Novo Nordisk –a focused healthcare company

Novo Nordisk investor event in connection with ADA

San Diego, 25 June 2023

Forward-looking statements

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- Statements containing projections of or targets for revenues, costs, income (or loss), earnings per share, capital expenditures, dividends, capital structure, net financials and other financial measures,
- Statements regarding future economic performance, future actions and outcome of contingencies such as legal proceedings, and
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For an overview of some, but not all, of the risks that could adversely affect Novo Nordisk's results or the accuracy of forward-looking statements in this Annual Report 2022, reference is made to the overview of risk factors in 'Risk management' of this Annual Report 2022.

Unless required by law, Novo Nordisk is under no duty and undertakes no obligation to update or revise any forward-looking statement after the distribution of this Annual Report 2022, whether as a result of new information, future events, or otherwise.

Important drug information

Victoza® and Ozempic® are approved for the management of type 2 diabetes only
Saxenda® and Wegovy® are approved for the treatment of obesity only

Strategic Aspirations 2025 | Highlights first three months 2023

Purpose and sustainability (ESG)

Progress towards zero environmental impact

- Carbon emissions decreased by 21% vs Q1 2019[1]

Adding value to society

- Medical treatment provided to 37.2 million people living with diabetes
- Reaching more than 42,000 children in Changing Diabetes® in Children programme

Being recognised as a sustainable employer

- Share of women in senior leadership positions has increased to 39% from 37% end of March 2022

Innovation and therapeutic focus

Further raise innovation bar for Diabetes treatment

- Regulatory submission of once-weekly insulin icodec
- Completion of phase 3 trial PIONEER PLUS
- Completion of phase 1/2 trials with GLP-1/GIP

Develop superior treatment solutions for obesity

- Phase 3a trials REDEFINE 2 & 3 initiated with CagriSema

Strengthen and progress Rare Disease pipeline

- Somapacitan approved in the US for GHD in children
- CRL received for concizumab in the US

Establish presence in Other serious chronic diseases

- Phase 1 trials initiated with cell therapy treatment

Commercial execution

Diabetes value market share increased by 1.7%-points to 32.2%[2]

Obesity care sales of DKK 7.8 billion (+124% at CER)

Rare disease sales of DKK 4.6 billion (-16% at CER)

Financials

Sales growth of 25% (CER) and operating profit growth of 28% (CER)

Operational leverage reflecting sales growth

Free cash flow of DKK 24.8 billion and DKK 23.5 billion returned to shareholders

[1]Scope 1,2 and partial scope 3 limited to CO2 emissions from business flights and product distribution; [2]MAT (Moving annual total) value market share
VP: Vice president; CER: Constant exchange rates; CRL: Complete Response Letter; US: United States; GHD: Growth Hormone Deficiency; GIP: Gastric inhibitory polypeptide; GLP-1: Glucagon Like Peptide 1
Note: The strategic aspirations are not a projection of Novo Nordisk's financial outlook or expected growth

Strategic Aspirations 2025 | Today with emphasis on Innovation and therapeutic focus

Purpose and sustainability (ESG)

- Progress towards zero environmental impact
- Being respected for adding value to society
- Being recognised as a sustainable employer

Innovation and therapeutic focus

- **Further raise the innovation-bar for diabetes treatment**
- **Develop a leading portfolio of superior treatment solutions for obesity**
- **Strengthen and progress the Rare disease pipeline**
- **Establish presence in Other serious chronic diseases focusing on CVD, NASH and CKD**

Commercial execution

- Strengthen Diabetes leadership - aim at global value market share of more than 1/3
- More than 25 billion DKK in Obesity sales by 2025
- Secure a sustained growth outlook for Rare disease

Financials

- Deliver solid sales and operating profit growth
- Drive operational efficiencies across the value chain to enable investments in future growth assets
- Deliver free cash flow to enable attractive capital allocation to shareholders

CVD: Cardiovascular disease; NASH: Non-alcoholic steatohepatitis; CKD: Chronic kidney disease.
Note: The strategic aspirations are not a projection of Novo Nordisk's financial outlook or expected growth.

Today’s speakers

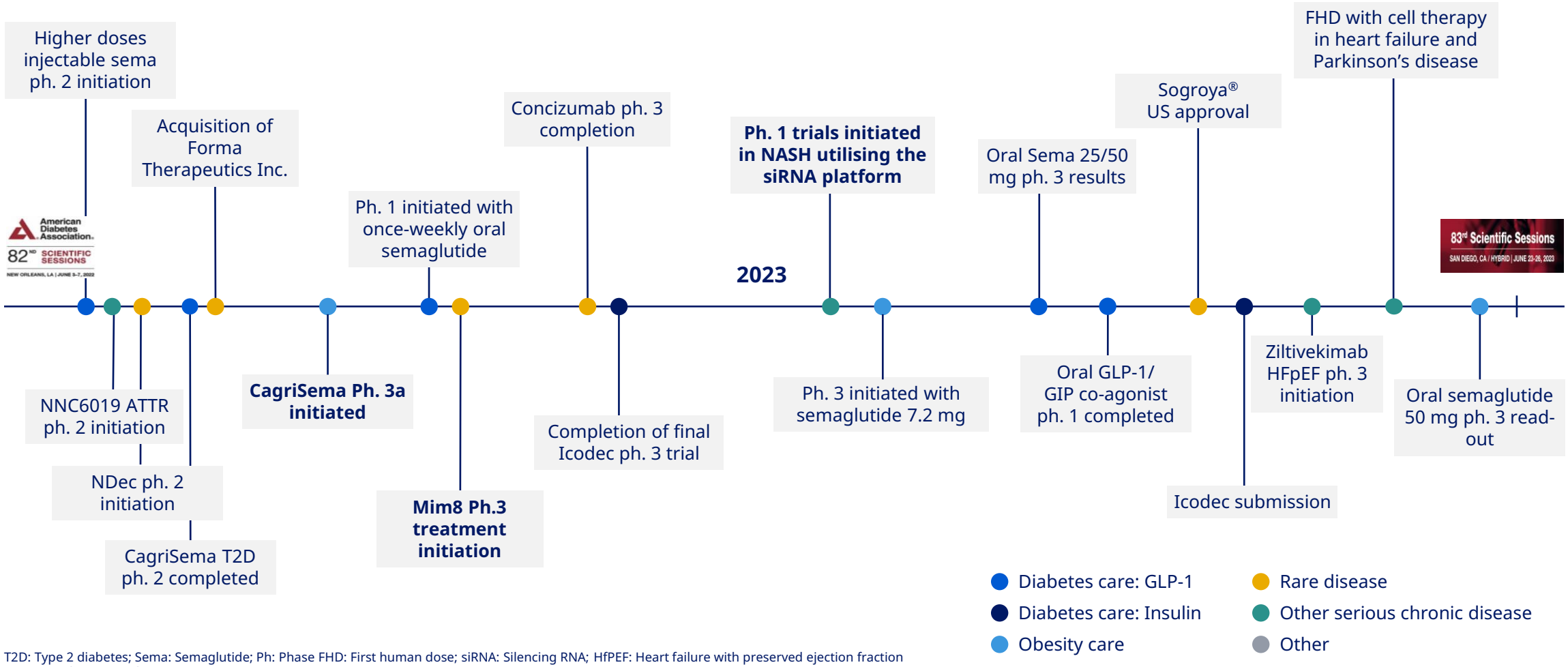
Martin Holst Lange
Executive Vice President and
Head of Development

Stephen Charles Langford Gough
Senior Vice President and
Global Chief Medical Officer

Agenda

Introduction		*Daniel Bohsen & Martin Holst Lange*
Insulin		
	Insulin Icodec	*Stephen Gough*
GLP-1 in diabetes		
	CagriSema in diabetes	*Martin Holst Lange*
	Oral semaglutide in diabetes	*Stephen Gough*
GLP-1 in obesity		
	Oral semaglutide in obesity	*Stephen Gough*
	Semaglutide 2.4 mg: STEP HFpEF	*Martin Holst Lange*
Q&A		*All*

Since ADA 2022, progress has been made across the Novo Nordisk pipeline



T2D: Type 2 diabetes; Sema: Semaglutide; Ph: Phase FHD: First human dose; siRNA: Silencing RNA; HfPEF: Heart failure with preserved ejection fraction
Note: Timeline non-exhaustive

Agenda

Introduction		*Daniel Bohsen & Martin Holst Lange*
Insulin		
	Insulin Icodec	*Stephen Gough*
GLP-1 in diabetes		
	CagriSema in diabetes	*Martin Holst Lange*
	Oral semaglutide in diabetes	*Stephen Gough*
GLP-1 in obesity		
	Oral semaglutide in obesity	*Stephen Gough*
	Semaglutide 2.4 mg: STEP HFpEF	*Martin Holst Lange*
Q&A		*All*

Diabetes is a serious chronic disease requiring treatment intensification over time

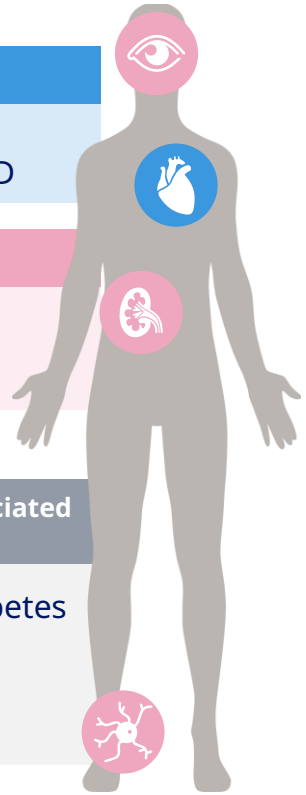
Diabetes is associated with multiple comorbidities

Macrovascular

- Includes angina, CAD, MI, stroke, PAD, CHF, and CKD

Microvascular

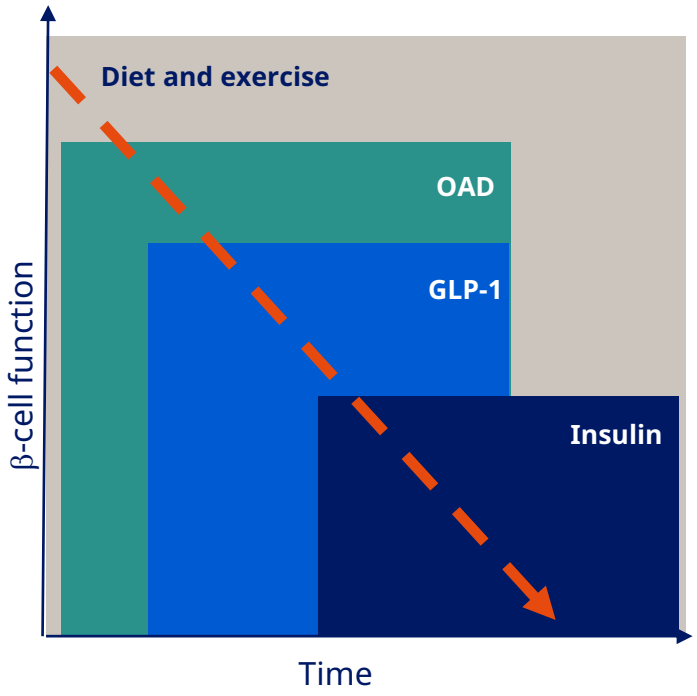
- Retinopathy
- Nephropathy
- Neuropathy



A 0.4% HbA1c reduction is associated with reductions of[1]:

- 10% death related to diabetes
- 7% all cause mortality
- 21% amputation or death from PVD

Despite many new treatment options, many patients eventually need insulin

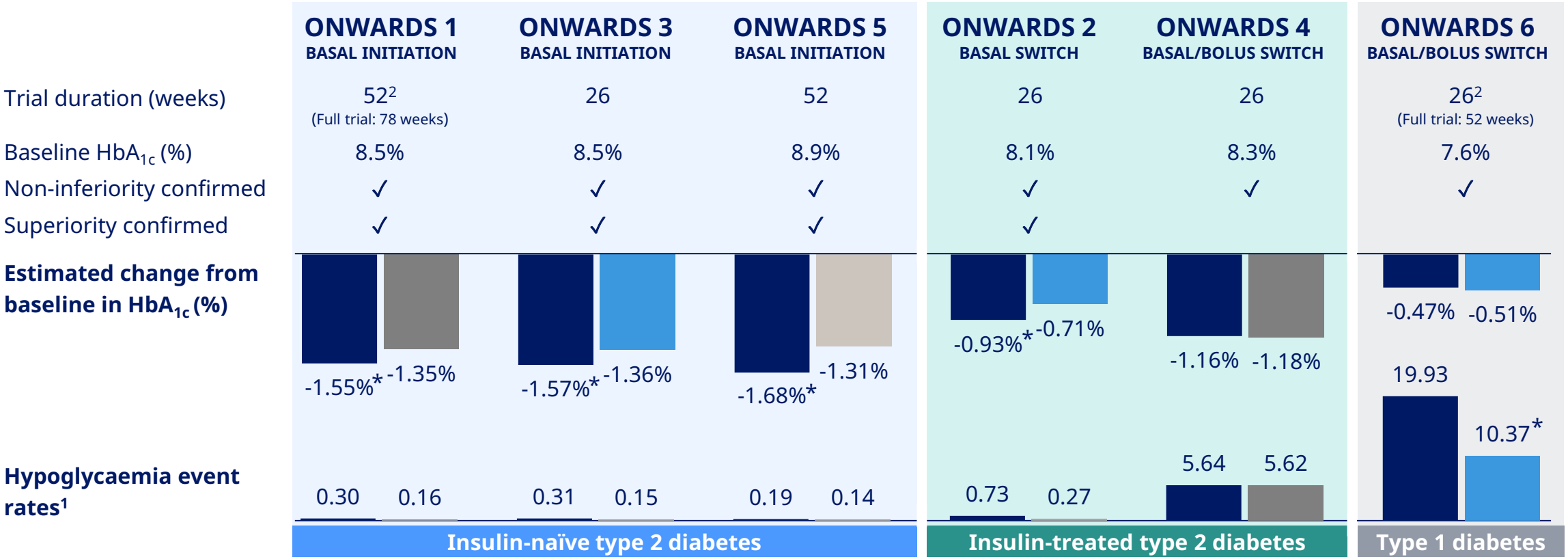


The burden of treatment may be a barrier for good glycaemic control

- 50% of patients needing insulin delay initiation by an average of 15 months due to needle aversion, anxiety over insulin and fear[2]
- >90% of physicians and patients have a wish for good glycaemic control with insulin not injected every day[3]

[1]Association of glycaemia with macrovascular and microvascular complications of type 2 diabetes (UKPDS 35): prospective observational study - PMC (nih.gov) - Linear relationship inferred, to estimate the point estimate with a 0.4% decrease in A1c. [2] Unpublished Novo Nordisk market research. [3]Peyrot M et al. Diabet Med. 2012;29(5):682–689.
CAD: Coronary artery disease; MI: Myocardial infarction; PAD: Peripheral arteries disease; CHF: Congestive heart failure; CKD: Chronic kidney disease; OAD: Oral anti diabetics; GLP-1: Glucagon-like peptide-1; PVD: Peripheral vascular disease

Once-weekly insulin icodec appeared to be effective and to have a safe profile in the phase 3 ONWARDS programme



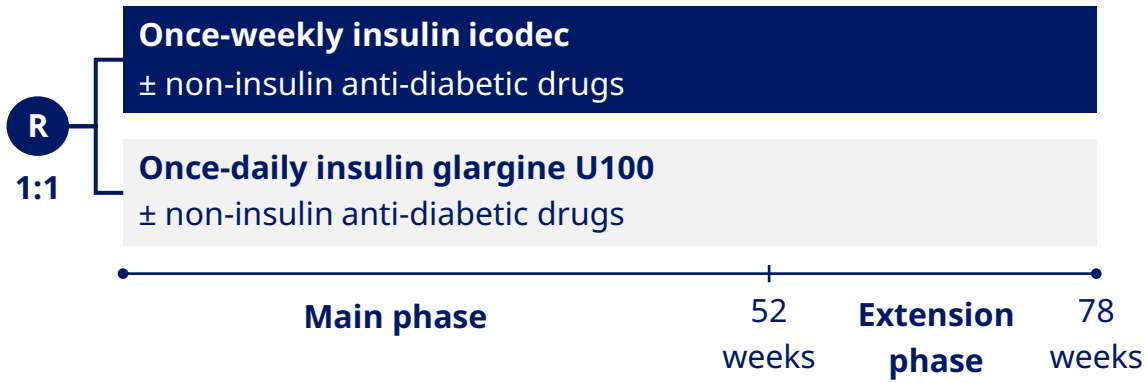
In people with type 2 diabetes: *No statistical difference in estimated hypoglycaemia events*

Once-weekly insulin icodec | Once-daily insulin glargine U100 | Once-daily insulin degludec | Once-daily basal insulins

*Statistically significant. 1 Severe or clinically significant hypoglycaemia events (blood glucose <3 mmol/L) per patient year, included for end of trial/end main phase in-trial. 2 Duration refers to trial main phase.
ONWARDS 1: QW insulin icodec vs QD insulin glargine U100 both with non-insulin anti-diabetic treatment in insulin-naïve people with T2D; ONWARDS 2: QW insulin icodec vs QD insulin degludec in people with T2D switching from a QD insulin; ONWARDS 3: QW insulin icodec vs QD insulin degludec in insulin-naïve people with T2D; ONWARDS 4: QW insulin icodec vs QD insulin degludec both with mealtime insulin in people with T2D treated with basal and bolus insulin; ONWARDS 5: QW insulin icodec vs QD basal insulin with an app providing dosing recommendation in insulin-naïve people with T2D; ONWARDS 6: QW insulin icodec vs QD insulin degludec both with mealtime insulin in people with T1D
T1D: Type 1 diabetes; T2D: Type 2 diabetes. Note: Overview refer to primary end-points in main phases of trials

ONWARDS 1 compared insulin icodec with insulin glargine U100 in people with T2D initiating basal insulin

ONWARDS 1 enrolled 984 patients with Type 2 Diabetes



Objective:

- To confirm the efficacy and safety of once-weekly insulin icodec in insulin-naïve patients with type 2 diabetes

Primary endpoint:

- Change in HbA_{1c} from baseline to week 52

Extension phase:

- A 26-week extension included in the trial design to assess long-term safety in people with T2D

Inclusion criteria:

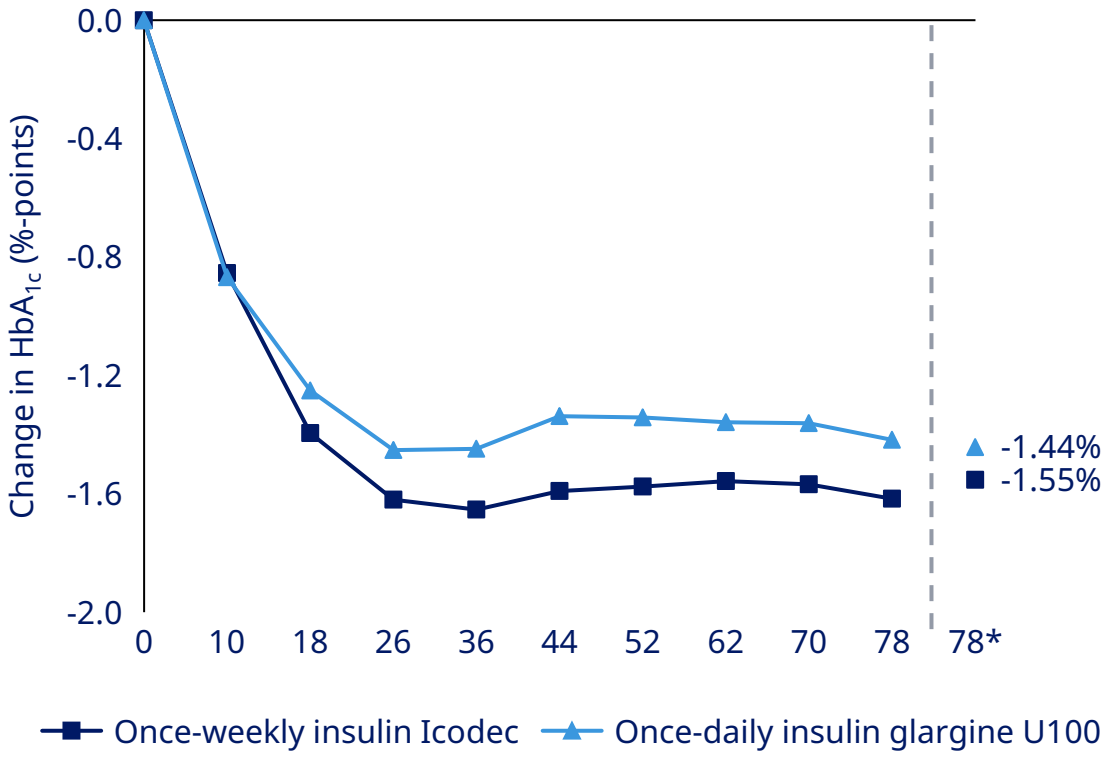
- T2D treated with OADs* ± GLP-1 RA s.c.
- Age ≥18 years
- HbA_{1c} 7-11%
- BMI ≤ 40 kg/m2

*Pre-trial all OADs including oral GLP-1s are allowed but SU and glinides are to be discontinued at randomisation
T2D: Type 2 diabetes; R: Randomisation; OAD: Oral anti Diabetics; s.c.: subcutaneous; BMI: Body mass index; GLP-1: Glucagon-like peptide-1

Once-weekly insulin icodec showed HbA_{1c} reduction of -1.55% after 78 weeks of treatment in phase 3 trial ONWARDS 1

Greater reduction in HbA_{1c} after 78 weeks with insulin icodec

Mean baseline HbA_{1c}: 8.5%



Note: Observed data are in-trial. Week 78* is estimated mean change in HbA1c based on ANCOVA with missing data derived from multiple imputation

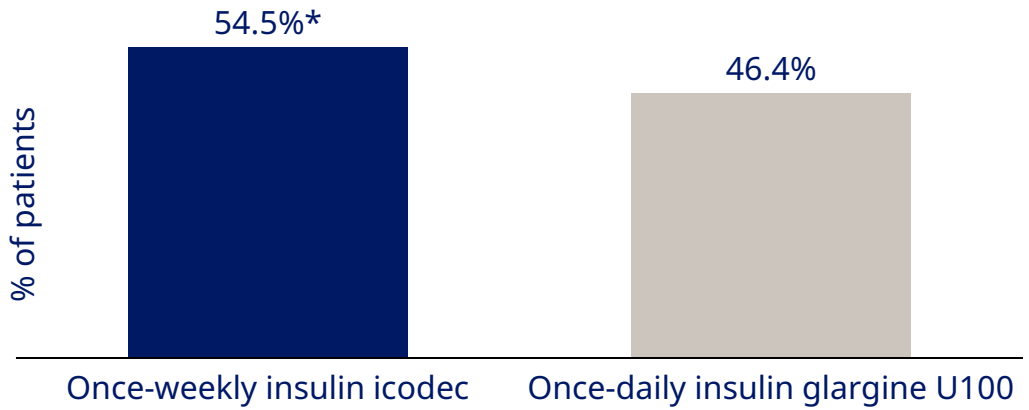
Overall hypoglycaemia in the trial

On treatment	Once-weekly insulin icodec				Once-daily insulin glargine U100			
	N	(%)	E	R	N	(%)	E	R
Level 2: Clinically significant hypo	61	(12.4)	226	0.30	66	(13.4)	114	0.15
Level 3: Severe hypo	1	0.2	1	0.001	6	(1.2)	7	0.009
Level 3 or 2: Severe or clinically significant hypo	61	(12.4)	227	0.30	70	(14.2)	121	0.16

Note: Clinically significant hypoglycaemia (level 2): Plasma glucose value of < 3.0 mmol/L (54 mg/dL) confirmed by blood glycose meter. Severe hypoglycaemia (level 3): Hypoglycaemia with severe cognitive impairment requiring external assistance for recovery. Data is on-treatment.
N: Number of patients with one or more events; %: Percentage of patients with one or more events; E: Number of events; R: Rate (number of events per patient year of exposure; Hypo: Hypoglycaemia

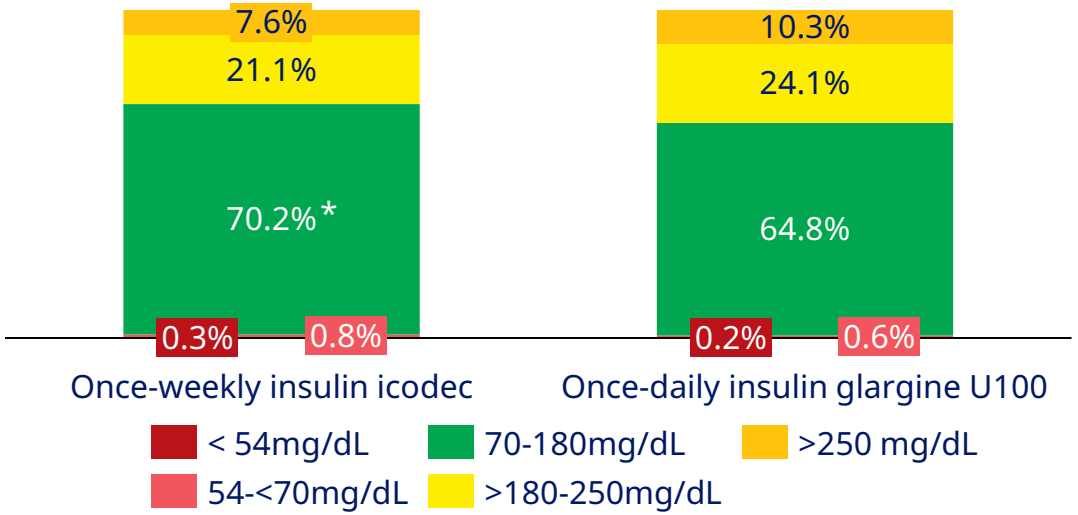
In the trial, more patients on insulin icodec reached HbA_{1c} target without hypoglycaemia and a longer TIR vs insulin glargine U100

Achievement of HbA_{1c} target after 78 weeks without hypoglycaemia[1]



EOR = 1.4 [1.06 to 1.80]$_{95\%\ CI}$

Statistically significantly longer TIR for insulin icodec vs insulin glargine U100 measured with CGM from week 74 to 78



Achievement of HbA_{1c} target <7.0% without hypoglycaemia[1]

- Statistically significantly more participants achieved the HbA_{1c} target without severe or clinically significant hypoglycaemia with insulin icodec compared to insulin glargine U100

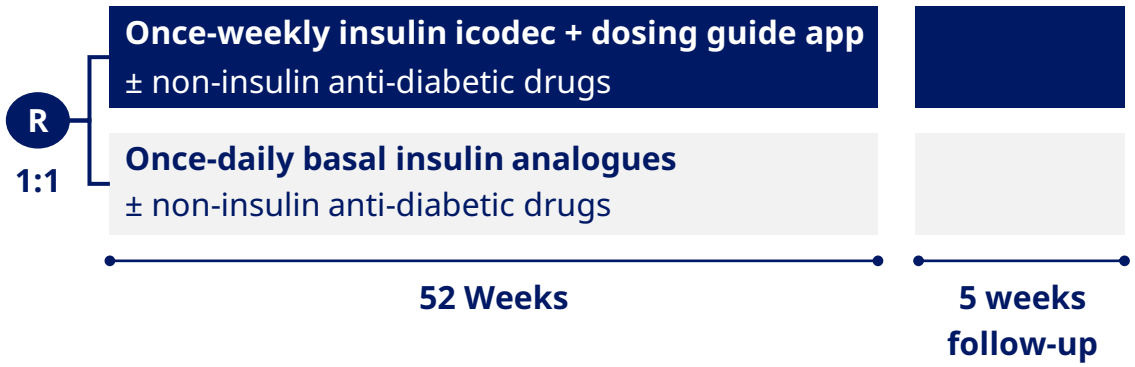
Time in range

- 70-180 mg/dL from week 74 to week 78 was 70.2% with once-weekly insulin icodec and 64.8% with once-weekly insulin glargine, statistically significant difference in favor of once-weekly insulin icodec vs once-daily insulin glargine U100

1 Specifically an HbA1c <7% without level 2 or 3 hypoglycaemic episodes during the prior 12 weeks; * Statistically significant difference in favour of insulin icodec.
Note: The binary response after 78 weeks is analysed using a binary logistic regression model (logit link) with treatment and region as fixed factors, and the baseline HbA1c value as covariate. For TIR: Time spent is defined as 100 times the number of recorded measurements in a given range, divided by the total number of recorded measurements
TIR: Time in range; CGM, continuous glucose monitor; CI: Confidence interval; EOR: Estimated odds ratio

ONWARDS 5 included real-world elements and compared once-weekly insulin icodec with once-daily basal insulins in T2D

Onwards 5 enrolled 1085 patients with Type 2 Diabetes



Objective:

- To confirm the efficacy of HbA1c and safety of insulin icodec with a dosing guide app providing dosing recommendation vs once-daily basal insulin analogues, both in combination with any non-insulin antidiabetic medication in insulin-naïve T2D patients

Trial design:

- The trial included real-world elements to reflect real-world insulin use with fewer planned site visits, no upper limit on HbA1c and minimal exclusion criteria.

Key endpoints:

- Change in HbA_{1c}
- Patient Related Outcomes (PROs)
- Level 2 and 3 hypoglycaemia events

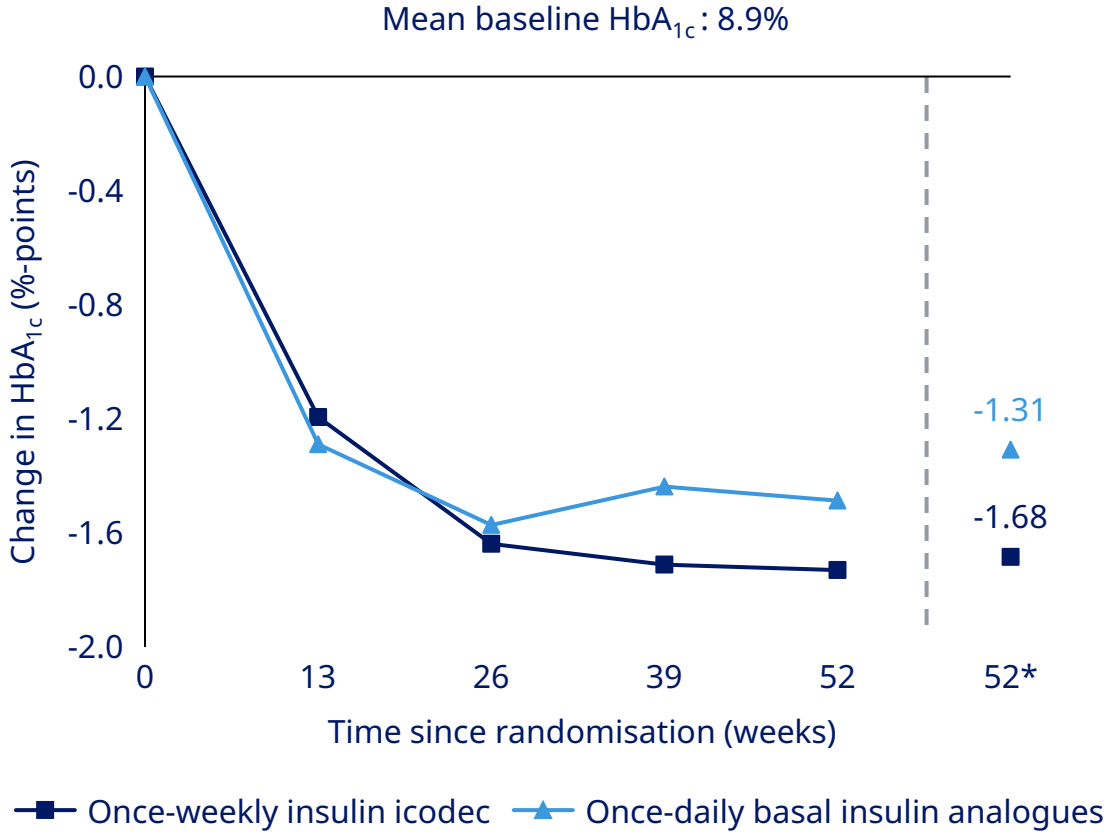
Inclusion criteria:

- Insulin-naïve people with type 2 diabetes
- No limitations on use of oral antidiabetic treatments
- Age ≥ 18 years, HbA_{1c} > 7.0%

T2D: Type 2 diabetes; R: Randomisation. Once-daily basal insulin analogues include insulin degludec and insulin glargine U100 and U300

In the trial, insulin icodec appeared to have a safe profile and showed superior HbA_{1c} reduction vs daily basal insulin analogues

Superior reduction in HbA_{1c} from baseline to 52 weeks



Note: Observed data are in-trial. Week 52* is estimated mean change in HbA1c based on ANCOVA with missing data derived from multiple imputation. Insulin icodec was in combination with a dosing guide app. Once-daily basal insulin analogues include insulin degludec and insulin glargine U100 and U300

Overall hypoglycaemia in the trial

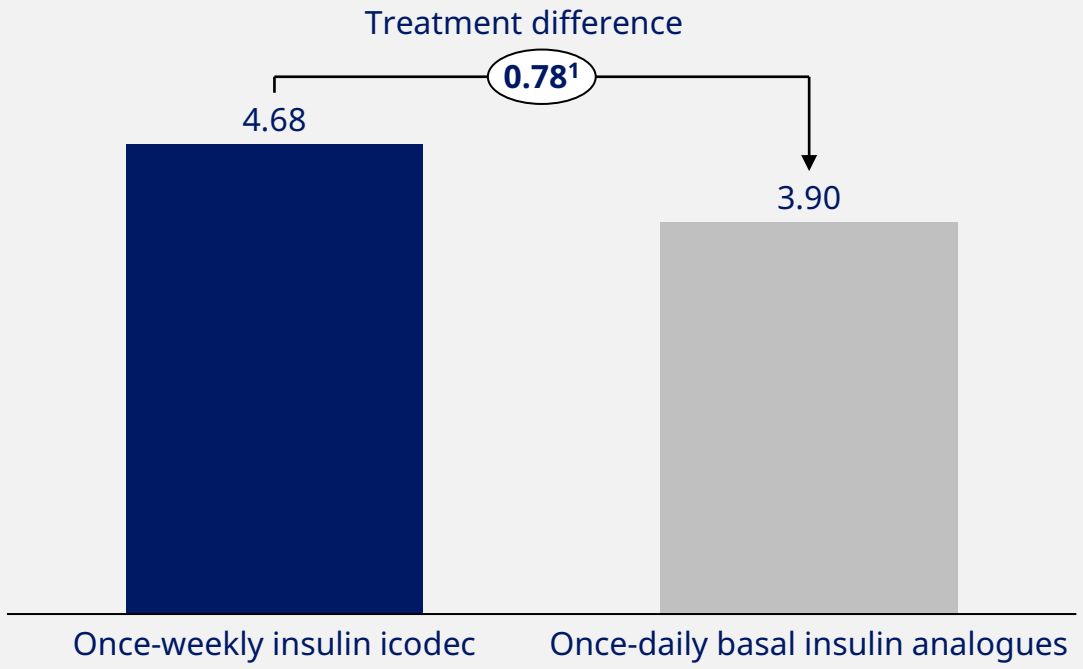
On treatment	Once-weekly insulin icodec				Once-daily basal insulin analogues			
	N	(%)	E	R	N	(%)	E	R
Level 2: Clinically significant Hypo*	64	(11.8)	104	0.19	42	(7.8)	76	0.13
Level 3: Severe Hypo*	0	-	-	-	4	(0.7)	5	0.01
Level 3 or 2: Severe or clinically significant Hypo*	64	(11.8)	104	0.19	45	(8.4)	81	0.14

Note: Clinically significant hypoglycaemia (level 2): Plasma glucose value of < 3.0 mmol/L (54 mg/dL) confirmed by blood glycose meter. Severe hypoglycaemia (level 3): Hypoglycaemia with severe cognitive impairment requiring external assistance for recovery. Data is on-treatment.
N: Number of patients with one or more events; %: Percentage of patients with one or more events; E: Number of events; R: Rate (number of events per patient year of exposure; Hypo: Hypoglycaemia

Insulin icodec showed superiority in both patient reported outcomes endpoints vs daily basal insulins in ONWARDS 5

DTSQ total treatment score: Health-related quality of life questionnaire

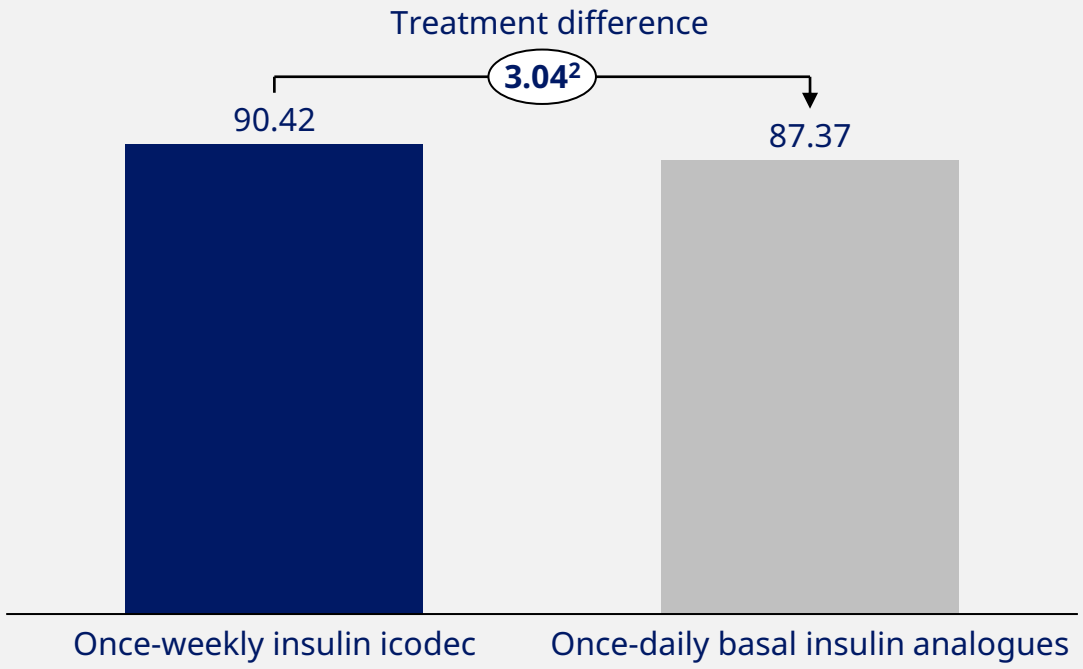
Treatment satisfaction score: 1-6



Estimated mean change from baseline

TRIM-D compliance domain score: Compliance questionnaire

Treatment satisfaction score: 1-100



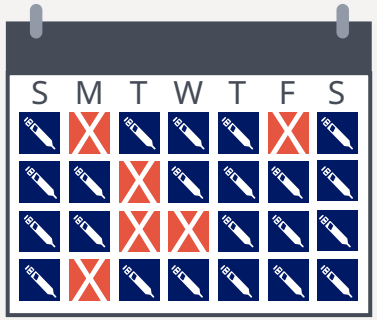
Estimated mean difference at week 52

[1]Treatment difference = 0.78 [0.10;1.47]95% CI, P value: 0.0247
[2]Treatment difference = 3.04 [1.28;4.81]95% CI, P value: 0.0007
DTSQ: Diabetes Treatment Satisfaction Questionnaire; TRIM-D: Treatment-Related Impact Measure Diabetes
Note: Insulin icodec was in combination with a dosing guide app. Once- daily basal insulin analogues include insulin degludec and insulin glargine U100 and U300

Insulin icodec has the potential to reduce treatment burden for both insulin naïve people or those switching from a daily basal

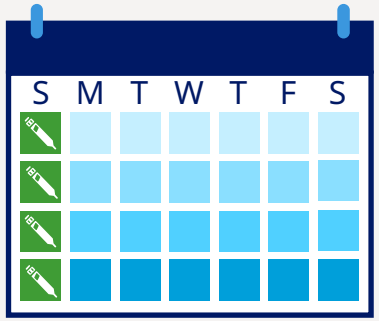
Icodec has the potential to reduce treatment burden

Once daily basal insulin



- Many injections per week (>365 per year)

Once-weekly insulin icodec



- One injection per week (52 per year)

Icodec titration scheme in type 2 diabetes

Naïve to insulin treatment

Single Starting Dose
70 units

Prior basal insulin treatment

Single Starting Dose
10.5 x Daily Basal Insulin Dose
Second Dose
Daily Basal Insulin Dose x 7

Note: Graphic on left illustrates conceptual differences

Insulin: Key take-aways

Despite many new treatment options, many patients eventually need insulin treatment

The burden of treatment and daily injections can be a barrier for good glycaemic control

Insulin icodec appears to have a superior efficacy profile with added weekly convenience and a low rate of hypoglycemia*

Overall, insulin icodec has the potential to be an ideal starter insulin for people with T2D

*Less than one event per year for level 2 or 3 hypoglycemia in the insulin naïve and in the basal switch T2D population
T2D: Type 2 Diabetes

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	Semaglutide 2.4 mg: STEP HFpEF	*Martin Holst Lange*
Q&A		*All*

GLP-1 RAs have proven positive effects beyond glycaemic control in T2D and may hold further potential

Glucagon-like peptide-1 receptor agonists to expand the healthy lifespan: Current and future potentials

Frederik Flindt Kreiner | Bernt Johan von Scholten | Peter Kurtzhals | Stephen Charles Langford Gough

Global Medical Affairs, Novo Nordisk A/S, Søborg, Denmark

Correspondence
Stephen Charles Langford Gough, Global Medical Affairs, Novo Nordisk A/S, Søborg, Denmark.
Email: secg@novonordisk.com

Abstract

To help ensure an expanded healthy lifespan for as many people as possible worldwide, there is a need to prevent or manage a number of prevalent chronic diseases directly and indirectly closely related to aging, including diabetes and obesity. Glucagon-like peptide 1 receptor agonists (GLP-1 RAs) have proven beneficial in type 2 diabetes, are amongst the few medicines approved for weight management, and are also licensed for focused cardiovascular risk reduction. In addition, strong evidence suggests several other beneficial effects of the pleiotropic peptide hormone, including anti-inflammation. Consequently, GLP-1 RAs are now in advanced clinical development for the treatment of chronic kidney disease, broader cardiovascular risk reduction, metabolic liver disease and Alzheimer's disease. In sum, GLP-1 RAs are positioned as one of the pharmacotherapeutic options that can contribute to addressing the high unmet medical need characterising several prevalent aging-related diseases, potentially helping more people enjoy a prolonged healthy lifespan.

KEYWORDS
Alzheimer's disease, cardiovascular diseases, chronic kidney diseases, diabetes mellitus, glucagon-like peptide-1, healthy aging, non-alcoholic steatohepatitis, obesity

1 | INTRODUCTION

Increased age is associated with frailty and diseases of varying severities, and for many, the hope of a long and healthy lifespan therefore becomes elusive. Nevertheless, overall life expectancy has increased markedly during the past decades, owing to a large extent to the introduction of medicines such as statins and anti-hypertensives. These and newer-generation drugs have resulted in a lower prevalence and severity of age-related illnesses such as cardiovascular disease (CVD).

To sustain and reinforce this positive trend and help ensure a prolonged healthspan for more people across the world, novel pharmacotherapeutics and optimal use of existing options are arguably needed.

Glucagon-like peptide-1 (GLP-1) receptor agonists (RAs) are an example of a drug class with proven or potential benefits across a range of prevalent age-related conditions and complications (Müller et al., 2019). Originally developed to manage blood glucose levels in type 2 diabetes (T2D), GLP-1 RAs have subsequently been confirmed to have marked benefits on body weight and CVD risk. Furthermore, evidence from

Abbreviations: CHIP, clonal haematopoiesis of indeterminate potential; CKD, chronic kidney disease; CVD, cardiovascular disease; CVOT, cardiovascular outcomes trial; DKD, diabetic kidney disease; DM, diabetes mellitus; GIP, gastric inhibitory peptide; GLP-1, glucagon-like peptide-1; GLP-1R, glucagon-like peptide-1 receptor; HFpEF, heart failure with preserved ejection fraction; MACE, major adverse cardiovascular event; NAFLD, non-alcoholic fatty liver disease; NASH, non-alcoholic hepatosteatosis; RA, receptor agonist; T2D, type 2 diabetes.

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Proven GLP-1 RA effects in T2D

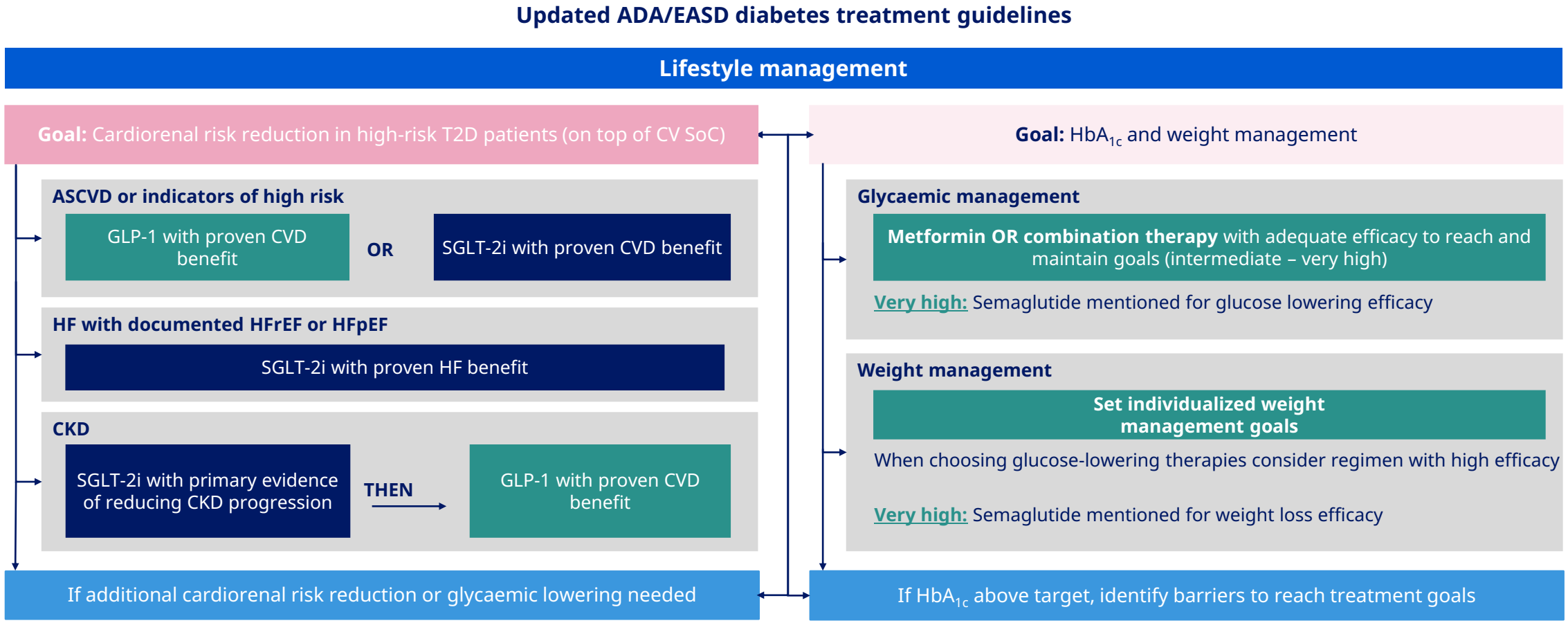
- Glycaemic control
- Weight loss
- CV risk reduction

Hypothesized GLP-1 RA effects

- Chronic kidney disease
- Alzheimer's disease
- Metabolic liver syndrome
- Peripheral artery disease

GLP-1 RA: Glucagon like peptide-1 receptor agonist; T2D: Type 2 diabetes; CV: Cardiovascular

GLP-1 RAs recommended as first line treatment for people with T2D with established ASCVD or with multiple CV risk factors

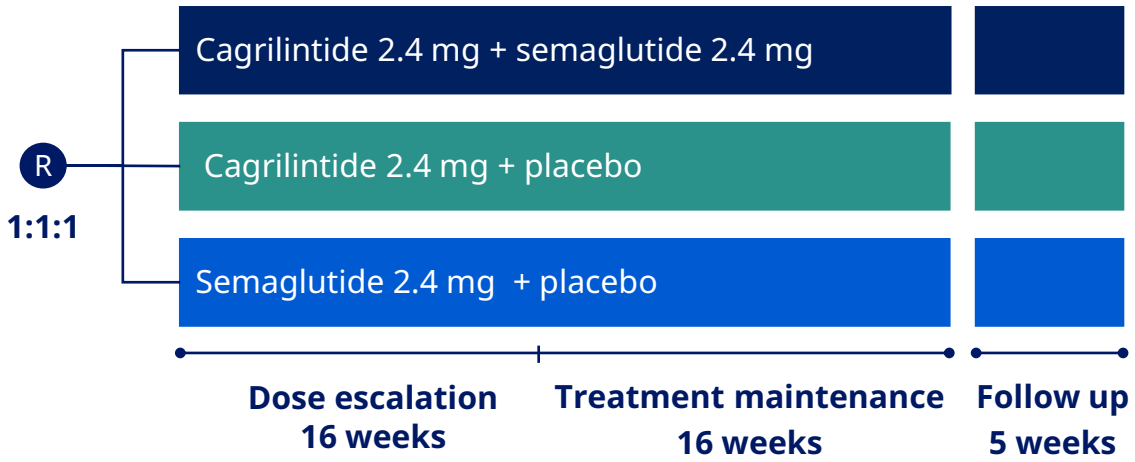


Sources: Adapted from: "Standards of Medical Care in Diabetes – 2022" Supplement 1, p.133; diabetes.org. American Diabetes Association & "Management of Hyperglycemia in Type 2 Diabetes, 2022. A Consensus Report by the American Diabetes Association (ADA) and the European Association for the Study of Diabetes (EASD)", Davies MJ. Et al, Diabetes Care 2022 (https://doi.org/10.2337/dci22-0034)

GLP-1 RA: Glucagon like peptide-1 receptor agonist; ADA: American Diabetes Association; EASD: European Association for the Study of Diabetes; T2D: Type 2 diabetes; CV: Cardio vascular; SoC: Standart of care; ASCVD: Atherosclerotic cardiovascular disease; CVD: Cardiovascular disease; SGLT-2i: Sodium/glucose co-transporter-2 inhibitors; HF: Heart failure: HFrEF: Heart failure with reduced ejection fraction; HFpEF: Heart failure with preserved ejection fraction; CKD: Chronic kidney disease

Phase 2 trial for CagriSema in people with type 2 diabetes was successfully completed in Q3 2022

Exploratory phase 2a trial of CagriSema in 92 patients with T2D



Objective:

- To compare the efficacy and safety of CagriSema vs its individual components in patients with T2D

Primary endpoint:

- Change from baseline to week 32 in HbA_{1c}

Secondary endpoints:

- Change from baseline to week 32 in body weight
- Safety
- CGM: Mean glucose levels, time in range

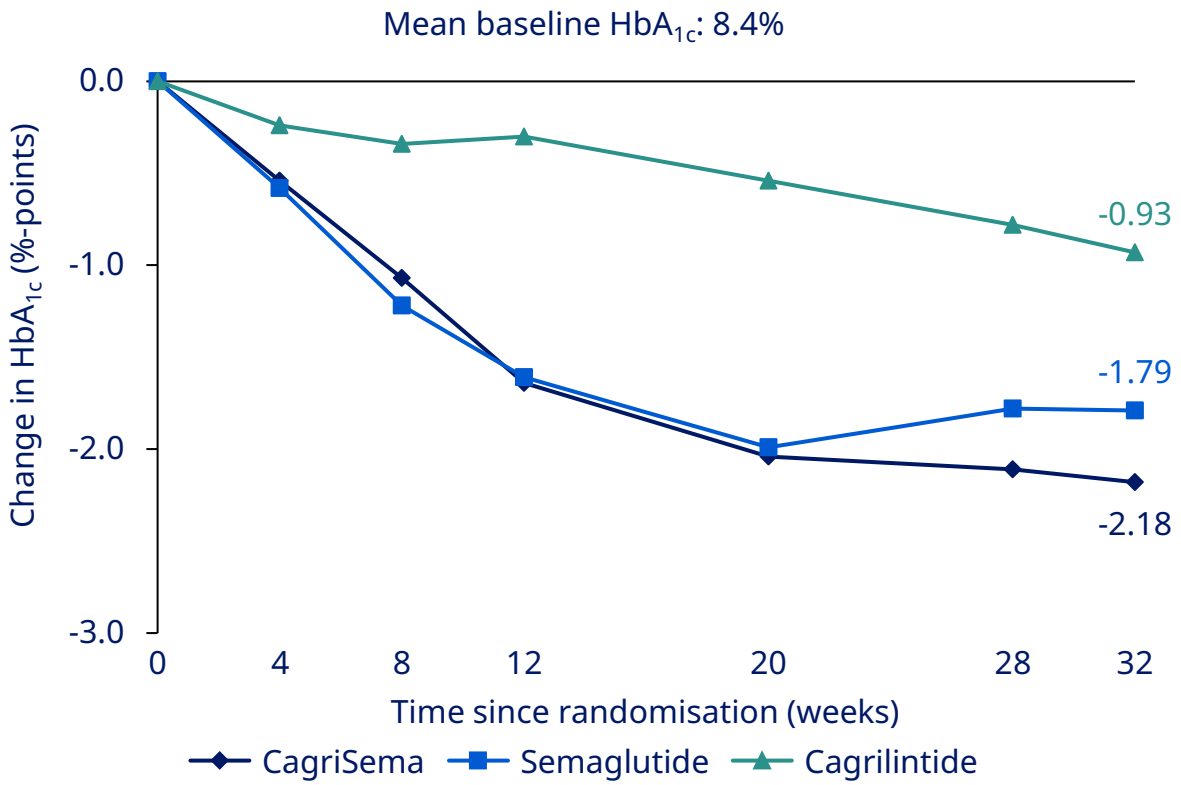
Inclusion criteria:

- Type 2 diabetes
- HbA_{1c} 7.5–10.0%
- Metformin +/- SGLT-2i
- BMI ≥27 kg/m2

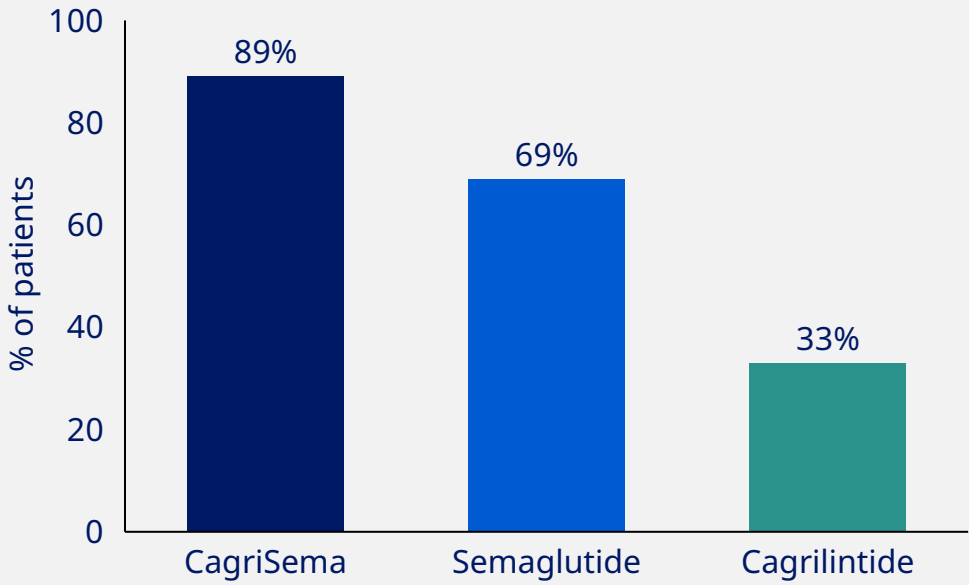
T2D: Type 2 diabetes; R: Randomisation; BMI: body mass index; CGM: Continuous glucose monitoring; SGLT-2i: Sodium/glucose co-transporter-2 inhibitors
Note: CagriSema is a fixed dose combination of injectable cagrilintide 2.4 mg and injectable semaglutide 2.4 mg

Mean HbA_{1c} reduction from baseline was -2.18 %-points and 89% reached HbA_{1c} target when treated with CagriSema

Higher HbA_{1c} reduction with CagriSema compared to monocomponents



Achievement of HbA_{1c} target <7.0% after 32 weeks

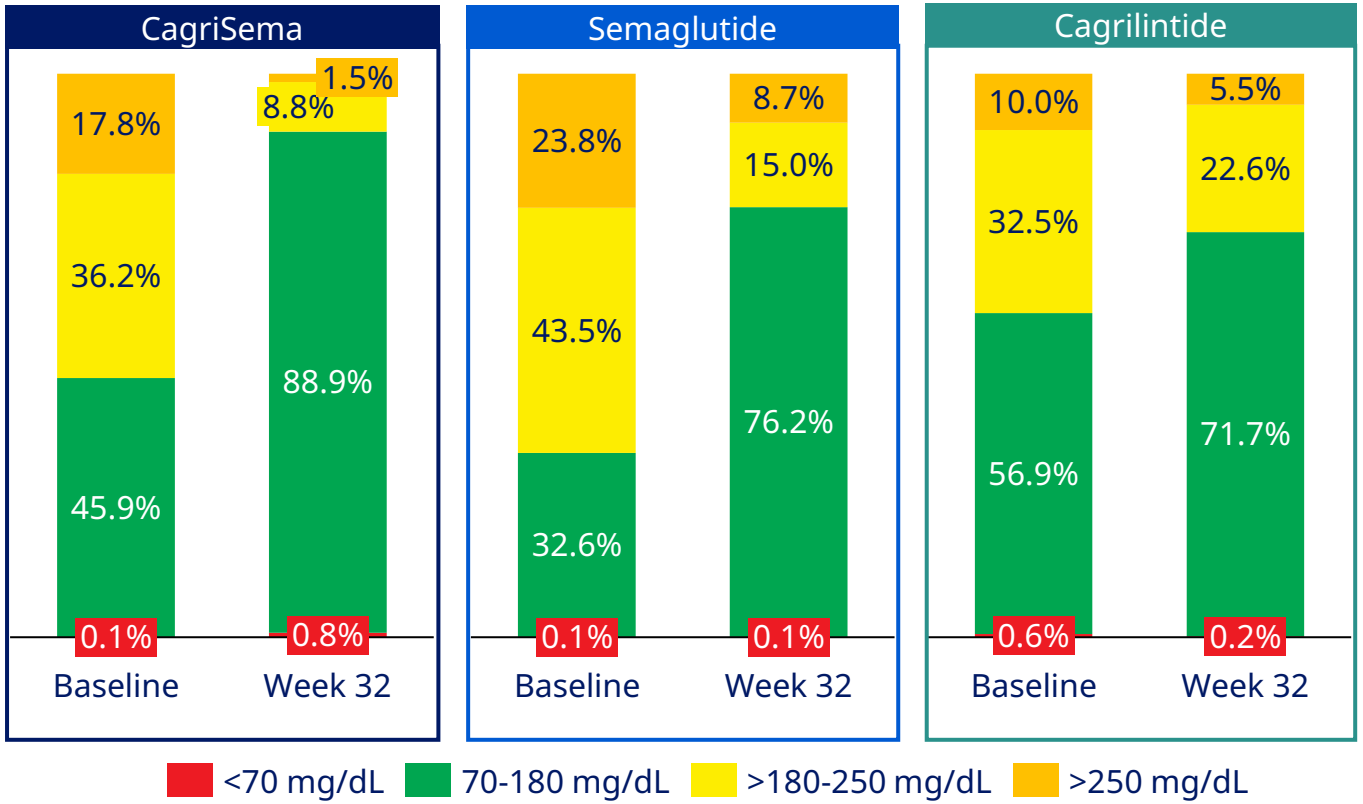


- More participants achieved the HbA_{1c} target when treated with CagriSema compared to the monocomponents

Note: Data shown is trial product estimands. CagriSema is a fixed dose combination of injectable cagrilintide 2.4 mg and injectable semaglutide 2.4 mg

With CagriSema, time in range reached ~90% at week 32 and mean glucose levels decreased by ~64 mg/dL

Longer time in range for CagriSema vs semaglutide and cagrilintide



Time in range

- Time in range goes “beyond” HbA1c for detailed insights into glycemic control in people with diabetes
- Time in range (70–180 mg/dL) increased in all groups, reaching 88.9% with CagriSema at week 32

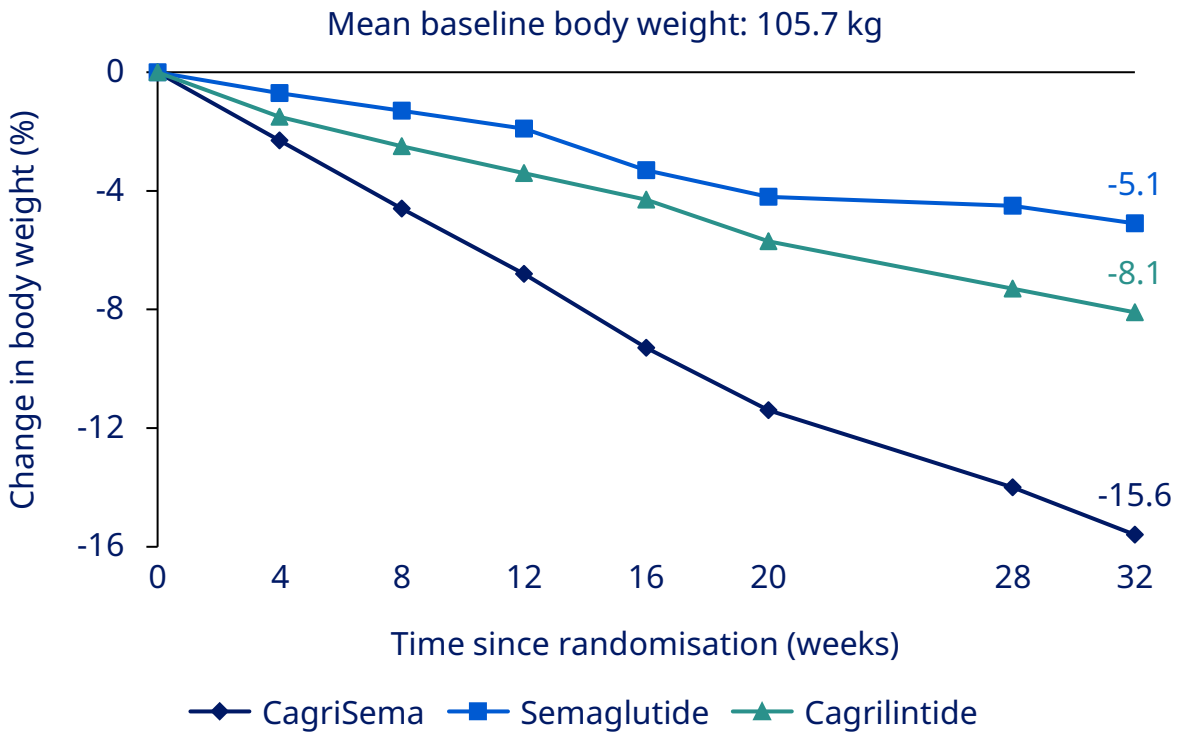
Mean glucose levels

- Decreased from baseline to week 32 in all groups, reaching -63.9mg/dL for CagriSema, -43.6 mg/dL for semaglutide and -23.4 mg/dL for cagrilintide

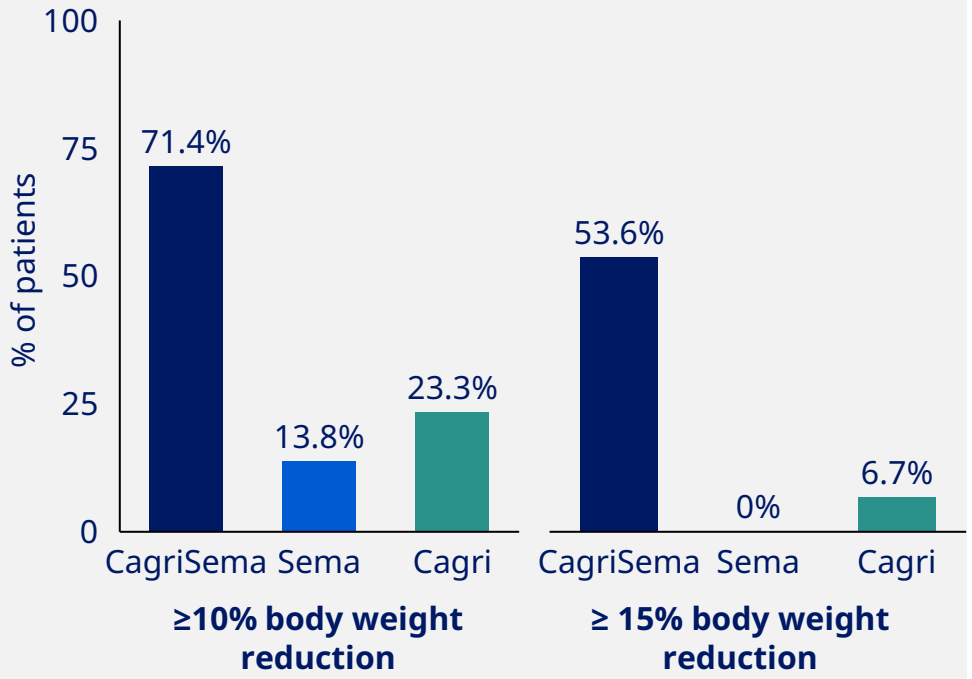
Note: Data shown is trial product estimands
Note: CagriSema is a fixed dose combination of injectable cagrilintide 2.4 mg and injectable semaglutide 2.4 mg
TIR: Time in range

Mean weight loss was -15.6% and more than half of patients achieved ≥15% weight loss when treated with CagriSema

Higher body weight reduction with CagriSema compared to semaglutide and cagrilintide alone



Categorical weight loss after 32 weeks of treatment



Note: Data shown on weight loss over time is trial product estimands. Data on categorical weight loss is from post-hoc analysis (descriptive), from the on-treatment period.
Note: CagriSema is a fixed dose combination of injectable cagrilintide 2.4 mg and injectable semaglutide 2.4 mg. Sema: Semaglutide; Cagri: Cagrilintide

In the phase 2 trial, CagriSema appeared to have a safe and well-tolerated profile

	CagriSema 2.4 mg (n = 31)		Semaglutide 2.4 mg (n = 31)		Cagrilintide 2.4 mg (n = 30)	
	n	%	n	%	n	%
AEs	21	67.7	22	71.0	24	80.0
Severity of AEs						
Mild	18	58.1	13	41.9	20	66.7
Moderate	14	45.2	16	51.6	13	43.3
Severe	0	0.0	1	3.2	1	3.3
Gastrointestinal adverse events	18	58.1	10	32.3	10	33.3
Serious AEs	0	0.0	2	6.5	4	13.3
AEs leading to drug withdrawal	**0**	**0.0**	**1**	**3.2**	**0**	**0.0**

Gastrointestinal adverse events were all mild or moderate in severity and the majority occurred during dose escalation

GLP-1: Glucagon like peptide-1; AE: Adverse event
Note: CagriSema is a fixed dose combination of injectable cagrilintide 2.4 mg and injectable semaglutide 2.4 mg

Phase 3 trial programme in type 2 diabetes, REIMAGINE, expected to initiate in second half of 2023

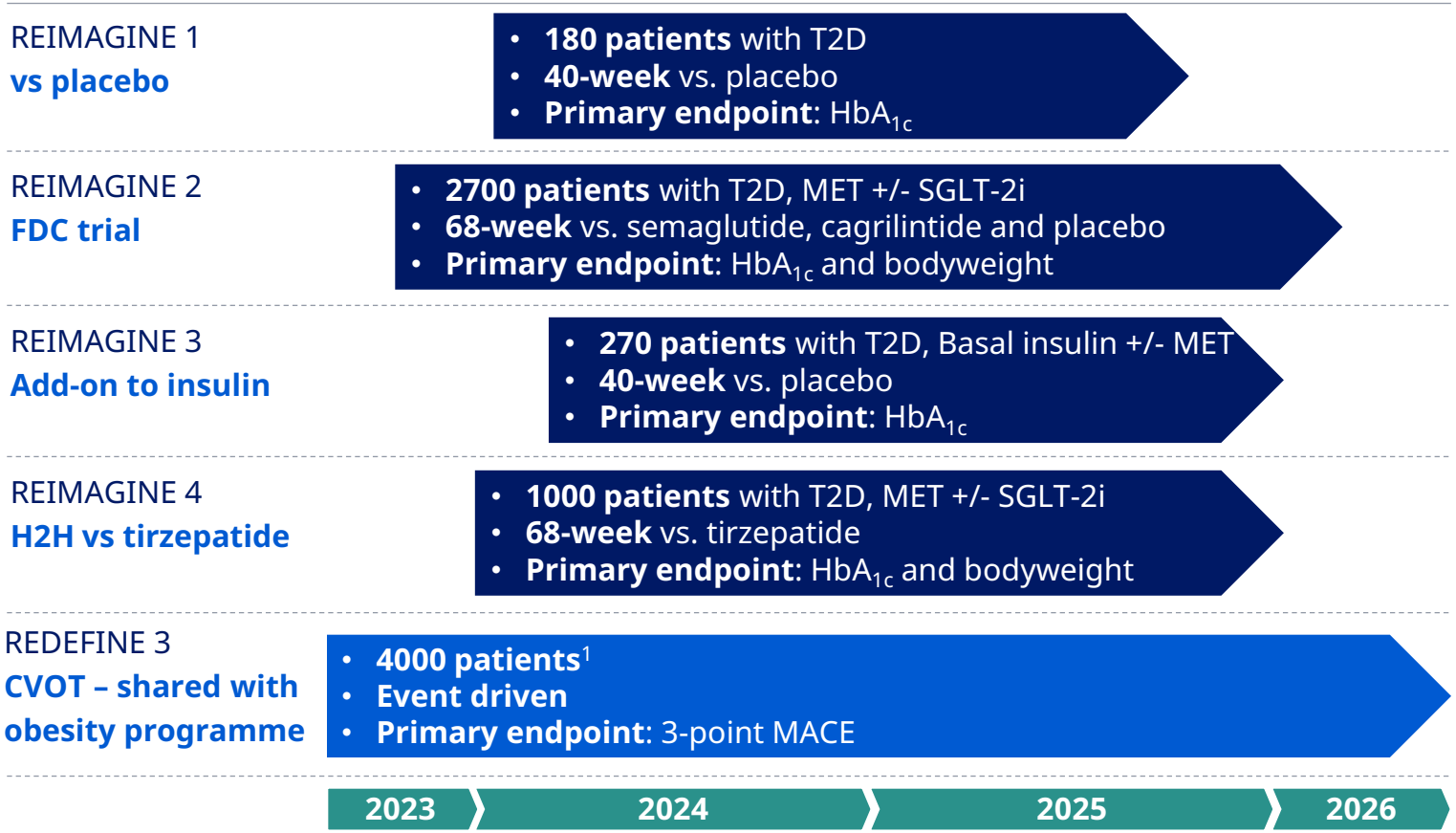
CagriSema characteristics

CagriSema is a fixed dose combination of injectable cagrilintide 2.4 mg and semaglutide 2.4 mg

Phase 3a programme with CagriSema in T2D:

- Aims to confirm efficacy and safety across four global trials
- Expected completion during 2025/2026

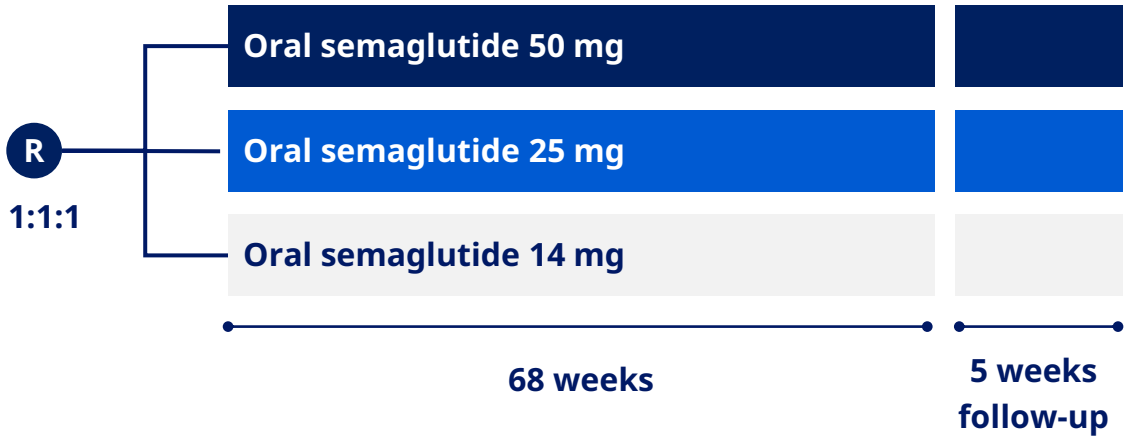
Global phase 3 trial programme



1 65% of patients with T2D, 35% without T2D
FDC: Fixed dose combination; T2D: Type 2 Diabetes; H2H: Head-to-head; CVOT: Cardiovascular outcomes trial; 3P: Three point; MACE: Major adverse cardiovascular event; MET: Metformin; SGLT-2i: sodium-glucose co-transporter-2 inhibitor
Note: CagriSema is a fixed dose combination of injectable cagrilintide 2.4 mg and injectable semaglutide 2.4 mg

PIONEER PLUS with oral semaglutide in people with type 2 diabetes was successfully completed in Q2 2023

PIONEER PLUS enrolled 1606 patients with T2D



Objective:

- To compare the safety and efficacy of once daily oral semaglutide 25 mg and 50 mg with oral semaglutide 14 mg in people with T2D

Primary endpoint:

- Change from baseline to week 52 in HbA_{1c}

Secondary confirmatory endpoints:

- Change from baseline to week 52 in body weight

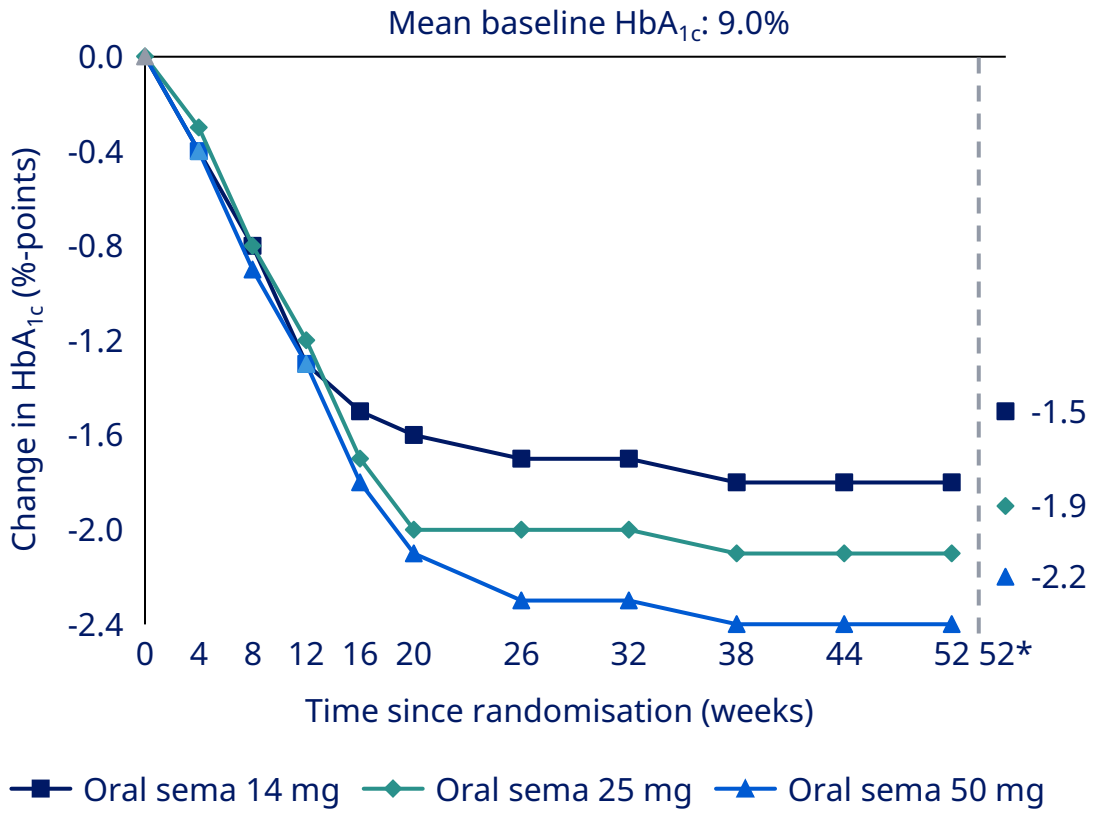
Key Inclusion criteria:

- Type 2 diabetes
- HbA_{1c} 8.0–10.5%
- BMI ≥25 kg/m2
- Stable dose of 1-3 OADs (metformin, SU, SGLT-2i or DPP-4i)

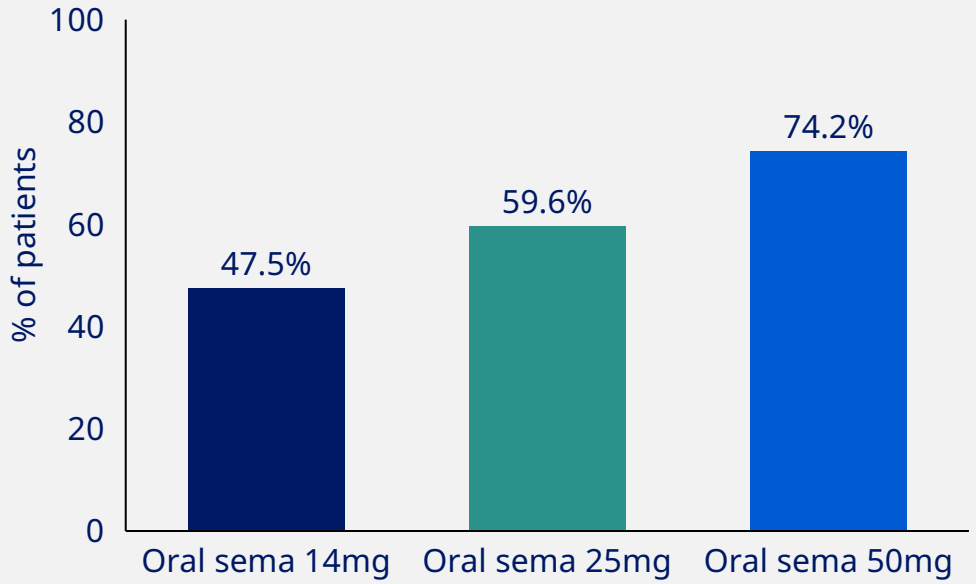
T2D: Type 2 diabetes; R: Randomisation; BMI: body mass index; SGLT-2i: Sodium/glucose co-transporter-2 inhibitors

Oral semaglutide 25 and 50 mg demonstrated statistically significant and superior reduction in HbA_{1C} compared to 14 mg

Superior reduction in HbA_{1c} from baseline to 52 weeks



Achievement of HbA_{1c} target <7.0% after 52 weeks

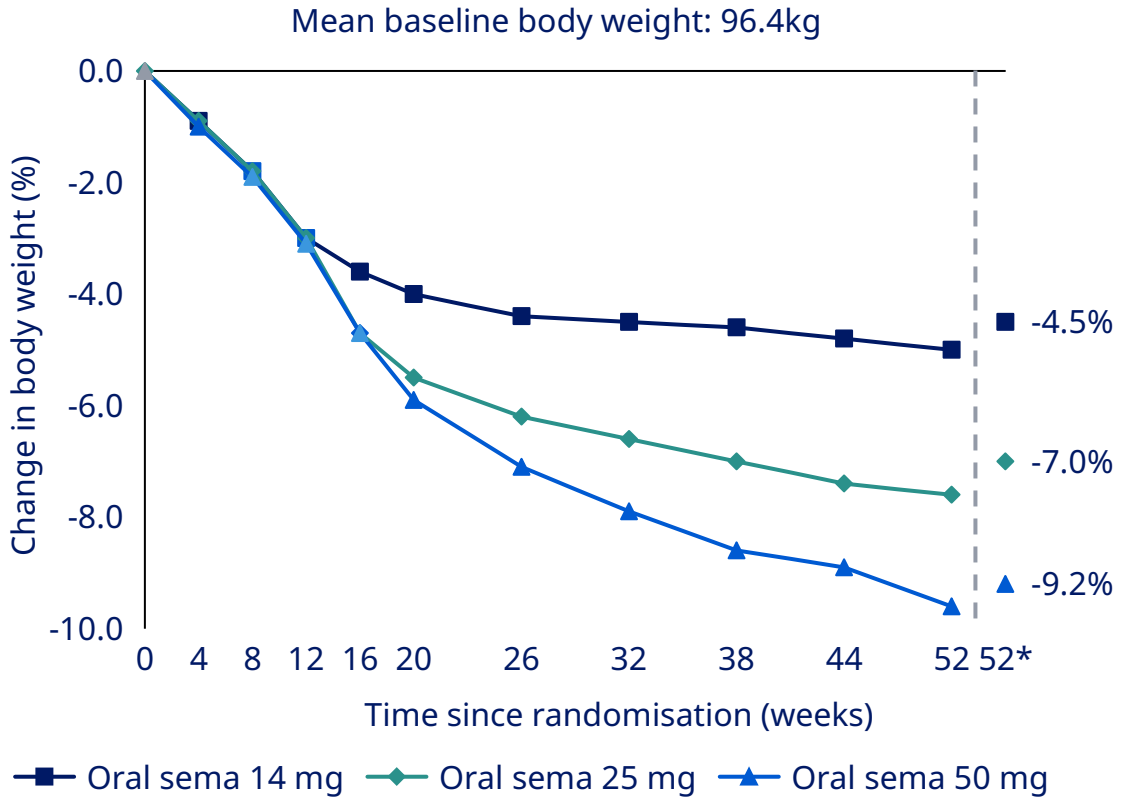


- More participants achieved the HbA_{1c} target after 52 weeks with oral semaglutide 25 and 50 mg compared to 14 mg

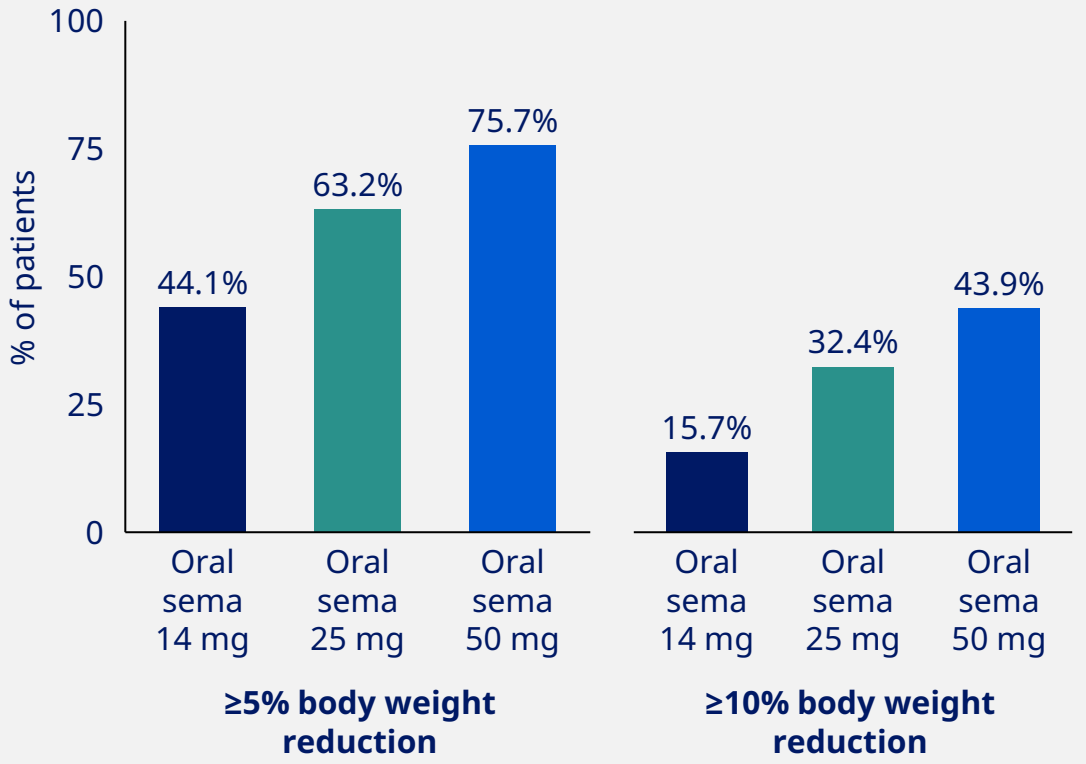
Note: Observed data are on-treatment. Week 52* is the HbA_{1c} change using the trial product estimand. HbA_{1c} targets are shown with trial product estimand data
Sema: Semaglutide

Oral semaglutide 25 and 50 mg demonstrated statistically significant higher weight loss vs 14 mg in the PIONEER plus trial

Higher body weight reduction with oral semaglutide 25 mg and 50 mg compared to 14 mg



Categorical weight loss after 52 weeks of treatment



Note: Observed data are on-treatment. Week 52* is the body weight change using the trial product estimand.
Sema: Semaglutide

The safety profile of oral semaglutide 25 and 50 mg was generally consistent with the GLP-1 receptor agonist drug class

	Oral semaglutide 14 mg (n = 534)		Oral semaglutide 25 mg (n = 534)		Oral semaglutide 50 mg (n = 534)	
	n	%	n	%	n	%
AEs	404	(75.7)	422	(79.0)	428	(80.1)
Gastrointestinal adverse events	225	(42.1)	282	(52.8)	286	(53.6)
Serious AEs	53	(9.9)	57	(10.7)	44	(8.2)
AEs leading to drug withdrawal	54	(10.1)	66	(12.4)	68	(12.7)

Safety:

- Majority of gastrointestinal adverse events were mild or moderate in severity
- The majority occurred during dose escalation
- In the trial, oral semaglutide 25 and 50 mg appeared to have a safe and well-tolerated profile

GLP-1: Glucagon like peptide-1; AE: Adverse event; T2D: Type 2 diabetes

GLP-1 diabetes: Key take-aways:

GLP-1 RA's have demonstrated several benefits and are recommended as first line treatment for some people with T2D in international treatment guidelines

In the phase 2 trial, CagriSema showed improved reduction of HbA_{1c} and of body weight as well as longer time in range vs monocomponents

CagriSema appeared to have a safe and well-tolerated profile. Phase 3 in T2D is expected to be initiated during H2 of 2023

Based on the efficacy profile in PIONEER PLUS, oral semaglutide 25 and 50 mg may provide the option for patients to progress to higher doses if additional glycaemic control or weight loss is needed

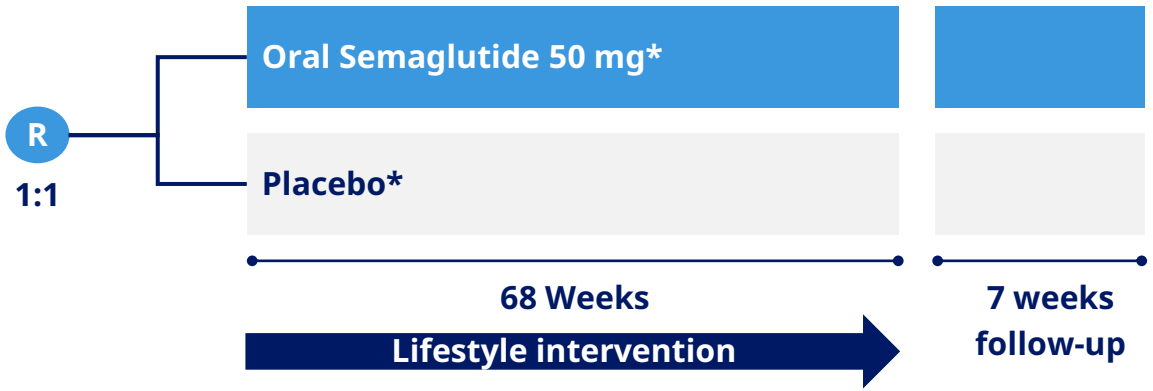
GLP-1 RA: Glucagon like peptide-1 receptor agonist; T2D: Type 2 diabetes
Note: CagriSema is a fixed dose combination of injectable cagrilintide 2.4 mg and injectable semaglutide 2.4 mg

Agenda

Introduction		*Daniel Bohsen & Martin Holst Lange*
Insulin		
	Insulin Icodec	*Stephen Gough*
GLP-1 in diabetes		
	CagriSema in diabetes	*Martin Holst Lange*
	Oral semaglutide in diabetes	*Stephen Gough*
GLP-1 in obesity		
	Oral semaglutide in obesity	*Stephen Gough*
	Semaglutide 2.4 mg: STEP HFpEF	*Martin Holst Lange*
Q&A		*All*

OASIS 1 with oral semaglutide 50 mg in people with overweight or obesity has been successfully completed

OASIS 1 enrolled 667 patients with overweight or obesity



Objective:

- To compare the safety and efficacy of 50 mg oral semaglutide with placebo in people with overweight or obesity without T2D

Co-primary endpoints:

- Percentage change in body weight from baseline to week 68
- Achievement of ≥5% weight loss from baseline at week 68

Confirmatory secondary endpoints:

- Achievement of ≥10%, ≥15% and ≥20% weight loss from baseline at week 68

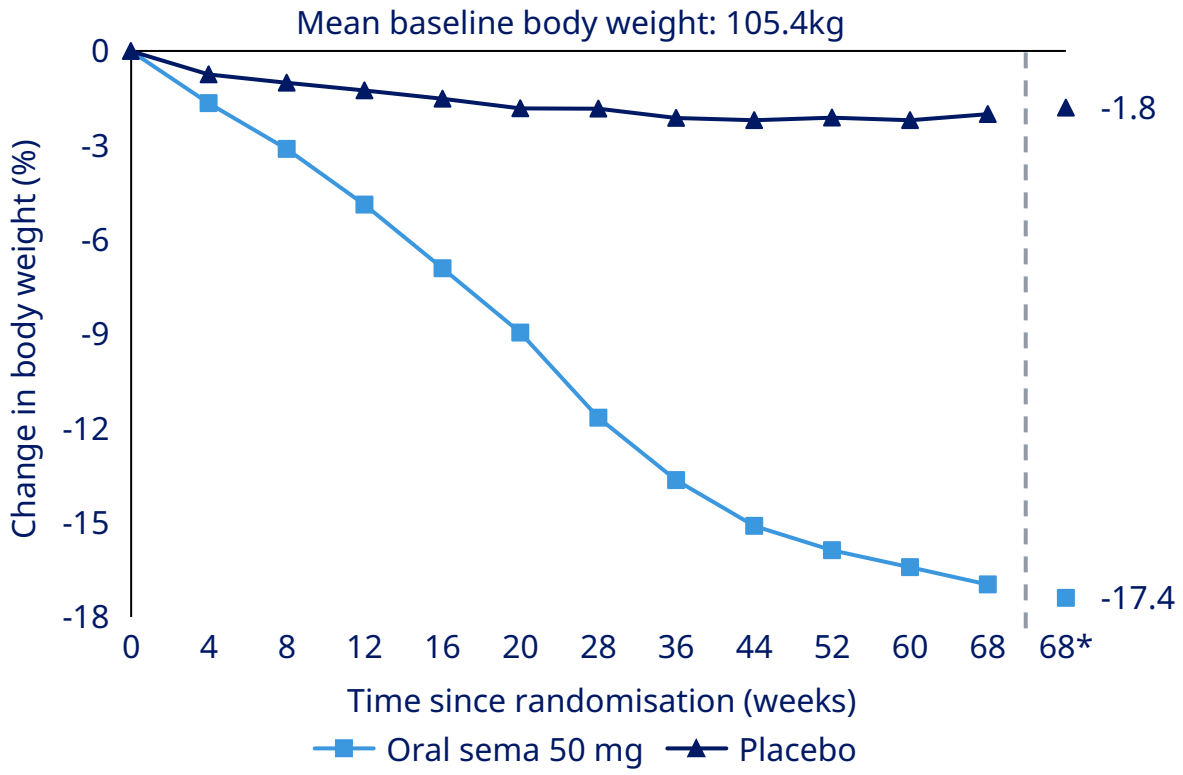
Inclusion criteria:

- BMI: ≥27 kg/m^2 with ≥ 1 weight-related comorbidity, or
- BMI: ≥30 kg/m^2
- Weight-related comorbidities are hypertension, dyslipidaemia, obstructive sleep apnoea and CVD
- ≥1 self-reported dietary weight loss effort

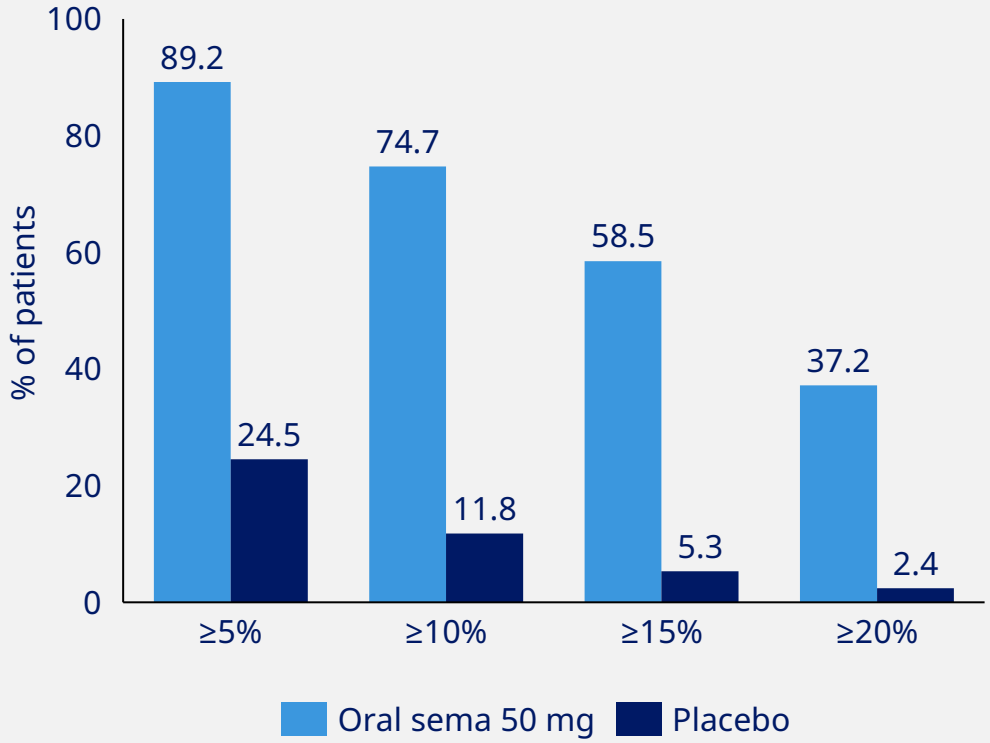
*As an adjunct to a reduced-calorie diet and increased physical activity in adults with obesity or with overweight and weight-related comorbidities (Weight-related comorbidities are hypertension, dyslipidaemia, obstructive sleep apnoea and CVD)
T2D: Type 2 diabetes; R: Randomisation; BMI: body mass index

Oral semaglutide 50 mg in overweight or obesity demonstrated superior body weight reduction in the OASIS 1 trial vs placebo

OASIS 1 showed significantly greater weight loss compared to placebo



Categorical weight loss % at week 68



Note: Observed data are on-treatment. Week 68* is the body weight change using the trial product strategy
Sema: Semaglutide

The safety profile of oral semaglutide 50 mg was generally consistent with the GLP-1 receptor agonist drug class

	Oral semaglutide 50 mg (n = 334)		Placebo (n = 333)	
	n	%	n	%
AEs	307	(91.9)	285	(85.6)
Gastrointestinal adverse events	268	(80.2)	154	(46.2)
Serious AEs	32	(9.6)	29	(8.7)
AEs leading to drug withdrawal	19	(5.7)	12	(3.6)

Safety:

- Majority of gastrointestinal adverse events were mild or moderate in severity
- The majority occurred during dose escalation
- In the trial, oral semaglutide 50 mg appeared to have a safe and well-tolerated profile.

GLP-1: Glucagon like peptide-1; AE: Adverse event

Phase 3 trial programme for oral semaglutide 50 mg in overweight or obesity, OASIS

Oral semaglutide characteristics

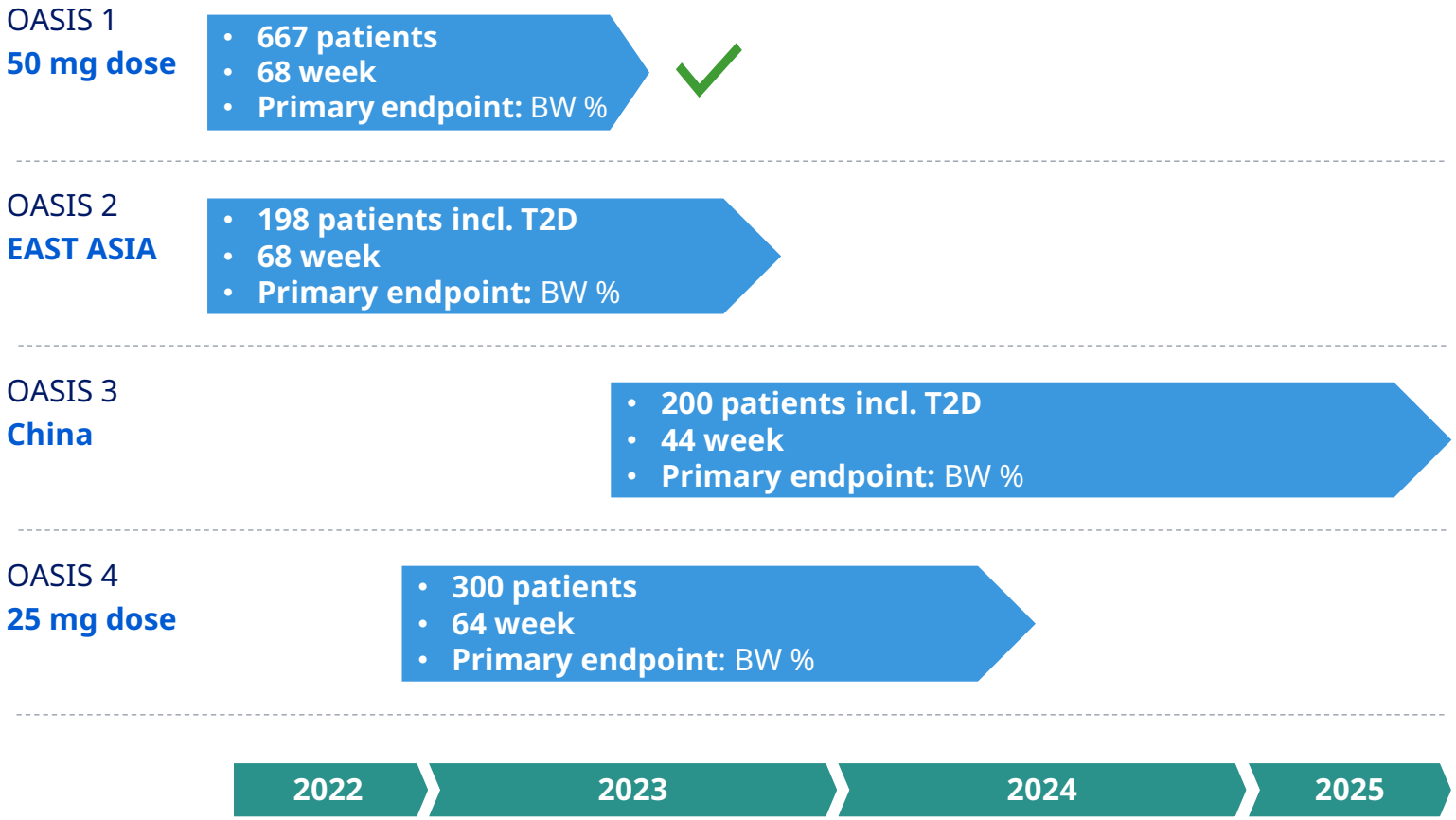
Oral semaglutide 50mg:

- Semaglutide tablets in overweight or obesity
- Once daily tablet

Phase 3a programme with oral semaglutide 50 mg

- Aims to confirm efficacy and safety
- Submission in US and EU expected during 2023
- The global launch of oral semaglutide 50 mg is contingent on portfolio prioritisations and manufacturing capacity

Focused phase 3 trial programme



BW: Body weight; T2D: Type 2 diabetes

Obesity is associated with multiple comorbidities, which may be improved with weight management

Life expectancy decreases as BMI increases[1]

Normal BMI

Almost 80% chance of reaching age 70

BMI 35–40 kg/m²

~60% chance of reaching age 70

BMI 40–50 kg/m²

~50% chance of reaching age 70

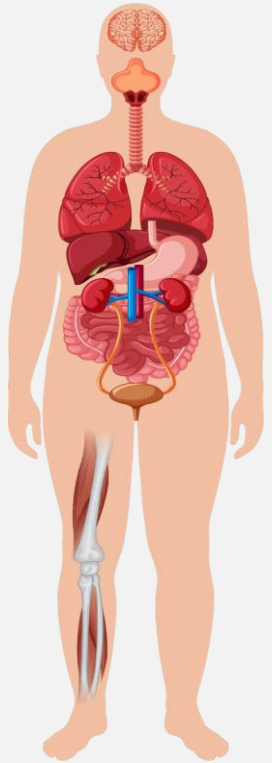
Obesity related comorbidities[2]

Mental

- Depression
- Anxiety

Mechanical

- Asthma
- GERD
- Physical functioning
- Incontinence
- Knee osteoarthritis
- Sleep apnea
- Chronic back pain



Metabolic

- NAFLD
- Gallstones
- Infertility
- Type 2 diabetes
- Prediabetes
- Thrombosis
- Gout
- Cancers*
- CVD:
  - Stroke
  - Dyslipidemia
  - Hypertension
  - Coronary artery disease
  - HFpEF

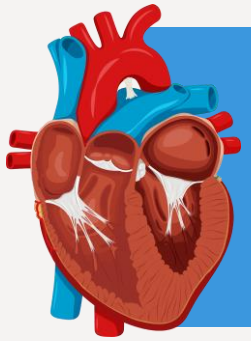
*Including breast, colorectal, endometrial, oesophageal, kidney, ovarian, pancreatic and prostate

1 Prospective Studies Collaboration. Lancet. 2009;373:1083–96. 2 Adapted from Sharma AM. Obes Rev 2010;11:808–9; Guh DP et al. BMC Public Health 2009;9:88; Luppino FS et al. Arch Gen Psychiatry 2010;67:220–9; Simon GE et al. Arch Gen Psychiatry 2006;63:824–30; Church TS et al. Gastroenterology 2006;130:2023–30; Li C et al. Prev Med 2010;51:18–23; Hosler AS. Prev Chronic Dis 2009;6:A48.

BMI: Body mass index; GERD: gastro-oesophageal reflux disease; HFpEF: heart failure with preserved ejection fraction; NAFLD: non-alcoholic fatty liver disease; CVD: Cardiovascular disease; HFpEF: Heart failure with preserved ejection fraction

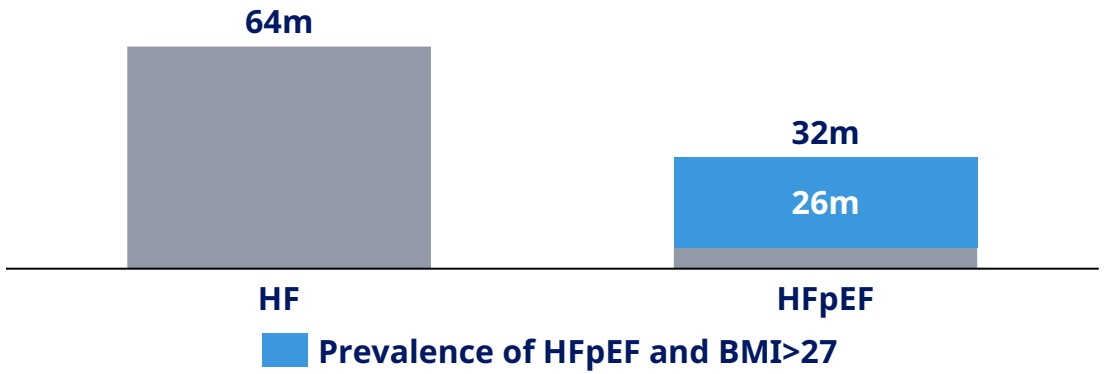
HFpEF compromises ~50% of all HF cases, and ~80% of HFpEF patients live with overweight or obesity

Heart failure with preserved ejection fraction



- Impaired filling capacity
- Stiff and thick ventricle
- LVEF ≥50%

Approximately 26 million people have HFpEF and BMI>27[1,2]



Patients with HFpEF are under a great burden[3]

- Higher mortality rate
- Higher risk of hospitalisation
- Higher burden of debilitating symptoms, physical limitations and poor quality of life

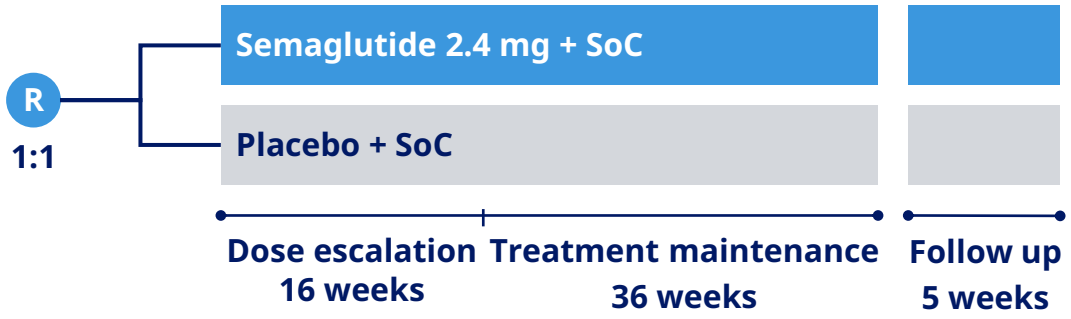
The key goals of therapy[3]

- Prolong survival
- Reduce hospitalisations
- Reduce symptoms; improve quality of life and functional status

1. Groenewegen A et al. Eur J Heart Fail 2020;22:1342–13561; Gurwitz JH et al. Am J Med 2013;126:393–400; 2. Haass M et al. Circulation 2011;4:324–331; Kitzman DW, et al. J Am Coll Cardiol 2016;68:200–203 3. Ponikowski P et al. Eur J Heart Fail 2016;18:891–975
LVEF: Left ventricular ejection fraction; HF: Heart failure; HFpEF: Heart Failure with preserved ejection fraction

Phase 3 trial STEP HFpEF with semaglutide 2.4 mg has been successfully completed in Q2 2023

STEP HFpEF trial with 529 people with obesity and HFpEF



STEP HFpEF

Objective:

- Evaluate the effect on HF specific symptoms, physical function and body weight compared with placebo

Dual primary endpoints:

- Change in KCCQ from baseline to week 52
- Change in body weight from baseline to week 52

Key secondary endpoints:

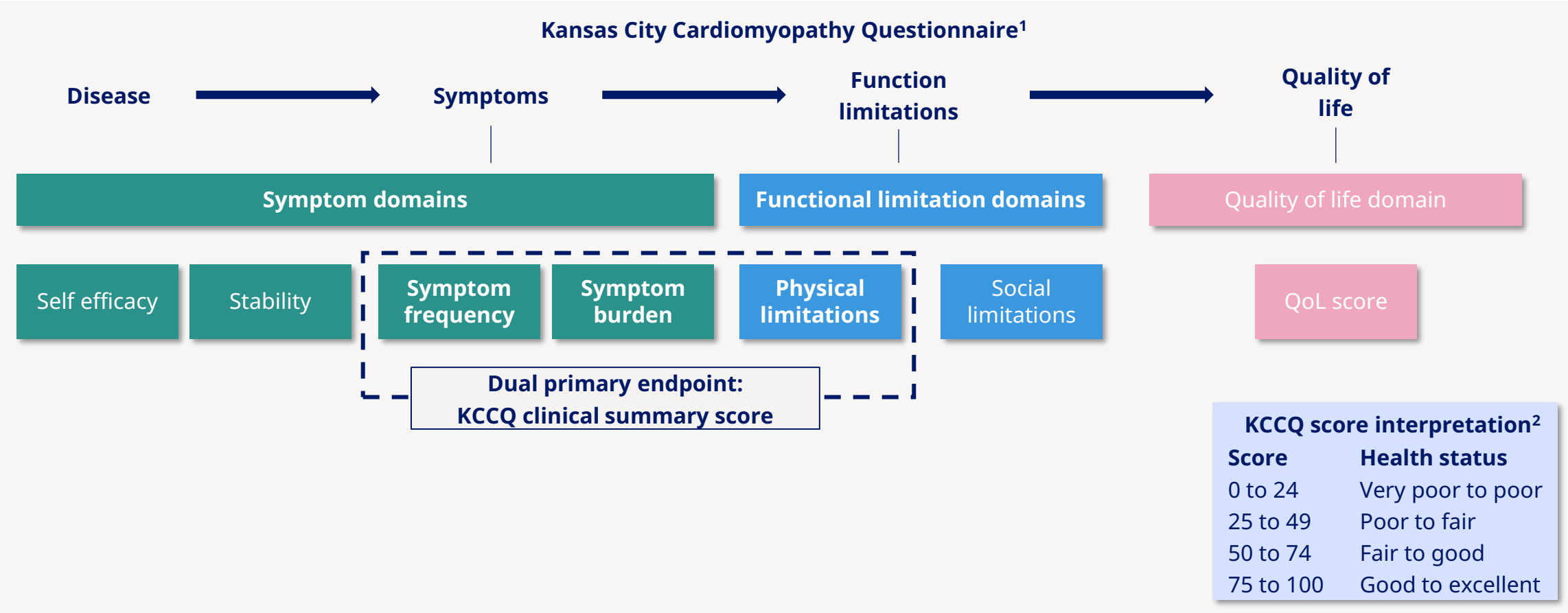
- Change in 6MWD from baseline to week 52
- Composite endpoint (all cause death, HHF, KCCQ, 6MWD) from baseline to week 52

Inclusion criteria:

- BMI ≥30 kg/m2
- NYHA II-IV
- Ejection fraction ≥45%

R: Randomisation; HF: Heart Failure; HFpEF: Heart Failure with preserved ejection fraction; SoC: Standard of care; KCCQ: Kansas City Cardiomyopathy Questionnaire; 6MWD: 6-min walking distance; HHF: Heart failure hospitalization; NYHA: New York Heart Association classification

The Kansas City Cardiomyopathy Questionnaire, a patient reported outcome, was primary endpoint in the STEP HFpEF trial



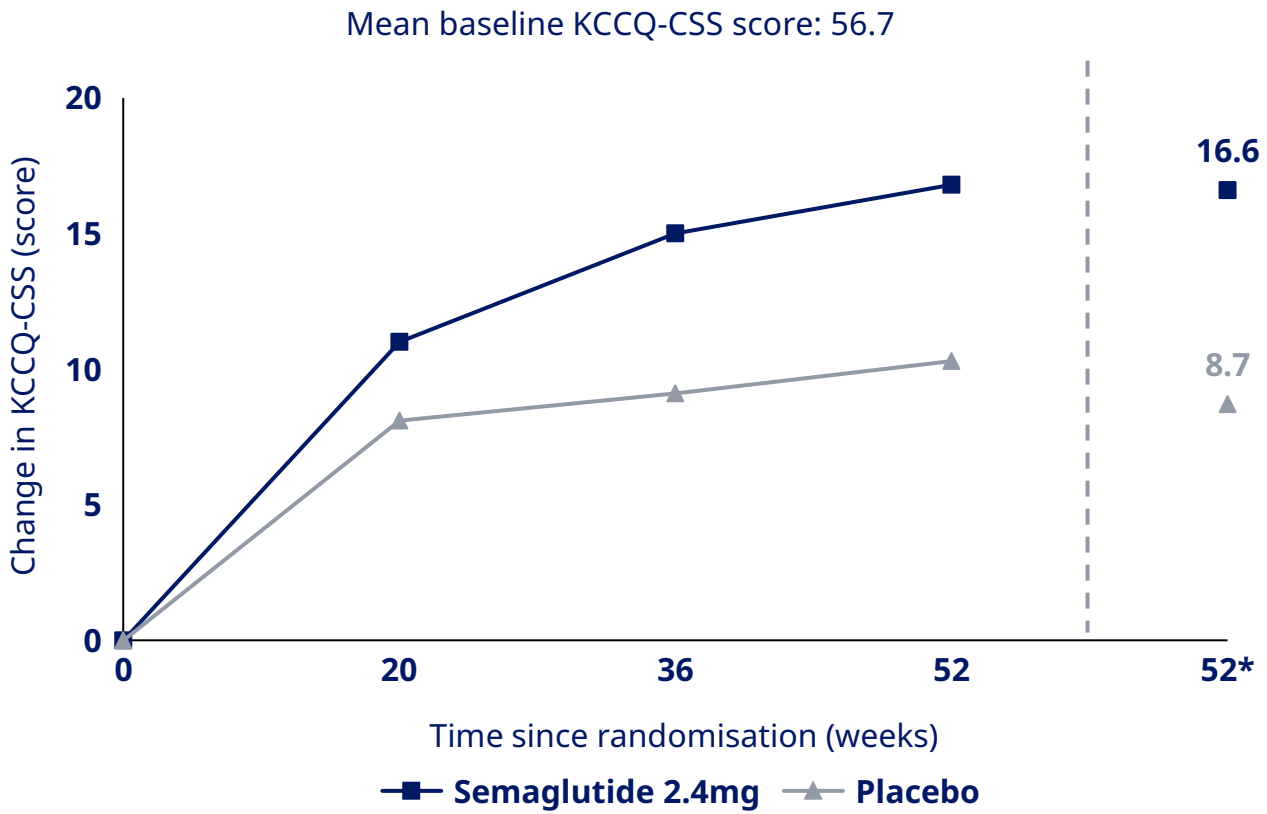
KCCQ score interpretation[2]

Score	Health status
0 to 24	Very poor to poor
25 to 49	Poor to fair
50 to 74	Fair to good
75 to 100	Good to excellent

1 Adapted from: Spertus JA. et al. JACC 2020; 76: 2379-2390; Kelkar AA et al. JACC Heart Fail 2016;4:165–175; Nassif ME et al. Circulation 2019;140:1463–1476 2. Enright PL. et al. Respir Care 2003; 48: 783–785. 2 Spertus JA, et al. JACC State-of-the-Art Review. J Am Coll Cardiol. 2020 Nov 17;76(20):2379-2390.
HFpEF: Heart Failure with preserved ejection fraction; KCCQ: Kansas City Cardiomyopathy Questionnaire

Semaglutide 2.4 mg demonstrated superior improvement on the primary endpoint of KCCQ-CSS vs placebo

Superior improvement in KCCQ-CSS score in patients treated with semaglutide 2.4 mg



Key highlights

Primary endpoints:

- KCCQ-CSS estimated treatment difference between semaglutide 2.4 mg and placebo of 7.8

KCCQ in perspective

Clinicians' assessments of clinical change[1]:

- Small: ±5 points
- Moderate-to-large: ±10 points
- Large-to-very large: ±20 points

Patients' self-classifications of improvements[1]:

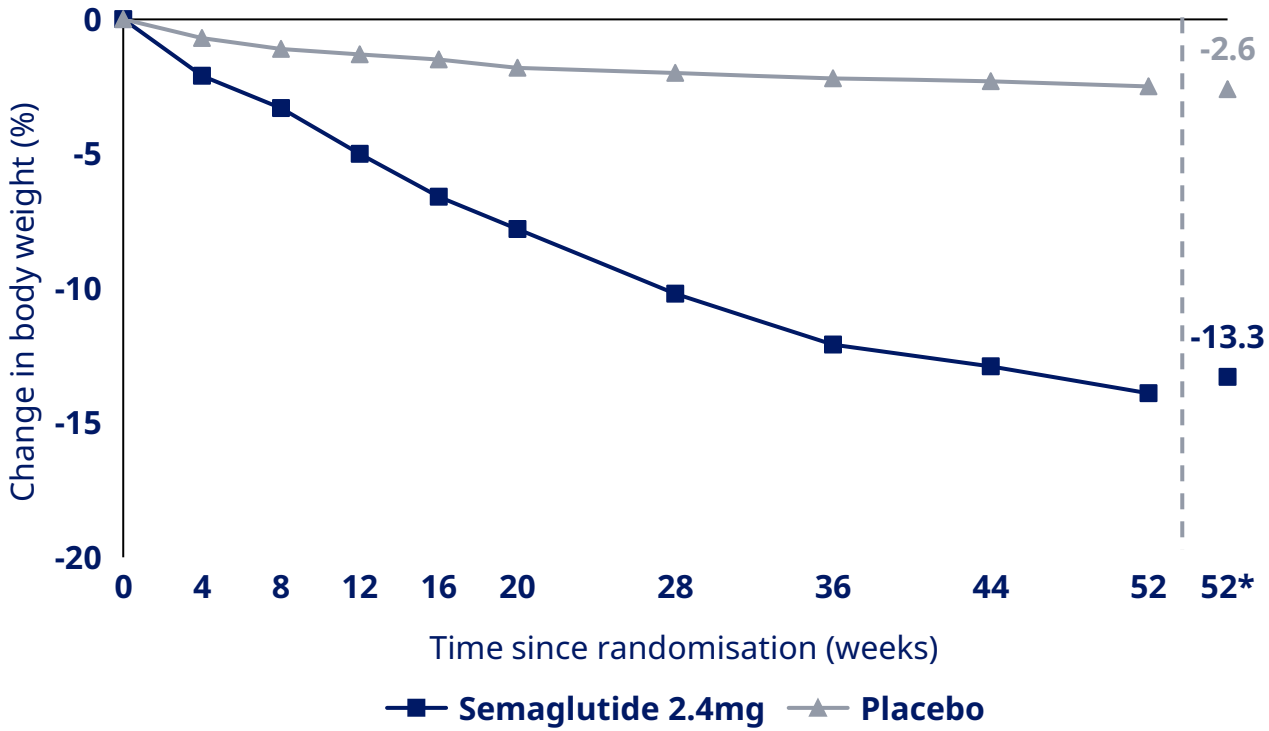
- Minimal clinically important difference for 'little improvement': 4.5 points

1 Spertus JA, et al. JACC State-of-the-Art Review. J Am Coll Cardiol. 2020 Nov 17;76(20):2379-2390.
Note: Data shown is the treatment policy estimand. *Lines are based on observed data where the value denoted after 52 weeks is estimated mean value derived based on multiple imputation
KCCQ-CSS: Kansas City Cardiomyopathy Questionnaire Clinical summary score

Semaglutide 2.4 mg demonstrated superior reduction on the other primary endpoint of body weight vs placebo

Clinically relevant and sustained weight loss in patients treated with semaglutide 2.4 mg

Mean baseline body weight: 108.4 kg



Key highlights

Primary endpoint:

- Estimated treatment difference in body weight change between semaglutide 2.4 mg and placebo of -10.7%

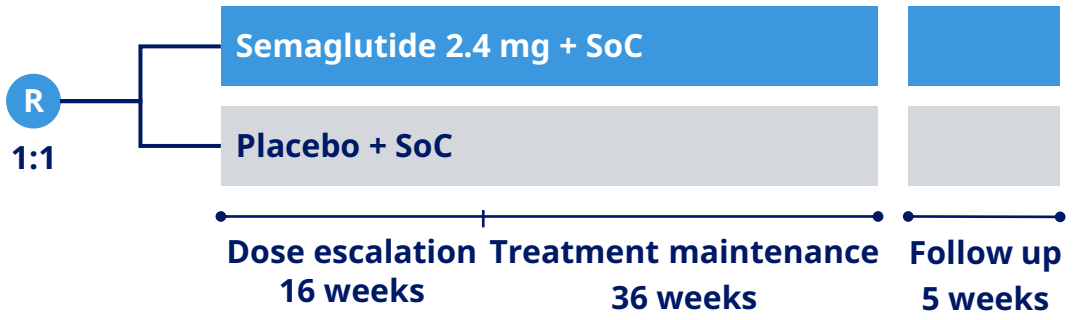
Safety:

- Overall, the safety profile in HFpEF patients is consistent with previous data for semaglutide 2.4 mg

Note: Data shown is the treatment policy estimand. *Lines are based on observed data where the value denoted after 52 weeks is estimated mean value derived based on multiple imputation
HF: Heart failure

The ongoing STEP HFpEF-DM trial is to be included in the regulatory submission

STEP HFpEF-DM trial with 610 people with obesity, HFpEF and T2D



Trial design and next steps

Dual primary endpoints:

- Change in KCCQ from baseline to week 52
- Change in body weight from baseline to week 52

Inclusion criteria:

- BMI ≥30 kg/m2
- NYHA II-IV
- Ejection fraction ≥45%
- HbA_{1c} ≤10.0%

Next steps:

- Completion of STEP HFpEF-DM trial expected in H2 2023
- Combined regulatory submission of both trials in H1 2024
- Decision expected late 2024/early 2025

R: Randomisation; HF: Heart Failure; HFpEF: Heart Failure with preserved ejection fraction; SoC: Standard of care; KCCQ: Kansas City Cardiomyopathy Questionnaire; 6MWD: 6-min walking distance; NYHA: New York Heart Association classification

GLP-1 obesity: Key take-aways:

In OASIS 1, oral semaglaglutide 50 mg showed efficacy broadly on par with injectable semaglutide 2.4 mg

A high unmeet need exists within obesity-related HFpEF

Semaglutide 2.4 mg demonstrated superiority on the dual primary endpoint vs placebo in the STEP HFpEF trial

Strategic aspirations 2025

Purpose and sustainability (ESG)

- Progress towards zero environmental impact
- Being respected for adding value to society
- Being recognised as a sustainable employer

Innovation and therapeutic focus

- Further raise the innovation-bar for diabetes treatment
- Develop a leading portfolio of superior treatment solutions for obesity
- Strengthen and progress the Rare disease pipeline
- Establish presence in Other serious chronic diseases focusing on CVD, NASH and CKD

Commercial execution

- Strengthen Diabetes leadership - aim at global value market share of more than 1/3
- More than 25 billion DKK in Obesity sales by 2025
- Secure a sustained growth outlook for Rare disease

Financials

- Deliver solid sales and operating profit growth
- Drive operational efficiencies across the value chain to enable investments in future growth assets
- Deliver free cash flow to enable attractive capital allocation to shareholders

CVD: Cardiovascular disease; NASH: Non-alcoholic steatohepatitis; CKD: Chronic kidney disease.
Note: The strategic aspirations are not a projection of Novo Nordisk's financial outlook or expected growth.

Agenda

Introduction		*Daniel Bohsen & Martin Holst Lange*
Insulin		
	Insulin Icodec	*Stephen Gough*
GLP-1 in diabetes		
	CagriSema in diabetes	*Martin Holst Lange*
	Oral semaglutide in diabetes	*Stephen Gough*
GLP-1 in obesity		
	Oral semaglutide in obesity	*Stephen Gough*
	Semaglutide 2.4 mg: STEP HFpEF	*Martin Holst Lange*
Q&A		*All*

Investor contact information

Share information

Novo Nordisk's B shares are listed on the stock exchange in Copenhagen under the symbol 'NOVO B'. Its ADRs are listed on the New York Stock Exchange under the symbol 'NVO'.

For further company information, visit Novo Nordisk on: www.novonordisk.com

Upcoming events

10 August 2023	Financial statement for the first six months of 2023
02 November 2023	Financial statement for the first nine months of 2023
31 January 2024	Financial statement 2023

Investor Relations contacts

Novo Nordisk A/S
Investor Relations
Novo Alle 1
DK-2880 Bagsværd

Daniel Muusmann Bohsen	+45 3075 2175	dabo@novonordisk.com
David Heiberg Landsted	+45 3077 6915	dhel@novonordisk.com
Jacob Martin Wiborg Rode	+45 3075 5956	jrde@novonordisk.com
Mark Joseph Root (USA)	+1 848 213 3219	mjhr@novonordisk.com