EP-104GI: Preparing for the RESOLVE Part 2 Interim Data Release

Targeting EoE to improve patients' lives.

November 13, 2026



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This presentation also contains estimates and other statistical data made by independent parties and by the Company relating to share value and other data about our industry. The Company obtained this data from its own internal estimates and research and from academic and industry research, publications, surveys, and studies conducted by third parties, including a research report conducted by Clearview that the Company commissioned. These data involve a number of assumptions and limitations, are subject to risks and uncertainties, and are subject to change based on various factors, including those discussed in our public filings on SEDAR+ and EDGAR. These and other factors could cause results to differ materially from those expressed in the estimates made by the independent parties and us. The Company has not independently verified any of the data from third party sources referred to in this presentation or ascertained the underlying assumptions relied upon by such sources. This data involves a number of assumptions and limitations, and you are cautioned not to give undue weight to such estimates.

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Setting the Stage for Interim Data From RESOLVE Part 2

Level Setting

What We Learned From Part 1

Open-label signals in swallowing, tissue response and durability

RESOLVE Part 2

What the Part 2 Interim Will Test

Two doses versus placebo (vehicle) with the primary endpoint at six months: Early data at 52 weeks on durability of effect. Focus remains on the patient symptoms and their objective correlates (EoEHSS/EREFS)

Looking Forward

Blinded Baseline and Safety from Part 2 setting the stage

Who are the patients? What are the key endpoints?

Interim readout expected December 2026: Eupraxia's first controlled data against eosinophilic esophagitis (EoE).

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EP-104GI Is Focused on What Matters to Patients: Feeling Better

What patients want

Swallow more comfortably, control disease progression and reduce the burden of ongoing treatment*.

1

Inflammation

A complex Th2 inflammatory process where the drivers are multifactorial and upstream treatment has strongest potential

2

Fibrosis

Chronic inflammation leads to submucosal fibrosis

3

Barrier dysfunction

A key pathologic feature of EoE and a central target of treatment, measured in EoEHSS subscores

*Market research completed by Clearview Healthcare Partners 2025, and market research completed by Eupraxia.

A Multifaceted Disease Calls for a Multifaceted View of Response

Symptoms

- **SDI**
- **DSQ**

Focused on dysphagia and odynophagia

Histology

- **EoEHSS**
- **Eosinophils**

EoEHSS looks at inflammation, fibrosis and the pathologic features of eosinophils

Endoscopy

- **EREFS**

The visual scoring of the inflammatory and fibrotic features of EoE

No single measure tells the whole story. Confidence comes when symptoms, histology and endoscopy improve together, which is also what patients want from a new EoE therapy.

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SDI and DSQ Measure Symptoms Differently and Are Not Interchangeable

	SDI	DSQ *(not measured in Part 1)*
What it captures	Dysphagia frequency and intensity	Daily dysphagia & Odynophagia
Reported scale	0–9	0–84
How to read change	Lower is better	Lower is better
Key distinction	Patients in Clinical Remission: • ≥ 3-point reduction in SDI Score	Assess change from baseline and versus vehicle. Clinical responders: • ≥30% reductions from baseline

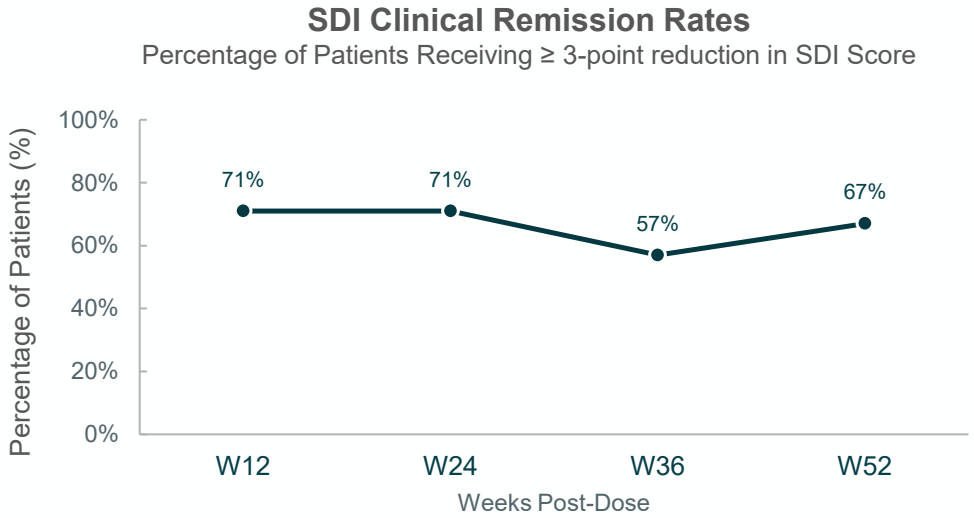
SDI: 64% of patients in Cohorts 5-9 in Part 1 maintained remission through to 52 weeks

DSQ: Not measured in the Part 1 of RESOLVE

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Phase 2b Doses: Symptom Benefit Seen Early and Sustained to 52 Weeks

Part 1 Cohorts 8b and 9 Combined



Early and sustained symptom improvement, with the majority of patients achieving clinical remission at every assessment through Week 52.

71%

Early clinical benefit

71% of patients achieved clinical remission by Week 12 following a single treatment

67%

Durable symptom improvement

Benefits persisted to 52 weeks, with 67% of 120mg and 160mg patients in clinical remission

n= 7 for weeks 0 – 36; n=3 for week 52

Histology: EoEHSS Grade and Stage, Eosinophil Counts

Grade

How severe are the tissue abnormalities?

Stage

How extensive are the tissue abnormalities?

Eosinophils

Direct count vs pathologic findings in EOEHSS

Inflammatory Sub Scores

1) **Eosinophilic** Surface Layering (ESL)
2) **Eosinophilic** Abscess (EA)
3) Surface Epithelial Alteration (SEA)
4) **Eosinophilic** Inflammation (EI)

Architectural Sub Scores

5) Basal Zone Hyperplasia (BZH)
6) Dyskeratotic Epithelial Cell (DEC)
7) Dilated Intercellular Spaces (DIS)
8) Lamina Propria Fibrosis (LPF)

EoEHSS is a more encompassing histologic endpoint than eos/hpf as it considers other hallmarks of eosinophils that are relevant to disease control, and not simply the number of eosinophils

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EoEHSS: The Scoring Range Depends on How Scores Are Combined

Grade measures severity. Stage measures extent. Each is calculated separately.

Eight histologic features, each scored 0–3 for grade and 0–3 for stage. Lower scores indicate less pathology.

0–24

Raw total for one biopsy

Add the eight feature scores, separately for grade and stage.

8 features × maximum 3 = 24

0–3

Sum of three normalized sites

Add the 0–1 scores for proximal, middle and distal sites.

When not breaking into anatomic areas the 0-1 composite is the norm

0–1

Composite score

Divide the raw total by the maximum for evaluable features.

A mean of normalized regional scores also remains on a 0–1 scale.

Derive a normalized score per biopsy

Used in RESOLVE Part 1 & Part 2

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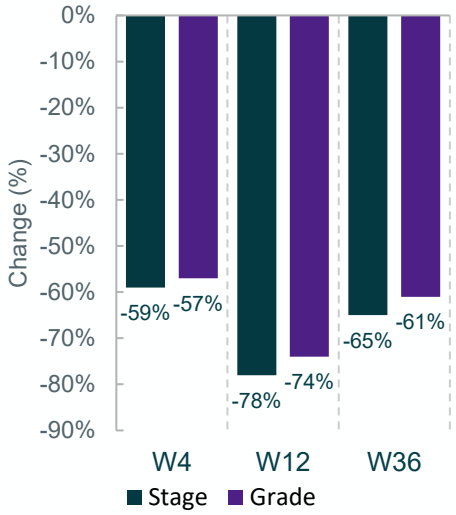
Phase 2b Doses: Early and Durable Improvement in Histology (EoEHSS)

Part 1 Cohorts 8b and 9 Combined

Mean EoEHSS score (0-1) by visit, including Week 0 baseline



Mean percent change in EoEHSS from baseline



~60%
Week 4

Rapid histologic improvement
Both severity (grade) and extent (stage) of tissue abnormalities improved approximately 60% within four weeks

>60%
at W36

Durable histologic benefit
Both grade and stage remained more than 60% below baseline at Week 36 following a single administration

Rapid, substantial and sustained improvements in both the severity and extent of esophageal tissue abnormalities, following a single treatment.

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EoEHSS composite (0-1) grade and stage, cohorts 8b and 9 combined; n=7.

Endoscopy: EREFS Scores the Appearance of the Esophagus

Letter color:

- *Inflammatory*
- *Structural*

E	R	E	F	S
Edema	**Rings**	**Exudates**	**Furrows**	**Strictures**

The Hirano EREFS assesses the severity of five endoscopic features of EoE at their most severe location. RESOLVE reports a 0–9 scale; many other studies use 0–18.

Check the scoring convention before comparing EREFS across studies because 0-9 and 0-18 (or 0-27) scales are not comparable.

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EREFS: the scoring range changes what the number means

The same five endoscopic features can be graded and combined differently. The results are not comparable.

0–9 component set: *edema 0–1 + rings 0–3 + exudates 0–2 + furrows 0–2 + stricture 0–1*

0–27

Sum of three regions

Score proximal, middle and distal regions separately, then add all three.

0–9	0–9	0–9
Proximal	Middle	Distal

0–18

Sum of two regions

Score proximal and distal regions separately, then add both totals.

0–9	0–9
Proximal	Distal

0–9

Worst feature across the esophagus

Score each feature at its most severe location, then add the five scores.

The maximum for each feature can come from a different region.

0–9
Worst of each feature

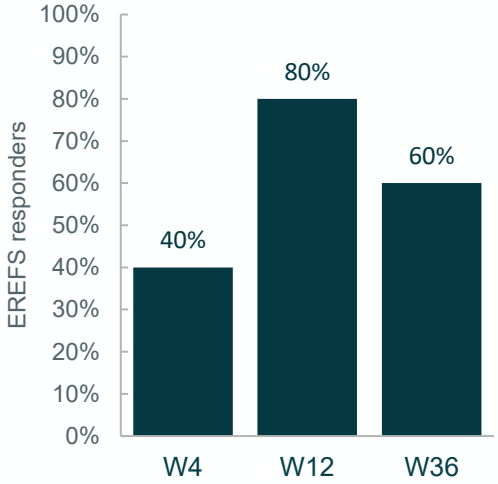
Used in RESOLVE Part 1 & Part 2

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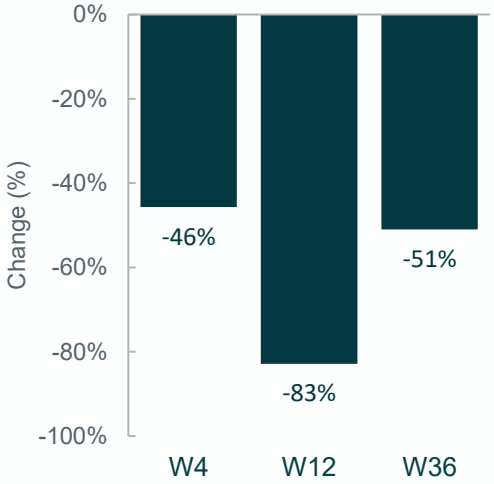
Phase 2b Doses: Endoscopic Scores (EREFS) Improved Early With Durability

Part 1 Cohorts 8b and 9 Combined, including only patients with baseline EREFS over 2

Patients with EREFS baselines over 2 with clinically meaningful responses



Mean percent change in total EREFS (0-9)



80%

Clinically meaningful responses (EREFS decrease to ≤ 2) observed in 80% of patients (with baselines > 2) by week 12.

60%
at W36

Durable benefit: 60% achieved clinically meaningful responses, with mean EREFS remaining 51% below baseline

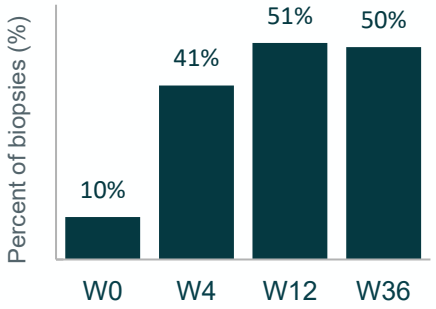
Robust and sustained responses; meaningful improvements in endoscopic scores observed to 36 weeks

Total EREFS (0-9), cohorts 8b and 9 combined; n=5

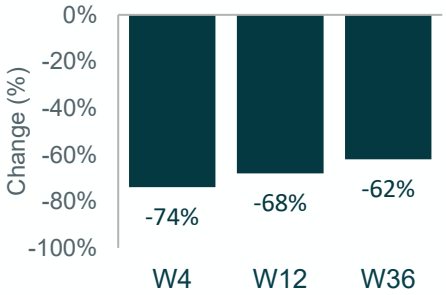
Phase 2b Doses: Eosinophil Counts Fell Early and Stayed Down Through Week 36

Part 1 Cohorts 8b and 9 Combined

Percent of biopsies ≤ 6 eos/hpf



Percent change from baseline



Sustained improvement in PEC, an inflammatory biomarker, supports EP-104GI's potential for durable disease control.

%

What PEC shows

PEC counts eosinophils in the tissue, not the actual health of the tissue itself

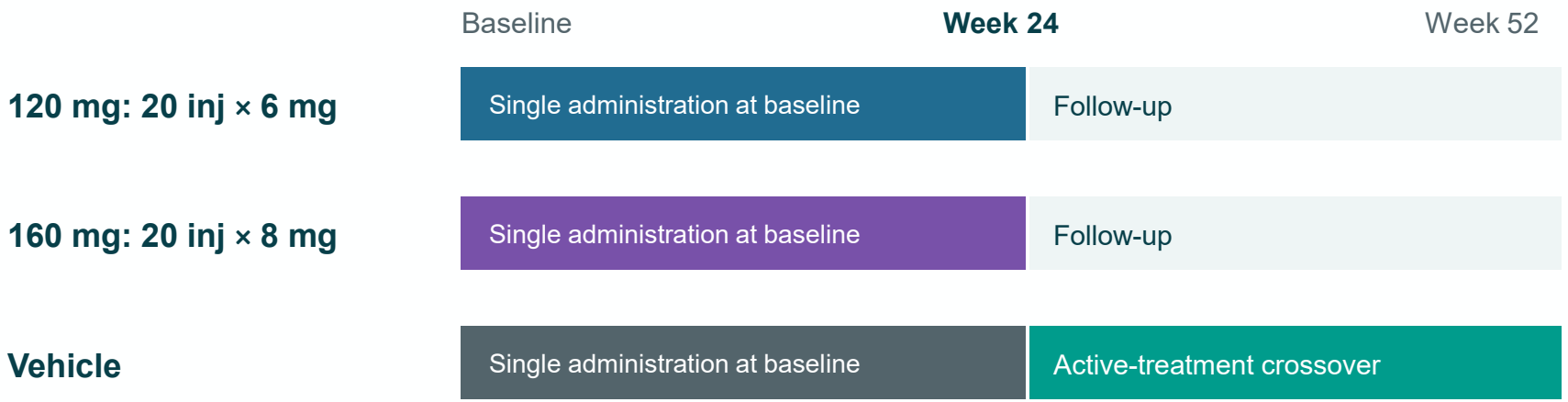
Noisy Surrogate Biomarker

Eos/hpf does not have a clinical correlate, and has a high inter / intra variability among patients

Mean peak eosinophil count, absolute and percent change from baseline at Weeks 4, 12 and 36. Cohorts 8b and 9 combined n=7.

RESOLVE Part 2: Two Active Doses Versus Vehicle Through Week 24, Then a Blinded Cross-Over of Vehicle Patients

Randomized, blinded, vehicle-controlled dose optimization



n=122 (1:1:1 allocation) • Controlled to week 24 • Vehicle crosses over • Follow-up to week 52

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What the December Interim Will Report

December 2026

Key Time Points:

- First 60 patients to reach 24 weeks
- First 20 patients to reach 52 weeks

Endpoints

- Symptoms *(SDI, DSQ)*
- Histology *(EoEHSS, PEC)*
- Endoscopy *(EREFS)*
- Safety

01 Controlled comparisons

Interim data release will center around week 24 primary endpoint versus placebo, and week 52 durability versus baseline

02 Additional datasets

There may be additional timepoint and endpoint analyses as well

03 Clinical improvement and durability of response

RESOLVE Part 1 and 2 were designed to inform development based upon EP-104GI's ability to control the progression of EoE within patients

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RESOLVE Baselines are Consistent Between Part 1 and Part 2

	RESOLVE Part 1	RESOLVE Part 1 (Cohort 8b/9 only)	RESOLVE Part 2
Patients, n=	32	7	122
Age, years	40.6 ± 13.2	37.4 ± 12.3	39.8 ± 11.9
Male, n (%)	14 (44%)	5 (71%)	86 (71%)
BMI, kg/m²	26.5 ± 6.2	25.1 ± 4.0	28.9 ± 5.5
Prior Therapies			
Proton pump inhibitor	24 (75%)	3 (43%)	103 (84%)
Swallowed topical corticosteroid	13 (41%)	4 (57%)	69 (56%)
Biologic	1 (3%)	1 (14%)	23 (18%)

Why baseline matters

Guides available room for absolute improvement

Absolute changes are comparable only between similar baselines

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Data is pre-liminary and subject to change with cleaning

Symptoms: SDI and DSQ

	RESOLVE Part 1 *(Cohort 8b/9 only)*	RESOLVE Part 2
Patients, n=	7	122
SDI Baseline	6.14 ± 1.1	5.8 ± 1.5
% in Clinical Remission: week 24 / week 52	71% / 67%*	*Included in the interim*
DSQ Baseline	*Not measured*	39.5 ± 11.4
Change vs Baseline	-	*Included in the interim*
Change vs Placebo	-	*Included in the interim*
Clinical Responders (≥30% reductions from baseline)	-	*Included in the interim*

*Only Cohort 9 (Cohort 8b has not yet reached this timepoint)

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Histology: EoEHSS

	RESOLVE Part 1 *(Cohort 8b/9 only)*	RESOLVE Part 2
Baseline EoEHSS *(range, 0-1)*		
Patients, n=	7	119
Grade, mean ±std:	0.62 ± 0.12	0.33 ± 0.21
Stage, mean ±std:	0.66 ± 0.14	0.34 ± 0.24
Mean reduction from baseline		
Grade, mean change ±std (12 week):	0.45 ± 0.15	*Included in the interim*
Stage, mean change ±std (12 week):	0.52 ± 0.22	*Included in the interim*
% reduction from baseline		
Grade, mean percent change ±std (12 week):	74% ± 25%	*Included in the interim*
Stage, mean percent change ±std (12 week):	78% ± 24%	*Included in the interim*

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Endoscopy: EREFS

	RESOLVE Part 1 *(Cohort 8b/9 only)*	RESOLVE Part 2
Baseline EREFS *(baseline of >2)*		
Patients, n/N (%)=	5/7 (71%)	78/118 (66%)
Mean baseline score, ± std (0-9)	5.4 ± 1.5	4.39 ± 1.1
Responders *(baseline EREFS >2 who become ≤2)*		
Week 12 / Week 36	4 of 5 / 3 of 5	*Included in the interim*
EREFS Reduction *(baseline EREFS >2)*		
Mean Reduction From Baseline		
Week 12 / Week 36	4.2 / 2.8	*Included in the interim*
Mean Percentage Reduction From Baseline		
Week 12 / Week 36	82.9% / 51.0%	*Included in the interim*

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Histology: PEC

	RESOLVE Part 1 *(Cohort 8b/9 only)*	RESOLVE Part 2
Baseline PEC		
Patients, n=	7	119
mean, (eos/hpf) ±std	100.8 ± 54.1	51.0 ± 52.7
Histologic Remission vs placebo		
Percent reduction from baseline ±std (week 12)	68.0% ± 37.0%	*Included in the interim*
Percent of biopsies ≤ 6 eos/hpf ±std (week 12)	50.8% ± 33.1%	*Included in the interim*

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Blinded TEAE and SAE Summary

Most Common TEAEs (Occurring in ≥ 5% of Participants): Part 1 and Part 2

Preferred Term	Total (n=154) n (%)	Average Time to Resolution (days)
Any TEAE	112 (73%)	18
Pain	23 (15%)	4
Nausea	16 (10%)	14
Upper respiratory tract infection	10 (7%)	10
Oropharyngeal pain	9 (6%)	10
Oesophageal discomfort	8 (5%)	5

- One patient in the data set had oropharyngeal candidiasis
- No patients in either parts of RESOLVE has had adrenal suppression or glucose derangement
- Injection procedure has been well tolerated
- SAEs were reported in 6 participants (3.9%) across the Part 1 and 2 portions of the study

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Data cutoff 30 October 2026
TEAE, treatment-emergent adverse event; SAE, serious adverse event

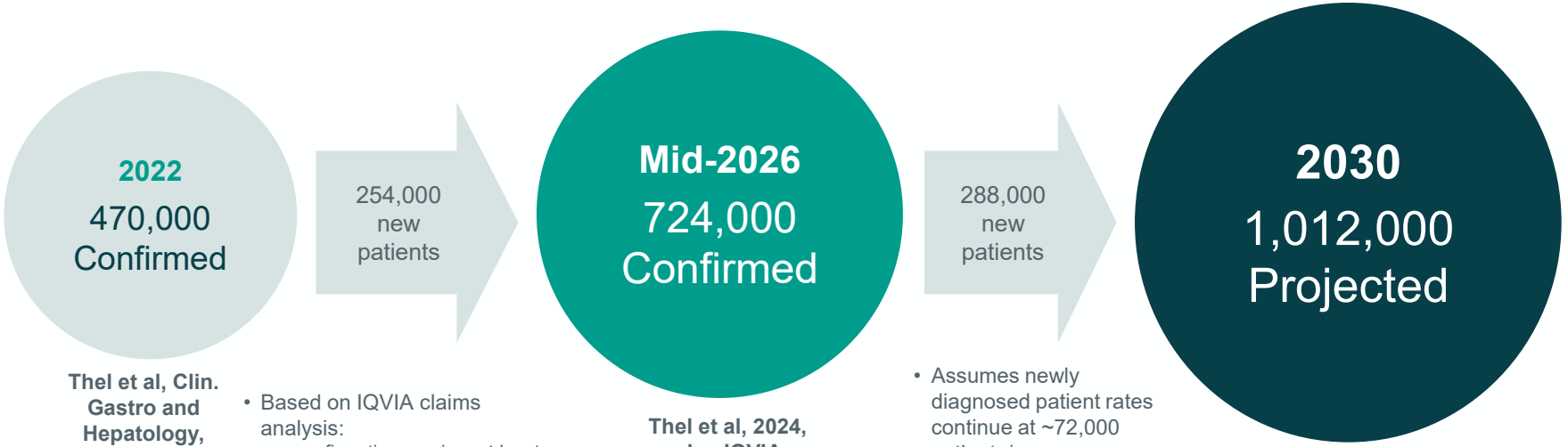
What Anchors Success in Part 2 and Supports the Potential of EP-104GI?

Dimension	What would build confidence?
Symptoms	SDI % Clinical Remission at weeks 24 and 52 DSQ separation from PBO at week 24 DSQ change from baseline at week 52
Disease activity	A meaningful response across holistic measures of tissue inflammation and fibrosis (EoEHSS), with endoscopic context (EREFS), versus placebo (24w) and baseline (52w) Change from baseline in absolute and percentage terms
Durability	Benefit through the 24-week controlled period Durability versus baseline to 52 weeks
Safety and procedure	An acceptable drug and administration profile for the intended use.

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The US Population of Diagnosed EoE Patients Continues to Grow

Projected to reach ~1 million by 2030 based on stable 2022-2026 growth rates



Thel et al, Clin. Gastro and Hepatology, 2024

- Based on IQVIA claims analysis:
  - confirmation requires at least 2 K20.0 diagnosis claims 30-180 days apart
  - Must be new patients
- Growth rate has been constant over 3.5 years at ~72,000 new confirmed patients/year

Thel et al, 2024, plus IQVIA claims analysis from 2022 to 2026

- Assumes newly diagnosed patient rates continue at ~72,000 patients/year

Thel et al, 2024, plus IQVIA claims analysis, plus projections

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EP-104GI Is Positioned to Potentially Take a Leading Role in 2nd Line Therapy

1st Line Therapy

- PPIs
  - Historically used as 1st line due to low cost, and ease of use[1]
  - High non-responder rate (~60%)[1]
- Dietary Therapy
  - Patients find dietary therapy difficult to adhere to, resulting in poor adoption and compliance[1,2]

2nd Line Therapy

- **Topical Corticosteroids (TCS)**
  - Burdensome dosing regimen and oral side effects result in low adherence[1,2,3]
  - Intermittent treatment with oral steroids shown to be no better than placebo[3]

3rd Line Therapy

- Biologics
  - Recommended in ACG guidelines for patients that are refractory to dietary therapy, PPIs and TCS[4]
  - Demonstrated the largest magnitude of response in DSQ in clinical trials[5]
  - Despite positive results, there are patients that are non-responders, or that poorly tolerate treatment[1,6]

EP-104GI

- Potential to fit into early EoE management, with endoscopy required to diagnose and follow progress of disease

- Improved convenience, compliance and PK profile has the potential to provide a superior treatment option for 2nd line therapy compared to oral topical steroids

- Deep tissue delivery, and constant corticosteroid exposure provides the opportunity as an alternative to biologics in patients that fail topical steroids
- Fluticasone has the potential for anti-fibrotic efficacy

1. Eupraxia Market research with ClearView Consulting, 2023
2. Am J Gastroenterol 2022;117(9):1412–1418
3. UEG Presentation 2026 Alain Schoepfer - EOS-3
4. American Journal of Gastroenterology 120(1):p 31-59, January 2025
5. Eupraxia internal analysis of Phase 3 results
6. N Engl J Med 2022;387:2317-2330

How to Read the December Data

Part 1 established an early, durable signal. December delivers the first controlled data.

01	**Read across all measures**	EoE is a complex inflammatory disease wherein no single measure (symptoms, histology or endoscopy) tells the whole story
02	**Compare like with like**	Each PRO examines different responses in patients EoEHSS and EREFS results need to be converted to the same scale for comparison
03	**Baselines matter**	Absolute movement will depend on the baselines; percent change will not
04	**The interim is valuable**	RESOLVE interim, while not powered for statistical significance, may inform efficacy in symptoms, histology, endoscopy and safety

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