

VICORE PHARMA

Unlocking the potential of a new class of drugs – Angiotensin II type 2 receptor (AT2R) agonists

October 2026

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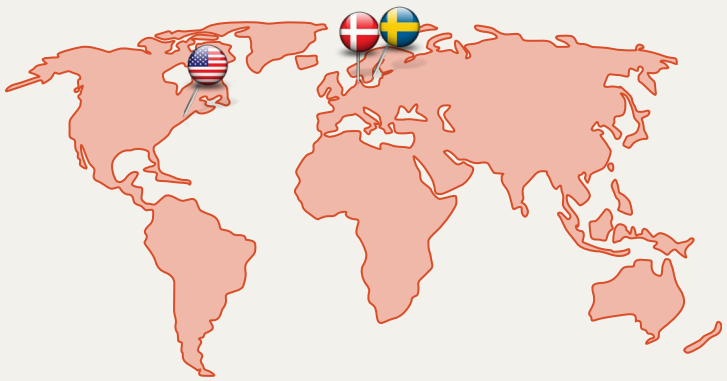
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Company overview

Vicore Vision

Transform the lives of patients where modulation of the angiotensin II type 2 receptor (AT2R) may play a central role in halting and reversing disease pathology



Locations

Stockholm, Sweden
Cambridge, Massachusetts, USA
Copenhagen, Denmark

Financials

Dual listing on Nasdaq Stockholm (VICO) and Nasdaq US (VCRE), and funded well past Phase 2b data

$257m As of October 12, 2026
market cap

$93m As of June 30, 2026
financial position

Shareholders

Vicore is backed by leading specialist investors in the US and Europe

Pipeline

Unlocking the potential of a new class of drugs – angiotensin II type 2 receptor (AT2R) agonists

Vicore's lead program, buloxibutid, is an oral small molecule AT2R agonist, which has received Orphan Drug and Fast Track designation from FDA and is currently being investigated in a global 52-week Phase 2b trial in IPF, ASPIRE

Compound	Indication	Preclinical	Phase 1	Phase 2	Phase 3	Comments	Rights
Buloxibutid	**IPF**			→		Phase 2b ongoing (NCT06588686) Enrollment complete Targeting topline readout in mid-2027	Global ex-Japan rights Japan: NIPPON SHINYAKU CO., LTD.
New AT2R agonists are in early-stage discovery							

Phase 2b ASPIRE study passed its pre-planned futility analysis and remains on track for topline results in mid-2027

- **Pre-specified futility criteria were not met**
- **Independent Data Monitoring Committee (iDMC) recommended that ASPIRE continue without modification**
- **In parallel, the iDMC's regular safety and benefit-risk review raised no concerns**
- **ASPIRE remains on track for 52-week topline results in mid-2027**

Futility analysis

- Based on efficacy data from the first ~100 randomized patients (~27% of enrolled patients)
- Primary endpoint (change from baseline in FVC at Week 52) for the high dose of buloxibutid (100 mg twice daily) vs. placebo
- Conditional power approach to estimate probability of success at final readout, with pre-specified threshold of below 20% to consider stopping the study
- Vicore remains blinded: no treatment effect estimates or conditional power values disclosed to the company

Next steps

APR 2026

Enrollment completed ahead of schedule: n=378 randomized at >100 sites in 14 countries incl. the US

OCT 2026

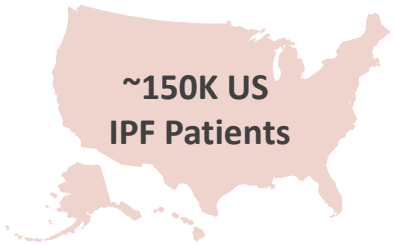
Futility analysis passed; ASPIRE continues as designed

MID-2027

Database lock; 52-week topline results

IPF is a progressive, fatal disease with significant unmet need despite available therapies

Orphan disease with high unmet need





Where only ~1/4 of US patients initiate treatment[1]



And the high discontinuation rate leads to an average time on treatment of only

10 months[1]

The majority of the IPF market is not adequately addressed today

Limitations of available treatment options

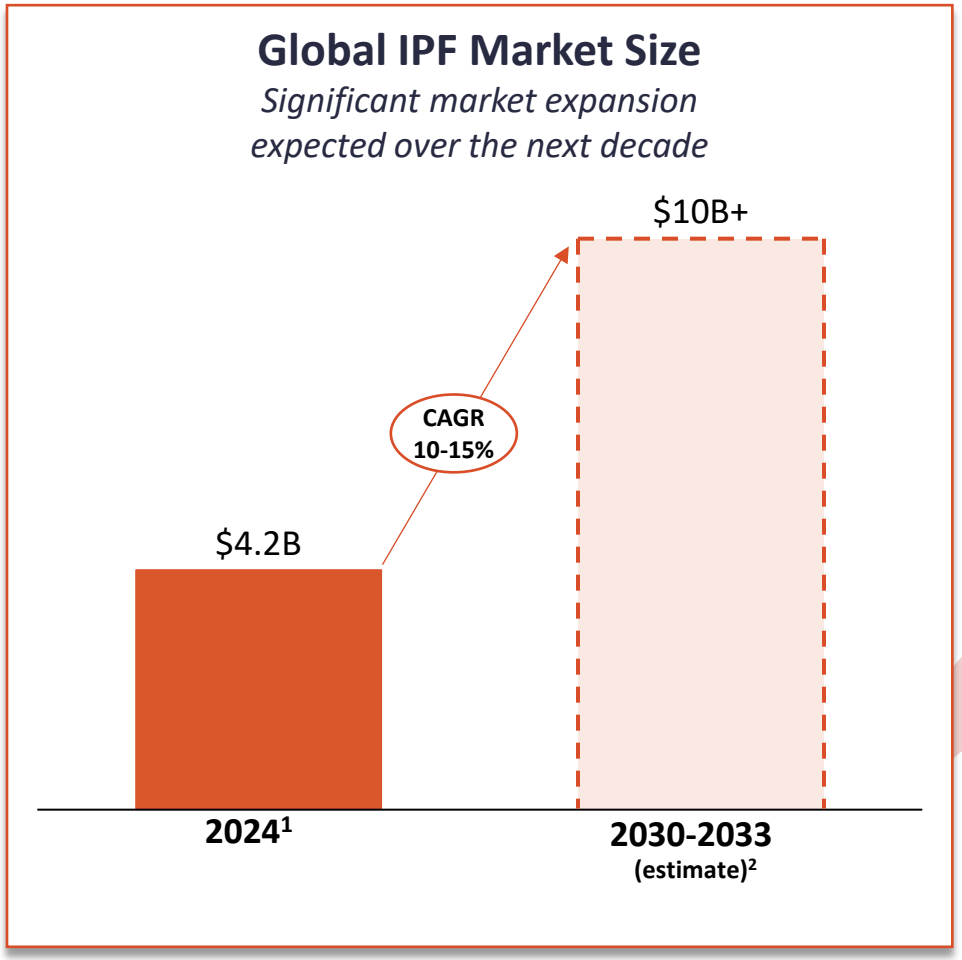
Three FDA-approved therapies:

OFEV® Esbriet® JASCAYD®

- Existing therapies offer only modest slowing of disease progression and have not demonstrated quality of life benefit
- Significant GI side effects limit uptake, often requiring dose reductions and contributing to high discontinuation rates
- Despite available treatments, the 5-year mortality rate is 80%[2]
- There are no approved disease-modifying therapies today

(1) Dempsey et al. Ann Am Thorac Soc. 2021; (2) IPF Foundation

IPF is a large and growing market with urgent need for innovation



Drivers of Market Growth Today

- **New Approvals:** Jascayd
- **Disease Awareness:** Rising diagnosis rates and expected broader treatment adoption
- **Epidemiology:** Aging population and increasing disease prevalence

White Space for Market-Shifting Innovation

- **Disease-Modifying Efficacy:** Stabilization or improvement in lung function
- **Well-Tolerated & Combinable Therapies:** Expanding treatment pool, extending time on therapy, and reducing discontinuations

(1) Company reports (note: combined sales of marketed drugs Ofev and Esbriet where Ofev sales include SSc-ILD); (2) Global Data, The Insights Partners

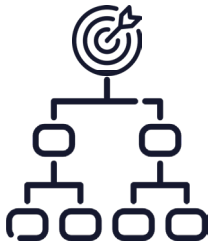
Buloxibutid is positioned to potentially transform the IPF landscape

Recently approved and late-stage IPF therapies have demonstrated modest reduction of lung function decline, with many associated with tolerability or administration challenges. Following these programs, buloxibutid is the most advanced IPF therapy in global development.

	Vicore pharma **Buloxibutid**	Boehringer Ingelheim Jascayd (nerandomilast)	United Therapeutics Tyvaso (treprostinil)	Bristol Myers Squibb Admilparant
MOA	**AT2R agonist** Novel endogenous upstream and multi-modal mechanism	PDE4B antagonist	prostacyclin analog	LPA1 antagonist
Dosing & Administration	**Oral BID** Convenient oral dosing	Oral BID	Nebulized formulation, 48 (12x4) breaths per day	Oral BID
Tolerability	**Favorable and combinable tolerability profile[1];** mild-to-moderate hair loss	GI-tolerability issues, further exacerbated on top of SoC	Cough, throat irritation, headache, nausea and flushing	Favorable overall profile; transient reduction in blood pressure
Efficacy	**Mean FVC improvement[2]** Observed +216mL vs. baseline at 36 weeks Potential to stabilize and improve lung function	Incremental efficacy +68.8mL vs. placebo at 52 weeks	Pooled efficacy: TETON-1&2 +111.8mL vs. placebo at 52 weeks	Incremental efficacy +45.5mL vs. placebo at 26 weeks
	Value Proposition	**Key Challenges**		
	Combination of improved efficacy, favorable tolerability profile, and convenient dosing	Offers only incremental improvement in efficacy and tolerability	Inconvenient dosing and administration and difficult tolerability profile	Limited efficacy demonstrated at 26 weeks

(1) Tolerability based on clinical data generated to date; (2) Efficacy data observed in the Phase 2a AIR trial
Graphic is not meant to represent head-to-head study. Cross-trial comparisons are challenging due to differences in trial design, patient selection, and analysis method

Buloxibutid is an AT2R agonist with the potential to offer a differentiated treatment standard in IPF



Upstream MoA with strong preclinical data

- AT2R expressed on alveolar progenitor cell (AEC2)
- Upstream mechanism is believed to drive alveolar repair, resolve fibrosis, and promote vascular function



Encouraging clinical data observed in the Phase 2a AIR trial

- Observed mean FVC change from baseline of +216 mL at 36 weeks, with benefit observed across all subgroups[1]
- Synthetic control arm analysis reinforces the meaningful treatment effect observed with buloxibutid
- Good gastrointestinal tolerability and no treatment-related SAEs
- Biomarker data highly supportive of suggested MoA



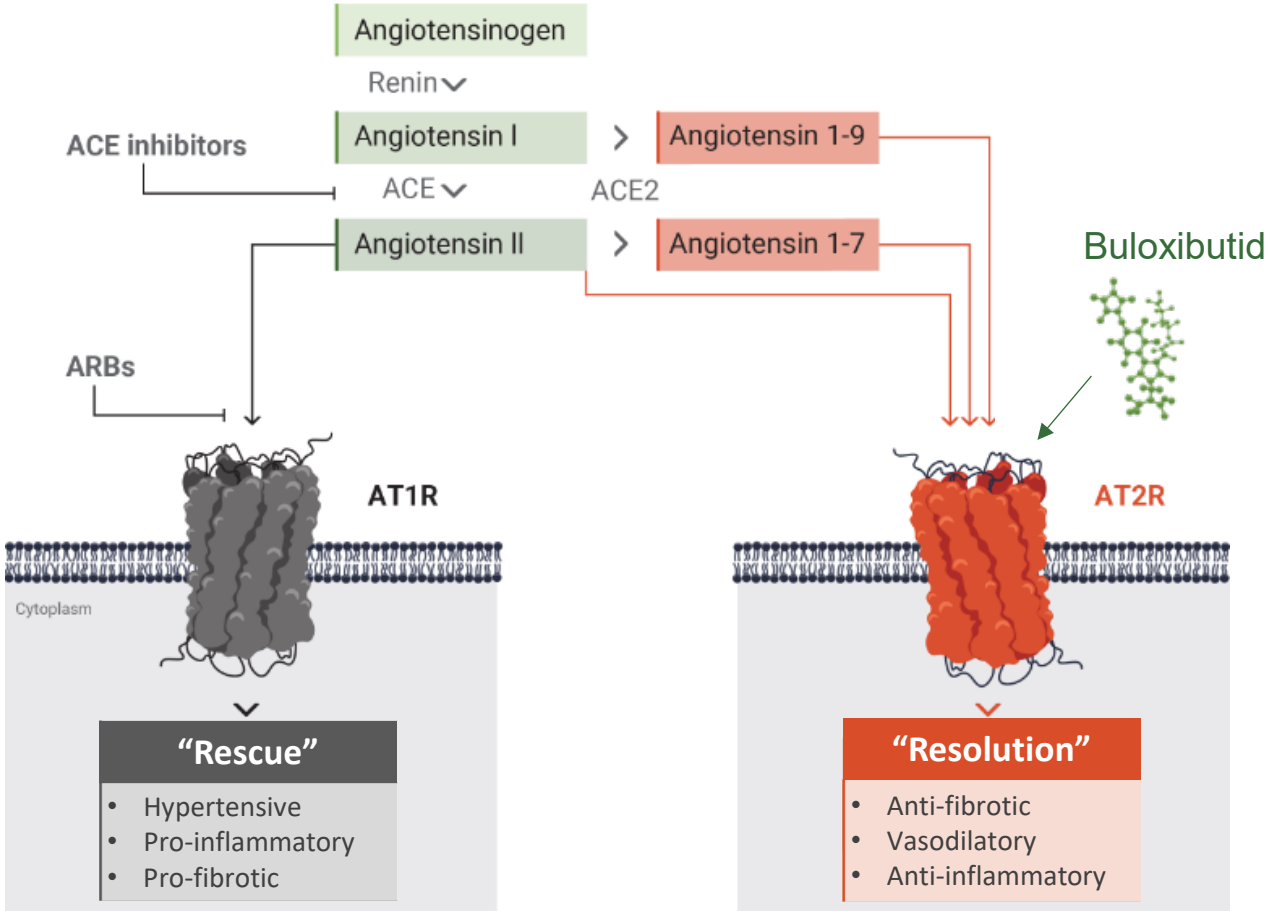
Phase 2b ASPIRE: confirming clinical activity in a randomized, placebo-controlled trial

- 52-week treatment
- Fully enrolled (N=378)
- IPF patients on stable nintedanib/SoC or not on SoC[2]
- Global footprint

ASPIRE

(1) Mean FVC change observed in patients that completed the Phase 2a clinical trial; (2) As nerandomilast is approved in the United States, patients receiving stable background nerandomilast therapy were eligible for enrollment in the trial, though this is anticipated to represent a small subset of the study population

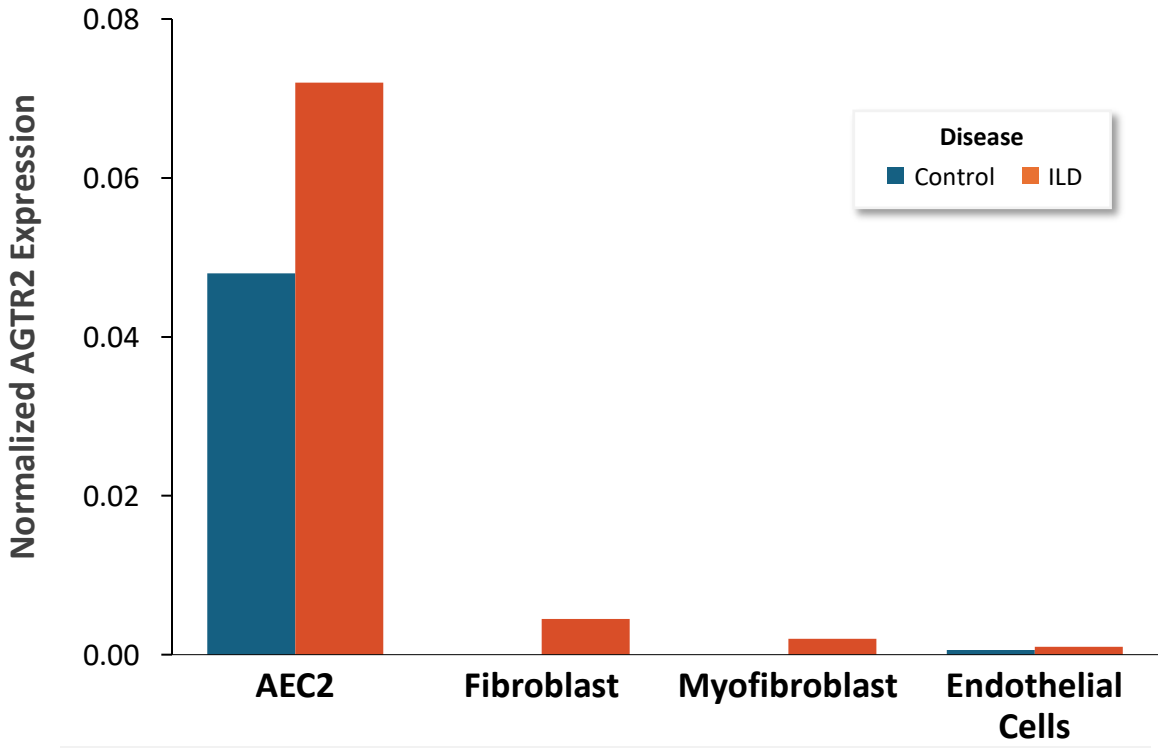
AT2R agonism is an upstream intervention driving tissue repair



- AT2R is constitutively expressed in the lung, primarily on alveolar epithelial type 2 cells (AEC2) – the "alveolar repair cell"
- AT2R activation engages tissue-protective pathways via AEC2s, promoting inhibition of fibrotic progression and fibrosis resolution, anti-inflammatory effects, vasodilation, and reversal of vascular remodeling
- Buloxibutid is an oral, selective AT2R agonist
- AT1R effects include increase in blood pressure, a key reason for ACE inhibitor and ARB development

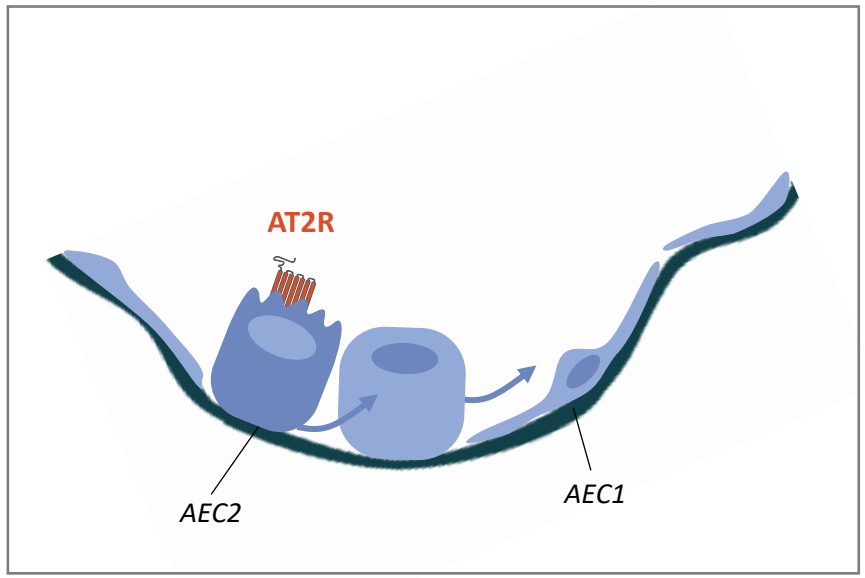
AT2R is highly expressed in human IPF lungs and on precursor alveolar epithelial type 2 cells (AEC2s)

AT2R Expression is Elevated in IPF Lung[1]



AGTR2 expression is enriched in AEC2s and increased in IPF lungs. Low-level AGTR2 transcripts are also detectable in fibroblasts, myofibroblasts and endothelial cells, with higher expression observed in diseased *vs.* healthy tissue

AT2R is Highly Expressed on AEC2s

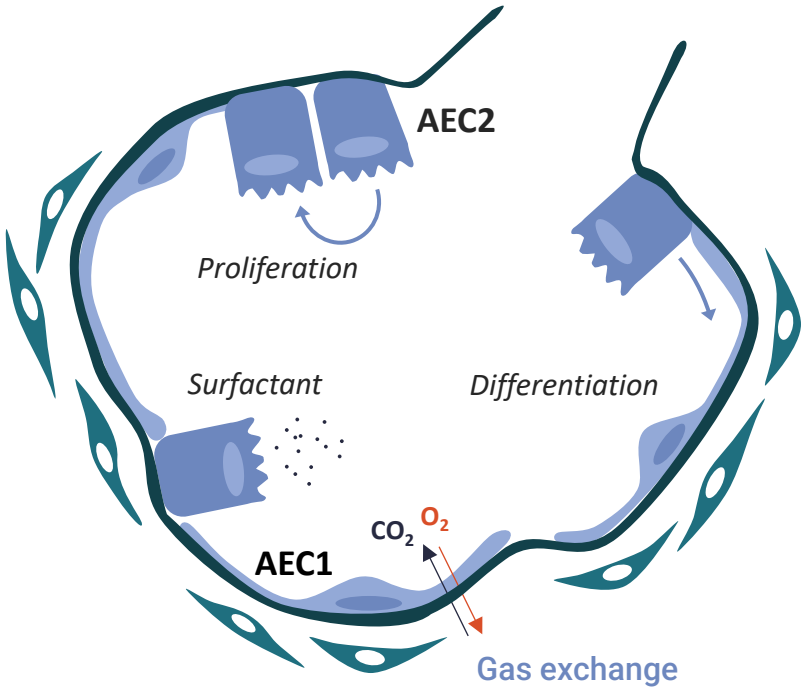


Single-cell analysis shows high AT2R expression on AEC2 in the lung, the progenitor cell that differentiates into AEC1 gas exchange cells

(1) Adapted from IPF Cell Atlas (Banovich/Kropski). AGTR2 expression values represent normalized, variance-stabilized scRNA-seq expression units derived using Seurat SCTransform normalization (relative transcript abundance). AGTR2 is the gene encoding the AT2 receptor (AT2R) and is the name used in the IPF Cell Atlas.

Alveolar epithelial cells are critical for healthy lung function

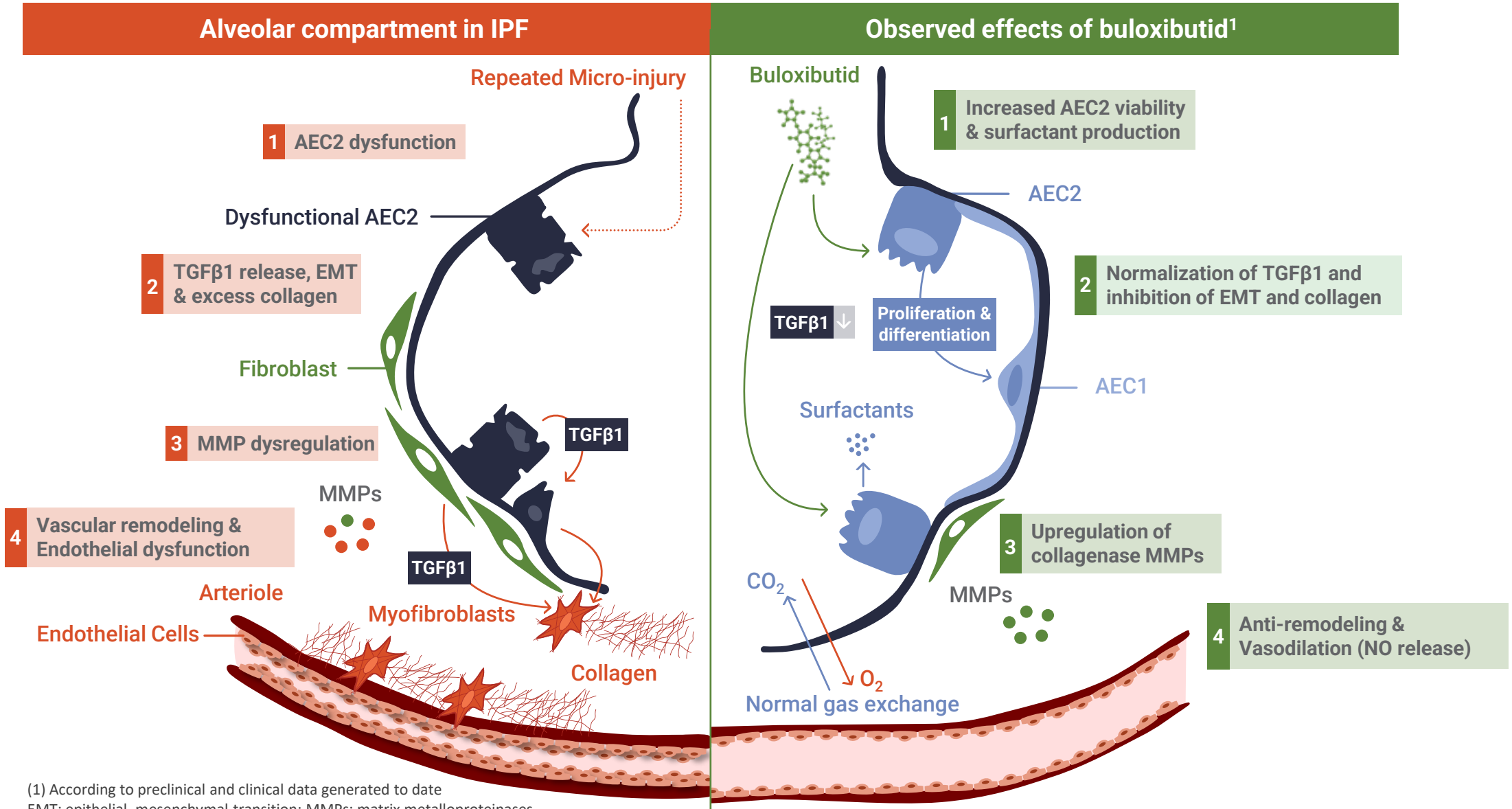
Healthy alveolus



AEC: alveolar epithelial cell

- The alveolar epithelium is exposed to damaging irritants in inhaled air
- AEC1 is the predominant alveolar cell type and is responsible for gas exchange
- AEC2 is a progenitor cell that is critical for alveolar integrity and function:
  - Proliferates to form new AEC2
  - Differentiates to AEC1 that need to be replaced
  - Produces surfactant to maintain alveolar integrity
- AT2R is expressed on AEC2

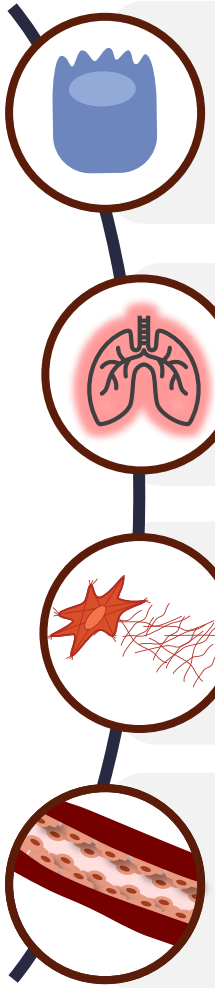
Buloxibutid is an oral, selective AT2R agonist that is associated with tissue repair via AEC2 precursor epithelial cells



(1) According to preclinical and clinical data generated to date
EMT: epithelial–mesenchymal transition; MMPs: matrix metalloproteinases

Buloxibutid is designed to target key disease drivers in IPF, with a potentially disease-modifying mechanism through tissue repair

Effects Observed in Preclinical Studies



Tissue repair and regeneration

Buloxibutid is designed to target precursor epithelial cells (AEC2) to drive tissue repair, offering a potentially disease-modifying mechanism of action

Anti-inflammatory

Buloxibutid is associated with inhibition of pro-inflammatory cytokine release through inhibition of NF-κB signaling

Anti-fibrotic

Buloxibutid is associated with restoration of dysfunctional AEC2 and surfactant production, normalization of TGFβ1 levels, inhibition of EMT and collagen deposition, as well as break down of existing collagen build up

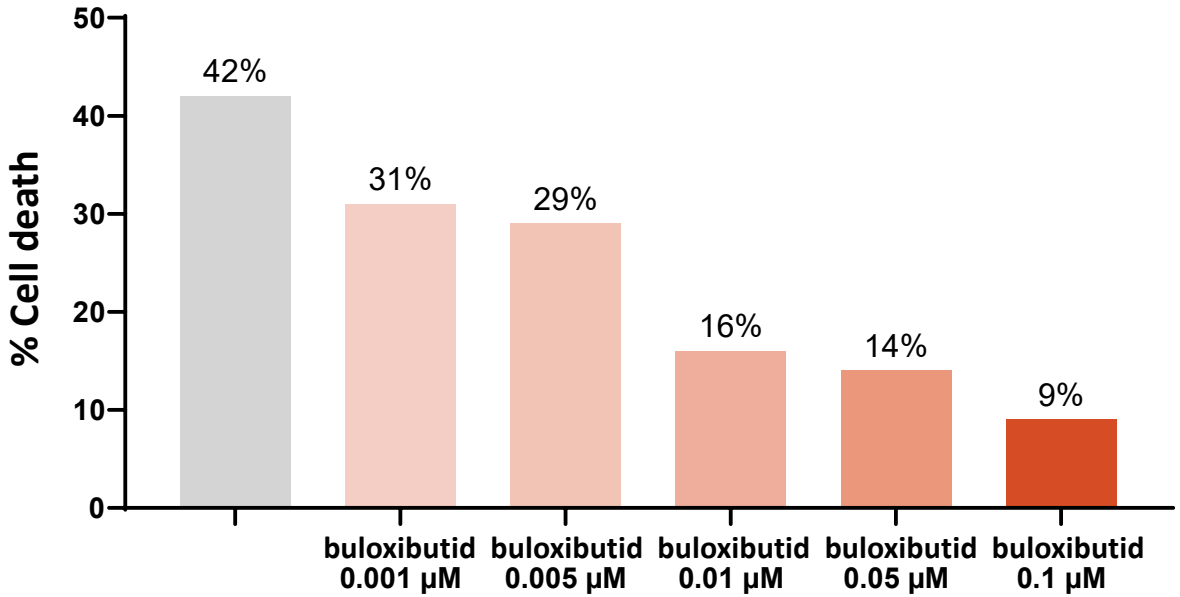
Reverses vascular remodeling

Buloxibutid is associated with vasodilation and reversal of vascular remodeling through NO release

EMT: epithelial–mesenchymal transition

Buloxibutid is designed to protect AEC2s and drive increased surfactant production

Buloxibutid associated with reduced apoptosis of AEC2s[1]



- Cultured A549 cells (human AEC2 cell line)
- Bleomycin (10µg/ml) induced apoptosis

Increase in surfactant protein expression associated with buloxibutid in ex vivo human IPF precision cut lung slices[2]



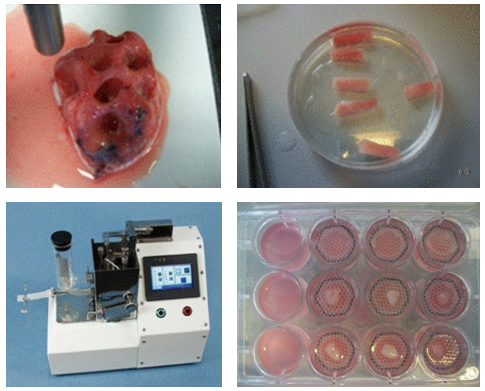
- Human precision cut IPF lung slices ± 1 µM buloxibutid
- One patient, 5 pooled lung slices

Treatment with buloxibutid is associated with protection of AEC2s, driving increased surfactant production to potentially address alveolar collapse

(1) Adapted from Nalbandyan et al. FASEB 2018; (2) Vicore data on file

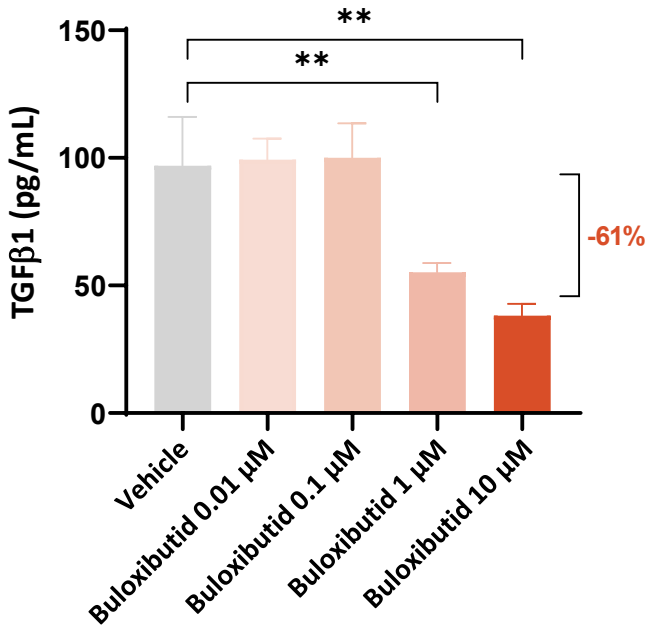
Buloxibutid is associated with TGFβ1 and collagen reduction in human IPF lung slices

Human precision cut lung slices (PCLuS)

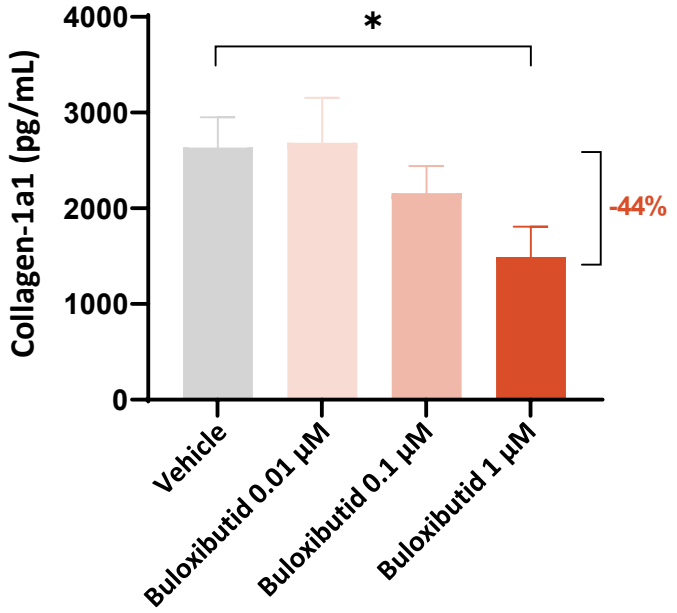


- Lung tissue collected from IPF patients undergoing transplant
- Intrinsic fibrosis, no stimuli added

TGFβ1 protein levels in PCLuS



Collagen protein levels in PCLuS

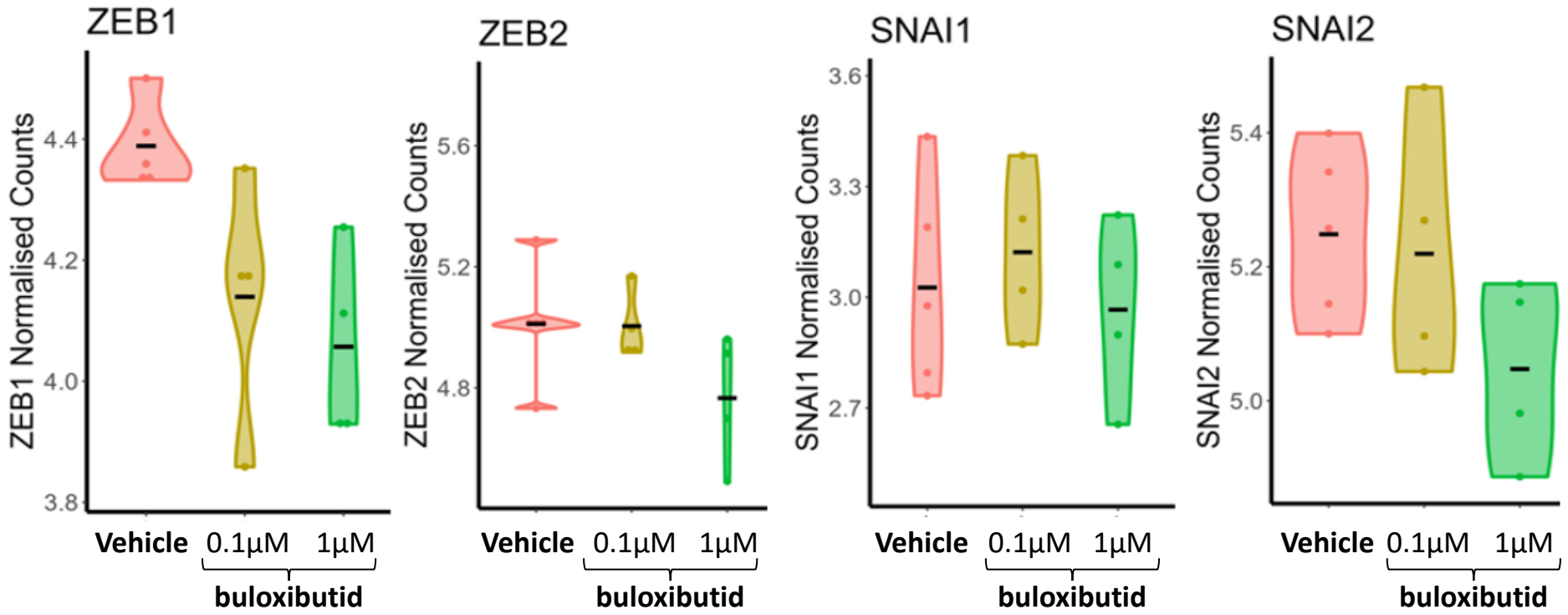


Dose-dependent reduction of TGFβ1 and Collagen-1a1 protein

Data represent averages +/- SEM of 5 separate tissue slices at each concentration, sampled after 144h exposure to buloxibutid or vehicle

Source: Vicore data on file
*p<0.05, **p<0.01, ***p<0.001; t-test versus vehicle

Buloxibutid is associated with downregulated expression of EMT transcription factors in AEC2

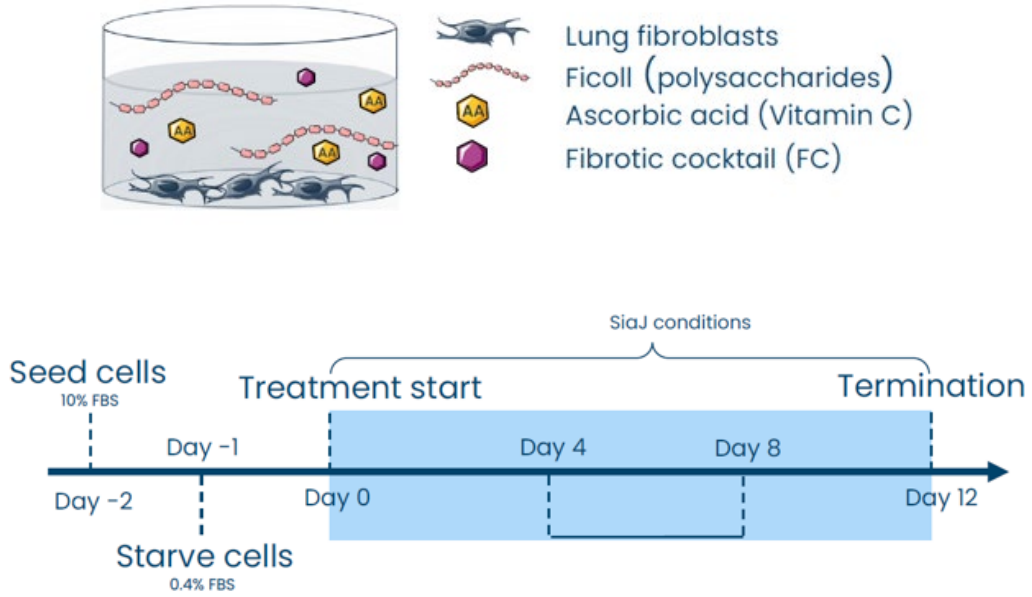


- Primary AEC2 cultures established from normal surgically resected human lung
- Buloxibutid treatment under baseline conditions with no stimuli added

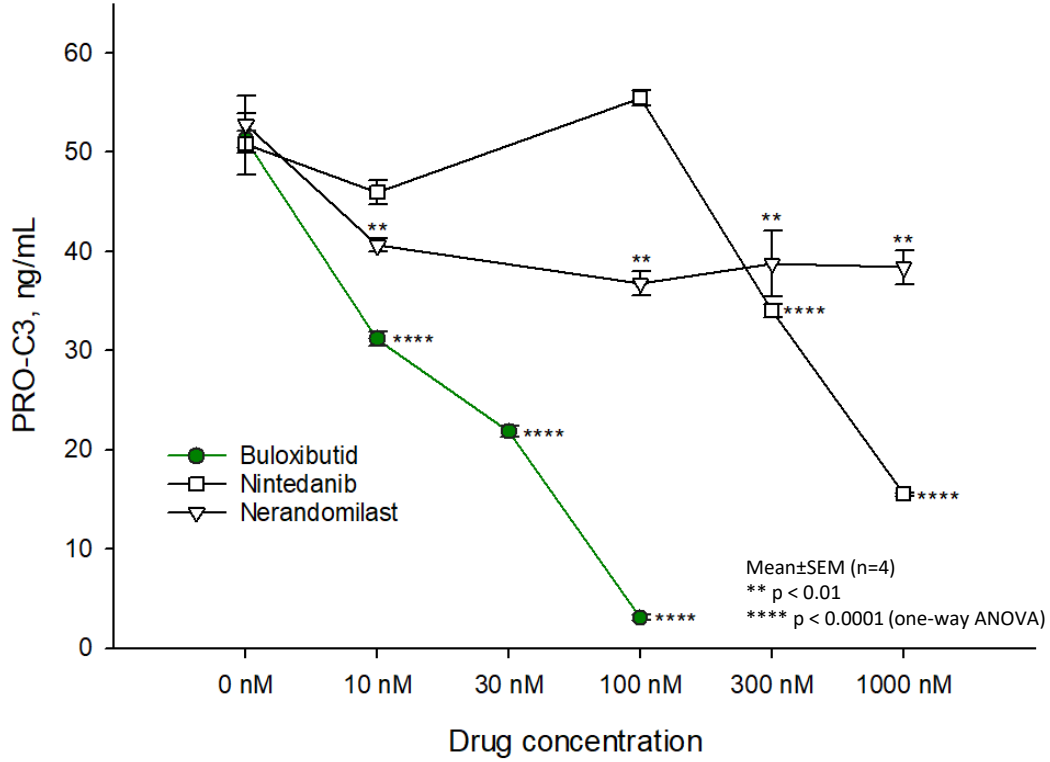
Source: Conforti et al. 2023, manuscript (Vicore collaboration with U. of Southampton)

Collagen biomarker PRO-C3 inhibited in human lung fibroblast assay treated with buloxibutid, suggesting resolution of fibrosis

Human lung fibroblast assay methodology



Impact on type III collagen biomarker PRO-C3



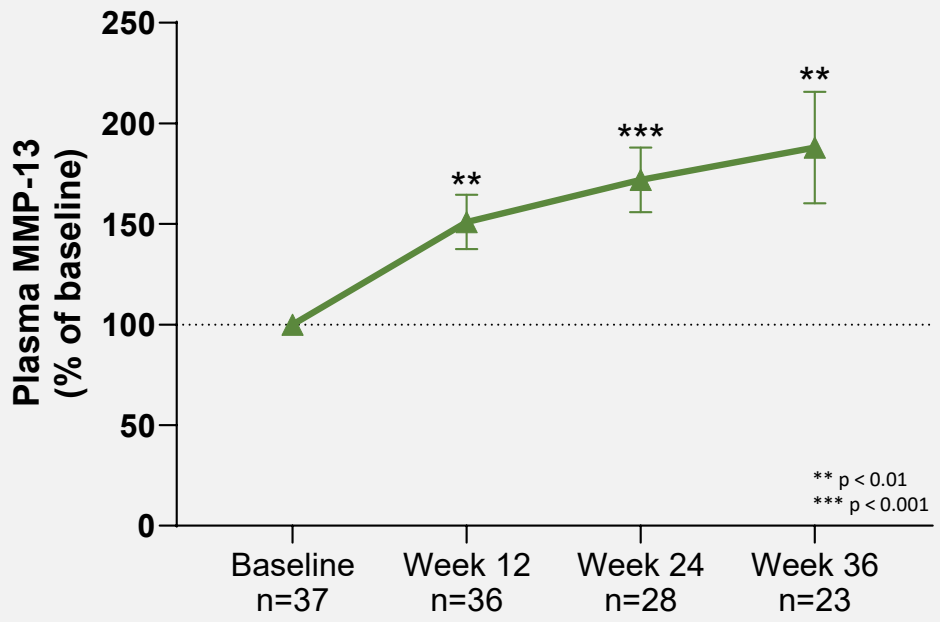
Buloxibutid associated with potent and dose-dependent inhibition of PRO-C3, suggesting inhibition of type III collagen formation and fibrotic activity. In a preclinical in vitro assay, buloxibutid showed potent inhibition of IPF biomarker PRO-C3 compared to nintedanib and nerandomilast, which may be indicative of its anti-fibrotic mechanism.

MMP-13 demonstrates antifibrotic activity and is crucial for lung repair in IPF

Collagenase MMP dysregulation contributes to IPF pathogenesis

- MMP-13 is an enzyme able to cleave fibrillar collagens and plays a significant role in the degradation of the ECM
- In mouse models, MMP-13 deficiency has been shown to[1,2]:
  1. Decrease collagenolytic activity
  2. Promote lung fibrosis
  3. Attenuate fibrosis resolution

Buloxibutid associated with increased plasma MMP-13 in the Phase 2a AIR trial



Patients treated with buloxibutid showed a significant increase in plasma levels of the collagenolytic collagenase MMP-13, suggesting that buloxibutid has the potential to degrade fibrosis

(1) Cabrera et al., 2019; (2) Nkyimbeng et al., 2013
ECM: extracellular matrix; MMP: matrix metalloproteinases

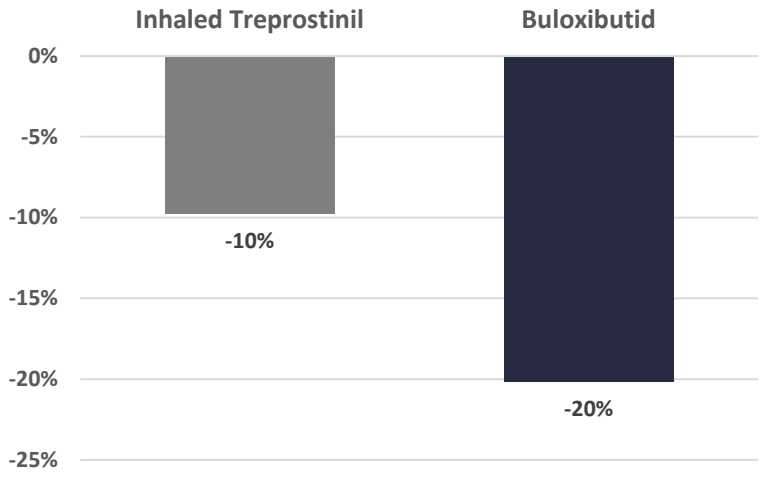
Buloxibutid demonstrated greater reduction in key hemodynamic and vascular remodeling parameters compared to inhaled treprostinil in preclinical Sugen-Hypoxia rat model

Inhaled treprostinil and buloxibutid were evaluated in separate studies using the same study protocol

Hemodynamic Parameters

RVSP

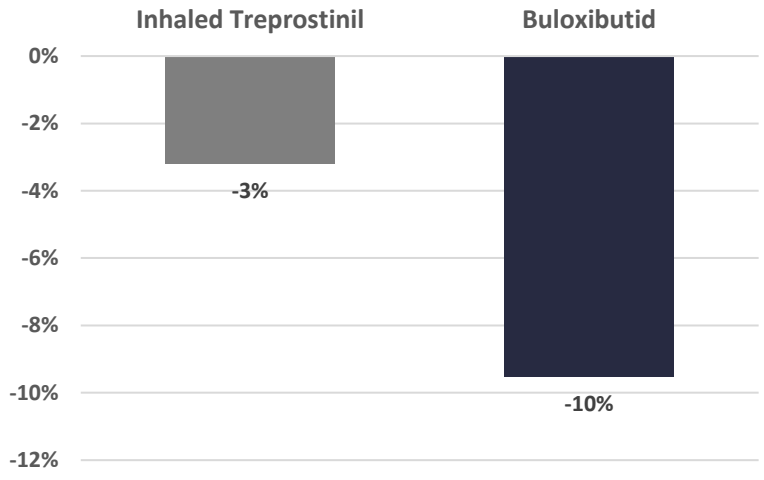
Reduction in RVSP from SuHx control



Right Ventricular Remodeling

Fulton's Index

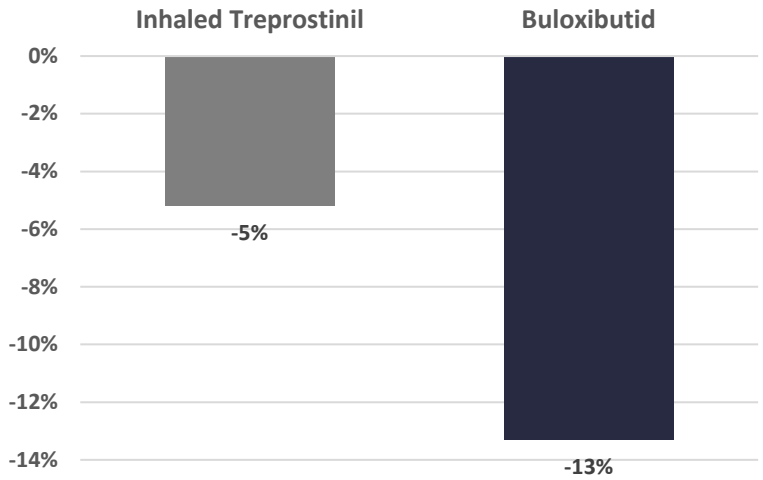
Reduction vs. SuHx control



Pulmonary Vascular Remodeling

Wall Thickness

Reduction vs. SuHx control



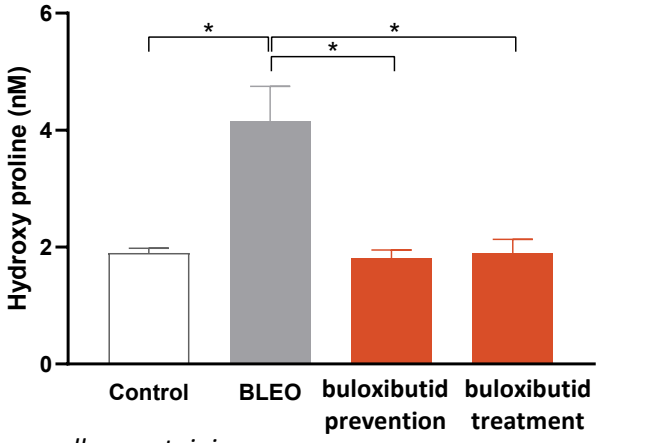
***Inhaled treprostinil**: adapted from Corboz, et al., J. Pharmacol. Exp. Ther. 2022 – Dose: 65 µg/kg*
***Buloxibutid**: adapted from Tornling, et al., Int. J. Mol. Sci. 2023 – Dose: average result of 2 mg/kg and 20 mg/kg dose*

Clinically relevant concentrations of buloxibutid demonstrated greater reduction compared to the Sugen-Hypoxia control than clinically relevant dose of inhaled treprostinil across key readouts, including RVSP, mPAP (data not shown), Fulton's index, wall thickness and muscularization (data not shown)

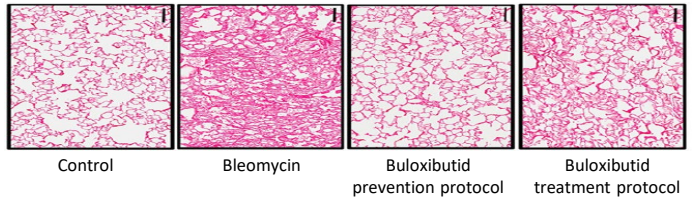
SuHx: sugen-hypoxia; mPAP: mean pulmonary artery pressure; RVSP: right ventricular systolic pressure

Strong preclinical in vivo evidence for buloxibutid in pulmonary fibrosis

Bleomycin



Lung collagen staining

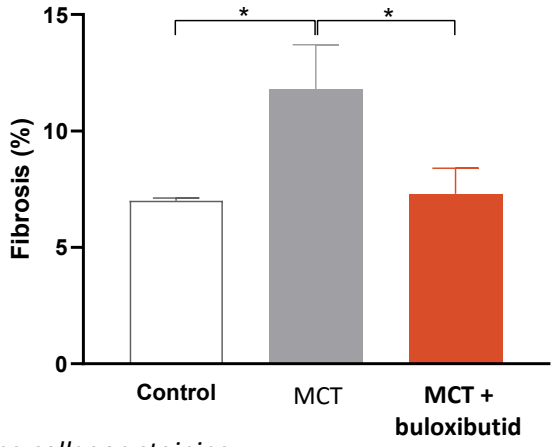


- Buloxibutid 0.03 mg/kg/day i.p. once daily, 14 days (Treatment). N=5 control and 7-8 in treatment groups

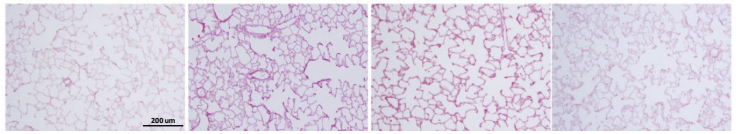
Adapted from (1)

- **Normalized collagen synthesis and attenuation of disrupted lung architecture**

Monocrotaline



Lung collagen staining

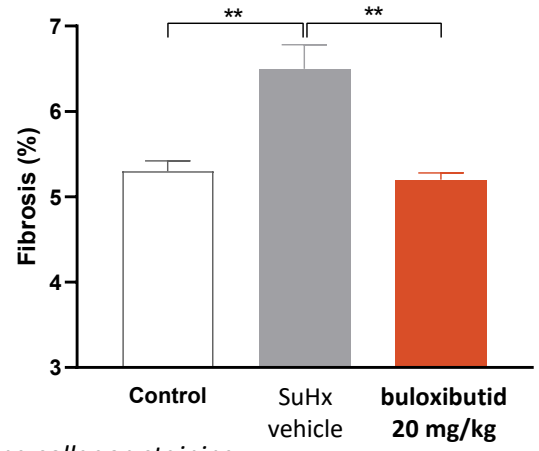


- Buloxibutid 0.03 mg/kg/day i.p. once daily for 2 weeks
- N=14 per treatment group

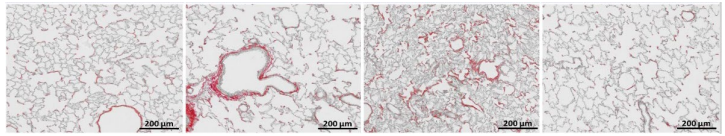
Adapted from (2)

- **Reversal of pulmonary fibrosis and prevention of right ventricular fibrosis**
- **Reversal of vascular remodeling and improved right heart function**

Sugen-Hypoxia



Lung collagen staining



- Buloxibutid p.o. for 34 days, initiated 21 d. after SuHx-period. N=10-11 per treatment group

Adapted from (3)

- **Reversal of fibrosis**
- **Reversal of vascular remodeling**
- **Reduced RVSP and right ventricular hypertrophy**

(1) Rathinasabapathy et al. Front Physiol. 2018; (2) Bruce et al. Br J Pharmacol. 2015; (3) Tornling et al. Int J Mol Sci. 2023
RVSP: right ventricular systolic pressure

Buloxibutid has an extensive and robust safety database, with over 350 patients dosed across nine completed clinical trials



Buloxibutid has been tested extensively in the clinic, generating a robust safety database

- Not including patients enrolled in the ongoing Phase 2b ASPIRE trial, a total of **366 trial participants** have been exposed to buloxibutid over the course of 9 completed clinical trials
- In the recently completed Phase 2a AIR trial, IPF patients were exposed to buloxibutid for **36 weeks**



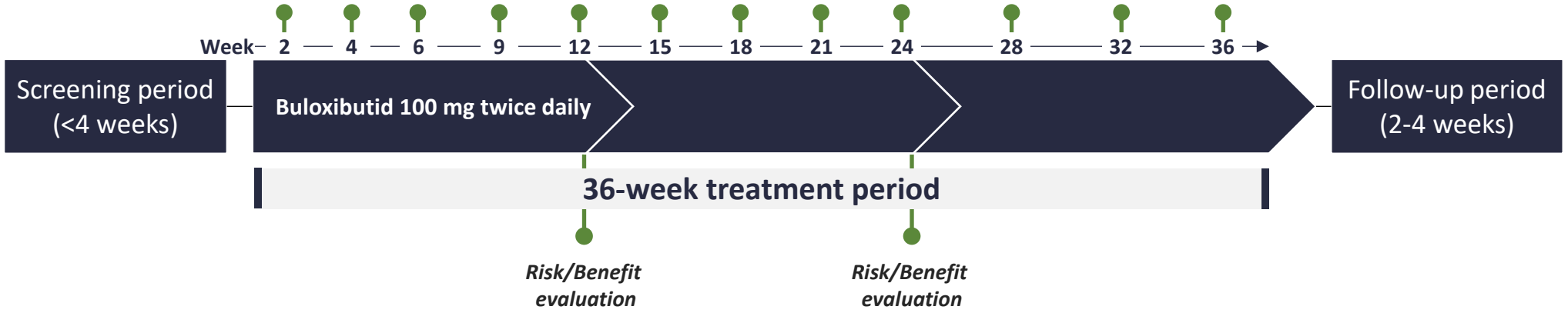
No significant safety risks have been identified for buloxibutid to date based on current clinical dataset

- The only identified risk of treatment with buloxibutid is mild to moderate hair loss, which was observed to be reversible, in 19% of participants in the Phase 2a AIR trial
- Across the robust safety dataset, there have been no treatment-related SAEs

AIR: An open-label Phase 2a trial of oral buloxibutid 100 mg BID for up to 36 weeks in treatment-naïve IPF patients

Patient population

Treatment-naïve IPF patients with centrally HRCT-confirmed diagnosis



Primary endpoint
Safety and tolerability

Secondary endpoint
Change in forced vital capacity (FVC) from baseline

Exploratory endpoints
Effect on selected biomarkers

AIR baseline patient characteristics are in line with other IPF trials

Key Characteristics

		AIR (N=52)	INPULSIS 1&2 (N=1,061)[1]	
Age (years) - Mean (SD)		**67 (9)**	67 (8)	In line with other trials
Gender	Males	**77%**	80%	
	Females	**23%**	20%	
Ethnicity	White	**27%**	57%	Enrolled study population has disease severity comparable to global IPF study populations[2]
	Asian	**73%**	30%	
BMI (kg/m^2) – Mean (SD)		**24.6 (4.1)**	28 (4.6)	
FVC % predicted - Mean (SD)		**75.5 (14)**	79.7 (17)	In line with other trials
% SoC	Pirfenidone	**0%**	0%	As with the INPULSIS trials, AIR patients were treatment-naïve
	Nintedanib	**0%**	0%	

(1) INPULSIS 1&2 were the Phase 3 studies that led to the approval of nintedanib; Richeldi et al. N Engl J Med. 2014; (2) Kirov et al. Am J Respir Crit Care Med. 2026;212(Suppl 1):A2817 (ATS 2026 abstract)

Treatment emergent adverse events: buloxibutid shows better tolerability than SoC

	Comparison to SoC		Buloxibutid
	Ph3 INPULSIS-1 *52-week treatment*[1]		**Ph2a AIR** *36-week treatment*
	Nintedanib	**Placebo**	**Buloxibutid**
	N=309	**N=204**	**N=52**
Any AE	96%	89%	71%
Common AEs (Non-exhaustive)			
Diarrhea	62%	19%	6%
Nausea	23%	6%	4%
Acute exacerbation of IPF	10%	10%	6%
Cough	15%	13%	8%
Vomiting	13%	2%	2%
COVID-19	n/a	n/a	6%
Hair loss[2]	n/a	n/a	19%
Fatal AE	4%	5%	4%
Severe AE	26%	18%	6%
Serious AE	31%	27%	10%

Good GI tolerability

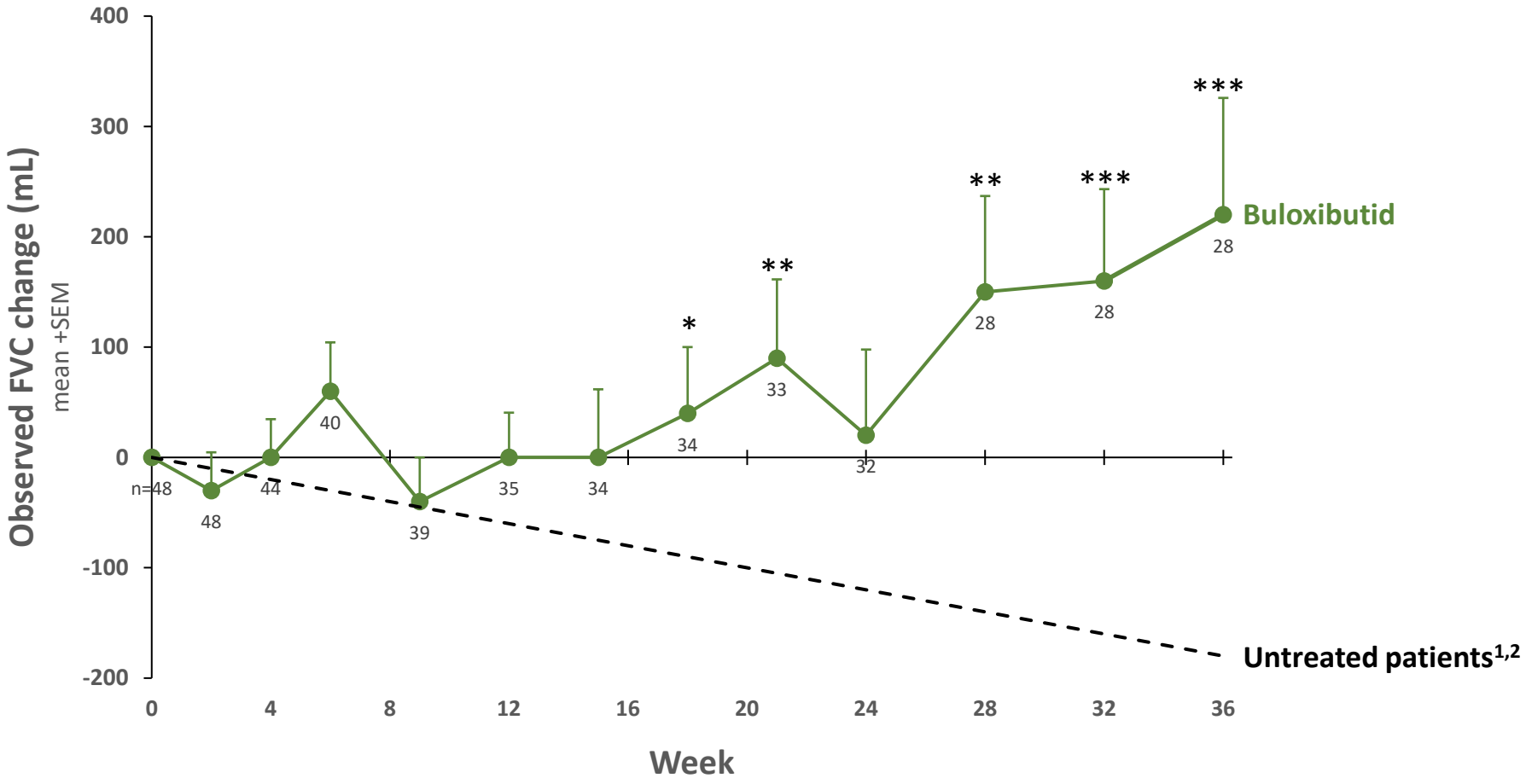
Low rate of exacerbations and cough worsening

No observed serious, severe, or fatal AEs related to buloxibutid

Buloxibutid has a favorable tolerability profile allowing it to be potentially combined with other therapies for IPF

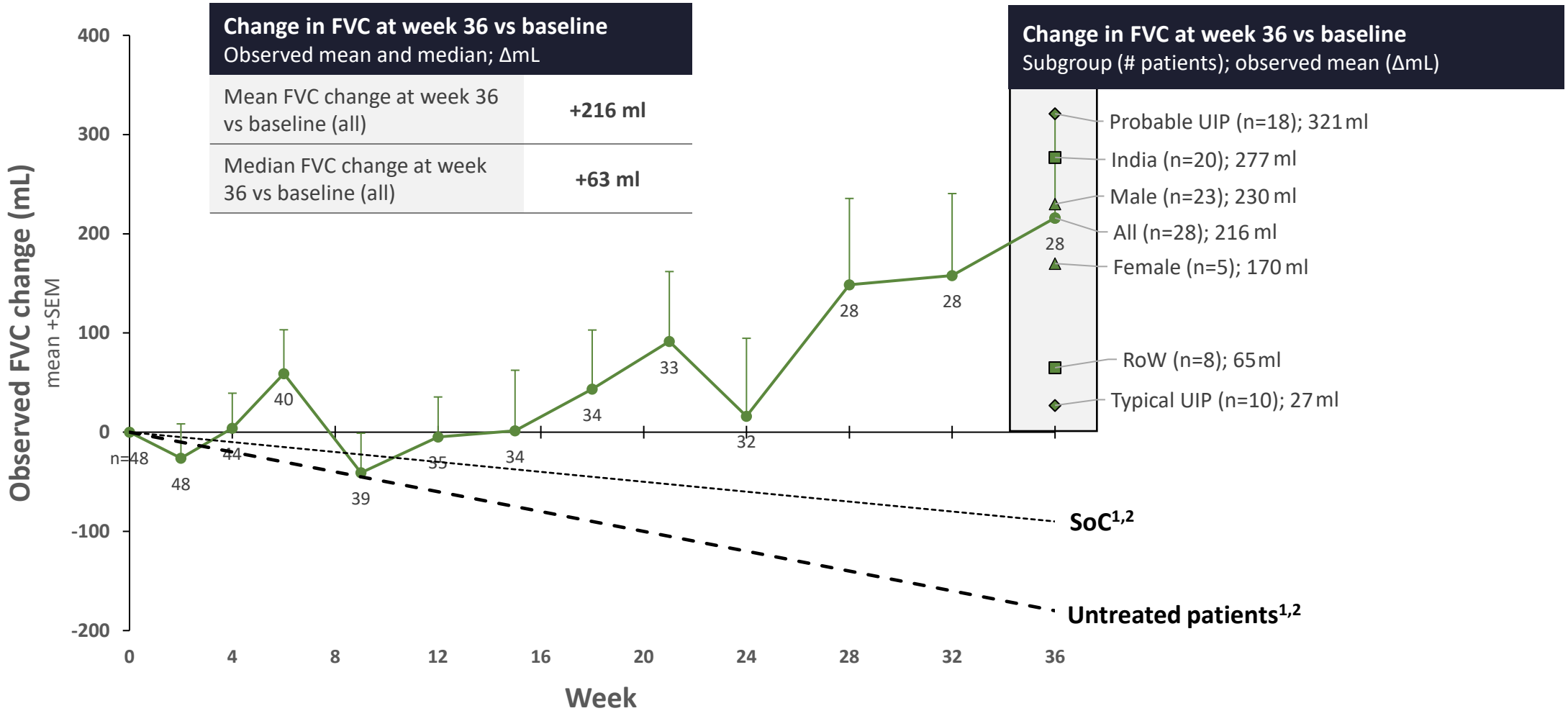
(1) N Engl J Med. 2014; (2) Hair loss was mild to moderate and was observed to be reversible. One patient discontinued treatment due to hair loss.
Note: Rash, gastroesophageal reflux disease, elevated creatinine, and pyrexia were also reported at 8% in AIR trial

Buloxibutid was observed to stabilize and improve lung function over the 36-week Phase 2a AIR trial



Note: N=48 patients with 2-week change from baseline FVC data. Observed values, no imputation.
*p<0.05, **p<0.01, ***p<0.001; t-test versus expected untreated decline corresponding to -120 mL/24 weeks
(1) Noble et al. Eur Respir J. 2016; (2) Richeldi et al. N Engl J Med. 2014

All subgroups show FVC stabilization and improvement over baseline at 36 weeks



Note: N=48 patients with 2-week change from baseline FVC data. Observed values, no imputation.
Note: Probable UIP and Typical UIP according to HRCT categorization at baseline
(1) Noble et al. Eur Respir J. 2016; (2) Richeldi et al. N Engl J Med. 2014

Development of a Synthetic Control Arm analysis to contextualize buloxibutid's effect in the AIR trial

IPF Patient External Control Data

- Mean 12-month FVC change -170.3 ml

Filter IPF Patient Data using Air Trial Inclusion Criteria

- Age >= 40 years
- FVC % predicted >= 60%
- FEV1/FVC >= 70%
- Treatment-naïve patients

External Control Arm Generation

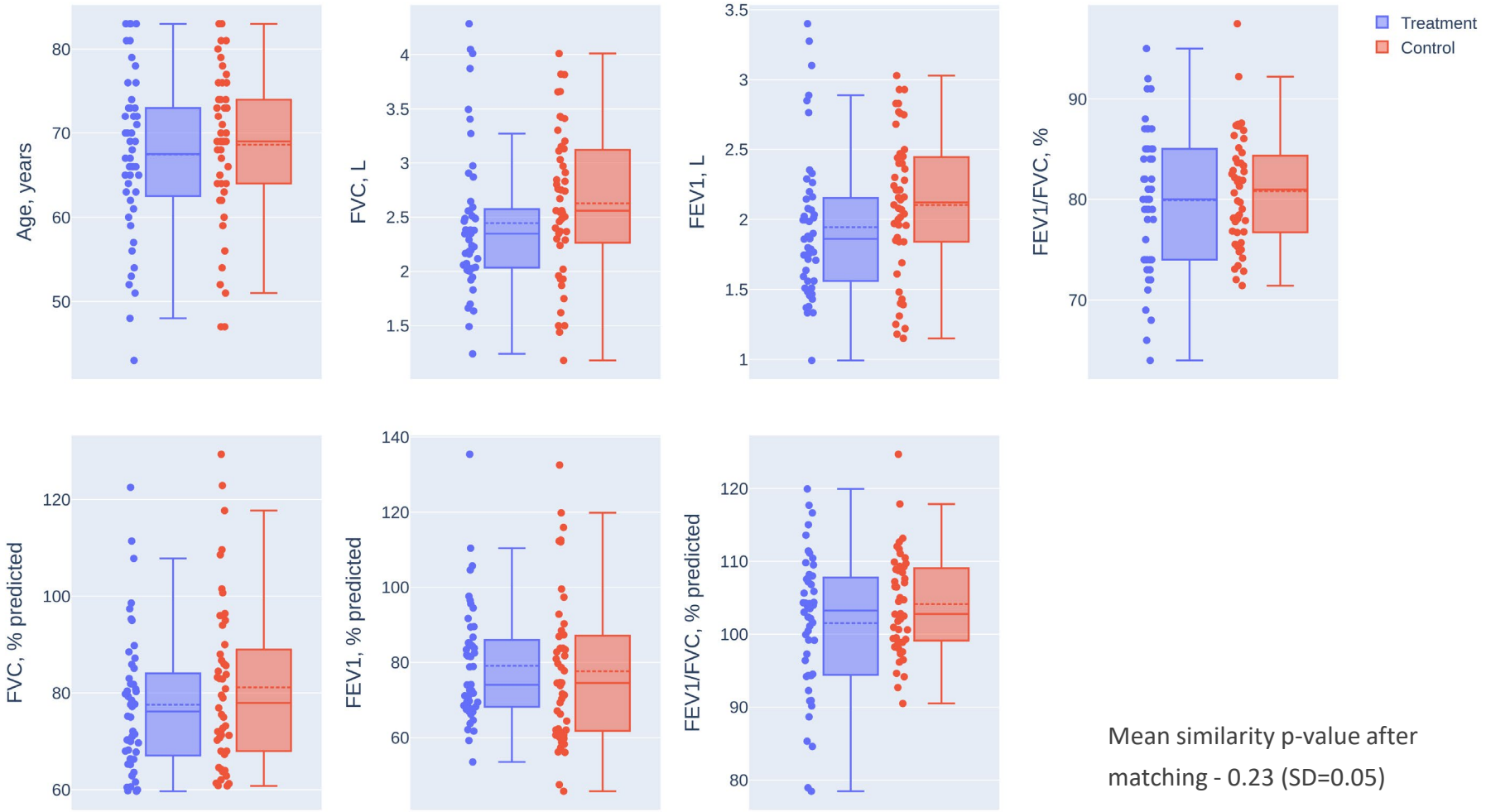
- ~30,000 randomly sampled groups of 48 patients generated from filtered control data
- 1:1 treatment-control ratio
- Matching on 8 clinical variables at baseline
- Univariate and multivariate tests of similarity with control
- 408 randomly sampled groups accepted as control arms based on the baseline similarity tests
- Mean similarity p-value = 0.23 (SD = 0.05)

Efficacy Testing

- Follow-up time – 36 weeks
- AIR – mean FVC change +23.2 ml
- Control – mean FVC change -114.8ml

Note: Qureight analysis

IPF patients selected for the Synthetic Control Arm analysis are highly matched to the Phase 2a AIR patient baseline characteristics

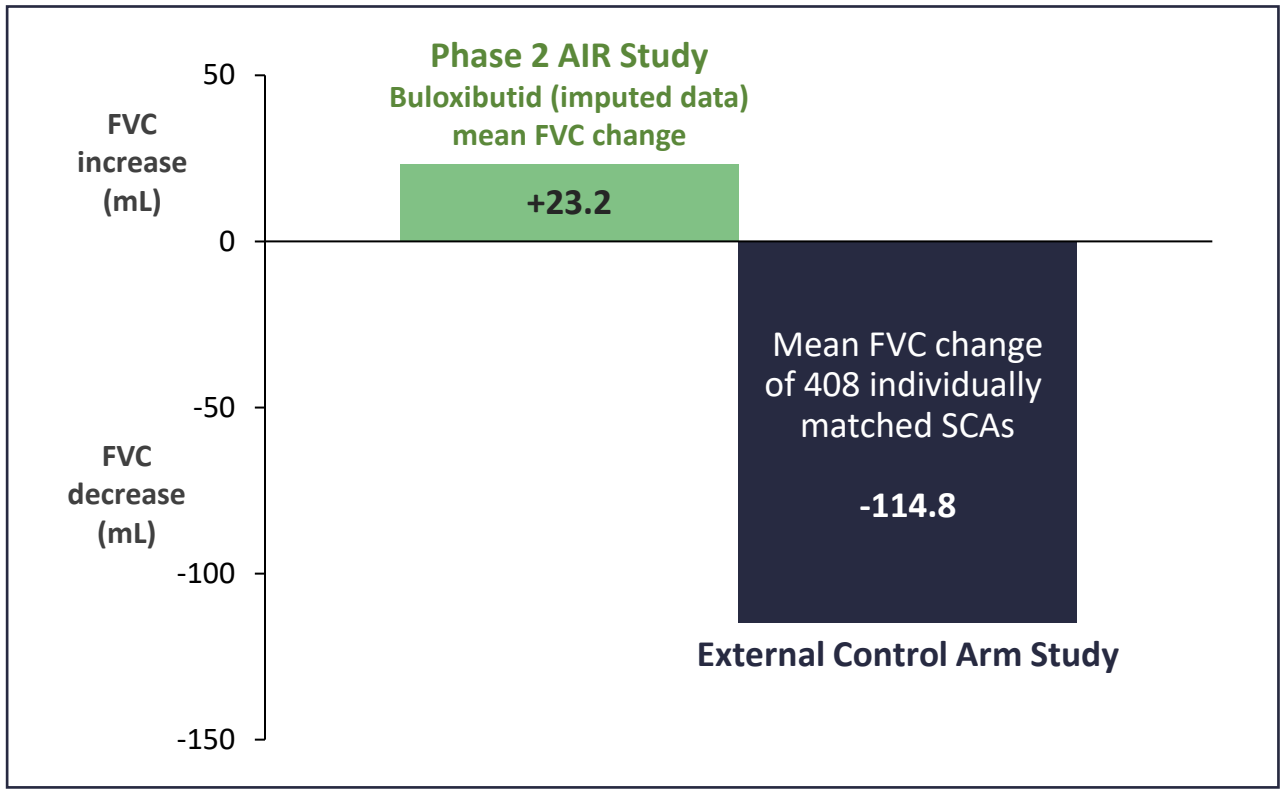


Mean similarity p-value after matching - 0.23 (SD=0.05)

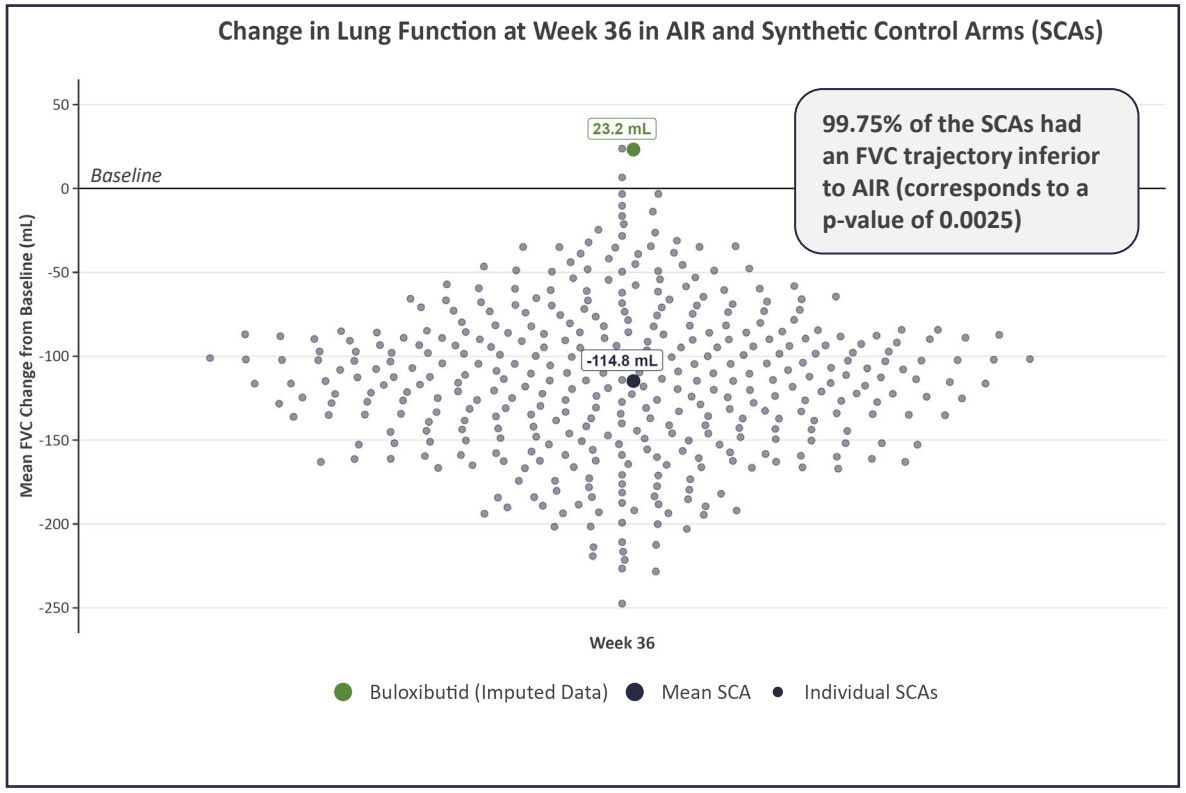
Note: Qureight analysis
Graphs show baseline characteristics of the filtered external IPF population (before the matching) versus AIR

A Synthetic Control Arm analysis supports a clinically meaningful treatment effect

Change in FVC in the Phase 2a AIR IPF trial compared to the external control arm study



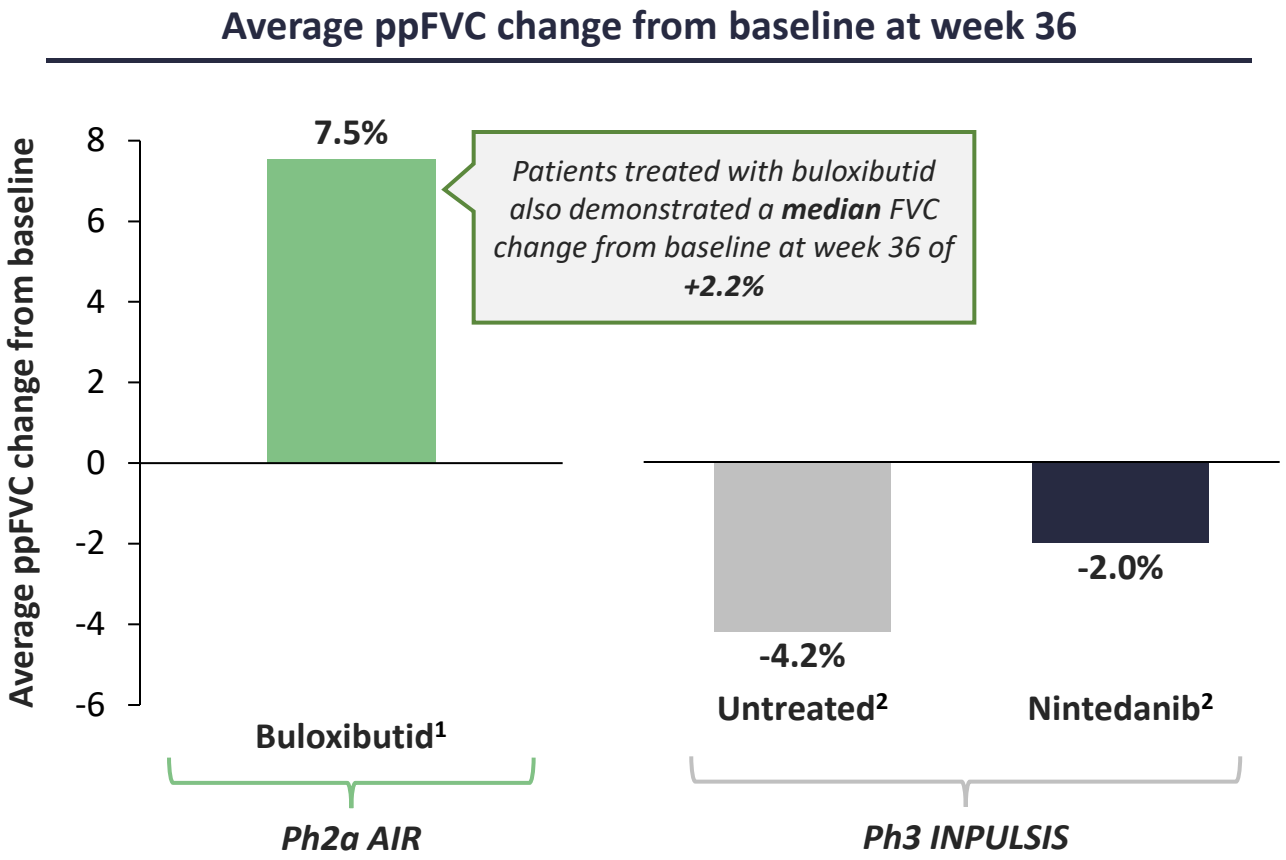
408 individual matched Synthetic Control Arms (SCAs) generated by Monte Carlo cross validation



The Monte Carlo approach demonstrates that in patients without significant differences in core baseline parameters, buloxibutid showed statistically significant treatment effect compared to control FVC distribution

Note: Qureight analysis

Buloxibutid is associated with a significant increase in ppFVC, consistent with its observed impact on absolute FVC

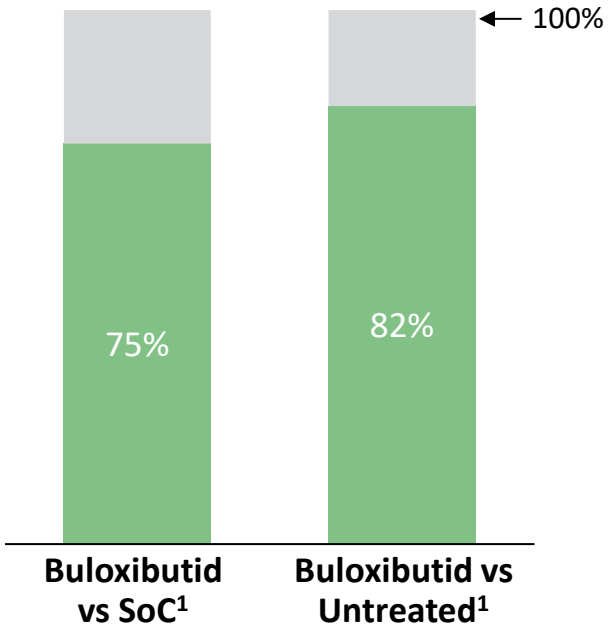


Average increase of 7.5 percentage points in ppFVC at 36 weeks from baseline

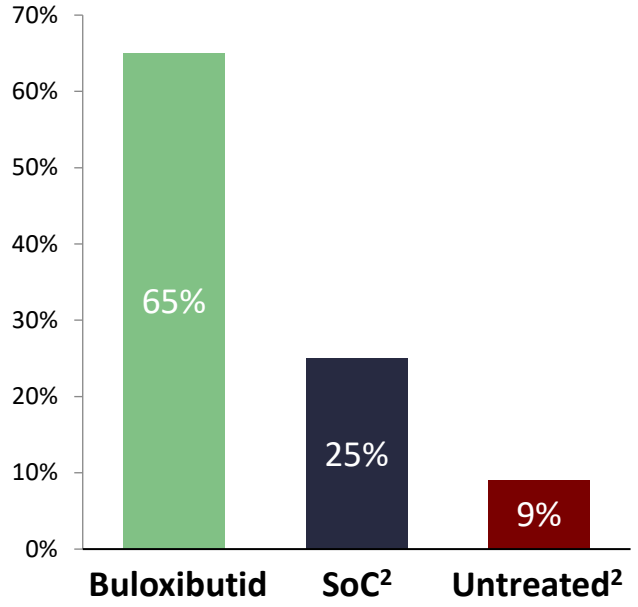
(1) Average ppFVC for patients who have completed the week 36 visit in Phase 2a AIR (N=28); (2) 36 week estimated ppFVC for nintedanib and placebo, INPULSIS trial (Richeldi et al. N Engl J Med. 2014)
Analysis based on historical data and does not represent head-to-head study. Cross-trial comparisons are challenging due to differences in trial design, patient selection, and analysis method.

Buloxibutid showed favorable results compared to historical standard of care and untreated decline at 36 weeks

Percentage of patients showing more favorable expected ΔFVC



Percentage of patients with improved lung function (FVC) vs baseline



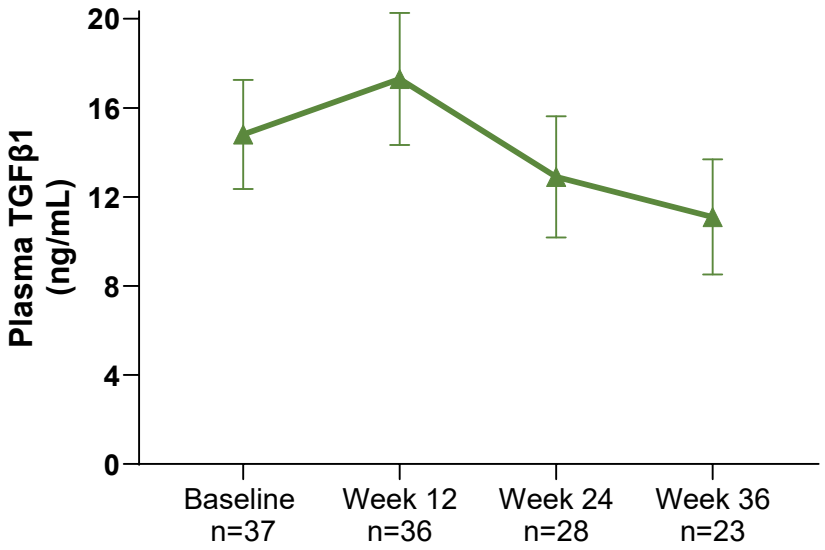
Patients treated with buloxibutid showed more favorable expected change in FVC compared with untreated patients and those treated with current standard of care at 36 weeks

Most patients treated with buloxibutid were observed to have improved lung function at 36 weeks, showing more favorable results compared to historical SoC and untreated patients

(1) Based on historical data (Richeldi et al. 2014); (2) Based on historical data (Flaherty et al. 2018)
Note: 25% of patients treated with nintedanib over 52 weeks showed improvement or no decline in FVC in the INPULSIS trials, and for untreated patients the number was 9%.
Analysis based on historical data and does not represent head-to-head study. Cross-trial comparisons are challenging due to differences in trial design, patient selection, and analysis method.

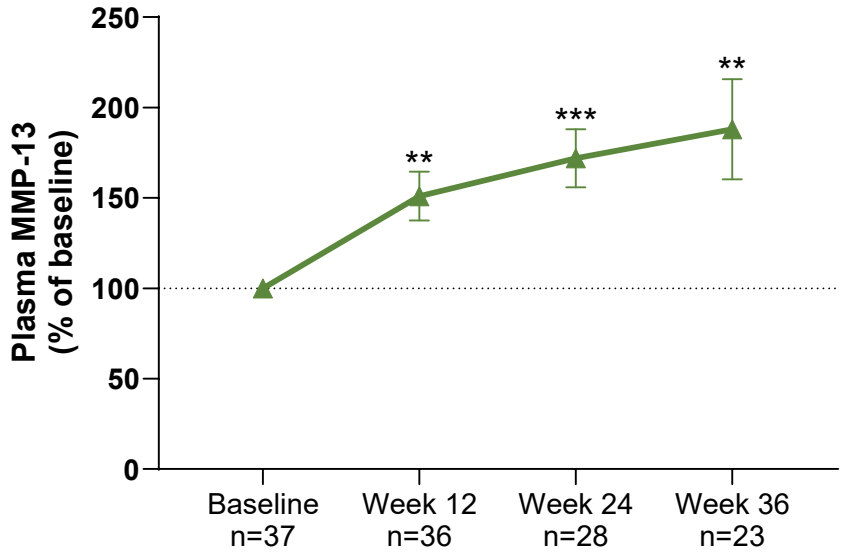
Buloxibutid is associated with increase of collagenase MMP-13 and decrease of TGFβ1 in the Phase 2a AIR trial

Plasma TGFβ1



TGFβ1 is a key fibrotic driver in IPF; reduced TGFβ1 is consistent with buloxibutid's mechanism of action and translational data

Plasma MMP-13



MMP-13 is an antifibrotic collagenase that plays a key role in fibrotic resolution

Note: Phase 2a data shown as mean ±SEM
** p<0.01, ***p<0.001 paired t-test vs baseline

Phase 2b ASPIRE Trial: Robust randomized trial with global footprint

ASPIRE is a randomized, double-blind, placebo-controlled, parallel-group, multicenter, dose-finding trial

Trial Design

Screening

Randomization 1:1:1

N=378

- Buloxibutid 50mg BID
- Buloxibutid 100mg BID
- Placebo BID

IPF patients stable on nintedanib/SoC or not on SoC[1] (no access, refused, intolerant or failed)

Follow-up

Baseline — **52-week treatment duration** — Last Dose

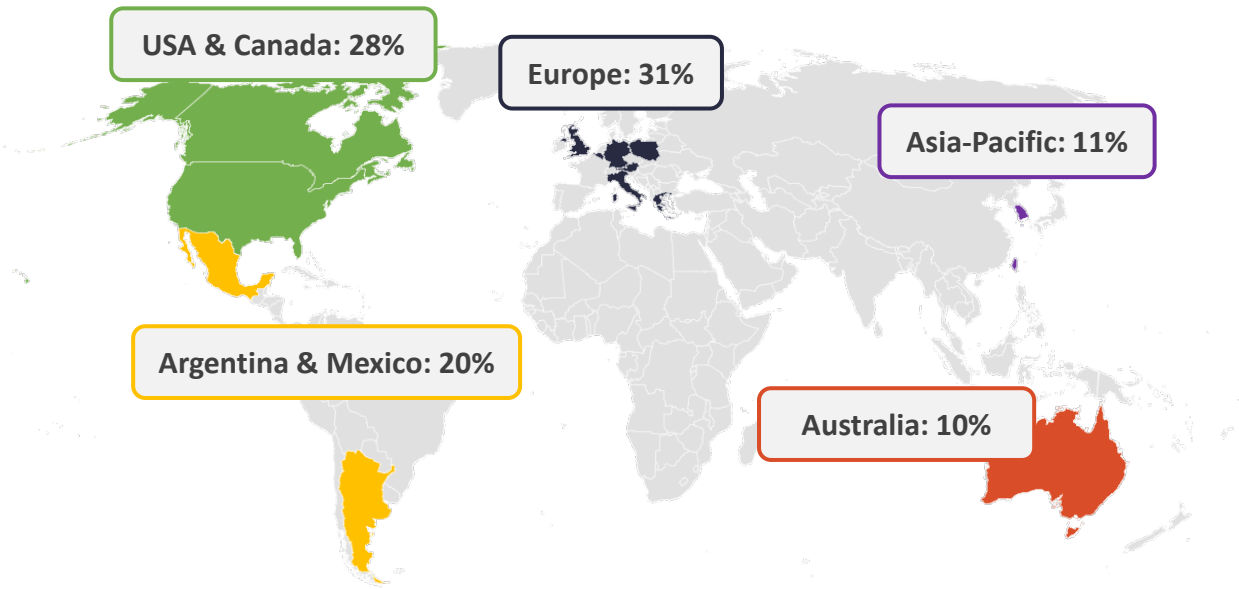
Primary Endpoint:
Change from baseline in FVC at 52 weeks

Key Secondary Endpoint:
Proportion of patients with disease progression at 52 weeks

Global Footprint

>100 sites across 14 countries

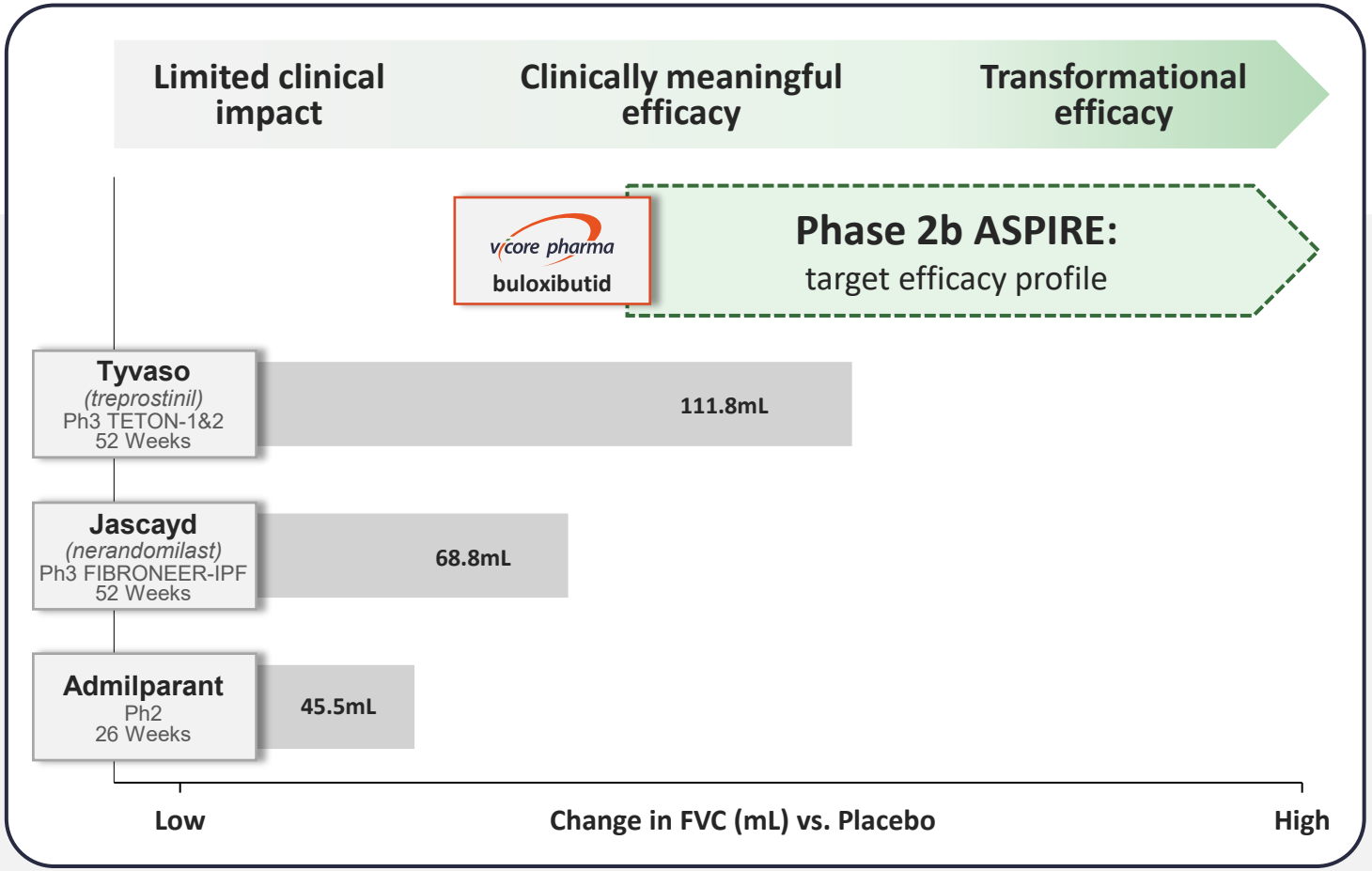
Proportion of Patients Randomized by Region*



*Preliminary data, reflecting 16 June 2026 database extract

(1) As nerandomilast is now approved in the United States, patients receiving stable background nerandomilast therapy will be eligible for enrollment in the trial, though this is anticipated to represent a small subset of the study population.

Phase 2b ASPIRE trial: designed to position buloxibutid as a differentiated and highly competitive therapy for IPF in a multi-billion-dollar market



Defining Success in IPF

01 Efficacy

Clinically meaningful impact on FVC versus placebo

02 Tolerability

Safety and tolerability profile supportive of chronic use, adherence, and quality of life

03 Combinability

Mechanistic synergy and tolerability profile suitable for combination use

Buloxibutid combines the potential for disease-modifying efficacy with a favorable tolerability profile, positioning it to potentially reshape the IPF treatment paradigm

Graphic is not meant to represent head-to-head study. Cross-trial comparisons are challenging due to differences in trial design, patient selection, and analysis method.

ASPIRE baseline characteristics

Characteristics	ASPIRE (N=377*)
Age (years) – Mean (SD)	71.1 (7.5)
Gender	
Males	78.2%
Females	21.8%
Ethnicity	
White	86%
Asian	13%
American Indian or Alaska Native	1%
Black or Afro American	<1%
Time since diagnosis (years) – Mean (SD)	2.4 (1.7)
BMI (kg/m^2) – Mean (SD)	27.9 (4.8)
Smoking status	
Never smoked	36.9%
Former smoker	61.5%
Current smoker	1.6%
FVC (liter) – Mean (SD)	2.9 (0.8)
FVCpp – Mean (SD)	81.3% (17.6)
FEV1/FVC ratio – Mean (SD)	0.8 (0.06)
DLCOpp, Hb corrected – Mean (SD)	54.1% (15.7)
Oxygen saturation – Mean (range)	96% (86-100)
Background antifibrotic treatment at study start	
Not on antifibrotic treatment	40.3%
On antifibrotic treatment	59.7%

67.8% of the patients not on antifibrotic treatment have never been treated with an antifibrotic treatment (27.3% of all patients)

*Total randomized participants exposed to at least one dose of IMP

BMI: body mass index; DLCO: diffusing capacity of the lungs for carbon monoxide; FEV_1: forced expiratory volume in 1 second; FVC: forced vital capacity; FVCpp: FVC percent predicted; Hb: haemoglobin; SD: standard deviation

Preliminary data, reflecting 16 June 2026 database extract

ASPIRE baseline characteristics are in line with the latest IPF Ph3 trials

Characteristics	ASPIRE	FIBRONEER-IPF	TETON-1 & 2	ALOFT-IPF
	All patients (N=377*)	All patients (N=1,177)	All patients (N=1,191)	All patients (N=1,251)
Age (years) – Mean (SD)	71.1 (7.5)	70.2	72.3	71.0
Gender				
Males	78.2%	83.0%	78.7%	79.4%
Females	21.8%	17.0%	21.3%	20.6%
Ethnicity				
White	86%	68%§	87.2%	57.7%
Asian	13%	32%	8.0%	40.4%
American Indian or Alaska Native	1%	<1%	0.3%	-
Black or Afro American	<1%	<1%	1.0%	-
Other	-	0%	3.6%†	1.8%‡
Time since diagnosis (years) – Mean (SD)	2.4 (1.7)	3.5	3.7 (2.9)	2.1
Smoking status				
Never smoked	36.9%	29.0%	34.6%	-
Former smoker	61.5%	68.8%	63.7%	-
Current smoker	1.6%	2.2%	1.7%	-
FVC (liter) – Mean (SD)	2.9 (0.8)	2.8	2.7 (0.8)	2.7
FVCpp – Mean (SD)	81.3% (17.6)	78.2%	75.7% (17.4)	78.9%
DLCOpp, Hb corrected – Mean (SD)	54.1% (15.7)	50.9%	48.8% (18.8)	51.9%
Background antifibrotic treatment at study start				
Not on antifibrotic treatment	40.3%	22.3%	23.5%	35.9%
On antifibrotic treatment	59.7%	77.7%	76.5%	64.1%

*Total randomized participants exposed to at least one dose of IMP

ASPIRE data: preliminary data, reflecting 16 June 2026 database extract

BMI: body mass index; DLCO: diffusing capacity of the lungs for carbon monoxide; FEV_1: forced expiratory volume in 1 second; FVC: forced vital capacity; FVCpp: FVC percent predicted; Hb: haemoglobin; SD: standard deviation

† includes Native Hawaiian or Other Pacific Islander, multiple or unknown; ‡ American Indian, Alaska Native, Black or Afro American, unknown or not reported; § FIBRONEER-IPF ethnicity from prescribing information; all other FIBRONEER-IPF values pooled across arms (N=1177) from Richeldi L et al. N Engl J Med. 2025.

FIBRONEER-IPF: Richeldi L et al. N Engl J Med. 2025; JASCAYD® (nerandomilast) Prescribing Information. Boehringer Ingelheim Pharmaceuticals, Inc. Revised August 2026; TETON-1 & 2: Nathan SD et al., N Engl J Med. 2026; ALOFT-IPF: Maher TM et al. Am J Respir Crit Care Med. 2026.

Vicore's partnership with Nippon Shinyaku for buloxibutid in Japan

NIPPON SHINYAKU CO., LTD.

Partnership Overview

Vicore Pharma and Nippon Shinyaku have entered an exclusive license agreement to **develop and commercialize the drug candidate buloxibutid in Japan**.

Financial Terms

Vicore has received an **upfront payment of USD 10 million** and is eligible for up to **USD 275 million in milestones**, plus tiered royalties on net sales in Japan up to the low 20s. In addition, Nippon Shinyaku will cover a portion of global non-clinical, CMC, and late-stage clinical development costs.

Strategic Benefits

The partnership leverages Nippon Shinyaku's **local expertise to address IPF**, a condition with limited treatment options in Japan, enhancing Vicore's global IPF strategy. Nippon Shinyaku is a **leader in the development of therapies for rare respiratory diseases** in Japan, including the discovery and development of Uptravi for PAH.

Strong leadership team with extensive industry experience



AHMED MOUSA
CHIEF EXECUTIVE OFFICER
Experienced biotech executive with a background in molecular biology, law, and business development.

pieris
COVINGTON



HANS JEPPSSON, PhD
CHIEF FINANCIAL OFFICER
Cross-disciplinary background in finance and medicine. Former Danske Bank: Equity analyst.

Danske Bank
AstraZeneca



BERNT VAN DEN BLINK, MD, PhD
CHIEF MEDICAL OFFICER
Board-certified pulmonologist with 25+ years of experience in IPF and ILD drug development. Former senior clinical leader at Kinevant, Promedior, and Galapagos.

Erasmus MC
Promedior
Galápagos



ROBERT SLACK, PhD, FRSB
CHIEF SCIENTIFIC OFFICER
Former VP of respiratory biology at GSK; Former CSO at Galecto. 25 years of experience in drug development.

GSK
Galecto



MIKAEL NYGÅRD, PhD
CHIEF OPERATING OFFICER
Experienced healthcare Business Development executive, has led M&A and Corporate Development functions.

Humana
BCG BOSTON CONSULTING GROUP



HELEN BARKER
CHIEF TECHNOLOGY OFFICER
Pharmaceutical scientist and business leader, with over 25 years of experience delivering the technical and strategic development of novel compounds, devices, and companies.

Pfizer
ZIARCO
UNIVERSITY OF OXFORD



JIMMIE HOFMAN
CHIEF BUSINESS OFFICER
Business Development executive with extensive deal-making experience.

pieris

vcore pharma

Board of Directors

HANS SCHIKAN, PharmD – CHAIRMAN
25 years management experience in global pharmaceuticals (e.g. CEO of Prosensa). Extensive board work experience from US Nasdaq-listed biotech firms.

ANN BARBIER, MD, PhD
More than 20 years of experience in drug discovery and development in rare diseases, including rare respiratory diseases.

ELISABETH BJÖRK, MD, PhD
Broad drug development experience, formerly leading global late-stage development activities in CVRM at AstraZeneca. Extensive board work experience in small and mid-size international life science companies.

JACOB GUNTERBERG
Experienced venture capitalist and life science sector financier.

HEIDI HUNTER
25 years in senior pharmaceutical development and commercialization positions.

YASIR AL-WAKEEL, BM BCH
A seasoned executive board member and strategic advisor with focus on strategic finance and business development in biotech companies.

PETER GUENTER
Nearly four decades of global pharmaceutical leadership experience (e.g., former CEO of Merck Healthcare, former CEO of Almirall).



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