Invex Therapeutics

Phase II Clinical Results & Capital Raise Investor Presentation

May 2020

ASX Code: IXC

invex THERAPEUTICS

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Invex Therapeutics - Executive Summary

- Clinical stage drug development company targeting the orphan disease Idiopathic Intracranial Hypertension (IIH)
  - Repurposed Exenatide (Presendin™) formulation
  - Large, growing market for IIH, Total Addressable Market of up to **~A$1.6 billion** annually in the USA and Europe
  - No approved (regulatory cleared) or efficacious treatments currently available for IIH patients
  - **Orphan Drug Designation in the USA and EU** provides expedited, cost-effective drug development pathway, approval/registration as well as commercial exclusivity for up to 10 years
  - Invex expects top-line Phase III data in 2H 2023 and regulatory approval for Presendin™ in 2024

- Phase II data **strongly** supports moving Presendin™ into Phase III clinical development in **1H 2021**
  - **Met all Primary Endpoints** for a >10% reduction of Intracranial Pressure[1] (ICP) at 2.5 hours ($p<0.048$), 24 hours ($p<0.03$) and 12 weeks ($p<0.058$)
  - **Statistically significant improvement in Key Clinical Endpoints[2]**
    - 7.7 day reduction in Monthly Headache Days
    - Visual acuity improvements equivalent to 1 full line on chart
- Transaction for entire Company preferred as value creation event for shareholders, versus licensing or partnering

Clear Statistical and clinical evidence of efficacy in primary and secondary endpoints demonstrates a strong and sustained drug effect in the IIH population

1. *Based on sample size, the pre-defined level of significance (study statistician & investigators) was $p<0.10$.*
2. *Clinical Endpoints were not powered for significance*

Phase II Trial Design

Randomised double blinded placebo controlled clinical study[1]

12 weeks

Placebo, 2x day

Exenatide, s.c. 10μg, 2x day

- n=16
- Female, 18-60 years old
- Confirmed IIH diagnosis
- Real-time ICP measurement

Primary endpoints

Change in intracranial pressure @ 2.5hrs, 24hrs and 12 weeks

80% statistically powered to see a 10% reduction in ICP

Exploratory endpoints – headache & vision

Headache frequency, severity, duration, analgesic use, HIT-6

Visual field assessment, visual acuity, OCT measurement

<u>Not</u> powered for significance

1. http://www.isrctn.com/ISRCTN12678718

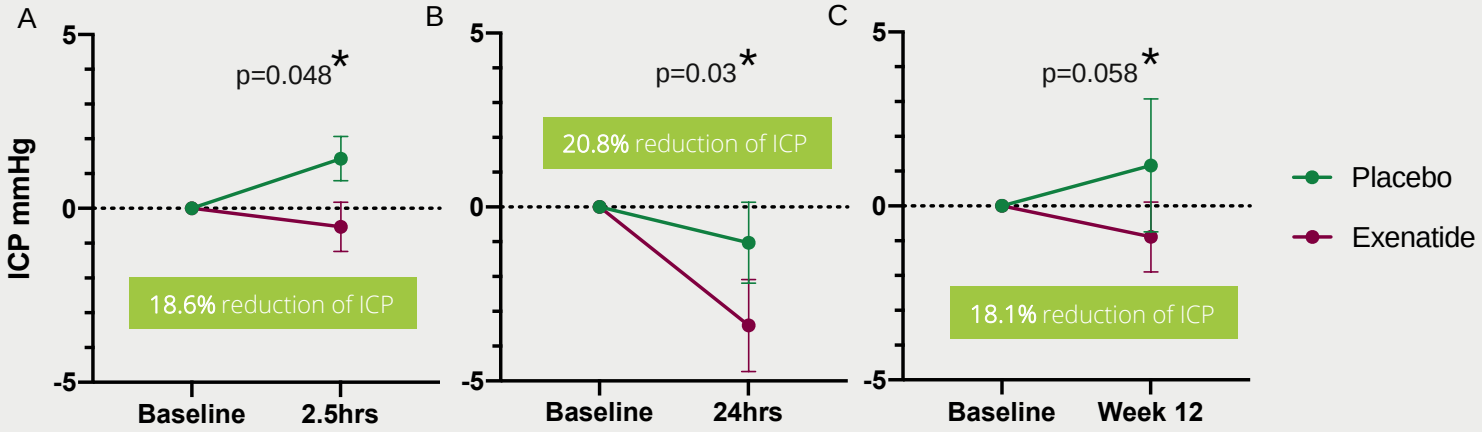
Phase II Trial - Design Considerations

- Measuring ICP by lumbar puncture is inaccurate and highly variable
- Reliable & stable baseline data established through substantial lead-in data collection
  - Participants completed a daily headache diary in the month before visits 1 and 2
- IIH patients enrolled into the study underwent an invasive neurosurgery procedure to implant a telemetric intracranial pressure monitor into the right frontal lobe
  - Significantly increases the reliability (accuracy and number) of ICP measurement
    - Continuous ICP measurements @5Hz over 30 mins at each time point
    - ICP value per patient is the mean of ~9,000 individual pressure measurements
    - Each patient provides >36,000 individual data points to investigators over the study period
    - Highly accurate, low variation = fewer patients required to achieve statistical power
  - Approach limits the number of participants as requires invasive surgery not likely to result in patient benefit – i.e. ethical considerations
- ICP reduction in IIH patients of 16.5% has been shown in a clinical study of weight loss in IIH patients to be clinically meaningful[1]

1. Sinclair et al (BMJ) 2010; 341. Low energy diet and intracranial pressure in women with idiopathic intracranial hypertension: prospective cohort study

Primary Endpoints – Exenatide Reduces ICP in IIH Patients

- The primary endpoints of the study assessed differences in intracranial pressure (ICP) between the Exenatide treatment arm and placebo at (A) 2.5 hours, (B) 24 hours and at (C) 12 weeks
- Exenatide reduced ICP at all three time points in a statistically significant manner (*p<0.10, hierarchical regression[1])
- Confirmation Exenatide mechanism of action & clinical proof of concept

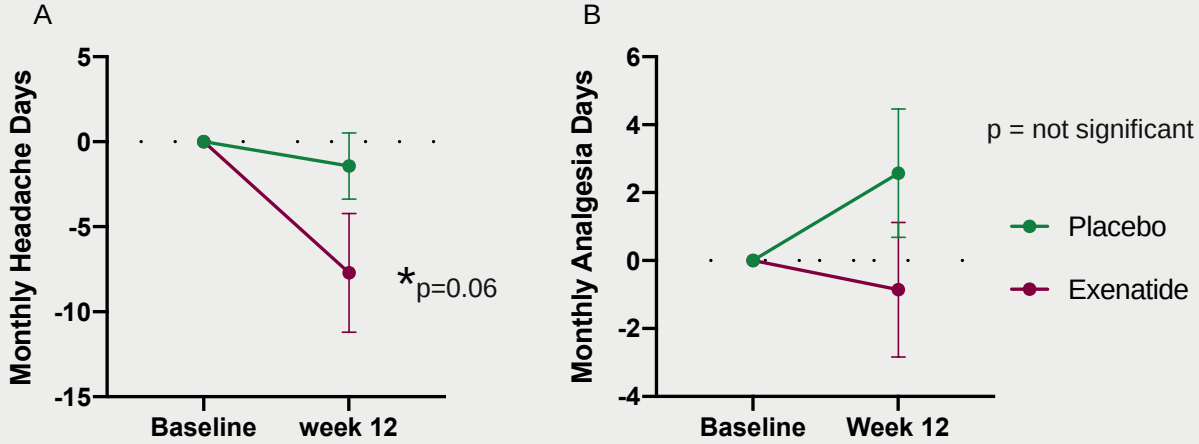


- Exenatide achieved a reduction in ICP of between **18.1%-20.8%** in IIH patients versus placebo over the study duration
- The observed reduction in ICP was double the pre-study hurdle of **10%**
- Significantly exceeds what is considered clinically meaningful (**16.5%**) in IIH

1. *Based on sample size, the pre-defined level of significance (study statistician & investigators) was p<0.10.*

Secondary Endpoint – Exenatide Reduces Headache Frequency

- Headache frequency data shown in the figure below (A) highlights a statistically significant beneficial reduction in Monthly Headache Days in Exenatide treated patients
- Analgesic use (B) also shows a reduction in the use of pain medication by IIH patients taking Exenatide, though not statistically significant

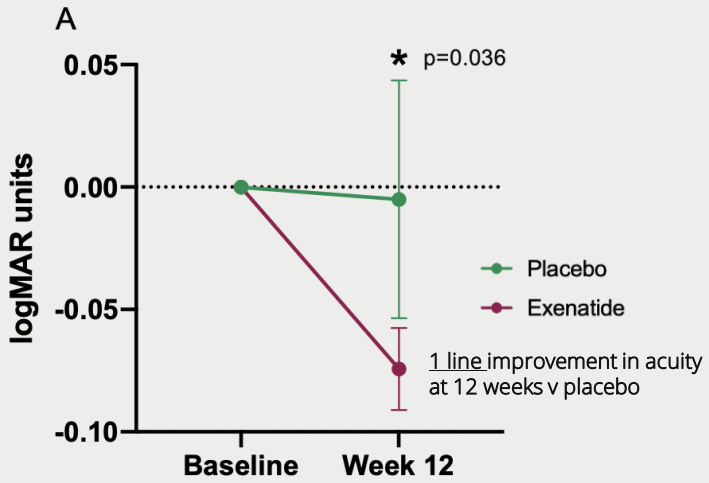


- A reduction of 7.7 days would be clinically meaningful in migraine
- IIH headaches share many features with migraine where the accepted minimal clinically important reduction is 1.5-2 headache days per month[1]
- A reduction in Monthly Headache Days is a well recognised and validated endpoint by regulators in headache studies
  - appropriate primary endpoint in a Phase III registration study

1. Mollan S P et al., Curr Opin Neurol. 2019 Feb;32(1):92-98, Tepper et al., Lancet Neurol. 2017 Jun;16(6):425-434, Silberstein et al., Silberstein et al., 2017, Goadsby et al., Goadsby et al., 2017, Camporeale et al., Camporeale et al., 2018

Secondary Endpoint – Exenatide Improves Visual Acuity

- Visual acuity was assessed using a Logarithm of the Minimum Angle of Resolution Chart – LogMAR assessment
- Despite not being powered, the improvement in VA in the Exenatide arm was large enough to show a statistically significant and clinically meaningful improvement in visual acuity, an important clinical consideration for IIH patients[1]

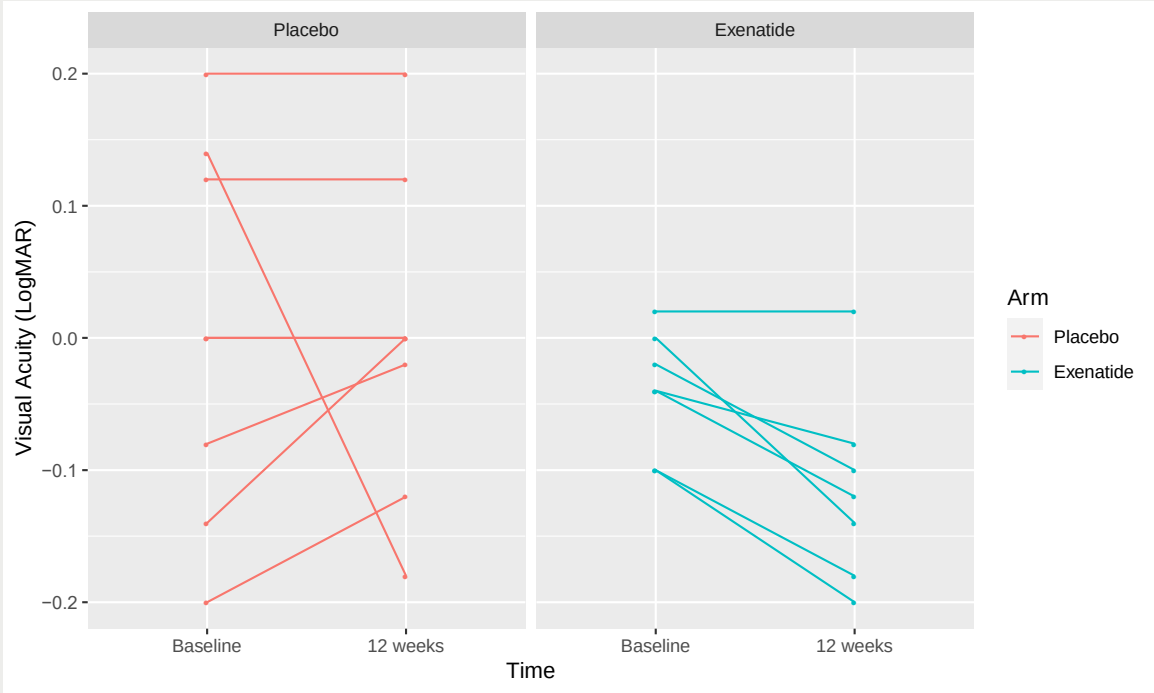


- No determination of a minimal clinically important improvement in LogMAR in IIH
- An improvement equivalent to a whole line (-0.1) on the acuity chart is a significant change for an IIH patient and would be considered a "clinically relevant recovery" by KOLs
- For patients, such an improvement could mean the difference between being able to drive or not (for example)

1. Mollan SP, et al. Idiopathic intracranial hypertension: consensus guidelines on management (2018);

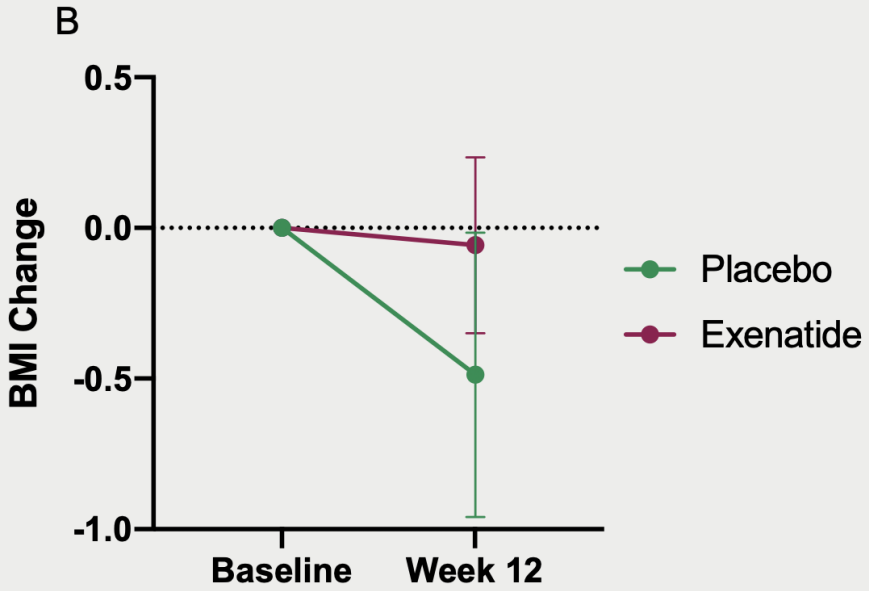
Exenatide Improved Visual Acuity in Majority of IIH Patients

- LogMAR improved in all but one of the Exenatide treated patients, and in only a single patient on placebo, further supporting the breadth and certainty of this observed improvement in vision with Exenatide



Exenatide Benefit Not Due to Weight Loss

- IIH patients on Exenatide did not lose weight during the course of the study
- Patients on Placebo lost a small amount of weight equivalent to 0.5 BMI units
- The benefit of Exenatide use could not be explained by these patients losing weight



Safety & Adverse Events

- No serious adverse events (AE) were observed related to the use of Exenatide
- Overall, adverse events were relatively low, with nausea the most common seen in >85% of patients treated with Exenatide
- Nausea is a known and the most frequent AE of sub-cutaneous administration of this formulation of Exenatide (Byetta®)[1]

Event	Number & Arm*	Description
Serious Adverse Events (SAE)	1,P	Thyrotoxicosis (unrelated, participant continued in study)
Adverse Events (AE)	3, E	Nausea – required treatment
	4, E	Nausea - mild
	1, E 2, P	Minor wound infection (unrelated, participant continued in study)
	1, P	Post-operative swelling

* P = Placebo group, E = Exenatide Group

1. https://www.accessdata.fda.gov/drugsatfda_docs/label/2014/021773s036lbl.pdf

Patient Baseline Characteristics

	Exenatide		Placebo		Differences	
	Median (range)	Mean (SD)	Median (range)	Mean (SD)	Wilcoxon rank sum p	chi-squared p
Number	7		8			
Age	25 (18, 57)	28 (13)	26 (23, 38)	28 (6)	0.560	
Gender (% female)	100		100			
BMI (kg/m2)	35.5 (31.3, 54.4)	37.6 (7.9)	39.9 (29.4, 44.2)	38.6 (4.7)	0.281	
ICP (mmHg)	21.9 (17.4, 28.5)	22.3 (3.6)	24.2 (19.3, 30.2)	24.6 (4.1)	0.281	
Monthly Headache Days	21 (13, 28)	22 (5)	12 (0, 21)	10 (9)	0.015*	
Monthly analgesic frequency	7 (3, 16)	7.9 (4.5)	3 (0, 8)	3.4 (2.8)	0.054	
Headache severity (VRS 0-10)						
Category 1						0.13?
Mild, n (%)	0 (0%)		3 (38%)			
Moderate	6 (86%)		5 (62%)			
Severe	1 (14%)		0 (0%)			
LogMar visual acuity	0.0 (-0.1, 0.0)	0.0 (0.1)	0.0 (-0.2, 0.2)	0.0 (0.1)	0.522	
Perimetric mean deviation worst eye dB (HVF 24-2 Sita standard)	-0.4 (-2.5, 0.3)	-0.6 (1.0)	-2.5 (-5.1, 0.5)	-2.7 (1.9)	0.072	
Optical Coherance Tomography RNFL wost eye (um)	128 (91, 236)	153 (59)	161 (85, 337)	183 (100)	0.852	
Headache disability (HIT-6)						0.218
Little-to-no impact, n (%)	0 (0%)		2 (25%)			
Moderate	0 (0%)		1 (13%)			
Severe	5 (71%)		2 (25%)			
Substantial	2 (29%)		3 (38%)			
Quality of Life (SF-36)						
PCS summary	53.5 (10.2, 71.9)	50 (20)	59.1 (26.7, 80.2)	58 (17)	0.418	
MCS summary	46.1 (7.5, 67.0)	43 (23)	49.7 (26.0, 75.5)	47 (17)	0.852	
Creatinine (µmol/L)	69 (51, 77)	68 (9)	69 (48, 72,)	66 (8)	0.601	
ALT (IU/L)	22 (15, 45)	27 (14)	16 (12, 46)	21 (12)	0.363	
HDL (mmol/L)	1.15 (0.73, 1.82)	1.26 (0.36)	1.49 (1.18, 1.82)	1.48 (0.24)	0.117	
Cholesterol (mmol/L)	4.5 (3.7, 5.9)	4.53 (0.79)	4.2 (3.7, 6.2)	4.76 (1.0)	0.727	
Triglycerides (mmol/L)	1.0 (0.6, 2.2)	1.26 (0.65)	1.2 (0.9, 1.4)	1.14 (0.18)	0.907	
HbA1c (mmol/mol)	37 (32, 38)	35.4 (2.7)	37 (29, 38)	35.0 (3.9)	1.000	

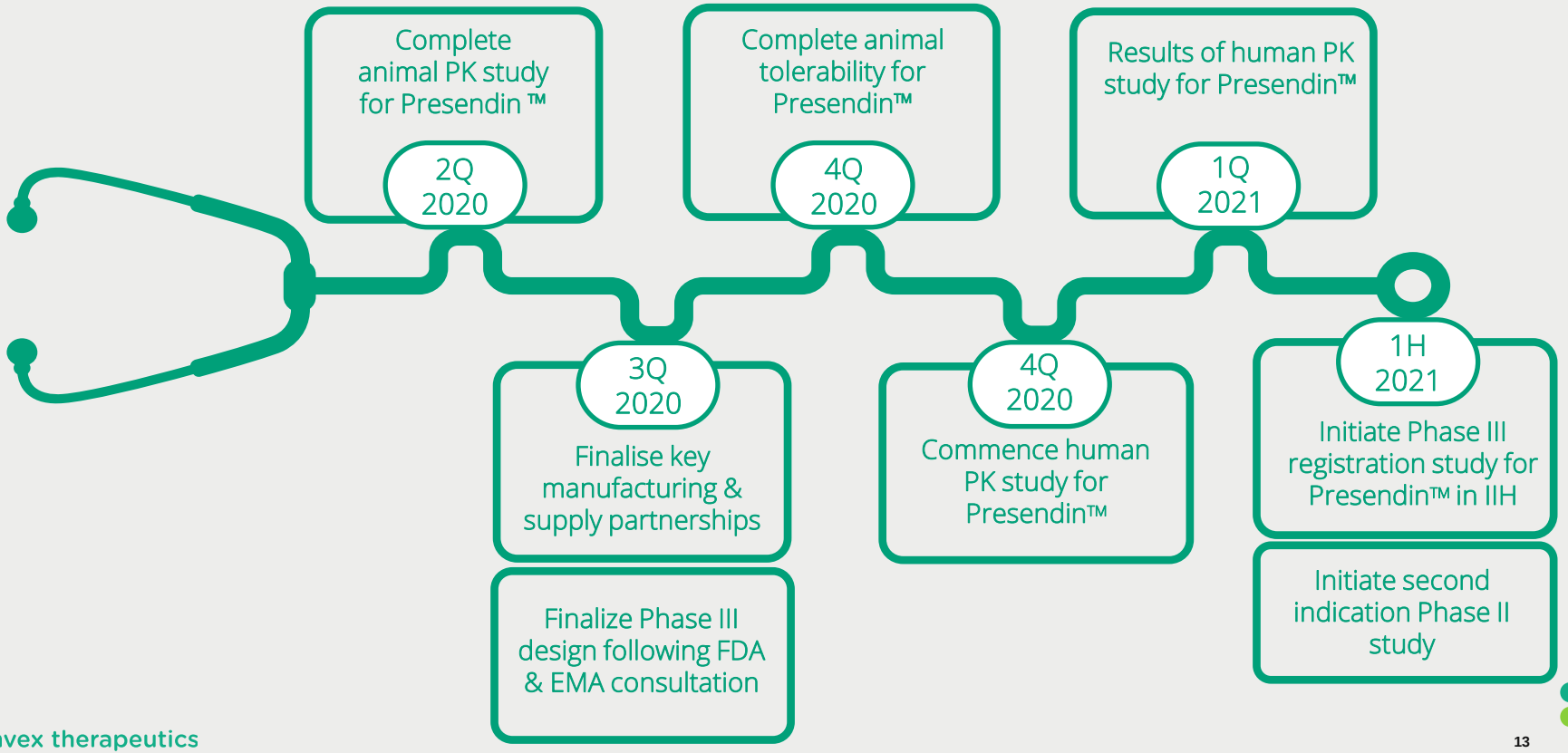
Despite the relatively small number of participants, the study was well balanced at baseline

No significant difference in BMI or ICP between the arms at baseline

The only significant difference between the groups (at baseline) being in Monthly Headache Days (MHD), where the difference was skewed by 2 patients in the Placebo Group with very low MHD at baseline

No significant difference in visual acuity between the arms at baseline

Timeline – Key Milestones to Market Entry



Summary - Exenatide in IIH Clinical Study

- Phase II data **strongly** supports moving Presendin™ into Phase III clinical development in **1H 2021**
  - **Met all Primary Endpoints** for a >10% reduction of Intracranial Pressure[1] (ICP) at 2.5 hours ($p<0.048$), 24 hours ($p<0.03$) and 12 weeks ($p<0.058$)
  - **Statistically significant improvement in Key Clinical Endpoints[2]**
    - 7.7 day reduction in Monthly Headache Days
    - Visual acuity improvements equivalent to 1 full line on chart

Strength of the outcomes for both primary & key clinical endpoints
implies a clear & strong drug effect in the IIH population & supports progression to a single Phase III clinical trial for registration in the USA and Europe

1. *Based on sample size, the pre-defined level of significance (study statistician & investigators) was $p<0.10$.*
2. *Clinical Endpoints were not powered for significance*

Capital Raising

- $26.2 million Share Placement to Sophisticated and Professional Investors at $1.30 per share
- The offer price represents:
  - 13% discount to last closing price of $1.495
  - 4% discount to the 15 day VWAP of $1.35
- Bell Potter Securities Limited appointed Sole Lead Manager
- Forrest Capital & CPS Securities appointed Co-Managers

Pro-Forma Capital Structure - $26.2 million placement	
Current Shares on Issue	55 million
Placement shares issued (Tranche 1)	12.5 million
Placement shares issued (Tranche 2)	7.65 million
Pro-forma Shares on Issue	75.15 million
Pro-forma Cash[1]	$36.6 million
Pro-forma Enterprise Value (EV)[2]	$75.7 million

1. Cash as at 31 March 2020 - $10.4 million; 2. Assumes share price of $1.495

Use of Funds

- Seeking to raise $26.2 million in a two tranche share placement

$26.2 million	
Completion of Presendin™ pre-Phase III development	$1.3 million
Presendin™ Phase III registration study in IIH	$16.0 million
Drug manufacture and supply for Phase III & commercialisation	$3.5 million
Clinical development second indication	$3.9 million
Offer Costs / Other	$1.5 million
TOTAL	$26.2 million

Timetable*

Event	Date
Trading Halt	Monday 18 May 2020
ASX Announcement – Clinical Trial results	Wednesday 20 May 2020
Placement Bookbuild Commences	Wednesday 20 May 2020
Allocations and Signed Acceptances	Thursday 21 May 2020
ASX Announcement – Placement, Investor Presentation, Trading Halt Lifted	Friday 22 May 2020
Settlement of Tranche 1 Placement Shares	Wednesday 27 May 2020
Allotment of Tranche 1 Placement Shares on ASX	Thursday 28 May 2020
Extraordinary General Meeting (EGM) to Approve Tranche 2 Placement	On or around 29 June 2020
Settlement of Tranche 2 Placement Shares	On or around 2 July 2020
Allotment of Tranche 2 Placement Shares on ASX	On or around 3 July 2020

* Timetable is indicative and subject to change

Reformulation & Regulatory Update

✓ Patent applications on the new formulation of Exenatide (Presendin™) filed in March 2020

✓ Pharmacokinetic (PK) evidence obtained in mouse models has shown that Invex's novel proprietary formulation (Presendin™) provides the targeted PK – i.e. immediate onset with a Cmax below that of Byetta combined with delayed release over 24 hours

- Confirmatory second animal (rat) pharmacokinetic (PK) study results of Exenatide re-formulations expected by end 2Q CY2020
- Complete animal (rat) tolerability study for Presendin™ in 4Q 2020
- PK study in up to 30 healthy (but overweight) volunteers, utilising 1x daily sub cutaneous (s.c.) injection of Presendin™ and 48 hour monitoring under negotiation with qualified CROs - study commencing in 4Q CY2020 (data reported 1Q 2021)
- Contract manufacturers for supply of Exenatide and formulation of Presendin™ for the human PK study, Phase III trial and commercial supply expected to be in place during 3Q CY2020
- Phase III design submitted to US FDA and EMA for feedback on overall design, endpoints, statistical plan, etc
  - Based on Phase II data, Invex has the option to use either Monthly Headache Days or a Visual Acuity
  - Final design lock 3Q 2020
  - Company on track to commence the study in the 1H CY2021

Likely Second Orphan Indication: IIH-WOP

- Idiopathic Intracranial Hypertension (IIH) – Without Papilloedema (WOP)
- Rare sub-population of IIH patients, representing **5.7%** of IIH patients[1]
- **1,225** patients in the EU/USA, representing a TAM of **A$95 million** per annum
- Invex to initiate Phase II clinical trial in 1H 2021 using Presendin™
- Optimum development pathway under investigation
- This second orphan indication offers additional value creation from a portfolio of clinical assets for prospective third-party acquirers

1. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4326261/

Summary

- Large, growing market for IIH with **no approved (regulatory cleared) or efficacious drug-based interventions**
- **Orphan Drug Designation in the USA and EU** provides expedited, cost-effective clinical trial recruitment, reporting and approval/registration as well as commercial exclusivity for up to 10 years
- Strong Phase II clinical data
- Capital raise to fully fund Phase III clinical trial for Presendin™ through to top-line results in **2H 2023**
- Plan to initiate Phase II clinical trial in IIH-WOP with Presendin™ in **1H 2021**
- Transaction for entire Company preferred as value creation event for shareholders, versus licensing or partnering

Contacts

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- meets the investment activity criteria specified in clause 38 of Schedule 1 of the FMC Act;
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- is a government agency within the meaning of clause 40 of Schedule 1 of the FMC Act; or
- is an eligible investor within the meaning of clause 41 of Schedule 1 of the FMC Act.

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Company Overview

Company snapshot

Company	
Repurposed Proven Drug	Presendin™ (Exenatide)
Clinical Stage	Phase II
Orphan Disease Focus	IIH^ + Other
Orphan Designation Granted	USA + EU
Development Path	Single Phase III for regulatory clearance
Total Addressable Market	~$1.6 billion annually
Valuation Drivers	Clinical, regulatory, patent

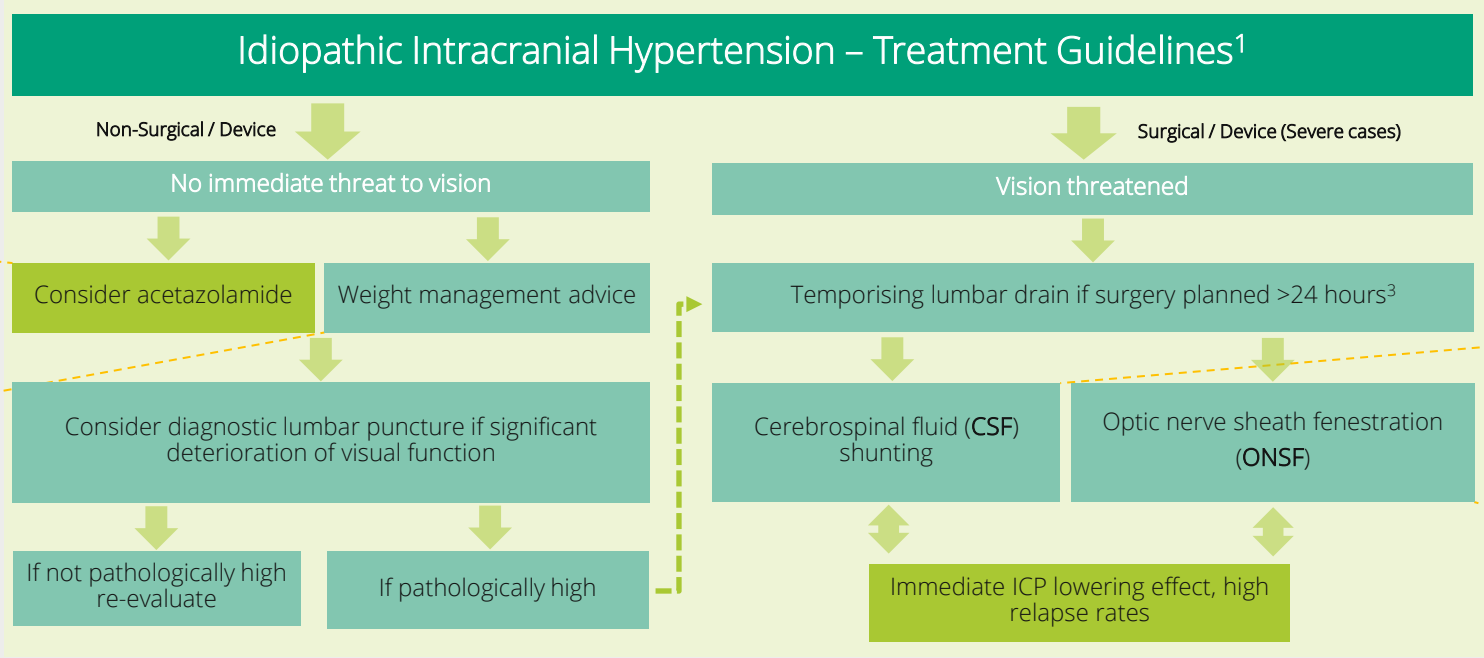
Capital Structure (Pre Placement)	
Shares on Issue	55.0 million
Unlisted Options	3.51 million
Cash (31 Mar-20)	$10.4 million
Market Cap (as at 15 May-20)	$82.2 million

Major Shareholders	
Directors / Management	20%
Minderoo Group	9.1%
JK Nominees Pty Ltd	7.3%
Tisia Nominees Pty Ltd	7.2%
Oaktone Nominees	6.3%
University of Birmingham	3.6%
Top 20 Shareholders	**73%**

Board of Directors	
Dr Jason Loveridge	Chairman
Professor Alexandra Sinclair	Executive Director & Chief Scientific Officer
Mr David McAuliffe	Non-Executive Director
Ms Narelle Warren	Non-Executive Director, CFO & Co. Sec.

^IIH – Idiopathic Intracranial Hypertension

Current treatments for IIH are limited



Presendin™ target markets

1. Mollan SP, et al. Idiopathic intracranial hypertension: consensus guidelines on management (2018); 2. Ball et al., A randomised controlled trial of treatment for IIH (2011), Wall et al, The IIH treatment trial: clinical profile as baseline (2014); 3. Thurtell et al., IIH recognition, treatment and ongoing management (2013); 4. Sergott et al., Optic nerve sheath decompression: a clinical review..(1990); Banta and Farris, Pseudotumor cerebi and optic nerve sheath decompression (2000); 5. Li et al., Meta-analysis: pharmacologic treatment of obesity (2005), Ko et al., Weight gain and recurrence in idiopathic intracranial hypertension (2011)

Total addressable market (TAM) – expected to grow

3.4% Estimated growth in incidence per annum[5]

55,000 Estimated annual incidence in 2030

>A$2.3bn Implied TAM in 2030

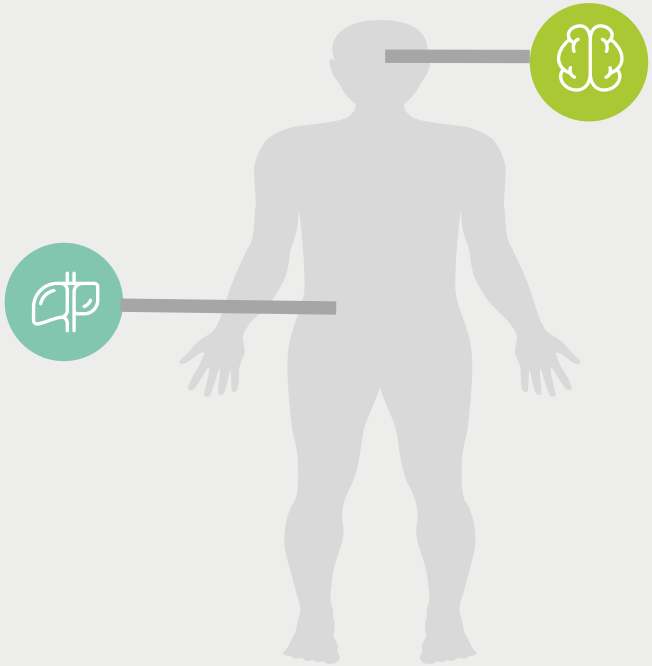
1. Mollan et al., The expanding burden of idiopathic intracranial hypertension (2019) incidence rate of 4.7/100,000 general population, n =23,182 . Targets markets are EU 27(& UK) + USA
2. Mollan SP, et al. Idiopathic intracranial hypertension: consensus guidelines on management (2018) ; Invex estimate re % presenting headache severity
3 Simoens et al., "what price do we pay for repurposing drugs for rare diseases"? (2016) – avge 66x & Invex initial pricing analysis => pricing subject to change
4. D. Friesner et al., Idiopathic intracranial hypertension in the USA: the role of obesity in establishing prevalence and healthcare costs (2010)
5. Assumes average of obesity growth rates in UK (https://www.oecd.org/els/health-systems/Obesity-Update-2017.pdf) and historical incidence growth rate

Repurposing Exenatide for IIH

- Exenatide was approved in 2005 in the US & 2006 in the EU for the treatment of Type II diabetes]
- Currently marketed by AstraZeneca in two dosage formulations
- In its Byetta® form Exenatide is administered as a twice-daily, sub-cutaneous injection or as Bydureon®, as a once weekly injection
- Exenatide is well tolerated and considered a standard of care in Type II diabetic patients
- Invex has a robust, proprietary, patented position covering the use of Exenatide for IIH

Exenatide - Diabetes

- Small peptide that binds to the GLP-1 receptor
- GLP-1 receptor agonists, like Exenatide, decrease fluid secretion in the kidney and are used extensively to treat diabetes
- Byetta® CY19 sales of **US$110m,** Bydureon® CY19 sales of **US$549m**[1]
- Current formulations provide an exposure that is either too short or too long to effectively treat IIH



Exenatide - IIH

- Invex has demonstrated GLP-1 receptors are expressed in the choroid plexus region of the brain and that in animal models:
  - Exenatide can bind to these receptors
  - Provides fast onset of action (within 60 mins)
  - 50% reduction in ICP over 6 days in animal models
  - Reduce cerebrospinal fluid secretion (CFS)
- Current Phase II examining efficacy in IIH patients

Reduced CFS secretion reduces ICP and has the potential to alleviate severe headache and visual impairment caused by raised ICP in IIH patients

1. https://www.astrazeneca.com/content/dam/az/PDF/2019/full-year/Full-year_and_Q4_2019_results_announcement.pdf

Exenatide reformulation strategy

Exenatide @ current diabetic dose[1] tested in Phase II to demonstrate proof of concept in IIH patients

Current dose not optimal to treat IIH

Current formulations have either insufficient half life[2] or too slow onset[3] & are intolerable at higher doses for effective use in IIH patients

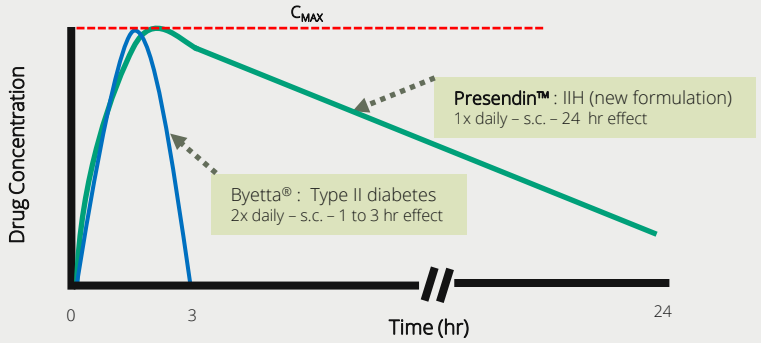
Invex is developing a novel, patented once daily s.c. formulation of Exenatide

Risk for off label use of Byetta® or Bydureon® is minimal as no correct dosage available & safety issues associated with either under or overdosing

[1] 10mg pre-filled injection pens, [2] Byetta [3] Bydureon

Reformulation – Clinical and regulatory requirements

- Ex-AstraZeneca's Exenatide formulation team engaged to help work on Presendin™ repurposing
- Pharmacokinetic (PK) evidence obtained in mouse models has shown that Invex's novel 24 hour proprietary formulation of Exenatide (i.e. Presendin™) provides both immediate onset and delayed release (see chart below[1]) of Exenatide, consistent with Invex's re-formulation strategy for Exenatide
- A second animal (rat) PK & local tolerability study is required to confirm the local safety and PK of Presendin™
- A final PK study in ~20 healthy volunteers, utilising 1x daily sub cutaneous (s.c.) injection of Presendin™ and 48 hour monitoring to be performed
  - Confirm the PK profile of Presendin™ established in animal models
  - Demonstrate in man that the PK profile of Presendin™ is within the already established safety profile of Byetta®
- Patent applications for novel Presendin™ formulation are in process
- Formulation excipients are confidential, but are commonly used, safe and already known to and cleared by regulators in the USA and Europe
- Commercial manufacture of Exenatide is already well established
- Manufacture of final formulation (at commercial scale) likely to be straightforward
- Target gross margins estimated at ~90%



[1] *Illustrative, not actual data*

How the Phase II Achieves Sufficient Statistical Power to Observe an Effect on ICP

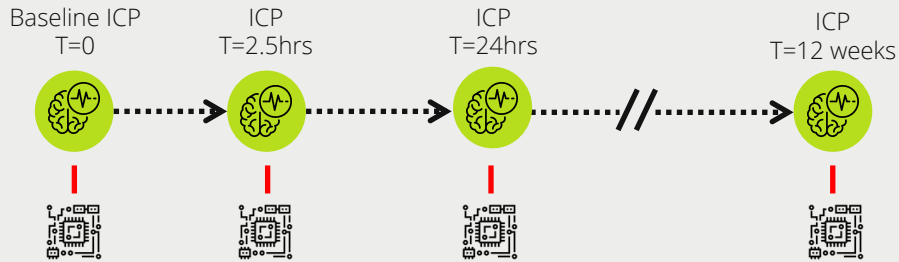
Surgically implanted Telemetric Intracranial Pressure Monitor

IIH Patient

ICP VARIABILITY CONTROLLED

- ICP varies throughout the day in tandem with posture and other variables
- ICP has not been studied in an IIH population before: utilisation of continuous ICP monitoring allows this for the **first time**
- Normal variation in ICP in study population analysed by monitoring ICP over a continuous period whilst patients undertook normal daily activities
- Additional short monitoring programme following changes in posture over 24 hours both before the baseline of the study and during the study period

- IIH patients enrolled with >25cm H_2O (>19mm Hg) ICP [as per IIH diagnostic criteria]
- Normal range: 7.5–20cm H_2O (5-15 mm Hg) in supine position
- Statistically significant reduction in ICP will be achieved with >10% change from baseline ICP



- **Continuous ICP measurements @5Hz over 30 mins at each time point**
- ICP value per patient is the mean of **9,000** individual pressure measurements
- Each patient provides **>36,000** individual data points to investigators over study period
- Highly accurate, low variation = **fewer patients required to achieve statistical power**

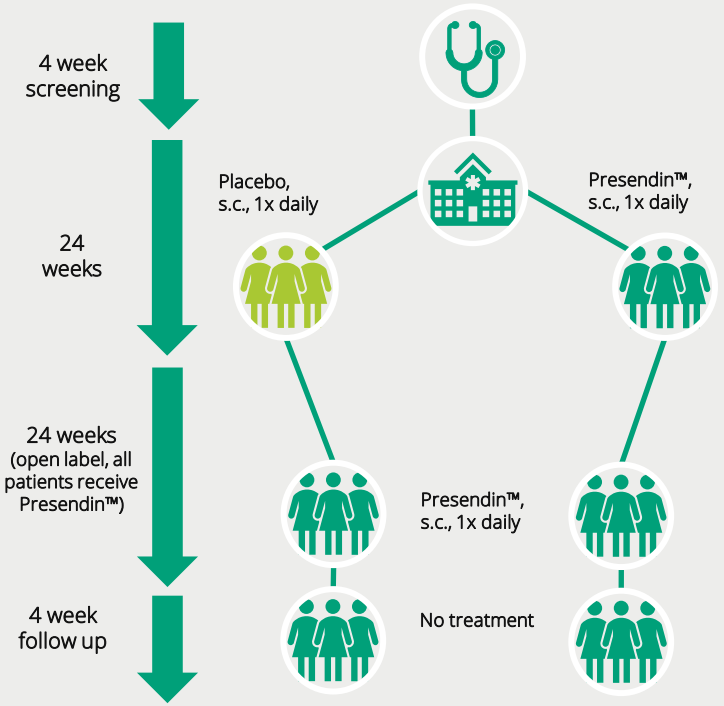
Benefits of orphan drug designation

Orphan Drug Designation granted in 2017 by EMA (EU) & FDA (USA)	Designation granted for treating rare diseases: <200k patients in USA, < 5/10,000 in the EU[1]
Single pivotal Phase III registration study required for approval	High patient need will facilitate rapid recruitment
7 years (USA) & 10 years (EU) marketing exclusivity[1]	Exclusivity in IIH for Exenatide represents a significant barrier to entry for off-label use of Byetta® and Bydureon®
Price premium for orphan drugs, greater market access (reimbursement)	Pricing on average increases 66x repurposing drugs from common disease to treating a rare (orphan) disease[2] – Invex initial pricing estimate conservatively presented Unmet need often drives closer alignment between KOLs and patient groups; reducing payer influence[3]
Tax incentives, filing fee waivers & greater regulator access[1]	Tax credits of up to 50% of clinical development costs Waive the ~US $2.9 million Prescription Drug User Fee Act (PDUFA) application fee paid prior to regulatory review

1. https://rarediseases.info.nih.gov/files/fda%20orphan%20drugs.pdf ; https://www.ema.europa.eu/en/human-regulatory/research-development/orphan-designation/orphan-incentives / overview
2. Simoens et al., "what price do we pay for repurposing drugs for rare diseases"? (2016)
3. Ware et al, US Market Access: How Does It Differ for Orphan and Rare Disease States? (2015)

Indicative Phase III design[1]

Randomised double blinded placebo controlled multi-centre clinical study



Criteria

- >18 years old
- Sig. raised ICP & confirmed IIH diagnosis by Updated Modified Dandy criteria
- No previous surgery for IIH (ONSF, CSF shunts)
- 1:1 randomisation
- ~250 patients
- Interim analysis at 6 month follow up once 50% patients treated (not assessing efficacy)

World class Medical Advisory Board established by Invex to provide input on trial design as well as regulatory and reimbursement requirements

Probable Primary endpoints

90% statistical power to detect an effect

Headache[2]: Monthly headache days

OR

Probable Secondary endpoints

80% statistical power to detect an effect

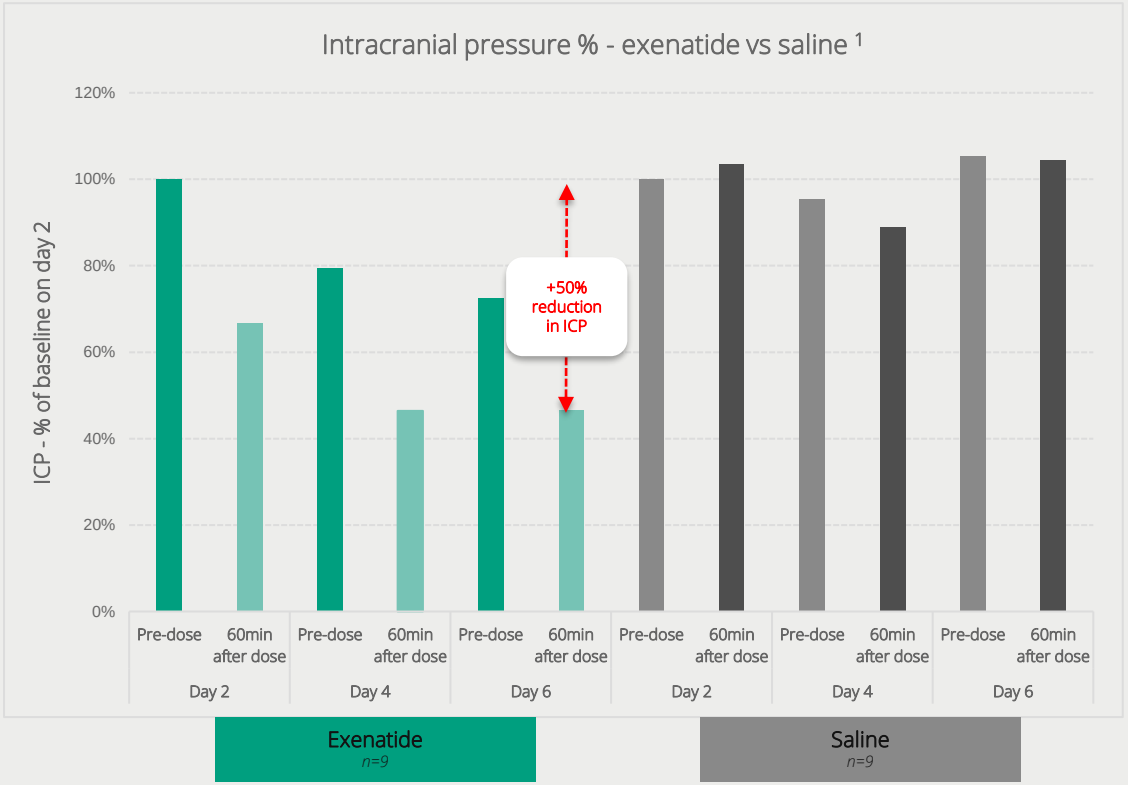
Change in Perimetric Mean Deviation (PMD)[3] at week 24

Visual Acuity, Optic Nerve Head magnitude, VFQ-25

Adverse events, weight, Quality of Life measures, HIT-6

1. Subject to final design considerations and regulatory clearance to commence a study
2. Headache causes major morbidity in almost all patients with IIH
3. PMD gives an overall value of the total amount of visual field loss, with normal values typically within 0 decibels dB to -2dB. The MD value becomes more negative as the overall field worsens. For the Presendin™ clinical trial, the inclusion criteria requires patients with confirmed PMD of -7.0 to -2.0 decibels (db)

Invex scientific data validates approach for IIH



- *Treatment was given daily for 5 days, and ICP was recorded on days 2, 4, and 6, before and after the rats received a subcutaneous (SC) injection of either saline (n = 9) or exendin-4 (20 µg/kg) (n = 9)*
- *Demonstrated +50% reduction in intracranial pressure compared to control*
- *Data published in leading journal - Botfield et al., Sci. Transl. Med. 9 (2017)*

Science Translational Medicine

1. Hannah F. Botfield et al., Sci Transl Med (2017)