Clinical Stage Programs Addressing Urgent Need for Overcoming Antibiotic Resistance

Corporate Presentation
November 2025

BiomX

NYSE American: PHGE

SAFE HARBOR STATEMENT

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

35% ➡ Resistance Rate of *S. Aureus to antibiotic Methicillin*[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]

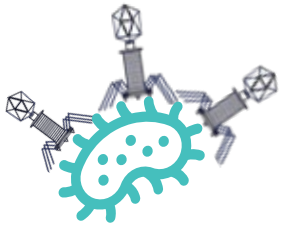
$100T

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

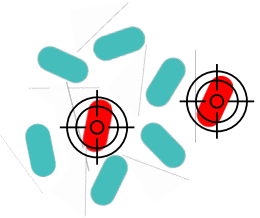
Phage Therapy: A century-old solution with renewed promise

Key Advantages

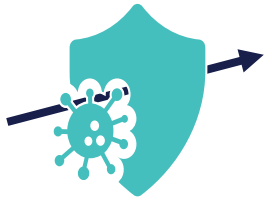


Active against Antibiotic Resistant Strains

Safe Modality, Inert to Human Cells

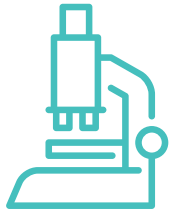


Targets Only Harmful Bacteria – No Disruption to Microbiome



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

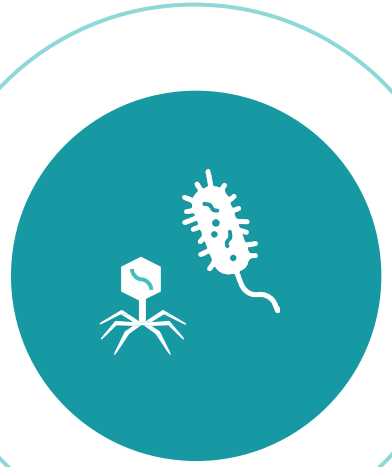
BiomX

Nov. 2023: BiomX positive P1b/2a data

43 patients

Cystic Fibrosis

BiomX



Phage Therapy Clinical Trails

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

- 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

BiomX

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

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

BX004

Target: *P. aeruginosa*

Cystic Fibrosis

November 2023, Positive Phase 2 results

- **Phase 2b** Cystic Fibrosis – Expected readout Q2 2026
- **Phase 2 Ready** Non-Cystic Fibrosis Bronchiectasis (NCFB)[2]
- **Phase 2 Ready** HAP/VAP[2]

BX211

Target: *S. aureus*

Diabetic Foot Osteomyelitis

March 2025, Positive Phase 2 statistically significant results targeting S. aureus in DFO

- **Phase 2 Completed** Diabetic Foot Osteomyelitis
- **BX011**[1] → **Phase 2a** Diabetic Foot Infection
- **Phase 2 Ready** Prosthetic Joint Infection (PJI)[2]

Validated Targets

Unlocks Direct Phase 2 Expansion Opportunities

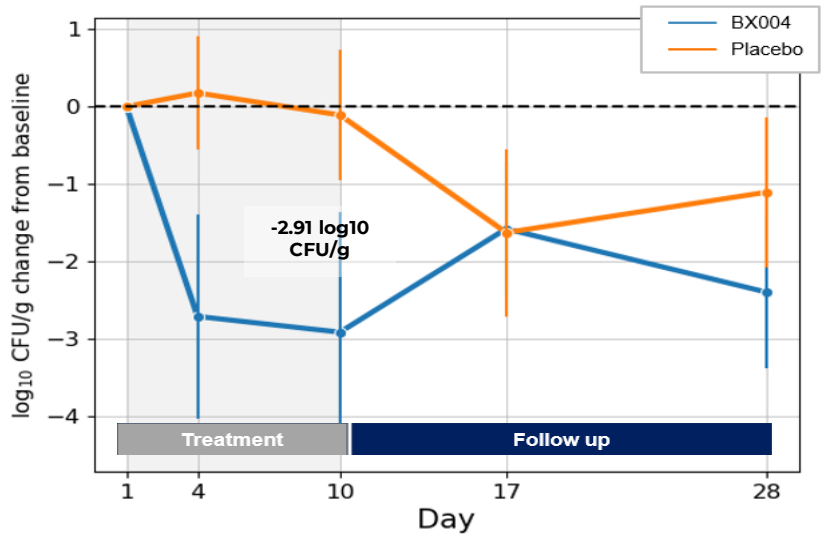
Additional Potential Indications with Shared Target Pathogenic Bacteria

1. BX011 is a next-gen fixed multi-phage cocktail, applied topically to target *S. aureus* infections, amongst the cocktail is phage previously evaluated in the Company's phase 2 DFO trial
2. Additional potential indications that could be pursued with shared target bacteria as parent program

BiomX's Groundbreaking Phase 2 Results

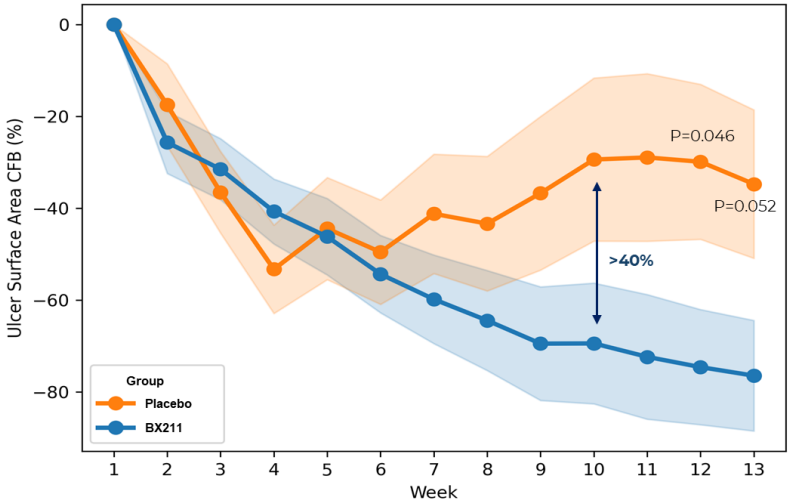
Efficacy of phage therapy across indications

Cystic Fibrosis (BX004): On top of antibiotic 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

Diabetic Foot Osteomyelitis (BX211): On top of antibiotic SoC



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

- 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;

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

Strong Science & Scientific Founders

nature Cell Science nature reviews immunology

Prof. Rotem Sorek

Head of microbial genomics group at Weizmann Institute

Phage genomics and CRISPR research

nature medicine Cell npj | biofilms and microbiomes

Prof. Eran Elinav

Principal investigator at Weizmann Institute

Immune system and intestinal microbiome interactions

nature nature biotechnology Cell Host & Microbe Cell Genomics

Prof. Timothy K. Lu

Associate professor leading synthetic biology group, MIT

Synthetic biology, biochemical engineering

nature WILEY American Society for Microbiology | Journal of Bacteriology PNAS

Dr. Carl Merril

National Institutes of Health, Adaptative Phage Therapeutics

Trusted by top biotech and healthcare investors

DEERFIELD® Advancing Healthcare®

AMR ACTION FUND

OrbiMed Healthcare Fund Management

≥ $215 M Raised[1]

Working with mission-aligned global leaders

CYSTIC FIBROSIS FOUNDATION

WRAIR

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

Notable Scientific Publications

nature communications

Phage therapy with nebulized cocktail BX004-A for chronic *Pseudomonas aeruginosa* infections in cystic fibrosis: a randomized first-in-human trial

Cell Supports open access

Targeted suppression of human IBD-associated gut microbiota commensals by phage consortia for treatment of intestinal inflammation

nature communications

Bacteriophage therapy against pathological *Klebsiella pneumoniae* ameliorates the course of primary sclerosing cholangitis

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

BX004

Cystic Fibrosis and NCFB

BiomX

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]

BiomX

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

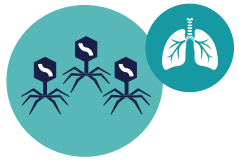
Phase 1b/2a Study Design: Multicentered, double blind, placebo-controlled study to assess safety, reduction of PsA burden and improvement in clinical outcomes

Enrollment:

43 CF patients with chronic PsA infections

Standard of care antibiotic, no restriction on CFTR modulators

BX004



Intervention:
Nebulized dosing

Part 1[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

Topline results from Part 1 and 2 available

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

Part 1, at Day 15: 2.7 $\log_{10}$ CFU/g treatment effect (represents approximately a 500-fold, or 99.8% , greater bacterial reduction with BX004 versus 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

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[1]

In Part 1, 1 of 7 (14.3%) treated patients also had converted based on physician report

Clinical efficacy

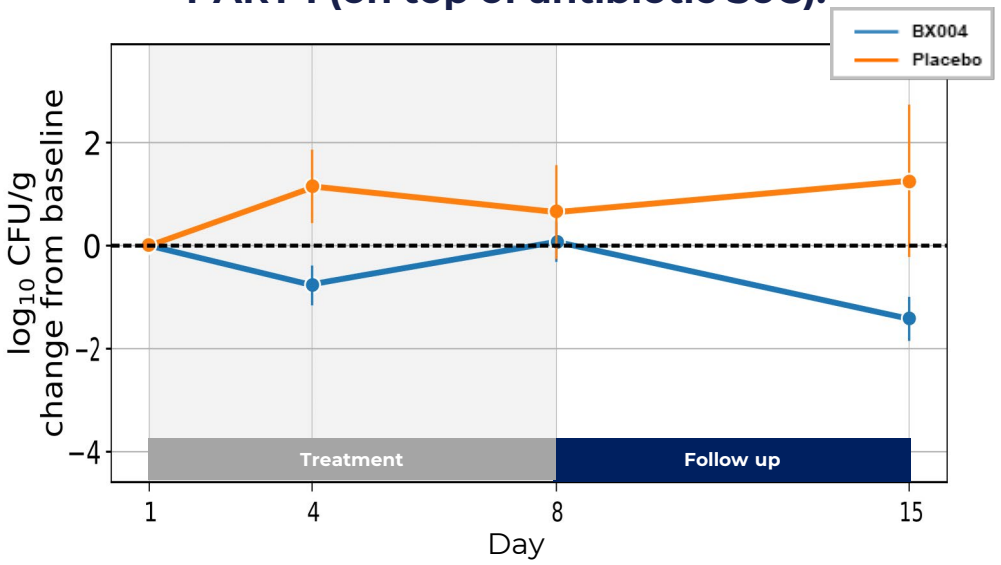
BX004 showed signals of improvement in pulmonary function vs. placebo: Relative FEV1[2] improvement (5.67%) and CF Questionnaire-Revised respiratory[2] (8.87 points) at Day 17 (1 week after EOT) in subgroup of patients with reduced lung function[3]

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

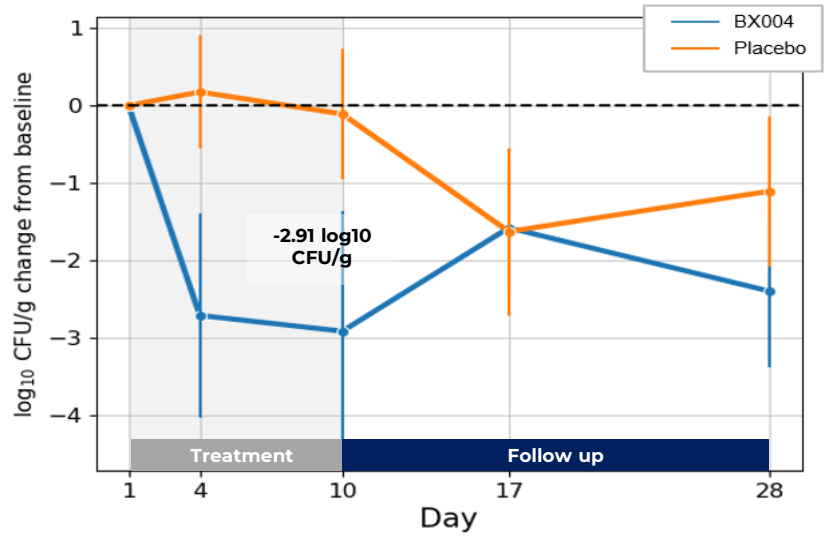
PART 1 (on top of antibiotic SoC):



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

	BX004 (N=7)	**Placebo** (N=2)	**Difference**
D4	**-0.77 (0.32)**	**1.15 (0.47)**	**-1.9**
D8	**0.08 (0.33)**	**0.65 (0.62)**	**-0.57**
D15	**-1.42 (0.36)**	**1.26 (1.02)**	**-2.7**

PART 2 (on top of antibiotic SoC, continuous subgroup):



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**

1. CFU– Colony forming units
2. In graph omitted data of days 2 and 3 which received escalating dose

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]

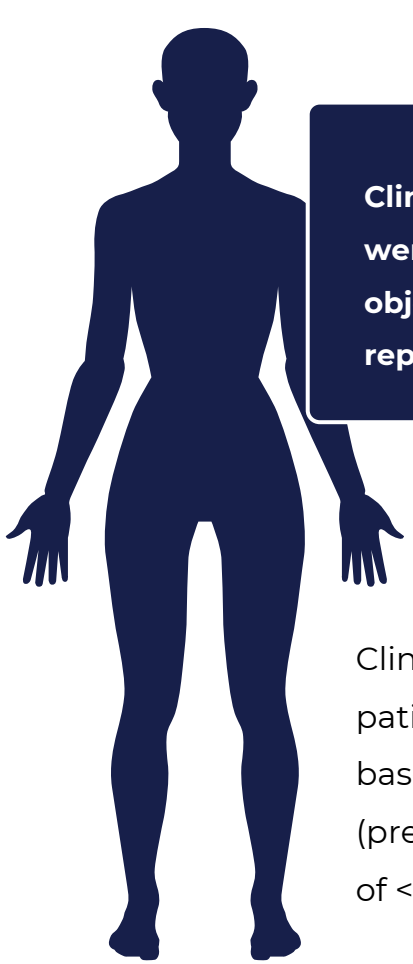
Patients which were converted:

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

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

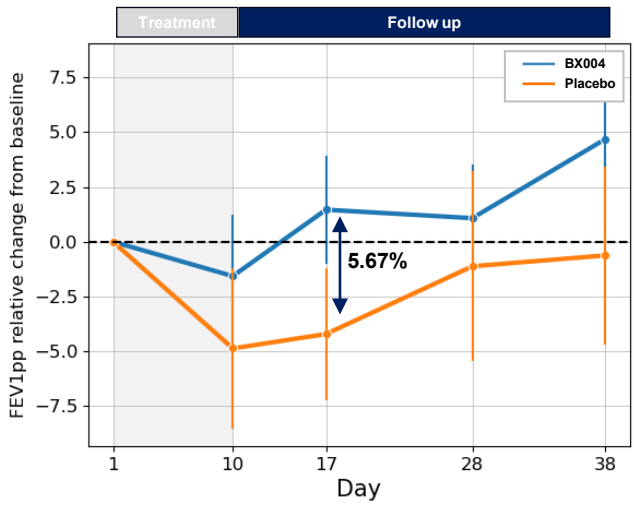
Efficacy (3): BX004 shows meaningful clinical improvement after 10 days of treatment in multiple clinical readouts



Clinical improvements were observed on both objective & patient reported outcomes

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

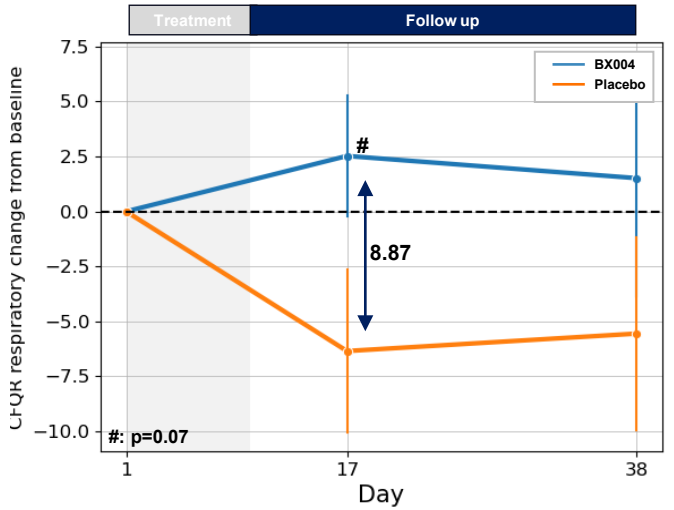
ppFEV1



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**

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

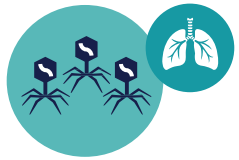
International, multicenter, double blind, placebo-controlled study to assess reduction of PsA burden and improvement in clinical outcome

Enrollment:

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

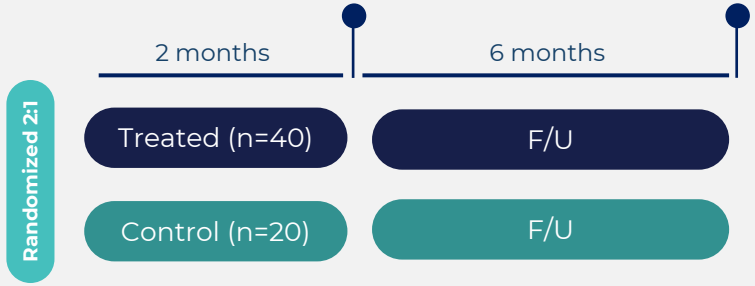
Standard of care antibiotic, no restriction on CFTR modulators

BX004



Intervention:
Nebulized dosing

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 Q2 2026

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

Non-Cystic Fibrosis Bronchiectasis: Market Expansion Potential

CF and NCFB have similar lung structural abnormalities

These structural abnormalities predispose patients to *Pseudomonas aeruginosa* infections[1]

~25% of NCFB patients have chronic *P. aeruginosa* infections

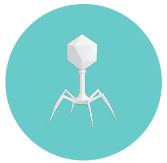
Physicians treat both CF and NCFB the same way

With no approved anti-bacterial, NCFB patients are treated off-label with CF anti-bacterial therapies

10x

NCFB patient population is approximately ten times larger than CF

- CF: ~100,000 patients worldwide[2]
- NCFB: ~1,000,000+ patients worldwide[3]



BX004 Ability to Address NCFB

Common bacteria	Similar patient populations	Common organ	Same delivery method	Phase 2 validation	NCFB Phase 2 ready
✓	✓	✓	✓	✓	✓

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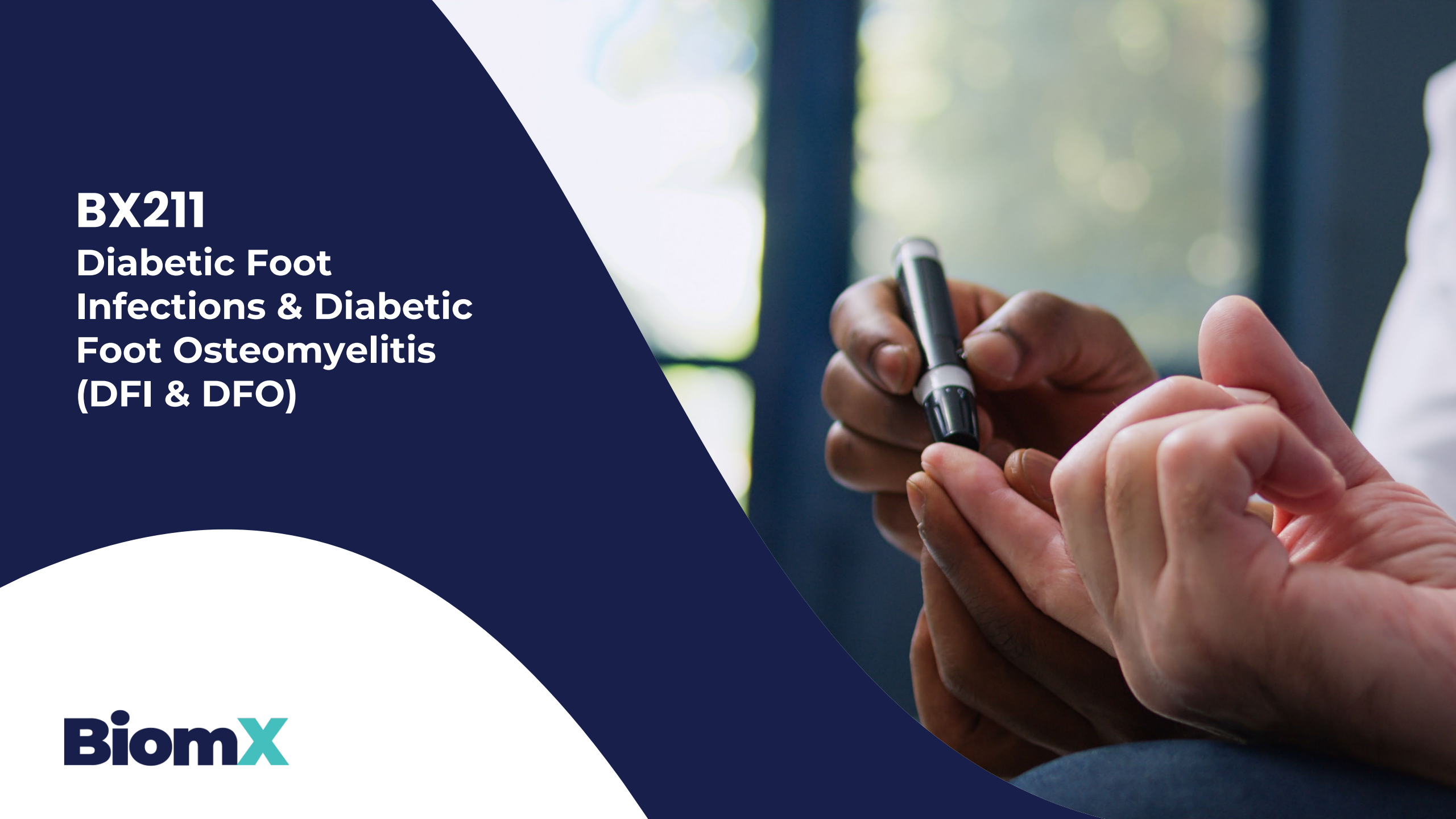
1. Chalmers, et al. The Lancet Respiratory Medicine (2023) 11: 637-649
2. National Heart, Lung, and Blood Institute (NHLBI). (2024, Nov 15). What Is Cystic Fibrosis? "Nearly 40,000 children and adults in the United States — and more than 100,000 worldwide — are now living with cystic fibrosis."
3. Bronchiectasis & NTM Association / COPD Foundation. (2025, February 18). Bronchiectasis and NTM Association and 25 global partners unite for World Bronchiectasis Day. Retrieved from https://www.copdfoundation.org/About-Us/Press-Room/Press Releases/Article/2219/Bronchiectasis-and-NTM-Association-and-25-global-partners-unite-for-World-Bronc.aspx

BX211

Diabetic Foot Infections & Diabetic Foot Osteomyelitis (DFI & DFO)



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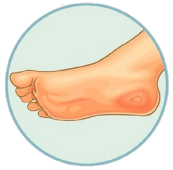
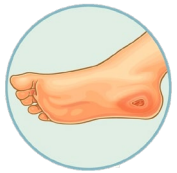
Disease Burden: DFI & DFO drive diabetic amputations, burdening the healthcare system

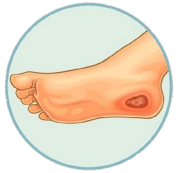
DFI to DFO
Bacterial infection spreading from soft tissue to bone



Superficial ulcer



DFI



DFO

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)

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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

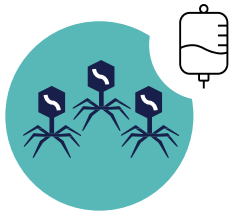
Primary Endpoint:
Percent area reduction of study ulcer through Week 13

Enrollment:

41 patients with Diabetic Foot Osteomyelitis positive for S. aureus

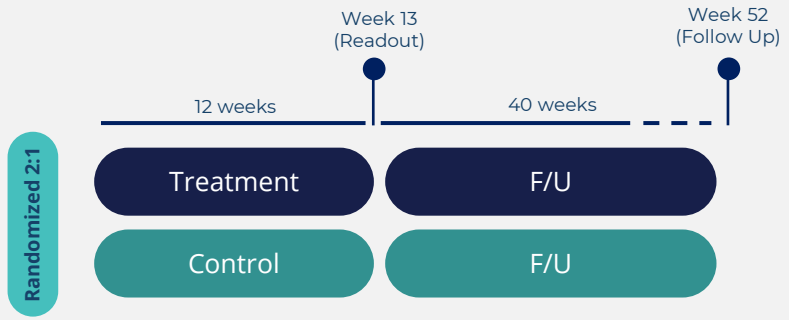
Background standard of care antibiotic

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*

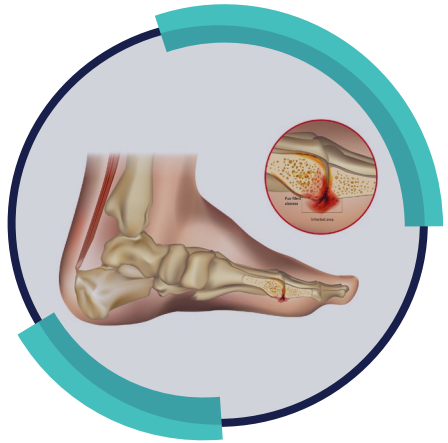
Topline results from week 13 available

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**

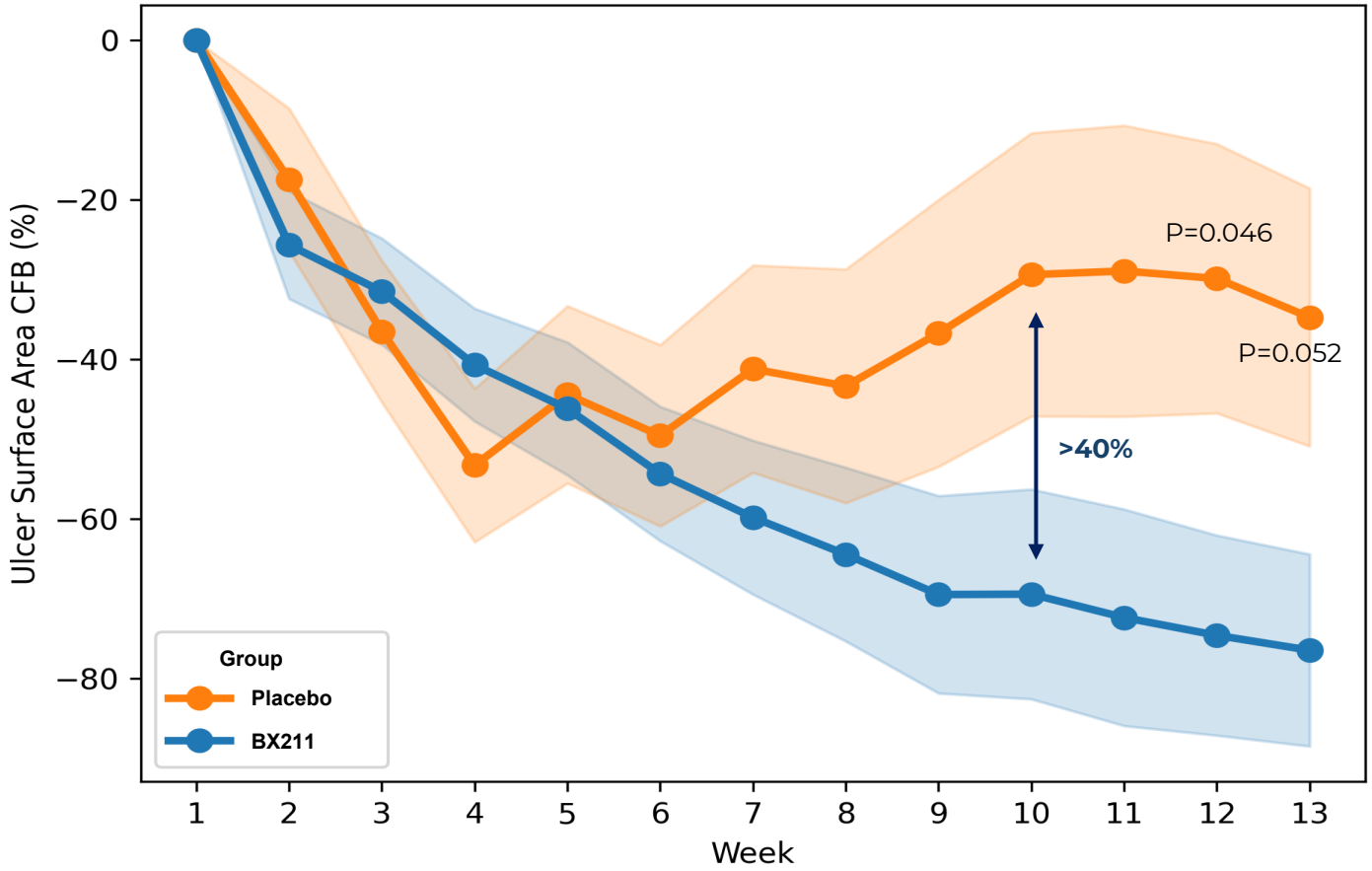
1. Ulcer depth was classified according to deepest tissue involved as measured by swab)

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)



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

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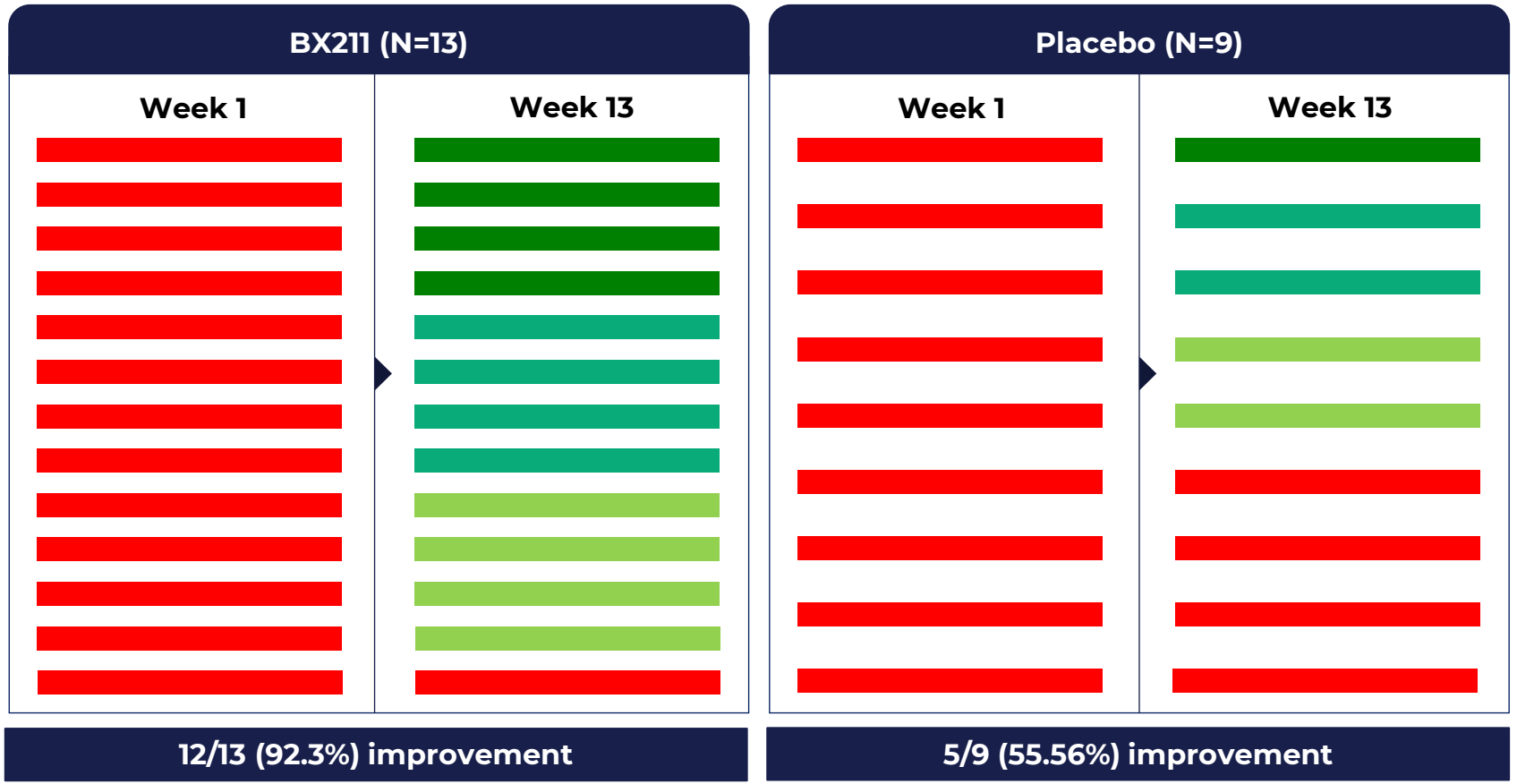
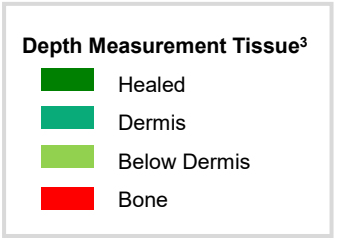
1. Full Analysis Set (FAS) population, all data are MMRM (Mixed Model Repeated Measure) LS mean and SEs (Standard Error)
2. Not adjusted
3. Primary endpoint

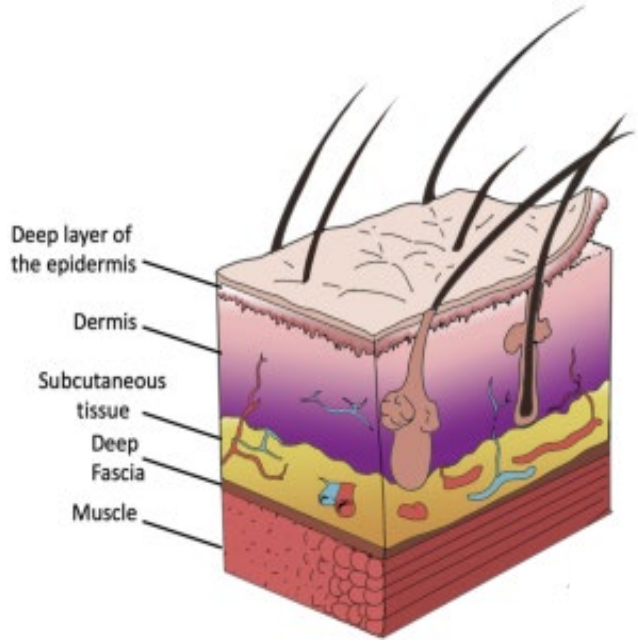
PAR – Percent Area Reduction, CI - Confidence Interval, CFB – Change From Baseline

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]







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.

Summary

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