ARROWHEAD PHARMACEUTICALS

Fiscal 2024 Second Quarter Conference Call – Prepared Remarks

May 9, 2024

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 2024 second quarter ended March 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, our interim chief medical scientist, will provide an update on our cardiometabolic pipeline; Dr. James Hamilton, our Chief of Discovery & Translational Medicine, will provide an update on our earlier stage programs; and Ken Myszkowski, our chief financial officer, will give a review of the financials.

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.

As we discussed on our last conference call, Arrowhead has reached a point where our business requires a greater degree of focus. We are in the process of building out our expertise within the cardiometabolic space and focusing more of our spend in that area. These are wholly appropriate actions because our cardiometabolic programs represent a substantial amount of potential near-, mid-, and long-term value. We need to ensure that they are properly resourced, both from financial and human capital standpoints, and that they are at the center of investor analysis of our business. This is a good thing for Arrowhead. We have two late-stage drug candidates with data across diverse populations from ultra-rare to highly-prevalent, spanning over a thousand human subjects. We see a train of potential value creation with plozasiran and zodasiran, and expect to file NDAs or supplements to expand those labels almost every year over the next 5-6 years. This is a pipeline

within just 2 drugs and I believe we will start unlocking value in the very near term. Further, we expect to expand our cardiometabolic reach into obesity and metabolic disease with 2 additional drug candidates reaching the clinic this year.

The plozasiran PALISADE Phase 3 study in patients with familial chylomicronemia syndrome, or FCS, is clinically complete. The last patient's last visit occurred last week, the database should be locked over the next 2 weeks, and I expect to disclose top line data at our cardiometabolic webinar in June with a fuller dataset hopefully presented this year at an appropriate medical conference. We believe that plozasiran will become our first commercial product and we are preparing for an NDA submission for use in FCS patients by the end of the year with a potential launch in 2025. To this end, our commercial preparations are well underway. We have begun building our commercial team including people with deep expertise in cardiometabolic marketing, commercial operations, and market access. We're also in the later stages of solidifying a specialty pharmacy and patient hub system that will be ready to help ensure FCS patients get plozasiran soon after its anticipated approval. Beyond our commercial infrastructure, we have begun building out our medical affairs team, with a focus on field support, to help clinicians better understand APOC3 inhibition. Additionally, we have begun helping physicians who request early access to plozasiran do so for appropriate FCS patients prior to approval.

We are also studying plozasiran in the broader severe hypertriglyceridemia, or SHTG, population. Toward that end, we have begun screening patients in two Phase 3 studies, SHASTA-3 and SHASTA-4, and are preparing a third P3 in SHASTA-5. Of course it is early, but our aggressive goal is to complete enrollment of those studies in 2025. SHASTA-3 and SHASTA-4 are 52-week

studies and SHASTA-5 is an acute pancreatitis study that will follow patients until a set number of pancreatitis events is reached.

Turning to zodasiran, we submitted briefing documents including P3 study designs for patients with homozygous familial hypercholesterolemia (or HoFH) to the FDA and expect an End of Phase 2 meeting this month. We hope to initiate Phase 3 soon after we receive regulatory feedback.

We have also completed our analysis of how to move forward in the large mixed dyslipidemia population with a cardiovascular outcomes trial, or CVOT. We have submitted our proposal to the FDA and expect feedback over the next month and then will seek input from the EMA and other regulatory authorities. We will provide detailed information about our plans, expected timing, and costs once we know we have regulatory alignment on design.

Plozasiran and zodasiran are important candidates for us because they offer new and expanding commercial opportunities over the next several years, and because clinical data have suggested that they have a high probability of success. Bruce will talk more specifically about results, but a lot of data have been presented recently and we have been encouraged by the safety and tolerability, target engagement, and downstream changes to lipids and lipoproteins across multiple patient populations.

As I mentioned, over a thousand people have enrolled in the plozasiran and zodasiran clinical studies. Safety and tolerability data have given us confidence that these could be appropriate therapeutics not only for small and medium-sized populations, but also, importantly, broad mixed dyslipidemia populations.

Target engagement, measured by circulating protein knockdown of APOC3 for plozasiran and ANGPTL3 for zodasiran, have been impressive and consistent. The exact numbers will vary a bit depending on the study population, duration of treatment, dose level, and measurement timepoint. However, we are consistently seeing mean max knockdown exceeding 75-90% with a long duration of effect that supports a quarterly dosing interval for plozasiran and zodasiran. This is what we designed the programs to achieve, so we are very encouraged to see clinical results consistent with our expectations.

The downstream change to various lipids and lipoproteins have been favorable and consistent with published genetic data in APOC3 and ANGPTL3 deficient humans and consistent with experimental data in animals receiving APOC3 or ANGPTL3 inhibitors. Similar to target engagement, the exact changes varied a bit between different study populations, but generally speaking subjects treated with plozasiran or zodasiran showed improvements in multiple atherogenic lipid and lipoprotein levels, including remnant cholesterol which is increasingly viewed as an important target for new therapies to address atherosclerotic cardiovascular disease, or ASCVD.

Numerous epidemiologic studies have shown an association between higher triglyceride rich lipoproteins, or TRLs, and an increased risk of ASCVD. Despite potent LDL-Cholesterol lowering therapies, residual ASCVD risk persists due in part to high levels of atherogenic TRLs. Remnant cholesterol is also believed to be a major contributor to the residual risk of atherosclerotic cardiovascular disease after LDL is well controlled.

We believe plozasiran and zodasiran represent significant opportunities to help a lot of patients. For all the reasons I mentioned, we are moving as quickly as

possible toward treatments in FCS, HoFH, high risk HeFH, SHTG, and the very large population of patients with ASCVD due to mixed dyslipidemia.

We believe we can help a large number of patients and create a substantial amount of value with plozasiran and zodasiran alone. However, it makes sense to leverage our growing cardiometabolic capabilities by expanding the vertical. We expect to introduce 2 new candidates into the clinic in the fourth quarter aimed at obesity and metabolic disease. These are ARO-INHBE, a liver-directed candidate targeting Inhibin E, and an undisclosed candidate targeting adipose directly. We will discuss these in more depth during a focused webinar in the summer.

We continue to make progress beyond the cardiometabolic vertical as well. Within pulmonary, the ARO-MMP7 and ARO-MUC5AC Phase 1 studies continue to enroll patients, and the ARO-RAGE Phase 1 study is enrolling high FeNO patients with moderate to severe asthma. The FeNO cohorts have been slow to enroll because the high baseline FeNO required of the study has led to a high screen-fail rate. We believe in the candidate and the target engagement data has been what we had hoped for, so we are not going to wait for that to read-out before progressing to a Phase 2 study. We have designed a Phase 2 study in asthma patients and are moving toward launching that in the 4th quarter. ARO-RAGE tolerability has been good in the Phase 1 study, we have seen clear evidence of substantial target engagement in the Phase 1, and data in animal models were very encouraging. The RAGE pathway has also generated a good amount of KOL interest so we are excited to move forward as quickly as we can.

Moving to our newer programs, during the last quarter we began dosing in two new clinical programs: ARO-CFB for the treatment of diseases associated with activation of the complement pathway; and ARO-DM1 for the treatment of type-1

myotonic dystrophy, or DM1. These programs fit well with ARO-C3 and ARO-DUX4, respectively. The former is enrolling the patient portion of a P1/2 study and together with ARO-CFB provides a focused portfolio in complement-mediated diseases. ARO-DUX4 is enrolling FSHD patients in a P1/2 study and together with ARO-DM1 creates a focused skeletal muscle portfolio.

We now have 14 clinical-stage programs, 10 of which are wholly-owned. I expect we could have 18 clinical programs by the end of the year. This is a lot and they certainly can be difficult to track and properly value by investors. We think of our wholly-owned assets in a series of verticals. As we have discussed, the cardiometabolic vertical is our primary focus, but beyond that we have:

- A pulmonary vertical;
- A complement vertical;
- A muscular disease vertical; and, by the end of the year,
- A CNS vertical

We expect to partner within these 4 verticals in order to limit our spend and bring in capital to properly fund our cardiometabolic vertical and our other research programs, but we believe this is the way investors should look at our pipeline. Understanding and properly valuing these assets can still be difficult, so we recently announced the upcoming 2024 Summer Series of R&D webinars to highlight some of our work.

Starting this month and continuing each month through September, we will host 5 webcast events. Each event will feature presentations by Arrowhead team members and external key opinion leaders, who will discuss disease areas and treatment landscapes. We will talk about Arrowhead's candidates, the biological rationale and preclinical data supporting each target, and our clinical development strategy

for each pipeline program. The series is designed to highlight important value drivers in a focused way.

The Summer Series schedule is as follows:

- May 23 is muscle vertical day where we will cover ARO-DM1 and ARO-DUX4;
- June 25 is cardiometabolic day where we will give an overview of plozasiran and zodasiran data to date, including P3 PALISADE FCS data, and talk about the future of the programs and the diseases we aim to treat;
- July 16 is pulmonary day, which includes ARO-RAGE, ARO-MUC5AC, and ARO-MMP7;
- August 15 is obesity and metabolic disease day, where we will talk about ARO-INHBE and the undisclosed adipose candidate; and
- September 25 is CNS day, where we will highlight our central nervous system programs, including updates on the platform and on a specific undisclosed candidate planned to enter clinical development later this year.

In addition to the Summer Series, we also recently announced a busy month of presentations at medical and scientific meetings. These include presentations at TIDES USA, the American Thoracic Society 2024 International Conference, the International Conference on Antiviral Research, European Atherosclerosis Society Congress, and the National Lipid Association Scientific Sessions. These are all planned for May. In addition, we plan to present on many of our programs at several medical meetings throughout the year. We have a lot going on, including a lot of exciting results to talk about.

During the last few months, we also strengthened our balance sheet with two inflows. The first was done in January when we announced an equity financing with gross proceeds of $450 million.

The second was just announced last week. That was a $50 million milestone payment that we received from Royalty Pharma following the completion of enrollment of the Phase 3 OCEAN(a) - Outcomes Trial of olpasiran, being conducted by Amgen. We originally licensed olpasiran, previously called ARO-LPA, to Amgen in 2016 and then monetized our future royalty stream in a transaction with Royalty Pharma in 2022. Arrowhead is further eligible to receive up to an additional $375 million from Amgen and $110 million from Royalty Pharma in aggregate development, regulatory, and sales milestone payments associated with olpasiran.

This is a good example of how we use partnering and creative financing structures as important parts of our long-term financing strategy. We are always working on potential future deals and now is no exception. We are confident that we can complete additional transactions this year to further strengthen our balance sheet to support future clinical development and commercialization of our wholly owned programs.

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

Bruce Given

Thank you, Chris, and Good Afternoon everyone.

Chris discussed plozasiran and zodasiran at a high level, but I want to spend some time going over a few specific things: First, the data on the SHASTA-2 study of plozasiran that we presented at ACC and simultaneously published in JAMA Cardiology; Second, the design and status of SHASTA-3, 4, and 5; Third, expectations for our upcoming EAS and NLA presentations; and lastly, a review of the soon to report PALISADE study of plozasiran in familial chylomicronemia syndrome or FCS.

Let's jump right in with the SHASTA-2 study of plozasiran. To review, plozasiran is designed to reduce production of apolipoprotein C-III, or APOC3, a component of triglyceride rich lipoproteins, or TRLs, and a key regulator of triglyceride metabolism. APOC3 increases plasma TG levels by inhibiting breakdown of TRLs by lipoprotein lipase. It also inhibits uptake of remnant cholesterols, derived from TRLs, by hepatic receptors in the liver.

The SHASTA-2 study was a double-blind, placebo-controlled Phase 2b study in adults with severe hypertriglyceridemia, or SHTG. Three dose levels of plozasiran (10 mg, 25 mg and 50 mg) were evaluated against placebo in 229 participants who had mean fasting triglycerides of greater than or equal to 500 mg/dL at screening. Each participant received subcutaneous injections on day 1 and week 12 with subjects then followed all the way out to week 48. The primary objective of the study was to evaluate the safety and efficacy of plozasiran in adults with SHTG and to select a dosing regimen for later stage clinical studies in this patient population.

SHTG is characterized by TG levels greater than 500 mg/dL and is known to significantly increase the risk of ASCVD and acute pancreatitis, often with recurrent attacks requiring repeat hospital admissions and worsening outcomes.

Pancreatitis risk is proportional to the number, characteristics, and concentrations of TRLs and increases as triglycerides levels increase. Currently available drug therapies generally don't sustainably reduce TGs below the pancreatitis risk threshold.

In addition to SHASTA-2, there is also an open label extension study that is ongoing. Final data from the double-blind treatment period of the SHASTA-2 study were presented at ACC and published in JAMA Cardiology. These were exciting data which received a lot of attention and were well received at ACC and in subsequent discussions with physicians.

With respect to pharmacologic activity, treatment with plozasiran led to dose-dependent placebo-adjusted reductions in triglycerides at 24 weeks, which was the primary endpoint. The reductions observed were -49%, -53%, and -57% for the 10, 25 and 50 mg doses respectively. For comparison, currently available drugs usually would be expected to produce reductions of maybe 20% or so. As expected, these triglyceride reductions were driven by corresponding placebo-adjusted reductions in APOC3 of -68%, -72%, and -77% at week 24. All these measures were highly statistically significant.

Mean maximum, non-placebo adjusted reductions from baseline in triglycerides and APOC3 were up to 86% and 90%, respectively, and typically occurred around week 16 or week 20.

Importantly, we also looked at the percentage of patients who met the goal of reducing triglyceride levels below 500 mg/dL, a level above which the risk of acute pancreatitis meaningfully increases. Among subjects treated with plozasiran, at the week 24 trough timepoint >90% receiving the 25 or 50 mg doses achieved a

triglyceride level less than 500 mg/dL In addition, around half of the subjects at these doses achieved normal triglyceride levels of less than 150 mg/dL at week 24, which is surprising given the high mean starting levels of almost 900 mg/dL.

In addition to reductions in triglycerides, subjects treated with plozasiran also showed improvements in multiple atherogenic lipid and lipoprotein levels, including remnant cholesterol, HDL-cholesterol, and non-HDL cholesterol.

Plozasiran demonstrated a favorable safety profile in SHASTA-2. Observed adverse events generally reflected the comorbidities and underlying conditions of the study population. The adverse event and serious adverse event profiles were generally similar across treatment groups, although worsening of diabetes appeared more frequently with the 50 mg dose. All serious treatment emergent adverse events were deemed not related to plozasiran.

Overall then, the deep, consistent, and sustained reductions in APOC3 and triglycerides and improvement in multiple atherogenic lipoprotein levels, give us a level of confidence as we initiate Phase 3 studies in patients with SHTG. These Phase 3 studies are called SHASTA-3, SHASTA-4, and SHASTA-5.

I will start with descriptions of SHASTA-3 and 4, since they are very similar to each other and are being initiated now. Both 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.

The primary endpoint for the studies is placebo-adjusted percent change in fasting serum TG levels at Month 12. SHASTA-3 is planned to include approximately 405 subjects and SHASTA-4 is planned to include approximately 300 subjects.

We have begun activating sites for these studies, and will activate others as quickly as possible. There are already patients in screening, so we expect to have the first subjects dosed soon. This has moved very rapidly and I'm proud of the work done by all the Arrowhead teams involved, our CRO, and the investigators and institutions that are participating in the studies.

I also want to give a quick update on SHASTA-5. We are still finalizing some details about the study but it is currently planned as a multi-center, randomized, double-blind, placebo-controlled Phase 3 study to evaluate plozasiran vs placebo in approximately 140 adult subjects with SHTG at high risk of acute pancreatitis. Subjects must have TG levels greater than 880 mg/dL and history of acute pancreatitis events and will be randomized in a 1:1 ratio to either receive plozasiran 25 mg or placebo, dosed quarterly. The primary endpoint of the study is incidence of adjudicated acute pancreatitis events compared with placebo.

Now that SHASTA-3 and SHASTA-4 have been initiated, the plozasiran clinical development team is finalizing the SHASTA-5 design and working to initiate the study as soon as possible. We think performing a dedicated study in the high risk population, if successful, will be useful for payers on a global basis.

Next, I want to highlight some upcoming presentations on plozasiran and zodasiran. At the European Atherosclerosis Society, or EAS on May 28 and 29, we will be presenting final results from the MUIR study of plozasiran and from the ARCHES-2 study of zodasiran. Both of these studies are in a mixed hyperlipidemia populations, recruited with identical enrollment criteria. For clarity, the field is moving away from the term mixed dyslipidemia to the term mixed hyperlipidemia, so expect to see and hear the 2 terms used synonymously.

I already described plozasiran mechanistically, but to review, zodasiran is designed to reduce production of angiopoietin-like protein 3, or ANGPTL3, which like ApoC3 is a hepatocyte expressed regulator of triglyceride metabolism.

However, ANGPTL3, while similar to ApoC3 in having an effect on lipoprotein lipase, also impacts endothelial lipase and non-LDL receptor mediated uptake of LDL. As such, by reducing ANGPTL3, zodasiran causes some downstream changes in atherogenic lipids and lipoproteins that are different than those produced by plozasiran. These include additional reductions in LDL-C and Apolipoprotein B, while also driving similar reductions in triglycerides, remnant cholesterol and non-HDL cholesterol reductions seen with plozasiran. This is why we are taking a very close look at the various options for Phase 3 clinical development in an ASCVD population with mixed hyperlipidemia, a population of patients estimated to be around 20 million in the U.S. alone. We have engaged with external advisors and have completed an exhaustive analysis of the potential studies and designs. We have recently completed a submission to the FDA on a potential study design and will have additional interactions on the specifics over the coming 30-60 days. We will talk more about our plans after we receive feedback.

Upstream of that, the coming EAS presentations will be a good way for folks outside the company to see some of the data that have gone into our thinking. We and our KOL advisors believe there really is not a bad choice between the two. As you will see, results from both the MUIR and ARCHES-2 studies look compelling.

Now moving to the PALISADE study of plozasiran in patients with FCS. PALISADE included FCS patients who were genetically confirmed, and somewhere around half who were clinically diagnosed. FCS is a severe and ultrarare genetic disease often caused by various monogenic mutations. FCS leads to extremely high TG levels, which can lead to various serious signs and symptoms, most notably including acute and potentially fatal pancreatitis. Currently, the available therapeutic options leave most FCS patients persistently vulnerable to pancreatitis.

The PALISADE study is a Phase 3 placebo-controlled study to evaluate the efficacy and safety of plozasiran in adults with FCS. The primary endpoint of the study is percent change from baseline in fasting triglycerides at Month 10. A total of 75 subjects distributed across 39 different sites in 18 countries were randomized to receive 25 mg plozasiran, 50 mg plozasiran, or matching placebo once every three months. Participants who completed the randomized period are eligible to continue in a 2-part extension period, where all participants are receiving plozasiran.

The last study visit for the last patient enrolled in PALISADE occurred about a week ago. This will be Arrowhead's first completed Phase 3 study and represents a significant milestone for the company. Importantly, it brings plozasiran potentially closer to the FCS patients that may benefit.

Our goal now is to work efficiently to generate initial study results and provide a topline data readout as soon as our cardiometabolic webinar next month and subsequently present a fuller dataset at an appropriate medical meeting. This is an exciting time at Arrowhead as we eagerly await these results.

I will now turn the call over to James.

James Hamilton

Thank you, Bruce.

The discovery and early development teams made some notable progress over the last quarter, and we also have a busy several months ahead with the Summer Series of R&D webinars that Chris mentioned earlier. We do an enormous amount work in seeking to innovate new medicines that is often only recognized once there is a clinical candidate, so I wanted to talk for a moment about how we see our priorities and the goals of the team:

1. Push the TRiM™ platform to new cell types and continually seek to optimize the safety and activity of each construct.
2. Develop new candidates against attractive gene targets where using RNA interference is the only or best method to inhibit the target.
3. Conduct IND-enabling nonclinical studies and first-in-human clinical studies in the most efficient manner possible to get meaningful readouts that accelerate mid and late-stage development.
4. Develop assets which can be readily partnered and support business development activities, which remains a key strategic focus as our pipeline has continued to grow.

I think we've made good strides in these areas recently. Let's talk about a few examples.

We have continued to expand the reach of the TRiM™ platform. We now have clinical programs in three different tissue types – liver, lung, and muscle. We also expect in the very near future to have clinical programs in two additional tissues – CNS and adipose. Each one of these expands the universe of diseases we can address and the number of patients that we can potentially help.

During the CNS R&D webinar scheduled for September, we plan on giving an update on a specific candidate that is currently undisclosed and highlight the significant progress we're making on a subcutaneously administered construct designed to deliver siRNA across the blood brain barrier to the CNS without the need for intrathecal administration. This is a much more patient friendly mode of administration and may be able to access tissues in the deep brain that have been difficult to access with IT injections. This is potentially a big step forward for us and the field overall and we are excited about the progress.

During the obesity/metabolic R&D webinar currently scheduled for August, we will also talk about platform advancement and pipeline expansion. The pipeline is expanding by two programs, and we will talk about the addition of adipocytes as a new cell type we can access with the TRiM™ platform. As you all know, the obesity space has recently gained a lot of attention with the successes of GLP1 agents, however we see clear areas that remain underserved. We have not disclosed much publicly about the development of our two obesity programs, so this event will be a good opportunity to get people up to speed on where we are and where we see the clinical development programs going.

Moving on to current clinical development programs, during the last quarter, we brought two new agents into the clinic.

First, ARO-CFB is designed to reduce hepatic expression of complement factor B, which plays an important regulatory role in amplifying complement alternative pathway activation and has been identified as a promising therapeutic target. ARO-CFB is being developed as a potential treatment for complement mediated kidney diseases such as IgA nephropathy, which is the most common glomerular disease worldwide and carries a high lifetime risk of progression to end-stage renal disease. Additionally, ARO-CFB may have clinical applications in non-renal diseases involving complement activation.

Last month we announced that we had dosed the first subjects in a Phase 1/2a clinical trial of ARO-CFB designed to enroll up to 66 healthy volunteers and patients with complement mediated kidney disease.

The second new clinical program is ARO-DM1, is designed to reduce expression of the dystrophia myotonica protein kinase, or DMPK, gene in the muscle as a potential treatment for patients with type 1 myotonic dystrophy, or DM1. Pathogenesis of DM1 is driven by abnormal DMPK transcripts that cause mis-regulated splicing, known as spliceopathy, for certain messenger RNAs which are directly linked to the clinical manifestations of DM1.

In March we announced that we had initiated and dosed the first subjects in 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 DM1.

Moving on to our clinical stage pulmonary programs ARO-RAGE, ARO-MUC5AC, and ARO-MMP7. We continue to enroll patients across all three programs and are confident that we will have multiple opportunities for clinical readouts this year. The first of these will occur at ATS later this month. We are scheduled to present a poster on ARO-RAGE which will include data from mild to moderate asthma patient cohorts that we have not reported on previously.

To review, ARO-RAGE is designed to reduce expression of the receptor for advanced glycation end products, or RAGE, as a potential treatment for inflammatory pulmonary diseases. We are currently enrolling asthma patients with high baseline levels of fractional exhaled nitric oxide, or FeNO, which is a biomarker for IL-13 driven type 2 inflammation in the lung. We are expecting to have high FeNO cohorts enrolled and dosed late this year.

The next programs are ARO-MUC5AC, which is designed to reduce production of mucin 5AC, or MUC5AC, as a potential treatment for muco-obstructive pulmonary diseases, and ARO-MMP7, which is designed to the reduce expression of matrix metalloproteinase 7, or MMP7, as a potential treatment for idiopathic pulmonary fibrosis, or IPF. Both ARO-MUC5AC and ARO-MMP7 have already enrolled and dosed healthy volunteers and we anticipate the patient cohorts will be enrolled and dosed in time to enable initial clinical readouts in the second half of the year.

Our pulmonary R&D webinar scheduled for July will be review these programs in more detail.

I will now turn the call over to Ken.

Ken Myszkowski

Thank you, James, and good afternoon everyone.

As we reported today, our net loss for the quarter ended March 31, 2024 was $125.3 million or $1.02 per share based on 123.3 million fully-diluted weighted average shares outstanding. This compares with net income of $48.7 million or $0.45 per share based on 108.1 million fully-diluted weighted average shares outstanding for the quarter ended March 31, 2023.

No revenue was recorded in the quarter ended March 31, 2024. Revenue of $146.3 million was recorded in the quarter ended March 31, 2023.

Revenue is recognized as we complete our performance obligations or key developmental milestones are reached. Revenue in the prior period primarily related to the recognition of payments received from our license and collaboration agreements with Takeda and GSK.

Total operating expenses for the quarter ended March 31, 2024 were $126.2 million, compared to $98.1 million for the quarter ended March 31, 2023. The key drivers of this change were increased research and development costs, primarily compensation costs and candidate costs as the Company's pipeline of clinical candidates has increased and advanced into later stages of development.

Net cash used in operating activities during the quarter ending March 31, 2024 was $92.4 million, compared with $31.7 million during the quarter ending March 31, 2023. The increase in cash used in operating activities is driven primarily by higher research and development expenses as well as the prior period including $40 million cash receipt of revenue milestones.

Our footprint expansion is mostly complete with final payments to be made over the next several months totaling about $50 million, after which we expect capital expenditures to be nominal. With construction effectively complete, we are currently undertaking commissioning and qualification activities, which puts us on track for manufacturing drug material to support clinical trials at the facility later this year.

Turning to our balance sheet, our cash and investments totaled $523.1 million at March 31, 2024, compared to $403.6 million at September 30, 2023. The increase in our cash and investments was primarily related to the $450 million equity issuance, partially offset by our ongoing cash burn.

Our common shares outstanding at March 31, 2024, were 124.1 million.

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

Chris Anzalone

Thanks Ken.

This has been another quarter of solid execution for Arrowhead. Our Phase 3 PALISADE study of plozasiran is clinically complete, which sets us up to take the next step in growth for Arrowhead as we make the transition into a commercial organization, provided we receive regulatory approval.

We also initiated the SHASTA-3 and -4 Phase 3 studies of plozasiran in patients with SHTG and are finalizing the design and preparation to initiate SHASTA-5 in

patients with SHTG at high risk of acute pancreatitis. We are waiting for FDA feedback on a Phase 3 program to address ASCVD, which we will discuss after we reach regulatory alignment.

In addition to progress in cardiometabolic, we have been very productive in platform development and pipeline expansion. Our TRiM™ platform can now deliver to CNS and adipose tissue, and we will soon have new clinical programs targeting those tissues. We also initiated clinical studies during the quarter for two new candidates, ARO-DM1 and ARO-CFB.

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

Operator