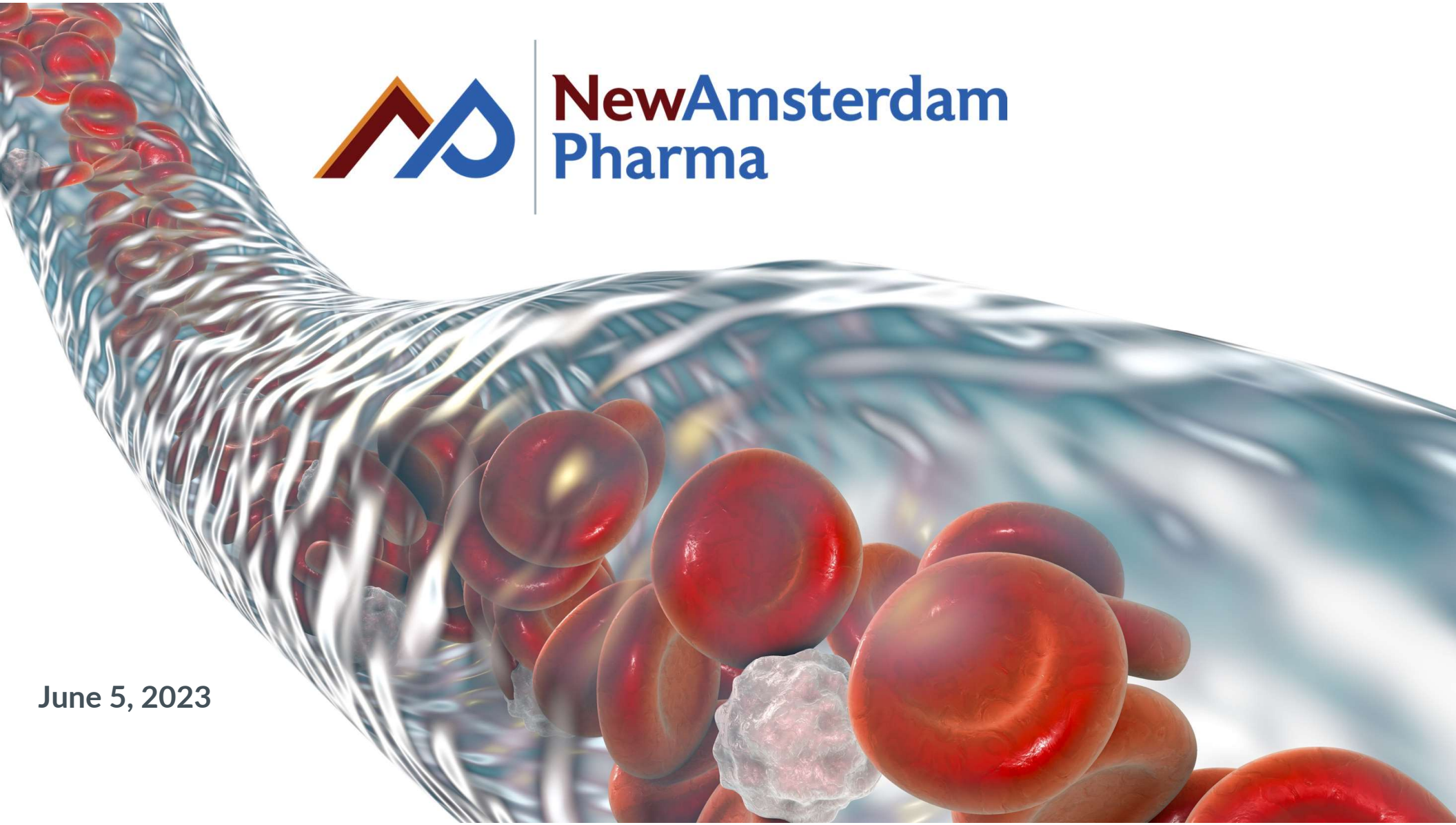
NewAmsterdam Pharma



June 5, 2023

Disclaimer

This presentation (together with oral statements made in connection herewith, this "Presentation") is for informational purposes only. This Presentation shall not constitute an offer to sell, or the solicitation of an offer to buy, any securities, nor shall there be any sale of securities in any states or jurisdictions in which such offer, solicitation or sale would be unlawful. You agree to keep any information provided herein confidential and not to disclose any of the information to any other parties without prior express written permission of NewAmsterdam Pharma Company N.V. ("NewAmsterdam" or the "Company"). Neither the information contained in this Presentation nor any further information made available by the Company or any of its affiliates or employees, directors, representatives, officers, agents or advisers in connection with this Presentation will form the basis of, or be construed as, a contract or any other legal obligation.

Forward Looking Statements

Certain statements included in this Presentation that are not historical facts are forward-looking statements for purposes of the safe harbor provisions under the United States Private Securities Litigation Reform Act of 1995. Forward-looking statements generally are accompanied by words such as "believe," "may," "will," "estimate," "continue," "anticipate," "intend," "expect," "should," "would," "plan," "predict," "potential," "seem," "seek," "future," "outlook" and similar expressions that predict or indicate future events or trends or that are not statements of historical matters. These forward-looking statements include, but are not limited to, statements by NewAmsterdam regarding estimates and forecasts of other financial and performance metrics and projections of market opportunity; expectations and timing related to the success, cost and timing of product development activities, including timing of initiation, completion and data readouts for clinical trials and the potential approval of the Company's product candidate; the size and growth potential of the markets for the Company's product candidate; the therapeutic and curative potential of the Company's product candidate; financing and other business milestones; and the Company's expected cash runway. These statements are based on various assumptions, whether or not identified in this Presentation, and on the current expectations of the Company's management and are not predictions of actual performance. These forward-looking statements are provided for illustrative purposes only and are not intended to serve as and must not be relied on as a guarantee, an assurance, a prediction, or a definitive statement of fact or probability. Actual events and circumstances are difficult or impossible to predict and may differ from assumptions. Many actual events and circumstances are beyond the control of the Company. These forward-looking statements are subject to a number of risks and uncertainties, including changes in domestic and foreign business, market, financial, political, and legal conditions; risks related to the approval of NewAmsterdam's product candidate and the timing of expected regulatory and business milestones; ability to negotiate definitive contractual arrangements with potential customers; the impact of competitive product candidates; ability to obtain sufficient supply of materials; the impact of COVID-19; global economic and political conditions, including the Russia-Ukraine conflict; the effects of competition on NewAmsterdam's future business; and those factors discussed in documents filed by the Company with the SEC. Additional risks related to NewAmsterdam's business include, but are not limited to: uncertainty regarding outcomes of the Company's ongoing clinical trials, particularly as they relate to regulatory review and potential approval for its product candidate; risks associated with the Company's efforts to commercialize a product candidate; the Company's ability to negotiate and enter into definitive agreements on favorable terms, if at all; the impact of competing product candidates on the Company's business; intellectual property-related claims; the Company's ability to attract and retain qualified personnel; and the Company's ability to continue to source the raw materials for its product candidate, together with the risks described in the Company's filings made with the U.S. Securities and Exchange Commission from time to time.

If any of these risks materialize or NewAmsterdam's assumptions prove incorrect, actual results could differ materially from the results implied by these forward-looking statements. There may be additional risks that are presently unknown by the Company or that NewAmsterdam currently believes are immaterial that could also cause actual results to differ from those contained in the forward-looking statements. In addition, forward-looking statements reflect NewAmsterdam's expectations, plans, or forecasts of future events and views as of the date of this Presentation and are qualified in their entirety by reference to the cautionary statements herein. NewAmsterdam anticipates that subsequent events and developments will cause the Company's assessments to change. These forward-looking statements should not be relied upon as representing NewAmsterdam's assessments as of any date subsequent to the date of this Presentation. Accordingly, undue reliance should not be placed upon the forward-looking statements. Neither NewAmsterdam nor any of its affiliates undertakes any obligation to update these forward-looking statements, except as required by law.

Market Data

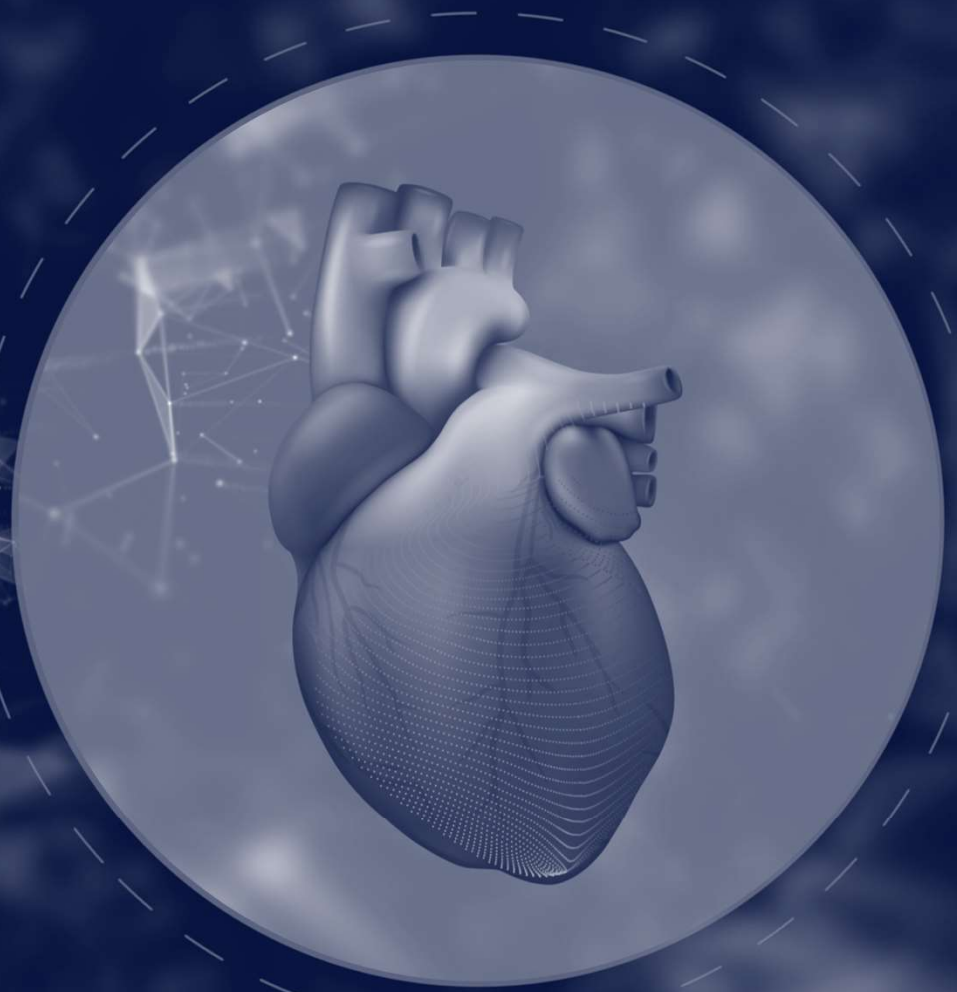
Certain information contained in this Presentation relates to or is based on third-party studies, publications, surveys and NewAmsterdam's own internal estimates and research. In addition, all of the market data included in this Presentation involves a number of assumptions and limitations, and there can be no guarantee as to the accuracy or reliability of such assumptions. Finally, while NewAmsterdam believes its internal research is reliable, such research has not been verified by any independent source and NewAmsterdam cannot guarantee and makes no representation or warranty, express or implied, as to its accuracy and completeness.

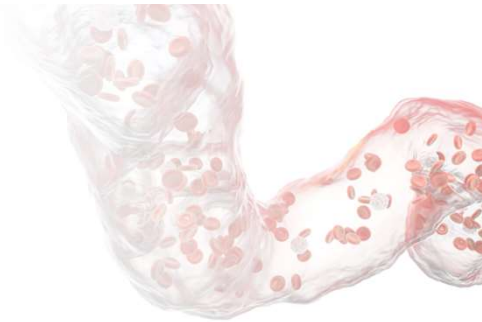
Trademarks

This Presentation contains trademarks, service marks, trade names, and copyrights of NewAmsterdam and other companies, which are the property of their respective owners. The use or display of third parties' trademarks, service marks, trade name or products in this Presentation is not intended to, and does not imply, a relationship with NewAmsterdam or an endorsement or sponsorship by or of NewAmsterdam. Solely for convenience, the trademarks, service marks and trade names referred to in this Presentation may appear with the TM or SM symbols, but such references are not intended to indicate, in any way, that NewAmsterdam will not assert, to the fullest extent permitted under applicable law, their rights or the right of the applicable licensor to these trademarks, service marks and trade names.

NewAmsterdam Pharma

Summary of clinical data





rose 2

The combination of Obicetrapib and Ezetimibe observed to lower LDL-C in Patients on High Intensity Statins: Results from the ROSE2 Trial (NCT05266586).

Christie M Ballantyne, Stephen J Nicholls, Marc Ditmarsch, John J Kastelein, Douglas Kling, Danielle L Curcio, Michael H Davidson

NewAmsterdam Pharma

ROSE2 trial: Obicetrapib and high intensity statin therapy

Objective **To evaluate the effect of obicetrapib 10 mg in combination with ezetimibe 10 mg on top of HIS on LDL-C**

Inclusion criteria

- A stable dose of High Intensity Statins (A 40 / 80; R 20 / 40) 8 weeks prior to screening
- Fasting LDL-C levels >70 mg/dL (1.8 mmol/L)

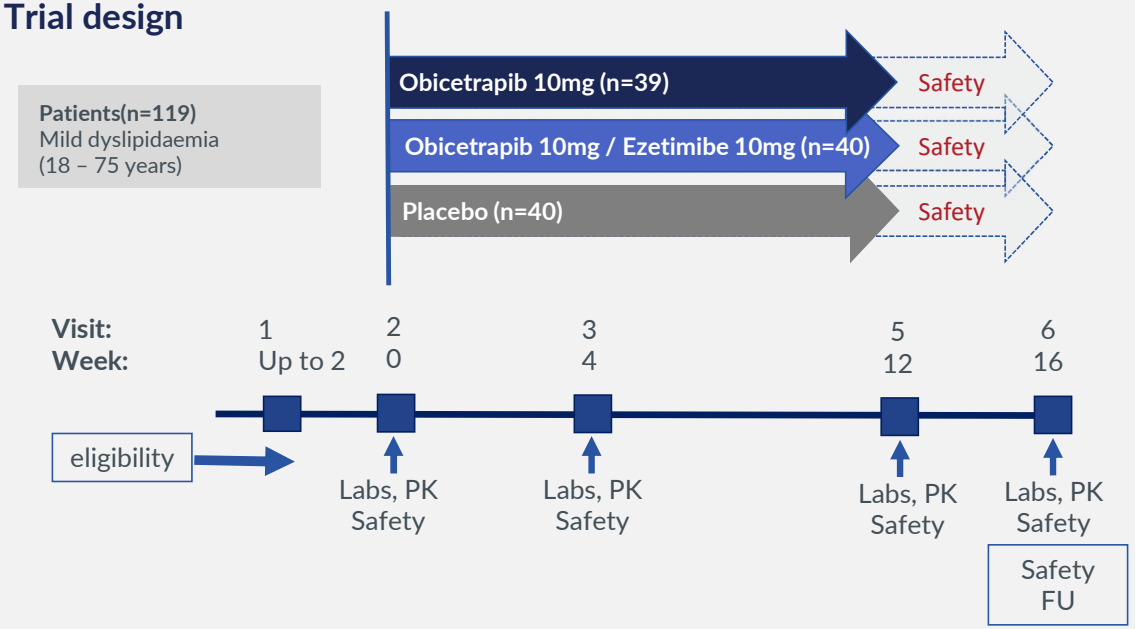
Exclusion criteria

- Current significant CV disease
- HbA1c ≥10%
- Uncontrolled hypertension

Primary efficacy endpoint

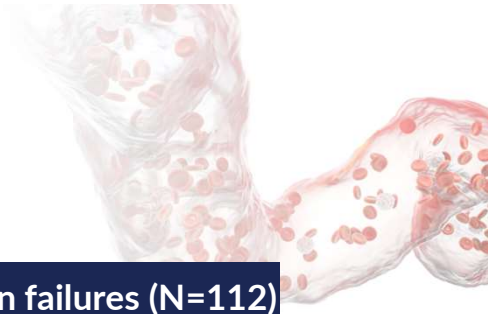
- Percent change from baseline in LDL-C compared to the placebo group

Trial design



Source: Ballantyne CM, et al. J. of Clinical Lipidology 2023 (to be published June 3, 2023)

Patient disposition



	Screened (N=231)			
				Screen failures (N=112)
Randomized (N=119)	N=40	N=39	N=40	N=119
Discontinued treatment (N=9)	N=4	N=3	N=2	N=9
Primary efficacy assessment (on-treatment) (N=97)	N=40	N=26	N=31	N=97
Safety population (N=119)	N=40	N=39	N=40	N=119
	Placebo	Obicetrapib 10mg	Obicetrapib 10 mg / Ezetimibe 10mg	Total

Source: Ballantyne CM, et al. J. of Clinical Lipidology 2023 (to be published June 3, 2023)

Baseline characteristics

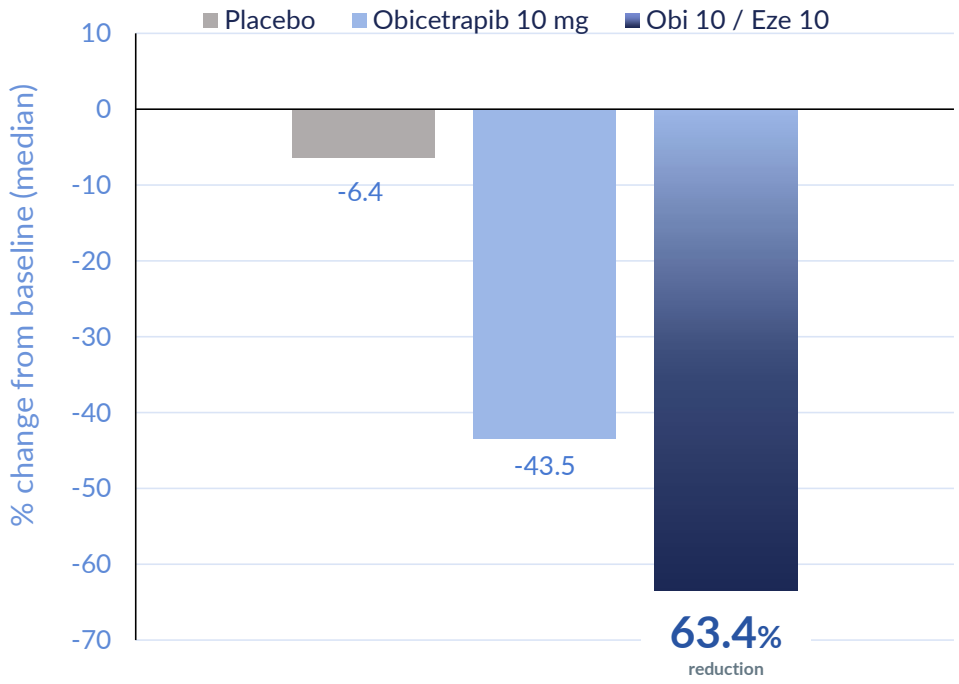
		Placebo N=40 (%)	Obicetrapib 10 mg N=26 (%)	Obicetrapib 10mg / Ezetimibe 10 mg N=31 (%)
	Mean Age (yrs)	60.6	64.8	63.5
	Female %	35	34.6	38.7
	Mean BMI (kg/m^2)	30.8	29.9	31.8
Race %	White	75	88.5	93.5
	Black / African American	22.5	11.5	6.5
Statin use (%)	Atorvastatin 40/80 mg	75	69.2	80.6
	Rosuvastatin 20/40 mg	25	30.8	19.4
Baseline level (Median)	LDL-C (mg/dL)	95.5	100	87
	HDL-C (mg/dL)	42.5	47	46

NewAmsterdam Pharma

Source: Ballantyne CM, et al. J. of Clinical Lipidology 2023 (to be published June 3, 2023)

Obicetrapib/ezetimibe observed to lower LDL-C by 63.4% on top of HIS in ROSE2

LDL-C (mg/dL), on-treatment population



Median (min, max) LDL-C levels (mg/dL) at baseline & EoT

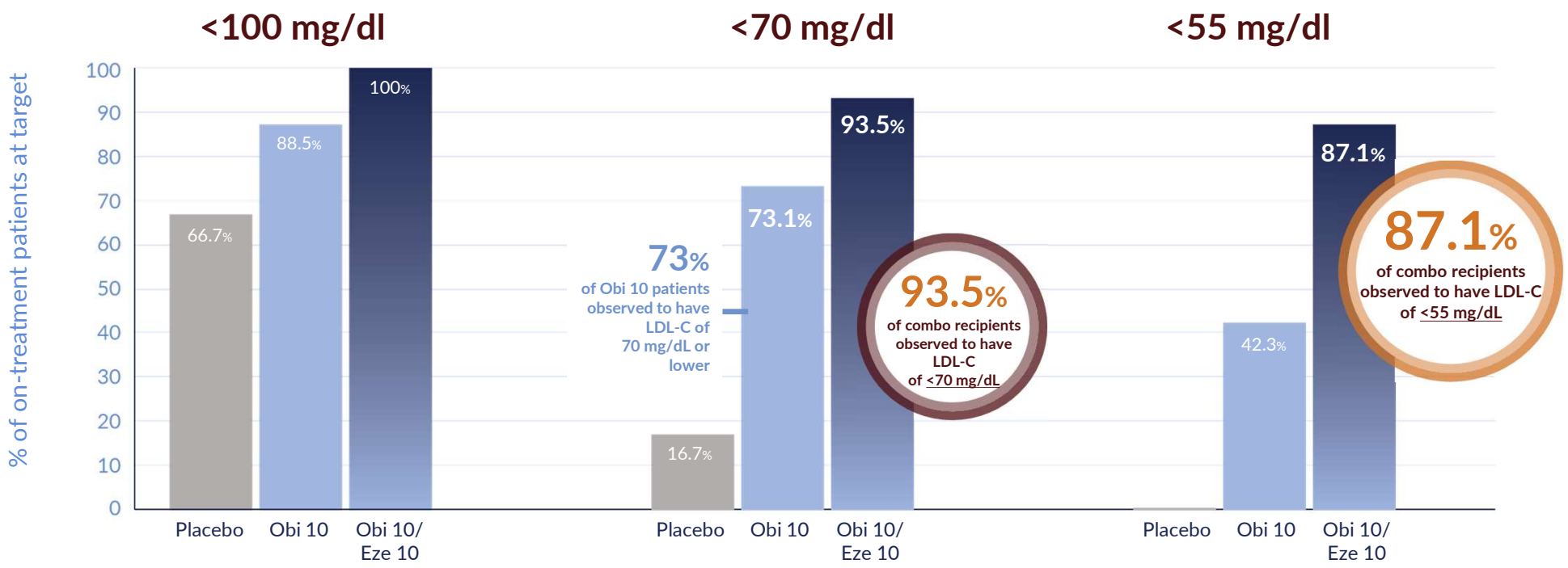
Time	Placebo	Obi 10 mg	Obi 10 / Eze 10
Baseline Median	95.5 (60, 211) (N=40)	100.0 (35, 189) (N=26)	87.0 (62, 152) (N=31)
EoT Median	88.0 (55, 188) (N=36)	55.5 (21, 148) (N=26)	39.0 (15, 96) (N=31)
% Change from Baseline (median)	-6.4 (-36.4, 96.7) (N=36)	-43.5 (-78.4, 22.6) (N=26)	-63.4 (-83.7, -29.7) (N=31)
% Change from Baseline LS mean (95% CI)	-0.85 (-7.75, 6.05)	-39.20 (-47.41, -30.99)	-59.23 (-66.75, -51.71)
P-value	-	**<0.0001**	**<0.0001**

NewAmsterdam Pharma

Source: Ballantyne CM, et al. J. of Clinical Lipidology 2023 (to be published June 3, 2023)

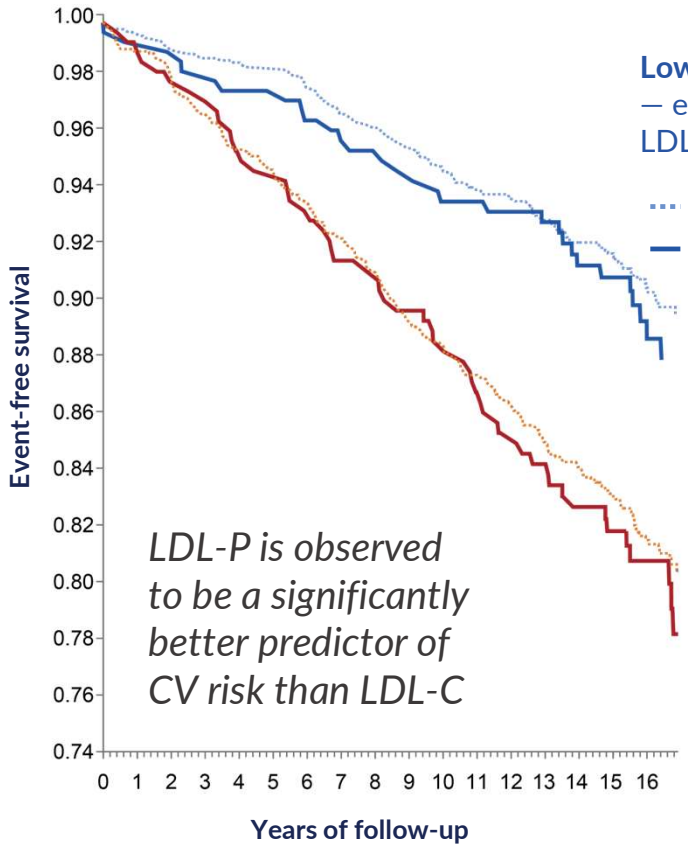
Positive LDL goal attainment observed with ezetimibe + obicetrapib combination, including >87% of patients observed to attain <55 mg/dl LDL-C levels

% of patients observed with the following LDL-C levels:



Source: Ballantyne CM, et al. J. of Clinical Lipidology 2023 (to be published June 3, 2023)

LDL-P believed to be one of the most robust predictors of cardiovascular risk



Low LDL-P confers a lower risk — even in patients with high LDL-C

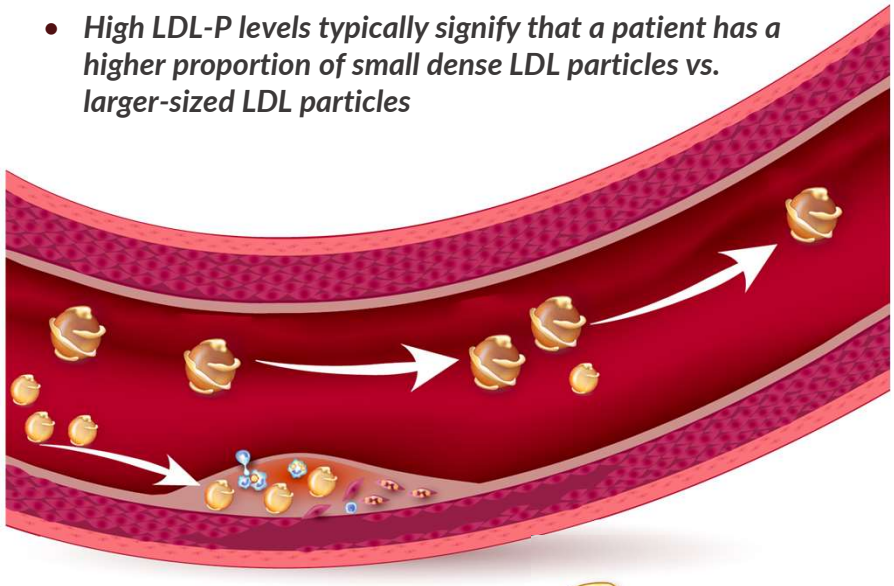
- Low LDL-P, Low LDL-C (n = 1,249)
- Low LDL-P, High LDL-C (n = 284)

High LDL-P confers a higher risk — even in patients with low LDL-C

- High LDL-P, High LDL-C (n = 1,251)
- High LDL-P, Low LDL-C (n = 282)

LDL-P is observed to be a significantly better predictor of CV risk than LDL-C

- ***Small dense LDL particles are more likely to be trapped in arterial wall than larger-sized LDL particles***
- ***High LDL-P levels typically signify that a patient has a higher proportion of small dense LDL particles vs. larger-sized LDL particles***



Even though all LDL particles contain only one ApoB protein, small dense LDL particles have a less massive ApoB protein

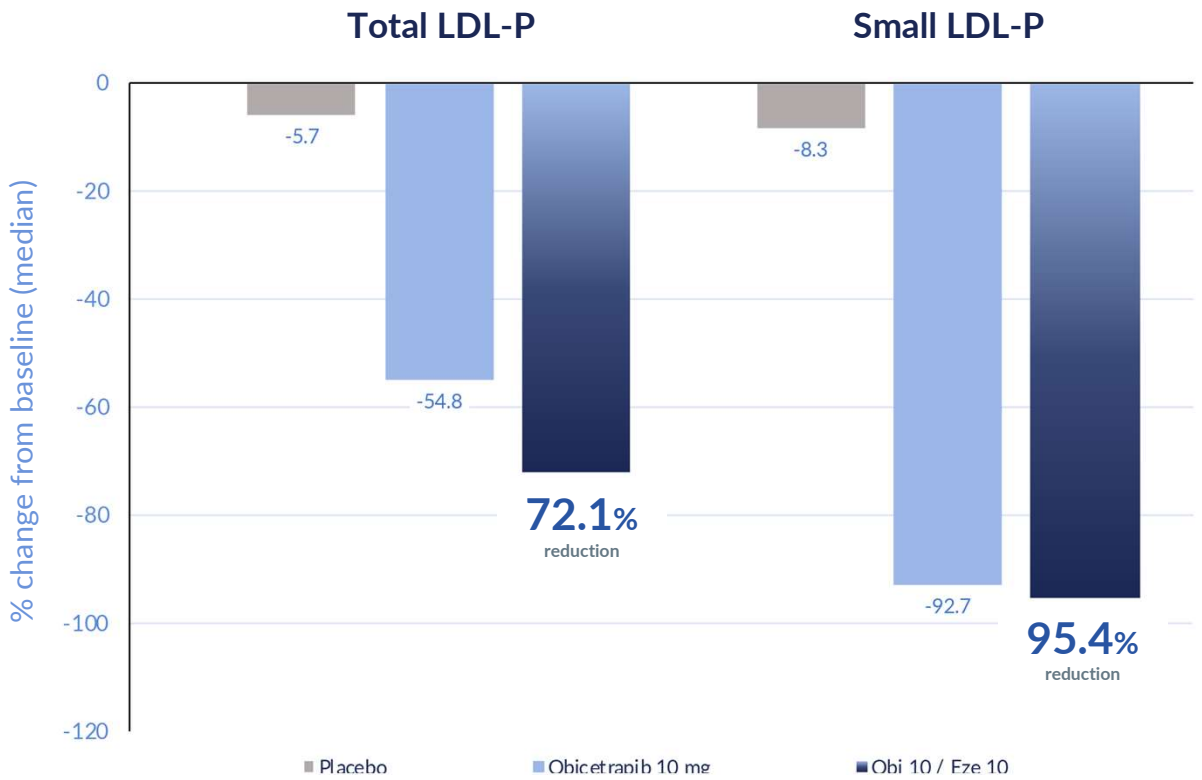
= Larger-sized LDL

= Small dense LDL

NewAmsterdam Pharma

Source: Cromwell WC, et al. Clin Lipidol. 2007 December 1; 1(6): 583–592

ROSE2 showed significant reduction in total and small LDL particles, bringing patients who had baseline elevated LDL-P to optimal parameters[1]



Patients taking the Obi/Eze combo observed to achieve optimal LDL-P profiles

Lipoprotein fractionation 1	ROSE2 placebo	ROSE2 Obi / Obi + Eze
LDL-P (nmol/L)	1012.8	495 / 300
Small LDL-P (nmol/L)	717.5	73.4 / 47.5
LDL size (nm)	20.26	21.0 / 21.0

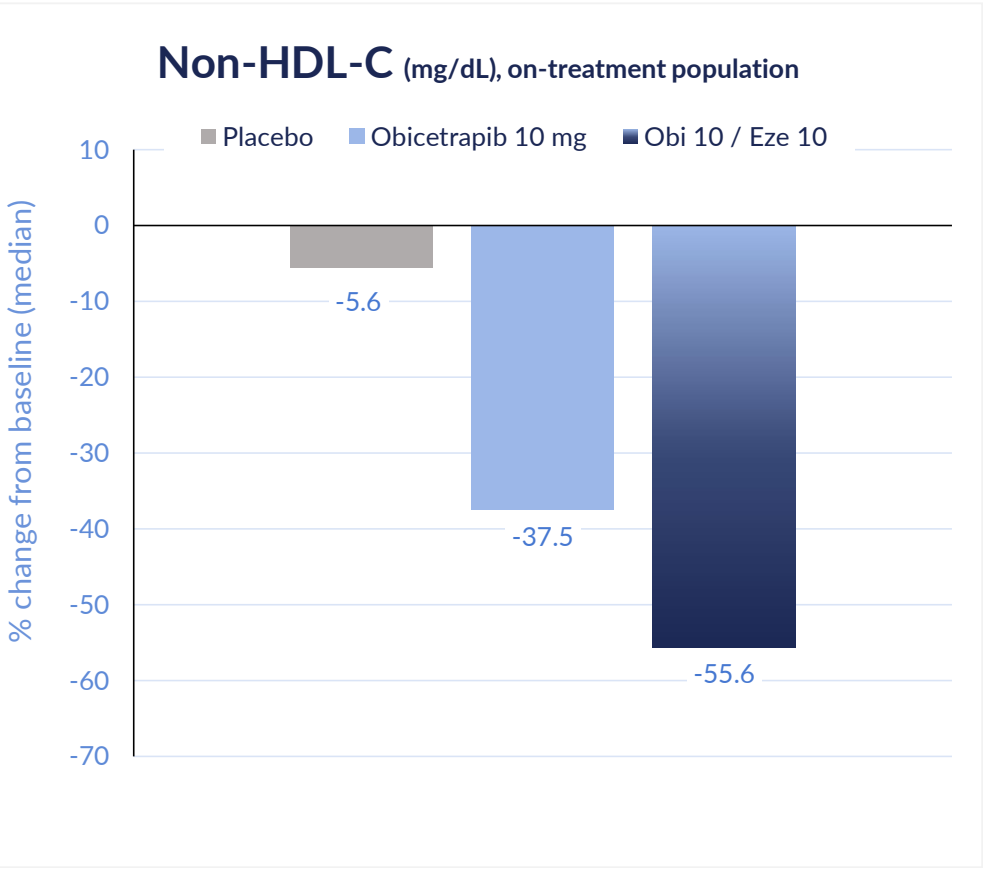
Key[2]

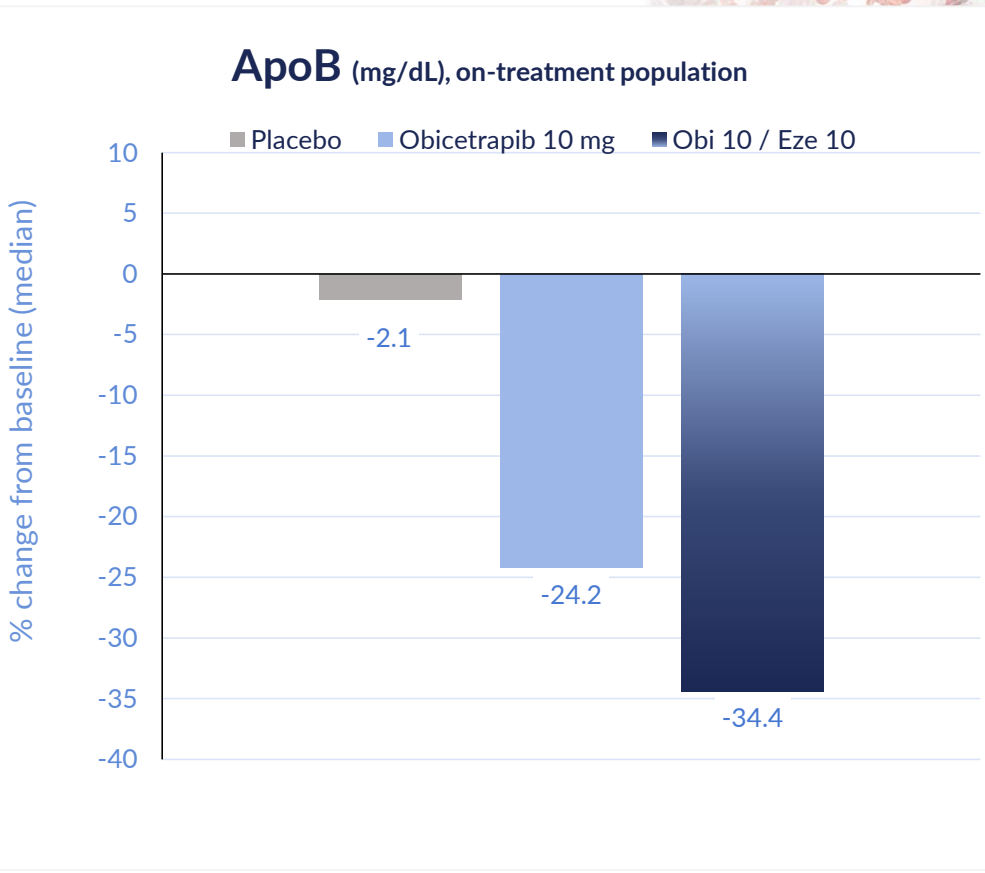
	High	Moderate	Optimal
LDL-P (nmol/L)	>1816	935-1816	<935
Small LDL-P (nmol/L)	>820	467-820	<467
LDL size (nm)	≤20.5	N/A	>20.5

NewAmsterdam Pharma

Sources: 1. Ballantyne CM, et al. J. of Clinical Lipidology 2023 (to be published June 3, 2023), 2. LipoFraction NMR practitioner Guidelines

ROSE2: Non-HDL-C and ApoB percent change from baseline (Day 84)





NewAmsterdam Pharma

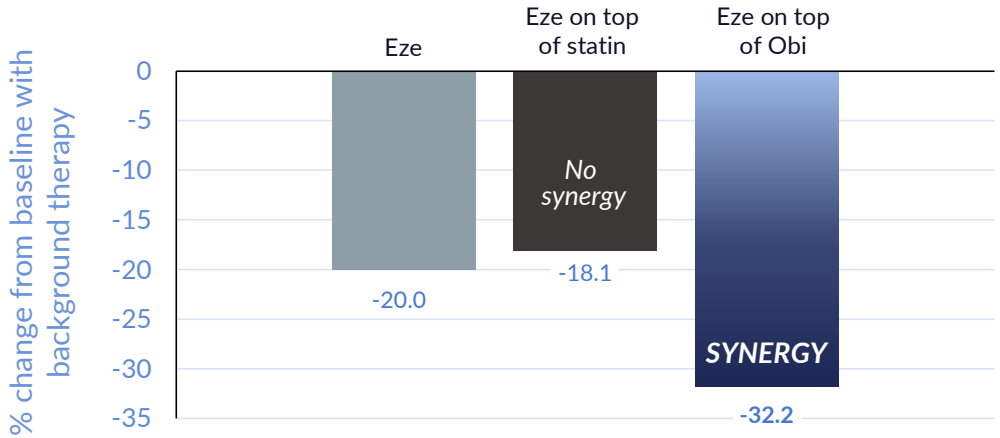
Source: Ballantyne CM, et al. J. of Clinical Lipidology 2023 (to be published June 3, 2023)

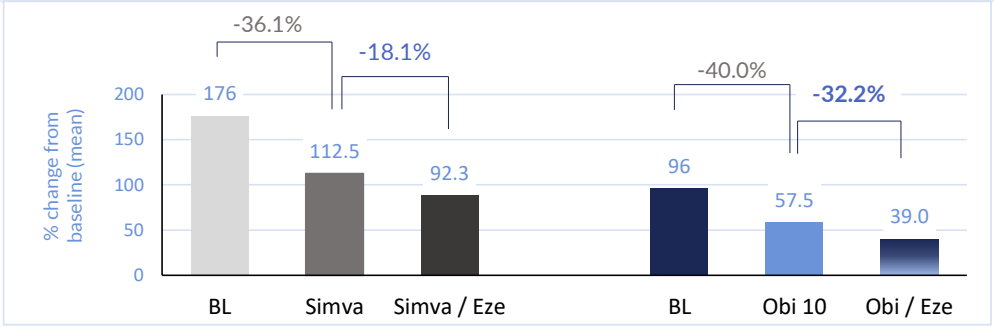
ROSE2 Safety: TEAEs, TESAEs, and withdrawal overview (safety population)

	Placebo N= 40, N (%)	Obicetrapib 10 mg N= 39, N (%)	Obi 10 mg / Eze 10 mg N= 40, N (%)
TEAEs (%)			
TEAEs	16 (40)	8 (20.5)	11 (27.5)
Related TEAEs	2 (5.0)	4 (10.3)	5 (12.5)
Severe TEAEs	2 (5.0)	1 (2.6)(1)	0 (0)
TESAEs			
TESAEs, total	1 (2.5)	1 (2.6) (1)	0 (0)
Deaths	0	0	0
Withdrawal's study / medication			
TEAEs leading to discontinuation of study drug	2 (5.0)	2 (5.1) (1)	1 (2.5) (1)

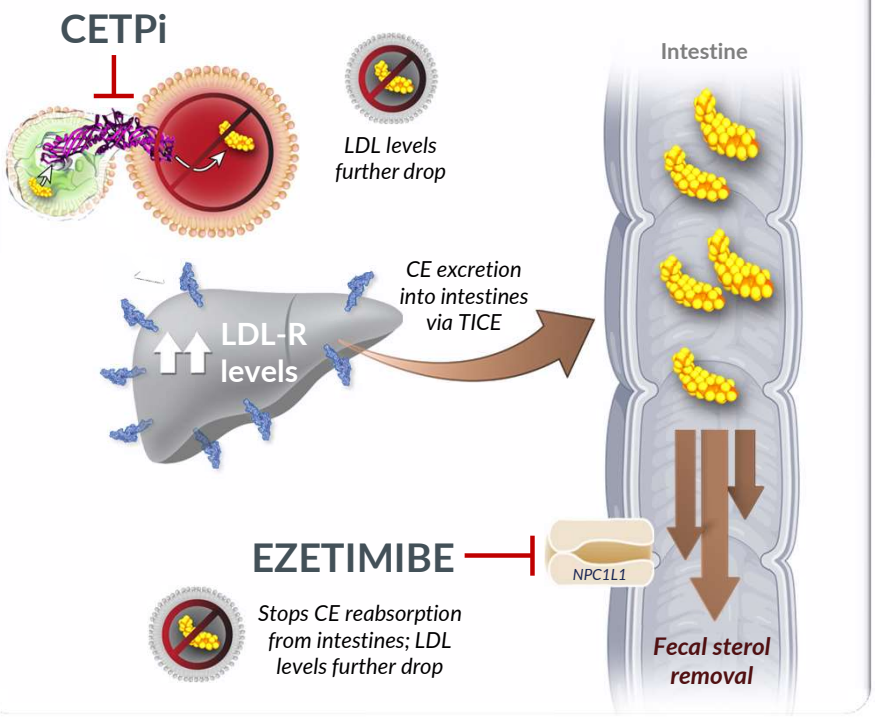
Source: Ballantyne CM, et al. J. of Clinical Lipidology 2023 (to be published June 3, 2023)
(1) The severe TEAE and the TESAEs experienced in the 10 mg group was a cardiac disorder. TEAEs leading to discontinuation of the study drug included abdominal pain, tachycardia and nervous system disorders.

Stronger LDL-lowering observed with ezetimibe in obicetrapib combo vs. ezetimibe with statins, potentially due to a synergistic mechanism of action for obi/eze combo[1]





Obicetrapib is designed to promote more cholesterol excretion into the intestines (via TICE) while ezetimibe is designed to block cholesterol reabsorption into the body, synergistically enhancing fecal sterol removal of cholesterol

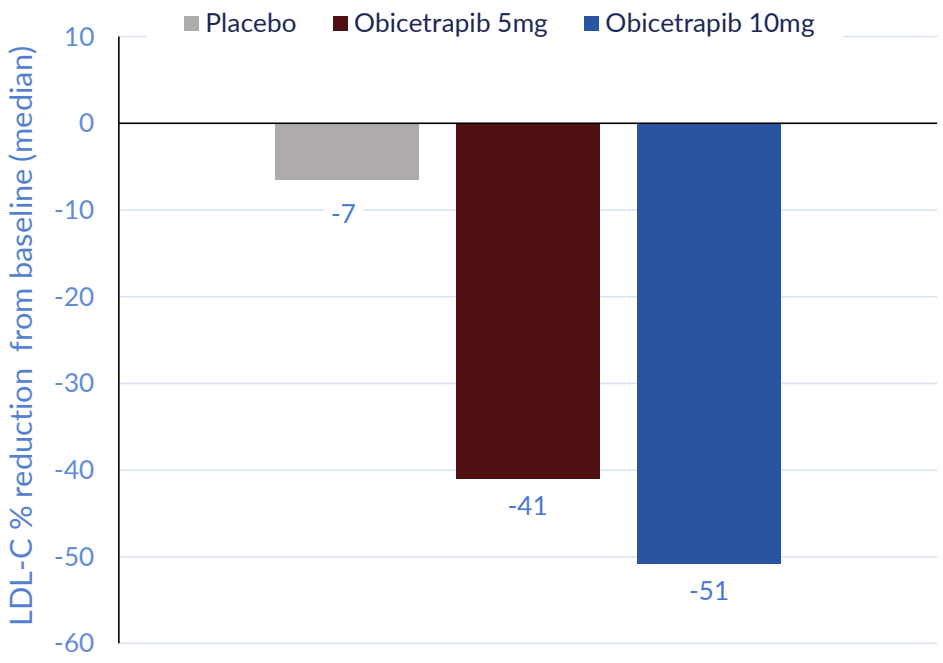


NewAmsterdam Pharma

Source: Ballantyne CM, et al. J. of Clinical Lipidology 2023 (to be published June 3, 2023)
Note: The calculations included in the graphs here represent the Company's hypothetical calculation assuming one patient was treated with each drug independently.

In ROSE Phase 2b clinical trial, obicetrapib demonstrated robust LDL-C lowering as adjunct to high intensity statins[1]

Preparative ultra-centrifugation (PUC) is "gold-standard" for LDL-C quantification



Median (min, max) LDL-C levels (mg/dL) at baseline and EoT

Time	Placebo	Obicetrapib 5mg	Obicetrapib 10mg
Baseline Median	90.0 (63, 204) N=40	95.0 (54, 236) N=39	88.0 (39, 207) N=40
EoT Median	86.0 (43, 137) N=39	53.0 (13, 126) N=39	49.5 (23, 83) N=40
% Change from Baseline (median)	-6.5 (-53.9, 31.6) N=39	-41.45 (-71.2, 62.3) N=38*	-50.75 (-76.9, 15.6) N=40
% Change from Baseline LS mean (95% CI)	-6.7 (-13.17, -0.24)	-35.65 (-42.19, -29.10)	-46.77 (-53.16, -40.38)
p-value compared to placebo	-	**<0.0001**	**<0.0001**

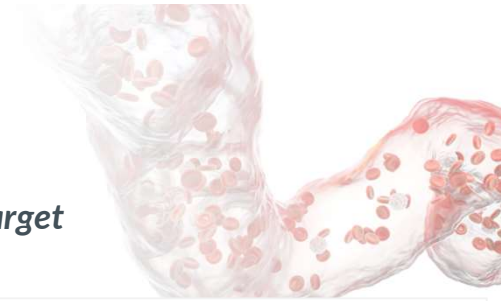
NewAmsterdam Pharma

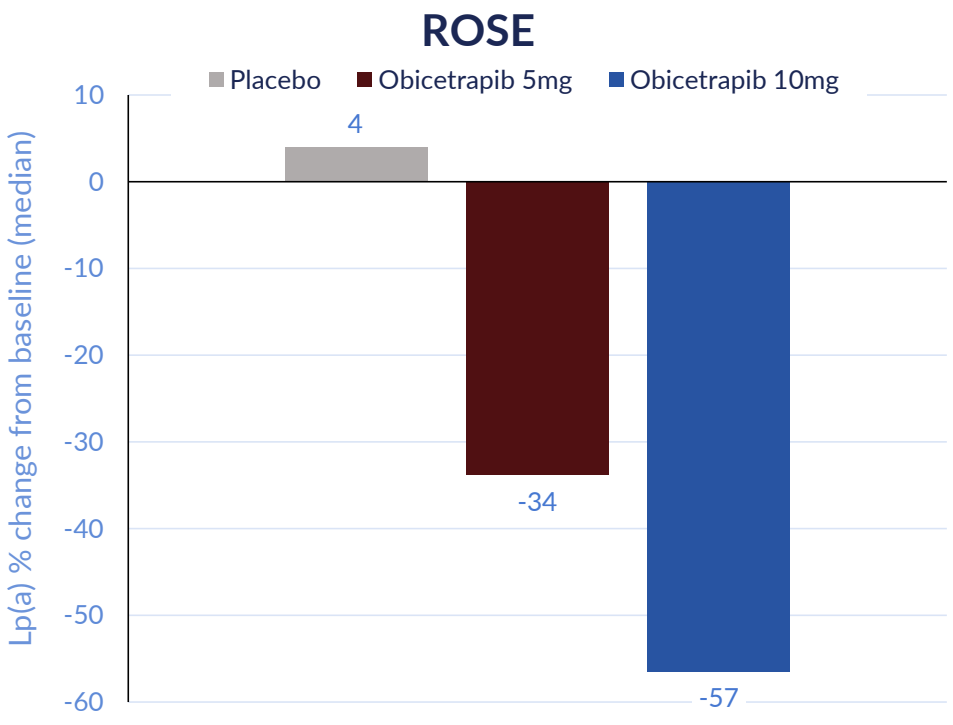
* In obicetrapib 5mg arm, 40 patients were randomized. N-value at end-of-treatment decreased to 38 because one patient was missing an LDL value at baseline and a second patient was missing an LDL value at end-of-treatment reading.

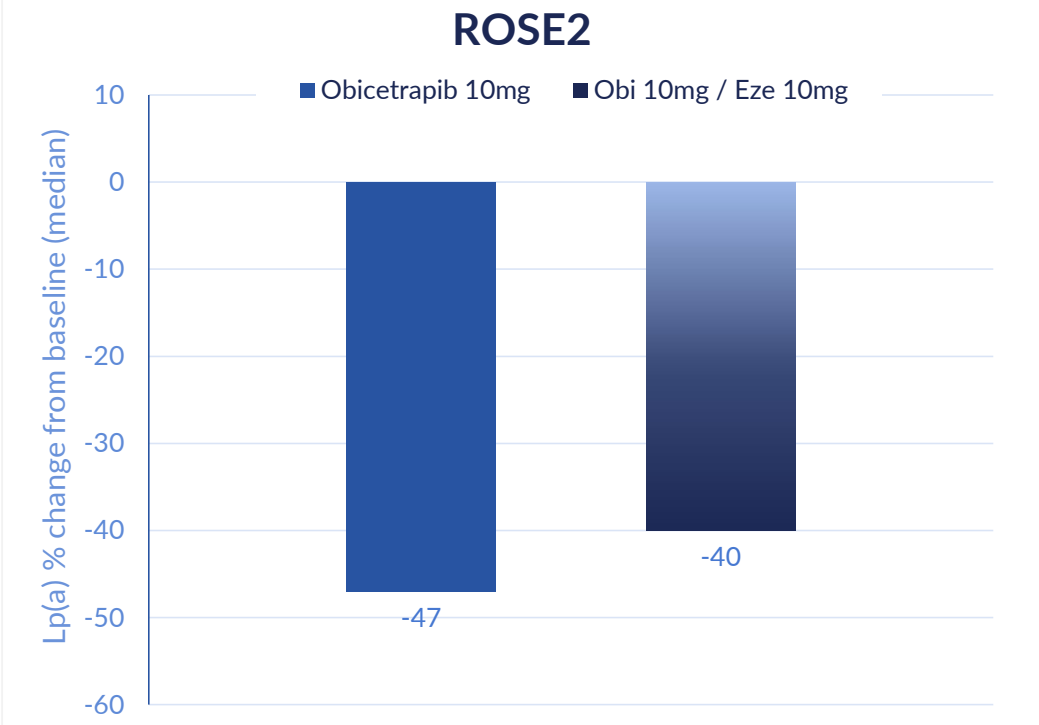
Source: 1. Nicholls SJ, et al. Nat Med 2022;28:1672-1678.

Lp(a) percent reduction from baseline in ROSE[1] and ROSE2[2]

- *Lp(a) is emerging as a strong and independent marker of CVD risk and an exciting new CVD drug target*



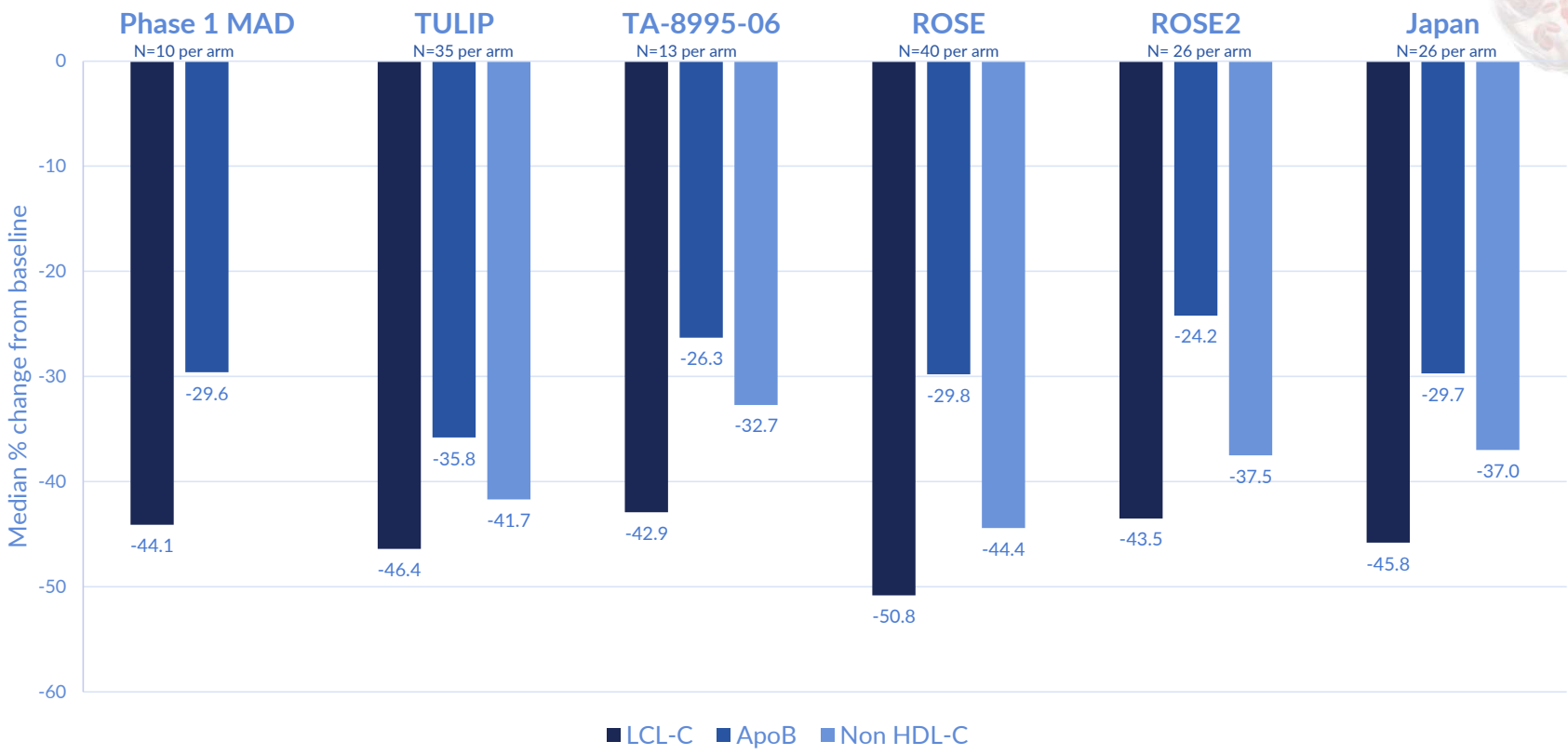




NewAmsterdam Pharma

Source: 1. Nicholls SJ, et al. Nat Med 2022;28:1672-1678. 2. Ballantyne CM, et al. J. of Clinical Lipidology 2023 (to be published June 3, 2023)

Changes in lipid biomarkers for obicetrapib 10mg monotherapy across phase 1/2 studies



Obicetrapib safety profile in ROSE and across multiple studies: overview of AEs, SAEs and withdrawals

Well tolerated safety profile; Similar rates of drug discontinuation were observed for obicetrapib and placebo

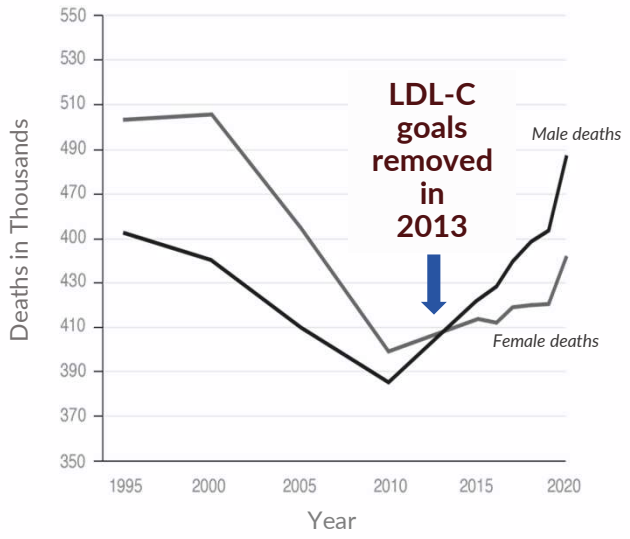
ROSE Safety	Placebo (N=40)	Obicetrapib, 5mg (N=40)	Obicetrapib, 10mg (N=40)
TEAEs (%)			
TEAEs, total	19 (47.5)	15 (37.5)	8 (20.0)
TEAEs, related	4 (10.0)	2 (5.0)	1 (2.5)
TEAEs, severe	1 (2.5)	0	0
TESAEs			
TESAEs, total	2 (5.0)	0	0
TESAEs, related	0	0	0
Deaths	0	0	0
Withdrawals study / medication			
TEAEs leading to discontinuation of study drug	1 (2.5)	0	0

Pooled Safety	Comparator[1] (N=231)	Obicetrapib Pooled 5mg + 10mg[2] (N=309)
TEAEs (%)		
TEAEs, total	136 (58.9)	173 (55.9)
TEAEs, related	45 (19.5)	49 (15.8)
TEAEs, severe	5 (2.2)	7 (2.3)
TESAEs		
*TESAEs, total	6 (2.6)	4 (1.3)
TESAEs, related	0	0
Deaths	0	0
Withdrawals study / medication		
TEAEs leading to discontinuation of study drug	13 (5.6)	13 (4.2)

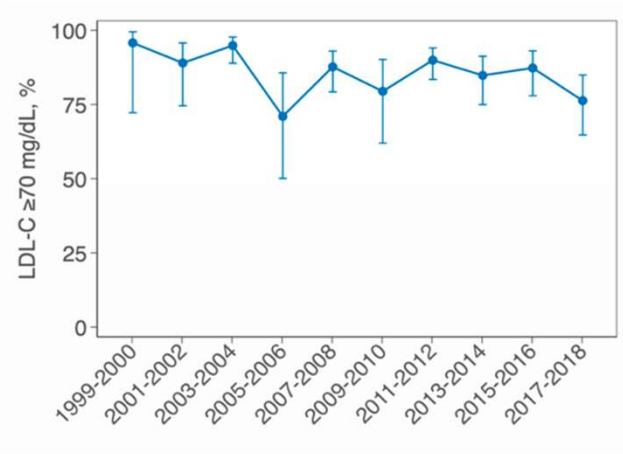
NewAmsterdam Pharma

* There were three additional TESAEs in other obicetrapib dose arms: two in the TULIP 2.5mg arm, and one in the Lp(a) 2.5mg arm; none were considered to be related to study drug.
(1) The Comparator group included patients receiving placebo and non-obicetrapib monotherapy.
(2) The pooled obicetrapib group includes patients treated with obicetrapib as a monotherapy and in combination with atorvastatin, rosuvastatin and ezetimibe.

Despite availability of statins, tremendous unmet need remains – with resurgance of the "lower-is better" paradigm

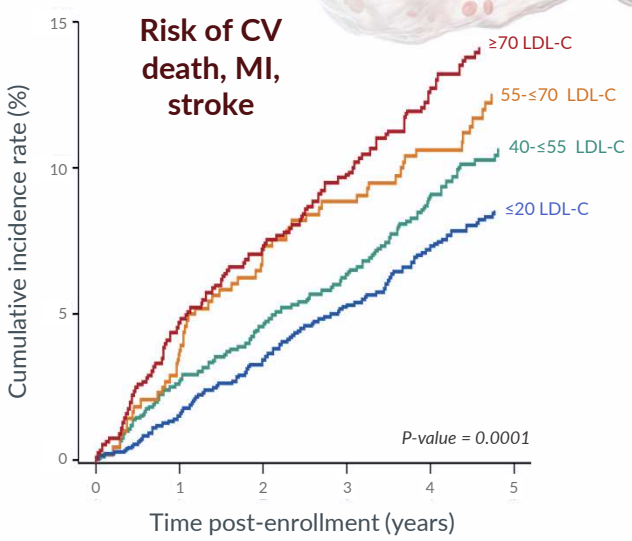


Despite statins, **CVD deaths are on the rise**



Trends in prevalence of high LDL-C in US adults, NHANES 1999-2018 with history of ASCVD[2]

~75% of ASCVD patients are NOT at their **risk-based LDL-C goal**



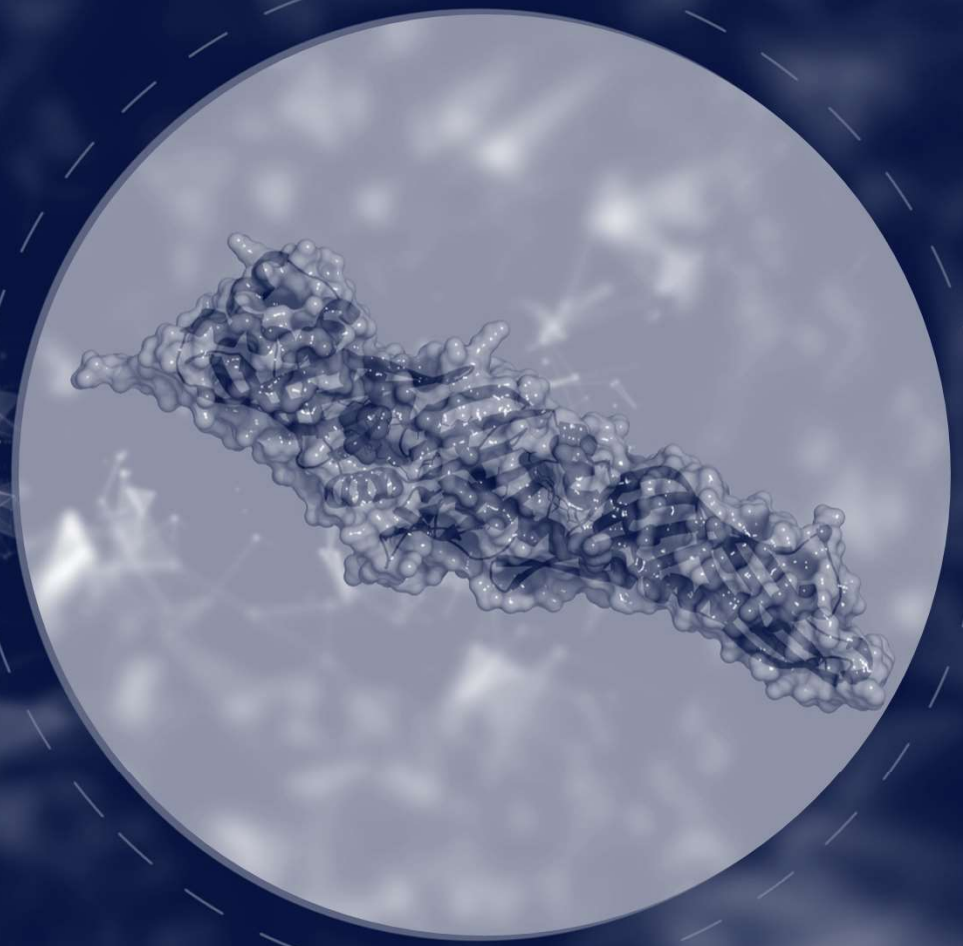
Numerous studies demonstrate resurgence of paradigm **"lower is better"**

Sources: Trinity NewAmsterdam Market Research Summary; Trinity quantitative market research with N = 100 PCPs and Cardiologists; Bloomberg Prescription Data; IQVIA Rx Tracker. (1) Literature review suggesting hypercholesterolemia prevalence of ~94mm in the US (average of He et al. 2020, Mercado et al. 2015, Muntner et al. 2013) and ~137mm in EU5 (average of Gomez-Huelgas et al. 2010, Guallar-Castillon et al. 2012, Tragni et al. 2012, Grau et al. 2011 (3) 8mm statin-intolerant & 22mm above LDL-C target: Percentage of patients in each category estimated from Trinity quantitative market research and the – percentages were then applied to the estimated 84mm treated number above. (4) <1mm branded patients: 2020 US prescription data for Repatha, Praluent, and Nexletol/Nexlizet were pulled from the Bloomberg Prescription Data Portal that Trinity subscribes to; assuming 12 scripts/year and 70% compliance for PCSK9s (based on PCSK9 literature) and 59% compliance for Nex/Nex (based on statin literature) patient volume estimates were derived from the prescription data and extrapolated to the EU5. (5) Gaba P, et. al., Association Between Achieved Low-Density Lipoprotein Cholesterol Levels and Long-Term Cardiovascular and Safety Outcomes: An Analysis of FOURIER-OLE. Circulation. 2023 Feb 13. doi: 10.1161/CIRCULATIONAHA.122.063399.

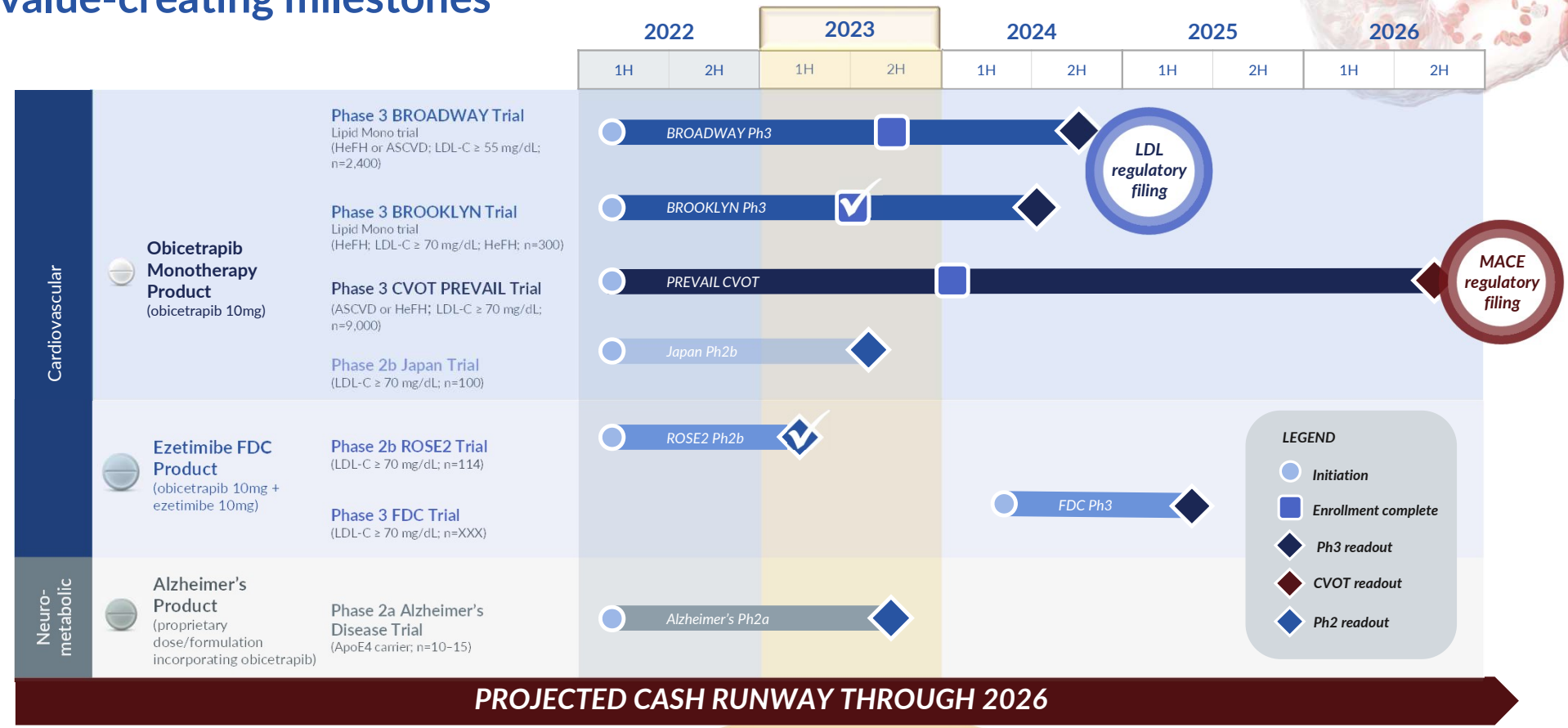
NewAmsterdam Pharma

NewAmsterdam Pharma

Clinical development



Current cash expected to fund obicetrapib development through several value-creating milestones



PROJECTED CASH RUNWAY THROUGH 2026

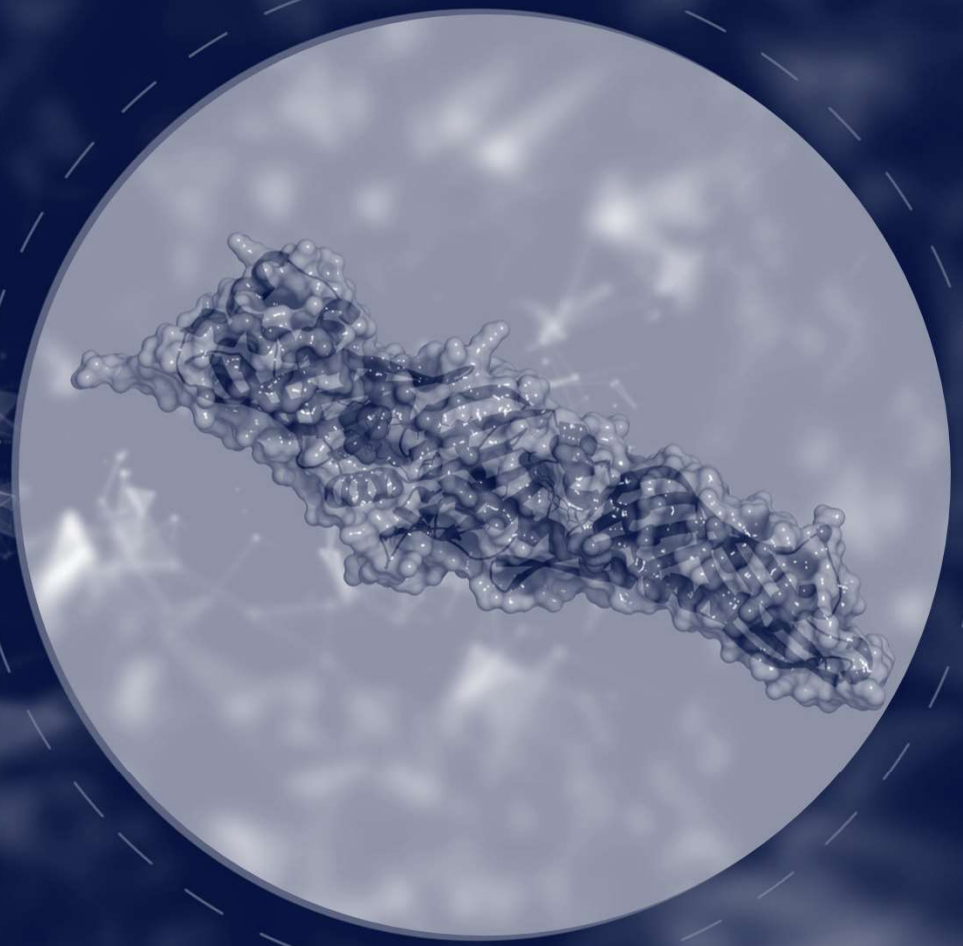
Numerous catalysts expected throughout 2023

NewAmsterdam Pharma

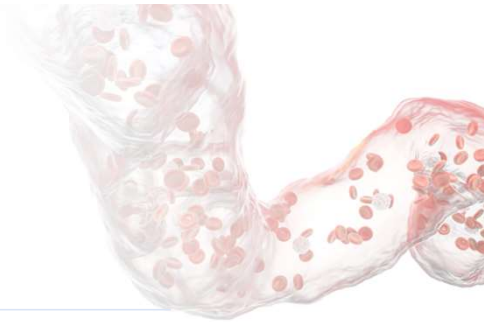
Note: Other than as noted, the pipeline represents trials that are currently ongoing. Projections are subject to inherent limitations. Actual results may differ from expectations. The timing of regulatory submissions is subject to additional discussions with regulators.

NewAmsterdam Pharma

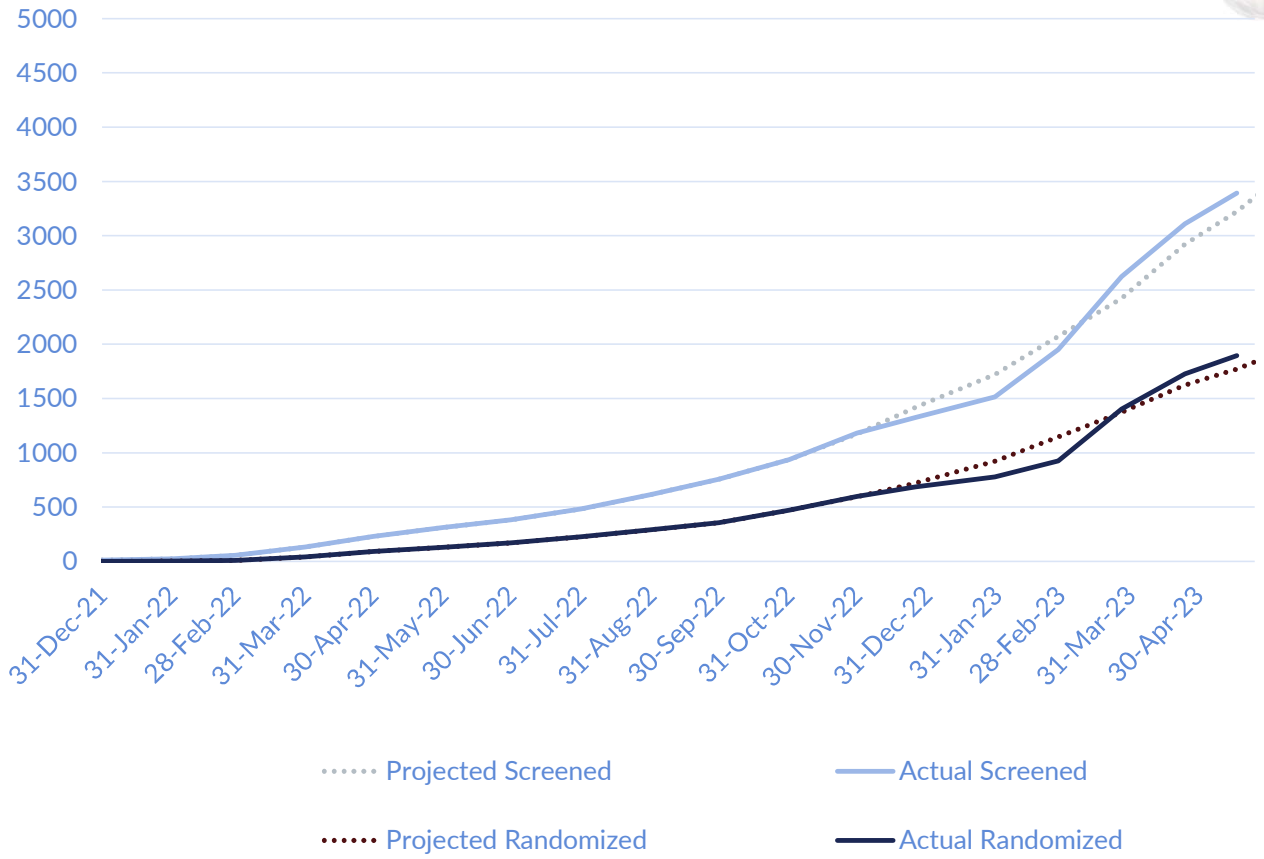
Clinical Trial Progress Update



BROADWAY enrollment on schedule to finish mid-2023



- ASCVD or HeFH with LDL ≥ 55 mg/dL; n=2400
- Randomization 2:1; obicetrapib 10 mg:placebo
- Primary endpoint: LDL-C
- Baseline LDL-C = 102 mg/dL; Woman: 35%; Average age: 65 years

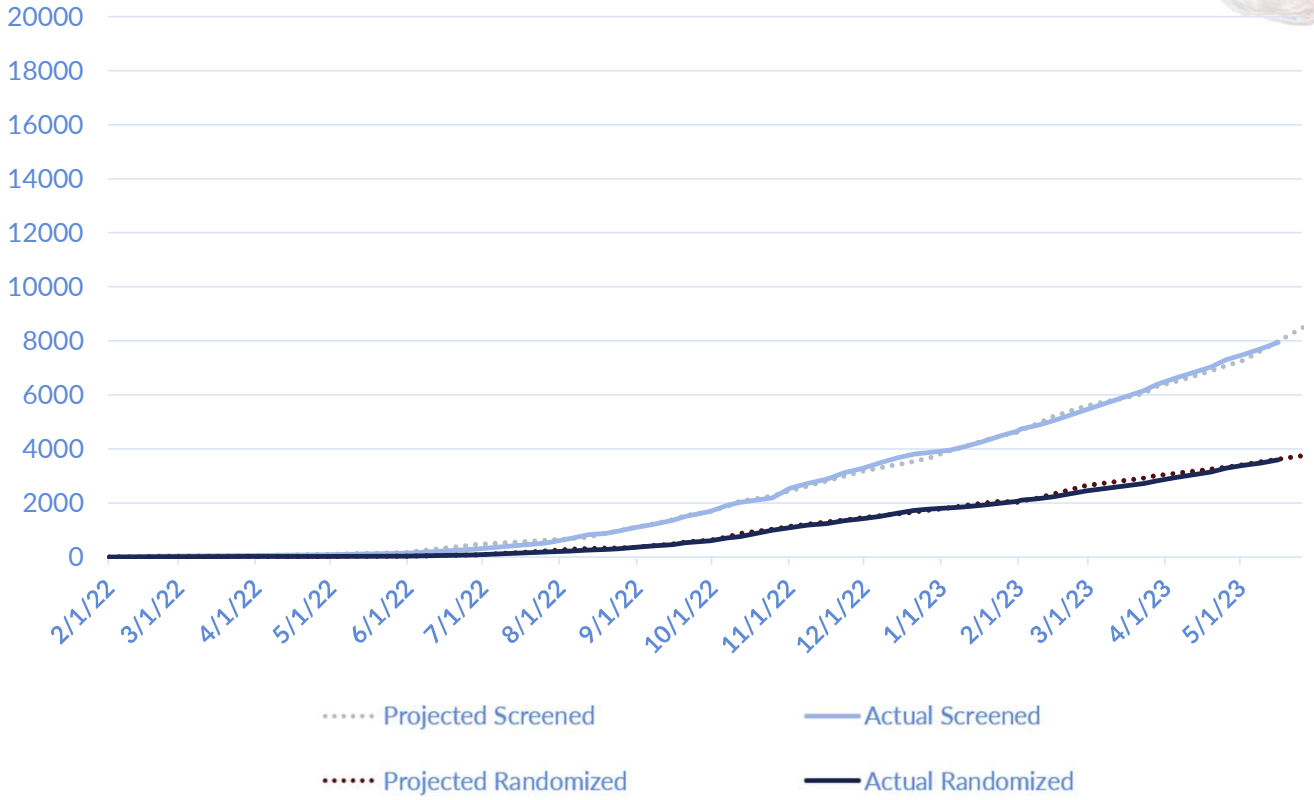


NewAmsterdam Pharma

Data as of May 25, 2023

PREVAIL enrollment currently on schedule to complete 1Q 2024

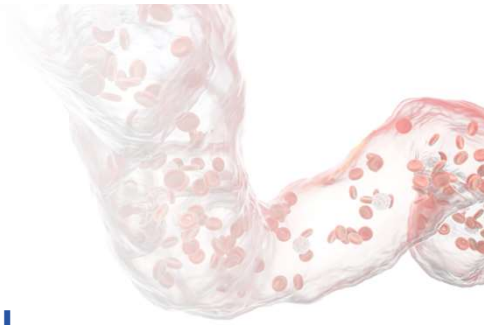
- ASCVD with LDL ≥ 70 mg/dL; n=9000
- Randomization: 1:1; Obi 10 mg vs placebo
- Primary endpoint: MACE-4
- Baseline LDL: 110 mg/dL; Women: 31%; Average age: 65 years



NewAmsterdam Pharma

Data as of May 25, 2023

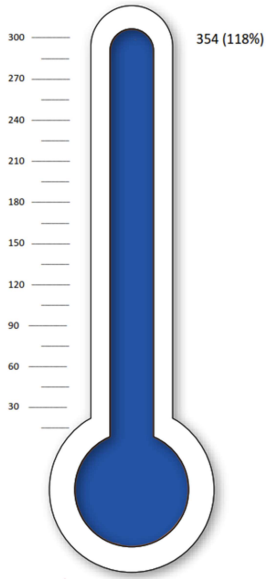
Update on phase 3 trial enrollment



BROOKLYN

HeFH with LDL ≥ 70 mg/dL
N=300

Randomization: 2:1
Obi 10 mg vs placebo
Primary Endpoint: LDL-C
Baseline mean LDL: 122 mg/dL
Women: 53%
Average Age: 57 years

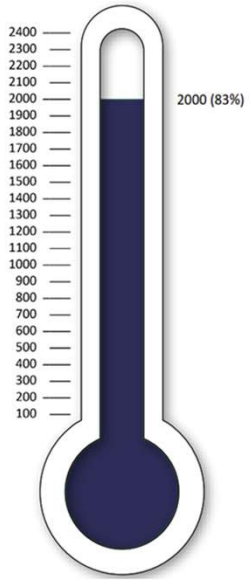


Enrollment completion: ~~July~~ April 2023

BROADWAY

ASCVD or HeFH with LDL ≥ 55 mg/dL
N=2400

Randomization: 2:1
Obi 10 mg vs placebo
Primary Endpoint: LDL-C
Baseline mean LDL: 102 mg/dL
Women: 35%
Average Age: 65 years

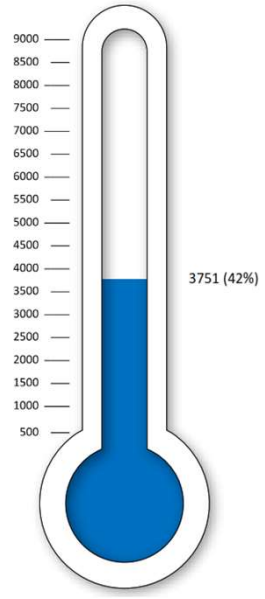


Mid-2023
expected

PREVAIL

ASCVD with LDL ≥ 70 mg/dL
N=9000

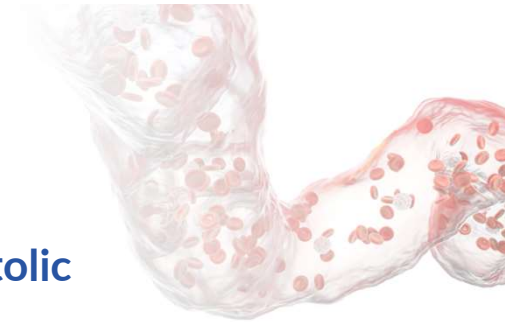
Randomization: 1:1
Obi 10 mg vs placebo
Primary Endpoint: MACE-4
Baseline mean LDL: 110 mg/dL
Women: 31%
Average Age: 65 years



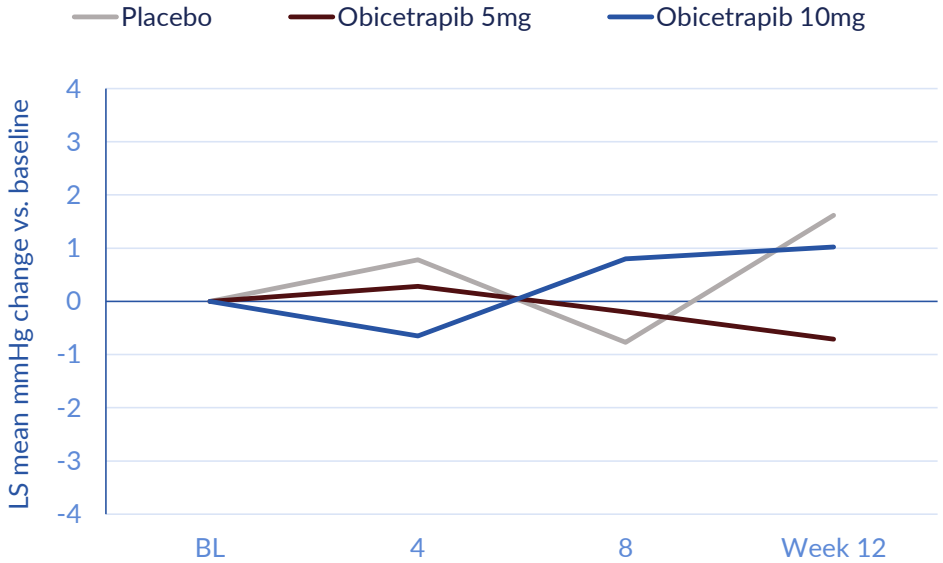
1Q 2024
expected

NewAmsterdam Pharma

Pooled phase 2 trial blood pressure data



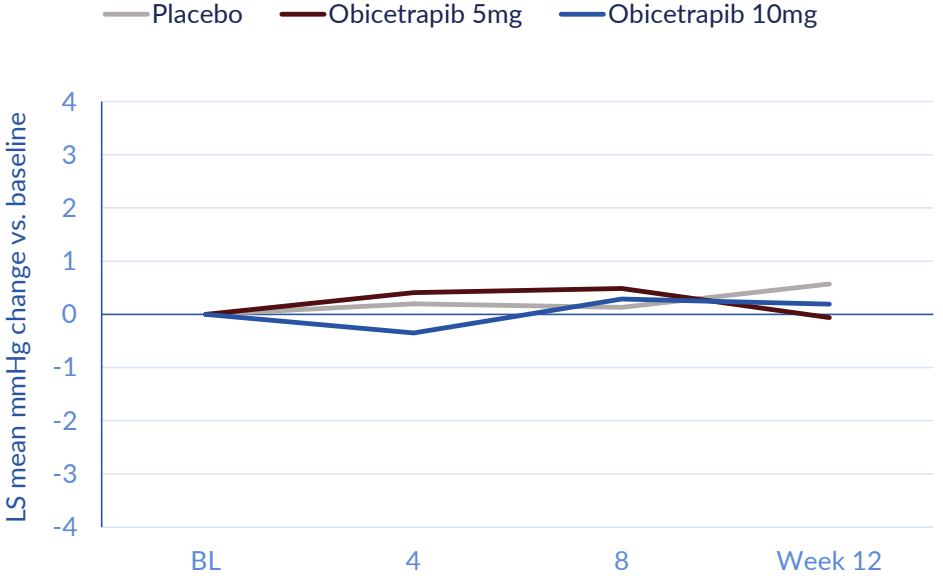
Systolic



	BL	4	8	Week 12
Placebo (N)	229	222	180	157
Obi 5 mg (N)	135	134	130	63
Obi 10 mg (N)	240	237	155	188

Table 2.1 Pooled Analysis of TULIP, OCEAN, ROSE & ROSE2

Diastolic

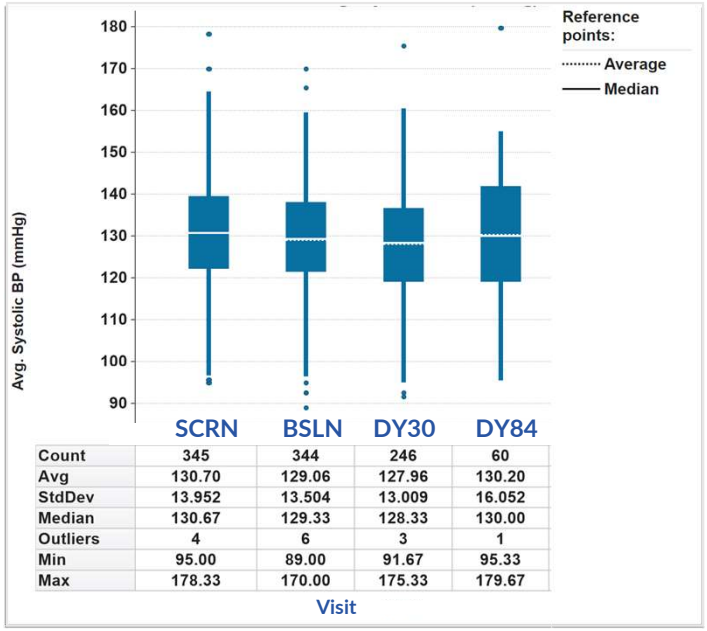


	BL	4	8	Week 12
Placebo (N)	229	222	180	157
Obi 5 mg (N)	135	134	130	63
Obi 10 mg (N)	240	237	155	188

Table 2.3 Pooled Analysis TULIP, OCEAN & ROSE

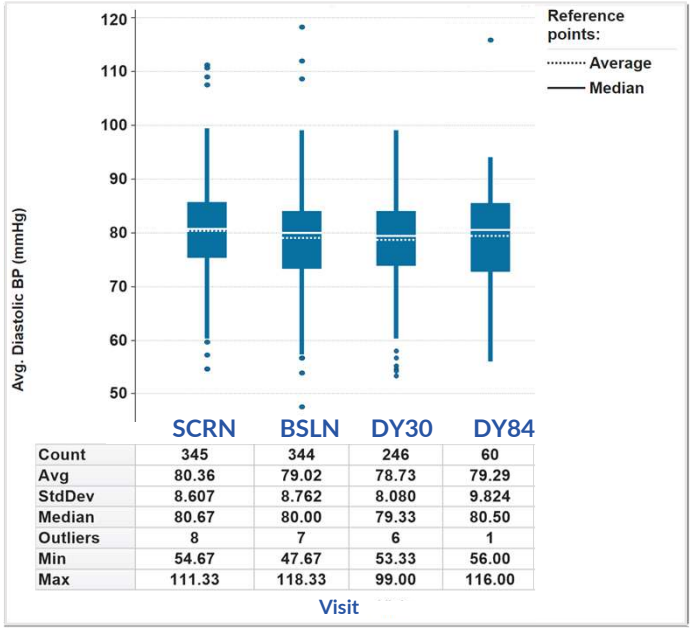
BROOKLYN: Aggregate blinded average blood pressure is stable over time

Average Systolic BP (mmHg) by Visit



	SCRN	BSLN	DY30	DY84
Count	345	344	246	60
Avg	130.70	129.06	127.96	130.20
StdDev	13.952	13.504	13.009	16.052
Median	130.67	129.33	128.33	130.00
Outliers	4	6	3	1
Min	95.00	89.00	91.67	95.33
Max	178.33	170.00	175.33	179.67

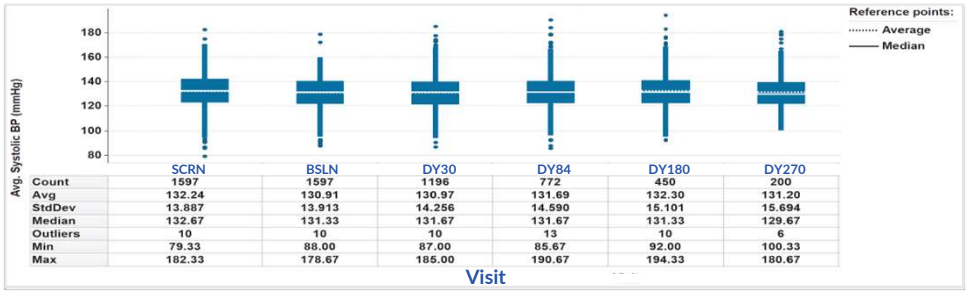
Average Diastolic BP (mmHg) by Visit



	SCRN	BSLN	DY30	DY84
Count	345	344	246	60
Avg	80.36	79.02	78.73	79.29
StdDev	8.607	8.762	8.080	9.824
Median	80.67	80.00	79.33	80.50
Outliers	8	7	6	1
Min	54.67	47.67	53.33	56.00
Max	111.33	118.33	99.00	116.00

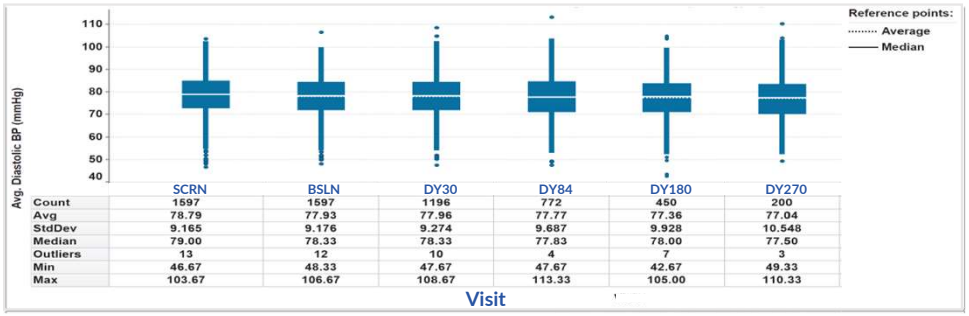
BROADWAY: Aggregate blinded average blood pressure is stable over time

Average Systolic BP (mmHg) by Visit



	SCRN	BSLN	DY30	DY84	DY180	DY270
Count	1597	1597	1196	772	450	200
Avg	132.24	130.91	130.97	131.69	132.30	131.20
StdDev	13.887	13.913	14.256	14.590	15.101	15.694
Median	132.67	131.33	131.67	131.67	131.33	129.67
Outliers	10	10	10	13	10	6
Min	79.33	88.00	87.00	85.67	92.00	100.33
Max	182.33	178.67	185.00	190.67	194.33	180.67

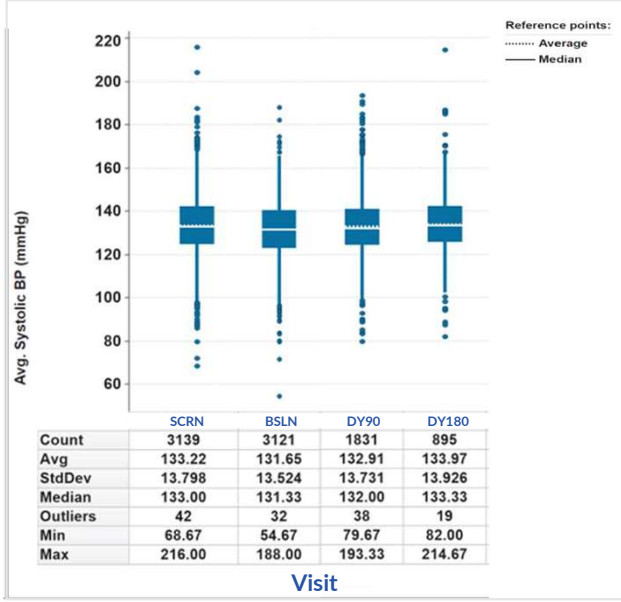
Average Diastolic BP (mmHg) by Visit



	SCRN	BSLN	DY30	DY84	DY180	DY270
Count	1597	1597	1196	772	450	200
Avg	78.79	77.93	77.96	77.77	77.36	77.04
StdDev	9.165	9.176	9.274	9.687	9.928	10.548
Median	79.00	78.33	78.33	77.83	78.00	77.50
Outliers	13	12	10	4	7	3
Min	46.67	48.33	47.67	47.67	42.67	49.33
Max	103.67	106.67	108.67	113.33	105.00	110.33

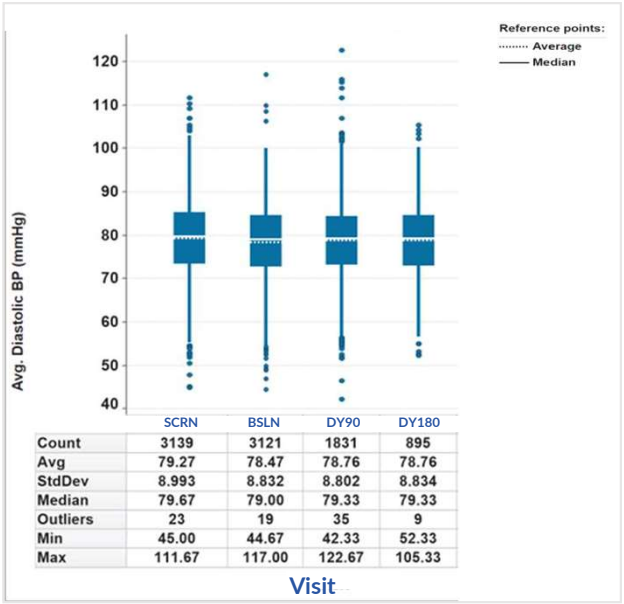
PREVAIL: Aggregate blinded average blood pressure is stable over time

Average Systolic BP (mmHg) by Visit



	SCRN	BSLN	DY90	DY180
Count	3139	3121	1831	895
Avg	133.22	131.65	132.91	133.97
StdDev	13.798	13.524	13.731	13.926
Median	133.00	131.33	132.00	133.33
Outliers	42	32	38	19
Min	68.67	54.67	79.67	82.00
Max	216.00	188.00	193.33	214.67

Average Diastolic BP (mmHg) by Visit

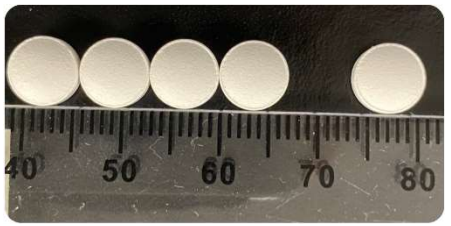


	SCRN	BSLN	DY90	DY180
Count	3139	3121	1831	895
Avg	79.27	78.47	78.76	78.76
StdDev	8.993	8.832	8.802	8.834
Median	79.67	79.00	79.33	79.33
Outliers	23	19	35	9
Min	45.00	44.67	42.33	52.33
Max	111.67	117.00	122.67	105.33

We have selected a Fixed Dose Combination (FDC) of Obicetrapib + Ezetimibe

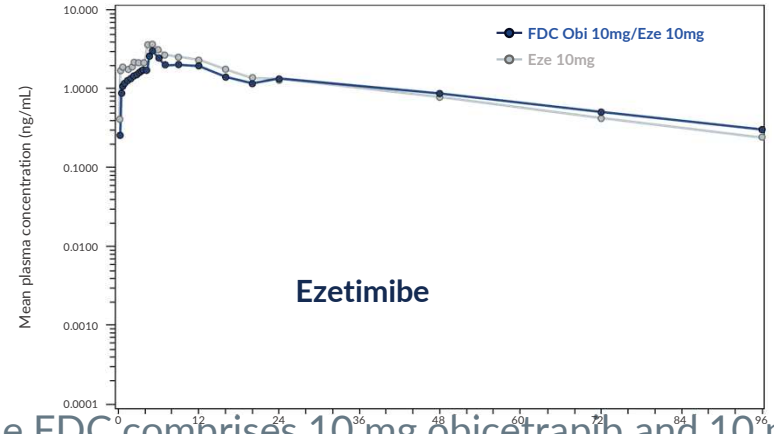
- We recently completed a bioavailability study comparing two FDC formulations of obicetrapib + ezetimibe to the component products
- An FDC formulation was selected based on comparable bioavailability and is planned to be advanced into a Phase 3 safety & efficacy trial
- An End-of-Phase 2 meeting has been granted by FDA and scheduled for June 2023 to review the design of our Phase 3 study
- The Phase 3 trial is expected to begin in 1Q 2024
- We currently expect to submit an NDA for the FDC on or around the same time as the obicetrapib monotherapy

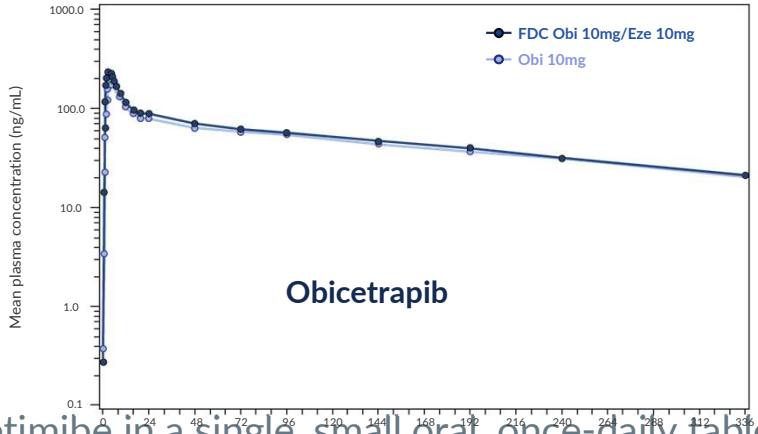
Fixed-Dose Combo Tablet



Fixed dose combination Obi + Eze: Development update

- FDC formulation observed to have comparable pharmacokinetic (PK) profiles to individual products

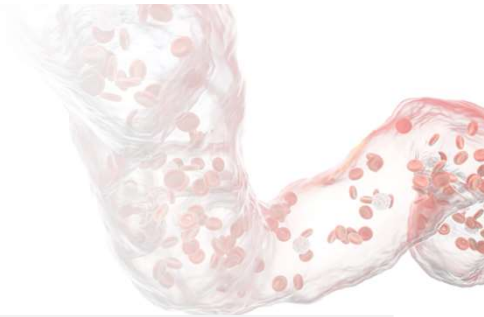




- The FDC comprises 10 mg obicetrapib and 10 mg ezetimibe in a single, small oral, once-daily tablet, with CoGs comparable to obicetrapib 10 mg tablet
- FDC Phase 3 trial is planned to start in Q1 2024
- The planned manufacturing site for FDC was selected and technology transfer is ongoing for anticipated NDA readiness and commercial supply

NewAmsterdam Pharma

Proposed fixed dose combination phase 3 trial design



Inclusion criteria

- LDL-C ≥ 70 mg/dL
- ASCVD, ASCVD risk equiv, or HeFH
- 18-75 years

Primary endpoint

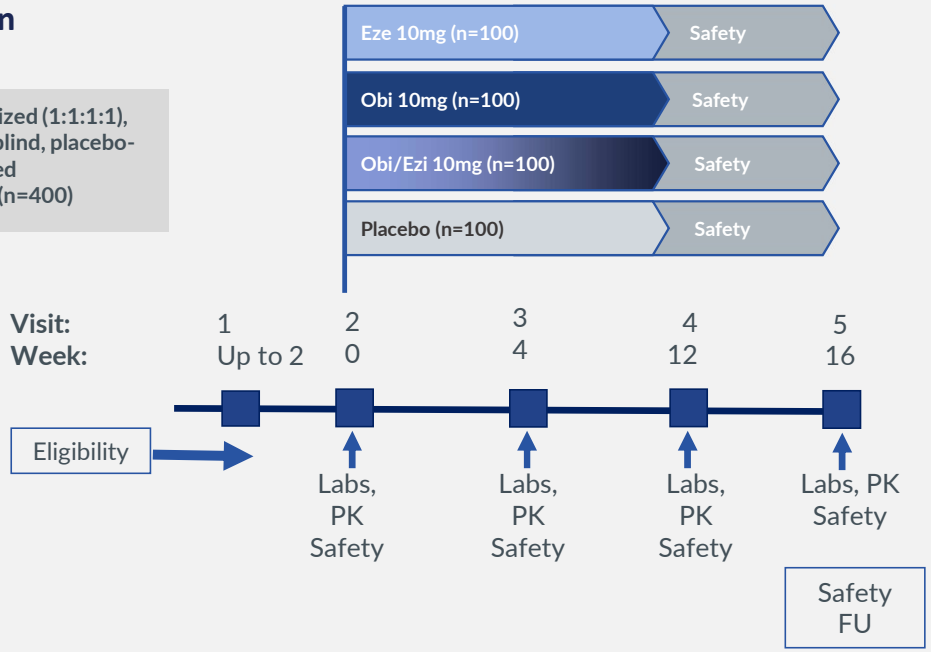
- Percent change from baseline in LDL-C compared to placebo

Primary efficacy endpoint

- **Percent change from baseline in LDL-C** for the combination therapy group compared to the placebo group

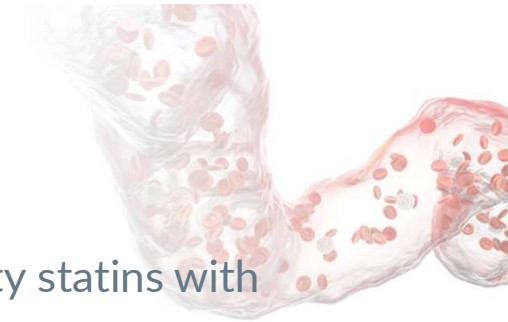
Trial design

- **Randomized (1:1:1:1), double-blind, placebo-controlled**
- **Patients(n=400)**



NewAmsterdam Pharma

Summary of key messages



- ROSE2: 63% median LDL-C reduction observed in patients on high intensity statins with obicetrapib 10mg in combination with ezetimibe
- Japan Phase 2: 46% median LDL-C reduction observed with obicetrapib 10mg; largely consistent with observed results from obicetrapib 10mg across six clinical trials (Range 43-51%) and potentially enabling PMDA regulatory path for approval aligned with the rest of the world
- Well tolerated in Phase 2 trials and Phase 3 blinded safety, including frequent blood pressure assessments, is encouraging
- Robust reductions in Lp(a) and small LDL particles as well as documented diabetes benefits in the CETP inhibitor class are encouraging
- FDC formulation selected with Phase 3 initiation anticipated in Q1 24
- Enrollment in Phase 3 trials is progressing on-track with completion of the two pivotal LDL trials expected in H2 24 and CVOT expected in H2 26