BioCryst Pharmaceuticals, Inc.

Corporate Presentation

January 2025

Forward-looking statements

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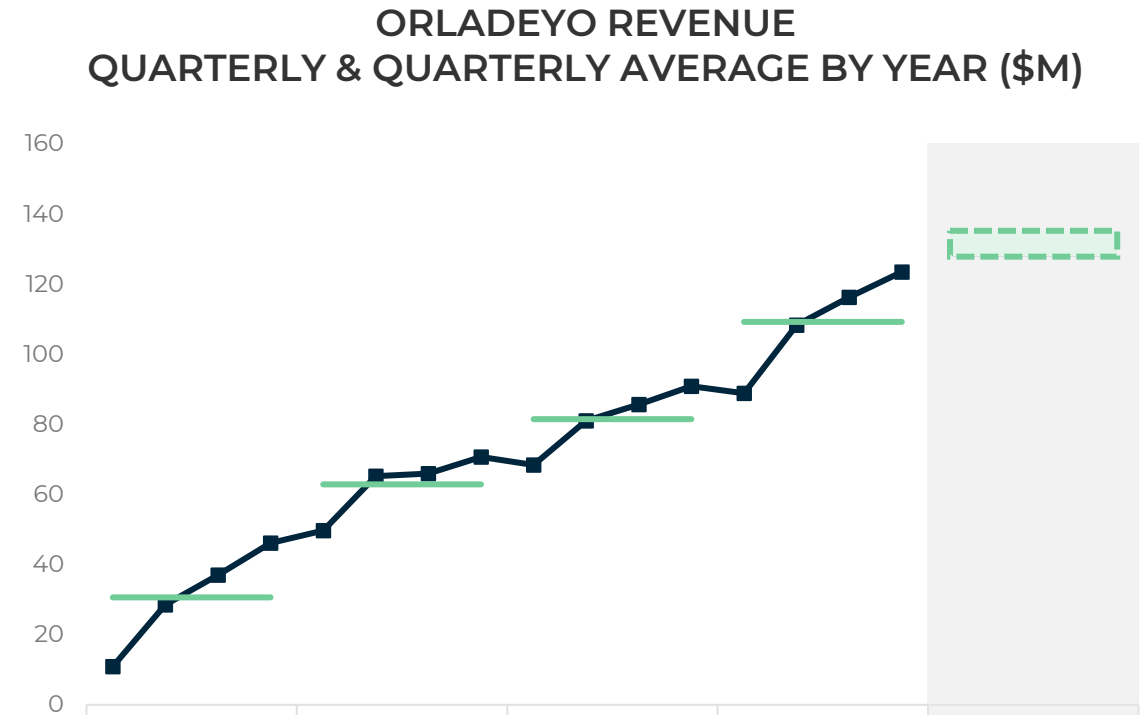
BioCryst: durable, profitable growth through the decade with pipeline optionality

2024 highlights and 2025 outlook

COMMERCIAL EXCELLENCE	• **2024 Results:** $437M global ORLADEYO® revenue (34% growth) and $450M total revenue • Over 1,200 US prescribers • Commercially available in over 30 countries
CLINICAL PROGRESS	• ORLADEYO pediatric program on track for regulatory submission in 2025 • BCX17725 (Netherton syndrome) and avoralstat (DME) advancing into patients in 2025
BUILDING SUSTAINABLE PROFITABILITY	• Achieved goal for full-year 2024 operating profit[1] • On track for sustainable quarterly positive EPS and cash flow in 2H25 • Revenue expected to grow at ~20% CAGR over next 3 years, vs. ~5% for operating expenses
2025 REVENUE GUIDANCE	• **ORLADEYO**: $515-535M • **Total revenue**: $540-560M

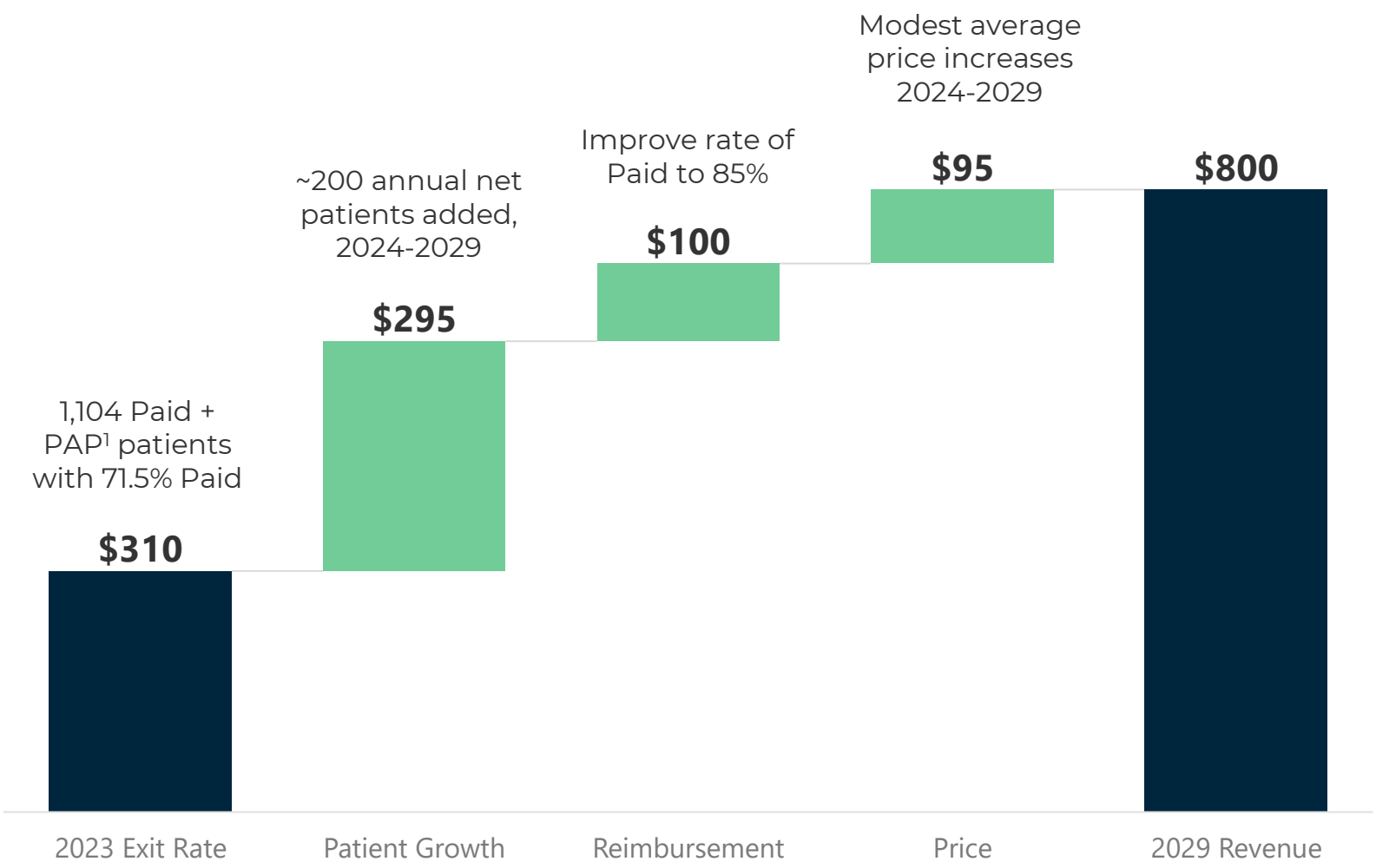
1. Excluding stock-based compensation expense

Strong ORLADEYO growth to continue in 2025



	2021	2022	2023	2024	2025 Guidance
Revenue ($M)	123	252	326	437	515-535
Growth ($M)	+123	+129	+74	+111	+78-98
Growth (%)	–	+105%	+30%	+34%	+18-22%

Path to $800M US revenue in 2029



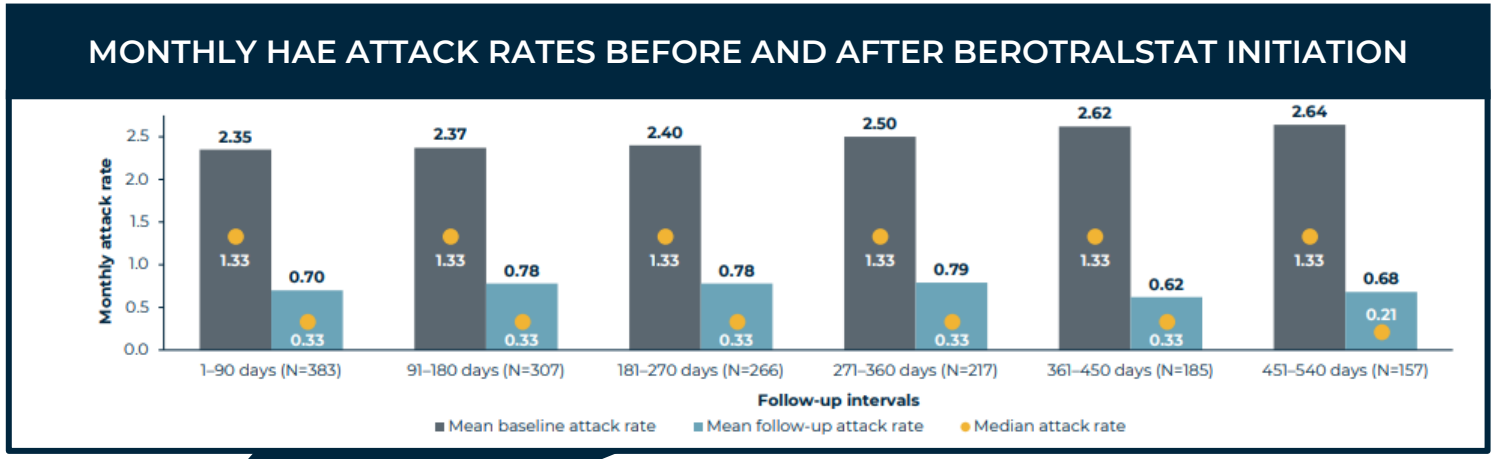
ASSUMPTIONS

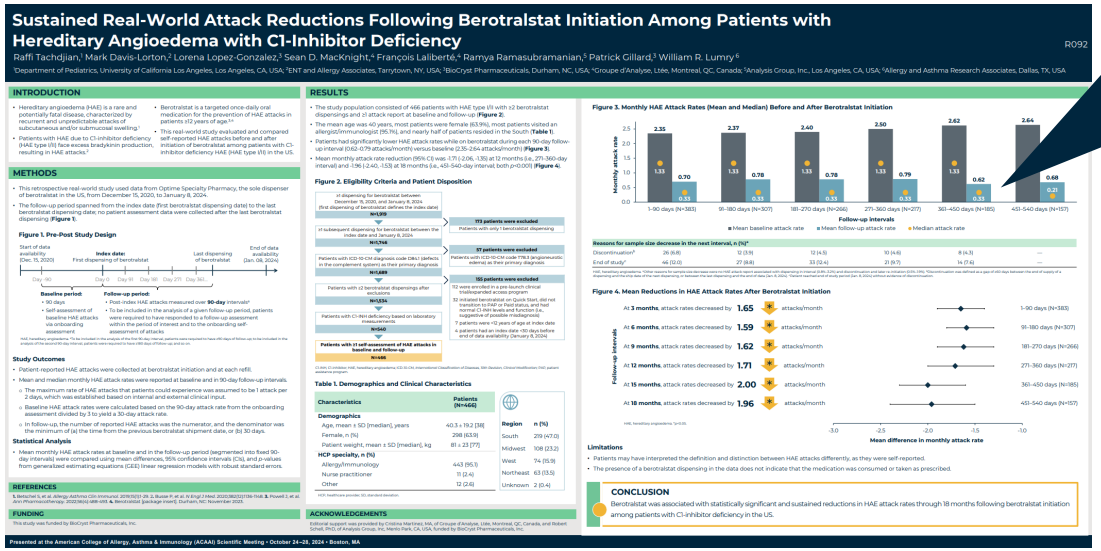
- 15-20% gross-to-net on Paid shipments
- Compliance in low-90s%

1. PAP is the company's long-term patient assistance program

REAL WORLD EVIDENCE: patients with HAE Type 1 and 2 have significant and sustained attack reduction on ORLADEYO

- Median attack rate of 1/3rd of an attack per month in a study population of over 450 patients




Sustained Real-World Attack Reductions Following Berotralstat Initiation Among Patients with Hereditary Angioedema with C1-Inhibitor Deficiency

R092

Raffi Tachdjian,[1] Mark Davis-Lorton,[2] Lorena Lopez-Gonzalez,[3] Sean D. MacKnight,[4] François Laliberté,[4] Ramya Ramasubramanian,[5] Patrick Gillard,[3] William R. Lumry[6]

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INTRODUCTION

- Hereditary angioedema (HAE) is a rare and potentially fatal disease, characterized by recurrent and unpredictable attacks of subcutaneous and/or submucosal swelling[1]
- Patients with HAE due to C1-inhibitor deficiency (HAE type I/II) face excess bradykinin production, resulting in HAE attacks.[2]
- Berotralstat is a targeted once-daily oral medication for the prevention of HAE attacks in patients ≥12 years of age.[3,4]
- This real-world study evaluated and compared self-reported HAE attacks before and after initiation of berotralstat among patients with C1-inhibitor deficiency HAE (HAE type I/II) in the US.

METHODS

- This retrospective real-world study used data from Optime Specialty Pharmacy, the sole dispenser of berotralstat in the US, from December 15, 2020, to January 8, 2024.
- The follow-up period spanned from the index date (first berotralstat dispensing date) to the last berotralstat dispensing date; no patient assessment data were collected after the last berotralstat dispensing (**Figure 1**).

Figure 1. Pre-Post Study Design

[a]HAE, hereditary angioedema. [b]To be included in the analysis of the first 90-day interval, patients were required to have ≥90 days of follow-up to be included in the analysis of the second 90-day interval, patients were required to have ≥180 days of follow-up, and so on.

Study Outcomes

- Patient-reported HAE attacks were collected at berotralstat initiation and at each refill.
- Mean and median monthly HAE attack rates were reported at baseline and in 90-day follow-up intervals.
  - The maximum rate of HAE attacks that patients could experience was assumed to be 1 attack per 2 days, which was established based on internal and external clinical input.
  - Baseline HAE attack rates were calculated based on the 90-day attack rate from the onboarding assessment divided by 3 to yield a 30-day attack rate.
  - In follow-up, the number of reported HAE attacks was the numerator, and the denominator was the minimum of (a) the time from the previous berotralstat shipment date, or (b) 30 days.

Statistical Analysis

- Mean monthly HAE attack rates at baseline and in the follow-up period (segmented into fixed 90-day intervals) were compared using mean differences, 95% confidence intervals (CIs), and p-values from generalized estimating equations (GEE) linear regression models with robust standard errors.

RESULTS

- The study population consisted of 466 patients with HAE type I/II with ≥2 berotralstat dispensings and ≥1 attack report at baseline and follow-up (**Figure 2**).
- The mean age was 40 years, most patients were female (83.9%), most patients visited an allergist/immunologist (55.1%), and nearly half of patients resided in the South (**Table 1**).
- Patients had significantly lower HAE attack rates while on berotralstat during each 90-day follow-up interval (0.62–0.79 attacks/month) versus baseline (2.35–2.64 attacks/month) (**Figure 3**).
- Mean monthly attack rate reduction (95% CI) was -1.71 (-2.06, -1.35) at 12 months (i.e., 271–360-day interval) and -1.96 (-2.40, -1.53) at 18 months (i.e., 451–540-day interval; both p<0.001) (**Figure 4**).

Figure 2. Eligibility Criteria and Patient Disposition

Table 1. Demographics and Clinical Characteristics

Characteristics	Patients (N=466)
Demographics	
Age, mean ± SD [median], years	40.3 ± 19.2 [38]
Female, n (%)	298 (63.9)
Patient weight, mean ± SD [median], kg	81 ± 23 [77]
HCP specialty, n (%)	
Allergy/Immunology	443 (95.1)
Nurse practitioner	11 (2.4)
Other	12 (2.6)

Region	n (%)
South	219 (47.0)
Midwest	108 (23.2)
West	74 (15.9)
Northeast	63 (13.5)
Unknown	2 (0.4)

HCP, healthcare provider; SD, standard deviation.

Reasons for sample size decrease in the next interval, n (%)[a]

	1–90 days (N=383)	91–180 days (N=307)	181–270 days (N=266)	271–360 days (N=217)	361–450 days (N=185)
Discontinuation[b]	26 (6.8)	12 (3.9)	12 (4.5)	10 (4.6)	8 (4.3)
End of study[c]	46 (12.0)	27 (8.8)	33 (12.4)	21 (9.7)	14 (7.6)

[a]HAE, hereditary angioedema. [b]Other reasons for sample size decrease were in HAE attack reports associated with dispensing in interval (0.8%–2.3%) and discontinuation and later re-initiation (0.0%–1.9%). [c]Discontinuation was defined as a gap of ≥30 days between the end of supply of a dispensing and the first date of the next dispensing, or between the last dispensing and the end of data (Jan. 8, 2024). [d]Patient reached end of study period (Jan. 8, 2024) without evidence of discontinuation.

Figure 4. Mean Reductions in HAE Attack Rates After Berotralstat Initiation

HAE, hereditary angioedema. [a]p<0.05.

Limitations

- Patients may have interpreted the definition and distinction between HAE attacks differently, as they were self-reported.
- The presence of a berotralstat dispensing in the data does not indicate that the medication was consumed or taken as prescribed.

CONCLUSION

Berotralstat was associated with statistically significant and sustained reductions in HAE attack rates through 18 months following berotralstat initiation among patients with C1-inhibitor deficiency in the US.

REFERENCES

1. Betschel S, et al. Allergy Asthma Clin Immunol. 2019;15(1):29. 2. Busse P, et al. N Engl J Med. 2022;386(12):1134–1148. 3. Powell J, et al. Ann Pharmacother. 2022;56(4):488–499. 4. Berotralstat [package insert]. Durham, NC: November 2023.

FUNDING

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ACKNOWLEDGEMENTS

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Presented at the American College of Allergy, Asthma & Immunology (ACAAI) Scientific Meeting • October 24–28, 2024 • Boston, MA

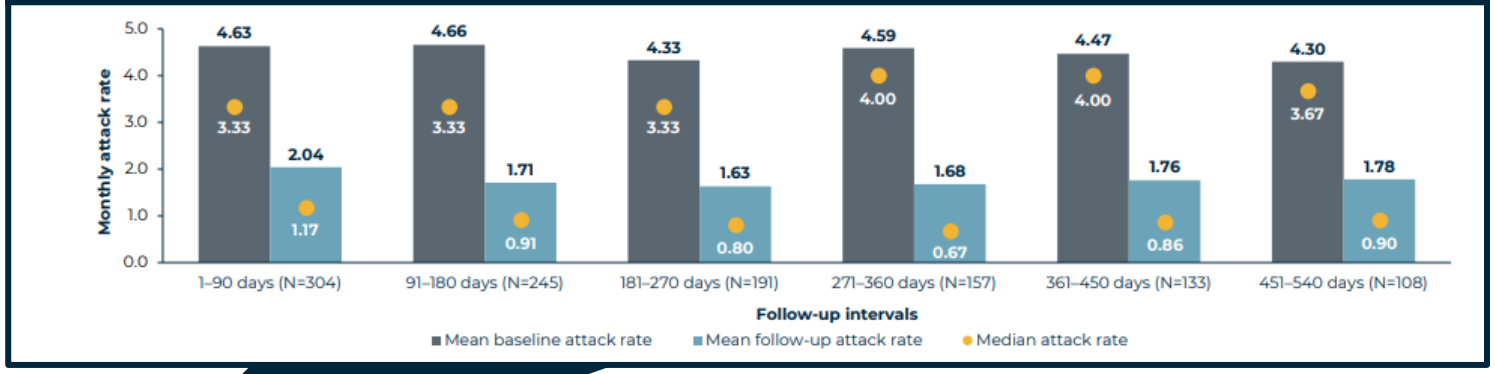
- The primary reason for reduced patient counts over time was that patients had not been on ORLADEYO long enough to be evaluated at all time points
- Only 68 (14.6%) out of 466 patients in this study discontinued therapy

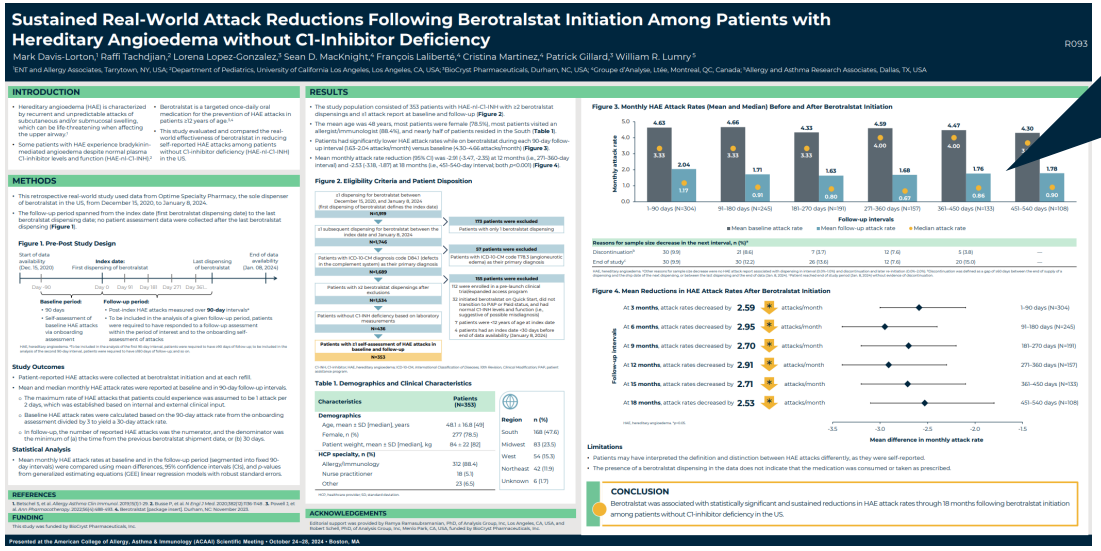
Source: Sustained Real-World Attack Reductions Following Berotralstat Initiation Among Patients with Hereditary Angioedema with C1-Inhibitor Deficiency
Presented at the ACAAI Scientific Meting 2024 • October 24-28, 2024

REAL WORLD EVIDENCE: patients with HAE-nl-C1-inh have significant and sustained attack reduction on ORLADEYO

- Median attack rate of <1 per month in study population of over 350 patients
- Excellent attack reduction and control for a population that has struggled to find effective therapy

MONTHLY HAE ATTACK RATES BEFORE AND AFTER BEROTRALSTAT INITIATION





Sustained Real-World Attack Reductions Following Berotralstat Initiation Among Patients with Hereditary Angioedema without C1-Inhibitor Deficiency

R093

Mark Davis-Lorton,[1] Raffi Tachdjian,[2] Lorena Lopez-Gonzalez,[3] Sean D. MacKnight,[4] François Laliberté,[4] Cristina Martinez,[4] Patrick Gillard,[3] William R. Lumry[5]

[1]ENT and Allergy Associates, Tarrytown, NY, USA; [2]Department of Pediatrics, University of California Los Angeles, Los Angeles, CA, USA; [3]BioCryst Pharmaceuticals, Durham, NC, USA; [4]Groupe d'Analyse, Ltée, Montreal, QC, Canada; [5]Allergy and Asthma Research Associates, Dallas, TX, USA

INTRODUCTION

- Hereditary angioedema (HAE) is characterized by recurrent and unpredictable attacks of subcutaneous and/or submucosal swelling, which can be life-threatening when affecting the upper airway.
- Some patients with HAE experience bradykinin-mediated angioedema despite normal plasma C1-inhibitor levels and function (HAE-nl-C1-INH).[1]
- Berotralstat is a targeted once-daily oral medication for the prevention of HAE attacks in patients ≥12 years of age.[2,3]
- This study evaluated and compared the real-world effectiveness of berotralstat in reducing self-reported HAE attacks among patients without C1-inhibitor deficiency (HAE-nl-C1-INH) in the US.

METHODS

- This retrospective real-world study used data from Optime Specialty Pharmacy, the sole dispenser of berotralstat in the US, from December 15, 2020, to January 8, 2024.
- The follow-up period spanned from the index date (first berotralstat dispensing date) to the last berotralstat dispensing date; no patient assessment data were collected after the last berotralstat dispensing **(Figure 1)**.

Figure 1. Pre-Post Study Design

HAE, hereditary angioedema. *One inclusion in the analysis of the first 90-day interval, patients were required to have ≥90 days of follow-up (as to be included in the analysis of the second 90-day interval, patients were required to have ≥180 days of follow-up and so on.

Study Outcomes

- Patient-reported HAE attacks were collected at berotralstat initiation and at each refill.
- Mean and median monthly HAE attack rates were reported at baseline and in 90-day follow-up intervals.
  - The maximum rate of HAE attacks that patients could experience was assumed to be 1 attack per 2 days, which was established based on internal and external clinical input.
  - Baseline HAE attack rates were calculated based on the 90-day attack rate from the onboarding assessment divided by 3 to yield a 30-day attack rate.
  - In follow-up, the number of reported HAE attacks was the numerator, and the denominator was the minimum of (a) the time from the previous berotralstat shipment date, or (b) 30 days.

Statistical Analysis

- Mean monthly HAE attack rates at baseline and in the follow-up period (segmented into fixed 90-day intervals) were compared using mean differences, 95% confidence intervals (CIs), and p-values from generalized estimating equations (GEE) linear regression models with robust standard errors.

REFERENCES

1. Betschel S, et al. Allergy Asthma Clin Immunol. 2019;15(1):29. 2. Busse P, et al. N Engl J Med. 2020;382(12):178-1148. 3. Powell J, et al. Ann Pharmacotherapy. 2022;56(4):488-493. 4. Berotralstat [package insert]. Durham, NC: November 2023.

FUNDING

This study was funded by BioCryst Pharmaceuticals, Inc.

RESULTS

- The study population consisted of 353 patients with HAE-nl-C1-INH with ≥2 berotralstat dispensings and ≥1 attack report at baseline and follow-up **(Figure 2)**.
- The mean age was 48 years, most patients were female (78.5%), most patients visited an allergist/immunologist (88.4%), and nearly half of patients resided in the South **(Table 1)**.
- Patients had significantly lower HAE attack rates while on berotralstat during each 90-day follow-up interval (1.63–2.04 attacks/month) versus baseline (4.30–4.66 attacks/month) **(Figure 3)**.
- Mean monthly attack rate reduction (95% CI) was -2.91 (-3.47, -2.35) at 12 months (i.e., 271–360-day interval) and -2.53 (-3.18, -1.87) at 18 months (i.e., 451–540-day interval; both $p<0.001$) **(Figure 4)**.

Figure 2. Eligibility Criteria and Patient Disposition

Table 1. Demographics and Clinical Characteristics

Characteristics	Patients (N=353)
Demographics	
Age, mean ± SD [median], years	48.1 ± 16.8 [49]
Female, n (%)	277 (78.5)
Patient weight, mean ± SD [median], kg	84 ± 22 [82]
HCP specialty, n (%)	
Allergy/Immunology	312 (88.4)
Nurse practitioner	18 (5.1)
Other	23 (6.5)

Region	n (%)
South	168 (47.6)
Midwest	83 (23.5)
West	54 (15.3)
Northeast	42 (11.9)
Unknown	6 (1.7)

HCP, healthcare provider; SD, standard deviation.

ACKNOWLEDGEMENTS

Editorial support was provided by Ramya Ramasubramanian, PhD, of Analysis Group, Inc, Los Angeles, CA, USA, and Robert Schell, PhD, of Analysis Group, Inc, Menlo Park, CA, USA, funded by BioCryst Pharmaceuticals, Inc.

Figure 3. Monthly HAE Attack Rates (Mean and Median) Before and After Berotralstat Initiation

Reasons for sample size decrease in the next interval, n (%)[a]					
Discontinuation[b]	30 (9.9)	21 (8.6)	7 (3.7)	12 (7.6)	5 (3.8)
End of study[c]	30 (9.9)	30 (12.2)	26 (13.6)	12 (7.6)	20 (15.0)

HAE, hereditary angioedema. [a]Other reasons for sample size decrease were no HAE attacks report associated with dispensing in interval (0.3%–0.9%) and discontinuation and then re-initiation (0.3%–0.9%). [b]Discontinuation was defined as a gap of ≥60 days between the end of supply of a dispensing and the index date of the next dispensing, or between the last dispensing and the end of data (Jan. 8, 2024). [c]Patient reached end of study period (Jan. 8, 2024) without evidence of discontinuation.

Figure 4. Mean Reductions in HAE Attack Rates After Berotralstat Initiation

HAE, hereditary angioedema. *p<0.05.

Limitations

- Patients may have interpreted the definition and distinction between HAE attacks differently, as they were self-reported.
- The presence of a berotralstat dispensing in the data does not indicate that the medication was consumed or taken as prescribed.

CONCLUSION

Berotralstat was associated with statistically significant and sustained reductions in HAE attack rates through 18 months following berotralstat initiation among patients without C1-inhibitor deficiency in the US.

Presented at the American College of Allergy, Asthma & Immunology (ACAAI) Scientific Meeting • October 24–28, 2024 • Boston, MA

- The primary reason for reduced patient counts over time was that patients had not been on ORLADEYO long enough to be evaluated at all time points
- Only 75 (21.2%) out of 353 patients in this study discontinued therapy

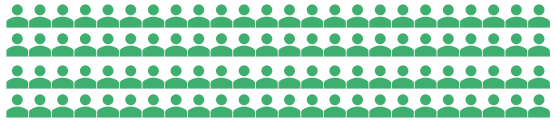
Source: Sustained Real-World Attack Reductions Following Berotralstat Initiation Among Patients with Hereditary Angioedema without C1-Inhibitor Deficiency
Presented at the ACAAI Scientific Meting 2024 • October 24-28, 2024

Comprehensive annual research + market simulation

OUR MODEL STARTS WITH PREFERENCE AND SIMULATES 6,000 MARKET INTERACTIONS BETWEEN HCPS, PATIENTS, & PAYERS

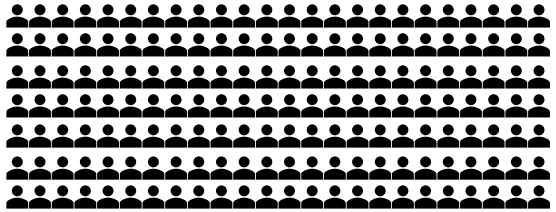
Research Sample*

PATIENTS



n=100 HAE patients

PHYSICIANS



*n=100 AIs**, and n=75 non-AIs***

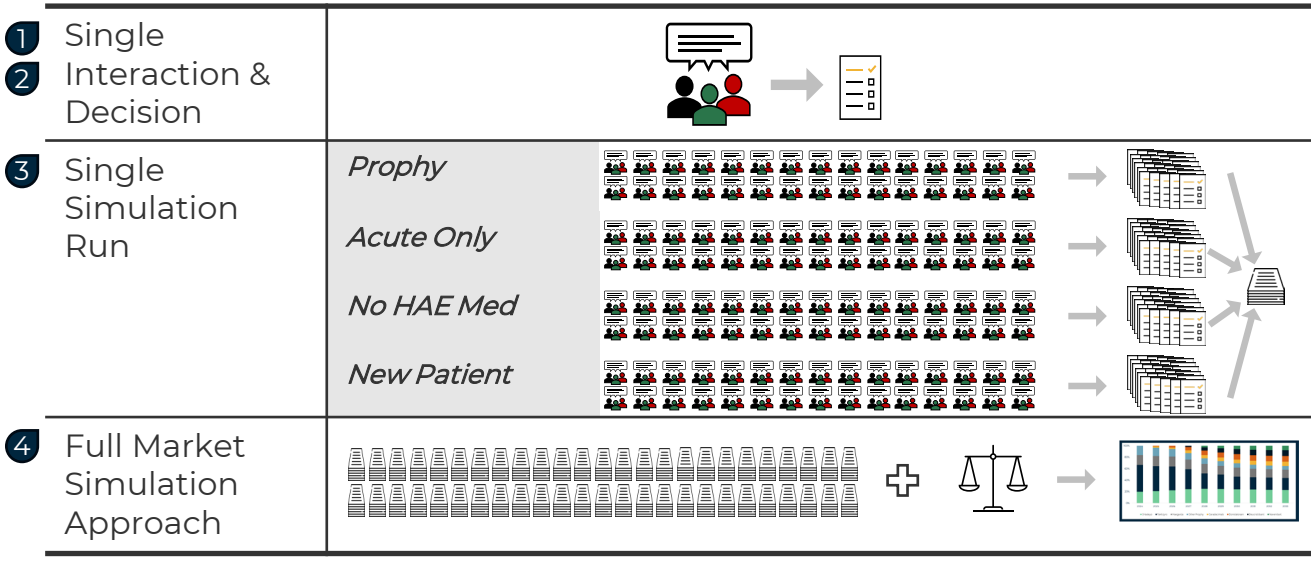
PAYERS

n=56 decision makers covering over 200 million total lives.

Market Model Simulation (Monte Carlo)

1. A patient, physician, and payer are randomly selected from survey respondents.
2. The model evaluates individual prescribing decisions based on patient preference, physician preference & payer approval within a framework of market dynamics (e.g., awareness, adoption, launch timing)
3. For a single simulation run, the process is repeated 30 times for each patient category
4. The simulation is then repeated 50 times (6,000 interactions) to create a generalized distribution, then scaled and weighted to HAE total population

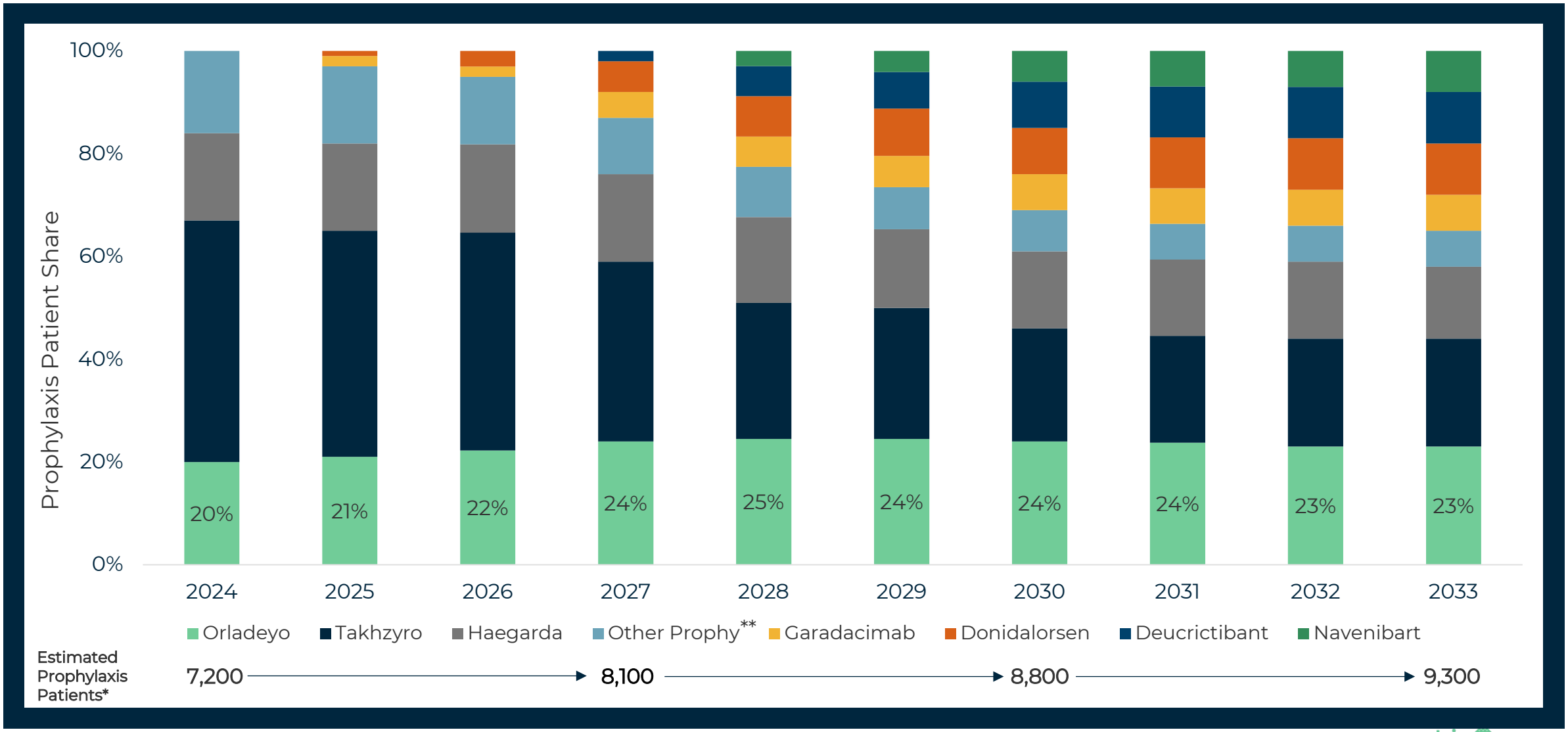
Modeling Process - Visual Example



* Choice-based conjoint
** HAE treaters: Allergists & Immunologists

Monte Carlo simulation outcome: U.S. prophy market share

ORLADEYO REACHES A STEADY STATE OF OVER 2,000 PATIENTS IN U.S. DURING 2028, EVEN AS NEW PRODUCTS GAIN SHARE



Source: BioCryst Internal Market Research Study (Conducted Jun 2024) *Source: 2018-2023 administrative claims data
**Other Prophy: Any other current medication (including acute) taken prophylactically for HAE

Our pipeline

ASSET	PROGRAM	LEAD OPTIMIZATION	PRE-CLINICAL	PROOF OF CONCEPT†	PIVOTAL‡	APPROVED / COMMERCIAL
ORLADEYO® (berotralstat) Oral Plasma Kallikrein Inhibitor	Hereditary Angioedema (HAE)					
ORLADEYO® (berotralstat) Oral Plasma Kallikrein Inhibitor (age ≥2 years)	Hereditary Angioedema (HAE)					
BCX17725 Protein Therapeutic	Netherton Syndrome					
Avoralstat Ocular Plasma Kallikrein Inhibitor	Diabetic Macular Edema (DME)					
Oral C5 Inhibitor	Complement-Mediated Diseases					
Oral C2 Inhibitor	Complement-Mediated Diseases					
Bifunctional Complement Inhibitor	Complement-Mediated Diseases					

**ORLADEYO (age ≥ 2 years), BCX17725, and avoralstat are investigational and have not been deemed safe and effective by the FDA.*

†Proof of Concept is typically Phase 1 or 2.

‡Pivotal is typically Phase 3.

This is BIG: bringing ORLADEYO to children

- Despite significant innovation in HAE prophylaxis for adults, there is still high unmet need in children
- Injectable therapies are the only FDA-approved options for children ages 2 to <12
- Positions ORLADEYO to be the market leading prophylaxis for children (~500 patients in US)

New dosage form: granules (2x3 mm)

APeX-P

- Ages 2 to <12
- Open label, multi-center
- Safety & PK study
- Analysis completed - submission planning underway

On track for NDA filing in 2025

Treating Netherton syndrome (NS) with a targeted KLK5 inhibitor: BCX17725

High unmet need

Severe, rare, genetic and lifelong disease with no approved targeted therapies

Validated target

Well-understood biological cause: mutation in SPINK5 gene

BCX17725 functionally replaces the missing protein

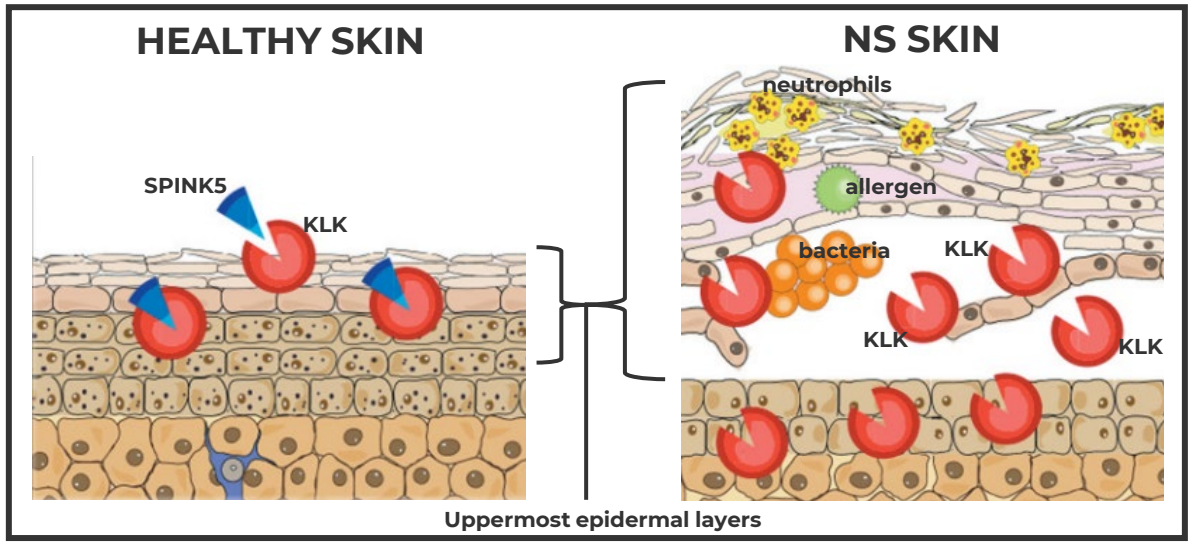
Under-diagnosed Population

Diagnosed US population of ~1,600[1] with potential to grow to 3,000-5,000 with greater diagnosis and treatment

Next milestone: initial data in 2025

1. Based on healthcare claims analysis
Image: https://www.nethertonsyndrome.com/about-nethertons.php

BCX17725 addresses the underlying disease biology in Netherton syndrome



Modified from Petrova and Hovnanian, 2020 Expert Opinion Orphan Drugs[1]

- Patients with NS have a mutation in the SPINK5 gene which causes a deficiency in the SPINK5 protein
- The SPINK5 protein is an important natural regulator of KLK5, a serine protease involved in skin turnover
- Unregulated KLK5 activity causes symptoms of NS by preventing formation of healthy skin barrier
- BCX17725 targets KLK5, providing functional replacement of the missing regulator protein to correct disease biology
- BCX17725 has the potential to improve both dermatologic and atopic disease symptoms

1. Petrova E and Hovnanian A. *Exp Opin Orphan Drugs* (2022) 8(11): 455-487

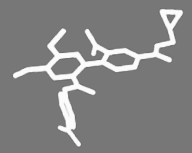
Addressing DME with a potent plasma kallikrein inhibitor: avoralstat suprachoroidal injection[1]

Alternative MOA

Compelling evidence for plasma kallikrein activity in DME pathobiology

New options are needed: up to 40% of patients have persistent DME despite anti-VEGF treatment

Right drug + delivery



Avoralstat has ideal properties for ophthalmic dosing: high potency and low solubility/depot effect

Potential for disease modifying outcomes + extended dosing interval

Significant market opportunity

~1.5M DME patients in US

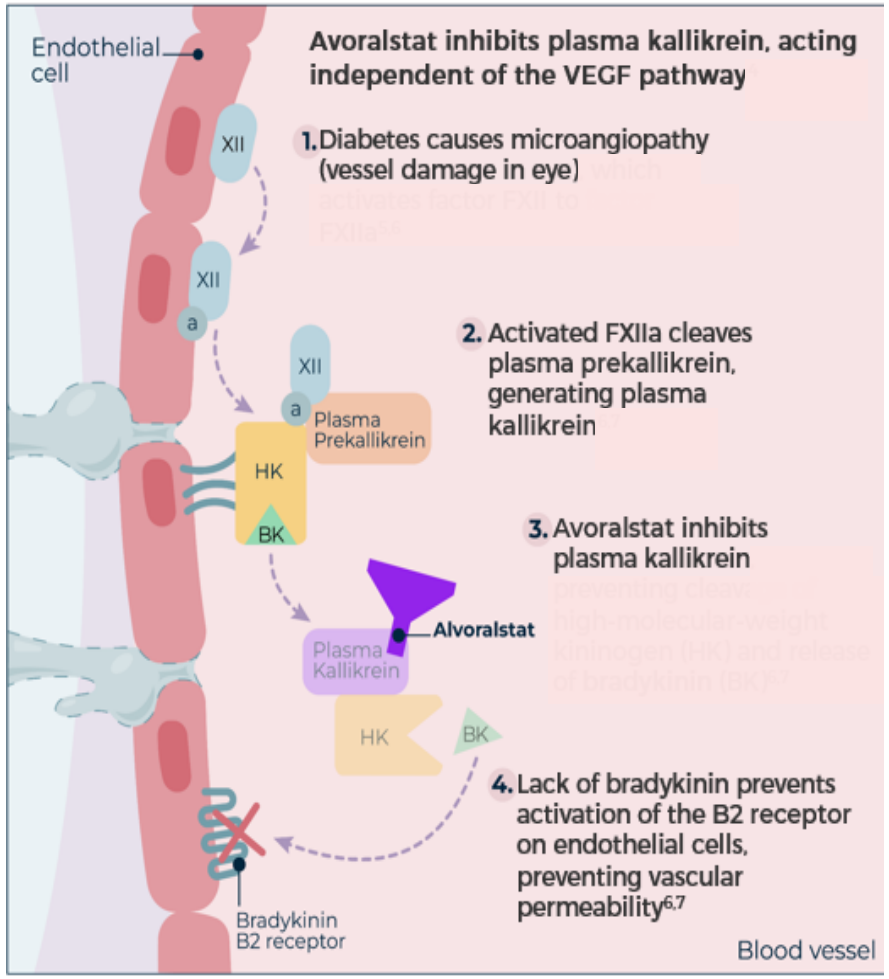
Est. $4B VEGF market by 2028

Next milestone: begin patient studies in 2025

1. SCS Microinjector® is licensed from Clearside Biomedical, Inc.; SCS, suprachoroidal space

Avoralstat: a potent drug targeting DME

Potential to treat all DME Patients via VEGF-independent pathway

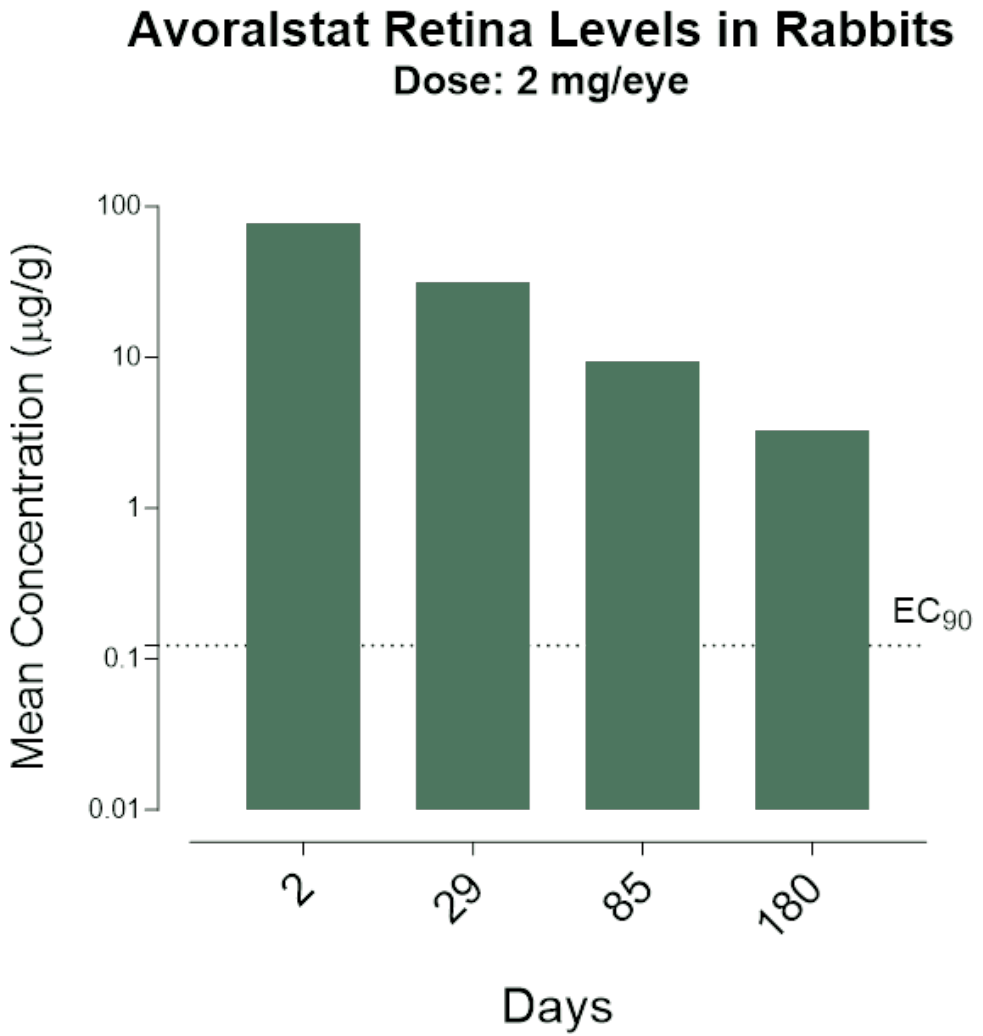


- Hyperglycemia damages retinal vasculature
- Damaged endothelium activates plasma Kallikrein (pKal)
- Elevated pKal levels seen in vitreous of DME patients
- Elevated pKal produces bradykinin leading to vascular leakage
- Avoralstat blocks pKal and bradykinin production
- Avoralstat has similar effect to VEGF inhibitors in well-established non-clinical model

BK, bradykinin; HK, high molecular weight kininogen

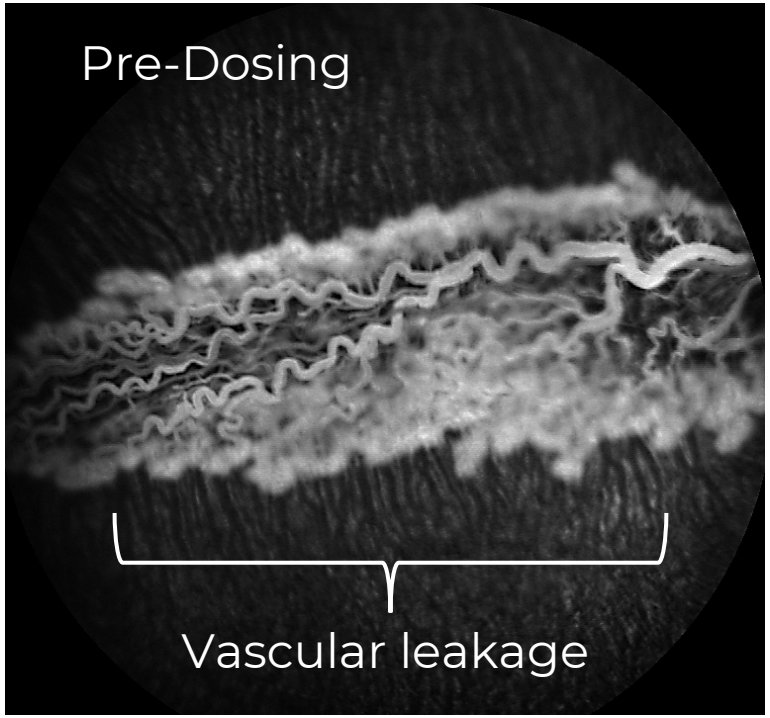
1. Trinh HM, et al. *World J Pharmacol.* 2016;5(1):1-14. 2. Yang S, et al. *Front. Pharmacol.* 2021;12:727870. 3. Kita T, et al. *Diabetes.* 2015;64(10):3588-3599. 4. Lang GE, et al. *TSVT.* 2020;9(4)1-12.

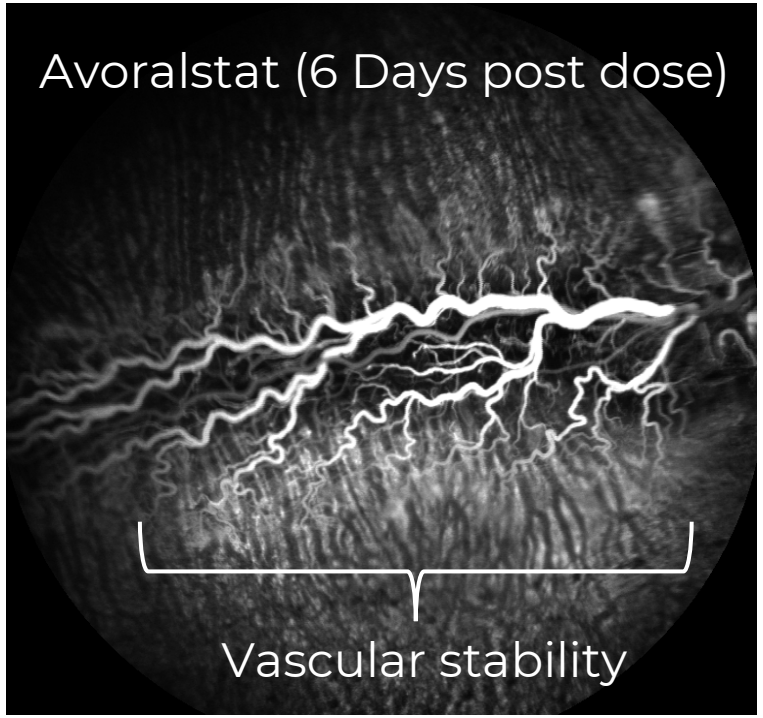
Suprachoroidal depot leads to 3+ months of sustained avoralstat levels in the retina[1]



1. BioCryst Pharmaceuticals nonclinical data on file 2025

Avoralstat has similar effect to VEGF inhibitors in well-established nonclinical model[1]





1. BioCryst Pharmaceuticals nonclinical data on file 2025., Kumar et al. Int J Ophthalmol. 2022 Jan 18;15(1):15-22.

Financial independence and clear path to profitability

2024

Full year operating profit[1]

2025

Approach quarterly positive EPS & cash-flow in 2H

2026

Full year positive EPS & cash-flow

1. Excluding stock-based compensation expense

Key milestones in 2025

2025	File pediatric NDA for ORLADEYO
2025	Begin avoralstat clinical evaluation in patients
2H25	Obtain initial BCX17725 clinical data
2H25	Approach sustainable quarterly positive EPS & cash flow

Finance summary

(Figures in millions)

Q3 2024 CASH POSITION	
Cash, cash equivalents, restricted cash & investments at December 31, 2023	$391
Cash, cash equivalents, restricted cash & investments at June 30, 2024	$338
Cash, cash equivalents, restricted cash & investments at September 30, 2024	$352
Senior credit facility[A]	$324

2025 FY GUIDANCE	
ORLADEYO revenue	$515-535
Total product revenue	$540-560
Operating expenses	$485-495
Operating expenses (excluding stock-based compensation)	$425-435

A – From Pharmakon Advisors, $300M drawn at issuance in Q2 2023. The $324M balance above represents $300M initial issuance plus PIK interest to-date (did not elect the PIK option for Q3 2024; the PIK option has now expired)

Traditional debt and royalty breakdown

	September 30, 2024	December 31, 2023
Royalty financing obligations - current	33,000	23,565
Royalty financing obligations - long-term	481,775	508,034
Total royalty financing obligations	514,775	531,599
Secured term loan	314,333	303,231

	Traditional Debt	Commercial Royalty
Initial amount	$300M term loan	$425M royalty upfronts
Partner(s)	Pharmakon (2023)	RP (2020, 2021) [A] OMERS (2021) [A]
Description	• Rate: 3 mo. SOFR +7.00% (With PIK option: +7.25%) • Maturity: April 2028 bullet • Financial covenants: None • PIK option: 50% of interest for first six quarters	• Non-recourse (payments funded with revenues) • Considered a “debt instrument” per GAAP • An effective interest rate is calculated based on forecasted royalties, which determines interest expense • Current balance = prior balance + interest expense – royalty paid • If interest expense > royalties paid, balance increases • If royalties paid > interest expense, balance decreases

A – Royalty terms described on next slide

Royalty obligations: terms

	Upfront	Product	Rate Tiers (Key Territories[B])	Rate Tiers (Other Markets[B])	Cumulative Payback Cap
RP 2020	$125M	ORLADEYO	$0-350M: 8.75% $350M-550M: 2.75% Over $550M: None	$0-150M: 20% $150M-230M: 10% Over $230M: None	None
RP 2021	$150M[A]	ORLADEYO	$0-350M: 0.75% $350M-550M: 1.75% Over $550M: None	$0-150M: 3% $150M-230M: 2% Over $230M: None	None
OMERS 2021	$150M	ORLADEYO	$0-350M: 10% $350M-550M: 3% Over $550M: None	$0-150M: 20% $150M-230M: 10% Over $230M: None	1.55x

A – Royalty Pharma made an additional $50M equity investment in conjunction with the 2021 Royalty Purchase Agreement

B – The "Key Territories" include the United States, key European markets and other markets where ORLADEYO is sold directly or through distributors. The "Other Markets" include revenue from licensees outside the Key Territories.