Innovating Women’s Reproductive Health and Pregnancy Therapeutics
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FOCUSED ON UNMET NEEDS IN WOMEN’S HEALTH

LINZAGOLIX
Potential to relieve symptoms from heavy menstrual bleeding due to uterine fibroids and pain associated with endometriosis

OBE022
Potential to delay preterm birth to improve newborn health and reduce medical costs

NOLASIBAN
Potential to improve live birth rate following IVF & ET (repositioning)
**MULTIPLE LATE-STAGE PROGRAMS TO DRIVE VALUE**

<table>
<thead>
<tr>
<th>PHASE 1</th>
<th>PHASE 2</th>
<th>PHASE 3</th>
<th>MARKET SIZE</th>
<th>MILESTONES</th>
</tr>
</thead>
</table>
| **LINZAGOLIX** (OBE2109)  
Oral GnRH receptor antagonist | | | ~4M women diagnosed and treated in U.S. | Positive 24W primary endpoint results  
24W primary endpoint data Q2:20  
MAA/NDA: Q4:20 / Q1:21 |
| Uterine Fibroids – Ph3 PRIMROSE 2 EU & U.S. * | | | | |
| Uterine Fibroids – Ph3 PRIMROSE 1 U.S. | | | | |
| Endometriosis – Ph3 EDELWEISS 2 U.S. | | | ~5M women diagnosed and treated in U.S. | Initiated Ph3 in Q2:19  
Positive Phase 2b results in 2018/19 |
| Endometriosis – Ph3 EDELWEISS 3 EU & U.S. | | | | |
| Endometriosis – Ph2b EDELWEISS | | | | |
| **OBE022**  
Oral PGF$_2$α receptor antagonist | Preterm Labor – Ph2a PROLONG * | | 500,000 annual cases in each of U.S and Europe | Interim update in 60 patients Q1:20  
Pre-clinical/Phase 1 complete |
| | Preterm Labor – Ph1 | | | |
| **NOLASIBAN**  
Oral oxytocin receptor antagonist | IVF – Ph3 IMPLANT 2/4 EU | | Resuming development  
> 2M IVF Global cycles/year | Positive IMPLANT 2 Ph3 Results  
IMPLANT 4 Ph3 missed primary endpoint  
Partnership with Yuyuan BioScience Technology (PRC) |
| | IVF – Ph 1/2 in China | | | |

* Primary and secondary endpoints met
Multiple value driving catalysts in the upcoming year

- Two ongoing Phase 3 linzagolix trials in uterine fibroids to generate additional data starting in Q2:20
- First linzagolix regulatory filing in uterine fibroids planned for late 2020
- Phase 2 results of OBE022 expected in 2H:20
- Corporate objective to establish commercial partnerships for Linzagolix that maximize compound value and prudently manage cash investments
- Resuming Nolasiban in IVF – YUYUAN Ltd (CHINA) partnership – aiming at assessing higher and longer exposure to nolasiban around embryo transfer in a potentially “enriched” IVF population
Linzagolix (OBE2109)

Optimizing Approach for Reducing Estrogen to Treat Uterine Fibroids and Endometriosis
LINZAGOLIX: DOSE-DEPENDENT REDUCTION OF ESTROGEN TO TREAT UTERINE FIBROIDS & ENDOMETRIOSIS

Validated MoA: Inhibition of endogenous GnRH signaling

- Linzagolix binds competitively to pituitary gland GnRH receptors
- Prevents receptor activation by endogenous GnRH
  - Induces neither downregulation nor desensitization of the receptors
- Immediate onset of action leads to rapid, dose-dependent suppression of gonadotropins, LH and FSH
- Gonadotropin suppression leads to a dose-dependent decrease in blood estradiol concentration
# LINZAGOLIX: PK PROFILE

<table>
<thead>
<tr>
<th>Dose options</th>
<th>Linzagolix</th>
<th>Orilissa (Elagolix)</th>
<th>Relugolix</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Endometriosis</strong></td>
<td>75 mg</td>
<td>150 mg</td>
<td>40 mg with ABT</td>
</tr>
<tr>
<td></td>
<td>200 mg with ABT</td>
<td>400 mg (200 BID) with ABT</td>
<td></td>
</tr>
<tr>
<td><strong>Uterine Fibroids</strong></td>
<td>100 mg</td>
<td>600 mg (300 BID) with ABT</td>
<td>40 mg with ABT</td>
</tr>
<tr>
<td></td>
<td>200 mg with ABT</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Dosing frequency / day</strong></td>
<td>1 x</td>
<td>1x or 2x</td>
<td>1x</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PK Characteristics</th>
<th>Linzagolix</th>
<th>Orilissa (Elagolix)</th>
<th>Relugolix</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Half-Life</strong></td>
<td>14-15 hours</td>
<td>2-6 hours</td>
<td>37-42 hours</td>
</tr>
<tr>
<td><strong>Bioavailability</strong></td>
<td>&gt; 80%</td>
<td>30 – 50%</td>
<td>11%</td>
</tr>
<tr>
<td><strong>Hepatic Elimination</strong></td>
<td>Moderate</td>
<td>Major</td>
<td>Major</td>
</tr>
<tr>
<td><strong>Food Effect</strong></td>
<td>No</td>
<td>No*</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>CYP3A4 induction (ABT, contraception)</strong></td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Note: The data on this page are not from head-to-head comparisons.

* In a dedicated food effect study using a single 200 mg dose, there was a decrease of 24% and 36% in AUC and Cmax, respectively, under high-fat meal conditions; however, labelling states elagolix can be taken without regard to meals.
UTERINE FIBROIDS: A LARGE MARKET WITH UNMET NEED

Total U.S. costs estimated at up to $34B/yr from direct costs, lost workdays and complications

9 million women in the U.S. suffer from fibroids

70%+ of women have fibroids by age 50

Quality of Life

Premenopausal women may experience heavy menstrual bleeding, anemia, bloating, infertility, pain and swelling

600,000 Hysterectomies are performed annually in the U.S.

300,000 Are because of uterine fibroids

> 4 million women in the U.S. are treated annually for fibroids
MARKET FEEDBACK
WHAT MATTERS FOR UTERINE FIBROIDS PATIENTS?

Method Discreet choice modeling based on the responses of 101 U.S. patients with symptomatic uterine fibroids

Rank ordered perceived incremental value of the tested component levels in UF patients choice

Utility values are calculated for each attribute level to express their perceived relative value for patients when choosing the UF treatment they would prefer to receive instead of the current/latest one

The ‘full package’ is required to win
ABT matters for women

Source: AplusA US patient research (n = 101), Oct-Dec 2019
The trial was powered under the assumption of a 30% placebo response rate based on historical studies.

### PRIMROSE 1 & 2: PHASE 3 CLINICAL TRIALS FOR THE TREATMENT OF UTERINE FIBROIDS

<table>
<thead>
<tr>
<th><strong>Main Study (N=500, 100/arm)</strong></th>
<th><strong>Primary Endpoint:</strong> Responder-HMB Reduction Q4:19/Q2:20</th>
<th><strong>Follow up</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Screening</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Placebo + placebo add-back</td>
<td>Placebo + placebo add-back</td>
<td></td>
</tr>
<tr>
<td>100 mg + placebo add-back</td>
<td>200mg + add-back</td>
<td>Follow-up</td>
</tr>
<tr>
<td>100 mg + add-back</td>
<td>100 mg + placebo add-back</td>
<td></td>
</tr>
<tr>
<td>200 mg + placebo add-back</td>
<td>200 mg + placebo add-back</td>
<td></td>
</tr>
<tr>
<td>200 mg + add-back</td>
<td>200 mg + add-back</td>
<td></td>
</tr>
</tbody>
</table>

**PRIMROSE 1**
100% U.S. sites

**PRIMROSE 2**
70% European sites
30% U.S. sites

- Aiming to support the registration of two regimens of administration
### PRIMROSE 2: DEMOGRAPHIC AND BASELINE CHARACTERISTICS

<table>
<thead>
<tr>
<th></th>
<th>Placebo</th>
<th>Linzagolix 100 mg</th>
<th>Linzagolix 100 mg + ABT</th>
<th>Linzagolix 200 mg</th>
<th>Linzagolix 200 mg + ABT</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Analysis Set n=102</td>
<td>n=97</td>
<td>n=101</td>
<td>n=103</td>
<td>n=98</td>
<td>n=501</td>
<td></td>
</tr>
<tr>
<td>Age (years) - mean (SD)</td>
<td>42.9 (5.3)</td>
<td>43.4 (5.4)</td>
<td>42.5 (5.1)</td>
<td>42.7 (5.8)</td>
<td>43.1 (4.8)</td>
<td>42.9 (5.3)</td>
</tr>
<tr>
<td>BMI (kg/m²) - mean (SD)</td>
<td>26.83 (5.42)</td>
<td>27.44 (5.67)</td>
<td>27.22 (5.82)</td>
<td>26.82 (5.55)</td>
<td>26.80 (5.47)</td>
<td>27.02 (5.57)</td>
</tr>
<tr>
<td>Hb &lt; 10 g/dL – n(%)</td>
<td>14 (13.7)</td>
<td>21 (21.6)</td>
<td>16 (15.8)</td>
<td>18 (17.5)</td>
<td>24 (24.5)</td>
<td>93 (18.6)</td>
</tr>
<tr>
<td>Hb &lt; 12 g/dL – n(%)*</td>
<td>51 (50.0)</td>
<td>61 (62.9)</td>
<td>59 (58.4)</td>
<td>57 (55.3)</td>
<td>56 (57.1)</td>
<td>284 (56.7)</td>
</tr>
<tr>
<td>MBL** (mL) at baseline mean (SD)</td>
<td>218 (128)</td>
<td>246 (161)</td>
<td>193 (92)</td>
<td>219 (136)</td>
<td>212 (142)</td>
<td>218 (134)</td>
</tr>
<tr>
<td>95% Caucasian / 5% Black</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Anemia – hemoglobin value is less than less than 12.0 g/dL
** MBL: Menstrual Blood Loss
### PRIMROSE 2 PHASE 3 – UTERINE FIBROIDS

**DOSE-DEPENDENT SUPPRESSION OF E2**

<table>
<thead>
<tr>
<th>Group</th>
<th>Median Serum E2 pg/mL</th>
<th>Weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placebo</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Linzagolix 100 mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Linzagolix 100 mg + ABT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Linzagolix 200 mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Linzagolix 200 mg + ABT</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### E2 Target Range

E2 range: symptom relief without BMD harm

**E2 Target Range**
PRIMROSE 2 – PRIMARY ENDPOINT ACHIEVED FOR BOTH TARGET DOSING REGIMENS – RESPONDER* ANALYSIS

* Proportion of women with menstrual blood loss ≤ 80 mL (by alkaline hematin method) and ≥ 50% reduction from baseline
# KEY SECONDARY ENDPOINTS ACHIEVED

<table>
<thead>
<tr>
<th>Key Secondary Endpoints</th>
<th>Measurement</th>
<th>p-value</th>
</tr>
</thead>
</table>
| Reduction in menstrual blood loss | • Time to reduced menstrual blood loss (i.e., ≤80 mL and ≥50% reduction from baseline) up to Week 24  
  • Number of days of uterine bleeding for the last 28-day interval prior to Week 24 | p < 0.001     |
| Amenorrhea              | • Percentage at Week 24  
  • Time to amenorrhea up to Week 24                                           | p < 0.001     |
| Improvement in anemia   | • Hemoglobin level at week 24 in anemic subjects (defined as subjects with Hb < 12 g/dL at baseline) | p < 0.001     |
| Reduction in pain       | • Change from baseline pain score at week 24                                 | p < 0.001     |
| Reduction in volume     | • Fibroid volume change from baseline at Week 24 for 100mg without ABT and 200mg with ABT  
  • Uterine volume change from baseline at Week 24                                | p < 0.055/0.008 |
| Improvement in quality of life | • Change from baseline health-related quality of life (UFS-QoL*) at Week 24 | p < 0.001     |

* UFS-QoL = Uterine Fibroids Symptoms and Health-Related Quality of Life questionnaire
PRIMROSE 2: SIGNIFICANT AMENORRHEA RESPONSE FOR BOTH TARGET DOSES

Note: Error bars are 95% CI
PRIMROSE 2: PAIN REDUCTION AND PATIENT SATISFACTION FOR BOTH TARGET DOSES

Note: Error bars are 95% CI; * p<0.001

Pain Reduction

Patient Global Impression of Improvement

<table>
<thead>
<tr>
<th>% SUBJECTS MUCH OR VERY MUCH IMPROVED</th>
<th>Placebo</th>
<th>Linzagolix 100mg</th>
<th>Linzagolix 100mg + ABT</th>
<th>Linzagolix 200mg</th>
<th>Linzagolix 200mg + ABT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>33.3</td>
<td>48.7</td>
<td>73.5</td>
<td>75.0</td>
<td>87.5</td>
</tr>
</tbody>
</table>

p=0.047 p<0.001 p<0.001 p<0.001

Note: Error bars are 95% CI, * p<0.001
**RECENT TRIALS OF GnRH ANTAGONISTS IN UTERINE FIBROIDS**

Caution advised when comparing across clinical trials. Below data are not head-to-head comparison, and no head-to-head trials have been completed, nor are underway.

<table>
<thead>
<tr>
<th></th>
<th>Linzagolix</th>
<th>Relugolix</th>
<th>Elagolix</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mean Age (y)</strong></td>
<td>43.1</td>
<td>41.3</td>
<td>42.6</td>
</tr>
<tr>
<td><strong>Baseline Menstrual Blood Loss (mL per cycle)</strong></td>
<td>212</td>
<td>229</td>
<td>238</td>
</tr>
<tr>
<td><strong>Dose Regimen</strong></td>
<td>200mg + ABT Once daily</td>
<td>40mg + ABT Once daily</td>
<td>300mg + ABT Twice daily</td>
</tr>
<tr>
<td><strong>Responder² Rate (RR) (%)</strong></td>
<td>93.9</td>
<td>73.4</td>
<td>68.5</td>
</tr>
<tr>
<td><strong>Placebo-adjusted RR (%)</strong></td>
<td>64.5</td>
<td>54.8</td>
<td>60.0</td>
</tr>
<tr>
<td><strong>Amenorrhea (%)</strong></td>
<td>80.6</td>
<td>52.3</td>
<td>48.1</td>
</tr>
<tr>
<td><strong>Placebo-adjusted RR (%)</strong></td>
<td>68.8</td>
<td>46.8</td>
<td>43.7</td>
</tr>
<tr>
<td><strong>Pain</strong></td>
<td>✓</td>
<td>✓</td>
<td>NR</td>
</tr>
<tr>
<td><strong>Fibroid Volume</strong></td>
<td>✓</td>
<td>✓</td>
<td>NR</td>
</tr>
<tr>
<td><strong>Uterine Volume</strong></td>
<td>✓</td>
<td>✓</td>
<td>NR</td>
</tr>
<tr>
<td><strong>Menstrual Blood Loss</strong></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Anemia</strong></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Quality of Life</strong></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>BMD Loss (% Spine)</strong></td>
<td>-1.31</td>
<td>-0.36</td>
<td>-0.76</td>
</tr>
</tbody>
</table>

Source: Company information – Note: NR = not reported.

² PRIMARY ENDPOINT: Proportion of women with menstrual blood loss ≤ 80 mL (by alkaline hematin method) and ≥ 50% reduction from baseline.
### SUMMARY OF ADVERSE EVENTS

<table>
<thead>
<tr>
<th>Treatment emergent adverse events, n (%)</th>
<th>Placebo</th>
<th>Linzagolix 100 mg</th>
<th>Linzagolix 100 mg + ABT</th>
<th>Linzagolix 200 mg</th>
<th>Linzagolix 200 mg + ABT</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n=105</td>
<td>n=99</td>
<td>n=102</td>
<td>n=104</td>
<td>n=101</td>
<td>n=511</td>
</tr>
<tr>
<td>Subjects with at least one TEAE</td>
<td>47 (44.8)</td>
<td>50 (50.5)</td>
<td>45 (44.1)</td>
<td>62 (59.6)</td>
<td>51 (50.5)</td>
<td>255 (49.9)</td>
</tr>
<tr>
<td>Vascular disorders*</td>
<td>6 (5.7)</td>
<td>15 (15.2)</td>
<td>12 (11.8)</td>
<td>36 (34.6)</td>
<td>14 (13.9)</td>
<td>83 (16.2)</td>
</tr>
</tbody>
</table>

* Vascular disorders include hot flushes, hypertension, flushing, varicose veins

- Most common TEAEs (>5%)
  - Hot flushes (13.9%)
  - Anemia (10.4%)
  - Headache (6.8%)
**PRIMROSE 2 BMD % CHANGE FROM BASELINE AT WEEK 24 CONSISTENT WITH INDICATIVE REFERENCES**

Patients in the trial received no vitamin D or calcium supplementation

**ELAGOLIX/MPA**

“The absence of significant bone loss was supported if the lower bounds of the CIs for the mean percentage change in BMD were $\geq -2.2\%$ for both the spine and femur at week 24, which was selected to reflect recommendations from the FDA (internal communication)”*

**ELAGOLIX NDA Review 2018**

“FDA considers BMD loss of $\leq 3\%$ to be within the variability of DXA measurement.”

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Literature supports relationship between BMD, RACE & BMI

Race is one of the most important determinants of BMD

- Blacks consistently reported to have higher BMD than other races\(^1,2\)
  - Unadjusted LS/FN BMDs \(7-12\%\) & \(14-24\%\) higher in black vs white women\(^6\)
- Caucasian race is a known risk factor for lower BMD and fracture\(^3,4,5\)

Body weight and body mass index (BMI) are positively correlated with BMD and protective against bone loss\(^7-15\)

- Low body weight or BMI is a risk factor for low bone mass and increased bone loss
- In some studies, weight more predictive than BMI

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\(^{1}\)Powe EC et al, NEJM 2013; 369(21); \(^{2}\)Looker AC et al, Osteoporos Int 2009; 20:1141–1149
PRIMROSE 2: BMD DATA INTERPRETATION (II)

Study populations not similar for risk of BMD loss

<table>
<thead>
<tr>
<th>Subjects (n)</th>
<th>PRIMROSE 2 – OVERALL POPULATION</th>
<th>PRIMROSE 2 US Only</th>
<th>PRIMROSE 1 US only</th>
<th>ELARIS-I (ELGX)</th>
<th>ELARIS-2 (ELGX)</th>
<th>LIBERTY 1 (RLGX)</th>
<th>LIBERTY 2 (RLGX)</th>
</tr>
</thead>
<tbody>
<tr>
<td>501</td>
<td>48</td>
<td>526</td>
<td>308</td>
<td>283</td>
<td>255</td>
<td>254</td>
<td></td>
</tr>
<tr>
<td>Black (%)</td>
<td>5.2%</td>
<td>52%</td>
<td>64.3%</td>
<td>68/66%</td>
<td>67/66%</td>
<td>42/41%</td>
<td>42/42%</td>
</tr>
<tr>
<td>Age (mean year/SD)</td>
<td>42.9 (5.3)</td>
<td>41.8 (5.6)</td>
<td>41.6 (5.9)</td>
<td>41/42</td>
<td>42/42</td>
<td>42/41</td>
<td>42/42</td>
</tr>
<tr>
<td>Height (mean cm/SD)</td>
<td>165.5 (6.1)</td>
<td>165.7 (6.8)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Weight (mean Kg/SD)</td>
<td>74.06 (15.90)</td>
<td>91.48 (19.78)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>BMI (mean /SD)</td>
<td>27.02 (5.57)</td>
<td>33.29 (6.95)</td>
<td>32.70 (6.84)</td>
<td>34/33</td>
<td>34/33</td>
<td>32/31</td>
<td>32/31</td>
</tr>
</tbody>
</table>

PRIMROSE 1 trial – read-out 24 weeks – 2Q:20
In the overall population in the PRIMROSE 2 trial, the non-ABT group, BMD loss inversely related to BMI
ENDOMETRIOSIS: AN EMOTIONALLY AND PHYSICALLY PAINFUL CONDITION

Total U.S. costs estimated at up to $22B/yr

176 million women worldwide suffer from endometriosis

60% of women will feel symptoms by age 16

Quality of Life
Premenopausal women may experience pelvic pain, pain during intercourse and defecation, infertility and emotional distress

Endometriosis affects up to
10% in the general population
50% in the infertile population
60% in patients with chronic pelvic pain

5 million women in the U.S. are treated annually for endometriosis
EDELWEISS PHASE 2B – ENDOMETRIOSIS: DOSE-DEPENDENT SUPPRESSION OF E2

E2 range: Symptom relief without BMD harm

Endometriosis Patients
Week 24 Modeled E2 Data

E2 concentration (pg/ml)

Linzagolix Daily Dose (mg) for 24 Weeks

(whiskers represent 10% / 90% percentile)

Target Range

E2 range: Symptom relief without BMD harm
PHASE 2B EDELWEISS CLINICAL TRIAL: ENDOMETRIOSIS PATIENTS

Enrollment 328 patients, ~65/arm
50 sites in U.S. (n=177)
14 sites in EU (n= 151)

**BMD**: Bone Mineral Density

* Titration after 12 weeks based on E2 serum level at weeks 4 and 8

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**MAIN STUDY**

**PRIMARY ENDPOINT:**
VRS Pain Score Responder Rate
JUNE 2018

**SECONDARY ENDPOINT:**
BMD**
SEPTEMBER 2018

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**PLACEBO**
- 50mg daily
- 75mg daily
- 100mg daily
- 200mg daily
- 75mg daily*

**50mg daily**
- 12 WEEKS

**75mg daily**
- 12 WEEKS

**100mg daily**
- 24 WEEKS

**200mg daily**
- 24 WEEKS

**75mg daily***
- 24 WEEKS

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**OPTIONAL EXTENSION:**
6M + 6M FOLLOW-UP

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* Titrated dose 50-100mg

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RESULTS:
1H 2019
LINZAGOLIX PHASE 2B ENDOMETRIOSIS: KEY DOSES MET EFFICACY ENDPOINTS

- Potential point of differentiation as 75mg partial suppression dose is nearly as effective as 200mg full suppression dose

* p value <0.05  ** p value <0.01  *** p value <0.001 for linzagolix doses compared to placebo
PHASE 2B EDELWEISS TRIAL
75mg EFFECTIVE WITHOUT SIGNIFICANTLY AFFECTING BMD

Mean % change in BMD from baseline to 24 weeks (12 weeks for placebo)

-1.6% lower bound CI for 75mg
-3.6% lower bound CI for 200mg

Error bars are 95% CIs

ABT: Add Back Therapy (estradiol + norethindrone acetate)
LINZAGOLIX PHASE 3 ENDOMETRIOSIS TRIALS: EDELWEISS 2 AND 3

MAIN STUDY

INITIATED 1H:19

PLACEBO
- 75mg daily
- 200mg daily + ABT

6 MONTHS TREATMENT

CO-PRIMARY ENDPOINT: DYS/ NMPP RESPONDER ANALYSIS

FOLLOW UP

75mg daily
- 200mg daily + ABT

6 MONTHS EXTENSION STUDY

FOLLOW-UP

LEAD-IN

11±5 WEEKS

6 MONTHS
LINZAGOLIX: A SIGNIFICANT OPPORTUNITY

LINZAGOLIX is the only GnRH antagonist intended to be developed as two different, SIMPLE & WELL TOLERATED regimens for both indications.

1. Large markets with significant unmet need in U.S.
   - ~ 4M treated for heavy menstrual bleeding resulting from uterine fibroids
   - ~ 5M treated for endometriosis associated pain

2. Potentially best-in-class GnRH antagonist
   - Best-in-class response for HMB control in uterine fibroids and pain control in endometriosis with full suppression option
   - Only option under development for women with uterine fibroids who cannot or do not want to take ABT in both indications
   - Convenient, oral, once-daily dosing

3. Significant revenue opportunity
   - IP protection beyond 2036
OBE022

POTENTIAL TO DELAY PRETERM BIRTH TO IMPROVE NEWBORN HEALTH AND REDUCE MEDICAL COSTS
Preterm delivery is a life-altering and costly condition. Preterm labor is the leading cause of death of children under 5 years of age, with more than 1 in 10 babies being born premature. In 2015, there were 1 million premature deaths in children under 5 years of age. Babies surviving early birth face a greater likelihood of lifelong disabilities. The economic burden of preterm delivery in the U.S. is tremendous, with costs for a preterm infant (U.S.) averaging $50K, $195K for a survivor born 24-26 weeks, $26B+ in economic burden, and $16.9B+ in U.S. Infant medical care costs.
MODE OF ACTION OF PGF$_{2\alpha}$ RECEPTOR ANTAGONIST TO CONTROL PRETERM LABOR

Phospholipids

Arachidonic Acid

PGHS-1/2 = COX1/2

PGH2

PGE2

EP1
EP3

EP2
EP4

PGF$_{2\alpha}$

FP

UTERUS: contract relax contract

Selectively blocks the PGF$_{2\alpha}$ receptor

Has the potential to treat preterm labor with improved safety over NSAIDs
OBE022: PROLONG PH2A STUDY PART B

Study design:
Double-blind, randomized Atosiban + OBE022 versus Atosiban + Placebo

Endpoint:
Complete 7 days of dosing without delivery

Dosing: 7 days up to 60 patients
Followed thru delivery

Interim Update 30 patients
Interim Update 60 patients

Main Study completion 120 patients

Final Part B: Main analysis

24-month Infant FU

Q1:18 2H:20 2H:22

IDMC Reviews
FINANCIAL OUTLOOK

SEPTEMBER 30, 2019 CASH:
$91 million

EXPECTED CASH RUNWAY:
Q1:21 with credit facility

2020 investment includes FOUR ONGOING Phase 3 trials:

PRIMROSE 1
PRIMROSE 2
EDELWEISS 2
EDELWEISS 3