



Entera Bio Ltd.
Global Leader in Oral Peptide Therapeutics

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Entera Mission:

- **To develop transformative, first-in-class oral peptide treatments**
- **To invest in therapeutic spaces that have been ignored and require urgent attention**
- **To drive value for patients, clinicians and healthcare ecosystems smartly and expeditiously**
- **To think outside the box, innovate and cultivate our science, strategy and people everyday**

- **TO NEVER GIVE UP ON OUR MISSION**

Entera Company Background

First-in-Class Oral Peptides Designed to Empower Patients and Unlock Clinician Access

Proprietary N-Tab[®] Science and 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

Corporate

Global interdisciplinary team
Nasdaq: ENTX, 49M shares outstanding

Lead Asset – EB613 (Osteoporosis)

First oral tablet to democratize anabolic (bone building) treatment

Women centric condition with persistent treatment gap

Validated MOA, PTH(1-34), teriparatide

Disruptive ~\$4–6B+ US market opportunity

Robust placebo controlled Ph2 data

Streamlined Phase 3 Program Pursuant to FDA's December 2025 BMD Qualification

Diversified Pipeline

Rare Endocrine: Hypoparathyroidism
Metabolic /Obesity
GI Inflammation: Short Bowel Syndrome

Additional oral peptide development via partnership model where N-Tab[®] can be combined with unique targets

Entera Oral Peptide Tablet Pipeline

Program	Indication	Target	Preclinical	Phase 1	Phase 2	Phase 3	Partner
EB613	Osteoporosis	PTH 1-34, teriparatide	▶				
EB612	Hypoparathyroidism	LA-PTH 1-34	▶				OPKO (Entera - 50% Ownership)
EB618	Obesity / Metabolic	GLP-1 & Glucagon Agonist	▶				OPKO (Entera - 40% Ownership)
GLP-2	Short Bowel Syndrome	Long Acting GLP-2	▶				OPKO
EB613	Stress Fractures	PTH 1-34	▶				Investigator Sponsored Trial

Entera Core Team

Bringing Together Scientific Excellence to Deliver Better Treatment Outcomes Globally



Miranda Toledano

Chief Executive Officer and Board Member



Felicia Cosman, MD

Chief Clinical Advisor (Endocrinology)
and SAB Chair



Steven R. Goldstein, MD

Chief Clinical Advisor (Gynecology)



Gregory Burshtein, PhD

Chief of Research and Development



Hillel Galitzer, PhD

Chief Operating Officer



Michal Kushnir

Director of Program Management



Helen Pentikis, PhD

Clinical Pharmacology Specialist



Rachel B. Wagman, MD, FACE, FACP

Chief Clinical Advisor



Cherin Smith, PMP

EVP Clinical Operations



Anke Hoppe

VP of Clinical Operations



Osnat Bar-Peled, PhD

Executive Director of IP



Constantin Itin, RPh, PhD

VP of Preclinical Development



Dana Yaacov, CPA

Chief Financial Officer



N-Tab[®] Proprietary Platform



Barriers to Oral Peptide Delivery

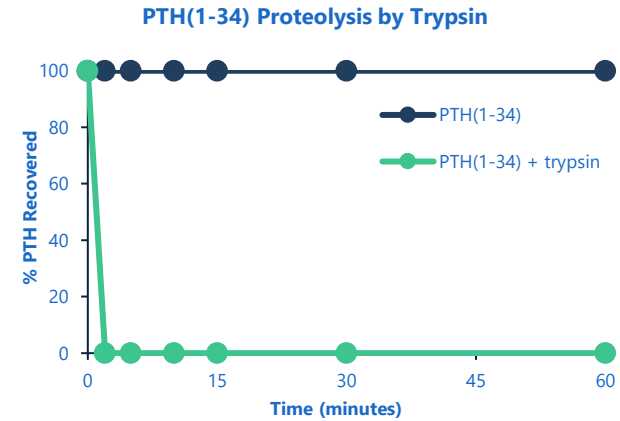
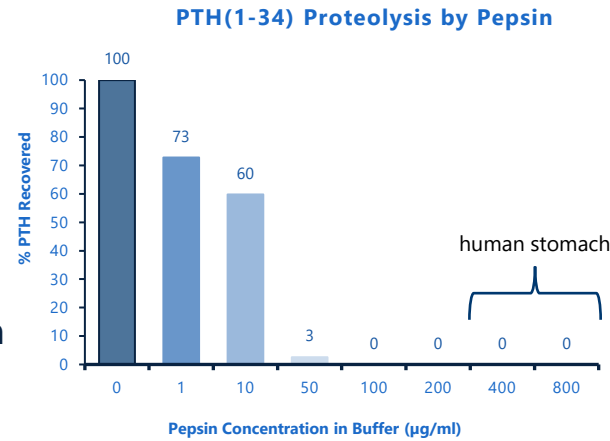
Proteolytic Degradation

Stomach:

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

Small Intestine:

- Trypsin & α-chymotrypsin degradation
- Brush-border metabolism



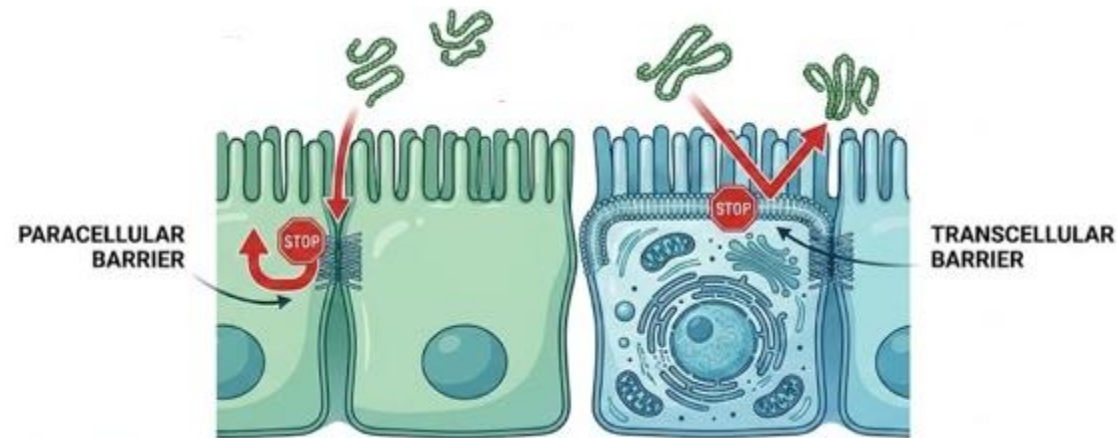
100%

peptide breakdown within few min 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%

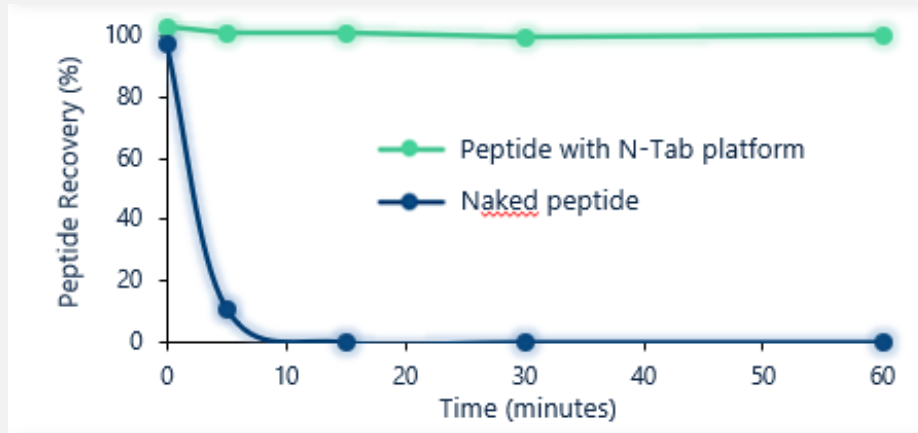
typical oral bioavailability for unformulated peptides

Unlocking Oral Peptide Absorption: Two Synergistic Mechanisms of the N-Tab[®] Platform

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

1 Proteolysis Inhibition

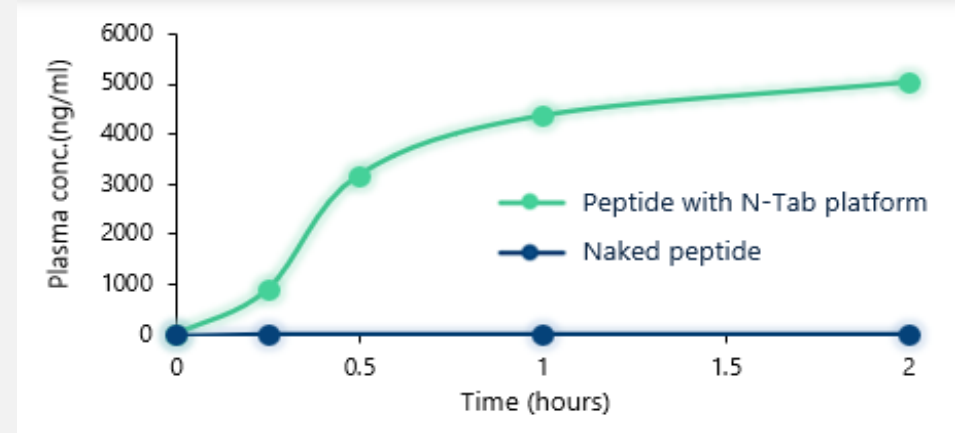
**Proteases Blocked.
Peptide Survives.**



The naked peptide is completely degraded within 5 minutes. With the N-Tab platform the peptide is stabilized in the GI tract

2 Permeability Enhancement

**Membrane Fluidity Increased.
Drug Absorbed Systemically.**



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

How N-Tab[®] Works – From Administration to Therapeutic Blood Levels

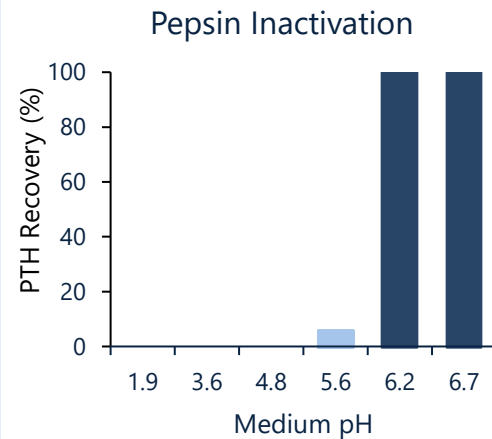
1. Dissolution

A single N-Tab tablet enters the stomach and immediately dissolves, simultaneously releasing the drug and the absorption enhancer at the absorption site



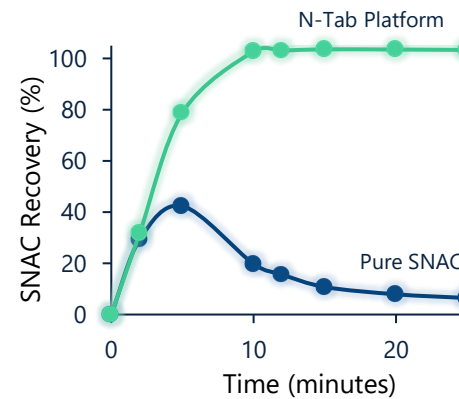
2. Proteolysis Inhibition

Local increase in pH and viscosity inhibit pepsin activity preventing peptide degradation



3. Platform Stability

The N-Tab platform further enhances the effect of the permeability enhancer, supporting a sustained absorption phase



4. Absorption

Permeability enhancer transiently increases enterocyte membrane fluidity, allowing peptide absorption and systemic exposure

Formulation	C _{max}	AUC _{0-3hr}
N-Tab-based tablet	281 ng/ml	551 hr*ng/ml
SNAC-based tablet	41 ng/ml	75 hr*ng/ml

~5 kDa peptide tablet achieved significantly higher systemic exposure vs the tablet based on SNAC only

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 Hypoparathyroidism and Osteoporosis

✓ 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**

✓ Favourable patient and clinician surveys

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

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



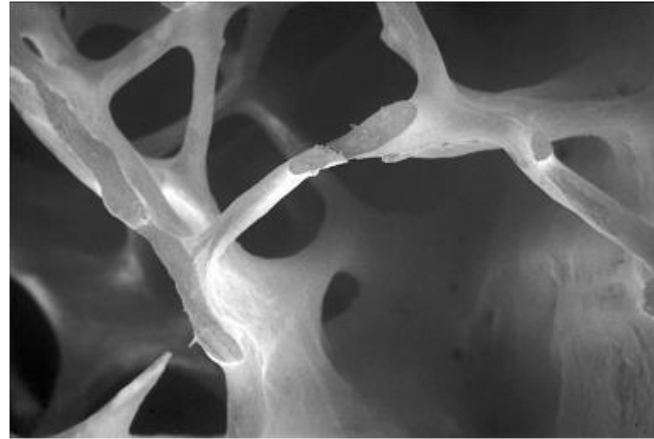
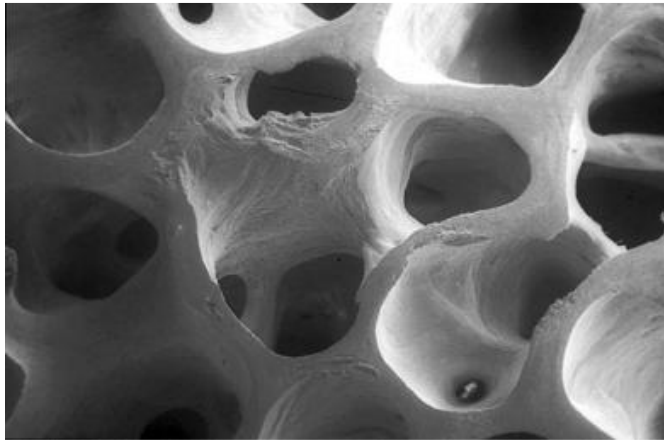
EB613: First Oral Anabolic (Bone Building) Tablet



- ✓ 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 tx in silent asymptomatic condition
- ✓ Potentially widens access from endo/rheum specialists (~15% Rx) to primary care/Gyn (~80% Rx)
- ✓ Potential for preferred tiering addresses huge healthcare burden
- ✓ Derisked asset, Phase 3 ready with efficient path to registration

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



Dysregulated Bone Remodeling:

Increased Osteoclast Activity ↑
resorption (CTX biomarker)

Reduced Bone Formation ↓
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

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

Diagnosed

~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

~13M 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 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[®]**

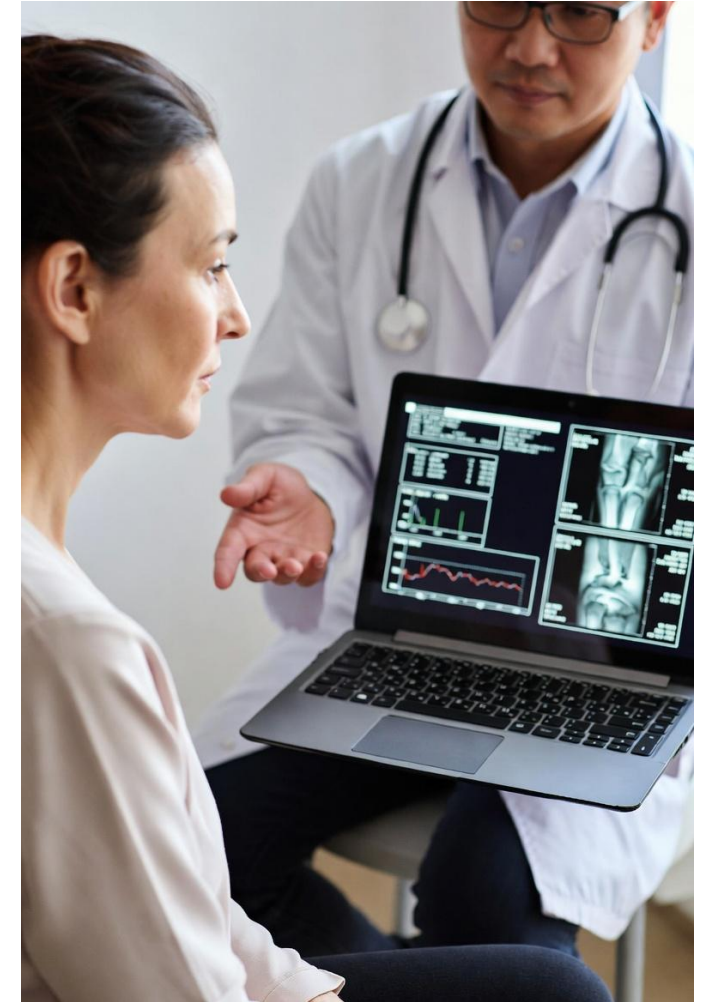
~6%

**2 monthly "in-
office" injections**

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

Why an Oral Osteoanabolic?

- 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
- Patients **less willing to take daily injections** in silent, asymptomatic disease
- There are major barriers to prescribing currently approved injectable anabolics only available as **“buy and bill”** and through **“specialty pharmacies”**
- 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



EB613 Oral PTH (1-34) Tablet Treatment

Clinical Overview



EB613: First Once Daily Anabolic Tablet Treatment for Osteoporosis

Oral PTH(1-34) in a daily tablet (QD), LD Forteo[®]/Forsteo[®]

Thesis

EB613 is intended to provide an oral anabolic treatment earlier in an osteoporosis patient's journey
Aligns with endocrinology/ women's health focus – bone health, menopause, longevity portfolios

Dual MOA

Rapid stimulation of osteoblast activity to increase new bone formation (PINP) with rapid suppression of bone resorption (CTX)

Clinical Efficacy

Placebo-controlled Phase 2 study in 161 post-menopausal women produced a rapid onset of action with significant increases in BMD at both cortical bone (femoral neck and hip region) and cancellous bone (spine)¹

Safety Profile

AES in line with PTH agonists: headache, nausea, and dizziness

Opportunity

Three approved anabolic drugs require daily/monthly subcutaneous (SC) injections which limits patient access. Oral administration also expands access for HCPs who manage osteoporosis patients including gynecologists, women's health specialists and primary care providers as well as endocrinologists and rheumatologists

Target Patients

Sample target patients include postmenopausal women with:

- T-scores \leq -2.5 at total hip, femoral neck or lumbar spine with no fracture history
- low bone mass or osteoporosis and history of nonvertebral fracture more than 2 years ago
- low bone mass or osteoporosis and radiographic evidence of vertebral fracture

FDA Plan

505(b)(2) Pathway: A single 12-month placebo-controlled Phase 3 registrational study with BMD as primary endpoint and scientific bridge to LD Forteo, to be supported by a 12-month extension study

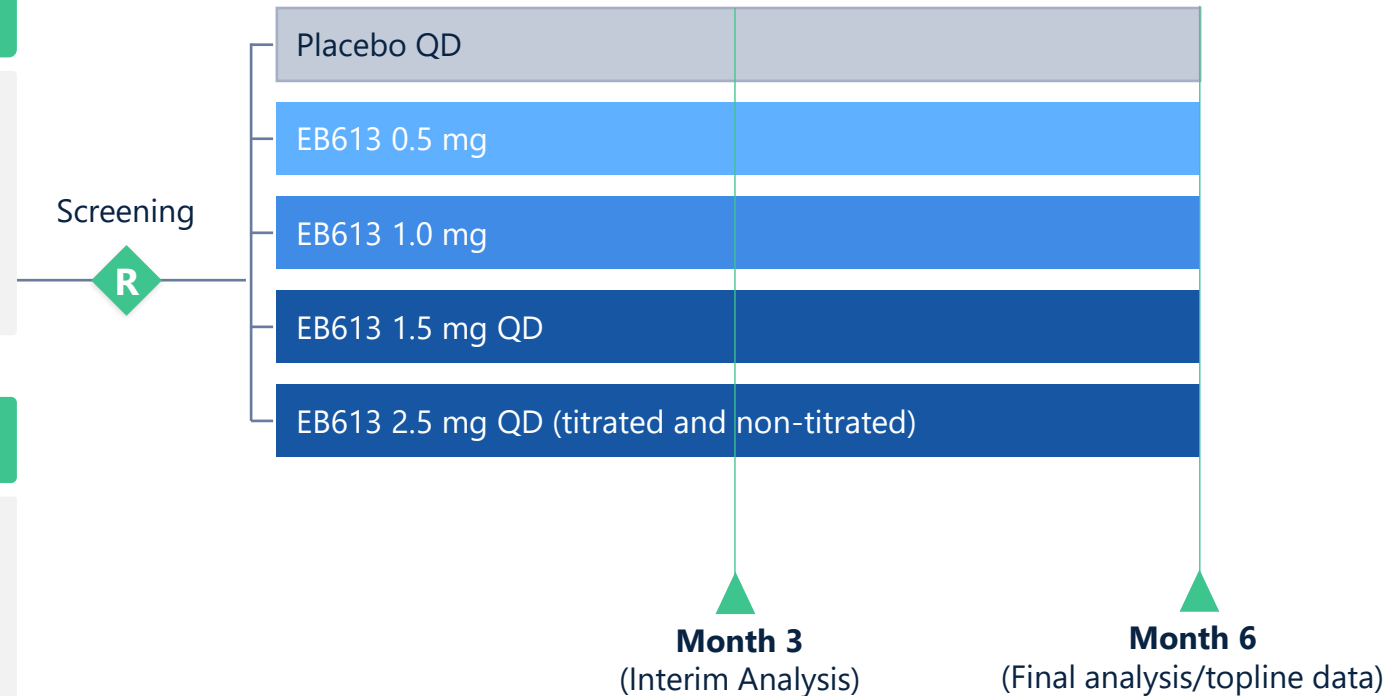
EB613 Phase 2 Clinical Study in Postmenopausal Women with Osteoporosis

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

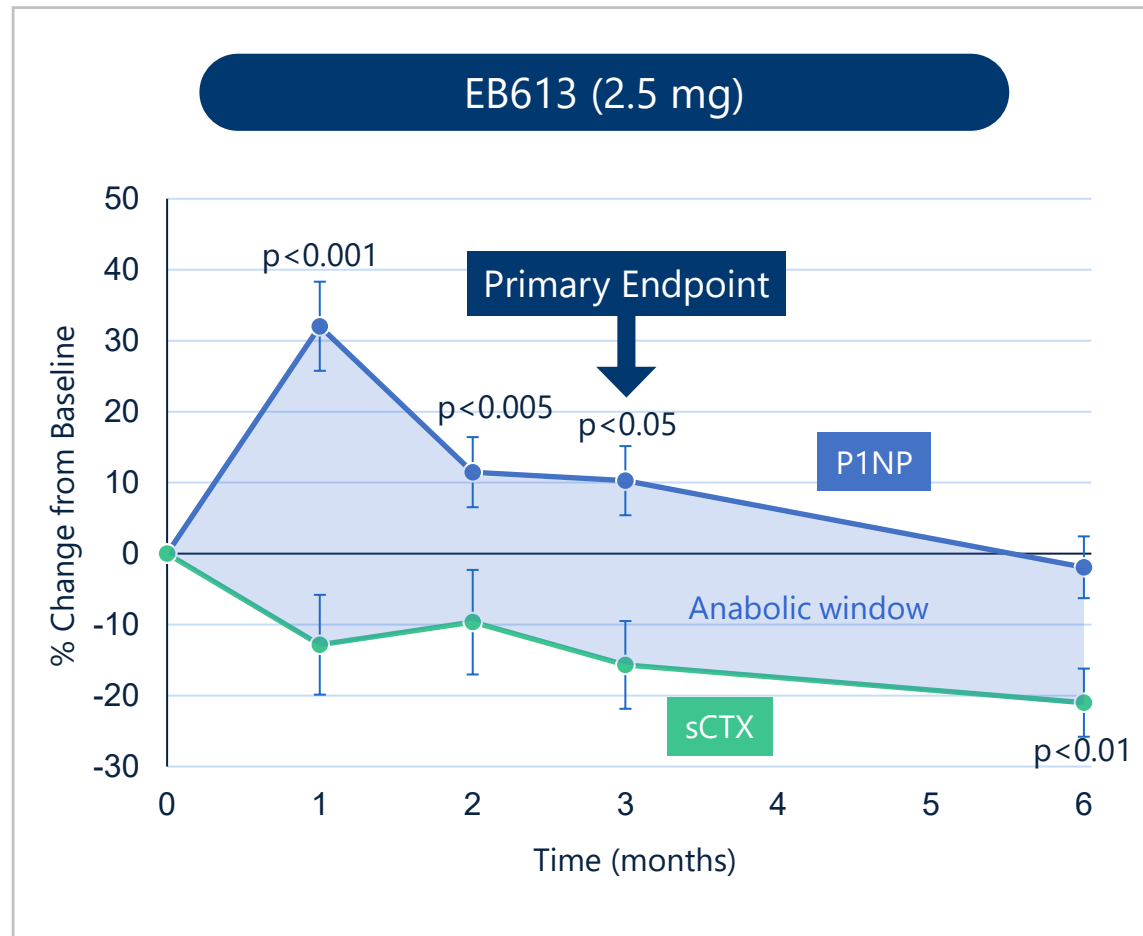
BMD % change from baseline
Serum OC and CTX % change from baseline at Months 1, 2, 3, and 6
Serum PINP % change at Months 1, 2, and 6
Plasma PTH(1-34) at T15 min

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

Conducted at 4 sites; Enrollment: 161 patients (118 active, 43 placebo)

EB613 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



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Editorial

ASBMR
The American Society for Bone and Mineral Research

OXFORD

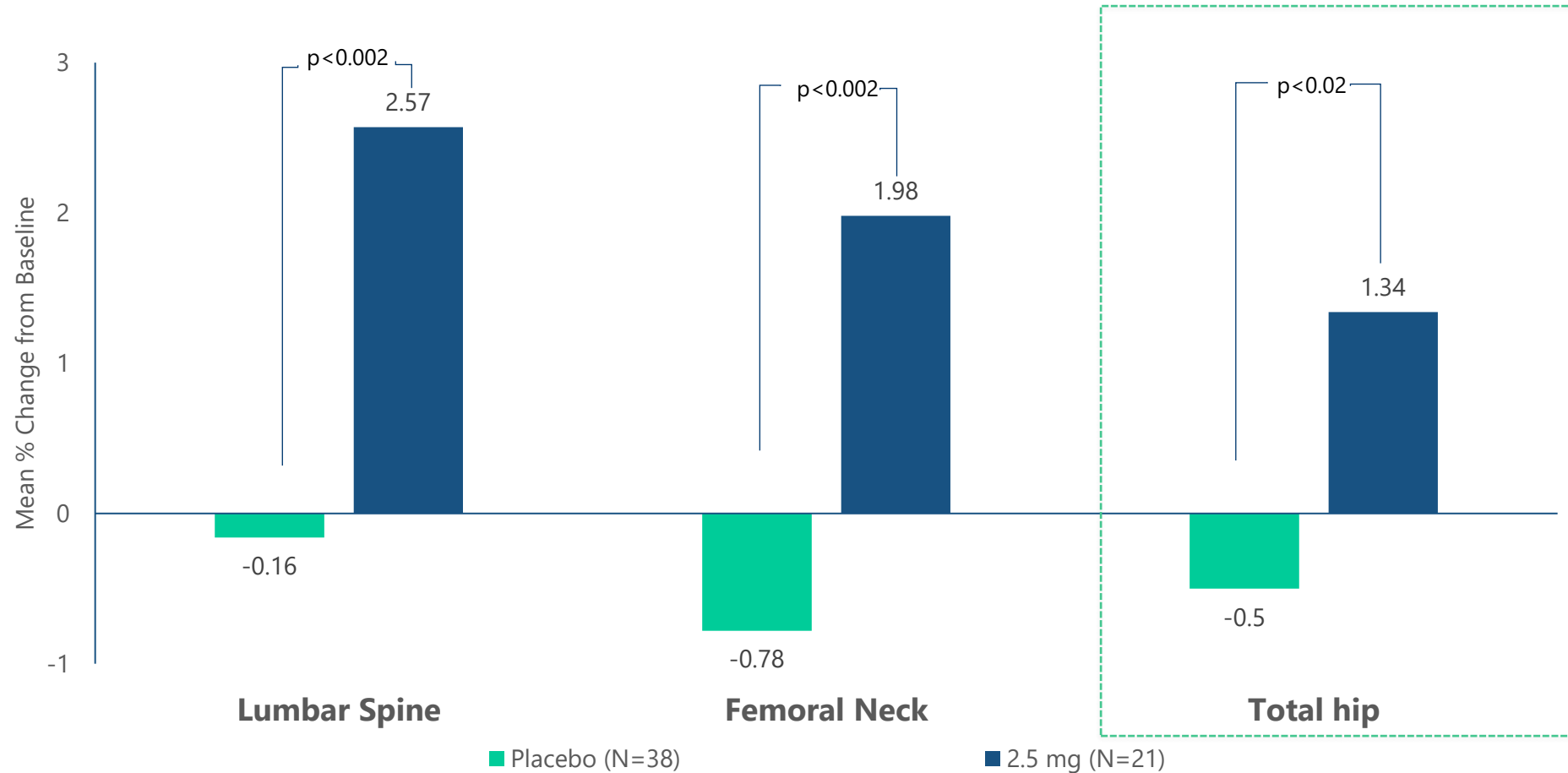
A novel oral hPTH(1-34) unveils the promise of modeling-based anabolism with no increase in bone remodeling

Jacques P. Brown^{1,2,*}

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²Infectious and Immune Diseases Axis, CHU de Québec-Université Laval Research Centre, Quebec, Quebec G1V 4G2, Canada

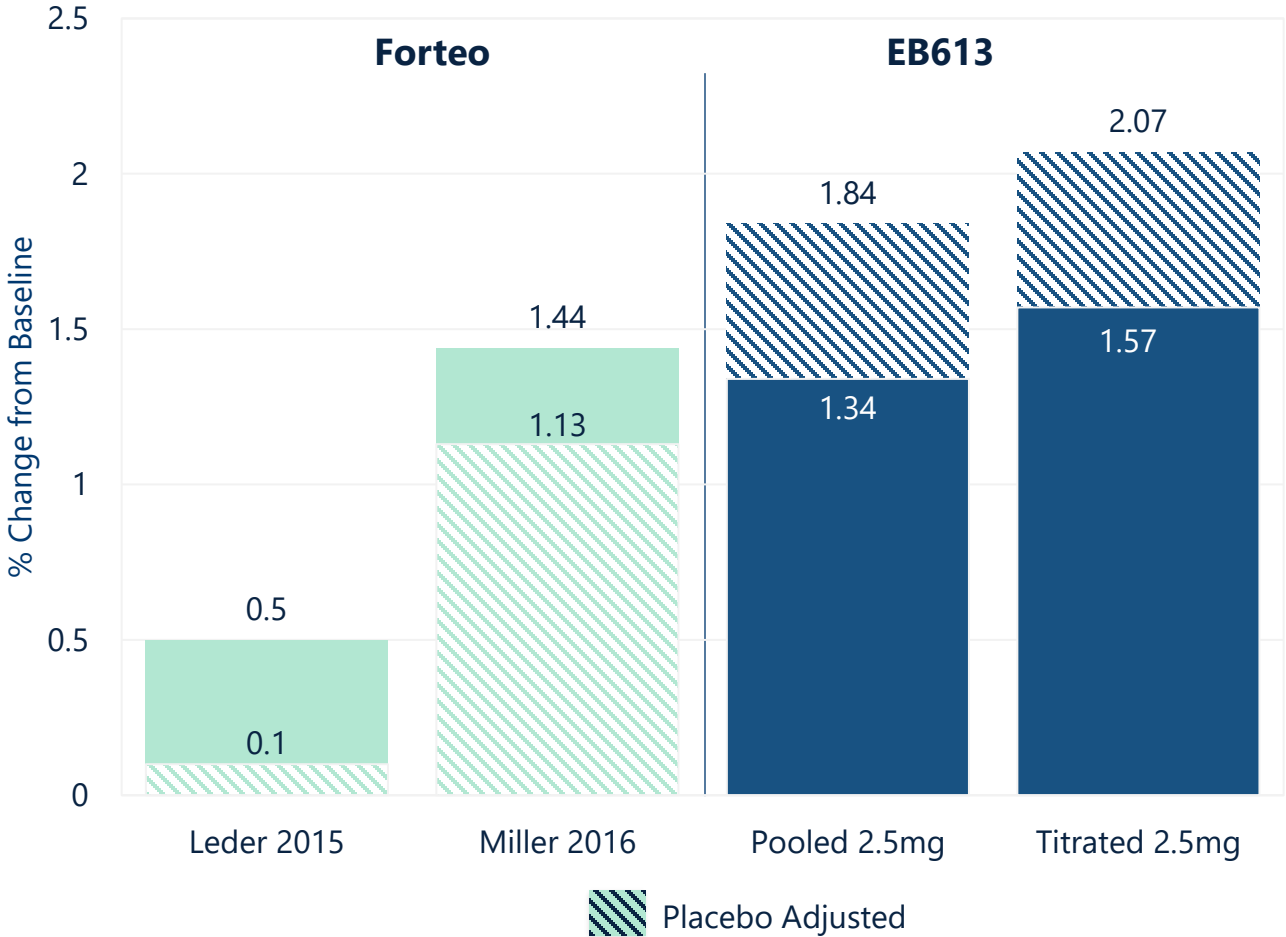
An ideal osteoanabolic treatment would be one that could optimize the impact on modeling (formation) while producing lesser changes in resorption (remodeling) – JBMR, June 2024

6 Months Treatment with EB613 2.5 mg Produced Significant Increases in BMD at All Skeletal Sites



	Lumbar Spine	Femoral Neck	Total Hip
Placebo Adjusted	2.73	2.76	1.84

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



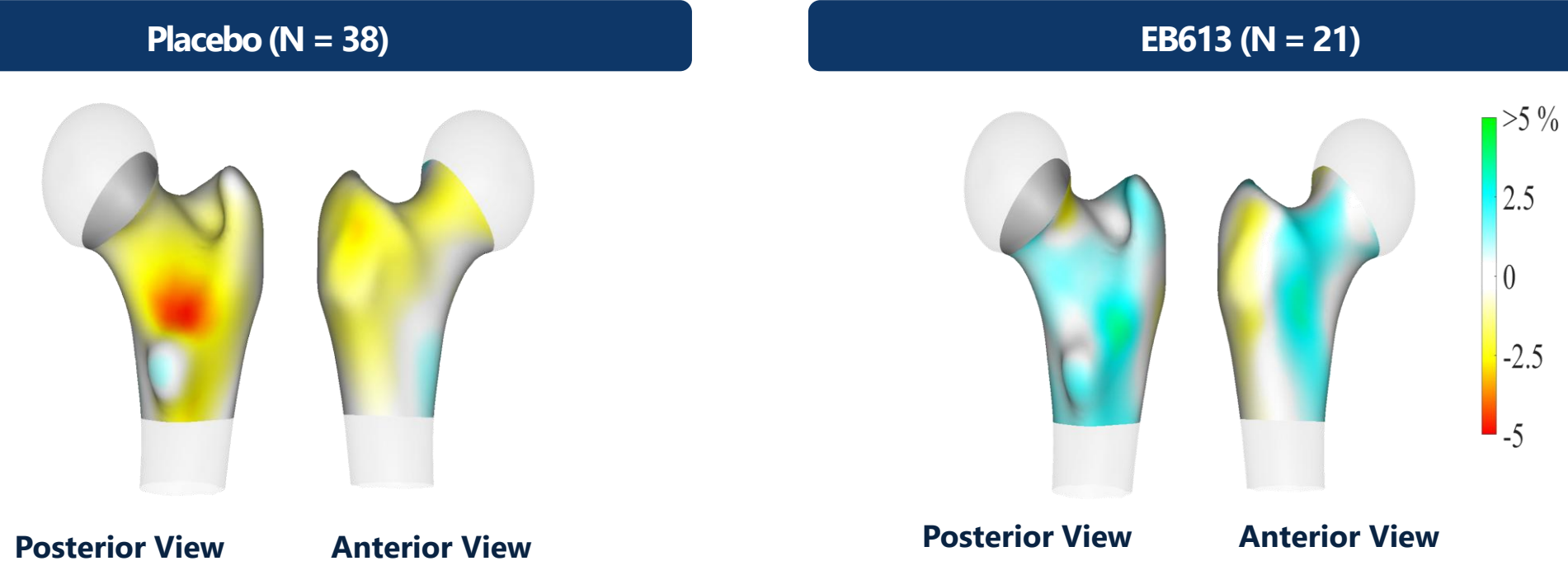
- Total Hip BMD is an FDA Efficacy Endpoint as of 12/19/2025
- 6 months of daily Forteo injections resulted in a 0.1 – 1.13% increase in Total Hip BMD¹
- 6 months of daily Oral EB613 2.5mg resulted in a 1.84 – 2.07% increase in Total Hip BMD²

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

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

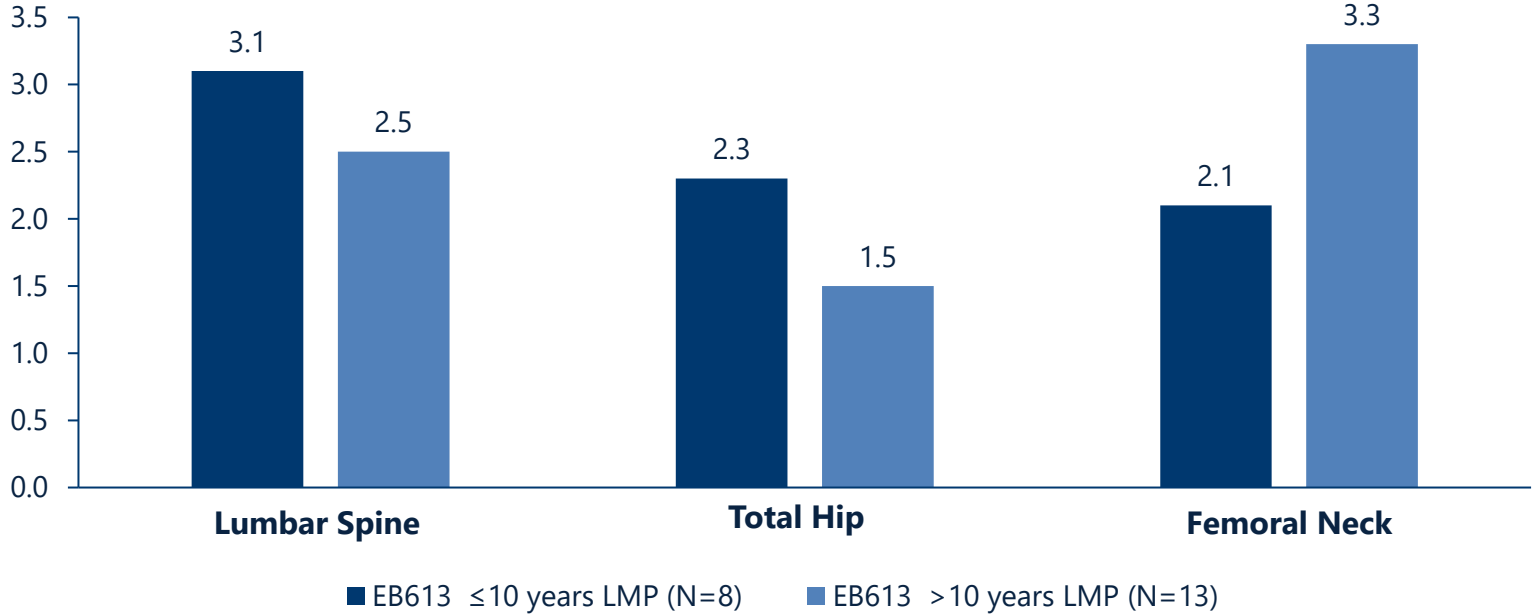
- EB613 showed an early effect on both trabecular and cortical bone of the proximal femur consistent with the dual mechanism of increased formation and decreased resorption
- Comparable assessment with Forteo (teriparatide) and Tymlos (abaloparatide) on cortical bone at 6 months¹



Significant BMD Improvements in Early Postmenopausal Women at 6 Months

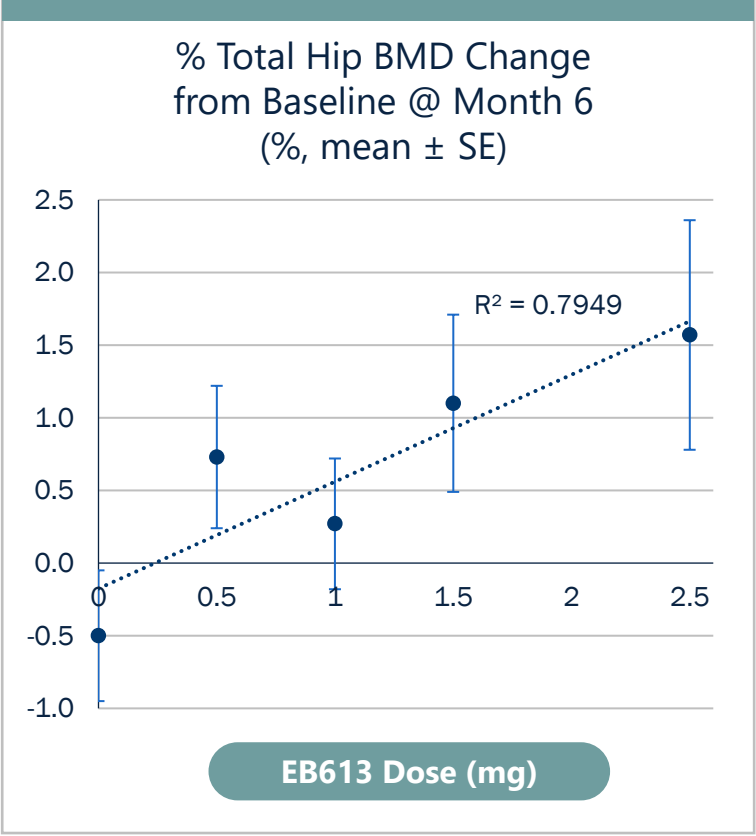
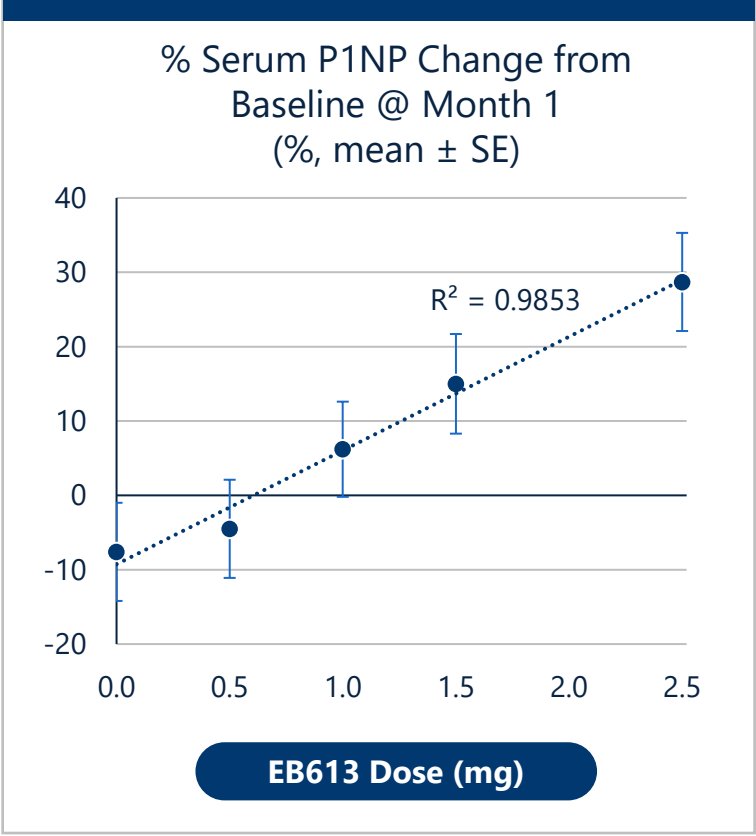
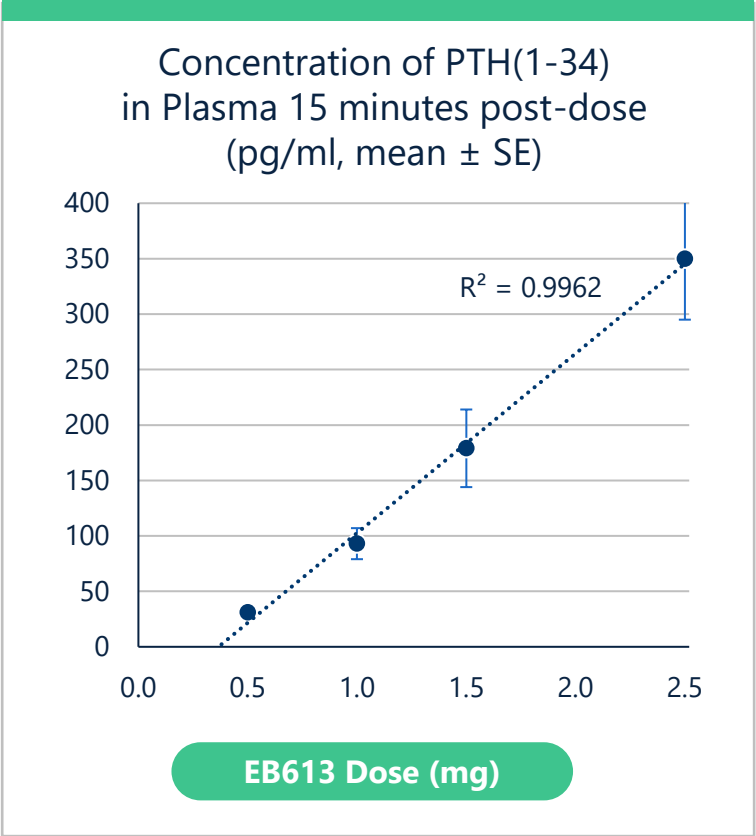
Post-hoc EB613 Phase 2 analysis: BMD outcomes by time since last menstrual period (LMP)

Placebo adjusted % BMD change at Month 6 <10y vs >10y since last menstrual period (LMP)



For younger high-risk women without a prior fracture, BMD is the single most important predictor of osteoporotic fractures

EB613 Showed Linear Dose Response Across PTH Exposure, P1NP Biomarker, and BMD



EB613 produced a statistically significant BMD dose response in lumbar spine BMD ($p < 0.0001$), femoral neck BMD ($p < 0.002$), and total hip BMD ($p < 0.008$)

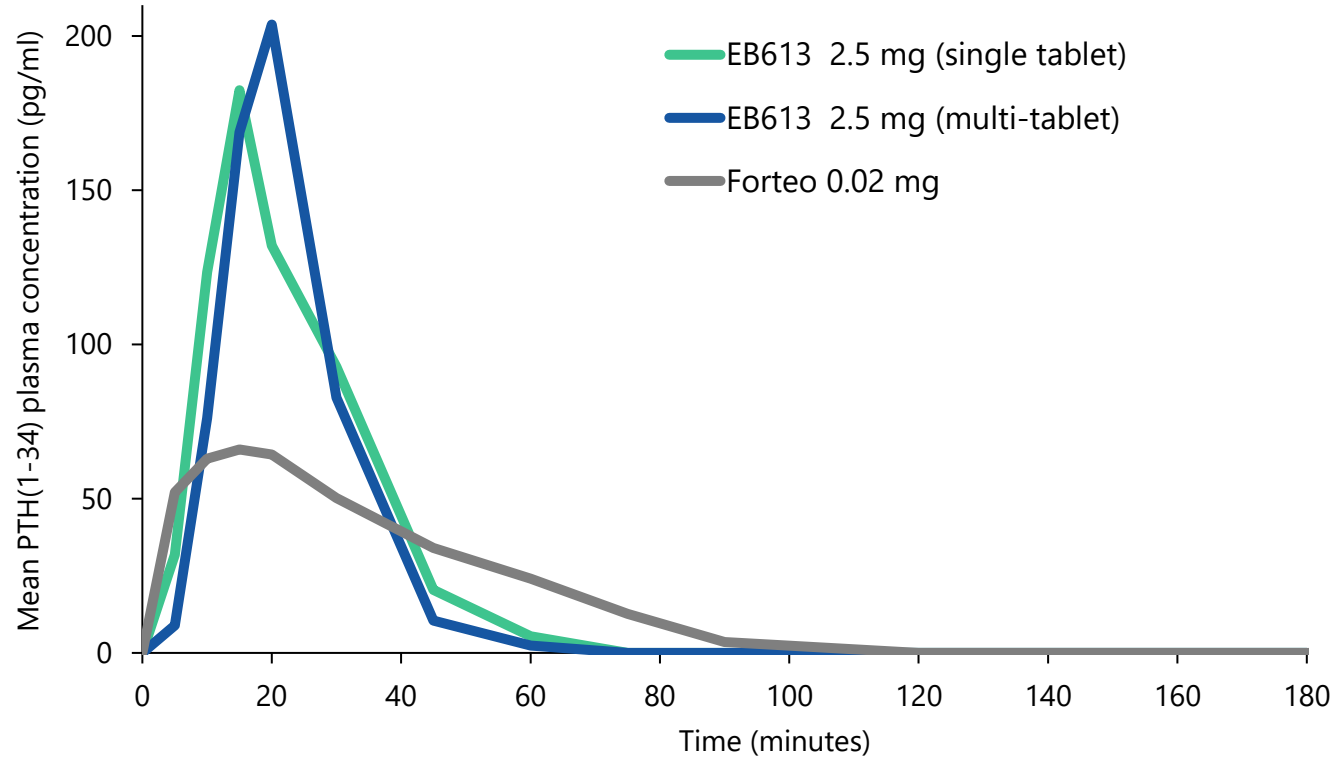
EB613 Phase 2 Safety Profile Consistent with PTH Agonists

Most Common Treatment Emergent AE (≥5% of participants)

	EB613 Treated (N=118) n (%)
Headache	21 (17.8)
Nausea	18 (15.3)
Dizziness	13 (11.0)
Nasopharyngitis	7 (5.9)
Back pain	7 (5.9)
Palpitation	6 (5.1)
Dyspepsia	6 (5.1)
Presyncope	6 (5.1)

- Similar AE profile to that reported for Forteo[®] and other PTH agonists
- Mechanistic symptoms of orthostatic hypotension
 - headache, nausea, and dizziness
- EB613 was not associated with serum calcium increases or hypercalcemia adverse events
- 2.5 mg dose with titration (1.5 mg for 1 month, 2.0 mg for the next month and 2.5 mg during months 3 to 6) well tolerated
- No serious AEs related to EB613

Phase 1 Bridging Study Supports Advancement of EB613 Single Tablet into Phase 3



Similar T_{max} , C_{max} , and total systemic exposure (AUC) were observed for EB613 formulations

AUC of EB613 2.5 mg is comparable to Forteo SC, but duration of exposure is slightly shorter



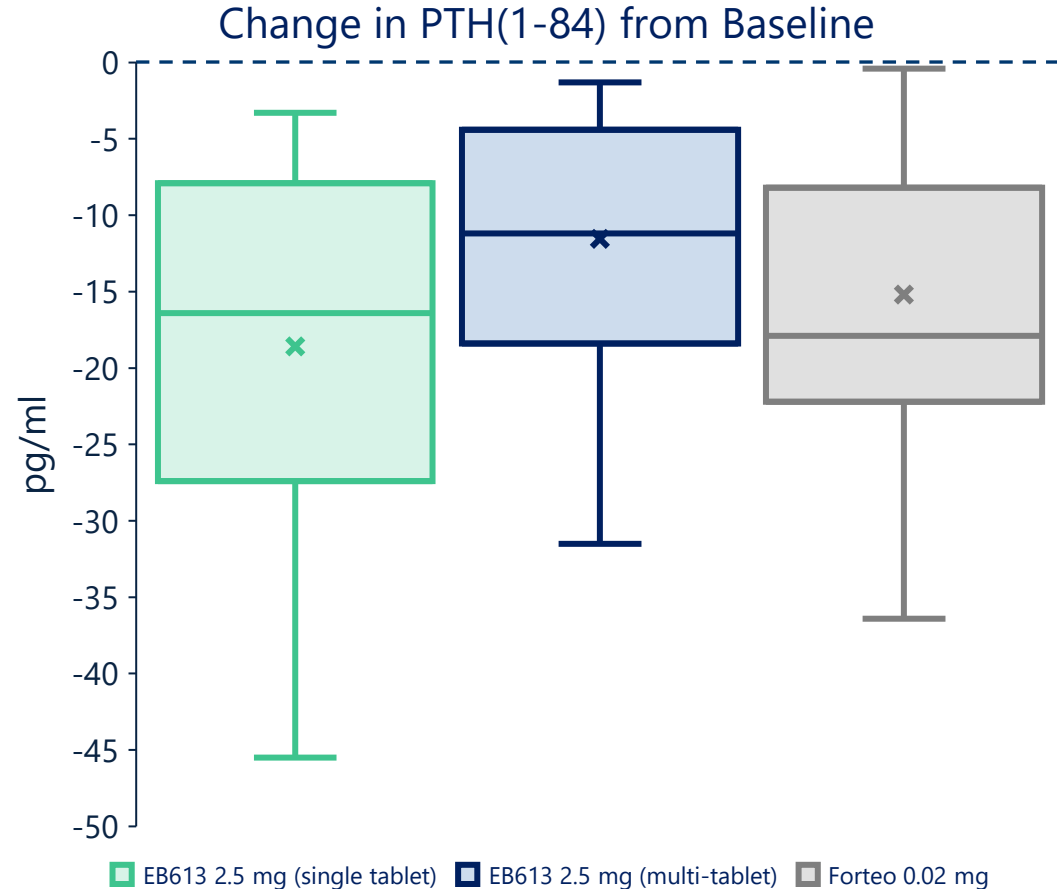
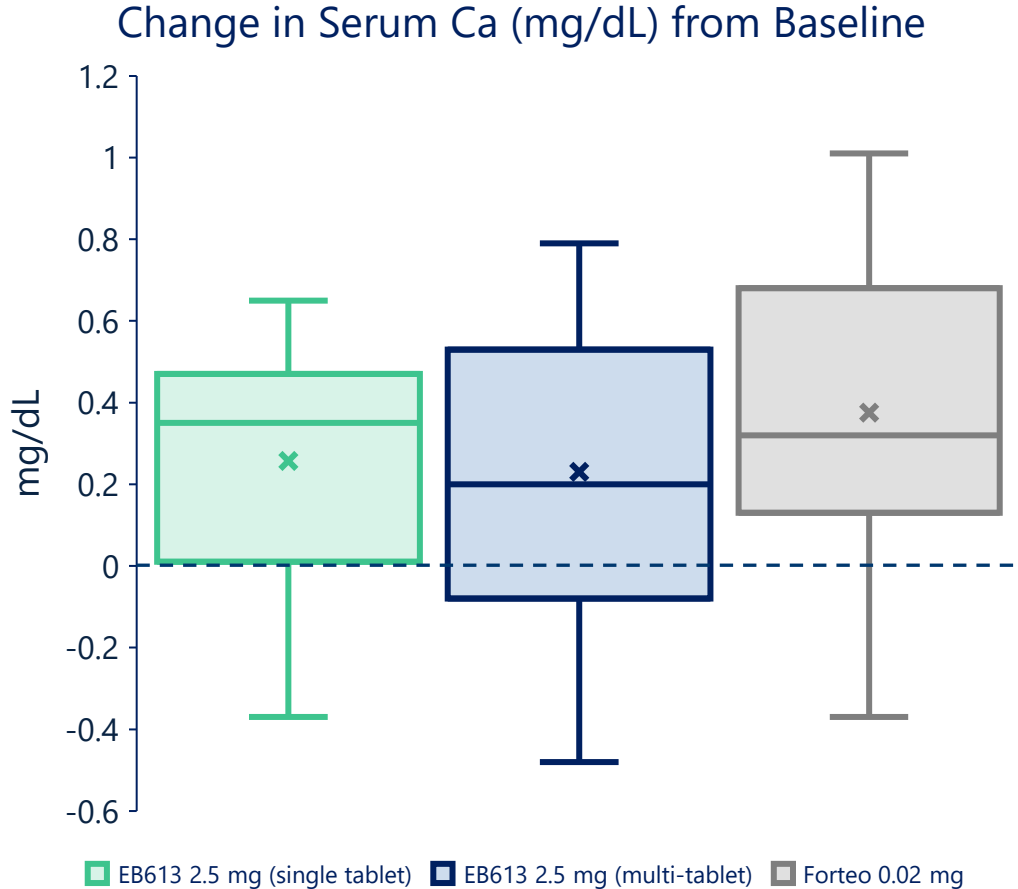
Multi-tablet 2.5 mg EB613



Single tablet 2.5 mg EB613

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

Phase 1 Bridging Study - Comparable Calcemic Effects and Suppression of Endogenous PTH



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.

Overview of Safety for EB613

Phase 1 and phase 2

- In the clinical development program, the final single-tablet formulation and the multi-unit formulations have been administered collectively to a total of 270 subjects in phase 1 (n=117) and phase 2 (n=153) studies in:
 - healthy volunteers
 - postmenopausal women with low BMD or osteoporosis
 - male and female patients with hypoparathyroidism in doses up to 9mg daily
- EB613 has been well-tolerated, and no new drug-related AEs were identified in the Phase 1 and Phase 2 studies
- The incidence of mechanistic AEs, which are common to PTH agonists including both teriparatide and abaloparatide, including hypercalcemia, tachycardia, and orthostatic hypotension, were similar to or lower with EB613 as compared to Forteo in Phase 1 studies

Safety Profile of EB613 vs Forteo in Comparative Phase 1 studies

EB613 has been compared with Forteo in three phase 1 studies, N = 102 subjects received both drugs

	Forteo	EB613 ¹
Number of study drug administrations	87	432
Treatment related AEs	11% (10)	5% (20)
Symptoms of orthostatic hypotension²	2.3% (2)	2.5% (11)
Nausea: the most frequent AE of EB613	2.3% (2)	1.4% (6)
Hypercalcemia: the most frequent AE of Forteo	3% (3)	<1% (2)

¹All EB613 doses were included in the safety analysis

²Events of orthostatic hypotension symptoms including dizziness, headache, palpitations, tachycardia, nausea

EB613

Phase 3 Design and Proposed Registrational Strategy



FDA Qualification of Total Hip BMD as Regulatory Endpoint, December 19 2025



DRUG DEVELOPMENT TOOL
QUALIFICATION DETERMINATION
DDT-BMQ-000054

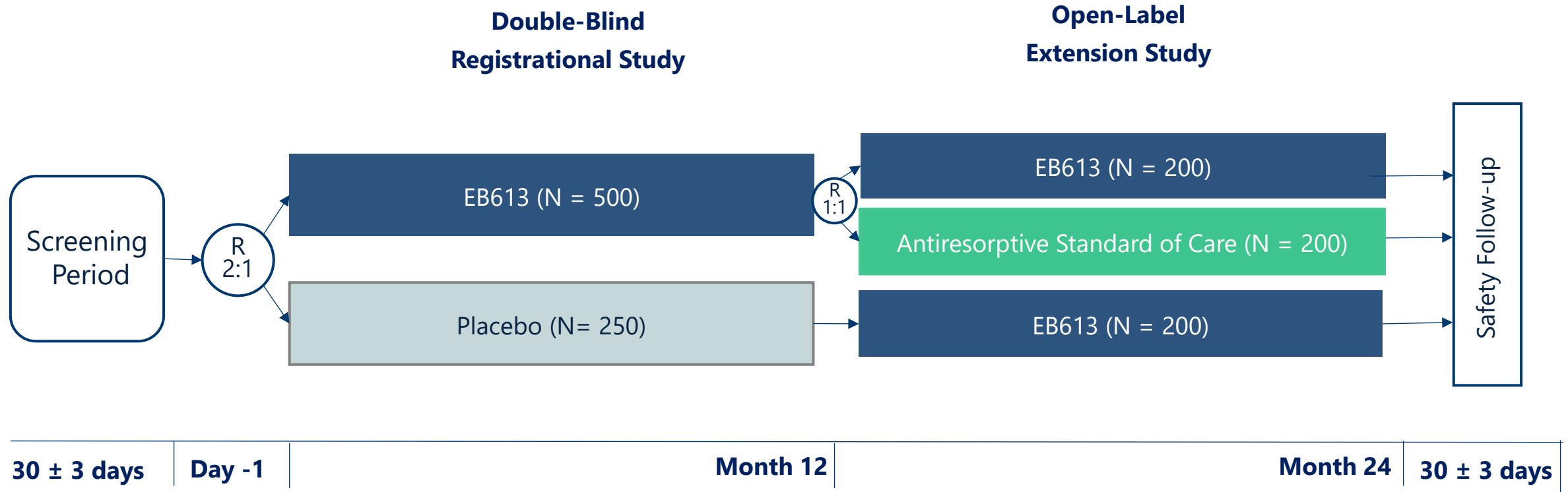
December 19, 2025

Currently available treatments for osteoporosis have limitations with respect to both efficacy and safety. There is need for novel products with enhanced efficacy, tolerability, and ease of use. The

This FQP for the surrogate efficacy endpoint proposes in the context of use (COU) that “the percentage change in total hip bone mineral density (BMD) assessed by dual-energy X-ray absorptiometry (DXA) can be used as a surrogate endpoint for the assessment of investigational anti-osteoporosis drug treatments for post-menopausal women at risk for osteoporotic fracture”.

current approval paradigm using fracture endpoint faces multiple challenges: 1) it requires trials of long duration (2-5 years); 2) Placebo-controlled trials in high-risk patients are no longer ethical due to the availability of effective treatments, necessitating active controls or enrollment of lower-risk patients; 3) Large sample sizes are required to adequately power studies.

EB613 Phase 3 Development Plan



Key Eligibility Criteria



Inclusion 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**
- **Eligible fracture types:**
 - One mild vertebral fracture
 - Non-vertebral fractures (other than hip or pelvis) >2 years



Exclusion Criteria

- **Very high risk for fracture, defined as one of the following**
 - Prior fracture of hip or pelvis, >1 mild vertebral fracture, or any moderate-severe vertebral fracture
 - Other non-vertebral fracture in the last two years, or
 - BMD T-score < -3.50 at lumbar spine, total hip, or femoral neck
- **Appropriate exclusions/washout periods for other osteoporosis medications**

EB612 Program

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

In Partnership with OPKO



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 Profile

Oral Long-acting PTH(1-34) Tablet for Hypoparathyroidism

MOA: First-in-Class Oral, Long-Acting PTH(1-34) Protein Replacement Therapy Tablet

Dosage Form: Daily Single Tablet

Pharmacokinetics and Pharmacodynamics:

>24 hours exposure following a single dose with a robust PD response

Production process: Scalable pharmaceutical production process

Shelf-life: Long shelf-life at convenient storage conditions

Oral Peptide

Tablet friendly for patient compliance
Differentiation vs small molecules (Safety, DDI)

Sustain PTH Exposure

Prolonged plasma half-life
>72h
Potential low mg daily dose

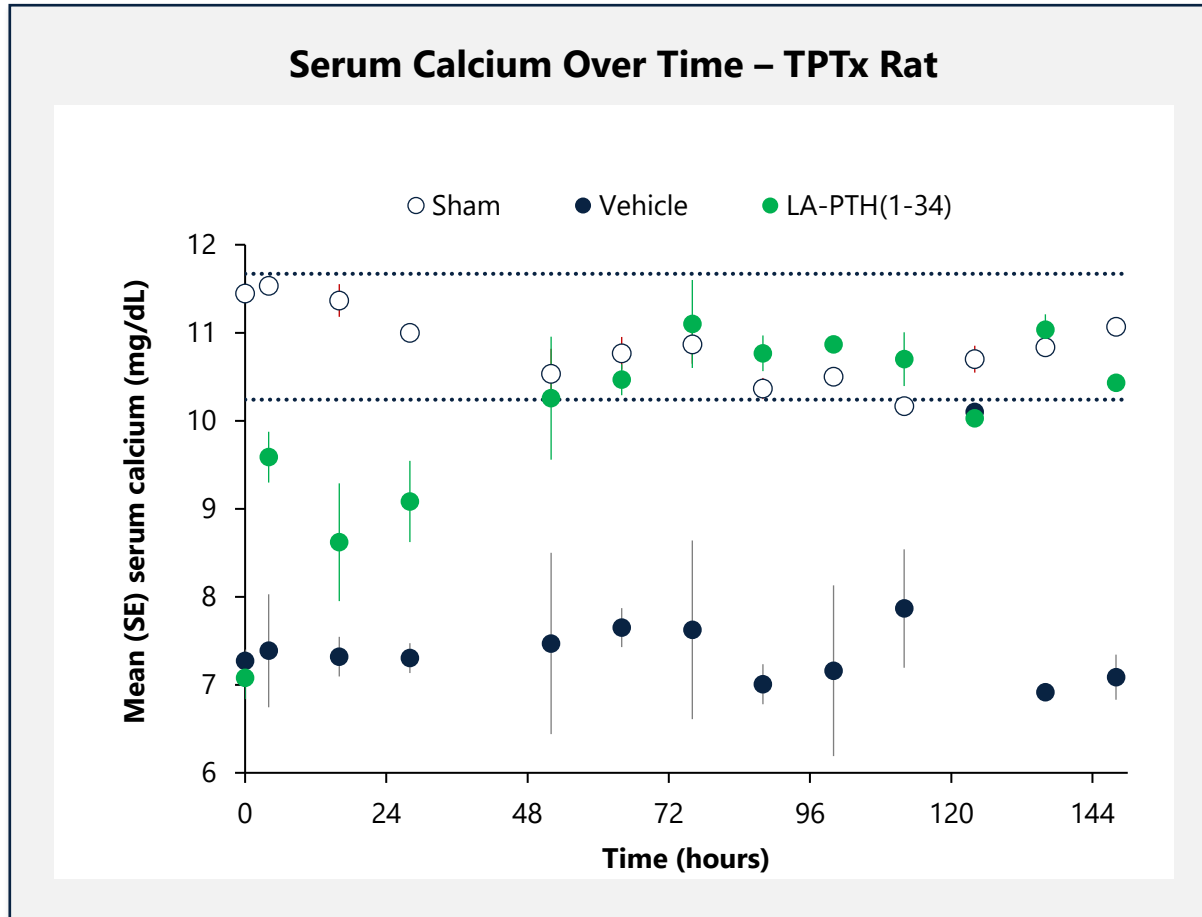
Cross-Species Preclinical Validation

Pharmacodynamic effect in TPTx rat and two large animal species - providing a robust translational package for IND-enabling studies

Well Tolerated

Favorable early tolerability signal

EB612: LA-PTH(1-34) Variant Normalizes Serum Calcium in TPTx Rat Model



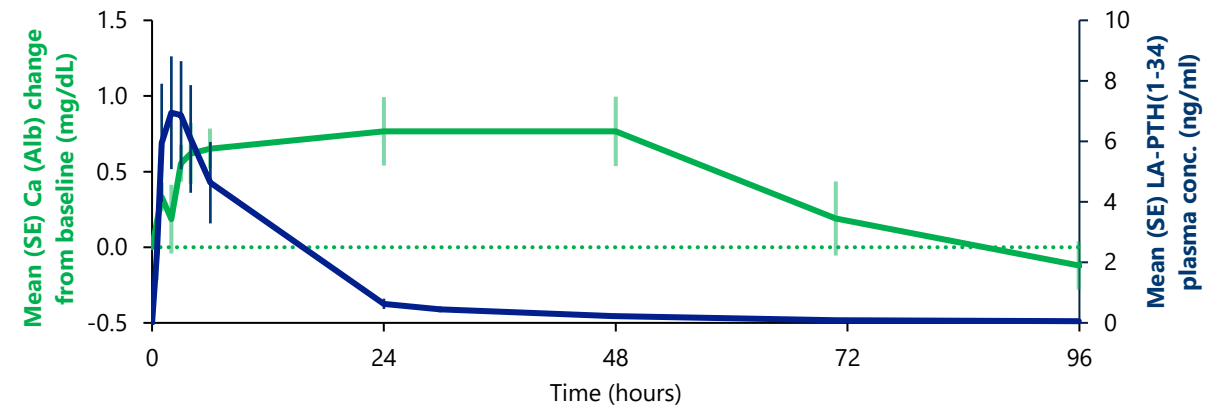
- The thyroparathyroidectomized (TPTx) rat is the universally accepted gold-standard model of surgical hypoparathyroidism
- The drug was administered intravenously to TPTx male SD rats on a daily basis for one week (n=9 in each arm).
- **Full Calcium Normalisation**
EB612 restored serum calcium and reduced phosphate to levels comparable to sham control animals
- Calcemic effects observed in the TPTx rat model are consistent with those reported in similar studies with other clinically validated PTH-replacement therapies for hypoparathyroidism

EB612: Long-Lasting Serum Calcium Elevation in Large Animal Models

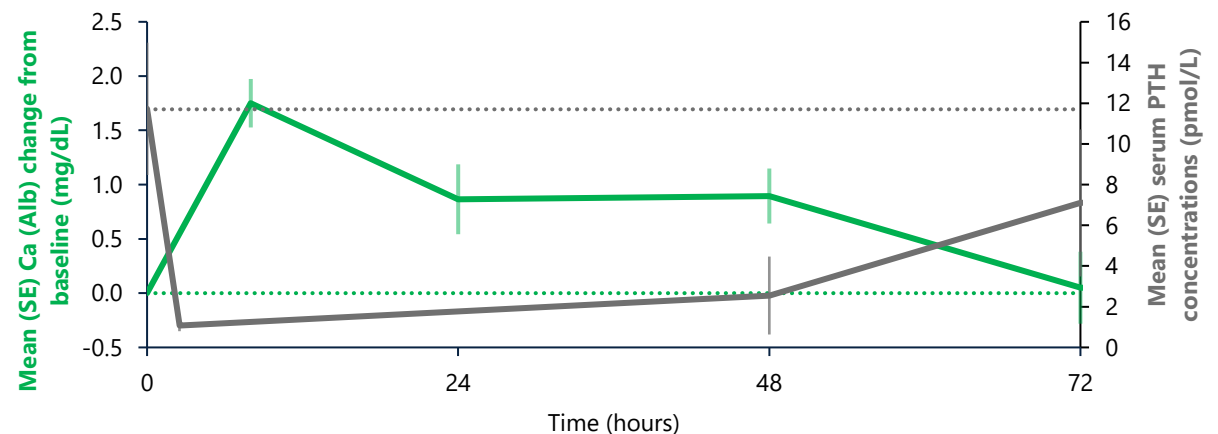
Cross-species validation

- **Rapid onset** - A single EB612 tablet achieved maximal plasma levels 2 to 3 hours post-dose
- **Prolonged PK profile** - The drug remained detectable in plasma for approx. three days
- **Sustained calcemic effect** ~48-72h supports QD dosing
- **Consistently lowering endogenous PTH(1-84)**
- **Well tolerated** in single dose, large animal studies

Minipig model



Non-human Primate model



GLP1/Glucagon and GLP2 Programs

In Partnership with OPKO



First Oral Once Daily OXM (GLP-1/Glucagon Dual Agonist) Tablet for Obesity and Metabolic Disorders

> 1 billion people suffer from obesity globally; market is estimated to grow to \$100B by 2030

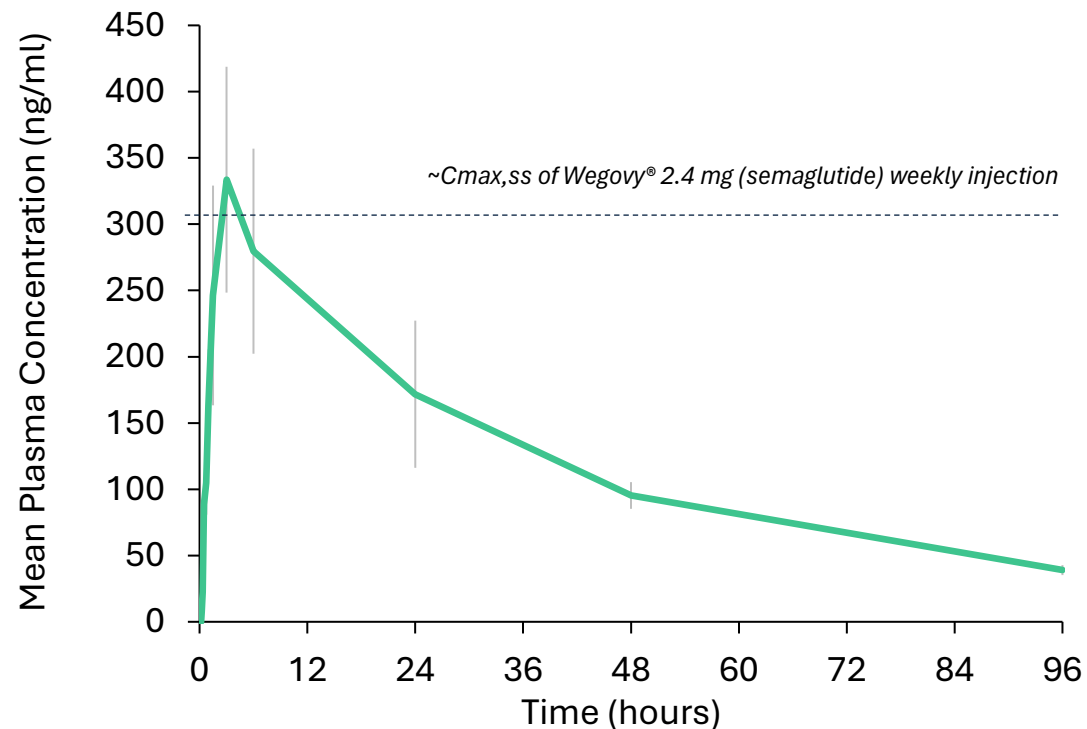
SUN-680. First-in-Class Oral Dual GLP-1/Glucagon Agonist for Patients with Obesity and Metabolic Disorders: In Vivo Pharmacokinetic and Pharmacodynamic Results

Gregory Burshtein¹, Constantin Itin¹, Daniel Pery¹, Eli Reichman¹, Hillel Galitzer¹, Michal Kushnir¹, Ahuva Bar-Ilan², Moran Golan²,
Laura Moschovich², Miri Zakar², Amit Rivkin², Moran Levy², Miranda Toledano¹, Jane Hsiao³

¹Entera Bio Ltd., Jerusalem, Israel, ²OPKO Biologics Ltd. Kiryat Gat, Israel, ³OPKO Health Inc. Miami, FL, USA



Oral OXM Tablets in Minipigs



Extended Plasma Half-Life: Biologic half-life consistent with the half-life reported for semaglutide in a similar animal model

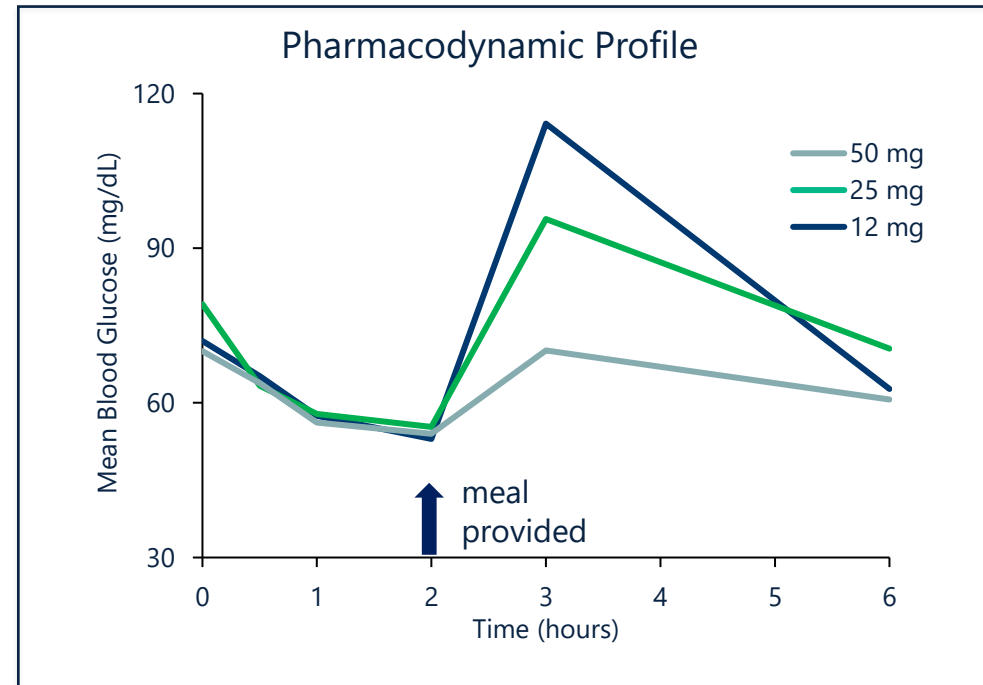
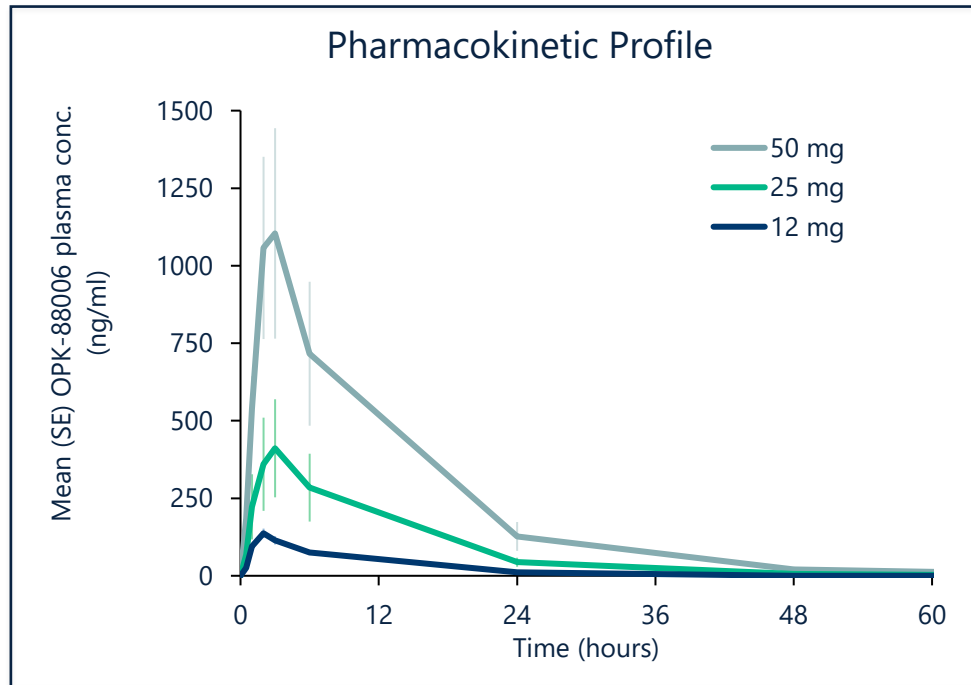
Robust Oral Bioavailability: Plasma concentrations following a single oral dose were similar to the reported clinical steady state concentration following a 2.4 mg subcutaneous dose of Wegovy (semaglutide)

Pharmacologic Effect: Statistically significant reduction in plasma glucose levels compared with placebo in rats

Favorable Profile: PK profile and bioavailability observed in vivo appears suitable for daily tablet dosing using Entera's N-Tab[®] technology platform

N-Tab[®] Oral OXM IND filing expected pursuant to SC OXM filing (2026E)

EB618: Dose-Proportional PK/PD Effect in Non-Human Primate DRF Study



- **Robust bioavailability** - dose-proportional systemic exposure and low variability
- **Well tolerated** - no safety concerns were identified, at doses exceeding the anticipated clinical dose range by more than tenfold (mg/kg body weight)
- **A dose-proportional pharmacologic effect** on postprandial blood glucose levels

First Oral Once Daily GLP-2 Tablet for Patients with SBS

Oral GLP-2 offers less-invasive administration with titratable dosing for personalized treatment in this rare and diverse condition ~30k patients across US and EU

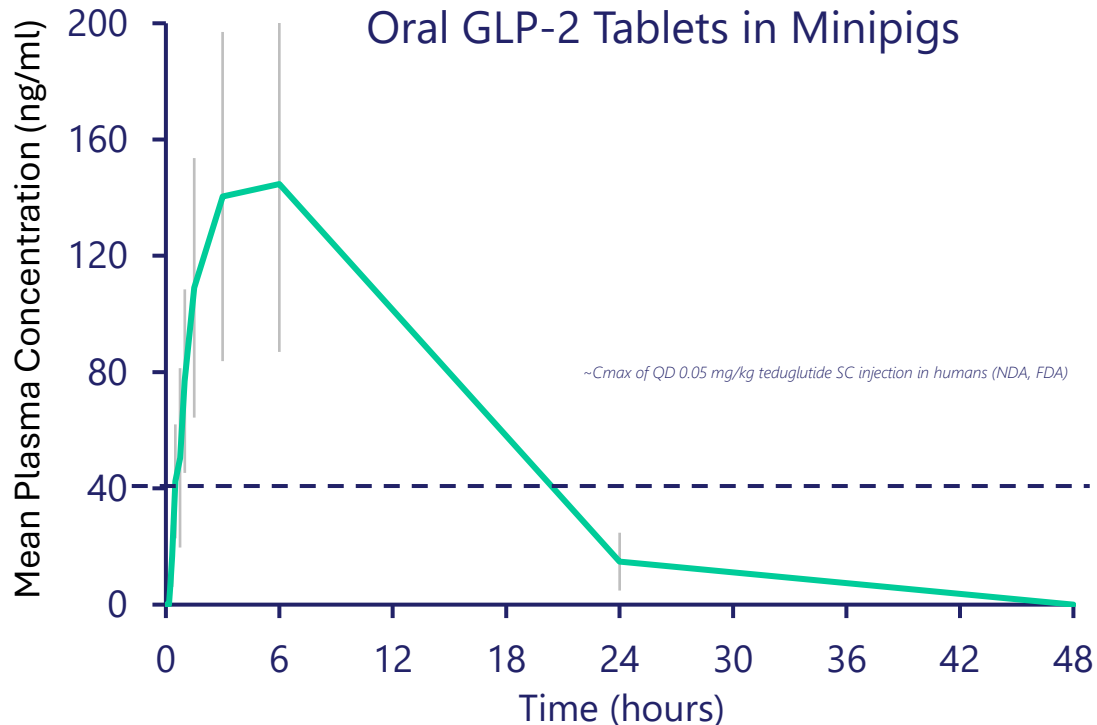


OPKO

A FIRST-IN-CLASS ORAL GLP-2 ANALOG FOR TREATMENT OF SHORT BOWEL SYNDROME

LB055

Gregory Burshtein¹, Constantin Itin¹, Daniel Pery¹, Eli Reichman¹, Hillel Galitzer¹, Michal Kushnir¹, Ahuva Bar-Ilan², Moran Golan², Laura Moschovich², Miri Zakar², Amit Rivkin², Moran Levy², Miranda Toledano¹, Jane Hsiao³
¹Entera Bio Ltd., Jerusalem, Israel, ²OPKO Biologics Ltd. Kiryat Gat, Israel, ³OPKO Health Inc. Miami, FL, USA



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

EB613 Patient and Clinical Surveys



EB613: Driving Value Across All Key Stakeholders

Healthcare Provider Surveys

GYNs, PCPs, Rheums and Endos likely to prescribe

Oral administration and known mechanism supports wide adoption

Patient Surveys

55% interested in oral bone-building therapy

70% Prioritize increasing bone density

47% Currently untreated despite high need

Payers & Market Access

Oral formulation expected to improve adherence, reduce costs

Differentiated profile supports favorable access

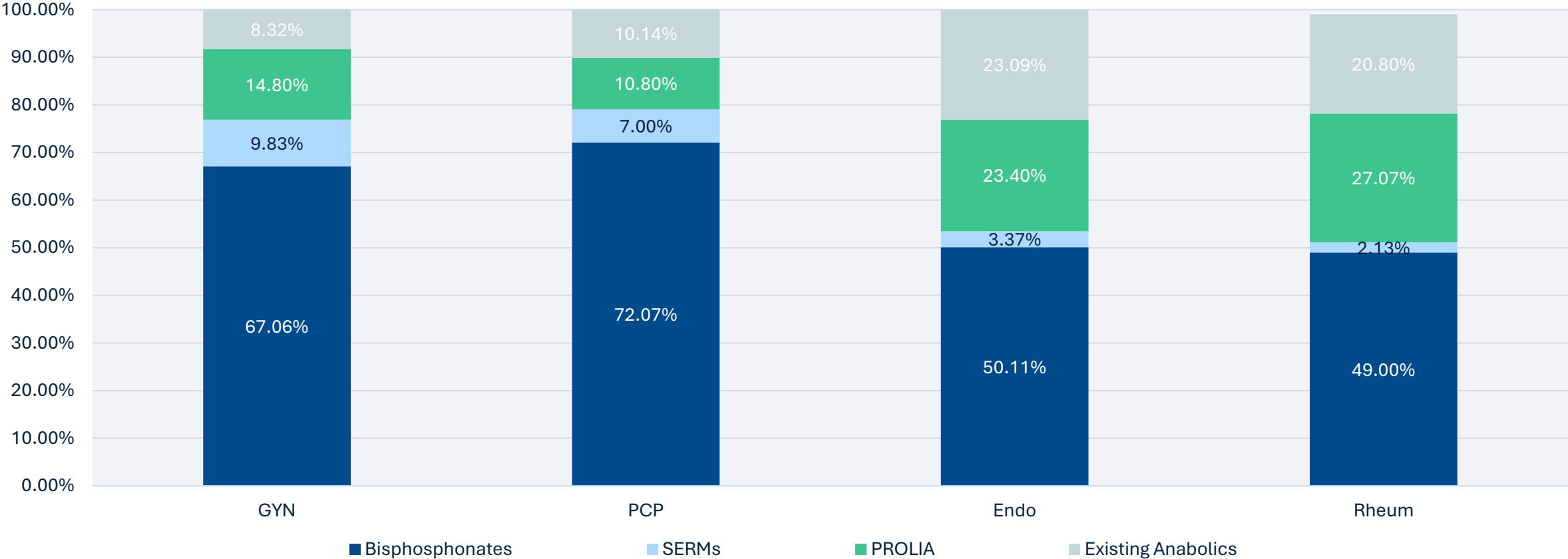
Robust Commercial Opportunity

First and Only Once-Daily Oral Anabolic in Development

Estimated 38% patient share across specialties

Oral Bisphosphonates and Prolia Dominate Across All Clinician Groups (76%), While Current Use Of Anabolic Therapies Remains Limited (~15%)

Consistent prescribing patterns across major treating clinicians

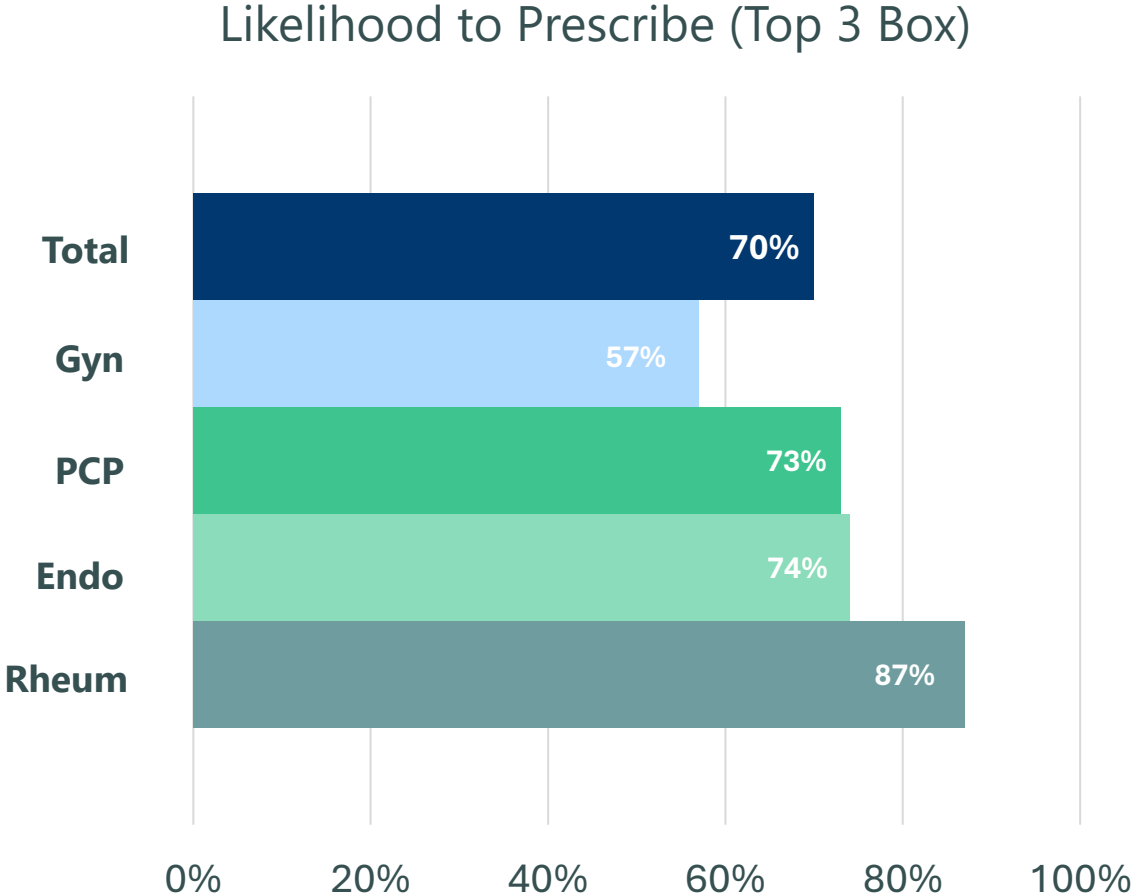


[Q7] Of your postmenopausal patients with osteoporosis who are currently using a prescription medication, please indicate the percent use of each of the following treatment options in the past 6 months:

EB613 – A New Oral Anabolic Agent Poised To Transform Osteoporosis Treatment

- Physicians who rated their likelihood to prescribe as 8, 9, or 10 are represented visually
- ENDOs are extremely enthusiastic about willingness to prescribe EB613

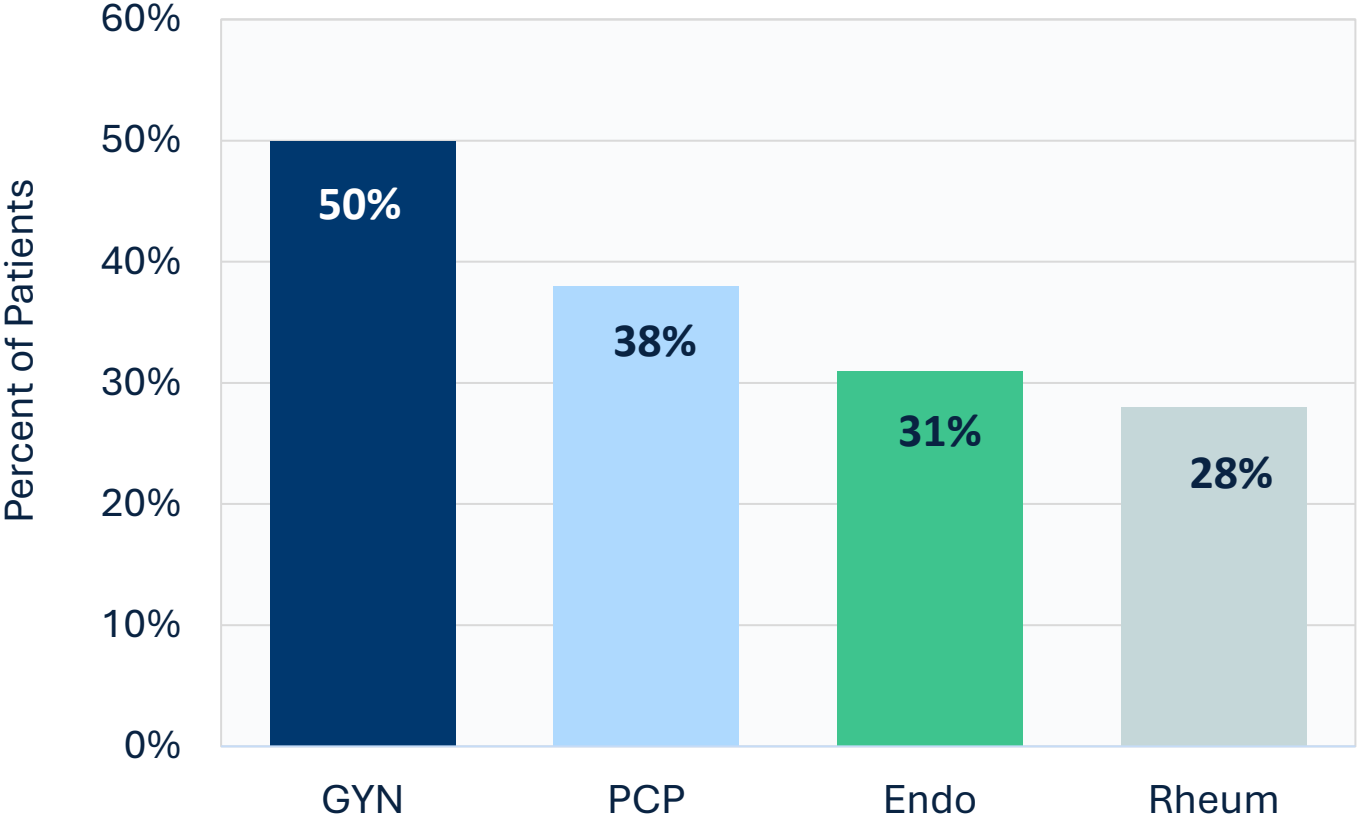
Overwhelming prescriber confidence in EB613 across all physician segments



[Q25] How likely are you to prescribe it on a scale of 1 to 10 where 1 is "not at all likely to prescribe" and 10 is "extremely likely to prescribe"?

Across All Specialties EB613 Demonstrates Strong Adoption Potential

EB613 Expected Patient Market Share by Specialty



This broad acceptance across specialties, with a **38%** overall patient market share, underscores the potential for EB613 to become a game-changing treatment in osteoporosis.

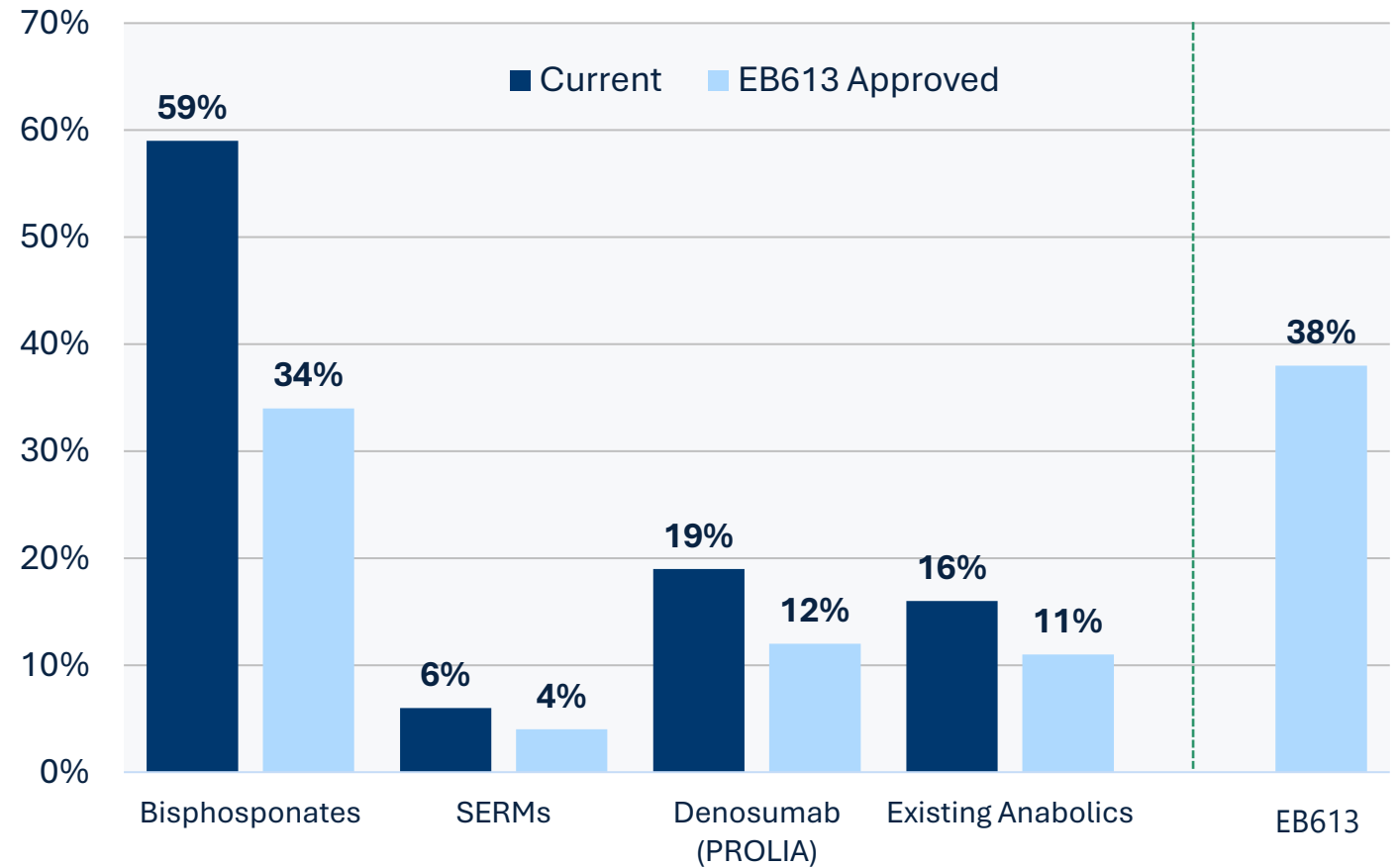
These results signal a significant shift and readiness of HCPs to integrate EB613 into clinical practice.

[Q26] Considering your total postmenopausal osteoporosis population, what percentage of patients would you prescribe Product E for?

EB613 Is Poised To Take Share From All Established Therapies

- EB613 is likely to become a preferred oral anabolic option in osteoporosis treatment, displacing both oral bisphosphonates, denosumab, and existing anabolics
- ENDOs report that nearly half (47%) of patients rejecting anabolics would be open to taking EB613, showing strong potential for this oral alternative
- GYNs report that over half (56%) of patients who previously refused injectable anabolic treatments would choose EB613

Preference Share by Type of Therapy, Current and After EB613 Approval



2023 Survey: OB/GYN and GYN Practices Are the Natural Hubs for Advocacy of Women's Bone Health

At the 2023 global menopause society conference, a 19-question, self-administered survey assessed osteoporosis knowledge and treatment practices of 129 responding physicians from OB/GYN (63%) and GYN (37%) practice specialties.

89% of respondents

routinely include bone health issues in their standard GYN care in menopausal and perimenopausal patients.

- 92% order DXA scans
- 82% are familiar with FRAX

71% of respondents

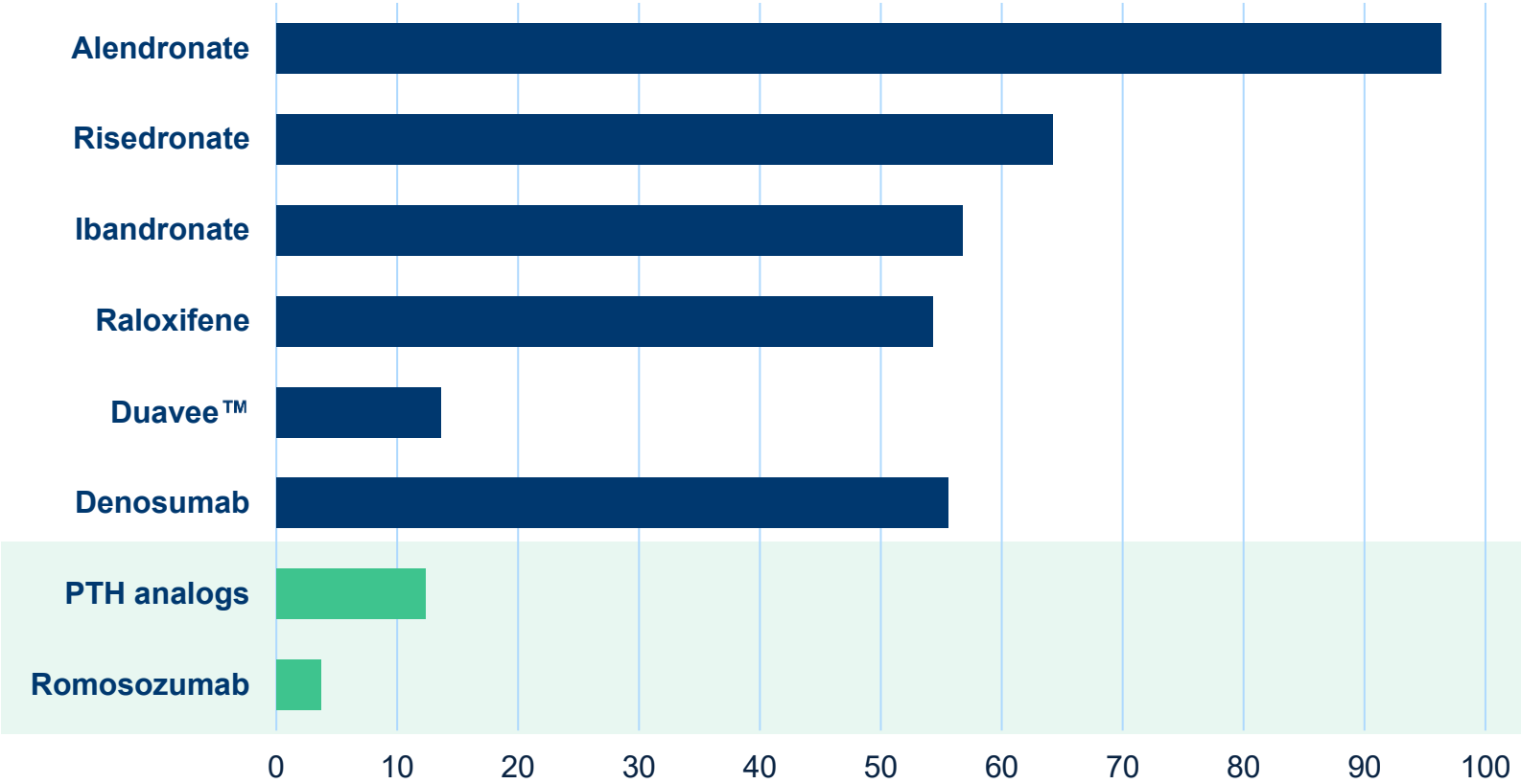
treat patients to **prevent** osteoporosis.

64% of respondents

treat patients **with** osteoporosis.

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

Percentage of respondents who treat patients with osteoporosis by drugs prescribed (n=81)



Of the **64% of respondents** who treat patients with osteoporosis, only **12%** prescribe injectable anabolics.

Evolving the Route of Administration (Such as an Oral Anabolic Minitablet) Dramatically Shifts OB/GYN and GYN Willingness to Prescribe

Availability of an oral anabolic would shift the use of anabolics

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%**.

Thank you

IR@enterabio.com

