KAMADA INVESTOR PRESENTATION

NASDAQ & TASE: KMDA

April 2019

FORWARD LOOKING STATEMENT

This presentation is not intended to provide investment or medical advice. It should be noted that some products under development described herein have not been found safe or effective by any regulatory agency and are not approved for any use outside of clinical trials.

This presentation contains forward-looking statements, which express the current beliefs and expectations of Kamada's management. Such statements involve a number of known and unknown risks and uncertainties that could cause Kamada's future results, performance or achievements to differ significantly from the prospected results, performances or achievements expressed or implied by such forward-looking statements. Important factors that could cause or contribute to such differences include, but are not limited to, risks relating to Kamada's ability to successfully develop and commercialize its products and product candidates, the progress and results of any clinical trials, the introduction of competing products, the impact of any changes in regulation and legislation that could affect the pharmaceutical industry, the difficulty of predicting, obtaining or maintaining U.S. Food and Drug Administration, European Medicines Agency and other regulatory authority approvals, the regulatory environment, restrains related to third parties' IP rights and changes in the health policies and structures of various countries, environmental risks, changes in the worldwide pharmaceutical industry and other factors that are discussed under the heading "Risk Factors" of Kamada's 2017 Annual Report on Form 20-F as well as in Kamada's recent Forms 6-K filed with the U.S. Securities and Exchange Commission.

This presentation includes certain non-IFRS financial information, which is not intended to be considered in isolation or as a substitute for, or superior to, the financial information prepared and presented in accordance with IFRS. The non-IFRS financial measures may be calculated differently from, and therefore may not be comparable to, similarly titled measures used by other companies. In accordance with the requirement of the SEC regulations a reconciliation of these non-IFRS financial measures to the comparable IFRS measures is included in an appendix to this presentation. Management uses these non-IFRS financial measures for financial and operational decision-making and as a means to evaluate period-to-period comparisons. Management believes that these non-IFRS financial measures provide meaningful supplemental information regarding Kamada's performance and liquidity.

Forward-looking statements speak only as of the date they are made, and Kamada undertakes no obligation to update any forward-looking statement to reflect the impact of circumstances or events that arise after the date the forward-looking statement was made, except as required by applicable securities laws. You should not place undue reliance on any forward-looking statement and should consider the uncertainties and risks noted above, as well as the risks and uncertainties more fully discussed under the heading "Risk Factors" of Kamada's 2018 Annual Report on Form 20-F as well as in Kamada's recent Forms 6-K filed with the U.S. Securities and Exchange Commission.

KAMADA COMPANY OVERVIEW

COMMERCIAL

2	**FDA approved** products: **GLASSIA®** for AATD; **KEDRAB®** for Post-exposure prevention of rabies infection
4	IgG products marketed world wide
20	Products exclusively distributed in Israel

US Commercial Partners

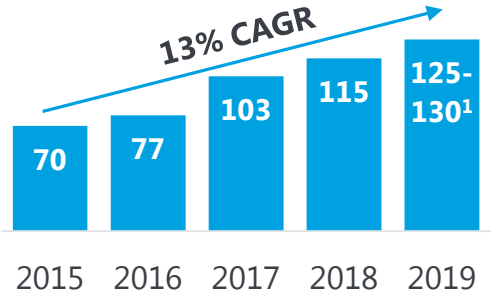
Takeda / Shire

KEDRION BIOPHARMA

ADVANCED CLINICAL PIPELINE

Lead product candidate:	**Inhaled AAT** for AATD
Development programs:	AAT-IV for GvHD; Lung Transplant; T1D
Early Stage programs:	rAAT; Organ Preservation

Revenues US$M



$230M
Market Cap (03/29/19)

$50.6M
Cash (12/31/18)

No debt

1. *Guidance*

HIGH VALUE PRODUCT PORTFOLIO AND PIPELINE

Product	Indication	Phase I / Phase II / Phase III / Market	
Glassia® (IV AAT)	AAT Deficiency	FDA approved (2010) Launched (2010)	U.S. distribution through Takeda / Shire
KamRab®/KedRab® (IM Anti-Rabies)	Prophylaxis for Rabies	FDA approved (2017) Launched (2018)	U.S. distribution through KEDRION BIOPHARMA
Clinical Development			
Inhaled AAT	AAT Deficiency [1]	EU Phase 2/3 (completed) MAA withdrawn (June 2017) EMA accepted new Ph3 design US Phase 2 (completed) FDA review of path forward	May seek partner upon IND/CTA approval
G1-AAT (IV)	Graft vs Host Disease (GvHD) [1]	Phase 1/2 (completed) Phase 2 (ongoing)	Ph2 in collaboration with MAGIC [3]
L1-AAT (IV)	Lung Transplant	Phase 2 (ongoing)	In collaboration with Takeda/Shire
D1-AAT (IV)	Type 1 Diabetes [2]	Phase 2 (completed)	Seeking partner for further development
Early Stage Development			
Recombinant AAT	AAT Deficiency	Early development	
AAT (liquid)	Organ preservation	Ex-Vivo study	Massachusetts General Hospital

1. *Orphan drug designation (US & EU); 2. Orphan drug designation (US only);*
3. *Mount Sinai Acute GVHD International Consortium*

EXPERIENCED MANAGEMENT TEAM

Amir London	CEO
Chaime Orlev	CFO
Michal Ayalon, PhD	VP Research and Development
Yael Brenner	VP Quality
Eitan Kyiet	VP Business Development
Eran Nir	VP Operations
Orit Pinchuk	VP Regulatory Affairs & PVG
Ariella Raban	VP Human Resources
Michal Stein, MD	VP Medical Director (Immunology)
Naveh Tov, MD, PhD	VP Clinical Development & Medical Director (Pulmonary)

INCREASING REVENUE GROWTH AND PROFITABILITY

US $ M	FY 2015 Audited	FY 2016 Audited	% Change 2016/2015	FY 2017 Audited	% Change 2017/2016	FY 2018 Unaudited	% Change 2018/2017
Proprietary Products	43	56	30%	80	42%	91	14%
Distribution Products	27	21	-22%	23	8%	24	2%
Total Revenues	**70**	**77**	**10%**	**103**	**33%**	**115**	**11%**
Gross Profit	**15**	**21**	**39%**	**32**	**50%**	**42**	**30%**
Gross Profit (%)	**22%**	**28%**		**31%**		**36%**	
R&D	(17)	(16)		(12)		(10)	
S&M and G&A	(10)	(11)		(13)		(12)	
Operating Profit (Loss)	**(11)**	**(5)**		**7**		**19**	
Net Profit (Loss)	**(11)**	**(7)**	**40%**	**7**	**204%**	**22**	**223%**
Adjusted EBITDA[1]	**(6)**	**(1)**	**83%**	**11**	**1200%**	**24**	**108%**

2019 Revenue Guidance of $125-130M;
An anticipated 9% to 13% Increase Over Full-Year 2018
Continued Profitability and Positive Cash Flow

1. *See Appendix A for Adjusted EDITDA reconciliation*

Alpha-1 Antitrypsin Deficiency (AATD)

WHAT IS ALPHA-1 ANTITRYPSIN

- **Alpha-1 Antitrypsin (AAT)**

  52-kDa serum serine-protease inhibitor that is produced by hepatocytes and mononuclear phagocytes.
  It is the most predominant protease inhibitor in the plasma.
  Concentrations of 1-3 mg/ml that are upregulated several folds during inflammation.

- **Clinical Presentation**

  Subjects genetically deficient of AAT have low circulating levels and are at increased risk for lung, liver and pancreatic diseases.

- **Extensively used and extremely safe**

  Plasma-derived AAT has been used since the 1980's and its safety profile is exceptional.

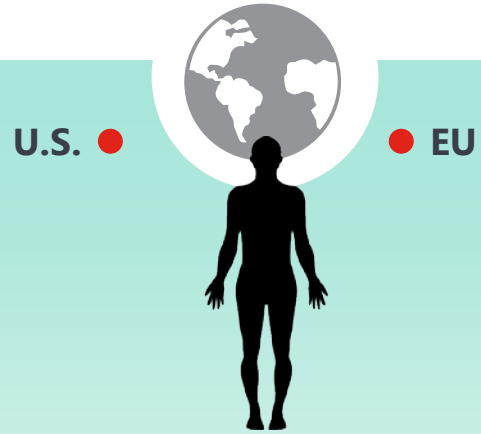
  AAT is extensively researched for use in multiple indications due to its anti-inflammatory and immunomodulatory properties.

  AAT is an acute phase protein with a major role within the inflammatory processes homeostasis.

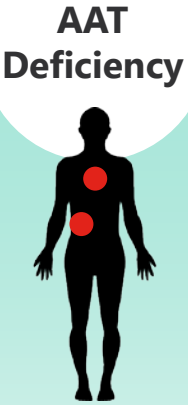
AAT DEFICIENCY

Potentially Lethal and Often Undiagnosed

Genetic condition causing decreased levels of AAT in blood and tissues



Affects more than 100,000 people in the U.S. and lower numbers in Europe



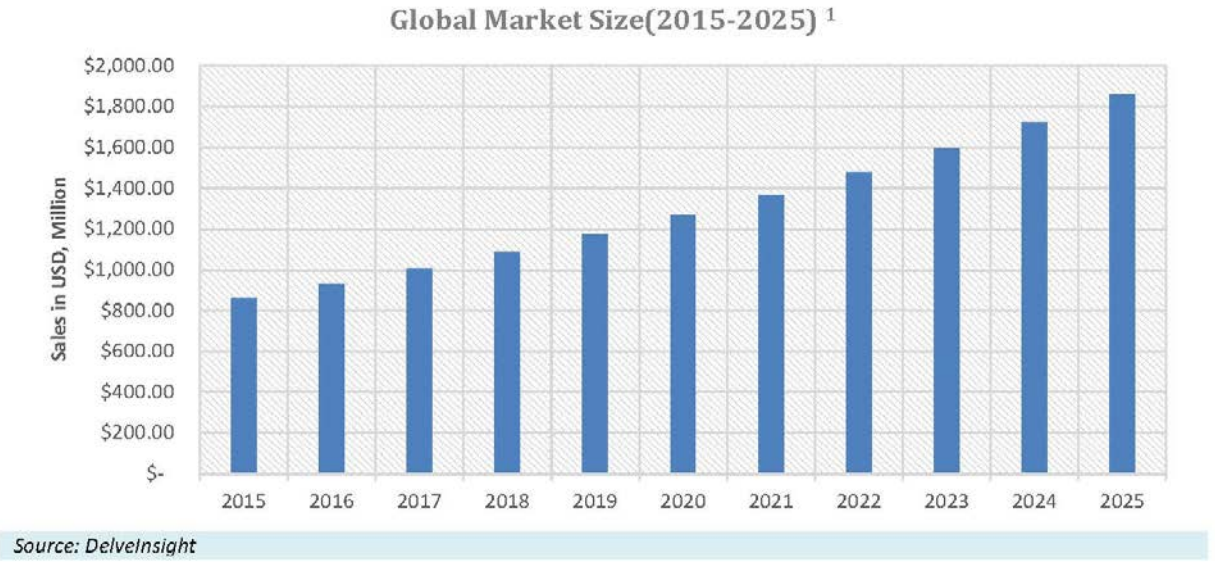
Causes predisposition to lung and liver diseases

AAT deficiency-associated lung disease is characterized by airway obstruction and destructive changes in the lungs (Emphysema)

AAT DEFICIENCY (AATD) IS A $1B MARKET

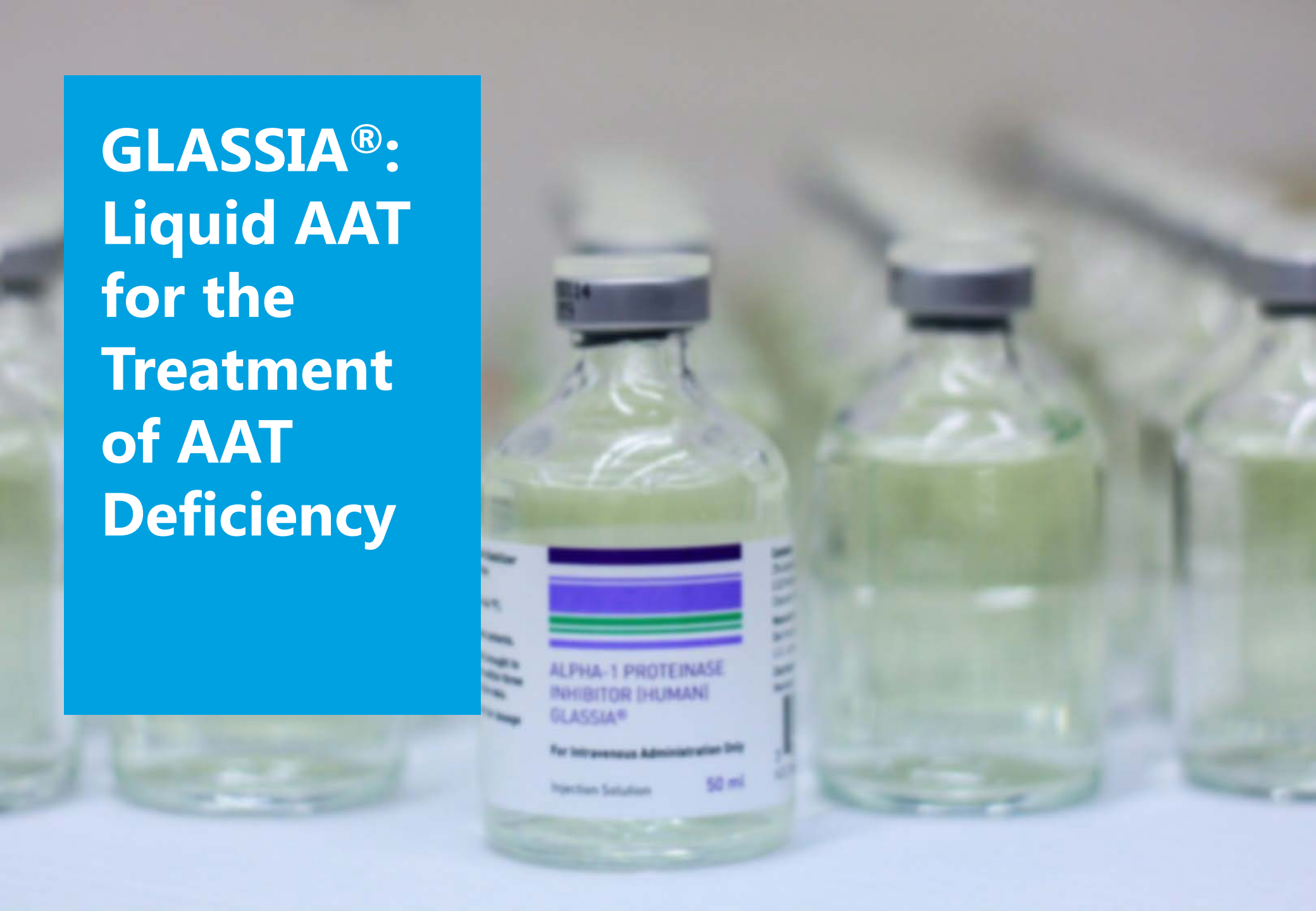
Significant expansion opportunity

- Most of AATD patients are **undiagnosed & untreated**
- Better disease awareness and availability of diagnostics contribute to increased demand
- Growing U.S. market – 6-8% annual growth[1]
- Average annual reimbursement (U.S.) **~$80-$100K per patient**



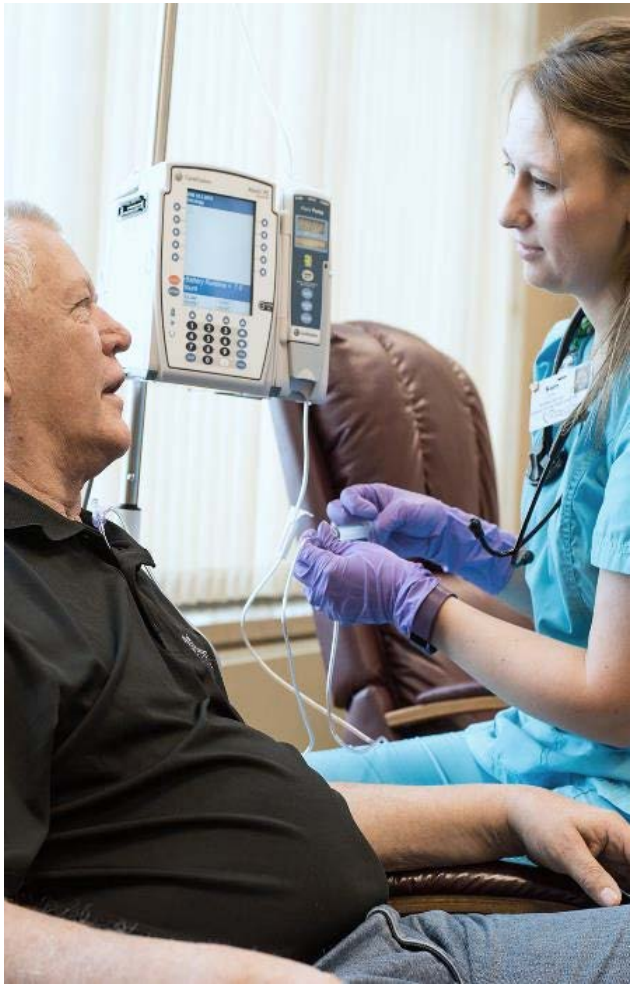
- **AATD prevalence[1]: Approx. 115,000 (U.S.) & 72,000 (EU5)** but only approx. 7,300 (U.S.) and 1,800 (EU5) patients treated [1]
- **Expected to reach $1.8B by 2025**

1. Source: Delveinsight AATD – Market Insights, Epidemiology and Market Forecast – 2015; 2017 data



GLASSIA®: Liquid AAT for the Treatment of AAT Deficiency

GLASSIA® IS A DIFFERENTIATED PRODUCT



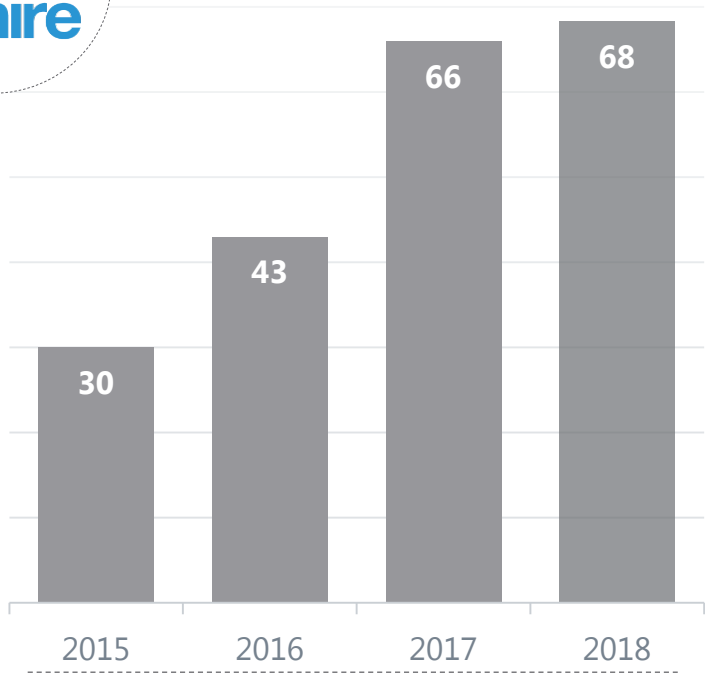
- Glassia® was the first liquid, FDA-approved ready-to-use, plasma-derived AAT product:
  - No reconstitution required
  - Reduces treatment time
  - Reduces risk of contamination and infection
- Kamada's highly purified liquid product is manufactured through a proprietary process
- Glassia® is sold in the U.S. by Takeda/Shire
- Self-infusion approved by FDA in 2016

GROWTH OF GLASSIA DRIVEN BY STRATEGIC PARTNERSHIP WITH TAKEDA/SHIRE

Significant Revenues to Kamada through 2020, followed by 20 Years of Royalties

- Cumulative minimum/maximum revenues of $120M/$150M to Kamada expected for 2019-2020
- Kamada is the BLA holder; Kamada manufactures and supplies Glassia to Takeda/Shire at least through 2020
- Commencing 2021, Shire/Takeda has the option to manufacture Glassia and pay royalties (low DD%[1] through 2025 & SD%[2] thereafter) to Kamada through 2040
- Territories – U.S., Canada, Australia, and New Zealand
- Agreement covers all future AAT-IV indications in the territories

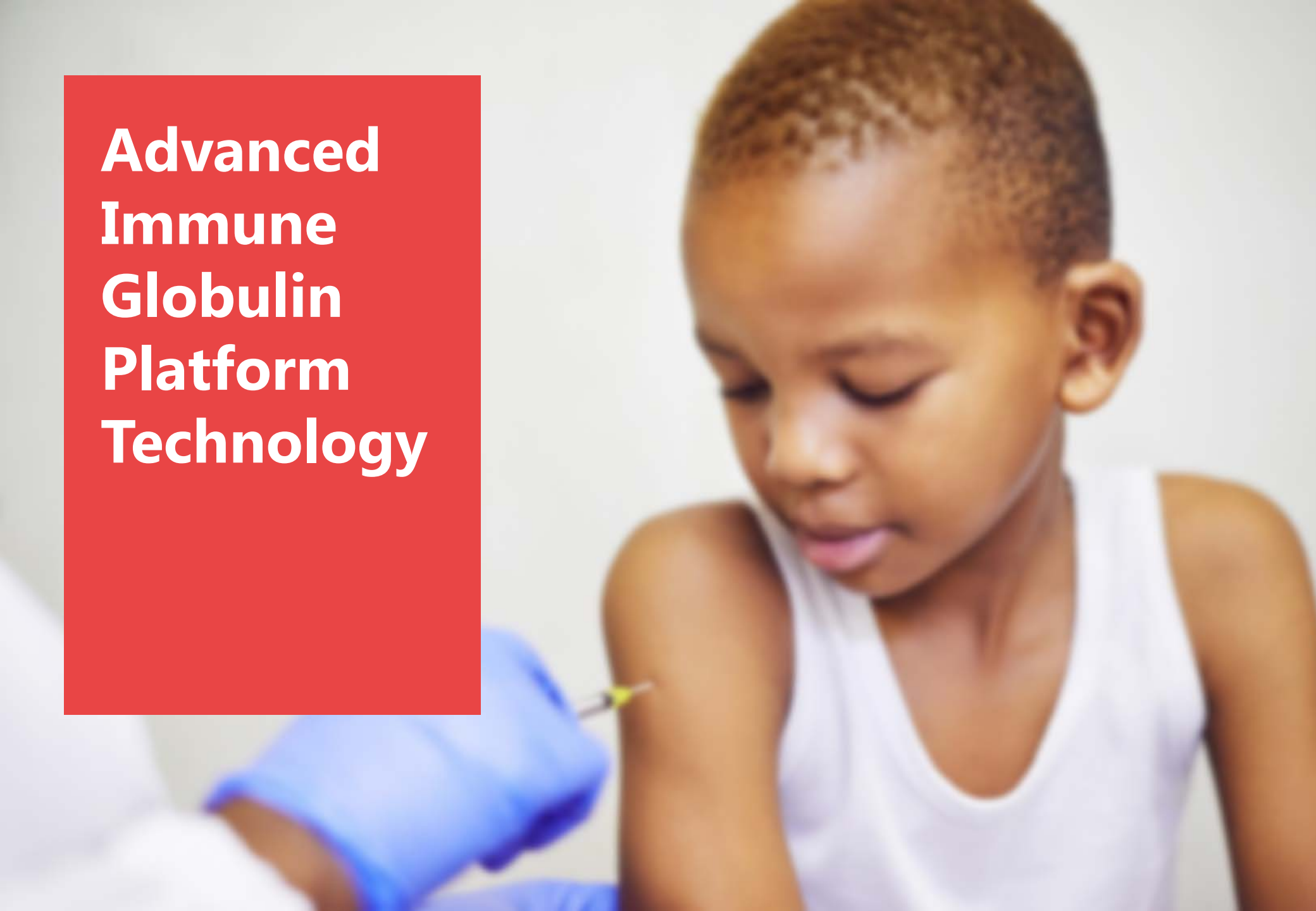
Glassia is sold in 5 countries majority of sales in the U.S.



Glassia World Wide Revenues (in $M)

1. *Double Digits*
2. *Single Digits*

Advanced Immune Globulin Platform Technology



KamRAB/KedRAB

Human Rabies Immune Globulin

U.S. Market:
Strategic agreement with Kedrion for the clinical development and marketing of KedRAB in U.S.

KEDRION BIOPHARMA

Substantial WW Market (WHO estimates)
~10 million people worldwide require medical treatment against rabies each year after being exposed to an animal suspected of rabies infection

U.S.

U.S. Market

- FDA Approval - August 2017
- Successful product launch: April 2018 in collaboration with Kedrion
- $12M – Kamada's FY2018 KedRAB sales to Kedrion
- Approx. 40,000 post-exposure prophylaxis treatments administered each year, representing approx. $150M market opportunity[1]

Worldwide

- More than 1.5M vials sold by Kamada to date = approx. 300,000 people treated WW
- Major markets: India, Thailand, Israel, Russia
- Health Canada Approval – November 2018
- Approved Supplier of the WHO/PAHO

1. *The plasma protein market in the United States, 2017, The Marketing Research Bureau Inc*

IMMUNE-GLOBULINS PORTFOLIO

KamRAB

Post-exposure prevention of rabies infection (KedRab in the US)

KamRho D IV

Second-line therapy for pediatric and adult patients with ITP[1]

KamRho D IM

Prevention of Rh-D immunization in Rh-negative pregnant women

Anti- Snake Venom

Israeli MOH strategic partnership supplying all national treatment requirements

1. *Immune Thrombocytopenic Purpura*

Distribution Product Segment

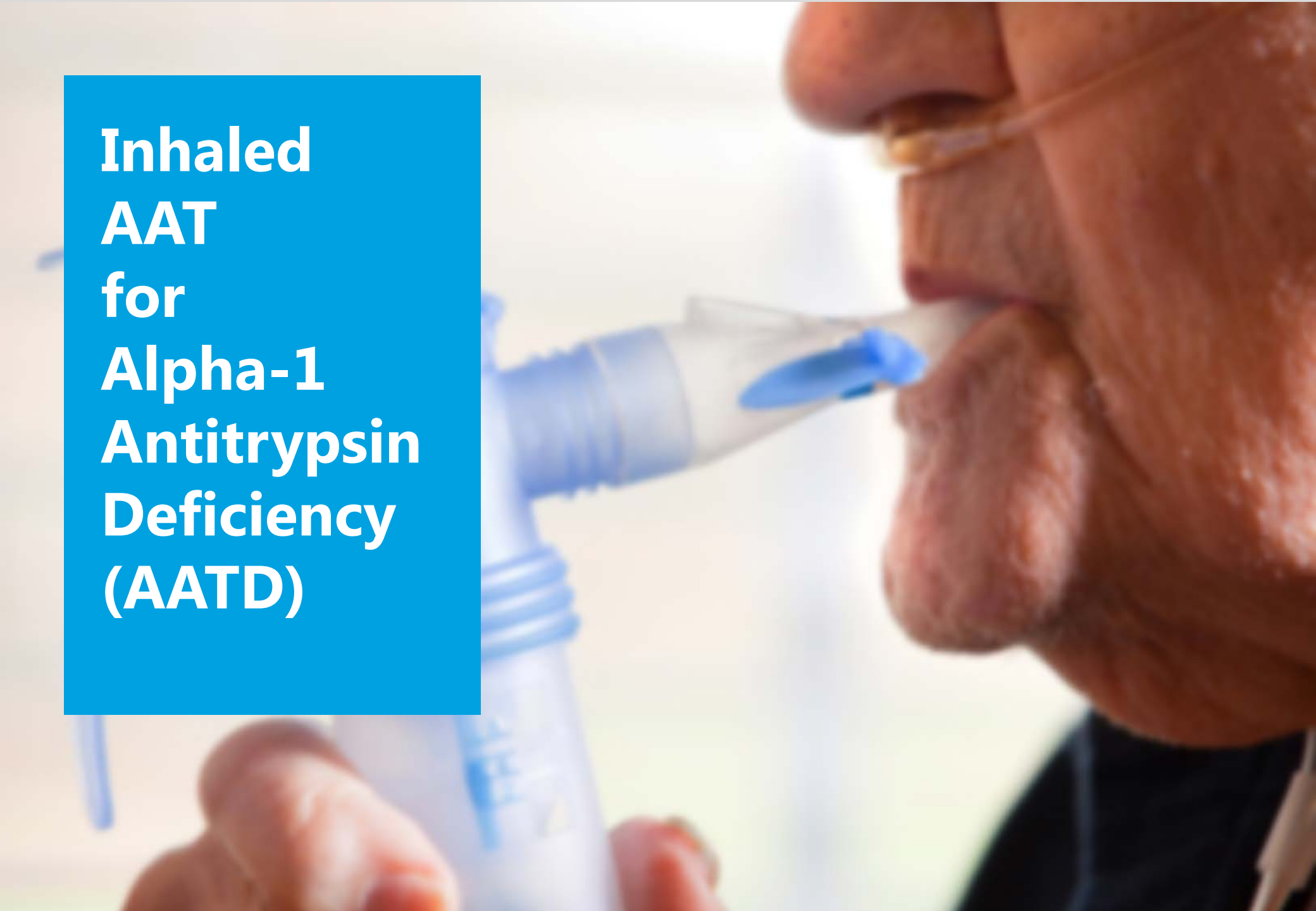
DISTRIBUTION PRODUCTS SEGMENT

Exclusive distributor in Israel for leading biopharmaceutical companies

- Marketing and distribution of specialty pharmaceutical products of leading international pharmaceutical companies in the Israeli market through a dedicated salesforce
- Expanding product portfolio through new agreements

Main therapeutic fields	
Immunology	Hematology & Hemophilia
Hospital & Critical Care	Respiratory
Infectious Diseases	Transplantation

Inhaled AAT for Alpha-1 Antitrypsin Deficiency (AATD)



INHALED AAT ANTICIPATED BENEFITS

Inhaled AAT targets a world wide market of over $1B

Alpha-1 Foundation survey[1] confirms high level of patients' interest in Inhaled-AAT

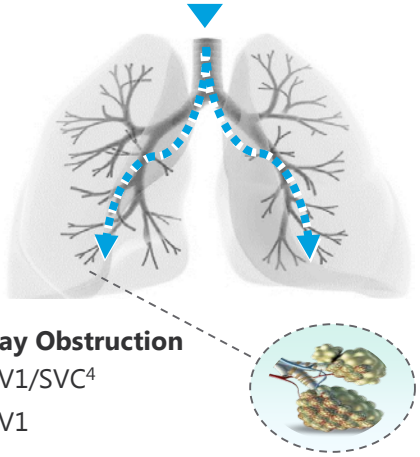
Improved Quality Of Life (QOL)

X3

ELF[2] levels 2-3 fold greater than IV

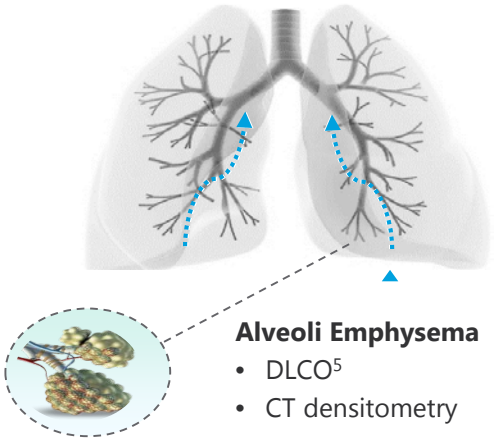
Most effective mode of treatment for reaching primary site of injury[3]

Inhaled AAT ~ 50% of the dosage reaches **airway tree** and alveoli



Airway Obstruction
- FEV1/SVC[4]
- FEV1

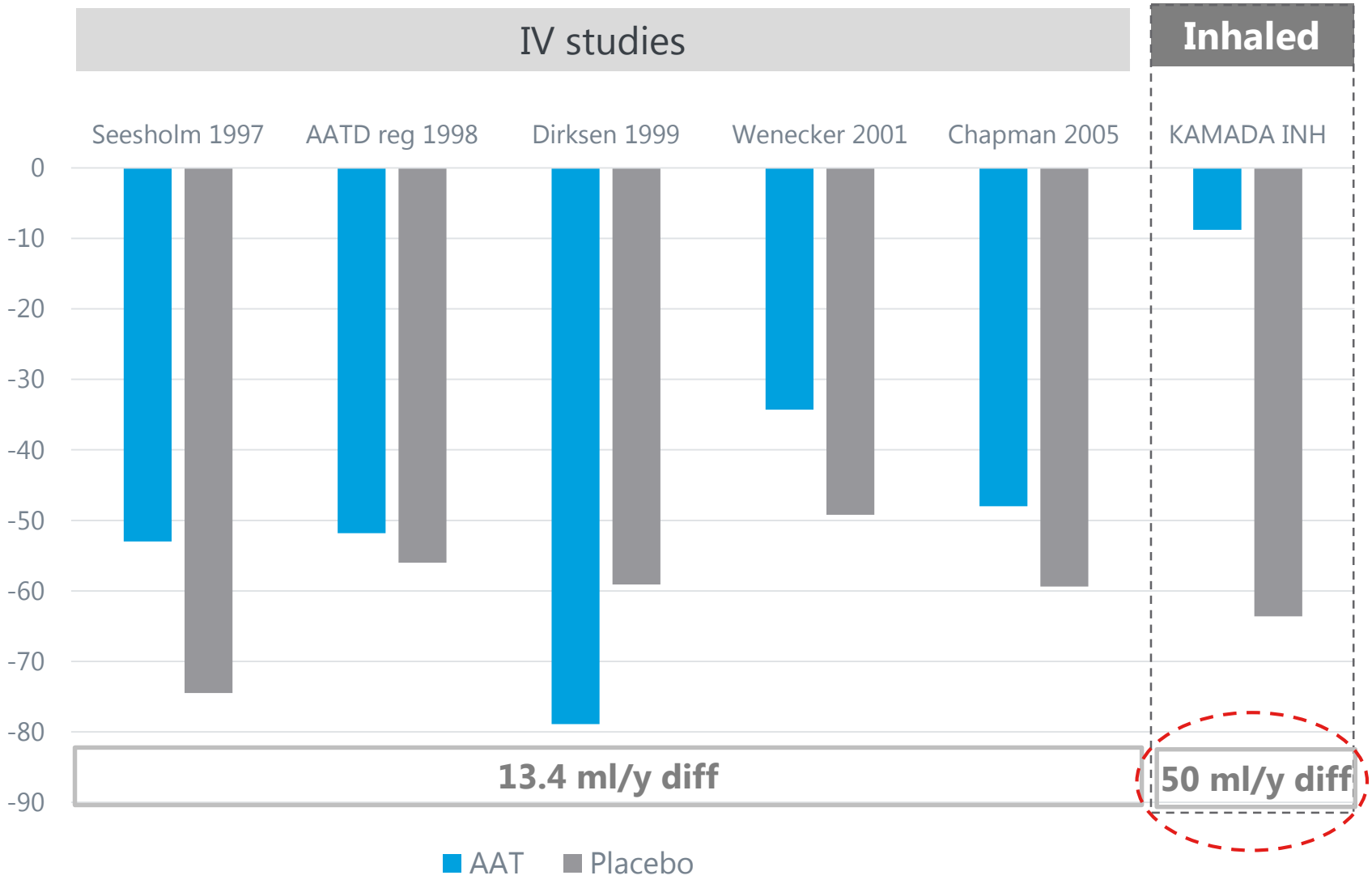
Intravenous AAT ~ 2% of the dosage reaches alveoli and **airway tree**



Alveoli Emphysema
- DLCO[5]
- CT densitometry

1. COPD: Journal of Chronic Obstructive Pulmonary Disease, Volume 10, 2013; 2. ELF = Epithelial Lining Fluid
3. Kamada's clinical data; 4. Forced Expiratory Volume/Slow Vital Capacity; 5. Diffusing Capacity Carbon Monoxide

INHALED AAT DEMONSTRATED REDUCED FEV1[1] DETERIORATION COMPARED TO AAT-IV



1. FEV1 = Forced Expiratory Volume in The 1st Second

INHALED AAT MOVING FORWARD

U.S.

FDA

- Ongoing discussions with the FDA addressing concerns and questions regarding the safety and efficacy of Inhaled AAT for the treatment of AATD
- Revised proposed Ph3 protocol and additional information provided during recent months to the FDA
- Continued clinical development pending IND approval

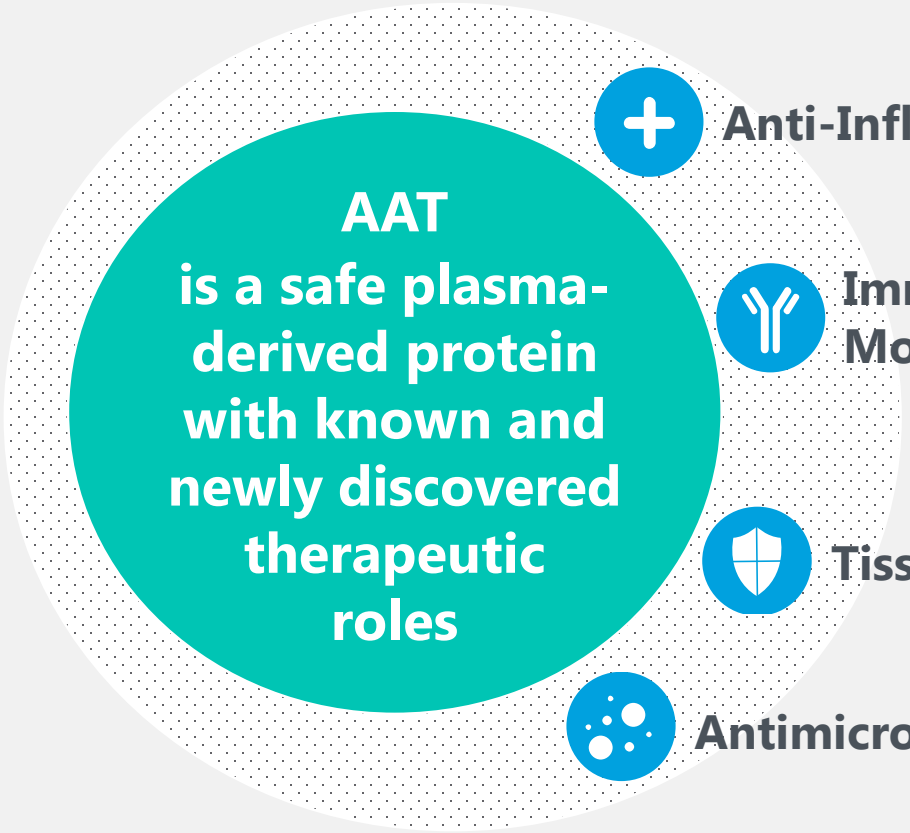
EU

EUROPEAN MEDICINES AGENCY
SCIENCE MEDICINES HEALTH

- Phase 2/3 completed; Study endpoints were not met; statistical significant lung function improvement was observed
- MAA submitted based on data showing Lung Function Improvements; MAA withdrawn (June 2017) EMA viewed data as insufficient for approval
- Proposed new Ph3 protocol accepted by EMA in a Scientific Advice meeting (July 2018)

Considering all strategic options for Inhaled-AAT, including marketing partner

AAT REPRESENTS AN EXCITING POTENTIAL THERAPY FOR MULTIPLE INDICATIONS



01	GvHD
02	Lung Transplant
03	Type-1 Diabetes

Strong safety profile, encouraging pre-clinical data and clinical experience coupled with biochemical rationale may position AAT as a high-potential future treatment in various indications

01 GRAFT VERSUS HOST DISEASE (GVHD):
A Major Complication of Hematopoietic Cell Transplantation

DEADLY SIDE EFFECTS

30-40%	of bone marrow transplantations will develop acute GvHD
40-50%	of acute GvHD will not respond to steroid treatment (SR-aGvHD)
~70%	mortality rate of patients with SR-aGvHD

SEARCHING FOR AN EFFECTIVE TREATMENT

No established prophylactic treatment

Existing prophylaxis may be associated with severe AEs

No established treatment for GvHD – An Unmet Medical Need

01 COLLABORATION WITH MAGIC[1] TO EVALUATE AAT FOR PREEMPTION OF SR-GVHD

Proof-of-Concept Study:

- Open label single arm multicenter study conducted in 5 US centers which are members of Mount Sinai Acute GVHD International Consortium (MAGIC) [1]
- Study is co-funded by Mount Sinai and Kamada, and is sponsored by the Icahn School of Medicine at Mount Sinai (ISMMS) and Led by Prof James L.M. Ferrara, MD, and Prof. John Levine, MD, MS
- Interim results expected by the end of 2019

Kamada has exclusive rights to develop and commercialize AAT for preemption of GvHD using the MAGIC Biomarkers

Innovative approach	• Utilization of novel blood biomarker algorithms may identify patients at high risk for SR-GvHD and non-relapse mortality (NRM) • Early intervention could prevent patients from further disease deterioration
Study objective	• To assess the safety and preliminary efficacy of IV AAT as preemptive therapy in patients at high risk for the development of SR-GvHD after BMT
Design	• 30 patients treated with IV AAT for 2 months with a follow-up period of 1 year after BMT
Endpoints	• Proportion of High Risk patients who develop SR-GvHD by day 100 post BMT, as well as safety, severity of GvHD, mortality, etc.

1. *A consortium of 23 BMT centers in the USA, Europe and Asia that conducts clinical trials to prevent and treat acute GVHD (aGvHD).*

02 ADVANCING THE LUNG TRANSPLATATION OPPORTUNITY

Lungs have the highest rate of rejection among transplanted solid organs

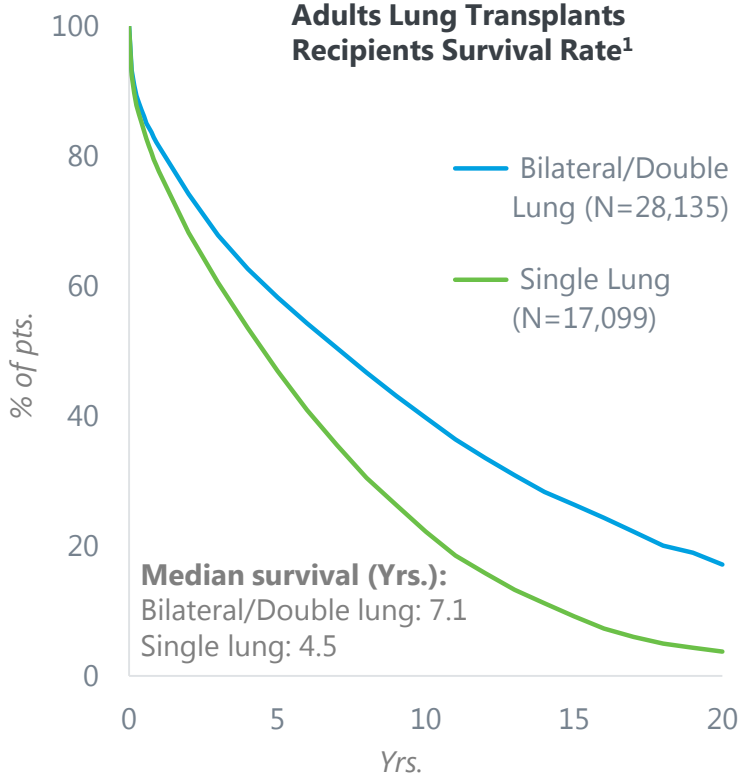
~33% will experience acute rejection within the first year

~50% will develop chronic rejection within the first 5 years

No new treatment options have been made available for years

Strong need for improved post-transplant therapies over existing options (toxicity, immunosuppressive)

Kamada initiated the first clinical trial designed specifically to prevent lung transplant rejection



1. *JHLT. 2015 Oct;34(10): 1264-1277*

02 ON-GOING PHASE 2 STUDY WITH AAT IV
For Prevention of Lung Transplant Rejection

Phase 2:

- Prospective, open label, standard-of-care (SOC) controlled, randomized, parallel group single center study
- In collaboration with Shire/Takeda led by Prof. Mordechai Kramer, Rabin Medical Center, Israel
- Top-line data from the Phase 2 trial anticipated by the end of 2019.

Study objective	• To assess the safety of AAT IV and the effect on rate and severity of acute and chronic lung rejection as well as pulmonary infections, in subjects undergoing first lung transplantation
Design	• 30 lung transplant recipients randomized 2:1 to receive AAT IV on top of standard-of-care (SOC) or SOC alone, for 48 weeks plus 12 months of follow-up
Endpoints	• Safety: Related adverse events (AEs) • Efficacy: Changes in FEV1 from baseline and overall effect, incidence and rate of acute lung rejection
Interim results (29 Pts; 1 year)	• IV AAT demonstrated a trend towards improvements in multiple key clinical outcomes, including days on mechanical ventilation post-transplant, pulmonary function at week 4 and week 48 post-transplant and the six-minute walk test.

03 AAT (IV) AS POTENTIAL TREATMENT FOR NEWLY DIAGNOSED TYPE-1 DIABETES (T1D) PATIENTS

MARKET OPPORTUNITY	AAT IMPACT	EXPECTED BENEFITS
Type-1 Diabetes Occurs when the immune system attacks and destroys beta cells in the pancreas	**Studies have shown that AAT may protect beta cell islets**	**Preservation of beta cells correlates with reduced risk of long-term complications**
• More than 10 million suffer from Type 1 diabetes globally • 100,000 new patients/year diagnosed globally • In the U.S. alone: 3 million patients, with 30,000 new patients diagnosed annually[1]	Preclinical models have shown that administration of AAT: • Delays the progression of autoimmune diabetes • Inhibits insulitis and beta-cell apoptosis • Decreases beta-cell inflammation	• DCCT[2] indicated that patients with C-peptide on MMTT ≥0.2 pmol/mL were less likely to develop retinopathy and hypoglycemia complications[3] • Higher / sustained levels of C-peptide correlate with reduced incidences of microvascular complications[3]

1. *JDRF publication; 2. The Diabetes Control and Complications Trial (DCCT)*
3. *Greenbaum et al, 2012; 3. Steffes et al, 2013*

03 T1D - PHASE 2 STUDY

Phase 2 Completed:
Double-Blind, Randomized, Placebo-Controlled, Multicenter Study

Study objective	• To evaluate efficacy and safety of AAT) in treatment of newly diagnosed Type 1 Diabetes patients
Design	• Two doses, placebo controlled, randomized with 70 pediatric and young adult patients. One year study
Endpoints	• Beta cell preservation (C-peptide AUC), HbA1C, hypoglycemic events and insulin daily dose
Results	• In overall study population, no significant treatment effect was observed. • In the pre-determined subgroup of patients between the ages of 12-18 years old, a trend toward better efficacy was demonstrated in the high dose arm of AAT (120mg/kg) • Presented results in an oral session at 78th Scientific Sessions of the American Diabetes Association (ADA), 2018

KEY VALUE CREATING 2019 MILESTONES

Inhaled AAT for AATD - Continued FDA discussion targeting IND approval	**1H/2019**
Inhaled AAT for AATD phase 3 pivotal study – First patient in (pending IND/CTA approval)	**2H/2019**
Organ preservation program – Define regulatory and commercial path	**1H/2019**
Lung transplant phase 2 study – Top line data	**End of 2019**
GvHD phase 2 study – Last Patient In and interim report	**End of 2019**
Secure strategic collaborations through co-development agreements for IgG and /or AAT for new indications	**2019**
Achieve $125-130 million in annual revenues, profitable, cash flow positive	**2019**

INVESTMENT HIGHLIGHTS

COMMERCIAL STAGE BIOPHARMA	• Leader in plasma-derived protein therapeutics, focused on Alpha-1 Antitrypsin (AAT) and specific hyper-immune IgGs
	• 2 FDA approved products
	  • *Glassia® for AAT Deficiency (AATD); first FDA-approved liquid, ready-to-use IV AAT. Commercialized in the U.S. through Takeda. Estimated revenues: $120-$150 MM (2019-2020 cumulative); followed by 20 years of royalties.*
	  • *KedRAB® for anti-rabies prophylaxis treatment. Commercialized in the U.S. through Kedrion. Launched in April 2018.*

BROAD PIPELINE/ IP	• Focused on global leadership in AATD
	• Inhaled AAT for AATD
	  • *Completed Ph2 (U.S.) and Ph2/3 (EU), MAA withdrawn June 2017;*
	  • *EMA accepted new pivotal Phase 3 design;*
	  • *FDA discussions ongoing re development path forward;*
	  • *New pivotal Phase 3 pending IND/CTA approval*
	• AAT IV for other indications developed through strategic collaborations
	• Fully integrated propriety manufacturing technology for protein purification from human plasma
	• Distributed biopharmaceutical products segment in Israel

COMPELLING FINANCIAL PROFILE	• 2017 Revenue: $102.8M (33% YoY); aEBITDA: $11.5M • 2018 Revenue: $114.5M (11% YoY); aEBITDA: $23.9M; cash flow positive • 2019 Revenue guidance: $125-$130M; profitable; cash flow positive • Cash: $50.6M (December 31, 2018); No Debt • Strong balance sheet allows execution on pipeline and business development initiatives • Listed on TASE (2005) & Nasdaq (2013)

THANK YOU

www.kamada.com

APPENDIX A

Appendix A: Reconciliation of Non-IFRS Measures

Adjusted EBITDA is defined as net income (loss), plus income tax expense, plus financial expense, net, plus depreciation and amortization expense, plus non-cash share-based compensation expenses, plus or minus income or expense in respect of exchange and translation differences and derivatives instruments not designated as hedging.

We present adjusted EBITDA because we use this non-IFRS financial measure to assess our operational performance, for financial and operational decision-making, and as a means to evaluate period-to-period comparisons on a consistent basis. Management believes this non-IFRS financial measure is useful to investors because: (1) they allow for greater transparency with respect to key metrics used by management in its financial and operational decision-making; and (2) they exclude the impact of non-cash items that are not directly attributable to our core operating performance and that may obscure trends in the core operating performance of the business.

Non-IFRS financial measures have limitations as an analytical tool and should not be considered in isolation from, or as a substitute for, our IFRS results. We expect to continue reporting non-IFRS financial measures, adjusting for the items described below, and we expect to continue to incur expenses similar to certain of the non-cash, non-IFRS adjustments described below. Accordingly, unless otherwise stated, the exclusion of these and other similar items in the presentation of non-IFRS financial measures should not be construed as an inference that these items are unusual, infrequent or non-recurring. Adjusted EBITDA is not a recognized term under IFRS and does not purport to be an alternative to any other IFRS measure. Moreover, because not all companies use identical measures and calculations, the presentation of adjusted EBITDA may not be comparable to other similarly titled measures of other companies.

(US$K, Unaudited)	YE2015	YE2016	YE2017	YE2018
Net Income (Loss)	(11,270)	(6,733)	6,901	22,296
Taxes on income	0	1,722	269	(1,955)
Financial expenses (income) , net	471	(343)	(338)	(480)
Depreciation and amortization expense	3,227	3,501	3,523	3,703
Share-based compensation charges	1,907	1,071	483	948
Expense (income) in respect of currency exchange and translation differences and derivatives instruments, net	(625)	(127)	612	(602)
Adjusted EBITD	(6,290)	(909)	11,450	23,910

INHALED AAT – IN THE WORDS OF THE KEY OPINION LEADERS

EU Phase 2/3:

"The study results demonstrated primarily that the overall treatment effect on lung functions, is of significant clinical value. This study is the first study ever that is indicative of inhaled AAT's ability to potentially reduce lung inflammation as expressed by its preservation of lung function and the changes shown in symptoms."

***Prof. Jan Stolk*, MD,** Department of Pulmonology, Leiden University Medical Center, Principal Investigator of the Phase 2/3 clinical trial and acting Chairman of the Alpha 1 International Registry (AIR)

"The study analysis suggests exciting results that may lead to wider acceptance of the inhaled route of administration of alpha- 1 antitrypsin augmentation therapy, which could be a real breakthrough for AATD patients."

***Robert A. Sandhaus*, Ph.D., M.D., FCCP,** Founder and Director of the Alpha1-Antitrypsin Deficiency Program at National Jewish Health in Denver, Colorado, and the Clinical Director of the Alpha-1 Foundation

"These new analyses confirm the clinically-meaningful lung function improvement seen with inhaled AAT patients in this study. These results are impressive and underscore the initial findings from this study. In my opinion, inhaled AAT has shown to be an efficacious treatment for this orphan disease."

***Prof. Kenneth Chapman*, M.D.,** Director of the Canadian Registry for the Alpha-1 Antitrypsin Deficiency (Asthma and Airway Centre in Toronto Western Hospital, University of Toronto) and an investigator in the Phase 2/3 clinical trial.

US Phase 2:

"The results of this study are extremely compelling. Based on the results of this study, it is clear that inhaled AAT is the most effective mode of treatment for reaching the primary sites of potential lung injury, and restoring AAT inhibitory capacity. I look forward to the start of a pivotal study in the U.S. to confirm these results."

***Prof. Mark Brantly*, MD,** the Primary Investigator in this study who serves as a Vice Chair of Research, Department of Medicine, Chief Division of Pulmonary, Critical Care and Sleep Medicine, Professor of Medicine, Molecular Genetics and Microbiology at the University of Florida College of Medicine and Alpha One Foundation Research Professor.

AAT IV – NEW INDICATIONS IN THE WORDS OF THE KEY OPINION LEADERS

GvHD Phase 2:

"…we are very excited to initiate the first preemptive treatment study utilizing the MAGIC biomarkers. AAT has shown encouraging efficacy signals in previous GvHD studies… We believe that Kamada's IV AAT is a promising drug candidate for the preemption of SR-aGvHD, which could positively impact survival rates."

Prof. John Levine, M.D., M.S., *Professor of Pediatrics and Medicine, Hematology and Medical Oncology at the Tisch Cancer Institute at ISMMS and Co-Director of MAGIC*

GvHD Phase 2:

"We are delighted to collaborate with Kamada on this groundbreaking, first-in-class trial… Identification of risk through biomarkers is at the forefront of GvHD research, and we believe this trial is a key milestone in our effort to make transplant safer and more effective."

James L.M. Ferrara, M.D., *Professor of Pediatrics, Oncological Sciences and Medicine, Hematology and Medical Oncology at the Tisch Cancer Institute at ISMMS, and Co-Director of MAGIC*

Lung Transplant Phase 2:

"Decreasing post-transplantation mechanical ventilation duration of lung-transplanted patients and reducing proportion of PGD are meaningful clinical targets that may also reduce long-term complications, such as chronic rejection… I am encouraged by the interim results of this study and believe that further advanced powered studies are warranted to validate these meaningful signals of improvement."

Prof. Mordechai R. Kramer, M.D., *head of the Pulmonary Institute, Rabin Medical Center (Belinson Campus) and a professor at Sackler Medical School Tel-Aviv University. He is an expert in all areas of pulmonary care and considered one of the top specialists in the field.*

T1D Phase 2:

"Given this study was not powered to show efficacy, the results are very encouraging… The results of this subgroup are intriguing and warrant further studies in a larger population. Subgroup segmentation by age is common in this complicated disease, and the fact that we see the same positive trend in this age group for all three measures – C-peptide, daily insulin requirement, and HbA1C – suggests that the results are consistent and could be promising."

Peter Gottlieb*, M.D., Professor of Pediatric and Medicine, Barbara Davis Center for Diabetes, University of Colorado School of Medicine and a leading member in TrialNet, an NIH-sponsored network of institutions and researchers dedicated to the prevention of type-1 diabetes.*