VERRICA™ PHARMACEUTICALS

Reinventing Skin Science

Company Overview

March 2019

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Developing novel dermatology products

Providing meaningful benefit for people living with skin diseases

Reinventing Skin Science by focusing on development and commercialization

Late-stage medical dermatology company

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INVESTMENT HIGHLIGHTS

Two of the Largest Unmet Needs in Dermatology
- Prevalence of ~6 million in molluscum contagiosum[(1)] and ~22 million in common warts in the U.S.[(2)]
- No FDA approved drugs to treat molluscum or warts

Positive Topline Phase 3 Results in Molluscum Contagiosum
- Achieved statistical significance for primary endpoints in our Phase 3 CAMP-1 and CAMP-2 pivotal trials for VP-102
- P-value <0.0001 for primary endpoint in both pivotal trials

Favorable Tolerability
- No serious adverse events in VP-102 treated patients

Physician Acceptance
- 95% of pediatric dermatologists have used API[(3)]

Innovative Product Candidate
- Drug-device combination of a proprietary formulation and a novel single-use applicator

Barriers to Competition
- New chemical entity regulatory exclusivity upon approval
- IP pending on product candidate, including on novel formulation, applicator and methods of use
- Drug-device combination makes a 'true generic' unlikely

Proven Team
- Industry-leading, experienced management team with extensive product launch experience

(1) Prevalence in the US of 5.1% to 11.5% in children aged 0-16 years. (Fam Pract. 2014 Apr;31(2):130-6). US Census estimates ~69.4MM children aged 0 to 16 years in 2016.
(2) IMS National Disease and Therapeutic Index (NDTI) Rolling 5 Years Ending June 2016. Nguyen et al, Laser Treatment of Nongenital Verrucae A Systemic Review. JAMA Dermatology. 2016; 152(9): 1025-1033
(3) Based on a survey of 115 dermatologists the results of which have been extrapolated to pediatric dermatologists.

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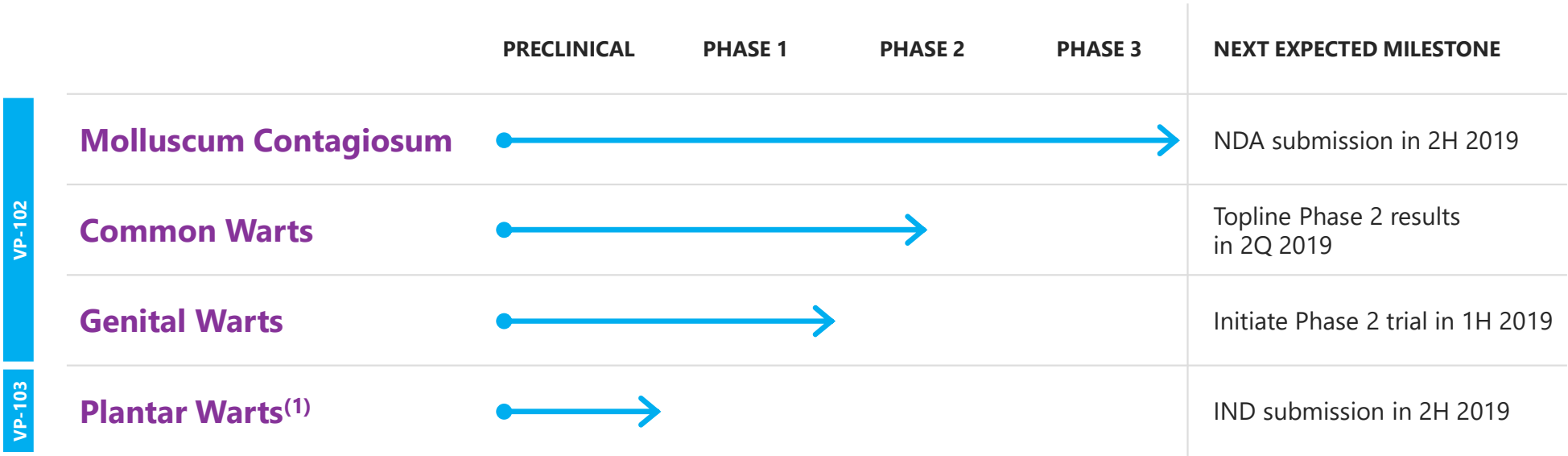
OUR PRODUCT PORTFOLIO



We retain exclusive, royalty-free rights to our product candidates across all indications globally

(1) Phase 2 ready assuming leverage of data from VP-102.

THE PROBLEM

Molluscum Contagiosum

MOLLUSCUM BACKGROUND

OVERVIEW

Caused by a pox virus

Primarily infects children, with the highest incidence occurring in children <14 years old

Highly contagious

If untreated, lesions persist an average of 13 months, with some cases remaining unresolved for 2+ years

Often leads to anxiety and social challenges for the patients and parents and negatively impacts quality of life

ETIOLOGY AND CLINICAL PRESENTATION

Transmission

- Skin to skin contact
- Sharing of contaminated objects (e.g., clothing, towels, swimming pool toys)

Diagnosis & Symptoms

- Typically 10 to 30 lesions
- 100+ lesions can be observed
- Lesions may be the only sign of infection and are often painless
- Can be diagnosed with skin biopsy to differentiate from other lesions

Complications

- Skin irritation, inflammation, and re-infection
- Follicular or papillary conjunctivitis if lesions on eyelids
- Cellulitis

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CURRENT TREATMENTS FOR MOLLUSCUM ARE NOT FDA APPROVED AND HAVE MANY LIMITATIONS

Broad use limited by unproven efficacy, scarring, lack of availability, safety concerns & pain

Significantly undertreated patient population

	DESCRIPTION	LIMITATIONS
Cryotherapy	Freezing the lesions with liquid nitrogen	• Pain and scarring • Unsuitable for use in children
Curettage	Using a curette or a surgical instrument with a scoop at the tip to scrape the lesions	• Pain and scarring • Unsuitable for use in children
Laser Surgery	Applying a laser to target and destroy the lesions	• Pain, cost and lack of availability • Unsuitable for use in children
Topical Products	Applying various acids (e.g. salicylic acid), creams or blistering solutions to destroy the lesions	• Unproven efficacy
Off-Label Drugs	Retinoids, antiviral medicines, or immune modulating therapies	• Limited efficacy • Side-effects
Natural Remedies	Applying natural oils (e.g. tea tree oil) with antimicrobial properties	• Unproven efficacy • Pain, irritation and allergic reactions

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THE SOLUTION

VP-102

VP-102 IS A PROPRIETARY DRUG-DEVICE COMBINATION OF CANTHARIDIN ADMINISTERED THROUGH OUR SINGLE-USE PRECISION APPLICATOR

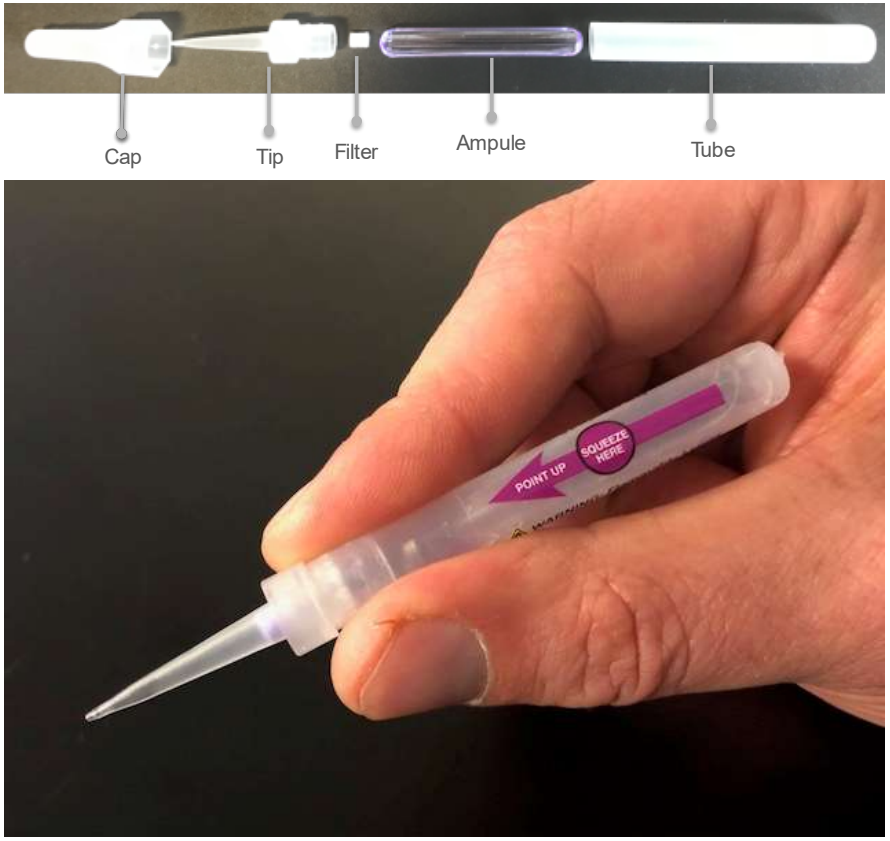
GMP-controlled formulation of cantharidin with:

- API that is greater than 99% pure
- Defined pharmaceutical batch process

Long-term, room temperature **stability**

Visualization agent to see which lesions have been treated

Bittering agent to mitigate oral ingestion by children



Mechanism of Action and Clinical Evidence

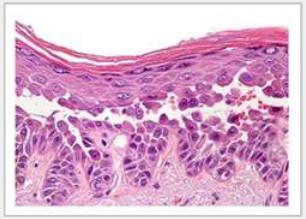
CANTHARIDIN HAS A PROVEN DUAL MECHANISM OF ACTION

1 Targeted Destruction of Infected Skin Leads to Lesion Clearance

Once applied, cantharidin activates neutral serine proteases that cause degeneration of the desmosomal plaque, leading to detachment of tonofilaments from desmosomes.(1)

This leads to intraepidermal blistering and nonspecific lysis of the skin, causing the tissues containing the virus to separate from the surrounding skin.

Since acantholysis is intraepidermal, healing occurs without scarring.



Desmosome Cleavage and Blister Formation

2 Elicits Inflammation & Immune Response with Potential to Boost Viral Immune Response

Leukocyte infiltration includes neutrophils, macrophages, B and T cells and eosinophils

Release of chemokines and cytokines including TNF-a, IL-8 and CXCL-5

Cantharidin is used in the laboratory as a model for studying leukocyte trafficking and cytokine production.(2)

Lymphocyte | Neutrophil | Eosinophil | Macrophage

(1) J Invest Dermatol. 1962 Jul;39:39-45.
(2) J Immunol Methods. 2001 Nov 1;257(1-2):213-20.2

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SIGNIFICANT CLINICAL PROGRESS OF VP-102 FOR THE TREATMENT OF MOLLUSCUM

	TRIAL AND STATUS	FORMULATION / APPLICATION METHOD	TRIAL DESIGN	TRIAL OBJECTIVES
PHASE 3	**Pivotal Trial CAMP-1** Complete	VP-102	• N=266 • Conducted under SPA • Randomized, double blind, multi-center, placebo controlled	• To evaluate the efficacy of dermal application of VP-102 relative to placebo for complete clearance at day 84 • To assess the safety and tolerability of VP-102
PHASE 3	**Pivotal Trial CAMP-2** Complete	VP-102	• N=262 • Randomized, double blind, multi-center, placebo controlled	• To evaluate the efficacy of dermal application of VP-102 relative to placebo for complete clearance at day 84 • To assess the safety and tolerability of VP-102
PHASE 2	**Innovate Trial** Complete	VP-102	• Open-label, single-center • N=33	• To determine possible systemic exposure from a single 24-hour application of VP-102 • To confirm safety and efficacy with applicator
PHASE 2	**Pilot Trial** Complete	Our proprietary formula of cantharidin used in VP-102, applied with the wooden stick part of a cotton-tipped swab	• Open-label, single-center • N=30	• To evaluate safety and efficacy and determine optimal treatment duration

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WE HAVE SUCCESSFULLY COMPLETED TWO PIVOTAL PHASE 3 TRIALS (CAMP-1 & CAMP-2) IN MOLLUSCUM

Trial Design

Two identically designed, randomized, double-blinded, multicenter, placebo controlled trials

CAMP-1 conducted under FDA Special Protocol Assessment (SPA)

12-week study period

Endpoints

Primary:
Percent of subjects with complete clearance of molluscum at Day 84

Secondary:
Percent of subjects with complete clearance at week 3, 6, and 9
Safety & tolerability

Population

Subjects 2+ years of age with MC lesions who have not received any type of treatment within the past 14 days

Enrollment complete with 266 subjects for CAMP-1 and 262 subjects for CAMP-2

Application

Study drug (VP-102 or placebo) is administered topically to all treatable lesions every 21 days until clearance or a maximum of 4 applications

VP-102 or placebo will be left on for 24 hours before removal with soap and warm water

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DEMOGRAPHICS IN PHASE 3 MOLLUSCUM TRIALS

	CAMP-1		CAMP-2	
	VP-102 (N=160)	Placebo (N=106)	VP-102 (N=150)	Placebo (N=112)
Randomized	160	106	150	112
Completed	150 (94%)	100 (94%)	139 (93%)	108 (96%)
Age (years)				
Mean	7.5	6.3	7.4	7.3
Median	6.0	5.0	6.0	6.0
Min, Max	2, 41	2, 40	2, 60	2, 54
Gender				
Female	85 (53%)	61 (58%)	69 (46%)	46 (41%)
Male	75 (47%)	45 (42%)	81 (54%)	66 (59%)

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MOLLUSCUM HISTORY FOR SUBJECTS IN PHASE 3 TRIALS

CAMP-1	VP-102 (N=160)	Placebo (N=106)
Time Since Clinical Diagnosis (days)		
Mean	127	129
Median	25	32
Min, Max	1, 1247	1, 1302
Age at Diagnosis		
Mean	7.1	6.1
Any Previous Treatment for Molluscum?		
Yes	41 (26%)	30 (28%)
Active Atopic Dermatitis		
Yes	12 (8%)	13 (12%)
Baseline Lesion Count		
Mean	22	25
Min, Max	1, 107	1, 110

CAMP-2	VP-102 (N=150)	Placebo (N=112)
Time Since Clinical Diagnosis (days)		
Mean	118	124
Median	28	31
Min, Max	1, 977	1, 957
Age at Diagnosis		
Mean	7.1	7.0
Any Previous Treatment for Molluscum?		
Yes	48 (32%)	42 (38%)
Active Atopic Dermatitis		
Yes	11 (7%)	7 (6%)
Baseline Lesion Count		
Mean	19	20
Min, Max	1, 184	1, 86

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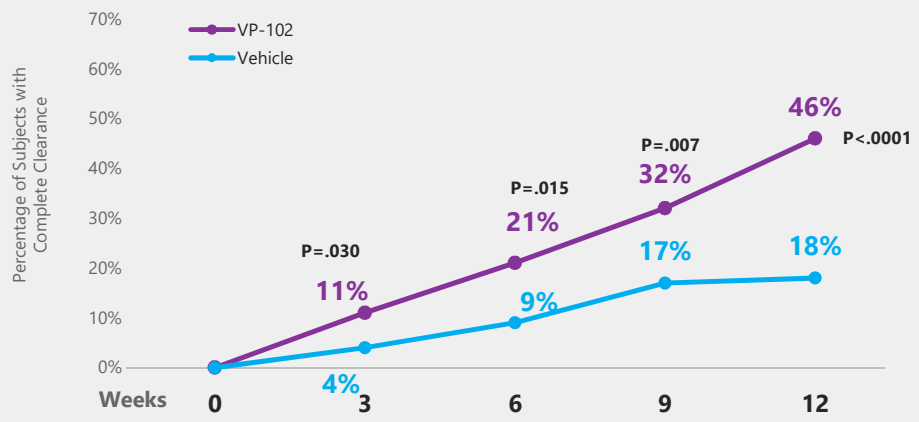
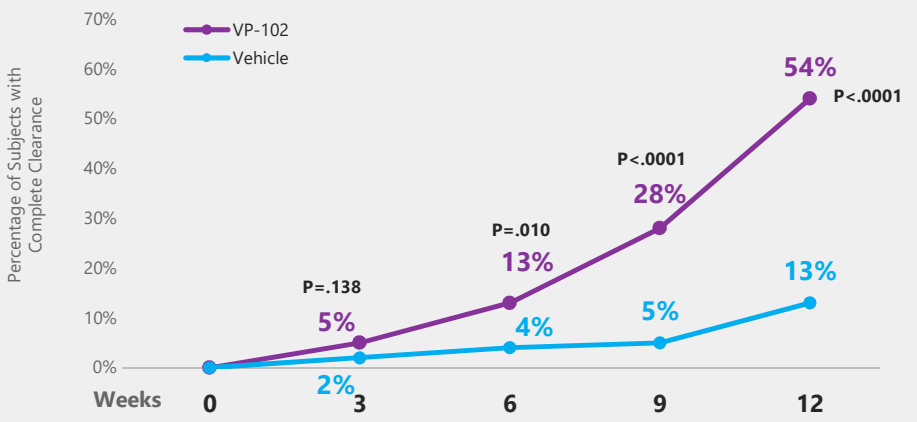
PHASE 3 STUDIES IN MOLLUSCUM DEMONSTRATE STATISTICALLY SIGNIFICANT EFFICACY ON PRIMARY ENDPOINT OF COMPLETE CLEARANCE

CAMP-1 Complete Clearance: ITT Population



	Week 3	Week 6	Week 9	Week 12
Lesion Count	↓ 38%*	↓ 45%*	↓ 51%*	↓ 69%*
% Change from Baseline	↓ 5%	↑ 5%	↑ 10%	↑ 20%

CAMP-2 Complete Clearance: ITT Population



	Week 3	Week 6	Week 9	Week 12
Lesion Count	↓ 24%*	↓ 58%*	↓ 71%*	↓ 83%*
% Change from Baseline	↑ 9%	↓ 13%	↓ 20%	↓ 19%

* Lesion count p<0.05 (pre-specified exploratory endpoint)

Note: Data reported reflects lesion count % change from baseline information for CAMP-1 resulting from continued analysis of complete data set for CAMP-1 and CAMP-2 post release of topline Phase 3 results on 3 Jan 2019.

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SAFETY SUMMARY FOR MOLLUSCUM PHASE 3 TRIALS

CAMP-1

Subjects with at least one…	VP-102 (N=161) n (%)	Placebo (N=104) n (%)
TEAE (Treatment Emergent AE)	159 (99)	76 (73)
Mild TEAE	157 (98)	66 (64)
Moderate TEAE	105 (65)	41 (39)
Severe TEAE	19 (12)	1 (1)
TEAE related to drug	158 (98)	60 (58)
Serious TEAE	0 (0)	1 (1)
TEAE leading to discontinuation	5 (3)	0 (0)
Local Skin Reaction TEAE	158 (98)	60 (58)

AE= Adverse Event

Note: Data reported reflects AE information for CAMP-1 resulting from continued analysis of complete data set for CAMP-1 and CAMP-2 post release of topline Phase 3 results on 3 Jan 2019.

CAMP-2

Subjects with at least one…	VP-102 (N=150) n (%)	Placebo (N=112) n (%)
TEAE (Treatment Emergent AE)	143 (95)	74 (66)
Mild TEAE	141 (94)	74 (66)
Moderate TEAE	60 (40)	18 (16)
Severe TEAE	4 (3)	0 (0)
TEAE related to drug	143 (95)	67 (60)
Serious TEAE	0 (0)	0 (0)
TEAE leading to discontinuation	1 (1)	1 (1)
Local Skin Reaction TEAE	143 (95)	67 (60)

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CAMP-1
ADVERSE EVENTS (1)

	VP-102 (N=161) n (%)			Placebo (N=104) n (%)		
PREFERRED TERM NAME	**MILD**	**MOD**	**SEV**	**MILD**	**MOD**	**SEV**
Application site vesicles	79 (49.1)	70 (43.5)	8 (5.0)	25 (24.0)	4 (3.8)	0 (0.0)
Application site pruritus	85 (52.8)	18 (11.2)	1 (0.6)	33 (31.7)	5 (4.8)	0 (0.0)
Application site pain	58 (36.0)	45 (28.0)	7 (4.3)	18 (17.3)	2 (1.9)	0 (0.0)
Application site erythema	32 (19.9)	37 (23.0)	0 (0.0)	21 (20.2)	9 (8.7)	0 (0.0)
Application site scab	46 (28.6)	16 (9.9)	0 (0.0)	24 (23.1)	1 (1.0)	0 (0.0)
Application site discoloration	48 (29.8)	5 (3.1)	1 (0.6)	16 (15.4)	2 (1.9)	0 (0.0)
Application site dryness	23 (14.3)	1 (0.6)	0 (0.0)	11 (10.6)	0 (0.0)	0 (0.0)
Application site edema	15 (9.3)	6 (3.7)	0 (0.0)	4 (3.8)	2 (1.9)	0 (0.0)

(1) AEs occurring in >10% of subjects in any arm

Note: Data reported reflects AE information for CAMP-1 resulting from continued analysis of complete data set for CAMP-1 and CAMP-2 post release of topline Phase 3 results on 3 Jan 2019.

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CAMP-2
ADVERSE EVENTS (1)

	VP-102 (N=150) n (%)			Placebo (N=112) n (%)		
PREFERRED TERM NAME	**MILD**	**MOD**	**SEV**	**MILD**	**MOD**	**SEV**
Application site vesicles	108 (72.0)	30 (20.0)	3 (2.0)	34 (30.4)	0 (0.0)	0 (0.0)
Application site scab	74 (49.3)	11 (7.3)	0 (0.0)	20 (17.9)	2 (1.8)	0 (0.0)
Application site pruritus	60 (40.0)	5 (3.3)	0 (0.0)	29 (25.9)	8 (7.1)	0 (0.0)
Application site pain	69 (46.0)	14 (9.3)	0 (0.0)	16 (14.3)	0 (0.0)	0 (0.0)
Application site erythema	41 (27.3)	28 (18.7)	1 (0.7)	22 (19.6)	6 (5.4)	0 (0.0)
Application site dryness	35 (23.3)	4 (2.7)	0 (0.0)	19 (17.0)	1 (0.9)	0 (0.0)
Application site discoloration	39 (26.0)	7 (4.7)	0 (0.0)	9 (8.0)	0 (0.0)	0 (0.0)

(1) AEs occurring in >10% of subjects in any arm

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Our Opportunity in Common Warts

VERRUCA VULGARIS (COMMON WARTS)

OVERVIEW

Caused by Human Papilloma virus (HPV)

Infects patients of all ages

Persistent infection, highly refractory

Typically 2-5 lesions

No FDA approved drug for the treatment of common warts

ETIOLOGY AND CLINICAL PRESENTATION

Transmission

- Skin to skin contact
- Sharing of infected articles of clothing

Diagnosis & Symptoms

- Dome shaped flesh-colored lesions commonly on the hands, fingers, knees or elbows
- Lesions may occur in groups or in a linear pattern
- Lesions can cause considerable pain and discomfort, may spread with skin trauma, and can be itchy

Complications

- Scarring may occur
- Dyspigmentation of affected areas
- Bacterial superinfection of lesions
- Irritation, pain, and redness of surrounding skin

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PHASE 2 STUDY (COVE-1) IN COMMON WARTS IS ONGOING

Study Design

- Open label, single center
- Efficacy, safety & tolerability
- Study has two cohorts

Endpoints

Primary
Percent of subjects with complete clearance of all treatable warts (baseline and new) at Day 84

Secondary
Percent of subjects achieving complete clearance of all treatable warts at Visits 2, 3, and 4

Patients

Cohort 1: 21 subjects 2+ years of age with common warts, who have not received any type of treatment within the past 14 days

Cohort 2: ~35 subjects 12+ years of age with common warts, who have not received any type of treatment within the past 14 days

Application

- Study drug (VP-102) is administered topically to each treatable wart to a maximum of 4 applications or until complete clearance
- Frequency of administration is at least 14 days (cohort 1) or 21 days (cohort 2)
- VP-102 will be left on for 24 hours before removal with soap and warm water

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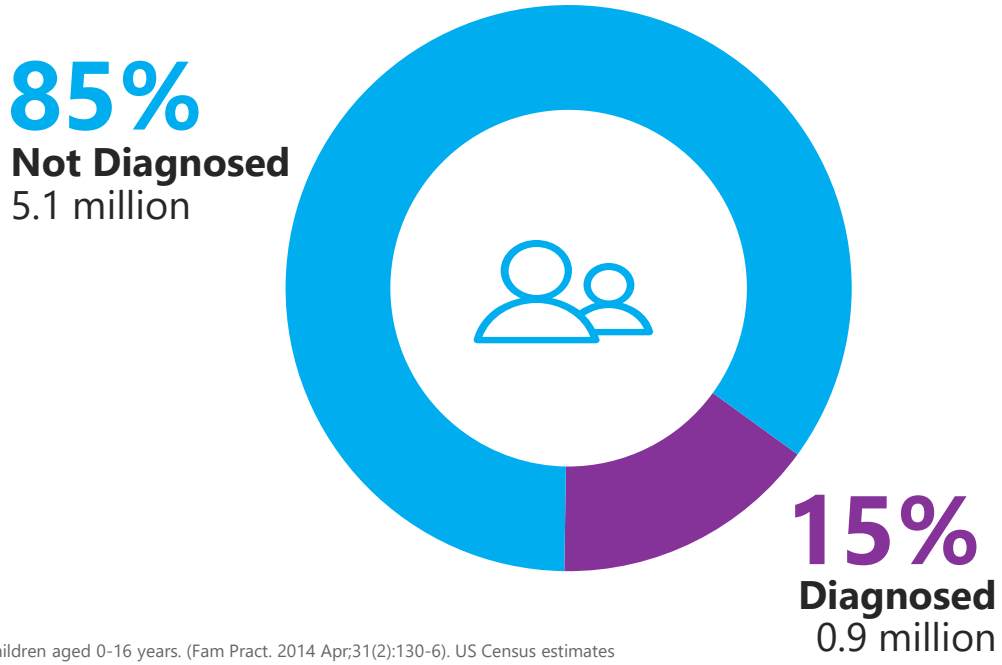
MC Commercial Opportunity

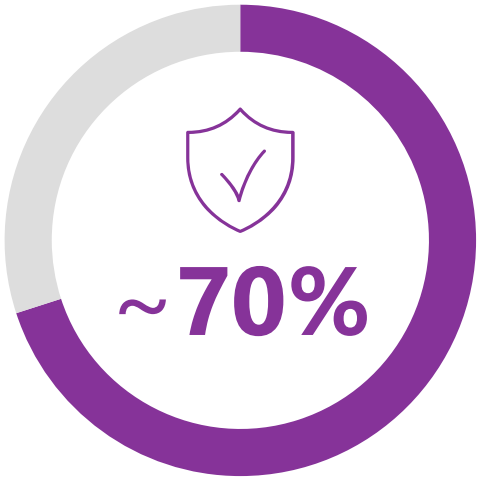
REALIZING THE MOLLUSCUM OPPORTUNITY

US Prevalence of **~6 million in molluscum**(1) with **~1 million diagnosed annually**(2)

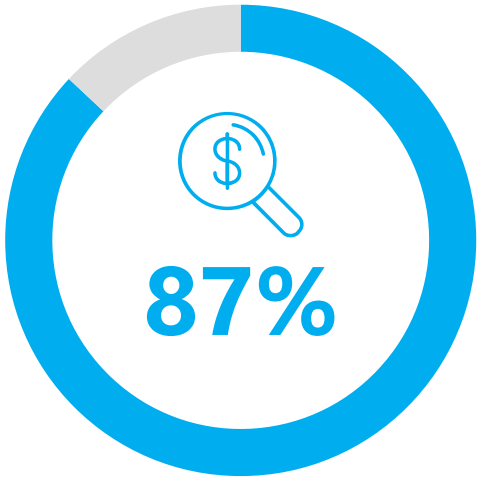


(1) Prevalence in the US of 5.1% to 11.5% in children aged 0-16 years. (Fam Pract. 2014 Apr;31(2):130-6). US Census estimates ~69.4MM children aged 0 to 16 years in 2016.
(2) IQVIA projected dataset for 12 months ending October 2017

DERMATOLOGISTS ARE FAMILIAR WITH VP-102'S API & WOULD USE IF AVAILABLE



Physicians who do not use the API of VP-102 **stated inaccessibility as a primary reason why they are not using**(1)



Physicians reported they **would use VP-102 if the cost of the drug was covered**(2)

(1) Pompei DT et al. Cantharidin Therapy: Practice patterns and attitudes of health care providers. Journal of the American Academy of Dermatology. 2013; 68(6). Survey of 400 healthcare providers, 87.7% of responders were US based dermatologists.
(2) Company survey of 40 physicians.

PHYSICIANS ARE HIGHLY FAVORABLE TO VP-102 PROFILE

Derms and Ped Derms (1)

KEY REASONS TO USE IF APPROVED

- Efficacy
- Precise and pain free application
- FDA approval
- Convenience of administration

Pediatricians (1)

KEY REASONS TO USE IF APPROVED

- Efficacy
- Fits into their current office model
- Frustrated with not treating and having no viable options

Scale of 1 (unlikely to use at all) **to 7** (highly likely to use)

(1) Physician Qualitative research- one-hour individual interviews [n=30 Pediatricians, 13 Dermatologist, 5 Pediatric Dermatologists]

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INITIAL PAYER RESEARCH SUGGESTS FAVORABLE REIMBURSEMENT LANDSCAPE FOR VP-102

	COHORT SIZE	AVERAGE LIVES COVERED
Medical Directors	7	9.8M
Pharmacy Directors	6	4.2M
IDN Stakeholders	2	6.5M

The 15 Payer Organizations and Plans Represented in the Interviews **Cover a Total of 105 Million Commercial & Medicaid Lives**

Source: Third party study commissioned by the Company.

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INITIAL PAYER RESEARCH SUGGESTS FAVORABLE REIMBURSEMENT LANDSCAPE FOR VP-102

Key Takeaways

1. Payers interviewed **recognize a significant unmet need** for molluscum contagiosum and lack of an effective treatment

2. Some of the **key concerns** mentioned about the undertreatment of the condition include the **risk of infection, scarring, or spread of the disease**

3. Payers **perceived VP-102 to be highly favorable** based on the majority of patients experiencing clearance within 12 weeks

4. Given the unmet need and favorable clinical outcomes in Phase 2 trials, **payers anticipate the majority of patients would have access to VP-102** with minimal to no restrictions

Source: Third party study commissioned by the Company.

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INTEGRATED COMMERCIAL APPROACH WITH MULTIPLE STRATEGIC LEVERS

Commercial Strategy

KOL Engagement

Strong established relationships and support

Buy and Bill or Specialty Pharmacy

Distribution with supportive HUB services

Dedicated Field reimbursement Team

Specialized Sales Team

Targeting office based dermatologists and select pediatricians

Dedicated Institutional Team

Specialists to promote to pediatric dermatologists in academic settings and group practices

Disease Awareness

Increase treatment seekers through cost-efficient consumer advertising

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PRE-COMMERCIALIZATION ACTIVITIES ONGOING

ENGAGEMENT AT KEY CONFERENCES

The Society for Pediatric Dermatology	Winter Clinical Dermatology	Fall Clinical Dermatology Conference® Poster Presentation
American Academy of Dermatology AAD 1938	American Academy of Pediatrics National and Regional Meetings	SDPA Society of Dermatology Physician Assistants National and Regional Meetings
South Beach Symposium clinical + aesthetic dermatology	Maui Derm The Dermatology Meetings	

DISEASE AWARENESS

Caregiver MC education through digital and social tools

HCP MC education through congresses, speaker programs, and professional journal space

OTHER

Trade distribution channel development

Customer segment insights

Brand strategy, customer segmentation, and targeting

Commercial systems infrastructure

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VERRICA HAS SEVERAL POTENTIAL WAYS TO MAINTAIN EXCLUSIVITY

Regulatory Exclusivity

5.5 years of exclusivity for cantharidin as API potentially available upon approval (inclusive of potential for 6 months for pediatric indication)

Compounding Pharmacies

If VP-102 is approved, traditional compounding pharmacies will NOT be able to continue compounding cantharidin regularly or in inordinate amounts, except under patient specific circumstances as prescribed by a physician.

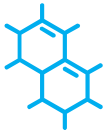
The FDA has the authority to regulate compounders. Improper compounding can result in monetary fines plus felony convictions in case of repeat offenses and intent to fraud/mislead.

Manufacturing

VP-102 has the potential to address stability issues with standard packaging and container/ closure systems

Limited commercial CMOs with facilities for handling highly potent and highly flammable liquid products

Entered into a supply agreement for naturally-sourced cantharidin; subject to specified minimum annual purchase orders and forecasts, supplier agreed that it will not supply cantharidin, any beetles or other raw material from which cantharidin is derived to any other customer in North America



True Generic Unlikely

Unlikely to receive approval under an ANDA due to uniqueness from patent pending protection and significant differences likely between VP-102 and potential competitors

Cannot do traditional PK/bioequivalence study (no blood level profile for VP-102)

May require new clinical studies with new formulation and new delivery approach that shows equivalence without violating any of Verrica's IP

VERRICA PHARMACEUTICALS

OVERVIEW OF INTELLECTUAL PROPERTY PORTFOLIO

KEY CLAIMS AND PATENT APPLICATIONS	VALUE TO VERRICA
1 Our specific formulation (VP-102), key safety additions and novel cantharidin formulations (PCT/US2014/052184)	May prevent generics from copying our ether-free formulation or from making similar formulations
Single use applicator containing cantharidin formulations (PCT/US2014/052184)	May prevent generics from utilizing a single-use applicator for cantharidin that contains both a glass ampule to maintain product stability and a filter placed prior to dispensing tip, which helps increase administration accuracy and prevents direct contact with skin
2 Specific design of our commercial applicator (PCT/US2018/036353)	May prevent generics from utilizing a similar applicator
3 Methods of use for cantharidin in the treatment of molluscum (PCT/US2018/037808 and PCT/US2018/036353)	May prevent generics from a similar treatment regimen and label
4 Methods for purifying cantharidin and analyzing cantharidin or cantharidin solutions (PCT/US2016/14139)	May force generics to find alternative methodologies to produce GMP cantharidin or determine if their API or drug product is GMP compliant
5 Methods for complete cantharidin synthesis (PCT/US2015/066487)	Synthetic version would reduce risks of outside contaminants and environmental factors affecting the naturally-sourced API. May prevent generics competing with a synthetic version of cantharidin

Any patents issued from our applications are projected to expire between 2034 and 2039, excluding any patent term adjustment and patent term extensions

VERRICA PHARMACEUTICALS

SIGNIFICANT RECENT AND EXPECTED MILESTONES

	DATE	EVENT
✓	1Q 2018	Received go ahead from FDA to initiate two Phase 3 trials, including SPA on pivotal trial
✓	1Q 2018	Initiated Phase 3 trials for molluscum and Phase 2 trial for warts
✓	1Q 2018	Executed purchase order for API that is expected to last through commercial launch
✓	1Q 2018	Hired COO, CFO, CCO and CMO with significant commercial experience and track record of success
✓	2Q 2018	Added dermatology veteran Mark Prygocki and KOL Dr. Gary Goldenberg to the Board of Directors
✓	3Q 2018	Entered into a supply agreement for naturally-sourced cantharidin
✓	3Q 2018	Completed enrollment in two pivotal Phase 3 trials in molluscum
✓	1Q 2019	Positive topline results from two pivotal Phase 3 trials in molluscum
⬡	1H 2019	Initiate Phase 2 trial in genital warts
⬡	2Q 2019	Topline results from Phase 2 trial in common warts
⬡	2H 2019	VP-102 NDA submission in molluscum
⬡	2H 2019	VP-103 IND submission in plantar warts
⬡	2H 2019	Initiate pivotal trials in common warts

VERRICA PHARMACEUTICALS

INVESTMENT HIGHLIGHTS

Two of the Largest Unmet Needs in Dermatology
- Prevalence of ~6 million in molluscum contagiosum[(1)] and ~22 million in common warts in the U.S.[(2)]
- No FDA approved drugs to treat molluscum or warts

Positive Topline Phase 3 Results in Molluscum Contagiosum
- Achieved statistical significance for primary endpoints in our Phase 3 CAMP-1 and CAMP-2 pivotal trials for VP-102
- P-value <0.0001 for primary endpoint in both pivotal trials

Favorable Tolerability
- No serious adverse events in VP-102 treated patients

Physician Acceptance
- 95% of pediatric dermatologists have used API[(3)]

Innovative Product Candidate
- Drug-device combination of a proprietary formulation and a novel single-use applicator

Barriers to Competition
- New chemical entity regulatory exclusivity upon approval
- IP pending on product candidate, including on novel formulation, applicator and methods of use
- Drug-device combination makes a 'true generic' unlikely

Proven Team
- Industry-leading, experienced management team with extensive product launch experience

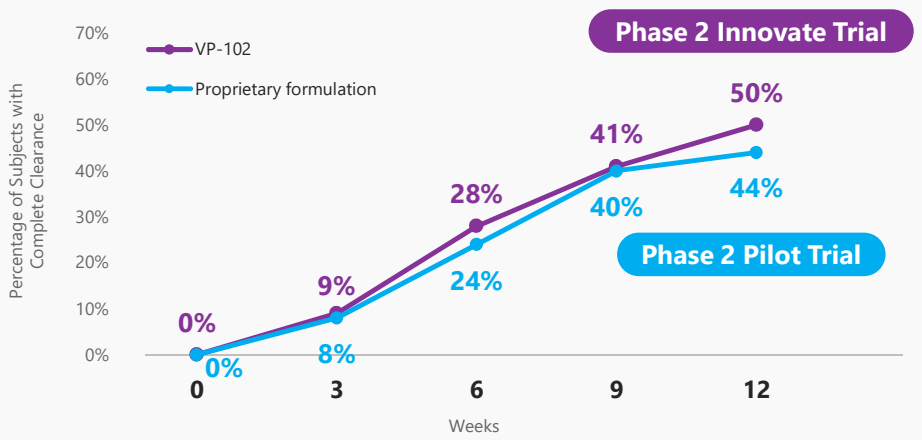
(1) Prevalence in the US of 5.1% to 11.5% in children aged 0-16 years. (Fam Pract. 2014 Apr;31(2):130-6). US Census estimates ~69.4MM children aged 0 to 16 years in 2016.
(2) IMS National Disease and Therapeutic Index (NDTI) Rolling 5 Years Ending June 2016. Nguyen et al, Laser Treatment of Nongenital Verrucae A Systemic Review. JAMA Dermatology. 2016; 152(9): 1025-1033
(3) Based on a survey of 115 dermatologists the results of which have been extrapolated to pediatric dermatologists.

VERRICA PHARMACEUTICALS

Appendix

PHASE 2 TRIAL DATA DEMONSTRATES A FAVORABLE PROFILE FOR VP-102 IN MOLLUSCUM CLEARANCE

VP-102 Complete Clearance



HISTORICAL RESULTS FROM THIRD-PARTY TRIALS(1)

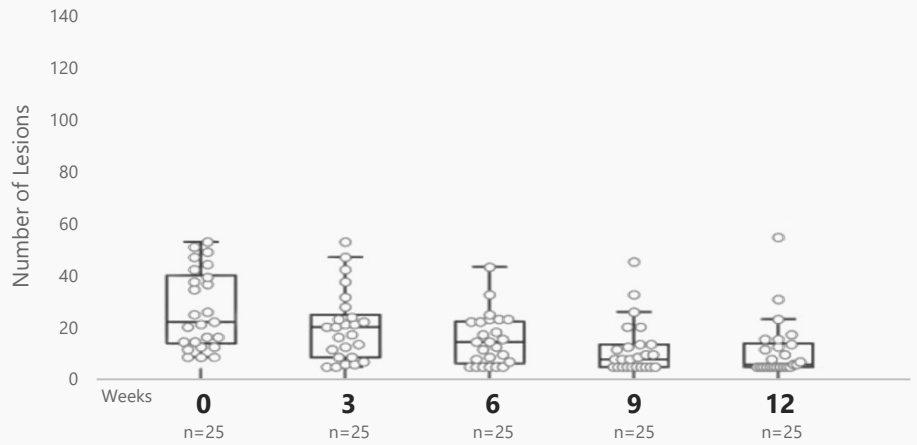
(1) Historical placebo data from third-party trials with cantharidin; No head-to-head trials have been run against VP-102.
(2) Burke BE, Baillie J, Olson RD. Essential oil of Australian lemon myrtle (Backhousia citriodora) in the treatment of molluscum contagiosum in children. Biomedicine & Pharmacolotherapy 2004; 58: 245-247.
(3) Syed TA, Lundin S, Ahmad M. Topical 0.3% and 0.5% podophyllotoxin cream for self-treatment of molluscum contagiosum in males. Dermatology 1994; 189:65-68.
(4) Garelik J, Schairer D, Hwang H, Viola K, Cohen S. Safety and efficacy of topical cantharidin for the treatment of pediatric molluscum contagiosum: a prospective, randomized, double-blind, placebo-controlled trial. Unpublished.
(5) Dosal C, Stewart PW, Lin JA, Williams CS, Morrell DS. Cantharidin for the treatment of molluscum contagiosum: a prospective, double-blinded, placebo-controlled trial. Pediatric Dermatology 2014;31(4):440-449.
(6) Theos AU, Cummins R, Silverberg NB, Paller AS. Effectiveness of imiquimod cream 5% for treating childhood molluscum contagiosum in a double-blind, randomized pilot trial. Cutis 2004 Aug;74(2):134-8, 141-2.
(7) FDA Clinical Executive Summary for Imiquimod for Pediatric Molluscum. NDA Submission Number 20723. Submission Code SE8-020. Letter Date September 21, 2006.
(8) Olsen JR, Gallacher J, Finlay AY, Piguet V, Francis NA. Time to resolution and effect on quality of life of molluscum contagiosum in children in the UK: a prospective community cohort study. Lancet Infect Dis 2015;15(2):190-195. Natural history point estimates for the percent resolution at Weeks 12 and 18 were derived using the steepest slope of the % resolution versus time (months) curve corresponding to a linear portion between months 8 to 17. This portion of the curve shows the highest rate of resolution and demonstrates 50% of patients resolved the infection over 9 months. This supports point estimates of 17% at 12 weeks and 25% at 18 weeks.

VERRICA PHARMACEUTICALS

PHASE 2 TRIAL DATA DEMONSTRATES A FAVORABLE PROFILE FOR VP-102 IN MOLLUSCUM CLEARANCE

PHASE 2 – PILOT TRIAL

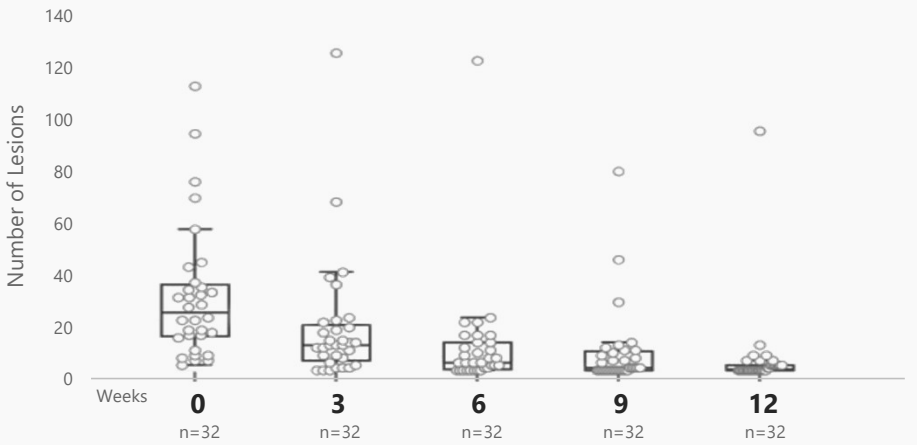
Lesion Clearance After VP-102 (No Applicator)



% reduction in lesion count compared to baseline:					
	Mean	↓ 32%	↓ 50%	↓ 66%	↓ 71%
	Median	↓ 27%	↓ 56%	↓ 86%	↓ 93%

PHASE 2 – INNOVATE TRIAL[1]

Lesion Clearance After VP-102 (w/Applicator)



% reduction in lesion count compared to baseline:					
	Mean	↓ 50%	↓ 72%	↓ 77%	↓ 90%
	Median	↓ 59%	↓ 85%	↓ 95%	↓ 98%

(1) Trial enrolled 33 subjects into either the exposure group (N=17) or the standard group (N=16) with 32 subjects completing the trial. Exposure group subjects were required to have 21 or more lesions at the baseline visit and standard group subjects had 1 to 20 lesions.

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HISTORICAL COMPOUNDED CANTHARIDIN PRESENTS A NUMBER OF LIMITATIONS

1 Varying concentration

- Evaporation of volatile solvents leads to concentration increases
- Patients can receive more drug than clinically necessary resulting in excessive blistering

2 Inconsistent purity and lack of controlled product manufacturing

- Risk of impurities present such as residual solvents and pesticides

3 Lack of reimbursement

- Not FDA approved and therefore not eligible for drug reimbursement

4 Inconvenient and variable administration

- Application with the wooden stick part of a cotton-tipped swab can lead to patients receiving more drug than necessary
- Inability for physicians to identify where the drug has been applied

5 Limited availability

- Illegal to import formulated cantharidin
- Generally not available in hospitals and academic settings, which require FDA approved product
- Only an estimated 7% of 503B compounders produce formulations containing cantharidin(1)

(1) Based on 70 503B facilities and 5 compounders of cantharidin per FDA database.

VERRICA PHARMACEUTICALS

MANAGEMENT TEAM WITH EXTENSIVE PRODUCT LAUNCH AND DERMATOLOGY EXPERIENCE

Ted White
President & Chief Executive Officer
NOVARTIS
AQUA Pharmaceuticals an Almirall company

Chris Degnan
Chief Financial Officer
AstraZeneca
endo
KPMG

Patrick Burnett
MD, PhD
Chief Medical Officer
NOVARTIS
SUN Pharmaceutical Industries Ltd.
Johns Hopkins School of Medicine
School of Medicine Vanderbilt University

Linda Palczuk
Chief Operating Officer
AstraZeneca
Osiris Therapeutics, Inc.

Joe Bonaccorso
Chief Commercial Officer
NOVARTIS
Pierre Fabre

Selected Launched Products

CRESTOR rosuvastatin calcium
Nexium esomeprazole / esomeprazole
ELIDEL Pimecrolimus Cream 10 mg/g
LAMISIL SINGELDOS
Acticlate (Doxycycline Hyclate USP) Tablets 75 mg 150 mg
Cosentyx (secukinumab)
Hemangeol PROPRANOLOL HYDROCHLORIDE
Diovan valsartan capsules
Seroquel Quetiapine Fumarate

VERRICA PHARMACEUTICALS

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Dova Pharmaceuticals

Ted White

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Novartis

AQUA Pharmaceuticals, an Almirall company

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Gary Goldenberg, MD

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Goldenberg Dermatology

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Wake Forest University

Glenn Oclassen

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PARATEK

Transcept Pharmaceuticals, Inc.

Sean Stalfort

Director

PBM Capital Group

avexis

Dova Pharmaceuticals

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HIGHLY ACCLAIMED SCIENTIFIC ADVISORY BOARD

Mark Lebwohl, MD*

Waldman Chair of Dermatology, Icahn School of Medicine at Mount Sinai

Former President of the American Academy of Dermatology

Steven Cohen, MD

Chief of Dermatology at the Albert Einstein School of Medicine

Elaine Siegfried, MD

Professor of Dermatology and Pediatrics at the St. Louis University School of Medicine

Anthony Mancini, MD

Head of the Division of Dermatology at Feinberg School of Medicine at Northwestern University

Janice Pelletier, MD

Professor at the University of Vermont College of Medicine

Dean Morrell, MD

Director of the residency training program and professor at UNC

Matt Davidson, PhD

Founder

Former Chief Scientific Officer of Verrica

(1)(*)We intend to engage Dr. Lebwohl as principal investigator for future clinical trial(s) in our common warts program.