Liquidia R&D Day

Webcast presentation

October 28, 2025

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Forward-looking statements

This presentation includes, and our response to questions may include, forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 ("PSLRA"). All statements contained in this presentation other than statements of historical facts, including statements regarding our future results of operations and financial position, our strategic and financial initiatives, our business strategy and plans and our objectives for future operations, are forward looking statements. Such forward-looking statements, including statements regarding clinical trials, clinical studies and other clinical work (including the funding therefor, anticipated patient enrollment, safety data, study data, trial outcomes, timing or associated costs), regulatory applications and related submission contents and timelines, the timelines or outcomes related to patent litigation with United Therapeutics in the U.S. District Court for the District of Delaware and U.S. District Court for the Middle District of North Carolina, or other litigation between Liquidia and United Therapeutics or others, including rehearings or appeals of decisions in any such proceedings, the issuance of patents by the USPTO and our ability to execute on our strategic or financial initiatives, the potential for additional funding under the HCR Agreement, our anticipated use of net proceeds funded under the HCR Agreement, our estimates regarding future expenses, capital requirements and needs for additional financing, and potential revenue and profitability of YUTREPIA involve significant risks and uncertainties and actual results could differ materially from those expressed or implied herein. YUTREPIA's approval and our launch of YUTREPIA remain subject to ongoing litigation in which United Therapeutics is seeking injunctive relief, which could block our ability to continue to sell YUTREPIA for one or both of PAH and PH-ILD. The words "anticipate," "believe," "continue," "could," "estimate," "expect," "intend," "may," "plan," "potential," "predict," "project," "should," "target," "would," and similar expressions are intended to identify forward-looking statements. We have based these forward-looking statements largely on our current expectations and projections about future events and financial trends that we believe may affect our financial condition, results of operations, business strategy, short-term and long-term business operations and objectives and financial needs. These forward-looking statements are subject to a number of risks discussed in our filings with the U.S. Securities and Exchange Commission as well as a number of uncertainties and assumptions. Moreover, we operate in a very competitive and rapidly changing environment, and our industry has inherent risks. New risks emerge from time to time. It is not possible for our management to predict all risks, nor can we assess the impact of all factors on our business or the extent to which any factor, or combination of factors, may cause actual results to differ materially from those contained in any forward-looking statements we may make. In light of these risks, uncertainties and assumptions, the future events discussed in this presentation may not occur and actual results could differ materially and adversely from those anticipated or implied in the forward-looking statements. Although we believe that the expectations reflected in the forward-looking statements are reasonable, we cannot guarantee that future results, levels of activity, performance, achievements or events and circumstances reflected in the forward-looking statements will occur. We are under no duty to update any of these forward-looking statements after the date of this presentation to conform these statements to actual results or revised expectations, except as required by law. This presentation also contains estimates and other statistical data made by independent parties and by us relating to market size and growth and other data about our industry. This data involves a number of assumptions and limitations, and you are cautioned not to give undue weight to such estimates. In addition, projections, assumptions and estimates of our future performance and the future performance of the markets in which we operate are necessarily subject to a high degree of uncertainty and risk. This presentation includes long-term goals that are forward-looking, are subject to significant business, economic, regulatory and competitive uncertainties and contingencies, many of which are beyond our control and are based upon assumptions with respect to future decisions, which are subject to change. Actual results will vary, and those variations may be material. Nothing in this presentation should be regarded as a representation by any person that these goals will be achieved. We have no obligation under the PSLRA to update any forward-looking statements, and we undertake no duty to update our goals or to update or alter any forward-looking statements, whether as a result of new information, future events or otherwise.

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Enhancing drug delivery to the lungs to **make every breath count**

Liquidia Corporation is a biopharmaceutical company **driven by science and compassion** to **revolutionize care** for patients with challenging **respiratory and vascular diseases** through precise, innovative therapies that **restore health and hope**

- **Improving drug delivery**
- **Using proprietary technologies**
- **Reducing burden of administration**
- **Helping patients breathe easier & live longer**

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Ideal product profile for inhaled delivery

Therapeutic goal is to optimize each aspect

Targeted lung delivery

Reduces off-target toxicity from oral, IV/SC delivery

Portable

Convenience & ease-of-use to support compliance

Tolerable

Customizable and not dose limited

Titratable

Wide dose range to extend time on treatment

Dosing frequency

Easy and simple regimen

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Yutrepia addresses the first four elements now

Therapeutic goal is to optimize each aspect

Targeted lung delivery	Portable	Tolerable	Titratable	Dosing frequency
PRINT® Technology	Low-effort Trusted device	INSPIRE (PAH) ASCENT (PH-ILD)	Titratable in PAH, PH-ILD	4x daily

YUTREPIA™ (treprostinil) inhalation powder

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L606 improves the inhaled product profile as the market expands

Therapeutic goal is to optimize each aspect

Targeted lung delivery	Portable	Tolerable	Titratable	Dosing frequency
Liposomal Technology	Rapid, breath-actuated nebulizer	Further improved tolerability	Over 48-weeks of treatment	2x daily to minimize peak to trough excursions

YUTREPIA™ (treprostinil) inhalation powder

L606 (liposomal treprostinil inhalation solution)

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Meet today's invited expert speakers

Key opinion leaders

Dr. Richard Channick, MD

Saul Brandman Endowed Chair in Pulmonary Arterial Hypertension

Co-Director, Pulmonary Vascular Disease Program

Professor of Medicine

Pulmonary and Critical Care Division

David Geffen School of Medicine at UCLA

Dr. Rajan Saggar, MD

Professor of Medicine

Director, Pulmonary Hypertension Program

Co-Director Pulmonary Vascular Disease Program

Lung & Heart-Lung Transplant and Pulmonary Hypertension Programs

David Geffen School of Medicine, UCLA

Dr. Ricardo Restrepo-Jaramillo

Associate Professor of Medicine, Morsani College of Medicine

Medical Director Center For Pulmonary Vascular Diseases

University of South Florida/ Tampa General Hospital

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Today's outline

- Our objectives
- Understanding PAH and PH-ILD today
- ASCENT study in PH-ILD (Week 24 data)
- L606, treprostinil liposomal inhalation suspension in U.S. (Week 48 data)
- Physician Roundtable Q&A

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Unmet Needs for Patients with PAH and PH-ILD

Dr. Richard Channick, MD

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WHO clinical classification of PH

Group 1

PAH

- Idiopathic/heritable
- Associated conditions

Pressure in pulmonary arteries leads to vascular resistance, increased right ventricular pressure, right heart failure and death

Group 2

PH associated with left heart disease

- IpcPH
- CpcPH

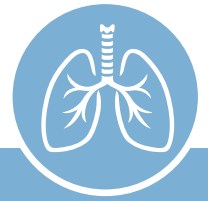
Group 3

PH associated with lung disease

- Non-severe PH
- Severe PH

Chronic hypoxia can **cause pulmonary vascular remodeling** and subsequent **elevation of pulmonary vascular resistance** (PVR)

Ultimately leading to the development of PH within the course of ILD[3]



Group 4

PH associated with pulmonary artery obstructions

- CTEPH
- Other pulmonary

Group 5

PH with unclear or multifactorial mechanisms

- Hematological disorders
- Systemic disorders

CpcPH, combined post- and pre-capillary pulmonary hypertension; CTEPH, chronic thromboembolic pulmonary hypertension; ILD, interstitial lung disease; IpcPH, isolated post-capillary pulmonary hypertension; PAH, pulmonary arterial hypertension; PH, pulmonary hypertension.

1. Humbert M et al. *Eur Heart J.* 2022;43(38):3618-3731. doi:10.1093/eurheartj/ehac237 2. Chang KY et al. *J Am Heart Assoc*. 2022;11(9):e024969. doi:10.1161/JAHA.121.024969
3. Kacprzak A et al. *Diagnostics*. 2023;13(14):2354. doi:10.3390/diagnostics13142354

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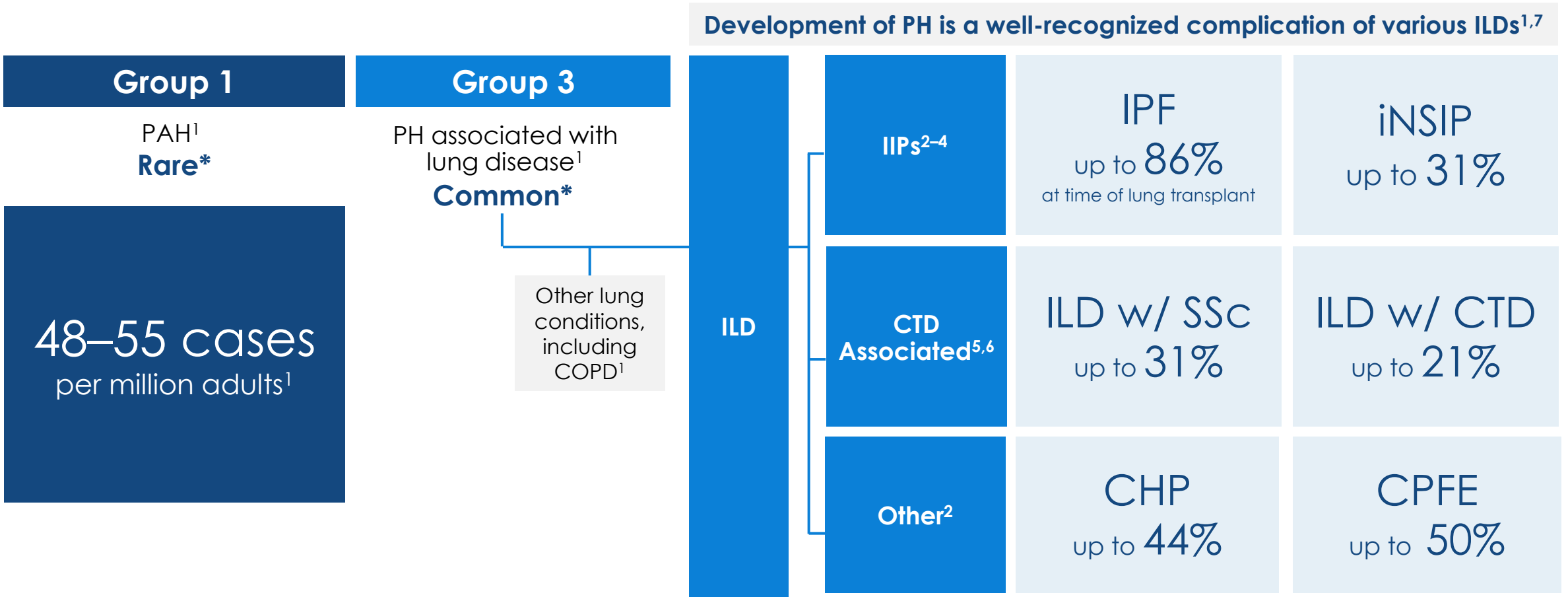
Prevalence estimates may change with increased focus on treatment



*Within pulmonary hypertension. CHP, chronic hypersensitivity pneumonitis; COPD, chronic obstructive pulmonary disease; CPFE, combined pulmonary fibrosis and emphysema; CTD, connective tissue disease; IIP, idiopathic interstitial pneumonia; iNSIP, idiopathic non-specific interstitial pneumonia; IPF, idiopathic pulmonary fibrosis.

1. Humbert M et al. *Eur Heart J.* 2022;43(38):3618-3731. doi:10.1093/eurheartj/ehac237 2. Nikkho SM et al. *Pulm Circ.* 2022;12(3):e12127. doi:10.1002/pul2.12127 3. Parikh R et al. *Pulm Circ.* 2022;12(4):e12141. doi:10.1002/pul2.12141 4. Rahaghi FF et al. *Chest.* 2022;162(1):145–155. doi:10.1016/j.chest.2022.02.012 5. Young et al. *Arthritis Rheumatol.* 2017;71(8):1339–1349. doi:10.1002/art.40862 6. Hyldgaard et al. *J Clin Med*. 2021;10(21):4830. doi:10.3390/jcm10214830 7. Kacprzak A et al. *Diagnostics.* 2023;13(14):2354. doi:10.3390/diagnostics13142354

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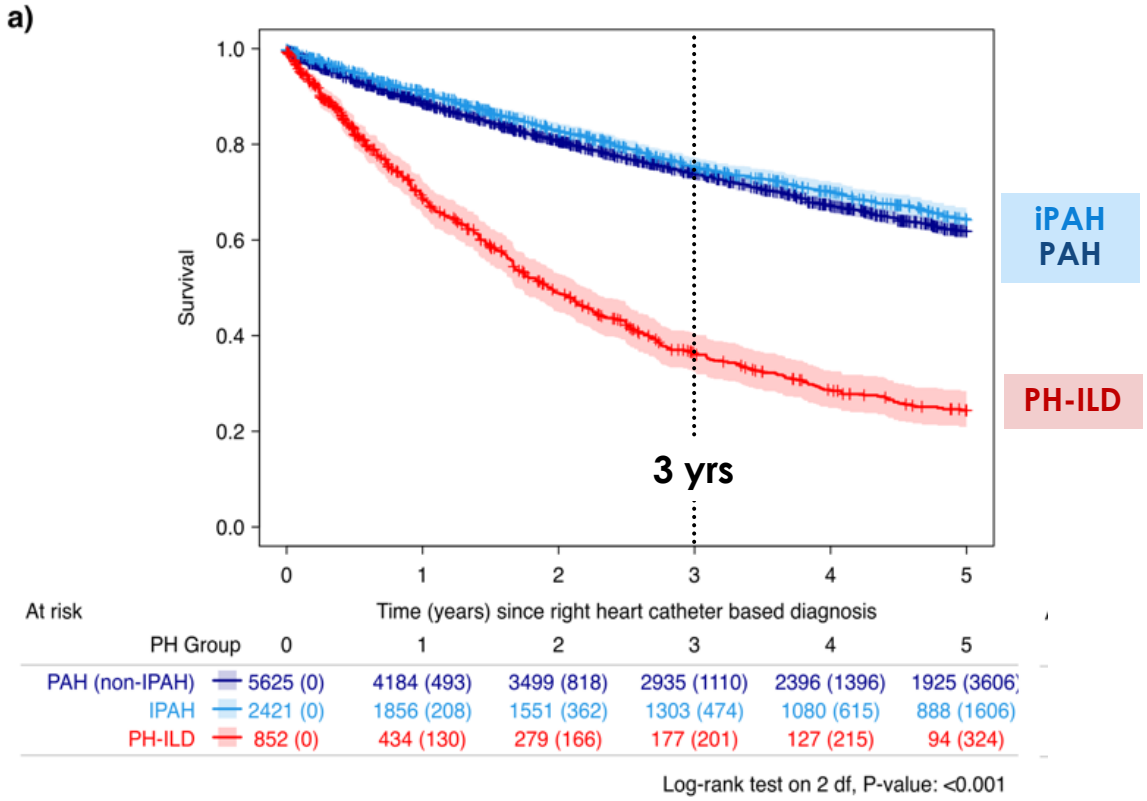
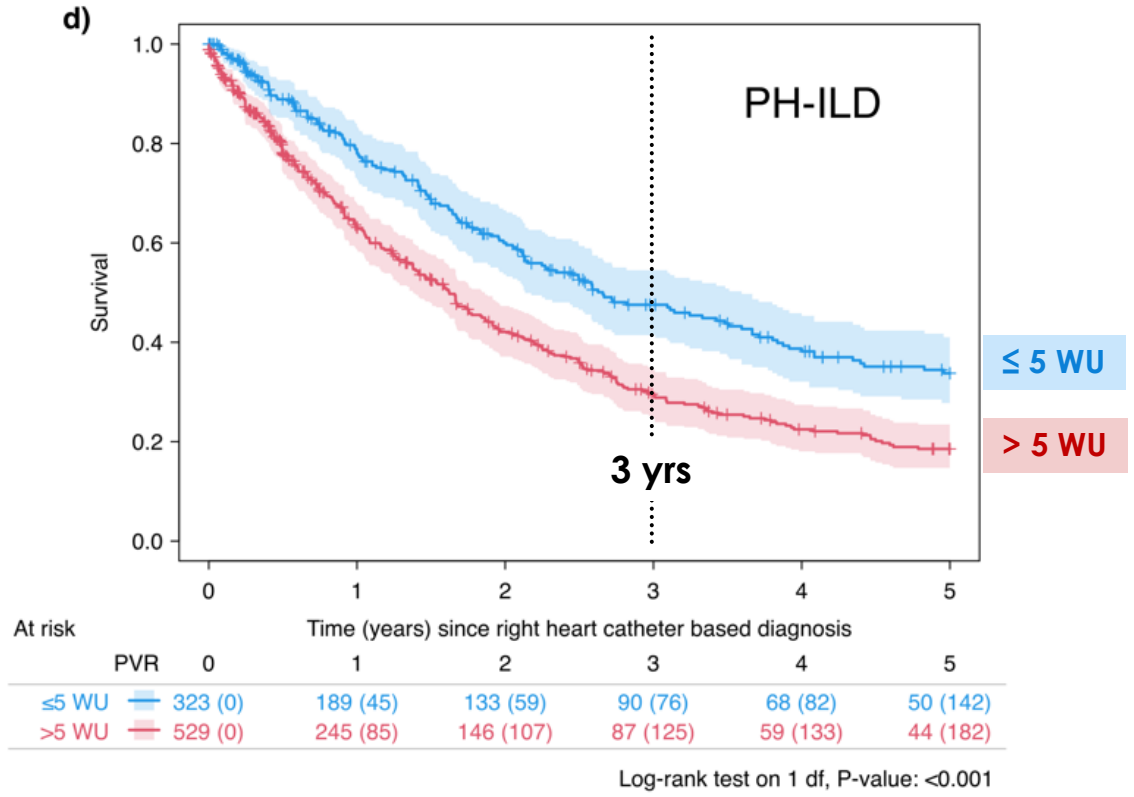
Recent real-world data reinforces poor outcomes in PAH & PH-ILD

PVRI GoDeep Registry[1]

Risk of death is 2x higher in PH-ILD vs PAH



PVR is the strongest predictor of survival



Yogeswaran et al "Hemodynamics and PDE5i Treatment in PH-ILD" *Am J Respir Crit Care Med* Vol 211, Iss 10, pp 1855–1866, Oct 2025

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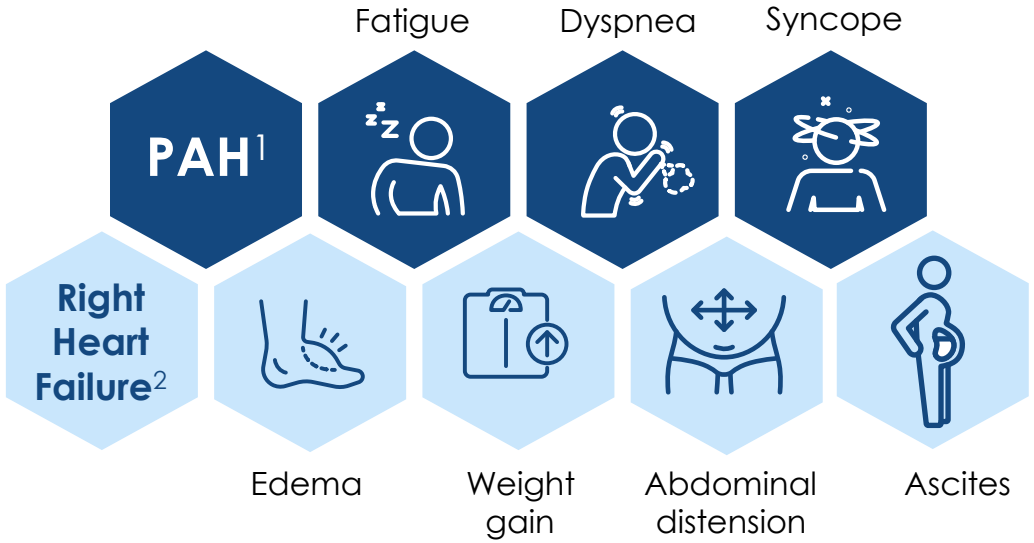
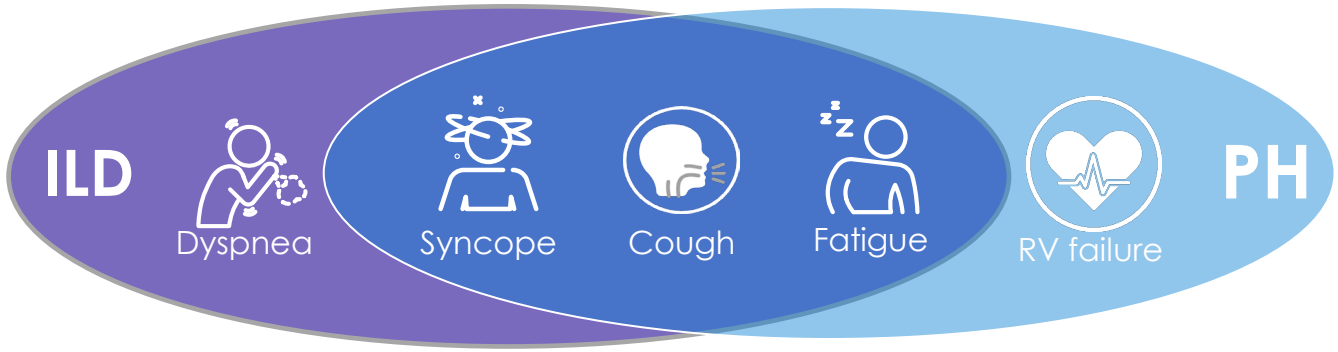
Symptoms can be similar with different diagnosis

Early diagnosis and intervention may result in better clinical outcomes





Detection: Assessment by Lung and Heart Specialist[1]

- Echocardiography
- CPET

Confirmation: Comprehensive PH Workup by PH Center[1]

- 6MWD
- Blood test
- Echocardiography or cMRI
- ABG or O_2 saturation
- Disease-specific HR-QoL
- CPET & RHC

Monitor for signs and symptoms disproportionate to ILD severity[3]

- Altered heart sounds
- Jugular venous distention
- Signs of right heart failure
- Ankle swelling/peripheral edema
- Hepatomegaly/ascites
- ILD requiring oxygen

Perform screening tests[3]

- Pulmonary function tests
- CT scan
- Oxygen saturation
- 6MWD
- Echocardiography

Confirm PH diagnosis[3]

- Right heart catheterization

1. Humbert M, et al. *Eur Heart J*. 2022;43(38):3618-3731. doi:10.1093/eurheartj/ehac237 2. Watson RD, et al. *BMJ*. 2000;320(7229):236-239. doi:10.1136/bmj.320.7229.236; 3. Rahaghi FF et al. *Chest*. 2022;162(1):145–155. doi:10.1016/j.chest.2022.02.012

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Recently updated 7th WSPH hemodynamic definitions

PH

mPAP >20 mmHg

Pre-capillary PH

mPAP >20 mmHg

PAWP ≤15 mmHg

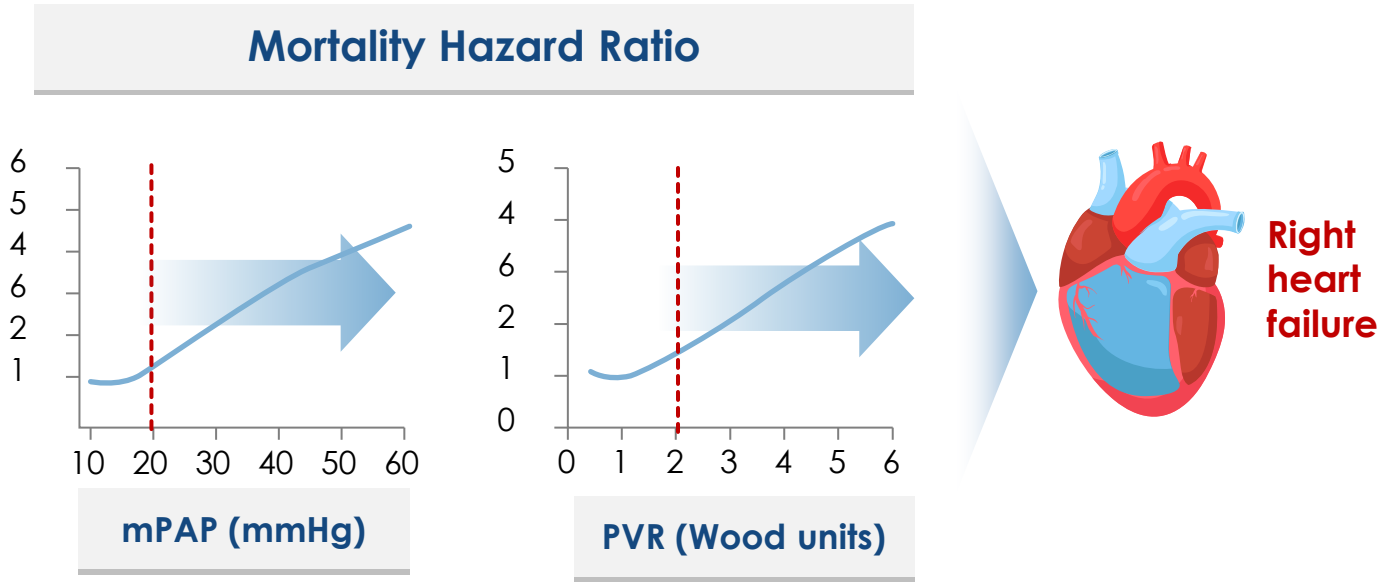
PVR >2 WU

PH-ILD[1–4]

CLD with PH

mPAP > 20 mmHg

PVR ≥3 WU



BLPH=borderline pulmonary hypertension; CpcPH=combined post-capillary and pre-capillary pulmonary hypertension;CI=cardiac index; CLD=chronic lung disease; ERS=European Respiratory Society; ESC=European Society of Cardiology; IpcPH=Isolated post-capillary Pulmonary Hypertension mPAP=mean pulmonary arterial pressure; MPH=mild pulmonary hypertension; PAWP=pulmonary arterial wedge pressure; PVR=pulmonary vascular resistance; SPH=severe pulmonary hypertension; WSPH=World Symposium on Pulmonary Hypertension; WU=wood units.

1. Humbert M et al. *Eur Heart J.* 2022;43(38):3618–3731. doi:10.1093/eurheartj/ehac237 2. Simonneau G et al. *Eur Respir J*. 2019;53:1801913. doi:10.1183/13993003.01913-2018 3. Kovacs G, Bartolome S, Denton CP, et al. Definition, classification and diagnosis of pulmonary hypertension. *Eur Respir J* 2024; 64: 2401324 [DOI: 10.1183/13993003.01324-2024]. 4. Modified from Shlobin OA. *Eur Respir J.* 2024:2401200. 5. Piccari L, et al. *Respiration*. 2022;101(8):717-727. doi: 10.1159/000524263

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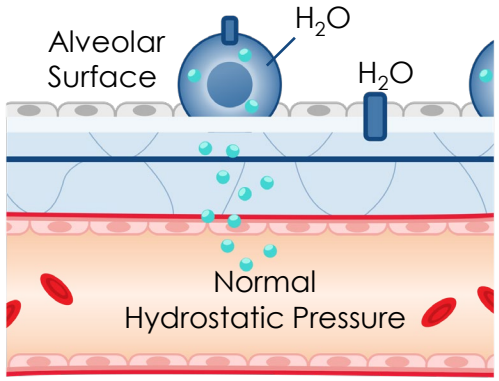
Prostacyclin pathway will remain critical to treatment

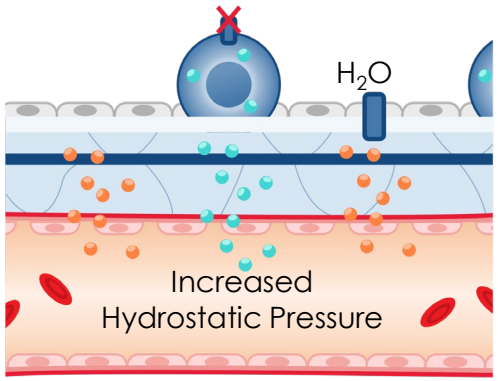
Targets the major pathologic changes that occur in PAH and PH-ILD

Patients with PAH have **decreased levels of endogenous prostacyclin**, a potent vasodilator and **anti-inflammatory** agent[1]

Normal capillaries[2]

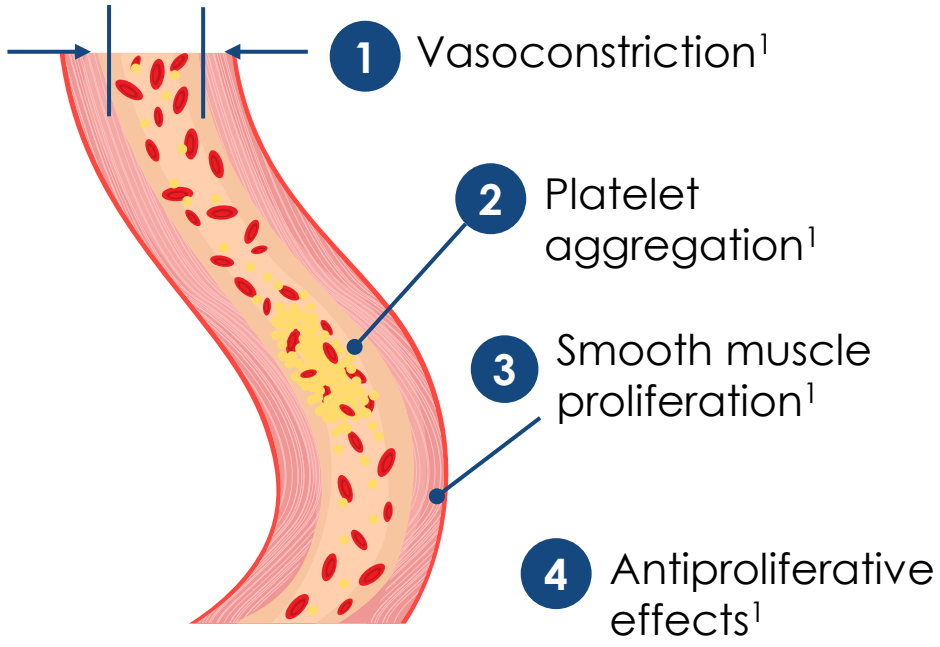


Capillaries in PH[2]



- Endothelial cell breaks
- Impaired permeability
- Protein loss

Prostacyclin mimetics have the potential to **improve blood flow to the lungs, decrease PAP, improve exercise capacity, and/or improve QoL**[1]



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The last 30 years has been an effort in optimizing delivery

Inhaled has potential to maximize the balance of efficacy, tolerability and convenience

1990s

Parenteral

1995 (epoprostenol) IV

- **Proved concept**
- Mortality benefit
- Systemic toxicities, site pain

2000s

Parenteral

2002 (treprostinil) SC	2004 (treprostinil) IV

- Dose limiting systemic AEs
- Infection
- Injection site pain

Inhaled: Nebulized

2004 (iloprost) 6-9x	2009 (treprostinil) 4x

- Large non-portable device
- Prolonged nebulization time
- Frequent administration
- Limited dose range

2010s

Oral

2013 (treprostinil) tid	2015 (selexipag) bid

- Dose limiting systemic AEs
- Requires up-titration, challenging
- Time to titrate can be long

Inhaled: DPI

2022 (treprostinil)

- Cough & Throat irritation
- High resistance device
- Limited dose range

2020s

Inhaled: DPI

2025 (treprostinil)

Yutrepia™ (treprostinil) inhalation powder

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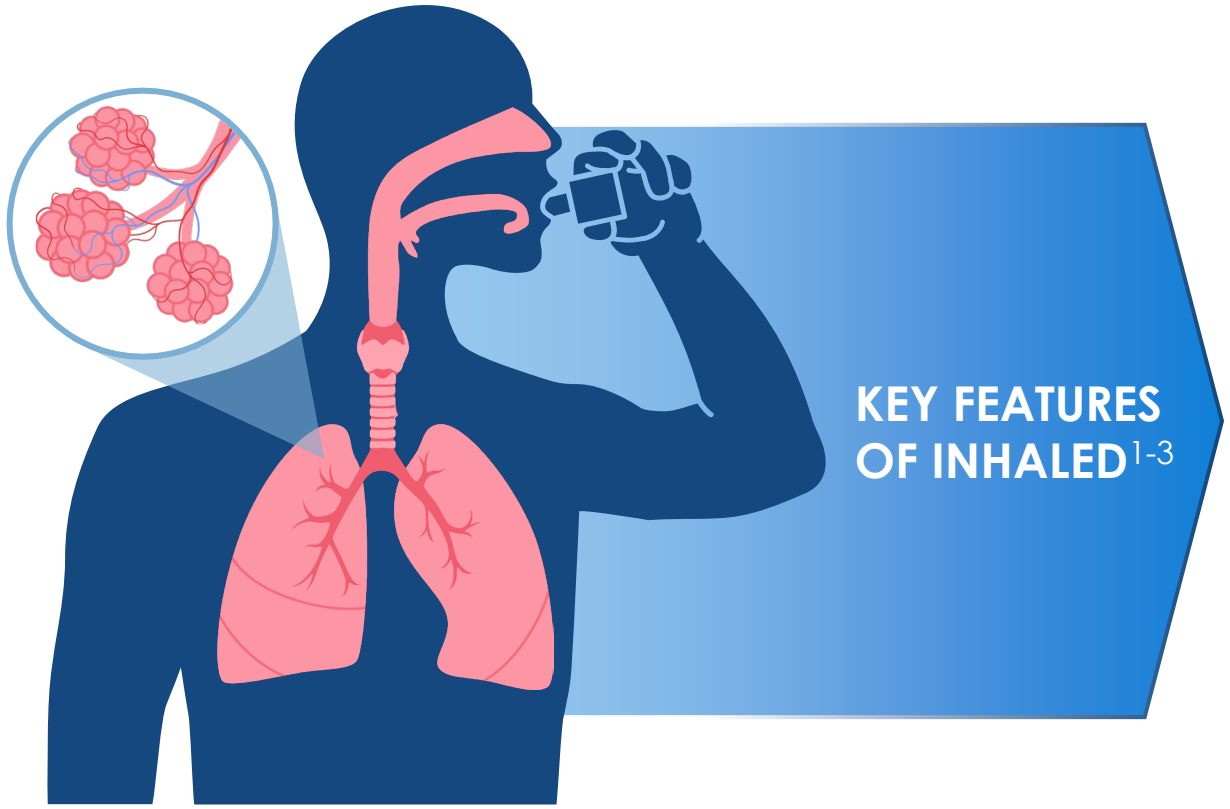
Increasing interest to optimize inhaled delivery given the benefits

Local delivery for local disease



- **Reduced risk of systemic adverse effects**
- **Delivery of drug directly to lungs**
- **Enhanced pulmonary specificity**
- **Higher local drug conc. at lower dose**
- **Improved ventilation/perfusion matching**
- **May aid in patient compliance**

1. Berkenfeld K, et al. *AAPS PharmSciTech*. 2015;16(3):479-490. doi:10.1208/s12249-015-0317 2. Roscigno RF, et al. *Vascul Pharmacol*. 2021;138:106840. doi:10.1016/j.vph.2021.106840
3. Hill NS, et al. *Respir Care*. 2015;60(6):794-805. doi:10.4187/respcare.03927

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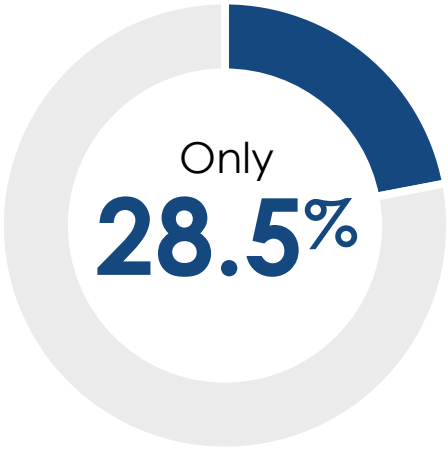
Higher doses of inhaled treprostinil correlate to better outcomes

Retrospective analysis of 5,000 PAH patients (2009–18)*

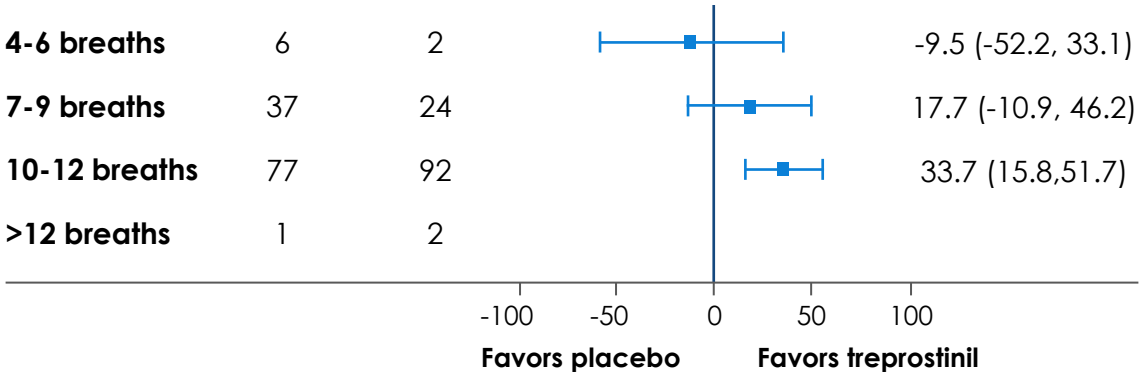


of patients were titrated >9 breaths QID

Patients with 12 or more breaths had better clinical outcomes

Analyses of peak 6MWD at week 16 in PH-ILD[1,2]

Maximum study drug dose	Inhaled tre (n)	Placebo (n)	LS mean difference (95% CI)
4-6 breaths	6	2	-9.5 (-52.2, 33.1)
7-9 breaths	37	24	17.7 (-10.9, 46.2)
10-12 breaths	77	92	33.7 (15.8,51.7)
>12 breaths	1	2	



10 or more breaths of inhaled treprostinil had favorable improvements in 6MWD

*These data are from a Phase 4, retrospective, real-world analysis of patients prescribed inhaled treprostinil solution from a specialty pharmacy database between September 2009 and June 2018. Of the 6709 patients who met all study eligibility criteria, a random sample of 5000 patients was selected for further analysis using simple random sampling with equal probability.
Shapiro S et al. *Pulm Circ*. 2021;11(4):20458940211052228. doi:10.1177/20458940211052228

6-minute walk distance (6MWD); 1. Nathan et al, *CHEST Journal*, February 2023, Vol. 163, Issue 2, P398-406; 2. Supplement to: Waxman et al, *N Engl J Med* 2021;384:325-34

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Real-world challenges with Tyvaso DPI in PH-ILD

Prostacyclin naïve patients showed worse tolerability and discontinued faster

Methods

- We prospectively gathered data on patients with PH-ILD who we initiated on treprostinil DPI (either naively or transition from inhaled treprostinil) to analyze safety and tolerability: BNP, 6-minute walk data, spirometry with DLCO, and RVSP and TAPSE on echocardiogram.
- Following transition, we recorded data obtained through routine standard-of-care testing at our center to ensure safety and tolerability in this patient population. (Table 2)
- This study was approved by the IRB at National Jewish Health.

Table 2: Discontinuation Rates of Tyvaso DPI

Naïve DPI Discontinuation Rate
26 started, 18 discontinued
11 transitioned to nebulizer 7 discontinued treatment completely
69% discontinuation rate
Discontinued due to cough (5), Hypotension (1), Clinical Worsening (9), Self-discontinuation (2), Death (1)

Transition DPI Discontinuation Rate
22 started, 11 discontinued
7 transitioned back to nebulizer 5 discontinued treatment completely
50% discontinuation rate
Discontinued due to cough (1), Hypotension (1), Clinical Worsening (6), Lung Transplant (2), Death (1)

Results

- 22 patients with PH-ILD were transitioned from the nebulized treprostinil to the treprostinil DPI at equivalent doses between July 2022 and April 2023. The most common form of ILD was CTD-associated ILD. (Table 1)
  - 50% of whom discontinued the treprostinil DPI
  - Average treatment duration on DPI prior to discontinuation was a mean of 195 days, median 223 days (min 13 - max 358)
- 26 patients with PH-ILD started the treprostinil DPI naively, titrating from 16 mcg to 64 mcg between July 2022 and April 2023.
  - 69% of whom discontinued the treprostinil DPI
  - Average treatment duration on DPI prior to discontinuation was a mean of 78 days prior to stopping, median 40 days (min 4 –max 171)
- The most common reasons for discontinuation were clinical worsening and cough
  - Clinical worsening was defined by our group as at least having one of the following: worsening testing upon follow up (PFT, Echo, 6MWT), reported increased shortness of breath, and/or increased oxygen requirement.

Rice et al, Tolerability and Efficacy of Treprostinil Dry-Powdered Inhaler in Patients with Pulmonary Hypertension Related to Fibrosing Interstitial Lung Disease at a Large Tertiary Referral Center, 2023 Pulmonary Hypertension Professional Network Symposium, September 28-30, 2023 [Poster]

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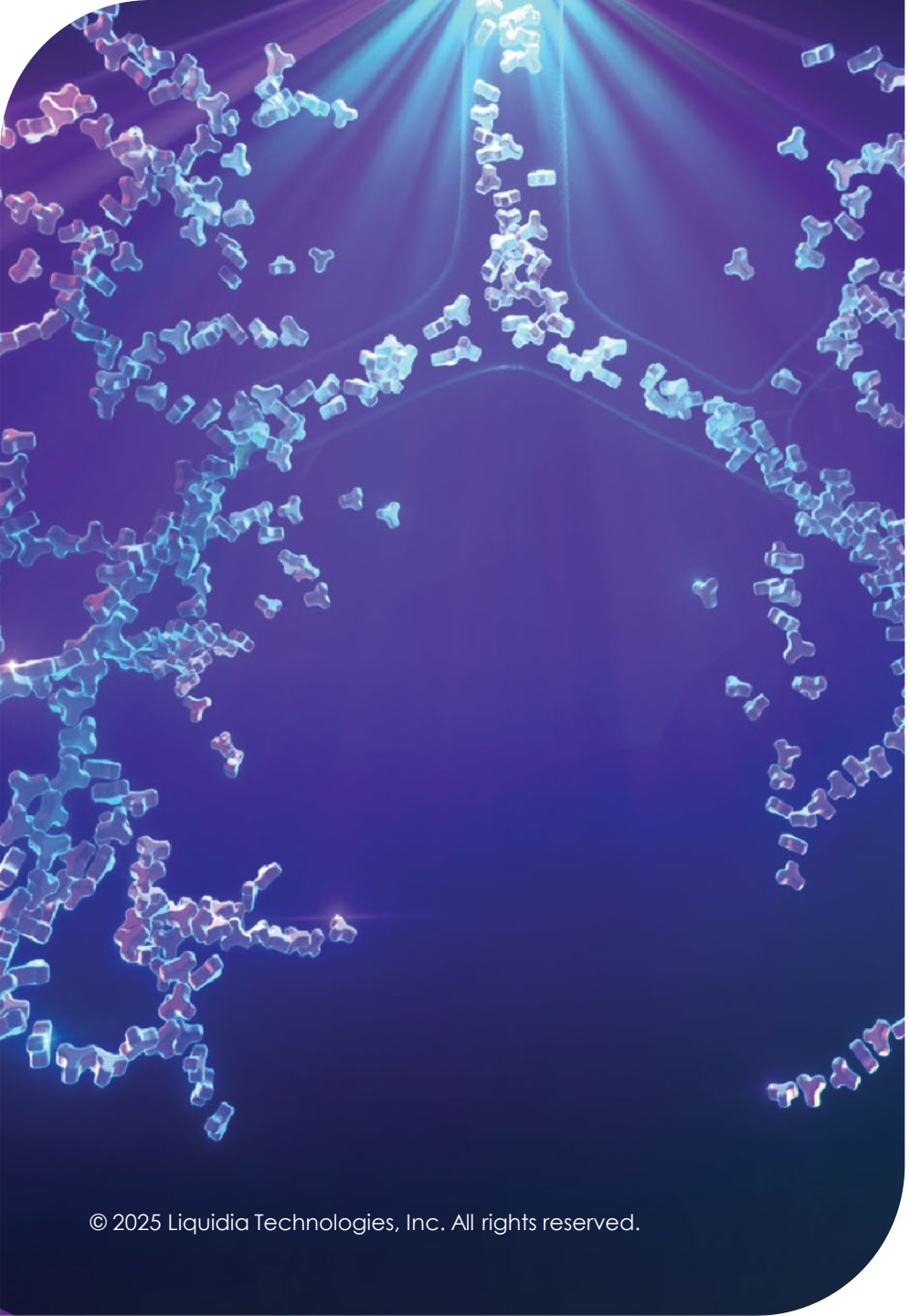

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Yutrepia™ (treprostinil) inhalation powder

APPROVED FDA May 23, 2025

YUTREPIA is a dry-powder formulation of treprostinil enabled by PRINT® technology[1] designed for

- **Enhanced** deep-lung delivery[1–3]
- **Ease of use** with a low-effort device[1,4–6]
- **Titration** to higher therapeutic doses[1,7]

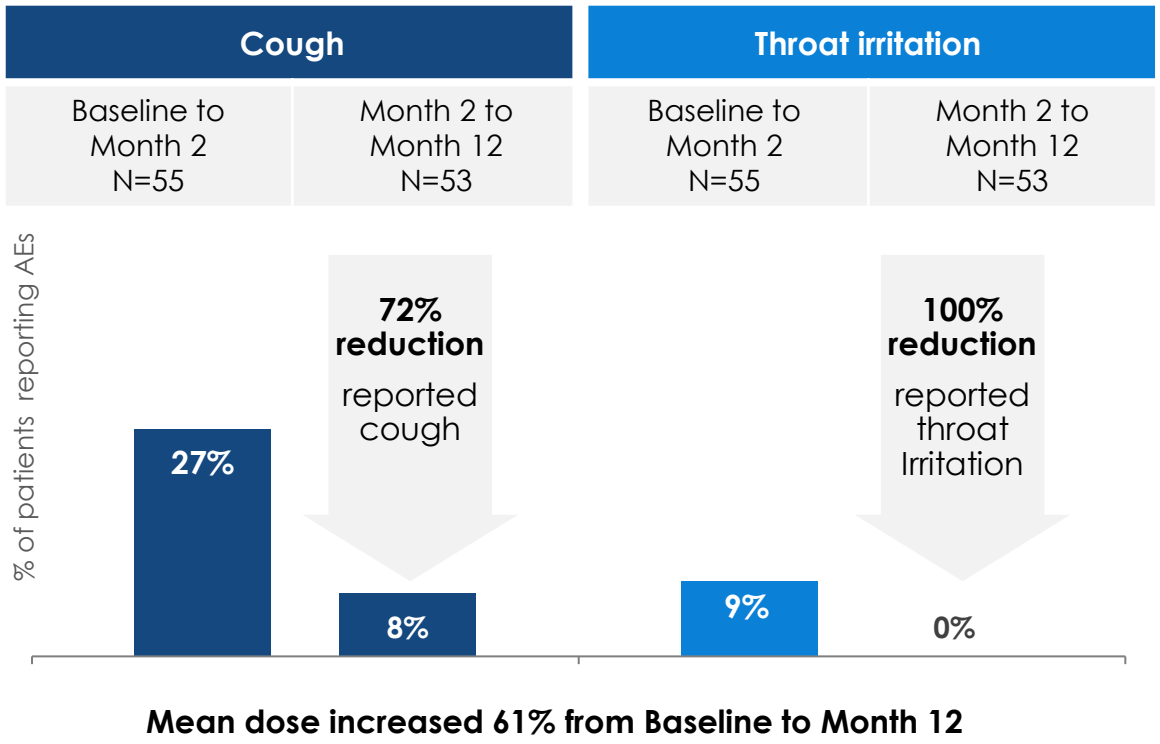
PRINT® is a registered trademark of Liquidia Technologies, Inc.

1. Hill NS et al. *Pulm Circ*. 2022;12(3):e12119. doi:10.1002/pul2.12119 **2.** Garcia A et al. *J Drug Deliv*. 2012;2012:941243. doi:10.1155/2012/941243 **3.** Roscigno RF et al. *Vascul Pharmacol*. 2021;138:106840. doi:10.1016/j.vph.2021.106840 **4.** Patel S et al. Robustness of YUTREPIA, a dry-powder inhaled formulation of treprostinil, in patient misuse scenarios. Poster presented at: CHEST 2022 Annual Meeting; October 16-19, 2022; Nashville, TN. **5.** Price D et al. *Multidiscip Respir Med*. 2015;10:36. doi:10.1186/s40248-015-0033-0 **6.** National Health Service Sunderland. Sunderland COPD Inhaler Guide. National Health Service; 2020. **7.** YUTREPIA. Prescribing information. Liquidia Technologies, Inc; 2024.

INSPIRE study reinforced tolerability profile of Yutrepia over time

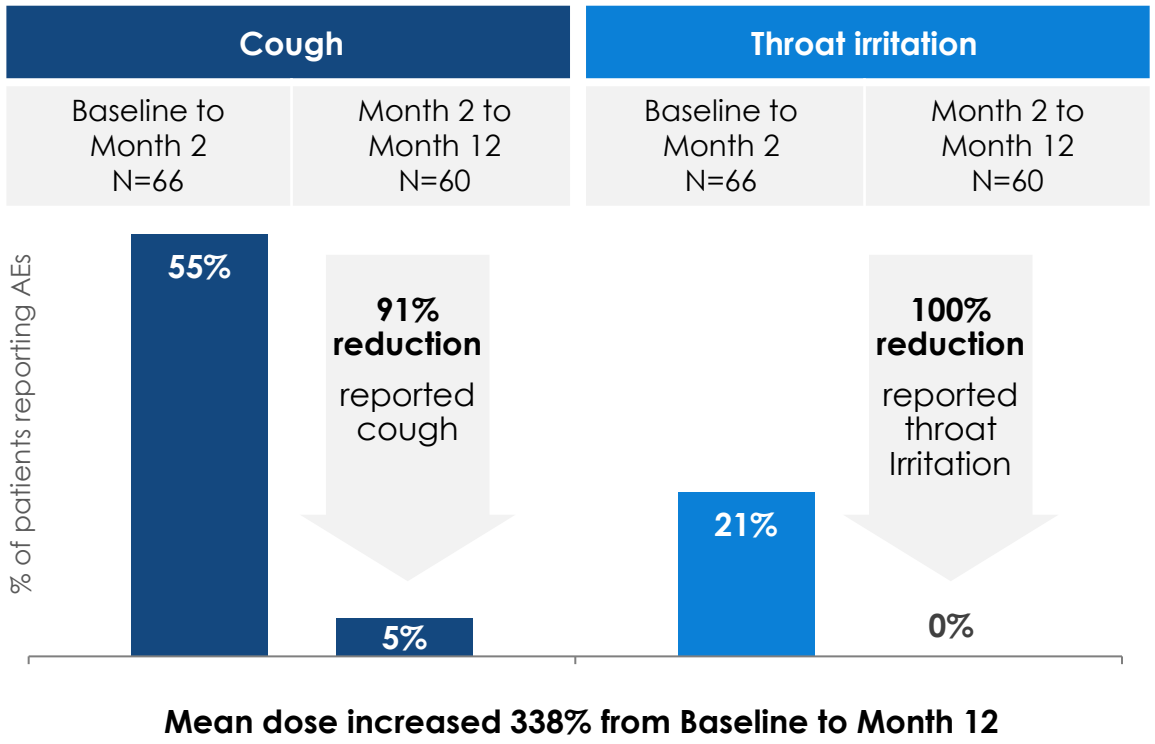
Important related TEAEs decreased from Month 2 to Month 12[1,2,3]

Tyvaso transition patients



Mean dose increased 61% from Baseline to Month 12

Patients naïve to prostacyclin



Mean dose increased 338% from Baseline to Month 12

1. Yutrepia Prescribing Information, Table 2: Adverse Reactions Occurring in ≥ 4% of Patients in the INSPIRE Study; 2. Hill et al, "Safety and Tolerability of LIQ861 in Pulmonary Arterial Hypertension (PAH): Results From INSPIRE Study" Poster, ATS 2022; 3. Liquidia Data on File

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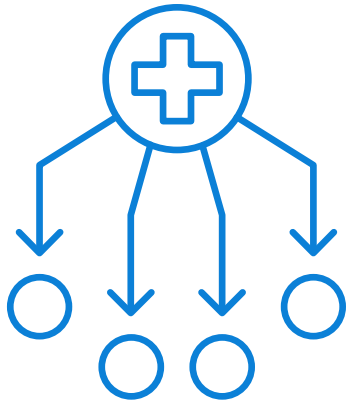
Standard of care is rapidly changing with new options Real world experience

Major themes of a changing landscape



- **Dose matters in PAH and PHILD**
- **Inhaled therapy to avoid or delay the need for parenteral**
- **Facilitating transition off parenteral with addition of sotatercept**
- **Inhaled therapy allowing physicians to start prostacyclin earlier**
- **New delivery methods are allowing higher doses of treprostinil**
- **Transitioning from oral prostacyclin pathway drugs to inhaled**

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ASCENT Study in PH-ILD @ Week 24

YUTREPIA™ (treprostinil) inhalation powder

Dr. Rajan Saggar, MD

Liquidia

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ASCENT Cohort A

Open-label, Multicenter Study to Evaluate Safety and Tolerability of LIQ861 in Patients with Newly Diagnosed PH-ILD

PATIENTS

- N=54
- Age 18-80 years

KEY INCLUSION CRITERIA

- mPA ≥30 mmHg & PVR ≥3 WU or
- mPA ≥21 mmHg & PVR ≥3 WU*
- Baseline 6MWD ≥125m
- CT Chest consistent with ILD or CPFE
- FEV_1/FVC ≥70%

Screening 28 days	52-week TREATMENT PERIOD LIQ861+ RS00 Model 8 Dry Powder Inhalation (DPI) Device				
Week	**D1 Baseline**	**Week 8**	**Week 16**	**Week 24**	**Week 52**
Target Dose (mcg) QID	**26.5**	**132.5**	**159**	**185.5**	**EOS**

PRIMARY SAFETY ENDPOINTS

- **Incidence of treatment-emergent drug- or device-related AEs and serious AEs**

EXPLORATORY ENDPOINTS

- Echocardiogram
- Dyspnea-12, Emphasis 10, simplified cough score
- 6MWD & cardiac effect
- CT CHEST

6MWD=6-Minute Walk Distance; CE=cardiac effect; CT=computed tomography; CPFE=combined pulmonary fibrosis and emphysema; FEV1/FVC=forced expiratory volume in 1 second to forced vital capacity; ILD=interstitial lung disease; WU=wood units; PH-ILD=pulmonary hypertension associated with interstitial lung disease. Reference: LTI-401 Protocol, p.20-22.

*Limited subset of patients

ASCENT (NCT06129240)

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Most PH-ILD patients remained on treatment at Week 24

ASCENT: Week 24

Assessed for Eligibility (n=73)

↓

Received LIQ861 (n=54)

↓

Completed Week 24 of Study Assessment (n=39)

Patients	@ Week 8		@ Week 16		@ Week 24	
Completed n (%)	53	(98.1)	43	(79.6)	**39**	**(72.2)**
Missed Study visit	-	-	1	(1.9)	-	-
Discontinued	1	(1.9)	10	(18.5)	**15**	**(27.8)**
Physician Decision			1	(1.9)	1	(1.9)
Withdrawal of Patient			2	(3.7)	2	(3.7)
Protocol Violation			1	(1.9)	3	(5.6)
Lung Transplant*			3	(5.6)	3	(5.6)
Adverse Event	1	(1.9)	3	(5.6)	6	(11.1)
	• lung neoplasm		• lung neoplasm • chronic pancreatitis • coronavirus		• lung neoplasm (2) • bronchitis (1) • chronic pancreatitis (1) • coronavirus (1) • sudden cardiac death (1)	

*Lung transplant listing was approved upon enrollment per agreement with Sponsor; transplantation was expected to occur ~ 3 months pending donor availability; Liquidia Data on File.

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Baseline demographics

ASCENT: Week 24

Naïve PH-ILD	N=54
Age, mean ±SD, y	68.5 ± 8.9
Sex, Female (%)	28 ± 51.9%
Duration of PH Diagnosis, y	0.5 ± 0.8
Duration of ILD Diagnosis, y	5.1 ± 5.7
ILD Subtypes (%)	
IIPs	26 (48.1%)
Autoimmune ILDs	19 (35.2%)
HP	1 (1.9%)
Other ILDs	3 (5.6%)
CPFE	5 (9.3%)
# Background antifibrotics, n (%)	
Nintedanib	19 (35.2%)
Pirfenidone	4 (7.4%)
Background PH Drugs, n (%): **PDE5i**	7 (13%)

Peak Inspiratory Flow Rate (L/min)	**Mean = 90.6** ± 22.3 Median = 90.0 Range = 39-120

Hemodynamics	Mean ±SD
mPAP (mmHg)	33.4 ± 8.4
PCWP (mmHg)	8.6 ± 3.3
Cardiac Output (L/min)	4.5 ± 0.9
PVR (WU)	6.0 ± 2.9

Pulmonary Function Test	Mean ±SD
FVC, L	2.07 ± 0.767
FVC (% predicted)	65.9 ± 20.7
FEV1/FVC	79.6 ± 17.1
DLCO (% predicted)	36.2 ± 13.9

Clinical Characteristic		Mean ±SD
6MWD (Meters), ±SD		298.1 ± 80.3
NTPro-BNP (pg/ml)	[GM=210.5]	611.0 ± 1246.0
Dyspnea-12		11.7 ± 6.8
EmPHasis-10		24.6 ± 9.7
Simplified Cough Score		1.3 ± 0.8

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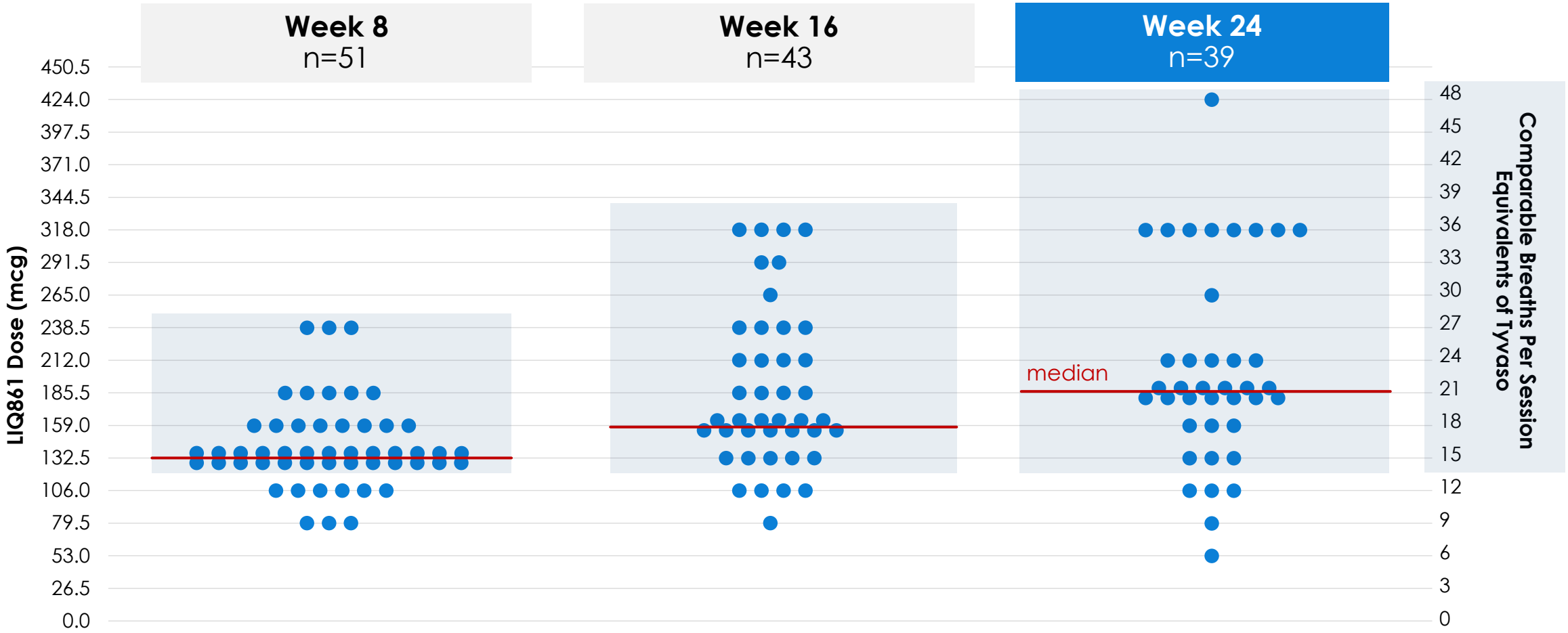
At each time point, more than 80% patients receive ≥ 132.5 mcg

ASCENT: Week 24



Liquidia Data on File; at Week 16, one patient discontinued dosing on clinic visit, which is recorded as 0 mcg

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No significant changes in tolerability as dose was titrated

ASCENT: Week 24 (n=54)

	Cumulative TEAEs		
Treatment-related TEAEs n (%)	**Week 8**	**Week 16**	**Week 24**
Median Dose (mcg)	132.5	159	**185.5**
Cough	23 (42.6)	26 (48.1)	**26 (48.1)**
Headache	7 (13.0)	10 (18.5)	**10 (18.5)**
Oropharyngeal pain	3 (5.6)	4 (7.4)	**4 (7.4)**
Fatigue	2 (3.7)	4 (7.4)	**4 (7.4)**
Throat Irritation	2 (3.7)	4 (7.4)	**4 (7.4)**
Diarrhea	2 (3.7)	3 (5.6)	**3 (5.6)**
Dry Throat	3 (5.6)	3 (5.6)	**3 (5.6)**

Cough Severity

- Mild n=24 (44.4)
- Moderate n=2 (3.7)

No discontinuations due to cough at Week 24

- **No treatment-related SAEs**
- Treatment related AE's predominantly mild to moderate

Treatment-emergent adverse event.(TEAE); AE reported if > 5%; severe TEAEs (n=2): respiratory tract irritation (1); hypoxia (1)
Liquidia Data on File

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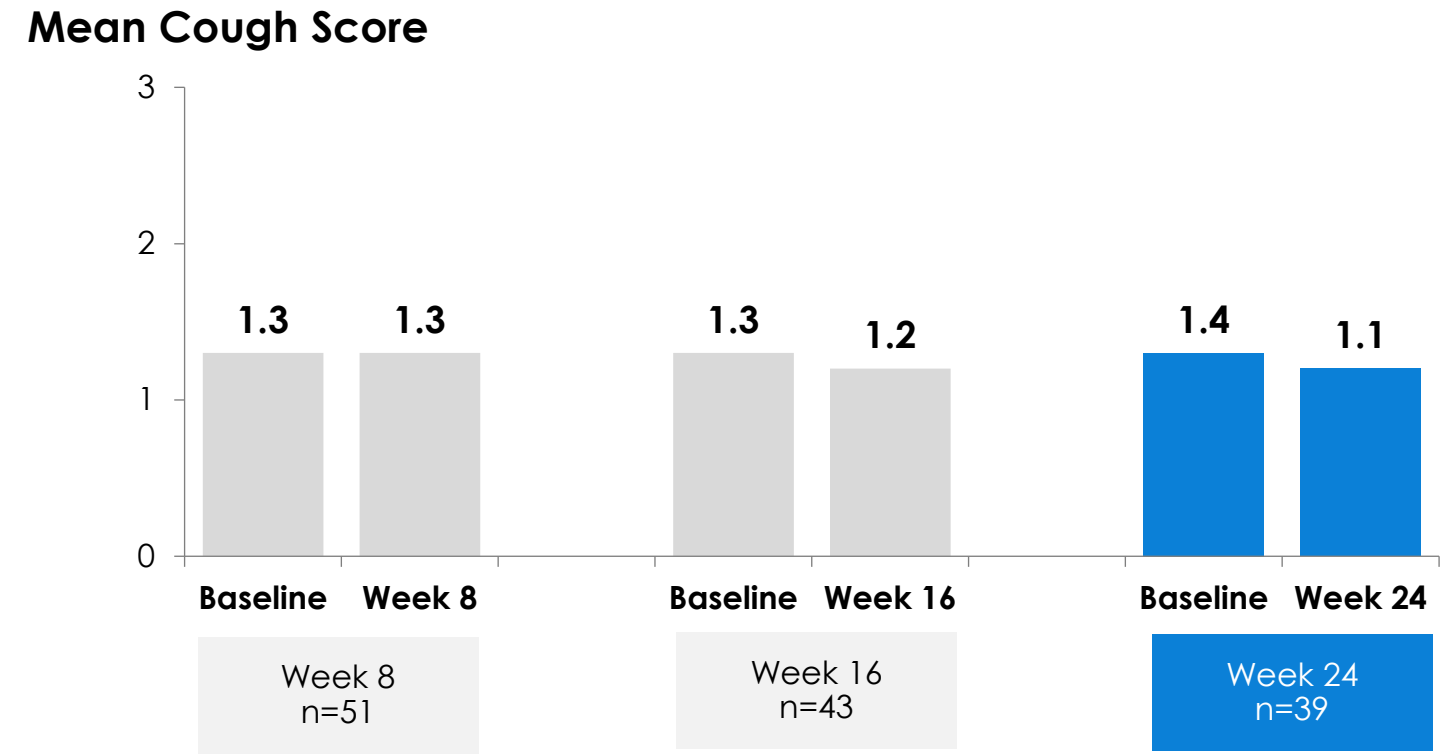
Mean daytime cough scores remained stable as dose was titrated

ASCENT: Week 24

Score	Daytime Cough
0	**No cough**
1	**Transient cough** occasionally during the daytime
2	**Frequent cough** mildly affecting daily life
3	**Frequent cough** severely affecting daily life

Instructions: The patient should circle the score that best describes their cough over the past two weeks

Cough Scores from Baseline to Week 8, Week 16, Week 24



Wang Z, Wang M, Wen S, Yu L, Xu X. Types and applications of cough-related questionnaires. *J Thorac Dis*. 2019 Oct;11(10):4379-4388.
Liquidia data on file

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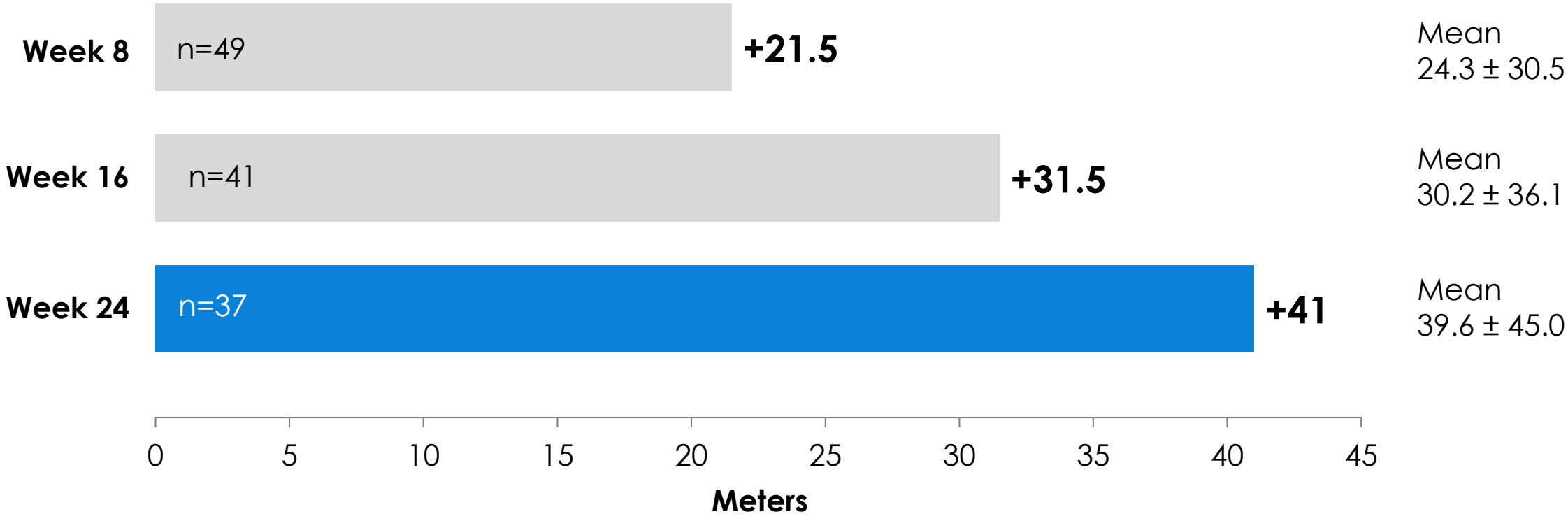
Δ6MWD from baseline continued to increase

ASCENT: Week 24

Median change from baseline in 6MWD



Mean ± Standard Deviation, Liquidia data on file

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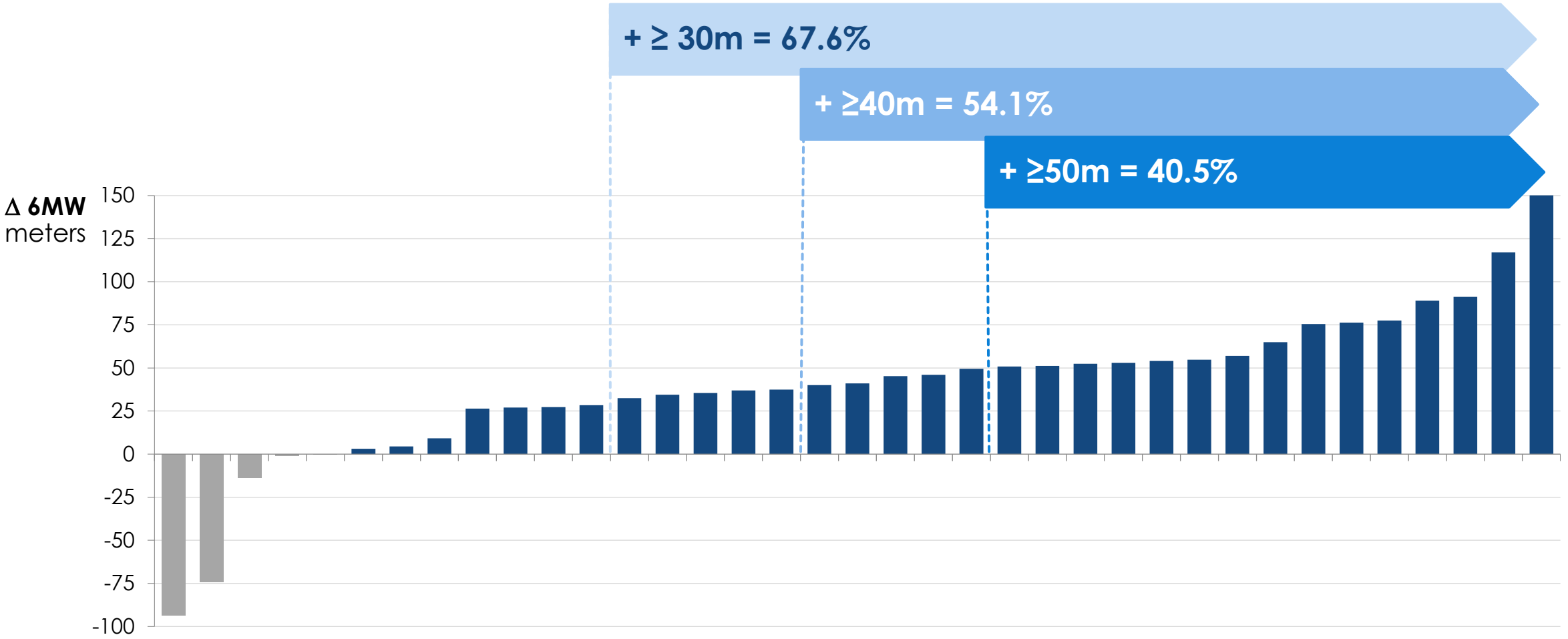
Most patients improved Δ6MWD by at least 40 meters (54%)

ASCENT: Week 24 by patient



Liquidia Data on File

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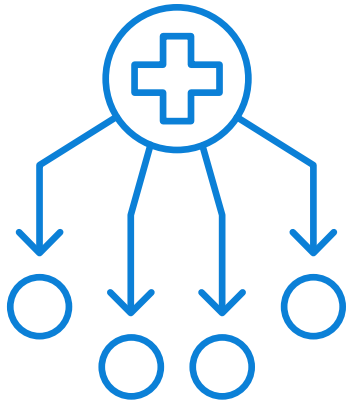
Summary of ASCENT at Week 24

Thoughts on PH-ILD at UCLA



- **Patients continue to titrate to higher doses**
- **No meaningful change in tolerability**
- **Continued improvement in Δ6MWD to +41 meters**

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L606 (treprostinil liposomal inhalation suspension)

Dr. Rajeev Saggar

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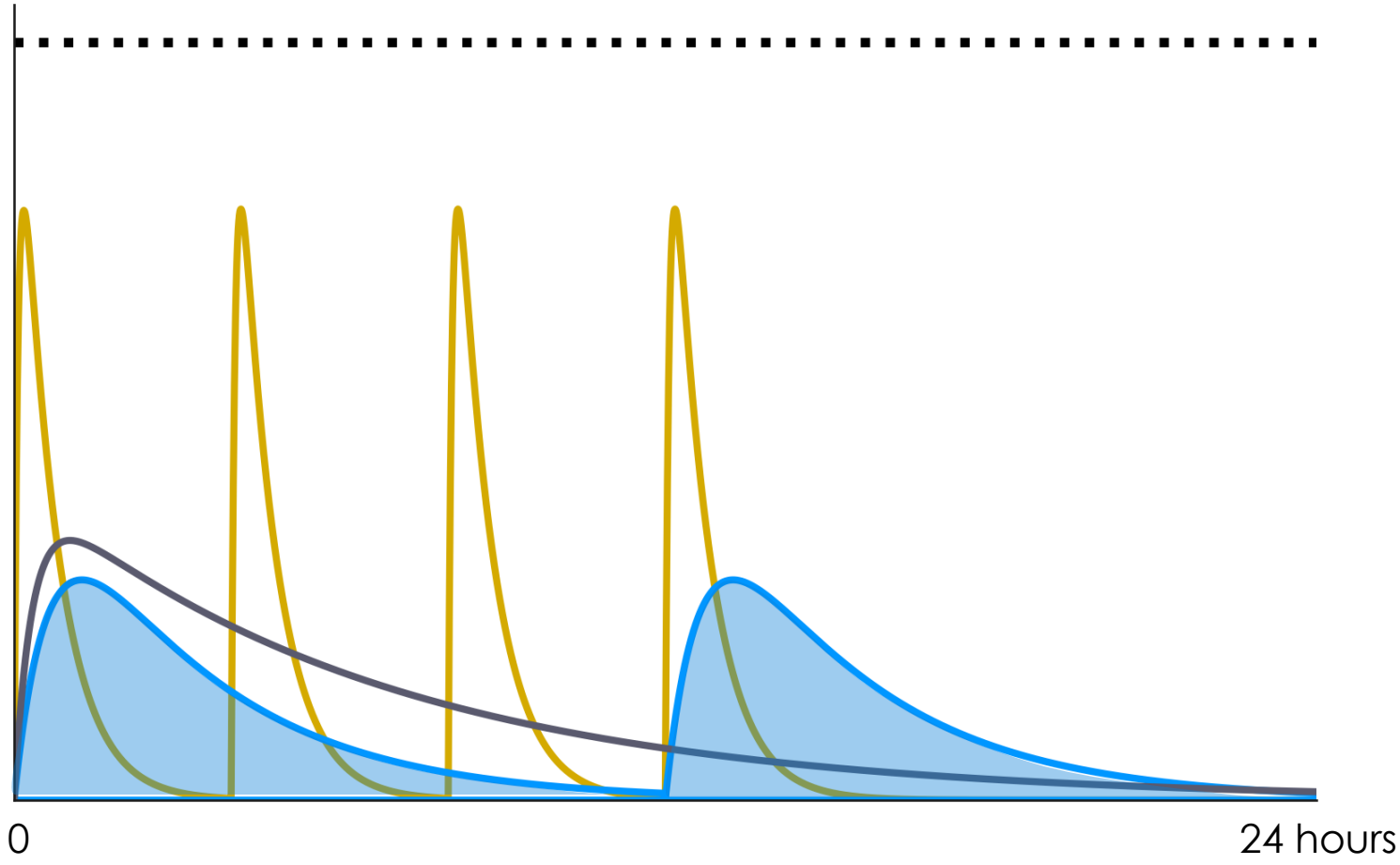
Classic formulation challenge to optimize exposure over 24 hours

Illustrative example



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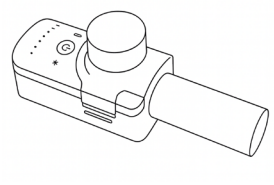
Introduction to L606 Liposome technology

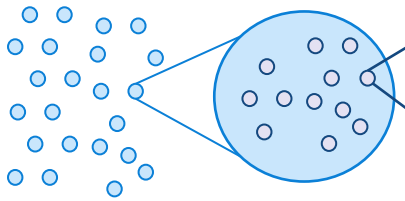
Nanosized liposomes are delivered in micron sizes aerosol droplets

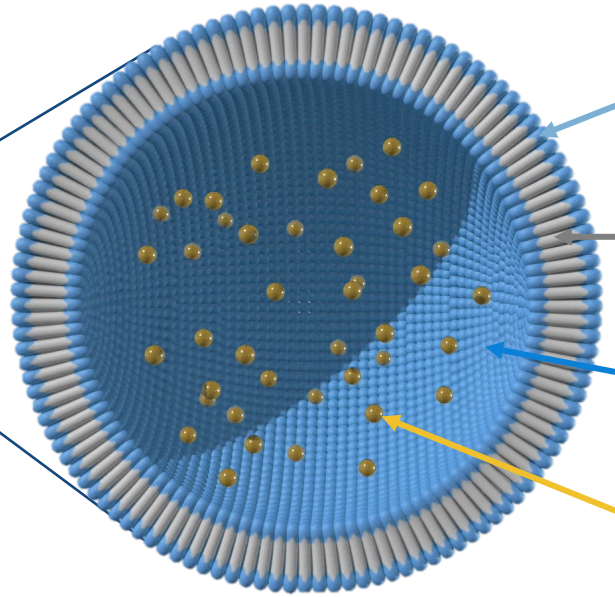
Vibrating Mesh nebulizer

Aerosol Droplet ~4 µm
contain liposomes

A single liposome is between 100-140nm







Phospholipids

Bilayer lipid membrane

Inner Aqueous Compartment

Treprostinil

Pulses to form aerosol droplets

Aerosol Droplets

Single droplet contains liposomes

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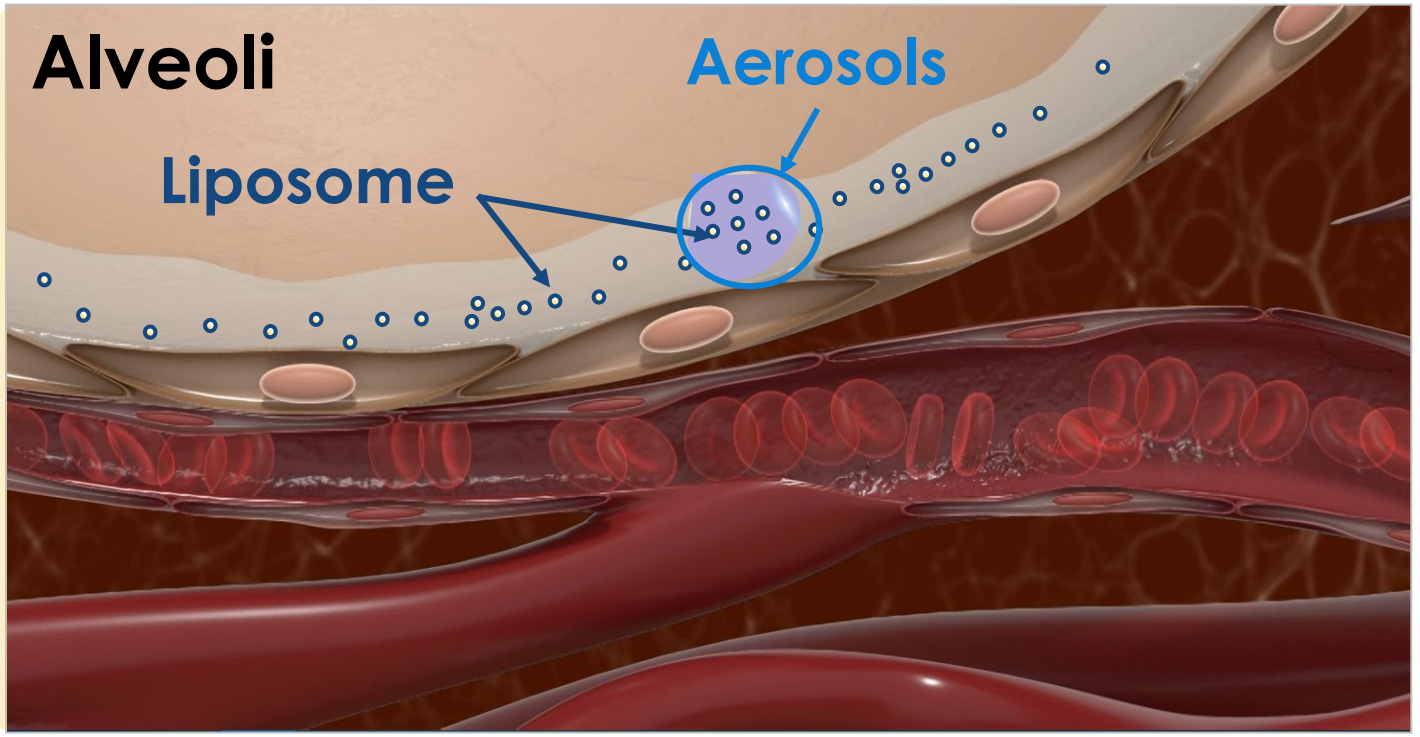
Liposome-containing aerosols are deposited in lung periphery

Pulmonary pharmacokinetics of inhaled L606 liposomes



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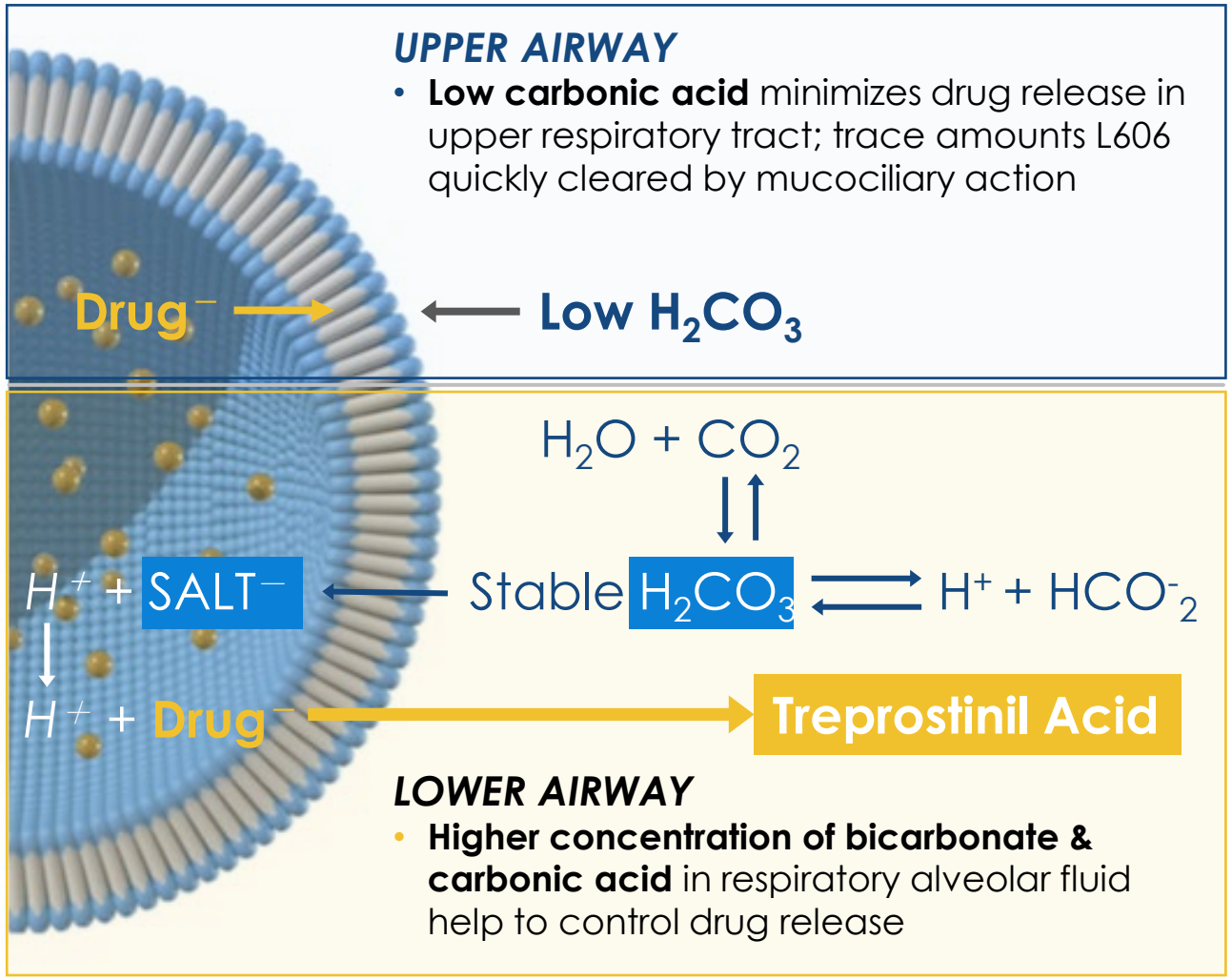
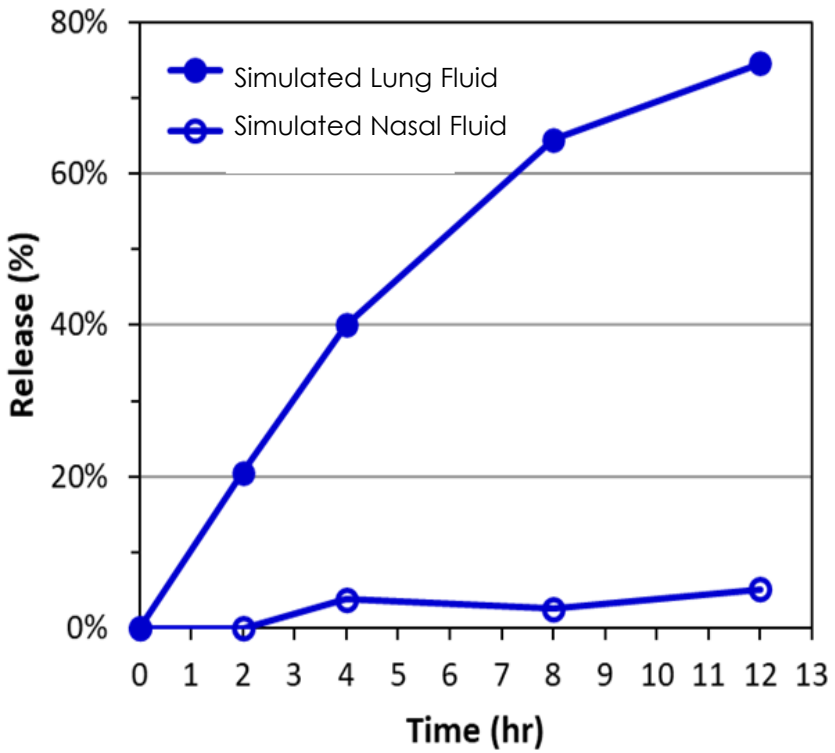
Liposomes extended drug release with salt-sensitive process



- **Controlled release rate in lower airway**



- **Minimal release rate in upper airway**

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Phillips Medisize
a molex company

FOX™ Vibrating Mesh Nebulizer

The FOX device is a handheld, breath-activated, battery-powered inhalation system that delivers nebulized liquid drugs with high performance using a vibrating mesh technology.

The FOX device is suitable for the delivery of small molecules and biologics formulated as solutions or nanosuspensions.

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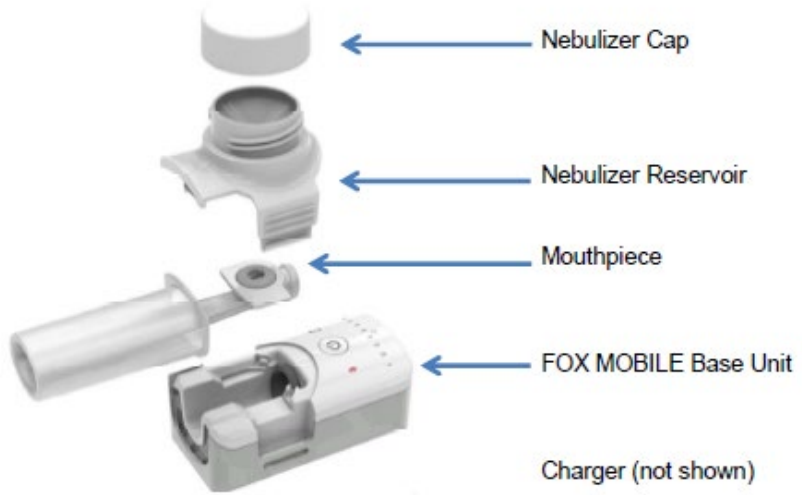
L606 can be rapidly administered in about 1 minute

Highly portable vibrating mesh nebulizer delivers L606 doses of less than 500µL

Older technology

FOX Mobile uses breath-activated technology



L606 drug is supplied in 6 different dose strengths in disposable ampules that are used in combinations across a wide dose range

Tyvaso® is registered trademark of United Therapeutics Corporation

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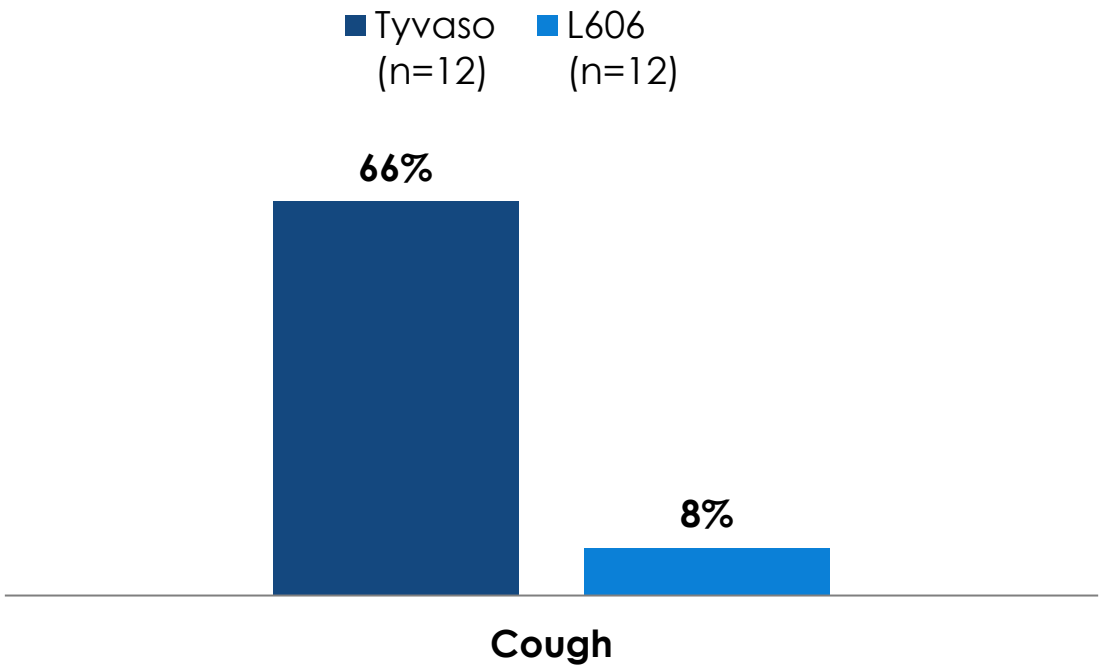
Phase 1 cross-over study supports similar PK, better tolerability

Subjects were healthy volunteers

7.3-fold lower C_{max} with similar AUC

PK Parameters[1]		Tyvaso n = 12	L606 n = 12
Dose	µg	54	51
T_{max}	h (median)	0.18	1.25
C_{max}	pg/mL	**1090 (38.4)**	**140 (24.0)**
AUC_{inf}	h*pg/mL	**1040 (27.5)**	**1050 (18.3)**
T ½	h	0.445 (14.6)	4.81 (29.2)
CL/F	L/h	52.0 (27.5)	48.8 (18.3)

Lower cough incidence with L606 in SAD study



*Geometric mean (geometric CV%)

1. Phase 1 (Part B) as published in Tully et al. Clinical Pharmacokinetics of an Extended-Release Formulation of Inhaled Liposomal Treprostinil (L606) to Reduce Dosing Frequency [POSTER]. Pulmonary Vascular Research Institute (PVRI) 2024 Annual Congress; 2024 Feb 2, London.

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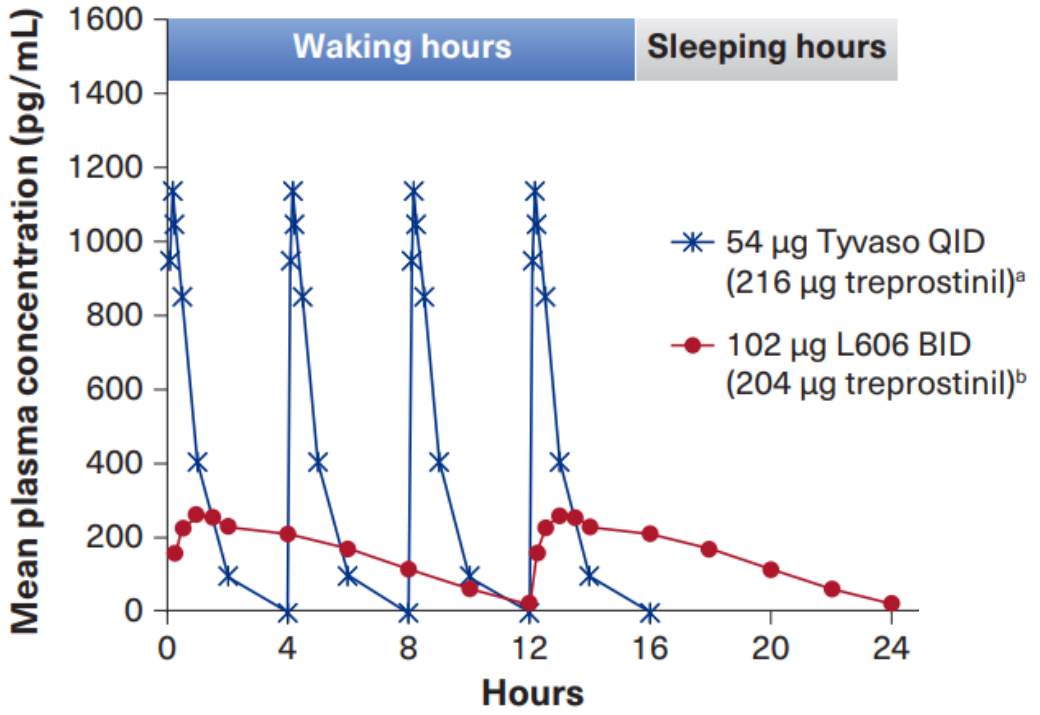
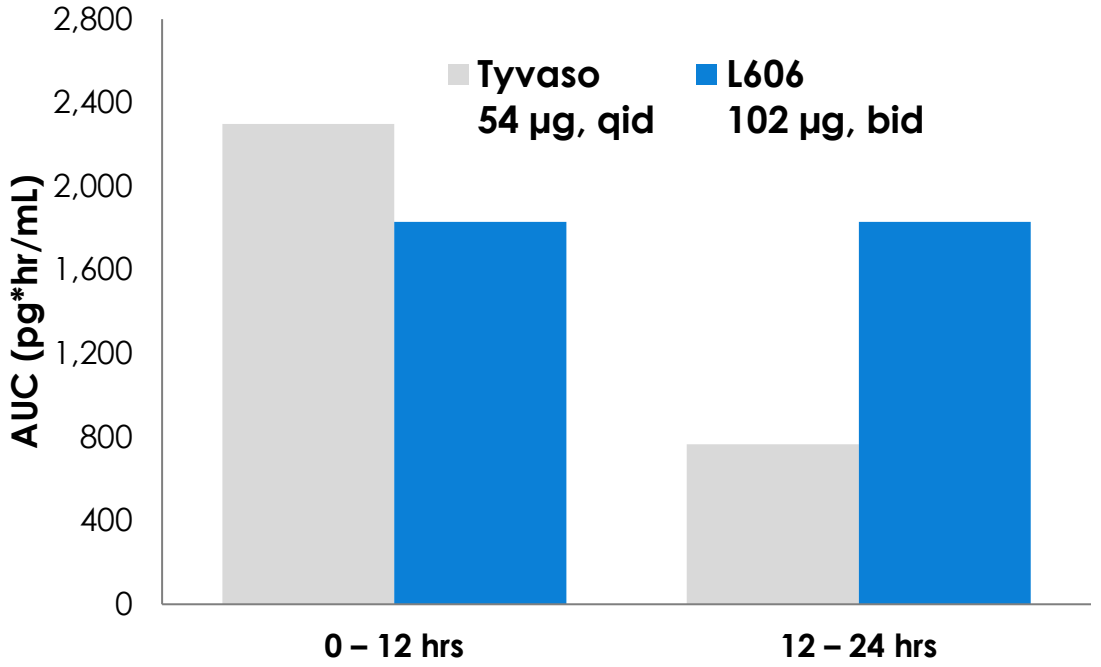
L606 provides more consistent exposure over 24 hours with bid dosing

Provides therapeutic levels during sleeping hours

Modeled AUC of daily dosing (24hrs) is similar



L606 offers more consistent exposure



Tully et al. Clinical Pharmacokinetics of an Extended-Release Formulation of Inhaled Liposomal Treprostinil (L606) to Reduce Dosing Frequency, Pulmonary Vascular Research Institute (PVRI) 2024 Annual Congress; 2024 Feb 2, London.

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Clinical Data from U.S. Open-Label Study

L606 (treprostinil liposomal inhalation suspension)

Dr. Ricardo Restrepo-Jaramillo

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Phase 3 study evaluating safety & tolerability in PAH or PH-ILD patients

Initiated by Pharmosa in 2021 and amended and led by Liquidia since July 2023

PATIENTS

- N=28
- Age 18-80 years

KEY INCLUSION CRITERIA

Cohort A (Transitions):

- PAH and PH-ILD
- Stable on Tyvaso

Cohort B (Naïve):

- PAH
- Naïve to prostacyclin

Screening 28 days	48-week TREATMENT PERIOD L606 + Vibrating mesh nebulizer				
Week	**Week 2,4,8**	**Week 12**	**Week 24**	**Week 36**	**Week 48**
Endpoints	●	● Δ	● Δ	● Δ	● Δ

● PRIMARY SAFETY ENDPOINTS

- **Incidence of treatment-emergent drug- or device-related AEs and serious AEs**

Δ EXPLORATORY ENDPOINTS

- **Change in peak and trough 6MWD**
- **Treatment Satisfaction Questionnaire for Medication (TSQM)** transition patients only

Link to clinicaltrials.gov: NCT04691154

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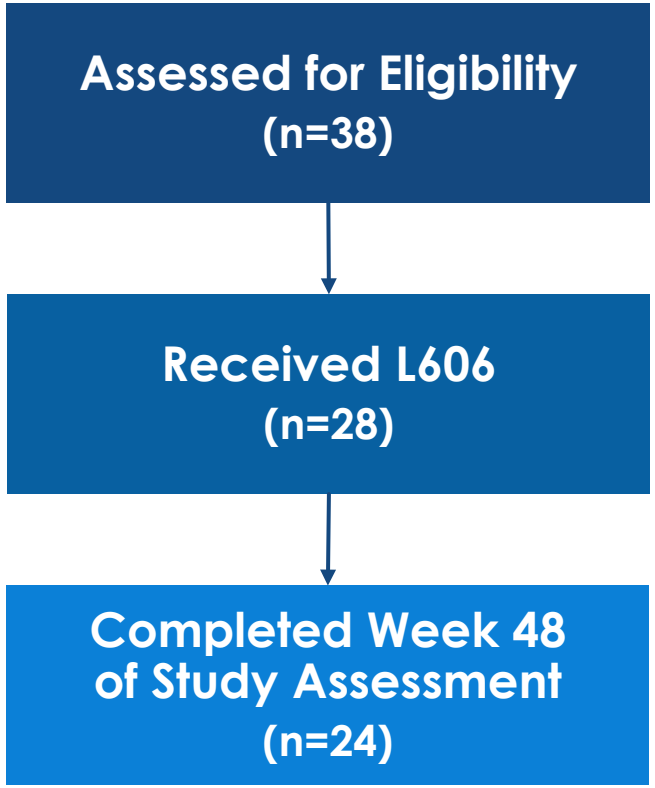
Most patients continued treatment with L606

L606 Open-Label (U.S.): Week 48



Patients Completed Week 48 Visit, n (%)		
Completed	**24**	**(85.7)**
Discontinued	**4**	**(14.3)**
Protocol Violation	1	
Adverse Event	3	

- Chest discomfort (related, moderate)
- Dyspnea (possibly related, mild)
- Respiratory failure, transplant (not related, severe)

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Participant demographics show naïve patients earlier in disease

L606 Open-Label (U.S.): Week 48

		Cohort A Tyvaso Transition			Cohort B PCY Naïve	Overall
		PAH (N=18)	PH-ILD (N=5)	Total (N=23)	PAH (N=5)	(N=28)
Age, years median (min, max)		64.5 (21, 75)	66 (56, 74)	65 (21, 75)	57 (29, 60)	61 (21, 75)
Female, n (%)		15 (88.9)	1 (20.0)	16 (69.6)	5 (100)	21 (75.0)
White, n (%)		15 (83.3)	4 (80.0)	19 (82.6)	3 (60.0)	22 (78.6)
BMI, kg/m^2 median (min, max)		27.3 (22.3, 39.7)	32.6 (27.3, 36.8)	28.3 (22.3, 39.7)	26.1 (21.7, 33.6)	27.4 (21.7, 39.7)
Duration of Dx, yr median (min, max)		7.8 (0.6, 21.2)	3.9 (1.2, 9.9)	6.95 (0.6, 21.2)	1.05 (0.4, 15.5)	6.57 (0.4, 21.2)
No. PAH Rx, n (%)	1	-	1 (20.0)	1 (4.3)	3 (60.0)	4 (14.3)
	2	1 (5.6)	4 (80.0)*	5 (21.7)	2 (40.0)	7 (25.0)
	3	17 (94.4)	-	17 (73.9)	-	17 (60.7)
NYHA Class n (%)	II	11 (61.1)	2 (40.0)	13 (56.5)	2 (50.0)	15 (55.6)
	III	7 (38.9)	3 (60.0)	10 (43.5)	2 (50.0)	12 (44.4)

*PH-ILD Patients on 2 PAH medicines included inhaled treprostinil & PDE5; body mass index (BMI)

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Baseline disease characteristics show stable population of patients

L606 Open-Label (U.S.): Week 48

	Cohort A Tyvaso Transition			Cohort B PCY Naïve	Overall
	PAH (N=18)	**PH-ILD (N=5)**	**Total (N=23)**	**PAH (N=5)**	**(N=28)**
6MWD, meters* median (min, max)	390.5 (219.7, 525)	396 (231.7, 446)	396 (219.7, 525)	395 (240, 490)	395.5 (219.7, 525)
NT-proBNP, pg/mL median (min, max)	176 (41, 1194)	152 (33, 452)	168 (33.3, 1194)	206.5 (45, 946)	168 (33, 1194)

*6MWD is comparable to other contemporaneous PAH studies at ~400m

Six Minute Walk Distance (6MWD), N-terminal pro B-type natriuretic peptide (NT-proBNP), forced expiratory volume (FEV), forced vital capacity (FVC)

Source: Liquidia Data on File

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Well tolerated with no treatment related SAEs or dose modifications

L606 Open-Label (U.S.): Week 48

	Cohort A Tyvaso Transition			Cohort B PCY Naïve	Overall
	PAH (N=18)	**PH-ILD (N=5)**	**Total (N=23)**	**PAH (N=5)**	**(N=28)**
Any TEAE	15 (83.3)	5 (100)	20 (87.0)	5 (100)	25 (89.3)
Treatment Related TEAE	5 (33.3)	2 (40.0)	8 (34.8)	2 (40.0)	10 (35.7)
Serious TEAE (SAE)	3 (16.7)	2 (40.0)	5 (21.7)	1 (20.0)	6 (21.4)
Treatment Related SAE	-	-	-	-	-
Treatment related TEAE Led to Dose Reduction	1 (5.6)		1 (4.3)	-	1 (3.6)
Treatment Discontinuation	1 (5.6)	1 (20.0)	2 (8.7)	1 (20.0)	3 (10.7)
Death	-	-	-	-	-

Six Minute Walk Distance (6MWD), forced vital capacity (FVC), forced expiratory volume (FEV), N-terminal pro B-type natriuretic peptide (NT-proBNP)
Liquidia data on file

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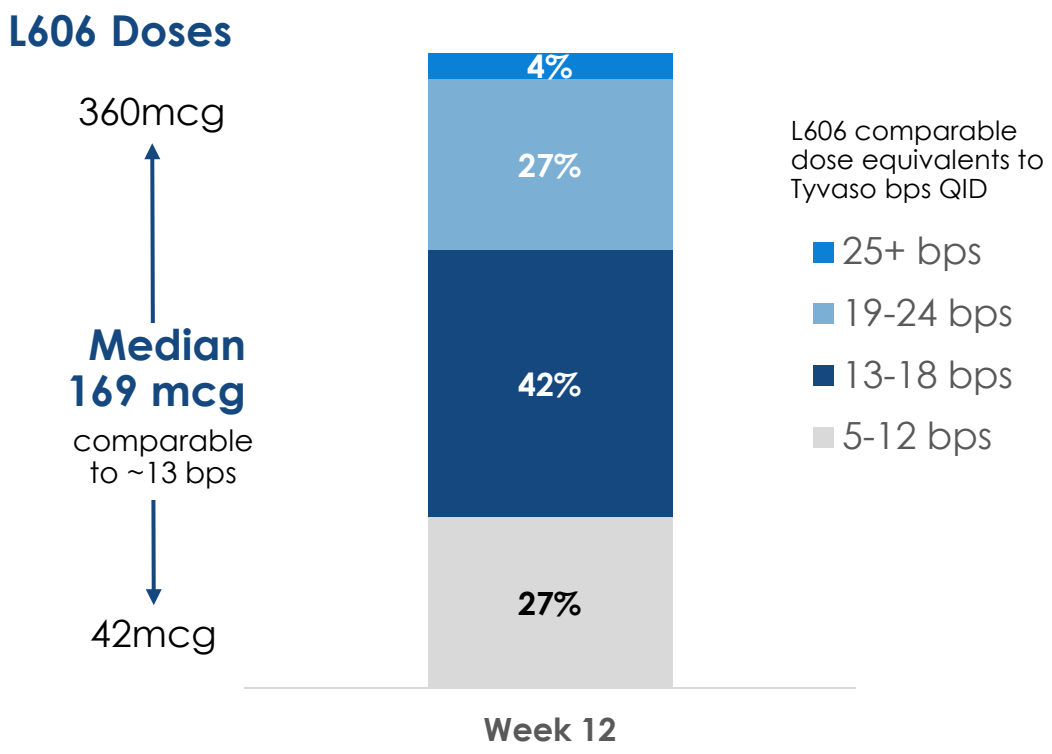
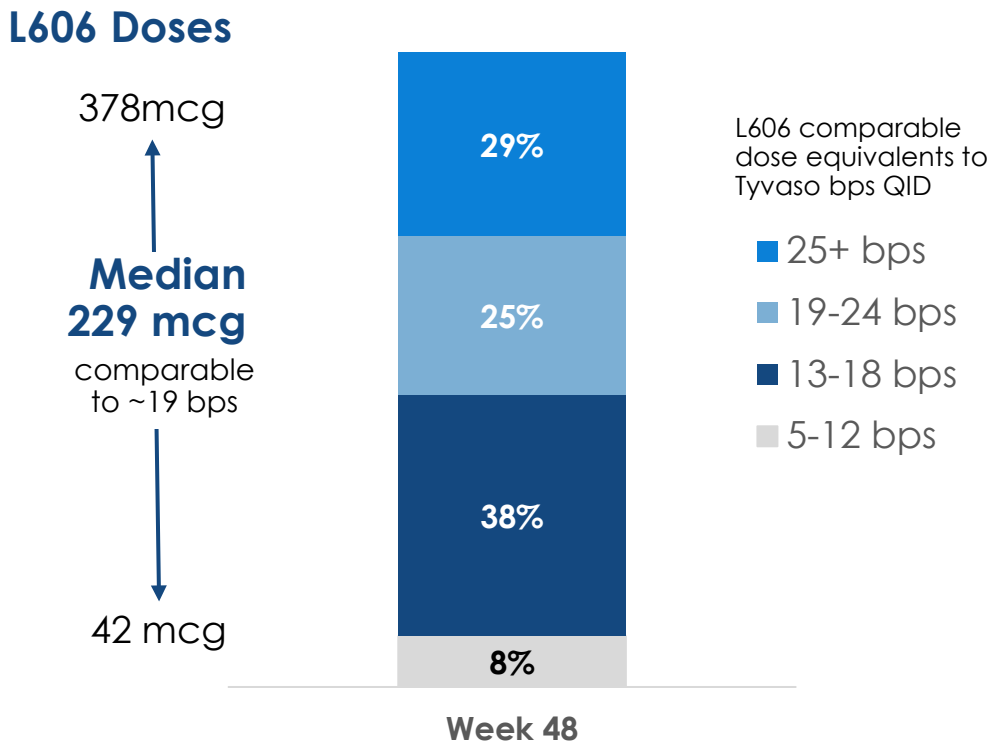
Most patients titrated to doses comparable to >12 bps Tyvaso QID

L606 Open-Label (U.S.): Week 48

Week 12 (n=26)



Week 48 (n=24)



Breaths per session (bps) QID, Liquidia data on file

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L606 is very tolerable with 4 (14%) patients reporting related cough

L606 Open-Label (U.S.): Week 48

Most Common TEAEs Reported > 10 %	TEAE		Related TEAE	
	%	n	%	n
Cough	**32.1**	9	**14.3**	4
Dyspnea	**28.6**	8	**3.6**	1
Fatigue	**21.4**	6	**3.6**	1
Dizziness	**21.4**	6	**3.6**	1
Nausea	**10.7**	3	**3.6**	1
Pruritis	**10.7**	3	**3.6**	1
COVID 19	17.9	5	-	-
Edema	14.3	4	-	-
Nasopharyngitis	10.7	3	-	-
Pneumonia	10.7	3	-	-
Upper Respiratory Tract Infection	10.7	3	-	-
NT-pro-BNP increased	10.7	3	-	-
Arthralgia	10.7	3	-	-
Back Pain	10.7	3	-	-
Hypotension	10.7	3	-	-

Cough Severity	Related TEAE	
	%	n
Mild	14.3	4
Moderate	-	-
Leading to DC	-	-

Liquidia data on file

Liquidia

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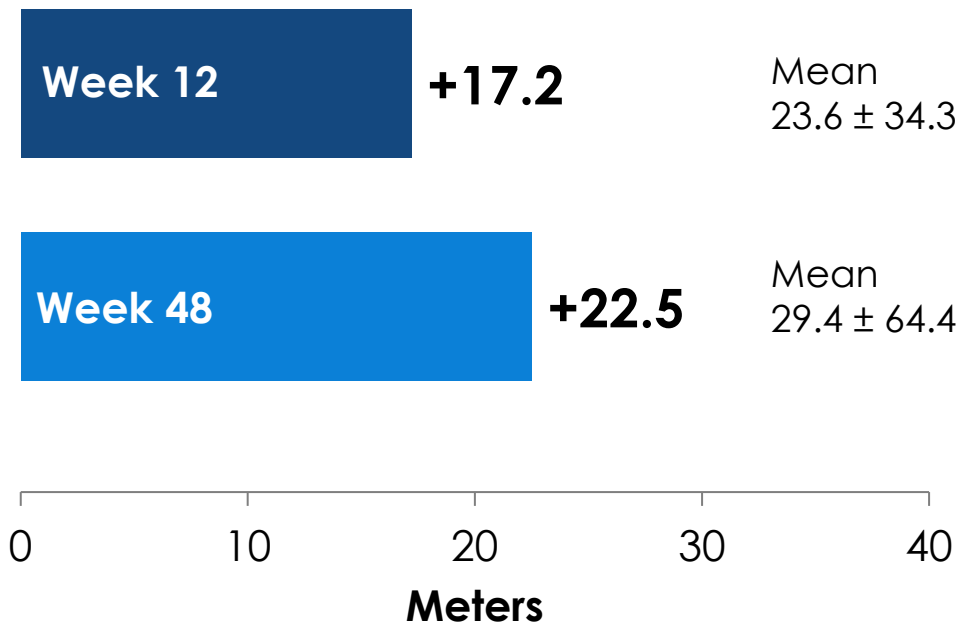
Most patients maintained or improved 6MWD over time

L606 Open-Label (U.S.): Week 48

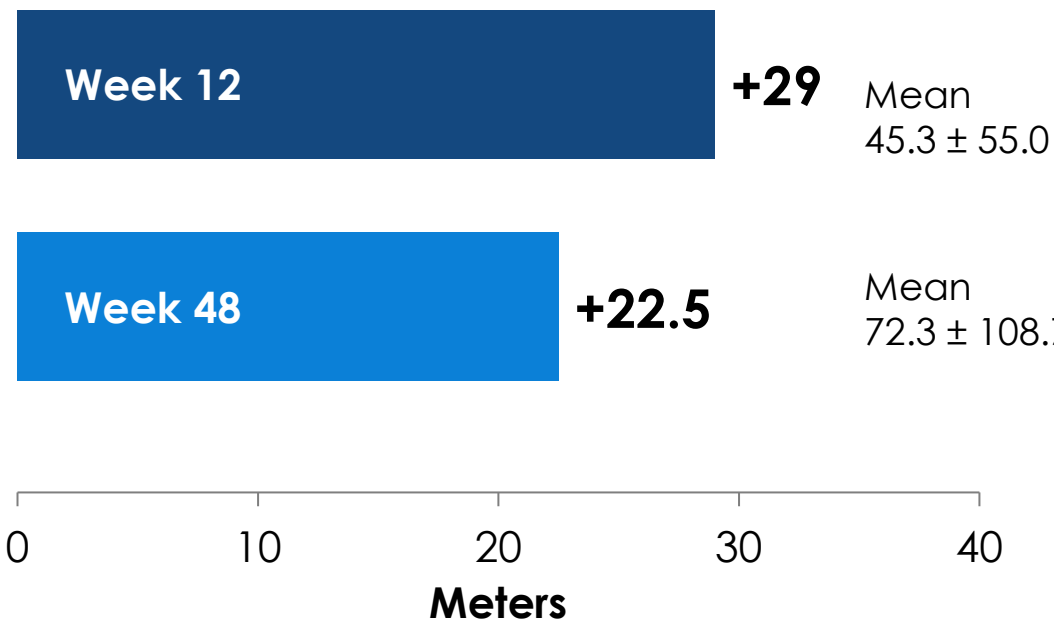
All participants (N=24)

Median change from baseline in 6MWD at peak



Cohort B: PCY Naïve (N=4)

Median change from baseline in 6MWD at peak



Mean ± Standard Deviation, Liquidia data on file

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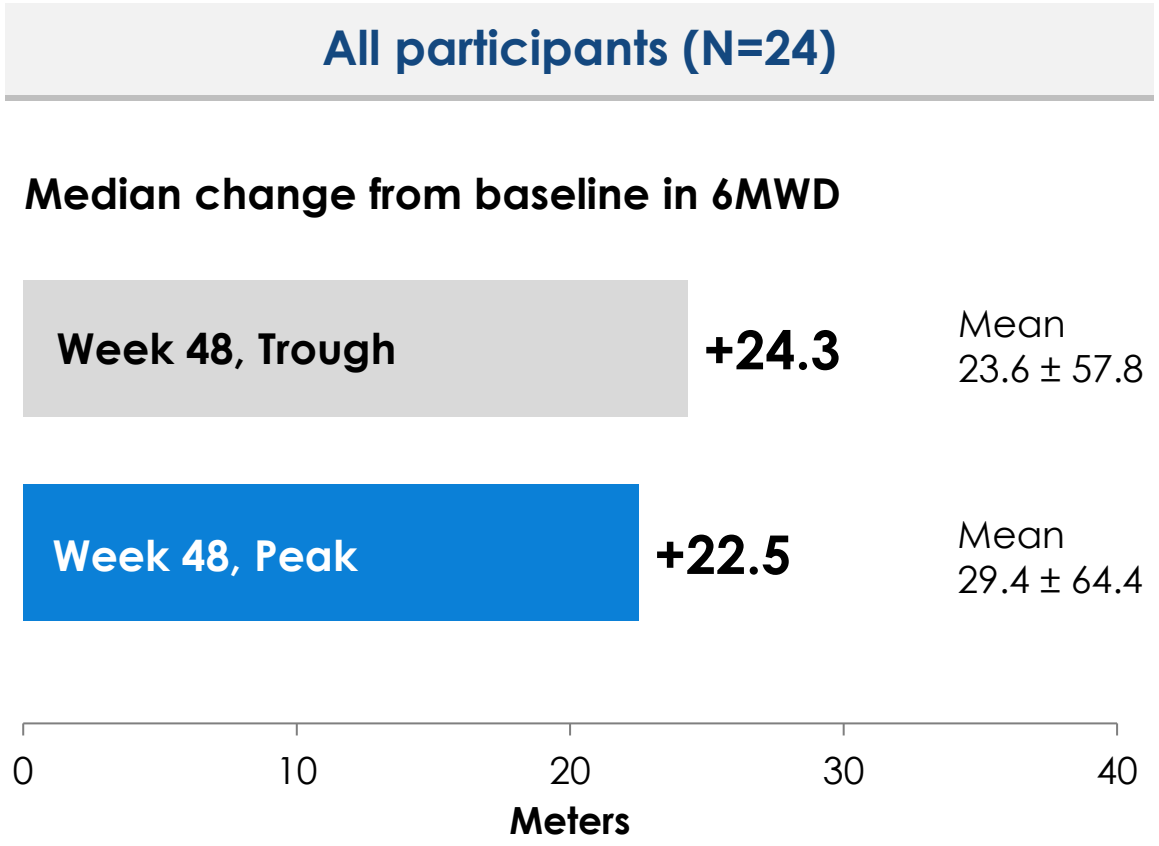
Observed minimal variability between peak and trough measures

L606 Open-Label (U.S.): Week 48



Trough 6MWD conducted in morning of visit; Peak 6MWD conducted within 90-120 minutes after administering clinically observed dose
Mean ± Standard Deviation, Liquidia data on file

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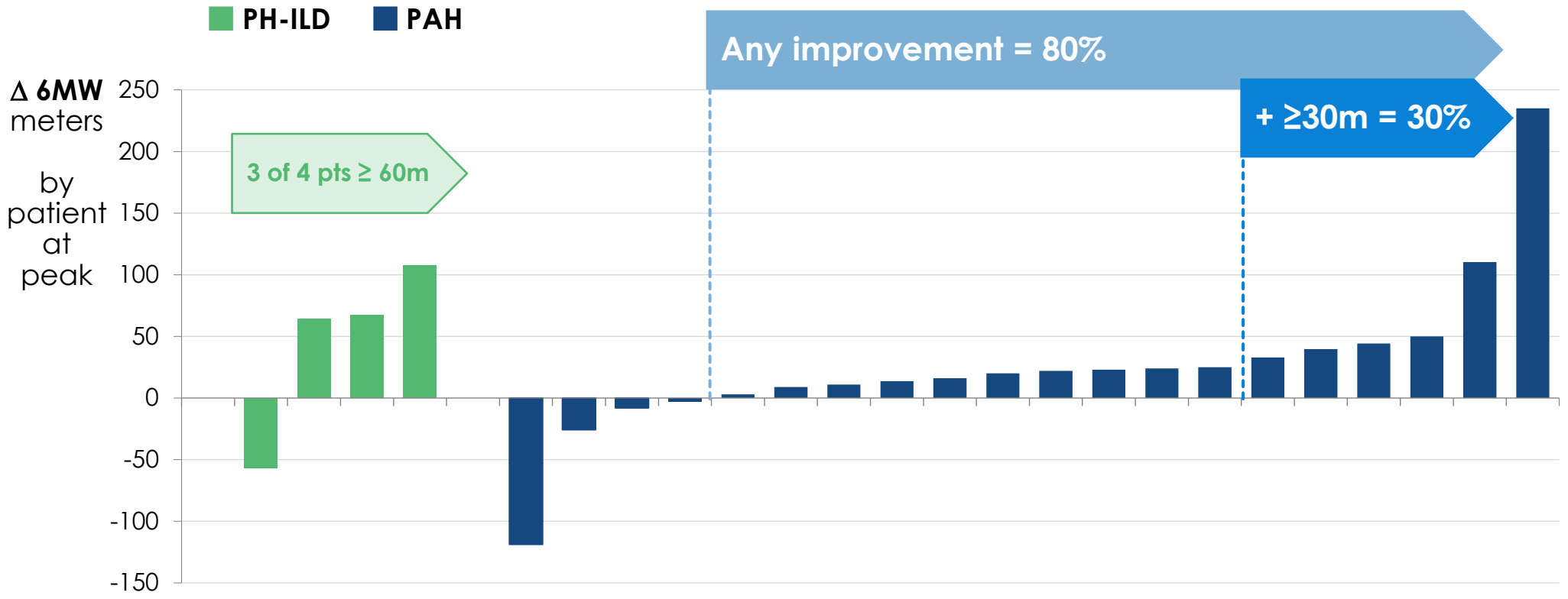
Most patients maintained or improved Δ6MWD at Week 48

L606 Open-Label (U.S.): Week 48



Liquidia Data on File; PAH patient (-118m) had knee surgery prior to conducting the 6MWD at Week 48
Liquidia data on file

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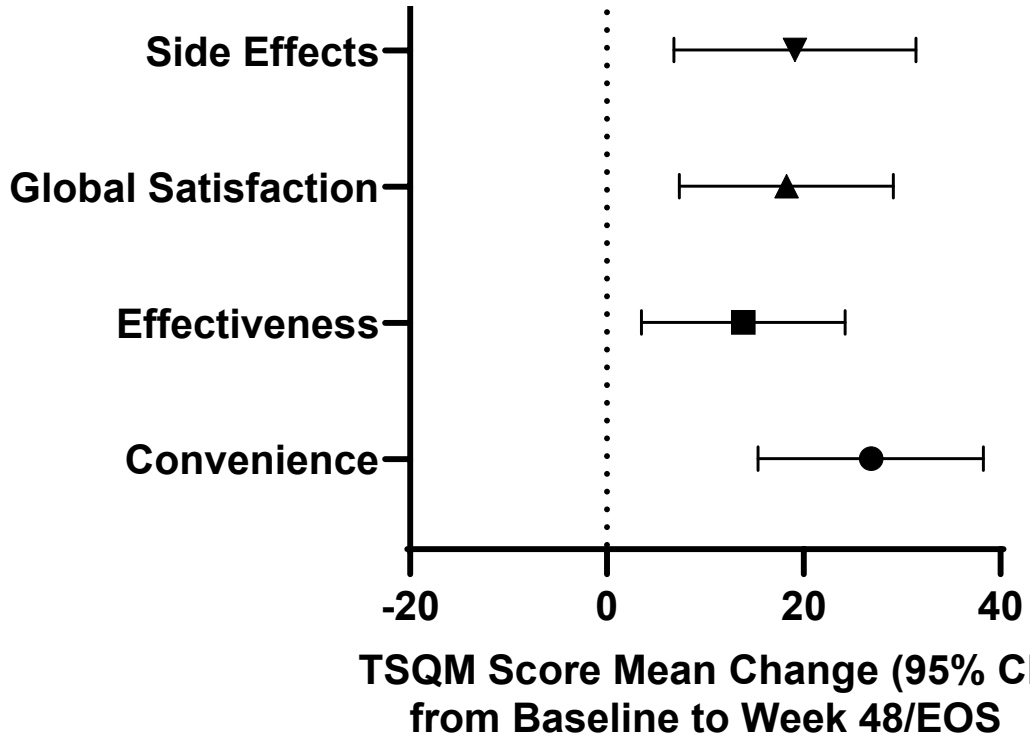
Mean TSQM improved across all dimensions measured at 95% CI

L606 Open-Label (U.S.): Week 48

Cohort A: Tyvaso Transitions



Scores range from 0 to 100, with higher scores indicating greater satisfaction.

Treatment Satisfaction Questionnaire for Medication (TSQM), Scores range from 0 to 100, with higher scores indicating greater satisfaction
Liquidia data on file

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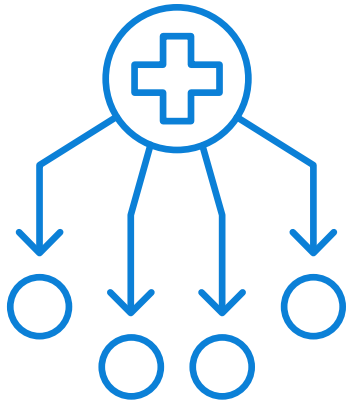
Summary of L606 results

Thoughts on inhaled and sustained release



- **L606 was well-tolerated in patients over 48 weeks**
- **Only 4 patients reports mild related cough over 48 weeks (14%)**
- **Most patients maintained or improved in 6MWD**
- **Observed minimal variability between peak and trough measures**

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Re-Spire Pivotal Study

L606 (treprostinil liposomal inhalation suspension)

Dr. Rajeev Saggar

Liquidia

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Seeking PAH & PH-ILD indication for L606 with one pivotal trial

Three data sets required per FDA and EMA feedback

Completed

Comparable bioavailability to Tyvaso® in Phase 1[1]

Ongoing

Open-label safety study in U.S. of PAH & PH-ILD[2]

Planned

Randomized placebo-controlled for efficacy in PH-ILD

Plan to initiate sites globally

20+ countries

Powered by Bing

1. Phase 1 study NCT04041648; 2. Open label PAH & PH-ILD study NCT04691154

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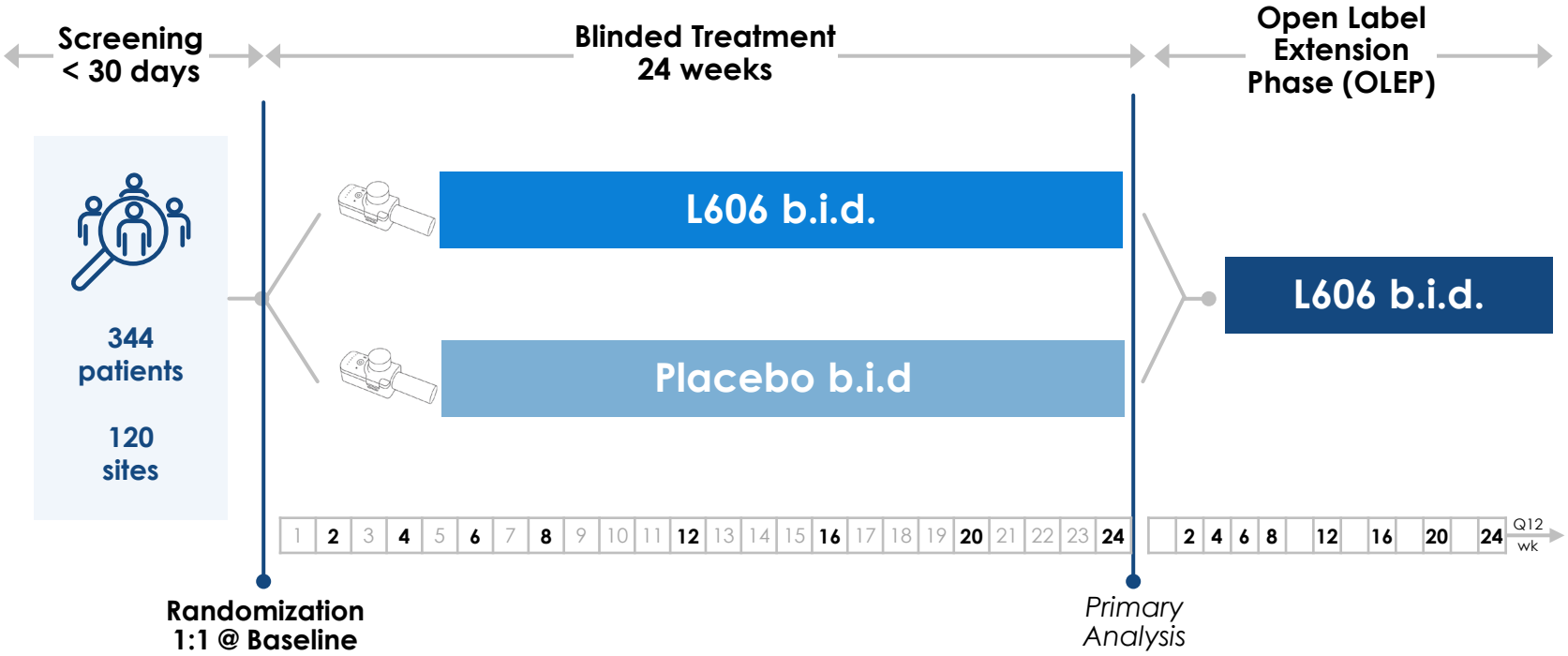
Phase 3, multi-center, randomized (1:1), double-blind, placebo-controlled, parallel group study



Primary Endpoint

- **Change from BL in peak 6MWD (wk 16)**

Secondary Endpoint

- **Change from BL in peak 6MWD (wk 24)**
- Change from BL in trough 6MWD (wk 16)
- TTCW from randomization

Baseline (BL), Six Meter Walk Distance (6MWD), Time to Clinical Worsening (TTCW), Quality of Life (QOL), Clinical Worsening Event (CWE), Combined Pulmonary Fibrosis and Emphysema (CPFE)

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Key enrollment eligibility criteria

Any fibrotic ILD including Combined Pulmonary Fibrosis Emphysema

ILD diagnosed on institutional HRCT Chest

- HRCT Chest to be performed within12-months of screening
- If HRCT Chest > 12-months a scan be performed during screening

Eligibility based on central read from two independent thoracic radiologists

- Consistent with ILD – evidence of diffuse parenchymal disease
- Evidence of "fibrosis"
- Total Lung Emphysema must be ≤ 15%

Allow patients on approved anti-fibrotic treatment (pirfenidone/nintedanib)

- Started at least 30-days prior to screening & stable dose with intent to continue throughout study
- This could also include possible new drugs approved for IPF/fibrotic ILD during the study e.g., PDE4-inhibitor

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Q&A Discussion

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Q&A session

Dr. Roger Jeffs
Chief Executive Officer

Dr. Rajeev Saggar
Chief Medical Officer

Dr. Richard Channick, MD

Dr. Rajan Saggar, MD

Dr. Ricardo Restrepo-Jaramillo

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Drivers of future value for Liquidia's programs

Portfolio built on optimizing inhaled delivery

Exposure drives **Efficacy**

Tolerability drives **Durability**

Convenience drives **Compliance**

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Thank you for joining us today!

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