Obseva

nature meets nurture

Focused on unmet needs in women's reproductive health

September 2021

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Investor highlights

1. Pursuing large indications for conditions that compromise **women's reproductive health and beyond**
2. Linzagolix has potential **best in class efficacy, favorable tolerability, and unique flexible dosing options**
3. Global licensing agreement with **Organon to develop and commercialize ebopiprant**, the only known product in development for preterm labor
4. Business model built on strong **global partnerships and collaborations**
5. Seasoned **leadership team** with a track record for success

Product overview

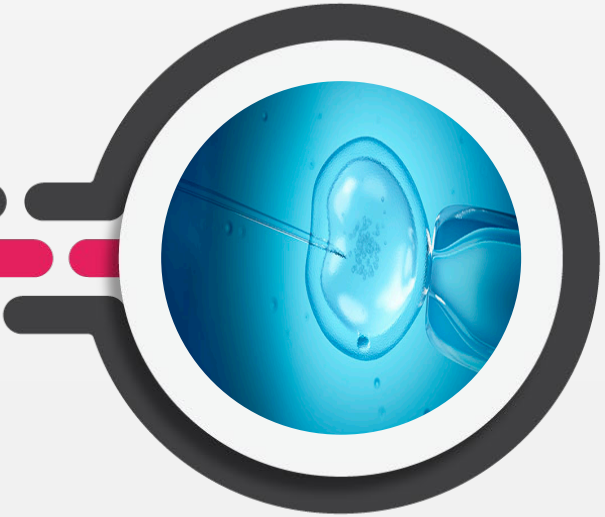
LINZAGOLIX

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

EBOPIPRANT

Potential to delay preterm birth to improve newborn health and reduce medical costs[1]

NOLASIBAN



Potential to improve live birth rate following IVF & embryo transfer

[1]The global development, manufacturing and commercial rights of ebopiprant are licensed to Organon

Multiple development programs drive value

	Phase 1	Phase 2	Phase 3	Next Milestones
LINZAGOLIX Oral GnRH receptor antagonist	Uterine Fibroids – Ph3 PRIMROSE 2 (EU & US) Uterine Fibroids – Ph3 PRIMROSE 1 (US)			NDA submission (Q3:21) MAA for uterine fibroids expected recommendation (Q4:21)
	Endometriosis – Ph3 EDELWEISS 3 (EU & US)			EDELWEISS 3: Completed enrollment with primary endpoint readout expected (Q4:21)
EBOPIPRANT Oral $PGF_{2\alpha}$ receptor antagonist	Preterm Labor – Ph2b (EU & Asia)			Global rights licensed to Organon
NOLASIBAN Oral oxytocin receptor antagonist	IVF – Ph1/2 (China)			Rights licensed to YuYuan Bioscience for development and commercialization in China

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yselty®
linzagolix

DESIGNED TO TREAT MORE WOMEN SUFFERING FROM UTERINE FIBROIDS

Yselty®, our proposed trade name for linzagolix, is conditionally acceptable for the FDA. Linzagolix has not been approved by FDA for any indication for use. Linzagolix is an investigational drug.

Uterine fibroids

A significant unmet need translating into a multibillion market

$34B/yr

total **US** costs from direct costs, lost workdays and complications

9 million

women in the **US** affected by 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 US

300,000

are because of uterine fibroids

>4 million

women in the **US** are treated annually for fibroids

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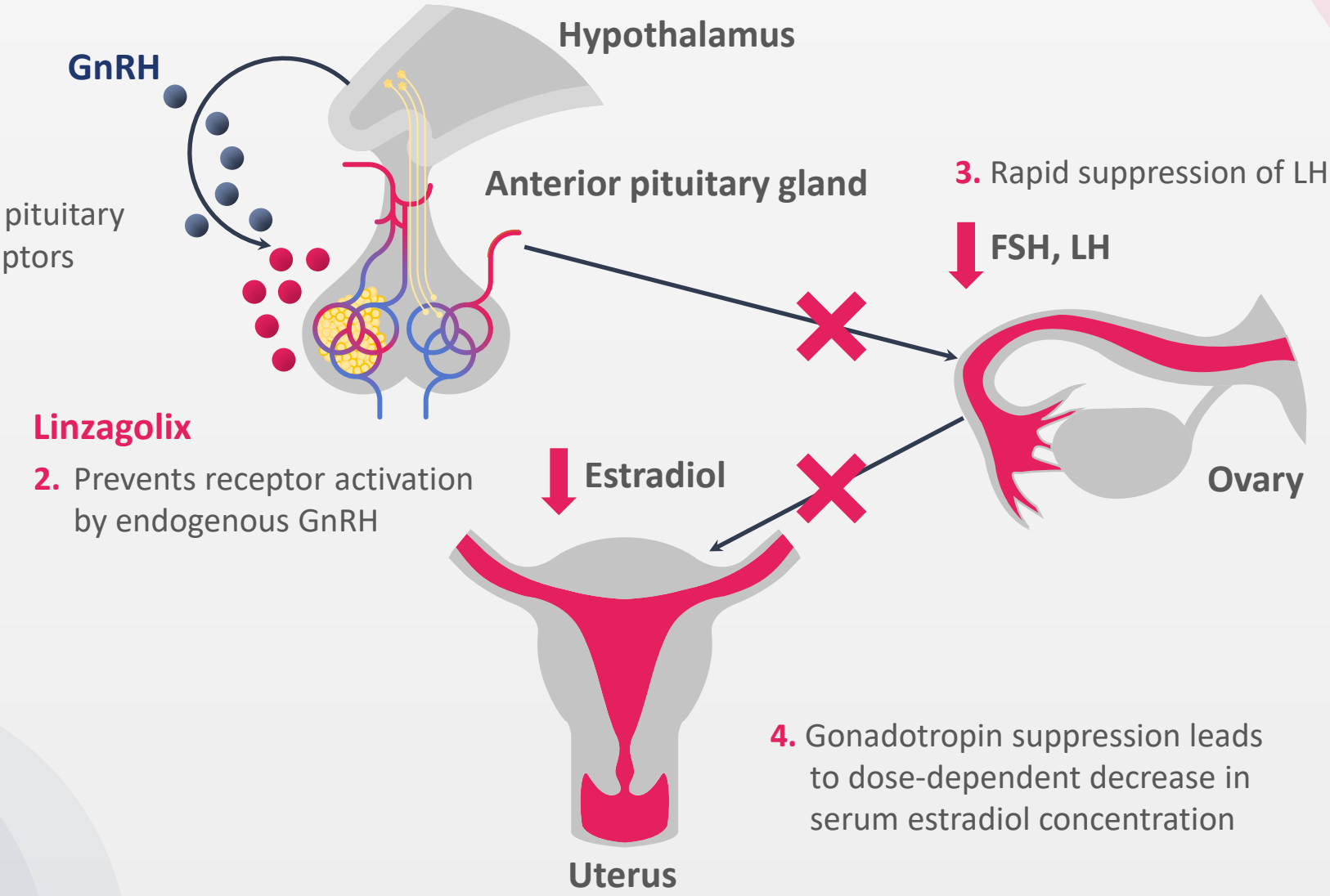
Cardozo et al., Am J Obstet Gynecol 2012; Stewart et al. NEJM, 2015; Flynn et al., Am J Obstet Gynecol 2006; Truven Health, Fibroid Foundation website; Epidemiology of women's health, Jones & Bartlett Learning, Ruby T. Senie, 2014

GnRH antagonist mechanism of action

1. Linzagolix binds competitively to pituitary gland GnRH receptors



2. Prevents receptor activation by endogenous GnRH

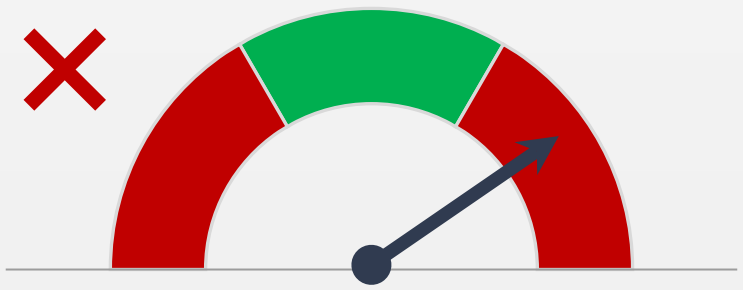
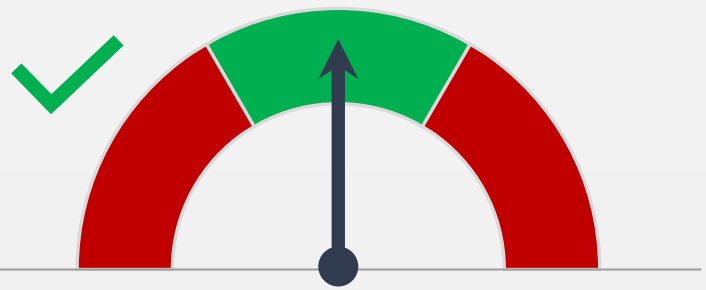
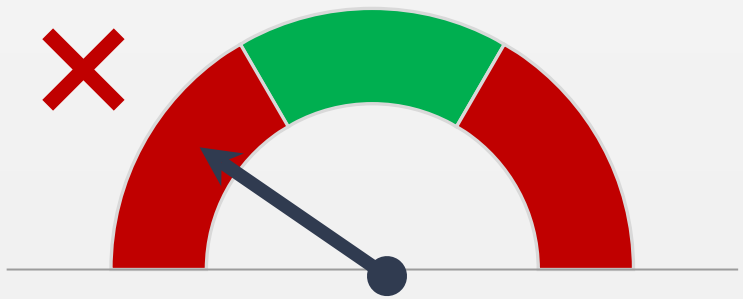
3. Rapid suppression of LH and FSH

4. Gonadotropin suppression leads to dose-dependent decrease in serum estradiol concentration

Promise of GnRH antagonists

Dose dependent reduction of estradiol (E2)

Women with symptoms of uterine fibroids

No estradiol suppression	Target estradiol	Full estradiol suppression
		
Disease Symptoms – Heavy menstrual bleeding/anemia – Abdominal/pelvic pain and pressure	**Outcomes** – Reduction in bleeding – Minimal to no impact on BMD	**Symptoms/Safety Concerns** – BMD loss – Hot flushes
	***ABT not required**	***ABT required for long term use (>6 months)**

*ABT: 1mg estradiol/0.5 mg norethisterone acetate

A potential new gold standard treatment for uterine fibroids

Differentiated PK/PD profile

1

Bioavailability > 80%

2

Half-life 14-15 hours

3

No CYP3A4 induction/food effect

Reliable absorption

Predictable exposure/effect with each dose

Optimal balance for dosing and effectiveness

- Convenient once-daily dosing that fits into women's busy lives
- Blood levels that last long enough to allow flexibility in dosing time

"No hassle" administration profile

- Can be taken with or without food
- No relevant interactions with hormonal add-back therapy, oral iron, calcium or other common medications

Uterine fibroids are ruining lives…

No two women are the same, but millions share a common problem: suffering the daily consequences of uterine fibroids

For long-term use for women for whom ABT is appropriate

Linzagolix 200 mg once daily with concomitant ABT

For long-term use for women with a contraindication to or who prefer to avoid ABT

Linzagolix 100 mg once daily without ABT

For short-term use (up to 6 months) when rapid reduction in fibroid and uterine volume is desired

Linzagolix 200 mg once daily without ABT

ABT-containing regimens may be contraindicated in up to 50% of US women with uterine fibroids based on the elagolix US label* and analysis of CDC data**

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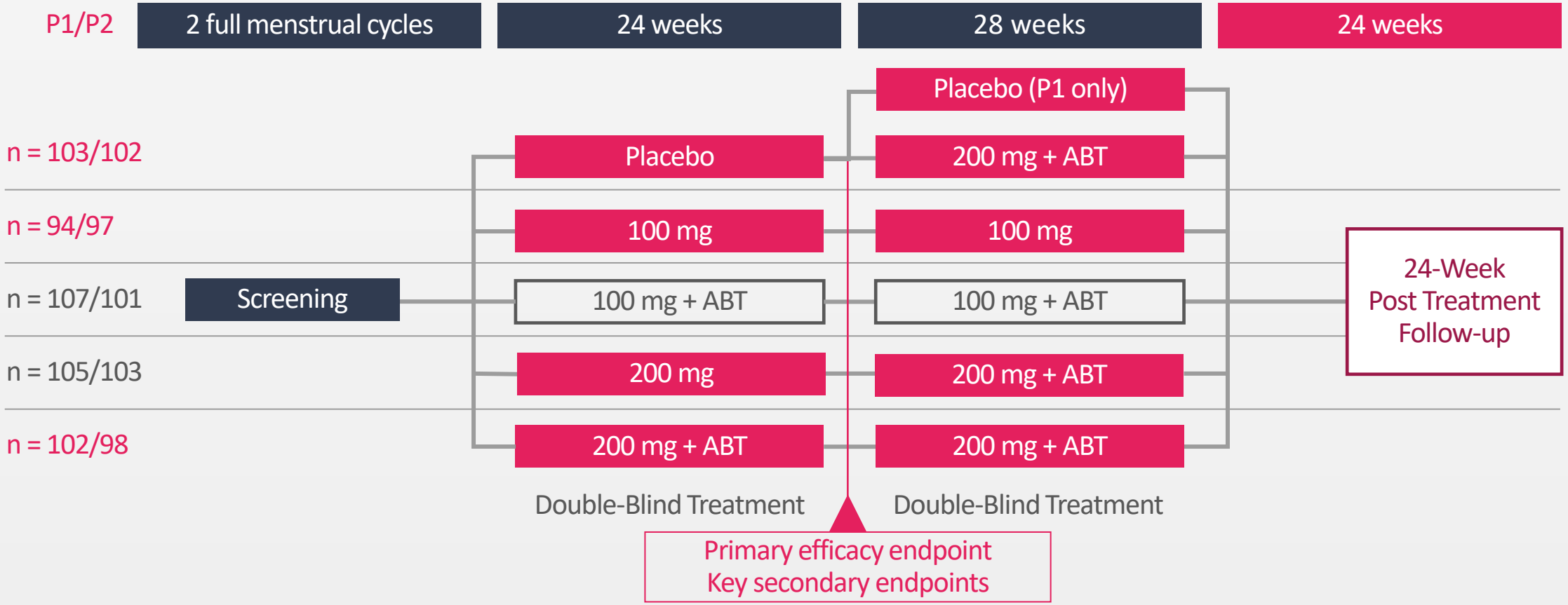
*US FDA elagolix PI, section 4. Contraindications and section 5.1. Warnings and precautions – thromboembolic disorders and vascular events

** Current Cigarette Smoking Among Adults in the United States. Centers for Disease Control and Prevention https://www.cdc.gov/tobacco/data_statistics/fact_sheets/adult_data/cig_smoking/index.htm#nation

The hypothetical patients represented on this slide are for illustrative purposes only as no strength of linzagolix has been approved nor is there FDA-approved Prescribing Information to guide clinical decisions

Phase 3 registration studies

PRIMROSE 1 (US) and PRIMROSE 2 (EU/US)



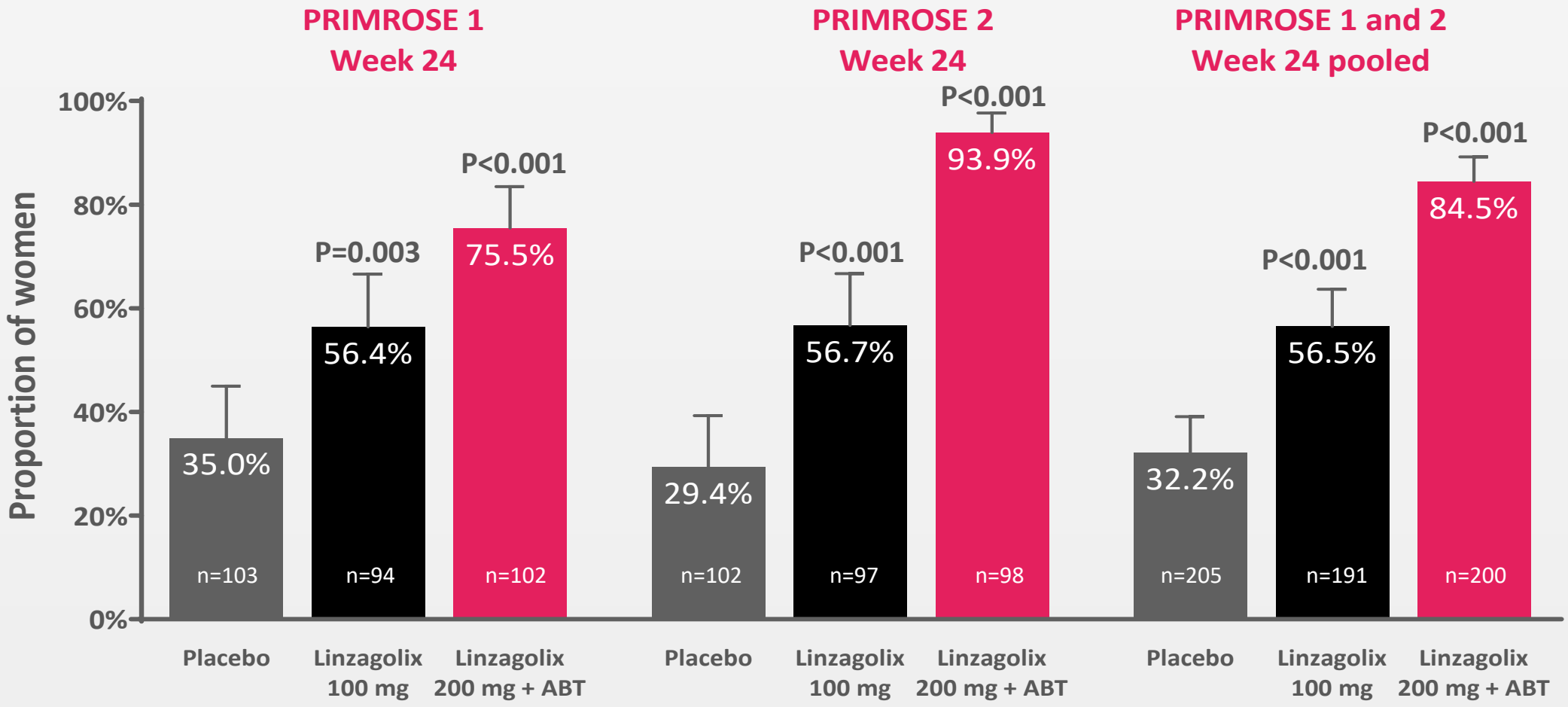
Primary efficacy endpoint: proportion of women with menstrual blood loss ≤ 80 mL (by alkaline hematin method) and ≥ 50% reduction from baseline

Patients in the studies received no Vitamin D or calcium supplementation

ABT = Add Back Therapy (1mg estradiol + 0.5 mg norethindrone acetate)

PRIMROSE 1 and 2 achieved primary endpoint for both doses

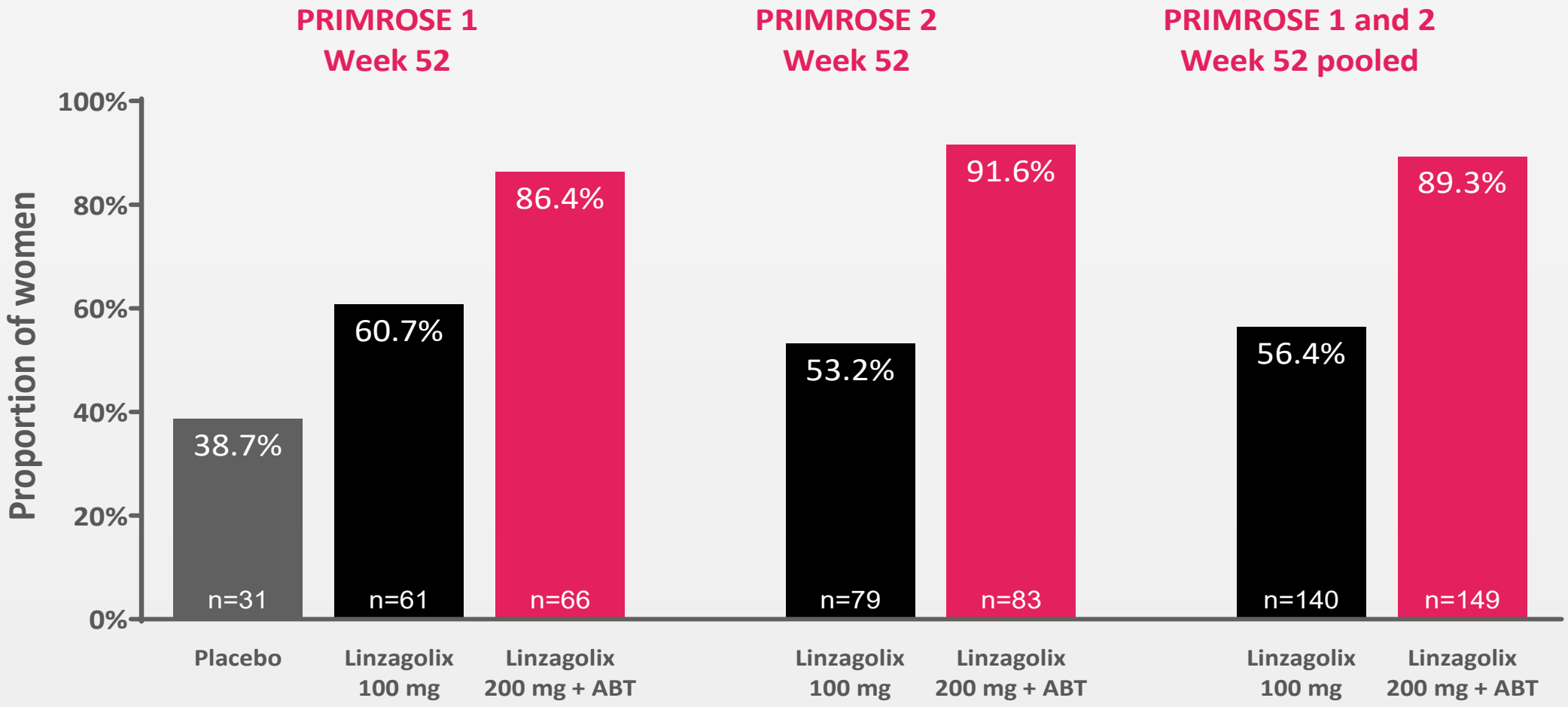
Responder* analysis at week 24



*Proportion of women with menstrual blood loss ≤ 80 mL (by alkaline hematin method) and ≥ 50% reduction from baseline
Error bars are 95% CI

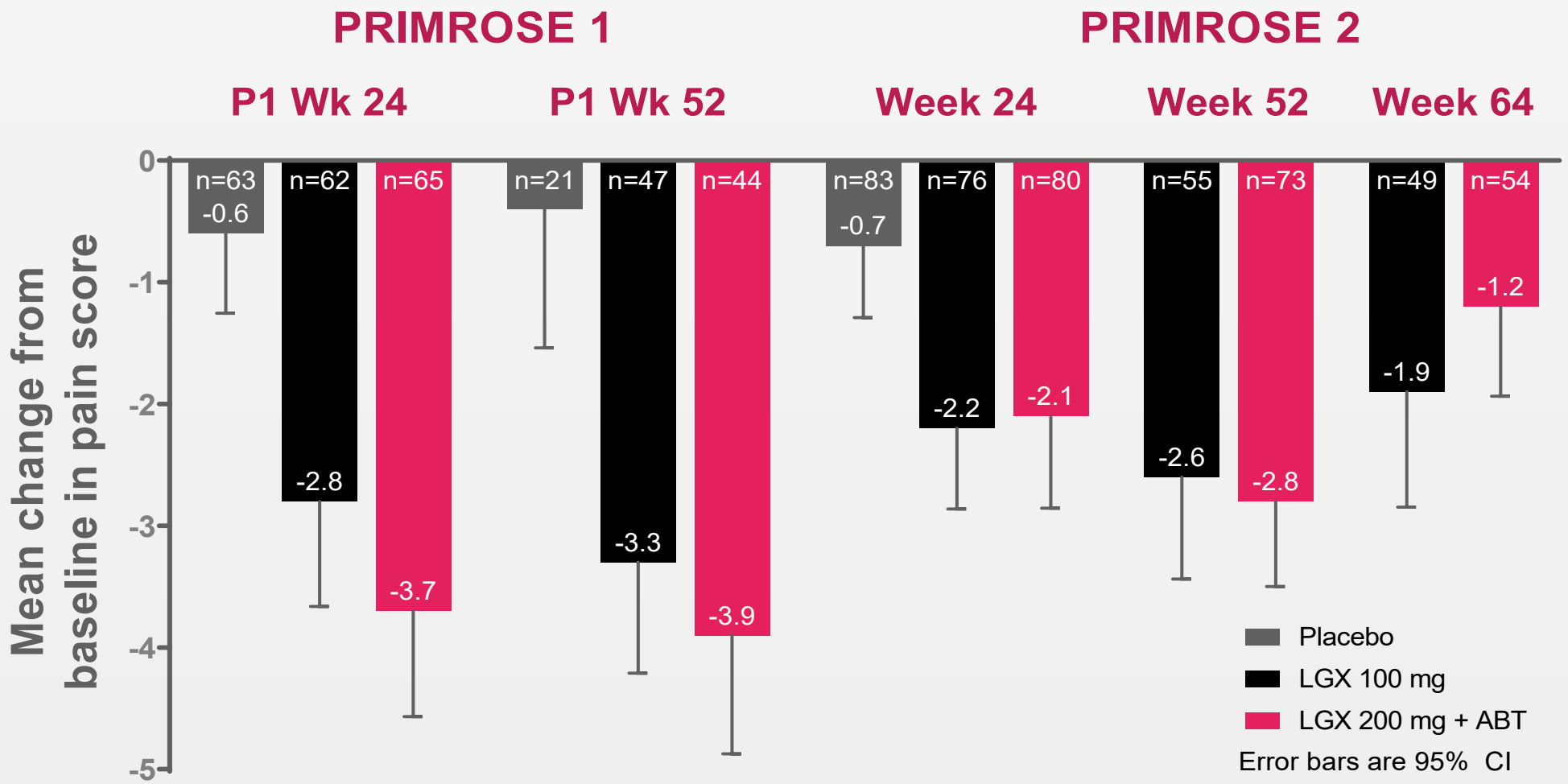
PRIMROSE 1 and 2 achieved sustained reduction in MBL

Responder* analysis at week 52



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

Significant pain reduction maintained at weeks 52 and 64

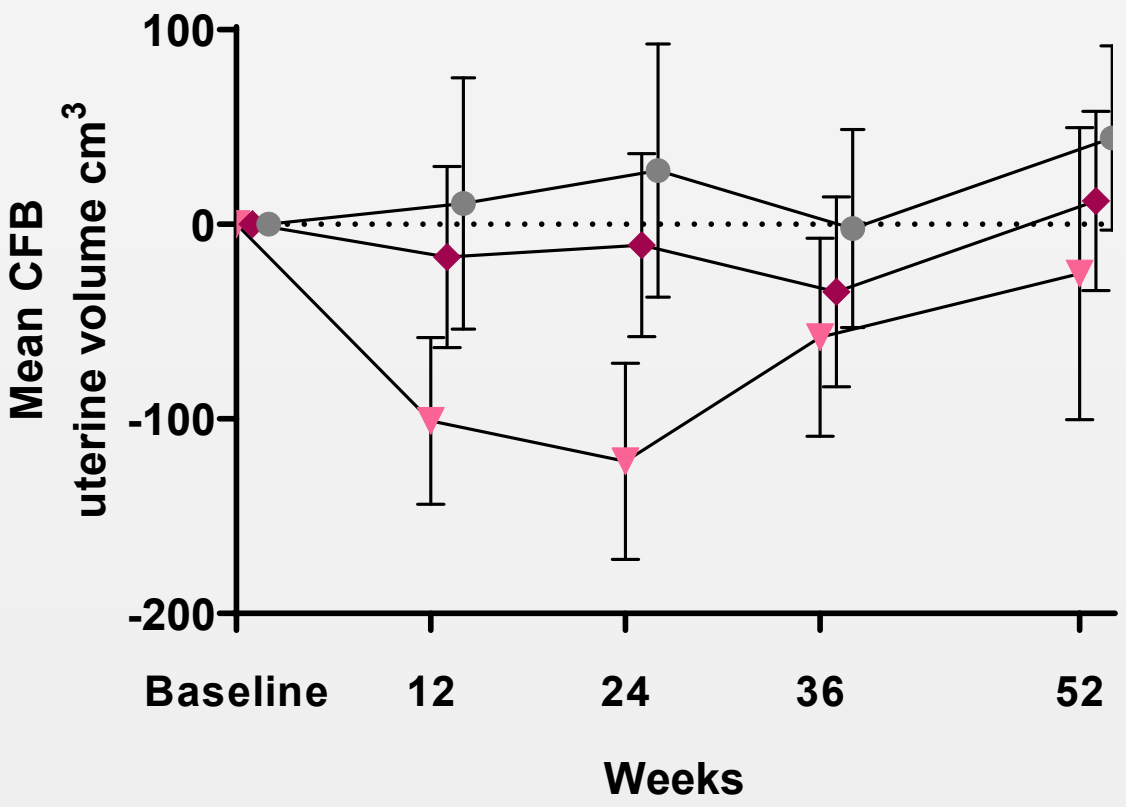


Pain assessed on Numerical Rating Scale: 0-10

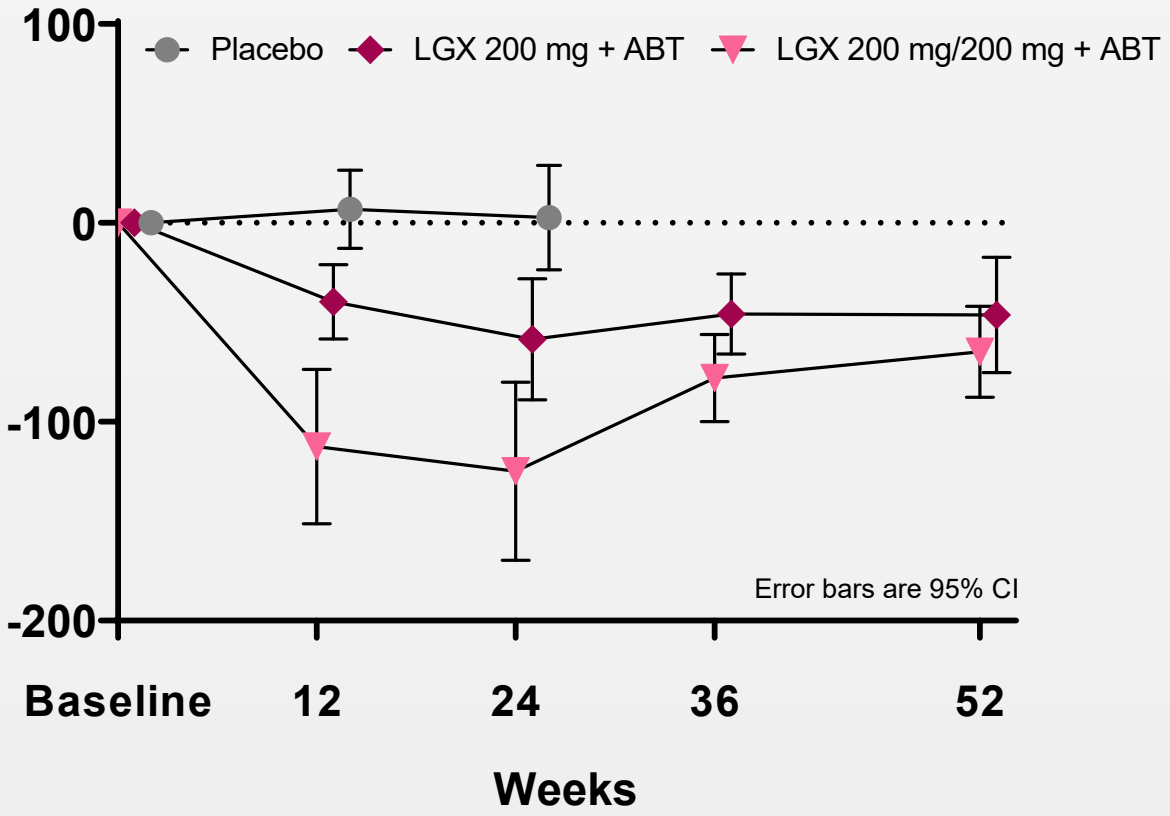
LGX 200 mg without ABT significantly reduces uterine volume

Substantial reduction compared to placebo & LGX 200 mg with ABT at Week 24

PRIMROSE 1

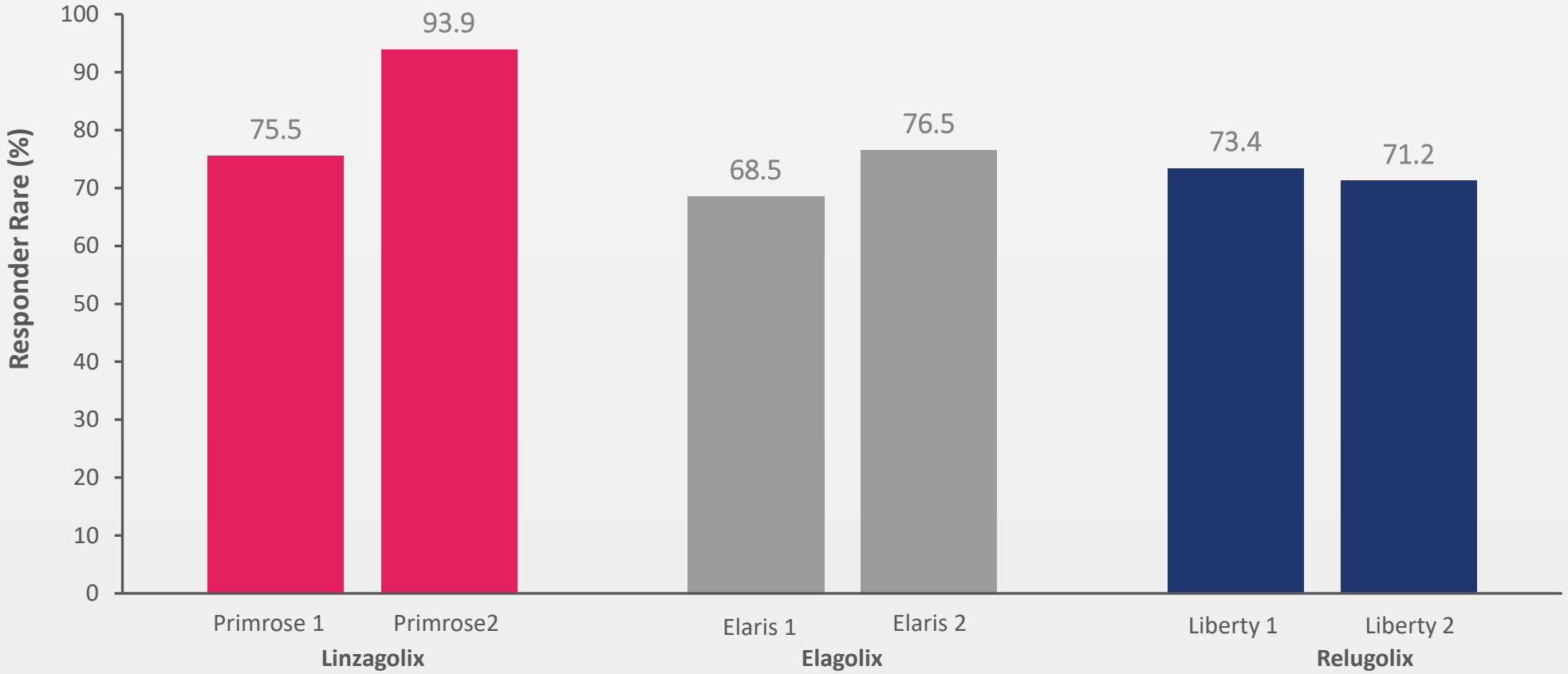


PRIMROSE 2



24-week efficacy data support linzagolix as potential best-in-class GnRH antagonist

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



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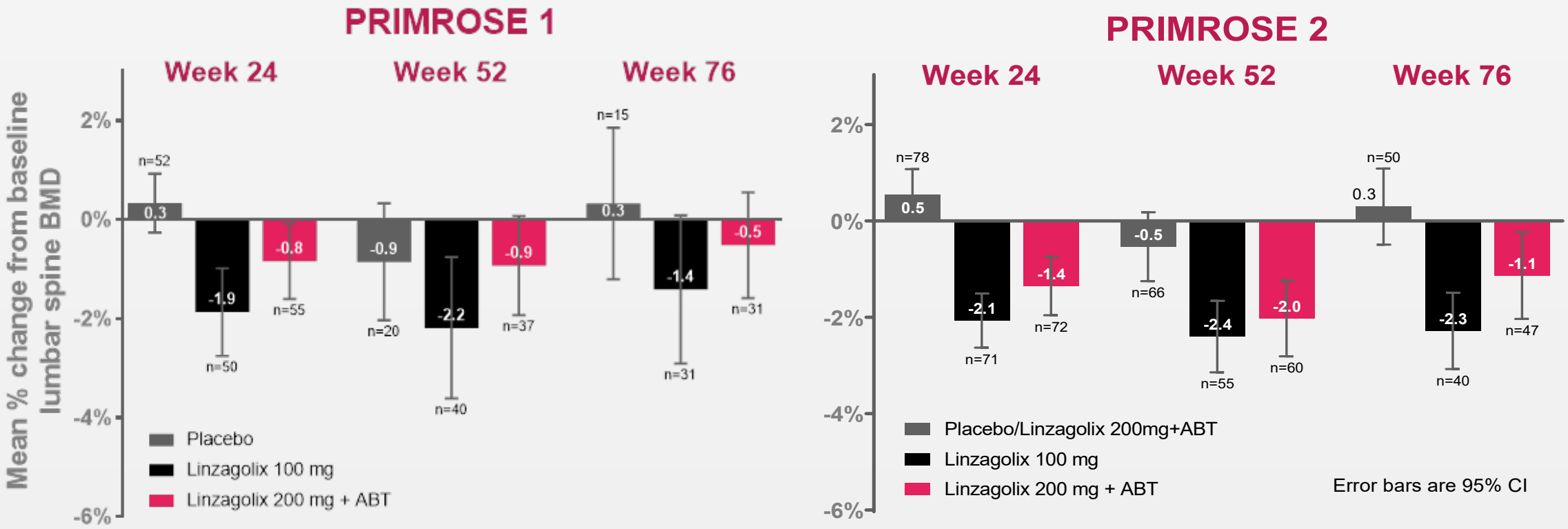
Data collected from 6 separate studies

Minimal BMD change with both doses, plateauing after week 24

Expected age-related BMD decline observed in placebo arm at Week 52



Favorable tolerability profile

Summary of adverse events—week 24 to 52

	PRIMROSE 1			PRIMROSE 2	
	Placebo	Linzagolix 100 mg	Linzagolix 200 mg + ABT	Linzagolix 100 mg	Linzagolix 200 mg + ABT
Number (%) of women	**n=31**	**n=62**	**n=70**	**n=79**	**n=84**
Subject with at least one TEAE	**12 (38.7)**	**25 (40.3)**	**25 (35.7)**	**22 (27.8)**	**21 (25.0)**
TEAE leading to discontinuation	**1 (3.2)**	**2 (3.2)**	**1 (1.4)**	**7 (8.9)**	**1 (1.2)**
SAE related to linzagolix	**0**	**0**	**0**	**0**	**0**
Occurrence after week 24 of most frequently reported AEs (> 5%) up to week 24					
Hot flush	**0**	**1 (1.6)**	**0**	**2 (2.5)**	**3 (3.6)**
Headache	**1 (3.2)**	**3 (4.8)**	**0**	**1 (1.3)**	**1 (1.2)**
Anemia	**1 (3.2)**	**0**	**0**	**2 (2.5)**	**1 (1.2)**

Linzagolix, designed to treat more women…

Robust clinical data driving differentiated profile

Linzagolix 200 mg once daily with concomitant ABT

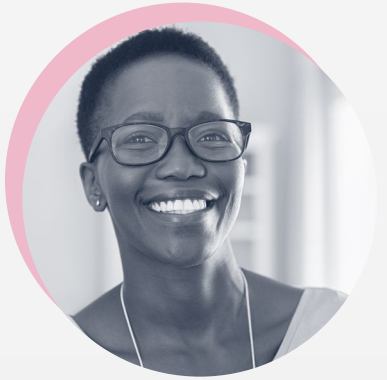
For long-term use for women for whom ABT is appropriate

+

Linzagolix 100 mg once daily without ABT

For long-term use for women with a contraindication to or who prefer to avoid ABT

+



Linzagolix 200 mg once daily without ABT

For short-term use (up to 6 months) when rapid reduction in fibroid and uterine volume is desired

Potentially best-in-class, only GnRH antagonist to address the non-ABT market ✓

Favorable efficacy rates and tolerability profile compared to other GnRH antagonists for the ABT regimen ✓

Unique set of treatment options and complementary solution for uterine fibroids surgeons for pre-op ✓

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The hypothetical patients represented on this slide are for illustrative purposes only as no strength of linzagolix has been approved nor is there FDA-approved Prescribing Information to guide clinical decisions

Linzagolix: Potentially “best-in-class” GnRH antagonist

	Linzagolix	Elagolix	Relugolix
Flexible dosing to allow dose dependent reduction of estradiol (E2)	√	X	X
For long-term use for women for whom ABT is appropriate*	84%	72.2%[+]	72.3%[++]
For long-term use for women with a contraindication to or who prefer to avoid ABT	56%	X	X
Significant reduction in pain	√	X (NR)	√
Once a day dosing	√	X	√
Favorable bioavailability	>80%	30-50%	11%
No food effect**	√	X	X
Favorable tolerability profile	√	√	√
Minimal BMD change	√	√	√

Source: Company information Note: NR = Not reported. ABT=add-back therapy
*Primary endpoint: Proportion of women with menstrual blood loss ≤ 80 mL (by alkaline hematin method) and ≥ 50% reduction from baseline
** In a dedicated food effect study using a single 200 mg dose of elagolix, there was a decrease of 24% and 36% in AUC and Cmax, respectively, under high-fat meal conditions; however, labeling states elagolix can be taken without regard to meals; in a food effect study of relugolix, AUC and Cmax decreased by 38% and 55% respectively, after administration following consumption of a high-fat, high-calorie meal; however, labeling states the decrease in exposure is not clinically meaningful and relugolix can be taken without regard to meals.
[+]Simon et al, Obstet Gynecol 135, 1313-1326 2020
[++] Venturella R et al, ESHRE 2020 abstract.
Note: The data on this page are not from head-to-head comparisons.

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Thank you

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