Novo Nordisk – a focused healthcare company

Novo Nordisk investor event in connection with ADA

New Orleans, 05 June 2022

Forward-looking statements

Novo Nordisk's reports filed with or furnished to the US Securities and Exchange Commission (SEC), including the statutory Annual Report 2021 and Form 20-F, which both were filed with the SEC in February 2022 in continuation of the publication of this Annual Report 2021, 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, including 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, 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, 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 2021, reference is made to the overview of risk factors in 'Risk management' of this Annual Report 2021.

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 2021, 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

Today’s speakers

Karsten Munk Knudsen
Executive Vice President and
Chief Financial Officer

Martin Holst Lange
Executive Vice President and
Head of Development

Mads Frederik Rasmussen
Senior Vice President and
Head of Clinical Drug Development

Agenda

Introduction		Karsten Munk Knudsen
Obesity care	*Post hoc analysis of STEP 1 and 4, STEP TEENS results and SELECT-LIFE*	Martin Holst Lange
GLP-1 Diabetes	*Semaglutide in chronic kidney disease and peripheral artery disease*	Mads Frederik Rasmussen
Insulin	*Insulin icodec hypoglycaemia frequency, results from ONWARDS 1, ONWARDS 2, and ONWARDS 6*	Martin Holst Lange
Q&A		All

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Strategic Aspirations 2025 | Highlights first three months 2022

Purpose and sustainability (ESG)

Progress towards zero environmental impact:

- Carbon emissions increased by 46% vs first quarter of 2021 and decreased 25% vs first quarter of 2019

Adding value to society:

- Positive scientific opinion from EMA on human insulin with more flexible storage option without refrigeration
- Two months' supply of diabetes and haemophilia medication donated to the Ukrainian Ministry of Health

Being recognised as a sustainable employer:

- Share of females in senior leadership positions has increased to 37% from 35% in the first quarter of 2021

Innovation and therapeutic focus

Further raise innovation-bar for Diabetes treatment:

- Approval of Ozempic® 2.0 mg in the US
- Successful completion of first phase 3 trial with once-weekly insulin icodec
- Phase 1 trial with Ideal Pump insulin successfully completed
- Phase 1 initiated with a once-daily oral GLP-1/GIP agonist

Strengthen and progress Rare disease pipeline

- Concizumab phase 3 trial successfully completed in people with haemophilia A and B with inhibitors

Commercial execution

Diabetes value market share increased by 1.2 percentage point to 30.5%[1]

Obesity care sales increased by 107% at CER to DKK 3.4 billion

Rare disease sales increased by 3% at CER to DKK 5.4 billion

Financials

Sales growth of 18% and Operating profit growth of 18%:

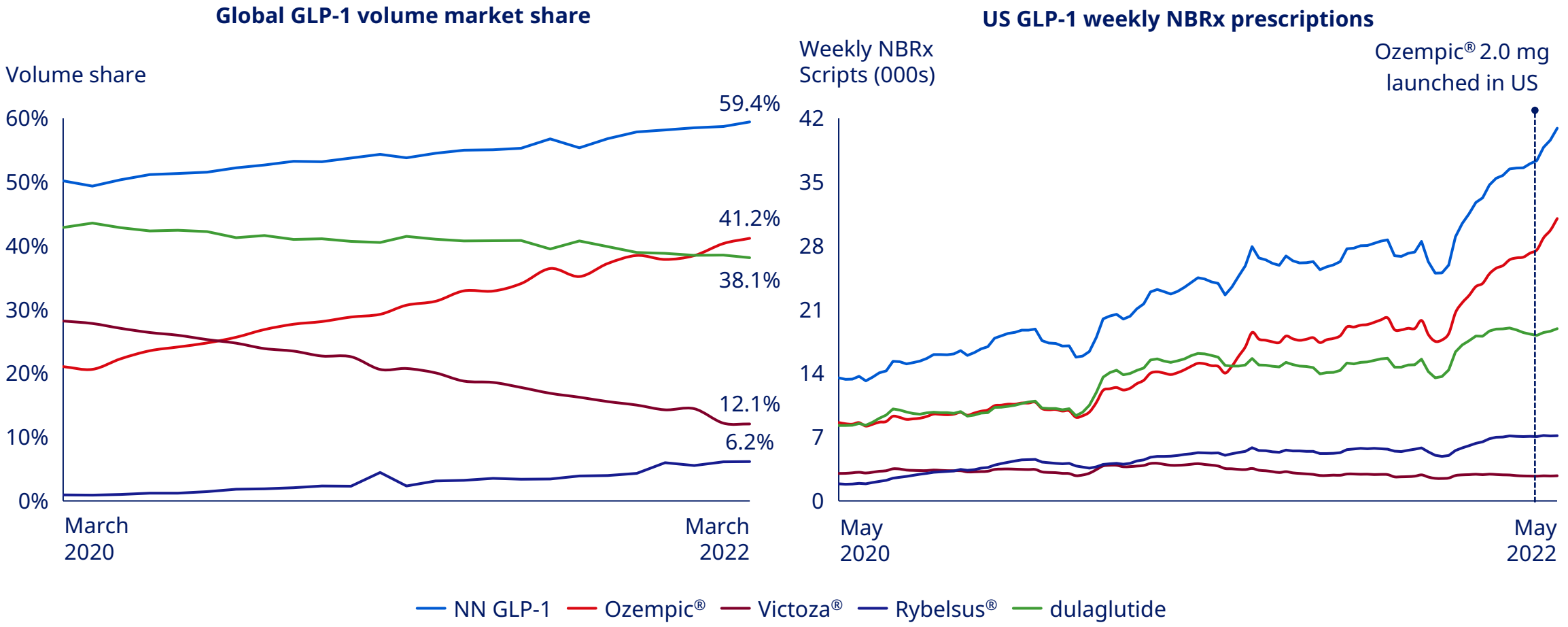
- Sales in International Operations grew by 13%
- Sales in the US grew by 23% with 67% of sales coming from products launched since 2015

Gross margin positively impacted by continued productivity gains in Product Supply

Free cash flow of DKK 21.6 billion and DKK 20 billion returned to shareholders during first quarter

[1] MAT (Moving annual total) value market share. IO: International Operations
The strategic aspirations are not a projection of Novo Nordisk's financial outlook or expected growth.

Ozempic® is now the global GLP-1 volume market leader and the 2.0 mg dose has just been launched in the US



NBRx: New-to-brand prescriptions; Scripts: prescriptions; RHS: Right-hand-side, LHS: Left-hand-side
Source: LHS: IQVIA Midas applied IQVIA spot rate, monthly data. RHS: IQVIA Xponent, Weekly (ending 13 May 2022) Each data points represents a rolling four-week average

Strategic Aspirations 2025 | Today with emphasis on Innovation and therapeutic focus

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, NASH 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
  - Deliver 6-10% sales growth in IO
  - Transform 70% of sales in the US[1]
- 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

[1] From 2015 to 2022, 70% of sales to come from products launched from 2015. IO: International Operations; CVD: Cardiovascular disease; NASH: Non-alcoholic steatohepatitis; CKD: Chronic kidney disease.
Note: The strategic aspirations are not a projection of Novo Nordisk's financial outlook or expected growth.

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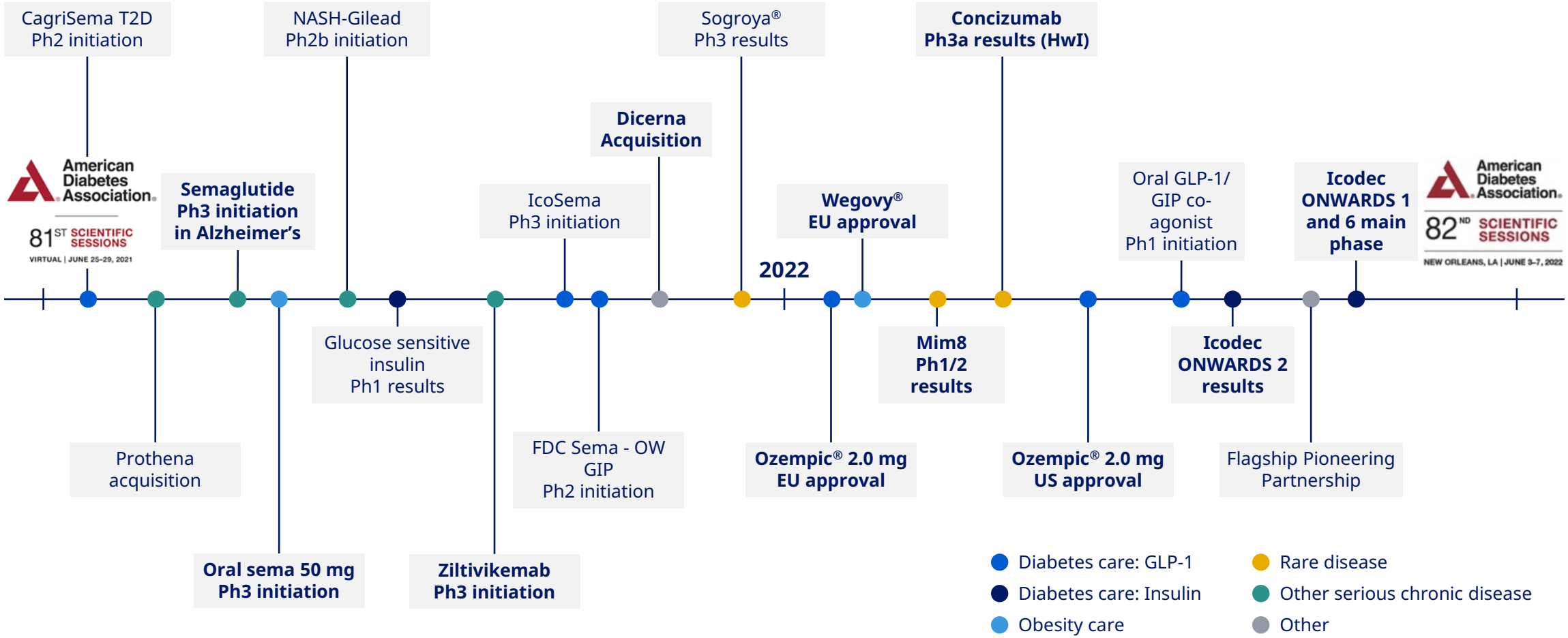
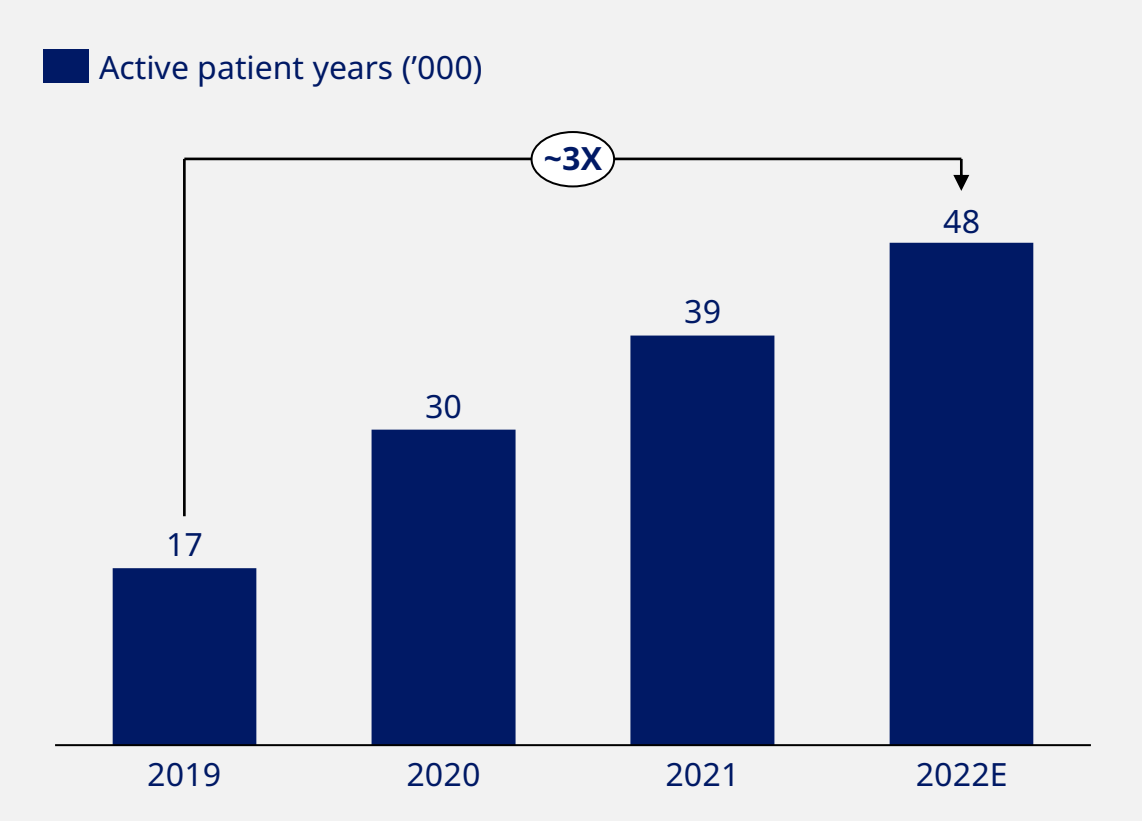
Since the ADA 2021, progress has been made across the Novo Nordisk pipeline



T2D: Type 2 diabetes; Sema: Semaglutide; Ph: Phase; OW: Once-weekly; HwI: Haemophilia with inhibitors
Note: Timeline non-exhaustive

Research and development activity is at an all time high

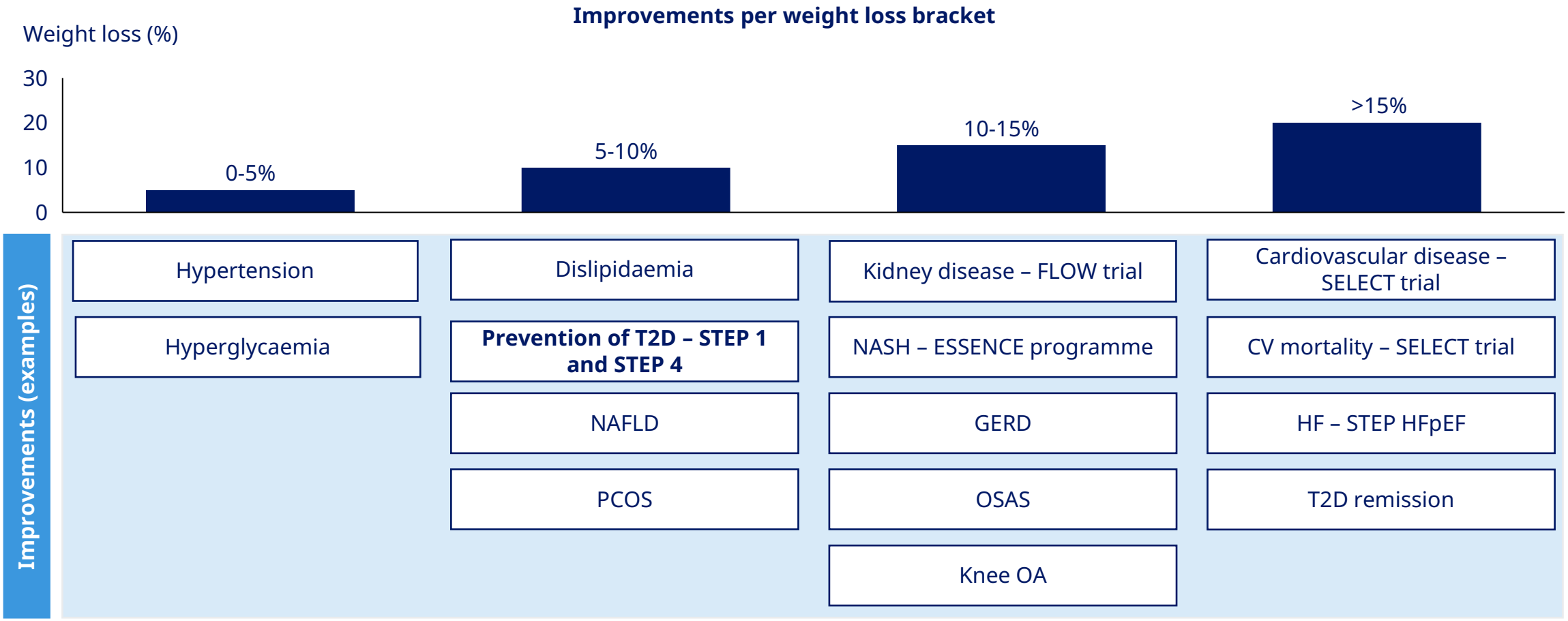
Patient years in trials increasing over last four years



Active phase 3 trials across all therapy areas

CKD: Chronic kidney disease; CVD: Cardiovascular disease; RBD: Rare blood disorders; RED: Rare endocrine disorders

Weight loss is associated with improvements of multiple comorbidities

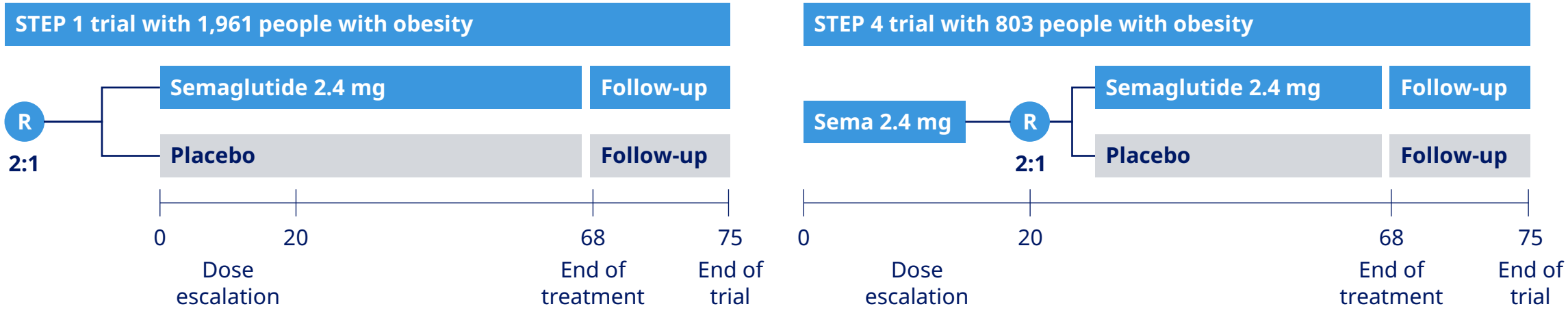


T2D: Type 2 diabetes; NAFLD: Non-alcoholic fatty liver disease; PCOS: Polycystic ovary syndrome; NASH: Non-alcoholic steatohepatitis; GERD: Gastroesophageal reflux disease; OSAS: Obstructive sleep apnoea syndrome; OA: Osteoarthritis
HF: Heart failure

Sources: Garvey WT et al. Endocr Pract 2016;22 (Suppl. 3):1–203; Look AHEAD Research Group. Lancet Diabetes Endocrinol 2016;4:913–21; Lean ME et al. Lancet 2018;391:541–5; Benraoune F and Litwin SE. Curr Opin Cardiol 2011;26:555–61; Sundström J et al. Circulation 2017;135:1577–85., Morales E and Praga M. Curr Hypertens Rep 2012;14:170-176

The 10-year risk of type 2 diabetes was assessed post hoc in STEP 1 and STEP 4

STEP 1 and STEP 4 trial design



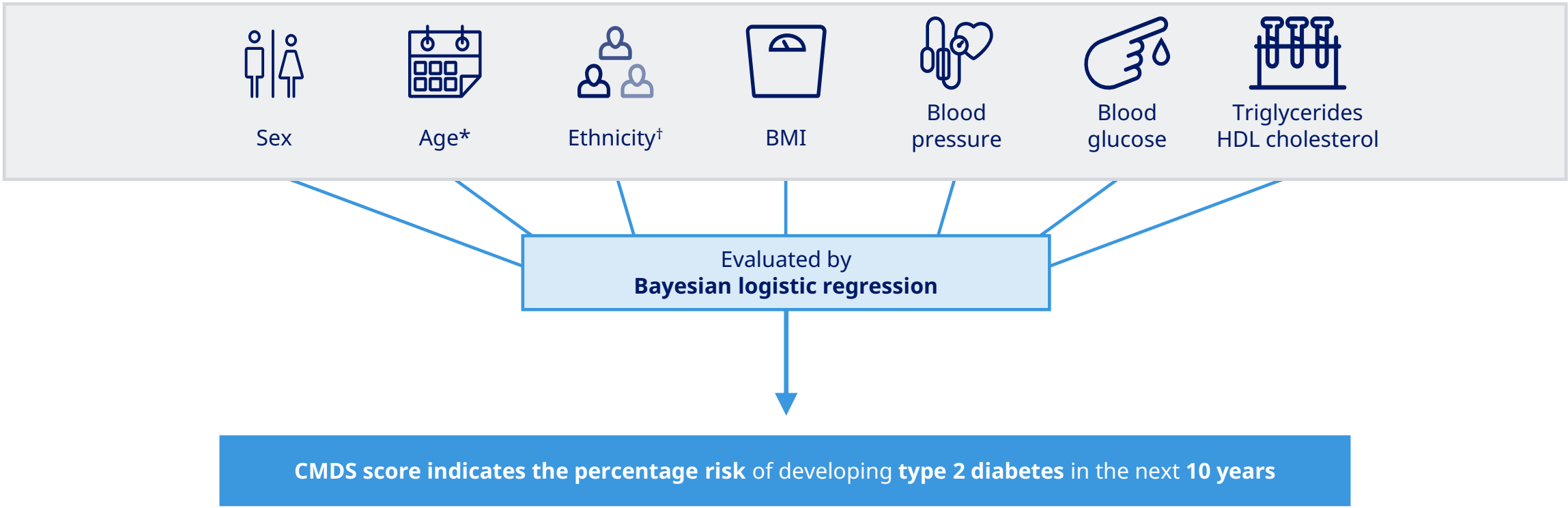
The effect of once-weekly s.c. semaglutide (sema) 2.4 mg on the risk of developing T2D in people with obesity is unknown.

Weight management with sema vs placebo plus diet and exercise was assessed[1] in participants with overweight/obesity in STEP 1 and STEP 4.

[1]The 10-year T2D risk was calculated post hoc using Cardiometabolic Disease Scoring (CMDS).
T2D: Type 2 diabetes; s.c.: Subcutaneous; sema: semaglutide
Source: Garvey, et. al. Poster 2-LB presented at the 82nd Scientific Sessions of the American Diabetes Association 2022, June 3-7, 2022 (New Orleans, LA, USA) meeting)

Cardiometabolic Disease Scoring (CMDS) is a validated tool to assess 10-year type 2 diabetes risk

CMDS was applied post hoc to the STEP 1 and 4 trials of once-weekly s.c. semaglutide 2.4 mg

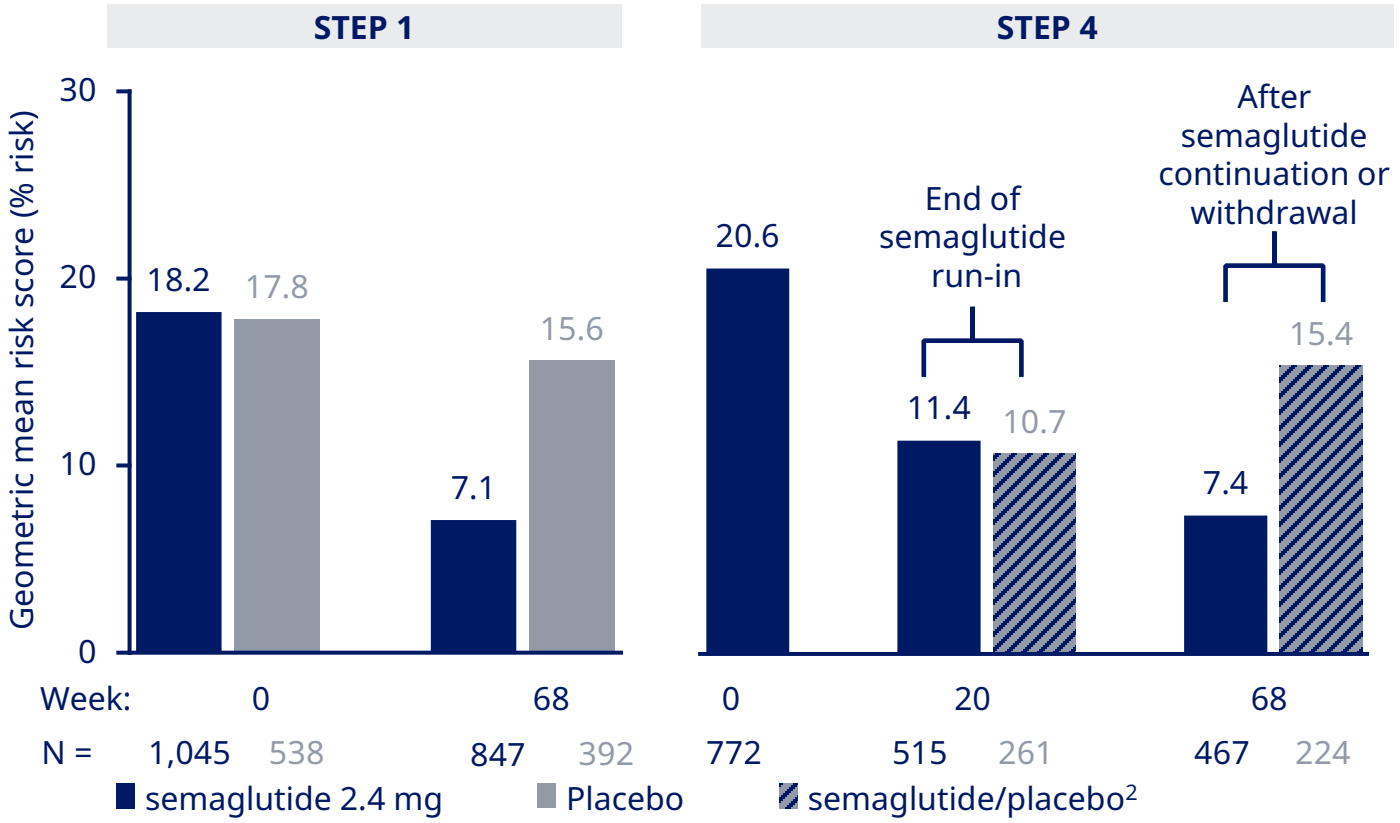


*CMDS was developed and validated in individuals aged ≥45 years. †CMDS was developed and validated in Black and White individuals. ADA, American Diabetes Association; ARIC, Atherosclerotic Risk in Communities; ATP, Adult Treatment Panel; BMI, body mass index; CMDS, Cardiometabolic Disease Scoring; HDL, high-density lipoprotein; REGARDS, Reasons for Geographic And Racial Differences in StrokeSource

Wilkinson L, Yi N, Mehta T, Judd S, Garvey WT. Development and validation of a model for predicting incident type 2 diabetes using quantitative clinical data and a Bayesian logistic model: A nationwide cohort and modeling study. PLoS Med. 2020 Aug 7;17(8):e1003232. doi

CMDS analysis indicates that sema 2.4 mg reduces the 10-year risk of developing T2D in people with overweight/obesity by ~60%

Absolute 10-year T2D risk scores in the overall STEP 1 and STEP 4



Semaglutide 2.4 mg could help prevent T2D in people with obesity

- Semaglutide 2.4 mg treatment reduces the 10-year risk of T2D by ~60% regardless of initial glycaemic status
- Sustained treatment required to maintain this benefit
- Treatment effect similar in participants with normoglycaemia and prediabetes

[1]The 10-year T2D risk was calculated post hoc using Cardiometabolic Disease Scoring (CMDS). [2] 20 weeks of semaglutide followed by 48 weeks of placebo
T2D: Type 2 diabetes; s.c.: Subcutaneous; sema: semaglutide
Source: Garvey, et. al. Poster 2-LB presented at the 82nd Scientific Sessions of the American Diabetes Association 2022, June 3-7, 2022 (New Orleans, LA, USA)

Semaglutide 2.4 mg was investigated in an adolescent population in the STEP TEENS phase 3 trial

Childhood obesity affects the life of many

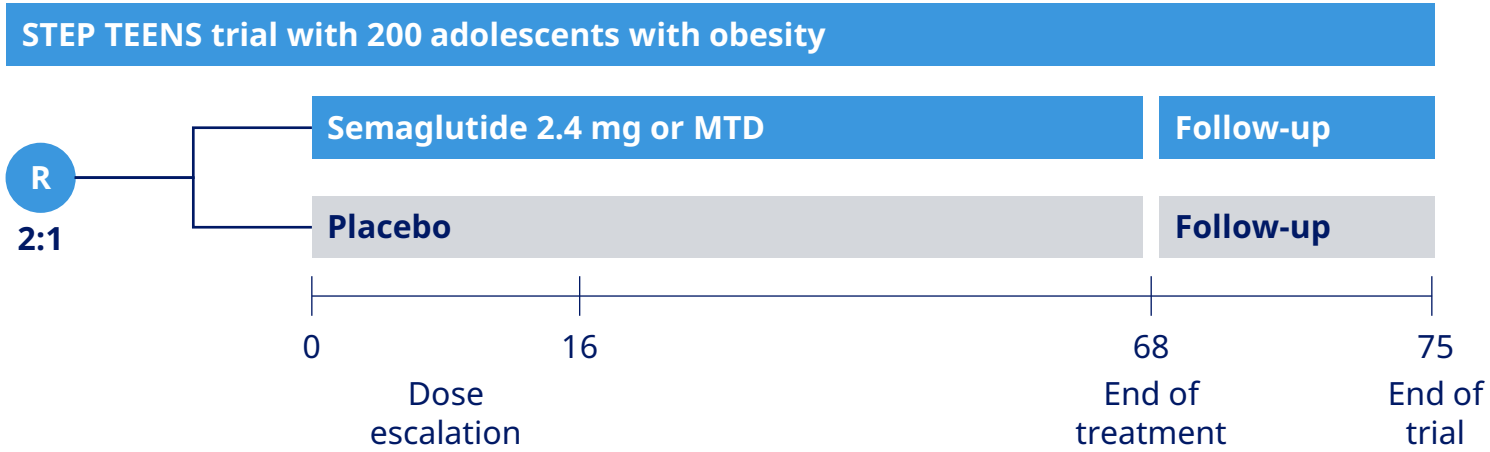
>150m

Characteristics:

- Increasing rapidly
- Associated with multiple obesity-related complications
- Independent risk factor for obesity in adulthood
- Predisposing to both reduced life expectancy and quality of life

Besides Saxenda®, very few pharmacotherapies approved for use in adolescents with obesity

STEP TEENS comparing the effects and safety and tolerability of sema 2.4 mg vs placebo



Endpoints

- Primary: Change in BMI (%)
- Confirmatory secondary: ≥5% body weight reduction
- Supporting secondary endpoints include : IWQOL-Kids, lipids, etc.

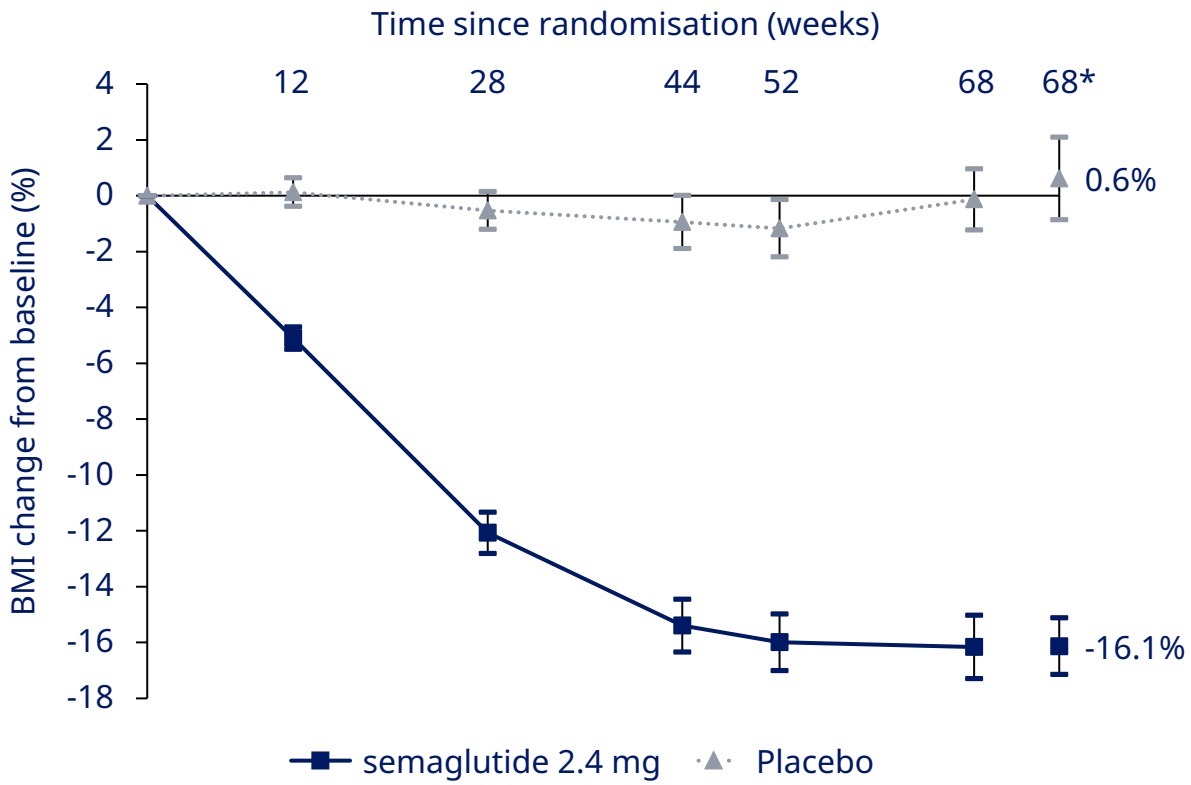
Key inclusion criteria

- 12 to <18 years
- Tanner stage 2-5
- BMI ≥95th percentile* or BMI ≥85th percentile* with ≥1 weight-related comorbidity[1]

*On sex-specific BMI-for-age Growth Charts (cdc.gov). [1] Hypertension, dyslipidaemia, obstructive sleep apnoea or Type 2 diabetes
MTD: Maximum tolerated dose; s.c.: Subcutaneous; Sema: Semaglutide; BMI: Body Mass Index; IWQOL: Impact of Weight on Quality of Life
Source: Atlas of Childhood Obesity, October 2019 (estimating +250m children living with obesity in 2025)

BMI reduction of 16% in adolescents treated with semaglutide 2.4 mg in the STEP TEENS trial

STEP TEENS showed greater than 16% reduction in BMI



Data from STEP TEENS

- Average age 15.4 years
- 62% female
- Average BMI of 37.0 kg/m^2

Semaglutide 2.4 mg was superior to placebo on %-change in BMI and 5% body weight responders

- BMI: 16.7% ETD, 5% body weight responders: 72.5%
- Improvements seen in all other weight-related parameters as well as also CV risk factors and glucose metabolism

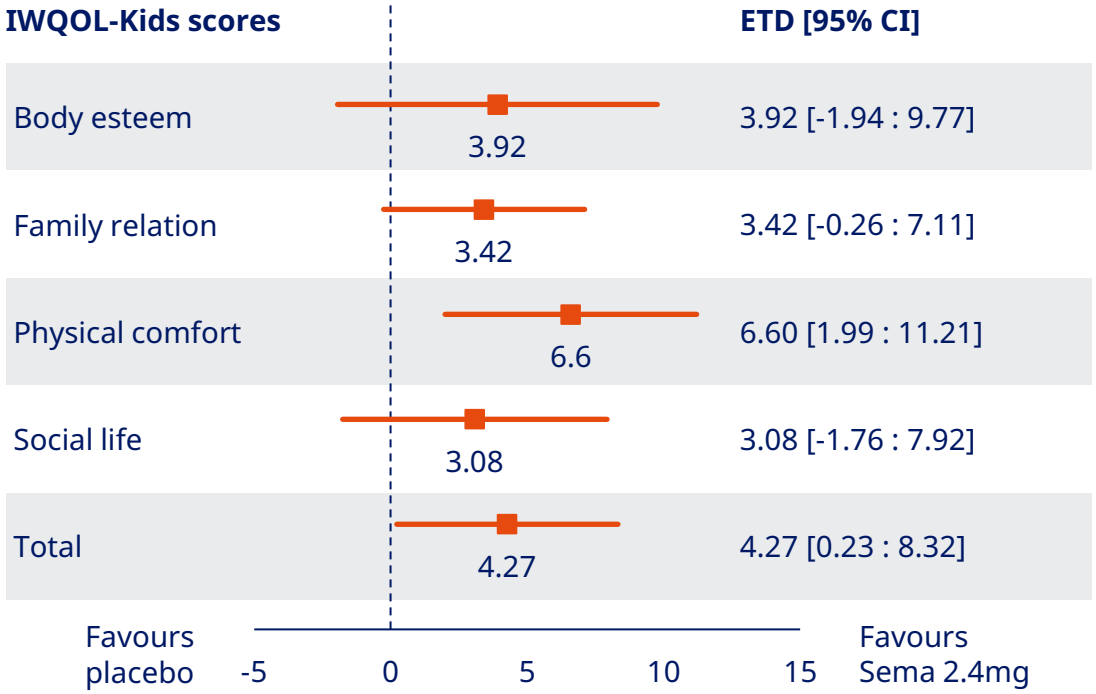
Semaglutide 2.4 mg appeared well-tolerated

- Safety and tolerability were consistent phase 3 data in adults and the GLP-1 RA class in general

* Lines are based on observed mean data where the value denoted after 68 weeks is the estimated mean value
Note: Treatment policy estimand
IWQOL-Kids: Impact of Weight on Quality of Life-Kids; ETD: Estimated treatment difference; CV: Cardiovascular

First anti-obesity medication showing weight-related quality of life benefit in a study of an adolescent population

Sema 2.4 mg showed a statistically significant treatment difference versus placebo in the IWQOL-Kids

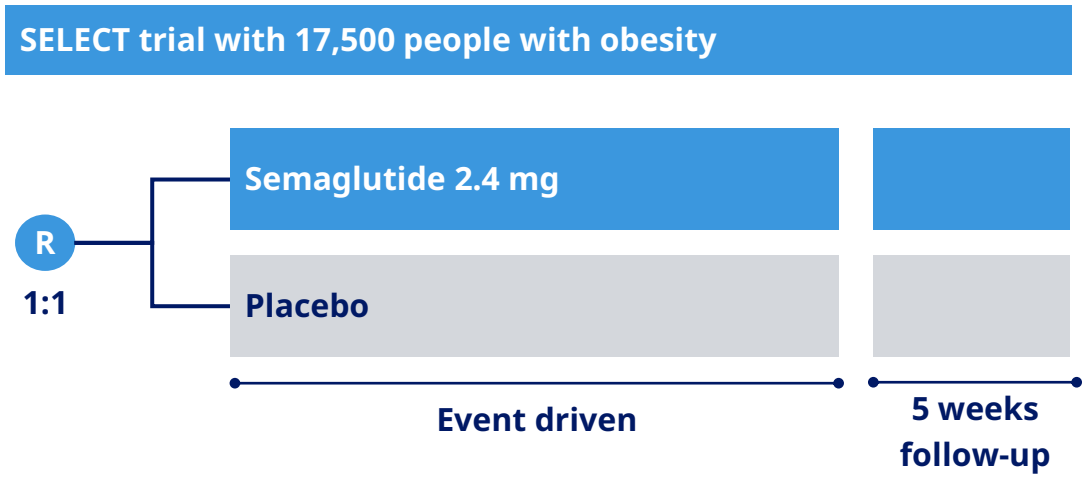


Exploratory endpoint:
Impact of Weight on Quality of Life-Kids

- Semaglutide 2.4 mg improved weight-related quality of life as measured by IWQOL-kids
- Results suggest a benefit of semaglutide 2.4mg vs placebo across all domains giving a statistically significant benefit on total score
- Strongest benefit of semaglutide 2.4mg vs placebo was seen in the physical comfort score (statistically significant)

ETD derived based on multiple imputation; sema: Semaglutide; AOM: Anti-obesity medication
IWQOL-Kids: Impact of Weight on Quality of Life-Kids, ETD: estimated treatment difference, CI: confidence interval, Sema: Semaglutide.

The interim analysis for the SELECT trial is expected to be conducted in the third quarter of 2022



Objective
Demonstrate that semaglutide 2.4 mg lowers the incidence of MACE vs placebo

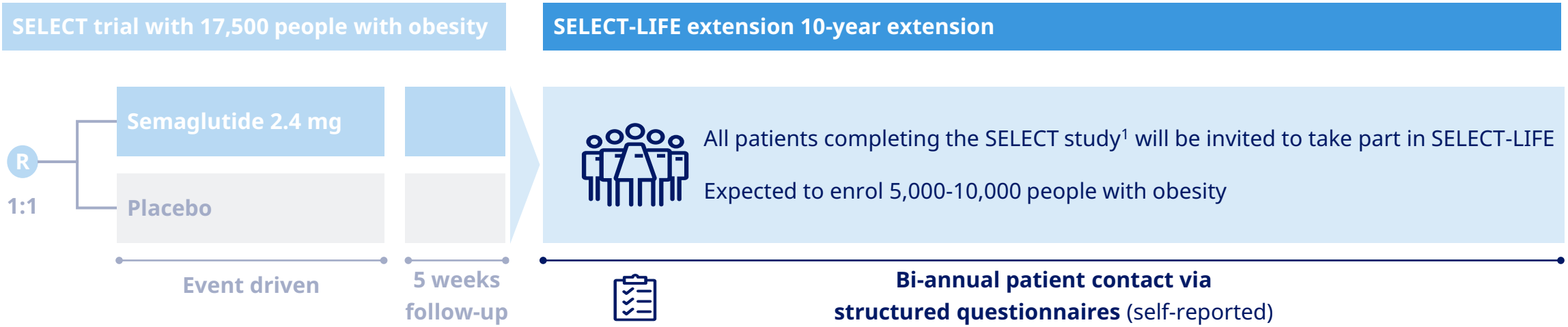
Primary endpoint
Time from randomisation to first occurrence of MACE[1]

Secondary endpoints
CV death, all-cause death, 5-point MACE composite, composite HF, composite nephropathy, glucose metabolism, other metabolic parameters

Stopping at interim
A decision to stop the trial based on the interim analysis follows assessment of the totality of the data

[1] MACE includes non-fatal myocardial infarction, non-fatal stroke, and cardiovascular death.
MACE: Major adverse cardiovascular events; HF: Heart failure; CV: Cardiovascular

SELECT-LIFE is a 10-year observational follow-up study with twice-yearly collection of self-reported patient data



Purpose of SELECT-LIFE

Improve understanding of obesity and its complications, positively impact future treatment guidelines and contribute to improved clinical care in people living with obesity and CVD

Regular data publications are expected

Examples of endpoint focus areas

- Survival
- Cardiovascular events
- Type 2 diabetes
- Obesity-related complications

[1] Within countries participating in SELECT-LIFE
CVD: Cardiovascular Disease

Obesity: Key take-aways

A post hoc analysis of STEP 1 and 4 indicates a ~60% reduction in the 10-year risk of developing type 2 diabetes

STEP TEENS in adolescents reads out with around 16% reduction in BMI

SELECT interim analysis expected to be conducted in the third quarter of 2022

SELECT-LIFE, a 10-year observation follow-up study, to improve understanding of obesity and its complications long-term

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Investigating semaglutide effects beyond glucose lowering in people with type 2 diabetes

FOCUS
Diabetic retinopathy outcomes trial

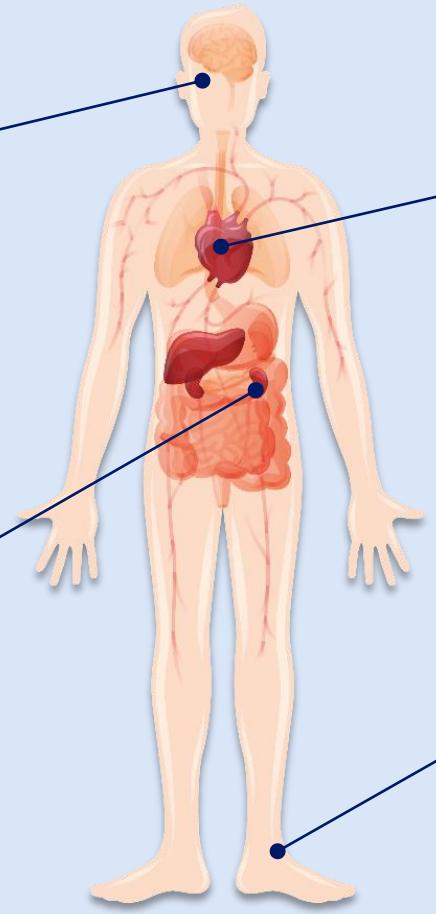
Semaglutide 1.0 mg, injectable + standard of care

- ~1,500 patients with T2D for 10 or more years
- Primary endpoint: Presence of ≥3 steps ETDRS patient level progression
- Estimated completion in 2027

FLOW
Chronic kidney disease outcomes trial

Semaglutide 1.0 mg, injectable

- ~3,500 patients with T2D, moderate to severe CKD
- Primary endpoint: Time to first occurrence of a composite outcome event[2]
- Estimated completion in 2024



SOUL
Cardiovascular outcomes trial

Semaglutide 14 mg, oral

- ~9,600 patients with T2D, established CVD or CKD
- Primary endpoint: Time to first major adverse cardiovascular event[1]
- Estimated completion in 2024

STRIDE
Peripheral arterial disease

Semaglutide 1.0 mg, injectable

- ~800 patients with type 2 diabetes and PAD
- Primary endpoint: Change in maximum walking distance
- Estimated completion in 2024

[1]Major adverse cardiovascular event defined as CV death, non-fatal stroke or non-fatal myocardial infarction; [2]Defnined as persistent eGFR decline of ≥50% from trial start, reaching end stage renal disease, death from kidney disease or death from cardiovascular disease
T2D: Type 2 diabetes; CVD: Cardiovascular disease; PAD: Peripheral arteries disease; ETDRS: Early treatment diabetic retinopathy study; CKD: Chronic kidney disease

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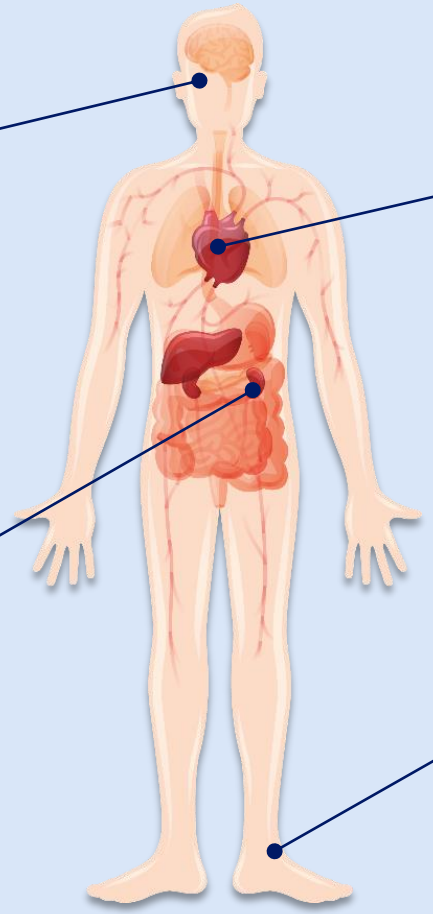

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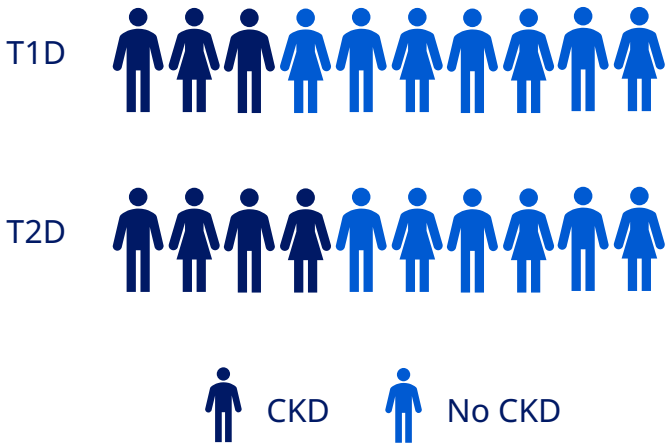
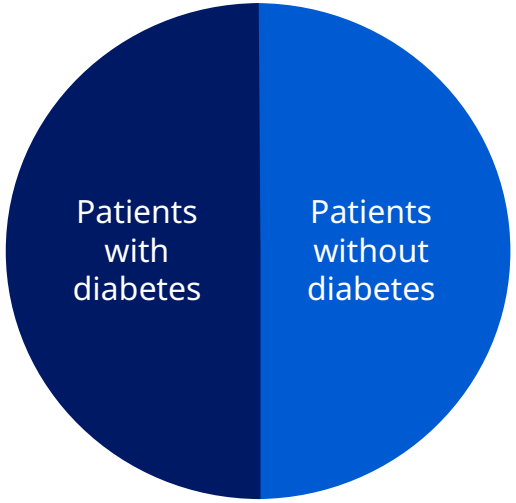
T2D: Type 2 diabetes; CVD: Cardiovascular disease; PAD: Peripheral arteries disease; ETDRS: Early treatment diabetic retinopathy study; CKD: Chronic kidney disease

Chronic kidney disease is common in patients with diabetes and remains a large unmet need

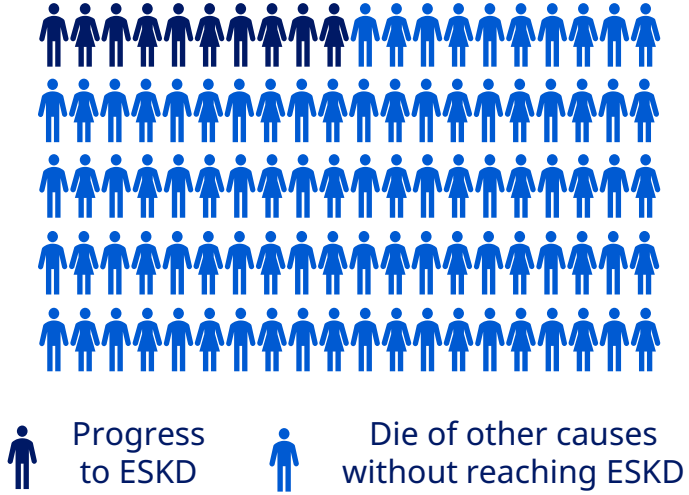
Chronic kidney disease (CKD) is common in patients with diabetes



Diabetes is directly correlated with ~ 50% of all ESKD cases

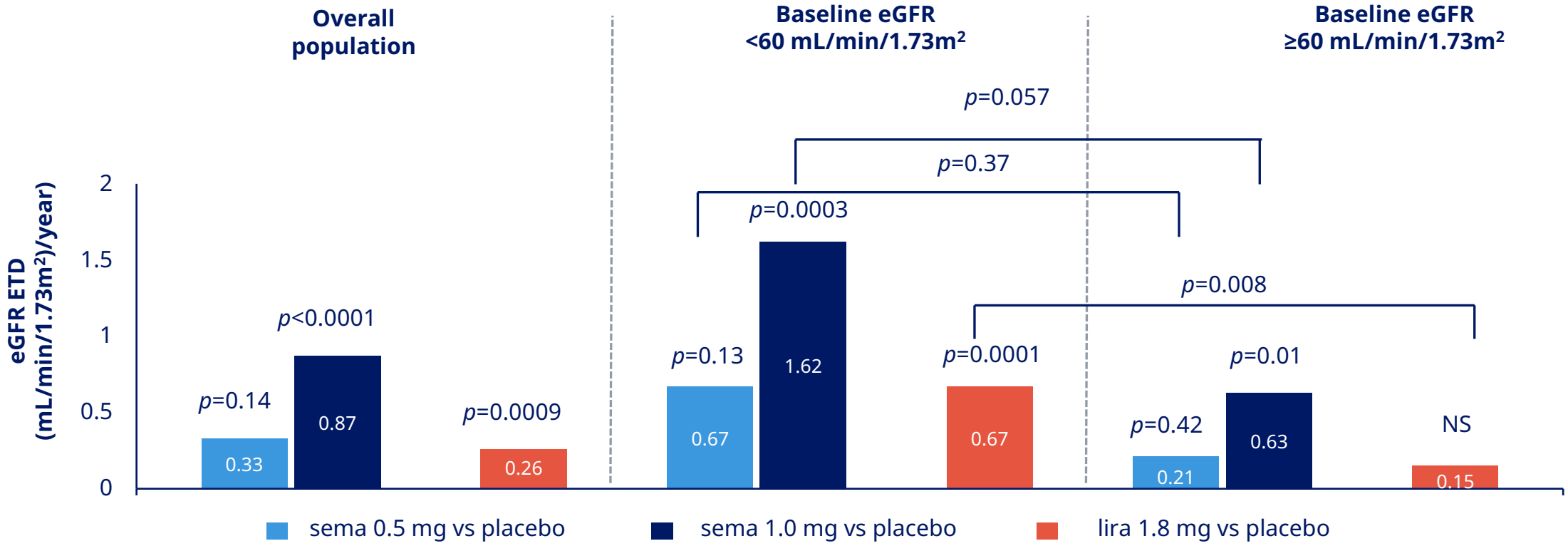


10 in 100[1] patients with diabetic kidney disease progress to ESKD



[1]4–17% at 20 years
CKD: Chronic Kidney Disease; ESKD: End Stage Kidney Disease; T1D: Type 1 diabetes; T2D: type 2 diabetes
Sources: Alicic RZ et al. Clin J Am Soc Nephrol 2017; Zelnick LR et al. Clin J Am Soc Nephrol 2017; Ghaderian SB et al. J Renal Inj Prev 2015; Pálsson R & Patel UD. Adv Chronic Kidney Dis 2014; Afkarian M et al. J Am Soc Nephrol 2013

Attenuated loss of kidney function observed across SUSTAIN 6 and LEADER



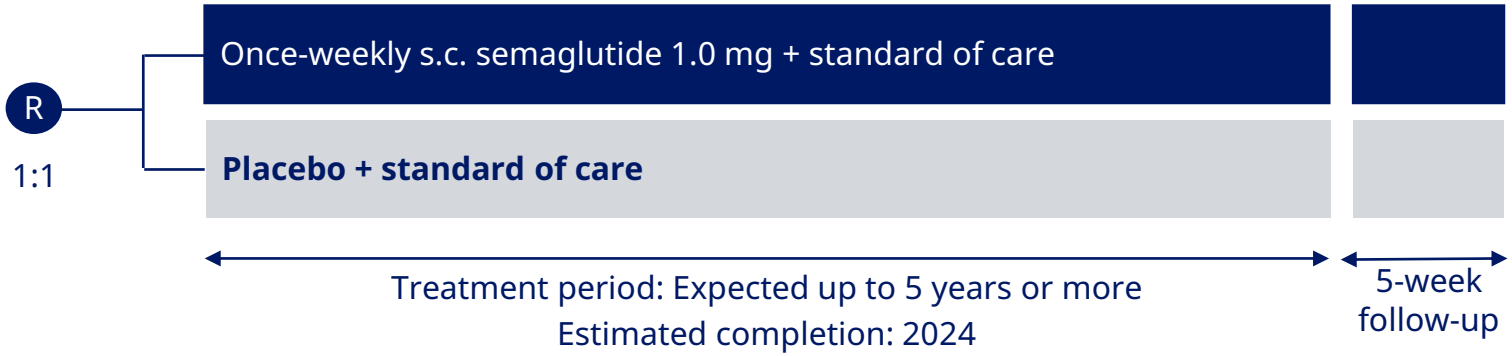
CI: confidence interval; eGFR: estimated glomerular filtration rate; HR, hazard ratio; ETD: Estimated treatment difference; eGFR: estimated glomerular filtration rate; Sema: Semaglutide; Lira: Liraglutide; NS: Non-significant
Source: Presented at the 56th European Renal Association - European Dialysis and Transplant Association (ERA-EDTA) Congress, 13–16 June 2019; Budapest, Hungary, Poster F482

Semaglutide 1.0 mg is investigated in people with diabetes and chronic kidney disease in the ongoing phase 3b trial FLOW

Phase 3b trial for semaglutide 1.0 mg in ~3,500 people with type 2 diabetes and chronic kidney disease

Inclusion

- T2D, HbA_{1c} ≤10%
- eGFR ≤75 to ≥50[1] and UACR >300 to <5,000 mg/g OR eGFR <50 to ≥25[1] and UACR >100 to <5,000 mg/g
- RAAS blocker



Trial objective

- Demonstrate that semaglutide delays the progression of renal impairment and lowers risk of renal - and CV mortality

Primary end-points

Time to first occurrence of a composite endpoint:

- Onset of persistent ≥50% reduction in eGFR
- Onset of persistent eGFR <15 mL/min/1.73 m2
- Initiation of chronic renal replacement therapy (dialysis or kidney transplantation)
- Renal death
- CV death

Secondary end-points

- Change in eGFR (total eGFR slope)
- 3-point MACE
- All-cause death

[1] mL/min/1.73 m2

T2D: Type 2 diabetes; UACR: Urine albumin-creatinine ratio; RAAS: Renin-angiotensin-aldosterone system; CV: Cardiovascular; MACE: Major adverse cardiovascular events; eGFR: estimated glomerular filtration rate; Sc: Subcutaneous

FLOW is investigating kidney outcomes and the role of GLP-1 in a trial population with multiple risk factors and comorbidities

Trial baseline characteristics

	Trial population, N=3,535
Age, years mean (SD)	66.6 (9.0)
HbA_{1c}, % mean (SD)	7.8 (1.3)
Diabetes duration, years mean (SD)	17.4 (9.3)
eGFR, mL/min/1.73m^2 mean (SD)	47.0 (15.1)
UACR, mg/g, median (min.-max.)	567 (1-11,852)
Diabetic comorbidities	
Diabetic neuropathy[1] (%)	1,519 (43.0)
Diabetic retinopathy in at least one eye[2] (%)	1,578 (44.6)
Diabetic macular edema in at least one eye[2] (%)	241 (6.8)
Very high CKD progression risk, n (%)	2,414 (68.2%)

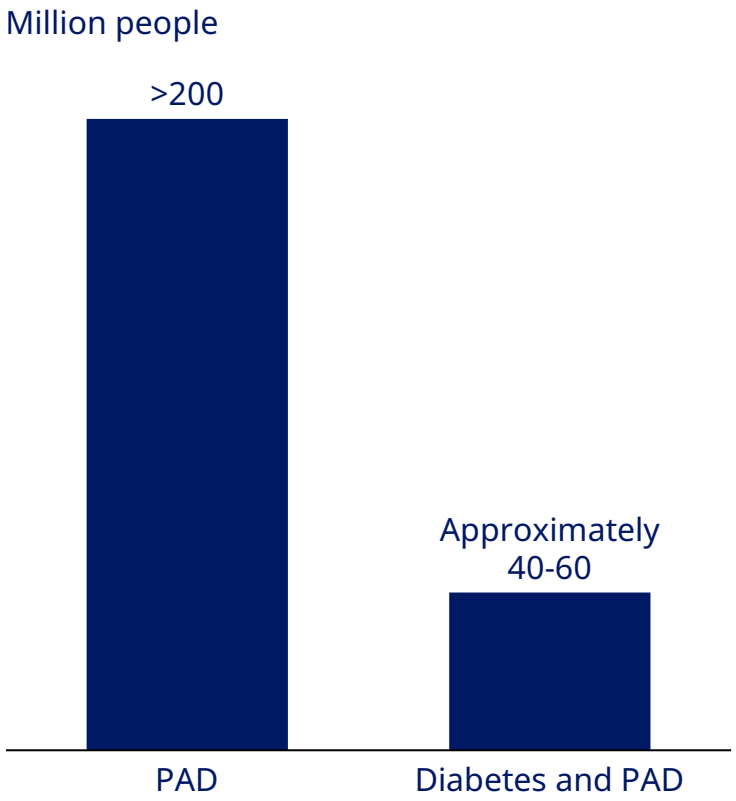
Key take-aways

- First and only kidney outcomes trial specifically designed and powered to assess whether treatment with a GLP-1 can reduce risk of kidney failure and loss of kidney function
- Patients with high risk of CKD progression with long diabetes duration, high medication use and prevalent comorbidities
- No observed association of HbA_{1c} or diabetes duration with KDIGO risk category
- FLOW, alongside SOUL, SELECT and REMODEL trials, will assess the effect of semaglutide in the interconnected disease areas of CKD, T2D, obesity and CVD

[1] Based on medical history; [2] Based on eye examination at baseline
UACR: Urine albumin-creatinine ratio; CKD: Chronic kidney disease; SD: Standard deviation; eGFR: estimated glomerular filtration rate; T2D: Type 2 diabetes; CVD: Cardiovascular disease; KDIGO: Kidney Disease: Improving Global Outcomes
Source: ADA 2022 poster 747-P: Baseline characteristics of subjects in the once-weekly semaglutide FLOW kidney outcomes trial (diabetes status)

Limited treatment options for the millions of people with type 2 diabetes and peripheral artery disease (PAD)

20-30% of people with PAD have diabetes



People with type 2 diabetes are at higher risk of suffering from PAD

Factors increasing risk of PAD in people with type 2 diabetes

- Duration of diabetes
- Age
- Presence of peripheral neuropathy
- Poor glycaemic control

Low diagnosis rates and limited treatment options

- Difficult to diagnose due to peripheral neuropathy
- Treatment is
  - diet, exercise, secondary prevention medicine
  - endovascular treatment and surgical thromboendarterectomy
  - open surgical revascularisation or amputation

Unmet need: Limited treatment options for people with type 2 diabetes and PAD

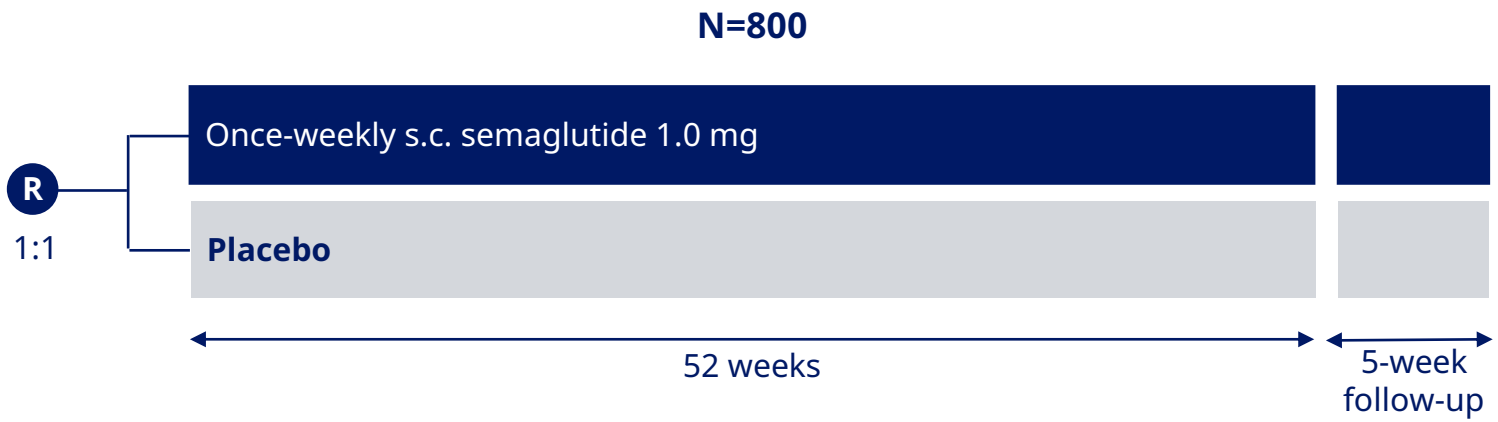
PAD: Peripheral artery disease; MACE: Major adverse cardiovascular events.
Sources: Fowkes FG et al. Lancet 2013;382:1329–40 (LHS). RHS: Thiruvoipati T et al. World J Diabetes 2015;6:961–69 (RHS); Aboyans V et al. Eur Heart J 2018;39:763–816; Gerhard-Herman MD et al. Circulation 2017;135:e686–e725; Komai H. Ann Vasc Dis 2019;12:151–6; Salhiyyah K et al. Cochrane Database Syst Rev. 2015;9(9):CD005262; Hennion DR and Siano KA. Am Fam Physician. 2013 Sep 1;88(5):306–310.

The ongoing STRIDE phase 3a trial investigates semaglutide for the treatment of peripheral artery disease in people with T2D

Phase 3a trial (STRIDE) for semaglutide 1.0 mg in type 2 diabetes for treatment of PAD expected to read out in 2024

Inclusion criteria

- Adults with T2D and PAD
- Intermittent claudication stage Fontaine IIa≥ 3 months
- Max walking distance ≤600m



Primary end-point
Change in maximum walking distance on a constant load treadmill test

Secondary end-points

- Change in pain-free walking distance on a constant load treadmill test
- Change in Vascular Quality of Life Questionnaire-6 (VascuQoL-6) score

Next steps
Estimated completion is during 2024

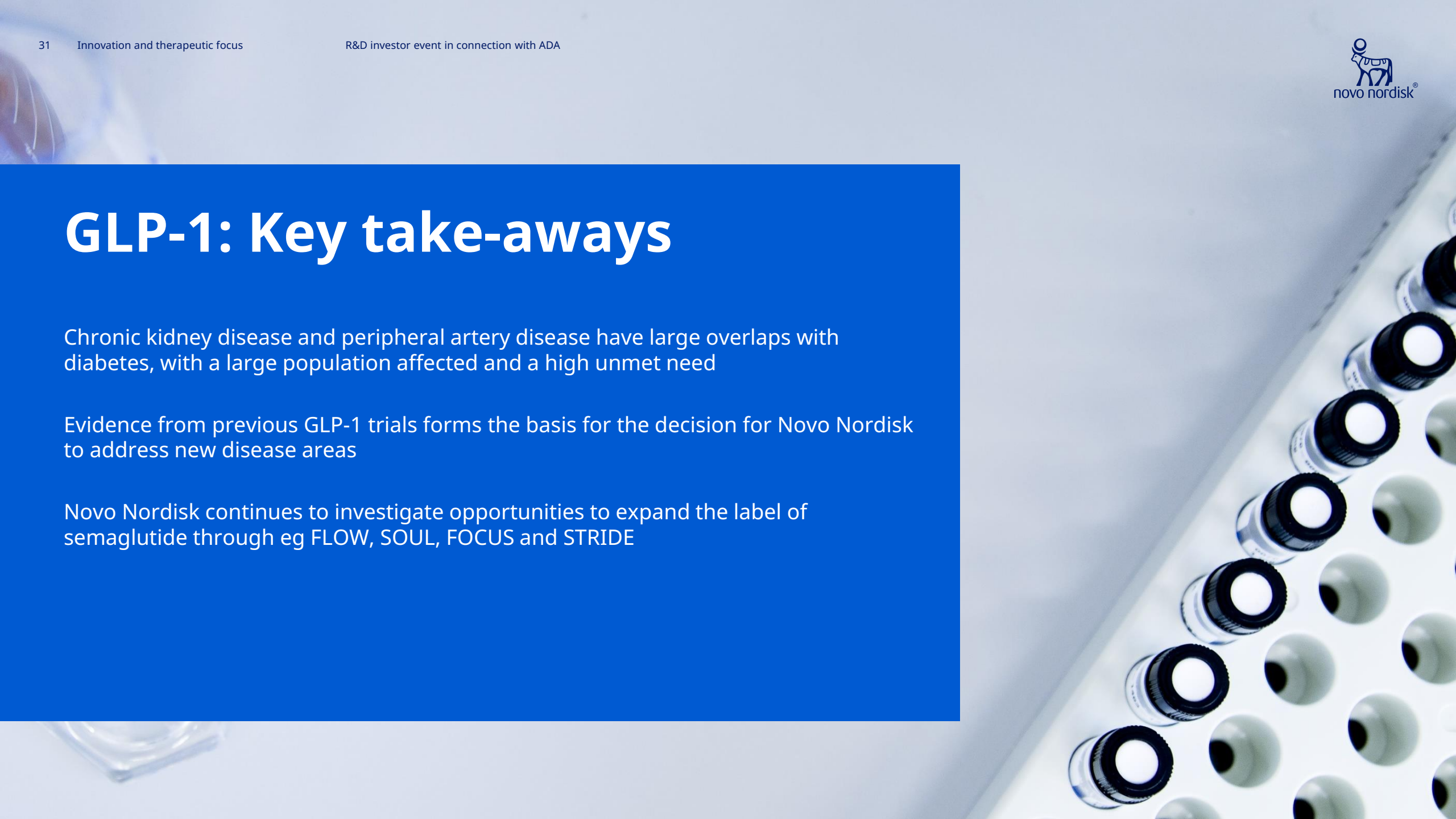
R: Randomisation; PAD: Peripheral artery disease; T2D: Type 2 Diabetes; S.c.: Subcutaneous
Source: ClinicalTrials.gov identifier: NCT04560998

GLP-1: Key take-aways

Chronic kidney disease and peripheral artery disease have large overlaps with diabetes, with a large population affected and a high unmet need

Evidence from previous GLP-1 trials forms the basis for the decision for Novo Nordisk to address new disease areas

Novo Nordisk continues to investigate opportunities to expand the label of semaglutide through eg FLOW, SOUL, FOCUS and STRIDE

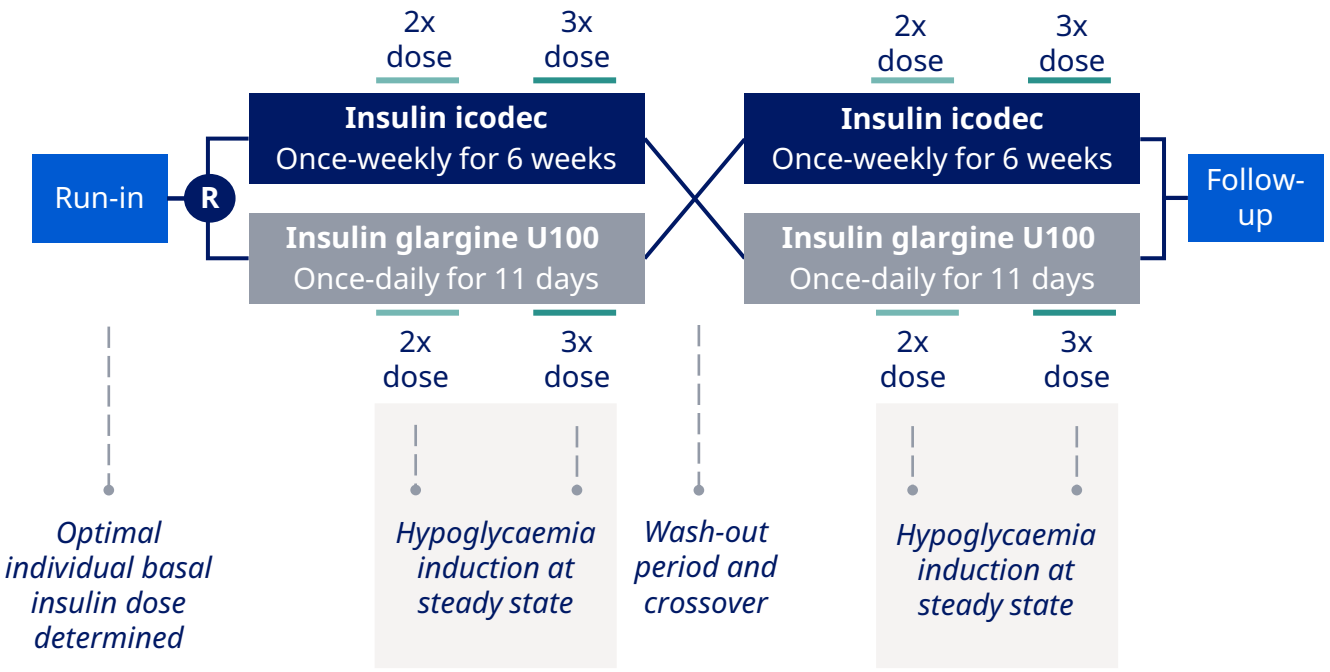


Agenda

Introduction		Karsten Munk Knudsen
Obesity care	*Post hoc analysis of STEP 1 and 4, STEP TEENS results and SELECT-LIFE*	Martin Holst Lange
GLP-1 Diabetes	*Semaglutide in chronic kidney disease and peripheral artery disease*	Mads Frederik Rasmussen
Insulin	*Insulin icodec hypoglycaemia frequency, results from ONWARDS 1, ONWARDS 2, and ONWARDS 6*	Martin Holst Lange
Q&A		All

Hypoglycaemia frequency and physiological response to double or triple doses of insulin icodec vs insulin glargine U100

Design of the two-period crossover trial



Objective

To compare between once-weekly insulin icodec and once-daily insulin glargine U100 in people with type 2 diabetes

Specifically:

- **Hypoglycaemia frequency** after double or triple doses
- **Physiological response to hypoglycaemia** after a triple dose in patients with plasma glucose <54 mg/dL and/or hypoglycaemia symptoms

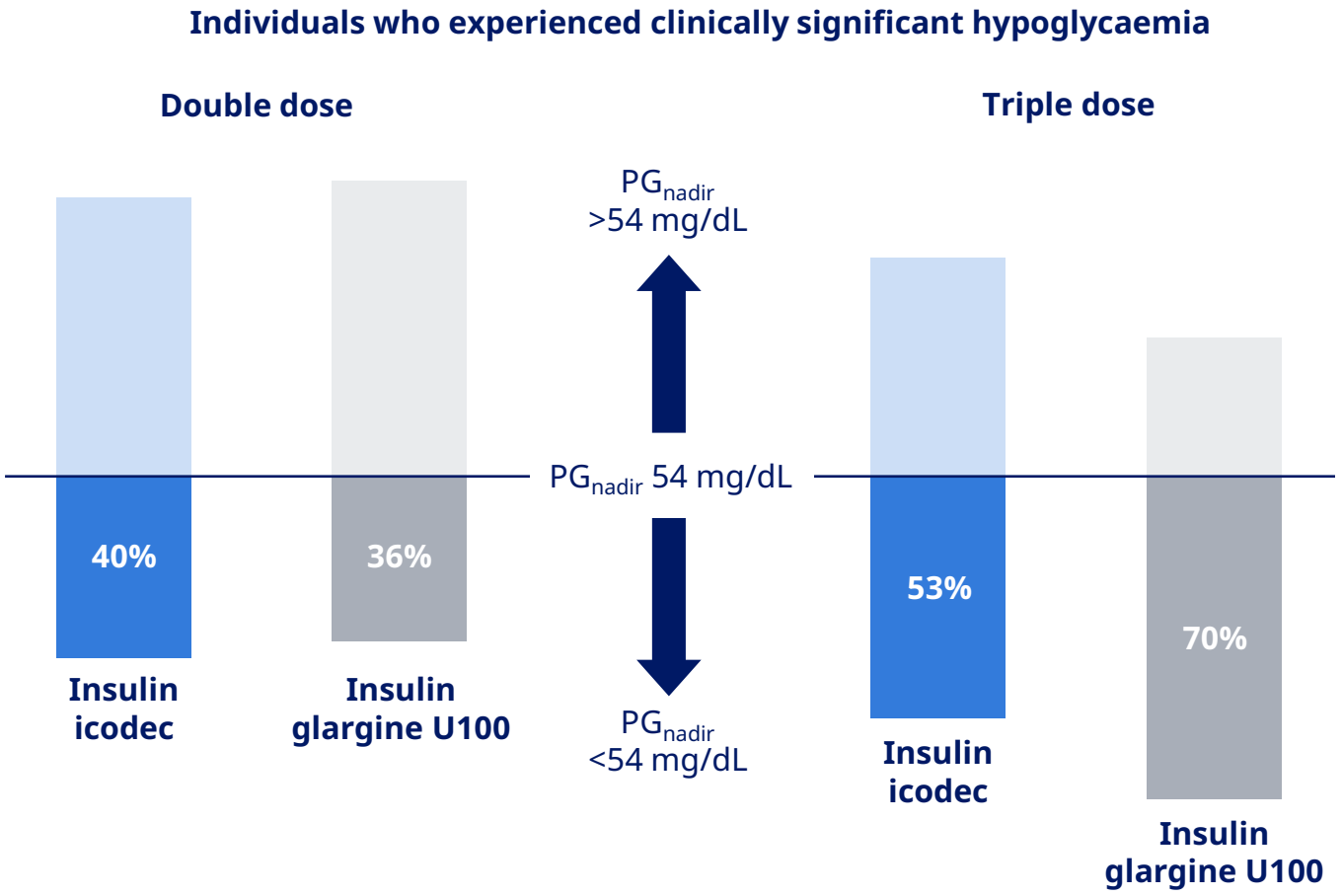
Inclusion criteria

- **43 people with T2D** on basal insulin ± OAD
- **Age:** 18-72 years
- **HbA_{1c}:** ≤9.0%
- **BMI** :18.5-37.9 kg/m^2

T2D: Type 2 diabetes; OAD: Oral anti-diabetic; BMI: Body mass index

Source: Pieber T, Arfelt K, Cailleteau R, et al. Hypoglycaemia Frequency and Physiological Response to Double or Triple Doses of Once-Weekly Insulin Icodec vs Once-Daily Insulin Glargine in Type 2 Diabetes. American Diabetes Association 82nd Session. Session: Insulins. Oral presentation 216-OR; 2022 Jun 3-7. New Orleans, LA.

Comparable clinically significant hypoglycaemia for insulin icodec vs insulin glargine U100 in the trial



Key findings

Hypoglycaemia frequency

Comparable proportions of individuals experienced clinically significant hypoglycaemia with once-weekly insulin icodec vs once-daily insulin glargine U100 after double and triple doses

Physiological response to hypoglycaemia after 3x dose

During hypoglycaemia, a comparable symptomatic response and a moderately greater endocrine response were seen for insulin icodec

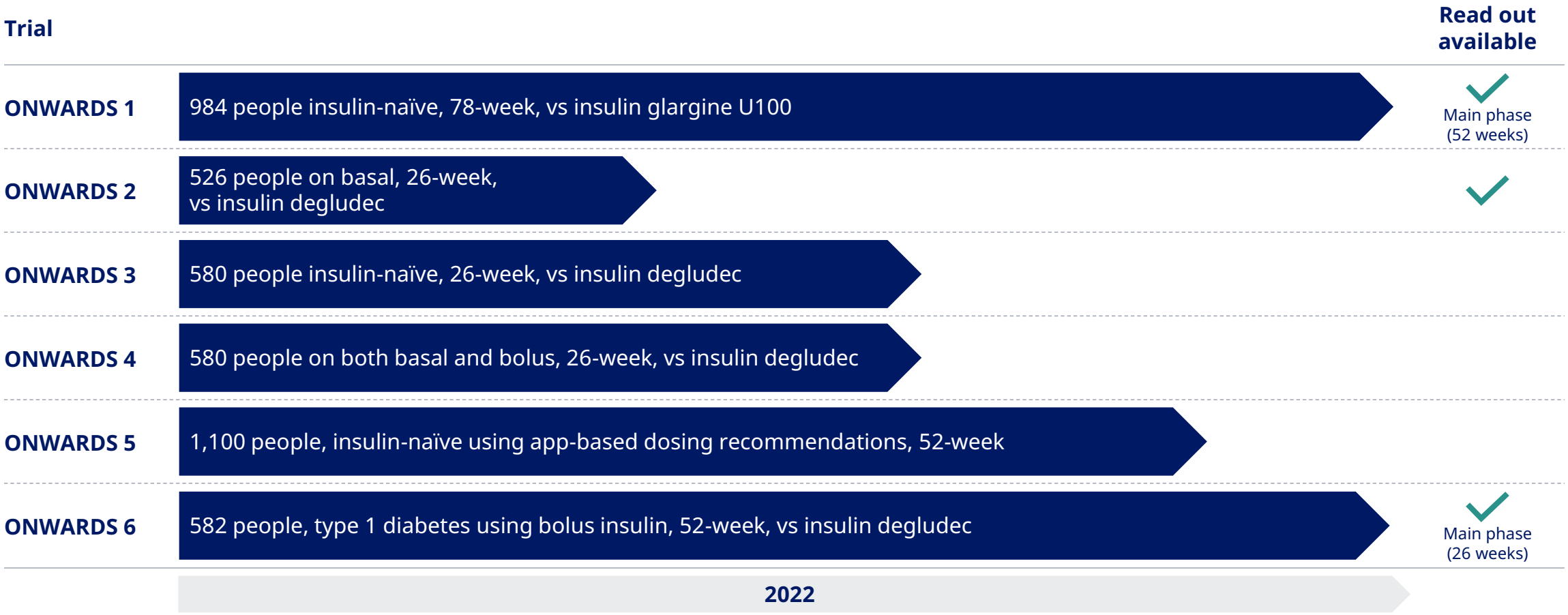
Overall safety

No severe hypoglycaemic episodes during the treatment periods and no serious AEs following the induced hypoglycaemic episodes or during the trial overall

AE: Adverse events; PG: Plasma glucose

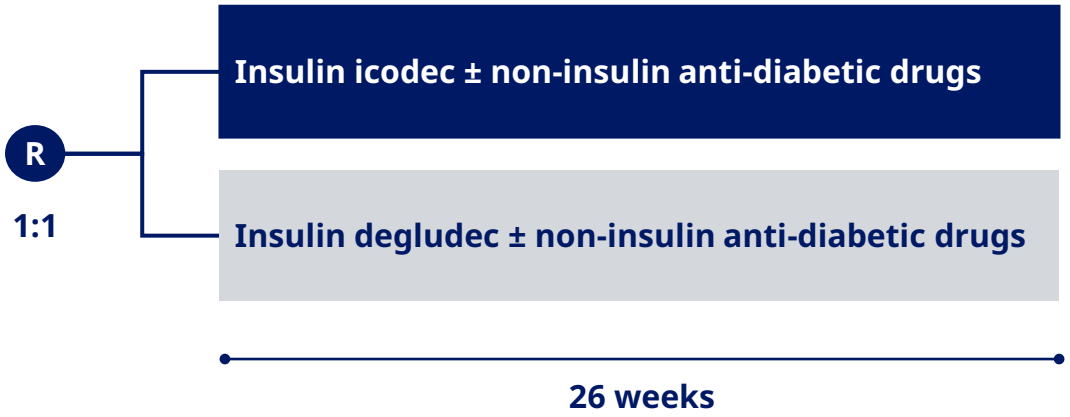
Source: Pieber T, Arfelt K, Cailleteau R, et al. Hypoglycemia Frequency and Physiological Response to Double or Triple Doses of Once-Weekly Insulin Icodec vs Once-Daily Insulin Glargine in Type 2 Diabetes. American Diabetes Association 82nd Session. Session: Insulins. Oral presentation 216-OR; 2022 Jun 3-7. New Orleans, LA.

The first three trials of the ONWARDS programme have read out



ONWARDS 2 was completed as the first of six trials in the phase 3 programme for once-weekly insulin icodec

The ONWARDS 2 phase 3a trial has been completed



Included 526 people with type 2 diabetes

Objective

To confirm the efficacy (non-inferiority on HbA_{1c}) and safety of once-weekly insulin icodec in patients with type 2 diabetes treated with basal only insulin

Primary endpoint

- Change in HbA_{1c} from baseline to week 26

Inclusion criteria

- T2D treated with basal insulin ± OADs* ± GLP-1 s.c.
- Age ≥18 years
- HbA_{1c} 7-10%
- BMI ≤ 40 kg/m2

*Pre-trial all OADs including oral GLP-1s are allowed but SU and glinides are to be discontinued at randomisation
T2D: Type 2 diabetes; OAD: Oral anti Diabetics; s.c.: subcutaneous; BMI: Body mass index, SU: Sulfonylurea

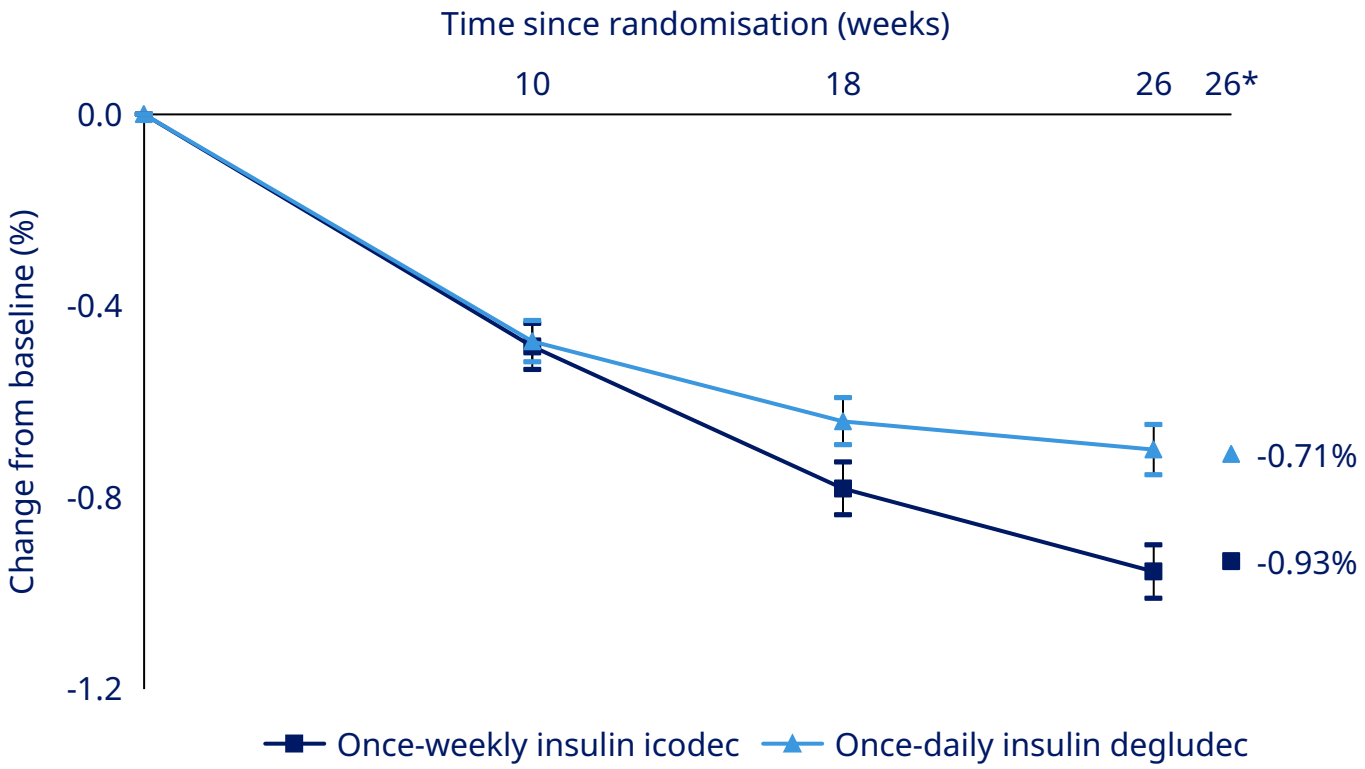
Simple and easy titration for insulin icodec in the ONWARDS programme

	Pre-breakfast SMPG		Dose adjustment insulin icodec	Dose adjustment comparator
	mmol/L	mg/dL		
Lowest of the SMPG values	<4.4	<80	-20	-3
Mean of the SMPG values	4.4–7.2	80–130	0	0
	>7.2	>130	+20	+3

SMPG: Self-measured plasma glucose; mmol/L: Millimoles per litre
Note: Starting dose: 70U weekly (Ico) and 10U daily (IGlar) Dose adjustment based on the three pre-breakfast SMPG values measured on two days prior to titration and on the day of the titration

ONWARDS 2 met its primary endpoint and demonstrated superiority on HbA_{1c} reduction compared to insulin degludec

Superior change in HbA_{1c} from baseline over time 26 weeks



Note: Overall baseline HbA_{1c} of 8.13%

Key highlights

Primary endpoint:

- From an overall baseline HbA_{1c} of 8.13%, once-weekly insulin icodec achieved a superior reduction in estimated HbA_{1c} compared to insulin degludec
- Estimated treatment difference: -0.22%

* Lines are based on observed data where the value denoted after 26 weeks is estimated mean value derived based on multiple imputation

No statistically significant difference in hypoglycaemic events in ONWARDS 2

Overall hypoglycaemic episodes in the trial

On treatment	Insulin icodec				Insulin degludec			
	N	(%)	E	R	N	(%)	E	R
Level 2: Clinically significant hypo	37	(14.1)	1.13	0.73	19	(7.2)	0.41	0.27
Level 3: Severe hypo	0				1	(0.4)	0.01	0.01
Level 3 or 2: Severe or clinically significant hypo	37	(14.1)	1.13	0.73	19	(7.2)	0.42	0.27

Key highlights

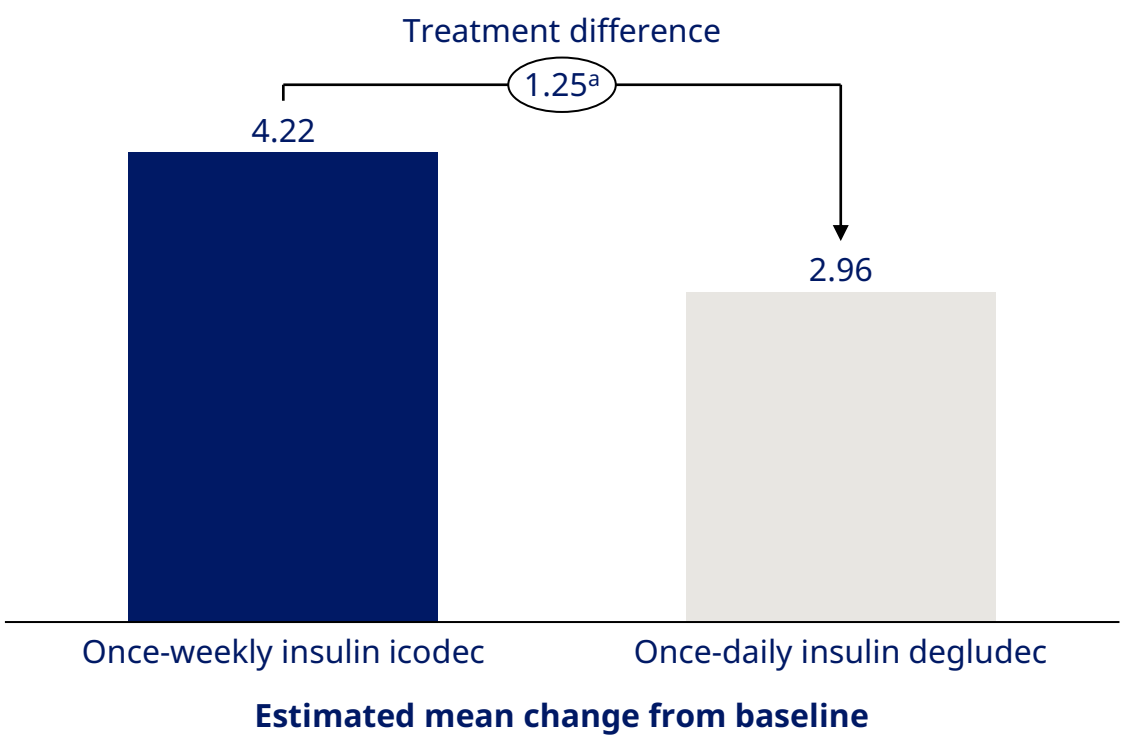
- No statistically significant difference in estimated rates of severe or clinically significant hypoglycaemia events
  - 0.73 events[1] for insulin icodec and 0.27 events for insulin glargine
- In the trial, once-weekly insulin icodec appeared to have a safe and well-tolerated profile

[1] Events measured as per patient year

Hypo: hypoglycaemia; N: Number of subjects with one or more events, %: Percentage of subjects with one or more events, E: Number of events, R: Rate (number of events per patient year of exposure, hypoglycaemia alert value (level 1): Plasma glucose value of < 3.9 mmol/L (70 mg/dL) and >= 3.0 mmol/L (54 mg/dL) confirmed by BG meter. Clinically significant hypoglycaemia (level 2): Plasma glucose value of < 3.0 mmol/L (54 mg/dL) confirmed by blood glycose meter. Severe hypoglycaemia (level 3): Hypoglycaemia with severe cognitive impairment requiring external assistance for recovery. Note: Lines in graph 1 are based on observed data where the value denoted after 26-week is estimated mean value

ONWARDS 2 showed a statistically significant improvement in quality of life compared to insulin degludec

ONWARDS 2 quality of life assessment



ONWARDS 2 treatment satisfaction

Patient reported clinical outcome assessments via a Diabetes Treatment Satisfaction Questionnaire (DTSQ) without assistance of site personnel

The DTSQs were measured at baseline and end of treatment and he treatment satisfaction is evaluated across six dimensions including:

- Convenience
- Flexibility
- Satisfaction
- Recommend treatment

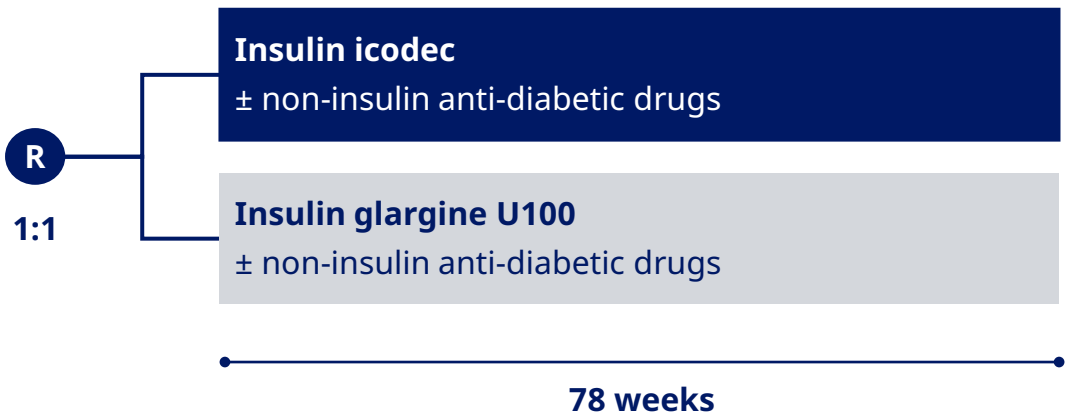
Conclusion

- Statistically significant improvement of treatment satisfaction score in favour of insulin icodec

[a] Treatment difference = 1.25 [0.41;2.10]95% CI,, P value: 0.0036

ONWARDS 1 comparing insulin icodec in insulin-naïve patients with insulin glargine U100

ONWARDS 1 trial design



Included 984 people with type 2 diabetes

Objective

To confirm the efficacy (non-inferiority on HbA_{1c}) and safety of once-weekly insulin icodec in insulin-naïve patients with type 2 diabetes

Primary endpoint

- Change in HbA_{1c} from baseline to week 52

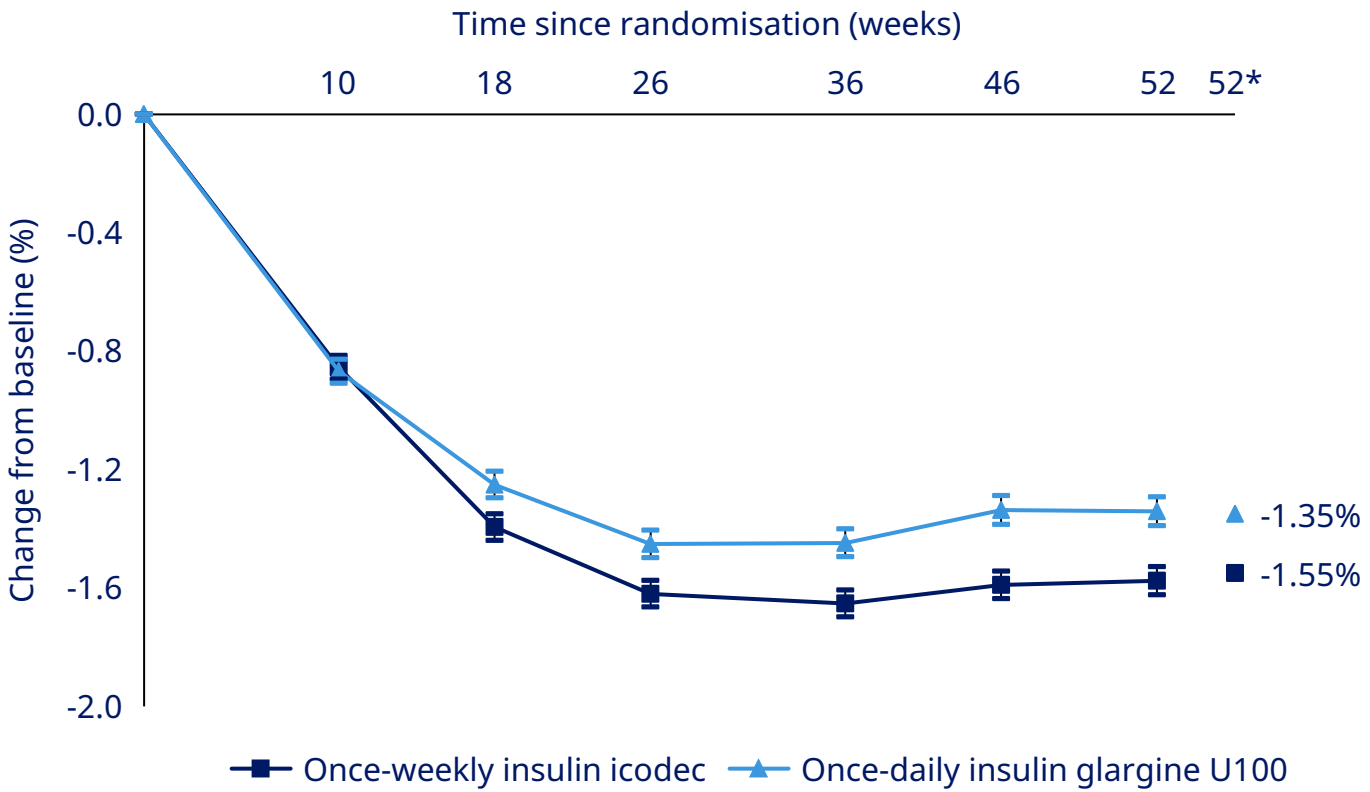
Inclusion criteria

- T2D treated with OADs* ± GLP-1 s.c.
- Age ≥ 18 years
- HbA_{1c} 7.0-11.0%
- BMI ≤ 40 kg/m^2

*Pre-trial all OADs including oral GLP-1s are allowed but SU and glinides are to be discontinued at randomisation
T2D: Type 2 diabetes; OAD: Oral anti Diabetics; s.c.: Subcutaneous; BMI: Body mass index, SU: Sulfonylurea

ONWARDS 1 met its primary endpoint and demonstrated superior HbA_{1c} reduction compared to insulin glargine U100

Superior change in HbA_{1c} from baseline over time 52 weeks



Note: Overall baseline HbA_{1c} of 8.5%

Key highlights from main phase

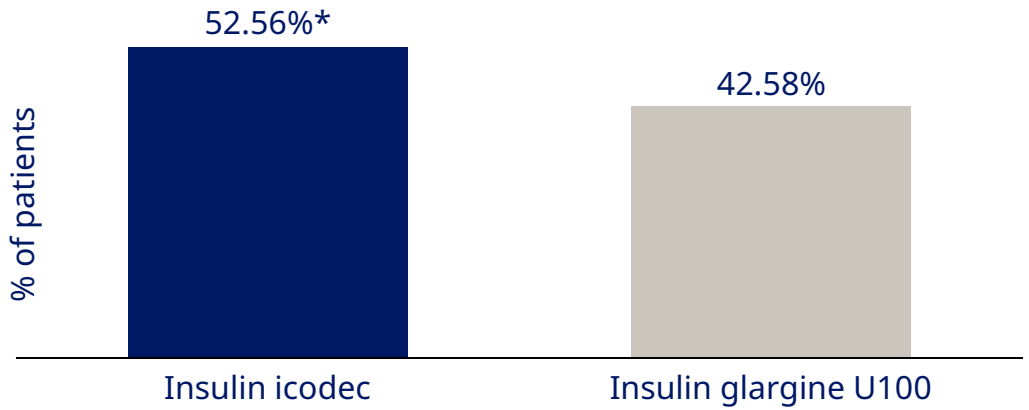
Primary endpoint:

- From an overall baseline HbA_{1c} of 8.5%, once-weekly insulin icodec achieved a superior reduction in estimated HbA_{1c} of -1.55% compared to -1.35% for insulin glargine U100
- Estimated treatment difference: -0.19%

*Lines are based on observed data where the value denoted after 52 weeks is estimated mean value derived based on multiple imputation

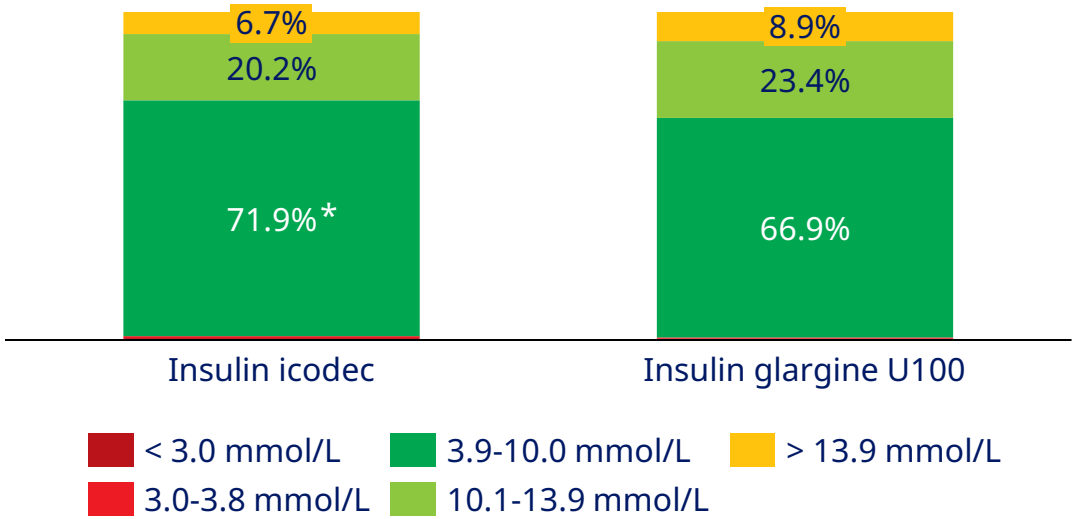
With insulin icodec, more patients reached HBA_{1c} target without hypoglycemia and achieved superior time in range

Achievement of HbA_{1c} target after 52 weeks without hypoglycemia[1]



EOR = 1.49 [1.15, 1.94] 95% CI

Superior time in range for insulin icodec vs insulin glargine U100



Achievement of HbA_{1c} target <7.0%

- More participants achieved the HbA_{1c} target without any severe or clinically significant hypoglycaemia when treated with insulin icodec compared to insulin glargine U100

Time in range

- 3.9–10.0 mmol/L from week 48 to week 52 was 71.94% with insulin icodec and 66.90% with insulin glargine U100, confirming superiority of insulin icodec vs insulin glargine U100
- Broadly equal to one additional hour in range per day

[1] Specifically an HbA1c <7% without level 2 or 3 hypoglycaemic episodes; * Statistically significant difference in favour of insulin icodec.
CI: Confidence interval, No correction for multiplicity. HbA_{1c}: Haemoglobin A_{1c}. The binary response after 52 weeks is analysed using a binary logistic regression model (logit link) with treatment and region as fixed factors, and the baseline HbA_{1c} value as covariate. Missing HbA_{1c} measurements are imputed using the same method as specified for the primary analysis before the target achievement criterion is applied; EOR: Estimated odds ratio

No statistically significant difference in hypoglycaemic events in ONWARDS 1

Overall hypoglycaemic episodes in the trial

On treatment	Insulin icodec				Insulin glargine U100			
	N	(%)	E	R	N	(%)	E	R
Level 2: Clinically significant hypo	48	(9.8)	1.43	0.29	49	(10.0)	0.75	0.15
Level 3: Severe hypo	1	(0.2)	0.01	0.00	3	(0.6)	0.03	0.01
Level 3 or 2: Severe or clinically significant hypo	48	(9.8)	1.44	0.30	52	(10.6)	0.78	0.16

Key highlights from main phase

Safety

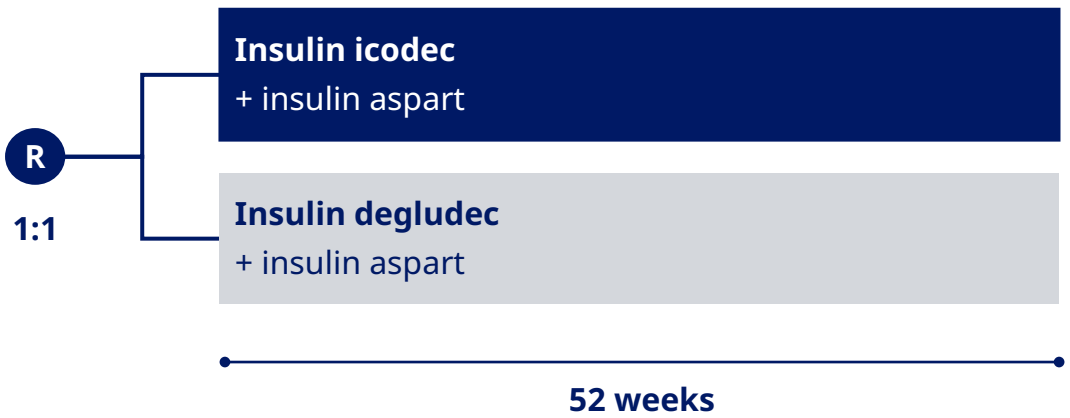
- No statistically significant difference in estimated rates of severe or clinically significant hypoglycaemia events
  - 0.30 events[1] for insulin icodec and 0.16 events for insulin glargine U100
- Insulin icodec appeared to have a safe and well-tolerated profile

[1] Events measured per patient year

Hypo: hypoglycaemia; N: Number of subjects with one or more events, %: Percentage of subjects with one or more events, E: Number of events, R: Rate (number of events per patient year of exposure, hypoglycaemia alert value (level 1): Plasma glucose value of < 3.9 mmol/L (70 mg/dL) and >= 3.0 mmol/L (54 mg/dL) confirmed by BG meter. Clinically significant hypoglycaemia (level 2): Plasma glucose value of < 3.0 mmol/L (54 mg/dL) confirmed by blood glycose meter. Severe hypoglycaemia (level 3): Hypoglycaemia with severe cognitive impairment requiring external assistance for recovery.

ONWARDS 6 in type 1 diabetes patients on bolus insulin and insulin icodec or insulin degludec

ONWARDS 6 trial design



Included 582 people with type 1 diabetes

Objective

To confirm the efficacy (non-inferiority on HbA_{1c}) and safety of once-weekly insulin icodec + bolus insulin in patients with type 1 diabetes

Primary endpoint

- Change in HbA_{1c} from baseline to week 26

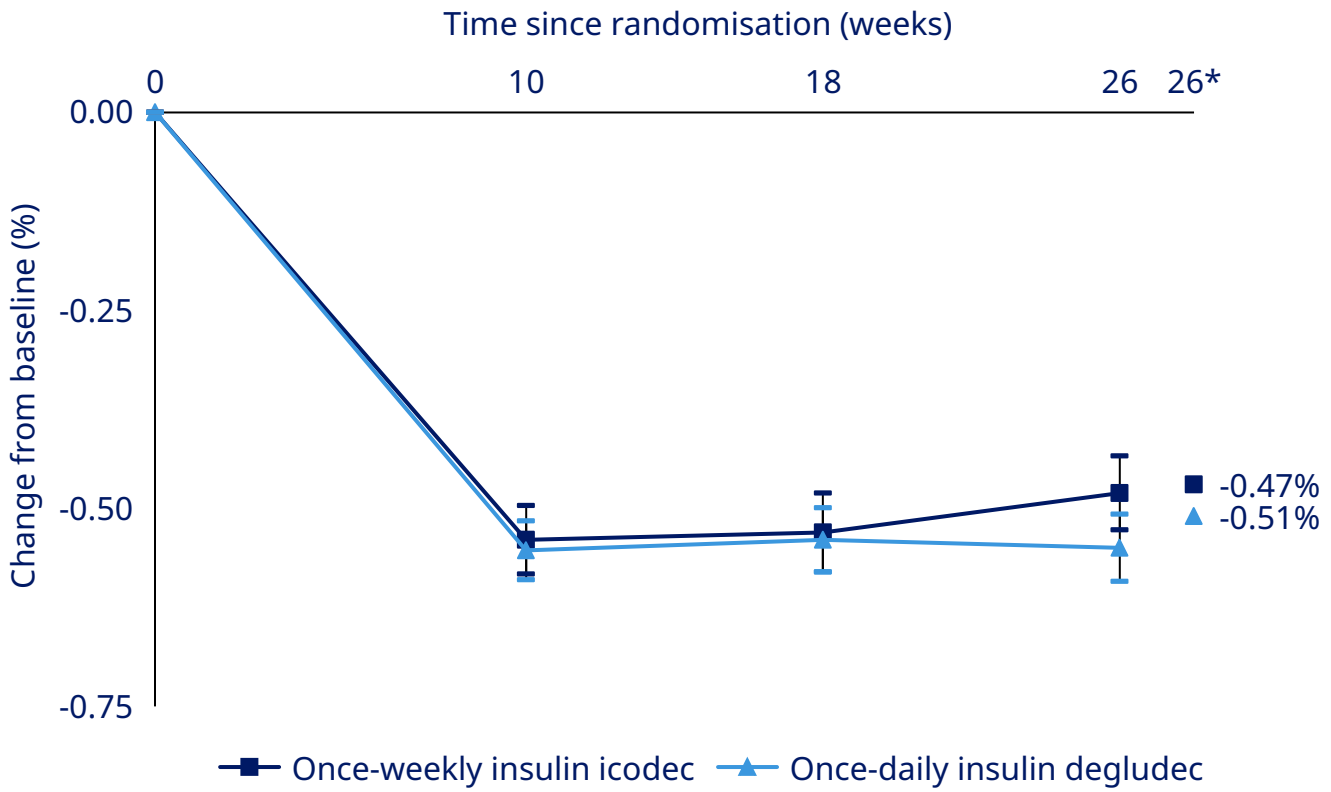
Inclusion criteria

- T1D treated with basal-bolus insulin
- Age ≥ 18 years
- HbA_{1c} < 10%

*Pre-trial all OADs including oral GLP-1s are allowed but SU and glinides are to be discontinued at randomisation
T1D: Type 1 diabetes

ONWARDS 6 met its primary endpoint of demonstrating non-inferiority in reducing HbA_{1c} compared to insulin degludec

Non-inferior change in HbA_{1c} from baseline over 26 weeks



Note: Overall baseline HbA_{1c} of 7.6%

Key highlights from main phase

Primary endpoint:

- From an overall baseline HbA_{1c} of 7.6%, once-weekly insulin icodec achieved a reduction in estimated HbA_{1c} of -0.47% compared to -0.51% for insulin degludec in a T1D population
- Estimated treatment difference: 0.05%

* Lines are based on observed data where the value denoted after 26-week is estimated mean value 26 derived based on multiple imputation
T1D: Type 1 diabetes

Statistically significant difference in hypoglycaemic events in people with type 1 diabetes in ONWARDS 6 trial

Overall hypoglycaemic episodes in the trial

On treatment	Insulin icodec				Insulin degludec			
	N	(%)	E	R	N	(%)	E	R
Level 2: Clinically significant hypo	246	(84.8)	27.89	19.60	223	(76.4)	14.78	10.26
Level 3: Severe hypo	9	(3.1)	0.47	0.33	9	(3.1)	0.17	0.12
Level 3 or 2: Severe or clinically significant hypo	247	(85.2)	28.36	19.93	223	(76.4)	14.95	10.37

Key highlights

- A statistical difference in the estimated rates of severe or clinically hypoglycaemia events[1]
  - 19.93 events for insulin icodec vs 10.37 events for insulin degludec
- Insulin icodec appeared to have a safe and well-tolerated profile

[1] Events measured as per patient year
Hypo: hypoglycaemia; N: Number of subjects with one or more events, %: Percentage of subjects with one or more events, E: Number of events, R: Rate (number of events per patient year of exposure, hypoglycaemia alert value (level 1): Plasma glucose value of < 3.9 mmol/L (70 mg/dL) and >= 3.0 mmol/L (54 mg/dL) confirmed by BG meter. Clinically significant hypoglycaemia (level 2): Plasma glucose value of < 3.0 mmol/L (54 mg/dL) confirmed by blood glycose meter. Severe hypoglycaemia (level 3): Hypoglycaemia with severe cognitive impairment requiring external assistance for recovery.

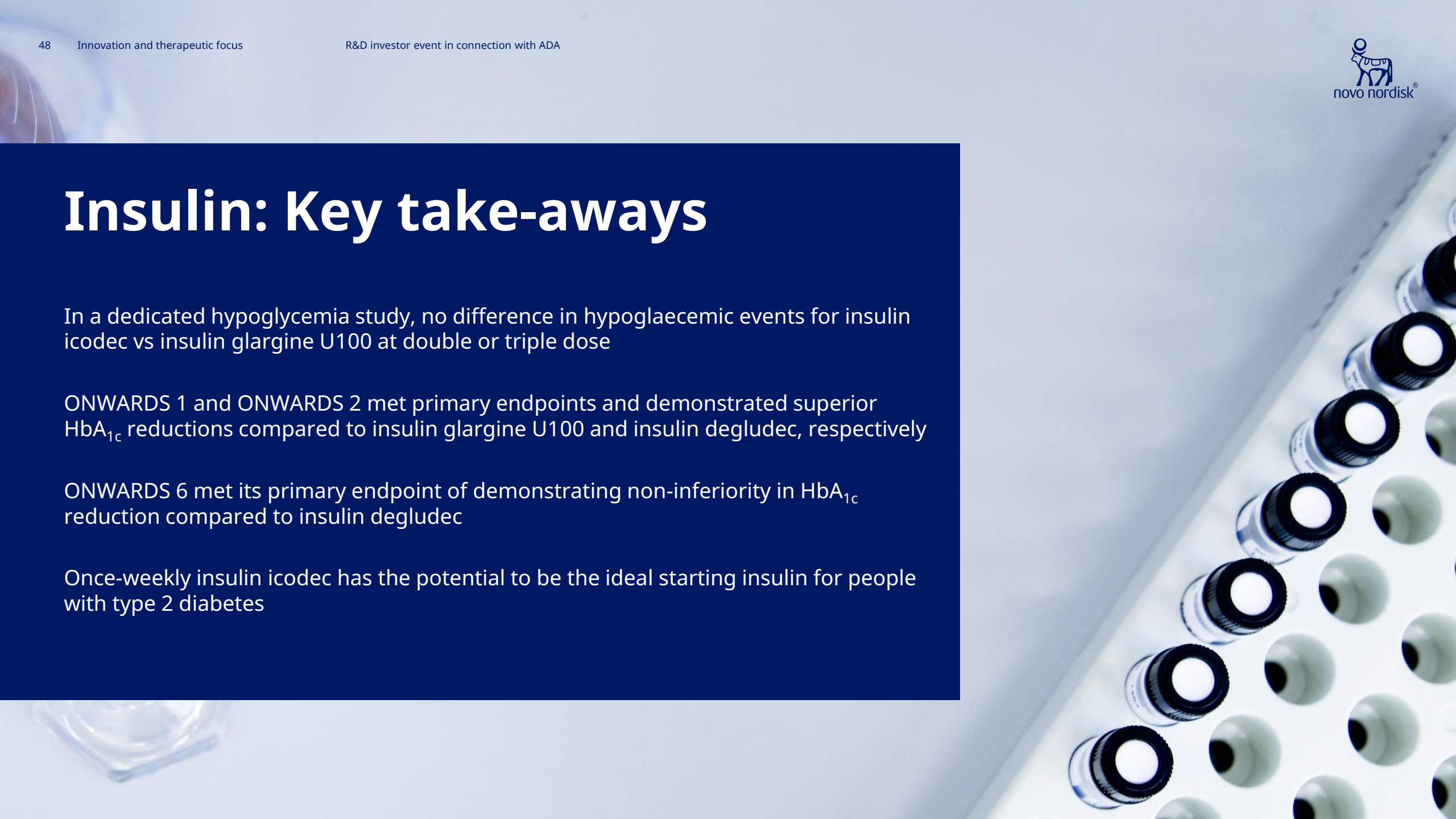
Insulin: Key take-aways

In a dedicated hypoglycemia study, no difference in hypoglaecemic events for insulin icodec vs insulin glargine U100 at double or triple dose

ONWARDS 1 and ONWARDS 2 met primary endpoints and demonstrated superior HbA_{1c} reductions compared to insulin glargine U100 and insulin degludec, respectively

ONWARDS 6 met its primary endpoint of demonstrating non-inferiority in HbA_{1c} reduction compared to insulin degludec

Once-weekly insulin icodec has the potential to be the ideal starting insulin for people with type 2 diabetes



R&D milestones for 2022

Clinical milestones[1] Regulatory milestones[1]

	Project	Q1 2022	Q2 2022	Q3 2022	Q4 2022
Diabetes care	**Ozempic® 2.0 mg**	US decision ✓			
	FDC Sema – OW GIP		Phase 1 results		
	CagriSema T2DM			Phase 2 results	
	Higher doses inj. sema			Phase 2 initiation	
	Rybelsus®		CN submission		
	Icodec			Phase 3a results	
	Ideal Pump insulin	Phase 1 results ✓			Phase 1 results
	Oral GLP-1/GIP co-agonist	Phase 1 initiation ✓			
Obesity care	**SELECT CVOT**			Potential interim analysis	
	CagriSema				Phase 3 initiation
	LA-GDF15			Phase 1 results	
Rare disease	**Sogroya®** (somapacitan)		US/EU/JP submission (GHD)		
	Mim8	Phase 1/2 results ✓			Phase 3 treatment[2]
Other serious chronic diseases	**Concizumab**	Phase 3a results (HwI) ✓	US submission (HwI)	Phase 3a results (HA/HB)	
	Eclipse/Ndec			Phase 2 initiation	
	PRX004 (ATTR-CM)		Phase 2 initiation		

[1] Expected to be published in the given quarter or in the subsequent quarterly company announcement. [2] First patient first visit in Q4 2021, which is solely for baselining purposes
Note: Trial initiations could be impacted by COVID-19; GHD: Growth Hormone Deficiency; sema: semaglutide; HwI: Haemophilia with inhibitors; ATTR-CM: Transthyretin Amyloid Cardiomyopathy; CVOT: Cardiovascular Outcomes Trial; Inj.: Injectable; Sema: Semaglutide

Strategic aspirations 2025

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, NASH 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
  - Deliver 6-10% sales growth in IO
  - Transform 70% of sales in the US[1]
- 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

[1] From 2015 to 2022, 70% of sales to come from products launched from 2015. IO: International Operations; CVD: Cardiovascular disease; NASH: Non-alcoholic steatohepatitis; CKD: Chronic kidney disease.
Note: The strategic aspirations are not a projection of Novo Nordisk's financial outlook or expected growth.

Agenda

Introduction		Karsten Munk Knudsen
Obesity care	*Post hoc analysis of STEP 1 and 4, STEP TEENS results and SELECT-LIFE*	Martin Holst Lange
GLP-1 Diabetes	*Semaglutide in chronic kidney disease and peripheral artery disease*	Mads Frederik Rasmussen
Insulin	*Insulin icodec hypoglycaemia frequency, results from ONWARDS 1, ONWARDS 2, and ONWARDS 6*	Martin Holst Lange
Q&A		All

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

04 August 2022	Financial statement for the first six months of 2022
02 November 2022	Financial statement for the first nine months of 2022
01 February 2023	Financial statement 2022

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