Entera Bio Ltd.

Corporate Presentation

NASDAQ: ENTX



Disclaimer

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Important factors that could cause actual results to differ materially from those reflected in Entera's forward-looking statements include, among others: changes in the interpretation of clinical data; results of our clinical trials; the FDA's interpretation and review of our results from and analysis of our clinical trials; unexpected changes in our ongoing and planned preclinical development and clinical trials, the timing of and our ability to make regulatory filings and obtain and maintain regulatory approvals for our product candidates; the potential disruption and delay of manufacturing supply chains; loss of available workforce resources, either by Entera or its collaboration and laboratory partners; impacts to research and development or clinical activities that Entera may be contractually obligated to provide; overall regulatory timelines; the size and growth of the potential markets for our product candidates; the scope, progress and costs of developing Entera's product candidates; Entera's reliance on third parties to conduct its clinical trials; Entera's ability to establish and maintain development and commercialization collaborations; Entera's operation as a development stage company with limited operating history; Entera's competitive position with respect to other products on the market or in development for the treatment of osteoporosis, hypoparathyroidism, short bowel syndrome, obesity, metabolic conditions and other disease categories it pursues; Entera's ability to continue as a going concern absent access to sources of liquidity; Entera's ability to obtain and maintain regulatory approval for any of its product candidates; Entera's ability to comply with Nasdaq's minimum listing standards and other matters related to compliance with the requirements of being a public company in the United States; Entera's intellectual property position and its ability to protect its intellectual property; and other factors that are described in the "Cautionary Statement Regarding Forward-Looking Statements," "Risk Factors" and "Management's Discussion and Analysis of Financial Condition and Results of Operations" sections of Entera's most recent Annual Report on Form 10-K filed with the SEC, as well as Entera's subsequently filed Quarterly Reports on Form 10-Q and Current Reports on Form 8-K. There can be no assurance that the actual results or developments anticipated by Entera will be realized or, even if substantially realized, that they will have the expected consequences to, or effects on, Entera. Therefore, no assurance can be given that the outcomes stated or implied in such forward-looking statements and estimates will be achieved. Entera cautions investors not to rely on the forward-looking statements Entera makes in this presentation. The information in this presentation is provided only as of the date of this presentation, and Entera undertakes no obligation to update or revise publicly any forward-looking statements, whether as a result of new information, future events or otherwise, except to the extent required by law.

To Develop Transformative, First-in-Class Oral Peptide Treatments

Our Mission

Focus Where It Matters

Invest in therapeutic spaces that have been ignored and require urgent attention

Deliver Value, Fast

Drive value for patients, clinicians and healthcare ecosystems smartly and expeditiously

Think Beyond the Obvious

Think outside the box, innovate and cultivate our science, strategy and people everyday

Oral Peptides Developed to Empower Patients and Unlock Clinician Access

Proprietary N-Tab® Platform

- Innovative first-in-class oral peptides
- Large (4kD+) linear, hydrophilic targets
- Simple once a day tablet treatment
- Robust protein design and modification capability via OPKO partnership

Focused Portfolio Strategy

Validated targets, near-term clinical readouts and multi-billion-dollar market opportunities

Corporate Snapshot

TICKER	**Nasdaq: ENTX ; 173M shares outstanding**
TEAM	**Global interdisciplinary team**
FINANCING	**$275M financing secures runway into 2030**

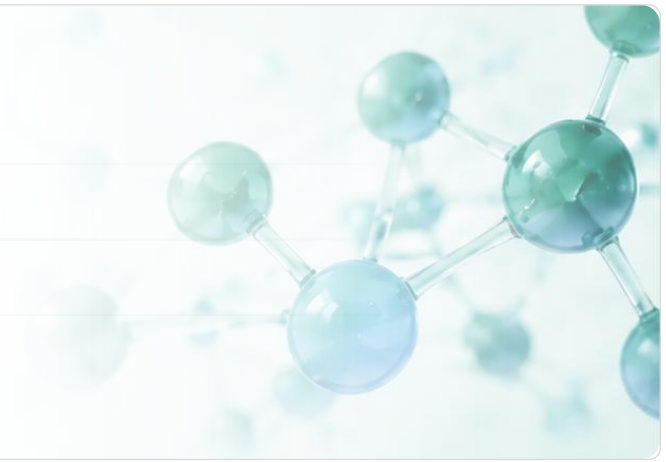
Lead Asset – Fully Funded Through PDUFA (2030E)



EB613 (Osteoporosis): First oral tablet designed to democratize anabolic (bone-building) treatment. Osteoporosis is a women centric condition with a persistent treatment gap. Robust Phase 2 data supports a derisked Phase 3 program with blockbuster sales potential in the US alone

- ✓ Validated MOA - PTH(1-34), teriparatide
- ✓ Robust Phase 2 data
- ✓ FDA-aligned Phase 3 registrational Plan
- ✓ Multi-billion $ market opportunity

Diversified Pipeline



Rare Endocrine: Hypoparathyroidism

Metabolic: Obesity, partnered program

GI Inflammation: Short Bowel Syndrome

Partnership model: Additional oral peptide programs via partnership, combining N-Tab® with new targets

Entera Oral Peptide Pipeline

Multiple pathways to significant value creation

Program	Indication	Target	Preclinical	Phase 1	Phase 2	Phase 3	Ownership*
EB613	Osteoporosis	PTH (1-34) Agonist teriparatide				Q4/26 Ph3 registrational study initiation	Entera
EB612	Hypoparathyroidism	Acylated PTH (1-34) Agonist		2027 Ph1 study initiation			Entera OPKO (50%-50%)
EB618	Obesity / Metabolic	GLP-1 & Glucagon Agonist					Entera OPKO (40%-60%)
GLP-2	Short Bowel Syndrome	Long Acting GLP-2					Entera OPKO
EB613	Stress Fractures	PTH 1-34	Investigator Sponsored Trial				Entera

*EB612 and EB618 are being co-developed with Opko Health Inc. pursuant to 2025 Collaboration and License Agreement and 2026 Amendment

Entera Core Team

Bringing Together Scientific Excellence to Deliver Better Treatment Outcomes Globally



Miranda Toledano
Chief Executive Officer and Board Member



Gregory Burshtein, PhD
Chief Scientific Officer



Hillel Galitzer, PhD
Chief Operating Officer



Riccardo Camisasca, MD
Chief Medical Officer



Dana Yaacov, CPA
Chief Financial Officer



Michele McDermott, MD
SVP Medical Affairs



Michal Kushnir
Head of Program Management



Helen Pentikis, PhD
Clinical Pharmacology



Cherin Smith, PMP
SVP Clinical Operations



Osnat Bar-Peled, PhD
Executive Director of IP



Felicia Cosman, MD
Chair, Scientific and Clinical Advisory Board



Rachel B. Wagman, MD, FACE, FACP
Chief Clinical Advisor



Steven R. Goldstein, MD
Chief Clinical Advisor (Gynecology)

N-Tab® Proprietary Platform

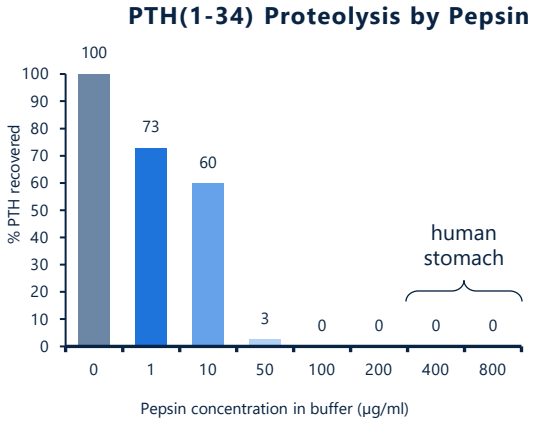


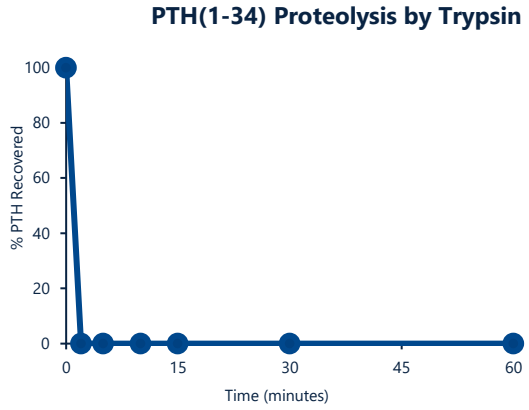
Barriers to Oral Peptide Delivery

Proteolytic Degradation

Stomach:
- Pepsin-mediated peptide cleavage
- Acidic pH → protein denaturation

Small Intestine:
- Trypsin & α-chymotrypsin degradation
- Brush-border metabolism





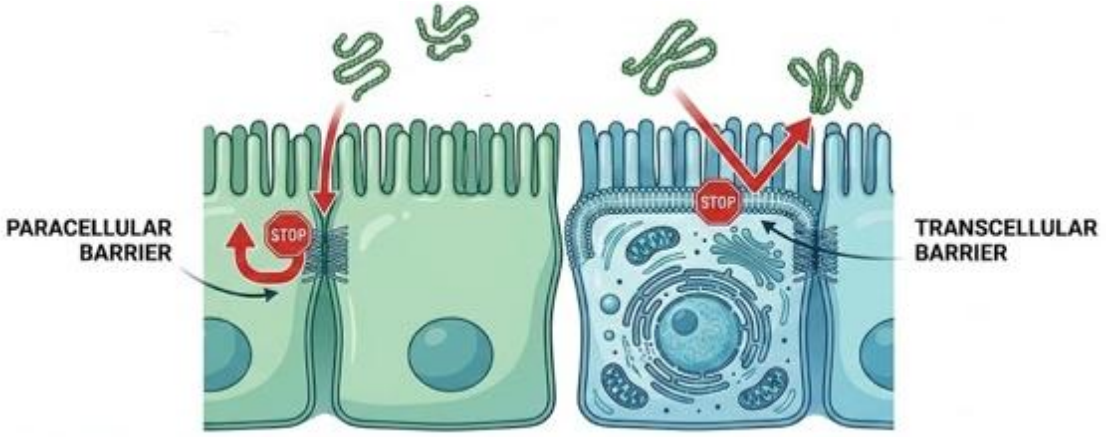
100%

peptide breakdown within a few minutes of luminal exposure

Epithelial Permeability Barrier

Paracellular:
- Too large for tight junction transport

Transcellular:
- Too hydrophilic to cross the
- hydrophobic core of enterocyte barrier



~0%

typical oral bioavailability for unformulated peptides

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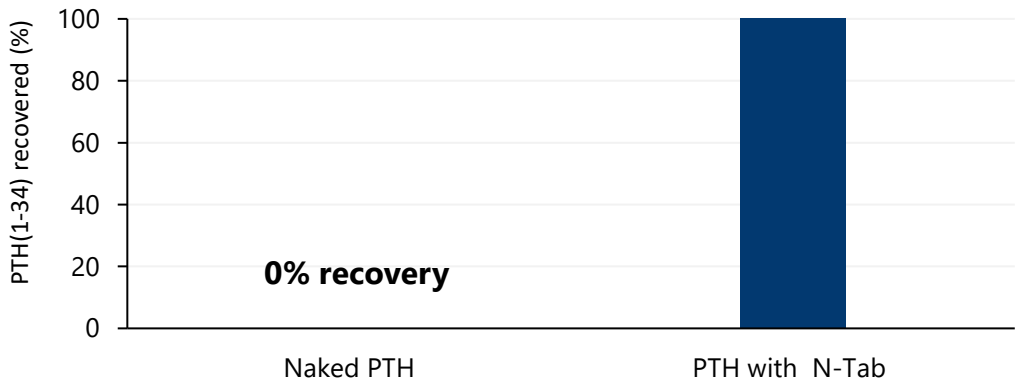
Two Synergistic Mechanisms of the N-Tab® Platform

The N-Tab® platform overcomes enzymatic degradation and enhances permeability for improved bioavailability

Proteolysis Inhibition

Protease Activity is Blocked. Peptide Survives.

PTH Stability in Gastric Medium (*in vitro*)

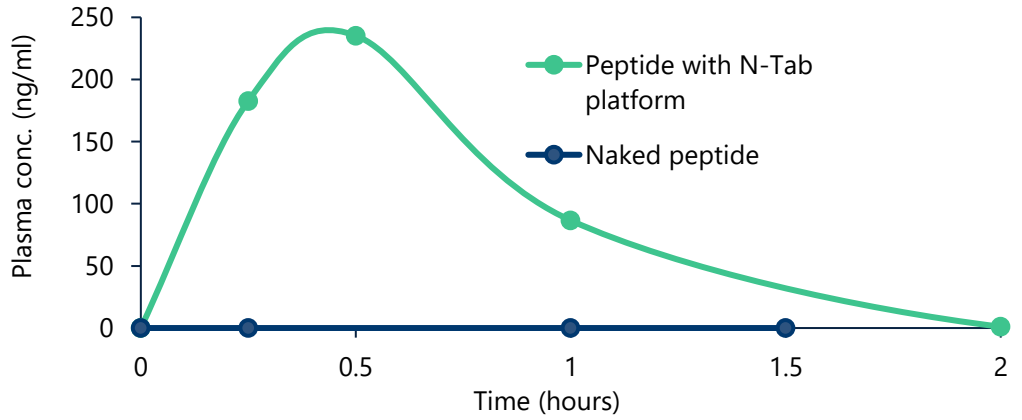


The naked peptide is completely degraded in the stomach within 5 minutes. N-Tab platform locally stabilizes the peptide

Permeability Enhancement

Membrane Fluidity Transiently Increased. Drug Absorbed Systemically.

Peptide Absorption (*in vivo*)



The N-Tab platform transiently increases enterocytes membrane fluidity, enabling transcellular permeation of the peptide through the gastric wall

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N-Tab®: Core Platform Advantages

Advantageous Pharmacokinetic Profile

Overcomes oral bioavailability challenges of peptides enabling therapeutically relevant systemic exposure

Gastric absorption with **rapid onset of action**

✓ **Reproducible PK profile**

Clinically Proven

Demonstrated **consistent exposure** and **robust pharmacodynamic responses** in clinical studies

Successful Phase 2 studies in osteoporosis and hypoparathyroidism

✓ **Three Phase 1 and three Phase 2 (n=270)**

Broad Applicability

Versatile platform enabling conversion of diverse peptide drugs into oral formulations

Peptide size range – Feasibility to orally deliver peptides ranging in size from 0.9 kDa to ~20 kDa was demonstrated in vivo

✓ **>10 assets across 7 therapeutic areas**

Rapid Development Path

Customized large animal model as a proof-of-concept tool to assess feasibility

Based on **approved pharmaceutical excipients** to streamline the regulatory pathway

Conventional manufacturing equipment and **scalable process for commercial supply**

✓ **~16-month formulation-to-IND**

Safety Profile

Compared with small molecules, oral peptides have **greater target receptor selectivity**

The effect on the cellular membrane is short lasting with **no local tissue damage** to GI tract

Oral dosing is **less immunogenic**

✓ **>25,000 doses administered in clinical trials with no serious adverse events attributed to the platform**

Patient Compliance Uplift

Conventional **small once-daily tablet**

Convenient storage

Oral vs. injectable drives a significant positive impact on treatment **compliance and patient quality of life**

✓ **Favorable patient and clinician surveys**

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EB613 Oral PTH (1-34), Teriparatide Tablet Treatment

First Once Daily Oral Osteoanabolic for Post-Menopausal Women with Osteoporosis



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EB613: First Oral Anabolic (Bone Building) Tablet

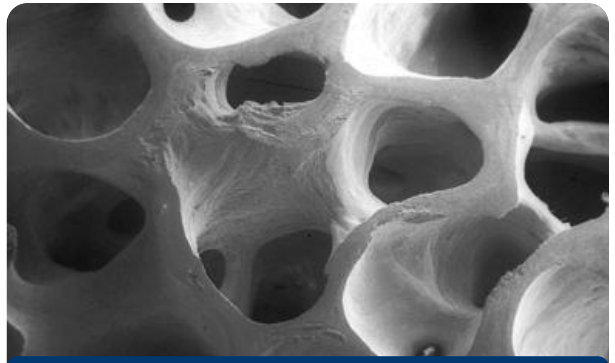
- Derisked asset, phase 3 ready with efficient path to registration
- Oral tablet with identical API as blockbuster SC injection, Forteo® (Eli Lilly, approved since 2002, ~$1.7BN peak sales)

- Phase 2 showed comparable efficacy/safety as Forteo
- Unique dual MOA rapidly stimulates osteoblasts to increase new bone formation (PINP) and suppresses bone resorption (CTX)

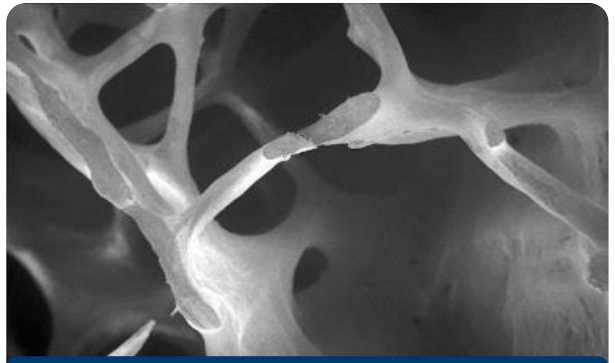
- Oral supports earlier osteoanabolic intervention in line with guidelines
- Patients prefer oral treatment in silent asymptomatic condition
- Potentially widens access from endo/rheum specialists (~15% Rx) to primary care/Gyn (~80% Rx)

Our Mission is to Democratize Anabolic Therapy so Every Woman can Protect her Bone Health and Deter the Risk of Fracture

Osteoporosis is the Most Common Metabolic Bone Disease Worldwide



Healty Bone
Dense trabecular structure



Osteoporotic Bone
Reduced and fragile trabecular structure

Dysregulated Bone Remodeling:

Increased Osteoclast Activity ↑
Bone resorption (CTX biomarker)

Reduced Bone Formation ↓
Bone formation (P1NP biomarker)

- Characterized by low bone mass, deteriorated skeletal microarchitecture, compromised bone strength, and increased risk of fracture
- Postmenopausal women are at highest risk of developing osteoporosis-related fractures, especially in the first 5-10 years after menopause
- Multiple guidelines recommend anabolic (bone forming) treatment as frontline treatment because of its superiority in rapidly increasing BMD and lowering fracture risk vs. anti-resorptive treatment
- The 3 approved anabolic drugs (Forteo®, Tymlos®, Evenity®) require daily/"in-office" monthly subcutaneous (SC) injections which limits both clinician and patient access

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Osteoporosis Related Fractures Afflict More Women than Heart Attack, Breast Cancer and Stroke Combined Yet a Treatment Gap Persists Globally

200M

Women worldwide are affected by osteoporosis

1 in 3

Women and 1 in 5 men over the age of 50 will suffer an osteoporosis related fracture

54M

Americans at risk

~13M

Prevalence

~60%

Do not accept or have access to currently available treatment options

>2M

Osteoporosis fractures (US) affect quality of life, disability, and premature death

>20%

of hip-fracture patients die within one year of the event

2019

Date of last approved osteoporosis drug

Phase 3 registrational program included ~11,300 subjects

EB613 Addresses the Treatment Gap in the Osteoporosis Patient Journey

~10M diagnosed with osteoporosis in the US, with estimated less than ~40% treated
There is need for novel products with enhanced efficacy, tolerability, and ease of use – FDA (2025)*

Anti-Resorptive

1st Line Bisphosphonates Fosamax®

~60%

Oral, Highly Accessible

~50% discontinue within 12 month due to AEs acid reflux, concerns over ONJ, AFF

RANK-Ligand Inhibitor (SC) Prolia®

~20%

SC injection every 6 months

Risk of Multiple Vertebral Fractures upon discontinuation, ONJ, AFF

EB613

- **First PTH Anabolic Tablet**
  Facilitates earlier bone building intervention to prevent fractures
- **High Accessibility to Patients and Clinicians**
  Primary Care, GYN, Endo, Rheum
- **Ease of Administration is Critical**
  In a silent progressive asymptomatic disease patients strongly prefer oral tablets
- **Mitigated Risk**
  Addresses patients' fear of injections and AEs such as Osteonecrosis of the Jaw (ONJ) and Atypical Femoral Fracture (AFF)

Injectable Anabolic

PTH Receptor Agonist Forteo®, Tymlos®

~9%

Daily SC injection

Many HCPs do not have in-office resources to bill for injectable drugs

Anti-Sclerostin Evenity®

~6%

SC injection every 6 months

CVD black box, Requires resources to buy and bill for and administer

*FDA Full Qualification Package Integrated Review, BMD as Validated Surrogate Endpoint for Post-Menopausal Women with Osteoporosis., December 19 2025
AFF=Atypical Femoral Fracture; ONJ=Osteonecrosis of the jaw

EB613 Phase 2 Clinical Study in Postmenopausal Women with Osteoporosis

6-month, randomized, dose-ranging, placebo-controlled study in postmenopausal women with osteoporosis - met primary and secondary endpoints

Key Inclusion Criteria

50+ years old

3+ years postmenopause

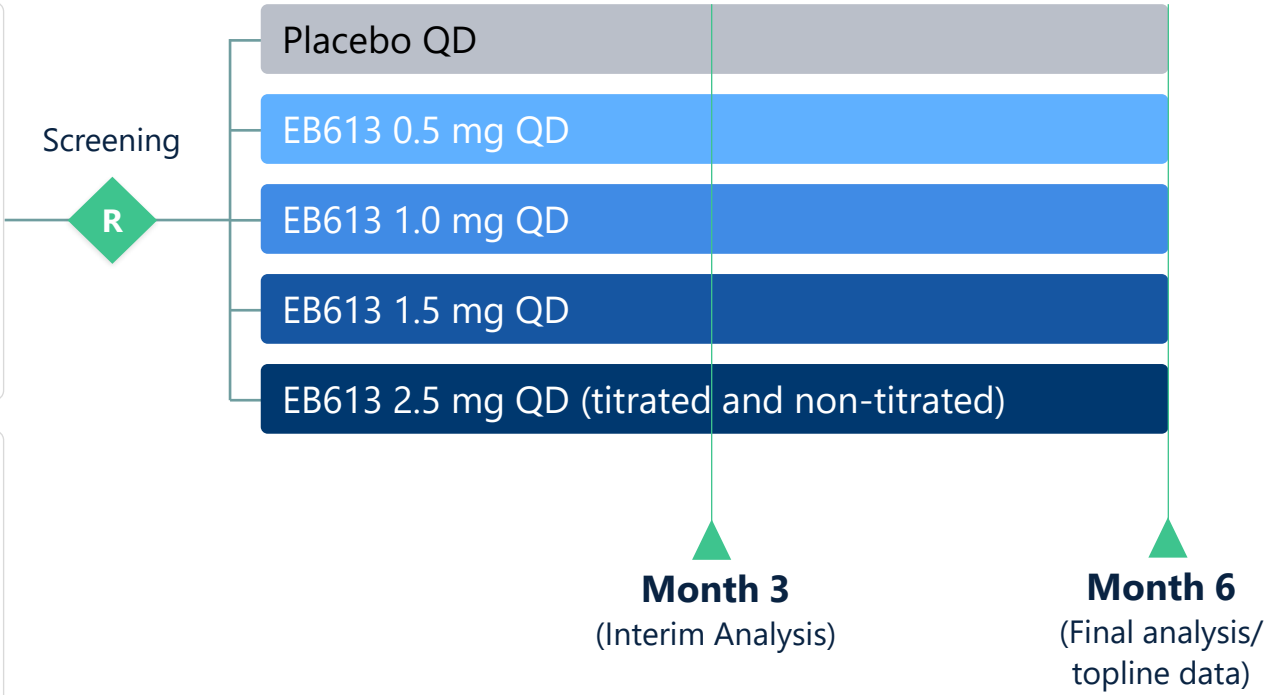
Low bone mass (≤-2.0 in at least one site)

High risk; no prior fracture

Key Exclusion Criteria

Osteoporosis treatment within last 2 years

Severe osteoporosis that precludes placebo



Primary Endpoint

Serum PINP % change from baseline (placebo-adjusted) at Month 3

Secondary Endpoints

BMD % change from baseline

Serum OC and CTX % change from baseline at Months 1, 2, 3, and 6

Serum PINP % change at Months 1, 2, and 6

Plasma PTH(1-34) at T15 min

4 Study Sites | **161** Patients Enrolled | **118 / 43** Active / Placebo

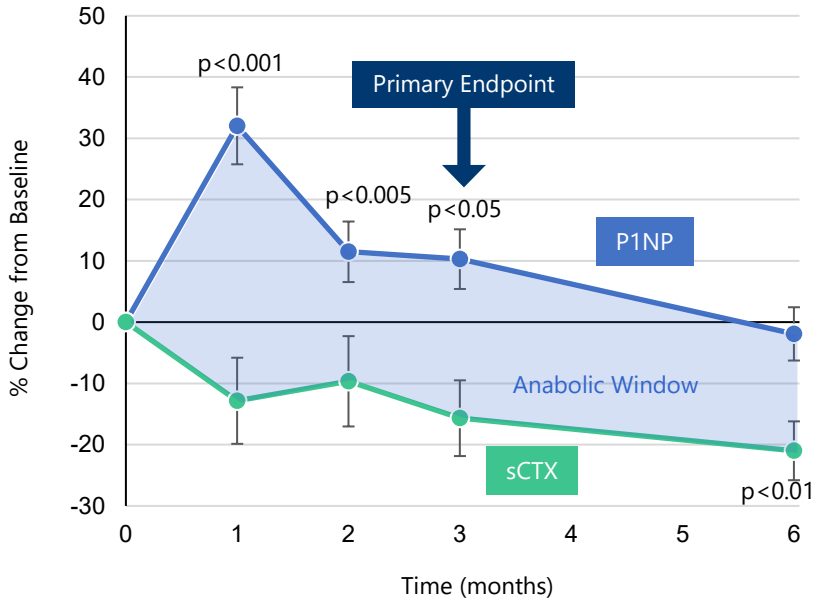
Tripto-Shkolnik et al., J Bone Miner Res 2024

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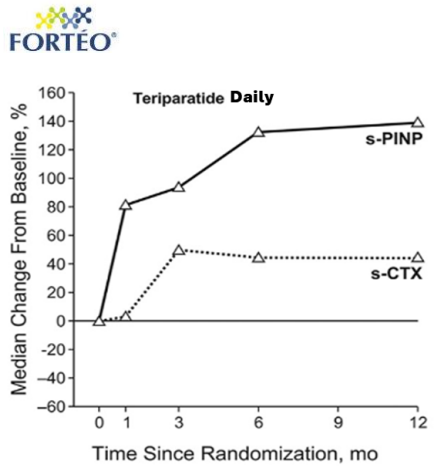
EB613 Rapidly Induces Bone Formation (P1NP) while Reducing Resorption (CTX)

EB613's dual mechanism stimulates new bone formation on trabecular and cortical (periosteal and/or endosteal) bone surfaces by preferential stimulation of osteoblastic activity over osteoclastic activity

EB613 (2.5 mg) Shows Dual MOA

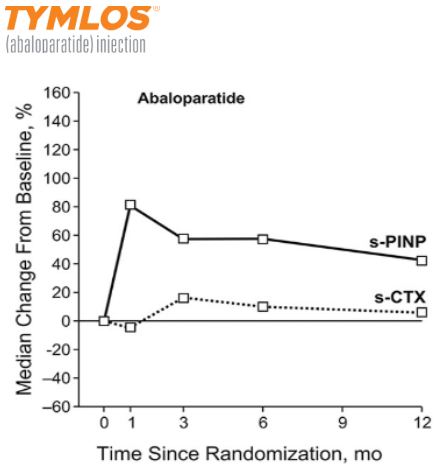


Every Commercial Anabolic has a Distinct Bone-Turnover-Marker (BTM) Profile



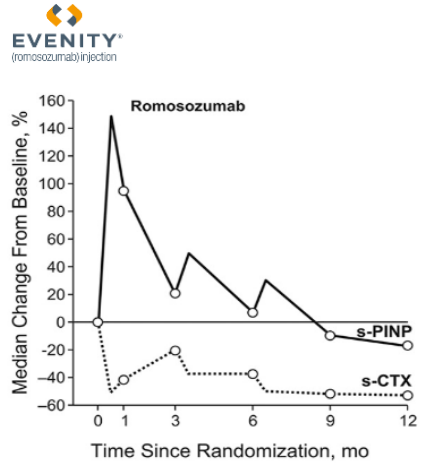
Remodeling

Teriparatide (Forteo®)
Remodeling-based anabolism - both P1NP and CTX rise



Remodeling

Abaloparatide (Tymlos®)
Less remodeling anabolism - smaller CTX rise



Dual Moa

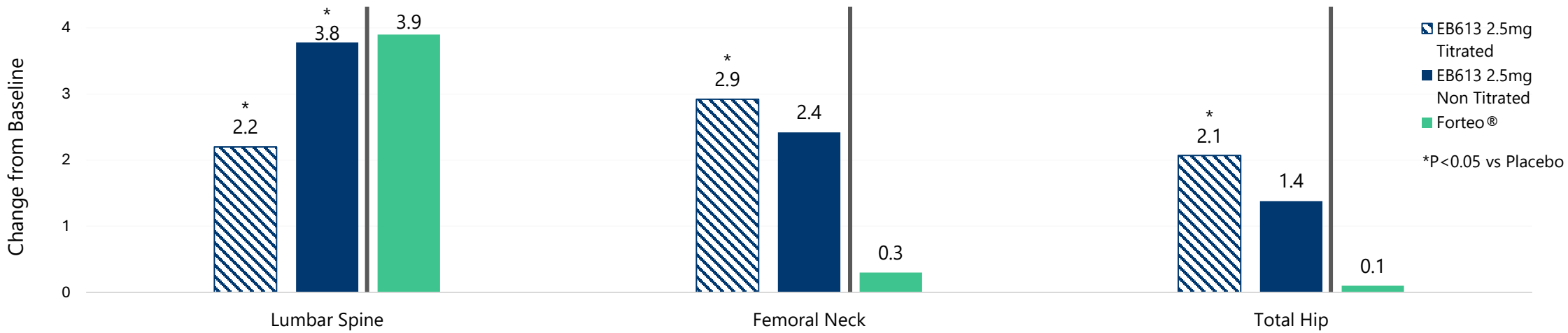
Romosozumab (Evenity®)
Modelling based anabolism – CTX decrease

P1NP = bone formation marker; CTX = bone resorption marker. Shaded region = anabolic window (formation minus resorption)

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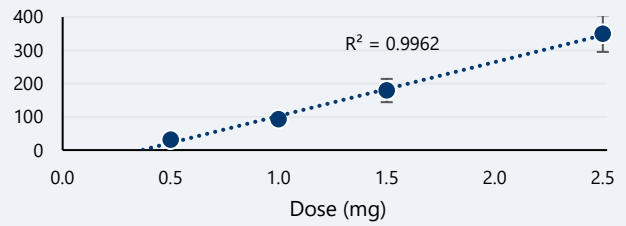
EB613 Produced Statistically Significant Increases in BMD across All Skeletal Sites - with a Clear Dose Response

Placebo Adjusted BMD for EB613 vs. Published Forteo® Data in a Similar Patient Population

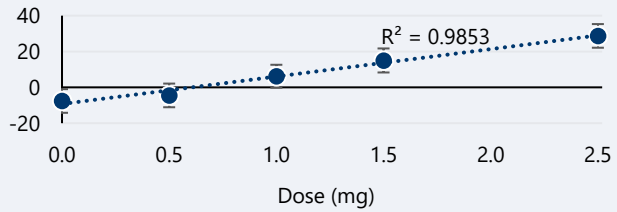


Dose-Response PK/PD Relationship (EB613 0.5-2.5 mg)

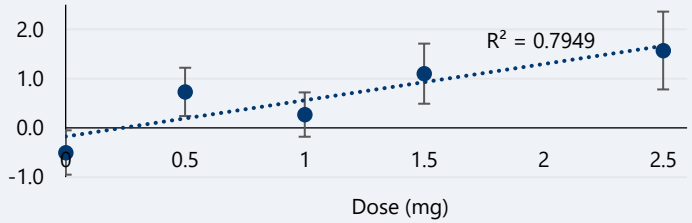
Concentration of PTH(1-34) in Plasma
15 minutes post-dose (pg/ml, mean ± SE)



% Serum P1NP Change from Baseline
@ Month 1 (%, mean ± SE)



% Total Hip BMD Change from Baseline
@ Month 6 (%, mean ± SE)

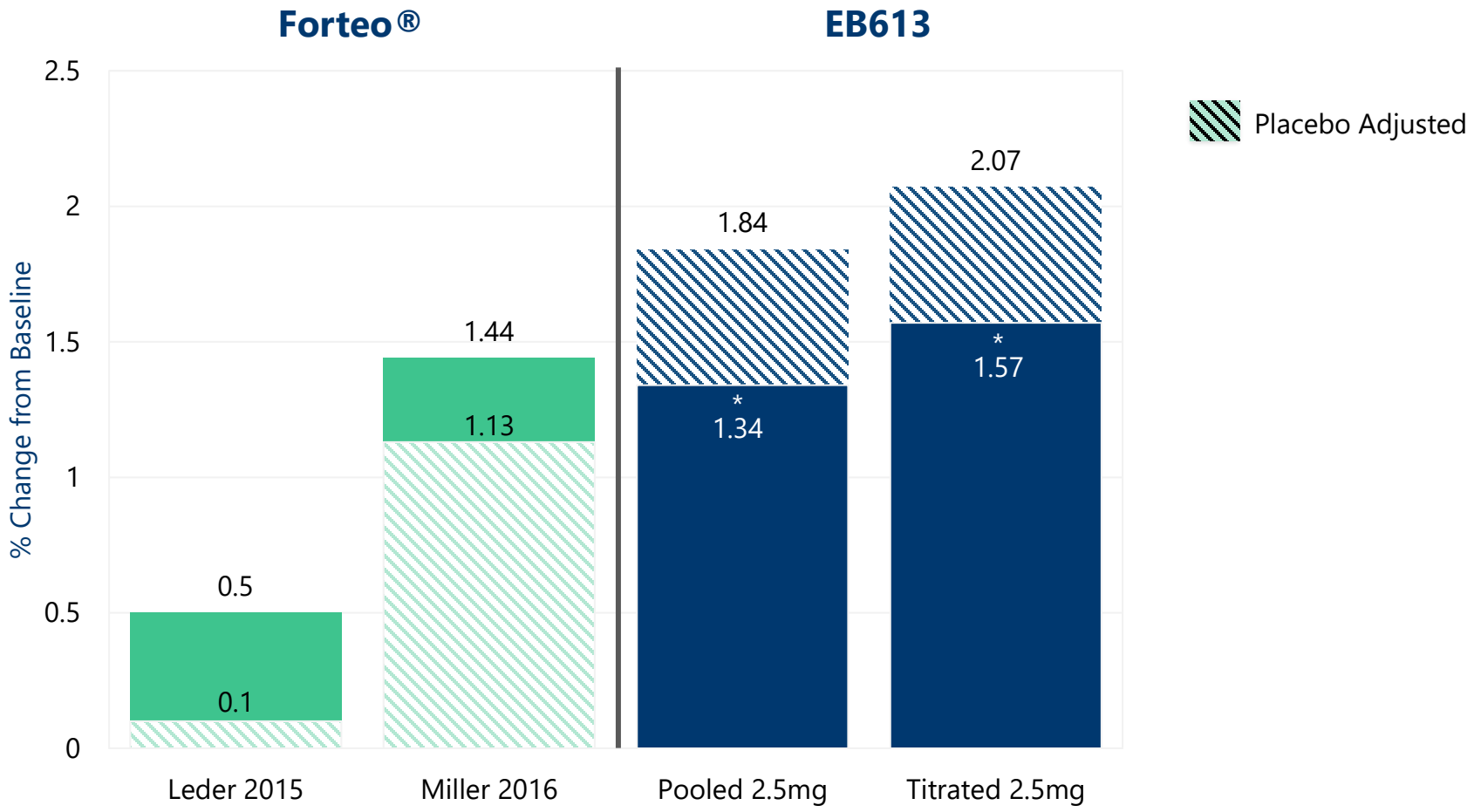


1. Forteo® data based on Leder BZ et.al. JCEM (2015) N=39, and Miller et.al. JAMA (2016) N= 754
2. EB613 data based on Tripto-Shkolnik L et.al. JBMR (2024) Pooled 2.5mg N=21, Titrated 2.5mg N=14

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EB613 Produced Comparable Total Hip BMD Increases as Forteo® 6 Month Published Data

Total Hip BMD is an FDA Efficacy Endpoint as of 12/19/2025



*P<0.05 vs Placebo

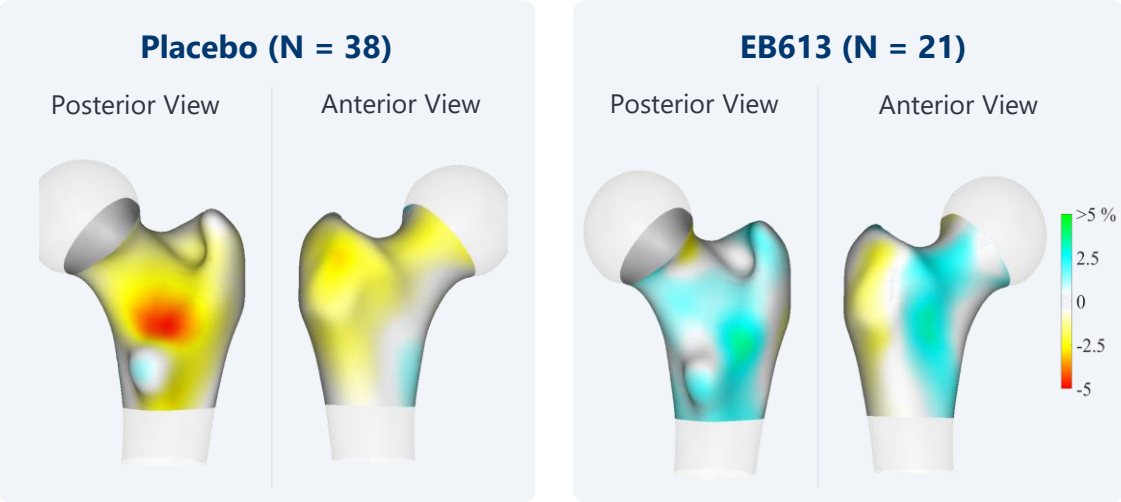
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Exploratory Data Support the Dual Mechanism; Subgroup Signal in High Risk Fracture

Effects of EB613 on Trabecular and Cortical Bone Using 3D-DXA

Average Cortical Surface BMD % Change from Baseline to Month 6 for EB613 and Placebo (3D-DXA)

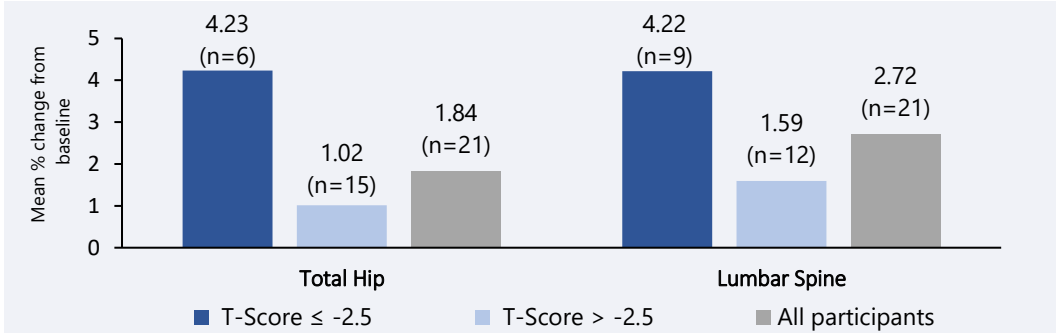


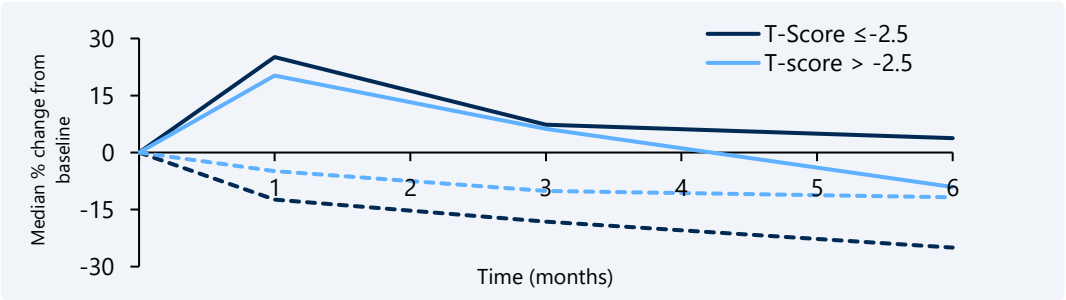
Cyan/green = increased cortical BMD; Yellow/red = Decreased.

EB613 showed an early effect on both trabecular and cortical bone of the proximal femur consistent with the dual mechanism of increased formation and decreased resorption. Comparable assessment with Forteo (teriparatide) and Tymlos (abaloparatide) on cortical bone at 6 months[1]

Post-hoc EB613 Phase 2 analysis: Enhanced Anabolic Effects in Participants at High Risk of Fracture

Placebo adjusted % BMD change at Month 6





EB613 demonstrates a more pronounced effect on Lumbar Spine and Total Hip BMD, as well as a more significant dual effect on bone turnover markers (P1NP and CTX), in patients with a baseline BMD T-score ≤ −2.5, consistent with the Phase 3 study design

Cortical sBMD (mg/cm2) is calculated as the multiplication of the cortical thickness and the cortical volumetric BMD

1. Winzenrieth R et al., Osteoporos Int 2021; 32: 75-583.

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EB613 Has Been Well-Tolerated Across the Phase 1/2 Program

No new drug-related safety signals identified to date, supporting advancement into Phase 3

N = 270
Total Exposed

6 months
Duration of Exposure

0%
SAE Rate Related to EB613

Up to 9mg
Dose

Overall Tolerability and Safety

- Administered to 270 subjects across 3 Phase 1 (n=117) and 3 Phase 2 studies (n=153) in healthy volunteers, postmenopausal osteoporosis, and hypoparathyroidism populations
- Well-tolerated overall; no new drug-related AEs identified across the Phase 1/2 program
- No serious adverse events assessed as drug-related

Phase 2 Safety Overview

- Most common treatment emergent AE (≥5% of all participants): headache, nausea, and dizziness
- EB613 was not associated with serum calcium increases or hypercalcemia adverse events
- Titration reduced mild/moderate orthostatic symptoms

Summary of Cross-over Phase 1 Studies vs. Forteo

	Forteo	EB613[1]
Number of study drug administrations	102	552
Treatment related AEs	10% (10)	4% (20)
Symptoms of orthostatic hypotension[2]	2% (2)	2% (11)
Nausea: the most frequent AE of EB613	2% (2)	1% (6)
Hypercalcemia: the most frequent AE of Forteo	3% (3)	<1% (2)

EB613 has been compared with Forteo in three Phase 1 studies, N = 102 subjects received both drugs; 1All EB613 doses were included in the safety analysis; 2Events of orthostatic hypotension symptoms including dizziness, headache, palpitations, tachycardia, nausea

All mechanistic AEs occurred at rates consistent with (or lower than) Forteo with no dose-limiting safety findings identified to date across the Phase 1/2 program

ENT-01-2011 CSR, ENT-02-2013 CSR, ENT-11-2023 CSR

EB613 Phase 2 Safety Profile in Patients with Osteoporosis

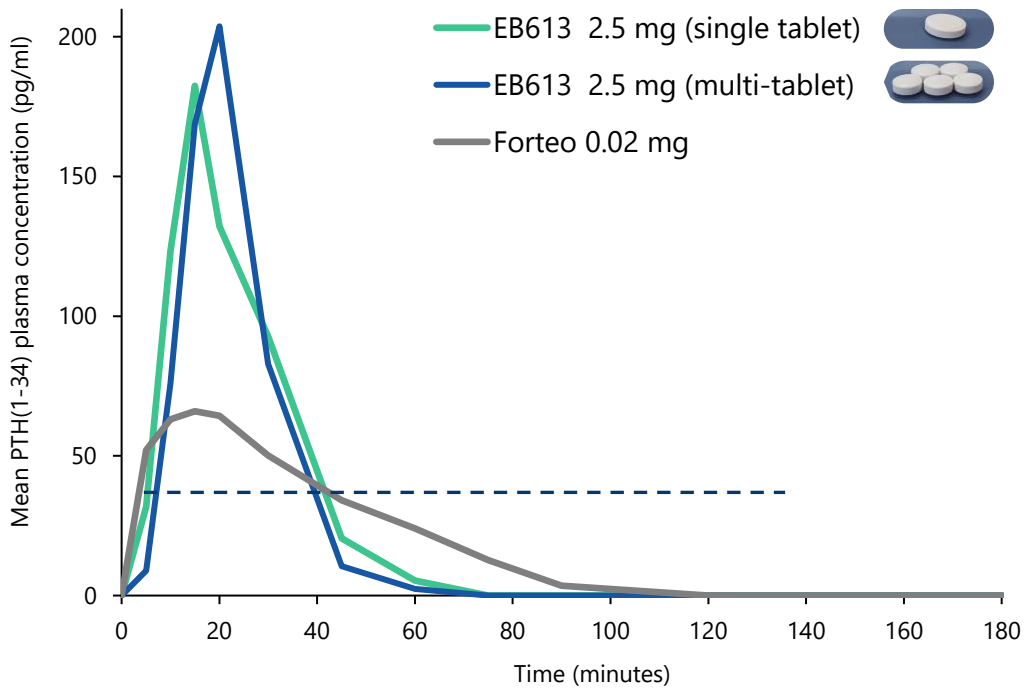
Titration substantially reduced drug-related adverse events (ENT-07-2019)

- Discontinuations due to mild and moderate orthostatic symptoms (headache, nausea, palpitations, dizziness): 21% with EB613 2.5 mg constant vs 0% with EB613 2.5 mg titrated
- Mild and moderate orthostatic symptoms (headache, nausea, palpitations, presyncope, tachycardia, dizziness): 74% with EB613 2.5 mg constant vs 35% with EB613 2.5 mg titrated

Drug–Related Orthostatic Symptoms	EB613 2.5 mg Non-Titrated (N=19)	EB613 2.5 mg Titrated (N=17)
Nausea	36.8% (7)	29.4% (5)
Dizziness	26.3% (5)	5.9% (1)
Presyncope	21.1% (4)	0% (0)
Headache	15.8% (3)	17.6% (3)
Asthenia	10.5% (2)	5.9% (1)
Tachycardia	5.3% (1)	0% (0)
Palpitations	5.3% (1)	11.8% (2)

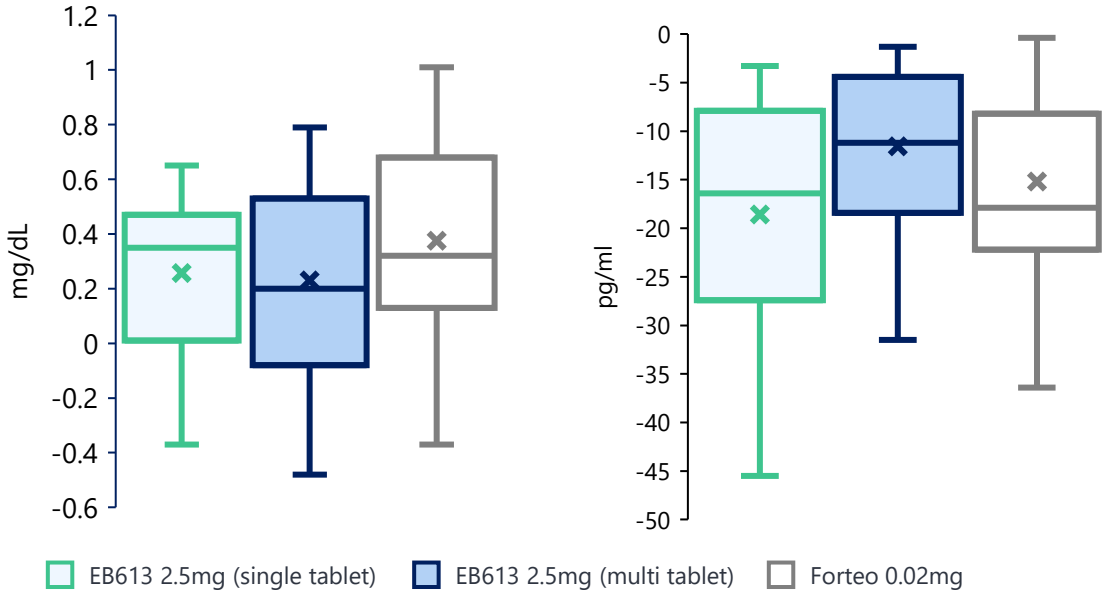
Phase 1 Bridging Study - Comparable PK Exposure Profile Resulting in Comparable PD Outcome, Supports Advancement of EB613 Single Tablet into Phase 3

EB613 single tablet showed similar PK profile to multi-tablet EB613 treatment tested in Phase 2 study



Change in Serum Ca from Baseline

Change in PTH(1-84) from Baseline



Serum Ca and PTH(1-84) were measured 3 hours following EB613 dose and 4 hours following Forteo. The box represents the interquartile range (25th–75th percentile), with the line inside the box indicating the median. The mean is shown as an x. The whiskers extend to the minimum and maximum values within the typical range.

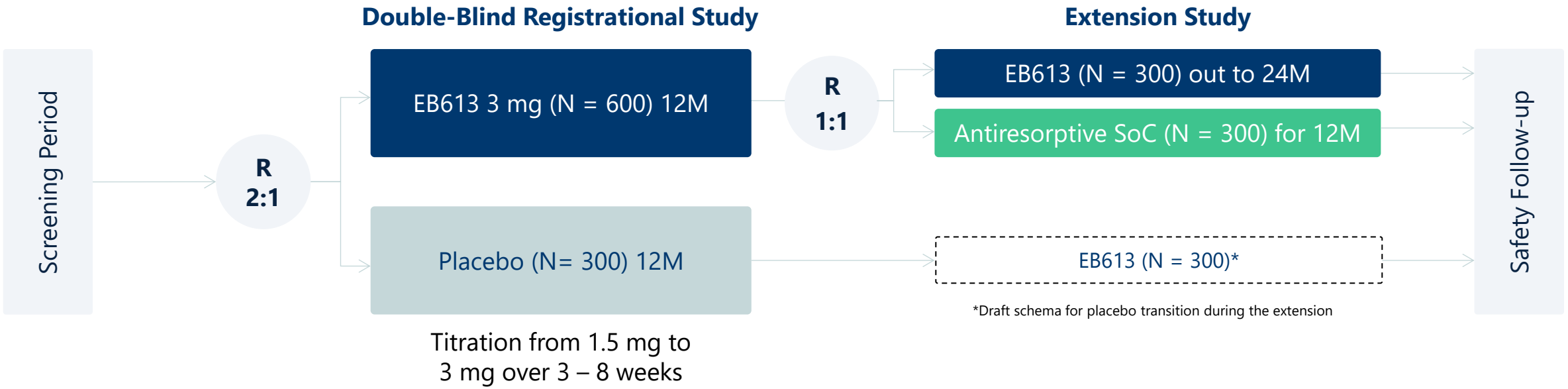
Burshtein et. al., Transforming Anabolic Treatments for Osteoporosis: New Clinical Data Supports a Single EB613 Tablet [Oral PTH(1-34)] as the Final Candidate for a Phase 3 Study, Endo 2026 Oral Presentation

EB613
Phase 3 Design and Proposed Registrational Strategy



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EB613 Phase 3 Development Plan



Key Eligibility Criteria

- Ambulatory women ≥50 and ≤ 90 years of age
- Postmenopausal ≥5 years
- BMD T-score ≤ - 2.50 at lumbar spine, total hip, or femoral neck
- Exclude very high risk for fracture*
- Appropriate exclusions/washout periods for other osteoporosis medications

- **Primary endpoint:** % change total hip BMD at 12M
- **Secondary endpoints:** % change lumbar spine and femoral neck BMD at 12M
- **Safety endpoints:** Treatment-emergent AEs, changes in vital signs, clinical labs, and bone histology
- **Other endpoints:** PK, bone turnover markers, and bone histomorphometry

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EB613 Patient and Clinician Surveys



Why an Oral Osteoanabolic? Why Now?

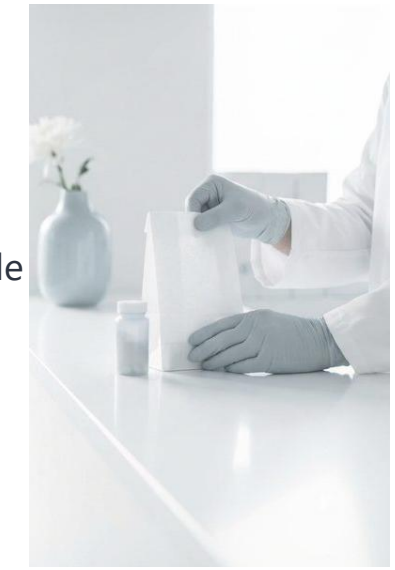
Persistent treatment chasm

- 1 in 3 women over age 50 will experience a fracture in their lifetime
- **Yet more than 80% will not receive treatment after a fracture**
- Clinical guidelines recommend osteoanabolics as frontline treatment ("replace lost bone first")
- **Yet injectable anabolics make up <~15% of estimated Rx**



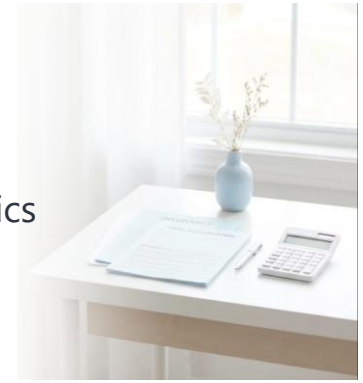
Access

There are major barriers to prescribing currently approved injectable anabolics, only available as **"buy and bill"** and through **"specialty pharmacies"**



Pharmacoeconomic barriers

- Medical practices **cannot afford to purchase and manage reimbursement** for injectable osteoanabolics
- Prior authorizations and in-office injections place an **unacceptable economic and staffing burden** on healthcare providers



Patient Preference

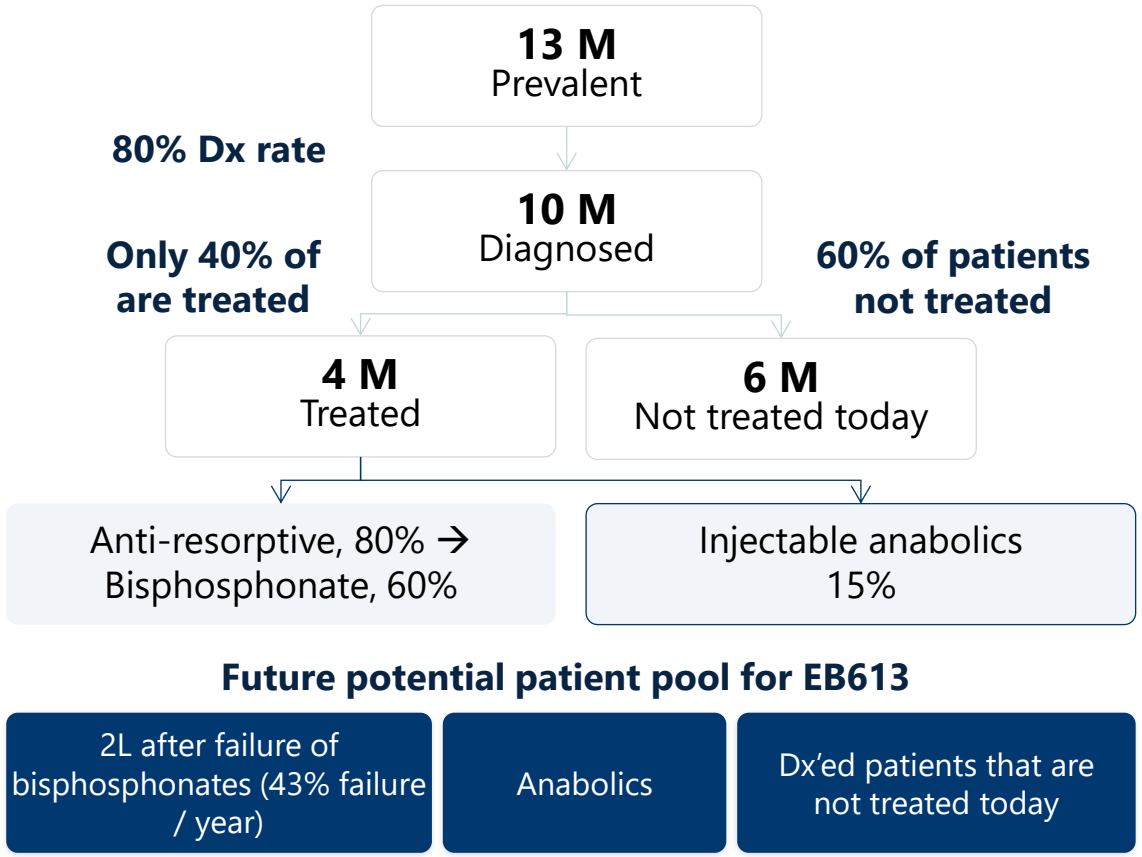
Patients are **less willing to take daily injections** in silent, asymptomatic disease



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The Market is Primed for EB613: Multiple Tailwinds Drive Uptake

US Current Osteoporosis Patient Pool



Future potential patient pool for EB613

- 2L after failure of bisphosphonates (43% failure / year)
- Anabolics
- Dx'ed patients that are not treated today

EB613: First and Only Once-Daily Oral Anabolic in Development

HCP SURVEYS

- GYNs, PCPs, Rheums and Endos likely to prescribe
- Oral administration and known mechanism support wide adoption

PATIENT SURVEYS

55% interested in oral bone-building therapy

70% prioritize increasing bone density

PAYERS & MARKET ACCESS

- Oral formulation expected to improve adherence, reduce costs
- Differentiated profile supports favorable access

38% estimated patient share across HCP specialties

EB613 is a potential ecosystem builder & game changer for patients

*FDA Full Qualification Package Integrated Review, BMD as Validated Surrogate Endpoint for Post-Menopausal Women with Osteoporosis., December 19 2025

EB613 Addresses the Treatment Gap in the Osteoporosis Patient Journey

Survey supports broad, cross-specialty prescriber demand

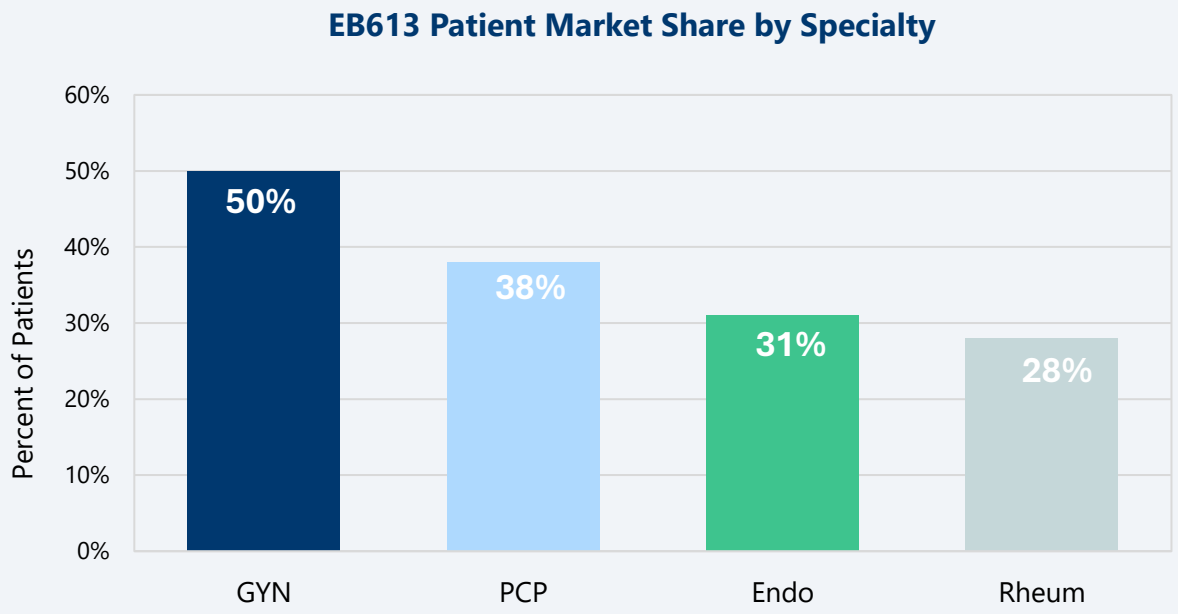
A new oral anabolic agent poised to transform osteoporosis treatment

- Survey results demonstrate strong EB613 adoption and high likelihood to prescribe across all specialties
- Estimating a **38%** overall patient market share (vs 15% share of injectable anabolics today)

And to take share from all established therapies

- EB613 likely to become a preferred oral anabolic option, displacing both bisphosphonates, denosumab, and existing anabolics

EB613 White Space - A Game-Changing Treatment in Osteoporosis

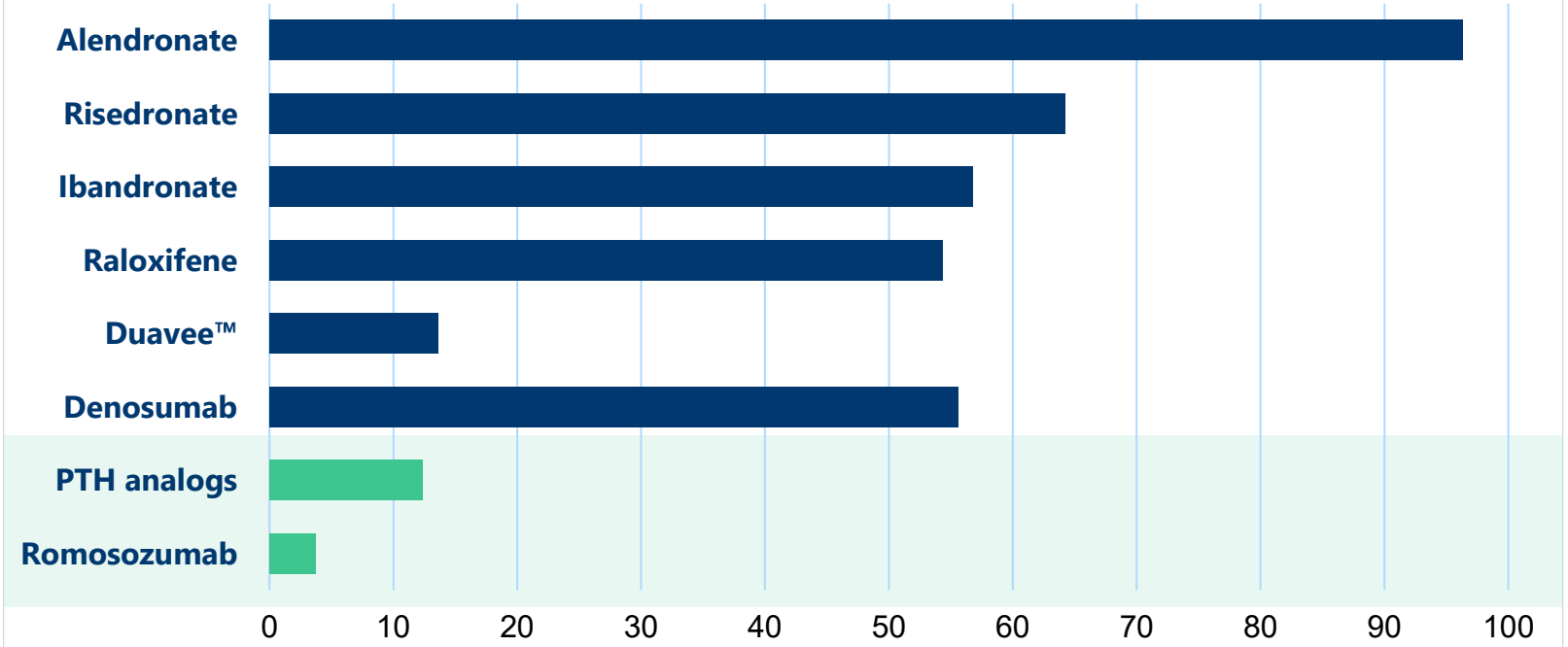


- ENDOs report that nearly half (**47%**) of patients rejecting anabolics would be open to taking EB613
- GYNs report that over half (**56%**) of patients who previously refused injectable anabolic treatments would choose EB613

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OB/GYN and GYN Practices Are the Natural Hubs for Advocacy of Women's Bone Health

GYN Osteoporosis Treatment Selection Reflects the Underutilization and Limited Market Penetration of Injectable Anabolics



89%

of respondents routinely include bone health (DXA scans) in perimenopause and menopause patients

Only **12%**

prescribe injectable anabolics

2023 Global Menopause Society survey data from 129 OB/GYN physicians

An Oral Anabolic Tablet like EB613 Dramatically Shifts OB/GYN and GYN Willingness to Prescribe

In treaters of osteoporosis (n=75),

from **12%** to **92%**

Of treaters who **do not use** injectable anabolics (n=63),

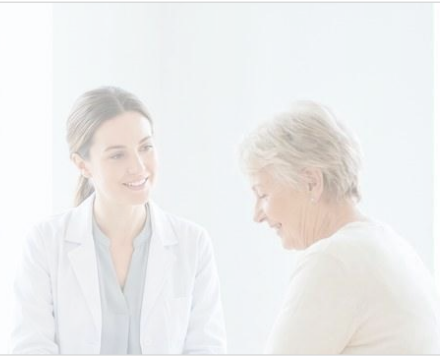
92% would prescribe an oral anabolic

Of treaters **using** injectable anabolics (n=10),

100% would prescribe an oral anabolic

Even in those who do not treat osteoporosis (n=28),

from **0%** to **50%**



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EB612 Program

First Daily Oral Acylated PTH(1-34) Replacement Therapy for the Treatment of Hypoparathyroidism

In Co-Development with OPKO



OPKO Biologics Entera

Hypoparathyroidism: Significant Unmet Need Remains

Current therapies leave the majority of patients inadequately controlled or burdened by daily injections

>200K

Patients (US + EU)
Predominantly women

~75%

Post-surgical cases
Thyroid /Parathyroid surgery

Daily

Injection burden
Palopegteriparatide (Yorvipath, 2024)

Conventional Therapy – Standard of Care

High-dose oral calcium (up to 3 g/day) + active vitamin D analogs
Goal: maintain serum Ca in low-normal range

But fails to address:

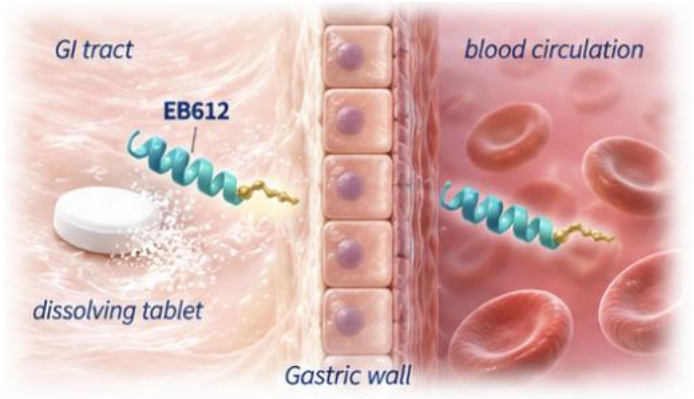
- ✗ Restore physiological Ca–phosphate homeostasis
- ✗ Prevent hypercalciuria and kidney disease
- ✗ Normalize patient quality of life - fatigue, cramps, cognitive symptoms persist

Current Approved / in Clinical Development

Natpara - rhPTH 1-84 (Takeda)	Discontinued	**Daily SC injection**; withdrawn due to manufacturing issues (rubber particulates)
Yorvipath - Palopegteriparatide (Ascendis)	Approved	**Once-daily SC injection**
Eneboparatide (AZN/Alexion)	Regulatory Filing Pending	**Once-daily SC injectable** PTH analog, 31.1% achieved composite primary endpoint at week 24; immunogenicity in majority of patients
Canvuparatide (MBX Biosciences)	Phase 3 (to be initiated)	**Once-weekly SC injection**
SEP-479 (Septerna)	Phase 1 (data expected in late 2026/early 2027)	Oral **small molecule** PTHR1 (Previous molecule SEP786 discontinued February 2025 due to safety)

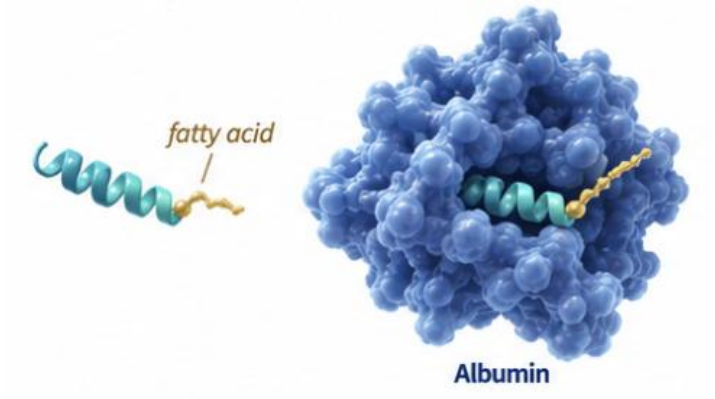
EB612: Acylated PTH(1-34) Analog Designed for Sustained, Once-Daily Oral Dosing for Hypoparathyroidism

A Oral Tablet Absorption



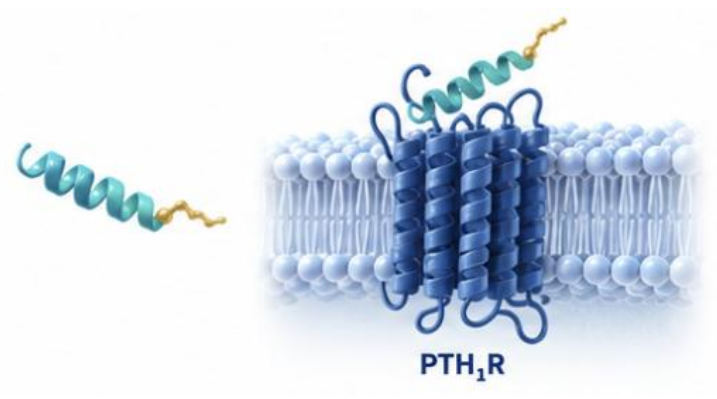
N-Tab® protects EB612 from GI degradation and enables absorption across the gastric wall

B Albumin Binding Extends Systemic Drug Half-life



Conjugated fatty-acid (acylation) enables reversible binding to serum albumin, protecting EB612 from rapid clearance and prolonging its circulation

C Sustained PTH



Gradual release from the albumin maintains PTH_1R engagement over an extended interval - supporting once-daily oral dosing

Enhanced Pharmaceutical Properties

N-Tab® technology enables robust bioavailability and achievement of therapeutic plasma levels with sub-mg daily dose

Longer Duration of Action

Achieved sustained calcium elevation for ~3 days from a single oral dose in animal models, vs. minimal and brief response with unmodified PTH(1-34)

Peptide Modality Advantage

Native PTH-like binding delivers receptor selectivity, with decades of clinical precedent and reduced off-target potential vs. small molecules

More Convenient Dosing

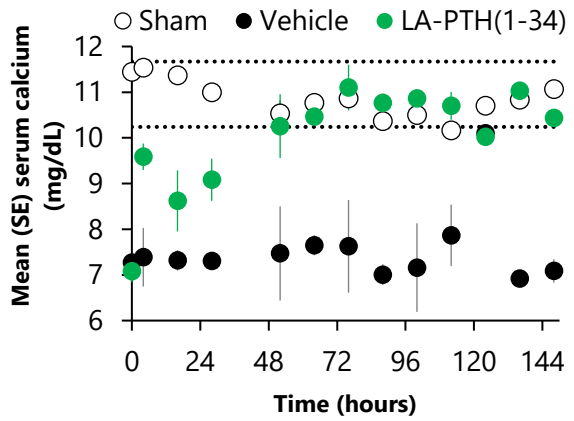
Designed for a single, once-daily oral tablet - replacing daily PTH injections

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EB612: Sustained Serum Calcium Control: Cross-Species Validation

Full Calcium Normalization

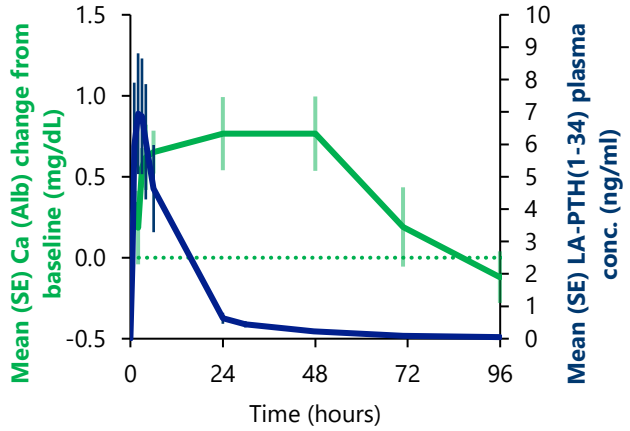
TPTx rat



EB612 restored serum calcium and reduced phosphate to levels comparable to sham control animals

Prolonged PK Profile

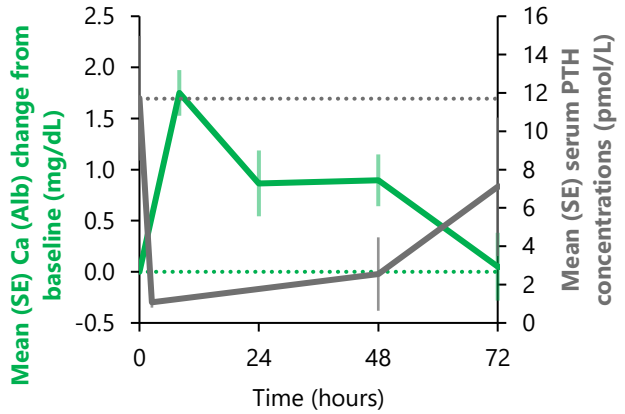
Minipig model



A single EB612 tablet achieved maximal plasma levels 2 to 3 hours post-dose. The drug remained detectable in plasma for approx. three days

Sustained Calcemic Effect

Non-human Primate model



~48-72h supports QD dosing; Consistently lowering endogenous PTH(1-84)

Calcemic effects observed with EB612 are consistent with those reported in similar studies with other clinically validated PTH-replacement therapies for hypoparathyroidism

Burshtein et. al., Pre-Clinical Results for EB612: First-in-Class Oral Long-Acting PTH(1-34) Analog as Hormone Replacement Tablet for Patients with Hypoparathyroidism, [Poster presentation]. ENDO 2026: The Endocrine Society Annual Meeting, Chicago, IL, USA.

GLP1/Glucagon & GLP2 Programs

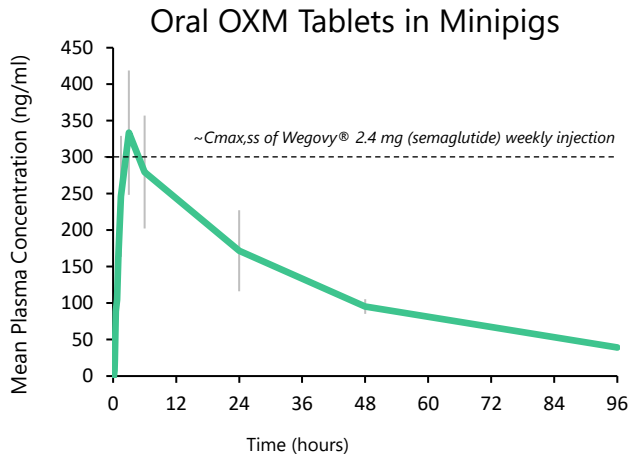
In Co-Development with OPKO

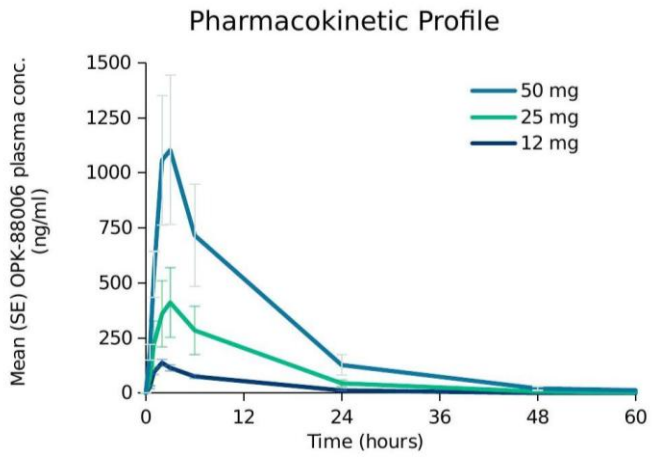


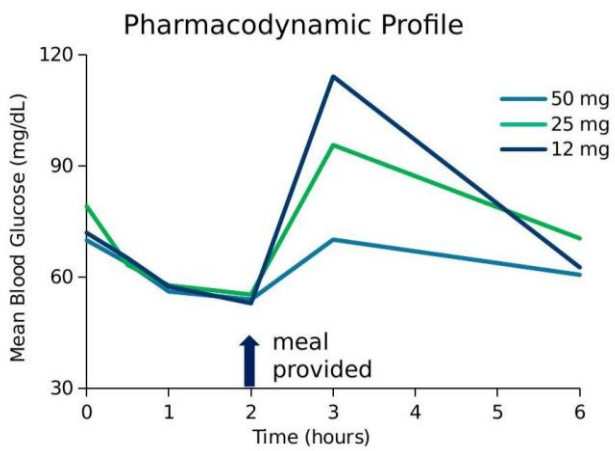
OPKO Biologics Entera

EB618: Preclinical Package Supports the First Oral, Once-Daily GLP-1/Glucagon Agonist for Patients with Metabolic Disorders

GLP-1 therapies surpassed $40 billion in sales in 2024 and the opportunity for oral agents remains significant







Favorable Profile

Single oral dose in minipigs reached plasma levels comparable to steady-state SC semaglutide (Wegovy® 2.4 mg weekly)

Dose-proportional PK

Dose-proportional, low-variability systemic exposure across a >4-fold dose range (12–50 mg) in non-human primates

Safety + Pharmacology

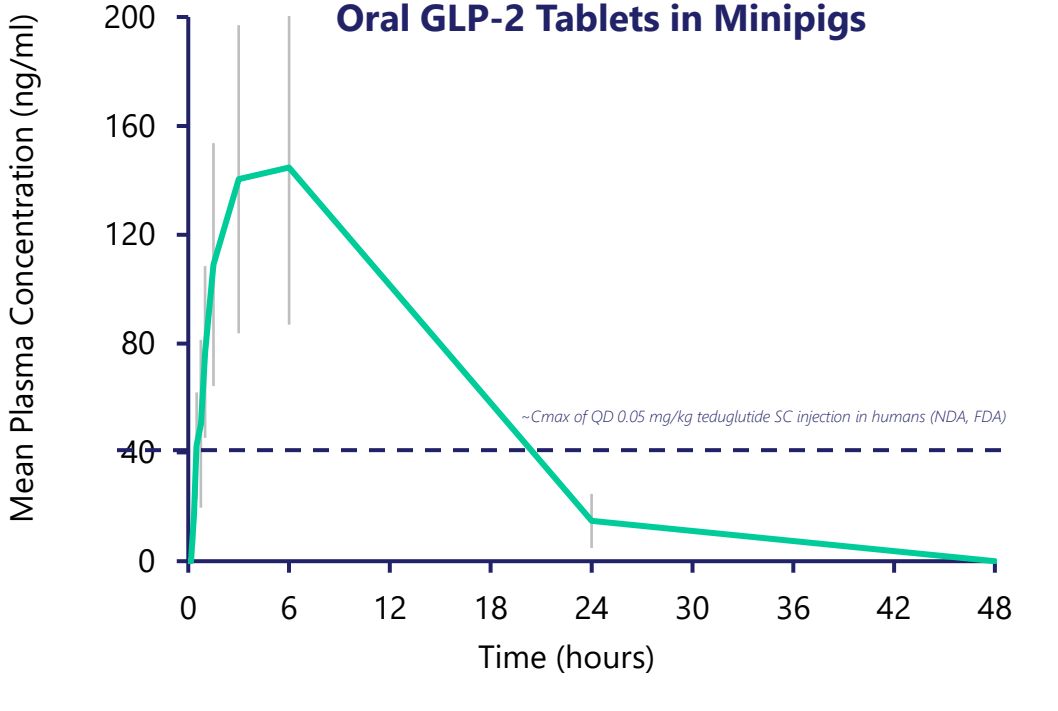
Well tolerated at ≥10x the anticipated clinical dose; dose-dependent, statistically significant reduction in postprandial glucose

EB618 shows oral bioavailability, dose-proportional PK/PD, and a favorable safety margin.
Oral OXM IND filing expected pursuant to SC OXM filing

Burshtein et al., SUN-680, First-in-Class Oral Dual GLP-1/Glucagon Agonist for Patients with Obesity and Metabolic Disorders: In Vivo PK/PD Results, [Poster]. ENDO 2025.Burshtein et al., EB618, First-in-Class Oral Tablet of Dual GLP-1/Glucagon Receptor Agonist for Patients with Obesity and Metabolic Disorders: Results from PK-PD Study in Non-Human Primates, [Poster]. ENDO 2026: The Endocrine Society Annual Meeting, Chicago, IL, USA

First Oral GLP-2 Tablet Demonstrates Sustained Systemic Exposure Supporting Once-Daily Dosing for SBS

A validated GLP-2 target, a ~$800M GATTEX market, and an opportunity to transform treatment for ~30K SBS patients across the US & EU



Extended Plasma Half-Life: Approximately 15 hours, an 18-fold improvement over teduglutide (Gattex®), the only approved GLP-2 therapy

Robust Oral Bioavailability: Peak plasma concentrations reached ~200 ng/ml (Cmax), substantially exceeding the reported Cmax of daily teduglutide subcutaneous injection in humans

Prolonged Exposure: Systemic exposure (AUC ~2 h*µg/ml) was maintained for more than 24 hours with relatively low variability, supporting once-daily oral dosing

Pharmacologic effect: Rodent repeat-dose PK/PD studies showed clear pharmacologic activity in intestinal tissue

Favorable Safety Profile: No signs of toxicity were observed in preclinical studies

Oral GLP-2 has the potential to deliver effective GLP-2 replacement without daily injections, with flexible dosing tailored to individual SBS needs

OPKO Entera

Thank you

INVESTOR RELATIONS

IR@enterabio.com

Nasdaq: ENTX | www.enterabio.com