ARROWHEAD PHARMACEUTICALS

Fiscal 2026 Second Quarter Conference Call – Prepared Remarks

May 7, 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 second quarter ended March 31, 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.

During the fiscal second quarter and the period since our last earnings call, we have continued to execute well against our commercial, R&D, and corporate goals. Arrowhead is now on the strongest footing of our history.

- We are commercial;
- We have clear line-of-sight to expand our commercial opportunities and footprint;
- Our pipeline is larger than ever;
- Our discovery capabilities are broader than ever; and
- Our balance sheet is stronger than ever.

This is an historic time for our company. We are uniquely positioned to deliver important medicines to the patients who need them and create substantial value for our shareholders.

Let's talk about some of our recent progress and begin with commercial. As you recall, the FDA approved REDEMPLO in November 2025 as an adjunct to diet to reduce triglycerides in adults with FCS. FCS is a severe, rare disease, with an estimated 6,500 people in the U.S. living with genetic or clinical FCS, characterized by TG levels that can be 10 to 100 times higher than normal. This leads to a substantially increased risk of developing acute, recurrent, and potentially fatal pancreatitis.

As we reported last quarter, the U.S. REDEMPLO launch was off to a strong start. That momentum has continued into the current quarter, and we are now seeing around 30 new prescriptions written each week. Greater than 400 prescriptions have been written since launch, and more than 10% of these have been for patients switching from our competitor's APOC3 inhibitor. Of course, each prescription needs to be fully adjudicated with payers before becoming paid claims, but we offer a robust Quick Start program to support these FCS patients in the interim. The volume of physicians writing prescriptions and the number of patients receiving REDEMPLO continues to exceed our initial expectations.

With respect to pricing, we updated REDEMPLO's U.S. wholesale acquisition cost, or WAC, to $45,000 per patient per year. This represents a premium to our competitor's WAC pricing. We believe this is appropriate given that clinical data suggest we have a clearly and demonstrably superior product in terms of TG reduction, safety profile, and convenience.

As part of the One-REDEMPLO unified pricing model, this price is intended to remain consistent across FCS and SHTG, if that indication is approved. We continue to see this strategy as potentially simplifying payer contracting and eliminating pricing complexity that could complicate future formulary negotiations. The response from payers to this strategy has been positive and our interactions to date have been productive.

Beyond the U.S., we secured positive regulatory action in four additional geographies for REDEMPLO in patients with genetically confirmed and clinically defined FCS. We received approvals from The Australian Therapeutic Goods Administration, The Chinese National Medical Products Administration, and Health Canada. In addition, the European Medicines Agency's Committee for Medicinal Products for Human Use adopted a positive opinion, recommending the approval of REDEMPLO. This is an impressive result achieved by our global regulatory team in a very short period, and further reflects the strength of our clinical data in FCS and the value that REDEMPLO offers to patients.

REDEMPLO will be available later this year in Canada and we anticipate it will be marketed independently by Arrowhead. Pending a marketing authorization decision from the European Commission, we expect to launch REDEMPLO later this year in select EU countries and likely in the UK as well. In Greater China, REDEMPLO will be marketed by Sanofi.

In addition to our regulatory team, the rest of the R&D organization has performed extremely well and has made progress in the broader portfolio. Our drive to expand our platforms in order to increase the number and types of diseases we can address continues, even as we grow as a commercial entity.

During the recent period we have made rapid progress across the pipeline, including programs targeting genes expressed in liver, skeletal muscle, adipose, CNS, and lung, as well as the first dual-functional siRNA designed to silence the expression of two genes with a single molecule. We believe the depth and breadth of our clinical pipeline is unmatched, and we expect to continue to lead the field in innovation. Importantly, many of these programs will have clinical readouts this year, so investors and others may start to properly value the broader pipeline.

As we look to near-term clinical data releases, we anticipate 4 important events.

- First, the Phase 3 SHASTA-3 and -4 studies of plozasiran in SHTG patients should be ready for top-line data release in Q3. This is an important read-out that will drive our anticipated supplemental NDA, or sNDA, as we seek to expand the population of patients we can treat with plozasiran. We expect to continue to see a favorable safety profile and substantial reduction in TGs, and we are cautiously optimistic that we could see an improvement in acute pancreatitis risk.
- Second, we expect to have early data from the ongoing Phase 1/2 study of ARO-DIMER-PA in patients with mixed hyperlipidemia in Q3. We believe this will be the world's first clinical data of a single RNAi molecule designed to simultaneously silence the expression of 2 proteins. If we see good reduction of PCSK9 and APOC3, and therefore reductions in LDL-cholesterol and TGs, we could have a very powerful and unique therapy for the roughly 20 million people in the US living with mixed hyperlipidemia. More broadly, the data could provide initial clinical proof of concept for our growing dimer platform and pipeline. Expect to see additional dual-functional dimers in the clinic in 2027.

- Third, we expect to have early data from the ongoing Phase 1/2 study of ARO-MAPT around the end of Q3 or early Q4. As you recall, this is our first candidate using our CNS platform designed to deliver RNAi molecules to the brain via simple subcutaneous administration. ARO-MAPT targets the Tau protein, which is increasingly validated for the potential treatment of Alzheimer's and other Tauopathies. We believe that positive early data could be substantially disruptive. It could represent a great leap forward in treating Tauopathies and, more broadly, open the door to using RNAi to treat a broad range of conditions from neurodegenerative disorders to obesity. If early ARO-MAPT data are encouraging, expect a substantial expansion of our CNS pipeline, beginning at the end of 2026.
- Fourth, we expect to provide clinical updates on ARO-INHBE and ARO-ALK7 throughout the second half of the year. Regarding ARO-INHBE, we plan to present additional data at various conferences and launch a P2 study. For ARO-ALK7, we expect to provide additional data from the ongoing Phase 1/2 study. We see these as potentially important therapies for metabolic disorders and represent our first steps into obesity and MASH. We expect to have additional candidates in this space by the end of the year and into 2027.

Moving on to financial and portfolio management. Arrowhead took important steps to ensure that we are properly funded to advance our commercial and development portfolio, and we also entered into a license agreement for a program that achieved clinical proof-of-concept but is not one that we wish to take forward. This is key to Arrowhead's strategy, since we are extraordinarily productive in discovery and early development but cannot commercialize everything independently. Let's talk about the steps we took.

First, we dramatically strengthened our balance sheet, allowing us to push multiple programs toward commercialization and potentially through multiple independent and partner launches. During the quarter we completed the largest fund raising Arrowhead has ever conducted. We closed concurrent public offerings of $700 million of 0% coupon convertible senior notes and $230 million of common stock. Both offerings were several times oversubscribed, reflecting investor confidence in our portfolio and our ability to continue to build value.

Second, and just this week, we announced an exclusive worldwide license agreement with Madrigal Pharmaceuticals for ARO-PNPLA3, Arrowhead's clinical stage program designed to treat a genetically-defined population of MASH patients. Under the terms of the agreement, Madrigal will make a $25 million upfront payment to Arrowhead. Arrowhead is also eligible to receive development, regulatory, and sales milestone payments of up to $975 million. Arrowhead is further eligible to receive tiered royalties up to mid-teens.

Madrigal's leadership in the MASH space makes it a natural and attractive partner to advance ARO-PNPLA3 into Phase 2 studies and toward potential commercialization. This transaction with Madrigal underscores Arrowhead's disciplined business development strategy, demonstrating our ability to partner high-potential, clinically validated programs with leading organizations.

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 five and a half months since the FDA approval of REDEMPLO on November 18, 2025, and we continue to be very pleased with the trajectory of the launch. Today I would like to cover five areas: prescription and patient dynamics, payer coverage developments, pricing strategy, commercial infrastructure expansion, and our international and SHTG outlook.

Let's start with prescription and patient dynamics. REDEMPLO's launch continues to build strong and consistent momentum. Through the fiscal second quarter ending March 31, 2026, we have seen prescriptions accelerating week-over-week, growing nearly 3-fold from the start to the end of the quarter. That momentum has continued into the current quarter, with total prescriptions written exceeding 400; representing over 40% growth over just the last four weeks alone.

The awareness and conviction driving this prescription growth are encouraging. REDEMPLO awareness among the prescribers who matter most has increased meaningfully. Critically, this awareness has translated into conviction: nearly all REDEMPLO prescribers surveyed report being satisfied or highly satisfied with the product, and REDEMPLO is perceived strongest on the efficacy outcomes FCS patients care about most — triglyceride reduction and acute pancreatitis risk reduction.

The patient mix continues to reflect what we expected. Approximately 85% of prescriptions are from patients naive to the APOC3 class — a strong signal that physicians are identifying and treating FCS patients who have never had access to an effective therapy. Switch patients largely account for the remainder.

Patient persistence data is equally encouraging. Refill activity is accelerating meaningfully — an important early validation of both clinical effectiveness and patient satisfaction with REDEMPLO's once-quarterly dosing profile.

Geographic distribution of prescribing is balanced across the country. This breadth of prescriber activation across all territories signals that patient identification capability is building at scale across the organization — not concentrated in a handful of high-volume centers — which gives us confidence in the durability of the prescription growth trajectory.

Turning to payer access, we are making meaningful and consistent progress. Our market access team has been actively engaged with the largest payers in the country, covering the vast majority of U.S. lives, to support continued patient access. These discussions are proceeding as expected and, in some cases, have already led to REDEMPLO's improved coverage. Additional formulary coverage decisions are expected in the coming months across both commercial and government segments.

A particularly important development in the payer landscape is the diagnostic pathway flexibility that major payers are recognizing. The coverage policies taking shape across major payers reflect both genetic testing and clinical criteria as valid routes to diagnosis. This is critical for ensuring that all appropriate REDEMPLO patients can access treatment — because a meaningful proportion of real-world FCS patients are clinically diagnosed rather than genetically confirmed, and policies that require genetic confirmation as a prerequisite would create an unnecessary and inappropriate barrier.

As Chris mentioned, we have made a proactive decision to reduce the list price of REDEMPLO to $45,000 per patient per year. This decision reflects our commitment

to optimizing market access for FCS patients and is consistent with our belief that a competitive and rational price point accelerates formulary decisions and reduces friction in the prior authorization process. We have always believed that REDEMPLO's clinical profile is best-in-class, and the $45,000 price point reflects a premium value supported by the clinical evidence.

With the FCS launch performing ahead of our expectations, and with potential expansion into SHTG on the horizon, we are making deliberate and sequenced investments to scale our commercial infrastructure.I will speak more on this in the future, but the field infrastructure we are building will be sized and structured for both the current expanded FCS accessible population and also the future SHTG opportunity as it unfolds in the future.

On international expansion, REDEMPLO received regulatory approval in both Canada and China in January and most recently in Australia last month. All three markets are currently in pre-launch phase as we work through the pricing and reimbursement frameworks in each country. We look forward to providing updates on those timelines as they develop.

Also last month, CHMP (the Committee for Medicinal Products for Human Use) recommended EU marketing authorization for Redemplo in Europe for FCS without requiring genetic confirmation. Consequently, we anticipate an EMA approval decision in the June to July timeframe. We intend to commercialize REDEMPLO directly in Europe, supported by contracted infrastructure which encompasses market access strategy, account management deployment, medical science liaison support, and broader stakeholder engagement including medical congresses and patient advocacy group engagement. We believe this model is the right approach for

Arrowhead and are pleased with the readiness of that team as we approach the anticipated EMA decision.

Finally, I want to comment on the SHTG program, which represents the most significant near-term value catalyst for the Cardiometabolic franchise.We are approaching what we expect to be a highly meaningful series of milestones. Top-line results from SHASTA-3 and SHASTA-4, our two registrational Phase 3 studies in severe hypertriglyceridemia, are expected in Q3. We head into the data readout with confidence grounded in the strength of REDEMPLO's established mechanism of action and the consistency of the APOC3 biology we have observed across our full clinical program to date. We also intend to present the data at a major medical congress, which we hope will be with a simultaneous publication in a top tier medical journal.

We then expect to file an sNDA with the FDA before the end of 2026, with an anticipated regulatory approval based on an expected standard review timeline targeted in second half of 2027. Additional regulatory filings in other jurisdictions are planned to follow thereafter.

The SHTG opportunity represents a patient population that is substantially larger than FCS, with over one million high-risk patients in the United States alone. The commercial infrastructure investments we are making for FCS today are also designed with that launch in mind.

In summary, the REDEMPLO launch is progressing well and continues to exceed our expectations across prescription volume, patient dynamics, and payer access. Physician satisfaction and forward prescribing intent are both extremely strong. Refill activity is accelerating. And we have a series of highly anticipated milestones

in the second half of 2026 that we believe will be transformative for the Cardiometabolic franchise and for Arrowhead.

With that, I'll turn the call over to James Hamilton to discuss the broader R&D portfolio.

James Hamilton

Thank you, Andy.

As Chris mentioned, we have a very broad pipeline with over 20 clinical programs, so I will focus on areas with upcoming readouts. First, I'd like to announce that we are planning to host three webcasts over the coming months as part of our R&D Webinar Summer Series. Each webcast will cover a specific aspect of our pipeline where we expect to have upcoming data readouts this year. These include:

1. Cardiometabolic, including plozasiran, zodasiran, and ARO-DIMER-PA;
2. Obesity, including ARO-INHBE and ARO-ALK7; and,
3. ARO-MAPT, including the blood-brain-barrier, or BBB, platform

I'll now give status updates from the quarter on these specific areas.

First, let's review the suite of Plozasiran Phase 3 studies, SHASTA-3, SHASTA-4, SHASTA-5, and MUIR-3, designed to support supplemental NDA filings to expand the REDEMPLO label beyond genetic and clinical FCS into patients with SHTG.

SHASTA-3 and SHASTA-4 together enrolled over 750 patients and have a primary endpoint of change in triglycerides from basline, with a key secondary endpoint of acute pancreatitis rates. MUIR-3, which enrolled over 1400 patients, is designed to supplement the SHASTA studies with additional patient safety data. We are also enrolling patients at high risk of acute pancreatitis in SHASTA-5 to directly assess the ability of plozasiran to reduce the risk of acute pancreatitis as the primary endpoint. Should SHASTA-3 and -4 show a statistically significant improvement in acute pancreatitis risk, we will re-assess whether there is added value in continuing SHASTA-5.

We remain on schedule to complete the blinded portion of the SHASTA-3, SHASTA-4, and MUIR-3 in mid-2026 to support a planned topline data readout in the third quarter. This would further support our plans for an sNDA submission for SHTG before the end of this year.

Before moving on to zodasiran, I'd like to highlight a presentation we made with new long-term efficacy and safety data for plozasiran across a spectrum of patients with hypertriglyceridemia at the American College of Cardiology conference in March.

The data were from a two-year open-label extension of the two Phase 2b double-blind, placebo-controlled studies of plozasiran: SHASTA-2, conducted in adults with severe hypertriglyceridemia, and MUIR, which enrolled patients with hypertriglyceridemia.

During the two-year open label extension, patients saw median reductions in their triglycerides of 83% in sHTG patients from SHASTA-2 and 67% in HTG patients from MUIR, with additional reductions in remnant and non-HDL-cholesterol.

Ninety six percent of sHTG patients achieved TGs below 500 mg/dL and 63% achieved TGs below 150 mg/dL, with 93% of HTG patients achieving TGs below 150 mg/dL. Importantly, no adjudicated acute pancreatitis events occurred in any patient receiving plozasiran during the 2-year Phase 2b Open-Label Expansion (OLE) Study.

These findings support the potential of plozasiran as a promising new approach to managing patients with moderate to severe HTG phenotypes who are at risk of AP and potentially other cardiometabolic comorbidities.

I now want to give a quick update on the YOSEMITE Phase 3 study of zodasiran, which is being developed as a potential treatment for homozygous familial hypercholesterolemia, or HoFH, a rare genetic condition that leads to severely elevated LDL-cholesterol and early onset cardiovascular disease. Zodasiran is the fourth investigational RNAi-based candidate developed by Arrowhead to reach late-stage pivotal studies.

YOSEMITE is designed to enroll approximately 60 individuals with HoFH over the age of 12, who will be randomized (2:1) to receive 5 doses of 200 mg zodasiran or placebo. The primary endpoint is the percent change from baseline to month 12 in fasting LDL-C.

Enrollment has been on track and we are confident that the study can be fully enrolled this year to enable study completion and potential NDA filing before the end of 2027.

The last program within cardiometabolic is ARO-DIMER-PA, the first dual-functional siRNA designed to silence the expression of two genes with a single

RNAi molecule. ARO-DIMER-PA is being developed as a potential treatment for ASCVD due to mixed hyperlipidemia by silencing expression of both PCSK9 and APOC3.

In January we initiated a Phase 1/2a placebo-controlled dose-escalating study to evaluate the safety, tolerability, pharmacokinetics, pharmacodynamics, and effects on LDL-Cholesterol and triglycerides using single-dose ARO-DIMER-PA in part 1 and multiple doses in part 2, in up to 78 adults with mixed hyperlipidemia.

Enrollment in this study has been rapid, and we are on schedule to have sufficient data to provide the first clinical readout in Q3 of 2026. This is a very interesting program, and we think the preclinical data have been highly compelling. We have some innovative ideas on later-stage trial designs that potentially accelerate the path to regulatory approval, so we are eager to have a first clinical readout to start moving ahead with later studies, if supported by initial data.

Lastly, I want to give an update on the status of the ARO-MAPT first-in-human study. ARO-MAPT is being developed as a potential treatment for tauopathies including Alzheimer's disease, a progressive neurodegenerative disease characterized by cognitive and functional decline. Alzheimer's disease is the most common cause of dementia, affecting an estimated 32 million people worldwide, and is part of a group of neurodegenerative diseases called tauopathies that are marked by the abnormal tau accumulation and formation of tau tangles in neurons. Tau related pathology may be a critical driver of neurodegeneration, and targeting tau is a promising strategy to potentially slow or stop cognitive and functional decline.

ARO-MAPT is Arrowhead's first investigational RNAi-based therapy to utilize a new proprietary delivery system which, in preclinical studies, has achieved blood-brain-barrier penetration and deep knockdown of target genes across the central nervous system, including deep brain regions, after subcutaneous injection. This underscores Arrowhead's leadership in the delivery of siRNA to multiple tissues and cell types throughout the body utilizing our proprietary and differentiated Targeted RNAi Molecule, or TRiM, platform.

In December 2025 we dosed the first subjects in a Phase 1/2 clinical trial of ARO-MAPT. This study is a placebo-controlled dose-escalating study to evaluate the safety, tolerability, pharmacokinetics, and pharmacodynamics of ARO-MAPT in up to 64 healthy subjects and up to 48 patients with mild cognitive impairment due to Alzheimer's disease and mild Alzheimer's disease dementia. In Part 1a of the study, healthy subjects will receive one or three weekly doses of ARO-MAPT or placebo by subcutaneous injection. In Parts 1b and Part 2 health volunteers and Alzheimers disease patients respectively will receive multiple escalating doses of ARO-MAPT or placebo.

We are nearing completion of enrollment of the single-dose portion of the study in healthy volunteers and have begun enrollment in the multi dose cohorts in both healthy volunteers and patients with Alzheimer's disease. This keeps us on pace for an initial data readout at the end of Q3 or early Q4.

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 March 31, 2026 was 132.7 million dollars, or a loss of 93 cents per share, based on 142.4 million fully diluted weighted-average shares outstanding. This compares to net income of 370.4 million dollars, or $2.75 per share, for the quarter ended March 31, 2025, based on 134.5 million fully diluted weighted-average shares outstanding in that quarter. Recall that in the prior year quarter, we recorded over $540 million dollars in revenue solely related to the Sarepta transaction executed at that time.

Revenue for this quarter totaled 74 million dollars, driven primarily by our license and collaboration agreements with Sarepta and with Novartis. Of this amount, approximately 42 million related to the Sarepta collaboration. This includes 28 million from ongoing recognition of the initial Sarepta consideration, 10 million related to reimbursement of incurred pre-clinical collaboration program costs, and 4 million for clinical supply provided to them under a clinical supply agreement. In addition, we recognized 20 million of the 200 million dollar upfront payment received from Novartis in October under that agreement, bringing year to date recognition of the Novartis upfront to 54 million, with the remaining 146 million dollars to be deferred over time as we fulfill our preclinical obligations. We also recorded $11 million related to the Asset Purchase Agreement between Sanofi and Visirna, our majority owned subsidiary in China, to develop and commercialize investigational Plozasiran in Greater China, almost entirely due to the January approval of FCS in that region by the Chinese National Medical Products Administration.

As mentioned previously, we are not intending to headline specific REDEMPLO product sales numbers until such time as they become a meaningful driver to our financials. That said, net sales can be derived from our disclosures.. as the

difference between total net revenue and collaboration revenue, and represents approximately $1 million for the quarter. This is our first full quarter of REDEMPLO sales and, on a unit basis, that figure compares favorably to the first full commercial quarter of the other approved APOC3 inhibitor.

Turning now to expenses, total operating expenses for the quarter were approximately $215 million, roughly flat with operating expenses in the first fiscal quarter. This compares to $162 million in the prior-year quarter, representing an increase of $53 million year over year. This increase was driven by $40 million of higher R&D expenses and $13 million of higher SG&A expenses… fully in line with our expectations.

The increase in R&D expense was primarily attributable to ongoing progression of our Phase 3 registrational studies for plozasiran in sHTG as well as our early-stage pipeline programs including the DIMER and MAPT. Fiscal year to date, almost two thirds of the clinical trial spend can be attributed to our Plozasiran phase three studies. As James already mentioned, the registrational sHTG studies for Plozasiran should readout in the summer, and clinical trial spend for these programs should thereafter moderate accordingly.

SG&A expenses increased year-over-year compared to the prior year's second fiscal quarter, primarily driven by ongoing investments to support the commercialization of REDEMPLO. As previously discussed, we are continuing to build our commercial capabilities to fully support the FCS launch. We continue to leverage and invest in these capabilities to support REDEMPLO in FCS, while also positioning the organization to support potential future launch in sHTG. And we expect ultimately to leverage these same capabilities for the advancement of zodasiran for the treatment of HoFH.

Turning to the balance sheet… cash and investments on hand totaled nearly $1.8 billion as of March 31, 2026. Common shares outstanding at quarter end were 140.6 million.

In this quarter alone, we brought in over one billion dollars including approximately $850 million, net, from our January financing transactions, consisting of a concurrent offering of zero percent convertible senior notes and common stock, along with associated capped call transactions. Other notable inflows in the quarter include the $200 million received from Sarepta upon achieving the second DM1 program milestone, as well as a $50 million anniversary payment under the Sarepta long-term collaboration agreement.

All of this is very much in line with the information provided previously during our February earnings call.

We believe our strong balance sheet provides us with significant financial flexibility to support ongoing clinical development, to advance current and future commercialization activities, and to execute against our long-term strategic priorities.

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

Chris Anzalone

Thanks Dan.

As we build out our commercial team and focus on efficiently bringing REDEMPLO to the patients who need it, we have not lost sight on continuing to expand our pipeline and ultimately increasing the number of medicines we can offer to a wide variety of patients. Our business has become more complex as we grow in all these areas, but we continue to innovate and execute well. We see multiple key potential value creating events in the second half of 2026 that, together, speak to our priorities.

Here are just a few of the events we are tracking:

- SHASTA-3, SHASTA-4, and MUIR-3, which is the suite of Phase 3 clinical studies designed to support an sNDA for REDEMPLO in patients with SHTG, is on schedule for completion and topline readout in Q3.
- The first clinical readout for ARO-DIMER-PA, targeting both PCSK9 and APOC3, for LDL and TG lowering is also expected in Q3.
- The first clinical readout for ARO-MAPT is expected around the end of Q3 or early Q4. It is being developed as a potential treatment for tauopathies including Alzheimer's disease, and is our first program using the CNS delivery platform designed to cross the blood-brain-barrier after systemic delivery via subcutaneous administration.
- Additional ARO-INHBE and ARO-ALK7 data releases are planned in 2026 for this novel non-incretin strategy which had quite encouraging early data, particularly in diabetic obese patients in combination with tirzepatide and with liver fat reductions as mono-therapy or in combination with tirzepatide.

As James mentioned, we are planning to webcast three presentations as part of our Summer Series of R&D Webinars to go over cardiometabolic broadly, obesity, and

ARO-MAPT. These can serve as a review of the programs and results to date, and as a primer for the potentially important readouts coming up later this year.

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

Operator