Etrasimod
ELEVATE UC 12
and 52 Results

Exciting Investigational Asset: Potential Best In Class UC Therapy
Forward-Looking Statements

This presentation and our discussions during this conference call will include forward-looking statements that are subject to substantial risks and uncertainties, many of which are beyond our control, that could cause actual results to differ materially from those expressed or implied by such statements. We may include forward-looking statements about, among other topics, etrasimod and Pfizer’s Inflammation & Immunology pipeline, inline products and product candidates, including anticipated regulatory submissions, data read-outs, study starts, approvals, clinical trial results and other developing data, revenue contribution, growth, performance, timing of exclusivity and potential benefits; expectations for the ulcerative colitis market and the S1P class; anticipated operating and financial performance; capital allocation objectives; future opportunities and strategies; and growth potential. Among other things, statements regarding growth; the development or commercial potential of the product pipeline, inline products, product candidates and additional indications, including expected clinical trial protocols, the timing of the initiation and progress of clinical trials and data read-outs from trials; the timing for the submission of applications for and receipt of regulatory approvals; expected profile and product labeling; and expected breakthrough, best or first-in-class or blockbuster status of products are forward-looking and are estimates that are subject to change and clinical trial and regulatory success. These statements are subject to risks, uncertainties and other factors that may cause actual results to differ materially from past results, future plans and projected future results. Additional information regarding these and other factors affecting such statements can be found in Pfizer’s Annual Report on Form 10-K for the fiscal year ended December 31, 2021 and its subsequent reports on Form 10-Q, including in the sections thereof captioned “Risk Factors” and “Forward-Looking Information and Factors That May Affect Future Results”, as well as in our subsequent reports on Form 8-K, all of which are filed with the U.S. Securities and Exchange Commission and available at www.sec.gov and www.pfizer.com. Potential risks and uncertainties also include the impact of, and delays caused by, COVID-19, including on sales and operations, and on employees, manufacturing, supply chain, marketing, research and development and clinical trials. The forward-looking statements in this presentation and made during our discussions speak only as of the original date of this presentation and we undertake no obligation to update or revise any of these statements. Cross-trial comparisons are not based on head-to-head studies and no direct comparisons can be made.
Today’s Speakers

Mike Vincent
I&I Chief Scientific Officer

Mike Gladstone
I&I Global President

Mike Corbo
I&I Chief Development Officer

Sheldon Sloan
Arena VP Etrasimod UC Team Lead
Phase 3 trials show potential best-in-class efficacy

Efficacy of etrasimod may be competitive with market leading biologics

Safety profile in phase 3 was consistent with previous studies and the S1P class

Overall results support proposed positioning of etrasimod as the 1st line oral therapy after conventional failures for UC patients
Ulcerative Colitis

Disease Overview

*Ulcerative Colitis* (UC) is a chronic and often debilitating inflammatory bowel disease that affects an estimated **1 million people in the US**

Symptoms include **chronic diarrhea** with blood and mucus, **abdominal pain** & cramping, and **weight loss**, which can interfere with **work**, **family** and **social activities**

*Newly diagnosed patients* often have **frequent flares** that are frequently treated with corticosteroids, which can lead to steroid dependence
Current Ulcerative Colitis (UC) Treatment Algorithm

Significant Unmet Need

UC Treatment Paradigm Follows a Fail-First Approach to Stepping Up

- **Aminosalicylate**
- **Corticosteroids**
- **Thiopurines**
- **Biologics/Biosimilars**
- **JAKs**
- **Cyclosporine/Tacrolimus/Surgery**

Disease Severity

Time

- **Induction**
- **Maintenance**

Physicians and patients often delay progression to more advanced therapies to avoid a lifetime of injections and associated risks.
### Sphingosine 1-Phosphate (S1P) Receptors

**Responsible for Regulating Multiple Biological Processes**

<table>
<thead>
<tr>
<th>Receptor Subtype</th>
<th>Receptor Function</th>
</tr>
</thead>
</table>
| S1P1             | • Trafficking, localization & function of immune cells  
|                  | • Maintenance of barrier function in blood vessels  
|                  | • Constriction of blood vessels  
|                  | • Regulation of heart rate and rhythm  
| S1P2 & S1P3      | • Regulation of immune functions  
|                  | • Inhibition of cytokines that promote inflammation  
| S1P4             | • Degradation of S1P receptors reduces migration of immune cells that mediate inflammation  
|                  | • Selective modulation of S1P1, S1P4, and S1P5 may contribute to a differentiated benefit risk profile  
| S1P5             | • Trafficking & localization of Natural Killer Cells  

S1P1 = Sphingosine 1-Phosphate Receptor 1; S1P2 = Sphingosine 1-Phosphate Receptor 2; S1P3 = Sphingosine 1-Phosphate Receptor 3; S1P4 = Sphingosine 1-Phosphate Receptor 4; S1P5 = Sphingosine 1-Phosphate Receptor 5

---

ELEVATE UC 12 and 52 Results Investor Call
Etrasimod: Potentially Differentiated Oral S1P Receptor Modulator

Differentiated Pharmacology vs Approved S1P Modulators

- Differentiation: Etrasimod is a potent S1P1 agonist & partial S1P4 and S1P5 agonist
- Safety: Data support no dose titration or in-clinic first dose monitoring

S1P = Sphingosine 1-Phosphate; S1P1 = Sphingosine 1-Phosphate Receptor 1; S1P2 = Sphingosine 1-Phosphate Receptor 2; S1P3 = Sphingosine 1-Phosphate Receptor 3; S1P4 = Sphingosine 1-Phosphate Receptor 4; S1P5 = Sphingosine 1-Phosphate Receptor 5
Etrasimod Phase 2 OASIS Study

Competitive Efficacy Observed in Ulcerative Colitis

Clinical Remission – OASIS 12 Week

- Placebo (n=54):
  - 5.6%
- Etrasimod 1mg (n=52):
  - 15.6%
- Etrasimod 2mg (n=50):
  - 30.6%

Endoscopic Improvement – OASIS 12 Week

- Placebo (n=54):
  - 17.8%
- Etrasimod 1mg (n=52):
  - 22.5%
- Etrasimod 2mg (n=50):
  - 41.8%

*Statistically significant

- Etrasimod Phase 2 efficacy demonstrated “Best-in-Class” potential in Ulcerative Colitis
  - Observed to have improved efficacy in clinical remission & endoscopic improvement in cross trial comparison

- Strong portfolio fit – Diversifies I&I pipeline, strengthens leadership in Inflammatory Bowel Disease

1. Not head-to-head data, no conclusions can be made
Etrasimod Phase 3 Clinical Data
ELEVATE Utilized Treat-Through Design over a Traditional Re-Randomization

TREAT-THROUGH TRIALS: All patients who enroll in the trial are counted in the week 52 analysis.

RE-RANDOMIZATION OF RESPONDER TRIALS: Only patients meeting objective criteria of clinical response at end of induction are counted in the week 52 analysis.

Re-randomization trial design tends to increase the percentage of responders at end of study assessment resulting in higher treatment arm remission rates compared to treat-through trials.
ELEVATE Program: Etrasimod in UC Utilized a Treat-Through Design

<table>
<thead>
<tr>
<th>Treat-through*</th>
<th>Endpoints</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>12-Week induction</strong></td>
<td><strong>Co-Primary Endpoints</strong></td>
</tr>
<tr>
<td>Etrasimod, 2 mg</td>
<td>- Clinical remission: Week 12; Week 52</td>
</tr>
<tr>
<td>Placebo</td>
<td><strong>Key Secondary Endpoints:</strong></td>
</tr>
<tr>
<td>Week 12</td>
<td>- Endoscopic improvement: Week 12; Week 52</td>
</tr>
<tr>
<td></td>
<td>- Symptomatic remission: Week 12; Week 52</td>
</tr>
<tr>
<td></td>
<td>- Mucosal healing: Week 12; Week 52</td>
</tr>
<tr>
<td></td>
<td>- Corticosteroid-free remission: Week 52</td>
</tr>
<tr>
<td></td>
<td>- Clinical remission at both Week 12 and Week 52</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>40-Week Treatment Period</strong></th>
<th><strong>Primary Endpoint</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Etrasimod, 2 mg</td>
<td>- Clinical remission: Week 12</td>
</tr>
<tr>
<td>Placebo</td>
<td><strong>Key Secondary Endpoints:</strong></td>
</tr>
<tr>
<td>Week 52</td>
<td>- Endoscopic improvement</td>
</tr>
<tr>
<td></td>
<td>- Symptomatic remission</td>
</tr>
<tr>
<td></td>
<td>- Mucosal healing</td>
</tr>
</tbody>
</table>

**Open-label Extension (Up to 5-Years)**

**52-Week Treat-Through**
- N=433

**12-Week Induction**
- N=334

R, randomization; UC, ulcerative colitis.

* In contrast to a rerandomized trial design, patients did not need to reach the objective criteria of clinical response to continue past Week 12.
ES, endoscopic subscore; MMS, Modified Mayo Score; RB, rectal bleeding; SF, stool frequency.

Data were from reported randomized strata. Percent of patients with clinical remission at Week 12 was derived from Cochran-Mantel-Haenszel analysis.

* Clinical remission defined as SF subscore =0 (or 1 with a ≥1-point decrease from baseline), RB subscore =0, and ES ≤1 (excluding friability).

ES, endoscopic subscore; MMS, Modified Mayo Score; RB, rectal bleeding; SF, stool frequency.

Data were from reported randomized strata. Percent of patients with clinical remission at Week 12 was derived from Cochran-Mantel-Haenszel analysis.

* Clinical remission defined as SF subscore =0 (or 1 with a ≥1-point decrease from baseline), RB subscore =0, and ES ≤1 (excluding friability).
### ELEVATE UC 52: Key Secondary and Secondary Efficacy Endpoints at Weeks 12 and 52

#### Baseline MMS 5 to 9 (N=409)

<table>
<thead>
<tr>
<th>Secondary Endpoint</th>
<th>Subject, %</th>
<th>Week 12</th>
<th>Week 52</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Endoscopic Improvement</strong></td>
<td>14.1% (19/135)</td>
<td>35.0% (96/274)</td>
<td>37.2% (102/274)</td>
</tr>
<tr>
<td><strong>Symptomatic Remission</strong></td>
<td>10.4% (14/135)</td>
<td>21.5% (29/135)</td>
<td>18.5% (25/135)</td>
</tr>
<tr>
<td><strong>Mucosal Healing</strong></td>
<td>21.5% (58/274)</td>
<td>4.4% (6/135)</td>
<td>8.1% (11/135)</td>
</tr>
<tr>
<td><strong>Clinical Response</strong></td>
<td>18.5% (25/135)</td>
<td>34.1% (46/135)</td>
<td>23.0% (31/135)</td>
</tr>
</tbody>
</table>

**Key Secondary Endpoints**

- **Endoscopic improvement** defined as ES ≤1 (excluding friability).
- **Symptomatic remission** defined as SF subscore = 0 (or 1, with a ≥1-point decrease from baseline) and RB subscore =0.
- **Mucosal healing** defined as ES of ≤1 (excluding friability) with histologic remission measured by a Geobes Index score <2.
- **Clinical response** defined as ≥2 point & ≥30% decrease from baseline in MMS and ≥1-point decrease from baseline in RB subscore or an absolute RB subscore ≤1 and was not a key secondary endpoint.

#### ELEVATE UC 12 and 52 Results Investor Call

**Placebo ETR 2mg**

- **Week 12**
  - Endoscopic Improvement: Δ = 21.2% (P < 0.001)
  - Symptomatic Remission: Δ = 26.7% (P < 0.001)
  - Mucosal Healing: Δ = 24.6% (P < 0.001)
  - Clinical Response: Δ = 16.9% (P < 0.001)

- **Week 52**
  - Endoscopic Improvement: Δ = 24.9% (P < 0.001)
  - Symptomatic Remission: Δ = 18.4% (P < 0.001)
  - Mucosal Healing: Δ = 18.4% (P < 0.001)
  - Clinical Response: Δ = 24.9% (P < 0.001)

**Placebo ETR 2mg**

- **Week 12**
  - Endoscopic Improvement: Δ = 26.7% (P < 0.001)
  - Symptomatic Remission: Δ = 21.2% (P < 0.001)
  - Mucosal Healing: Δ = 26.6% (P < 0.001)
  - Clinical Response: Δ = 21.2% (P < 0.001)

- **Week 52**
  - Endoscopic Improvement: Δ = 24.6% (P < 0.001)
  - Symptomatic Remission: Δ = 18.4% (P < 0.001)
  - Mucosal Healing: Δ = 24.9% (P < 0.001)
  - Clinical Response: Δ = 28.3% (P < 0.001)

**Delta Values**

- Δ = 26.7%
- P < 0.001

---

**Notes:**

- ES, endoscopic subscore; MMS, Modified Mayo Score; RB, rectal bleeding; SF, stool frequency.
- Endoscopic improvement defined as ES ≤1 (excluding friability).
- Symptomatic remission defined as SF subscore = 0 (or 1, with a ≥1-point decrease from baseline) and RB subscore =0.
- Mucosal healing defined as ES of ≤1 (excluding friability) with histologic remission measured by a Geobes Index score <2.
- Clinical response defined as ≥2 point & ≥30% decrease from baseline in MMS and ≥1-point decrease from baseline in RB subscore or an absolute RB subscore ≤1 and was not a key secondary endpoint.
ELEVATE UC 52: Sustained Clinical Remission and CS-Free Clinical Remission

**Key Secondary Endpoints**
Baseline MMS 5 to 9 (N=409)

- **Placebo**
  - **Sustained Clinical Remission**: 2.2% (3/135)
  - **12-Week CS-Free Remission Among All Subjects**: 6.7% (9/135)

- **ETR 2 mg**
  - **Sustained Clinical Remission**: 2.2% (3/135)
  - **12-Week CS-Free Remission Among All Subjects**: 17.9% (49/274)

**Exploratory Endpoint**
Baseline MMS 4 to 9 (N=433)

- **Placebo**
  - **Sustained Clinical Remission**: 7.3% (3/41)
  - **12-Week CS-Free Remission Among Subjects With Baseline CS Use**: 31.2% (29/93)

- **ETR 2 mg**
  - **Sustained Clinical Remission**: 15.8% (6/38)
  - **12-Week CS-Free Remission Among Subjects With Baseline CS Use**: 32.1% (88/274)

**Δ** = 15.8% $P<.001$

CS, corticosteroid.

- Sustained clinical remission was defined as clinical remission at both Weeks 12 and 52.
- CS-free clinical remission was defined as clinical remission at Week 52 with no use of CS for at least the last 12 study weeks.
ELEVATE UC 12 Primary and Key Secondary Efficacy Endpoints at Week 12

Baseline MMS 5 to 9 (N=334)

**Primary Endpoint**

- Placebo: 15.2% (17/112)
- Etrasimod 2 mg: 24.8% (55/222)

**Δ = 9.7%**  
**P = 0.0264**

**Key Secondary Endpoints**

- Endoscopic Improvement: Δ = 12.1%  
  **P = 0.0092**

- Symptomatic Remission: Δ = 17.5%  
  **P = 0.0013**

- Mucosal Healing: Δ = 7.4%  
  **P = 0.0358**

- Clinical Response: Δ = 21.2%  
  **P = <0.001**

**Secondary Endpoint**

- Placebo: 18.8% (21/112)  
  (68/222)
- Placebo 2 mg: 30.6%  
  (33/112)
- Placebo 2 mg: 29.5%  
  (104/222)
- Placebo 2 mg: 8.9%  
  (10/112)
- Placebo 2 mg: 16.2%  
  (36/222)
- Placebo 2 mg: 41.1%  
  (46/112)
- Placebo 2 mg: 62.2%  
  (138/222)

**ES**, endoscopic subscore; **MMS**, Modified Mayo Score; **RB**, rectal bleeding; **SF**, stool frequency.

* Clinical remission defined as SF subscore =0 (or 1 with a ≥1-point decrease from baseline), RB subscore =0, and ES ≤1 (excluding friability).

† Endoscopic improvement defined as ES ≤1 (excluding friability).

‡ Symptomatic remission defined as SF subscore = 0 (or 1, with a ≥1-point decrease from baseline) and RB subscore =0.

§ Mucosal healing defined as ES of ≤1 (excluding friability) with histologic remission measured by a Geobes Index score <2.

¶ Clinical response defined as ≥2 point & ≥30% decrease from baseline in MMS and ≥1-point decrease from baseline in RB subscore or an absolute RB subscore ≤1 and was not a key secondary endpoint.

*Clinical Response was not a key secondary endpoint
Etrasimod Induction: Cross Trial Comparison (Not Head-to-Head)

Efficacy May Compare Favorably Across Contemporary UC Trials, although no conclusions can be drawn

Clinical Remission\(^1,2\)

\[\text{Percent of Subjects} \]

<table>
<thead>
<tr>
<th>S1Ps</th>
<th>Placebo Etrasimod</th>
<th>Placebo Etrasimod</th>
<th>Placebo Ozanimod</th>
</tr>
</thead>
<tbody>
<tr>
<td>Week 12(^3) (S1P)</td>
<td>p=0.026</td>
<td>p&lt;0.001</td>
<td>P&lt;0.001</td>
</tr>
<tr>
<td>15%</td>
<td>25%</td>
<td>7%</td>
<td>18%</td>
</tr>
<tr>
<td>Week 10(^3) (S1P)</td>
<td>27%</td>
<td>6%</td>
<td>8%</td>
</tr>
</tbody>
</table>

1. Note: No direct head-to-head data available. Caution advised when comparing across studies; 2. Data from FDA labeling information 3. Clinical remission defined as Modified Mayo RB=0, ES≤1, SF≤1 w/1 pt improvement 4. Clinical remission defined as a Modified Mayo RB=0, ES≤1, SF≤1 and not worse than baseline 5. Clinical remission defined as total mayo score ≤2 6. Clinical remission defined as total mayo score ≤2 w/RB=0

\(\text{S1P} = \text{Sphingosine 1-Phosphate}; \text{JAK} = \text{Janus Kinase}; \text{TNF} = \text{Tumor Necrosis Factor}; \alpha4\beta7 = \text{Alpha 4 Beta 7 Integrin}; \text{IL-12} = \text{Interleukin T2}; \text{IL-23} = \text{Interleukin 23}\)
Etrasimod Induction: Cross Trial Comparison (Not Head-to-Head)

Efficacy May Compare Favorably Across Contemporary UC Trials, although no conclusions can be drawn

### Clinical Remission$^{1,2}$

<table>
<thead>
<tr>
<th></th>
<th>S1Ps</th>
<th>Biologics</th>
<th>JAKs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Percent of Subjects</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Placebo Etrasimod</td>
<td>15%</td>
<td>9.2%</td>
<td>5%</td>
</tr>
<tr>
<td>Placebo Etrasimod</td>
<td>25%</td>
<td>18.5%</td>
<td>26%</td>
</tr>
<tr>
<td>Placebo</td>
<td>6%</td>
<td>16.5%</td>
<td>19%</td>
</tr>
<tr>
<td>Placebo Ozanimod</td>
<td>7%</td>
<td>5%</td>
<td>7%</td>
</tr>
<tr>
<td>Placebo</td>
<td>18%</td>
<td>17%</td>
<td>7%</td>
</tr>
<tr>
<td>Placebo Adalimumab</td>
<td>18%</td>
<td>19%</td>
<td>4%</td>
</tr>
<tr>
<td>Placebo Adalimumab</td>
<td>7.2%</td>
<td></td>
<td>8%</td>
</tr>
<tr>
<td>Placebo Vedolizumab</td>
<td>5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Placebo Ustekinumab</td>
<td>7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Placebo Upadacitinib 45mg QD</td>
<td>5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Placebo Upadacitinib 45mg QD</td>
<td>4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Placebo Tofacitinib 10mg BID</td>
<td>8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Placebo Tofacitinib 10mg BID</td>
<td>4%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

$^1$ Note: No direct head-to-head data available. Caution advised when comparing across studies; 2. Data from FDA labeling information 3. Clinical remission defined as Modified Mayo RB=0, ES≤1, SF≤1 and not worse than baseline 5. Clinical remission defined as total mayo score ≤2 6. Clinical remission defined as total mayo score ≤2 w/RB=0

S1P = Sphingosine 1-Phosphate; JAK = Janus Kinase; TNF = Tumor Necrosis Factor; α4β7 = Alpha 4 Beta 7 Integrin; IL-12 = Interleukin 12; IL-23 = Interleukin 23
# Overall Summary of TEAEs and Serious Adverse Events

<table>
<thead>
<tr>
<th>Subjects, n (%) [# of events]; NOTE: data are not exposure adjusted</th>
<th>ELEVATE UC 52 Safety Set (N=433)</th>
<th>ELEVATE UC 12 Safety Set (N=354)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Placebo (n=144)</td>
<td>Etrasimod 2 mg (n=289)</td>
</tr>
<tr>
<td>Participants with any TEAE</td>
<td>81 (56.3) [238]</td>
<td>206 (71.3) [636]</td>
</tr>
<tr>
<td>Participants with any serious TEAE</td>
<td>9 (6.3) [10]</td>
<td>20 (6.9) [22]</td>
</tr>
<tr>
<td>Any TEAE leading to study discontinuation</td>
<td>7 (4.9) [7]</td>
<td>12 (4.2) [12]</td>
</tr>
<tr>
<td>TEAE leading to death</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Serious adverse events (in &gt;1 subject)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ulcerative colitis</td>
<td>3 (2.1) [3]</td>
<td>6 (2.1) [6]</td>
</tr>
<tr>
<td>Anemia</td>
<td>1 (0.7) [1]</td>
<td>2 (0.7) [2]</td>
</tr>
</tbody>
</table>

TEAE, treatment-emergent adverse event..
## Summary of Most Frequently Reported TEAEs

<table>
<thead>
<tr>
<th>Subjects, n (%) [# of events]; NOTE: data are not exposure adjusted</th>
<th>ELEVATE UC 52 Safety Set (N=433)</th>
<th>ELEVATE UC 12 Safety Set (N=354)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Placebo (n=144)</td>
<td>Etrasimod 2 mg (n=289)</td>
</tr>
<tr>
<td>Most frequently reported TEAEs&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headache</td>
<td>7 (4.9) [12]</td>
<td>24 (8.3) [36]</td>
</tr>
<tr>
<td>Worsening of UC</td>
<td>13 (9.0) [13]</td>
<td>22 (7.6) [24]</td>
</tr>
<tr>
<td>Covid-19 infection</td>
<td>9 (6.3) [9]</td>
<td>20 (6.9) [20]</td>
</tr>
<tr>
<td>Dizziness</td>
<td>1 (0.7) [1]</td>
<td>15 (5.2) [17]</td>
</tr>
</tbody>
</table>

<sup>a</sup> Most common TEAEs are presented among those reported in ≥3% of etrasimod-treated patients and greater than placebo in either study.
## Potential Differentiation vs. Ozanimod

*Ulcerative Colitis (UC) Profile Comparison, Subject to Approval and Labeling*

<table>
<thead>
<tr>
<th></th>
<th>etrasimod&lt;sup&gt;1&lt;/sup&gt;</th>
<th>ozanimod&lt;sup&gt;2,3&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Onset of action</strong></td>
<td>• Day 3: 53% reduction in lymphocytes</td>
<td>• Day 3: 15% Lymphocyte reduction</td>
</tr>
<tr>
<td><strong>1&lt;sup&gt;st&lt;/sup&gt; Dose Titration required</strong></td>
<td>• No – Therapeutic dose on day 1</td>
<td>• Yes – 7 days in 3 dose strengths</td>
</tr>
<tr>
<td><strong>Heart Rate Effect</strong></td>
<td>• Day 1: ~&lt;10 bpm mean change from baseline in phase 2</td>
<td>• Day 1: 0.23 mg: - 0.7 bpm&lt;br&gt;• Fully titrated dose (1 mg): - 8 bpm</td>
</tr>
<tr>
<td><strong>Lymphocyte recovery to normal range</strong></td>
<td>• Ph 1: Returns to normal range within 7 days</td>
<td>• Ph 3: 80% of normal by day 90</td>
</tr>
<tr>
<td><strong>Drug-Drug Interactions</strong></td>
<td>• Limited</td>
<td>• Metabolite inhibits a major enzyme (MAO) that affects clearance of other medications (SSRIs, opioids) and tyramine-rich foods</td>
</tr>
</tbody>
</table>

No Head to Head data; no conclusions can be made.

1. Target labeling, subject to approval/labeling; 2. [https://packageinserts.bms.com/pi/pi_zeposia.pdf](https://packageinserts.bms.com/pi/pi_zeposia.pdf); 3. [https://www.accessdata.fda.gov/drugsatfda_docs/nda/2020/209899Orig1s000ClinPharmR.pdf](https://www.accessdata.fda.gov/drugsatfda_docs/nda/2020/209899Orig1s000ClinPharmR.pdf);

Pts = Patients; MAO = Monoamine Oxidase Inhibitors; DDI = Drug Drug Interactions; SSRIs = Selective Serotonin Reuptake Inhibitor; bpm = Beats Per Minute
Etrasimod Commercial Outlook
Key Dynamics in Ulcerative Colitis

1M adults in US market with UC

Market projected to grow ~2x by 2030

Unmet need remains: Only ~14% of patients achieve long-term remission with SoC

Patients need options with a favorable benefit-risk profile
Diversity of Options benefits UC Patients: If approved, etrasimod has potential to fill a gap in treatment paradigm

Emerging Etrasimod Profile

- Potential for Best-in-Class Efficacy
- Dosing and safety consistent with prior studies and S1P class
- Overall benefit/risk shows a very competitive profile
- Potential First Line\(^2\) novel agent\(^1\)

1. Subject to labeling, 2. *First-line= post-conventional treatment e.g., 5-ASA/corticosteroids*
# Etrasimod has Potential to Grow in GI Indications

## Next Steps for Etrasimod in GI

<table>
<thead>
<tr>
<th>Indication</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ulcerative Colitis</td>
<td>Anticipate Filing Q3 2022</td>
</tr>
<tr>
<td>Crohn’s</td>
<td>Ph2/3 Expected Readout Q4 2023</td>
</tr>
<tr>
<td>Eosinophilic Esophagitis (EoE)</td>
<td>Ph2 Expected Readout Q4 2022</td>
</tr>
</tbody>
</table>

All dates are projections and subject to change.
Leading in three core disease areas of high unmet need...

Cross-Disease Area Platform: Anti-fibrotics

- Targeting whitespace diseases and mechanisms driven by I&I pathways
- Delivering a diversified portfolio of complementary modalities and MOAs
- Augmenting within our focus areas, where we can win

... delivering breakthroughs that enable patients to thrive in remission...

... and transforming how we, our business and our industry works

- Digitally-led, virtual development and complementary MoAs that give patients options
- New platforms and structures for digital-first engagements with our customers
- Clinically-validated digital products (Therapeutics, Diagnostics and Biomarkers)

To be the bold ones who won’t stop until patients find relief
Question & Answer Session
Common Designs of Ulcerative Colitis Phase 3 Trials

**TREAT-THROUGH TRIALS:** All patients who enroll in the trial are counted in the week 52 analysis.

**RE-RANDOMIZATION OF RESPONDER TRIALS:** Only patients meeting objective criteria of clinical response at end of induction are counted in the week 52 analysis.

Re-randomization trial design tends to increase the percentage of responders at end of study assessment resulting in higher treatment arm remission rates compared to treat-through trials.