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"From Science to Long-Term Value Creation"

Speakers

- Christophe Douat – CEO
- Adolfo Lopez Noriega – Head of Research & Development
- David Martin – Head of Intellectual Property
- Sébastien Enault – Chief Business Officer
- David Heuzé – Head of Corporate & Financial Communications, and ESG

David Heuzé

Hello everyone, thank you for joining our online R&D Day. If you wish to follow along the presentation, the slides are available on our website. Before we start, I would like to draw your attention to slide 2, which contains important information regarding forward-looking statements. Please note that today's discussion may include projections and assumptions, and we therefore encourage you to review this information carefully.

After the presentations, we will open the floor for Q&A session. And with that, I am very pleased to invite Christophe Douat, our Chief Executive Officer, to open today's meeting. Christophe.

Christophe Douat

Thank you, David. This is a very special moment for us. Good morning, everyone. Welcome and thank you for joining us today for our R&D Day. Today is about one fundamental idea: how we turn science into long-term value creation. At Medincell, innovation is not an abstract concept. It is something very tangible, something that reaches patients, supports physicians, and ultimately transforms lives. And what we are building here is much bigger than individual products. We are building a platform, a model, a company designed to create value over the long term. We are deeply proud of what our teams have achieved, from a strong foundation in polymer science rooted in world-class research, to a company that now operates at a global level. We have built an exceptional R&D organization bringing together talent from more than 30 countries, creating one of the highest concentrations of expertise into the world in our field. And what excites us even more than what we have done is what is now ahead of us. At the core of everything we do, there is a very clear ambition: unlock the full potential of long-acting injectables, improve adherence, enhance treatment efficiency, and ultimately transform patients' lives.

This is what drives our R&D teams every day. Because of our space, success is not measured by technical achievement alone. It is measured by real-world impact. Now let me step back and remind you of our strategy. We are executing what we call our Shift to Growth strategy, built around 3 engines operating in parallel. First, UZEDY, our Risperidone LAI, already demonstrating very strong adoption in a very competitive market. Second, Olanzapine LAI, waiting for regulatory approval, with the potential to unlock a very significant market opportunity. And third, innovation and R&D, which is the focus of today, because this, this third engine is what will define our future. This third engine is about disciplined and focused investment. We invest in R&D to broaden our innovation platform, to expand our portfolio and extend our network of partners. Approximately two-thirds of our operating expenses today go into R&D. Because we see innovation not as a cost, but as the core driver of long-term value creation. And most importantly, we do this with discipline, allocating capital where we can create real differentiation. Our approach to value creation is very clear. We are building a long-term royalty engine. Each successful program adds a new layer, what we call a string of pearls, stacking revenue streams over time.

UZEDY is the first validation, Olanzapine LAI will be the next one, and more will follow. This is how we build sustainable, scalable growth. Now, to explain how we execute this third engine, how we turn science into products and products into long-term value, I'm joined today by three key leaders of Medincell: Adolfo, Head of R&D; David, Head of Intellectual Property; Sébastien, Chief Business Officer. Together, they will walk you through our technology platform, our innovation strategy, and our IP and partnering model. With that, I will now hand over to Adolfo, who will take you deeper into the evolution of our technology.

Adolfo Lopez Noriega

Thank you, Christophe, and hello everyone. My name is Adolfo Lopez Noriega and I am the Head of Research and Development at Medincell. Over the next few minutes, I'd like to share how we're building our R&D roadmap for long-acting injectables and how it supports Medincell's growth, future products, partnerships, and long-term value. My objective today is not to go into organizational details or scientific depth. I would like to explain how our R&D choices reduce risk, open up new opportunities, and support sustainable value creation. Let me start with 3 clear takeaways which will structure everything I will show you today. First, adoption drives value in long-acting injectables, not duration alone, and adoption is something we intentionally design for. Second, our platform strategy enables us to scale innovation across products and indications rather than depend on individual assets. And third, beyond the platform, we invest selectively in focused internal and external R&D to accelerate development and solve product-specific challenges. These three points form the backbone of our R&D roadmap. I will come back to this message throughout the presentation. As Christophe said, our R&D is built around a world-class team in polymer science and drug delivery. However, expertise alone is not enough.

What matters the most is how R&D connects to value-creating functions across the company. We work hand in hand with our IP team to ensure that innovation is protected at the right level and at the right time. David Martin will provide details around this after me. We also work closely with business development to ensure that R&D priorities are aligned with real market needs and partner expectations. This tight integration reduces downstream development risk and ensures that innovation translates into commercially relevant, partner-ready products. This slide is especially important because it explains why some long-acting products succeed while others do not. When long-acting injectables are discussed, attention is often focused on duration: 1, 2, or 3 months, or even longer. Our experience shows that duration alone does not drive adoption. In practice, adoption has two dimensions. First, physician adoption, driven by ease of initiation, safety, predictability, and integration into clinical workflows. And second, patient adoption, which is driven by comfort, confidence, convenience, and adherence. If a product is difficult to initiate, if it's challenging to administer, or uncomfortable for the patients, adoption will remain limited, no matter how long it lasts. That is why adoption, and not duration alone, is the true commercial differentiator.

Let me illustrate this with a concrete example. We have demonstrated the critical importance of adoption through the outstanding success of UZEDY. UZEDY offers several differentiating features beyond controlled release over 1 or 2 months. One key example is immediate onset of action, which is a very tangible illustration of adoption-driven design. Immediate onset means that therapeutic concentrations are reached shortly after administration, as shown in the graph illustrating risperidone concentration over time. For physicians, this simplifies initiation protocols because no oral supplementation is required, and for patients, it provides early confidence that the treatment is working. Beyond onset of action, UZEDY integrates additional features that remove common hesitation points in real-world use. Subcutaneous administration, under the skin, rather than intramuscular enables thinner needles and easier injections, which improves patient comfort. No need for loading dose or oral supplementation simplifies treatment initiation for both clinicians and patients. And ready-to-use formulations reduce preparation errors and make administration more straightforward in care settings. Consistent performance regardless of injection site increases flexibility and predictability. Individually, each of these features may appear incremental, but taken together, they have a meaningfully significant impact on prescribing behavior by reducing complexity and building confidence. Another essential factor for adoption is trust in safety.

With Olanzapine LAI, our objective was to address the safety limitations that constrained earlier products. As you may know, a previous olanzapine LAI developed by Eli Lilly was associated with rare but serious overdose-like reactions following injection, which are known as PDSS (Post-injection Delirium/Sedation Syndrome). These reactions were likely due to the unintended intravascular administration of the product. And this resulted in heavy regulatory restrictions and ultimately limited commercial adoption. Using BEPO, we demonstrated a fundamentally different safety profile. In clinical study conducted by our partner Teva, approximately 4,000 injections were administered with no overdose-like events observed or suspected. This outcome is not only technical — it can translate directly into physician confidence, regulatory credibility, and real-world usability. But how did we manage to avoid these PDSS? There are two main reasons. First, the product is administered under the skin rather than into the muscle, and this reduces the risk of unintended intravascular exposure. Second, we precisely control the release of olanzapine from BEPO, thereby avoiding high initial plasma concentrations, as you can see on the image. This is what we refer to as burst control. A successful long-acting injectable must deliver the right duration, the right dose across patient populations, and critically, robust and predictable release behavior.

And this is exactly what we have achieved with Olanzapine. I often say that the profile that you are seeing here is the dream profile for anyone working in drug delivery. Now, designing a single successful product is very important. But sustainable value creation requires platforms. Our strategy is to continuously extend our innovation platform so that knowledge, data, and development effort can be leveraged across multiple products, indications, and partnerships. This platform-driven logic has been the foundation of our R&D activities over recent years. I will now take you through our innovation roadmap. And we should start with the foundation, which is BEPO. Let me briefly remind you how it works. BEPO is an in situ forming depot technology based on solvent exchange. When a solution of our proprietary copolymers in a biocompatible solvent containing the drug is injected under the skin, solvent diffusion causes the polymers to precipitate and form a depot that traps the drug at the injection site. Drug release occurs through diffusion and polymer degradation, both of which we can precisely control. What you see on the video is exactly what happens with UZEDY under the skin. One of BEPO's strengths is its simplicity from a manufacturing perspective.

The drug product is composed of just 3 elements: the API, a biocompatible solvent that ensures injectability, and proprietary copolymers that control the release. This simplicity supports robustness, reproducibility, and scalability, which are key requirements for development and partnering. But what makes BEPO powerful is not the chemistry itself, but the level of control it gives us over long-acting product performance. I mentioned that BEPO is simple from a manufacturing standpoint, but it is highly complex from a formulation perspective. The API, solvent, and polymer components can be finely tuned,

allowing us to control release profiles, injection volume, viscosity, stability, and storage conditions. As we have discussed earlier, all these parameters directly affect patient and clinician adoption. This flexibility strengthens reliability and builds partner confidence across our portfolio. BEPO enabled the development of first- and best-in-class products such as UZEDY, and Olanzapine LAI. However, we wanted to achieve similar outcomes with more challenging molecules, and we wanted to do so by building on the strong foundation of BEPO. And this is how BEPO STAR was developed. BEPO STAR is based on the same proven chemistry as BEPO, but instead of linear polymers such as the ones that you see on the left of the screen, it uses branched copolymers — which are polymers with more than two arms — also known as star-shaped polymers.

Our final goal using these polymers was to achieve improved control of drug release, but not only. One immediate benefit of using BEPO STAR is lower injection force and viscosity compared with BEPO. This is what you are seeing on this slide, which compares ease of injection and viscosity of formulations with either BEPO or BEPO STAR formulations. Lower viscosity and injection force directly improve patient comfort and usability and open the door to the use of autoinjectors. As we have discussed earlier, this strongly enhances adoption. Another improvement with BEPO STAR relates to depot degradation. Let me explain this graph. This graph shows the rate at which depots made either from BEPO or BEPO STAR resorb after injection, and you can see clear differences. Compared with BEPO, BEPO STAR shows faster resorption at later stages, resulting in more rapid complete degradation. This feature is particularly important for regulators for very long-acting products, where rapid depot resorption after drug delivery is expected. However, the most striking improvement with BEPO STAR is release control. I will share some remarkable results on this with you. This graph shows plasma concentrations in rats for a small hydrophilic molecule delivered using BEPO or BEPO STAR. BEPO exhibits a high initial burst followed by a rapid decline, whereas BEPO STAR achieves minimal burst and sustained exposure.

At the end of this study, we recovered the depots, and approximately 60% of the payload had not yet been released from BEPO STAR, whereas BEPO was exhausted. This suggests that delivery could have continued for several additional weeks. These results illustrate how release can be precisely controlled for molecules with narrow therapeutic windows, which may cause side effects if delivery is not carefully managed. It also demonstrates that BEPO STAR can support ultra-long duration. One class of molecules with narrow therapeutic windows requiring precise control of plasma exposure and duration is GLP-1 analogs. These are typically large peptides that are very difficult to formulate as long-acting injectables. On this graph, you can see what we can achieve with BEPO STAR: a very low burst and sustained exposure over 1 month. As you may imagine, this opens significant opportunities for Medincell — opportunities that could not be addressed with BEPO. And what makes BEPO STAR particularly valuable is that this platform was developed using the same underlying chemistry as BEPO. The polymers are also based on PEG and PLA building blocks. And why does this matter? Because manufacturing relies on the same synthetic procedures, we can use the same formulation processes, and we have a de-risked regulatory foundation.

In other words, BEPO STAR enabled immediate internal implementation at Medincell based on our existing know-how and expertise, while significantly expanding value creation potential. This is why BEPO STAR is currently being used across all our development programs at Medincell. But we do not stop here. Beyond BEPO STAR, we continue to expand our formulation toolbox and push the boundaries of what is possible in long-acting injectables. Platform innovation may allow us to address narrow therapeutic window APIs, highly soluble molecules, ultra-long-acting indications, higher doses, and simplified administration. We are currently developing new families of long-acting injectables, and the results so far are outstanding. The direction remains the same: how can we further improve adoption for patients and clinicians? This slide illustrates why we are so excited. This new technology shows further improvements in ease of injection compared to BEPO STAR. And as we have said several times, this parameter is fundamental for product acceptability. Our platform innovation also demonstrates excellent release control for highly soluble molecules, something that could not be achieved either with BEPO or with BEPO STAR. Compared with BEPO STAR, sustained exposure is significantly extended, as shown in this graph depicting plasma concentrations in rats. We are really excited. This new platform opens the door to indications that were previously out of our reach.

This innovation is already being tested in several of our programs. I have delivered quite a lot of information, but I would like one message to be clear. Our platform expansion strategy is about expanding reach, not about replacing existing platforms. BEPO, BEPO STAR, and newer platforms are complementary, and together they form a robust toolbox for portfolio expansion. This summary slide illustrates that each platform extension expands our capabilities to formulate. The idea is to build a toolbox from which we can select the technology that best fits a given API. As a final point on platforms, let me give you some visibility on applicability and timelines. The timelines shown here illustrate how these platforms translate into clinical and commercial value over time. BEPO STAR may enter clinical trials in 2028, with a potential commercial launch around 2033. And regarding the next platform extension, we are ready to accelerate development to reach the market as quickly as possible. So far, I have focused on platform expansion. However, we know that platforms alone do not solve all our challenges. We have complementary R&D initiatives to provide further value. We pursue complementary innovation along three dimensions: API optimization, delivery devices, and external technology scouting.

Over the recent years, we have developed significant capabilities in API optimization with the objective of making difficult-to-formulate molecules compatible with BEPO. This can be achieved through approaches such as API engineering or the development of new products also. We are also exploring advanced delivery devices. As discussed, several times, adoption by clinicians and patients is critical, and one key moment for long-acting injectables is the injection procedure itself. Our goal is to make injections as comfortable as possible for patients and as simple as possible for clinicians. Finally, we have built strong capabilities in scouting external technologies. We closely monitor developments in our field and pay particular attention to academic groups and small companies developing technologies that may complement our platforms. These initiatives are not isolated. They are deliberately combined to expand the opportunity space and accelerate value creation. Before closing, I would like to spend a couple of minutes on time, which is a key structural challenge in long-

acting injectables. Because of the longer duration of action, development inherently takes longer, which is why we focus on generating decision-enabling data earlier, reducing uncertainty sooner, and shortening timelines wherever scientifically possible. Through automation, parallel workflows, and data-driven approaches, we have reduced formulation timelines by approximately 50%.

The objective of this acceleration is to improve capital efficiency, enable earlier partnering, and drive earlier value inflection. So that was it. I conclude here. And I hope that I have made it clear that R&D at Medincell is fundamentally about execution and value creation. We design long-acting injectables for real-world adoption, extend scalable platforms to fuel growth, and accelerate development through targeted investments that reduce risk and expand opportunity. This R&D roadmap is a key enabler of Medincell's Shift to Growth. I will now hand over to David Martin, who will explain how we protect this value through intellectual property and know-how.

David Martin

Firstly, thank you very much, Adolfo, for this review of R&D topics. My name is David Martin. I'm a patent attorney with 25 years' experience in the life science and pharmaceutical industries, and I'm Head of Intellectual Property here at Medincell. So I'll start with this first slide. This shows a top-level review of what I'll be talking about today. And there are 3 main takeaway messages from my talk. Firstly, IP is central to Medincell's value creation model. This is because the primary revenue for Medincell in the future will be royalties from patent rights. In this context, the longer the duration of patent protection that we get for products, the longer we get royalties. And I'll give you some examples of what this means in reality. I'll then discuss how Medincell has a proven strategy to build multi-layered patent protection for products incorporating our formulation technology. This gives extended patent protection to our partners and, like I've said, is a revenue driver for Medincell. I'll then highlight our patent portfolio and explain how patents and know-how are important to support partnerships, royalties, and build long-term value creation. And this topic will be picked up again by Sébastien, who follows after my presentation.

So firstly, I start with UZEDY. As you know, this was the first commercialized product which incorporated our BEPO formulation technology. UZEDY was launched in 2023 in partnership with Teva. Now, on launch, UZEDY had over 19 years of patent protection. And this length of patent protection, when launched, is very rare for a pharmaceutical product. We achieved this by obtaining multiple layers of patent protection. As you see here, the first layer is a BEPO platform technology patent protection. This expires in the US in 2033. Then we added two more layers. One layer protected the combination of the drug product with our BEPO formulation. And then we added another layer of protection to the use of the drug product. And together, these patent rights extend protection and royalties to 2042. So our IP protection is not just one patent, right. It's a stack of layered protections, each reinforcing the other. This provided value to our partners since there is an opportunity to extend patent protection long before and beyond their core technology, and it means they have the benefit of exclusivity for the formulation. And as I mentioned before, it creates value for Medincell by generating revenues over an increased time.

Now, UZEDY is not just a one-off. In this slide, we consider Olanzapine. This will be the next product to be launched that incorporates BEPO formulation technology. This product will again be launched in partnership with Teva in the near future, and on launch, it will have around 17 years of patent protection. Again, we have different layers of patent rights. One layer protects the formulation, and the other layers protect a combination of the drug product with the BEPO formulation and the use of the drug product to treat specific patients. Together, these rights will generate revenue until 2044. Again, this length of time is very rare for a pharmaceutical product, and again, it provides value to the partners since they have exclusivity. And again, it provides royalties, revenues, well into the future. So how do we achieve this long protection for our products and the partners? Our patent strategy delivers layered patent rights. Each layer adds longer patent protection, which means longer royalty revenue. First, we have the platform technology protection, and importantly, our platform patent rights are granted in all major territories. Then we have the product layer. This protects the drug product, the combination of API with BEPO formulation.

And for UZEDY, the product is patented to 2040, and Olanzapine to 2044, as I just said. And there are other examples in different programs. So for example, our pain management program has formulation protection. Our female contraception program has pending formulation protection rights. So we have a proven strategy for obtaining product protection. Then we have additional life-span layers which extend the lifetime of patent rights. These additional rights relate to different innovations — for example, methods of treatment or specific patient populations using our formulations. We patent other opportunities as they arise. So you can see our IP protection is not just a single patent, right. It's a stack of protections reinforcing each other. And this stack of protections means a stack of royalty revenue generation. It also optimizes patent duration to protect the commercial lifecycle of the product. Now, why is this important? Because partners don't want to just access our platform patent rights. Our IP strategy provides value to partners, since there is an opportunity to extend patent protection long beyond core technology protection. And this provides revenue to Medincell long into the future. Now, the Olanzapine and UZEDY patent rights are excellent examples of the strategy, and we have others in our pipeline.

So, this strategy is not theoretical — it is proven. And as Sébastien will explain shortly, how the success of our IP strategy is an important part of our business development strategy. I'll now discuss how our patent rights for platform formulation protection have expanded over time. Here we see the multiple versions of the BEPO technology, and for each innovation, we restart the clock — meaning the 20-year protection begins again for each of these new formulation innovations. For BEPO, we have first-generation protection to 2033 in the US. In what we call internally BEPO 3+, we have protection to 2038. For BEPO STAR, we have protection to 2040, and we have patents granted in all major territories for all these formulation technologies. Then for the ongoing platform improvement which Adolfo was talking about, for each new

innovation arising, we will file for new patent protection, which will run for another 20 years. So you can see these improvements create additional patent rights, and these additional patent rights are opportunities to generate revenue for Medincell. Now, by ensuring our IP strategy is positioning right at the center of our research activities, we monitor ongoing improvements and we file patent applications only when we're confident we have the right data to make a strong patent.

Now I want to show you how Medincell continuously invests in its IP. On the left, you'll see the strong growth in the number of patent families over the years. Now, you may see the number can pause or even reduce from time to time, and I don't hide this. This is really important. It shows active management of the IP portfolio. We do this by reviewing the portfolio and we limit investment in IP rights which will not provide value to Medincell, and we instead prioritize investment in innovations that translate into real market value. In this way, we ensure IP decisions are business-driven decisions. But you can see the growth is in one direction. You can also see the chart on the right. This is also important. It shows the balance between granted and pending patent rights. The rise in granted patents indicates the success we have in obtaining these rights, and the rise in the number of pending patent rights indicates the vibrancy of the patent portfolio. These IP rights are key revenue drivers to the company. They grow as we grow in our success. I now want to emphasize another crucial component of our IP strategy: know-how.

While patent rights provide strong legal protection, they are published and expire after 20 years. These are the visible rights. In contrast, know-how does is not published and does not expire. It's hidden. This is the secret glue that holds our strategy together. We deliberately keep this know-how secret to create an extra barrier to market for competitors. So for example: what's the best way to make the polymers? Secret know-how. What's the best quality of polymers to use? Secret know-how. How are the formulations developed? Know-how. How do we select the best formulations? Know-how. This know-how is confidential to Medincell. Like with biologics, how you make something is as important as what you make. This know-how and our success in using it commercially is a crucial component to Medincell's financial future. It is important as know-how is a barrier to entry for competitors, and it is a control point in a relationship with partners. So what does all this matter? It matters because our IP rights are essential for our business development activities, as Sébastien will explain shortly. Partners want to access our patent rights. They are impressed with our multi-layered patent strategy. They need to access know-how to make formulations.

Together with our expertise in developing successfully commercialized products, our IP position is one of the reasons partners choose to work with Medincell. And that's the end for me today. I'll hand over now to Sébastien, who will explain how central partners are to Medincell's value creation model.

Sébastien Enault

Thank you, David. Hello everyone. As Chief Business Officer, my objective today is simple: to explain how Medincell creates long-term value from its technology platforms and why partnerships and alliances are central to maximizing that value over time. You've just heard about the evolution of our technologies with Adolfo and the strength of our intellectual property and know-how with David. What I would like to do now is to connect the dots: how technology, IP, medical, marketing, business insight, business development, and alliance management translate into sustainable long-term value creation. So today I have 3 main takeaways. First, Medincell as a key player in the LAI ecosystem. Second, how we selectively build a portfolio of blockbuster-potential LAIs. And third, how we focus on maximizing long-term value through partnerships with Big Pharma companies and innovative biotech companies. Before talking about the strategic roadmap that we have deployed to build our portfolio and come up with transformative partnerships, it's important to understand the overall market we are addressing today and the one that we will be addressing in the long term. The LAI market is not new. The first LAI was approved in the '60s, but this is really with the introduction of the first antipsychotic LAI in 2003 that the market value significantly increased.

Last year, the market was roughly $20 billion with still the biggest piece of the cake for antipsychotics. And clearly, Medincell is in a great position with UZEDY and LAI, approved in 2023 and, fingers crossed, 2026, that will ensure accumulated market shares for Medincell in the long term. Adherence issues across chronic diseases is really a structural driver. LAIs directly address non-adherence, which is a major issue in psychiatry, but not only. It's also the case in oncology, infectious diseases, endocrinology, and other therapeutic areas. Poor adherence leads to relapse, hospitalization, and treatment discontinuation. This is a huge economic burden. So there is a strong incentive for patients, payers, and pharma companies to adopt long-acting injectables. In this industry, timelines are pretty long. To develop an LAI takes time. So it's critical to carefully understand the market and its evolution over time. If we look at the LAI market in the coming 20 years, the good news, it will still be growing and even better, much faster. One of the major inflection points in the LAI market is the entry of GLP-1 for type 2 diabetes and obesity. It was a couple of years ago, for which the growth will be the most important, from 10-15% market share to 30-35%.

And the need is there. As I said, adherence is key for chronic diseases, and GLP-1 today show probably the highest discontinuation rate. There was a big analysis last year that revealed that roughly 65% of patients under injectable GLP-1 therapy stopped their treatment after 1 year and 85% after 2 years. This knowledge of the LAI ecosystem is very critical to build the long-term strategy of the company and define where to go to maximize the biggest value. Talking about value, let me start with what I believe is one of Medincell's most powerful and sometimes underestimated assets: our position in the industry. Over the last 2 decades, we have put significant effort to increase the visibility of the company. The best way to do that is to prove to the industry that we are capable to deliver. And this is what we did. Over the last 2-3 years, only a few LAIs were approved, and none of them show better product features than UZEDY. Everybody agrees on this: pharma companies — not only Teva, but our existing and new partners — all the analysts, and the medical community. Two companies, ROVI and Indivior, that had a risperidone LAI, left because of UZEDY.

The industry knows how challenging it is to formulate Olanzapine. Eli Lilly failed. Zyprexa is a clinical and commercial flop. Teva had zero PDSS in Phase 3 after 3,600 injections. It's unbelievable, and the industry is aware of that. Medincell is not an early-stage drug delivery company anymore. Our technology is used in products that are given to patients. Companies such as AbbVie have no doubt about our technology and our ability to deliver. This is the reason why, in this strategic alliance with AbbVie, Medincell has full responsibilities for all of the preclinical activities until the IND. No doubt as well in terms of our capability to supply the required quantity of GMP-grade copolymers, thanks to our joint venture with Corbion. Something that I can witness as well is how the industry and competitors perceive Medincell as a model to follow in terms of innovation and IP know-how strategies. So Medincell is a company with real credibility and reputation. Now the question is how we are going to use this position to create value for the company long term. Whatever we're talking about — internal or external programs at Medincell — we deploy our technologies on applications where we see the biggest impact.

Our objective is to develop best-in-class products and be much better than the other LAIs. We have this strong mindset not to just develop a different formulation but a different treatment paradigm, not only to address treatment adherence. Drug delivery is a powerful tool to improve the performance of a molecule. It can be when a drug cannot be given orally, when pharmacokinetics and pharmacodynamics can really be improved, or when local delivery matters, allowing high concentration at the target site while limiting systemic toxicity. Lifecycle management. I guess you've heard about the patent cliff. The patent cliff is when a company has a blockbuster product that is losing its IP protection. This loss of exclusivity allows generics to come in, and it can be dramatic for the originator of the product. Usually for small molecules, revenues can drop by 80-90% in a year. Slower with biologics, but still a major erosion of 30-70% in a year. A big wave of patent cliff is coming — the largest since 2010. Between 2025 and 2035, the pharma patent cliff will represent roughly $400 to $600 billion of revenues at risk globally for Big Pharma companies. Merck with Keytruda, BMS and Pfizer with Eliquis, Johnson & Johnson with STELARA, Novo Nordisk with Ozempic.

Even AbbVie will be impacted on two major products. Except if there is a long-term lifecycle management strategy in place. This is one of our pillars in our portfolio strategy — not only with approved molecules but also with assets in late-stage clinical development. So now let's dig into our pipeline. Today, not necessarily about our late-stage assets, but I wanted to give you the opportunity to learn more about what is behind the blue boxes for which we have never disclosed much information. We are very cautious to have a good balance in our portfolio and the ratio between internal and external programs, and also the level of risk associated with the stage of development for identified molecule candidates, as you can see on this slide. In terms of therapeutic area, clearly there is no question. We have firmly established Medincell as a long-acting injectable leader for schizophrenia. We have not only maintained this position but expanded it, launching new internal and external programs that reinforce our leadership position. But our ambition doesn't stop there. Medincell has never been confined to a single therapeutic area or indication. Our motivation is to advance long-acting injectables across a broad range of therapeutic areas and indications.

This commitment to being therapeutic area agnostic empowers us to pursue new horizons and deliver transformative solutions in the future. To develop best-in-class LAIs, choosing the right molecule is very important, but not sufficient. What truly determines long-term success is having the right partner on board. This is our business model. It works. And our selection criteria are clear. We have to find the right partner that is convinced by the LAI strategy and that will follow the strategy for the coming 10, 15, 20 years. So I have two main questions. The first one: when to partner? And the second: which partners? We know that we want to generate maximum value long-term. Big Pharma and innovative biotech companies are ideal partners, and they are greatly complementary. Number 1, Big Pharma — well, obviously. They cover a lot of therapeutic areas and indications. They have the financial strength and all the expertise to reach the market. And post-approval, they can deploy significant commercial capabilities. AbbVie was clearly one of our top priorities. The company invested more than $60 billion in terms of R&D over the last 10 years. We are talking about 12 blockbusters in AbbVie's product pipeline. And AbbVie is certainly one of the best companies to protect key assets.

Let's take the example of Humira. Humira has 9 indications, 130 patents, and cumulative total sales of $220 billion. Number 2, innovative biotech companies. To me, they ensure a new wave of innovative products and new treatment modalities. Some of them could be the future Big Pharma of tomorrow. I met Gilead for the first time when it was a biotech company of fewer than 2,000 employees, in 2007, and now the company has a market cap of $165 billion. Similar story for Regeneron, Moderna, and many others. Some of our biotech partners have strong financial capabilities and can be the Big Pharma of tomorrow. One of them recently raised more than $150 million, and another one went public raising almost $300 million. We know and we already anticipate that potentially some of our biotech partners will be acquired by Big Pharma. They have already put in place some types of business arrangements with Big Pharma. This is what we see regularly in the industry. In CNS, I'm thinking about the acquisition of Karuna by BMS for $14 billion, Intra-Cellular Therapies by Johnson & Johnson for $14 billion as well, Cerevel by AbbVie for $9 billion. But not only in CNS — in other therapeutic areas as well.

Let's take oncology with the acquisition of Seagen by Pfizer for $43 billion, and Horizon by Amgen in immunology for $28 billion. Also, being at Medincell for a long time, it was very important to take into consideration lessons learned from the past. History has told us that pure generic makers are not our ideal partners, with the exception of Teva, which deployed the New Therapeutic Entity strategy in 2010, and now Teva is a great innovative company. Pure generic companies only focus on replicating something that works. They are not originators of the product. Therefore, they do not project themselves in the long term. So to recap: Big Pharma and innovative companies as target partners. There are two different ways to work with them. It can be from scratch when we join our forces since the beginning. This was the case with Teva on Olanzapine LAI. In this configuration, the partner pays for the overall development. After the formulation stage, if we have successfully identified the lead formulation, we execute a licensing agreement where Medincell will receive an upfront payment and later on development and commercial milestones plus royalties. Today, our financial standing and our ability to form partnerships are stronger than ever before.

It was part of our Shift to Growth strategy that we applied a couple of years ago. This enhanced position allows us to explore a variety of deal structures tailored to each asset and potential partner. Our partnering strategy can be deployed in two manners — and this answers the second question: when to partner. Now we can invest and initiate internal programs when we believe that formulating a given molecule as a long-acting injectable will create substantial long-term value. And our objective is pretty clear: to generate high-value data that positions Medincell optimally to engage partners and negotiate in a strong position. Our objective is not necessarily to sign partnerships as quickly as possible. Our objective is to sign partnerships at the right time, when the data package is strong enough to maximize the value of the deal. This can take time. But over the long term, it is absolutely worth it. Generating this level of data represents an investment of a few million per program. This is not a cost — this is a strategic investment. And the proof is very clear. This is exactly what we did with the first AbbVie program. To make a long story short, we screened the entire AbbVie product pipeline.

247 molecules. 200 molecules approved. 47 molecules in clinical development. 36 molecules were selected as potential good candidates as LAIs. 14 were selected based on their physicochemical properties. Finally, we came up with a preselection of 6 molecules. We decided to take the most promising opportunity and put it in the lab as our top priority to generate a data package proving that we could formulate the molecule. At the same time, we started building a robust business case internally with the inputs of physicians, key opinion leaders, and payers to validate the pricing and reimbursement strategies. And we initiated first discussions with AbbVie. First positive signals. So we kept going. At a certain level of maturity in terms of data, negotiations and due diligence processes started. And finally, not only on this specific opportunity — we were also proactive enough to have AbbVie committed on 6 programs, whatever the stage of development of the assets or the therapeutic areas. I'll let you think about the real potential of having 6 blockbuster LAIs approved through this collaboration with AbbVie and the long-term value it may represent for Medincell. By generating substantial de-risking data upfront, we were able to secure an upfront payment of $35 million.

Development and commercial milestones up to $315 million per program, and a royalty stream in the low double-digit range. Compared to the earlier partnership with Teva, this represented a step change in value capture, and we intend to keep deploying this strategy for very specific assets and identified partners. Today, all of our internal programs clearly fit with this strategy. The objective is to invest ourselves, or alongside our partners, to push a little bit further the time for licensing — from early formulation stage to beyond. Going back to Christophe's slide in terms of long-term royalties objectives, as I said, with more data, we are in a stronger position and we can afford to change the financial terms. I am personally convinced that the key driver for the long-term revenue growth of the company is to counterbalance the ratio early payments versus backloaded deals, with higher royalty payments. Based on previous and ongoing partnering discussions, we know what can be envisioned or not, depending on the partners. I'll let you just imagine the impact that an additional 1% royalty could have on a multibillion-dollar product for Medincell. Let's do a quick math exercise. For a $5 billion annual revenues product, pushing royalties from 7% to 10%, that's $150 million that can be added every year as revenues, just for one product.

Without zero expenses on our side — that I would like to remind you. And if this product is above $5 billion for 10 years, it represents $1.5 billion for Medincell. And again, just for one product. So, just to conclude, let me go back to my 3 main takeaway messages. The first one: Medincell is clearly a partner of choice in this LAI ecosystem. We have and we keep building a strong portfolio of blockbuster-potential LAIs. And we focus really on maximizing this long-term value through transformative partnerships — as I said, with Big Pharma companies and innovative biotech companies. Thank you for your attention.

David Heuzé

Thank you all for the presentation. We will now move on to the Q&A session with questions from analysts joining us from the United States and Europe. Analysts, you can raise your hand if you have questions. Our first question comes from Raghuram Selvaraju from H.C. Wainwright. Ram, you can open your mic.

Raghuram Selvaraju (H.C. Wainwright)

Yes. Can you hear me? So, very interesting presentations and congratulations on all the progress, first of all. And I have 4 quick ones. Firstly, maybe you can comment on when you expect, approximately, in the development of the candidates being advanced under the AbbVie collaboration, you and AbbVie would be in a position to disclose the identities of the APIs in question. That is question number one. Number two is, with respect to the overall approach in neuroscience, could you maybe elaborate on the specific areas within neuroscience beyond schizophrenia where you expect there to be the most significant potential for applicability of your LAI platform technology? Thirdly, this is a patent question. As you look at the difference between BEPO STAR and BEPO platform technologies, specifically, what might make BEPO STAR more defensible, more likely to produce more difficult-to-challenge patent claims versus BEPO? And are there in fact more layers of protection available because BEPO STAR is a more sophisticated technology platform? And then lastly, this is a business development question. You pointed out the potential for Medincell to seek partners among both big pharma and innovative biotechs. And I was wondering — in the case of innovative biotechs, you may partner with a company that is developing the next blockbuster, but it itself does not wish to directly commercialize such a product.

Maybe its ultimate goal is to sell itself. So what strategies can you undertake to optimize Medincell's intrinsic value in such a partnership when potentially your partner might itself want to be bought by someone else? How do you, for example, ensure that your royalty stream is protected and taken off the top, as it were, from whatever product might ultimately be commercialized, even if your original partner undergoes a change of control? Thank you.

Christophe Douat

Well, thanks a lot, Ram. Hello. What I suggest is maybe, Sébastien, you take questions 1 and 2, David questions 3, and I will answer question 4.

Sébastien Enault

Yeah, so thanks, Ram. Actually very, very good questions. Just going back to AbbVie and actually when we can expect the first AbbVie program going to Phase 1. And as you know, this is one of our top priorities at Medincell, but also for AbbVie. The deal that we have, AbbVie has secured rights to be committed to 6 LAI programs in total, but the top priority is really to move the first one into clinical studies. So this is actually our key objective and it is going the case in the coming months. About the disclosure of the molecule that is part of this first program, this is not public information and for confidentiality reasons, AbbVie does not want to disclose this information publicly because, as you know, competition is quite significant in the pharma industry. About where to go beyond schizophrenia: over the last year, we really wanted to focus on schizophrenia and the development of LAIs in schizophrenia. And this is what we have done. We had this clear position with UZEDY and olanzapine LAI, but there is also a big wave of a lot of different products for this specific indication.

And this is what we have executed. We signed actually new programs for this specific indication. We have also integrated a new internal program for this. And there was also a new wave of new drugs covering new mechanisms of action. I can mention muscarinic agonists, and today there are probably 7 companies working on it. This is not only in schizophrenia. Some of the companies are also focusing on additional indications with muscarinic agonists. I am thinking about psychosis in Alzheimer's disease patients, Bipolar I mania, and a few other indications. So this is a way to improve our leadership position in this field. But I would say that Medincell is really a kind of therapeutic area agnostic company. So we obviously want to extend the scope of LAIs where there are already existing LAIs, but we also want to develop LAIs in therapeutic areas or indications where there is no existing LAI yet.

David Martin

Thank you very much for your question. It is very interesting to compare the options for patentability between the different technology platforms we have. If I remember correctly, you asked about the potential and defensibility of BEPO and BEPO STAR patent right. Firstly, to make it clear, we have patents granted on BEPO and BEPO STAR — the platform technologies — in all major jurisdictions. They are good, strong, defensible patent rights. When it comes to building further formulation patents on top of that existing protection, patent strategies really rely on really two things, I would say: the data that you generate when you are using the formulations, and the way in which you build the story behind what is innovative about them. And these options are available for both BEPO and BEPO STAR. We see success — as we have seen before — with BEPO. And I think for BEPO STAR, as long as we adopt a similar strategy, we should have success again in the future.

Christophe Douat

Thanks a lot, David. So on question 4 Ram: you know, of course, all large biotechs have the objective to be acquired, and it is very rare that they would go commercial, and even when they do, they end up getting acquired. The last example, of course, is Intra-Cellular Therapies, which took lumateperone to market to about $700 million in sales and was acquired by J&J for $14.6 billion. We know the case well. As you know, Dr. Sharon Mates, its CEO and co-founder, is on our board. So, as it is a very likely scenario, we build this scenario into our contracts and legal agreements from the beginning, to make sure that all the rights get transferred to the big pharma company, which is a good scenario because they are the ones that have the resources and power to commercialize. However, we always, in all our contracts, regardless of the partner, build reversion rights as well in case of a stoppage of the program.

David Heuzé

Thank you, Christophe. Next question is from Matt Hershenhorn from Oppenheimer. Matt, you can open your mic. Hello.

Matt Hershenhorn (Oppenheimer)

Yes, you can hear me? Okay, perfect.

Yes. Thank you very much for doing this event and congratulations on all the progress. So I wanted to also ask about the potential to apply your LAI technology to the muscarinic compounds, just considering COBENFY and the current limitations there with side effects that drive patient discontinuations. How do you envision your LAI formulation overcoming those limitations? And how feasible would an LAI version be for COBENFY, which obviously combines two drugs, from a release engineering standpoint, especially when you involve more than one active agent and need to coordinate the release kinetics? And separately, I was wondering — as you alluded to — there are studies ongoing for COBENFY and muscarinics

beyond just schizophrenia, such as psychosis associated with Alzheimer's dementia. Just curious, especially considering an LAI technology for those patients where adherence might be a little more difficult within the elderly population and the safety that goes along with that. Really appreciate your time. Thank you.

Christophe Douat

Thanks a lot. It is a great question because it is in a space we know well. And I think, Sébastien, you are best placed to answer this one?

Sébastien Enault

Yeah, probably I can start with the business component. I will let Adolfo answer on the technology. You are right about COBENFY. This is a very good product in schizophrenia. But this drug also presents some drawbacks. And as you say, side effects are quite common. And actually, physicians sometimes have to prescribe antiemetics in combination with COBENFY. Plus, we addressed this question about treatment adherence, and COBENFY is given twice a day. So this is not really optimal for both patients and physicians. So in terms of how we can use a drug delivery tool or long-acting injectable platform, well, obviously there is really something to do. And I know that BMS is thinking about a long-term lifecycle management strategy with COBENFY. They have several Phase 3 studies for additional indications beyond schizophrenia — like you say, psychosis in Alzheimer's disease patients, Bipolar I, and also a pediatric indication for autism. But I think in terms of lifecycle management strategy, thinking about LAI could really represent great value if BMS wants to keep its position as the leader with muscarinic agonists.

Christophe Douat

Adolfo, is it an easy one to formulate?

Adolfo López Noriega

It is not an easy one, but we have demonstrated in the past with different proof-of-feasibility studies that we can co-formulate two different APIs within the same formulation and achieve the same exposure for both. So this is something we can definitely do. The platform is compatible with the release of several APIs at the same time. And in case of difficulties, as I was explaining during the presentation, we have developed a series of tools that can allow us to tune the APIs to make them more compatible with each other. So this is definitely something that is not easy, but it is something that we can do.

Christophe Douat

Thank you.

David Heuzé

Thank you. Next question comes from Shan Hama from Jefferies. Shan, you can open your mic.

Shan Hama (Jefferies)

Hi there. Thank you so much for the presentation. 3 questions, if I may. So in terms of the patent — with each innovation restarting the clock — what really matters here in terms of preventing generic entrance? Is it the tech protection? Is it the formulation protection? That is my first question. And then my second question please is: when it comes to business development, how are you thinking about licensing agreements and acquisitions in terms of the tech, therapeutic area as well as urgency timeline to execute? And then my final question, if I may — given the expectation that endocrinology is set to take the largest share of the LAI market by 2045, plus the efforts made with BEPO STAR in terms of incorporating peptides, is this a therapeutic area you are assessing or interested in entering? Thanks so much.

Christophe Douat

Hello, Shan, thanks a lot. David, the first question is for you.

David Martin

Hello, Shan, thank you for your question. It is a very good one. You asked about the different generations of BEPO and how the patent rights expiry would impact the entry of generics. So there are a couple of topics to pick up on here. Firstly,

I think, looking at the expiry of the BEPO platform technology patent rights, that is one angle, one aspect, but we have to remember — as I talked about in my presentation — that our IP rights are a mixture of that and also the know-how. So how do you actually go ahead and prepare these different copolymers that are needed in the formulations, and how do you actually know what the formulations are ultimately? In addition to that, there is of course our formulation patent protection, which broadly claims the specific APIs in combination with the BEPO formulations. So a generic would have difficulty in circumventing that more specific formulation patent protection as well. I have forgotten the rest — what was the next question? I am sorry.

Christophe Douat

So the two other questions were for Sébastien.

Sébastien Enault

It was just on the BD side about our licensing strategy. But just to be clear — are you talking about the licensing out strategy of the company, or about licensing in, in terms of new technologies or assets?

Shan Hama (Jefferies)

In licensing technologies.

Sébastien Enault

In licensing technologies. This is something that Adolfo actually explained in the presentation. To me, honestly, we have made significant progress in all the generations of technologies. And I can say that now we can formulate molecules that, for us, were science fiction a couple of years ago. So this is great. But I think we also have to be pragmatic, and in all of our analyses — I mentioned the patent cliff analysis — or sometimes, you know, we are in close relationship with big pharma companies when they give us wish lists in terms of drug delivery needs — molecules to formulate — we know that some of them will still be challenging even if we are going to make additional improvements with our technologies. So we have deployed internally a kind of scouting strategy roadmap where we have initiated close relationships with academic research institutes and biotech companies to complement BEPO, but also to use new technologies as standalone technologies that can do things that can really ensure long-term value creation for the company, and to address big therapeutic areas, big indications, and also new treatment modalities.

Christophe Douat

Sébastien, the third question is about peptides.

Sébastien Enault

When we talk about peptides, I would probably say two categories. Small peptides, and Medincell is already committed with a couple of partnerships and also internal programs with small peptides. And when we switch to larger peptides, thinking about GLP-1, the field is actually growing and it will be quite massive. So the great news is that Adolfo has shown great data with GLP-1 agonists. And there are plenty of companies in the field. And we know that now we are talking about dual agonists, triple agonists. There are plenty of not only approved GLP-1 agonists, but late-stage compounds that have recently shown great data in clinical studies. I am thinking about obesity data in terms of weight loss. So what we have done in schizophrenia with the LAI waves — this is something that we can anticipate in a bunch of new indications and new therapeutic areas, and we do not want to miss this GLP-1 wave, for sure.

Christophe Douat

Adolfo, maybe for some of our audience who is not as knowledgeable about APIs, could you explain what a peptide is and why it is different from small molecules?

Adolfo López Noriega

So a peptide is a chain of different amino acids. That means that typically a peptide is going to be of a larger molecular weight than a small molecule. If you keep growing a peptide and you keep adding amino acids, you will reach a protein. So a large peptide is in the borderline between a peptide and a protein. Small peptides typically are hydrophilic, which makes them difficult to formulate. And that is why I think that explains why we are so happy with the results we have shown. And then large peptides can be even more complex because they can sometimes have conformations that are related to

their activity. So they are not easy molecules to formulate at all, which again gives additional value to the results that we have shown today.

Christophe Douat

Thank you, very informative.

David Heuzé

Thank you. Next question is from Nicolas Pauillac of Kepler Cheuvreux. Nicolas, you can open your mic.

Nicolas Pauillac (Kepler Cheuvreux)

Yes, hi guys, I hope you can hear me and thanks for the presentation. Maybe 3 questions on my end. The first one is just a follow-up on this discussion around GLP-1. Given the fact that we already have some products that are in late-stage development for 1 month, long-acting versions of GLP-1, don't you think that the market might already be there when it comes to long-acting? So really just to follow up on that. And then the two other questions are more big picture. You mentioned during the slides that you intend to maximize the deal value. Are we to understand that there is a world in which in the future, because you have stronger cash flows coming in, you would be willing to fund Phase 1 or Phase 2 of a study to make sure that you get to, as you mentioned, this 10% or 15% royalties rate? And then lastly, just to understand the decision-making process when it comes to licensing — is it more you that are looking at the pipeline of companies and saying, okay, maybe we can plug our technology there, and once you see it is working, you are kind of knocking on the pharma door? Or is it more the other way around, with people coming to you?

Christophe Douat

Thank you, great questions. Maybe I will get Sébastien to answer the first and last questions, and I will answer the middle one.

Sébastien Enault

Thank you, Nicolas. I was taking notes at the same time, just not to forget something. About GLP-1 — yes, you are right. And going back to schizophrenia and LAIs for this indication, this is what we have seen at the very beginning: daily, weekly, monthly, 3-month, 6-month products. And this is something that will be reproduced with GLP-1. It was daily, it is now weekly, and monthly with some products. I am thinking also of the acquisition of Metsera by Pfizer. But we know the need. And again, we are pretty close to the big pharma companies and innovative biotech companies in the field. And we know that the trend will be more toward quarterly injection rather than monthly in the future. As I said, the discontinuation rate is pretty long. We are talking about chronic diseases. So 3 months will be better than 1 month. And we know that Medincell is well positioned in the field. I do not know if we will have questions about competitors, but one of them actually signed a deal with a company. But we know that with that technology, going beyond 1 month is impossible. So they cannot actually develop a long-acting formulation of a large peptide above 1 month.

So Medincell will be in a strong position to do that. Going back to the question about how we can maximize long-term value, and if we look beyond where we are, we have two strategies. And again, we have a strong BD team at Medincell. It is now based in France, but not only. We have reinforced our BD team — now we have people in Asia and in the US. They are very active. We screen probably 2,000–3,000 companies every year to find the future great candidates to be integrated within our platform. And we have some partnering requests, more and more. So this is actually a great thing, because now we have a pretty good position in the LAI field. So we spend time to look at each opportunity. Sometimes we take the opportunity — but also the risk — to invest ourselves and to generate data. This is what happened with the first AbbVie case. And this is an open question internally: if we can go further. I think yes, we can generate more value long-term. And switching from, I would say, single-digit royalties, as was the case previously, to low double digits, I think we can expect higher royalties if we spend more money in some key programs in the future.

And about the process and decision-making, we usually do a very exhaustive, long exercise. Clearly, with big pharma, we have probably taken 25 big pharma companies and screened their entire pipelines — all of the big pharma companies — to really, from hundreds and hundreds of molecules, identify only a few. And we now have great internal expertise. We have medical marketing and business insight connections. We are in contact with key opinion leaders, payers, and physicians. We can now anticipate what the pricing and reimbursement strategies could be. We can invest, we can discuss with partners, and then we can select and pick up the right opportunity — both for Medincell and for our partners.

Christophe Douat

Thank you, Sébastien.

David Heuzé

Okay, next question is from Les Sulewski from Truist. Les, you can open your mic.

Les Sulewski (Truist)

Thank you. Good morning. Thanks for doing this call. So first, Christophe, maybe you can address the milestone timing perspective. Can you speak to the quantum and expected timelines of the commercial milestones from Teva on the UZEDY and the olanzapine LAI programs? Second question is, how many active feasibility studies are ongoing today versus a year ago? And have you shifted to BEPO STAR for all these studies, or is there still a valid use for the future formulations with the original BEPO technology — or is the shift mostly because of the longer IP protection? And then lastly, you briefly mentioned the ability for BEPO STAR use with autoinjectors. Can you comment on the progress with this administration method? Thank you.

Christophe Douat

So I will answer the first one, and maybe Adolfo, you can answer the others. So I remind everybody that on Teva, we have $150 million of milestones due along the commercial life of the product and based on sales levels. On AbbVie, the total amount of milestones — development plus commercial — is $315 million per program. The split is not publicly known, but if you use the same ratio as Teva, which reflects an NPV-based ratio, you would end up around $60 million in development milestones and maybe $250 million in commercial milestones, which are built obviously on levels we thought would be attainable. On Teva in particular, those milestones were negotiated in 2013, when the lead program in long-acting injectable in schizophrenia had just above the billion-dollar mark in sales.

Adolfo López Noriega

So the first question was about the number of programs we have nowadays compared to one year ago. I honestly do not have a figure in mind. What I can tell you is that we are much, much, much busier in the lab. I do not want to give a fake number, but I think this is related to two facts. First — and I have been at Medincell for some time now —11 years now, 11 and a half. Not as many as some of you, but getting there. So I have witnessed that with UZEDY and its success, the doors are opening much more easily. And second, as Sébastien just said, BD efforts are multiplying, and we see the results of this. We are really, really busy in the lab, I can say that. And you mentioned you were wondering about the utilization of BEPO STAR versus BEPO Linear. Just to be clear, as I was saying during the presentation, our policy is not about excluding one of the technologies. It is about using the technology that fits the best.

However, of course, every new program that enters the lab today is tested both with BEPO and BEPO STAR. This is our strategy, and the product that works the best is the one that is moved forward. I think that answered that question. The second question — was there a question about autoinjectors? Yes, about BEPO STAR being more compatible with autoinjectors. This is an active research line. As I mentioned before, we are actively working on evaluating different types of injectors that can answer different needs. Obviously, autoinjectors is one of them. Making the injection process easier for the patient is one of our focuses. And obviously, BEPO STAR, since it presents lower viscosity and a lower injection force, is better suited for this type of device than BEPO.

Christophe Douat

Maybe you can give us an idea of how much less viscous BEPO STAR is versus BEPO.

Adolfo López Noriega

You have seen figures in the presentation, but to compare things correctly — and I am going to be a little technical here — polymers are large molecules, and you have to compare polymers that have the same molecular weight, okay, the same size. And this is what we are comparing, because otherwise we would just be cheating. So when we compare BEPO and BEPO STAR formulations with polymers of the same molecular weight and the same content, the figures show that we can lower the viscosity by a factor of 4 or 5, which is huge.

Christophe Douat

Okay, very, very impressive.

David Heuzé

Thank you. Next question comes from Marc Goodman of Leerink Partners. Actually, this is Basma on behalf of Mark.

Basma Radwan (Leerink Partners)

Hi. Hi. Good afternoon. Thank you for taking our questions. I would like to follow up further on the indications beyond schizophrenia and more specifically within neuroscience. We were just wondering if you can provide some color on why the LAI has not entered a market like depression, for instance, or epilepsy. Does it have something to do with the chemical structure of the standard molecules used in these indications, or basically the unmet need was not as pressing as it was for schizophrenia? The second question we have is on the sweet spot for the duration of the LAI. I heard that the quarterly injection seems to be optimal for GLP-1. Is it the same across all indications — does 3 months seem like the nice sweet spot? That is it for us. Thank you.

Christophe Douat

Sébastien, I think these two questions are for you.

Sébastien Enault

Yes. In neuroscience, well, obviously our objective is to extend the applications of BEPO and all of the new generations of BEPO outside schizophrenia. So schizophrenia, bipolar disorder, but there are a bunch of indications that we can target with LAIs, because we are talking about chronic diseases where adherence is a key problem. Also, what we want to do — and this is also the case with some biotech companies — it is not necessarily only about the question of treatment adherence. There are some drugs we are working on that have to be improved in terms of PK and PD profile, and there are many other aspects for which we can apply our technology. About epilepsy — this is an indication that we are looking at, like many of us, every time we look at the treatment regimen for specific indications. And for some indications like epilepsy, sometimes we are talking about not a monotherapy, but patients who are epileptic having to take several drugs at the same time. So one can argue about whether having an LAI could be really beneficial compared to polymedication. About the sweet spot in terms of duration for LAIs, it is very important to anticipate what will be the market need.

And for GLP-1, from weekly to monthly, and potentially in the future with quarterly injection. But this is not the case for all indications, and even for all of our partners. We have partners today who have NCEs in clinical development, but we are considering lifecycle management. It can be from daily subcutaneous injection to weekly, and as a second lifecycle management layer, monthly injections. So sometimes it is not necessary to go very far in terms of extended durations, because development of LAIs takes time. And sometimes, looking at the competitive landscape of our partners, it is not necessarily a good fit to develop 3 or 6 months because, knowing the loss of exclusivity of the molecule or the advancement of competition, we have to reach the market as soon as possible. So there are several components, and sometimes longer duration is not necessarily what needs to be followed.

Christophe Douat

Maybe you could elaborate a bit on the peptide case, which is a bit different in terms of duration.

Sébastien Enault

Yes, because peptides by definition have very short half-lives, and sometimes some companies we are working with find this a nightmare, because they would have to inject even twice daily a peptide that can show great efficacy. But now there is something to do with the formulation, and this is something I really want to insist on today: BEPO and all the generations of BEPO are great drug delivery tools to maximize the performance of molecules, and not only just to extend duration between injections.

Christophe Douat

Thank you, Sébastien.

David Heuzé

Next question comes from Michael DiFiore from Evercore. Hi Mike.

Michael DiFiore (Evercore)

Hi guys, thanks so much for putting on this event. A few questions for me. Just to clarify BEPO STAR — exactly how large a peptide can this platform formulate in terms of amino acids, versus, I guess, your next-gen platform innovation? And when would the new platform innovation be ready for the clinic? I recognize it is pretty early. Second question: in terms of GLP-1s and incretin therapies, will the BEPO STAR platform be applicable to the entire class, including amylin analogs? And how might a product's lipidation technology interfere with your technology? And the last question is kind of a general legal question. I know that you emphasize that the know-how is unpublished. But I am not a patent lawyer — in the event of litigation, how might your unpublished know-how work against you in terms of providing adequate description, which is often required in patent litigation? Thank you.

Christophe Douat

So maybe, Adolfo, you take questions 1 and 2, and David, of course, question 3.

Adolfo López Noriega

So if I understand correctly, your first question was about how large the peptides are that we can formulate with BEPO STAR. With the results that you have seen on the screen, we are working with a peptide that is beyond 30 amino acids — so already quite a large peptide. We have experience in the past with peptides larger than 40 amino acids. We have worked and are actively working with others. You were wondering about the timeline for the next generation we introduced today. And the answer is that we will get there as soon as necessary. We have the capabilities today and the knowledge and experience from BEPO and BEPO STAR to accelerate if we need. As I mentioned during the presentation, we are already evaluating this new generation in the lab with molecules that have market potential. So if results are positive, we are ready to push the accelerator and move as quickly as possible.

Christophe Douat

Adolfo, maybe give us some color about the excitement that this new generation is creating internally.

Adolfo López Noriega

I think it is not only internal excitement. I am sure that in the audience there are many people who have worked in drug delivery and know how extremely difficult it is to control the delivery of a small hydrophilic molecule. And for those that are not familiar — this is very, very difficult with our type of formulations, with polymer-based formulations, especially when we are speaking about injectables and in situ forming depots. This is extremely positive. In the time I have been at Medincell, we have not seen anything like this.

Christophe Douat

Yeah, it is probably the most excitement we have seen internally on innovation. Absolutely. Just for some of the audience, can you explain what a hydrophilic molecule is and why it is difficult to formulate, versus hydrophobic ones like risperidone and olanzapine?

Adolfo López Noriega

Exactly. And actually, to be more precise, I say hydrophilic, but we should actually be speaking about aqueous solubility. So a product that is very soluble is very difficult to control the release. You can imagine that the molecule is inside the depot — inside the reservoir — and then diffusion will happen from the depot. If the molecule is very soluble in the surrounding environment, diffusion is going to happen very, very easily. I think this is easy to understand. So what we have managed to do is to make networks or depots that actually hinder this diffusion. And that is really difficult. And we are very proud of what we have achieved.

Christophe Douat

Big achievement. Congratulations.

Adolfo López Noriega

There was a second question around the lipidation of GLP-1 peptides, and definitely this complexifies the formulation of this type of molecule. And once again, that is why I keep saying it — but it is the reality — that is why we are so happy and so proud with the results that we have shared with you today. The fact that despite the lipidation, and despite the fact that these molecules are very easy to dissolve in water, we have managed to achieve sustained exposure for 1 month. And

even more importantly, with a very reduced burst at the beginning — a really reduced peak of concentration just after administration — which is a must for this type of molecule.

Christophe Douat

So, exciting things, and as we said in the presentation, more to come. And David, please, question number 3.

David Martin

Okay, this is the question about know-how and how it can be used in litigation and enforcement procedures. So there are a couple of points to make about this. Know-how can be things like unpublished best ways to manufacture copolymers, for example. In this sort of situation, the barrier to market would be primarily: what is the best and most optimal way to make the copolymers in sufficient quantities of commercial grade for use commercially? The second thing to remember about know-how is that it is more about experience and selection criteria. How do we know which is the best sort of candidate to take forward from a feasibility study into lead formulation selection? This is really where our experience comes to the fore. As far as these being unpublished know-hows — we do have internal catalogs of what our know-hows are. So if they were to be needed in any sort of litigation or enforcement procedures, we can rely on the fact that we know what our know-hows are, and they are recorded internally to support that.

Christophe Douat

Yes. And I should say, David, that one of the reasons you joined us is to do just that — to prepare for potential future litigations. Yes, we all know that it happens regularly in pharma companies, and you work with the best litigation lawyers worldwide. Indeed, indeed.

David Heuzé

We have time for one last question. Yes, it seems that Nicolas Pauillac of Kepler Cheuvreux has another question?

Nicolas Pauillac (Kepler Cheuvreux)

Yes, yes, thanks for taking my follow-up and sorry for making you go over time. You had this slide about the expected loss of exclusivity and the patent cliff over the next 10 years. Very interesting, but it would be interesting to know — as of today, in your portfolio, how much of the development is focused on lifecycle management that might happen on these drugs, and how much is really focused on innovative drugs where you are starting from zero with the companies? And just on the timeline when it comes to these kinds of lifecycle management projects — do you think that you have the right commercial opportunity when we know that, for instance, Gilead, whom you mentioned, already has their long-acting capabilities in HIV? So is it really about finding what they are missing and knocking on the door?

Sébastien Enault

Thank you. Just this table of the loss of exclusivity with a lot of drugs from big pharma companies — this exhaustive list goes until, I think, 2035. Internally at Medincell, we are looking at molecules that will be losing IP protection beyond that. So today, we are looking at drugs — future blockbuster drugs — that will be off-patent in 2038, 2039. Just to give you the big picture, this is a very long exercise, but at the end it works, because we know that we can identify a real opportunity for the company that really wants to protect its assets. And it is also very important to have clear timelines in mind. If we develop a 1-month product, how long is it going to take? When can we expect the approval? And we can also make sure that the company will still have the commercial teams and the sales force to have a clear lifecycle management strategy. And the proportion of innovative drugs versus approved drugs for which we apply lifecycle management — this is very important to have a good balance. There are plenty of opportunities to take approved molecules and do lifecycle management.

The risk is much lower. The drug has already been approved. We use the 505(b)(2) pathway for the FDA. So we can go fast and the risk is lower, as I said. But we also see that there are great molecules even in late-stage clinical development — even with new mechanisms of action — that can really be the blockbusters of tomorrow. So this is something that we want to keep controling and to have the right balance between truly innovative and approved assets. And then the other question — what about Gilead and HIV? Yes, for HIV prophylaxis. You are right. We are talking about CABENUVA and many other products that are already very long-acting. And this question about timelines of development is also key — whether it is an internal program or a program we may have with a partner. We know it is going to take time. So should we be very relevant with a 12-month product for HIV prophylaxis in many years from now? This is a challenging question that we are actually asking ourselves internally.

David Heuzé

Thank you, Sébastien. And the last question, in fact, is from Martial Descoutures of Oddo BHF. Martial?

Martial Descoutures (Oddo BHF)

Hello, hello. Do you hear me?

David Heuzé

Yes, we can hear you, Martial.

Martial Descoutures (Oddo BHF)

Great. Thank you very much. Yes, sorry, very, very short question. Do you see maybe any changes in the production process for the next BEPO generation? So is it possible to have an update on your capacity of production and where we could expect the next step? Plus, in parallel, could we have maybe a new strategy with the new BEPO generation, such as maybe to be more focused on new molecular entities, for example? Thank you.

Christophe Douat

You can take the first one, and maybe the last one as well. Thank you, Martial.

Adolfo López Noriega

Yeah, thank you very much, Martial. That is a very, very interesting question. So regarding the development of new generations of BEPO and BEPO STAR, we consider the risk to be manageable. We are already implementing them in our development programs. As I explained before, we built on the same chemistry as BEPO just to be able to move forward as quickly as possible, and that is exactly what is happening. Regarding future generations, for any generation to come, as I was explaining during the presentation, what matters for us is adoption. That comes from the very beginning of any kind of platform development we do. So this means that we are using building blocks for future generations that are already de-risked, that are going to be simple or easy to move forward. So we foresee — and that is why we are being so optimistic — that there will be no issues in moving forward any of these new platforms when we decide to do so.

Christophe Douat

Thank you, Adolfo.

Sébastien Enault

And about the use of new generations of BEPO with NCEs versus approved molecules, I would say it depends. It depends on the molecule. It also depends on the partners sometimes. There are some big pharma partners who, because of the pressure of the competitive landscape and loss of exclusivity — where they are going to lose patent protection — prefer to use the first generation of BEPO, because there was already what you might call a stamp — already approved by the FDA, already in UZEDY, and soon to be in Olanzapine LAI. But we also have some partners today who are applying a lifecycle management strategy quite early in development. Sometimes they have a drug just in Phase 2, but they are already anticipating a lifecycle management strategy with a long-acting injectable formulation. In that case, they will prefer to use the next generation of BEPO, and not necessarily the first generation. So again, this is really about the right proportion and something that we discuss with our partners — what is the best strategy. Thank you, Sébastien.

David Heuzé

And thank you. We have come to the end of the meeting. A replay of the webcast will be available on our website right after this meeting. As a reminder, our next scheduled update will be the publication of our financial results on Tuesday, June 16th. And once more, thank you all for the presentation. Thank you all for your interest in Medincell, and we look forward to speaking with you again soon. Thank you all.