Veru Inc.
Nasdaq: VERU
Miami, Florida

Focused on Cardiometabolic Diseases

Veru Corporate Presentation
February 26, 2026
Oppenheimer Healthcare Conference

Forward looking statements and safe harbor

This presentation contains "forward-looking statements" as that term is defined in the Private Securities Litigation Reform Act of 1995, including, without limitation, express or implied statements related to the planned design, enrollment, timing, commencement, interim and full data readout timing, scope and regulatory pathways for the continued development of enobosarm in patients with obesity, including the planned PLATEAU Phase 2b study; whether clinically meaningful incremental weight loss in the PLATEAU Phase 2b study will continue to be seen as an acceptable primary endpoint by the FDA to support potential approval; whether the FDA will continue to accept 3mg as an acceptable dosage for enobosarm in the planned PLATEAU Phase 2b study or in any other studies; whether the FDA will further evolve its position on the acceptable patient population for the PLATEAU Phase 2b study or any other future studies; whether the results of the Phase 2b QUALITY study and the extension maintenance study of enobosarm will be replicated to the same or any degree in the planned PLATEAU Phase 2b study or in any future Phase 3 studies; the expected costs, timing, patient population, design, endpoints and results of the planned PLATEAU Phase 2b study or any future Phase 3 studies of enobosarm in patients with obesity; whether the Company will be able to raise sufficient capital, dilutive or otherwise, to fund the PLATEAU Phase 2b study of enobosarm in patients with obesity or any other studies; whether the Company will be able to recruit a sufficient number of patients in a timely manner for the PLATEAU Phase 2b study; whether the modified-released formulation of enobosarm will be developed successfully and whether such formulation will have the same effectiveness or bioequivalence as the current formulation, and whether and when such modified-release formulation will be available for any planned or future clinical studies; whether and when any patents will actually issue regarding such modified-release formulation; whether the Company will be able to obtain sufficient tirzepatide or any other GLP-1 RA drugs in a timely or cost-effective manner in the planned PLATEAU Phase 2b study or any future Phase 3 studies; whether enobosarm will cause weight loss or preserve muscle in, or meet any unmet need for, obesity patients and whether it will cause weight loss in the planned PLATEAU Phase 2b study or any future Phase 3 studies or, if approved and commercialized, in clinical practice; whether patients treated with enobosarm for a longer period of time than in the Phase 2b QUALITY study will experience weight loss or have a greater loss of adiposity or greater weight loss than with tirzepatide, semaglutide or other GLP-1 drug alone; whether and when enobosarm will be approved by the FDA as a weight loss drug or a body composition drug or any other type of drug; and whether and when the Company will be able to further advance the development of sabizabulin in atherosclerotic disease. The words "anticipate," "believe," "could," "expect," "intend," "may," "opportunity," "plan," "predict," "potential," "estimate," "should," "will," "would" and similar expressions are intended to identify forward-looking statements, although not all forward-looking statements contain these identifying words. Any forward-looking statements in this presentation are based upon current plans and strategies of the Company and reflect the Company's current assessment of the risks and uncertainties related to its business and are made as of the date of this presentation. The Company assumes no obligation to update any forward-looking statements contained in this presentation because of new information or future events, developments or circumstances. Such forward-looking statements are subject to known and unknown risks, uncertainties and assumptions, and if any such risks or uncertainties materialize or if any of the assumptions prove incorrect, our actual results could differ materially from those expressed or implied by such statements. Factors that may cause actual results to differ materially from those contemplated by such forward-looking statements include, but are not limited to: the development of the Company's product portfolio and the results of clinical studies possibly being unsuccessful or insufficient to meet applicable regulatory standards or warrant continued development; the Company's ability to reach agreement with FDA on study design requirements for the Company's planned clinical studies, including for the planned PLATEAU Phase 2b study for enobosarm and the cost thereof; potential delays in the timing of and results from clinical trials and studies, including as a result of an inability to enroll sufficient numbers of subjects in clinical studies or an inability to enroll subjects in accordance with planned schedules; the ability to fund planned clinical development as well as other operations of the Company; the timing of any submission to the FDA or any other regulatory authority and any determinations made by the FDA or any other regulatory authority; the potential for disruptions at the FDA or other government agencies to negatively affect our business; any products of the Company, if approved, possibly not being commercially successful; the ability of the Company to obtain sufficient financing on acceptable terms when needed to fund development and operations; demand for, market acceptance of, and competition against any of the Company's products or product candidates; new or existing competitors with greater resources and capabilities and new competitive product approvals and/or introductions; changes in regulatory practices or policies or government-driven healthcare reform efforts, including pricing pressures and insurance coverage and reimbursement changes; the Company's ability to protect and enforce its intellectual property; costs and other effects of litigation; the Company's ability to identify, successfully negotiate and complete suitable acquisitions or other strategic initiatives; the Company's ability to successfully integrate acquired businesses, technologies or products; and other risks detailed from time to time in the Company's press releases, shareholder communications and Securities and Exchange Commission filings, including the Company's Form 10-K for the year ended September 30, 2024, and subsequent quarterly reports on Form 10-Q. These documents are available on the "SEC Filings" section of our website at www.verupharma.com/investors.

Drug candidate pipeline
Cardiometabolic biopharmaceutical company

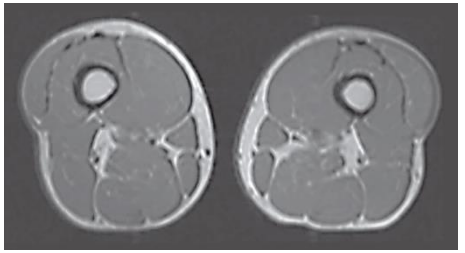
Program	Mechanism	Indication	Phase 1	Phase 2	Phase 3	Marketed
Cardiometabolic Obesity Program						
Enobosarm and GLP-1 receptor agonist for incremental weight loss	Oral Selective androgen receptor modulator (SARM) + GLP-1 receptor agonist	Incremental weight loss by preserving muscle, function, and reducing fat in patients receiving semaglutide for weight reduction	Phase 2b PLATEAU study		First Patient In – Q1 2026 Interim Analysis – Q2 2027 Topline Data – Q4 2027	
		Preserve muscle and function and augment fat loss in older patients receiving a semaglutide for weight loss	Phase 2 QUALITY Study		Completed – 2025	
Cardiometabolic Atherosclerosis Program						
Sabizabulin	Oral microtubule disruptor, broad anti-inflammatory agent	To treat inflammation to slow the progression or promote the regression of atherosclerosis in patients with stable coronary artery disease	Planned Phase 2			

Dates of future events set forth in this table are expected dates

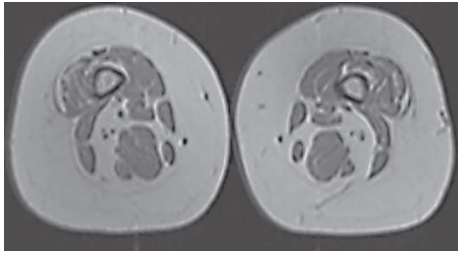
Major problem: Older sarcopenic patients with obesity are at the highest risk when taking a GLP-1 RA drug because they start out with low muscle reserves

Potential risks for older sarcopenic obese patients taking a GLP-1 RA drug[1-4]:

Normal MRI of the quadriceps area[5]



Sarcopenic obese MRI of the quadriceps area[5]

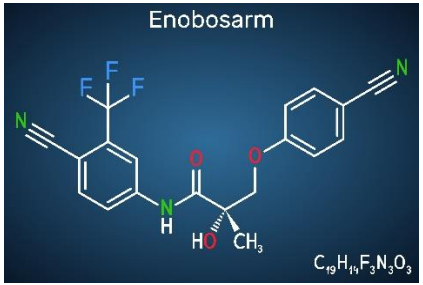


[1]Wennamethee SG et al. Current Diabetes Reports 2023|[2]Murdock et. al., PMC PubMed Central NIH, Skelet Muscle. 2022 Dec 21;12(1):26 | [3]Spanoudaki M et al. Life 13:1242, 2023|[4]Roh E et al. Front Endocrinol 11: 2020|[5]Batsis J et al. Nature Reviews Endocrinology 14:513-537, 2018

Enobosarm (Ostarine, MK2866, GTx-024) clinical product profile
A nonsteroidal, selective androgen receptor modulator[1,2]

Data from 6 clinical trials (muscle endpoints) in 1,100 patients and in preclinical studies, support potential for:

- Once-daily oral dosing
- Activates the androgen receptor, a well-established mechanism
- Agonist, partial agonist, or antagonist depending on tissue



Efficacy

- Demonstrates tissue-selective activity
- Improves muscle mass and physical function[2,6]
- Stimulates lipolysis, inhibits lipogenesis, and decreases fat mass[7,8]
- Builds and heals bone-potential to treat/prevent bone loss/osteoporosis[3-5]

Safety Features

- Lack of masculinizing effects in women
- Not converted to estrogen or dihydrotestosterone
- No liver toxicity - No drug induced liver injury by Hy's law observed in clinical studies (27 clinical studies/1,560 subjects)
- Low potential for drug-drug interactions[9]

[1]Narayanan R et al. Mol Cell Endocrinol 2017|[2]Dalton JT et al. Curr Opin Support Palliat Care 7:345-351, 2013|[3]Kamrakova M et al Calcif Tissue Int 106:147-157,2020|[4]Hoffman DB et al. J Bone Metab 37:243-255, 2019|[5]Kearbey JD et al Pharm Res 26:2471-2477, 2009| [6]Dobs AS et al. Lancet Oncol 14:335-45, 2013|[7]Dalton JT et al. J Cachexia Sarcopenia Muscle 2:153-161, 2011|
[8]Leciejewska N et al. J Phys and Pharma 70:525-533, 2019 | [9] Coss C et al. Invest New Drugs 34:458-67, 2016.

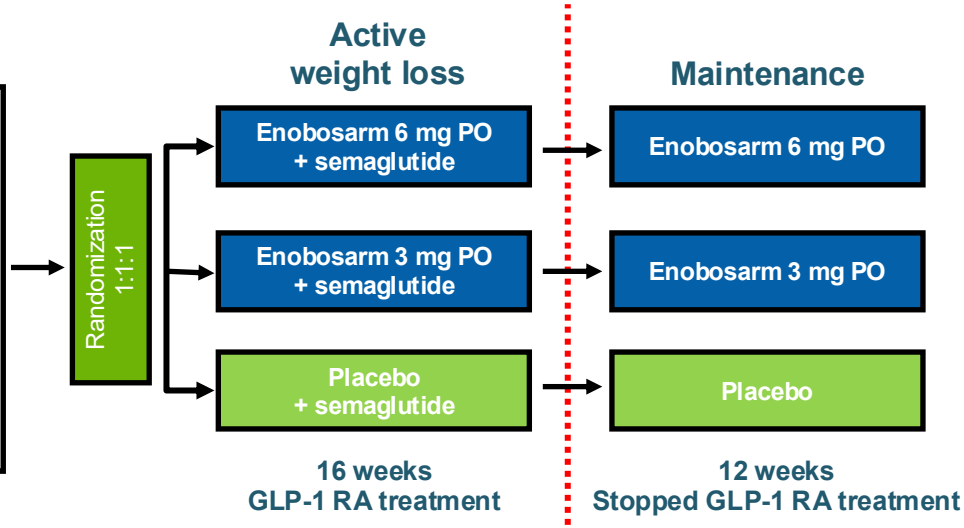
Completed positive Phase 2b QUALITY clinical trial study in 2025

Evaluated enobosarm in 168 patients with obesity taking semaglutide for weight loss

Sample size calculation
- n=168 patients

(~55 subjects/arm)

Key Inclusion criteria:
- Obese or overweight
- Age ≥60 years
- GLP-1 RA semaglutide is indicated



Primary endpoint (16 weeks):
- Lean body mass (muscle mass) measured by DXA scan

Secondary endpoints:
- Total body fat
- Total body weight
- Stair climb physical function test
- HbA1c

Principal Investigator:

Steven B. Heymsfield, M.D., Professor and the Director of the Body Composition-Metabolism Laboratory at the Pennington Biomedical Research Center in Baton Rouge, Louisiana

Primary endpoint met: Preservation of total lean body mass at 16 weeks

	Placebo + semaglutide n=53	Enobosarm 3 mg + semaglutide n=53	Enobosarm 6 mg + semaglutide n=53
Total lean mass change			
Mean percent (%) change (SE)	-4.14% (0.65)	+0.293 (0.65)*	-2.29% (0.65)**
Percent (%) preservation of lean mass vs placebo		100%	45%
Total fat mass change			
Mean percent (%) change (SE)	-8.04% (1.00)	-9.04% (1.01)	-11.39% (1.01)***
Percent (%) change in fat loss vs placebo		12%	42%
Body weight change			
Mean percent (%) change (SE)	-5.57 % (0.51)	-4.39% (0.50)#	-5.85% (0.50)#
Composition of weight loss			
Percent (%) fat loss	66% fat loss	100% fat loss	83.3 fat loss
Percent (%) lean mass loss	34% lean mass loss	0% lean mass loss	16.7% lean mass loss

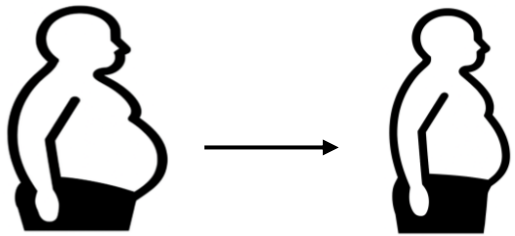
- **Lean mass was fully preserved by enobosarm 3 mg**
- **Incremental fat loss by both Enobosarm 3 mg and enobosarm 6 mg**
- **Body weight change was similar across groups**
- **Overall, enobosarm 3 mg caused weight loss to be 100% fat**

*Least square mean : * p<0.001 **p=0.039 ***p=0.017 MMRM: #Not statistically significant*

Incremental weight loss was observed in the enobosarm 3 mg patients with a BMI ≥ 35 at 16 weeks

Total median body weight analysis in patients with BMI ≥ 35

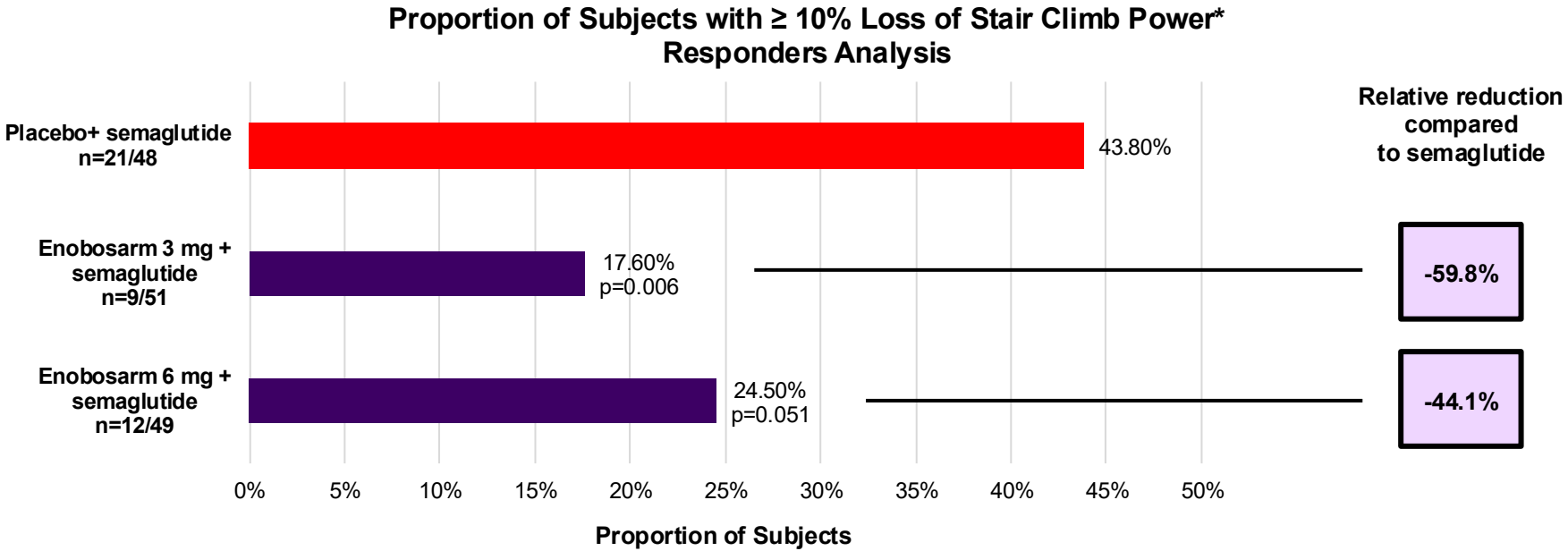
	Placebo + semaglutide 16 weeks n=19	Enobosarm 3 mg + semaglutide 16 weeks n=26	Percent (%) difference between groups
Total body weight			
Median % change	-4.70%	-5.58%	18.7% additional weight loss
Proportion of patients that lost at least 5% of body weight	9/19 (47.4%)	17/26 (65.4%)	38.0% higher proportion
Lean body mass			
Median % change	-4.71%	-0.76%	84% preservation of lean body mass



- **Enobosarm 3 mg + semaglutide showed incremental weight loss vs. placebo + semaglutide**
- **A higher proportion of enobosarm 3 mg patients achieved ≥ 5% weight loss compared to placebo + semaglutide**
- **Incremental weight loss was observed even though enobosarm 3 mg + semaglutide preserved ~84% of lean body mass**

Semaglutide treatment causes a loss in physical function (stair climb)

Enobosarm prevented the decline in stair climb power at 16 weeks



A loaded 8 step stair climb test was conducted at 16 weeks and a ≥ 10% decline in stair climb power was selected as a threshold cut off as this represents > 7 years of loss of stair climb power with aging[1-2]

* Odds Ratio| [1]Van Roie E PLOS ONE 14:e0210653, 2019|[2] Meulemans L et al. Aging Clin and Exp Res 37:72, 2025.

Positive safety profile – Adverse events

Adverse Events[1] and Adverse Events of Special Interest

Adverse Event	Placebo + semaglutide (n=56)	Enobosarm 3 mg + semaglutide (n=56)	Enobosarm 6 mg + semaglutide (n=56)
Nausea	11 (20%)	6 (11%)	8 (14%)
Gastroesophageal Reflux Disease	7 (13%)	3 (5%)	0 (0%)
Diarrhea	4 (7%)	1 (2%)	7 (13%)
Vomiting	2 (4%)	1 (2%)	4 (7%)
Constipation	8 (14%)	7 (13%)	6 (11%)
Alanine aminotransferase increased	0 (0%)	1 (2%)[2]	6 (11%)[3]
Aspartate aminotransferase increased	0 (0%)	0 (0%)	1 (2%)[3]
Obstructive sleep apnea syndrome	9 (16%)	10 (18%)	11 (20%)
Upper respiratory tract infection	1 (2%)	1 (2%)	4 (7%)
Headache	2 (4%)	4 (7%)	1 (2%)
Fatigue	4 (7%)	0 (0%)	4 (7%)

1: Adverse event (≥ 4 subjects in any dose group) from Day 1 to Day 112 || 2: Graded as mild in severity; levels returned to baseline while on drug, no associated increase in alkaline phosphatase or total bilirubin || 3:All graded as mild in severity; all returned to or toward baseline/upper limit of normal, no associated increases in alkaline phosphatase or total bilirubin.

FDA provides regulatory clarity for the development of enobosarm as a muscle preservation drug in combination with a GLP-1 RA in September 2025[1-3]

- **The regulatory landscape and FDA guidance continues to evolve** for muscle preservation drugs in the treatment of obesity. Based on FDA feedback on Veru's clinical development program for enobosarm:
- **FDA has now concluded that incremental weight loss with enobosarm in combination with a GLP-1 RA treatment over the GLP-1 RA treatment alone is an acceptable primary endpoint to support approval**
  - **The amount of incremental weight loss required for approval depends:**
    - **At least a 5% placebo-corrected weight loss at 52 weeks of maintenance treatment alone would support efficacy for approval**
    - **Alternatively, if incremental weight loss of <5% (including similar weight loss) is observed at 52 weeks of maintenance treatment with a clinically significant positive benefit, such as clinically beneficial preservation in physical function, a drug in combination with GLP-1 RA may be approvable**
- **Secondary endpoints** including physical function (stair climb assessment) improvement that is linked to to a patient reported outcome of mobility/disability (SF -36 PF-10 or IWQOL-Lite CT) would be acceptable
- FDA states It may be reasonable to **first establish efficacy in older adults** who may be at greater risk of harm due to muscle loss, but the development should be expanded to younger patients with obesity
- Based on the Phase 2 QUALITY clinical study, **enobosarm 3mg dose is the reasonable dose for further development**

[1] Obesity and Overweight Guidance for Industry January 2025|[2] Regulatory workshop Society on Sarcopenia, Cachexia, and Wasting Disorders Washington DC December 2024|[3] FDA-Veru correspondence 2024 and 2025 (on file)

BMD is another path to regulatory approval for body composition improvement

FDA Qualifies Total Hip Bone Mineral Density (BMD) as Surrogate Endpoint for Osteoporosis Drug Development

[December 19, 2025] The U.S. Food and Drug Administration (FDA) today qualified total hip bone mineral density (BMD) as assessed by dual energy X-ray absorptiometry (DXA) as a validated surrogate endpoint to support clinical trials of investigational therapies for post-menopausal women with osteoporosis at risk for fracture.

GLP-1 RA treatment has also been associated with bone loss and fractures

Both semaglutide and tirzepatide have been reported to cause bone loss at the lumbar spine and hip[1-3]

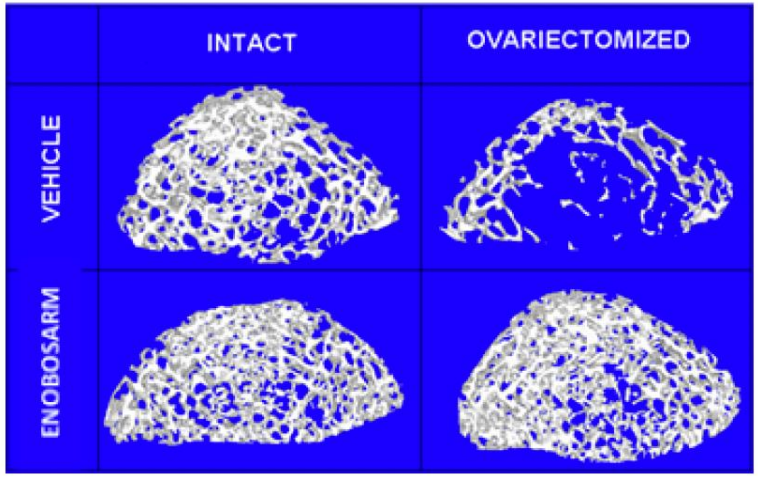
wegovy®
semaglutide injection **2.4 mg**

HIGHLIGHTS OF PRESCRIBING INFORMATION
These highlights do not include all the information needed to use WEGOVY® safely and effectively. See full prescribing information for WEGOVY®.
WEGOVY® (semaglutide) injection, for subcutaneous use

Fractures
In the cardiovascular outcomes trial in adults, more fractures of the hip and pelvis were reported on WEGOVY® than on placebo in female patients: 1.0% (24/2448) vs. 0.2% (5/2424), and in patients ages 75 years and older: 2.4% (17/703) vs. 0.6% (4/663), respectively.

[1] Hansen M et al. eClinicalMedicine 72:102624 2024 | [2] Liu H et al. Bone Research 13:99 2025 | [3] Liu Y et al. J Endo Soc Abstract ID bvaf149.558 2025 | [4] Wegovy PI page 4

Preclinical data supports ability of enobosarm (ostarine) as both anabolic and anti-resorptive agent to increase bone mineral density in rat models of postmenopausal women and male osteoporosis



Bone microCT

- Enobosarm uniquely prevents and treats both cortical and trabecular bone loss and reduces body fat in rat model of postmenopausal osteoporosis[1,2,4]
  - Anabolic: stimulates osteoblasts
  - Anti-resorptive: inhibits osteoclasts
- Enobosarm improves bone healing in rat model of postmenopausal osteoporosis[5]
- Enobosarm improves muscle strength and body composition and prevents bone loss in orchidectomized rats[3]

[1]Kearbey JD et al Pharm Res 24:328-335, 2007 | [2]Kearbey JD et al Pharm Res 26:2471-2477, 2009| [3] Gao W et al Endocrinology 146:4887-4897, 2005| [4] Hoffman DB et al. J Bone Metab 37:243-255, 2019 | [5]Kamrakova M et al Calcif Tissue Int 106:147-157,2020.

Major problem: Patients with obesity taking a GLP-1 RA hit a weight loss plateau

HEALTH

The Ozempic Plateau

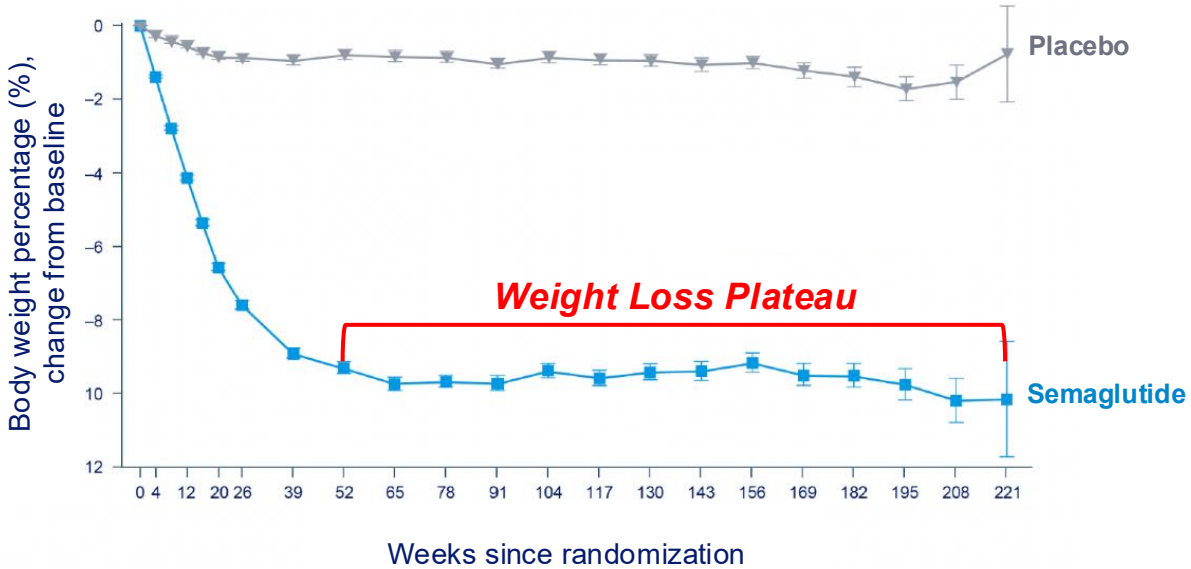
Everyone hits a weight-loss plateau, but the race is on for next-generation drugs that can help patients lose even more weight.

By Sarah Zhang

Illustration by The Atlantic. Source: Getty.

JANUARY 17, 2024

SELECT Trial:
Effect of semaglutide vs placebo on body weight (4.25 years)[1]



[1]Lincoff AM, Brown-Frandsen K, Colhoun HM, et al. Semaglutide and cardiovascular outcomes obesity without diabetes. N Engl J Med 2023;389:2221-32. DOI: 10.1056/NEJMoa2307563

Major problem: 62.6% of patients on tirzepatide still have obesity and have hit a weight loss plateau by 72 weeks

SURMOUNT-1 study: Tirzepatide Changes in BMI[1]

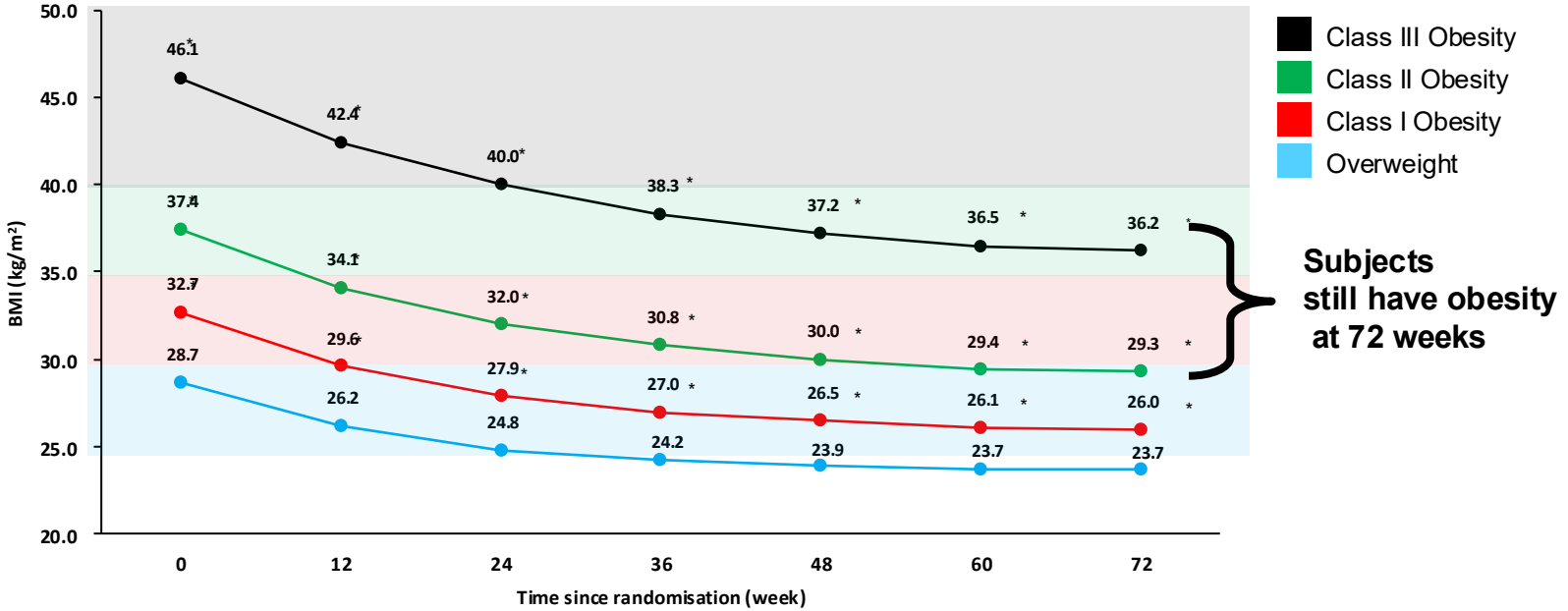


FIGURE 1 Mean BMIT over time by baseline BMI category in SURMOUNT-1. *p<0.05 for comparison of mean BMI of the given BMI category versus >27-<30 kg/m² (overweight) based on analysis of variance (ANOVA) model. BMI, body mass index.

[1]Horn D et al. Clin Obesity 15:e12734 2025 (Figure 1)

Key problems with GLP-1 RA treatments

Tissue nonselective weight loss, lose both muscle and fat
GLP-1 RAs reduce both muscle and fat, with lean mass making up 20–50% of total weight lost

Loss of muscle is most harmful in older sarcopenic obese patients
Higher risk for poor balance, reduced gait, falls, fractures, disability, hospitalization, and mortality

Weight loss plateau
~88% of patients hit a plateau after 60–72 weeks on GLP-1 therapy

Persistent obesity
Even after prolonged GLP-1 treatment, ~2/3 of patients remain obese, especially those with baseline BMI ≥35

Enobosarm

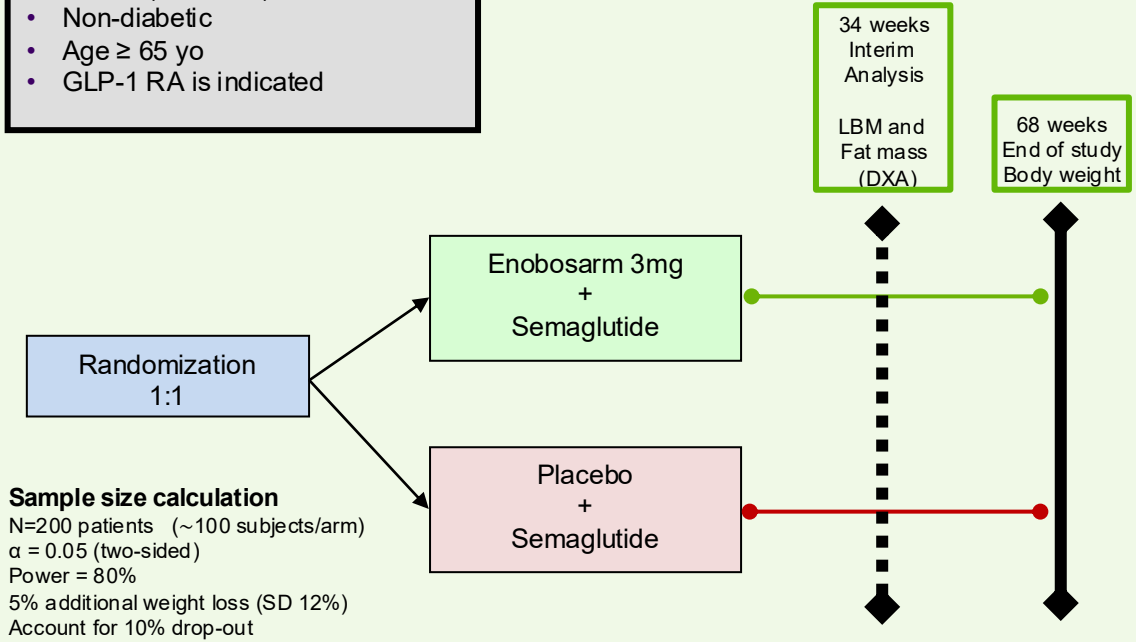
Unmet need
Need therapy that causes weight reduction by preserving muscle and only losing fat

Phase 2b PLATEAU clinical study design – Initiates Q1 2026

Double blind study to evaluate enobosarm 3 mg on total body weight, body composition (DEXA), physical function, and safety in obese patients taking semaglutide for weight reduction

Key Inclusion criteria:
- Obese (BMI ≥ 35)
- Non-diabetic
- Age ≥ 65 yo
- GLP-1 RA is indicated

Study duration is 68-week, Double-Blind Design



Sample size calculation
N=200 patients (~100 subjects/arm)
α = 0.05 (two-sided)
Power = 80%
5% additional weight loss (SD 12%)
Account for 10% drop-out
Oral semaglutide weight loss at 68 weeks is 15.7%

Primary endpoint

Total body weight

Secondary endpoints

- Stair climb test (power & time)
- Physical function PRO (SF-36 PF-10 physical and IWQOL-Lite CT physical function PRO)
- Total fat mass (DXA scan)
- Total lean mass (DXA scan)
- Bone mineral density (DXA scan)
- HbA1c
- HOMA-IR (insulin resistance)
- Mobility-disability assessment
- High sensitivity C-reactive protein

Principal Investigator:

Steven B. Heymsfield, M.D., Professor and the Director of the Body Composition-Metabolism Laboratory at the Pennington Biomedical Research Center in Baton Rouge, Louisiana

Evidence that enobosarm, an androgen receptor agonist, by preserving muscle and augmenting fat loss may result in clinically meaningful incremental weight loss in patients receiving a GLP-1 RA

Incremental weight loss was observed in the enobosarm 3 mg patients with a BMI ≥ 35 at 16 weeks

Total median body weight analysis in patients with BMI ≥ 35

	Placebo + semaglutide 16 weeks n=19	Enobosarm 3 mg + semaglutide 16 weeks n=26	Percent (%) difference between groups
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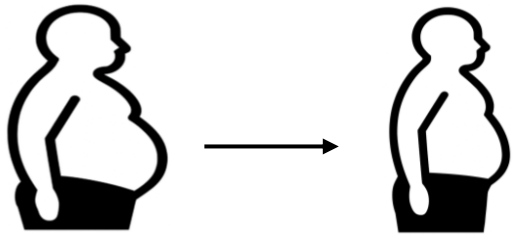

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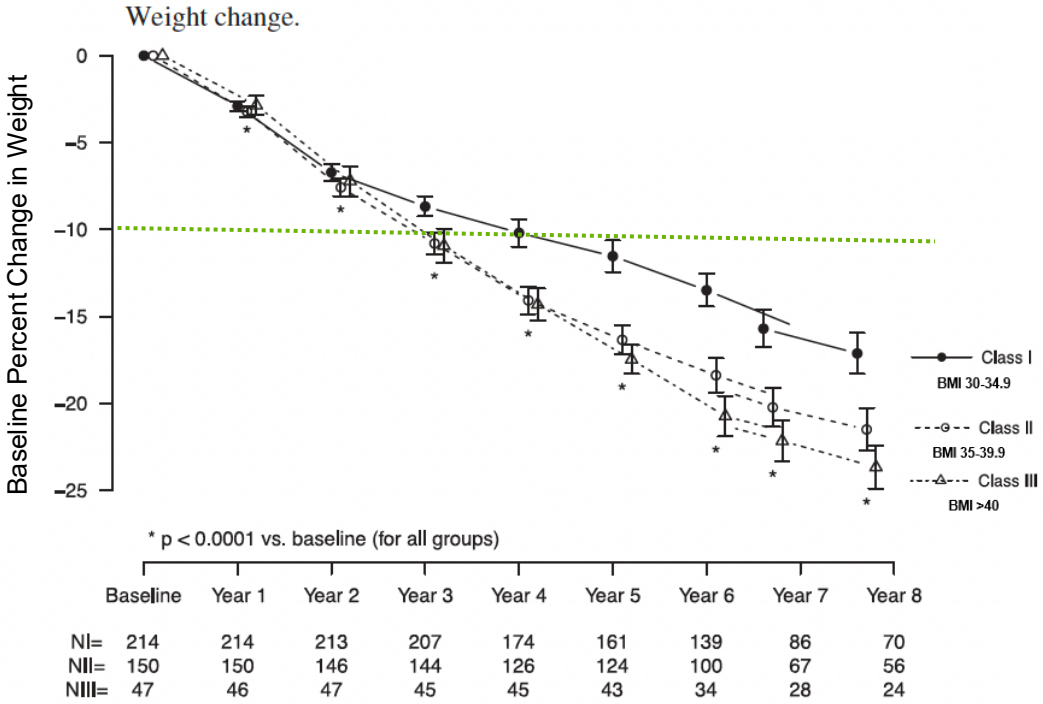
- **Incremental weight loss was observed even though enobosarm 3 mg + semaglutide preserved ~84% of lean body mass**

Does muscle preservation help overcome the weight loss plateau?

Effect of long-term testosterone in hypogonadal men with obesity (8 years)[1]



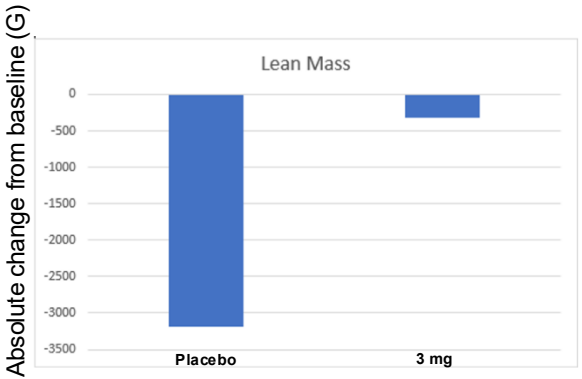
- **Androgen receptor activation (testosterone)** in obese hypogonadal men produced **continuous weight loss over 8 years**[1]
- **No weight-loss plateau** was observed, unlike with GLP-1 therapies
- **Preserving muscle** may be the **key to consistent weight loss**

[1]Saad F et al. Int J Obesity 40: 162-170, 2016.

Enobosarm preserved lean mass, reduced fat, and caused greater weight reduction in the Phase 3 504 clinical trial in advanced non-small cell lung cancer patients on chemotherapy[1]

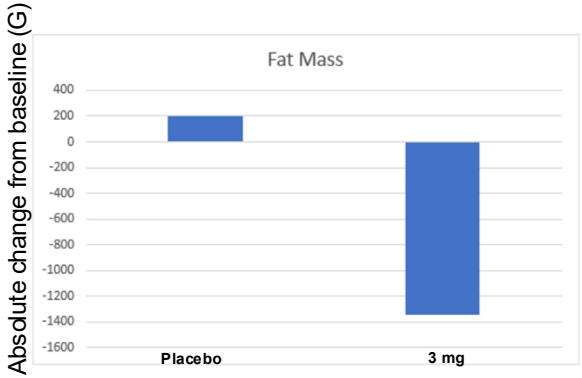
Post-hoc analysis of obese subpopulation (BMI ≥ 30)

Total lean body mass
Up to 3 months visit



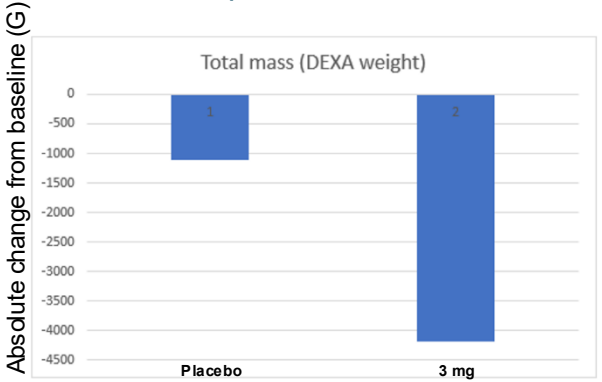
Percent change = +4.96%
Placebo n=15, Treated n=14

Total fat mass
Up to 3 months visit



Percent change = - 5.77%
Placebo n=15, Treated n=14

Total body weight
Up to 5 months visit



Percent change = - 4.51%
Placebo n=12, Treated n=12

[1] Study G300504 CSR data on file Veru

Lean mass preservation eventually leads to significant incremental weight loss

Bimagrumab + semaglutide delivered -6.4% incremental weight loss at 72 weeks

Scholar Rock

Phase 2 EMBRAZE Trial[1]

Group	Weight loss (24 wks)	Lean mass preservation (24 wks)
Placebo + tirzepatide	-12.5%	
Apitegromab + tirzepatide	-13.4%	54.9%

Apitegromab= antimyostatin

REGENERON

Phase 2 COURAGE Trial[2]

Group	Weight loss (26 wks)	Lean mass preservation (26 wks)
Placebo + semaglutide	-10.4%	
Low dose trevogrumab + semaglutide	-9.9%	50.8%
High dose trevogrumab + semaglutide	-11.3%	51.3%
Trevogrumab +garetosmab + semaglutide	-13.2%	80.9%

Trevogrumab= anti-GDF8/ antimyostatin
Garetosmab= anti-Activin A

Versanis

Phase 2 BELIEVE Trial[3]

Group	Weight loss (16 wks)	Weight loss (24 wks)	Weight loss (72 wks)	Lean mass preservation (72 wks)
Placebo + semaglutide 2.4	-7%	-10%	-15.7%	
Bimagrumab 10mg + semaglutide 2.4	-8%	-11%	-18.7%	
Bimagrumab 30 mg + semaglutide 2.4	-9%	-14%	-22.1% 6.4% greater weight loss	61%

Bimagrumab= antimyostatin

[1]Scholar Rock Press Release 6/25| [2]Regeneron Press Release 6/25 |[3] Lilly-Versanis presentation ADA 6/25

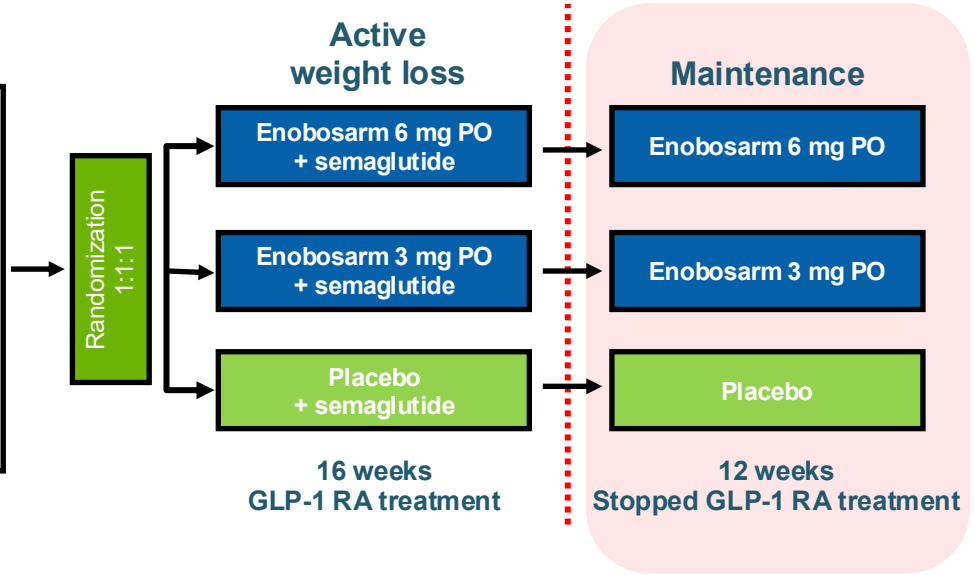
Phase 2 QUALITY Trial maintenance period

GLP-1 RA stopped at 16 weeks and patients maintained on enobosarm or placebo for 12 weeks

Sample size calculation
- n=168 patients

(~55 subjects/arm)

Key Inclusion criteria:
- Obese or overweight
- Age ≥60 years
- GLP-1 RA semaglutide is indicated



Primary endpoint (16 weeks):
- Lean body mass (muscle mass) measured by DXA scan

Secondary endpoints:
- Total body fat
- Total body weight
- Stair climb physical function test
- HbA1c

Principal Investigator:

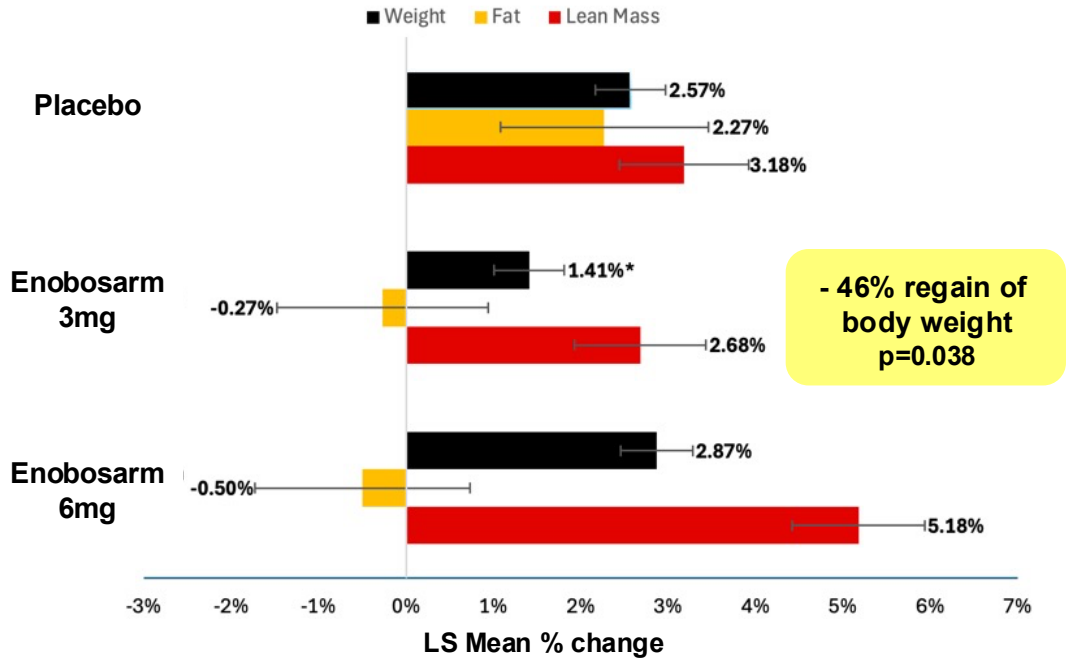
Steven B. Heymsfield, M.D., Professor and the Director of the Body Composition-Metabolism Laboratory at the Pennington Biomedical Research Center in Baton Rouge, Louisiana

Phase 2 QUALITY Trial maintenance period

Enobosarm 3mg monotherapy significantly reduced body weight regain by 46% and both doses of enobosarm prevented fat regain

- **Active weight loss period of 16 weeks:**
  - Weight loss was similar across treatment groups with the semaglutide + placebo group losing an average of 11.88 lbs
- **Maintenance period semaglutide discontinued for 12 weeks:**
  - **Placebo monotherapy group regained 43% (5.06 lbs)** of body weight lost in Phase 2b QUALITY study
  - **Enobosarm 3mg monotherapy significantly reduced the body weight regained by 46%** compared to placebo monotherapy

Effects of enobosarm monotherapy on weight, fat, and lean mass regain after stopping GLP-1 for 12 weeks

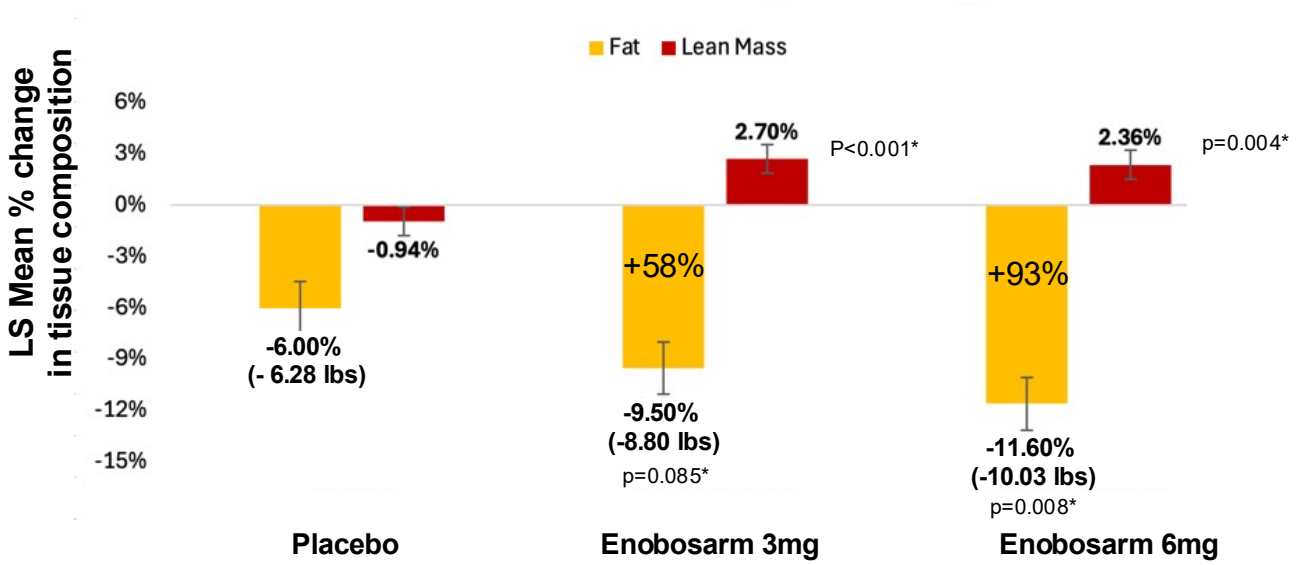


* ANCOVA Least Square (LS) Mean p=0.038

Phase 2 QUALITY Maintenance Extension clinical trial - Preservation of lean matters

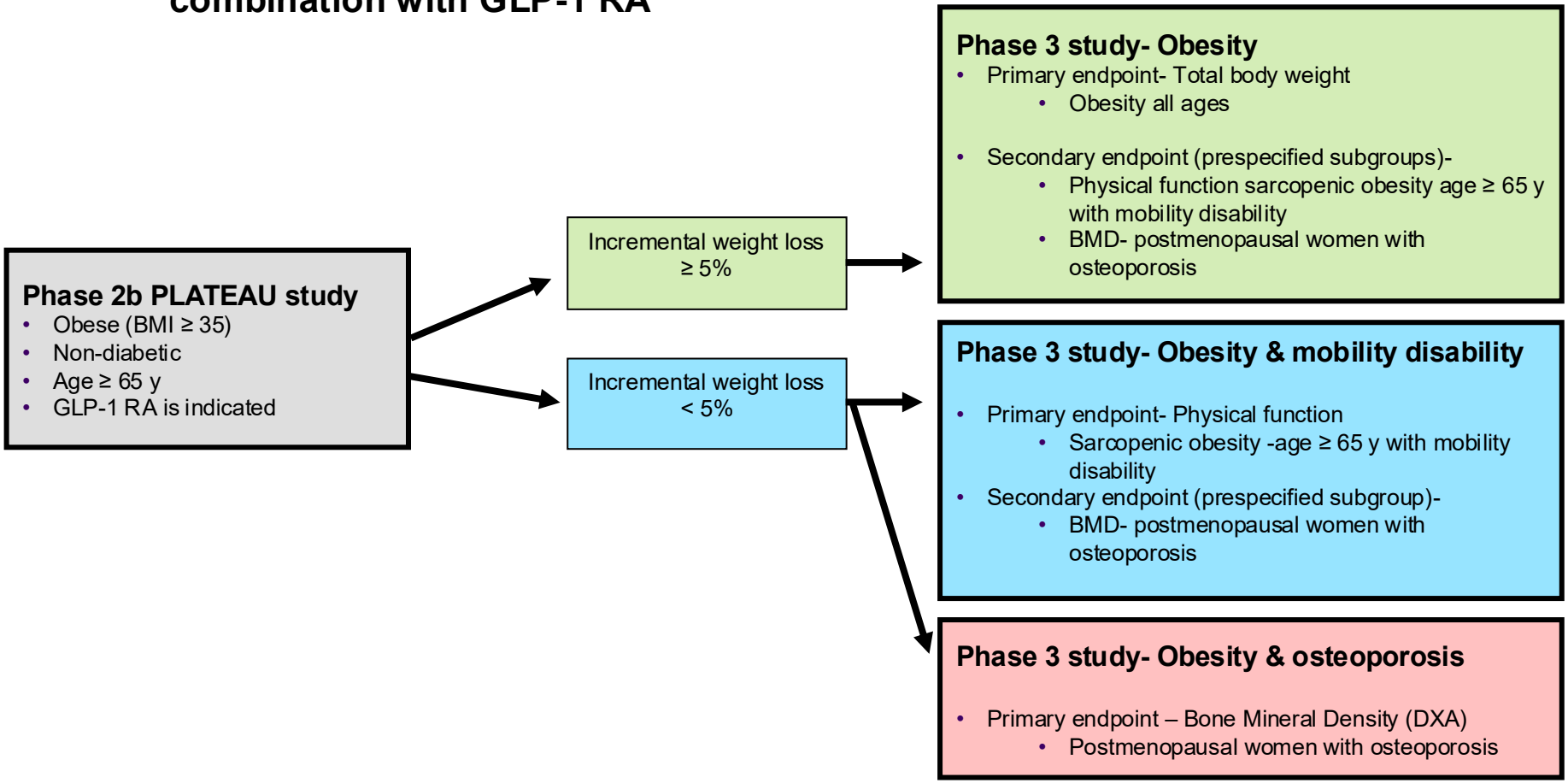
The enobosarm + semaglutide followed by enobosarm monotherapy regimen, was more effective in preserving lean mass and causing greater loss of fat by the end of the study

Fat mass and lean mass at end of study
(Active weight loss followed by maintenance - Day 1-196; 28 weeks)



* Mixed Model for Repeated Measures (MMRM)

Possible regulatory pathways for approval for enobosarm in combination with GLP-1 RA



Financial highlights

Balance Sheet as of December 31, 2025	
Cash	$ 33.0 mm
US NOL carryforward	$161.8 mm
Common Shares Outstanding[1]	16.1 mm
Net proceeds from public offering[2]	$23.4 mm

1 An aggregate of 25.9 million warrants, stock options and stock appreciation rights are outstanding and are, or could potentially be, dilutive in excess of the 16.1 million common shares above

2 On October 31, 2025, Veru received net proceeds from an underwritten public offering of approximately $23.4 million, after deducting the underwriting discounts and commissions and estimated costs payable by the Company, in exchange for (i) 1,400,000 shares of common stock, (ii) pre-funded warrants to purchase up to 7,000,000 shares of our common stock, (iii) accompanying Series A warrants to purchase up to 8,400,000 shares of our common stock at an exercise price of $3.00, and (iv) accompanying Series B warrants to purchase up to 8,400,000 shares of our common stock at and exercise price of $3.00.

Competitive Landscape – Phase 2 clinical studies

	Enobosarm 3mg + semaglutide 16 weeks	Apitegromab + tirzepatide 24 weeks	Trevogrumab + semaglutide 26 weeks	Bimagrumab +semaglutide 72 weeks
Route of administration	Oral	IV	IV	IV
Patient population	Older than 60 years	Adults	Adults	Adults
Lean mass preservation vs placebo	100% lean mass preservation	55% lean mass preservation	53% lean mass preservation	61% lean mass preservation
Fat mass loss vs placebo	19% more fat loss	6% more fat loss	12% more fat loss	64% more fat loss
Incremental weight loss vs placebo	No	No	No	Yes, incremental weight loss -6.4%
Tissue composition of weight lost	100% fat/ 0% lean	85% Fat/ 15% lean	83% Fat/ 17% lean	93% Fat/ 7% lean
Physical performance measurement	Preservation of physical function (Stair climb Test)	None	None	None Grip strength test

SAFETY

	Sema* alone	Sema2.4 alone	Enobo3 +Sema*	Bima10 +Sema2.4	Bima30 +Sema2.4
Muscle spasms	3.6%	8.9%	1.8%	63.6%	63.6%
Diarrhea	7%	35.7%	2%	54.5%	49.1%
Nausea	20%	46.4%	11%	61.8%	49.1%
Constipation	13%	28.6%	13%	27.3%	16.4%
Vomiting	4%	16.1%	2%	18.2%	12.7%

*Maximum semaglutide dose achieved was 1.7mg

- **Enobosarm 3 mg** is the **only oral muscle preservation drug** — all others are IV formulations
- **Enobosarm 3 mg preserved 100% of lean mass**, outperforming all competitors (53–61%)
- **Enobosarm 3 mg preserved physical function** (stair climb power); physical function not measured by others
- **Enobosarm 3 mg did not increase the incidence of adverse events**, with markedly fewer cases of muscle spasms, nausea, and gastrointestinal effects compared to IV competitors

Obesity program
Clinical milestones

Obesity Program

Enobosarm + GLP-1 RA combination