Resverlogix
BET Inhibition for Global Vascular Risk
BIO CEO & Investor Conference
New York, NY

February 12-13, 2018

TSX: RVX
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## Apabetalone Development Highlights

### Main Subject Matter
- Apabetalone, the only-in-class BET inhibitor (BETi), reduces key risk factors for high risk cardiovascular and renal patients resulting in reduction of Major Adverse Cardiac Events (MACE), observed renal improvement markers

### Advanced Mechanism
- Epigenetic modulation of gene expression makes BETi a novel approach
  - No known BETi competitor for next 9 plus years

### Confirmed Science
- Proteomics, genomics, pathway analysis, mechanism of action are all very well understood

### Clinical Evidence
- Phase 2b data – up to 62% RRR of MACE in high risk CVD patients
- Phase 3 BETonMACE trial 90% enrolled
  - CVD/CKD risk biomarkers tracked to date - positive

### Corporate Expansion
- Resverlogix corporate goal is to expand commercial partner program
# Capitalization and Financial Profile

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Founded</strong></td>
<td>2001</td>
</tr>
<tr>
<td><strong>Ticker</strong></td>
<td>TSX: RVX</td>
</tr>
<tr>
<td><strong>Market Cap</strong></td>
<td>~C$300MM</td>
</tr>
<tr>
<td><strong>Long Term Debt</strong></td>
<td>~C$0.0MM</td>
</tr>
<tr>
<td><strong>Shares Outstanding</strong></td>
<td>175.04MM</td>
</tr>
<tr>
<td><strong>Cash Burn (Annual)</strong></td>
<td>~C$40.0M</td>
</tr>
<tr>
<td><strong>Finance</strong></td>
<td>$87MM – Announced October 2017</td>
</tr>
</tbody>
</table>

**RVX Top Shareholders**

- Shenzhen Hepalink Pharmaceutical Co Ltd.
- Eastern Capital, Ltd.
- NGN Capital
- Donald J. McCaffrey
- Norman C.W. Wong
- Efung Capital
- CD Venture
- Wayne Chiu (Co-founder)
- Widely Held

- RVX shareholder base consists of several long term investors who have been supportive over 10 years
- RVX maintains a diversified public market float of approximately 54M shares or ~$130MM
2017 Major Accomplishments

- FDA approvals for a CKD Trial and BETonMACE
- Successful Data from Kidney Trial in New Zealand
- Over $100MM in Financing Completed
- Four Publications in 2017, Five already in the works for 2018
- $68.8MM Long Term Debt Repaid – IP unencumbered

- Q1 2017
- Q1 & Q3 2017
- Q3 & Q4 2017
- Q1-Q4 2017

Additional Communications
Numerous additional news releases occurred in 2017 new analysis reports.
Upcoming Clinical Year Estimates

- **First US Patient Randomized in BETonMACE Phase 2a Dialysis Study**
- **BETonMACE Enrollment Completed**
- **Fabry’s Disease First Patient Enrollment**
- **Top Line Data for BETonMACE**

**Additional Clinical Targets**

*Several additional targets exist and the order of launch may alternate*
Apabetalone has been tested in multiple clinical trials with a good safety and efficacy profile.
RVX-208, an Inducer of ApoA-I in Human Liver Fibrosis

Benefit of Apabetalone on Plasma Proteins in Renal Disease

Downregulation of the Complement Cascade In Vitro, in Mice and in Patients with Cardiovascular Disease by the BET Protein Inhibitor Apabetalone (RVX-208)

Autoimmune Disease
Unique Mechanism of Action

**Transcriptional Regulation**
Mechanism is based on changing the levels of disease causing proteins by modulating their expression at the gene level.

Apabetalone – reduces expression of disease mediators

**Protein Targeting**
Focus on reducing or blocking the activity of one disease protein by using an inhibitor or antibody.

Antibody or Inhibitor – blocks activity of one mediator of disease

**Genome Editing**
The mechanism is based on cutting and pasting undesired/desired sequences into or out of the DNA, thereby altering the gene sequence and then re-introducing the modified DNA into the body.

CRISPR – gene editing within a cell sub population
BET Inhibition Impacts the Pathways that Drive Cardiovascular Disease and Kidney Diseases

Apabetalone, a bromodomain extra-terminal (BET) protein inhibitor, inhibits BRD4, thereby regulating the expression of genes and restoring the function of pathways underlying the pathogenesis of CVD and kidney disease.

- **Reduced MACE & Renal Improvement**
- **Reduced mediators that promote inflammation of the vasculature**
- **Increased ApoA-I, positive effects on lipid content of HDL**
- **Delayed and reduced oral glucose absorption and endogenous production**
- **Reduced components and function of the complement cascade**
- **Reduced mediators that promote calcium deposition in the vasculature**
- **Increased ApoA-I, positive effects on lipid content of HDL**
- **Reduced mediators that promote calcium deposition in the vasculature**
MACE: Major Adverse Cardiac Events including: death, myocardial infarction, stroke, coronary revascularization, hospitalization for acute coronary syndrome or heart failure

Decrease in MACE was most profound in patients who had a higher level of inflammation such as patients with diabetes.
BETonMACE CV Outcomes Study Design

2,400 + subjects
- double blinded
- 1-2 week statin run-in

**Study Design**

1. **Screening**
   - 1-2 weeks

2. **Randomization (1:1)**
   - 1-2 weeks

3. **Treatment Duration**
   - Up to 104 weeks

4. **End of Treatment**
   - 4-16 weeks

The study is an event-based trial and continues until 250 narrowly defined MACE events have occurred.

- **Treatment Groups**
  - Atorvastatin or Rosuvastatin run-in
  - Apabetalone 200mg daily + standard of care
  - Placebo + standard of care

- **Standard of Care**
  - 20-80 mg atorvastatin or 10-40 mg rosuvastatin
**Key inclusion criteria**

- Type II Diabetes Mellitus
  - HbA1c > 6.5% or history of diabetes medications
- CAD event 7 days - 90 days prior to screening
  - Myocardial infarction (MI), unstable angina or percutaneous coronary intervention
- HDL <40 mg/dL for males and <45 mg/dL for females

**Primary Objective**
To evaluate if treatment with apabetalone as compared to placebo increases time to the first occurrence of triple MACE. Triple MACE is defined as a single composite endpoint of: 1) CV death or 2) non-fatal MI or 3) stroke.

**Primary Endpoint**
Time from randomization to the first occurrence of adjudication-confirmed triple MACE defined as a single composite endpoint of: 1) CV Death or 2) Non-fatal MI or 3) Stroke.

**Secondary Endpoint**
- Time from randomization to the first occurrence of adjudication-confirmed MACE including revascularization and unstable angina
- Changes in apoA-I, apoB, LDL-C, HDL-C, and TG
- Changes in HbA1c, fasting glucose, and fasting insulin
- Changes in ALP and eGFR
## Screening & Baseline Clinical Chemistry

As of December 4, 2017

<table>
<thead>
<tr>
<th>Parameter</th>
<th>N</th>
<th>Median (min, max)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>2,091</td>
<td>62 (33, 88)</td>
</tr>
<tr>
<td>Alkaline Phosphatase†, U/L</td>
<td>2,065</td>
<td>78 (5, 915)</td>
</tr>
<tr>
<td>HDL-C, mg/dL</td>
<td>2,074</td>
<td>33 (14, 47)</td>
</tr>
<tr>
<td>hsCRP†, mg/L</td>
<td>425</td>
<td>2.9 (0.2, 162.1)</td>
</tr>
<tr>
<td>Fibrinogen‡, mg/L</td>
<td>406</td>
<td>387 (92, 730)</td>
</tr>
<tr>
<td>LDL-C, mg/dL</td>
<td>2,057</td>
<td>65 (3, 232)</td>
</tr>
<tr>
<td>Apolipoprotein A-I†, mg/dL</td>
<td>415</td>
<td>118 (58, 179)</td>
</tr>
<tr>
<td>Glucose, mg/dL</td>
<td>2,074</td>
<td>135 (41, 555)</td>
</tr>
<tr>
<td>HbA1c, %</td>
<td>2,035</td>
<td>7.3 (4.5, 15.1)</td>
</tr>
<tr>
<td>Platelets, 10⁹/ L</td>
<td>1,976</td>
<td>248 (6, 989)</td>
</tr>
<tr>
<td>NLR, ratio</td>
<td>1,993</td>
<td>2.6 (0.6, 16.5)</td>
</tr>
</tbody>
</table>

**Males**

- 75.6% males

**Statin Allocation**

- 52% atorvastatin
- 48% rosuvastatin

† results from visit 2/wk 0, whereas all other values are from visit 1/screening.
• ~ 90% enrolled
• CKD Subgroup: ~11% of patients have eGFR<60 at screening
• Cognition Subgroup: ~18% of patients have completed MoCA at Baseline; Target patients are those with baseline MoCA ≤ 25
• Consistent data repeatable positive effects in key CVD and CKD biomarkers
• New data to target MoCA in elderly cognition subgroup (70 and over)
• Projected primary MACE rate still 8.0 per 100 patient years on top of aggressive standard of care = strong unmet need
Patient Enrichment Strategy

Relative Annual Major Adverse Cardiac Event (MACE) Rates In Various Patient Groups

- General Population: 0.2%
- Diabetics: 2.6%
- ACS Patients with Diabetes: 9.5%
- Dialysis Patients: 13.8%
- ACS Patients with CKD: 31.6%
- ACS Patients on Dialysis: 33.1%

**Future High Risk Target Patients**

**BETonMACE Target Patients**

Sources: Calculated from CDC Heart Disease Facts; Holden, SE. et al. 2015; White, WB. et al. 2013; Kim, H. et al. 2015; Cardarelli, F. et al. 2008; Okada, T. et al. 2008
Market Opportunity Pathways

Diabetes/ACS
- BETonMACE derived 2,400 patients
- MACE reduction
- 2-3 Million patients

CKD/ESRD
- BETonMACE sub population derived 300-400 patients
- Improved renal function in sub-group
- Reduced MACE
- Future trials in CKD Stage 3-4 Diabetic Nephropathy ESRD
- 6 Million Patients

Expanded Programs
- BETonMACE sub-population data analysis
- Cognition and dementia
- 2+ Million Patients

Improving Global Vascular Risk
Balanced for Success!

THREE KEY DEVELOPMENT TARGETS ARE IN PLACE

INNOVATION
Resverlogix owns the world's most advanced BRD4 epigenetics program

EFFICACY
Clinical and safety data is continuing to suggest a successful program

PHARMACO-ECONOMICS
The payor groups now hold the power to determine success
Based on SUSTAIN/ASSURE, NNT and cost/event prevented were favourable versus comparators in their respective patient populations.

### Number Needed to Treat (NNT) per MACE event prevented (1 Year Kaplan Meier Estimate unless otherwise specified)

<table>
<thead>
<tr>
<th>Trial</th>
<th>Molecule</th>
<th>Trial Size</th>
<th>Treatment Duration (Years)</th>
<th>Absolute NNT/Yr</th>
<th>Kaplan Meier (KM) NNT/Yr</th>
<th>Annual Medication Cost/Patient</th>
<th>Annual Cost per Event Prevented (KM)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUSTAIN/ASSURE</td>
<td>Apabetalone</td>
<td>497</td>
<td>0.4 – 0.5</td>
<td>23</td>
<td>22</td>
<td>$2,400 - $4,200</td>
<td>$52,800 - $92,400</td>
</tr>
<tr>
<td>ASSERT/SUSTAIN/ASSURE</td>
<td></td>
<td>798</td>
<td>0.25 – 0.5</td>
<td>11</td>
<td>22</td>
<td>$2,400 - $4,200</td>
<td>$52,800 - $92,400</td>
</tr>
<tr>
<td>ODYSSEY LONG-TERM</td>
<td>Alirocumab</td>
<td>2,338</td>
<td>1.6</td>
<td>97</td>
<td>83</td>
<td>$14,560</td>
<td>$1,208,480</td>
</tr>
<tr>
<td>POOLED ODYSSEY</td>
<td></td>
<td>3,459</td>
<td>1.6</td>
<td>NA</td>
<td>167</td>
<td>$14,560</td>
<td>$2,431,520</td>
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<tr>
<td>OSLER 1-2</td>
<td>Evolocumab</td>
<td>4,465</td>
<td>0.9</td>
<td>83</td>
<td>81</td>
<td>$14,100</td>
<td>$1,142,104</td>
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<tr>
<td>IMPROVE-IT</td>
<td>Ezetimibe</td>
<td>18,144</td>
<td>6.0</td>
<td>333</td>
<td>250*</td>
<td>$2,844</td>
<td>~$711,000</td>
</tr>
<tr>
<td>EMPA-REG OUTCOMES</td>
<td>Empagliflozin</td>
<td>7,042</td>
<td>3.1</td>
<td>194</td>
<td>87</td>
<td>$4,126</td>
<td>$358,769</td>
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<tr>
<td>DEFINE</td>
<td>Anacetrapib</td>
<td>1,612</td>
<td>1.5</td>
<td>244</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

Note: Medication cost based on US WAC cost (PriceRx); Kaplan Meier estimates are based on digitized curves from publications.

*No patient population standardization has been applied so additional population specific factors beyond severity can also influence NNT values.

*1 year showed no benefit to calculate NNT, estimated by taking 5 year KM rate of 50 x 5 years.

Apabetalone’s potential economic benefit is even more pronounced when considering cost of competitive PCSK9i products.

Apabetalone HEOR Evidence Benchmarking - Final Results v4.0 Oct 2015

RVX testing further price bands: Tier 3 based on higher risk populations.
• RVX performed multiple outreach reports with leading US KOL payers for market pricing analytics

• Apabetalone target plan: higher risk CVD patients (e.g. Diabetes with recent ACS, CKD, Dialysis, Dementia) supported positive pricing and reimbursement with leading US payer groups

• Higher risk patients represent significantly increased burdens to healthcare systems on account of greater costs associated per patient per year

• Payer responses shows strong support for pricing value proposition falls within ICER range of $140-175K USD. This ICER range represents superior value proposition versus current CVD risk competitors such as PCSK9s and SGLT2s

• Global pricing band planned by US market first, then European, Canada with applicable discounts
## Payer KOL Outreach: Key Payer Support

<table>
<thead>
<tr>
<th>Organization</th>
<th>Lives Covered</th>
<th>MACE Reduction: Unmet need in Recent ACS and T2DM patients</th>
<th>MACE Reduction: Unmet need in CKD patients</th>
<th>ICER Threshold per annum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payer 1</td>
<td>55 M</td>
<td>Moderate to High</td>
<td>Moderate to High</td>
<td>$ &lt; 100,000</td>
</tr>
<tr>
<td>Payer 2</td>
<td>65 M</td>
<td>Moderate to High</td>
<td>Moderate to High</td>
<td>$ &lt; 200,000</td>
</tr>
<tr>
<td>Payer 3</td>
<td>37 M</td>
<td>Moderate to High</td>
<td>Moderate to High</td>
<td>$ &lt; 100,000</td>
</tr>
<tr>
<td>Payer 4</td>
<td>40 M</td>
<td>Moderate to High</td>
<td>Moderate to High</td>
<td>$ &lt; 150,000</td>
</tr>
<tr>
<td>Payer 5</td>
<td>11 M</td>
<td>Moderate to High</td>
<td>Moderate to High</td>
<td>$ &lt; 150,000</td>
</tr>
</tbody>
</table>

- 5 Payers - **208 million** lives covered, Key C Suite executives contacts – President, Chief Medical Directors, COO, Executive VP Pharmacy
- Pricing bands support average ICER Target Threshold of approximately **$140,000-$200,000 USD**
- Pricing bands support average price of **$6,000 - $12,000** based on new enriched high risk patients
Apabetalone Opportunity

Highlights

• Novel, first in class, technology – no competitor 8 – 10 years
• Clear science and clinical data supporting strong rationale for risk reduction
• Growing BET literature publications in CVD / Renal risk
• Strong KOL Payers and Prescriber support
• Transformative science and unprecedented commercial opportunity