THE COOLEST CATHETER ABLATION TECHNOLOGY

Adagio™ MEDICAL

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TD Cowen 45th Annual Healthcare Conference
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WHY ADAGIO MEDICAL

Unique near-term opportunity with purpose-designed system for ventricular tachycardia ablations

✓ **Large Unmet Need: $300 million served Market with Established Reimbursement**
- Highly under-penetrated with potential 2-3x growth opportunity

✓ **2 Year Regulatory and Clinical Head Start**
- Improved Safety, effectiveness and usability[1]
- ~200 patients treated globally; U.S. IDE Underway.

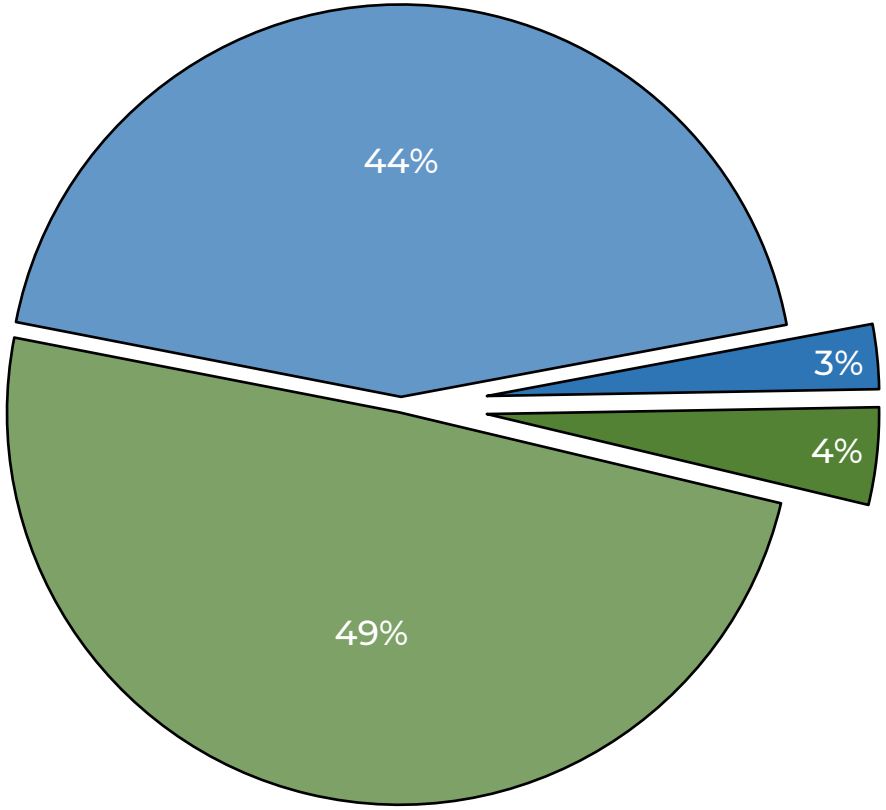
✓ **Broad indication and highly sought-after performance characteristics**
- Demonstrated in successful CE-Mark trial and commercial experience

Key near-term value drivers:
- US Pivotal IDE primary endpoints in 2025
- Product design optimization program
- Pulsed Field Cryoablation IP

VENTRICULAR TACYCARDIA (VT) ABLATIONS: LARGE, UNDERPENETRATED MARKET OPPORTUNITY

ESTIMATED MARKET OPPORTUNITY, ANNUAL PROCEDURES[1]

ESTIMATED TAM: ~1.5M VT ABLATION PROCEDURES



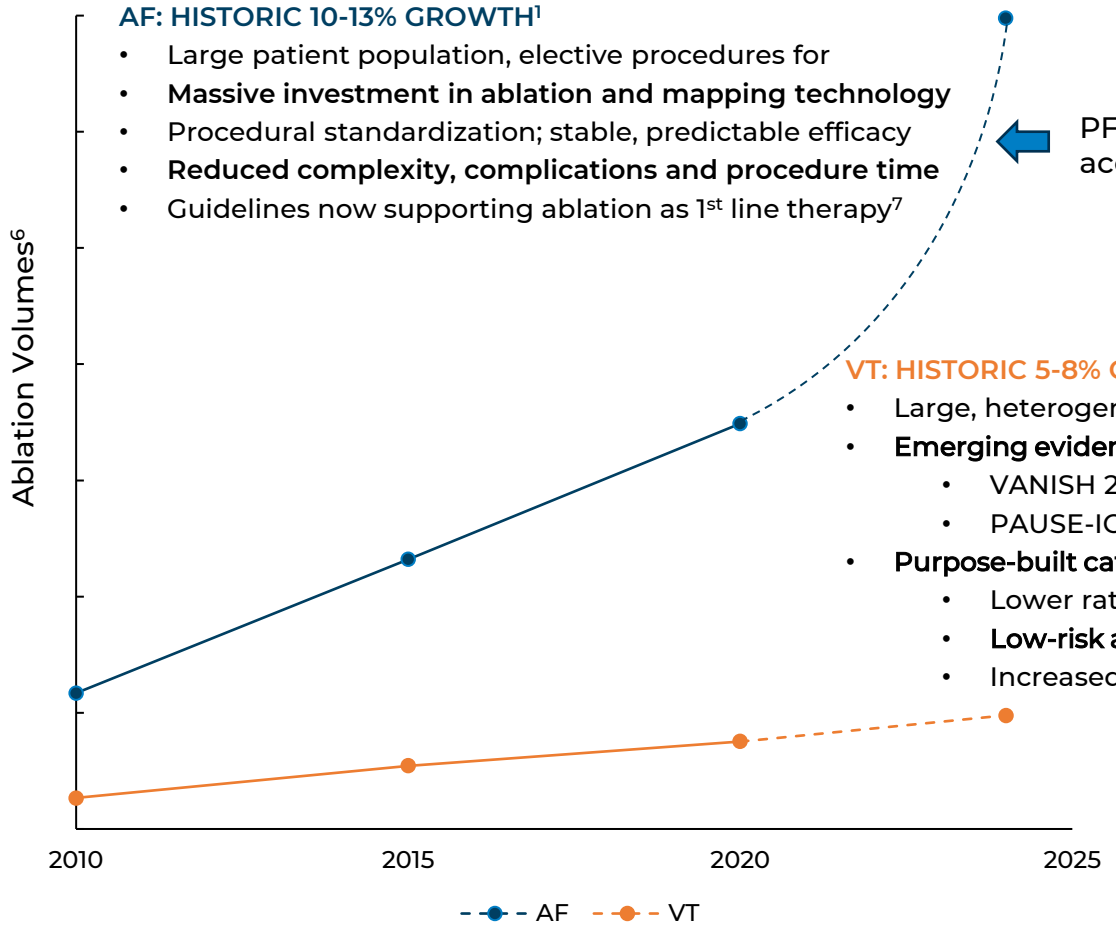
CURRENT PROCEDURAL VOLUMES (SAM) ~100K

- Two distinct patient subsets, same technology
  - Scar-related VTs in patients with structural heart disease
  - High burden, symptomatic idiopathic arrhythmias: VTs and PVCs (premature ventricular contractions)

VT MARKET POISED FOR AF-LIKE ACCELERATION

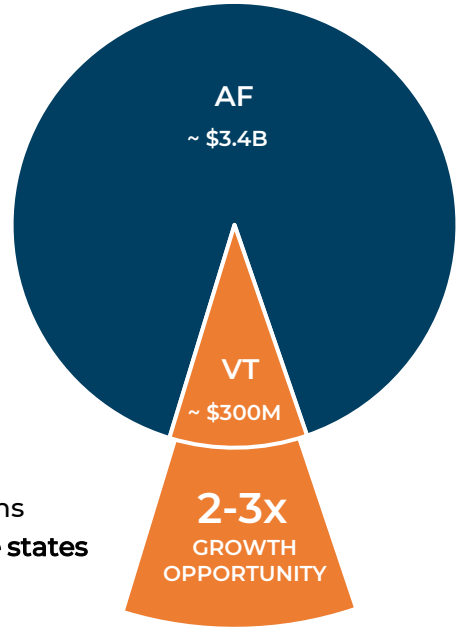
with stronger guidelines recommendations and purpose-built catheter

COMPLEX ABLATIONS MARKET DYNAMICS



For illustration purposes only. 2010-2020 data are adopted from Eckardt L, Deldl F, Busch S, et al. 10-year follow-up of interventional electrophysiology: updated German survey during the COVID-19 pandemic. Clinical Research in Cardiology (2023) 112:784–794. 2020-2024 data are approximation of the overall market trends as described in (1).

COMPLEX ABLATIONS CATHETER MARKET SIZE TODAY: ~ $3.7B[1]



CURRENT PROCEDURAL COMPLICATIONS[4,5]	
Death	2.7%
Perforations/tamponade	2.0%
Major Bleeding	5.6%
Vascular	1.7%
Stroke	0.4%
Unspecified	1.8%
Total Complication Rate	**11.5%**

~ $1B

ULTRA-LOW TEMPERATURE VT CRYOABLATION

System and catheter purpose-designed for ventricular ablations
2-year head start on regulatory approvals

DIFFERENTIATED AND HIGHLY DESIRABLE FUNCTIONAL PERFORMANCE

- Large, durable lesions of **titratable depth (>10 mm)**
- Endocardial ablations of mid-myocardial scar
- Catheter stability during energy delivery
- Time and effort efficient procedures with few lesions
- No catheter irrigation simplifies hemodynamic management in HF patients

- Clinically tested in patients with ischemic and non-ischemic cardiomyopathy - routinely used in all-comer patient population (including idiopathic VT/PVCs)

-196^{0}C LN_2 Cryoablation Console

* Image adopted from: Mayo Clinic, https://www.mayoclinic.org/, with modifications/

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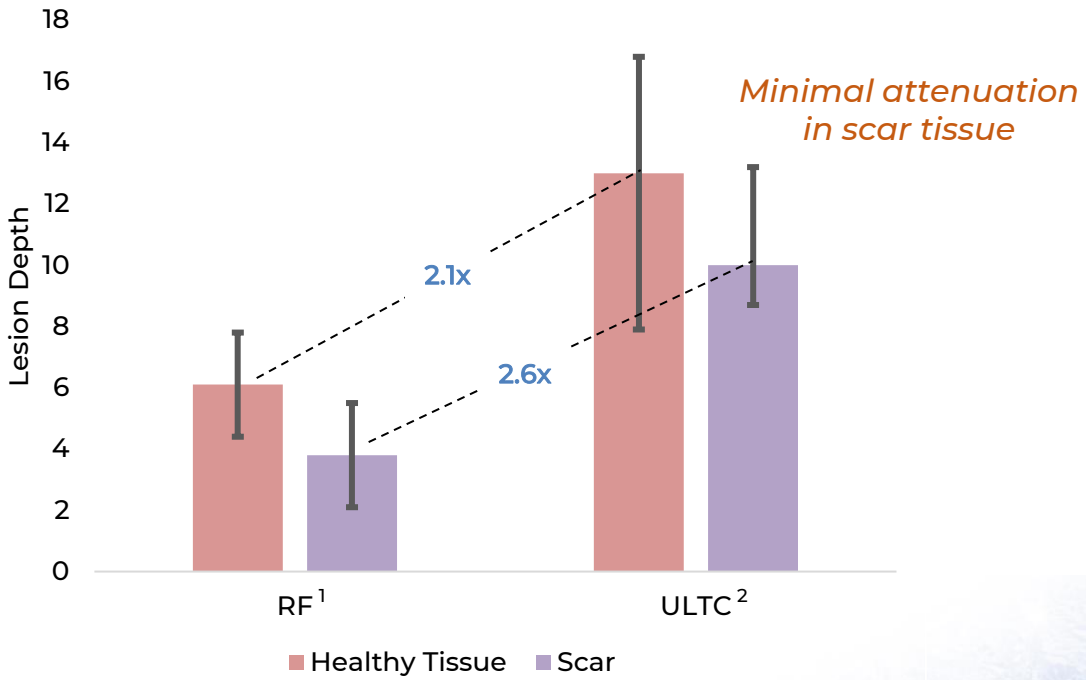
ULTRA-LOW TEMPERATURE CRYOABLATION (ULTC): SAFE, LARGE AND DEEP VENTRICULAR LESIONS

ULTC FREEZE AND LESIONS (PRE-CLINICAL)

Video courtesy Dr. Petr Neuzil, Nemecina Na Homolce, Prague, CZ.
Preclinical images are adopted from Verma et al.[3]

VENTRICULAR LESION DEPTH FROM DIFFERENT ENERGY SOURCES



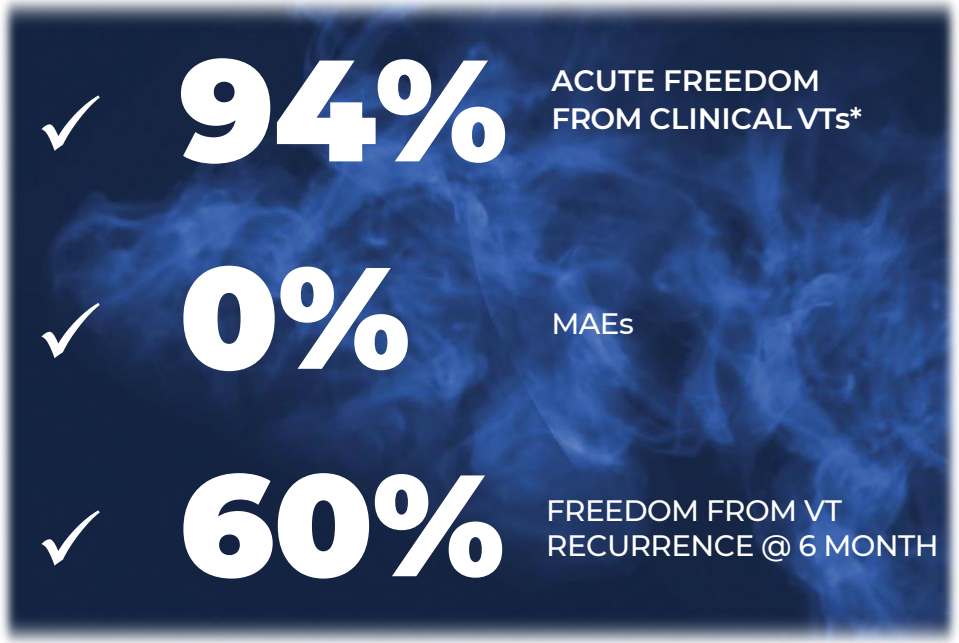
UNIQELY SUITABLE ANATOMIC TARGETS

- Deep (as well as large area) ischemic scars
- Mid-myocardial non-ischemic scars
- All-cause sub-epicardial circuits from endocardium

IMPACTFUL CLINICAL RESULTS: CRYOCURE-VT[1,2]

Nine (9) centers in EU and Canada; 64 patients with ischemic and non-ischemic cardiomyopathy; data used for CE Mark

- **Efficient Procedures**
  - Average Procedure Time: 185 min (*vs 225 - 273 min for RF*[3])
  - Average # of Lesions per Patient: 9 (*vs 24 - 34 for RF*[4,5])
- **Safety Profile**
  - 0% Major Adverse Events ← FDA Trial Primary Endpoint
- **Acute Effectiveness**
  - 94% non-inducibility of clinical VTs
  - 97% elimination of VT morphologies
- **Chronic effectiveness @ 6 months**
  - 60.3% freedom from VT recurrence ← FDA Trial Primary Endpoint
  - 81.0% freedom from ICD shock
  - No difference between ischemic & non-ischemic outcomes
- **Sustained improvement in VT burden & toxic Rx use**
  - 6-mo median number of events reduction from 4 to 0
  - 60% reduction in amiodarone use



* patients with inducible clinical VTs pre-ablation and which were non-inducible post-ablation

PROVEN SAFETY AND EFFECTIVENESS

Adagio Results Exceed Hurdles of Currently Approved and Investigational Devices for VT

Manufacturer / Device / Study		Energy Source	*Indication*	Access	Procedure Time, min	# of Lesions	Irrigation Volume, L	*Acute Complications* [a]			*Acute Effectiveness* [b]	*Chronic Effectiveness* [c]
								All	*Death*	*Stroke*		
Adagio[1]	**CRYOCURE-VT**	**ULTC**	**ICM+NICM**	**Endo**	**188**	**9**	**0**	**6.1%**	**0%**	**0%**	**94%**	**60%**
JnJ[2]	Thermocool PM	RF	ICM	Endo	270	34	1.5	4.3%	1.3%	0%	76%	62%
JnJ[3,7]	Thermocool IDE	RF	ICM	Endo	315	24	1.3	18.0%	3.4%	0%	49%	53%
Abbott[6]	LESS-VT IDE	RF	NICM	Endo+Epi	232[d]	NR	0.75[d]	21.1%	1.2%	0.6%	93%	58%
Thermedical[4]	SERF Needle	RF	ICM+NICM	Endo	282	10	0.09	18.8%	6.3%	6.3%	97%	50%
BWH & JnJ[5]	SERF Needle	RF	ICM+NICM	Endo	316	12	0.07 (est.)	19.5%	0%	0%	65%	40%

[a] All complications reflect the rate of "serious adverse events" although the definitions vary between the studies
[b] Acute effectiveness reflects non-inducibility of the targeted VTs, although definitions vary between the studies
[c] Chronic effectiveness reflects primary endpoints of the study inclusive of the freedom from recurrence at 6 months, although definitions vary between the studies
[d] Index procedure only. Higher values reported in limited number of staged procedures

Cleared by FDA in for use in U.S.

Investigational Device in the US

*For reference only: variability in end-points definition and lack of randomization

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FULCRUM-VT* PIVOTAL STUDY

Proposed Indication: treatment of scar-mediated monomorphic ventricular tachycardia (MVT) by ablation of arrhythmogenic tissues that drive and maintain these arrhythmias.

- **Study Design**
  - Single arm; 206 patients across ~20 sites
  - Ischemic cardiomyopathy
  - Non-ischemic cardiomyopathy

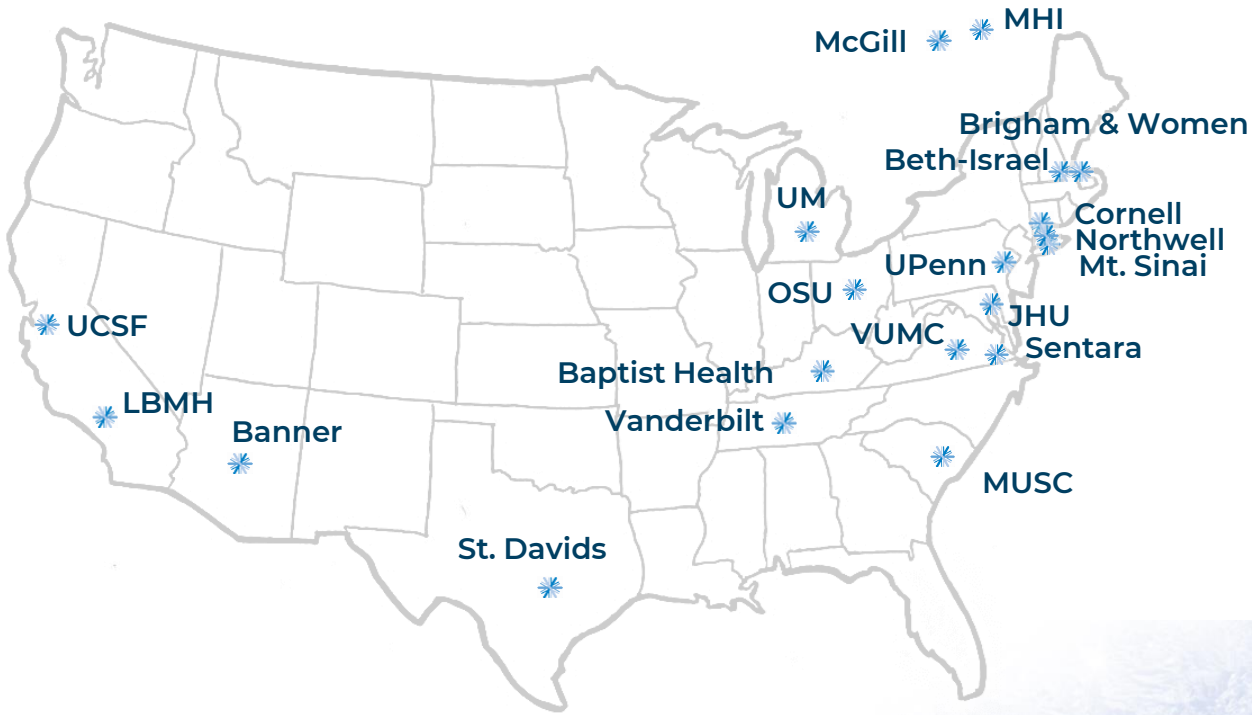
  } ~50/50 split

- **Performance Goals**[1]

Goals	Metrics	Value	Cryocure-VT Reference
Primary Safety	Major Adverse Events @ 7 days	≤ 20%	0%
Primary Effectiveness	Freedom from VT recurrence @ 6 month	≥ 50%	60%

- **Status**
  - > 35% enrolled
  - Expected primary end points: 2H' 2025

FULCRUM-VT CENTERS

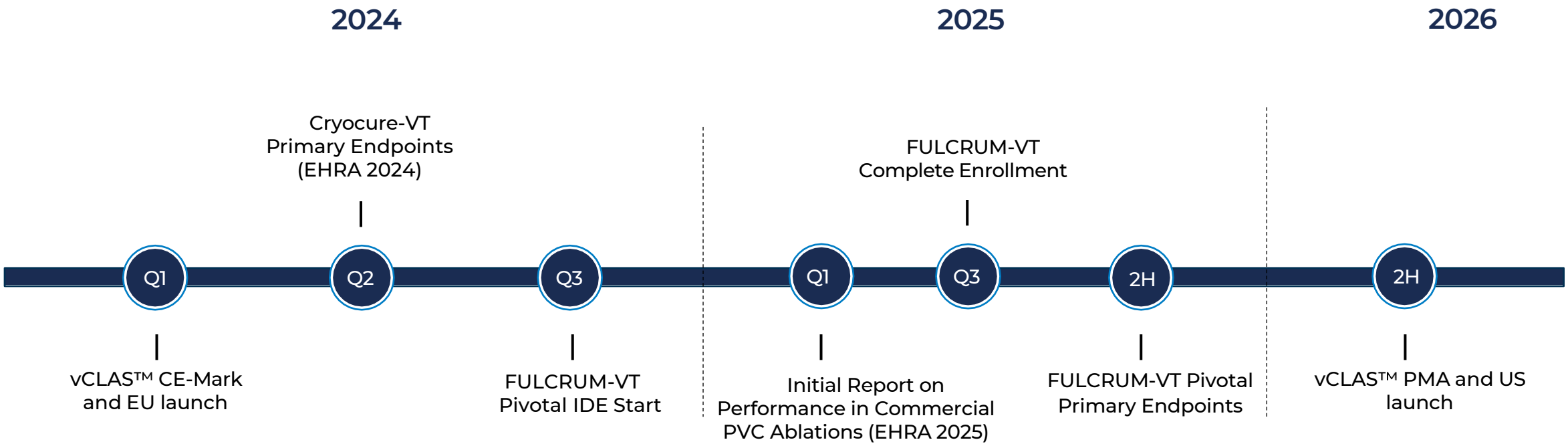


*FEASIBILITY OF ULTRA-LOW TEMPERATURE CRYOABLATION FOR RECURRING MONOMORPHIC VT, NCT #05675865

2. Adagio Medical CS-300. Data on File.

FULCRUM-VT PRIMARY ENDPOINTS - 2025

+ Other Key Clinical Read-outs



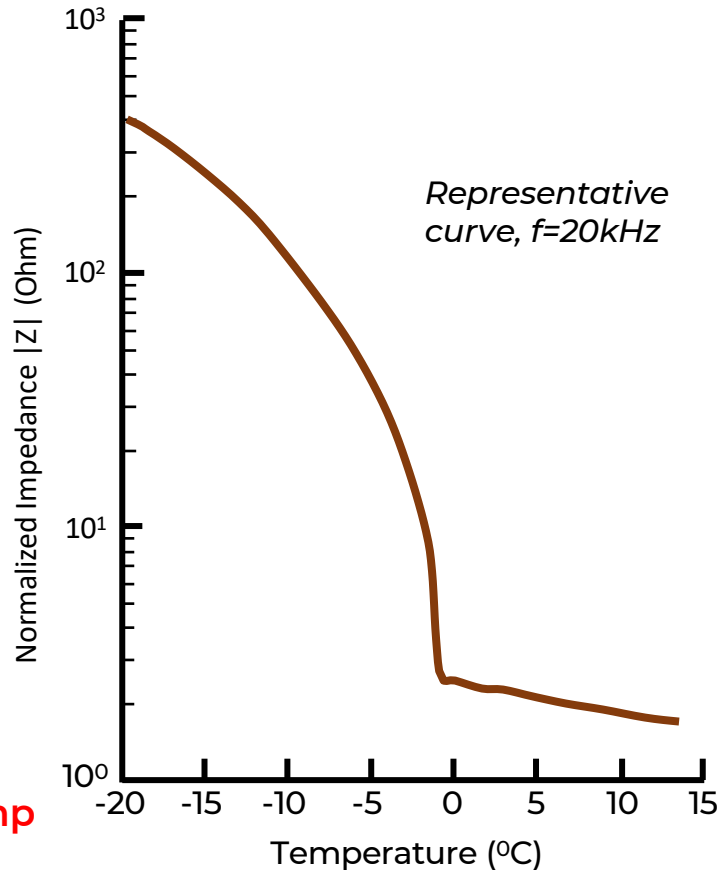
Note: Milestones are preliminary and subject to change. Please see Disclaimer – Forward-Looking Statements on slide 2.

PFCA: DESIRED DEPTH WITH LESS ENERGY

Pulsed Field Cryoablation (PFCA): short duration ULTC followed by PFA using the came catheter

INCREASED IMPEDANCE OF FROZEN TISSUE DRAMATICALLY REDUCES PFA CURRENT[1]

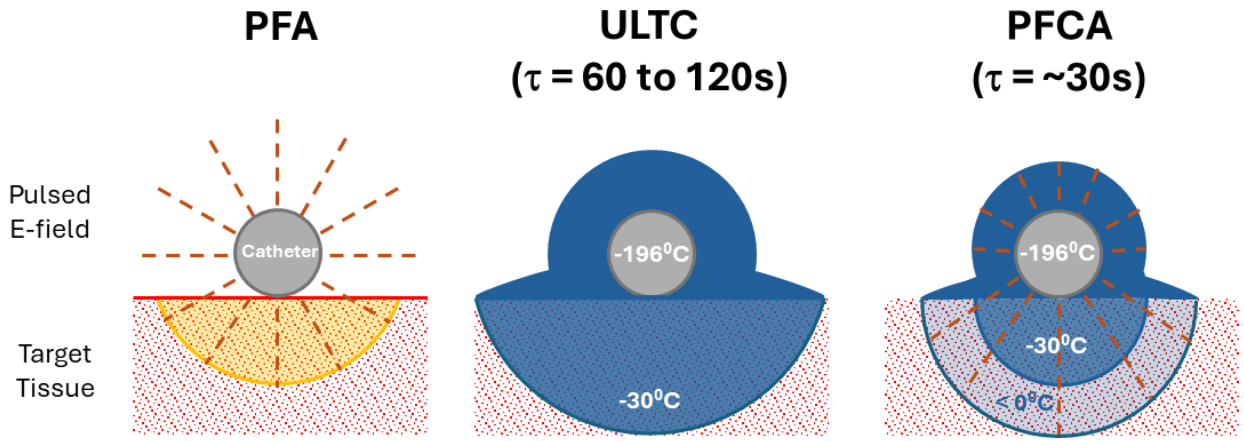
Atrial PFCA[7]: < 1 Amp



Representative curve, f=20kHz

Atrial PFA[6]: up to 25 Amp

CONCEPT AND POTENTIAL BENEFITS OF PFCA[2,3,4]



τ - energy application time per lesion

- Consistent tissue contact
- No phrenic nerve capture
- No skeletal muscle activation
- No or minimized microbubbles
- No or minimized coronary spasm[5]

Demonstrated in AF- but of even higher importance for VT ablations

LEADERSHIP TEAM: ~200 YEARS OF MEDTECH EXPERIENCE

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John Dahldorf
Chief Financial Officer

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THANK YOU

REFERENCES

Slide #3

1. Market size and growth potential are based on management's analysis and projections using internal and third-party estimates and resources, subject to certain assumptions and limitations.
Note: Management's analysis and estimates which are subject to significant uncertainty and may prove to be incorrect.

Slide #4

1. Total available and currently served market sizes are based on management's analysis and projections using internal and third-party estimates and resources, subject to certain assumptions and limitations.
Note: Management's analysis and estimates which are subject to significant uncertainty and may prove to be incorrect.

Slide #5

1. The current catheter market size, historical and future market growth are based on management's analysis and calculations using internal and third-party estimates and resources, subject to certain assumptions and limitations.
2. Sapp JL, Tang ASL, Parkash R, Stevenson WG, et al, Catheter Ablation or Antiarrhythmic Drugs or Ventricular Tachycardia. N Engl J Med 2024 Nov 16. doi: 10.1056/NEJMoa2409501
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Slide #7

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2. Dewland TA, Higuchi S, Venkateswaran R, Lee C, Gerstenfeld EP. AB-452672-2 Ultra-low Temperature Cryoablation Versus Ultra-low Temperature Cryoablation Combined With Pulsed Field Ablation In A Swine Ventricular Infarct Model. Heart Rhythm 2023;20:S92-S93. doi: doi.org/10.1016/j.hrthm.2023.03.395 . Reference slide #87 for further detail.
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Slide #8

1. De Potter T, , Balt, JC, Boersma L, et al. First-in-Human Experience With Ultra-Low Temperature Cryoablation for Monomorphic Ventricular Tachycardia. J Am Coll Cardiol EP 2023; 9(5):686-691
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Slide #9

1. Verma A, Essebag V, Neuzil P , et al. Cryocure-VT: the safety and effectiveness of ultra-low-temperature cryoablation of monomorphic ventricular tachycardia in patients with ischaemic and non-ischaemic cardiomyopathies. EP Europace 2024; 26(4):euae076
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7. Thermocool SmartTouch Bi-Directoinal Navigation Catheter, Instructions For Use. https://www.e-ifu.com/search-document-metadata/THERMOCOOL%20SMARTTOUCH%E2%84%A2%20Bi-Directional%20Navigation%20Catheter

Slide #10

1. Adagio Medical CS-300, Data on File.

Slide #13

1. Fischer G et al. Impedance and conductivity of bovine myocardium during freezing and thawing at slow rates – implications for cardiac cryoablation. Medical
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6. Verma A, Neal R, Evans J, et al. Characteristics of pulsed electric field cardiac ablation porcine treatment zones with a focal catheter. J Cardiovasc Electrophysiol. 2023;34:99–107.
7. Adagio Medical Internal Assessments.

APPENDIX

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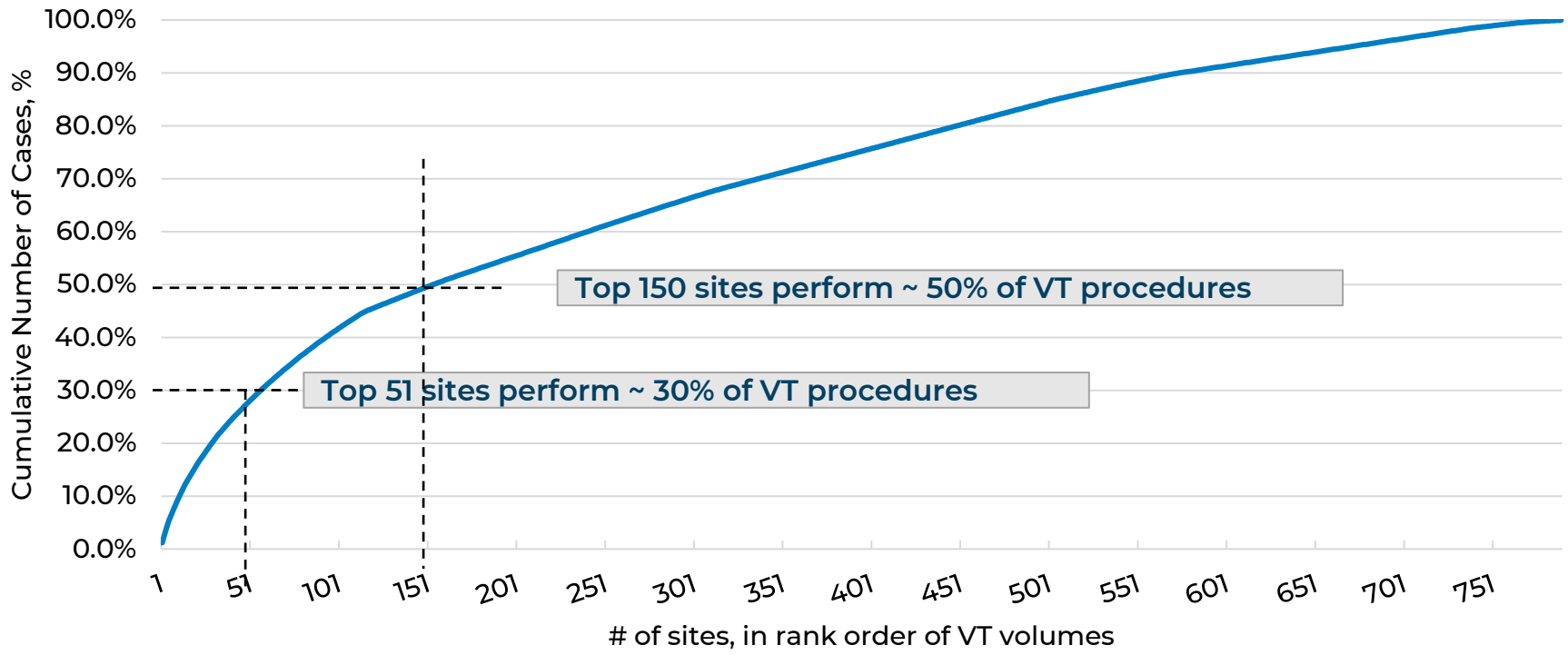
US MARKET- EARLY MARKET PENETRATION OPPORTUNITY

US VT MARKET STRUCTURE[1]



1) Based on management's analysis of Medicare FFS data, subject to certain assumptions and limitations. Please see Slide #71 which is part of Appendix II - Market Sources & Analysis for further details.

BOARD OF DIRECTORS: OVER 150 YEARS OF MEDTECH EXPERIENCE

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Cardiac Surgeon

Sandra Gardiner
FLG Partners
FMR CFO Pulse Biosciences

Tim Moran
CEO, Avertix

Keyvan Mirsaeedi-Farahani, MD
Perceptive Advisors

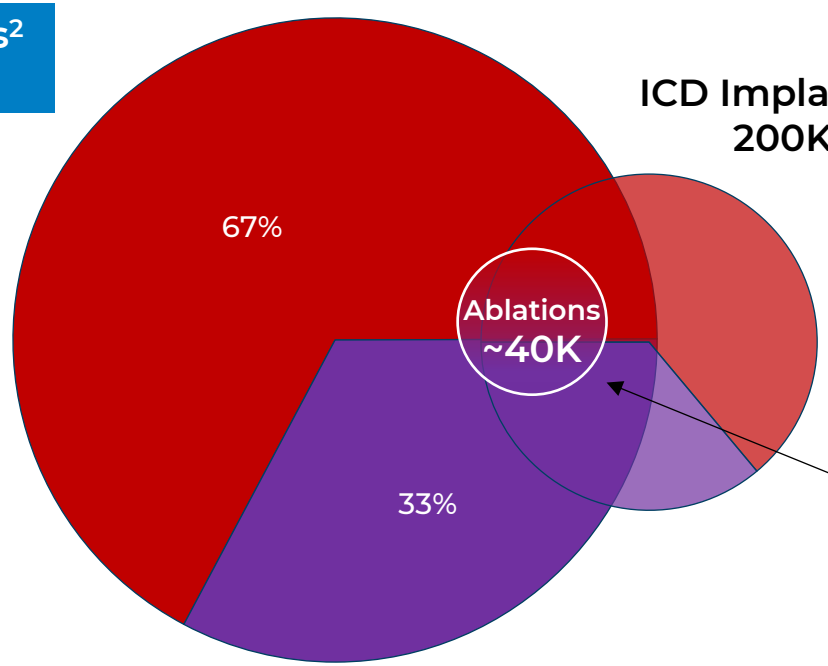
VENTRICULAR ABLATIONS: 1.5M PTS. OPPORTUNITY

With the exception of the specific PVC presentation, current guidelines treat VT ablation as 2nd line therapy after antiarrhythmic Rx[7,8]

Structural Heart Disease Arrhythmias Estimated Annual TAM

VT Events[2] ~ 700K

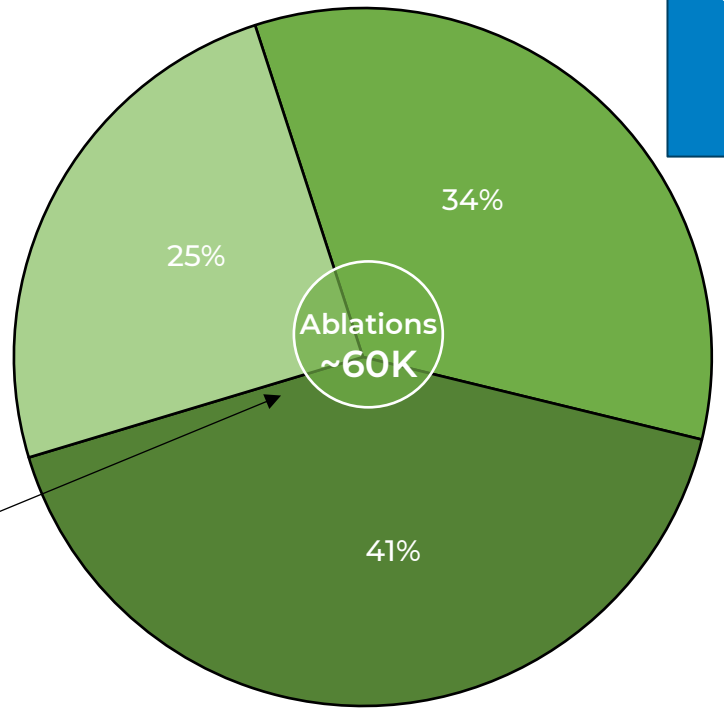
ICD Implants[3,4,5] 200K+



Current SAM: ~100K procedures[9]

Idiopathic Arrhythmias Estimated Annual TAM

High Risk VT/PVC Events[6] ~800K



- Coronary (Ischemic) Heart Disease
- Non-Ischemic Cardiomyopathies
- High Burden Idiopathic VT
- High Burden Symptomatic PVC
- VA-Induced Cardiomyopathy

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6. Management analysis of WW population incidence based on Sirichand SS, Killu AM, Parmanadhan, et al. Incidence of Idiopathic Ventricular Arrhythmias A Population-Based Study. Circ Arrhythm Electrophysiol. 2017;10:e004662
7. . Cronin EM, Bogun FM, Maury P, et al. 2019 HRS/EHRA/APHRS/LAHRS expert consensus statement on catheter ablation of ventricular arrhythmias. Heart Rhythm 2020; 17:e3-e154
8. Zeppenfeld K, Tfelt-Hansen J, da Riva Marta, et al. 2022 ESC Guidelines for the management of patients with ventricular arrhythmias and the prevention of sudden cardiac death. European Heart Journal (2022) 43, 3997–4126
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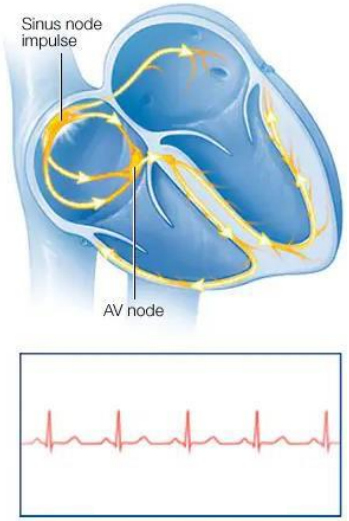
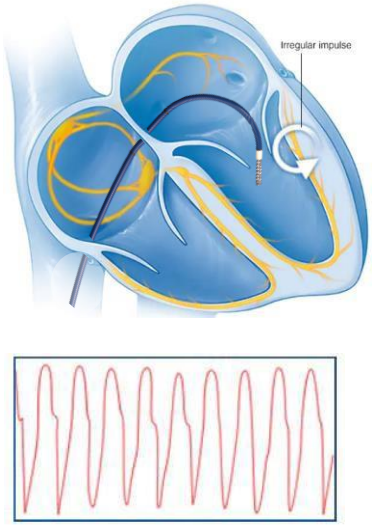
Adagio™ MEDICAL

VENTRICULAR TACHYCARDIA (VT)

Normal Electrical Conduction



Ventricular Tachycardia (VT)

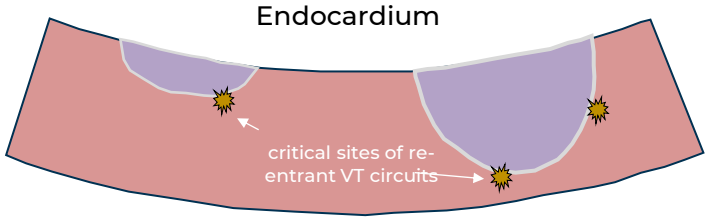


Adopted from: Mayo Clinic, https://www.mayoclinic.org/

- Catheter ablation creates lesions in myocardial tissue which interrupt VT circuits
- Requires lesion depth and durability to achieve acute success and minimize future recurrences

SCAR-MEDIATED VTs

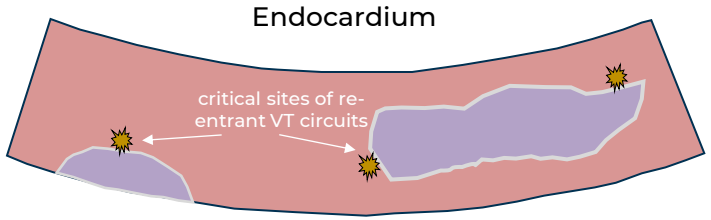
ISCHEMIC SCAR[1,2]



Epicardium with coronary vessels

< 10% require additional epicardial ablations[3]

NON-ISCHEMIC SCAR[2,4,5]

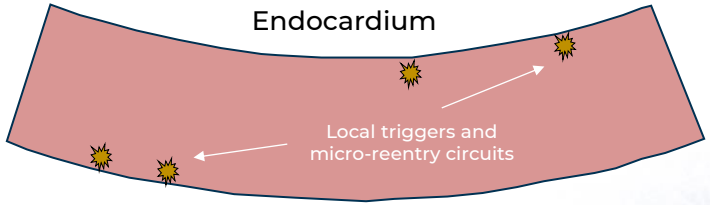


Epicardium with coronary vessels

> 30% require epicardial or endo-epicardial ablations[3,6]

IDIOPATHIC VTs

LOCAL TRIGGERS AND RE-ENTRY[7]



Epicardium with coronary vessels

anatomically-specific localized endocardial and epicardial ablation sites

1. Bourantas CV, Nikitin NP, Loh HP, et al. Prevalence of scarred and dysfunctional myocardium in patients with heart failure of ischaemic origin: A cardiovascular magnetic resonance study. Journal of Cardiovascular Magnetic Resonance 2011, 13:53
2. Piers SRD, Tao Q, de Riva Silva M, et al. CMR–Based Identification of Critical Isthmus Sites of Ischemic and Nonischemic Ventricular Tachycardia. J Am Coll Cardiol Img 2014;7:774–84
3. Dinov B, Fielder L, Schonbauer R, et al. Outcomes in Catheter Ablation of Ventricular Tachycardia in Dilated Nonischemic Cardiomyopathy Compared With Ischemic Cardiomyopathy. Circulation. 2014;129:728-736.
4. Kanagasundram A, John RM, Stevenson WG. Sustained Monomorphic Ventricular Tachycardia in Nonischemic Heart Disease: Arrhythmia-Substrate Correlations That Inform the Approach to Ablation. Circ Arrhythm Electrophysiol. 2019;12:e007312
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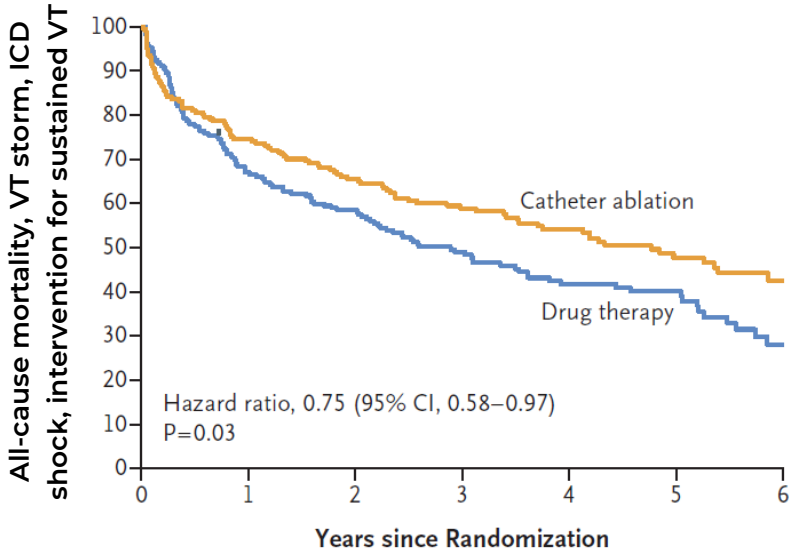
6. Vaseghi M, Hy TY, Tung R, et al. Outcomes of Catheter Ablation of Ventricular Tachycardia Based on Etiology in Nonischemic Heart Disease. J Am Coll Cardiol EP 2018;4:1141–50
7. Muser D, Tritto M, Mariani MV, et al. Diagnosis and Treatment of Idiopathic Premature Ventricular Contractions: A Stepwise Approach Based on the Site of Origin. Diagnostics 2021,;11:1840.

RECENT TRIALS POSITIVE FOR EARLY VT ABLATION

VANISH-2[1]

Ablation vs AAD in post-MI ICD patients with prior VT events

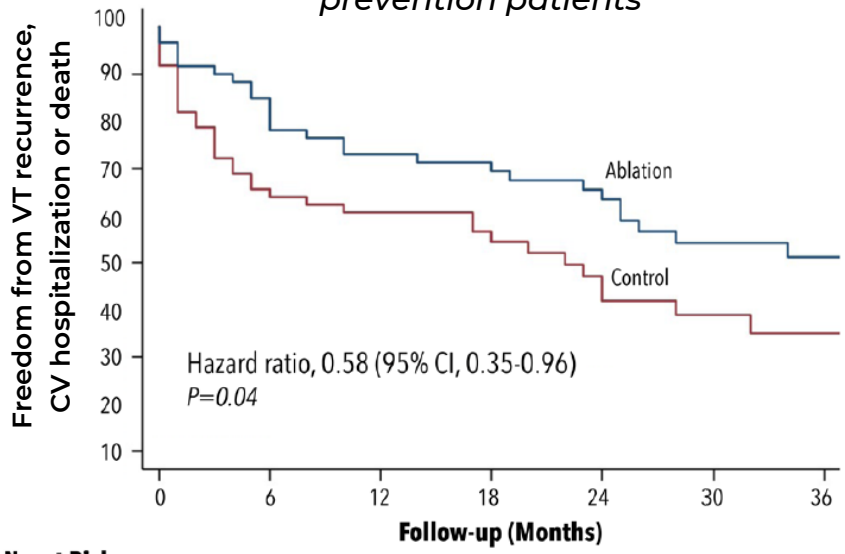


No. at Risk							
Catheter ablation	203	149	129	95	75	48	24
Drug therapy	213	142	123	81	57	37	13

- 100% ICM
- Epicardial approach: NR
- Procedure time: 212 (168-280) min
- 12.3% of peri-procedural complications (ablation arm)
  - Death: 1%
  - Stroke: 1%
  - Heart Block: 1%
  - Perforation: 0.5%

PAUSE-SCD[2]

Prophylactic ablation + ICD vs AAD + ICD in secondary prevention or inducible primary prevention patients



No. at Risk							
Control	61	40	36	26	18	11	8
Ablation	60	50	43	39	32	21	13

- 35% ICM, 65% NICM (including 35% ARVC)
- Epicardial approach: 55.4%
- Procedure time: 240 (166-280) min
- 8.3% procedure-related complications

Cardiac ablation appears superior to AAD as both prophylaxis and response to VT events in ICD population ➡ consideration for 1st line therapy

1. Sapp JL, Tang ASL, Parkash R, Stevenson WG, et al, Catheter Ablation or Antiarrhythmic Drugs or Ventricular Tachycardia. N Engl J Med 2024 Nov 16. doi: 10.1056/NEJMoa2409501
2. Tung R, Xue Y, Chen M, Jiang C, et al. First-Line Catheter Ablation of Monomorphic Ventricular Tachycardia in Cardiomyopathy Concurrent With Defibrillator Implantation: The PAUSE-SCD Randomized Trial. Circulation. 2022;145:1839–1849

RECENT TRIALS POSITIVE FOR VT ABLATION AS A 1st LINE THERAPY

VANISH-2[1]

Ablation vs AAD in post-MI ICD patients with prior VT events

416 patients: 100% ICM

An initial strategy of catheter ablation led to a lower risk of a composite primary endpoint of all-cause death, ventricular tachycardia storm, appropriate ICD shock, or sustained ventricular tachycardia treated by medical intervention than antiarrhythmic drug therapy.

PAUSE-SCD[2]

Ablation + ICD vs AAD + ICD in secondary prevention or inducible primary prevention patients

180 patients: 35% ICM, 65% NICM

Early catheter ablation performed at the time of ICD implantation significantly reduced the composite primary outcome of VT recurrence, cardiovascular hospitalization, or death.

1. Sapp JL, Tang ASL, Parkash R, Stevenson WG, et al, Catheter Ablation or Antiarrhythmic Drugs or Ventricular Tachycardia. N Engl J Med 2024 Nov 16. doi: 10.1056/NEJMoa2409501
2. Tung R, Xue Y, Chen M, Jiang C, et al. First-Line Catheter Ablation of Monomorphic Ventricular Tachycardia in Cardiomyopathy Concurrent With Defibrillator Implantation: The PAUSE-SCD Randomized Trial. Circulation. 2022;145:1839–1849

PFCA: COMBINING THE BENEFITS OF ULTC AND MINIMIZING THE LIMITATIONS OF PFA

PFA Console

Cryoablation Console

Connected to standalone or integrated cryoablation and PFA consoles

Single catheter with ablation element capable of both ultra-low temperature cryoablation and PFA

Lesion Formation:

1. Short duration ultra-low temperature cryoablation
2. Immediately followed by PFA

Adagio™ MEDICAL

VT MARKET POISED FOR AF-LIKE ACCELERATION

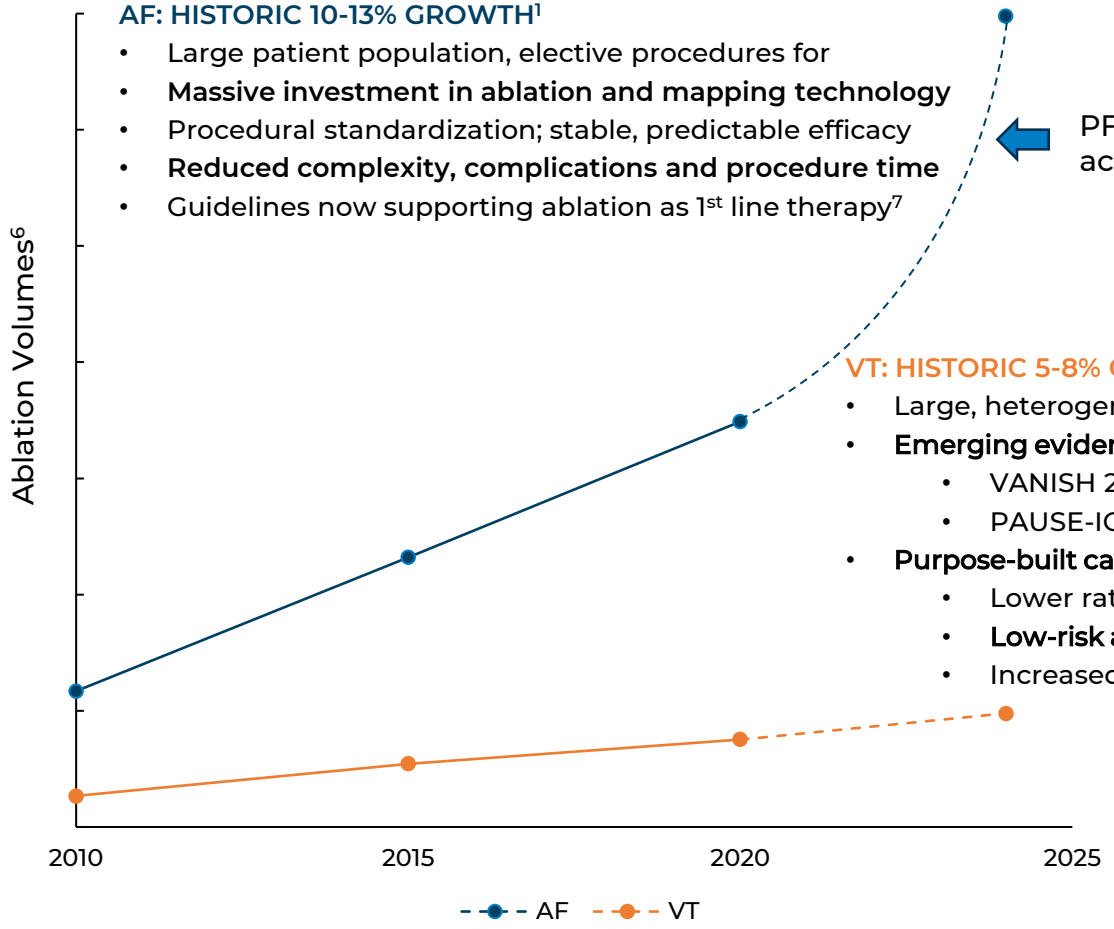
with stronger guidelines recommendations and purpose-built catheter

COMPLEX ABLATIONS MARKET DYNAMICS

AF: HISTORIC 10-13% GROWTH[1]

- Large patient population, elective procedures for
- **Massive investment in ablation and mapping technology**
- Procedural standardization; stable, predictable efficacy
- **Reduced complexity, complications and procedure time**
- Guidelines now supporting ablation as 1st line therapy[7]

PFA-driven market acceleration[1]

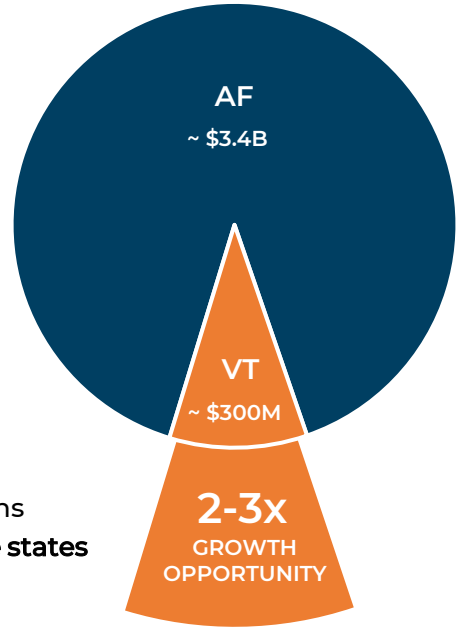


VT: HISTORIC 5-8% GROWTH[1] POISED FOR ACCELERATION

- Large, heterogeneous (and sick) patient population
- **Emerging evidence for ablation as a 1st line therapy[2,3]**
  - VANISH 2
  - PAUSE-ICE
- **Purpose-built catheter further improving risk/benefit of ablations**
  - Lower rate of procedural and peri-procedural complications
  - **Low-risk approaches to challenging anatomies and disease states**
  - Increased overall effectiveness and QOL improvement

CURRENT PROCEDURAL COMPLICATIONS[4,5]	
Death	2.7%
Perforations/tamponade	2.0%
Major Bleeding	5.6%
Vascular	1.7%
Stroke	0.4%
Unspecified	1.8%
Total Complication Rate	**11.5%**

COMPLEX ABLATIONS CATHETER MARKET SIZE TODAY: ~ $3.7B[1]



~ $1B

For illustration purposes only. 2010-2020 data are adopted from Eckardt L, Deldl F, Busch S, et al. 10-year follow-up of interventional electrophysiology: updated German survey during the COVID-19 pandemic. Clinical Research in Cardiology (2023) 112:784–794. 2020-2024 data are approximation of the overall market trends as described in (1).