ARROWHEAD PHARMACEUTICALS

Fiscal 2022 First Quarter Conference Call – Prepared Remarks

May 10, 2022

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 Vincent Anzalone, Vice President of Investor Relations for Arrowhead. Please go-ahead Vince.

Vince Anzalone

Good afternoon everyone. Thank you for joining us today to discuss Arrowhead's results for its fiscal 2022 second quarter ended March 31, 2022.

With us today from management are president and CEO Dr. Christopher Anzalone, who will provide an overview of the quarter; Dr. Javier San Martin, our chief medical officer, will provide an update on our mid and later stage clinical pipeline; Dr. James Hamilton, our senior vice president 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. We will then open the call to your 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.

With that said, I'd 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.

I want to start by saying thank you to all those who joined us yesterday in Verona, Wisconsin for the ground-breaking ceremony at the site of our new manufacturing and lab facilities, including mayor Diaz, Secretary Hughes, and Governor Evers.

Many people from BioForward, the local universities, the cities of Madison and Verona, and the state of Wisconsin have been very supportive of Arrowhead over the years. We appreciate their partnership as we grow our business and capabilities to support potential future commercial opportunities for our investigational RNAi-based medicines.

To that end, we announced yesterday that we received awards of up to $18.5 million in incentives to invest in the local region and create new jobs. These incentives help to defray some of the buildout costs for our Verona facility, but importantly they demonstrate the commitment of the region to expand the number of highly skilled jobs and attract talent. We have been very impressed with the quality of the workforce and intend to be a long-time contributor to the growing biotech ecosystem in Wisconsin.

So, what does this new manufacturing facility and associated office and lab facility do for Arrowhead? First, it increases our control over manufacturing at all scales, which should decrease costs and increase our speed and flexibility. Second, it enables us to better control IP as we develop new methods of manufacturing aimed at decreasing costs and increasing purity and scale. Third, it makes us a better and more complete partner to those companies bringing the drugs we create to patients. And fourth, it provides additional, specialized lab space to enable continued growth and innovation as we bring RNAi to new cell types and address new diseases.

This is an investment in Arrowhead's future as a vertically integrated commercial stage pharmaceutical company. We are making this investment now because we have a high degree of confidence in our investigational medicines, both wholly-owned and partnered. This is an important step when a development stage company is serious about becoming a commercial entity.

Let's talk about some of the recent progress we've made toward that transition.

First, we initiated the PALISADE study, Arrowhead's first Phase 3 study of ARO-APOC3 in patients with familial chylomicronemia syndrome, or FCS. FCS is a

rare disease in which patients have extraordinarily high triglyceride levels, often in the thousands of milligrams per deciliter. This can lead to severe and recurrent bouts of pancreatitis, which often involves hospitalization and can be fatal. In addition, these patients experience multiple additional symptoms which adversely impact quality of life. These patients have no FDA approved treatment options. Our clinical data in prior studies of ARO-APOC3 have shown clear and dramatic reductions in triglycerides, so we are confident that ARO-APOC3 is doing what it is designed to do. We are working to accrue patients in the PALISADE study as quickly as possible since there is such high unmet need for these patients.

In addition to starting our first Phase 3 study, we also completed enrollment in the Phase 2b ARCHES-2 study of ARO-ANG3, our other wholly-owned investigational cardiometabolic candidate for patients with mixed dyslipidemia. This study enrolled over 200 patients with elevated triglycerides and LDL-cholesterol. Completion of ARCHES-2 is anticipated around the end of this year and we intend to release topline data in the first half of 2023. These data will inform the next phase of development and potentially provide a path to another late-stage clinical study that we hope will be registrational.

We also recently initiated the GATEWAY study of ARO-ANG3 in patients with homozygous familial hypercholesterolemia, or HoFH. This study will evaluate the ability of ARO-ANG3 to reduce LDL-cholesterol in patients with the most serious and rare form of familial hypercholesterolemia. We view the HoFH opportunity in a similar way to the FCS opportunity for ARO-APOC3, where there may be a rapid path to approval in a narrower patient population with severe disease, while we conduct larger clinical studies in higher prevalence indications. As I mentioned earlier, our investment in the new manufacturing facility is to support our growth

into a commercial stage company. We think there are multiple opportunities to get there in the near to mid-term and we are preparing on all fronts.

To that end, we appointed a new member to our board of directors. Vicki Vakiener is an accomplished commercial pharmaceutical executive with decades of experience building commercial organizations and launching new products across multiple therapeutic areas. She will have an important voice on the board and provide valuable input as our commercial strategy maps out.

I also want to give a brief update on our later stage partnered candidates. These are:

- Olpasiran targeting Lp(a) with Amgen;
- ARO-AAT, also called TAK-999, with Takeda;
- JnJ-3989, formerly ARO-HBV, for chronic HBV infection with Janssen; and
- ARO-HSD for treatment of NASH with GSK.

Amgen has indicated publicly that Phase 2 clinical data for Olpasiran is expected around the middle of the year. They have also indicated that if the data are consistent with the positive data seen in Phase 1, that they would move rapidly to start a Phase 3 study. We are very excited about this program and eager to see the Phase 2 data. We believe that elevated triglycerides, Lp(a), LDL-cholesterol, and possibly low levels or poorly functioning HDL, are all contributors to the substantial remaining risk of cardiovascular disease, even in patients on maximal LDL lowering therapies. We have candidates addressing all of these. Our two wholly-owned programs, ARO-APOC3 and ARO-ANG3, and our partnered program with Amgen may be able to address multiple lipids that contribute to this

risk. We still need to conduct clinical studies to assess their efficacy and safety, but we have a high degree of confidence in these programs.

Moving on to TAK-999, we are on schedule to collect the last 12-month biopsy from the last patient in the SEQUOIA study in June or July of this year. After this sample is taken, all clinical samples will be processed and analyzed, and biopsies will be prepped and read. This process will likely take a few months, so we should have data available in the fall. Our intention would be to present those data in an appropriate forum.

According to our agreement, Takeda will lead clinical development and regulatory interactions after Phase 2. We will still be closely involved with the process and have had a very productive relationship with our colleagues at Takeda. We look forward to additional regulatory interactions this year and moving the program forward rapidly.

JnJ-3989, formerly ARO-HBV, is being investigated in multiple large P2 studies that all include a follow up phase. Together these will include close to a thousand patients on various combination therapies, and we would expect regular readouts for the foreseeable future as data come in. Public data thus far suggest that JnJ-3989 is doing what it is designed to do and substantially reducing viral antigens. We are excited to see these data and are hopeful that they will point to a treatment that is desperately needed by the 300 million people thought to suffer from chronic HBV infection world-wide.

Our partnership with GSK for ARO-HSD closed at the end of the first quarter this year. Since then, we have been working productively together and expect GSK to initiate a Phase 2 study this year in patients with NASH. This represents a large

unmet medical need; HSD is a genetically-validated target; we believe we were the first to address this target clinically; and our Phase 1 data were compelling in terms of knock down, tolerability, and transaminase decreases in patients with suspected NASH.

Complementing our mid and later stage pipeline, we were also active during the quarter expanding our early-stage clinical pipeline. We believe sustainable growth requires a diversified portfolio of candidates across therapeutic area, disease prevalence and patient population size, and across stage of development. So, it's critical that we both advance our later stage programs and also constantly expand our early-stage pipeline.

We must also remember that Arrowhead is really good at moving rapidly from idea to the clinic. We likely will not have the bandwidth to commercialize everything we produce, and we certainly do not intend to tap the brakes on early development. As such, some of those programs will be partnered to (a) put them in the hands of companies that will move aggressively to get them to patients; and (b) provide capital for us to commercialize our wholly-owned assets. Developing important new medicines is an expensive business, and we have the luxury of not being solely dependent on the capital markets to fund this. We expect this year, and every year for the foreseeable future, to bring in significant capital from new and existing partnerships. I expect Arrowhead to commercialize a variety of important medicines, and a targeted partnership strategy helps provide necessary capital for this while also providing potentially substantial long-term economics.

We added three new clinical programs over the recent period:

- ARO-C3 for treatment of complement mediated diseases, for which we initiated a Phase 1/2 clinical study; and,

- Our second and third pulmonary programs, ARO-RAGE and ARO-MUC5AC, for which we filed CTAs to initiate Phase 1/2 clinical studies.

We will talk more about ARO-RAGE and ARO-MUC5AC at our upcoming Pulmonary R&D day on May 26. Arrowhead team members and two external key opinion leaders will talk about the treatment landscape for various muco-obstructive and inflammatory lung diseases and the role that RAGE and MUC5AC may play in addressing them. We will also discuss other advancements in the pulmonary platform and disclose the next pulmonary candidate we expect to bring to the clinic.

During the quarter, we also presented interim results of a Phase 1b dose-finding study of ARO-HIF2, our investigational candidate for patients with clear cell renal cell carcinoma. The data presented provide initial proof of target engagement based on reductions in HIF2α expression. We have been working on a HIF program for over a decade using different strategies and many different iterations of our delivery technologies. Our goals for that program were threefold:

1. We wanted to develop a HIF2α targeted therapy because there is supportive evidence that it could have an effect for RCC patients and it had historically been undruggable with small molecules or monoclonal antibodies;
2. We wanted to validate that we could get functional delivery of siRNA to solid tumors, indicating that we may have a platform that can be applied to additional targets and cancer types; and,
3. We wanted to use the tumor delivery program as a way for us to learn critical lessons that could be applied to delivery systems targeted to various other extra-hepatic tissues.

We think we accomplished numbers 2 and 3, but the therapeutic landscape has changed for goal number 1. The competitive environment is dramatically different today than it was just a few years ago, with one small molecule HIF2 α inhibitor FDA approved and others in clinical development. We have examined the data from our clinical study, and at this point, based on the competitive environment, we have decided not to continue further development of ARO-HIF2. This decision was made after significant deliberation and analysis and we would like to acknowledge and give our sincere thanks to the investigators, site staff, and of course patients who participated in our clinical study.

However, as I mentioned, we did accomplish some important things with our first tumor targeted program. Probably the most critical piece that has wide-reaching implications is that we learned more about how to optimize each individual component of the system to squeeze as much knockdown as possible out of each siRNA molecule. These lessons made it possible for us to develop the technology to get to various other extra-hepatic tissues. We believe we are now much better at several things including:

- Trigger design
- Optimizing chemical modifications
- Ligand design and selection
- Linker optimization, and
- Design and use of PK/PD enhancing structures, as well as other things that can optimize target engagement

We also believe that we have a good start in an oncology platform. We saw clear target engagement, suggesting that we are able to deliver to solid tumors: in short, we're on the board. We are now using the lessons we learned from that study to

further optimize the platform for use in other tumor types against new targets. We believe that RNAi can play a role in cancer treatment and we are pushing in that direction.

I want to highlight one more piece of corporate news. We recently announced that Arrowhead formed a joint venture, called Visirna Therapeutics, with Vivo Capital to expand the reach of innovative medicines in Greater China. Vivo provided initial funding of $60 million to Visirna, which will have exclusive rights to develop and commercialize four of Arrowhead's investigational therapeutics for cardiometabolic diseases in mainland China, Hong Kong, Macau, and Taiwan. Arrowhead has a majority stake in Visirna after accounting for shares reserved for the employee stock ownership plan and is further eligible to receive potential royalties on commercial sales.

China is an increasingly important market for global pharmaceutical products. We believe to be successful in China you are better off in a dedicated entity with its own management and development staff that understand and are solely focused on the intricacies of China's clinical, regulatory, and commercial environment. That is what we envision Visirna becoming.

We were looking for more than just a financial investor, and Vivo checked all the necessary boxes. Vivo has unique expertise, experience, and a local network to draw upon. That makes them a very valuable partner in this joint venture. We think this transaction allows us to maximize value and maximize the probability of success without losing focus on our core target markets for future commercialization. Really a win-win scenario and a transaction that we think over time has the potential to become substantially more valuable.

We view this as another quarter where we executed well and achieved some key corporate goals. For a company our size, both with respect to headcount and market value, we have a uniquely broad and diverse set of assets. A key part of the Arrowhead DNA is a devotion to speed and precision, and a commitment to bring RNAi to intractable diseases. This prior period is a good example of that.

With that overview, I'd now like to turn the call over to Dr. Javier San Martin. Javier?

Javier San Martin

Thank you, Chris, and good afternoon everyone.

I will provide updates on enrollment for the VISTA set of studies of ARO-ANG3 and the SUMMIT studies of ARO-APOC3 and give some forward guidance on anticipated timelines.

I will start with the VISTA studies of ARO-ANG3, our investigational medicine designed to reduce production of angiopoietin-like protein 3 as a potential treatment for patients with dyslipidemia. There are currently two active studies. ARCHES-2 in patients with mixed dyslipidemia and GATEWAY in patients with HoFH.

ARCHES-2 is a double-blind, placebo-controlled Phase 2b study. ARCHES-2 is fully enrolled with 204 patients with triglycerides between 150 and 500 mg/dL and non-HDL-cholesterol greater 100 mg/dL or LDL-cholesterol greater than 70 mg/dL being randomized in a 3:1 ratio to receive a subcutaneous injection of ARO-ANG3 or placebo on day 1 and week 12. Three dose levels of ARO-ANG3,

50 mg, 100 mg, and 200 mg, are being evaluated against placebo. The duration of the study is approximately 42 weeks from screening to the week 36 end-of-study examination. After completing the week 36 visit, participants will be eligible to continue in an open-label extension period.

We anticipate that ARCHES-2 will be complete around the end of 2022 and topline data will be available to share in the first half of 2023.

The next active study is GATEWAY, an open-label Phase 2 clinical study to evaluate the efficacy and safety of investigational ARO-ANG3 in up to 16 subjects with HoFH. Two dose levels of ARO-ANG3 (200 mg and 300 mg) will be evaluated in subjects with documented HoFH based on genotype or clinical criteria, and with fasting LDL-C greater 100 mg/dL and fasting triglycerides less than 300 mg/dL at screening. Subjects will receive a subcutaneous injection of ARO-ANG3 on day 1 and day 84 and may be eligible to participate in an optional open-label extension study. The primary objective of the GATEWAY study is to evaluate the efficacy and safety of ARO-ANG3 in subjects with HoFH and the primary endpoint is the percent change in fasting calculated LDL-C from baseline to week 24.

We just started opening clinical sites and enrolling GATEWAY a few weeks ago, so we don't have great visibility into how long it may take to accrue all 16 patients. Our goal is to have the study fully enrolled or at least have a meaningful amount of patients enrolled by the end of the year. Since this is an open label study, we may be able to view results in somewhat real time, so we intend to share data in 2023 when possible.

Next, I will provide an update on the SUMMIT studies of ARO-APOC3, our investigational medicine targeting apolipoprotein C-III being studied in patients with various lipid disorders. There are three active studies, SHASTA-2 in patients with severe hypertriglyceridemia, or sHTG; MUIR in patients with mixed dyslipidemia; and PALISADE in patients with FCS.

SHASTA-2, is a double-blind, placebo-controlled Phase 2b study in up approximately 216 patients with triglycerides greater than 500 mg/dL. Three dose levels of ARO-APOC3 (10 mg, 25 mg and 50 mg) will be evaluated against placebo. The primary objective of the SHASTA-2 study is to evaluate the safety and efficacy of ARO-APOC3 and to select a dosing regimen for later stage clinical studies in this patient population.

Moving on to the MUIR study, which is a double-blind, placebo-controlled Phase 2b study in approximately 320 patients with triglycerides between 150 and 500 mg/dL and non-HDL-cholesterol greater 100 mg/dL or LDL-cholesterol greater than 70 mg/dL. In three cohorts (10 mg, 25 mg, 50 mg), each participant will receive a subcutaneous injection on day 1 and week 12 for a total of 2 injections. In one additional 50 mg cohort, each participant will receive a subcutaneous injection on day 1 and week 24 for a total of 2 injections. The primary objective of the MUIR study is to evaluate the safety and efficacy of ARO-APOC3 and to select a dose and dosing regimen for later stage clinical studies in patients with mixed dyslipidemia.

SHASTA-2 and MUIR are both approximately 50% enrolled and we anticipate full enrollment in the fourth quarter of 2022. This would allow for study completion in 2023.

The last study in the SUMMIT program is PALISADE, a Phase 3 study in approximately 72 patients with FCS. The primary endpoint of PALISADE is the percent change from baseline at Month 10 in fasting triglycerides. Additional secondary and exploratory endpoints include the change in other lipid parameters, incidence of acute pancreatitis, and other measures. We are working hard to open clinical sites around the world to accrue the study as fast as possible. We originally anticipated recruiting a number of patients in Russia, Ukraine, and Belarus. However, due to the ongoing conflict we have closed all clinical sites in the region. We are adding clinical sites in additional countries to maintain patient accrual. Our current goal is to have PALISADE fully enrolled in the middle of 2023 which would allow for study completion in 2024.

I will now turn the call over to Dr. James Hamilton. James?

James Hamilton

Thank you, Javier.

I want to give updates on a few of our early-stage clinical programs and preclinical programs.

Let’s start with ARO-C3, our investigational RNAi therapeutic designed to reduce production of complement component 3, or C3, as a potential therapy for various complement mediated diseases. During the quarter we dosed the first subjects in a clinical study. It is a Phase 1/2, placebo controlled, dose-escalating study to evaluate the safety, tolerability, pharmacokinetics, and pharmacodynamics of ARO-C3 in up to 24 adult healthy volunteers, up to 24 adult patients with

paroxysmal nocturnal hemoglobinuria (PNH), and up to 14 adult patients with complement-mediated renal disease.

In Part 1, healthy volunteers will receive a single subcutaneous injection of ARO-C3 or placebo. In Part 2, eligible subjects with PNH or complement-mediated renal disease will be enrolled to receive open-label ARO-C3.

We have completed dosing in three of four planned cohorts in Part 1 and expect to dose escalate to the final planned cohort. We intend to initiate Part 2 in patients when we have selected a dose from Part 1 in the next quarter or so.

Moving on to our first planned skeletal muscle-targeted candidate ARO-DUX4, our investigational candidate designed to target the gene that encodes human double homeobox 4 protein, or DUX4, as a potential treatment for patients with facioscapulohumeral muscular dystrophy, or FSHD. FSHD patients have no real therapeutic options so we are moving as quickly as possible to begin clinical studies.
However, it has been challenging for the field to identify a reliable biomarker of DUX4 expression or of disease activity in patients with FSHD. Thus, it is likely that phase 1 results may not be informative with regards to pharmacodynamic biomarkers and may only inform on initial safety. Longer phase 2 studies may be required to see any signs of favorable changes on imaging or in clinical endpoints. As such, in an effort to de-risk phase 2 studies, we have opted to wait for the results of chronic toxicology studies prior to filing a CTA for ARO-DUX4. We will provide an update on timing of this CTA when we have a clear assessment on chronic tox results.

The next update I want to give is on our discovery stage programs with Janssen, called ARO-JNJ2 and ARO-JNJ3. We previously delivered candidates to Janssen that met the parameters described in the research plan. Both candidates achieved the desired level of safety and activity. Janssen then had a period in which to do disease model and biology work on the targets they selected before having to opt-in and exercise the option to take an exclusive license to the candidates. That period has now expired and Janssen did not elect to exercise their option. Because of this we are removing the programs from our active pipeline.

The first discovery program outside of hepatitis B in our collaboration with Janssen is JNJ-75220795, formerly called ARO-JNJ1. This is an investigational siRNA therapeutic developed using Arrowhead's proprietary TRIM™ platform and is designed to reduce expression in the liver of patatin like phospholipase domain containing 3, or PNPLA3, as a potential treatment for patients with non-alcoholic steatohepatitis, or NASH. This program is in a Phase 1 clinical study and continues to progress as planned in clinical development.

The last programs I want to discuss are our newest pulmonary candidates, ARO-RAGE and ARO-MUC5AC. We filed CTAs last quarter and I am pleased to announce that both programs have received provisional approval from an ethics committee and now have regulatory clearance to begin clinical studies. We anticipate first-in-human studies will begin around the middle of 2022.

The first program, ARO-MUC5AC, targets expression of MUC5AC, a mucin protein with upregulated expression in the asthmatic airway. ARO-MUC5AC is an extremely exciting program, in part because it represents a fundamentally new way of treating muco-obstructive disease. The second program, ARO-RAGE, targets

expression of the Receptor for Advanced Glycation End products, or RAGE. RAGE represents an upstream mediator of the inflammatory cascade.

We believe they both have a differentiated mechanism and offer potential advantages over currently available therapies for various muco-obstructive and inflammatory pulmonary diseases. We will describe these programs in more detail at our Pulmonary R&D day on May 26.

I will now turn the call over to Ken Myszkowski. Ken?

Ken Myszkowski

Thank you, James, and good afternoon everyone.

As we reported today, our net income for the three months ended March 31, 2022 was $44.4 million or $0.41 per share based on 107.9 million fully-diluted weighted average shares outstanding. This compares with net loss of $26.8 million, or $0.26 per share based on 103.9 million fully-diluted weighted average shares outstanding, for the three months ended March 31, 2021.

Revenue for the quarter ended March 31, 2022 was $151.8 million, compared to $32.8 million for the quarter ended March 31, 2021. Revenue in the current period primarily relates to the recognition of $120 million upfront payment received under our collaboration agreement with GSK, and recognition of a portion of the upfront payments received from our license and collaboration agreements with Takeda and Horizon. The upfront payment for GSK was recognized as revenue entirely this quarter, as our performance obligations are substantially complete. Revenue for our collaboration agreements with Takeda and Horizon will be recognized as we

complete our performance obligations, which include managing the ongoing AAT phase 2 clinical trials for Takeda, and delivering a phase 1 ready candidate to Horizon. There remains $167.6 million of revenue to be recognized associated with the Takeda collaboration which we anticipate will be recognized over approximately 2-3 years, and there remains $20 million of revenue to be recognized for Horizon, which we anticipate will be recognized by the end of calendar 2022. Revenue in the prior period primarily related to the recognition of a portion of the milestones received from our license and collaboration agreements with Janssen and Takeda.

Total operating expenses for the quarter ended March 31, 2022 were $110.3 million, compared to $61.0 million for the quarter ended March 31, 2021. This increase is primarily due to increased clinical candidate costs as our pipeline has expanded and advanced through clinical trial stages, as well as increased compensation expense.

Net cash provided by operating activities during the six months ended March 31, 2022 was $1.4 million, compared with net cash provided by operating activities of $225.0 million during the six months ended March 31, 2021. The key driver of this change was the collection of the $120 million upfront payment from GSK in the current period, versus the collection of the $300 million upfront payment from Takeda in the prior period. We continue to estimate our operating cash burn to be $60 to $80 million per quarter in fiscal 2022, excluding any incoming milestone payments from our partners. In addition, we are expanding our manufacturing capabilities and our R&D facilities. Because these two projects have only recently begun, our capital expenditures in fiscal 2022 will be lower than originally estimated but capital expenditures will increase significantly next year.

Turning to our balance sheet, our cash and investments totaled $603.5 million at March 31, 2022, compared to $613.4 million at September 30, 2021. The decrease in our cash and investments was primarily due to cash used for operating activities, offset by the collection of the $120 million upfront payment from GSK in January 2022. Our common shares outstanding at March 31, 2022, were 105.7 million.

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

Chris Anzalone

Thanks Ken. And thanks to all of you for joining us today.

When markets go through cycles of intense pressure, as they are today, investors seek value. Each investor needs to define for themselves what value means, but I see value in a biotech company through several questions:

- Does the company have multiple potential drugs?
- Are those potential drugs built on a platform with known safety and activity parameters?
- Are those drugs addressing real unmet medical needs in a unique way?
- Does the company have sufficient capital and access to capital?
- Does the company have a track record of execution?
- Does the company have the ability and commitment to continued pipeline growth?
- Is the company focused on long-term growth and getting drugs to patients?

These may seem simple and straight-forward, but precious few companies our size can answer all these questions in the affirmative. I believe that we do, and by focusing on core principles such as these, Arrowhead is well positioned to do right by the patients we serve and create substantial value for our shareholders.

I believe we have a pipeline that is substantially larger than any company our size and larger than most companies several times our size. Everything we do is built on RNAi and the TRiM platform, both of which are increasingly validated clinically. Whether addressing chronic HBV, where it is thought that someone in the world dies every 30 seconds from complications of the infection, or cardiovascular disease, we are addressing clear unmet medical needs and we believe we are the first to use RNAi against every target we are going after. We have a strong balance sheet and, importantly, access to ongoing capital as our current partnerships mature and trigger milestone payments. We have demonstrated our consistent ability to move rapidly to the clinic and into later stage trials. Our pipeline continues to grow, with 3 new candidates entering clinical studies over the past 6 months alone and we expect more through the end of the year. While the current market dynamics are uncomfortable, we are laser-focused on getting our current and future drug candidates to the patients who need them and trust that this commitment will create substantial value for our shareholders.

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

Operator