



# COVINNOVATIONS

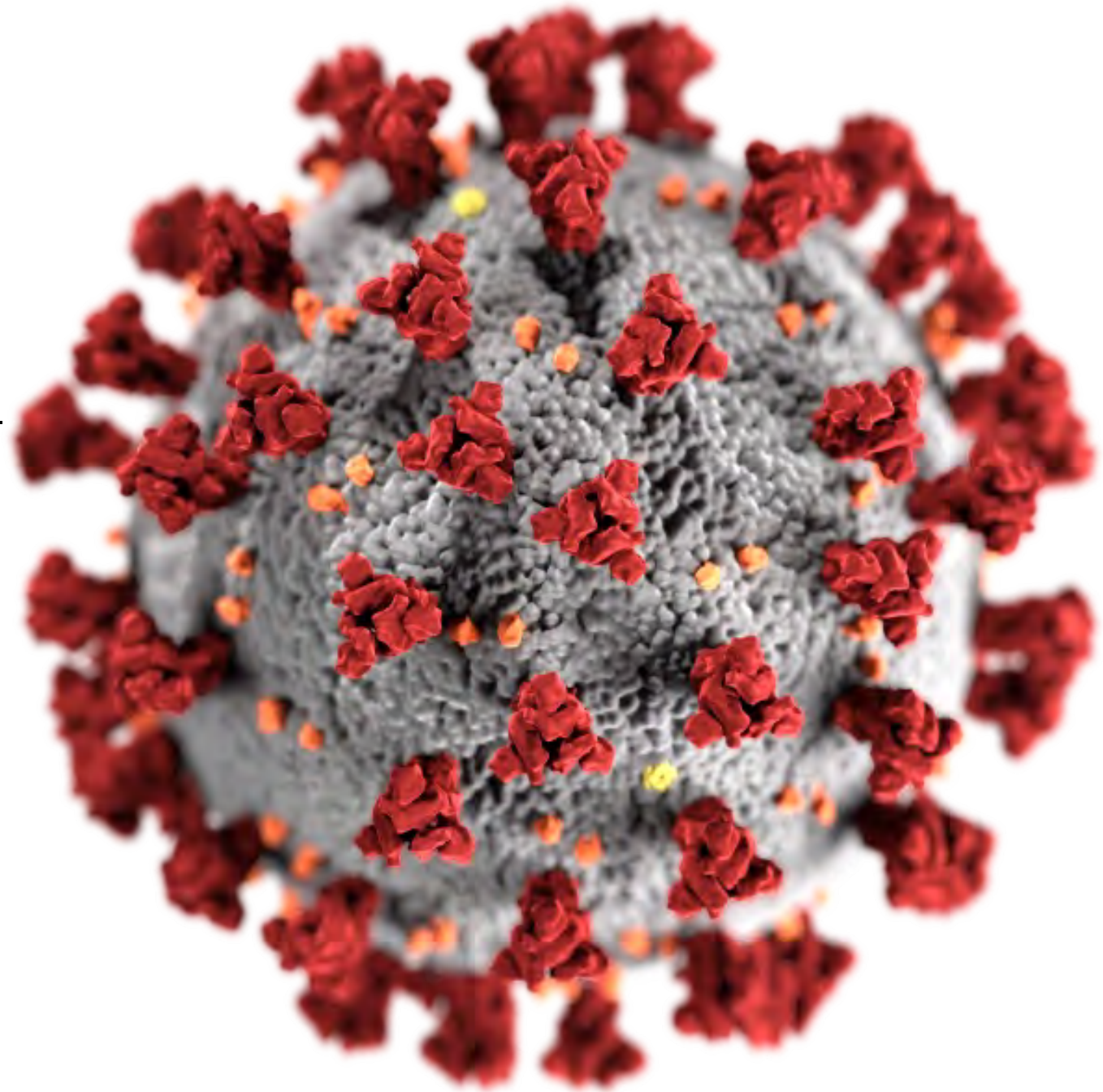
Our goal is to alleviate pandemic infectious diseases that impact our global community.

## Executive Summary

- COVI-001 has significant clinical efficacy, patent protection and first-to-market position
- COVI-001 satisfies clear unmet needs for patients and healthcare environment
- Ask: \$25M Series A fundraise

# The Unmet Need

- There are no effective treatments to cure the sickest ICU patients with COVID-19
- Dexamethasone is the best available weapon.
- There are no FDA approved treatments for late-stage/severe COVID-19



# The Unmet Need: Newly Reported Deaths Last 7 Days



11.05.22

All		Europe	North America	Asia	South America	Africa	Oceania				
#	Country, Other	Cases in the last 7 days	Cases in the preceding 7 days	Weekly Case % Change	Cases in the last 7 days/1M pop	Deaths in the last 7 days	Deaths in the preceding 7 days	Weekly Death % Change	Deaths in the last 7 days/1M pop	Population	
	World	2,065,438	2,531,011	-18%		8,101	10,508	-23%			
1	<a href="#">USA</a>	189,609	273,243	-31%	566	1,548	2,281	-32%	5	335,251,946	
2	<a href="#">Germany</a>	252,641	398,437	-37%	2,993	991	1,062	-7%	12	84,410,641	
3	<a href="#">UK</a>	17,660	37,167	-52%	257	737	1,003	-27%	11	68,720,327	
4	<a href="#">Russia</a>	42,362	52,659	-20%	290	497	580	-14%	3	146,080,815	
5	<a href="#">Taiwan</a>	204,620	243,770	-16%	8,555	455	438	+4%	19	23,917,605	
6	<a href="#">France</a>	153,743	224,810	-32%	2,343	404	503	-20%	6	65,611,363	
7	<a href="#">Japan</a>	375,907	272,236	+38%	2,994	387	364	+6%	3	125,571,177	
8	<a href="#">Italy</a>	110,988	208,501	-47%	1,842	335	559	-40%	6	60,253,923	
9	<a href="#">Brazil</a>	26,916	36,302	-26%	125	276	478	-42%	1	216,094,853	
10	<a href="#">Philippines</a>	6,461	9,040	-29%	57	245	253	-3%	2	112,994,709	



# The Problem: COVID-19's Lethal Trigger

- **Rapid Viral Spread → Overactive Immune Response → Death**
- **Reduction of circulating viral load is needed**
- **Inflammation modulation is necessary**

# The Solution: COVI-001

## Oral Fixed Dose Combination Therapy for Severe COVID-19



Mechanism of Action: Immune System Modulator



Has anti-inflammatory and antiviral activity



Low side effects

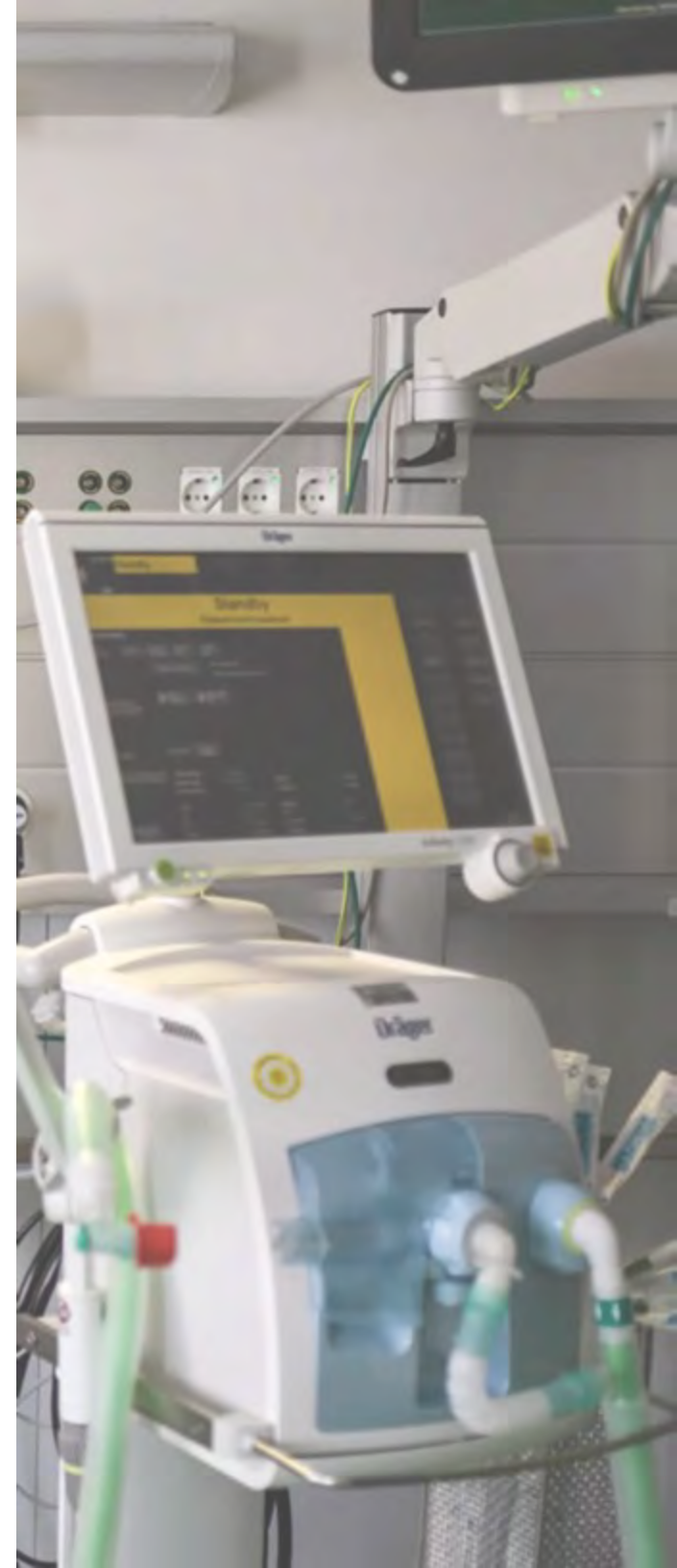


Significant clinical efficacy when added to current standard of care

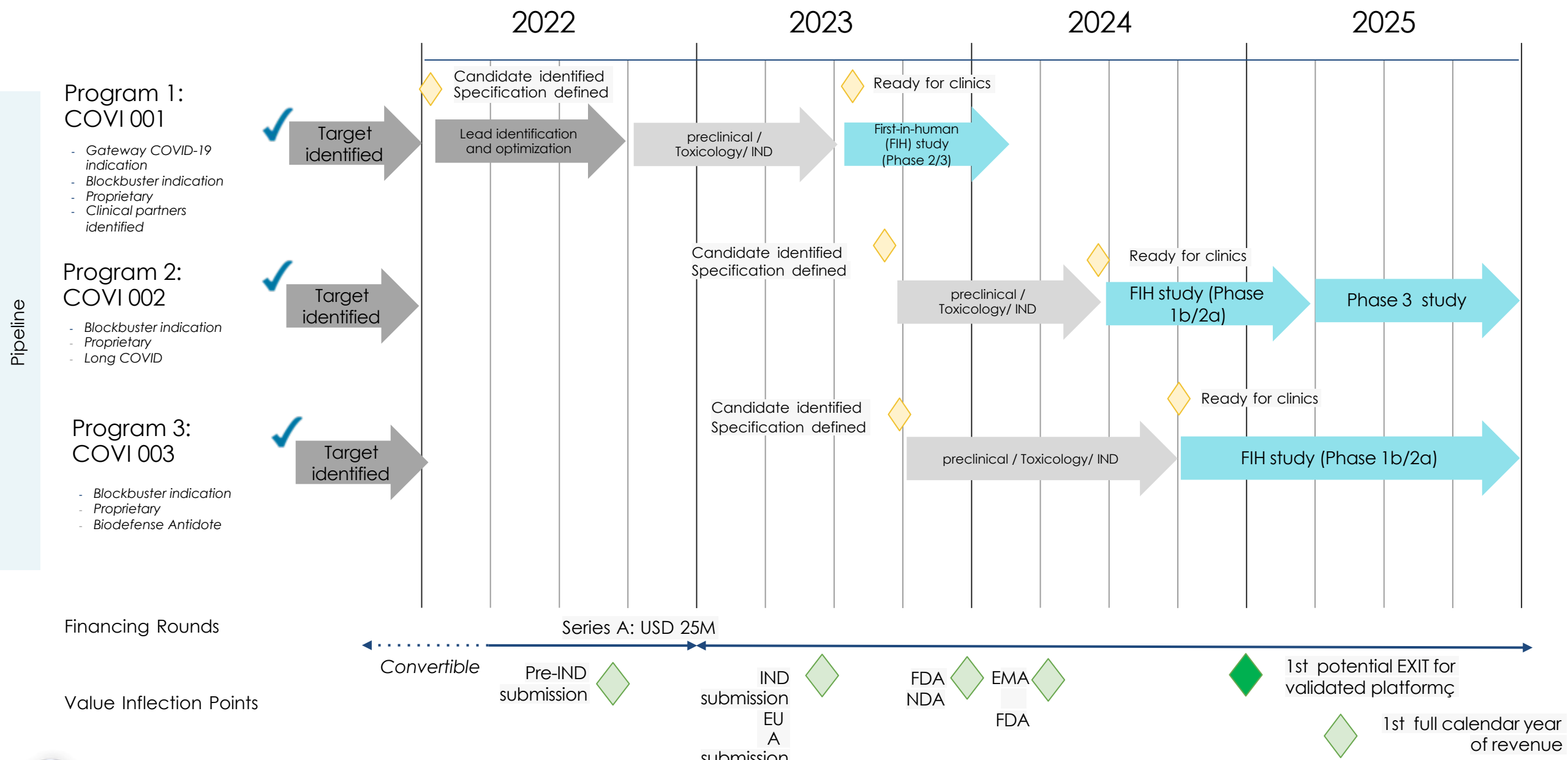
# COVI-001: Retrospective Chart Review

In a 2020 clinical study of 121 patients hospitalized for COVID-19- induced oxygen-hunger. 77 patients on one drug component of COVI-001 demonstrated:

- 68% reduction in mortality ( $p < 0.02$ )
- 37% reduction in length of hospital stay ( $p < 0.01$ )
- 93.5% survival rate ( $p < 0.02$ )



# Drug Development Program Timelines



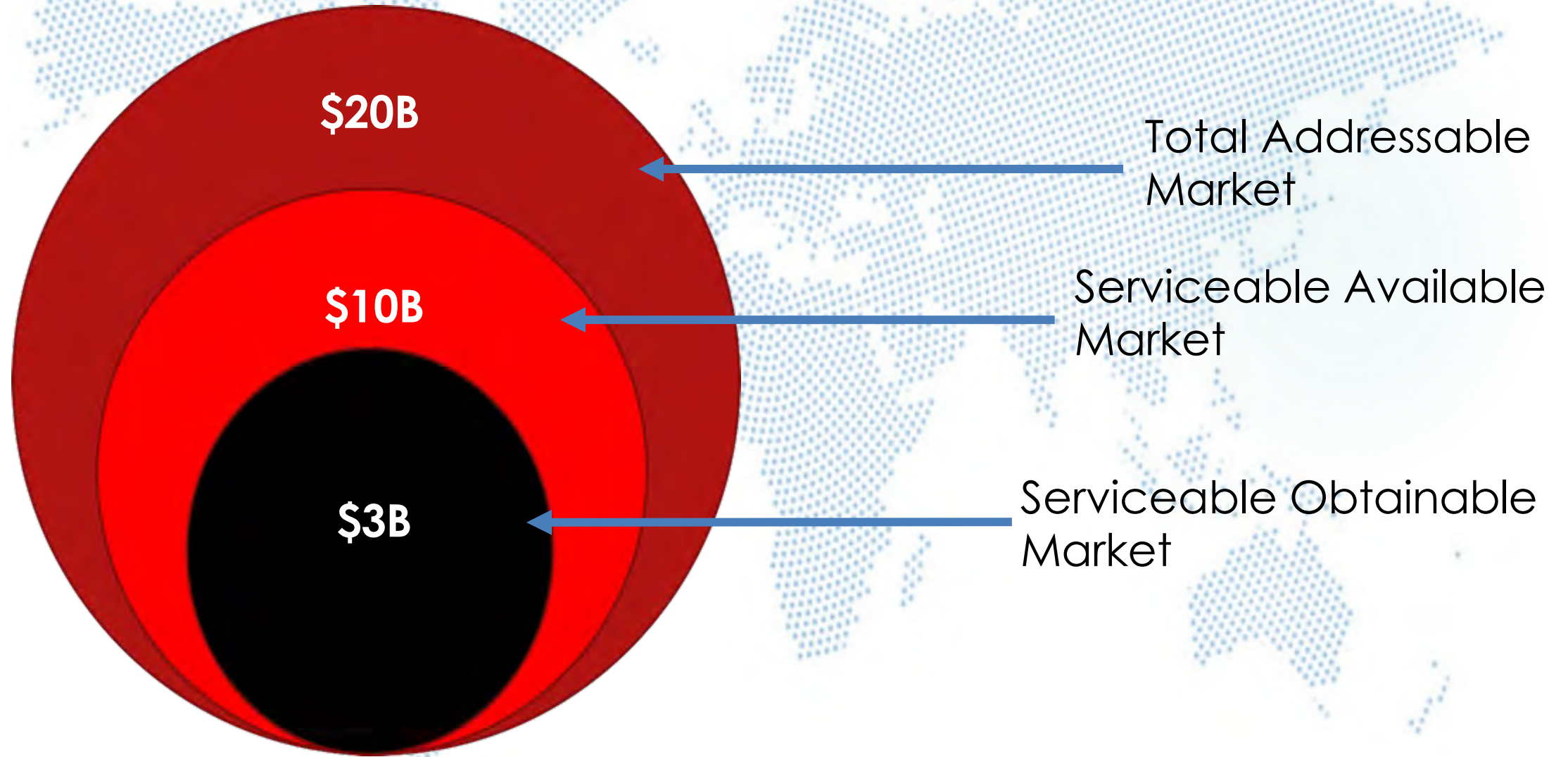
# Strong IP Estate and First-to-Market

- Our unpublished human data, is the only human data using this API combination in COVID-19 patients, giving us first-to-market advantage
- Our IP estate has multiple strong patent applications for use, method and composition
  - Nine (9) provisional utility patent applications;
  - One (1) US utility application; and
  - Two (2) International Patent Cooperation Treaty (PCT) applications
- Early and broad adoption as the standard of care is predicted



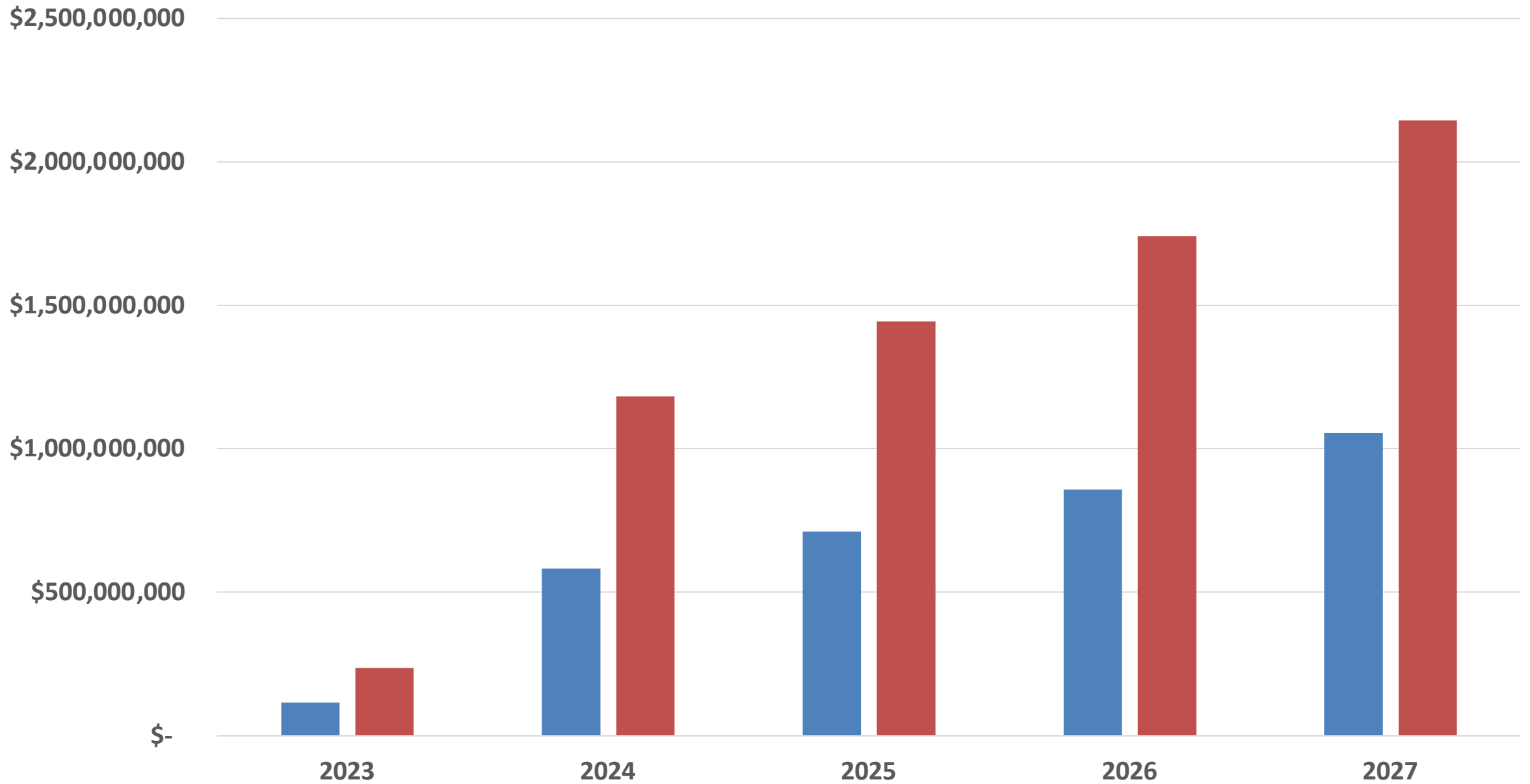


# COVI-001 Market Potential 2023-2027



# Global Hospital Revenue Forecast

US = Domestic  
ROW= Rest of World



■ US ■ ROW



# \$70B COVID-19 Therapeutic Global Market by 2030

2022 trending towards \$35B with 10% CAGR

Drug	Company	MOA	Indication	Admin	DDI	\$\$\$	'22 Annual Revenue
COV-001	CovInnovations	ISM	Severe	Oral	Low-Medium	\$500	\$1.9B***
Paxlovid	Pfizer	Antiviral	Mild to Moderate	Oral	High	\$529	\$22B
Molnupiravir	Merck	Antiviral	Mild to Moderate	Oral	Low	\$707	\$6B
Remdesivir	Gilead	Antiviral	Mild to Moderate	IV	Low	\$4,680	\$5B
Bebtelovimab	Eli Lilly	mAbs	Mild to Moderate	IV	Low	\$2,200	\$2.2B

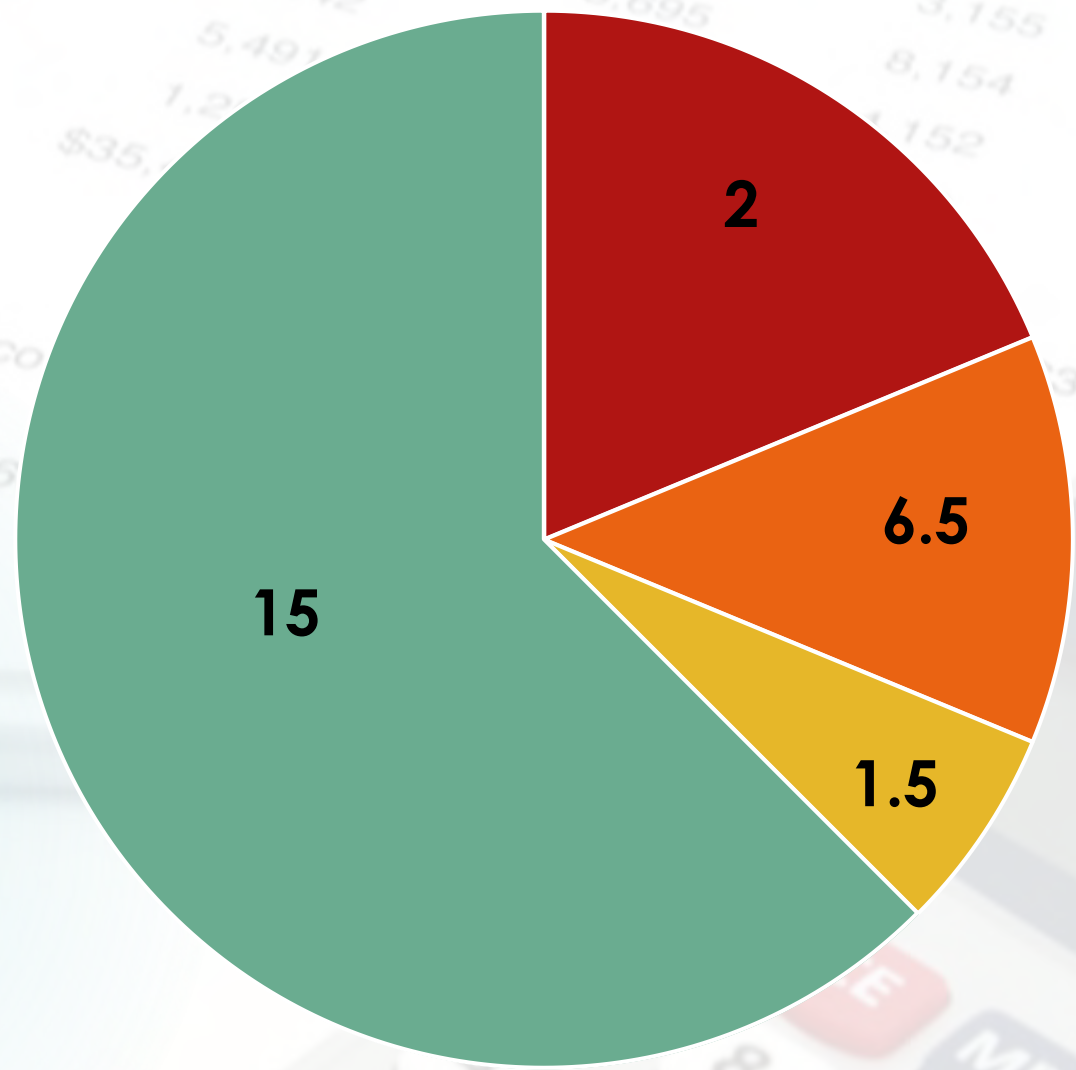
Source: <https://aspr.hhs.gov/COVID-19/Therapeutics/Documents/side-by-side-overview.pdf>

\*\*\*Note: first full calendar year revenue 2024



# The Ask: \$25M Series A

Use of Funds



Expense (in millions)

- IP
- Drug Development
- SG&A
- Clinical Trials



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COVID-19 EUA / BLA Go-to-Market Strategy

# Engagement model ensures operational excellence to optimize EUA success

Centralized engagement model via PM Office ensures efficient execution of strategic vision

## Steering Committee ①

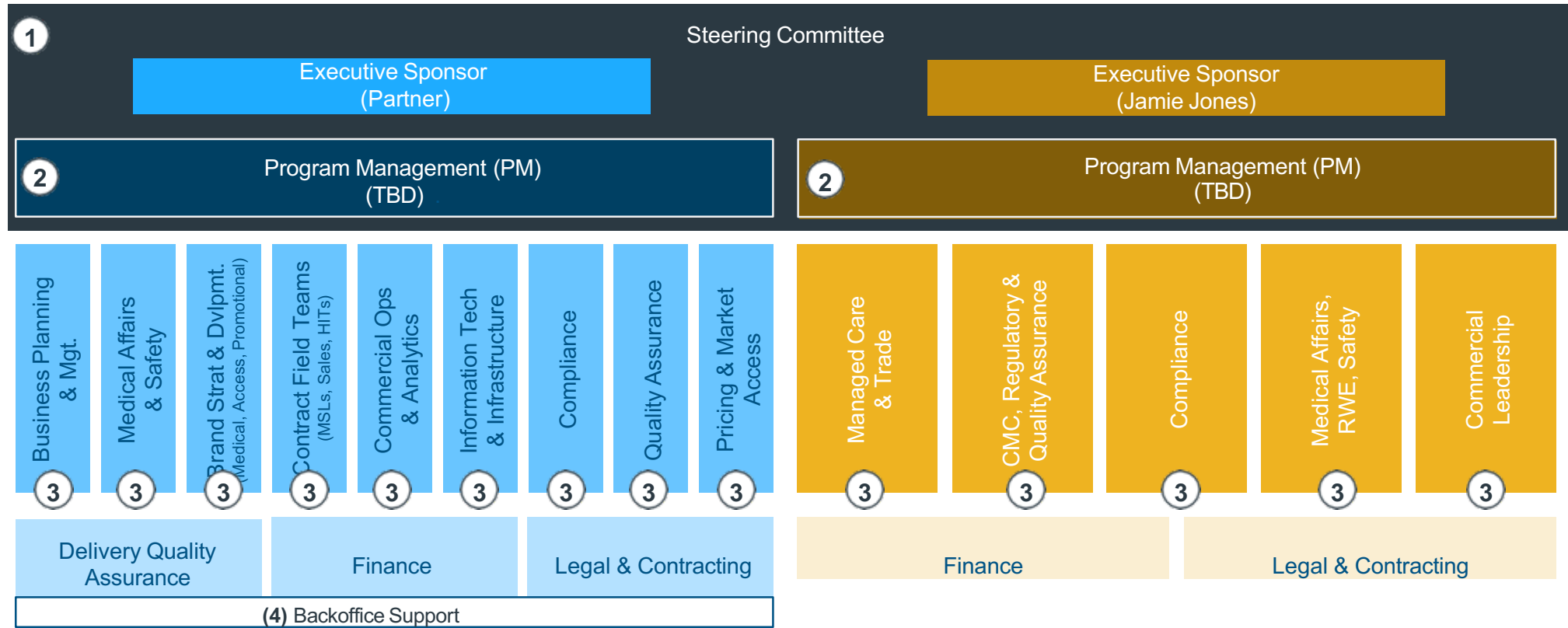
- Sets Business Direction
- Resource Allocation
- Issue Resolution Decisions

## Program Mgt. ②

- Program Governance
- Milestone & Status Reporting
- RAID Management
- RISK Mitigation
- Change Control
- Cross Project Coordination

## Workstream Mgt. ③

- Workstream Milestone Mgt
- Detailed Requirements
- Subject Matter Expertise
- Issue Detection
- Resolution Proposals



Strategic Partner



# Create unique ability to bridge the EUA period to the commercial continuum brings inherent value

*Partnership model fueled by Data / Analytics / Technology to help optimize Critical Success Factors*

**EUA Strategy Provides Insight and Data/Analytics to Accelerate the Performance of Your Sales team**



Data	Advanced Analytics	Technology	Resources	Measurement KPIs
<p><b>Multi-Sourced Information:</b></p> <p>Rx, Inventory movement, and/or Claims, OneKey Reference Data</p>	<p>Custom AI/ML algorithms to enable real-time Triggers &amp; Alerts</p> <p>COVID Decision Tool</p>	<p>Enabling your EUA and Launch trajectory.</p> <p>OCE CRM</p> <p>IQ 20/20 - Reporting</p> <p>IDP Snowflake-based Data Warehouse</p>	<p>Best in class resources through experienced recruiting, training, coaching and management</p>	<p>Mutually agreed upon KPIs informed by IQVIA data, along with clinical and commercial ADHD SMEs</p>
<b>Informed to succeed</b>	<b>Right HCP, Right Time</b>	<b>Dynamic decision-making enablement</b>	<b>Maximized field effectiveness</b>	<b>Optimize &amp; Adjust</b>

## Continuous Partnership Framework

# Strategy for EUA Activation helps deliver information & education to treaters so can be used with the patients who need it

*EUA limits the deployed activities and establishes a leverageable foundation to support commercial launch.*

## Business Planning & Mgt.

- EUA Model Planning & CSFs
- Go-To-Market (Launch) Model Planning & CSFs
- PMO (Business & Technology)
- GTM HCP/HCO Engagement Strategy & Sourcing Model
- Awareness, Trial, and Usage Studies

## Medical Affairs & Safety

- KOL profiling & mapping
- Scientific comms. platform design
- Medical Information Call Center
- Product Quality Complaint Processing
- Pharmacovigilance & Safety Reporting
- Real World Evidence generation (post marketing study)

## Compliance

- MLR Governance & Support
- Compliance SOP Assessment
- Transparency SOP Dev
- Transparency Reporting
- Fair Market Value
- HCP & Funding Process Design

## Pricing & Market Access

- Pricing & Contracting Strategy (& Targeting)
- Distribution Strategy
- Payer Positioning & messaging, Content Dev
- 3PL Data Aggregation

## Contract Field Teams & Support

- MSL Team Field Sizing, Recruiting, Training
- Ongoing Resource Mgt & Support
  - Med. Science Liaisons
  - Access Advisor
  - Key Account Managers
  - Hospital Sales Reps
  - HCP Sales Reps

## Brand Strategy & Development

- Positioning, Messaging & Content Dev (MSLs, MI FAQs, HCP Web Site)
- Product Website with HCP login if needed
- Positioning, Messaging & Content Dev (Product Web Site)
- Positioning, Messaging & Content Dev (Promotional HCP & Payer)
- Digital Engagement Strategy (Medical)
- Digital Engagement Strategy (Promo)
- Multi-channel mktg. design & execution

## Commercial Operations & Analytics

- Data Strategy & Procurement
- Promotional Segmentation, Targeting & Alignments
- Incentive Compensation Design & Administration
- Data Stewardship
- EUA Data Analysis & KPI selection
- Speaker Bureau & Events (Virtual Ad-Boards KOLs, HCPs, Payers)

## Information Technology & Infrastructure Support

- IT Roadmap
- CRM Implementation & Support
- BI/Analytics, Field Reporting Implementation/Support
- MLR Content Management

## Quality Assurance

- Quality SOPs
- Quality Management Automation

- **EUA Scope**
- Launch Scope



# Highlights of an EUA Activation Program

*EUA priorities drive plans and preparations*

Program Component	Output or Description
1. Program Management & EUA activation plan	Overall Program management of the EUA program and delivery
2. KOL & Hospital Identification & Mapping	MSL call and contact targets
3. Pricing study and finalization	Pricing study, Product dossier, HEOR
4. EUA Product Website	Product Website
5. EUA HCP Registration Website	EUA program registration website
6. Medical Information Content and Call Center	Call Center, Collect product quality, AEs event details. Develop FAQ, Standard Responses, Approved Email content, etc.
7. Pharmacovigilance	Monitoring and reporting of PV events per regulatory requirements
8. CRM Systems setup	CRM to support MSL and KAM persona interactions
9. MLR Content and Processes	Develop Med-Legal-Regulatory Process and Service to support execution
10. Training Materials development/delivery	Product and Medical training for MSL, Hospital, & Home Healthcare Partner
11. Field Teams: MSL, KAM Recruiting and Hiring	Hire and rollout MSL and KAM teams
12. Trade Readiness & NAM Team Onboarding	Market Access Program Plan and implementation of syndicated NAM Team
13. EUA Analytics, MDM, and Reporting	Abbreviated Reporting and MDM stewardship to support EUA
14. Compliance Risk Assessment & Policies	Develop risk assessment program and standard operating procedures
15. Hospital to Home Healthcare Continuity of Care Strategy	Develop overall hospital engagement / HHC strategy to support continuity of care

# EUA Activation Timeline & Milestones for COVI-001

All milestone dates are presumed for scoping purposes.



◆ Estimated milestone completion dates

# Treatment decisions for critical COVID-19 is mainly driven by guidelines / protocols (based on recent literature) and treatment availability/supply

## TREATMENT DECISION DRIVERS



### Guidelines/Protocol

- Physicians prescribe according to hospital protocols and guidelines, taking into account:
  - **Published data**
  - Patient's **clinical status and symptoms** (i.e. SpO<sub>2</sub>, HFNC, ventilation)
  - **Comorbidities** that may be contraindicated with certain drugs



### Availability and Supply

- COVID-19 drugs may be in **short supply** (i.e. convalescent plasma) and will be reserved for patients who need it most



### Hospital Formulary

- Formulary decisions are made based on the **safety and efficacy data** that is available
- Formulary inclusion plays only a small role in physicians' treatment decisions since **non-formulary drugs can be obtained and used** if clinically appropriate



### Patient/Family Input

- Patients and/or family members may request treatments heard from sources such as **social media**
- Physicians are willing to try therapies requested if **clinically appropriate, available, and affordable for the patient**

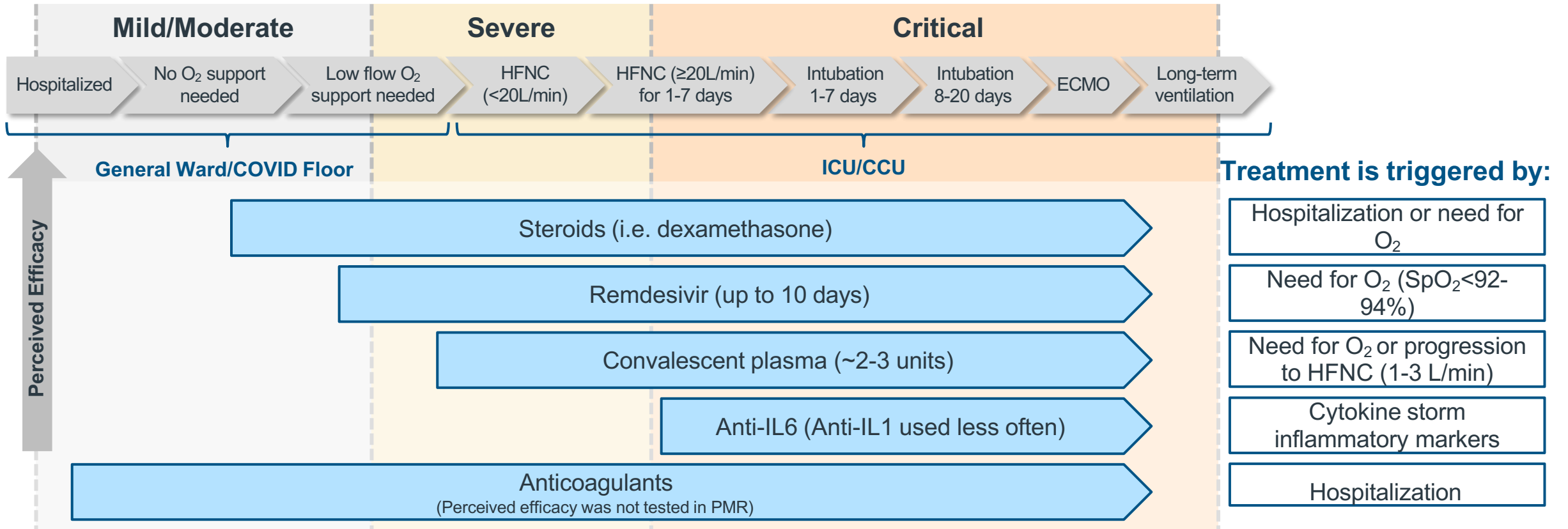
Mentioned More in Interviews

Mentioned Less in Interviews

*Stakeholders are aware that new data and novel therapeutics have been continuously emerging, and treatment protocols and available options are changing on an extremely frequent basis*

# Patients are initially treated with steroids & anticoagulants; if disease progresses, remdesivir, plasma, & anti-IL6s may be used

## TREATMENT ALGORITHM



“We will typically start steroids first and then prescribe remdesivir and convalescent plasma if they are getting worse and need to be admitted to the ICU.”  
-Infectious Disease Physician

“If a patient comes in and requires oxygen, they will get remdesivir and steroids. Convalescent plasma is administered if the patient does not respond well to steroids and remdesivir.”  
-ICU Pulmonologist

“If a patient needs 1-3L of oxygen, they will get remdesivir and steroids. If they need greater than 3L, I will also prescribe convalescent plasma.”  
- Infectious Disease Physician

# Most therapies for COVID-19 are on hospital formulary and available for ICU specialists with limited restrictions

## CURRENT FORMULARY INCLUSION

	Formulary Inclusion	Restrictions
Remdesivir	✓	<p><b>Therapies have similar restrictions:</b></p> <ul style="list-style-type: none"> <li>Specialist approval (most often ID, sometimes pulmonologist and intensivist)</li> <li>Minimal restrictions by patient type, but use must be supported by some level of clinical evidence</li> </ul>
Convalescent Plasma	✓	
Steroids (e.g. dexamethasone)	✓	
Anti-IL1 (e.g. anakinra/Kineret)	✓ / ~	
Anti-IL6 (e.g. tocilizumab/Actemra)	✓ / ~	

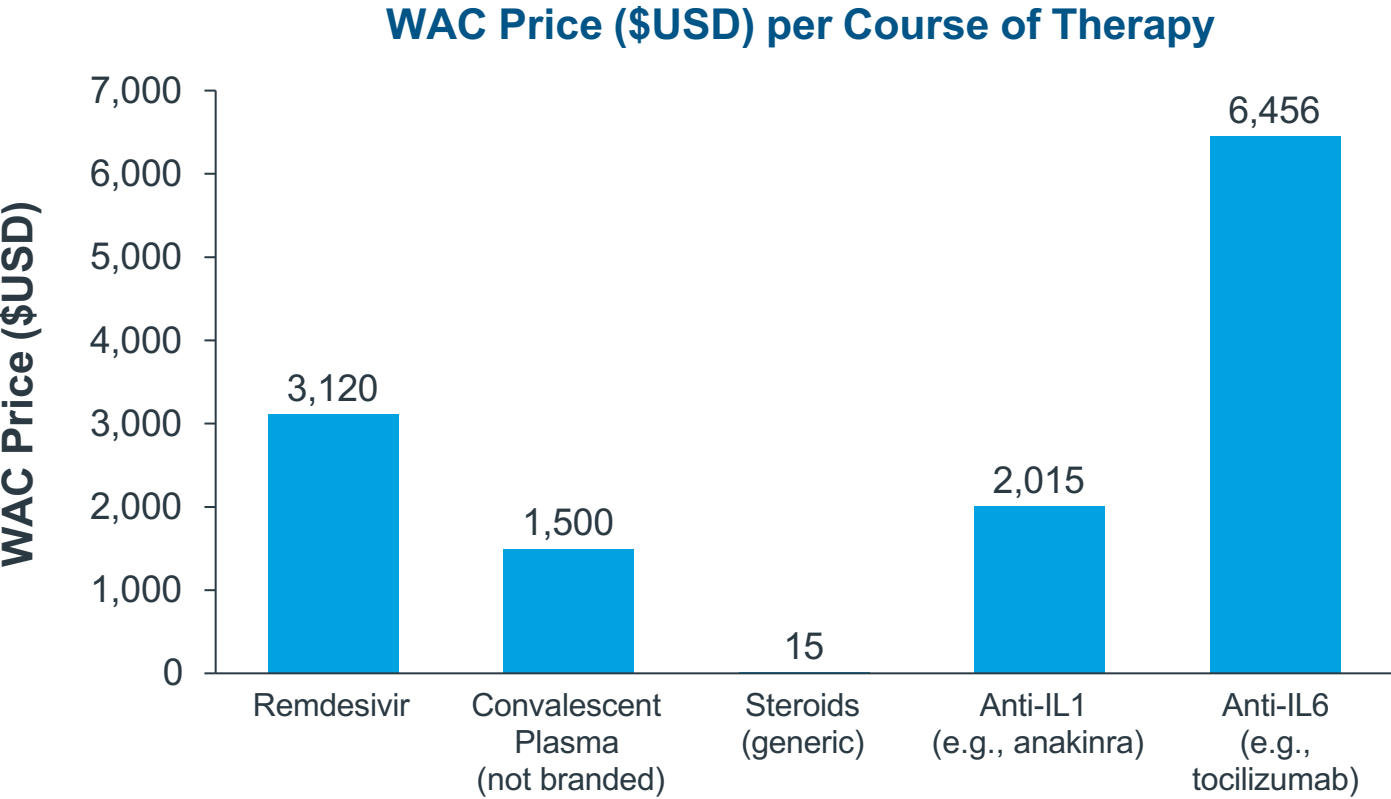
**Formulary Inclusion**

- COVID physicians have **broad access to therapies**, assuming evidence exists to support the intended use
- Hospitals often have protocols to drive appropriate use, however these **are not typically strictly enforced**
  - Protocols and restrictions are implemented via EHR, or if stricter, with sign-off of pharmacist / ICU head
  - Use of high-cost products may be more closely monitored, such as requiring sign-off by department head
  - Protocols are evolving as data becomes available
- Hospitals have **previously controlled** use of therapies, however this is **related to supply issues**, particularly with plasma and the early days with remdesivir, rather than cost
  - Supply and federal requirements (i.e., documentation needed for EUA products) are more typical barriers
- New products can be added **relatively quickly** (as fast as 1 week for review and to become available in some cases)
  - Federal requirements and delay in receiving supply can add a few weeks or months to the timeline

✓ Available    ~ Available, but not often in protocols

# Available branded therapies for COVID-19 are priced between ~\$2,000-\$6,500 per course of therapy

## THERAPY COSTS



### Current Therapy Costs

- Given the **unmet need in critical patients** and **efficacy**, stakeholders do not see existing therapies as price benchmarks
  - Available therapies are being used broadly, rather than only in critical patients
- Costs per course of therapy may differ by patient: patients may receive a different total dose based on physician prescribing
- Dexamethasone** is considered an affordable, highly-effective option, however pharmacists and MCOs recognize it is **not a price benchmark** for novel branded therapies
  - Cost is not a concern when considering adding-on steroids to branded therapy

Pipeline competitors may impact the price benchmark  
 (e.g. Regeneron contracted 70-300K courses of treatment with HHS for ~\$450M, equivalent to ~\$1,500 - \$6,430 per course)

# In addition to cost of pharmacologic therapies, length of stay is a more critical driver of hospital costs for COVID patient management

## HOSPITAL COST STRUCTURE

### Number of Mentions of Hospital Cost Drivers (unaided)

Hospital Cost Drivers	Hospital Pharmacists
Length of stay in ICU or general ward	8
Pharmaceutical interventions	6
Ventilation, dialysis, non-pharma interventions	3
Lab tests, imaging	2
Staff (nurses, specialists)	2
COVID-specific activities (personal protective equipment, renovations)	2



- LoS is the primary cost concern, and serves as a catch-all for typical resource use (staffing, labs, etc.)
- Staffing (nurses, specialists, etc.) is often captured in the cost of the bed



- Therapeutic interventions are considered expensive, however no specific agent is highlighted individually
- Non-pharma interventions, particularly ventilation, are also significant cost drivers in the ICU/CCU

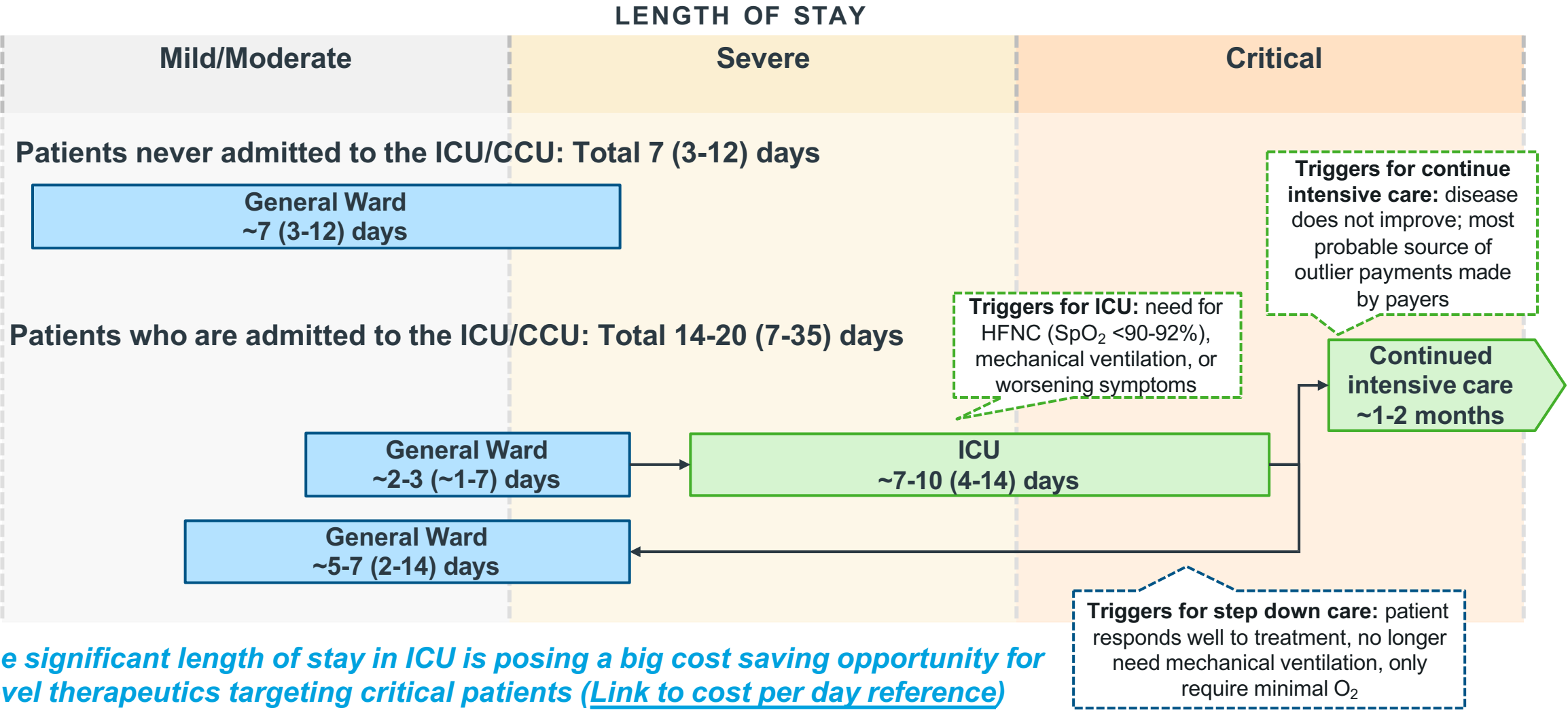


- Hospitals have taken on additional expenses to address COVID patients, including greater use of PPE and setting up COVID-specific wards

“I look at baseline cost of ICU per day. Plasma and other medications can be expensive, comorbidities make costs skyrocket. It comes down to the number of interventions in ICU and number of days.”  
 – Hospital Pharmacist

“If I can better manage ICU time or determine which patients can be prioritized for ICU, I can better allocate staff resources.”  
 – Hospital Pharmacist

# Patients admitted to the ICU spend 14-20 days total in the hospital, with 7-10 of those days in the ICU



*The significant length of stay in ICU is posing a big cost saving opportunity for novel therapeutics targeting critical patients ([Link to cost per day reference](#))*



# Hospitals are reimbursed for COVID-19 patients primarily through Diagnosis Related Groups (DRGs) and case rates

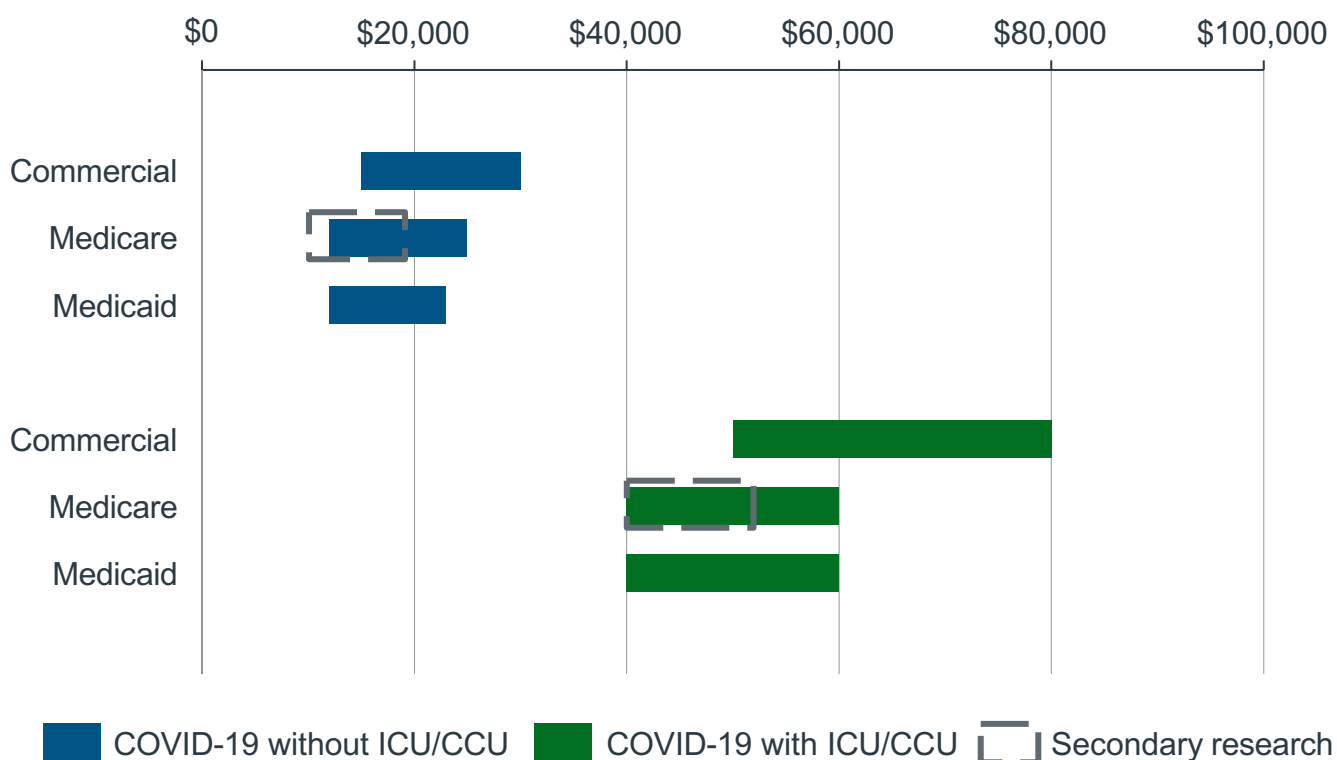
## COVID-19 FUNDING & REIMBURSEMENT

Funding Mechanism	Diagnosis Related Group (DRG)* (Commonly Used)	Case Rate (Commonly Used)	Per Diem (Rarely Used)	Percent of Charges (Rarely Used)
	<ul style="list-style-type: none"> <li>• DRG determined by diagnoses/procedures codes from ICD-10-CM</li> <li>• Pay per admission</li> <li>• For cases that are above a cost threshold, hospitals may receive supplemental payments known as outlier payment</li> </ul>	<ul style="list-style-type: none"> <li>• Hospital is paid flat rate regardless of charges</li> <li>• Hospitals and MCOs negotiate rate</li> <li>• Charges/length of stay only used for threshold determination</li> </ul>	<ul style="list-style-type: none"> <li>• Fixed amount per day</li> <li>• Length of stay matters to MCOs, but charges do not</li> <li>• More common for specialized academic/tertiary hospitals</li> </ul>	<ul style="list-style-type: none"> <li>• Hospital is paid based on services provided</li> <li>• Common for national PPOs and financially challenged rural hospitals</li> </ul>
Reimbursement	<p>Inpatient reimbursement for <b>Medicare and Medicaid coverage is almost exclusively DRG-based</b></p> <p>For <b>commercial coverage</b>, rates are negotiated between hospitals and commercial payers (MCOs) – case rate (similar to DRG), % of charges (fee for service/FFS), or per diem</p> <ul style="list-style-type: none"> <li>• Commercial insurers frequently follow CMS’s lead when it comes to DRG/case rates for in-patient reimbursement (but may be ~20% higher)</li> <li>• Due to the case rate reimbursement model, <b>MCOs have minimal risk and do not manage hospital-based diseases</b></li> </ul>			
Carve-outs	<ul style="list-style-type: none"> <li>• High-cost therapeutics can be reimbursed separately (“carved out”) of a DRG if it would otherwise be too expensive to be used as part of the DRG</li> <li>• Products can be carved out for CMS through the NTAP system, however this often takes 2-3 years</li> </ul>			

# Hospitals are reimbursed for COVID-19 patients primarily through DRGs / case rates, which range from ~\$40K-\$80K for ICU patients

## COVID-19 FUNDING & REIMBURSEMENT

DRG/Case Rate Ranges by Patient Severity & Payer Type



“We get outlier payments about 10% of the time, usually when a patient has a lot of comorbidities leading to a longer than average stay in the ICU.”  
– Hospital Pharmacist

### COVID-19 Reimbursement

- DRG reimbursements **vary based on patient severity and comorbidities**; negotiated case rates between payers and hospitals also differ significantly between payers/hospitals
  - DRGs are **not specific to COVID**
- Remdesivir ~\$3,120 was **not viewed as a significant burden, but more than normal**
- No COVID therapies are currently carved out of DRG → a possibility of New Technology can be explored
- **Outlier payments are made in 5-15% of cases** and on average are ~20-30% of the total DRG value
  - Outlier payments help recoup cost overages, however the hospital does **not recover the full cost of service**
- Revisions to DRGs or creation of COVID-specific DRGs are **unlikely in the near future**: DRGs are updated every 2-3 years based on retrospective analysis of costs
  - Revisions to DRG would require deliberate action by CMS in response to hospital requests, which is unlikely
  - MCOs will follow CMS’s lead regarding changes (or lack thereof) to DRGs

# Hospital administrators recognize significant potential cost offsets with efficacious treatments, assuming demonstrated LoS reduction

## COST OFFSETS

Treatment Setting	Average Cost to Hospital per Day	Reduction in LoS	Cost Offsets
In ICU/CCU with ventilation	~\$5,000 - \$5,700 (1 <sup>st</sup> day in ICU can be ~\$10K)	-5 days	~\$25,000 - \$28,500
In general ward	~\$1,700 - \$2,200	-5 days	~\$8,500 - \$11,000

Estimated cost per day is well-aligned with pharmacist and MCO expectations

Reduction in LoS is feasible given clinical benefit, however it needs to be demonstrated in trial

LoS is sufficient: other benefits such as reduced need for ventilators will be captured by stepping down patient

“These cost savings seem reasonable and fall in line with expectations. It could allow for premium pricing, but higher price would eat into LoS offsets.”  
-Hospital Administrator

“I want to see the actual data but if this could reduce mechanical ventilation and length of stay.”  
-Hospital Administrator

# While reimbursement for COVID-19 has evolved, additional funding mechanisms can take ~2-3 years

## FUTURE REIMBURSEMENT DYNAMICS

### Expansion of DRG

- DRGs may take ~2-3 years to update; policy stakeholders do not expect revisions in the near future without legislative intervention
- While MCOs negotiate rates with hospitals in an ongoing basis, commercial/Medicare Advantage follow CMS trends

### Alternative Sources

- Pharmacists and MCOs consider current funding sufficient for COVID: alternative funding (e.g., through legislation) is unlikely to be specifically for COVID-19

### Carve Out

- Carve out for CMS requires NTAP program, which can take ~2-3 years; commercial is unlikely to carve out without NTAP
- Some academic and tertiary hospitals have carve out clauses for high-cost treatment, but these are for specialized facilities and are not product-specific

**Available funds to pay for are unlikely to change in the next few years**

“We are currently looking at the effectiveness of the 20% add-on payment. Hospitals initially conducted less procedures and they used it to make up for lost income. I think the DRG will go down, not up in future.”

– Policy Stakeholder

“Since COVID is a unique cost, I think Medicare could create a new code for it. That way they ensure hospitals get reimbursed and they don’t overpay for other respiratory related diseases.”

– MCO Payer

# Proposed Go-To-Market Partnership Model

	EUA Fees	Launch Start Up	Year 1 Ops	Grand Total
<b>Business Planning &amp; Mgt.</b>	\$139,000	\$496,034	\$58,333	\$693,367
<b>Medical Affairs &amp; Safety</b>	\$736,825	\$680,000		\$1,416,825
<b>Pricing &amp; Market Access</b>		\$375,000	\$42,000	\$417,000
<b>Contract Field Teams*</b>	\$2,747,435	\$239,728	\$8,387,654	\$11,374,817
<b>Brand Strategy &amp; Development</b>	\$100,000	\$868,000	\$75,000	\$1,043,000
<b>Comm Ops &amp; Analytics</b>	\$188,000	\$330,638	\$537,258	\$1,055,896
<b>IT &amp; Support</b>	\$412,400	\$479,345	\$298,338	\$1,190,083
<b>Quality Assurance</b>		\$140,000	\$72,000	\$212,000
<b>Compliance</b>	\$135,000	\$278,000	\$62,173	\$475, 173
<b>Total</b>	<b>\$4,458,660</b>	<b>\$3,886,745</b>	<b>\$9,532,756</b>	<b>\$17,878,161</b>
<b>RWE</b>	N/A	TBD, Scoping Rqd.	TBD, Scoping Rqd.	
<b>MICC, PQC, AE/SRL (Med Affairs)</b>	Included Above	Excluded Above	Excluded Above	

**\*Contract Field Teams Deployment/Salary:**

**10 MSLs: \$180K**

**4 CNEs: \$100K**

**10 Sales Reps: \$140K**

**2 Key Account Managers: \$150K**

**Access Advisor: \$10K per month**



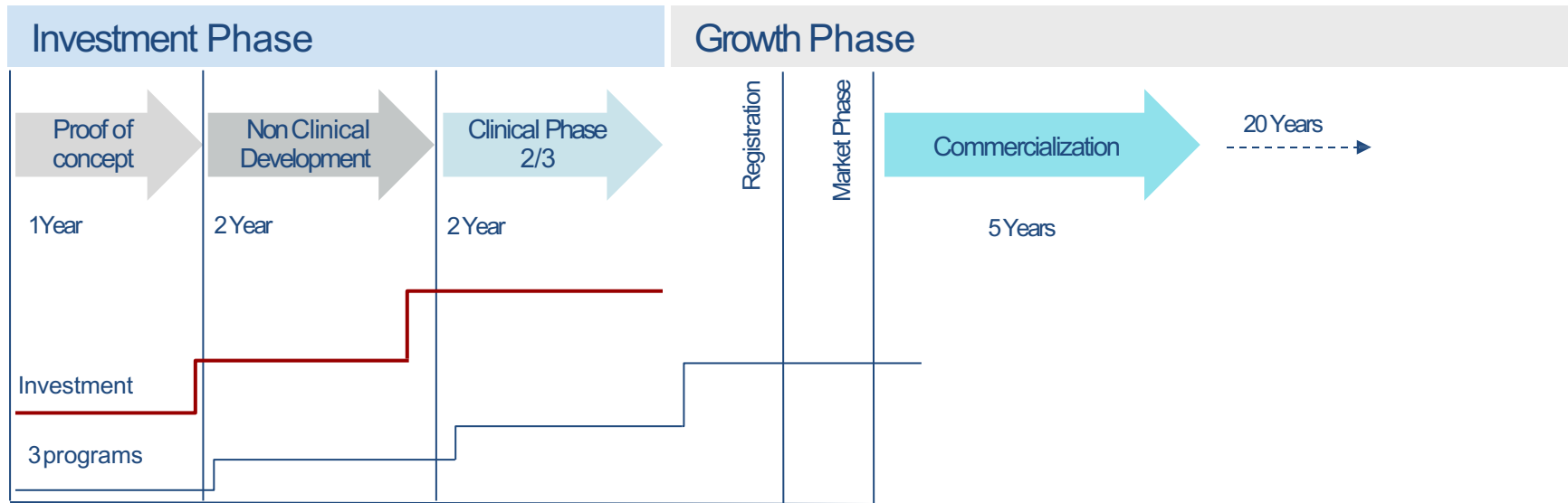
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## **Financing Strategy**

**Financing plan and investment case  
(incl. key assumptions and valuation sensitivities)**

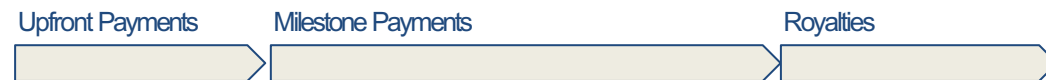
# Business Model and Value Creation

First Exit opportunity in 2024



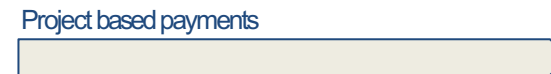
## Growth Enabling Revenues:

Indication specific licencing of assets



## Potential Revenue Streams:

Research collaborations on core technologies







# Strategic Roadmap

## Short Term 2022 - 2025

## Long Term 2025 - Market

**Strategy**

- Develop 3 indications to proof of efficacy in human for licensing by end of 2024
- Maximise the monetization of platform development through collaborations and partnerships
- Generate recurring income through global sales, licensing and co-developments

- Develop compelling indications in the COVID-19 space
- Establish key partnerships based on established differentiation
- Generate growth capital through licensing of clinical, device and diagnostic assets

**Focus**

- Human proof of concept
- Pipeline development and platform validation
- Monetization of know how and technology
- Company established for growth

- Pipeline development
- Growth of the company to multiply the platform value
- Business development and strategic collaborations

**Investment Areas**

- Clinical programs
- Commercial operations
- Platform technologies enabling clinical and pipeline development

- Clinical programs and strategic exploratory programs

**Value Generated**

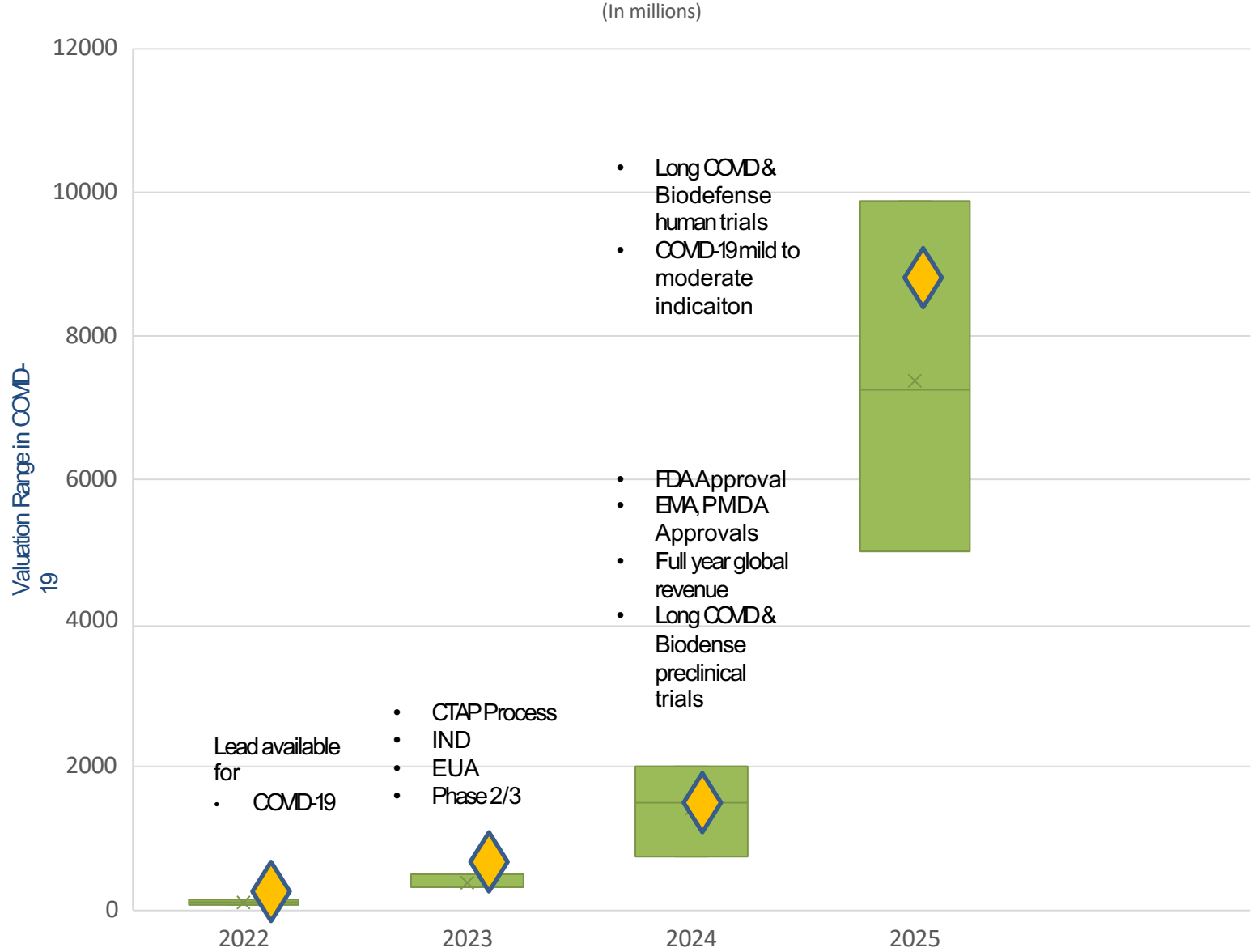
- 3 drug candidates validated in human (Phase 2)
- Drug candidates synergize with further indications
- Revenues and validation through commercialization and technology licensing deals

- Increasing pipeline

# Overview key assumption

	Asset COVI 001	Asset COVI 002	Asset COVI 003	Comments/Source
Valuation Approach	EV/Revenue Multiple	EV/Revenue Multiple	EV/Revenue Multiple	Enterprise Value to Revenue Multiple is a valuation metric used to value a business by dividing its enterprise value (equity plus debt minus cash) by its annual revenue
Discount Rate	15%	15%	15%	15%
Revenue Starting Year	2023	2026	2026	
Probability to market	62%	59%	62%	Sources: FDA, Booz Allan
# of years included in forecast	5	0	0	
Geographical region used	US, EU, Japan, WOW	US, 2027 for EU, Japan, WOW	US	
Patient segmentation	1st line treatment	1st line treatment	1st line treatment	
Market share	10% in 2023 to peak to 60% in 2027			
Sales Price	Ex-factory price: USA: USD 633 WOW: USD 500	Ex-factory price: TBD	Ex-factory price: TBD	

# Value inflection and Return on Investment



- Valuations for Series A is based on benchmark cases and expected multiple assumptions
- Valuation at exit is based on 5.6x median EV/Revenue Multiple calculation
- IRR's and multiples represent an attractive investment opportunity
- Value is mainly driven by COVID-001 asset
- Early licencing deals are not reflected in the current business case

# Value inflection and Return on Investment

(In millions)



Financing Round	Convertible	Series A	Exit
Exit Multiple	500	20	
Financing needs	1	25	
Pre-Money Valuation Ranges	15-75	100-500	1,900-9,895
(reference values applied for calculation)	(9)	(16)	(450)

# Ownership over time

Expected ownership at pre-Series A and post-series A based on the following assumptions:

- Series A raise only capital raise until relizable revenue in 2H of 2023

	Pre-Series A	Series A
Existing shareholders	100%	60%
Convertible loan investors	0%	5%
Series A	0%	25%
ESOP (incl. exercised)	0%	10%
Total	100.00%	100.00%

# CovInnovations Leadership Team



## **Aury Nagy, M.D.**

Board Chairman, Founder and Chief Science Officer

- Neurosurgeon and board member of the Nevada State Medical Board and former Chief of Neurosurgery at University Medical Center
- Graduated from Yale University, Baylor College of Medicine, and George Washington School of Medicine Department of Neurological Surgery
- Studied at Stanford, Harvard, Duke, Cal Western, LSU, University of Arizona, and the University of Pennsylvania

## **Jamie Jones**

CEO

- Senior Executive with 30 years experience at Pfizer, Gilead Sciences, Alnylam Pharmaceuticals, and Double Rainbow Biosciences
- Track record of ten drug launches, engineered commercial startups on three continents, and an award-winning industry executive for innovation, groundbreaking marketing, and sales strategies
- MBA in Marketing and a BS in Finance from the University of Central Florida

## **Kristine Leavitt, MSN, FNP-BC**

Chief Operating Officer

- Board-certified nurse practitioner in family medicine, hospice, and palliative care
  - Former program coordinator for the University Medical Center of Southern Nevada's transplant program
- Master of Science in Nursing (MSN) from the University of Nevada – Las Vegas

## **Amy Stone, Ph.D.**

Lead Scientist

- Assistant Professor of Microbiology and Immunology, Touro University Nevada, Henderson, NV
- Graduated with Ph.D. in Immunology from University of Colorado Denver, CO and B.A. in Biochemistry and Molecular, Cellular, and Developmental Biology from University of Colorado Boulder

## **Richard Renfrow**

CMC-Lead

- Assistant Professor of Microbiology and Immunology, Touro University Nevada, Henderson, NV
- Graduated with Ph.D. in Immunology from University of Colorado Denver, CO and B.A. in Biochemistry and Molecular, Cellular, and Developmental Biology from University of Colorado Boulder

# CovInnovations Board of Directors

## **Aury Nagy, M.D.**

Board Chairman, Founder and Chief Science Officer

## **Elliot Goldstein, MD**

Founder and former CEO of ProMIS Neurosciences, Inc. (Toronto: PMN.TO, CAD 5 million market cap). He has 30 years of experience bringing products through the FDA to market, including cyclosporine

## **Eric Henderson**

Founder and CEO of CBG consulting. He has contributed to US companies securing approximately \$25 billion in projects financed annually and assisting US and global companies with participating in World Bank-financed procurement opportunities in more than 150 countries. Mr. Henderson earned an MA in international relations and affairs from American University.

## **Ibrahim Pataudi**

Vice President of Business Development for NuID, a blockchain company with National Security Agency (NSA) contracts. Mr. Pataudi earned a bachelor's degree in International Relations and Affairs from Claremont McKenna College.

## **Mansoor Ijaz**

Founder and CEO of Crescent Global Partners. Mr. Ijaz is a proprietary trader and hedge-fund manager who founded Crescent Investment Management in New York in 1990. Crescent, and its successor companies, operate CARAT, a proprietary trading system developed by Ijaz in the late 1980s during his graduate research studies at MIT.



# Contact Us

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