



Hypoglycemia in Type 1 Diabetes and the Cadisegliatin Phase 3 Program

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Agenda

SESSION	KEY TOPICS	SPEAKER
Introduction	Purpose of the event (problem of hypoglycemia) & introduction of speakers	Paul Sekhri Chief Executive Officer
Inevitability of Hypoglycemia in T1D	Current practice/background; what is T1D?; incidence of T1D; SOC and treatment goals; drivers of hypoglycemia risk even with current device technology	Schafer Boeder, MD Paradigm Clinical Research & The University of California San Diego
Impact of Hypoglycemia on Daily & Long-Term Living	Underestimation of hypoglycemia; patients impacted & how; clinical and social aspects of hypoglycemia; how hypoglycemia concerns impact HCP treatment advice	
The Lived Experience of Type 1 Diabetes	Day in the life (carb. counting, insulin dosing decisions, device management, constant monitoring), quality of life, anxiety and fear of hypoglycemia, technology limitations	Alisa Weilerstein Living with Type 1 Diabetes
vTv Market Research	Reinforce KOL perspective with insights from market research	Martin Lafontaine Chief Commercial Officer
Cadisegliatin & Phase 3 CATT1	Glucokinase activation/MOA; Phase 2 data review; CATT1, CATT1 Hybrid designs	Klara Klein, MD, PhD University of North Carolina at Chapel Hill School of Medicine
Corporate Summary	Summary and upcoming events and catalysts	Paul Sekhri Chief Executive Officer
Q&A and Concluding Remarks	Open floor Q&A with concluding remarks	All

Featured Guest Speakers



Schafer Boeder, MD

Hypoglycemia in T1D

Board-certified endocrinologist, Medical Director at Paradigm Clinical Research, and Associate Professor of Medicine at the University of California San Diego



Alisa Weilerstein

Living with Type 1 Diabetes

Internationally acclaimed cellist and 2011 MacArthur Fellow; living with type 1 diabetes since age nine



Klara Klein, MD, PhD

Cadisegliatin & Phase 3 CATT1

Assistant Professor, Division of Endocrinology and Metabolism, University of North Carolina at Chapel Hill, and Director of the Endocrine Diabetes and Obesity Clinical Research Unit (EnDO CRU)



Hypoglycemia in T1D

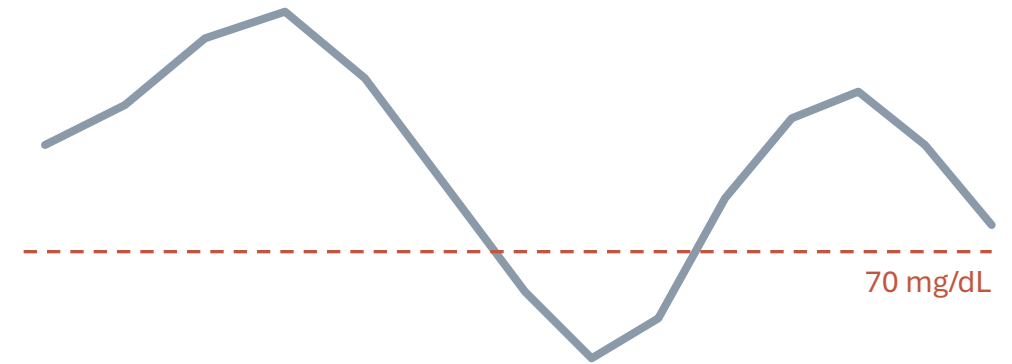
Schafer Boeder, MD

The Persistent Burden of Hypoglycemia

Severe events, frequent lows and daily life in type 1 diabetes

Schafer Boeder, MD

Endocrinologist and clinical investigator, type 1 diabetes
vTv Therapeutics Analyst & KOL Day · October 2026



Disclosures

Clinical research funding

Biomea Fusion	Novo Nordisk
Carmot Therapeutics	Pfizer
Dexcom	REMD Therapeutics
Eli Lilly	Structure Therapeutics
Lexicon Pharmaceuticals	vTv Therapeutics

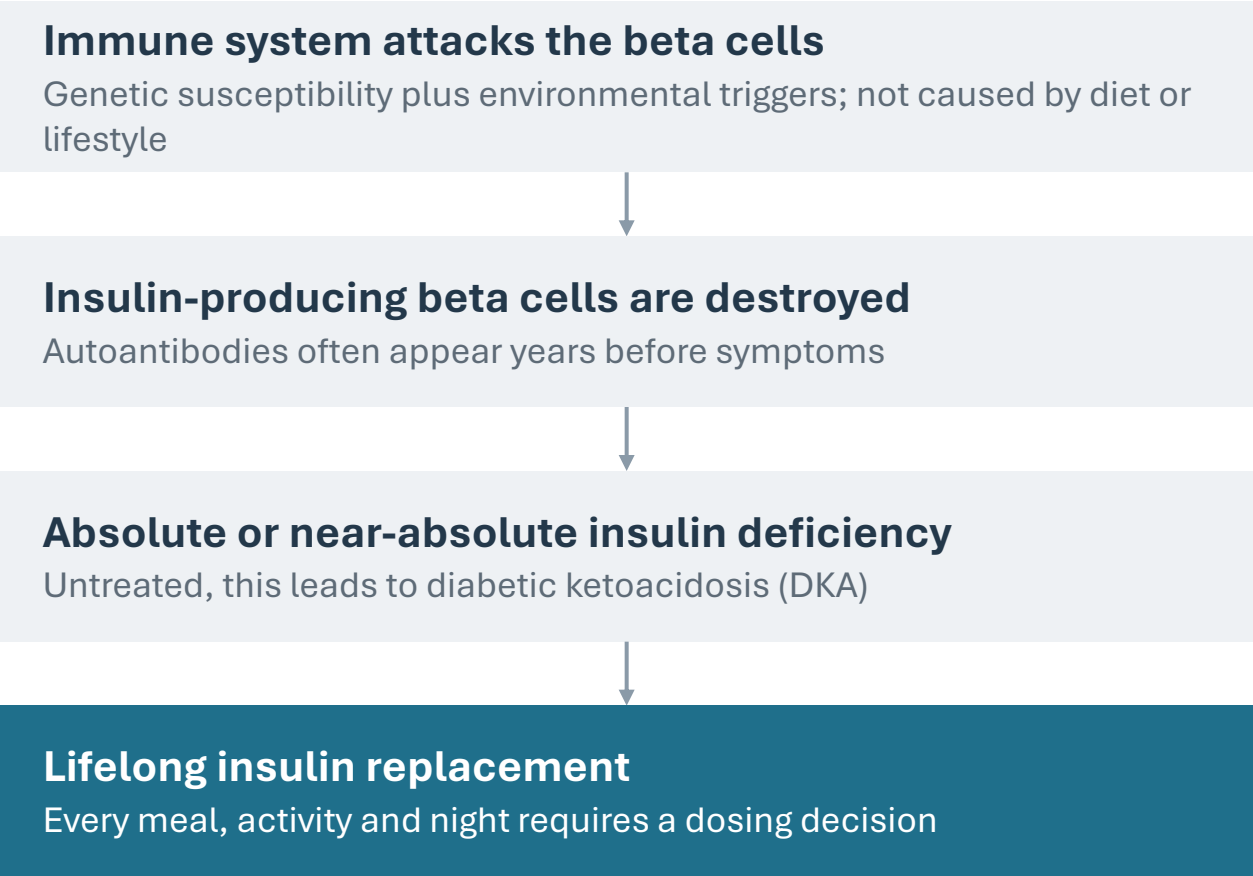
Consulting / Advisory

Cecelia Health
Novo Nordisk
Persperion Diagnostics

Grant funding

NIH
Breakthrough T1D
Diabetes Research Connection

T1D is autoimmune loss of insulin production; about 2.1 million Americans with T1D depend on lifelong insulin



WHO LIVES WITH T1D

2.1 million

Americans with diagnosed type 1 diabetes

1.8M

adults aged 20+ (~86%)

314K

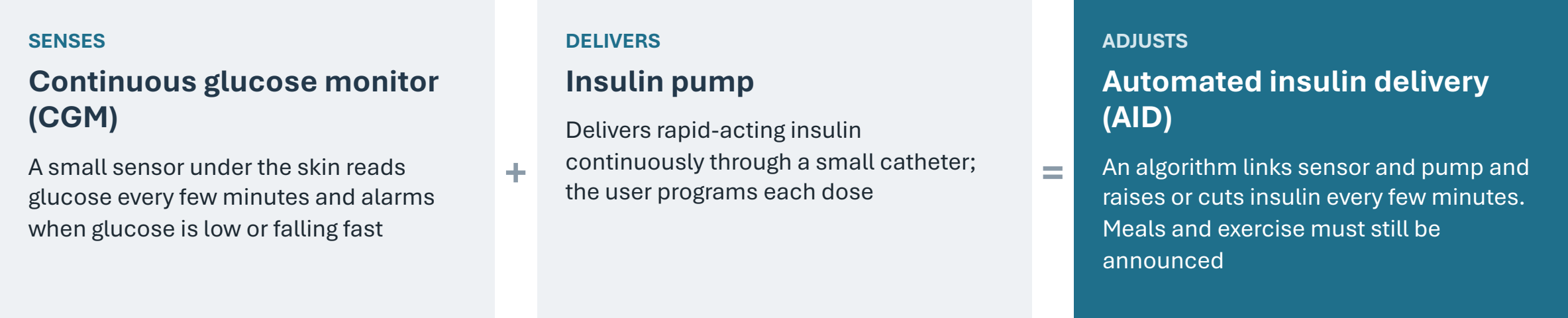
children and adolescents under 20

9.5M

people with T1D worldwide in 2025, projected to reach 14.7M by 2040; the largest growth is among adults

Sources: CDC National Diabetes Statistics Report (updated 2026; 2023 data); Ogle GD et al. Diabetes Res Clin Pract 2025;225:112277 (IDF Atlas 11th ed. / T1D Index v3.0); Holt RIG et al. ADA/EASD consensus report on the management of type 1 diabetes in adults. Diabetes Care 2026;49:1–42.

CGM and automated insulin delivery have transformed care, yet many adults still miss glucose targets



CGM VS. FINGERSTICK TESTING (24 STUDIES)

-0.24%

A1C (absolute)

+5.6%

time in range (absolute)

-2.4%

time below range (absolute)

42%

of adults using a 2nd generation AID, the most advanced systems studied, did not report an A1C of 7% or below

Sources: Holt RIG et al. Diabetes Care 2026 (ADA/EASD consensus; CGM meta-analysis); Wu Z, et al. Diabetes Obes Metab. 2026;28(2):1150–1159 (Canadian BETTER registry survey; second-generation AID, n=372; self-reported A1C). 42% calculated from 58.1% achieving A1C ≤7%.

Tighter glucose control reduces long-term complications but raises the risk of hypoglycemia

Intensive insulin therapy lowers average glucose to reduce long-term risk, which moves people closer to the hypoglycemia edge



Harm in minutes to hours

Confusion, seizure, loss of consciousness, falls and accidents

Harm over years

Damage to eyes, kidneys, nerves and blood vessels; DKA when insulin is missing

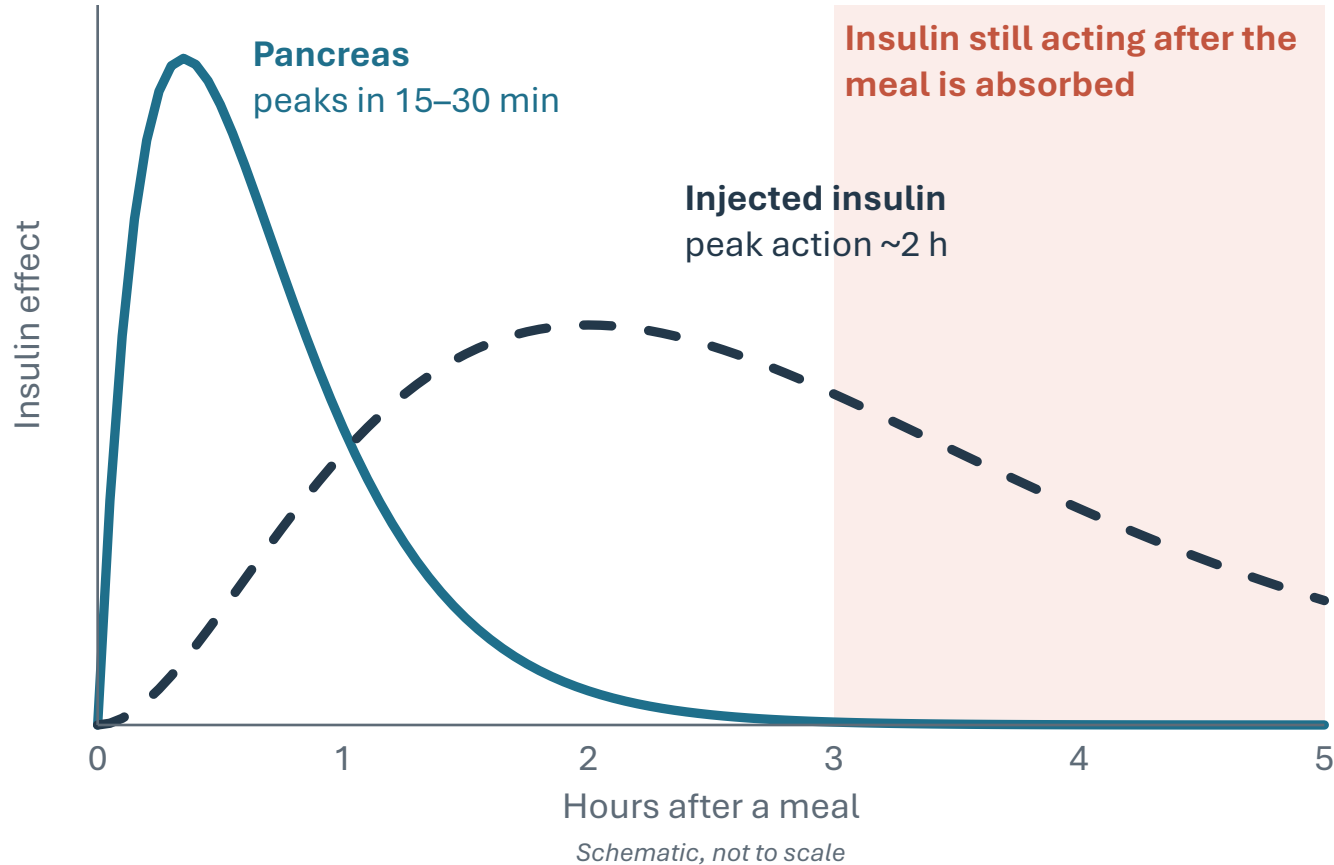
INTENSIVE VS. CONVENTIONAL THERAPY IN THE DCCT (1,441 PEOPLE, ~6.5 YEARS)

39–76% lower risk of eye, kidney and nerve complications

2–3× higher rate of severe hypoglycemia

Sources: DCCT Research Group. N Engl J Med 1993;329:977–986; Holt RIG et al. Diabetes Care 2026 (ADA/EASD consensus). Glucose thresholds per ADA/EASD CGM targets.

Insulin injected under the skin cannot reproduce the timing of the pancreas



Wrong route

The pancreas releases insulin into the vein to the liver, which clears about 70% before it reaches the rest of the body

Wrong timing

Insulin injected under the skin is absorbed slowly, peaks around 2 hours and lingers for hours

No recall

Once delivered, insulin cannot be removed. AID can stop giving more, but cannot take back what is already acting

T1D also impairs the body’s natural defenses against falling glucose

AS GLUCOSE FALLS TO	WITHOUT DIABETES	IN TYPE 1 DIABETES	
~80 mg/dL	Pancreas stops releasing insulin	LOST	Injected insulin keeps acting
~65–70 mg/dL	Pancreas releases glucagon, which tells the liver to release glucose	LOST	Glucagon response is typically lost within a few years of diagnosis
~65–70 mg/dL	Adrenaline rises and raises glucose	REDUCED	Often blunted, especially after recent lows
~50–55 mg/dL	Warning symptoms (shaking, sweating, hunger) prompt the person to eat	REDUCED	Can be weak or absent: impaired awareness

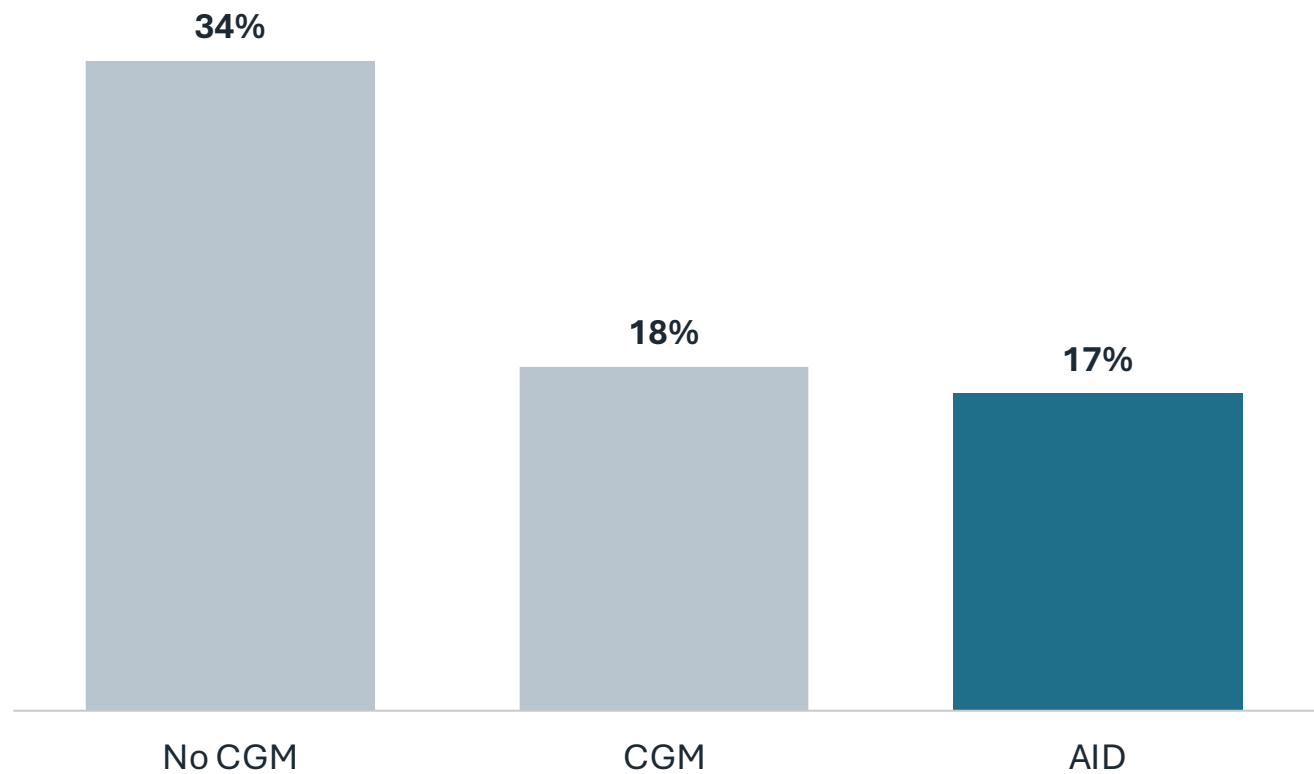
MEANWHILE, INSULIN NEEDS CHANGE HOUR BY HOUR WITH

- Meals
- Exercise
- Sleep
- Illness
- Alcohol
- Stress and hormones
- Variable absorption

Glycemic thresholds are approximate. Sources: Cryer PE. Diabetes 2008;57:3169–3176 (counterregulation and hypoglycemia-associated autonomic failure); Holt RIG et al. Diabetes Care 2026 (ADA/EASD consensus).

AID lowers hypoglycemia, but severe events persist among technology users

Adults with ≥1 severe hypoglycemic event in the past year, by technology
T1D Exchange online survey, 2021 (n=2,074)



AMONG AID USERS

1 in 6
reported a severe event in the past year

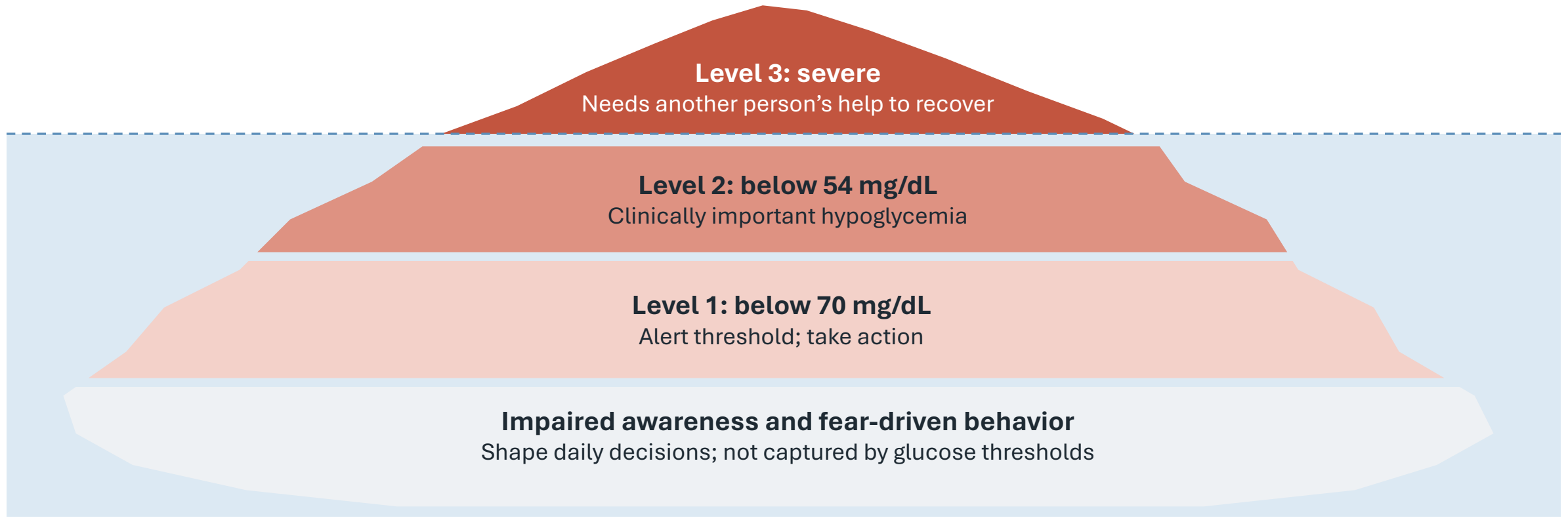
SEVERE HYPOGLYCEMIA EMERGENCIES, US ADULTS

25.7 **25.6**
2011 2020

Adjusted rate per 1,000 person-years, claims-based study of 67,901 U.S. adults with T1D (2011–2020). No meaningful decline over a decade of new insulins and devices

Severe hypoglycemia is self-reported (survey) or emergency/hospital-coded (claims), which likely undercounts events treated at home. Sources: Sherr JL et al. Diabetes Care 2024;47:941–947; McCoy RG, et al. Diabetes Care. 2023;46:e69–e71.

Hypoglycemia is a spectrum; severe events are only its most visible part



~1 hour a day

below 70 mg/dL still meets the <4% consensus target

~14 minutes a day

below 54 mg/dL still meets the <1% target

Four clinically meaningful hypoglycemia burdens

CURRENT EXPOSURE

Frequent Level 2

Below 54 mg/dL daily, almost daily or a few times per week

Why it matters

Impairs thinking during episodes; repeated lows blunt defenses

25% survey

Published: No directly comparable published estimate found

HISTORY

Prior severe (Level 3)

At least one episode in the past year that needed another person's help

Why it matters

Strongest predictor of the next severe event

15% survey

Published: 20% in T1D Exchange survey

PHYSIOLOGY

Impaired awareness

Rarely or never feels the warning symptoms of a low

Why it matters

Raises severe-event risk; first sign may be confusion

18% survey

Published: 25–30% (ADA/EASD consensus)

BEHAVIOR

Fear-driven avoidance

A1C above 7% and strongly agrees they keep glucose high, or can't aim lower, because of lows

Why it matters

Trades hypoglycemia risk today for complication risk later

46%* survey

Published: 43% reported fear as a barrier to glycemic targets (adult T1D study; different definition)

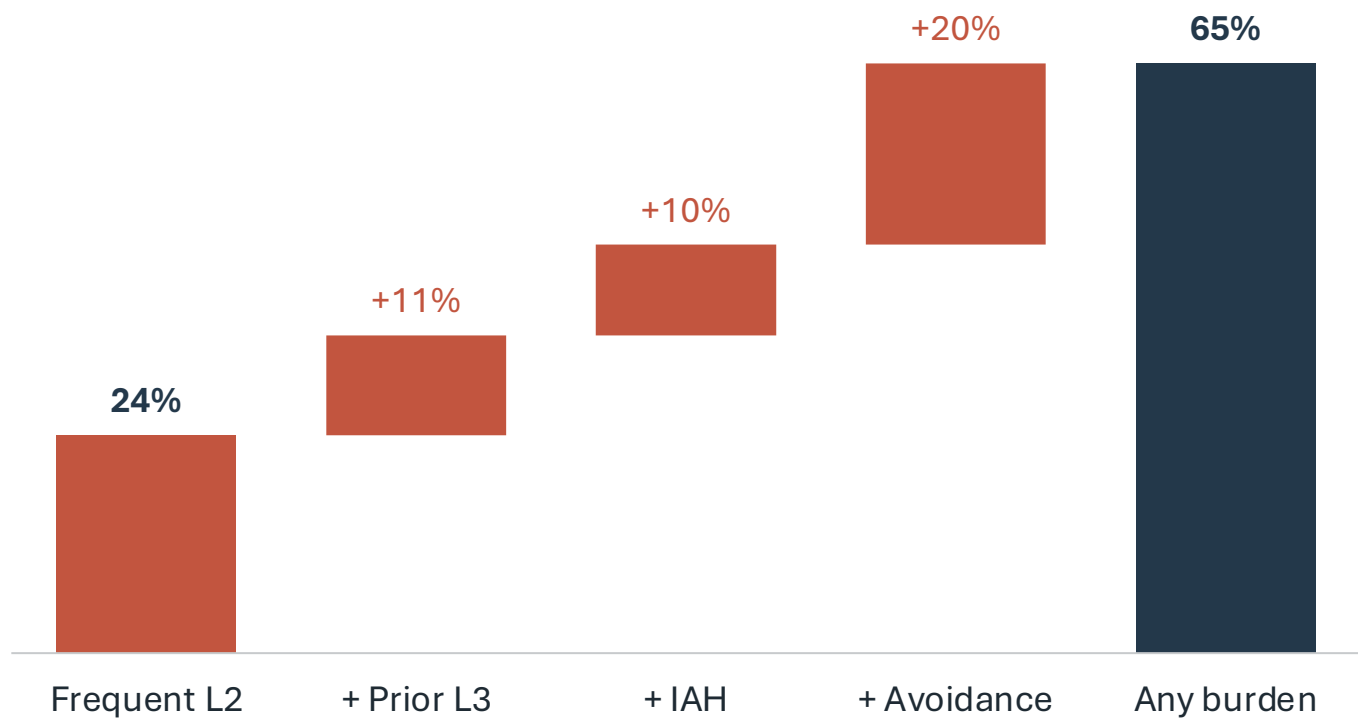
These groups overlap. Percentages describe each group separately and cannot be added together.

*Share of adults with A1C >7%. Survey: dQ&A online panel of US adults with T1D, Jul–Aug 2025 (n=674), self-reported; sponsored by vTv Therapeutics (IHSG 2026 presentation).
Published: Sherr JL et al. Diabetes Care 2024;47:941–947; Holt RIG et al. Diabetes Care 2026; Talbo et al. Endocrine Practice. 2026;32(5):720–727.

Removing the overlap, about two-thirds of adults with T1D carry at least one clinically meaningful hypoglycemia burden

Adults with T1D with ≥1 clinically meaningful direct or indirect hypoglycemia burden, each person counted once

Weighted for A1C distribution



HOW EACH PERSON IS COUNTED ONCE

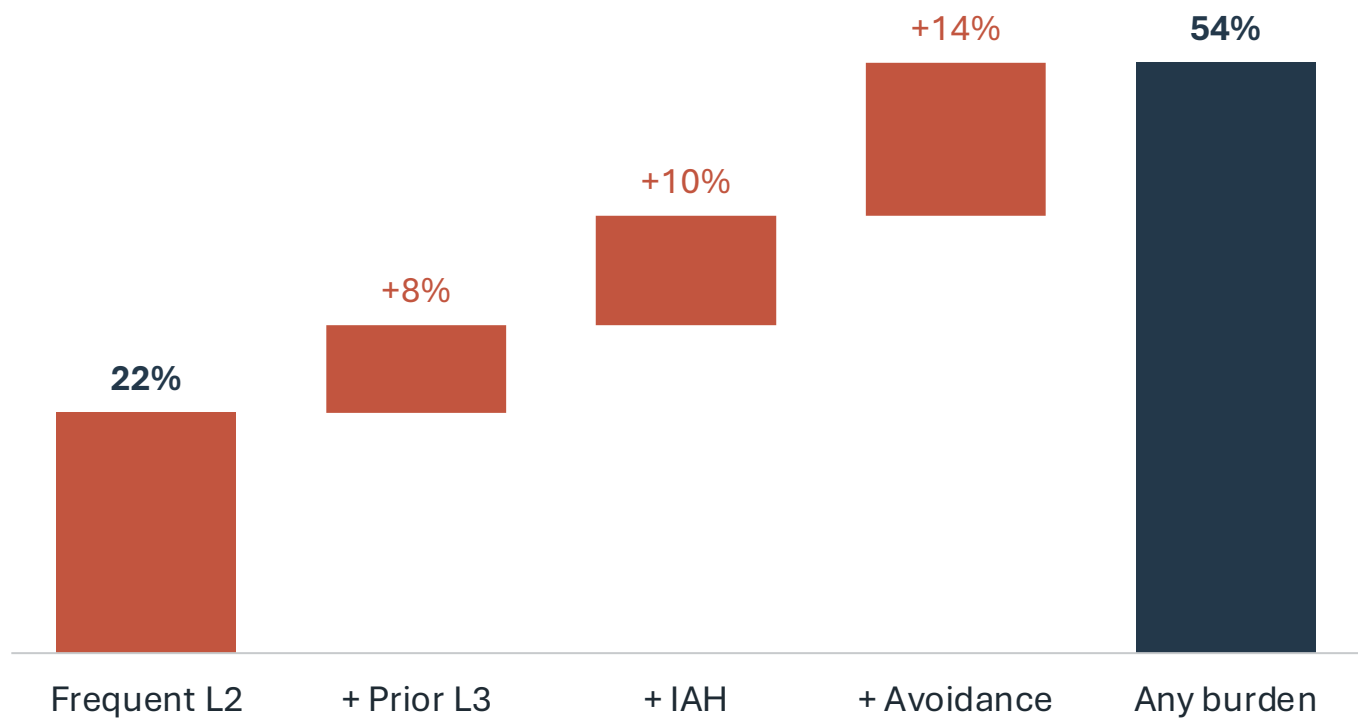
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IAH, impaired awareness of hypoglycemia
Survey: dQ&A online panel of US adults with T1D, Jul–Aug 2025 (n=674; 64% A1D, 31% MDI+CGM, 5% MDI); self-reported; sponsored by vTv Therapeutics.
Sources: Bell T et al., IHSG Advances in Hypoglycemia 2026.
A1C weighting per Ebekoziien O, et al. Longitudinal trends in glycemic outcomes and technology use for over 48,000 people with type 1 diabetes (2016–2022) from the T1D exchange quality improvement collaborative. Diab Technol Ther 2023 Nov;25(11):765-73.

Removing the overlap, about half of adults with T1D on AID carry at least one clinically meaningful burden

Adults with T1D on AID with ≥ 1 clinically meaningful direct or indirect hypoglycemia burden, each person counted once

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Source: Bell T, et al. Breakthrough T1D Clinical & Research Congress 2026.
A1C weighting per Wu Z, et al. Diabetes Obes Metab. 2026;28(2):1150-1159 (BETTER registry analysis).

Hypoglycemia shapes the whole day, not just the minutes of an episode



NIGHT

Sleep

Lows during sleep are often missed or wake the person and family; the next day starts tired



BEFORE DRIVING

Driving

Glucose must be checked and safe before getting behind the wheel



WORKDAY

Work

A low slows thinking and speech and interrupts meetings, exams and shifts



AFTER WORK

Exercise

Activity needs planning: less insulin, extra carbohydrate, lows hours later



EVENINGS AND TRAVEL

Social life

Meals out, alcohol, time zones and new routines all raise risk

AROUND THE CLOCK

Constant vigilance

Checking the CGM and making dosing and food decisions many times a day

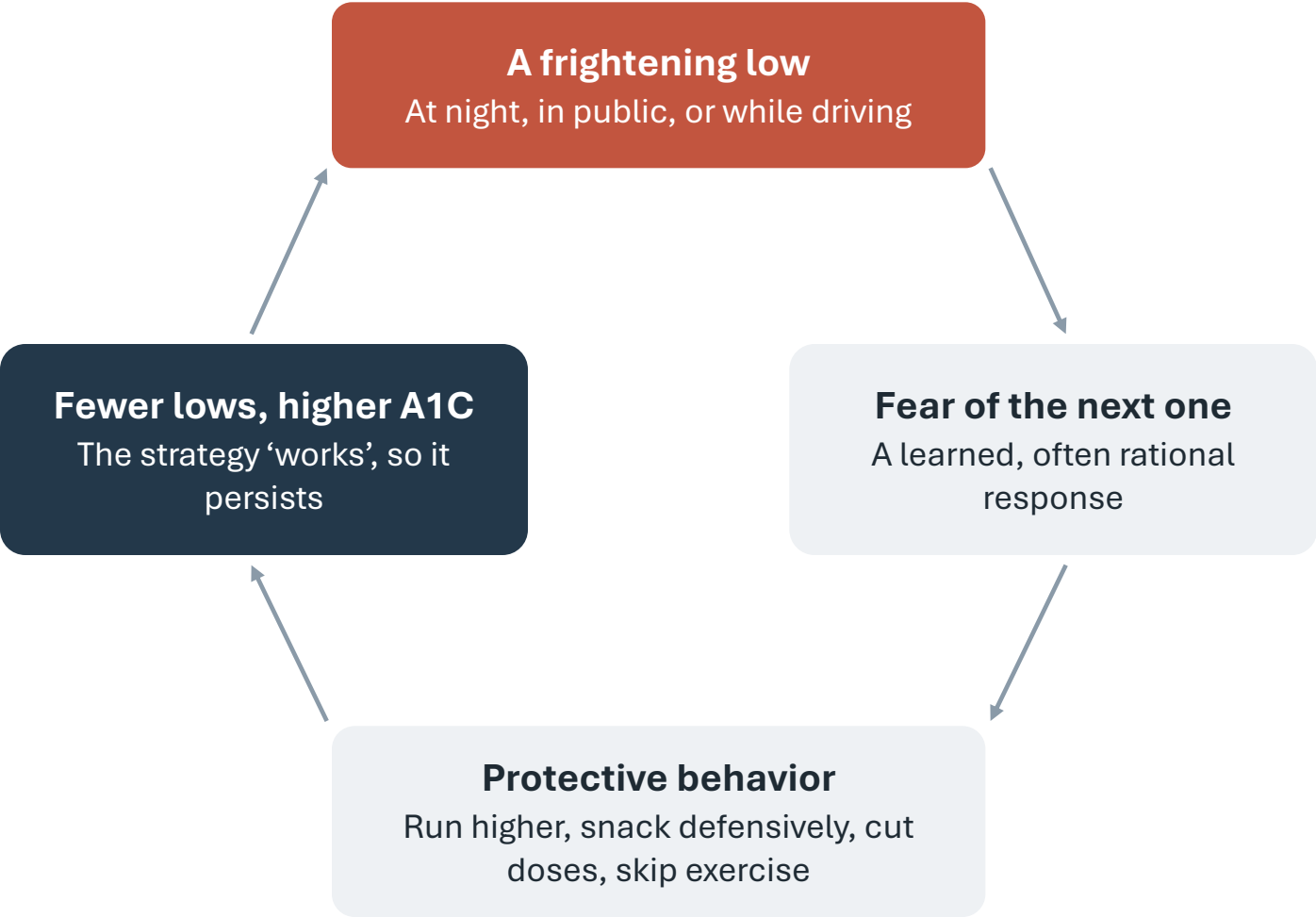
Always prepared

Carrying fast-acting glucose and glucagon everywhere

Shared burden

Partners and parents follow alerts remotely and wake at night

Fear of hypoglycemia is often a learned, rational response, and it pulls glucose higher



FEAR AS A BARRIER

43%

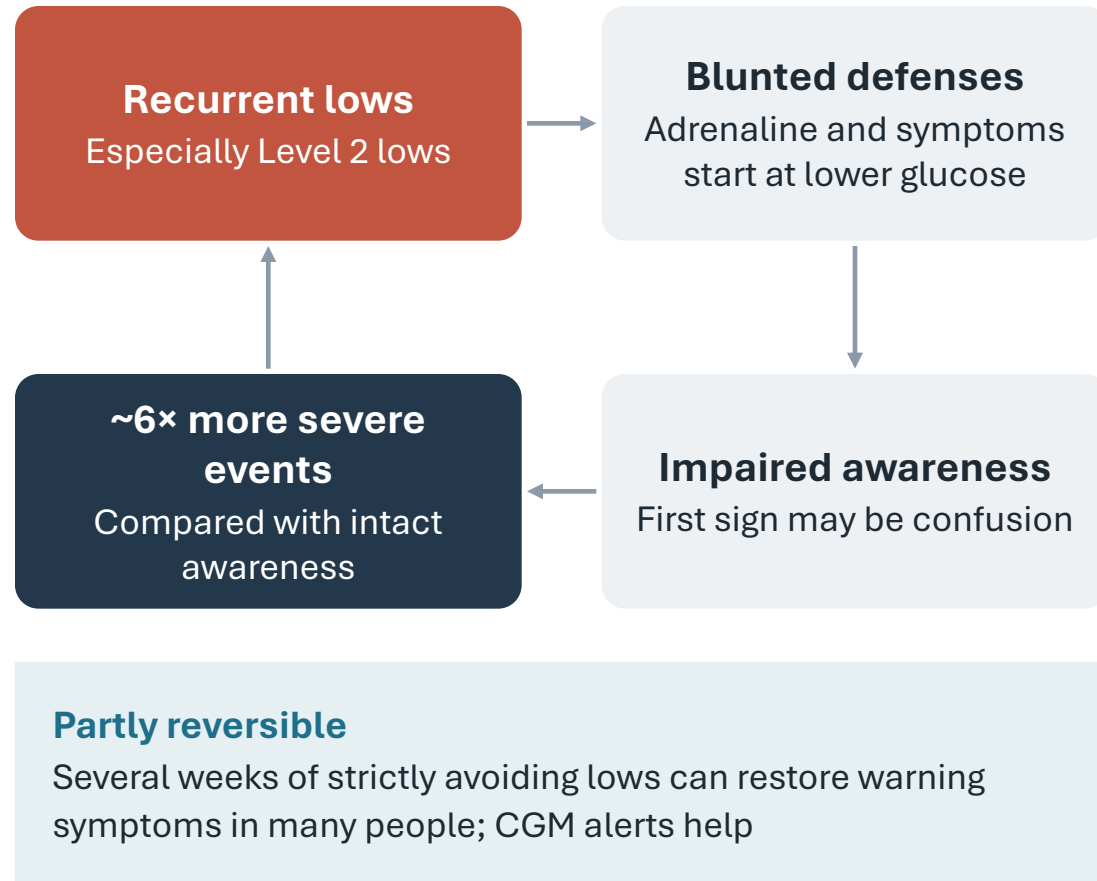
of adults with T1D said fear of hypoglycemia keeps them from reaching optimal glucose levels

Online registry of adults with T1D (n=1,437); single screening question

+0.48% higher A1C on average in those who saw fear as a barrier, after adjustment

Recurrent lows blunt the warning system; acute harms are established, long-term effects less certain

THE IMPAIRED-AWARENESS CYCLE



CONSEQUENCES, BY STRENGTH OF EVIDENCE

ESTABLISHED

- Impaired thinking, judgment and coordination during episodes
- Seizure or loss of consciousness in severe events
- Falls, injuries and driving accidents
- Acute cardiac effects, including altered heart rhythm

ASSOCIATED

- Higher cardiovascular events and mortality after severe episodes; causality not proven
- Estimated >8% of deaths in people with T1D under 56
- Small cognitive decrements after decades of severe events (DCCT-EDIC, 32 years)

Technology has helped reduce the hypoglycemia problem, but has not removed it

1 Hypoglycemia is intrinsic to insulin replacement
Injected insulin cannot switch off, and T1D removes the body's own defenses

2 The burden is broad
Frequent Level 2, prior severe events, impaired awareness and fear-driven avoidance: up to 65% of adults in a 2025 survey

3 Technology has helped reduce the problem
CGM and AID reduce lows, yet ~54% AID of users still report at least one clinically meaningful hypoglycemia burden

4 Hypoglycemia shapes behavior and control
Avoiding lows keeps glucose higher, trading safety today for complication risk later

CGM and AID have transformed type 1 diabetes care, but they have not removed the burden of hypoglycemia. Its clinical burden reaches well beyond severe events.



The Lived Experience of Type 1 Diabetes

Alisa Weilerstein



vTv Market Research

Martin Lafontaine

Living with T1D is Like Driving on a Narrow, Slippery and Dangerous Road



Hyperglycemia:
cumulative, long-term
organ damage

TOO LITTLE
INSULIN

TOO MUCH
INSULIN

! Hypoglycemia: immediate
neurologic damage

Cadisegliatin: A Large Opportunity in a Long-Underserved Market

~2M

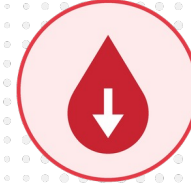
with type 1 diabetes in the U.S.^{1,2}

~9.5M people living with T1D globally in 2025, expected to grow to 14.7M by 2040³

~75%

with T1D fail to lower their blood glucose to achieve target HbA1c⁴

By not achieving the ADA recommended target of HbA1c <7.0%, people with T1D are exposed to an increased risk of diabetes-related complications⁵



Hypoglycemia

Hypoglycemia is common in people with T1D and most have several mild to moderate events per week⁶

Hypoglycemic events range from life-disruptive to life-threatening

Hypoglycemia is the most important limiting factor in the glycemic management of T1D⁵

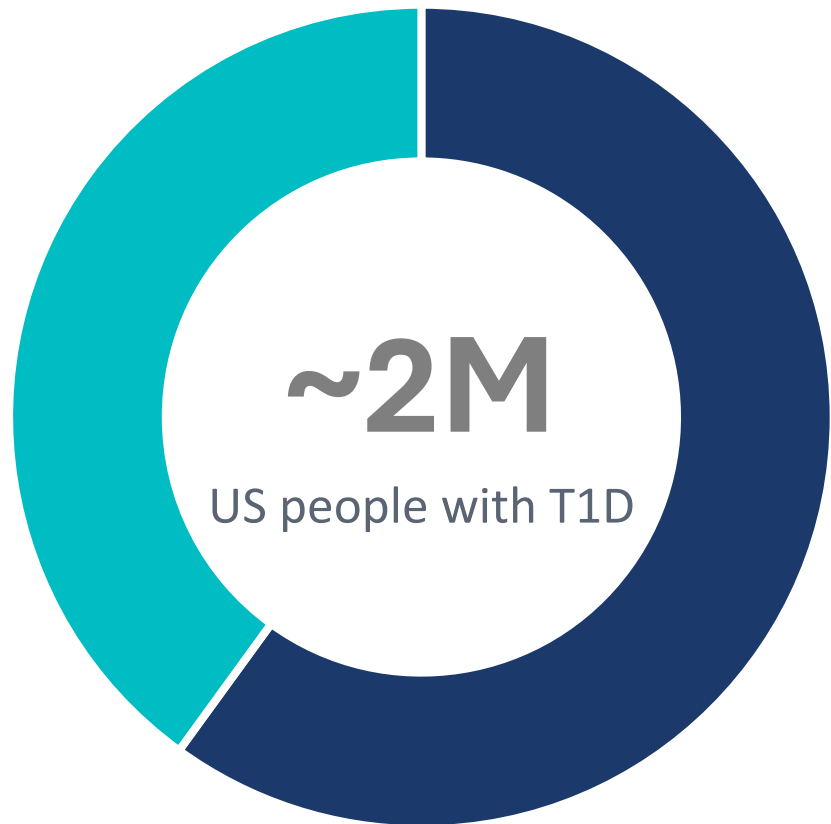
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Oral adjunctive therapies for T1D

Since insulin was discovered in 1921, no oral adjunctive therapy (one injectable) to treat T1D has been approved in the U.S.

Current Therapy Landscape – US T1D

~2 million US people with T1D^{1,2}, by insulin delivery method



● **~60%**

Multiple Daily Injections, CGM or BGM⁴

~1.2 million people⁵

● **~40%**

Pump/Automated Insulin Delivery³

~800,000 people⁵

No oral FDA-approved adjunct therapy to insulin to manage blood glucose in T1D

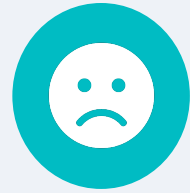
Hypoglycemia Burden: Beyond the Frequency or Severity of Episodes

In a recent survey¹ with 702 US Adults living with T1D:

T1D INDIVIDUALS

PERSPECTIVE

What people living with type 1 diabetes say about low blood glucose



88%

strongly agree or somewhat agree with the sentence:
"I hate having low blood glucose."



87%

of adults with T1D with an HbA1C >7% strongly agree or somewhat agree to **often** keeping their blood glucose higher than they should to avoid lows, **or** that they would aim for lower blood glucose if it was not for the risk of hypoglycemia



85%

of adult AID users with an HbA1C >7% strongly agree or somewhat agree to **often** keeping their blood glucose higher than they should to avoid lows, **or** that they would aim for lower blood glucose if it was not for the risk of hypoglycemia

Hypoglycemia is the most important limiting factor in the glycemic management of T1D²

ADA/EASD 2026 Consensus Report on the Management of T1D in Adults

1: vTv Data on File, dQ&A Consumer Market Research, 2025 (N=702). For presentation purposes only: findings reflect a survey of 702 respondents and should not be generalized to the entire T1D population. 88%: all respondents (N=702). 87% and 85%: only respondents with available HbA1c data and HbA1c >7.0% (n=185 and AID users n=102, respectively). Survey questions: "When thinking about your experiences with hypoglycemia, how much do you agree or disagree with the following statements?" (Strongly disagree – Strongly agree, 5-point scale). I hate having low blood glucose. I often keep my blood glucose higher than I should to avoid lows. If it were not for the risk of hypoglycemia, I would aim for lower blood glucose; 2: The Management of T1D in Adults. The Updated 2026 Consensus Report by the American Diabetes Association (ADA) and the European Association for the Study of Diabetes (EASD). September 2026.



ENDOCRINOLOGISTS
PERSPECTIVE

*What US adult
endocrinologists say and
think about hypoglycemia*

Hypoglycemia is a Top Priority and Concern for Endocrinologists

In a recent survey¹ with 45 US Adult Endocrinologists treating people with T1D:



85%

said that the short-term risk of hypoglycemia is an equal or higher treatment priority than the long-term hyperglycemia risk for most of their T1D patients



78%

strongly agree or agree that avoiding hypoglycemia is a significant challenge in managing their T1D patients



86%

strongly agree or agree that fear of hypoglycemia significantly interferes with patients trying to achieve an HbA1c < 7.0% (53 mmol/mol)

Hypoglycemia is the most important limiting factor in the glycemic management of T1D²

ADA/EASD 2026 Consensus Report on the Management of T1D in Adults

1: dQ&A EU and US Endocrinologists Market Research. Data on file. 2026. N=45 US Adult Endocrinologists. For presentation purposes only: findings reflect a survey of 45 US endocrinologists and should not be generalized to the entire endocrinologist population. Survey questions: Q1: How do you balance long-term hyperglycemia risk vs. short-term hypoglycemia risk when setting treatment priorities for your T1D patients? Long-term risks from hyperglycemia are significantly more important / Long-term risks from hyperglycemia are slightly more important, both have equal importance / Short-term risks from hypoglycemia are slightly more important / Short-term risks from hypoglycemia are significantly more important. Q2: How much do you agree or disagree with statements about hypoglycemia and your T1D patients? (Strongly disagree – Strongly agree, 5-point scale) Avoiding hypoglycemia is a significant clinical challenge in managing my patients. Q3: Fear of Hypoglycemia significantly interferes with patients achieving an HbA1C < 7.0% (53mmol/mol) (Strongly disagree – Strongly agree, 5-point scale); 2: The Management of T1D in Adults. The Updated 2026 Consensus Report by the American Diabetes Association (ADA) and the European Study for Diabetes (EASD) September 2026.

Reducing the Risk of Hypoglycemia Total Addressable Market in T1D (TAM)

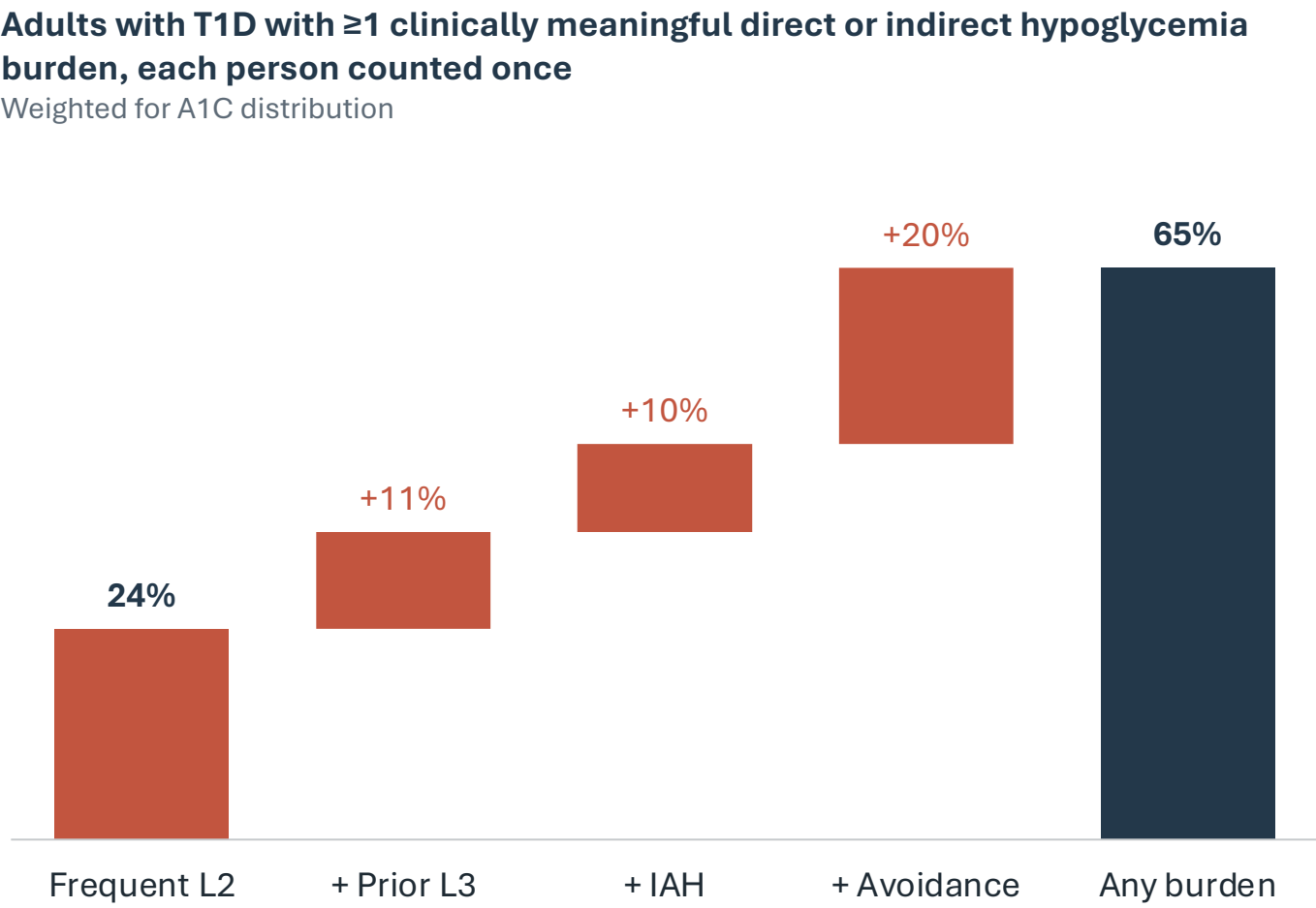
Our belief: virtually all individuals with T1D, independent of technology



- Hypoglycemia risk is an inherent risk to disease management in practically all individuals with T1D as exogenous insulin is not subject to the body's normal feedback mechanisms^{1,2}
- Real-world prevalence data show that hypoglycemia exposure is near-universal, not occasional, with most individuals with T1D having several episodes of mild-to-moderate hypoglycemia events each week^{3,4,5}

Note: "Virtually all" reflects that nearly all adults with T1D are candidates for a therapy that may reduce hypoglycemia risk; a small subset (e.g., contraindications, those having received pancreatic transplant) may fall outside the addressable population.

Removing the overlap, about two-thirds of adults with T1D carry at least one clinically meaningful hypoglycemia burden



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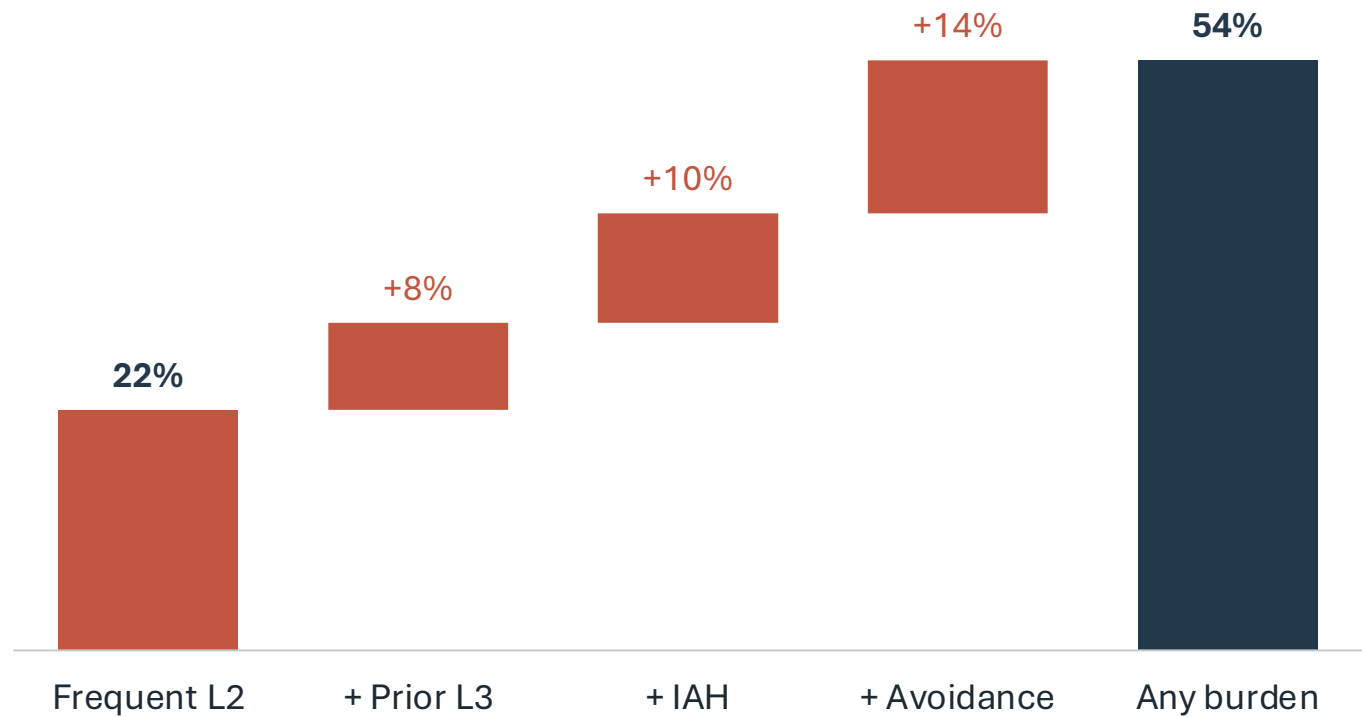
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Survey: dQ&A online panel of US adults with T1D using AID, Jul 17–Aug 1, 2025 (n=429 of 674); self-reported; sponsored by vTv Therapeutics.

Source: Bell T, et al. Breakthrough T1D Clinical & Research Congress 2026.

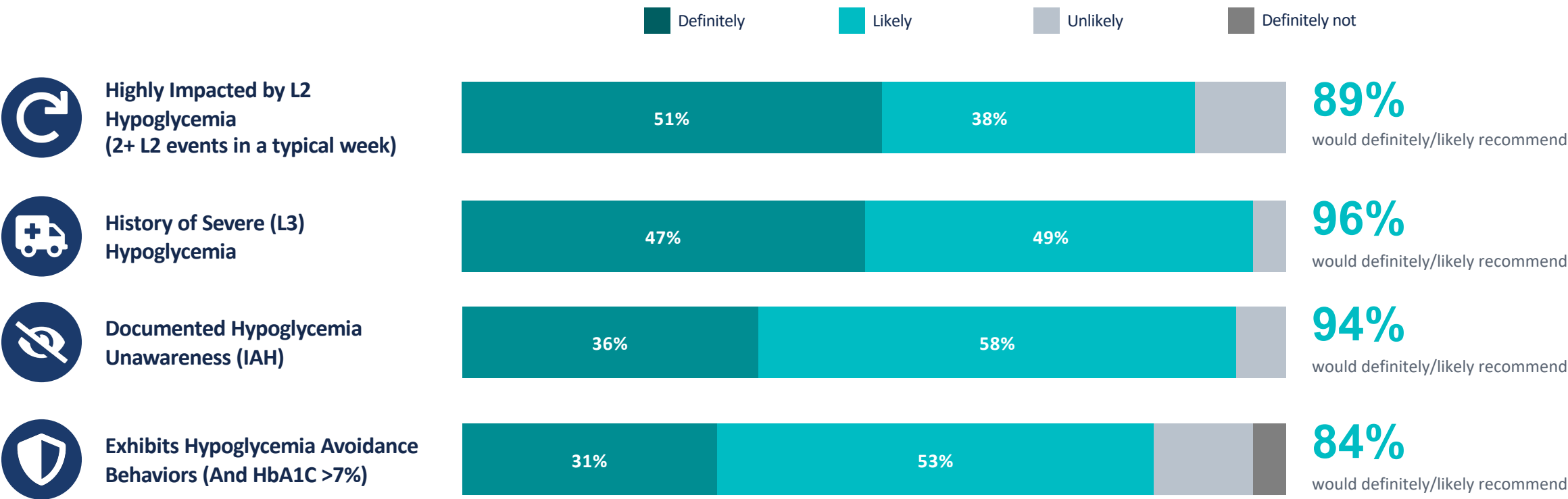
A1C weighting per Wu Z, et al. Diabetes Obes Metab. 2026;28(2):1150-1159 (BETTER registry analysis).

US Adult Endocrinologists likelihood to Recommend a Hypoglycemia-Reducing Therapy Across All Four Hypoglycemia Burden Segments¹

How likely would you be to recommend a once daily oral adjunct therapy to insulin to your Type 1 patients who fit the following criteria? (Definitely / Likely / Unlikely / Definitely not).

Potential benefits include a

- 30% reduction in the combined Level 2 and severe hypoglycemia events
- No change in HbA1c or Time-In-Range (no improvement or no worsening in patients with an average HbA1c of 7.5% at baseline)
- A 5% Insulin Daily Dose reduction.
- Respondents were also given a quick explainer on the MOA and were told to assume the therapy was generally well tolerated with no additional risks of weight gain, nausea, diabetic ketoacidosis (DKA) or high cholesterol compared to only using insulin, and that the therapy would be covered by insurers.





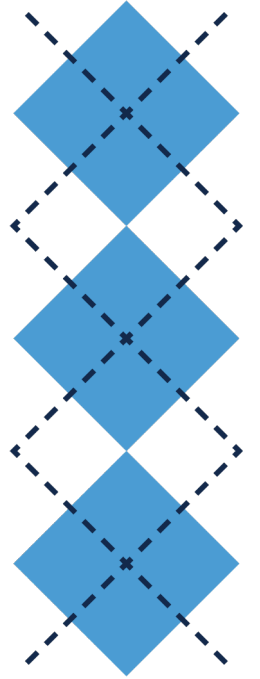
Cadisegliatin and the Phase 3 CATT1 Program

Klara Klein, MD, PhD

Cadiseagliatin as an adjunctive therapy to insulin in people living with type 1 diabetes

Klara Klein, MD, PhD

**Assistant Professor, Division of Endocrinology and Metabolism
Director, Endocrine, Diabetes, and Obesity Clinical Research Unit**



**School of
Medicine**

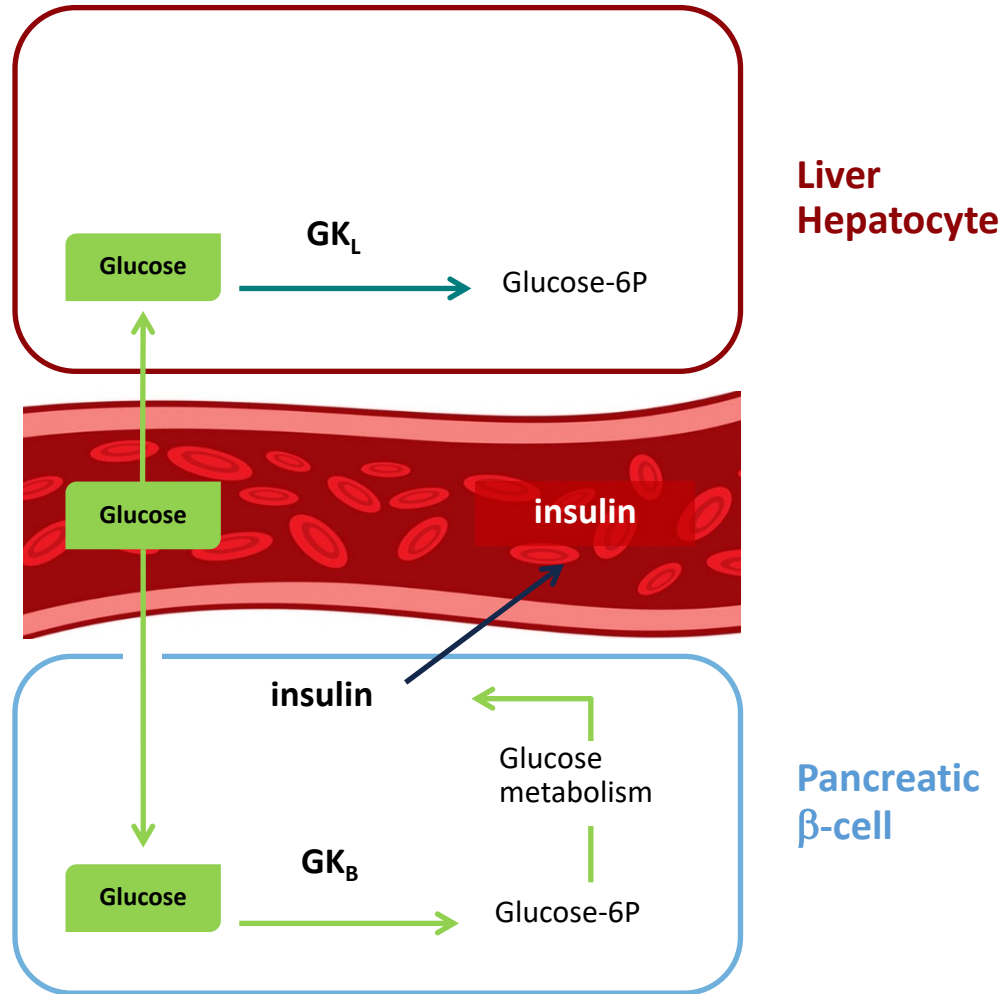
Disclosures

- I have consulted for Antag Therapeutics, Corxel, Eli Lilly and Company, Novo Nordisk, Pfizer, Roche Pharmaceuticals, and vTv Therapeutics.
- I received research related contracts (paid to the institution) from Bayer, Boehringer-Ingelheim, Carmot, Diasome, Gentibio, Eli Lilly and Company, Novo Nordisk, Rhythm Pharmaceuticals, Roche Pharmaceuticals, and vTv Therapeutics.

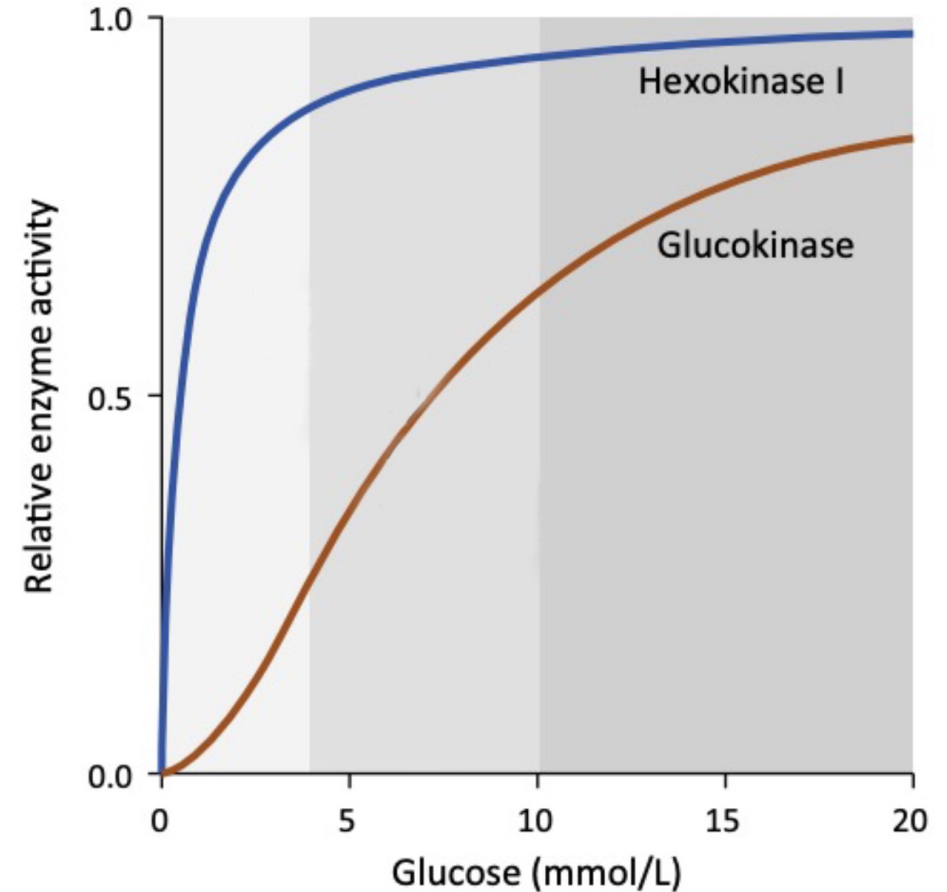
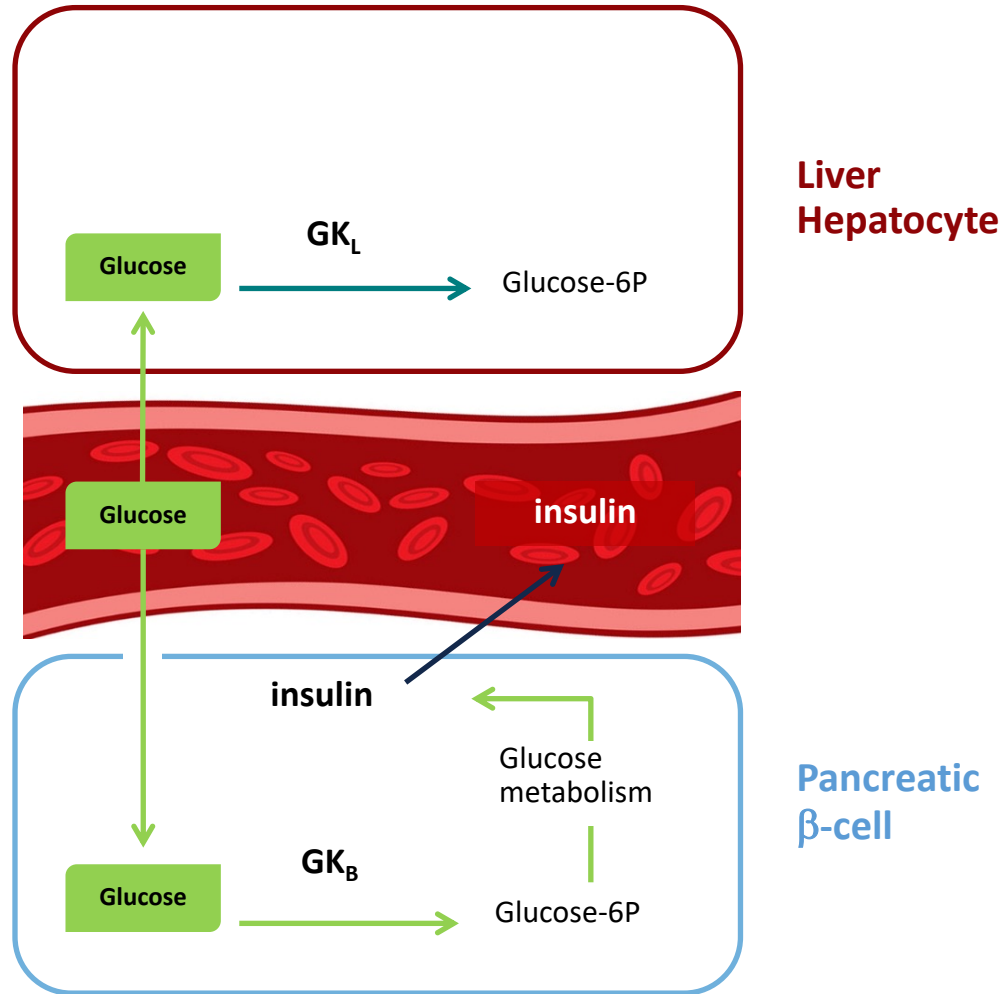
Objectives

- **Overview of cadisegliatin mechanism of action**
- **Review of cadisegliatin Phase 2 data**
- **Outline of ongoing and upcoming cadisegliatin trials**

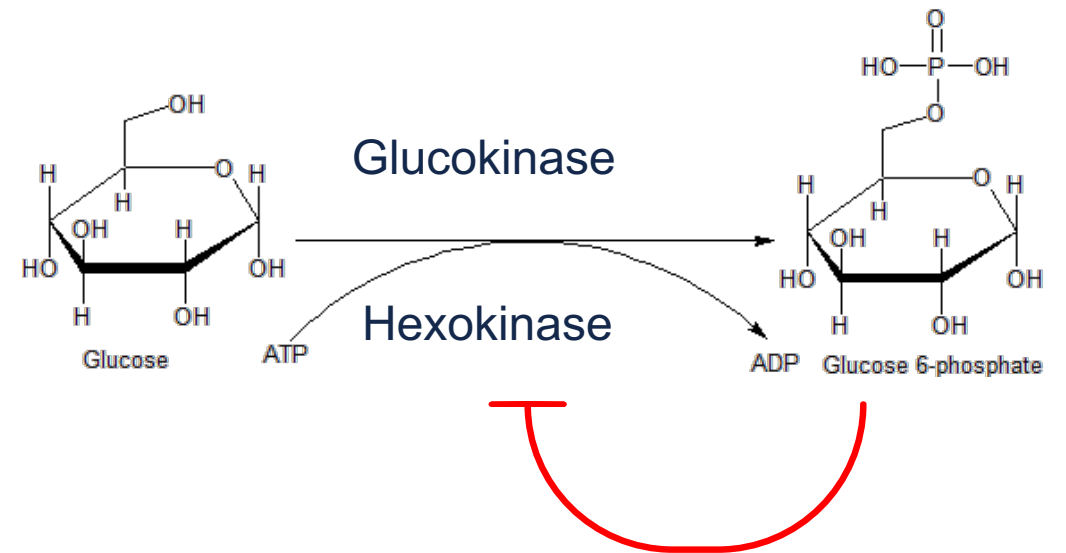
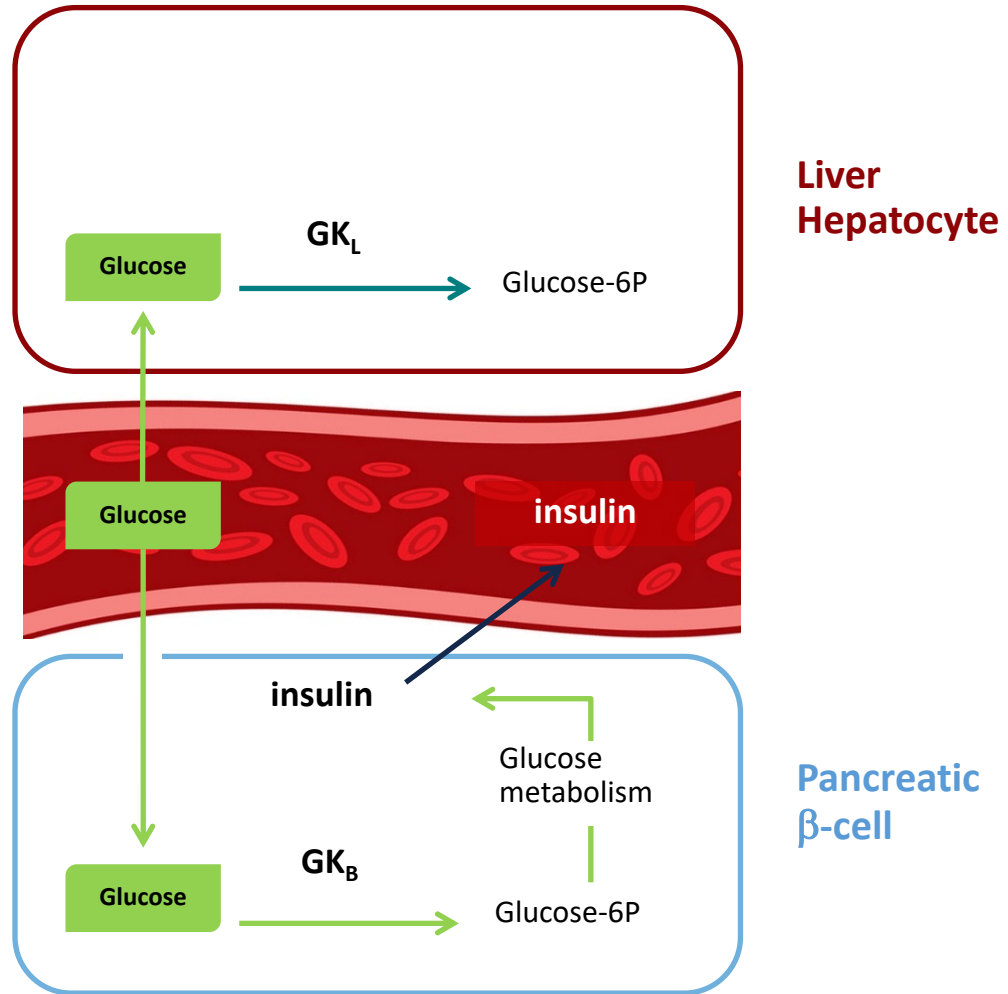
Glucokinase (GK) is a molecular glucose sensor



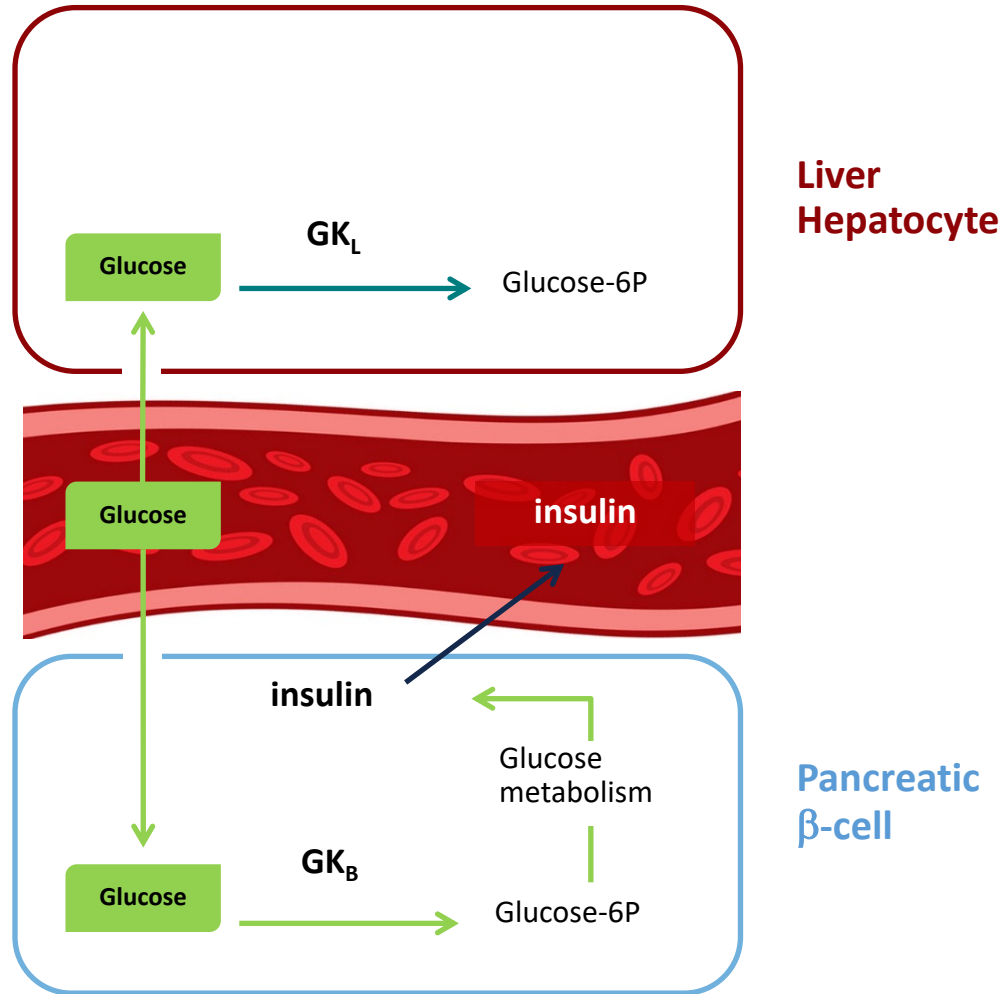
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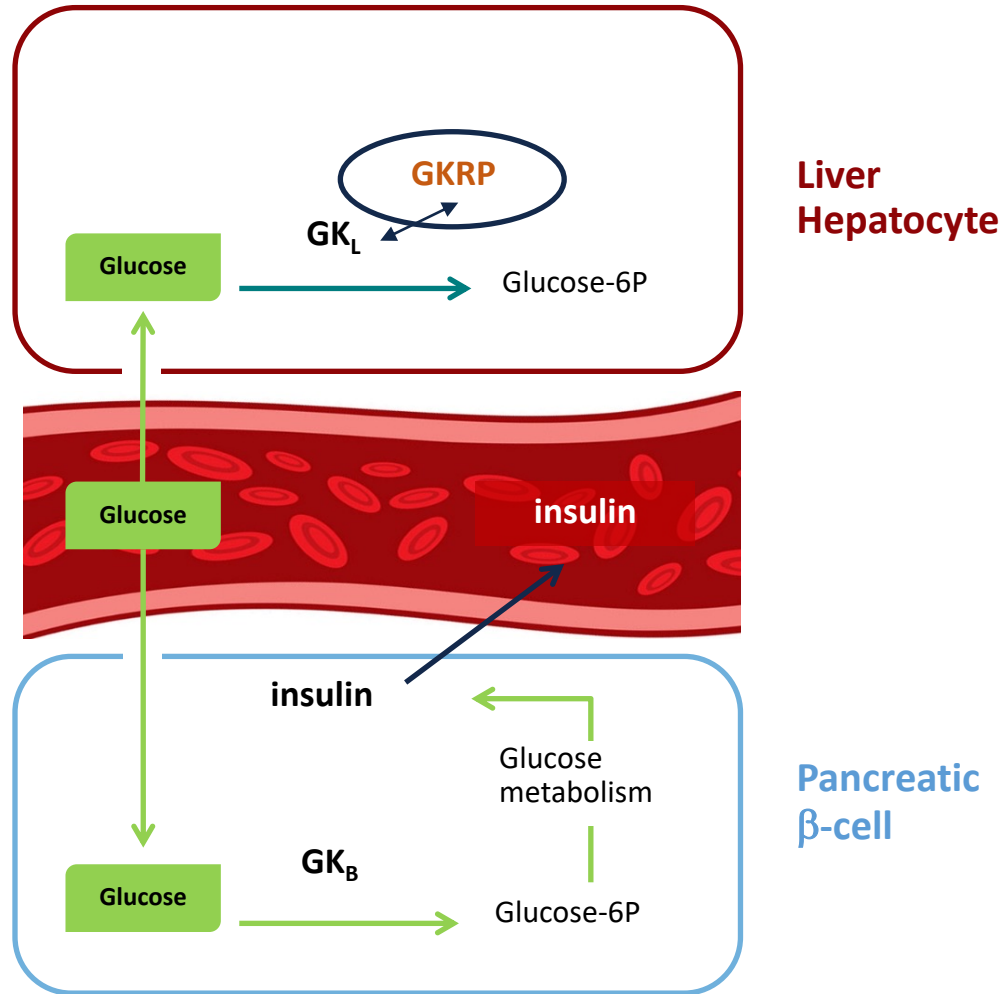
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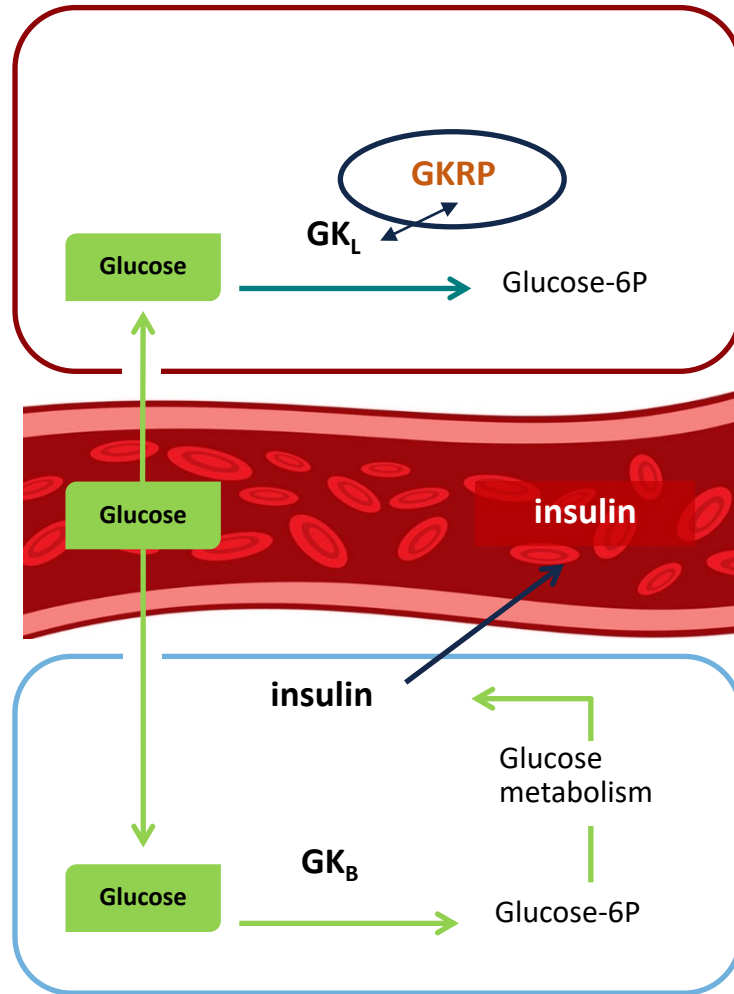
Hepatic GK has unique properties



Hepatic GK has unique properties

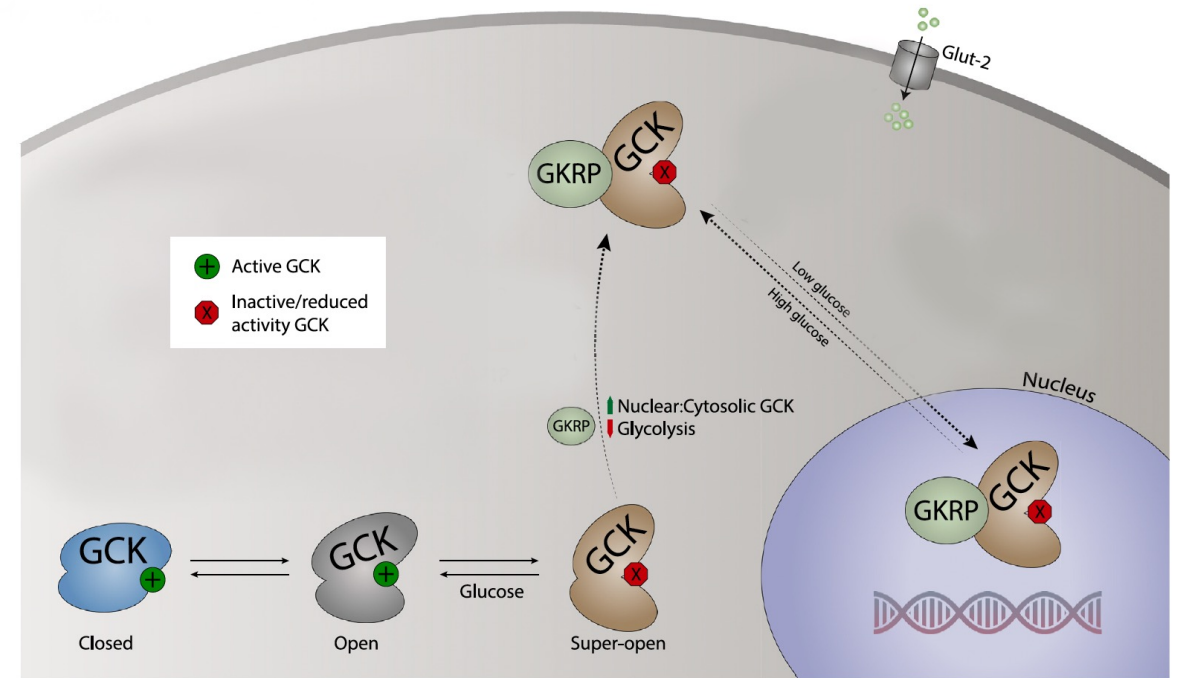


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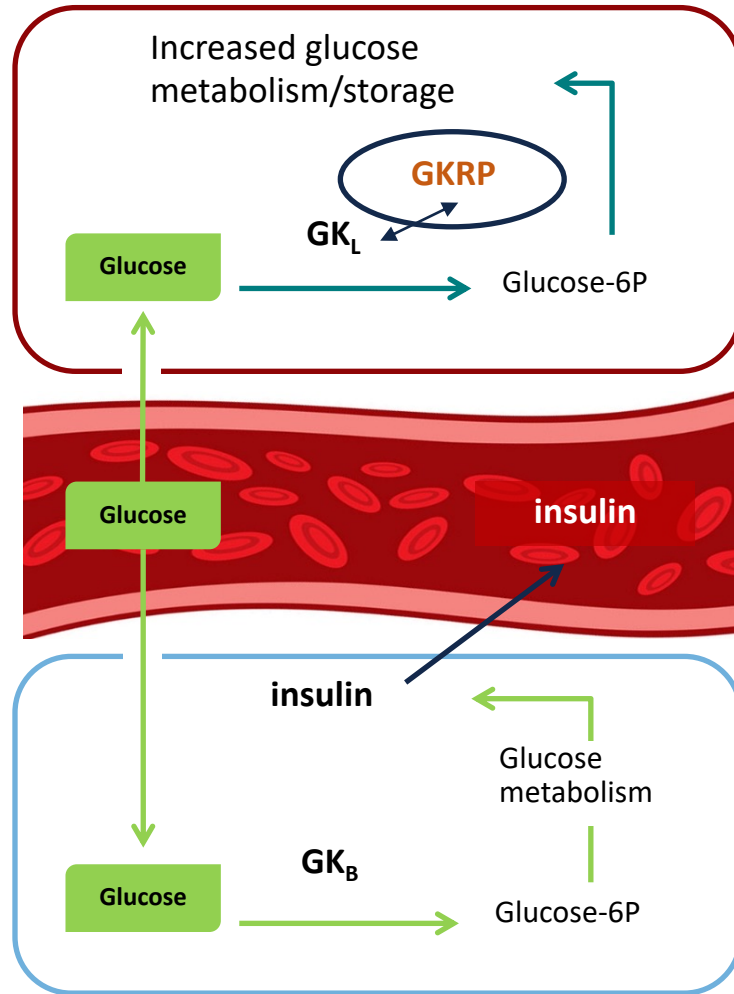


Liver
Hepatocyte

Pancreatic
 β -cell

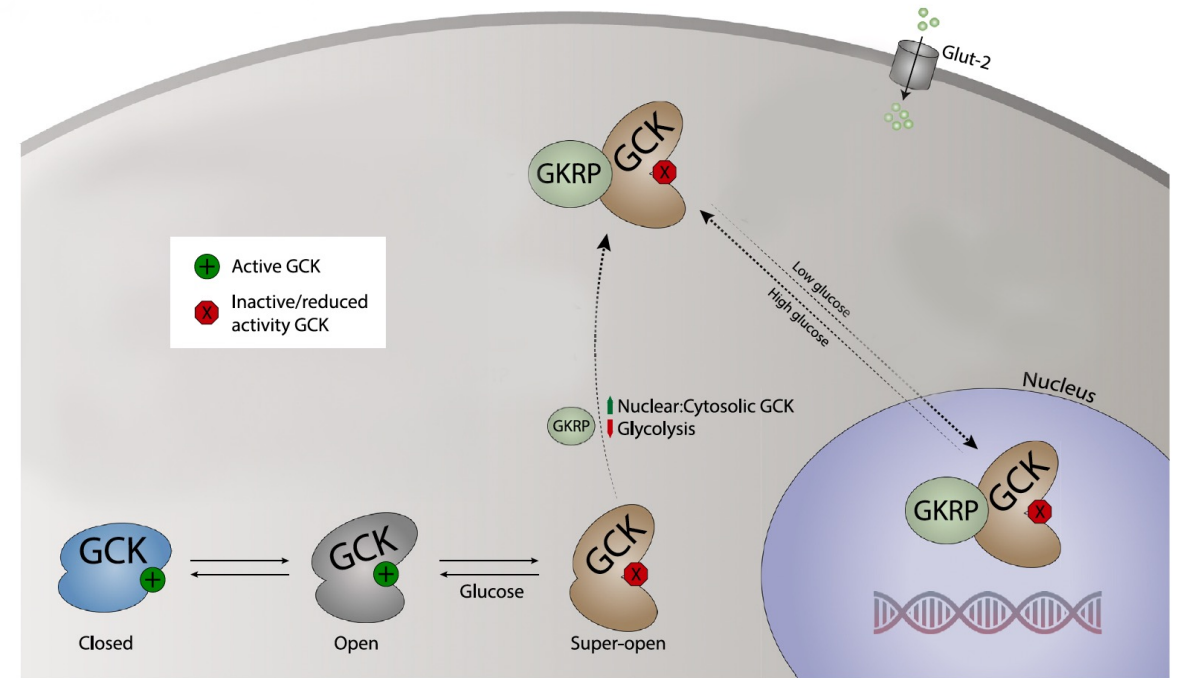


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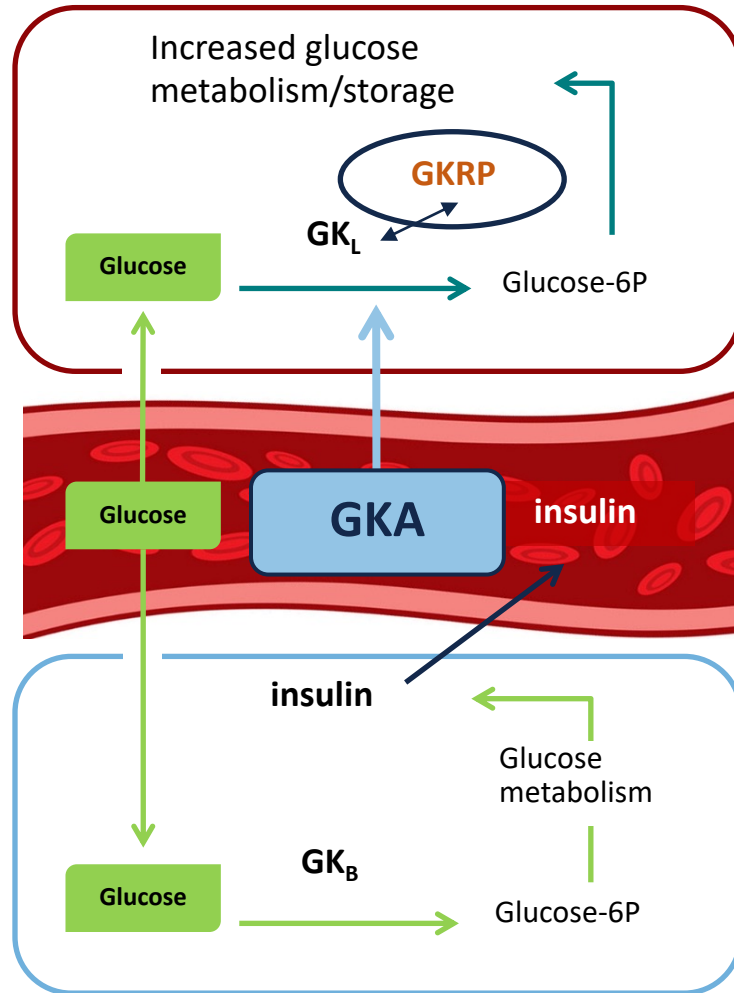


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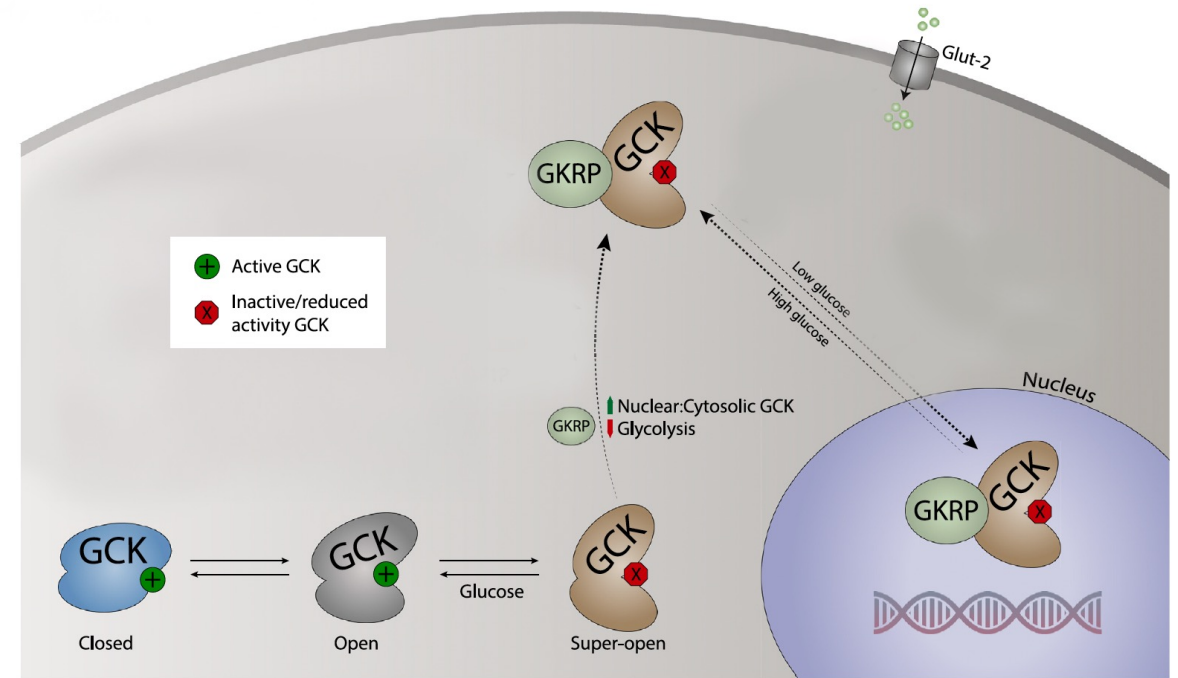


Hepatic GK has unique properties

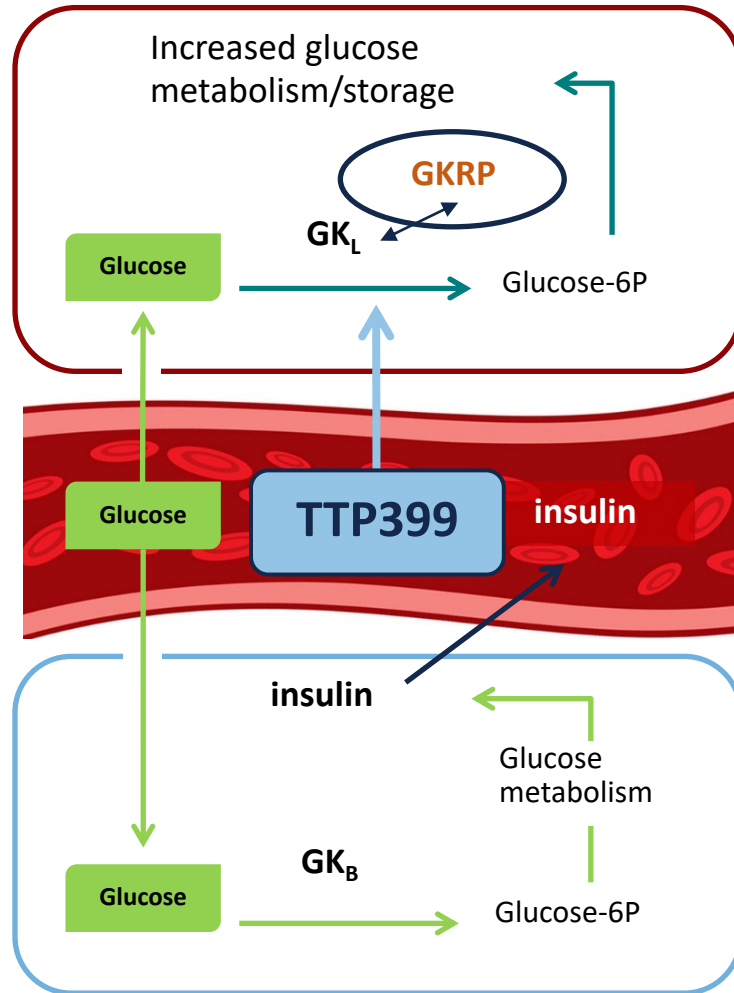


Liver
Hepatocyte

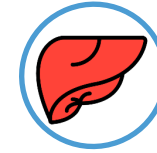
Pancreatic
 β -cell



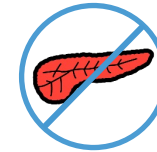
Liver-selective GK activation shows promise for diabetes



Liver
Hepatocyte



TTP399 is designed to activate GK in the liver

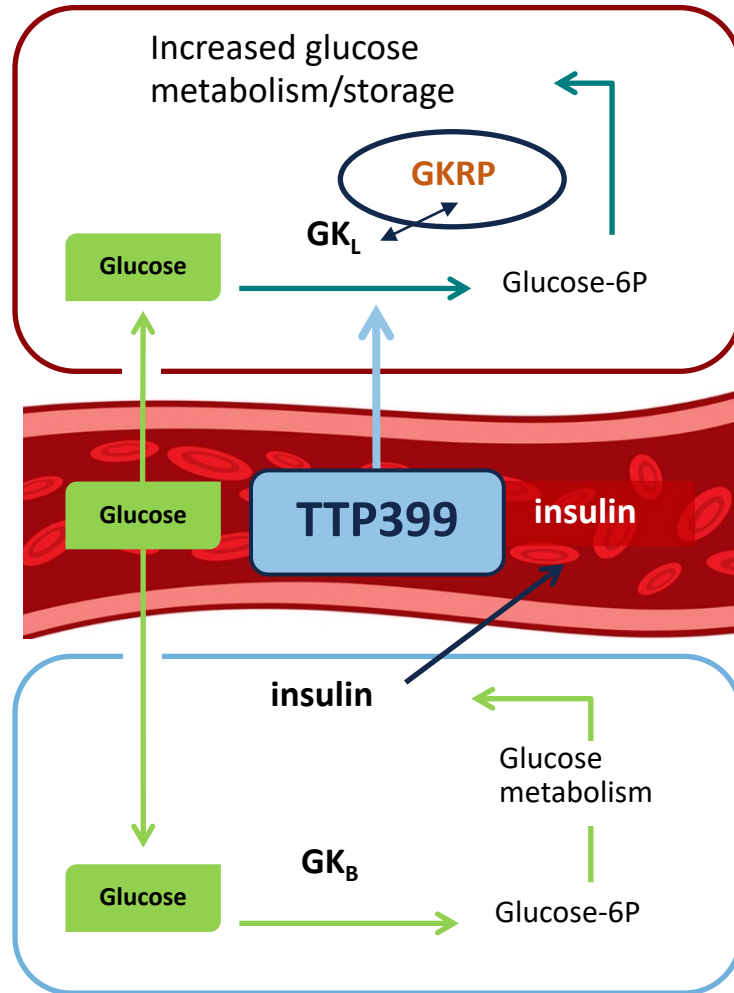


TTP399 did not activate GK in β -cells

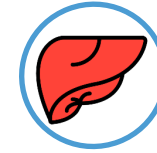
Pancreatic
 β -cell

*Cadisegliatin is also known as TTP399

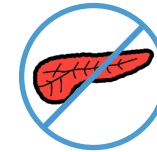
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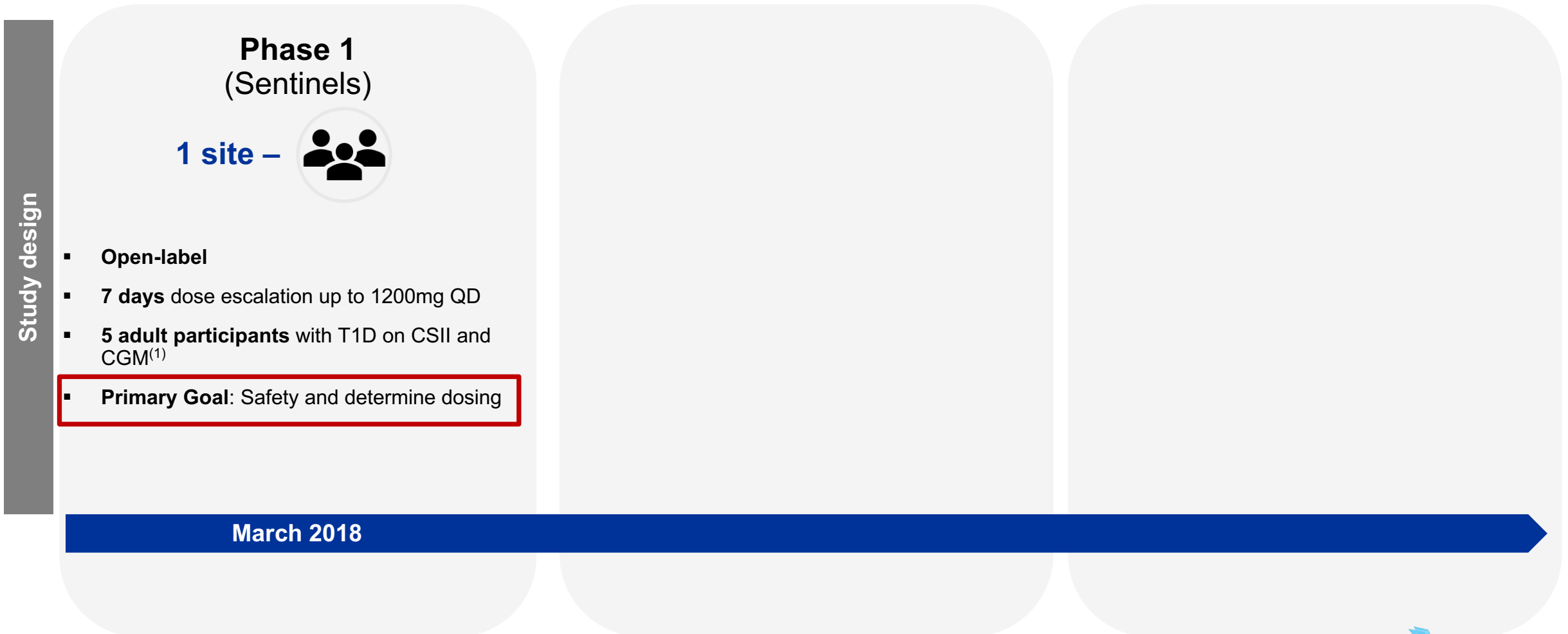


TTP399 did not disrupt the interaction between GK and GKRP (GK Regulatory Protein) keeping physiological control of GK

Pancreatic
 β -cell

*Cadisegliatin is also known as TTP399

TTP399-203 (SimpliciT1): Adaptive Phase 1b/2 Study Trial Design



Note: ClinicalTrials.gov Identifier: NCT03335371.

(1) Continuous Subcutaneous Insulin Infusion (CSII) and Continuous Glucose Monitoring (CGM). Part 1 required CGM and CSII. Participants on multiple daily injections and self monitored blood glucose with capillary glucose meter were not excluded in Part 2.

TTP399-203 (SimpliciT1): Adaptive Phase 1b/2 Study Trial Design

Study design

Phase 1 (Sentinels)

1 site –



- **Open-label**
- **7 days** dose escalation up to 1200mg QD
- **5 adult participants** with T1D on CSII and CGM⁽¹⁾
- **Primary Goal:** Safety and determine dosing

Phase 2 (Part 1)

4 sites -



- **Randomized, Double-blind, Placebo control**
- **Treat to target** design
- **12 weeks Oral** dosing 800mg/placebo
- **19 adult participants** with T1D on CSII and CGM⁽¹⁾
- **Primary Endpoint:** Δ in HbA1c

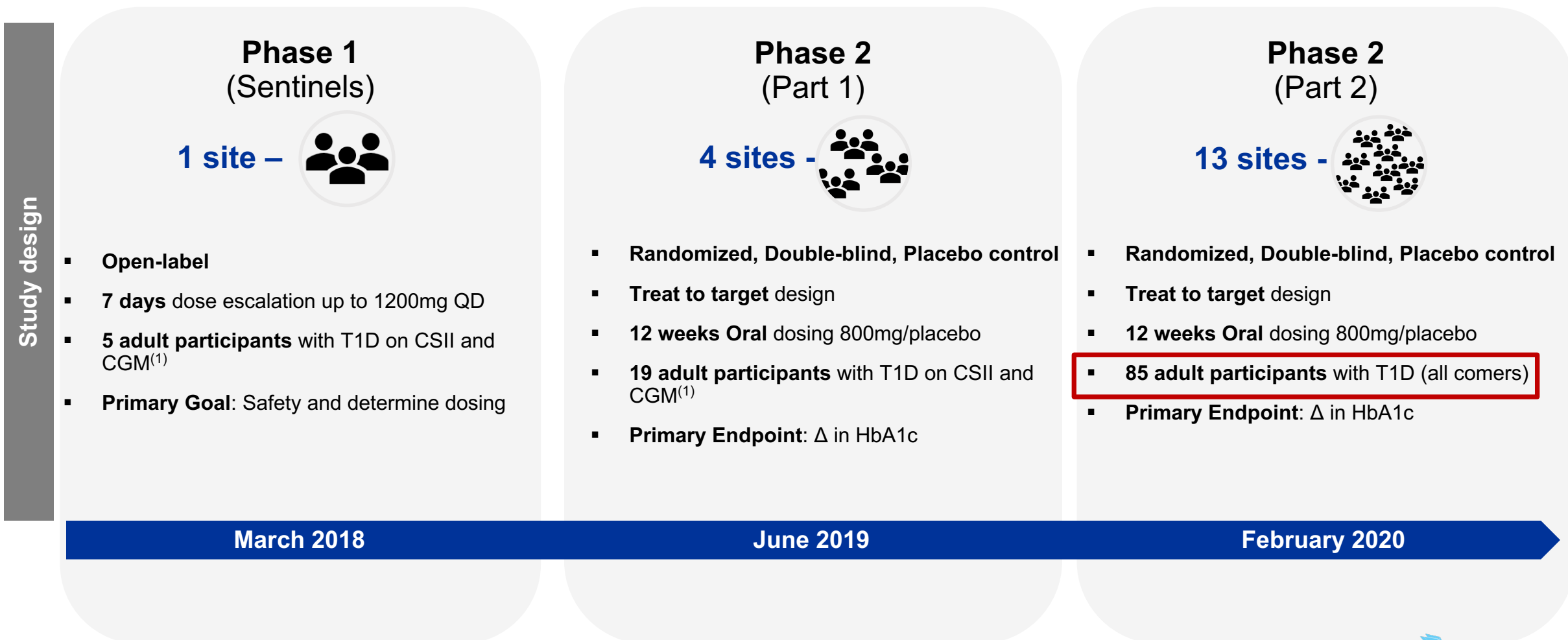
March 2018

June 2019

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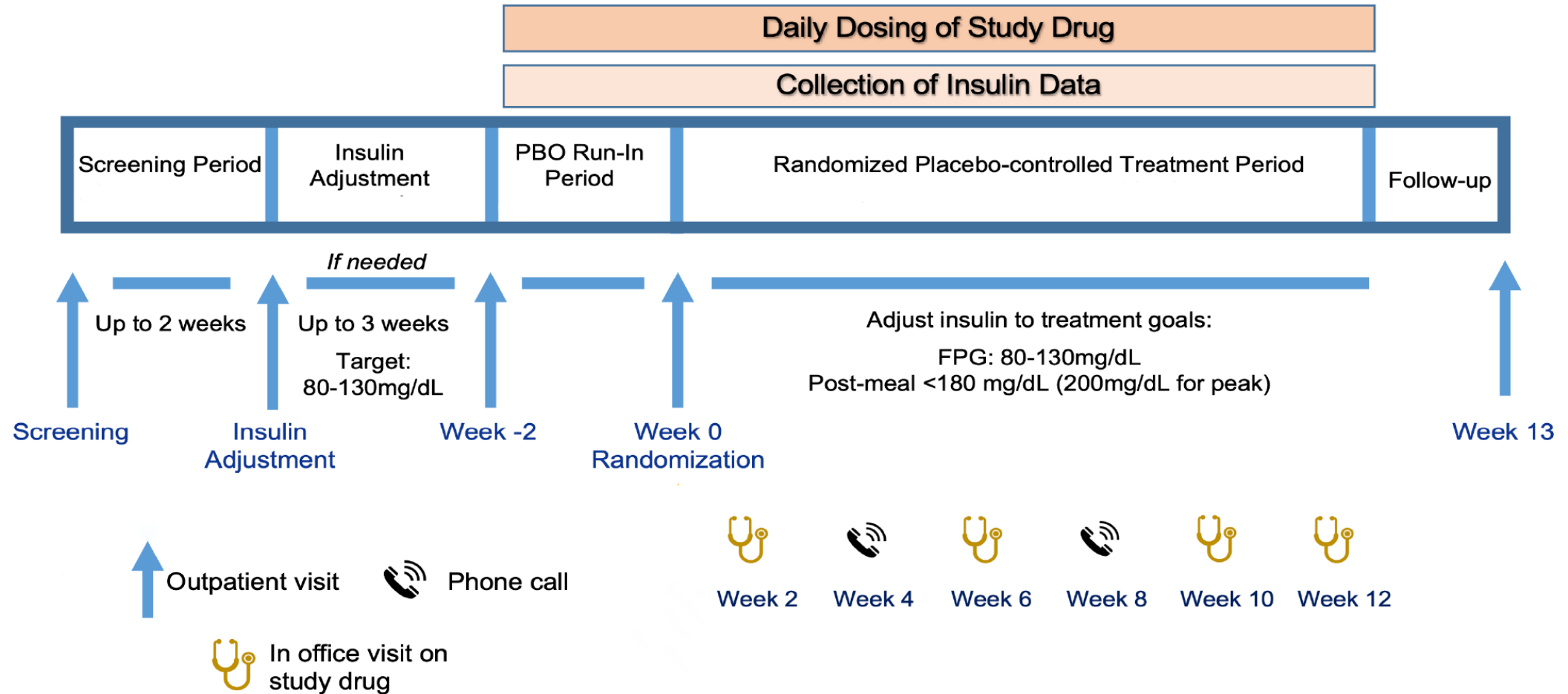
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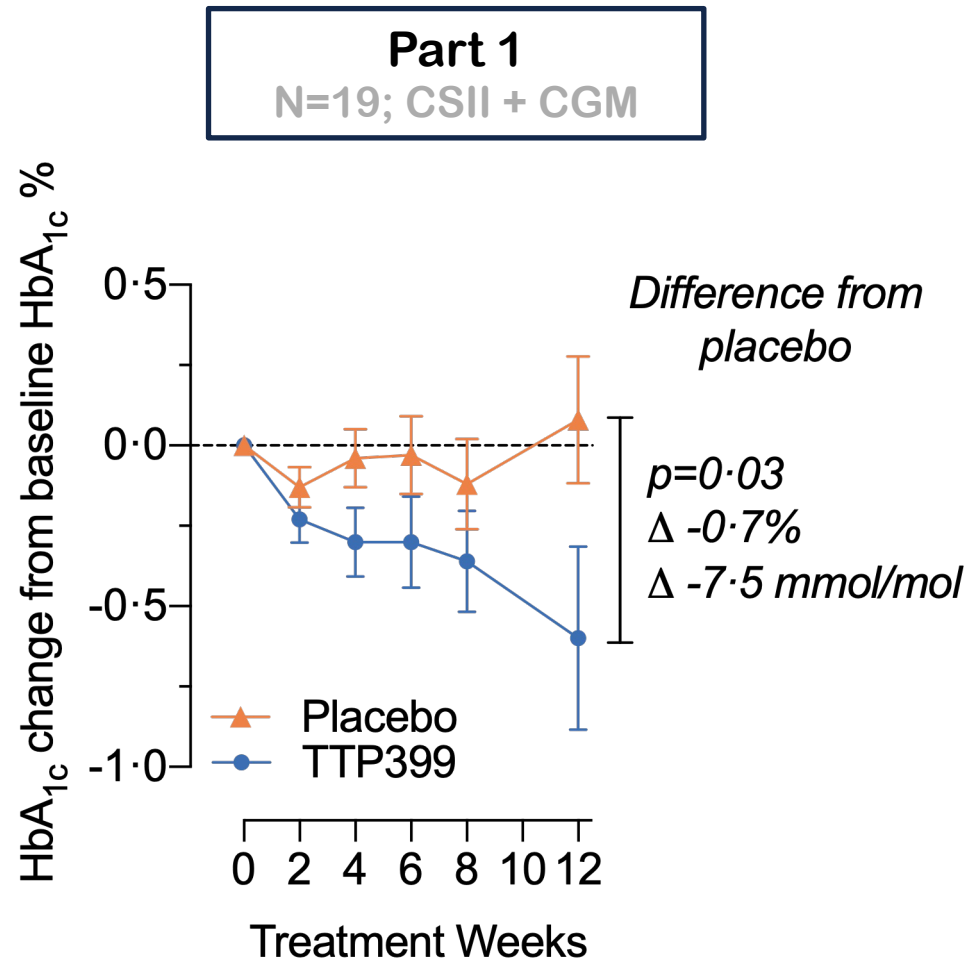
SimpliciT1: Adaptive Phase 1b/2 Study Trial Design



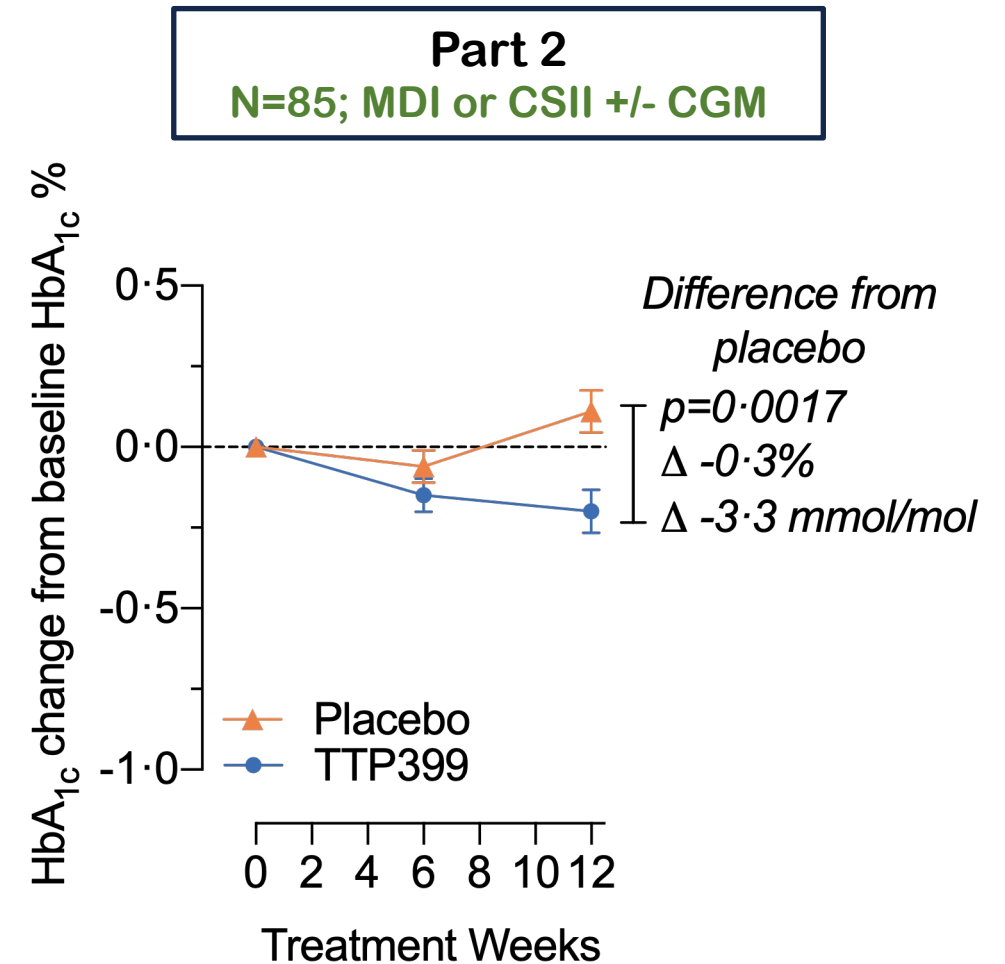
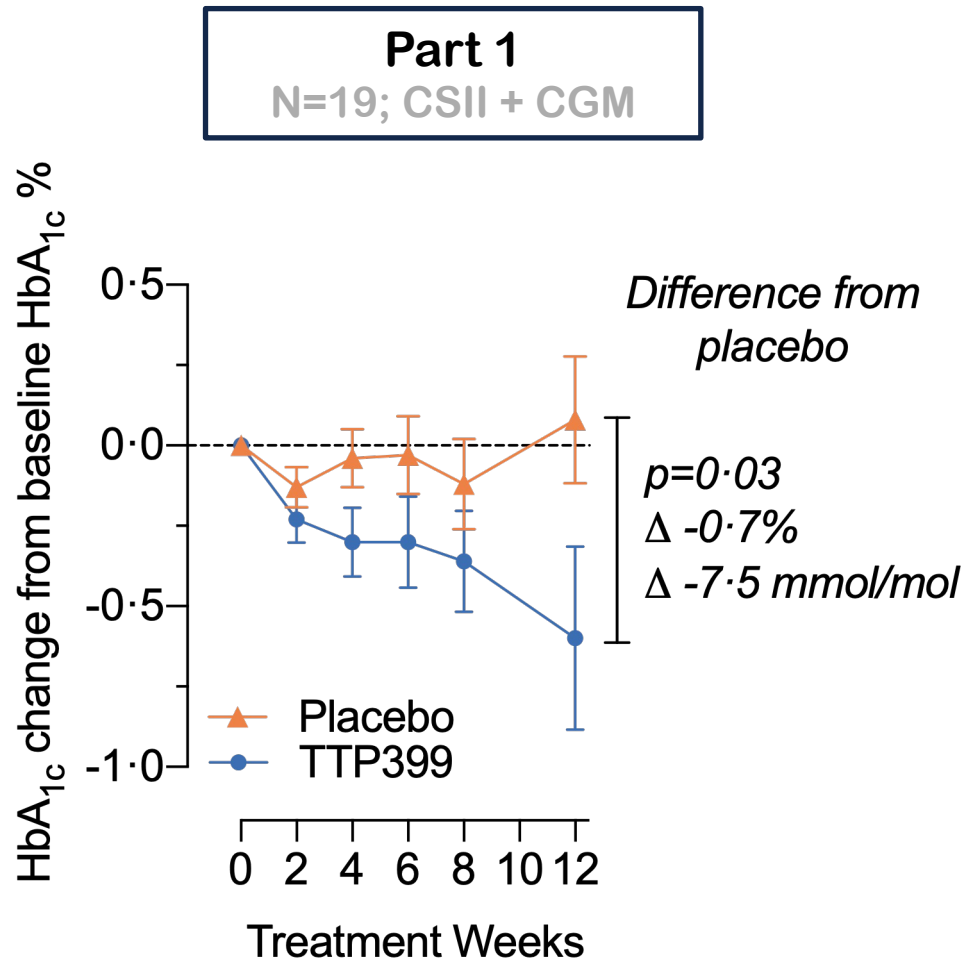
N=104: N=19 for Part 1 and N=85 for Part 2

Modified from: Klein, et al. Diabetes Care. 2021.

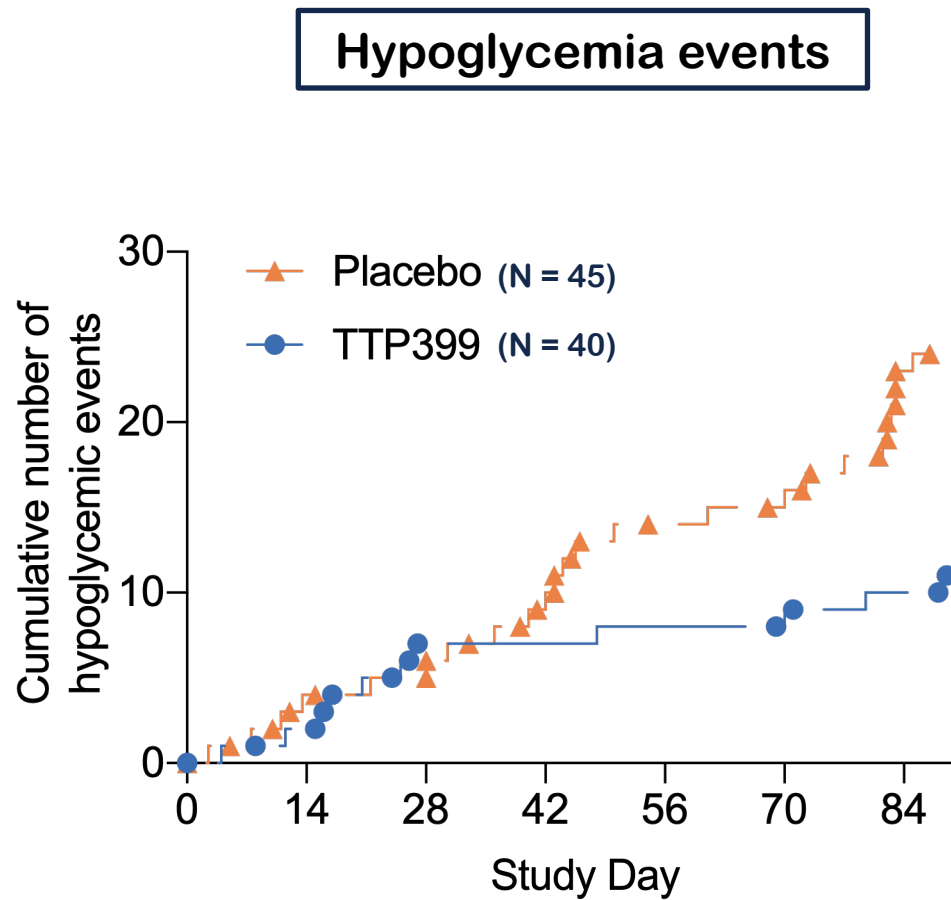
TTP399 improved glycemic control in both Part 1 and Part 2



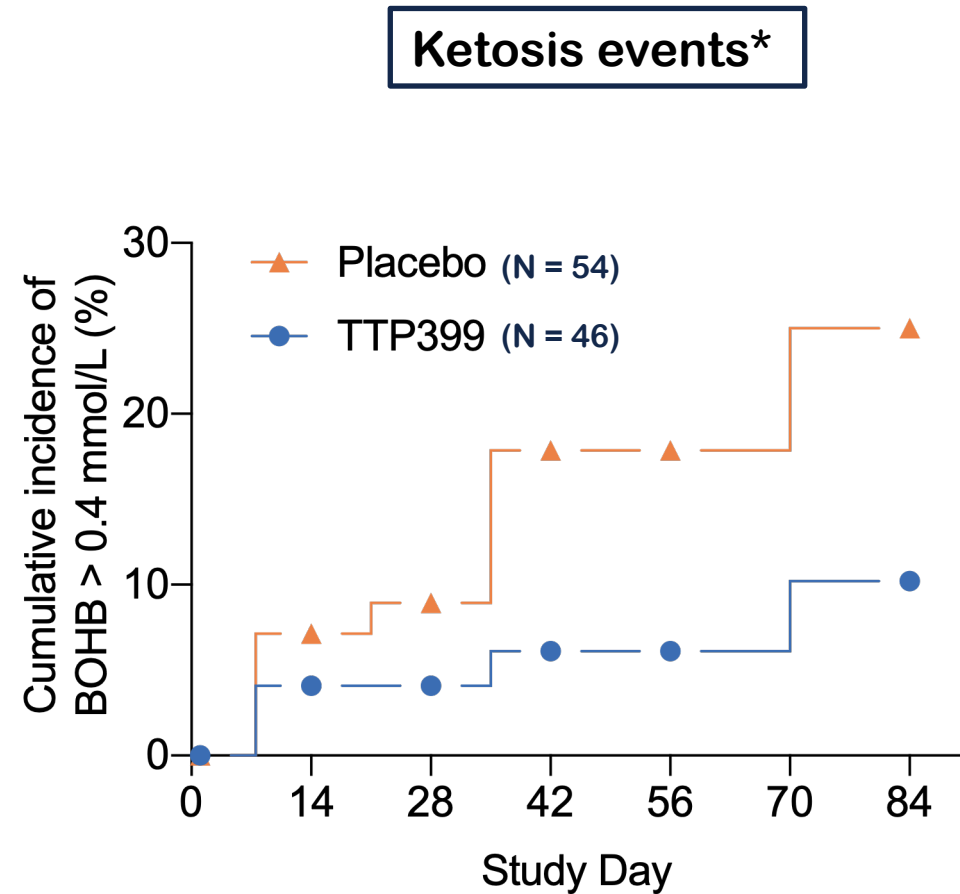
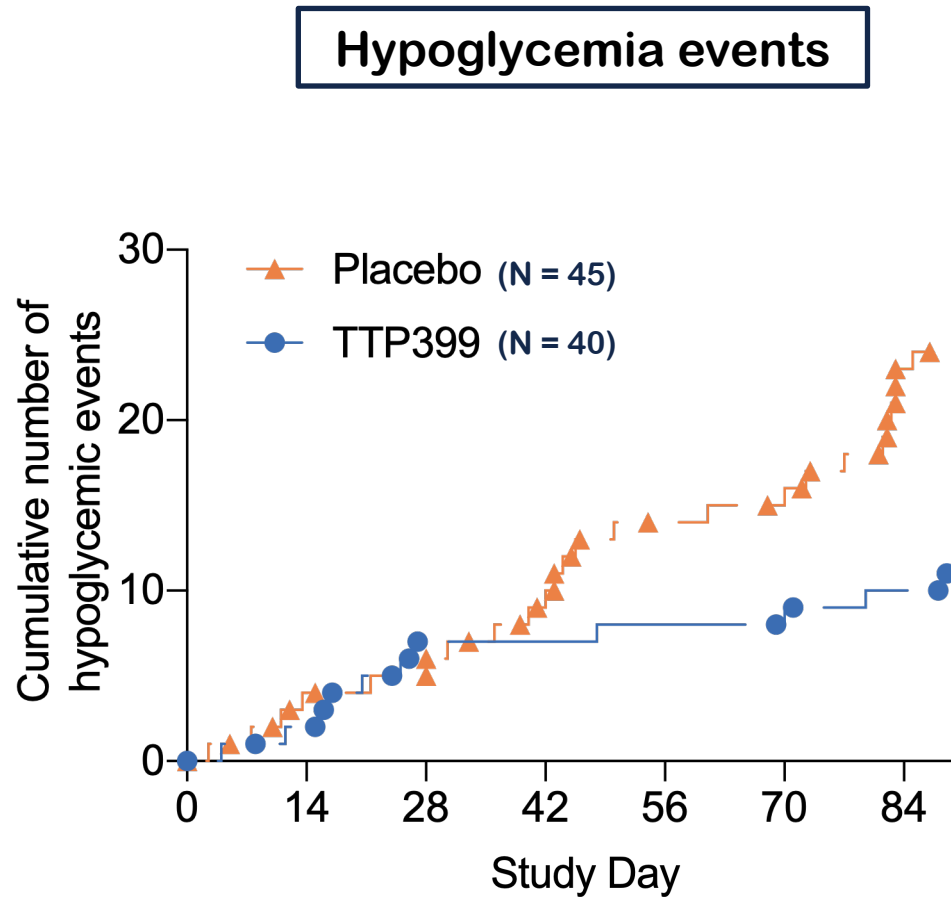
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A reduction in hypoglycemia and ketosis events was noted

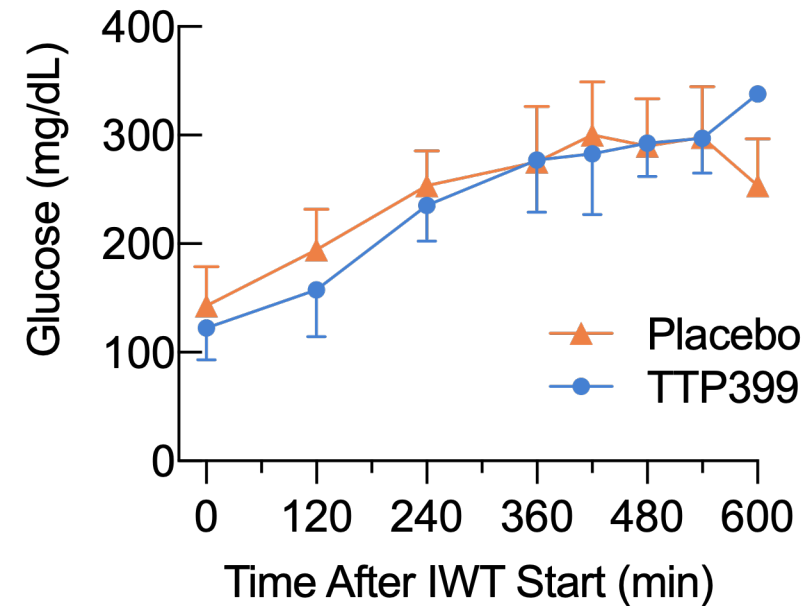


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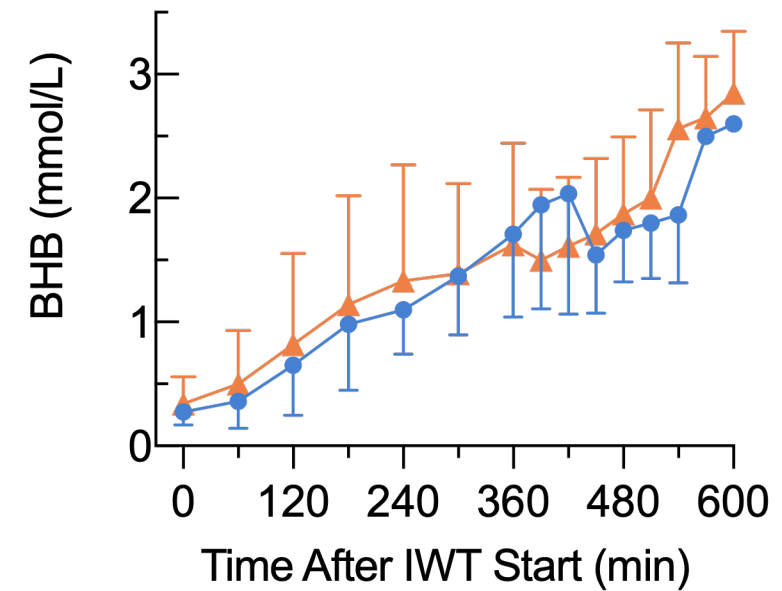


*Data shown is a meta-analysis from Part 1 and Part 2.

Cadisegliatin did not increase ketosis risk during insulin withdrawal

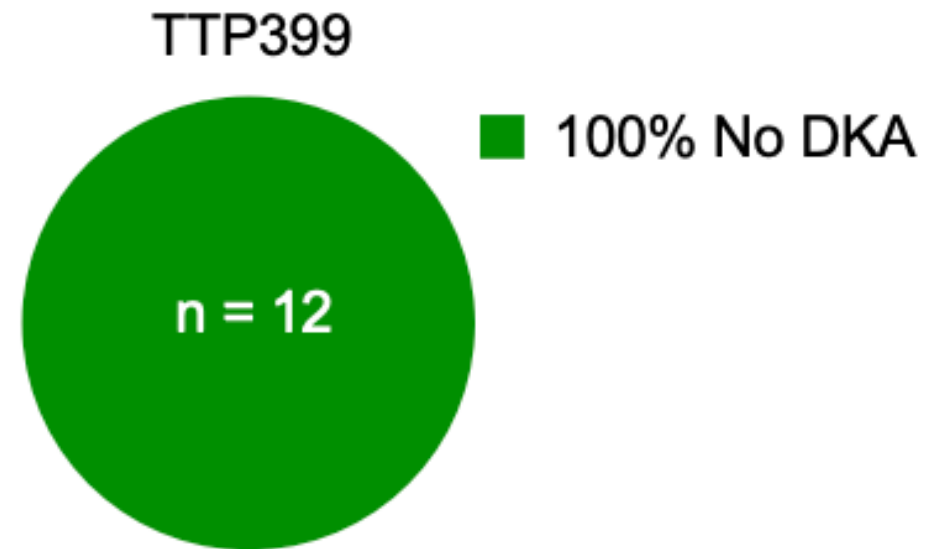
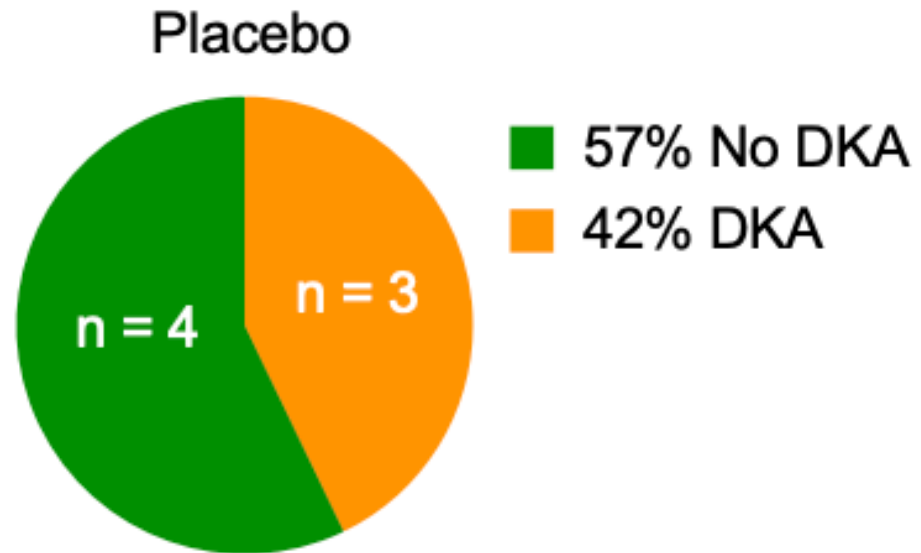


Time (min)	0	60	120	180	240	300	360	390	420	450	480	510	540	570	600
Placebo (n)	10	10	10	10	9	9	9	8	8	7	7	7	4	2	2
TTP399 (n)	12	12	12	12	11	11	9	9	8	5	5	3	3	1	1



Time (min)	0	60	120	180	240	300	360	390	420	450	480	510	540	570	600
Placebo (n)	10	10	10	10	9	9	9	8	8	7	7	7	4	2	2
TTP399 (n)	12	12	12	12	11	11	9	9	8	5	5	3	3	1	1

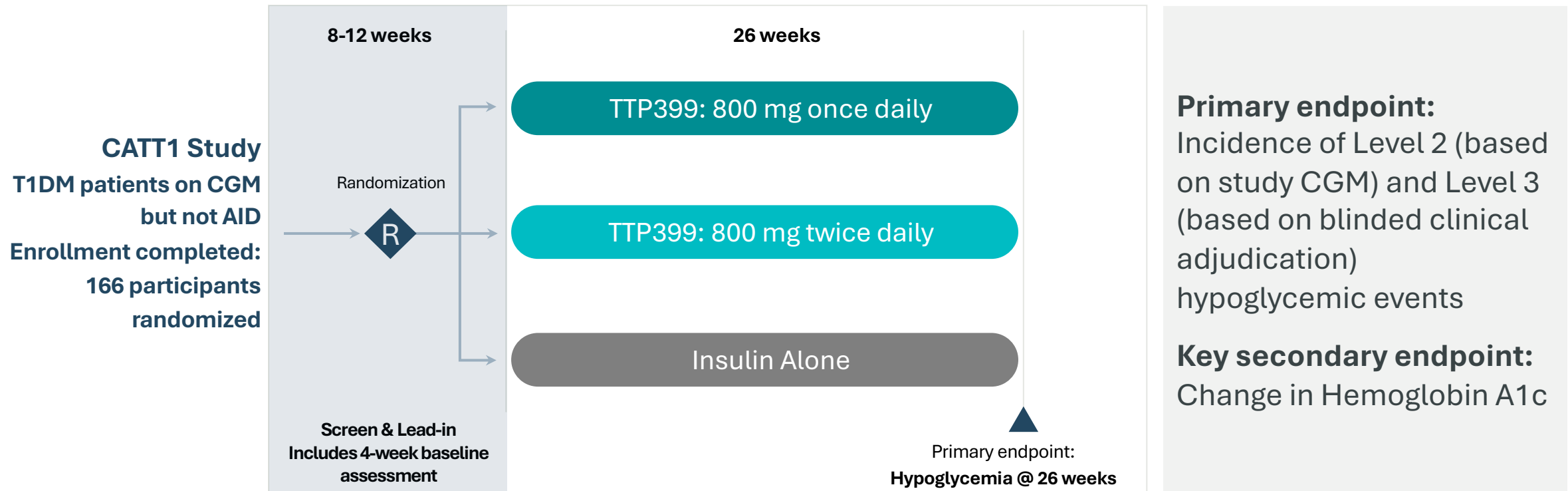
...with signals for improved ketosis risk



Cadisegliatin improved glycemia with a reduction in hypoglycemia and no evidence of increased risk of ketosis.

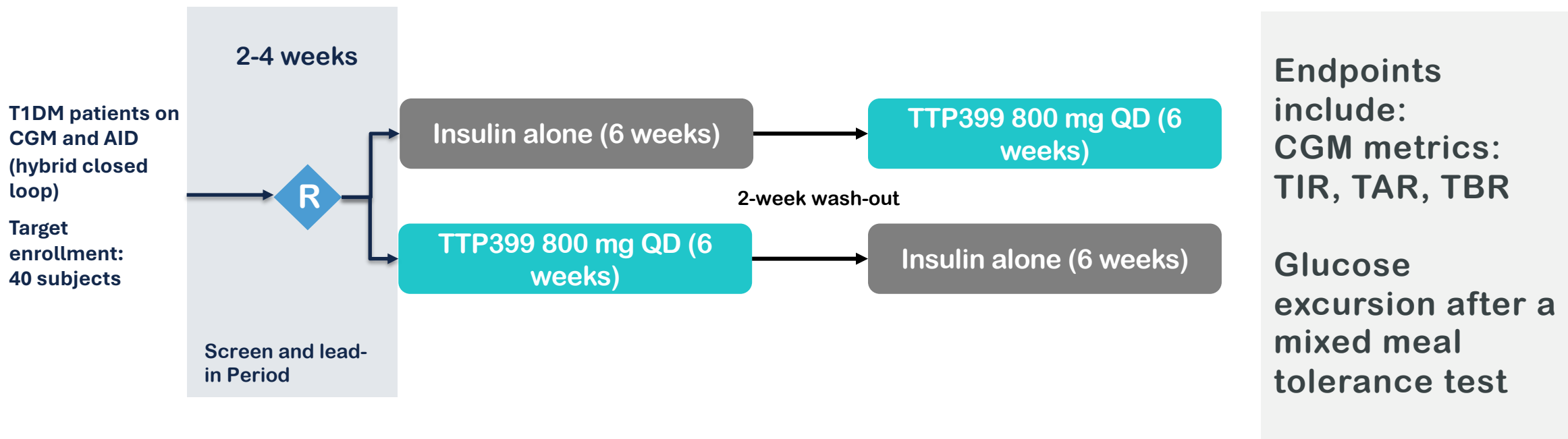
What's next?

Cadisegliatin Phase 3 CATT1 Study* – Informed by FDA Advice and Published Guidance for Endpoint Selection, Exposure, and Population Criteria



CATT1 will use continuous glucose monitoring (CGM) to measure reduction of hypoglycemic events in accordance with the FDA draft guidance issued in 2023 on diabetes-related clinical trials**

Cadiseagliatin Phase 2a Hybrid CATT1 Study*



Hybrid CATT1 will inform the design and operational aspects of future phase 3 research

Summary results from two completed clinical studies of cadisegliatin in type 1 diabetes



- HbA1c reduction between 0.3-0.7%

Summary results from two completed clinical studies of cadisegliatin in type 1 diabetes



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- Reduction in hypoglycemia



- Phase 3 study (target N=150) currently underway (CATT1)

Summary results from two completed clinical studies of cadisegliatin in type 1 diabetes



- HbA1c reduction between 0.3-0.7%



- No evidence of increased risk for DKA



- Reduction in hypoglycemia

- Phase 3 study (target N=150) currently underway (CATT1)



- Well-tolerated



Corporate Summary

Paul Sekhri

Corporate Summary

01 Late-stage asset

▶ Cadisegliatin, currently in Phase 3 development, has the potential to become the first oral adjunctive therapy for type 1 diabetes (T1D) in the U.S.; CATT1 enrollment is complete, with topline results expected mid-2027; Phase 2a Hybrid CATT1 study in T1D patients using hybrid closed-loop insulin delivery systems expected to initiate before year-end 2026

02 Significant unmet need and commercial opportunity

▶ ~75% of people living with T1D in the U.S. do not achieve ADA recommended blood glucose levels (HbA1c <7%), with hypoglycemia being the major limiting factor in the glycemic management of T1D and type 2 diabetes (T2D)^{1,2}

03 Experienced leadership

▶ Led by seasoned biopharma executives with a strong track record of advancing novel therapies for metabolic diseases and diabetes

04 Strong balance sheet

▶ \$86.6M cash (at 6/30/2026) provides runway well past the CATT1 topline data readout

05 Deep pipeline of differentiated assets

▶ Additional clinical-stage assets in immunology/inflammation, metabolism, and oncology disease areas present opportunities for significant non-dilutive funding



Q&A and Concluding Remarks



Thank you!

Contact us: jfraunces@lifesciadvisors.com