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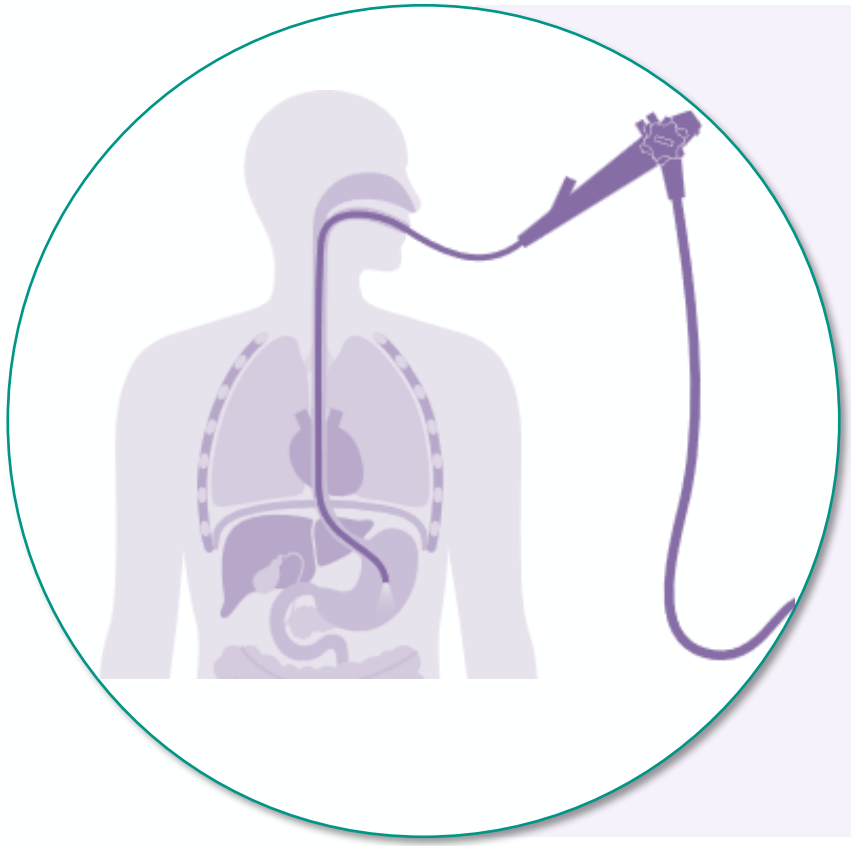
Upper Endoscopies and EoE Patients

Understanding how EP-104GI administration fits within Clinical Practice

July 2026

NASDAQ: EPRX

EP-104GI Administration Aligns with EoE Standard of Care



EP-104GI

- Novel long-acting fluticasone propionate formulation
- Currently investigated for the treatment of eosinophilic esophagitis (EoE) as a once yearly administration
- Encouraging efficacy and safety data indicating potential for a once-a-year therapy
- Injected in the esophageal wall during an **annual routine endoscopy**

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Agenda

- **Introduction**
  - **Jeymi Tambiah, MBChB, FRCS, MS, FAPCR, FFPM**
    Chief Medical Officer
    Eupraxia Pharmaceuticals
- **Overview of Endoscopies and Administration of EP-104GI**
  - **Waqqas Afif MD, M.Sc (Epi), FRCP(C)**
    Associate Professor of Medicine
    Department of Gastroenterology
    McGill and MUHC GI and Hepatology Division Director
- **US Endoscopy Practices/Facilities – Logistics & Business Model**
  - **Dr Mark DeLegge, MD, FACG, CNSP, AGAF, FASGE**
    Senior Medical Director, GI/Hepatology Center of Excellence, IQVIA
    Fellowship in Gastroenterology and Nutrition, Medical College of Virginia
    Board certified in Internal Medicine, Gastroenterology and Nutrition
- **Primary Market Research on Incorporating EP-104GI into Current GI Practices**
  - **Paul Brennan M.Sc., CLP**
    Chief Corporate Development Officer
    Eupraxia Pharmaceuticals

Overview of Endoscopies and Administration of EP-104GI

Dr Waqqas Afif, MD, M.Sc (Epi), FRCP(C)

Associate Professor of Medicine
Department of Gastroenterology
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Endoscopy: A Ubiquitous, Standardized Clinical Tool

- An endoscopy uses a thin, flexible, camera-tipped scope to visualize the inside of the GI tract in real time
- It is a common procedure used in almost all hospitals
- Usually outpatient and performed under sedation.
- It includes:
  - Upper endoscopy, colonoscopy, bronchoscopy, cystoscopy

- Mature infrastructure: standardized training, credentialing, reimbursement, and safety monitoring already exist across essentially every hospital and ambulatory surgery center.

Endoscopists Both Diagnose and Treat with the Endoscope

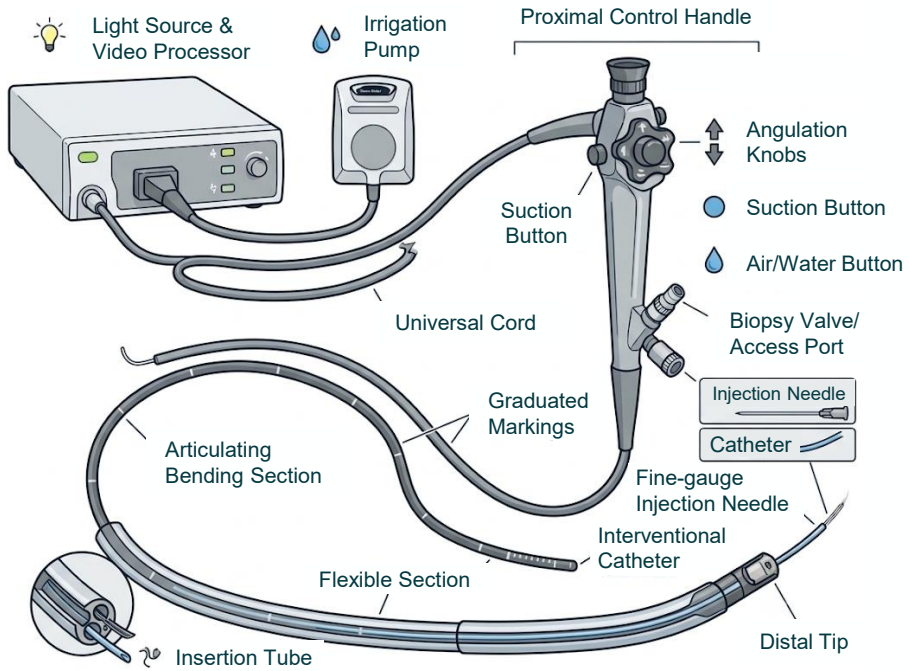
Diagnostic

- Direct visualization and grading of mucosa
- Targeted biopsy

Therapeutic

- Injection therapies (needle catheters)
- Resection: EMR / ESD for lesions.
- Dilation: balloon for strictures
- Hemostasis: clips, cautery, banding.

Upper GI Endoscope



Channels in the endoscope accommodate wires, forceps, needles, and catheters for procedures

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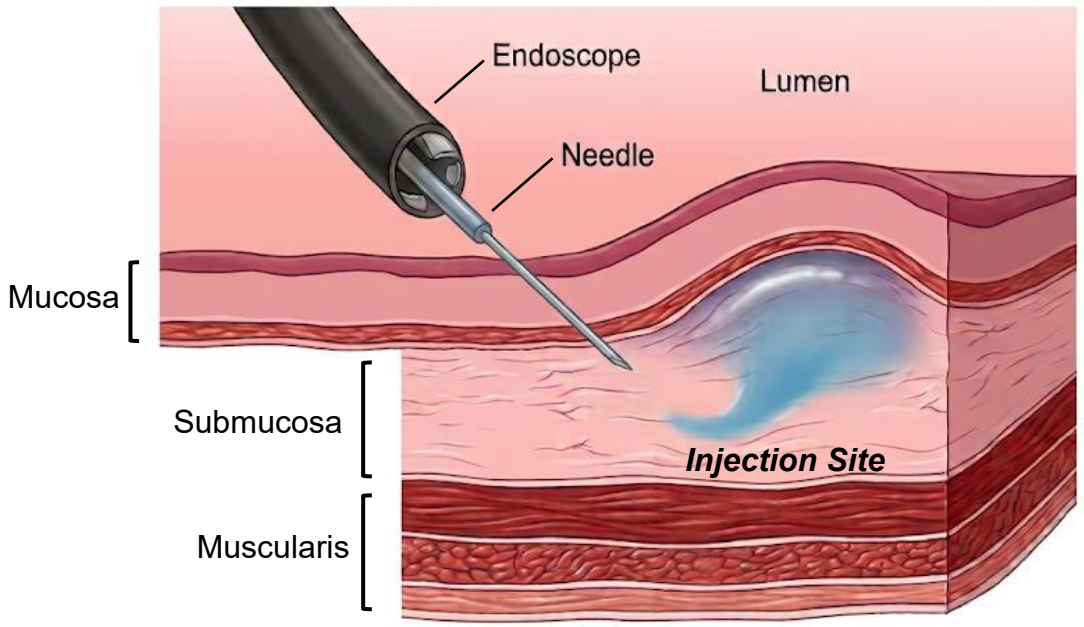
Submucosal Injections in the GI Tract Are Common

Endoscopic Submucosal Injection



Common techniques use multi-site injections in patterns into the esophagus wall:

- ***Submucosal lift*** *to elevate lesions or polyps before resection*
- ***Hemostatic injection*** *for bleeding*
- ***India-ink tattooing*** *for lesion marking*
- ***Botox injections*** *for motility disorders*
- ***Triamcinolone*** *for strictures*

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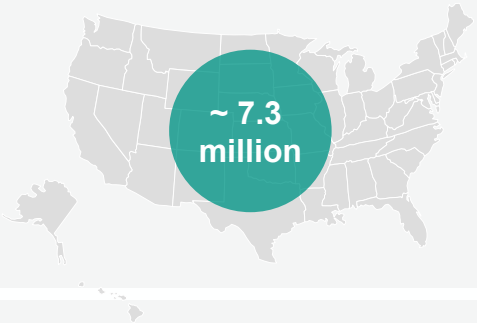
The Upper Endoscopy is a Daily, High-Volume Procedure

Upper endoscopies typically target:

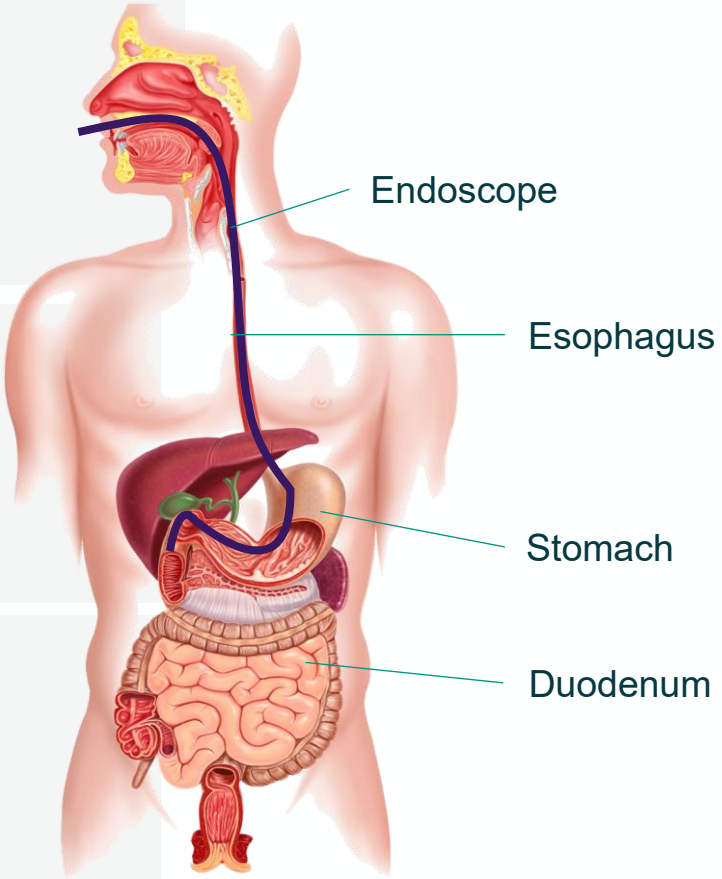
The esophagus, stomach, and duodenum,
(called **esophagogastroduodenoscopy** or **EGD**)

There are **~ 7.3 million upper Endoscopies** annually in US adults (2022 figures)*



Typical procedure

Under light or deep sedation	Same-day discharge	Diagnostic EGD duration: 10–20 minutes	Total suite time booked: 30-45 minutes



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* Peery et al, Gastroenterology. 2025 May;168(5):1000-1024.

The Endoscopy Process for an EoE Patient is Typically a Three Step Procedure

Intake

~30 minutes

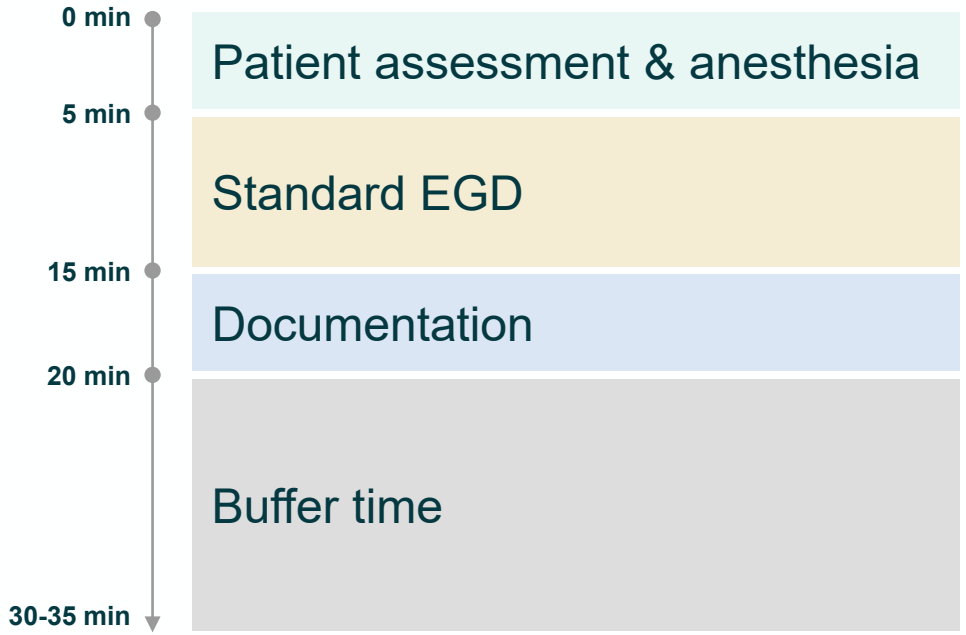
Performed in a Pre-Procedure Bay

Includes:

- Consenting
- Pre-procedure checklist

Endoscopy (EGD) Procedure

~30 minutes



Recovery

~30-60 minutes

Performed in a Recovery Bay

Includes:

- Monitoring
- Documentation
- Discharge
- Etc.

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EP-104GI Administration Integrates Well With Routine Endoscopy For EoE

1. Reconstitution of EP-104GI two components by nurse during endoscopy preparation
2. EP-104GI injections performed efficiently after visual exam and biopsies

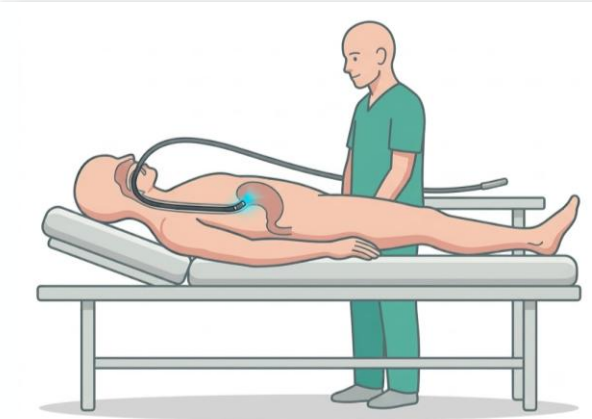
Intake, assessment & anesthesia

EP-104GI Reconstitution

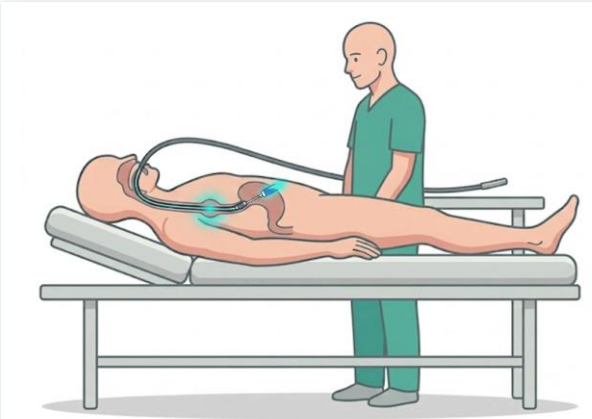
Particles ***Vehicle*** ***Injection-ready***

Endoscopy

Examination & biopsies



EP-104GI Administration



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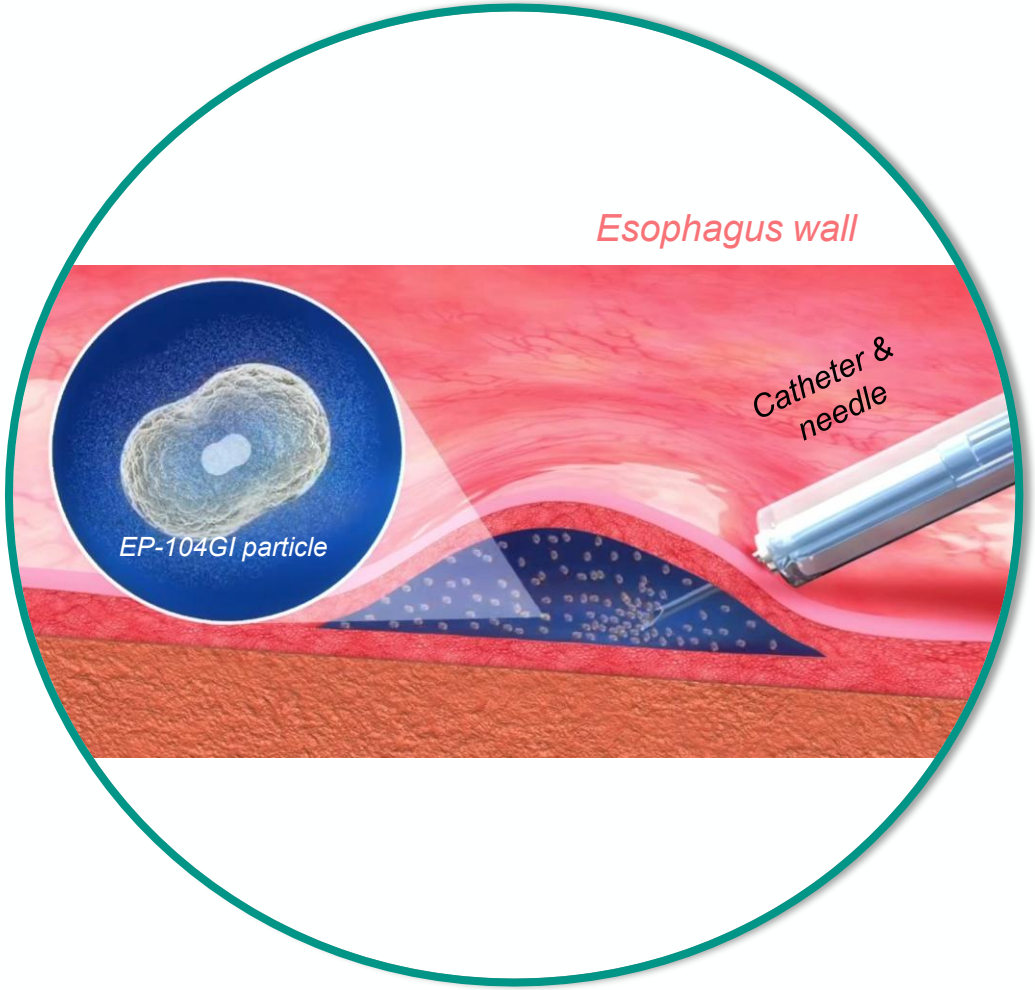
EP-104GI is Injected Using Standard Endoscopic Injection Procedures

1. The needle is positioned and inserted in the submucosa

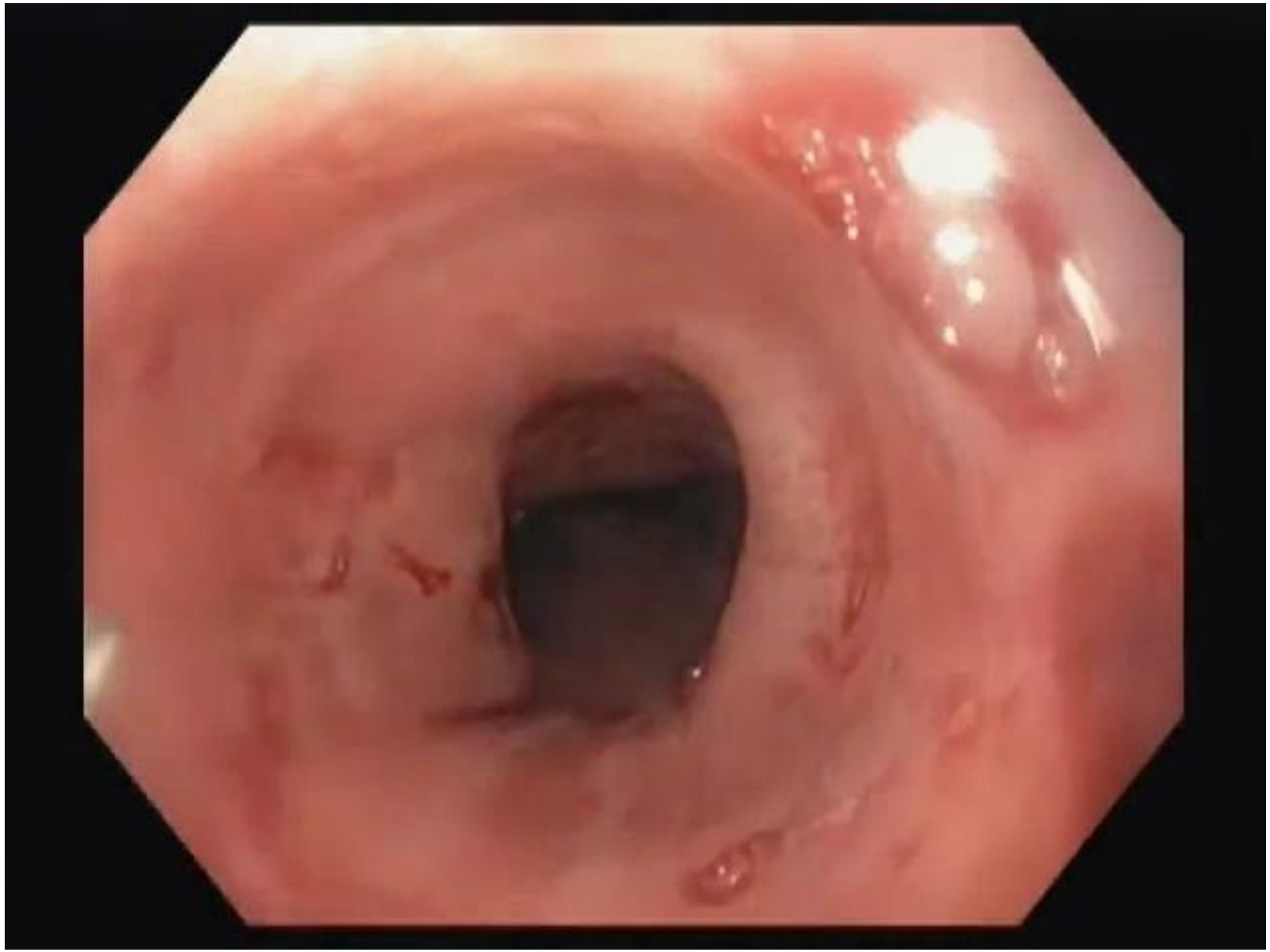
2. The suspension is injected to form a “bleb” that will dissipate after a few minutes



EP-104GI submucosal injection

EP-104GI is Injected Using Standard Endoscopic Injection Procedures

Video of EP-104GI injections into EoE patient following biopsies during **RESOLVE** study



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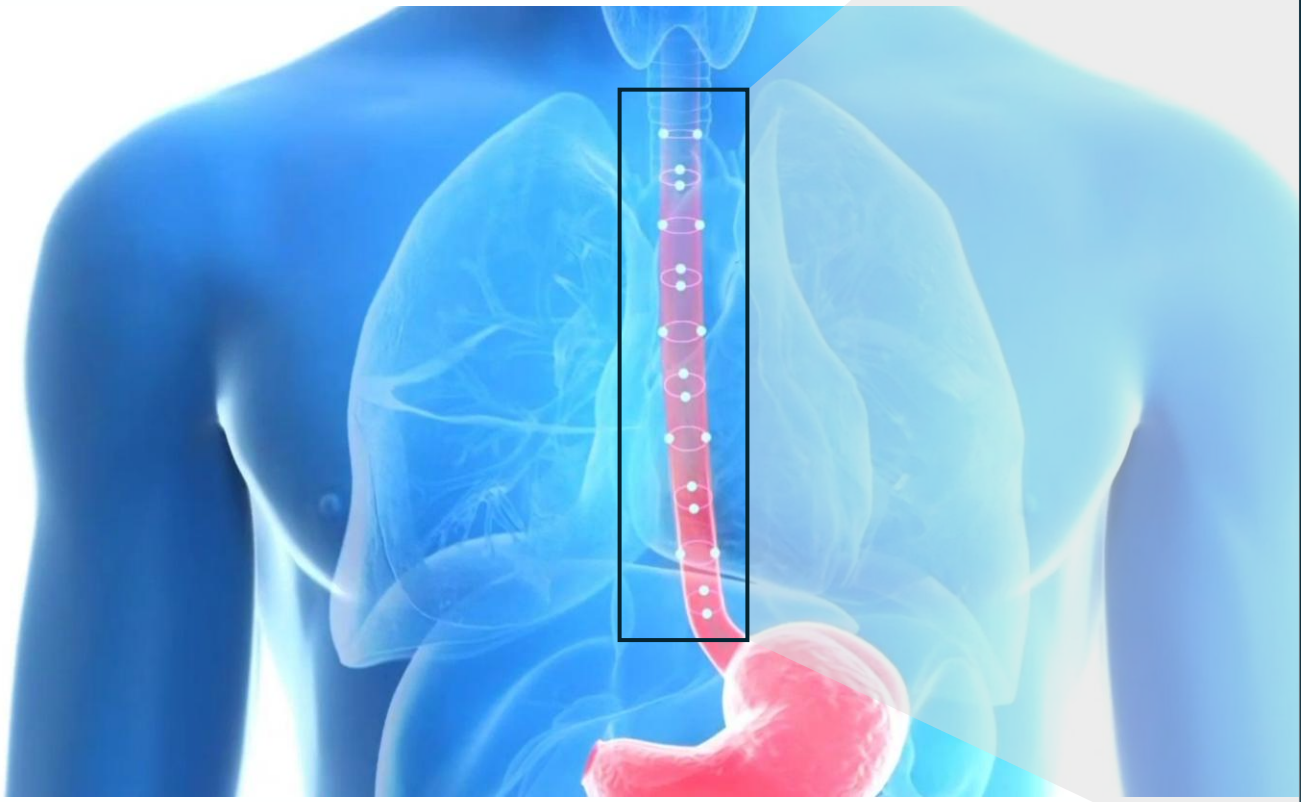
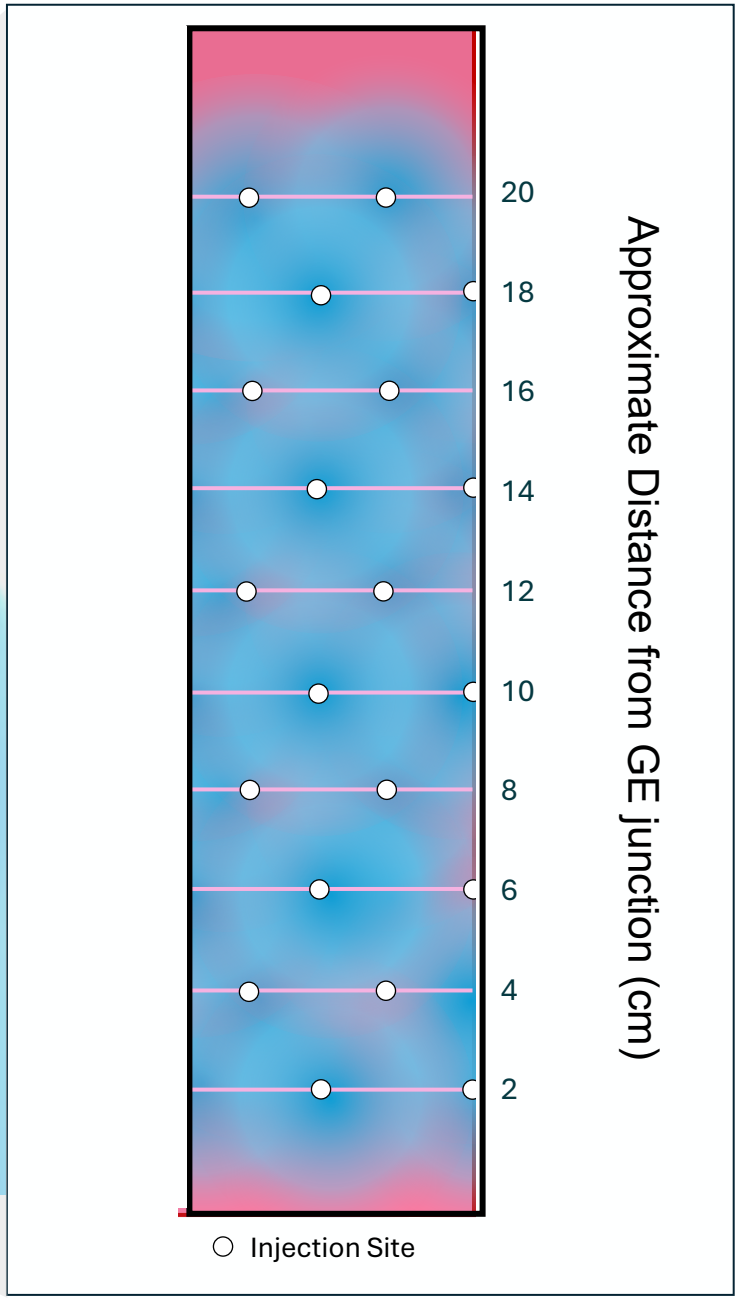
EP-104GI Injection Pattern Provides Coverage of the Full Esophagus

- Total of 20 injections in pairs spaced by 2cm, throughout the esophagus length





Model of Esophageal Coverage by EP-104GI Injection Pattern

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EP-104GI Administration Should be Easily Integrated into GI Care for EoE Patients

Upper endoscopies are a common, standardized tool used by GI specialists to both diagnose and treat patients

Submucosal injections are a common procedure used by endoscopists when performing endoscopies

Administration of EP-104GI by submucosal injection is similar to already established injection procedures

Reconstitution and injection of EP-104GI can be integrated into existing procedures for treating EoE patients

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Endoscopy Practices in the US – Logistics & Business Model

Dr Mark DeLegge, MD, FACG, CNSP, AGAF, FASGE

Senior Medical Director, GI/Hepatology Center of Excellence, IQVIA
Fellowship in Gastroenterology and Nutrition, Medical College of Virginia
Board certified in Internal Medicine, Gastroenterology and Nutrition

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Gastroenterologists Practice Across Multiple Outpatient Settings

Site-of-care selection is often driven by case complexity and reimbursement

	ASC	HOPD	Office
Structure	Free-standing facility built for same-day procedures	Hospital-based unit with full clinical backup and strict oversight	Procedure suite inside physician's clinic or office
Case Type	Routine, low-risk cases in generally healthy patients	More complex and severe cases	Basic diagnostics with limited equipment
Financials	Lower overhead and cost	Highest cost and reimbursement	Lowest reimbursement, with no facility fee
Market Dynamics	Increasingly favored by payers due to lower costs	Decreasing preference due to viability of ASCs	No impact

Many HCPs, who split time between ASCs and HOPDs, elect to complete more complicated or risky procedures at HOPD where they have privileges even if they primarily practice at ASC

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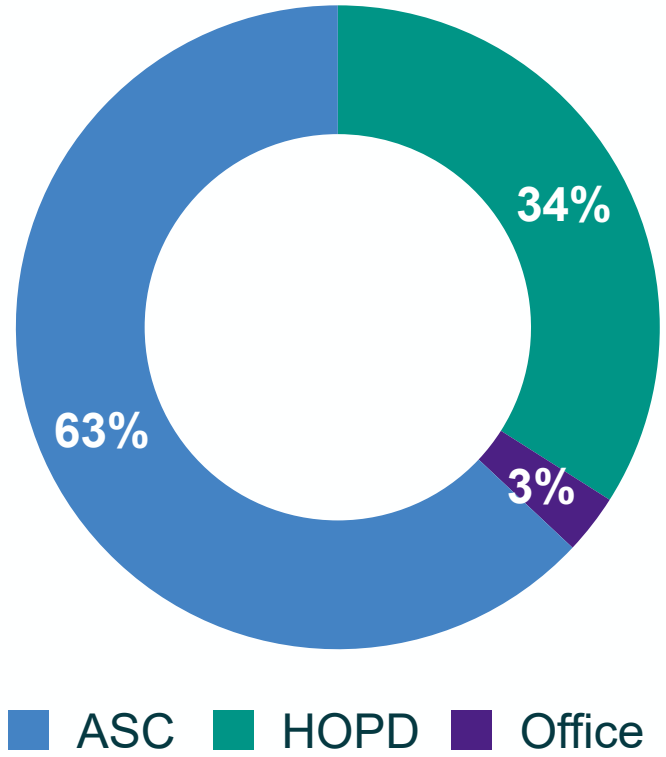
Sources: IQVIA PMR: Gastroenterologists, n=8; Nurse Practitioners, n=8, Practice Administrators, n=7; Billing Specialists, n=5; IQVIA LAAD Data; Consulting and Analytics

ASC + HOPD Dominate Endoscopy Volumes, with Site-of-Care Driving the Majority of Reimbursement Variability

Proportion of Upper Endoscopies by Site of Care (US)*



- **Approximately 94% of endoscopies are conducted in outpatient settings**
- Based on IQVIA claims data, **ambulatory surgery centers (ASCs) represent the dominant site of care** for common upper endoscopy procedures (~63% of volume), driven by their **ability to efficiently handle high volumes of routine cases at lower cost,** while outpatient hospitals account for a smaller share (~34%) and physician offices remain limited (~3%)
- **Reimbursement economics vary by site of care,** with HOPD payments highest and ASC payments moderately lower

*Includes CPT codes: 43235, 43236, 43239, 43200, 43201, 43202; Abbreviations: ASC: ambulatory surgery center, HOPD: hospital outpatient department, OBS: office-based surgery EGD: esophagogastroduodenoscopy; Sources: IQVIA PMR: Gastroenterologists, n=8; Nurse Practitioners, n=8, Practice Administrators, n=7; Billing Specialists, n=5; IQVIA LAAD Data; Consulting and Analytics

Planning, Logistics and Economics for Endoscopies Involves Multiple Stakeholders

Stakeholder	Role / influence
Patient	Experiences symptoms, consents to treatment, and adheres to follow-up
Gastroenterologist	Diagnoses, determines treatment decision and procedure
Endoscopy nurse(s)	Prepares the patient, supports post-procedure recovery and instructions
Endoscopy technician	Prepares the suite, assists during the procedure, and supports cleaning and room turnover
Practice administrator	Manages scheduling, product acquisition, billing, and the site-of-care economics that make adoption viable
Pathologist	Performs histology central to diagnosis and to monitoring treatment response
Anesthesia / sedation provider	Delivers sedation for the endoscopic procedure, ensuring patient comfort and safety
Payer	Determines coverage, reimbursement, and prior-authorization pathways that shape patient access and practice margin

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Most Endoscopy Practices (HOPD and ASCs) Handle a Variety of Patient Types in a Typical Morning

Typical Gastroenterologist's Morning

	Scheduled	*Actual*	
8 AM	*30 min*	*15 min*	**Standard EGD**
	30 min	*25 min*	**Screening colonoscopy**
	30 min	*20-30 min*	**EGD for EoE**
	30 min	*35 min*	**Colonoscopy with polypectomy**
	30 min	*45 min*	**EGD with complication**
11-12 PM	*30 min*	*15 min*	**Diagnostic sigmoidoscopy**

Site of Care	**HOPD**	**ASC**	**Office**
Procedures per physician per day	10-12	12-16	1-2 (variable)

Variation is Routine

Most ASCs and HOPD handle both upper and lower endoscopies in the same facility

Case lengths typically vary from 5 minutes (plus room turnover) to 60+ minutes,

Case Mix:

Practices mix long and short procedures to buffer delays and maintain overall throughput

Daily Throughput Unchanged:

Any minor overrun evens out across the remaining procedures in the day

Expected and manageable delay:

Stakeholders have noted that delays are manageable until it reaches 30 minutes or more

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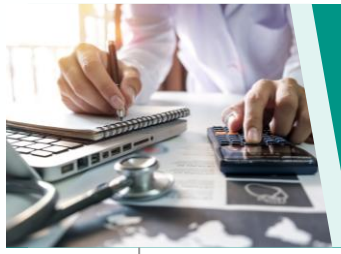
Sources: IQVIA PMR: Gastroenterologists, n=8; Nurse Practitioners, n=8, Practice Administrators, n=7; Billing Specialists, n=5; IQVIA Secondary (CMS)

The Revenue Model for EGDs Considers Procedure Payments for Both the Facility and the Physician



Payment for an EGD typically involves two major components related to the procedure:

1. **Professional fees** paid to the physician performing the procedure

2. **Facility fees** paid to the ASC or HOPD for performing the procedure
   - Facility fees cover the costs of running the facility, nursing, technician, anesthesia, ancillaries, administrators, etc.

The amount paid to the physician and facility is set by the payers (Medicare, Medicaid, Private) according to the procedure(s) that are being performed, and the facility that is being used

Procedures are identified by a Current Procedural Terminology Code **(CPT Code)**

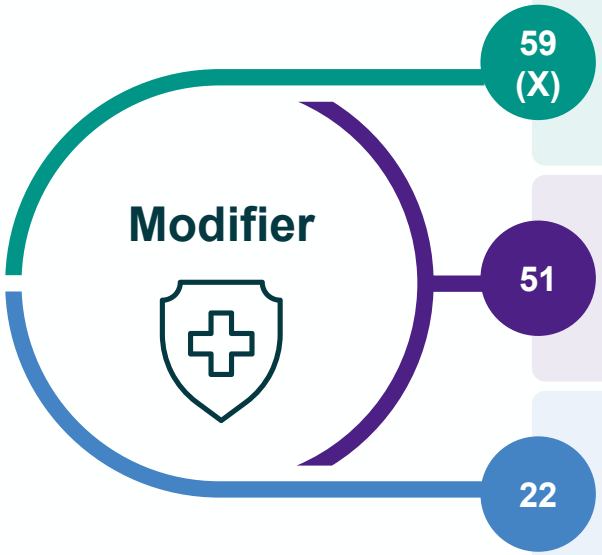
The amount paid for a specific CPT code facility will vary according to:

- **The Payer Type**
  (Private >> Medicare/Medicaid)
- **The Facility Type**
  (HOPDs >> ASCs)

Typical Coding Frameworks Used to Support EoE Related Endoscopies

Key Reimbursement Codes & Modifiers

Scenario	EGD Family
Diagnostic endoscopy	43235 - Diagnostic EGD, including brushing/washing
Endoscopy with injections	43236 - EGD with directed submucosal injection(s), any substance
Endoscopy with biopsy	43239 - EGD with biopsy, single or multiple



59 (X)

Used when **two procedures** are normally bundled but are **clinically separate**

51

Used when **multiple procedures** are performed in the **same session**

- Primary procedure paid at 100%, secondary reduced
- Medicare does not typically approve

22

Used when **procedure was substantially greater** than typically required

Requires detailed documentation of:

- Increased time
- Technical difficulty
- Severity of condition

Sources: IQVIA PMR: Gastroenterologists, n=8; Nurse Practitioners, n=8, Practice Administrators, n=7; Billing Specialists, n=5; IQVIA Secondary (Medcare, EZMD, AAPC, CMS)

Endoscopy Suites Can Supplement Their Revenue by Providing Physician Administered Drugs Under Buy-and-Bill

Buy and bill is a reimbursement model in which a healthcare provider purchases a specialty medication administers it to the patient, and then submits a claim to the patient's third-party payer for both the drug and its administration

1. Buy

- The clinic purchases the drug at its acquisition cost and holds it in inventory.

2. Administer

- The physician administers it in-clinic during the patient's scheduled procedure.

3. Bill

- The clinic bills the payer under the medical benefit using the drug's J-code, plus the usual procedure fees.

- **Medicare pays about ASP + 4-6%;**
- **Commercial Payers Average ASP based on 5 benchmark products was +20%[1]**

ENDOSCOPY CLINICS ALREADY HAVE EXPERIENCE WITH BUY AND BILL

- Botox – Injected via sclerotherapy needle during EGD into the LES for achalasia, the pylorus for gastroparesis, or the internal sphincter for chronic anal fissure
- Injectafer and Venofer for the iron-deficiency anemia that's endemic in IBD and GI-bleed patients
- Entyvio, administered by IV infusion to treat adults with moderately to severely active CD and UCs

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1. IQVIA LAAD 3.0 Remittance data; US Market Access Strategy Consulting analysis (benchmarks were Entyvio, Lucentis, Ocrevus, Skyrizi and Botox)

Practice Economics is the Net Sum of Revenue, Cost and Volume

Revenue

Driven by reimbursement mechanics including physician and facility fees, CPT coding, payer mix, and variability in coverage, denials, and payment structures

Can be supplemented with Buy and Bill

Cost

Comprises drug, ancillary, staffing, physician time, and anesthesia expenses per procedure

Volume

Determined by procedure and injection time, room turnover, capacity constraints, case mix, and ability to optimize throughput and backfill displaced cases

Practice Economics

Per-procedure revenue and cost with throughput to estimate total revenue, cost, profit, and incremental margin vs baseline scenarios

Sources: IQVIA PMR: Gastroenterologists, n=8; Nurse Practitioners, n=8, Practice Administrators, n=7; Billing Specialists, n=5; IQVIA Secondary

Primary Market Research on Incorporating EP-104GI into Current GI Practices

Paul Brennan, M.Sc., CLP

Chief Corporate Development Officer
Eupraxia Pharmaceuticals

Eupraxia Have Conducted Multiple Separate Projects to Understand How EP-104GI will Fit into Clinical Practice

1. EoE Commercial Assessment with ClearView Healthcare Partners – Nov 2023
   - To seek a commercial assessment for RP-104GI in EoE in particular, defining addressable patient populations and evaluating potential clinical development approach across that spectrum of opportunities
   - *Involved 16 GI Docs and 4 payers*

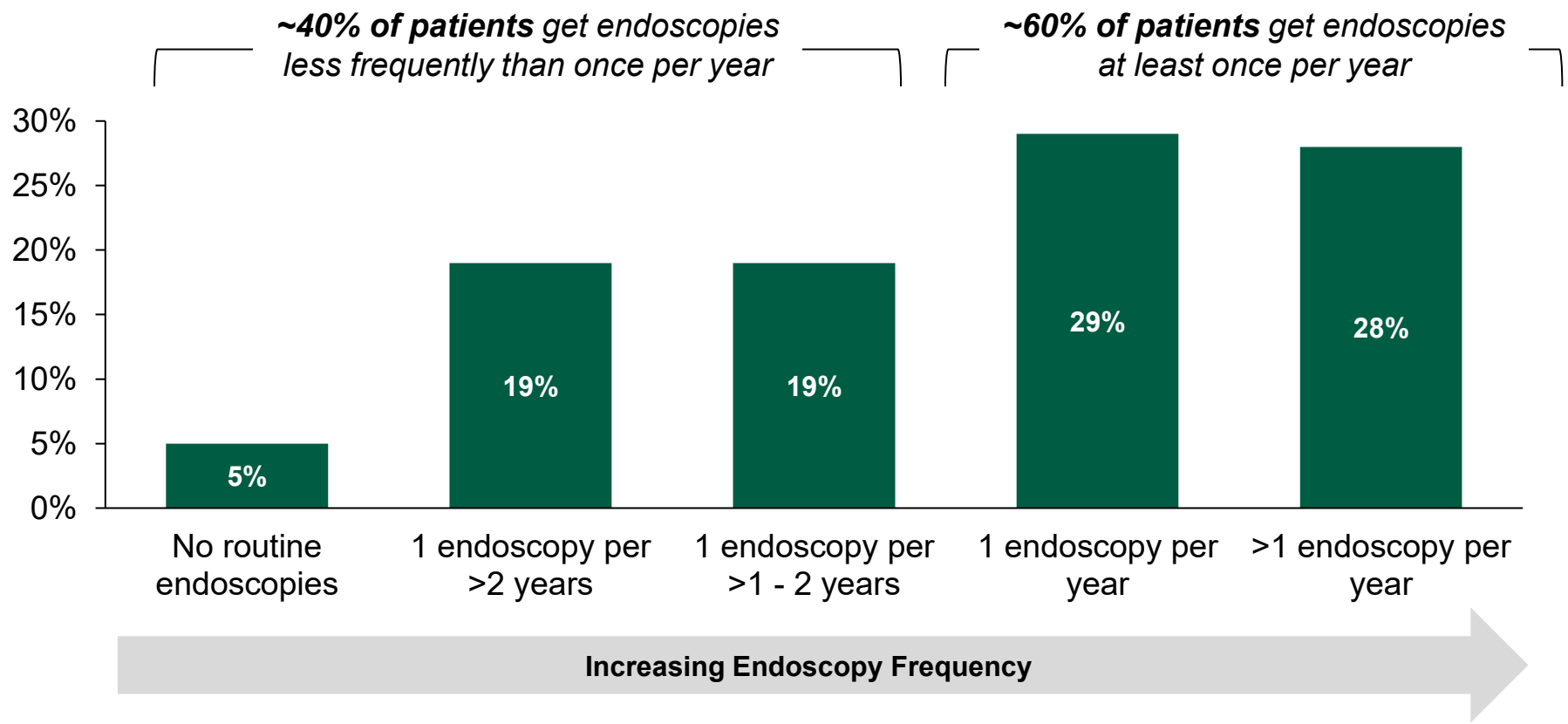
2. EoE Patient Journey and Profile Testing with ClearView Healthcare Partners – July 2025
   - Characterize the EoE patient journey and understand involvement and behavior of key stakeholders
   - Evaluate patient receptivity to the EP-104GI profile
   - Identify key points in journey where patients are lost or delayed that may impact use of EP-104GI
   - Also updated the commercial assessment
   - *Involved 65 patients, 12 KOLs and 8 Payers*

3. Practice Logistics and Economics Market Research with IQVIA – July 2026

Majority of Patients get Endoscopies at Least Once per year

80% of All Patients Receive Endoscopies at Least Once Every 2 Years

Frequency of Endoscopies



Source: Quantitative Survey Responses; ClearView Analysis.

Practice Logistics and Economics Market Research with IQVIA

Eupraxia retained IQVIA to:

(i) perform a primary market research informed assessment of Endoscopy suite workflows
(ii) determine how EP-104GI will be incorporated into clinical practice, and
(iii) to determine how its use will influence practice economics

The project has 3 outputs:

Primary Market Research (PMR) directed research with key stakeholders to determine endoscopy suite workflows and related economics; and to assess the how EP-104GI would affect workflows

An assessment across different facilities and different payers of the **reimbursement rates** associated with performing EoE related endoscopies, and injecting pharmaceuticals

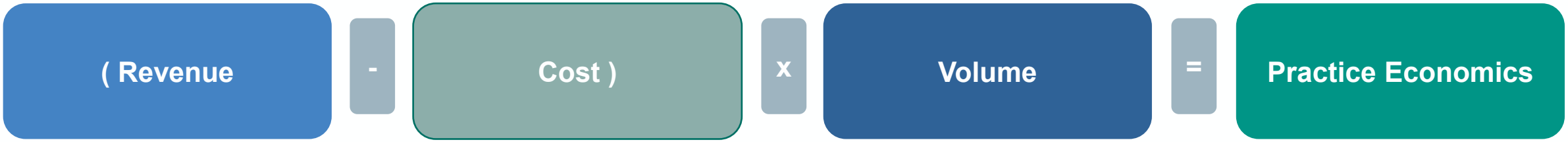
Creation of an Excel **financial model** of the Endoscopy Suite Practice to quantify financial effect of EP-104GI administration of practice economics

Multiple Stakeholders with Expertise Across Different Settings and Facilities Were Interviewed for Their View of EP-104GI Adoption Dynamics

Stakeholder Interviews		Virtual	Sample Sub-quotas
HCPs	**Gastroenterologists**	8	Variety of sub-quotas represented, including: - Geography - Urbanicity - Site of Care (HOPD, ASC, office) - Practice Size - Number of EoE patients - Roles and Responsibilities
	Nurses	8	
Other Stakeholders	**Practice Decision Makers/Admins**	7	
	Billing Specialists	5	
	Total Interview Sample	**28**	

In addition to blinded primary market research Eupraxia relied on its KOL network of EoE specialists to review the project assumptions, construct relevant discussion guide prior to starting interviews, and to review the conclusions of the project

At its Essence, Practice Economics can be Evaluated Through a Framework Calculation that Compares Revenue, Cost and Volume



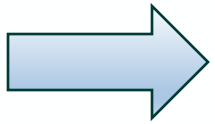
This framework served as the foundation for the analyses, assumptions, and economic model presented throughout the IQVIA project.

Sources: IQVIA PMR: Gastroenterologists, n=8; Nurse Practitioners, n=8, Practice Administrators, n=7; Billing Specialists, n=5; IQVIA Secondary

Administration of EP-104GI Can Supplement both Physician and Endoscopy Suite Revenue Through Upgrades to CPT Coding

EoE Patient with a Biopsy

43239: EGD with biopsy



Same EoE Patient now receiving EP-104GI

43239: EGD with biopsy
+
50% of 43236 EGD with injection

In combined injection and biopsy sessions, 43239 becomes the primary code due to higher reimbursement, with 43236 appended as secondary; Medicare reimburses the secondary code at roughly 50% of its standalone rate

Example of how administration of EP-104GI will change coding for a patient undergoing biopsy

Sources: IQVIA PMR: Gastroenterologists, n=8; Nurse Practitioners, n=8, Practice Administrators, n=7; Billing Specialists, n=5; IQVIA Secondary (Medcare, EZMD, AAPC, CMS)

Changes to CPT Coding – (EGD with Biopsy) versus (EGD with Biopsy plus Injection) Provide Greater Reimbursement to Both Physician and Facility

Procedure and Total Cost of Care Reimbursement by Payer Channel and CPT Code

(Jan. 2023 – Jun. 2026)

Procedure	CPT Code(s) Used	Payee	HOPD Private Average	HOPD Med. Adv. Average	HOPD Med. B Average	ASC Private Average	ASC Med. Adv. Average	ASC Med. B Average
EGD with Biopsy	43239	EGD Procedure[1]	$646	$1,962	$479	$418	$247	$241
		Total Visit Cost of Care[2]	$2,093	$4,646	$3,014	$1,641	$1,196	$1,134
EGD with Biopsy plus Injections	43239 plus 43236	EGD Procedures[1] incremental amount	**$2031** **+$1,385**	**$3685** **+$1,723**	**$1,907** **+$1,428**	**$767** **+$349**	**$496** **+$249**	**$481** **+$240**
		Total Visit Cost of Care[2] incremental amount	$4,690 +$2,597	$6,708 +$2,026	$4,083 +$1,238	$1,839 +$198	$1,260 +$64	$1,496 +$362

1. "EGD Procedure" is the total reimbursement paid to the site of care, and the treating physician, for the specified CPT Code
2. "Total Visit Cost of Care" is is the total reimbursement paid to the site of care and to the treating physician for all components of treatment received by the patient, when the identified CPT code(s) has been used. The total cost of care also includes the CPT reimbursement specific to the code

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Source: IQVIA LAAD 3.0 Remittance data; US Market Access Strategy Consulting analysis

Buy and Bill Provides an Additional Opportunity to Supplement Income

Buy and Bill for EP-104GI is a Likely Outcome for Endoscopy Suites

Buy and bill common for higher-cost, provider-administered specialty medications requiring immediate in-office use
- During market research the participants spontaneously highlighted the potential upside of Buy and Bill

EP-104GI is expected to meet criteria for unique J-Code: (i.e., it is physician administered)

Inventory and storage straightforward

Pre-authorizations easily managed given endoscopies are scheduled

Not unusual for payers: Premium priced EoE treatments (e.g. **Dupixent**) already broadly reimbursed.

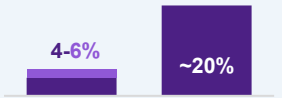
Not unusual for Endoscopy clinics: Already handling buy and bill products in the clinic (**Botox, Entyvio**)

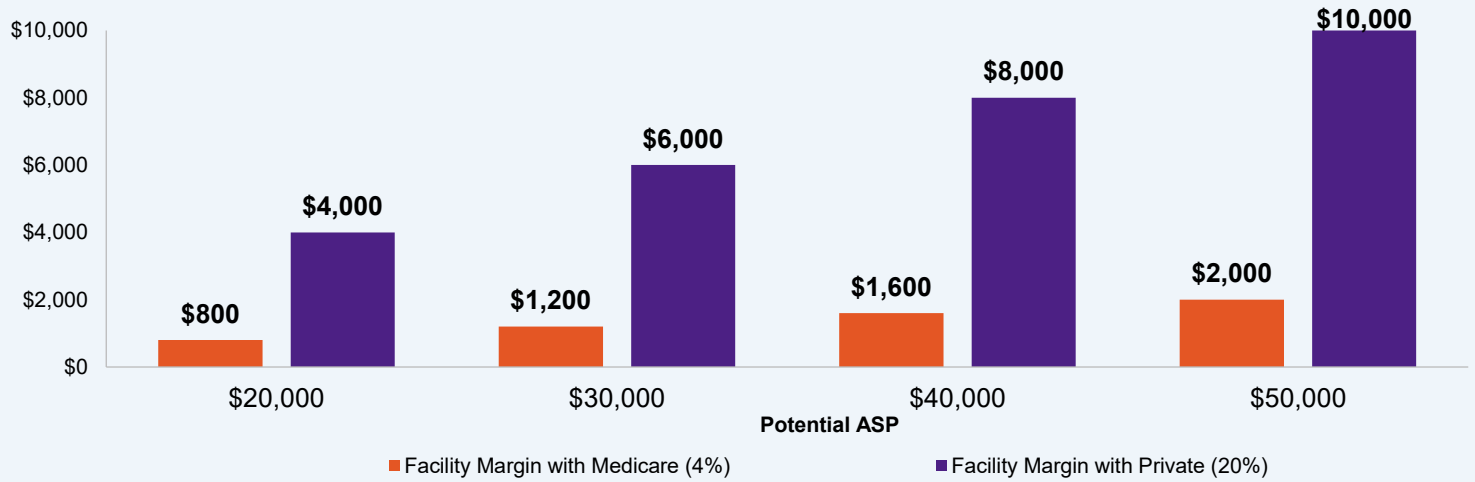
Sources: IQVIA PMR: Gastroenterologists, n=8; Nurse Practitioners, n=8, Practice Administrators, n=7; Billing Specialists, n=5; IQVIA Secondary (Medcare, EZMD, AAPC, CMS)

The Potential Revenue from Buy and Bill is Highly Attractive

EP-104GI likely to be a high value treatment: Single administration expected to provide coverage for full year (WAP for a year of Dupixent is ~$109K)

Current margins for Buy and Bill for Medicare are are **4-6%** of ASP, Margin for 5 benchmark products was **~20%** for private insurance[1]





Buy and Bill could more than double the revenue an endoscopy clinic receives for treating an EoE Patient

1. IQVIA LAAD 3.0 Remittance data; US Market Access Strategy Consulting analysis (benchmarks were Entyvio, Lucentis, Ocrevus, Skyrizi and Botox)

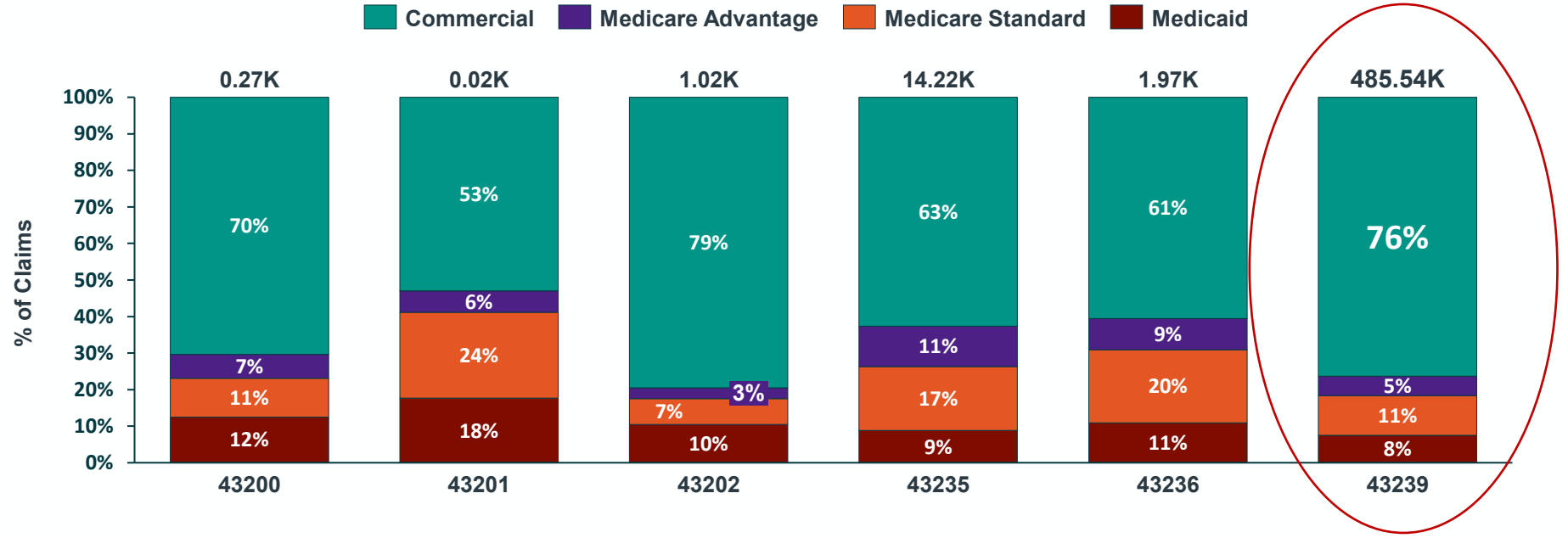
For EoE Diagnosed Patients, Payer Channel Mix is Heavily Concentrated Within the Commercial Payer Channel

The higher concentration of Commercial payer channel volume observed for EoE patients aligns with analog market findings for EoE patients across other products

CPT Code	CPT Code Description
43200	Diagnostic Esophagoscopy
43201	Esophagoscopy with Submucosal Injection
43202	Esophagoscopy with Biopsy
43235	Diagnostic Esophagogastroduodenoscopy (EGD)
43236	EGD with Submucosal Injection
43239	EGD with Biopsy

EoE Patient Payer Channel Mix by CPT Code

(Endoscopy Procedures Only; EoE Patients Only**; All Channels; Jan. 2023 – Jun. 2026)*



* Limited to CPT codes of interest
** EoE Diagnosis Codes: K200, 53013
Source: IQVIA LAAD 3.0 Remittance data; US Market Access Strategy Consulting analysis

No Incremental Equipment or Overhead Cost, as EP-104GI Layers Onto Infrastructure that is Already Fully in Place

Storage

- **Storage needs minimal;** vial and vehicle storage within capabilities of practices

Equipment & Capital

- Procedure rooms, endoscopes, sedation setups, and standard ancillary **supplies are already in place for therapeutic endoscopy**
- No substantial new requirement or spacing needs

Administrative Support

- Practice administrator responsibilities for drug procurement, inventory management, and buy-and-bill tracking layer onto existing duties **without requiring new roles or dedicated headcount**
- Annual dosing creates a **predictable, low-frequency administrative event** manageable within current processes

Training & Onboarding

- **Endoscopic injections are already routine** for gastroenterologists familiar with Botox, sclerotherapy, EMR, and submucosal lifts
- Reconstitution is **within the capabilities** of all nurses
- No **simulation equipment, training rooms, or certification programs** required

Sources: IQVIA PMR: Gastroenterologists, n=8; Nurse Practitioners, n=8, Practice Administrators, n=7; Billing Specialists, n=5

Staffing Should be Unchanged; EP-104GI Integrates into Existing Team Responsibilities Without Requiring New Roles or Additional Headcount

Note: Practices may vary in exact staffing structure

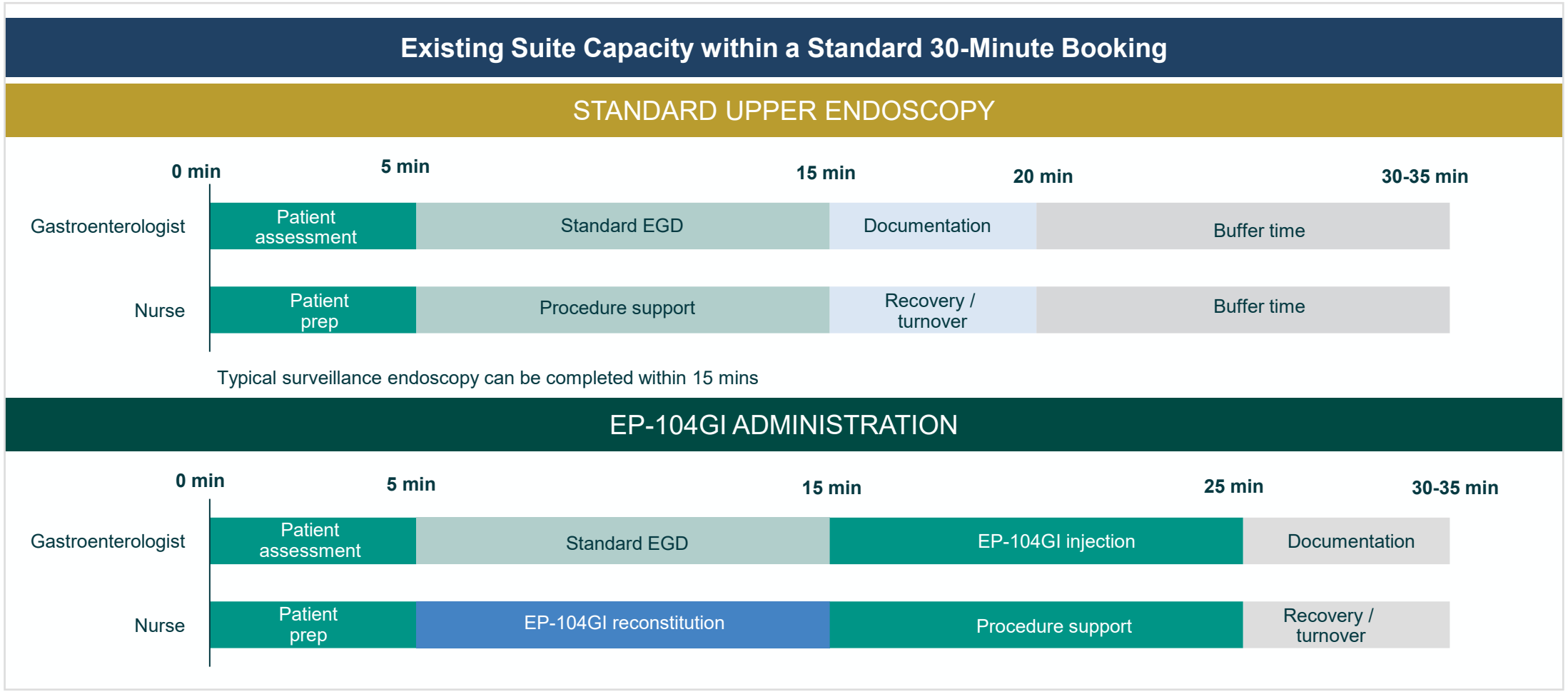
	Estimated Rate	Number of Staff		Staff Time	
		Standard EGD	EP-104GI Impact	EP104GI Incremental Time	Driver of Time Increase
Circulating RN	**$50/hour**	**1**	**1**	No Change	Room coordination, documentation, and materials staging remain within the standard block; absorbed by existing buffer
Pre-Op RN	**$50/hour**	**1**	**1**	No Change	EP-104GI eligibility check and readiness confirmation fold into the existing pre-op checklist and consent workflow
Procedure RN	**$50/hour**	**1**	**1**	+10-15 min	Reconstitution and support just prior to and as during as injections are administered
Recovery RN	**$50/hour**	**1**	**1**	Small	Potential increase due to additional anaesthesia recovery time
Endoscopy Tech	**$25/hour**	**1**	**1**	+10-15 min	Support as injections are performed
	No impact on Staffing Needs			**Minimal impact on staffing time; Impact absorbed by scheduling buffer**	

*"You already have your fixed costs in place, whether it's the clinic, the staff, the nursing. It might have additional timing costs that might impact some, you know, what you could already schedule, but. No, **I don't see any material changes from an operations standpoint or financially.**"*

- Practice Administrator

Sources: IQVIA PMR: Gastroenterologists, n=8; Nurse Practitioners, n=8, Practice Administrators, n=7; Billing Specialists, n=5

EoE Procedure Frequency and Existing Scheduling Flexibility Prevent any Meaningful Throughput Impact

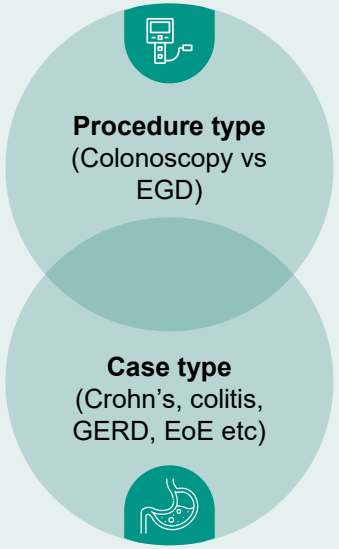


Sources: IQVIA PMR: Gastroenterologists, n=8; Nurse Practitioners, n=8, Practice Administrators, n=7; Billing Specialists, n=5

Due to Patient Type Variability, Adding EP-104GI will have Little Effect on the Total Number of Procedures a Practice can Complete in a Single Day

Patient Mix:

Practices typically mix:



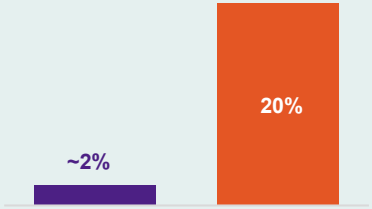
Variation in case length is routine:

Case lengths typically vary from **5 minutes** (plus room turnover) to **60+ minutes,** and practices typically mix long and short procedures to buffer delays and maintain overall throughput

EoE makes up a small proportion of all Endoscopies:

In 2022 there were 23 million endoscopies performed in the US[1] (7.2 million upper endoscopies) and 470,000 EoE patients[2]

- IQVIA claims analysis tells us that **~4%** of EGD volume is for EoE[4]
- Even our respondents, who were enriched for treating EoE patients, tended not to have more than **20%** volume of EoE patients

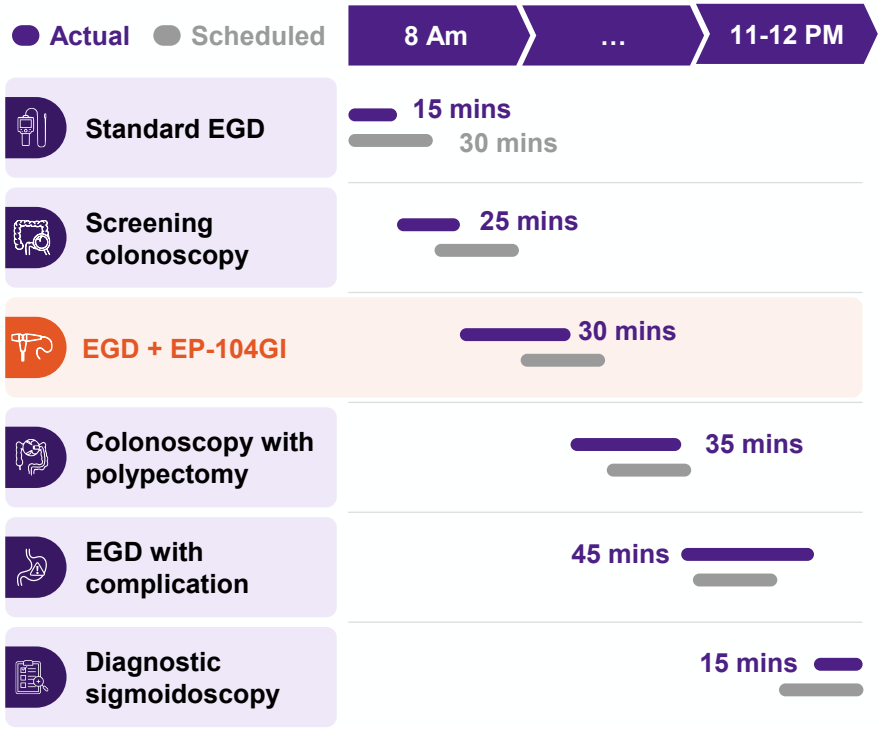


Delays in procedures are frequent and anticipated:

Stakeholders have noted that delays up to 30 minutes or more for EoE patients are unlikely to disturb their daily routine

Typical Gastroenterologist's Morning[3]

Procedures vary from 15 to 45 minutes; all are scheduled for 30 minutes



1. Peery et al, Gastroenterology. 2025 May;168(5):1000-1024\ 2. Thel et al, Clin Gastrneterol Hepatol, 2025 Feb 3. Sources: IQVIA PMR: Gastroenterologists, n=8; Nurse Practitioners, n=8, Practice Administrators, n=7; Billing Specialists, n=5; IQVIA Secondary (CMS) 4. IQVIA claims analysis project for Eupraxia

Viewed Through the Lens of Practice Economics, EP104-GI has the Potential to Generate Favorable Returns to Physicians, HOPDs and ASCs

(Revenue	-	Cost)	x	Volume	=	Practice Economics

Existing coding & reimbursement pathways could create additional revenue opportunity for practices administering EP-104GI

Buy and Bill could dramatically supplement revenue

Incremental operating costs are limited as:

(i) no additional equipment, overhead or staff anticipated, and

(ii) procedures expected to occur within existing allotted schedules

EP-104-GI can be incorporated Into individual EoE Endoscopy workflow and day-to-day scheduling without materially:

(i) reducing procedure volume or

(ii) increasing scheduled time

With a potential for increased revenue via improved billing, and/or buy and bill, and little impact on cost and revenue, EP-104GI is expected to be accretive to practice economics

Sources: IQVIA PMR: Gastroenterologists, n=8; Nurse Practitioners, n=8, Practice Administrators, n=7; Billing Specialists, n=5; IQVIA Secondary

Market Research Feedback

*"**The additional 10 to 15 minutes, that's not something that would deter us.** That's reasonable."*

- Practice Administrator

*"If we're **doing it at an ASC that we own, we benefit off that profit margin**."*

- Billing Specialist

*"If I went over, it's not really a big deal. I'm sure I won't be doing five of them a day. So, if I'm just doing one a day and the next endoscopy takes five minutes, **everything evens out.**"*

- Gastroenterologist

***Familiar with injections:** "Injection, banding, resections, stenting. Those are pretty routine things to do."*

- Gastroenterologist

- In response to being shown EP-104GI's method of preparation, and administration, neither medical or administrative respondents had concerns about the ability to integrate EP-104GI into their practices.
- Several expressed the opinion that using EP-104GI would increase revenue, and making EP-104GI available to patients would be a selling feature for their facilities

*"We **have all the supplies**. Everything is available."*

- Nurse

*"It **actually improves my financial standpoint** because during this procedure, I'm sure there's a code for it, which would be additional compensation for the endoscopy."*

- Gastroenterologist

*"The reconstituting is a little different than most products that we use, but **the idea itself is not out of the ordinary** for the staff to do."*

- Gastroenterologist

*"Overall, for an endoscopy, it costs us anywhere between $800 to $1,000 per procedure**. Whether it's with this drug or without, that cost doesn't change — the room, the staff, the equipment — it's all already there."***

- Practice Admin

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Thank you!

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