ARROWHEAD PHARMACEUTICALS

Fiscal 2026 Second Quarter Conference Call – Prepared Remarks

August 4, 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 fiscal 2026 third quarter ended June 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 is now on the strongest footing of its history. Two weeks ago, we reported positive top line Phase 3 results from the global SHASTA-3 and SHASTA-4 studies in patients with severe hypertriglyceridemia, or sHTG, and we expect additional results to be presented later this month at the European Society of Cardiology Congress. These data made clear to us that REDEMPLO is needed therapy for sHTG patients. To that end, we announced today that we have acquired a priority review voucher which can accelerate the regulatory review process in the U.S. from 10 months to 6 months, potentially bringing this important medicine to patients as quickly as possible. To me, this is an expression of Arrowhead values: push to create the best medicines and be creative and aggressive to rapidly get them to the patients who need them.

Let’s talk about the SHASTA-3 and -4 topline results. Both studies met their primary endpoint and every prespecified secondary endpoint — a clean sweep across two pivotal trials. Median triglyceride reductions from baseline were 79% and 81% in SHASTA-3 and SHASTA-4, respectively. These results were deep, durable, and remarkably consistent across both studies.

Just as encouraging, safety and tolerability remained favorable and consistent with everything we've seen in prior studies. We observed:

- no new safety signals,
- no clinically meaningful differences in routine laboratory measures,
- no clinically meaningful adverse changes in liver enzymes,
- no hypersensitivity cases, and
- no thrombocytopenia signal.

In a prespecified MRI-PDFF subgroup, there was no statistically significant difference in mean liver fat content between plozasiran and placebo.

The acute pancreatitis findings are, in our view, the standout result. Across the broad sHTG population — patients with triglycerides above 500 mg/dL, with or without a prior history of pancreatitis — cumulative acute pancreatitis events were reduced by 78% versus placebo. And in the highest-risk subgroup, patients with triglycerides above 880 mg/dL and a prior history of acute pancreatitis, we saw a 100% reduction in events versus placebo.

Detailed results are expected to be presented as a HOT LINE Late Breaker at the European Society of Cardiology Congress on August 30, followed by an Arrowhead webcast on August 31st.

We intend to submit an sNDA to the FDA before the end of 2026, followed by additional global filings. If approved, sHTG would represent a substantially larger commercial opportunity than FCS, and it would let us utilize the infrastructure we're building today for a much broader patient population. We believe the SHASTA results materially de-risk our most important near-term label-expansion opportunity and further strengthen the foundation of our cardiometabolic franchise.

As we consider how we could fit into sHTG therapeutic paradigms, we think of REDEMPLO in three ways: Safe, Simple, and Strong.

- **Safe** because of the impressive tolerability we saw in the PALISADE P3 and resulting clean label in FCS, combined with what we saw in SHASTA-3 and -4 across multiple measures including quiet liver enzymes, no hypersensitivity, and no increase in liver fat.
- **Simple** because of quarterly dosing, no anticipated need for liver enzyme monitoring, and a 25mg dose for all patients rather than having to titrate up, and
- **Strong** because of unprecedented reductions in triglyceride levels from baseline across multiple studies.

We see this as a clearly compelling value proposition for patients, healthcare providers, and payors. Therefore, the speed at which we can bring plozasiran to the broader sHTG patient population is critical. The possibility of shaving 4 months off the approval process through the priority review voucher we acquired is important. We have a saying at Arrowhead that is even etched in the floor of one of our facilities: it is that **Every Day Matters**. This is a driving principle for us from discovery to early development to late-stage clinical to regulatory interactions and

ultimately to the last mile: getting important medicines to the patients who need them.

Turning to execution of this last mile, our U.S. REDEMPLO launch for FCS continued to build real momentum during the quarter. We've seen greater than a **doubling** of prescriptions quarter of quarter. Andy will walk through our progress in a moment, including prescription and market-access progress, and I think you'll come away as encouraged as we are.

This launch in FCS is giving us valuable experience and a scalable foundation to build on. Physicians are identifying previously untreated FCS patients, prescribing activity is broad, and our team is building the capabilities we'll need for a much larger potential sHTG launch.

We also continued to expand REDEMPLO's reach outside the United States. In May, Australia's Therapeutic Goods Administration approved REDEMPLO as the first and only medicine approved for FCS in Australia, including genetically confirmed and clinically diagnosed adults. In June, the European Commission formally granted marketing authorization — making REDEMPLO the first and only oligo-based medicine authorized by the EC for adults with FCS diagnosed through either clinical criteria or genetic testing. Together with our approvals in the United States, Canada, China, and Australia, the EU authorization gives REDEMPLO an approved footprint across five geographies, an achievement we're very proud of. We're now working through country-specific reimbursement and launch processes, while Sanofi leads commercialization in Greater China.

All of the commercial infrastructure we're building is intended not only to hopefully bring plozasiran to sHTG patients, but also to serve as the basis of our

broader cardiometabolic franchise, which we expect to include zodasiran, ARO-Dimer-PA, obesity treatments, and other candidates you will hear more about in coming quarters. We're building a large number of potential medicines that could all use mostly the same commercial channels, hopefully providing us with substantial scalability and cost-effective growth.

We view plozasiran as providing us with a strong value foundation. Our intention is to build on that aggressively, and we have made good progress recently toward that end.

At EASL, we presented interim Phase 1/2a data for ARO-INHBE in obesity and MASH, and the results were compelling. ARO-INHBE achieved dose-dependent Activin E reductions, with a mean maximum reduction over 85% after a single 400-milligram dose, with effects persisting beyond three months. In a small subgroup with obesity and elevated baseline liver fat receiving at least 200 milligrams as monotherapy, the placebo-adjusted post-dose reduction in liver fat was 44%. The program has been generally well tolerated, and we're now engaging regulators on potential Phase 2 designs and endpoints.

We continue to make progress in the ARO-ALK7 Phase 1/2 program and expect to release more data from that study in the 4th quarter. Further, we expect to file a CTA for a new obesity candidate against an undisclosed target by end of the year.

Our June cardiometabolic R&D webinar highlighted plozasiran, zodasiran, and ARO-DIMER-PA. The zodasiran Yosemite P3 study in HoFH patients is fully enrolled and we expect to have data in Q3 2027 and hopefully file an NDA by end of 2027. ARO-DIMER-PA is designed to silence both APOC3 and PCSK9 and, therefore, reduce both LDL-cholesterol and triglycerides. We believe this could be

a uniquely powerful therapy for the roughly 20m people in the US with both elevated LDL and TGs. We expect to release early data from our Phase 1 study in September.

During the quarter, we also presented our subcutaneous CNS delivery work around ARO-MAPT at TIDES. This is an important piece of our pipeline and we expect to release early data from our Phase 1 study in September. This is a potentially exciting dataset not only because of the potential of ARO-MAPT against Alzheimer's disease and other tauopathies, but also because we think it could provide the first clinical proof of concept that we are able to address brain targets with RNAi using a simple subcutaneously-administered conjugate.

Our partnership strategy remains a key part of our model and value proposition. In May, we announced an exclusive worldwide license agreement with Madrigal for ARO-PNPLA3, a program for a genetically defined MASH population. Phase 1 data showed liver-fat reductions of up to 46% after a single dose in homozygous carriers of the PNPLA3 I148M variant, with rapid onset, durability through at least 24 weeks, and no clinically meaningful adverse events observed. Under the agreement, Arrowhead received a $25 million upfront payment, and is eligible for up to $975 million in development, regulatory, and sales milestones, and tiered royalties to the mid-teens.

We believe that Arrowhead is something truly unique in biotech.

- We have an approved product and positive pivotal data that we believe supports a potentially much larger indication that we think could drive peak sales in the $3 - 4bn per year range.

- We have commercial infrastructure that is effective, growing, and capable of being the basis for multiple additional products.
- We have a set of platforms that enable us to address liver, adipose, muscle, lung, and CNS targets and we believe virtually everything we have introduced to the clinic has translated from animal models to humans.
- By the end of this year, we expect to have 23 individual drug candidates in clinical trials (11 wholly-owned, 12 partnered) and we have a high degree of confidence that the overwhelming majority of these could eventually be approved products.
- We have the potential for substantial future partner income from milestones and royalties.
- And we have the financial resources to keep this engine running and growing.

So as you look at the patients we can help and the value we can create, of course look to plozasiran. But also look to the engine we have built and the dozens of new medicines we can bring to patients.

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. It has now been approximately eight and a half months since the FDA approval of REDEMPLO last November, and we continue to be very pleased with the progress of the launch. Today, I'd like to first walk through where we stand with our FCS launch — (1) prescription and patient dynamics, (2) payer coverage, (3) pricing and competitive positioning, (4)

commercial infrastructure, and (5) international expansion — and then turn to some reflections on our recent SHTG clinical trial results.

Let's start with prescription and patient dynamics.

REDEMPLO prescription volume roughly doubled over the course of the fiscal third quarter, and that momentum has continued into the current quarter. We have supported more than 400 unique prescribers of REDEMPLO, with the specialty mix continuing to be led by preventive cardiology and endocrinology, consistent with prior quarters and our expectations at launch. Patient origination remains steady from prior communications across new-to-therapy versus switch patients, and the volume of physicians writing prescriptions and patients receiving REDEMPLO for FCS continues to exceed our internal targets. In recent market tracking studies, healthcare professional respondents indicate steadily increasing awareness and depth of product knowledge, with consistently high marks for REDEMPLO – both in absolute terms and relative to competition.

Turning now to payer coverage developments.

We continue to see strong momentum in the publication of payer policies and overall coverage across payer segments. REDEMPLO now has favorable policies in place for the most significant payers and overall coverage is progressing at a fast trajectory for the brand. We expect the remaining coverage gap to continue closing over the coming months. Our Market Access team remains focused on ensuring both genetically confirmed and clinically diagnosed FCS patients have access to REDEMPLO and nearly all published payer policies reflect the ability for physicians to diagnose FCS patients using clinical criteria alone.

Next, pricing and competitive positioning.

As a reminder, REDEMPLO's U.S. WAC is $45,000 per patient per year under our One-REDEMPLO unified pricing model and we believe the value of REDEMPLO is supported by its highly differentiated efficacy, safety profile, and dosing convenience. We've said consistently that we believe REDEMPLO offers physicians and patients a best-in-class option, and we remain confident that both the clinical data and the commercial model we've built position us well in FCS as we head towards the potential launch in SHTG. Ultimately, we believe physicians and patients should have the freedom to choose the therapy that best fits a given patient's clinical profile, and we'll continue to let the product profile of Redemplo in FCS make our case.

On our commercial infrastructure.

Our field organization continues to scale in a deliberate, sequenced way, sized for both the current FCS opportunity and the future SHTG opportunity as it unfolds. Our commercial team's tenure and productivity continue to build, and we're seeing that reflected in the prescription and payer metrics I just walked through. Importantly, if the launch timing for SHTG is accelerated as we expect, we will be ready. Just this past week, in fact, we onboarded the next wave of field personnel. This team will be in the field this month educating stakeholders on FCS and REDEMPLO.

Lastly, a word about international expansion.

REDEMPLO is now approved for FCS in the United States, Canada, China, Australia, and the European Union. On the EU approval specifically, REDEMPLO's label uniquely covers both genetically confirmed AND clinically diagnosed FCS patients — that is to say, it’s the only therapy in Europe with clinical FCS on label. We view this as a meaningful differentiator given that a substantial share of real-world FCS patients are diagnosed clinically rather than

genetically. We expect reimbursement will proceed on a country-by-country basis over approximately the next 12 months, beginning with Germany in the coming weeks.

I'll wrap up my remarks with some reflections on what's ahead for plozasiran in SHTG.

As Chris highlighted, we recently announced topline results from the Phase 3 SHASTA-3 and SHASTA-4 studies of plozasiran in severe hypertriglyceridemia, and we believe these are best-in-class results. Both studies met their primary endpoint, with median triglyceride reductions of 79% and 81% from baseline at month 12 in SHASTA-3 and SHASTA-4, respectively, compared to approximately 27% for placebo. Just as importantly, in a pre-planned pooled analysis, plozasiran achieved a statistically significant reduction in acute pancreatitis events versus placebo across the broad sHTG population studied — a 78% reduction in cumulative AP events. And in the subset of patients at the very highest risk, those with triglycerides above 880 milligrams per deciliter and a prior history of pancreatitis, we saw a 100% reduction in AP events versus placebo. The safety and tolerability profile remained consistent with what we've seen across the plozasiran program to date, with no new safety signals, no clinically meaningful liver findings, and no hypersensitivity or thrombocytopenia signal. We see this data set as a powerful validation of plozasiran's profile across the full spectrum of sHTG, and it gives us continued confidence in our planned supplemental NDA submission, which remains on track for before the end of this year.

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

James Hamilton

Thank you, Andy.

I'd like to share our plans for R&D milestones and data readouts throughout the rest of the year but first let's review the R&D team's accomplishments over the last quarter and beyond.

We made large strides in advancing our cardiometabolic programs. Specifically, the Arrowhead team locked study databases and analyzed data for MUIR 3, SHASTA 3 and SHASTA 4 ahead of schedule, culminating in the release of topline SHASTA 3 and SHASTA 4 data at the end of last month. As already mentioned, Plozasiran achieved deep and durable reductions in triglycerides translating into a statistically significant reduction in acute pancreatitis events. Plozasiran also demonstrated a favorable safety profile, with no statistically significant difference in liver fat in the treatment group versus placebo. We remain excited about sharing detailed results, which are planned for presentation at the upcoming European Society of Cardiology meeting later this month. The MUIR 3 study achieved its intended purpose as a study designed to build the Plozasiran safety database. We plan on presenting data from this study at a future medical conference. Additionally during the quarter, Plozasiran received Australian and European Commission approval as an adjunct to diet in FCS patients

Switching gears to Zodasiran, in development for the treatment of homozygous familial hypercholesterolemia or HoFH. We completed enrollment of the Phase 3 YOSEMITE study in mid-July. Importantly, the study was designed to enroll 60 HoFH patients. However, due to strong demand we ended up enrolling 70 patients all with genetically confirmed or clinically defined HoFH. This is a one year study, so we would expect study completion mid-2027 with data in the 2H of 2027.

Also in cardiometabolic, the ARO-DIMER-PA phase 1/2a study in patients with mixed hyperlipidemia is nearing full enrollment and we plan to share topline data in September.

Elsewhere in our pipeline, we continue to make progress with both the ARO-INHBE and the ARO-ALK7 programs. As Chris already highlighted, we presented data from the ARO-INHBE Phase 1 study demonstrating a 44% reduction in liver fat in patients with hepatic steatosis at baseline. As a reminder, liver fat reductions of better than 30% are generally thought to translate into histologic and clinical benefit. An ARO-INHBE Phase 2b clinical trial protocol has been submitted to regulators. The trial is designed to evaluate the effects of various doses of ARO-INHBE on liver fat, liver histology, body weight and body composition in obese patients with MASH. The study is intended to evaluate diabetic and non-diabetic patients as well as those on and not on stable incretin therapy. As the study is under regulatory review we plan on sharing the study design details once agreed upon with regulators.

We intend to provide a data update, primarily focused on ALK7 towards the end of the year.

We've long held the belief that the CNS represents the next frontier for siRNA therapeutics with a large number of gene targets amenable to a gene silencing approach. Historically, the field has been severely limited by the requirement of intrathecal administration. This is a limitation Arrowhead hopes to remove with pioneering technology designed to deliver siRNA therapeutics across the blood brain barrier. ARO-MAPT is Arrowhead's first molecule based on this delivery platform. MAPT is the gene encoding the tau protein. Abnormal Tau accumulation is widely believed to be a critical component of the pathologic cascade leading to

Alzheimer's disease. Additionally, other forms of abnormal tau accumulation are known to directly cause MAPT variant frontotemporal dementia as well as progressive supranuclear palsy. A phase 1 clinical trial of ARO-MAPT in healthy volunteers is reaching full enrollment and the second phase of this study in Alzheimer's patients is actively enrolling. As Chris mentioned, we are targeting this September for topline data release from the healthy volunteers. This will be a very important data readout as it could pave the way for later stage tauopathy clinical trials. Additionally, achieving successful MAPT gene silencing will validate the platform for use in numerous additional CNS programs in our preclinical pipeline, which includes partnered programs.

I will now turn the call over to Dan Apel.

Dan Apel

Thank you, James, and good afternoon everyone.

As we reported today, net loss for the quarter ended June 30, 2026 was $194.3 million dollars, or a loss of $1.36 per share, based on 143.4 million fully diluted weighted-average shares outstanding. This compares to a net loss of $175.2 million, or a loss of $1.26 per share, for the prior year quarter ended June 30, 2025, based on 139.0 million fully diluted weighted-average shares outstanding in that quarter.

Revenue for the quarter totaled approximately $75 million, compared to $28 million in the prior-year quarter. Revenue was driven by our license and collaboration agreements with Sarepta, Madrigal, Novartis, and Sanofi… together with commercial sales of REDEMPLO.

Of the total, approximately $26 million related to the Sarepta collaboration… mainly from ongoing recognition of initial consideration under that agreement, as well as reimbursement of certain clinical and manufacturing expenses.

For the Novartis collaboration, we recognized approximately $20 million in the quarter bringing fiscal year-to-date revenue recognition to approximately $75 million. As of June 30th, of the initial $200 million of cash received upfront, approximately $125 million of consideration remains in deferred revenue and will be recognized over time as we fulfill our preclinical research and development obligations.

We also recognized the full $25 million upfront payment from Madrigal following completion of the license and technology transfer for ARO-PNPLA3. As previously announced, Arrowhead remains eligible to receive up to $975 million in development, regulatory and sales milestones… as well as tiered royalties on future commercial sales ranging from the high-single digits to the mid-teens. Finally, we recognized approximately $1.2 million for transitional services and commercial FCS supply to Sanofi under our license agreement for Greater China.

As mentioned previously, we are not intending to **headline** specific REDEMPLO product sales numbers until they become a meaningful driver to our financials. That said, commercial revenue can be derived from our disclosures as the difference between total revenue and collaboration revenue, and represented approximately $2.4 million for the quarter. This is more than double the approximately $1 million recorded in the prior quarter… and we have been very encouraged by the continued progress we are seeing in the launch.

Turning now to expenses, total operating expenses for the quarter were approximately $245 million, compared to $193 million in the prior-year quarter.

The $52 million year-over-year increase was driven by approximately $36 million of higher R&D expense and $16 million of higher SG&A expense.

R&D expense was approximately $198 million. The increase year over year was primarily attributable to a $32 million increase in candidate costs, reflecting continued progression of our pipeline through clinical development… including the Phase 3 registrational program for plozasiran in sHTG… as well as increased manufacturing and clinical supply activity. In line with our forecast, this also contributed to the tick up in expenses when compared to fiscal quarter two. Salaries were also higher, driven by increased headcount to support manufacturing operations and a broader clinical pipeline.

As James discussed, SHASTA-3 and SHASTA-4 have now read out with positive topline results. Accordingly, we expect costs associated with active execution of those studies to begin to moderate down over time, beginning in fiscal 2027. At the same time, we will continue to invest in regulatory activities, commercial supply readiness for a potential sHTG launch, and advancement of our broader pipeline… so quarterly R&D expense will continue to be highly influenced by program timing and clinical activity.

SG&A expense was approximately $47 million in the quarter, compared to $31 million in the prior-year quarter. The increase was primarily driven by ongoing investments supporting the commercialization of REDEMPLO… including commercial headcount, marketing and launch support, and other outside services. Given the opportunity we are seeing in FCS, we have expanded and are continuing to expand our commercial footprint… and our capabilities … where appropriate. We're building these capabilities to support the current FCS launch, but we've designed them to scale — supporting potential future indications for plozasiran, and ultimately zodasiran in HoFH.

Turning to the balance sheet… cash and investments on hand totaled approximately $1.6 billion as of June 30, 2026. Common shares outstanding at quarter end were 141.1 million.

As we have disclosed, we have entered into an asset purchase agreement for an issued FDA priority review voucher which we plan to use with our upcoming sNDA submission for plozasiran in sHTG. Under the terms of the APA, we will pay the current holder $215 million dollars at closing, which we expect to occur in our fiscal fourth quarter following HSR clearance. According to our projections, should we gain approval in sHTG, the increase in present value of REDEMPLO… simply as a result of shifting our launch aspirations and uptake curve forward by four months… provides a greater than 3x return on the PRV investment. Further, it is easy to layer …ON TOP of that … incremental value we might reasonably expect to achieve commercially, should we be able to shorten our competitor's first-mover advantage.

As a concluding remark, we believe that our strong balance sheet provides significant financial flexibility to support ongoing clinical development, current and future commercialization activities, and our long-term strategic priorities.

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

Chris Anzalone

Thanks Dan.

We've made so much progress during the first half of the year, but the second half of 2026 is equally packed with potentially important and value creating events.

First, we want to move as quickly as possible to get our sNDA submitted for plozasiran, supported by the strong clinical data from the SHASTA-3 and SHASTA-4 studies. The priority review voucher we acquired could help us get this important new medicine to patients with sHTG as rapidly as possible. Physicians and patients are eagerly anticipating this medicine, so we are working hard to make it happen.

Beyond plozasiran, we have some important data readouts and events planned before the end of the year that could represent important de-risking and potential value creating events. These readouts include the following:

1. The first clinical readout for ARO-DIMER-PA, the first dual-functional siRNA candidate targeting both PCSK9 and APOC3, for LDL and TG lowering is expected in September.
2. The first clinical readout for ARO-MAPT being developed as a potential treatment for tauopathies including Alzheimer's disease, representing our first program using the subcutaneously administered CNS delivery platform designed to cross the blood-brain-barrier after systemic delivery. This is expected in September. And,
3. Additional ARO-INHBE and ARO-ALK7 data releases are planned in the fourth quarter for this novel non-incretin strategy which had quite encouraging early data in obesity and MASH.

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

Operator