Pharming Group N.V.

Corporate presentation

January 2025

NASDAQ: **PHAR** | EURONEXT Amsterdam: **PHARM**

Forward-looking statements

This presentation may contain forward-looking statements. Forward-looking statements are statements of future expectations that are based on management's current expectations and assumptions and involve known and unknown risks and uncertainties that could cause actual results, performance, or events to differ materially from those expressed or implied in these statements. These forward-looking statements are identified by their use of terms and phrases such as "aim", "ambition", ''anticipate'', ''believe'', ''could'', ''estimate'', ''expect'', ''goals'', ''intend'', ''may'', "milestones", ''objectives'', ''outlook'', ''plan'', ''probably'', ''project'', ''risks'', "schedule", ''seek'', ''should'', ''target'', ''will'' and similar terms and phrases. Examples of forward-looking statements may include statements with respect to timing and progress of Pharming's preclinical studies and clinical trials of its product candidates, Pharming's clinical and commercial prospects, and Pharming's expectations regarding its projected working capital requirements and cash resources, which statements are subject to a number of risks, uncertainties and assumptions, including, but not limited to the scope, progress and expansion of Pharming's clinical trials and ramifications for the cost thereof; and clinical, scientific, regulatory, commercial, competitive and technical developments. In light of these risks and uncertainties, and other risks and uncertainties that are described in Pharming's 2023 Annual Report and the Annual Report on Form 20-F for the year ended December 31, 2023, filed with the U.S. Securities and Exchange Commission, the events and circumstances discussed in such forward-looking statements may not occur, and Pharming's actual results could differ materially and adversely from those anticipated or implied thereby. All forward-looking statements contained in this presentation are expressly qualified in their entirety by the cautionary statements contained or referred to in this section. Readers should not place undue reliance on forward-looking statements. Any forward-looking statements speak only as of the date of this presentation and are based on information available to Pharming as of the date of this presentation. Pharming does not undertake any obligation to publicly update or revise any forward-looking statement as a result of new information, future events or other information.

Building a leading global rare disease biopharma company

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Market RUCONEST® for acute HAE attacks in key markets – U.S. focus

Positive cash flow from RUCONEST® revenue funds Joenja® (leniolisib) launches & pipeline development

- Revenue FY23 US$227.1M
  9M24 US$172.6M (+12% vs. '23)
- Increase in patients and prescribers driving growth
- Patients reliant on RUCONEST® despite increased therapy options

Global approvals and commercialization of Joenja® (leniolisib) for APDS

Successful commercialization of Joenja® (leniolisib) – first and only FDA approved treatment for APDS

- Revenue – U.S. and NPP
  9M24 US$31.9M (+210% vs. '23)
- Strong focus on patient finding
- U.K., Israel approvals
- Regulatory reviews ongoing in EUR, CAN, AUS
- Pediatric and Japan clinical trials

Ongoing pipeline development and management of rare disease assets

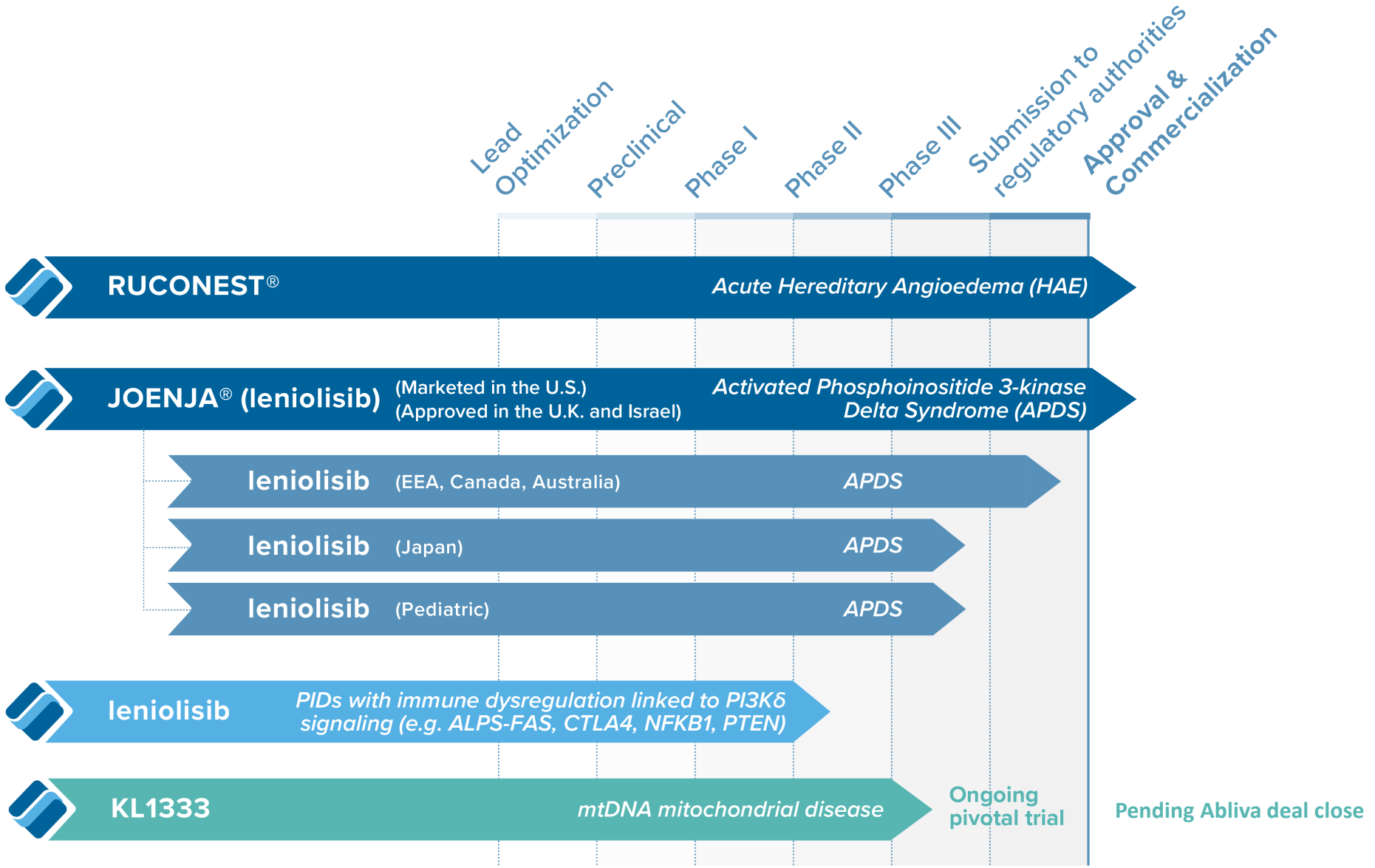
Advance internal projects and rare disease in-licensing and acquisition strategy

- KL1333 for mtDNA mitochondrial disease – pivotal study, significant commercial opportunity, potential first to market end 2028
- Leniolisib for PIDs with immune dysregulation linked to PI3Kδ signalling (Phase II) ~5x APDS pop.
- Undisclosed 3rd PID indication (Phase II planned)

2024 Total Revenue Guidance - $280 – $295M (14 – 20% growth)
Driven by Joenja®

Pending Abliva deal close

Pipeline – multiple commercial stage rare disease products



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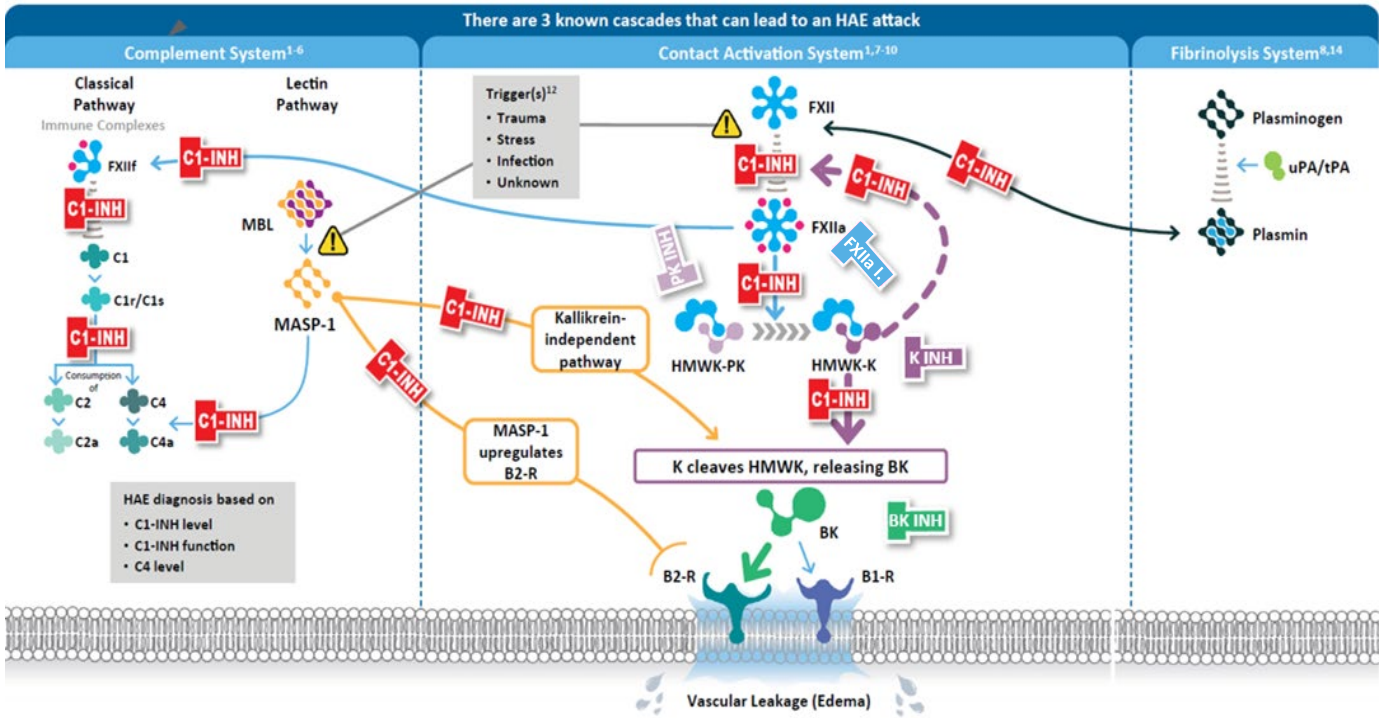
RUCONEST®

C1-INH targets the root cause of HAE
Addresses patient needs unmet by other therapies

TARGET	BRAND NAME	GENERIC NAME	STATUS	TYPE
C1 Inhibitor	Ruconest	C1 esterase inhibitor (recombinant)	Marketed	OD
	Berinert	C1 esterase inhibitor (human)	Marketed	OD
	Haegarda	C1 esterase inhibitor (human)	Marketed	Prophy
	Cinryze	C1 esterase inhibitor (human)	Marketed	Prophy
Pre-Kallikrein	n/a	donidalorsen	Phase 3	Prophy
	n/a	NTLA-2002	Phase 1/2	Prophy
Plasma Kallikrein	Kalbitor	ecallantide	Marketed	OD
	Orladeyo	berotralstat	Marketed	Prophy
	Takhzyro	lanadelumab	Marketed	Prophy
	n/a	sebetralstat	NDA	OD
	n/a	STAR-0215	Phase 2	Prophy
FXIIa	n/a	garadacimab	BLA	Prophy
Bradykinin B2	Firazyr	icatibant	Marketed	OD
	n/a	deucrictibant (PHVS416)	Phase 3	OD
	n/a	deucrictibant (PHVS719)	Phase 2	Prophy

Overview of Marketed and In-Development Therapies and Their Targets Within the Three Known Cascades Leading to HAE Attacks



Source: Cascade Adapted from a clinical cascade developed in partnership with Dr. Allen Kaplan. This is a current scientific understanding of the cascades.
Clinical implications are unknown.

RUCONEST® (rhC1INH): trusted treatment cornerstone for HAE

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- The only recombinant treatment that targets the root cause of HAE by replacing missing or dysfunctional C1-INH
- 2nd most prescribed product for acute attacks
  Typical patient: failed icatibant (BK inh) and on prophy Tx (K inh)
- Well-tolerated and effective treatment option for acute hereditary angioedema (HAE) - including breakthrough attacks
- 97%: needed just 1 dose of RUCONEST®[1]
  93%: acute attacks stopped with RUCONEST® for at least 3 days[2]
- Strong U.S. in-market demand –
  New enrollments up 25% in FY23
  ~100 enrollments in 3Q24
- Performing well in leading U.S. revenue indicators: patients on therapy, vials shipped, physicians prescribing (786, +57 vs. 2023)
- Revenue:
  FY23 US$227.1M (+10%)
  9M24 US$172.6M (+12%)
- Strong growth in 2024, well positioned vs. acute orals in late-stage development

References: 1. RUCONEST®. Prescribing information. Pharming Healthcare Inc; 2020. 2. Bernstein JA, et al. *Ann Allergy Asthma Immunol.* 2017;118(4):452-453. 3. Data on file. Pharming Healthcare Inc; 2019
The most common adverse reactions (incidence ≥2%) were headache, nausea and diarrhea. The most serious adverse reaction reported in clinical trials was anaphylaxis.

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Joenja® (leniolisib)

U.S. launch of Joenja®: first and only approved therapy for APDS, corrects the underlying immune defect

Joenja® (leniolisib) is a prescription medicine that is used to treat activated phosphoinositide 3-kinase delta (PI3Kδ) syndrome (APDS) in adult and pediatric patients 12 years of age and older

APDS is a complex syndrome caused by pathogenic variants of the PI3Kδ enzyme, with significant mortality

Joenja® is an oral, selective PI3Kδ inhibitor designed to help regulate the hyperactive signaling pathway

FDA approval (March 2023) based on randomized pivotal study and OLE study
U.S. launch (April 2023)

Joenja® is an oral immune modulator targeting the root cause of APDS

- Normalizes the hyperactive PI3Kδ pathway to correct the underlying immune defect in APDS patients
- Helps address both immune deficiency and immune dysregulation

No drug-related serious adverse events or study withdrawals in Joenja® trials
Clinical data and tolerability for long term treatment

Please see Important Safety Information and full Prescribing Information available at joenja.com

Rao VK, et al. Blood. 2023;141(9):971-983
Rao VK, et al. Poster presented at: 64th Annual American Society of Hematology Annual Meeting; December 10-13, 2022; New Orleans, LA.

Joenja® (leniolisib) – strong execution and growth opportunity

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Joenja® U.S. (APDS)	Leniolisib (APDS)	Leniolisib for Primary Immunodeficiencies (PIDs)
• Marketed (12+) • Found >230 of ~500 patients • 93 patients on paid therapy + 5 pending • >30 diagnosed patients (12+) not yet enrolled and >60 pediatric • Growth potential from patient finding and VUS efforts	• Found >870 patients globally • Global expansion / regulatory reviews • Pediatric studies / label expansion (>25% patients) • 164 patients in EAP, clinical studies, and NPP	• Phase II POC trial in PIDs with immune dysregulation linked to PI3Kδ signaling • Similar to APDS • Received regulatory feedback on third PID indication, preparing to initiate Phase II study

Prevalence: **~1.5 / million ~2,400 patients**

~7 / million

- Revenues:
  - U.S. commercial sales
  - Europe / RoW access program
- 3Q24 revenue US$11.3M
- 9M24 revenue US$31.9M
- U.S. Pricing
  - 30-day supply $47,220
  - Annual cost (WAC) $566,640
- Global expansion:
  - Europe, U.K., Japan, Asia Pacific, Middle East, Latin America and Canada

Hiding in plain sight: Patient finding strategy

Medical education to raise awareness of APDS and share leniolisib data

- Conferences and congresses
- Abstracts
- Publications

Genetic testing

- Sponsored, no-cost testing program
- Assistance from Genetic counselors
- Partnering with genetic testing companies to identify APDS patients

Family testing

- Inherited disease* but most APDS patients do not have diagnosed family members
- Cooperating with clinicians to educate/encourage family testing
- Genetic testing offered through partner Genome Medical

VUS resolution

- Validation studies with various laboratories to confirm which Variants of Uncertain Significance (VUSs) should be classified as APDS
- Diagnose additional APDS patients amongst those who have clinical symptoms and a VUS test result (>1,200 patients in U.S.)**
- Variant curation (ClinGen, Genomenon)
- Functional testing (PI3K pathway activity)
- Multiplexed assays of variant effect (MAVE) study (identified hyperactive variants, analyzing results)

*APDS genes are autosomal dominant meaning there is a 50% chance that a blood relative of an APDS patient may also carry that gene and in turn have APDS.
**To date Pharming has identified more than 1,200 patients in the U.S. with VUSs. As results become available, patients with validated variants could be diagnosed with APDS and be eligible for Joenja® treatment.

Joenja® – geographic / pediatric / indication expansion

Europe – CHMP review extended to January 2026
- Single outstanding CMC request
- Positive clinical benefit and safety concluded

U.K. marketing authorization received September 25, 2024
- Under evaluation by NICE

Japan clinical study: Patient enrollment is now complete
- PMDA filing mid-2025

Expanded Access and Named Patient Programs

Israel marketing authorization received April 30, 2024

CAN, AUS submissions under regulatory review
- Australia approval in 2025*

Pediatric studies
- 4 to 11 years – Positive topline data
- 1 to 6 years – Enrollment continuing
- Filing to begin 2H 2025

Initiated Phase II trial for PIDs with immune dysregulation linked to PI3Kδ signaling

* Anticipate regulatory action in 2025 for Australia

Leniolisib for PIDs with immune dysregulation

- **Primary Immunodeficiencies (PIDs) are a broad group of disorders with key potential features:**
  - Genetic basis
  - Immune dysfunction → increased risk of infection
  - Immune dysregulation → lymphoproliferation and autoimmunity
  - High morbidity and mortality

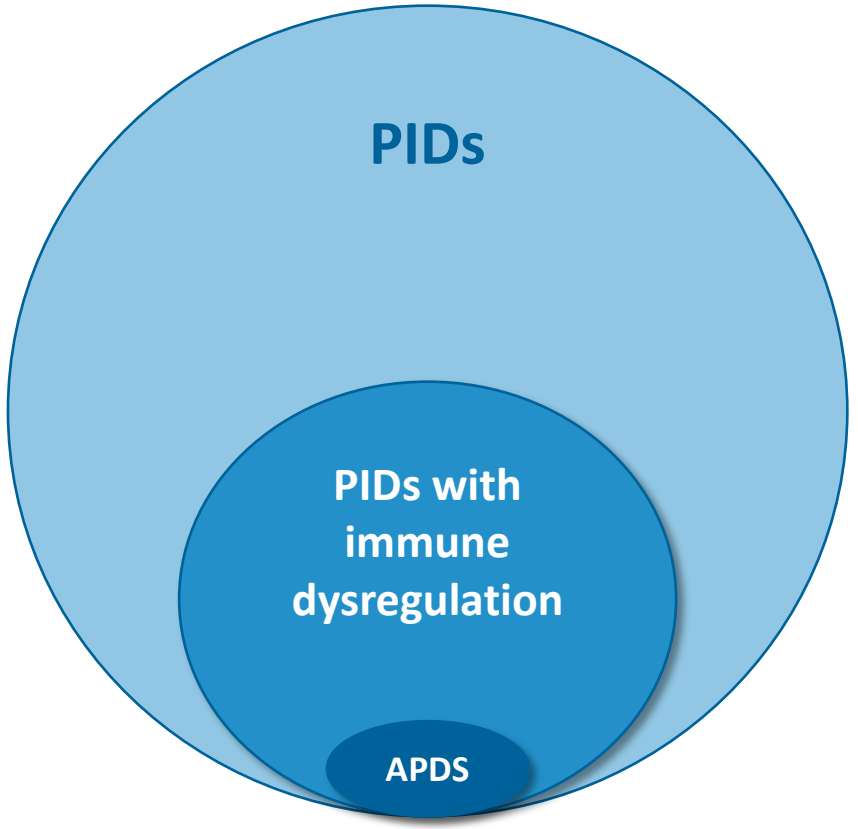
- **Pharming developing leniolisib for PIDs with immune dysregulation beyond APDS**

PIDs with immune dysregulation linked to PI3Kδ signaling

- Multiple PIDs with alterations in PI3Kδ signaling (including ALPS-FAS, CTLA4 haploinsufficiency, NFKB1 haploinsufficiency and PTEN deficiency)
- Clinical manifestations, disease onset and severity similar to APDS
- No approved therapies
- Prevalence ~7/million (approximately five times that of APDS)
- Phase II proof of concept clinical trial started October 2024

Next indication

- Received regulatory feedback on clinical development plan



Not to scale with population sizes

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Proposed Abliva AB Acquisition (KL1333)

Acquisition terms and financial details

Acquisition Terms

- Acquisition through a public tender offer under Swedish Takeover Act and Nasdaq Stockholm Takeover Rules
- Offer price of SEK 0.45 in cash for each share in Abliva AB, totalling approximately $66M USD *
- Minimum share acquisition target of 90% + 1 share
- Subject to customary regulatory approval

Financial Details

- Acquisition of shares with available cash
- Available cash and future cash flows expected to cover KL1333 development and pre-launch costs and current pipeline investments
- KL1333 in-licensed by Abliva from Yungjin Pharm, which is entitled to milestone and royalty payments **

Timing

- The acceptance period is expected to commence on or around January 16, 2025, and to expire on or around February 7, 2025

Transaction confirms our strategy of developing a high-value pipeline

*Based on an exchange rate of 0.0911 SEK / USD from 13 December 2024

**Worldwide rights, excl. Japan and South Korea primarily for the treatment of genetic mitochondrial disease; single-digit to low double-digit royalties on net sales, plus development and commercial milestone payments

Attractive rare disease opportunity with blockbuster potential

Mitochondria are the "powerhouses" of cells

- Producing chemical energy to power the human body, in particular muscle cells

Primary mitochondrial diseases are rare disorders affecting the mitochondria's ability to generate energy

- Patients suffer from severe fatigue, myopathy (muscle weakness) and reduced life expectancy
- Debilitating symptoms where patients cannot lead normal lives (e.g., loss of job, social isolation, depression)

KL1333 is a novel, first-in-disease therapy using a mechanism of action that addresses the underlying disorder

- Targets mitochondrial DNA (mtDNA) driven primary mitochondrial diseases with >30,000 diagnosed patients in US, EU4 & UK

Pivotal study is ongoing with positive interim analysis confirming the FDA-agreed primary endpoints

- Read-out anticipated in 2027 with potential FDA approval by end of 2028

Attractive commercial opportunity with significant unmet medical need and no approved therapies

- Builds on Pharming's expertise to bring novel, life-changing rare disease therapies to patients
- Enables the ability to leverage Pharming's existing rare disease commercial infrastructure

Pivotal study design based on regulatory and patient advocacy input

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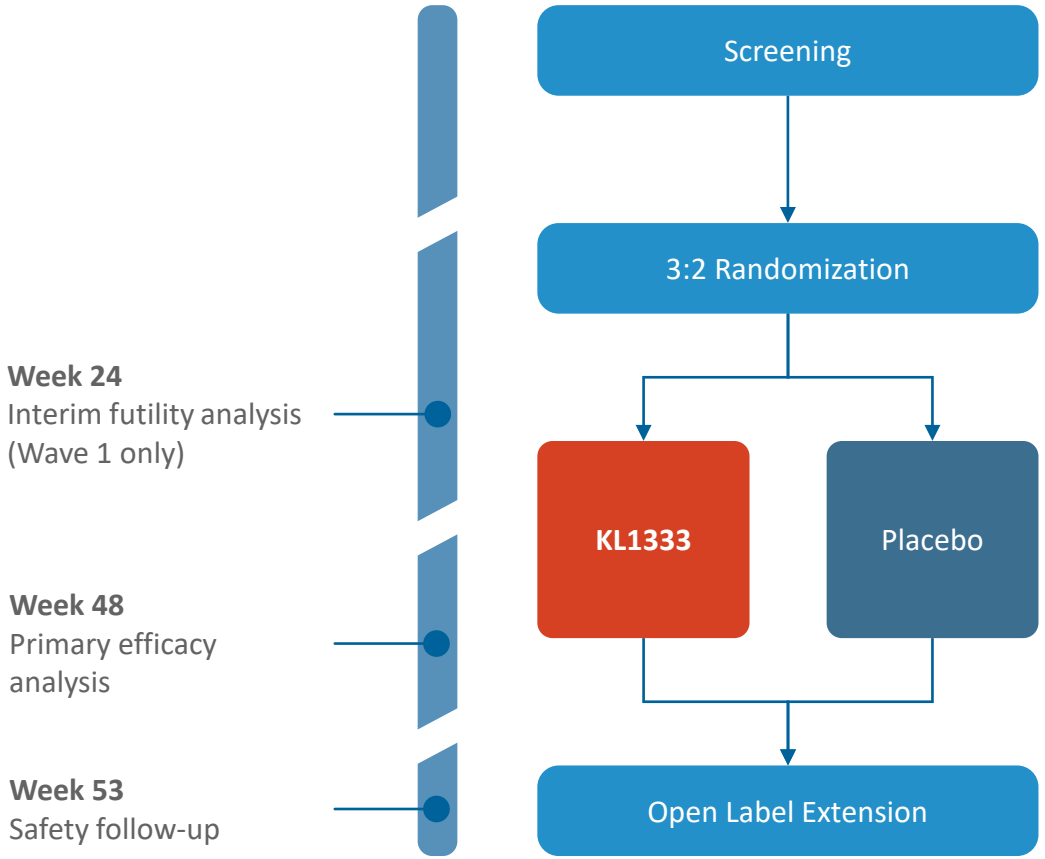
Regulatory Feedback

- Both FDA and EMA accepted study as registrational
- FDA said achieving one of the two endpoints would be sufficient for filing
- Conducted regular and detailed discussions with the FDA to facilitate alignment

Study Design

- **Methodology**
  - Randomized, double-blind, parallel-group, placebo-controlled pivotal study
- **Patients Included**
  - Adult PMD patients with mtDNA mutations* with fatigue and myopathy
- **Primary Endpoints**
  - Fatigue using the PROMIS Fatigue Mitochondrial Disease Short Form
  - Muscle weakness using the 30 second Sit-to-Stand test

Study Schematic



*Most prevalent mtDNA disorders include m.3243A>G associated MELAS-MIDD spectrum disorders, single large scale mtDNA deletion associated KSS-CPEO spectrum disorders, other multisystemic mtDNA-related disease (including MERRF)

FALCON study – positive interim analysis

Pivotal FALCON Study

WAVE 1 – Fully enrolled

- 40 patients recruited across six countries (U.S., UK, France, Spain, Belgium, Denmark)
- 18 sites activated
- Interim analysis at 24 weeks conducted in Q3 2024

WAVE 2 – Expansion

- 180 total patients treated for 48 weeks
  - Wave 1 sites ready to start enrolling
  - Wave 2 sites undergoing activation
- Readout anticipated 2027

Interim Futility Analysis:

Positive outcome achieved, with both primary endpoints having passed futility

- Promising differences favoring the active arm vs. placebo for both primary efficacy endpoints; if trends continue consistently, we expect a successful result at the completion of this trial
- Data monitoring committee (DMC) recommended continuing with Wave 2:
  - Safety and tolerability profile acceptable
  - No changes to study design
  - 180 total patients confirmed in the study

First-in-disease rare disease therapy with blockbuster potential

- Builds on Pharming's existing rare disease expertise and infrastructure
- **KL1333 positioned to become first standard of care in mtDNA mitochondrial disease**
- **Large commercial opportunity with >30,000 mtDNA diagnosed patients in US, EU4 and UK**
- Concentrated centers of excellence and strong advocacy groups
- Small molecule tablet has low COGS and easy route of administration

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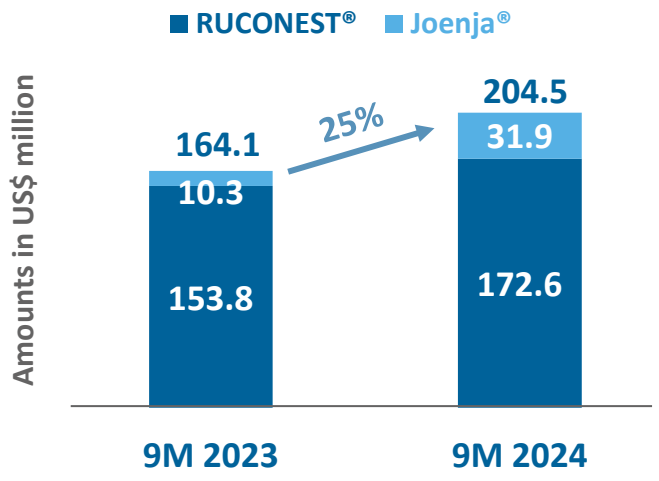
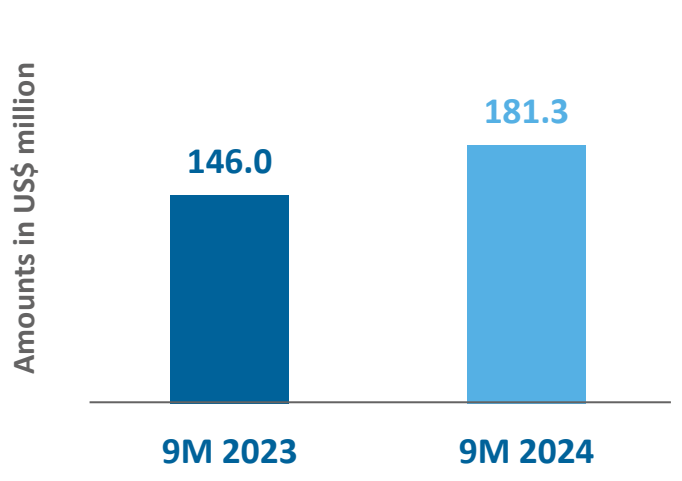
Financials and Outlook

Financial highlights: 9M 2024 vs 9M 2023

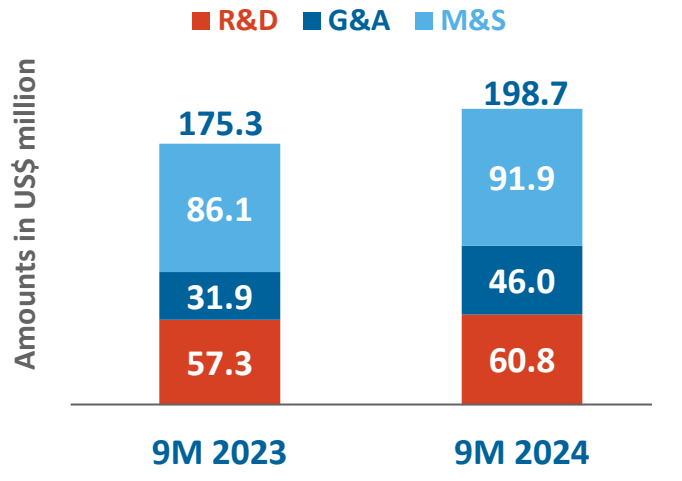
Revenues



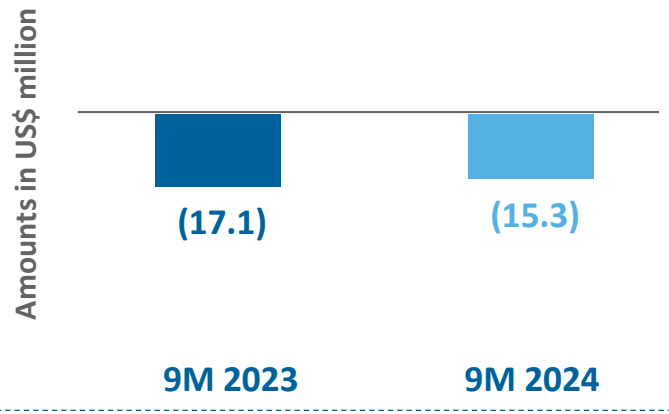
Gross profit



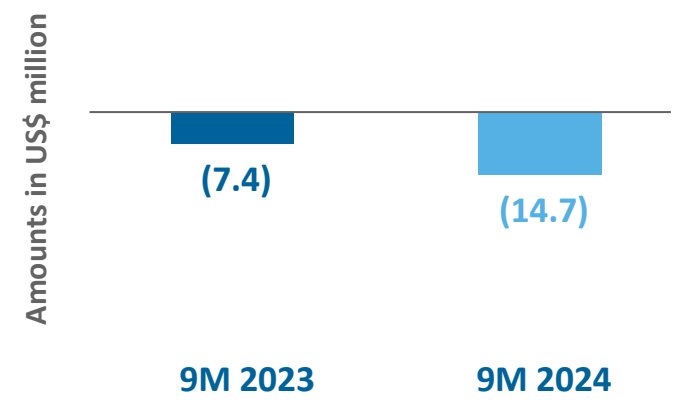
OpEx development



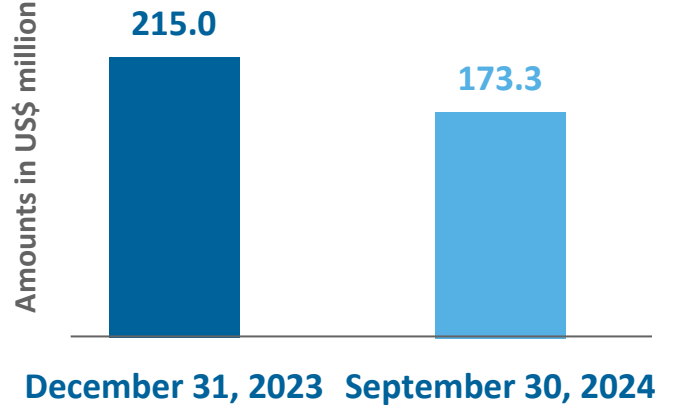
Adjusted (non-GAAP) Operating profit (loss)*



Net profit (loss)

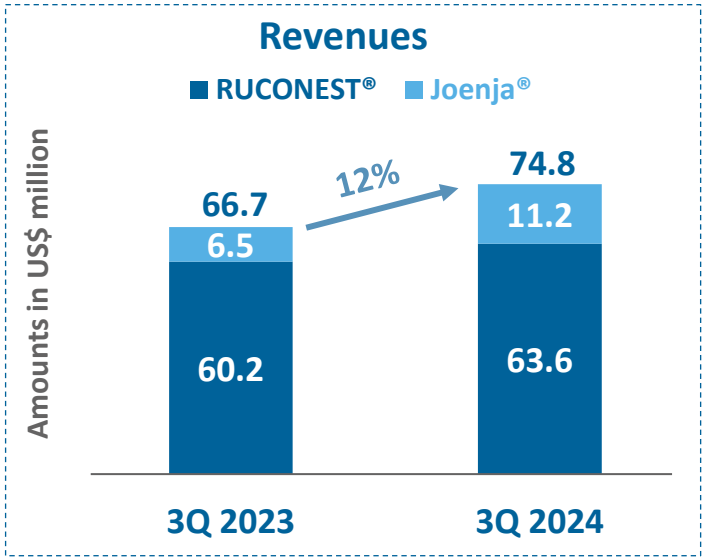


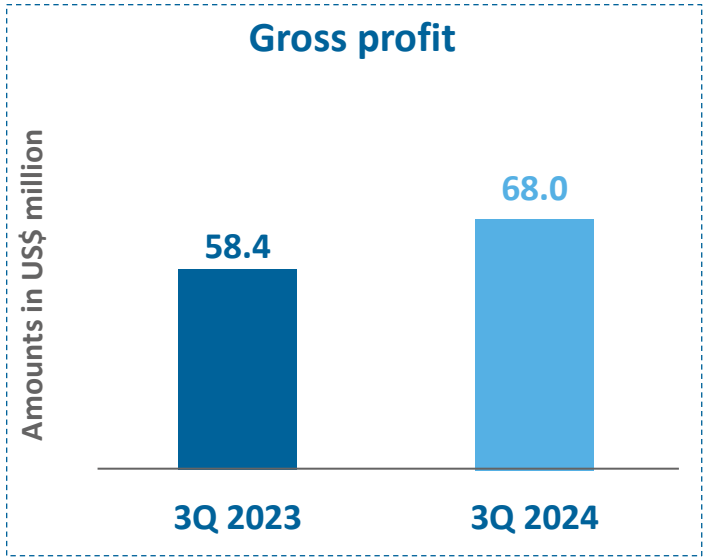
Overall Cash and Marketable Securities**

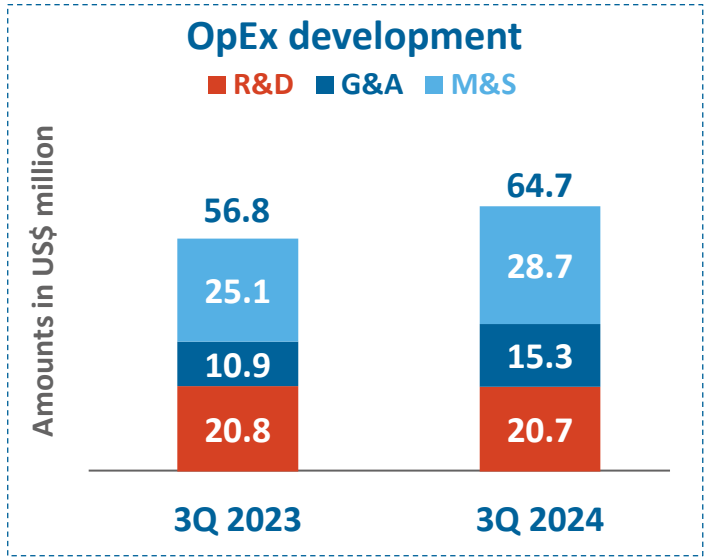


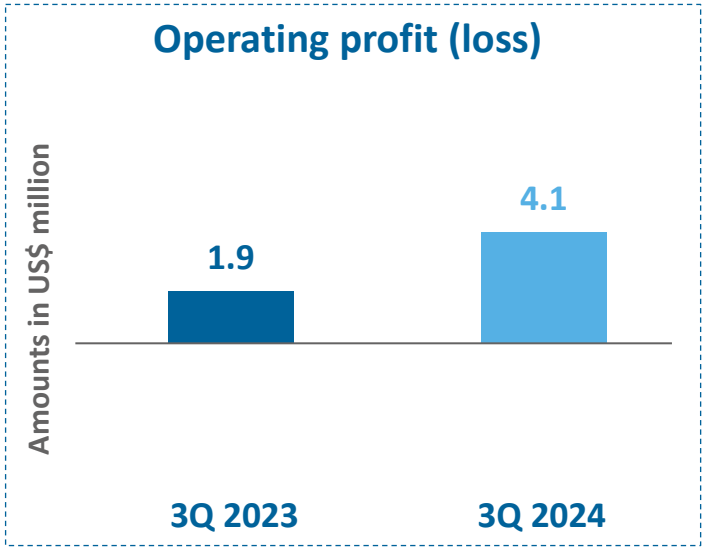
* Operating profit (loss) for 9M 2023 excludes milestone payments for Joenja® (US$10.5 million) and gain on sale of Priority Review Voucher to Novartis (US$21.1 million).
** US$30.4 million of the US$41.6 million decrease in overall cash and marketable securities is due to convertible bond refinancing.

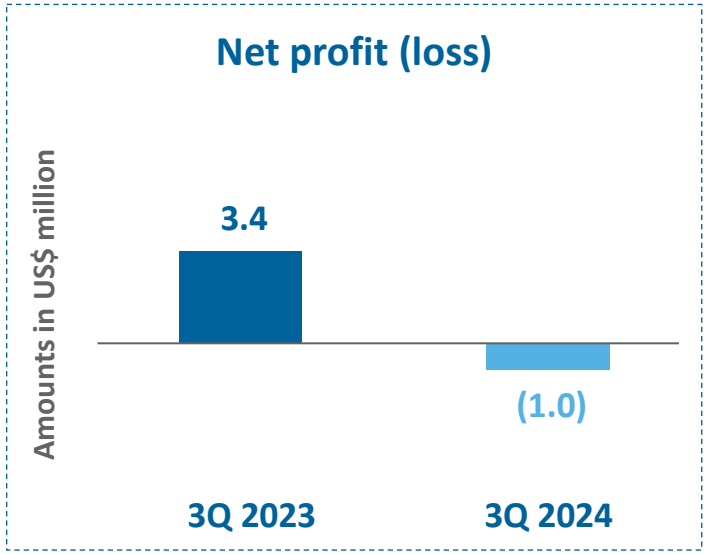
Financial highlights: 3Q 2024 vs 3Q 2023

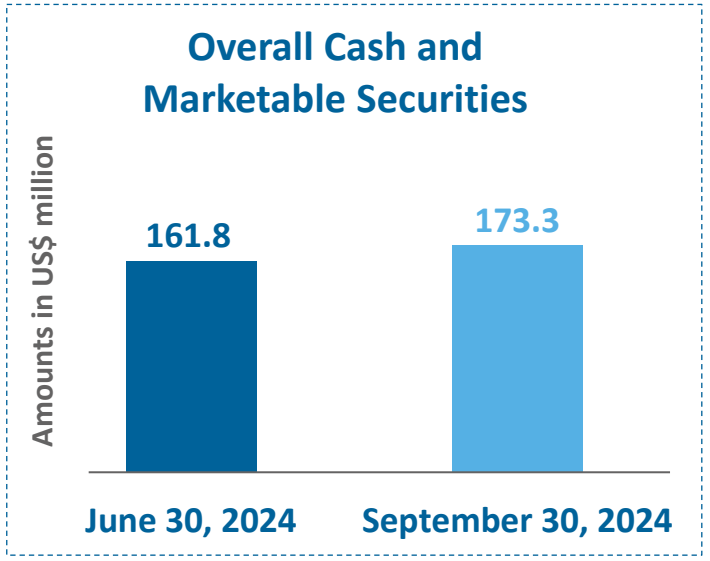












Pharming 2024 Outlook

- Total revenues between US$280 and US$295 million (14% to 20% growth).
- Joenja® (leniolisib) U.S.: Continued progress finding additional APDS patients, supported by family testing and VUS validation efforts, and subsequently converting patients to paid therapy.
- Leniolisib ex-U.S.: Increasing revenues through our Named Patient Program and other funded early access programs in key global markets.
- Completion of leniolisib clinical trials to support regulatory filings for approval in Japan and pediatric label expansion in key global markets.
- Progress towards regulatory approvals for leniolisib in the EEA, Canada and Australia.
- Advancing the Phase II clinical trial for leniolisib in PIDs with immune dysregulation linked to PI3Kδ signaling to significantly expand the long-term commercial potential of leniolisib.
- Continued focus on potential acquisitions and in-licensing of clinical stage opportunities in rare diseases (e.g. immunology, hematology, respiratory and gastroenterology).

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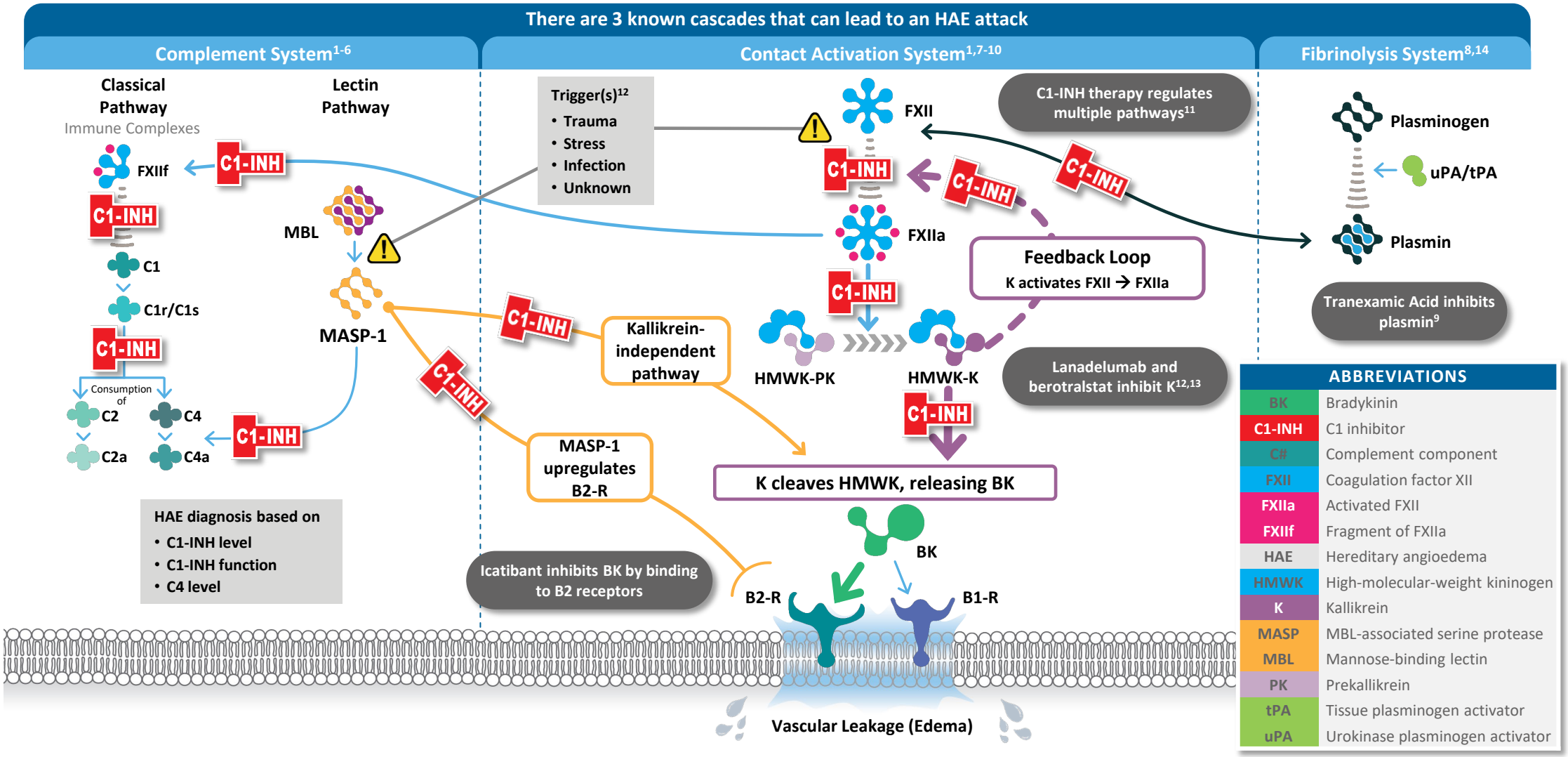
Appendix

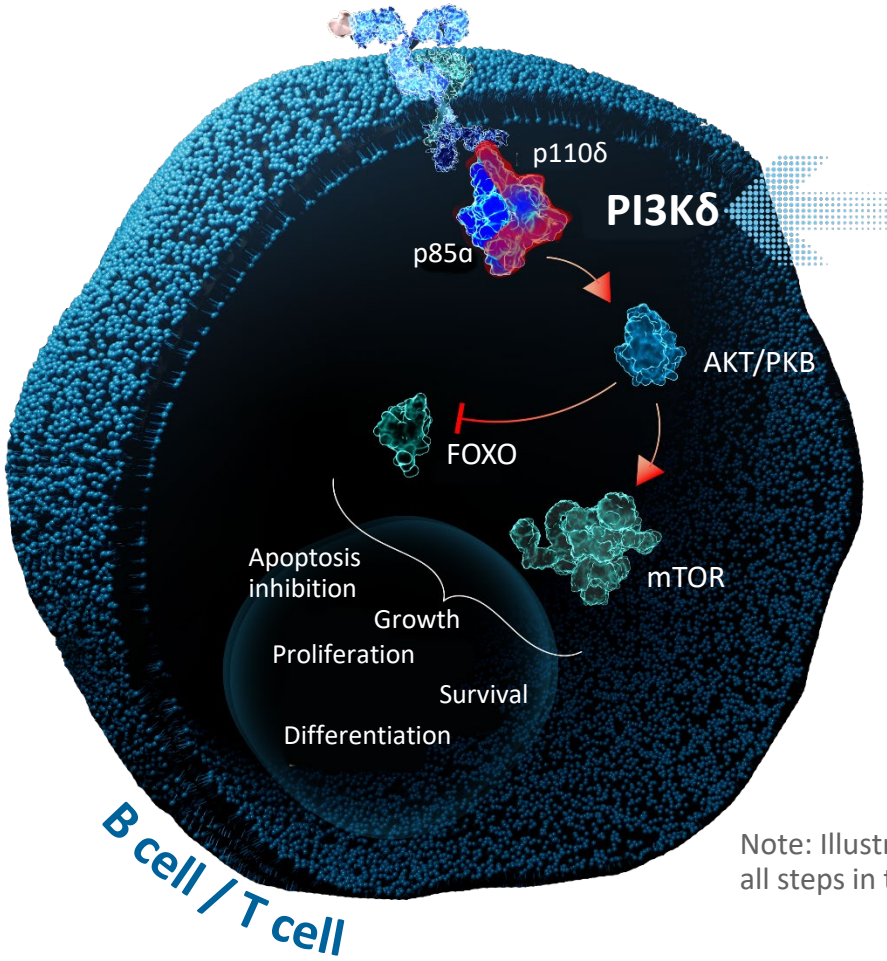
C1-INH targets the root cause of HAE



Adapted from a clinical cascade developed in partnership with Dr. Allen Kaplan. This is a current scientific understanding of the cascades. Clinical implications are unknown.

APDS is a rare, primary immunodeficiency (PID) Genetic defect leads to PI3Kδ hyperactivity

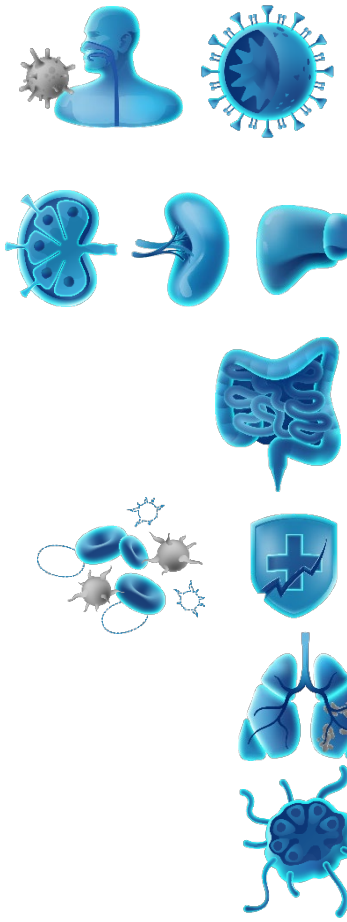
Hyperactive PI3Kδ results in dysregulated B and T cell development[1-3]



The PI3Kδ enzyme is at the beginning of a complex signaling pathway

Note: Illustration does not include all steps in the signaling pathway.

Immune imbalance leads to diverse signs and symptoms[1,4-6]



Severe, recurrent, persistent infections
- Sinopulmonary
- Herpesvirus (especially EBV and CMV)

Lymphoproliferation
- Lymphadenopathy
- Splenomegaly/hepatomegaly
- Nodular lymphoid hyperplasia

Enteropathy

Autoimmunity
- Cytopenias
- Autoimmune disorders
- Autoinflammatory disorders

Bronchiectasis

Lymphoma

FOXO, forkhead box O; mTOR, mammalian target of rapamycin; PI3Kδ, phosphoinositide 3-kinase delta; PKB, protein kinase B.

1. Lucas CL, et al. *Nat Immunol*. 2014;15(1):88-97. 2. Fruman DA, et al. *Cell*. 2017;170(4):605-635. 3. Okkenhaug K, Vanhaesebroeck B. *Nat Rev Immunol*. 2003;3(4):317-330. 4. Coulter TI, et al. *J Allergy Clin Immunol*. 2017;139(2):597-606. 5. Elkaim E, et al. *J Allergy Clin Immunol*. 2016;138(1):210-218. 6. Jamee M, et al. *Clin Rev Allergy Immunol*. 2020;59(3):323-333.

APDS is a rare, primary immunodeficiency (PID) first characterized in 2013

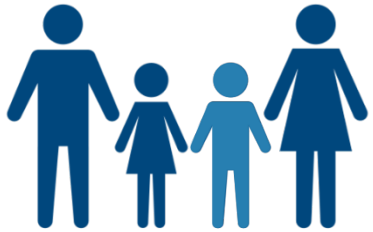
Activated phosphoinositide 3-kinase delta (PI3Kδ) syndrome (APDS)

Global prevalence estimated at 1.5 patients per million population*

To date, Pharming has identified >840 diagnosed APDS patients in select global markets**

(as of December 31, 2023)

A genetic test can provide a definitive diagnosis of APDS



The signs and symptoms of APDS vary widely, even among family members with the same genetic variant, resulting in potential delays in diagnosis and care

Until now, treatments for APDS have addressed the symptoms of the disease which manifest early in childhood, but not the root cause of APDS

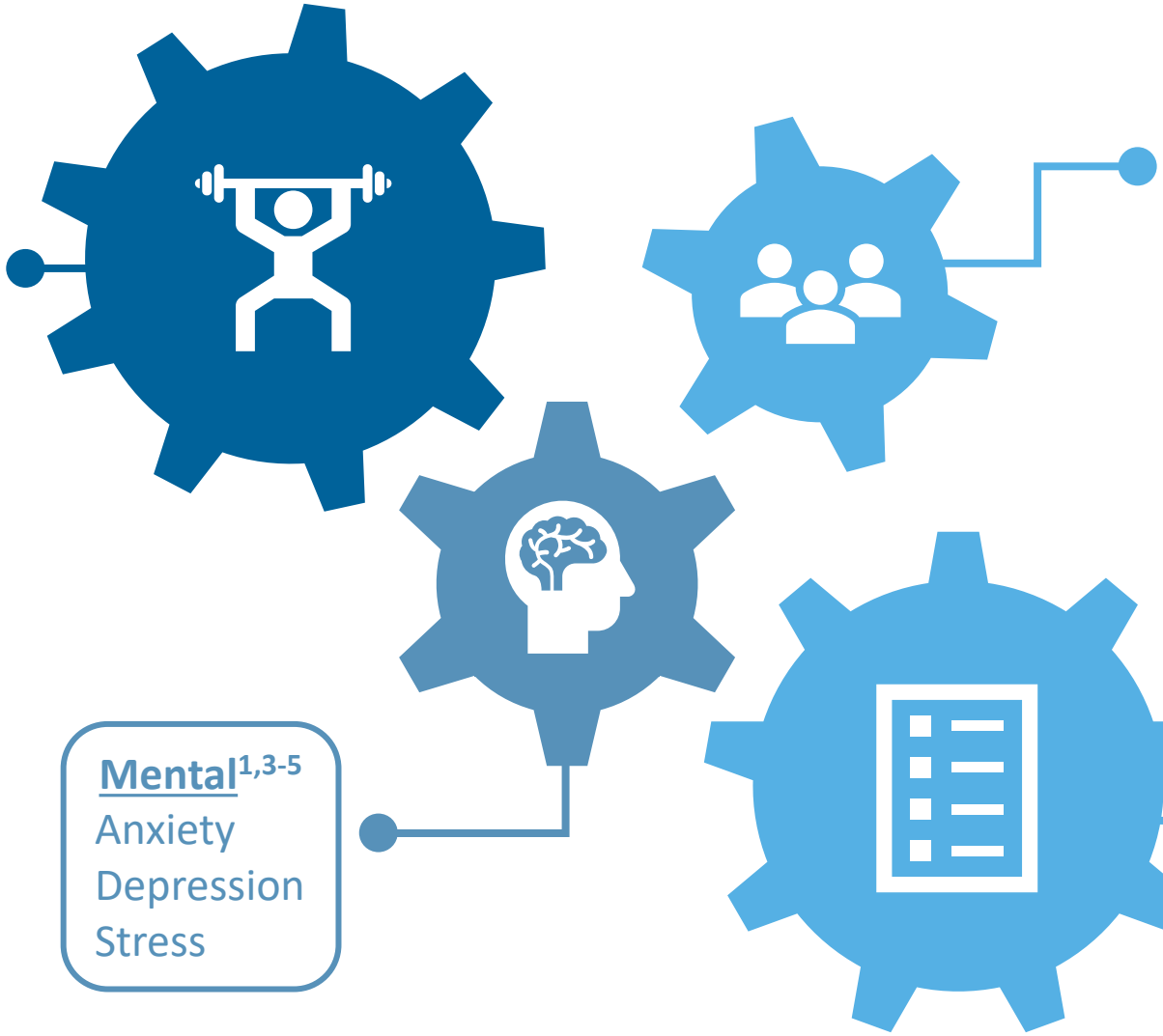
Without an indicated treatment specifically for APDS, physicians could only manage symptoms

*Size based on available literature

**>730 of these patients are in key global launch markets in the U.S., Europe, the U.K., Japan, Asia Pacific, Middle East, and Canada with total prevalence of ~2000 APDS patients

APDS can impact many facets of life

Physical[1,2]
Frequent infections
Swollen glands
Shortness of breath
Coughing/wheezing
Chest or joint pain
Fatigue
Inability to exercise
Hearing loss
Diarrhea
Skin problems



Social[3,4]
Missing school, work, or daily activities

Treatment Burden[1-4]
Frequent hospitalizations
Surgeries
Visiting multiple doctors
Invasive or time-consuming treatments

Mental[1,3-5]
Anxiety
Depression
Stress

APDS, activated phosphoinositide 3-kinase δ syndrome.
1. Coulter TI, et al. *J Allergy Clin Immunol*. 2017;139(2):597-606. 2. Elkaim E, et al. *J Allergy Clin Immunol*. 2016;138(1):210-218. 3. Rider NL, et al. *J Clin Immunol*. 2017;37(5):461-475.
4. Jiang F, et al. *Allergy Asthma Clin Immunol*. 2015;11:27. 5. Kuburovic NB, et al. *Patient Prefer Adherence*. 2014;8:323-330.

Heterogeneous, evolving symptomology can often lead to missed diagnoses

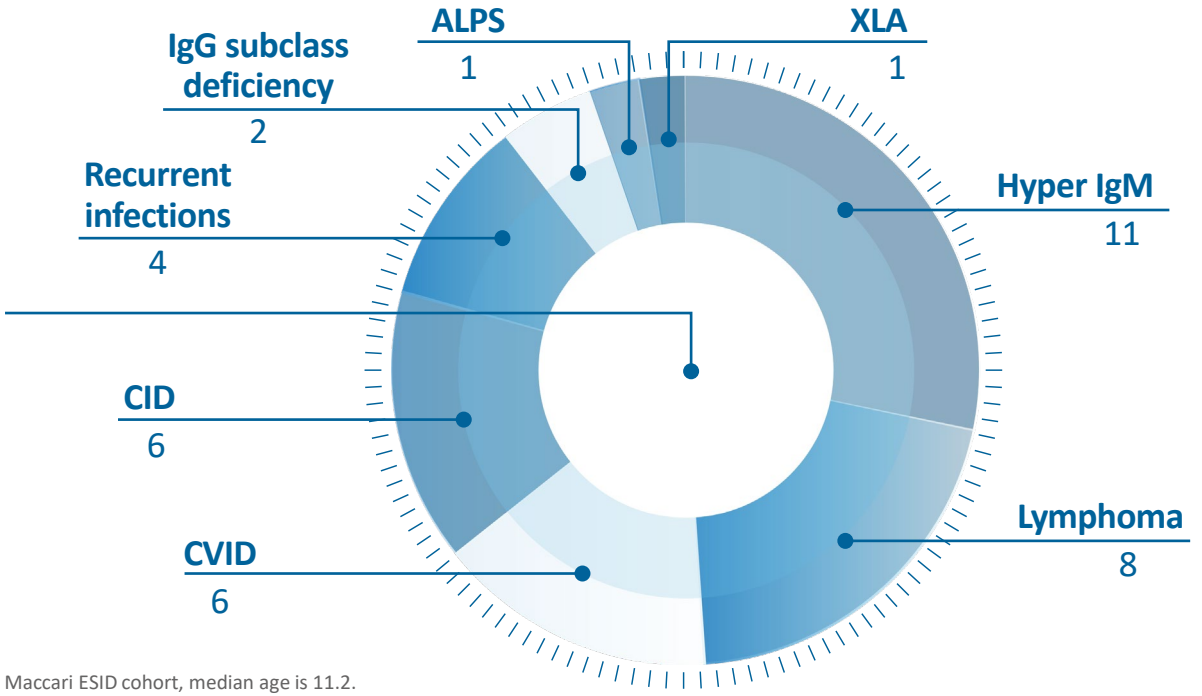
Timeline of the most common pathologies* seen in APDS[1-4]

Median age at diagnosis:
12 years (7-year median diagnosis delay)

<1 year (range, 1 month-10 years)	3 years (range, 1-6 years)	5 years (range, 1-18 years)	10.5 years (range, 6-15 years)	11.2 years† (range, 18 months-39 years)	18 years (range, 1.5-40 years)
Sinopulmonary infections	Benign lymphoproliferation	Enteropathy	Autoimmunity	Bronchiectasis	Malignancy

Cytopenias, arthritis, or other dysregulation‡

APDS has often been diagnosed as another PI or condition, causing delays in diagnosis[1]



Improved identification of symptoms, increased genetic testing, and earlier diagnosis are needed

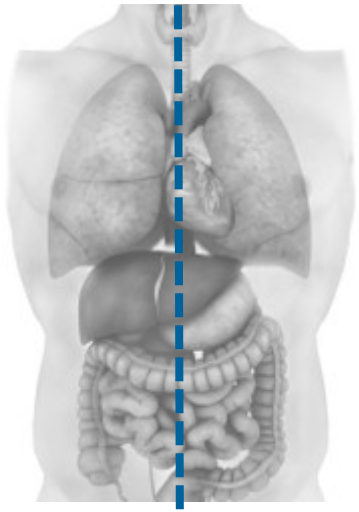
*Pathologies can occur at any time.
†In Elkaim APDS2 cohort, median age of bronchiectasis is 13; in Maccari ESID cohort, median age is 11.2.
‡No median ages are available for these manifestations.
ALPS, autoimmune lymphoproliferative syndrome; CID, combined immunodeficiency; CVID, common variable immune deficiency; ESID, European Society for Immunodeficiencies; HIGM, hyper immunoglobulin M syndrome; IgG, immunoglobulin G; PI3Kδ, phosphoinositide 3-kinase delta; XLA, X-linked agammaglobulinemia.

1. Jamee M, et al. *Clin Rev Allergy Immunol*. 2020;59(3):323-333. 2. Maccari ME, et al. *Front Immunol*. 2018;9:543. 3. Elkaim E, et al. *J Allergy Clin Immunol*. 2016;138(1):210-218.e9. 4. Coulter TI, et al. *J Allergy Clin Immunol*. 2017;139(2):597-606.

Management for APDS[1,2] prior to Joenja®

Immune Deficiency

- Antimicrobial prophylaxis
- Immunoglobulin replacement therapy



Immune Dysregulation

- Corticosteroids
- Other immunosuppressants
- mTOR inhibitors

None of these therapies are FDA-approved for APDS treatment

Hematopoietic stem cell transplant

APDS, activated phosphatidylinositol 3-kinase δ syndrome; IRT, immunoglobulin replacement therapy; mTOR, mammalian target of rapamycin; PI, primary immunodeficiency; PIRD, primary immune regulatory disorder.

1. Coulter TI, et al. *J Allergy Clin Immunol*. 2017;139(2):597-606. 2. Elkaim E, et al. *J Allergy Clin Immunol*. 2016;138(1):210-218. 3. Chan AY, et al. *Front Immunol*. 2020;11:239.
4. Chinn IK, et al. *J Allergy Clin Immunol*. 2020;145(1):46-69.

Joenja® clinical trial designs

Pivotal Trial - Part 1: Dose-finding[1,2]

- Nonrandomized, open-label, dose-escalating
- 6 patients with APDS
- 12 weeks
- 10 mg, 30 mg, 70 mg bid (4 weeks each dose)
- 70 mg bid selected for Part 2

Pivotal Trial - Part 2: Efficacy & Safety Evaluation[3]

- Randomized, triple-blinded, placebo-controlled
- 31 patients with APDS (21 Joenja®, 10 placebo)
- 12 weeks
- 70 mg bid
- Co-primary efficacy end points
  - Change from baseline in log^{10}-transformed SPD of index lesions
    - Also assessed as % change
  - Change from baseline in percentage of naïve B cells out of total B cells
- Secondary and exploratory end points
- Safety

Open-label extension study[4,5]

- Nonrandomized, open-label, long-term study
- 35 patients with APDS from Parts 1 and 2
- 2 patients with APDS previously treated with investigational PI3Kδ inhibitors
- Ongoing
- 70 mg bid
- Long-term safety, tolerability, efficacy, and pharmacokinetics

bid, twice a day; PI3Kδ, phosphoinositide 3-kinase delta; SPD, sum of product diameters

1. Rao VK, et al. *Blood*. 2017;130(21):2307-2316. 2. NCT02435173. ClinicalTrials.gov. https://clinicaltrials.gov/ct2/show/NCT02435173. Updated May 6, 2015. Accessed March 13, 2023. 3. Rao VK, et al. *Blood*. 2023;141(9):971-983.
4. NCT02859727. ClinicalTrials.gov. https://clinicaltrials.gov/ct2/show/NCT02859727. Updated October 31, 2022. Accessed March 3, 2023. 5. Data on file. Pharming Healthcare Inc; 2022.

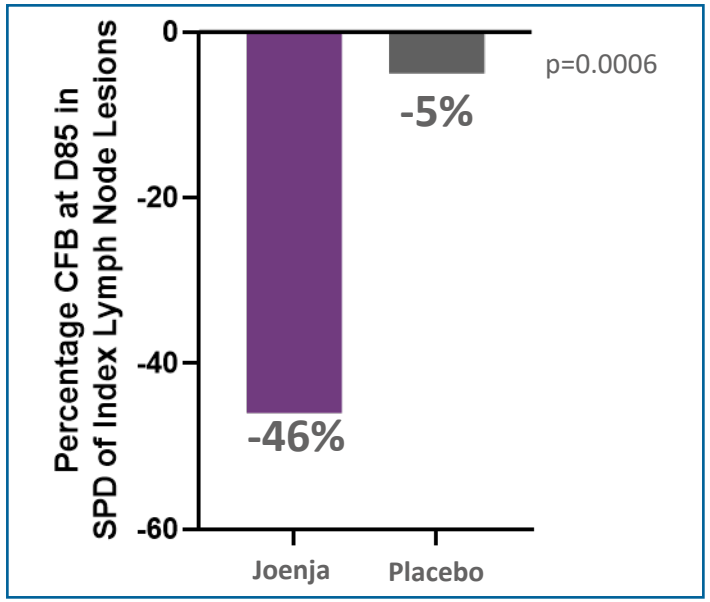
Joenja® addresses the underlying cause of APDS to help restore immune balance – Phase 3 co-primary endpoints

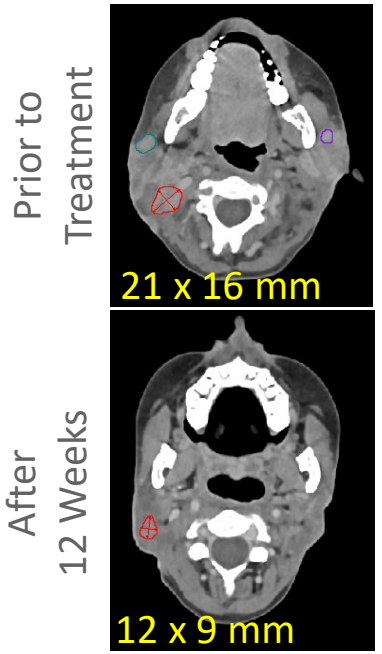
At 12 weeks Joenja® decreased lymphadenopathy and increased naïve B cells

Immune Dysregulation

Change from baseline in index nodes*

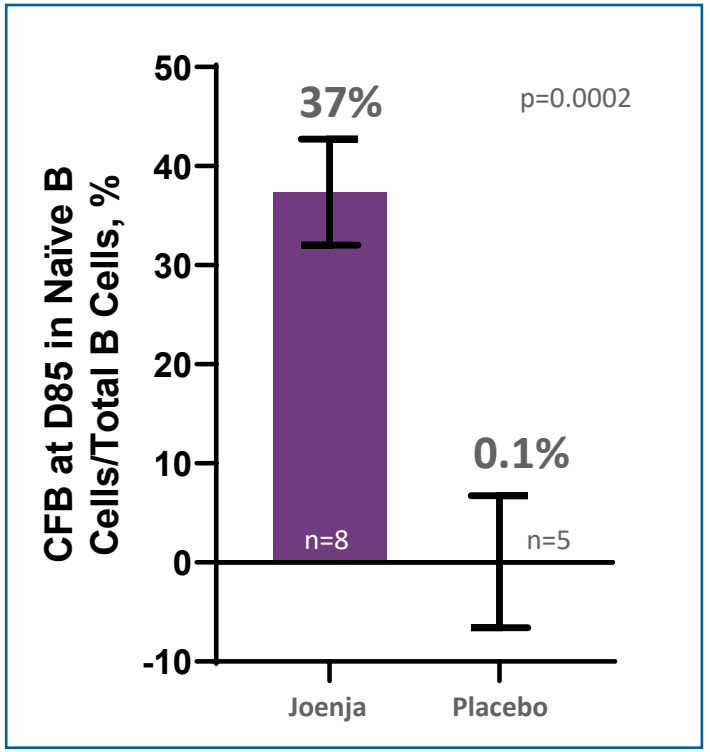
Log_{10}-transformed SPD of index lesions	Joenja (n=18)	Placebo (n=8)
Baseline mean (SD)	3.03 (0.42)	3.05 (0.39)
Change from baseline, LS mean (SE)	-0.27 (0.04)	-0.02 (0.05)
Difference vs placebo (95% CI)		-0.25 (-0.38, -0.12)





Immune Deficiency

Change from baseline in naïve B cells†



Data were analyzed using an ANCOVA model with treatment as a fixed effect and baseline as a covariate. Use of glucocorticoids and IRT at baseline were both included as categorical (Yes/No) covariates. Baseline is defined as the arithmetic mean of the baseline and D1 values when both are available, and if either baseline or the D1 value is missing, the existing value is used. P-value is 2-sided. Least square means are graphed. Error bars are standard error of the mean.

*The analysis excluded 2 patients from each treatment group due to protocol deviations and 1 Joenja patient having complete resolution of the index lesion identified at baseline.

†Out of 27 patients in the PD analysis set, 13 patients met the analysis requirements, including having a percentage of <48% of naïve B cells at baseline, to form the B-PD analysis set.

Joenja [package insert]. Leiden, The Netherlands: Pharming Technologies B.V.; 2023.

Please see Important Safety Information and full Prescribing Information available at joenja.com

Joenja® significantly reduced splenomegaly

Secondary endpoint: Significant reductions in spleen size by 2D and 3D analysis compared to placebo

- The adjusted mean difference in bidimensional spleen size between Joenja® (n=19) and placebo (n=9) was -13.5 cm^2 (95% CI: -24.1, -2.91), *P*=0.0148
- The adjusted mean difference in 3D spleen volume between Joenja® (n=19) and placebo (n=9) was -186 cm^3 (95% CI: -297, -76.2), *P*=0.0020

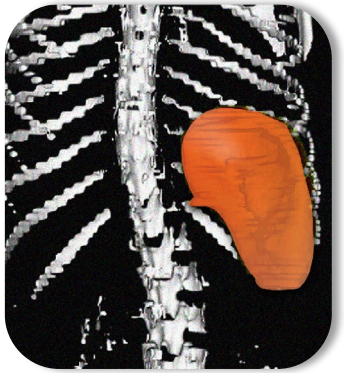
at week 12

27%

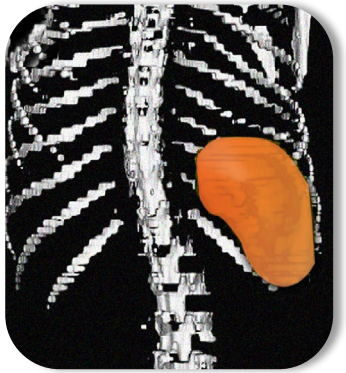
reduction in 3D spleen volume*

Secondary measure: spleen volume scan results of actual patient illustrate average improvement documented for patients taking Joenja®

Prior to treatment:
491 mL



At week 12:
314 mL



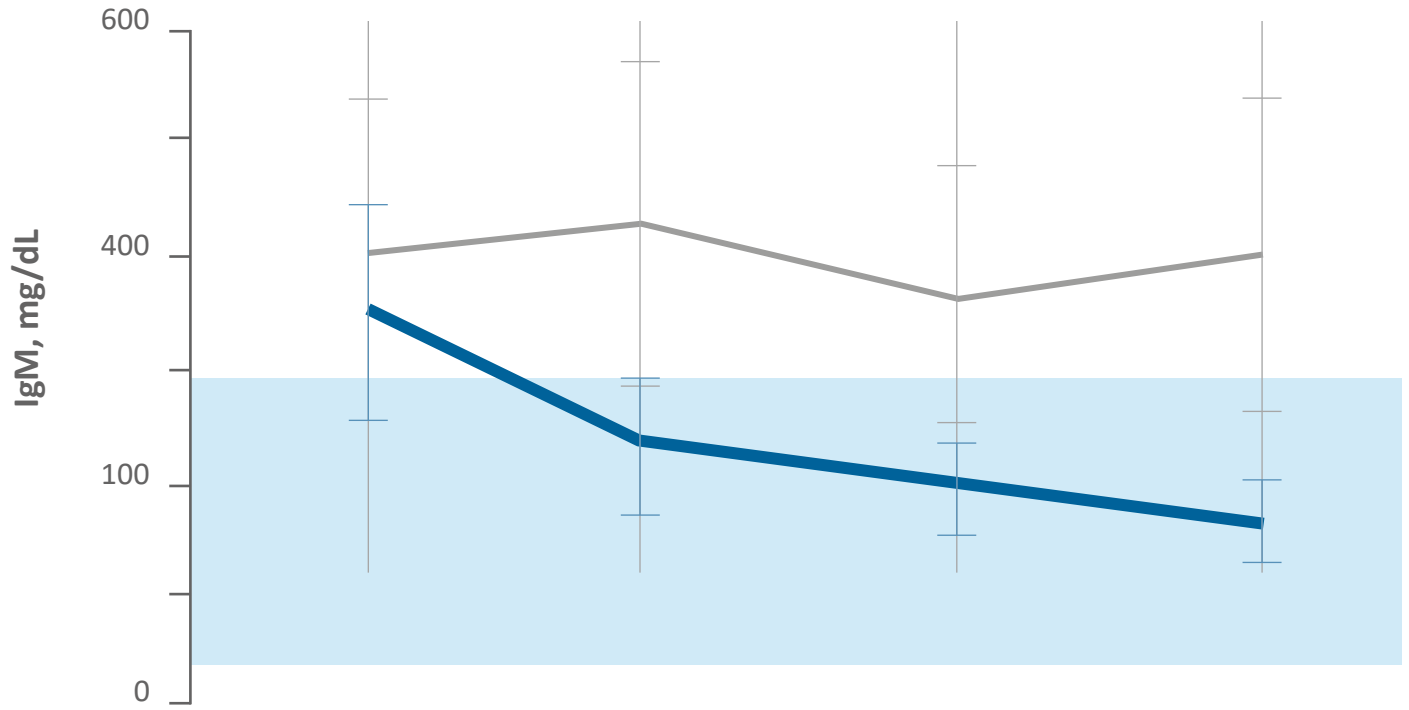
Actual patient images of a 17-year-old male. As individual results vary, images may not be representative of all patients.

Rao VK, et al. Blood. 2023;141(9):971-983.

*In the PD analysis set, the mean (SD) percentage change from baseline to week 12 in 3D spleen volume (mm^3) was -26.68% (12.137) with Joenja® (n=19) and -1.37% (24.238) with placebo (n=9). The ANCOVA model was used with treatment as a fixed effect and log_{10}-transformed baseline as a covariate for index and non-index lesions. The use of both glucocorticoids and IV Ig at baseline was included as categorical (yes/no) covariates.
This analysis excluded 2 patients in each treatment group. In the Joenja® group, 1 patient with a complete index lesion response was excluded, and 3 patients were excluded for no non-index lesion at baseline.
PD, pharmacodynamics.

An exploratory end point showed Joenja® reduced IgM levels

Mean serum IgM rapidly reduced to within normal limits



		Baseline	Week 4	Week 8	Week 12
Joenja®	n	21	20	21	21
Placebo	n	10	10	10	10

- In the Joenja® arm, IgM was elevated above normal limits in 6 patients at baseline, and by week 12 was reduced in all, with 50% returning to within normal limits
- In contrast, IgM was elevated above normal limits at baseline in 4 patients in the placebo arm, and by week 12 levels remained stable or elevated, with 0% returning to within normal limits

Error bars are standard error of the mean. Safety analysis set (N=31) shown. Blue box indicates IgM normal range.
Soluble biomarkers, including IgM, were prespecified exploratory endpoints in the protocol. Although an observational decrease in IgM was noted in some patients, no statistical significance can be made from this analysis, and no conclusions should be drawn.
Rao VK, et al. Blood. 2023;141(9):971-983

Joenja® safety profile

Phase 3 Trial[1,2]

Adverse reactions reported by ≥2 patients treated with Joenja and more frequently than placebo

	Joenja (n=21) n (%)	Placebo (n=10) n (%)
Headache	5 (24)	2 (20)
Sinusitis	4 (19)	0
Dermatitis atopic*	3 (14)	0
Tachycardia†	2 (10)	0
Diarrhea	2 (10)	0
Fatigue	2 (10)	1 (10)
Pyrexia	2 (10)	0
Back pain	2 (10)	0
Neck pain	2 (10)	0
Alopecia	2 (10)	0

- Study drug-related AEs occurred in 8 patients; the incidence was lower in the Joenja arm (23.8%) than in the placebo arm (30.0%)
- No AEs led to discontinuation of study treatment

Open-label Extension Study[3]

Data cutoff for interim analysis: December 13, 2021

- 32/37 patients reported ≥1 AE
- 78.4% of AEs were grade 1, 48.6% grade 2, 27.0% grade 3, 0% grade 4
- No SAEs related to Joenja

Most common AEs	n
Upper respiratory tract infection	8
Headache	6
Pyrexia	6
Otitis externa	5
Weight increase	5
COVID-19, positive/negative	5/14

One patient with significant baseline cardiovascular comorbidities suffered cardiac arrest resulting in death at extension Day 879; determined by investigator not to be related to study drug

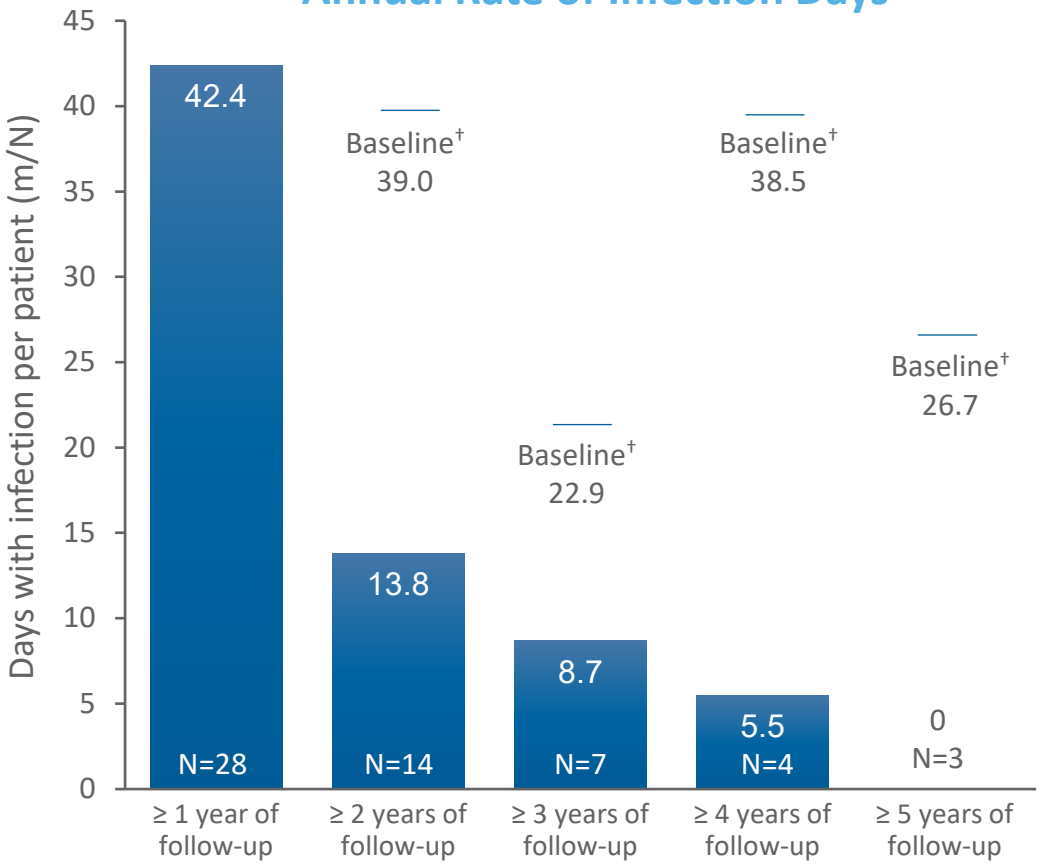
Across all trials[2]

- 38 patients had a **median exposure of ~2 years**
- 4 patients had **>5 years of exposure**

A patient with multiple occurrences of an AE is counted only once in the AE category. Only AEs occurring at or after first drug intake are included.
*Includes dermatitis atopic and eczema. †Includes tachycardia and sinus tachycardia.
AEs, adverse events; **ALT**, alanine aminotransferase; **AST**, aspartate aminotransferase; **SAE**, serious adverse event.
1. Rao VK, et al. Blood. 2023;141(9):971-983. **2.** Joenja [package insert]. Leiden, The Netherlands: Pharming Technologies B.V.; 2023. **3.** Data on file. Pharming Healthcare Inc; 2022.
Please see Important Safety Information and full Prescribing Information available at joenja.com

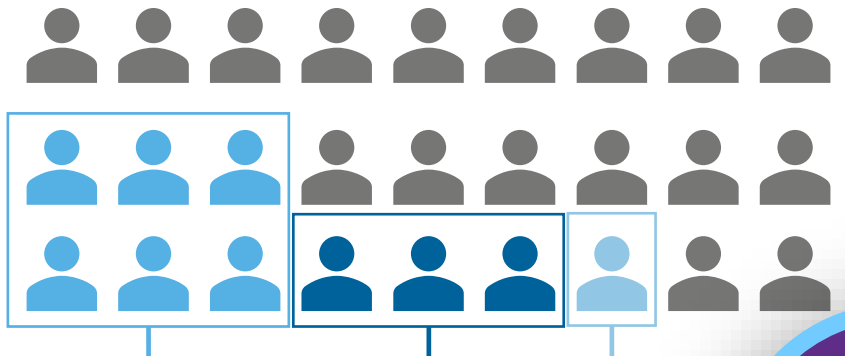
Open-label extension interim analysis of days spent with infections and IRT reduction

Annual Rate of Infection Days*



Physician-reported IRT Reduction‡

Of 27 patients receiving IRT:



6 achieved IRT freedom§

3 reduced use 50%‖

1 reduced use 30%

37% OF PATIENTS RECEIVING IRT REDUCED OR DISCONTINUED DOSE

At the data cutoff, **4** of the patients who were **IRT free** had been so for **1 – 2.5 years**

Although safety was the primary objective of the open-label study, this post hoc analysis from the open-label study was not powered to provide any statistical significance of efficacy and therefore no conclusions should be drawn.

*Infections that developed during the study were reported as adverse events. Investigators were requested to inquire about signs and symptoms of infections at each visit, with a particular focus on bacterial enterocolitis. Patients were not provided an infection diary to document infections occurring between visits. One patient was excluded from the analysis due to an incorrect year that was recorded for an infection.
†Baseline infections are each group's year 1 annual rate of infections. N values changed because patients were in the OLE for different lengths of time. ‡Data on concomitant medication usage was reported at each patient visit. §One patient had a subsequent one-time dose. ‖One patient achieved IRT freedom for 3 months but subsequently restarted IRT.
IRT, immunoglobulin replacement therapy; **m**, number of infection days; **N**, number of patients in follow-up category.
Rao VK, et al. Poster presented at: *64th Annual American Society of Hematology Annual Meeting*; December 10-13, 2022; New Orleans, LA.
Please see Important Safety Information and full Prescribing Information available at joenja.com

VUS by the numbers

VUSs frustrate patients and doctors, limiting diagnosis of genetic diseases such as APDS

Pharming is aware of **~1,200 US patients** harboring *PIK3CD/R1* VUSs

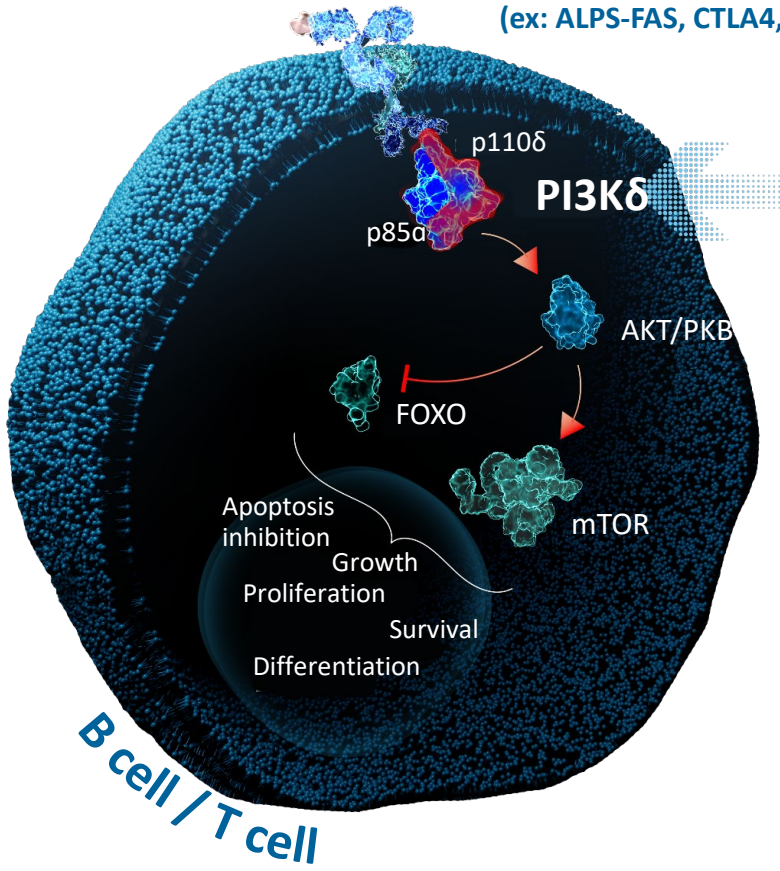
- This figure will continue to grow over time
- VUS are identified at ~4x the rate of likely pathogenic/pathogenic (LP/P) variants
- Similar VUS frequencies expected worldwide
- Published literature, which includes more than 1.5 million patients, showed that 20% of reclassified VUSs are upgraded to LP/P
- Pilot study in 25 VUS patient samples - findings consistent with APDS identified in 5 patients (20%) including patient preparing for enrollment

No systemic initiatives exist to resolve *PIK3CD/R1* VUSs, yet these patients remain a significant opportunity to identify incremental patients with APDS

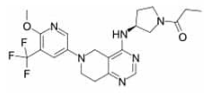
Given importance of PI3Kδ in B & T cells, immune dysregulation in PIDs can occur via alterations in PI3Kδ signaling

Altered PI3Kδ signaling can occur in multiple PID genetic disorders beyond APDS

(ex: ALPS-FAS, CTLA4, NFKB1, PTEN) [1-4]



leniolisib



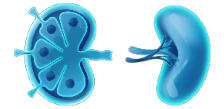
High unmet medical need

- no approved therapies other than Joenja® (leniolisib) for APDS:

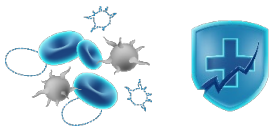
SOC immunosuppressives (e.g. rapamycin) have limited efficacy and significant tolerability concerns

Note: Illustration does not include all steps in the signaling pathway.

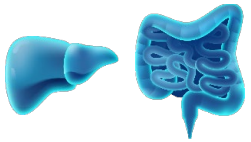
Clinical manifestations, disease onset and severity similar to APDS [5-10]



Lymphoproliferation
- Lymphadenopathy
- Splenomegaly/hepatomegaly
- Nodular lymphoid hyperplasia



Autoimmunity
- Cytopenias
- Autoimmune disorders
- Autoinflammation



GI Disease
- Autoimmune enteropathy
- Nodular regenerative hyperplasia

Pulmonary Disease
- GLILD
- Bronchiectasis

Infections
- Sinopulmonary
- Herpesvirus

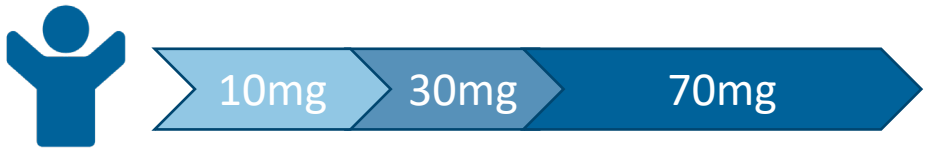
Lymphoma

FOXO, forkhead box O; mTOR, mammalian target of rapamycin; PI3Kδ, phosphoinositide 3-kinase delta; PKB, protein kinase B.

1. Volkl et al. Blood 2016; 128(2):227-238. 2. Tsujita, et al. J Allergy Clin Immunol. 2016;138(6):1872-80. 3. Rowshanravan B, et al. Blood. 2018;131(1):58-67. 4. Additional unpublished collaborator data. 5. Bride K & Teachey D. F1000Res. 2017;6:1928 6. Kuehn HS, et al. Science 2014; 345:1623-27. 7. Lorenzini T, et al. J Allergy Clin Immunol. 2020:146:901-11. 8. Eissing, et al. Transl Oncol. 2019;12(2):361-3672. 9. Coulter TI, et al. J Allergy Clin Immunol. 2017;139(2):597-606. 10. Schwab C, et al. J Allergy Clin Immunol. 2018;142(6):1932-1946.

PIDs linked to PI3Kδ signaling – Phase II study design

Phase II proof of concept clinical trial – single arm, open-label, dose range-finding study (N=12)



- Patients with PIDs linked to PI3Kδ signaling, e.g. ALPS-FAS[1], CTLA4 haploinsufficiency[2], NFKB1 haploinsufficiency[3], PTEN deficiency[4] (treatable population ~7/million)
- Primary: Safety & Tolerability
- Secondary/Exploratory: PK/PD, efficacy measures
- 10/30/70 mg: 4/4/12 wks treatment, respectively
- Pick Best Dose regimen for Phase III

National Institute of Allergy and Infectious Diseases

Lead Investigator: Gulbu Uzel, M.D., Senior Research Physician

Co-Investigator: V. Koneti Rao, M.D., FRCPA, Senior Research Physician
Primary Immune Deficiency Clinic (ALPS Clinic)

1. Bride K & Teachey D. F1000Res. 2017;6:1928. ; Rao VK & Oliveria JB. Blood 2011; 118(22):5741-51.
2. Kuehn HS, et al. Science 2014; 345:1623-27. ; Schwab C, et al. J Allergy Clin Immunol. 2018;142(6):1932-1946.
3. Lorenzini T, et al. J Allergy Clin Immunol. 2020:146:901-11.
4. Eissing M, et al. Transl Oncol. 2019;12(2):361-367. ; Tsujita, et al. J Allergy Clin Immunol. 2016;138(6):1872-80.

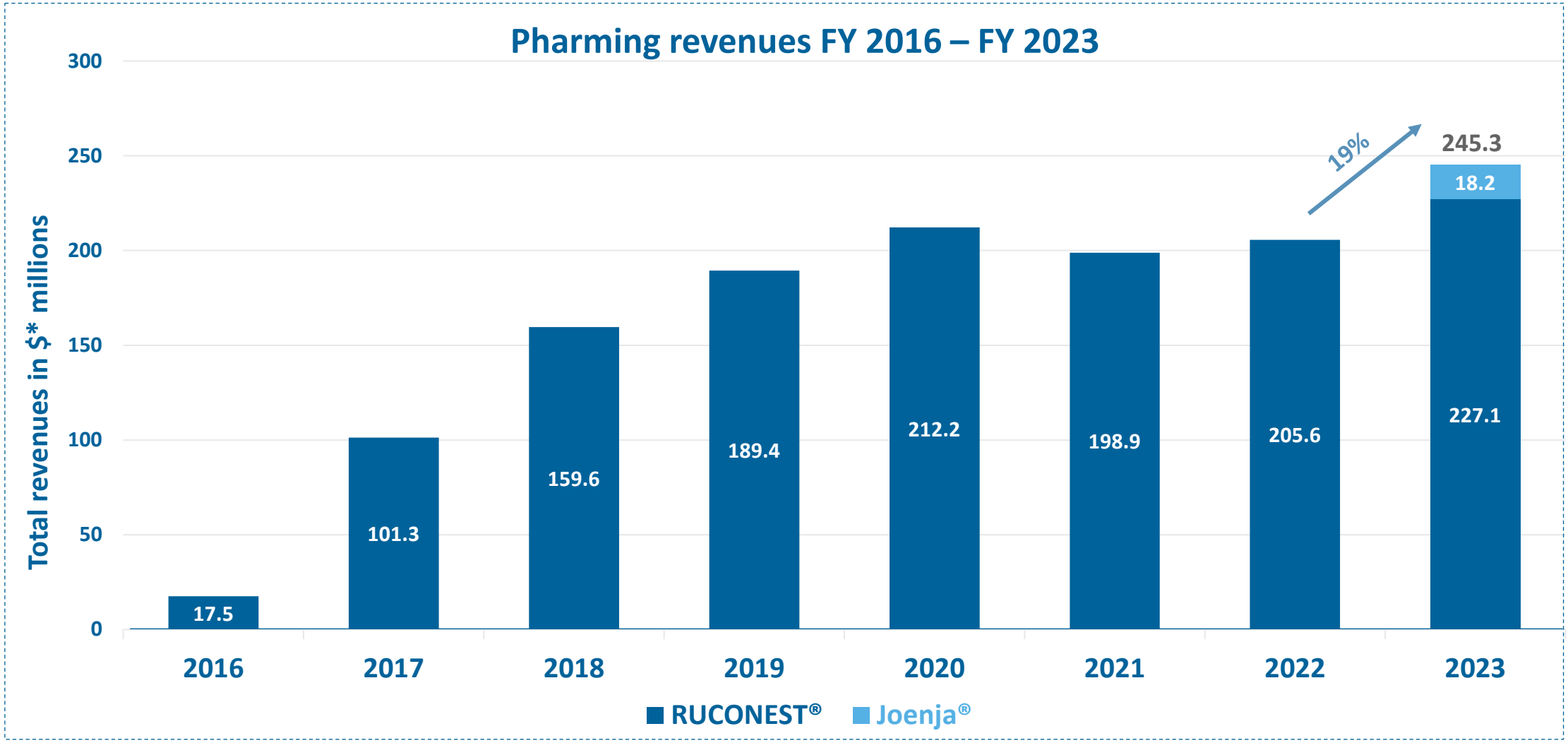
Epidemiology of PIDs linked to PI3K signaling

Genetic PID Type	Prevalence References	Current/Future[9] Prevalence Estimate (per million)	% Targeted for Leniolisib Treatment	Targeted Population (per million)
ALPS-FAS	ESID registry (236 patients): 6 /mill.[1] PID KOLs – 4 /mill[2]	5/10	30%[3]	3
CTLA4	ESID registry (38 patients): 1 /mill.[4] USIDNET registry (28 patients): 2 /mill.[5] Pharming lit review: 1.5/mill.[13] PID KOLs – 10 /mill.[2]	2/4	50%[6]	2
NFKB1	ESID registry (25 patients): 0.75 /mill.[10] USIDNET registry (6 patients): 0.4 /mill. [11] Pharming lit review: 2/mill.[12] PID KOLs – 10 /mill.[2]	2/4	50%[14]	2
PTEN	All PTEN patients NORD: 5/ mill.[7] PID KOLs – 4 /mill.[2]	5/10	5%[8]	0.5
			TOTAL Population (includes future patient diagnosis)	**7.5****

*** SOCS1 and NRAS/KRAS patient pools also included in the ph2 study provide some additional, however limited, contributions to the estimated prevalence*

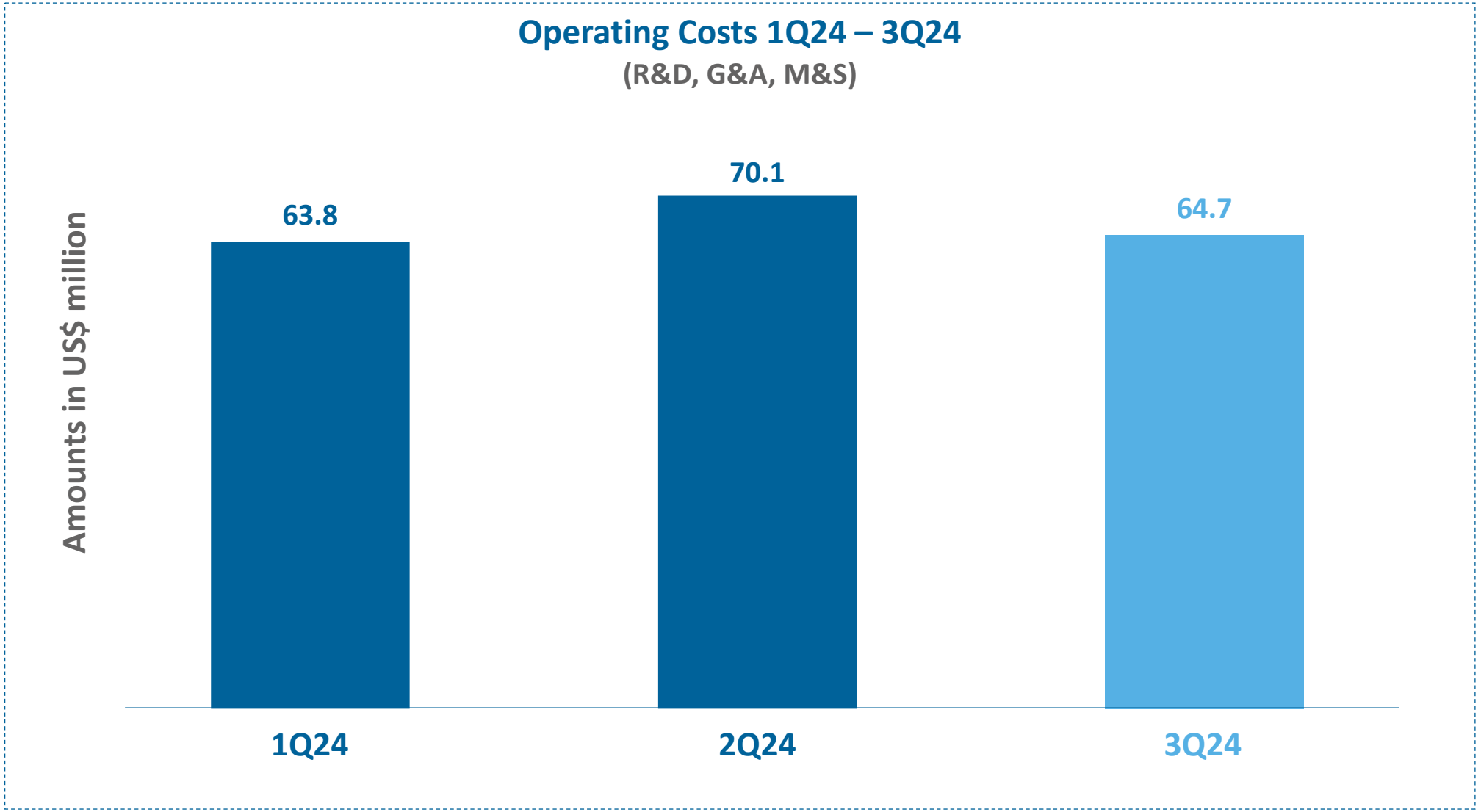
1. Based on 1.4% of PID patients reported as ALPS in the ESID registry & overall PID prevalence of 1/2500. 2. Median from survey of 7 PID KOL opinions. 3. Most ALPS-FAS patients are well treated, with 30% in need of better treatment (KOL opinion). 4. Based on 0.2% of PID patients reported as CTLA4 in the ESID registry & overall PID prevalence of 1/2500. 5. Based on 0.5% of PID patients reported as CTLA4 in the USIDnet registry (5489 patients usidnet.org) & overall PID prevalence of 1/2500. 6. 1/3 of CTLA4 patients are considered asymptomatic, others well treated (Hao & Cook. Front Immunol. 2022 12:806043). 7. Overall PTEN Hamartoma Tumor Syndrome prevalence (NORD). 8. Based on Pharming literature review, KOL feedback and PTEN Foundation registry review (>500 patients) identifying PTEN patients with an immune dysregulation phenotype. 9. Conservative 2x scaling for additional undiagnosed patients to be identified through future patient finding activities. This is based on Pharming APDS experience. 10. Based on 0.15% of PID patients reported as NFKB1 in the ESID registry & overall prevalence of 1/2500. 11.Based on 0.11% of PID patients reported as NFKB1 in the USIDnet registry (5489 patients usidnet.org) & overall PID prevalence of 1/2500. 12. Pharming literature review (6 NFKB1 pubs): of all CVID patients with genetic drivers 6% were NFKB1; CVID prevalence ~100 /mill., 30% with genetic drivers (30 /mill.), 30*0.06 = 2/mill 13. Pharming literature review (7 CTLA4 pubs): of all CVID patients with genetic drivers 5% were CTLA4; CVID prevalence ~100 /mill., 30% with genetic drivers (30 /mill.), 30*0.05 = 1.5/mill 14. KOL opinion approx. half of NFKB1 patients need better therapy

RUCONEST® and Joenja® driving revenue growth



- From FY 2016 – FY 2020 Pharming Group reported earnings in EUR. Revenues during this time frame have been converted to USD. In 2021, Pharming Group began reporting earnings in USD.
- 4Q 2020 and 1Q 2021 quarterly fluctuations and volatility from COVID-19.

OpEx development – 2024 quarterly



2024 Financial guidance

	FY 2024 Revenue Guidance	% Growth vs. FY 2023
Total Revenues	US$280 - 295 million	14-20%

- Joenja® significant driver of revenue growth, continued RUCONEST® growth
- Joenja® revenue assumptions:
  - Continued growth in patients on paid therapy
  - Continued high (monthly) adherence (compliance) rates >85%
  - U.S. Pricing: 30-day supply $47,220, Annual cost (WAC) $566,640, GTN Discount ~15%
- OpEx adjustments to continue in 4Q

Pharming®

Pharming Group N.V.

Appendix

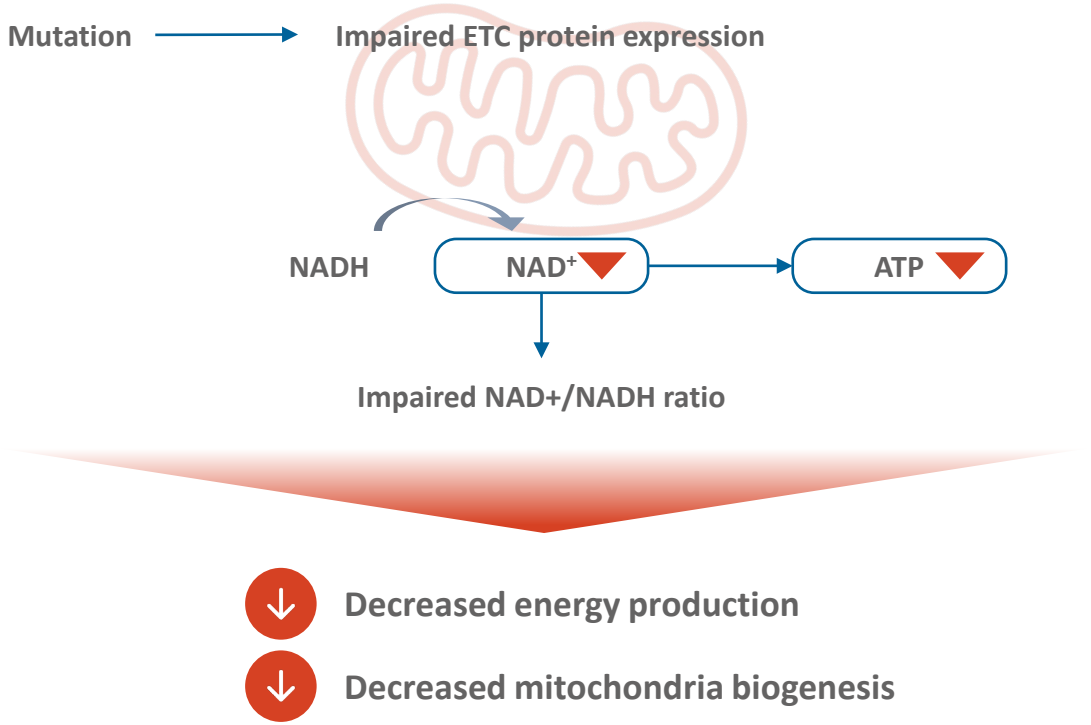
Proposed Abliva AB Acquisition (KL1333)

Dysfunctional mitochondria produce less ATP

Primary Mitochondrial Disease (PMD)

- Mitochondria, often described as the “powerhouses” of cells, are crucial for energy production
- Mitochondrial diseases are a group of genetic disorders characterized by dysfunctional mitochondria due to mutations in mitochondrial (mtDNA) or nuclear DNA
- The abnormal NAD^+/NADH ratio results in decreased ATP production, contributing to organ dysfunction and disease deterioration
- For patients this means symptoms of severe fatigue and muscle weakness – symptoms which patients report as the most troublesome*

Dysfunctional Mitochondria



*Voice of the Patient Report, United Mitochondrial Disease Foundation, 2019.

NAD: Nicotinamide adenine dinucleotide; NADH: Nicotinamide adenine dinucleotide + hydrogen; ETC: Electron transport chain.

Heavy patient burden with no approved therapies

Presentation and Diagnosis

- Patients present to their primary care doctor and then often get referred to a neurologist for musculoskeletal issues
- Either the neurologist or a referral to a metabolic geneticist will result in a diagnosis
- Many patients are diagnosed at academic centers specializing in mitochondrial disease
- A combination of routine lab tests and genetic testing available from major testing labs help to diagnose patients

Impact

- Patients heavily burdened in their daily lives including symptoms like severe fatigue, myopathy, and metabolic dysfunction
- Impact on QoL including loss of job, loss of independence, depression/anxiety
- Primary mitochondrial diseases lead to a three-to-four-decade reduction in life-expectancy

Treatment

- No approved treatment options
- Patients are limited to using vitamins, supplements, and physical therapy

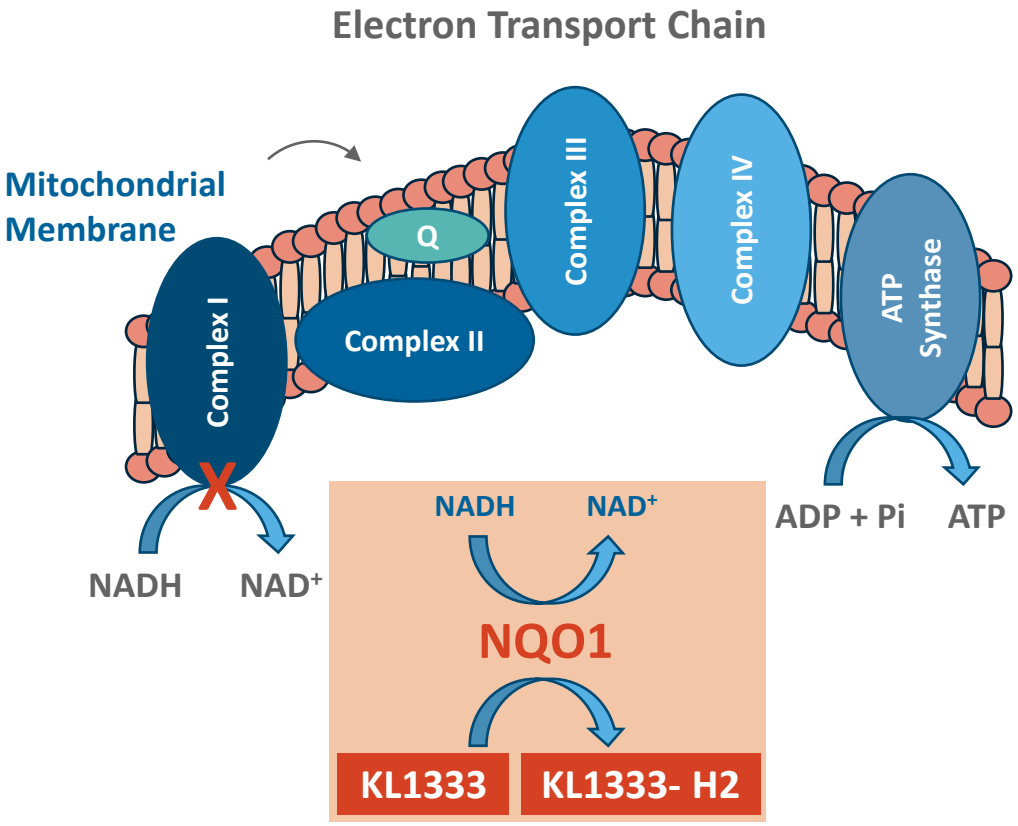
" On the worst days I will be crying in frustration because going to the kitchen seems equivalent to climbing a mountain and just trying to process what others are saying to me involves all the energy and concentration that I have."

United Mitochondrial Disease Foundation, Voice of the Patient Conference, 2019

KL1333 corrects the underlying pathophysiology

KL1333 normalizes conversation of NADH to NAD+ via NQO1

Normalizes the NAD+/NADH Ratio



Restored Energy Metabolism

- Restored energy regulation and improved ETC function
- Stimulation of mitochondria biogenesis
- Overall resulting in symptom reduction and expected disease modification

KL1333: First-in-disease small molecule with unique MOA

Attributes

- Directly increases the NAD+/NADH ratio via NQO1
- Unique MoA works upstream from all competing MoA in PMD
- Oral, small molecule, BID dosing
- Favourable safety profile
- Favourable IP protection
- Orphan Drug Designation in US & EU and FDA Fast Track
- Potential first-in-disease with registrational clinical study

Outcomes

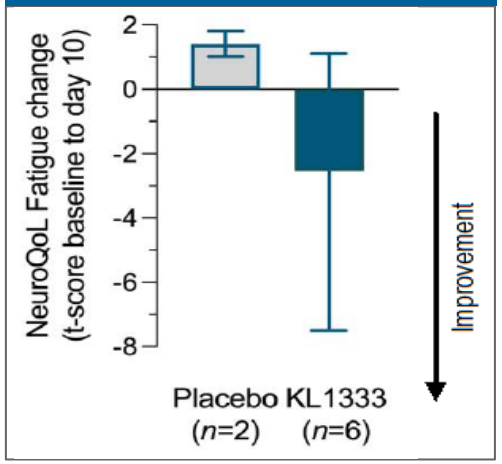
- Improved energy regulation and ETC function
- Stimulation of mitochondria biogenesis
- Fatigue reduction
- Increased exercise capacity

Phase 1b demonstrated significant activity vs. placebo

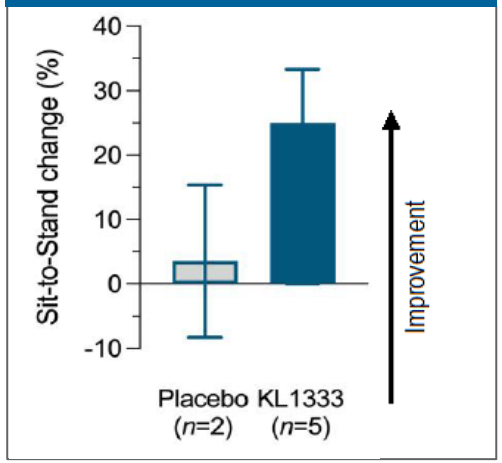
The placebo-controlled Phase 1b study demonstrated that KL1333 reduced patients' fatigue and myopathy after only 10 days, 50 mg/day

- KL1333 demonstrated efficacy in the phase 1b placebo-controlled portion with patients diagnosed with mtDNA mitochondrial disease
  - Fatigue reduction (NeuroQoL fatigue change)
  - Muscle function improvement (30 seconds sit-to-stand)
- KL1333 showed efficacy signals after 10 days using 50 mg/day
- Mitochondrial patients have increased lactate levels and increasing the concentration of KL1333 resulted in an improved lactate/pyruvate ratio, reflecting target engagement
- No serious adverse events reported

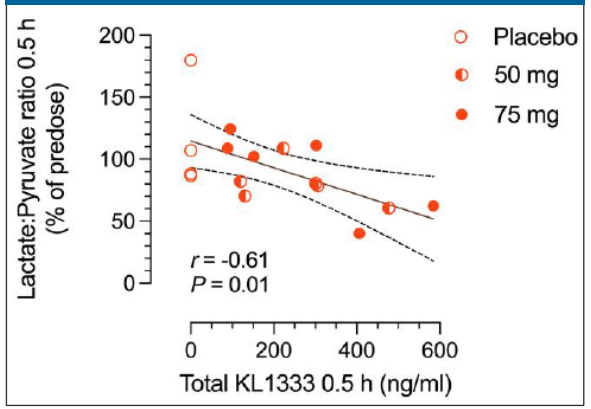
Fatigue Reduction
Changes from baseline to day 10



Muscle Function Improvement
Changes from baseline to day 10

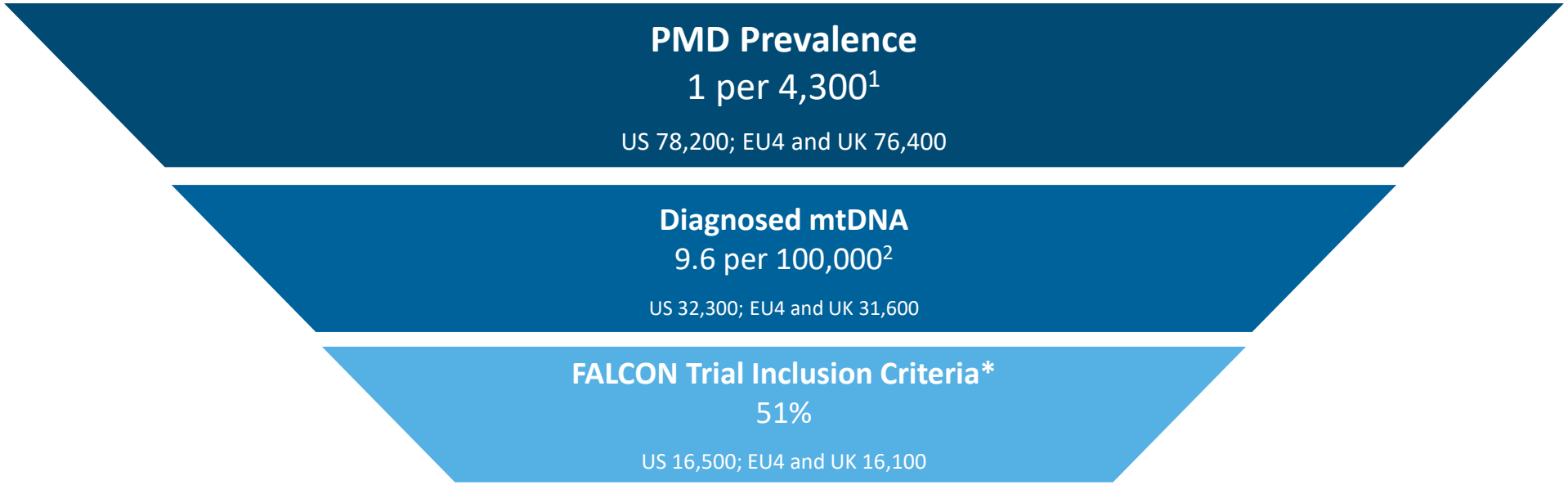


Lactate:Pyruvate Ratio
Changes from baseline to day 10



Source: Pizzamiglio C et al., Optimizing rare disorder trials: a phase 1a/1b randomized study of KL1333 in adults with mitochondrial disease, Brain, 2024.

Significant revenue opportunity for KL1333

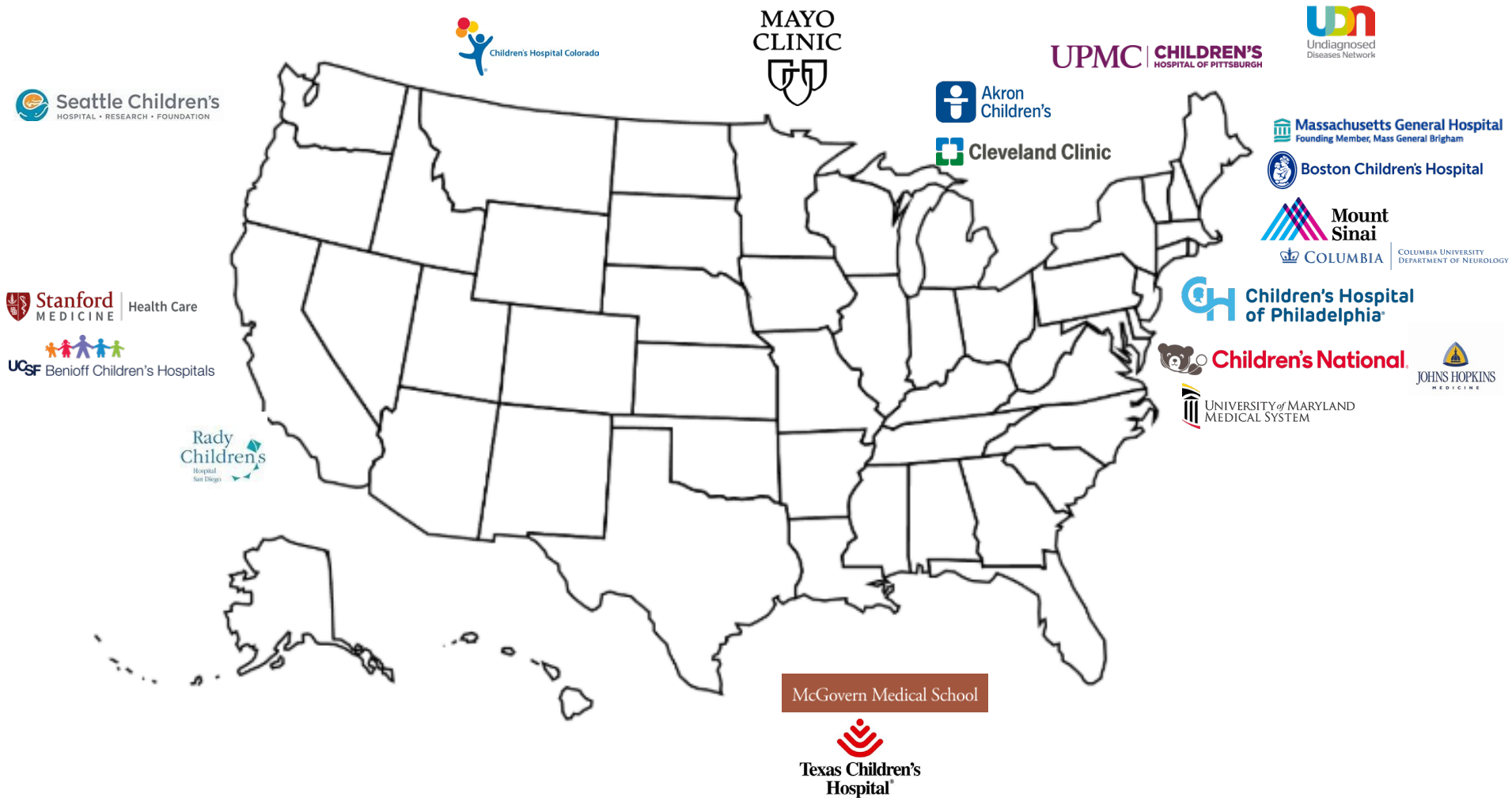


>30,000 diagnosed mtDNA mitochondrial disease patients addressable in the US, EU4 and UK

*mtDNA mutations including m.8344A>G MELAS-MIDD, MERRF, KSS-CEPO, large scale mtDNA deletions

[1] Gorman, G.S. et al. Prevalence of nuclear and mitochondrial DNA mutations related to adult mitochondrial disease. Ann Neurol 2015 May;77(5):753-9.
[2] Gorman, G.S. et al. Mitochondrial Diseases. Nat. Rev. Vol 2, 1-22 (2016).

Majority of patients diagnosed and treated in US Centers of Excellence or academic institutions



Mitochondrial Care Network – Centers: www.mitonetwork.org/centers

Other programs focus on different patient population or failed with different MOA

Previous programs failed due to old mechanisms of action or evaluating the wrong endpoints

Asset	Type	MOA / ROA	Stage	Patient Group	Comments
ABLIVA **KL1333**	Small molecule	NAD+/NADH modulator Oral	Pivotal	mtDNA mutations (e.g., mtDNA deletion, m.8344A>G, MELAS-MIDD, MERRF, KSS-CEPO)	▪ Ongoing potentially registrational phase 2 study ▪ FALCON pivotal study reported positive 24w interim analysis
Stealth BIOTHERAPEUTICS **Elamipretide**	Peptide	Cardiolipin stabilizer Subcutaneous	Phase 3	nDNA mutations	▪ nDNA represents about 20% of PMD patients ▪ In discussions with FDA for ultra rare Barth syndrome
Tisento THERAPEUTICS **Zagociguat**	Small molecule	Guanylate cyclase stimulator Oral	Phase 2b ready	MELAS	▪ Completed open-label MELAS phase 2a ▪ Phase 2b trial planned with focus on fatigue, myopathy and cognition
KHONDRION **Sonlicromanol**	Small molecule	Redox modulator Oral	Phase 3 ready	mtDNA mutation (MELAS-MIDD)	▪ Phase 2a study in m.3243A>G patients showed predominantly neutral results across multiple endpoints ▪ Phase 2b study failed primary endpoint, positive changes in post-hoc analyses and open-label extension
Reneo **Mavodelpar**	Small molecule	PPARδ agonist Oral	NA	mtDNA in the interventional trial and extended to include nDNA in the OLE	Phase 3 failed to achieve primary endpoint of 12-minute walk test
astellas **Boicedelpar**	Small molecule	PPARδ agonist Oral	NA	Mixed population of mtDNA and nDNA	Phase 2 program using 6-minute walk test terminated