EDISON

SynAct Pharma

Differentiated inflammation resolution approach

Initiation of coverage

Pharma and biotech

28 October 2025

SynAct Pharma is focused on inflammation resolution therapeutics. Its lead asset, resomelagon, is differentiated by its novel mechanism, targeting specific melanocortin receptor subtypes believed to have direct effects on the immune system. The main target indication in the chronic inflammation and autoimmune space is rheumatoid arthritis (RA); the most significant upcoming catalyst will be the results from the ongoing Phase IIb ADVANCE trial (expected in Q126). Beyond the lead programme, other opportunities are being pursued in acute inflammation, with a focus on host-directed therapy for viral infections, providing an expandable opportunity for resomelagon. The current pro forma cash position of SEK104.3m (bolstered by a directed share issue and conversion of warrants) should provide operational headroom to 2027, past key upcoming milestones. We initiate coverage with a valuation of SEK1.97bn or SEK36.9 per share.

Year end	Revenue (SEKm)	PBT (SEKm)	EPS (SEK)	DPS (SEK)	P/E (x)	Yield (%)
12/23	0.0	(149.7)	(4.34)	0.00	N/A	N/A
12/24	0.0	(90.8)	(2.08)	0.00	N/A	N/A
12/25e	0.0	(118.3)	(2.15)	0.00	N/A	N/A
12/26e	0.0	(56.4)	(0.90)	0.00	N/A	N/A

Note: PBT and EPS are normalised, excluding amortisation of acquired intangibles, exceptional items and share-based payments.

Main opportunity lies in chronic inflammation

The primary target indication for resomelagon is in RA. Backed by promising data from the Phase IIa BEGIN trial and a sub-set of patients in the Phase IIb EXPAND trial, SynAct is now assessing resomelagon in the Phase IIb ADVANCE trial as a combination treatment with standard-of-care methotrexate, seeking to confirm its potential effectiveness in newly diagnosed RA patients with moderate-to-high disease activity. Topline results, anticipated by end-Q126, represent an important upcoming inflection point.

Backed by a novel mechanism of action

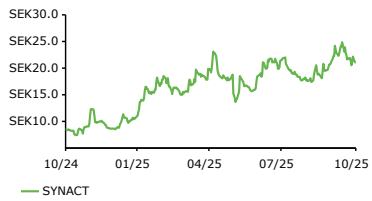
Resomelagon is designed to be a once-daily oral treatment. It selectively targets melanocortin receptors 1 and 3. Stimulation of these receptors simultaneously reduces the release of pro-inflammatory cytokines and promotes pro-resolution pathways, restoring balance to the immune system, rather than suppressing it. To our knowledge, this represents a novel mechanism, and we highlight that an opportunity exists beyond RA, with the second development track focused on the host-directed therapy space for hyperinflammation caused by viral infections.

Valuation: SEK1.97bn or SEK36.9 per share

We value SynAct across four programmes (first-line RA, flares in RA, viral infections and polymyalgia rheumatica), although the investment case currently rests on the most clinically advanced programme, first-line RA. We assume a 30% PoS, a 2031 launch and peak sales of c $2.3bn for first-line RA (c 80% of our overall valuation). We estimate gross cash of SEK68.9m at end-H125, another SEK35.4m from warrant conversion and a SEK30m committed loan should be sufficient to fund operations into 2027. We model a partnership agreement for resomelagon in 2027.

Price	**SEK22.20**
Market cap	**SEK1,141m**
	SEK9.42/US$
Pro forma net cash as of 30 June 2025	SEK104.3m
Shares in issue	53.3m
Code	SYNACT
Primary exchange	OMX
Secondary exchange	N/A

Share price performance



%	1m	3m	12m
Abs	5.4	7.2	144.0
52-week high/low		SEK25.3	SEK7.3

Business description

SynAct Pharma is a clinical-stage biotechnology company focused on the development of treatments to resolve, rather than inhibit, ongoing inflammatory processes in acute and chronic diseases.

Next events

PMR Phase IIa trial launch	Q425
RESOVIR-2 Phase II dengue trial completion	Q226
ADVANCE Phase IIb RA trial results	Q126

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Investment summary

Company description: Resolving inflammation via melanocortin modulation

SynAct is a clinical-stage biotech, based in Sweden and Denmark, developing novel treatments to promote inflammation resolution. It was listed on the Spotlight Stock Market from 2016, before moving to Nasdaq Stockholm in July 2022. Its pipeline comprises one clinical-stage drug candidate and one preclinical candidate. Lead asset resomelagon is an oral small molecule, selectively targeting melanocortin receptors 1 and 3. When these receptors are activated, this is believed to provide direct anti-inflammatory effects, resolving inflammation without suppressing the immune system. The development strategy for resomelagon involves two key clinical tracks, being pursued in parallel. The first is focused on the chronic inflammation and autoimmune space, aiming to position the drug candidate as a safe, effective and convenient treatment option for RA, to be used in combination with methotrexate in the first-line setting. Prior clinical data have highlighted an opportunity for newly diagnosed RA patients. It is currently being tested in the Phase IIb ADVANCE trial, aiming to confirm the potential of resomelagon in this RA patient population, and potentially identifying clinically relevant doses to be considered for a future Phase III programme. Topline results are expected by end-Q126, representing SynAct's most significant upcoming inflection point, in our view. The second development track is in the host-directed therapy space for viral infections. Backed by promising data in COVID-19, SynAct is exploring resomelagon in dengue fever, with potential to expand to a broader range of respiratory infection settings. SynAct's preclinical candidate is TXP-11, a peptide-based melanocortin modulator (designed for intravenous administration) with potential for improved efficacy and safety compared to resomelagon. Management envisions its use in hospital patients at risk of developing organ- or life-threatening hyperinflammation; it is anticipated to enter the clinic in 2026.

Financials: Operational headroom into 2027, past near-term milestones

As a clinical-stage biotechnology company, SynAct Pharma remains pre-revenue, with operations funded primarily through external capital raises. Since its IPO in 2016, we estimate SynAct has raised over SEK700m to support ongoing R&D, including c SEK90m to date in 2025 (comprising a SEK37m directed issue, a SEK20m rights issue and SEK35.4m from warrant conversions in H225). The company reported an end-H125 cash balance of SEK68.9m, which, together with post-period warrant proceeds, implies a pro forma net cash position of SEK104.3m. Based on our projected cash burn of c SEK100m through H225 and FY26, we estimate SynAct is funded into FY27, comfortably covering the expected Phase IIb ADVANCE trial readout and other near-term clinical milestones.

Valuation: rNPV of SEK36.9/share, indicating value to be unlocked

We value SynAct at SEK1.97bn (SEK36.9/share) based on a risk-adjusted net present value (rNPV) model applying a 12.5% discount rate. Our valuation captures contributions from resomelagon across first-line RA, flares in RA, viral infections and polymyalgia rheumatica (PMR). First-line RA remains the core value driver, contributing c 80% (SEK 29.8/share) of our total valuation, followed by RA flares (c 15%), respiratory viral infections (5%) and PMR (1%). While SynAct has another asset, TXP-11, under development, it is currently in pre-clinical stage and we therefore exclude it from our valuation currently. Our model also incorporates the latest pro forma cash balance and assumes a 2027 partnering transaction for resomelagon, with a blended royalty rate of 20% on future sales.

Sensitivities: Typical for biotechs – clinical execution and partnering risks

SynAct is subject to typical biotech risks, including clinical trial setbacks, regulatory uncertainties and funding challenges. Company-specific risks include clinical-stage activities resting on one drug candidate, with the lead programme's trial design stemming from post-hoc analyses of data from a prior Phase IIb study, carrying some risk (that identified trends may not be reproduced in a prospective study). While proof-of-concept has been established in various indications, its progression to late-stage development rests on confirming efficacy in larger, randomised, placebo-controlled trials, such as the ADVANCE study. Further, the lead programme targets RA, a competitive space with numerous treatment options available, and SynAct will need to offer differentiation to garner notable market share. SynAct faces an extended time to market before generating recurring revenue, meaning it is reliant on external financing sources, heightening execution, funding and dilution risks. Management is seeking partnership opportunities for subsequent development activities and potential commercialisation. While such arrangements could significantly reduce its financing and commercial risks, the timing and monetary value of such a partnership is challenging to predict.

Pipeline targeting both chronic and acute inflammatory conditions

SynAct's clinical development pipeline centres on treating inflammation through resolution, backed by the company's experience and capabilities in melanocortin receptor biology (Exhibit 1). The pipeline is spearheaded by lead asset resomelagon (formerly AP1189). Resomelagon is a small molecule drug candidate, designed to selectively stimulate melanocortin receptors 1 and 3 (MC1R and MC3R) within target cells in the immune system, which are believed to be directly involved in inflammation and its resolution. SynAct's most advanced programme is assessing resomelagon as a potential treatment for RA, more specifically, targeting newly diagnosed patients. It is currently being evaluated in the Phase IIb ADVANCE clinical trial. Patient enrolment has been progressing according to plan, and is on track to be complete by end-2025, and the announcement of topline results, expected in Q126, represents the most significant upcoming catalyst, in our view. Also in the chronic inflammation space, resomelagon is being tested in PMR, a condition characterised by pain, stiffness and inflammation in the muscles around the shoulders, neck and hips. A Phase IIa investigator-initiated trial is expected to launch in H225.

Beyond RA and PMR, SynAct is exploring the potential application of resomelagon as a host-directed treatment in viral infections, based on the candidate's ability to address viral-induced acute hyperinflammatory responses. This has been supported by the prior clinical study RESOVIR-1 in COVID-19 patients, alongside additional preclinical research. It is now being assessed in the Phase IIa RESOVIR-2 trial, aiming to address hyperinflammation in patients with dengue fever. While the clinical portion of the study awaits the next seasonal disease period in Brazil (expected in Q126), we note that SynAct may consider alternative indications characterised by hyperinflammatory responses in viral infections, where resomelagon's mechanism of action may also be applicable; we await further details on this front.

The remaining programme for resomelagon is in idiopathic membranous nephropathy (IMN), a rare disease associated with the development of proteinuria and nephrotic syndrome. While a Phase IIa trial had been ongoing, we understand that the pace of recruitment had been very slow, and hence, we understand that the programme may not extend past its current stage. Nevertheless, we view SynAct's expandable pipeline for resomelagon favourably, offering some diversity in terms of the indications that may be targeted, broadly focused on two main channels: the chronic inflammation and autoimmune space (such as RA), and viral conditions associated with acute inflammation.

SynAct's second asset is TXP-11, a peptide drug candidate that has been designed to selectively target MC1R and MC3R. Management believes that its intravenous administration approach may have applications in complicated medical conditions, such as preventing organ failure during surgery, whereby patients are hospitalised and face risk of developing organ- and/or life-threatening hyperinflammation. It is currently in the preclinical stages of development, and on track to commence first in-human studies from 2026.

Exhibit 1: SynAct Pharma's clinical development pipeline

Source: SynAct Q225 report

Addressing unmet needs in inflammation & autoimmune diseases

Rheumatoid arthritis: A chronic, progressive condition

RA is a chronic, progressive, systemic autoimmune disease. Unlike osteoarthritis, which arises from wear and tear, RA is caused by the immune system erroneously targeting and attacking healthy parts of the body, such as its cells and tissues, as if they were aberrant, triggering persistent inflammation. This affects the lining of joints, causing painful swelling that leads to the erosion of cartilage and bone, and ultimately joint destruction, deformity and disability. While over time, the condition can also affect other parts of the body, such as the lungs, eyes, skin and cardiovascular system, initially, it will typically present as symmetrical joint pain, stiffness and swelling, mainly affecting hands, wrists and feet.

The burden of RA is substantial, both medically and from an economical perspective, and we highlight that delays in diagnosis or access to treatment can exacerbate these effects in the long term. In 2019, it was estimated that RA affects 18 million people worldwide, though some studies estimate it has a prevalence upward of 1% in developed countries. It affects women more than men (ratio of around 3:1), and peak incidence is in people aged above 55 years old. The disease has a significant impact on quality of life through pain, lack of mobility and loss of independence, all of which contribute to a reduced ability to work. Many patients are forced to leave the workforce early or reduce their hours due to disability. As a knock-on effect of this, healthcare costs are driven by the need for chronic pharmacotherapies, surgical interventions and long-term supportive care. In developed healthcare systems, targeted synthetic and biologic disease-modifying anti-rheumatic drugs (DMARDs) have transformed outcomes for many patients. However, access remains uneven, and some patients have inadequate responses, responses that are not durable or intolerances to current available treatment options. This creates an ongoing need for new agents that offer improved efficacy, safety and convenience. We highlight that there are currently no curative treatment options for RA.

The number of RA cases is expected to rise significantly in years to come, driven by population growth, ageing demographics and lifestyle factors. It has been estimated that global cases may reach c 30 million by 2050. As such, while the RA treatment market was valued at c $26bn in 2024, it is projected to reach c $41bn by 2033, corresponding to a sizeable compound annual growth rate of 5.6%.

The current RA treatment landscape and limitations

Upon diagnosis with RA, initial management of the condition centres on a conventional synthetic DMARD. Methotrexate is usually the anchor therapy, sometimes with the use of glucocorticoids (a class of corticosteroid) as a bridge to establish disease control, while patients wait for methotrexate to take effect. If disease activity persists after an adequate trial of methotrexate at optimised doses, often alongside folate supplementation (used to try and help manage the side effects associated with methotrexate, particularly at higher doses), clinicians typically add or switch to advanced therapies, taking more of a treat-to-target approach (a proactive management approach that involves setting pre-defined goals, such as remission or low disease activity, and regularly monitoring progress toward those goals). This may include the addition of a biologic DMARD, of which there are many sub-categories:

- TNF inhibitors (eg adalimumab, etanercept, infliximab). Note that adalimumab is the generic name for AbbVie's blockbuster Humira, which has been one of the world's best-selling drugs.
- IL-6 pathway inhibitors (eg, tocilizumab, sarilumab).
- T-cell activation blockers (eg, abatacept).
- B-cell depleters (eg, rituximab).

Other targeted synthetic DMARDs are also widely used, such as Janus kinase (JAK) inhibitors (eg, tofacitinib, baricitinib, upadacitinib, filgotinib). Combination therapy is a common strategy in RA, so various combinations of the above may be tried, in an aim to reach management goals. Notably, many biologics and JAK inhibitors often show better durability and efficacy when used with background methotrexate, due to reduced anti-drug antibody formation and through complementary anti-inflammatory mechanisms. However, despite showing potent efficacy and rapid disease control, the benefit-risk ratio of biologic DMARDs and JAK inhibitors has not been shown to be favourable enough to replace csDMARDs as initial therapy in most patients. While biologics parenteral administration limits convenience and can be associated with treatment resistance, as well as malignancy signals, currently approved JAK inhibitors come with black-box warnings around thromboembolic events. This limits their usage to later lines of treatment.

Unfortunately, despite treat-to-target approaches improving outcomes for some patients, many do not achieve sustained remission or even a lowering in disease activity. Patients often cycle through multiple types of the aforementioned treatments, all of which carry the risk of side effects and complications, but face diminishing returns over the long term, with incomplete disease control still leading to progressive joint damage. RA is characterised as difficult-to-treat once a patient has failed to achieve disease control after treatment with at least two targeted agents with different mechanisms.

In our view, the investment thesis for new early-RA treatments rests on altering the trajectory of the disease, rather than chasing control after chronicity has been established, as suggested in multiple studies. There is a narrow therapeutic window in the first few months after the onset of symptoms where prompt modulation of the exacerbated inflammatory activity can minimise disease progression. Current practice still sees delays from symptoms to definitive diagnoses, and hence, delays for the initiation of treatment (often methotrexate) and subsequent escalation (if needed), heightening the risk of difficult-to-treat disease later on. Even with early methotrexate, many patients do not achieve sustained remission. As a result, patients and clinicians desire treatments that deliver rapid onset (on the scale of weeks, rather than months), as they seek higher rates of remission, steroid independence and the possibility of durable disease modification (often defined by the maintenance of remission after dose reduction or withdrawal). Novel efficacious agents that can be deployed upfront in the early stages of the RA treatment regimen, with favourable safety profiles, would address a clear and valuable gap.

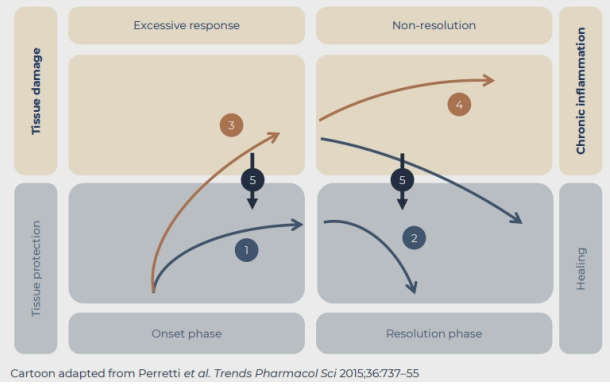
Resomelagon: A first-in-class inflammation resolution therapy

Novel mechanism of action through biased melancortin receptor stimulation

Resomelagon is intended to be a once-daily oral treatment. It has, to our knowledge, a novel mechanism of action as a selective melanocortin agonist, designed to resolve inflammation by targeting key cells within the immune system. Importantly, resomelagon (and the peptide candidate TXP-11) specifically stimulate the receptor subtypes MC1R and MC3R. This is believed to both lead to anti-inflammatory activity (by reducing the release of pro-inflammatory cytokines), and promote pro-resolution pathways (by increasing efferocytosis in macrophages, meaning that ‘dead’ cells in the body are more effectively ‘buried’). We highlight that there are five different types of melanocortin receptors. MC4R is mainly found in the central nervous system, playing a role in the regulation of food metabolism, ultimately regulating appetite. MC5R is expressed in only some subtypes of immune-active cells, such as in the eye, though it plays a role in various physiological processes. MC2R is primarily found in adrenal glands, and is involved in the production of the stress hormone cortisol. It is particularly important that resomelagon does not stimulate MC2R, since the overproduction of cortisol would lead to significant side effects and tolerability issues.

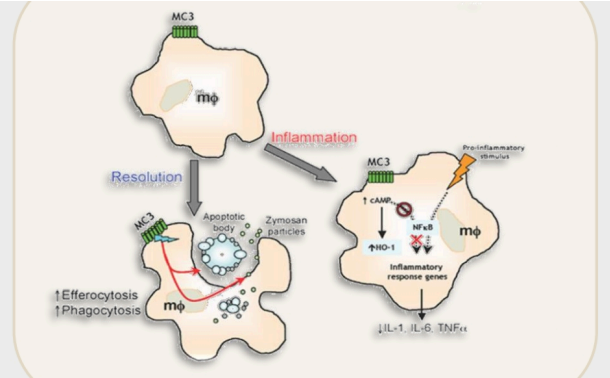
In summary, the design of resomelagon to selectively stimulate MC1R and MC3R supports its application as a drug candidate that management expects will promote the resolution of inflammation, rather than being an immunosuppressant like many current treatment options in inflammation (Exhibit 2 and Exhibit 3). In Exhibit 2, the labels 1 and 2 refer to a typical physiological immune response whereby inflammation is effectively controlled to safely promote healing, and the labels 3 and 4 refer to pathological immune responses whereby failure to achieve resolution can lead to chronic inflammation. Label 5 describes the intended action of resomelagon which has been designed to activate the immune system to limit inflammatory responses and promote endogenous resolution pathways, ultimately aiming to restore tissues and their functions.

Exhibit 2: Resomelagon promotes resolution of inflammation



Source: SynAct

Exhibit 3: Resomelagon's mechanism of action



Source: SynAct

In preclinical research (using mice models), the drug candidate has been shown to induce anti-inflammation by preventing the accumulation of neutrophils and lowering levels of pro-inflammatory cytokines. The research also showed that in ongoing cases of inflammation, resomelagon treatment was associated with the rapid clearance of neutrophils, by efferocytosis in macrophages. Early clinical studies (AP1189-CS001 and AP1189-CS004) identified that once-daily dosing could achieve target efficacy levels which may be achieved without increasing the risk of receptor desensitisation and tachyphylaxis (the appearance of a progressive decrease in response to a given dose following repeat administrations). In addition, these early tests in humans showed that the drug candidate was well tolerated, with no signs of immunosuppression or dose-limiting adverse events. Overall, the preclinical and early clinical data were supportive of resomelagon as a potential treatment for inflammatory conditions.

Clinical development progress: BEGIN (Phase IIa) and EXPAND (Phase IIb)

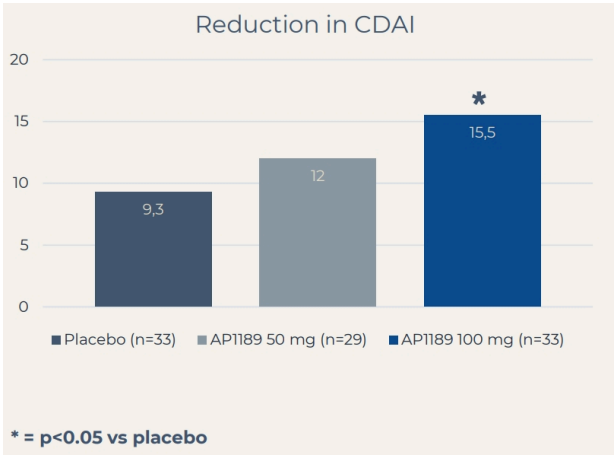
SynAct has conducted various Phase II clinical studies exploring the potential of resomelagon in RA.

The Phase IIa BEGIN trial was a double-blinded, multi-centre, two-part, randomised, placebo-controlled study to investigate the efficacy, safety and tolerability of resomelagon (at two doses, 50mg and 100mg, administered once daily) in addition to methotrexate in early RA patients with active disease. The primary endpoint measure was based on reduction in disease activity from high (defined by a clinical disease activity index (CDAI) score >22) to moderate or low activity, across the four-week treatment duration.

The BEGIN study concluded in late-2021, showing favourable safety and tolerability outcomes. In terms of the primary efficacy results based on CDAI changes, the data demonstrated dose-dependent responses across the 50mg and 100mg doses of resomelagon. The 100mg dose group showed a statistically significant greater mean reduction in CDAI across the trial duration relative to the placebo group (mean reduction in CDAI – resomelagon 100mg (n=33): 15.5 points; placebo (n=30): 9.3 points; p=0.0394). The 50mg dose (n=29) group showed a 12 point reduction, which, although trended towards a more favourable outcome compared to placebo, was not statistically significant (Exhibit 4). Furthermore, the number of patients going from severe to moderate disease (defined by a CDAI score ≤22) were 62%, 52% and 40% for resomelagon 50mg, 100mg and placebo, respectively, highlighting the potential of resomelagon to provide favourable outcomes for RA patients.

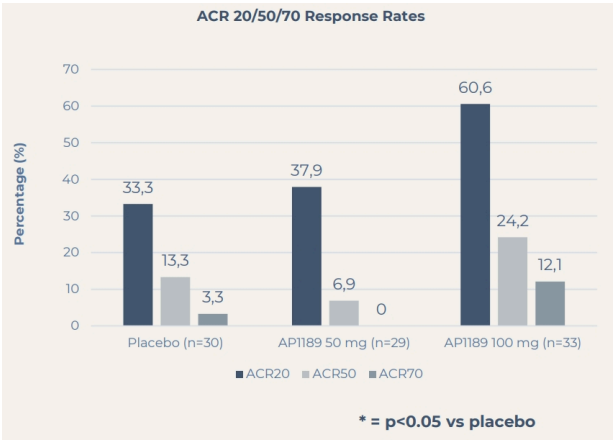
The study also measured American College of Rheumatology (ACR) response rates, to assess reductions in swollen and tender joint counts (alongside some additional RA criteria). The data showed that the 100mg resomelagon treatment group exhibited a significantly higher portion of patients achieving ACR20 (indicating at least a 20% reduction in swollen and tender joint counts, alongside 20% improvements in the additional criteria) compared to the placebo group (ACR20 – resomelagon 100mg (n=33): 60.6%; placebo (n=30): 33.3%; p=0.0437) after the four weeks of treatment. Again, each of the ACR 20/50/70 response rates were found to be dose-dependent, providing real evidence of the effect of the drug candidate and supporting its proposed mechanism of action (Exhibit 5). Despite the positive trend, statistical significance was not observed for the 100mg arm, versus placebo, in ACR 50/70.

Exhibit 4: CDAI results from BEGIN



Source: SynAct

Exhibit 5: ACR response rates from BEGIN



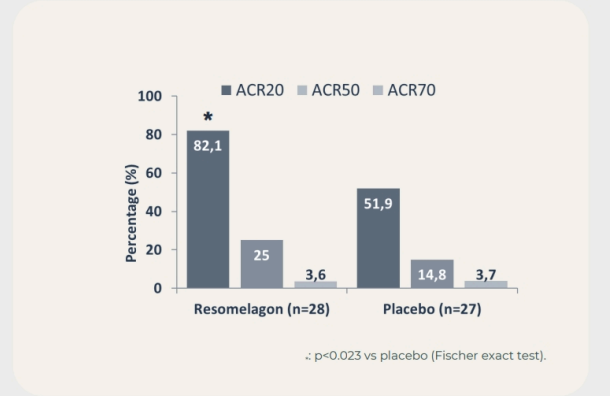
Source: SynAct

The Phase IIb EXPAND trial was a double-blinded, multi-centre, randomised, placebo-controlled study to evaluate the efficacy and safety of resomelagon (at 100mg, administered once daily) in early RA patients with high disease activity (again, CDAI >22), specifically who were naive to DMARD treatment (this was not specified in BEGIN). In the EXPAND study, 120 patients were randomised to either resomelagon treatment or placebo, in combination with methotrexate, but for a treatment duration of 12 weeks (versus four weeks in BEGIN).

Topline results for this trial were presented in September 2023. As with prior clinical research, resomelagon was found to be safe and well tolerated, showing treatment-emergent adverse event outcomes comparable to that of the placebo group. Efficacy measures were based on ACR response rates, alongside changes in CDAI scores and other RA disease activity measures. Disappointingly, there was no statistically significant difference observed between the resomelagon and placebo groups in terms of the ACR20 response rates at week 12 (54.7% and 55.7%, respectively). However, a more detailed analysis of the patient data revealed that a portion of the participants included (c 39% of the patients) did not show signs of systemic inflammation (characterised by high-sensitive C-reactive protein (CRP) measures), and a fraction of patients was diagnosed only after significant disease progression, whereby some had not had adequate treatment for years prior to the study. Management noted that, in hindsight, these patients should not have been included in this trial.

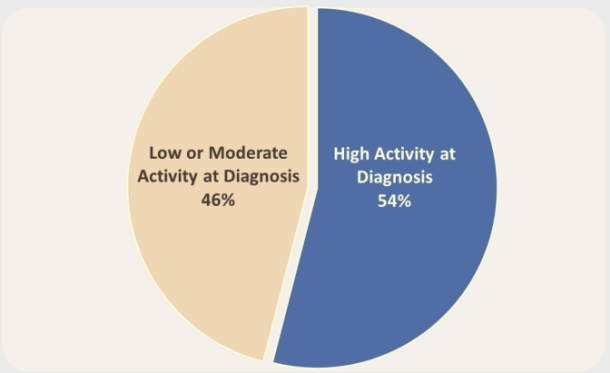
Upon inspection of the subset of patients who were considered to be newly diagnosed (ie, RA diagnosis received within six months of the trial) and those who did show signs of systemic inflammation (through elevated blood CRP levels), the ACR20 response rate was reported as 82% in the resomelagon group (n=28) compared to 52% in the placebo group (n=27), representing a statistically significant benefit (p=0.023), albeit in a smaller patient population than intended (Exhibit 6). We highlight that, while these encouraging data identified through post-hoc analyses were taken from just a specific subset of patients, this does correspond to the highly relevant patient segment that experiences high disease activity upon recent diagnosis, reflecting over half of the overall patient population (Exhibit 7). We also note that the relevant patient population from EXPAND closely matches the patient population from BEGIN (newly diagnosed RA patients), with resomelagon's potential also reflected in CDAI measures from EXPAND: resomelagon (n=28): 24.6 points; placebo (n=27): 14.7 points; p<0.01. The findings and conclusions from the BEGIN and EXPAND studies led to the design of the current ongoing ADVANCE trial. As mentioned above, we highlight here that a key sensitivity lies around the use of post-hoc analyses. Since the positive data from EXPAND relate to only a post-hoc defined portion of the total trial population, the outcome from ADVANCE will be crucial in confirming the potential in a prospectively-designed trial in this subpopulation.

Exhibit 6: ACR response rates in the selected subset of patients from EXPAND



Source: SynAct

Exhibit 7: Portions of RA patients classified as having high disease activity upon diagnosis



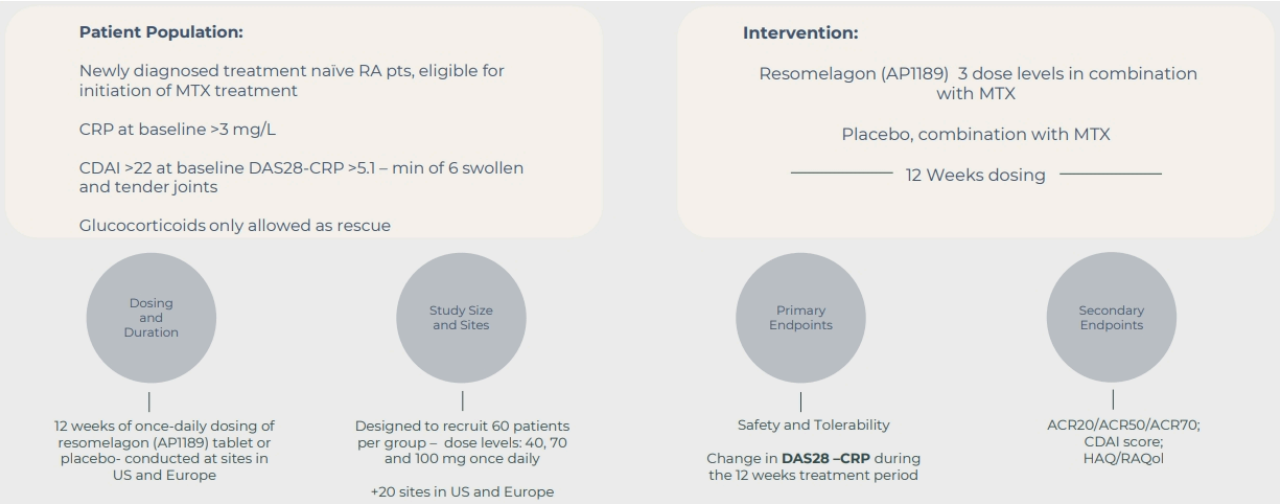
Source: SynAct

Ongoing: ADVANCE Phase IIb trial

The Phase IIb ADVANCE trial is double blinded and placebo controlled, and has been designed to include a 12-week treatment duration, specifically focused on newly diagnosed and treatment naive RA patients (as with EXPAND) with high disease activity (including signs of systemic inflammation, defined by elevated levels of CRP at baseline, the target subpopulation of the post-hoc analyses from EXPAND) who are eligible for methotrexate treatment (Exhibit 8). The trial aims to recruit a total of 240 patients, who will be randomised to either placebo or one of three doses of resomelagon (40mg, 70mg or 100mg) to be administered daily as part of a combination treatment regime with methotrexate. The primary endpoint will be based on DAS28-CRP measures (which provide disease activity scores to describe the severity of RA using clinical and laboratory data, specifically looking at CRP), alongside safety and tolerability. The choice of DAS-28-CRP as primary endpoint is in line with the FDA's guidelines for efficacy readout parameters in Phase II dose-ranging studies. ACR response rates and CDAI scores are included as secondary endpoint measures. A key objective of ADVANCE is to confirm the results seen in BEGIN and the subset of patients in EXPAND, but in a larger patient population, while also identifying clinically relevant doses of resomelagon to be considered for a future Phase III programme. ADVANCE commenced in September 2024, and has been running since then at over 30 sites across the US and Europe.

Management expects patient recruitment for ADVANCE to be complete by end-2025, with top-line results guided for Q126. In our view, this upcoming readout represents the most significant upcoming inflection point for SynAct, as it will confirm the potential of resomelagon in this RA patient population. Ultimately, if successful, management believes that resomelagon could be a safe, effective and convenient treatment option to be used in combination with methotrexate in the first-line setting for newly diagnosed RA patients, helping with disease control and reducing dependence on glucocorticoids, while preventing the necessity for second-line treatments. We also understand that it may be applicable beyond the first-line setting as an alternative to corticosteroids following flare-ups, though we await further clarification on this front.

Exhibit 8: Design of the ongoing Phase IIb ADVANCE trial



Source: SynAct

The competitive landscape in RA

Looking at the competitive landscape for emerging RA treatments, we see a range of approaches, reflecting both the substantial unmet need in the space, as well as the potentially considerable commercial opportunity, with approximately 80 distinct therapeutic candidates in Phase II or Phase III clinical programmes. While there are already a range of treatment options available (as discussed above), the current pipeline represents a shift from traditional DMARDs to more sophisticated targeted approaches, ultimately seeking superior efficacy and/or improved safety profiles. We present below some examples of approaches that appear to have some traction:

- **Bruton's tyrosine kinase (BTK) inhibitors:** BTK inhibitors modulate B-cell proliferation, preventing abnormal B-cells from dividing and killing aberrant B-cells. While these have been approved for various haematological malignancies, there are currently no FDA-approved BTK inhibitors specifically for RA. Some big pharma companies have explored their potential in the indication. For example, Roche's fenebrutinib showed promise in a Phase II programme in RA, although Roche has since prioritised multiple sclerosis as the target indication for the candidate. Note: we have recently seen two notable BTK inhibitor approvals, Sanofi's rilzabrutinib (brand name: Wayrilz) for immune thrombocytopenia and Novartis's remibrutinib (brand name: Rhapsido) for chronic spontaneous urticaria. These highlight the entrance of BTK inhibitors into the autoimmune space, which may spur some renewed interest in their use in conditions like RA.
- **Next-generation T-cell depleters:** AnaptysBio is developing rosnilimab, a pathogenic T-cell depleter that can be administered via subcutaneous injection or intravenous infusion. The candidate completed a Phase IIb trial in February 2025, presenting encouraging response rates, some of the highest seen in recent RA clinical trials, positioning it as a potentially transformative therapy for the condition.

Our key take-away is that the closest next-generation competitors to SynAct's lead drug candidate will be small molecule BTK inhibitors, as they allow for the convenience of oral administration. While AnaptysBio's candidate is promising, resomelagon's differentiating factor will likely be its convenience (the full extent of its efficacy is yet to be confirmed). However, there are few active late-stage programmes from big pharma at present, creating headroom for SynAct to differentiate with resomelagon, should the clinical data confirm its efficacy and favourable safety profile.

Polymyalgia rheumatica: A glucocorticoid-dependent condition

Like RA, PMR is a chronic inflammatory rheumatic condition that affects older adults (almost exclusively affecting individuals over 50 years of age and primarily women) and is considered the second-most common inflammatory rheumatic disease in this population, after RA. It is characterised by aching pain and pronounced stiffness in the shoulders and hips. Symptoms are typically bilateral (occurring on both sides of the body), and most prominent in the morning, or after extended periods of inactivity. The mainstay therapy for PMR involves glucocorticoids. Once initial symptoms are considered to be controlled and inflammatory markers appear normalised, a structured taper is used to

minimise excessive steroid exposure. Relapses are managed by stepping back to the last effective dose, then resuming a slower taper.

Steroid dependency and toxicity represent a central challenge within the current PMR treatment landscape. Many patients relapse during tapering, leading to prolonged courses and high cumulative exposure. Long-term glucocorticoids carry well-recognised risks that are particularly relevant in older adults. These include fractures due to osteoporosis, worsening diabetes, hypertension, weight gain, cataracts, glaucoma, skin bruising and increased susceptibility to infection. Balancing symptom control against these risks is difficult, and adherence to tapering schedules is inconsistent.

We believe that the unmet need in this space is clear. Patients would benefit from therapies that control symptoms quickly, preventing relapse, and enabling timely steroid tapers with lower burdens from associated side effects. Agents that modulate key inflammatory pathways implicated in PMR and that demonstrate reduction in cumulative steroid doses, relapse rates and patient reported pain and stiffness would be considered clinically meaningful. In terms of clinical development paths, endpoints that resonate with practice include: time to sustained remission; proportion of patients achieving low dose or steroid-free status; reduction in flare frequency; and improvements in function and quality of life. The competitive landscape in PMR is evolving with several biologics and JAK inhibitors under clinical development. Kevzara (sarilumab), Sanofi/Regenron's IL-6 inhibitor, was approved by the FDA in February 2023 and, more recently, Novartis has reported that its IL-17A inhibitor Cosentyx (secukinumab) has met the primary and secondary endpoints in the Phase III REPLENISH trial in PMR, paving the way for a potential approval.

A potential expandable application of resomelagon

As part of SynAct's redefined strategy for resomelagon (announced in June 2025), it is now exploring the potential application of the drug candidate in PMR. This came about following observations of resomelagon being most effective as an early intervention treatment for chronic inflammatory and autoimmune conditions. As such, SynAct entered into a clinical collaboration with established Nordic rheumatologists, aiming to evaluate the potential of resomelagon to reduce the dependence on glucocorticoids in PMR. A Phase IIa investigator-initiated clinical programme based in Denmark is on track to be launched by end-2025, whereby the drug candidate will be evaluated, compared to placebo, following oral administration once daily in PMR patients for a treatment duration of three months, post tapering of glucocorticoids. The PMR study has been agreed between the investigator and SynAct as a part of a long-term collaboration initiated with the BEGIN study in RA.

While we recognise this as a possible expandable application of SynAct's lead asset, we also acknowledge that this programme will involve investigator-initiated clinical studies. As such, SynAct will have limited control over how the programme runs. Regardless, the clinical insights could enhance resomelagon's data package, potentially making it more attractive to prospective partners, if the outcomes are supportive.

Viral infections: Host-directed therapy opportunity

The hidden battle: When the body's defence system becomes the enemy

Beyond the programmes in chronic inflammation, the second development track that SynAct is investigating for resomelagon is in the acute host-directed therapy space for viral infections. In extreme cases, some patients suffering with certain types of viral infections can experience hyperinflammation, that is, a dysregulated immune response characterised by uncontrolled inflammation of tissues and organs, which can ultimately lead to dysfunction disproportionate to the viral burden. Host-directed therapies aim to target the maladaptive pathways, rather than the pathogen(s). The objective is to specifically target the inflammation, and restore homeostasis, without preventing control of the viral infection itself. The rationale for SynAct's focus on this space stems from the potential of the lead drug candidate to address viral-induced hyperinflammation through its mechanism of action, designed to promote resolution, rather than broad immunosuppression, which would impair the body's ability to fight infection.

Since host-directed therapies target patient responses to viral infections, the approach is agnostic with respect to the specific virus causing the hyperinflammation, representing potential investment appeal as it is not limited to specific pathogens. As such, resomelagon holds promise in a range of viral infection types, ranging from COVID-19 (a viral infection associated with severe impact of the lungs) to arboviral infections (those caused by infection from mosquito bites, which can lead to more systemic effects), as seen in SynAct's clinical development strategy to date. In our view, as new viral challenges persist globally, host-directed therapies that could address the common pathway of hyperinflammation may offer more durable and versatile treatment options than pathogen-specific approaches alone.

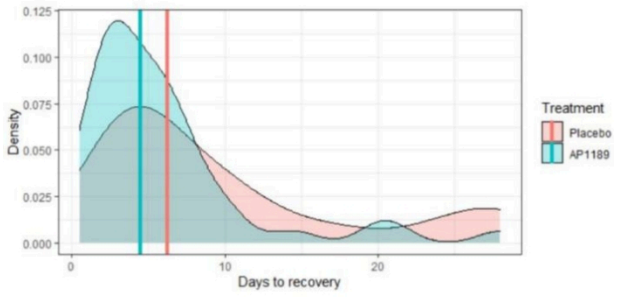
SynAct is sponsoring, and is engaged in, the strategic RESOVIR collaboration focused on viral inflammation research. This is a scientific and clinical collaboration between: Professor Mauro Teixeira, MD, PhD, Universidade Federal de Minas, Belo Horizonte, Brazil; Professor Mauro Perretti, PhD, William Harvey Research Institute, Barts and London School of Medicine, Queen Mary University, London, UK; and SynAct.

COVID-19 experience: RESOVIR-1 served as proof-of-concept

With COVID-19, infection of the lungs is often associated with the onset of acute respiratory insufficiency, leading to oxygen supplementation being required to maintain respiration. As such, it was one of the target indications in which SynAct sought proof-of-concept for resomelagon as a potential intervention, as part of the RESOVIR collaboration.

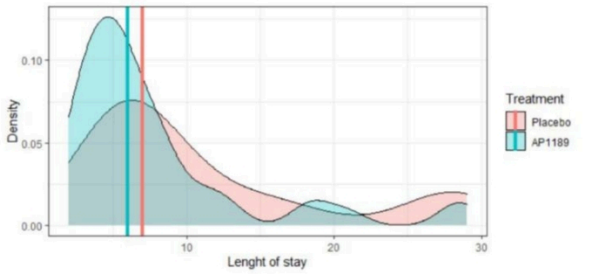
The RESOVIR-1 study was a placebo-controlled Phase IIa trial (n=60), involving the treatment of hospitalised COVID-19 patients requiring supplemental oxygen with resomelagon (100mg administered once daily for two weeks), compared to placebo. Positive data were reported in 2021, and subsequently published in the *British Journal of Pharmacology* in 2024. The results showed that all resomelagon treated patients achieved respiratory recovery 2 days quicker (33%, on average) than the placebo group (4 days versus 6 days, respectively;p=0.017) (Exhibit 9). Furthermore, the resomelagon group was discharged (on average) 1 day quicker than the placebo group (6 days vs 7 days for the placebo group; p=0.038) (Exhibit 10). Notably, on day five, 33% of the resomelagon group had been discharged, compared to zero patients that were receiving placebo (p=0.0054), highlighting the potential benefit of resomelagon treatment in this setting.

Exhibit 9: RESOVIR-1 data showing faster respiratory recovery with resomelagon in COVID-19 patients



Source: Company resources

Exhibit 10: RESOVIR-1 data showing reduced time at hospital with resomelagon treatment in COVID-19 patients



Source: Company resources

We believe that the RESOVIR-1 study results serve as an encouraging proof-of-concept for resomelagon's mechanism of action and application as a host-directed therapy. The clinical study was subsequently supported by additional preclinical research in COVID-19 models, which further underscored the promise of resomelagon to address COVID-19-induced hyperinflammation. We highlight that preclinical research also showed the potential of resomelagon to modulate inflammatory responses and restore homeostasis of the immune system to arboviral infections, which led to the subsequent RESOVIR-2 clinical programme, and supports the agnostic appeal of the drug candidate.

Dengue fever: RESOVIR-2 Phase II study

Arboviruses are a group of viruses transmitted to humans from the bites of infected mosquitoes (or ticks or other arthropods). Better-known examples include dengue, Zika virus, chikungunya and yellow fever. Infections from such viruses are typically concentrated in tropical and subtropical geographies where transmission cycles are usually dictated by local mosquito populations. We note that these infections have also spread in recent years to parts of Europe and the US, where mosquitoes have become endemic. While many cases of arboviral infection can resolve without complications, severe disease and hyperinflammation can occur when the immune system responds excessively, leading to internal bleeding and potentially systemic organ damage. The World Health Organization estimates that dengue alone may affect up to 400 million people per year, with the geographic range of these diseases expanding due to climate change, urbanisation and increased global travel.

In April 2025, SynAct announced the RESOVIR-2 Phase II trial, focused on dengue fever. This is a randomised, placebo-controlled study, testing resomelagon (once daily dosing) compared to placebo (1:1 randomisation across the two arms; expected n=120), as an add-on to standard treatment in patients with symptomatic dengue fever. The potential effect of resomelagon will be assessed using a composite clinical endpoint measuring the time to disease resolution, with secondary endpoints evaluating ability to reduce the incidence of warning signs of, and/or the development of, severe dengue. The launch of RESOVIR-2 will be contingent on the next seasonal disease period in

Brazil, anticipated in Q126.

We understand that the Phase II trial in dengue will serve as a proof-of-concept study, which the company will use to determine its future strategy in the host-directed therapy space. One potential avenue may include respiratory infections associated with hospitalisations (such as acute respiratory distress syndrome, caused by conditions such as influenza or respiratory syncytial virus for example), though we await further clarity on this front.

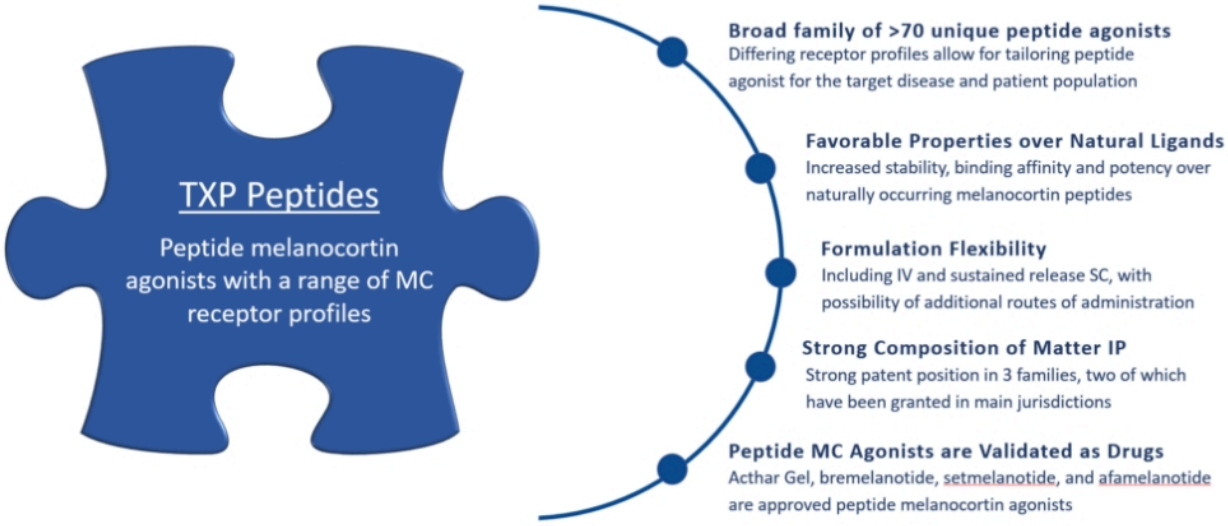
Preclinical pipeline: TXP-11 and future opportunities

TXP-11: Biologic melanocortin agonist

SynAct's melanocortin agonist portfolio was extended beyond resomelagon, when the company acquired Swiss biotechnology company TXP Pharma in January 2023. The main target of this acquisition was the TXP portfolio of peptide candidates (over 70 unique analogues of the naturally occurring melanocyte stimulation hormone, with a range of selectivities for melanocortin receptors), with TXP-11 being the main focus (Exhibit 11). TXP-11 has also been designed to target MC1R and MC3R, though unlike resomelagon it is administered intravenously. Management believes it may differentiate itself (compared to resomelagon) by being potentially more potent at its therapeutic targets, and perhaps offering a more favourable safety profile. The most probable application will be in patients with complicated medical conditions who are hospitalised and are at risk of developing organ- or life-threatening hyperinflammation. SynAct plans to position TXP-11 as an intervention to prevent organ failure after major surgeries, traumas and/or infections. While it is currently in the preclinical stages of development, we understand that it has completed the toxicology studies required before entering the clinic. Management expects it to enter first-in-human studies from 2026.

Although it is in the early stages of development, we believe that TXP-11 adds optionality to SynAct's pipeline. We look forward to further updates regarding its development, in the near to medium term.

Exhibit 11: Overview of the TXP peptide portfolio



Source: SynAct website

Building a patent estate around its inflammation resolvers

Since its 2024 annual report, SynAct has announced multiple patent developments for resomelagon, notably relating to its exclusivity in Europe (covering the clinical formulation of resomelagon) and the US (covering composition of matter and the use of resomelagon in combination with methotrexate for RA), all reinforcing its protection up to 2042 in these key regions. As of the 2024 annual report, resomelagon was protected by nine distinct patent families, covering the use of the active substance for the treatment of arthritic diseases in combination with methotrexate up to 2040 in most European countries and in Hong Kong, supplemented with an add-on patent corporation treaty application, which may extend this protection up to 2042. Separately, patent applications have been filed for the use of resomelagon in inflammatory viral disorders, which would provide protection for this use up to 2041 and potentially beyond 2045.

The company also holds the rights to a patent portfolio to protect its TXP peptides, including TXP-11, across three patent families. These have been granted in major geographies, including the US, Europe and Japan, providing protection to at least the end of 2033, though SynAct is in the process of broadening the scope of this protection, potentially up to 2041.

Management and board

CEO: Jeppe Øvlesen. Mr Øvlesen is an experienced biotech executive and has been involved as founder, CEO, chairman and board member in a string of companies including Action Pharma, CLC Bio, Cetrea, ChemoMetec, Perfusion Tech, Resother Pharma, Cercare Medical, PNN Medical, GO Pen, Cereno Scientific and TXP Pharma. Mr Øvlesen was CEO of SynAct Pharma from 2015 to 2023, taking the company public at Spotlight and later at Nasdaq (Stockholm). Mr Øvlesen returned as CEO and board member in 2024. Mr Øvlesen holds an MBA from the University of Hartford, United States.

CFO: Björn Westberg. Björn Westberg has more than 25 years of experience in the life science sector and has served as a chief financial officer since 2001. Prior to joining SynAct Pharma in June 2023, he was CFO at privately held Attgeno. Before that he was CFO at global cloud software company Enea and Swedish medtech Bonesupport, both of which are listed on Nasdaq Stockholm, and pharmaceutical developer and manufacturer Recipharm. He started his career at AstraZeneca where he worked in various capacities from 1989 to 2001. In September 2025, it was announced that Björn Westberg will be leaving the company. He will remain in the role until a successor has been appointed.

CSO: Thomas Jonassen, MD. Thomas Jonassen, MD, is associate professor of cardiovascular pharmacology, University of Copenhagen, and visiting professor at the William Harvey Research Institute, Barts and London School of Medicine. He has published more than 50 scientific publications and is the inventor of six granted patents in the US and Europe. Dr Jonassen is co-founder and current CSO and board member at SynAct Pharma, co-founder of ResoTher Pharma Aps, co-founder and former CSO at Action Pharma and co-founder of TXP Pharma (a company acquired by SynAct). Action Pharma sold its lead drug development candidate to AbbVie for $110m and TXP Pharma sold various rights to Questcor Pharmaceuticals for $100m in milestone payments. Dr Jonassen is co-inventor of SynAct's drug candidate resomelagon.

CBO: Mads Bjerregaard. Mads Bjerregaard joined SynAct as CBO in September 2025. He has held leading positions in life science companies during his more than 20 years of experience, including commercial and business development roles in Danish-based biopharma and med-tech companies Lundbeck, Zealand Pharma and UNEEG Medical. Throughout his career, Mads has lived and worked internationally and has been pushing innovation towards commercialisation in neurology, endocrinology and gastroenterology. Mads holds a master's degree from Copenhagen Business School.

COO: Thomas Boesen, PhD. Thomas Boesen, PhD has more than 20 years of experience in the biotech and pharma industry. He holds a PhD in bio-organic chemistry from Copenhagen University with studies at Cambridge University, and an MA in technology management with studies at Roskilde and Edinburgh Universities. Dr Boesen's achievements include being an inventor on 35 granted patents and holding several managing positions. Dr Boesen has been part of the successes of Action Pharma and Epitherapeutics, and he was co-founder of MedChem and TXP Pharma. He brings insight in drug development throughout the clinical phases, with a focus on CMC and external collaboration. Prior to joining SynAct Pharma, Dr Boesen was with Novo Nordisk for five years.

Chairman: Anders Kronborg. Anders Kronborg has more than 30 years of financial and leadership experience. He is currently CEO at ResoTher Pharma, as well as a board member at the Swedish biotech company Aqilion. Anders holds a master's degree in economics and spent close to 10 years in the Ministry of Finance, ending as head of department. From 1996 to 2007, Anders held a variety positions as CEO or CFO in different Danish media companies. In 2007, he

joined the Swedish investment company Kinnevik. From 2012 to 2015, he was the COO for the entire group. Anders then moved to the pharmaceutical industry and from 2015 to 2022 he served as CFO and interim CEO at LEO Pharma (a Danish company with a turnover of more than SEK10bn). He spent his time growing the company through several M&A activities.

Member of the board: Jeppe Ragnar Andersen. Jeppe Andersen has extensive financial and leadership experience spanning around 20 years. He is currently the CEO of Sanos Group, a global multi-niche contract research organisation with full service clinical capabilities. Jeppe is also board member in Arctic Therapeutics and CEO of NBCD (part of Sanos Group). He has a master of science in pharmacy from Copenhagen University and a master of business administration from the Quantic School of Business and Technology, Washington, US, and extensive experience in the management of clinical trials and associated companies.

Member of the board: Sten Scheibye. Sten Scheibye has a long career in pharma and med-tech, where he has been active for over 30 years. He has held positions such as medical sales rep, medical registration officer dealing with the FDA and the EU authorities. Later he moved into commercial roles and senior leadership positions. For 13 years Sten was CEO of the Danish-listed company Coloplast. During his tenure, Coloplast increased its turnover sixfold and share price eightfold. Sten has focused on board positions where he has held numerous roles in private and public entities. He has served as chairman of Novo Nordisk, where he had a seat on the board for 10 years until he became chairman of the Novo Nordisk Foundation and Novo Holdings. Sten has a PhD in organic chemistry from Aarhus University and a bachelor of commerce from Copenhagen Business School.

Member of the board: Sten Sörensen. Sten Sørensen has extensive leadership experience in the pharmaceutical and biotech industries spanning over 30 years. He is currently CEO and board member of the clinical stage biotech company Cereno Scientific, where he joined as a board member in 2014 and assumed the CEO role in 2015 when the company was still privately held and in early project stage. Under Sten's leadership, the company has been propelled into a promising three candidate drug pipeline, all potentially groundbreaking therapies in rare and common cardiovascular and pulmonary diseases with high unmet needs. Before Cereno, Sten held senior positions in major pharmaceutical companies including head of international marketing operations for the SEK10bn pharma portfolio at Monsanto (GD Searle, Chicago, US) and global marketing director for the SEK4bn portfolio of Secondary Prevention Products, Cardiovasculars at AstraZeneca (Gbg, Sweden). Sten is chairman of SARomics Biostructures since 2013 and holds a bachelor's degree in chemistry from Lund University.

See below for an Edison TV executive interview we recently conducted with Jeppe Øvlesen and Thomas Jonassen, MD.

SynAct Pharma - Edison TV executive interview

Source: Edison Investment Research

Sensitivities

SynAct is exposed to the usual risks associated with biotechnology companies focused on drug discovery and development, such as the unpredictable nature of clinical trial outcomes, regulatory discussions, the success of competitors and potential partnering setbacks, alongside risks associated with financing and the potential commercialisation of its drug candidate(s).

More specifically for SynAct, in our view, the main sensitives centre around its concentration risk with a single clinical-stage drug candidate, resomelagon, for value creation. To date, resomelagon has shown favourable safety and tolerability outcomes, somewhat de-risking its development in this regard. It has also shown proof-of-concept, in both chronic inflammatory conditions (RA) and as a host-directed therapy for viral infections (COVID-19), the two main development tracks being pursued, adding some confidence to further development efforts in these areas. For the lead programme, the key sensitivity comes from the use of post-hoc analyses, following the unanticipated initial outcome of the EXPAND trial. The positive subset data from this study only related to a portion of the total trial population, and hence there is a risk that these identified outcomes from patients with elevated CRP may not be reproduced in the prospectively-defined ADVANCE trial. Therefore, the results of ADVANCE represent a highly important upcoming inflection point for SynAct.

We also note that RA in particular is a highly competitive space, and SynAct will need to prove that resomelagon offers notable differentiation, through efficacy and/or through its convenient oral administration, if it is to garner meaningful market share. Resomelagon's propensity to progress to late-stage clinical development will be contingent on it confirming its potential in the ongoing Phase IIb ADVANCE in RA, and the Phase II RESOVIR-2 trial in dengue fever. We highlight that SynAct's reliance on one clinical-stage candidate is somewhat tempered by the fact that it is being actively developed across multiple indications, adding some diversity to its potential. This also extends to additional indications either being pursued or planned, such as PMR, and its potential in other respiratory infections associated with hospitalisations. Furthermore, SynAct is not a single-asset biotech, as it is also developing preclinical candidate TXP-11, adding some optionality to its pipeline.

In addition to the risks related to clinical development, resomelagon commercial uptake, if it is approved, will be influenced by a combination of pricing dynamics and payor acceptance given the presence of low-cost generics (methotrexate, steroids) and biosimilars in RA, which may necessitate price rationalisation and/or discounts to drive market penetration. Furthermore, demonstration of a steroid-sparing benefit in the real-world setting will be critical for reimbursement success.

Access to financing is another key sensitivity to be considered, which is true for nearly all early- or mid-clinical-stage biotechnology companies. Given SynAct's current stage of clinical development, it faces a relatively extended time to market before it will generate recurring revenue streams, meaning it may be reliant on external sources of financing, which heightens execution, funding and dilution risks. While we estimate the company currently has a cash runway into 2027, it may be required to raise additional capital to continue its clinical development activities. If this is realised through equity issuances, this may result in shareholder dilution. Management is actively seeking partnership opportunities to continue the development of its drug candidates from Phase III. While this would reduce financing risks from SynAct's point of view, we note that there remains an ongoing uncertainty regarding the timing and scope of such deals, which is an important consideration for investors. However, we believe that the outcomes of the current ongoing clinical trials, if positive, could be triggers to accelerate the launch of any potential partnerships.

Valuation

We value SynAct at SEK1.97bn or SEK36.9 per share using a risk-adjusted NPV approach with a 12.5% discount rate. Our valuation primarily reflects contributions from lead asset resomelagon across (1) RA, both early-stage patients and flare-ups post-biologics DMARD therapy, (2) inflammation related to respiratory viral infections and (3) PMR. We exclude the IMN indication from our valuation given the patient recruitment challenges in the ongoing Phase IIa study and the likelihood of programme discontinuation. Our valuation also incorporates pro-forma net cash of SEK104.3m, which includes an end-H125 cash balance of SEK68.9m plus SEK35.4m from post-period warrant conversions (discussed in more detail in the Financials section below).

Note that while the company has another development asset in it pipeline, TPX-11 (targeting post-surgical organ failure), given that its still in pre-clinical development, we exclude it from our current valuation for SynAct but note the upside potential on clinical entry.

We list below the underlying assumptions for our rNPV for resomelagon.

Rheumatoid arthritis (newly diagnosed patients and flares)

Indication focus: While we believe resomelagon's applicability may span a range of chronic autoimmune/inflammatory conditions (where glucocorticoids are widely utilised), given the focus of the Phase IIb ADVANCE trial, our base case centres on newly diagnosed, moderate-to-severe RA patients (in combination with methotrexate). We also see potential for the drug in flare management in patients receiving biologic DMARDs. Our model assumes that SynAct (or a licensing partner) will explore this as a future label expansion within the broader RA space.

Target population – first-line RA: We assume an RA incidence of 70 per 100,000 people. Taking guidance from the ongoing Phase IIb ADVANCE trial, we estimate the addressable patient population in the first line setting to be newly diagnosed RA patients, with moderate-to-severe disease characterised by a CDAI>22 (60% of the newly diagnosed patients) and high-sensitivity CRP>3mg/l (we estimate 80% of patients have CDAI>22). We assume 80% of this patient subset will be treated with methotrexate. Our model incorporates target markets of the US and EU5, given that these make up the bulk of the global market opportunity for the drug. This translates to an eligible patient population of c 94,000 in the US and 88,000 in the EU5 per year, growing at 1.5% y-o-y.

Flares: We assume an RA prevalence of 1.36 million in the US and 1.64 million in the EU5. We assume the addressable patient population to be the proportion of existing RA patients treated with biologics (30% of patients suffering from RA), of which we understand that around 30% on average suffer from flare-ups annually. This translates to an addressable patient population of c 122,000 in the US and 147,000 in the EU5 per year, growing at 1.5% y-o-y.

Peak penetration rates: We assume peak penetration rates of 25% across both indications, with peak sales achieved seven years post launch. Given the lack of other glucocorticoids-sparing treatments, this could turn out to be conservative, should efficacy be established in larger, randomised clinical trials.

Treatment duration: For first-line newly diagnosed patients, we have split our assumed treatment duration for eligible patients based on estimated response rates seen in the Phase IIa BEGIN study. We assume 40% of the resomelagon plus methotrexate treated patients will be able to achieve ACR50 or ACR70 or above (>50% and >70% improvement in RA symptoms). We estimate this patient cohort will stay on treatment for the long term, with a 25% annual drop-out rate. For the remaining patient population with an improvement in symptoms of less than 50%, we assume a treatment duration of six months.

Given the transient nature of flares and taking guidance from the average treatment periods with glucocorticoids, we assume an average treatment duration of six months for this indication.

Drug pricing: We model a monthly treatment cost for resomelagon of $3,500 (list price) in the primary US market, with an effective price of $2,100, assuming a 40% payor discount and a 2% y-o-y increase. The pricing is benchmarked (with a material 40–50% discount) to the average monthly price of approved biologics and JAK inhibitors for RA, with costs ranging from $6,000 to $8,000 per month. We believe that a conservative estimate for resomelagon is prudent as more competitive pricing (both methotrexate and glucocorticoids are generic and several lower-priced anti-TNF biosimilars have entered the market) will likely aid in improved regulatory and reimbursement discussions. For Europe, we model an effective monthly price of around $1,000.

Trial costs and timelines: The ongoing ADVANCE trial commenced in September 2024 and topline readouts are expected by end-Q126. Based on the R&D expenses over the past three quarters and accounting for non-trial related spending, we estimate an overall trial cost of SEK90–100m for the ongoing Phase IIb study, which translates to a per-patient trial cost of SEK375–420k or $40–45k per patient. We estimate that the company needs to invest a further SEK70–75m between Q325 and Q126 on the ADVANCE trial, following which we assume the next phase of development to be undertaken by a licensing partner.

Peak sales potential and launch timelines: We forecast commercial sales for resomelagon to 2045 across both indications, projecting peak sales to be achieved in 2040 based on the drug's IP protection. We estimate peak global sales of $2.3bn in newly diagnosed RA patients and $1bn in flares. We assume a probability of success (PoS) of 30% in the first-line combination setting and a more conservative 15% PoS in flares given clinical assessment of resomelagon for this sub-class is yet to be initiated. This is also subject to revision based on resomelagon's progress through the clinic. We also highlight the possibility of further label expansion to other autoimmune indications, which would add to the upside potential. We estimate Phase III study completions in newly diagnosed patients and flares in 2029 and 2030, with market launches in 2031 and 2032, respectively.

Licensing economics: We expect the company to seek partnership opportunities in 2026 following topline readouts from the ADVANCE trial and prior to commencement of the Phase III trial in newly diagnosed RA patients, which we estimate will be initiated in 2027 once a partner has been on-boarded. To establish potential deal economics for

resomelagon, we have reviewed similar-stage licensing deals in RA and related autoimmune conditions over the past 10 years (those with deal terms available). As reflected in Exhibit 12 below, there is a high level of variability in deal structuring and economics, which we believe stems from factors such as the strength of existing clinical data, targeted indications and deal timing. To avoid any ambiguity related to upfront and milestone payment structuring, we use a more simplified approach by solely assuming royalty payments, offsetting the lack of upfront and milestone payments by incorporating a higher blended royalty rate of 20% for any future partnering deal (typical royalty rates range from mid-single-digits to mid-teens).

Exhibit 12: Selected licensing deals in autoimmune conditions

Deal date	Licensor	Licensee	Asset	Mechanism of action	Status on deal date	Upfront payment	Milestones/royalties	Notes
Oct-23	Ichnos Sciences	Astria Therapeutics	Telazorlimab	Monoclonal antibody targeting OXO40	Phase II	$15m	Up to $305m +tiered royalties (mid single-digit to low double-digit)	To be developed for atopic dermatitis and potentially other allergic and immunological diseases. Ichnos to receive up to $20m in development milestones, up to $70m in regulatory milestones and up to $215m in commercial milestones.
Oct-23	Alfasigma SpA	Galapagos	Jyseleca (filgotinib)	JAK-1 inhibitor	On market	€50m	Up to €120m + tiered royalties (mid single-digit to mid-double-digit on European sales)	Jyseleca is approved in Europe and Japan in adults with moderate to severe active rheumatoid arthritis in September 2020. Was rejected by the FDA in 2020.
Mar-23	Nurix Therapeutics	Gilead Sciences	GS-6791 (NX-0479)	Protein degrader of IRAK4	Pre-clinical	$20m	Up to $425m +tiered royalties (low-double digit)	Part of the original June 2019 collaboration between Gilead and Nurix to develop a portfolio of protein degrader molecules. Option for GS-6791 exercised in March 2023. Phase I trial commenced in Q225. Potential target indications include rheumatoid arthritis and atopic dermatitis.
Dec-22	Nimbus Therapeutics	Takeda	Zasocitinib (TAK-279)	TYK2 inhibitor	Phase III-ready	US$4bn	Two milestone payments to $1bn each upon achieving annual net sales of $4bn and $5bn, respectively	Being developed for several autoimmune conditions such as plaque psoriasis, psoriatic arthritis and IBD.
Nov-21	Xencor	Zenas BioPharma	Obexelimab	Bifunctional antibody targeting CD19 and FcγRIIb	Phase II	N/A	Up to $480m + tiered royalties (mid single-digit to mid-teens)	Currently in Phase III development for Phase III for Immunoglobulin G4-related disease (IgG4-RD). Also under development for moderate to severe rheumatoid arthritis.
Jun-20	Alpine Immune Sciences	Abbvie	Acazicolcept (ALPN-101)	Dual CD28 / ICOS antagonist	Phase II-ready	$60m	Up to $805m + tiered royalties (high single-digit to low double-digit)	Phase II study in systemic lupus erythematosus initiated in June 2021 but was stopped prematurely in 2024 due to slower recruitment and higher than expected trial costs. Deal terms
Jul-17	Nektar Therapeutics	Eli Lilly	Rezpeg (NKTR-358)	PEG-conjugated IL-2 agonist	Phase I	$150m	Up to $250m + double-digit royalties	Phase II trial in systemic lupus erythematosus failed to meet the primary endpoint. Rights returned to Nektar in 2023.
Dec-15	Galapagos	Gilead Sciences	Jyseleca (filgotinib)	JAK-1 inhibitor	Phase II	$300m + $425m equity investment	Up to $1.35bn + tiered royalties starting 20%	Gilead decided not to pursue filgotinib in rheumatoid arthritis in the US in 2020, following a complete response letter from the FDA. European rights returned to Galapagos in 2022.
Mar-15	Hanmi Pharmaceutical	Eli Lilly	Poseltinib (HM71224)	Bruton's tyrosine kinase (BTK) inhibitor	Phase II-ready	US$50m	Up to $640m + tiered double-digit royalties	Rights returned to Hanmi in 2019 after an unsuccessful Phase II study in rheumatoid arthritis.

Source: EvaluatePharma, Edison Investment Research

Respiratory viral infections

In its most recent strategic update in June 2025, SynAct recognised acute inflammatory conditions associated with viral infections as its second growth pillar, alongside autoimmune disease. While we believe that SynAct's immediate focus will likely be RA, given the early proof-of-concept delivered by the Phase IIa study RESOVIR-1 in COVID-19 and additional support possible from the planned Phase IIa RESOVIR-2 study in dengue fever, we incorporate this market opportunity in our valuation for SynAct, albeit with a higher risk adjustment.

Target indications: While SynAct has maintained resomelagon's potential applicability in managing hyperinflammation related to both respiratory viral infections and arboviral infections, we believe a greater commercial opportunity lies in targeting infections prevalent in the major pharma markets of the US and Europe. Since we assume a licensing deal for resomelagon in 2027, we model the partner undertaking a Phase II pathogen-independent proof-of-concept study in 2028, targeting hyperinflammation induced by respiratory viral conditions. We include respiratory syncytial virus (RSV), influenza and COVID-19 as the target indications, given these have the largest incidence and hospital admission rates in the US, with similar demographics in Europe.

Addressable patient population: We assume the target patient population will comprise patients admitted to the ICU with the aforementioned conditions. While we note that hospital and ICU admissions related to these infections can have material seasonal and year-on-year variability, we calculate an average of 160,000–170,000 ICU admissions per year in the US related to these infections, with a similar figure in the EU5. We assume a peak penetration of 20% for resomelagon, to be achieved in 2037.

Treatment duration and pricing: Based on average ICU days across these indications (ranging from 5 to 14 days on average), we estimate an average treatment duration of 10 days for resomelagon with a more intensive treatment regime. We assume a treatment cost of around $5,000 in the US (list price), with an effective price of $3,750/patient, assuming a 25% payor discount (we assume a 2% y-o-y price increase). For context, remdesivir, the broad-spectrum antiviral medication used to treat COVID-19, was launched at a list price of $3,120 for a five-day treatment (wholesale acquisition price of $2,340). For Europe, we assume the effective price to be 50% of the US rates.

Launch timelines, peak sales and PoS: We estimate a 2031 launch for resomelagon as treatment for

hyperinflammation related to these indications, with peak sales of $250m, to be achieved in 2040. While we await clarity from the company on the finalised target conditions, given the clinical work already undertaken in COVID-19, we assign a 15% PoS to the programme. We assume a 20% royalty rate on sales from the assumed licensing deal.

Polymyalgia rheumatica

We also include PMR in our valuation for resomelagon, but view this as an outside opportunity for SynAct at present. The company expects a Phase IIa investigator-initiated trial to be launched by end-2025, evaluating oral administration of once daily resomelagon in PMR patients for a treatment duration of three months, post tapering of glucocorticoids. Based on a PMR incidence of 50 per 100,000 population and a 40% relapse probability during tapering with glucocorticoids, we estimate the addressable patient population to be around 70,000 patients in the US with a similar figure for the EU5 (with a 1.5% y-o-y growth rate). We assume a Phase IIb trial to be initiated by a licensing partner in 2028. Based on the Phase IIa clinical trial plan, we estimate a three-month treatment duration, with an effective treatment cost of c $5,000 in the US and $2,500 in Europe, with a 2% y-o-y growth. We estimate a launch timeline of 2032 and peak sales of $180m (to be achieved in 2040). We model a peak penetration rate of 20%, to be achieved in 2038 and assign a PoS of 10% to this programme.

Our rNPV valuation for SynAct, detailed by target indications, is presented in Exhibit 13.

Exhibit 13: SynAct rNPV valuation

Product	Indication	Expected launch	Peak sales ($m)	NPV (SEKm)	Probability	rNPV (SEKm)	rNPV/share (SEK)
Resomelagon	Rheumatoid arthritis – newly diagnosed patients	2031	2,300	5,506.1	30%	1,589.2	29.8
	Rheumatoid arthritis – flares	2032	1,000	2,177.3	15%	299.5	5.6
	Respiratory viral-infections	2031	250	674.9	15%	101.2	1.9
	Polymyalgia rheumatica	2032	180	375.1	10%	28.9	0.5
Direct costs to 2035 less tax				(153.1)		(153.1)	(2.9)
Pro forma net cash at end-June 2025				104.3		104.3	2.0
Valuation				**8,684.6**		**1,970.0**	**36.9**

Source: Edison Investment Research

Scenarios

Our base case rNPV valuation for SynAct as defined above aligns with our central assumptions, although we caution that it is highly sensitive to estimations on market penetration and launch success. Given the inherent riskiness and uncertainty surrounding the target programmes, we also present bull and bear case scenarios below, reflecting varying penetration assumptions across the target programmes (Exhibit 14). While the bull case valuation accounts for success across all target programmes with material market capture, the bear case valuation illustrates a more conservative outlook, valuing resomelagon only on two opportunities (first-line RA and viral infections) with more modest peak penetration estimates.

Exhibit 14: rNPV scenarios

	Peak penetration				
Scenarios	First-line RA	Flares	Viral infections	PMR	rNPV (SEK)
Bear case	10%	0%	10%	0%	**10.9**
Base case	25%	25%	20%	20%	**36.9**
Bull case	50%	40%	40%	30%	**74.5**

Source: Edison Investment Research

Given the significant weighting of the RA first-line treatment opportunity in our valuation, we also present a sensitivity table that provides a range of valuations based on different probabilities of success in this indication and discount rates (Exhibit 15).

Exhibit 15: Sensitivity of rNPV to first-line RA success probabilities and discount rates (SEK/share)

Discount rates	Probability of Success 15.0%	20.0%	25.0%	30.0%	35.0%	40.0%	45.0%
9.5%	31.5	39.0	46.6	54.1	61.6	69.2	76.7
10.5%	27.6	34.3	40.9	47.6	54.3	60.9	67.6
11.5%	24.2	30.1	36.0	41.9	47.8	53.7	59.6
12.5%	21.2	26.4	31.7	**36.9**	42.2	47.4	52.7
13.5%	18.6	23.2	27.9	32.6	37.3	41.9	46.6
14.5%	16.3	20.4	24.6	28.8	32.9	37.1	41.3
15.5%	14.2	18.0	21.7	25.4	29.1	32.8	36.6

Source: Edison Investment Research

Financials

Operating performance: Reflecting intensifying clinical activity

Typical of a clinical-stage biopharma company, SynAct Pharma is pre-revenue, with the primary source of capital being external financing in the form of capital raises. Since its incorporation in 2016, we estimate the company to have raised upwards of SEK700m in external capital (comprising equity issues and warrant conversions), including over SEK90m in FY25 thus far. SynAct reported its Q225 results in August 2025; Q225 was an active period marked by the company refining its strategic priorities for its lead programme (announced in June 2025), resomelagon, as it progresses through the clinic.

Operating expenses for H125 were reported to be SEK58.4m, up 30.2% y-o-y (H124: SEK44.9m). This increase was primarily driven by the material uplift in R&D expenses (+196% y-o-y to SEK45.2m), following the initiation of the Phase IIb ADVANCE trial in September 2024. R&D as a percentage of operating expenses increased to 77.3% from 34.0% in H124. This increase in R&D was partially offset by lower G&A expenses, which dropped 54.7% y-o-y to SEK13.3m in H125. We believe this to be the normalised long-term G&A level for SynAct, with the H124 figure affected by the one-time severance payment related to the previous CEO. The company recognised tax benefits of SEK8.2m in H125 versus SEK2.3m in H124 in the form of R&D tax credits related to the company's R&D activities. The increase in this figure can be attributed directly to the higher R&D for the period. Overall, the reported net loss increased to SEK52.2m, a 19.9% jump over the H124 figure of SEK43.5m. Operating cash outflows, however, remained relatively stable at SEK47.6m (H124: SEK47.3m), benefiting from a favourable working capital position, which offset the increased operating loss.

Near-term estimates: Driven by clinical and strategic plans for resomelagon

While SynAct has several programmes ongoing, we base our near-term (FY25 and FY26) forecasts on the ongoing clinical development work in RA and plans in viral infections and PMR. As noted above, we expect a licensing deal for resomelagon to come through in 2027 and therefore project no revenues for FY25 and FY26. In terms of operating expenses, with the Phase IIb ADVANCE trial nearing completion (patient recruitment is expected to complete by end-FY25, with top-line readout by end-Q126), we estimate that H225 R&D expenses will be in line with the prior quarters and project FY25 R&D of SEK90.4m. For FY26, we project a lower R&D expense of SEK27.6m, but note that this figure could trend higher should the company choose to initiate a smaller Phase II study testing resomelagon as a treatment in flares related to RA (we estimate a 100-patient study would cost the company c SEK50m). We also estimate that the quarterly G&A figures will remain broadly stable across the next few periods and forecast G&A expenses of SEK26.6m and SEK27.2m in FY25 and FY26, respectively. Overall, we project operating losses of SEK117.0m and SEK54.8m for FY25 and FY26.

Balance sheet: Recent capital injections extend runway into FY27

Being clinical stage, access to capital has been a key sensitivity for SynAct to ensure adequate headroom while implementing its clinical plans. As noted above, the company has been successful in raising equity capital in the past to back its R&D efforts. SynAct ended H125 with a gross cash balance of SEK68.9m, supported by a SEK20m rights issue and a SEK37m directed issue in the first half. Post-period, the cash position has been bolstered by the exercise of warrants by shareholder Heights Capital Management (HCM), worth SEK35.4m in total. HCM had been issued 3,375,000 warrants (expiring 13 October 2025) by SynAct as part of the October 2023 directed issue (worth

SEK60.5m), of which it converted 1m warrants in July 2025 and another 1m in August 2025, against an issue of 2,008,200 shares in total. In September 2025, the remaining 1,375,000 warrants held by HCM were acquired by Hunter Capital (corresponding to 1,380,637 shares in SynAct), although we understand that these have not been converted to shares under an agreement with SynAct. Based on our projected burn rates, we estimate that the cash on hand at end-H125, alongside the subsequent SEK35.4m capital injection, provides a cash runway into 2027 for SynAct, well past the upcoming readouts from the ADVANCE trial and subsequent partnering/outlicensing discussions. SynAct raised a SEK30m credit facility with Hunter Capital in June 2025 (5% set-up fee; 6% annual interest rate), which can be drawn down up to 31 December 2026. Management highlighted that this will only be used as a secondary financing option (to equity capital or non-dilutive funding from partners). The facility remains unutilised to date (and is likely to be unused following the additional funds from the warrants exercise), but we believe that it does provide a safety net for the company, should it plan for additional clinical activity on other indications (such as flares related to RA).

Exhibit 16: Financial summary

SEKm	2022	2023	2024	2025e	2026e
Year end 31 December	IFRS	IFRS	IFRS	IFRS	IFRS
PROFIT & LOSS					
Revenue	0.00	0.00	0.00	0.00	0.00
Licensing income	0.00	0.00	0.00	0.00	0.00
Royalties	0.00	0.00	0.00	0.00	0.00
Others	0.00	0.00	0.00	0.00	0.00
Cost of Sales	0.00	0.00	0.00	0.00	0.00
Gross Profit	0.00	0.00	0.00	0.00	0.00
R&D expenses	(70.07)	(105.06)	(49.31)	(90.35)	(27.59)
G&A expenses	(35.61)	(44.83)	(40.49)	(26.64)	(27.17)
EBITDA	(104.64)	(149.18)	(89.36)	(116.34)	(54.08)
Operating Profit (before amort. and except.)	(105.71)	(149.94)	(89.98)	(116.99)	(54.76)
Intangible Amortisation/impairment	0.00	(74.56)	0.00	0.00	0.00
Exceptionals	0.00	0.00	0.00	0.00	0.00
Other	0.00	0.00	0.00	0.00	0.00
Operating Profit	(105.71)	(224.50)	(89.98)	(116.99)	(54.76)
Net Interest	(1.36)	0.22	(0.85)	(1.32)	(1.64)
Profit Before Tax (norm)	(107.07)	(149.72)	(90.82)	(118.30)	(56.40)
Profit Before Tax (reported)	(107.07)	(224.28)	(90.82)	(118.30)	(56.40)
Tax	7.86	8.47	8.42	8.14	8.14
Profit After Tax (norm)	(99.21)	(141.25)	(82.40)	(110.16)	(48.26)
Profit After Tax (reported)	(99.21)	(215.81)	(82.40)	(110.16)	(48.26)
Average Number of Shares Outstanding (m)	27.59	32.52	39.53	51.17	53.33
Basic EPS - normalised (SEK)	(3.60)	(4.34)	(2.08)	(2.15)	(0.90)
Basic EPS - reported (SEK)	(3.60)	(6.64)	(2.08)	(2.15)	(0.90)
BALANCE SHEET					
Fixed Assets	2.37	152.96	156.67	156.03	155.35
Intangible Assets	0.00	152.16	154.59	154.59	154.59
Tangible Assets	2.10	0.66	1.94	1.29	0.61
Investments	0.27	0.14	0.14	0.14	0.14
Current Assets	140.23	75.06	94.00	64.61	17.03
Stocks	0.00	0.00	0.00	0.00	0.00
Debtors and prepaid expenses	23.76	4.48	24.32	2.50	2.50
Cash	108.25	62.40	61.21	53.63	6.06
Other	8.23	8.19	8.47	8.47	8.47
Current Liabilities	15.01	24.94	28.46	16.53	16.53
Creditors and accrued expenses	9.63	19.48	27.44	15.51	15.51
Short-term borrowings	0.00	0.00	0.00	0.00	0.00
Lease liabilities and others	5.38	5.45	1.02	1.02	1.02
Long-Term Liabilities	1.06	26.90	27.89	27.56	27.56
Long-term borrowings	0.00	0.00	0.00	0.00	0.00
Other long-term liabilities	1.06	26.90	27.89	27.56	27.56
Net Assets	126.52	176.19	194.32	176.54	128.28
CASH FLOW					
Operating Cash Flow	(117.56)	(100.18)	(89.20)	(98.61)	(47.58)
Net interest	0.00	0.00	0.00	0.00	0.00
Tax	0.00	0.00	0.00	0.00	0.00
Capex	0.00	0.00	0.00	0.00	0.00
Acquisitions/disposals	0.03	0.37	0.00	0.00	0.00
Financing	200.71	53.98	87.41	91.03	0.00
Dividends	0.00	0.00	0.00	0.00	0.00
Net Cash Flow	83.18	(45.82)	(1.79)	(7.57)	(47.58)
Opening net debt/(cash)	(24.00)	(108.25)	(62.40)	(61.21)	(53.63)
Other	1.06	(0.03)	0.61	0.00	0.00
Closing net debt/(cash)	(108.25)	(62.40)	(61.21)	(53.63)	(6.06)

Source: SynAct Pharma, Edison Investment Research

Contact details	Revenue by geography
SynAct Pharma AB (publ) Scheelevägen 2 SE-223 63 Lund Sweden https://synactpharma.com/en/	N/A

Management team

CEO: Jeppe Øvlesen

Mr Øvlesen is an experienced biotech executive and has been involved as founder/CEO/chairman/board member in a string of companies including Action Pharma, CLC Bio, Cetrea, ChemoMetec, Perfusion Tech, Resother Pharma, Cercare Medical, PNN Medical, GO Pen, Cereno Scientific and TXP Pharma. Mr Øvlesen was CEO of SynAct Pharma from 2015 to 2023, taking the company public at Spotlight and later at Nasdaq (Stockholm). Mr Øvlesen returned as CEO and board member of SynAct Pharma in 2024. Mr Øvlesen holds an MBA from University of Hartford, United States.

CFO: Björn Westberg

Björn Westberg has more than 25 years of experience in the life science sector and has served as a chief financial officer since 2001. Prior to joining SynAct Pharma in June 2023, he was CFO at privately held Attgeno. Before that he was CFO at global cloud software company Enea and Swedish medtech Bonesupport, both of which are listed on Nasdaq Stockholm, and pharmaceutical developer and manufacturer Recipharm. He started his career at AstraZeneca where he worked in various capacities from 1989 to 2001. In September 2025, it was announced that Björn Westberg will be leaving the company. He will remain in the role until a successor has been appointed.

CSO: Thomas Jonassen, MD

Thomas Jonassen, MD, is associate professor at cardiovascular pharmacology, University of Copenhagen, and visiting professor at William Harvey Research Institute, Barts and London School of Medicine. He has published more than 50 scientific publications and is the inventor of six granted patents in the US and Europe. Dr Jonassen is co-founder and current CSO and board member at SynAct Pharma, co-founder of ResoTher Pharma Aps, co-founder and former CSO at Action Pharma and co-founder of TXP Pharma. Action Pharma sold its lead drug development candidate to AbbVie for $110m and TXP Pharma sold various rights to Questcor Pharmaceuticals for $100m in milestone payments. Dr Jonassen is co-inventor of resomelagon.

CBO: Mads Bjerregaard

Mads Bjerregaard joined Synact as CBO in September 2025. He has held leading positions in life science companies during his more than 20 years of experience, including commercial and business development roles in Danish-based biopharma and med-tech companies Lundbeck, Zealand Pharma and UNEEG Medical. Throughout his career, Mads has lived and worked internationally and has been pushing innovation towards commercialisation in neurology, endocrinology and gastroenterology. Mads holds a master's degree from Copenhagen Business School.

CMO: Kirsten Harting, MD

Kirsten Harting, MD and executive MBA, has more than 30 years of experience in the established pharma industry and biotech and is the chief medical officer at SynAct Pharma. She qualified as a medical doctor from Copenhagen University and has an executive MBA from Copenhagen Business School (former SIMI). She has had responsibility for the development and approval of several drugs reaching the market.

COO: Thomas Boesen, PhD

Thomas Boesen, PhD, has more than 20 years of experience in the biotech and pharma industry. He holds a PhD in bioorganic chemistry from Copenhagen University, with studies at Cambridge University, and an MA in technology management with studies at Roskilde and Edinburgh Universities. Dr Boesen's achievements include being an inventor on 35 granted patents and holding several managing positions. Dr Boesen has been part of the successes of Action Pharma and Epitherapeutics, and he was co-founder of MedChem and TXP Pharma. Prior to joining SynAct Pharma, Dr Boesen was with Novo Nordisk for five years.

Principal shareholders	%
Sanos Group NBCD A/S	10.63
Avanza Pension	9.88
Thomas Ringberg	5.14
Thomas Jonassen	4.77
Nordnet Pension Insurance	4.31
Oliver Aleksov	2.07
Handelsbanken Funds	1.60
Kenneth Bjerg-Nielsen	1.60
Johannes Schildt	0.97
Hunter Capital AB	0.94
OR Invest A/S	0.75
Quantass ApS (Jeppe Øvlesen)	0.69
Patrik Strempl	0.66
SEB Funds	0.62
Futur Pension	0.54
Heights Capital Management	0.47
Boesen Biotech ApS (Thomas Boesen)	0.46
Engin Avci	0.41
Swedbank Insurance	0.41
Per Granath	0.41

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