Forward Looking Statement

This presentation and the oral commentary may contain forward-looking statements that involve future events. These forward-looking statements include terminology such as “believe,” “will,” “may,” “estimate,” “continue,” “anticipate,” “contemplate,” “intend,” “target,” “project,” “should,” “plan,” “expect,” “predict,” “could,” “potentially” or the negative of these terms. All statements other than statements of historical facts contained in this presentation, including statements regarding our future financial condition, timing for and outcomes of clinical results, prospective products, preclinical and clinical pipelines, regulatory objectives, business strategy and plans and objectives for future operations, are forward looking statements. Such statements are predictions only and involve known and unknown risks, uncertainties and other important factors that may cause our actual results, performance or achievements to be materially different from any future results, performance or achievements expressed or implied by the forward-looking statements. These risks and uncertainties include, among others, the costs, timing and results of preclinical studies and clinical trials and other development activities for lonafarnib, interferon lambda, and avexitide, and any of our future product candidates; our ability to achieve timelines and obtain approval without the need to conduct large Phase 3 clinical trials for our product candidates or additional exploratory or pivotal trials beyond what we anticipate; our ability to obtain funding for our operations, including funding necessary to complete all clinical trials that may potentially be required to file any NDA or MAA for our product candidates, and complete all clinical trials that may potentially be required to file for regulatory approval, for any of our product candidates; the uncertainties inherent in the initiation and enrollment of clinical trials; expectations of expanding on-going clinical trials; availability and timing of data from clinical trials; the unpredictability of the duration and results of regulatory review; the commercialization of our product candidates, if approved, including whether commercializing lonafarnib for use in the progeria and progeroid laminopathies indications would result in receipt of a priority review voucher or otherwise be cash flow positive as a program for us; our plans to research, develop and commercialize our product candidates; our ability to attract collaborators with development, regulatory and commercialization expertise; the size and growth potential of the markets for our product candidates, and our ability to serve those markets; our ability to obtain favorable reimbursement and pricing and the rate and degree of market acceptance of our product candidates; regulatory developments in the United States and foreign countries; the performance of our third-party suppliers and manufacturers; market acceptance for approved products and innovative therapeutic treatments; competition; the accuracy of our estimates regarding expenses, future revenues, capital requirements and needs for additional financing; our expectations regarding the period during which we qualify as an emerging growth company under the Jumpstart Our Business Startups Act of 2012, or the JOBS Act; the possible impairment of, inability to obtain and costs of obtaining intellectual property rights; impacts of COVID-19 pandemic on our operations; and possible safety or efficacy concerns, general business, financial and accounting risks and litigation. Because forward-looking statements are inherently subject to risks and uncertainties, some of which cannot be predicted or quantified and some of which are beyond our control, you should not rely on these forward-looking statements as predictions of future events. More information concerning us and such risks and uncertainties is available on our website and in our press releases and in our public filings with the U.S. Securities and Exchange Commission. We are providing this information as of its date and do not undertake any obligation to update or revise it, whether as a result of new information, future events or circumstances or otherwise. Additional information may be available in press releases or other public announcements and public filings made after the date of this presentation.

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## Highlights

### DIVERSE PIPELINE
- Focus on rare and ultra-rare diseases with no approved therapies
- Late stage assets with paths to commercialization
- 4 Breakthrough Therapy Designations

### LEADER IN HDV
- Only oral therapy in development (Lonafarnib)
- Two complementary therapeutic options (Lonafarnib and peginterferon lambda)
- $1B+ annual commercial opportunity in U.S. and E.U.

### PROGERIA NDA & MAA SUBMITTED
- Lonafarnib first commercial opportunity in 2020
- Survival benefit in ultra-rare pediatric disease
- Priority Review Voucher upon approval

### AVEXITIDE PROGRAM
- Phase 3 ready pipeline asset for Post-Bariatric Hypoglycemia
Leader in Hepatitis Delta Virus (HDV)

Developing and Commercializing 2 Late Stage Therapies

Lonafarnib

PHASE 3

Rare Disease

Orphan Designation

Breakthrough Therapy Designation

Peginterferon Lambda

PHASE 3 READY
HDV: Most Severe Form of Viral Hepatitis

Always a Co-infection with HBV

HDV: Most Severe Form of Viral Hepatitis

Rapid Disease Progression to Cirrhosis

- 70% Within 5-10 years
- 20% Within 5 years

HBV Mono-infection

HDV/HBV Co-infection

Hepatitis B Population

HDV 4-6%
15-20M HDV Patients Worldwide

Migration Contributing to Globalization of Disease
HDV: High Unmet Need and Disease Burden

LOW SURVIVAL RATE

~60% Mortality1
Within 10 Years

Similar to some cancers

HIGH COST TRANSPLANTS

~$575K Cost2
>14,000 person Waiting List

25% of people on waiting list die each year before receiving a liver transplant1

No approved treatment

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1 Serrano et al, EASL 2011  
2 UPMC Health Beat, 2018, US liver transplant cost
HDV Market Opportunity

CONSERVATIVE MARKET PENETRATION, ORPHAN PRICING

ADDRESSABLE MARKET

~300,000 Patients\(^1\)

~100K in US

~200K in EU

CONSERVATIVE PENETRATION

~3% of Patients\(^2\)

~3K in US

~6K in EU

ORPHAN PRICING

Per Year\(^3\)

~$150,000 in US

~$98,000 in EU

>$1B Potential Peak Year Market Opportunity\(^2,3\)

\(^1\) Triangle Insights 2016  \(^2\) Conservative penetration for illustrative purposes  \(^3\) Pricing for illustrative purposes
Eiger HDV Franchise

Lonafarnib + Ritonavir
1st in class small molecule, oral prenylation inhibitor
Phase 3

Peginterferon Lambda
1st in class type III interferon
Phase 3 Ready
Eiger HDV Franchise

Lonafarnib + Ritonavir

1st in class small molecule, oral prenylation inhibitor
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Peginterferon Lambda

1st in class type III interferon
Phase 3 Ready
HDV Requires HBsAg to Complete Virus Assembly

**HDV** consists of a single stranded, circular RNA virus, with an envelope made up of HBsAg

**HBsAg Acquired Through PROTEIN PRENYLATION**
This is mechanism targeted by lonafarnib
Lonafarnib for HDV

FIRST AND ONLY ORAL AGENT IN DEVELOPMENT FOR HDV

• Well-characterized in patients
  - > 2,000 patients dosed in oncology program by Merck (Schering)
  - > 90 children dosed in Progeria program by Boston Children’s Hospital
  - > 170 patients dosed in HDV program
    - Longest duration of dosing > 10 years

• Most common experienced AEs are GI related (class effect)

• Patent estate covers broad range of lonafarnib + ritonavir doses and durations
  - US, Europe, Japan, China and South Korea
Reducing HDV-RNA with IFN-α Improves Survival

HDV-RNA SUPPRESSION IMPROVES CLINICAL OUTCOMES

Interferon-α for 48 Weeks with 15 year Follow Up

Change in HDV-RNA

Survival

Log Change in Serum HDV-RNA

Proportion of Patients Surviving

Farci et al, Gastroenterology 2004: Long-Term Benefit of Interferon-α Therapy of Chronic HDV: Regression of Advanced Hepatic Fibrosis

P = 0.009

n=36

n=13

n=12

n=11

n=36
Lonafarnib Phase 2 Data

TWO LONAFARNIB-BASED REGIMENS IDENTIFIED FOR REGISTRATION

Change in Log HDV-RNA

Week

Yurdaydin et al; J Hepatology 2018, Phase 2 LOWR 2 Study, Abstract #PS-161

100-fold INCREASE IN ACTIVITY

≥ 2 log Decline HDV-RNA + ALT Normalization

COMPOSITE ENDPOINT

29%

63%

LNF 50 mg BID + RTV (N=12)

LNF 50 mg BID + RTV + PEG IFN-alfa-2a (N=4)
All patients will be maintained on background HBV nucleoside therapy. Superiority over PEG IFN-alfa-2a not required.

N=400 allows for single pivotal study for registration

* biopsy

PEG IFN-alfa-2a

On-treatment
48 weeks

Post-treatment
24 weeks

N = 175
ALL-ORAL
Lonafarnib 50 mg BID
Ritonavir 100 mg BID
Follow Up

N = 125
COMBO
Lonafarnib 50 mg BID
Ritonavir 100 mg BID
PEG IFN-alfa-2a
Follow Up

N = 50
MONO
PEG IFN-alfa-2a
Follow Up

N = 50
Placebo
Follow Up
**Phase 3 Global Study**

**Stratification based on baseline viral load**

High baseline viral load >4 log HDV RNA

Low baseline viral load <4 log HDV RNA

<table>
<thead>
<tr>
<th>Stratification</th>
<th>On-treatment 48 weeks</th>
<th>Post-treatment 24 weeks</th>
</tr>
</thead>
</table>
| ALL-ORAL  N = 175 | Lonafarnib 50 mg BID  
Ritonavir 100 mg BID | Follow Up |
| COMBO  N = 125 | Lonafarnib 50 mg BID  
Ritonavir 100 mg BID  
PEG IFN-alfa-2a | Follow Up |
| MONO  N = 50 | PEG IFN-alfa-2a | Follow Up |
| N = 50 | Placebo | Follow Up |

* biopsy

All patients will be maintained on background HBV nucleoside therapy. Superiority over PEG IFN-alfa-2a not required.
Phase 3 Global Study

ORAL PATHWAYS TO APPROVAL

Stratification based on baseline viral load

High baseline viral load

>4 log HDV RNA

Low baseline viral load

<4 log HDV RNA

On-treatment
48 weeks

Post-treatment
24 weeks

N = 175
ALL-ORAL
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N = 50
MONO
PEG IFN-alfa-2a
Follow Up

N = 50
Placebo
Follow Up

Primary Endpoint at Week 48

≥ 2 log decline in HDV RNA
+ Normalization of ALT

Secondary Endpoint at Week 48

Histologic improvement
Improvement of fibrosis

Contribution of effect only

* biopsy
All patients will be maintained on background HBV nucleoside therapy.
Superiority over PEG IFN-alfa-2a not required.
COMBO PATHWAYS TO APPROVAL

Phase 3 Global Study

**Primary Endpoint at Week 48**

≥ 2 log decline in HDV RNA + Normalization of ALT

**Secondary Endpoint at Week 48**

Histologic improvement
Improvement of fibrosis

---

**Stratification based on baseline viral load**

- **High baseline viral load** >4 log HDV RNA
- **Low baseline viral load** <4 log HDV RNA

**On-treatment**

- **ALL-ORAL**
  
  N = 175
  
  Lonafarnib 50 mg BID Ritonavir 100 mg BID
  
  Follow Up

- **COMBO**
  
  N = 125
  
  Lonafarnib 50 mg BID Ritonavir 100 mg BID PEG IFN-alfa-2a
  
  Follow Up

- **MONO**
  
  N = 50
  
  PEG IFN-alfa-2a
  
  Follow Up

- **Placebo**
  
  N = 50
  
  Follow Up

---

* biopsy

All patients will be maintained on background HBV nucleoside therapy. Superiority over PEG IFN-alfa-2a not required.
Study Mirrors HDV Global Footprint

HDV Phase 3 Sites

20 COUNTRIES

90 ACTIVE SITES

Key sites to be activated: NIH, Mongolia, Germany
Eiger HDV Franchise

Lonafarnib + Ritonavir
1st in class small molecule, oral prenylation inhibitor
Phase 3

Peginterferon Lambda
1st in class type III interferon
Phase 3 Ready
Peginterferon Lambda (Lambda)

A WELL TOLERATED TYPE III INTERFERON

- Binds to a unique receptor vs type I IFN-α
  - Highly expressed on hepatocytes
  - Limited expression on hematopoietic and CNS cells
- Uses similar downstream signaling pathway to IFN-α
- 3,000+ patients in 19 clinical trials (HCV / HBV / HDV)
LIMT: Phase 2 Lambda Monotherapy Study

36% DURABLE VIROLOGIC RESPONSE (DVR) WITH LAMBDA

Mean Decline Log HDV RNA IU/mL

Lambda 180 mcg QW (N=14)

BLQ = below the limit of quantification
Robogene® 2.0 HDV RNA PCR assay, LOQ = 14 IU/mL; LOD = 6 IU/mL
Etzion et al, EASL 2019; dose reductions allowed
Lambda is Phase 3 Ready for HDV

CONCURRENCE WITH FDA & EMA ON SINGLE PIVOTAL STUDY

Arm 1
N=100
Nuc Run-in

12 weeks

Lambda 180 mcg QW

Follow-up

Arm 2
N=50
No TRx

12 weeks

48 wk
Lambda 180 mcg QW

Follow-up

HBV Nuc

12 weeks

48 weeks

24 weeks
Lambda is Phase 3 Ready for HDV

CONCURRENCE WITH FDA & EMA ON SINGLE PIVOTAL STUDY

Arm 1
N=100

Arm 2
N=50

Nuc Run-in

Randomization

Lambda 180 mcg QW

Follow-up

12 weeks

48 weeks

24 weeks

No TRx

48 wk
Lambda 180 mcg QW

Follow-up

12 weeks

Primary Endpoint Comparison

Primary Endpoint*

DVR at 24 Weeks Post-TRx versus Placebo at 12 Weeks Post-No TRx

HBV Nuc

*Randomization

*Primary Endpoint Comparison
A WELL TOLERATED INTERFERON FOR COMBINATION

**Primary Endpoint:**
> 2 Log HDV RNA reduction at EOT

**Secondary Endpoint:**
Histological improvement (biopsy confirmed)

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**On-treatment** 24 Weeks

Lambda 180 mcg QW
Lonafarnib 50 mg BID
Ritonavir 100 mg BID

**Post-treatment** 24 Weeks

Follow Up

End of Study Data in 2020

*N=26*
>50% HDV RNA Undetectable / BLQ at Week 24

INTERIM END OF TREATMENT DATA (N=19)

% of Patients Week 24 HDV RNA

<table>
<thead>
<tr>
<th>% of Patients</th>
<th>Week 24 HDV RNA</th>
</tr>
</thead>
<tbody>
<tr>
<td>95%</td>
<td>&gt; 2 Log Decline</td>
</tr>
<tr>
<td>53%</td>
<td>BLQ</td>
</tr>
<tr>
<td>37%</td>
<td>Undetectable</td>
</tr>
</tbody>
</table>

BLQ = below the limit of quantitation
Franchise Delivering Optionality for Patients

- Potential HDV cure and maintenance therapies
- Foundational therapies for future combinations

Lonafarnib/Ritonavir
- ALL ORAL

Lonafarnib/Ritonavir + Lambda
- COMBO

Lambda
- MONOTHERAPY SUB Q
Eiger HDV Treatments: Options and Convenience

All oral or once weekly injection

Phase 3

OTHER HDV INVESTIGATIONAL THERAPY

Lyophilized powder
1-2 injections / dose / day

Phase 3
Lambda for Mild COVID-19 Could Be A Promising Approach

THERAPEUTIC WINDOWS OF INTERVENTION

**Early Infection**
- Treatment of Mild Illness
  - IFNα

**Progressive Infection and Hyperinflammation**
- Treatment of Severe Disease
  - IFNα

**Respiratory Failure**
- SARS-CoV-2
  - Cytokine Storm
    - TNF | IL-1 | IL-6 | MCP-1
  - Neutrophils | Monocytes
  - Cytokines | IFNαβ

**Severity**

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**Severity**
- Mild Symptoms
  - Fever (≤ 38.5 °C)
  - Cough, Running Nose, Headache
- Moderate to Severe Symptoms
  - Pneumonia
  - Shortness of Breath
  - Oxygen Saturation Drop
  - Abnormal Chest Imaging
- Severe Symptoms
  - ARDS
  - Shock
  - Cardiac Dysfunction

**Disease Course (Time)**

Based on Andreakos et al 2020, EMBO Molecular Medicine
Lambda in Covid-19: Investigator Sponsored Studies

EIGER INVOLVED IN PROTOCOL DEVELOPMENT, REGULATORY INTERACTION, AND LAMBDA SUPPLY

- Multiple Institutions / Protocols processing in parallel:
  - Stanford University (Upinder Singh, MD – Palo Alto)
  - Toronto General Hospital (Jordan Feld, MD – Toronto)
  - Mount Sinai (Scott Friedman, MD – NYC)
  - Soroka University (Ohad Etzion, MD – Israel)
  - Mass General Hospital (Raymond Chung, MD – Boston)
  - Johns Hopkins University (Mark Sulkowski, MD – Baltimore)

- ~700 patients to be dosed across sites
- First patients dosed
Progeria: Ultra-rare, Fatal, Premature Aging Pediatric Disease

HUTCHINSON-GILFORD PROGERIA SYNDROME

- Point mutation in the Lamin A gene
  - Results in a farnesylated aberrant protein, Progerin
  - Disruption of scaffold structure of the nuclear membrane
- Accelerated atherosclerosis with cardiovascular decline
- Average lifespan = 14.5 years
- Prevalence of 1 in 20 million (~400 worldwide)
  - 1 child born each year in the US
- No FDA approved Rx
Lonafarnib Improved Survival in Progeria

77% REDUCTION IN RISK OF MORTALITY COMPARED TO NO TREATMENT

Gordon, L et al, JAMA, 2018, 319(16): 1687
Average follow-up period of 2.2 years
Working with Patient Groups Worldwide

FDA Approval Expected 2020

90+ CHILDREN TREATED WITH LONAFARNIB
Progeria Launch Establishes Eiger as a Commercial Stage Company

COMMERCIALIZATION ROADMAP

• Established Managed Access Program (MAP) for Progeria
• Develop market access strategies and patient support programs
• Leverage 2020 Progeria launch for HDV commercialization
• Select core distribution network in the U.S. and Europe
• Identify key specialty pharma partners in the U.S.
Lonafarnib for HDV and Progeria

DISTINCT DISEASES, DISTINCT TREATMENT REGIMENS, DISTINCT COMMERCIAL STRATEGIES

**HDV**

Lonafarnib Boosted with Ritonavir ± Peginterferon-Alfa

**PROGERIA**

Zokinvy (Lonafarnib) capsules 50 mg/75 mg

Lonafarnib Monotherapy (Weight-based)
Impact of COVID-19 on Clinical and Business Operations

CONTINUE TO MONITOR CLOSELY, INCLUDING EFFECTS ON CLINICAL DEVELOPMENT PLANS

• Business Operations
  - Remote operations to maintain safety and well-being of our employees and business continuity
  - Disciplined expense management

• Phase 3 HDV D-LIVR Study
  - Full enrollment anticipated in 2021
  - Prioritizing patient safety and study integrity
  - Enrollment and dosing of patients on-going
  - Adequate clinical drug product supply

• Progeria Commercialization
  - Regulatory reviews of NDA and MAA progressing
  - No anticipated impact to commercial launch, including availability of commercial drug supply

• Lambda COVID-19 Investigator Sponsored Studies
  - First-line immune defense in respiratory infections
  - Strong support from KOLs
  - Six international studies initiating and enrolling
## Late Stage Pipeline: Near-Term Value Creating Catalysts

<table>
<thead>
<tr>
<th>Targeted Indication</th>
<th>Drug</th>
<th>Orphan US / EU</th>
<th>Breakthrough Therapy</th>
<th>Rare Pediatric Disease*</th>
<th>Status</th>
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<tbody>
<tr>
<td><strong>Hepatitis Delta Virus</strong></td>
<td>Lonafarnib + Ritonavir</td>
<td>✔️</td>
<td>✔️</td>
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<td>Phase 3 Enrolling</td>
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<td></td>
<td>Peginterferon Lambda</td>
<td>✔️</td>
<td>✔️</td>
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<td>Phase 3 Ready</td>
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<td><strong>Progeria and Progeroid Laminopathies</strong></td>
<td>Lonafarnib</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>NDA / MAA Submitted</td>
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<td><strong>Post-Bariatric Hypoglycemia</strong></td>
<td>Avexitide</td>
<td>✔️</td>
<td>✔️</td>
<td>N/A</td>
<td>Phase 3 Ready</td>
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<tr>
<td><strong>Congenital Hyperinsulinism</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Phase 2</td>
</tr>
</tbody>
</table>

* PRV Eligible Upon Approval
Post-Bariatric Hypoglycemia (PBH)

**COMPLICATION OF BARIATRIC SURGERY FOR MORBID OBESITY**

- Dangerously low blood sugar after meals
- Impacts ~10% of Roux-en-Y (RYGB) patients and ~2.5% of Sleeve Gastrectomy (SG) patients

**PREVALENCE**

~120K in U.S. | ~30K in EU

No approved therapy

*American Society for Metabolic and Bariatric Surgery 2015

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**AVEXITIDE**

Phase 2 Primary Endpoint Achieved
Improved Postprandial Glucose Nadir

- Phase 3 Ready

- Glucose (mg/dL)
- Placebo: 47.1
- 30 mg BID: 57.1
- 60 mg QD: 59.2

- P=0.0002
- P=0.0011

**Phase 3 Ready**
Congenital Hyperinsulinism (CHI)

**ULTRARARE PEDIATRIC METABOLIC DISORDER**

- Most frequent cause of persistent hypoglycemia in neonates and children
- Occurs in **1:25,000** to **1:50,000** live births
- Characterized by fasting and protein-induced hypoglycemia

Results in **PERMANENT BRAIN DAMAGE** with neurodevelopmental deficits in up to 50% of patients

Near-total pancreatectomy is often indicated and leads to **life-long insulin-dependent diabetes (IDDM)**

**AVEXITIDE**

Reduced Mean Glucose Infusion Rate (n=4 infants)
## Experienced Management Team

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Company Logos</th>
</tr>
</thead>
<tbody>
<tr>
<td>DAVID CORY, RPH, MBA</td>
<td>Business Founder, President, Chief Executive Officer</td>
<td>gsk, INTERMUNE, Prestwick Pharmaceuticals, COTHERIX</td>
</tr>
<tr>
<td>SRI RYALI, MBA</td>
<td>Chief Financial Officer</td>
<td>aimune, Jazz Pharmaceuticals, ONYX, AMGEN</td>
</tr>
<tr>
<td>STEPHANA PATTON, PHD, JD</td>
<td>General Counsel, Corporate Secretary, Chief Compliance Officer</td>
<td>Salix, biodelivery, BIOTIME</td>
</tr>
<tr>
<td>ELDON MAYER, MBA</td>
<td>Executive Vice President, Chief Commercial Officer</td>
<td>Rigel, QUESTCOR</td>
</tr>
<tr>
<td>JIM SHAFFER, MBA</td>
<td>Chief Business Officer</td>
<td>Schering-Plough</td>
</tr>
<tr>
<td>INGRID CHOONG, PHD</td>
<td>Senior Vice President, Clinical Development</td>
<td>sunesis, Berkeley, Stanford Medicine</td>
</tr>
</tbody>
</table>
Leader in HDV
Late stage pipeline with 1st in class therapies
Strong clinical data
Large commercial market (HDV)
Progeria approval expected with PRV
$78M cash & investments as of 3/31/20