KAMADA INVESTOR PRESENTATION

NASDAQ & TASE: KMDA

November 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 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 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.

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 Shire plc. Estimated revenues: $177-$228 MM (2018-2020); followed by 20 years of royalties.*
	  • *KedRAB® for anti-rabies prophylaxis treatment. Commercialized in the U.S. through Kedrion Biopharma. Launched in Q1/2018.*

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: $102.8 MM (+33% YoY) • 2018 Revenue Guidance: $102-$108MM[1]; Profitable; Cash flow positive • Cash: $44.9 MM (September 30, 2018); No Debt • Strong balance sheet allows execution on pipeline and business development initiatives • Listed on TASE (2005) & Nasdaq (2013)

1. *The previously provided 2018 revenue guidance of $116-$120 million has been revised; As a result of a recently settled labor strike, part of 2018 planned product shipments are likely to be delayed and supplied in early 2019*

HIGH VALUE PRODUCT PORTFOLIO AND PIPELINE

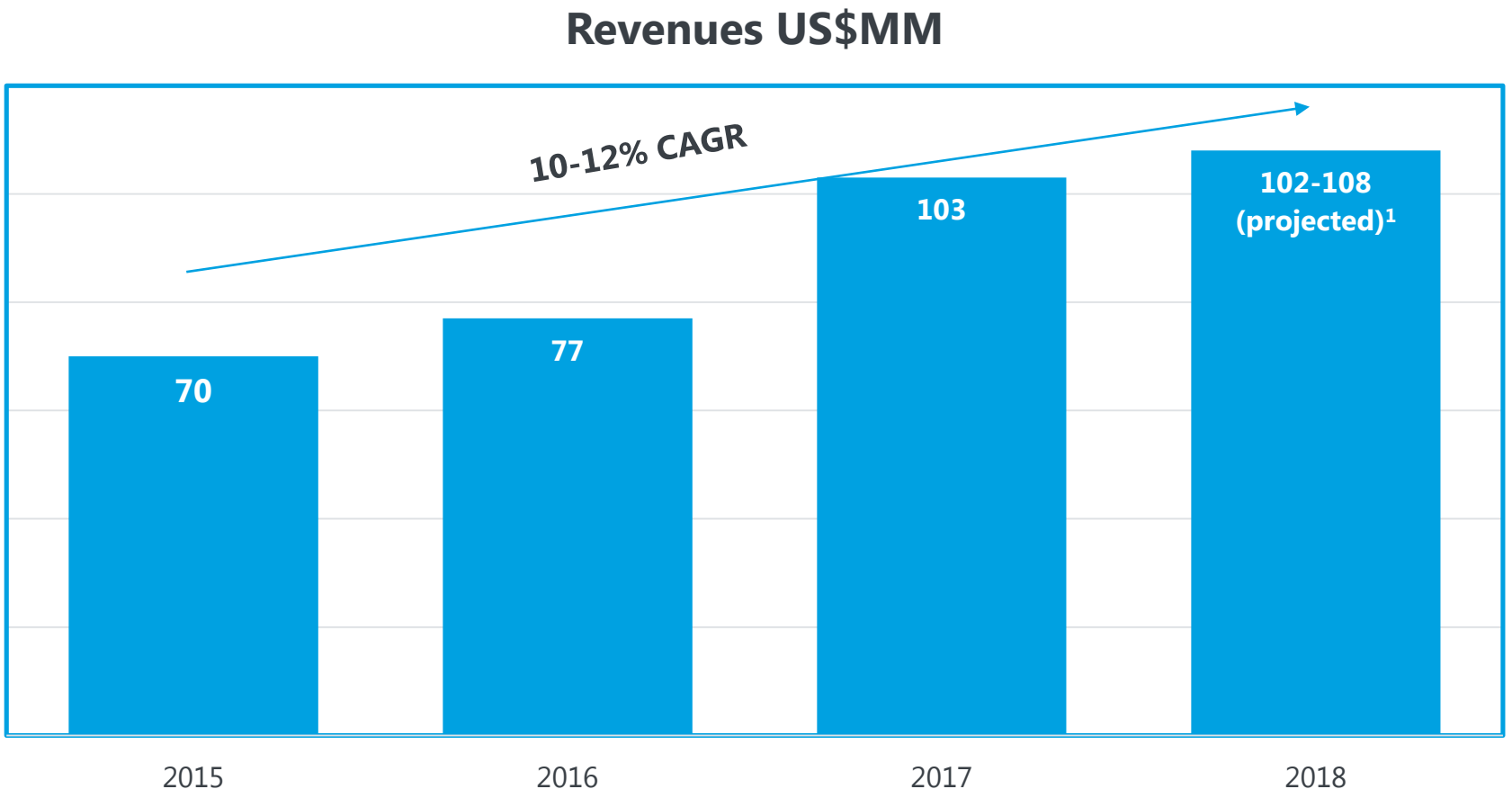
Product	Indication	Phase I / Phase II / Phase III / Market	
Glassia® (IV AAT) *	AAT Deficiency	FDA approved (2010) ----------	U.S. distribution through Shire
KamRab®/KedRab® (IM Anti-Rabies)	Prophylaxis for Rabies	FDA approved (2017) ----------	U.S. distribution through KEDRION BIOPHARMA
Clinical Development			
Inhaled AAT	AAT Deficiency [1]	EU Phase 2/3 (completed) ---------- MAA withdrawn (June 2017) EMA accept 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 Shire plc
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
Eitan Kyiet	VP Business Development
Eran Nir	VP Operations
Yael Brenner	VP Quality
Liliana Bar, PhD	VP Research and Development
Orit Pinchuk	VP Regulatory Affairs & PVG
Naveh Tov, MD, PhD	VP Clinical Development & Medical Director (Pulmonary)
Michal Stein, MD	VP Medical Director (Immunology)
Ariella Raban	VP Human Resources

DEMONSTRATED STRONG SALES GROWTH DRIVEN BY GLASSIA



1. *The previously provided 2018 revenue guidance of $116-$120 million has been revised; As a result of a recently settled labor strike, part of 2018 planned product shipments are likely to be delayed and supplied in early 2019*

INCREASING REVENUE GROWTH AND PROFITABILITY

US $ MM	FY 2015 Audited	FY 2016 Audited	% Change 2016/2015	FY 2017 Audited	% Change 2017/2016	1H 2017 Unaudited	1H 2018 Unaudited	% Change 2018/2017
Proprietary Products	43	56	30%	80	42%	34	38	14%
Distribution Products	27	21	-22%	23	8%	11	13	22%
Total Revenues	**70**	**77**	**10%**	**103**	**33%**	**44**	**51**	**16%**
Gross Profit	**15**	**21**	**39%**	**32**	**50%**	**14**	**18**	**26%**
Gross Profit (%)	**22%**	**28%**		**31%**		**32%**	**34%**	
R&D	(17)	(16)		(12)		(7)	(5)	
S&M and G&A	(10)	(11)		(13)		(6)	(6)	
Operating Profit (Loss)	**(11)**	**(5)**		**7**		**1**	**6**	
Net Profit (Loss)	**(11)**	**(7)**	**40%**	**7**	**204%**	**1**	**7**	**667%**
Adjusted EBITDA[1]	**(6)**	**(1)**		**11**		**4**	**9**	

2017 Revenue Exceeded Guidance of $100M

2018 Revenue Guidance of $102-108M[2];
Continued Profitability and Positive Cash Flow

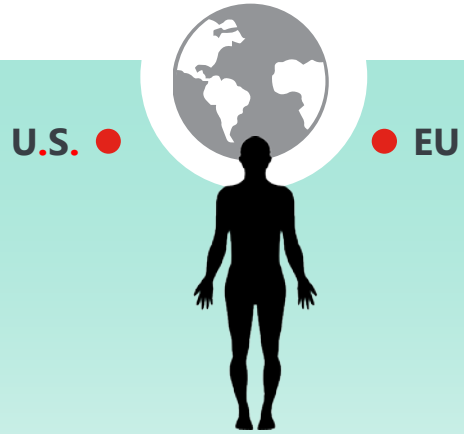
1. *See Appendix A for Adjusted EDITDA reconciliation*
2. *The previously provided 2018 revenue guidance of $116-$120 million has been revised.*

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 than 100,000 people in the U.S. and slightly lower number in Europe

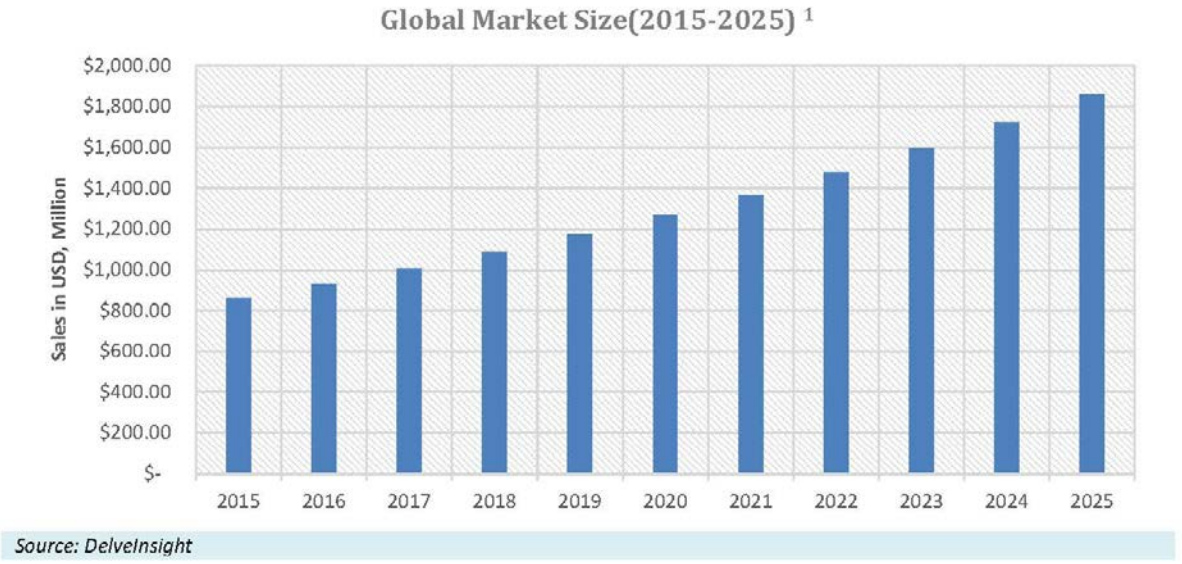
Predisposes to lung and liver diseases

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

AAT DEFICIENCY (AATD) MARKET

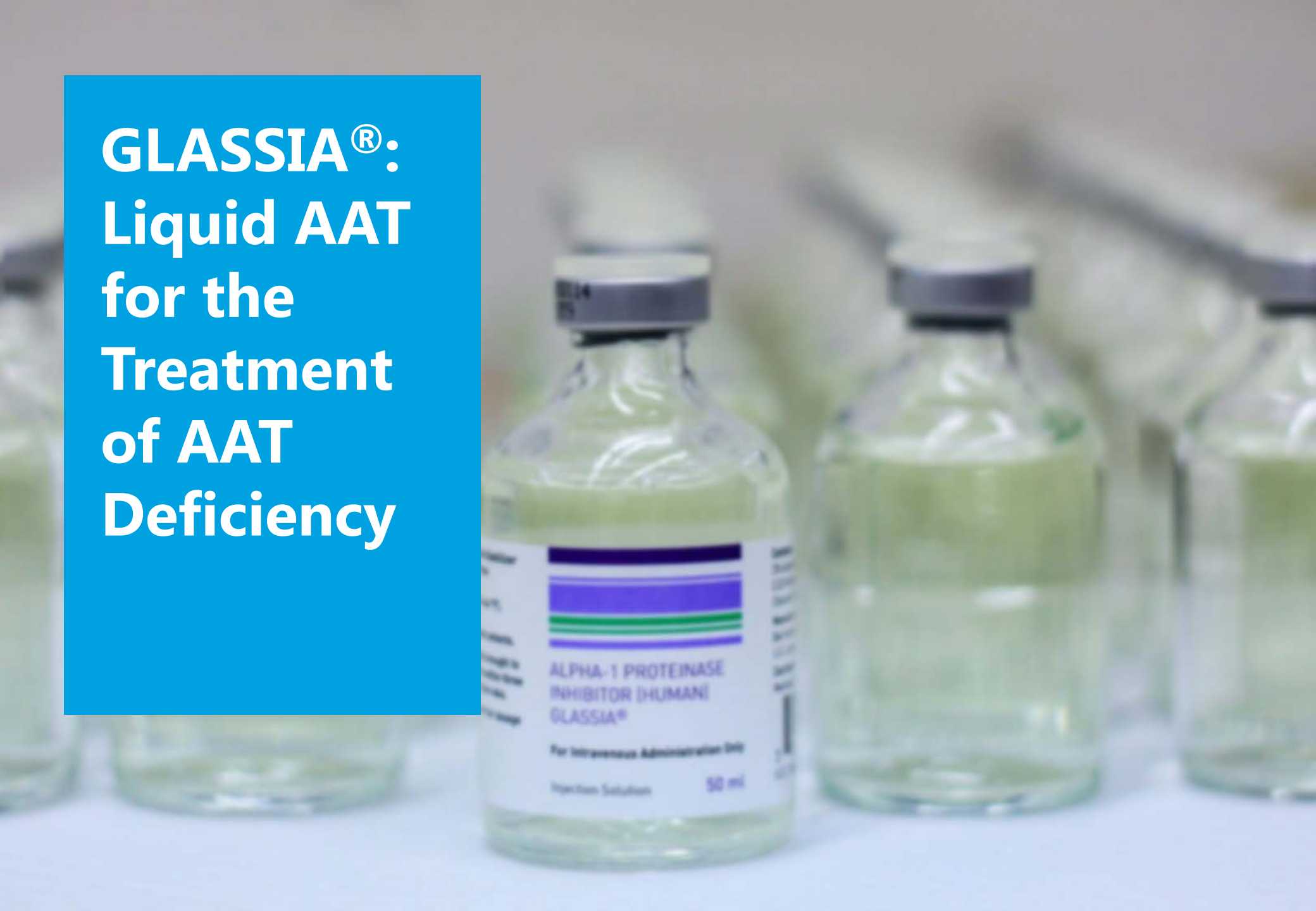
Significant expansion opportunity

- Majority of patients suffering from AATD still remain undiagnosed & untreated
- Better diseases awareness and expanded diagnostics is contributing to increased demand
- Expected growth of U.S. market – approx. 6-8% annually[1]
- Chronic therapy creates sustainable product revenue opportunity
- Average annual reimbursement (U.S.) ~$80-$100K per patient
- Greater AAT use in Europe and other regions could further accelerate market growth



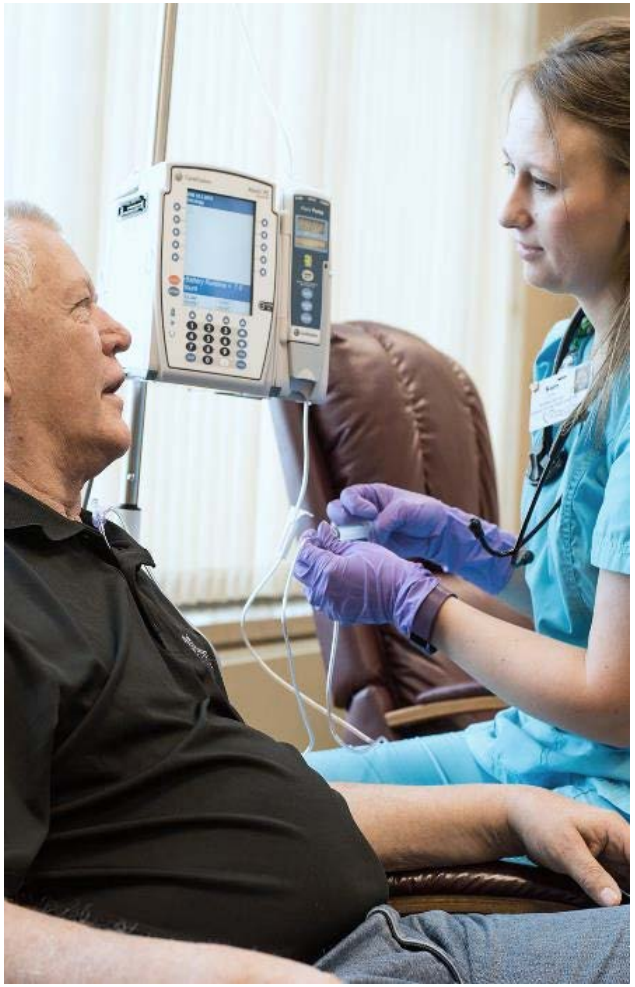
- **AATD prevalence [1]: ~115,000 (U.S.); ~72,000 (EU5)** but only ~7,300 (U.S.) or ~1,800 (EU5) patients are treated [1]
- **Current market size is ~ $1B WW**
- **Expected to reach $1.8B by 2025**

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



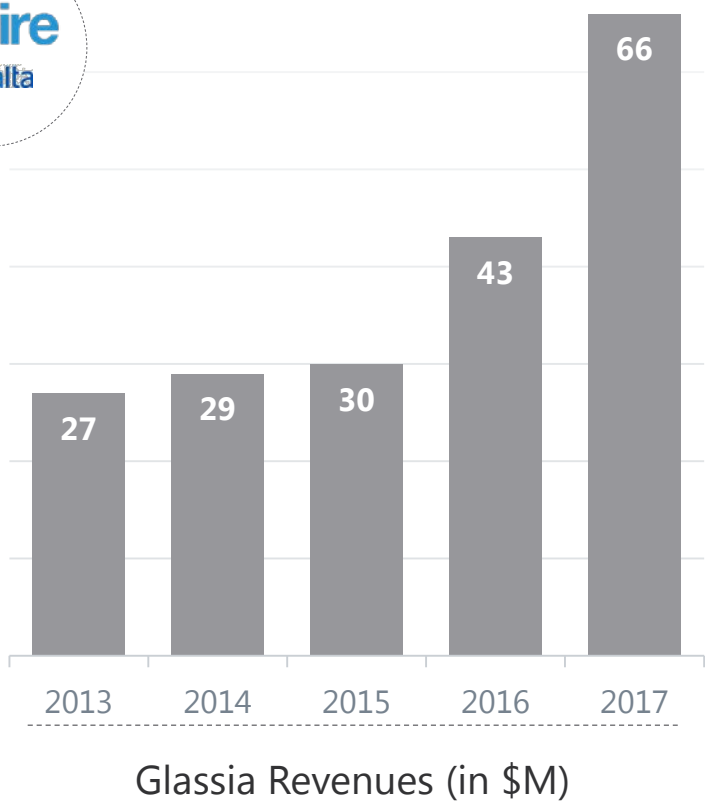
- Glassia® is the first liquid, FDA-approved ready-to-use, plasma-derived AAT product:
  - No reconstitution required
  - Reduces treatment time
  - Reduces risk of contamination and infection
- Kamada's highly purified liquid product is manufactured through a proprietary process
- Glassia® is sold in the U.S. by Shire plc
- 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 $177MM/$228MM to Kamada expected for 2018-2020
- Kamada manufactures and supplies Glassia to Shire through 2020
- Commencing in 2021, Shire has option to manufacture Glassia and pay royalties 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, with majority of sales in the U.S.



Glassia Revenues (in $M)

KamRAB/ KedRAB: Human Rabies Immune Globulin

KamRAB/KedRAB

Human Rabies Immune Globulin

U.S. Opportunity:
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
- Product launch: Q1/2018 in collaboration with Kedrion
- **~40,000 post-exposure prophylaxis treatments** administered each year, representing **~$150 million market opportunity**[1]
- **Limited competition in US**

Worldwide

- More than 1.5MM vials sold by Kamada to date = ~ **300,000 people treated WW**
- 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

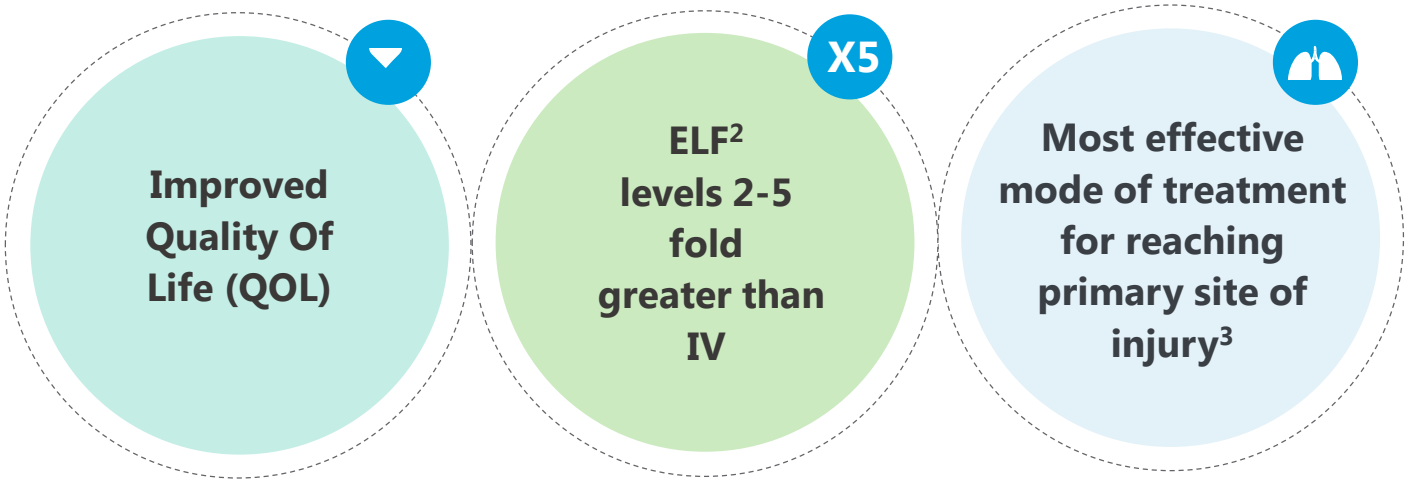
1. *The plasma protein market in the United States, 2017, The Marketing Research Bureau Inc*

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

ANTICIPATED BENEFITS OF INHALED AAT

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

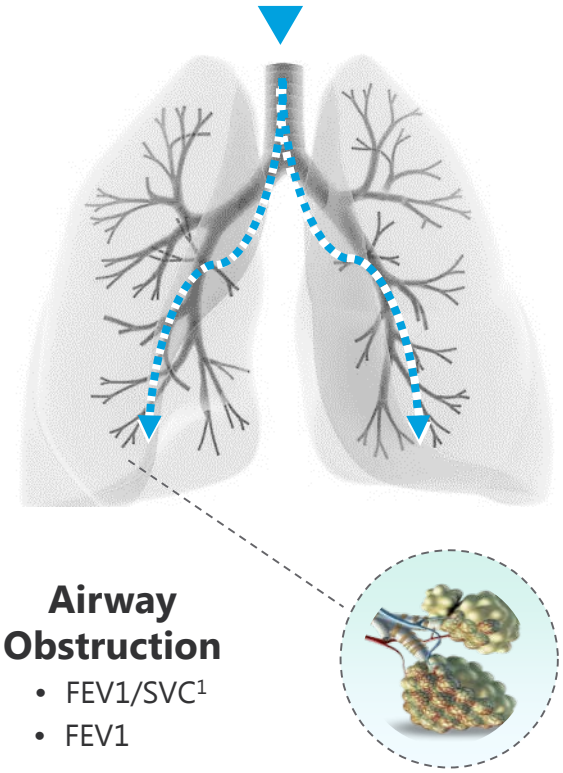
Inhaled AAT opportunity is estimated by Kamada at over $1B world wide



1. *COPD: Journal of Chronic Obstructive Pulmonary Disease, Volume 10, 2013 - Issue 4;*
2. *ELF = Epithelial Lining; 3. Based on Kamada's clinical data*

INHALATION ENABLES DELIVERY OF AAT 5X HIGHER THAN INTRAVENOUS

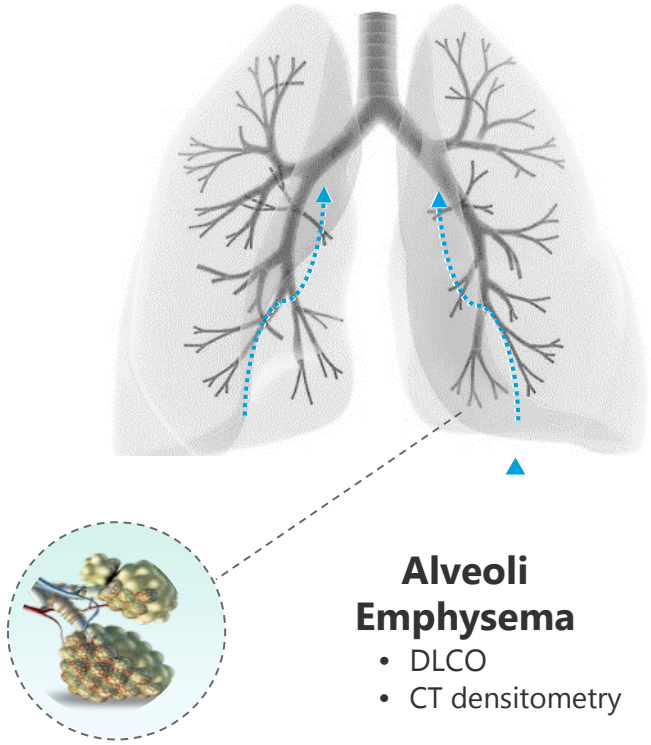
Inhaled AAT ~ 50% of the dosage reaches **airway tree** and alveoli



Airway Obstruction

- FEV1/SVC[1]
- FEV1

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

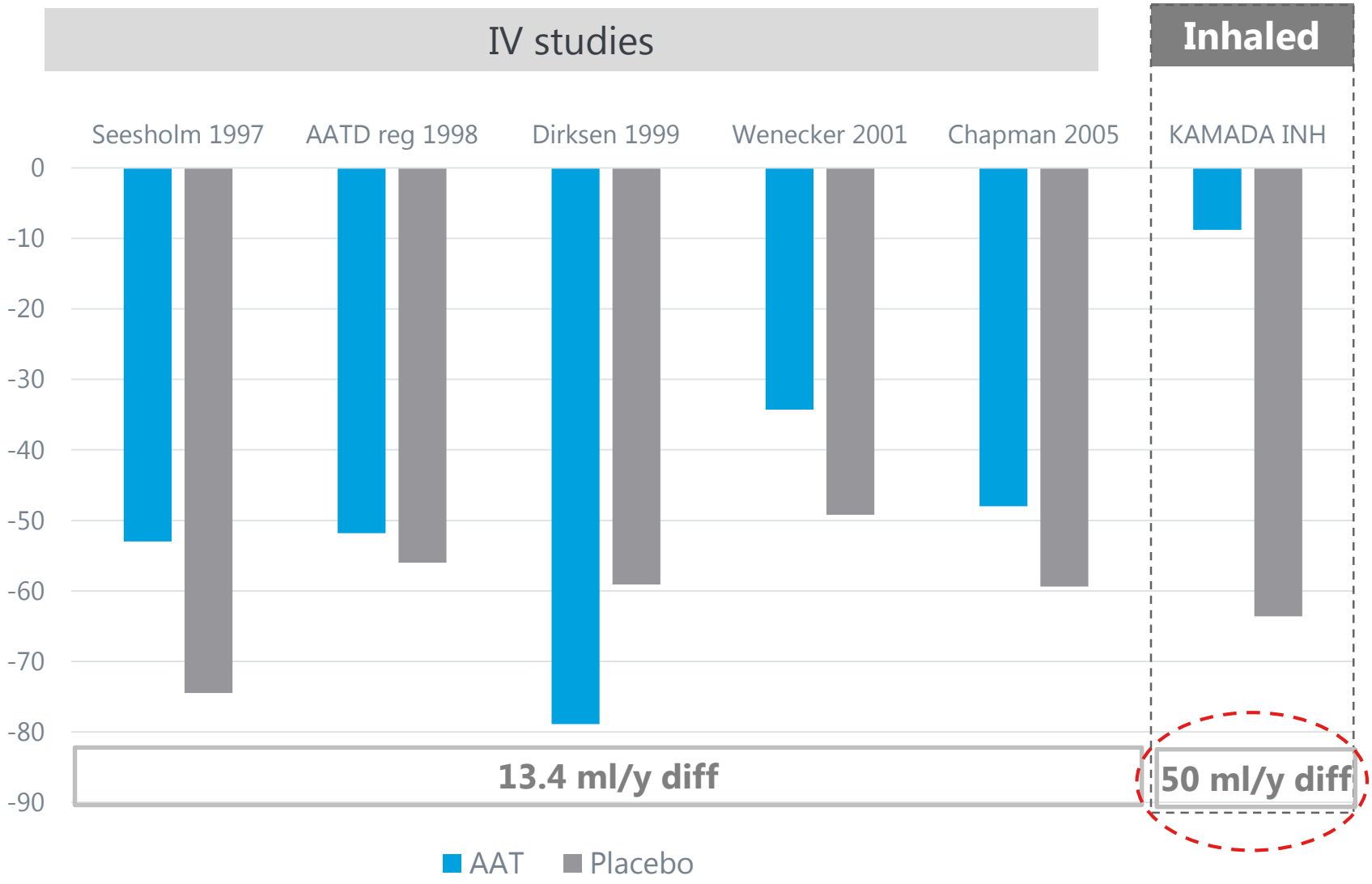


Alveoli Emphysema

- DLCO
- CT densitometry

1. FEV = Forced Expiratory Volume. SVC = Slow Vital Capacity.

INHALED AAT SLOWED FEV1[1] DETERIORATION BETTER THAN PREVIOUS AAT-IV TRIALS



1. FEV = Forced Expiratory Volume

INHALED AAT: MOVING FORWARD

U.S.

- 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 to the FDA during Q3 2018
- Continued clinical development pending IND approval by FDA

EU

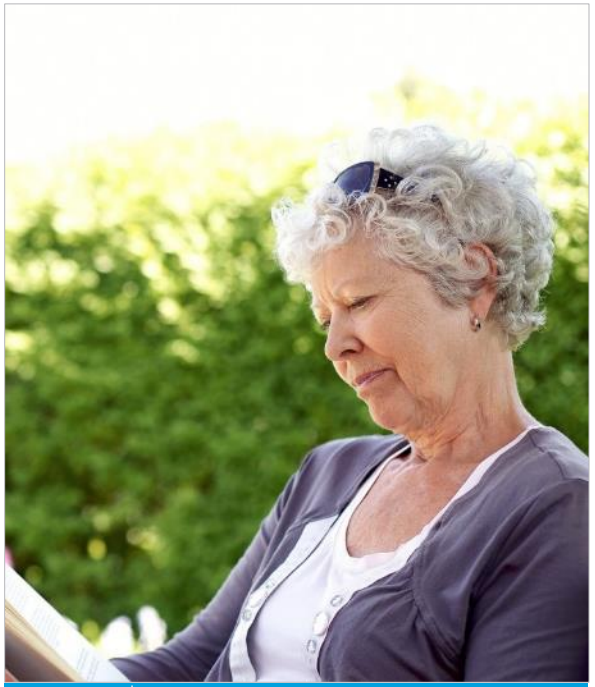
- Phase 2/3 completed; Study endpoints were not met; statistical significant lung function improvement was observed
- MAA submitted based on data showing Lung Function Improvements; MAA withdrawn (June 2017) EMA viewed data as insufficient for approval
- Proposed new Ph3 protocol accepted by EMA in a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

Considering all strategic options for Inhaled-AAT, including seeking a partner

IMMUNE-MODULATORY INDICATIONS

01

Graft versus Host Disease



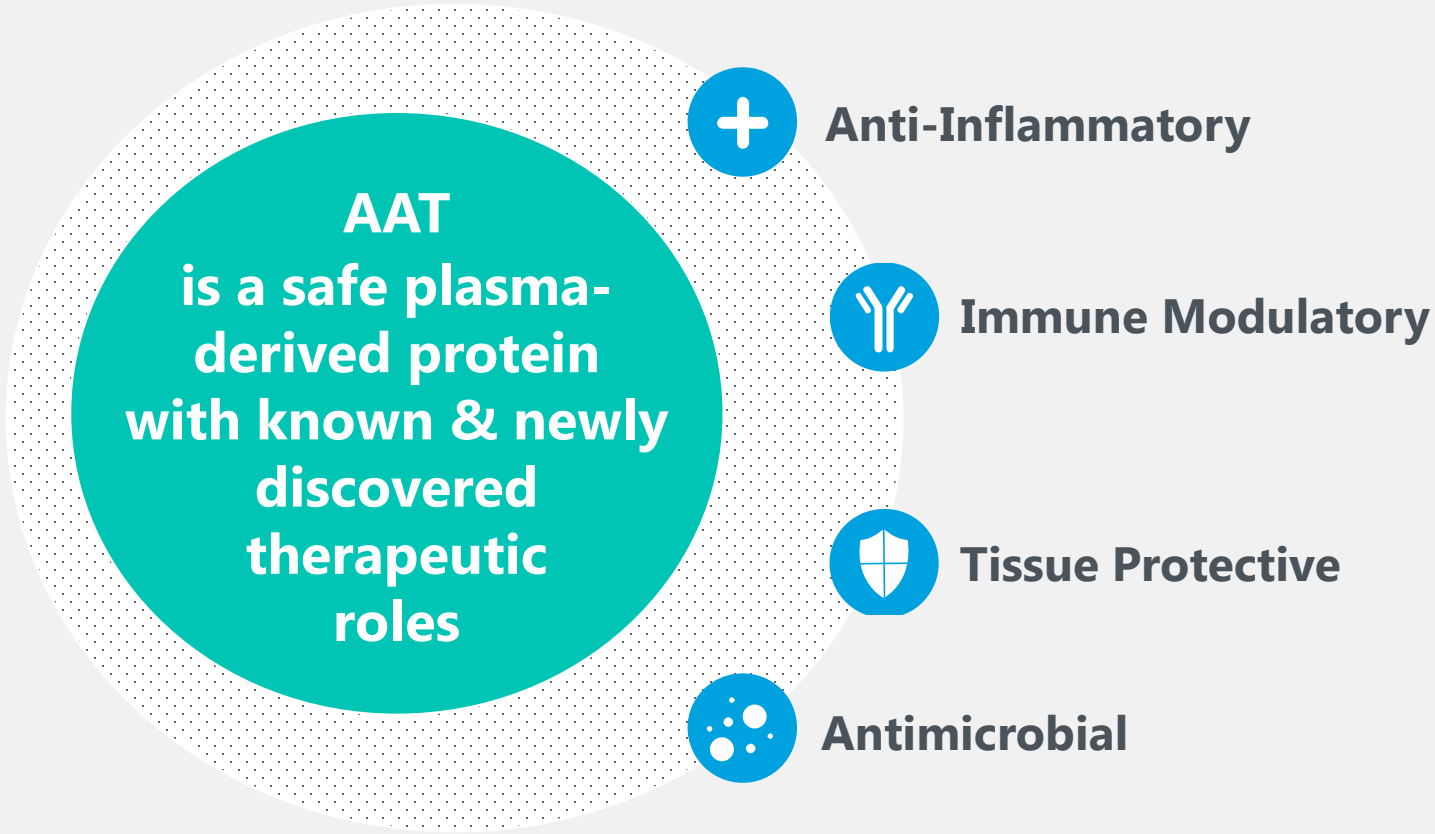
02

Lung Transplantation

03

Type-1 Diabetes

AAT REPRESENTS 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.

01 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 prophylaxis care 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 patients at high risk of lethal GvHD and non-relapse mortality in advance of symptoms onset

Background	No laboratory test can predict the risk of non-relapse 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*

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

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) and Led by Prof James L.M. Ferrara, MD, and Prof. John Levine, MD, MS
- Top-line results expected to be available during the second half of 2019

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.

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 AAT to Treat Lung Transplantation

ADVANCING THE LUNG TRANSPLATATION OPPORTUNITY

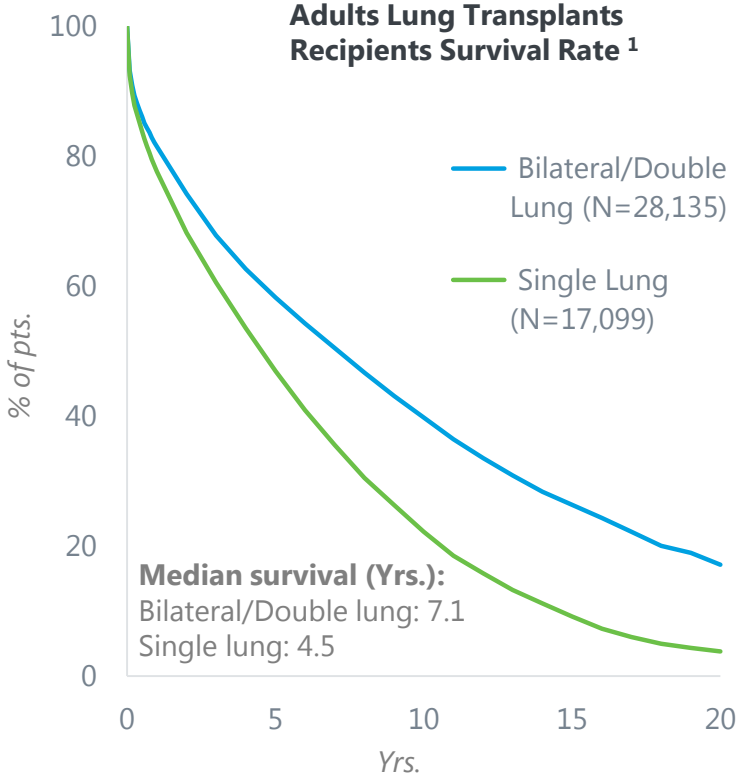
Lungs have the highest rate of rejection among transplanted solid organs

~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
- Next interim report will include data from one-year of treatment for all patients, and is expected in H2 '18
- Top-line data from the Phase 2 trial anticipated in H2 '19.

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.

03 AAT to Treat Newly Diagnosed Type-1 Diabetes

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 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

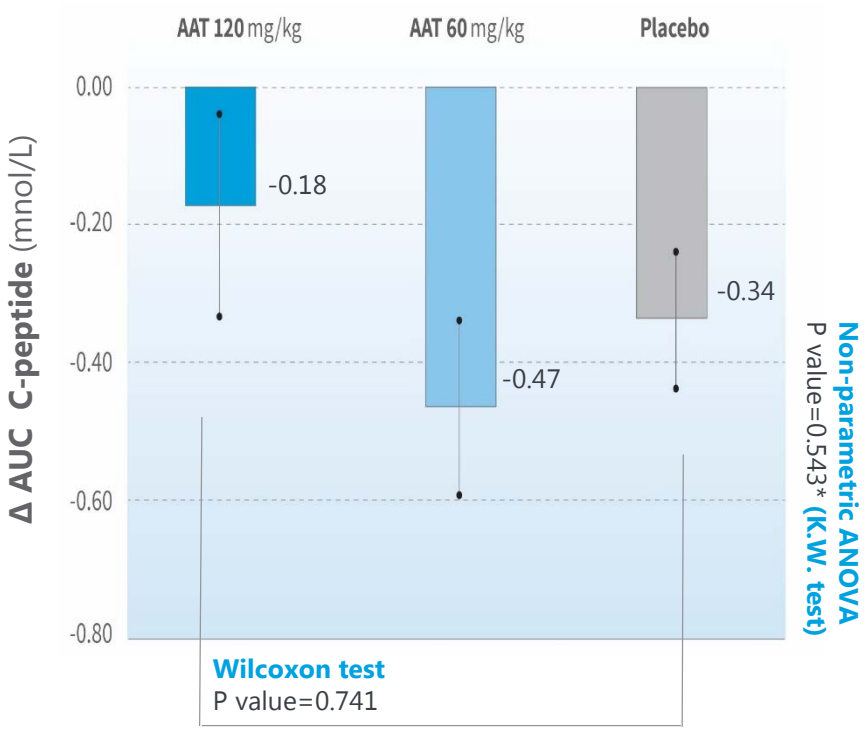
Study objective	• To evaluate efficacy and safety of AAT) in treatment of newly diagnosed Type 1 Diabetes patients
Design	• Two doses, placebo controlled, randomized with 70 pediatric and young adult patients. One year study
Endpoints	• Beta cell preservation (C-peptide AUC), HbA1C, hypoglycemic events 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)

BETA CELL FUNCTION AND INSULIN AT 1 YEAR

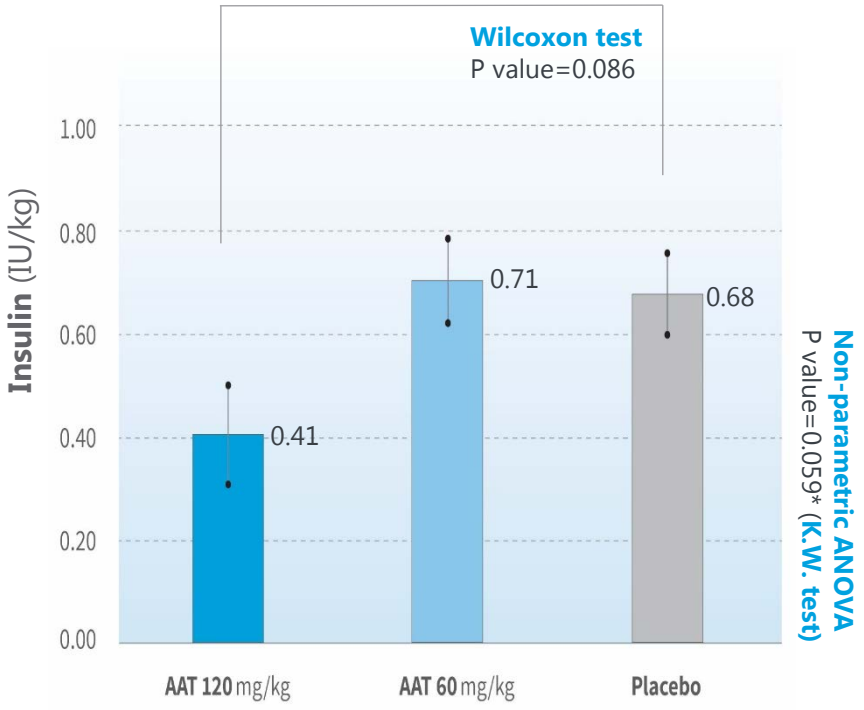
Subgroup Analysis, Ages 12-18

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

Δ Stimulated AUC



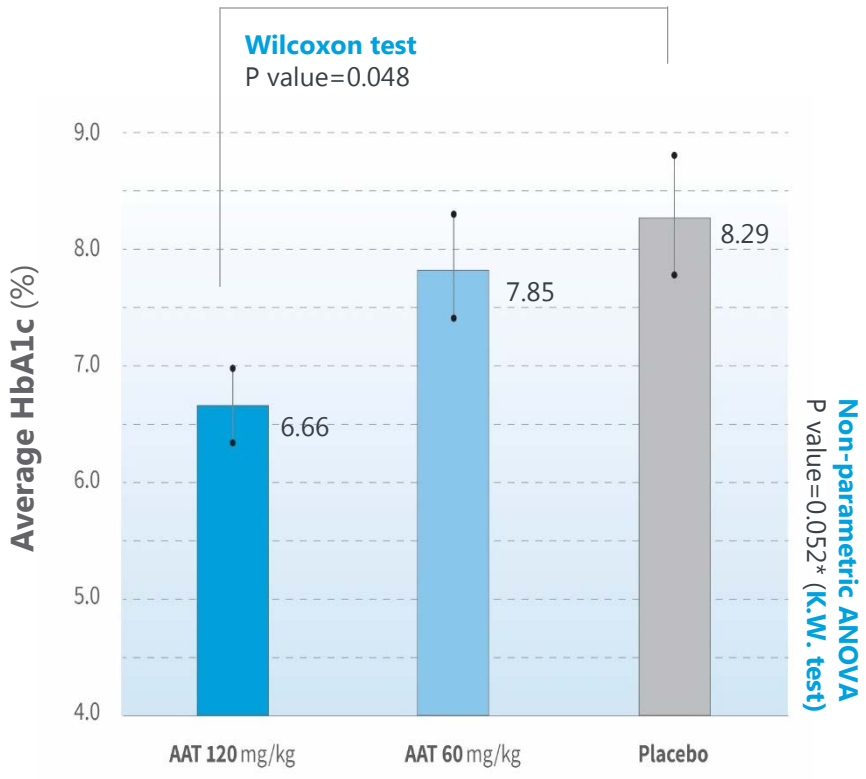
Insulin Requirement at 1 Year



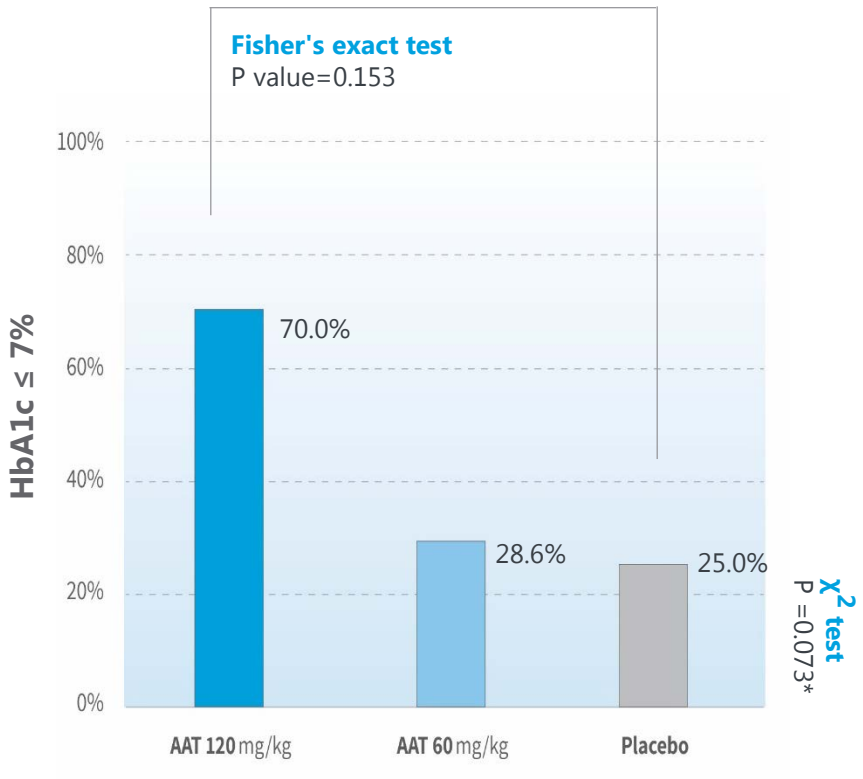
GLYCEMIC CONTROL RESULTS AT 1 YEAR

Subgroup Analysis, Ages 12-18

% HbA1c



Patients with HbA1c ≤ 7%



AAT FOR T1D - NEXT STEPS

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

Distribution Product Segment

DISTRIBUTION SEGMENT

Exclusive distributor in Israel of leading biopharmaceutical companies

Medical Field	Product/Brand Name	Description
Immunology	Intratect & Gammaplex[1]	Gamma-globulins 5% IV
Hospital & Critical Care	Vialabex/Zenalb/Albiomin[1]	Human serum Albumin
	Heparin sodium injection	Heparin sodium 5000 IU/ml
Infectious Disease	Ixiaro	Japanese encephalitis vaccine
	Varitect [1]	Varicella zoster IgG
	Megalotect [1]	CMV IgG
Hematology and Hemophilia	Optivate [1]	Coagulation Factor VIII (human)
	Replenine [1]	Coagulation Factor IX (human)
Respiratory	Foster	Beclometasone+ Formoterol inhaled
	Bramitob	Tobramycin, inhaled
	Provocholine	Methacholine, inhaled
Liver	Zutectra [1]	Hepatitis B IgG S.C
	Hepatect [1]	Hepatitis B IgG I.V

Additional products are under registration with the Israeli MOA

1. Plasma-derived protein therapeutics

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 AATD: Scientific Advice in EU	✓ Q3/2018
Inhaled AAT for AATD: Continued FDA discussion targeting approved IND	Q3/2018
Initiating inhaled AAT for AATD phase III study	Post IND/CTA approval
Interim report for Phase II for lung transplant trial (1 year treatment)	2H/2018
Seeking collaboration to advance type-1 diabetes program	2018
Achieve $102-108 million in annual revenues, profitable, cash flow positive	2018

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 Shire plc. Estimated revenues: $177-$228 MM (2018-2020); followed by 20 years of royalties.*
	  • *KedRAB® for anti-rabies prophylaxis treatment. Commercialized in the U.S. through Kedrion Biopharma. Launched in Q1/2018.*

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: $102.8 MM (+33% YoY) • 2018 Revenue Guidance: $102-$108MM[1]; Profitable; Cash flow positive • Cash: $44.6 MM (June 30, 2018); No Debt • Strong balance sheet allows execution on pipeline and business development initiatives • Listed on TASE (2005) & Nasdaq (2013)

1. *The previously provided 2018 revenue guidance of $116-$120 million has been revised; As a result of a recently settled labor strike, part of 2018 planned product shipments are likely to be delayed and supplied in early 2019*

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, 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:

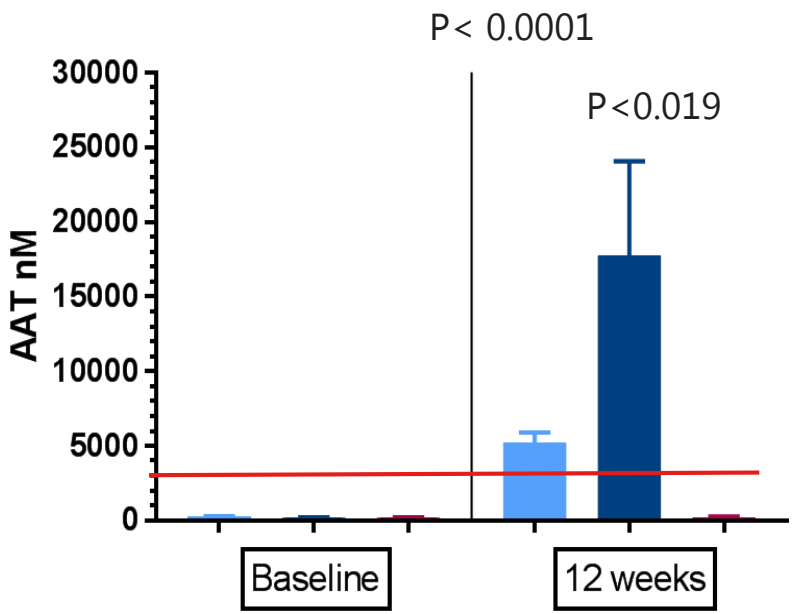
"The results of this study are extremely compelling. Based on the results of this study, it is clear that inhaled AAT is the most effective mode of treatment for reaching the primary sites of potential lung injury, and restoring AAT inhibitory capacity. I look forward to the start of a pivotal study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

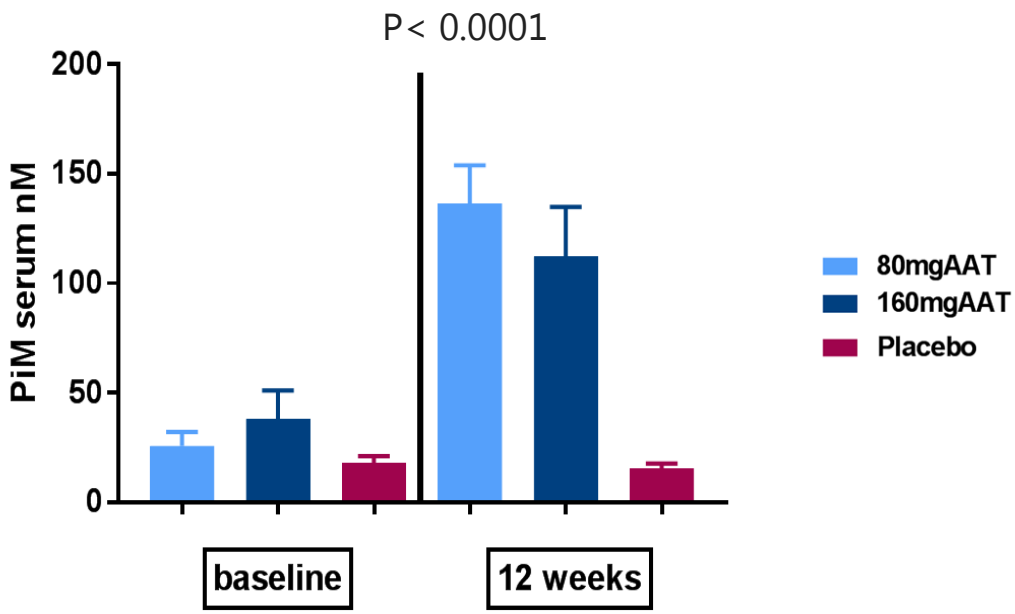
INHALED AAT PHASE II U.S.

ELF AAT Antigenic Level & Inhibitory Capacity Increased Significantly

ELF[1] AAT Antigenic Level



PiM serum level



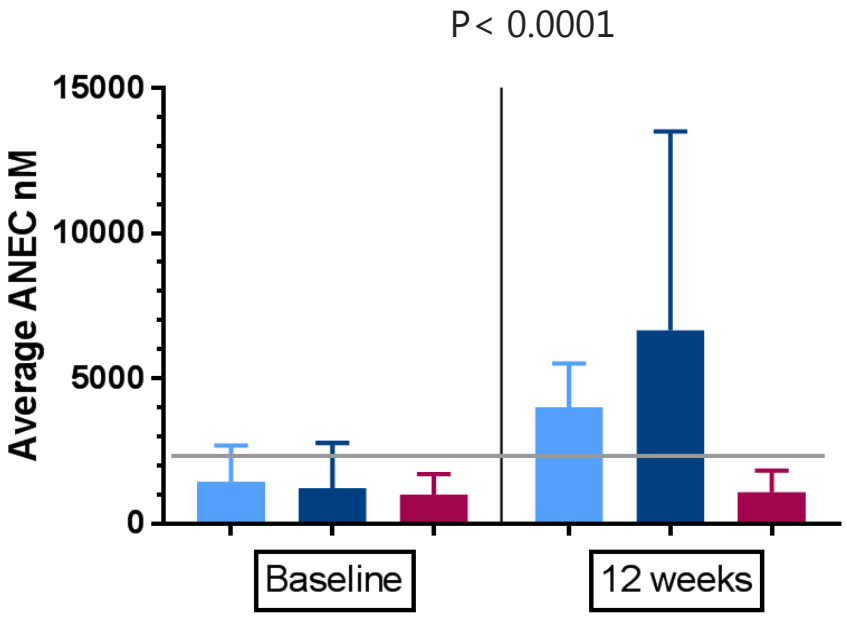
Higher AAT ELF level is reasonably likely to predict clinical benefit

1. *ELF = Epithelial Lining Fluid*

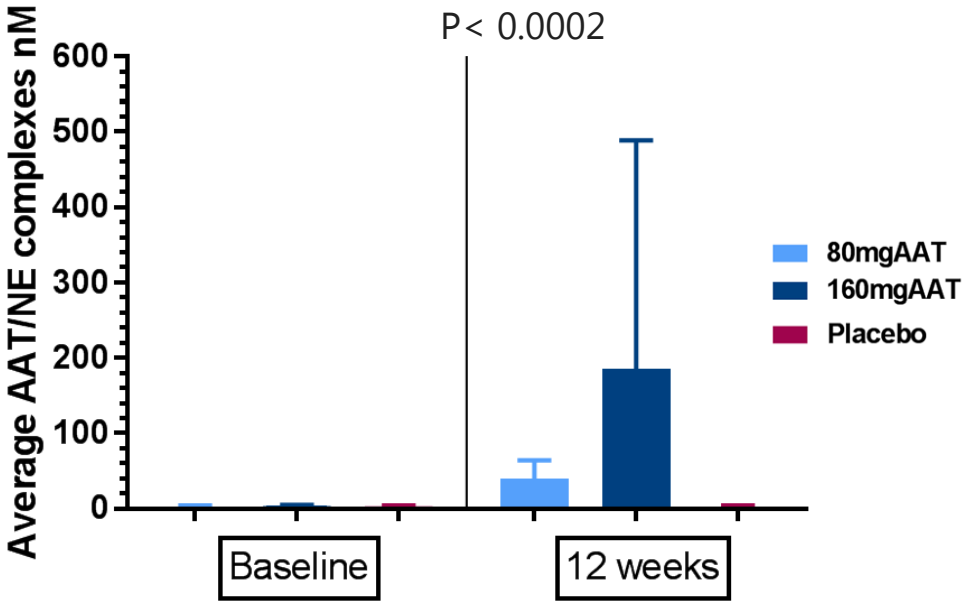
INHALED AAT PHASE II U.S.

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*

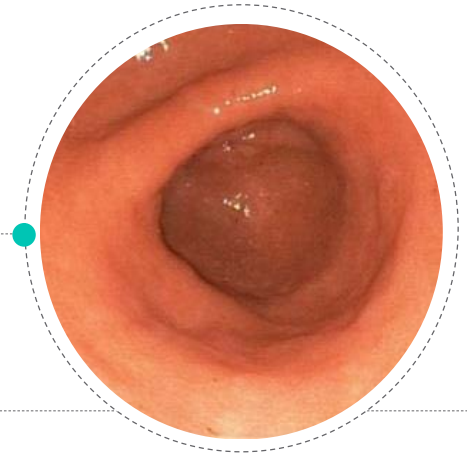
GVHD PROOF-OF-CONCEPT STUDY WITH AAT (IV)

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

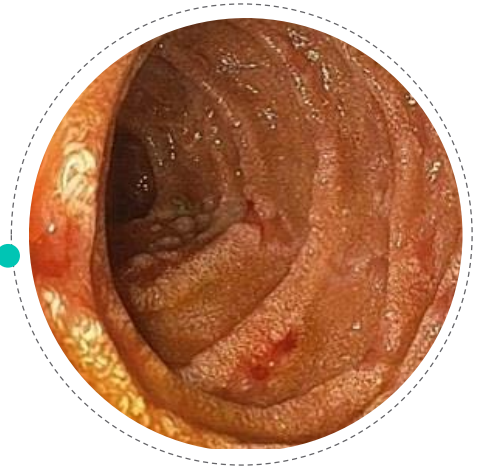
Phase I/II study:

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

"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.**"