UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 8-K

CURRENT REPORT
Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934

Date of Report (Date of earliest event reported): **September 26, 2024**

BiomX Inc.
(Exact Name of Registrant as Specified in its Charter)

Delaware	**001-38762**	**82-3364020**
(State or other jurisdiction of incorporation)	(Commission File Number)	(I.R.S. Employer Identification No.)

708 Quince Orchard Rd, Suit 205 Gaithersburg, MD	**20878**
(Address of Principal Executive Offices)	(Zip Code)

Registrant's telephone number, including area code: **(844) 972-0500**

n/a
(Former name or former address, if changed since last report)

Check the appropriate box below if the Form 8-K filing is intended to simultaneously satisfy the filing obligation of the registrant under any of the following provisions:

☐ Written communications pursuant to Rule 425 under the Securities Act (17 CFR 230.425)

☐ Soliciting material pursuant to Rule 14a-12 under the Exchange Act (17 CFR 240.14a-12)

☐ Pre-commencement communications pursuant to Rule 14d-2(b) under the Exchange Act (17 CFR 240.14d-2(b))

☐ Pre-commencement communications pursuant to Rule 13e-4(c) under the Exchange Act (17 CFR 240.13e-4(c))

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	**Trading Symbol(s)**	**Name of each exchange on which registered**
Units, each consisting of one share of Common Stock, $0.0001 par value, and one Warrant	PHGE.U	NYSE American
Common Stock, $0.0001 par value	PHGE	NYSE American

Indicate by check mark whether the registrant is an emerging growth company as defined in Rule 405 of the Securities Act of 1933 (§230.405 of this chapter) or Rule 12b-2 of the Securities Exchange Act of 1934 (§240.12b-2 of this chapter).

Emerging growth company ☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Item 7.01 Regulation FD Disclosure.

BiomX Inc., or the Company, from time to time, presents and/or distributes to the investment community at various industry and other conferences slide presentations to provide updates and summaries of its business. On September 26, 2024, the Company posted an updated corporate slide presentation in the "Investors" portion of its website at www.biomx.com. A copy of the slide presentation is furnished pursuant to Item 7.01 as Exhibit 99.1 hereto. The Company undertakes no obligation to update, supplement or amend the materials attached hereto as Exhibit 99.1

Item 9.01. Financial Statements and Exhibits.

(d) Exhibits

Exhibit	**Description**
99.1	Investor Presentation dated September 26, 2024
104	Cover Page Interactive Data File (embedded within the Inline XBRL documents)

SIGNATURE

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned hereunto duly

authorized.

BIOMX INC.

September 26, 2024

By: /s/ Jonathan Solomon
Name: Jonathan Solomon
Title: Chief Executive Officer

BiomX

Revolutionizing the Treatment of Infections Associated with Chronic Disease Through Phage Therapy

INVESTOR PRESENTATION

SEPTEMBER 2024

NYSE American: PHGE

SAFE HARBOR STATEMENT

About this Presentation

The information contained in this presentation has been prepared by BiomX Inc. and its subsidiaries (collectively, the "Company" or "BiomX") and contains information pertaining to the business and operations of the Company. The information contained in this presentation is current only as of the date on its cover. For any time after the cover date of this presentation, the information, including information concerning our business, financial condition, results of operations and prospects, may have changed. The delivery of this presentation shall not, under any circumstances, create any implication that there have been no changes in our affairs after the date of this presentation. We have not authorized any person to give any information or to make any representations about us in connection with this presentation that is not contained herein. If any information has been or is given or any representations have been or are made to you outside of this presentation, such information or representations should not be relied upon as having been authorized by us.

Forward-Looking Statements

This presentation contains certain "forward-looking statements" within the meaning of the "safe harbor" provisions of the U.S. Private Securities Litigation Reform Act of 1995. Forward-looking statements can be identified by words such as: "target," "believe," "expect," "will," "may," "anticipate," "estimate," "would," "positioned," "future," and other similar expressions that predict or indicate future events or trends or that are not statements of historical matters. Forward-looking statements are neither historical facts nor assurances of future performance. Instead, they are based only on BiomX management's current beliefs, expectations and assumptions. For example, when we discuss future potential clinical trials, including their design, objectives, costs, endpoints, potential benefits and timing, the potential outcomes of discussions that we may have with the U.S. Food and Drug Administration and foreign regulatory agencies, potential commercial opportunities, our financial needs to fund future clinical trials and our ability to protect our intellectual property assets in the future we are making forward-looking statements. In addition, past and current pre-clinical and clinical results, as well as compassionate use, are not indicative and do not guarantee future success of BiomX clinical trials. Because forward-looking statements relate to the future, they are subject to inherent uncertainties, risks and changes in circumstances that are difficult to predict and many of which are outside of our control. Actual results and outcomes may differ materially from those indicated in the forward-looking statements. Therefore, you should not rely on any of these forward-looking statements. You should review additional disclosures we make in our filings with the Securities and Exchange Commission (the "SEC"), which are available on the SEC's website at www.sec.gov. Except as required by law, we are under no duty to (and expressly disclaim any such obligation to) update or revise any of the forward-looking statements, whether as a result of new information, future events or otherwise.

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Trademarks and Service Marks

The trademarks and service marks included herein are the property of the owners thereof and are used for reference purposes only. Such use should not be construed as an endorsement of such products.

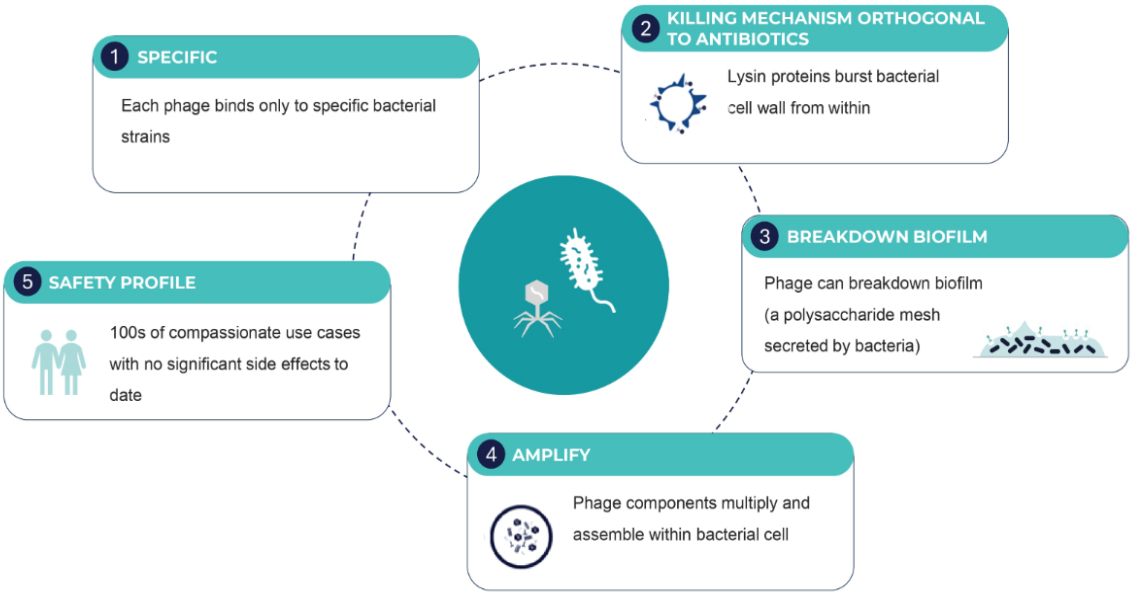
FDA

This presentation concerns certain products that are under clinical investigation and which have not yet been cleared for marketing by the U.S. Food and Drug Administration. These products are currently limited by federal law to investigational use, and no representation is made as to the safety or effectiveness of these products for the purposes for which they are being investigated.

AT-A-GLANCE

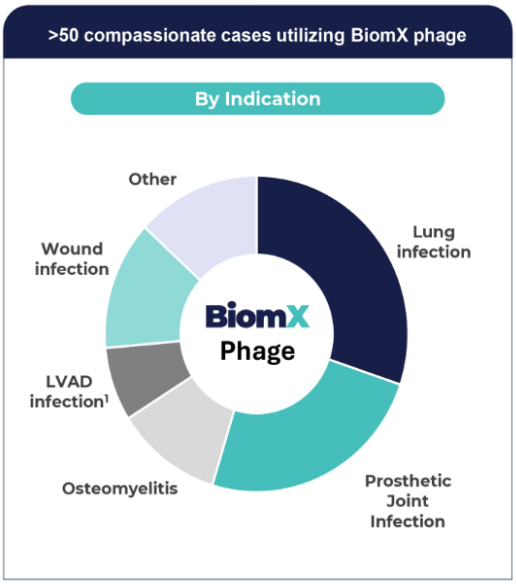
Company	Clinical stage biotech harnessing the therapeutic potential of phage therapy
Unmet need	Treatment of underlying persistent infections in chronic diseases that become harder to treat as antibiotic-resistant pathogens emerge
Therapeutic Focus	• Respiratory – Cystic Fibrosis (CF), Non-Cystic Fibrosis Bronchiectasis (NCFB) • Diabetic Foot Osteomyelitis (DFO)
Pipeline Highlights	• BX004 for CF – Positive results in P1b/2a study. P2b results expected in Q3 2025 • BX211 for DFO – Ongoing P2 study, results expected Q1 2025
Partners	CYSTIC FIBROSIS FOUNDATION
Key Investors	DEERFIELD Advancing Healthcare™ · AMR ACTION FUND · OrbiMed Healthcare Fund Management

Phage: Nature's tool to target bacteria

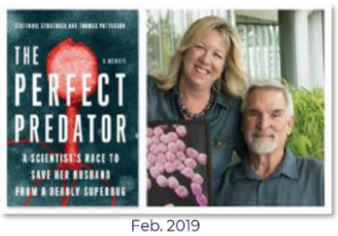


1. Kortright et al. (2019), Cell Host & Microbe

Phage therapy picking up momentum

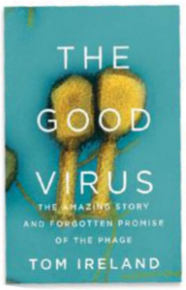


100 cases of compassionate phage treatment (Belgian consortium)[2]
- 35 hospitals, 29 cities
- Clinical improvement reported in **77% of cases**



Feb. 2019

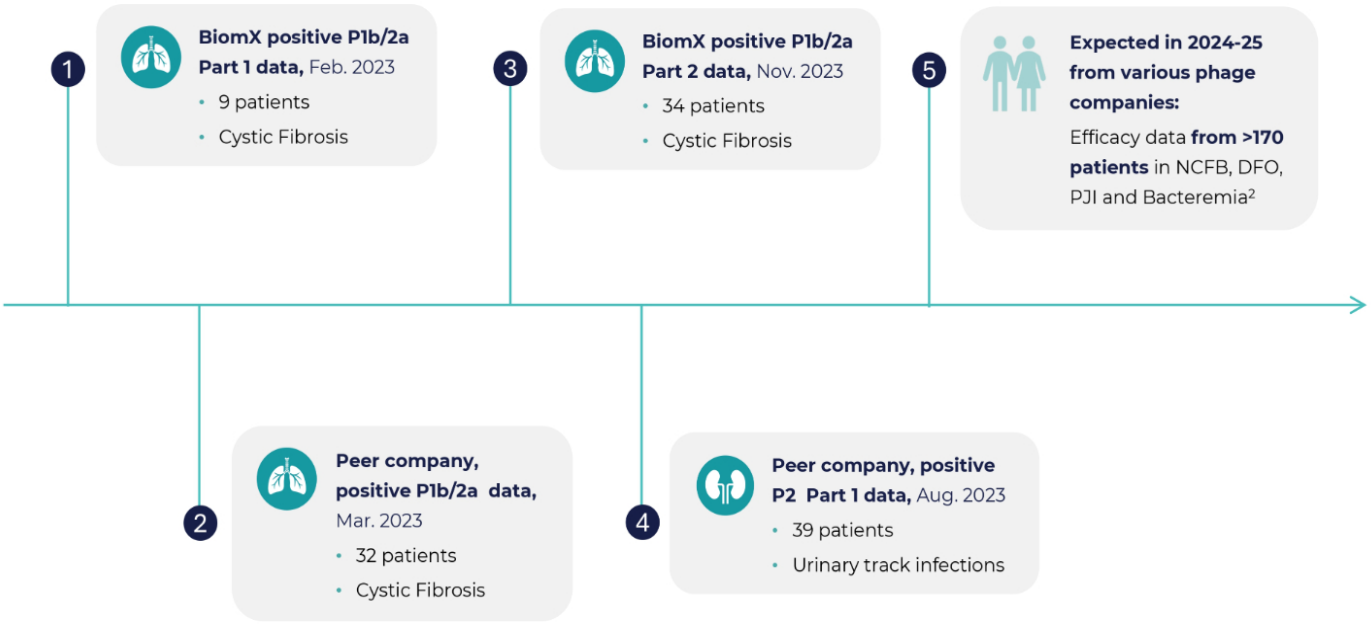
Sept. 2023



Aug. 2023

1. LVAD - Left Ventricular Assist Devices
2. Jean-Paul Pirnay et al. Nature Microbiology, Volume 9,, June 2024, 1434–1453

Accumulating clinical efficacy and safety data for phage therapy in the industry[1]



1. Press releases of BiomX and other companies developing phage therapies
2. NCFB - Non-Cystic Fibrosis Bronchiectasis, DFO – Diabetic Foot Osteomyelitis, PJI – Prosthetic Joint Infections

Pipeline

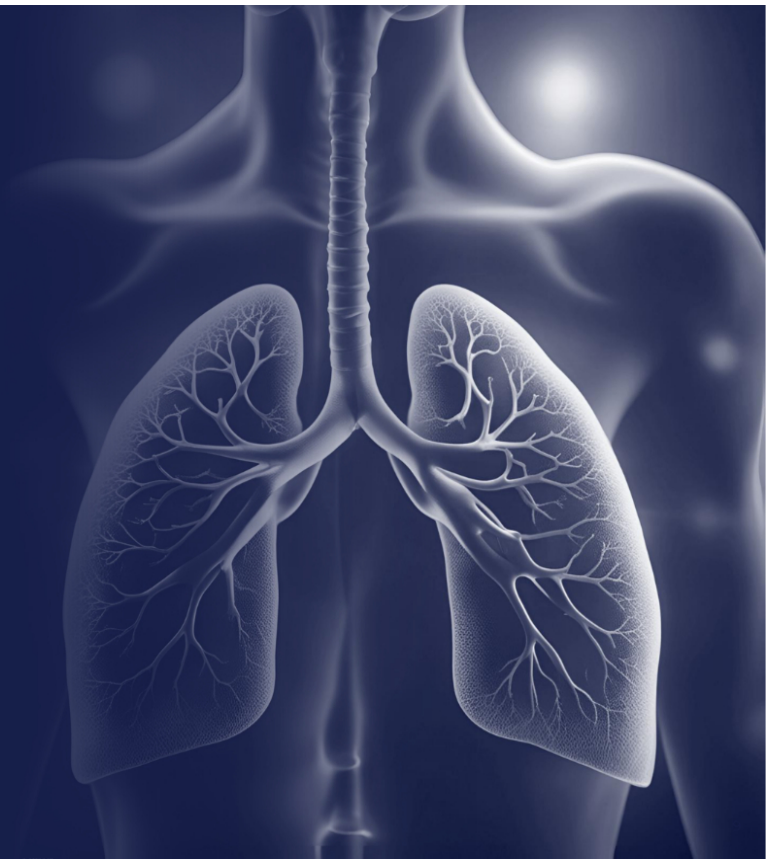
BiomX harnesses its proprietary Bolt platform to develop novel phage therapies to treat underlying persistent infections in chronic diseases that become harder to treat as antibiotic-resistant pathogens emerge

Program	Indication	Preclinical	Phase I	Phase II	Expected readout	Partners
BX004[1]	Cystic Fibrosis				Ph2b topline expected Q3 2025	CYSTIC FIBROSIS FOUNDATION
BX004	Non-Cystic Fibrosis Bronchiectasis (NCFB)					
BX211	Diabetic Foot Osteomyelitis				Ph2 topline expected Q1 2025 and Q1 2026	

1. Granted Orphan Drug Designation and Fast Track by the FDA

BX004

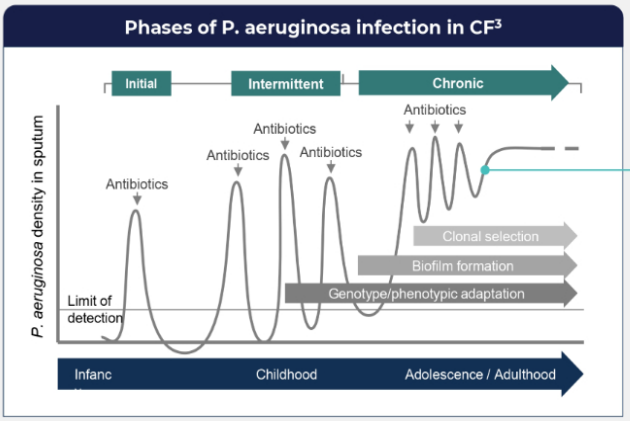
CYSTIC FIBROSIS and NCFB



Chronic pulmonary infections and the inflammatory response are a primary cause of death in CF patients

CF causes severe damage to the lungs, digestive system and other organs with > 80% of deaths from respiratory failure. 105K individuals are estimated to live with CF worldwide, with 33k in the US alone[1]

After prolonged and repeated antibiotic courses, increased resistance to antibiotics has lowered efficacy, creating a large unmet need for CF patients suffering from chronic Pseudomonas aeruginosa (PsA) infections - Estimated at **17,000 patients in the US and Western Europe[2]**



Lack of antibiotic efficacy driven by:

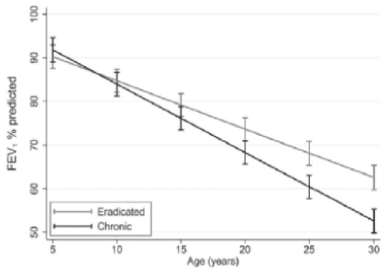
1. *P. aeruginosa* strains with multidrug resistance (MDR)

2. Formation of biofilm => making infection harder to treat

1. CF Foundation estimates across 94 countries (https://www.cff.org/intro-cf/about-cystic-fibrosis)
2. CFF Annual Data Report 2019, ECFS patient registry report, 2020
3. Nicole M. Bouvier et al., 2016

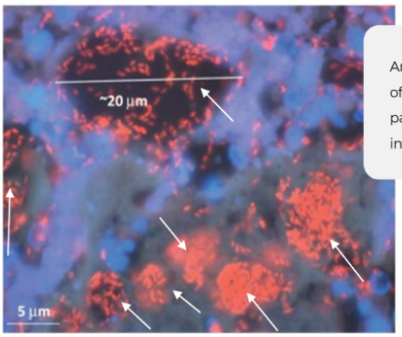
Pseudomonas aeruginosa (PsA) bacteria are associated with decreased lung function (FEV1) in CF patients

PsA colonization associated with lower FEV1[1]



Eradicated – Cleared early/first time PsA when treated with the antibiotic eradication treatment
Chronic –Did not clear early/first time PsA infection when treated with the antibiotic eradication treatment

PsA colonization associated with lower FEV1[2]



Arrows show aggregates of PsA (red) within biofilm patches surrounded by inflammatory cells (Blue)

PsA bacteria and biofilm lead to persistent inflammation causing tissue damage and eventually necrosis of lung tissue

1. Isabel Gascon Casaredi et al., Journal of Cystic Fibrosis 22 (2023) 98–102
2. Bjarnsholt et al., Trends in Microbiology 2013

BX004 – BiomX's proprietary phage cocktail has the potential to treat CF patients with chronic PsA lung infections

Nebulizer

Product – Proprietary phage cocktail targeting PsA

Patient population – CF patients with chronic PsA lung infections

Delivery – Nebulized

Key features – Potentially effective on antibiotic resistant strains, enables breakdown of biofilm

Potential impact:

- Suppression/eradication of PsA (CFU in sputum)
- Improved lung function (FEV1)
- Fewer exacerbations, hospitalizations
- Increased efficacy of antibiotic treatment
- Reduced oral, inhaled and IV antibiotic treatments

PHASE 1B/2A STUDY – Study design[1]

Multicentered, double blind, placebo controlled study to asses safety, reduction of PsA burden and improvement in clinical outcomes

Total enrollment:

43 CF patients with chronic PsA infections

Standard of care antibiotic, no restriction on CFTR modulators

BX004

Intervention: Nebulized dose

Part 1
7 days - Single ascending dose followed by multiple doses[2]

- Treated – 7 subjects
- Control – 2 subjects

Part 2
10 days of same dose, twice daily

- Treated – 23 subjects
- Control – 11 subjects

Key Endpoints:

- Safety and tolerability
- Decrease in *PsA* burden
- FEV1 (forced expiratory volume)
- CFQ-R (CF Questionnaire-Revised) and CRISS

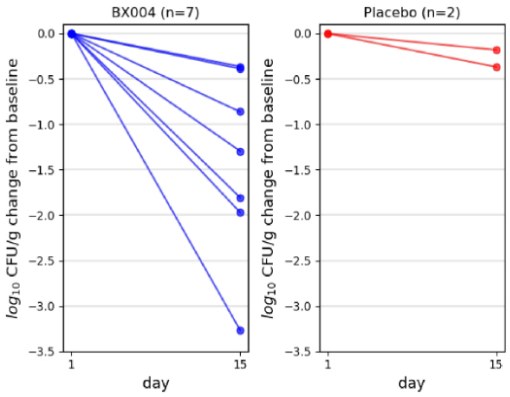
1. Study design informed by input from the CF Foundation
2. 7 days duration (3 ascending, 4 multiple dosing)

Phase 1b/2a – Result highlights (Parts 1 and 2)

- Study drug was well-tolerated
- In Part 1, Mean PsA CFU/g[1] reduction at Day 15: -1.42 log10 CFU/g (BX004) compared to -0.28 log10 CFU/g (placebo)
- Culture conversion: Part 2, in the BX004 arm, 3 of 21 (14.3%) patients converted to sputum culture negative for PsA after 10 days of treatment compared to 0 out of 10 (0%) in the placebo arm[2]. In Part 1, 1 of 7 (14.3%) treated patients also had converted based on physician report
- Part 2: BX004 showed signals of improvement in pulmonary function vs. placebo : Relative FEV1[3] improvement (5.67%) and CF Questionnaire-Revised respiratory[3] (8.87 points) at Day 17 (1 week after EOT[3]) in subgroup of patients with reduced lung function[4]
- Part 2: In full population, BX004 vs. placebo PsA levels were more variable. In a prespecified subgroup of patients on SOC[3] inhaled antibiotics on continuous regimen, BX004 vs. placebo showed bacterial reduction of 2.8 log10 CFU/g at EOT[3], exceeding Part 1 results

1. CFU– Colony forming units
2. In patients that had quantitative CFU levels at study baseline
3. FEV1 (or ppFEV1) – percent predicted forced expiratory volume in 1 second, CF Questionnaire-Revised Respiratory – a PRO (Patient reported outcome) for respiratory parameters in CF aptients, EOT – End of treatment, SOC – standard of care
4. Predefined group with Baseline FEV1<70%

PART 1 BX004 demonstrated greater reduction in PsA levels compared to placebo



	BX004	Placebo
n	7	2
Mean reduction (SD) Log_{10} CFU/g	**-1.42 (1.03)**	**-0.28 (0.13)**
Max, Min	-3.27, -0.37	-0.37, -0.18

1. CFU– Colony forming units

PART 2 BX004 showed greater conversion (bacterial culture turned negative) in treatment over placebo

In the BX004 arm 3 out of 21 (14.3%) patients converted to sputum culture negative for P. aeruginosa after 10 days of treatment (2 already after 4 days)[2]. In the placebo arm 0 out of 10 (0%)[2]

Patients which were converted:

Patient	Duration of PsA infection (years)	Baseline *PsA*[1] in sputum (CFU/g)
1	**18**	**$2.40x10^3$**
2	**13**	**$5.60x10^7$**
3*	**35**	**$1.09x10^7$**

*Subject had negative sputum culture for P. aeruginosa at D4, D10, D28, D38, and at follow-up standard of care clinic visits (D63, D150, and D175)

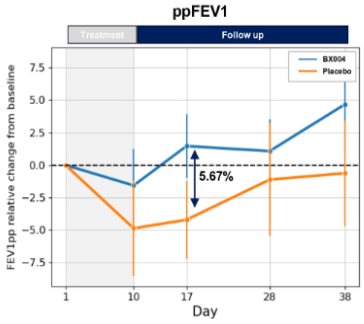
In addition, in Part 1 of the study, one subject in the BX004 arm (1/7: 14.3%) who was persistently positive for PsA for at least 13 years had a 3.3 log reduction at D15 later converted to sputum negative

1. PsA – Pseudomonas aeruginosa, CFU/g – Colony forming units per gram
2. In patients that had quantitative CFU levels at study baseline

PART 2 BX004 shows meaningful clinical improvement after 10 days of treatment in multiple clinical readouts

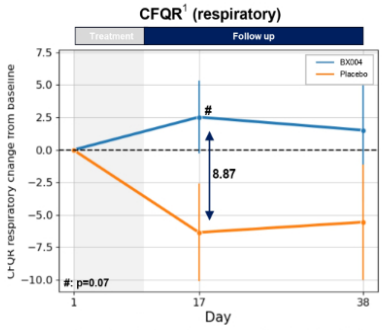
Clinical improvements were observed on both objective & patient reported outcomes

Clinical readouts in patients with reduced baseline lung function (predefined group, ppFEV1 of <70%)



ppFEV1 change from Baseline: Mean(SE)

	BX004 (N=12)[3]	Placebo (N=8)[2]	Difference
D10	-1.57 (2.64)	-4.86 (3.39)	3.29
D17	1.46 (2.33)	-4.21 (2.78)	5.67
D28	1.07 (2.32)	-1.12 (3.96)	2.19
D38	4.68 (3.28)	-0.62 (3.65)	5.3



CFQR respiratory change from Baseline: Mean(SE)

	BX004 (N=12)[3]	Placebo (N=8)[2]	Difference
D17	2.52 (2.61)	-6.35 (3.45)	8.87
D38	1.51 (5.1)	-5.56 (4.05)	7.07

1. PRO (Patient reported outcome) - CF Questionnaire-Revised for respiratory parameter
2. 2. BX004: D38 N=7, Placebo: D28 N=7, D38 N=6
3. 3. BX004: D17 and D38 N=11, Placebo: D17 and D38 N=7

PHASE 2B STUDY – Study design

International, multicenter, double blind, placebo controlled study to assess reduction of PsA burden and improvement in clinical outcome

Total enrollment:

Objective: ~60 CF patients with chronic PsA infections

Standard of care antibiotic, no restriction on CFTR modulators

BX004

Intervention: Nebulized dose

Part 2b
2 months of same dose, twice daily

Randomized 2:1

- Treated (n=40)
- Control (n=20)

Key Endpoints:

- Decrease in PsA burden (incl. Culture conversion/eradication)
- FEV1 (forced expiratory volume)
- CFQ-R (CF Questionnaire-Revised) and CRISS
- Safety and tolerability

Topline results expected in Q3 2025

*Subject to discussions with FDA, and further consultation. Number of subjects under the study stated is an objective and actual numbers may vary

BX004 is a promising candidate for treating NCFB

Non Cystic Fibrosis Bronchiectasis (NCFB) is a chronic progressive inflammatory lung disease with >1 million diagnosed patients (US, 5EU and Japan)[1]

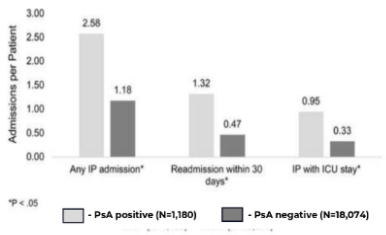
Characterized by permanent dilatation of the bronchi caused by multiple etiologies but with similar symptoms

No FDA approved treatments. Insmed recently announced positive results with brensocatib (reversible inhibitor of dipeptidyl peptidase 1) for treatment of NCFB

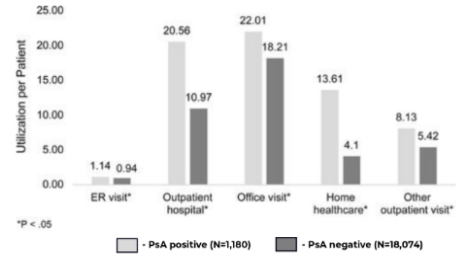
NCFB patients infected with *PsA* present worse clinical symptoms compared to non-infected patients

More frequent inpatient and outpatient encounters in NCFB patients positive for *PsA*[2]

Inpatient encounters within 1 year



Outpatient encounters within 1 year

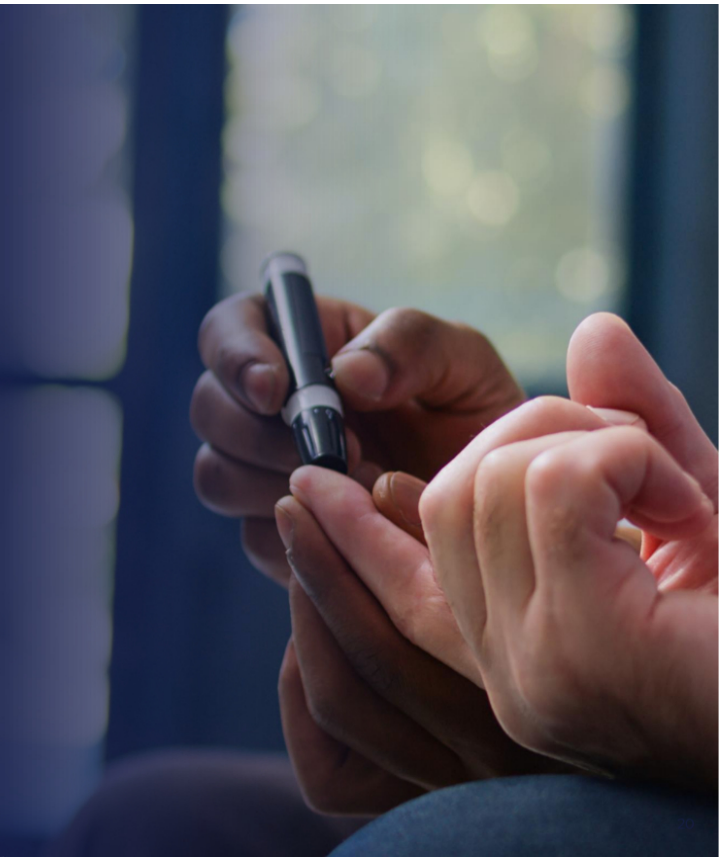


- PsA – *Pseudomonas Aeruginosa*, IP: In Patient
- Based on 19,254 NCFB patient registries in the US between 2006-2020, IQVIA's PharMetrics Plus database

1. Weycker, Chron Respir Dis. 2017, Quint, European Respiratory Journal, 2016, Ringshausen, European Respiratory Journal, 2019, Henkle, Chest, 2018, Asakura, American Journal of Respiratory and Critical Care Medicine 2024, Insmed Commercial Presentation June 4th, 2024
2. Franklin et. al, JME, Apr 2024

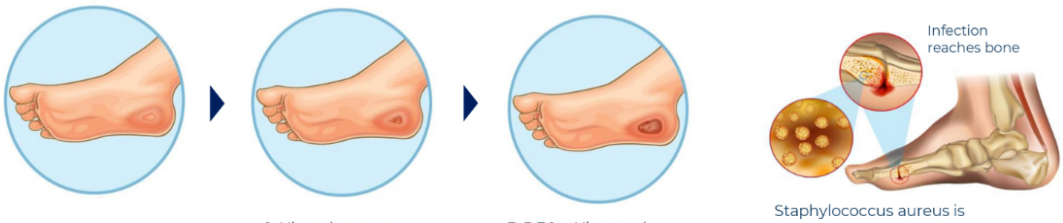
BX211

Diabetic Foot Osteomyelitis (DFO)



High unmet need in DFO

DFO is a bacterial infection of the bone in patients with diabetes that is caused by bacteria spreading from adjacent infected soft tissue



1. Superficial ulcer

2. Ulcer deepens extending through subcutis, and becomes infected

3. DFO – Ulcer and infection further penetrate and reach bone, displaying destruction of periosteum

Staphylococcus aureus is the most common bacteria present in DFO

Standard of care

- Hospitalization and off-loading (removing all pressure from foot, reducing patient mobility)
- Debridement and/or antibiotic therapy, typically 4-6 weeks of IV/oral antibiotics

30-40% of DFO cases result in amputation

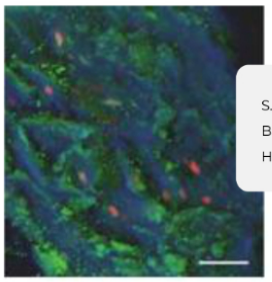
Biofilm and antibiotic resistance among key drivers of treatment failure

Key drivers of treatment failure:

- Biofilm - S. aureus inhabiting biofilms are 10 to 1,000-fold more resistant to antibiotics, compared to planktonic cells
- Poor blood supply limits effective concentration of IV/oral antibiotics
- Antibiotic resistance

- S. aureus present in ~50% of DFO cases
- While other organisms are often present, S. aureus is considered the main pathogenic species, due to its rapid doubling time and arsenal of virulence factors

S. aureus forms biofilm patches in diabetic foot ulcers



S. aureus bacteria (green)
Bacterial biofilms, EPS (blue)
Host cell nuclei (red)

Confocal laser scanning microscopy of soft tissue from patient with diabetic foot ulcer infected by S. aureus

Multiple compassionate treatments of DFO patients demonstrate potential for phage treatment

12 DFO cases (*S. aureus*)

9 patients
- Single phage against S aureus
- Topical application or injection to bone, surrounding tissue
- 3-7 weekly applications
- Olympia, Washington

3 patients
- Administration – Direct application
- 6-45 days of application
- Jerusalem, Israel

Outcome (in 11 out of 12 patients)
- Clearance of soft tissue infection and DFO
- Wound healing
- Prevented amputation

11 Osteomyelitis cases (not DFO, various bacteria)

No. of cases	Bacteria	Treatment
1	*A.baumanii* and *K. pneumonia*	IV, 11 days
5*	*P. aeruginosa*	IV 2 weeks or direct application, 7-12 days
2	*P. aeruginosa* and *S. epidermidis*	Direct application, 7-10 days
1	*E.faecalis*	Direct application, 7 days
1	*S.agalactiae* and *S aureus*	Direct application, 9 days
1*	*S.aureus*	IV

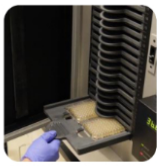
Outcome - at least 8 reported as clinical recovery

Fish 2017, Fish 2018, Suh 2022, Onallah 2023

BX211 phage treatment for DFO patients with S. aureus

- **Product** – Phage treatment targeting *S. aureus*. Phage, originating from a 'phage-bank', are personally matched for each patient
- **Patient population** – DFO patients with *S. aureus infection*
- **Delivery** – IV + topical
- **Treatment -** On top of standard of care
- **Key features** – Is potentially effective on antibiotic resistant strains, enables breakdown of biofilm, and improves antibiotic penetration
- **Potential impact:** (1) Prevent amputations (2) Shorten time to healing

1 **BIOPSY**



3 **MATCH PHAGE TO S. AUREUS ISOLATE**

Proprietary Phage Susceptibility Test (PST) platform

2 **CULTURE**

S. aureus bacterial culture

4 **PHAGE THERAPY ACCESSED AT HOSPITAL**

Phage-bank 'ATM-like' dispensing system

PHASE 1B/2A STUDY – Study design

Multicenter, double blind, placebo controlled study to assess improvement of clinical outcomes

Enrollment:

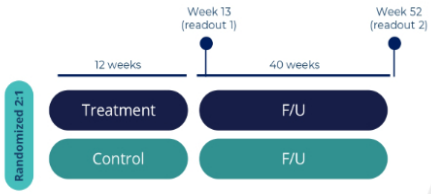
Objective: Up to 45 patients with Diabetic Foot Osteomyelitis positive for S. aureus

Background standard of care antibiotic

BX211

Intervention: IV & topical single dose[1]

Duration: 12 weeks of once weekly treatment[1]



Key Endpoints:

- Percent area reduction of study ulcer through Week 13
- Time to complete ulcer healing
- Time to 85% CRP[2] reduction
- Percentage of subjects with amputation-free survival at Week 52
- Safety and tolerability

Topline results from week 26 expected in Q1 2025, and from week 52 expected in Q1 2026

1. Topical for 12 weeks, IV only in week 1
2. C-reactive protein

Summary

UNMET NEED

- In several chronic diseases, such as CF, NCFB, and diabetes, underlying related infections become harder to treat as resistant pathogens emerge
- Accordingly, the need for new antimicrobial therapies becomes more urgent every year

PHAGE THERAPY - PICKING UP MOMENTUM

- BiomX and peer companies have shown evidence of clinical effects with phage therapy
- Hundreds of cases of compassionate usage of phage

BX004

- *Pseudomonas aeruginosa* ('PsA') lung infections are a leading cause of morbidity and mortality In CF. Potential commercial opportunity of > $1.5 billion worldwide[1]
- Positive results in a Phase 1b/2a study - 14.3% of patients in the BX004 arm converted to sputum culture negative for PsA after 10 days of treatment compared to none in the placebo arm[2]
- Phase 2b readout expected 3Q25

BX211

- Diabetic Foot Osteomyelitis ('DFO') patients represent the majority of 160K lower limb amputations in diabetic patients annually in the US[3] . Potential commercial opportunity of > $2 billion worldwide[3]
- Phase 2 ongoing, readout expected in 1Q25

FINANCING AND INVESTORS

- Publicly traded (NYSE American: PHGE)
- $32.7 million cash and cash equivalents as of June 30, 2024
- Key investors: DEERFIELD, AMR, OrbiMed

1. See slide 28
2. In patients that had quantitative CFU levels at study baseline
3. See slide 29

Thank you

BiomX

BX004 CF addressable market of > $1.5 billion worldwide

	BX004	References/Comments
Patient population (US)	~8,000	Number of CF patients with chronic PsA infections[1]
Potential effect on *PsA* CFU in lungs	Suppression/eradication of *PsA* (CFU in sputum)	Magnitude observed under tobramycin Phase 3 study was ~1.5-2 log[2]
Potential impact on lungs	Improved lung function (FEV1)	Magnitude observed under tobramycin Phase 3 study was 8-12%[2]
Potential pricing in the US	$100K - $120K annually per patient	Benchmarks (cost annually per patient): Trikafta: $300K, alternating antibiotics treatment, Tobi Podhaler and Cayston solution: $80K, Arikayce for MAC: $100-120K[3]
Market potential	**~$1 Billion in the US alone** (worldwide $1.6 billion)[4]	US patient population times potential pricing

BiomX

1. CFF 2019 Patient Registry Annual Data Report
2. See slide on Tobramycin study
3. Trikafta and Arikayce – Publicly announced pricing, First Databank, Jan. 8, 2021, public pricing information. for alternating Tobi Podhaler and Cayston solution assumes 65% compliance
4. Assumes rest of the world outside US comprises 40% of total market (Vertex annual report, publicly available pricing for Vertex drugs)

BX211 DFO addressable market of >$2B worldwide

	BX211	References/Comments
General patient population	160,000	Lower limb amputations (LLA), diabetic patients annually, US[1]
Assumed relevant population for BX211 treatment	40,000 (25% of 160,000)	Deductions due to[2]: - 85% of amputation are due to DFO - 50% positive for S. aureus - 60% not urgent amputations, enabling biopsy and treatment 85% X 50% X 60% = 25%
Pricing	$25,000	Based on 50% of the saved $50K amputation costs[3]
Relevant market for BX211, US	**$1 Billion**	40K times $25K
Relevant market for BX211, Worldwide	**>$2 Billion**	ROW is over $1 billion, based on the following: . Annual incidence of LLA in the OECD is 3-4 higher than the US[4] Assuming OECD pricing is 50% of US pricing.

1. (1) CDC National Diabetes Statistics Report, 2020 (2) Brooks, 2021; Giurato, 2017, Lesens, 2014 (3) Nilsson, 2018; Brooks, 2021 (4) Hughes, 2020; OECDiLibrary Diabetes care report,2017

Executive team

JONATHAN SOLOMON | CEO & BOARD MEMBER

Prior to his role in BiomX, Mr. Solomon was a co-founder, president, and CEO of ProClara (formerly NeuroPhage), which is pioneering an approach to treating neurodegenerative diseases. Under his leadership, the company raised more than $100 million and launched an ongoing clinical trial related to Alzheimer's disease. Mr. Solomon holds a B.Sc. magna cum laude in Physics and Mathematics from the Hebrew University, an M.Sc. summa cum laude in Electrical Engineering from Tel Aviv University, and an M.B.A. with honors from the Harvard Business School.

MERAV BASSAN, PHD | CDO

Dr. Bassan was most recently Vice President Head of Translational Sciences at Teva Pharmaceutical Industries, Inc., where she was responsible for early stages of clinical development via translation from animal data to human. Prior to this role, Dr. Bassan served as Vice President of Project Leadership at Teva Pharmaceutical, where she managed project leaders overseeing end-to-end drug development at pre-clinical, PI-III and post marketing stages in multiple therapeutic areas, such as pain, oncology, women's health, endocrinology, GI, biosimilars and other areas. Overall, Dr. Bassan has over 20 years of leadership experience with clinical and drug development teams in her various roles at Teva Pharmaceutical and other smaller biotech companies.

MARINA WOLFSON | CFO

Marina Wolfson has served as the Senior Vice President of Finance and Operations of the Company since December 2019. Ms. Wolfson's experience includes working with large pharmaceutical and hi-tech companies, as well as venture capital funds. Prior to joining the Company, Ms. Wolfson worked as Vice President of Finance at BioView Ltd. (TASE) from 2010 to 2019 and a senior auditor at Ernst & Young, an international auditing and business advisory firm 2007 to 2010. Ms. Wolfson is a certified public accountant in Israel and holds a B.A in Economics and Accounting (with honors) and an MBA (with honors, specializing in finance) from Ben-Gurion University.

Executive team (cont'd)

INBAL BENJAMINI-ELRAN | CHRO

Ms Benjamini-Elran has over 15 years of experience in executive HR roles in global and diverse environments. At Teva Pharmaceuticals Industries Inc (NYSE:TEVA) she served in various senior roles including Director of HR of the European HQ (Netherlands) and HR manager of R&D API division. Her most recent experience was as Head of HR at Herzog, one of the largest law firms in Israel and as an independent HR consultant, advising a variety of companies in the Israeli hi-tech and biotech sectors. Ms. Benjamini-Elran holds an MBA from Bar-Ilan University and a BA in behavioral science from Ben-Gurion University.

MICHAEL BILLARD | General Manager, U.S.

Mr. Michael Billard has over twenty-years of experience in biotech, pharma, and consumer product development. He served as VP, Project Execution at Adaptive Phage Therapeutic since September 2020, which was acquired by the Company in March 2024. Prior to that, he held senior leadership roles at Propella Therapeutics, Inc., Paragon Bioservices and DSM Nutritional Products (formerly Martek BioSciences) along with project management positions at MedImmune, Inc. and Baxter Healthcare Corporation. Mr. Billard earned his Master of Science in Biotechnology from Johns Hopkins University.

Board of directors

RUSSELL G. GREIG, PH.D.
CHAIRMAN OF THE BOARD OF DIRECTORS

Russell G. Greig, Ph.D. worked at GlaxoSmithKline for three decades, most recently as President of SR One, GlaxoSmithKline's corporate venture group. Prior to joining SR One, he served as President of GlaxoSmithKline's Pharmaceuticals International from 2003 to 2008 as well as on the GlaxoSmithKline corporate executive team. Currently, Dr. Greig serves as Chairman of MedEye Solutions in the Netherlands, eTheRNA in Belgium and Sanifit in Spain.

ALAN MOSES, MD
DIRECTOR

Alan Moses, M.D., was co-founder and co-director of the Clinical Investigator Training Program at Beth Israel Deaconess-Harvard Medical School-MIT. Dr. Moses served as Senior Vice President and Chief Medical Officer of the Joslin Diabetes Center in Boston. He was appointed Professor of Medicine at Harvard Medical School. Over the course of 14 years at Novo Nordisk, Dr. Moses served in multiple roles, rising to the position of Senior Vice President and Global Chief Medical Officer.

EDDIE WILLIAMS
DIRECTOR

Mr. Eddie Williams is a well-recognized, senior global life sciences executive with extensive boardroom and commercial operations experience. He most recently served as a Special Advisor to the Chief Executive Officer of Ascendis Pharma, Inc., and previously as their interim U.S. Chief Commercial Officer.

JONATHAN SOLOMON
DIRECTOR

Prior to his role in BiomX, Mr. Solomon was a co-founder, president, and CEO of ProClara (formerly NeuroPhage), which is pioneering an approach to treating neurodegenerative diseases. Under his leadership, the company raised more than $100 million and launched an ongoing clinical trial related to Alzheimer's disease.

JONATHAN LEFF
DIRECTOR

Jonathan Leff is a Partner on the Therapeutics team at Deerfield and Chairman of the Deerfield Institute, and joined the Firm in 2013. He focuses on venture capital and structured investments in biotechnology and pharmaceuticals. He is a member of the Boards of several public and private healthcare companies as well as several not-for-profit organizations, including the Spinal Muscular Atrophy Foundation and the Columbia University Medical Center.

GREG MERRIL
DIRECTOR

Mr. Greg Merril is a serial life-science entrepreneur, recognized by Ernst & Young as a regional Entrepreneur of the Year winner. He has served as Chair of several international phage therapy conferences. As prior founding CEO of Immersion Medical (NASDQ: IMMR) he led the creation of the world's first commercially successful virtual reality surgical training simulators.

JESSE GOODMAN, MD, MPH
DIRECTOR

Jesse Goodman, M.D., M.P.H. is Professor of Medicine at Georgetown University and Director of the Center on Medical Product Access, Safety and Stewardship which focuses on science and policy to address public health needs including antimicrobial resistance. He is Attending Physician in Infectious Diseases at Georgetown University, Washington DC Veterans Administration and Walter Reed Medical Centers.

SUSAN BLUM
DIRECTOR

Ms. Blum is the Chief Financial Officer of Melinta Therapeutics, LLC. ("Melinta"), a company focused on the development and commercialization of innovative therapies for acute and life-threatening illnesses. She joined Melinta in 2016 as the company's Controller, and then served as Vice President of Finance & Chief Accounting Officer prior to being appointed to the CFO position in 2021.