



MEIRAGTx

Gene Therapy for the Treatment of Radiation-Induced Xerostomia: AAV2-hAQP1 Program Update

December 13, 2022

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1. Introduction

Zandy Forbes, PhD
President & CEO MeiraGTX

2. Radiation-Induced Xerostomia: Disease Background and Unmet Medical Need

Robert K. Zeldin, MD
Chief Medical Officer MeiraGTX

3. Treating Physician Perspective

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Professor, Department of Otolaryngology/Head & Neck Surgery
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4. AQUAx Phase 1 Study Data and Future Plans

Zandy Forbes, PhD
President & CEO MeiraGTX

Salivary Gland Gene Therapy for Radiation-Induced Xerostomia

Robert K. Zeldin, MD



Serious, debilitating complications as a result of reduced saliva production

- ❖ RIX is one of the most frequent complications of radiation treatment for head and neck cancer
- ❖ 85% of radiation-treated patients experience reduced saliva production, of whom 40% have persistent Grade 2/3 RIX
- ❖ Persistent Grade 2/3 RIX is a common, durable and severely debilitating condition
- ❖ Patients experience:
 - Difficulty eating, chewing and swallowing; taste alterations
 - Speech difficulties and abnormalities
 - Uncontrollable dental caries with severe tooth decay/periodontal disease
 - Inability to wear dentures
 - Oral pain and throat pain
 - Burning mouth sensation in 40% of patients
 - Harmful changes in oral flora



Currently therapies only treat symptoms, with limited efficacy and poor tolerability, leaving a significant unmet need in grade 2/3 RIX

- ❖ Providers generally recommend lifestyle interventions first (e.g., extra water consumption) followed by topical agents (e.g., artificial saliva) for RIX patients. Saliva substitutes such as carboxymethyl cellulose and mucin have short term benefit and are disliked by patients
- ❖ 75% of grade 2 & 3 RIX patients are treated with oral sialogogues - pilocarpine or cevimeline
 - Do not improve salivary gland functionality
 - Not well tolerated
 - Majority of patients experience side effects including flushing, upset stomach, and sweating
 - Contraindicated in a variety of conditions
- ❖ Sialogogues have decreasing efficacy with increasingly severe RIX
- ❖ ~83% of treated grade 2 & 3 patients either experience no response or don't tolerate the drugs
- ❖ AAV2-hAQP1 is the only known treatment in the clinical pipeline

Large indication for a gene therapy: both prevalence and incidence

- ❖ >170,000^{1,2,3} long term (2 years post successful treatment) grade 2/3 RIX patients currently in the US alone
- ❖ 54,000^{1,2} new cases of head and neck cancer per year in the US with >15,000 new long-term grade 2/3 RIX patients
- ❖ No effective treatment for long term grade 2/3 RIX
- ❖ Patients are in the healthcare system in remission for head and neck cancer and seeing physicians at least annually
- ❖ Low dose, low cost of goods, large market for gene therapy = strong commercial opportunity

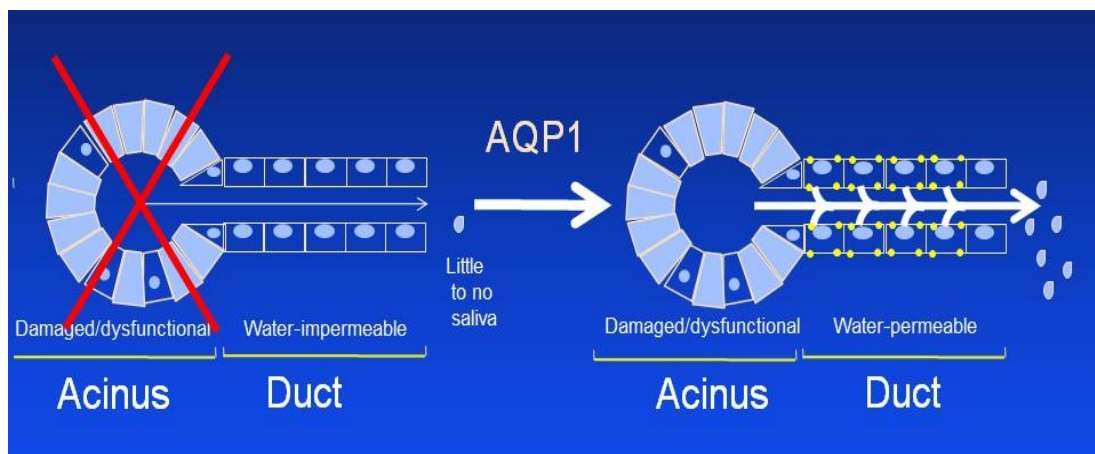
¹ SEER, Cancer.net

² Marta GN et al (2014). Intensity-modulated radiation therapy for head and neck cancer: systematic review and meta-analysis. *Radiother Oncol.* 110(1):9-15

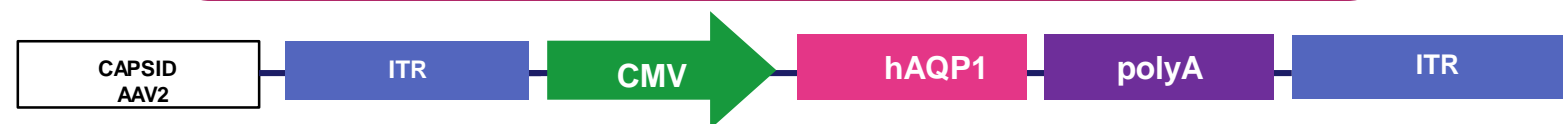
³ Jensen S.B., et al. (2010). A systematic review of salivary gland hypofunction and xerostomia induced by cancer therapies: prevalence, severity and impact on quality of life. *Support Care Cancer.* 18(8):1039-1060

Mechanism of Action:

- Water-impermeable duct cells generate an osmotic gradient (lumen > interstitium)
- Introduction of human aquaporin 1 gene (hAQP1) to duct cells via viral vector makes cells permeable to water
- Allows water to flow into the salivary duct and out to the mouth



Viral Vector Configuration:



Capsid - AAV2:

- Transduces human primary salivary gland tissue more effectively than any other known capsids
- Local transduction: AAV2 stickiest of capsids. The target is the single layer of duct cells and remaining acinar cells

Promoter – CMV promoter:

- Drives strong, durable expression in salivary glands

Gene – hAQP1:

- Human water channel that provides membranes with high permeability to water, permitting water to move in the direction of an osmotic gradient

Local Non-invasive Delivery:

- Delivered via catheter into the opening of the parotid duct

¹Rouleau, Tanya S. et al, A retrospective, cohort study of the prevalence and risk factors of oral burning in patients with dry mouth
Oral Surg Oral Med Oral Pathol Oral Radiol Endod 2011;111:720-725

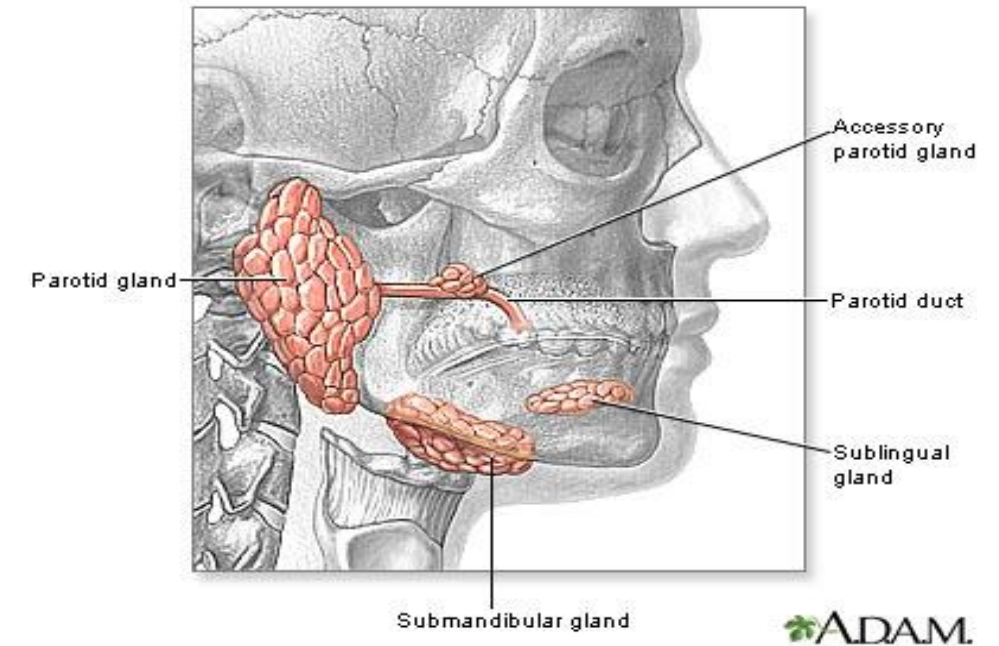
Clinical Perspective

Michael Brennan, DDS, MHS, FDS RCSEd

A background image showing a close-up of laboratory glassware. A pipette is positioned above a test tube, with a single drop of liquid about to fall into it. Other test tubes are visible in the foreground and background, all slightly out of focus. The overall color palette is light blue and white.

❖ Therapy well suited to outpatient treatment

- Simple, minimally-invasive procedure
- No anesthesia needed
- Small volume of vector required
- Local administration, no systemic exposure
- Well tolerated by patients



❖ ENT surgeons and many dentists/oral surgeons already trained in this procedure

AAV2-hAQP1 provides a one-time treatment with the potential for restoration of salivary function in patients with intractable RIX – a severe condition with no current effective treatment options



AQUAx Phase 1 Study Data

Zandy Forbes, PhD



Study Design

- Open label, multi-center, dose escalation study at 4 sites in USA and Canada
- One-time administration of AAV2-hAQP1 to one (unilateral) or both (bilateral) parotid glands
- Four dose escalating cohorts with 3 participants per cohort for both unilaterally-treated and bilaterally-treated participants
- All participants are followed for 1-year post-treatment and then enrolled in long-term follow-up study for a total of 5 years

Cohort	Dose
1	1×10^{11} vg/gland (single gland)
2	3×10^{11} vg/gland (single gland)
3	1×10^{12} vg/gland (single gland)
4	3×10^{12} vg/gland (single gland)

Primary Endpoint

- Safety

Secondary Endpoints

- Patient reported measures of xerostomia symptoms
 - Global Rate of Change Questionnaire (GRCQ)
 - Xerostomia Questionnaire (XQ)
- Whole saliva flow rate

1b	3×10^{10} vg/gland (both glands)
2b	1×10^{11} vg/gland (both glands)
3b	3×10^{11} vg/gland (both glands)
4b	1×10^{12} vg/gland (both glands)

Study Status:

- Enrollment completed in the four unilateral treated cohorts Nov 2021 (n=12)
- Enrollment completed in the four bilateral treated cohorts March 2022 (n=12)

Data Presented Today:

- Data from all unilateral cohort subjects (n=12) out to 12 months post treatment
- Data from all bilateral cohort subjects (n=12) out to 6 months post treatment

Safety:

- AAV2-hAQP1 treatment appears safe and well tolerated at each dose tested
- No dose limiting toxicity or drug related serious adverse events

Activity:

- Improvements observed in both of the patient reported assessments of xerostomia symptoms, GRCQ and XQ, in both unilateral and bilateral treated cohorts at 12 and 6 months post treatment, respectively
- Improvements in salivary flow were seen in unilateral as well as bilateral cohorts
- Durability out to 2 years in 3 participants and 3 years in 1 participant

- ❖ **Hyposalivation: Objective measure of saliva production – assessed by collecting whole saliva**
- ❖ **Xerostomia: Subjective feeling of dry mouth – assessed using patient reported outcome measures (PROs)**
- ❖ **Relationship between Xerostomia and Saliva Production**
 - Xerostomia symptoms are associated with reduction in saliva production
 - Xerostomia severity (or PRO score) is not directly correlated with an absolute volume of saliva production

ASCO GUIDELINES

TABLE 1. Definitions Related to Dysfunction of the Salivary Glands

Salivary gland hypofunction	Reduced salivary flow rate as measured objectively. Saliva flow rate is considered low when < 0.2 ml/min for unstimulated whole saliva ¹¹
Hyposalivation	Pathologic low saliva secretion, commonly defined as an unstimulated whole saliva flow rate of ≤ 0.1 ml/min or a stimulated whole saliva flow rate of ≤ 0.7 ml/min measured by sialometry ¹¹
Xerostomia	Patient-reported, subjective sensation of oral dryness. Although xerostomia most frequently occurs when the unstimulated whole saliva flow rate is reduced by about 45%-50% of the normal secretion of that person, ¹² there are no specific threshold levels of salivary flow rate that characterize xerostomia. The degree of xerostomia may be affected by factors other than salivary flow rates
Whole saliva	Derives from the major salivary glands (the parotid, submandibular, and sublingual glands, which account for 90% of the saliva secretion) and the minor salivary glands (which account for the remaining 10%)

- ❖ Patients are asked if there is a change in their symptom of Dry Mouth
- ❖ They may reply, “Better”, “Worse”, or “About the Same”
- ❖ If patients reply “Better” or “Worse”, they are asked to quantify the change on a 7-point scale with **the maximum score of 7** and “a very important change” and 1 being the minimum
- ❖ A 2-point change is “large enough to be important” to the patient
- ❖ Anything 3 points or greater is considered a substantial improvement over standard of care and “transformative” by KOLs
- ❖ This questionnaire is very similar to the “Global Improvement” tool accepted by the FDA to approve Cevimeline

GLOBAL RATINGS OF CHANGE

- 1.0 Overall, has there been any change in your **Dry Mouth** since you received study treatment? Please indicate if there has been any change in your **Dry Mouth** by choosing one of the following response options:
(Place an “X” in the appropriate box below)
1. WORSE (if **WORSE**, go to question 2.0)
 2. ABOUT THE SAME (if **SAME**, go to question 4.0)
 3. BETTER (if **BETTER**, go to question 3.0)
- 2.0 How much **WORSE** would you say your **Dry Mouth** has been since you received study treatment? Please choose one of the following response options: **(Record the appropriate response option in the box below)**
1. almost the same, not important
 2. a little worse, but large enough to be important
 3. somewhat worse, still a small change, but large enough to be important
 4. moderately worse, an important change for the worse
 5. a good deal worse, an important change for the worse
 6. a great deal worse, a very important change for the worse
 7. a very great deal worse, a very important change for the worse
- (go to question 4.0)
- 3.0 How much **BETTER** would you say your **Dry Mouth** has been since you received study treatment? Please choose one of the following response options: **(Record the appropriate response option in the box below)**
1. almost the same, not important
 2. a little better, but large enough to be important
 3. somewhat better, still a small change, but large enough to be important
 4. moderately better, an important improvement
 5. a good deal better, an important improvement
 6. a great deal better, a very important improvement
 7. a very great deal better, a very important improvement
- (go to question 4.0)

GRCQ: Strong, Durable Improvements in Xerostomia Scores 12 Months Post Treatment Following Unilateral Treatment

GRCQ UNILATERAL

Dry Mouth Symptoms?
Better (+), Worse (X),
or Same (=), How Much Better/Worse?

Cohort	Participant	Day 90	Day 180	Day 360	Year 2	Year 3
1	1-1	+, 5	+, 6	+, 7	+, 7	+, 7
	1-2	+, 3	+, 3	+, 6	+, 2	
	1-3	+, 3	+, 3	=	+, 4	
2	2-1	=	=	=		
	2-2	+, 2	+, 4	+, 4		
	2-3	+, 6	+, 6	+, 6		
3	3-1	+, 4	+, 3	+, 3		
	3-2	=	=	=		
	3-3	NA	=	+, 5		
4	4-1	+, 4	+, 4	+, 4		
	4-2	=	=	=		
	4-3	+, 4	+, 4	+, 6		

GRCQ Score for Unilateral Treatment (n=12) All participants to 12 months or more

- ❖ 8/12 participants at 12 months reported symptoms of dry mouth as 'better' following treatment
- ❖ Each of the 8 participants reported a score of 2 or more ie: "an important change"
- ❖ 4 participants rated the change in xerostomia symptoms with the highest improvement scores of 6 or 7 denoting "a very important improvement"
- ❖ Improvement in xerostomia symptoms can be seen persisting through 2 years in three patients
- ❖ Participant 1-1 reached the 3-year assessment and the maximum score of 7 was maintained
- ❖ No participant reported any worsening of xerostomia symptoms

GRCQ: Strong Improvements in Xerostomia Scores Following Bilateral Treatment at 6 Months

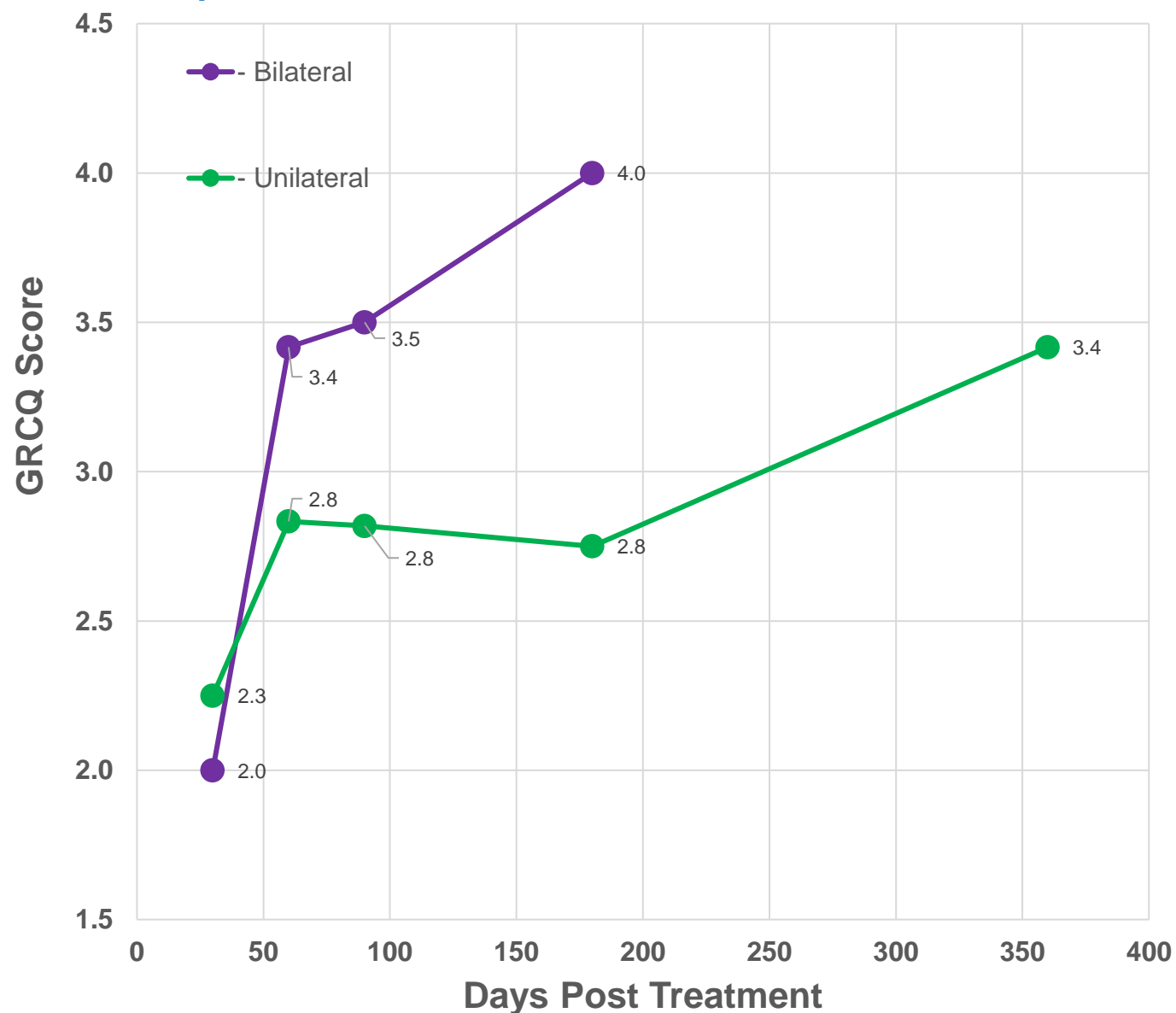
GRCQ BILATERAL		Dry Mouth Symptoms? Better (+), Worse (X), or Same (=), How Much Better/Worse?	
Cohort	Participant	Day 90	Day 180
1b	1b-1	+, 4	+, 4
	1b-2	+, 4	+, 5
	1b-3	+, 5	+, 6
2b	2b-1	+, 1	=
	2b-2	+, 5	+, 5
	2b-3	+, 1	+, 2
3b	3b-1	+, 2	=
	3b-2	+, 6	+, 7
	3b-3	+, 6	+, 6
4b	4b-1	+, 4	+, 4
	4b-2	+, 4	+, 5
	4b-3	=	+, 4

GRCQ Score for Bilateral Treatment (n=12) All participants to 6 months

- ❖ 10/12 participants at 6 months reported symptoms of dry mouth as ‘better’ following treatment
- ❖ Each of these participants rated changes in xerostomia scores that were important or very important with a score of 2 or more at 6 months
- ❖ 3 participants rated the change in xerostomia symptoms with scores of 6 or 7 denoting “a very important improvement”
- ❖ No participant reported any worsening of xerostomia symptoms
- ❖ For all patients including bilateral and unilateral (n=24), 18/24 or 75% reported dry mouth as ‘better’ with a clinically meaningful score of 2 or more

GRCQ: Overall Improvement Greater in Bilateral compared to Unilateral treatment group; Unprecedented 4-point Improvement at 6 Months

GRCQ improvements for Bilateral and Unilateral and Treated Cohort



n=12 unless otherwise indicated

- ❖ In the overall cohorts the average improvement score in GRCQ was greater in bilateral compared to unilateral
- ❖ Overall improvements were maintained and increased over time in both unilateral and bilateral cohorts
- ❖ A 2-point change in GRCQ compared to placebo is considered significant by KOLs
- ❖ Anything 3 points or greater is considered a substantial improvement over standard of care and “transformative” by KOLs
- ❖ Unilateral cohort achieved overall improvement of >3 points at 12 months
- ❖ Bilateral cohort achieved overall improvement of >3 points at 2 months and an overall improvement of 4 points by 6 months

- A Patient Reported Outcome measure
- 8 symptom-specific questions wherein the patient rates each symptom from 0 (not present) to 10 (worst possible)
- Responses are summed (0-80), providing an overall measure of disease burden
- **An improvement (decrease) of 8 points (or 10%) or more is considered clinically meaningful**
- **A decrease in score of 10 or greater is considered a substantial improvement over standard of care and “transformative” by KOLs**

Xerostomia-Specific Questionnaire (XQ)

Objective: To measure patient-reported xerostomia (decreased saliva flow) associated with radiation therapy (RT) for head-and-neck cancer

Instructions: Patients are to rate (circle) each of the eight items on a scale from 0 to 10; the higher the score, the worse the xerostomia

1.	Rate your difficulty in talking due to dryness	0	1	2	3	4	5	6	7	8	9	10
2.	Rate your difficulty in chewing due to dryness	0	1	2	3	4	5	6	7	8	9	10
3.	Rate your difficulty in swallowing solid food due to dryness	0	1	2	3	4	5	6	7	8	9	10
4.	Rate the frequency of your sleeping problems due to dryness	0	1	2	3	4	5	6	7	8	9	10
5.	Rate your mouth or throat dryness when eating food	0	1	2	3	4	5	6	7	8	9	10
6.	Rate your mouth or throat dryness while not eating	0	1	2	3	4	5	6	7	8	9	10
7.	Rate the frequency of sipping liquids to aid swallowing food	0	1	2	3	4	5	6	7	8	9	10
8.	Rate the frequency of sipping liquids for oral comfort when not eating	0	1	2	3	4	5	6	7	8	9	10

Xerostomia Questionnaire (XQ): Very Strong Improvements (Decrease in Score) Compared to Baseline Observed in Unilateral and Bilateral Cohorts

Change From Baseline Unilateral

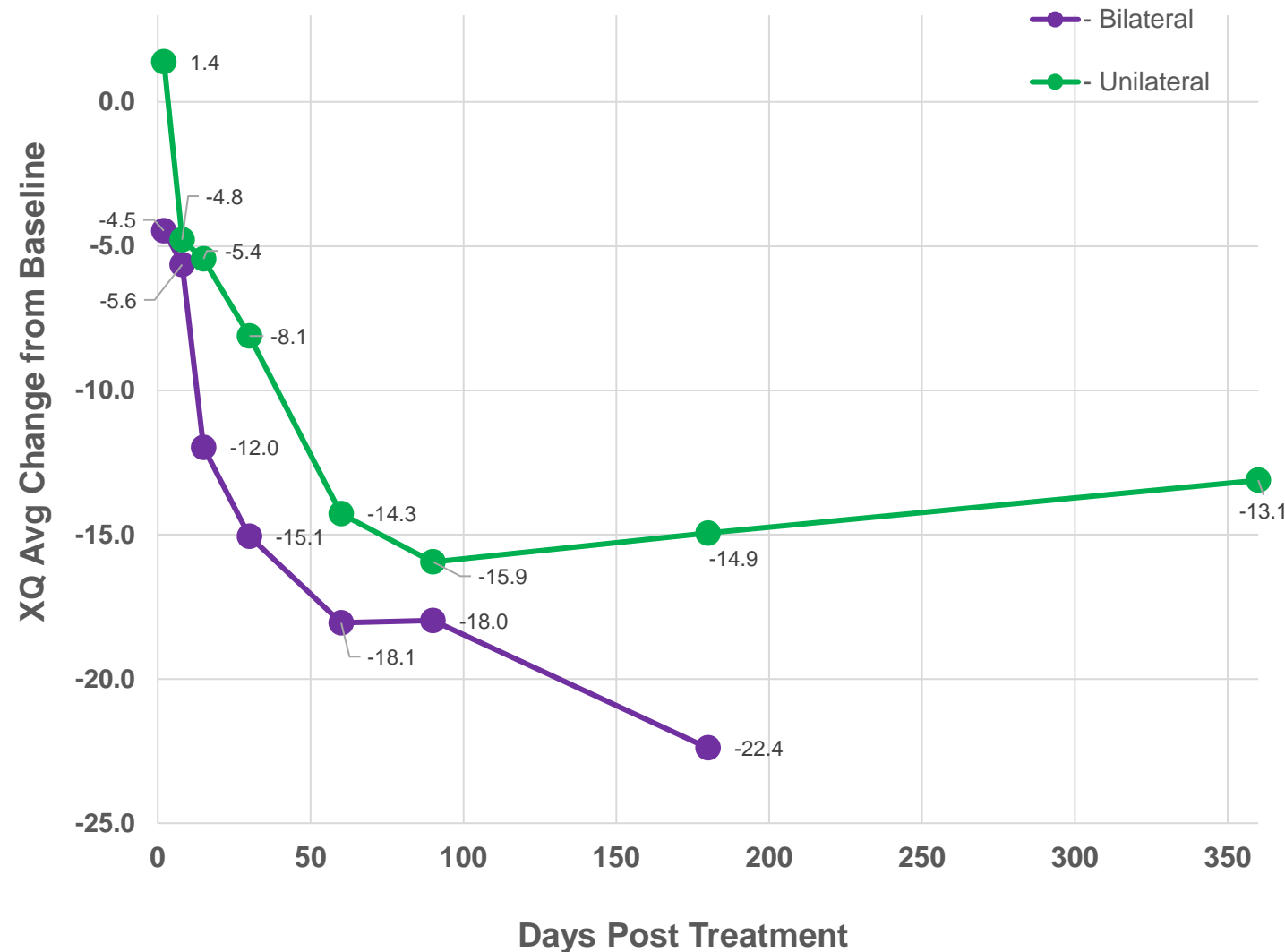
Change From Baseline Bilateral

Cohort	Participant	Day 90	Day 180	Day 360	Year 2	Year 3
1	1-1	-14.7	-14.7	-18.7	-19	-18
	1-2	-8.3	-0.3	-17.3	-7	
	1-3	-6.3	-6.3	-3.3	-6.3	
2	2-1	-14.0	-9.0	-8.0		
	2-2	-23.0	-24.0	-21.0		
	2-3	-38.7	-29.7	-34.7		
3	3-1	-19.3	-20.3	2.7		
	3-2	7.7	1.7	-0.3		
	3-3	5.3	-1.7	-4.7		
4	4-1	-37.7	-34.7	-12.7		
	4-2	-3.3	0.7	3.7		
	4-3	-39.0	-41.0	-43.0		

Cohort	Participant	Day 90	Day 180
1b	1b-1	-15.3	-17.3
	1b-2	-31.3	-26.3
	1b-3	-11.0	-10.0
2b	2b-1	-7.3	-11.3
	2b-2	-34.7	-33.7
	2b-3	-15.7	-23.7
3b	3b-1	-4.0	-5.0
	3b-2	-26.3	-30.3
	3b-3	-29.7	-44.7
4b	4b-1	-27.0	-35.0
	4b-2	-16.0	-31.0
	4b-3	2.7	-0.3

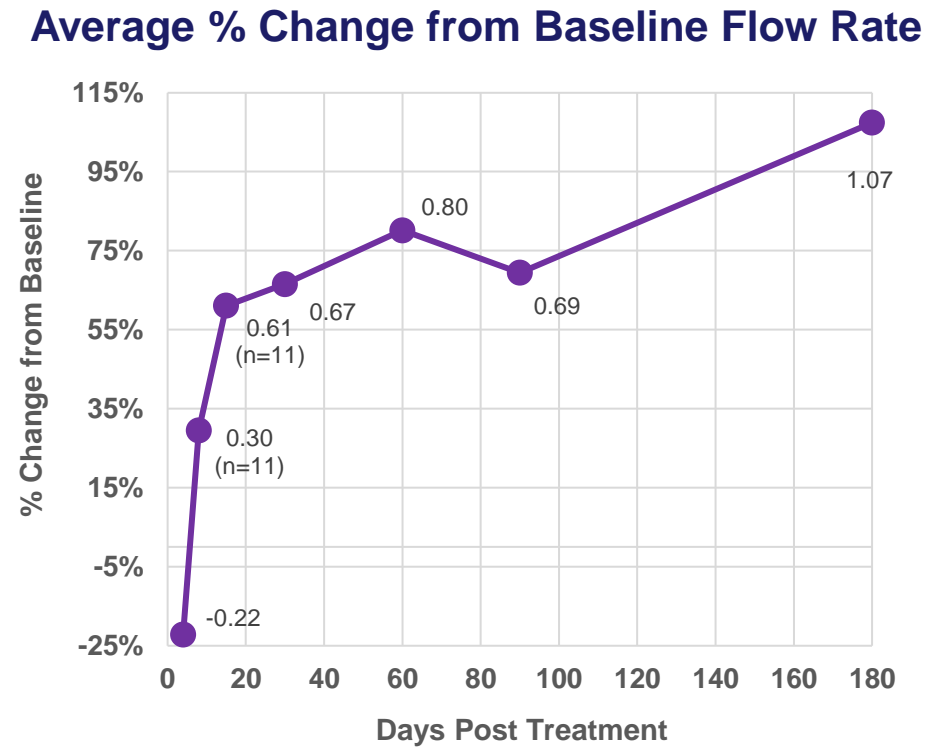
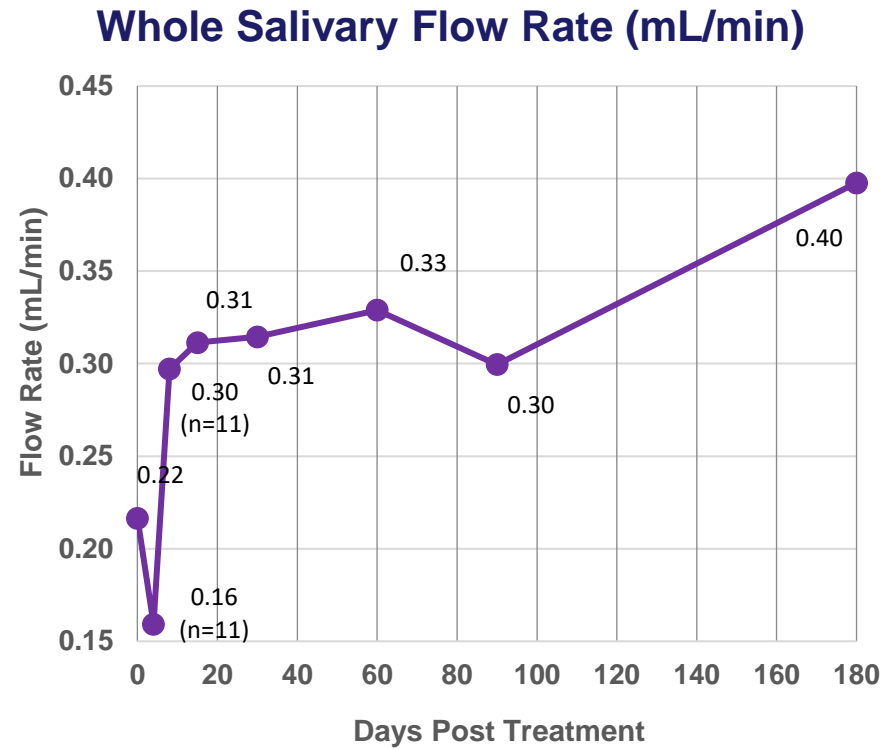
- ❖ **Unilateral:** 7/12 had score improvements (decrease) >8 at 12 months
- ❖ **Bilateral:** 10/12 had score improvements >8 out to 6 months
- ❖ **Overall:** 17/24 (71%) had an improvement following treatment of >8 points
- ❖ A decreased score of 10 is considered transformative
- ❖ 6/12 or 50% of unilateral at 12 months and 10 of 12 or 83% of bilateral at 6 months achieved 10 point or greater decline
- ❖ There was good concordance with the individual patients who responded in XQ and GRCQ

XQ: Substantial Clinically Meaningful Improvements in XQ in both Unilateral and Bilateral treated groups



- ❖ **Unilateral:** 13-point improvement from baseline at 12 months
- ❖ **Bilateral:** 22-point improvement from baseline at 6 months
- ❖ Improvement in XQ was observed rapidly post treatment
- ❖ In both groups XQ scores improved (declined) >8 points soon after treatment, and >10 points within 2 months after treatment
- ❖ This level of benefit is considered transformative by KOLs
- ❖ As with the GRCQ the degree of improvement was greater in bilateral compared to unilateral treated cohorts

Bilateral Cohorts: Meaningful Improvement in Unstimulated Whole Saliva Production Achieved Reaching Normal Levels Following AAV2-hAQP1 Treatment

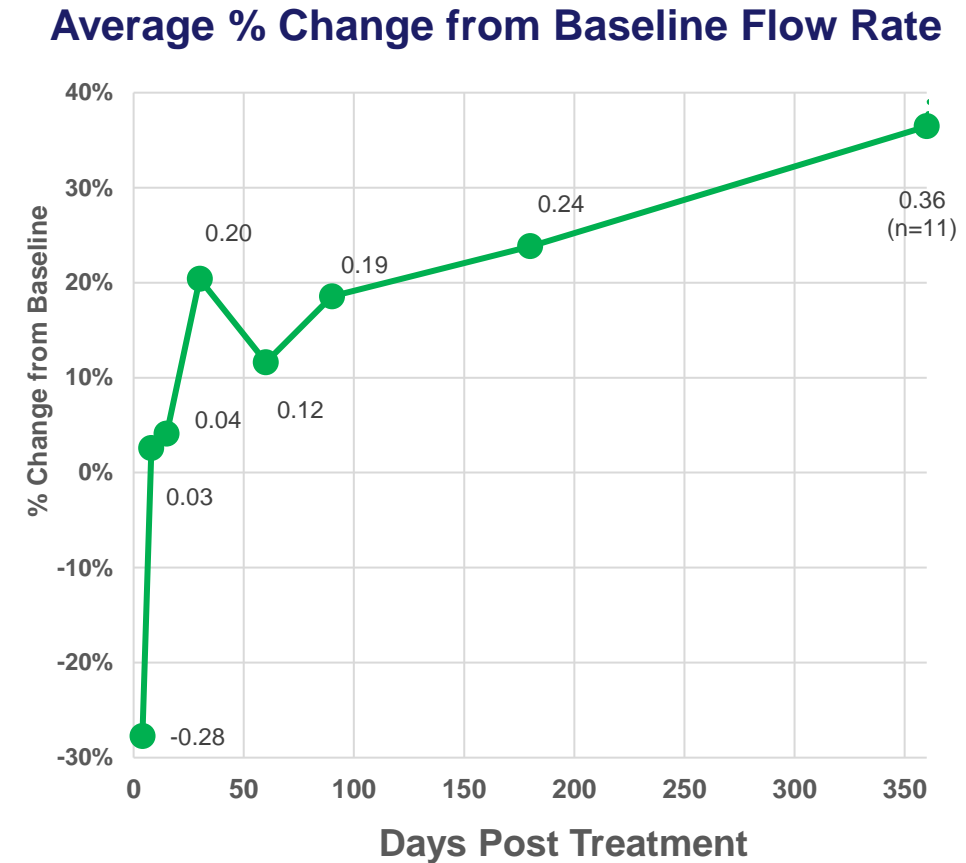
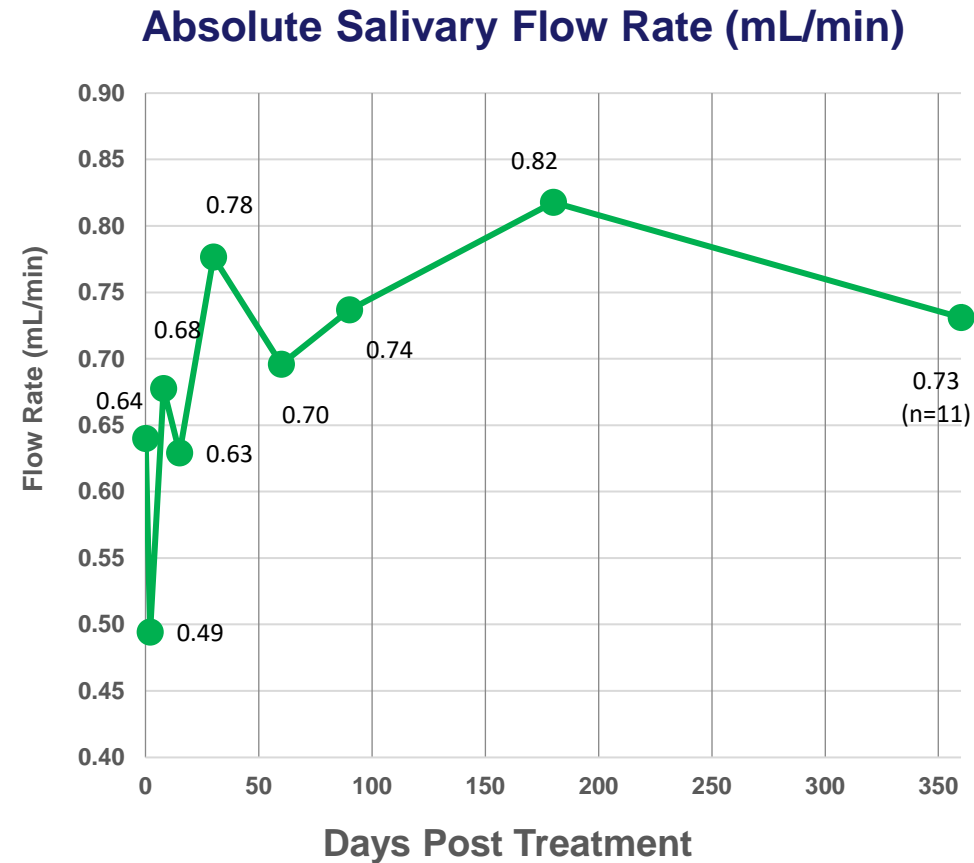


- Meaningful increase in whole salivary flow was seen in bilateral treated patients
- The overall flow rate improved to an average of 0.4mL/min which is in the normal range for unstimulated whole saliva production
- Normal unstimulated salivary flow rate averages 0.3-0.4 mL/min
- If flow rate of unstimulated saliva is >0.1-0.2mL/min, then salivary hypofunction is diagnosed with associated xerostomia likely

- The average % change from baseline was 100% at 6 months
- This is clinically meaningful as a 50% reduction in whole saliva volume is associated with xerostomia symptoms

- Based on both absolute whole resting saliva as well as the overall % change from baseline – the improvement in unstimulated salivary flow in the bilateral are of clinically meaningful size

Unilateral Treated Subjects Also Showed Improvement in Absolute Whole Saliva Measures (Stimulated)



- Increase in whole salivary flow was seen in unilateral treated patients
- Whole saliva was collected using gum stimulation, however this was directly following citric acid stimulation for extended periods with manipulations to attempt collection from individual glands
- Normal stimulated salivary flow rate averages 1.5–2.0 mL/min
- A diagnosis of hyposalivation is made with flow rate $\leq 0.5\text{--}0.7$ mL/min

Improvements in Both Xerostomia Severity Scores and Saliva Production Demonstrated Following AAV2-hAQP1 treatment

SUMMARY

- ❖ Meaningful improvements in xerostomia symptoms were reported across both unilateral and bilateral treated cohorts
- ❖ For all treated patients, including unilateral and bilateral treated, 18/24 (75%) reported a clinically meaningful score of 2 or more
- ❖ Using the XQ severity scale, 17/24 (71%) had an improvement of >8 points and 16/24 (67%) had an improvement of 10 or more points
- ❖ Increases in whole saliva flow rates observed post-treatment, providing objective evidence supporting biological activity
- ❖ Unstimulated whole saliva flow increased meaningfully in the bilaterally treated cohorts with improvement to normal levels being achieved 6 months post treatment
- ❖ Greater improvements were observed in bilaterally treated patients across every assessment compared to unilateral
- ❖ Early long-term follow-up data suggest durability of improvement 2+ years post-treatment

Phase 2 randomized, double-blind, placebo-controlled two dose study expected to initiate 1H 2023

Study Design

- Randomized, double-blind, placebo-controlled
- Two active doses of AAV2-hAQP1

Primary Efficacy Endpoints

- Change from Baseline to 12 Months in Whole Saliva Flow Rate

Key Secondary Endpoints

- Change from Baseline to 12 Months in:
 - Global Rate of Change Questionnaire
 - Symptom-specific Xerostomia Questionnaire

Program Timeline:

- Full 12-month data from the bilateral cohorts in the Phase 1 AQUAx Study will be available early Q2 2023
- EOP1 FDA Meeting complete and feedback received Q4 2022
- Clinical material manufactured in-house using proprietary platform process - very high full ratio and yield (presented at ESGCT 2022)
- Phase 2 study expected to initiate 1H 2023

AAV-AQP1 is a Potentially Transformative Treatment for Grade 2/3 Radiation-Induced Xerostomia

- AAV2-hAQP1 has potential to become a standard of care for long term grade 2/3 radiation induced xerostomia patients based on its disease-modifying mechanism of action and meaningful improvements in both objective and subjective assessments of disease
- Salivary gland cells are very slowly dividing, and a single administration is anticipated to have a durable effect
- The one-time treatment is a minimally invasive, non-systemic administration delivered through an outpatient cannulation procedure that ENTs are already familiar with. It is a small locally delivered dose of AAV2-hAQP1 with excellent safety profile.
- AAV2-hAQP1 treatment for grade 2/3 xerostomia is a large commercial opportunity given the high unmet need, large prevalent population as well as very large incidence population globally – with no current effective treatments and no other known treatment in the clinic
- AAV2-hAQP1 uses a small locally delivered dose, COGS are low, with plasmid production, viral vector manufacturing and QC analytics all in-house at Meira, providing flexibility to support a range of sustainable price points for patients and payors



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Audience Q&A