Erik Hageman (on the right) is one of Denmark’s longest-living people with type 1 diabetes, pictured here with his son Lars, who also has type 1 diabetes, and his grandchildren (from the left) Clara, Emilie and Holger.

Novo Nordisk – a focused healthcare company

Novo Nordisk investor event in connection with ADA
San Diego, 25 June 2023
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 breaches, 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 disputes, 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
Progress towards zero environmental impact
• Carbon emissions decreased by 21% vs Q1 2019¹

Adding value to society
• Medical treatment provided to 37.2 million people living with diabetes
• Reaching more than 42,000 children in Changing Diabetes® in Children programme

Being recognised as a sustainable employer
• Share of women in senior leadership positions has increased to 39% from 37% end of March 2022

Diabetes value market share increased by 1.7%-points to 32.2%²

Obesity care sales of DKK 7.8 billion (+124% at CER)

Rare disease sales of DKK 4.6 billion (-16% at CER)

Further raise innovation bar for Diabetes treatment
• Regulatory submission of once-weekly insulin icodoc
• Completion of phase 3 trial PIONEER PLUS
• Completion of phase 1/2 trials with GLP-1/GIP

Develop superior treatment solutions for obesity
• Phase 3a trials REDEFINE 2 & 3 initiated with CagriSema

Strengthen and progress Rare Disease pipeline
• Somapacitan approved in the US for GHD in children
• CRL received for concizumab in the US

Establish presence in Other serious chronic diseases
• Phase 1 trials initiated with cell therapy treatment

Sales growth of 25% (CER) and operating profit growth of 28% (CER)

Operational leverage reflecting sales growth

Free cash flow of DKK 24.8 billion and DKK 23.5 billion returned to shareholders

¹Scope 1, 2 and partial scope 3 limited to CO2 emissions from business flights and product distribution; ²MAT (Moving annual total) value market share
VP: Vice president; CER: Constant exchange rates; CRL: Complete Response Letter; US: United States; GHD: Growth Hormone Deficiency; GIP: Gastric inhibitory polypeptide; GLP-1: Glucagon Like Peptide 1
Note: The strategic aspirations are not a projection of Novo Nordisk’s financial outlook or expected growth
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
- 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

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.
Today’s speakers

Martin Holst Lange
Executive Vice President and
Head of Development

Stephen Charles Langford Gough
Senior Vice President and
Global Chief Medical Officer
Agenda

Introduction

Insulin

Insulin Icodec

GLP-1 in diabetes

CagriSema in diabetes
Oral semaglutide in diabetes

GLP-1 in obesity

Oral semaglutide in obesity
Semaglutide 2.4 mg: STEP HFpEF

Q&A

Daniel Bohsen & Martin Holst Lange

Stephen Gough

Martin Holst Lange

Stephen Gough

Stephen Gough

Martin Holst Lange

All
Since ADA 2022, progress has been made across the Novo Nordisk pipeline

- Higher doses injectable sema ph. 2 initiation
- Acquisition of Forma Therapeutics Inc.
- Ph. 1 initiated with once-weekly oral semaglutide
- Concizumab ph. 3 completion
- Ph. 1 trials initiated in NASH utilising the siRNA platform
- Oral Sema 25/50 mg ph. 3 results
- Oral GLP-1/GIP co-agonist ph. 1 completed
- Oral semaglutide 50 mg ph. 3 read-out
- FHD with cell therapy
- NDec ph. 2 initiation
- NNC6019 ATTR ph. 2 initiation
- CagriSema Ph. 3a initiated
- CagriSema Ph. 3a treatment initiation
- Completion of final Icodec ph. 3 trial
- Ph. 3 initiated with semaglutide 7.2 mg
- Ph. 3 initiated with semaglutide 7.2 mg
- Ziltivekimab HFpEF ph. 3 initiation
- Oral GLP-1/GIP co-agonist ph. 1 completed
- Icodec submission
- Icodec ph. 3 trial
- Concizumab ph. 3 completion
- Diabetes care: GLP-1
- Diabetes care: Insulin
- Obesity care
- Rare disease
- Other serious chronic disease
- Other

Note: Timeline non-exhaustive

T2D: Type 2 diabetes; Sema: Semaglutide; Ph: Phase; FHD: First human dose; siRNA: Silencing RNA; HFpEF: Heart failure with preserved ejection fraction
Agenda

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Insulin

Insulin Icodec

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Oral semaglutide in diabetes

GLP-1 in obesity

Oral semaglutide in obesity

Semaglutide 2.4 mg: STEP HFpEF

Q&A

Daniel Bohsen & Martin Holst Lange

Stephen Gough

Martin Holst Lange

Stephen Gough

Stephen Gough

Martin Holst Lange

All
Diabetes is a serious chronic disease requiring treatment intensification over time

**Diabetes is associated with multiple comorbidities**

- **Macrovascular**
  - Includes angina, CAD, MI, stroke, PAD, CHF, and CKD

- **Microvascular**
  - Retinopathy
  - Nephropathy
  - Neuropathy

A 0.4% HbA1c reduction is associated with reductions of:

- 10% death related to diabetes
- 7% all cause mortality
- 21% amputation or death from PVD

**Despite many new treatment options, many patients eventually need insulin**

**The burden of treatment may be a barrier for good glycaemic control**

- 50% of patients needing insulin delay initiation by an average of 15 months due to needle aversion, anxiety over insulin and fear²
- >90% of physicians and patients have a wish for good glycaemic control with insulin not injected every day³

1Association of glycaemia with macrovascular and microvascular complications of type 2 diabetes (UKPDS 35): prospective observational study - PMC (nih.gov) - Linear relationship inferred, to estimate the point estimate with a 0.4% decrease in A1c. ²


CAD: Coronary artery disease; MI: Myocardial infarction; PAD: Peripheral arteries disease; CHF: Congestive heart failure; CKD: Chronic kidney disease; OAD: Oral anti diabetics; GLP-1: Glucagon-like peptide-1; PVD: Peripheral vascular disease
Once-weekly insulin icodex appeared to be effective and to have a safe profile in the phase 3 ONWARDS programme

### ONWARDS 1: Basal Initiation
- **Trial duration (weeks):** 52 (Full trial: 78 weeks)
- **Baseline HbA$_1c$ (%):** 8.5%
- **Non-inferiority confirmed:** ✓
- **Superiority confirmed:** ✓

### ONWARDS 3: Basal Initiation
- **Trial duration (weeks):** 26
- **Baseline HbA$_1c$ (%):** 8.5%
- **Non-inferiority confirmed:** ✓
- **Superiority confirmed:** ✓

### ONWARDS 5: Basal Initiation
- **Trial duration (weeks):** 52
- **Baseline HbA$_1c$ (%):** 8.9%
- **Non-inferiority confirmed:** ✓
- **Superiority confirmed:** ✓

### Hypoglycaemia event rates$^1$

<table>
<thead>
<tr>
<th>Insulin-naive type 2 diabetes</th>
<th>Insulin-treated type 2 diabetes</th>
<th>Type 1 diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Once-weekly insulin icodex</strong></td>
<td>-1.55%*$^-$1.35%</td>
<td>19.93</td>
</tr>
<tr>
<td><strong>Once-daily insulin glargine U100</strong></td>
<td>-1.57%*$^-$1.36%</td>
<td>5.64</td>
</tr>
<tr>
<td><strong>Once-daily insulin degludec</strong></td>
<td>-1.68%*</td>
<td>0.73</td>
</tr>
</tbody>
</table>

**In people with type 2 diabetes:** No statistical difference in estimated hypoglycaemia events

### ONWARDS 2: Basal Switch
- **Trial duration (weeks):** 26 (Full trial: 52 weeks)
- **Baseline HbA$_1c$ (%):** 8.1%
- **Non-inferiority confirmed:** ✓
- **Superiority confirmed:** ✓

### ONWARDS 4: Basal/Bolus Switch
- **Trial duration (weeks):** 26
- **Baseline HbA$_1c$ (%):** 8.3%
- **Non-inferiority confirmed:** ✓
- **Superiority confirmed:** ✓

### ONWARDS 6: Basal/Bolus Switch
- **Trial duration (weeks):** 26
- **Baseline HbA$_1c$ (%):** 7.6%
- **Non-inferiority confirmed:** ✓
- **Superiority confirmed:** ✓

---

$^*$Statistically significant. 1 Severe or clinically significant hypoglycaemia events (blood glucose <3 mmol/L) per patient year, included for end of trial/end main phase in trial. 2 Duration refers to trial main phase.

ONWARDS 1: QW insulin icodex vs QD insulin glargine U100 both with non-insulin anti-diabetic treatment in insulin-naïve people with T2D; ONWARDS 2: QW insulin icodex vs QD insulin degludec in people with T2D switching from a QD insulin; ONWARDS 3: QW insulin icodex vs QD insulin degludec in insulin-naïve people with T2D; ONWARDS 4: QW insulin icodex vs QD insulin degludec both with mealtime insulin in people with T2D treated with basal and bolus insulin; ONWARDS 5: QW insulin icodex vs QD basal insulin with an app providing dosing recommendation in insulin-naïve people with T1D; ONWARDS 6: QW insulin icodex vs QD insulin degludec both with mealtime insulin in people with T1D T1D: Type 1 diabetes, T2D: Type 2 diabetes. Note: Overview refer to primary end points in main phases of trials.
ONWARDS 1 compared insulin icodec with insulin glargine U100 in people with T2D initiating basal insulin

ONWARDS 1 enrolled 984 patients with Type 2 Diabetes

Objective:
- To confirm the efficacy and safety of once-weekly insulin icodec in insulin-naïve patients with type 2 diabetes

Primary endpoint:
- Change in HbA1c from baseline to week 52

Extension phase:
- A 26-week extension included in the trial design to assess long-term safety in people with T2D

Inclusion criteria:
- T2D treated with OADs* ± GLP-1 RA s.c.
- Age ≥18 years
- HbA1c 7-11%
- 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; R: Randomisation; OAD: Oral anti Diabetics; s.c.: subcutaneous; BMI: Body mass index; GLP-1: Glucagon-like peptide-1
Once-weekly insulin icodec showed HbA$_{1c}$ reduction of -1.55% after 78 weeks of treatment in phase 3 trial ONWARDS 1.

Greater reduction in HbA$_{1c}$ after 78 weeks with insulin icodec
Mean baseline HbA$_{1c}$: 8.5%

Overall hypoglycaemia in the trial

<table>
<thead>
<tr>
<th>On treatment</th>
<th>Once-weekly insulin icodec</th>
<th>Once-daily insulin glargine U100</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N  (%)</td>
<td>E</td>
</tr>
<tr>
<td>Level 2: Clinically significant hypo</td>
<td>61 (12.4)</td>
<td>226</td>
</tr>
<tr>
<td>Level 3: Severe hypo</td>
<td>1 (0.2)</td>
<td>1</td>
</tr>
<tr>
<td>Level 3 or 2: Severe or clinically significant hypo</td>
<td>61 (12.4)</td>
<td>227</td>
</tr>
</tbody>
</table>

Note: Clinically significant hypoglycaemia (level 2): Plasma glucose value of < 3.0 mmol/L (54 mg/dL) confirmed by blood glucose meter. Severe hypoglycaemia (level 3): Hypoglycaemia with severe cognitive impairment requiring external assistance for recovery. Data is on-treatment.

N: Number of patients with one or more events; %: Percentage of patients with one or more events; E: Number of events; R: Rate (number of events per patient year of exposure; Hypo: Hypoglycaemia

Note: Observed data are in-trial. Week 78* is estimated mean change in HbA1c based on ANCOVA with missing data derived from multiple imputation.
In the trial, more patients on insulin icodec reached HbA\textsubscript{1c} target without hypoglycaemia and a longer TIR vs insulin glargine U100

**Achievement of HbA\textsubscript{1c} target after 78 weeks without hypoglycaemia\textsuperscript{1}**

- Statistically significantly more participants achieved the HbA\textsubscript{1c} target without severe or clinically significant hypoglycaemia with insulin icodec compared to insulin glargine U100

<table>
<thead>
<tr>
<th>% of patients</th>
<th>Once-weekly insulin icodec</th>
<th>Once-daily insulin glargine U100</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pct</td>
<td>54.5%*</td>
<td>46.4%</td>
</tr>
</tbody>
</table>

EOR = 1.4 [1.06 to 1.80]\textsubscript{95% CI}

**Statistically significantly longer TIR for insulin icodec vs insulin glargine U100 measured with CGM from week 74 to 78**

<table>
<thead>
<tr>
<th>% of patients</th>
<th>Once-weekly insulin icodec</th>
<th>Once-daily insulin glargine U100</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;54 mg/dL</td>
<td>0.3%</td>
<td>0.8%</td>
</tr>
<tr>
<td>54-&lt;70 mg/dL</td>
<td>7.6%</td>
<td>21.1%</td>
</tr>
<tr>
<td>70-&lt;180 mg/dL</td>
<td>70.2%*</td>
<td>64.8%</td>
</tr>
<tr>
<td>&gt;180 mg/dL</td>
<td>10.3%</td>
<td>64.8%</td>
</tr>
</tbody>
</table>

**Time in range**

- 70-180 mg/dL from week 74 to week 78 was 70.2% with once-weekly insulin icodec and 64.8% with once-weekly insulin glargine, statistically significant difference in favor of once-weekly insulin icodec vs once-daily insulin glargine U100

\textsuperscript{1} Specifically an HbA\textsubscript{1c} <7% without level 2 or 3 hypoglycaemic episodes during the prior 12 weeks; * Statistically significant difference in favour of insulin icodec.

Note: The binary response after 78 weeks is analysed using a binary logistic regression model (logit link) with treatment and region as fixed factors, and the baseline HbA\textsubscript{1c} value as covariate. For TIR: Time spent is defined as 100 times the number of recorded measurements in a given range, divided by the total number of recorded measurements.

TIR: Time in range; CGM, continuous glucose monitor; CI: Confidence interval; EOR: Estimated odds ratio
ONWARDS 5 included real-world elements and compared once-weekly insulin icodec with once-daily basal insulins in T2D

Onwards 5 enrolled 1085 patients with Type 2 Diabetes

Objective:
- To confirm the efficacy of HbA1c and safety of insulin icodec with a dosing guide app providing dosing recommendation vs once-daily basal insulin analogues, both in combination with any non-insulin antidiabetic medication in insulin-naïve T2D patients

Trial design:
- The trial included real-world elements to reflect real-world insulin use with fewer planned site visits, no upper limit on HbA1c and minimal exclusion criteria.

Key endpoints:
- Change in HbA1c
- Patient Related Outcomes (PROs)
- Level 2 and 3 hypoglycaemia events

Inclusion criteria:
- Insulin-naïve people with type 2 diabetes
- No limitations on use of oral antidiabetic treatments
- Age ≥ 18 years, HbA1c > 7.0%

T2D: Type 2 diabetes; R: Randomisation. Once-daily basal insulin analogues include insulin degludec and insulin glargine U100 and U300.
In the trial, insulin icodec appeared to have a safe profile and showed superior HbA$_{1c}$ reduction vs daily basal insulin analogues.

Superior reduction in HbA$_{1c}$ from baseline to 52 weeks
Mean baseline HbA$_{1c}$: 8.9%

Overall hypoglycaemia in the trial

<table>
<thead>
<tr>
<th>On treatment</th>
<th>Once-weekly insulin icodec</th>
<th>Once-daily basal insulin analogues</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N   (%)</td>
<td>E</td>
</tr>
<tr>
<td><strong>Level 2:</strong> Clinically significant Hypo*</td>
<td>64   (11.8)</td>
<td>104</td>
</tr>
<tr>
<td><strong>Level 3:</strong> Severe Hypo*</td>
<td>0   -</td>
<td>-</td>
</tr>
<tr>
<td><strong>Level 3 or 2:</strong> Severe or clinically significant Hypo*</td>
<td>64   (11.8)</td>
<td>104</td>
</tr>
</tbody>
</table>

Note: 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. Data is on-treatment.

N: Number of patients with one or more events; %: Percentage of patients with one or more events; E: Number of events; R: Rate (number of events per patient year of exposure; Hypo: Hypoglycaemia

Note: Observed data are in-trial. Week 52* is estimated mean change in HbA1c based on ANCOVA with missing data derived from multiple imputation. Insulin icodec was in combination with a dosing guide app. Once-daily basal insulin analogues include insulin degludec and insulin glargine U100 and U300.
Insulin icodex showed superiority in both patient reported outcomes endpoints vs daily basal insulins in ONWARDS 5

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Estimated mean change from baseline</th>
<th>Estimated mean difference at week 52</th>
</tr>
</thead>
<tbody>
<tr>
<td>Once-weekly insulin icodex</td>
<td>4.68</td>
<td>90.42</td>
</tr>
<tr>
<td>Once-daily basal insulin analogues</td>
<td>0.78</td>
<td>3.04</td>
</tr>
</tbody>
</table>

1Treatment difference = 0.78 [0.10;1.47] 95% CI, P value: 0.0247
2Treatment difference = 3.04 [1.28;4.81] 95% CI, P value: 0.0007

DTSQ: Diabetes Treatment Satisfaction Questionnaire; TRIM-D: Treatment-Related Impact Measure Diabetes

Note: Insulin icodex was in combination with a dosing guide app. Once-daily basal insulin analogues include insulin degludec and insulin glargine U100 and U300.
Insulin icodéc has the potential to reduce treatment burden for both insulin naïve people or those switching from a daily basal

Icodec has the potential to reduce treatment burden

Icodec titration scheme in type 2 diabetes

**Once daily basal insulin**

- Many injections per week (>365 per year)

**Once-weekly insulin icodéc**

- One injection per week (52 per year)

**Single Starting Dose**

- 70 units

**Naïve to insulin treatment**

**Prior basal insulin treatment**

**Single Starting Dose**

- 10.5 x Daily Basal Insulin Dose

**Second Dose**

- Daily Basal Insulin Dose x 7

Note: Graphic on left illustrates conceptual differences
Insulin: Key take-aways

Despite many new treatment options, many patients eventually need insulin treatment.

The burden of treatment and daily injections can be a barrier for good glycaemic control.

Insulin icodex appears to have a superior efficacy profile with added weekly convenience and a low rate of hypoglycemia.*

Overall, insulin icodex has the potential to be an ideal starter insulin for people with T2D.

*Less than one event per year for level 2 or 3 hypoglycemia in the insulin naïve and in the basal switch T2D population.
T2D: Type 2 Diabetes.
Agenda

**Introduction**

Daniel Bohsen & Martin Holst Lange

**Insulin**

Insulin Icodec  
Stephen Gough

**GLP-1 in diabetes**

CagriSema in diabetes  
Martin Holst Lange

Oral semaglutide in diabetes  
Stephen Gough

**GLP-1 in obesity**

Oral semaglutide in obesity  
Stephen Gough

Semaglutide 2.4 mg: STEP HFpEF  
Martin Holst Lange

**Q&A**  
All
GLP-1 RAs have proven positive effects beyond glycaemic control in T2D and may hold further potential

**Proven GLP-1 RA effects in T2D**
- Glycaemic control
- Weight loss
- CV risk reduction

**Hypothesized GLP-1 RA effects**
- Chronic kidney disease
- Alzheimer’s disease
- Metabolic liver syndrome
- Peripheral artery disease

GLP-1 RA: Glucagon like peptide-1 receptor agonist; T2D: Type 2 diabetes; CV: Cardiovascular
GLP-1 RAs recommended as first line treatment for people with T2D with established ASCVD or with multiple CV risk factors

Updated ADA/EASD diabetes treatment guidelines

**Lifestyle management**

**Goal:** Cardiorenal risk reduction in high-risk T2D patients (on top of CV SoC)

- **ASCVD or indicators of high risk**
  - GLP-1 with proven CVD benefit
  - SGLT-2i with proven CVD benefit

- **HF with documented HFrEF or HFpEF**
  - SGLT-2i with proven HF benefit

- **CKD**
  - SGLT-2i with primary evidence of reducing CKD progression

**Goal:** HbA1c and weight management

- **Glycaemic management**
  - Metformin OR combination therapy with adequate efficacy to reach and maintain goals (intermediate – very high)
  - Very high: Semaglutide mentioned for glucose lowering efficacy

- **Weight management**
  - Set individualized weight management goals
  - When choosing glucose-lowering therapies consider regimen with high efficacy
  - Very high: Semaglutide mentioned for weight loss efficacy

If additional cardiorenal risk reduction or glycaemic lowering needed:

- **If HbA1c above target, identify barriers to reach treatment goals**


GLP-1 RA: Glucagon like peptide-1 receptor agonist; ADA: American Diabetes Association; EASD: European Association for the Study of Diabetes; T2D: Type 2 diabetes; CV: Cardiovascular; SoC: Standard of care; ASCVD: Atherosclerotic cardiovascular disease; CVD: Cardiovascular disease; SGLT-2i: Sodium/glucose co-transporter-2 inhibitors; HF: Heart failure; HFrEF: Heart failure with reduced ejection fraction; HFpEF: Heart failure with preserved ejection fraction; CKD: Chronic kidney disease
Phase 2 trial for CagriSema in people with type 2 diabetes was successfully completed in Q3 2022

Exploratory phase 2a trial of CagriSema in 92 patients with T2D

Objective:
- To compare the efficacy and safety of CagriSema vs its individual components in patients with T2D

Primary endpoint:
- Change from baseline to week 32 in HbA1c

Secondary endpoints:
- Change from baseline to week 32 in body weight
- Safety
- CGM: Mean glucose levels, time in range

Inclusion criteria:
- Type 2 diabetes
- HbA1c 7.5–10.0%
- Metformin +/- SGLT-2i
- BMI ≥27 kg/m2

T2D: Type 2 diabetes; R: Randomisation; BMI: body mass index; CGM: Continuous glucose monitoring; SGLT-2i: Sodium/glucose co-transporter-2 inhibitors
Note: CagriSema is a fixed dose combination of injectable cagrilintide 2.4 mg and injectable semaglutide 2.4 mg
Mean \( \text{HbA}_{1c} \) reduction from baseline was -2.18 \%-points and 89\% reached \( \text{HbA}_{1c} \) target when treated with CagriSema.

- More participants achieved the \( \text{HbA}_{1c} \) target when treated with CagriSema compared to the monocomponents.

Note: Data shown is trial product estimands. CagriSema is a fixed dose combination of injectable cagrilintide 2.4 mg and injectable semaglutide 2.4 mg.
With CagriSema, time in range reached ~90% at week 32 and mean glucose levels decreased by ~64 mg/dL

Longer time in range for CagriSema vs semaglutide and cagrilintide

<table>
<thead>
<tr>
<th></th>
<th>CagriSema</th>
<th>Semaglutide</th>
<th>Cagrilintide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>17.8%</td>
<td>23.8%</td>
<td>10.0%</td>
</tr>
<tr>
<td></td>
<td>36.2%</td>
<td>43.5%</td>
<td>32.5%</td>
</tr>
<tr>
<td></td>
<td>45.9%</td>
<td>76.2%</td>
<td>56.9%</td>
</tr>
<tr>
<td>Week 32</td>
<td>88.9%</td>
<td>76.2%</td>
<td>71.7%</td>
</tr>
</tbody>
</table>

Time in range
- Time in range goes “beyond” HbA1c for detailed insights into glycemic control in people with diabetes
- Time in range (70–180 mg/dL) increased in all groups, reaching 88.9% with CagriSema at week 32

Mean glucose levels
- Decreased from baseline to week 32 in all groups, reaching -63.9 mg/dL for CagriSema, -43.6 mg/dL for semaglutide and -23.4 mg/dL for cagrilintide

Note: Data shown is trial product estimands
Note: CagriSema is a fixed dose combination of injectable cagrilintide 2.4 mg and injectable semaglutide 2.4 mg
TIR: Time in range
Mean weight loss was -15.6% and more than half of patients achieved ≥15% weight loss when treated with CagriSema.

Note: Data shown on weight loss over time is trial product estimands. Data on categorical weight loss is from post-hoc analysis (descriptive), from the on-treatment period.

Note: CagriSema is a fixed dose combination of injectable cagrilintide 2.4 mg and injectable semaglutide 2.4 mg. Sema: Semaglutide; Cagri: Cagrilintide.
In the phase 2 trial, CagriSema appeared to have a safe and well-tolerated profile

<table>
<thead>
<tr>
<th></th>
<th>CagriSema 2.4 mg (n = 31)</th>
<th>Semaglutide 2.4 mg (n = 31)</th>
<th>Cagrilintide 2.4 mg (n = 30)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AEs</td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Gastrointestinal AEs</td>
<td>21</td>
<td>67.7</td>
<td>22</td>
</tr>
<tr>
<td>Severity of AEs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild</td>
<td>18</td>
<td>58.1</td>
<td>13</td>
</tr>
<tr>
<td>Moderate</td>
<td>14</td>
<td>45.2</td>
<td>16</td>
</tr>
<tr>
<td>Severe</td>
<td>0</td>
<td>0.0</td>
<td>1</td>
</tr>
<tr>
<td>Serious AEs</td>
<td>0</td>
<td>0.0</td>
<td>2</td>
</tr>
<tr>
<td>AEs leading to drug withdrawal</td>
<td>0</td>
<td>0.0</td>
<td>1</td>
</tr>
</tbody>
</table>

Gastrointestinal adverse events were all mild or moderate in severity and the majority occurred during dose escalation

GLP-1: Glucagon like peptide-1; AE: Adverse event
Note: CagriSema is a fixed dose combination of injectable cagrilintide 2.4 mg and injectable semaglutide 2.4 mg
### Phase 3 trial programme in type 2 diabetes, REIMAGINE, expected to initiate in second half of 2023

**CagriSema characteristics**

- CagriSema is a fixed dose combination of injectable cagrilintide 2.4 mg and semaglutide 2.4 mg

**Phase 3a programme with CagriSema in T2D:**
- Aims to confirm efficacy and safety across four global trials
- Expected completion during 2025/2026

**Global phase 3 trial programme**

<table>
<thead>
<tr>
<th>Trial</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>REIMAGINE 1 vs placebo</td>
<td>• 180 patients with T2D&lt;br&gt;• 40-week vs. placebo&lt;br&gt;• Primary endpoint: HbA1c</td>
</tr>
<tr>
<td>REIMAGINE 2 FDC trial</td>
<td>• 2700 patients with T2D, MET +/- SGLT-2i&lt;br&gt;• 68-week vs. semaglutide, cagrilintide and placebo&lt;br&gt;• Primary endpoint: HbA1c and bodyweight</td>
</tr>
<tr>
<td>REIMAGINE 3 Add-on to insulin</td>
<td>• 270 patients with T2D, Basal insulin +/- MET&lt;br&gt;• 40-week vs. placebo&lt;br&gt;• Primary endpoint: HbA1c</td>
</tr>
<tr>
<td>REIMAGINE 4 H2H vs tirzepatide</td>
<td>• 1000 patients with T2D, MET +/- SGLT-2i&lt;br&gt;• 68-week vs. tirzepatide&lt;br&gt;• Primary endpoint: HbA1c and bodyweight</td>
</tr>
<tr>
<td>REDEFINE 3 CVOT - shared with obesity programme</td>
<td>• 4000 patients&lt;br&gt;• Event driven&lt;br&gt;• Primary endpoint: 3-point MACE</td>
</tr>
</tbody>
</table>

1 65% of patients with T2D, 35% without T2D

FDC: Fixed dose combination; T2D: Type 2 Diabetes; H2H: Head-to-head; CVOT: Cardiovascular outcomes trial; 3P: Three point; MACE: Major adverse cardiovascular event; MET: Metformin; SGLT-2i: sodium-glucose co-transporter-2 inhibitor

Note: CagriSema is a fixed dose combination of injectable cagrilintide 2.4 mg and injectable semaglutide 2.4 mg.
Objective:
- To compare the safety and efficacy of once daily oral semaglutide 25 mg and 50 mg with oral semaglutide 14 mg in people with T2D

Primary endpoint:
- Change from baseline to week 52 in HbA1c

Secondary confirmatory endpoints:
- Change from baseline to week 52 in body weight

Key Inclusion criteria:
- Type 2 diabetes
- HbA1c 8.0–10.5%
- BMI ≥25 kg/m2
- Stable dose of 1-3 OADs (metformin, SU, SGLT-2i or DPP-4i)

PIONEER PLUS enrolled 1606 patients with T2D

PIONEER PLUS with oral semaglutide in people with type 2 diabetes was successfully completed in Q2 2023

T2D: Type 2 diabetes; R: Randomisation; BMI: body mass index; SGLT-2i: Sodium/glucose co-transporter-2 inhibitors
Oral semaglutide 25 and 50 mg demonstrated statistically significant and superior reduction in HbA$_{1C}$ compared to 14 mg.

- More participants achieved the HbA$_{1C}$ target after 52 weeks with oral semaglutide 25 and 50 mg compared to 14 mg.

---

**Note:** Observed data are on-treatment. Week 52* is the HbA$_{1C}$ change using the trial product estimand. HbA$_{1C}$ targets are shown with trial product estimand data. Sema: Semaglutide.
Oral semaglutide 25 and 50 mg demonstrated statistically significant higher weight loss vs 14 mg in the PIONEER plus trial

Higher body weight reduction with oral semaglutide 25 mg and 50 mg compared to 14 mg

Mean baseline body weight: 96.4kg

Categorical weight loss after 52 weeks of treatment

≥5% body weight reduction

<table>
<thead>
<tr>
<th>Treatment</th>
<th>≥5% Body Weight Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral sema 14 mg</td>
<td>44.1%</td>
</tr>
<tr>
<td>Oral sema 25 mg</td>
<td>63.2%</td>
</tr>
<tr>
<td>Oral sema 50 mg</td>
<td>75.7%</td>
</tr>
</tbody>
</table>

≥10% body weight reduction

<table>
<thead>
<tr>
<th>Treatment</th>
<th>≥10% Body Weight Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral sema 14 mg</td>
<td>15.7%</td>
</tr>
<tr>
<td>Oral sema 25 mg</td>
<td>32.4%</td>
</tr>
<tr>
<td>Oral sema 50 mg</td>
<td>43.9%</td>
</tr>
</tbody>
</table>

Note: Observed data are on-treatment. Week 52* is the body weight change using the trial product estimand.

Sema: Semaglutide
The safety profile of oral semaglutide 25 and 50 mg was generally consistent with the GLP-1 receptor agonist drug class

<table>
<thead>
<tr>
<th></th>
<th>Oral semaglutide 14 mg (n = 534)</th>
<th>Oral semaglutide 25 mg (n = 534)</th>
<th>Oral semaglutide 50 mg (n = 534)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>AEs</td>
<td>404</td>
<td>(75.7)</td>
<td>422</td>
</tr>
<tr>
<td>Gastrointestinal adverse events</td>
<td>225</td>
<td>(42.1)</td>
<td>282</td>
</tr>
<tr>
<td>Serious AEs</td>
<td>53</td>
<td>(9.9)</td>
<td>57</td>
</tr>
<tr>
<td>AEs leading to drug withdrawal</td>
<td>54</td>
<td>(10.1)</td>
<td>66</td>
</tr>
</tbody>
</table>

Safety:
- Majority of gastrointestinal adverse events were mild or moderate in severity
- The majority occurred during dose escalation
- In the trial, oral semaglutide 25 and 50 mg appeared to have a safe and well-tolerated profile
GLP-1 diabetes: Key take-aways:

GLP-1 RA’s have demonstrated several benefits and are recommended as first line treatment for some people with T2D in international treatment guidelines.

In the phase 2 trial, CagriSema showed improved reduction of HbA$_{1c}$ and of body weight as well as longer time in range vs monocomponents.

CagriSema appeared to have a safe and well-tolerated profile. Phase 3 in T2D is expected to be initiated during H2 of 2023.

Based on the efficacy profile in PIONEER PLUS, oral semaglutide 25 and 50 mg may provide the option for patients to progress to higher doses if additional glycaemic control or weight loss is needed.

GLP-1 RA: Glucagon like peptide-1 receptor agonist; T2D: Type 2 diabetes

Note: CagriSema is a fixed dose combination of injectable cagrilintide 2.4 mg and injectable semaglutide 2.4 mg.
Agenda

Introduction
Insulin
  Insulin Icodec
  EASD
GLP-1 in diabetes
  CagriSema in diabetes
  Oral semaglutide in diabetes
GLP-1 in obesity
  Oral semaglutide in obesity
  Semaglutide 2.4 mg: STEP HFpEF
Q&A

Daniel Bohsen & Martin Holst Lange
Stephen Gough
Martin Holst Lange
All
OASIS 1 with oral semaglutide 50 mg in people with overweight or obesity has been successfully completed

Objective:
• To compare the safety and efficacy of 50 mg oral semaglutide with placebo in people with overweight or obesity without T2D

Co-primary endpoints:
• Percentage change in body weight from baseline to week 68
• Achievement of ≥5% weight loss from baseline at week 68

Confirmatory secondary endpoints:
• Achievement of ≥10%, ≥15% and ≥20% weight loss from baseline at week 68

Inclusion criteria:
• BMI: ≥27 kg/m² with ≥ 1 weight-related comorbidity, or
• BMI: ≥30 kg/m²
• Weight-related comorbidities are hypertension, dyslipidaemia, obstructive sleep apnoea and CVD
• ≥1 self-reported dietary weight loss effort

*As an adjunct to a reduced-calorie diet and increased physical activity in adults with obesity or with overweight and weight-related comorbidities (Weight-related comorbidities are hypertension, dyslipidaemia, obstructive sleep apnoea and CVD)

T2D: Type 2 diabetes; R: Randomisation; BMI: body mass index
Oral semaglutide 50 mg in overweight or obesity demonstrated superior body weight reduction in the OASIS 1 trial vs placebo

OASIS 1 showed significantly greater weight loss compared to placebo

Mean baseline body weight: 105.4kg

Categorical weight loss % at week 68

Mean baseline body weight: 105.4kg

Change in body weight (%)

Time since randomisation (weeks)

Oral semaglutide 50 mg

Placebo

≥5%

≥10%

≥15%

≥20%

89.2

74.7

58.5

37.2

24.5

11.8

5.3

2.4

0

20

40

60

80

100

% of patients

Note: Observed data are on-treatment. Week 68* is the body weight change using the trial product strategy

Sema: Semaglutide
The safety profile of oral semaglutide 50 mg was generally consistent with the GLP-1 receptor agonist drug class.

### Safety:
- Majority of gastrointestinal adverse events were mild or moderate in severity
- The majority occurred during dose escalation
- In the trial, oral semaglutide 50 mg appeared to have a safe and well-tolerated profile.

<table>
<thead>
<tr>
<th></th>
<th>Oral semaglutide 50 mg (n = 334)</th>
<th>Placebo (n = 333)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>AEs</td>
<td>307</td>
<td>(91.9)</td>
</tr>
<tr>
<td>Gastrointestinal adverse events</td>
<td>268</td>
<td>(80.2)</td>
</tr>
<tr>
<td>Serious AEs</td>
<td>32</td>
<td>(9.6)</td>
</tr>
<tr>
<td>AEs leading to drug withdrawal</td>
<td>19</td>
<td>(5.7)</td>
</tr>
</tbody>
</table>
Phase 3 trial programme for oral semaglutide 50 mg in overweight or obesity, OASIS

**Oral semaglutide characteristics**

- Oral semaglutide 50mg:
  - Semaglutide tablets in overweight or obesity
  - Once daily tablet

- Phase 3a programme with oral semaglutide 50 mg
  - Aims to confirm efficacy and safety
  - Submission in US and EU expected during 2023
  - The global launch of oral semaglutide 50 mg is contingent on portfolio prioritisations and manufacturing capacity

**Focused phase 3 trial programme**

- **OASIS 1 50 mg dose**
  - 667 patients
  - 68 week
  - Primary endpoint: BW %
  - 2023

- **OASIS 2 EAST ASIA**
  - 198 patients incl. T2D
  - 68 week
  - Primary endpoint: BW %
  - 2024

- **OASIS 3 China**
  - 200 patients incl. T2D
  - 44 week
  - Primary endpoint: BW %
  - 2024

- **OASIS 4 25 mg dose**
  - 300 patients
  - 64 week
  - Primary endpoint: BW %
  - 2025

BW: Body weight; T2D: Type 2 diabetes
Obesity is associated with multiple comorbidities, which may be improved with weight management.

**Life expectancy decreases as BMI increases**

<table>
<thead>
<tr>
<th>BMI</th>
<th>Chance of reaching age 70</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal BMI</td>
<td>Almost 80% chance</td>
</tr>
<tr>
<td>BMI 35–40 kg/m²</td>
<td>~60% chance</td>
</tr>
<tr>
<td>BMI 40–50 kg/m²</td>
<td>~50% chance</td>
</tr>
</tbody>
</table>

**Obesity related comorbidities**

**Mental**
- Depression
- Anxiety

**Mechanical**
- Asthma
- GERD
- Physical functioning
- Incontinence
- Knee osteoarthritis
- Sleep apnea
- Chronic back pain

**Metabolic**
- NAFLD
- Gallstones
- Infertility
- Type 2 diabetes
- Prediabetes
- Thrombosis
- Gout
- Cancers*
- CVD:
  - Stroke
  - Dyslipidemia
  - Hypertension
  - Coronary artery disease
  - HFpEF

*Including breast, colorectal, endometrial, oesophageal, kidney, ovarian, pancreatic and prostate


BMI: Body mass index; GERD: gastro-oesophageal reflux disease; HFpEF: heart failure with preserved ejection fraction; NAFLD: non-alcoholic fatty liver disease; CVD: Cardiovascular disease; HFpEF: Heart failure with preserved ejection fraction.
HFpEF compromises ~50% of all HF cases, and ~80% of HFpEF patients live with overweight or obesity

**Heart failure with preserved ejection fraction**

- Impaired filling capacity
- Stiff and thick ventricle
- LVEF ≥50%

**Approximately 26 million people have HFpEF and BMI>27**

<table>
<thead>
<tr>
<th>HF</th>
<th>HFrEF</th>
</tr>
</thead>
<tbody>
<tr>
<td>64m</td>
<td>32m</td>
</tr>
<tr>
<td>26m</td>
<td></td>
</tr>
</tbody>
</table>

**Patients with HFpEF are under a great burden**

- Higher mortality rate
- Higher risk of hospitalisation
- Higher burden of debilitating symptoms, physical limitations and poor quality of life

**The key goals of therapy**

- Prolong survival
- Reduce hospitalisations
- Reduce symptoms; improve quality of life and functional status


LVEF: Left ventricular ejection fraction; HF: Heart failure; HFpEF: Heart Failure with preserved ejection fraction
Phase 3 trial STEP HFpEF with semaglutide 2.4 mg has been successfully completed in Q2 2023

Objective:
• Evaluate the effect on HF specific symptoms, physical function and body weight compared with placebo

Dual primary endpoints:
• Change in KCCQ from baseline to week 52
• Change in body weight from baseline to week 52

Key secondary endpoints:
• Change in 6MWD from baseline to week 52
• Composite endpoint (all cause death, HHF, KCCQ, 6MWD) from baseline to week 52

Inclusion criteria:
• BMI ≥30 kg/m²
• NYHA II-IV
• Ejection fraction ≥45%

STEP HFpEF

Semaglutide 2.4 mg + SoC
Placebo + SoC

Dose escalation 16 weeks
Treatment maintenance 36 weeks
Follow up 5 weeks

R: Randomisation; HF: Heart Failure; HFpEF: Heart Failure with preserved ejection fraction; SoC: Standard of care; KCCQ: Kansas City Cardiomyopathy Questionnaire; 6MWD: 6-min walking distance; HHF: Heart failure hospitalization; NYHA: New York Heart Association classification
The Kansas City Cardiomyopathy Questionnaire, a patient reported outcome, was primary endpoint in the STEP HFpEF trial

The Kansas City Cardiomyopathy Questionnaire (KCCQ) is a patient-reported outcome that assesses the impact of heart failure on daily life. It comprises several domains: symptom frequency, symptom burden, physical limitations, social limitations, self-efficacy, and stability. The dual primary endpoint in the STEP HFpEF trial was the KCCQ clinical summary score.

**KCCQ Score Interpretation**
- Score 0 to 24: Very poor to poor
- Score 25 to 49: Poor to fair
- Score 50 to 74: Fair to good
- Score 75 to 100: Good to excellent

---


HFpEF: Heart Failure with preserved ejection fraction; KCCQ: Kansas City Cardiomyopathy Questionnaire
Semaglutide 2.4 mg demonstrated superior improvement on the primary endpoint of KCCQ-CSS vs placebo

Superior improvement in KCCQ-CSS score in patients treated with semaglutide 2.4 mg

Mean baseline KCCQ-CSS score: 56.7

Key highlights

Primary endpoints:
- KCCQ-CSS estimated treatment difference between semaglutide 2.4 mg and placebo of 7.8

KCCQ in perspective

Clinicians’ assessments of clinical change\(^1\):
- Small: ±5 points
- Moderate-to-large: ±10 points
- Large-to-very large: ±20 points

Patients’ self-classifications of improvements\(^1\):
- Minimal clinically important difference for ‘little improvement’: 4.5 points

Note: Data shown is the treatment policy estimand. *Lines are based on observed data where the value denoted after 52 weeks is estimated mean value derived based on multiple imputation.
KCCQ-CSS: Kansas City Cardiomyopathy Questionnaire Clinical summary score

Change in KCCQ-CSS (score)

Time since randomisation (weeks)

Semaglutide 2.4mg  Placebo
Semaglutide 2.4 mg demonstrated superior reduction on the other primary endpoint of body weight vs placebo

Clinically relevant and sustained weight loss in patients treated with semaglutide 2.4 mg
Mean baseline body weight: 108.4 kg

Key highlights

Primary endpoint:
- Estimated treatment difference in body weight change between semaglutide 2.4 mg and placebo of -10.7%

Safety:
- Overall, the safety profile in HFpEF patients is consistent with previous data for semaglutide 2.4 mg

Note: Data shown is the treatment policy estimand. *Lines are based on observed data where the value denoted after 52 weeks is estimated mean value derived based on multiple imputation.
HF: Heart failure
The ongoing STEP HFpEF-DM trial is to be included in the regulatory submission

**Trial design and next steps**

**Dual primary endpoints:**
- Change in KCCQ from baseline to week 52
- Change in body weight from baseline to week 52

**Inclusion criteria:**
- BMI ≥ 30 kg/m²
- NYHA II-IV
- Ejection fraction ≥ 45%
- HbA₁c ≤ 10.0%

**Next steps:**
- Completion of STEP HFpEF-DM trial expected in H2 2023
- Combined regulatory submission of both trials in H1 2024
- Decision expected late 2024/early 2025

---

**STEP HFpEF-DM trial with 610 people with obesity, HFpEF and T2D**

- **Dose escalation:** 16 weeks
- **Treatment maintenance:** 36 weeks
- **Follow up:** 5 weeks

- **Semaglutide 2.4 mg + SoC**
- **Placebo + SoC**

---

R: Randomisation; HF: Heart Failure; HFpEF: Heart Failure with preserved ejection fraction; SoC: Standard of care; KCCQ: Kansas City Cardiomyopathy Questionnaire; 6MWD: 6-min walking distance; NYHA: New York Heart Association classification
GLP-1 obesity: Key take-aways:

In OASIS 1, oral semaglaglutide 50 mg showed efficacy broadly on par with injectable semaglutide 2.4 mg.

A high unmeet need exists within obesity-related HFpEF.

Semaglutide 2.4 mg demonstrated superiority on the dual primary endpoint vs placebo in the STEP HFpEF trial.
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
- 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

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

Insulin

- Insulin Icodec

GLP-1 in diabetes

- CagriSema in diabetes
- Oral semaglutide in diabetes

GLP-1 in obesity

- Oral semaglutide in obesity
- Semaglutide 2.4 mg: STEP HFpEF

Q&A

Daniel Bohsen & Martin Holst Lange

Stephen Gough

Martin Holst Lange

Stephen Gough

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

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Upcoming events

10 August 2023  Financial statement for the first six months of 2023
02 November 2023  Financial statement for the first nine months of 2023
31 January 2024  Financial statement 2023