Entera Bio Ltd.

Global Leader in Oral Peptide Therapeutics

Disclaimer

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Entera Mission:

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

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

Entera Company Background

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

Proprietary N-Tab® Science and Platform

Innovative first-in-class oral peptides

Large (4kD+) linear, hydrophilic targets

Simple once a day tablet treatment

Robust protein design and modification capability via OPKO partnership

Corporate

Global interdisciplinary team

Nasdaq: ENTX, 49M shares outstanding

Lead Asset – EB613 (Osteoporosis)

First oral tablet to democratize anabolic (bone building) treatment

Women centric condition with persistent treatment gap

Validated MOA, PTH(1-34), teriparatide

Disruptive, $4–6B+ US market opportunity

Robust placebo controlled Ph2 data

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

Diversified Pipeline

Rare Endocrine: Hypoparathyroidism

Metabolic /Obesity

GI Inflammation: Short Bowel Syndrome

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

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Entera Oral Peptide Tablet Pipeline

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

Entera Core Team

Bringing Together Scientific Excellence to Deliver Better Treatment Outcomes Globally

Miranda Toledano
Chief Executive Officer and Board Member

Felicia Cosman, MD
Chief Clinical Advisor (Endocrinology) and SAB Chair

Steven R. Goldstein, MD
Chief Clinical Advisor (Gynecology)

Gregory Burshtein, PhD
Chief of Research and Development

Hillel Galitzer, PhD
Chief Operating Officer

Michal Kushnir
Director of Program Management

Helen Pentikis, PhD
Clinical Pharmacology Specialist

Rachel B. Wagman, MD, FACE, FACP
Chief Clinical Advisor

Cherin Smith, PMP
EVP Clinical Operations

Anke Hoppe
VP of Clinical Operations

Osnat Bar-Peled, PhD
Executive Director of IP

Constantin Itin, RPh, PhD
VP of Preclinical Development

Dana Yaacov, CPA
Chief Financial Officer

N-Tab® Proprietary Platform

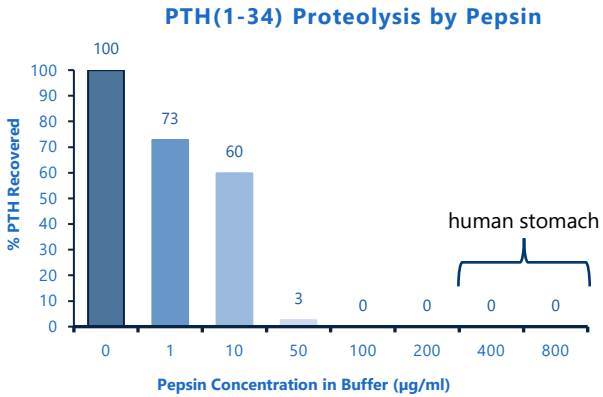
Barriers to Oral Peptide Delivery

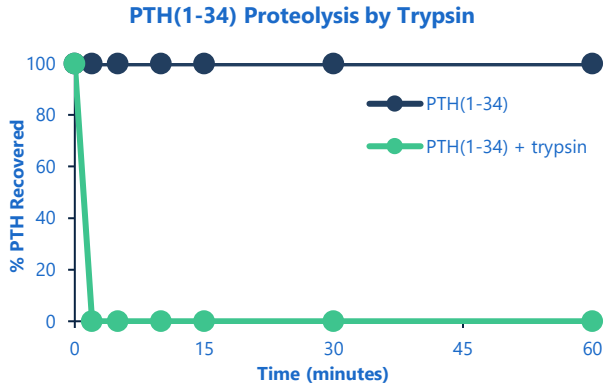
The GI tract is designed to efficiently digest proteins and peptides into amino acids

Proteolytic Degradation

In the acidic gastric environment, most peptides are rapidly cleaved by pepsin

In the small intestine, trypsin and α-chymotrypsin further degrade peptide drugs



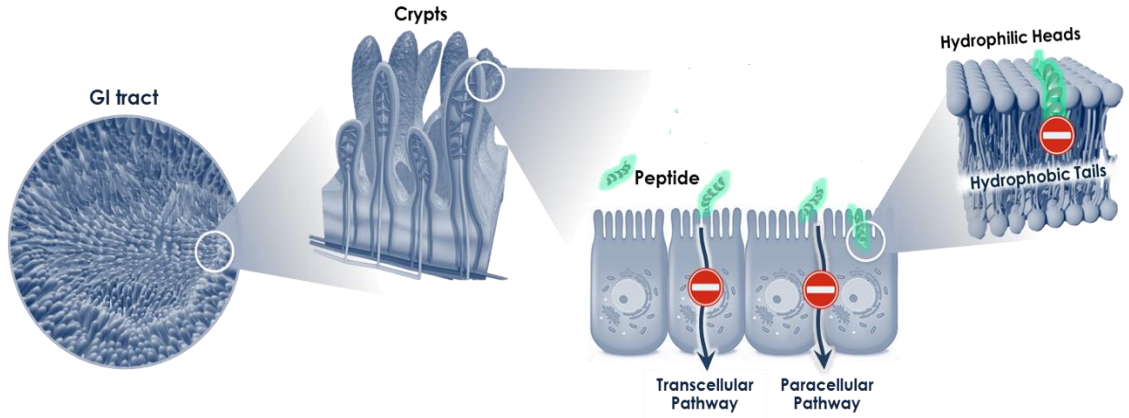


100%

peptide breakdown within a few minutes of luminal exposure

Epithelial Permeability Barrier

Therapeutic peptides are too hydrophilic to cross the enterocyte barrier transcellularly, and too large to pass through it paracellularly



~0%

typical oral bioavailability for unformulated peptides

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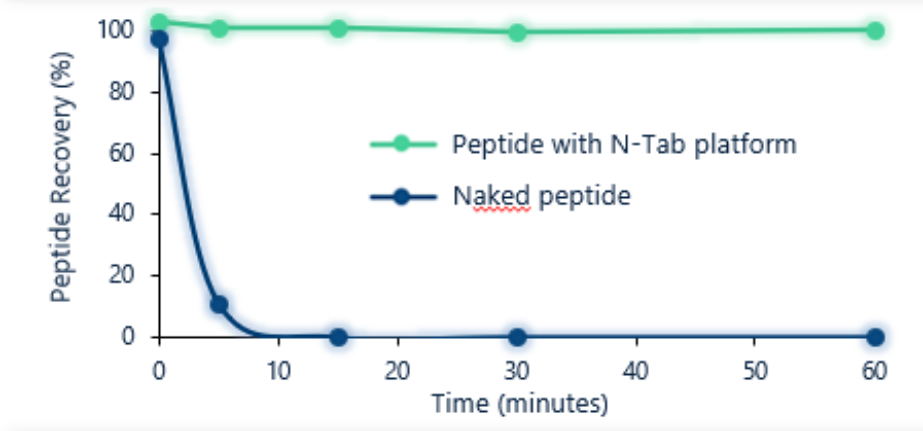
Unlocking Oral Peptide Absorption: Two Synergistic Mechanisms of the N-Tab® Platform

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

1 Proteolysis Inhibition

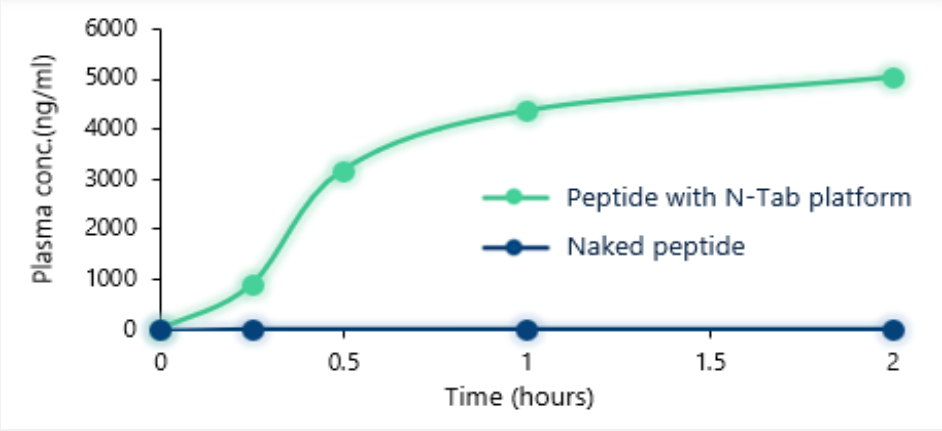
Proteases Blocked.
Peptide Survives.



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

2 Permeability Enhancement

Membrane Fluidity Increased.
Drug Absorbed Systemically.



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

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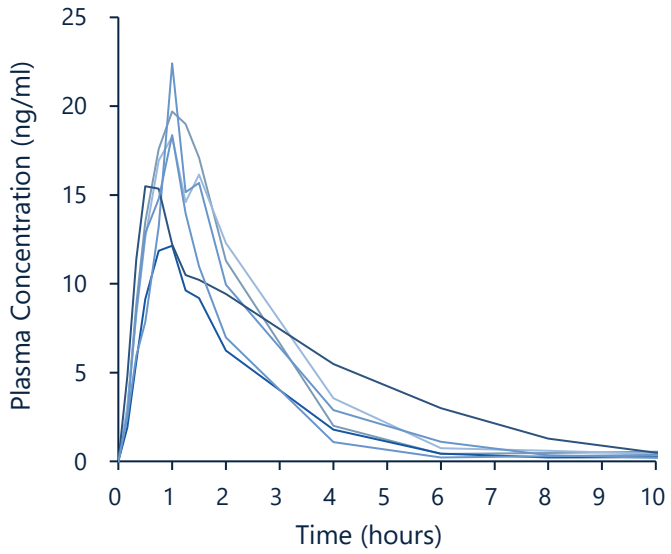
Pharmacokinetic Validation Across Peptides

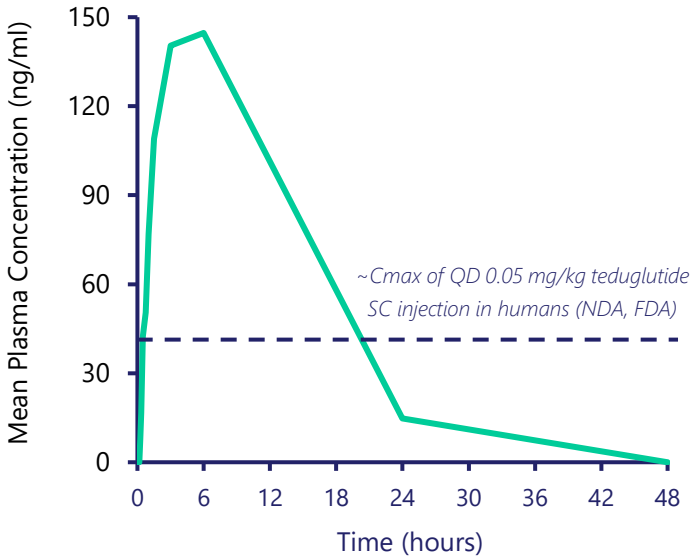
Pre-clinical evidence in large animals

~1 kDa Peptide (Undisclosed)



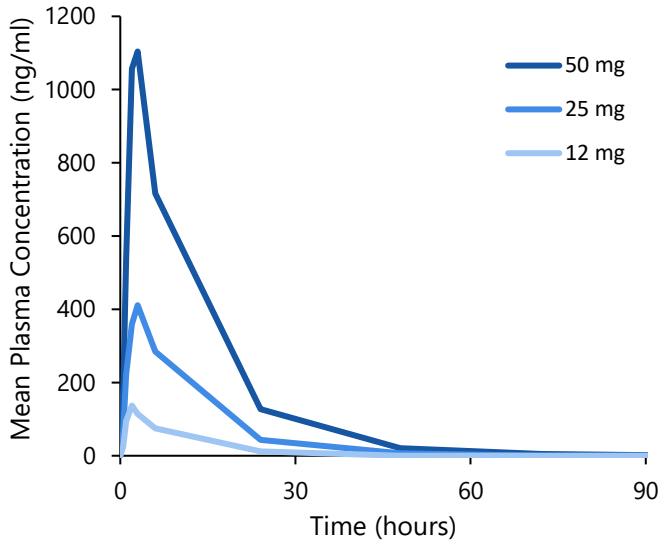
Key finding:
~ 10% bioavailability and low pharmacokinetic variability in dogs

~4 kDa Peptide (GLP-2)



Key finding:
Systemic exposure was maintained in mini-pigs for **more than 24 hours**, supporting once-daily oral dosing

~5 kDa Peptide (Undisclosed)



Key finding:
Dose proportional exposure in non-human primates

The platform works: meaningful systemic exposure was shown across multiple oral peptide programs

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N-Tab®: Core Platform Advantages

Advantageous Pharmacokinetic Profile

Overcomes oral bioavailability challenges of peptides enabling therapeutically relevant systemic exposure

Gastric absorption with **rapid onset of action**

✓ **Reproducible PK profile**

Clinically Proven

Demonstrated **consistent exposure** and **robust pharmacodynamic responses** in clinical studies

Successful Phase 2 studies in Hypoparathyroidism and Osteoporosis

✓ **Three phase 1 and three phase 2 (n=270)**

Broad Applicability

Versatile platform enabling conversion of diverse peptide drugs into oral formulations

Peptide size range – Feasibility to orally deliver peptides ranging in size from 0.9 kDa to ~20 kDa was demonstrated in vivo

✓ **>10 assets across 7 therapeutic areas**

Rapid Development Path

Customized large animal model as a proof-of-concept tool to assess feasibility

Based on **approved pharmaceutical excipients** to streamline the regulatory pathway

Conventional manufacturing equipment and **scalable process for commercial supply**

✓ **~16-month formulation-to-IND**

Safety Profile

Compared with small molecules, oral peptides have **greater target receptor selectivity**

The effect on the cellular membrane is short lasting with **no local tissue damage** to GI tract

Oral dosing is **less immunogenic**

✓ **>25,000 doses administered in clinical trials with no serious adverse events attributed to the platform**

Patient Compliance Uplift

Conventional **small once-daily tablet**

Convenient storage

Oral vs. injectable drives a significant positive impact on treatment **compliance and patient quality of life**

✓ **Favourable patient and clinician surveys**

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

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

EB613: First Oral Anabolic (Bone Building) Tablet

- ✓ Oral tablet with identical API as blockbuster SC injection, Forteo® (Eli Lilly, approved since 2002, ~$1.7BN peak sales)
- ✓ Phase 2 showed comparable efficacy/safety as Forteo
- ✓ Unique dual MOA rapidly stimulates osteoblasts to increase new bone formation (PINP) and suppresses bone resorption (CTX)
- ✓ Oral supports earlier osteoanabolic intervention in line with guidelines
- ✓ Patients prefer oral tx in silent asymptomatic condition
- ✓ Widens access from endo/rheum specialists (~15% Rx) to primary care/Gyn (~80% Rx)
- ✓ Potential for preferred tiering addresses huge healthcare burden
- ✓ Derisked asset, Phase 3 ready with efficient path to registration

Our Mission is to Democratize Anabolic Therapy so Every Woman can Protect her Bone Health and Deter the Risk of Fracture

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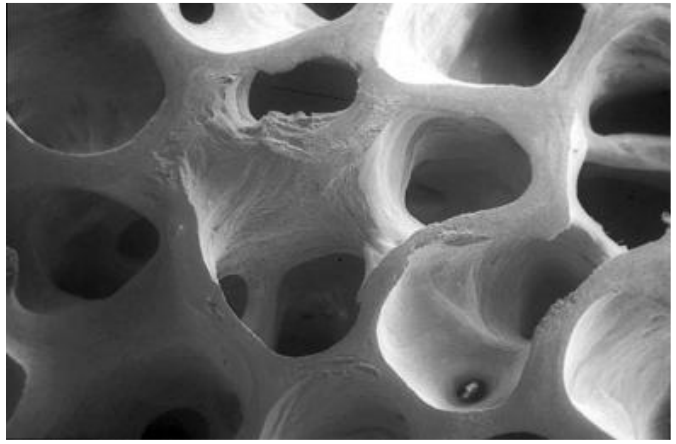
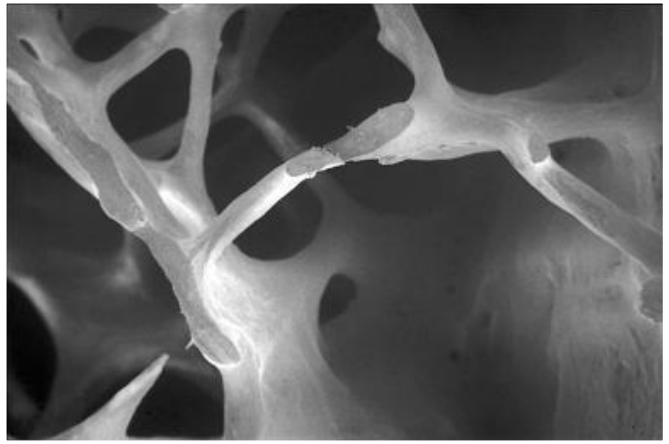
Osteoporosis is the Most Common Metabolic Bone Disease Worldwide





Dysregulated Bone Remodeling:

Increased Osteoclast Activity ↑
resorption (CTX biomarker)

Reduced Bone Formation ↓
formation (P1NP biomarker)

- Characterized by Low Bone Mass, Deteriorated Skeletal Microarchitecture, Compromised Bone Strength, and Increased Risk of Fracture
- Postmenopausal women are at highest risk of developing osteoporosis-related fractures, especially in the first 5-10 years after menopause
- Multiple guidelines recommend anabolic (bone forming) treatment as frontline treatment because of its superiority in rapidly increasing BMD and lowering fracture risk vs. anti-resorptive treatment
- The 3 approved anabolic drugs (Forteo®, Tymlos®, Evenity®) require daily/"in-office" monthly subcutaneous (SC) injections which limits both clinician and patient access

Osteoporosis Related Fractures Afflict More Women than Heart Attack, Breast Cancer and Stroke Combined Yet a Treatment Gap Persists Globally

200M

Women worldwide are affected by osteoporosis

1 in 3

Women and 1 in 5 men over the age of 50 will suffer an osteoporosis related fracture

54M

Americans at risk

~13M

Diagnosed

~60%

Do not accept or have access to currently available treatment options

>2M

Osteoporosis fractures (US) affect quality of life, disability, and premature death

>20%

of hip-fracture patients die within one year of the event

2019

Date of Last Approved Osteoporosis Drug

Phase 3 Registrational Program Included ~11,300 subjects

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EB613 Addresses the Treatment Gap in the Osteoporosis Patient Journey

~13M diagnosed with osteoporosis in the US, with estimated less than ~40% treated

There is need for novel products with enhanced efficacy, tolerability, and ease of use – FDA (2025)*

Anti-Resorptive

1st Line Bisphosphonates Fosamax®

~60%

Oral, Highly Accessible

~50% discontinue within 12 month due to AEs acid reflux, concerns over ONJ, AFF

RANK-Ligand Inhibitor (SC) Prolia®

~20%

SC injection every 6 months

Risk of Multiple Vertebral Fractures upon discontinuation, ONJ, AFF

EB613

- **First PTH Anabolic Tablet**
  Facilitates earlier bone building intervention to prevent fractures
- **High Accessability to Patients and Clinicians**
  Primary Care, GYN, Endo, Rheum
- **Ease of Administration Critical**
  In a silent progressive asymptomatic disease patients strongly prefer oral tablets
- **Mitigated Risk**
  Addresses patients' fear of injections and AEs such as Osteonecrosis of the Jaw (ONJ) and Atypical Femoral Fracture (AFF)

Injectable Anabolic

PTH Receptor Agonist Forteo®, Tymlos®

~9%

Daily SC injection

Many HCPs do not have in-office resources to bill for injectable drugs

Anti-Sclerostin Evenity®

~6%

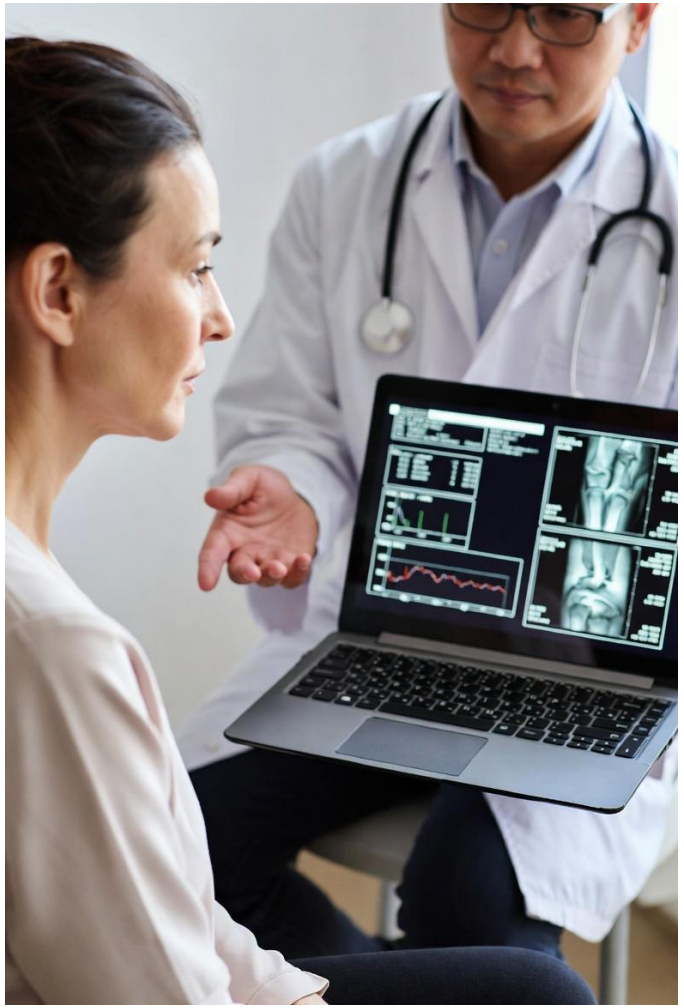
2 monthly "in-office" injections

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

*FDA Full Qualification Package Integrated Review, BMD as Validated Surrogate Endpoint for Post-Menopausal Women with Osteoporosis., December 19 2025
AFF=Atypical Femoral Fracture; ONJ=Osteonecrosis of the jaw

Why an Oral Osteoanabolic?

- 1 in 3 women over age 50 will experience a fracture in their lifetime
  Yet more than 80% will not receive treatment after a fracture
- Clinical guidelines recommend osteoanabolics as frontline treatment ("replace lost bone first")
  Yet injectable anabolics make up <~15% of estimated Rx
- Patients **less willing to take daily injections** in silent, asymptomatic disease
- There are major barriers to prescribing currently approved injectable anabolics only available as **"buy and bill"** and through **"specialty pharmacies"**
- Medical practices **cannot afford to purchase and manage reimbursement** for injectable osteoanabolics
- Prior authorizations and in office injections place an **unacceptable economic and staffing burden** on healthcare providers



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EB613 Oral PTH (1-34) Tablet Treatment

Clinical Overview

EB613: First Once Daily Anabolic Tablet Treatment for Osteoporosis

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

Thesis	EB613 is intended to provide an oral anabolic treatment earlier in an osteoporosis patient's journey Aligns with endocrinology/ women's health focus – bone health, menopause, longevity portfolios
Dual MOA	Rapid stimulation of osteoblast activity to increase new bone formation (PINP) with rapid suppression of bone resorption (CTX)
Clinical Efficacy	Placebo-controlled Phase 2 study in 161 post-menopausal women produced a rapid onset of action with significant increases in BMD at both cortical bone (femoral neck and hip region) and cancellous bone (spine)[1]
Safety Profile	AES in line with PTH agonists: headache, nausea, and dizziness
Opportunity	Three approved anabolic drugs require daily/monthly subcutaneous (SC) injections which limits patient access. Oral administration also expands access for HCPs who manage osteoporosis patients including gynecologists, women's health specialists and primary care providers as well as endocrinologists and rheumatologists
Target Patients	Sample target patients include postmenopausal women with: - T-scores $\leq$ -2.5 at total hip, femoral neck or lumbar spine with no fracture history - low bone mass or osteoporosis and history of nonvertebral fracture more than 2 years ago - low bone mass or osteoporosis and radiographic evidence of vertebral fracture
FDA Plan	505(b)(2) Pathway: A single 12-month placebo-controlled Phase 3 registrational study with BMD as primary endpoint and scientific bridge to LD Forteo, to be supported by a 12-month extension study

1. Tripto-Shkolnik et al., J Bone Miner Res 2024

EB613 Phase 2 Clinical Study in Postmenopausal Women with Osteoporosis

Key Inclusion Criteria

50+ years old

3+ years postmenopause

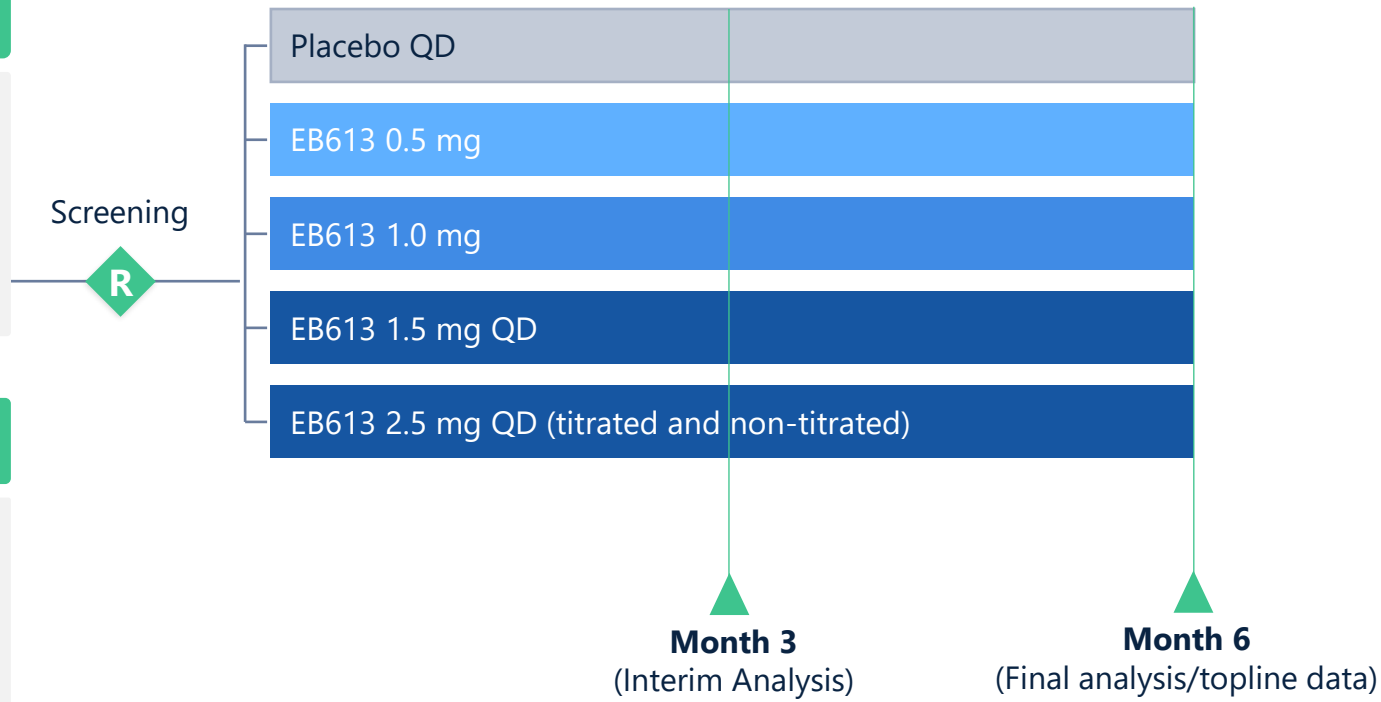
Low bone mass (≤-2.0 in at least one site)

High risk; no prior fracture

Key Exclusion Criteria

Osteoporosis treatment within last 2 years

Severe osteoporosis that precludes placebo



Primary Endpoint

Serum PINP % change from baseline (placebo-adjusted) at Month 3

Secondary Endpoints

BMD % change from baseline

Serum OC and CTX % change from baseline at Months 1, 2, 3, and 6

Serum PINP % change at Months 1, 2, and 6

Plasma PTH(1-34) at T15 min

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

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

Tripto-Shkolnik et al., J Bone Miner Res 2024

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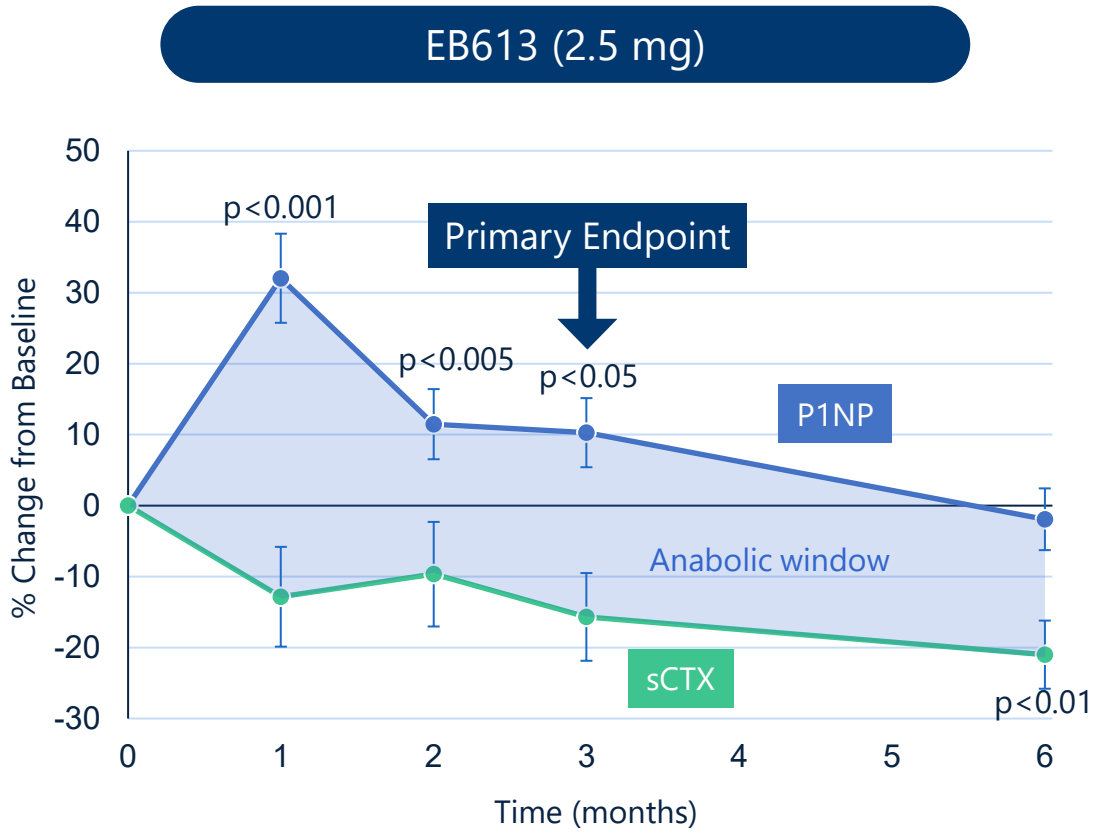
EB613 Induces Bone Formation (P1NP) while Reducing Resorption (CTX)

EB613's dual mechanism stimulates new bone formation on trabecular and cortical (periosteal and/or endosteal) bone surfaces by preferential stimulation of osteoblastic activity over osteoclastic activity



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Editorial

ASBMR The American Society for Bone and Mineral Research

OXFORD

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

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

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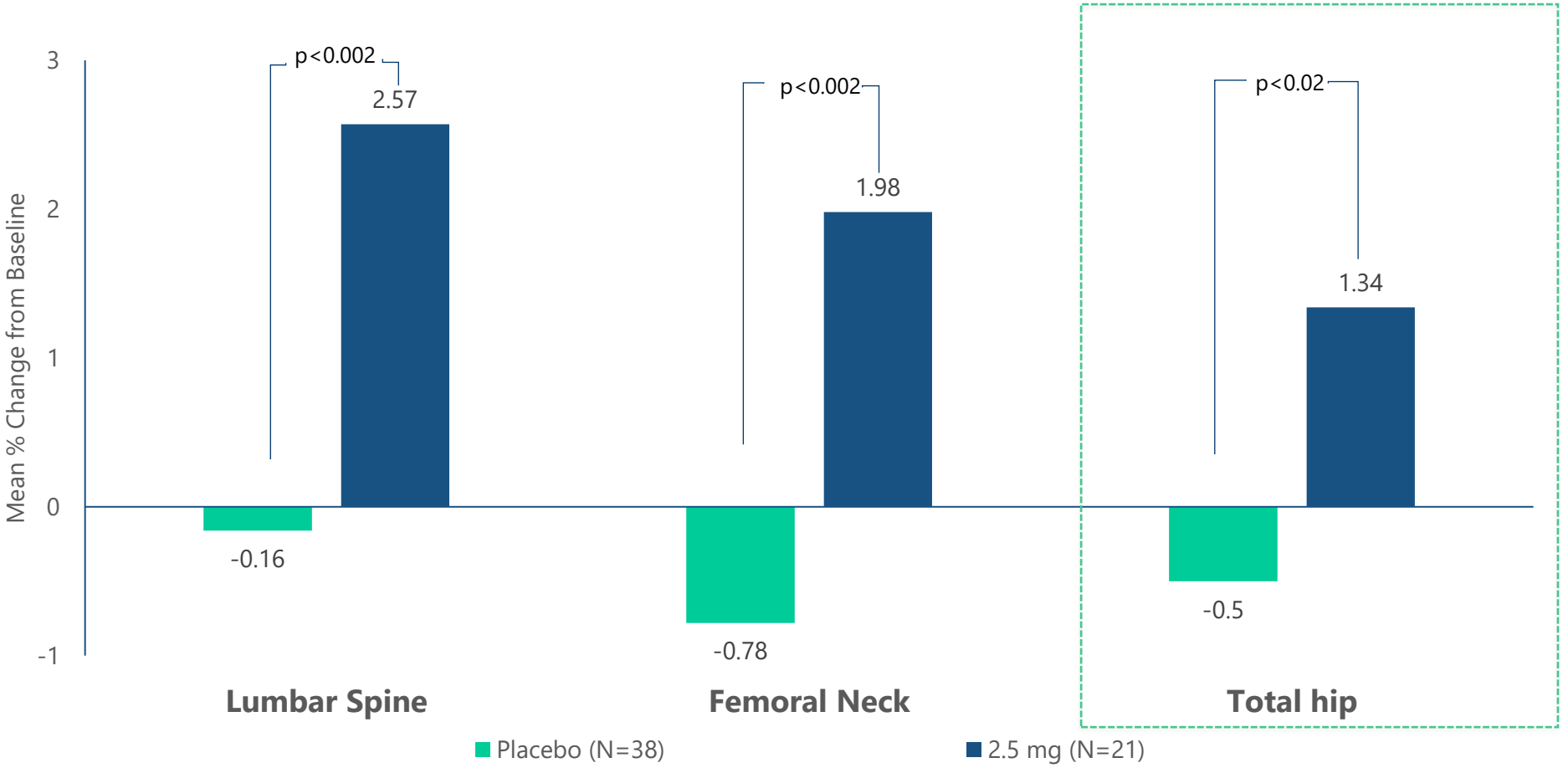
6 Months Treatment with EB613 2.5 mg Produced Significant Increases in BMD at All Skeletal Sites



	Lumbar Spine	Femoral Neck	Total Hip
Placebo Adjusted	2.73	2.76	1.84

Tripto-Shkolnik et al., J Bone Miner Res 2024

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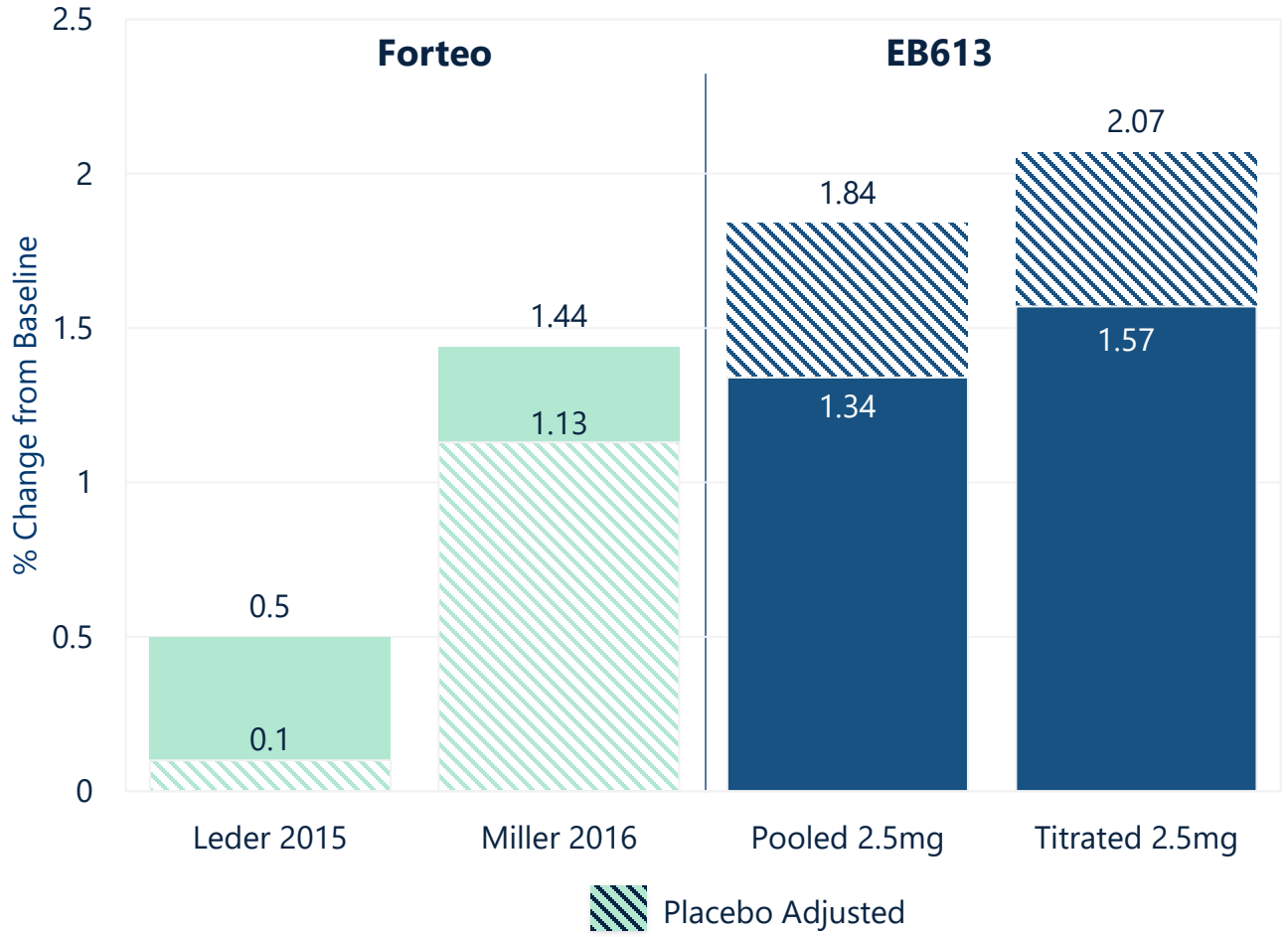
EB613 Produced Comparable Total Hip BMD Increases as Forteo® Published 6 Month Data



- Total Hip BMD is an FDA Efficacy Endpoint as of 12/19/2025
- 6 months of daily Forteo injections resulted in a 0.1 – 1.13% increase in Total Hip BMD[1]
- 6 months of daily Oral EB613 2.5mg resulted in a 1.84 – 2.07% increase in Total Hip BMD[2]

1. Forteo® data based on Leder BZ et.al. JCEM (2015) N=39, and Miller et.al. JAMA (2016) N= 754
2. EB613 data based on Tripto-Shkolnik L et.al. JBMR (2024) Pooled 2.5mg N=21, Titrated 2.5mg N=14

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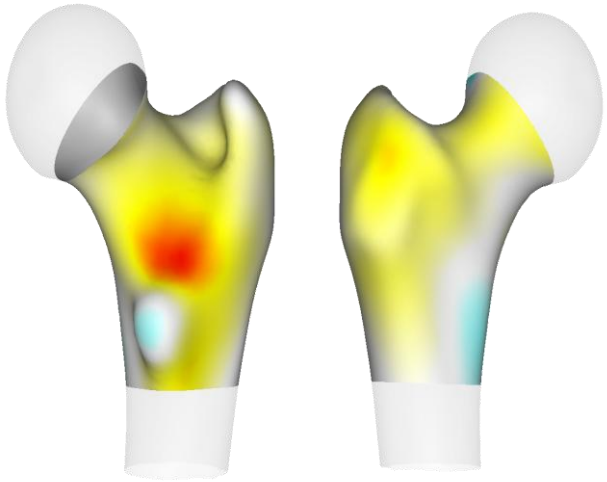
Effects of EB613 on Trabecular and Cortical Bone Using 3D-DXA

Average Cortical Surface BMD % Change from Baseline to Month 6 for EB613 and Placebo

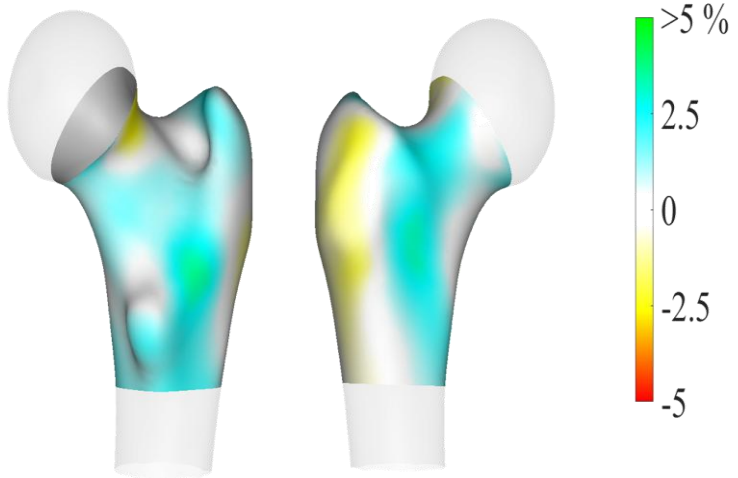
- EB613 showed an early effect on both trabecular and cortical bone of the proximal femur consistent with the dual mechanism of increased formation and decreased resorption
- Comparable assessment with Forteo (teriparatide) and Tymlos (abaloparatide) on cortical bone at 6 months[1]

Placebo (N = 38)



Posterior View Anterior View

EB613 (N = 21)



Posterior View Anterior View

Cortical sBMD (mg/cm^2) is calculated as the multiplication of the cortical thickness and the cortical volumetric BMD

1. Winzenrieth R et al., Osteoporos Int 2021; 32: 75-583.

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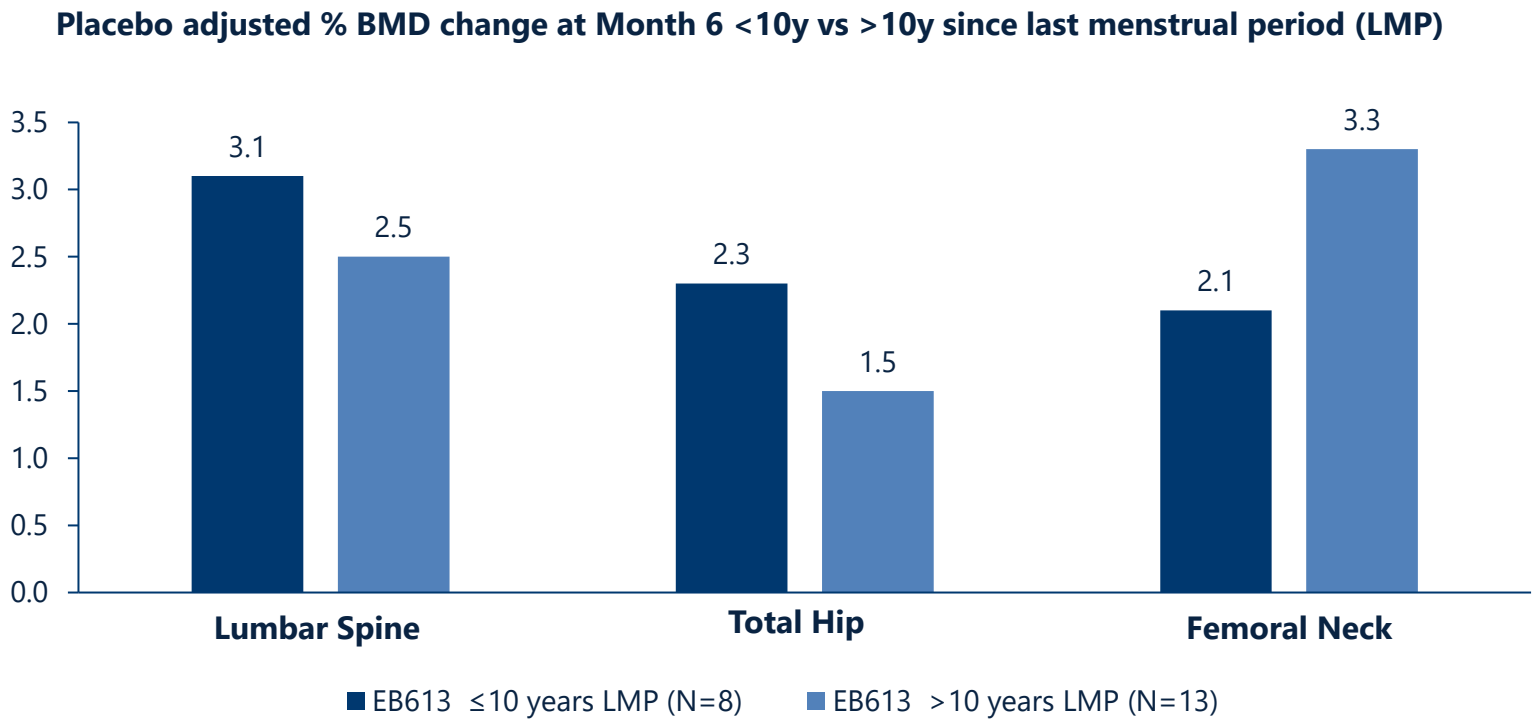
Significant BMD Improvements in Early Postmenopausal Women at 6 Months

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



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

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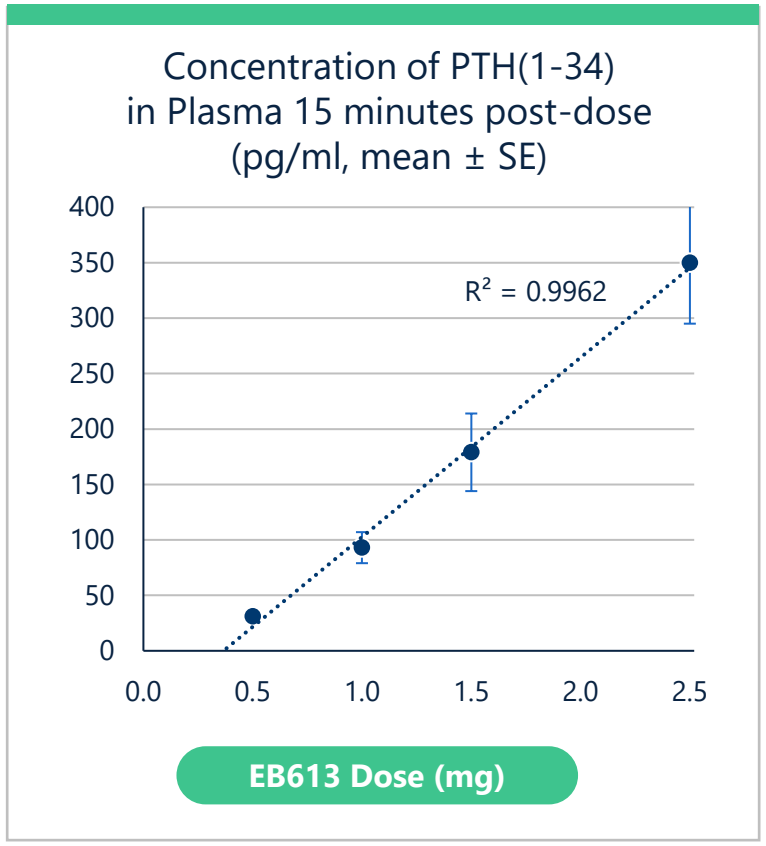
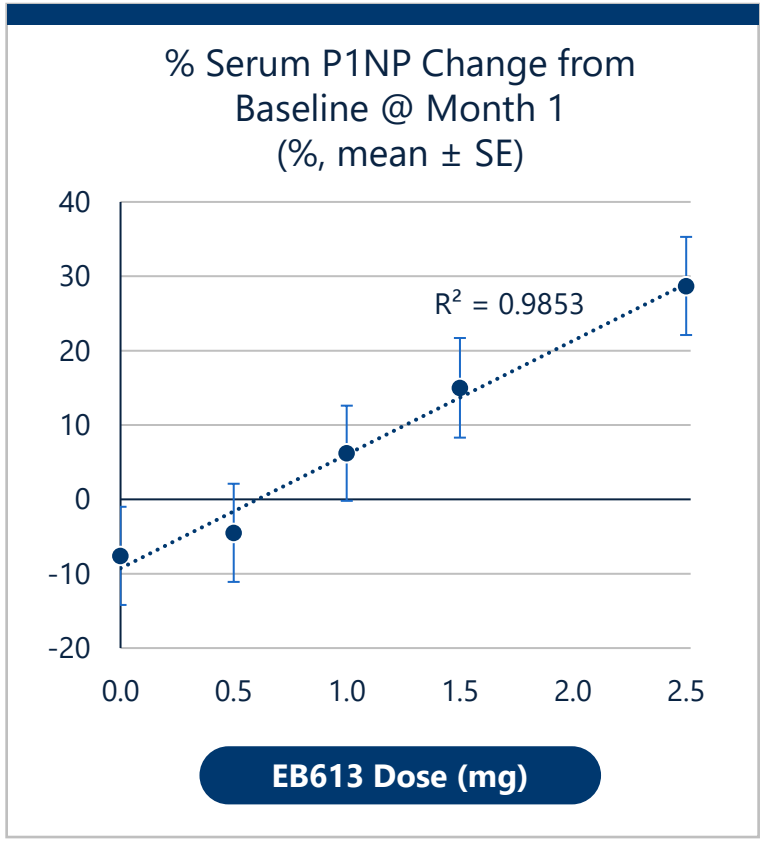
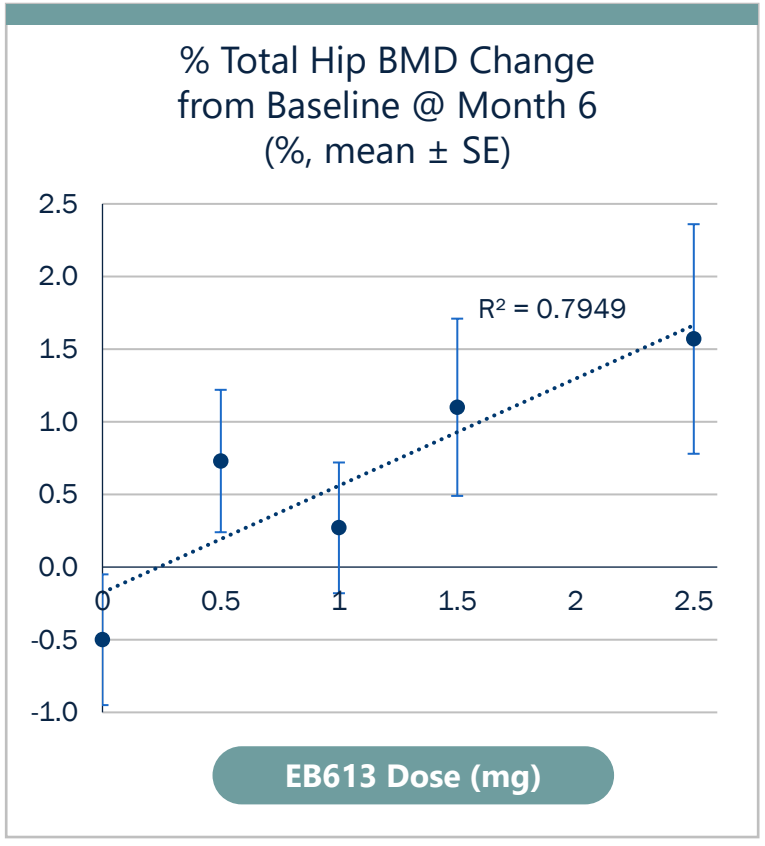
EB613 Showed Linear Dose Response Across PTH Exposure, P1NP Biomarker, and BMD







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

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EB613 Phase 2 Safety Profile Consistent with PTH Agonists

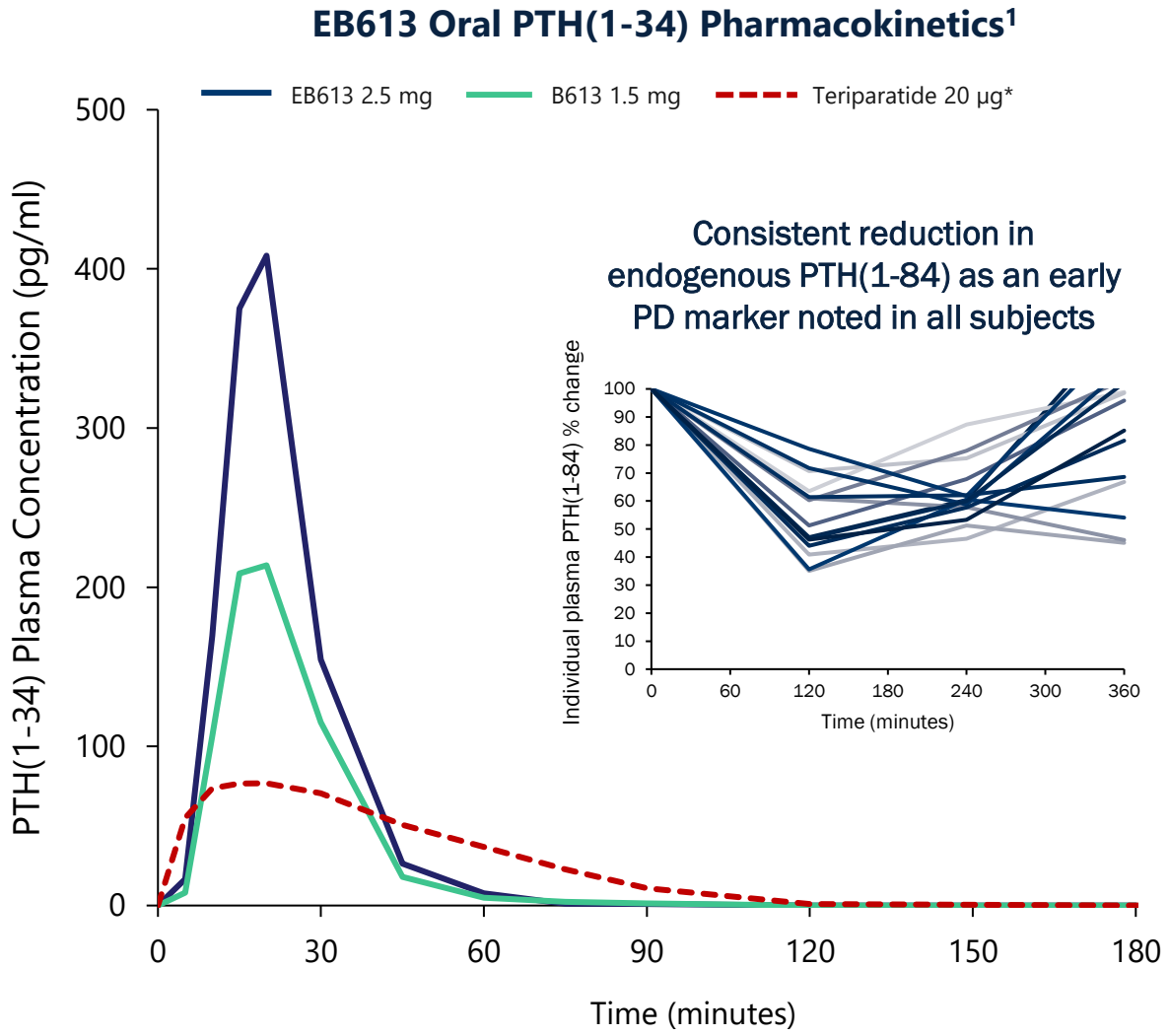
Most Common Treatment Emergent AE (≥5% of participants)	EB613 Treated (N=118) n (%)
Headache	21 (17.8)
Nausea	18 (15.3)
Dizziness	13 (11.0)
Nasopharyngitis	7 (5.9)
Back pain	7 (5.9)
Palpitation	6 (5.1)
Dyspepsia	6 (5.1)
Presyncope	6 (5.1)

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

Tripto-Shkolnik et al., J Bone Miner Res 2024

EB613 Pharmacokinetics: Robust Bioavailability in Phase 1 and Phase 2 Studies

- **EB613 pulsatile PK profile**:
  - Rapid increase in plasma PTH(1-34) levels, with peak concentrations within 20 minutes
  - Rapid elimination phase
- Overall duration of systemic exposure is shorter than that of SC injection Forteo®
- **Distinct EB613 PK profile may optimize the impact on formation while producing lesser changes on resorption**
- EB613 Clinical Package Includes 6 Studies:
  - Phase 1 studies: 3
  - Phase 2 studies: 3



* Forteo® 20 µg subcutaneous

[1] G Burshtein G et al., EB613 (oral PTH[1-34]) Tablets) show differentiated pharmacokinetic profile from Forteo – new results from Phase 1b open-label study. J Bone Miner Res 2024; 39 (Suppl 1): 210.

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Overview of Safety for EB613

Phase 1 and phase 2

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

Safety Profile of EB613 vs Forteo in Comparative Phase 1 studies

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

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

[1]All EB613 doses were included in the safety analysis

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

ENT-01-2011 CSR, ENT-02-2013 CSR, ENT-11-2023 preliminary [1]safety data for the final 15-subject cohort of ENT-11-2023 study are still pending formal analysis

EB613
Phase 3 Design and Proposed Registrational Strategy

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

U.S. FOOD & DRUG ADMINISTRATION

DRUG DEVELOPMENT TOOL QUALIFICATION DETERMINATION
DDT-BMQ-000054

December 19, 2025

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

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

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

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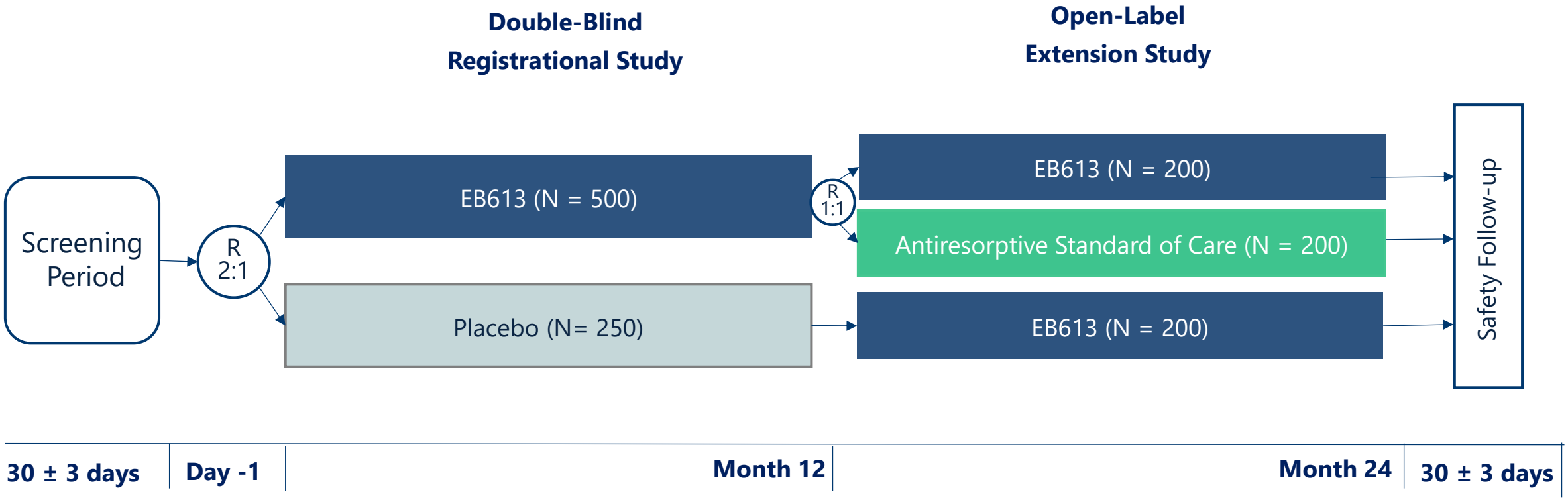
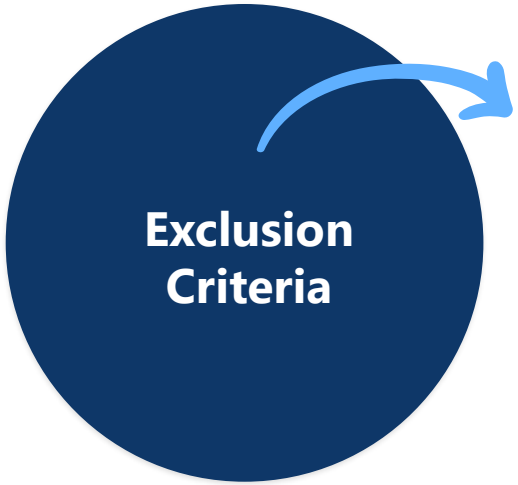
EB613 Phase 3 Development Plan



Key Eligibility Criteria

- **Ambulatory women ≥50 and ≤ 90 years of age**
- **Postmenopausal ≥5 years**
- **BMD T-score ≤ - 2.50 at lumbar spine, total hip, or femoral neck**
- **Eligible fracture types:**
  - One mild vertebral fracture
  - Non-vertebral fractures (other than hip or pelvis) >2 years



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

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EB613 Patient and Clinical Surveys

EB613: Driving Value Across All Key Stakeholders

Healthcare Provider Surveys

GYNs, PCPs, Rheums and Endos likely to prescribe

Oral administration and known mechanism supports wide adoption

Patient Surveys

55% interested in oral bone-building therapy

70% Prioritize increasing bone density

47% Currently untreated despite high need

Payers & Market Access

Oral formulation expected to improve adherence, reduce costs

Differentiated profile supports favorable access

Robust Commercial Opportunity

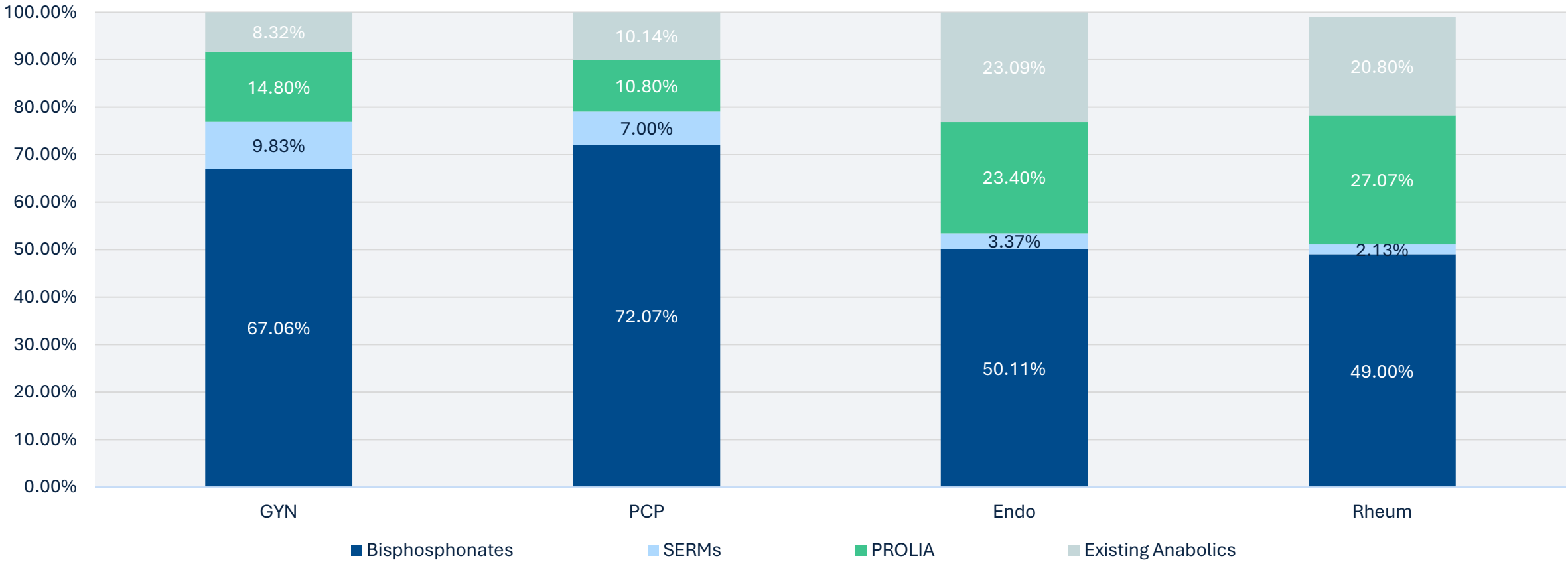
First and Only Once-Daily Oral Anabolic in Development

Estimated 38% patient share across specialties

Source: Entera market research

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

Consistent prescribing patterns across major treating clinicians



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

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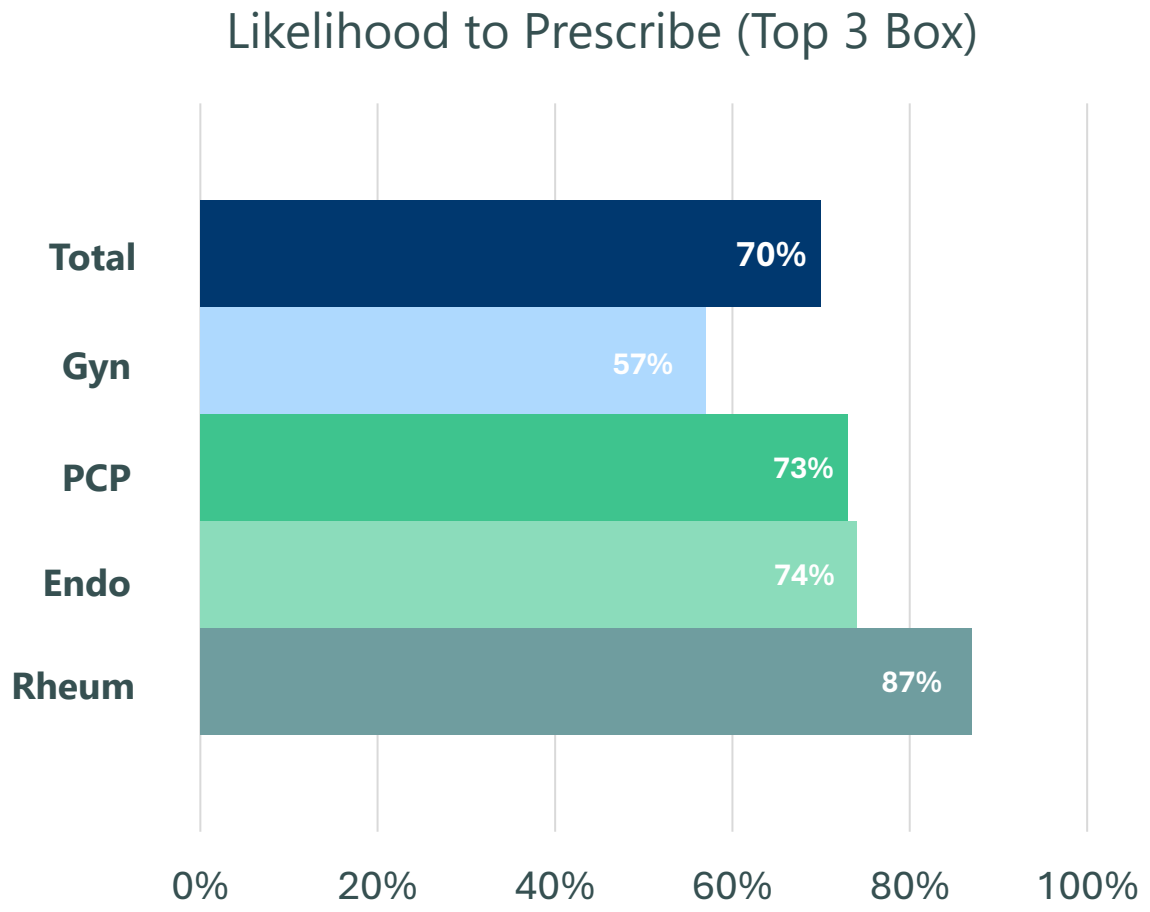
EB613 – A New Oral Anabolic Agent Poised To Transform Osteoporosis Treatment

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

Overwhelming prescriber confidence in EB613 across all physician segments



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

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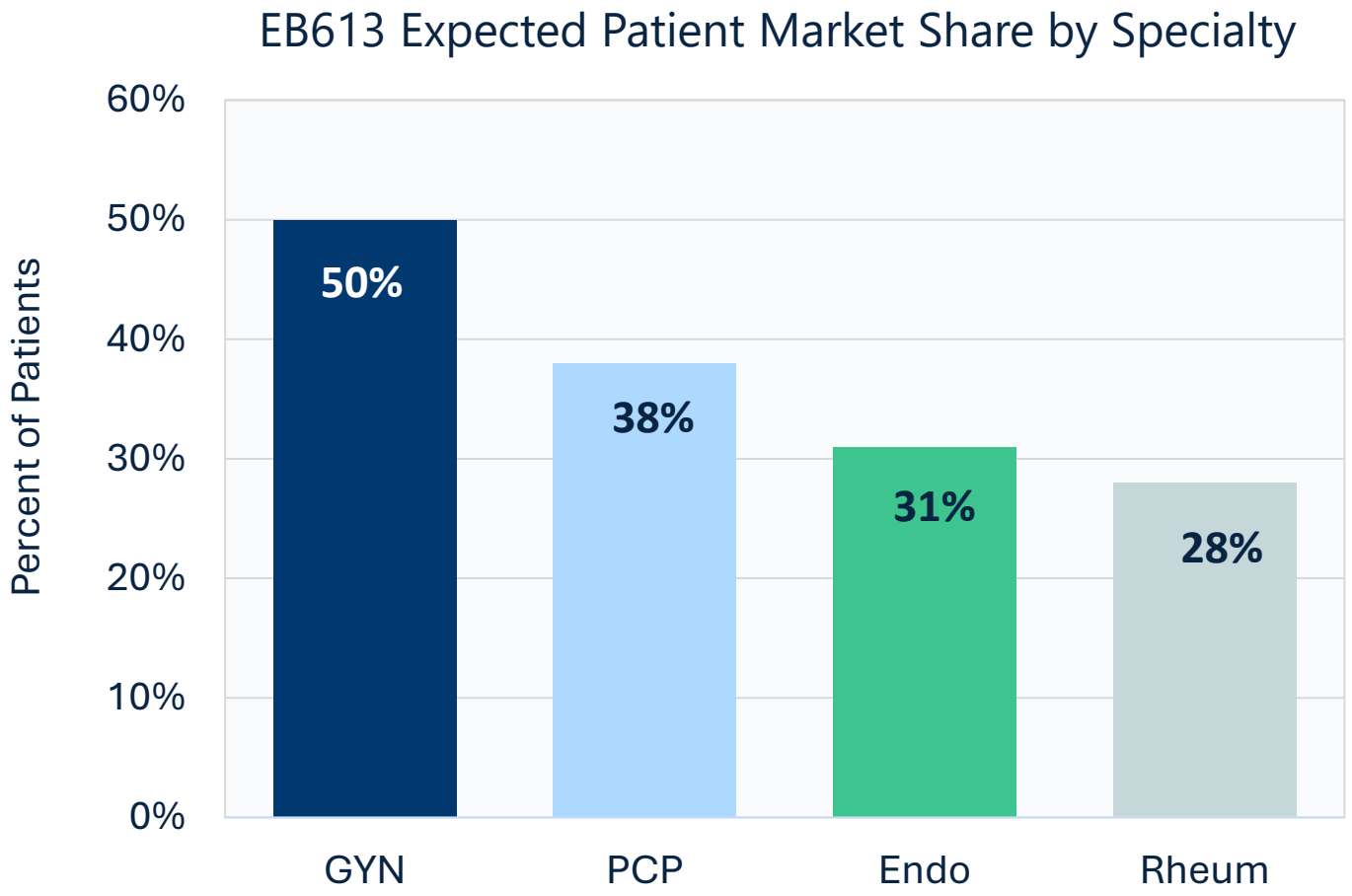
Across All Specialties EB613 Demonstrates Strong Adoption Potential



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

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

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

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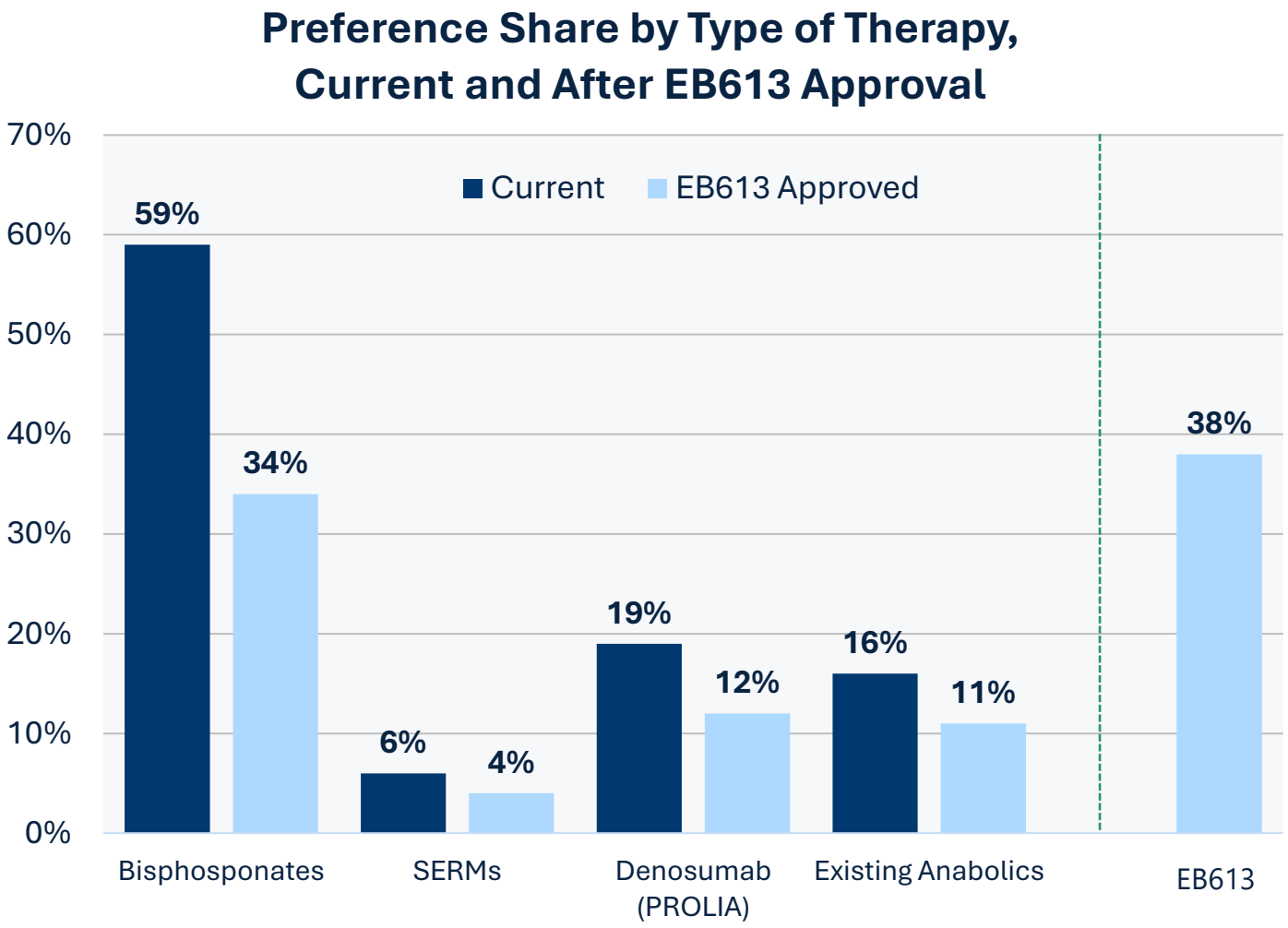
EB613 Is Poised To Take Share From All Established Therapies

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



Source: Market research survey, 2024 by Fit2Market

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

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

89% of respondents

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

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

71% of respondents

treat patients to **prevent** osteoporosis.

64% of respondents

treat patients **with** osteoporosis.

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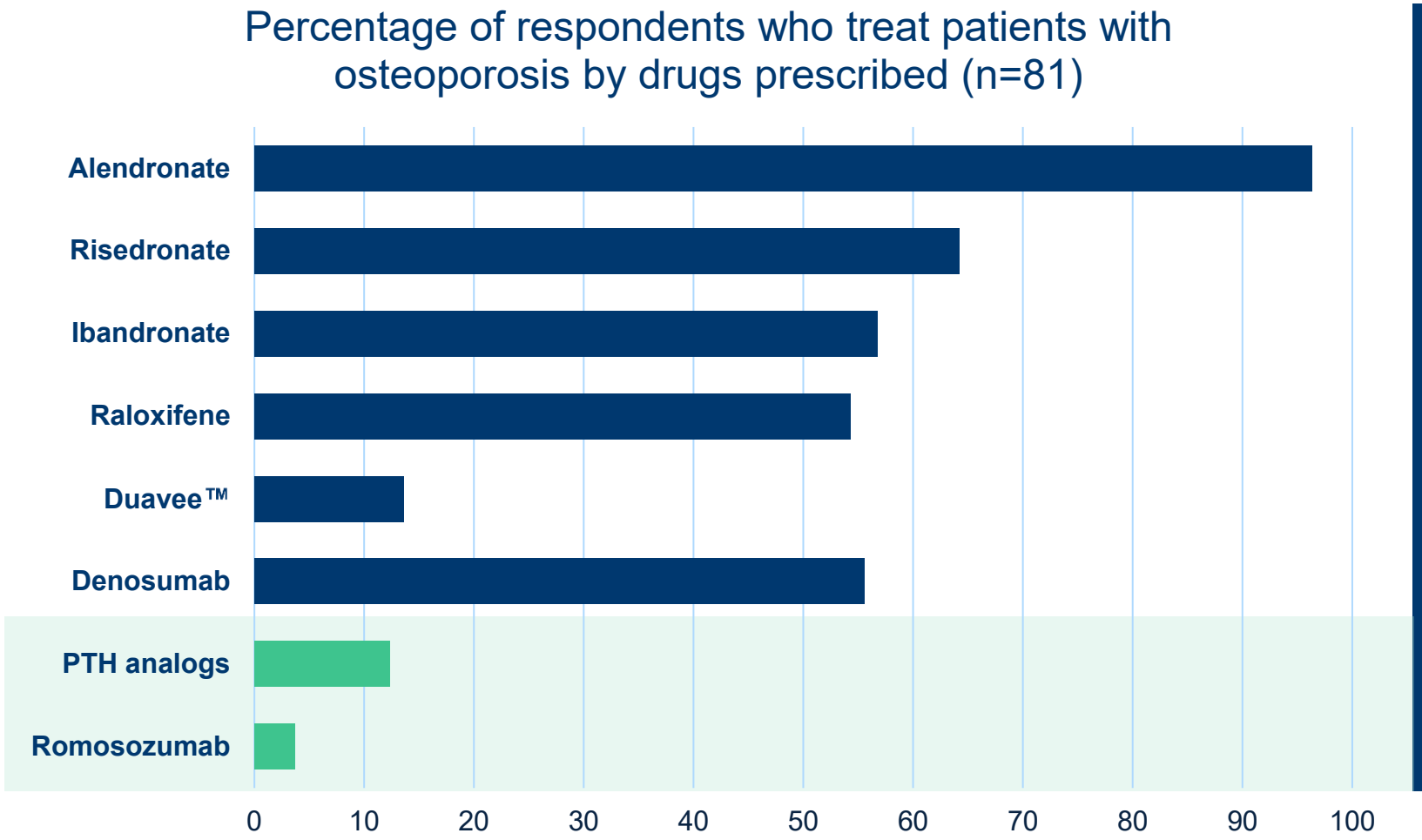
GYN Osteoporosis Treatment Selection Reflects the Underutilization and Limited Market Penetration of Injectable Anabolics



Of the **64% of respondents** who treat patients with osteoporosis,

only **12%** prescribe injectable anabolics.

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

Availability of an oral anabolic would shift the use of anabolics

In treaters of osteoporosis (n=75),

from **12%** to **92%.**

Of treaters who **do not use** injectable anabolics (n=63),

92% would prescribe an oral anabolic.

Of treaters **using** injectable anabolics (n=10),

100% would prescribe an oral anabolic.

Even in those who do not treat osteoporosis (n=28),

from **0%** to **50%.**

EB612 Program

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

In Partnership with OPKO

Hypoparathyroidism - Overview

- Rare endocrine disorder caused by **insufficient PTH(1-84)** → leads to **hypocalcemia and hyperphosphatemia**
- **~200K–300K patients** across the **US, EU, and Japan,** predominantly women
- Most commonly occurs **after neck surgery (~75%)**; can also be autoimmune or genetic
- Complications include **renal impairment, calcifications, and neuromuscular symptoms**

Conventional Therapy

- **High-dose oral calcium** (up to 3 g/day) supplements and **active vitamin D analogs** have been the standard of care for years
- These therapies aim to maintain serum calcium in the low-normal range but:
  - **Does not restore physiological calcium–phosphate homeostasis**
  - **Increases risk of hypercalciuria and kidney disease**

Approved and Investigational PTH Analogs for Hypoparathyroidism

N-Tab® LA-PTH positioned as first-in-class oral peptide therapy for patients with hypoparathyroidism

Early PTH Replacement Attempts

- Short acting PTH(1-34)(unmodified teriparatide) effect on serum Ca not sufficient
- PTH(1-84) - NATPARA injection was approved for the treatment of hypoparathyroidism in 2015 but was discontinued in 2024 by Takeda due manufacturing problems

Palopegteriparatide (Yorvipath, Ascendis) - Approved PTH Analog (FDA, 2024; EU 2023)

- Once daily SC injection of PEGylated PTH(1-34) prodrug designed for continuous release of active PTH(1-34)

PTH Peptide Analogs in Clinical Development

Eneboparatide (AZN) – once-daily injectable PTH analog with short PK but extended PD effect; Phase 3 (Topline data Meets Endpoint March 2025, final data expected at H1 2026)

Canvuparatide (MBX) – Once weekly injectable acylated PTH prodrug; Phase 2 (Topline data Meets Endpoint Sep 2025)

Oral small molecule PTHR1 SEP-479 (Septerna Ph1 in H1 2026; Previous molecule SEP786 discontinued February 2025 due to safety)

EB612: Entera Historical Oral PTH (1-34) Daily Tablets for Hypoparathyroidism

Study Design

Phase 2a, open-label, 16 week, multicenter pilot study to evaluate the safety, tolerability and PK (NCT02152228)

Population: N=19 with hypoPT ≥ 1 year, taking ≥1 g/day calcium and 25(OH)D 20 ng/ml

Treatment: first 3 doses of EB612 0.75 mg QID administered at research center; then self administered

Results

Efficacy:

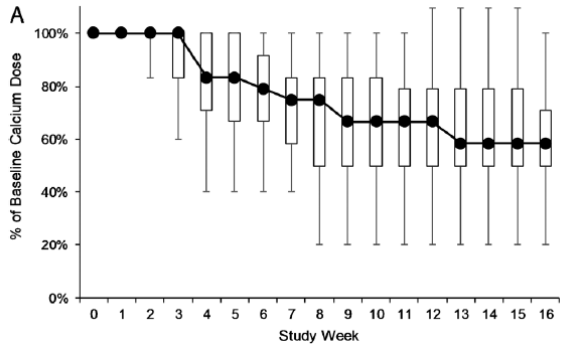
- 42% reduction (p=0.001) from baseline in median calcium supplement use
- Maintenance of median Ca levels above the lower target level for hypoparathyroidism patients (>7.5 mg/dL) throughout the study
- Rapid decline of 23% (p=0.0003) in median serum phosphate levels 2 hours post first dose maintained for the duration of the study

Safety:

- One subject experienced 4 AEs and left the study after the first day
- One subject experienced an unrelated SAE prior to the administration of the first dose

Oral Calcium Intake

Per Protocol Analysis (N=15)



Phase 1 Study Results Of EB612, A First-in-Class Oral PTH(1-34) Analog For The Treatment Of Hypoparathyroidism (June 2024, ENDO 2024 Poster)

- Study tested a new generation of N-Tab® with PTH(1-34) dosed twice a day (BID) in healthy volunteers (n=15)
- Significant systemic exposure was reported following both administrations of EB612 tablets with PD effects (serum levels of calcium (albumin corrected), phosphate, and 1,25(OH)2-Vitamin D, endogenous PTH)

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EB612: Oral LA-PTH (1-34) Daily Tablets for Hypoparathyroidism

- **Indication:** Chronic Hypoparathyroidism, orphan status
- **MOA:** First-in-Class Oral, Long-Acting PTH(1-34) Protein Replacement Therapy Tablet
- **Dosage Form**: Single Tablet QD
- **Regimen and administration**: Once a day dosing following an overnight fast
- **Pharmacokinetics and Pharmacodynamics**: >24 hours exposure following a single dose with a robust PD response
- **Production process**: Standard simple pharmaceutical production process
- **Shelf-life**: Long shelf-life at convenient storage conditions

GLP1/Glucagon and GLP2 Programs

In Partnership with OPKO

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

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

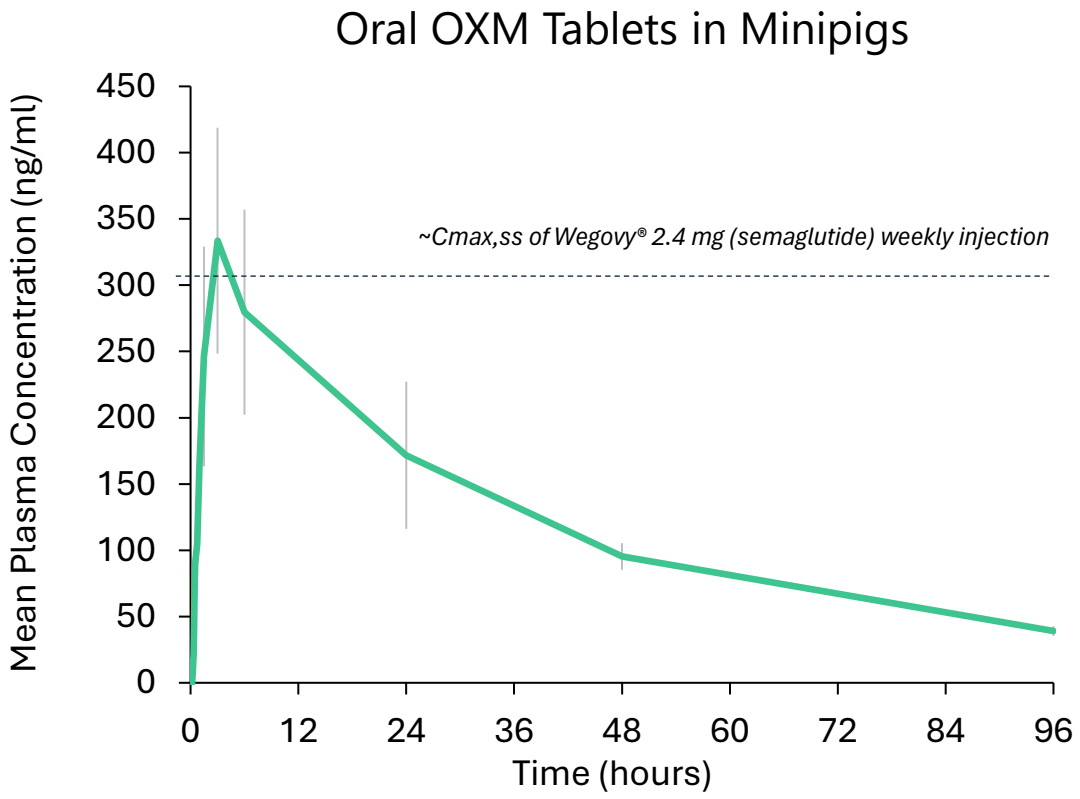
SUN-680. First-in-Class Oral Dual GLP-1/Glucagon Agonist for Patients with Obesity and Metabolic Disorders: In Vivo Pharmacokinetic and Pharmacodynamic Results

Gregory Burshtein[1], Constantin Itin[1], Daniel Pery[1], Eli Reichman[1], Hillel Galitzer[1], Michal Kushnir[1], Ahuva Bar-Ilan[2], Moran Golan[2], Laura Moschcovich[2], Miri Zakar[2], Amit Rivkin[2], Moran Levy[2], Miranda Toledano[1], Jane Hsiao[3]

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

Entera Bio

OPKO



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

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

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

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

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

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

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

Entera Bio

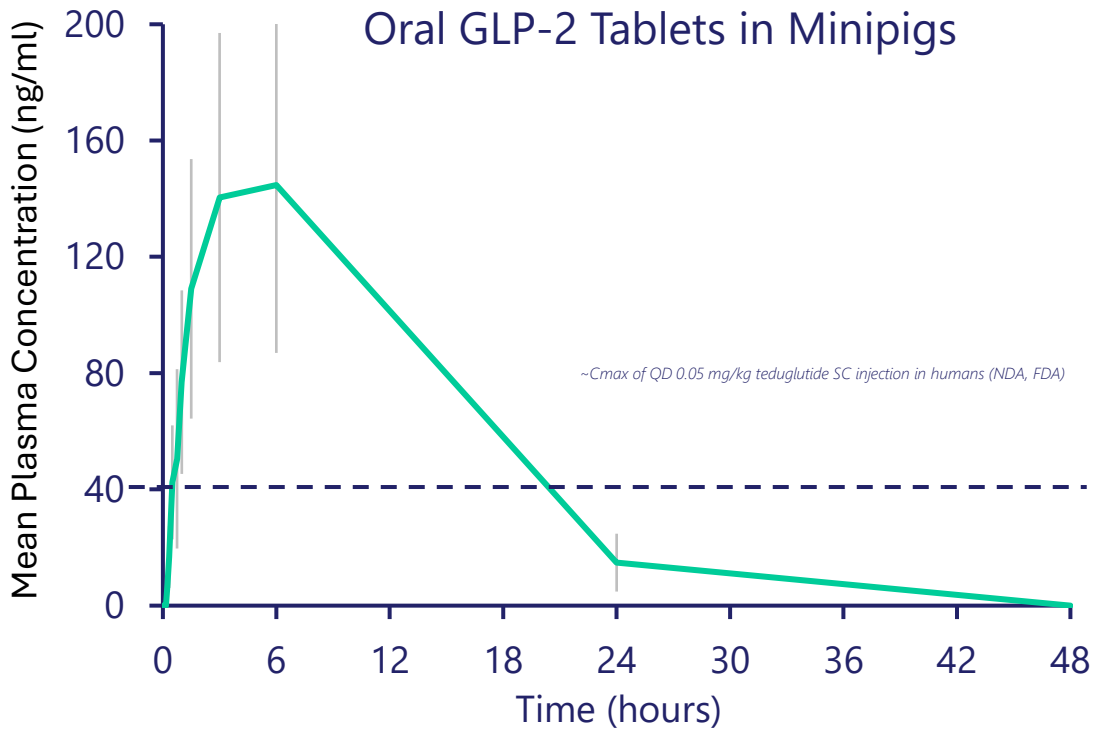
OPKO

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

LB055

Gregory Burshtein[1], Constantin Itin[1], Daniel Pery[1], Eli Reichman[1], Hillel Galitzer[1], Michal Kushnir[1], Ahuva Bar-Ilan[2], Moran Golan[2], Laura Moschcovich[2], Miri Zakar[2], Amit Rivkin[2], Moran Levy[2], Miranda Toledano[1], Jane Hsiao[3]

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



Extended Plasma Half-Life: Approximately 15 hours, an 18-fold improvement over teduglutide (Gattex®), the only approved GLP-2 therapy

Robust Oral Bioavailability: Peak plasma concentrations reached ~200 ng/ml (Cmax), substantially exceeding the reported Cmax of daily teduglutide subcutaneous injection in humans

Prolonged Exposure: Systemic exposure (AUC ~2 h*µg/ml) was maintained for more than 24 hours with relatively low variability, supporting once-daily oral dosing

Pharmacologic effect: Rodent repeat-dose PK/PD studies showed clear pharmacologic activity in intestinal tissue

Favorable Safety Profile: No signs of toxicity were observed in preclinical studies

Thank you

IR@enterabio.com