KAMADA INVESTOR PRESENTATION

NASDAQ & TASE: KMDA

February 2018

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 pharmaceutical products, 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 2016 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 2016 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 PROFILE

COMMERCIAL STAGE BIOPHARMA	• Leader in plasma-derived protein therapeutics for orphan indications, focused on Alpha-1 Antitrypsin ("AAT") and specific hyper-immune IgGs
	• 2 FDA approved products
	  • Glassia® for AAT Deficiency; first FDA-approved liquid, ready-to-use IV AAT. Commercialized in the US through Shire plc.
	  • KedRAB® for anti-rabies prophylaxis treatment. Commercialized in the US through Kedrion Biopharma.

BUILDING PIPELINE/ IP	• Inhaled AAT - completed Phase 2 (US) and Phase 2/3 (EU)[1]. Plan to initiate additional pivotal Phase 3 trial in 2018, pending IND approval. • AAT IV developed for additional orphan indications • Fully integrated propriety manufacturing technology for extraction & purification of proteins from human plasma
FINANCIAL SUMMARY	• 2017 Revenue : $103 MM (represents 33% annual growth and exceeded annual guidance) • 2018 Revenue Guidance : $116-$120MM • Market Cap = ~$180 MM [2]; Cash: $43 MM; No Debt [3] • Ticker: KMDA; Listed on TASE (2005) and Nasdaq (2013) • Employees = 402 [2]

1. MAA withdrawn – June 2017; 2. As of December 31, 2017; 3. As of December 31, 2017 (including ST investments)

HIGH VALUE PRODUCT PIPELINE

Product	Indication	Phase I / Phase II / Phase III / Market	Partners
Glassia® (IV AAT)*	AAT Deficiency	FDA approved (2010)	U.S. Shire
KamRab®/KedRab® (IM Anti-Rabies)	Prophylaxis for Rabies	FDA approved (2017)	U.S. KEDRION BIOPHARMA
Inhaled AAT	AAT Deficiency[1]	EU Phase 2/3 (completed)[2] US Phase 2 (completed)	
D1-AAT (IV)	Type 1 Diabetes[3]	Phase 2 (completed)	U.S. Shire
G1-AAT (IV)	Graft vs Host Disease (GvHD)[4]	Phase 1/2 (completed)	U.S. Shire
L1-AAT (IV)	Lung Transplant	Phase 2 (ongoing)	U.S. Shire

** Recombinant AAT for AAT Deficiency in early development stages*

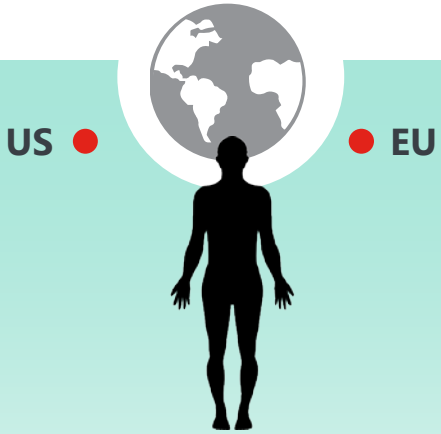
1. *Orphan drug designation (US & EU); 2. MAA withdrawn – June 2017; 3. Orphan drug designation (US only)*
4. *Orphan drug designation (US & EU)*

Alpha-1 Antitrypsin Deficiency (AATD)

AAT DEFICIENCY

Potentially Lethal and Often Undiagnosed

Genetic/Hereditary condition causing decreased levels of AAT in blood and tissues



Affects more then 100,000 people in the US and slightly lower number in Europe

Predisposes to lung and liver diseases

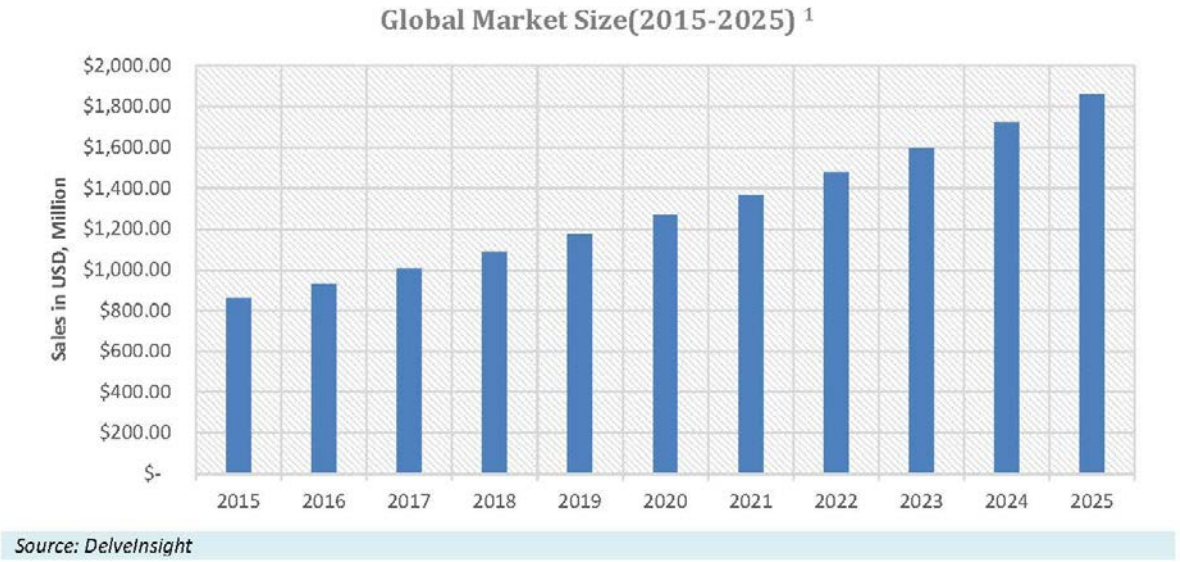
AAT deficiency-associated lung disease is characterized by airway obstruction and destructive changes in the lungs (Emphysema)

Comments/reference

AAT DEFICIENCY (AATD) MARKET

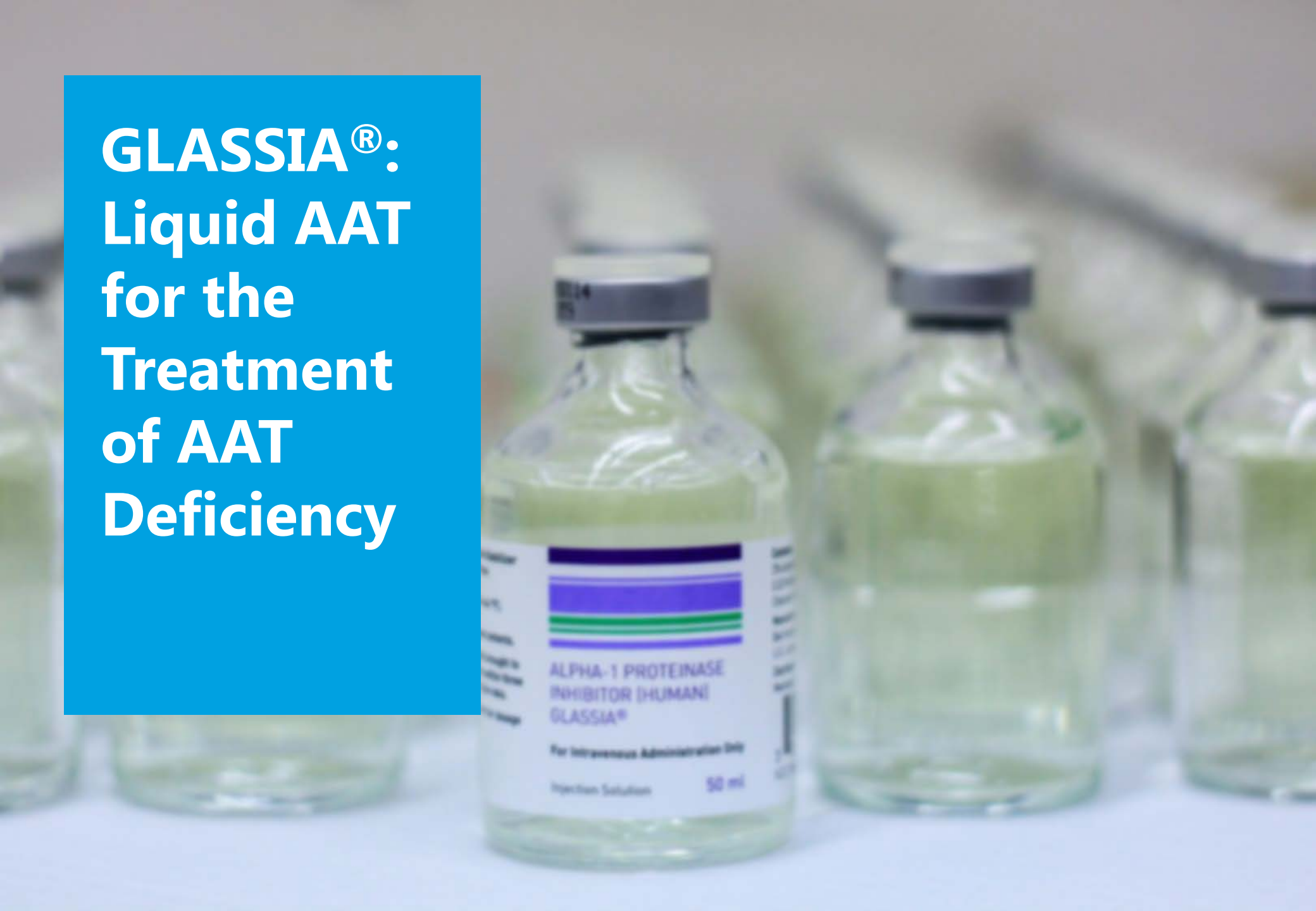
Significant expansion opportunity

- Majority of patients suffering from AATD still remain undiagnosed & untreated
- Better diseases awareness and expanded diagnostics is contributing to increased demand
- Expected growth of US market – approx. 8% annually[1]
- Greater AAT use in Europe and other geographies could further accelerate market growth
- Chronic therapy creates sustainable product revenue opportunity
- Average annual reimbursement of treatment at ~$80-$100K per patient



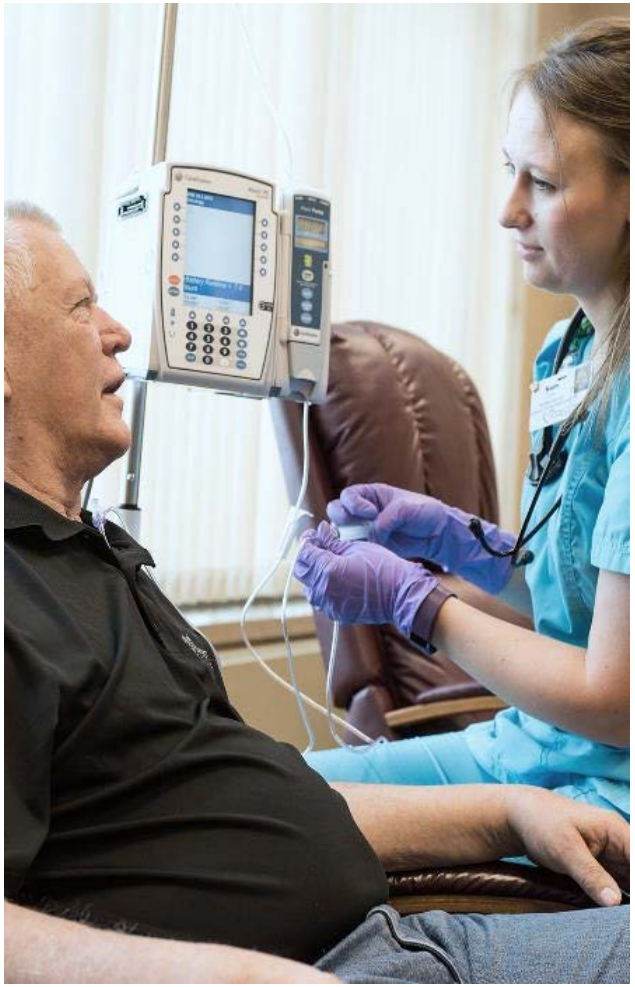
- **AATD prevalence [1]: ~115,000 (U.S.); ~72,000 (EU5)** but only ~7,300 (U.S.) or ~1,800 (EU5) patients are treated [1]
- **Current market size is ~ $1B WW**
- **Expected to reach $1.8B by 2025**

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



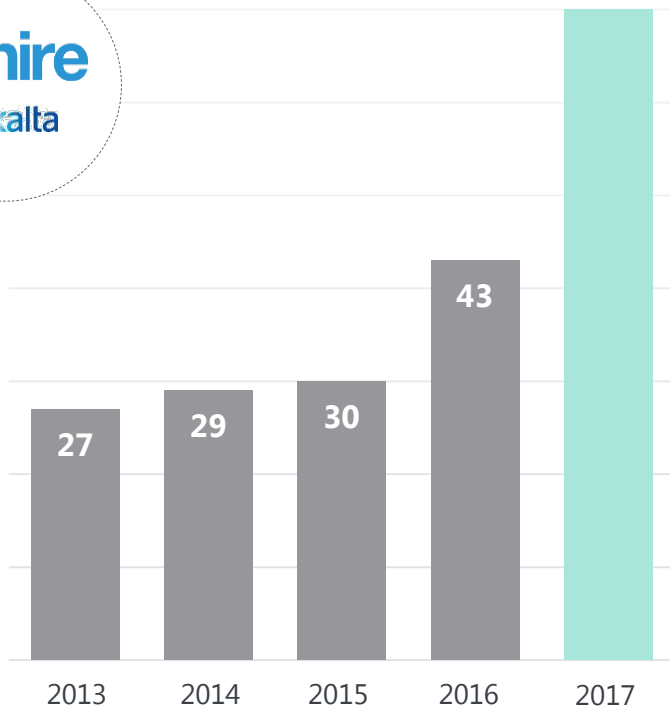
- Glassia® is the first liquid, FDA-approved ready-to-use, plasma-derived AAT product:
  - No reconstitution required
  - Reduces treatment time
  - Reduces risk of contamination and infection
- Kamada's highly purified liquid product is manufactured through a proprietary process
- Glassia® is sold in the U.S. by Shire plc
- Number of patients on Glassia increased by approx. 25% per year in each of 2014, 2015 and 2016
- Self-infusion approved by FDA in 2016

GROWTH OF GLASSIA® DRIVEN BY STRATEGIC PARTNERSHIP WITH SHIRE

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

- Minimum/max revenues of $237MM/$282MM to Kamada expected for 2017-2020
- Kamada manufactures and supplies Glassia to Shire through 2020
- Commencing on 2021, Shire has an option to manufacture Glassia and pay royalties to Kamada through 2040
- Territory – U.S., Canada, Australia and New Zealand
- Agreement covers all future AAT IV indications in the territory

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



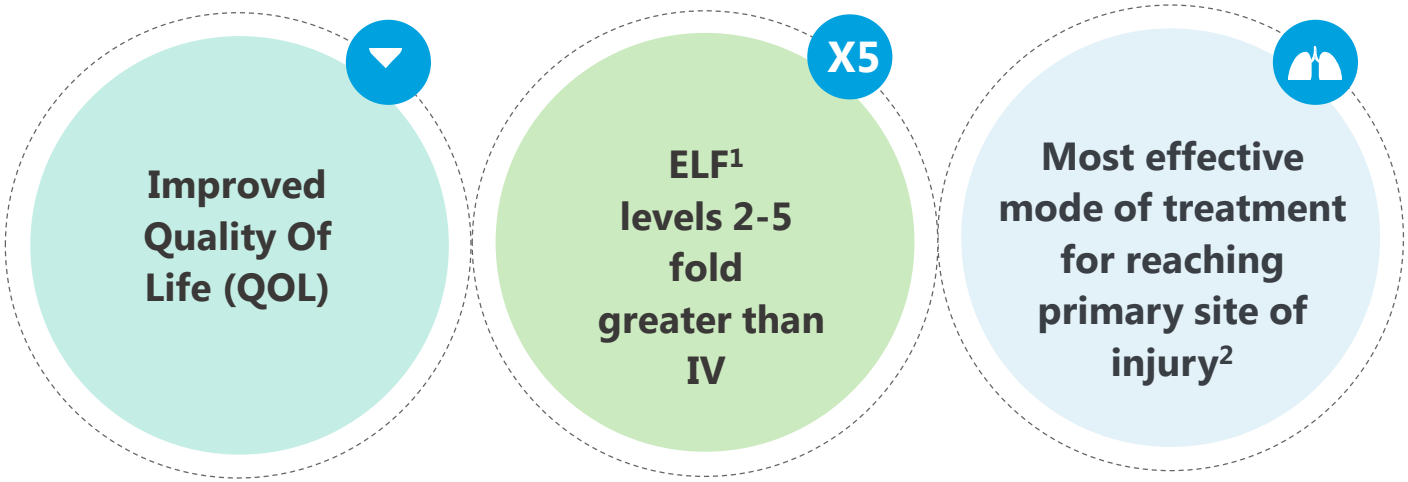
Glassia Sales w/o Milestone Revenues (in $M)

Inhaled AAT to Treat Alpha-1 Antitrypsin Deficiency (AATD)

ANTICIPATED BENEFITS OF INHALED AAT

Alpha-1 Foundation Survey Confirms Inhaled-AAT as a Preferred Treatment Approach

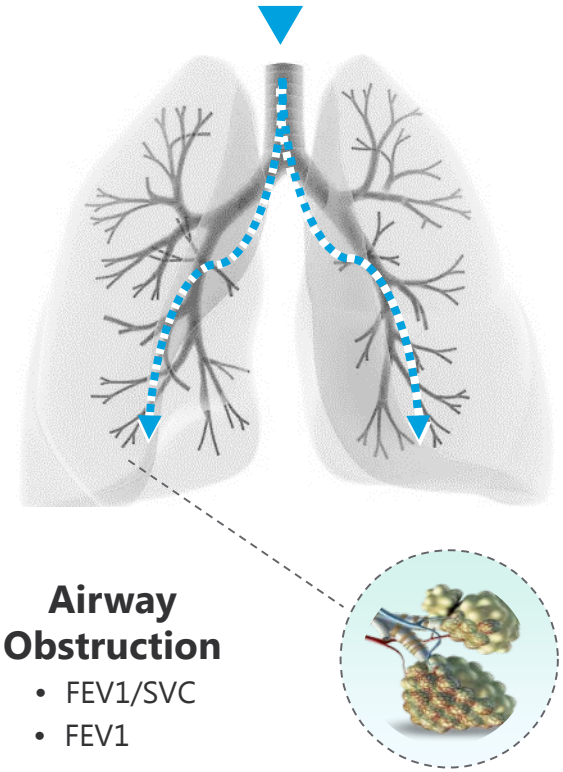
Inhaled AAT opportunity is estimated by Kamada at $1B



1. *ELF = Epithelial Lining Fluid;*
2. *Based on Kamada's clinical data*

INHALATION ENABLES DELIVERY OF AAT 5X HIGHER THAN INTRAVENOUS

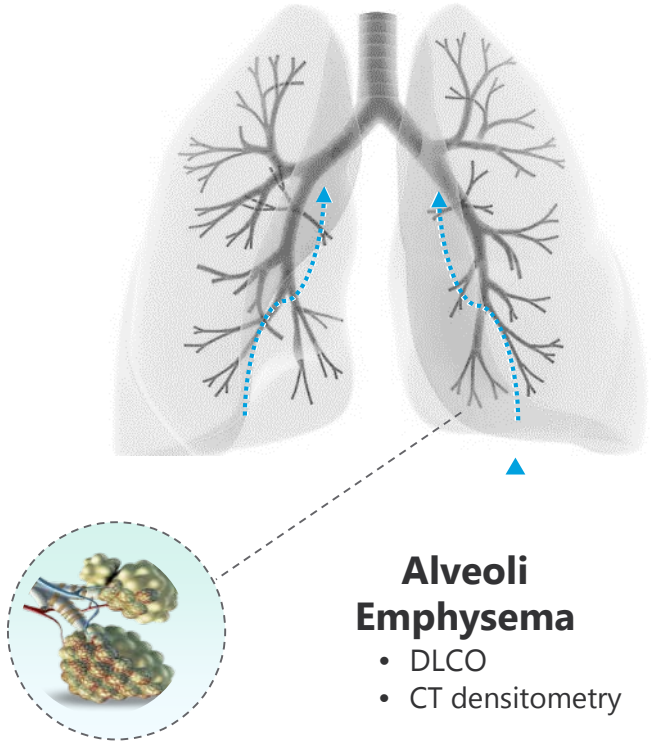
Inhaled AAT ~ 50% of the dosage reaches **airway tree** and alveoli



Airway Obstruction

- FEV1/SVC
- FEV1

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



Alveoli Emphysema

- DLCO
- CT densitometry

Comments/reference

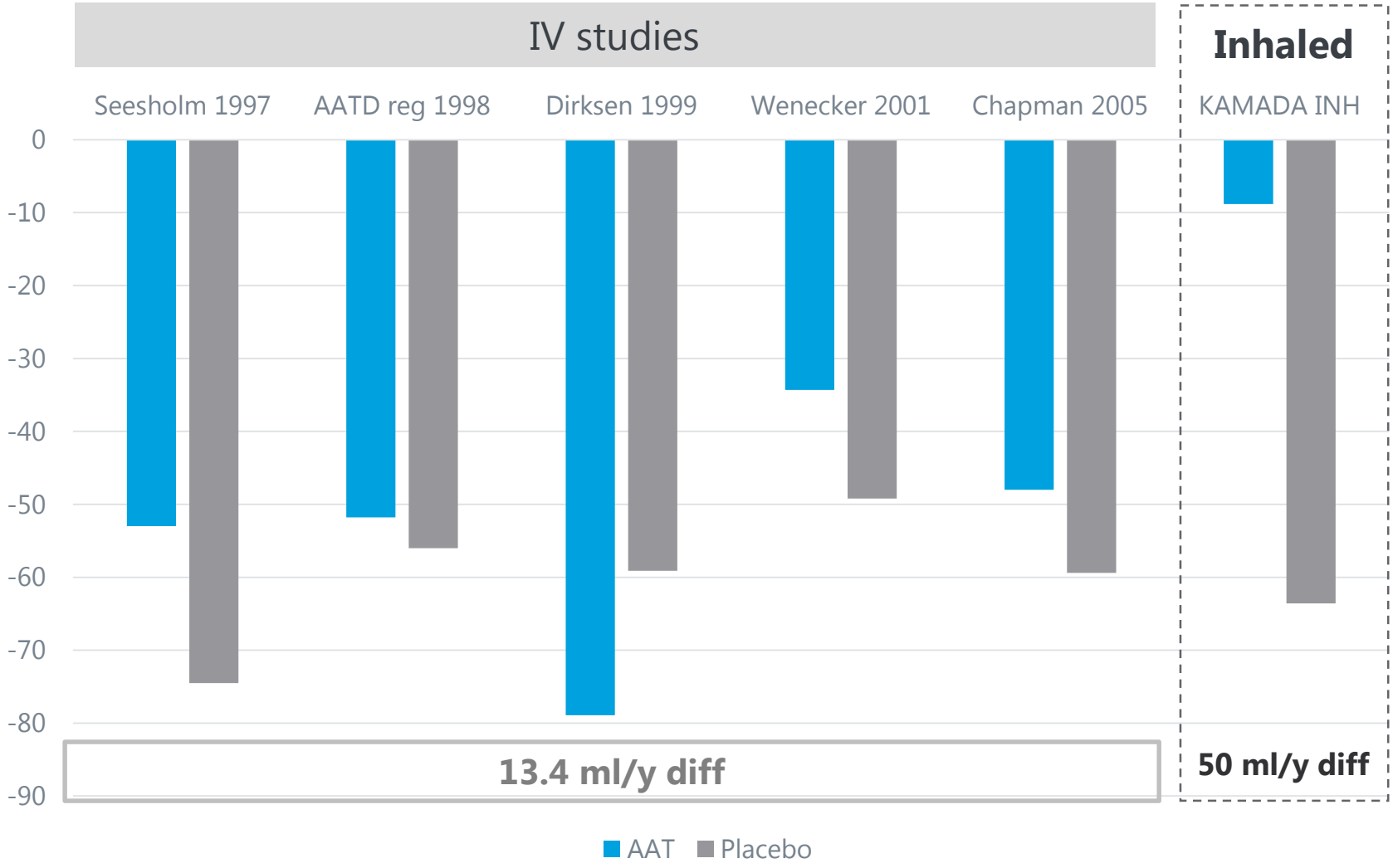
INHALED AAT PHASE II/III TRIAL - POST-HOC RESULTS

Spirometry Measures (MMRM[1])

Lung Function	Least Squares Means (SEM) (Changes at Week 50 from Baseline)		P-Value[1] (Changes at Week 50)	Least Squares Means (SEM) method: Overall treatment effect		P-Value[1] (Overall Effect)
	AAT (N=84)	Placebo (N=81)		AAT (N=84)	Placebo (N=81)	
FEV_1 (L)	**-12mL**	**-62mL**	0.0956	**+15mL**	**-27mL**	**0.0268**
FEV_1 (% of predicted)	-0.1323	-1.6205	0.1032	0.5404	-0.6273	0.0658
FEV_1/SVC (%)	0.6183	-1.0723	**0.0132**	0.6230	-0.8715	**0.0074**

1. MMRM = Mixed Model Repeated Measure
FEV = Forced Expiratory Volume. SVC = Slow Vital Capacity.

INHALED AAT SLOWED FEV1 DETERIORATION BETTER THAN FORMER IV TRIALS

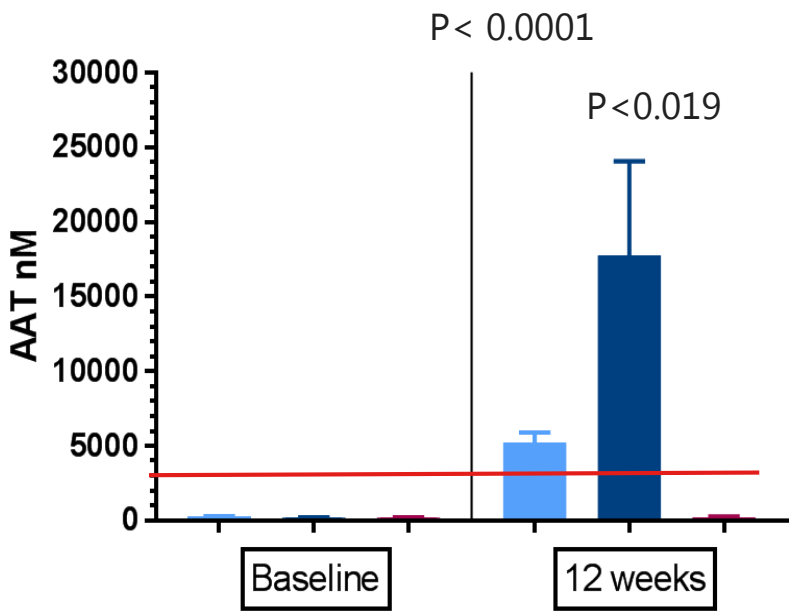


Comments/reference

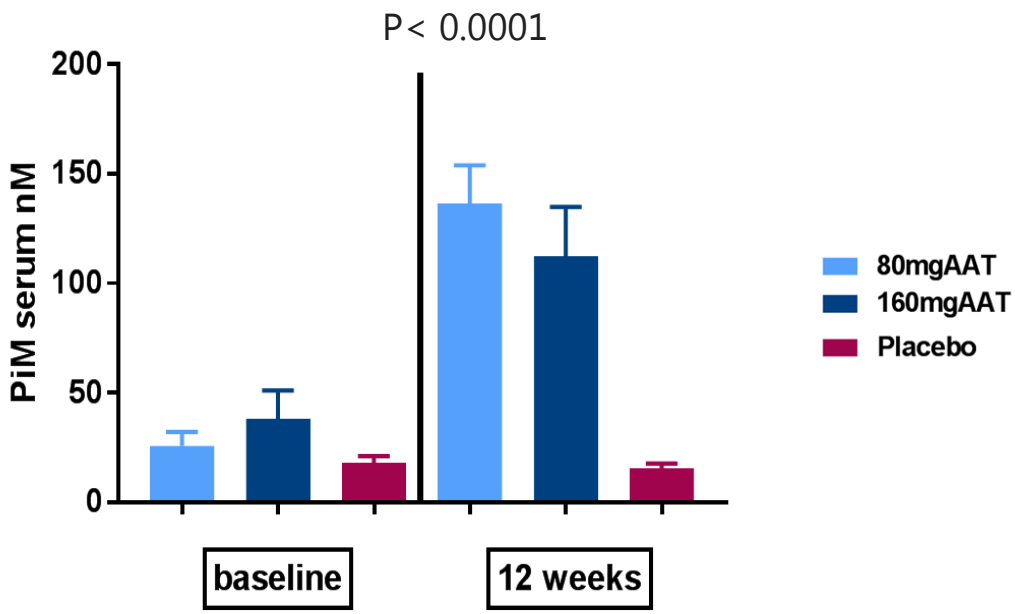
INHALED AAT PHASE II U.S.

ELF AAT Antigenic Level & Inhibitory Capacity Increased Significantly

ELF[1] AAT Antigenic Level



PiM serum level



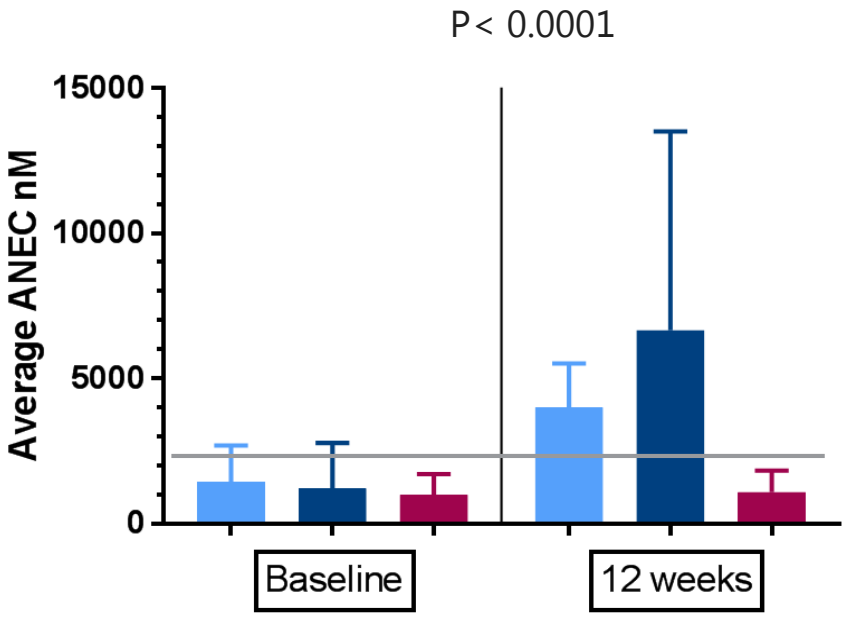
AAT ELF level is reasonably likely to predict clinical benefit

1. *ELF = Epithelial Lining Fluid*

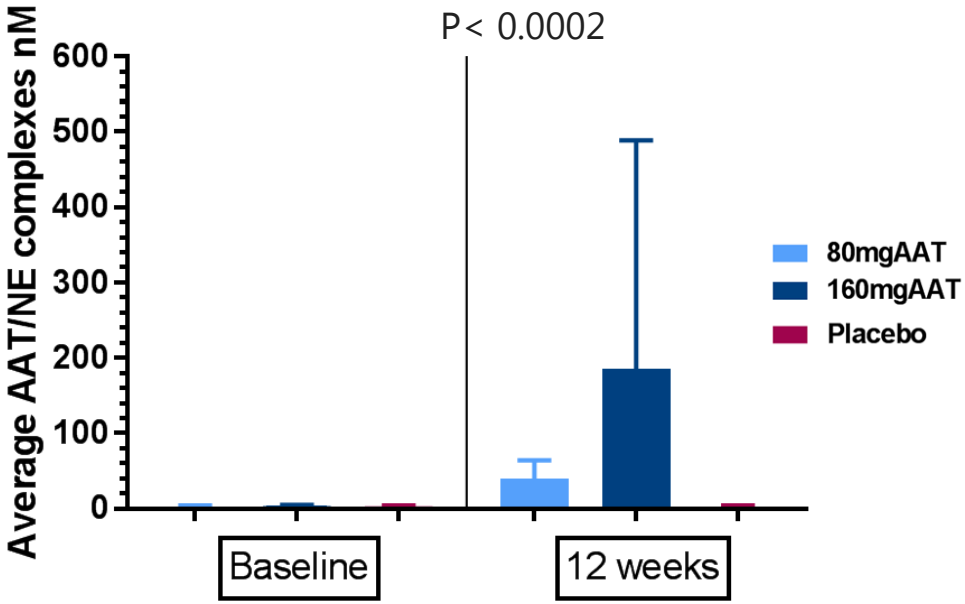
INHALED AAT PHASE II U.S.

ELF AAT-NE complexes & Inhibitory Capacity Increased Significantly

ANEC[1]



ELF AAT – NE Complexes



Inhaled AAT is the most effective means
to restore AAT inhibitory capacity
in the airways (ANEC[1] & AAT-NE Complexes)

1. *Anti-Neutrophil Elastase Capacity*

INHALED AAT: MOVING FORWARD

US

- In discussions with the FDA to obtain guidance on the clinical/ regulatory pathway for the Inhaled AAT in the U.S.
- Expecting an approved IND by Mid-2018
- Expecting to initiate a Phase 3 study in H2 2018, pending FDA approved IND

EU

- Phase 2/3 completed; Primary endpoint was not met
- MAA submitted based on Lung Function Improvements; MAA withdrawn in June 2017
- Plan to resubmit MAA after next Phase 3 study is successfully completed

KamRAB/ KedRAB: Human Rabies Immune Globulin

KamRAB/KedRAB

Human Rabies Immune Globulin

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

KEDRION BIOPHARMA

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
- Product launch: Beginning 2018 in collaboration with Kedrion
- **~40,000 post-exposure prophylaxis treatments** administered each year, representing **~$100 million market opportunity**[1]

Worldwide

- More than 1.5MM Vials sold to date (2ml) = ~ **300,000 people treated w/w**
- Major markets: India, Thailand, Israel, Russia
- Approved Supplier of the WHO
- November 2017: Signed new $13 MM supply agreement with an international organization for 2018-2020

1. *The plasma protein market in the United States, 2015, The Marketing Research Bureau Inc*

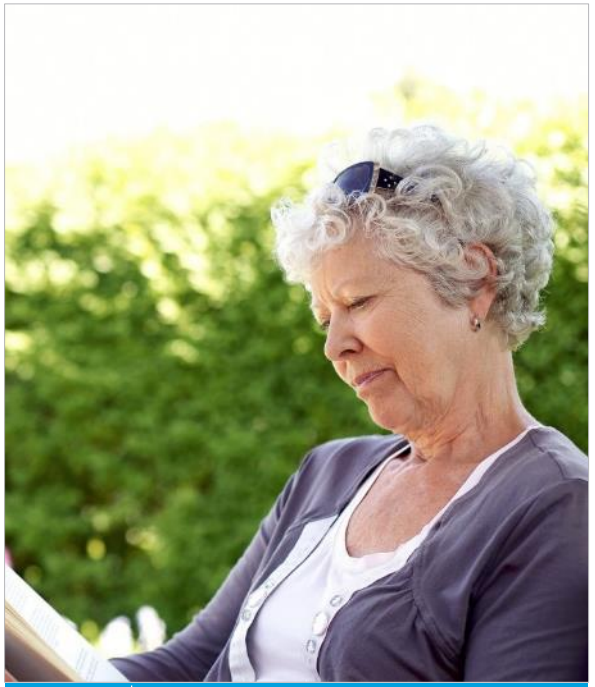
IMMUNE-MODULATORY INDICATIONS

01

Type-1 Diabetes

02

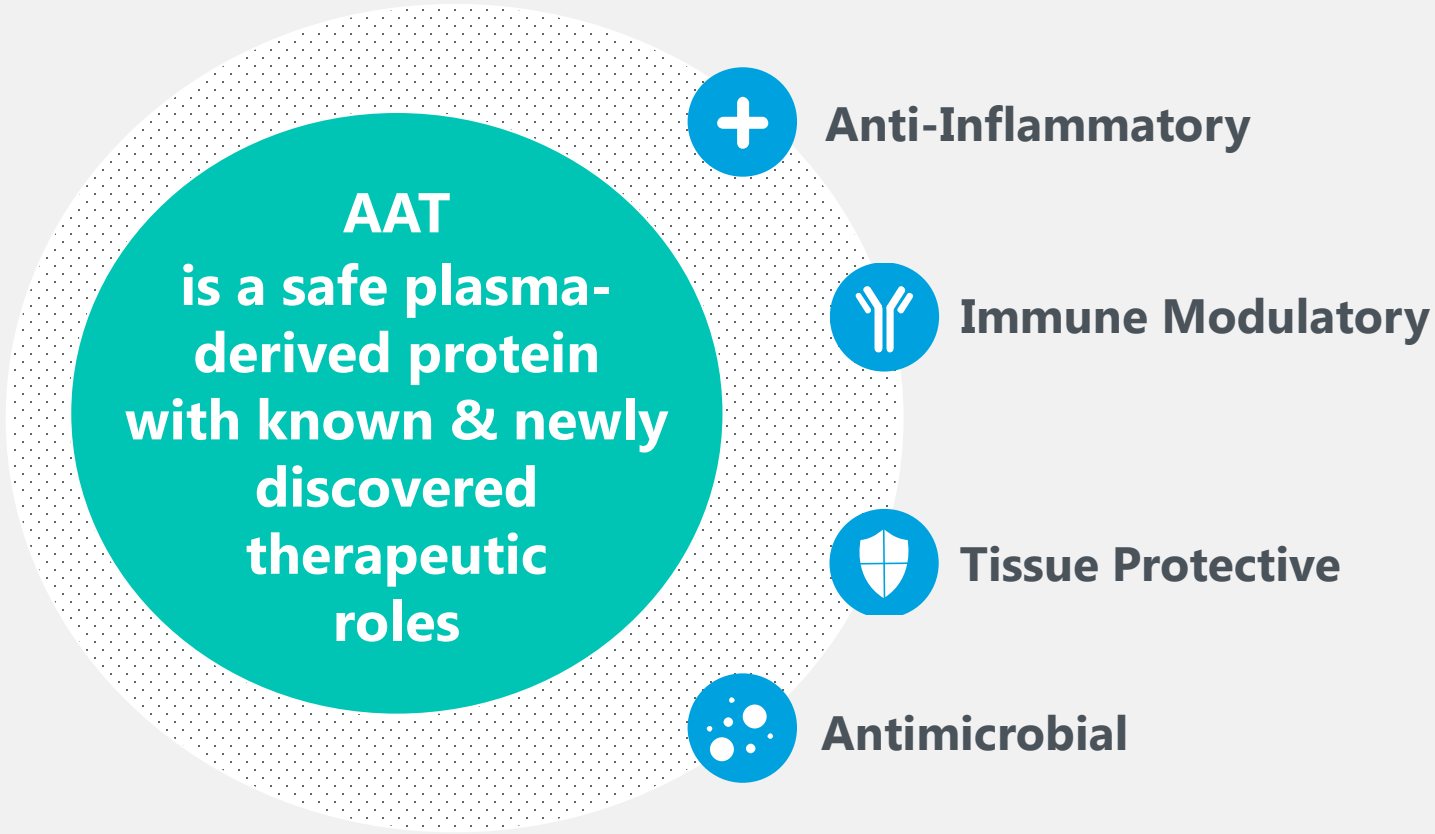
Graft versus Host Disease



03

Lung Transplantation

AAT SERVES AS AN EXCITING POTENTIAL THERAPY FOR MULTIPLE INDICATIONS



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

Comments/reference

01 AAT to Treat Newly Diagnosed Type-1 Diabetes

AAT (IV) IS A PROMISING POTENTIAL TREATMENT FOR NEWLY DIAGNOSED TYPE-1 DIABETES PATIENTS

MARKET OPPORTUNITY	AAT IMPACT	BENEFITS
Type-1 Diabetes Occurs when the immune system attacks and destroys beta cells in the pancreas	**Studies have shown that AAT protects 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]	• 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 the microvascular complications[3]

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

PHASE II STUDY

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

Study objective	• To evaluate the efficacy and safety of plasma-derived, Alpha-1 Antitrypsin (AAT) in the 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 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) • In the overall study population no significant treatment effect was observed.

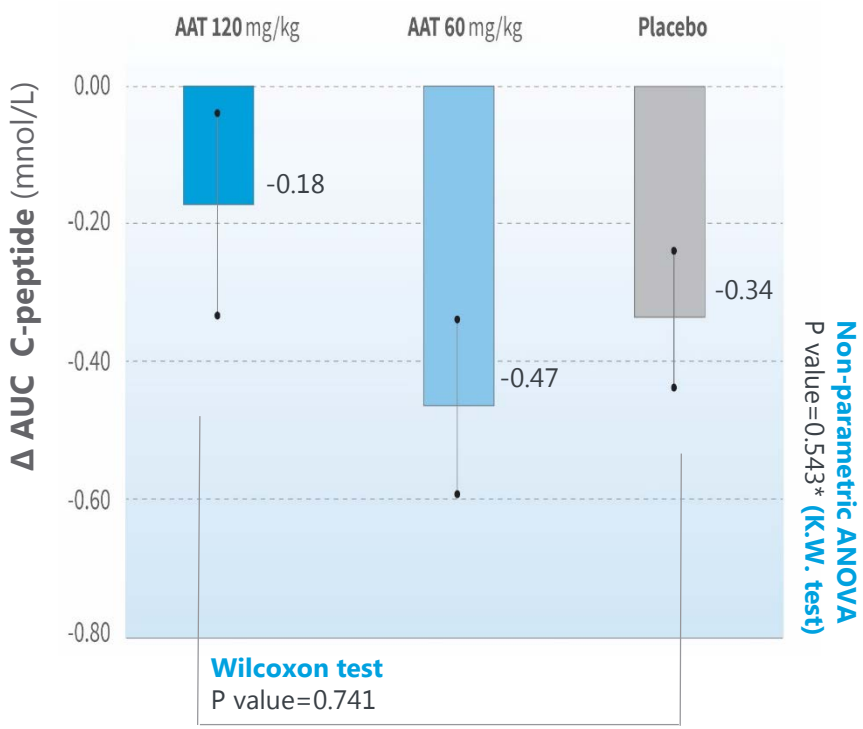
Comments/reference

BETA CELL FUNCTION AND INSULIN AT 1 YEAR

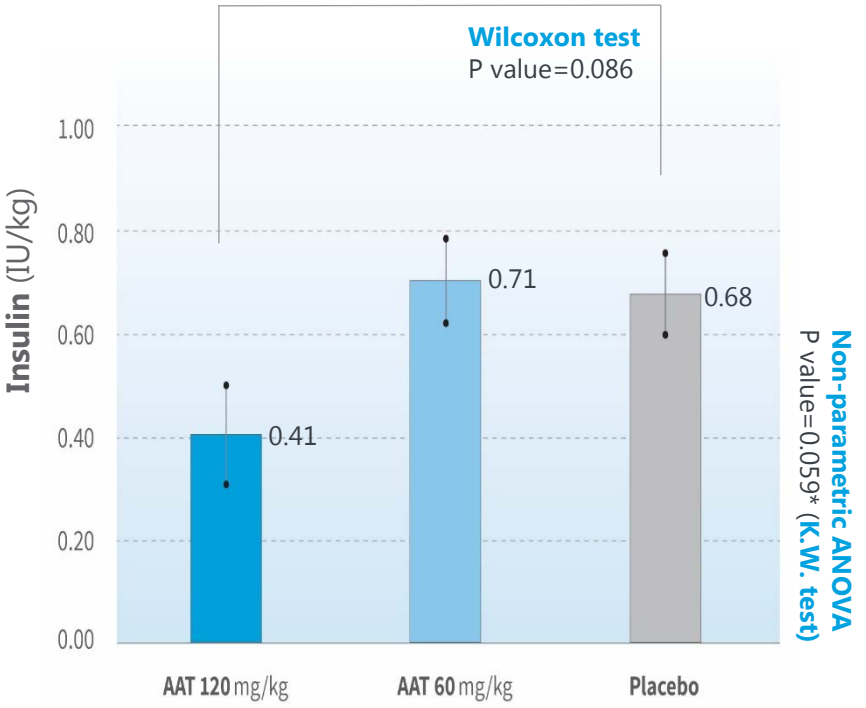
Subgroup Analysis, Ages 12-18

Beta-Cell Function by MMTT AUC C-peptide at 1 Year

Δ Stimulated AUC



Insulin Requirement at 1 Year

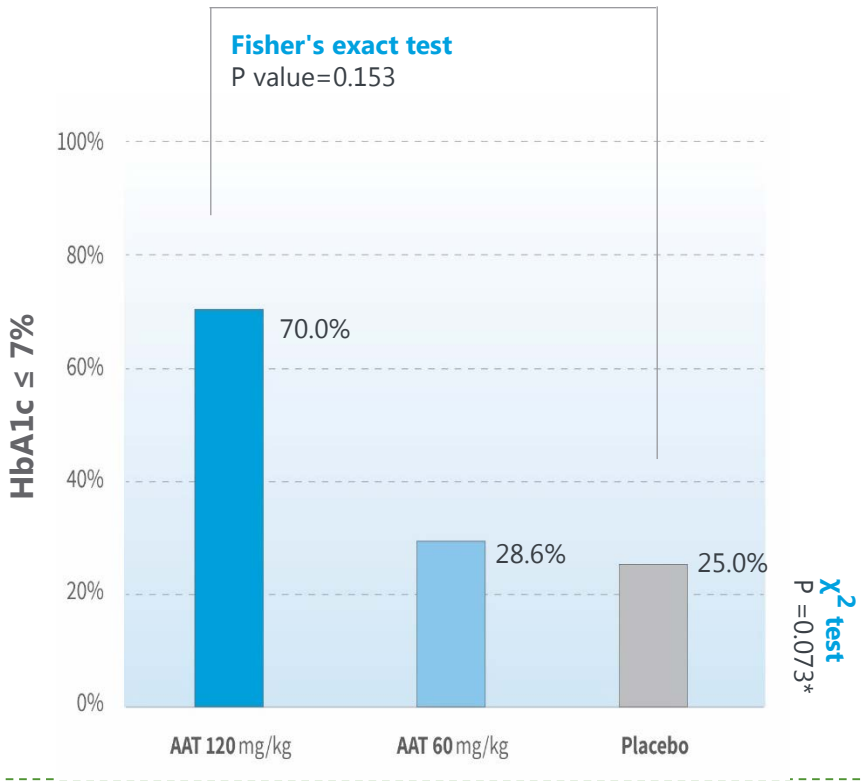


GLYCEMIC CONTROL RESULTS AT 1 YEAR

Subgroup Analysis, Ages 12-18

% HbA1c

Patients with HbA1c ≤ 7%



Comments/reference

"AAT COULD BE AN EFFECTIVE TREATMENT OPTION FOR NEWLY DIAGNOSED 12-18 YEARS OLD T1D PATIENTS"

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.

"Given this study was not powered to show efficacy, the results are very encouraging.

These findings suggest that **administration of AAT could be an effective treatment option for newly diagnosed T1D patients who are 12-18 years old.** 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.**"

AAT FOR T1D - NEXT STEPS

- Full data set analysis and publication
- Regulatory advice (US/EU)
- Seek strategic partner for collaboration in further product development

02

AAT to Treat Graft versus Host Disease

GRAFT VERSUS HOST DISEASE (GVHD):
A Major Complication in 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

Standard of care prophylaxis exhibits poor efficacy/severe AE's

No FDA-approved specific drug for GvHD indication – An Unmet Medical Need

Estimated Market Size[1]: **~ $500 MILLION**

1. *Company estimates*

AN EARLY-BIOMARKER PREDICTS LETHAL GVHD

Study performed by Matthew J. Hartwell, et al., the Icahn School of Medicine at Mount Sinai [1] suggests that a biomarker algorithm can identify patient at high risk of lethal GvHD and nonrelapse mortality in advance of symptoms onset

Background	No laboratory test can predict the risk of nonrelapse mortality (NRM) or severe GvHD after hematopoietic cellular transplantation (HCT) prior to the onset of GVHD symptoms.
Method	Patient blood samples on day 7 after HCT were obtained from a multicenter set of 1,287 patients, and 620 samples were assigned to a training set. We measured the concentrations of 4 GVHD biomarkers (ST2, REG3α, TNFR1, and IL-2Rα)
Results	A 2-biomarker model (ST2 & REG3α) concentrations identified patients with a cumulative incidence of 6-month NRM of 28% in the high-risk group and 7% in the low-risk group (P<0.001). GVHD-related mortality was greater in high-risk patients (18% vs. 4%, P<0.001), as was severe gastrointestinal GVHD (17% vs. 8%, P<0.001). The same algorithm can be successfully adapted to define 3 distinct risk groups at GVHD onset.
Conclusion	A biomarker algorithm based on a blood sample taken 7 days after HCT can consistently identify a group of patients at high risk for lethal GVHD and NRM.

1. *Matthew J. Hartwell, et al. An early-biomarker algorithm predicts lethal graft-versus-host disease and survival. JCI Insight. 2017;2(3):e89798. doi:10.1172/jci.insight.89798*

NEXT STUDY OF AAT (IV) FOR GVHD

Collaboration with Mt. Sinai to evaluate AAT for preemption of aGvHD

Proof-of-Concept Study:

- Open label single arm multicenter study to be 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)
- Led by Prof James L.M. Ferrara, MD, and Prof. John Levine, MD, MS

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

Innovative approach	• Biomarker based algorithm to diagnose patients at risk to develop steroid-resistant GvHD (SR-GvHD) at day 7 after bone marrow transplantation (BMT). • 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.

This study replaces the previously planned phase II/III study which was designed to treat aGvHD patients in First Line setting

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

03 AAT to Treat Lung Transplantation

ADVANCING THE LUNG TRANSPLATATION OPPORTUNITY

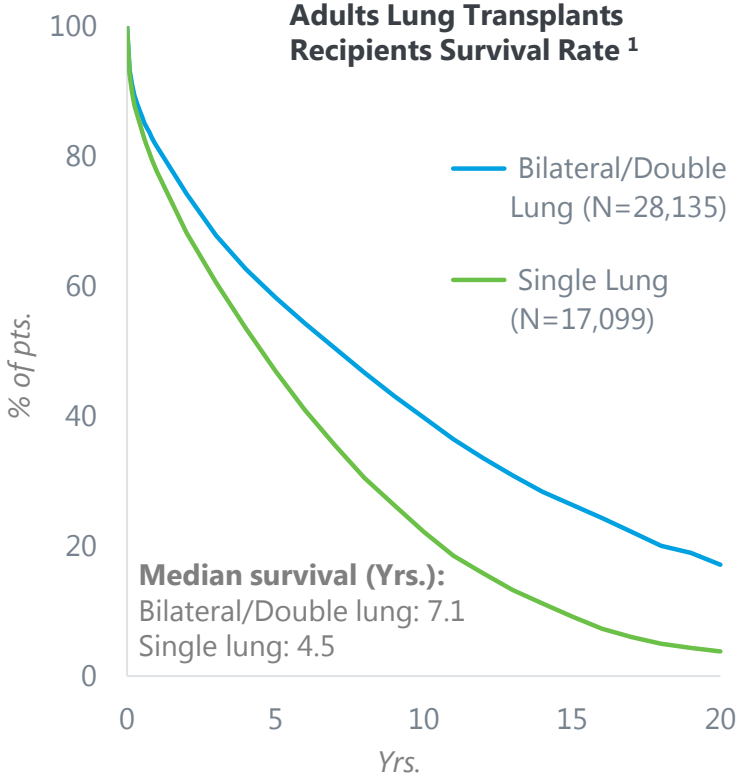
Lungs have the highest rate of rejection among transplanted solid organs

~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

Physician feedback indicates 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



Potential Market Size[2] ~ $400-500 MILLION

1. *JHLT. 2015 Oct;34(10): 1264-1277; 2. Company estimates*

ON-GOING PHASE II STUDY WITH AAT IV

For Prevention of Lung Transplant Rejection

Phase II:
Prospective, open label, standard-of-care (SOC) controlled, randomized, parallel group single center study

In collaboration with Baxalta/Shire led by Prof. Mordechai Kramer, Rabin Medical Center, Israel

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 period
Endpoints	• Safety: Related adverse events (AEs) • Efficacy: Changes in FEV1 from baseline and overall effect, incidence and rate of acute lung rejection
Interim results (16 Pts; 6 months)	• IV AAT demonstrated favorable safety and tolerability profile in 10 patients during first six months of treatment, consistent with previously observed results in other indications.

"Preclinical data published in Blood suggest that IV AAT has an immunomodulatory and anti- inflammatory mechanism of action that would support its efficacy in the prevention of lung transplant rejection" (Prof. Mordechai Kramer)

Comments/reference

Distribution Product Segment

DISTRIBUTION SEGMENT

Exclusive distributor in Israel of leading biopharmaceutical companies

Medical Field	Product/Brand Name	Description
Respiratory	Bramitob	Tobramycin, inhaled
	Foster	Beclometasone+ Formoterol inhaled
	Provocholine	Methacholine, inhaled
Infectious Disease	Ixiaro	Japanese encephalitis vaccine
	Varitect	Varicella zoster IgG
	Megalotect	CMV IgG
Hospital & Critical Care	Heparin sodium injection	Heparin sodium 5000 IU/ml
	Albumin	Human serum Albumin
Hematology and Hemophilia	Factor VIII	Coagulation Factor VIII (human)
	Factor IX	Coagulation Factor IX (human)
Liver	Zutectra	Hepatitis B IgG S.C
	Hepatect	Hepatitis B IgG I.V
Immunology	IVIG	Gamma-globulins 5% IV

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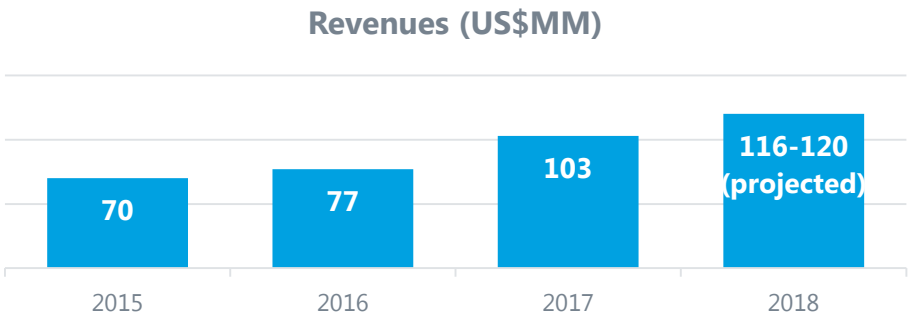
Financials

INCREASING REVENUES AND GROSS PROFITS

2017 Exceeded Revenues Guidance of $100M

2018 Revenues Guidance $116-120M; Profitable

US $ MM	FY 2015 Audited	FY 2016 Audited	% YoY 2016/2015	FY 2017 Unaudited	% YoY 2017/2016
Proprietary Products	43	56	30%	80	42%
Distribution Products	27	21	-22%	23	8%
Total Revenues	**70**	**77**	**10%**	**103**	**33%**
Gross Profit	**16**	**22**	**38%**	**32**	**50%**
Gross Profit (%)	**23%**	**29%**		**31%**	
R&D	(17)	(16)		(12)	
S&M and G&A	(11)	(11)		(13)	
Operating Profit (Loss)	**(12)**	**(5)**		**7**	
Net Profit (Loss)	**(11)**	**(7)**	**36%**	**7**	**200%**
Adjusted EBITDA[1]	**(6)**	**(1)**		**11**	



1. *See Appendix A for a reconciliation of Adjusted EDITDA to IFRS Net Profit (Loss)*

EXPECTED 2018 MILESTONES

Initiating next GvHD study in collaboration with Mt. Sinai Hospital and the MAGIC consortium	**Q1/2018**
Rabies product launch in the U.S.	**Q1/2018**
Inhaled AAT for AAT Deficiency: • **Approved IND for registration trial in US** • **Scientific Advice in EU**	**Mid 2018**
Initiating inhaled AAT for AATD phase III study (post IND approval)	**H2/2018**
Interim report for Phase II for lung transplant trial (1 year treatment)	**H2/2018**
Advancing type-1 diabetes program through collaboration	**H2/2018**
Achieve $116-120 million in annual revenues, profitable, cash flow positive	**2018**

KAMADA INVESTMENT HIGHLIGHTS

- **Commercial stage global biopharmaceutical company focused on Alpha-1 Antitrypsin Deficiency (AATD) and Specific Hyper-Immune IgGs**
- **2017 revenues at $103MM. 2018 guidance of strong 13-17% revenue growth**
- **Two FDA approved products**
  - **Glassia®** for AATD; Marketed in the US by Shire plc; Unique and differentiated product profile in a fast growing market
  - **KedRab** for Post-Exposure Prophylaxis Anti-rabies; marketed in the US by Kedrion
- **Novel inhaled AAT developed as a second generation product for AATD**
  - Phase 3 study, pending approved IND, expected to be initiated H2/ 2018
- **Robust IV AAT pipeline for additional orphan indications**
  - Type-1 Diabetes, Graft vs. Host Disease, Lung Transplant Rejection
- **Strategic partnerships with industry leaders** → Shire, Kedrion, Biotest and PARI
- **Integrated, Efficient and Scalable Patented Platform Technology; including an FDA-approved manufacturing facility**
- **Distributed biopharmaceutical products segment in Israel**
- **Strong Financial Profile with Growing Profitability;** $43M cash & forecast positive cash flow in 2018

THANK YOU

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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, and plus one-time management compensation payment.

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
Net Income (Loss)	(11,270)	(6,733)	6,901
Taxes on income	0	1,722	269
Financial expenses (income) , net	471	(343)	(338)
Depreciation and amortization expense	3,227	3,501	3,523
Share-based compensation charges	1,907	1,071	483
Expense (income) in respect of currency exchange and translation differences and derivatives instruments, net	(625)	(127)	612
Adjusted EBITDA	(6,290)	(909)	11,450

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."

Professor 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.

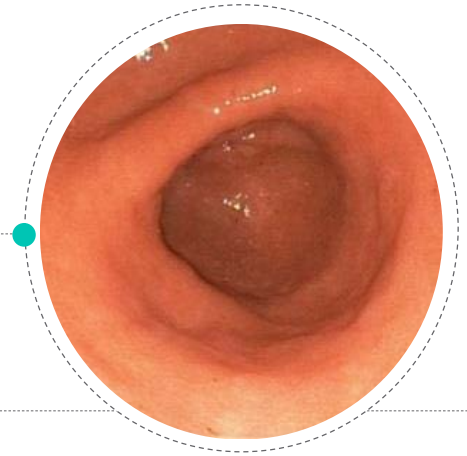
GVHD PROOF-OF-CONCEPT STUDY WITH AAT (IV)

For Graft-Versus-Host Disease (published 1/2016)

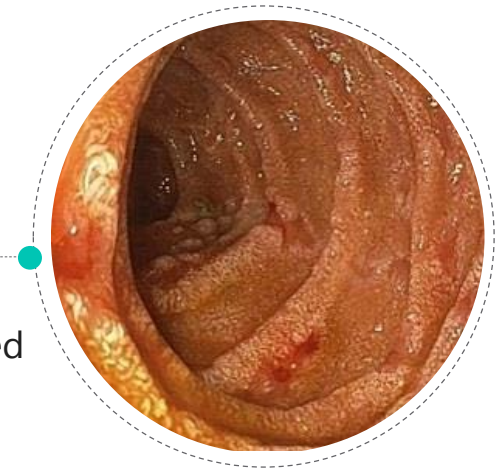
Phase I/II study:

Open label of 24 patients with steroid-resistant GvHD bone- following allogeneic marrow stem cell transplant

Study Design	4 dose groups - 15 day regimen. Doses given on days: 1, 3, 5, 7, 9, 11, 13 and 15
Primary Endpoint	% of patients who experience no toxicity and in whom GVHD is stable or improved
Results	• Encouraging preliminary clinical results; • Stool AAT levels showed a decrease in intestinal AAT loss, suggesting healing of the bowel mucosa



BEFORE Duodenits suspect severe upper and lower GVHD



AFTER 8 DOSES OF AAT Moderate mucosal denudement and edema noted throughout the duodenum

Comments/reference

CLINICAL DEVELOPMENT FOR NEWLY DIAGNOSED TYPE-1 DIABETES: NEW EXCITING PROSPECTS

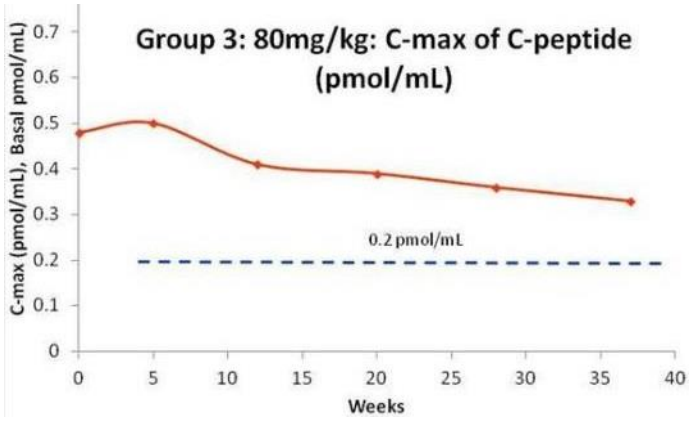
Phase I/II: Open Label Study to evaluate the safety, tolerability and efficacy of AAT on beta cell preservation and glycemic control on newly diagnosed T1D pediatric patients (N=24)

AUC% for C-peptide decreased 23% from baseline vs. ~40-50% expected decrease after 12-15 months from diagnosis

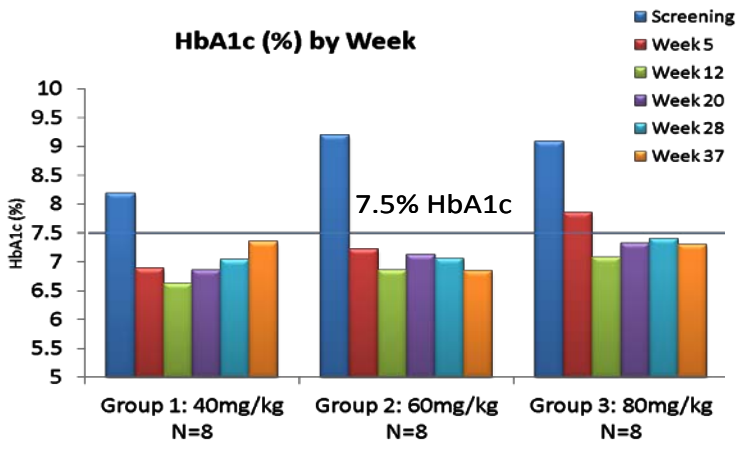
Specific diabetes antibody levels decreased in all groups from baseline to study completion, a decrease that may indicate an immune modulatory effect

At end-of-study, 38% of patients decreased insulin dose

All subjects completed the study. No Serious AEs occurred. AEs were mild and mostly infusion-related (fatigue, headache)



End-of-study slope analysis of C-peptide [max] and C-peptide [AUC] revealed no significant changes from baseline



HbA1C data indicated that almost all patients reached glycemic control

Comments/reference