ARROWHEAD PHARMACEUTICALS

Fiscal 2026 Fourth Quarter Conference Call – Prepared Remarks

November 12, 2026

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, Senior 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 2026 fiscal year ended September 30, 2026.

With us today from management are president and CEO Dr. Chris Anzalone, who will provide an overview; Andy Davis, senior vice president and head of the global cardiometabolic franchise, who will provide an update on commercialization activities; Dr. James Hamilton, chief medical officer and head of R&D, who will discuss our development programs; and Dan Apel, chief financial officer, who will give a review of the financials.

Following management’s prepared remarks, we will 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 Chris.

Chris Anzalone

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

Arrowhead has fundamentally changed over the past 12 months. Where there was once a company that relied solely on great scientific promise, there is now a company that is beginning to translate promise into real patient outcomes and the potential for durable shareholder value growth. We are building a commercial business around REDEMPLO, we have delivered the pivotal data we believe is needed to pursue a much larger market in severe hypertriglyceridemia (or sHTG), and we have demonstrated new capabilities that substantially expand what our RNAi platform can do. I believe we approach 2027 with the strongest combination of near-term commercial opportunity and scientific capability in our history.

For the long-term we intend Arrowhead to become a substantial pharmaceutical company that introduces important new medicines into the market virtually *every* year. We believe we've demonstrated that we have the platforms and development capabilities to do this, and the result could be an engine that improves innumerable patient lives and creates substantial value. But first things first. We need to build a commercial presence that matches the excellence we've built in discovery and development, and we need to demonstrate that we are capable of building out a new market, finding the patients who could benefit from our medicines, and growing a profitable business. Simply put, commercial progress with REDEMPLO is critical. We are focused on continued success serving the FCS market, planning a rapid launch into sHTG, and positioning Arrowhead to maximize the sHTG market opportunity.

Of course revenue levels, growth, and profitability will ultimately be the only metrics that matter when assessing how we are doing with REDEMPLO. However, that will not tell the full story until after the first several quarters of our planned sHTG launch, as payer policies are being worked out, coverage is being secured, and provider outreach is initiated. So during this period, we will regularly refer to 3 metrics that we believe capture the breadth and depth of early market penetration. They are:

1. Total number of new-to-brand patient prescriptions,
2. Number of distinct prescribers writing prescriptions, and
3. Number of lives covered on payer formularies.

We believe there are large pools of patients who can benefit from REDEMPLO, and these 3 metrics are intended to reflect how well we are building pipes to reach them.

We launched into the narrow FCS market about 11 months ago and are still in the pipe-building phase. This work has progressed well. As of September 30, we had 950 new-to-brand patient prescriptions, representing a 63% increase over the prior quarter end. This growth rate continues to increase rapidly, as we have added another ***300*** since then. At September 30, over 640 distinct individual prescribers wrote first time prescriptions and that number has grown to over ***860*** since then. There are now over 160 million lives covered in payer formularies in the U.S. We are seeing strong demand for REDEMPLO and continue to work with payers to increase the rate at which prescriptions are converted to paid shipments. This is still a choke point and there is substantial work to do, but we are off to a good start.

The pipes we are laying are critical for the FCS market and, importantly, directly applicable to the next stage of our business in sHTG. We intend to enter sHTG with an organization that already understands the medicine, its prescribers, and the practical work needed to get patients on treatment.

Let's now look forward. We are preparing aggressively for a potential U.S. launch in sHTG in the second quarter of 2027, subject to successful FDA review and approval. The FDA granted plozasiran entry into the Split Real Time Application Review, or STAR, pilot program for our planned sHTG supplement. STAR provides a six-month Priority Review framework and the possibility of action earlier than the formal goal date. We submitted our sNDA on November 2nd, so we expect to receive our PDUFA date over the next 50 days or so. We are very optimistic about the potential for this launch. We believe the clinical profile, the unmet need, and the capabilities we are building position REDEMPLO to become the leading treatment in this market.

That conviction begins with the data. In July, we announced that SHASTA-3 and SHASTA-4 met their primary endpoint and every prespecified secondary endpoint. The detailed results presented at the European Society of Cardiology Congress in August and at the American Heart Association just last weekend reinforced the consistency of plozasiran's activity. Median triglyceride reductions from baseline were 79% and 81% at month 12. In the pooled analysis, cumulative acute pancreatitis events were reduced by 78% versus placebo across the broad sHTG population studied, with an impressive 100% reduction in patients at highest risk of acute pancreatitis.

These are results that we believe can change treatment expectations. Physicians see patients whose triglycerides remain dangerously elevated despite existing approaches. Our goal is to deliver those physicians a medicine that can produce deep, sustained reductions with a simple quarterly injection, supported by evidence of fewer acute pancreatitis events in the SHASTA-3 and 4 studies. We believe that is a powerful proposition for patients and payers alike.

We continue to describe the profile we are pursuing as Safe, Simple, and Strong. Safe reflects the favorable tolerability observed in all our studies: no increase in liver fat, no hypersensitivity, and no notable changes in liver values. Simple reflects a fixed 25-milligram dose administered once every three months: we don’t expect a need to monitor liver enzymes and there will be no need to titrate the dose up. Strong reflects the depth of triglyceride lowering and the pancreatitis results. The FDA will determine the final sHTG label, but we have a high degree of confidence in this medicine.

We continue to see the potential for REDEMPLO to generate $3 billion to $4 billion in annual U.S. sales over time in sHTG. Those are large numbers, but we

see many ways to get there. While there are thought to be 3 to 3.5 million people in the U.S. with TGs greater than 500 mg/dl, we believe the early adopters will be the population at highest risk within this group. This is comprised of those patients with TGs greater than 880 without a history of pancreatitis and those with TGs greater than 500 that have a history of acute pancreatitis. Together, we believe this population totals almost 1 million people in the U.S., and their enhanced risk of acute pancreatitis would suggest that they are in real need of treatment. In SHASTA-3 and -4, the number of patients needed to treat in order to prevent a single acute pancreatis event was 9 in patients with TGs >880 without a history of pancreatitis and those with TGs >500 *and* a history of pancreatitis. Within that latter group alone, the NNT was only 3. These are very compelling numbers, and keep in mind that this is just after 1 year. We would expect those NNTs to decrease further over longer treatment periods.

Our data suggest that this patient population could benefit from REDEMPLO, but a valid question is how long it will take to educate patients and providers about the need to treat. There is clearly already some appreciation for this. For instance, we believe that around 1 million people with TGs greater than 500 are on prescription fish oils. This suggests to us that providers already have an urgency to treat TG levels for at least these patients. Remember that these fish oils only reduce TGs by 20-30%, while REDEMPLO reduced TGs by around 80% from baseline in SHASTA-3 and -4.

Outside the U.S. our business is advancing as well. REDEMPLO became available for prescription, dispensing, and reimbursement in Germany in August, following the European Commission's June authorization. In addition, in October the UK Medicines and Healthcare products Regulatory Agency, or MHRA, authorized REDEMPLO in the United Kingdom for adults with FCS and The UK National

Institute for Health and Care Excellence, or NICE, issued guidance recommending funding for NHS in England and Wales. These milestones expand the foundation for our global cardiometabolic business.

Besides our commercial buildout, our discovery engine has delivered two important clinical advances. In September, ARO-DIMER-PA demonstrated that one RNAi molecule can silence both PCSK9 and APOC3 in people with mixed hyperlipidemia. That opens an important new approach to ASCVD due to mixed hyperlipidemia and gives us a basis for developing additional medicines that address more than one disease driver at a time.

Then, in October, ARO-MAPT produced substantial and sustained reductions in tau measured in the cerebrospinal fluid after subcutaneous administration. We view this as early clinical validation of our ability to deliver RNAi across the blood-brain barrier. The opportunity to address CNS targets with an injection under the skin could dramatically expand the diseases we can pursue. I do not think this breakthrough can be overstated. We intend to move decisively to build on these results.

This is the model we have been building for years. Establish delivery to a cell type, learn how to do it reliably, and then apply that capability to additional targets. Our clinical work now spans the liver, lung, muscle, adipose tissue, and CNS, with additional tissue types being studied preclinically. Every successful expansion gives us the potential to create multiple new medicines and additional opportunities for partnerships.

Our cardiometabolic franchise illustrates how that can translate into an efficient commercial business. REDEMPLO, zodasiran, ARO-DIMER-PA, and our obesity

and MASH programs could serve related physician audiences. We intend to build an organization that can support several products through much of the same infrastructure. That is an important part of how we think about growth and long-term returns on the capital we invest.

We have also announced an agreement with Sixth Street to retire our existing debt at a discount to the minimum multiple on invested capital provided for in the existing arrangement, and to establish a new facility at a lower cost of capital. The refinancing is designed to extend our debt maturity and provide financing terms more consistent with Arrowhead's current stage.

We have a great deal to execute, and we are approaching it with urgency. The potential sHTG launch is our most important near-term commercial priority. We believe it can change the scale of Arrowhead's business, while the rest of our pipeline creates opportunities well beyond REDEMPLO. I am more optimistic than ever about the patients we can help and the value we can build.

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

Andy Davis

Thank you, Chris, and good afternoon, everyone.

We are approaching one year since REDEMPLO's initial FDA approval, and the FCS launch continues to progress. I'll cover three measures of this progress: (1) growth in prescriptions, (2) expansion of the prescriber base, and (3) advancements in market access. Then I'll connect them to our planned sHTG launch, anticipated in the second calendar quarter of 2027.

First, growth in prescriptions.

Total prescriptions grew 63% in the fiscal fourth quarter, and that momentum has carried into this quarter, taking us well past 1,250 cumulative new-to-brand prescriptions. On prior calls, I cited a run rate of 20 to 30 new prescriptions per week. Recent trends support approximately 50 to 60 per week.

We are encouraged by the sustained increase in demand. Since expanding our field team this summer, we are reaching substantially more healthcare professionals, and we are seeing strong interest in REDEMPLO from prescribers across specialties. It's important to note, however, that these are written prescriptions, not paid claims. Moving from prescription to treatment requires patient engagement, benefit verification, physician office support, and prior authorization submission and approval. Our dedicated Redemplo Reimbursement Navigator team is heavily focused on educating offices on the reimbursement process to convert this demand into treatment starts and durable access.

Second, expansion of the prescriber base.

Unique prescribers grew over 50% in the fiscal fourth quarter. Since then, in the last five weeks alone, we added as many prescribers as in the entire fourth quarter, bringing the total as of the first week of November to over 860. We view this as an important indicator of future growth and of productive field engagement with the right providers.

The specialty mix is led by cardiology and endocrinology, with internal medicine a growing share. These are the same specialties we expect to engage for sHTG, should REDEMPLO be approved for that use next year.

Repeat prescribing is also building, with approximately 27% of prescribers having written for more than one patient. In recent market tracking research, prescribing physicians report strong satisfaction and high, and increasing, likelihood to recommend REDEMPLO since launch.

Third, advancements in market access.

Payers representing the vast majority of U.S. covered lives have published utilization management *policies* for REDEMPLO in FCS. These policies describe the criteria by which a payer will evaluate a reimbursement request. Additionally, more than 160 million U.S. lives now have *coverage* for REDEMPLO – with coverage defined as those eligible patients with a reimbursement pathway under the applicable policy criteria. Both of these metrics have grown steadily since launch. Our objective is to expand access for appropriate patients with genetically confirmed or clinically diagnosed FCS and to help practices navigate requirements efficiently. We are working with payers, specialty pharmacies, and physician offices to move prescriptions through the process and resolve points of friction. Broadening access and improving the patient journey are central priorities as we prepare for a much larger opportunity.

Turning to sHTG, our enthusiasm is high. We are preparing for a potential launch in the second calendar quarter of 2027, subject to FDA approval. Our initial focus is on patients at high risk of acute pancreatitis, including those with triglycerides at or above 880 mg/dL, or above 500 mg/dL with a prior history of pancreatitis. We

have described this as approximately one million people in the U.S. within the broader sHTG market.

We have identified more than 20,000 healthcare professionals across relevant specialties as likely sHTG treaters, and we are well advanced in building our HCP engagement, patient services, distribution, and market access capabilities. Our expanded sales team is now largely in place, building relationships and mapping priority accounts in preparation for a potential sHTG launch. What we are learning now will help us execute as the addressable population expands.

Our One-REDEMPLO pricing approach supports this transition. The current U.S. wholesale acquisition cost is $45,000 per patient per year, and we intend to hold a consistent U.S. price across FCS and sHTG if the broader indication is approved. We believe that simplicity supports productive payer discussions and a clear value proposition.

Outside the U.S., Germany and the UK are now active commercial markets. In the UK, the reimbursement authority recently issued final guidance recommending REDEMPLO for genetically confirmed FCS, supporting reimbursement in England and Wales. We are working to serve eligible patients there now.

To recap, the FCS launch is showing increased prescription demand, a broadening prescriber base, and important advancements in access. This is the progress we intend to carry into sHTG. We believe the opportunity ahead is significant, and our team is preparing accordingly.

With that, I'll turn the call over to James.

James Hamilton

Thank you, Andy.

The fourth quarter and subsequent period included important progress in our late-stage cardiometabolic programs and clinical validation of two new applications of Arrowhead's TRiM platform. I will begin with plozasiran and then discuss zodasiran, ARO-DIMER-PA, our CNS efforts, as well as obesity and MASH.

For plozasiran, the SHASTA-3 and SHASTA-4 results give us a strong basis for the sHTG sNDA, which, as Chris mentioned, has been submitted. Both trials evaluated 25 milligrams every three months, and both met their primary and all prespecified secondary endpoints. In addition to the triglyceride reductions Chris described, more than 90% of treated patients achieved triglycerides below 500 milligrams per deciliter at month 12, and more than half achieved triglycerides below 150 mg/dL.

In the pooled acute pancreatitis analysis, the overall reduction in cumulative events was 78% versus placebo. Among patients with a prior history of acute pancreatitis, the event-rate reduction was 91%, with an estimated number needed to treat of three over one year to prevent one event. In the highest-risk subgroup, with triglycerides above 880 and a prior history of pancreatitis, no events were observed in the plozasiran group. These subgroup findings support our focus on patients with substantial ongoing risk.

Safety remained favorable overall and consistent with our previous experience. Treatment-emergent adverse event rates were similar in the pooled placebo and pooled active groups. There were no cases of anaphylaxis or systemic

hypersensitivity, no clinically meaningful platelet changes, and no meaningful liver enzyme elevations relative to placebo. The MRI substudy showed no statistically significant change in hepatic fat fraction. Worsening glycemic control was reported more frequently with plozasiran, 14.3% versus 8.7% in placebo, with mean changes in HbA1c consistent with previous experience and importantly, no progressive worsening of HbA1c over time.

Our regulatory package draws on SHASTA-3, SHASTA-4, and the MUIR-3 safety database. Working within the STAR process, which includes Priority Review, we continue to anticipate an efficient review. Entry into STAR reflects the FDA's assessment that the application meets the program's criteria for a potentially meaningful improvement over available therapy on clinically relevant endpoints. Approval and the ultimate label remain subject to regulatory review.

Turning to zodasiran, in July we completed enrollment in the global Phase 3 YOSEMITE study in homozygous familial hypercholesterolemia, or HoFH. We enrolled 70 patients, above the original target of 60, reflecting strong interest in this population. The trial evaluates quarterly dosing and the change in LDL cholesterol at month 12 as the primary endpoint. We anticipate study completion in mid-2027 and data in the second half of next year, with a potential regulatory filing thereafter if the results support it. Our previously stated goal has been an NDA filing by year end 2027.

Next, ARO-DIMER-PA. The interim single-dose results announced in September showed mean maximal reductions of 89% in PCSK9 and 95% in APOC3. The corresponding mean maximal lipid reductions were 65% for LDL cholesterol, 78% for triglycerides, 73% for remnant cholesterol, and 66% for ApoB. These are early

dose-escalation results, but the ability to affect both pathways with one molecule leading to large reductions in atherogenic lipoproteins is highly encouraging.

No drug-related serious adverse events were reported in that interim analysis. Injection-site events and headache were the most commonly reported treatment-emergent events. Multiple-dose assessment continues, and we expect additional clinical data around mid 2027. We are evaluating a development strategy that could first seek approval based on LDL cholesterol lowering, subject to regulatory agreement.

Turning to the CNS, our October 14 presentation included the first interim healthy-volunteer results for subcutaneous ARO-MAPT. At the 12.8-milligram-per-kilogram regimen, administered on days 1 and 15, mean CSF total tau fell 73% by day 105, with a maximum individual reduction of 85%. Day 105 was 90 days after the last dose. These findings support the potential for maintenance dosing every three months or less frequently.

ARO-MAPT was generally well tolerated in the interim analysis. There were no serious treatment-emergent adverse events or adverse events leading to discontinuation, and no persistent anemia or neurobehavioral adverse events were reported. These results provide evidence of target engagement in healthy volunteers.

Multi-dose healthy volunteers cohorts are fully enrolled and enrollment in early Alzheimer's patient cohorts is ongoing. We expect additional healthy volunteer data and Alzheimer’s patient data in 2027. We have also begun regulatory discussions around clinical studies in MAPT-associated frontotemporal dementia and progressive supranuclear palsy.

We have multiple additional CNS programs in development. As discussed at our October webinar, we are targeting CTAs for two wholly owned candidates around the end of 2026 or early 2027 and additional CNS clinical entries by the end of 2027. The objective is to apply this delivery capability across a much broader set of diseases.

Lastly, we remain on track to share updates from our obesity programs, specifically focused on the ALK7 non-diabetic monotherapy cohorts and the type 2 diabetic tirzepatide combo cohorts before the end of the year.

I will now turn the call over to Dan Apel.

Dan Apel

Thank you, James, and good afternoon everyone. I'll provide a brief outline of our financial results for the full fiscal year ended September 30, 2026, and then discuss our financial position following several recent developments.

As we reported today, net loss [attributable to Arrowhead] for fiscal year 2026 was $724.2 million dollars, or a loss of five dollars and eleven cents per share, based on 141.9 million fully diluted weighted-average shares outstanding. This compares to a net loss of $1.6 million dollars, or a loss of one cent per share, based on 133.8 million fully diluted weighted-average shares in fiscal year 2025.

Two factors drove much of the year-over-year change. First, fiscal year 2025 benefited from $829 million in collaboration revenue, largely from the initial

recognition of the Sarepta and Sanofi arrangements. Second, fiscal year 2026 includes a one-time $215 million expense for the priority review voucher we acquired in September. Excluding that expense, net loss would have been approximately $509 million.

Turning to revenue, revenue for fiscal year 2026 totaled $450.8 million, compared to $829.4 million in fiscal 2025. Revenue in fiscal 2026 was driven by our license and collaboration agreements with Sarepta, Novartis, Madrigal and Sanofi, together with our first year of commercial sales of REDEMPLO.

Of that total, $317 million related to the Sarepta collaboration. This included the $181 million recognized for the second DM1 milestone, ongoing recognition of the initial Sarepta consideration, reimbursement of incurred collaboration program costs, and revenue under the clinical supply agreement. The $317 million compares to $697 million from the prior period, with the year-over-year decrease related to the one-time recognition in fiscal 2025 of the transfer of the initial Sarepta licenses.

For the Novartis collaboration, we recognized $89.0 million during the year, nearly all of which relates to the $200 million upfront payment we received in October. As of September 30, 2026… we still carried approximately $113 million of deferred revenue … which will be recognized over time as we fulfill our research and development obligations.

During the year, we also recognized a $25 million upfront payment from Madrigal for ARO-PNPLA3, following completion of that license and technology transfer. And we recognized $13.3 million related to Sanofi and Greater China, compared to

$130 million in the prior year which related to the upfront consideration received when that agreement closed.

Finally, fiscal year 2026 also marked our first year of commercial sales of REDEMPLO, with net product revenue of approximately $6.6 million. As both Chris and Andy have mentioned, we are very pleased by the reception from patients, physicians and payors, and how the underlying prescription volume and net sales are developing. While we have consistently stated that FCS revenue will have an immaterial impact to our 2026 financial statements, we continue to invest in supporting this FCS launch and preparing for the potential blockbuster opportunity in sHTG.

Turning to expenses, total operating expenses for fiscal 2026 were approximately $1.16 billion, compared to $731 million in fiscal 2025. The $427 million increase includes the $215 million priority review voucher expense. Excluding the voucher, operating expenses were approximately $943 million, an increase of $212 million year-over-year, driven by $132 million of higher R&D expense and $78 million of higher SG&A expense.

R&D expense for the year … was $739 million, compared to $607 million in the prior year. Candidate costs accounted for $96 million, or the majority, of that increase.

Taken as a whole, these R&D investments supported the positive pivotal sHTG results reported this summer, the advancement of our broader pipeline, and our efforts towards commercial manufacturing readiness in Verona. As a reminder, the

Verona plant provides us accelerated and enhanced ability to prioritize and make new clinical GMP oligonucleotide drug substance, and will be used to support future commercial products, the first one planned being Zodasiran.

SG&A expense for the year was $202 million, compared to $124 million in the prior year. The increase was driven primarily by our investment in the commercialization of REDEMPLO. As we have discussed, these capabilities more than support the current FCS launch, and were built with the intention of being fully leverageable for the potential sHTG launch, and, ultimately, for Zodasiran in HoFH. As of today, our commercial organization is largely in place, and we expect only incremental additions as we approach a potential U.S. sHTG launch.

Turning now to the balance sheet, cash and investments totaled nearly $1.2 billion as of September 30, 2026, compared to $0.9 billion a year earlier. Cash used in operating activities was approximately $272 million for the fiscal year. Importantly, that year-end balance is after funding both our operating activities and the $215 million purchase of the priority review voucher. Common shares outstanding at year end were approximately 141.3 million.

As to the voucher, following the FDA's acceptance of plozasiran into the STAR pilot program in October, it is no longer needed for our planned sHTG supplemental application, and is eligible to be sold to a third party. Publicly announced PRV transactions over the last 12 months have ranged from approximately $180 million to $220 million. Purely illustratively, if we were to sell our PRV at prevailing market rates, our cash and investments would be approximately $1.4 billion on a rounded pro forma basis. To be clear though, we

have not entered into a sale agreement, and no PRV sale proceeds are included in our reported statements.

Finally, I'd like to highlight the refinancing we recently completed with Sixth Street on November 2. We replaced the prior facility with a new $400 million senior secured term loan at three-month SOFR plus 5.50%, compared to the prior facility's 15% annual rate. We also negotiated, significantly, a $68 million discount to the minimum amount required to retire the old facility in 2028. The new loan matures on November 2, 2031, has no scheduled principal amortization before maturity, and, importantly, eliminates any and all required cash sweeps to 6th Street tied to product sales, royalties, milestones, or any existing, or new, licensing and partnership proceeds.

To put our debt position in context, our funded debt now consists principally of the new $400 million term loan due in November 2031 and $700 million of zero-percent convertible notes due in January 2032. In other words, no principal payments are required before late 2031. Compared with the retired structure, this materially lowers our borrowing cost, extends maturity and improves our near-term liquidity and flexibility.

Taken together, we believe our strong balance sheet with approximately $1.2 billion of reported cash and investments, a transferable PRV with demonstrated market value and a meaningfully lower-cost, longer-dated debt structure, provides us substantial financial flexibility to support our current clinical and preclinical priorities, current and future commercialization activities, and our long-term strategic priorities.

Lastly, and unrelated to our financial position, we announced today our decision to change our fiscal year end to December, to align with the calendar year. The calendar quarter ranging from October to December 2026 will be what is called a transitional quarter period, with fiscal quarter one 2027 now referring to January through March 2027. We believe this change will ease a number of administrative burdens associated with a September year end, and, ahead of a potential sHTG launch, will improve company and investor communication.

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

Chris Anzalone

Thanks Dan.

I want to close with what we believe the next year can mean for Arrowhead. REDEMPLO has given us our first commercial foundation. We view that as a launching pad that is intended to enable us to address the sHTG opportunity rapidly.

We are targeting the second quarter of 2027 for a potential U.S. sHTG launch, subject to FDA approval. We believe we have the data to support a highly differentiated medicine, a large population with substantial unmet need, and a growing commercial organization that understands how to serve physicians and patients and how to navigate the payer landscape. We intend to build the leading franchise around that combination.

The coming period should also bring important opportunities beyond REDEMPLO, including:

- Additional obesity data by the end of 2026;
- Additional ARO-DIMER-PA data in the first half of 2027;
- The YOSEMITE P3 readout in HoFH in the second half of 2027;
- Zodasiran NDA filing by the end of 2027;
- Initial patient data from ARO-MAPT in the second half of 2027;
- New candidates emerging from our dimer and CNS platforms throughout 2027; and
- The opportunity to receive milestone payments from existing partnerships and the possibility of new deals throughout 2027.

We have worked for years to build a company that can repeatedly create important medicines and participate meaningfully in the value they generate. We now have much more evidence that this model can work. We are commercial. Our mid and late-stage pipeline is advancing. And our ability to reach new tissues and targets continues to expand.

That is why we are so optimistic. We believe the next stage of Arrowhead's growth can be substantially larger than the last, and we are working to make that happen.

Thank you for joining us today and I would now like to open the call to your questions.

Operator