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): **June 9, 2025**

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.)

22 Einstein St., Floor 4 Ness Ziona, Israel	**7414003**
(Address of Principal Executive Offices)	(Zip Code)

Registrant's telephone number, including area code: **+972 723942377**

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**
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 June 9, 2025, 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 June 9, 2025
104	Cover Page Interactive Data File (embedded within the Inline XBRL documents)

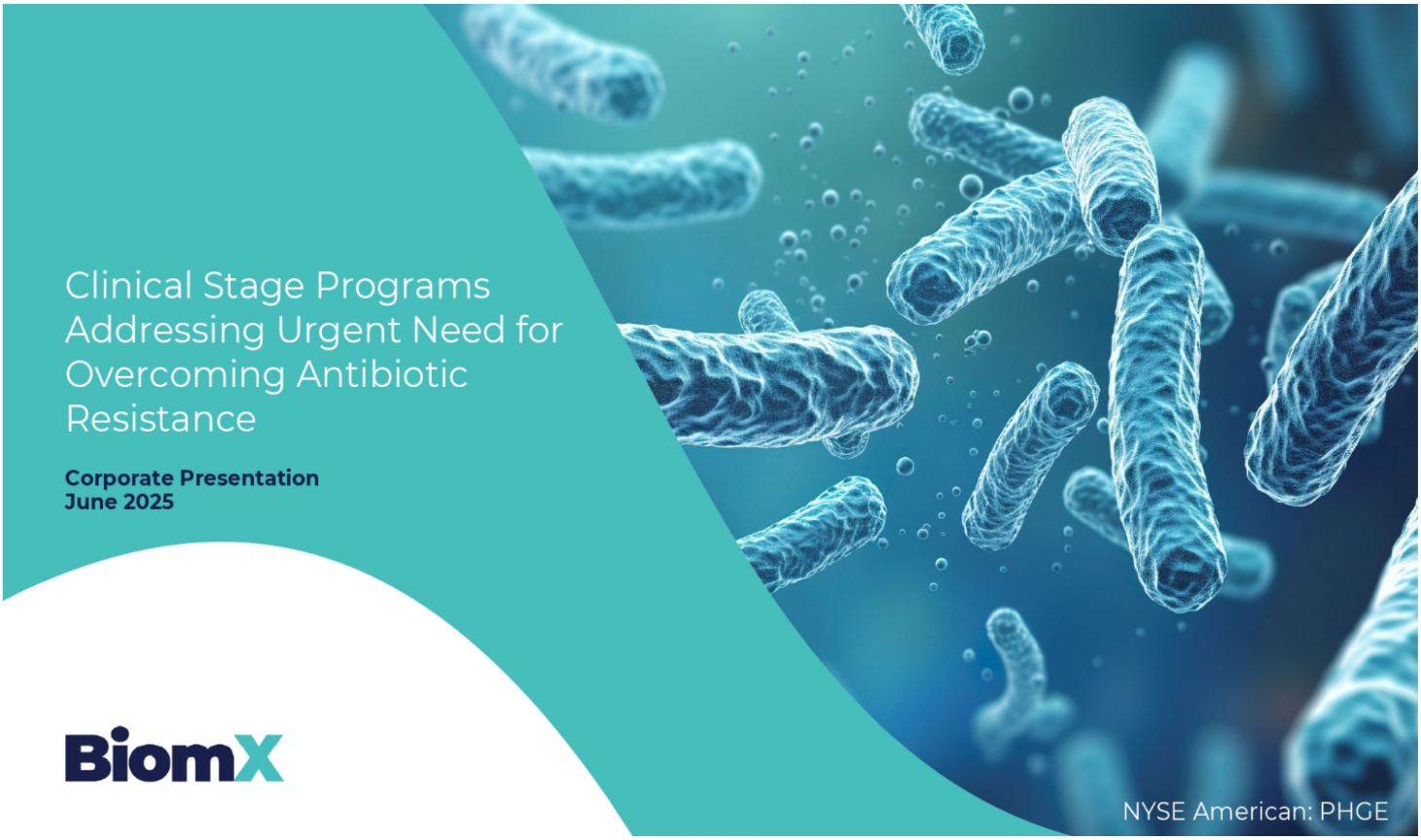
SIGNATURE

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.

June 9, 2025

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



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 thereof, the potential outcomes of discussions that we may have with the U.S. Food and Drug Administration ("FDA") and foreign regulatory agencies, including timing thereof, the use of Real World Evidence and potential to obtain accelerated approval, among others, potential commercial opportunities, the potential to use our product candidates for new indications, our financial needs to fund future clinical trials, forecasted expenses 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 FDA. 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.

Opportunity: Clinical stage programs targeting a critical threat to the global healthcare system – antibiotic resistance

Phage Therapy Promise

Alarming rise in antimicrobial resistance signals urgent need for better treatment

Phage therapy emerging as a powerful solution for persistent infections, supported by growing body of efficacy and safety data

BX211
– *S. aureus* infections

Positive efficacy and safety data **(Phase 2)** in DFI & DFO with *S. aureus* infection, showing **sustained ulcer reduction** and **superior recovery outcomes** in bone-depth ulcers

Potential additional Phase 2 ready indications: **PJI**

BX004
– *P. aeruginosa* infections

Positive Phase 1b/2a data in CF patients with *P. aeruginosa* infection, demonstrating **sputum culture conversion**, **improved lung function,** and **bacterial reduction**

Phase 2b study ongoing

Potential additional Phase 2 ready indications: **NCFB, HAP/VAP**

DFI: Diabetic Foot Infection; DFO: Diabetic Foot Osteomyelitis; PJI: Prosthetic Joint Infection
CF: Cystic Fibrosis; NCFB: Non-cystic Fibrosis Bronchiectasis; HAP/HVP: Hospital-acquired / Ventilator-associated Pneumonia

Antimicrobial Resistance: Rising concerns and limited treatment options underscore the urgent need for novel therapies

42% Resistance Rate for Cephalosporin-resistant *E. coli*[1]

35% Resistance Rate for Methicillin-resistant *S. aureus*[1]

70% Increase in Death Associated with Antimicrobial Resistance Expected by 2050[2]

>2x Increase in Death Associated with Antibiotic Resistant *S. aureus* from 1990 to 2021[2]

10M

Annual Deaths by 2050
WHO projected Antimicrobial Resistance Mortality[3]

$100T

Drug Resistant Infection Cumulative Economic Loss by 2050[4]

1. World Health Organization (2022). Global antimicrobial resistance and use surveillance system (GLASS) report 2022.
2. GBD 2021 Antimicrobial Resistance Collaborators (2024) *Lancent*. Global burden of bacterial antimicrobial resistance 1990-2021: a systematic analysis with forecasts to 2050
3. World Health Organization. (2019, April 29). New report calls for urgent action to avert antimicrobial resistance crisis
4. O'Neill, J. (2016). Tackling drug-resistant infections globally: Final report and recommendations. Review on Antimicrobial Resistance

Phage Therapy: A century-old solution with renewed promise

Key Advantages

- Active against Antibiotic Resistant Strains
- Safe Modality, Inert to Human Cells, and Supported by FDA
- No Disruption to Microbiome - Targets Only Harmful Bacteria
- Penetrates and Disrupts Biofilm
- Self-Amplifying Phages Increase Efficacy of Each Dose
- Ability to Launch Straight into Early/Mid Clinical Development

Though first discovered >100 years ago, phage therapy struggled to gain traction—now, with rising antibiotic resistance and recent positive clinical data, we believe that its breakthrough moment has finally arrived

Phage Therapy Momentum: Growing clinical data signal a pivotal moment ahead[1]

March 2025: BiomX positive P2 data
41 patients
Diabetic Foot Osteomyelitis
BiomX

Nov. 2023: BiomX positive P1b/2a data
43 patients
Cystic Fibrosis
BiomX

Aug. 2024: Peer company reported positive P2 Part 1 data[2]
39 patients
Urinary tract infections

May 2025: Peer company reported Positive P2 data[3]
50 patients
Bacteremia

Phage Therapy Clinical Trails

- Emergence of first well-controlled, double-blind, placebo-controlled phage therapy trials
- BiomX – the first to show statistically significant clinical efficacy in a chronic bacterial infection
- Phage therapy – added benefits on top of standard-of-care, including antibiotics
- Phage therapeutics targeting high-need indications—some with no approved treatments

1. Press releases of BiomX and other companies developing phage therapies. Disclaimer: BiomX is not responsible for, and expressly disclaims responsibility for, the content of third party press releases
2. Locus Biosciences. Locus Biosciences Announces Positive Results from Part 1 of ELIMINATE Phase 2 Trial of the Engineered Bacteriophage Therapy LBP-EC01 Published in The Lancet Infectious Diseases. GlobeNewswire. August 12, 2024.
3. Armata Pharmaceuticals Announces Positive Topline Data from the Phase 1b/2a diSArm Study of Intravenously Administered AP-SA02 in Complicated Staphylococcus aureus Bacteremia. PR Newswire. May 19, 2025

BiomX—Built on a Strong Foundation: Backed by leaders in science, industry, and capital

Strong Science & Scientific Founders

Prof. Rotem Sorek
Head of microbial genomics group at Weizmann Institute
Phage genomics and CRISPR research
nature | Cell | Science | nature reviews immunology

Prof. Eran Elinav
Principal investigator at Weizmann Institute
Immune system and intestinal microbiome interactions
nature medicine | Cell | npj | biofilms and microbiomes

Prof. Timothy K. Lu
Associate professor leading synthetic biology group, MIT
Synthetic biology, biochemical engineering
nature | nature biotechnology | Cell Host & Microbe | Cell Genomics

Trusted by top biotech and healthcare investors

DEERFIELD Advancing Healthcare™ | AMR ACTION FUND | OrbiMed Healthcare Fund Management

≥ $215 M Raised[1]

Partnered with mission-aligned global leaders

CYSTIC FIBROSIS FOUNDATION | WRAIR

~$40 M Non-diluted Funding from U.S. Navy

BiomX

1. >$200M raised from the investors listed, among others

Shared Targets, Expanded Potential: Clinical efficacy opens the door to potential additional Phase 2 studies across related infections

BX211
Target:
S. aureus

→ **BX211**
Diabetic Foot Osteomyelitis
March 2025, Positive Phase 2 statistically significant results

→ **Phase 2/3** Diabetic Foot Infection & Osteomyelitis

⇢ **Phase 2 Ready** Prosthetic Joint Infection (PJI)[1]

BX004
Target:
P. aeruginosa

→ **BX004**
Cystic Fibrosis
November 2023, Positive Phase 2 results

→ **Phase 2b** Cystic Fibrosis – Expected readout Q1 2026

⇢ **Phase 2 Ready** Non-Cystic Fibrosis Bronchiectasis (NCFB)[1]

⇢ **Phase 2 Ready** HAP/VAP[1]

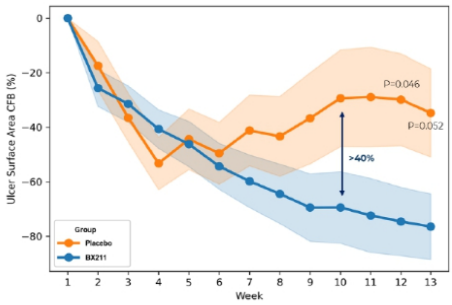
⇢ Additional Potential Indications with Shared Target Pathogenic Bacteria

BiomX

1. Additional potential indications that could be pursued with shared target bacteria as parent program

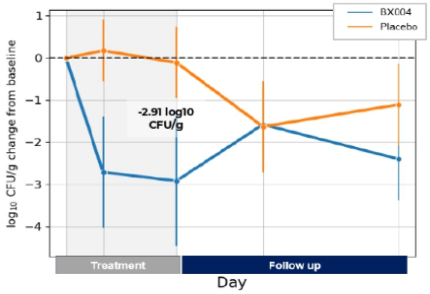
BiomX's Groundbreaking Phase 2 Results

Diabetic Foot Osteomyelitis (BX211):



The 1st multi-center, double-blind, placebo-controlled clinical study to demonstrate statistically significant efficacy of a phage therapy in a clinical endpoint for a chronic bacterial infection

Cystic Fibrosis (BX004, on top of continuous SoC):



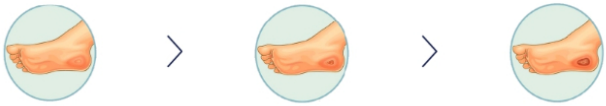
Demonstration of ability of phage to convert chronic lung infections (13-35 yrs, $>10^7$ PFU/g) to sputum culture negative with 10 days of phage treatment & signals of improvement vs placebo in pulmonary function and PROs

- Two positive phase 2 trials in separate indications
- Two different bacterial targets
- Two routes of administration

CFB – Change From Baseline; SoC – Standard of Care; CFU – Colony Forming Units; PFU – Plaque Forming unit;

Disease Burden: DFI & DFO drive diabetic amputations, burdening the healthcare system

DFI to DFO
Bacterial infection spreading from soft tissue to bone



Staphylococcus aureus is the most common bacteria present in DFI / DFO

Standard of Care
Suboptimal efficacy leading to high rate of amputation

Moderate-to-severe DFI & DFO SoC: 4 – 6 weeks of IV/oral antibiotics / debridement / offloading

Approved Therapy: Last drug approved for DFI in 2005 with no approved drugs for DFO in the US

Poor Prognosis: 20-40% of cases result in amputation, increasing 5-year mortality rate up to 50%

Economic Burden
Significant burden on both patients and healthcare system

>38M
Diagnosed diabetes, US 2024[1]

~160K
Lower limb amputations due to DFI/DFO[2]

~8B
Annual cost to US healthcare system (~$50K direct cost per patient)

BiomX

1. CDC National Diabetes Statistics Report, last visited March 2025 based on crude estimates for 2021
2. American Diabetes Association. (n.d.). *Amputation Prevention Alliance*. Retrieved June 8, 2025Nilsson, 2018 & Brooks 2021

Phase 2 Study Design: Multicenter, double blind, placebo-controlled study to assess improvement of clinical outcomes

Primary Endpoint:
Percent area reduction of study ulcer through Week 13

Enrollment:

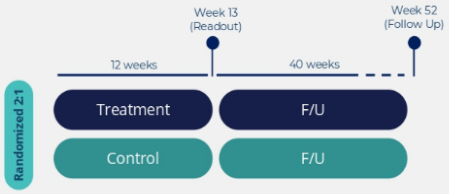
41 patients with Diabetic Foot Osteomyelitis positive for S. aureus

Background standard of care antibiotic

BX211

Intervention:
IV & topical

Duration: 12 weeks of once weekly treatment
IV in week 1, topical for 12 weeks



Primary Endpoints:

- Percent area reduction of study ulcer through Week 13

BX211:

- Phage originating from a 'phage-bank', personally matched for each patient's *S. aureus*

Topline results from week 13 available

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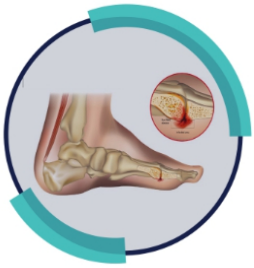
Results Highlight: Phase 2 diabetic foot osteomyelitis

Safe and **well-tolerated**

Sustained and statistically significant **PAR ulcer size reduction**[1]

- ✓ Separation from placebo starting at week 7 with a difference greater than 40% by week 10



Statistically significant **improvements in ulcer depth** in patients with ulcers at **bone depth**

Favorable trends compared to placebo across **several additional clinical parameters**

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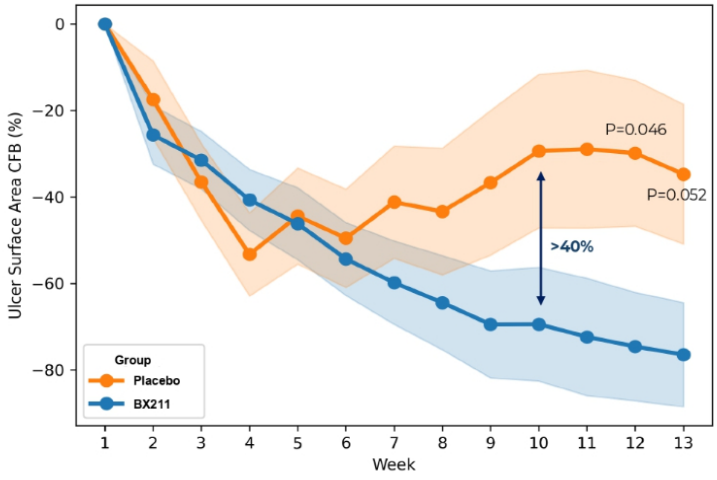
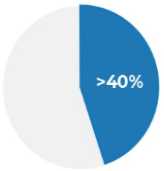
1. Ulcer depth was classified according to deepest tissue involved as measured by swab
PAR- Percentage Area Reduction

Efficacy (1): BX211 showed clinically relevant, statistically significant[1], reduction in ulcer surface area

Percent Area Reduction (PAR) from baseline of ulcer surface area (LS Mean ± SE)[2]
(See detailed data in next slide)



From week 10 and on, BX211 showed an ulcer surface area reduction of >40% compared to placebo



WEEKS

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15

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1. Not adjusted
2. Areas colored in orange and blue reflect the standard error. Full Analysis Set (FAS) population, all data are MMRM (Mixed Model Repeated Measure) LS mean and SEs (Standard Error)
PAR – Percent Area Reduction, CI - Confidence Interval, CFB – Change From Baseline

Efficacy (2): BX211 showed clinically relevant, statistically significant[2], reduction in ulcer surface area

Percent Area Reduction (PAR) from baseline of ulcer surface area (LS Mean ± SE)[1]
(Detailed data from previous slide)

PAR at week:	BX211		Placebo		Difference (95% CI)	P-value[2]
	N (%)	Mean (95% CI)	N (%)	Mean (95% CI)		
Week 12	22 (84.6%)	-74.57% (-100.78, -48.35)	12 (80.0%)	-29.85% (-65.08, 5.38)	**-44.72%** (-88.65, -0.78)	0.046
Week 13	20 (76.9%)	-76.43% (-101.56, -51.30)	12 (80.0%)	-34.70% (-68.42, -0.99)	**-41.73%** (-83.80, 0.34)	0.052

	BX211		Placebo		Difference (95% CI)	P-value
	N, e (%)	Mean (95% CI)	N, e (%)	Mean (95% CI)		
Through weeks 1 to 13[3]:	N=26, e=264 (90.5%)	-57.05% (-39.07, -75.04)	N=15, e=164 (84.1%)	-37.09% (-12.91, -61.27)	**-19.96%** (10.20, -50.12)	0.186

N = Number of patients, e = Number of events

Week	1	2	3	4	5	6	7	8	9	10	11	12	13
BX211 (N)	26	23	23	25	24	23	22	19	23	23	22	22	20
Placebo (N)	14	14	13	12	14	12	12	12	12	12	12	12	12

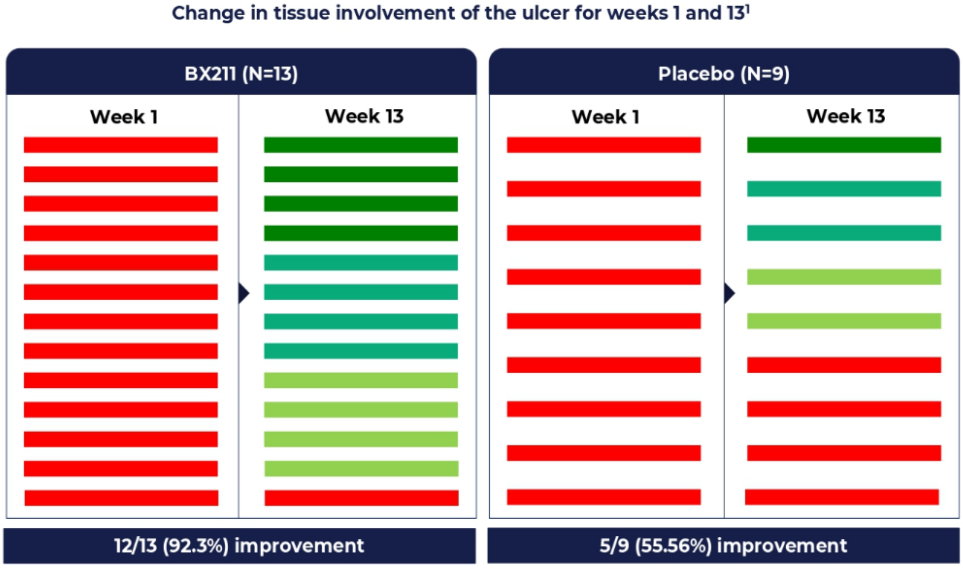
BiomX

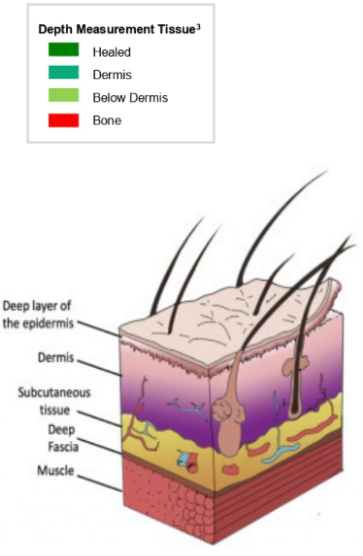
1. Full Analysis Set (FAS) population, all data are MMRM (Mixed Model Repeated Measure) LS mean and SEs (Standard Error)
2. Not adjusted
3. Primary endpoint

PAR – Percent Area Reduction, CI - Confidence Interval, CFB – Change From Baseline

Efficacy (3): Patients with ulcers at bone depth[1] displayed statistically significant[2] better recovery in the BX211 group

Change in tissue involvement of the ulcer for weeks 1 and 13[1]





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1. For all patients at FAS (Full Analysis Set) population that had measured bone involvement at baseline and have a measured tissue involvement at week 13 as measured by a swab
2. The statistical test performed is Miettinen-Nurminen test, with p= 0.048, not adjusted
3. In the figure, to avoid unblinding, Subcutaneous, Fascia and muscle were placed in the same group.

BX004

Cystic Fibrosis and NCFB

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Cystic Fibrosis: Chronic pulmonary infections and the inflammatory response are primary causes of death in CF

Cystic Fibrosis
Thick mucus promotes chronic bacteria infections

Thick, sticky mucus traps bacteria and hinders normal airway clearance, fostering **chronic lung infections**, **often driven by *Pseudomonas aeruginosa***

Standard of Care
Antibiotic resistance is associated with worse outcomes

Chronic management: Inhaled antibiotics, CFTR[1] modulators, airway clearance therapies, azithromycin

Drug-resistance: After prolonged and repeated antibiotic courses, increased resistance to antibiotics lowers efficacy and drives lung function decline and mortality in CF

Large Unmet Need
A significant number of CF patients suffer from chronic PsA infections

~105K
Prevalent CF Patients, Worldwide[2]

~33K
Prevalent CF Patients, US[2]

~17K
CF Patients Suffering from Chronic PsA infections, US and Western EU[3]

1. CFTR- Cystic fibrosis transmembrane conductance regulator
2. CF Foundation estimates across 94 countries (https://www.cff.org/intro-cf/about-cystic-fibrosis)
3. CFF Annual Data Report 2019, ECFS patient registry report, 2020

Phase 1b/2a Study Design: Multicentered, double blind, placebo-controlled study to assess safety, reduction of PsA burden and improvement in clinical outcomes

Key Endpoints:

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

Topline results from Part 1 and 2 available

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CFTR - cystic fibrosis transmembrane conductance regulator;
Image of phage product is intended as an illustration only, and may not represent the number of phages administered
1. Study design informed by input from the CF Foundation
2. 7 days duration - 3 ascending, 4 multiple dosing

Results Highlight: Phase 1b/2a cystic fibrosis (Part 1 and 2)

Study drug was well-tolerated

Reduction in bacterial load	Culture conversion	Clinical efficacy
Part 1, at Day 15: -1.42 log10 CFU/g (BX004) compared to -0.28 log10 CFU/g (placebo) In Part 2, in a prespecified subgroup of patients on SOC inhaled antibiotics on continuous regimen, BX004 vs. placebo showed bacterial reduction of 2.8 log10 CFU/g at EOT, exceeding Part 1 results	**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[1]. In Part 1, 1 of 7 (14.3%) treated patients also had converted based on physician report	**BX004 showed signals of improvement in pulmonary function vs. placebo**: Relative FEV1[2] improvement (5.67%) and CF Questionnaire-Revised respiratory[2] (8.87 points) at Day 17 (1 week after EOT) in subgroup of patients with reduced lung function[3]

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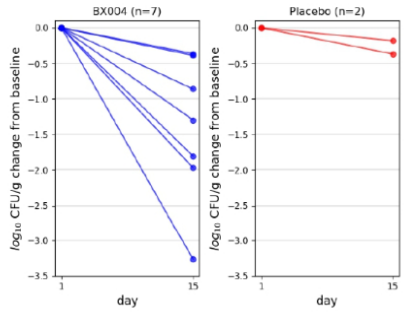
CFU– Colony forming units; SOC – standard of Care; EOT – End of treatment,
1. In patients that had quantitative CFU levels at study baseline
2. FEV1 (or ppFEV1) – percent predicted forced expiratory volume in 1 second; CF Questionnaire-Revised Respiratory – a PRO (Patient reported outcome) for respiratory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

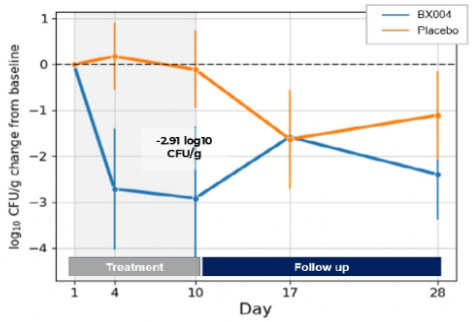
Efficacy (1): BX004 demonstrated greater reduction in PsA levels compared to placebo

PART 1 (after 7d of treatment):



	BX004	Placebo
n	7	2
Mean reduction (SD) Log10 CFU/g	**-1.42 (1.03)**	**-0.28 (0.13)**
Max, Min	-3.27, -0.37	-0.37, -0.18

PART 2 (on top of continuous SoC):



CFU/g log change from Baseline: Mean (SE)

	BX004 (N=7)[1]	Placebo (N=5)	Difference
D4	**-2.71 (1.21)**	**0.18 (0.64)**	**-2.89**
D10	**-2.91 (1.4)**	**-0.11 (0.73)**	**-2.8**
D17	**-1.58 (0.77)**	**-1.63 (0.95)**	**0.05**
D28	**-2.4 (0.9)**	**-1.1 (0.85)**	**-1.3**

CFU- Colony forming units

1. BX004-A: D10 N=6

Efficacy (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]

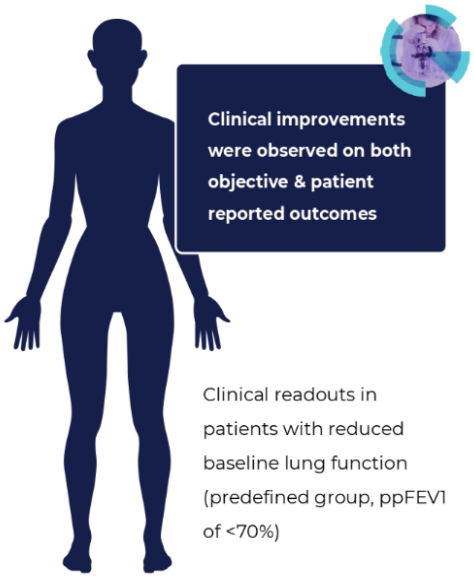
Patients which were converted:

Patient	Duration of PsA infection (years)	Baseline *PsA*[1] in sputum (CFU/g)
1	**18**	**2.40x10³**
2	**13**	**5.60x10⁷**
3	**35**	**1.09x10⁷**

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

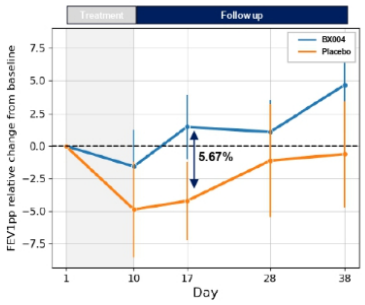
Efficacy (3): BX004 shows meaningful clinical improvement after 10 days of treatment in multiple clinical readouts



Clinical improvements were observed on both objective & patient reported outcomes

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

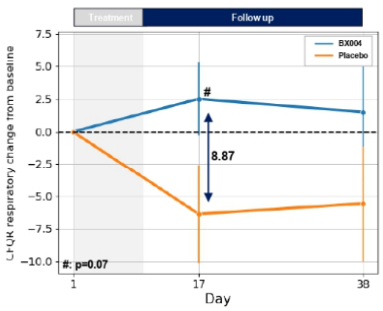
ppFEV1



ppFEV1 change from Baseline: Mean(SE)

	BX004 (N=12)[2]	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[1] (respiratory)



CFQR respiratory change from Baseline: Mean(SE)

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

BiomX

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

Enrollment:

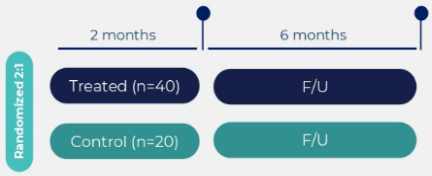
Objective: ~60 CF patients[1] with chronic PsA infections

Standard of care antibiotic, no restriction on CFTR modulators

BX004

Intervention:
Nebulized dose

Part 2b
2 months of same dose, twice daily



Key Endpoints:

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

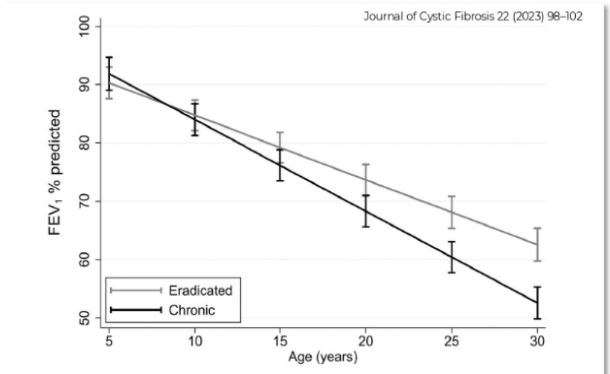
Topline results expected in Q1 2026

BiomX

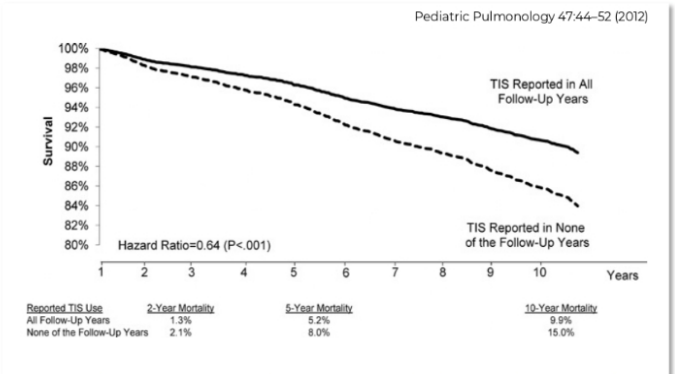
1. Subject to discussions with FDA, and further consultation. Number of subjects under the study stated is an objective and actual numbers may vary
Image of phage product is intended as an illustration only, and may not represent the number of phages administered

Real-world Evidence: Potential for accelerated approval[1]

Peer-reviewed publications demonstrated that P. aeruginosa (*PsA*) reduction improves patient outcomes, and ongoing real-world evidence (RWE) analysis may support regulatory filings



Eradication of *PsA* slows lung function decline (vs. chronic *PsA* infection) in CF patients



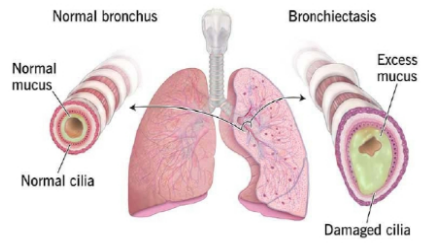
CF patients treated with tobramycin inhalation solution (TSI) demonstrated reduced mortality

RWE analysis and **similar bacteria reduction seen in BX004 CF study** supports potential for **accelerated approval**

1. Pending discussion with regulators that is expected in H2 2025

NCFB: A promising next candidate given its medical similarity to cystic fibrosis

Non-Cystic Fibrosis Bronchiectasis (NCFB)

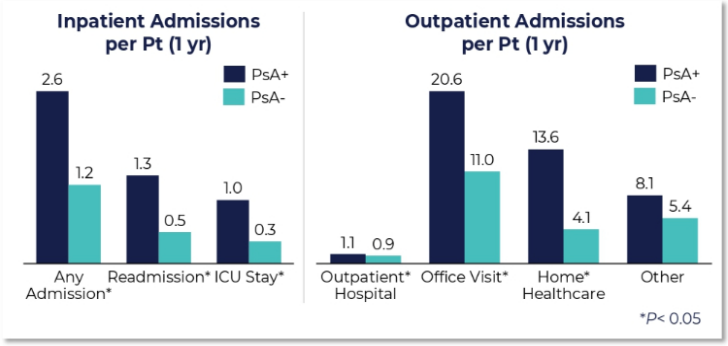


A chronic progressive inflammatory lung disease with:

>1 M Diagnosed patients (US, EU5, Japan)[1]

0 Approved treatments

Worse Clinical Symptoms and More Inpatient / Outpatient Encounters Associated with *PsA* Infections[2]



Bacteria linked to CF and NCFB are largely the same — highlighting strong scientific rationale and disease overlap that support **pursuing NCFB**

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
Image source: Cleveland Clinic: Bronchiectasis

CMC & IP

BiomX

GMP Production Experience

Internal GMP Facility (BiomX):

- ✓ 10 drug substance (DS) batches at 4–20L scale
- ✓ Clinical-scale master phage seed (MPS) manufacturing (~300 vials)
- ✓ DP cream/gel manufacturing (up to 11kg batches in 50g containers)
- ✓ Sterile drug product (DP) manufacturing (up to 900 vials/batch)

External CMO Partnerships (Supplemental Capacity):

- ✓ 10 MPS and corresponding production banks (300–500 vials each)
- ✓ Multi-phage DS production at 4–50L scale
- ✓ Sterile DP manufacturing (up to 3,000 vials/batch)

Integrated model provides flexibility and scalability to support clinical and development-stage programs

Regulatory Experience

- ✓ Successfully engaged in **4 pre-IND interactions** across diverse routes of administration: oral, systemic, topical, and inhaled
- ✓ **Multiple active INDs and IMPDs** supporting early- and mid-stage clinical development
- ✓ Demonstrated regulatory alignment for **first-in-human (FIH)** and **Phase 2 trials**
- ✓ Experience with regulatory submissions in both the **U.S. and EU**, including **oral, inhaled, and topical phage delivery formats**

BiomX Manufacturing Capabilities

Area	400 m^2
Room's classifications	Class B,C and D Fully controlled clean rooms (temp., pressure, RH)
Phage production per year	- 2,000L
No. of production suites	2 Phage production and 2 Drug product formulation and filling (liquid and creams)
Capabilities for sterile products	In preparation, clean room class B available
DS scale	18-40L working volume in Bioreactor per batch
DP scale topical	11kg per batch established, 200-250 containers of 50 g
Quality Control (QC)	2 dedicated labs to support IPC, release and stability
Quality Assurance (QA)	Phase 2 compliant quality systems
Aerosol characterization	Dedicated equipment – breathing simulator

Robust IP Portfolio Protecting Core Phage Assets Through 2045

- **3 patent families with expirations through 2045,** covering key aspects of phage discovery, formulation, and application
- **2 families in national phase** (USA, Europe, Japan, Australia, Canada, China) and **1 in pre-PCT stage**, ensuring global protection
- **Comprehensive IP coverage includes:**
  - Therapeutic phage cocktails (e.g., Staphylococcus, Pseudomonas)
  - Broad phage combination strategies
  - Claims on phage synergy to suppress resistance/mutant escape
  - Genetic sequence variants and engineering strategies
  - Synthetic phages with heterologous sequences
  - Use of phages in combination with antibiotics

- **Freedom-to-operate strategy** in major markets
- Claims designed to support both **clinical assets and future pipeline expansion**
- **Ongoing IP filings** to expand coverage of novel phage constructs and production methods

Summary

BiomX

Driving Next Phase of Growth

ANTIBIOTIC RESISTANCE

Rapidly growing global concern, driving the need for new anti-infectives such as bacteriophage therapy

Increased chronic diseases and global conflicts driving further antibiotic use and hence resistance

PHAGE THERAPY - MOMENT HAS ARRIVED

Rapidly growing global concern, driving the need for new anti-infectives such as bacteriophage therapy

Increased chronic diseases and global conflicts driving further antibiotic use and hence resistance

BX211

The incidence of moderate-severe DFI + DFO annually in the US is approximately 400,000. Presenting a potential commercial opportunity of > $2.5 billion worldwide[1]

Positive results in Phase 2 study; preparing Phase 2/3 pending FDA feedback

Potential for additional DHA funding to support future clinical trial, to date ~40M non dilutive funding provided

Launch of Prosthetic Joint Infection Phase 2 study ready, pending funds, increasing potential commercial opportunity

BX004

Pseudomonas aeruginosa ('PsA') lung infections are a leading cause of morbidity and mortality In CF, and present a potential commercial opportunity of > $1.5 billion worldwide[1]

Phase 2b readout expected Q1 26

Real world evidence plan to be presented during H2 2025, if approved may provide pathway for expedited approval

Launch of Non-Cystic Fibrosis Bronchiectasis phase 2 study ready, pending funds, increasing potential commercial opportunity

FINANCING AND INVESTORS

Publicly traded (NYSE American: PHGE)
$21.1 million cash and cash equivalents as of March 31, 2025

Key investors:

DEERFIELD Advancing Healthcare™

AMR ACTION FUND

OrbiMed Healthcare Fund Management

BiomX

1. BiomX commercial estimates

Strong Leadership

Management

Jonathan Solomon
Chief Executive Officer, Director
Former co-Founder and CEO Proclara

Merav Bassan, PhD,
Chief Development Officer
20 years drug & clinical development at Teva

Marina Wolfson, CPA,
Chief Financial Officer
Former Bioview, Ernst & Young

Inbal Benjamini-Elran,
Chief HR Officer
Former HR roles at Teva and Herzog Law

Board of Directors

Russell Greig, PhD
Chairman of the Board
Former president of GSK Pharma International & SR one, GSK corporate venture group

Alan Moses, MD
Director
Former Global Chief Medical Officer of Novo Nordisk

Jonathan Leff
Director
Partner on the Therapeutics team at Deerfield and Chairman of the Deerfield Institute

Jesse Goodman, MD, MPH
Director
Professor of Medicine at Georgetown University and Director of the Center on Medical Product Access

Greg Merril
Director
Former CEO APT, founding CEO of Immersion Medical (NASDQ: IMMR)

Susan Blum
Director
Chief Financial Officer of Melinta Therapeutics, LLC. ("Melinta")

Eddie Williams
Director
Former special advisor to the CEO of Ascendis Pharma, Inc.

Scientific Founders

Prof. Rotem Sorek
Head of microbial genomics group at Weizmann Institute
Phage genomics and CRISPR research

Prof. Timothy K. Lu
Associate professor leading synthetic biology group, MIT
Synthetic biology, biochemical engineering

Prof. Eran Elinav
Principal investigator at Weizmann Institute
Immune system and intestinal microbiome interactions

BiomX

2 Phage Therapy Programs

2 Phase 2 Studies

Reputable Investors & Partners

DEERFIELD® Advancing Healthcare™

AMR ACTION FUND

OrbiMed Healthcare Fund Management

CYSTIC FIBROSIS FOUNDATION

≥ $215 M Raised

~$40M Non-Dilutive

3 Patent Families

Robust Scientific Expertise

≥ 50% PhDs in Leadership

≥ $4 B Addressable Market World-wide

Strong Manufacturing Capabilities