Arcutis Biotherapeutics, Inc.(3Q 2025 Earnings)

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Corporate Speakers:

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- Frank Watanabe; Arcutis Biotherapeutics, Inc.; President, Chief Executive Officer
- Todd Edwards; Arcutis Biotherapeutics, Inc.; Chief Commercial Officer
- Latha Vairavan; Arcutis Biotherapeutics, Inc.; Chief Financial Officer
- Patrick Burnett; Arcutis Biotherapeutics, Inc.; Chief Medical Officer
- Douglas DiRuggiero; Georgia Dermatology Physician Assistant Society; Founding President
- Unidentified Speaker; Arcutis Biotherapeutics, Inc.; Unknown

PRESENTATION

Operator^ Good day. And thank you for standing by. Welcome to the Arcutis Biotherapeutics 2025 Third Quarter Financial Results and Investor Day presentation. (Operator Instructions)

Please be advised that today's conference is being recorded.

I would now like to hand the conference over to your first speaker today, Brian Schoelkopf, Head of Investor Relations.

Please go ahead.

Brian Schoelkopf^ Thank you. Good morning, everyone. And thank you for joining us today to review our third quarter 2025 financial results and business update, and for our extended Investor Day presentation.

Slides for today's call are available on the Investors section of the Arcutis website.

Joining me on the call today are Frank Watanabe, President and CEO of Arcutis; Todd Edwards, Chief Commercial Officer; Patrick Burnett, Chief Medical Officer; and Latha Vairavan, Chief Financial Officer.

We will also be joined later in the call by Douglas DiRuggiero, a certified physician assistant and doctor of medical science, who has specialized in dermatology for the past 25 years and is the founding President of the Georgia Dermatology Physician Assistant Society.

I would like to remind everyone that we will be making forward-looking statements during this call. These statements are subject to certain risks and uncertainties.

And our actual results may differ.

We encourage you to review all of the company's filings with the Securities and Exchange Commission including descriptions of our business and risk factors.

With that, let me hand it over to Frank for a brief introduction of today's call.

Frank Watanabe^ Thanks, Brian, and thanks to all of you for joining us today and freeing up some additional time in your calendars for what we believe will be a compelling review of the strong foundation of our business today and a more in-depth look at our strategy to sustain our growth in the future.

We'll start today's call by reviewing our commercial and financial results for the third quarter.

As you'll hear from Todd and Latha in a moment, we achieved yet another strong quarter with robust net product revenue growth and continued steady growth of prescriptions across all approved formulations and indications for ZORYVE.

We'll then move on to the Investor Day presentation, where we'll do a deep dive into why we are excited by and confident in the future of Arcutis and our unique potential to address key unmet needs for patients impacted by immune-mediated dermatological diseases. Today's discussion on our corporate strategy is timely and pertinent as we approach cash flow positivity, enabling us to self-fund investments in our business that will sustain the continued growth of Arcutis.

Our excitement is grounded first in the outstanding growth opportunities for ZORYVE, a revolutionary topical agent that is already reshaping the treatment of chronic inflammatory skin diseases and impact we foresee only amplifying in the years ahead.

As you'll hear today, we have multiple opportunities to grow and further expand our ZORYVE business, and we have the capabilities and resources to exploit those opportunities.

We'll also go into more detail today about our exciting pipeline building efforts, starting with ARQ-234, a novel biologic with best-in-class potential to address a large unmet need in atopic dermatitis. Complementing the ZORYVE franchise, ARQ-234 and future pipeline opportunities will enable us to extend our mission to champion meaningful innovation for patients impacted by immune-mediated skin conditions and strengthen Arcutis' position as one of the industry's most consequential medical dermatology powerhouses.

I'd also like to take a moment to thank the Arcutis team for their efforts and commitment to bringing better outcomes to patients living with serious skin diseases.

Their unwavering dedication underlays our achievements to date and will be the foundation for the ambitious plans we discussed today.

So thank you all again for taking the time to join us today. And now I'll turn the call over to Todd for our Q3 commercial update.

Todd Edwards^ Thank you, Frank. And good morning, everyone. Turning to Slide 6.

As Frank noted, we continued to deliver strong revenue growth, driven by the increase in adoption of the ZORYVE portfolio by both patients and clinicians across all improved indications.

In the third quarter, we generated net product revenues of $99.2 million, reflecting 22% sequential growth and a 122% increase compared to the same quarter of 2024. The substantial revenue expansion was fueled by growing demand for ZORYVE supported by rising prescription volume across all products in our portfolio.

This accessible launch is a reform for the treatment of plaque psoriasis, the scalp and body contributed meaningfully to the expansion in demand and helped to offset typical third quarter seasonality headwinds.

Improved gross to net rates during the period also contributed to sequential sales growth driven by reduced utilization of patient co-pay programs as patients progress through their annual deductibles earlier in the year than anticipated.

As a result, we expect the quarter-on-quarter gross to net improvement will be more limited in the fourth quarter, consistent with historical trends with only modest additional benefit expected from co-pay program usage.

On Slide 7. Consistent with previous quarters, our Q3 growth was driven by sustained demand growth across all strengths and indications.

Total prescriptions for ZORYVE increased by 13% compared to Q2 and by 92% versus Q3 2024.

Weekly prescriptions on a rolling 4-week average basis reached a new record high with over 17,000 scripts. Following the FDA approval as the [reform] is 0.3% of the treatment of plaque psoriasis, the scalp and body in May and a subsequent launch in June, we experienced particularly strong performance from the foam product, with product revenue increasing by more than 25% versus the prior quarter. The inflection in total ZORYVE volume following the launch as illustrated in the graph, demonstrates the significant impact of this new indication launch.

Importantly, we also continued to see steady and growing volume for ZORYVE cream 0.3% during the period, reflecting sustained demand across both formulations in plaque psoriasis.

Overall, our sustained momentum in Q3 highlights ZORYVE's exceptional utility, the growing confidence in our brand among both clinicians and patients and more importantly, the broader treatment shift driven by steroid conversion.

In today's presentation, we will further discuss the dynamics behind the shift away from topical clinical steroids. And I look forward to sharing the additional actions we are taking to catalyze and accelerate this transition in the near term.

Looking ahead to the fourth quarter, we anticipate continued strong net sales growth driven by increased patient demand, even as we expect only nominal improvements in our gross to net rate compared to the third quarter. This growing demand will be further supported by the launch of ZORYVE cream 0.05% for atopic dermatitis, age 2 to five years old.

With that, I'll turn the call over to Latha to review Q3 financial results.

Latha Vairavan^ Thank you, Todd.

I'm now on Slide 8.

As Todd just reviewed, we generated net product revenues in the third quarter of approximately $99.2 million which is up 122% from Q3 of 2024 and 22% from Q2 of this year. Cost of sales in the third quarter were $8.7 million compared to $5.5 million in Q3 2024, primarily driven by increased ZORYVE rev sales volume.

For the third quarter, our R&D expenses were $19.6 million versus $19.5 million for the corresponding period in 2024.

Our R&D spend was consistent with prior year as clinical expenditures shifted from ARQ-255 to pediatric [reforma last] studies. Moving forward, we expect an increase in our R&D spend in 2026 as we continue to advance ZORYVE life cycle management, clinical development activities and initiate our Phase I trial of ARQ-234.

SG&A expenses were $62.4 million for the third quarter of 2025 versus $58.8 million in the same period last year, a 6% increase attributable to investments in our continued commercialization efforts of ZORYVE, but SG&A expenses were down approximately 10% as compared to the second quarter of 2025 primarily due to a decrease in promotional and marketing spend resulting from timing of expenditures between quarters.

Net income for the quarter was $7.4 million compared to a net loss of $41.5 million for the same period last year and a loss of $15.9 million for the second quarter of 2025. The net profit generation in the quarter was driven by the $17.7 million of sequential increase in net sales concurrent with a $5.4 million reduction in operating expense.

While we do not expect our net income to remain positive in the near term, the improving operational leverage that we demonstrated in the quarter with growing net sales contribution from ZORYVE outpacing increases to our core expense base speaks to the profit generation capacity of the ZORYVE franchise.

We previously communicated that we anticipated achieving cash flow breakeven in 2026.

However the continued momentum of ZORYVE net sales growth, combined with our expense discipline has facilitated the acceleration of this important milestone, and we now expect to achieve cash flow breakeven in the fourth quarter of 2025.

Now turning to Slide 9.

Our cash and marketable securities balance as of September 30, 2025, was $191 million, with cash burn from operations of $1.8 million for the period.

We have total debt of $108.5 million and have the option to withdraw another $100 million in whole or in part at our discussion through the middle of 2026 providing us with the flexibility to invest in the continued expansion of our business. The success of the ZORYVE franchise and the economies of scale we are generating will permit us to invest in the business for the sustained growth over the years ahead.

I will elaborate on this when discussing our capital allocation strategy later in today's presentation.

With that, I'll turn the call back over to Frank to kick off the Investor Day portion of today's call.

Frank Watanabe^ Thanks, Latha.

We founded Arcutis in 2016 to address what we saw as a significant innovation gap in the immunodermatology drug development space.

We recognize that the vast majority of dermatology patients were being treated by older therapies that offered inadequate efficacy, did not target specific disease mediators and/or carried substantial safety and tolerability issues.

So we set out to identify, develop and commercialize best-in-class molecules that would address unmet needs in dermatology by directly targeting immunological mediators of inflammatory diseases.

We have been extremely focused, deliberate and successful against this goal, steadily executing on the promise of ARQ-151 and ARQ-154, now known as ZORYVE Cream and ZORYVE Foam as a true pipeline in a molecule opportunity.

As we approach the significant milestone of achieving cash flow breakeven, we've been thoughtfully planning Arcutis' next phase where we will apply the same focus and dedication to ensuring long-term growth, success and most importantly, continued impact for patients.

As outlined on Slide 11, Three pillars provide the strategic framework for sustaining our company's near- and long-term growth.

First, we will continue to grow our core ZORYVE business as we establish ZORYVE as the foundational therapy for adults and children who need ongoing therapeutic solutions for managing psoriasis, [cebroid] dermatitis and atopic dermatitis. A significant component of the grow pillar is our sustained efforts to meet the increasing calls for safer, more targeted topical alternatives to topical steroids. A topic we will be spending a good deal of time today talking about.

This pillar also includes our efforts to expand into primary care and pediatrics and in-line growth opportunities, such as our recent launches in scalp and body psoriasis and pediatric atopic dermatitis and incremental data generation opportunities to bolster ZORYVE's position for our currently approved indications.

Second, we plan to expand the ZORYVE franchise through strategic life cycle management.

Specifically, we are evaluating new potential indications that represent significant unmet needs and where patients would benefit from ZORYVE's unique profile.

Our new indication exploration, a core tenet of our clinical development strategy will be guided by a large body of case reports from clinicians who have used ZORYVE in various other inflammatory dermatosis and have seen encouraging signs of efficacy. And finally, we will build our pipeline advance by advancing other innovative medicines for patients, leveraging the best-in-class clinical development and commercialization capabilities we have developed at Arcutis.

Our focus initially will be on ARQ-234 and in parallel on potentially sourcing promising external innovation.

As you'll see on Slide 12, we've designed today's agenda to align with these three strategic pillars I just reviewed.

We'll cover sustainable growth drivers for ZORYVE's current indications.

As part of the presentation, Patrick will host a Q&A with the imminent dermatology physician assistant, Douglas DiRuggiero to gain a clinician's perspective on the changing treatment landscape.

We'll follow this with an overview of our expansion efforts including our exploration of potential new indications for ZORYVE with initial efforts in vitiligo and (inaudible).

And finally, on the ZORYVE re front, we'll provide some insights into peak sales potential.

We'll then move forward to a discussion of our pipeline building strategy, which will include a review of ARQ-234 and its opportunity to address a significant unmet need in atopic dermatitis and an overview of our framework for evaluating business development opportunities. Lastly, we'll wrap up with a review of our capital allocation and balance sheet strategy before opening up the call to Q&A.

With that, let's dive right into the agenda. Turning to Slide 13.

It's been just over three years since we received our first FDA approval for ZORYVE.

Since that time and as we've demonstrated yet again today with our Q3 financial results, we've achieved meaningful and sustained growth in our three current indications through a steady drumbeat of new formulations expanded adoption within those syndications and strong execution, leading to consistent prescription growth quarter-on-quarter.

But beyond these individual milestones, it's important to consider ZORYVE from a 30,000-foot view. And what we see from that perspective is that there has never been a product as uniquely suited to the treatment of immune-mediated inflammatory skin diseases as ZORYVE.

As we outlined on this slide, ZORYVE's unique profile, which is truly exceptional amongst topical agents can be categorized into three key buckets.

First is ZORYVE's [pleotropic] mechanism of action, combined with its variety of formulations. Patrick will go into more detail on the MOA later in the presentation.

But at a high level, [PDE4] has demonstrated the potential to impact multiple inflammatory cytokines, decreased neuronal itch signaling and increased melanocyte activity.

Second is ZORYVE's rapid and robust efficacy, spanning multiple dimensions in multiple dermatosis.

As you might imagine, the first and second bucket gives ZORYVE remarkable potential utility across a wide breadth of inflammatory skin conditions, not only psoriasis, atopic dermatitis and [set] derm but potentially well beyond our three initial indications.

And third and critically is ZORYVE's safety and tolerability profile, which enables its use anywhere in the body and for any duration.

Safety with chronic use is a key differentiator versus topical steroids and an essential characteristic for the treatment of conditions that often require therapeutic solutions, not just for a month or two, but for years and often a lifetime. This unique profile is set against the backdrop of an emerging sea change in dermatology where the prolonged use of corticosteroids, historically the standard of care across many inflammatory dermatosis and is facing increased scrutiny and where there's a call to action by a growing number of dermatology clinicians and patients for long-term targeted nonsteroidal treatment strategies.

For immune-mediated inflammatory skin conditions, ZORYVE is the right drug with the right profile at the right moment. And because of this convergence of factors and the opportunity for ZORYVE (inaudible) growth is vast.

I'll now turn the call over to Todd to review ZORYVE's opportunity through market landscape lens.

Todd Edwards^ Thanks, Frank.

Slide 15 provides a clear illustration of the sizable and realistic market opportunity for ZORYVE.

In the U.S., across our currently approved indications of psoriasis, sender and atopic dermatitis, the diagnosed population totals approximately 30 million patients.

Of these patients, about 19 million people are already receiving topical treatment, primarily topical corticosteroids prescribed by clinicians in every specialty.

Within this group, roughly 8 million are being treated in a dermatology specialty setting.

The area where acute has concentrated its commercialization efforts to date.

As a result, the serviceable obtainable market of patients who are already under dermatology care and are already receiving a topical prescription for their psoriasis, AD or seb derm is both substantial and highly addressable. The key question then is what share of this market will ZORYVE recapture?

Given ZORYVE's differentiated clinical profile, the strong foundation established during the early phases of commercialization, broad reimbursement coverage, the shifting treatment landscape and the strategic actions we are taking to drive both prescribing breadth and depth, we believe increasing the ZORYVE share to 15% to 20% of topical steroid prescriptions or potentially more is both realistic and achievable.

As we'll outline further today, there are compelling reasons to believe ZORYVE is positioned for significant and sustained growth in the years ahead.

Now turning to Slide 16. The foundation of our conviction is rooted in what we are already seeing playing out in the market.

On the left side of the slide, you can see that over the last six quarters, the branded [non-sola] has been carving out a meaningful foothold in the topical market.

During this period, the [non-serotopical] volume, shown by the middle grade has increased over 60%, while topical steroids represented by the yellow line, has essentially remained flat.

Within the non-sorted class, ZORYVE is clearly the growth driver, with volumes increasing nearly 200% for the same period as shown by the top most line.

Corticosteroids still account for the vast majority of topic descriptions today, which is not surprising, given they have been the topical standard of care for chronic inflammatory skin conditions for over 70 years.

However the treatment landscape is shifting in both the U.S. and globally, there is a growing demand for innovation in the topic of [second], innovation that can -- that can deliver improved outcomes and safety.

As a result, we are beginning to see erosion to the topical steroid share within the topical market.

Importantly, this version is in its early stages, and there remains a substantial base of topical steroid prescriptions available for conversion.

The chart in the center shows nearly 70% of the 24 million annual prescriptions for psoriasis, AD and seb derm written by dermatology specialists are still for topical steroids. This acquaints to roughly 17 million topical steroid prescriptions each year, a substantial base that will continue to fuel ZORYVE's growth for the years to come. And that does not yet account for the PCP MP opportunity. ZORYVE's outsized growth compared to the broader nonstretopical classes already translated into a meaningful increase in market share.

As shown on the right-hand side, nearly half of all brand topical prescriptions are now written for ZORYVE.

With this leading position, ZORYVE is exceptionally well positioned to capture the ongoing shift away from steroids. Next, Patrick will do a deeper dive on the state of the conversion of topic steroids and the factors driving the shift in practice. Patrick?

Patrick Burnett^ Thank you, Todd. And good morning, everyone.

We want to spend some time expanding on the momentum behind steroid conversion.

First, because it signals a crucial paradigm shift in the treatment of immune-mediated inflammatory skin diseases. And second, because it provides a key data point to support our obtainable market thesis that Todd outlined.

So what exactly is driving this conversion?

And why does it matter? The first successful use of corticosteroids for chronic inflammatory skin diseases was reported in 1952.

In more than 70 years, we've seen remarkable scientific and medical innovations across many therapeutic areas and treatment modalities.

But topical steroids have remained a mainstay in the management of conditions like atopic dermatitis and psoriasis. The introduction of biologics has represented a major advancement in the treatment of immune-mediated inflammatory skin conditions.

However, even as the introduction of these novel therapeutics has benefited the subset of patients with more severe diseases. Topicals overwhelmingly remain the first-line therapy for the vast majority of patients. And even patients on biologics often continue to rely on adjunctive topical treatments in order to manage residual disease and breakthrough flares.

There's an increasing recognition among health care providers, professional societies and patients that the long-term use of topical steroids can be associated with serious adverse effects that can both be local and systemic and this is at the stage for intensifying calls to limit long-term topical corticosteroid use and embrace innovation in the topical modality.

So that you can understand, what is galvanized this loud global call of concern about the use of topical corticosteroids, I want to help frame the problem at hand.

And to accomplish this, we've adopted a slide from a recent review article written by Douglas DiRuggiero who I was speaking to later in this program.

On the left-hand side of Slide 17, we see the list of common local adverse effects of chronic steroid treatment. Most of these were well documented all the way back into the 60s and include skin barrier damage, atrophic changes like stria or stretch marks, cataract formation and delayed wound healing.

Importantly, adverse effects related to topical corticosteroids are not limited to local effects.

What you see on the right hand of the slide is the list of systemic effects, which are broad and deep including disruptions in reproductive endocrinology growth suppression, osteoporosis and bone fracture, diabetes and ophthalmic effects including cataracts and glaucoma.

The clear association of cumulative topical steroid exposure and increased risk of bone fracture and diabetes have only been fully appreciated more recently as topical multiple publications emerge that validate the growing concern that long-term adverse effects of topical steroid use are not that different from the well-known adverse effects that have made systemic steroids a treatment of last resort for most inflammatory diseases.

While the risk of these effects increases with steroid potency and duration of use, there have been cases reported with low potency agents or short periods of use.

Additionally, infants and children may be most at risk because their skin disease typically involve a higher body surface area than adults and their immature skin barrier can result in greater permeability. And lastly, patient populations at even higher risk include those who use topical corticosteroids on the face or genital areas, as [center] skin is not only more prone to local adverse effects, but is associated with greater skin permeability and drug absorption, especially in those with atopic dermatitis, separate dermatitis, given the skin barrier dysfunction inherent in these diseases.

Clinicians are often increasingly realizing that many patients are not only exposed to topical steroids, but also may be using other steroid treatments like inhaled, intranasal and even oral steroids and this total cumulative steroid exposure dramatically increases the risk of adverse steroid effects.

Given all this, you can also understand why we are so passionate about addressing these mounting concerns and leveraging scientific innovation to bring more targeted therapeutic solutions to patients that is both effective and safe.

As you can see on Slide 18, in August of this year, two of the primary professional dermatology societies in the U.S. The Society of Dermatology Physician Assistance, the SDPA, and the Society of Dermatology Nurse Practitioners, the SDNP, issue statements recognizing the emerging evidence of these potential adverse effects and the importance of incorporating advanced topical targeted therapies that reduce the reliance on chronic topical steroid use.

These statements are the latest in a growing list of high-profile calls for the limited use of topical steroids due to the adverse effects including calls from regulatory agencies in Canada, United Kingdom and India, other professional societies, such as the International [Eczema Council], British Dermatological Nursing Group British Association of Dermatologists and the American Academy of Family Physicians, patient advocacy groups like National Eczema Society and National Eczema Association as well as several recently published physician expert consensus panel recommendations.

As you can see, this represents not merely an isolated regional appeal, but a global groundswell.

In the U.S., the recent acknowledgment by the SDPA and the SDNP is particularly important given the key role physician assistance and nurse practitioners play in

treatment decisions for patients with chronic inflammatory skin conditions. Next, we'd like to share a conversation I recently had with Douglas DiRuggiero on the evolving topical treatment landscape for immune-mediated dermatosis.

Douglas DiRuggiero is a certified physician assistant and a doctor of Medical Science, who specialized in dermatology for the past 25 years. Douglas practices with the skin cancer and cosmetic dermatology center, nationally recognized provider of advanced adult and pediatric dermatology care in Northwest Georgia and Southeast Tennessee. Douglas is also the Founding President of the Georgia Dermatology of Physicians Assistance Society and recently was named a national Honoree by the National Psoriasis Foundation, the first time a physician assistant ever received this award.

He's written and spoken extensively on the topic of potential adverse effects from prolonged use of topical corticosteroids.

I think it might be good to frame the conversation with Douglas by highlighting the role that physician assistance and nurse practitioners play in the dermatology field. NPs and PAs are providing an increasing amount of direct dermatology care including prescription writing, this expanding role is in part being driven by heightened demand for dermatological care as dermatologists provide care in medical dermatology as well as surgical procedures and cosmetic services. These NP and PA providers are failing critical gaps and ensuring patients with skin conditions have access to the vital and high-quality care they need.

Well Douglas, I want to thank you for joining me here and being willing to come on and share some of your insights over the almost 30 years of practice that you've had.

And especially, I want to talk to you coming out of your paper that you published on the impact of topical corticosteroids systemically.

I found that to be a really excellent review, learned a lot from it.

I thought it would be great to have you come on and share your perspective that led to that.

Patrick Burnett^ And I think a good place to start is just kind of what is your personal experience been with the use of topical corticosteroids over the time that you've been in practice, you've seen a lot change and our understanding of therapeutics change.

So what's your -- been your personal experience and also a little bit about how that may have evolved over that time?

Douglas DiRuggiero^ Well first off, an honor to be here. Thank you for inviting me. when I stepped into dermatology 26 years ago and have been there ever since.

I was very easily [would] into topical corticosteroids as being the medication that is for all things. And it's had an impact, I would say, on the trajectory of dermatology, probably more than any other product in our specialty.

And so it's -- and it's been around for a long time 1952 when it was first compounded into something that we could use on the skin, and it's been used ever since. And so my experience when I got into this in 1999, it was a topical corticosteroids were a mainstay of therapy, first line, second line, third line, maintenance therapy, all of the above.

But we didn't have the targeted therapeutics we have now to address some of these systemic diseases with systemic therapy.

So we were using a lot of topical steroids and topical tar and [Anthera] lot of compounded things in phototherapy and a lot of the old traditional systemic medications.

So the playing field has changed tremendously not just with targeted systemic therapeutics, but now with vehicles, with delivery systems to the skin and with active ingredients that are finally giving us the efficacy of steroids without the side effects that we have always known about have largely not largely, but I'd say, to a certain extent, maybe turn a blind eye to and we simply can't do any longer.

There's just too much data out there, both to the public knowledge and to the prescribers knowledge that we have to face the facts that steroids carry a lot of dangerous. And we can't transfer that danger or at least I can't transfer that danger any longer on to my patients without really having a lot of information to give them.

So it's a shared decision-making process.

Patrick Burnett^ Yes. That was one of the things I really took away from your paper.

I think that historically, there's been a lot of conversation around local side effects. And I think a lot of people felt somewhat comfortable, especially when there wasn't another option with that.

But I think one of the things that you really highlight well in the paper are some of the new areas of data that have come out kind of highlighting these systemic effects.

Is there kind of like one aspect of that in particular that impacted you the most? I know in the paper, you talked about diabetes, you talk about bone fracture and osteoporosis. Any particular area that was impactful for you?

Douglas DiRuggiero^ Well I'll tell you two stories that drove that, and I'll answer that question indirectly through this.

I had a patient who is a 13-year-old boy, who came in for eczema, atopic dermatitis and I put them on triamcinolone, which is a very commonly prescribed mid-potency prescription steroid and he was a type 1 diabetic. He had been since he was about 6.

So he had a pump and he had a monitor, and he was able to watch his sugars closely. And the mother came in, this is about three years ago and told me that we can put [triamcinolone] on his two forearms, and we can watch his blood sugar go up 40 points in 40 minutes.

And I was just like shocked by that, that they could see that rapid of a rise in his glucose levels with the application of a topical steroid cream, on about 5% to 7% of his body service here, not like this whole body.

I began doing some research on this and say, what are really the systemic side effects to this.

We are focused in dermatology, and we do a good job of counting our patients against the cutaneous side effects.

If you use it too long, and in the wrong areas and unfolds, it could extend the skin, what we call (inaudible), you could have [strand] stretch marks, you would get steroid-induced acne or folliculitis, you get unwanted hair or hypertrycosis.

It could create dyschromia, discoloration.

I asked all of these very experienced derm providers.

If a mom wants steroids and she's demanding to have them, what reasons will you give her or to an adult patient, what reason would you give them on why they should not have more steroids topically. And they all listed all of those things. No one listed anything systemic because we [fastly] associate all the systemic side effects with giving them systemic steroids. And we do not and have not been trained and do not recognize the whole body of information is out that shows that these medicines are highly absorbed, and they act like a systemic drug like you're taking it orally or injecting it.

And so yes, we have a lot of data out there that shows that it will raise blood sugar, diabetes, it can create something called [cushanoid] syndrome or adrenal insufficiency.

But the surprising one for me is the data out there on developing a vascular necrosis of the hip. 20 and 30-year olds that have only been on topicals, no other systemic case reports, having had hip replacements.

I highlighted a couple of those in the recent lecture I gave. [Osteopritic] fractures, I did -- talked about a case report an 11-year-old we've been using mid- to high potency corticosteroid creams only, no systemics, just topicals for three years and had a [wrist]

fracture and a full body osteoporosis like an 80-year-old and this kid's 11 and had [osteopretic] fracture.

And so we are seeing now that increase in ocular pressure in the eye.

We used to think that if you just use steroids around the eye, you increased your chance of that now.

We know you can use steroids anywhere on the body and increase your risk of glaucoma and increased ocular pressure.

So we can't turn a blind eye any longer to the internal systemic impact of using an external topical steroid because it is acting like we're giving it internally, and we've got to face those facts. And it should change the way we prescribe and it should change the way we educate our patients about these things.

Patrick Burnett^ What are you hearing from your peers on this idea of the role of topical corticosteroids and how that may be changing over recent times?

Douglas DiRuggiero^ It's really a lot of shock to be honest with you, when they see the data because it's not something that's being talked about in the clinic that these trials and these case reports and these meta-analysis and the system analysis of are not really being championed and put forth. And quite frankly, we're being forced by insurance companies in a lot of areas to use topical corticosteroids first line before we can go and use the medicines that we feel like are safer and work just as well. And so some of it is for step through therapies and some of it is just simply lack of knowledge.

So the reaction I get is using one of like, I just cannot believe. And when I present this information, I really present it in a very self-reflective way because I have been one of the top [riders] of topical corticosteroids in my state for many years.

So I mean I'm looking in the mirror and saying, how much have I contributed to these things without knowing it but I can't willingly continue to contribute to it. And so I think that's what a lot of people have.

I've got a lot of incredible comments, e-mails, people have called me to tell me about the impact that this data has had on them and how it's changing the way that they are (inaudible) patients, how they're beginning to keep track of the grams of steroids that they're giving out how they're asking about other forms of steroids that the patients are getting.

These are just not things that we've been used to slowing down and monitoring what we were calling this corticosteroid stewardship in order to catch up to some of our colleagues that are overseas or in Canada where they're beginning to heavily monitor these products and give patient warnings when they're dispensed from the pharmacy.

Other countries are beginning to see this and have already begun to be proactive with educating and monitoring these things in the U.S. really needs to take a role in this, in my opinion. And I feel like a lot of us in dermatology have the ability and now have some momentum to make this happen.

Patrick Burnett^ And you made reference to these advanced targeted topical therapies like ZORYVE. How do that they've kind of played into this evolution and this change over the course of your practice, given that topical corticosteroids are still the majority of the prescriptions that are written for patients with some of these chronic inflammatory skin diseases like atopic dermatitis, psoriasis and (inaudible)?

Douglas DiRuggiero^ In the second quarter of 2025.

So I don't have the third quarter numbers, but in the second quarter, so fairly recently, how many prescriptions do you think were field of topical corticosteroids by dermatology practices? So just derm providers, not family care, not any other specialty. Most -- the highest number I have people guess is 500,000 in a quarter. Most we're guessing 200,000 to 300,000 written by the 20-or-so thousand derm providers that are out there.

And when I tell them it's 2.9 million not over the span of a year, but in one quarter, 2.9 million prescriptions of topical corticosteroids filled, not even written filled by patients that are receiving the prescriptions from derm providers.

I mean you talk about jaws dropping when they realize how much of this we are contributing to this. And so I mean even if I can change 1% of that, I mean at 1%, 29,000, if even if you can less than 29,000, that's a huge, I think, impact over one quarter time.

So I think the numbers are really alarming to us in dermatology when we are faced with them and we realize how much we are contributing to this to this problem. And so now we have such fantastic alternatives like ZORYVE.

I mean we have had nonsteroidal topical (inaudible) inhibitors, TCIs, I mean the first one was approved in 2000. And so then the next one was improved in 2001. And so we had these two topical cases. The problem was is that the tolerability is hard particularly [tacrolimus] is things and burns and not as much with [pericularmas], but they don't work very well.

It's just their efficacy was very lackluster and then we had a PDE4 inhibitor first generation, I would call it an old generation that came out in around 2014, '16 and again, tolerability, low efficacy.

And so patients want to get clear, and we want to see them get clear.

So it was hard to put peculate but now have something that is like ZORYVE, a medication that's in my hands right now that I can say this works as well as a mid to high potency steroid in my experience and the studies can back this up, and this is once a day,

and you can use it anywhere. That's the beauty of a product like ZORYVE is that there's no limitations from how long a patient can use it. There's no limitations on where they can use it.

We have been -- I have been contributing to such a complex regimen of care where you can use this low potency stereo interface and you're going, this mid-potency steroid here.

This one is for your scalp because it's a solution. This is a ointment if it's really thick. This one is a [remit] -- and these patients have these draw pools of cranes in all of these written out plans on red lights and green lights and when to use it and not to use it. And you should see the relief on their face say, "This is one cream that you can use anywhere, at any time it's only once a day and it's got great clearance, and it's going to create itch data and great clearance of disease, whether that's atopic dermatitis or psoriasis."

Patrick Burnett^ So in that setting, what do you see as the biggest barrier then for some of these advanced targeted topical therapies? What do you see is kind of that barrier, you've talked about some of the differences in the profile between them and steroids. And we -- I talked about that earlier as well.

But is it really a profile issue? Or are there other things that are playing into this kind of transition that you're talking about?

Douglas DiRuggiero^ Well I've mentioned this earlier, and that's step-through therapies.

Our largest barrier are insurance plans forcing us to write things that we don't want to write first or to try them or to make it very difficult to get these things approved.

So really, the issue when a rep comes in, it's not where you give us a trial or you try medicine. They really need to be saying for almost every medication now is, will you fight for us. Just to try it is one thing.

The try it just means they're going to get denied, and then you move on back to your generic prescribing habit.

But he's going to have to rise up a little bit and fight for a product that you know is safer and works well. That's how these insurance companies are going to be convinced that the demand is there.

I think it's easy to convince patients of the safety.

I think it's easy to give them samples or to get them started on something and they see it works.

So I think the two main categories is always safety.

Safety is always in the driver seat and anything in efficacy or its effectiveness is ride and shotgun.

So those are the two things in the front seat, you want to be safe and you want it to work. And then in the back seat of any car, is it convenient? Can you get it filled, does -- will the patient be compliant and when you got something once a day, compliance is high.

You've got something that doesn't burn or (inaudible) compliance is high. You've got something that works. Compliance is high.

What's not compliant is often an insurance company trusting us to be doing the name we think is best for our patient. And I think that's one of the larger blocks.

Improvements are being made I will say the words out, I have a lot more patients coming in because of TikTok.

I know we kind of throw TikTok and Google, Dr. Google under the bus a lot, but there are some ways where it's been very beneficial. And in terms of informing patients about corticosteroid withdrawal and all the dangers of it, I have a lot of patients who come in and they are -- they sit there and they asked me, what is what you're writing me a steroid stairway because I don't want my child on a steroid. They're now preemptively saying, "I don't want to be on a topical steroid." And so I've seen a shift in the last two years, in particular, when more and more patients despite their insurance, despite their economic status.

They themselves are beginning to say, "I don't want to be on this. And I'm in [World Georgia]. (inaudible) not like there's a high [fluting] area, where you'd expect that to happen." I'm in a very rural area, and I still have patients on a weekly basis who are questioning me, is this more (inaudible) steroid because I don't want to be on that. Pediatricians already tried.

I don't want my chart on it.

I don't want to be on it.

I had a guy came in the other day when they talk of dermatitis, he's 40 years old, had it since he was -- birth. He says, if you're going to write me a prescription for (inaudible), this would be the last time you've ever seen me.

It was his first visit with me.

I was like, well okay.

Well I don't plan to do that, but it's nice to know to convince you and says, "My wife makes you come in every two years to see if there's anything new that's out. Tell me what I've got, list my options." And so -- so we're seeing a shift.

It may not be as fast as we want it to be, but it's happening.

It's happening.

Patrick Burnett^ Next, on Slide 20, I want to come back to an analysis that we shared in 2023 on historical analogs, where newer classes of medicines disrupted established treatment paradigms, unset unseating entrenched generic standards of care. These are four different diseases that had firmly established generic standards of care that were disrupted by safer, more effective or more convenient innovative treatments, across the market for anticoagulation, depression, GERD and schizophrenia.

It required between five and 10 years before the newer innovative therapies were able to capture 50% of the serviceable obtainable market.

It's just been over three years since we received our initial indication in psoriasis just under two years for seb derm in only 15 months since our launch in AD.

We're just getting started and look forward to the continuing evolution of the treatment paradigm for these diseases.

Imagine the growth potential if the topical anti-inflammatory market only converted half as much as these other markets.

Now on Slide 21, we highlight key aspects of the topical steroid profile that have driven their wide adoption in dermatology so that we can understand the profile that a nonsteroidal alternative needs to achieve in order to successfully compete.

It really comes down to two key characteristics.

First, like topical corticosteroids, the drug needs to be effective in resolving both inflammation and itch and it needs to do so quickly.

Second, topical steroids work on many of the most common skin diseases like atopic dermatitis, psoriasis and cebra dermatitis, as well as many of the more rare conditions, where there may not currently be any FDA-approved treatment.

So like topical corticosteroids, the drug also needs to work broadly across indications. This is distinct from the expectation for a systemic treatment where a more targeted therapy is desired.

Now consider what characteristics a drug would need to move beyond competing with topical steroids, but rather displacing them as a superior therapy for chronic inflammatory dermatosis. Patients with these chronic conditions desperately need topical drugs that can be used safely over an extended period of time to avoid flare ups, while mitigating the risks and adverse effects associated with prolonged topical corticosteroid use.

In addition, the treatment needs to be safe and convenient to use in multiple areas of the body including topical including difficult-to-treat areas like the scalp and sensitive areas like the face and growing, all of which can be affected by inflammatory dermatosis.

I'll walk through ZORYVE's MOA in detail a bit later in my presentation. Like steroids, ZORYVE has a broad impact on multiple biological processes implicated in immune-mediated inflammatory skin conditions. This distinguishes ZORYVE from biologics that target very specific pathways and other branded topicals that work on a narrower set of mechanisms. And in fact, as Frank mentioned earlier, ZORYVE as a potent inhibitor of [PDI], has even broader effects than steroids, directly impacting neuronal itch signaling and melanocyte function in addition to reducing inflammation.

We've amassed a substantial body of clinical data supporting our six FDA approvals that demonstrate the safety and efficacy profile of ZORYVE with prolonged use across multiple disease states and essentially every area of the body.

As you can see, ZORYVE checks all the boxes for the ideal profile, not only to compete with, but also to potentially replace topical steroids, helping explain why ZORYVE continues to rapidly gain share from topical corticosteroids.

I'll now turn it over to Todd to discuss our ongoing commercial efforts in the primary care physician and pediatric specialties.

Todd Edwards^ Thank you, Patrick.

I'm now on Slide 22, expanding the breadth of prescribers beyond dermatology will be a key driver of ZORYVE's continued growth.

Our initial focus was on dermatology practices, which provided a time and resource efficient rollout, given that the relatively small base of dermatology prescribers account for roughly half of all topical scripts for inflammatory dermatosis.

While we continue to make strong inroads among dermatology practitioners, we have also ramped up efforts to expand the reutilization in primary care and pediatric settings, where over 13 million topical prescriptions are written a year for our current indications. These initiatives are being advanced through our partnership with (inaudible).

In the primary care and pediatric setting, many providers have had limited exposure to topical nonrate treatments, intended default to prescribing steroids. (inaudible) team is deploying a targeted high-frequency approach to drive initial trial and ultimately, adoption of ZORYVE among these providers and their patients.

As our thyroid conversion movement continues to gain momentum and visibility, we expect it will increasingly influence prescribing habits in these settings.

While the overall universe of providers in primary care and pediatrics is vast, our joint commercial strategy with (inaudible) is both strategic and highly focused.

As shown in the pie charts on the right side of this slide, of the more than 0.5 million total PCP and pediatricians in the U.S.

The top 30,000 prescribers were about 5%, right, 4 million prescriptions or nearly a third of all prescriptions in these segments. These high-volume prescribers are the focus of our efforts and give us confidence that we will be able to officially drive growth with this strategy.

Our activation in primary care and pediatrics is still in the early days. And we are determined to drive ZORYVE's penetration in these settings to ensure this large pool of patients is provided with alternative treatment option to topical steroids.

I will now turn the call back over to Patrick, who will discuss in more depth the opportunities to continue growing ZORYVE and psoriasis setter and AD through targeted clinical activities.

Patrick?

Patrick Burnett^ Great. Thank you, Todd.

We'll now turn to the growth opportunities for ZORYVE presented by further extension of our current indications, ensuring that we can deliver ZORYVE to as broad a number of patients with psoriasis, [cebra] dermatitis and atopic dermatitis as possible who would benefit from the unique profile of this drug remains a key priority.

Our planned and ongoing label expansion efforts to support pediatric patients with plaque psoriasis and pediatric and infant patients suffering with atopic dermatitis are central to advancing this goal as we've outlined here on Slide 23. Pediatric and infant atopic dermatitis patients urgently need innovative alternatives to topical corticosteroids.

Unlike other inflammatory skin conditions, atopic dermatitis often presents at early ages for patients. Nearly 10 million children in the U.S. are impacted by atopic dermatitis with roughly 60% developing symptoms in their first year of life.

Atopic dermatitis presents unique challenges in these younger age groups not only because the skin is more sensitive, but also because the condition often covers a greater percentage of their total body surface area compared to adolescent in adults. Parents of these pediatric patients are particularly sensitive to potential negative effects from topical steroids.

These concerns range from the impact of chronic steroid use on the child's growth and bone development to more immediate complications like application to the child space or contact with the eyes and mouth and can be difficult to control. Given the size of the

patient population and the acute need and desire for safer and more tolerable therapeutic interventions, we've been methodically pursuing label expansions for ZORYVE to younger ages of atopic dermatitis patients.

Earlier this month, we received approval of our supplemental NDA for ZORYVE Cream 0.05% for the treatment of children aged two to five years old with atopic dermatitis, a population of about 1.8 million patients. Commercial launch efforts are underway, and we're excited to be bringing this important new -- this new therapeutic option to clinicians and most importantly, to pediatric patients and their caregivers.

We're simultaneously pursuing development of ZORYVE Cream 0.05% in atopic dermatitis for even younger AD patients, ages three months to 24 months.

Enrollment in our integument infant trial for this age range has been brisk and exceeded typical enrollment patterns and our expectations, confirming that there is significant interest in nonsteroidal treatment options.

In addition to atopic dermatitis, we're also pursuing a label expansion to treat pediatric plaque psoriasis patients.

While this patient population is smaller than that of pediatric atopic dermatitis there is still an acute need for better therapeutic options that we're always trying to meet.

On September 2, we announced that we are submitting a supplemental NDA for ZORYVE cream 0.3% to expand its indication to the treatment of plaque psoriasis in children ages two to 5.

If approved, the ZORYVE cream would be the first and only topical PDE4 inhibitor indicated for plaque psoriasis in children as young as 2, offering patients and caregivers, an important alternative to topical steroids and vitamin D analogs.

ZORYVE Cream is uniquely formulated to be effective, safe and well tolerated for all areas of the body including sensitive areas such as intratrigenous skin, where plaque psoriasis often presents in children. There are very limited FDA-approved treatment options for plaque psoriasis for children under 6.

We're very proud of this clinical data package and that we have compiled to support this sNDA, and we look forward to the FDA's decision. Next, on Slide 24, I'll discuss incremental data generation opportunities that our clinical team is pursuing to further bolster ZORYVE's position within our currently approved indications. The utility of these efforts is to produce a clinical data that can be referenced with health care providers that further support the robust and diverse effects of ZORYVE in plaque psoriasis, atopic dermatitis and separate dermatitis.

The intent of these efforts is to enhance the label of current indications by establishing ZORYVE among health care providers as a foundational choice amongst various options

in controlling these dermatoses. Examples of note in this effort include polymer plantar psoriasis, nail psoriasis, and cicatricial or scarring alopecia, when it occurs alongside a seborrheic dermatitis. Like nail psoriasis, [palmoplantar] psoriasis is a manifestation of plaque soriasis in a particular body area and both conditions are part of our indicated patient treatment population for ZORYVE. [Palmar-plantar] and nail psoriasis present unique clinical challenges and have historically been less responsive to standard of care topical therapies and even available systemic therapies.

However we've received indications from the field, both through formal case reports and informal dialogue with HCPs that ZORYVE is impactful in addressing these challenging locations.

Our intention is to validate this impact through a generation of data that could be made available to the HCPs we engage with.

We believe that demonstrating efficacy in these difficult-to-treat patients will incline practitioners to default towards the use of ZORYVE in their preferred topical therapy for their psoriasis patients.

Now currently, scarring alopecia, a group of related conditions, leading to the irreversible hair loss have no FDA-approved treatment. Clinicians tell us that many patients with scarring alopecia also present with seborrheic dermatitis, and there's a belief that these two conditions may be linked.

This comorbidity is particularly well documented in publications that demonstrate that over half of patients with central centrifical sycatritial alopecia, also known as [CCCA] one form of scarring alopecia, also have seborrheic dermatitis and researchers have proposed that aggressive management of their receptor may reduce the disease incidence, reduce its severity and a psychological burden in patients with CCCA.

Again, if the clinical data that we produce validates a unique efficacy profile for patients with seborrheic dermatitis and scarring alopecia we believe that it will drive preferential usage of ZORYVE versus other sebderm treatments. This incremental data generation opportunity requires small data sets, a minimal investment while driving depth of prescriptions in these underserved subpopulations.

As such, they're highly resource efficient. This effort will help further guide clinical treatment decisions.

Now turning to Slide 25.

We you can see select images from case reports that we've received in both palmoplantar psoriasis and nail psoriasis.

While the meaningful effect of ZORYVE represented in these pictures needs to be validated through our own clinical evaluation, it's easy to see why we're receiving such excited feedback from the field on the potential for these subsets of patients.

So I'll turn it back over to Todd to contextualize the impact that the components of our strategy we have reviewed so far to grow and expand ZORYVE will have on our market opportunity.

Todd Edwards^ Thank you, Patrick. Turning to Slide 26. This morning, we've highlighted the key drivers that sustained ZORYVE's growth in our current indications, continued conversion from steroids expansion into the PCP and pediatric specialties label expansion and generation of intraretinal data for patient subpopulations. These levers of growth will expand our market opportunity in two distinct ways.

First, our tenable market will increase to 17 million patients as we continue to broaden our focus beyond the dermatology setting, doubling the patient population across specialties where we have a commercial presence.

Second, we expect to drive continued expansion in ZORYVE's share of total topical prescriptions. To frame the opportunity just within the subset of health care providers, we target across dermatology primary care and pediatrics. Every 1 percentage point of share gain in topical steroid prescriptions equates to approximately $150 million in annual net sales.

As we build share from our current position to the 15% to 20% range that we believe is achievable, ZORYVE will establish itself as a blockbuster franchise across these three indications alone.

Now Patrick will discuss our plans to expand ZORYVE into new markets.

Patrick Burnett^ Thank you, Todd. Transitioning now from growing our core ZORYVE business in our currently approved indications to expanding the ZORYVE franchise by exploring potential new indications for ZORYVE. Pursuing new patient populations that may benefit from ZORYVE has been a principal focus for our clinical development strategy from the outset. This is evidenced by the five expansions we have secured across plaque psoriasis, seborrheic dermatitis and atopic dermatitis following our initial plaque psoriasis approval in 2022.

We believe that there are additional skin diseases that may respond to and more patients who may benefit from ZORYVE.

This belief is not only supported by our understanding of ZORYVE's broadly applicable anti-inflammatory and antipruritic properties as well as its potential impact on stimulating melanocytes, but also by the direct and ongoing feedback we've received from health care providers in the field on their real-world ZORYVE experiences.

So that you can understand how and why ZORYVE has potential across such a breadth of skin diseases, I want to take a moment to reorient you to ZORYVE's MOA, its mechanism of action. Notably, it's pleotropic nature. ZORYVE inhibits phosphodiesterase four or PDE4.

It's an enzyme that plays a key role in inflammation.

PDE4 regulates inflammation by increasing levels of cyclic adenosine monophosphate or cyclic AMP an intracellular messenger in immune cells. The increase in cyclic AMP in turn impacts multiple biological processes implicated in immune-mediated inflammatory skin conditions.

Specifically, it reduces the expression of multiple key pro-inflammatory cytokines including interferon gamma, type 1 interferon alpha, TNF alpha, IL-4, IL-6, IL-17 and IL-23, which spans signaling through the TH1, TH2 and TH17 immune-mediated responses. PDE4 also plays a key role in sensory neuron activation.

So inhibiting PDE4 likely direct likely directly mediates the itch sensation.

PDE4 inhibition also normalizes keratinocyte activation and differentiation, which can lead to mitigation of the epidermal barrier dysfunction that occurs in many inflammatory dermatosis. And finally, it increases melanocyte proliferation, melanocyte gene and protein expression and protects melanocytes from apoptosis.

The breadth of mechanisms and pathways that ZORYVE impacts stands in stark contrast to the very limited and specific pathways targeted with biologics for inflammatory dermatosis. These targeted therapies generally impact one or a handful of cytokines involved in the inflammatory cascade. This narrow focus limits the ability of these therapeutics to be applied widely across dermatosis in the same way that ZORYVE.

For example, inhibiting IL-23 is wonderful to treat psoriasis, but it has no impact on atopic dermatitis or many other inflammatory dermatoses, ZORYVE's unique pleiotropic MOA may also be an important differentiator between it and other topical anti-inflammatory treatments. Critically, ZORYVE affects this broad set of inflammatory pathways in inflammatory dermatosis without causing systemic immune suppression and thus avoids the deleterious effects that often a company knocking down the immune system broadly with systemic therapeutics.

It also avoids many of the deleterious side effects of topical steroid usage including local skin adverse effects as well as systemic adverse effects such as HPA access suppression, glycemic rate dysregulation, osteoporosis and osteoporotic fractures and ophthalmological AEs. ZORYVE's comprehensive MOA, coupled with a very favorable safety and tolerability profile enables us uniquely to have broad application across an exceptionally wide range of indications and patient populations. To date, this spanned plaque psoriasis, AD and seborrheic dermatitis.

It may also enable us to treat diseases where topical corticosteroids have no impact or not used, such as hidradenitis separative and [Haley Haley] disease or where their efficacy is low and use is limited due to topical adverse events, as is the case in vitiligo and cutaneous lupus.

Now I'd like to talk about how ZORYVE [pleatropic] MOA translates broadly in the clinical setting.

As part of our obligations as a manufacturer of ZORYVE, our medical team monitors this clinical feedback. To date, as shown on Slide 29, we've identified more than 40 published case reports from clinicians who've used ZORYVE in a multitude of other inflammatory dermatosis that have seen encouraging signs of efficacy. These clinicians have experienced a safe, tolerable, versatile and effective profile of ZORYVE in their psoriasis, AD and seb derm patients that have independently chosen to investigate novel applications of the therapy.

The efforts of these clinicians serve as valuable initial signals that our life cycle management process then builds upon. This pursuit of potential new indications is aligned with our original understanding of ZORYVE's pipeline in a molecule opportunity, our approach to assessing these potential opportunities is stepwise and resource efficient as outlined by the simple graphic on the right-hand side of this slide.

As indications of interest come to light, we'll conduct exploratory Phase II proof-of-concept studies where appropriate to evaluate the degree of response and understand potential safety and efficacy. Based on the results of these initial studies, our analysis of the unmet need and the addressable patient populations for a given disease as well as discussions with regulatory agencies will then decide if proceeding with a registrational trial is prudent use of capital given the anticipated return on investment.

Importantly, the investment we plan to make in pursuit of these additional potential indications involves very efficient deployment of capital.

For the FDA to approve ZORYVE for these additional patient populations, we would immediately realize operating leverage on our existing sales force, supply chain and operational foundation already in place to serve patients for our core ZORYVE business.

As we reviewed on our Q2 call we selected two initial exploratory indications, vitiligo and [hydranitis] super tivo or HS, and our underway with proof-of-concept Phase IIa studies, and we anticipate initiating several other Phase II studies in 2026.

On Slide 30, you can see select images from compelling case reports, we've received in patients with just some of the skin diseases that were listed on the previous slide, lupus, [Haley Haley] disease and neurodermatitis of the scalp.

Now I'd like to turn to the unmet needs and potential opportunity in vitiligo and hydrants [Superteva]. The first two potential indications we're exploring based on case reports from the field, starting with vitiligo on Slide 31.

The immune-mediated inflammatory condition, this immune mediated inflammation condition is characterized by the loss of pigment or melanin and patches of the skin, resulting in white or light colored areas.

In vitiligo, the body's immune system mistakenly attacks and destroys melanocytes, which are cells responsible for pigment production and skin pigmentation. There are several vitiligo types based on patterning distribution of depigmented patches and nonsegmental or generalized is the most common. There's no cure for vitiligo. Topical corticosteroids have been standard of care but have limited efficacy and the prolonged use side effects can be a challenge.

Opzelura received approval by the FDA in 2022 for the treatment of nonsegmental vitiligo and nearly half of Opzelura's current usage is for this indication. You'll recall that as part of the multi-pathway MLA, PV4 inhibition with roflumilast, the active ingredient in ZORYVE that only regulates inflammation, the underlying cause of vitiligo, but also increases melanocyte proliferation, melanocyte gene and protein expression and protects melanocytes from hepatosis.

In line with the MOA, we've been highly encouraged by multiple case reports from clinicians who pursued vitiligo as a novel application of ZORYVE and showed success treating vitiligo with ZORYVE 0.3% cream once a day.

In the ongoing Phase II proof-of-concept study, we plan to enroll 20 patients in determining whether to advance the program to a Phase III trial, we'll consider the clinical profile we see in the Phase II trial, along with data observed in the field. A rigorous evaluation of the commercial opportunity we would expect based on clinical results and how that compares to results from our other life cycle management trials.

For vitiligo, in particular, a clinical result that we may find compelling could be Opzelura-like efficacy with more rapid onset of symptom relief and a more convenient dosing regimen.

While we, of course, need input from regulatory agencies in determining what an appropriate Phase III trial design might look like, we anticipate the size and cost of registrational program would be similar to those that we've conducted with ZORYVE approved indications.

However the duration of treatment on how quickly the disease respond to treatment could impact development cost.

We believe that there are aspects of ZORYVE's profile that would make it a compelling therapeutic option relative to the current available treatments such as a once-daily dosing

and the fact that ZORYVE is not contraindicated with therapeutic biologics or immunosuppressants.

Now let's take a look at ZORYVE's potential opportunity in [hydriditis superativa], or HS, on Slide 32.

HS is a chronic recurrent and inflammatory skin condition that causes painful nodules, abscesses and tunnels. Currently, diagnosis and treatment rates remain low as treatment options are limited. HS involves disregulation of several key immune pathways addressed by ZORYVE's MOA including TNF alpha, IL-6, IL-17 and 23 and interferon gamma. Topical and oral antibiotics are common first-line therapies for mild HS, but provide insufficient relief with a high proportion of patients not improving or relapsing. Beyond antibiotics, options are limited to systemic therapeutics including corticosteroids, expensive biologics or difficult surgical procedure-based therapies.

It's also worth noting that there are extensive off-label experiences with a (inaudible), an oral PDE4 inhibitor in the treatment of HS.

In short, this is a painful, very difficult to manage chronic disease with many patients not served by the currently available therapeutic approaches.

It's our belief that an effective nonantibiotic topical anti-inflammatory would be an important therapeutic option in the treatment paradigm of these underserved patients, particularly at the milder end of the severity spectrum.

In the ongoing Phase II proof-of-concept study, we plan to enroll 20 patients, evaluate the efficacy, tolerability and rate of relief onset provided by ZORYVE how we approach the decision on whether to advance the program to a Phase III trial will be equivalent to the approach in vitiligo.

We'll evaluate the strength of clinical data and implicit commercial opportunity and hold that against other opportunities we have across our life cycle management program.

The addressable patient population is also compelling with a 3 million to 3.5 million patient prevalence. Unfortunately, the diagnosis rate amongst these patients is low at less than 15%, in part driven by a dearth of effective therapeutic interventions, which are available.

Industry projections predict substantial expansion of the diagnosis and treated HS population over the next decade based on the belief that much like psoriasis and atopic dermatitis before it, new therapeutic options should drive greater disease awareness, diagnosis and broader treatment. Currently, development of novel therapeutics for HS is most concentrated in the more severe stages of disease and primarily consists of systemic treatments.

We believe that ZORYVE, if it demonstrates activity in the clinic, could be an important topical therapy for mild to moderate disease and used in complement to systemic treatments currently approved and in development.

Now on Slide 33, you can see compelling examples of the impact of ZORYVE in patients with vitiligo and HS.

On the left-hand side, there's visible repigmentation in two vitiligo patients over a period of seven and five months.

On the right-hand side, you can see meaningful clearance of [hidradenitis super teva] lesions over just a 30-day period with reduction of inflammation and also a normalization of pigment. These select examples help demonstrate the encouraging signals that we're receiving from clinicians and why we are excited to further validate the effects of there for these conditions in a controlled clinical setting.

I'll now turn it over to Todd.

Todd Edwards^ Thank you, Patrick.

I'm now on Slide 34.

As we look to the future and potentially expand the ZORYVE portfolio, it is pertinent to reemphasize the competing effect of additional indications on prescriber behaviors that we have previously highlighted.

We have observed that clinicians who prescribe ZORYVE across multiple indications generates significantly higher prescription volume overall, as they recognize both the broad disease management benefits and exceptional tolerability profile ZORYVE provides their patients.

We expect the potential introduction of additional label expansions and communications or further compound this trend, serving as a key driver of depth of prescription writing among HCPs is supporting sustained volume growth for ZORYVE in the years ahead.

Now to Slide 35. The important efforts being undertaken by the clinical team at Arcutis have the potential to expand the patient population that can benefit from ZORYVE.

Should these clinical efforts prove successful and regulatory approval is secured.

We will see increases to our total serviceable and (inaudible) market that drive increased commercial opportunity for the franchise.

I'll now hand it back to Frank.

Thank you.

Frank Watanabe^ Before shifting gears and spending time on our vision for building our clinical pipeline, I want to take a minute to pull together all the foundational elements of the exceptional opportunity that we have with ZORYVE.

We are pursuing a massive treated patient population with more than 17 million patients in the obtainable market.

In ZORYVE we have a drug that shares all of the most important qualities that have led to TCS as being a backbone in dermatology for decades, primarily its magnitude of efficacy across multiple inflammatory dermatosis.

But what ZORYVE delivers that TCS don't is the characteristic of being safe and tolerable for prolonged use in these chronic diseases, the ability to be used in every area of the body and mechanistic dimensions with respect to neuronal signaling and melanocytes that aren't part of the TCS profile. And we're bringing this therapy to market at a time when there is a seismic shift occurring and how clinicians and patients think about the appropriate use of topical steroids to manage these diseases.

This confluence of factors gives us tremendous confidence in the meaningful and sustainable growth prospects of ZORYVE. Taken together, we see a future for ZORYVE where our share of the topical steroid market increases from the 3% roughly level where we're currently sitting to a share of 15% to 20% or greater. This growth of share will not happen overnight.

As we discussed earlier, this type of therapeutic conversion takes time to effect.

But the reasons discussed -- for the reasons discussed, we are confident that we are on a course to achieve this level of penetration.

What's more, as we approach this inflection point of generating positive cash flows from our core business, we will have additional resources to reinvest in ZORYVE to catalyze the share growth. Beyond the immediate opportunity offered by our currently approved indications, the peak potential for ZORYVE will also be driven by expanding our indicated patient population through life cycle management, as Patrick just walked us through.

With consideration of both of these dynamics, we see a peak market potential across the ZORYVE portfolio of somewhere between $2.6 billion and $3.5 billion.

We'd like to now move to the final pillar of our corporate strategy, building for the future through a pipeline of innovative medicines.

As I touched upon at the outset of today's presentation, our mission is to bring meaningful innovation to patients impacted by immune-mediated inflammatory skin diseases.

As we approach sustained profitability, we are well positioned to extend our focus to building and advancing an innovative pipeline to address additional unmet needs in line with our mission. These pipeline efforts include initiating the Phase I clinical study of ARQ-234 in atopic dermatitis and ongoing efforts to evaluate externally sourced assets. Patrick will come back now on to walk through us through both of these components of our innovative pipeline strategy.

Patrick Burnett^ Thanks, Frank.

I'm now on Slide 39.

As we highlighted in our last call we achieved an important milestone with our IND submission in Q2 for ARQ-234 as a novel systemic treatment for moderate to severe atopic dermatitis.

As we gear up to initiate our clinical study of ARQ-234.

We want to spend some time today highlighting the untapped opportunity in the atopic dermatitis market and important potential role that this molecule may play in it.

ARQ-234 is an agonist of the CD200R immune checkpoint, which is a clinically validated target found on activated immune cells. The use of the immune checkpoint inhibition in oncology revolutionized the treatment of many cancers, harnessing the body's own immune system by inhibiting immune checkpoints such as PD-1, PD-L1 has transformed the paradigm for how oncologists approach and think about treating many cancers.

By acting upon the CD200R mechanism, we're looking to use immune checkpoints in reverse, agonizing versus inhibiting the immune checkpoint in order to reestablish homeostasis of the immune system and patients experiencing excessive immune activation that drives autoimmune diseases. This sort of checkpoint [agonism] represents a novel and potentially powerful approach to the control of atopic dermatitis and other autoimmune diseases.

While there's reason to believe that this mechanism could be impactful across multiple autoimmune and inflammatory diseases will first evaluate its impact in atopic dermatitis, where clinical validation is strongest.

AD still offers a compelling opportunity for the development of new biologics for two primary reasons.

First, compared to other inflammatory dermatosis like plaque psoriasis, penetration of biologics is in the early stages. Roughly 25% of eligible patients receive systemic therapies for plaque psoriasis while only 10% of eligible patients receive systemic therapy in AD. There's reason to believe that as new biologics enter the category, the total

biologic penetration of the market will expand in turn, as was observed in plaque psoriasis, where the market grew by nearly 300% from 2014 to 2024 to approximately $23 billion following the introduction of IL-23 and IL-17 targeting therapies.

Similar growth is anticipated in AD in the years ahead with projections reflecting a greater than 10% CAGR through the end of the decade, resulting in greater than 80% growth in U.S. sales for this indication.

Second, and related, clinicians are eager to be equipped with biologic options beyond dupilumab and dupilumab is a leading biologic approved for AD currently.

However a significant unmet need remains.

But we have heard clearly in our conversations with clinicians is the desire for new mechanisms to address atopic dermatitis in patients who do not adequately respond to dupilumab, which works by blocking the inflammatory mediators IL-4 and IL-13. CD200R agonism represents a unique mechanism of action, complementary to and differentiated from other AD therapies targeting IL-4 IL-13 or OX40 and OX40 ligand.

ARQ-234 has the potential to differentiate on multiple metrics including efficacy, responder sets, durability of response, frequency of dosing and safety.

What's been demonstrated in clinical development efforts from other biopharmas targeting the CD200R access is that the durability of response off treatment after final dose is promising. This may be a unique benefit of restoring immune homeostasis more broadly with the checkpoint mechanism versus targeting specific cytokines or other components of the greater immune cascade.

The development landscape for CD200R is relatively nascent but I will still highlight a few aspects of our candidate that we believe give us the potential to differentiate our program from other CD200R programs being or previously having been pursued. ARQ-234 targets a different and we believe optimized binding site at the native location.

It also has a higher affinity as a fusion protein versus a monoclonal antibody.

We also observed an extended half-life for the molecule driven by selective mutations engineered into the fusion protein. Given its unique profile, ARQ-234 has the potential to be a class-leading program and highly differentiated from other systemic therapies in the AD market, a market we believe will produce ample and compelling opportunity for new therapeutic entrants for years to come.

And considering a recent setback in development programs targeting other MOAs in AD such as [OX40], time is right for us to move this program into clinical development. From a portfolio strategy perspective, we also believe there are compelling reasons to advance a program like ARQ-234 that has been -- that has best-in-class potential for more

severe diseases to complement the strong position we've already established with ZORYVE.

I'd like to touch on our framework for evaluating potential external oil innovations. And from the outset, our stated strategy at Arcutis was to identify, develop and commercialize best-in-class molecules against validated targets, enabling us to develop differentiated products in less time at lower cost and at substantially lower risk than other approaches.

As you can see on Slide 20, the strategy remains unchanged and continues to guide our business development evaluation framework.

In addition to clinically validated targets and differentiated product profiles we're seeking opportunities that are at a stage where the clinical and commercial expertise we've already amassed will create shareholder value. And perhaps most importantly, we're interested in opportunities that will deliver substantial innovation to address significant unmet medical needs in immune-mediated disease.

Finally, as Frank has stated previously given the number of internal opportunities in front of us, we see business development as an attractive opportunity but not as a strategic imperative.

So we will remain disciplined in evaluating business development opportunities and in deciding whether to acquire additional assets.

I'll now hand the call over to Latha to discuss our 2026 sales outlook and our capital allocation strategy.

Latha Vairavan^ Thank you, Patrick.

I'm on Slide 42.

As we detailed at the opening of today's call Q3 2025 was yet another strong quarter for ZORYVE, tailwinds from our ongoing product launches and continued demand growth despite the typical seasonality led to substantial sequential growth.

We are confident that this momentum will continue through the end of 2025 into 2026 and beyond.

As we began to exit the launch period across our ZORYVE indications, we anticipate more predictability in our rate of growth, allowing us to be more precise in anticipating the trajectory of sales for future periods.

Considering this, today, we will provide sales guidance for the first time.

In 2026, we anticipate full year net product revenues to be in the range of $455 million to $470 million.

We also anticipate continued strong net sales growth in the fourth quarter of 2025, driven by increased patient demand, even as we expect only nominal improvement in our gross to net rate compared to the third quarter. Turning now to our capital allocation strategy.

As we highlighted earlier today, we anticipate achieving the meaningful milestone of cash flow breakeven beginning in Q4 of this year.

The expense base considered in these cash flow forecast contemplates our continued investment in growing and expanding ZORYVE as we detail today and the advancement of ARQ-234.

We are confident that we will be able to fund these investments with the capital produced from our core ZORYVE business. This will be enabled by a dynamic where the timing of continued improvement of cash flow generation from the ZORYVE franchise lines up with increasing resource requirements.

We will continue to be protective of shareholder capital and be attentive to managing our capital allocation to ensure that this dynamic plays out.

We are fortunate to have a portfolio of high ROI investment opportunities paired with a cash flow-generating franchise, like ZORYVE.

I will now hand the call back to Frank for some closing remarks.

Frank Watanabe^ Thank you, Latha.

We are at an exciting inflection point at Arcutis.

We have built a solid foundation for our business with the successful launch of ZORYVE and look forward to sustained and substantial growth with the franchise.

Our initial success with ZORYVE will not only allow us to reinvest in that core business, but also to invest in expanding to potential new indications to ensure that sustained momentum and also allow us to continue to build and advance a pipeline of innovative therapies to bring new solutions to patients impacted by immune mediated skin diseases, the grounding mission and guiding force of our enterprise. And with that, we'll open up the call to Q&A.

QUESTIONS AND ANSWERS

Brian Schoelkopf^ Thank you, Frank. Unfortunately, Todd is under the weather today and will not be able to join us for the Q&A session, but I am joined by Frank, Latha and Patrick. (Operator Instructions)

So we'll jump right in.

First question for the team here on the conversion of topical steroids.

You spoke in the call to the evolution in treatment paradigm with topical corticosteroids starting to be displaced with nonsteroidal topicals.

What actions are you taking or do you plan to take to accelerate this transition?

Unidentified Speaker^ Yes. Brian, thanks. This is, I think, an extremely important question given the criticality of this process to the future for ZORYVE. And I think it's really important to emphasize that this trend towards topical stewardship and being more judicious in the use of topical steroids for really short duration treatment is a trend that's being -- that's emerging in dermatology and it's really being driven by the dermatology clinicians themselves.

And as you heard from Patrick and Douglas on the call today, there's this growing body of evidence that demonstrates the serious adverse effects that come from prolonged topical corticosteroid use, both locally and systemically, the side effects and dermatology clinicians are learning about that as Doug shared, they're talking about it and they're adjusting their practice.

I was actually at the fall clinical conference this past weekend, and there was quite a bit of discussion from the podium about this Patrick mentioned the SDNP and the SDPA statement.

So this is something that's happening organically and it's going to benefit the entire [non steroid] topical class as a whole.

But specifically, it's going to help us given our very strong share of that nonsteroidal market.

In terms of what Arcutis specifically is going to be doing to accelerate that trend.

I think really there are three levers you can think about.

I think the first one is the sales force. The second is on market access and the third is around our marketing activities.

We're already in a very good place vis-a-vis the sales force and market access.

We added about 40 reps last year around the atopic dermatitis launch.

So we have a very strong field presence that covers the dermatology clinicians that are writing about 90% of all the topical prescriptions in dermatology.

And then from access -- from an access standpoint, I think folks know we have very strong coverage across commercial beneficiaries as well as Medicaid beneficiaries and we're working on expanding the Medicaid even further, and we're also hoping to start obtaining Medicare coverage as well.

So I think we're in a really good place from a coverage standpoint. And then finally, with regard to marketing, again, I think we're in a very strong position.

We've been very thoughtful as a company about our marketing investments. because we have to be careful about how we allocate capital, but also because we've been benefiting from this organic shift that I mentioned before that's happening from the grass roots in dermatology.

So I think as ZORYVE, the franchise starts generating cash, as Latha mentioned, this is probably one of those areas where we'll be making some incremental investments in our marketing spend.

Brian Schoelkopf^ Great. Thank you. The next question here relates to the commentary on peak sales. The question is, as part of your peak sales guidance, you said you can reach 15% to 20% share of the topical corticosteroid market.

What gives you confidence that you can grow from your current roughly 3% share position to that range?

And any commentary on how long that process and that share gain will take?

Unidentified Speaker^ Sure.

So you're going to hear from me a lot since Todd is sick today.

But I think the best indicator this transition is already happening and it's going to continue to -- is the rate with which we're already seeing the nonsteroidal topicals take share from topical corticosteroids.

As mentioned earlier in the call the non-steroidal class is growing very rapidly albeit from a small base, but taking into account the fact that the nonsteroidal market has grown 50% roughly just in the last year alone, right? So there's a very, very strong growth trend and a lot of that's being driven by ZORYVE.

I think that it's important to remember that while we're seeing this very strong growth trend in steroid conversion and this conversation with a topical steroid stewardship, it is a very recent phenomenon.

If you think about it, the [led wall] paper just came out in January of this year, the SDNP and SDPA statements just came out a few months ago.

So these conversations are happening right now and they really weren't happening nearly as much a year ago.

So I think we're really just at the very beginning of seeing the impact of this change in the thinking amongst dermatologists.

In terms of specifically what's going to be the drivers for ZORYVE's market share going forward, again, I think the most important driver is the increased focus on stewardship of topical steroids that we just talked about and that's going to rely -- it's going to necessitate a much greater reliance on nonsteroidal topicals like ZORYVE.

And again, we stand to differentially benefit from that shift given our (inaudible) share of the non steroidal class and our growing share of the non-steroidal classes we've discussed already.

I think a second lever is our expansion into new treatment settings as we continue to gain awareness and adoption in primary care and pediatrics via our [Cola] partnership. Third, I think the incremental data generation that Patrick highlighted today is going to be a driver of prescriber behavior for certain key populations like patients with nail psoriasis or palmoplantar psoriasis, which are in our current indication, but we don't have all that much data around that yet.

So that will be an important incremental data set.

On the access front, we're in a great place with the reimbursement, but we have further opportunities to go in terms of expanding our Medicaid coverage and also picking up Medicare coverage.

And then lastly, actions that we take that really highlight or drive patient awareness to reinforce the trends that we're already seeing where patients are coming in and asking their doctors for something that's not a steroid, right? There's a great deal of public conversation around this topic. And I think that's going to be another important driver for (inaudible) forward growth. From a timing perspective, again, if you look at the analogs that Patrick spoke about earlier, these paradigm shifts in treatment practice do take time to effect.

I think we're very encouraged by the rate of adoption that we're seeing already.

And I think the demand growth that you saw this quarter is a good data point to show that that's happening.

But the shift from these outdated topical steroids to the newer advanced topical therapies is going to take some time.

If you look at the analogs somewhere between five and 10 years for that to happen, and we're still very early in that process with the topical steroids.

So I think it's hard to say, but it's not going to happen overnight, but I think we're very confident is going to happen for all the right clinical reasons, and we're already starting to see these trends play out.

Brian Schoelkopf^ Okay. Great. And we'll shift gears here to ARQ-234.

We've had a few questions come in on this, several of them just making reference to any clinical evidence that already exists derisking the class or the target.

But more specifically a question regarding ARQ-234.

Eli Lilly discontinued its CD200R agonist after stopping the Phase II trial in atopic dermatitis for strategic reasons. Are there any learnings you've taken from that program that can be applied to 234 or any comments you can make on differentiation between the two programs?

Frank Watanabe^ Yes.

So Patrick, do you want to take that one?

Patrick Burnett^ Yes. Thanks, Frank. Yes. No. We've watched the [OLE] program very, very closely. And I touched on this a little bit in the presentation.

I think one of the key reasons why we are confidently moving forward with ARQ-234 really has to do with the structure. The Lilly molecule was a monoclonal antibody that bind outside of the native binding site, whereas we're a fusion protein that's engineered for an extended half-life and also has two high-affinity modified CD200 ligand.

So really a very different molecular approach. And we have preclinical evidence that suggests that we're getting a higher affinity.

So we feel very good about that and as well as this kind of extended PK half-life that we think could have benefit with regard to our dosing frequency.

Of course, that has to be proven out in this study that we're planning to get started at the beginning of 2026.

So we have watched that program very carefully. And again, a lot of times, it comes down to also execution of a study, and we've conducted many studies in atopic dermatitis. And I think we have an excellent clinical development and clinical operations team. And so I think that will also help us to get a very clear understanding.

The [GWAS] data and the kind of early like evidence that pushed Lilly into atopic dermatitis still remains.

We think that, that's very compelling. And we think the ARQ-234 is the right molecule and atopic dermatitis is the right disease for us to serve further.

So we're looking forward to getting that kickoff.

Brian Schoelkopf^ Okay. Great. The next question here is on the LCM activity.

With vitiligo and HS, the question is, as you're investigating ZORYVE in vitiligo and HS, how do you think about competitive dynamic with other drugs that are already approved or in development for those indications? And then as a second part to this question, can you say more about trial design, example, size, whether or not it's controlled and duration of study?

Frank Watanabe^ Sure. Yes. Patrick, I think that's probably the best handled by you again.

Patrick Burnett^ Okay.

Sounds good. Yes.

So looking at our life cycle management and competitive dynamics with the HS and vitiligo.

I think the best place for us to start is to look at these indications where we're already approved and already in a competitive situation with both topical corticosteroids and branded topicals.

And here, what are the elements of our profile that have allowed us to be so successful. And it really comes down to efficacy, safety, tolerability once daily in ease of use, pretty much anywhere on the body as well as our commercial execution and our access.

So we have a lot of confidence in our clinical development and our commercial execution and our ability to leverage these capabilities for both of these new indications.

Now thinking specifically about vitiligo, this is a disease where I believe that once daily dosing is going to be really important for patients. Vitiligo patients have to treat for a long period of time months typically before they start to see benefit with pretty much any treatment.

And so the ability to do that just once a day is going to -- it's typically offered improved compliance compared to daily dosing.

Now for the same reason, the rate of repigmentation is another key potential differentiator.

So this is something we're going to be looking at really closely as we conduct this next study, and we'll have to see those results once they get into the clinic.

So turning to [hidradenitis suprtiva]. Here, there's a lot of white space for a topical therapeutic that's targeting inflammation.

Right now treatments are primarily topical antibiotics and then patients kind of leap all the way to a systemic therapy.

So being able to have an effective topical treatment that could be used in the earlier stage patients as monotherapy and for later-stage patients in as adjunctive treatment to complement their systemic therapy is a very, very strong profile. And that's similar to what we've seen in atopic dermatitis and psoriasis. And in fact, [hidradenitis Supertea] systemic therapies leave a lot of room for some adjunctive therapy to really help patients to get to their target treatment.

So we're very optimistic about how this profile fits with both of those indications.

Brian Schoelkopf^ Perfect.

Okay.

So moving on to next question here, and this is focused on the results for quarter three, specifically on net sales. And the question is, can you bridge us from the 13% sequential total prescription demand growth to the 22% sequential revenue growth for the quarter?

Frank Watanabe^ Yes.

Sure.

It's a great question.

I think that the primary thing that's driving the nonvolume component of the growth of our product revenue is really improvement in gross to net.

I think what we saw in the quarter was, if you think about it, if a patient is still in their deductible for the year, we're buying them down to $0 or $35.

And so Arcutis is having to pick up that additional cost from their deductible until they reach their annual deductibles.

What we saw in Q3 was that patients have progressed through their annual deductibles, probably at a rate higher than we had expected. And so we're seeing reduced usage of our co-pay program, and that directly translates into more revenue per prescription, happened earlier than we had anticipated.

But I think that also probably means that there might not be as much improvement in Q4 on that component as we saw in Q3.

So I think we expect [GTN] to be very stable, probably between Q3 and Q4.

And I think it's important to emphasize that all of the other things that can contribute to non-demand revenue growth really were not material in this period.

So it's really just the demand growth and then the improvement in gross net, which is driving this outperformance.

Brian Schoelkopf^ Okay. Great. The next question here is on the topic of external innovation and business development. The question reads, Frank mentioned sourcing external innovation. Would you elaborate on the stage of development the type of assets from a modality perspective, and then therapeutic categories that you're interested in, specifically, are you looking for something more adjacent to ZORYVE or more distant from ZORYVE from a diversification perspective?

Frank Watanabe^ Yes. Sure.

So Patrick is leading all these efforts.

So I think I'm going to ask Patrick to take that one.

Patrick Burnett^ Yes.

I think if you look at our pipeline, we have ARQ-234 that's just going to be entering into the clinic and then not spending a lot of time talking about the life cycle management opportunities for ZORYVE.

So ideally, we'd be looking for an asset which is kind of fitting in between those 2.

But I think we're really opportunistic with regard to most importantly, finding something that we are very confident about, and we're very excited about is fitting an unmet need. Again, we're prioritizing dermatology because we think that fits best with our expertise.

But just given the breadth of knowledge across the team and experience outside of dermatology we're not limiting ourselves to dermatology.

So we're really looking across inflammation at adjacencies there for assets that would fit very well into our development pipeline.

So I think what we're really -- as I mentioned in the discussion, what we're really looking for is the right asset, and we don't feel compelled to necessarily bring one in just because of where we are with our pipeline.

Because we feel they are confident about moving 234 forward and all the opportunity that we have with the ZORYVE life cycle management.

Brian Schoelkopf^ Okay. Great. And then -- and staying maybe for a moment on 234, A question came in here. Will ARQ-234 target in AD patients overlap with the ZORYVE target population for that indication? Or how should we think about that?

Frank Watanabe^ Yes, Patrick, that's probably back to you again.

Patrick Burnett^ Yes.

So our approved indication for atopic dermatitis, goes down to the age of and is in the mild to moderate space.

So development in systemics and biologics, in particular, typically focuses on moderate to severe.

So there is some overlap between the two of them.

But I think most importantly, one of the advantages of the ZORYVE profile is that whether it's label, with its safety profile, it's not excluded from being used with systemic therapy.

And so that's one of the areas that we've heard from a lot of our customers that they found it to be helpful. And oftentimes, patients who are in that moderate to severe area will get pushed down into a more mild to moderate category where they would be, while on a biologic or systemic would be appropriate for use with ZORYVE.

So we don't see them necessarily as competitive just as we don't see ourselves competing with systemic treatments, but more as complementing each other in the kind of ability to be able to maintain a patient for this chronic disease for their lifetime without having them resort to topical corticosteroids.

Brian Schoelkopf^ Okay. Great. The next question here is back on the topic of BD, and I think we hit on this a little bit, but given your foothold in dermatology offices, would you consider adding a biologic against a novel dermatology target to develop or would you also consider partnering one already in the development for U.S. rights, just to better kind of titrate on what we're looking at there.

Frank Watanabe^ So that was a two-part question, right? I think the question was would we consider a biologic in AD? And would we consider partnering commercial stage product?

Brian Schoelkopf^ Correct.

Frank Watanabe^ Yes.

So look, on the first one, we absolutely would consider partnering a biologic in the space in and I think that's really the long and the short of what Patrick was just talking about.

We're really agnostic to modality and our Arcutis treatment modality.

So whether it's an oral and injectable or a topical, we can work on any of those. And so we're evaluating that full landscape in terms of our business development efforts.

In terms of partnering on something that's already commercial stage and in the marketplace, I wouldn't say never, but it's probably not the highest priority.

We've built an exceptionally strong development organization at Arcutis across clinical and manufacturing. You think about nine successful Phase IIIs, six FDA approvals and I think this team has proven time and again, its ability to execute development programs and create shareholder value. And part of our thinking around business development is how we continue to leverage this really very strong development engine that we've built.

In a commercial stage is more leveraging the commercial organization that we have, but the commercial organization we have is pretty busy with launching all these various indications for ZORYVE.

So I would say that's probably a lower priority for us in terms of the business development and commercial stage products.

Brian Schoelkopf^ Okay. Great. And then another one here, staying on the BD topic, and this one is more about how we think about potential size constraints.

So is there any limit in terms of size that we would consider? And then depending on the size, different considerations from financing strategy to support that?

Frank Watanabe^ Well I would say with the stock performance today, we -- it's probably a little bit bigger.

But Latha, you want to maybe take that one?

Latha Vairavan^ Absolutely.

So I think -- our core focus is on the balance sheet is based on ZORYVE trajectory [builds], we will, as I said, focus on our milestone of hitting cash flow breakeven in Q4 of this year. And from more focus on our grow and expand, as Frank outlined today, and funding those activities. And then next, if you think about innovative BD, we have quite a bit of flexibility with our debt facility with SLR and also depending on the asset and the quantum and as Frank said, based on today's stock price, we'll think about the funding mechanisms that are optimal to our capital strategy and how to allocate them for BD.

Brian Schoelkopf^ Okay. Great. Next question here is going back to the topic of life cycle management for ZORYVE. And this is a two-part question.

First, across the different indications that we highlighted in the presentation earlier, how do we think about prioritizing those?

Kind of what is the framework for choosing where we would go next? And then the second is -- how do you think the addition of new indications will potentially benefit your commercial efforts in psoriasis, sebderm in atopic dermatitis?

Frank Watanabe^ Yes.

So maybe I'll take the second half of that question and then Patrick, I'll turn it over to you to talk about the first one.

I think that as you think about really replacing topical steroids as the go-to topical therapy in dermatology. The more opportunities the doctor has to write our product, the better it starts becoming a habit.

It's the default treatment choice, right?

And you see that in the data that we presented before in terms of what happens when a doctor goes from writing ZORYVE for one indication to two indications to three indications, right? It doesn't go up in steps that goes up exponentially. one to two is threefold. two to three -- one to three is a tenfold increase in their prescribing. And we would expect to see a similar kind of dynamic when they're using -- when they can use ZORYVE for almost every patient they have walking through their office door.

So I think that there will be a synergistic effect with our existing indications as doctors use ZORYVE even more and more. And one of the things that we've actually found, particularly in the access front, I would say, is the more doctors use ZORYVE, the more they use ZORYVE, right? Because they know how effective it is, how well tolerated it is, and most importantly, I think how easy it is to get for their patients there's a growing confidence with familiarity. And I think expanding indications, we should see something very similar happen with that in addition to the growth from the new indication itself. And then Patrick, do you want to maybe address the prioritization question?

Patrick Burnett^ Yes, absolutely.

So as we think about prioritizing and we're starting with HS and vitiligo.

But those are not the extent of the indications that we're looking at, and we shared kind of this broad list. And I think that is one of the key components for replacing steroids as you can't replace steroids if they work across many, many indications with a treatment that only works across one or two.

So I think that's a really critical part of our topical corticosteroid replacement.

As we think about prioritizing those, it really comes down to what's the clinical profile that we're seeing? What's the efficacy and the safety that we're seeing and that will come from both -- are studies that we're conducting as well as from reports coming in from the field. And every day, we're hearing more and more about those, and that shapes our kind of understanding of what's the level of unmet need. And what is the kind of profile and efficacy that we expect to be able to see. And then it's combining that with the commercial assessment so that we can really understand how that profile fits.

And I touched on that just a little bit with the kind of the first question we had about life cycle management, about what do we want to see in vitiligo, what do we want to see in HS. And that really gets at trying to fit in that commercial assessment to make sure that we're developing in an indication where we're going to have a market when we get to the other side.

But we know for both HS and vitiligo that these are very favorable.

We'll do the same kind of activity as we look towards new indications beyond those.

Brian Schoelkopf^ Very good.

So turning now to the recent launch of ZORYVE Foam 0.3 and scalp and body involve plaque psoriasis.

So the recent growth for the cream 0.3% was more muted compared to the foam. This is in quarter three.

Is this a result of plaque psoriasis switching to foam from cream?

Or how do you see that dynamic playing out between the two products?

Frank Watanabe^ Yes.

We've gotten this question on a number of occasions. And I think it's very unlikely that a patient who is stable on the cream is going to switch to the foam.

I certainly have heard of patients who have received prescriptions for both products, and there's no reason why patients can't -- if you had a plaque on your elbow and a plaque on your scalp, maybe the doctor gives you both although you can use the foam on the body and it works just the same as the cream.

I think we continue to see growth in [NRxs] for the cream.

So I don't think that we get this question about cannibalization.

I don't think there's any cannibalization going on because the cream is still growing.

What I do think we're probably seeing is that for new patients who haven't been on ZORYVE yet, more patients now especially psoriasis patients are getting the foam and those in some cases are patients maybe who might have gotten the cream in the past.

I think it's also important to emphasize and I've said this before, but from a shareholder standpoint, it really doesn't matter which SKU they get as long as they're getting ZORYVE, right? The COGS is essentially the same across the products.

The price is the same. The access is very similar.

So as long as total ZORYVE volume is growing, shareholders are benefiting from that growth. And I think having both the cream and the foam has options in psoriasis and now having two different presentations for atopic dermatitis tailor for those patients and having the phone for seb derm is we're just giving doctors more and more opportunities to use ZORYVE treat their patients with inflammatory skin diseases.

Brian Schoelkopf^ Okay. And then we probably have time for just one more question here, and this final question will be on the incremental data generation opportunities that Patrick was referring to in the presentation earlier. And the question is for the data generation opportunities in your current indications, the patient figures indicated on the slide, are those incremental new patients that will be covered and add to the market opportunity? Or how do we think about that?

Frank Watanabe^ Yes. Another great question.

So in terms of incremental data generation, those are really patients that are already in our serviceable obtainable market.

So for example, the nail psoriasis patient population, we talked about 3 million to 5 million psoriasis patients having nail crisis. That is part of the already targeted psoriasis market that we talked about.

But what we do expect is that will drive a differentially greater uptake in these subpopulations, particularly the really hard subpopulations, nail psoriasis is one of the hardest things to treat. Even with a biologic, it often doesn't clear palmoplantar psoriasis is another form of plaque psoriasis that is often very difficult to treat.

And so if we can generate very strong data on ZORYVE's efficacy in those very tough to treat patient population, you would expect to see even greater adoption of ZORYVE in those subsets of patients. And that's why we think that this incremental data generation is so important. And Patrick, I don't know if you have any other thoughts that you wanted to add to that?

Patrick Burnett^ No. I completely agree.

If you see a patient come in with psoriasis and you always check their nails, every psoriasis patient gets their nails and elbows checked. And you've seen nail psoriasis and the first thing that you think about is that ZORYVE is going to benefit that and nobody else with a topical therapy, and you might not have to stick them on a systemic therapy.

I think that is a huge advantage for us and really kind of changes someone's perception of the profile in an even more favorable way.

So I totally agree with what you said, Frank.

Brian Schoelkopf^ Okay. Great. And that will take us to time for the Q&A session.

We'd just like to thank you all again for making time in your busy schedule today to join us for this Investor Day.

Unidentified Speaker^ Thank you.