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Capital Markets

RBC Capital Markets, LLC
Lisa Walter, Ph.D. (Analyst)
(212) 858-6021,
lisa.a.walter@rbccm.com
Luca Issi, Ph.D. (Analyst)
(212) 266-4089,
luca.issi@rbccm.com
Shelby Hill, Ph.D. (Senior Associate)
(332) 204-2106,
shelby.hill@rbccm.com
Cassie Yuan, Ph.D. (Senior Associate)
(212) 863-4811,
cassie.yuan@rbccm.com

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KOL Optimistic About TKI Class for wAMD and Thinks 30-50% of Patients Could Be Low Hanging Fruit

Our view: We hosted a KOL dinner with an experienced retina specialist to discuss the current treatment paradigms for wAMD and the long-acting TKI's in development from OCUL and EYPT. While our KOL has 40-50% of patients on a longer-acting anti-VEGF, he notes these drugs have offered only incremental benefits to patients, with most on average only having their dosing intervals extended by 1-2 weeks, and only 10-15% of patients sustained with q16w dosing. KOL thinks new treatments like the long-acting TKIs, which have the potential to extend dosing intervals by 4 weeks or more in the real-world, would offer a huge benefit, especially to his 30-50% of patients who are stuck with a high injection burden. Currently, our KOL views both long-acting TKI programs from OCUL and EYPT similarly, but does flag some small differences with the RoA and performance of the bioerodible implant. On OCUL's pivotal SOL-1 study, our KOL thinks the readout is challenging to predict given the novel trial design, but is optimistic and assigns a 50-75% PoS. KOL would be happy to see 80-90% of patients rescue injection-free at 6 months in the treatment arm, and thinks the control arm could have a response rate anywhere from 7% to 20%. In terms of what would be a good % delta at 9-months, KOL does not think the retina community will get hung up on these details if the drug is approved. KOL thinks questions remain on the regulatory path to approval with SOL-1 alone, however our KOL notes that first-mover advantage is helpful as it gives time for physicians to experience the drug in the real-world, which is more informative than the pivotal study data.

KOL Background - Our KOL is based locally in NY and is a board certified ophthalmologist and retina surgeon, with 15 years of experience. Our KOL performs on average 60-70 intravitreal injections daily, 700-800 monthly, and 8,000-9,000 annually. He typically sees 300-400 wAMD patients, 200-300 DME patients, and has smaller numbers of DR and RVO patients. Our KOL typically spends 4 days a week in the clinic, and 1 day per week in surgery.

KOL's Current Use of Anti-VEGF Suggests 40-50% on Longer-Acting Anti-VEGFs, and Co-Pay Expense Has Impacted Some Patients - In the KOL's practice, which is part of the Retina Consultants of America, there is a preference to use biosims and branded drugs, and to avoid compounded Avastin (concerns over compounding pharmacies, possible contamination risk, and least durable), unless forced to use it due to step-through requirements from payors. For the long-acting anti-VEGFS, KOL has 20% on Vabysmo, and 20-30% on Eylea HD. For the rest, KOL has ~20% on aflibercept biosim Pavblu, 20-30% on 2 mg Eylea, 10% on Avastin and very few on Lucentis. KOL notes some patients prefer Lucentis due to lowest co-pay of the branded drugs, which has become a bigger issue since co-pay assistance organizations like Good Days have stopped funding retinal disease (Lucentis co-pay is $80, vs $350 for Pavblu and $500 for Vabysmo/HD). KOL notes 2025 saw more patients stop treatment or skip visits in his clinic due to the co-pay underfunding issue, with many patients being supported by this for many years and caught off-guard when they needed to cover the costs. In terms of patient compliance, KOL thinks the 40% drop-out rate after 1 year of treatment cited by drug developers seems high and thinks in his clinic it is closer to 15%. However, KOL acknowledges that most retina clinics do not do a good job of tracking patients who are lost to follow-up, so it is difficult to know what the real number is.

In KOL's Practice, Longer-Acting Anti-VEGFs Incrementally Extend Dosing Intervals, but Many Patients Still Require Frequent Injections - On current SoC, KOL has found that most patients can go longer in between doses with EyleaHD and Vabysmo, however he notes most patients are typically only extended by 2 weeks from their prior interval. ***continued on page 2...***

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(i.e. if sustained q8w with 2 mg Eylea, may be extended to q10w with HD/Vabysmo). While the clinical studies demonstrated ~75% getting out to intervals of q12w or q16w, in the real-world this is not the case, partly because the studies allowed for some fluid to recur before re-dosing (unlike in clinical practice). Overall, KOL thinks HD/Vabysmo offer an incremental benefit to patients, but he thinks any drug which could extend dosing intervals by 4 weeks or more, like the TKIs from OCUL/EYPT, would constitute a paradigm shift.

For the Long-Acting TKIs, KOL Thinks 30-50% of Patients With High Injection Burden Will be The Low-Hanging Fruit - KOL thinks his peers in the retina community are already viewing the TKIs from OCUL and EYPT as treatments with potential to extend the dosing interval beyond what has been achieved with HD/Vabysmo, however the question remains just how much further. If approved, KOL would try the TKI's in patients with a high injection burden (q4w/q8w dose intervals), and thinks about 30-50% of his patients could fit this profile. For patients who are maintained with quarterly dosing, he may also consider trying a TKI, but in patients who are truly sustained with q16w (he estimates 10-15% of patients are on this treatment regimen) he is not sure if he would risk switching these patients for the possibility of q24w or just 1 less injection per year. If annual dosing becomes a possibility with OCUL's SOL-1 study, KOL might consider switching a q16w patient only after ~1 year of experience with using the TKI and strong confidence in both the efficacy and safety profile.

KOL Notes Differences Between OCUL and EYPT, but Does Not Have a Preference - KOL thinks OCUL may have a slight advantage with their RoA as Axpaxli is using a smaller 25 gauge needle vs EYPT's Duravyu is using a larger 22 gauge needle which can be more uncomfortable. However, he also notes he has not had issues with using a 22 gauge needle for Ozurdex treatment (sustained delivery steroid) which is sometimes dosed up to 3x per year in uveitis patients (not dissimilar to EYPT which is targeting 2 injections per year). While OCUL's hydrogel delivery is estimated to fully diffuse by 9 months, EYPT's insert should completely erode in humans by 18 months, meaning that there is overlap of inserts under a Q6M dosing schedule (However, EYPT has also commented at the 6-month mark, only 1/3 of the insert remains by the time the new one is injected, and at 9 months only 10% of the insert remains). Our KOL has had a similar experience with Ozurdex, where the implant is not fully gone and leaves a carcass around for 1 year or more, and overlaps with a new implant. However, our KOL notes this does not seem to bother patients and has not impacted their vision in his experience. When pressed on whether he had a preference between the two programs, KOL currently thinks of them as similar and part of the same drug class, similar to how he thinks about Vabysmo and HD (he uses both drugs in his practice and uptake is influenced more by payers and rebate dynamics vs preference).

KOL Notes OCUL's SOL-1 Is Harder To Predict Given Unprecedented Trial Design, and Assigns a 50-75% PoS - Our KOL underscored that he finds SOL-1 hard to predict given the patient enrollment criteria is selecting for anti-VEGF "super-responders" (patients need to respond to 2 aflibercept loading doses with a 10-letter gain or achieve visual acuity of 20/20) which may only reflect about 25% or less of patients in the real world, and that patients would never be left to lose 15 letters before they were re-treated. He thinks the trial is designed for the FDA and has the deck stacked in favor of the treatment arm. He does not think the retina community will find the trial results informative as the control arm is irrelevant to SoC (single dose of 2 mg aflibercept) and primary endpoint designed around vision loss (% of patients losing <15 letters BCVA) does not serve as a good proxy for how patients are managed in practice. Our KOL is optimistic the trial will meet the bar for superiority (15% delta minimum) and assigns a 50-75% PoS (not dissimilar to our prior KOL conversations), but notes in general retina docs will not get too hung up on what the specific delta is once approved. Retina docs are unlikely to debate whether a 50% or 30% delta is good or bad once a drug is approved, rather they will form their opinion of the drug

with real-world use in patients.

For SOL-1 KOL Thinks 80-90% Rescue-Free at 6 Months Would Be Impressive, and Control Could Have 20% Responders - Our KOL would be impressed if the treatment arm demonstrated 80-90% rescue-injection free at 6-months. In terms of what to expect with the control arm, our KOL notes there is very little data available tracking durability of 2mg aflibercept beyond q12w intervals, and even less data in terms of a how a group of "super-responders" might perform. In our KOL's experience, he finds about 7-8% of patients do not need further anti-VEGF treatment once their eye becomes dry, but given the super-responder population he thinks 20% might meet the primary endpoint in SOL-1. Overall, KOL notes the separation between the two arms will be most important, and he would not be turned off if the control happens to outperform as in the real-world no one would use 2 mg aflibercept in that manner. In terms of absolute change in BCVA (potentially a secondary endpoint), KOL acknowledges there could be a risk the control arm outperforms due to more rescues and this could raise some eyebrows, however he thinks the OCUL team has put a lot of thought into the study design must have an angle that suggests to them this outcome would be unlikely.

KOL Notes First-Mover Advantage Has Benefits in Retina Space - On the FDA's recent shift from requiring two pivotal studies for approval to only one, KOL thinks there is some uncertainly around this in regard to OCUL. KOL thinks the details may still need to be worked out with the FDA, and if initial approval is based on SOL-1 alone, questions remain on what the label could look like (will re-dosing be included, will use be limited to 1 year - similar to what happened with Izervay for GA). That said, if SOL-1 is acceptable to approve Axpaxli, this would likely provide OCUL with first-mover advantage (SOL-1 anticipated to readout 1Q26 vs EYPTs first study anticipated to read out mid'26), which will help for retina physicians to gain real-world experience with the treatment. The retina community is relatively small and close-knit with doctors often trading notes at conferences or over message boards/chat rooms, and opinions on new drugs travel fast. KOL noted that when Vabysmo and HD were approved, no one thought q16w dosing would be possible right away based on the trial results, doctors needed to try the drugs first and see how they perform. With first-mover advantage, docs will have longer to experience how a new drug works.

KOL Sides With OCUL on No Sham Injections - KOL thinks there has been a shift within the ophthalmology division at the FDA on the use of sham-injections, historically used in retina studies to maintain blinding when different dose intervals between treatment and control are used. KOL thinks the FDA would rather not see sham injections being used as there are concerns the patient can tell the difference between a real intrvatireal injection where the needle pierces the eye (some pain associated with this), vs sham injections where the blunt end of a syringe with no needle touches the white of the eye (no pain). That said, KOL noted in his experience with performing sham injections for trials, no patient has ever expressed to him that they knew they received a sham injection. KOL also noted FDA wanted to utilize saline intravitreal injections as a control, however the retina community pushed back on this (no medical need for saline, intravitreal injections come with 1/1000 risk of endophthalmitis).

Companies mentioned

EyePoint, Inc. (NASDAQ: EYPT US; $17.37; Outperform; Speculative Risk)
Ocular Therapeutix, Inc. (NASDAQ: OCUL US; $11.50; Outperform; Speculative Risk)

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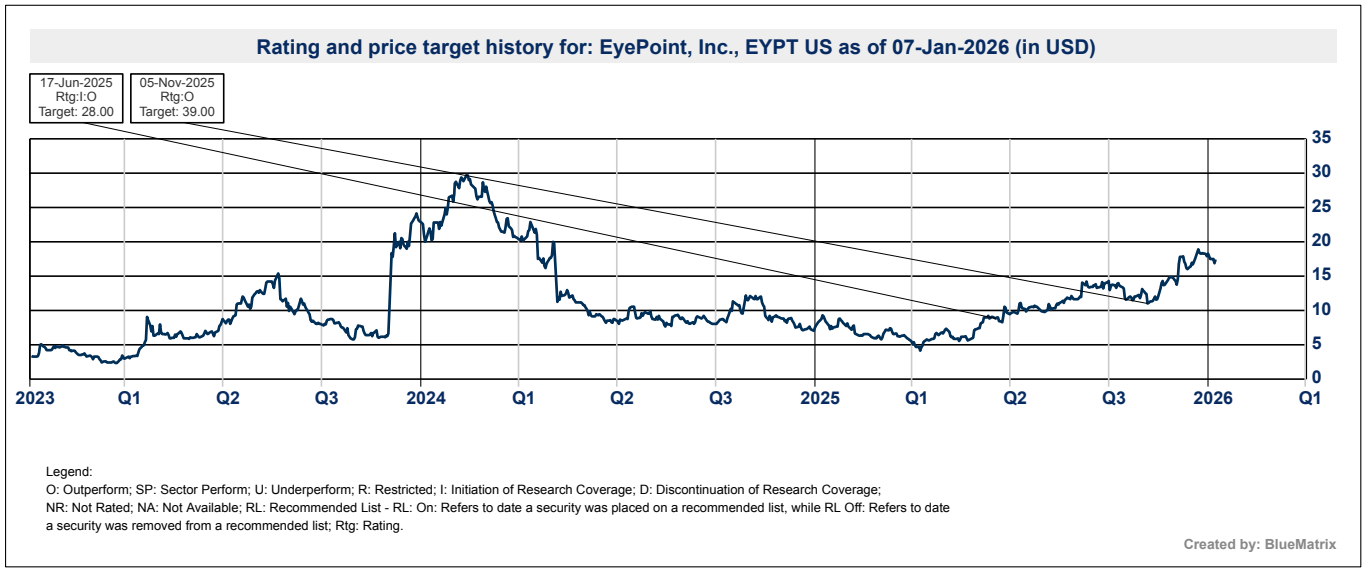

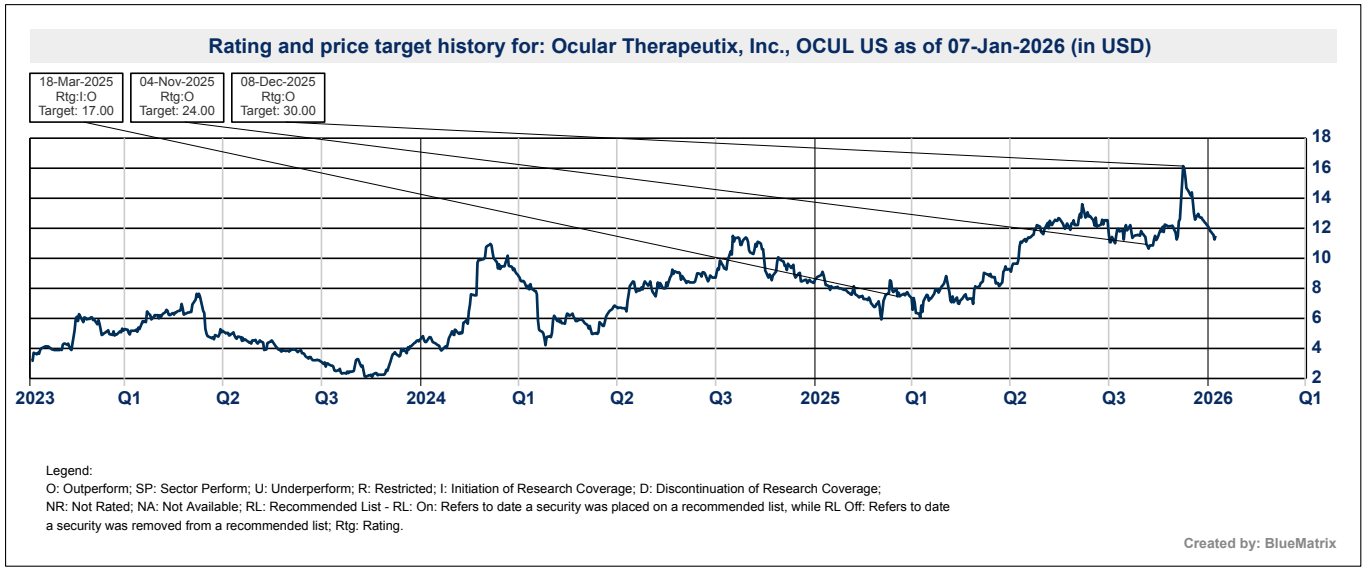

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Risks to rating and price target

Risks include clinical trial execution for Duravyu, emergence of a safety signal, commercial resilience for anti-VEGFs, greater than anticipated competition from OCUL, RGNX/ABBV, FDMT, regulatory uncertainties, IP risk, and pricing pressure.

Ocular Therapeutix, Inc.

Valuation

Our $30 price target is based on a DCF analysis that assumes a 10% WACC (same for all stocks in our coverage), 2% terminal growth rate (with a 0-3% range applied to our coverage depending on the relative maturity of the platforms), 75% PoS for wAMD, 55% PoS for DR, 100% for Dextenza, and 20% for the platform. Non-PoS adjusted platform value is determined by the sum of the terminal value of the individual programs. This price target supports our Outperform, Speculative Risk rating. We assign a Speculative Risk qualifier given unpredictability of future revenues and expenses and stock price volatility that could result in substantial upside/ downside swings not anticipated in our valuation.

Risks to rating and price target

Risks include clinical trial execution for Axpaxli, emergence of a safety signal for Axpaxli, commercial resilience for anti-VEGFs, greater than anticipated competition from EYPT, RGNX/ABBV, FDMT, regulatory uncertainties, IP risk, and long-term pricing pressure (wAMD).

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