08 - 05 - 2025

BridgeBio Pharma

Second Quarter 2025 Earnings

BridgeBio Pharma

Second Quarter 2025 Earnings

CORPORATE SPEAKERS:

Chinmay Shukla
BridgeBio Pharma; Senior Vice President of Strategic Finance and BridgeBio
Neil Kumar
BridgeBio Pharma; Chief Executive Officer
Matthew Outten
BridgeBio Pharma; Chief Commercial Officer
Thomas Trimarchi
BridgeBio Pharma; President, Chief Financial Officer
Justin To
BridgeBio Pharma; Chief Operating Officer, Skeletal Dysplasias and Gene Therapy
Ananth Sridhar
BridgeBio Pharma; Chief Operating Officer, BridgeBio Cardiorenal
Christine Siu
BridgeBio Pharma; Chief Operating Officer, In-Residence

PARTICIPANTS:

Salim Syed
Mizuho; Analyst
Tyler Van Buren
TD Cowen; Analyst
Biren Amin
Piper Sandler; Analyst
Cory Kasimov
Evercore; Analyst
Mani Foroohar
Leerink Partners; Analyst
Gregory Harrison
Scotiabank; Analyst
Anupam Rama
JPMorgan; Analyst
Paul Choi
Goldman Sachs; Analyst
Andrew Tsai
Jefferies; Analyst

BridgeBio Pharma

Second Quarter 2025 Earnings

PRESENTATION:

Operator^ Good afternoon. (Operator Instructions)

Before we begin, I would like to remind everyone that today's call may contain forward-looking statements within the meaning of the federal securities laws including but not limited to statements about BridgeBio's future operating and financial performance, business plans and prospects and strategy.

These statements are based on current expectations and assumptions that are subject to risks and uncertainties, which could cause actual results to differ materially from those expressed or implied in these forward-looking statements.

For a discussion of these risks and uncertainties, please refer to the disclosure in today's earnings release. and BridgeBio's periodic reports and SEC filings.

All statements made here are based on information available to BridgeBio as of today.

And the company undertakes no obligation to update any forward-looking statements made during this call except as required by law.

With that completed, BridgeBio you may begin your conference.

Chinmay Shukla^ Good afternoon, everyone. And thank you for joining BridgeBio Pharma's second quarter 2025 earnings call.

I'm Chinmay Shukla, Senior Vice President of Strategic Finance and BridgeBio.

With me today are Neil Kumar, our CEO; Matt Outten, our Chief Commercial Officer; and Tom Trimarchi, our President and Chief Financial Officer.

During today's call we will cover our strong and accelerating launch of Attruby.

We will provide updates on our late-stage pipeline including the three key Phase III trials in ADH1, LGMD2I and (inaudible). Following our prepared remarks, we will open the call for questions.

For the Q&A session, we'll also be joined by Ananth Sridhar, Justin To and Christine Siu who lead our stage 3e programs.

Before we begin, I would like to remind you that this call will include forward-looking statements based on current expectations. These statements represent our judgment as of today and may involve risks and uncertainties that could cause actual results to differ materially.

With that, I'll turn it over to Neil.

Neil Kumar^ Thanks to everyone on the line for the time.

Welcome to our Q2 earnings call.

As always, this is a forum whereby we can communicate to you both on (inaudible) results and business strategy. A key aspect of that is ensuring we are communicating the data you feel is important and that we're doing it in a way that's clear.

On our last call we spent a lot of time talking about how we make decisions internally and focused on an NPV led characterization of our business.

Your feedback, which is important, suggested that we spend less time on that and more time on the commercial, medical and scientific performance of the business.

We're excited to do that today because there's much to talk about as the business continues to deliver with the performance of Attruby and as it positions itself for three Phase III readouts in the coming months. across ADH1, LGMD2I and achondroplasia.

The continued star of the show was Attruby. The first and most important way we've monitored this launch to date is by the number of unique patient prescriptions, which now sits at an absolute number of 3,751 coupled with 1,074 unique prescribers.

We're seeing growth in both the number of new prescribers as well as the depth of prescribing at their practices.

For those following week by week status, we've seen over 30% growth in weekly scripts. That acceleration is even greater than our internal projections given that this was the first full quarter with three players in the ATTR cardiomyopathy market.

This prescribing ties to about 100% revenue growth that we've seen in Q2, around $78 million in global sales and $71.5 million in U.S. net sales. And of course, all of these numbers connect to the most important set of facts here.

First, Attruby is now positively impacting thousands of patient lives.

Second, given the fact that all three bands in this space are growing, we are collectively doing a better job of identifying patients.

And third, we offer what we feel is a best-in-class clinical and data package in the ATTR cardiomyopathy space.

As discussed before, we have the responsibility to distribute Attruby as widely as possible so it can be used by any patient that needs it. And to that end, we continue to have the most generous access programs in this space and are proud that the programs we've pioneered are now being rolled out across the industry to improve access for patients. A second key aspect of our responsibility is to further investigate the existing data and perform novel clinical studies to better understand how Attruby can maximally help specific patient profiles.

In any disease category, it is precisely this type of cell population analysis that allows physicians to deploy the right drug for the right patient.

In the case of Attruby over the last quarter, we published (inaudible) results one of which deals with the scientific underpinnings of the disease and two of which touch on important cell populations. The first of these publications further strengthens the connection between ever better stabilization and ever better clinical outcomes. Recall that prior to the Attruby CM study, this connection had already been observed in three ways.

First, by looking at the discretion outcomes between mid-half which is a 50% stabilizer and 20 mg tafamidis, which is a 35% stabilizer.

Second, by looking at the genotype and phenotype of the disease and the associated rescue mutations. And third, through a small study that have been conducted by academic and BU suggesting that ever higher tetrameric stabilization as measured by serum TTR levels correlate to better clinical outcomes. A broad analysis of the attribute data set for the first time isolates the connection between ever higher levels of stabilization as measured by serum TTR levels, which in turn are easily measurable in the clinical context and downstream clinical outcomes in both the wild side and variant context.

Importantly, as more at all show in a published paper recently, every one mg per deciliter increase in serum TTR leads to a 5% decrease in risk of mortality. Recent work published by authors in Europe intervening at all, also observes this correlation at a quantitative level, and they extend from it the recommendation that serum TTR be used to stage patients with cardiomyopathy. All of this is especially important given that patients who switch from tafamidis to aparamitus in the context of the attribute (inaudible) all experienced significant increases in serum TTR, with an average rise of 3.4 mg per deciliter.

Moving to key subpopulation analyses, the first cell population we wanted to look at was the variant subtype.

As KOLs at the NAC have published, patients with the most common cardiomyopathic variant V122I, have a 50% probability of survival as compared to even wild-type ATTR cardiomyopathy patients.

As some of you on the call may remember, Acoramidis has a superior binding profile compared to other stabilizers, not only in wild-type patients, but also in the variant population as suggested

by two prior publications and reinforced by an upcoming paper that has been submitted for publication that details both biochemical and clinical outcome advantages of Attruby as compared to other stabilizers in the variant population.

Once again, we've been able to establish the advantage of that greater stabilization in this subpopulation and we're able to publish a 59% hazard reduction in time to first event CBH or ACM and that is associated with a p-value of 0.011. To our knowledge, this is the greatest degree of risk reduction that's been observed in the variant population with the highest degree of statistical significance in the field.

Finally, we published on another important subpopulation, namely patients with cardiac arrhythmic involvement.

In terms out that this population is luckily more common than certainly I would have thought at the outside of our studies in ATTR cardiomyopathy.

Indeed, more than 50% of the population within Attruby had Afib allowing us to ask the following questions. Those treatment with truVreduce the consequences of AFib and might even stave off the occurrence of AFib.

It turned out importantly that it is able to do both.

We observed a 43% reduction in risk of CDH associated with cardiac arrhythmia and a 17% reduction in the onset of AFib. Again, we believe this is the best data in the AFib subpopulation published where other stabilizers appear to have had some effect and were knockdowns to our knowledge based on published AE tables appear not to have had benefit on AFib occurrence.

All of this research is complemented by our ACT-EARLY trial.

In discussions with clinicians and health care policy leaders alike, I've been struck by the enthusiasm associated with this courageous trial that seeks to marry what's known about the path and mechanism of this mass action disease with a bold strategy that extends service to patients beyond the acute phase of disease to potential prevention.

What ACT-EARLY early reinforces is that the earlier we find patients and the more quickly we can act on disease, the better off patients are. That's why we also believe that the rapid onset of stabilization and the associated escalation of serum TTR associated with Attruby and the 3-month separation on CVH and ACM has been demonstrated is a critical aspect of our drug's differentiation.

We'll continue to publish on this, Attruby rapid action, and we'll have more to say about it at this year's ESG conference. The sum of this ever-evolving corpus of clinical research, coupled with our efforts in the field, should be increasing scientific share of voice, which in turn should drive treatment in naive share growth.

With treatment in naive populations being the most important battle, we believe, to win for patients. Matt will have more to say on the specifics of our launch in some moments.

As I mentioned in my opening comments, beyond all of the activity around Attruby, BridgeBio is now poised to become a diversified fully integrated biopharma company with the delivery of up to three novel best or first-in-class assets in high unmet need areas. Each of these high unmet needs represent the potential for our drugs to serve additional tens of thousands of patients and each individually represents billion-plus dollar opportunities.

Turning to the first of these important readouts in autosomal dominant hypocalcemia type 1 or ADH1.

As a reminder, this condition, which has no available pharmaceutical therapies to date is one that arises uniformly from gain of function mutations in the calcium sensing receptor and leads to low serum calcium and high urine calcium levels which in turn drives all of the downstream morbidity associated with this condition.

BridgeBio is developing in its Phase III, a negative allosteric modulator of the calcium sensing receptor with the goal to show statistically significant normalization of urinary and serum calcium levels as compared to current standard of care. Given the lack of available pharmaceutical therapy or really anything reasonable for these patients, our base case expectation for the trial is simply to deliver statistically significant normalization as compared to standard of care with a safe, easy-to-take oral drug.

The upside expectation, which is certainly consistent with both the biology and what we've seen in the clinic to date would be response rates at 50% or greater for the patients that we serve. That would be a truly disruptive result.

And who are these patients? How many are there? As with many conditions, a lack of pharmaceutical therapy means that this is a poorly characterized and underdiagnosed condition.

Today we believe that there are some 3,000 diagnosed patients in the U.S. alone.

But in recent amber, we have released and that's consistent with observations others have made in large genetic databases indicates that the genetic prevalence is up to 12,000 patients in the U.S. alone.

The good news here is that we know where to look to find these patients.

As we've discussed before, sequencing efforts in the nonsurgical parathyroidism space have consistently identified missing ADH1 patients to the tune of 20% to 25%. Further, our experience in TTR where the overall marketplace was also about 1/5 diagnosed, suggests tactics around education and awareness that we believe are applicable to this launch.

The results of this Phase III are anticipated this fall.

Importantly, and by the way, this is the case for all of our three late-stage medicines. There is substantial promise and follow-on indications for Encaleret.

Specifically in this case, in hypoparathyroidism.

We plan to present at ASBMR compelling data suggesting the promise of encaleret in chronic hypoparathyroidism.

In a cohort of 10 patients encaleret normalized urine and serum calcium levels in 80% of patients within five days of dosing.

Importantly, this drug brings differentiated promise to the HP community across at least three potential dimensions.

First, it's oral.

Second, it potentially normalizes urine calcium, the cause of downstream kidney conditions. And third, it might avoid potential downstream bone-associated absorption issues that could require (inaudible).

Turning now to linger muscular dystrophy type 2 (inaudible). This is the second of our first-in-class products addressed to a deleterious condition to add no available pharmaceutical therapies. Here again, we focused at the intersection of being both safe and highly efficacious, employing again a small molecule approach to target this well-tested added source. This condition uniformly arises from loss of function mutations in an not called FKRP, salient HP opportunity for Encaleret based on data published and the time value of money.

In summary, BridgeBio stands at the doorstep of transforming itself from a company that is predominantly defined by one asset to a company that is serving a multiplicity of important genetic disease markets and with the capabilities in place across this ecosystem to do even more.

Matthew Outten^ Thanks, Neil.

I'm pleased to report that Attruby has achieved exceptional performance in the second quarter of 2020. The generating $71.5 million in net product revenue, representing 100% growth over quarter one, essentially a doubling of net product revenue. The launch of Attruby has accelerated with new patient adds now at around 120 patients per week versus 100 patients per week previously. The uptick has been driven by momentum in treatment-naive patients.

This strong launch trajectory is driven by more patients starting therapy along with an increasing number of prescribers choosing Attruby for their patients.

We are operating in a large and fast-growing market. The ATTR-CM category is expanding rapidly and is expected to reach $15 billion to $20 billion at peak. This strong tailwind provides a significant runway for continued growth and reinforces our conviction in Attruby becoming a category-defining therapy.

In addition to the significant unmet need in ATTR-CM and the compelling value proposition of a TrueView versus our competitors, our clinical data continues to demonstrate Attruby's remarkable efficacy.

As Neil outlined, we are continuing to generate evidence reinforcing Attruby's position on the standard of care for ATTR-CM patients, especially in the treatment-naive setting.

Let me touch on a few key highlights underlying our commercial performance in the second quarter.

Attruby has a strong and expanding prescriber base. COEs and community HCPs continue to prescribe Attruby at steady rates with new prescribers initiating therapy each week. Those who have written in the past continue to do so and new adopters continue to expand.

Attruby has strong momentum with new starts, capturing share from patients initiating ATTR-CM therapy for the first time and show strong momentum against peak market share expectations of 30% to 40%. This is leading to increased demonstrated demand across segments.

Fill rates remain robust, well above industry averages, with Attruby's (inaudible) patient support programs pulling through the increased prescriptions. Further, days of inventory on hand declined from Q1 to Q2, consistent with increasing familiarity and comfort among specialty pharmacies and distributors with our just-in-time supply model.

So why are new prescribers writing and why do current prescribers write more Attruby.

The #1 reason is differentiated efficacy.

Attruby stands out as the only medication with near complete stabilization in the label. Having a near-complete stabilizer has been a welcome addition to the market versus a partial stabilizer and a partial knockdown. Beyond choosing efficacy is a primary reason to start Attruby. HPPs are worried about affordability.

Attruby continues to be the least expensive medication in the ATTR-CM category with most patients paying $0 out of pocket reinforcing BridgeBio's commitment to accessibility.

In fact, in Q2, almost 90% of all Attruby patients paid $0 for Attruby.

Additionally, we have seen that patients on Attruby tend to stay on Attruby and refill prescriptions on time each month. This is likely due to two factors: first, our access and support programs.

Our generous assistance programs continue to make Attruby accessible, seamless and simple for patients and providers.

Secondly, favorable IRA policies have significantly improved out of pocket costs for oral medications.

ATTR-CM patients are on average on seven to eight other medications with a typical out-of-pocket for oral drugs being between $0 to $2,000 max annually. This also means that patients add Attruby for no additional cost, as I had already mentioned.

To close, I want to note that the success of this launch reflects our ability to effectively translate strong science into real-world impact and commercial success. This performance not only reinforces confidence in Attruby's future but also gives us conviction in our ability to execute future rare disease launches with similar excellence across BridgeBio's portfolio.

As we've discussed, BridgeBio has three additional potential launches coming over 2026 and 2027.

The launch of Attruby has allowed BridgeBio to build a strong commercial infrastructure. This includes top industry talent, but also the basis for the programs and launch plan that will be used to execute these launches. Each of these launches has peak sales potential of more than $1 million in the U.S. market alone.

We look forward to updating you on our commercial readiness in future calls.

Now I'll turn it over to discuss our corporate strategy and give an update on our pipeline programs.

Thomas Trimarchi^ Thank you, Matt. And good afternoon, everyone.

I'll now discuss our financial results for the second quarter of 2025.

Please note that our commentary on today's call will focus on GAAP financials unless otherwise indicated. Total revenues were $110.6 million in Q2 2025, consisting of Attruby net product revenue, royalty revenue and license and services revenue compared to $2.2 million for the same period last year. $108.4 million increase in total revenues was primarily due to a $71.5 million increase in net product revenue from our commercial product, driven by strong demand across all major prescribers and patient segments.

We also recorded $1.6 million in royalty revenue from ex U.S. net sales of (inaudible) in Europe and Japan. License and services revenue increased by $35.3 million, largely due to the $30 million regulatory milestone recognized under the license agreement with (inaudible) pricing approval of Biantra by the National Health Insurance in Japan in May 2025.

Total operating costs and expenses for the second quarter of 2025 were $244.8 million compared to $177.7 million in the same period in the prior year. The $67.1 million increase in operating costs and expenses is primarily driven by $69.6 million increase in SG&A expenses, partially offset by a $3.5 million decline in R&D expenses. This reflects our continued investment in the Attruby brand awareness and ongoing investments in our late-stage clinical programs.

Included in our total operating costs and expenses was $37.7 million of stock-based compensation expense compared to $21.5 million in the second quarter of 2024.

We expect operating expenses to remain stable through year-end with continued revenue growth driven by Attruby.

Turning to our balance sheet.

We ended the second quarter with a strong cash position of $756.9 million in cash, cash equivalents and marketable securities. This includes proceeds from our strategic monetization of Byondra European royalties for $300 million, which has significantly strengthened our financial flexibility together with the proceeds from Attruby sales.

Looking ahead, we expect our cash runway to extend through multiple value-creating milestones.

In closing, our commercial launch Attruby is accelerating, and our pipeline has never been stronger.

We look forward to the data-rich months ahead with top line results from ADH1 and LGMD2IR9 in the fall of 2025, achondroplasia in early 2026 and to continue our mission to serve patients and create lasting value for our stakeholders.

With that, I'll turn the call back over to Chinmay.

Chinmay Shukla^ Thank you, Neil, Matt and Tom.

Operator, please open the line for questions. Thank you.

QUESTION & ANSWER:

Operator^ (Operator Instructions) We'll go first to Salim Syed at Mizuho.

Salim Syed^ Congrats on the quarter.

I guess one from us on the 120 patient adds.

So obviously (inaudible), so obviously that's faster than the 109 patient adds if we use the April and February numbers that you guys provided.

I'm just curious if you can just break that down a little bit more, what you think is driving that patient add number? And specifically, if you can, how you would envision that number changing in the third and fourth quarter this year?

And also, Neil, I don't know if you can comment on this, but I think it's -- or Matt, I think it's one of the more important metrics if you can provide, just what percentage of naive coming into the marketplace do you think you got in the second quarter?

Chinmay Shukla^ Salim, thanks for the question.

I'm going to pass it on to Matt to talk about the first piece and then Neil to comment about the second piece.

Matthew Outten^ Sure. And thanks for the question.

I guess to respond to the first half of your question, we're seeing strength in treatment-naive starts and continued switch activity. The market itself is expanding, driven by increased screening and awareness.

We're seeing that quarter-over-quarter.

Unique patient starts and prescriber counts are both increasing. And this has resulted in BridgeBio becoming the partner of choice for health care professionals.

In addition, the Attruby profile really resonates, both patients and doctors are drawn to it. Benefits as soon as three months and a 50% reduction in hospitalization rates, and that's across subgroups and across patients switching from other therapies, as Neil mentioned in his opening comments, -- so I think it's a combination of excellent data, an ever-expanding market and the best team in the industry. Neil, if you want to address the second part?

Neil Kumar^ Yes.

It's hard to tell Salim, exactly what the NBRx share is just because we don't precisely know where the knockdowns stand in terms of that.

But best guess, it's somewhere in the 18% to 20% range, and it's been growing pretty healthily. And just to add to Matt's point, I mean I think just for being out in the field, a couple of things are starting to drive, I would say, our commercial momentum.

But the first is better and better access.

The second and I think critically is increasing scientific share of voice.

I think that serum TTR paper actually did a lot of work for us this quarter, and we can build on that.

The fact that ever-increasing amounts of stabilization or in this case, with every additional mg per deciliter increase in serum TTR, you're getting a 5% decrease in mortality. And the fact that, that just got confirmed by a European group, I think two days ago, the Mini paper came out as well. That's starting to become a really salient feature of both staging patients and deciding which therapy to put them on.

So I think that, coupled with the variant data, coupled with the AFib data, they'll continue to drive momentum here.

We just got to continue to educate.

Operator^ We'll move next to Tyler Van Buren at TD Cowen.

Tyler Van Buren^ Congratulations on the progress.

So last quarter, you all noted the lower-than-expected utilization of the 28-day free trial and the patient assistant programs, while gross to net modestly boosted net revenue per patient.

So could you discuss those kind of three components and how the trends evolved in the second quarter compared to the first quarter and how you expect them to trend moving forward as we head into the second half of the year?

Chinmay Shukla^ Tyler, thanks for the question.

We did indeed see normalization on all of those three fronts, the 28-day free trial, the utilization and the gross to net.

But let me turn it over to Neil to give more commentary on what we saw and what we expect to see going forward.

Neil Kumar^ Yes. I don't have much to add.

As Chinmay said, we did see normalization there. Maybe I'll talk a little bit about why this is so important to us.

Obviously with the variant data, the highest risk reduction shown in the V122I population and the broad variant population, and we'll have another publication out on that in the coming months, coupled with statistical significance, which is the first we've seen of that.

It's really important for us to be able to serve the underpenetrated populations here with ATTR cardiomyopathy.

And these programs are a really important feature of that.

So maybe less important than the COEs, which is probably where we had initial momentum and much more important as we drive out into the community and drive out into communities that have historically been underserved. And I'm aware of kind of some of the narrative around (inaudible) man, you guys look at the Alnylam launch, it at double the cost. Like why do you price where you price? Why do you guys have a generous access program and suite, et cetera, et cetera.

Look, I think long term, when you look at any category, I've honestly never seen a drug with better point estimates and a lower price, not ultimately do really well in terms of end market share.

So we're in this for the long game. Honestly, these generous access programs, where we price the product, the continued education. And I think the price and these access programs will stand us in good stead long term.

But yes, I think you should expect to see the GPM stay normalized over the longer course of time and not go back to what we saw initially.

Operator^ We'll move next to Biren Amin at Piper Sandler.

Biren Amin^ So it seems I guess per day in the third quarter accelerated compared to the prior period while you guys face a new competitor.

Can you just maybe talk about community versus academic market share for Attruby? And then maybe a question on the pipeline.

What are your thoughts on infigratinib's potential market share in (inaudible)? And how are you positioning the hypochondroplasia program given the recent preclinical data?

Chinmay Shukla^ Ben, thank you for your question.

I'm going to pass it on to Matt to talk about what's driving the acceleration in the launch and specifically in the treatment-naive segment, both in the COEs and in the community setting. And then I'll pass on to Justin to talk about BNP program.

Matthew Outten^ I mean I think it's the overall data package combined with the unmet need, patients either are not being treated effectively and are looking for something else. And so that's one patient profile. There's also patients who are newly diagnosed and are seeking something that can work very fast and hit all the endpoints that they're trying to hit.

So I think regardless of the type of patients coming in, and then that can be even then split into more subgroups.

We have variant populations, you have patients with AFib.

Everybody is looking for something that can work quickly and for a long time.

And I think that, that is what has gotten us off to such a fast start. And the question is, how do you keep that momentum going? Well the market itself keeps growing every quarter. And that's because more and more people now are looking for the disease and finding it.

So more patients sort of show up even without us doing anything in that regard.

But then when they do show up and they find the information that we have, whether it's online or from their physician themselves, I think then they're impressed and want to try Attruby.

Neil Kumar^ And maybe just to build on that and addressing this specifically to your question, it's still a majority in the COE or COE capitated practices. Recall that 65% of cardiovascular practices are capitated or JVs in some way with a major provider in their space.

But we are seeing a pickup in the community. And I think that has to do with a lot of the awareness stuff that we and others are doing.

So it's still a majority in COE or COE capitated practices, but I expect it will continue to disperse over time.

I don't know Justin (inaudible).

Justin To^ Yes. (inaudible) just as a reminder, when we started this program, we have two key criteria, right? The first was to have a daily oral treatment option for families who are tired of injections. And the second is to have deeper levels of efficacy by not only hitting the MAPK pathway, but also STAT1. And our best-in-class HP data and proportionality data from our Phase II validate our hypothesis and most importantly, with the convenience factor of a daily oral.

Now we've consistently done market research that shows an oral with similar efficacy at CMPs would take about 60% of the market in a market. Why? Because clinicians and families all view an oral as better than either a daily or weekly injectable. And this market research has been done by others across indications as well that (inaudible).

Now we know BioMarin showed some data yesterday on its long-acting CMP, which doesn't change our expectations here.

We actually know from their existing Phase II data that efficacy on HP and CGMP (inaudible) plateau above their go-ahead commercial dose.

So a program that achieves higher levels of CNP here don't really matter. And if anything, it makes it even more important to have a therapy that impacts STAT1 since it looks like effects on that here.

Now on hypochondroplasia, we're really excited about our recent data that we just published in the Journal of Mineral and Bone Research that shows infigratinib has low single-digit in vitro potency against the most common hypochondroplasia mutations and similar efficacy across hypochondroplasia mouse models as it did compared to achondroplasia mouse models.

So given that, we expect similar best-in-class efficacy profile in our hypochondroplasia program as well.

So more to come there.

Operator^ We'll take our next question from Cory Kasimov at Evercore.

Cory Kasimov^ Question for you on encaleret.

I'm curious kind of what your market research is suggesting would be considered a meaningful win in the upcoming Phase III CALIBRATE trial.

Chinmay Shukla^ Cory, thanks for the question.

I'm going to pass on to Ananth, who leads the program to talk about it.

Ananth Sridhar^ Yes. Thanks, Cory.

For this program in ADH1 in particular, we see any successful study as a win, really a home run for this community. And as we've discussed in the past and as the investor community is familiar that the available conventional therapy or standard of care to our knowledge, offers pretty meager benefit on the composite endpoint, which we are evaluating in our Phase III, which is concomitant normalization of both blood and urine calcium, which are both important biomarkers in terms of biochemistry is for the condition.

So what we see as a step change for this community is really we can see a majority of patients achieving those criteria on encaleret, we see as both clinically meaningful and statistically significant, likely statistically significant benefit achieved for the study for the patient population.

And as a reminder, Cory, if we looked at our Phase II cohort on the same criteria at the same time point, we saw nine out of 13 around 69% of our study participants able to achieve that on encaleret in that same group, none or 0% were able to achieve that criteria on standard of care.

Operator^ We'll take our next question from Mani Faroohar at Leerink Partners.

Mani Foroohar^ Congrats on the quarter.

I've got a couple, and I'm going to follow here in lead by starting on the pipeline and going to commercial.

For LimbgroMB2I, can you lay out based perhaps on your KOL conversations and your interactions with the regulators, what the bar is in terms of key efficacy and biomarker thresholds for potential approval based on the upcoming interim data? And then I have a commercial question and a follow-up.

Chinmay Shukla^ Sure.

I'll pass on to Christine to talk about LGMP2I.

Christine Siu^ So for the top line data that we're expecting later this fall, we're going to be looking for a few different things in the data that would kind of represent a win for us, both in terms of being clinically meaningful as well as supporting a regulatory approval on an accelerated basis.

So first, we're going to look for really a robust effect on the biomarkers.

The primary endpoint is glycosylated alpha-dystroglycan. And what we're hoping to see there would be consistent with our Phase II results where we saw an elevation in glycosylated oxidase (inaudible). And we think anything kind of 5% or more there would be clinically meaningful.

In addition, we're going to look to see a robust reduction in CK of about 40% or more.

On the functional endpoints, what would be considered a win there is a trend in one or more of those outcome measurements.

It's important to note that we do not expect statistical significance at the 12-month time point. The trial was powered to show it. And the FDA has indicated that it is not a requirement for accelerated approval to see statistical significance in any of the clinical outcomes.

So again, just looking for trends in one or more of the functional outcomes. And then the third thing we'd like to see is a well-tolerated safety profile consistent with our Phase II results. And I

think if we saw all of those, we'd be quite encouraged. Keep in mind, there's really no available treatments today for this indication.

So we're pretty excited about the FDA to have a first-to-market safe and oral therapy for this.

Mani Foroohar^ Great. And hopping over to commercial.

I guess a little bit of a composite question. Alnylam talked a lot about -- on their call about adding patient volume for (inaudible) in both switch and new market and new patient -- new to therapy patients. Pfizer talked on pricing, how net price had evolved and they have been doing more contracting to maintain share.

So for each of these competitors, what are you seeing in terms of impact on your own contracting and pricing? And also in terms of volume, are you seeing more impact -- more impact and more competitors and sort of more active competition on the switch side? Is it primarily competitive intensity for new-to- therapy patients? Like how should we interpret both of those commentaries from those separate calls? And how they inform how we think about the competitive dynamic in what is now multipayer market?

Chinmay Shukla^ Mani, thanks for the question.

As we noted in our PR, most of our growth came from the treatment-naive section and increasing share there where we've seen it grow month-over-month.

But let me pass it on to Neil to talk in more detail about these things as he's been out of the field.

Neil Kumar^ Yes. Thanks, Mani.

I mean I guess I'd say, first and foremost, where we're seeing more pressure from the part of the knockdown is in the switch category, obviously for us.

We were 100% in the switch share prior to.

So obviously you're going to be under pressure there.

Recall there's a couple of other modes by which they're getting patients on drug initially.

One is combination. And actually, a, we're seeing a lot of combo -- when people do reach for the combo, we are seeing people try to use the best stabilizer coupled with the knockdown agent.

So we've got some combo stuff there and as does obviously the (inaudible) combo.

Then they had the bolus, right? They had their patients that rolled over.

We didn't have that because you obviously gave away free drug for life. And then they've got what they've got in the naive population. Honestly, we're not seeing a ton of competition there from Alnylam.

We're seeing much more of it from Pfizer.

So then turning to what Pfizer is doing.

We're also not seeing like a ton of race to the bottom GPN contracting type activity in this space.

We've made it very clear that we stand on this price.

We came in where we came in.

We think it's the right thing and the ethical thing for the patient population, but there's not a whole lot of backdoor games that we're playing at all, and we're not seeing it from a competition either.

So outside of the buy-and-bill dynamic associated with the knockdowns, we're not seeing a whole lot of competition in that vein. The competition is much more so around clinical differentiation and efficacy.

Did that answer your question?

Mani Foroohar^ Yes. Thanks.

It's very helpful.

Operator^ We'll move next to Greg Harrison at Scotiabank.

Gregory Harrison^ Congrats on another quarter of success with the launch and uptake of Attruby.

I wanted to ask where you have identified areas for growth within the Attruby launch? And separately, what is BridgeBio excited about executing on for the remainder of the year?

Chinmay Shukla^ Greg, thanks for the question. Maybe I'll first pass it on to Neil and then to Matt to talk about what we're excited about when it comes of Attruby and the company. Neil?

Neil Kumar^ I think as it pertains to Attruby, I'm excited about a lot of different things, but I'd start with the continued clinical and efficacy differentiation that we've been working on.

I really like the way that we've started to port the story from overall, how does this work in the population to specific subpopulations.

I think the AFib story or the cardiac arrhythmic story is a really powerful one and certainly opened my eyes to the power of these types of things, be it a variant story, be it a cardiac arrhythmic story, be it someone who has renal involvement story, on and on, et cetera, et cetera.

So I think that's thing number one that gets me excited.

Thing number two that gets me excited is the concept of early impact and efficacy.

I think for the longest time we sort of regarded this as kind of a static picture as soon as things were diagnosed.

But obviously the earlier we go, the better we do in terms of all of the clinical trials. And now we're running this prevention study. And we have drugs that I think leave patients either unprotected for long periods of time like you see knockdown go from 60% to 82% over the course of 22 months or you have prompt resolution of destabilization like you do in the case of acoramidis where you're almost immediately stabilizing that protein and getting the serum TTR levels up by day 28.

So we look forward to continuing to elaborate on that early action through publications on a go-forward basis.

So I would say that's one thing. The second thing has to do with access.

Obviously given the fact that the knockdowns are already there in polyneuropathy, given the fact that TAP is already out there, our new-to-market eds are just coming off.

We're working really hard with local ISPs to make sure that it's as easy to prescribe Attruby as it is anything else.

We're working with new technologies that allow us to work through forms that are provider-centric, and we're working carefully with Panther and Norcini to have this sort of white glove service for patients.

So again, I think if that revs up over a long period of time this is going to be a really nice suite of programs and support for patients.

I don't know Matt, if you'd add anything.

Matthew Outten^ I'd just echo maybe one of the comments that you made, making sure that anyone who wants a truly can get it is sort of our primary driver right now and how do we work through any access challenge that might appear.

So the new to market edits coming off.

We've been on the market, I guess, a little over seven months now.

So this is right in that sweet spot when you start to see all of those things happening, and we are seeing that now. That's going to continue.

We keep talking about how we believe in HCP choice. And I think we've set ourselves up, as you can see from the many programs and different things that we're doing to try to make sure that it truly is one of those choices and making sure that the physicians have access to the right therapy for each patient without any unnecessary barriers.

Operator^ We'll go next to Anupam Rama at JPM.

Anupam Rama^ For Attruby, just thinking about prescribing metrics here, it looks like you grew 300-plus unique docs quarter-over-quarter. Just wondering what's resonating with both new prescribers as well as repeat prescribing dynamics and where you're seeing the most growth in terms of academic versus community centers?

Chinmay Shukla^ Anupam, thank you for the question.

I'm going to pass it on to Matt to talk about it.

Matthew Outten^ Sure. And thanks for the question.

First, I think when HCPs try Attruby and they see how quickly it works, it reinforces the decision that they made to prescribe Attruby.

So prescription just naturally turns to two and so on. Patients and HCPs talk about their experience not just with a doctor-patient relationship, but also within the patient and physician communities.

And their experience with the efficacy of Attruby, but also with all of our support programs that we've made available, I think, has made a tremendous impact.

You mentioned community versus COEs, but I think this kind of an impact is equally important in both settings, maybe for different -- potentially different reasons. And so HCPs who haven't written, they write. They see this.

We're out there with our field teams and they go ahead and make that decision. And then once they've written and those who have written, they continue to write more Attruby while we do our best to make it easy each and every time.

So I would expect that you'll see these numbers continue to grow both in the academic and the community centers every quarter.

Operator^ We'll take our next question from Paul Choi at Goldman Sachs.

Paul Choi^ Congratulations on all the progress.

I want to turn maybe back to the pipeline for a moment and talk about encaleret and ADH1 and the potential lateral to hypoparathyroidism.

Can you maybe speak to your level of conviction as to how success in ADH1 could translate to hypoparathyroidism? And maybe a little more specifically, how you're thinking about responder rates might compare to some of the existing or clinical stage therapies with regard to use of supplements or decreasing use of supplements specifically?

Chinmay Shukla^ Paul, thank you for the question.

I'll pass on to Ananth to talk about this.

Ananth Sridhar^ Sure. Paul, as it relates to your question, especially thinking as ADH1 is the most common genetic subset of hypopara.

So there really is a strong read-through that you're alluding to a positive study in ADH1 would technically derisk a lot of the further evaluation that we can and will endeavor to do in chronic hypoparathyroidism broadly.

I think the key aspects that I think would be important on the read-through is one importantly, a rapid and durable benefit of blood and urine calcium.

I think if we see that in ADH1 population, it will certainly be encouraging as that is a critical unmet need and a clinical need for the hypopara community.

And then the other is going to be on the safety aspect.

So the broad exposure at the doses we're evaluating in ADH1 will also be an important derisking signal for the chronic hypoparathyroidism development program.

In terms of the response rates, I think I'll point the community to our presentation of our Sentinel study of encaleret in chronic hypoparathyroidism, which we intend to present at the American Society of Bone Mineral Research meeting, which is taking place next month.

In that cohort, we resolved that within five days of dosing initiation with encaleret, 80% of study participants were able to normalize both blood and urine calcium concomitantly. This study did not evaluate whether patients can come off standard of care that will be evaluated in a longer-term study.

But importantly, this is a key differentiating element, which Neil touched on in the earlier remarks, which encaleret could differentiate in this patient population with three critical elements.

One is oral Two, it may have a benefit on urine calcium on 24-hour urinary calcium excretion to the extent that other therapies have not yet shown to date. And three, it could avoid long-term bone resorptive effects that may have been seen and may continue to be seen with long-term PTH replacement therapy.

Operator^ And we'll take our final question today from Andrew Tsai at Jefferies.

Andrew Tsai^ Congrats on the launch execution.

So I think one of the thematic discussion points is that Attruby could be differentiated based on a lot of data you've generated over the past few months.

So operationally speaking, how do you exactly leverage the data to convince payers and doctors to use Attruby more in the first-line setting over the coming years? And can you summarize all the additional data sets that you plan to generate over the next, let's just say, 12 to 24 months? Can we get a glimpse of the real-world data on like NT-proBNT troponin all the way to hard outcomes data?

And then really quickly, can you quantify the inventory changes in Q2 relative to Q1?

Chinmay Shukla^ Sure. Andy, thank you for your question.

I'm going to pass on to Neil to talk about the Attruby data, and then Matt and I can talk a little bit about inventory at the end, but let me pass on to Neil to talk about the differentiation.

Neil Kumar^ Yes. Thanks, Andy.

I guess your first question was what are the tactics we're using to educate in and around the data that we have produced.

Obviously there are the obvious aspects of this at conferences, publications, et cetera.

I think our medical affairs team has done a nice job of increasing our scientific share of voice.

And obviously I think we have the highest velocity of publication in this sector so far.

So that's given us an opportunity to share something new with the physicians that we do see.

The second piece of it, honestly, has been conversations as you say, put some fraction of your patients on the Attruby to Matt's earlier point and see what the experience is. And I think we feel

very comfortable, obviously with the two real-world evidence studies that have posted to date out of Dr. Masri's lab and Dr. Moore's lab, that continued outperformance in the real-world setting, and we're doing a lot more of this now on the health economic and real-world setting side, just what do hospitalizations look like with one stabilizer versus the next, what do overall expenses look like with various SPs, et cetera, et cetera.

So we're doing a lot of that type of work, and I think that's another way that we can allow the data to resonate.

A summary of the data, I think of the new data that we just put out has to be the variant data, the 59% relative risk reduction with the stat sig, the AFib data, the (inaudible) reduction along with the 43% reduction in (inaudible) associated hospitalization. And then the third, and I think, honestly, the most important was the connection once again between ever higher levels of stabilization as measured by serum TTR and better outcomes as measured by mortality.

But I think those were the salient data pieces to date. And then on a go-forward basis, you can expect that -- as I mentioned earlier, that we're going to publish on all of those fronts plus more.

One thing we're definitely going to be looking at is the rapidity of response because I think that now that we've got the PK data from the knockdowns, I think that actually is a huge differentiator of the rapidity of response.

So you should see a lot more publications coming out on that front.

I think the second is the real-world experience with these products. both from the standpoint of biomarkers.

I think (inaudible), yes, definitely.

I think serum TTR, yes, definitely. And then quality of life and hospitalization measures and then health economic parameters as well.

It's interesting, if you go over to Europe, like we -- there are countries where we're the only brand, like we won the national bid, and there are major hospitals in areas like Germany where Attruby is frontline. And I think we're sort of looking at those types of very dispassionate, but yet still trying to make a choice between these various data sets, analogs and saying what really resonated with them in that data and how do we bring some of those messages over to the U.S. market.

So I don't know Matt or (inaudible) you want to (inaudible) add anything?

Matthew Outten^ No. I can touch on the inventory question, if that works.

I just would make a couple of comments.

One, the held inventory is lower in Q2 versus Q1 as suppliers get used to our just-in-time model. And so why? Well you can get Attruby in less than 48 hours.

We talk about that for patients all the time but it's not just patients.

Our suppliers can also get Attruby in less than 48 hours as well.

So the sort of old way of doing the supply and demand model, which is, hey, I have to hold multiple weeks of inventory or more because I'm worried about running out or not being able to get some.

I think we've sort of changed the game a bit in that.

So now that people realize that, that's true, they don't have to hold the sort of historical larger levels. And so you're seeing that play out in the market now. And I think that's just due to the confidence that our distributors have in us.

Chinmay Shukla^ As Matt said, the days went down because of the accelerating patient demand and the model being more familiar to our suppliers.

I appreciate your question.

Operator^ And that concludes our Q&A for today.

I will now hand it back to the company.

Chinmay Shukla^ Thank you all for joining us on our Q2 earnings call.

We look forward to updating you again in our next earnings call. Thank you.

Bye.

Operator^ And this concludes today's conference. Thank you for your participation.

You may now disconnect.