

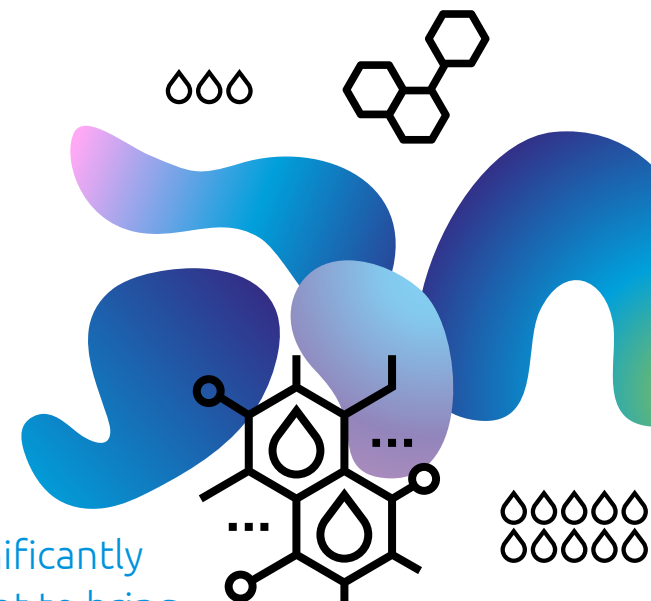


Focused innovation – from bench to bedside

Idorsia aims to deliver new products with the potential to significantly change the treatment options in their target diseases. We want to bring new perspectives to the discovery, development, and commercialization of innovative treatments, challenging accepted paradigms to answer the questions that matter most.

We have a diversified and balanced portfolio, comprising assets developed and marketed by Idorsia and assets that are partner-led to maximize the value we have created. Our drug discovery engine has produced innovative drugs with the potential to transform the treatment paradigm in multiple therapeutic areas, including CNS, cardiovascular, and immunological disorders, as well as orphan diseases.

The company also has a vaccine platform for the discovery and development of glycoconjugate vaccines containing synthetic antigenic glycan molecules, with or without a carrier protein, to prevent infection.



Our Innovation



Innovation Portfolio

Daridorexant

Aprocitentan

Lucerastat

Early-stage clinical pipeline

Preclinical pipeline

Partner-led portfolio

Key portfolio assets



Compound	Target indication	Mechanism of action	P1	P2	P3	R	C	Status
QUVIVIQ™ (daridorexant)	Insomnia	Dual orexin receptor antagonist	■	■	■	■	■	Commercially available in the US, Germany, Italy, Switzerland, Spain, the UK, Canada, Austria, France, Sweden and Finland; approved throughout the EU
Lucerastat	Fabry disease	Glucosylceramide synthase inhibitor	■	■	■	□	□	Regulatory pathway to registration agreed with the FDA and in line with the feedback received from EMA. The program is expected to support a potential regulatory filing as early as 2029
Daridorexant	Pediatric insomnia	Dual orexin receptor antagonist	■	■	□	□	□	Phase 2 in pediatric insomnia ongoing – fully recruited with results expected in Q2 2026
IDOR-1117-2520	Psoriasis	CCR6 receptor antagonist	■	■	□	□	□	Proof-of-concept study recruiting – readout expected in Q1 2027
ACT-1004-1239	Progressive multiple sclerosis	CXCR7 / ACKR3 receptor antagonist	■	■	□	□	□	Proof-of-concept study in preparation – initiation expected in Q1 2026, readout expected in Q2 2028
ACT-777991	Vitiligo	CXCR3 antagonist	■	■	□	□	□	Proof-of-concept study in preparation – initiation expected in 2026, readout expected in 2027
Synthetic Glycan Vaccine Platform			Idorsia will seek a partner for the platform or individual vaccines					
IDOR-1134-2831	<i>Clostridioides difficile</i> infection	Synthetic glycan vaccine	■	□	□	□	□	Phase 1 data showing safety and immunogenicity – advanced to a higher-dose cohort, with top-line results anticipated in mid-2026 – partnership discussions activated.

P1: Phase 1, P2: Phase 2, P3: Phase 3, R: Registration, C: Commercially available

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Compound	Target indication	Mechanism of action	Partner Terms	P1	P2	P3	R	C	Status
TRYVIO™ (aprocitentan)*	Systemic hypertension in combination with other antihypertensives	Dual endothelin receptor antagonist	In partnership discussions: worldwide development and commercialization rights	■	■	■	■	■	Commercially available in the US
JERAYGO™ (aprocitentan)*	Resistant hypertension in combination with other antihypertensives	Dual endothelin receptor antagonist	In partnership discussions: worldwide development and commercialization rights	■	■	■	■	□	Approved in the EU, UK, Switzerland, and Canada
QUVIVIQ™ (daridorexant)	Insomnia	Dual orexin receptor antagonist	Nxera Pharma: license to develop and commercialize for Asia-Pacific region (excluding China)	■	■	■	■	■	Launched for the treatment of insomnia in Japan; Phase 3 ongoing in South Korea
QUVIVIQ™ (daridorexant)	Insomnia	Dual orexin receptor antagonist	Simcere: license to develop and commercialize for Greater China region	■	■	■	■	□	Launched for the treatment of insomnia in China and Hong-Kong
Selatogrel	Acute myocardial infarction	P2Y ₁₂ inhibitor	Viartis: worldwide development and commercialization rights	■	■	■	□	□	Phase 3 "SOS-AMI" program ongoing
Cenerimod	Systemic lupus erythematosus	S1P ₁ receptor modulator	Viartis: worldwide development and commercialization rights	■	■	■	□	□	Phase 3 "OPUS" program ongoing
Daridorexant	Posttraumatic stress disorder (PTSD)	Dual orexin receptor antagonist	US Department of Defense (DOD): Idorsia is supporting a clinical study sponsored by the US DOD to develop new therapies to treat PTSD	■	■	□	□	□	Phase 2 ongoing
ACT-1002-4391	Immuno-oncology	EP ₂ /EP ₄ receptor antagonist	Owkin: global license to develop and commercialize	■	□	□	□	□	Phase 1 ongoing

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P1: Phase 1, P2: Phase 2, P3: Phase 3, R: Registration, C: Commercially available

*The rights for aprocitentan have been transferred to Idorsia Investments SARL to allow the repayment of newly created notes issued in connection with the repurchase offer completed in August 2025. More details on the transfer can be found in the [press release](#) issued on May 21, 2025 and on the exchange offer in the [press release](#) issued on August 27, 2025.

Daridorexant



Daridorexant is a dual orexin receptor antagonist (DORA) which blocks the binding of the wake-promoting orexin neuropeptides. Rather than inducing sleep through broad inhibition of brain activity, daridorexant selectively blocks the activation of orexin receptors. Consequently, daridorexant decreases the wake drive, allowing sleep to occur, without altering the proportion of sleep stages.

Chronic insomnia disorder is a condition of overactive wake signaling, which can have a profound effect on patients' lives. It can be defined as a combination of dissatisfaction with sleep quantity or quality and a significant negative impact on daytime functioning. It involves difficulty initiating and/or maintaining sleep at least three times a week for a minimum of three months.

Chronic insomnia disorder as a persistent disorder is quite different from a brief period of poor sleep, and it can take its toll on both physical and mental health. Idorsia's research has shown that poor-quality sleep can affect many aspects of daily life, including the ability to concentrate, mood, and energy levels.

Chronic insomnia disorder is a common problem, with the prevalence being approximately 10%. On this basis, and assuming a US adult population of around 250 million, there are approximately 25 million adults in the US who suffer from chronic insomnia disorder.

The treatment landscape

The goal of treatments for insomnia is to improve sleep quality and quantity, as well as daytime functioning, while avoiding next-morning residual effects. Current recommended treatment of insomnia includes sleep hygiene recommendations, cognitive behavioral therapy, and pharmacotherapy.

With regard to prescription medications, patients are treated with products indicated for insomnia, as well as off-label treatments. The on-label treatment category primarily comprises drugs that induce sleep by enhancing GABA, the primary inhibitory neurotransmitter in the brain, which works by slowing brain activity in a non-targeted manner. There are two main categories of GABA agonists – benzodiazepines and non-benzodiazepines. In addition, other approved insomnia medications include a melatonin receptor agonist and a low-dose tricyclic antidepressant. The first products in a new class of dual orexin receptor antagonists are available in North America

and certain Asia-Pacific markets. These have now been joined by daridorexant, which is available in the US and the first countries in Europe. The most widely used off-label treatment for insomnia in the US is a selective serotonin reuptake inhibitor (SSRI) which has an off-target sedation effect.

Global registration program

The Phase 3 registration program comprised two three-month studies, together with a long-term double-blind extension study. The program is now complete, having enrolled around 1,850 patients with insomnia. As insomnia often presents later in life, and elderly patients are more likely to experience fragmented sleep, early awakening, and daytime sleepiness, around 40% of the recruited population was aged 65 years or older.

The placebo-controlled studies investigated the effects of three doses of daridorexant (Study 1: 50 mg and 25 mg; Study 2: 25 mg and 10 mg) on sleep and daytime functioning parameters – objectively

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in a sleep lab by polysomnography and subjectively with a daily patient diary at home. The impact of insomnia on patients' daytime functioning was measured daily using the sleepiness domain score from the Insomnia Daytime Symptoms and Impacts Questionnaire (IDSIQ) – a patient-reported outcome (PRO) instrument validated according to the FDA Guidance for Industry, including patient input.

More than 800 patients continued treatment in the 40-week extension study, which measured the effect of all three doses versus placebo, generating data for long-term treatment of insomnia.

As reported by Mignot E, et al. in the February 2022 issue of *The Lancet Neurology*, the pivotal studies demonstrated that daridorexant significantly improved sleep onset, sleep maintenance and self-reported total sleep time at months 1 and 3 compared to placebo. The largest effect was observed with the highest dose (50 mg), followed by 25 mg, while the 10 mg dose did not have a significant effect. In all treatment groups, the proportions of sleep stages were preserved, in contrast to findings reported with benzodiazepine receptor agonists.

A major focus of the trials was to evaluate the impact of daridorexant on daytime functioning in patients with insomnia, as assessed by the IDSIQ. The sleepiness domain score of the IDSIQ was evaluated as a key secondary endpoint in both pivotal studies, and comparisons to placebo included control for multiplicity. Daridorexant 50 mg demonstrated a highly significant improvement in daytime sleepiness at month 1 and month 3, while the sleepiness domain score was not significantly improved on 25 mg in either study at either timepoint. Daridorexant 50 mg also improved the additional IDSIQ domain scores (alert/cognition, mood) and total score (p values <0.0005 versus placebo not adjusted for multiplicity). Improvements in daytime functioning with daridorexant 50 mg progressively increased over the three months of the study.

The overall incidence of adverse events was comparable between treatment groups. Adverse events occurring in more than 5% of participants were nasopharyngitis and headache. There were no dose-dependent increases in adverse events (including somnolence and falls) across the dosing range. Further, no dependence, rebound insomnia, or withdrawal effects were

observed upon abrupt discontinuation of treatment. Across treatment groups, adverse events leading to treatment discontinuation were numerically more frequent with placebo than with daridorexant.

In addition to the results published in *The Lancet Neurology*, the final results of the 40-week extension study with daridorexant became available in April 2021. This study collected information on the safety of long-term treatment, as well as allowing an exploratory analysis of the maintenance of efficacy. There were no new emerging safety findings. Moreover, efficacy for sleep and daytime functioning appeared to be maintained over the longer treatment duration.

Furthermore, a comprehensive clinical pharmacology program has been conducted, with a total of 26 studies assessing, for example, abuse liability, drug-drug interactions, next-morning driving in healthy participants, the effects of daridorexant on respiratory function in patients with chronic obstructive pulmonary disease or obstructive sleep apnea, and the pharmacokinetics of daridorexant in patients with liver and renal impairment.

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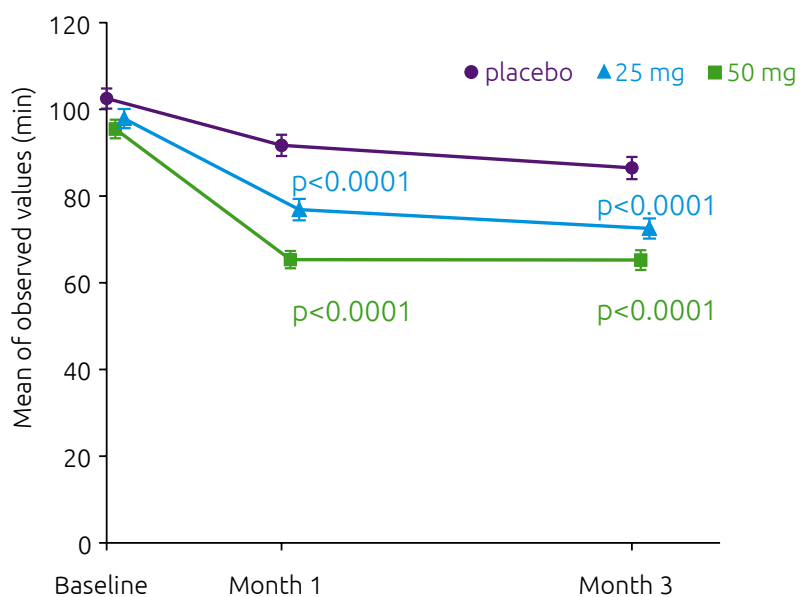
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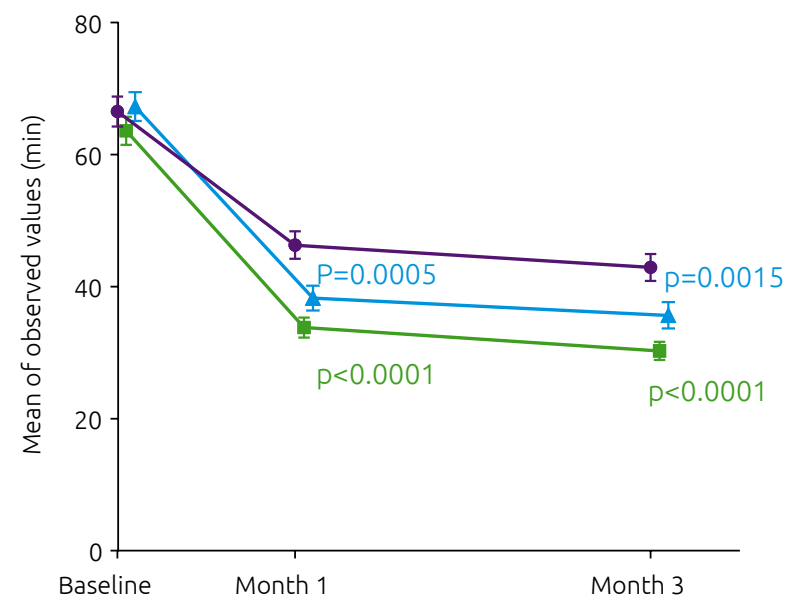
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Wake time after sleep onset



Latency to persistent sleep



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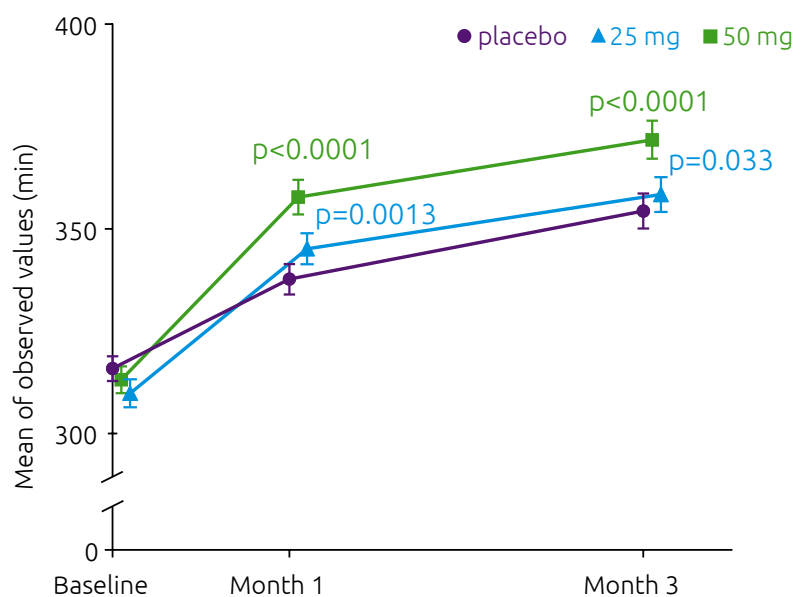
Mean of observed wake time after sleep onset (WASO) values at study timepoints in study 1.

Mean of observed latency to persistent sleep (LPS) values at study timepoints in study 1.

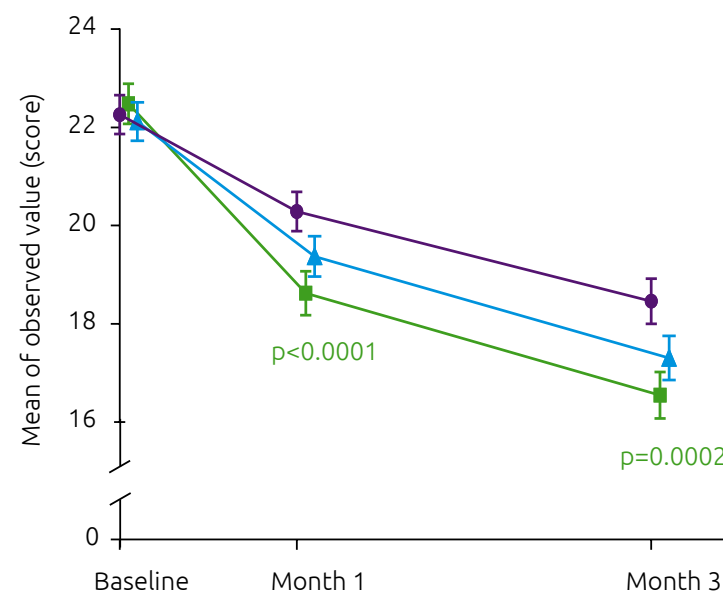
WASO and LPS values are the mean of polysomnography recordings obtained over two consecutive nights during the 3-month double-blind treatment period. Error bars show standard error of the mean. Two-sided p values shown are versus placebo, calculated using the linear mixed effects model for repeated measures.

Mignot E, et al. *Lancet Neurol.* 2022; 21: 125–39

Subjective total sleep time



IDSIQ sleepiness domain



Mean of observed self-reported total sleep time (sTST) values at study timepoints in study 1.

Mean of observed IDSIQ sleepiness domain scores at study timepoints in study 1.

Data for sTST and IDSIQ scores are based on the mean of daily entries in the 7 days before polysomnography nights. Error bars show standard error of the mean. Two-sided p values shown are versus placebo, calculated using the linear mixed effects model for repeated measures.

Mignot E, et al. *Lancet Neurol.* 2022; 21: 125–39

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Phase 4 study in patients with chronic insomnia and nocturia

In March 2025, data from a Phase 4 study with daridorexant in patients with chronic insomnia and nocturia was published in the [Journal of Sleep Research](#). The new data provides evidence of the benefit of daridorexant, at a daily dose of 50 mg, in patients aged ≥ 55 years with chronic insomnia and comorbid nocturia, with efficacy data on symptoms of both conditions, improvement in daytime functioning, and a good safety and tolerability profile.

Current status in the US

In January 2022, QUVIVIQ (daridorexant) 25 mg and 50 mg was approved by the US FDA for the treatment of adult patients with insomnia, characterized by difficulties with sleep onset and/or sleep maintenance. QUVIVIQ was launched in

the US in May 2022. For more information about QUVIVIQ in the US, see the [Full Prescribing Information](#).

Current status in the EUCAN region



In April 2022, marketing authorization for QUVIVIQ was granted by the European Commission and subsequently by the Medicines and Healthcare products Regulatory Agency (MHRA) in Great Britain for the treatment of adult patients with insomnia characterized by symptoms present for at least three months and considerable impact on daytime functioning, making it Europe's first approved dual orexin receptor antagonist. In November 2022, QUVIVIQ was launched in Italy and Germany, followed by Spain in September, UK in October 2023, Austria in February 2024, France in March 2024,

Sweden in September 2024, and Finland in June 2025.

For more information about QUVIVIQ in the EU, see the [Summary of Product Characteristics](#). Marketing authorization for QUVIVIQ was also granted by Swissmedic in December 2022, and the company made QUVIVIQ available to patients in Switzerland in June 2023. For more information about QUVIVIQ in Switzerland, see the [Patient Information and Information for Healthcare Professionals](#). Market authorization for QUVIVIQ was also granted by Health Canada in April 2023, and the company made it available to patients in Canada in November 2023. For more information about QUVIVIQ in Canada, see the [Product Monograph](#).

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Current status in global clinical development

Idorsia is conducting a Phase 2, dose-finding study to assess the efficacy, safety, and pharmacokinetics of multiple-dose oral administration of daridorexant in pediatric patients aged 10 to <18 years with insomnia disorder (NCT05423717). The primary objective of the study is to characterize the dose-response relationship of daridorexant on objective total sleep time (TST), using polysomnography. Patients will be randomized in a 1:1:1:1 ratio to 10 mg, 25 mg, or 50 mg daridorexant, or placebo and treated for 2 weeks. The study is expected to complete enrollment by the end of 2025 with readout expected in Q2 2026. The study is part of a US FDA-approved Pediatric Study Plan and an EU PDCO-approved Paediatric Investigational Plan.



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Milestones

- 2025 QUVIVIQ launched by Simcere in China and Hong Kong
- 2025 QUVIVIQ launched in Finland
- 2024 Nxera launches QUVIVIQ in Japan
- 2024 QUVIVIQ launched in Sweden
- 2024 Positive results in patients with insomnia and comorbid nocturia
- 2024 QUVIVIQ launched in Austria
- 2023 QUVIVIQ launched in Switzerland, Spain, UK, and Canada
- 2023 Citizens petition filed in the US to deschedule DORA class
- 2022 QUVIVIQ launched in Italy and Germany
- 2022 European Commission approves QUVIVIQ
- 2022 QUVIVIQ launched in the US
- 2022 Phase 3 data reported in The Lancet Neurology
- 2020 Both pivotal studies report positive results
- 2018 Initiation of Phase 3 registration program
- 2017 Completion of Phase 2 clinical program
- 2015 Initiation of Phase 1 clinical program

Key scientific literature

- Dauvilliers Y et al. Sleep Medicine. 2025. doi: 10.1016/j.sleep.2025.106523.
- Lederer K et al. Journal of Sleep Research. 2025. doi: 10.1111/jsr.70002
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- Zammit, G., et al. (2020). Neurology 94(21): 1-11.
- Muehlan, C., et al. (2020). J Clin Psychopharmacol 40(2): 157-166.
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- Boof, M. L., et al. (2019). Eur J Clin Pharmacol 75(2): 195-205.
- Muehlan, C., et al. (2019). Curr Drug Metab 20(4): 254-265.
- Muehlan, C., et al. (2019). Eur Neuropsychopharmacol 29(7): 847-857.
- Muehlan, C., et al. (2018). Clin Pharmacol Ther 104(5): 1022-1029.
- Treiber, A., et al. (2017). J Pharmacol Exp Ther 362(3): 489-503.
- Brisbane-Roch, C., et al. (2007). Nat Med 13(2): 150-5.

Aprocitentan



Aprocitentan is a once-daily, orally active, dual endothelin receptor antagonist, which inhibits the binding of ET-1 to ET_A and ET_B receptors. Aprocitentan has a low potential for drug-drug interaction and a mechanism of action that is ideally suited for lowering blood pressure in adult patients whose hypertension is not adequately controlled by other drugs.

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Hypertension is one of the leading causes of cardiovascular disease worldwide, impacting an estimated 1.3 billion people globally. Approximately 10% of these people have uncontrolled blood pressure (BP), despite receiving at least three antihypertensive medications from different classes, at optimal doses and they are categorized in hypertension guidelines as having resistant hypertension. Compared with adults whose hypertension is well controlled, adults with uncontrolled hypertension have greater risk of heart attack, heart failure, stroke, end-stage renal disease and death.

Endothelin (ET)-1, via its receptors (ET_A and ET_B), mediates a variety of effects such as vasoconstriction, fibrosis, cell proliferation, inflammation, aldosterone production and is upregulated in hypertension. Aprocitentan is a dual ERA that inhibits the binding of ET-1 to ET_A and ET_B receptors and hence the effects mediated by these receptors. The effects of ET-1 bear many similarities with the pathophysiology of hypertension and the resistance to other antihypertensive

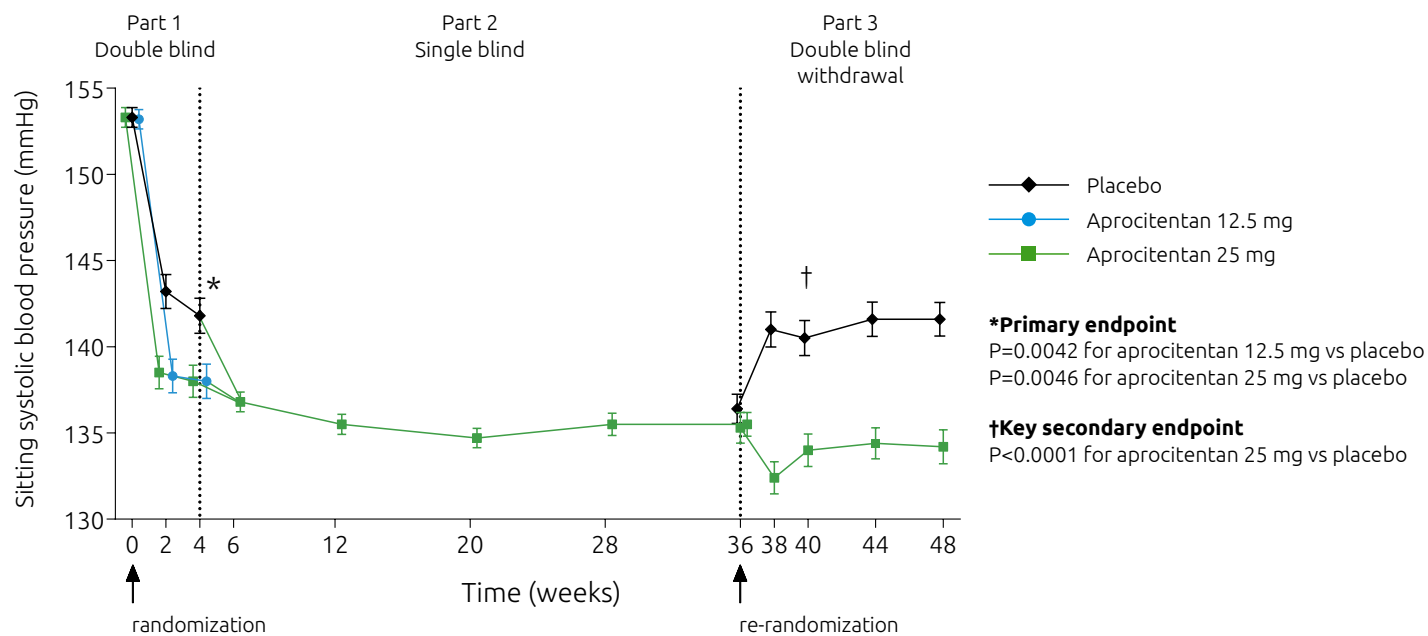
drugs in some patients (often with risk factors such as obesity, sleep apnea, older age, kidney failure, type 2 diabetes, and African Americans), can be explained by an endothelin-dependent hypertension.

Aprocitentan was evaluated as a monotherapy in a Phase 2 study in patients with hypertension, and as an add-on therapy in a Phase 3 study called PRECISION in patients with confirmed resistant hypertension. In the Phase 3 registration study, PRECISION, aprocitentan showed statistically significant and clinically meaningful reduction in BP which was maintained for up to 48 weeks when added to a combination of at least 3 background antihypertensive therapies in patients with resistant hypertension. In PRECISION, aprocitentan was generally well tolerated with no major safety concerns. The most frequent adverse event with aprocitentan was mild-to-moderate edema/fluid retention.

Global registration study

PRECISION was a multicenter, blinded, randomized, parallel-group, Phase 3 study, which was performed in hospitals or research centers in Europe, North America, Asia, and Australia. Patients were eligible for randomization if their sitting systolic blood pressure (SBP) was 140 mm Hg or higher despite taking standardized background therapy consisting of three antihypertensive drugs, including a diuretic. The study consisted of three sequential parts: Part 1 was the 4-week double-blind, randomized, and placebo-controlled part, in which 730 patients were randomized to aprocitentan 12.5 mg (n=243), aprocitentan 25 mg (n=243), or placebo (n=244) in a 1:1:1 ratio; Part 2 was a 32-week single (patient)-blind part, in which all patients received aprocitentan 25 mg (n=704); and Part 3 was a 12-week double-blind, randomized, and placebo-controlled withdrawal part, in which patients were re-randomized to aprocitentan 25 mg (n=307) or placebo (n=307) in a 1:1 ratio. The primary and key secondary endpoints were changes in

Aprocitentan has significant and sustained efficacy



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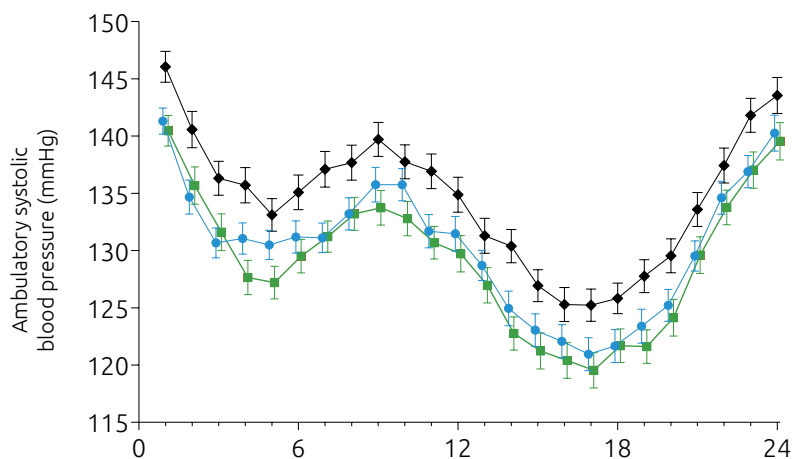
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Bars are standard error of the mean
Values are offset from each other for readability

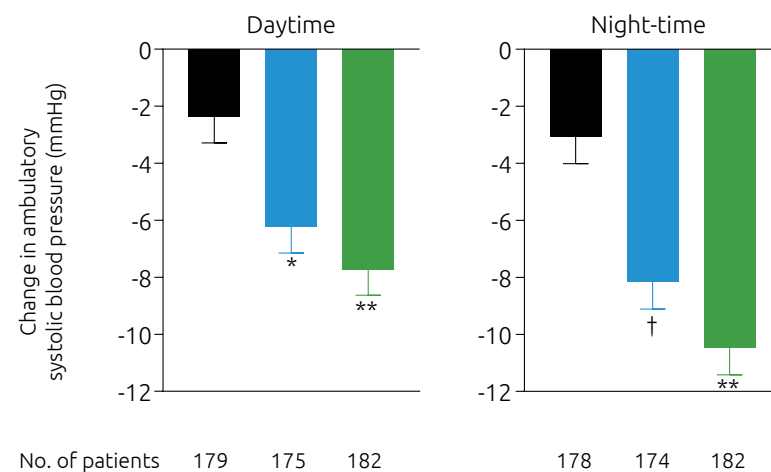
Schlaich MP, et al. *Lancet*. 2022; 400(10367):1927-1937.

Efficacy confirmed by Ambulatory BP monitoring at Week 4



◆ Placebo
 ● Aprocitentan 12.5 mg
 ■ Aprocitentan 25 mg

Bars are standard error of the mean
Values are offset from each other for readability



■ Placebo
 ■ Aprocitentan 12.5 mg
 ■ Aprocitentan 25 mg

*P=0.003, †P=0.0002, **P<0.0001 vs placebo, not corrected for multiplicity

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Schlaich MP, et al. *Lancet*. 2022; 400(10367):1927-1937.

unattended office SBP from baseline to week 4 and from withdrawal baseline to week 40, respectively. Secondary endpoints included 24-h ambulatory blood pressure changes.

At baseline, 69.2% of patients were obese or severely obese, 54.1% had diabetes, 22.2% had stage 3-4 chronic kidney disease and 19.6% had congestive heart failure. At randomization, 58% of 730 randomized patients remained on beta blocker in addition to the standardized background therapy i.e., were prescribed with four antihypertensive drugs.

As reported by Schlaich MP, et al. in the November 2022 issue of The Lancet, the least square mean change in office SBP at 4 weeks was -15.3 mmHg for aprocitentan 12.5 mg, -15.2 mmHg for 25 mg, and -11.5 mmHg for placebo, for a difference versus placebo of -3.8 mmHg ($p=0.0042$) and -3.7 mmHg ($p=0.0046$), respectively (the primary endpoint). Office diastolic blood pressure (DBP) also decreased with both aprocitentan doses compared to placebo (3.9 mmHg for the 12.5 mg dose and 4.5 mmHg for the 25 mg dose). Office SBP and DBP were maintained during Part 2 in patients previously receiving aprocitentan

and decreased within the first 2 weeks of Part 2 before stabilizing in those previously receiving placebo. In Part 3, office SBP after 4 weeks of withdrawal (week 40) (the key secondary endpoint) increased significantly with placebo compared to aprocitentan (5.8 mmHg; $p<0.0001$). Office DBP also increased with placebo compared to aprocitentan (5.2 mmHg; $p<0.001$). The difference between the two groups remained up to week 48.

The results from ambulatory BP monitoring confirmed those derived from office measurements. At the end of Part 1, aprocitentan, after placebo correction, decreased both the 24-hour ambulatory SBP (4.2 mmHg for the 12.5 mg dose and 5.9 mmHg for the 25 mg dose) and DBP (4.3 mmHg for the 12.5 mg dose and 5.8 mmHg for the 25 mg dose). The placebo-corrected SBP lowering effect was -5.1 mmHg and 7.4 mmHg during the night time and 3.8 mmHg and 5.3 mmHg during the daytime, for the 12.5 mg and 25 mg doses, respectively. In Part 3, after 4 weeks of withdrawal (week 40), both the 24-hour ambulatory SBP and DBP increased with placebo compared with aprocitentan (6.5 mmHg and 6.8 mmHg respectively).

The effect of aprocitentan was consistent across subgroups of age (including patients ≥ 75 years), sex, race (including patients with Black or African American origin), BMI, baseline CKD stage 3 and 4 (eGFR 15 to 60 ml/min) and urine albumin-to-creatinine ratio (UACR) and medical history of diabetes, and was consistent with the effect in the overall population.

Treatment-emergent adverse events (TEAEs) during the 4-week double-blind study period (Part 1) were reported in 27.6% and 36.7% of the patients treated with 12.5 and 25 mg aprocitentan, respectively, versus 19.4% in the placebo group. The most frequent adverse event with aprocitentan was mild-to-moderate edema/fluid retention leading to discontinuation in seven patients during the study. Edema/fluid retention was reported more frequently with aprocitentan than with placebo in a dose-dependent fashion (9.1%, 18.4%, and 2.1% for patients receiving aprocitentan 12.5 mg, 25 mg and placebo, during Part 1, respectively; 18.2% for patients receiving aprocitentan 25 mg during Part 2; and 2.6% and 1.3% for patients on aprocitentan 25 mg and placebo, during Part 3, respectively).

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Current status



In March 2024, TRYVIO™ (aprocitentan) 12.5 mg was approved by the US FDA for the treatment of hypertension in combination with other antihypertensive drugs, to lower blood pressure in adult patients who are not adequately controlled on other drugs. TRYVIO is commercially available in the US. For more information see the Full Prescribing Information including BOXED Warning ([PI and Medication Guide](#)).

Current status in the EUCAN region



On June 27, 2024, the European Commission granted market authorization for JERAYGO™ (aprocitentan) for the treatment of resistant hypertension in adult patients in combination with at least three antihypertensive medicinal products. The recommended dose is 12.5 mg orally once daily. The dose can be increased to 25 mg once daily for patients

tolerating the 12.5 mg dose and in need of tighter blood pressure (BP) control.

For more information on the marketing authorization of JERAYGO in the European Union, please review the [Summary of Product Characteristics \(SmPC\)](#).

European Commission marketing authorization through the centralized procedure is valid in all European Union Member States, as well as the European Economic Area countries Iceland, Liechtenstein and Norway, and Northern Ireland under the Northern Ireland Protocol. Market authorization for JERAYGO was also granted by the UK Medicines and Healthcare products Regulatory Agency on January 8, 2025, by Swissmedic in Switzerland on September 18, 2025, and by Health Canada in Canada on December 23, 2025.

Milestones

- 2025 Approved as JERAYGO (aprocitentan) by Health Canada
- 2025 Approved as JERAYGO (aprocitentan) by Swissmedic
- 2025 Approved as JERAYGO (aprocitentan) by the UK MHRA
- 2024 TRYVIO (aprocitentan) commercially available in the US
- 2024 Approved as JERAYGO (aprocitentan) by the EMA
- 2024 Approved as TRYVIO (aprocitentan) by the US FDA
- 2022 Phase 3 data simultaneously presented as late-breaker at AHA and published in The Lancet
- 2022 Phase 3 study successful
- 2018 Phase 3 study initiated
- 2017 Positive results for the dose-response study
- 2015 Initiation of Phase 2 dose-response study
- 2014 Initiation of Phase 1 clinical program

Key scientific literature

- Schlaich M, et al. The Lancet 2022; Dec 3;400(10367):1927-1937.
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- Iglarz M, et al. Clin Sci 2010; 119:453-63
- Clozel M. Can J Physiol Pharmacol 2022, 100:573-83.
- Verweij P., et al. Hypertension. 2020; 75:956–965

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Early-stage clinical pipeline

Preclinical pipeline

Partner-led portfolio



Lucerastat



Lucerastat is an oral inhibitor of glucosylceramide synthase, offering a potential new treatment approach for all patients living with Fabry disease, irrespective of the mutation type of the GLA gene.

Fabry disease is a rare, X-linked lysosomal storage disorder caused by mutations in the GLA gene that results in the absence or markedly reduced activity of the enzyme α -galactosidase A (α -GalA). α -GalA normally breaks down a fatty product known as globotriaosylceramide (Gb3) in the cells of the body. Deficiency over time results in an accumulation of Gb3 deposits throughout the body, leading to multisystem disease, mainly affecting the kidneys, heart, and nervous system.

The disease manifests in two main phenotypes: classic Fabry disease, typically presenting in childhood with severe, multisystemic involvement, and late-onset Fabry disease, which may emerge in adulthood with predominant cardiac or renal symptoms. Fabry disease affect a patient's life expectancy and quality of life. Due to its variable presentation and non-specific symptoms, Fabry disease is frequently underdiagnosed or misdiagnosed, leading to delays in treatment and increased risk of irreversible organ damage.

Lucerastat, an oral inhibitor of glucosylceramide synthase (GCS), acts by reducing the synthesis of the lipid Gb3 as opposed to supporting the breakdown of Gb3, thus reducing damaging build-up. This is known as Substrate Reduction Therapy (SRT).

Phase 3 MODIFY study ([NCT03425539](#)) and OLE ([NCT03737214](#))

MODIFY was a multicenter, double-blind, randomized, placebo-controlled, Phase 3 study evaluating lucerastat as an oral monotherapy for adults with Fabry disease. A total of 118 patients from 14 countries were randomized 2:1 to lucerastat or placebo. Upon completion of the double-blind period, 107 patients entered a long-term OLE assessing safety, tolerability, and renal outcomes. Primary results from MODIFY and the 12-month interim OLE analysis have been published in Nature Communications, ("[Lucerastat, an oral therapy for Fabry disease: Results from a pivotal phase 3 study and its open-label extension](#)", January 2026).

While the MODIFY study did not meet its primary endpoint of reducing neuropathic pain over six months, lucerastat demonstrated a robust pharmacodynamic effect, significantly reducing plasma and urinary Gb3 levels compared to placebo. These reductions were sustained over time in the OLE, with patients switching from placebo to lucerastat showing similar biomarker reductions.

More importantly, as presented at *WORLD Symposium™ 2026*, an interim analysis of the OLE, where ongoing patients had been treated with lucerastat for at least 42 months – some exceeding six years of continuous therapy – revealed a notable shift in renal function trajectory. Treatment with lucerastat was associated with a reduction in the rate of eGFR decline as compared to eGFR slope observed in the 2 years preceding their enrollment in MODIFY (eGFR slope, historical: -3.50; Lucerastat: -1.64). Lucerastat treatment was also associated with a particularly marked attenuation of kidney function

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loss in patients with severe disease course, such as classic males with Fabry disease (historical: -4.32; Lucerastat: -2.05), patients with impaired renal function at baseline (eGFR <90 mL/min/1.73m²) (historical: -6.18; Lucerastat: -2.49), Anti-Drug Antibody (ADA+) positive patients (historical: -7.75; Lucerastat: -3.43). The effect was independent of the gene variants' amenability to migalastat. Lucerastat also led to a 51% decrease in plasma Gb3 levels and was well-tolerated with long-term treatment. As the next steps for lucerastat are underway, the OLE study will be concluded. To ensure continuity of care for participants still receiving lucerastat at study closure, a post-trial access program is being established.

In addition, the positive impact on kidney function was supported by a kidney biopsy sub-study of six male adult patients with classic Fabry disease who had received lucerastat monotherapy for a median treatment period of 56 months. The study evaluated the number of kidney Gb3 inclusions using established quantitative (Barisoni Lipid Inclusion Scoring System (BLISS)) and semi-quantitative (Fabrazyme Scoring System (FSS)) methodologies. At enrollment in MODIFY, 4 participants were

ERT naïve or pseudo-naïve and 2 switched from ERT. Median kidney Gb3 BLISS score was 1.7 (range: 0.7–4.5; mean (SD): 2.41 (1.59)). Mean FSS scores were 0 indicative of “no or trace” accumulation (5/6 participants) or 1 indicative of mild accumulation (1/6). The 2 patients who switched from ERT had BLISS scores of 1.6-1.8 and a FSS score of 0. The results indicate that long-term treatment with lucerastat monotherapy was associated with low-to-no levels of kidney Gb3 inclusions.

Lucerastat was well tolerated. No clinically meaningful changes in vital signs or ECGs or marked laboratory abnormalities were observed. Two patients in each group (lucerastat 2.5%; placebo 5.4%) discontinued treatment due to adverse events. Serious adverse events were reported in 5 patients (6.3%) in the lucerastat group and in 1 patient (2.7%) in the placebo group.

Lucerastat for Fabry disease has received orphan drug designation in the US and the EU and is under review in Japan.

Current status

Idorsia has aligned with the US FDA on a streamlined registration strategy comprising two complementary clinical trials designed to definitively characterize lucerastat's renal effects. This program is also in line with the feedback received from European Medicines Agency.

Pivotal kidney biopsy study (n=16)

- **Adult males with Fabry disease, treatment-naïve or pseudo-naïve;**
- **Designed to show a decrease from baseline in renal Gb3 burden after 18 months of treatment.**

Renal function comparative study (n ≈ 74)

- **Adult patients with Fabry disease;**
- **Assessment of lucerastat versus established enzyme replacement therapies (agalsidase beta, pegunigalsidase alfa);**
- **Designed to reinforce lucerastat as the first oral therapy suitable for all patients with Fabry disease, irrespective of their mutation type.**

The program is expected to support a potential regulatory filing as early as 2029.



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Milestones

- 2026** New data and evaluation of long-term treatment with lucerastat presented at WORLD*Symposium™* 2026
- 2021** Phase 3 open label extension study continues
- 2021** Phase 3 study completed – primary endpoint not met
- 2018** Phase 3 study initiated
- 2016** Phase 1b study completed

Key scientific literature

- [Wallace E., et al. Mol Genet Metab. 2026;147\(2\):109659.](#)
- [Germain DP., et al. Mol Genet Metab. 2026;147\(2\):109423.](#)
- [Nordbeck P., et al. Nature Communications, 10 January 2026 \(online ahead of print\).](#)
- Guérard N., et al. Clin Pharmacol Ther. 2018; 103(4):703-11.
- Welford RWD., et al. Hum Mol Genet 2018; 27(19): 3392-3403

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Idorsia has developed platforms of expertise in families of molecular targets which allow high productivity in the generation of innovative compounds potentially addressing a wide range of high unmet medical needs.

IDOR-1117-2520 – CCR6 antagonist

Psoriasis

IDOR-1117-2520 is an oral first-in-class, selective CCR6 antagonist being investigated for the treatment of Th17-driven immunodermatology and autoimmune disorders. Idorsia is conducting a proof-of-concept / proof-of-mechanism study with IDOR-1117-2520 in patients with moderate to severe psoriasis. The inflamed psoriatic skin is characterized by the presence of pathogenic IL-17-secreting CCR6+ T cells and elevated CCL20 levels. The study is currently recruiting with results readout expected in Q1 2027.

ACT-1004-1239 – CXCR7 / ACKR3 antagonist

Progressive multiple sclerosis

ACT-1004-1239 is the first-in-class, oral, brain-penetrating drug with unique potential to transform treatment paradigm in MS by inducing remyelination and reducing neuroinflammation. Idorsia will conduct a proof-of-concept study with ACT-1004-1239 in patients with progressive MS. The study is expected to be initiated in Q1 2026 with results readout expected in Q2 2028.

ACT-777991 – CXCR3 antagonist

Vitiligo

ACT-777991 is a first-in-class, oral antagonist of the chemokine receptor CXCR3. CXCR3 is primarily implicated in the migration of CD8+ T cells, responsible for targeting and destroying melanocytes. Blocking CXCR3 with the antagonist ACT-777991 therefore has the potential to be an innovative precision therapy for vitiligo care or any immunodermatology and autoimmune disorders. Idorsia will conduct a proof-of-concept study with ACT-777991 in patients with vitiligo. The study is expected to be initiated in 2026 with results readout expected in 2027.

IDOR-1134-2831 – Synthetic glycan vaccine

Clostridioides difficile infection

On June 30, 2025, Idorsia announced a milestone in the development of its first bacterial vaccine based on the company's synthetic glycan chemistry platform. The *Clostridioides difficile* (C. difficile) vaccine is based on a synthetic glycan mimicking a surface glycan antigen and covers more than 90% of all existing strains of C. difficile bacteria and also targets the spores. Initial data showed that the vaccine is well-tolerated and showed immunogenicity in a Phase 1 study. The vaccine has advanced to a higher-dose cohort, with top-line results anticipated in mid-2026. Partnership discussions have been activated to accelerate the development of this vaccine.

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ACT-1016-0707 – LPA 1 receptor antagonist

Immune-mediated and fibrosis related disorders

Entry-into-human package complete. Potential best-in-class due to insurmountable binding mode – proven inhibitory activity in preclinical models of inflammation and fibrosis.

IDOR-1141-8472 – Orexin 2 receptor agonist

Narcolepsy, Hypersomnia

Entry-into-human package in progress. Potential best-in-class – sustained chronic efficacy in a preclinical model of narcolepsy.

IDOR-1126-6421 – Undisclosed mechanism

Organ injury / fibrosis

Entry-into-human package in progress. Broad potential of undisclosed mechanism for inhibiting organ injury and fibrosis – proven effectiveness in several preclinical models of organ injury.

IDOR-1134-9712 – CFTR type-IV corrector

Cystic Fibrosis

Entry-into-human package complete. A unique corrector targeting an Idorsia-identified binding site on the Cystic Fibrosis Transmembrane regulator (CFTR) protein. Potential synergy with other molecules.

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For Idorsia, sophisticated partnerships are a way of gaining strategic access to technologies or products and fully exploiting our discovery engine and clinical pipeline. We seek suitable external project partners to maximize the value of internal innovation.

TRYVIO/JERAYGO (in partnership discussions)

Aprocitentan to be licensed to a "to be defined" party for worldwide development and commercialization rights. TRYVIO is commercially available in the US. JERAYGO is approved in the EU, UK, Switzerland, and Canada.

Daridorexant (Nxera Pharma)

Daridorexant is licensed to Nxera Pharma in the Asia-Pacific region (excluding China). Launched for the treatment of insomnia in Japan; Phase 3 ongoing in South Korea.

Asia-Pacific region (excluding China): Australia, Brunei, Cambodia, Indonesia, Japan, Laos, Malaysia, Myanmar, New Zealand, Philippines, Singapore, South Korea, Thailand, Taiwan, and Vietnam.

Daridorexant (Simcere)

Daridorexant is licensed to Simcere in the Greater China region (Mainland China, Hong Kong, and Macau). Approved, under the tradename QUVIVIQ, for the treatment of insomnia in Hong-Kong in May 2024 and China in June 2025 and launched in September 2025.

Selatogrel and cenerimod (Viatris)

A joint development committee from Idorsia and Viatris is overseeing the development of two ongoing Phase 3 programs up to regulatory approval.

Selatogrel is a potent, fast-acting, reversible, and highly selective P2Y₁₂ inhibitor being developed in a Phase 3 study (NCT04957719) for the treatment of acute myocardial infarction ("SOS AMI") in patients with a recent history of AMI. It is intended to be self-administered subcutaneously via a drug delivery system (autoinjector).

Cenerimod is a highly selective S1P₁ receptor modulator, given as an oral once-daily tablet, which is being developed in a Phase 3 program known as "OPUS" (NCT05648500, NCT05672576, and NCT06475742) for the treatment of systemic lupus erythematosus (SLE).

Viatris has worldwide commercialization rights for both selatogrel and cenerimod.

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Daridorexant (DOD)

Idorsia is supporting a clinical study sponsored by the US Department of Defense (DOD) to develop new therapies for posttraumatic stress disorder (PTSD). The Phase 2 study will evaluate the safety, tolerability, and efficacy of potential therapeutic interventions, including daridorexant, in active-duty US service members and veterans with PTSD (NCT05422612).

ACT-1002-4391

Owkin has a global license to develop and commercialize ACT-1002-4391, Idorsia's novel, potent EP₂/EP₄ receptor antagonist with antitumor efficacy, to be used both as monotherapy and in combination with other oncology agents. The compound is in Phase 1 clinical development. Owkin will use its proprietary AI-based data-mining platform to generate clinical trial designs and to identify patients who may benefit from, and potential targets for, the compound.

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Idorsia is an independent biopharmaceutical company based on science and innovation. The company is specialized in the discovery, development, and commercialization of innovative small molecules, with the aim of transforming the horizon of therapeutic options. It is headquartered in Allschwil/Basel, Switzerland and is quoted on the SIX Swiss Exchange (tickersymbol: IDIA). All trademarks are legally protected by their respective owners.

Disclaimer This fact sheet has the sole purpose to provide members of the public with general information about the activities of Idorsia. The forward-looking statements in this fact sheet are based on current expectations and belief of company management, which are subject to numerous risks and uncertainties.

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