ARROWHEAD PHARMACEUTICALS

Fiscal 2025 First Quarter Conference Call – Prepared Remarks

February 10, 2025

1:30 PM Pacific time

Operator

Ladies and gentlemen, welcome to the Arrowhead Pharmaceuticals conference call. Throughout today's recorded presentation all participants will be in a listen-only mode. After the presentation, there will be an opportunity to ask questions. I will now hand the conference call over to Vince Anzalone, Vice President of Investor Relations for Arrowhead. Please go-ahead Vince.

Vince Anzalone

Good afternoon and thank you for joining us today to discuss Arrowhead's results for its fiscal 2025 first quarter ended December 31, 2024.

With us today from management are president and CEO Dr. Chris Anzalone, who will provide an overview of the quarter; Dr. Bruce Given, interim chief medical scientist, who will provide an update on our cardiometabolic pipeline; Andy Davis, senior vice president and head of global cardiometabolic franchise, who will provide an update on commercialization activities; Dr. James Hamilton, chief of discovery & translational medicine, who will discuss our earlier stage development programs; and Ken Myszkowski, chief financial officer, who will give a review of the financials. We will then open the call to questions.

Before we begin, I would like to remind you that comments made during today's call contain certain forward-looking statements within the meaning of Section 27A of the Securities Act of 1933 and Section 21E of the Securities Exchange Act of 1934. All statements other than statements of historical fact are forward-looking statements and are subject to numerous risks and uncertainties that could cause actual results to differ materially from those expressed in any forward-looking statements. For further details concerning these risks and uncertainties, please refer to our SEC filings, including our most recent annual report on Form 10-K and our quarterly reports on Form 10-Q.

I'd now like to turn the call over to Christopher Anzalone, President and CEO of the Company. Chris?

Chris Anzalone

Thanks Vince. Good afternoon everyone and thank you for joining us today.

Earlier today, we announced that the license and collaboration agreement with Sarepta Therapeutics has closed.

Arrowhead expects to receive a $500 million upfront payment in the next 10 days and has already received $325 million through the purchase by Sarepta of Arrowhead common stock priced at $27.25 per share. Arrowhead will also receive $250 million to be paid in annual installments of $50 million over 5 years and has the potential to receive an additional $300 million in near-term payments associated with the continued enrollment of a Phase 1/2 study of ARO-DM1,

which we are on track to achieve during the next 12 months. Taken together, this adds up to $1.375bn in cash payments.

We are also eligible to receive development milestone payments of between $110 million and $410 million per program and sales milestone payments of between $500 million and $700 million per program. The total potential value of this deal including upfront payments, equity investment, and potential milestones exceeds $11 billion. On top of that, we are also eligible to receive tiered royalties on commercial sales.

This was clearly a big deal and a critical step for Arrowhead to bring balance back to our business model, which, in part, relies on partnering non-core assets to provide capital for us to develop and commercialize our wholly owned assets. In addition to the substantial immediate capital infusion, the deal also accomplishes a few equally important goals:

1. Brings in a partner with extensive development, regulatory, and commercial expertise for development of the drugs that they have in-licensed.
2. Increases Arrowhead's focus in the cardiometabolic space.
3. Reduces the forward growth in our R&D expenses as Sarepta assumes clinical development responsibilities for multiple programs. And,
4. Provides the potential for substantial downstream non-dilutive capital as milestones and ultimately royalties are earned.

We are now funded into 2028 and potentially through multiple commercial launches, by Arrowhead and our partners. We believe we are now well positioned for growth in 2025 and beyond. We see 3 primary value drivers fueling this growth

from our internal development activities in the near-term: those being plozasiran, obesity, and CNS.

Let's begin with plozasiran. We expect our first commercial launch of plozasiran to drive substantial growth. Pending positive FDA review and approval, launch could take place late this year. We see the value proposition for plozasiran in FCS as quite clear and a substantial differentiation from any other available therapy. We think the magnitude and consistency of triglyceride lowering, the potential ability to get patients to triglyceride goal, convenient quarterly dosing schedule, and well-tolerated safety profile simply make plozasiran a very difficult drug candidate to compete against. But this is just the first step. We are also confident that our current Phase 3 studies, SHASTA-3, 4, and 5, have the potential to show similar differentiation and value in the much larger severe hypertriglyceridemia, or sHTG, population, and we believe this represents an attractive and underappreciated commercial opportunity. We are on pace to complete enrollment for the registrational SHASTA-3, SHASTA-4, and MUIR-3 studies this year, which would enable study completion in 2026 and a subsequent sNDA filing. That would substantially broaden the reach of plozasiran and provide a large opportunity for growth. As we have said in the past, we believe plozasiran has the potential to be a $2-3bn/year drug in the sHTG market alone.

Turning to obesity, we believe our two early-stage programs, ARO-INHBE and ARO-ALK7, represent high-value opportunities with near- and mid-term data readouts that could provide more clarity on where they may fit in the obesity and metabolic treatment paradigm. James will talk about the status of the programs in a moment, but we see the targets and pathways as very promising. Both programs are supported by published human genetics studies and the preclinical data have demonstrated dramatic results with the potential to fill gaps in the current standard

of care. The possibility of long-acting agents that spare muscle mass and enable visceral fat loss without dependence on caloric-restriction is exciting indeed. It appears that Arrowhead is the first company to start clinical studies against the INHBE target and may currently be the only company able to address the ALK7 target, which utilizes a new version of our TRiM™ platform capable of delivering to adipocytes.

The third area that we see driving near-term growth is our emerging CNS pipeline, including the new TRiM™ platform which, in animal models, appears capable of delivering siRNA across the blood-brain-barrier, including deep brain distribution using a subcutaneous injection. Near-term clinical proof of concept would be truly disruptive and we think would open the door to treating many millions of patients without adequate options. Our initial efforts with this platform address Huntington's, Alzheimer's, and Parkinson's disease: all devastating conditions that lack good treatment options. We believe that HTT, MAPT, and alpha-synuclein are the most validated targets in Huntington's, Alzheimer's, and Parkinson's, respectively and these are the targets we are addressing with ARO-HTT, ARO-MAPT, and ARO-SNCA, respectively. Our preclinical data in non-human primates have been very compelling and we are now focused on completing IND/CTA-enabling studies and GMP manufacturing to support early clinical trials. We anticipate having CTAs for ARO-HTT and ARO-MAPT towards the end of this year and for ARO-SNCA in early 2026. Sarepta has the right to take HTT forward and we are currently focused on keeping MAPT wholly-owned. We have not made a decision on partnering versus retaining ARO-SNCA.

As I mentioned, we believe the triumvirate of plozasiran, obesity, and CNS will be our primary near-term value drivers. It is also the way investors should think about our focus. We are building a growing cardiometabolic pipeline, which includes

obesity, and we will see where the new CNS platform takes us as clinical data come in.

In addition to plozasiran, ARO-ALK7, and ARO-INHBE, our cardiometabolic franchise includes zodasiran, our ANGPTL3-targeting drug candidate. We expect to begin a Phase 3 study in HoFH next quarter with zodasiran. We have a large amount of clinical data with this candidate and feel confident that it could be an effective medicine with an attractive dosing schedule in this population. This could be a relatively simple addition to our FCS and sHTG sales representatives' bags, so the incremental commercial costs associated with this additional potential product are expected to be minimal. The Phase 3 study will be small and this is a good use of fairly modest resources for us.

Where else can we go in cardiometabolic? As I mentioned, ARO-ALK7 is important not only because of the compelling target to treat obesity, but also as a proof of concept that we can address adipocytes. Adipose is the largest endocrine organ in the body and, as such, is expected to be a rich environment for cardiometabolic and obesity targets. We expect to build this out.

Similarly, we believe the initial candidates built on our new CNS platform are important because of the neurological targets they address, representing some of the most challenging, poorly treated public health crises remaining, and also because they offer the possibility of disruptive clinical proof of concept. We also see important opportunities to develop additional obesity candidates based on new CNS targets. Remember that RNAi is a rifle shot, and as our understanding of obesity increases, we see a role for highly specific intervention that could only be practical with systemic delivery. We believe that this has the possibility to treat

difficult diseases with reduced risk of safety and tolerability challenges that have led to so much disappointment in the CNS drug-development space.

This year we also plan to expand our cardiometabolic presence with a CTA for our first dimer. It is designed to silence expression of both APOC3 and PCSK9, and we hope it will combine the triglyceride-lowering qualities of plozasiran with the LDL-c -lowering properties of other PCSK9 inhibitors.

With this focus on cardiometabolic and a wait-and-see with CNS, we have a number of programs that are none-core. These are potential partnering opportunities and could bring in additional immediate and long-term capital.

Janssen generated compelling clinical data with ARO-PNPLA3 and addressing a genetically-defined MASH population that could number in the 10 million person range in the major pharmaceutical markets could be attractive to the right company. This is a program for which we will seek to partner.

We have learned much about our pulmonary platform through the various clinical programs. It appears to be well-tolerated and quite effective at delivering to the deep lung. It is our intention to find a good partner to help identify new deep lung targets and develop a suite of candidates. Similarly, we have been very impressed with knockdown data coming from the ARO-RAGE clinical studies, but given the complexity and expense associated with developing this as an asthma and or COPD drug, we will seek a partner for P2 and beyond.

Clinical data from both ARO-C3 and ARO-CFB have been quite good and both candidates appear to do what they are designed to do. There are clear markets one or both could address, including C3 glomerulopathy, IGA nephropathy, and certain

Lupus populations. We would like to find the right partners to develop these candidates.

This is where we are now and what we see as key growth drivers for the future. Let's review how we got here and a few key accomplishments from the quarter and since our last earnings call.

First, and most importantly, the U.S. FDA accepted the New Drug Application for investigational plozasiran for the treatment of familial chylomicronemia syndrome. This was our first NDA filing, which is a key milestone for Arrowhead, and we are pleased that it was accepted for filing. The FDA provided a PDUFA action date of November 18, 2025, and indicated it is not currently planning to hold an advisory committee meeting. We now know the potential launch date, pending FDA review and approval, so we continue our work to be ready for an efficient launch on day one. Andy will talk about that work in a moment.

Sticking with plozasiran, in November, we announced new results from the Phase 3 PALISADE study and the open-label extension from the Phase 2 MUIR and SHASTA-2 studies. These data were presented in two oral presentations at the American Heart Association Scientific Sessions 2024, and PALISADE data were simultaneously published in the AHA journal, Circulation. The data continue to be promising across studies, across the spectrum of triglyceride disorders, and after short and long-term follow up. In addition, plozasiran has been, overall, generally well-tolerated to date.

During the quarter, we also initiated a Phase 1/2a clinical trial of our first obesity candidate, ARO-INHBE, and recently received regulatory clearance in New Zealand to initiate a clinical study of our second obesity candidate, ARO-ALK7.

As I mentioned, these programs represent potential drivers of growth for Arrowhead, so we are excited to get both moving into and through early clinical studies.

Lastly, we presented interim healthy volunteer results from a Phase 1/2a clinical study of ARO-CFB for the treatment of complement mediated diseases. Data have been compelling so far and we anticipate additional data readouts later in the year.

With that overview, I'd now like to turn the call over to Bruce Given. Bruce?

Bruce Given

Thank you, Chris, and Good Afternoon everyone.

As Chris mentioned, the big highlight for the clinical and regulatory teams was the submission and subsequent acceptance of our first New Drug Application, or NDA, by the US FDA for investigational plozasiran for the treatment of familial chylomicronemia syndrome, or FCS. The FDA provided a PDUFA action date of November 18, 2025, and indicated it is not currently planning to hold an advisory committee meeting. We also expect to submit approval applications to additional global regulatory authorities in coming months for plozasiran for the treatment of patients with FCS.

FCS is a severe and rare disease often caused by various monogenic mutations that lead to extremely high triglyceride levels. A normal level is triglycerides below 150 mg/dL, but patients with FCS typically have triglycerides in the thousands. Such severe elevations can lead to various serious signs and symptoms including

acute and potentially fatal pancreatitis, chronic abdominal pain, diabetes, and cognitive issues.

The clinical basis of the NDA submission is comprised of the findings in the Phase 3 PALISADE study, which were positive, with supportive confirmatory evidence from the Phase 2 clinical studies of the SUMMIT Program. PALISADE successfully met its primary endpoint and all multiplicity-controlled key secondary endpoints, including statistically significant reductions in triglycerides, APOC3, and the incidence of acute pancreatitis.

In PALISADE, plozasiran achieved deep and durable reductions in triglycerides with median changes from baseline of approximately 80% in the plozasiran 25 mg group and a statistically significant 83% reduction in the risk of developing acute pancreatitis compared to placebo in the pooled plozasiran 25 mg and 50 mg group. Overall, plozasiran has been generally well-tolerated to date. In the PALISADE study, the most frequently reported treatment emergent adverse events for the 25 mg dose that is proposed for marketing approval were abdominal pain, COVID-19, nasopharyngitis, and nausea.

In addition to FCS, we are making good progress on the other Phase 3 studies in the SUMMIT program. These are SHASTA-3 and SHASTA-4 in patients with severe hypertriglyceridemia, or SHTG, and MUIR-3 in patients with mixed hyperlipidemia. The SHASTA studies are designed to assess safety and efficacy and the MUIR study is to provide additional safety data needed for the expected SHTG supplement to our plozasiran NDA.

The SHASTA studies are global, randomized, double-blind, placebo-controlled Phase 3 studies to evaluate the efficacy and safety of plozasiran in adult subjects

with SHTG and prior documented evidence of fasting TG levels greater than 500 mg/dL. Eligible subjects will be randomized to receive either plozasiran at 25 mg or placebo. The double-blind treatment period duration will be 1 year, where subjects receive a total of 4 quarterly doses. After Month 12, eligible subjects will be offered an opportunity to continue in an optional open-label extension.

SHASTA-3 and 4 and MUIR-3 are all enrolling well and we are on schedule to reach full planned enrolment this year, which would enable study completion in 2026 and subsequent SNDA filing.

We are also working towards initiating SHASTA-5, a Phase 3 study in patients with SHTG that are at high risk of acute pancreatitis. We intend to initiate that study this year.

In addition to the Phase 3 program for plozasiran, we are actively working on a study design and preparations for a Phase 3 study of zodasiran, our investigational RNAi therapeutic candidate designed to reduce production of angiopoietin-like protein 3, or ANGPTL3, which is a liver synthesized inhibitor of lipoprotein lipase and endothelial lipase, in patients with homozygous familial hypercholesterolemia, or HoFH, following a successful Phase 2 study called GATEWAY. We will provide more details on that study when it is initiated later this year. This is another program that makes sense as it is potentially complementary to the medical affairs and commercial organizations we are building to support a plozasiran launch and there is significant overlap in types of physicians who treat FCS and HoFH, both rare lipid disorders.

I will now turn the call over to Andy Davis.

Andy Davis

Thank you, Bruce.

The recent acceptance of our first NDA by the US FDA for investigational plozasiran is incredibly energizing for the FCS community. The frequent feedback we receive from both physicians and patient societies who have read about plozasiran in last year's publications continues to be very encouraging. They site several potential differentiating attributes of Plozasiran that I will discuss briefly..

First, the reduction in triglycerides is both deep and durable. As Bruce mentioned in his remarks, in PALISADE, Plozasiran reduced triglycerides from baseline by an unprecedented approximately 80% from baseline as early as month one and maintained this reduction with minimal variation throughout the full 12-month treatment period.

Second, people living with FCS – for the first time – have real hope of achieving triglyceride levels below guideline-directed risk thresholds associated with acute pancreatitis, such as 880 and even 500 mg/dL. At least half of the patients at the 25 mg dose in PALISADE saw TGs below 500 mg/dL, with approximately 75% achieving levels below 880 mg/dL. To support physician education on guideline-directed risk thresholds, we previously announced the launch of our disease awareness campaign. A key focus of our messaging is to educate the community about expert guidelines, which recommend maintaining triglyceride levels below 500 mg/dL to reduce the risk of acute pancreatitis.

Third, the triglyceride reductions from baseline were consistent in patients with genetically confirmed and clinically diagnosed FCS. Results from PALISADE

published in the journal *Circulation* showed that Plozasiran, at the 25 mg dose, induced rapid, deep, and sustained reductions from baseline in APOC3, of greater than -90%, and in triglycerides, of approximately -80%, independent of gene variants causing FCS. We believe this supports the potential value of Plozasiran in patients with clinically diagnosed disease, regardless of genetic status.

Fourth, Plozasiran is the first and only investigational medicine to achieve a statistically significant reduction in the risk of developing acute pancreatitis in patients with genetically confirmed and clinically diagnosed FCS. This is the outcome of most importance for physicians, patients, and payers.

And lastly, Plozasiran demonstrated generally favorable safety and tolerability with low rates of discontinuation for adverse events and is conveniently dosed every three months, potentially reducing the treatment burden on both physicians and patients.

As we prepare for the potential launch of Plozasiran at the end of this year, we have built highly experienced Market Access, and Marketing organizations and our Clinical Development colleagues have established a fully operational Medical Affairs function. Medical Science Liaisons from Medical Affairs are in the field conducting scientific exchange, our Market Access colleagues are presently engaging with payers to communicate clinical and economic evidence, and our National Sales Director will be executing our final field force hiring plans in the coming months. We are on track and we're incredibly excited about the possibility of bringing investigational Plozasiran to FCS patients and their families.

I will now turn the call over to James Hamilton.

James Hamilton

Thank you, Andy.

First, I want to give a quick review and update on two of the programs that are part of the Sarepta collaboration: ARO-DUX4 and ARO-DM1. These are both muscle targeted programs in Phase 1/2 studies which Arrowhead will continue to run until study completion, at which time Sarepta will assume responsibility for clinical development and ultimately commercialization.

We are currently conducting a Phase 1/2a double-blinded, placebo-controlled, dose-escalating study to evaluate single and multiple ascending doses of ARO-DM1 in up to 48 subjects with myotonic dystrophy. We are in the dose escalation stage of the study, and we are enrolling patients at a good pace. We expect to reach the enrollment targets in the Sarepta agreement, which would trigger an additional $300 million in payments, and potentially have first data to report this year, pending discussions with Sarepta and agreement on disclosure timing.

Moving on to the second Sarepta partnered muscle targeted program, ARO-DUX4 is also in a Phase 1/2a dose-escalating study to evaluate the safety, tolerability, pharmacokinetics, and pharmacodynamics of ARO-DUX4 in adult patients with FSHD type 1. The study is designed to enroll up to 52 subjects. Like ARO-DM1, we are in the dose escalation stage and should have first data available to report this year, also pending discussion and agreement with Sarepta.

These are both very interesting programs for muscle diseases with no adequate treatments available. Our preclinical data have been very compelling, and we believe the programs have the potential to be best-in-class. Our colleagues at

Sarepta have extensive neuromuscular development, regulatory, and commercial expertise so their input at this time is helpful and their strategic direction and involvement in future clinical development and commercialization will be critical. We have a high degree of confidence that the Sarepta team can help accelerate the programs and maximize the chances for clinical and commercial success.

I also wanted to give a quick update on our obesity programs, ARO-INHBE and ARO-ALK7. These programs both are designed to intervene in a biological pathway regulating fat storage which in an environment of nutrient excess, can become dysfunctional and overactive. ARO-INHBE is designed to reduce expression of Activin E, which is a ligand for adipose ALK7, while ARO-ALK7 is designed to reduce expression of the ALK7 receptor itself.

In preclinical models, both programs demonstrated substantial reductions in visceral fat mass versus control while simultaneously preserving lean mass, as predicted by the mechanism as understood. In addition, both targets are supported by human genetics, where loss-of-function carriers have favorable body composition and metabolic characteristics compared to non-carriers. We always prefer genetically validated targets because we think they reduce biology risk and give important insight into predicted safety and tolerability.

For ARO-INHBE, in December we began dosing in a Phase 1/2a dose-escalating study to evaluate the safety, tolerability, pharmacokinetics, and pharmacodynamics of ARO-INHBE in up to 78 adult volunteers with obesity. Part 1 of the study is designed to assess single and multiple doses of ARO-INHBE monotherapy, and Part 2 of the study is designed to assess ARO-INHBE in combination with tirzepatide, a subcutaneously administered GLP-1/GIP receptor co-agonist. We see the potential to have initial data from Part 1 of the study late this year.

For ARO-ALK7, we recently received regulatory clearance in New Zealand to initiate a Phase 1/2a first-in-human dose-escalating study to evaluate the safety, tolerability, pharmacokinetics, and pharmacodynamics of ARO-ALK7 in up to 90 adult volunteers with obesity. We are completing manufacturing of drug supply as we speak and anticipate dosing to initiate in the middle of the year.

During the last quarter, we also presented interim clinical data from a Phase 1/2a clinical study of ARO-CFB, which targets complement factor B and is being developed as a potential treatment for various complement mediated diseases. The data were presented at the 8th Complement-Based Drug Development Summit.

Complement factor B plays an important regulatory role in amplifying complement alternative pathway activation and has been identified as a promising therapeutic target for complement mediated kidney diseases such as immunoglobulin A nephropathy, or IgAN, which is the most common glomerular disease worldwide and carries a high lifetime risk of progression to end-stage renal disease.

In the Phase 1/2a study, circulating levels of CFB protein were reduced by a mean of up to 90% to date with a duration of response greater than 3 months. Additional data from higher dose levels and multi-dose cohorts are pending and will be presented at an appropriate medical conference. ARO-CFB also demonstrated reductions in measures of alternative complement pathway activation, with mean reductions at or approaching 100% in AH50 and Wieslab AP at multiple dose levels. ARO-CFB has been generally well-tolerated to date with safety data supportive of further clinical development. Treatment emergent adverse events have been mostly mild in severity with none leading to study or study drug discontinuation. We look forward to completing Part 1 of the study over the

coming months, and subsequently look ahead to Part 2 of the study in patients with immunoglobulin A nephropathy.

I will now turn the call over to Ken Myszkowski.

Ken Myszkowski

Thank you, James, and good afternoon everyone.

As we reported today, our net loss for the quarter ended December 31, 2024 was $173.1 million or $1.39 per share based on 124.8 million fully-diluted weighted average shares outstanding. This compares with net loss of $132.9 million or $1.24 per share based on 107.4 million fully-diluted weighted average shares outstanding for the quarter ended December 31, 2023.

Revenue for the quarter ended December 31, 2024 was $2.5 million, compared to $3.6 million for the quarter ended December 31, 2023. Revenue in the current period relates to our collaboration agreements with GSK. Revenue in the prior period primarily related to the recognition of revenue from our license and collaboration agreements with Takeda & GSK.

Revenue recognition related to the Sarepta license and collaboration agreement will begin during the quarter ending March 31, 2025. Revenue will be recognized over a period during which we are providing key performance obligations. This is primarily related to our responsibilities to manage certain clinical trials for the clinical candidates to which we granted Sarepta an exclusive license agreement.

Total operating expenses for the quarter ended December 31, 2024, were $163.9 million, compared to $140.1 million for the quarter ended December 31, 2023. The key drivers of this change were increased candidate costs and salaries as the Company's pipeline of clinical candidates has both increased and advanced into later stages of development.

Net cash used by operating activities during the quarter ended December 31, 2024, was $146.3 million, compared with $117.8 million for the quarter ended December 31, 2023. The increase in cash used by operating activities is driven primarily by higher research and development expenses.

Turning to our balance sheet, our cash and investments totaled $552.9 million at December 31, 2024.

Including the $825 million in upfront payments from the Sarepta agreements, our proforma cash and investments would be $1.4 billion at December 31, 2024. Based on expected cash inflows from the Sarepta agreements, debt repayments as well as other cash burn, we expect our cash and investments balance to be approximately $1 billion at the end of the 2025 and we expect to have a cash runway into 2028.

Our common shares outstanding at December 31, 2024, were 125.6 million.

With that brief overview, I will now turn the call back to Chris.

Chris Anzalone

Thanks Ken.

Not only do we see several growth drivers over the coming years, but we have a robust potential catalyst calendar in 2025. Throughout the year we expect multiple events that we believe are important.

For plozasiran, we expect the following key events:

- Initiate SHASTA-5 in patients at high risk of acute pancreatitis
- Fully enroll SHASTA-3 and 4 and MUIR-3
- Make additional global regulatory submissions
- Commercial launch in FCS, in the US and potentially the EU pending review and approval

For zodasiran, initiate the Phase 3 HoFH study.

For the obesity programs, we expect to initiate dosing in the Phase 1/2 study of ARO-ALK7 and potentially have the first data for Part 1 of the Phase 1/2 study of ARO-INHBE.

For fazirsiran, our investigational RNAi candidate partnered with Takeda and being developed to treat the liver disease associated with alpha-1 antitrypsin deficiency, we have the potential to reach full enrollment of the Phase 3 REDWOOD study.

For ARO-DUX4, ARO-DM1, and ARO-MMP7 we have the potential for initial data in the Phase 1/2 studies, and the potential to achieve $300 million milestones payments from Sarepta.

For both complement programs, ARO-CFB and ARO-C3 we have potential data readouts.

And lastly, for the emerging CNS pipeline we anticipate filing CTAs for our first systemically delivered and subcutaneously administered programs.

As always, there is a lot going on at Arrowhead to be excited about. Thank you for joining us today and I would now like to open the call to your questions.

Operator