Camurus

Positioned to outperform

- Clever best-in class drug development
- Impressive growth with more to come
- We initiate coverage with a BUY and a TP of SEK 750

A clear product offering with many attractive traits

By combining its proprietary drug-delivery technology with established drugs, Camurus is developing best-in-class long-acting drugs. Through safe, convenient and individualised treatment, the success of its flagship *Buvidal/Brixadi* has disrupted the market for opioid dependence treatment, capturing e.g. >30% of the total market in the Nordics, ~80% of the long-acting buprenorphine segment in Australia, and in its first year ~20% of the US long-acting BPN segment. This has validated the technology and significantly de-risked its additional pipeline. Its closest peer issued two profit warnings in 2024 and reduced 2025 guidance due to Camurus. Its second lead asset *CAM2029* is set for approval in acromegaly after a successful Ph 3 trial, but more importantly, CAM2029 for GEP-NET (GI cancer) with Ph 3 readout within 12 months will become a blockbuster if positive (est. 50% likelihood).

Impressive growth and overall very solid

We believe the revenue CAGR of ~39% since 2022 will continue, and estimate a risk-adj. CAGR of 34% to 2030e. A stable 92% GM adds massive operational leverage, and we see the envisioned 50% EBIT margin by 2027 as realistic (ABGSCe ~51%). Additionally, Camurus has a sturdy equity ratio of ~88% (incl. net cash of SEK 2.75bn).

BUY, TP SEK 750, with path to long-term value accretion

Coupled with remarkable growth, we estimate a P/E of ~25x in 2026e, ~15x in 2027e and ~9x in 2028e. While we set a six-month TP of SEK 750, our risk-adjusted DCF SOTP points to a fair value of SEK 932/share, indicating more upside. Camurus is not a binary case. Our bear case, i.e. the approved products Buvidal, Brixadi, soon-to-be CAM2029 for acromegaly and net cash alone justify today's share price with a fair value of SEK 530/share. Our bull case points to SEK 1,374/share.

Reason: Initiating coverage

BUY ● HOLD ○ SELL ○

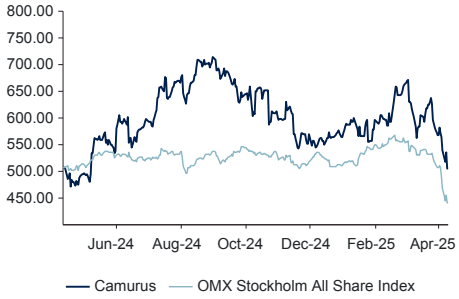
Healthcare

CAMX-SE/CAMX SS

Share price (SEK)	9/4/2025	507.00
Target price		750.0
MCap (SEKm)		29,852
MCap (EURm)		2,792
No. of shares (m)		58.9
Free float (%)		60.0

Next event Q1 Report 15 May 2025

Performance



Analyst(s): georg.tigalonov-bjerke@abgsc.no, +47 22 01 60 84
morten.larsen@abgsc.dk, +45 35 46 30 13

SEKm	2023	2024	2025e	2026e	2027e
Sales	1,725	1,880	2,639	3,351	4,800
EBITDA	540	484	953	1,451	2,441
EBITDA margin (%)	31.3	25.7	36.1	43.3	50.8
EBIT adj.	120	469	852	1,432	2,392
EBIT adj. margin (%)	6.9	25.0	32.3	42.7	49.8
Pretax profit	549	553	1,009	1,514	2,555
EPS	7.51	7.17	13.39	20.05	33.85
EPS adj.	1.96	7.19	12.28	20.06	32.92
Sales growth (%)	78.4	8.9	40.4	27.0	43.2
EPS growth (%)	nm	-4.5	86.8	49.8	68.9

Source: ABG Sundal Collier, Company Data

	2025e	2026e	2027e
P/E (x)	37.9	25.3	15.0
P/E adj. (x)	41.3	25.3	15.4
P/BVPS (x)	7.43	5.74	4.15
EV/EBITDA (x)	28.1	17.7	9.7
EV/EBIT adj. (x)	31.4	17.9	9.9
EV/sales (x)	10.15	7.66	4.96
ROE adj. (%)	19.9	25.6	31.3
Dividend yield (%)	0.0	0.0	0.0
FCF yield (%)	3.0	3.7	6.2
Le. adj. FCF yld. (%)	2.9	3.7	6.2
Net IB debt/EBITDA (x)	-3.8	-3.2	-2.7
Le. adj. ND/EBITDA (x)	-4.0	-3.4	-2.8

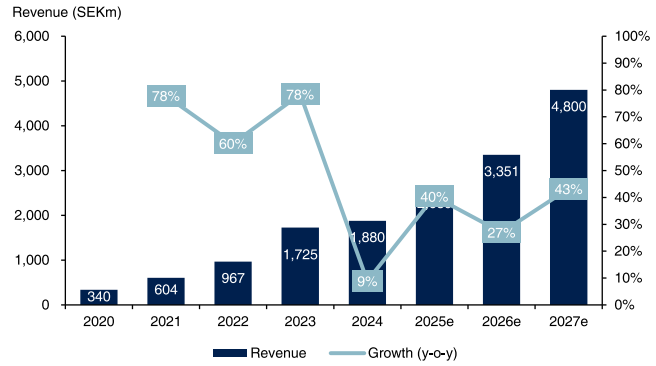
Company description

Camurus is a Swedish commercial-stage pharmaceutical company listed on Nasdaq Stockholm since 2015. It develops and commercialises innovative and long-acting medicines for the treatment of opioid dependence, pain, cancer and endocrine diseases. The company has over 250 employees and is headquartered in Lund (Sweden), with regional offices in the UK, Germany, Australia and the US.

Risks

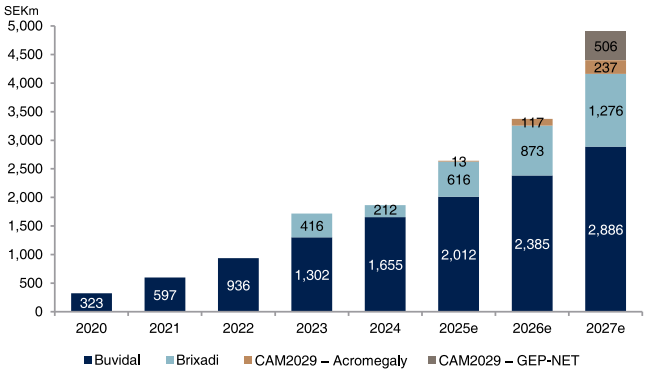
Camurus faces competition from larger peers, making continued innovation essential. R&D and partner execution remain inherent risks, as seen in the Brixadi journey. Future M&A adds risk around integration and information gaps. Patent coverage, cost inflation, and FX exposure also represent potential headwinds.

Revenue



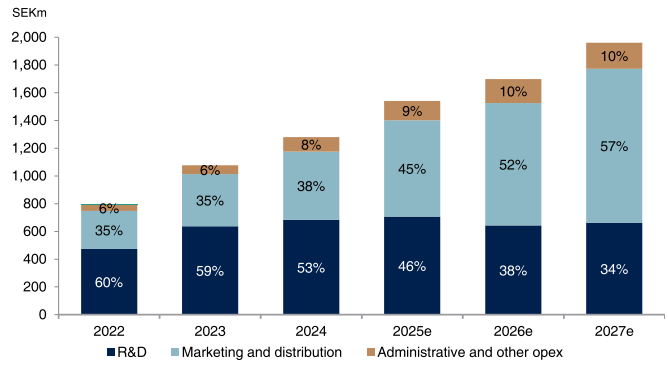
Source: ABG Sundal Collier, Company Data

Revenue by product



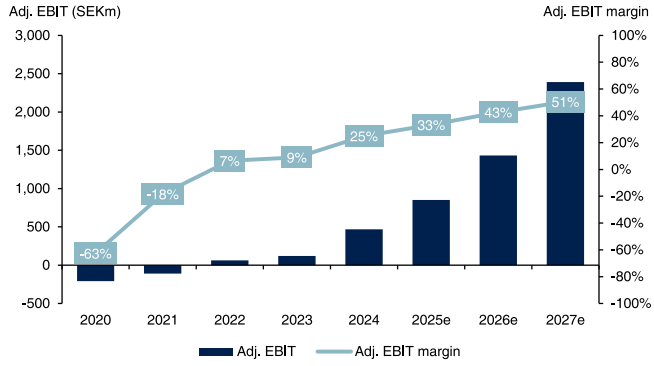
Source: ABG Sundal Collier, Company Data

OPEX



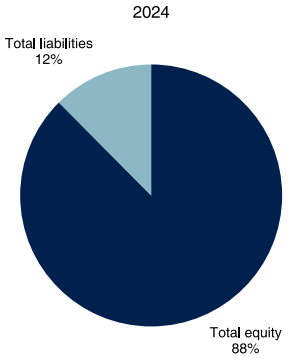
Source: ABG Sundal Collier, Company Data

Adj. EBIT margin (ex. milestones)



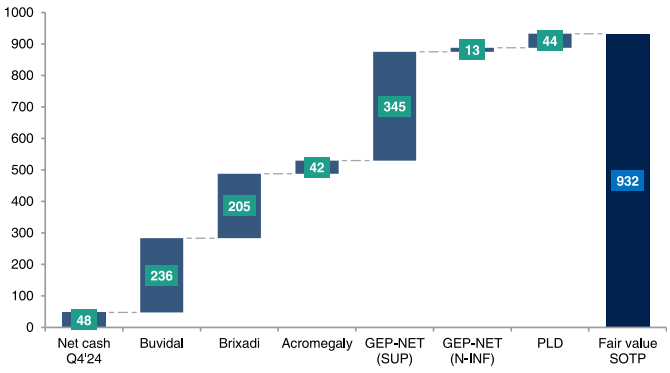
Source: ABG Sundal Collier, Company Data

Equity ratio



Source: ABG Sundal Collier, Company Data

Sum-of-the-parts – waterfall plot (risk-adjusted)



Source: ABG Sundal Collier, Company Data

Footnote: Net cash Q4'24 + Buvidal + Brixadi + Acromegaly = SEK 530

Contents

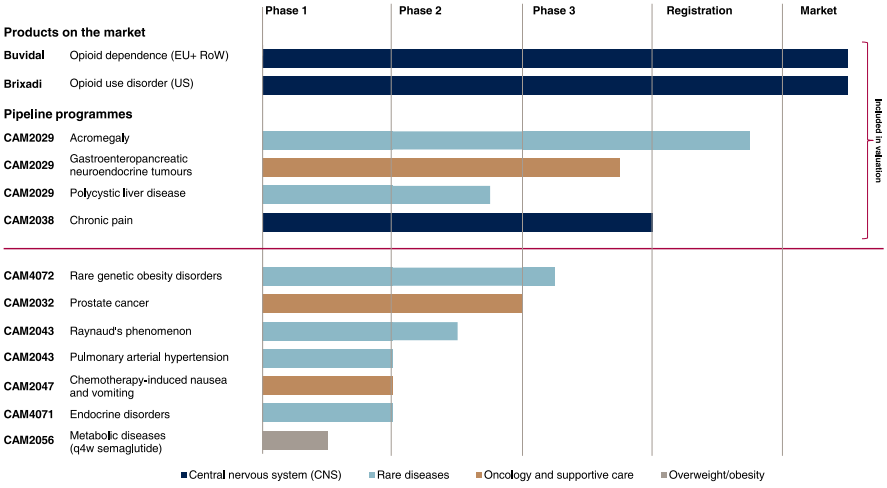
Investment case

We initiate coverage of Camurus with a BUY recommendation and a six-month target price of SEK 750. Our risk-adjusted DCF SOTP points to a fair value of SEK 932/share, a long-term bear case value at current share price levels (~SEK 530/share) and a long-term bull case value of SEK 1,374/share.

Intelligent business strategy

Camurus is a Swedish commercial-stage pharmaceutical company using its proprietary drug-delivery depot technology to develop best-in-class long-acting drugs based on already-approved substances. By combining this technology with well-established pharmaceutical substances that offer documented clinical efficacy and safety profiles, new proprietary medicines can be developed faster, cheaper and with less risk compared to the development of medicines with new active substances. The commercial success of its flagship drug *Buvidal/Brixadi* has validated the technology and significantly reduced the regulatory risks with its additional pipeline.

Camurus' approved products and pipeline



Source: ABG Sundal Collier, Camurus

Footnote: q4w = dosed every four weeks

Powerful opioid game

Camurus has delivered superbly with Buvidal/Brixadi in the aftermath of the global opioid crisis. This best-in-class long-acting depot formulation of *buprenorphine* (BPN) has disrupted the market of opioid dependence treatment by creating a product with the excellent properties of BPN that ensures much higher treatment adherence, all while greatly eliminating the risk of misuse and lethal overdose. Its success cannot be attributed to only one factor, but rather to a combination of Camurus facilitating individualised treatment through offering both weekly and monthly injections, multiple doses, multiple possible injection sites, a smaller needle and room temperature storage, as well as being the only long-acting drug to prove superiority over standard BPN.

Since its launch in early 2019, Buvidal has captured >30% of the *total* opioid treatment market in the Nordics, with Finland at ~65%. In Australia, where it has competed head-to-head with its main long-acting competitor *Sublocade* from opioid treatment pioneer *Indivior*, it has captured ~80% of the long-acting BPN segment. However, importantly, there is a large penetration spread, with e.g. the major European markets on average remaining at ~10% penetration, leaving much room to grow. As well, the US version Brixadi was launched in late 2023, and it was able to capture ~20% of the long-acting BPN segment within its first year in this large and important market. Consequently, its closest peer Indivior, issued two profit warnings in 2024 including a reduction of its 2025 guidance. This history points to impressive momentum for Camurus

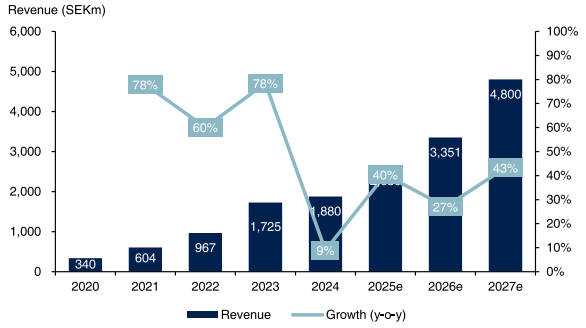
Blockbuster drug in Ph 3

Beyond opioid treatment, Camurus is developing *CAM2029* for the treatment of 1) acromegaly, 2) gastroenteropancreatic neuroendocrine tumours (GEP-NETs) and 3) polycystic liver disease (PLD). CAM2029 for acromegaly, with a successful Ph 3 and market approval around the corner, and PLD are nice additions to the product portfolio. However, the largest potential lies within the cancer space GEP-NETs. The two competing GEP-NET drugs by Novartis and Ipsen each had sales of over USD 1bn in 2024. Top-line results for the GEP-NET Ph 3 trial will likely come within 12 months. If Camurus can show superiority in terms of cancer control due to much greater drug exposure over time, for which we estimate a 50% likelihood of approval, CAM2029 will become a blockbuster.

Excellent growth coupled with a 92% gross margin

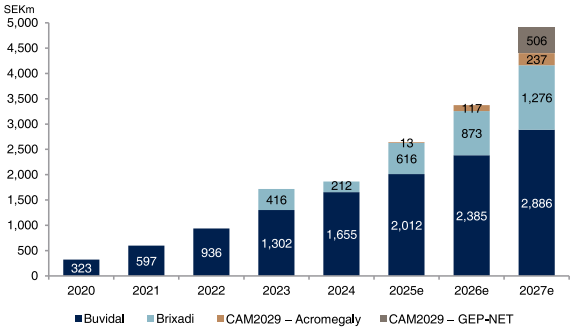
Camurus has shown steady high double-digit sales growth (19% in 2024 when adjusting for SEK 406m milestone payments for Brixadi in 2023), more specifically, a CAGR of ~53% since 2020 and ~39% since 2022. We are confident that the growth story will remain, and estimate a risk-adjusted CAGR of 34% until 2030e. On top of that, Camurus has created hefty operational leverage, with a stable 92% gross margin.

Steady double-digit revenue growth (SEK 406m in milestone revenue in 2023)



Source: ABG Sundal Collier, Company Data

CAM2029 will soon add to growth

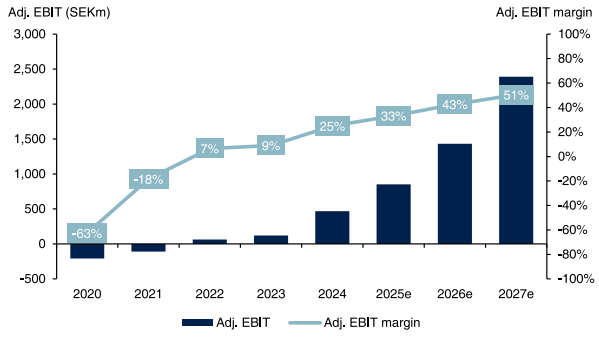


Source: ABG Sundal Collier, Company Data

Great EBIT margin and financial position

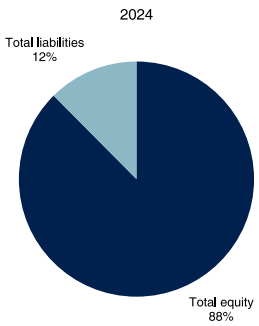
Camurus' main expenses are marketing and sales costs and R&D, while capex is very low due to mainly third-party manufacturing. We consider the 50% EBIT margin by 2027 envisioned by the company to be well within reach. Additionally, the balance sheet is sturdy, with an equity ratio of close to 90% and a net cash position of SEK 2.75 bn.

Steady improving adj. EBIT margin



Source: ABG Sundal Collier, Company Data

SEK 2.75bn cash out of SEK 3,3bn equity – no IBD



Source: ABG Sundal Collier, Company Data

ABGSCe vs. consensus and company guidance

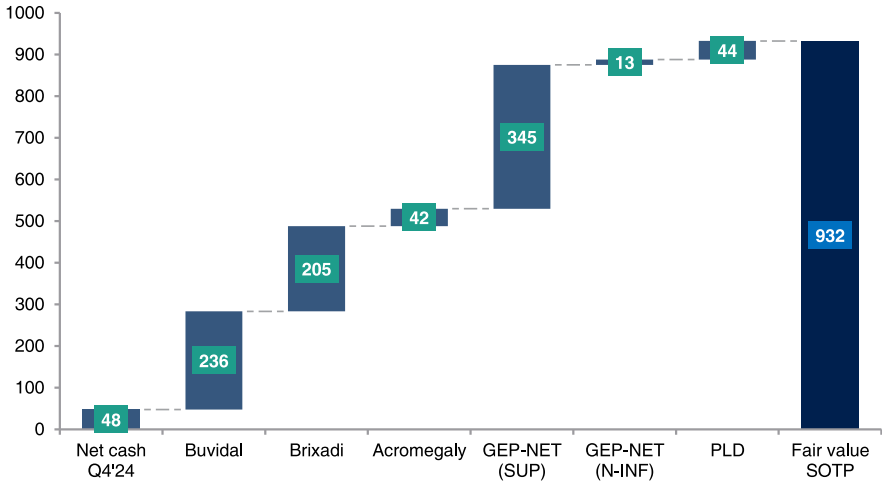
We believe parts of the consensus are too optimistic and/or have not been recently updated short-term, particularly on Buvidal and CAM2029 for acromegaly. For 2025e, when adjusting for the stronger SEK, we are in the low-mid guidance range for sales and mid-high range for pre-tax-profit. Importantly, we are above the 2027 visions of SEK 4.5bn revenue with a ~50% operating margin — we estimate ~SEK 4.8bn in revenue with a ~51% EBIT margin in 2027e.

Attractive valuation

We primarily value Camurus using a risk-adjusted DCF SOTP approach that combines the estimated valuations of: 1) Buvidal, 2) Brixadi royalties and sales milestones, and 3) CAM2029. We use a standard WACC of 9% and a terminal growth rate of 0% across all indications to stay prudent. We mainly use the multiples valuation as a sanity check, as good peers are scarce and Camurus' huge CAM2029 potential is not accounted for within a three-year timeframe. Still, given the remarkable growth rate — a P/E of ~25x in 2026e, ~15x in 2027e and ~9x in 2028e on our risk-adjusted estimates — we consider the valuation attractive.

Although we fully disregard the projects below the red line in the figure above, including rare genetic obesity disorders (CAM4072), Raynaud's phenomenon (CAM2043) and long-acting semaglutide (CAM2056), the valuation is appealing. The approved products Buvidal, Brixadi, soon-to-be CAM2029 for acromegaly, and net cash alone justify today's share price with a fair value of SEK 530 combined.

Sum-of-the-parts – waterfall plot (risk-adjusted)



Source: ABG Sundal Collier, Company Data

Footnote: Net cash Q4'24 + Buvidal + Brixadi + Acromegaly = SEK 530

In other words, the blockbuster candidate comes on top of the above. A superiority scenario for CAM2029 in GEP-NET, for which we estimate a decent 50% likelihood, would alone be worth more than the entire current market cap.

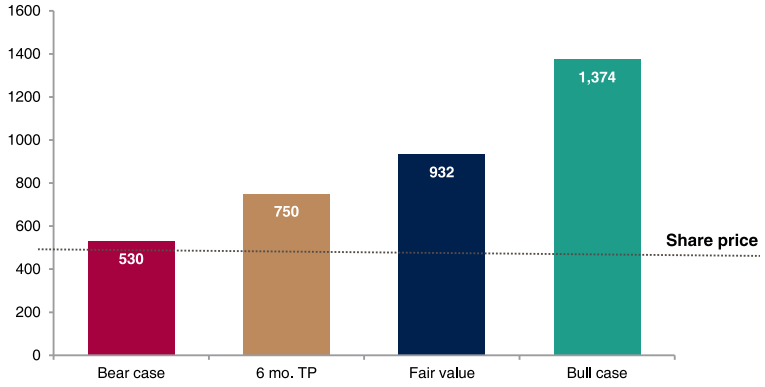
Sum-of-the-parts – table (Base case)

Base case SOTP	Value, de-risked (SEKm)	Risk-adjustment	Value, risked (SEKm)	Value/share (SEK)
Net cash Q4'24	2,853		2,853	48
Discounted EV – Buvidal	14,123	100%	14,123	236
Discounted EV – Brixadi	12,272	100%	12,272	205
Discounted EV – CAM2029 - Acromegaly	2,786	90%	2,507	42
Discounted EV – CAM2029 - GEP-NET (SUP)	41,398	50%	20,699	345
Discounted EV – CAM2029 - GEP-NET (N-INF)	1,908	40%	763	13
Discounted EV – CAM2029 - Polycystic liver d.	8,877	30%	2,663	44
Fair value SOTP	84,216		55,880	932

Source: ABG Sundal Collier, Company Data

While we have assigned a 50% likelihood for CAM2029 proving superiority, we are very confident that CAM2029 will at least be as good as the two competitors in terms of cancer control, i.e. proving non-inferiority, while better convenience profile comes in addition to that. This is key, as the non-inferiority scenario (we estimate 40% scenario likelihood) still covers the development, sales and marketing costs, providing important downside protection.

SOTP valuation range



Source: ABG Sundal Collier

Near-term triggers

Near-term triggers	
Q2'25e	POSITANO Ph 2b readout for PLD
Q2-Q3'25e	EU approval for CAM2029 for acromegaly
Q2-Q3'25e	Resubmission of NDA to the FDA for CAM2029 for acromegaly
H2'25	Ph 1 readout for once-monthly semaglutide (CAM2056)
Q4'25-Q1'26e	SORENTO Ph 3 readout for GEP-NET
Q4'25-Q1'26e	US approval for CAM2029 for acromegaly

Source: ABG Sundal Collier, Company Data

BUY — TP SEK 750

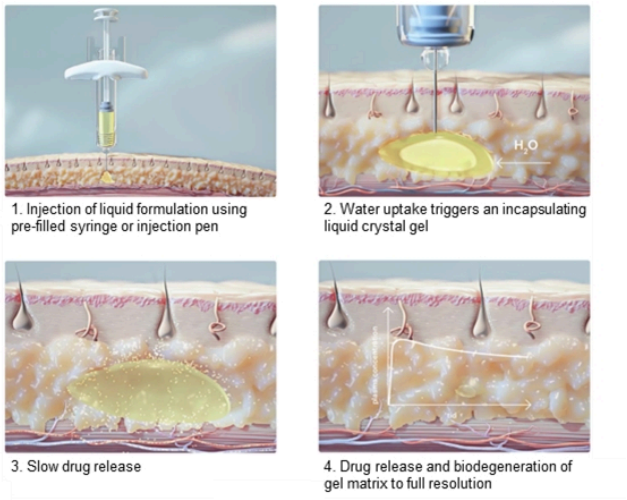
While the stock is up ~430% over the last five years, it is down ~30% from its peak levels in August 2024, primarily on acromegaly noise and general market uncertainty. We consider this a good buying opportunity, and initiate coverage with a BUY recommendation and a six-months target price of SEK 750. Our risk-adjusted DCF SOTP points to SEK 932/share, indicating even larger potential upside in the years to come.

FluidCrystal tech & broader strategy

Camurus' unique patent-protected FluidCrystal depot technology has been validated through more than 25 clinical trials and several market approvals, including Buvidal/ Brixadi for the treatment of opioid dependence. The technology entails a liquid lipid-based solution containing a dissolved established active pharmaceutical ingredient (API) for easy subcutaneous injection with extended and stable release.

Upon contact with tissue fluids, the FluidCrystal lipid solution transforms into a liquid crystalline gel that encapsulates the active ingredient and creates the desired depot effect. The pharmaceutical compound is slowly released as the depot is gradually biodegraded by enzymes in the tissue. The release can be controlled, from several days to weeks or months, depending on the lipid composition and other factors. This improves treatment efficacy by providing controlled exposure of the active ingredient over time and reduces the burden of frequent dosing, which increases treatment adherence. No chemical modification of the API is necessary, and it is suitable across small molecules, peptides and proteins.

FluidCrystal mode of action



Source: Company Data

Injections are done with either a pen injection device or a pre-filled conventional syringe; both avoid the complex reconstitution steps involved with several other long-acting injections. The state-of-the-art pen injection device allows for convenient self-administration (if the indication allows it, i.e. not suitable for opioid dependence), which saves time and improves flexibility and treatment adherence.

Camurus' pen injection device allows for convenient self-administration

Source: Company Data

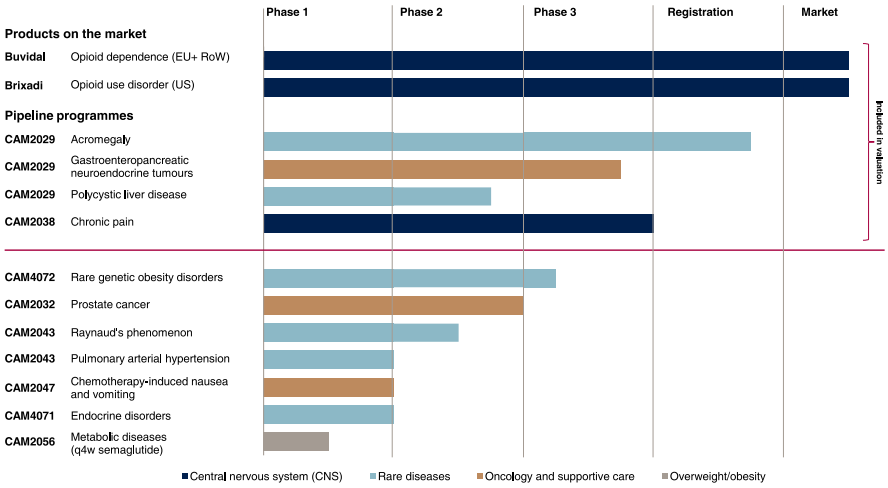
Pre-filled syringe

Source: The Index Project

By combining the FluidCrystal technology and well-established pharmaceutical substances (APIs) with documented clinical efficacy and safety profiles, development is streamlined, facilitating the use of abbreviated regulatory registration pathways, e.g. the 505(b)(2) in the US. Hence, new proprietary medicines can be developed faster, cheaper and with less risk compared to the development of medicines with new active substances. The approvals of weekly and monthly Buvidal/Brixadi have validated the FluidCrystal technology and significantly reduced the regulatory risks with Camurus' additional pipeline.

Camurus has a broad pipeline

Camurus' approved products and pipeline



Source: ABG Sundal Collier, Camurus

Footnote: q4w = dosed every four weeks

We do not currently include the assets below the red line in our valuation, as these projects are either long stalled or in the early stages, and therefore we believe their value is quite limited relative to the rest. However, these assets have the potential to develop, providing a clear, albeit modest, upside to our estimates. Nevertheless, the assets above the red line, i.e. Buvidal/Brixadi/CAM2038 and CAM2029, stand very well on their own.

M&A and new pipeline

Camurus continuously evaluates opportunities where it can best utilise its development expertise and FluidCrystal technology. New potential drug candidates may enter clinical phases after careful evaluation in pre-clinical studies of the target product profile in terms of drug loading, manufacturing, stability and in vivo drug release. An example of this is the newly launched once-monthly semaglutide (as opposed to Novo Nordisk's once-weekly Ozempic and Wegovy).

In terms of M&A, management stated as recently as the Q4'24 earnings call that they are primarily targeting commercial or pre-commercial assets (Ph 3 or later) that are synergistic with the current pipeline and/or commercial organisation. However, they may also consider Ph 2 assets under certain circumstances. In terms of disease areas, endocrinology (hormone disorders), niche oncology and CNS (central nervous system) are preferred.

Buvidal/Brixadi — Opioid use disorder

Opioid Use Disorder (OUD) is a chronic medical condition characterised by cravings for opioids. Opioids are a drug class that includes prescription painkillers (e.g. morphine, oxycodone and codeine), as well as illicit substances (e.g. heroin and fentanyl). While opioids are effective for pain management, their high potential for euphoria and addiction have caused a major worldwide health crisis. Apart from recreational drug abuse, this was especially fuelled by heavy marketing and promises from pharmaceutical companies to physicians that opioid pain medications were minimally addictive, as well as an increasing notion that pain should be treated at all costs. Camurus has carved out a leading position in the OUD market with its cutting-edge FluidCrystal-based products Buvidal (EU approval in 2018) and Brixadi (US approval in 2023). We devote a lot of attention to Buvidal/Brixadi, as this along with CAM2029 for the treatment of GEP-NETs constitutes the greater part of the valuation.

What is Buvidal/Brixadi?

Buvidal (European and RoW brand name) and *Brixadi* (US brand name) is a long-acting (once-weekly or -monthly) injectable depot formulation of buprenorphine (BPN), a partial mu-opioid receptor agonist designed for the treatment of opioid use disorder (OUD). It comes in a ready-to-use syringe, is available in multiple doses and can be initiated from day one. It is administered subcutaneously (i.e. only into the fatty layer underneath the skin, which is substantially less painful than intramuscularly) with a small needle by a healthcare professional. Camurus launched Buvidal in the EU and Australia in early 2019, which has been a huge success thanks to its efficacy and quality of life improvements for this vulnerable patient group. Brixadi was launched in the US in September 2023 together with US partner *Braeburn Inc*.

Camurus' partnership with Braeburn

In 2014, Camurus out-licensed Brixadi to Braeburn Inc., a US-based pharmaceutical company owned by the private equity company *Apple Tree Partners*. Under the agreement, Braeburn received the exclusive rights to Brixadi in North America and optional rights in certain Asian markets (expired in 2023) for the treatment of OUD and a possible label-extension against chronic pain. The agreement gave Camurus the rights to:

- USD 20m up front
- Regulatory milestones of USD 35m for OUD and USD 21m for chronic pain
- Sales milestones of up to USD 75m
- Mid-teen percentage royalties on Brixadi net sales

Additionally, Braeburn assumed responsibility for the development, regulatory approval and commercialisation of Brixadi. Braeburn was thought to be an appealing partner due to its OUD industry experience, where it shortly before had in-licensed Probuphine (six month buprenorphine implant). However, the Brixadi launch was severely delayed (2023 vs. early 2019 for Buvidal) due to three CRLs (complete response letter) issued by the FDA, of which the first in 2018 requested additional information and the latter two related to quality issues at Braeburn's contract manufacturer. As well, Camurus and Braeburn were in an arbitration process in 2020, after Camurus had issued Braeburn with a material breach notice questioning its performance. Although this was ruled in Braeburn's favour, it showcases the poor support that Camurus initially received in the US. Camurus also had to withdraw its EMA and TGA (Australia) applications for label-extension of Buvidal to include chronic pain in patients with OUD. The applications relied on positive Ph 3 clinical trial results from Braeburn in the US (completed in 2020), but the data was ultimately deemed insufficient.

Key timeline – Buvidal

Buvidal	
Date	**Key Events**
2005	FluidCrystal patents filed
2007	Start of development
Q4 '16	Positive Ph 3 efficacy study
Q2 '17	Positive Ph 3 safety study
Q4 '18	Approved for treating opioid dependence in the EU and Australia
Q1 '19	Launched in the EU as the first long-acting treatment of opioid dependence
Q3 '19	Launched and subsidised in Australia
Q4 '19	DEBUT trial showed superiority in patient satisfaction compared to daily buprenorphine
Q1 '21	EMA approves higher monthly dosing (160 mg)
Q2 '21	Key label updates in Australia: Higher monthly dosing (160mg) and removal of previous requirement of stabilisation on sublingual buprenorphine
Q2 '22	Launched in Egypt and Saudi Arabia as the first countries in the MENA region
Q2 '24	Showed effectiveness in treating opioid dependence in patients using fentanyl
Q1 '25	Launched in Switzerland, making Buvidal available in more than 20 countries

Source: ABG Sundal Collier, Company Data

Key timeline – Brixadi

Brixadi	
Date	**Key Events**
2005	FluidCrystal patents filed
2007	Start of development
Q1 '12	Pre-IND (investigational new drug) meeting with the FDA
Q4 '14	Partnership agreement with Braeburn Inc.
Q4 '15	Fast Track Designation granted by the FDA
Q4 '16	Positive Ph 3 efficacy study
Q2 '17	Positive Ph 3 safety study
Q3 '17	Submitted NDA (New Drug Application) for opioid use disorder
Q1 '18	First CRL (complete response letter) issued by the FDA
Q2 '20	Camurus and Braeburn enter arbitration proceedings over material breach allegations
Q4 '20	Second CRL by the FDA
Q4 '20	Braeburn ruled by ICC (International Court of Arbitration) not to have been in material breach
Q4 '21	Third CRL by the FDA
Q4 '22	Resubmission to the FDA
Q2 '23	FDA approval for treatment of moderate to severe opioid use disorder
Q3 '23	Launched in the US
Q2 '24	Showed effectiveness in treating opioid dependence in patients using fentanyl

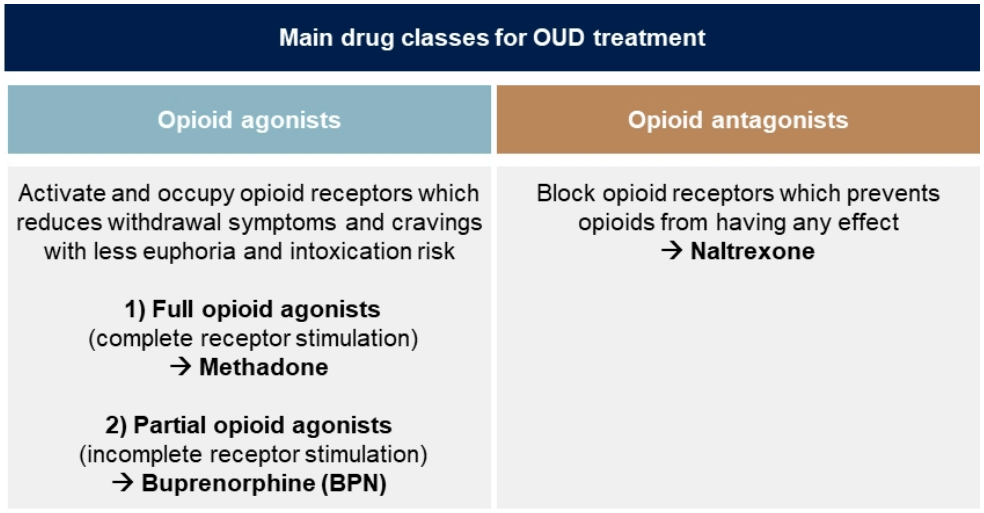
Source: ABG Sundal Collier, Company Data

Two medical approaches for treating OUD

Opioids are a class of drugs derived from the opium poppy, which includes prescription painkillers (e.g. morphine, oxycodone and codeine) as well as illicit substances (e.g. heroin and fentanyl).

Treatment of opioid use disorder (OUD) consists of psychotherapy (counselling and behavioural techniques) and prescribed medications. This is named *Medication-Assisted Treatment* (MAT). Since OUD is a chronic condition, ongoing treatment and long-term monitoring are normally required. The two main medical approaches are opioid *agonists* and opioid *antagonists* (“*anti-*” meaning “against” in Greek).

- Opioid agonists stimulate opioid receptors in the brain, which reduces withdrawal symptoms and cravings. Otherwise, withdrawal symptoms can be extremely unpleasant, including potential anxiety, depression, pain, vomiting and cold sweats, among others. Simply put, opioid agonists used in OUD treatment are less potent opium derivatives than their misused counterparts, which are substituted to even out withdrawal and significantly reduce the risk of overdosing in the process of rehabilitating drug addicts. These are categorised as either:
  - 1) *full* opioid agonists, which provide a complete stimulation of the receptors, most notably methadone, or
  - 2) *partial* opioid agonists, which provide a somewhat reduced effect, but importantly through their receptor binding may prevent stronger opioids from binding to the receptors. The most important is buprenorphine (the active pharmaceutical ingredient in Buvidal/Brixadi).
- Opioid *antagonists* work by *blocking* opioid receptors, which prevents opioids from binding to the receptors. This approach is used less frequently, as it requires that the individual has already detoxed from opioids while also offering lower adherence rates due to no mood stabilisation or craving effects. The most important opioid antagonist in the MAT setting is *naltrexone.*



Source: ABG Sundal Collier

The OUD market

The three approved medications for treating OUD are: methadone, buprenorphine and naltrexone. It is common for patients to begin treatment with daily oral buprenorphine (with or without naloxone). If they respond well, they may transition to longer-acting injectable forms. For individuals with strong dependence, methadone is often used as the initial therapy, with the intention of switching to buprenorphine after stabilisation. The three approved medications are available in different formulations and brands:

US approved products

Name	Substance	Form	Short/Long	Frequency	Company	Approval
Methadone	Methadone	Tablet	Short-acting	Daily	Generic	1972 (1947)
Subutex	BPN	Sublingual tablet	Short-acting	Daily	Indivior	2002
Suboxone	BPN/Naloxone	Sublingual tablet/film	Short-acting	Daily	Indivior	2002/2010
BPN	BPN	Sublingual tablet/film	Short-acting	Daily	Generic	2009
Vivitrol	Naltrexone	Intramuscularly	Long-acting	Monthly	Alkermes	2010
Zubsolv	BPN/Naloxone	Sublingual tablet	Short-acting	Daily	Orexo	2013
Bunavail	BPN/Naloxone	Buccal film	Short-acting	Daily	BDSI	2014
Probuphine	BPN	Subdermal implant	Long-acting	6-months	Titan	2016
Sublocade	BPN	SC injection	Long-acting	Monthly	Indivior	2017
BPN/Naloxone	BPN/Naloxone	Sublingual tablet/film	Short-acting	Daily	Generic	2013/2018
Brixadi	BPN	SC injection	Long-acting	Weekly/Monthly	Camurus	2023

Source: ABG Sundal Collier, Company Data

Footnote: BPN = buprenorphine. Naloxone resembles Naltrexone, but with much faster and shorter effect.

As a once-weekly or once-monthly buprenorphine (BPN) injection, Camurus' Buvidal/Brixadi is ideal for patients who are not fully detoxified and require opioid agonist treatment. Its main competitors are:

- Methadone (full opioid agonist) remains widely used as a daily oral tablet as it has by far the longest track record (~50 years) and has become a relatively inexpensive generic. Methadone is effective in reducing withdrawal symptoms and cravings, but can be easily be abused if not handled carefully. It is most commonly used in people who have abused illicit drugs for euphoric effects, such as heroin. However, because of its high potential for abuse, it is usually only dispensed during daily visits to specialist opioid treatment programmes. Patients on methadone are more difficult to switch to Buvidal/Brixadi, as they are more dependent on the stronger effects of a full opioid agonist (i.e. full activation of opioid receptors). Over time, however, the goal should be for many of these patients to become less dependent on the strong opioid effects.

Closer to this are the other buprenorphine-based drugs (partial opioid agonists). These drugs partially activate opioid receptors, helping to reduce cravings and withdrawal symptoms, but carry a much lower risk of misuse and fatal overdose (mainly due to respiratory depression). For buprenorphine in particular, it is important to note that its very high affinity for opioid receptors (binding strength) prevents more dangerous opioids such as heroin, morphine and fentanyl from binding to the receptors. The most important are:

- Indivior's Subutex (BPN sublingual tablet) and Suboxone (BPN/naloxone sublingual tablet/film) are daily medications approved in 2002. The naloxone component in Suboxone is an opioid antagonist that stops all opioid effects, and is only added to prevent abuse (crushing the tablets/extracting the film and injecting the powder), as naloxone is not activated when taken orally. This would inhibit any euphoria and cause severe unpleasantness.

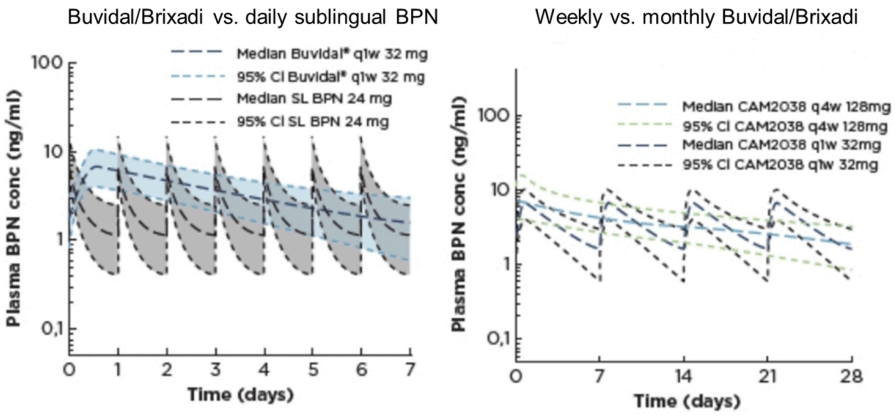
As the patents were about to expire, Indivior launched Suboxone sublingual film, a slightly different formulation with somewhat improved bioavailability. Subutex and Suboxone have been huge successes for Indivior. Indeed, Suboxone achieved blockbuster status in 2010, when global sales exceeded USD 1.2 billion, with US sales alone accounting for USD 1 billion (SEC). Suboxone sales showed strong resilience from 2013 to 2018 (still ~50% average market share in 2018) (Indivior), but this has declined rapidly since then, e.g. to ~15% in Q2'23 (Indivior). Nevertheless, the long period of strong resilience shows that the dynamics of the OUD market are different from most pharmaceutical markets. This can largely be explained by the disease and the patient population:

Subjective symptoms dominate (perceived differences potentially due to small differences are difficult to verify), higher scepticism of unfamiliar products, drug diversion/street value component (not uncommon to sell some of the prescribed medication on the street to finance treatment, more common in the US).

However, these daily medications are often problematic as many patients face a daily battle to avoid relapse. This has created a medical need for players such as Camurus. Long-acting products offer some key advantages:

- Convenience: They eliminate the need for daily administration. This is particularly inconvenient for methadone, which requires most patients to make daily, time-consuming and stigmatising clinic visits that tie up healthcare professionals.
- Improved patient adherence: Adherence is achieved over a week or month on the basis of a single dose administered by a clinician, rather than a daily decision by the patient to adhere to the dose. Patients are much less likely to relapse if the daily dosing battle can be eliminated.
- Efficacy: Long-acting formulations provide stable drug levels in the blood. The pharmacokinetic (what the body does with the drug) and pharmacodynamic (what the drug does to the body) profiles are much more stable compared to the large peaks and troughs seen with daily dosing. This is illustrated in the graphs below:

Blood plasma concentration for short vs. long-acting BPN



Source: ABG Sundal Collier, Company Data

- Indivior's *Sublocade* is the most important long-acting competitor. Like Buvidal/Brixadi, Sublocade is a subcutaneous long-acting BPN. Sublocade is a less flexible option, as it only comes in monthly dosing, i.e. does not allow for gradual transition via a period of weekly dosing. It was launched in the US in early 2018, and in Australia and certain European countries (under the brand name *Subutex prolonged release solution for injection*) in mid-2020.

- Another option is *Vivitrol*, a monthly intramuscular injection containing naltrexone, i.e. an opioid antagonist blocking opioid receptors. It is used less frequently, as patients have to be fully detoxed for a minimum of 7-10 days prior to initiating this opioid antagonist (otherwise they would experience massive discomfort), as well as due to lower adherence rates given no mood stabilisation and painful injections. Those who have already succeeded in this transition are a lot less likely to switch back to an opioid agonist, but market share from newer OUD patients may be captured. It is not approved in the EU.
- A final long-acting treatment is *Probuphine/Sixmo*, which is a six-month implant placed under the skin. It has seen very limited success, particularly due to the inconvenience of needing a small procedure every six months, but we mention it because the US rights were out-licensed to *Braeburn* in 2012-2018 (Camurus' US partner for Brixadi).

The following table gives a more detailed overview of the long-acting medication assisted treatments (MATs).

Competitive landscape in long-acting release

Brand name	Buvidal/Brixadi	Sublocade	Vivitrol	Probuphine
Company	Camurus	Indivior	Alkermes	Titan (Braeburn, Molteni)
Active Substance	Buprenorphine	Buprenorphine	Naltrexone	Buprenorphine
Approved - EU	Nov-18	May-20 (Subutex Prolonged-Release Solution for Injection)	No	June-19 (Sixmo)
Approved - US	May-23	Nov-17	2006/2010	May-16
Indication	OUD	OUD	Alcohol dependence, OUD	OUD
Presentation	Prefilled syringe	Prefilled syringe	Diluent + powder with Vivitrol microspheres + prepackaged preparation needle syringe	Surgical implant
Administration	Subcutaneous	Subcutaneous	Intramuscular	Subdermal
Doses	Weekly: 8mg/0.16ml, 16mg/0.32ml, 24mg/0.48ml, 32mg/0.64ml; Monthly: 64mg/0.18ml, 96mg/0.27ml, 128mg/0.36ml, 160mg/0.45ml	100mg/0.5ml, 300mg/1.5ml	380mg/3.4ml, requires an opioid-free duration of a minimum of 7-10 days	74.2mg/implant
Dosing Interval	Weekly/Monthly	Monthly	Monthly	Every six months
Needle Size	23G	19G	20G	na
Storage	Room temperature	As of recent up to 12 weeks room temperature storage. Historically refrigerator storage requirement.	Refrigerated. May be stored at room temperature for up to 7 days before use. Must be removed from cold storage at least 45 min before injection.	Room temperature
Day one initiation	Yes	No	No	No

Source: ABG Sundal Collier, Company Data

Footnote: G = Gauge. The bigger the number, the smaller the needle

Put simply:

1) Long-acting agents provide better efficacy and convenience than short-acting agents.

2) Among long-acting agents, Buvidal/Brixadi brings the best total package in terms of convenience and optionality.

Although, Camurus looks to capture market share from the other long-acting medications in the US, switching patients from methadone and particularly short-acting buprenorphine constitutes the biggest opportunity.

The table below shows net product sales in 2024 for the main branded OUD treatment players. However, a majority of patients use generic products.

Main branded OUD treatment players with net product sales in 2024

	Indivior	Alkermes	Orexo	Camurus	Braeburn**
Main OUD product(s)	Sublocade*, Suboxone	Vivitrol	Zubsolv	Buvidal	Brixadi (licensed from CAMX)
OUD net product sales, USDm	1,148	457	50	145	116
Market cap, USDm	1,207	5,534	51	3,517	n.a.

Source: ABG Sundal Collier, Company Data

*Footnote: *Sublocade with USD 756m*

***Braeburn is Camurus' US partner. Brixadi is the US brand name eqiuvalent to Buvidal in Europe and RoW. Camurus receives mid-teen royalites on Brixadi.*

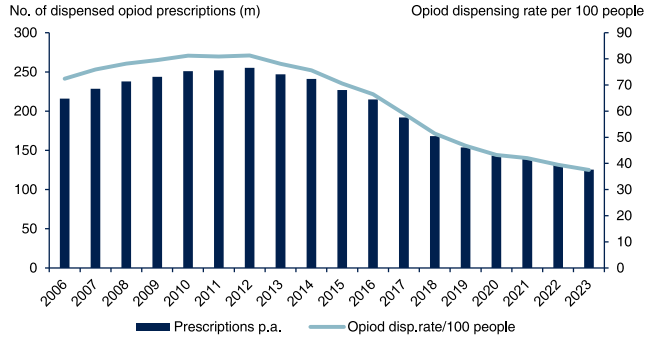
Opioid use disorder — US

Background for the US opioid epidemic

The US opioid epidemic is a major public health crisis that emerged in the late 1990s, caused by common misuse of prescription and non-prescription opioids. This was primarily fuelled by heavy marketing and promises from pharmaceutical companies to physicians that opioid pain medications, such as *OxyContin* and *Vicodin*, were minimally addictive, as well as an increasing notion that pain should be treated at all costs. In 1996, the American Academy of Pain Medicine and the American Pain Society issued a consensus statement which argued that opioids should have a role in the treatment of patients with chronic non-cancer pain and included statements such as: “Studies indicate that the *de novo* development of addiction when opioids are used for the relief of pain is low.” This was followed in many states by the passage of “Intractable Pain Acts”, which removed sanctions for prescription of long-term and high-dose opioid therapy that had previously been in place (Sullivan, *Pain*, 2013).

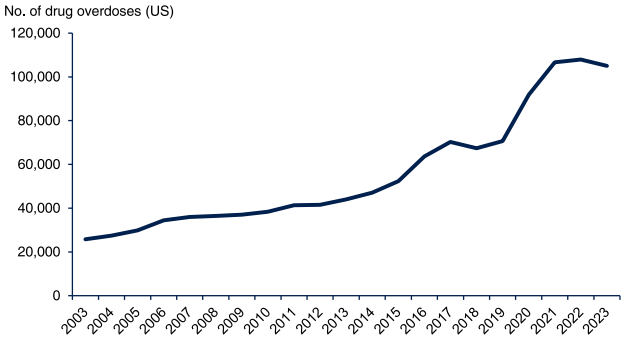
As overprescription worsened in the late 1990s and early 2000s, the crisis unfolded. Also, when authorities tried to put a stop to the escalating crisis by cutting back on prescription drug availability, many patients were left struggling with addiction. Unable to access their usual prescription medications, many turned to heroin, which was a lot cheaper than prescription drugs and was becoming more broadly available. Despite reduced opioid prescriptions after the peak in 2012, drug overdose rates continued to rise, and wereadditionally aggravated by the COVID-19 pandemic.

Total number and rate of dispensed opioid prescriptions



Source: ABG Sundal Collier, CDC

Number of drug overdoses on the rise – rolling 12 months



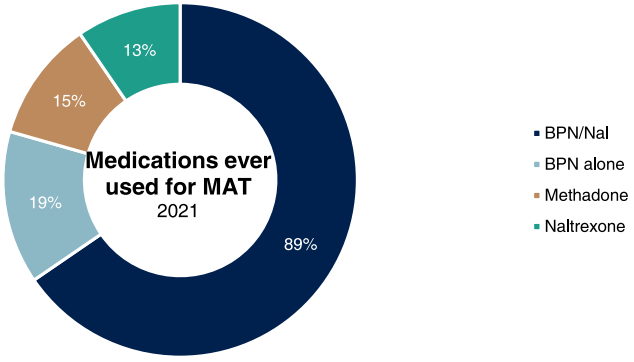
Source: ABG Sundal Collier, CDC

In its *2023 National Survey on Drug Use and Health, The Substance Abuse and Mental Health Services Administration* estimated that there were ~5.4 million Americans above 18 years with OUD, of which ~1 million (18.5%) received MAT (2023 National Survey on Drug Use and Health, SAMHSA).

US market constellation

As OUD in the US primarily is caused by prescription drug misuse, methadone is less used, and various buprenorphine-based products dominate the market. This is illustrated by the following chart, which depicts the findings from a 2021 survey, where MAT users were asked what kind of medications they have ever received:

Medications ever used by current patients, % of patients



Source: ABG Sundal Collier, NIH

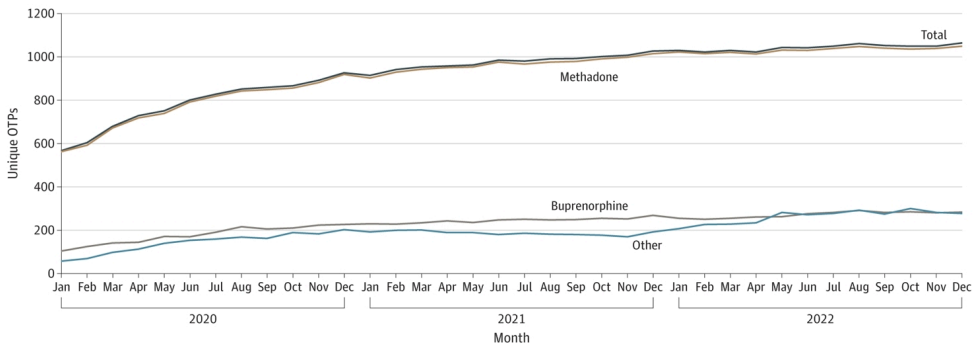
Footnote: Percentages do not add up to 100% since a single patient often has used more than one type of medication

Funding barriers and governmental support for OUD treatment

Due to the high risk of misuse, methadone can only be distributed though special federally run clinics called Opioid Treatment Programmes (OTPs). BPN (buprenorphine) on the other hand, can in addition to OTPs be provided in the outpatient setting by healthcare professionals with a standard controlled substances licence (mandatory for all physicians and nurse practitioners). However, until December 2022, only *X-waivered* clinicians were allowed to prescribe BPN. An X waiver referred to the Drug Addiction Treatment Act (DATA 2000) “waiver” legislation, which authorised the outpatient use of buprenorphine after having completed a training course. There were also limitations to the amount of prescriptions. This softening of BPN prescription rules has been beneficial to both patients and Camurus.

Today, both Medicare and Medicaid provide coverage to OTPs. However, while Medicaid has done this for several decades, Medicare did not begin covering opioid treatment programmes (OTPs) until January 2020. Because methadone needs to be dispensed by certified OTPs, a patient with traditional Medicare, prior to this change, could only receive methadone if they paid for the care out of pocket or if they were dually insured with Medicaid and the care was paid for via their Medicaid benefit (Nakamoto et al., *JAMA*, 2024). The policy change has contributed to a steady increase in the number of beneficiaries. Although OTPs are still dominated by methadone, there has been an increase in BPN, supported by Medicare.

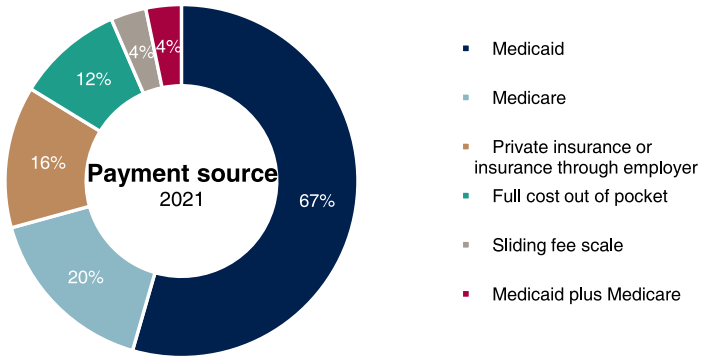
Trends in OTP (Medicare)



Source: ABG Sundal Collier, JAMA

BPN-based medications such as Suboxone, Sublocade and Brixadi can be covered by both Medicare and Medicaid both within and outside of Opioid Treatment Programs (OTPs), but coverage details and requirements vary.

Payment sources (US), % of patients



Source: ABG Sundal Collier, NIH

Additional funding may come from settlements with pharmaceutical companies ruled as being behind the opioid crisis, e.g. a USD 26bn 2021 settlement between the US Attorney General and the three largest US drug distributors and Johnson & Johnson .

One key part of the funding barrier is that many Medicare and Medicaid programmes require prior authorisations (PAs) for covering BPN prescriptions, which is a process used by Medicaid, Medicare, and private insurers to determine whether they will approve and cover a specific treatment before it is provided to the patient. PA requirements in Medicaid programmes have been rated by health care providers as the highest barrier to accessing MAT (Keshwani, Jama Health Forum, 2022). Fortunately, the trend is towards less stringent PA requirements. This may have a positive effect on Brixadi sales, although cheap BPN generics are likely to benefit the most in the short term.

The Prison System

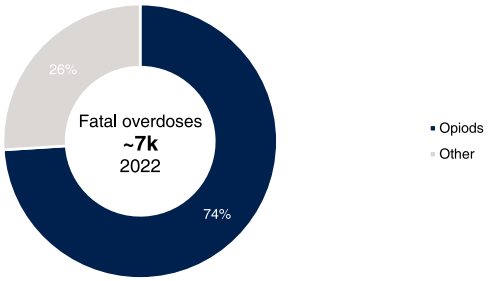
The criminal justice system has become a key area of concern within the opioid crisis, with approximately 15% of US inmates believed to have OUD. A significant challenge is the limited access to treatment. A US survey conducted between June 2022 and April 2023 found that fewer than half (~44%) of US prisons offer medications used for OUD. Among those that do, buprenorphine is provided by ~70% and methadone by ~47% (nih.gov). However, a key issue remains that the criminal justice system often mandates OUD treatment for detoxification only, especially during the intake or pretrial phase, while long-term treatment for recovery (e.g. ongoing use of buprenorphine or methadone) is not consistently mandated or supported, and often left up to individual correctional facilities or state policies. Nonetheless, stronger clinical evidence and guidance recommendations, increased funding (this channel is largely dependent upon government funding) and supportive activities from agencies like the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Bureau of Justice Assistance have started to materialise.

Opioid dependence in Europe

Big issue being dealt with relatively well

The European market differs both in terms of size and the main background for the opioid dependence. While the US situation predominantly was caused by a boom in opioid prescriptions and subsequent prescription opioids misuse, the European situation has to a larger degree developed due to *illicit* drug use. The number of opioid users is lower, but opioids are still present in ~75% of all drug-induced deaths, underscoring the risks associated with opioid use.

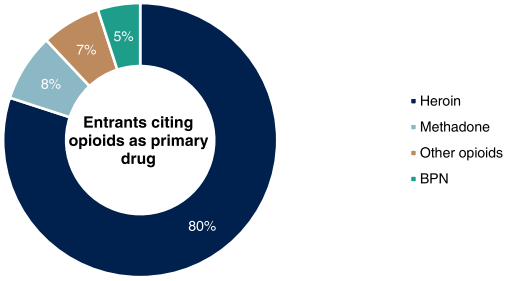
Opioids found in ~75% of all fatal overdoses in 2022



Source: ABG Sundal Collier, EUDA

Footnote: No. for EU, Turkey, and Norway

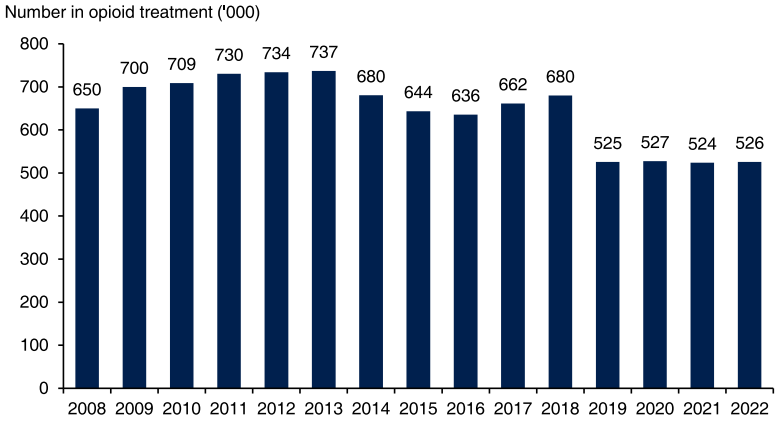
Heroin the main culprit in Europe



Source: ABG Sundal Collier, EUDA (2018)

The graph below shows relatively stable numbers of MAT patients over the past 15 years, which may be explained by the chronic nature of opioid dependence. The drop in 2019 relates to the UK being removed from the statistics.

Number in treatment in the EU

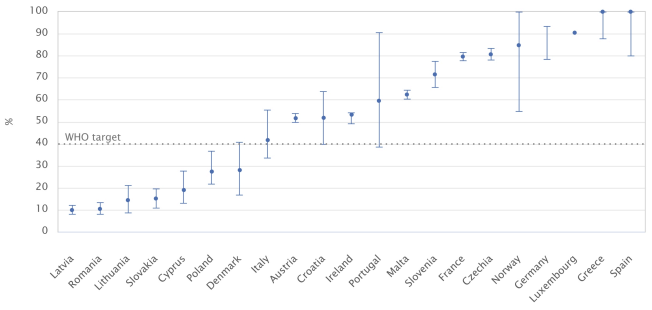


Source: ABG Sundal Collier, EUDA

*Footnote: *Incl. UK, Norway and Tyrkey until 2018, in 2019 UK was removed*

Coverage is relatively high in Europe as a whole, but varies widely between countries. Persistently low coverage, particularly in Eastern Europe, partly explains the lack of increase in treatment figures. Nevertheless, the graph on the right below shows a steady increase in the number of European countries introducing buprenorphine (BPN) treatment. This is positive for Camurus, as it is generally easier for a superior product like Buvidal to take market share from competitors than to find currently untreated patients. Budgetary constraints will often be the reason for low uptake, making it less likely to afford the premium of Buvidal compared to cheap generic options.

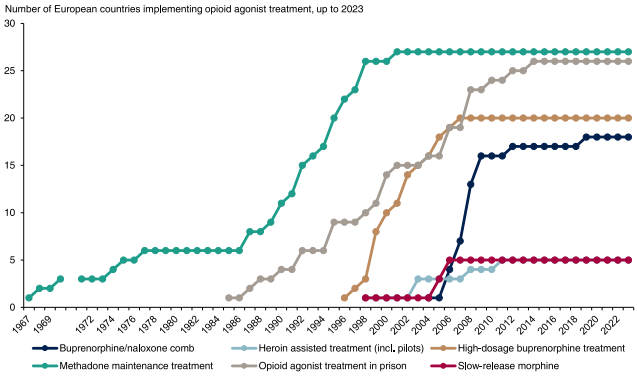
Coverage of opioid agonist treatment in 2022



Source: EUDA

Footnote: Coverage is defined as the share of high-risk opioid users receiving opioid agonist treatment

Number of European countries implementing opioid agonist treatment



Source: ABG Sundal Collier, EUDA

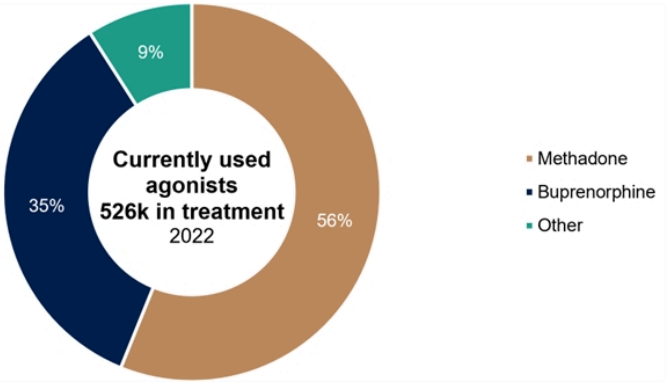
Similar to the US, securing adequate funding is essential for expanding the availability and uptake of MAT. Some countries have already taken steps in this direction. For instance in 2021, the Scottish Government announced a GBP 250m investment over five years aimed at increasing treatment access. Another example is the 10-year UK "From Harm to Hope" campaign launched in 2021, which targets drug-related harm and illicit drug use. Backed by over GBP 3bn in investment for the first three years, it allocated GBP 780m specifically for OUD services. Notably, long-acting buprenorphine was highlighted as a promising treatment option to be further supported (HM Government).

EU market constellation

Methadone is the dominant medication type, with a ~55% market share. Apart from its long track record (~50 years) and relatively low cost, this is explained by opioid misuse in Europe being related to illicit drug use to a larger degree, as well as fewer reimbursement issues (e.g. Medicare not covering Methadone until 2020). BPN (the active pharmaceutical ingredient in Buvidal) has an overall market share of ~35%.

However, the preference for methadone vs. BPN varies greatly across Europe, from close to 100% methadone share in some countries like Estonia and the Netherlands to less than 50% in Sweden, Norway, Finland and France. In France, for example, this can be explained by MAT largely being administered in the outpatient setting as opposed to special MAT clinics, as is the case in most European countries. In total, there are eight European countries where BPN is most abundant, with the other four being Croatia, Slovenia, Georgia and Cyprus.

Currently used agonists for MAT – EU, Norway and Turkey

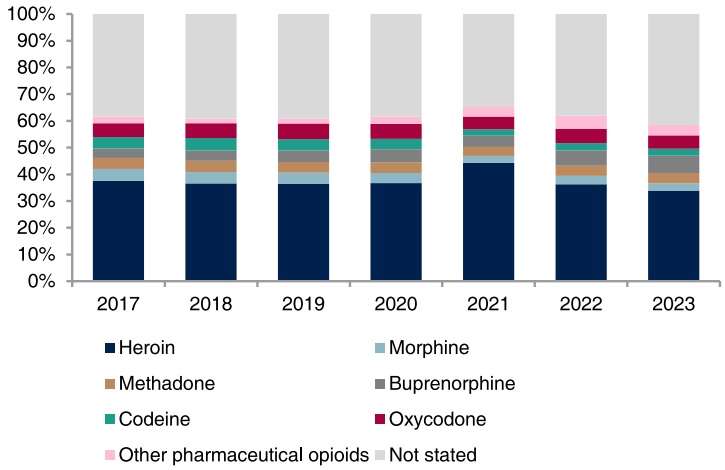


Source: ABG Sundal Collier, EUDA

Opioid dependence in Australia

Australia's opioid crisis sits somewhere between the US and Europe, but closer to the US. For much of the 2000s and 2010s, Australia saw a sharp rise in opioid-related harm, primarily driven by prescription opioids.

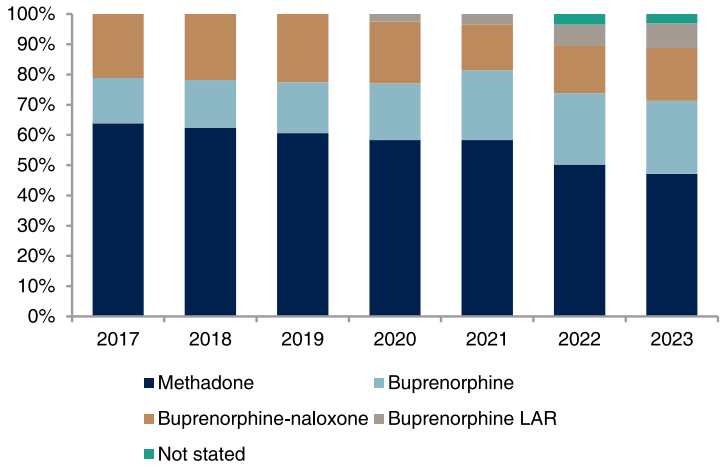
Proportion of patients by opioid type on a snapshot day, 2017-2023



Source: ABG Sundal Collier, Australian Institute of Health and Welfare

In 2023, ~56,000 individuals underwent medication-assisted treatment (MAT) on a snapshot day (including data for Western Australia), which has increased by ~20% since 2011 (AIHW). Similarly to Europe, there has been a trend of shifting from methadone to buprenorphine (BPN); in 2023, for the first time, more patients used BPN formulations than methadone, i.e. ~50% of the overall market. Still, methadone remains significantly more used than in the US.

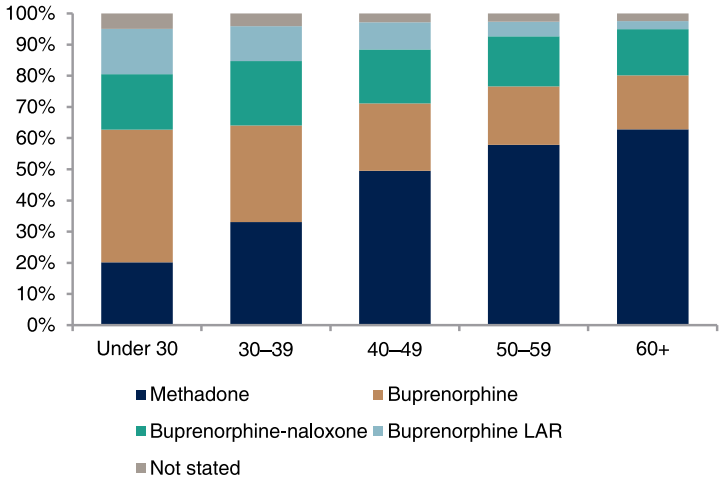
Proportion of patients receiving pharmacotherapy treatment on a snapshot day, 2017-2023



Source: ABG Sundal Collier, Australian Institute of Health and Welfare

The shift becomes further evident when age-stratifying the patients (although there is a retention bias, as methadone users are far less likely to be fully cured and ex. heroin users will be overrepresented among the oldest). BPN clearly is the preferred treatment option among young patients:

Proportion of patients by age group receiving pharmacotherapy treatment on a snapshot day, 2017-2023



Source: ABG Sundal Collier, Australian Institute of Health and Welfare

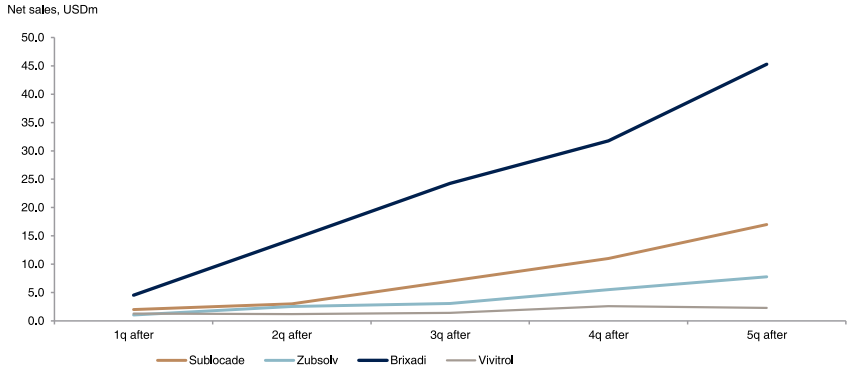
Australia has implemented measures to expand access to Buvidal, including allowing direct initiation without requiring prior use of sublingual formulations (initially required) and broadened prescribing authority from specialists to general practitioners.

However, in the numbers from the Australian Institute of Health and Welfare, there seems to be a massive underreporting of long-acting release BPN, i.e. only ~15% and ~16% of overall BPN formulations in 2022 and 2023, respectively. Contrary in 2024, Lintzeris et al. wrote an article in The Medical Journal of Australia where they estimated that approximately 50% of BPN treatment were long-acting formulations (Lintzeris et al., *Med J Aust*, 2024). This is also far more in line with statements by Camurus management, which at the Q1'23 earnings call stated that its ~80% share of the long-acting BPN market equated to ~20% of the overall OUD treatment market (i.e. long-acting BPN holding ~50% of BPN formulations and ~25% of the overall market)

Camurus has the remedy

As mentioned above, Buvidal/Brixadi (long-acting injectable depot formulation of buprenorphine) comes in a ready-to-use syringe, is available in multiple doses and can be started from day one. It is administered subcutaneously (i.e. only into the fatty layer under the skin, much less painful than an intramuscular injection) with a small needle by a healthcare professional. The active ingredient, buprenorphine, partially activates opioid receptors, helping to reduce cravings and withdrawal symptoms, but with a much lower risk of misuse and fatal overdose. Most importantly, buprenorphine has a very high affinity (binding capacity) for opioid receptors, preventing dangerous opioids such as heroin, morphine and fentanyl from binding to the receptors. Its great success since its launch in the EU and Australia in early 2019 is a testament to its efficacy and improvements in quality of life. Brixadi has also posted a very impressive performance following its launch in the US in September 2023, together with its US partner Braeburn.

Net sales first 18 months after launch

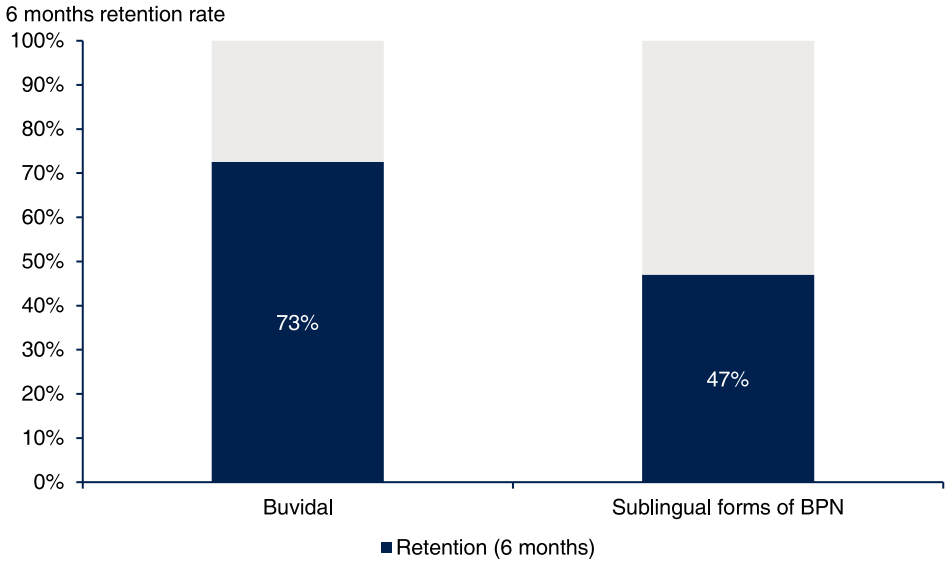


Source: ABG Sundal Collier, Company quarterly reports

Notably, Indivior (Camurus' main competitor in the long-acting OUD market) has seen slower than expected growth for Sublocade, leading Indivior to issue two profit warnings in 2024, attributing the decline to increased competition from Brixadi (Reuters). According to Camurus' CEO on the Q3'24 earnings call, Brixadi already had a ~20% share of the US long-acting BPN segment. Perhaps the dominance over Sublocade can be approximated to the situation in Australia, where Buvidal has ~80% of the long-acting BPN segment and 15-20% of the overall MAT market (bearing in mind that the long-acting segment is larger in Australia). We note that Indivior forecasts flat Sublocade sales growth for FY25 (-1% at the midpoint vs. FY24). From its peak in early 2023, Indivior's shares are down over 60%. Brixadi certainly looks set to cause Indivior headaches for years to come.

Still, switching patients over from sublingual BPN (short-acting), constitutes the biggest opportunity for Camurus due to its sheer size and poorer profile, including patient adherence. In the US, for example, Camurus management have disclosed that up to 70% of patients are coming from sublingual treatment.

Buvidal has a much higher retention rate vs. sublingual BPN



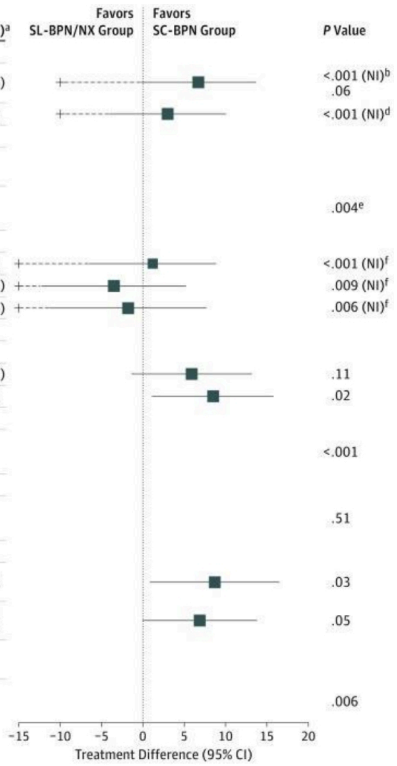
Source: ABG Sundal Collier, Lisbon Addictions

Buvidal/Brixadi — a summary of clinical studies

The submissions to the FDA, EMA, and TGA (Australia) included a total of seven studies, of which two were Ph 3 trials. Among the Ph 3 trials, one was a randomised, double-blind, *efficacy* trial, and one was an open-label long-term *safety* trial. Importantly, the Ph 3 efficacy trial with 428 patients had an *active* control, i.e. the control group received daily oral buprenorphine/naloxone. The trial was designed with two relatively similar primary endpoints to meet regulatory requirements from both the FDA and EMA. For the FDA, the primary endpoint was non-inferiority to sublingual buprenorphine/naloxone in terms of response rate, defined as no negative urine samples and no self-reported illicit opioid use. For EMA, the primary endpoint was the *proportion* of urine samples testing negative for illicit opioids during week 1-24, not including self-reports. Additionally, the study conducted a hierarchical test for superiority based on the *cumulative* distribution function (CDF) of the percentage of negative urine samples during weeks 4-24, which turned out positive (p = 0.004). The next outcome tested, superiority of response rate, was non-significant by only a relatively small margin (Lofwall et al., *JAMA Intern Med.*, 2018).

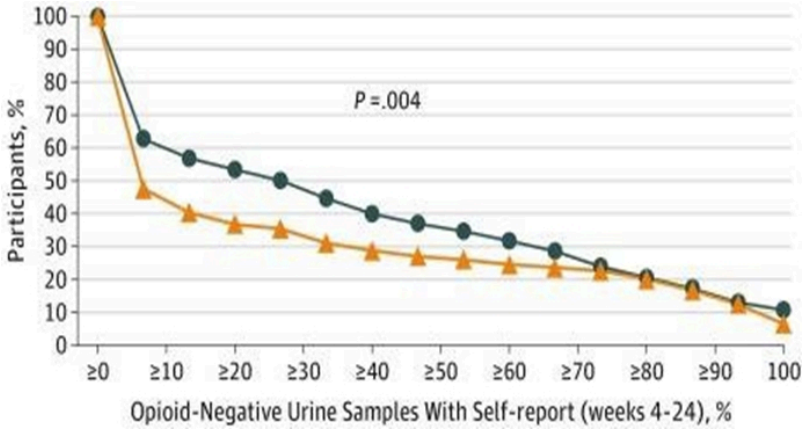
Pivotal Ph 3 results

Outcome	SL BPN/NX Group (n=215)	SC-BPN Group (n=213)	Treatment Difference (95% CI)[a]	P Value
Primary outcomes				
Opioid-negative urine samples (wk 1-24)	28.4 (2.5)	35.1 (2.5)	6.7 (−0.1 to 13.6)	<.001 (NI)[b] .06
No. (%) of responders[c]	31.0 (14.4)	37.0 (17.4)	3.0 (−4.0 to 9.9)	<.001 (NI)[d]
Secondary outcomes				
Weeks 4-24 opioid-negative urine samples with self-report, CDF, %[c]				
Median	0	27.6	NA	.004[e]
Mean (SE)	26.7 (2.5)	35.1 (2.5)		
Study retention, No. (%)				
Week 12 (phase 1)	170 (79.1)	171 (80.3)	1.2 (−6.4 to 8.8)	<.001 (NI)[f]
Week 24 (phase 2)	156 (72.6)	147 (69.0)	−3.5 (−12.2 to 5.1)	.009 (NI)[f]
Week 28 (follow-up)	126 (58.6)	121 (56.8)	−1.8 (−11.2 to 7.6)	.006 (NI)[f]
Other outcomes				
Opioid-negative urine samples, %				
Weeks 1-12 (phase 1), mean (SE)	29.9 (2.6)	35.8 (2.6)	5.9 (−1.3 to 13.1)	.11
Weeks 13-24 (phase 2), mean (SE)	25.4 (2.6)	33.9 (2.6)	8.5 (1.2 to 15.7)	.02
Weeks 4-24, IV use, CDF[c,g]				
Median	0	16.7	NA	<.001
Mean (SE)	15.4 (2.7)	30.9 (3.3)		
Weeks 4-24, no IV use, CDF[c,g]				
Median	13.3	33.3	NA	.51
Mean (SE)	38.5 (4.05)	39.9 (3.88)		
Sensitivity analyses				
Weeks 1-24 opioid-negative urine samples (missing not imputed), %	35.9 (2.77)	44.6 (2.8)	8.7 (0.9 to 16.4)	.03
Weeks 1-24 opioid-negative urine samples with self-report, %[c]	27.4 (2.45)	34.2 (2.46)	6.9 (0.0 to 13.7)	.05
Weeks 1-24 opioid-negative urine samples with self-report, CDF, %[c]				
Median	5.6	22.2	NA	.006
Mean (SE)	27.4 (2.47)	34.2 (2.43)		



Source: Lofwall et al., JAMA Intern Med., 2018

Superiority on key secondary endpoint

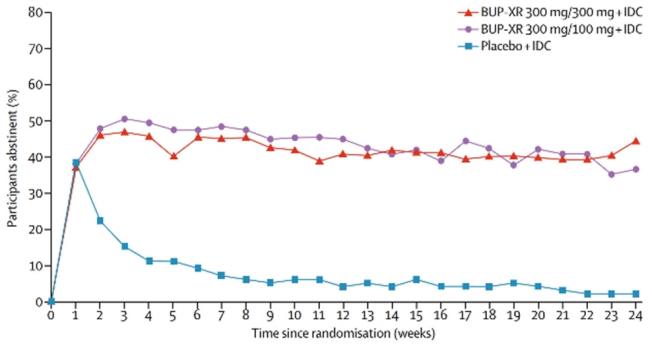


Source: Lofwall et al., JAMA Intern Med., 2018

Camurus' pivotal Ph 3 trial is the only trial among its long-acting rivals to go head-to-head vs. an active control. Additionally, the Vivitrol trial was open-label; only ~30% of patients had used opioids during the last 30 days, and people with cocaine abuse or heavy alcohol dependence were excluded (Lee et., *NEJM*, 2016).

The long-acting injectables have not been directly compared, and the different trial designs and patient populations make cross-trial comparison very difficult. Nonetheless, we note that within OUD, showing non-inferiority to SoC is a significant higher hurdle than showing superiority to placebo or counselling alone.

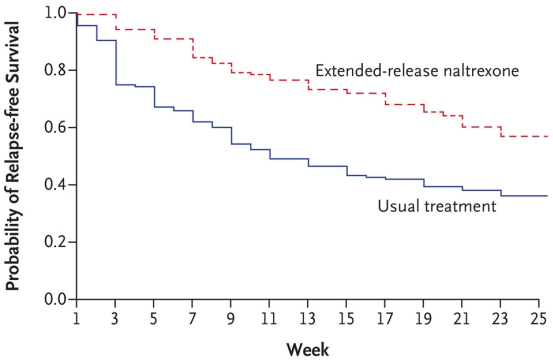
Sublocade superior vs. placebo in ~500 moderate-severe OUD patients



Source: Haight et al, Lancet, 2019

Footnote: "Abstinence" = The participant does not use the target drug at all during the evaluation period.

Vivitrol superior to counseling alone



No. at Risk												
Extended-release naltrexone	153	144	139	129	121	117	112	110	104	100	92	87	87
Usual treatment	155	116	104	96	84	76	72	67	65	61	59	56	56

Source: Lee et., NEJM, 2016

Buvidal/Brixadi is superior — summary

Key advantages compared to other OUD treatments	
Low Drug Level Fluctuations	Stable drug levels and effect, whereas short acting medications have large fluctuations
Superior Bioavailability	Higher bioavailability (~100%) than oral medications (20-50%), requiring lower doses and potentially causing less side effects
Higher Adherence	Eliminates the daily dosing battle, which greatly decreases relapse risk
No Misuse and Diversion Risk	Oral medications can easily be misused, abused or sold for profits.
Minimal Overdose Risk	Buprenorphine blocks the effects of heroin, morphine and fentanyl It only produces partial euphoria and has modest respiratory effects Oral medications carry significantly higher overdose risk
Less Strain on the Healthcare System	Fewer clinic visits, which frees up health care personel and decreases general costs and patient's dispensing costs
Individualised treatment	Multiple weekly and monthly doses
No Pre-Treatment Requirements	Day 1 treatment initiation possible as opposed to other injectables Sublocade requires >1 week of oral BPN. Opioid antagonists require the patient to be fully detoxed before initiation, creating a huge barrier for many.
Balanced effects	Opioid antagonists have no effect on cravings and abstinence, which ofen decreases patient satisfaction among some
Convenience	Alternative injectables have larger needles and fewer injection sites, which increases pain
No Risk for Paediatric Exposure	Oral medications may accidentally be consumed by children

Source: ABG Sundal Collier, Company Data

Compared to Sublocade, offering multiple dosing intervals allows tailoring treatment for improved adherence and convenience. Patients at higher risk of relapse can benefit from weekly dosing, while those who are more stable may transition to monthly injections. Weekly dosing offers a notable advantage in the initial phase where relapse risk is very high. It also aids with adjusting the dose. Additionally, Buvidal reaches steady-state levels by the fourth dose, while Sublocade does not achieve steady-state until the fourth to sixth dose (up to six months). This extended time to steady state may leave patients at increased risk for relapse during the initial months of Sublocade treatment.

Indivior is considering the launch of a three-month dosed formulation of Sublocade. In Q3'24, it initiated a Ph 2 trial exploring the pharmacokinetics, safety, and tolerability of two- and three-month dosed Sublocade vs. monthly dosing, which is projected to run until Q3'25. For this indication, we see limited value-add from dosing more frequently than monthly, which we consider a sweet spot between day-to-day life and very important regular follow-ups for this vulnerable patient group. Additionally, the product is far from the market. Thus, we currently do not include it in our estimates.

MENA offers untapped potential

In 2019, Camurus entered into a commercialisation partnership with *NewBridge Pharmaceuticals* for the distribution of Buvidal in 12 countries across the Middle East and North Africa (MENA). NewBridge is headquartered in Dubai, UAE, and is a regional pharmaceutical company that has specialised in in-licensing and commercialising FDA and EMA approved therapies. After early access programmes, Buvidal received its first full approvals in Egypt and Saudi Arabia in 2022. Thus, sales from MENA are still limited, but with > 1.5 million people are estimated to have OUD in the region, there is significant potential (Darjane et al., *Balkan Med J.*, 2025).

CAM2038 — Chronic pain

Camurus had to withdraw its EMA and TGA (Austrialia) applications for label-extension of Buvidal to include chronic pain in patients with OUD. The applications relied on positive Ph 3 clinical trial results from Braeburn in the US (~1000 patients, completed in 2020), but the data was ultimately seen to be insufficient for approval. During the Q4'22 earnings call, Camurus management indicated that it thinks regulators would likely accept a relatively modestly sized study, but has not shared any concrete plans for this.

There is a significant overlap to the OUD label, as ~45% of patients receiving opioid substitution therapy have chronic pain (Delorme et al., *The Journal of Pain*, 2023). The overlap is particularly common in the US, since OUD is to a large extent caused by prescription painkiller misuse. Therefore, we currently do not model CAM2038 against chronic pain separately, but rather incorporate its potential directly into our Buvidal and Brixadi estimates.

Main branded OUD treatment players with net product sales in 2024

	Indivior	Alkermes	Orexo	Camurus	Braeburn**
Main OUD product(s)	Sublocade*, Suboxone	Vivitrol	Zubsolv	Buvidal	Brixadi (licensed from CAMX)
OUD net product sales, USDm	1,148	457	50	145	116
Market cap, USDm	1,207	5,534	51	3,517	n.a.

Source: ABG Sundal Collier, Company Data

*Footnote: *Sublocade with USD 756m*

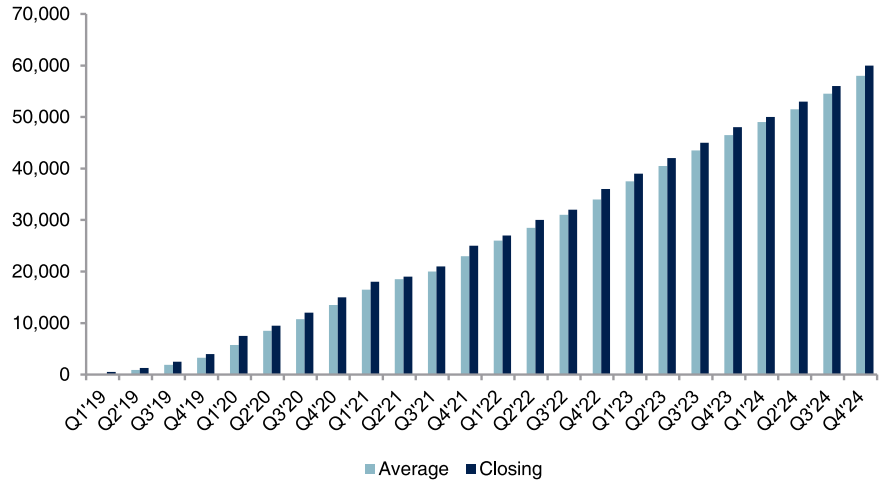
***Braeburn is Camurus' US partner. Brixadi is the US brand name eqiuvalent to Buvidal in Europe and RoW. Camurus receives mid-teen royalites on Brixadi.*

Market model — Buvidal/Brixadi

Given that Buvidal has been available in the European and Australian markets for several years, we base our sales estimates on real-world sales data. Camurus discloses both the regional breakdown of sales and the total number of patients at the end of each quarter. Using this information, we estimate patient distribution by region. We have used a combined top-down and bottom-up approach to calculate the implied penetration rates, prices and net sales per patient.

We only include high-risk opioid users or those who otherwise meet the DSM-5 criteria (Diagnostic and Statistical Manual of Mental Disorders, i.e. the key classification of mental disorders) for OUD as we consider high-risk users to be the most relevant for Buvidal/ Brixadi.

No. of Buvidal treated patients (EU, Australia & MENA)



Source: ABG Sundal Collier, Company Data

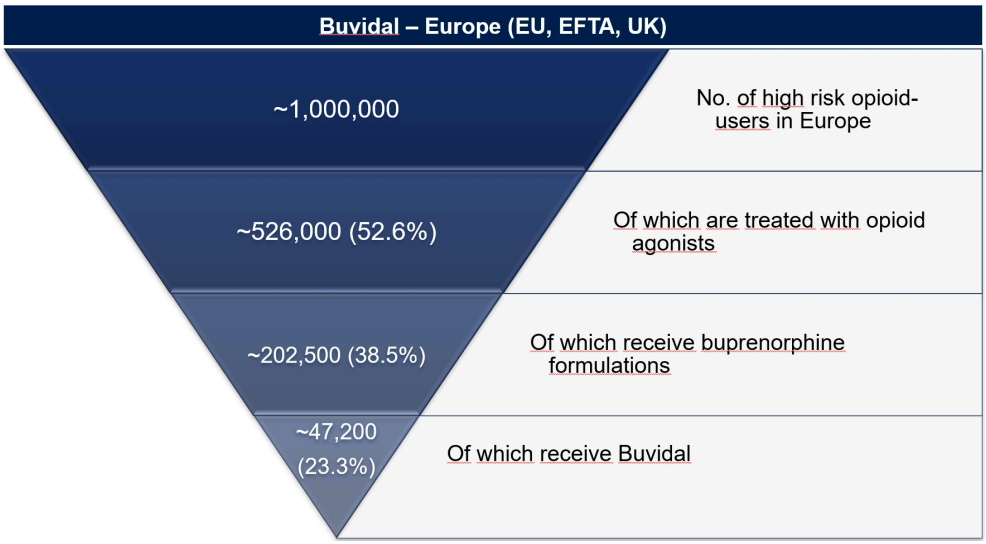
Target population

Europe (EU, EFTA, UK)

Based on still only high single-digit to low-double-digit *overall* OUD market share in the largest European countries and fresh market entries in others (in contrast to the Nordics with up to 30-35% overall and 70% market share in Finland), we believe Buvidal will continue to see large growth the coming years.

There are ~one million high-risk opioid users in the EU (The European Council), of which 526,000 were treated with opioid agonists in 2022 (including Norway and Turkey) (EUDA). We keep these figures flat going forward, and substitute Turkey with the UK and Switzerland. As shown on page 20, buprenorphine (BPN) had an overall market share of ~35% in 2022. We estimate that this will increase by ~2pp annually to ~50% in 2030. Based on the methodology described above, we estimate that ~38,000 of the on average 58,000 net Buvidal treated patients in Q4'24 came from Europe. The gross number of Buvidal treated patients (~20% non-adherent patients) comes out at ~47,000 patients (gross average of 72,500 overall), which equates to ~23.5% of the total European BPN market and ~9% of the overall OUD market. We estimate that the BPN share on average will increase by ~2.5pp annually to ~40% at peak in 2032. This equates to ~115,000 gross and ~92,000 net annually treated patients.

Estimated target population in Europe YE'24



Source: ABG Sundal Collier, Company Data

Footnote: Note that all numbers are estimates

Buvidal (EU, EFTA, UK) – estimates and assumptions

Buvidal – Europe (EU, EFTA, UK)	
BPN share of opioid agonists, current	38%
BPN share of opioid agonists, 2030	50%
Current penetration among total BPN	20%
Peak penetration among total BPN	40%
Annual prevalence increase	0%
Current average gross monthly price, EUR	300
Current average net monthly price, EUR	240
Annual price change	-2%
Price reduction on LOE	20%
Adherence	80%
LOE	2033
Peak sales	2,480,000

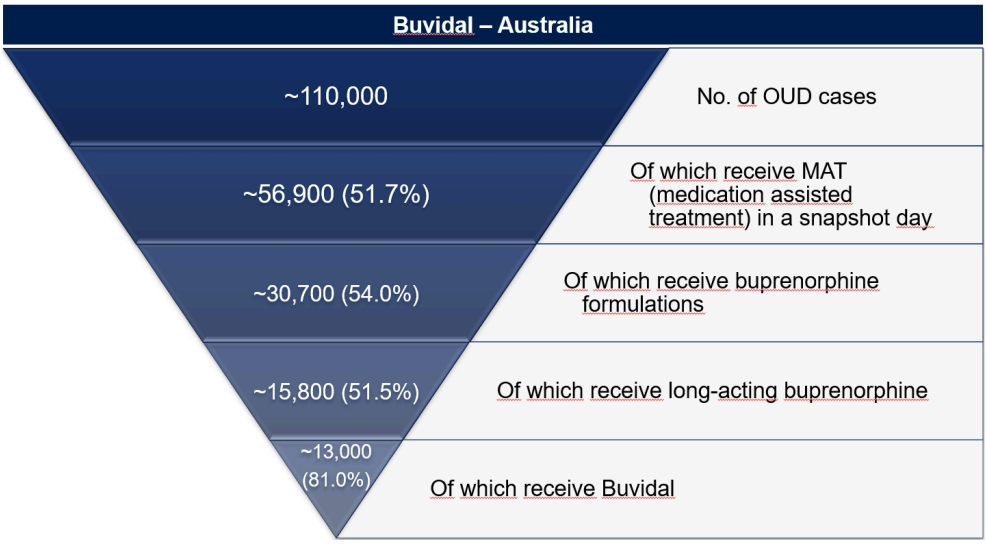
Source: ABG Sundal Collier, Company Data

Australia and MENA

We have used a combined top-down and bottom-up approach to calculate the implied penetration rates and prices. We estimate that on average, ~21,000 net patients were treated with Buvidal in the region in Q4'24. Historically, Australia has had the lion's share of patients in the region, and Camurus currently does not provide a sale split. Our calculations indicate that MENA has had a strong launch with ~1000 patients added yearly, and we estimate that it will surpass Australia in late 2026.

According to the Australian *Department of Health and Aged Care*, over 110,000 Australians were struggling with opioid dependence in 2019 (health.gov.au). As mentioned on page 21, ~56,000 Australians underwent medication-assisted treatment (MAT) on a snapshot day in 2023, which has increased by ~20% since 2011 (AIHW). As also showed on page 21, ~50% of this were buprenorphine formulations in 2023. We estimate that this number is closer to 54% today, and will continue to increase with ~1pp annually until a ~60% share in 2030. As also explained on page 22, ~50% of the BPN formulations was estimated to be long-acting BPN LAR in 2024, a figure we expect to increase with ~2pp until a ~65% share in 2032. Camurus has disclosed that it holds ~80% of the long-acting BPN-market. Our calculations put this at ~81% in Q4'24, which equates to ~13,000 patients. We model a flat 81% Buvidal share of the long-acting BPN segment. Thus, we estimate that Buvidal will hold ~53% of the total BPN market at peak in 2032, equating to ~21,000 annually net treated patients. Since the Australian statistics we have sited pertain to a *snapshot* day, we are already at the net figure.

Estimated target population in Australia YE'24



Source: ABG Sundal Collier, Company Data

Footnote: Note that all numbers are estimates

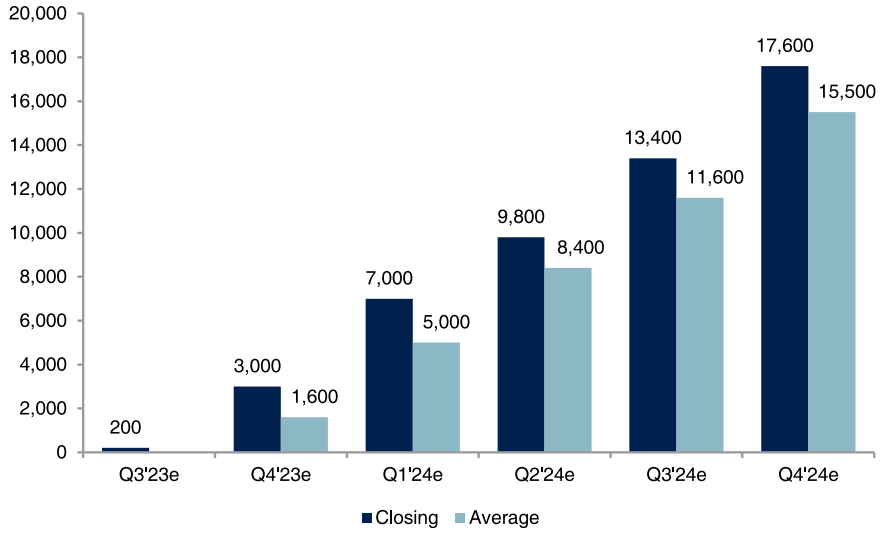
Buvidal (Australia) – estimates and assumptions

Buvidal – Australia (MENA incl. for average prices)	
BPN share of MAT, current	54%
BPN share of MAT, 2030	60%
Long-acting share of BPN, current	52%
Long-acting share of BPN, 2030	63%
Current penetration among LAR BPN	81%
Peak penetration among LAR BPN	81%
Current penetration among total BPN	41%
Peak penetration among total BPN	53%
Annual prevalence increase	0%
Current Australian gross monthly price, AUD	379
Current Australian net monthly price, AUD	341
Current average gross monthly price, AUD	399
Current average net monthly price, AUD	359
Annual price increase	0%
Price reduction on LOE	20%
Adherence	80%
Launch year	2027
LOE	2033
Peak sales	1,580,000

Source: ABG Sundal Collier, Company Data

US

Estimated no. of Brixadi treated patients (US)



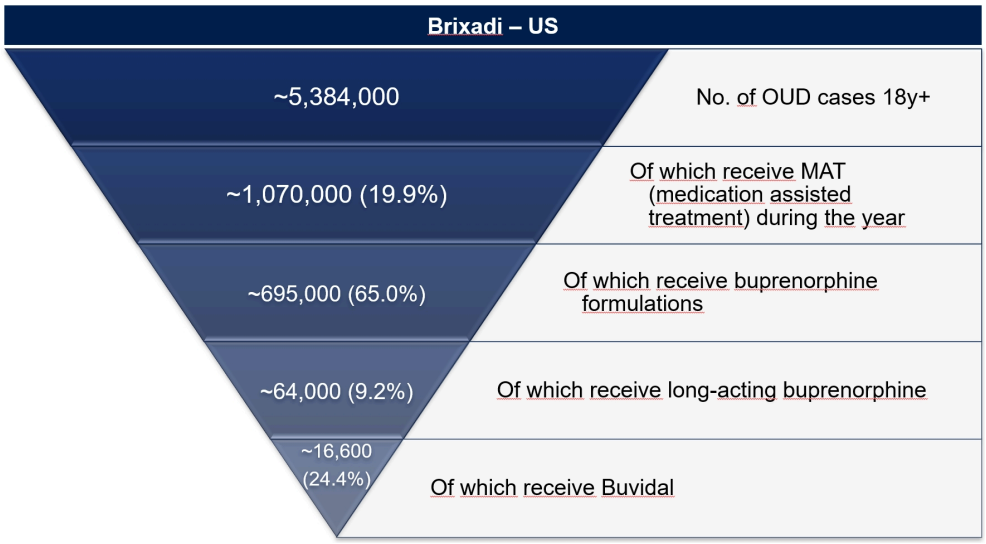
Source: AbG Sundal Collier, Company Data

For the US, we have also used current sales figures. Again, we have used a combined top-down and bottom-up approach to calculate implied penetration rates, prices and net sales per patient. However, due to the limited time in the US market, we base future sales estimates more on top-down market sizing. As Camurus is a second mover in the US, we estimate lower penetration rates than in the EU and RoW. We also believe that it will be somewhat more difficult for Camurus to dominate the long-acting BPN segment now that Indivior has launched a version of Sublocade that can be stored at room temperature for up to 12 weeks. Camurus has disclosed that it receives a mid-teens royalty on net sales of Brixadi from Braeburn. We therefore assume 16%.

Based on the *2023 National Survey on Drug Use and Health* by *The Substance Abuse and Mental Health Services Administration,* we model that there are 5.384 million Americans above 18y with OUD (2023 National Survey on Drug Use and Health, SAMHSA). We consider this a conservative estimate, and keep this base flat. The same report states that there were 996,558 Americans above 18y who received MAT in 2023, equating to 18.5% of OUD cases. This came after a 7.2% annual increase since 2021 (2021 National Survey on Drug Use and Health, SAMHSA). We model with half this CAGR until 2031, which leaves us at ~25% of Americans with OUD receiving MAT in 2031. Next, we estimate that currently ~65% of MAT users receive BPN formulations, increasing to ~70% in 2031.

Finally, based on Camurus' sales figures and Camurus management's comments on the Q3'24 earnings call that they already have a 20% share of the long-acting BPN market, we estimate that ~9% of these are on long-acting BPN, i.e. ~64,000. We model this to increase to ~30% by 2031, when Camurus will have a peak share of ~45% of the long-acting BPN market. This equates to ~123,000 net patients treated annually with Buvidal, which is still only ~13% of total BPN patients and less than ~10% of all MAT-treated patients. We consider these to be conservative estimates based on 1) how quickly Brixadi has taken market share from Sublocade (~20% in just one year), 2) the head-to-head dynamics in Australia and certain European countries, and 3) the market share of long-acting BPN in Australia and early-entry European countries.

Estimated target population in the US YE'24



Source: ABG Sundal Collier, Company Data

Footnote: Note that all numbers are estimates

Brixadi (US) – estimates and assumptions

Brixadi – US	
MAT uptake, current	20%
MAT uptake, 2030	24%
BPN share of MAT, current	65%
BPN share of MAT, 2030	69%
Long-acting share of BPN, current	9%
Long-acting share of BPN, 2030	28%
Current penetration among LAR BPN	24%
Peak penetration among LAR BPN	45%
Current penetration among total BPN	2%
Peak penetration among total BPN	13%
Current average gross monthly price	1,800
Current average net monthly price	1,039
Annual price increase	0%
Price reduction on LOE	40%
Adherence	80%
Launch year	2027
LOE	2032
Peak royalties (16% of net sales)	1,460,000

Pricing

By dividing product sales by the number of net Buvidal treated patients, we know that the average net price across all regions is ~SEK 2700 per month, i.e. ~EUR 250. We estimate an average monthly net price of EUR 240 in the EU. We arrive at this number by assuming a gross monthly price in the EU of EUR 300 based on previous statements by management of ~EUR 10 per day, with a gross-to-net discount of 20%.

After a 5% price reduction from 1 April 2023 as part of austerity measures, Australia's Pharmaceutical Benefits Scheme (PBS) has disclosed that the PBS-covered price is AUD 379 (PBS). The PBS covered price includes wholesale markup, pharmacy markup and dispensing fees. However, our calculations still point to a gross-to-net discount of ~10% on this, i.e. a net price of AUD 341. However, in order for the sales and patient distributions across the EU, Australia and MENA to add up, our calculation is that the net price in MENA is closer to AUD 400, which is very similar to the EU net price of EUR 240. Thus, we estimate an average net price of AUD 359 for Australia and MENA in Q4'24. We model that the average price will slightly increase to AUD 370 at YE'2026 due to a higher MENA share, before it tapers down again along with launches in poorer MENA countries.

The monthly cash price for Brixadi is ~USD 1800 (includes wholesale markup, pharmacy markup and dispensing fees) (drugs.com). Based on Brixadi sales figures assuming a 16% royalty rate, we arrive at a net monthly price of USD 1,039, i.e. a 42.3% discount from the cash price.

CAM2029
Treating acromegaly, GEP-NET & PLD

Introduction

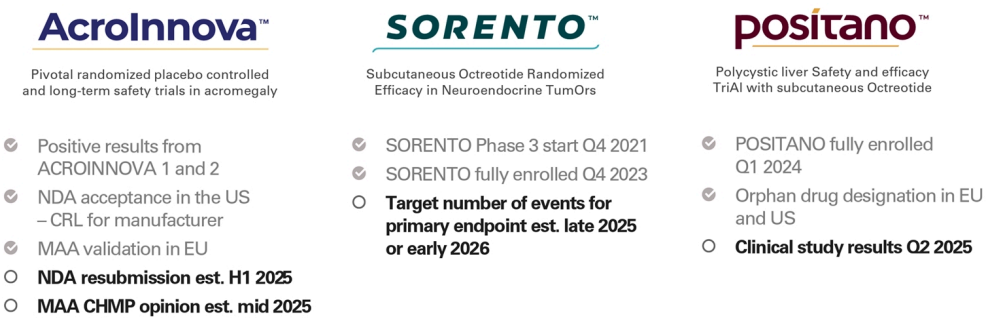
Utilising its FluidCrystal injection depot technology, Camurus is developing CAM2029 as a once-weekly or once-monthly subcutaneous injection of *octreotide,* i.e. a reformulation of *Novartis'* blockbuster *Sandostatin*, for the treatment of:

1) Acromegaly: Successful Ph 3, pending application in the EU, US approval paused due to third-party manufacturing issues

2) Gastroenteropancreatic neuroendocrine tumours (GEP-NETs): Ph 3 readout late 2025/ early 2026

3) Polycystic liver disease (PLD): Ph 2b readout in Q2 2025

CAM2029 – Status Praesens



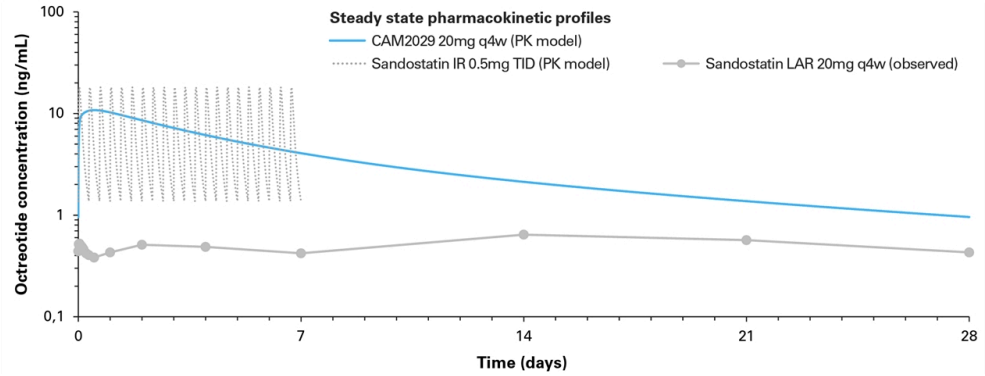
Source: Company Data

Octreotide is a synthetic analogue of the natural hormone *somatostatin.* Somatostatin and *somatostatin receptor analogues* (SSAs) inhibit the effects of *growth hormone* (GH), in addition to inhibiting proliferation of certain cells in the gut and pancreas that can favour cancer shrinkage. Synthetic analogues are used as they have much longer half-lives, i.e. 1.5-2 hours vs. ~three minutes. Octreotide and the very similar *lanreotide* are the two main SSAs. Currently, these are available as various generic once-daily injectables as well as a long-acting version by *Novartis* (Mcap ~EUR 220bn — Sandostatin) and Ipsen (Mcap ~EUR 9m — Somatuline) for the treatment of acromegaly and NETs. In the US, Camurus is developing CAM2029 under the brand name *Oclaiz* in acromegaly (and possibly GEP-NET). The European brand name has not been disclosed.

CAM2029 is designed to increase the bioavailability, i.e. how well it is taken up by the body, and consequently the exposure of octreotide. As the figure below shows, Camurus has demonstrated that CAM2029 has 4-5x greater bioavailability than Sandostatin LAR (long-acting release), and in the range of oral immediate release octreotide administered three times daily. In principle, this should lead to better disease control.

~5x higher octreotide plasma levels for CAM2029 vs. Sandostatin LAR

Which is in the range of 3x daily dosed octreotide



Source: Camurus

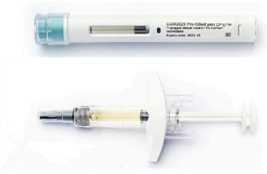
Footnote: SRL: somatostatin receptor ligand/agonist, PK: pharmacokintecs, IR: immediate release, LAR: long-acting release, TID: three times per day, q4w: every 4 weeks

But perhaps most importantly, CAM2029 is far more *convenient* than its competitors in regard to:

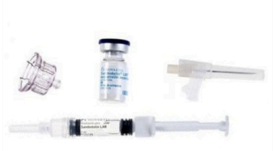
- Friendly administration: CAM2029 offers subcutaneous administration compared to intramuscular for Sandostatin LAR and deep subcutaneous for Somatuline Depot/ Autogel, which combined with more injection site options and a smaller needle reduces injection site pain. In addition, CAM2029 will be available as a *self-administered* injection pen device, significantly reducing frequent, time-consuming clinic visits and freeing up time for healthcare professionals. It is possible to self-administer Somatuline Autogel (Ipsen), although very few patients do so due to the larger needle and need for deeper injection, and it is not part of the US label. The older Somatuline Depot (Ipsen) and Sandostatin LAR (Novartis) cannot be self-administered.
- No strict storage requirement: While competition requires refrigerator storage, which significantly increases costs and may cause problems, CAM2029 can be stored at room temperature.
- No need for reconstitution: Unlike Sandostatin LAR, CAM2029 does not require mixing before administration, which speeds up the process and eliminates the risk of human error.

CAM2029 with much superior convenience

CAM2029 - 20mg - Camurus
Pre-filled pen/ready-to-use syringe
Self-administration
Smaller needle, subcutaneous administration
Room-temperature storage



Sandostatin LAR - 10, 20, 30mg - Novartis
Syring requiring mixing/reconstitution
Administration by healthcare professional
Larger needle, intramuscular administration
Refrigerated



Somatuline/Ipstyl Autogel - 60, 90, 120mg - Ipsen
Pre-filled syringe
Administration by healthcare professional
Larger needle, deep subcutaneous administration
Refrigerated

Source: ABG Sundal Collier, Company Data

In March 2022, Ipsen announced that they were investing ~EUR 60m into developing a state-of-the-art self-injecting device for Somatuline Autogel, with initial launches expected

in 2024 (Ipsen). However, since then there have been no official updates on the timeline. Still, we think it is fair to expect that a self-injector will be launched by Ipsen within two-three years.

Huge sales potential

Sandostatin and Somatuline each had sales above USD 1bn in 2024. Although CAM2029 will have a somewhat narrower label, it looks set to have blockbuster potential.

Camurus evidently shares this view. In a company presentation from March 2025, it provided the following peak sales estimates based on external market research:

CAM2029 peak sales estimates >2 billion USD across indications[1-4]

	TERRITORY	PATIENT POPULATION	EST. PEAK PATIENT SHARE	EST. PEAK SALES
ACRO[1]	EU/AUS	16,500[4]	20 – 35%	€30 – 65 million
	US	10,000	25 – 40%	$150 – 280 million
NET[1]	EU/AUS	68,000[4]	30%	€300 – 400 million
	US	37,000	40%	$1,200 – 1,500 million
PLD[1]	EU/AUS	15-18,000[4]	30 – 40%	€80 – 100 million
	US	12-13,000	30 – 40%	$200 – 300 million

[1]Globe Life Science Aug 2022, data on file;
[2]Globe Life Science 2020, data on file
[3]Assuming €10-12.5ks (EU/AUS) and $60-70K (US) per year net pricing in acromegaly, €15-20k (EU/AUS) and $80-100K (US) per year net pricing in NET, and €17.5k (EU/AUS) and $60K (US) per year net pricing in PLD
[4]Patient numbers extrapolated from 5EU estimates by assuming same prevalence across European countries and Australia

Source: Company Data

Past collaboration with Novartis

The somatostatin analogue business has obviously been highly profitable for Novartis, with Sandostatin LAR capturing blockbuster status. When the initial patents for short-acting Sandostatin expired in the early 2000s, Novartis managed to transfer a large proportion of the patients to the long-acting version (LAR). In fact, sales for the Sandostatin business increased from ~USD 600m in 2002 to ~USD 1,650m at peak in 2014, when the last LAR patents expired. Still, ~65% of Novartis' Sandostatin sales refer to the LAR version. This demonstrates the favouring of long-acting release (LAR) — which Camurus is also developing. Despite being off-patent, it took ~10 years for the first generic copies to emerge in Europe and the US, seemingly due to complex manufacturing steps. Teva and Pharmathen have received approvals for generic versions of Sandostatin LAR, but only Teva has launched its product (late 2024).

Between 2013-2018, CAM2029 was co-developed with Novartis, as Novartis presumably wanted to protect its LAR business. However, in 2018 Novartis terminated the collaboration due to re-prioritisation of its pipeline, returning the global rights to Camurus. Novartis' decision looks mainly to have been of a commercial nature. It had recognised the resilient sales of the LAR formulation and also recently had acquired *Advanced Accelerator Applications* with its lead-asset *Lutathera*, a radiopharmaceutical that had demonstrated greater efficacy in treating GEP-NETs — the greatest potential for somatostatin analogues. Also, shortly thereafter Novartis sold the worldwide rights of Signifor (another SSA) and Signifor LAR (long-acting release version), used for the treatment of acromegaly and Cushing's disease, to *Recordati Rare Diseases*.

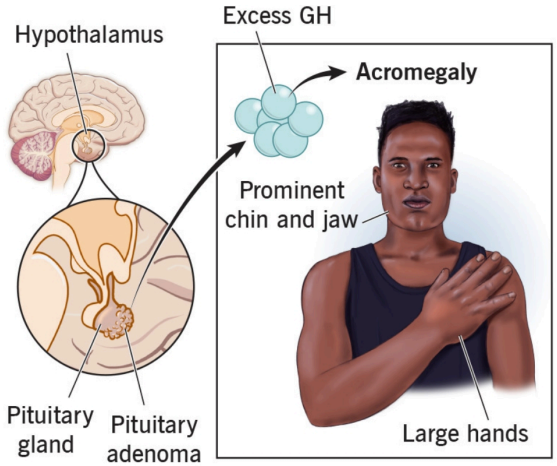
Acromegaly

Disease overview

Acromegaly is a rare disease characterised by excessive growth of body tissues and metabolic dysfunctions due to overproduction of growth hormone (GH). It is almost always (>99%) caused by a benign tumour on the pituitary gland (located at the base of the brain) (Barkan, *Encyclopedia of Endocrine Diseases*, 2004).

The most common symptoms are enlargement of hands, feet and facial features, but other organs grow as well, which frequently leads to comorbidities such as cardiovascular disease (main cause of death), joint pain and sleep apnea. Due to the elevated GH levels, patients also have a high predisposition for metabolic conditions like insulin resistance, diabetes and obesity. Acromegaly is usually a slow-progressing disease, and most patients are diagnosed between 30 and 50 years of age. Life expectancy is dependent on how early the disease is detected, but overall mortality rates (death rates) are approximately doubled compared to the general population (Esposito et al., *Eur J Endocrinol*, 2018). Average time from symptom onset to diagnosis is approximately five years.

Acromegaly – Disease Overview



Source: Cleveland Clinic, 2022

The elevated GH level increases *insulin-like growth factor 1* (IGF-1, a GH regulated protein synthesised mainly in the liver), which predominantly causes the clinical features and the systemic complications associated with increased mortality. Notion is that optimising GH/IGF-1 levels leads to better outcomes. The diagnosis of acromegaly requires the demonstration of high IGF-1 and GH levels, with IGF-1 being first-choice, as it is most reliant.

Standard of care

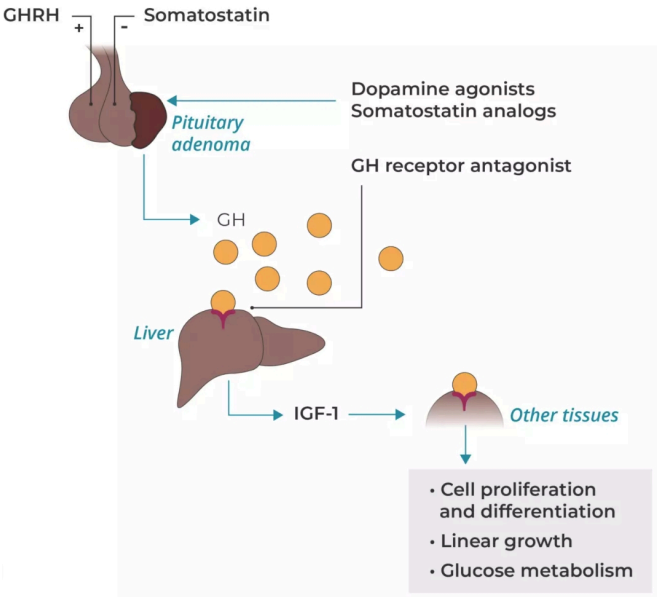
The aim is to normalise IGF-1 and GH levels and alleviate local tumour invasion (e.g. compression of the optic nerve). Surgical resection of the benign pituitary tumour is standard of care when feasible, predominantly performed with endoscopic access via the nasal cavity (transsphenoidal surgery). Comborbidities are treated and patients monitored including regular screening of IGF-1 and GH levels. Surgical remission is achieved in 75–90% of patients with *micro*adenomas (~25% of patients) and in 40–60% of patients with *macro*adenomas (~75% of patients), but with considerable variety reported based on surgical experience. Even when cure is not possible, de-bulking surgery results in a rapid GH decline and increases the effectiveness of adjuvant medication (Fleseriu et al., *Lancet Diabetes Endocrinol*, 2022).

Other patients may not be eligible for surgery (tumour not available, frail patients or patients declining surgery). For these patients, as well as those who experience uncontrolled disease after incomplete surgery, medical treatment is considered standard of care. These include:

- Somatostatin receptor analogues/agonists (SSAs): Most importantly Sandostatin LAR (octreotide) and Somatuline Autogel (lanreotide). Signifor (pasireotide) is a second-line option.
- Dopamine type 2 (D2) receptor agonist *Dostinex* (cabergoline)
- Growth hormone receptor antagonist *Somavert* (pegvisomant)

Octreotide and lanreotide are the preferred first line options.

Drug targets



Source: Crinetics Pharmaceuticals

Radiotherapy is typically reserved as a third-line option in patients that do not respond adequately to surgery and medical therapy, or have an invasive or expanding residual tumour, due to high risk of hypopituitarism (overly low production of the other pituitary hormones) and low risk of damaging nearby tissue like the brain (Fleseriu et al., *Lancet Diabetes Endocrinol*, 2022).

Acromegaly treatments

Brand name / Therapy	Surgery	Sandostatin LAR	Somatuline Autogel	Signifor	Dostinex	Somavert	Mycapssa	Radiation therapy
API / Therapy	Surgery	Octreotide	Lanreotide	Pasireotide	Cabergoline	Pegvisomant	Octreotide	Octreotide
Company	n.a.	Novartis	Ipsen	Recordati Rare Dis.	Pfizer	Pfizer	Chiesi Pharmaceutici	Chiesi Pharmaceutici
MoA / approach	Transsphenoidal Transcranial (rarely)	Injectable SSA	Injectable SSA	Injectable SSA	D2R agonist (Dopamine D2 receptor agonist)	GH receptor antagonist	Oral SSA	Stereotactic
Line of Therapy	1L	1L after surgery 1L if ineligible for surgery	1L after surgery 1L if ineligible for surgery	2L or 3L	2L in combination with SSA	2L 1L if pred. SSA-resistance	(1L after surgery) (1L if ineligible for surgery)	(1L after surgery) (1L if ineligible for surgery)
IGF-1 response rate	75-90% (microadenoma) 40-60% (macroadenoma)	30-55% (adjuvant) Less as primary	As Octreotide	~20% of OCT/LAN-resistant patients	30-40% but subsequent loss of effect	60-70% in real-world settings	Maintenance of biochemical control in ~60% of patients switched from OCT/LAN	~50-60% of patients at 5 years, ~80% at 10 years
Tumour volume reduction (>20%)	~100% of patients	Up to 50%	As Octreotide	~10-20% of OCT/LAN-resistant patients	Unknown	N.a., stable tumour volume in ~70%	Unknown	Tumour gorwth arrrest in >90% of patients
Positive response predictors	Small tumour No cavernous sinus inv. Low pre-op GH Low post-op GH	High SSTR2 expression Hypointensity on MRI Densely granulated Age > 40y No AIP mutations	As Octreotide	High SST2 & SST5 Hyperintensity on MRI Sparsely granulated	IGF-1 <1.5-2x ULN Prolactin concentration D2R expression	Non-obese Continous elevated IGF-1 Younger patients	As Octreotide	Unknown
Main adverse effects	Hypopituitarism (6-7%) Transient diabetes insipidus (8-9%)	Nausea Diarrhoea Gallstones Modest hyperglycaemia Injection site reactions	As Octreotide	As OCT/LAN but much higher rate of hyperglycaemia and diabetes	Postural dizziness GI intolerance	Liver enzymes elevation Lipodystrophy at injection site	As Octreotide, but more GI symptoms and no injection site reactions	New hypopituarism in 17-50% of patients Visual deficits Secondary malignancies Neurocogn. deficits (rare)

Source: ABG Sundal Collier, Adapted from Fleseriu et al., Lancet Diabetes Endocrinol, 2022, Crinetcs

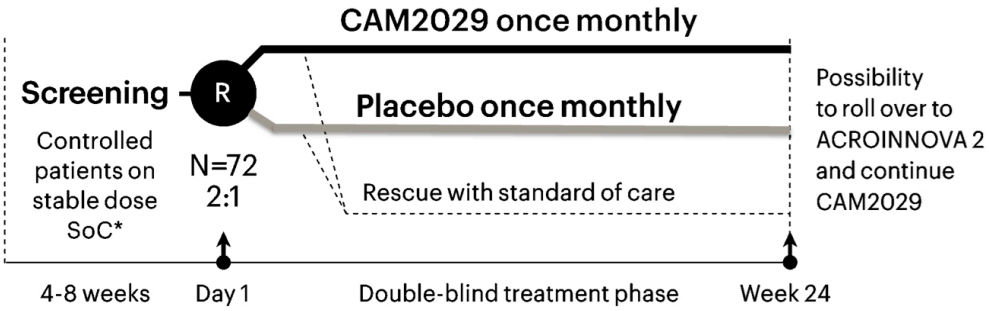
Camurus' remedy for acromegaly

CAM2029 for the treatment of acromegaly has been tested in several clinical trials, including the two Ph 3 trials *ACROINNOVA 1* and *ACROINNOVA 2*.

ACROINNOVA 1 — Primarily an efficacy trial:

- Ph 3, randomised, double-blind, placebo-controlled, multi-centre trial to assess efficacy and safety
- 72 patients with stable disease
- Switching to 20mg/1mL of CAM2029 or placebo once monthly instead of SoC (Sandostatin LAR or Somatuline Autogel) for 24 weeks
- Prior to trial start, patients were stable on SoC >3 months measured by IGF-1 ≤ 1x upper limit of normal (ULN) and adequate GH level

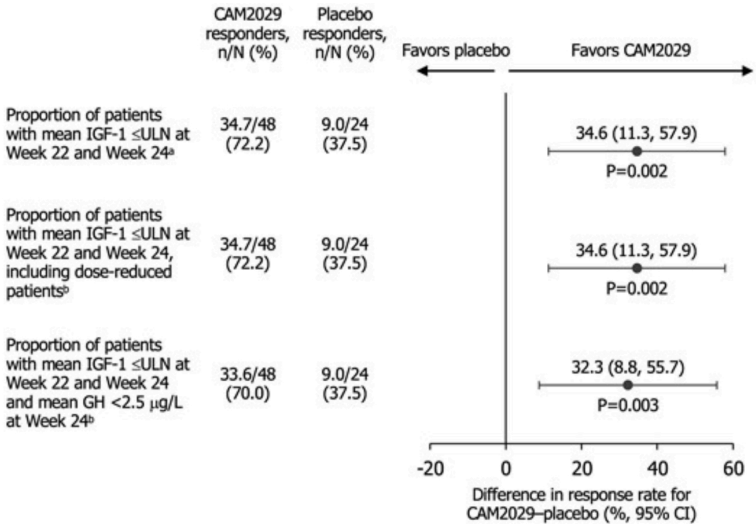
ACROINNOVA 1 – Primarily an efficacy trial



Source: Company Data

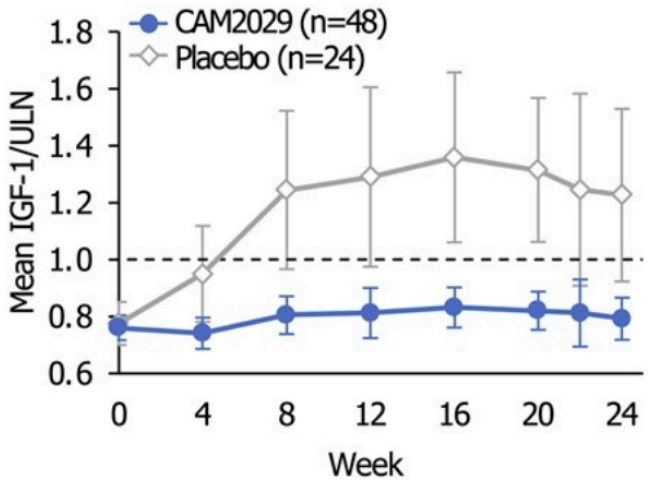
Those who received CAM2029 had significantly greater biochemical disease control, measured as IGF-1 and GH over 24 weeks, compared to placebo. The trial successfully met its primary endpoint, i.e. the proportion of patients with mean IGF-1 ≤1x ULN (upper limit of normal) at week 22 and 24, and the key secondary endpoints. No new or unexpected safety findings were observed, and the safety profile was consistent with SoC.

Successful primary endpoint for ACROINNOVA 1



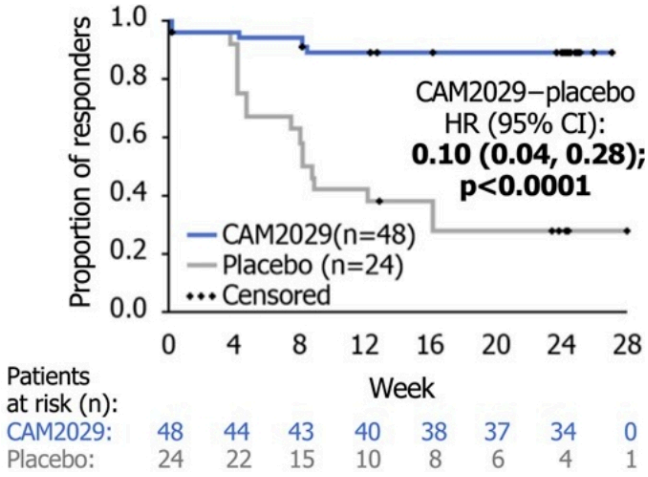
Source: Ferone et al., J. of Clin. Endocrin. & Metabolism, 2024

Mean IGF-1 remained stable at ≤ULN throughout the trial...



Source: Ferone et al., J. of Clin. Endocrin. & Metabolism, 2024

...and median time to loss of response was not reached (8.4 weeks in the placebo arm)



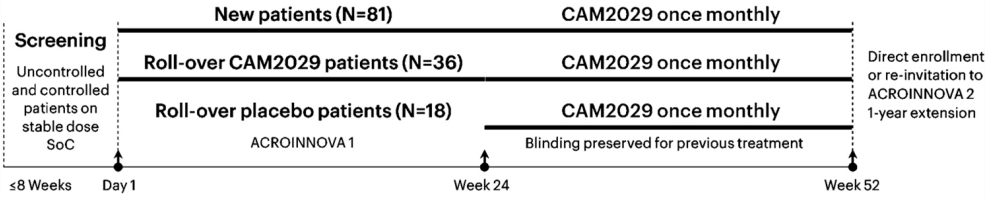
Source: Ferone et al., J. of Clin. Endocrin. & Metabolism, 2024

Secondary endpoints included GH levels, octreotide levels, and adverse events.

ACROINNOVA 2 — Primarily a safety trial

Camurus conducted the follow-up study *ACROINNOVA 2* — a 52-week, Ph 3, open-label, single-arm, multi-centre trial — in order to assess the long-term safety and efficacy of CAM2029. The trial showed that CAM2029 has an adequate safety profile and efficacy data in line with ACROINNOVA 1.

ACROINNOVA 2 – Primarily a safety trial



Source: Company Data

Approval status for CAM2029

In March 2024, the FDA accepted CAM2029's New Drug Application (NDA) for the treatment of acromegaly. However, just weeks before the October PDUFA date (the FDA's deadline for making a decision on the application), the FDA issued a Complete Response Letter (CRL) due to facility-related deficiencies identified during a Current Good Manufacturing Practices (cGMP) inspection at a third-party contract manufacturer. A CRL indicates that the application will not be approved in its current form. Consequently, the approval of the NDA is pending the resolution of the outstanding issues.

The manufacturer is awaiting a facility inspection report to assess the need for further corrections following a recent Official Action Indicated (OAI) classification for the site. This will determine the timing of the resubmission of the CAM2029 NDA to the FDA. On a positive note, there were no objections to the product itself. A resubmission is expected in H1 2025. There is currently limited visibility on the matter and further delays cannot be ruled out. We are cautiously assuming a Class 2 resubmission (six months review time instead of two months for Class 1).

Regarding the EU, Camurus announced in May 2024 that the European Medicines Agency (EMA) had accepted its Marketing Authorisation Application (MAA) for acromegaly. The application process in the EU is on track and a recommendation for marketing authorisation is expected in mid-2025.

We are confident that CAM2029 for the treatment of acromegaly will be approved soon in both the EU and the US, and apply a 90% probability of success to our estimates. Even if the resubmission is delayed or a new CRL is issued, we would view this primarily as short-term noise with very limited impact on the long-term story.

Two key questions arise:

1) Is CAM2029 superior to SoC?

Given the trial design, which compared CAM2029 head-to-head against placebo rather than the standard of care (SoC), it is not formally possible to conclude whether CAM2029 is superior to SoC. However, we can speculate on what a head-to-head comparison with SoC might have revealed. Secondary endpoints related to quality of life (QoL), including perceived disease and symptom burden, may suggest an advantage for CAM2029. However, in terms of biochemical control, we do not believe there is enough data to claim CAM2029's superiority. That said, CAM2029 does offer a clear benefit over SoC in terms of convenience (reliable self-administration, room temperature storage, etc.), which adds significant value. With this advantage, we expect CAM2029 to be well-received. Although the biochemical non-inferiority profile may limit Camurus from commanding a significant premium, we think CAM2029 will be preferred by many as long as pricing remains competitive.

Overall, we consider this a win for Camurus.

2) Is CAM2029 superior to potential new drugs entering the market?

In our view, this may prove more challenging for Camurus. After two successful Ph 3 trials, US pharma company Crinetics Pharmaceuticals has paltusotine on track for FDA approval in late 2025 (PDUFA date 25/09/25). Paltusotine is a once-daily oral somatostatin receptor 2 (SSTR2) agonist, which activates a subtype of somatostatin receptors to reduce GH levels.

Crinetics has suggested that the binding of paltusotine to SSTR2 results in less receptor internalisation compared to octreotide, and that this difference in internalisation may allow paltusotine to continue signalling when octreotide is unable to do so. Receptor internalisation is a common adaptive mechanism in response to signalling, leading to reduced effects with prolonged exposure. This phenomenon has been observed for SSTR1 to SSTR5. However, since growth hormone (GH) secretion is continuously inhibited even after prolonged treatment with somatostatin analogues (SSAs), SSTR desensitisation is generally considered to have little, if any, effect on SSA responsiveness. Paltusotine has high oral bioavailability (70%) when taken without food. Its half-life of ~30 hours compared to ~2 hours for oral octreotide makes it suitable for once-daily dosing.

To compare the two drugs, we will focus on Crinetic's PATHFNDR-1 study, which had a similar design to Camurus' ACROINNOVA 1. In contrast, PATHFNDR-2 was conducted in acromegaly patients who had not previously received medical treatment.

PATHFNDR-1 by Crinetics – overview

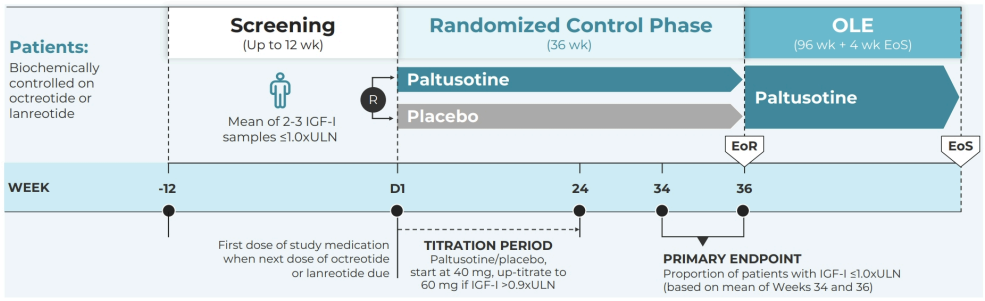
BACKGROUND

- Paltusotine is a once-daily, oral, selectively targeted somatostatin receptor type 2 agonist in development for the treatment of acromegaly and carcinoid syndrome
- PATHFNDR-1 (NCT04837040) evaluated the efficacy and safety of paltusotine in patients with acromegaly who had achieved biochemical control with octreotide or lanreotide injections and were switched to oral paltusotine

METHODS

- Enrolled patients had IGF-I ≤1 × ULN on a stable (≥12 weeks) dose of octreotide or lanreotide
- Patients randomized 1:1 to paltusotine 40 mg/day or placebo for 36 weeks
  - During the first 24 weeks, paltusotine dose titrated (range, 20-60 mg) based on IGF-I levels and tolerance
- IGF-I and GH measured centrally using iSYS immunoassays
- Acromegaly symptoms assessed with Acromegaly Symptom Diary (higher scores greater symptom burden)[1]
- Tumor volume measured by MRI scans, read centrally

Study Design



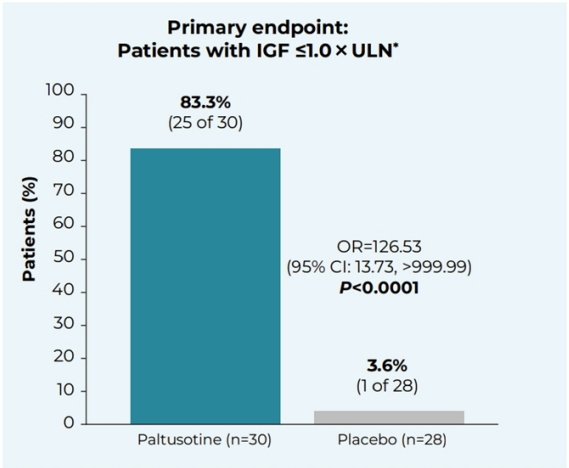
Source: Crinetics Pharmaceuticals

Footnote: OLE = Open Label Extension

Like any cross-trial comparison, comparing PATHFNDR-1 with ACROINNOVA 1 is not straightforward, but in this case there are some additional challenges. While the overall designs of the paltusotine and CAM2029 trials were similar, two important differences were:

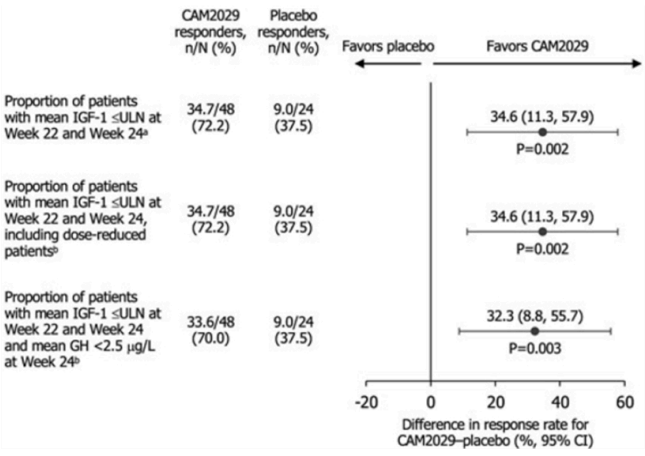
- PATHFNDR-1 trial (paltusotine) allowed for dose escalation if IGF-1 levels exceeded 0.9x ULN (upper limit of normal), whereas in ACROINNOVA 1 (CAM2029) the dose could only be reduced.
- Treatment duration and consequently the time available to show superiority vs. placebo (reasonable to assume that the delta gets bigger the longer patients are without treatment). PATHFNDR-1 had ~50% longer study duration, i.e. 22/24 weeks vs 34/36 weeks for ACROINNOVA 1.

Successful primary endpoint for PATHFNDR-1



Source: Crinetics Pharmaceuticals

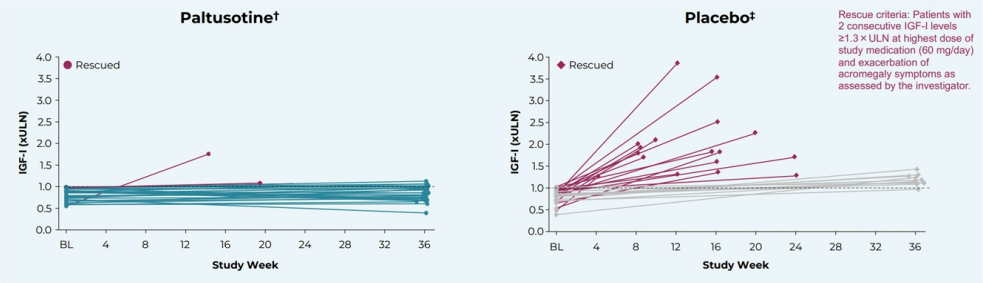
Successful primary endpoint for ACROINNOVA 1



Source: Ferone et al., J. of Clin. Endocrin. & Metabolism, 2024

At first glance, paltusotine seems like the winner, as it demonstrated higher rate of IGF-1 control in both absolute terms (83% vs. 72%) and delta compared to placebo (80% vs. 35%). But there are nuances to this that lead us to believe that the two drugs have relatively comparable efficacy. As mentioned, the paltusotine trial lasted 50% longer and the dose could be increased if biochemical control appeared to be at stake (while in the CAM2029 trial, the dose could only be lowered). Thus, it is plausible that a significant number of paltusotine patients would have missed the primary endpoint had they not been allowed to dose up, and vice versa for CAM2029. Even with the dose increase option, which 16 out of 30 needed, two out of the 30 paltusotine patients needed rescue therapy (if IGF-1 > 1.3x ULN). None of the CAM2029 patients needed rescue therapy.

Two paltusotine patients needed rescue therapy



Source: Crinetics Pharmaceuticals

There were also differences between the patient populations. In the PATHFNDR-1 trial (paltusotine), there appeared to be more severly disease-affected patients overall, as evidenced by a significantly higher incidence of typical acromegaly symptoms. However, in the trial, the mean time since diagnosis was longer in the treatment group than in the placebo group, while the opposite was true in the ACROINNOVA 1 study. In general, in stable and well-managed patients with acromegaly, a longer time since diagnosis means a less severe treatment population. Put simply, this is likely to have favoured paltusotine. Also, while CAM2029 showed mainly mild injection site adverse events comparable to placebo injections, paltusotine had more gastrointestinal adverse events such as diarrhoea and nausea, which is not surprising as it is an oral drug.

Interestingly, there is already an oral version of octreotide on the market. Mycapssa (owned by private Italian company Chiesi Farmaceutici) has been approved in the US (2020) and EU (2022) after showing non-inferiority to long-acting octreotide/lanreotide (IGF-1 normalisation achieved in ~58% of patients). However, sales have been very limited, mainly due to the twice-daily fasting schedule.

As Chiesi is a private company, we do not have the latest sales figures. The latest available sales figures are from Amryt Pharma in Q3'22 (later acquired by Chiesi). These state that Mycapssa sales increased 26.9% q-o-q to USD 5.7m and 292.8% y-o-y (Amryt Pharma), i.e. very limited sales although high growth. Our understanding is that uptake has not increased significantly since then.

Like Mycapssa, paltusotine requires an hour-long fast and multiple daily pills (from two to six), which, when added to other medications, may make compliance difficult and lead patients to prefer once-monthly injections. While people used to be quite sceptical about injections in general, this perception has changed in recent years, in parallel with small needles only requiring superficial subcutaneous administration, which have become harmless, especially with the normalisation of Ozempic, Wegovy, etc. Thus, new patients may well prefer a once-monthly injection only, as long as it is self-administered. And the existing pool of medically treated acromegaly patients, i.e. those who have become used to much worse injection regimens, which is the vast majority of long-term SSA users, we think will definitely prefer the once-monthly option.

However, paltusotine appears to be more potent than Mycapssa and is administered once daily, which is likely to make it more of a threat. The headline efficacy data of paltusotine vs. CAM2029 may be appealing, but in the real world, where the twice-daily dosing of

paltusotine and fasting requirements will inevitably lead to some missed doses, CAM2029 is much more likely to see full study results.

Overall, we see this as a draw, which is enough to leave the injectables dominating the space.

Key medical treatments

	Standard of care injectables	CAM2029	Paltusotine
Route	Syringe	Pre-filled pen	Oral
Decent IGF-1 control	Yes	Yes	Yes
At-home administration	No	Yes	Yes
Frequency	Monthly	Monthly	Once daily
Timing requirements	None	None	1h fast before food*
Room temperature storage	No	Yes	Yes

Source: ABG Sundal Collier, Company Data

*Footnote: *Mycapssa must be taken at least 1 hour before a meal and at least 2 hours after a meal*

Market model — Acromegaly

Disease frequency

Annual incidence and prevalence of acromegaly is estimated at ~4 and ~60 per 1 million people, respectively (Crisafulli et al., *Eur J Endocrinol.*, 2021). There is an estimated 2% yearly growth rate, mostly likely due to improved awareness and diagnostics.

Camurus has *orphan drug designation* for CAM2029 for the treatment of acromegaly in Europe. The orphan drug designation pathway is intended to incentivise drug manufacturers to pursue rare diseases. Among other, it gives tax benefits, decreased review time and may allow for only two clinical trials, i.e. only a Ph 1/2 and Ph 2/3 to reach the market. Also, if approved, orphan drug designation secures market exclusivity for 10-12 years in Europe and seven years in the US, but this timeframe is already covered by existing patents.

Target population

1) Medical treatment is predominantly indicated for patients with persistent disease after surgery. We segment our model into micro- and macroadenomas. As a reminder, surgical remission is usually achieved in 75–90% of patients with microadenomas (~25% of patients) and 40–60% of patients with macroadenomas (~75% of patients). This implies ~42% needing medical treatment, which is much in line with ~49% from a recent large real-world study (Giustina, *Pituitary*, 2024), and more so when you factor in recurrence rates after primary surgery (~5% first 5 years) (Katznelson, *JCEM*, 2014). We directly apply the middle range success values, as these include patients ineligible for surgery.

2) Partial resistance is observed in ~50% of patients receiving either octreotide or lanreotide, and complete resistance (i.e. GH and IGF-1 reduction <20%) is observed in ~10% of patients (Fleseriu et al., *Lancet Diabetes Endocrinol*, 2022). We calculate a weighted average responsiveness to octreotide by assuming that 25% of patients with partial resistance will not stay on SSAs for long. In reality this is likely to be a lower percentage, as partial resistance is usually dealt with by adding cabergoline to the SSA, which leads the vast majority to adequate GH and IGF-1 control. The weighted average comes out at 77.5%.

3) We model that 90% of these patients will remain lifelong SSA users, but on average only 10 months per year to stay conservative, since resistance development among responders is extremely rare.

4) Next, we estimate that 85% of the long-term SSA market wil be long-acting formulations, with paltusotine capturing the majority of the residual.

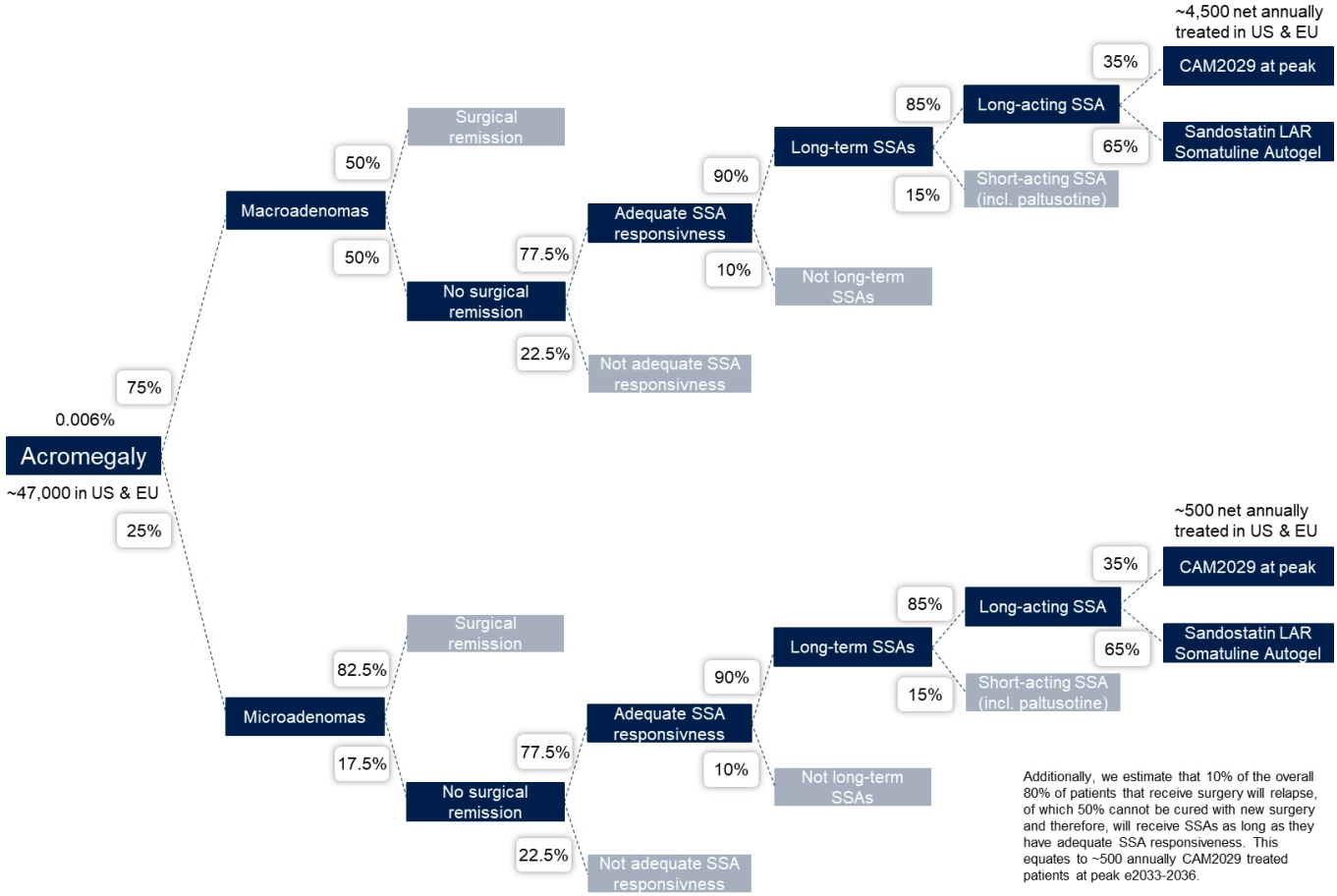
5) Finally, we estimate that CAM2029 will capture 35% of the long-acting SSA market given that it is priced on par with the competition, since it clearly has a superior convenience profile, with home administration being the most important distinguishing factor.

6) In addition, we model that 10% of patients with primary surgery will experience recurrence (~5% first 5 years), of which 50% will not be able to be cured by a new surgery, requiring lifelong medical treatment. This is also likely to be on the conservative side, as re-resections have lower success rates. The remaining steps are the same.

7) We leave out neo-adjuvant (before surgery) and other short-term SSA treatments, as these constitute relatively limited sales figures. Nevertheless, this leaves upside to our estimates.

Ultimately, we arrive at ~5,500 yearly CAM2029 treated patients at peak e2033-2036, which equates to ~10% of the total acromegaly population.

Estimated acromegaly treatment population – EU & US



Source: ABG Sundal Collier

Footnote: Note that all numbers are estimates

Pricing

Since CAM2029 has a *non-inferiority* label for acromegaly (in terms of efficacy), we believe that CAM2029 will be priced on par with the competition, which will allow it to capture large market shares. Furthermore, we assume flat net prices, as this is in line with recent trends and allows us to stay on the conservative side.

Public health authority records from the UK indicate a reimbursement price (list price + wholesale and pharmacy markup) for Sandostatin LAR 30 mg and Somatuline Autogel 90 mg of ~EUR 950 (HSE.ie), (NHS). Assuming a standard discount and rebate level of ~20%, we get to a net price of ~EUR 750. UK drug prices are generally lower than in Germany and the Nordics, but higher than in Southern and Eastern Europe. Thus, we consider it a fair midpoint for overall European prices.

As always, estimating the actual price a company receives for its products (close to net price), is considerably more difficult in the US due to the multi-layered value chain and a continuously inflating gross-to-net bubble. For the US, the current *cash price* (what a non-insured patient would pay out-of-pocket if buying the drug at a pharmacy) is ~USD 7,200 for Sandostatin LAR 30 mg and ~USD 8,500 for Somatuline Autogel 90 mg (drugs.com). Hence, we assume a middle-range cash price for CAM2029 of ~USD 8,000. In 2023, drugchannels.net estimated the gross-to-net discount to be ~50% for the top branded drugs. However, this figure was calculated from the *wholesale acquisition cost* (WAC) (the price a wholesaler pays to the companies), which implies an even higher discount to the cash price. We keep the 50% reduction also for the cash price, as we find it likely that the gross-to-net discount will be somewhat lower than for the absolute top-selling drugs. We assume 30% price erosion after patent expiry in 2037.

Acromegaly (CAM2029) – estimates and assumptions

	Acromegaly
Overall prevalence	0.006%
Annual prevalence increase	2.0%
Gross price – EU	950
Net price – EU	760
Gross price – US	8,000
Net price – US	4,000
Annual price increase	0.0%
No. of injections per month	1
Price reduction on LOE	30%
Adherence	10/12
Launch year	2026
LOE	2037
Peak penetration among long-acting SSAs	35.0%
Peak sales, unrisked	1,300,000
Risk-adjustment	90%
Peak sales, risk-adjusted	1,100,000

Source: ABG Sundal Collier, Company Data

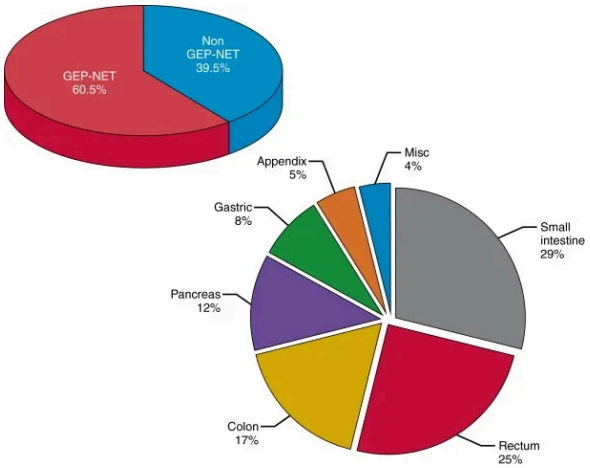
GEP-NET

We devote a lot of attention to CAM2029 for the treatment of GEP-NETs, as this together with Buvidal/Brixadi constitutes the greater part of the valuation.

What are GEP-NETs?

Neuroendocrine tumours (NETs) are a heterogeneous class of rare cancers that arise from specialised cells called *neuroendocrine* cells, i.e. cells with traits similar to both nerve cells and hormone-producing cells. These cells are scattered throughout the entire body, which explains why neuroendocrine tumours can occur anywhere in the body. However, approximately two-thirds of NETs occur in the *gastroenteropancreatic* system, which mainly includes the stomach, small intestine, colon, appendix, rectum, and pancreas, making gastroenteropancreatic NETs (GEP-NETs) the main subtype of NETs (Modlin, *Lancet Oncol.*, 2008).

NET Distribution



Source: OncoHema Key

While GEP-NETS are generally considered relatively indolent tumours, they may be more aggressive and associated with poor prognosis — for instance, they have taken the lives of celebrities like Steve Jobs and Aretha Franklin. Symptoms are vague and non-specific for the disease, leading to delayed diagnosis. Due to the deep localisation, a lump can only rarely be felt. A minority of patients (~20%) have a hormone-secreting tumour (termed functional tumour/carcinoid syndrome), which generally leads to somewhat earlier detection (Pavel et al., *Annals of Oncology*, 2020).

Classification

Besides organ localisation and hormone production, a cancer needs to be classified in order to determine the choice of treatment and prognosis. More so, we explain this because knowledge of the disease segmentation is crucial to understand the patient population that Camurus is targeting with CAM2029, i.e. both in order to assess the total market potential, but also to evaluate the likelihood of success for the ongoing Ph 3 trial in light of what its competitors have achieved. The WHO 2019/2022 grading system is mainly used for this purpose:

Tumour classification

	Ki-67 index (%)	Mitotic index
Well-differentiated NENs		
NET grade 1	< 3	< 2 / 10 HPF
NET grade 2	3-20	2-20 / 10 HPF
NET grade 3	> 20	> 20 / 10 HPF
Poorly differentiated NENs		
NEC grade 3	> 20	> 20 / 10 HPF

GEP, gastroenteropancreatic; HPF, high-power field; NEC, neuroendocrine carcinoma; NEN, neuroendocrine neoplasm; NET, neuroendocrine tumor; WHO, World Health Organization.

Source: Adapted from Yoo et al., Cancer Research and Treatment, 2020

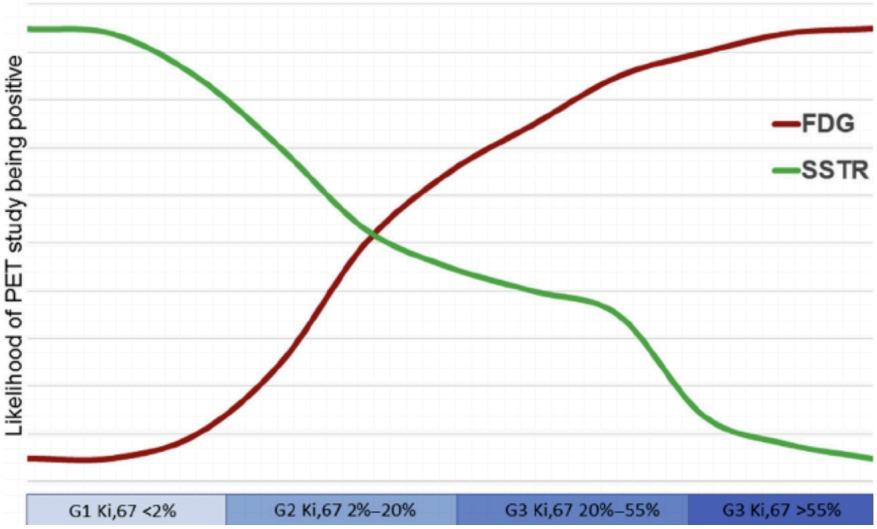
Footnote: NEN (neuroendocrine neoplasms) is the umbrella term that includes both neuroendocrine tumours (NETs) and neuroendocrine carcinomas (NECs).

The two main factors are:

- Histopathological growth pattern (well or poorly differentiated)
  - The cancer is called GEP-neuroendocrine *tumour* (GEP-NET) when it is still *well* differentiated and GEP-neuroendocrine *carcinoma* (GEP-NEC) when it is *poorly* differentiated. As mentioned, Camurus targets GEP-NETs, which constitute ~85% (Pavel et al., *Annals of Oncology*, 2020).
- Rate of cell division, i.e. how fast the tumour cells grow (Ki-67% and mitotic count)
  - The well differentiated tumours, i.e. GEP-NETS, are further classified from 1-3 based on Ki-67% (a protein only expressed in cells that are dividing, higher Ki-67% means more aggressive growth) and mitotic count (cell division numbers). Higher KI-67%/ mitotic count generally indicates a worse prognosis and a more advanced stage of disease.

With CAM2029, Camurus is targeting advanced (non-resectable and/or metastatic) GEP-NETS grade 1-2, but also grade 3, which are still well-differentiated and somatostatin receptor (SSTR) positive. However, SSTR expression is substantially lower in grade 3 tumours. As seen below, Ki-67% and SSTR expression have an inverse relationship, i.e. the higher the Ki-67% (and grade) the less SSTR expression.

Tumour grade expressed by Ki-67% is inversely correlated with SSTR expression



Source: Pattison & Hofman, PET Clinics, 2015

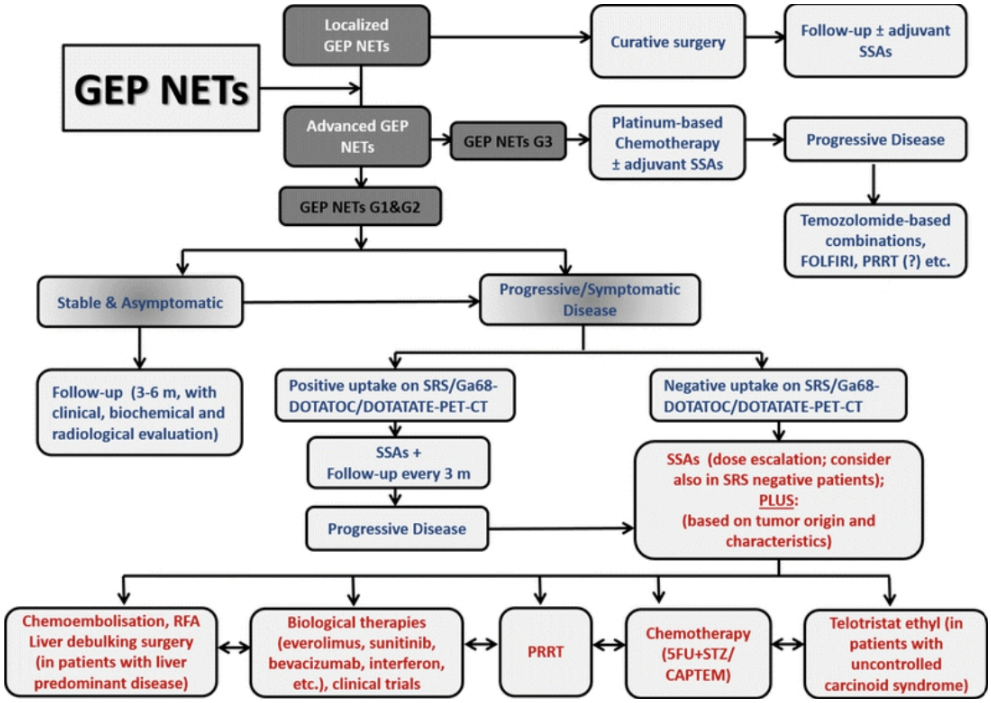
Footnote: Since data for the publication was collected, the lower limit for G1 has been extended to <3%

Standard of care

As mentioned, standard of care for GEP-NETs depends on localisation, including potential metastasis, tumour grade (Ki-67/mitotic count), differentiation and stage.

- Surgical resection is the preferred treatment for localised disease when feasible. It is the only potentially curative treatment option (Yoo et al, *Cancer Res Treat*, 2021).
- Apart from surgery, somatostatin analogues (SSAs), radioligands (i.e. peptide receptor radionuclide therapy (PRRT), most importantly Lutathera) and chemotherapy are the main pillars in modern GEP-NET treatment.
- Somatostatin receptor (SSTR) expression is especially important. Well-differentiated, low-to-intermediate-grade NETs (G1/G2 and some G3) often overexpress SSTRs, especially SSTR2, making them responsive to SSAs like octreotide (e.g. CAM2029) and lanreotide, which help control hormone secretion in functional tumours and slow overall tumour progression, as their SSTR2 interaction inhibits proliferative signalling pathways. SSAs safety profile is also significantly better than subsequent-line therapies, adding to their use.
- For patients with strong SSTR expression (examined with 68GaDOTATE-PET-CT, i.e. a special PET-CET), radioligands/PRRT (most importantly Lutathera) is an effective second-line therapy, delivering targeted radiation to tumour cells via SSTR binding.
- In contrast, the poorly differentiated NECs and G3 NETs often have low or absent SSTR expression, potentially making SSAs and PRRT ineffective. These cases require chemotherapy or targeted therapies like Afinitor (mTOR inhibitor) or Sutent (tyrosine kinase inhibitor).

Current standard of care for GEP-NETs



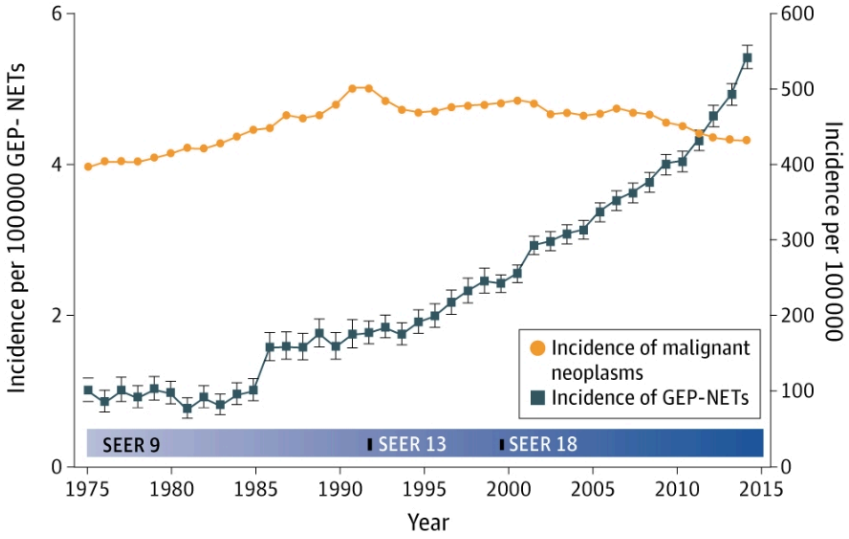
Source: Uri et al., Current treatment options in incology, 2017

Importantly for Camurus, ~80% of GEP-NETs express SSTR (Baldelli et al., *Front Endocrinol*, 2014), of which ~85% express STTR2 (Kim et al., *Cancer Res Treat*, 2011) (Wang et al., *Oncol Lett*, 2017), making SSAs the preferred treatment in SSTR2-positive GEP-NETs besides surgery.

Epidemiology

The incidence and prevalence of GEP-NETs continues to rise globally. In 2015, analysis of the SEER database indicated a US prevalence of ~0.04% (4 per 10,000) when counting people diagnosed with GEP-NENs (including the 15% GEP-NECs) within the past 20 years (Xu et al, *JAMA Open*, 2021). In the US, the incidence has increased more than 6-fold over the last four decades, with a predominant rise in localised tumours. A similar pattern is seen globally.

Large Increase of GEP-NETs



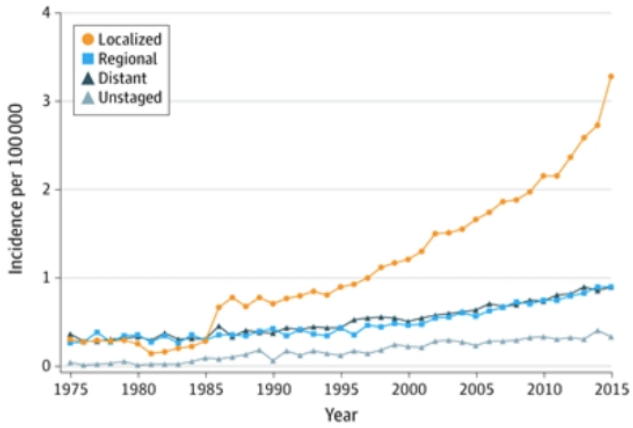
Source: Xu et al, JAMA Open, 2021

Footnote: The US SEER database shows the overall prevalence of GEP-NENs (GEP-neuroendocrine neoplasms), which is the umbrella term that includes both GEP-neuroendocrine tumours (GEP-NETs, ~85%) and neuroendocrine carcinomas (GEP-NECs, ~15%).

While some speculate about environmental or genetic factors, the main reason for the increased incidence of GEP-NETs is most likely better diagnostic tools and classification rather than an actual increase in cases. Improved detection methods, including advanced imaging (MRI, CT, PET-CT), endoscopy and immunohistochemical markers such as Ki-67, have led to more incidental diagnoses. Increased awareness among clinicians and improved tumour classification (WHO updates) have also contributed, reducing misdiagnosis in the past. In addition, longer life expectancy and expanded cancer screening programmes have led to more cases being detected.

The stage shift towards more localised disease (no spread to adjacent tissues or lymph nodes) and indirectly the grade shift (more patients with low grade Ki-67) can be seen in the graph below:

The majority of the increasing GEP-NEN incidence comes from localised disease



Source: Xu et al, JAMA Open, 2021

Footnote: GEP-NETs constitute ~85% of GEP-NENs

This is significant to know, as localised GEP-NETs normally do not require long-term somatostatin analogues (SSAs). Still, they may be used in specific cases:

- In symptomatic (functional) tumours to help control hormone-related symptoms (even if the tumour is localised).

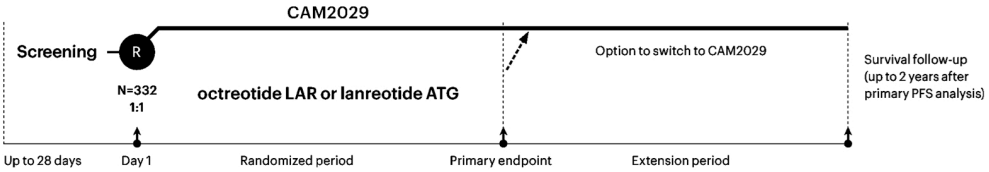
- In high-grade or incompletely resected tumours, SSAs may be considered to delay recurrence.
- In patients who are not surgical candidates due to comorbidities

Camurus' remedy for GEP-NET

Camurus is currently testing out CAM2029 in the Ph 3 study *SORENTO* (**S**ubcutaneous **O**ctreotide **R**andomised **E**fficacy in **N**euroendocrine **T**um**O**urs). The key features of SORENTO are:

- Randomised, active-controlled, open-label
- 332 patients with metastatic or unresectable GEP-NET, grade 1-3, somatostatin receptor (SSTR) positive
- Primary endpoint: mPFS of CAM2029 vs. current standard of care with either octreotide LAR or lanreotide ATG, evaluated by a Blinded Independent Review Committee (BIRC)
- Secondary endpoints: OS (overall survival), ORR (overall response rate), Time to tumour response and incidence of treatment-emergent adverse events, among others.
- At disease progression in the randomised part of the study, patients may proceed to an extension part with intensified treatment with CAM2029.
- This is the largest randomised clinical study of somatostatin analogues (SSAs) ever performed in GEP-NETs, involving more than 100 clinical sites in the US, Europe, Asia and Australia.

SORENTO trial design



Source: Company Data

Management has disclosed that the study population entails a majority of patients with grade 2, a few grade 3 and the rest grade 1.

Recruitment was completed in December 2023. After a 15 months analysis, which showed fewer-than-expected events (progression or death), indicating better SSA response and/or less aggressive disease, it was announced at the Q3'24 reporting that completion of the randomised part of the study is delayed from H1 2025 to late 2025 or early 2026. The latter seems slightly more likely based on recent communication, including the latest company presentation from March 2025, where the timeline for the randomised part has been extended into 2026.

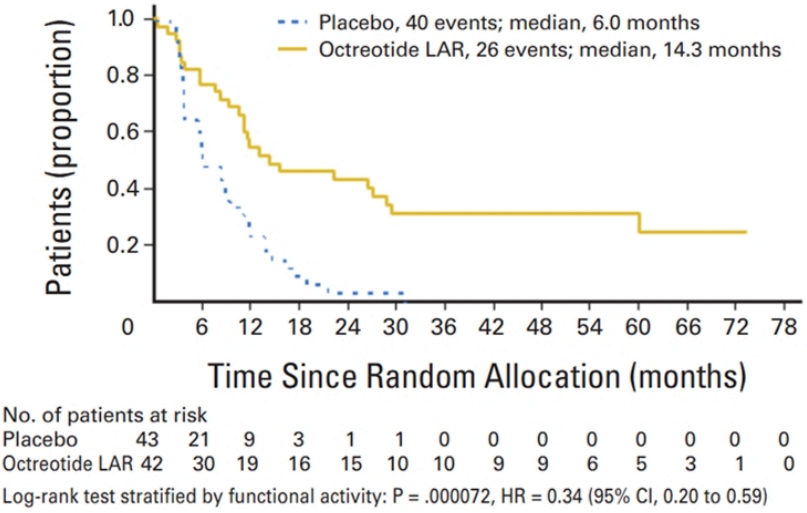
What has the competition achieved?

Unlike for acromegaly, where CAM2029 only needed to show *non-inferiority* to standard of care (SoC), Camurus is aiming at showing *superiority* vs. SoC for GEP-NETs. Thus, it is particularly important to look at the competitor's results.

Sandostatin LAR — Novartis:

The first major trial to show efficacy of somatostatin analogues (SSAs) in GEP-NETs was Novartis' PROMID trial, which evaluated Sandostatin LAR (long-acting octreotide) in grade 1 (G1) patients (characterised by a Ki-67 index < 2%).) and showed a more than twofold increase in median progression-free survival (mPFS) compared to placebo, extending it from six months to 14 months (HR = 0.34, 95% confidence interval [CI] 0.20 to 0.59; P = .000072). This confirmed the benefit of SSA therapy in patients with low Ki-67% (G1 NETs), although the absolute mPFS was lower than expected for both treatment arms, likely because the study population had a more advanced disease state compared to the typical G1 population.

PROMID by Novartis

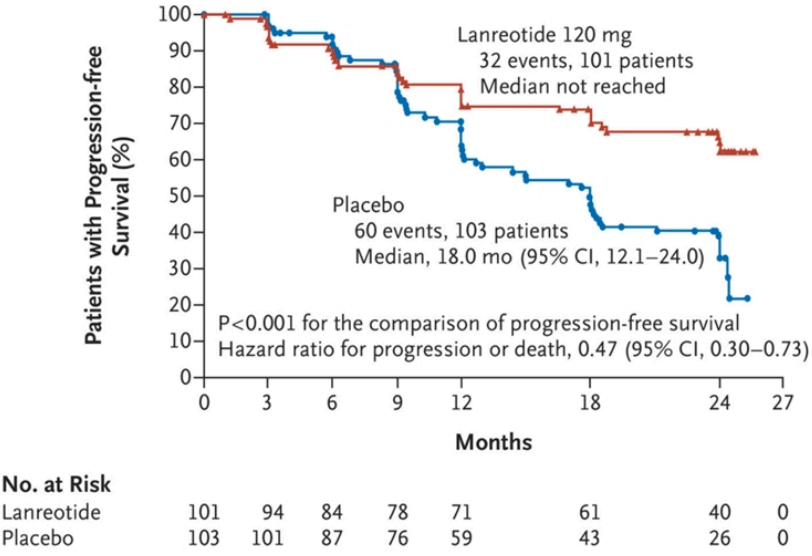


Source: Rinke et al., J. of Clin. Oncol, 2009

Lanreotide Autogel — Ipsen

Another peer is Ipsen's Somatuline Autogel (long-acting lanreotide), which was examined in the *CLARINET* and the *CLARINET FORTE trials.* At first glance, the Ph 3 CLARINET study may seem like a better comparison, as apart from grade 1 (G1), it also included ~30% G2 patients (Ki-67 of 3-10%, at the time G2 was only defined as up to 10%), whereas the PROMID trial by Novartis consisted of almost entirely G1 patients (Caplin et al., *NEJM*, 2014). However, the CLARINET patients in general had significantly more indolent and stable disease, i.e. indicated by a median time from diagnosis of ~33 months as opposed to ~4 months in the PROMID trial. Ultimately, the CLARINET study demonstrated a mPFS of 38.5 months for lanreotide LAR compared to 18 months for placebo.

CLARINET by Ipsen



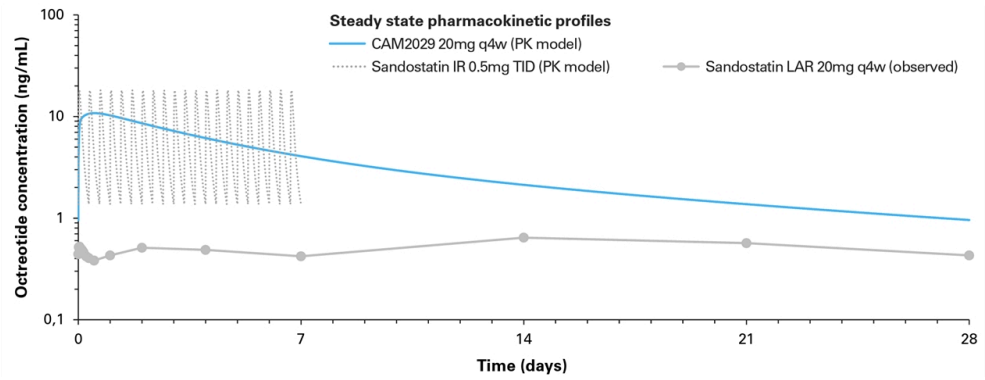
Source: Caplin et al., NEJM, 2014

So how do we evaluate CAM2029's chances of proving superiority?

The main rationale for SORENTO is the notion that increased plasma exposure of octreotide leads to better symptom and tumour control, while maintaining a favourable safety profile. According to management, the superior bioavailability and increased dosing of CAM2029 translates into an approximately seven times greater area under the curve (i.e. total drug exposure) for CAM2029 compared to Sandostatin LAR.

~5x higher octreotide plasma levels for CAM2029 vs. Sandostatin LAR with once-monthly dosing

While twice-monthly dosing increases this to ~7x



Source: Camurus

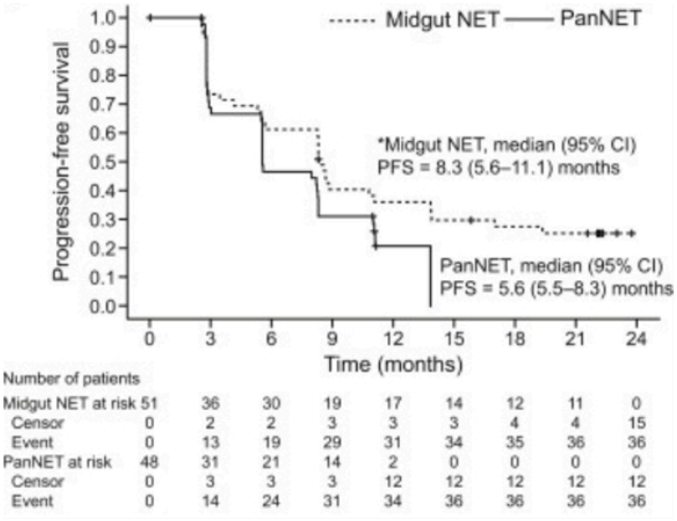
Footnote: SRL: somatostatin receptor ligand/agonist, PK: pharmacokintecs, IR: immediate release, LAR: long-acting release, TID: three times per day, q4w: every 4 weeks

Camurus is seeking to optimise the somatostatin analogue (SSA) effect for CAM2029 by administering CAM2029 twice as often as the comparator arm, which represents the SoC with either Sandostatin LAR or Somatuline Autogel, i.e. every two weeks instead of every month. As in the CLARINET and PROMID trials, patients must have advanced (unresectable and/or metastatic) disease. Patients must not have received consecutive treatment with long-acting SSAs for more than six months prior to randomisation. In order to maximise the potential benefit of higher doses, patients who progress and enter the extension phase will be offered weekly CAM2029. Camurus is committed to demonstrating the effects of higher doses.

SORENTO is powered for a hazard ratio of 0.65 and the primary endpoint of superiority in progression-free survival (PFS) of CAM2029 versus Sandostatin LAR or Somatuline Autogel will be assessed after 194 events of tumour progression or death. Secondary endpoints include overall survival (OS), octreotide plasma concentrations, multiple patient reported outcomes (PROs) (e.g. treatment satisfaction, quality of life) and safety. Based on historical matched controls, mPFS in the control arm was initially expected to be 18 months, which, with a hazard ratio of 0.65, would imply mPFS of 27.7 months in the CAM2029 arm.

Higher doses or shorter intervals between SSA injections is a common empirical approach in patients with well-differentiated GEP-NETs that are progressing. There are also retrospective data suggesting worse survival with lower than label doses and retrospective data supporting escalation of the standard dose of SSAs, particularly in patients with higher grade tumours. The only prospective (forward-looking) study of above-label dosing is the CLARINET FORTE trial, an open-label Ph 2 study by Ipsen in which patients with either pancreatic NET or midgut NET who were in active progression on the standard dose of Somatuline Autogel once-monthly were switched to twice-monthly injections. The primary endpoint of median progression-free survival (mPFS) was 5.6 months in the pancreatic NET cohort and 8.3 months in the midgut NET cohort, indicating some slowing of disease. The effects were greater in patients with Ki-67% < 10%.

CLARINET FORTE by Ipsen



Source: Pavel et al., European J. of Cancer, 2011

A last aspect we would like to touch upon is that while the PROMID and CLARINET trials were double-blinded, SORENTO is open-label, i.e. both patients and physicians will know which treatment is given. It is not unreasonable to assume that this will have an impact on patient reported outcomes (PROs), which are secondary endpoints. Since CAM2029 is dosed twice as frequently, we believe the open-label nature is inclined to make patients report *fewer disease*-related symptoms (most would think more drug means better disease control) and more *drug*-related symptoms. Since the safety profile is unlikely to become a significant issue, we consider the open-label design a small advantage for CAM2029.

Conclusion:

Taking all this into account, we estimate a 50% likelihood for CAM2029 showing superiority and a 40% likelihood for the non-inferiority scenario (secondary non-inferiority analysis from a pre-specified non-inferiority margin). Due to its currently unquestionable superior convenience, we still believe that a non-inferiority label would hold large value. However, two key assumptions would change:

- 1) Market penetration would suffer.
- 2) The market leader position in terms of convenience would be more vulnerable to the anticipated self-injector being launched by Ipsen.

With approximately half a year's time from top-line results to NDA (US)/MAA (EU) submissions, we estimate approval submissions in H2'26 and market launch in H2'27.

Guidelines

The ASCO (American) guidelines recommend SSAs (octreotide or lanreotide) as first line-medical treatment for SSTR-positive and/or functional metastatic G1 and G2 GEP-NENs. They also state that "Evidence supporting SSA use for tumour control is strongest in patients with low or low-intermediate grade SSTR-positive tumours (Ki-67 < 10%)" (Rivero et al., *J. of Clin. Oncol*, 2023). The ESMO (European) guidelines for GEP-NENs state that "SSAs can be recommended as first-line therapy for tumour growth control in advanced, slowly-growing SSTR-positive GI and Pan-NETs up to a Ki-67 of 10%." (Pavel et al. *J. Ann. Oncol*., 2020).

Other competitors

Beyond acromegaly, Crinetics is examining paltusotine in a Ph 2 trial for the treatment of GEP-NETs. However, Crinetics has narrowed down the patient population to only those with carcinoid syndrome (hormone secreting tumour), i.e. ~20% (Pavel et al., *Annals of Oncology*, 2020). In addition to only targeting carcinoid syndrome, we evaluate the oral option as less competitive compared to within acromegaly, as we see the frequent oral dosing as more of an issue here. Patients with GEP-NETs, particularly those with carcinoid syndrome, often experience nausea and lethargy. Our view is that multiple daily pills (from two up to six), on top of other medications, will see relatively few advocates. And as stated

for acromegaly, while people previously in general were quite sceptical about injections, this perception has changed over the past years in parallel with smaller needles and only requiring superficial subcutaneous administration, and being normalised by Ozempic, Wegovy etc. We see very little reason for the existing pool of medically treated GEP-NET patients, who have become used to worse injection regimens, to chose orals over the very convenient CAM2029, and we think it is likely that the same will apply for most new patients as well.

Lastly, *Lutathera*, a radioligand (injected targeted radiation therapy) developed by Novartis, has shown impressive results in the NETTER-1 and NETTER-2 trials. NETTER-1 was a Ph 3 trial in patients with grade 1-2 NETs who had progressed on somatostatin analogues. Lutathera on top of 30mg Sandostatin LAR (standard dose) significantly improved mPFS to 20 months vs. 8.5 months for 60mg Sandostatin LAR alone, with a substantially higher objective response rate (18% vs. 3%).

NETTER-2 was an open-label Ph 3 trial in patients with ~65% newly diagnosed higher grade 2 (10% ≤ Ki67 ≤20%) and ~35% grade 3 GEP-NETs (The ASCO Post, 2024). Lutathera on top of 30mg Sandostatin LAR demonstrated a mPFS of 22.8 months vs. 8.5 months for 60mg Sandostatin LAR alone, with a higher objective response rate (43% vs. 9.3%).

Both trials confirmed Lutathera's efficacy and passable safety profile, supporting its use in progressive G1/G2 NETs and as a first-line treatment for higher-grade G2/G3 GEP-NETs. However, *concurrent use of SSAs is part of the Lutathera label* and thus, we do not see a significant threat from Lutathera. Since Lutathera like chemotherapy and other late-stage therapies have a much harsher safety profile, and SSAs have a good safety profile, SSAs effects will continue to be optimised as baseline treatment.

In conclusion, SSAs will remain the dominant pharmaceutical therapy in SSTR-positive GEP-NETs for the foreseeable future.

Market model — GEP-NET

Other than for pricing, we argue that the actual numbers in the US and the EU must be very similar. Thus, we assume the same patient distributions across the regions. We have excluded RoW in order to stay conservative and leave upside to our estimates.

Disease frequency

GEP-NETs constitute ~85% of GEP-NENs, but we need to use GEP-NEN numbers, as all the following literature is based on GEP-NENs. In 2015, analysis of the SEER database indicated a US prevalence of ~0.04% for all GEP-NENs (Xu et al, *JAMA Open*, 2021). While the overall incidence seems to have increased by a CAGR of 4-5% according to different sources, the majority of the increase comes from localised disease (see chart on page 51). These do normally not require long-term SSAs treatment, and we therefore leave them out of our marked model. Hence, we only model with a 1% prevalence CAGR, as we consider this to be more representative of the actual target population, and consistent with the historical disease constellation that we have tracked down from other sources. Thus, we estimate a prevalence of 0.045% for GEP-NENs in 2025, which equates to ~152,000 people in the US and ~201,000 in the EU, respectively.

Target population — A very complicated exercise to do accurately

As a quick reminder, the SORENTO trial consists of grade 1-3 GEP-NETs with SSTR expression that are unresectable or metastatic. Camurus looks to capture both new and already existing patients.

While radical surgery is the only potentially curative treatment for NETs, fewer than 50% of tumours are fully resectable at diagnosis. To calculate the proportion of SSA treated patients, we use the extensive work by Dasari et al., who studied ~65,000 patients with neuroendocrine neoplasms (NENs) in the US between 1973 and 2012 (Dasari et al., *JAMA Oncol*, 2017). As a reminder, GEP-NENs constitute ~65% of all NENs. We assume that the patient distribution for GEP-NENs is the same as for NENs.

The study found the following disease stages:

GEP-NEN stages

	Localised	Regional	Metastatic
Stage	52.4%	20.2%	27.4%

Source: ABG Sundal Collier, Dasari et al., JAMA Oncol, 2017

1) We leave out the 52% of patients with localised disease (confined to the organ of origin) as most *localised* tumours *are* surgically resectable. We model with two remaining segments, i.e. metastatic disease (distant spread) and regional disease (spread to nearby organs or lymph nodes).

2) We model that 90% of all grade 1 and grade 2 patients with metastases that are SSTR2-positive will be treated with SSAs. SSAs can also be given with unspecified SSTR-type expression, but we prudently narrow it down to SSTR2-positive patients to ensure a substantial stay-on time. For grade 3 patients, we prudently decrease this to 50%. We know that ~80% of all GEP-NETs are SSTR-positive, of which 85% are SSTR2-positive, equating to ~68% overall. However, low grade tumours have a higher share of receptor positivity, as shown in the graph on page 49. Thus, we estimate that overall ~85% of grade 1, ~70% of grade 2 and ~40% of grade 3 tumours are SSTR2-positive.

3) In the data, ~51% had grade 1, ~16% grade 2 and ~33% grade 3/4 tumours. The split between grade 3 and 4 is not provided. However, grade 4 in the SEER database is relatively equivalent to GEP-NECs (which we empirically know constitute ~15%) (Das et al., *Curr Oncol Rep*, 2021) (Wu et al., *Int. J. Surg*, 2023), leaving grade 3 at ~18%.

For metastatic disease:

4) ~27% of patients presented with distant metastases at the time of diagnosis. However, this number will vary across grades (e.g. grade 1 will be underrepresented among patients

with distant metastases). This is well illustrated by a recent large Chinese population-based study:

Major skew of grade 1 towards resectable disease

	No surgery (n=1483)	Surgery (n=6032)
Grade 1	522 (35.2%)	3725 (61.8%)
Grade 2	219 (14.8%)	1067 (17.7%)
Grade 3	546 (36.8%)	945 (15.7%)
NEC	196 (13.2%)	295 (4.9%)

Source: ABG Sundal Collier, Adapted from Wu et al., Int. J. Surg, 2023

The data clearly show a major skew of grade 1 towards resectable disease, e.g. ~88% of grade 1 tumours receiving surgery. We find it reasonable to assume that this pattern holds true for the Western world. We therefore markedly adjust the percentage for the different grades, particularly decreasing the share of grade 1.

For regional disease:

4) ~20% of patients presented with regional disease at the time of diagnosis (spread to nearby organs or lymph nodes). As mentioned, most *localised* tumours *are* surgically resectable. On the other hand, most *regional* tumours *are not* fully resectable. We consider it fair to assume that the respective patient shares that deviate from the common practice roughly cancel each other out. In addition, patients that are eligible for surgery may still need additional treatment with SSAs, particularly if carcinoid syndrome is present (~20%). Thus, we model that 90% of grade 1 and grade 2 and 45% of grade 3 regional GEP-NETs receive SSAs, which we believe leaves upside to our estimates. We apply the same STTR2-positivity estimates as for metastatic disease above. Again, we adjust the grade-to-region-percentages.

Superiority scenario:

5) We estimate that long-acting injectables will be used by 90% of those who use SSAs (few patients will only be using short-acting formulations including orals). Given that CAM2029 is able to show superiority in SORENTO (we assign this a 50% likelihood), we estimate that CAM2029 will capture 60% of the long-acting SSA market — a figure that is arguably slightly on the lower side for this scenario. Lastly, we assume that these patients will stay on medications until death, but only 10 months per year.

Ultimately, we arrive at ~34,500 yearly CAM2029 treated patients at peak e2034-2036, which equates to ~9% share of the total GEP-NEN population.

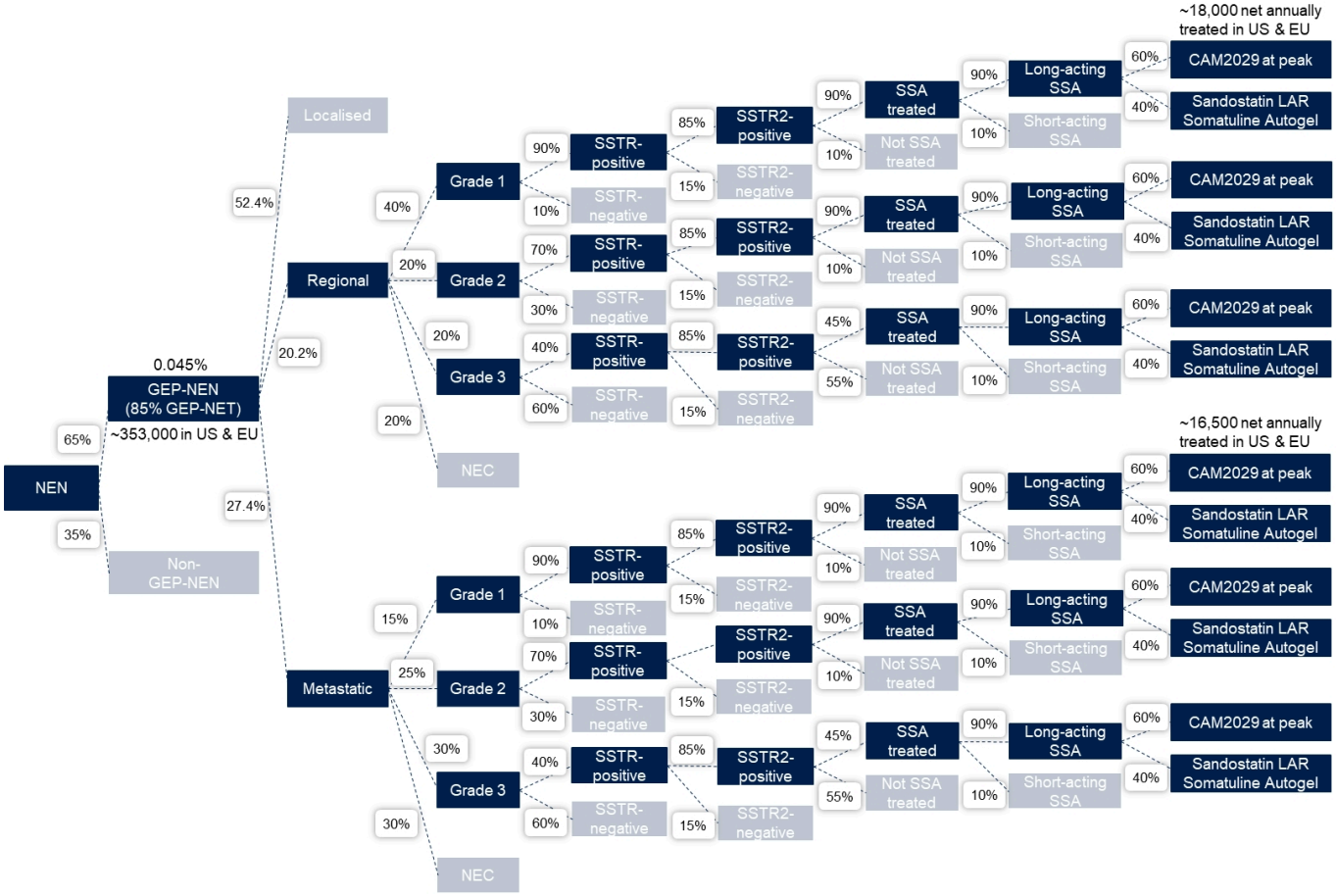
As a sanity check, a recent retrospective Swiss study found that 30% of GEP-NETs underwent therapy with SSAs, where most received it in the first-line setting (Stiefel et al., *BMC*, 2023). However, this included both short-term and long-term use and patients generally had more advanced disease than one would expect in the general population. Thus, we find our long-term use estimates to be reasonable and with significant room on the upside. This penetration level should be very feasible if CAM2029 proves superiority.

Non-inferiority scenario:

5) We estimate that long-acting injectables will be used by 85% of SSA users (still few patients will use short-acting formulations, including orals). Assuming that CAM2029 can only demonstrate non-inferiority (we assign a 40% probability to this scenario), we estimate that CAM2029 will capture 15% of the long-acting SSA market. Even if it only achieves non-inferiority in efficacy, CAM2029 will still be more convenient (reliable self-administration and significantly less painful) and will perform well against Sandostatin LAR, Somatuline Autogel and potential generics. Again, we assume that patients will take the drug until death, but only 10 months per year.

Ultimately, we arrive at ~7,500 yearly CAM2029 treated patients at peak e2034-2036, which equates to ~2% share of the total GEP-NEN population.

Estimated GEP-NET treatment population (superiority scenario) – EU & US



Source: ABG Sundal Collier

Footnote: Note that all numbers are estimates. The 15% non-GEP-NET patients are accounted for with the GEP-NEC groups, which are proportionally higher for regional and metastatic disease than localised disease.

Pricing

For both scenarios, we assume the same prices as discussed under "Pricing" for acromegaly on page 45**,** i.e. a net price of ~EUR 760 in the EU and ~USD 4000 in the US. However, net revenue per patient doubles, as dosing would be twice as frequent. We model with flat net prices, as this is more in line with recent trends and to stay on the conservative side. We assume 40% price erosion after patent expiry in 2037.

GEP-NET (CAM2029) – estimates and assumptions

	GEP-NET (superiority)	GEP-NET (non-inferiority)
Overall prevalence	0.038%	0.038%
Annual prevalence increase	1.0%	1.0%
Gross price – EU	950	950
Net price – EU	760	760
Gross price – US	8,000	8,000
Net price – US	4000	4000
Annual price increase	0.0%	0.0%
No. of injections per month	2	2
Price reduction on LOE	40%	30%
Adherence	10/12	10/12
Launch year	2027	2027
LOE	2037	2037
Peak penetration among long-acting SSAs	60.0%	15%
Peak sales, unrisked	15,900,000	3,400,000
Risk-adjustment	50%	40%
Peak sales, risk-adjusted	8,000,000	1,400,000

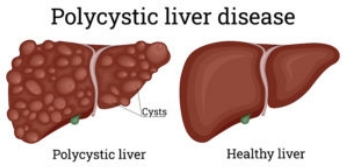
Source: ABG Sundal Collier, Company Data

Footnote: Prevalence estimate is for GEP-NETs (85% of GEP-NENs)

Polycystic liver disease

Disease overview

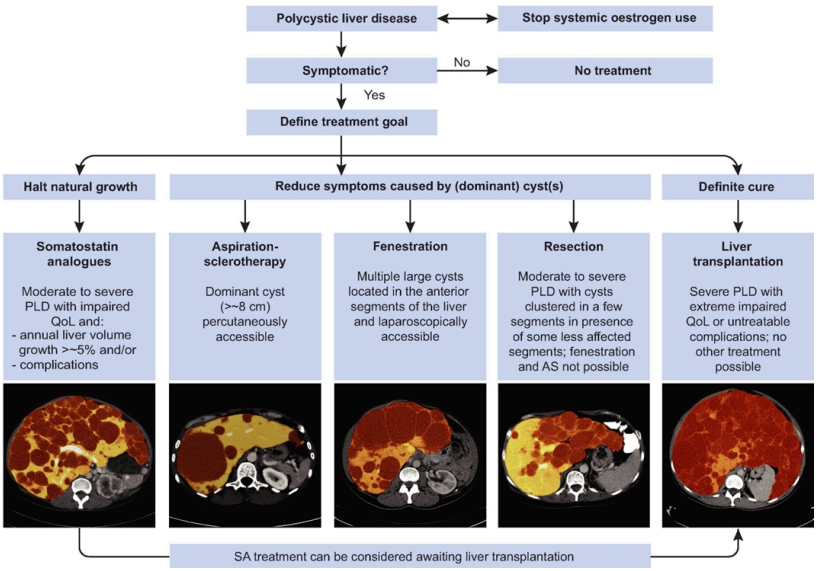
Polycystic liver disease (PLD) is a rare genetic disorder in which mutations in genes that code for proteins involved in the transport of fluid and the growth of epithelial (tissue lining) cells cause multiple cysts (fluid-filled sacs) to grow throughout the liver. While a normal liver has a smooth and uniform appearance, a polycystic liver can look like a cluster of large grapes. Patients may have isolated PLD (autosomal dominant PLD, ADPLD) or, more commonly, PLD in combination with polycystic kidney disease (~80% of patients with autosomal dominant polycystic kidney disease have liver cysts to some extent, ADPKD). Female sex, exogenous oestrogen and multiple pregnancies are risk factors. The majority of patients with PLD are asymptomatic and are diagnosed incidentally on imaging. However, in some patients, the increased size of the liver can cause abdominal pain and compression of adjacent organs, leading to symptoms such as dyspnoea, malnutrition and acid reflux. Diagnosis is made by finding >10 liver cysts on MRI, CT or ultrasound. (Kothadia et al., *StatPearls*, 2023).



Source: https://www.liverdoctor.com/liver-cysts/

In contrast to renal cysts, where decompressive treatment tends to reduce the risk of severe renal impairment, liver cysts only needs to be treated when the cysts become symptomatic. In patients with symptomatic PLD, the main goal is to reduce liver volume by reducing existing and new cyst formation. Depending on the total liver volume and the size and location of the liver cysts, different surgical procedures are standard of care. These include cyst aspiration and sclerotherapy (draining the fluid and destroying the inner lining), fenestration (removing the cyst wall), liver resection (removing entire segments of the liver) and liver transplantation. Liver transplantation is the only curative treatment, but is considered a last resort, mainly because of the shortage of organs. There are no approved drugs for PLD, but somatostatin analogues (SSAs) are often used off-label in moderate to severe cases.

PLD treatment algorithm



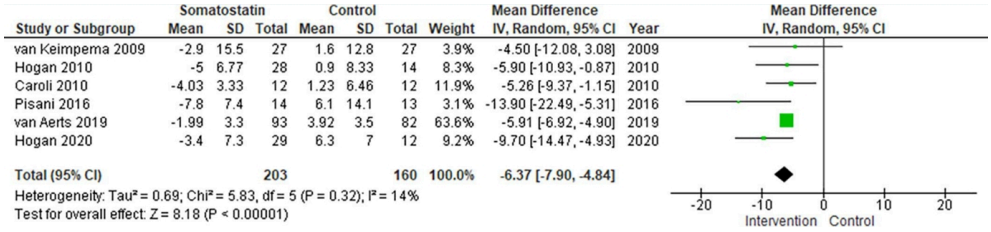
Source: van Aerts et al., J of Hepatology, 2018

The rationale for SSAs

As previously mentioned, somatostatin analogues (SSAs) bind to somatostatin receptors, which are widely expressed in many tissues, including epithelia that line cysts. Their activation reduces intracellular levels of *cAMP,* which is believed to prevent accumulation of fluid in liver cysts.

Suwabe et al. (Suwabe et al., PLoS One, 2021) recently conducted a meta-analysis based on six RCTs including a total of 363 patients (in total 264 nonduplicate studies identified). The meta-analysis found SSAs to be associated with a -6.37% (95% CI -7.90 to -4.84, p<0.00001) lower total liver volume growth rate compared to control.

Recent meta-analysis showed statistical significant SSA benefit



Source: Suwabe et al., PLoS One, 2021

The meta-analysis also showed a statistical significant improvement on total kidney volume growth (-3.66%; 95% CI -5.35 to -1.97, p<0.0001), but not on kidney function (measured by eGFR). The latter we do not consider decisive for PLD. Certain trials have indicated that discontinuation of therapy results in immediate recurrence of liver growth, indicating that continuous treatment is necessary to maintain the beneficial effect (Gevers et al., *Nature*, 2013).

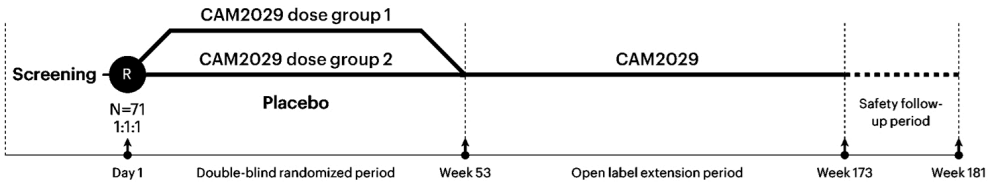
Still, SSAs are yet to get approved for treating PLD and are used off-label, presumably because of the trials' limited size (most) and/or single country (e.g. the DIPAK-trial by van Aerts et al. which is the largest study, was limited to centres in the Netherlands). Nevertheless, the trials support the rationale of CAM2029 for treating PLD.

Camurus' remedy for polycystic liver disease

Camurus is currently conducting the Ph 2b trial *POSITANO* (**Po**lycystic liver **S**afety and efficacy **T**ri**A**l with subcutaneous **O**ctreotide) to evaluate efficacy and safety of CAM2029 in patients with symptomatic liver disease (PLD). Key features of POSITANO are:

- Randomised, placebo-controlled, double-blind Ph 2b
- 10mg of CAM2029 every week or every second week vs. placebo
- 11 clinical centres in the US and Europe
- 52 weeks treatment, after which patients are offered to continue treatment with CAM2029 in an extended open label period of 120 weeks
- Primary endpoint is the change in height-adjusted total liver volume vs. baseline
- Secondary endpoints are change in self-reported PLD symptoms, several additional patient reported outcomes (PROs) and quality of life, octreotide plasma levels, safety and tolerability
- Readout is expected in H1 2025

POSITANO trial design



Source: Company Data

Camurus has *orphan drug designation* in Europe and the US for CAM2029 for the treatment of ADP**L**D, i.e. isolated polycystic liver disease. The orphan drug designation pathway is intended to incentivise drug manufacturers to pursue rare diseases. Among other, it gives tax benefits, decreased review time and may allow for only two clinical trials, i.e. only a Ph 1/2 and Ph 2/3 to reach the market. Hence, POSITANO could possibly be a pivotal trial. Our impression is that there is a small chance for this to be the case in the EU, while a Ph 3 trial highly likely will be needed in the US. We prudently assume that a Ph 3 trial will be needed both in the EU and the US. Also, if approved, orphan drug designation secures market exclusivity for 10-12 years in the EU and seven years in the US. Although the orphan drug designation currently only applies for the treatment of autosomal dominant polycystic liver disease (ADPLD), Camurus may get this extended. However, we do not view this as decisive for its value as the potential patent impact is limited, and we prudently assume that a Ph 3 will be needed anyway.

Based on the existing literature on SSA treatment for PLD, the Ph 2b study design and empirical data on Ph 2 likelihood of approval (LOA) (e.g. Hay et al., Nature Biotechnology, 2014) we estimate an LOA of 30%. We consider this a conservative estimate.

Market model — PLD

Disease frequency

The prevalence of isolated polycystic liver disease (ADP**L**D) is (1-10 in a million), whereas the prevalence of autosomal dominant polycystic kidney disease (ADPKD, of which ~80% have liver cysts to some degree) is ~1-2.5 per 1000. Thus, ADP**K**D represents the vast majority of patients with PLD (Mikolajczyk et al., *Clin. Gastroent. and Hep.*, 2017), (Kothadia, *StatPearls*, 2023). We use the middle range prevalence values, i.e. five per 1 million for ADP**L**D and 1.75 per 1000 for ADP**K**D.

Target population

It has been estimated that 10-30% of patients are symptomatic (Abu-Wasel, *World J. Gastroenterol.*, 2013), likely with ADP**K**D in the lower range and ADP**L**D in the higher range. According to Camurus' sources, an estimated 37,000 patients in the US, EU4 and UK are living with moderate-to-severe symptomatic PLD, of which a majority are women. We arrive at ~34,000 patients in the US and the EU.

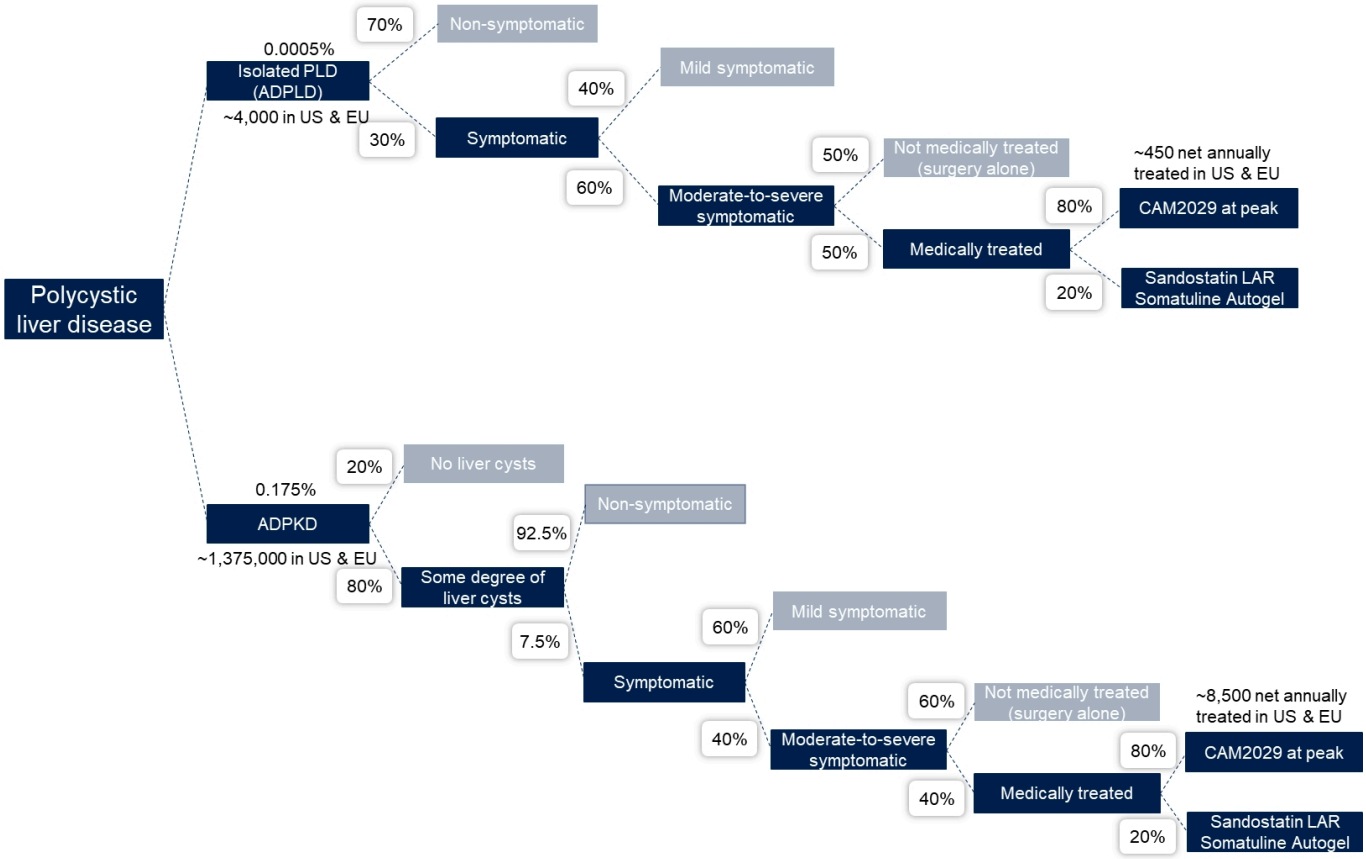
ADPLD

We model that 30% with ADP**L**D are symptomatic, of which 60% are moderate to severe, equating to ~700 patients in the EU and the US at any given time. Given a successful clinical package from Camurus, we estimate that 50% of these will be treated with SSAs. Although CAM2029 would be the only causative medication, we deduct 20% penetration to account for some centres potentially sticking to older SSAs off-label, giving 80% peak penetration level. Lastly, to stay prudent, we model that treatment will only be given nine months per year.

ADPKD

We model that 80% of ADPKD patients have concurrent liver cysts to some degree, and to stay prudent say that only 7,5% of these are *symptomatic.* Of these we estimate that 40% have *moderate to severe* symptomatic PLD, which equates to ~33,000 patients in the EU and the US at any given time. Given a successful clinical package from Camurus, we estimate that 40% of these will be treated with SSAs. Again, we deduct 20% penetration to account for some centres potentially sticking to older SSAs off-label, giving 80% peak penetration level. We model that treatment will only be given nine out of 12 months.

Estimated PLD treatment population – EU & US



Source: ABG Sundal Collier

Footnote: Note that all numbers are estimates

Pricing

We assume the same prices as discussed under "Pricing" for acromegaly on page 45, i.e. a net price of ~EUR 760 in the EU and ~USD 4000 in the US. However, as for GEP-NET, we assume twice-monthly dosing, which doubles net revenue per patient. Again, we model with flat net prices, as this is more in line with recent trends and to stay on the conservative side. We assume 30% price erosion after patent expiry in 2037.

PLD (CAM2029) – estimates and assumptions

PLD	
Overall prevalence	0.0005% & 0.175%
Annual prevalence increase	0.0%
Gross price – EU	950
Net price – EU	760
Gross price – US	8,000
Net price – US	4000
Annual price increase	0.0%
No. of injections per month	2
Price reduction on LOE	30%
Adherence	9/12
Launch year	2028
LOE	2037
Peak penetration among long-acting SSAs	80%
Peak sales, unrisked	3,700,000
Risk-adjustment	30%
Peak sales, risk-adjusted	1,100,000

Source: ABG Sundal Collier, Company Data

CAM2029 – estimates and assumptions

	Acromegaly	GEP-NET (superiority)	GEP-NET (non-inferiority)	PLD
Overall prevalence	0.006%	0.038%	0.038%	0.0005% & 0.175%
Annual prevalence increase	2.0%	1.0%	1.0%	0.0%
Gross price – EU	950	950	950	950
Net price – EU	760	760	760	760
Gross price – US	8,000	8,000	8,000	8,000
Net price – US	4,000	4000	4000	4000
Annual price increase	0.0%	0.0%	0.0%	0.0%
No. of injections per month	1	2	2	2
Price reduction on LOE	30%	40%	30%	30%
Adherence	10/12	10/12	10/12	9/12
Launch year	2026	2027	2027	2028
LOE	2037	2037	2037	2037
Peak penetration among long-acting SSAs	35.0%	60.0%	15%	80%
Peak sales, unrisked	1,300,000	15,900,000	3,400,000	3,700,000
Risk-adjustment	90%	50%	40%	30%
Peak sales, risk-adjusted	1,100,000	8,000,000	1,400,000	1,100,000

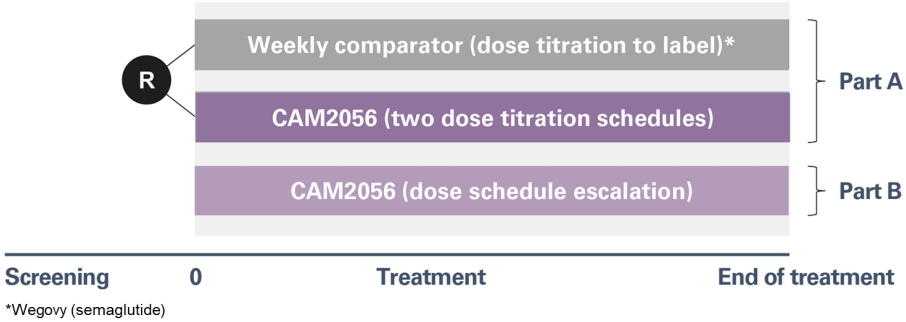
Source: ABG Sundal Collier, Company Data

Other projects

CAM2056 — once-monthly semaglutide

In Q4 2024, Camurus initiated a Ph 1 trial for once-monthly semaglutide (CAM2056) vs. once-weekly semaglutide, evaluating the pharmacokinetics, pharmacodynamics and safety in participants who are overweight or obese and otherwise healthy. Top-line results are expected in H2'25.

Ph 1 trial design for once-monthly semaglutide



Source: Company Data

As no collaboration with Novo Nordisk has been announced, it seems highly likely that Camurus is looking for a product launch after semaglutide goes off patent in 2031/2032. Camurus has communicated that it is unlikely for it to commercialise the product within general obesity/overweight itself, and an out-licensing deal seems to be the goal. However, Camurus could be looking at commercialising CAM2056 for niche subpopulations, e.g. in patients that suffer from addiction with or without obesity.

For now, we do not include CAM2056 in our valuation, as it is still in very early development. We are also uncertain about its value potential, as we are concerned about semaglutide's relevance in 6-7 years when the obesity space becomes very crowded (15+ new compounds look set to enter the market by 2029). Semaglutide may of course keep a special position due to its vast data package on non-weight loss health benefits (cardiovascular, kidney, addiction, possibly dementia, etc.). At the same time, there will be several generics for semaglutide. However, the 1/4 reduced need for fill-finish for CAM2056 (same amount of API, but only one injection pen per month needed instead of four) adds value. Still, as the obesity space looks to become a scaling game, including orals like Eli Lilly's orforglipron, we are hesitant about CAM2056's position.

Additionally, Camurus is exploring other compounds including long-acting incretins for the treatment of obesity and weight-loss in pre-clinical studies, which we currently do not include in the valuation.

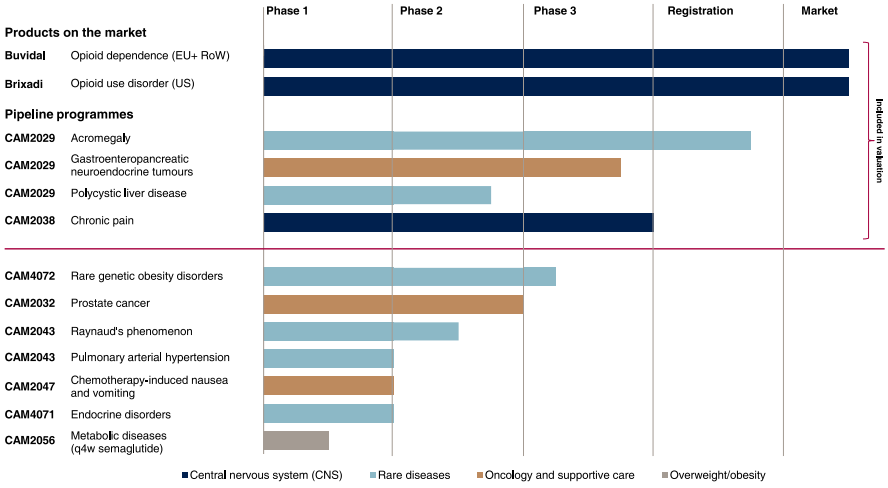
CAM4072 — Rare genetic obesity with Rhythm Pharmaceuticals

In 2016, Camurus entered into a licensing agreement with US obesity-focused biopharmaceutical company *Rhythm Pharmaceuticals.* The agreement gave Rhythm access to Camurus' FluidCrystal technology to develop a weekly formulation of Rhythm's *Imcivree* (daily injected setmelanotide, a melanocortin-4 receptor (MC4R) agonist) for the treatment of rare genetic obesity disorders. In addition to upfront and milestone payments totalling ~USD 65m (of which the majority is in sales milestones), Camurus was to receive tiered mid- to mid-high single-digit royalties on net sales of CAM4072. However, after having completed a randomised Ph 3 switch trial in 2023, which showed once-weekly setmelanotide to have a similar pharmacokinetic profile and BMI reduction as daily setmelanotide, the project was put on hold. Instead, Rhythm has chosen to continue with its in-house developed RM-718 (Ph 1 initiated in March 2024), also for weekly administration, as it believes it to have superior efficacy and not cause hyperpigmentation due to more specific MC4R affinity. Additionally, Rhythm recently in-licensed a once daily oral MC4R agonist (LB54640) from LG Chem. This has made CAM4072 a second back up. We consider the likelihood for any significant value add to Camurus too low to include it in our valuation.

Others

The remaining pipeline has stalled for long periods, and we consider the likelihoods of significant success here as too low to include.

Camurus' approved products and pipeline



Source: ABG Sundal Collier, Camurus

Footnote: q4w = dosed every four weeks

Financials

Management has a very good track record of delivering on or better than guidance, and general prudence in terms of its communication.

For 2025, Camurus guides for:

- Revenue growth of 45-61% to SEK 2.7-3.0bn, primarily driven by Buvidal and Brixadi with a small revenue contribution from the anticipated launch of CAM2029 in acromegaly.
- Pre-tax profit of SEK 0.9-1.2bn.
- R&D costs unchanged at the 2024 level.

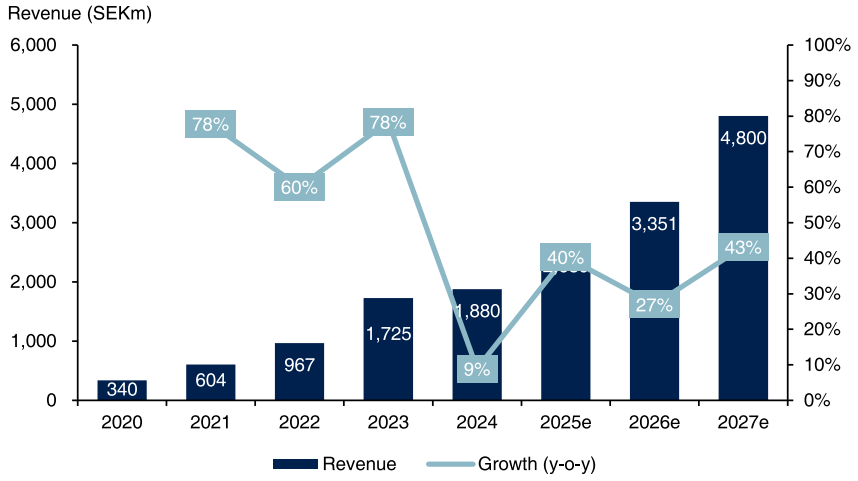
Long term, Camurus guides for continued deliverance in accordance with the five-year vision (2027) including:

- Revenue of SEK 4.5bn, i.e. five-fold revenue growth since 2022, i.e. SEK 4.5bn.
- Operating margin of ~50%.

Revenue

Our estimated revenue streams are as explained in the market models for Buvidal, Brixadi and the three CAM2029 indications (risk-adjusted). Camurus has delivered a revenue CAGR of ~53% since 2020 and ~39% since 2022.

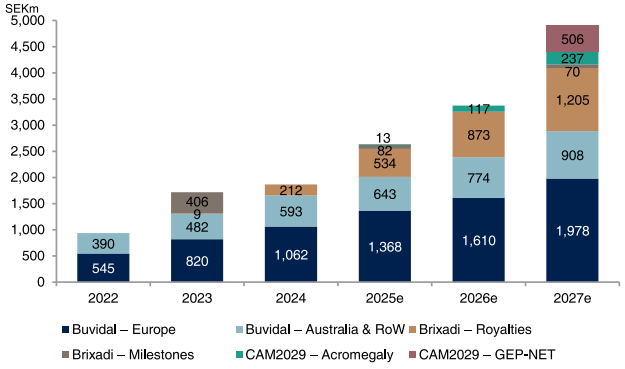
Steady double-digit revenue growth (SEK 406m in milestone revenue in 2023)



Source: ABG Sundal Collier, Company Data

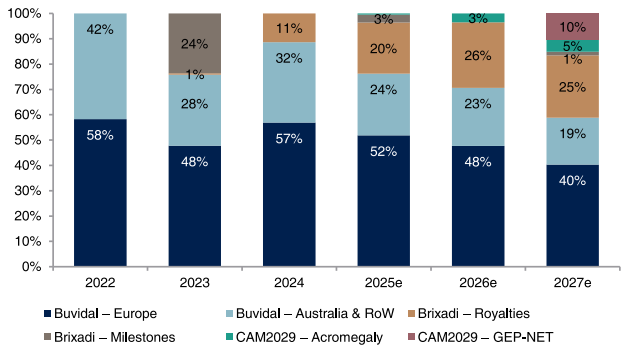
At first glance it may look as growth saw a sharp decrease in 2024. However, this is simply explained by the 2023 milestone payment of ~SEK 406m from Braeburn for US approval of Brixadi.

Strong opioid game...



Source: ABG Sundal Collier, Company Data

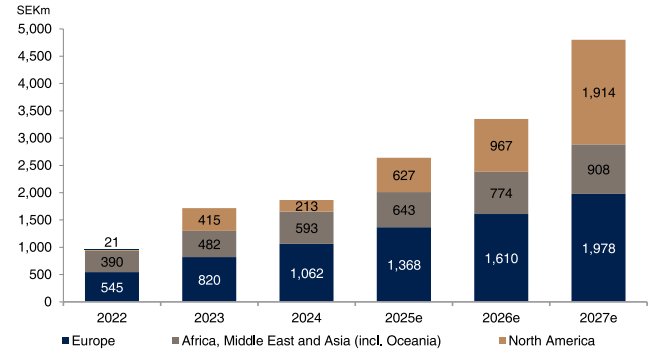
...but CAM2029 looks to become even stronger



Source: ABG Sundal Collier, Company Data

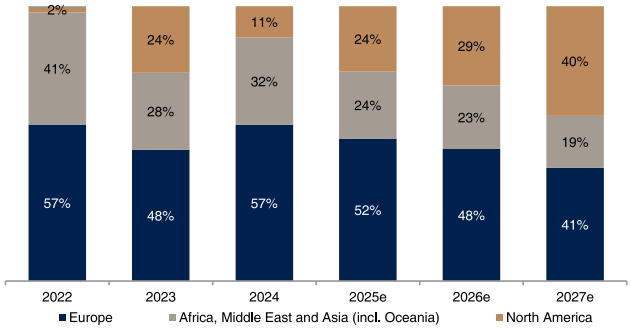
All regions are growing at double-digit rates, and the US in particular is excelling. We see limited downside risk to the growth trajectory besides potential failure of the Ph 3 SORENTO trial for GEP-NET. The OUD crisis is here to stay for the foreseeable future and there is no cure for the CAM2029 indications. Competitive risk is relevant, but Camurus' market leader position looks strong. The impact on Camurusfrom potentially prolonged US tariffs, will be minimal. The US partner Braeburn manufactures and sells Brixadi on its own, so there is no tariff impact. With regard to CAM2029, production and packaging will initially take place in the EU, with aims of moving the US share to the US near-to-mid-term. However, sales for CAM2029 will anyway be very limited until 2027e. Even in a worst case scenario, where US tariffs were to persist past President Donald Trump's second term, impact would be very small as we expect a long-term gross margin of 90% for CAM2029.

The US is becoming increasingly important...



Source: ABG Sundal Collier, Company Data

...but minimal potential tariff impact



Source: ABG Sundal Collier, Company Data

Costs

COGS

In 2024, Camurus had a gross margin of ~92% for Buvidal, whereas Brixadi royalties come additionally without any COGS. This has gradually improved since ~86% in 2021. Still, we model a flat 92% gross margin for Buvidal going forward to stay conservative. For CAM2029, we model a gross margin of 70% in year 1, 85% in year 2 and 90% from year 3 and forward.

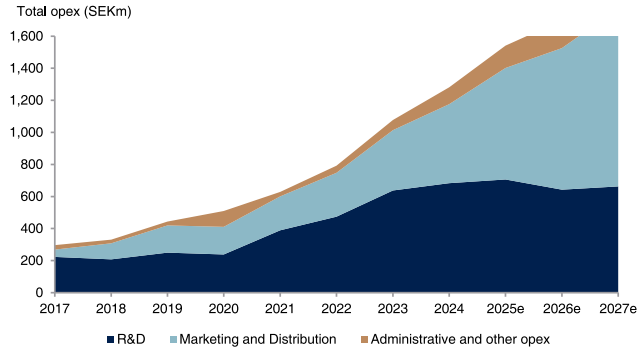
SG&A

Based on communication from Camurus management, we model an ~SEK 200m annual increase in *Marketing and Distribution costs* until 2029e in relation to the launch of CAM2029, of which the majority is to build the US commercial organisation. This constitutes a ~180% increase from the 2024 level. Similarly, we model a ~100% increase in administrative expenses until 2029e.

R&D

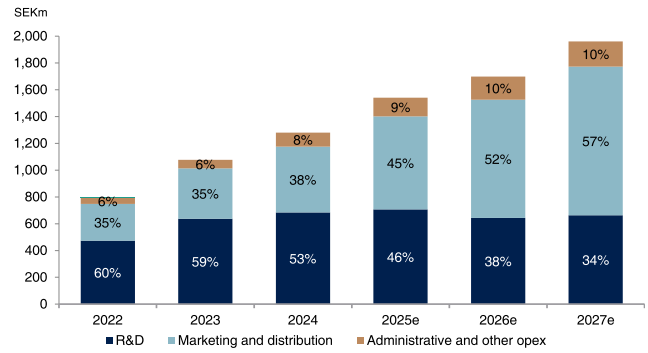
We have modelled that R&D costs peak in 2024-2025e before falling back to approximately the 2023 level in 2026e, thereafter increasing at an inflation rate of 2%. We acknowledge that R&D spending will probably pick up again, as Camurus is a drug platform company. However, because we have very limited visibility on what these projects may be, and therefore do not include them in our revenue estimates, we consider it most fair from a valuation standpoint to not include their specific costs, i.e. not punishing Camurus twice.

We have accounted for a large increase in marketing and distribution costs



Source: ABG Sundal Collier, Company Data

We have accounted for a large increase in marketing and distribution costs

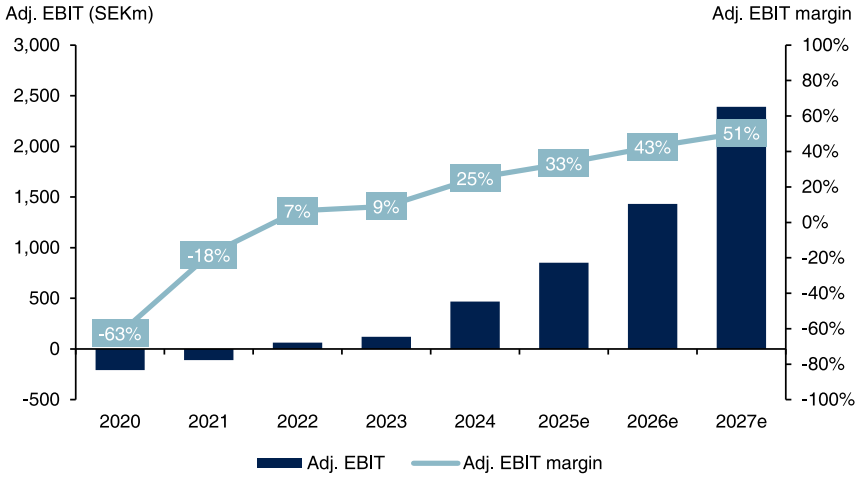


Source: ABG Sundal Collier, Company Data

EBIT margin

As mentioned, Camurus' 2027 vision is revenue of SEK 4.5bn with a ~50% operating margin. We consider this very realistic when accounting for risk-adjusted GEP-NET revenue.

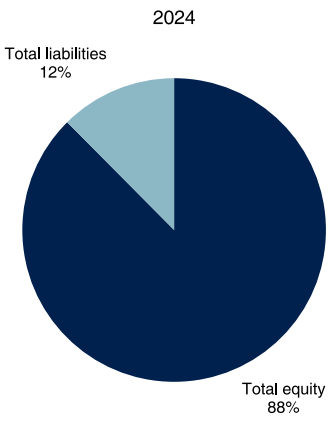
Steady improving adj. EBIT margin (ex. milestones)



Source: ABG Sundal Collier, Company Data

Finally, Camurus has a very solid balance sheet with an equity ratio of close to 90% and a net cash position of SEK 2.75bn.

SEK 2.75bn cash out of SEK 3,3bn equity – no IBD



Source: ABG Sundal Collier, Company Data

P&L estimates

Product and region segmented P&L

SEKm, Risk-adjusted	2020	2021	2022	2023	2024	2025e	2026e	2027e	2028e	2029e	2030e
Revenue by product											
Buvidal	323	597	936	1,302	1,655	2,009	2,359	2,704	2,969	3,238	3,509
Brixadi	13	3	21	415	213	618	873	1,276	1,596	1,961	2,194
CAM2029 – Acromegaly	0	0	0	0	0	13	117	237	362	492	629
CAM2029 – GEP-NET	0	0	0	0	0	0	0	583	1,773	2,996	4,252
CAM2029 – PLD	0	0	0	0	0	0	0	0	106	318	532
Of which Milestone Revenues	4	0	9	406	0	82	0	70	0	60	0
Revenue by region											
Europe	206	360	545	820	1,062	1,368	1,610	1,978	2,422	2,895	3,377
North America	13	3	21	415	213	627	967	1,914	3,341	4,931	6,421
Africa, Middle East & Asia (incl. Oceania)	117	237	390	482	593	643	774	908	1,044	1,181	1,319
Total revenue	**336**	**601**	**956**	**1,717**	**1,868**	**2,639**	**3,351**	**4,800**	**6,808**	**9,007**	**11,117**
Gross profit	301	515	853	1,595	1,738	2,475	3,131	4,424	6,240	8,351	10,272
OPEX	**-509**	**-629**	**-792**	**-1,077**	**-1,281**	**-1,541**	**-1,699**	**-1,962**	**-2,124**	**-2,274**	**-2,350**
Marketing and distribution costs	-172	-212	-274	-376	-492	-695	-883	-1,110	-1,251	-1,395	-1,446
Administrative expenses	-98	-28	-35	-49	-91	-127	-161	-176	-182	-176	-178
Research and development costs	-239	-389	-474	-638	-684	-706	-643	-663	-677	-691	-714
Other operating income	4	3	11	8	12	0	0	0	0	0	0
Other operating expenses	-1	-1	-9	-15	-13	-12	-12	-12	-13	-13	-12
EBITDA	**-194**	**-98**	**85**	**540**	**484**	**953**	**1,451**	**2,441**	**4,092**	**6,054**	**7,897**
EBITDA margin	*-57%*	*-16%*	*9%*	*31%*	*26%*	*36%*	*43%*	*51%*	*60%*	*67%*	*71%*
Depreciation & amortization	12	13	13	14	15	19	19	22	25	23	24
EBIT	**-205**	**-111**	**72**	**526**	**469**	**934**	**1,432**	**2,463**	**4,116**	**6,076**	**7,921**
EBIT margin	*-60%*	*-18%*	*7%*	*30%*	*25%*	*35%*	*43%*	*51%*	*60%*	*67%*	*71%*
Adj. EBIT (ex. Milestones)	**-210**	**-111**	**63**	**120**	**469**	**852**	**1,432**	**2,392**	**4,116**	**6,016**	**7,921**
Adj. EBIT margin	*-63%*	*-18%*	*7%*	*9%*	*25%*	*33%*	*43%*	*51%*	*60%*	*67%*	*71%*
Net financial expenses	-1	-1	1	23	83	75	81	92	128	188	278
Profit before tax	**-207**	**-112**	**73**	**549**	**553**	**1,009**	**1,514**	**2,555**	**4,244**	**6,264**	**8,199**
Net profit	**-169**	**-89**	**59**	**430**	**431**	**801**	**1,202**	**2,029**	**3,370**	**4,973**	**6,510**
EPS, calculated	-3	-2	1	7	7	13	20	34	56	83	109
Cash flow from operations	-239	-143	101	607	388	934	1,156	1,917	3,140	4,757	6,341
Capex	-3	-5	5	-10	-29	-21	-21	-21	-21	-21	-21
Free cash flow	**-3**	**-5**	**5**	**-10**	**-29**	**-21**	**-21**	**-21**	**-21**	**-21**	**-21**

Source: ABG Sundal Collier, Company Data

Valuation

We primarily value Camurus using a risk-adjusted DCF sum-of-the-parts approach that combines the estimated valuations of: 1) Buvidal, 2) Brixadi royalties and sales milestones, and 3) CAM2029, especially GEP-NET. We use a standard WACC of 9%, and in order to stay prudent, a terminal growth rate of 0% across all indications. We mainly use multiples valuation as a sanity check, as the companies' comparability is challenging and Camurus' huge CAM2029 potential is not accounted for within the timeframe. However, given the remarkable growth rate — a P/E of ~25x in 2026e, ~15x in 2027e and ~9x in 2028e on risk-adjusted estimates — we consider the valuation attractive for a quality company like this.

Multiples valuation

Peer valuation

	Mcap	EV/Sales			EV/EBITDA adj.			EV/EBIT adj.			P/E			Gross margin (%)			EBIT margin, adj. (%)			Sales CAGR (%)	
	SEKm	2025	2026e	2026e	2025	2026e	2027e	2025	2026e	2027e	2025	2026e	2027e	2025	2026e	2027e	2025	2026e	2027e	'21-24'	'24-'27e
OUD peers																					
Alkermes	46,531	2.9	2.6	2.6	15.4	15.7	19.6	16.4	17.5	20.7	15.8	15.6	17.3	85.9	86.9	87.5	18.4	16.6	14.3	9.9	-3.0
Collegium Pharmaceutical	8,176	1.7	1.1	n.a.	4.3	4.1	4.2	4.3	4.4	5.5	3.2	3.1	3.3	80.7	80.8	87.8	58.2	55.1	47.3	31.6	4.6
Emergent BioSolutions	2,329	n.a.	n.a.	n.a.	4.8	n.a.	n.a.	9.6	19.2	17.8	6.8	36.0	22.3	46.7	34.4	42.8	10.5	4.3	5.5	-16.2	-7.3
Indivior	11,498	0.9	0.8	0.9	4.8	4.5	4.2	6.4	5.7	5.1	7.2	6.1	5.2	84.2	83.0	82.4	20.7	22.3	23.7	17.4	-2.1
Orexo AB	486	1.2	1.3	1.3	21.4	54.4	88.9	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	87.1	85.3	84.2	-3.3	-5.7	-5.4	1.5	4.4
Average	**13,804**	**1.7x**	**1.5x**	**1.6x**	**10.1x**	**19.7x**	**29.2x**	**9.2x**	**11.7x**	**12.3x**	**8.3x**	**15.2x**	**12.0x**	**76.9%**	**74.1%**	**76.9%**	**20.9%**	**18.5%**	**17.1%**	**8.8%**	**-0.7%**
Median	**8,176**	**1.4x**	**1.2x**	**1.3x**	**4.8x**	**10.1x**	**11.9x**	**8.0x**	**11.6x**	**11.6x**	**7.0x**	**10.8x**	**11.2x**	**84.2%**	**83.0%**	**84.2%**	**18.4%**	**16.6%**	**14.3%**	**9.9%**	**-2.1%**
Drug Delivery peers																					
Halozyme Therapeutics	71,179	6.5	4.8	3.6	11.4	8.2	6.6	n.a.	n.a.	n.a.	11.8	8.7	7.1	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	31.8	19.1
Aptar Pharma	88,292	3.0	3.0	2.8	13.3	12.3	11.5	20.1	17.9	n.a.	25.8	23.0	19.9	37.7	38.1	37.1	14.5	15.4	n.a.	3.5	4.9
Xeris Biopharma	6,366	6.0	4.6	3.8	27.7	20.9	9.1	38.2	26.4	9.2	n.a.	36.0	10.7	84.3	85.4	85.7	8.4	10.0	24.4	60.0	22.5
Average	**55,279**	**5.2x**	**4.1x**	**3.4x**	**17.5x**	**13.8x**	**9.1x**	**29.1x**	**22.2x**	**9.2x**	**18.8x**	**22.6x**	**12.6x**	**61.0%**	**61.7%**	**61.4%**	**11.5%**	**12.7%**	**24.4%**	**31.8%**	**15.5%**
Median	**71,179**	**6.0x**	**4.6x**	**3.6x**	**13.3x**	**12.3x**	**9.1x**	**29.1x**	**22.2x**	**9.2x**	**18.8x**	**23.0x**	**10.7x**	**61.0%**	**61.7%**	**61.4%**	**11.5%**	**12.7%**	**24.4%**	**31.8%**	**19.1%**
Specialty Pharma peers																					
Agios Pharmaceuticals	14,074	25.8	9.1	4.1	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	82.1	89.9	57.6	-997	-217	-66	n.a.	118.0
Crinetics Pharmaceuticals	23,816	272	39	8.5	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	81.0	75.7	89.9	-8,330	-1,224	-262	-1.2	466.7
Harmony Biosciences	16,165	1.3	0.8	0.3	4.8	4.5	3.5	n.a.	n.a.	n.a.	9.2	7.2	5.5	76.0	78.2	78.3	n.a.	n.a.	n.a.	32.8	18.3
Ipsen	90,935	1.9	1.6	1.3	5.6	5.2	4.9	6.8	6.4	5.9	9.0	8.4	7.7	83.7	82.8	82.4	30.1	30.4	30.8	8.8	7.4
Pacira Biosciences	12,173	1.5	1.1	0.8	6.5	5.2	4.4	7.4	6	4.8	8.9	7.0	5.6	77.4	78.2	79.2	24.2	27.4	29.9	9.0	10.2
Supernus Pharmaceuticals	17,125	2.1	2.2	2.0	15.1	10.2	8.1	10.8	8.2	6.4	16.1	12.5	9.9	87.7	88.9	87.5	20.0	24.3	27.7	4.5	4.6
Travere Therapeutics	12,578	3.3	2.1	n.a.	n.a.	n.a.	n.a.	n.a.	27	5.5	n.a.	17.3	8.3	89.7	94.6	83.3	-39.6	7.5	31.4	0.8	42.5
UCB	312,187	3.8	3.2	2.9	12.8	10.2	8.7	19.4	14.2	11.4	17.9	13.6	10.6	72.5	73.7	75.2	19.9	23.9	27.4	2.1	11.3
Average	**29,795**	**2.0x**	**1.6x**	**1.1x**	**8.0x**	**6.3x**	**5.2x**	**8.3x**	**11.7x**	**5.6x**	**10.8x**	**10.5x**	**7.4x**	**82.9%**	**84.6%**	**82.1%**	**8.7%**	**22.4%**	**30.0%**	**11.2%**	**16.6%**
Median	**16,165**	**1.9x**	**1.6x**	**1.1x**	**6.0x**	**5.2x**	**4.6x**	**7.4x**	**7.3x**	**5.7x**	**9.1x**	**8.4x**	**7.7x**	**83.7%**	**82.8%**	**82.4%**	**22.1%**	**25.9%**	**30.4%**	**8.8%**	**10.2%**
Pharma Major peers																					
AstraZeneca	2,054,854	3.7	3.3	3.0	10.5	9.6	8.9	11.8	10.6	9.7	13.7	12.2	11.0	81.9	81.9	82.6	32.2	33.5	34.7	15.4	6.3
Eli Lilly	6,894,143	12.4	10.1	8.5	25.2	20.1	16.7	27.9	22.0	18.0	32.5	25.3	20.3	81.6	81.2	80.6	42.8	45.1	47.2	16.7	22.8
Novartis	2,184,326	4.1	3.9	3.7	9.6	9.3	9.0	10.4	10.3	9.7	11.5	11.0	10.3	81.2	81.2	81.1	39.1	38.7	39.8	-2.1	2.6
Novo Nordisk	2,153,559	5.3	4.5	4.0	10.4	8.9	7.9	11.4	9.8	8.7	14.9	12.2	10.7	83.9	83.5	83.2	46.9	47.3	47.4	27.3	16.0
Average	**3,321,720**	**6.4x**	**5.5x**	**4.8x**	**13.9x**	**12.0x**	**10.6x**	**15.4x**	**13.2x**	**11.5x**	**18.2x**	**15.2x**	**13.1x**	**82.2%**	**81.9%**	**81.8%**	**40.3%**	**41.2%**	**42.3%**	**14.3%**	**11.9%**
Median	**2,168,943**	**4.7x**	**4.2x**	**3.9x**	**10.5x**	**9.5x**	**9.0x**	**11.6x**	**10.4x**	**9.7x**	**14.3x**	**12.2x**	**10.9x**	**81.7%**	**81.6%**	**81.8%**	**40.9%**	**41.9%**	**43.5%**	**16.1%**	**11.2%**
Camurus	**34,580**	**10.2x**	**7.7x**	**5.0x**	**30.8x**	**17.7x**	**10.1x**	**31.5x**	**18.0x**	**10.0x**	**37.9x**	**25.3x**	**15.0x**	**93.8%**	**93.4%**	**92.2%**	**33.3%**	**42.7%**	**50.6%**	**46.0%**	**36.7%**
vs. OUD peers		**502%**	**427%**	**211%**	**204%**	**-10%**	**-66%**	**243%**	**54%**	**-19%**	**359%**	**67%**	**25%**	**17pp**	**19pp**	**15pp**	**12pp**	**24pp**	**33pp**	**37pp**	**37pp**
vs. Drug Delivery peers		**96%**	**86%**	**46%**	**76%**	**28%**	**11%**	**8%**	**-19%**	**8%**	**102%**	**12%**	**19%**	**33pp**	**32pp**	**31pp**	**22pp**	**30pp**	**26pp**	**14pp**	**21pp**
vs. Specialty Pharma peers		**401%**	**391%**	**350%**	**286%**	**182%**	**92%**	**278%**	**53%**	**76%**	**252%**	**141%**	**102%**	**11pp**	**9pp**	**10pp**	**25pp**	**20pp**	**21pp**	**35pp**	**20pp**
vs. Pharma Major peers		**60%**	**40%**	**4%**	**121%**	**48%**	**-6%**	**105%**	**36%**	**-14%**	**109%**	**67%**	**15%**	**12pp**	**11pp**	**10pp**	**-7pp**	**2pp**	**8pp**	**32pp**	**25pp**

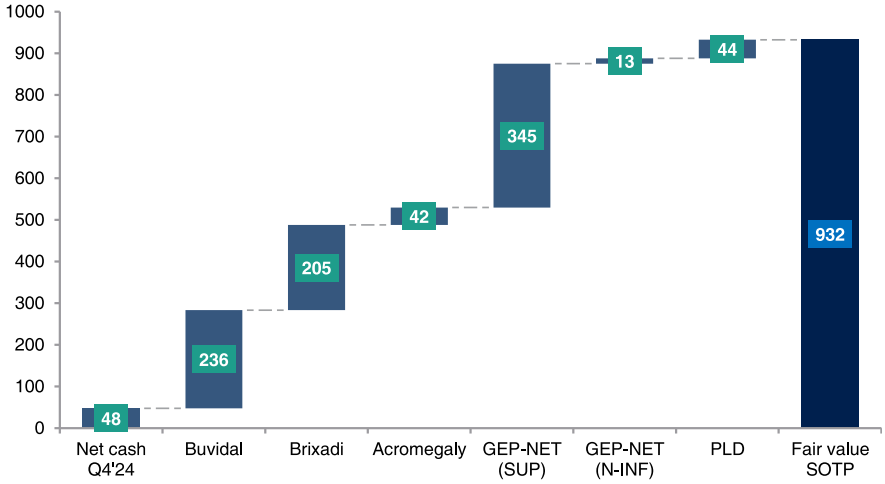
**ABGSC estimates*

Source: ABG Sundal Collier, FactSet

Risk-adjusted DCF sum-of-the-parts

We have split costs across all included indications, but with Buvidal and CAM-2029 for GEP-NET taking the greater part. As of now, we fully disregard the other projects including rare genetic obesity disorders (CAM4072), Raynaud's phenomenon (CAM2043) and long-acting semaglutide (CAM2056). Still, we find Camurus to be attractively valued — the approved products Buvidal, Brixadi, soon-to-be CAM2029 for acromegaly and net cash alone, sum up to SEK 530/share – justifying today's share price.

Sum-of-the-parts – waterfall plot (risk-adjusted)



Source: ABG Sundal Collier, Company Data

Footnote: Net cash Q4'24 + Buvidal + Brixadi + Acromegaly = SEK 530

Sum-of-the-parts – table (Base case)

Base case SOTP	Value, de-risked (SEKm)	Risk-adjustment	Value, risked (SEKm)	Value/share (SEK)
Net cash Q4'24	2,853		2,853	48
Discounted EV – Buvidal	14,123	100%	14,123	236
Discounted EV – Brixadi	12,272	100%	12,272	205
Discounted EV – CAM2029 - Acromegaly	2,786	90%	2,507	42
Discounted EV – CAM2029 - GEP-NET (SUP)	41,398	50%	20,699	345
Discounted EV – CAM2029 - GEP-NET (N-INF)	1,908	40%	763	13
Discounted EV – CAM2029 - Polycystic liver d.	8,877	30%	2,663	44
Fair value SOTP	84,216		55,880	932

Source: ABG Sundal Collier, Company Data

On top of the guaranteed products that alone justify today's share price, you get CAM2029 for GEP-NET. If CAM2029 proves superiority in GEP-NET, for which we estimate a 50% likelihood, *it will become a blockbuster* and alone be worth more than the entire current market cap.

Sum-of-the-parts – table (Bull case)

Bull case SOTP	Value, de-risked (SEKm)	Risk-adjustment	Value, risked (SEKm)	Value/share (SEK)
Net cash Q4'24	2,853		2,853	48
Discounted EV – Buvidal	14,123	100%	14,123	236
Discounted EV – Brixadi	12,272	100%	12,272	205
Discounted EV – CAM2029 - Acromegaly	2,786	100%	2,786	46
Discounted EV – CAM2029 - GEP-NET (SUP)	41,398	100%	41,398	691
Discounted EV – CAM2029 - Polycystic liver d.	8,877	100%	8,877	148
Fair value SOTP	82,308		82,308	1,374

Source: ABG Sundal Collier, Company Data

However, importantly the non-inferiority scenario (we estimate 40% scenario likelihood) still covers the development, sales and marketing costs, which provides an important downside protection.

Sum-of-the-parts – table (Bear case)

Bear case SOTP	Value, de-risked (SEKm)	Risk-adjustment	Value, risked (SEKm)	Value/share (SEK)
Net cash Q4'24	2,853		2,853	48
Discounted EV – Buvidal	14,123	100%	14,123	236
Discounted EV – Brixadi	12,272	100%	12,272	205
Discounted EV – CAM2029 - Acromegaly	2,786	90%	2,507	42
Discounted EV – CAM2029 - GEP-NET (SUP)	41,398	0%	0	0
Discounted EV – CAM2029 - GEP-NET (N-INF)	1,908	0%	0	0
Discounted EV – CAM2029 - Polycystic liver d.	8,877	0%	0	0
Fair value SOTP	84,216		31,755	530

Source: ABG Sundal Collier, Company Data

And should it not get the non-inferiority label (we estimate only ~10% likelihood) — not even in the EU — the cost ramp-up would be at a completely different level than we have assumed, i.e. only an additional annual ~SEK 200m needed for the acromegaly sales force as opposed to annually ~SEK 800m including GEP-NET.

We think that parts of the consensus are too optimistic and/or not recently updated short-term, particularly on Buvidal and CAM2029 for acromegaly, which the market also clearly does not believe in, as indicated by the current stock price. For 2025e, when adjusting for the strengthened SEK, we are in the low-mid guidance range for sales and mid-high range on pre-tax-profit. Importantly, we are above the 2027 visions of SEK 4.5bn revenue with ~50% operating margin — we estimate ~SEK 4.8bn in revenue with a ~51% EBIT margin in 2027e. We urge to see beyond near-term noise from the acromegaly CRL, as this has minimal impact on the long-term equity story.

While the stock is still up ~430% last five years, it is down ~30% from its peak levels in August 2024, primarily on this noise in addition to general market uncertainty. We consider this a good buying opportunity. We initiate coverage with a BUY recommendation and a six-months TP of SEK 750.

Key risks

As always, there are several risks that investors should keep in mind. In addition to broad equity market risk factors — such as overall macroeconomic conditions, interest rate levels, investor sentiment shifts, and the potential impact of individual shareholder actions on the share price — we also emphasise the following:

Competitive landscape risk

Camurus' FluidCrystal-based products provide a strong market proposition through their convenience and differentiation, but sustaining its position will require continued innovation. The competitive environment is evolving rapidly, and maintaining commercial momentum will hinge on Camurus' ability to remain relevant and agile against larger, better-resourced competitors. The company often operates alongside major pharmaceutical players with substantially greater scale across R&D, manufacturing, and/or commercialisation. For instance, Indivior is reported to have a sales force that is approximately three to four times larger than Braeburn's, giving it a notable advantage in terms of promotional reach and market penetration.

Price and reimbursement risk

Drug pricing continues to face ongoing scrutiny, especially in key regions such as the US and EU. Although Camurus's products stand out through their convenience and clinical benefits, the overall push for cost control and increasing availability of generics contribute to a tough market landscape. We observe selective pricing pressure from both public and private payors, particularly in areas with existing treatment alternatives. In addition, rivals with more extensive product portfolios may use bundled pricing approaches to strengthen their competitive positions.

Regulatory risk

Camurus operates in a highly regulated environment shaped by evolving policies, market-specific dynamics, and varying regulatory frameworks — all of which can significantly influence timelines and access to market. Even with positive clinical outcomes, the path to final approval may require prolonged regulatory interaction, as evidenced by CRLs that have postponed the launches of Brixadi and CAM2029. Additionally, the company's main customers — including public healthcare providers, insurers, and pharmaceutical partners — are also subject to changing regulations and reimbursement conditions.

R&D risk

Camurus is advancing a pipeline of clinical-stage assets built on established compounds, frequently aimed at indications with existing treatment options. This approach helps mitigate development risk, but does not eliminate it. Drug development is inherently complex, with uncertainties spanning clinical outcomes, safety profiles, trial execution, and regulatory requirements. Decisions are often made under conditions of limited data, and development timelines may be subject to change.

Partner risk

While Braeburn has performed well with Brixadi following its approval, the experience underscores the inherent risks involved in relying on external partners — especially when managing complex regulatory pathways.

M&A risk

Camurus has primarily expanded through organic growth but has disclosed an interest in pursuing acquisitions as part of its forward-looking strategy. While M&A can provide compelling growth opportunities, it also introduces a range of risks. Acquisitions may strain financial resources and lead to near-term disruptions during integration. One key challenge is the potential for asymmetric information — where sellers possess more insight into the asset than buyers — which can result in overvaluation or unexpected issues after the deal closes. Effectively managing these risks will be essential to generating long-term value from future transactions.

Patent risk

Camurus holds patent protection for its key products, including Brixadi (expiring in 2032), Buvidal (2033), and CAM2029 (2037). Continued success will depend on the company's ability to secure, maintain, and enforce its intellectual property rights. There is a risk that Camurus may not obtain broad enough patent coverage, or that existing third-party patents could restrict its operational flexibility, potentially impacting profitability. Our understanding is that Brixadi-related royalties can be expected to continue beyond the expiration of its patent, and our model reflects this assumption.

Key personnel risk

Camurus depends on key personnel across critical functions such as management, product development, manufacturing, quality assurance, and commercialisation. Retaining talent is important to ensure continuity and minimise employee turnover.

Cost inflation risk

Camurus is subject to cost inflation risks, particularly in relation to wages, raw materials, and manufacturing expenses. As the company grows and competes for skilled talent, upward pressure on salaries may challenge its ability to manage labour costs. Rising input or production costs could also compress margins, especially if Camurus is unable to offset these increases through pricing adjustments.

Currency risk

Camurus incurs most of its costs in SEK, while the majority of its revenue is generated in foreign currencies — primarily USD, EUR, and AUD — exposing the company to exchange rate fluctuations. Although currency futures have been used to hedge part of this exposure, the extent of the hedging is not fully disclosed, and the company's future hedging strategy remains uncertain.

Appendix 1: Management and Board

Fredrik Tiberg
President and CEO

- Appointed CEO in 2003, and board member since 2002. Holds 1,615,000 shares, 42,000 employee options and 4,000 performance share plan units.
- Over 30 years of biotechnology and pharmaceutical experience. Most recently as the CEO of Heptahelix AB. He has over 110 publications in peer-reviewed scientific journals and is named inventor on more than 400 patents and patent applications.
- Ph.D. in Physical Chemistry from Lund University. M.Sc. In Chemical Engineering from Lund Institute of Technology.

Jon U. Garay Alonso
CFO

- Appointed CFO in 2022. Holds 1,450 shares, 24,000 employee options and 2,300 performance share plan units.
- Over 20 years of experience in finance. Prior to joining Camurus, he spent 10 years at Baxter in different Finance Director roles within European businesses.
- Executive MBA postgraduate program and a General Management Program from IESE Business School, and a B.A. from Universidad Commercial de Deusto.
- Has resigned, will leave his position mid-August.

Richard Jameson
Chief Commercial Officer

- Appointed as Chief Medical Officer in 2016. Holds 9,193 shares, 24,000 employee options and 2,300 performance share plan units.
- More than 30 years of experience from the global pharmaceutical industry. This includes the position as regional director (EU/MENA) at Indivior, where he had a key role in the demerger from Reckitt Benckiser in 2014.
- B.Sc. (Hons.) in Applied Biological Sciences from University West of England.

Agneta Svedberg
Vice President Clinical Development

- Joined Camurus in 2015 and appointed VP Clinical Development in 2019. Holds 22,987 shares, 16,000 employee options and 1,500 performance share plan units.
- Over 30 years of experience within drug development from leading roles within both biotech and pharma, including Site Manager at Genmab, CEO at Cantargia and COO at Zealand Pharma.
- M.Sc. In Radiation Physics and B.Sc. in Medicine from Lund University. Also holds an executive MBA from the Executive Foundation Lund.

Annette Mattsson
Vice President Regulatory Affairs

- Joined Camurus in 2017 and appointed VP Regulatory Affairs in 2019. Holds 2,004 shares, 16,000 employee options and 1,500 performance share plan units.
- More than 30 years of regulatory experience from development projects. She has worked as European RA Director / Global RA at AstraZeneca and Global RA Portfolio Lead at LEO Pharma. She is also part of the steering committee of Medicon Village's Regulatory Affairs Pharma Network.
- Bachelor of Pharmacy from Uppsala University and has studied Business Economics at Lund University.

Fredrik Joabsson
Chief Business Development Officer

- Appointed Chief Business Development Officer in 2019 after having worked for Camurus since 2001. Holds 40,170 shares, 16,000 employee options and 1,500 performance share plan units.
- Over 20 years of experience within pharmaceutical R&D, business development, alliance management and investor relations. He is named inventor of several issued patents and has worked with formulation science and drug delivery systems development.
- Ph.D. in Physical Chemistry and M.Sc. In Chemistry from Lund University.

Maria Lundqvist
Global Head of HR

- Appointed Global head of HR in 2021. Holds no shares, 16,000 employee options and 1,500 performance share plan units.
- Over 20 years of experience from leadership roles within HR. Most recently she was HR Director Nordics at Teva Pharmaceuticals, where she had a key role in the integration of the Nordic part of Actavis. She has also held HR positions in Tetra Pak, Vestas and AstraZeneca.
- B.Sc. In Business Economics from Uppsala University.

Alberto M. Pedroncelli
Chief Medical Officer

- Appointed Chief Medical Officer in 2023. Holds 1,000 shares, 20,000 employee options and 1,500 performance share plan units.
- Leading expert in clinical development and medical affairs within endocrinology and oncology. Former Head of Clin. Development & Medical Affairs, Global Endocrinology at Recordati. Also spent over 10 years in leadership roles at Novartis, where he led the global submission of pasireotide in acromegaly and Cushing's syndrome. He has 150+ abstracts and over 30+ manuscripts in peer-reviewed scientific journals.
- MD from University of Milan, and Ph.D. Endocrinology at the post-graduate school at University of London.

Torsten Malmström
Chief Technical Officer

- Joined Camurus in 2013 and appointed CTO in 2020. Holds 35,363 shares, 26,000 employee options and 1,500 performance share plan units.
- Over 20 years of experience form the pharmaceutical industry. He has 10+ publications in peer-reviewed journals. Prior to joining Camurus, he worked as Director of Pharmaceuticals and Analytical Development at Zealand Pharma.
- Ph.D. and M.Sc. in Chemistry from Lund University.

Markus Johnsson
Senior Vice President R&D

- Appointed Senior VP R&D in 2022. Holds 21,000 shares, 9,500 employee options and 1,500 performance share plan units.
- Was VP Pharmaceutical & Analytical Development at Camurus from 2003 to 2017, before rejoining the company in 2021. In the meantime, he worked within Project Management at PolyPeptide Laboratories. He has 30+ publications in peer-reviewed scientific journals and is named inventor of over 400 patents and patent applications.
- Ph.D. in Physical Chemistry and M.Sc. in Chemistry from Uppsala University

Behshad Sheldon
President Camurus Inc

- Appointed president of Camurus Inc. in 2024. Holds 1,000 shares, 2,000 employee options and 1,500 performance share plan units.
- Holds over 25 years of experience from leading positions within international pharma. This includes roles as President and CEO at Braeburn Pharmaceuticals and senior positions at Smithkline Beecham, Bristol-Myers Squibb and Otsuka Pharmaceuticals.
- B.Sc. in Neuroscience from University of Rochester

Bo A. C. Tarras-Wahlberg
Vice President Legal & Group General Counsel

- Appointed VP Legal and Group General Counsel in 2024. Holds no shares, no employee options and 1,500 performance share plan units.
- Over 20 years of experience from the pharma and medical device industry. Prior to joining Camurus, he held various international senior legal positions within Baxter Healthcare and most recently as Associate General Councel, Western Europe Infusion Therapies & Technologies.
- Master of law (LLM) from Lund University

Per Olof Wallström
Chairman

Remuneration Committee

- Chairman of the Board since 2015 and board member since 2010. Independent in relation to the company, its management and its major shareholders. Holds 102,185 shares.
- Previous roles include CEO of Q-Med, Melacure and Karo Bio as well senior management positions at Merck Sharpe & Dohme, Astra, Pharmacia and Bristol Myers Squibb. Currently also a board of Arosia Communication and Nexttobe.
- M.Sc. In Pharmacy from Uppsala University.

Fredrik Tiberg
President & CEO

- Appointed CEO in 2003, and board member since 2002. Independent in relation to the company's major shareholders, but not the company and its management. Holds 1,615,000 shares, 42,000 employee options and 4,000 performance share plan units.
- Over 30 years of biotechnology and pharmaceutical experience. Most recently as the CEO of Heptahelix AB. He has over 110 publications in peer-reviewed scientific journals and is named inventor on more than 400 patents and patent applications.
- Ph.D. in Physical Chemistry from Lund University. M.Sc. In Chemical Engineering from Lund Institute of Technology.

Hege Hellström
Board Member

Audit Committee

- Board member since 2020. Independent in relation to the company, its management and its major shareholders. Holds 3,250 shares.
- Over 30 years of experience within sales, marketing and strategy development from Baxter Healthcare, Genzyme/Sanofi and Sobi. She is currently Chief Commercial Officer at Advicenne.
- B.Sc., Medical Laboratory Scientist from Oslo Metropolitan University

Jakob Lindberg
Board Member

Chairman of the Remuneration Committee

- Board Member since 2021. Independent in relation to the company, its management and its major shareholders. Holds no shares.
- More than 20 years of experience within pharmaceutical development, including ~10 years a CEO and CSO at Oncopeptides. Previous experience includes venture partner at Patricia Industries, analyst at Merrill Lynch & Co, Consultant at McKinsey & Co, and CEO of Cellectricon.
- Licentiate degree in molecular immunology, a M.Sc. in preclinical medicine from Karolinska Institute and a B.Sc. in economics from Stockholm University.

Stefan Persson
Board Member

Audit Committee

- Board Member since 2022. Independent in relation to the company and its management, but not its major shareholders. Holds 3,097 shares.
- The current President and CEO of Camurus' main shareholder, Sandberg Development. Persson has previously worked for Perstorp, Sony Ericsson, Bang & Olufsen and served as the CEO of Percise Biometrics.
- Educated within applied physics and electrical engineering at Linköping University.

Erika Södeberg Johnsson
Board Member

Chairman of the Audit Committee

- Board Member since 2023. Independent in relation to the company, its management and its major shareholders. Holds 608 shares.
- CFO of Novo Nordisk Foundation. Previous experience from investment banking at SEB Enskilda, CFO and Senior Advisor at Kinevik. She has also held various senior leader roles at Affibody, Karo Brio and Biotage.
- M.Sc. In Business and Economics from Stockholm School of Economics.

Appendix 2: Shareholders

15 largest shareholders

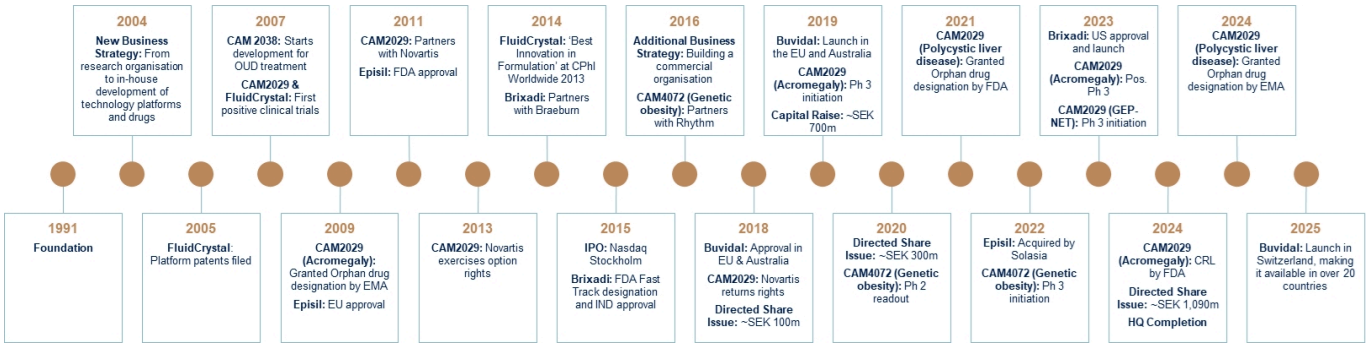
#	Name	Citizenship	Holding	Capital	Value (SEKm)	% of Votes
1	Sandberg Development AB	Sweden	20,530,692	34.9%	11,025.0	34.9%
2	State Street Bank and Trust	United States	3,063,735	5.2%	1,645.2	5.2%
3	Fjärde AP-fonden	Sweden	2,808,776	4.8%	1,508.3	4.8%
4	Swedbank Robur Fonder	Sweden	2,376,421	4.0%	1,276.1	4.1%
5	JP Morgan Chase Bank	United States	2,297,156	3.9%	1,233.6	3.9%
6	Fredrik Tiberg, CEO	Sweden	1,615,000	2.7%	867.3	2.8%
7	Handelsbanken fonder	Sweden	1,216,641	2.1%	653.3	2.1%
8	Avanza Pension	Sweden	1,083,456	1.8%	581.8	1.9%
9	SEB Investment Management	Sweden	994,624	1.7%	534.1	1.7%
10	The Bank of New York Mellon	United States	825,063	1.4%	443.1	1.4%
11	Afa Försäkring	Sweden	776,403	1.3%	416.9	1.3%
12	Norges Bank Investment Management	Norway	684,492	1.2%	367.6	1.2%
13	CS Client Omnibus	Switzerland	630,763	1.1%	338.7	1.1%
14	JP Morgan SE	United States	522,253	0.9%	280.4	0.9%
15	Länsförsäkringar Fondförvaltning	Sweden	485,830	0.8%	260.9	0.8%
	Top 15 largest shareholders		**39,911,305**	**67.8%**	**21,432**	**68.1%**
	Total other shareholders		18,967,713	32.2%	10,186	31.9%
	Total		**58,879,018**	**100%**	**31,618**	**100.0%**

Source: ABG Sundal Collier, Company Data

Footnote: As of 31 March 2025

Appendix 3: Company timeline

Company timeline



Source: ABG Sundal Collier, Company Data

Footnote: Capital raised in two rounds in 2019: Directed share issue (~SEK 300m) and rights issue (~SEK 400m)

Income Statement (SEKm)	2018	2019	2020	2021	2022	2023	2024	2025e	2026e	2027e
Sales	50	107	340	604	967	1,725	1,880	2,639	3,351	4,800
COGS	-7	-23	-35	-85	-103	-122	-130	-164	-220	-376
Gross profit	43	84	304	519	864	1,603	1,750	2,475	3,131	4,424
Other operating items	-310	-435	-498	-616	-779	-1,063	-1,266	-1,521	-1,680	-1,983
EBITDA	**-266**	**-351**	**-194**	**-98**	**85**	**540**	**484**	**953**	**1,451**	**2,441**
Depreciation and amortisation	4	5	7	6	5	4	4	2	2	13
of which leasing depreciation	0	-4	-5	-7	-8	-10	-11	-17	-17	-16
EBITA	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
EO Items	25	27	4	0	9	406	0	82	0	70
Impairment and PPA amortisation	0	0	0	0	0	0	0	0	0	0
EBIT	**-262**	**-360**	**-205**	**-111**	**72**	**526**	**469**	**934**	**1,432**	**2,463**
Net financial items	0	-2	-1	-1	1	23	83	75	81	92
Pretax profit	**-262**	**-362**	**-207**	**-112**	**73**	**549**	**553**	**1,009**	**1,514**	**2,555**
Tax	52	72	39	21	-18	-118	-124	-208	-312	-526
Net profit	**-209**	**-290**	**-167**	**-90**	**56**	**431**	**428**	**801**	**1,202**	**2,029**
Minority interest	0	0	0	0	0	0	0	0	0	0
Net profit discontinued	0	0	0	0	0	0	0	0	0	0
Net profit to shareholders	**-209**	**-290**	**-167**	**-90**	**56**	**431**	**428**	**801**	**1,202**	**2,029**
EPS	-5.34	-5.96	-3.07	-1.60	0.96	7.51	7.17	13.39	20.05	33.85
EPS adj.	-5.85	-6.40	-3.13	-1.61	0.85	1.96	7.19	12.28	20.06	32.92
Total extraordinary items after tax	20	21	4	0	7	319	0	65	0	56
Leasing payments	0	-4	-5	-7	-8	-10	-11	-17	-17	-16
Tax rate (%)	*20.0*	*19.8*	*19.0*	*19.1*	*24.0*	*21.5*	*22.5*	*20.6*	*20.6*	*20.6*
Gross margin (%)	*86.4*	*78.3*	*89.6*	*85.9*	*89.3*	*92.9*	*93.1*	*93.8*	*93.4*	*92.2*
EBITDA margin (%)	*-531.0*	*-327.3*	*-57.0*	*-16.2*	*8.8*	*31.3*	*25.7*	*36.1*	*43.3*	*50.8*
EBITA margin (%)	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*
EBIT margin (%)	*-522.1*	*-335.7*	*-60.4*	*-18.3*	*7.4*	*30.5*	*25.0*	*35.4*	*42.7*	*51.3*
Pre-tax margin (%)	*-521.8*	*-337.1*	*-60.8*	*-18.5*	*7.6*	*31.8*	*29.4*	*38.2*	*45.2*	*53.2*
Net margin (%)	*-417.3*	*-270.3*	*-49.3*	*-15.0*	*5.7*	*25.0*	*22.8*	*30.3*	*35.9*	*42.3*
Growth Rates y-o-y	-	-	-	-	-	-	-	-	-	-
Sales growth (%)	*-7.8*	*113.9*	*216.5*	*77.9*	*60.1*	*78.4*	*8.9*	*40.4*	*27.0*	*43.2*
EBITDA growth (%)	*10.7*	*31.8*	*-44.8*	*-49.5*	*-186.7*	*536.0*	*-10.4*	*97.0*	*52.3*	*68.2*
EBITA growth (%)	*--*	*--*	*--*	*--*	*--*	*--*	*--*	*--*	*--*	*--*
EBIT growth (%)	*10.7*	*37.5*	*-43.0*	*-46.1*	*-165.1*	*nm*	*-10.8*	*99.0*	*53.4*	*72.0*
Net profit growth (%)	*14.0*	*38.5*	*-42.3*	*-45.9*	*-161.4*	*676.6*	*-0.7*	*86.9*	*50.1*	*68.8*
EPS growth (%)	*10.8*	*11.7*	*-48.5*	*-47.8*	*-159.7*	*nm*	*-4.5*	*86.8*	*49.8*	*68.9*
Profitability	-	-	-	-	-	-	-	-	-	-
ROE (%)	*-65.7*	*-65.6*	*-22.6*	*-10.7*	*6.0*	*34.7*	*17.9*	*21.7*	*25.6*	*32.2*
ROE adj. (%)	*-72.0*	*-70.4*	*-23.1*	*-10.7*	*5.3*	*9.0*	*17.9*	*19.9*	*25.6*	*31.3*
ROCE (%)	*-66.8*	*-73.1*	*-26.8*	*-12.6*	*7.9*	*42.6*	*22.5*	*26.5*	*31.2*	*39.5*
ROCE adj. (%)	*-73.3*	*-78.5*	*-27.3*	*-12.6*	*6.9*	*11.2*	*22.5*	*24.4*	*31.2*	*38.4*
ROIC (%)	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*
ROIC adj. (%)	*-12.1*	*-8.7*	*-1.0*	*0.0*	*-1.5*	*-76.9*	*0.0*	*-12.9*	*0.0*	*-8.5*
Adj. earnings numbers	-	-	-	-	-	-	-	-	-	-
EBITDA adj.	*-292*	*-378*	*-198*	*-98*	*76*	*134*	*484*	*872*	*1,451*	*2,371*
EBITDA adj. margin (%)	*-581.6*	*-352.0*	*-58.4*	*-16.2*	*7.9*	*7.8*	*25.7*	*33.0*	*43.3*	*49.4*
EBITDA lease adj.	-266	-358	-203	-112	69	521	463	919	1,418	2,408
EBITDA lease adj. margin (%)	*-531.0*	*-333.8*	*-59.9*	*-18.6*	*7.2*	*30.2*	*24.6*	*34.8*	*42.3*	*50.2*
EBITA adj.	-25	-27	-4	0	-9	-406	0	-82	0	-70
EBITA adj. margin (%)	*-50.6*	*-24.7*	*-1.3*	*0.0*	*-0.9*	*-23.5*	*0.0*	*-3.1*	*0.0*	*-1.5*
EBIT adj.	-287	-387	-210	-111	63	120	469	852	1,432	2,392
EBIT adj. margin (%)	*-572.7*	*-360.4*	*-61.8*	*-18.3*	*6.5*	*6.9*	*25.0*	*32.3*	*42.7*	*49.8*
Pretax profit Adj.	-287	-388	-211	-112	64	143	553	927	1,514	2,484
Net profit Adj.	-230	-311	-171	-90	49	112	428	736	1,202	1,973
Net profit to shareholders adj.	-230	-311	-171	-90	49	112	428	736	1,202	1,973
Net adj. margin (%)	*-457.8*	*-290.1*	*-50.3*	*-15.0*	*5.0*	*6.5*	*22.8*	*27.9*	*35.9*	*41.1*

Source: ABG Sundal Collier, Company Data

Cash Flow (SEKm)	2018	2019	2020	2021	2022	2023	2024	2025e	2026e	2027e
EBITDA	-266	-351	-194	-98	85	540	484	953	1,451	2,441
Net financial items	0	-2	-1	-1	1	23	83	75	81	92
Paid tax	-0	-3	-4	-4	-7	-10	-12	-82	-312	-526
Non-cash items	40	10	77	18	38	-9	-60	-126	0	44
Cash flow before change in WC	-226	-346	-122	-84	117	544	495	820	1,221	2,050
Change in working capital	-48	-58	-117	-59	-16	62	-107	114	-65	-133

Cash Flow (SEKm)	2018	2019	2020	2021	2022	2023	2024	2025e	2026e	2027e
Operating cash flow	**-274**	**-404**	**-239**	**-143**	**101**	**607**	**388**	**934**	**1,156**	**1,917**
Capex tangible fixed assets	-1	-23	-2	-1	7	-1	-2	-1	-1	-1
Capex intangible fixed assets	-3	-2	-1	-4	-2	-9	-28	-20	-20	-20
Acquisitions and Disposals	0	0	0	0	-7	6	-0	0	0	0
Free cash flow	**-279**	**-430**	**-242**	**-148**	**100**	**602**	**358**	**913**	**1,135**	**1,896**
Dividend paid	0	0	0	0	0	0	0	0	0	0
Share issues and buybacks	93	651	344	106	58	33	1,312	0	0	0
Leasing liability amortisation	0	-4	-5	-7	-8	-10	-11	-17	-17	-16
Other non-cash items	5	55	7	-6	-10	-69	12	-90	0	-0
Balance Sheet (SEKm)	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025e**	**2026e**	**2027e**
Goodwill	0	0	0	0	0	0	0	0	0	0
Other intangible assets	16	37	37	34	24	23	23	22	21	20
Tangible fixed assets	11	11	9	10	9	16	41	57	74	90
Right-of-use asset	0	28	25	25	26	24	17	110	114	115
Total other fixed assets	0	0	0	0	0	0	0	0	0	0
Fixed assets	27	76	70	68	58	62	80	189	208	224
Inventories	10	33	111	107	107	101	140	175	212	282
Receivables	23	48	95	161	249	335	558	559	652	802
Other current assets	171	257	305	334	325	220	126	0	0	0
Cash and liquid assets	134	359	462	412	566	1,190	2,853	3,749	4,867	6,746
Total assets	**365**	**772**	**1,044**	**1,082**	**1,305**	**1,908**	**3,757**	**4,673**	**5,939**	**8,055**
Shareholders equity	252	632	847	849	995	1,493	3,290	4,091	5,292	7,321
Minority	0	0	0	0	0	0	0	0	0	0
Total equity	**252**	**632**	**847**	**849**	**995**	**1,493**	**3,290**	**4,091**	**5,292**	**7,321**
Long-term debt	0	0	0	0	0	0	0	0	0	0
Pension debt	71	0	0	0	0	47	53	53	53	53
Convertible debt	0	0	0	0	0	0	0	0	0	0
Leasing liability	2	27	25	26	26	25	17	107	107	107
Total other long-term liabilities	4	2	3	8	22	44	37	37	37	37
Short-term debt	0	0	0	0	0	0	0	0	0	0
Accounts payable	36	17	21	53	86	99	118	110	132	176
Other current liabilities	0	94	148	147	178	200	242	276	317	361
Total liabilities and equity	**365**	**772**	**1,044**	**1,082**	**1,305**	**1,908**	**3,757**	**4,673**	**5,939**	**8,055**
Net IB debt	-61	-331	-436	-386	-539	-1,119	-2,783	-3,589	-4,707	-6,586
Net IB debt excl. pension debt	-133	-331	-436	-386	-539	-1,165	-2,836	-3,642	-4,760	-6,639
Net IB debt excl. leasing	-63	-359	-462	-412	-566	-1,143	-2,800	-3,696	-4,814	-6,693
Capital employed	325	659	873	875	1,021	1,564	3,360	4,250	5,452	7,481
Capital invested	191	300	411	463	455	374	507	502	585	735
Working capital	168	226	343	403	418	356	463	349	414	547
EV breakdown	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Market cap. diluted (m)	19,890	24,641	27,690	28,508	28,986	29,151	30,227	30,382	30,382	30,382
Net IB debt adj.	-61	-331	-436	-386	-539	-1,119	-2,783	-3,589	-4,707	-6,586
Market value of minority	0	0	0	0	0	0	0	0	0	0
Reversal of shares and participations	0	0	0	0	0	0	0	0	0	0
Reversal of conv. debt assumed equity	-	-	-	-	-	-	-	-	-	-
EV	**19,829**	**24,309**	**27,253**	**28,122**	**28,446**	**28,032**	**27,444**	**26,793**	**25,675**	**23,796**
Total assets turnover (%)	11.9	18.9	37.4	56.8	81.0	107.4	66.4	62.6	63.2	68.6
Working capital/sales (%)	286.6	183.6	83.9	61.8	42.4	22.4	21.8	15.4	11.4	10.0
Financial risk and debt service	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Net debt/equity (%)	-24.3	-52.5	-51.5	-45.5	-54.2	-74.9	-84.6	-87.7	-88.9	-90.0
Net debt / market cap (%)	-0.3	-1.3	-1.6	-1.4	-1.9	-3.8	-9.2	-11.8	-15.5	-21.7
Equity ratio (%)	69.2	81.8	81.2	78.5	76.2	78.3	87.6	87.5	89.1	90.9
Net IB debt adj. / equity (%)	-24.3	-52.5	-51.5	-45.5	-54.2	-74.9	-84.6	-87.7	-88.9	-90.0
Current ratio	9.44	6.25	5.78	5.08	4.74	6.16	10.20	11.63	12.74	14.58
EBITDA/net interest	1,775.3	227.6	143.8	82.0	72.6	23.1	5.8	12.7	17.8	26.5
Net IB debt/EBITDA (x)	0.2	0.9	2.3	3.9	-6.4	-2.1	-5.8	-3.8	-3.2	-2.7
Net IB debt/EBITDA lease adj. (x)	0.2	1.0	2.3	3.7	-8.2	-2.2	-6.1	-4.0	-3.4	-2.8
Interest coverage	7.0	0.0	0.1	0.1	1.8	18.5	77.9	63.4	68.8	70.0

Source: ABG Sundal Collier, Company Data

Share Data (SEKm)	2018	2019	2020	2021	2022	2023	2024	2025e	2026e	2027e
Actual shares outstanding	39	49	55	56	57	57	60	60	60	60
Actual shares outstanding (avg)	39	49	55	56	57	57	60	60	60	60

Share Data (SEKm)	2018	2019	2020	2021	2022	2023	2024	2025e	2026e	2027e
All additional shares	1	9	6	2	1	0	2	0	0	0
Issue month	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Assumed dil. of shares from conv.	0	0	0	0	0	0	0	0	0	0
As. dil. of shares from conv. (avg)	0	0	0	0	0	0	0	0	0	0
Conv. debt not assumed as equity	0	0	0	0	0	0	0	0	0	0
No. of warrants	0	0	0	0	0	0	0	0	0	0
Market value per warrant	0	0	0	0	0	0	0	0	0	0
Dilution from warrants	0	0	0	0	0	0	0	0	0	0
Issue factor	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Actual dividend per share	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-
Reported earnings per share	-6.20	-6.23	-3.18	-1.66	1.01	7.78	0.00	-	-	-

Source: ABG Sundal Collier, Company Data

Valuation and Ratios (SEKm)	2018	2019	2020	2021	2022	2023	2024	2025e	2026e	2027e
Shares outstanding adj.	39	49	55	56	57	57	60	60	60	60
Diluted shares adj.	39	49	55	56	57	57	60	60	60	60
EPS	-5.34	-5.96	-3.07	-1.60	0.96	7.51	7.17	13.39	20.05	33.85
Dividend per share	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-
EPS adj.	-5.85	-6.40	-3.13	-1.61	0.85	1.96	7.19	12.28	20.06	32.92
BVPS	6.43	13.00	15.52	15.10	17.40	25.97	55.18	68.26	88.32	122.17
BVPS adj.	6.02	12.23	14.85	14.50	16.99	25.57	54.80	67.90	87.97	121.83
Net IB debt/share	-1.56	-6.82	-7.99	-6.86	-9.43	-19.45	-46.68	-59.89	-78.55	-109.91
Share price	507.00	507.00	507.00	507.00	507.00	507.00	507.00	507.00	507.00	507.00
Market cap. (m)	19,890	24,641	27,690	28,508	28,986	29,151	30,227	30,382	30,382	30,382
Valuation	-	-	-	-	-	-	-	-	-	-
P/E (x)	nm	nm	nm	nm	nm	67.5	70.7	37.9	25.3	15.0
EV/sales (x)	395.38	226.65	80.27	46.56	29.42	16.25	14.60	10.15	7.66	4.96
EV/EBITDA (x)	-74.5	-69.3	-140.7	-287.3	335.1	51.9	56.7	28.1	17.7	9.7
EV/EBITA (x)	--	--	--	--	--	--	--	--	--	--
EV/EBIT (x)	-75.7	-67.5	-132.8	-254.3	395.3	53.3	58.5	28.7	17.9	9.7
Dividend yield (%)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
FCF yield (%)	-1.4	-1.7	-0.9	-0.5	0.3	2.1	1.2	3.0	3.7	6.2
Le. adj. FCF yld. (%)	-1.4	-1.8	-0.9	-0.5	0.3	2.0	1.2	2.9	3.7	6.2
P/BVPS (x)	78.83	39.01	32.67	33.58	29.14	19.53	9.19	7.43	5.74	4.15
P/BVPS adj. (x)	84.16	41.46	34.15	34.97	29.85	19.83	9.25	7.47	5.76	4.16
P/E adj. (x)	nm	nm	nm	nm	nm	nm	70.6	41.3	25.3	15.4
EV/EBITDA adj. (x)	-68.0	-64.4	-137.6	-287.3	374.4	209.6	56.7	30.7	17.7	10.0
EV/EBITA adj. (x)	-781.3	-916.6	-6,154.8	--	-3,189.1	-69.0	--	-328.2	--	-338.4
EV/EBIT adj. (x)	-69.0	-62.9	-130.0	-254.3	451.3	234.0	58.5	31.4	17.9	9.9
EV/CE (x)	60.9	36.9	31.2	32.2	27.9	17.9	8.2	6.3	4.7	3.2
Investment ratios	-	-	-	-	-	-	-	-	-	-
Capex/sales (%)	9.5	24.2	1.0	0.8	0.6	0.6	1.6	0.8	0.6	0.4
Capex/depreciation	-1.1	-2.9	-0.3	-0.4	0.4	-0.7	-2.0	-1.1	-1.1	-0.7
Capex tangibles / tangible fixed assets	12.9	219.9	26.8	9.6	78.6	6.0	4.3	1.9	1.4	1.2
Capex intangibles / definite intangibles	21.0	6.6	2.6	11.8	8.1	40.4	121.5	92.8	96.6	102.1
Depreciation on intang / def. intang	0	0	0	0	0	0	0	0	0	0
Depreciation on tangibles / tangibles	40.83	84.51	131.13	128.25	139.46	89.18	35.77	33.86	25.91	33.30

Source: ABG Sundal Collier, Company Data

Analyst Certification

We, ABGSC Healthcare Research, Georg Tigalonov-Bjerke and Morten Larsen, analyst(s) with ABG Sundal Collier ASA , ABG Sundal Collier Denmark, filial af ABG Sundal Collier ASA, Norge, ABG Sundal Collier AB and/or ABG Sundal Collier Limited (hereinafter collectively referred to as "ABG Sundal Collier"), and the author(s) of this report, certify that not withstanding the existence of any such potential conflicts of interests referred to below, the views expressed in this report accurately reflect my/our personal view about the companies and securities covered in this report. I/We further certify that I/We has/have not been, nor am/are or will be, receiving direct or indirect compensation related to the specific recommendations or views contained in this report.

This report is produced by ABG Sundal Collier, which may cover companies either in accordance with legal requirements designed to promote the independence of investment research ("independent research") or as commissioned research. Commissioned research is paid for by the subject company. As such, commissioned research is deemed to constitute an acceptable minor non-monetary benefit (i.e., not investment research) as defined in MiFID II.

Stock ratings distribution

ABG Sundal Collier Ratings and Investment Banking by 4/10/2025

	Research Coverage	Investment Banking Clients (IBC)	
	% of	% of	% of
Total of Rating	Total Rating	Total IBC	Total Rating by Type
BUY	63.35%	22%	9.09%
HOLD	32.46%	3%	2.42%
SELL	2.88%	0%	0.00%

IBC: Companies in respect of which ABG SC or an affiliate has received compensation for investment banking services within the past 12 months.

Analyst stock ratings definitions

BUY = We expect this stock's total return to exceed the market's expected total return by 5% or more over the next six months.

HOLD = We expect this stock's total return to be in line with the market's expected total return within a range of 4% over the next six months.

SELL = We expect this stock's total return to underperform the market's expected total return by 5% or more over the next six months.

Analyst valuation methods

When setting the individual ratings for investment research ("independent research"), ABG Sundal Collier assumes that a normal total absolute return (including dividends) for the market is 8% per annum, or 4% on a 6-month basis. Therefore, when we rate a stock a BUY, we expect an absolute return of 9% or better over six months. Volatility and low trading volumes mean that we have a wider range for expected returns on small cap stocks than for large caps.

ABG Sundal Collier's analysts publish price targets for independent research and may publish valuation ranges for commissioned research. These price targets or valuation ranges rely on various valuation methods. One of the most frequently used methods is the valuation of a company by calculation of that company's discounted cash flow (DCF). Another valuation method is the analysis of a company's return on capital employed relative to its cost of capital. Finally, the analysts may analyse various valuation multiples (e.g., the P/E multiples and the EV/EBITDA multiples) relative to global industry peers. In special cases, particularly for property companies and investment companies, the ratio of price to net asset value is considered. Price targets and valuation ranges are changed when earnings and cash flow forecasts are changed. They may also be changed when the underlying value of a company's assets changes (in the cases of investment companies, real estate companies or insurance companies) or when factors impacting the required rate of return change.

Expected updates

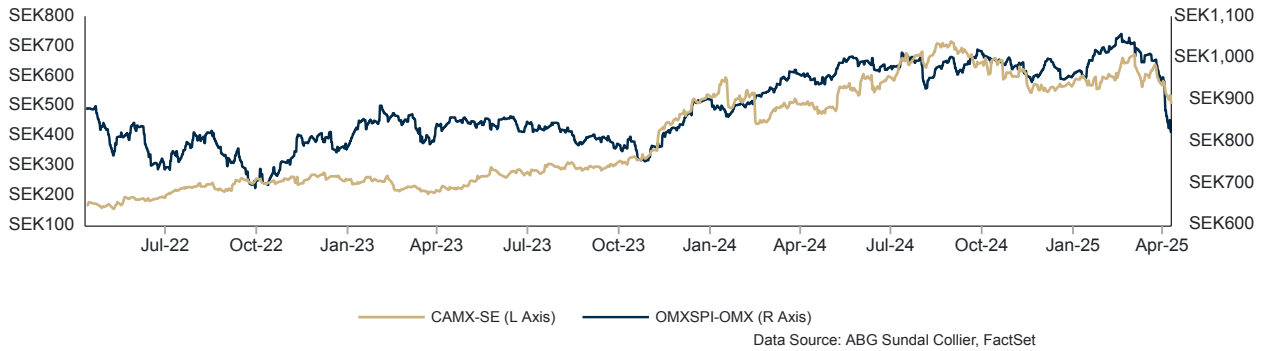
ABGSC has no fixed schedule for updating its research reports. Unless expressly stated otherwise, ABGSC expects (but does not undertake) to issue updates when considered necessary by the research department, for example following the publication of new figures or forecasts by a company or in the event of any material news on a company or its industry.

Stock price, company ratings and target price history

Company: Camurus **Currency:** SEK **Current Recommandation:** BUY

Date: 9/4/2025 **Current Target price:** 750.0

Current Share price: 507.00



Important Company Specific Disclosure

The following disclosures relate to the relationship between ABG Sundal Collier and its affiliates and the companies covered by ABG Sundal Collier referred to in this research report.

Unless disclosed in this section, neither ABG Sundal Collier nor any of their affiliated or associated companies and their directors, officers, representatives, and employees have any required regulatory disclosures to make in relation to an ownership position for the analyst(s) and members of the analyst's household, ownership by ABG Sundal Collier and/or its affiliates, ownership in ABG Sundal Collier Holding ASA by the company(ies) to whom the recommendation(s) refer(s) to, liquidity provision/market making agreement, managed or co-managed public offerings, compensation for provision of certain services, directorship of the analyst, or a member of the analyst's household, or in relation to any contractual obligations to the issuance of this research report.

A redacted version of this research report has been sent to Camurus for the purposes of checking its factual content only. Any changes made have been based on factual input received.

ABG Sundal Collier is not aware of any other actual, material conflicts of interest of the analyst or ABG Sundal Collier of which the analyst knows or has reason to know at the time of the publication of this report.

Production of recommendation: 4/10/2025 05:44.

All prices are as of market close on 9 April, 2025 unless otherwise noted.

For full details of recommendation and target price history for the subject company, please see company page on Research Web.

For details of recommendations and target prices for ABG Sundal Collier coverage universe, please see coverage page on ABG Sundal Collier's Research Web.

Disclaimer

This report has been prepared by ABG Sundal Collier ASA, ABG Sundal Collier Denmark, filial af ABG Sundal Collier ASA, Norge, ABG Sundal Collier AB and/or ABG Sundal Collier Limited and any of their directors, officers, representatives and employees (hereinafter collectively referred to as "ABG Sundal Collier"). This report is not a product of any other affiliated or associated companies of any of the above entities.

This report is provided solely for the information and use of professional investors, who are expected to make their own investment decisions without undue reliance on this report. The information contained herein does not apply to, and should not be relied upon by, retail clients. This report is for distribution only under such circumstances as may be permitted by applicable law. Research reports prepared by ABG Sundal Collier are for information purposes only. The recommendation(s) in this report is (are) has/have no regard to specific investment objectives and the financial situation or needs of any specific recipient. ABG Sundal Collier and/or its affiliates accepts no liability whatsoever for any losses arising from any use of this report or its contents. This report is not to be used or considered as an offer to sell, or a solicitation of an offer to buy. The information herein has been obtained from, and any opinions herein are based upon, sources believed reliable, but ABG Sundal Collier and/or its affiliates make no representation as to its accuracy or completeness and it should not be relied upon as such. All opinions and estimates herein reflect the judgment of ABG Sundal Collier on the date of this report and are subject to change without notice. Past performance is not indicative of future results.

The compensation of our research analysts is determined exclusively by research management and senior management, but not including investment banking management. Compensation is not based on specific investment banking revenues, however, it is determined from the profitability of the ABG Sundal Collier group, which includes earnings from investment banking operations and other business. Investors should assume that ABG Sundal Collier ASA, ABG Sundal Collier Denmark, filial af ABG Sundal Collier ASA, Norge and/or ABG Sundal Collier AB is seeking or will seek investment banking or other business relationships with the companies in this report.

The research analyst(s) responsible for the preparation of this report may interact with trading desk and sales personnel and other departments for the purpose of gathering, synthesizing and interpreting market information. From time to time, ABG Sundal Collier and/or its affiliates and any shareholders, directors, officers, or employees thereof may (I) have a position in, or otherwise be interested in, any securities directly or indirectly connected to the subject of this report, or (II) perform investment banking or other services for, or solicit investment banking or other services from, a company mentioned in this report. ABG Sundal Collier and/or its affiliates rely on information barriers to control the flow of information contained in one or more areas of ABG Sundal Collier, into other areas, units, groups or affiliates of ABG Sundal Collier.

Norway: ABG Sundal Collier ASA is regulated by the Financial Supervisory Authority of Norway (Finanstilsynet)

Denmark: ABG Sundal Collier Denmark, filial af ABG Sundal Collier ASA, Norge, is regulated by the Financial Supervisory Authority of Norway (Finanstilsynet) and the Danish Financial Supervisory Authority (Finanstilsynet)

Sweden: ABG Sundal Collier AB is regulated by the Swedish Financial Supervisory Authority (Finansinspektionen)

UK: This report is a communication made, or approved for communication in the UK, by ABG Sundal Collier Limited, authorised and regulated by the Financial Conduct Authority in the conduct of its business.

US: This report is being distributed in the United States (U.S.) in accordance with FINRA Rule 1220 by ABG Sundal Collier Inc., an SEC registered broker-dealer and a FINRA/SIPC member which accepts responsibility for its content and its compliance with FINRA Rule 2241. Research reports distributed in the U.S. are intended solely for “major U.S. institutional investors,” and “U.S. institutional investors” as defined under Rule 15a-6 of the Securities Exchange Act of 1934 and any related interpretive guidance and no-action letters issued by the Staff of the U.S. Securities and Exchange Commission (“SEC”) collectively (“SEC Rule 15a-6”). Each major U.S. institutional investor and U.S. institutional investor that receives a copy of this research report, by its acceptance of such report, represents that it agrees that it will not distribute this research report to any other person. This communication is only intended for major U.S. institutional investors and U.S. institutional investors. Any person which is not a major U.S. institutional investor, or a U.S. institutional investor as covered by SEC Rule 15a-6 must not rely on this communication. The delivery of this research report to any person in the U.S. is not a recommendation to effect any transactions in the securities discussed herein, or an endorsement of any opinion expressed herein. Any major U.S. institutional investor or U.S. institutional investor receiving this report which wishes to effect transactions in any securities referred to herein should contact ABG Sundal Collier Inc., not its affiliates. Further information on the securities referred to herein may be obtained from ABG Sundal Collier Inc., on request.

Singapore: This report is distributed in Singapore by ABG Sundal Collier Pte. Ltd, which is not licensed under the Financial Advisors Act (Chapter 110 of Singapore). In Singapore, this report may only be distributed to institutional investors as defined in Section 4A(1)(c) of the Securities and Futures Act (Chapter 289 of Singapore) (“SFA”), and should not be circulated to any other person in Singapore.

Canada: This report is being distributed by ABG Sundal Collier ASA in Canada pursuant to section 8.25 of National Instrument 31-103 or an equivalent provision and has not been tailored to the needs of any specific investor in Canada. The information contained in this report is not, and under no circumstances is to be construed as, a prospectus, an advertisement, a public offering or an offer to sell the securities described herein, in Canada or any province or territory thereof. No securities commission or similar regulatory authority in Canada has reviewed or considered this report, the information contained herein or the merits of the securities described herein and any representation to the contrary is an offence. Under no circumstances is this report to be construed as an offer to sell such securities or as a solicitation of an offer to buy such securities in any jurisdiction of Canada. Any offer or sale of the securities described herein in Canada may only be made in accordance with applicable securities laws and only by a dealer properly registered under such securities laws, or alternatively, pursuant to an applicable dealer registration exemption, in the Canadian jurisdiction in which such offer or sale is made.

Additional information available upon request. If reference is made in this report to other companies and ABG Sundal Collier provides research coverage for those companies, details regarding disclosures may be found on our website www.abgsc.com.

Norway
Ruseløkkveien 26, 8th floor
0251 Oslo
Norway
Tel: +47 22 01 60 00
Fax: +47 22 01 60 60

Denmark
Forbindelsesvej 12,
2100 Copenhagen
Denmark
Tel: +45 35 46 61 00
Fax: +45 35 46 61 10

Sweden
Regeringsgatan 25, 8th floor
111 53 Stockholm
Sweden
Tel: +46 8 566 286 00
Fax: +46 8 566 286 01

United Kingdom
10 Paternoster Row, 5th floor
London EC4M 7EJ
UK
Tel: +44 20 7905 5600
Fax: +44 20 7905 5601

USA
140 Broadway, Suite 4604
New York, NY 10005
USA
Tel. +1 212 605 3800
Fax. +1 212 605 3801

Singapore
10 Collyer Quay
Ocean Financial Center
#40-07, Singapore 049315
Tel +65 6808 6082

Germany
Schillerstrasse 2, 5. OG
60313 Frankfurt
Germany
Tel +49 69 96 86 96 0
Fax +49 69 96 86 96 99

Switzerland
ABG Sundal Collier AG
Representative Office
Schwanenplatz 4
6004 Lucerne
Switzerland
Tel +41 79 502 33 39