VERRICA™ PHARMACEUTICALS

Reinventing Skin Science

Company Overview

May 2020

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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 dermatology therapeutics 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

July 13, 2020 PDUFA Date for Ycanth™ (VP-102) for the Treatment of Molluscum Contagiosum

Positive Phase 3 Results in Molluscum Contagiosum

- Achieved statistical significance for primary endpoints in our Phase 3 CAMP-1 and CAMP-2 pivotal trials for Ycanth™ (VP-102)
- P-value <0.0001 for primary endpoint in both pivotal trials

Positive Topline Phase 2 Results in Common Warts

- VP-102 achieved positive results on both the primary endpoint of complete clearance of all treatable warts at Week 12 (Day 84) and the secondary endpoint of the percentage reduction of warts

Innovative Product Candidate

- Proprietary drug-device combination of formulation and single-use applicator

Physician Acceptance

- 95% of pediatric dermatologists have used API[3]

Barriers to Competition

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

Proven Team

- Industry-leading, experienced management team with extensive clinical development and 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

* Timing for initiating new clinical trials uncertain due to COVID-19 pandemic

TWO OF THE LARGEST UNMET NEEDS IN DERMATOLOGY

Molluscum

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

85%
Not Diagnosed
5.1 million

15%
Diagnosed
0.9 million

Common Warts

US Prevalence of **~22 million**(3) with **~1.5 million diagnosed annually**(4)

22M
Prevalence in U.S.

1.5M
Patients Diagnosed Annually

(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
(3) 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
(4) IQVIA Anonymous Longitudinal Patient Level Data (APLD) for 12 months ending September 2018

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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

YCANTH™
(VP-102)

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

GMP-controlled new formulation of 0.7% w/v cantharidin

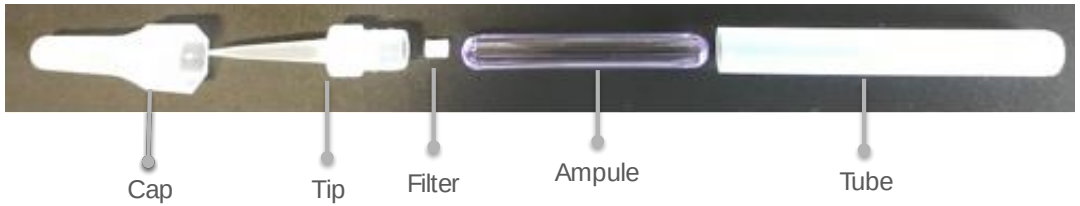
- Consistent and shelf-stable

Single-use applicator to reduce cross-contamination and allow for more effective application of drug by HCP

Visualization agent to identify treated lesions

Bittering agent to deter oral ingestion

Clinician administered, **In-Office** Procedure



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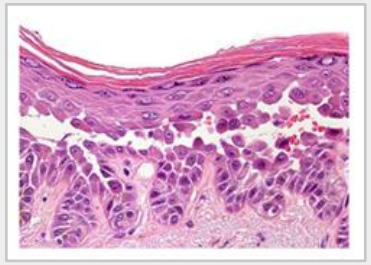
Molluscum Clinical Evidence

CANTHARIDIN ELICITS A DUAL RESPONSE IN THE SKIN

1 Superficial blistering of lesional skin

Cantharidin is a vesicant, causing the pharmacodynamic response of blistering in the skin.

Once applied, cantharidin activates neutral serine proteases that cause degeneration of the desmosomal plaque and intraepidermal blistering.(1)



Desmosome Cleavage and Blister Formation

2 Elicits Inflammation & Immune Response

Cantharidin stimulates leukocyte infiltration (e.g., neutrophils, macrophages, B and T cells and eosinophils) and the release of chemokines and cytokines including TNF-a, IL-8 and CXCL-5.(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

SIGNIFICANT CLINICAL PROGRESS OF YCANTH™ (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

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

	VP-102 (N=311)	Vehicle (N=216)
Age (years)		
Mean (SD)	7.5 (6.7)	6.8 (5.8)
Median	6.0	6.0
Range	2 – 60	2 – 54
Age Group – no. (%)		
≥2 to 5 yr	138 (44.4)	105 (48.6)
≥6 to 11 yr	139 (44.7)	89 (41.2)
≥12-18 yr	23 (7.4)	17 (7.9)
≥19 yr	11 (3.5)	5 (2.3)
Gender – no. (%)		
Female	155 (49.8)	105 (48.6)
Male	156 (50.2)	111 (51.4)
Race or Ethnic Group – no. (%)		
White	277 (89.1)	201 (93.1)
Black or African American	14 (4.5)	7 (3.2)
Asian	6 (1.9)	1 (0.5)
American Indian/Alaskan Native	0	1 (0.5)
Other	14 (4.5)	6 (2.8)

Note: Slide reflects pooled data from Phase 3 molluscum trials (CAMP-1 and CAMP-2)

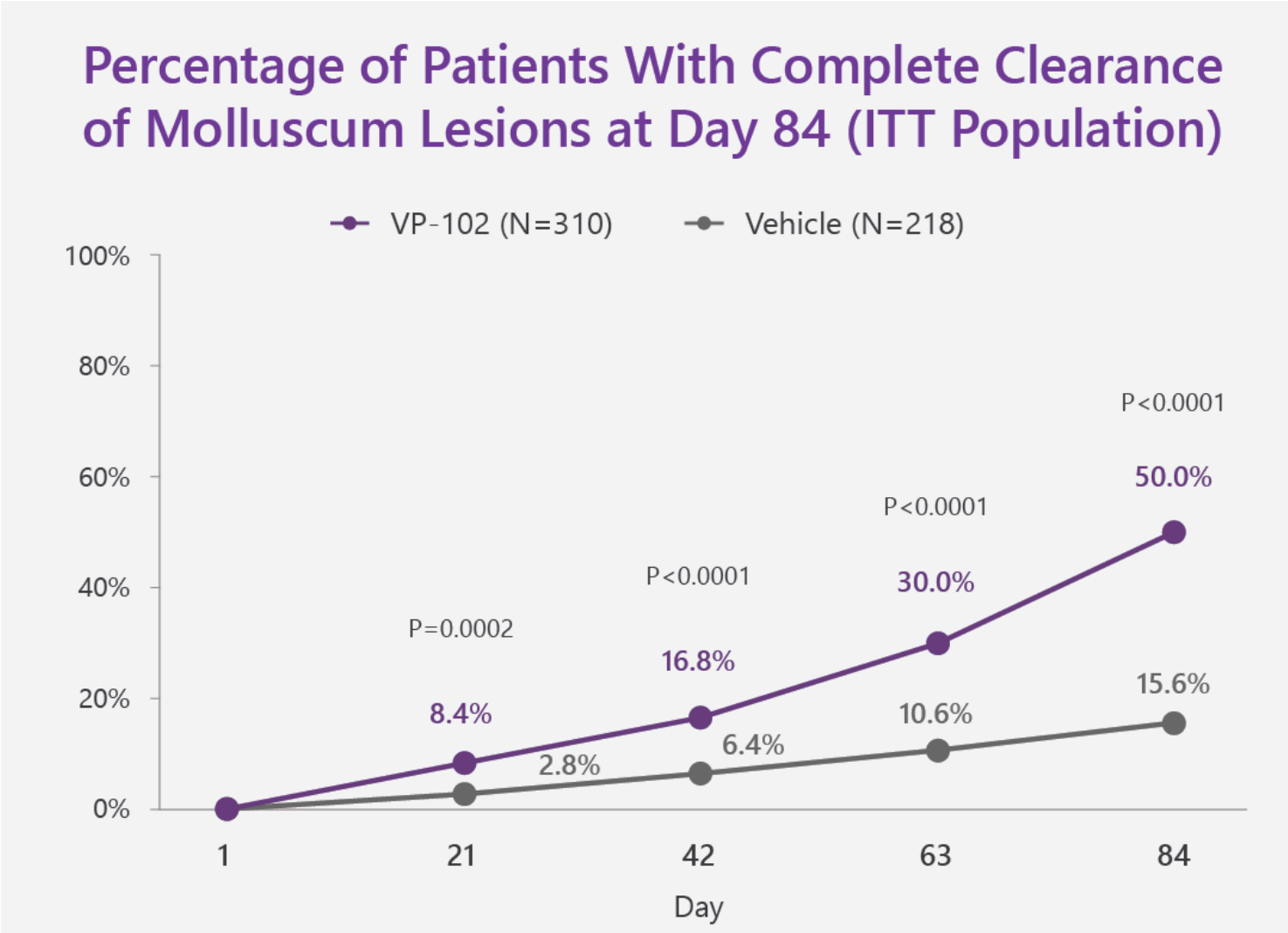
MOLLUSCUM HISTORY FOR SUBJECTS IN PHASE 3 TRIALS

	VP-102 (N=311)	Vehicle (N=216)
Baseline Lesion Count		
Mean (SD)	20.5 (23.1)	22.5 (22.3)
Median	12.0	15.5
Range	1 – 184	1 – 110
Time Since Clinical Diagnosis (days)		
Mean (SD)	123.3 (200.7)	126.2 (199.3)
Median	26.0	31.5
Range	1 – 1247	1 – 1302
Age at Diagnosis (years)		
Mean (SD)	7.1 (6.7)	6.5 (5.9)
Median	6.0	5.0
Range	1 – 60	1 – 54
Previous Treatment for Molluscum – no. (%)		
Yes	90 (28.9)	71 (32.9)
Atopic Dermatitis (AD) – no. (%)		
History or Active AD	50 (16.1)	35 (16.2)
Active AD*	23 (7.4)	20 (9.2)

* Active atopic dermatitis was determined by concomitant medication usage of the following medications during the study: topical corticosteroids, topical calcineurin inhibitors, and/or PDE-4 inhibitors.

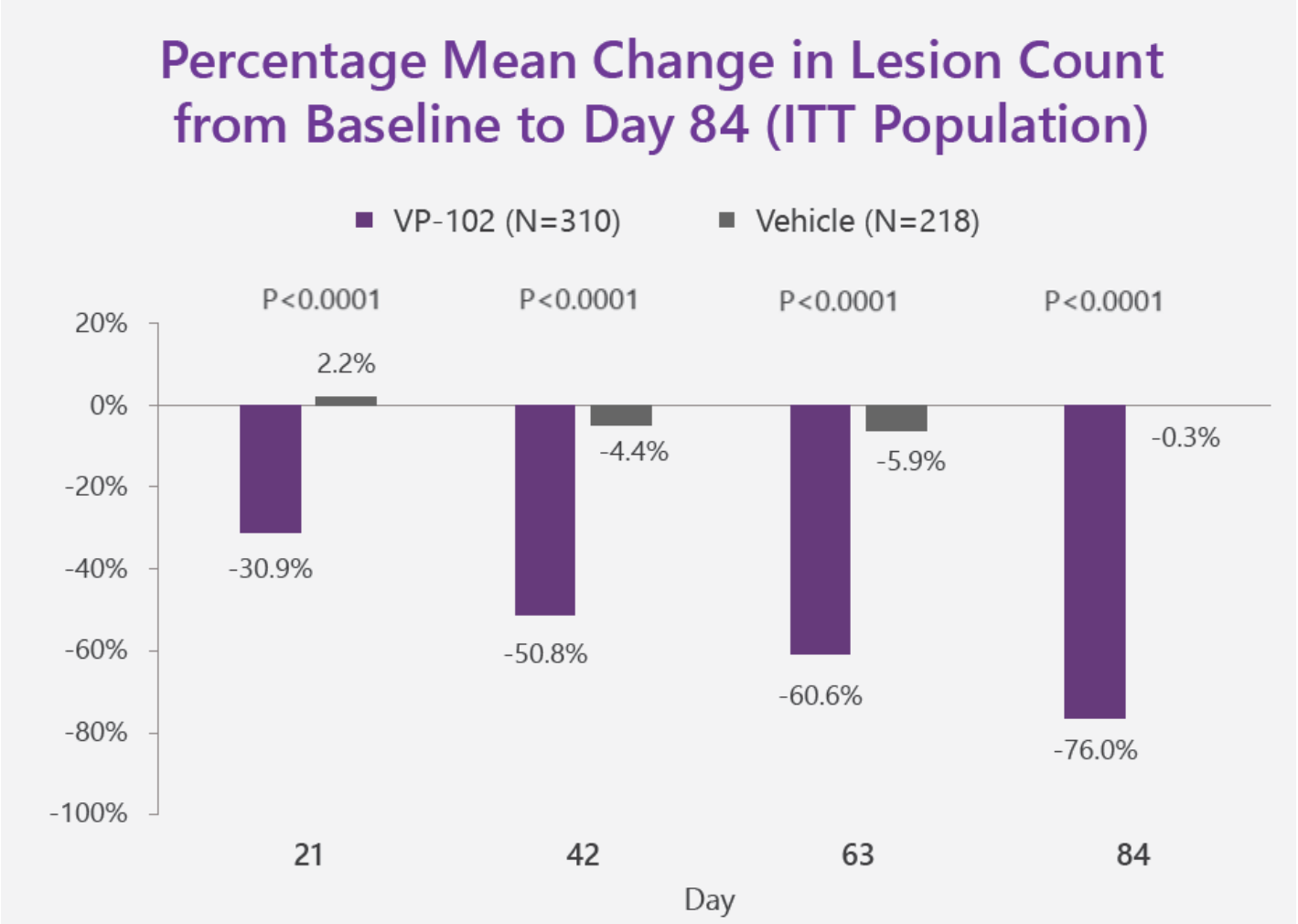
Note: Slide reflects pooled data from Phase 3 molluscum trials (CAMP-1 and CAMP-2)

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



Note: Slide reflects pooled data from Phase 3 molluscum trials (CAMP-1 and CAMP-2)

PHASE 3 STUDIES IN MOLLUSCUM DEMONSTRATE STATISTICALLY SIGNIFICANT EFFICACY ON PERCENT REDUCTION OF LESIONS



Note: Slide reflects pooled data from Phase 3 molluscum trials (CAMP-1 and CAMP-2)

SAFETY SUMMARY FOR MOLLUSCUM PHASE 3 TRIALS

Incidence of Treatment Emergent Adverse Events (TEAEs) ≥5%

	VP-102 (N=311)	Vehicle (N=216)
At Least One Incidence: N (%)		
Application Site Vesicles	298 (95.8)	63 (29.2)
Application Site Pain	193 (62.1)	36 (16.7)
Application Site Pruritus	169 (54.3)	75 (34.7)
Application Site Scab	147 (47.3)	47 (21.8)
Application Site Erythema	139 (44.7)	58 (26.9)
Application Site Discoloration	100 (32.2)	27 (12.5)
Application Site Dryness	63 (20.3)	31 (14.4)
Application Site Edema	29 (9.3)	10 (4.6)
Application Site Erosion	22 (7.1)	2 (0.9)

Treatment Emergent Adverse Events (TEAEs) ≥5% by Severity

	VP-102 (N=311)			Vehicle (N=216)		
At Least One Incidence: N (%)	**Mild**	**Moderate**	**Severe**	**Mild**	**Moderate**	**Severe**
Application Site Vesicles	187 (60.1)	100 (32.2)	11 (3.5)	59 (27.3)	4 (1.9)	0
Application Site Pruritus	145 (46.6)	23 (7.4)	1 (0.3)	62 (28.7)	13 (6.0)	0
Application Site Pain	127 (40.8)	59 (19.0)	7 (2.3)	34 (15.7)	2 (0.9)	0
Application Site Scab	120 (38.6)	27 (8.7)	0	44 (20.4)	3 (1.4)	0
Application Site Discoloration	87 (28.0)	12 (3.9)	1 (0.3)	25 (11.6)	2 (0.9)	0
Application Site Erythema	73 (23.5)	65 (20.9)	1 (0.3)	43 (19.9)	15 (6.9)	0
Application Site Dryness	58 (18.6)	5 (1.6)	0	30 (13.9)	1 (0.5)	0
Application Site Edema	21 (6.8)	8 (2.6)	0	7 (3.2)	3 (1.4)	0
Application Site Erosion	20 (6.4)	2 (0.6)	0	2 (0.9)	0	0

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Note: Slide reflects pooled data from Phase 3 molluscum trials (CAMP-1 and CAMP-2)

PHASE 3 DISCONTINUATION RATES DUE TO TREATMENT-RELATED ADVERSE EVENTS

N (%)	VP-102 (N=311)	Vehicle (N=216)
Application Site Vesicles	5 (1.6)	0 (0)
Application Site Pain	3 (1.0)	0 (0)
Application Site Pruritus	1 (0.3)	0 (0)
Contact Dermatitis	1 (0.3)	0 (0)
Total Discontinuation Rate	**6 (1.9)**	**0 (0)**

Note: Slide reflects pooled data from Phase 3 molluscum trials (CAMP-1 and CAMP-2)

MC Commercial Opportunity

REALIZING THE MOLLUSCUM OPPORTUNITY

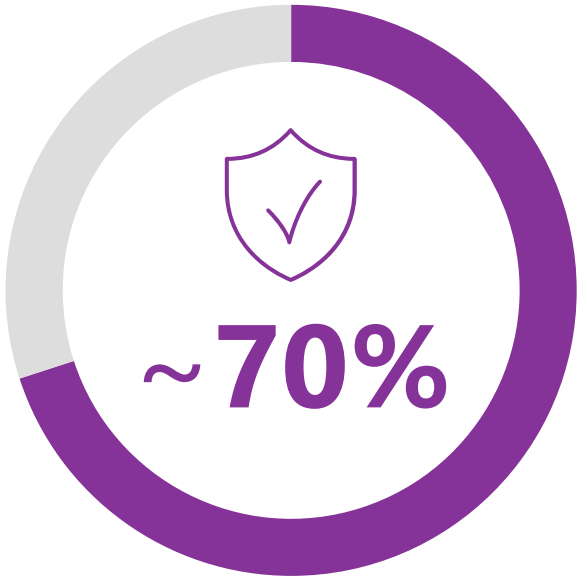
US Prevalence of **~6 million in molluscum**(1) with **~1 million diagnosed annually**(2)

85%
Not Diagnosed
5.1 million

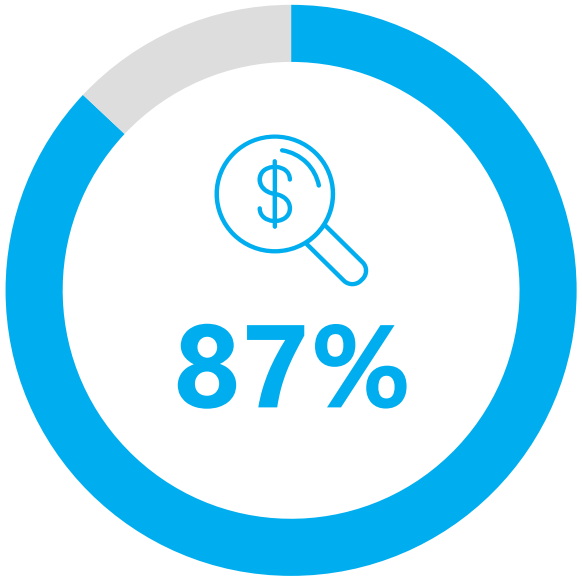
15%
Diagnosed
0.9 million

(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 API USED IN YCANTH™ (VP-102) & WOULD USE IF AVAILABLE



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



Physicians reported they **would use Ycanth™ (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 YCANTH™ (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]

INITIAL PAYER RESEARCH SUGGESTS FAVORABLE REIMBURSEMENT LANDSCAPE FOR YCANTH™ (VP-102)

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

Source: Third party study commissioned by the Company.

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

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INITIAL PAYER RESEARCH SUGGESTS FAVORABLE REIMBURSEMENT LANDSCAPE FOR YCANTH™ (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 Ycanth™ (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 Ycanth™ (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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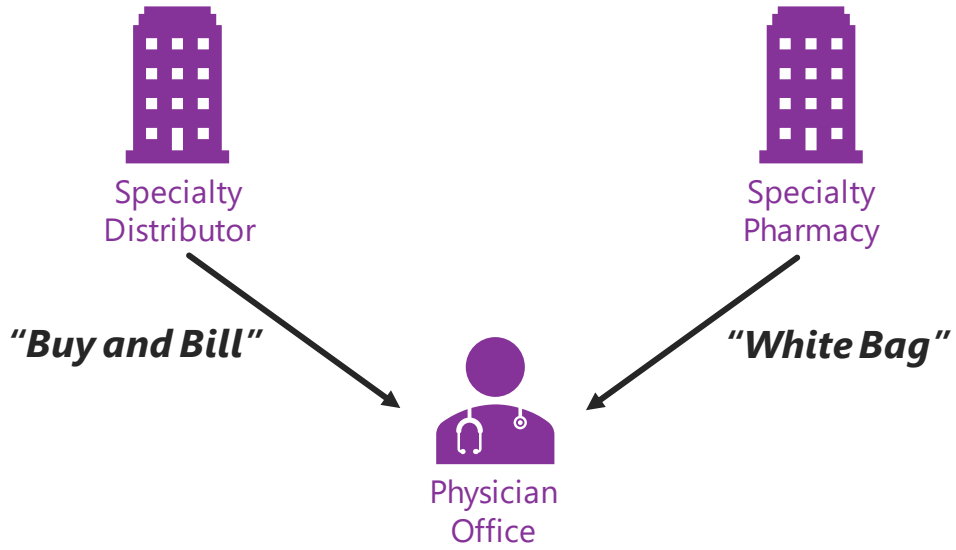
YCANTH™ (VP-102) DESIGNED TO BE CLINICIAN ADMINISTERED AND INTEND TO DISTRIBUTE THROUGH SPECIALTY PRODUCT CHANNELS, IF APPROVED



Potential Physician Reimbursement Opportunities	
"Buy and Bill"	**"White Bag"**
Office visit	Office visit
Procedure for lesion destruction	Procedure for lesion destruction
Ycanth™ (VP-102) = (ASP + X%)	

Distribution model will be supported by a patient and HCP services platform (HUB)

- Benefits investigation/verification to determine coverage
- Full reimbursement support for miscellaneous J-code under medical benefit (1)
- Prior authorization support
- Co-pay/co-insurance assistance

Dedicated field reimbursement team to support physician offices

(1) Verrica intends to file for a product-specific J-code for VP-102

Note: For illustrative purposes only. If approved, actual distribution channels and support services may change as strategy is finalized.

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	Society of Dermatology Physician Assistants (SDPA) EST 1994 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

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

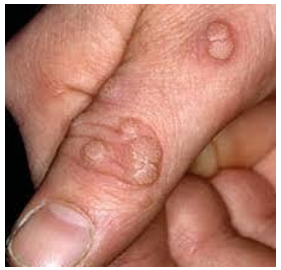
ETIOLOGY AND CLINICAL PRESENTATION

Transmission

- Skin to skin contact
- Touching of contaminated objects

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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WE HAVE SUCCESSFULLY COMPLETED A PHASE 2 STUDY (COVE-1) IN COMMON WARTS

Study Design

Efficacy, safety & tolerability

Open label study with two cohorts

Cohort 1: one center
Cohort 2: four centers

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

Change from baseline in number (%) of treatable warts at Day 84

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

Cohort 1 is treated until clear, Cohort 2 receives one additional treatment at the first visit clearance was observed up to a maximum of 4 total applications

Frequency of administration is at least 14 days (Cohort 1) or 21 days (Cohort 2)

Paring was allowed in Cohort 2

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

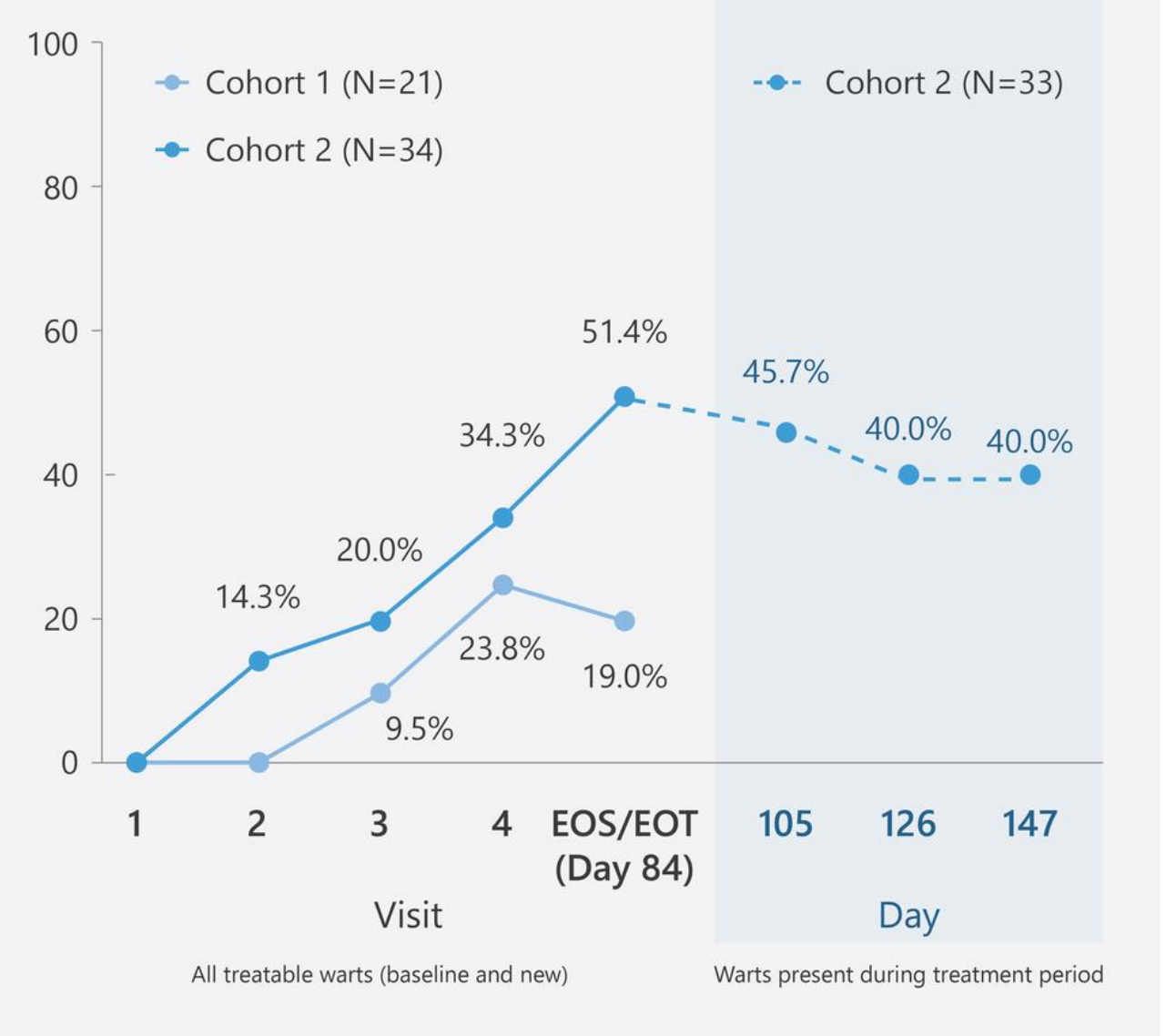
DEMOGRAPHICS IN COVE-1 STUDY

	Cohort 1 VP-102 (N=21)	Cohort 2 VP-102 (N=35)
Randomized	21	35
Age (years)		
Mean	38	38
Median	37	42
Min, Max	7, 83	12, 67
Gender (N (%))		
Female	11 (52.4%)	22 (62.9%)
Male	10 (47.6%)	13 (37.1%)

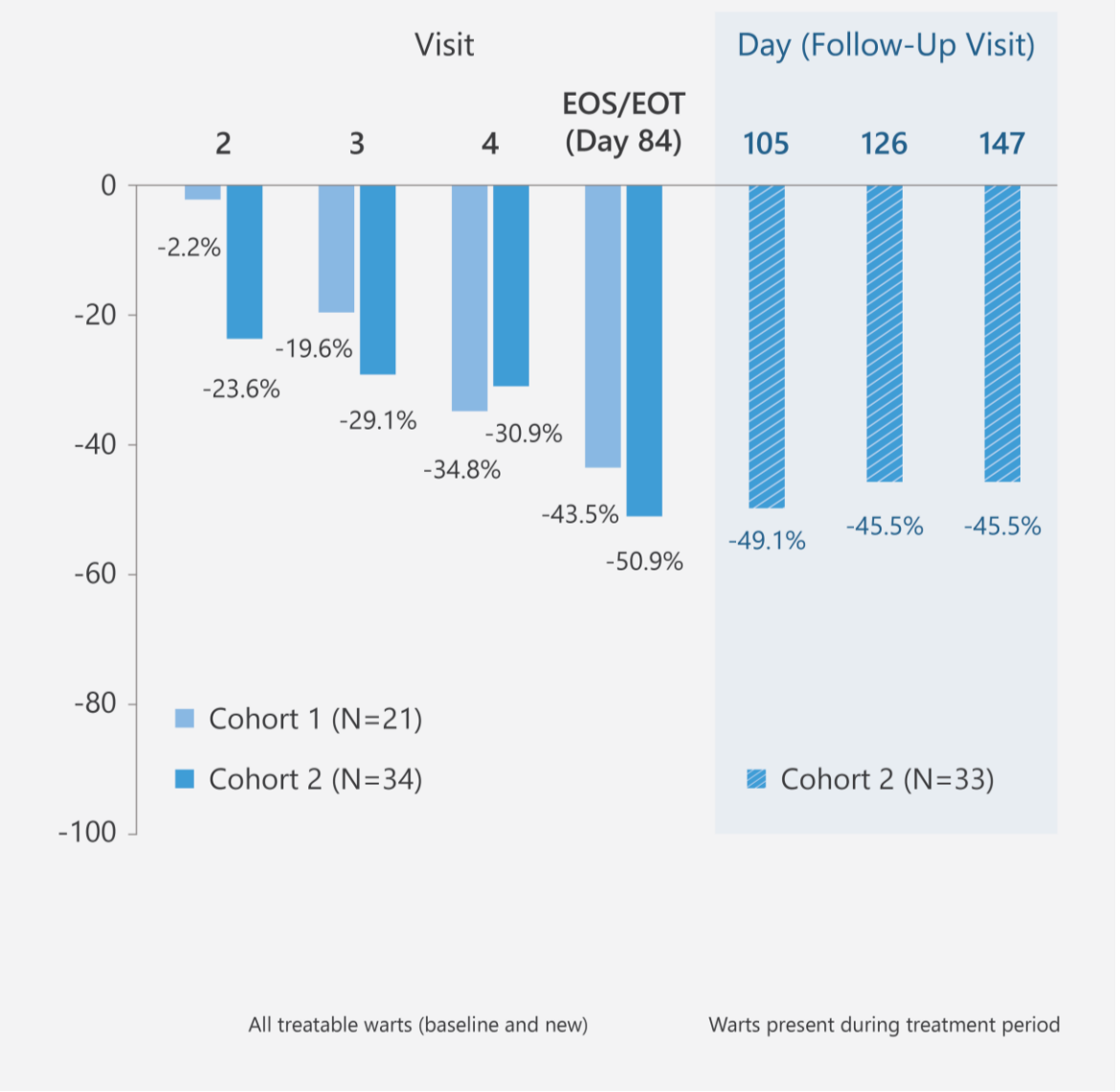
WART HISTORY FOR SUBJECTS IN COVE-1 STUDY

	Cohort 1 VP-102 (N=21)	Cohort 2 VP-102 (N=35)
Time Since Clinical Diagnosis (months)	70.3	15.9
Age at Diagnosis (mean, years)	32.1	36.4
Any Previous Treatments for Common Warts? (Yes)	3 (14.3%)	24 (68.6%)
Wart Number at Baseline (mean)	2.19	1.65

VP-102 DEMONSTRATED CLINICALLY MEANINGFUL EFFICACY ON PRIMARY ENDPOINT OF COMPLETE CLEARANCE IN COVE-1 STUDY



VP-102 DEMONSTRATED CLINICALLY MEANINGFUL EFFICACY ON PERCENT CHANGE IN NUMBER OF COMMON WARTS FROM BASELINE IN COVE-1 STUDY



ADVERSE EVENTS IN COVE-1 STUDY (INCIDENCE≥5%)*

	Cohort 1 N=21 (To Day 84)	Cohort 2 N=34 (To Day 147)
Incidence: N (%)		
Application Site Vesicles	20 (95.2)	27 (79.4)
Application Site Pain	15 (71.4)	26 (76.5)
Application Site Erythema	13 (61.9)	19 (55.9)
Application Site Pruritus	9 (42.9)	16 (47.1)
Application Site Scab	8 (38.1)	20 (58.8)
Application Site Dryness	6 (28.6)	13 (38.2)
Application Site Edema	4 (19.0)	6 (17.6)
Application Site Discoloration	1 (4.8)	8 (23.5)
Application Site Exfoliation	0	4 (11.8)
Application Site Erosion	0	3 (8.8)
Papilloma Viral Infection**	0	3 (8.8)

* Local skin reactions were expected due to the pharmacodynamic action of cantharidin. ** Warts reported with verbatim term of 'ring wart' and coded to MeDRA.

ADVERSE EVENTS FOR COVE-1 STUDY BY SEVERITY (INCIDENCE≥5%)

	Cohort 1 N=21 (To Day 84)			Cohort 2 N=34 (To Day 147)		
Incidence: N (%)	**Mild**	**Moderate**	**Severe**	**Mild**	**Moderate**	**Severe**
Application Site Vesicles	18 (85.7)	1 (4.8)	1 (4.8)	16 (47.1)	10 (29.4)	1 (2.9)
Application Site Pain	11 (52.4)	3 (14.3)	1 (4.8)	17 (50)	6 (17.6)	3 (8.8)
Application Site Pruritus	9 (42.9)	0	0	16 (47.1)	0	0
Application Site Erythema	7 (33.3)	5 (23.8)	1 (4.8)	14 (41.2)	5 (14.7)	0
Application Site Scab	6 (28.6)	1 (4.8)	1 (4.8)	18 (52.9)	2 (5.9)	0
Application Site Dryness	6 (28.6)	0	0	12 (35.3)	1 (2.9)	0
Application Site Edema	2 (9.5)	2 (9.5)	0	5 (14.7)	0	1 (2.9)
Application Site Discoloration	1 (4.8)	0	0	6 (17.6)	1 (2.9)	1 (2.9)
Application Site Erosion	0	0	0	0	2 (5.9)	1 (2.9)
Application Site Exfoliation	0	0	0	3 (8.8)	1 (2.9)	0
Papilloma Viral Infection	0	0	0	1 (2.9)	2 (5.9)	0

DISCONTINUATION RATES FOR COVE-1

	Cohort 1 VP-102 (N=21)	Cohort 2 VP-102 (N=35)
Discontinued (total, N(%))	4 (19.0%)	2 (5.7%)
Lost to follow-up	2 (9.5%)	1 (2.9%)
Withdrawal by subject	2 (9.5%)	0
Protocol violation	0	1 (2.9%)

REALIZING THE COMMON WARTS OPPORTUNITY

US Prevalence of **~22 million in common warts**(1) with **~1.5 million diagnosed annually**(2)

22M
Prevalence in U.S.

1.5M
Patients Diagnosed Annually

(1) 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
(2) IQVIA Anonymous Longitudinal Patient Level Data (APLD) for 12 months ending September 2018

Our Opportunity in External Genital Warts

CONDYLOMA ACUMINATUM (GENITAL WARTS)

OVERVIEW

Caused by human papilloma virus (HPV)

Lesions on the surface of the skin in the genital and perianal regions

Highly contagious and recurrences are common

Treatment options have limitations

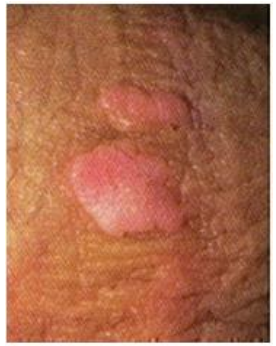
ETIOLOGY AND CLINICAL PRESENTATION

Transmission

- Skin to skin contact
- Spread through sexual contact

Diagnosis & Symptoms

- Can be flat, dome-shaped, keratotic, pedunculated and cauliflower-shaped
- Lesions may occur singularly, in clusters, or as plaques
- Lesions can be itchy, and can cause pain and discomfort



Complications

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

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PHASE 2 STUDY (CARE) IN EXTERNAL GENITAL WARTS (EGW)

Study Design

Multi-center, double-blind, placebo-controlled

Dose regimen, efficacy, safety & tolerability

Study comprised of two parts (A and B)

Primary objective of Part A is to identify the two best dosing regimens for evaluation in Part B

Endpoints

Primary

Percent of subjects with complete clearance of all treatable warts at Day 84

Secondary

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

Patients

Part A: ~18 subjects 18+ years of age with 2-30 external genital and/or perianal warts for ≥ 4 weeks at baseline visit

Part B: ~90 subjects 18+ years of age with 2-30 external genital and/or perianal warts for ≥ 4 weeks at baseline visit

Application

Study drug (VP-102) is administered topically to each treatable wart to a maximum of 4 applications or until complete clearance

Part A: To include 3 treatment groups with a 2-hour, 6-hour and 24-hour duration of skin exposure before removal with soap and warm water

Part B: Two selected treatment dosing regimens (duration of skin exposure) based on Part A with follow up period through Day 147

Frequency of administration is every 21 days

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Regulatory Exclusivity and Intellectual Property

VERRICA HAS SEVERAL POTENTIAL WAYS TO MAINTAIN EXCLUSIVITY

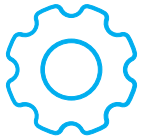
Regulatory Exclusivity

5 years of exclusivity for cantharidin as API potentially available upon approval (potential for additional 6 months for pediatric exclusivity where applicable)

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.

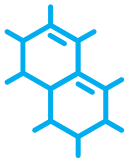


Manufacturing

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 Ycanth™ (VP-102) and potential competitors

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

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

OVERVIEW OF INTELLECTUAL PROPERTY PORTFOLIO

	KEY CLAIMS AND PATENT APPLICATIONS	VALUE TO VERRICA
1	Our specific formulation, Ycanth™ (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 2019	Positive topline results from two pivotal Phase 3 trials in molluscum
✓	2Q 2019	Positive topline results from Phase 2 trial in common warts
✓	2Q 2019	Initiate Phase 2 trial in external genital warts
✓	3Q 2019	Ycanth™ (VP-102) NDA submission in molluscum
✓	4Q 2019	FDA acceptance of Ycanth™ (VP-102) NDA submission in molluscum
✓	4Q 2019	VP-103 IND submission in plantar warts
⬡	2H 2020	Ycanth™ (VP-102) PDUFA Goal Date July 13, 2020 in molluscum
⬡	2H 2020	Topline results from Phase 2 trial in external genital warts
⬡	2H 2020	Commercial launch of Ycanth™ (VP-102) for molluscum
⬡	*	Initiate pivotal Phase 3 trials in common warts
⬡	*	Initiate Phase 2 trial in plantar warts

*** Timing for initiating new clinical trials uncertain due to COVID-19 pandemic**

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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

July 13, 2020 PDUFA Date for Ycanth™ (VP-102) for the Treatment of Molluscum Contagiosum

Positive Phase 3 Results in Molluscum Contagiosum

- Achieved statistical significance for primary endpoints in our Phase 3 CAMP-1 and CAMP-2 pivotal trials for Ycanth™ (VP-102)
- P-value <0.0001 for primary endpoint in both pivotal trials

Positive Topline Phase 2 Results in Common Warts

- VP-102 achieved positive results on both the primary endpoint of complete clearance of all treatable warts at Week 12 (Day 84) and the secondary endpoint of the percentage reduction of warts

Innovative Product Candidate

- Proprietary drug-device combination of formulation and single-use applicator

Physician Acceptance

- 95% of pediatric dermatologists have used API[3]

Barriers to Competition

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

Proven Team

- Industry-leading, experienced management team with extensive clinical development and 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.

Appendix

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

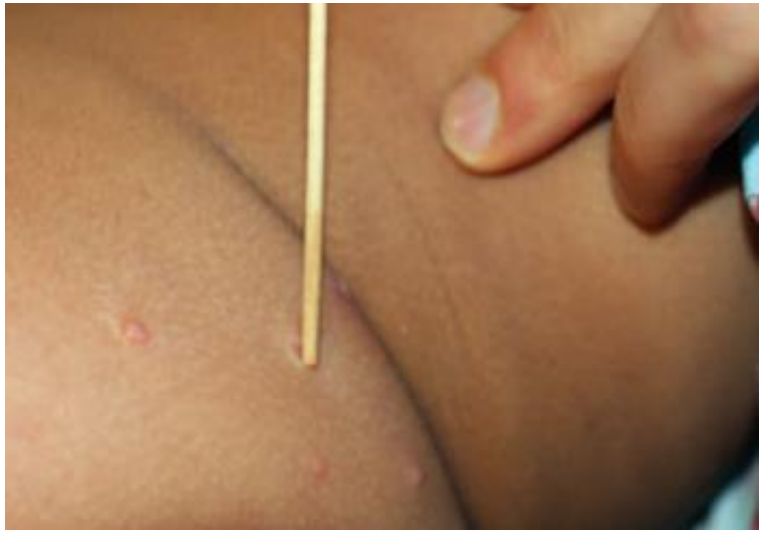
- Not FDA approved and therefore not eligible for drug reimbursement

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 57 503B facilities and 4 compounders of cantharidin per FDA database (January – June 2019).

MANAGEMENT TEAM WITH EXTENSIVE PRODUCT LAUNCH AND DERMATOLOGY EXPERIENCE

Ted White

President & Chief Executive Officer

NOVARTIS

AQUA PHARMACEUTICALS an Almirall company

A. Brian Davis

Chief Financial Officer

STRONGBRIDGE BIOPHARMA

tengion

NEOSE

Patrick Burnett

MD, PhD

Chief Medical Officer

NOVARTIS

SUN PHARMACEUTICAL INDUSTRIES LTD.

JOHNS HOPKINS SCHOOL of MEDICINE

SCHOOL OF MEDICINE VANDERBILT UNIVERSITY

Joe Bonaccorso

Chief Commercial Officer

NOVARTIS

Pierre Fabre

Selected Launched Products

Diovan 80 mg + 160 mg valsartan capsules

LAMISIL SINGELDOS

ELIDEL Pimecrolimus Cream 10 mg/g

Cosentyx (secukinumab)

Hemangeol PROPRANOLOL HYDROCHLORIDE

Acticlate (Doxycycline Hyclate USP) Tablets 75 mg 150 mg

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