Edesa Biotech®

Corporate Presentation

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February 2026

First-in-Class Development Pipeline

Advancing First-in-Class Therapeutics for Immuno-Inflammatory Conditions

Asset	Program	Indication	Pre-Clinical	Phase 1	Phase 2	Phase 3	Status	Comments
Anti-CXCL10 (mAb)	**EB06**	Vitiligo					CTA granted; IND in progress	First patient mid-2026*
sPLA2 Inhibitor (Small Molecule)	**Daniluromer**	Allergic Contact Dermatitis (ACD)					Ph3-ready	Partnering stage
Anti-TLR4 (mAb)	**Paridiprubart**	Acute Respiratory Distress Syndrome (ARDS)					Met primary and secondary endpoints	Evaluating partner opportunities and regulatory paths
							BARDA JustBreathe platform study	U.S. govt-funded

* Subject to timing of regulatory approval
CTA: Clinical Trial Application (Canada). IND: Investigational New Drug Application (US)

EB06 - Vitiligo

First-in-Class Anti-CXCL10 mAb

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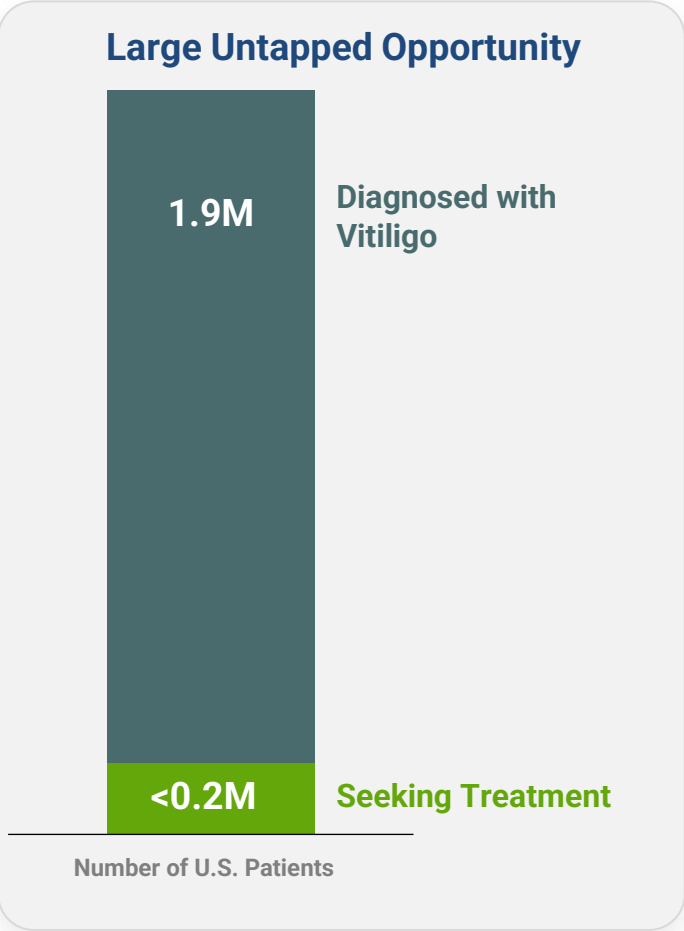
A Significant Unaddressed Market

Latent Market Comprised of Patients Waiting for Better Treatment Options



Large population but low proportion of patients seeking treatment due to **lack of effective and safe treatments**

New therapies likely to drive market growth

- Opzelura is the only approved product.
- Incyte reported that Opzelura **generated $678M***

Need for new options underscored by recent M&A activity

Teva entered into a strategic funding agreement with Royalty Pharma valued at up to $500M

Teva is developing an anti-IL-15 monoclonal antibody for the treatment of vitiligo

Sources: National Institute of Health and public reports
*Opzelura is marketed for the treatment of nonsegmental vitiligo and mild to moderate atopic dermatitis.

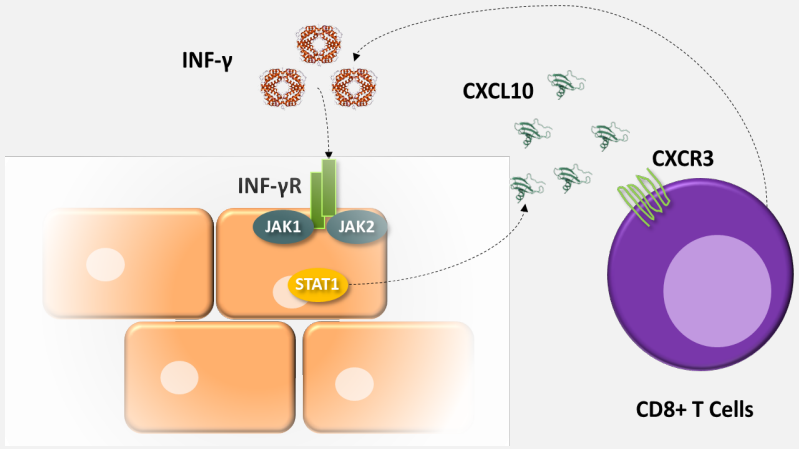
Vitiligo

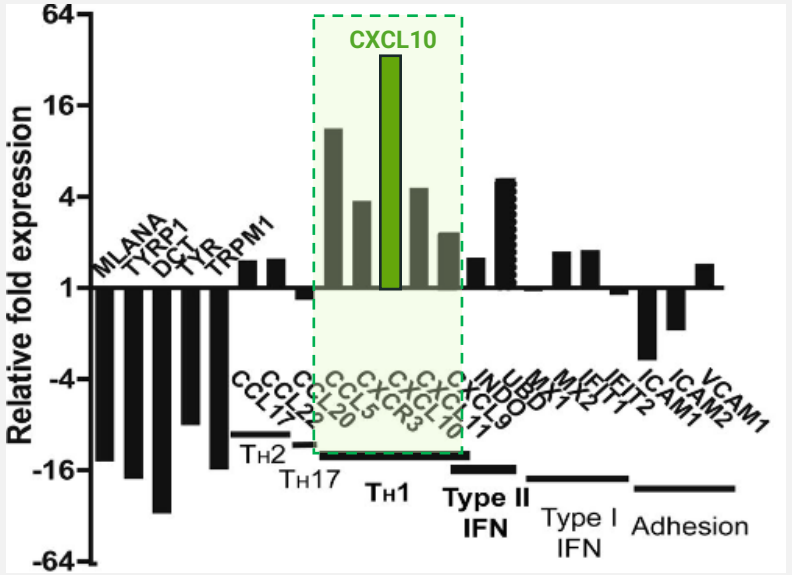
A Life-Altering Autoimmune Disease

- **High Prevalence – 0.5 to 2% Global Population**
  50% Onset Before Age 20; Must be Managed for Decades
  Associated with Type 1 Diabetes and Lupus, among others
- **Severe Quality of Life Impacts**
  Same or Worse than Atopic Dermatitis/Psoriasis
- **Interferon IFNγ-CXCL10-CXCR3 Chemokine Axis**
  CXCL10 is an IFN-γ induced chemokine and is elevated in serum of patients with vitiligo

  Its receptor CXCR3, is upregulated on autoreactive T cells in the blood and skin of patients with vitiligo
- **Therapies for Atopic Derm (Th2) or Psoriasis (Th17) are Largely Ineffective or Can Make Symptoms Worse**
  No Systemic Drugs Approved by FDA to Repigment Skin
  Topical and Phototherapies Limited Effectiveness
  Targeted Immunotherapies are Needed

IFNγ-CXCL10-CXCR3 Chemokine Axis Play a Key Role in the Pathogenesis of Vitiligo





Rashighi M et al. Sci Transl Med. 2014 Feb 12;6(223):223ra23

Vitiligo Treatment Paradigm

Limited Options with Topical Ruxolitinib as the Only Approved Product

TREATMENT

Topicals

Corticosteroids

Calcineurin inhibitors

Ruxolitinib

Phototherapy

Systemic Steroids

Surgery

Skin grafting

Hair follicle transplant

Significant Unmet Need

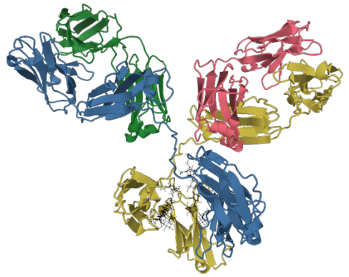
Large unaddressed market due to lack of approved and effective options

Only one approved drug with safety concerns (black box warnings)

Need for safe and effective systemic options, especially for high body surface area

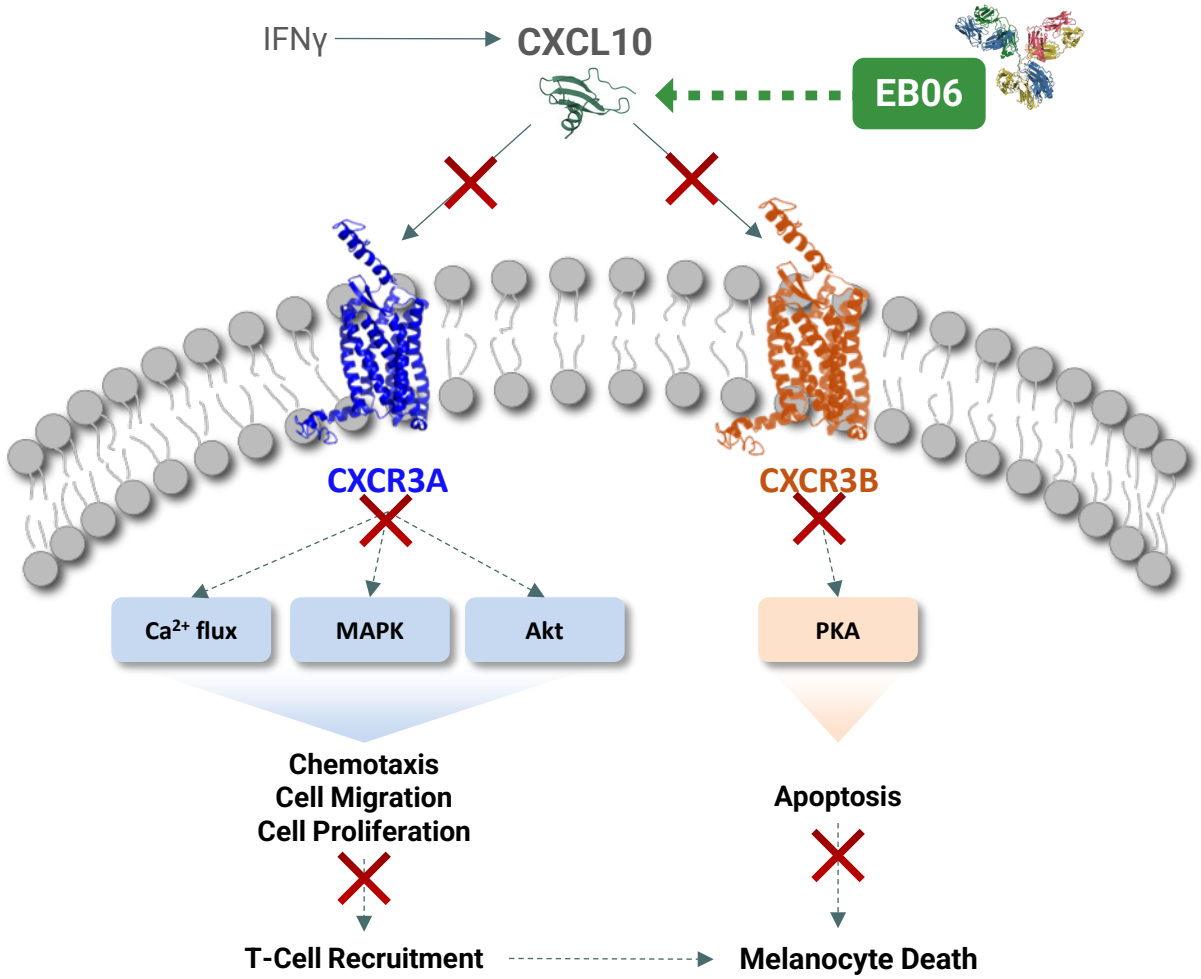
EB06 – Targeting the Chemokine CXCL10

Monoclonal Antibody that Directly Binds CXCL10 with High Affinity and Blocks it from Binding to CXCR3



Drug Profile

- A fully human IgG1k monoclonal antibody
- Binds specifically to CXCL10 with high affinity
- Sequesters and renders CXCL10 inactive
- Multiple manuf. runs by a leading CDMO; IV formulation; future subcutaneous



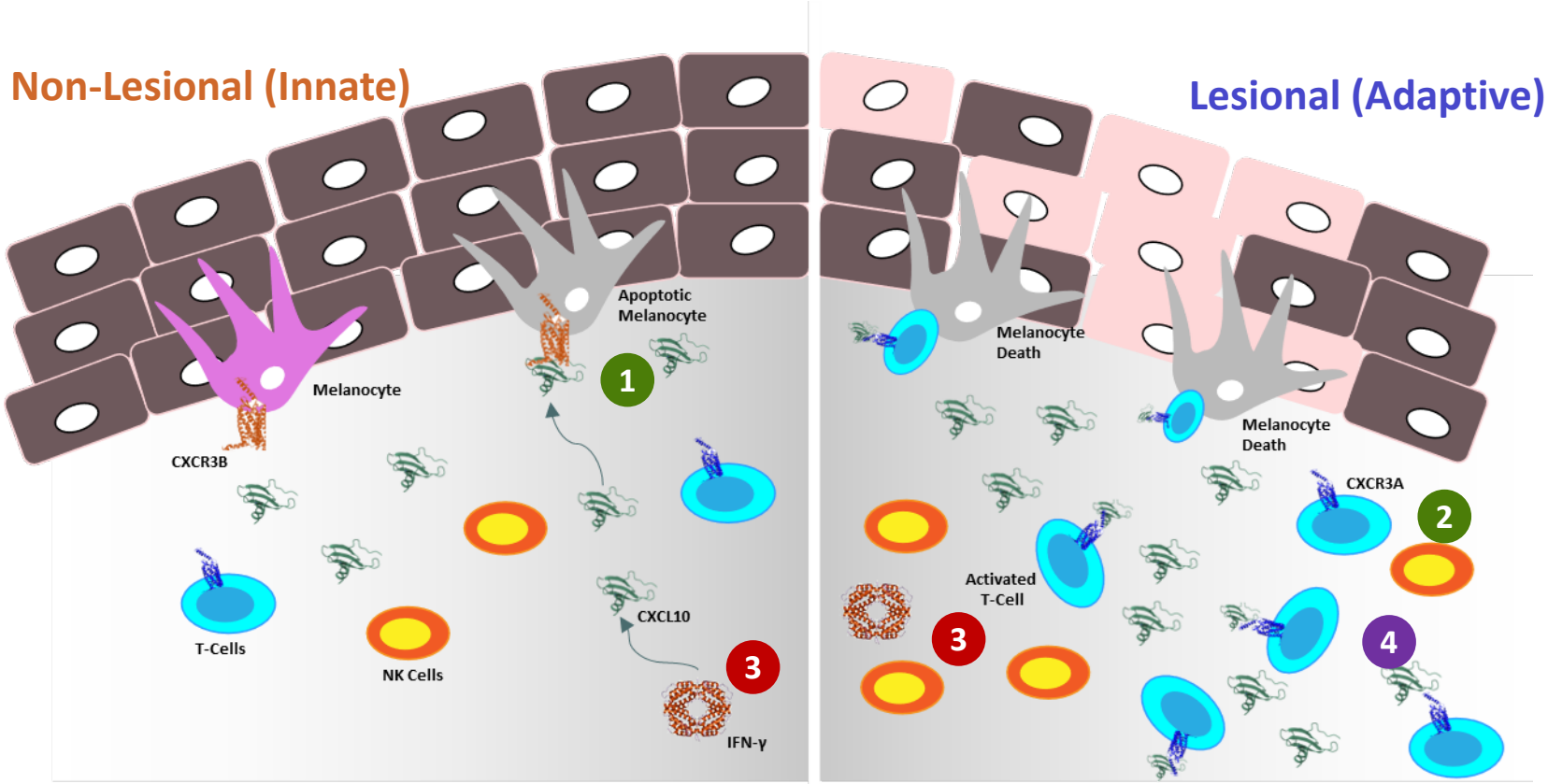
EB06 Positioning – Target Product Profile

Addressing Unmet Needs in Vitiligo

	Topical JAK Inhibitors (e.g. Ruxolitinib)	**Oral JAK Inhibitors** (e.g. ritlecitinib, povorcitinib)	**Biologics** (e.g. EB06, auremolimab)
Treats lesional and non-lesional skin	✗	✓	✓
Viable for patients with >10% BSA	✗	✓	✓
No Expected Safety Precaution (Black Box)	✗	✗	✓
No Daily Dosing required	✗	✗	✓

Targeting the IFNγ-CXCL10-CXCR3 Chemokine Axis

EB06 is an anti-CXCL10 Monoclonal Antibody that Can Act on Different Stages of Vitiligo



EB06 inhibits:

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1. CXCL10/CXC3B-mediated melanocyte apoptosis and antigen presentation
2. CXCL10/CXCR3A-mediated trafficking of anti-melanocytic CD8+ T cells to the epidermis

Incyte

Opzelura™ (ruxolitinib) interferes:

3. with the JAK-STAT signaling that leads to production of CXCL9/10.

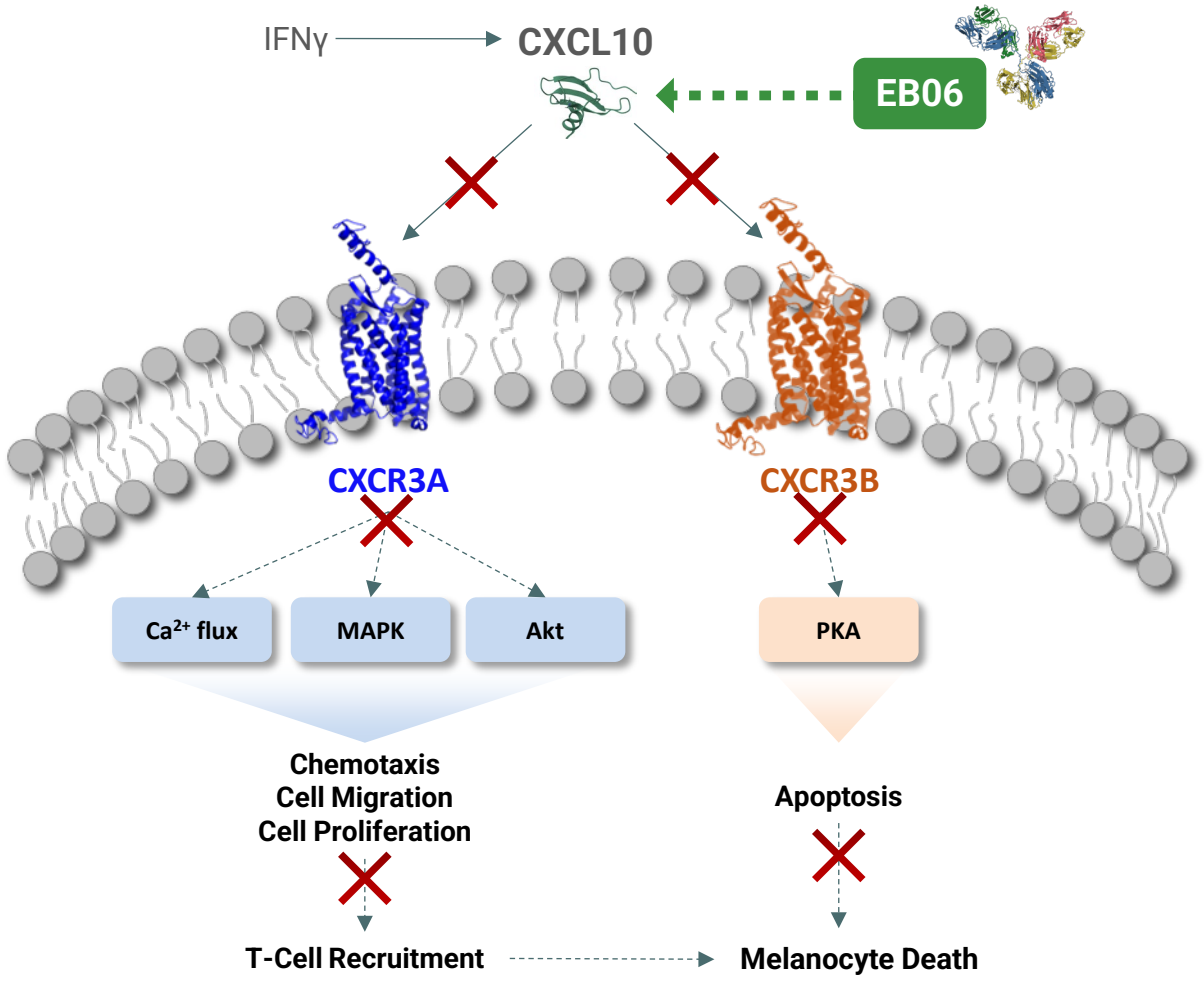
Villaris Therapeutics / Incyte

Auremolimab blocks:

4. IL15R leading to depletion of local effector T-cells.

CXCL10 Therapeutic Potential

Therapeutically Targeting - Substantiated in Preclinical Studies



1 Melanocyte Apoptosis

CXCL10/CXC3B mediates melanocyte apoptosis and activates anti-melanocytic CD8+ T-cells via CXCR3A

2 Knockout Mice

CXCL10 -/- mice do not develop vitiligo

3 Reverse Depigmentation

Anti-CXCL10 Ig in mice results in re-pigmentation of mice with vitiligo

4 Patient Samples

CXCL10 is predictive of disease progression and severity

Phase 2 Proof of Concept

Moderate to Severe Non-Segmental (Generalized) Vitiligo

Status	CTA approved & IND in progress
Subjects	Total of 160 evaluable patients randomized 1:1:1 (EB06, 2.5 mg/kg: EB06, 5 mg/kg: EB06, 10mg/kg: Placebo) across up to 25 study centers
Treatment Period	EB06 or placebo will be administered via IV every two weeks for up to 24 weeks, followed by a 12 week follow up period.
Primary Endpoint	Proportion of patients achieving F-VASI50 at week 24
Secondary Endpoints	Endpoints based on F-VASI50 and F-VASI75, mean % change in F-VASI, same for T-VASI and others Number of treatment-emergent adverse events and serious adverse events.

F-VASI = Facial Vitiligo Area Scoring Index; T-VASI = Total Vitiligo Area Scoring Index. Final study protocol subject to change

EB06: Anti-CXCL10 Monoclonal Antibody

Summary and Next Steps

Targeted Mechanism of Action
Binds free and bound CXCL10

65 Subjects Dosed
No Significant AEs

Biological Activity
Demonstrated

Phase 2 Ready
CTA Approved

Manufacturing
Leading CDMO

NEXT STEPS

IND in progress

CRO identified and ready to be initiated

Manufacturing campaign activities underway

Daniluromer

First-in-Class sPLA2 Inhibitor

Lead Indication: ACD

Status: Topline Results Available

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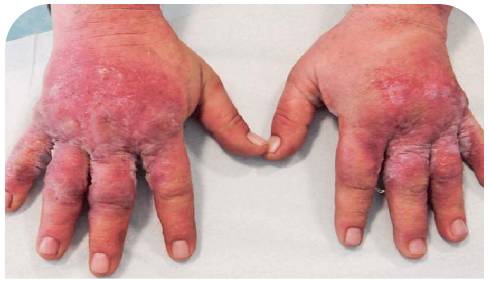
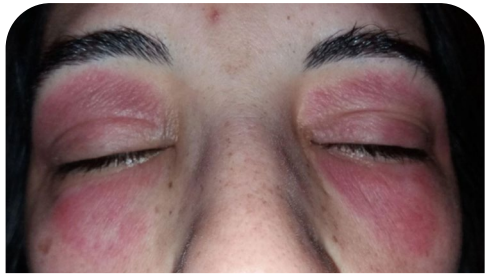
Allergic Contact Dermatitis (ACD)

The Leading Occupational Health Issue Related to Dermatology





ACD is a Type IV Hypersensitivity Reaction

- Immune system sensitized following initial contact with allergen
- Subsequent contact results in cell-mediated allergic response at the point of contact
- Often highly visible on face & hands

ACD Represents a Significant Unmet Need

3,000+
Contact Allergens

70%
Unable to fully avoid allergen

0
No Known Labelled Drugs

Adversely impacts both employees and employers

- Loss of productivity
- Complexity of mitigation
- Lost income & disability claims

Corticosteroids and immunomodulators have safety concerns and side effects

Significant Number of Patients with Chronic ACD

$4.7B **Total Addressable Market Opportunity**
7 major markets (US, UK, Germany, France, Spain, Italy, Japan) and Canada[1]

30M | Patients with ACD across 7 major markets (US, 5EU, Japan) and Canada

40% | Patients with chronic exposure or frequent recurring exposure to allergen[1]

5M | Addressable patient population

Physicians strongly desire additional treatment options, especially for hands and face[2]

"ACD…can make you quit your job."

"Maybe topical steroids help a little but I almost never use them"

"The burden of dermatitis is greater than that of psoriasis"

"Topicals are easier to use and they are a safer option than oral medications."

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1. Edesa estimate; addressable patient population assumes continuous and frequent allergen exposure and a body surface area <10%;
2. Company sponsored research, including KOL interviews

Daniluromer Market Positioning –Target Product Profile

Edesa's Cream is Being Developed to Address a Significant Unmet Need that Exists for Chronic ACD Patients

	Corticosteroids	TCIs	Daniluromer
Viable for acute ACD patients	✓	✓	✓
Viable for chronic ACD patients	✗	✗	✓
Safe for long term use	✗	✗	✓
No boxed warnings	✓	✗	✓
Clinical data specific to indication	✗	✗	✓

Daniluromer Cream

Positioned to be a **leading therapy option** for chronic, moderate to severe ACD patients.

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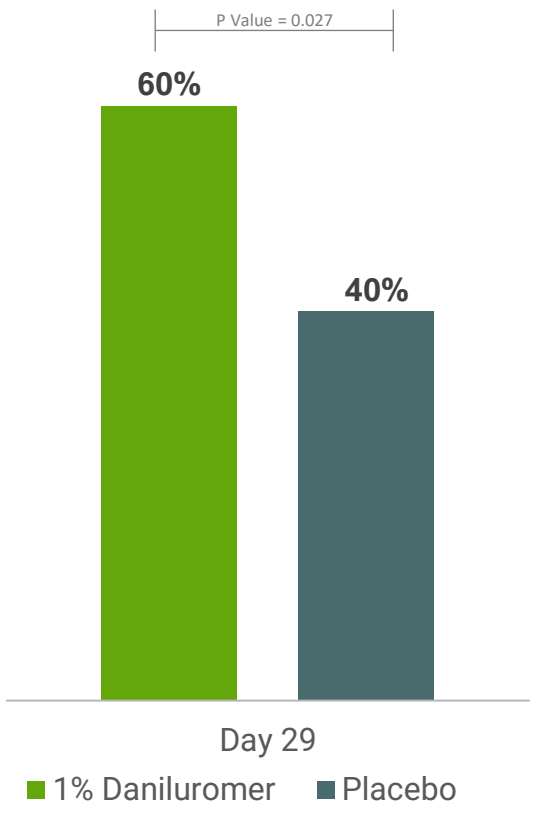
TCI: Topical calcineurin inhibitors

Phase 2B Results - – Composite CDSI and ISGA Scores

1.0% Daniluromer Met Primary Endpoint and a Key Secondary Endpoint with Statistical Significance

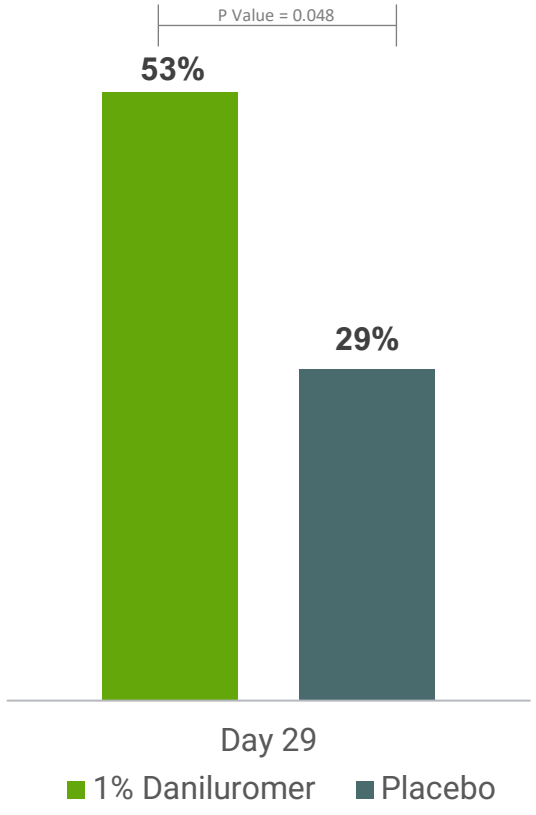
Total CDSI Score*

Mean % Improvement from Baseline



Total ISGA Score*

% Patients with a ≥2 Point Improvement from Baseline



* Intention to Treat (ITT) population; statistical analysis based on last observation carried forward (LOCF). Placebo (n=84); 1.0% Daniluromer Cream (n=19). Contact Dermatitis Severity Index (CDSI) at Day 29. Success on the Investigator's Static Global Assessment (ISGA) is defined as a 2-pt reduction and score indicating clear/almost-clear skin. Topline study data are preliminary and subject to change.

Summary of Results

Efficacy: 1.0% Daniluromer-treated patients demonstrated a relative improvement of >50% (CDSI) and >80% (ISGA) over placebo/vehicle.

Additional Signals:
Body Surface Area of 1.0% Daniluromer-treated lesions was reduced by 42.1% compared to 8.8% for placebo/vehicle (p=0.054).

Reduction for each component symptom of the CDSI:

- Redness (50% Daniluromer vs. 35.4% placebo; p=0.17)
- Pruritis (60.5% Daniluromer vs. 41.3% placebo; p=0.06)
- Fissures (63.1% Daniluromer vs. 44.3% placebo; p=0.02)
- Scaling (58.3% Daniluromer vs. 42.9% placebo; p=0.36)
- Dryness (62.9% Daniluromer vs. 35.9% placebo; p=0.02)

1.0% Daniluromer was Identified as Lowest Efficacious Dose:

Safety: No serious treatment-related adverse events were reported across all concentrations.

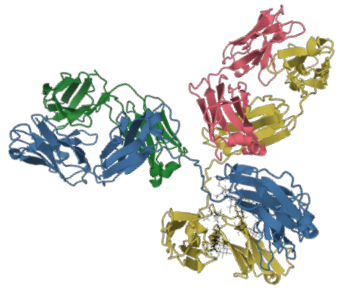
Paridiprubart

First-in-Class Anti-TLR4 mAb

Edesa Biotech™

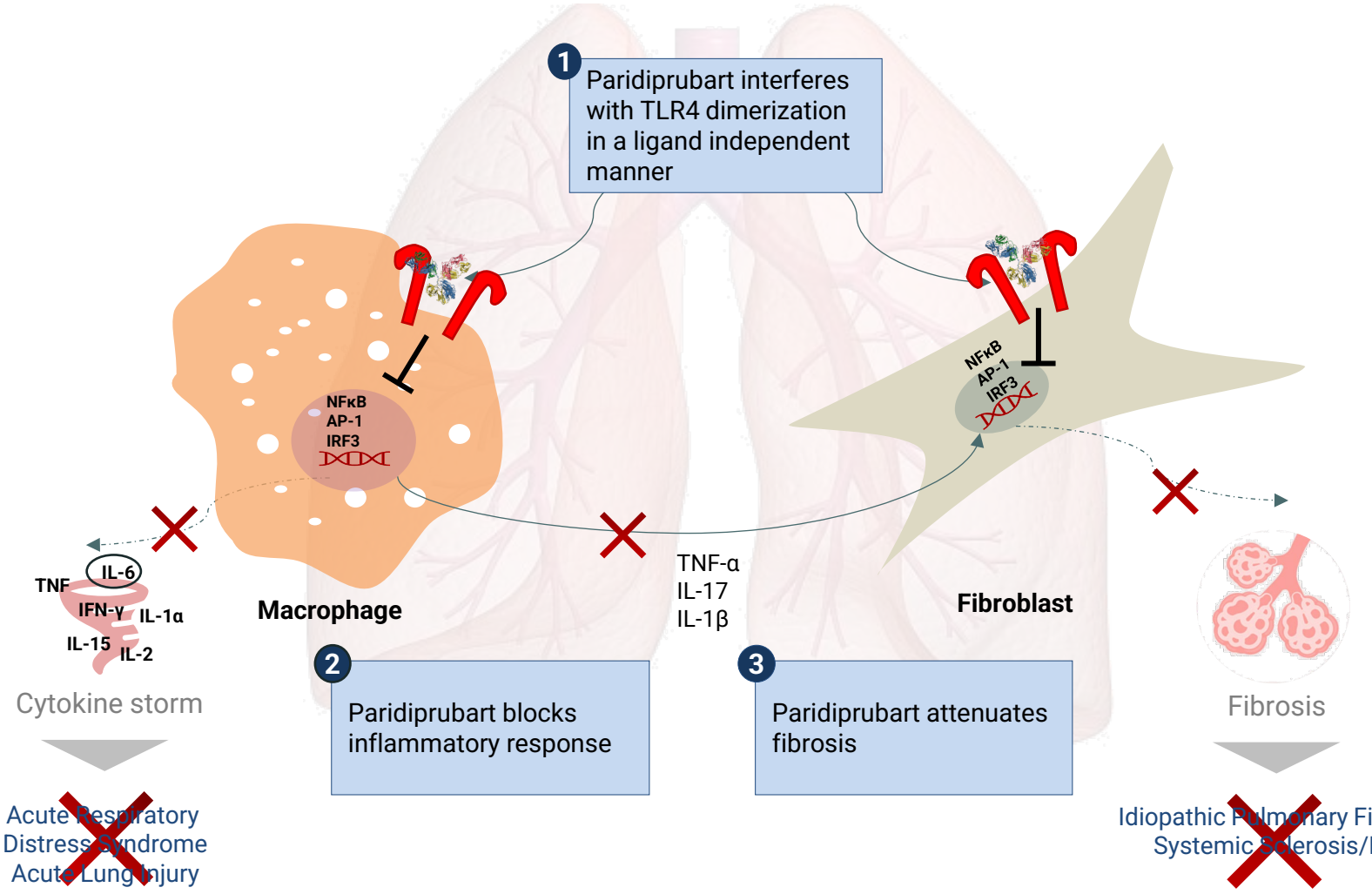
Paridiprubart – Anti-Toll-like Receptor 4 (TLR4) Antibody

First-in-Class mAb that Specifically Blocks TLR4 Signalling



Drug Profile

- A humanized IgG1k monoclonal antibody
- Binds to TLR4 with high affinity
- Extensive preclinical and clinical development
- Multiple manuf. runs by a leading CDMO



ARDS - A Significant Burden and Market Opportunity

Total Addressable Market

600,000
Estimated ARDS-Related ICU Admissions/Year

$5.2B

ARDS across the 7 major markets (US, UK, Germany, France, Spain, Italy, Japan) and Canada.[4]

Disease Burden

7 to 21 days
of ICU stay for surviving ARDS patients[1]

$100K+
average cost per patient in the US[2]

ARDS was historically underdiagnosed, with 2/3 cases with missed or delayed diagnosis[3]

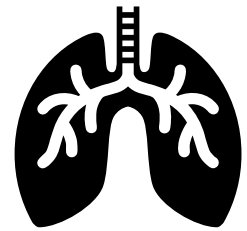
Growth Drivers

- New pathogens and outbreaks
- Increasing awareness and better diagnosis
- Ageing population
- Increasing incidence of co-morbidities/risk factors[3]

1. Bellani et at (2016), JAMA;
2. FAIR Health, Total Treatment Cost, Sept 2021; average allowed and charged cost per complex COVID-19 patient in the US.
3. Pfortmueller et al (2021), Best Pract Res Clin Anaesthesiol
4. Company estimate

Phase 3 - Baseline Characteristics - ARDS

Phase 3 ITT Patient Population Encompassed Multiple Potential Etiologies



ARDS Patients

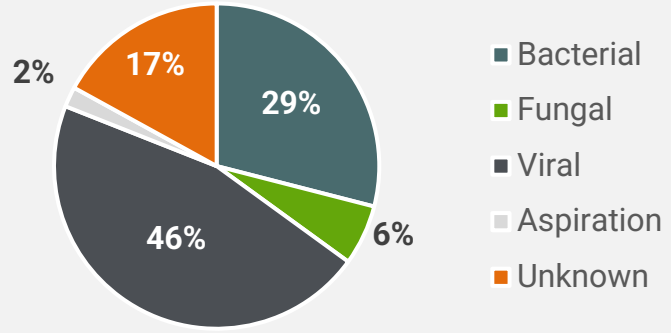
Baseline Conditions Associated with ARDS*

40%
Pneumonia

20%
Sepsis

1% Acute Pancreatitis

Pneumonia Types**



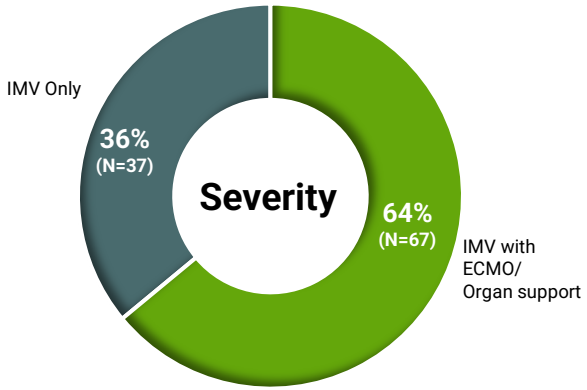
***Includes co-infections*

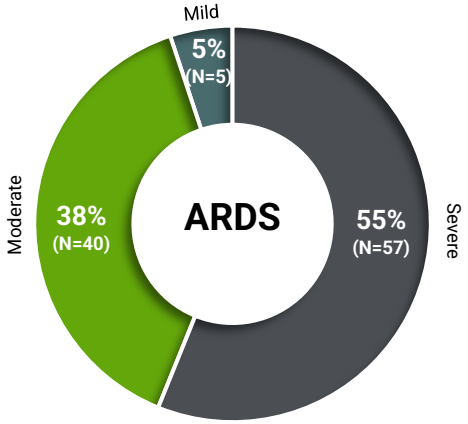
* N=104

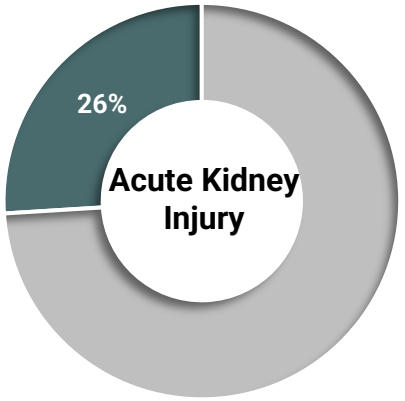
Baseline Characteristics - ICU

Phase 3 Intent-to-Treat (ITT) Patient Population

A total of **104 patients hospitalized in the ICU** and under invasive mechanical ventilation
Patients were required to have a positive Sars Cov2 test



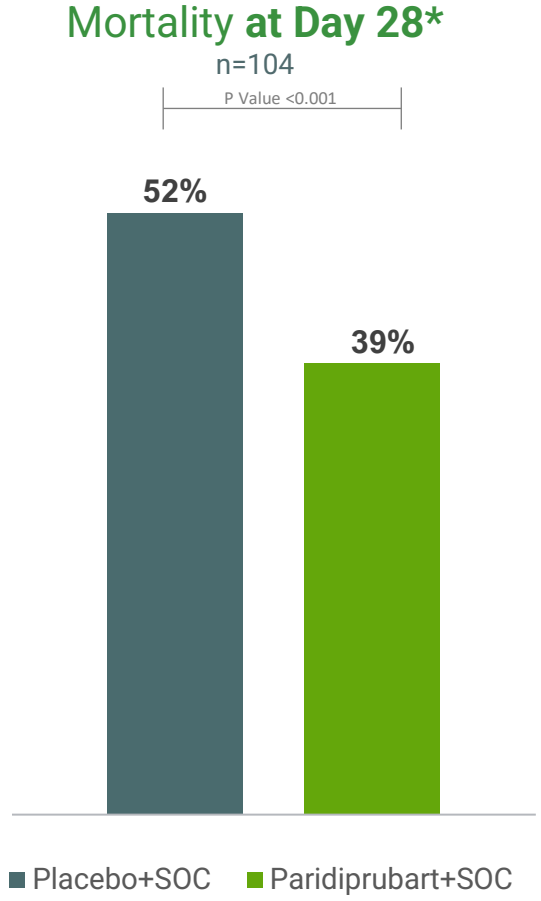


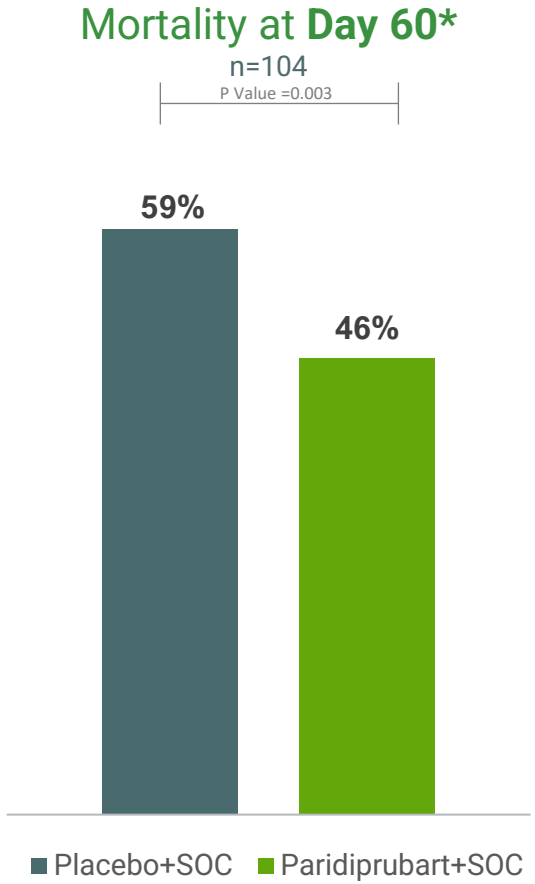


Mean Age	Antivirals	Steroids	Immunomodulators
51.5	9.6%	44.2%	9.6%
(20-86)	(10/104)	(45/104)	(10/104)

Phase 3 Results – Primary Endpoint 28-Day Mortality

Paridiprubart Met Primary and Secondary Endpoints with Statistical Significance





* Estimated risk of mortality using multivariate logistic regression derived risk differences (95% confidence interval). Final Phase 3 protocol comprised ICU patients with ARDS (mild/moderate/severe); Invasive Mechanical Ventilation and/or patients receiving organ support/ECMO; Company opted to truncate enrolment for business reasons: 104 Patients enrolled in intention-to-treat; 278 patients (safety ITT). Subject randomized 1:1 placebo plus standard of care (SOC) treatment or paridiprubart + SOC.

Summary of Phase 3 Results

28-Day Mortality Rate: Paridiprubart had a relative reduction in the risk of death of 25% compared to placebo

60-Day Mortality Rate: A durable survival benefit was also demonstrated. Paridiprubart had a relative reduction in the risk of death of 22% vs. placebo

Clinical Improvement at Day 28: Paridiprubart showed a 41% higher relative rate of clinical improvement, meaning patients no longer required IMV and/or organ support

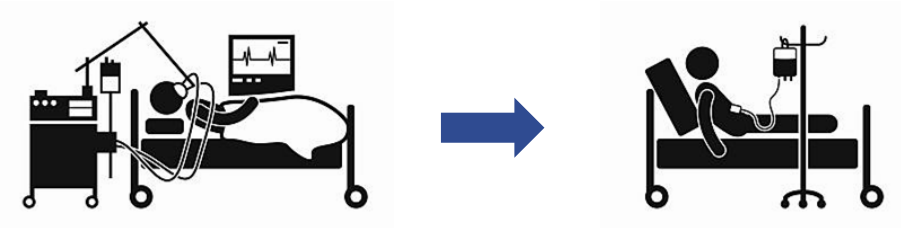
Other Signals: Paridiprubart reduced mortality in a population that included patients not on IMV

Safety Population: Favorable safety profile in 278 subjects

Paridiprubart Treatment Had Significant Impact on Clinical Improvement

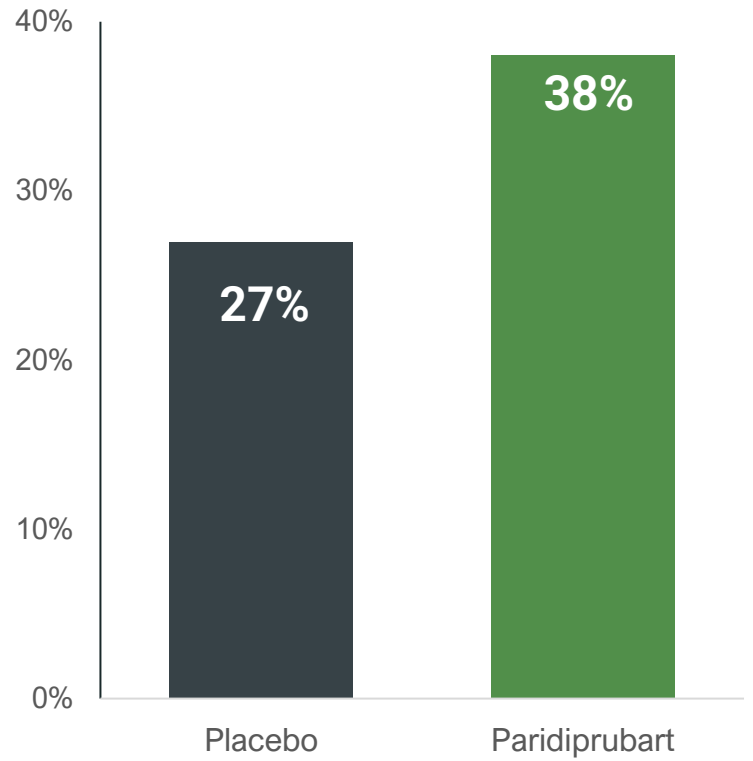
Treatment Nearly Doubled the Chance of Recovery by Day 28 - ITT

Secondary Endpoint
Proportion of Patients Who Achieved at Least a 2-Point Reduction in the WHO scale.



Implies that patients are no longer in the ICU requiring invasive mechanical ventilation and organ support at Day 28

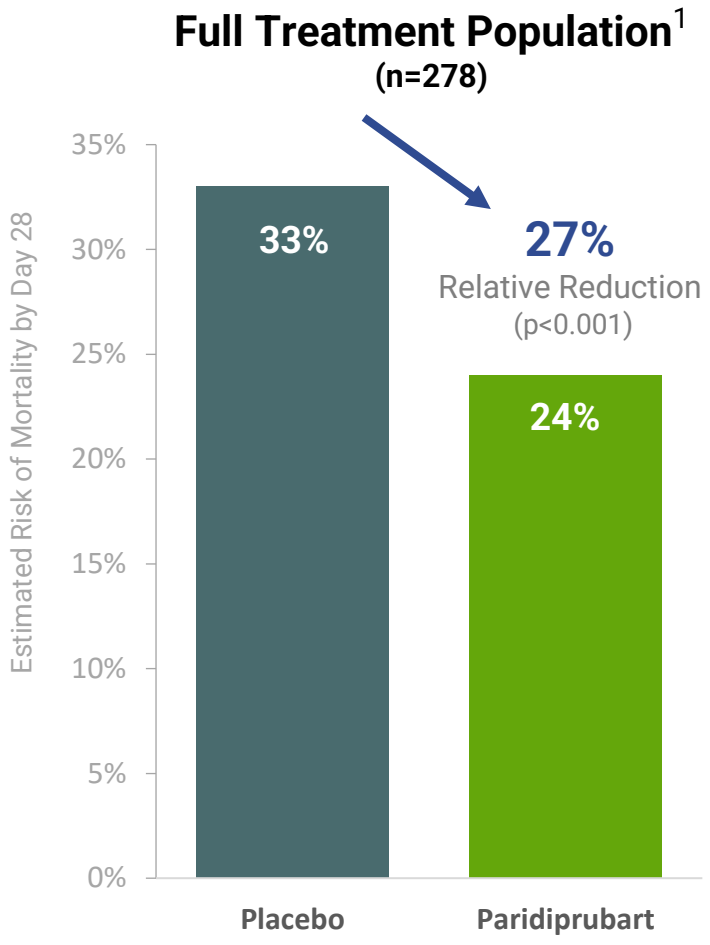
Estimated Proportion Achieving a 2-pt Reduction in WHO Scale (p<0.05)

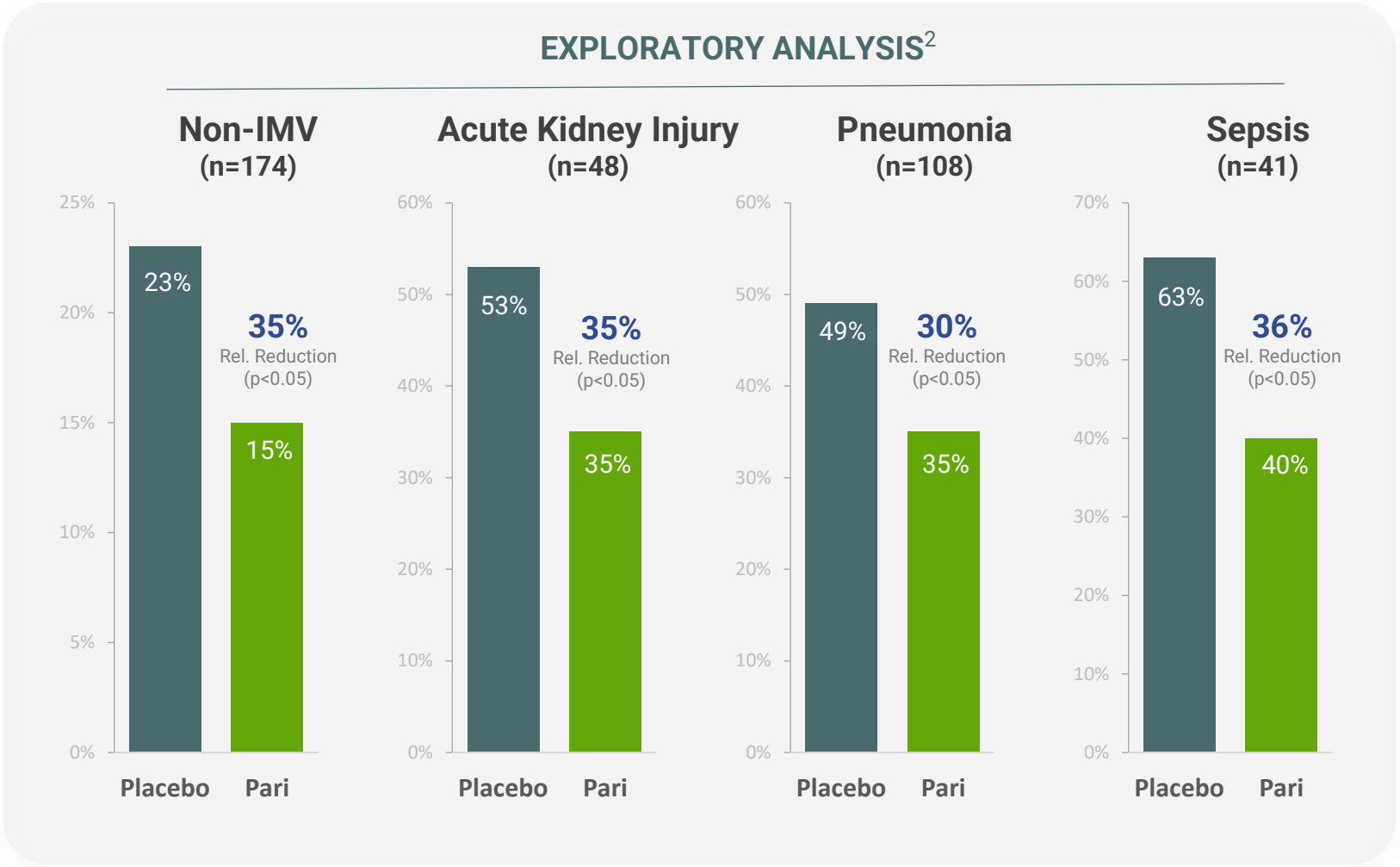


Patients Treated with Paridiprubart had a Significantly Higher Likelihood of Being Free from Mechanical Ventilation and Organ Support by Day 28 Compared to Placebo

Phase 3 Study – Additional Analysis

Survival Benefit Observed in Broader Population, Across Severity Groups and in Subjects with Serious Comorbidities





1) All subjects received placebo or paridiprubart plus standards of care. Estimated risk of mortality using multivariate logistic regression derived risk differences (95% confidence interval). 2) Nominal p-value, not adjusted for multiplicity. Source: Edesa Press Release

Safety Assessment

Paridiprubart Exhibits a Favorable Safety Profile

Parameter	Treatment Group			
	Paridiprubart (N=138)		Placebo (N=140)	
	N of Event	Patients (%)	N of Event	Patients (%)
Overall	51	13 (9.4%)	74	14 (10.0%)
Severity, n (%)				
Mild	21	8 (5.8%)	32	10 (7.1%)
Moderate	15	8 (5.8%)	21	8 (5.7%)
Severe	15	8 (5.8%)	21	9 (6.4%)
Seriousness, n (%)				
Persistent Disability	0	0 (0.0%)	1	1 (0.7%)
Prolongation of Hospitalization	2	1 (0.7%)	3	3 (2.1%)
Life Threatening	1	1 (0.7%)	13	8 (5.7%)
Medically Important	1	1 (0.7%)	6	4 (2.9%)
Relationship to study drug, n (%)				
Definitely	0	0 (0.0%)	1	1 (0.7%)
Possibly	0	0 (0.0%)	3	2 (1.4%)
Unlikely	12	7 (5.1%)	23	4 (2.9%)
Not related	39	10 (7.2%)	47	10 (7.1%)

Safety population for the Phase 3 study consisted of 278 patients (138 with Paridiprubart and 140 with placebo).

No treatment-related adverse events were observed.

A total of 460+ patients and healthy volunteers have been dosed with paridiprubart over the course of its development history, validating a favorable safety profile.

Patients may have experienced more than one adverse event. Death was not included in the descriptive statistics of TEAEs because mortality is a study endpoint.

Govt.-Funded Support for Paridiprubart

U.S. Platform Study of Host Directed Therapeutics

Status	Phase 2 Recruiting
Primary Endpoint	28-Day Mortality
Key Secondary Endpoints	Ventilation Free Days 60-Day Mortality
Target Population	Adult subjects with moderate to severe ARDS
Cohort Size	~200 subjects

Biodefense and Pandemic Preparedness

$117 million
United States Government

C$23 Million
Government of Canada

U.S. allocated $117M to evaluate three novel therapeutics for general ARDS, including Edesa's paridiprubart

Manufacturing scale-up supported by the Government of Canada's Strategic Innovation Fund

Clinical Summary

First-in-Class Therapeutics for Immuno-Inflammatory Diseases

EB06 – Vitiligo – Phase 2 Ready

Significant Transactions in this Therapeutic Area and Pathway

Daniluromer

Partnering Phase; Phase 3 Ready

Paridiprubart

Phase 3 Results; U.S. and Canada Government Support

Edesa Biotech

Experienced Leadership Team

Pharmaceutical Pipelines, Corporate Development & Strategic Transactions

Executive Management Team

Par Nijhawan, MD, FRCPC, AGAF
CEO and Board Director

Michael Brooks, PhD
President

Peter Weiler
Chief Financial Officer

Gary Koppenjan
VP, Corporate Affairs

Blair Gordon, PhD
VP, Research & Development

Select Strategic Transaction Experience of Leadership Team

EXZELL PHARMA	Stellar BIOTECHNOLOGIES	MFI Medical Futures Inc.	LIGHTCHAIN BIOSCIENCE	Yissum	pharma science	MATRIVAX	ceres	PENNSAID
Acquisition by Biolab Pharma 2022	Reverse Acquisition by Edesa 2019	Acquisition by Tribute Pharma 2015	In-License 2020	In-License 2016	Development/ Out-license 2017	Out-License 2017	Tender Offer by Land O'Lakes 2016	Sold U.S. Rights 2014

Independent Directors

Joan Chypyha	David Liu	Patrick Marshall	Sean MacDonald	Charles Olson	Carlo Sistilli, CPA, CMA
Alto Pharma	VELAN	Jouleia	DOMAIN THERAPEUTICS	NervGen Pharma	ARISTA HOMES

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