Pharming Group N.V. 3Q 2023 Results Call

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Sijmen de Vries, MD – Chief Executive Officer:
Good morning or good afternoon, ladies and gentlemen. I'm here with my three colleagues, Stephen Toor, our Chief Commercial Officer; Anurag Relan, our Chief Medical Officer; and Jeroen Wakkerman, our Chief Financial Officer. We are delighted to take you through the third quarter results of this year.

Before I do that, however, I would like to point you to the forward-looking statement slide because this presentation may contain or will probably contain forward-looking statements that, as you know, are statements of future expectations that are based on our current expectations and assumptions and involve known and unknown risks and uncertainties that could cause actual results, performance or events to differ materially from those expressed or implied in these statements. The rest I'll leave to you to read.

Let's move on to the next slide, about building a sustainable business in rare diseases as that's what we are about. This is a very interesting moment in time, the third quarter results of 2023. You see that on the left-hand side, how we are going to build the sustainable rare disease business.

We have significant positive cash flows for more than US$200 million of moving annual total sales of RUCONEST® that can fund Joenja® launches and pipeline development to start with. We are very pleased with the results and a strong revenue growth of RUCONEST®, 18% up on the second quarter and 11% up on last year's third quarter. Also, if you look back nine months, so year-to-date, 2% up on last year. That means that we are on track to deliver our low-single-digit revenue growth for RUCONEST® for 2023.

Then we move to the middle pillar, and you see there the global approvals and commercialization of Joenja® that can be funded from those cash flows from RUCONEST®. And we were very pleased to get a very fast approval from the FDA back in March, brought the product to the market and got reimbursed patients almost immediately when we are on the market.

Such that we could already record revenues in the second quarter of this year, which was the first quarter Joenja® was on the market. And now, we're very proud of the continued growth of Joenja®, where in this quarter, we booked US$6.5 million of revenues and year-to-date, US$10.3 million.

In addition to that, the regulatory reviews are ongoing for Joenja® in Europe, Canada, Australia, Israel, and we have a pediatric clinical trial program ongoing as our label is currently 12 years and upwards.

And on the right-hand side, you see further growth accelerators beyond Joenja® and APDS. First and foremost, and that is where we will come back to you before year-end to update you on that. We are in dialogue with the FDA about the second leniolisib indication, and we'll provide you with more details towards the end of the year, and my colleague, Anurag Relan will talk about that a lot more.

And last but not least, as we have a very strong commercialization infrastructure in both the US and Europe, we're hunting, as we speak, for new in-licensing opportunities or acquisitions for additional products in rare diseases that we can actually continue to develop – clinical development and bring to the market and then successfully commercialize it. So, we are looking for products that have clinical proof-of-concept.

And as you see on the next slide, you see that there is actually a space to have such products in our pipeline. You see here the extensive work we do by enlarging our footprint by means of bringing leniolisib to markets, as far as field as Japan, but also Canada, Australia and Israel, and the other indications.

So, you see the space in this pipeline to further accelerate the growth of the company going forward. With that said, I would like to now hand over to my colleague, Stephen Toor, who will give you some more insights in the commercialization operations on RUCONEST® and Joenja®. Stephen, over to you.

Stephen Toor – Chief Commercial Officer:
Thank you, Sijmen. Good morning, everybody. As Sijmen said, I'll give you a brief overview of RUCONEST® performance and also some insights around the Joenja® launch and update you on that progress today. Next slide, please.

As communicated at the end of 1Q, and as you're all aware, the HAE market underwent a significant event, which affected all products. The event was short-lived, and as we said we would, we bounced back strongly in 2Q and 3Q. As you can see in the first bullet, we posted strong growth in 3Q. Even with the softening for 1Q, as Sijmen showed, we have grown versus prior year. We are really pleased with our performance.

This has been driven by strong performances across all of our leading metrics, but I especially want to flag new patient enrollments, which have exceeded 70 over each of the past three quarters, which is stronger than we've seen in the past.

As Sijmen said, we continue to guide for low single-digit growth for RUCONEST® this year. Next slide, please.

As many of you know, RUCONEST® was launched in 2015. We've actually though been active in the HAE community since around 2000. And over those 23 years, we collaborated with all key stakeholders, including the clinical ones and patient advocacy groups such as the HAEA. That has

been the remainder driver for the consistent success of RUCONEST® over the nine years post-launch, and it's why the prescriber base continues to grow with 700 in the US to-date, and also why we've treated over 2,000 patients, and that metric continues to grow as well.

I think what that clearly underlines is the importance and the ongoing need for a recombinant IV C1 esterase inhibitor, and that's despite the fact over 70% of patients are now on prophylactic treatment today. The next slide, please.

Moving to Joenja®, as Sijmen showed earlier in the presentation, we're off to a very strong start in the US with our launch. As indicated in previous calls, and I think as everybody on this call knows in relation to the environment more broadly, access, once a patient is diagnosed, is one of our key pillars for success and the ongoing success of this launch.

We partnered with an organization called PANTHERx that specializes in ultra-rare or rare diseases to build a program that we thought would enable us to quickly provide patients with access to Joenja® once they're covered for chronic use. I'm pleased to report that in only six months post launch, Pharming's access and medical teams in partnership with key opinion leaders across the country have secured APDS coverage policies in over 90% of our target plans across commercial and government payers. And the result is a 93% approval rate with zero denials.

I just want to repeat those two, 93% approval rate was zero denials despite the rarity of this condition and the heavy lift in education. So that's really a very strong performance.

Also, as you know, from enrollment to shipment to patients, the gold standard in rare disease is 30 days. I'm pleased to report to you that we're averaging 26 days typically and sometimes getting from enrollment to put in product in patients' hand in less than 20 days. Really, this is based on exceptional customer focus and execution, which further instills, I believe, our confidence in our stakeholders, but most importantly, the patients and treating physicians. Next slide, please.

I've mentioned Pharming's strong customer and patient focus, and I think combined with the exceptional execution I've already mentioned, our US team have delivered strong results in that first six months since launch. We have, as the slide shows, 76 eligible patients, 63 shipping, and that represents well over half of the eligible patients we have on therapy.

This has led to the revenues of $10.3 million that Sijmen also showed. As already mentioned, payer discussions have and continue to go very well, which creates, importantly, an excellent environment for us to pull those patients through once they're diagnosed and enrolled.

Finally, I just want to flag now that we're through the immediate launch phase, and with many of the previously identified patients on therapy, we'll be placing additional time and resources now on family testing. Most of the patients we have are patient zero, so to speak. We believe there's a lot of opportunity there to help those families by better educating them and testing all of them to see whether there are others in need of therapy.

And with that, I'd like to hand over now to our CMO, Dr. Anurag Relan.

Anurag Relan, MD – Chief Medical Officer:
Thanks, Steve. I'll begin on the next slide with a little background information about APDS.

APDS was first described in 2013 and based on our estimates and literature review, we believe that there are more than 1,500 patients worldwide with APDS. We have already found more than 640 of those patients. These patients who have APDS have really had limited treatment options until recently to only treat the symptoms of the disease.

The disease manifests itself in childhood and worsens over time. Without anything specifically indicated for treatment, physicians and patients who are quite limited in their treatment options. As with most rare diseases, the signs and symptoms vary across patients. This makes the challenge of diagnosis even more difficult beyond just a rare disease.

Fortunately, there is a genetic test that can provide a definitive diagnosis for APDS, and I'll be spending more time in the coming slides talking about our plans and efforts to help find more patients with APDS.

On the next slide, we can see what Joenja® now brings to patients in the US as a potential treatment option for them for their condition. It is approved by FDA for the treatment of APDS in adults and pediatric patients from ages 12 years old and older. We have randomized clinical trial data showing that Joenja® met both primary endpoints as well as meeting several significant other clinically relevant endpoints.

In addition, we've seen a well-tolerated and generally safe adverse event profile. There were no drug-related serious adverse events in the study or withdrawals due to the drug in the study.

More importantly, we have long-term data, and I'll be sharing some of that with you that we've been publishing and presenting at conferences recently about the long-term benefits of using Joenja® over several years in many cases. This includes for patients in some cases to discontinue the use of immunoglobulin replacement therapy, reduction in infection rates, and persistence of the benefits that we see from the randomized clinical trial.

We can see that both in key measures of what's called lymphoproliferation, so their lymph nodes continue to stay not enlarged, and we see benefits also in their immune cell function. As Steve mentioned, this has led to a strong start for Joenja®. I think this speaks both to the unmet need that exists in this APDS population, but also speaks to the seriousness of the condition.

On the next slide, you can see some of our things that we're doing beyond the work that we've done in the US. As we discussed in August, we received the Day 180 List of Outstanding Issues from the European Medicines Agency, and we can confirm now that, in October, we have submitted our responses.

We remain on track to expect an opinion in this quarter and with potential approval two months later. If we receive a positive opinion from the CHMP in this quarter, we can then go ahead and file with the UK MHRA agency with potential approval also two months later. As we previously announced, we've started a program in Japan to enable registration there eventually. We've also

now filed in Australia, Canada, and Israel, and those applications are proceeding along their review plans.

We've also started a named patient program to eventually be able to help patients obtain access in territories across the world. Our pediatric study is enrolling quite well with the majority of enrollment already complete in the four to 11 study and the one to six-year-old study has now started recruiting. So, we expect that first patient also to be treated very soon. As Sijmen mentioned, we have been engaged with the FDA about the second indication, and we expect to be able to provide further details on the second indication later this quarter.

On the next slide, I want to review with you some of the patient finding efforts that we've initiated and are ongoing at this time. The first, of course, is APDS is a rare disease, and it's critical to raise awareness about APDS, and now we have a plethora of data also on leniolisib that we can share.

These data highlight the seriousness of APDS, and I think it also highlights, I think, the experience that we have with leniolisib in treating many of these patients. On top of that, we have our ongoing NavigateAPDS program that offers no cost testing available to patients in the US and Canada. These patients, once they have this testing available often have questions, so we have genetic counselors available to help them consider the testing and then also review the results with them.

Then a big effort that we're really pushing on right now is that when we look at the diagnosed patients that we have in the US, especially, we find that most of those patients actually don't have family members that have even been tested.

We know that APDS is an inherited disease, but there's this gap in terms of testing. We've initiated several efforts here, both with physicians and with family members themselves to be able to reduce the barriers to allow further testing amongst family members, which we think will be important to help uncover and find more patients.

On the next slide, I want to review with you a little bit of information on something called Variant of Uncertain Significance. What these are, are genetic test results that are basically unclear or unclassified at this point.

And with the growth in genetic testing, we get more of these inconclusive results. These are basically variants that have not been previously seen. This is really frustrating for patients and doctors because they have patients who have clinical symptoms of APDS often, but the genetic test result is inconclusive. We have several efforts ongoing, and I'm not going to review all of them with you in detail here, but these efforts involve trying to review the existing data and try to collate all of that information and publish that.

We just started a partnership, for example, with Genomenon to develop these genomic landscapes, which will be available to all clinicians to be able to easily access variant's information. We have a number of efforts ongoing to increase the availability of functional testing.

Then lastly, I think I'm really excited about this possibility of this new effort that we started looking at a way to, in a single experiment, test all possible variants and quickly determine whether a result

is pathogenic or disease causing or not. I think the nice thing here in a sense is that this is a problem – it's a new problem for APDS, but we're really using a playbook that exists already for many other genetic diseases. We're following that playbook to be able to help these APDS patients who may still have this unclear diagnosis.

On the next slide, you can see some of the conferences we've been presenting at and some of these abstracts we presented. These abstracts vary both in terms of what we're talking about in terms of the seriousness of the conditions, so the mortality, for example, associated with APDS, but also the healthcare costs associated with APDS and especially untreated APDS. These data, I think, highlight very nicely the serious burden that these APDS patients face.

On top of that, we continue to get more data out of our clinical trial program. We have a second interim analysis that will be published at the IPIC conference next month. And we also have a number of case series as well as abstracts on single patients. These are many times from our Expanded Access Program or Compassionate Use Program, where, for example, the second bullet under the IPIC heading is a patient who was previously transplanted unsuccessfully, unfortunately, but then was treated with leniolisib under this Compassionate Use Program and the data at the abstract will show the benefits that this patient was able to experience.

On top of that, on the next slide, you can see some of the publications. The first publication is the first interim analysis, and that's available now in a full paper. Then the next publication is also a key publication describing the mechanism of the action of leniolisib in APDS. I think it describes clearly how APDS leads to this primary immune deficiency with this immune dysregulatory phenotype and how leniolisib benefits in these patients. With that, I'll turn it over to my colleague, Jeroen Wakkerman, our Chief Financial Officer.

Jeroen Wakkerman – Chief Financial Officer:

Thank you very much, Anurag. Focusing first on the financial highlights of the third quarter 2023. Total revenues increased to US$66.7 million, so an increase of US$12.5 million or 23%. Gross profit increased to US$58.4 million, an increase of US$6.5 million.

Operating costs increased from US$44.7 million to US$56.8 million. And the increase of US$12.1 million is mainly because of R&D, additional investments of US$8 million, and marketing and sales of US$5 million. And that is all directed towards the launch – or most of it is directed to launch of Joenja® and the first development of the market.

The operating loss was a profit, in this case, is US$1.9 million, and the net profit was US$3.5 million in the quarter. And that was on the back of positive financing income and a tax credit, which is a timing effect. Sijmen mentioned it already, but the cash and cash equivalents increased to US$199 million at the end of the quarter.

Looking at the figures year-to-date, nine months year-to-date, the revenue increased by 9% to US$164.1 million. Gross profit increased to US$146 million. As was guided earlier this year, we further increased our OpEx, as I said, into mainly marketing and sales and R&D. The operating costs were US$175.3 million, i.e., an increase of US$48.4 million versus the same period last year. Consequentially, the operating loss was US$6.5 million for the three-quarter period. The net loss was US$7.4 million, which is an improvement from Q2 this year.

If we go to the next slide, we see the growth in revenue over the quarters. The third quarter revenue was US$66.7 million, and that's a 23% increase from last year, driven by both RUCONEST® and, obviously, Joenja®, as you can see on the picture. Also accelerated growth is seen in RUCONEST®.

You will remember that in 1Q, there was a temporary reimbursement issue, was a market circumstance. We had a dip in sales in RUCONEST®, but we have very well recovered from that. We are now on a positive note and that is in line with the guidance that we gave earlier this year.

Looking at the cost development, as I said, investments in the Joenja® launch and further development of leniolisib continues, and we have a quarterly OpEx of almost US$57 million. You see also that the increase is mainly, as you would expect, both in research and development and marketing and sales and the general and admin costs are relatively stable.

The increase in R&D, or at least they're stable for now, was mainly guided towards clinical, operational and medical affairs. And if you look at the development over the quarters, as we guided earlier in the year, is fairly stable, especially if you exclude the one-off milestone payment in the second quarter.

Then going to the outlook for this year. We remain on track for single-digit growth in RUCONEST® revenues, and that's only been confirmed by the numbers that we've shown in 3Q. Joenja® was approved in the first quarter, and we've been commercializing in the US since early April, as my colleague, Steve alluded to.

The CHMP opinion is expected in the fourth quarter of this year and marketing authorization subject to a positive outcome of the review is expected in Europe two months later. We will file leniolisib with UK's MHRA following the ECDRP route and we will continue to invest in accelerated growth for the future in operating costs.

In the remainder of the year, we will detail further our plans to develop leniolisib in additional indications. As Sijmen mentioned, we keep looking for investments on in-licensing and also acquisitions of assets in rare disease for future growth.

With that, I want to start or kick off the Q&A. Any questions are welcome. Thank you.

Operator: Thank you. To ask a question, you will need to press star one and one on your telephone and wait for your name to be announced. To withdraw your question, please press star one and one again. We will now go to your first question. And your first question comes from the line of Christian Glennie from Stifel. Please go ahead.

Christian Glennie (Stifel): Yeah. Good morning, good afternoon, guys. Thanks for taking the questions. Three, please. I'll take them in order. Let's start with RUCONEST® and a strong quarterly sales print. Just to be clear around whether there's anything to be aware of in the 3Q numbers, maybe they're stocking or some impact, that means it should be a clean quarter. And then any implications for – as we think about the fourth quarter as well, typically your strongest quarter, particularly in the US for RUCONEST®. Any reasons why 4Q wouldn't still be your strongest quarter for the year?

Sijmen de Vries: Thanks, Christian. That's an interesting question. Would you like to comment on that, Steve?

Stephen Toor: Yeah, sure. Thanks, Christian. So, you're right. 3Q is strong, and we occasionally see stocking, but it's sporadic. There's no real pattern to it. So, I would still expect, at this stage, 4Q to be our strongest quarter and for us to see end of the year strong.

Christian Glennie: Thanks. And then maybe a quick follow-up there. I mean anything – I mean, you've called out the new patient starts. I mean, I was just curious why you're still getting this very sort of strong patient starts and physician uptake and then anything else to comment on that?

Stephen Toor: Yes, it's interesting. We actually restructured our team a month before COVID hit, and then we had to mothball them. I think you're seeing a combination of different things happening. But certainly, the restructuring of that team is now paying off, and that's why you're seeing actually an increase in enrollment and expect consistent increase in enrollment across three quarters. So, I think that makes a big difference.

The other thing I would say is we have a very well tenured team so deep relationships within our physicians' offices and with their staff. I think that's really helped in identifying new patients. I mean as you would have heard us allude to, we have a much broader mix of patients now than we have historically, whereas if it launches you would expect, it was refractory patients who were predominantly using RUCONEST®. Now it's across mild, moderate, and severe. It's pretty evenly spread. I think it's a combination of time and market, trust, execution and as I mentioned earlier, the continued need for IV C1 esterase inhibitors despite the quite disruptive changes to the market.

Christian Glennie: Okay, thank you. And then turning to Joenja® then, if we can. Just firstly, on the European approval process, the advisory group meeting, as I understand, still to be held. Is there a timing on that or any outcome that comes from that advisory group meeting?

Anurag Relan: Hi Christian, it's Anurag. This meeting has been scheduled. It is a closed meeting, and we're not going to provide any further guidance on the ongoing regulatory interaction other than to say that we continue to expect the CHMP opinion in this quarter.

Christian Glennie: Okay, thank you. And then on – and then as we think about, obviously, the 3Q numbers around patient – patients on paid therapy and things. I mean, anything to flag in terms of expectations for 4Q versus the sort of current run rate of enrolled patients and patients on therapy. And then particularly maybe there's any commentary insight you can give on the numbers of patients, obviously, presuming a large proportion of starters by how many bridge packs are people having to give? you seem to imply you are getting patients on to paid therapy pretty quickly. But bridge is still something that's a reasonable factor in the mix.

Sijmen de Vries: Maybe, Steve, do you want to comment on that?

Stephen Toor: Certainly. So again, as Anurag said, Christian, we continue to aggressively pursue our patient finding efforts, and actually, we're ramping that up now. We're through that early launch and conversion state.

In terms of starter and bridge, yeah, I mean, we've actually – of course, most of those patients have been on starter, but we're having to bridge very few, or when we do, we bridge for a pretty short period of time relative to what we may have seen with RUCONEST® back in the past, and that's because of this pretty fast approval rate and our ability to get commercial product in patients' hands quickly. Yes, it's going very well in that regard, and we're not having to give away too much free stock.

Christian Glennie: Okay, great. Thanks. I'll jump back in the queue.

Operator: Thank you. We will now go to our next question. And the next question comes from the line of Alistair Campbell from Royal Bank of Canada. Please go ahead.

Alistair Campbell (RBC): Thanks very much. Hopefully, you can hear me. A couple of questions, please. Another follow-on on RUCONEST®, which is following on from Christian's question to an extent. But you're obviously pointing towards adding prescribing physicians, and that's growing at around give-or-take 10% per annum, but also the product is growing at low single digits. So how should I think about that disconnect? Is that a price effect? Or is that lower utilization per patient? Or is it just the incremental prescribers you're adding are sort of less active? So that's question one.

And then question two. If I could just sort of fish my look a bit on additional indications, looking at some of those publications you flagged in the presentation. I think one of the suggestions is you could look at areas where mTOR inhibitors are currently used, given us the same pathway. And that sort of brings to mind areas like autoimmune with things like transplant rejection. There are also oncology areas like neuroendocrine tumors. Can I press you to see whether any of those areas or things you're thinking about right now? Thanks.

Sijmen de Vries: So maybe the first question you want to answer, Stephen?

Stephen Toor: Certainly. So, you're right to flag, I think, the apparent or the perceived disconnect. For the most part, what I would say that is, is we went from 30% of patients on prophylactic therapy three, four years ago to over 70% now in the mid-70s. So, what you're seeing is better controlled patients having less attacks and therefore, utilizing less acute therapy.

But we haven't actually lost that many patients. What we've seen is, and we think of it as cohorts of mild, moderate and severe. So, not the disease itself but the number of attacks. With some patients in that severe end or frequent attack to move into the moderate, then the moderate into the mild area. So, it's more patients, more prescribing physicians, but often a less severe course of disease, leading to a slightly less acute utilization.

Alistair Campbell: Can I quickly follow up on that? If that sort of mix change in the patient population is – let's say, it's more or less played out, does that mean that perhaps as more physicians are added, that could that disconnect could actually lessen over time?

Stephen Toor: Logically, yes, it could.

Alistair Campbell: Okay, thank you.

Anurag Relan: And then I think your question about our next indication. I think you're thinking along the same lines that we are. For example, we know that in APDS in the past, especially, but even now in some areas, where Joenja® is not available, mTOR inhibitors are used. They have tolerability issues and they're not quite the perfect target for the condition itself.

We are looking at other areas where mTOR inhibitors are used and where leniolisib could prove to be better suited for that disease. I can already comment that we're not specifically looking within oncology. I think it's something that we may do in the future. But at the present time, we're really focused on other rare diseases where we think that this pathway is overactive, that some of the things that we see is basically trying to take the learnings from APDS. Some of the features of APDS that we see, where else do we see that type of problem in the immune system. And I think that's what we're in active discussions with the FDA on trying to finalize the clinical trial plan, and I expect to be able to give an update on that later this quarter.

Alistair Campbell: Great. Thanks very much.

Operator: Thank you. We will now go to the next question. And your next question comes from the line of Sushila Hernandez from Van Lanschot Kempen. Please go ahead.

Sushila Hernandez (Van Lanschot Kempen): Yes. Thank you for taking my question. Could you walk us through the development of your operating expenses? As you mentioned, we've seen an increase in marketing and sales costs due to the launch. But will this increase further? Or is this level what we can expect for the coming quarters? And also, on R&D costs with the second indication for leniolisib, is it feasible to target profitability next year? Thank you.

Jeroen Wakkerman: Yeah. Thank you very much for the question, Sushila. On OpEx for Joenja®, we will support the European launch going forward. So, we will shift probably some of the funds from the US to Europe.

On a net basis, it's too early to say what the outcome of that shift will be. And for next year also on the new indication, yes, we will invest in R&D and in a trial. Again, there it's too early to say what the exact cost is, but I don't expect necessarily a reduction in OpEx next year.

Sushila Hernandez: Okay. Thank you.

Operator: Thank you. We will now go to the next question. And your next question comes from the line of Joe Pantginis from H.C. Wainwright. Please go ahead.

Joe Pantginis (H.C. Wainwright): Hi guys. Thanks for taking the question. A couple if you don't mind. So first, I wanted to focus on Stephen's comment on the HAE market. Obviously, there's a lot of disruptive changes to the market that are either ongoing or coming. And I'll phrase my question this way. Obviously, we know where we stand and where Pharming stands with regard to the role of RUCONEST®.

But I guess, maybe more feedback from your new prescribers, for example, and even existing prescribers about the potential threats that are coming, even though they are focused on the prophylactic standpoint. So basically, the external views of needing a rescue therapy such as RUCONEST®.

Sijmen de Vries: Do you want to comment on that, Stephen?

Stephen Toor: Sure. We – I mean, as you know, Joe, we – good morning by the way. We hold our boards pretty regularly. We're all of us active in the year, myself and Anurag regularly in front of our customers in the US.

And I think certainly some of these – some physicians are quite excited by what may be coming in the future. I think what's interesting for me is, patients still need, despite all of these disruptions, that occasional bolus of therapy that you get from an IV product such as RUCONEST®. So, although we see disruption, and as I mentioned earlier, we see sometimes a decrease or in some places, even normalcy increase in utilization.

We still see the need there. I certainly wouldn't want to be complacent, and we look at the future as closely as any company would. But through all of the disruptions, certainly since I joined Pharming seven years ago, we see that initial period of disruption and fluctuation in volume. And then we see things settle down and we see a continued clinical need for an IV C1 esterase inhibitor. So, does that answer your question, Joe?

Joe Pantginis: Now, it certainly does. I appreciate that. And I guess, looking more towards just switching a little bit to Joenja®. Assuming a positive CHMP opinion later this quarter, maybe if you could provide a little more color with regard to your country-by-country strategy. I know previously you discussed targeting Germany first. But how should we view beyond that, how things should go?

Stephen Toor: Do you want me to take that one, Sijmen?

Sijmen de Vries: No, that's for you. Go ahead.

Stephen Toor: Yes. Thanks, Joe. You're right. I mean Germany would be the typical market to go to right out of the gate, and we'll certainly do that. We also will then target the other big four in Europe. Anurag mentioned the UK and a submission there specifically, there now that it's not part of the EU. And then we'll get through Spain, Italy, France, as major nations but we won't ignore the rest of Europe either.

So, we have a pretty lean operation in Europe, and we cluster the other 22 member states around those major markets. And you'll see us through '24 and '25 in a steady sequence start to go to all those markets.

And by the way, we've identified patients, I think, in every single one of those markets. And in addition to that, we have submissions in Australia, which will enable us to set up a base of operations in APAC in the key markets outside of Japan. The ongoing trial in Japan and a submission with Health Canada right now as well as that is a key market globally. I think we have a pretty careful, well-considered sequenced approach that gets us into markets at the right time. And you'll see that putting up through '24 and '25.

Joe Pantginis: Got it. And then just lastly, I guess it's a quick logistical question. With regard to the VUSs and unclassified variance, if you will, is there anything that needs to be done as you generate data about these variants on the regulatory front or in the label to identify these?

Anurag Relan: Hi, Joe. Good morning. So, the answer there is no. Because these patients actually have APDS, the label is for APDS. Right now, the question is this variant, which hasn't been previously described or previously published. When the genetic testing company gets that result, they don't know what to do with it, so they throw it into this bucket of the VUSs, and many, many results come back into this VUS classification.

But once that is reclassified based usually on functional testing data, or even as I mentioned, that using that multiplex approach. Once that's reclassified, then that patient has APDS and would qualify for treatment per the label.

Joe Pantginis: Great. Thanks for the clarification. And thanks for all the answers, guys.

Operator: Thank you. We will now go to your next question. And your next question comes from the line of Hartaj Singh from Oppenheimer. Please go ahead.

Hartaj Singh (Oppenheimer): Great. Thank you. Thanks for the – I got a couple of questions and really nice update everyone. The two questions I have just following up to a previous question on the cadence of the launches ex-US. I know Australia, Canada, Israel in '24 and '25, Europe later this year and then discussions there. Can you just give us an idea of the relative TAM of that market? And then could there be boluses in Europe, the UK, Australia, Canada, because you have been working very hard to identify patients. I imagine there are patients in these various territories, ready to get on drug and then how would pricing potentially look relative to the US market? So, that's the first question.

The second question is just on your family testing. Previous research we had done before leniolisib was approved, indicated there could be as little as one more family member and as much as three more extended family members that might have some indication of APDS and could potentially qualify for treatment.

I know these are early days, but if you could just give us some color around there. What do you expect to see as you ramp up this family testing? Thanks for the question.

Sijmen de Vries: Thanks, Hartaj. Steve, do you want to comment on those patient numbers ex-US?

Stephen Toor: Certainly. And I didn't quite catch the front end of the question, Hartaj, so if I miss anything, then please just pick me up as we go through. I think you're right to flag that the medical affairs group across the world have been actively identifying patients with key opinion leaders in those key centers in each country. There will be a bolus of patients awaiting therapy, and many of them will already be in the early access program, for example.

There will be a slight delay because from approval in many of those countries, you then need to negotiate reimbursement, which means we set the price slightly later than the clinical approval. But in terms of your pricing question, the price outside of the US will, as you know, for the most part, always be lower. It's highly unlikely to match that price, and there'll be a variation in what that price looks like country by country.

What I would say though is without preempting what that price might look like is, as with all ultra-rare diseases and rare diseases, we can still make a market and build a very healthy business in each of those countries, and that's fully what we expect to do.

Hartaj Singh: That's great, Stephen. And then just on the question of the family testing and then how big could that patient population be just roughly speaking?

Anurag Relan: Yes Hartaj, it's a great question. It's certainly something that we're trying to address right now, which is, we know it's an autosomal dominant transmitted disease. We expect that there should be other family members with the condition and as we said many times, it may not be immediate family members, even extended family members.

What we've been trying – what we've been a little surprised by though, and I guess it relates to the fragmented nature of our healthcare system is that oftentimes these family members haven't been tested. Some of that is just due to lack of awareness even amongst patients about the genetics of the disease, and some of that is just due to the healthcare system idiosyncrasies and how it's difficult to get genetic testing done.

We're changing the way we approach this and really moving – putting the patient right at the center of this. Allowing patients and families to actually initiate testing. If a patient is diagnosed with APDS and a family member wants to get tested, we started a program that will allow that to happen by having the family member themselves initiate the process, and it doesn't need to go through – for example, the patient specialists who may not be immediately available to see the family member, or the family member may not even be a patient in most cases.

I think removing these barriers to genetic testing to allow appropriate testing in family is, I think, will likely be a significant source of newly diagnosed patients. And we're starting that program – we've started a little bit of that already, but really putting that full force now.

Hartaj Singh: Great, Anurag. That helps. Thank you everyone for the question.

Operator: Thank you. And we'll now go to the next question. And your next question comes from the line of Simon Scholes from First Berlin. Please go ahead.

Simon Scholes (First Berlin): Yes, hello. Thanks for taking my question. So, you've already identified 150 APDS patients over the age of 12 in the US. I was just wondering, how many of those patients do you ultimately expect to be able to enroll?

Sijmen de Vries: I would say the vast majority of those, Simon, will if not almost all of it.

Simon Scholes: Okay. So almost all.

Sijmen de Vries: And that's just the beginning, right? Because you heard –

Simon Scholes: Yes, I know there are other patients. But I was just interested in patients you already identified, so we should assume over 90% or 95%?

Sijmen de Vries: Well, I think there will be a very high percentage of patients that indeed will be interested to get into major treatment, correct. That's our experience so far at least.

Simon Scholes: Okay. And particularly in the US, you don't expect to encounter a problem with the last 10% or 20% because of lack of insurance coverage. How does that work? I mean, presumably, there will be some patients without insurance coverage. Can you get those as on paid therapy as well?

Sijmen de Vries: Well, those questions are difficult to answer. But generally speaking, if we look at our experience in RUCONEST®, we don't see any issues with related to that coming up. And of course, RUCONEST® also has patients that have limited or no insurance coverage, but there's always a way and means. Maybe you want to comment on that, Stephen?

Stephen Toor: Yeah, I think there's all kinds of different types of support available for patients even – and also public programs that try and make sure that patients have access to something. To be honest, I haven't looked at this for a while, but I believe we have very, very few RUCONEST® patients, for example, in our patient assistance program, which will be essentially free supply on an ongoing basis.

Even when they are in there, every year, we're working with them and with their physicians to find an insurance plan for them. We'll find an option that will be to pay therapy. I apologize, I can't give you a specific answer, but if I look at the RUCONEST® experience and my experience in rare diseases outside of Pharming, I think the vast majority of patients in the end will be on paid therapy. It can sometimes just be a heavy lift to get those last few percent together.

Simon Scholes: Okay. Thanks very much. It's very helpful.

Operator: Thank you. As a reminder, if you would like to ask a question, please press star one and one on your telephone and wait for your name to be announced. And we'll now go to the next

question. And your next question comes from the line of Christian Glennie from Stifel. Please go ahead.

Christian Glennie: Hi guys. Just a quick follow-up, if I can, on Joenja® and the pediatric study in the four- to 11-year-olds, looking at enrollment almost complete there. So just a reminder in terms of the endpoint for that trial, the timing of the endpoint and, therefore, when we might see data? And then the expected sort of rough mix of the under 12s as it relates to these four- to 11-year-olds. So, I mean, if you think about, say, the 50 remaining patients identified in the US that we know, how many of those would be four to 11?

Anurag Relan: Let me answer the second question first, Christian. Based on our current experience in APDS, about a quarter of patients overall are below the age of 12. Amongst that quarter, at least three-quarters are in the age range of the first study or four to 11-year-old study.

We know these patients actually have the disease at birth and that many patients do begin to manifest symptoms early on. But oftentimes, they're not diagnosed at that very early age. And that results in many patients in this – in the older age groups, especially in that above four age group. That's a little bit on the breakdown of the age distributions across APDS.

In terms of the pediatric study and the endpoints that we've had in the adolescent and adult study. I think what we'll be able to do is once the study is fully enrolled, and we've got these last four patients enrolled, we'll give you some more guidance on the timing of the data releases as well as some of the regulatory work that we anticipate being able to do if the results are positive.

Christian Glennie: Okay. Thanks. That's helpful.

Operator: Thank you. There are currently no further questions. I will hand the call back.

Sijmen de Vries: All right. Thank you very much. Maybe a few closing remarks. Thanks for attending. You can see now that, as stated last quarter, the company is now starting a long growth trajectory, supported by the foundation that RUCONEST® provides, and driven by the future expansion of Joenja® outside of the United States but also inside the United States. Supported by lots of efforts that we are undertaking and initiating to actually broaden the patient base. As always, with new genetic diseases, the definition of the disease will broaden.

Therefore, we look forward to the future with optimism and with a company that will significantly grow and change over the coming years, putting us again as a combination of our commercialization capabilities, clinical development and regulatory skills, as hopefully, the ideal partner or go to partner in the future for other rare disease assets that we can take on board and actually complete the clinical development/approvals and do the successful commercialization as we do with RUCONEST® and with Joenja®.

Thank you very much for attending, and we look forward to updating you again on our full year results call, which will be in March of next year. Thank you very much. Goodbye.

[END OF TRANSCRIPT]