CLOSER LOOK

MEMORANDUM

Zealand 1Q26 – Positive topline phase 2 results for petrelintide announced, advancing to phase 3 trials in 2H26; combination phase 2 trial of petrelintide + enicepatide (CT-388) to launch in 1H26; full results of survodutide expected at ADA 2026 – May 7, 2026

Executive Highlights

- **Zealand presented its 1Q26 results today in a call led by CEO Dr. Adam Steensberg and CMO Dr. David Kendall** – see press release, presentation slides, workbook, and webcast.
- **Petrelintide (long-acting amylin analog)**, which is being co-developed and co-commercialized with Roche under a partnership initiated in March 2025, continues to be evaluated for obesity. In March 2026, Zealand and Roche announced positive topline results of the phase 2 ZUPREME-1 trial (n=493) of petrelintide in people with overweight or obesity and without T2D. The trial met its primary endpoint, with all five petrelintide doses demonstrating significant weight loss at Week 28. Based on these results, in April 2026, Zealand and Roche announced plans to advance petrelintide into phase 3 trials in 2H26. Full results of the ZUPREME-1 trial will be presented at ADA 2026.
    - **Topline results from the phase 2 ZUPREME-2 trial** (n=221) in people with overweight or obesity and T2D will be expected in 2H26. In 4Q25, Zealand shared that the trial had completed enrollment as of November 2025.
    - **Zealand and Roche also plan to advance petrelintide and enicepatide** (formerly known as CT-388) to a phase 2 trial in 1H26. This trial will assess the efficacy of an amylin and GLP-1/GIP fixed-dose combination for people with overweight or obesity.
- **Survodutide (dual glucagon/GLP-1 RA),** developed in partnership with Boehringer Ingelheim, continues to be **investigated for obesity and overweight in the phase 3** SYNCHRONIZE **program and for MASH in the LIVERAGE program**.
    - In April 2026, BI/Zealand announced positive topline results from the phase 3 SYNCHRONIZE-1 trial (n=725) of survodutide in people with overweight or obesity and without T2D. In the trial, survodutide conferred 16.6% weight loss compared with 3.2% with placebo at Week 76, assuming full treatment adherence. Full results from SYRNCHRONIZE-1 will be presented at ADA 2026.
    - Survodutide continues to progress in the broader SYNCHRONIZE program: (i) SYNCHRONIZE-2 trial (n=756) of survodutide in people with overweight or obesity with T2D was completed in March 2026; (ii) SYNCHRONIZE-CVOT trial (n=5,531) evaluates long-term CV outcomes, expected to be completed next month; (iii) SYNCHRONIZE-MASLD (n=218) of survodutide for overweight and obesity with MASH was completed in December 2025. **Results will be presented this year.**
- **While not mentioned on today's call, in 4Q25, Zealand announced it would reactivate the development of its in-house ZP6590, a GIP analog.** Management previously highlighted ZP6590 as a future combination partner with petrelintide to enhance sensitivity and adipose tissue biology, rather than as a standalone monotherapy.
- **In March 2026, Zealand announced its establishment of a new research hub in Cambridge, MA,** to expand its global discovery and strengthen its presence in the US metabolic ecosystem. The site will serve as Zealand's primary location in the US, expected to be operational by 2026.

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Pipeline Highlights

1. Petrelintide to advance to phase 3 trial in 2H26; combination phase 2 trial with enicepatide (CT-388) expected in 1H26

In March 2026, Zealand and Roche announced positive topline results of the phase 2 ZUPREME-1 trial (n=493) of petrelintide, a long-acting amylin analog, in people with overweight or obesity. The trial met its primary endpoint, with all five petrelintide doses demonstrating significant weight loss at Week 28. At Week 42, petrelintide led to 10.7% weight loss compared to 1.7% with placebo. Importantly, petrelintide demonstrated a placebo-like tolerability profile even at the most efficacious doses. Based on these results, in April 2026, Zealand and Roche announced plans to advance petrelintide into phase 3 trials in 2H26. Full results of the ZUPREME-1 trial will be presented at ADA 2026.

- **During Q&A,** management commented on the titration and duration of the upcoming phase 3 trial. Management explained that, given that the FDA requires one year of treatment at the marketed dose, there must be a balance between expediting the trial with fewer dose-escalation steps and ensuring adequate duration to achieve maximum weight-lowering effects. The company expects the length of the phase 3 trial for petrelintide to fall between 60 and 78 weeks.

Zealand and Roche also plan to advance petrelintide and enicepatide (formerly known as CT-388) to a phase 2 trial in 1H26. This trial will assess the efficacy of an amylin and GLP-1/GIP fixed-dose combination for people with overweight or obesity. As background, CT-388 is a candidate that Roche added to its pipeline in December 2023, following its acquisition of Carmot Therapeutics.

- **During Q&A, management spoke on where petrelintide might fit** into the obesity market, specifically as part of the amylin treatment class. The company is excited about the opportunity to not only develop petrelintide as a monotherapy but also as a combination treatment that offers a "number of opportunities to move into other segments of patients." The phase 2 combination trial has been designed to uncover answers to the right profile of the drug and target unmet needs among people with obesity and comorbidities. Therefore, the company does not have specific thresholds at the moment.

Furthermore, Zealand and Roche expect to report topline results from the phase 2 ZUPREME-2 trial (n=221) in people with overweight or obesity and T2D in 2H26. In 4Q25, Zealand shared that the trial had completed enrollment as of November 2025.

As a reminder, Zealand and Roche are co-developing and co-commercializing petrelintide and petrelintide-based

combination treatments from a partnership initiated in March 2025. The companies will have a 50/50 profit sharing on both monotherapy and combination treatments. Of note, in Zealand's presentation slide, the company announced $700 million in milestone payments in 2026, including $575 million (of total $1.2 billion) in development milestones and $125 million (of total $250 million) in anniversary payments. Moreover, Zealand will pay Roche $350 in four installments throughout 2026-2027 for CT-388.

2. Full phase 3 readouts for BI/Zealand's survodutide (dual glucagon/GLP-1 RA) expected at ADA 2026

Boehringer Ingelheim (BI) and Zealand have partnered on the development of survodutide, a dual glucagon/ GLP-1 RA, advancing it into clinical trials for obesity and overweight in the phase 3 SYNCHRONIZE program and for MASH in the LIVERAGE program.

In April 2026, BI/Zealand announced positive topline results from the phase 3 SYNCHRONIZE-1 trial (n=725) of survodutide in people with overweight or obesity and without T2D. In the trial, survodutide demonstrated 16.6% weight loss compared with 3.2% with placebo at Week 76, according to the efficacy estimand (assuming full treatment adherence). Furthermore, 85% of the survodutide group (compared to 39% with placebo) achieved ≥5% weight loss at Week 76. Survodutide also conferred significant reductions in fat mass and waist circumference. Full results from SYRNCHRONIZE-1 will be presented at ADA 2026.

- In today's call, management explained that initial analyses indicate that weight loss with survodutide was predominantly driven by the loss of fat tissue, with lean mass contributing only a small proportion of total weight loss. Management expressed excitement about these findings, as they demonstrate the potential of survodutide to improve metabolic health beyond weight loss alone.

Survodutide continues to progress in the broader SYNCHRONIZE program. Results from this program will support the regulatory submission of survodutide.

- The SYNCHRONIZE-2 trial (n=756) of survodutide in people with overweight or obesity with T2D was completed in March 2026. Management said results are expected at an undisclosed scientific meeting in 2026.
- The SYNCHRONIZE-CVOT trial (n=5,531) is also active and will evaluate long-term CV outcomes in participants with obesity and established CVD/CKD or risk factors for CVD. The study completed enrollment in 1Q25 and is expected to be completed next month. Management said results are expected at an undisclosed scientific meeting in 2026.
- The SYNCHRONIZE-MASLD (n=218) of survodutide for overweight and obesity with MASH was completed in December 2025. During Q&A, management said the company positions survodutide as a potential preferred treatment option in populations with obesity and MASH. Full results from this trial will be presented at ADA 2026.

Zealand is also evaluating survodutide in phase 3 trials for MASH.

- The LIVERAGE (n=1,800) trial of survodutide in MASH with moderate or advanced fibrosis (stage 2 or 3), expected to complete in December 2031. The trial is located across 524 sites, including those now recruiting participants.
- The LIVERAGE-Cirrhosis (n=1,590) trial of survodutide in MASH with compensated cirrhosis (stage 4 fibrosis), expected to complete in June 2029. The trial is located across 443 sites, including those now recruiting participants.

3. Development of ZP6590 (GIP analog) as a future combination treatment with petrelintide

While not mentioned in today's call, Zealand's pipeline includes ZP6590, a GIP analog for obesity. In 4Q25, management announced plans to reactivate the development of ZP6590 as a combination therapy with petrelintide, rather than a monotherapy for weight loss.

- Previously, at WCIRDC 2025, Zealand described ZP6590 as a candidate that could: (i) improve tolerability and adipose insulin sensitivity; (ii) reduce ectopic fat accumulation; and (iii) enhance metabolic flexibility.

- In 4Q25, management highlighted emerging evidence that GIP analogs can enhance insulin sensitivity and that amylin and incretin combinations can improve outcomes in complex metabolic disease. Management also shared that a phase 1 first-in-human trial is planned for 2026.

Close Concerns' Questions

1. To what extent does Zealand imagine the combination of petrelintide and enicepatide will further drive weight loss?
2. How does Zealand plan to approach its first regulatory submissions of survodutide in 2027? How is the company preparing for this milestone?
3. Does Zealand plan to initiate other partnerships to strengthen its pipeline for obesity and MASH?

Analyst Q&A

On petrelintide

Q (Kirsty Ross Stewart, BNP Paribas): On the upcoming phase 3 petrelintide trial, FDA guidance requires one year of treatment or the maximal dose in a phase 3 trial. Given you're expecting to reach the maximal dose in three steps, are you planning on running a 60-week trial and being able to narrow the gap versus Lilly on an additional titration step? Are there any other trial acceleration efforts that you're looking at using to kind of bring up that launch timeline?

Secondly, on the broader market, it's fair to say that the orals are exceeding initial market share expectations. It's maybe 15% of the US script volumes already going to the orals. So, just interested in your view on the importance of developing an oral asset, and perhaps maybe Paul can comment on the priorities for the pipeline efforts, how fast the list is developing in oral, and what, if anything, is visible on the priority list.

A (Dr. Adam Sinding Steensberg, President & CEO): I can assure you that we are doing a lot of things to accelerate the program together with our partner Roche, as we are very aware of the importance of speed to market. When you are building a new category, as we aim to do with the between side. We have a lot of effort in that one. When it comes to oral therapies, as we also announced at our Capital Markets Day, we are now collaborating with external parties on small molecules, and we are also exploring, broadly speaking, opportunities for all therapies with Amylin.

As a company, we are actually more excited about that opportunity in the future. So it's of course something we are investing in, and we are also excited to see how the latter, the ones that are taking off now. We need a few more months to see if they are or not, and how they are going to shape the market going forward. But it's an important thing to remember that in most patients, after a certain time, they will be off treatment with the phase one phase therapy.

So if anything, it will actually just, you can say, expand the number of patients who have been exposed to a 31 and also lived through some of the difficulties on the one hand, and thus expand the market opportunity for a novel category as we are developing with the petrelintide.

As to duration, you're right about the regulatory requirements for one year of exposure at the to be marketed treatment dose. And obviously, there is a balance between achieving that as rapidly as possible. One thing that helps you expedite phase 3 execution is fewer dose-escalation steps. On the other hand, you want an adequate duration to ensure that you reach the maximal weight-lowering effects. And as we've seen more broadly in the weight management space, some trials run beyond 60 weeks, up to 78 weeks, are the norm.

But to your second comment about triggers for speed, obviously, the sooner you can get to maintenance or the to-be-marketed treatment dose, the more rapidly you get the last patient's last visit. But that will be balanced not solely by the regulatory requirements, but also by looking to achieve the final nadir in weight reduction. That's possible. And again, those time intervals I quoted are the ones that are under consideration for our phase 3 program.

To add to Adam's comment, Kirsty is on orals. Obviously, one of these efforts is our announced partnership with OTTR, on which we're working with a number of potential oral assets, given the uptake. Certainly, we see the opportunity. It is

also our mind, however, that having efficacy and tolerability that mimic as closely as possible what is achieved with the peptide therapies.

Noting that if, for example, an oral amylin is achieved, we would expect the comparable efficacy and continued or even greater safety and tolerability profile. So work is underway on all fronts for potential oral assets as well. Thank you. Thanks very much.

Q (Kelsey Lucerne): We've seen companies in the field conducting studies to better position themselves for the maintenance market, done through independent phase 3 trials like the ATTAIN, MAINTAIN, or MariTime studies, which study or incorporate maintenance regimens into an open-label extension portion. So, as you prepare to launch the phase 3 program for petrelintide, what's your strategy to generate maintenance data to maximize the asset value?

A (Dr. Steensberg, President & CEO): Because this is the big dilemma in the current market that most patients fail to stay on the two other ones and thus never will get to experience the health benefits of the weight loss and the benefits of getting to these therapies. So we have a keen focus, of course, with Petrelintide and Opportunity. Now, to develop a medicine that can be used not only as a weight loss agent, but also as a chronic therapy, as they should be used in this category. It's too early for us to comment on the specific trial elements of our studies in more detail. But rest assured, once they get up and running, you will all get the insights, the program. It's a very ambitious program.

It's again the intent we have with this molecule is to, as David and I also shared in our prepared remarks, develop petrelintide as a first-choice medicine. If you consider a patient who thinks about going on a weight loss journey and an interaction with a health care prescriber. If you look at other chronic therapy areas, most patients are always exposed to the most tolerable approach that has a good chance of getting them to go. And that is our ambition with Petrelintide to make it a first-choice therapy that can help most patients get to the goal they are looking for.

And then, of course, as important, we need to make sure that patients also stay on therapy, so they don't lose the benefits of that weight loss. So, we will focus on both parameters in our program and look forward to providing further updates as we get these trials up and running.

Q (Alexandra Hammond, Wolfe Research): As you think about the phase two readout for petrelintide and CT-388 combo, is there a specific efficacy threshold that the combo needs to clear to justify moving into phase 3? How does tolerability kind of factor into that bar? Is there a scenario where a modest efficacy gain over a monotherapy is sufficient for that, if it can kind of preserve petrelintide efficacy, tolerability profile?

A (Dr. Steensberg, President & CEO): We are highly excited about the opportunity to not only develop between that as a monotherapy, as a first-choice therapy for the many whom we're looking for, that double-digit weight loss and a very benign ADC profile with the combination product. I think we actually believe we have a number of opportunities to move into other patient segments. Of course, there are still patients who need the highest weight loss. Those who would historically be candidates for bariatric surgery, for instance, as well as people living with obesity and type two diabetes at the same time, as David alluded to, a combination of 2 to 1 in memory, and could actually be a very interesting opportunity for such patients.

So I would say the phase two design that we know we're initiating now has been designed so we can actually get some answers to what the right profile of the drug is, and then targeting those specific needs. So I would say we don't have specific thresholds. We will, as we did with the twins. I'd look for the profile of the drug, and the specific patient needs in that portfolio of opportunities that we're developing with the patients who live with obesity and co-morbidities at the same time.

Q (Romi, Van Lanschot Kempen): Just wondering where ultimately you see petrelintide fitting into the general obesity market and more specifically within the amylin class based on the data we have to date. And secondly, I think you already mentioned this in the previous answer, but can you confirm your weight loss expectations for petrilintide for the phase 3 study?

A (Dr. Steensberg, President & CEO): I think when we at least look at the future obesity market, and when we base our market research on what we do with patients and other stakeholders in the market. It's important to recognize that obesity is a chronic disease. And for an individual patient, it's often a journey when you start a weight-loss program towards the objective of losing some weight. If you look at other chronic diseases where there are multiple options in the

diabetes, hypertension, and lipid-lowering spaces, most patients are often started on the most tolerable approach.

And then, after a few months, they will have an interaction with the health care provider to discuss whether they are on the right trajectory to achieve their goals. Has that changed, or are they not moving at the speed they are considering? If they are not, then you can start to have a conversation about whether we should make a change. And then you would often go to the more cumbersome, perhaps even slightly more effective tools, but you don't stop patients with the most cumbersome that you will just because it can provide a slightly more average weight loss. So this is why we can say the way we view this is that, and why we keep saying this is the first choice.

This is the logical first choice. The profile of petrelintide is what we have called the sweet spot: you can deliver double-digit weight loss with a selectivity profile. In phase 2, at the maximum effective dose, the effects were similar to placebo. The other thing which we think is you need to appreciate also, as we get into a mogotrade a new category, it's not just about effect and tolerability, it's also the experience that you have being on a drug. And as Dave had mentioned many times, Amylin works in a very distinct way.

By making people feel full faster. It doesn't affect your appetite to the extent that it will. It helps you feel full, fat that once you start eating, and we think it will add to the overall better experience of being on an Amylin and thus again serve that need as a first choice. I would like to further build on this.

If you are a patient who has spent, let's say, 30 years becoming morbidly obese or having a very high BMI, you don't need to solve that in two or three months. This is a journey that should be solved over a longer period. But still, it's a natural place to start with a product profile like petrelintide, if you then need more, that's where you turn to a combination product, as we are doing with petrelintide. And that's, that's the logical approach to treating patients in a more mature market.

That's why we continue to say that we are super excited with the profile that we saw because we actually expect that the upsurge between sites would be even better tolerated than what we have seen in the Phase one studies in a large cohort of patients, also having exposed patients to higher doses, which will not be carried forward into phase 3. But we do a lot to ensure safety around it. And so when we move into phase 3, we do expect to see, as David also alluded to earlier, higher weight-loss numbers as we enroll more female patients, run the study for longer, and address a few of the other trial-specific elements of the Phase two study. So we are very confident that we will get a profile of a drug that addresses the excess sector. What patients are looking for. And when you do market research, you will also hear that one in five patients is looking for weight loss of less than 10%. And four out of five patients are looking for a weight loss of less than 20%. The average weight loss patients experience, as anticipated in the real world today, is around 12%.

It's not the 22% or even higher numbers that people like to talk about. So we believe we have a product that speaks directly to what patients want. And the tolerability profile is so favorable that it would be considered a first-choice medicine if and when it reaches the market. Thank you.

Q (Mohit Bansal, Wells Fargo Securities): As payers increasingly focus on real-world adherence and durability. What evidence do you think you need to demonstrate that better tolerability translates into improved persistence independent of pricing and out-of-pocket cost sensitivity?

A (Dr. Steensberg, President & CEO): As we launch the petrelintide in the future, it will be incredibly important to collect real-world evidence for stay time for these medicines and use them as arguments for why you can actually provide additional value to society, and demonstrate that patients actually stay on therapy for longer. So that will be, of course, an important argument in this. I think, in this study, 98% of patients reached the top dose. So it's not that we don't actually consider that you need to titrate the amylin as you did in year one.

It's more about escalating. And if you look at the early data we released, even the lower doses, patients can expect quite significant weight loss. So it's a major difference here between the two other ones and the Amylin's, at least with petrelintide, it feels that if you believe that patients will be able to follow the escalation steps without having to individualize the titration for every patient, which will simplify the prescription, and in the real world, compared to what we see with the other ones today.

And we know with all of these centrally acting agents that dose escalation is an important part of the overall experience, given that in dose group three, you would have a limited number of dose escalation steps. That means you get to the maximally effective dose, not only in a high proportion of individuals, but at an earlier point in time. As regards to your

comment on switching, little is known. There were many studies many years ago with pramlintide and exenatide, where switching did occur because these are two distinct receptor families, and GLP-1 and amylin-based therapies act through these different systems.

It is anticipated that, if one switches from one to the other, a dose-escalation scheme that honors the newest therapy would be clinically appropriate. But obviously, that persistence studies the things you allude to in the real world will all be part of our consideration for a robust phase 3 program and beyond. To better understand how we can make the experience for patients, those living with obesity, their providers, and the pharmacists? All who are involved in this value chain, to make this the best experience possible? And again, simplicity with tolerability is only part of that story.

On survodutide

Q (Rajan Sharma, Goldman Sachs International): What are you looking for in SYNCHRONIZE muscle data presentation at ADA, which might give you incremental confidence in survodutide profile, both in MASH and obesity? And what do you think will be an acceptable discontinuation rate? Thank you. Thank you, Ross. And maybe just to start with Survodutide, I think we, of course, look very much forward to seeing the presentation of the full data on the specifics of losing fat versus muscle that was highlighted in the qualitative statement in the release.

You cannot underestimate the value, not only from the prescriber perspective, but also in terms of the health you can generate by mostly losing liver and visceral fat and then preserving muscles. But I think it's also something that will speak directly to the patients. If you have a product that can actually target the weight loss to the abdominal visceral and liver fat and protect the muscles to some degree. So that is, of course, a very important data set.

A (Dr. Steensberg, President & CEO): I think this is, you know, very simply a clinical assessment without biopsy to determine the suspected presence of liver disease, something that will obviously be quite common in the clinic. As a former practitioner, seeing a significant number of patients with diabetes coexisting, overweight and obesity, and abnormal liver function studies, this will be the first glimpse, if you will, into the potential without pursuing a liver biopsy, which is required in the LIVERAGE program and is the endpoint for indication seeking in that LIVERAGE program. But I think it will be a great bellwether of the potential of the LIVERAGE program to deliver and provide clinicians the confidence that, should they see patients who meet those clinical criteria, survodutide can and likely will be a preferred alternative to the petrelintide question and higher dose.

As you well know, phase two clinical trials are dose-ranging trials, and we saw significant reductions in body weight at each of the top three doses in exposure groups three, four, and five. It is unusual for one to reach a therapeutic efficacy plateau without tolerability limitations. So, in contrast to many incretin-based therapies, where dose-limiting events may occur due to tolerability issues or, in the case of GLP-based therapies, an increase in heart rate, we were able to achieve maximum efficacy at the dose, as shown in the top-line results. But the other two higher doses showed no greater abnormalities than either tolerability or new safety signals, which gives us great confidence in the safety margin at the maximally effective dose, following the mid-range or dose group three.

You could anticipate that if that is the maximally effective dose, it will be taken into phase three. We now also have, you know, nearly 150 individuals exposed to even higher doses with comparable safety and tolerability, which gives us great confidence in the safety margins of what is likely to be the maximally effective dose. Expect that and the details, obviously, on the full dataset will be available during the presentations at the American Diabetes Association Scientific Sessions.

Q (John, UBS): With the phase 3 muscle data for survodutide coming at ADA and the ongoing phase 3 MASH trials across F2 as in F4, could you outline the major differences between patients that you enroll for muscle to MASH trials? How much read across do you expect for muscle to match, and are there any biomarkers, subgroup analysis, or secondary endpoints for muscle that could be informative for fibrosis improvement, especially in F4 MASH?

A (Dr. Steensberg, President & CEO): BI is running the program, and we are entitled to a high single to low double digit royalties and outstanding milestones of around €350 million, and we cannot comment on the specifics for either the data that is going to be presented at the ADA here in June.

We also know, and I think that's been clear for a very long time, that they are extremely committed to the massive program with LIVERAGE one and two, where they are enrolling close to 3500 patients, both in 24. So it's two programs, one in obesity and one in MASH that they are highly committed to. And as I also alluded to in my prepared remarks, with this coming out of this quarter, where we have had phase two data for petrelintide and the decision to move into phase 3, which provides clarity on the near-term milestones from that program.

But as important, the phase 3 readout from survodutide has created a lot of clarity on our future revenue streams and de-risked, you can say, our operations, and added to our very strong financial position.

-- *by Esther Min, Kat Moon, and Kelly Close*