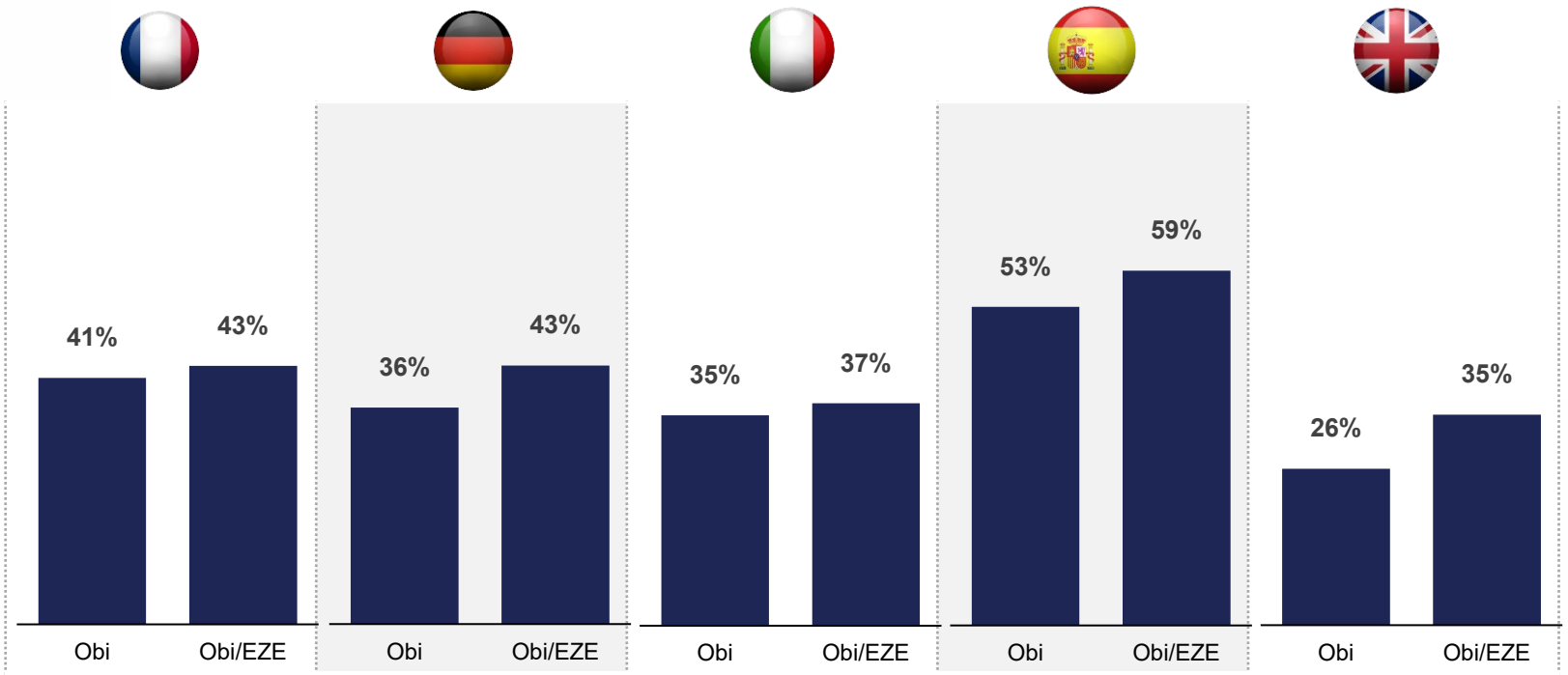

Branded agents have been
growing more than 50% YoY

**Market Growth of 7.3% in 2025, adds 70 million additional TRx's, of which 40 million are Non-Statin TRx's**

Source: IQVIA MIDAS
1. 30 Day TRx: Using Standard units, 30-day Rx has been estimated based on unit usage in 30 days
2. All Lipid Lowering therapies: Statins, Ezetimibe and combinations; PCSK9 and BPA;
3. Non-Statins : Ezetimibe and its combinations; PCSK9 and BPA;
4. Branded: PCSK9 and BPA;

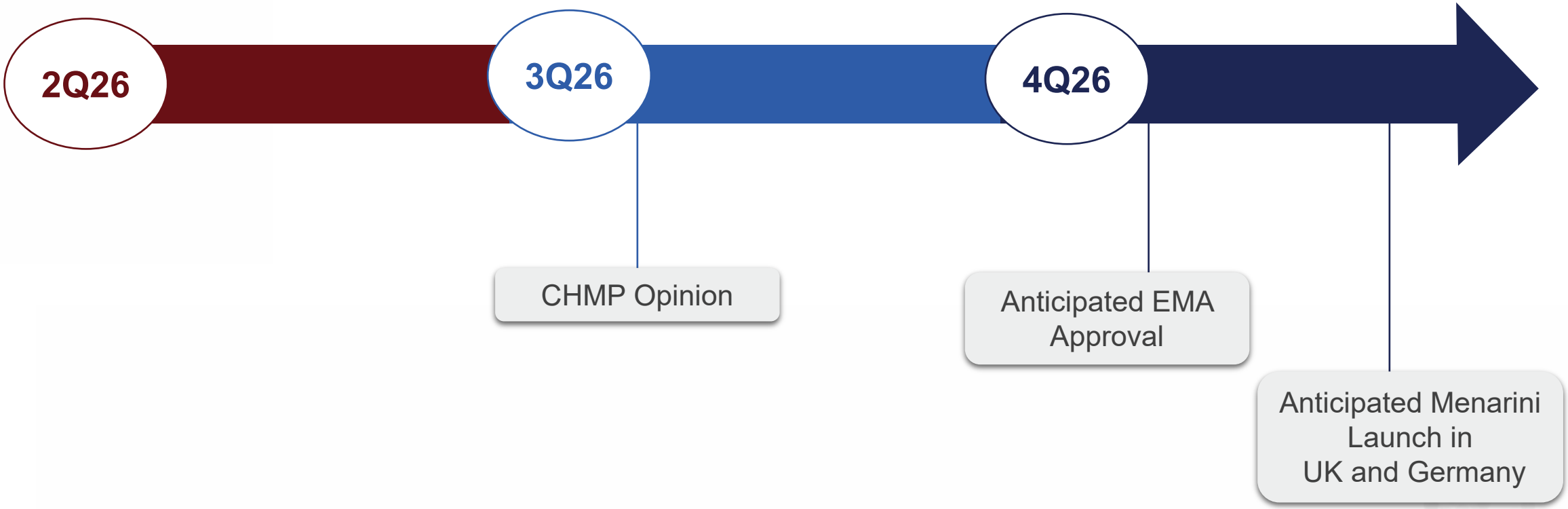
# Early Demand for Obicetrapib Franchise Across EU5 Markets

***Likelihood to Rx Obi/ Obi-Eze to At Least One Patient in the First 6 months After They Become Available***
*(7-point likelihood to Rx scale; % HCPs selecting 6 or 7)*




Source: Magnolia March 2025 HCP Demand Study, US: N=252 HCP Quantitative Respondents; EU5 Countries: N=100 HCP Quantitative Respondents In Each Market (500 Total).

# EU Regulatory and Launch Timeline



# Menarini: Well-positioned to Launch Obi Driven by a Strong CV Heritage, Leading Share of Voice, and Significant Local Presence

EU5

## GPs

1 MENARINI group SoV **11.2%**

| TOP CORPORATIONS | SOV% |
|---|---|
| 2 AstraZeneca | 5.3% |
| 3 GSK | 4.3% |
| 4 Boehringer Ingelheim | 3.4% |
| 5 Italfarmaco | 3.0% |
| 6 Viatris | 2.9% |
| 7 Pfizer | 2.6% |

## Cardiologists

1 MENARINI group SoV **10.6%**

| TOP CORPORATIONS | SOV% |
|---|---|
| 2 Novartis | 7.5% |
| 3 Daiichi Sankyo | 7.0% |
| 4 AstraZeneca | 6.8% |
| 5 Boehringer Ingelheim | 6.0% |
| 6 Bayer | 5.1% |
| 7 BMS | 4.5% |

## Internists

1 MENARINI group SoV **8.5%**

| TOP CORPORATIONS | SOV% |
|---|---|
| 2 GSK | 5.8% |
| 3 AstraZeneca | 4.9% |
| 4 Daiichi Sankyo | 4.0% |
| 5 Boehringer Ingelheim | 3.3% |
| 6 Sanofi | 3.2% |
| 7 Viatris | 2.7% |

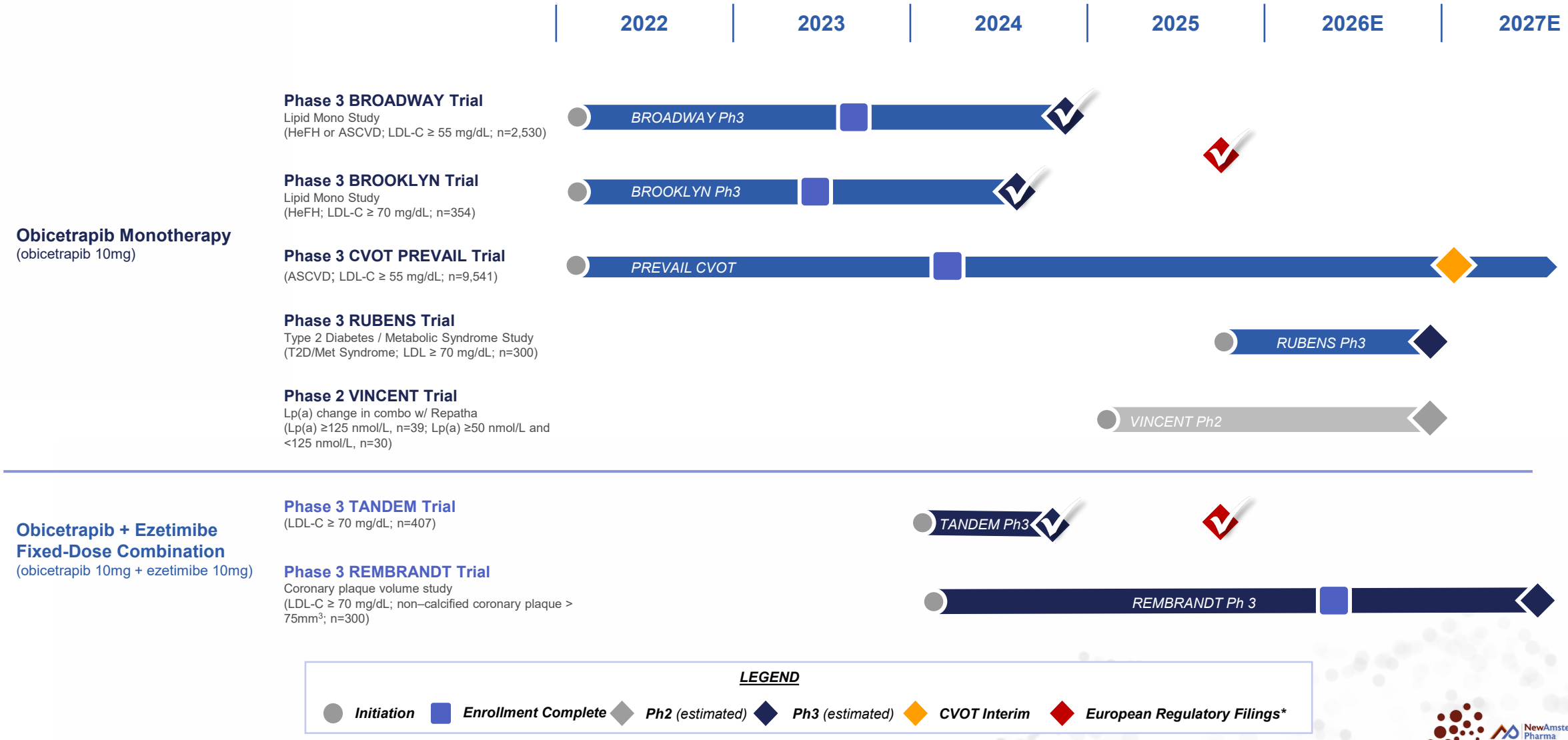
Source: IQVIA Data — Weighted calls face-to-face MAT Q1 2025; EU4 + UK. GPs: General Practitioners; SoV: Share of Voice; MAT: Moving Annual Total.

# Summary: If Approved, Obi/ Obi-Eze Can Redefine Post-Statin Treatment By Getting Patients to LDL-C Goal, While Mitigating Residual Lipid Risk

- **Significant unmet need** is driving innovation in the cardiometabolic space.
- **>60M addressable market** for Obi franchise in US alone (~21M untreated/ ~40M not at goal)
- Potential to be first LLT to launch with **3 successful Phase 3 studies** (BROOKLYN / BROADWAY / TANDEM) and available outcomes data (PREVAIL)
- Observed **powerful LDL-C efficacy**, with differentiated benefit on Lp(a), Small LDL-P, and rate of NODM
- Simple, oral, once daily, low dose option with a reported safety/tolerability profile **comparable to placebo**
- Medical Affairs education and engagement underway, with **industry-leading launch team** on board

# Concluding Remarks

# Multiple Data Readouts to Drive Future Momentum




*MAAs were filed and accepted for review by EMA, UK and Switzerland regulatory authorities

Note: Other than as noted, the pipeline represents trials that are currently ongoing. 2026 and beyond are projections and subject to inherent limitations. Actual results may differ from expectations.



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# The NewAmsterdam Value Proposition

- **Clinical Expertise:** Data driven clinical development increases probability of success
- **Differentiated Target Product Profile:** Phase 3 data demonstrates obicetrapib's potential impact on multiple CVD risk factors
- **Unmet Need:** Significant need for a potent, convenient, well-tolerated low-dose oral therapy
- **Experienced Leadership and Team:** Expanding team comprised of accomplished industry executives
- **KOL Support:** Physician community aware of unmet need and eager to leverage obicetrapib's differentiated profile to achieve desired clinical benefit, if approved
- **CMC Expertise and Manufacturing Capacity:** Preparing to meet anticipated demand for obicetrapib and the fixed dose combination, creating redundancy, expanding capacity and building inventory
- **Commercial Excellence:** Growing team with track record of blockbuster launch success and innovative go-to-market model
- **Strong Balance Sheet:** Cash runway expected to be sufficient to support U.S. commercial launch

# What to Expect in Next 12-18 Months with Potential Milestones Hitting as Momentum Continues to Build

RUBENS

**RUBENS Phase 3**

LDL-C, Lp(a), Safety, in Type 2 Diabetics

PREVAIL

**PREVAIL CVOT**

Interim Analysis

REMBRANDT

**REMBRANDT Phase 3**

NCPV, LDL-C, Lp(a), Safety

Enrollment Complete

SPINOZA STUDY

**SPINOZA Phase 2b trial**

Alzheimer's Disease

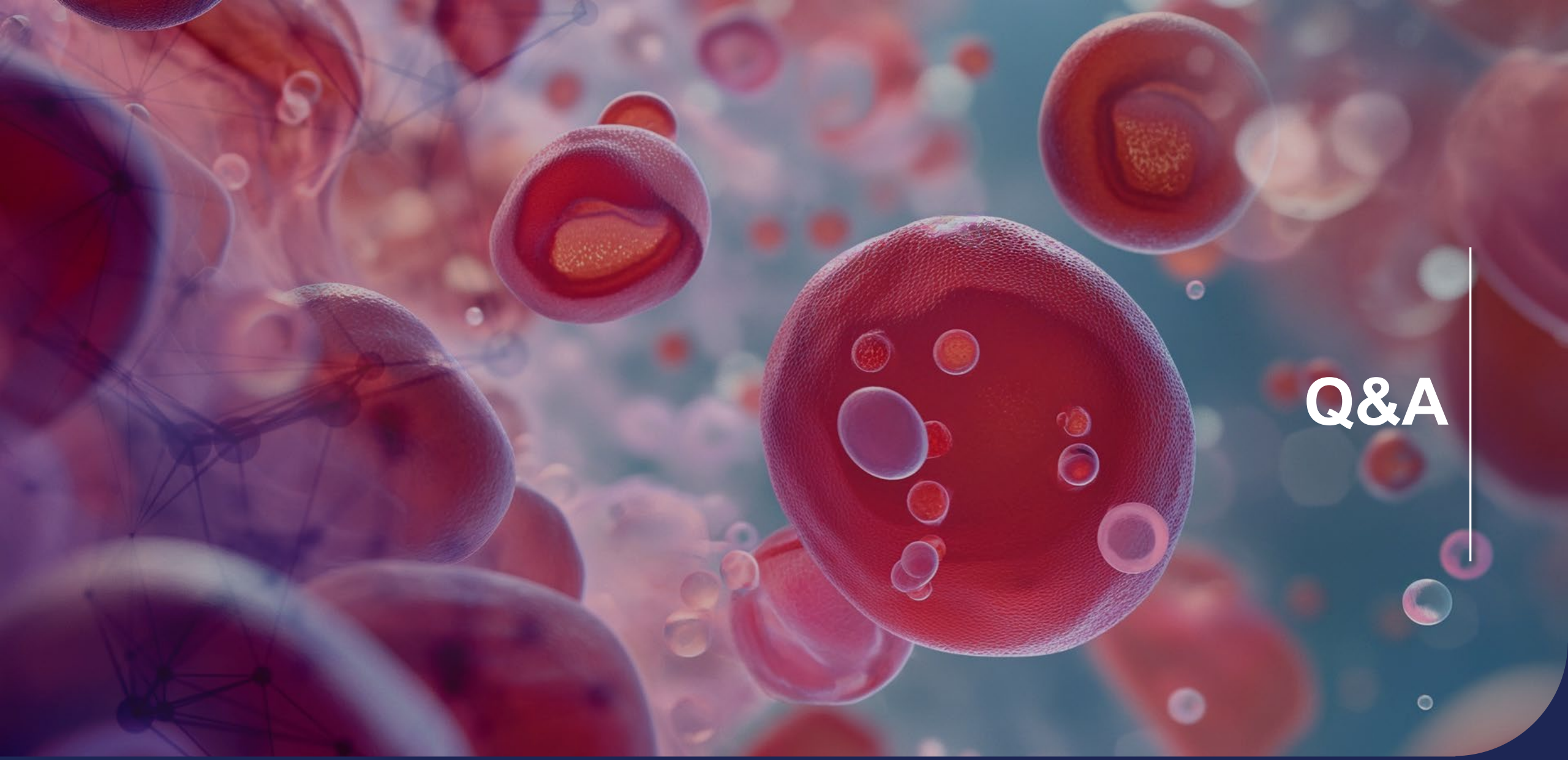
## Tailwinds Driving the Market

Recent guideline and label expansions

Increased treatment aimed at hitting LDL-C goals

Lp(a) gaining momentum as target, testing added to guidelines

Accelerated adoption of treatments adjunct to statins



# Q&A

# Thank You

NewAmsterdam Pharma

# Appendix: Prior CVOT Baseline Characteristics

**Table 1. Characteristics of the Patients at Baseline.***

| Characteristics | Evolocumab (N=13,784) | Placebo (N=13,780) |
|---|---|---|
| Age — yr | 62.5±9.1 | 62.5±8.9 |
| Male sex — no. (%) | 10,397 (75.4) | 10,398 (75.5) |
| White race — no. (%)† | 11,748 (85.2) | 11,710 (85.0) |
| Weight — kg | 85.0±17.3 | 85.5±17.4 |
| Region | | |
| North America | 2,287 (16.6) | 2,284 (16.6) |
| Europe | 8,666 (62.9) | 8,669 (62.9) |
| Latin America | 913 (6.6) | 910 (6.6) |
| Asia Pacific and South Africa | 1,918 (13.9) | 1,917 (13.9) |
| Type of atherosclerosis‡ | | |
| Myocardial infarction — no. (%) | 11,145 (80.9) | 11,206 (81.3) |
| Median time from most recent previous myocardial infarction (IQR) — yr | 3.4 (1.0–7.4) | 3.3 (0.9–7.7) |
| Nonhemorrhagic stroke | 2686 (19.5) | 2651 (19.2) |
| Median time from most recent previous stroke (IQR) — yr | 3.2 (1.1–7.1) | 3.3 (1.1–7.3) |
| Peripheral artery disease — no. (%) | 1,858 (13.5) | 1,784 (12.9) |
| Cardiovascular risk factors | | |
| Hypertension — no./total no. (%) | 11,045/13,784 (80.1) | 11,039/13,779 (80.1) |
| Diabetes mellitus — no. (%) | 5,054 (36.7) | 5,027 (36.5) |
| Current cigarette use — no./total no. (%) | 3854/13,783 (28.0) | 3923/13,779 (28.5) |
| Statin use — no. (%)§ | | |
| High intensity | 9,585 (69.5) | 9,518 (69.1) |
| Moderate intensity | 4,161 (30.2) | 4,231 (30.7) |
| Low intensity, unknown intensity, or no data | 38 (0.3) | 31 (0.2) |
| Ezetimibe — no. (%) | 726 (5.3) | 714 (5.2) |
| Other cardiovascular medications — no./total no. (%) | | |
| Aspirin, $P2Y_{12}$ inhibitor, or both | 12,766/13,772 (92.7) | 12,666/13,767 (92.0) |
| Beta-blocker | 10,441/13,772 (75.8) | 10,374/13,767 (75.4) |
| ACE inhibitor or ARB, aldosterone antagonist, or both | 10,803/13,772 (78.4) | 10,730/13,767 (77.9) |
| Median lipid measures (IQR) | | |
| LDL cholesterol — mg/dl | 92 (80–109) | 92 (80–109) |
| Total cholesterol — mg/dl | 168 (151–188) | 168 (151–189) |
| HDL cholesterol — mg/dl | 44 (37–53) | 44 (37–53) |
| Triglycerides — mg/dl | 134 (101–183) | 133 (99–181) |
| Lipoprotein(a) — nmol/liter | 37 (13–166) | 37 (13–164) |

**Table 1. Demographic and Baseline Characteristics of the Patients.***

| Characteristic | Alirocumab (N=9462) | Placebo (N=9462) |
|---|---|---|
| Age — yr | 58.5±9.3 | 58.6±9.4 |
| Female sex — no. (%) | 2390 (25.3) | 2372 (25.1) |
| Race — no. (%)† | | |
| White | 7500 (79.3) | 7524 (79.5) |
| Asian | 1251 (13.2) | 1247 (13.2) |
| Black | 235 (2.5) | 238 (2.5) |
| Other | 475 (5.0) | 451 (4.8) |
| Region of enrollment — no. (%) | | |
| Central and Eastern Europe | 2719 (28.7) | 2718 (28.7) |
| Western Europe | 2084 (22.0) | 2091 (22.1) |
| Canada or United States | 1435 (15.2) | 1436 (15.2) |
| Latin America | 1293 (13.7) | 1295 (13.7) |
| Asia | 1150 (12.2) | 1143 (12.1) |
| Rest of world | 781 (8.3) | 779 (8.2) |
| Medical history before index acute coronary syndrome — no. (%) | | |
| Hypertension | 6205 (65.6) | 6044 (63.9) |
| Diabetes mellitus | 2693 (28.5) | 2751 (29.1) |
| Current tobacco smoker | 2282 (24.1) | 2278 (24.1) |
| Family history of premature coronary heart disease | 3408 (36.0) | 3365 (35.6) |
| Myocardial infarction | 1790 (18.9) | 1843 (19.5) |
| Percutaneous coronary intervention | 1626 (17.2) | 1615 (17.1) |
| Coronary-artery bypass grafting | 521 (5.5) | 526 (5.6) |
| Stroke | 306 (3.2) | 305 (3.2) |
| Peripheral artery disease | 373 (3.9) | 386 (4.1) |
| Congestive heart failure | 1365 (14.4) | 1449 (15.3) |
| Index acute coronary syndrome — no. (%) | | |
| ST-segment elevation myocardial infarction | 3301 (34.9) | 3235 (34.2) |
| Non–ST-segment elevation myocardial infarction | 4574 (48.3) | 4601 (48.6) |
| Unstable angina | 1568 (16.6) | 1614 (17.1) |
| Missing data | 19 (<0.1) | 12 (<0.1) |
| Percutaneous coronary intervention or coronary-artery bypass grafting for index acute coronary syndrome — no. (%) | 6798 (71.8) | 6878 (72.7) |
| Median time from index acute coronary syndrome to randomization (IQR) — mo | 2.6 (1.7–4.4) | 2.6 (1.7–4.3) |
| Body-mass index‡ | 28.5±4.9 | 28.5±4.8 |

Source: Internal analysis | 1. Sayed et al. International Journal of Cardiology 406 (2024) 132074 2.McGuire et al. N Engl J Med 2025;392:2001-12. 3.Lincoff et al. N Engl J Med 2023;389:2221-32. 4. Sabatine et al. N Engl J Med 2017;376:1713-22. 5. Schwartz et al. N Engl J Med 2018;379:2097-107.

# Appendix: Prior CVOT Baseline Characteristics

**Table 1. Demographic and Baseline Patient Characteristics in the Intention-to-Treat Population.***

| Characteristic | Bempedoic Acid (N=6992) | Placebo (N=6978) |
|---|---|---|
| Age | | |
| Mean — yr | 65.5±9.0 | 65.5±8.9 |
| Distribution — no. (%) | | |
| <65 yr | 2859 (40.9) | 2907 (41.7) |
| ≥65 to <75 yr | 3070 (43.9) | 3027 (43.4) |
| ≥75 yr | 1063 (15.2) | 1044 (15.0) |
| Female sex — no. (%) | 3361 (48.1) | 3379 (48.4) |
| White race — no. (%)† | 6397 (91.5) | 6335 (90.8) |
| Hispanic or Latinx — no. (%)† | 1190 (17.0) | 1143 (16.4) |
| Body-mass index‡ | 29.9±5.2 | 30.0±5.2 |
| LDL cholesterol | | |
| Mean value — mg/dl | 139.0±34.9 | 139.0±35.2 |
| Distribution — no. (%) | | |
| <130 mg/dl | 3074 (44.0) | 3089 (44.3) |
| ≥130 to <160 mg/dl | 2213 (31.7) | 2250 (32.2) |
| ≥160 mg/dl | 1705 (24.4) | 1639 (23.5) |
| HDL cholesterol — mg/dl | 49.6±13.3 | 49.4±13.3 |
| Non-HDL cholesterol — mg/dl | 173.8±39.5 | 173.9±40.2 |
| Total cholesterol — mg/dl | 223.5±40.6 | 223.3±41.1 |
| Median triglycerides (IQR) — mg/dl | 159.5 (118.0–216.5) | 158.5 (118.0–215.0) |
| Median high-sensitivity CRP (IQR) — mg/liter | 2.3 (1.2–4.5) | 2.3 (1.2–4.5) |
| Estimated GFR — no. (%) | | |
| ≥90 ml/min/1.73 $m^2$ | 1216 (17.4) | 1233 (17.7) |
| ≥60 to <90 ml/min/1.73 $m^2$ | 4322 (61.8) | 4282 (61.4) |
| ≥30 to <60 ml/min/1.73 $m^2$ | 1437 (20.6) | 1444 (20.7) |
| Cardiovascular risk category — no. (%) | | |
| Primary prevention | 2100 (30.0) | 2106 (30.2) |
| Secondary prevention | 4892 (70.0) | 4872 (69.8) |
| Coronary artery disease | 3574 (51.1) | 3536 (50.7) |
| Peripheral arterial disease | 794 (11.4) | 830 (11.9) |
| Cerebrovascular atherosclerotic disease | 1027 (14.7) | 1040 (14.9) |
| Glycemic status — no. (%) | | |
| Diabetes§ | 3144 (45.0) | 3229 (46.3) |
| Inadequately controlled diabetes¶ | 1356 (19.4) | 1369 (19.6) |
| Statin use — no. (%) | 1601 (22.9) | 1573 (22.5) |
| Ezetimibe use — no. (%) | 803 (11.5) | 809 (11.6) |

Source: Internal analysis | 1. Sayed et al. International Journal of Cardiology 406 (2024) 132074 2.McGuire et al. N Engl J Med 2025;392:2001-12. 3.Lincoff et al. N Engl J Med 2023;389:2221-32. 4. Sabatine et al. N Engl J Med 2017;376:1713-22. 5. Schwartz et al. N Engl J Med 2018;379:2097-107.

# Appendix: Prior CVOT Baseline Characteristics

**Table 1. Baseline Characteristics of the Patients.***

| Characteristic | Semaglutide (N=8803) | Placebo (N=8801) |
|---|---|---|
| Age — yr | 61.6±8.9 | 61.6±8.8 |
| Male sex — no. (%) | 6355 (72.2) | 6377 (72.5) |
| Race or ethnic group — no. (%)† | | |
| White | 7387 (83.9) | 7404 (84.1) |
| Asian | 720 (8.2) | 727 (8.3) |
| Black | 348 (4.0) | 323 (3.7) |
| Other | 253 (2.9) | 273 (3.1) |
| Hispanic or Latino | 914 (10.4) | 908 (10.3) |
| Body weight — kg | 96.5±17.5 | 96.8±17.8 |
| BMI‡ | 33.3±5.0 | 33.4±5.0 |
| Waist circumference — cm | 111.3±13.1 | 111.4±13.1 |
| Glycated hemoglobin level — % | 5.78±0.34 | 5.78±0.33 |
| Distribution — no. (%) | | |
| <5.7% | 2925 (33.2) | 2980 (33.9) |
| ≥5.7% | 5877 (66.8) | 5819 (66.1) |
| Median high-sensitivity CRP level (IQR) — mg/liter | 1.87 (0.89–4.18) | 1.80 (0.86–4.06) |
| Cardiovascular inclusion criteria — no. (%) | | |
| Myocardial infarction only | 5962 (67.7) | 5944 (67.5) |
| Stroke only | 1578 (17.9) | 1556 (17.7) |
| Peripheral arterial disease only | 376 (4.3) | 401 (4.6) |
| Two or more inclusion criteria | 718 (8.2) | 719 (8.2) |
| Other§ | 169 (1.9) | 181 (2.1) |
| eGFR — ml/min/1.73 $m^2$ | 82.4±17.5 | 82.5±17.3 |
| Median lipid level (IQR) — mg/dl | | |
| Total cholesterol | 153 (131–182) | 153 (131–183) |
| HDL cholesterol | 44 (37–52) | 44 (37–52) |
| LDL cholesterol | 78 (61–102) | 78 (61–102) |
| Triglycerides | 134 (99–188) | 135 (100–190) |
| Systolic blood pressure — mm Hg | 131.0±15.6 | 130.9±15.3 |
| Diastolic blood pressure — mm Hg | 79.4±10.0 | 79.2±9.9 |
| Pulse — beats/min | 68.9±10.6 | 68.6±10.7 |
| EQ-5D-5L index score¶ | 0.88±0.15 | 0.88±0.15 |
| EQ-5D-VAS score¶ | 77.15±15.63 | 77.15±15.73 |

**Table 1. Characteristics of the Participants at Baseline.***

| Characteristic | Oral Semaglutide (N=4825) | Placebo (N=4825) |
|---|---|---|
| Age — yr | 66.1±7.6 | 66.1±7.5 |
| Female sex — no. (%) | 1376 (28.5) | 1414 (29.3) |
| Race or ethnic group — no. (%)† | | |
| White | 3327 (69.0) | 3321 (68.8) |
| Black | 124 (2.6) | 128 (2.7) |
| Asian | 1134 (23.5) | 1121 (23.2) |
| American Indian or Alaska Native | 7 (0.1) | 12 (0.2) |
| Native Hawaiian or Pacific Islander | 4 (<0.1) | 5 (0.1) |
| Other | 185 (3.8) | 192 (4.0) |
| Not reported | 44 (0.9) | 46 (1.0) |
| Hispanic or Latino ethnic group — no. (%)† | 674 (14.0) | 706 (14.6) |
| Body weight — kg | 87.5±19.1 | 88.3±19.6 |
| Body-mass index‡ | 31.0±5.7 | 31.2±5.9 |
| Glycated hemoglobin level — mmol/mol | 63.6±12.6 | 63.5±12.3 |
| Glycated hemoglobin level — % | 8.0±1.2 | 8.0±1.1 |
| Median duration of diabetes (IQR) — yr | 14.7 (9.0–20.8) | 14.6 (8.9–20.8) |
| History of cardiovascular or kidney disease — no. (%)§ | | |
| Cardiovascular disease only | 2730 (56.6) | 2738 (56.7) |
| Chronic kidney disease only | 632 (13.1) | 609 (12.6) |
| Both cardiovascular and chronic kidney disease | 1303 (27.0) | 1317 (27.3) |
| Hypertension — no. (%) | 4378 (90.7) | 4381 (90.8) |
| Current smoking — no. (%) | 545 (11.3) | 584 (12.1) |
| Systolic blood pressure — mm Hg | 134.6±16.3 | 134.7±16.4 |
| Diastolic blood pressure — mm Hg | 76.6±10.1 | 76.7±10.1 |
| Pulse — beats/min | 72.8±11.1 | 72.9±11.4 |
| Median high-sensitivity C-reactive protein level (IQR) — mg/liter | 2.0 (0.9–4.3) | 2.0 (0.9–4.5) |
| eGFR — ml/min/1.73 $m^2$¶ | 74.0±22.6 | 73.6±22.6 |

Source: Internal analysis | 1. Sayed et al. International Journal of Cardiology 406 (2024) 132074 2.McGuire et al. N Engl J Med 2025;392:2001-12. 3.Lincoff et al. N Engl J Med 2023;389:2221-32. 4. Sabatine et al. N Engl J Med 2017;376:1713-22. 5. Schwartz et al. N Engl J Med 2018;379:2097-107.