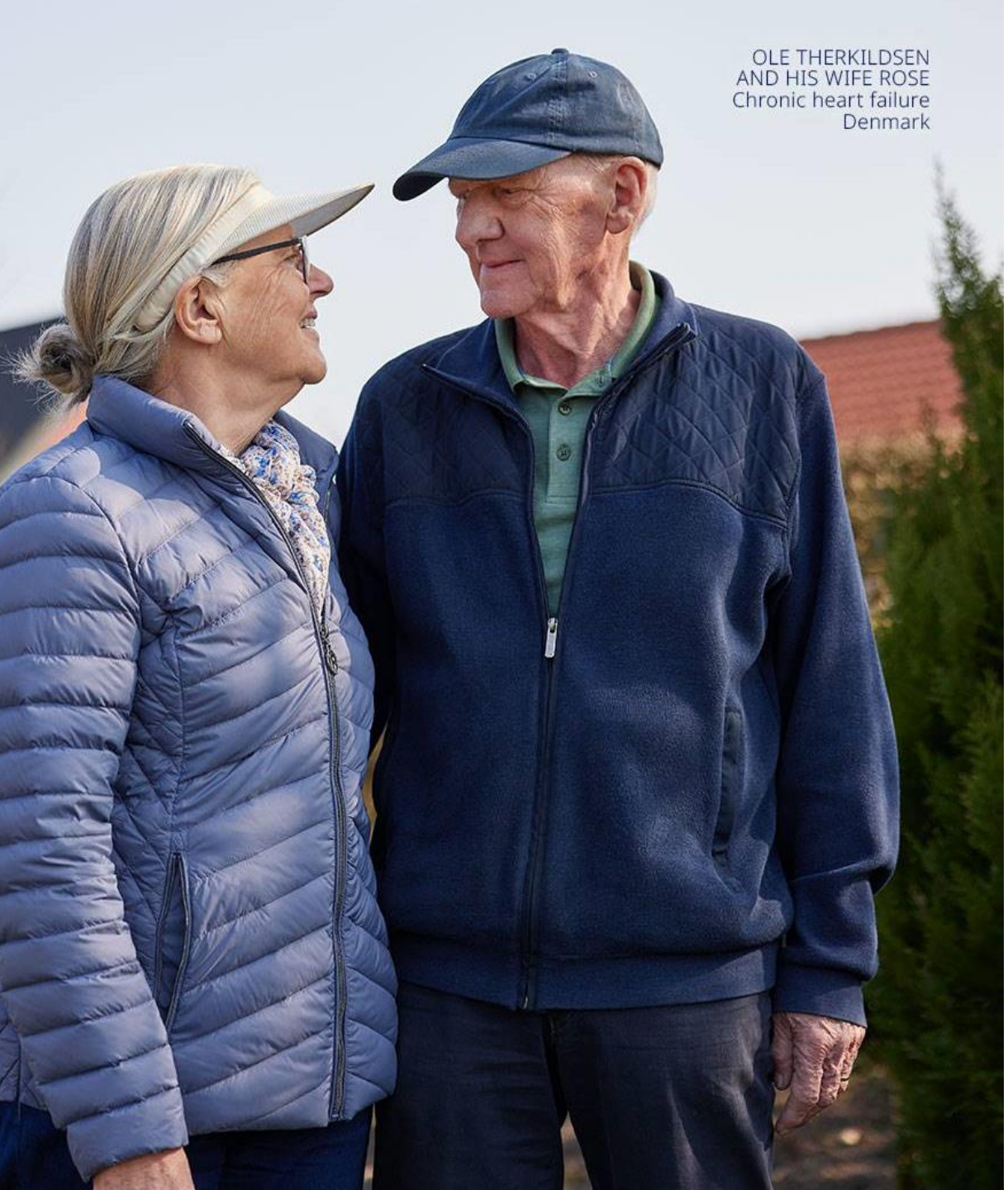


Novo Nordisk –a focused healthcare company

Investor event in connection with AHA

Philadelphia, 11 November 2023

Forward-looking statements

Novo Nordisk's reports filed with or furnished to the US Securities and Exchange Commission (SEC), including the statutory Annual Report 2022 and Form 20-F, which both were filed with the SEC in February 2023 in continuation of the publication of this Annual Report 2022, this presentation, and written information released, or oral statements made, to the public in the future by or on behalf of Novo Nordisk, may contain forward-looking statements. Words such as 'believe', 'expect, 'may', 'will', 'plan', 'strategy', 'prospect', 'foresee', 'estimate', 'project', 'anticipate', 'can', 'intend', 'target' and other words and terms of similar meaning in connection with any discussion of future operating or financial performance identify forward-looking statements. Examples of such forward-looking statements include, but are not limited to:

- Statements of targets, plans, objectives or goals for future operations, including those related to Novo Nordisk's products, product research, product development, product introductions and product approvals as well as cooperation in relation thereto,
- Statements containing projections of or targets for revenues, costs, income (or loss), earnings per share, capital expenditures, dividends, capital structure, net financials and other financial measures,
- Statements regarding future economic performance, future actions and outcome of contingencies such as legal proceedings, and
- Statements regarding the assumptions underlying or relating to such statements.

These statements are based on current plans, estimates and projections. By their very nature, forward-looking statements involve inherent risks and uncertainties, both general and specific. Novo Nordisk cautions that a number of important factors, including those described in this presentation, could cause actual results to differ materially from those contemplated in any forward-looking statements.

Factors that may affect future results include, but are not limited to, global as well as local political and economic conditions, such as interest rate and currency exchange rate fluctuations, delay or failure of projects related to research and/or development, unplanned loss of patents, interruptions of supplies and production, including as a result of interruptions or delays affecting supply chains on which Novo Nordisk relies, shortages of supplies, including energy supplies, product recalls, unexpected contract breaches or terminations, government- mandated or market-driven price decreases for Novo Nordisk's products, introduction of competing products, reliance on information technology including the risk of cybersecurity breeches, Novo Nordisk's ability to successfully market current and new products, exposure to product liability and legal proceedings and investigations, changes in governmental laws and related interpretation thereof, including on reimbursement, intellectual property protection and regulatory controls on testing, approval, manufacturing and marketing, perceived or actual failure to adhere to ethical marketing practices, investments in and divestitures of domestic and foreign companies, unexpected growth in costs and expenses, strikes and other labour market dispute, failure to recruit and retain the right employees, failure to maintain a culture of compliance, and epidemics, pandemics or other public health crises, and the effects of domestic or international crises, civil unrest, war or other conflict.

For an overview of some, but not all, of the risks that could adversely affect Novo Nordisk's results or the accuracy of forward-looking statements in this Annual Report 2022, reference is made to the overview of risk factors in 'Risk management' of this Annual Report 2022.

Unless required by law, Novo Nordisk is under no duty and undertakes no obligation to update or revise any forward-looking statement after the distribution of this Annual Report 2022, whether as a result of new information, future events, or otherwise.

Important drug information

Victoza® and Ozempic® are approved for the management of type 2 diabetes only
Saxenda® and Wegovy® are approved for the treatment of obesity only

Agenda

Introduction		***Daniel Bohsen***
SELECT	Introduction to the trial	*Martin Holst Lange*
	Efficacy	*Martin Holst Lange*
	Safety	*Robin Evers*
	Next steps	*Robin Evers*
Q&A		*All speakers*

Strategic Aspirations 2025 | Highlights first nine months of 2023

Light blue indicates developments in Q3 2023

Purpose and sustainability (ESG)

Progress towards zero environmental impact
- Carbon emissions decreased by 28% vs first 9M 2019[1]

Adding value to society
- Medical treatment to ~40 million people with diabetes
- Reached more than 46,000 children in Changing Diabetes® in Children programme
- Partnership with Aspen to produce human insulin for Africa

Being recognised as a sustainable employer
- Share of women in senior leadership positions has increased to 41% from 38% at end of September 2022

Innovation and therapeutic focus

Further raise innovation bar for Diabetes treatment
- Regulatory submission of once-weekly insulin icodec
- Initiation of phase 3 trial with CagriSema T2D
- FLOW stopped for efficacy based on interim analysis

Develop superior treatment solutions for obesity
- Regulatory submission of SELECT CVOT

Strengthen and progress Rare Disease pipeline
- Concizumab approved for HAwI/HBwI in Japan

Establish presence in other serious chronic diseases
- Acquisition of ocedurenone within CVD

Commercial execution

Diabetes value market share increased by 1.8%-points to 33.3%[2]

Obesity care sales of DKK 30.4 billion (+174% at CER)

Rare disease sales of DKK 12.6 billion (-18% at CER)

Financials

Sales growth of 33% (CER) and operating profit growth of 37% (CER)

Operational leverage reflecting sales growth

Free cash flow of DKK 75.6 billion and DKK 52.0 billion returned to shareholders

[1]Scope 1,2 and partial scope 3 limited to CO2 emissions from business flights and product distribution; [2]MAT (Moving annual total) value market share
9M: Nine months; CER: Constant exchange rates; HAwI/HBwI: Haemophilia A/B with inhibitors
Note: The strategic aspirations are not a projection of Novo Nordisk's financial outlook or expected growth

Today we focus on innovation and therapeutic focus with SELECT

Purpose and sustainability (ESG)

- Progress towards zero environmental impact
- Being respected for adding value to society
- Being recognised as a sustainable employer

Innovation and therapeutic focus

- Further raise the innovation-bar for diabetes treatment
- **Develop a leading portfolio of superior treatment solutions for obesity**
- Strengthen and progress the Rare disease pipeline
- Establish presence in Other serious chronic diseases focusing on CVD, MASH and CKD

Commercial execution

- Strengthen Diabetes leadership - aim at global value market share of more than 1/3
- More than 25 billion DKK in Obesity sales by 2025
- Secure a sustained growth outlook for Rare disease

Financials

- Deliver solid sales and operating profit growth
- Drive operational efficiencies across the value chain to enable investments in future growth assets
- Deliver free cash flow to enable attractive capital allocation to shareholders

CKD: Chronic kidney disease; CVD: Cardiovascular disease; MASH: Metabolic dysfunction-associated steatohepatitis
Note: The strategic aspirations are not a projection of Novo Nordisk's financial outlook or expected growth

Today’s speakers

Martin Holst Lange
Executive Vice President
Head of Development

Robin Evers
Senior Vice President
Head of Regulatory, Safety and QA

QA: Quality Assurance

Agenda

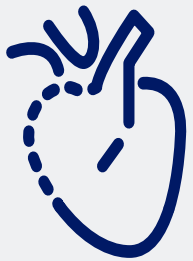
Introduction		*Daniel Bohsen*
SELECT	**Introduction to the trial**	***Martin Holst Lange***
	Efficacy	*Martin Holst Lange*
	Safety	*Robin Evers*
	Next steps	*Robin Evers*
Q&A		*All speakers*

SELECT assessed semaglutide 2.4 mg for cardiovascular risk in people with overweight, obesity and established CVD

There is an unmet need for weight management therapies that also reduce CV events

Obesity

- >764 million people estimated to live with obesity[1]
- >1 billion people predicted to have obesity by 2030[1]



Cardiovascular disease

- Responsible for 32% of all global deaths making CVD the leading cause of death world wide[2]

Each year ~2 million CV deaths is attributed to obesity[3]

SELECT is the largest clinical trial in Novo Nordisk's history

Event-driven trial duration:
4 years and 8 months

[1] World Obesity Federation, World obesity atlas 2022, [2]WHO, Fact sheet – CVDs, [3]GBD 2015 Obesity Collaborators et al. N Engl J Med 2017;377:13–27
CV: Cardiovascular; CVD: Cardiovascular disease

The primary objective of SELECT was to demonstrate that semaglutide 2.4 mg lowers the incidence of MACE

The primary objective

To demonstrate that semaglutide sc. 2.4 mg once-weekly lowers the incidence of major adverse cardiovascular events (MACE) versus placebo, both added to standard of care in people with established CVD and overweight or obesity

The secondary objectives

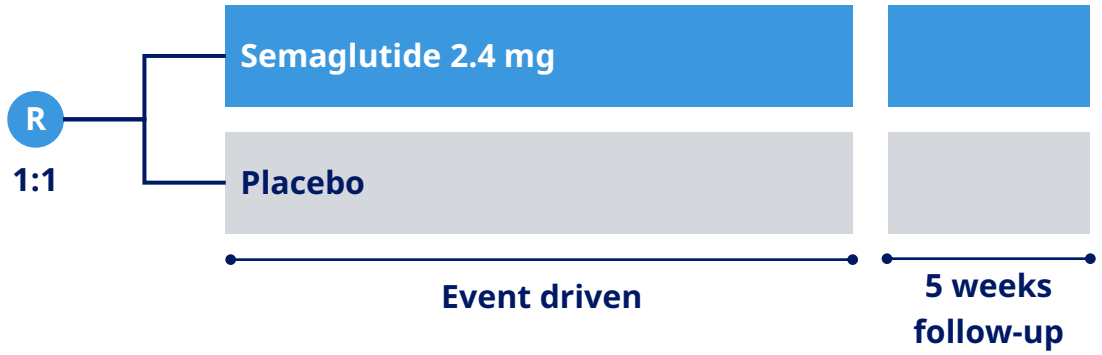
To compare the effect of semaglutide sc. 2.4 mg once-weekly versus semaglutide placebo both added to standard of care in subjects with established CVD and overweight or obesity with regards to:

- CV risk factors
- Mortality
- Glucose metabolism
- Body weight
- Renal function

CV: Cardiovascular; CVD: Cardiovascular disease; MACE: Major adverse cardiovascular events; sc.: Subcutaneous

SELECT was designed as a double-blinded, placebo-controlled, superiority trial

SELECT included 17,604 people with BMI>27 and established CVD



Primary endpoint
- Time from randomisation to first occurrence of 3-point MACE

Confirmatory secondary endpoints
Time from randomisation to:
- CV death
- First occurrence of heart failure composite endpoint
- All-cause death

Main inclusion criteria
- Patients with overweight or obesity (BMI ≥27 kg/m^2)
- Established cardiovascular disease (prior myocardial infarction, prior stroke, or symptomatic peripheral arterial disease)
- Age ≥45 years

Main exclusion criteria
- HbA1c ≥48 mmol/mol (6.5%) or a history of type 1 or type 2 diabetes

Trial information
- Double-blind, placebo-controlled, superiority trial
- Semaglutide 2.4mg added on top of standard of care[1]
- Dose reductions and treatment pauses allowed

[1]Blood pressure lowering therapy, lipid lowering therapy, antiplatelet and anticoagulant therapy, glycaemic control for patients developing T2D, healthy life-style guidance
BMI: Body mass index; CV: Cardiovascular; CVD: Cardiovascular Disease; MACE: Major adverse cardiovascular events
Sources: Lingvay, Semaglutide for cardiovascular event reduction in people with overweight or obesity: SELECT study baseline characteristics, 2023 Jan;31(1):111-122.

SELECT represents the general obese population with atherosclerotic cardiovascular disease across risk categories

Baseline characteristics

Male / Female	Mean age	Mean body weight
72.3 / 27.7%	61.6 years	96.7 kg

Mean BMI	Overweight/Obesity/ Severe obesity[1]
33.3 kg/m²	28.5 / 61.5 / 10.0%

Mean HbA_{1c}	Pre-diabetes[2]
5.8%	66.4%

CV comorbidities at baseline

Myocardial infarction[3]	Stroke[3]	PAD[3]
67.6%	17.8%	4.4%

Heart failure	Renal impairment Mild/Moderate/Severe[4]
24.3%	48.7 / 10.4 / 0.4%

Dyslipidemia	Hypertension	Median hsCRP
99.0%	81.8%	1.83mg/L

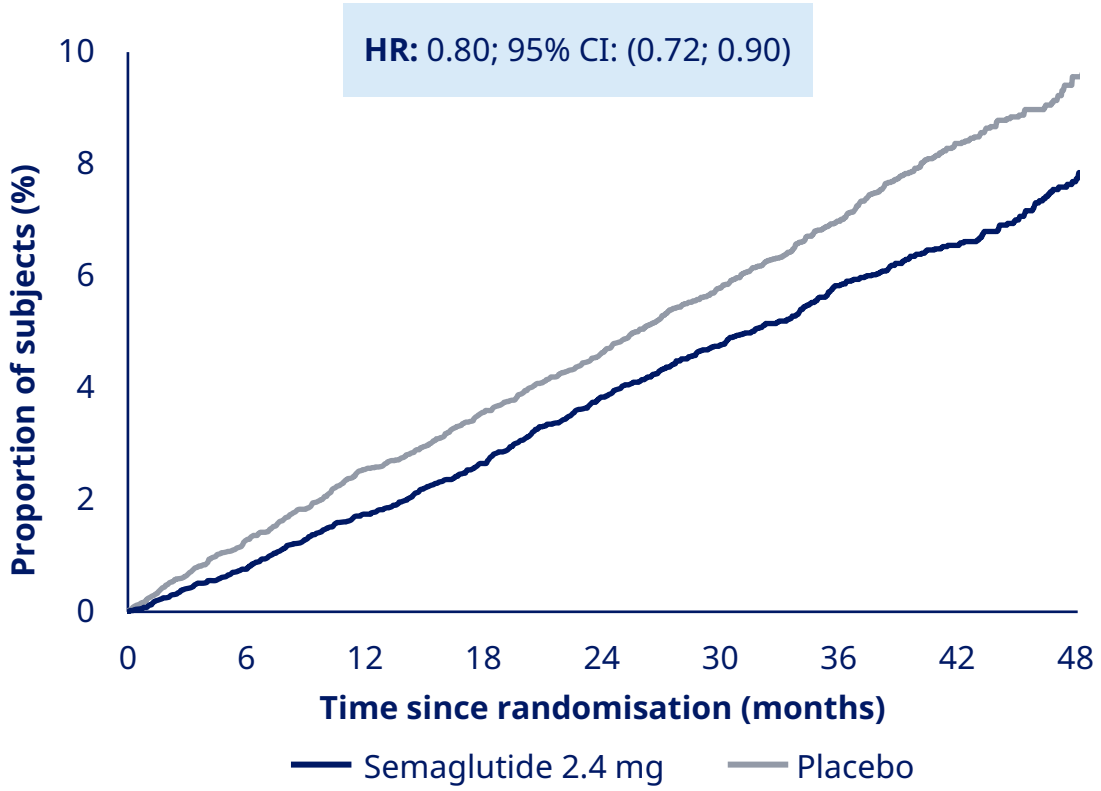
[1]Overweight (BMI 27 to <30), Obese (BMI 30 to <40), Severely Obese (BMI ≥40); [2]HbA1c 5.7-6.4% / 37-47mmol/L; [3]Only MI, only Stroke or only PAD; [4]Mild (eGFR 60-89 mL/min/1.73m²), Moderate (eGFR 30-59 mL/min/1.73m²), Severe (eGFR 15-29 mL/min/1.73m²)
BMI: body mass index; eGFR: estimated glomerular filtration rate; hsCRP: High-sensitivity C-reactive protein; MI: Myocardial infarction; PAD: Peripheral arterial disease
Notes: The eGFR was estimated using the CKD-EPI formula. Source: Lingvay, Ildiko et al. Obesity vol. 31,1 (2023)

Agenda

Introduction		*Daniel Bohsen*
SELECT	Introduction to the trial	*Martin Holst Lange*
	Efficacy	***Martin Holst Lange***
	Safety	*Robin Evers*
	Next steps	*Robin Evers*
Q&A		*All speakers*

Semaglutide 2.4 mg reduced cardiovascular risk by 20% in adults with overweight or obesity and established CVD vs placebo

Time-to-event analysis for primary efficacy endpoint (MACE)



Trial information

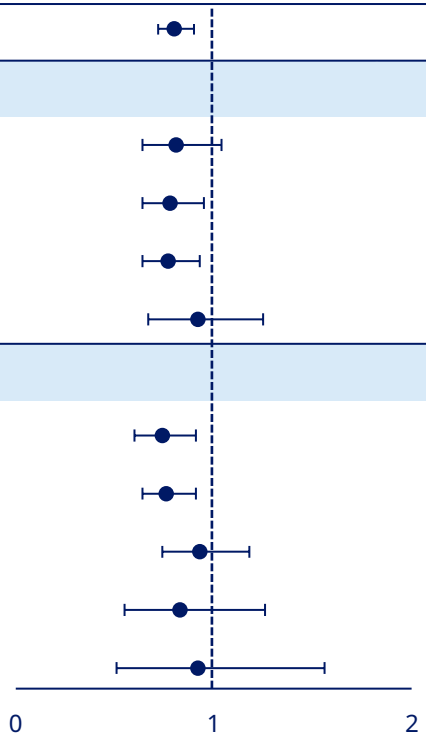
- **Trial completion rate:** 96.9% of patients completed the trial[1]
- **Exposure:** Mean time was 33.3 months in the semaglutide 2.4 mg group versus 35.1 months in the placebo group
- **Permanent premature discontinuation:** 26.7% in the semaglutide 2.4 mg group versus 23.6% in the placebo group

[1]Defined as having died or attended the last study visit. CI: Confidence interval; CVD: Cardiovascular disease; HR: Hazard ratio; MACE: Major adverse cardiovascular events
Note: Efficacy analyses based on treatment policy estimand; treatment effect regardless of treatment adherence. Cumulative incidence (using the Aalen–Johansen method) of the composite MACE primary endpoint. The HR was estimated using a Cox proportional hazards regression model.

Beneficial effects of semaglutide 2.4 mg on MACE were directionally consistent across prespecified patient subgroups

Patient subgroup analysis by age and BMI

	Semaglutide 2.4mg		Placebo		Hazard ratio 95% CI
	E	n	E	n	
MACE events	569	8803	701	8801	0.80 (0.72; 0.90)
Age					
<55	115	2057	141	2094	0.81 (0.64; 1.04)
≥55 to < 65	187	3387	234	3338	0.78 (0.64; 0.95)
≥65 to < 75	189	2656	247	2706	0.77 (0.64; 0.93)
≥75	78	703	79	663	0.92 (0.67; 1.25)
BMI					
<30	155	2555	200	2469	0.74 (0.60; 0.91)
≥30 to < 35	217	3693	286	3781	0.76 (0.64; 0.91)
≥35 to < 40	135	1687	142	1659	0.93 (0.74; 1.18)
≥40 to < 45	40	579	49	595	0.83 (0.55; 1.26)
≥45	22	289	24	297	0.92 (0.51; 1.65)

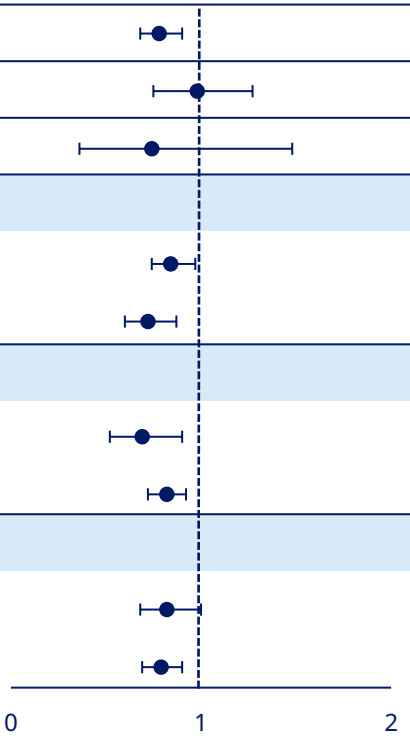


BMI: Body Mass Index; CI: Confidence interval; E: Number of events; n: Number of patients; MACE: Major adverse cardiovascular events
Note: Intention-to-treat population. MACE includes non-fatal myocardial infarction, non-fatal stroke, and cardiovascular death; For the subgroup analyses, HRs were estimated using a Cox proportional hazards regression with interaction between treatment group and the relevant subgroup as fixed factor. Except for the primary analysis, widths of the CIs were not adjusted for multiplicity

Beneficial effects of semaglutide 2.4 mg on MACE were directionally consistent across prespecified patient subgroups

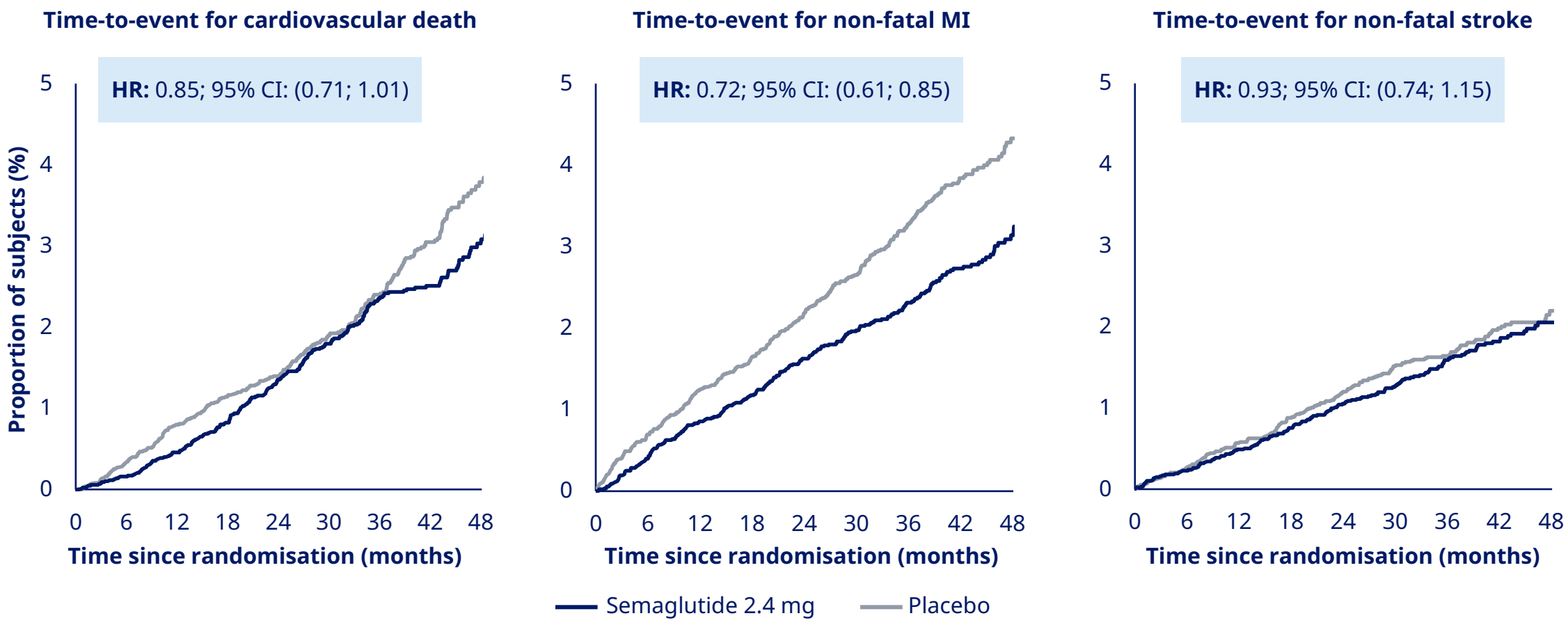
Patient subgroup analysis by CV comorbidities

	Semaglutide 2.4mg		Placebo		Hazard ratio 95% CI
	E	n	E	n	
Only MI	362	5962	455	5944	0.78 (0.68; 0.90)
Only Stroke	109	1578	109	1556	0.98 (0.75; 1.27)
Only PAD	13	376	19	401	0.74 (0.36; 1.48)
HF					
Yes	372	6647	438	6667	0.84 (0.74; 0.97)
No	197	2155	262	2131	0.72 (0.60; 0.87)
eGFR leve					
<60	94	963	127	935	0.69 (0.52; 0.90)
≥60	469	7761	572	7807	0.82 (0.72; 0.92)
HbA1c level					
<5.7	186	2925	228	2980	0.82 (0.68;1.00)
≥5.7	383	5877	473	5819	0.79 (0.69;0.90)



CI: Confidence interval; CV: Cardiovascular; E: Number of events; HbA1c: Hemoglobin A1c -; HF: Heart failure; HR: Hazard ratio; n: Number of patients; eGFR: estimated glomerular filtration rate; MACE: Major adverse cardiovascular event; MI: Myocardial infarction; PAD: Peripheral arterial disease. Note: Intention-to-treat population. MACE includes non-fatal myocardial infarction, non-fatal stroke, and cardiovascular death; For the subgroup analyses, HRs were estimated using a Cox proportional hazards regression with interaction between treatment group and the relevant subgroup as fixed factor. Except for the primary analysis, widths of the CIs were not adjusted for multiplicity

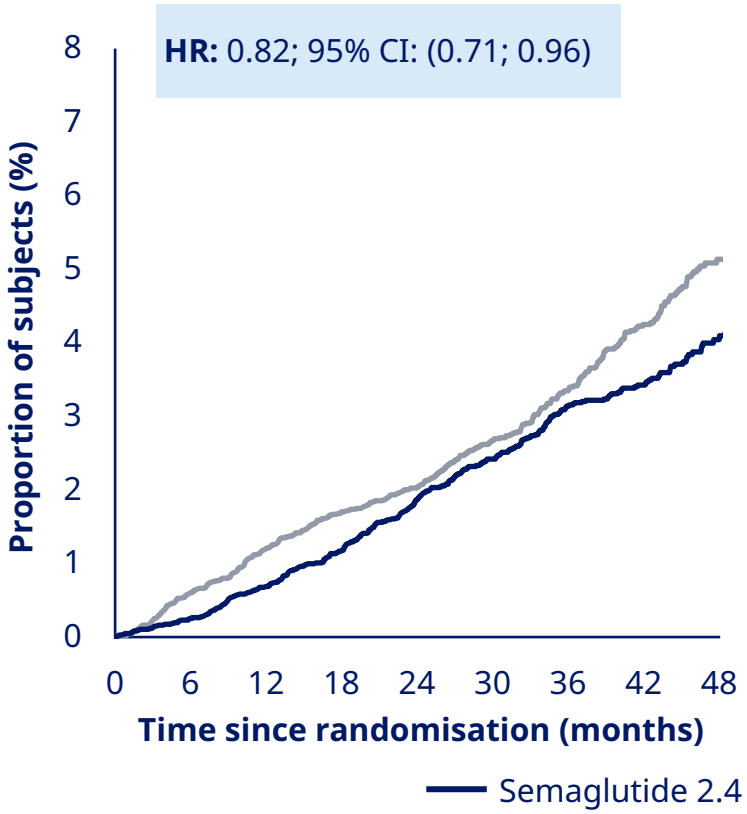
All three components of the primary endpoint contributed to the superior MACE reduction demonstrated by semaglutide 2.4 mg



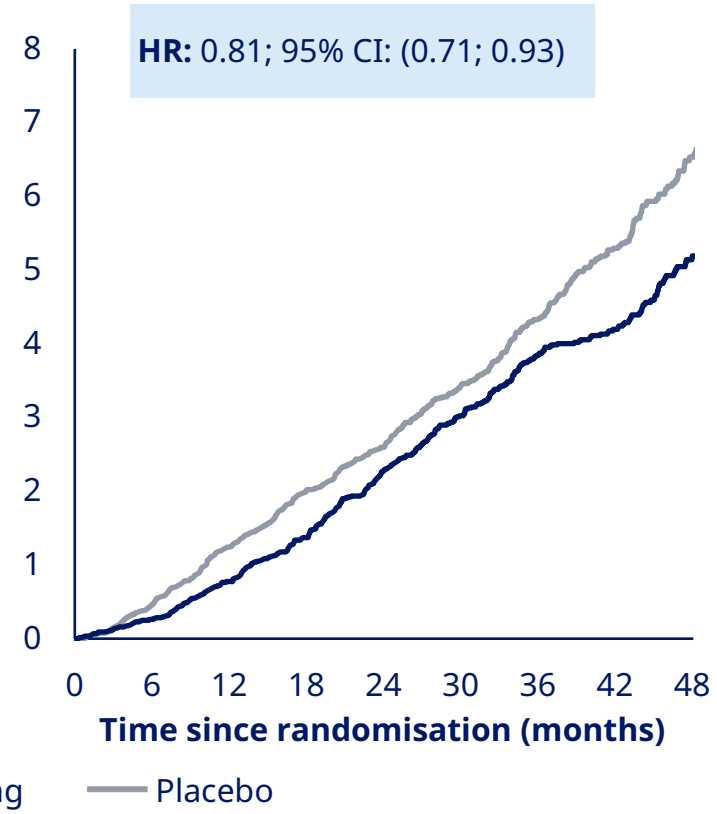
CI: Confidence interval; HR: Hazard ratio; MACE: Major adverse cardiovascular event; MI: Myocardial infarction
Note: Intention-to-treat population. Cumulative incidence (using the Aalen–Johansen method) of the individual components of MACE. The HR was estimated using a Cox proportional hazards regression model

In SELECT, semaglutide 2.4 mg reduced risk of the composite HF endpoint with 18% and all-cause death with 19% vs placebo

Time-to-event for composite heart failure



Time-to-event for all-cause death



Semaglutide 2.4 mg Placebo

Secondary Confirmatory Endpoints

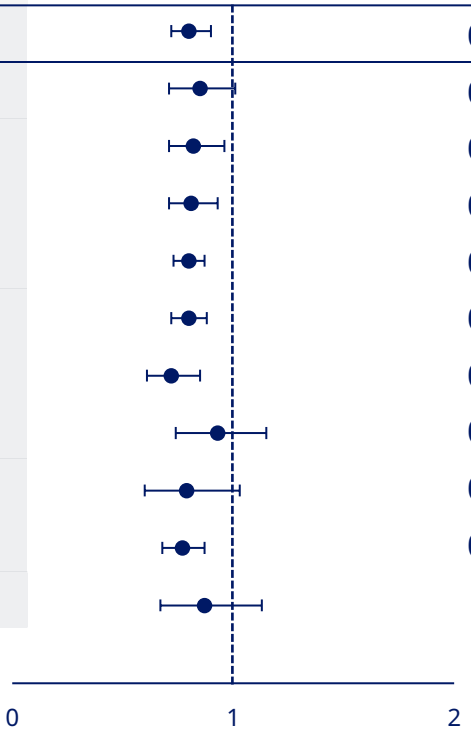
- **Testing hierarchy**: As the results on CV death was not statistically significant, the subsequent secondary endpoints were not tested for superiority
- The risk of **composite heart failure** events, comprising cardiovascular death, urgent heart failure visits and hospitalisations, was reduced by 18% compared to placebo
- The risk of **death from any cause** was reduced by 19% compared to placebo

CI: Confidence interval; CV: Cardiovascular; HF: Heart failure; HR: Hazard ratio
Note: Heart failure composite endpoint, Cardiovascular death and hospitalisation for heart failure, and urgent heart failure visit; Intention-to-treat population. Cumulative incidence (using the Aalen–Johansen method) composite heart failure and all-cause death endpoints. The HR was estimated using a Cox proportional hazards regression model

Beneficial effects of semaglutide 2.4 mg were directionally consistent across cardiovascular events

Primary and secondary cardiovascular time-to-event clinical endpoints

	Semaglutide 2.4 mg		Placebo		Hazard ratio 95% CI
	n	%	n	%	
Primary MACE endpoint	**569**	**6.5**	**701**	**8.0**	0.80 (0.72; 0.90)
Death from cardiovascular causes	223	2.5	262	3.0	0.85 (0.71; 1.01)
Heart failure composite endpoint	300	3.4	361	4.1	0.82 (0.71; 0.96)
Death from any cause	375	4.3	458	5.2	0.81 (0.71; 0.93)
Cardiovascular expanded composite endpoint	873	9.9	1,074	12.2	0.80 (0.73; 0.87)
CV composite endpoint with death from any cause	710	8.1	877	10.0	0.80 (0.72; 0.88)
Non-fatal myocardial infarction	234	2.7	322	3.7	0.72 (0.61; 0.85)
Non-fatal stroke	154	1.7	165	1.9	0.93 (0.74; 1.15)
Hospitalization or urgent medical visit for heart failure	97	1.1	122	1.4	0.79 (0.60; 1.03)
Coronary revascularization	473	5.4	608	6.9	0.77 (0.68; 0.87)
Unstable angina requiring hospitalization	109	1.2	124	1.4	0.87 (0.67;1.13)



CI: Confidence interval; CV: Cardiovascular; MACE: Major adverse cardiovascular event; n: Number of patients
Note: Intention-to-treat population. HRs were estimated using a Cox proportional hazards regression model. Widths of the CIs have not been adjusted for multiplicity

SELECT establishes semaglutide 2.4 mg as the only anti-obesity medication with proven cardiovascular benefits

SELECT met the primary endpoint: 20% risk reduction in **major adverse cardiovascular outcomes** demonstrated with semaglutide 2.4 mg vs placebo

The beneficial effects of semaglutide were **observed early** and were **directionally consistent** across cardiovascular endpoints and among prespecified patient subgroups

Superiority of semaglutide 2.4 mg vs placebo was not confirmed for time from randomisation to CV death (second in testing hierarchy)

CV death – HR 0.85; 95% CI: (0.71; 1.01)

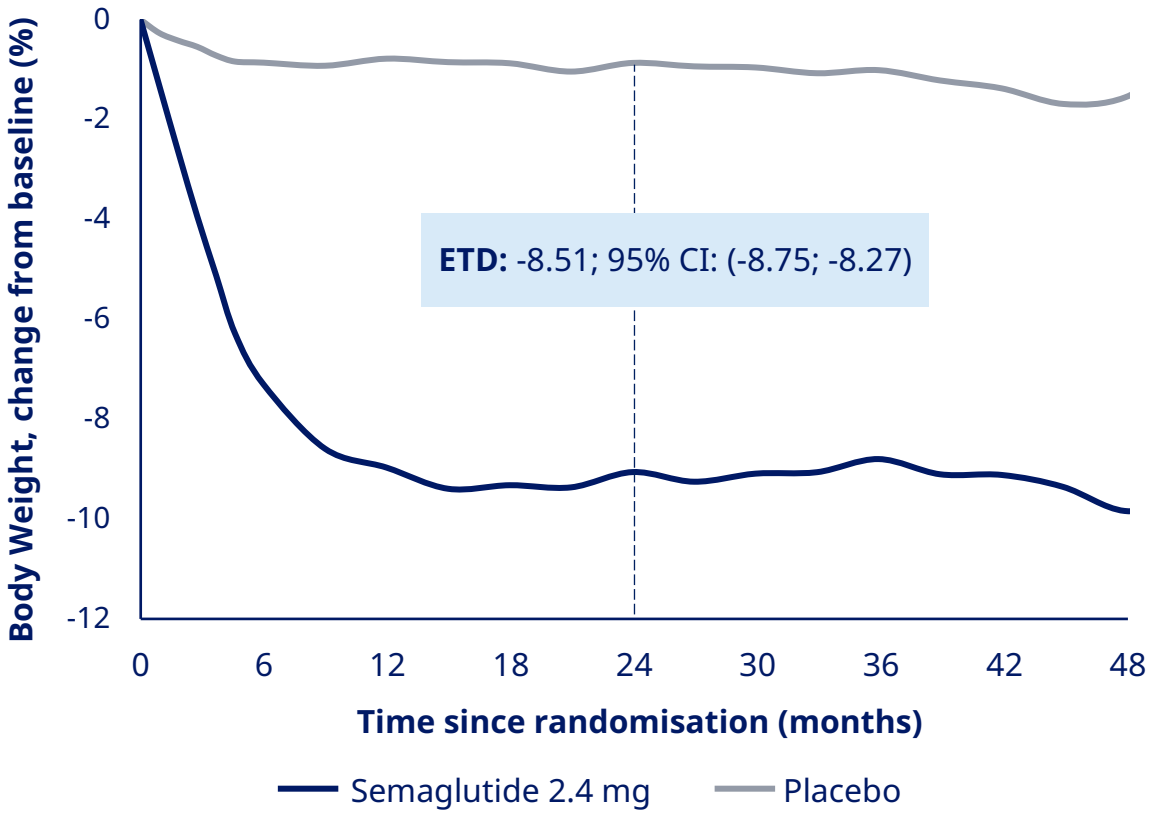
Reductions with upper end of confidence intervals below 1 were shown for:

Composite HF outcome - HR 0.82; 95% CI: (0.71; 0.96)
All cause death – HR 0.81; 95% CI [0.71; 0.93]

CI: Confidence Interval; CV: Cardiovascular; HF; Heart failure; HR: Hazard ratio

The SELECT trial showed that patients on semaglutide 2.4 mg had sustained weight-loss over the course of the trial

Observed change in weight from baseline by month



SELECT underlines the durability of weight loss

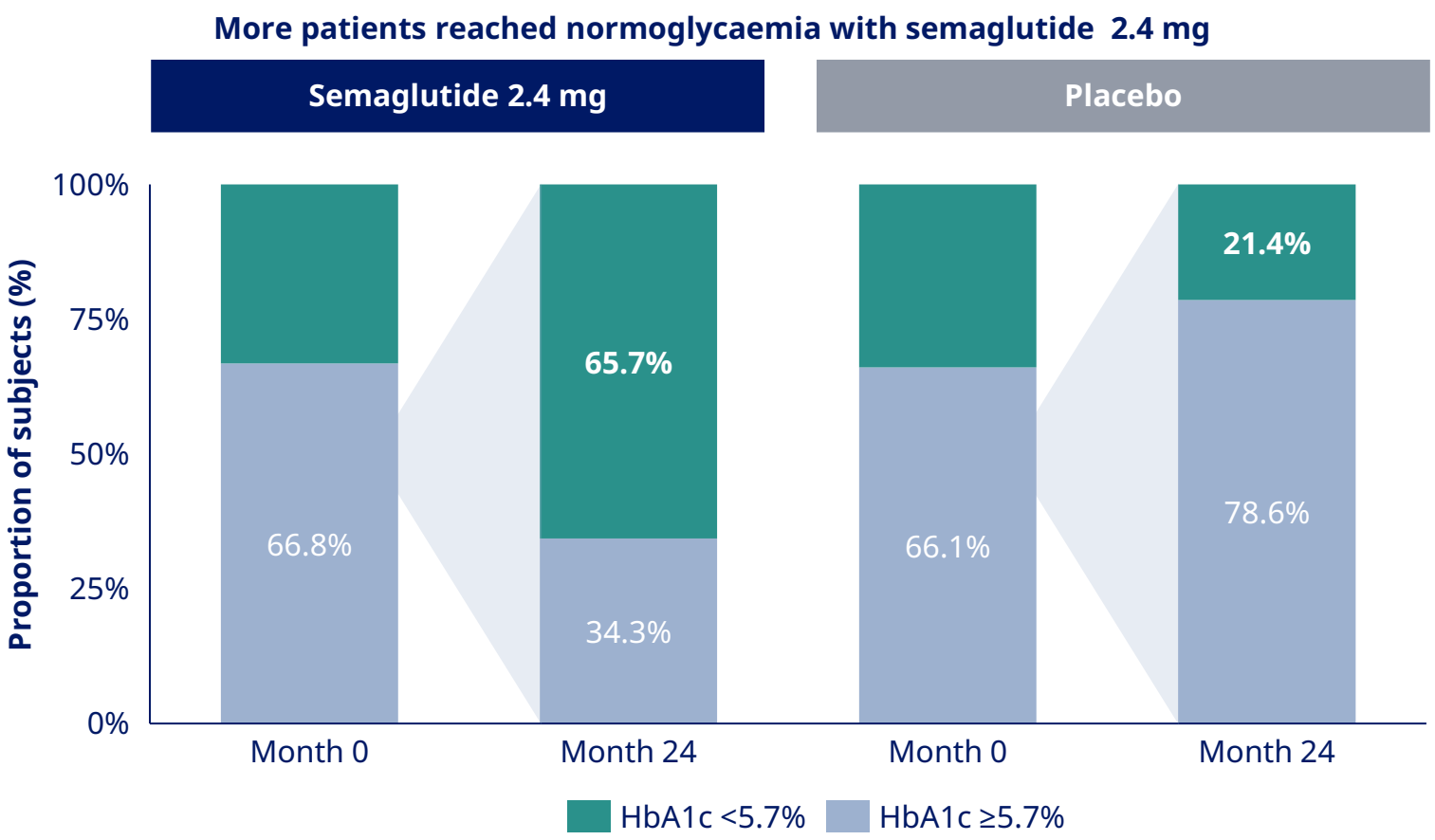
- In the SELECT trial, patients on semaglutide 2.4 mg demonstrated sustained weight loss for up to 4 years
- Recall that SELECT was not a dedicated weight loss trial

Key differences between the SELECT and STEP trials:

Parameter	SELECT	STEP 1
Baseline data	• Mean age: 61.6 years • Gender: 72.3% male • BMI: ~33.3	• Mean age: ~46 years • Gender: 74.1% female • BMI: 37.8
Primary endpoint	• 3-point MACE	• %-change in WL
Lifestyle intervention	• Healthy lifestyle advice as per SoC	• Reduced calorie diet • Physical activity programme
Flexible Protocol	• Yes (e.g. titration up/down/pauses)	• More rigid

BMI: Body mass index; CI: Confidence interval; ETD: Estimated treatment difference; MACE: Major cardiovascular event; SoC: Standard of care; WL: Weight loss
Note: Intention-to-treat population; Mean estimates are from an ANCOVA with treatment as fixed factor and baseline value as covariate. Before analysis, missing data were multiple imputed. The imputation model (linear regression) was done separately for each treatment arm and includes baseline value as a covariate and was fitted to all subjects with a measurement regardless of treatment status at week 104. The fitted model was used to impute values for subjects without a measurement at month 24. Mean estimates were adjusted according to observed baseline distribution

In SELECT, a higher proportion of pre-diabetic patients on semaglutide 2.4 mg returned to normoglycemia vs placebo

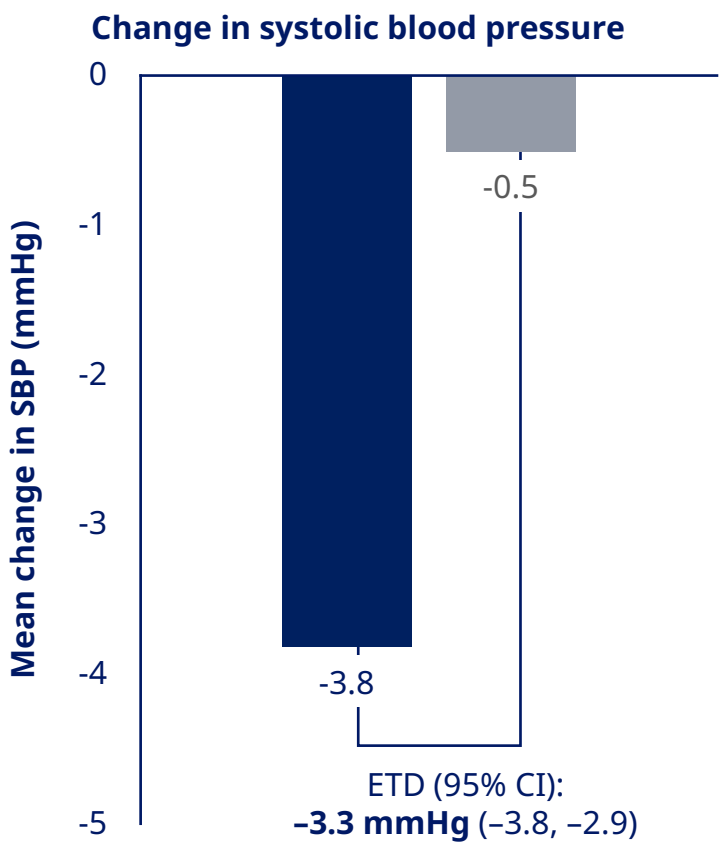


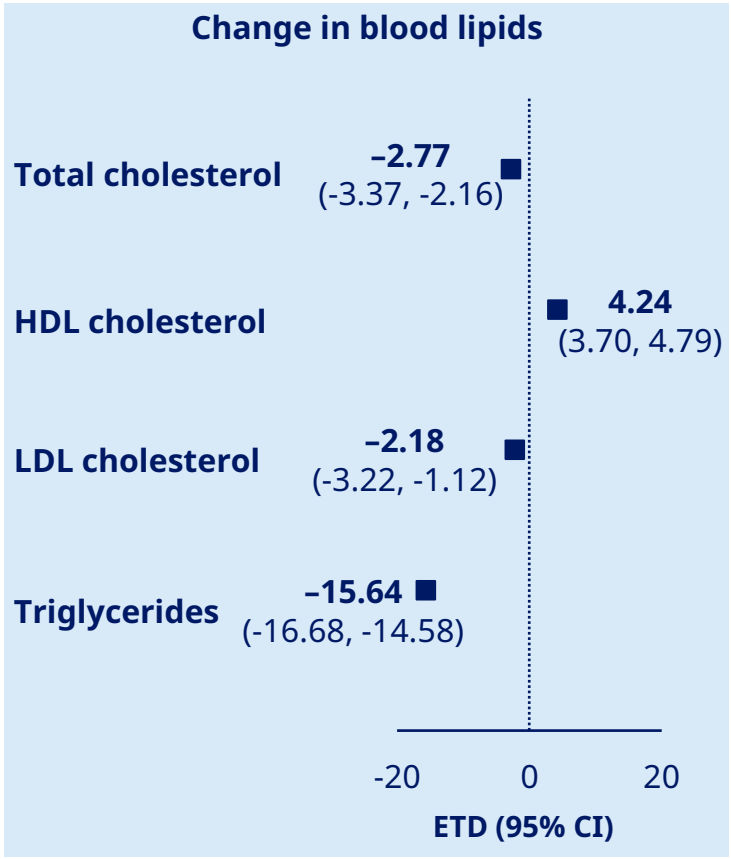
Glycaemic control with semaglutide 2.4 mg

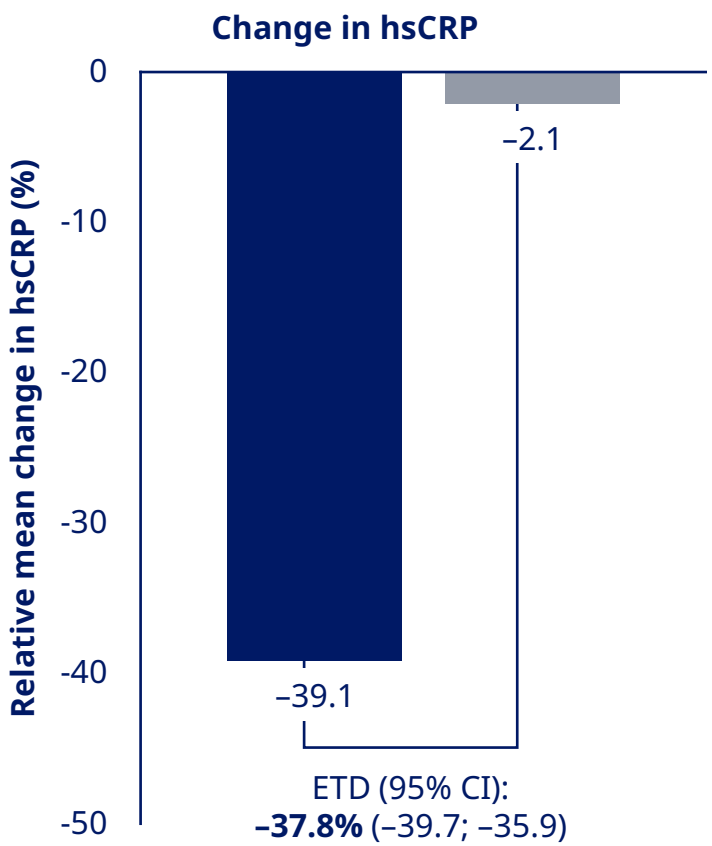
- **Patients with pre-diabetes (HbA1c ≥5.7%):** more patients on semaglutide 2.4 mg reached normoglycemia vs. placebo (65.7% vs 21.4%)
- Overall, there was a **73% risk reduction of developing HbA1c** ≥6.5% (48 mmol/mol)) for semaglutide 2.4 mg vs. placebo
- **Patients with baseline HbA1c < 5.7%:** there was a **67% risk reduction of developing prediabetes** (HbA1c ≥ 5.7 % (39 mmol/mol)) for semaglutide 2.4 mg vs. placebo

Note: Pre-diabetes endpoint assessed in those with a baseline (screening) measurement<5.7%. Change from baseline to month 24, estimated using ANCOVA with treatment as factor and the baseline value as covariate. HRs were estimated using a Cox proportional hazards regression model

In SELECT, semaglutide 2.4 mg reduced cardiovascular risk factors





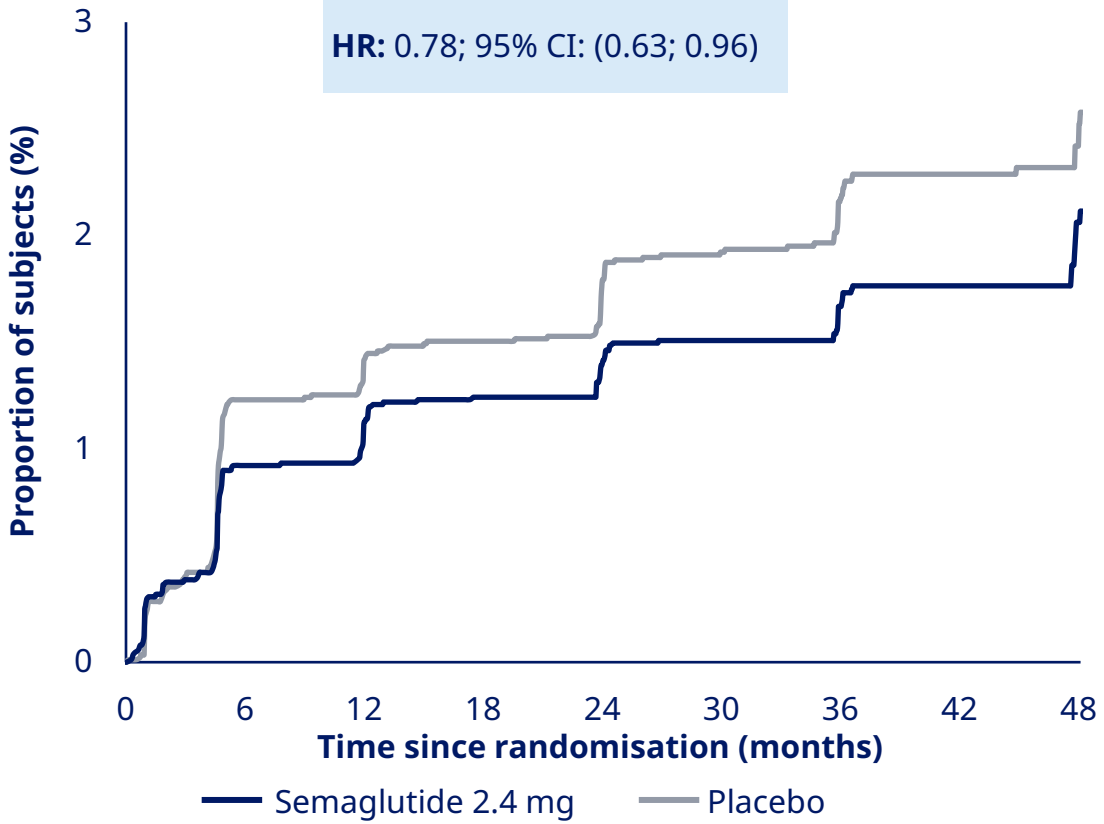


CI: Confidence interval; ETD: Estimated treatment difference; hsCRP: High-sensitivity C-reactive protein; SBP: Systolic blood pressure
Note: Change from baseline to month 24, estimated using ANCOVA with treatment as factor and the baseline value as covariate. CIs have not been adjusted for multiplicity.

In SELECT, semaglutide 2.4 mg showed a 22% risk reduction of chronic kidney disease progression and renal death

First nephropathy outcome

HR: 0.78; 95% CI: (0.63; 0.96)



Chronic kidney disease progression or renal death

- Further, the FLOW kidney outcomes trial recently stopped early as semaglutide 1.0 mg demonstrated a benefit in people with type 2 diabetes and chronic kidney disease vs placebo
  - The SELECT chronic kidney disease endpoint does not include CV death

CI: Confidence interval; CV: Cardiovascular; HR: Hazard ratio; sc.: Subcutaneous
Note: HRs were estimated using a Cox proportional hazards regression model. Widths of the CIs have not been adjusted for multiplicity. A 5-component composite nephropathy endpoint consisting of onset of persistent macroalbuminuria, persistent 50% reduction in eGFR compared with baseline (randomization), onset of persistent eGFR <15 ml/min/1.73m2, initiation of chronic renal replacement therapy (dialysis or transplantation), or renal death*

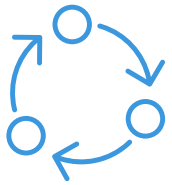
Agenda

Introduction		*Daniel Bohsen*
SELECT	Introduction to the trial	*Martin Holst Lange*
	Efficacy	*Martin Holst Lange*
	Safety	***Robin Evers***
	Next steps	*Robin Evers*
Q&A		*All speakers*

SELECT is the largest trial ever completed in Novo Nordisk and adds to the totality of safety data on semaglutide

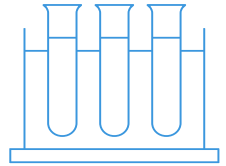
Magnitude of safety data collection

+ 14,000 SAEs
+ 10,000 Cases
+ 45,000 AEs



+74,000 follow-up visits

6,632 adjudicated events



+ 6,000,000 lab values

High-level overview of data collected

Serious adverse events

Areas of interest

- Pancreatitis
- Acute renal failure
- Gallbladder disease
- Malignant neoplasms
- Medication errors
- Misuse and abuse
- COVID-19

Thyroid cancer and suicide ideation

Adverse events leading to discontinuation of trial product

AE: Adverse events; SAE: Serious adverse events
Note: Events for adjudication done across death, acute coronary syndrome (acute MI, hospitalisation for unstable angina pectoris), stroke, coronary artery revascularisation, hearth failure hospitalisation or urgent heart failure visit, pancreatitis, nephropathy (events leading to renal replacement therapy)

Fewer serious adverse events were reported in the semaglutide 2.4 mg arm compared to placebo

	Semaglutide (n = 8,803)		Placebo (n = 8,801)		P value
	n	%	n	%	
Serious adverse events[1,2]	**2,941**	**33.4**	**3,204**	**36.4**	<0.001
Cardiac disorders	1,008	11.5	1,184	13.5	<0.001
Infections and infestations	624	7.1	738	8.4	0.001
Nervous system disorders	444	5.0	496	5.6	0.08
Surgical and medical procedures	433	4.9	548	6.2	<0.001
Neoplasms benign, malignant and unspecified	405	4.6	402	4.6	0.94
Gastrointestinal disorders	342	3.9	323	3.7	0.48

[1]This trial employed targeted safety data collection, in which the only adverse events systematically collected and reported were serious adverse events, adverse events leading to discontinuation of trial product irrespective of seriousness, or adverse events of prespecified special interest irrespective of seriousness; [2]Organised by organ class
n: number of subjects; %: percentage of subjects in full analysis set. Note: P values are two-sided and were calculated with a Fisher's exact test for the test of no difference

There were no unexpected findings in pre-specified adverse events of special interest evaluated in SELECT

	Semaglutide (n = 8,803)		Placebo (n = 8,801)		P value
	n	%	n	%	
Prespecified adverse events of special interest, irrespective of seriousness[1,2]					
COVID-19 related events	2,108	23.9	2,150	24.4	0.46
Malignant neoplasms	422	4.8	418	4.7	0.92
Gallbladder-related disorders	246	2.8	203	2.3	0.04
Acute renal failure	171	1.9	200	2.3	0.13
Acute pancreatitis[3]	17	0.2	24	0.3	0.28

[1]This trial employed targeted safety data collection, in which the only adverse events systematically collected and reported were serious adverse events, adverse events leading to discontinuation of trial product irrespective of seriousness, or adverse events of prespecified special interest irrespective of seriousness; [2]Based on prespecified MedDRA queries; [3]Acute pancreatitis events are those confirmed by the Events Adjudication Committee. Investigators reported pancreatitis (acute or other type) events in 29 patients (0.3%) in the semaglutide group and 30 patients (0.3%) in the placebo group. Source: Determining the Extent of Safety Data Collection Needed in Late-Stage Premarket and Postapproval Clinical Investigations, FDA Guidance, 2016
n: number of subjects; %: percentage of subjects in full analysis set. Note: P values are two-sided and were calculated with a Fisher's exact test for the test of no difference

SELECT safety data supports lack of causal association between use of semaglutide and thyroid cancer or suicidal ideation

	Semaglutide (n = 8,803)		Placebo (n = 8,801)		P value
Other serious adverse events	n	%	n	%	
Malignant neoplasms	**422**	**4.8**	**418**	**4.7**	**0.92**
Medulla Thyroid Cancer	0	0	3	0.03	
Thyroid Gland	6	<0.1	8	<0.1	
Psychiatric Disorders	**10**	**0.1**	**10**	**0.1**	
Event adjudication committee confirmed cause of death: Suicide	**5**	**0.1**	**3[1]**	**0.0**	

[1]One suicide where Event adjudication committee opted to consider suicide, rather than trauma
n: number of subjects; %: percentage of subjects in full analysis set

Higher permanent discontinuation rate in the semaglutide 2.4 mg arm was driven by gastrointestinal events

	Semaglutide (n = 8,803)		Placebo (n = 8,801)		P value
	n	%	n	%	
Adverse events leading to permanent discontinuation of trial product[1,2]	**1,461**	**16.6**	**718**	**8.2**	**<0.001**
Gastrointestinal disorders	880	10.0	172	2.0	<0.001
Nervous system disorders	124	1.4	92	1.0	0.03
Metabolism and nutrition disorders	108	1.2	27	0.3	<0.001
General disorders and administration-site conditions	105	1.2	47	0.5	<0.001
Neoplasms benign, malignant, and unspecified	80	0.9	105	1.2	0.07
Infections and infestations	75	0.9	84	1.0	0.47

[1]This trial employed targeted safety data collection, in which the only adverse events systematically collected and reported were serious adverse events, adverse events leading to discontinuation of trial product irrespective of seriousness, or adverse events of prespecified special interest irrespective of seriousness. [2]Organised by organ class
n: number of subjects; %: percentage of subjects in full analysis set. Note: P values are two-sided and were calculated with a Fisher's exact test for the test of no difference

In SELECT, semaglutide 2.4 mg appeared to have a safe and well-tolerated profile in line with previous semaglutide trials

The safety profile of semaglutide sc 2.4 mg in SELECT was similar to that observed in previous clinical trials with semaglutide

Serious adverse events were reported by a lower proportion of subjects in the semaglutide sc 2.4 mg group versus placebo

- Overall results: Semaglutide 2.4 mg: 33.4% versus placebo: 36.4%
- Difference driven by CV disorders, infections and surgical and medical procedures

No unexpected findings in the area of interests evaluated

- More subjects in the semaglutide 2.4 mg group reported events of gall-blader related disorders
- Similar proportion of subjects in each treatment group reported events of acute kidney injury, malignant neoplasms, acute pancreatitis and COVID-19

More subjects discontinued trial product permanently due to an AE in the semaglutide sc 2.4 mg group versus placebo

- Overall results: Semaglutide 2.4 mg: 16.6% versus placebo: 8.2%

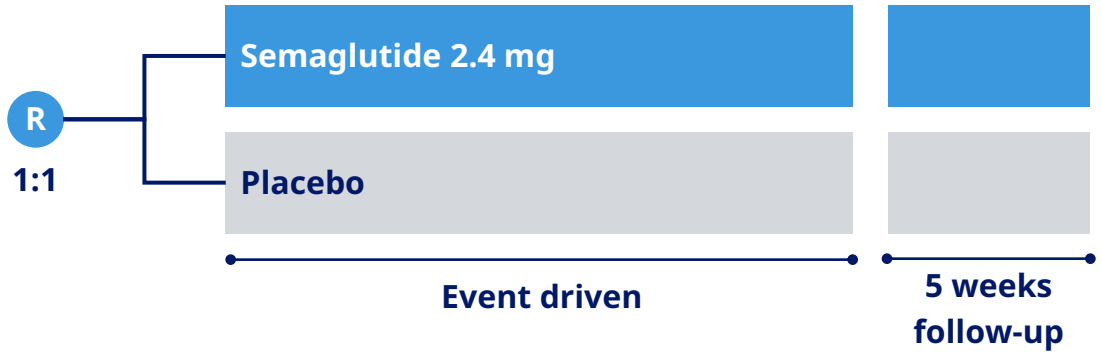
AE: Adverse event; CV: Cardiovascular; sc: Subcutaneous

Agenda

Introduction		*Daniel Bohsen*
SELECT	Introduction to the trial	*Martin Holst Lange*
	Efficacy	*Martin Holst Lange*
	Safety	*Robin Evers*
	Next steps	***Robin Evers***
Q&A		*All speakers*

SELECT has been filed for regulatory review in the US and EMA

SELECT trial with 17,604 people with BMI>27 and established CVD



Primary endpoint
- Time from randomisation to first occurrence of 3-point MACE[1]

Confirmatory secondary endpoints
Time from randomisation to:
- CV death
- First occurrence of heart failure composite endpoint
- All-cause death

Next steps:

- **SELECT submitted to FDA** (September 2023) and **EMA** (October 2023) for a label expansion with an expected decision in 2024
  - **US:** The FDA has granted priority review for the sNDA
- Primary endpoint is expected to be the focus with regard to submission and label
- Whether data from wide array of relevant clinical endpoints in the SELECT trial will be included in clinical sections is a review matter
- The totality of data expected to be addressed in engagement with authorities and payers

SELECT-LIFE
- Initiated to evaluate the long-term post-trial effects of semaglutide 2.4 mg once weekly on survival, cardiovascular disease, obesity and other metabolic-related outcomes.
- Expected completion in 2033

[1]MACE includes non-fatal myocardial infarction, non-fatal stroke, and cardiovascular death
BMI: Body mass index; CV: Cardiovascular; CVD: Cardiovascular Disease; MACE: Major adverse cardiovascular events; sc.: Subcutaneous; sNDA: Supplemental New Drug application

Closing remarks

SELECT met its primary objective by demonstrating that semaglutide 2.4 mg lowers the incidence of MACE by 20% compared to placebo

Beneficial effects were seen consistently across measured CV endpoints with semaglutide 2.4 mg

Safety data was in line with the known profile of semaglutide 2.4 mg and no unexpected safety findings were identified

SELECT is submitted to FDA that has granted priority review as well as EMA

Agenda

Introduction		*Daniel Bohsen*
SELECT	Introduction to the trial	*Martin Holst Lange*
	Efficacy	*Martin Holst Lange*
	Safety	*Martin Holst Lange*
	Next steps	*Robin Evers*
Q&A		***All speakers***

Investor contact information

Share information

Novo Nordisk's B shares are listed on the stock exchange in Copenhagen under the symbol 'NOVO B'. Its ADRs are listed on the New York Stock Exchange under the symbol 'NVO'.

For further company information, visit Novo Nordisk on: www.novonordisk.com

Upcoming events

31 January 2024	Financial statement 2023
7 March 2024	Capital Markets Day 2024

Investor Relations contacts

Novo Nordisk A/S
Investor Relations
Novo Alle 1
DK-2880 Bagsværd

Daniel Muusmann Bohsen	+45 3075 2175	dabo@novonordisk.com
David Heiberg Landsted	+45 3077 6915	dhel@novonordisk.com
Jacob Martin Wiborg Rode	+45 3075 5956	jrde@novonordisk.com
Sina Meyer	+45 30796656	azey@novonordisk.com
Frederik Taylor Pitter	+45 30758259	fptr@novonordisk.com