Ceryvyn
THERAPEUTICS

Investor Information

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EXECUTIVE CHAIR AND CEO

November 2026



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CYV-101 is an investigational product. It has not been approved by the Therapeutic Goods Administration, the US Food and Drug Administration or any other regulatory authority, and its safety and efficacy have not been established.

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Welcome to Ceryvyn

Welcome to Ceryvyn

Translating unique science into breakthrough medicines

Ceryvyn Therapeutics (ASX: CYV) is a clinical-stage Australian biopharmaceutical company developing medicines based on advances in human biology for patients with serious disease.

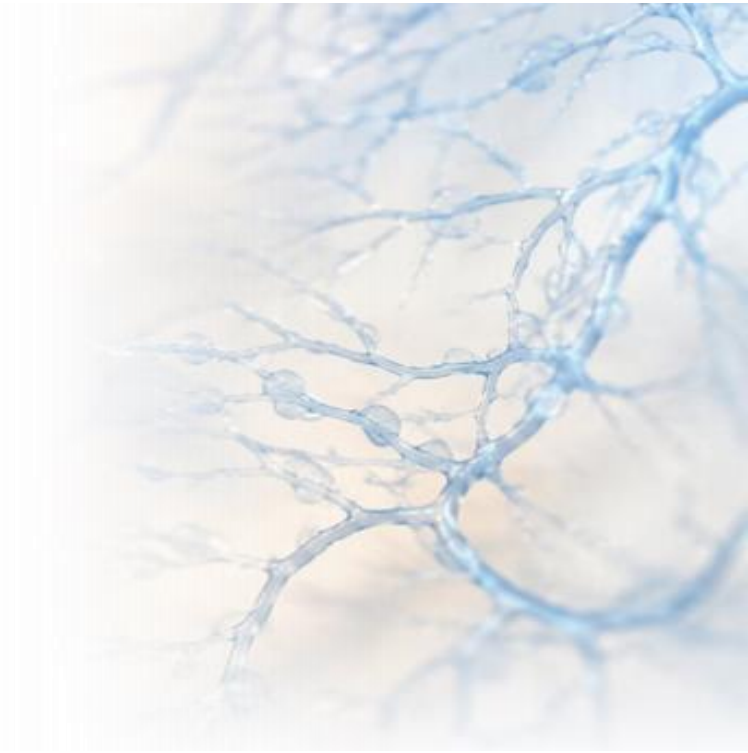
- **Focused on rare disease.** Our focus is lymphangioleiomyomatosis (LAM), a rare, progressive lung disease that almost exclusively affects women[1]. Abnormal cells proliferate in the lungs and lymphatics, forming cysts that destroy lung tissue. Approximately 5000 LAM patients[2] in the US and recent analysis suggests up to 250,000 undiagnosed worldwide[3]. There is no cure.
- **Our Approach.** CYV-101 is a first-in-class fusion protein designed to neutralise VEGF-C and VEGF-D. We intend to test whether inhibiting this pathway can reduce abnormal lymphatic remodelling in LAM.
- **Deep expertise.** A product of Australian science and Australian investment, led by Executive Chair and CEO Dr Jeremy Levin and guided by a scientific advisory board of global LAM thought leaders.



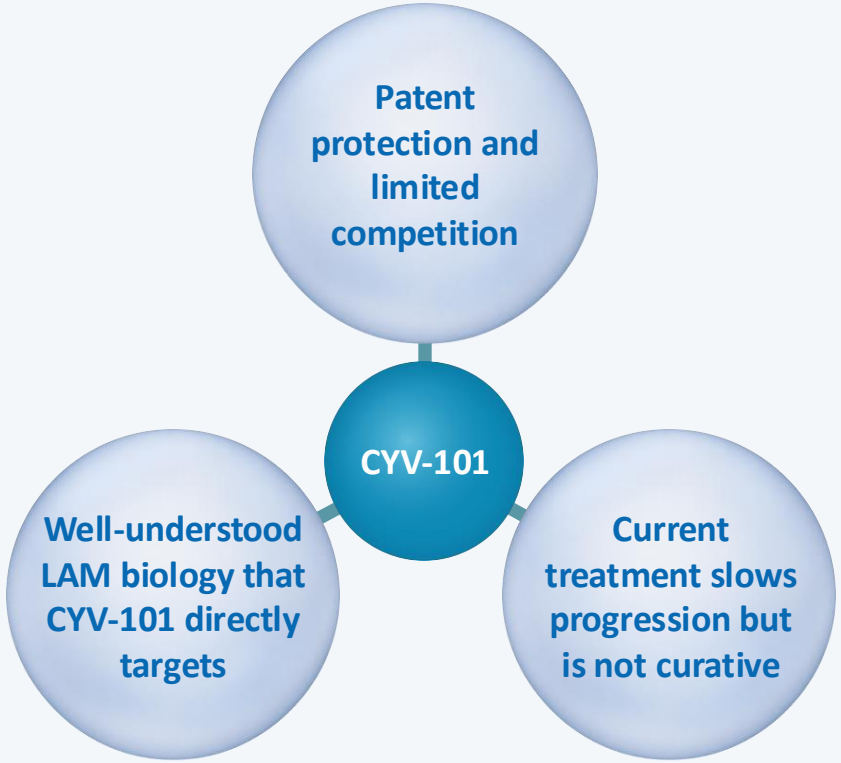
1. Lynn E, Forde SH, Franciosi AN, et al. Updated Prevalence of Lymphangioleiomyomatosis in Europe.
2. American Journal of Respiratory and Critical Care Medicine. 2024;209(4):456–459. DOI: 10.1164/rccm.202310-1736LE European prevalence study.
3. UT Southwestern LAM Clinic (utswmed.org); The LAM Foundation, Worldwide LAM Awareness Month (2024): up to 250,000 undiagnosed (estimate).

Why LAM offers a focused development opportunity

- Specialist centres provide a defined clinical development setting
- Established diagnostic criteria and biomarkers support patient identification
- Potential eligibility for orphan-drug incentive
- Established patient organisations may support trial awareness and recruitment
- Significant unmet need in a chronic disease managed through specialist centres



Ceryvyn's development strategy for LAM



Focused clinical development

LAM	Progressive lung disease affecting predominantly women
CYV-101	CYV-101 is a clinical-stage biologic with extensive human experience and a focus on LAM
Mechanism	Neutralising VEGF-C and VEGF-D to inhibit VEGFR-3 signalling associated with abnormal lymphatic remodelling
Focus	Disciplined execution and capital efficiency

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Lymphangioleiomyomatosis (LAM)

Understanding Lymphangioleiomyomatosis

19–23.5 women per million[8]

And up to 250,000 women worldwide may be undiagnosed (estimate)[6,7]

Genetic condition

Not caused by lifestyle choices

~35

Average age at diagnosis

- LAM is a low-grade neoplasm in the PEComa family, with abnormal cell growth and cystic lung destruction.[1,2]
- VEGF-C and VEGF-D drive LAM cell growth, promoting abnormal lymphatics and cause leak of lymphatic fluids.[2,3]
- Lung cysts destroy tissue and cause air leaks, reducing breathing capacity and potentially shortening lifespan.[1,2]
- Benign kidney tumours (angiomyolipomas) occur in about one-third to 40% of women with sporadic LAM.[4]
- mTOR inhibitors can stabilise disease on treatment, but do not cure LAM; progression can resume off therapy.[5]
- Opportunity for focused studies with meaningful mechanistic endpoints.

1. WHO Thoracic Tumours, 5th ed. (2021); Nicholson AG et al. J Thorac Oncol 2022;17(3):362–387 (LAM under PEComatous tumours).
2. McCarthy C et al. Lancet Respir Med 2021;9(11):1313–1327; Gupta N, Johnson SR. Am J Respir Crit Care Med 2024;209(4):358–359.
3. Issaka RB et al. Am J Pathol. 2009;175(4):1410–1420.
4. The LAM Foundation, Diagnosing LAM (about 40% of sporadic LAM; about one-third on its clinical-course page).
5. McCormack FX et al. N Engl J Med 2011;364(17); Am J Respir Crit Care Med 2016;194(6):748–761.
6. UT Southwestern Medical Center, Lymphangioleiomyomatosis (LAM) Clinic (utswmed.org).
7. The LAM Foundation, Worldwide LAM Awareness Month (2024) letter template: as many as 250,000 undiagnosed or misdiagnosed.
8. Lynn E et al. Am J Respir Crit Care Med 2024;209(4):456–459, as reported in Gupta N, Johnson SR. 2024;209(4):358–359.

Existing LAM patient journey

Current limitations and unmet clinical needs

Early symptoms	Non-specific breathlessness on exertion, cough and fatigue. Chest pain, lung collapse and/or coughing up blood.
Misdiagnosis	Often mistaken for asthma, emphysema, bronchitis or chronic obstructive lung disease.
Diagnosis	History, exam, CT Scan, Spirometry, VEGF D levels, other specialist tests.
Progression	Daily activities become harder, fatigue grows and quality of life is reduced. Hospital visits increase with pneumothorax.
Disease management	Rapamycin can stabilise some patients, but not all.[2] True disease control and restoration remain unmet.
Lung transplant or incapacitation	Quality of life and lifespan are significantly impacted when symptoms progress.

1. ATS/JRA guidelines recommend serum VEGF-D with an 800 pg/mL threshold to support diagnosis.
2. Drugs derived from rapamycin are not curative, but can slow the destructive progress of LAM in some patients.

Scientific rationale

Targeting VEGF-C/D pathway in LAM

“Lock and key” system

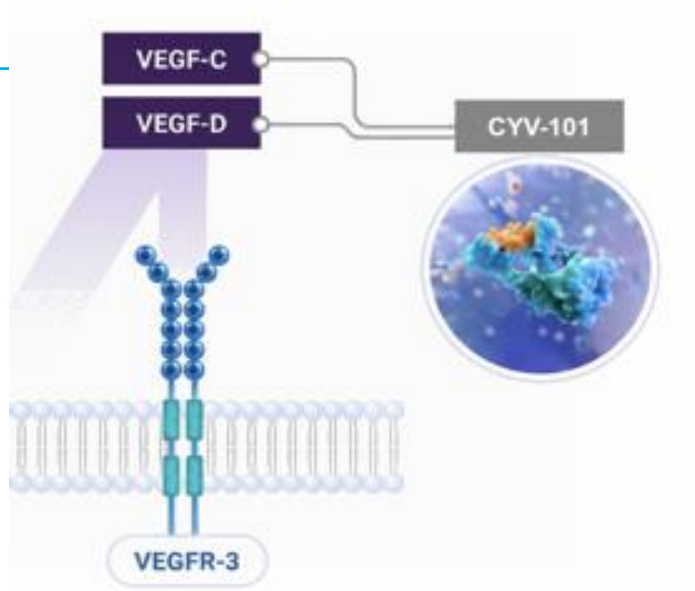
VEGF-C and VEGF-D are growth signals that tell lymphatic vessels to grow and become more permeable.

VEGFR-3 is the receptor on lymphatic cells that receives these signals.

When VEGF-C or VEGF-D bind to VEGFR-3, the lymphatic system gets a strong “expand and remodel” message. In LAM, this leads to abnormal, dilated, and leaky lymphatic vessels.

The problem[1]

In LAM, VEGF-C/D signalling through VEGFR-3 contributes to abnormal lymphatic growth and remodelling.



The mechanism

CYV-101 may potentially bind and neutralise VEGF-C and VEGF-D before they activate VEGFR-3. The proposed approach targets signalling associated with abnormal lymphatic remodelling in LAM. Clinical studies will test whether target engagement translates into patient benefit.

1. Issaka, R. B., et al. (2009). See Appendix for full citation.

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Ceryvyn Team

Focused, Efficient, Drug Developers

Our Board

Our Board brings extensive experience in drug development, biotechnology and VEGF biology, with a clear objective: advancing CYV-101 for patients with LAM



Medical doctor and scientist with 30+ years in biopharma. Executive Chairman of Ovid Therapeutics; former CEO of Teva and member of the Bristol-Myers Squibb Executive Committee. Emeritus Chairman of BIO.



20+ years in healthcare business development and investment at Johnson & Johnson and Sanofi. Non-Executive Director of Avecho and BioNSW; BioMelbourne Network Woman of the Year 2018.



20 years as a biotech investor and adviser. Founder and CIO of Scientia Capital; previously managed QIC's biotech fund and advised life sciences companies at Deloitte.

Science Advisory Board

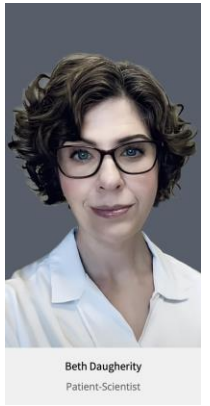
Ceryvyn has brought together global thought leaders in LAM with decades of clinical experience and patient collaboration to inform our development efforts



Professor and Director of Pulmonary, Critical Care and Sleep Medicine, University of Cincinnati. Founding Scientific Director of the LAM Foundation; PI of the MILES trial of sirolimus.



Conjoint Professor at UNSW and respiratory physician with 25+ years caring for women with LAM. Runs the LAM Clinic at Macquarie University Hospital, Sydney.



PhD and Assistant Professor at TTUHSC School of Pharmacy. A LAM patient turned researcher and patient advocate, studying hormonal pathways in LAM.

https://www.ceryvyn.com/team/

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Clinical Progress

Phase 1b/2a study of CYV-101 in LAM*

OBJECTIVE

Evaluate the safety, biological activity and potential clinical benefit of CYV-101 in patients with LAM

PRIMARY FOCUS

- Safety and tolerability
- Pharmacokinetics
- Immunogenicity
- VEGF-C / VEGF-D target engagement

KEY 3- and 6- MONTH MEASURES

- Hyperpolarised ^{129}Xe MRI
- FEV1
- DLCO (Carbon Monoxide Diffusing Capacity of the Lungs)
- 6-minute walk distance
- Oxygen desaturation
- Serum biomarkers (e.g. VEGF-D)

EXPLORATORY MEASURE

- Quantitative CT cyst burden
- Quality of life / dyspnoea
- Pneumothorax, chylous events, oxygen use

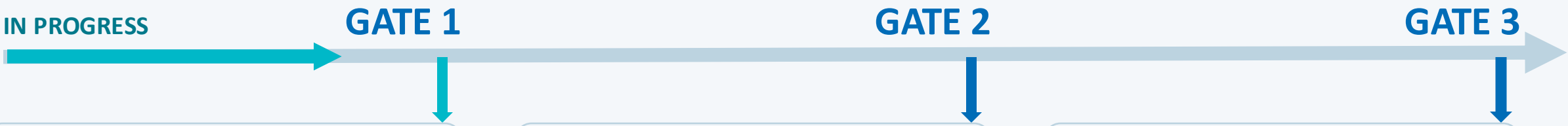
*Final details will be subject to review by full clinical and scientific board

Rigorous data-driven milestones

Preclinical inhalation and biology in large animal studies

Early human pharmacodynamic (PD) and tolerability

Clinical proof-of-concept in LAM



- Nebulisation performance
- Lung delivery feasibility
- Acceptable toxicology
- Early biological activity

- VEGF-C/D modulation
- Safety and tolerability
- Human biological signal

- Lung function
- Lymphatic outcomes
- Mechanistic validation
- Patient informed endpoints

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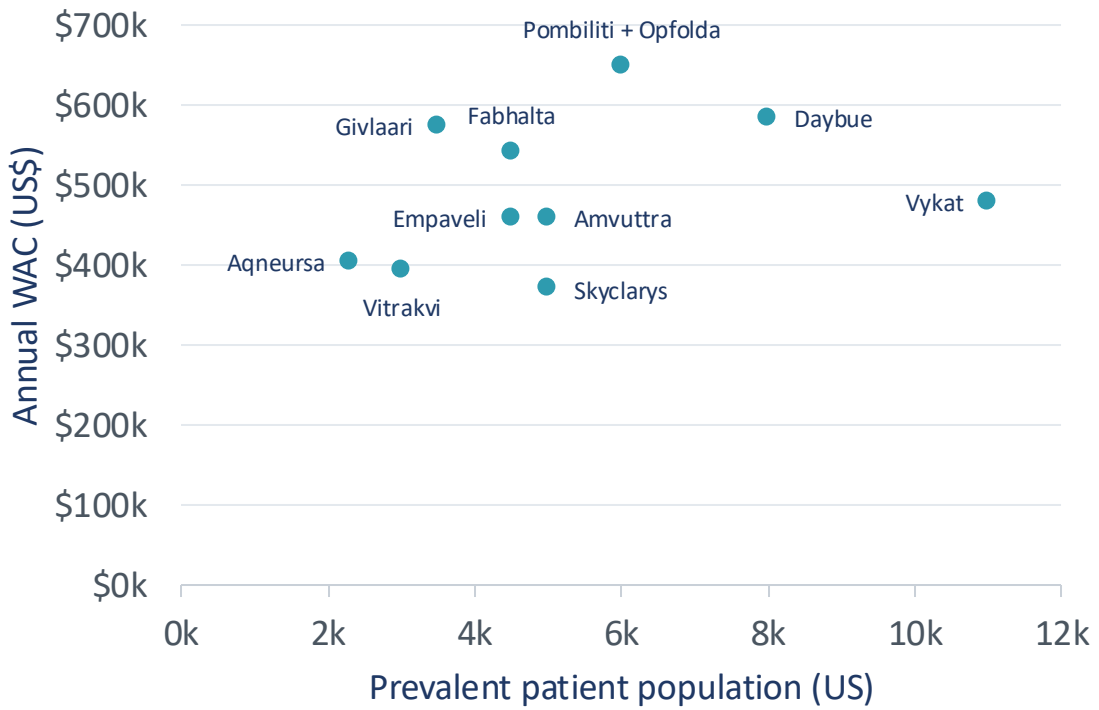
Market Context

Rare disease drugs with similar prevalence to LAM in the US

Annual price vs US prevalence[1]



Drug	US prevalence	Annual WAC	Total Annual Addressable Market
Aqneursa	2,300	$404,000	$929,200,000
Vitrakvi	3,000	$394,000	$1,182,000,000
Givlaari	3,500	$575,000	$2,012,500,000
Empaveli	4,500	$460,000	$2,070,000,000
Fabhalta	4,500	$542,000	$2,439,000,000
Amvuttra	5,000	$460,000	$2,300,000,000
Skyclarys	5,000	$370,000	$1,850,000,000
Pombiliti + Opfolda	6,000	$650,000	$3,900,000,000
Daybue	8,000	$585,000	$4,680,000,000
Vykat	11,000	$480,000	$5,280,000,000

LAM Prevalence

Approximately 5000 patients[2] in the US. Some estimates up to 250,000 women undiagnosed worldwide[3]

1. *Data Source: Ritu S. Baral / TD Cowen, unpublished recurring-therapy pricing analysis, supplied 12 Aug 2026; adapted by Ceryvyn*
2. Lynn E, Forde SH, Franciosi AN, et al.
   Updated Prevalence of Lymphangioleiomyomatosis in Europe
   American Journal of Respiratory and Critical Care Medicine. 2024;209(4):456-459.
   DOI: 10.1164/rccm.202310-1736LE
3. UT Southwestern Medical Center, LAM Clinic (utswmed.org); The LAM Foundation, Worldwide LAM Awareness Month (2024): as many as 250,000 undiagnosed or misdiagnosed world-wide (estimate).

Confidential

Regulatory strategy

Ceryvyn may seek orphan designation when appropriate

Orphan drug designation may unlock	
Market exclusivity	Potential post-approval exclusivity: 7 years in the US and 10 years in the EU, subject to conditions. Japan extends its re-examination period. Australia offers orphan registration fee waivers.[1]
Pricing and reimbursement	Orphan designation does not determine pricing or reimbursement, which depend on clinical evidence and national market conditions.
Regulatory incentives	US: qualifying tax credits and fee exemptions. EU: protocol assistance and fee reductions. Japan: priority review and incentives. Australia: fee waivers. Eligibility varies.[1]

1. FDA orphan designation; EMA market exclusivity and orphan incentives; PMDA orphan overview; TGA orphan designation. See appendix.

Corporate and financial overview

Company name

Ceryvyn Therapeutics

ASX ticker

CYV

Total ordinary shares on issue

1,367,978,173

Market capitalisation[2]

A$13.7 million

Financial position

A$27.5 million cash and cash equivalents (as at 30 September 2026)

No debt, clean balance sheet

Based on current forecast, Ceryvyn has sufficient cash to support the three-stage LAM development program. This may be subject to change.



1. As at 30 October 2026
2. As at 30 October 2026

Conclusion

	CYV-101 is an existing biologic with a differentiated mechanism targeting VEGF-C and VEGF-D.
	LAM provides an opportunity to test the role of abnormal lymphatic signalling in a serious progressive disease.
	Our development program is designed to establish safety, biological activity and evidence of clinical benefit.
	Preclinical inhalation and large-animal studies are underway, with predefined criteria for advancing into clinical development.
	Ceryvyn has the scientific expertise, clinical relationships and financial resources to execute its current development plan.



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Appendix

Citations

- Baldwin M. *CYV-101: A novel therapy for Wet AMD.* Corporate Presentation (Ceryvyn Limited; ASX PDF). January 2017. p. 11 (slide 11) (states “CYV-101 (soluble VEGFR-3, VEGF-C/-D ‘Trap’)”).
- Issaka, R. B., et al. (2009). Vascular Endothelial Growth Factors C and D Induce Proliferation of Lymphangioleiomyomatosis Cells through Autocrine Crosstalk with Endothelium. *The American Journal of Pathology, 175*(4), 1410–1420. https://doi.org/10.2353/ajpath.2009.080830
- Jackson TL et al. *A Randomized Controlled Trial of CYV-101, a VEGF-C/D Inhibitor for Neovascular Age-Related Macular Degeneration.* Ophthalmology. 2023 Jun; 130(6):588–597. Epub 2023 Feb 6.
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Citations: LAM disease facts

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- Nicholson AG, Tsao MS, Beasley MB, et al. The 2021 WHO Classification of Lung Tumors: Impact of Advances Since 2015. J Thorac Oncol. 2022;17(3):362–387. doi:10.1016/j.jtho.2021.11.003. Table 1 lists lymphangioleiomyomatosis under PEComatous tumors.
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- Gupta N, Johnson SR. Lymphangioleiomyomatosis: No Longer Ultra-rare. Am J Respir Crit Care Med. 2024;209(4):358–359. Describes LAM as a female-predominant low-grade neoplasm and reports the pooled prevalence from Lynn et al. (19 and 23.5 per million).
- The LAM Foundation. What is LAM? Patient information, accessed 2 October 2026. Reports an average diagnosis age of approximately 35 years.
- The LAM Foundation. Diagnosing LAM. Healthcare-provider guidance, accessed 2 October 2026. Reports renal angiomyolipomas in about 40% of sporadic LAM (about one-third on its Clinical Representation and Course of LAM page, which also gives the average diagnosis age of 35).
- UT Southwestern Medical Center. Lymphangioleiomyomatosis (LAM) Clinic. utswmed.org. Describes the estimated number of women with LAM and those who may be undiagnosed.
- The LAM Foundation. Worldwide LAM Awareness Month (2024) letter template, thelamfoundation.org. States as many as 250,000 undiagnosed or misdiagnosed.
- Kimura Y, Jo T, Hashimoto Y, et al. Epidemiology of patients with lymphangioleiomyomatosis: a descriptive study using the national database of health insurance claims and specific health checkups of Japan. Respir Investig. 2024 May. doi:10.1016/j.resinv.2024.03.010. Reports 28.7 per million women (2019).
- Population limitation: the 250,000 undiagnosed figure is a population-based estimate (up to 250,000 worldwide), not a validated count; it should keep its “estimate” label. Prevalence of 19–23.5 per million is a minimum pooled estimate (Lynn et al.).

Citations: economics, pricing and regulation

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