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U.S. FDA Approval of Furoscix ReadyFlow™

July 24, 2026

Cautionary Statement

Statements in this presentation that are not statements of historical fact are forward-looking statements that involve risks and uncertainties. Words such as "believes", "anticipates", "plans", "expects", "intend", "will", "goal", "potential" and similar expressions are intended to identify forward-looking statements. These forward-looking statements are based upon MannKind's current expectations.

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Agenda

1. Approval
2. Launch Strategy
3. Clinical Overview
4. Closing Remarks
5. Q&A

Michael Castagna
Chief Executive Officer

Ajay Ahuja, MD
Chief Medical Officer

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Approval of Furoscix ReadyFlow™

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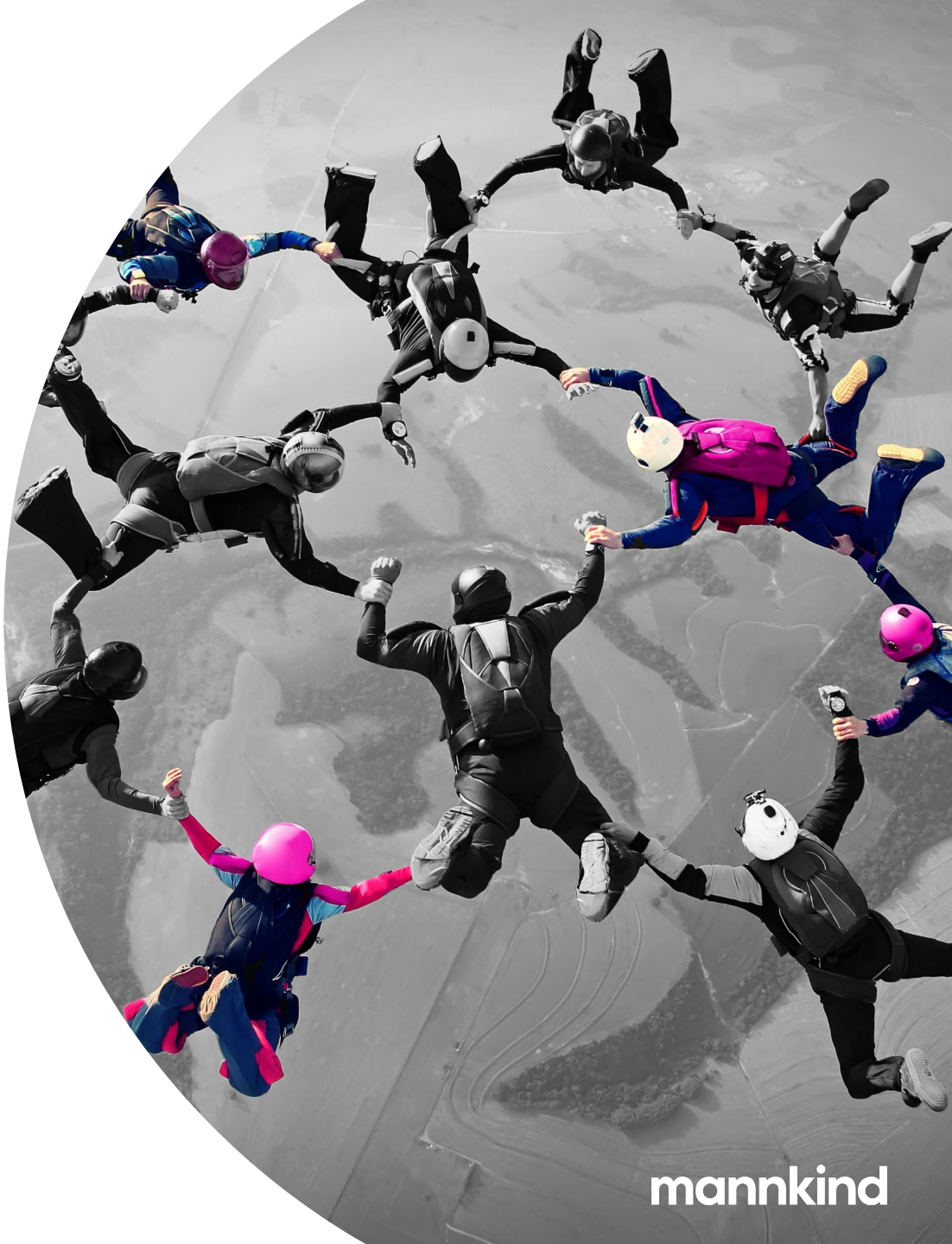
Highlights

- **Furoscix ReadyFlow™** Now Approved
- Announced PIPE financing of **$50 million** led by Frazier Life Sciences
    - Supports the $45 million contingent value rights payment triggered by FDA approval of Furoscix ReadyFlow



Furoscix ReadyFlow™ Now Approved

The first and only IV-equivalent diuretic delivered via autoinjector

Designed for at-home intervention

- Treats fluid overload in adults with **HF** or **CKD outside the hospital setting**
- May support **earlier intervention** beyond the hospital – across outpatient, post-discharge and home-based care settings

IV-equivalent performance

- Full 80 mg/mL dose delivered in **under 10 seconds** via a simple autoinjector
- Demonstrated **equivalent urine output, sodium excretion and potassium excretion** to IV furosemide
- Safety profile consistent with oral and IV furosemide
- Symptom relief may begin in **an hour or less**

Available by end of **August 2026**

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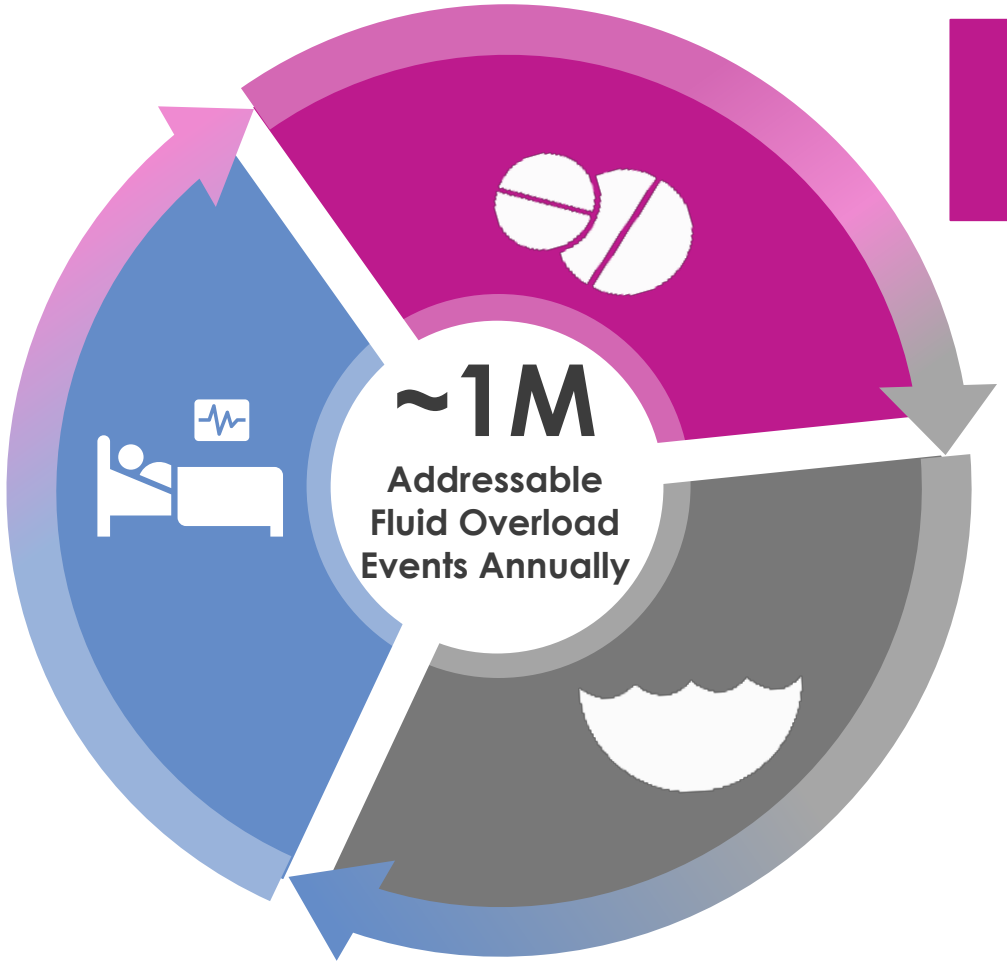
Furoscix Can Address Fluid Overload Across the Patient Journey

POST-HOSPITAL DISCHARGE

Use Furoscix to:

- Discharge early and resolve residual congestion at home
- Treat relapse congestion at home to potentially reduce avoidable 30-day readmissions



STABLE PATIENT TREATED AT HOME WITH ORAL DIURETIC

EARLY INTERVENTION

When fluid overload first presents, use Furoscix:

- At the first signs of worsening congestion
- When oral diuretic escalation is not effective
- As an alternative to IV diuretics in hospital or outpatient setting

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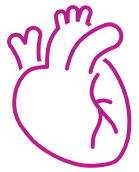
HF and CKD Place a Significant Economic Burden on the U.S. Healthcare System

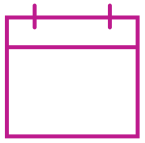


Heart Failure

Direct medical costs from **heart failure** in the U.S. is projected to approach $70B by 2030[1]

Chronic Kidney Disease

~15% of Medicare FFS beneficiaries have diagnosed **CKD**, yet they account for ~27% of total spending—approximately $86B annually[1]



High Readmission Burden

20–25% of patients hospitalized for **HF** experience readmission within 30-days[3]

Significant Hospitalization Burden

Hospitalizations among Medicare FFS beneficiaries with **CKD** account for approximately $26B in annual spending[1]

Reducing avoidable hospital admissions represents an important opportunity to improve patient care and lower healthcare costs.

1 Heidenreich PA, et al. J Card Fail. 2022;28(3):453-466. Heart Failure Society of America J Card Fail. 2026;32(2):439-498 2. USRDS 2025 Annual Data Report, CKD Vol., Ch. 6 — Healthcare Expenditures for Persons with CKD (NIDDK/NIH). 3. Retrum et al., Circ Cardiovasc Qual Outcomes 2013; Aranda et al., Clin Cardiol 2009 — Medicare claims analyses.

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From Hospitals to Cardiologists: CMS is Now Putting Specialists on the Hook for HF Costs

	Hospital Readmission Reduction Program (HRRP)	Ambulatory Specialty Model (ASM)	What It Means For Furoscix
Care Setting	Inpatient hospitals	Ambulatory cardiology (Medicare FFS)	**Reinforces at-home Furoscix use outside the hospital**
Primary Focus	30-day hospital readmission rates (incl. HF)	Longitudinal HF management; avoid hospitalizations & low-value care	**Directly aligns with Furoscix' core value proposition**
Who Bears Risk	Hospitals	Individual cardiologists in mandatory geographies	**Prescriber personally motivated to intervene earlier**
Payment at Stake	Up to 3% Medicare payment penalties to hospitals	±9% Part B; widening in later years	**~3× the financial signal of HRRP, with upside included**
Behavior Rewarded	Discharge planning; prevent readmits	Upstream chronic disease management; prevent hospitalizations altogether	**Furoscix ReadyFlow enables the exact behavior CMS is rewarding**
Launch / Duration	Implemented in 2012; ongoing	Performance 2027–2031; payment years 2029–2033	**Coincides with Furoscix ReadyFlow launch — clear tailwind for adoption**

1. CMS Hospital Readmissions Reduction Program. March 16, 2026. Accessed April 24, 2026. https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/hospital-readmissions-reduction-program-hrrp 2. CMS Ambulatory Specialty Model. April 23, 2026. Accessed April 24, 2026. https://www.cms.gov/priorities/innovation/innovation-models/asm

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Clinical Overview

Ajay Ahuja, MD, MBA

Executive Vice President, Chief Medical Officer

Cardiologist with 20+ years of biopharmaceutical leadership across cardiometabolic and respiratory diseases

- Leads MannKind's clinical development and medical activities across cardiometabolic and respiratory therapeutic areas
- Joined MannKind in 2025, bringing deep expertise across development-stage global biopharmaceutical companies
- Senior leadership roles at Kardigan Bio, Pfizer, and Novartis
- Trained at Harvard Medical School and served on staff at Boston Children's Hospital for over a decade

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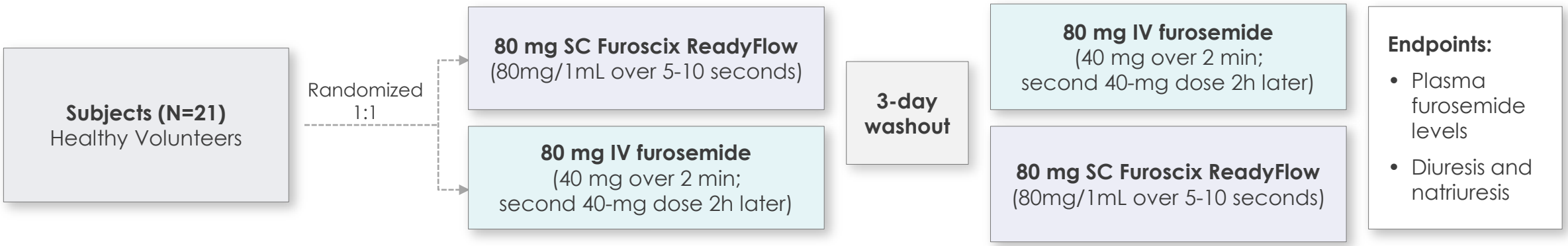
A Pivotal PK / PD Study Compared Furoscix ReadyFlow With IV Furosemide in Healthy Adult Volunteers

The pivotal PK/PD study was a prospective, randomized, non-blinded crossover study



Select Baseline Characteristics

Age, years Mean (SD)	BMI, kg/m^2 median (range)	eGFR, mL/min/1.73m^2 median (range)
57.6 (8.1)	27.4 (19.3-51.4)	79.0 (56-138)

Please visit www.Furoscix.com for Full Prescribing Information and Indications for Use.

Alcorn H et al. *Clin Ther*. 2025;47(11):1053-1060.

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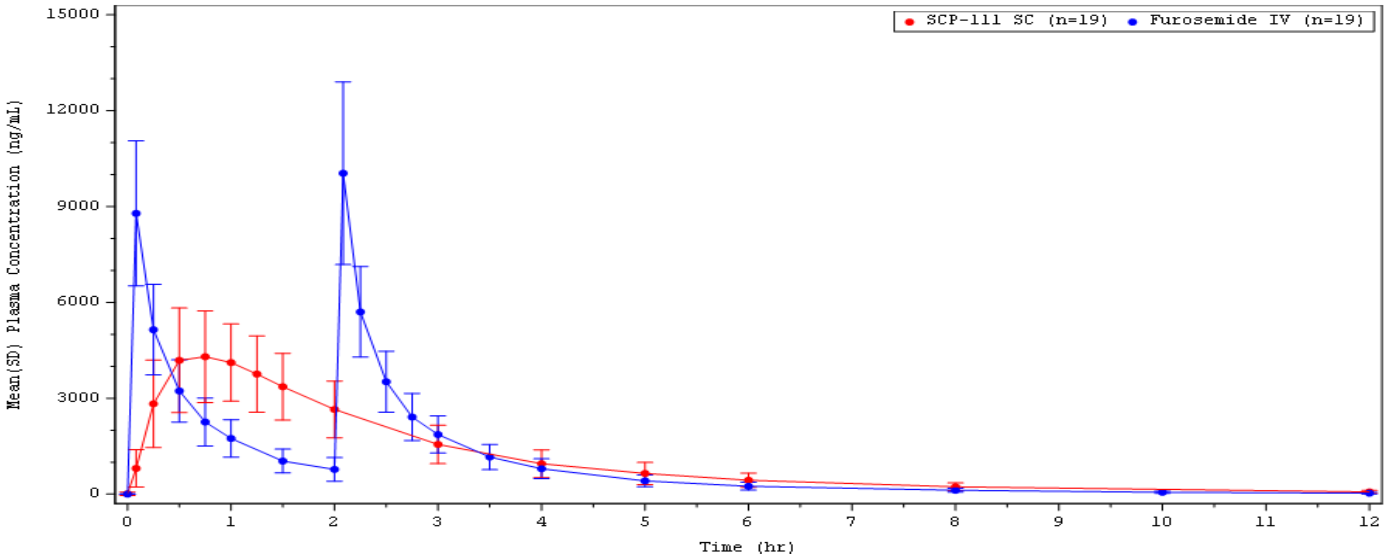
Furoscix ReadyFlow Achieved Its Primary Pharmacokinetic Endpoint

Bioavailability: 107.3% (90% CI: 103.9 – 110.8)



	SC ReadyFlow (n=19) *	IV Furosemide (n=19)*
C_{max} (ng/mL)	4,533 ± 1,498	10,088 ± 2,805
AUC_{last} (hr*ng/mL)	12,470 ± 4,010	11,684 ± 3,453
AUC_{inf} (hr*ng/mL)	12,714 ± 4,117	11,780 ± 3,507
$T_{1/2}$ (hr)	2.2 ± 0.3	1.9 ± 0.4
CL (L/hr)	6.87 ± 2.00	7.32 ± 1.97
V_d (L)	21.5 ± 5.6	19.8 ± 4.8

*21 subjects randomized, 2 subjects excluded (n=19); 1 subject discontinued study, 1 subject had high pre-dose furosemide concentration

Alcorn H et al. *Clin Ther*. 2025;47(11):1053-1060.

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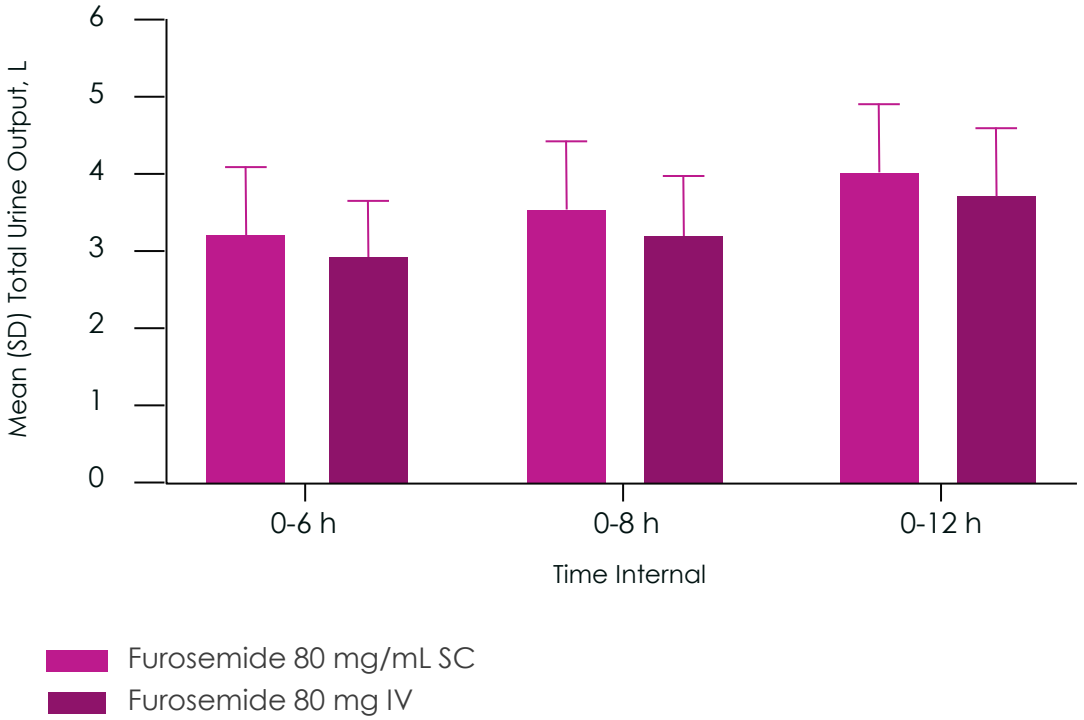
Furoscix ReadyFlow Achieved Its Secondary Pharmacodynamic Endpoints

Equivalent Urine Output at 6, 8, and 12 hours as compared to IV furosemide



	IV furosemide N=19*	SC ReadyFlow N=19*	p-value
Urine Output (mean (SD) Liters)			
0-6 hours	2.91 (0.72)	3.19 (0.88)	0.27
0-8 hours	3.19 (0.79)	3.52 (0.90)	0.23
0-12 hours	3.70 (0.95)	3.99 (0.96)	0.32
Urinary Sodium Excretion (mean (SD) mmol)			
0-6 hours	258 (99)	276 (111)	0.59
0-8 hours	264 (101)	280 (118) #	0.75
0-12 hours	273 (103)	288 (121) #	0.77
Urinary Potassium Excretion (mean (SD) mEq)			
0-6 hours	39.3 (14.6)	41.8 (10.5)	0.40
0-8 hours	44.5 (16.1)	47.0 (11.6) #	0.63
0-12 hours	52.6 (17.9)	55.1 (14.1) #	0.70

*21 subjects randomized, 2 subjects excluded (n=19); 1 subject discontinued study, 1 subject had high pre-dose furosemide concentration

Alcorn H et al. *Clin Ther*. 2025;47(11):1053-1060.

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Study Conclusions

- Furoscix ReadyFlow administered via an autoinjector achieved the bioavailability primary endpoint
- Furoscix ReadyFlow administered via an autoinjector achieved the pharmacodynamic secondary endpoints
- Furoscix ReadyFlow was generally well tolerated with respect to injection site pain and injection site adverse events
- Systemic adverse events were consistent with those reported in the prescribing information for IV and oral furosemide

For more information about Furoscix, please see the full Prescribing Information (www.furoscix.com/prescribing-information.pdf).

Launch Strategy

Furoscix ReadyFlow May Expand Who Is Treated And Enable Earlier Intervention

REDUCES TREATMENT BURDEN

Administration time in seconds vs. hours creates a simpler patient experience

"Sign me up — eliminating five hours."
- Patient

BROADENS PATIENT FIT

Simplicity may expand who is considered appropriate

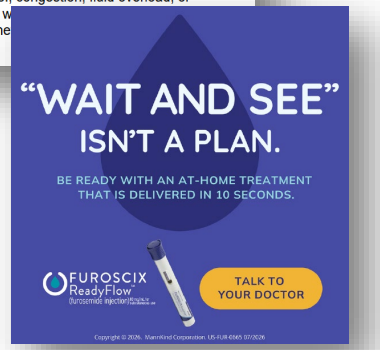
"Furoscix ReadyFlow is a game changer"
- HCP

SUPPORTS EARLIER INTERVENTION

Convenience may reduce hesitation as symptoms emerge

"The worst part of the whole thing [fluid overload] was I'd sit and debate, should I call my doctor?"
- Patient

Furoscix ReadyFlow Launch Campaign Is Built to Drive Immediate Awareness and Adoption



Field activation begins immediately

- Sales force launch training and deployment underway
- Integrated HCP and patient campaign ready across digital, field and point-of-care channels
- Major cardiology and nephrology conferences provide opportunities to build awareness and engage priority HCPs

ASN American Society of Nephrology

American Heart Association

HFSA HEART FAILURE SOCIETY OF AMERICA

ANNA American Nephrology Nurses Association

CAPP CARDIOLOGY ADVANCED PRACTICE PROVIDERS

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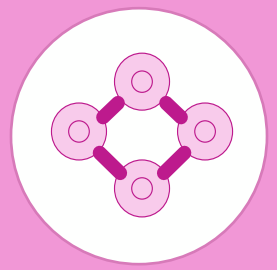
Furoscix ReadyFlow Approval Enables a Pathway for IDN Growth

01 Establish

Engage priority IDNs

Build awareness and clinical confidence

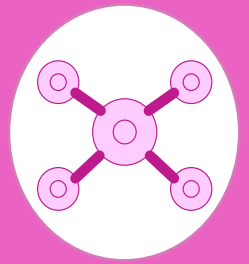
02 Embed



Integrate into care pathways

Support discharge, post-discharge and outpatient use cost-effectively

03 Expand



Scale across the health system

Reach more patients, providers and care settings

60+ PRIORITIZED IDNs

Furoscix ReadyFlow may help move Furoscix from **individual prescriber use** toward **broader, system-level adoption.**

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Closing Remarks

Major Catalysts Driving 2026 & Beyond

Afrezza Pediatrics

- Population expansion
- Unique value proposition addressing patient unmet needs
- Compounds growth as adolescents age into adults

APPROVED ☑

Furoscix ReadyFlow Autoinjector

- Reduces administration from hours to seconds
- Supports broader adoption
- Would significantly reduce cost of goods

APPROVED ☑

Nintedanib DPI

- Urgent need for new, effective therapies in IPF
- Lung targeted delivery addresses IPF tolerability barriers
- Key clinical de-risking step

Ph1b Readout Q3 ☐
Ph2 First Patient Q2 ☑

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Q&A

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