This presentation includes forward-looking statements. All statements contained in this presentation other than statements of historical facts, including, but not limited to, statements concerning the outcome or success of DBV Technologies’ (“DBV,” “we,” “us” or “our”) clinical trials, our ability to successfully gain regulatory approvals and commercialize products, our ability to successfully advance our pipeline of product candidates, the rate and degree of market acceptance of our products and our ability to develop sales and marketing capabilities, are forward-looking statements. The words “anticipate,” “believe,” “estimate,” “expect,” “intend,” “may,” “plan,” “predict,” “project,” “target,” “potential,” “will,” “would,” “could,” “should,” “continue,” and similar expressions are intended to identify forward-looking statements, although not all forward looking statements contain these identifying words.

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Epicutaneous immunotherapy and Viaskin® Peanut are under clinical investigation and have not been approved for marketing by any health or regulatory authority.
• Advancing novel skin immunotherapies for patients with food allergies and other immunological diseases
  – Limited innovation in the field of food allergies has left millions of patients underserved today

• We are focused on discovering, developing and commercializing our novel skin immunotherapy product candidates using our proprietary Viaskin Technology Platform
  – Activation of the immune system with the Viaskin patch
  – No active passage of antigen into the bloodstream
  – Proprietary manufacturing equipment designed, engineered and developed by DBV
### Building a Promising Pipeline of Viaskin Product Candidates

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>INDICATION</th>
<th>DEVELOPMENT STAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Viaskin Peanut</td>
<td>Peanut Allergy</td>
<td>PRE-CLINICAL: Ages 1-3&lt;br&gt;PHASE I: Adolescents &amp; Adults&lt;br&gt;PHASE III: Ages 4-11* (Breakthrough Therapy and Fast Track Designation**)</td>
</tr>
<tr>
<td>Viaskin Milk</td>
<td>Cow’s Milk Protein Allergy</td>
<td>PRE-CLINICAL: Ages 2-17 (Fast Track Designation***)&lt;br&gt;PHASE III: Ages 4-17</td>
</tr>
<tr>
<td>Viaskin Egg</td>
<td>Hen’s Egg Allergy</td>
<td>PRE-CLINICAL: Adolescents &amp; Adults&lt;br&gt;PHASE III: Ages 4-17</td>
</tr>
<tr>
<td>Mechanistic Study</td>
<td>Eosinophilic Esophagitis</td>
<td>PRE-CLINICAL: Ages 4-17</td>
</tr>
<tr>
<td>5 Programs</td>
<td>Undisclosed</td>
<td>PRE-CLINICAL: Infants</td>
</tr>
<tr>
<td>Diagnostics with</td>
<td>Cow’s Milk Protein Allergy</td>
<td>PRE-CLINICAL: Infants</td>
</tr>
<tr>
<td>Nestlé Health</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Randomized portion of Phase III program has completed
**US FDA Breakthrough Therapy and Fast Track designation in children
*** US FDA Fast Track designation in pediatric patients two and older
EPIT: Unlocking the Immune Properties of the Skin with the Viaskin Patch

EPIT targets the immune system on intact skin

- Condensation chamber formed by Viaskin patch allows natural epidermal water loss to solubilize dry antigens
- Langerhans cells capture solubilized antigen in the epidermis
- Keratinocytes help distinguish pathogens from harmless agents, influencing Langerhans cells to generate an appropriate immune response
- Langerhans cells can process antigens and migrate to regional lymph nodes

Transmission of immunogenic information, with no allergen passage to the bloodstream
Merging Science & Technology for Differentiated Drug Development

**Electrospray**: patented patch manufacturing technology that allows for precise antigen deposits without adjuvants

**Patented electrostatic patch with condensation chamber** allows the antigen to penetrate upper layer of epidermis

Where We Are Today

Viaskin Peanut pivotal Phase III data published in JAMA in 1Q 2019
✓ Significant difference in responder rates between Viaskin Peanut and placebo (p<0.001) suggests that treated patients are less likely to have allergic reactions due to accidental exposures to peanut

Progress made to date for expected BLA submission for Viaskin Peanut in 3Q 2019
✓ Action plan in place to submit the BLA in 3Q
✓ Information and data generation processes well underway

Leadership team expanded and strengthened in 1Q 2019
✓ Julie O’Neill joined to direct all manufacturing operations, including expected BLA resubmission
✓ Dr. Hugh Sampson to oversee scientific and medical strategy globally as CSO and interim CMO
✓ Organizational structure in place to support evolution into a potential commercial-stage company

U.S. launch preparation ongoing, with current build-up of commercial team in Summit, NJ
✓ Accomplished pharma commercial leader Kevin Trapp joined as CCO in August 2018
✓ Search for a US-based CMO ongoing

€122.8 million in cash and cash equivalents as of December 31, 2018, expected to be sufficient to meet projected 2019 milestones, including BLA resubmission
Recent Leadership Expansion: Transitioning from Late-Stage Research to Potential Commercial-Stage

Daniel Tassé
Chief Executive Officer

- Joined in 4Q 2018
- 30-year track record of building, growing and leading global pharmaceutical businesses
- Deep development, regulatory and commercial experience

Dr. Hugh Sampson
CSO & Interim CMO

- Appointed CSO in 2015 and interim CMO in 1Q 2019
- Leading expert in food allergies and immunology with 35+ years of experience

Julie O’Neill
Global Manufacturing

- Engaged in 1Q 2019 to direct all manufacturing operations
- Over 30 years of experience, including multiple FDA approvals

Alan Kerr
Head of Regulatory Affairs

- Joined June 2016
- 1Q 2019 update: will report to Daniel Tassé, CEO
- 30 years of experience, including several drug approvals/launches
Food Allergies: A Major Global Unmet Medical Need

• Every 7 minutes a child goes to the emergency room for an allergic reaction to food\(^2\)

• Each year, approximately 150 deaths are due to allergic reactions; most deaths occur in patients who are aware of their allergy\(^3\)

• Food allergies can cause severe, potentially fatal, allergic reactions, including anaphylaxis

• Eosinophilic esophagitis (EoE), a progressive inflammatory disease, is often caused by ingesting foods, such as peanut, milk and egg\(^4\)

• 50% of peanut-allergic patients experience accidental allergen ingestion over a median span of 5.6 years\(^6\)

\(^1\) Peanut allergy is one of the most common food allergies in children

\(^2\) In the U.S., approximately 1 million children ages 1-11 have a diagnosed peanut allergy\(^1,5\)

\(^3\) According to a recent study, approximately 150 deaths are due to allergic reactions, with most occurring in patients who are aware of their allergy.

\(^4\) Eosinophilic esophagitis is a progressive inflammatory disease that is often caused by ingesting foods such as peanut, milk, and egg.

\(^5\) In the U.S., approximately 1 million children ages 1-11 have a diagnosed peanut allergy.

\(^6\) According to a recent study, 50% of peanut-allergic patients experience accidental allergen ingestion over a median span of 5.6 years.

Peanut Allergy: A Daily Burden for Patients and Families Worldwide

Avoidance is difficult: the annual incidence of accidental ingestion is between 15% and 40%.

Many factors contribute to severity, making reactions unpredictable.

In children with peanut allergy, more than half of reactions are severe.

- Caregivers are constantly trying to both prevent and prepare for exposure
- Prevention involves watching and controlling the child’s environment at all times
- Caregivers are always vigilant and ready to intervene

73% of caregivers are most concerned with accidental exposure to peanuts in their kids’ daily life.

67% of caregivers believe it is more difficult to be a parent of a child with a peanut allergy than without.

60% of caregivers say their stress level has increased because of their child’s peanut allergy.

Our Solution for a Hard-to-Treat Disease

- Contamination leading to peanut consumption is a serious threat\(^1\)
- Estimated detectable peanut residue ranges from 0.025-45mg of peanut protein\(^2\)
- Desensitization therapies could offer significant reduction of the risks associated with accidental exposures \(^1,3,4,5\)

Yet, even amounts of less than 1 peanut kernel can cause severe reactions

**Balancing risk-benefit drug profiles for these patients has been a difficult task for the field**

**Viaskin Peanut** utilizes the skin’s immune properties, which amplifies minimal allergen exposure

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Viaskin Peanut Leads Our Food Allergy Pipeline

• Patients treated with Viaskin Peanut 250 µg were only exposed to ~1 peanut via the skin after 3 years\(^1,2\)

• Favorable tolerability observed in clinical trials of Viaskin Peanut to date
  - No cases of severe anaphylaxis due to treatment reported
  - Drop-out rate due to AEs < 2% after 12 months (Phase I, Phase II and Phase III trials)
  - Over 95% compliance observed for up to three years of treatment
  - Most commonly reported AEs are mild to moderate application-site reactions

• Consistent treatment benefit observed in multiple clinical trials
  - Statistically significant higher rate of responders compared to placebo after 12 months of treatment in Phase II and Phase III trials
  - Increase in CRD to peanut protein versus baseline observed between Viaskin Peanut and placebo after the first year of treatment
  - Exploratory analyses showed that changes in peanut-specific biomarkers support the immunomodulatory effect with Viaskin Peanut
  - Viaskin Peanut 250 µg has demonstrated potential desensitization after 12, 24\(^1,2\) and 36\(^1,2\) months of treatment

PEPITES Pivotal Phase III Trial Results (Fleischer, JAMA 2019)

Pivotal Global Randomized DBPC Phase 3 Trial

- 356 children aged 4 to 11 years
- 31 study locations (United States, Canada, Australia, Germany, and Ireland)

Primary Endpoint

Treatment responder definition (assessed using DBPCFC)
- For patients with a M0 ED \( \leq 10 \text{ mg} \): responder if ED \( \geq 300 \text{ mg} \) at M12
- For patients with a M0 ED \( > 10 \text{ mg} \) and \( \leq 300 \text{ mg} \): responder if ED \( \geq 1000 \text{ mg} \) at M12

Food Challenge Symptom Scoring

- Food challenges were discontinued when objective signs/symptoms emerged meeting prespecified stopping criteria requiring treatment
- Subjective symptoms (e.g., abdominal pain or oropharyngeal itching) were assessed and recorded, but alone were insufficient to stop the challenge

*Subjects were randomized 2:1, stratified by ED, to receive either Viaskin Peanut 250 µg or placebo patch. DBPC= double-blind, placebo-controlled; DBPCFC=DBPC food challenge; ED=eliciting dose; M=month.
Trial Population Included Patients with Multiple Allergic Conditions (Fleischer, JAMA 2019)

- Patient population included a high percentage of subjects with additional allergic conditions

356 Patients Randomized, n (%)  
- Active (VP250 μg): 238 (67%)  
- Placebo: 118 (33%)

Peanut Eliciting Dose (mg)  
- Median: 100  
- Mean: 140

Age, years, median (Q1, Q3)  
- Active: 7 (6,9)  
- Placebo: 7 (5,9)

Gender, n (%)  
- Male: 218 (61.2%)  
- Female: 138 (38.8%)
Primary Efficacy Outcome Showed Statistically Significant Treatment Effect (Fleischer, JAMA 2019)

- After 12 months, a significantly larger percentage of participants responded to Viaskin Peanut treatment vs placebo patch 35.3% vs 13.6% ($P<0.001$)

- The prespecified 15% lower bound of the 95% CI of the difference between treatment groups was not met (95% CI: 12.4, 29.8)
  - The authors of the publication concluded that the clinical relevance of this is not known

Confidence interval; ITT=intention-to-treat.
A difference in CRD was observed between the active and placebo groups (*P*<0.001*)

The median CRD in participants in the Viaskin® Peanut 250 µg group increased from 144 mg at baseline to 444 mg at Month 12

*Nominal P value.

CRD After 12 Months

<table>
<thead>
<tr>
<th></th>
<th>Mean (95% CI) (mg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placebo n=118</td>
<td>144 (905.7)</td>
</tr>
<tr>
<td>VP250µg n=238</td>
<td>212.5 (905.7)</td>
</tr>
<tr>
<td>Placebo n=118</td>
<td>144 (361)</td>
</tr>
<tr>
<td>VP250µg n=238</td>
<td>211.7 (444)</td>
</tr>
</tbody>
</table>

CI=confidence interval; VP=Viaskin Peanut.
Levels of IgE increased initially then returned to baseline

- Treatment groups were distinguishable based on levels of peanut-specific IgG4 as early as month 3
  - Levels of IgG4 steadily increased in Viaskin Peanut subjects and were greater than placebo at all time points

Changes in Biomarkers Support Immunomodulatory Effect of Viaskin Peanut (Fleischer, JAMA 2019)

• In a post-hoc analysis, 53.1% of subjects on Viaskin Peanut 250 µg increased their baseline ED from ≤100 mg to ≥300 mg, vs only 19% on placebo patch\(^1\)
  – Based on risk assessment modeling, raising ED from ≤100 mg to ≥300 mg is predicted to reduce the risk of reactions due to accidental exposure by >95%\(^2\)*

• An increase in ED was 4 times more likely to occur in the Viaskin Peanut group compared to placebo (OR=4.3)\(^3\)

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*Based on quantitative risk assessment modeling using national database of consumption data and levels of peanut protein contamination for selected pre-packaged foods.\(^2\)
*Based on ITT population; missing data calculated using mBOCF.\(^3\)

High Adherence and Low Discontinuation Due to TEAEs (Fleischer, JAMA 2019)

- 89.9% of all subjects completed the study, with similar discontinuation rates observed between treatment groups (10.5% in Viaskin® Peanut group, 9.3% in placebo group)
- Treatment adherence* was high (98.5%) across the total population, and comparable between groups
- 4/238 (1.7%) subjects treated with Viaskin Peanut discontinued due to TEAEs
  - 2 due to moderate anaphylaxis; 2 due to skin reactions ≤ grade 3

<table>
<thead>
<tr>
<th></th>
<th>Viaskin Peanut n (%)</th>
<th>Placebo n (%)</th>
<th>Total n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrolled</td>
<td>238</td>
<td>118</td>
<td>356</td>
</tr>
<tr>
<td>Completed</td>
<td>213 (89.5%)</td>
<td>107 (90.7%)</td>
<td>320 (89.9%)</td>
</tr>
<tr>
<td>Discontinued</td>
<td>25 (10.5%)†</td>
<td>11 (9.3%)</td>
<td>36 (10.1%)</td>
</tr>
<tr>
<td>Due to consent withdrawal</td>
<td>13 (5.5%)‡</td>
<td>6 (5.1%)</td>
<td>19 (5.3%)</td>
</tr>
<tr>
<td>Due to TEAE</td>
<td>4 (1.7%)</td>
<td>0 (0%)</td>
<td>4 (1.1%)</td>
</tr>
</tbody>
</table>

*Defined as the total number of patches applied in the treatment period divided by the number of days in that period.†
†Additional reasons for discontinuation from the Viaskin Peanut group included lost to follow-up (n=3), noncompliance (n=2), and other (n=3).‡
‡Includes one patient who experienced mild anaphylaxis but did not discontinue until 4 days after the event, due to parental consent withdrawal.†
TEAE=treatment-emergent adverse events.
Low Rates of Treatment-Related Serious AEs (Fleisher, JAMA 2019)

- Viaskin Peanut 250 µg: 12 SAEs* in 10 participants (4.2%); Placebo: 6 SAEs in 6 participants (5.1%)
  - 4 SAEs in 3 Viaskin Peanut participants considered related to treatment (1 probably related, 3 possibly related)
  - All were moderate anaphylaxis without evidence of cardiovascular, neurologic, or respiratory compromise
  - All resolved with standard treatment, including 1 dose of epinephrine per participant

*Serious AE defined according to the International Conference on Harmonization-Good Clinical Practice as any untoward medical occurrence that at any dose results in death; is life-threatening; requires hospitalization or prolongation of existing hospitalization; results in persistent or significant disability or incapacity; is a congenital anomaly or birth defect; is an important medical event that may not be immediately life-threatening or result in death or hospitalization but that may jeopardize the participant or require intervention to prevent one of the above outcomes.

AE=adverse event; SAE=serious adverse event.

Expanding to Toddlers: Part B of Phase III Study of VP in Ages 1-3 Initiated in October 2018

Positive DSMB from Part A:
No safety concerns identified

Part A: 51 patients randomized
Placebo (n = ~10)
100 µg (n = ~20)
250 µg (n = ~20)

Part B: ~350 additional patients
Highest safe dose (250 µg)
n = ~233
Placebo
n = ~117

100 µg dose
n = ~20

Selected dose = 250 µg dose

Study Population

Children ages 1-3 with peanut allergy
• > 0.7 kU/L peanut-specific IgE and ≥ 6 mm SPT* wheal
• Reactive dose at M0 ≤ 300 mg peanut protein

Efficacy Endpoints

Primary endpoint at M12¹
Treatment responders (%) in active group compared to placebo at DBPCFC:
• For patients with a M0 ED** ≤ 10mg: responder if ED ≥ 300 mg at M12
• For patients with a M0 ED > 10mg: responder if ED ≥ 1,000 mg at M12

Main secondary endpoints: CRD***, changes in peanut sIgE and sIgG4

1. The primary analysis evaluating the difference between Viaskin Peanut 250 µg and placebo is defined by reaching a lower bound of the two-sided 95% confidence interval (CI) of ≥15%
2. An interim analysis will be conducted by the DSMB after the first 50 patients have received 6 months of active treatment to assess the relative change in IgG4 levels in patients treated with Viaskin Peanut 250 µg compared to placebo (n=25).
Viaskin Milk: Milk Allergy (CMPA) Phase II Study
Identified Safe/Effective Dose for Children

**Pediatric Phase I/II USA & Canada**

- **Part A:** 18 patients
- **Part B:** 180 patients

**Phase I (Part A)**

- Cohort at 500µg dose
- Cohort at 300µg dose
- Cohort at 150µg dose

**Phase II (Part B)**

- FDA & DSMB
- Placebo
- 150 µg
- 300 µg
- 500 µg

**Open Label**

- 300 µg***

Food challenges optional following 12 and 24 months of receiving 300 µg

**Study Population**

- Children (2-11) and adolescents (12-17)
- Highly sensitive to milk (≥ 10 kU/L milk-specific IgE and ≥ 6 mm SPT* wheal)
- Reactive dose at baseline (M0) ≤300 mg cow’s milk protein (CMP) (~ ≤ 9.4 mL of cow’s milk)

**Efficacy Endpoints**

**Treatment responder definition at M12:**

- ≥ 10-fold increase in CRD** and at least 144 mg of CMP
- OR CRD ≥ 1,444 mg

**Key secondary endpoints:**

- Change from baseline in IgE, IgG4

* SPT: Skin Prick Test
** CRD: Cumulative Reactive Dose at Food Challenge
*** Protocol change implemented in August 2018 to switch all patients to 300 µg (from 500 µg) for treatment up to 24 months

Denotes a completed food challenge; Denotes a pending, optional food challenge
MILES Results: Support Viaskin Milk 300µg as the Potential First Treatment for CMPA in Children 2-11

Favorable safety, tolerability and compliance

• Overall discontinuation rate of 4.5%
  – 1.5% dropout due to AEs
• Most AEs related to application site (mild to moderate)
• No severe anaphylaxis
• No SAEs or epinephrine related to treatment
• Treatment adherence was high
  – Mean patient compliance > 95%

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Response Rate (ITT*)

<table>
<thead>
<tr>
<th>Group</th>
<th>% of Responders (90% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placebo</td>
<td>32.5%</td>
</tr>
<tr>
<td>150 µg</td>
<td>34.2%</td>
</tr>
<tr>
<td>300 µg</td>
<td>57.9%</td>
</tr>
<tr>
<td>500 µg</td>
<td>38.9%</td>
</tr>
</tbody>
</table>

* Missing data: failure imputation (considered as non-responders) in ITT population
P-values obtained using exact logistic regression
ITT, Intent-to-Treat
DBV Technologies: Pioneering a New Class of Immunotherapy

- CEO Daniel Tassé joined DBV in November 2018
- Submission of BLA for Viaskin Peanut in children ages 4-11 expected in 3Q 2019
- Phase III clinical program for Viaskin Peanut in children ages 4-11 completed (PEPITES & REALISE trials) in 2018
- Positive preliminary Phase I/II data in second food allergy candidate, Viaskin Milk
- Key commercial roles, including Kevin Trapp, Chief Commercial Officer, recruited and onboarded in Summit, New Jersey office
- Continuing to build a talented team with offices in US and France
- Year-end 2018 cash position of €122.8 million
Measuring Efficacy: Double-Blind Placebo-Controlled Food Challenge

- Standardized GMP challenge matrix
- Standardized semi-logarithmic increase of peanut protein doses (DBPCFC as per PRACTALL)
- Allergic symptoms are graded from a standardized published protocol
- Challenge stopped by clear objective symptoms

**DBPCFC: Efficacy Outcome Scoring with Standardized Challenge Matrix**

<table>
<thead>
<tr>
<th>CATEGORIES</th>
<th>OBJECTIVE SYMPTOMS</th>
<th>GRADE</th>
<th>SUBJECTIVE SYMPTOMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. SKIN</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>A. Erythematous rash: % area involved</td>
<td>0 1 2 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>B. Pruritus</td>
<td>0 1 2 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>C. Urticaria/Angioedema</td>
<td>0 1 2 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>D. Rash</td>
<td>0 1 2 3</td>
<td></td>
</tr>
<tr>
<td>II. UPPER RESPIRATORY</td>
<td>A. Sneezing/Itching</td>
<td>0 1 2 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>B. Nasal congestion</td>
<td>0 1 2 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>C. Rhinorrhea</td>
<td>0 1 2 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>D. Laryngeal</td>
<td>0 1 2 3</td>
<td></td>
</tr>
<tr>
<td>III LOWER RESPIRATORY</td>
<td>A. Wheezing</td>
<td>0 1 2 3</td>
<td></td>
</tr>
<tr>
<td>IV. GASTROINTESTINAL</td>
<td>A. Subjective Complaints</td>
<td>0 1 2 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>B. Objective Complaints</td>
<td>0 1 2 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diarrhea</td>
<td>0 1 2 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vomiting</td>
<td>0 1 2 3</td>
<td></td>
</tr>
<tr>
<td>V. CARDIOVASCULAR</td>
<td>Normal heart rate to bradycardia</td>
<td>0 1 2 3</td>
<td></td>
</tr>
</tbody>
</table>

* DBPCFC in PEPITES and VIPES at month 12, in OLFUS-VIPES DBPCFC included an additional 1,600mg step after the 1,000mg step at month 24 & 36
1. Cochrane et al, Allergy 2012
2. Double-Blind, Placebo-Controlled Food Challenge
3. Sampson et al, JACI 2012
Viaskin Platform
The Skin Has Important Immune Properties

- Immune functions of the skin include
  - Responding to trauma, toxins, and infectious agents
  - Maintaining self-tolerance, preventing allergy, and inhibiting autoimmunity

- Keratinocytes
  - Distinguish pathogens from harmless agents
  - Influence nearby Langerhans cells to generate an appropriate immune response

- Langerhans cells
  - Antigen-presenting cells that can process antigens and migrate to regional lymph nodes

Proprietary & Patented Manufacturing Capabilities Developed by DBV

• Modular components → technology versatility
  – Highly scalable
  – Broadly applicable platform

• Manufacturing capabilities
  – In-house development and engineering of electrospray machines
  – Development and engineering expertise at DBV

[ES GEN4.0 machine]
Core Innovation: Differentiated Electrospray Technology

- **Dose flexibility**
  - Biological API deposit between 20 and 500 µg/cm²

- **API stability**
  - Solid & soluble protein layer, no glue

- **Homogeneous repartition of API**
  - Uniform delivery into skin

- **Replicability**
  - High dosage control in each patch

- **Bioavailability**
  - High solubility from electrostatic forces instead of glue
Robust IP Portfolio: Core Technology, Broad MoAs & Specific Indications

- **Broad geographic applications**
  - USA, Europe, Australia, Canada

- **Long patent protection**
  - Initial core patents through 2022
  - Other key patents through 2029-35

- **Innovation-driven patent lifecycle management**