



Company Overview

April 2019

Copyright © 2019 Verrica Pharmaceuticals. All rights reserved.



DISCLAIMER

Certain information contained in this presentation and statements made orally during this presentation relates to or is based on studies, publications, surveys and other data obtained from third-party sources and Verrica's own internal estimates and research. While Verrica believes these third-party sources to be reliable as of the date of this presentation, it has not independently verified, and makes no representation as to the adequacy, fairness, accuracy or completeness of, any information obtained from third-party sources. While Verrica believes its internal research is reliable, such research has not been verified by any independent source.

This presentation contains forward-looking statements. Forward-looking statements are neither historical facts nor assurances of future performance. Instead, they are based on our current beliefs, expectations and assumptions regarding the future of our business, future plans and strategies, our clinical results and other future conditions. All statements other than statements of historical facts contained in this presentation, including statements regarding future results of operations and financial position, business strategy, current and prospective product candidates, planned clinical trials and preclinical activities, product approvals, degree of market acceptance of approved products, research and development costs, current and prospective collaborations, timing and likelihood of success, plans and objectives of management for future operations, and future results of anticipated product candidates, are forward-looking statements. The words "may," "will," "should," "expect," "plan," "anticipate," "could," "intend," "target," "project," "estimate," "believe," "predict," "potential" or "continue" or the negative of these terms or other similar expressions are intended to identify forward-looking statements, although not all forward-looking statements contain these identifying words.

The information in this presentation, including without limitation the forward-looking statements contained herein, represent our views as of the date of this presentation. Although we believe the expectations reflected in such forward-looking statements are reasonable, we can give no assurance that such expectations will prove to be correct. Accordingly, readers are cautioned not to place undue reliance on these forward-looking statements. Except as required by applicable law, we do not plan to publicly update or revise any forward-looking statements contained herein, whether as a result of any new information, future events, changed circumstances or otherwise. No representations or warranties (expressed or implied) are made about the accuracy of any such forward-looking statements. The forward-looking statements in this presentation involve risks and uncertainties that could cause actual results to differ materially from those reflected in such statements. Risks and uncertainties that may cause actual results to differ materially include uncertainties inherent in the drug development process and the regulatory approval process, our reliance on third parties over which we may not always have full control, and other risks and uncertainties that are described in our Annual Report on Form 10-K for the year ended December 31, 2018, filed with the U.S. Securities and Exchange Commission (SEC) on March 7, 2019, and our other filings made with the SEC. New risk factors and uncertainties may emerge from time to time, and it is not possible to predict all risk factors and uncertainties. There can be no assurance that the opportunity will meet your investment objectives, that you will receive a return of all or part of such investment. Investment results may vary significantly over any given time period. The appropriateness of a particular investment or strategy will depend on an investor's individual circumstances and objectives. We recommend that investors independently evaluate specific investments and strategies.

Developing
novel
dermatology
products



INVESTMENT HIGHLIGHTS

★ Two of the Largest Unmet Needs in Dermatology

- Prevalence of ~6 million in molluscum contagiosum⁽¹⁾ and ~22 million in common warts in the U.S.⁽²⁾
- No FDA approved drugs to treat molluscum or warts

★ Positive Topline Phase 3 Results in Molluscum Contagiosum

- Achieved statistical significance for primary endpoints in our Phase 3 CAMP-1 and CAMP-2 pivotal trials for VP-102
- P-value <0.0001 for primary endpoint in both pivotal trials

★ Favorable Tolerability

- No serious adverse events in VP-102 treated patients

★ Physician Acceptance

- 95% of pediatric dermatologists have used API⁽³⁾

★ Innovative Product Candidate

- Drug-device combination of a proprietary formulation and a novel single-use applicator

★ Barriers to Competition

- New chemical entity regulatory exclusivity upon approval
- IP pending on product candidate, including on novel formulation, applicator and methods of use
- Drug-device combination makes a 'true generic' unlikely

★ Proven Team





- Industry-leading, experienced management team with extensive product launch experience

(1) Prevalence in the US of 5.1% to 11.5% in children aged 0-16 years. (Fam Pract. 2014 Apr;31(2):130-6). US Census estimates ~69.4MM children aged 0 to 16 years in 2016.

(2) IMS National Disease and Therapeutic Index (NDTI) Rolling 5 Years Ending June 2016. Nguyen et al, Laser Treatment of Nongenital Verrucae A Systemic Review. JAMA Dermatology. 2016; 152(9): 1025-1033

(3) Based on a survey of 115 dermatologists the results of which have been extrapolated to pediatric dermatologists.

OUR PRODUCT PORTFOLIO

| | | PRECLINICAL | PHASE 1 | PHASE 2 | PHASE 3 | NEXT EXPECTED MILESTONE |
|--------|------------------------------------|---|---------|---------|---------|------------------------------------|
| VP-102 | Molluscum Contagiosum |  | | | | NDA submission in 2H 2019 |
| | Common Warts |  | | | | Topline Phase 2 results in 2Q 2019 |
| | Genital Warts |  | | | | Initiate Phase 2 trial in 1H 2019 |
| VP-103 | Plantar Warts⁽¹⁾ |  | | | | IND submission in 2H 2019 |

We retain exclusive, royalty-free rights to our product candidates across all indications globally

(1) Phase 2 ready assuming leverage of data from VP-102.

THE PROBLEM

Molluscum Contagiosum

Copyright © 2019 Verrica Pharmaceuticals. All rights reserved.



MOLLUSCUM BACKGROUND

OVERVIEW

Caused by a pox virus

Primarily infects children, with the highest incidence occurring in children <14 years old

Highly contagious

If untreated, lesions persist an average of 13 months, with some cases remaining unresolved for 2+ years

Often leads to anxiety and social challenges for the patients and parents and negatively impacts quality of life

ETIOLOGY AND CLINICAL PRESENTATION

Transmission

- Skin to skin contact
- Sharing of contaminated objects (e.g., clothing, towels, swimming pool toys)

Diagnosis & Symptoms

- Typically 10 to 30 lesions
- 100+ lesions can be observed
- Lesions may be the only sign of infection and are often painless
- Can be diagnosed with skin biopsy to differentiate from other lesions



Complications

- Skin irritation, inflammation, and re-infection
- Follicular or papillary conjunctivitis if lesions on eyelids
- Cellulitis

CURRENT TREATMENTS FOR MOLLUSCUM ARE NOT FDA APPROVED AND HAVE MANY LIMITATIONS

Broad use limited by unproven efficacy, scarring, lack of availability, safety concerns & pain

Significantly undertreated patient population



Copyright © 2019 Verrica Pharmaceuticals. All rights reserved.

| | DESCRIPTION | LIMITATIONS |
|-------------------------|---|---|
| Cryotherapy | Freezing the lesions with liquid nitrogen | <ul style="list-style-type: none"> • Pain and scarring • Unsuitable for use in children |
| Curettage | Using a curette or a surgical instrument with a scoop at the tip to scrape the lesions | <ul style="list-style-type: none"> • Pain and scarring • Unsuitable for use in children |
| Laser Surgery | Applying a laser to target and destroy the lesions | <ul style="list-style-type: none"> • Pain, cost and lack of availability • Unsuitable for use in children |
| Topical Products | Applying various acids (e.g. salicylic acid), creams or blistering solutions to destroy the lesions | <ul style="list-style-type: none"> • Unproven efficacy |
| Off-Label Drugs | Retinoids, antiviral medicines, or immune modulating therapies | <ul style="list-style-type: none"> • Limited efficacy • Side-effects |
| Natural Remedies | Applying natural oils (e.g. tea tree oil) with antimicrobial properties | <ul style="list-style-type: none"> • Unproven efficacy • Pain, irritation and allergic reactions |

THE SOLUTION

VP-102



VP-102 IS A PROPRIETARY DRUG-DEVICE COMBINATION OF CANTHARIDIN ADMINISTERED THROUGH OUR SINGLE-USE PRECISION APPLICATOR

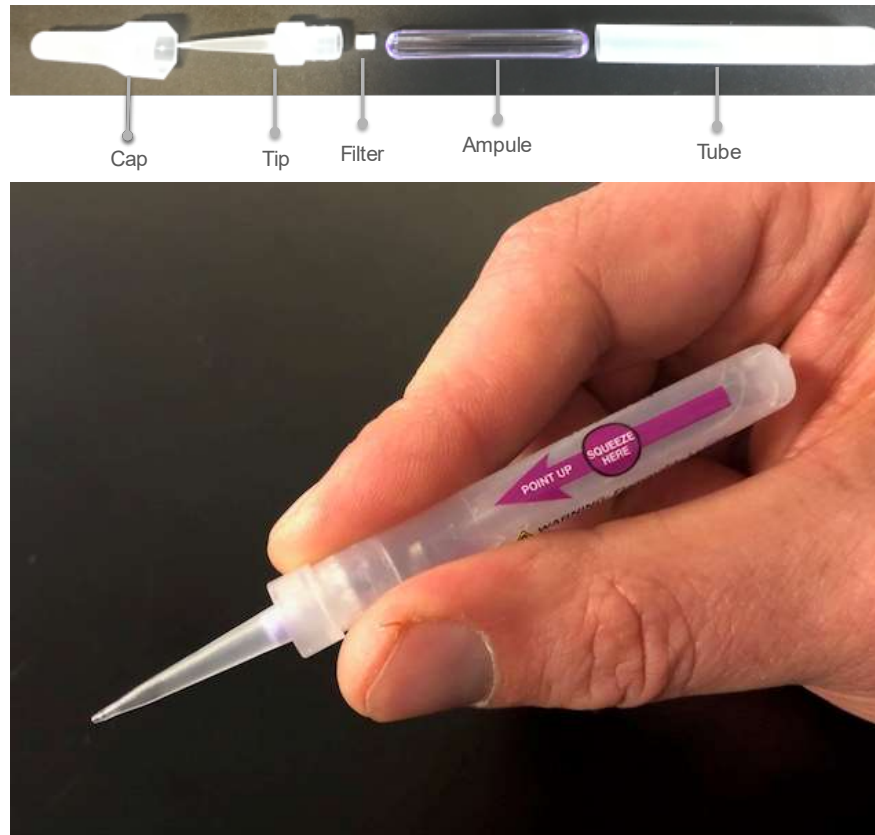
GMP-controlled formulation of cantharidin with:

- API that is greater than 99% pure
- Defined pharmaceutical batch process

Long-term, room temperature stability

Visualization agent to see which lesions have been treated

Bittering agent to mitigate oral ingestion by children



Mechanism of Action and Clinical Evidence

Copyright © 2019 Verrica Pharmaceuticals. All rights reserved.



CANTHARIDIN HAS A PROVEN DUAL MECHANISM OF ACTION

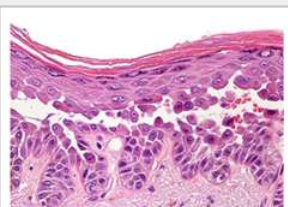
1

Targeted Destruction of Infected Skin Leads to Lesion Clearance

Once applied, cantharidin activates neutral serine proteases that cause degeneration of the desmosomal plaque, leading to detachment of tonofilaments from desmosomes.⁽¹⁾

This leads to intraepidermal blistering and nonspecific lysis of the skin, causing the tissues containing the virus to separate from the surrounding skin.

Since acantholysis is intraepidermal, healing occurs without scarring.



Desmosome Cleavage and Blister Formation

2

Elicits Inflammation & Immune Response with Potential to Boost Viral Immune Response

Leukocyte infiltration includes neutrophils, macrophages, B and T cells and eosinophils

Release of chemokines and cytokines including TNF- α , IL-8 and CXCL-5

Cantharidin is used in the laboratory as a model for studying leukocyte trafficking and cytokine production.⁽²⁾



(1) J Invest Dermatol. 1962 Jul;39:39-45.

(2) J Immunol Methods. 2001 Nov 1;257(1-2):213-20.2

SIGNIFICANT CLINICAL PROGRESS OF VP-102 FOR THE TREATMENT OF MOLLUSCUM

| | TRIAL AND STATUS | FORMULATION / APPLICATION METHOD | TRIAL DESIGN | TRIAL OBJECTIVES |
|---------|---|---|--|--|
| PHASE 3 | Pivotal Trial CAMP-1 Complete | VP-102 | <ul style="list-style-type: none"> N=266 Conducted under SPA Randomized, double blind, multi-center, placebo controlled | <ul style="list-style-type: none"> To evaluate the efficacy of dermal application of VP-102 relative to placebo for complete clearance at day 84 To assess the safety and tolerability of VP-102 |
| | Pivotal Trial CAMP-2 Complete | VP-102 | <ul style="list-style-type: none"> N=262 Randomized, double blind, multi-center, placebo controlled | <ul style="list-style-type: none"> To evaluate the efficacy of dermal application of VP-102 relative to placebo for complete clearance at day 84 To assess the safety and tolerability of VP-102 |
| PHASE 2 | Innovate Trial Complete | VP-102 | <ul style="list-style-type: none"> Open-label, single-center N=33 | <ul style="list-style-type: none"> To determine possible systemic exposure from a single 24-hour application of VP-102 To confirm safety and efficacy with applicator |
| | Pilot Trial Complete | Our proprietary formula of cantharidin used in VP-102, applied with the wooden stick part of a cotton-tipped swab | <ul style="list-style-type: none"> Open-label, single-center N=30 | <ul style="list-style-type: none"> To evaluate safety and efficacy and determine optimal treatment duration |

WE HAVE SUCCESSFULLY COMPLETED TWO PIVOTAL PHASE 3 TRIALS (CAMP-1 & CAMP-2) IN MOLLUSCUM



Trial Design

Two identically designed, randomized, double-blinded, multicenter, placebo controlled trials

CAMP-1 conducted under FDA Special Protocol Assessment (SPA)

12-week study period



Endpoints

Primary:

Percent of subjects with complete clearance of molluscum at Day 84

Secondary:

Percent of subjects with complete clearance at week 3, 6, and 9
Safety & tolerability



Population

Subjects 2+ years of age with MC lesions who have not received any type of treatment within the past 14 days
Enrollment complete with 266 subjects for CAMP-1 and 262 subjects for CAMP-2



Application

Study drug (VP-102 or placebo) is administered topically to all treatable lesions every 21 days until clearance or a maximum of 4 applications

VP-102 or placebo will be left on for 24 hours before removal with soap and warm water

DEMOGRAPHICS IN PHASE 3 MOLLUSCUM TRIALS

| | CAMP-1 | | CAMP-2 | |
|--------------------|-------------------|--------------------|-------------------|--------------------|
| | VP-102 (N=160) | Placebo (N=106) | VP-102 (N=150) | Placebo (N=112) |
| Randomized | 160 | 106 | 150 | 112 |
| Completed | 150 (94%) | 100 (94%) | 139 (93%) | 108 (96%) |
| Age (years) | | | | |
| Mean | 7.5 | 6.3 | 7.4 | 7.3 |
| Median | 6.0 | 5.0 | 6.0 | 6.0 |
| Min, Max | 2, 41 | 2, 40 | 2, 60 | 2, 54 |
| Gender | | | | |
| Female | 85 (53%) | 61 (58%) | 69 (46%) | 46 (41%) |
| Male | 75 (47%) | 45 (42%) | 81 (54%) | 66 (59%) |

MOLLUSCUM HISTORY FOR SUBJECTS IN PHASE 3 TRIALS

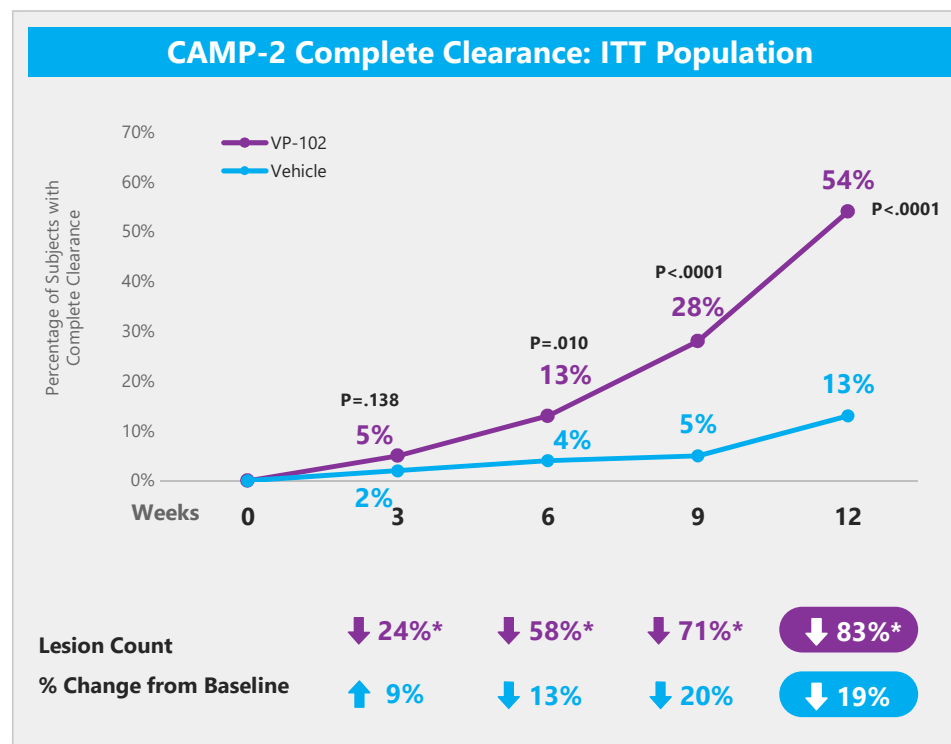
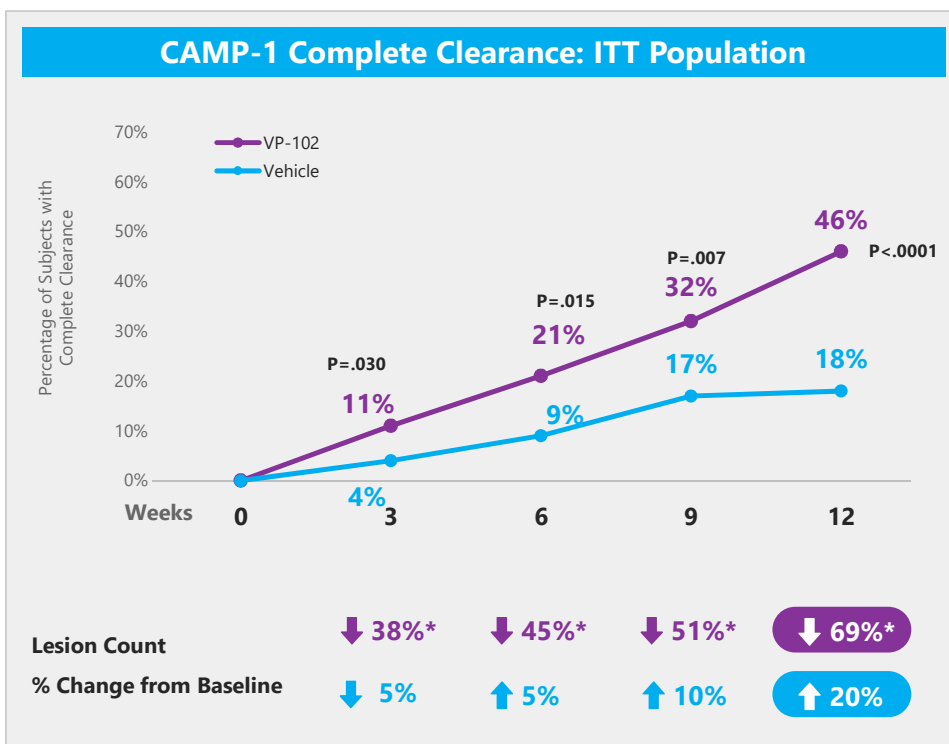
CAMP-1

| | VP-102 (N=160) | Placebo (N=106) |
|--|-------------------|--------------------|
| Time Since Clinical Diagnosis (days) | | |
| Mean | 127 | 129 |
| Median | 25 | 32 |
| Min, Max | 1, 1247 | 1, 1302 |
| Age at Diagnosis | | |
| Mean | 7.1 | 6.1 |
| Any Previous Treatment for Molluscum? | | |
| Yes | 41 (26%) | 30 (28%) |
| Active Atopic Dermatitis | | |
| Yes | 12 (8%) | 13 (12%) |
| Baseline Lesion Count | | |
| Mean | 22 | 25 |
| Min, Max | 1, 107 | 1, 110 |

CAMP-2

| | VP-102 (N=150) | Placebo (N=112) |
|--|-------------------|--------------------|
| Time Since Clinical Diagnosis (days) | | |
| Mean | 118 | 124 |
| Median | 28 | 31 |
| Min, Max | 1, 977 | 1, 957 |
| Age at Diagnosis | | |
| Mean | 7.1 | 7.0 |
| Any Previous Treatment for Molluscum? | | |
| Yes | 48 (32%) | 42 (38%) |
| Active Atopic Dermatitis | | |
| Yes | 11 (7%) | 7 (6%) |
| Baseline Lesion Count | | |
| Mean | 19 | 20 |
| Min, Max | 1, 184 | 1, 86 |

PHASE 3 STUDIES IN MOLLUSCUM DEMONSTRATE STATISTICALLY SIGNIFICANT EFFICACY ON PRIMARY ENDPOINT OF COMPLETE CLEARANCE



* Lesion count p<0.05 (pre-specified exploratory endpoint)

Note: Data reported reflects lesion count % change from baseline information for CAMP-1 resulting from continued analysis of complete data set for CAMP-1 and CAMP-2 post release of topline Phase 3 results on 3 Jan 2019.

Copyright © 2019 Verrica Pharmaceuticals. All rights reserved.

SAFETY SUMMARY FOR MOLLUSCUM PHASE 3 TRIALS

CAMP-1

| | VP-102 (N=161) n (%) | Placebo (N=104) n (%) |
|--|-----------------------------------|------------------------------------|
| Subjects with at least one... | | |
| TEAE (Treatment Emergent AE) | 159 (99) | 76 (73) |
| Mild TEAE | 157 (98) | 66 (64) |
| Moderate TEAE | 105 (65) | 41 (39) |
| Severe TEAE | 19 (12) | 1 (1) |
| TEAE related to drug | 158 (98) | 60 (58) |
| Serious TEAE | 0 (0) | 1 (1) |
| TEAE leading to discontinuation | 5 (3) | 0 (0) |
| Local Skin Reaction TEAE | 158 (98) | 60 (58) |

AE= Adverse Event

Note: Data reported reflects AE information for CAMP-1 resulting from continued analysis of complete data set for CAMP-1 and CAMP-2 post release of topline Phase 3 results on 3 Jan 2019.

Copyright © 2019 Verrica Pharmaceuticals. All rights reserved.

CAMP-2

| | VP-102 (N=150) n (%) | Placebo (N=112) n (%) |
|--|-----------------------------------|------------------------------------|
| Subjects with at least one... | | |
| TEAE (Treatment Emergent AE) | 143 (95) | 74 (66) |
| Mild TEAE | 141 (94) | 74 (66) |
| Moderate TEAE | 60 (40) | 18 (16) |
| Severe TEAE | 4 (3) | 0 (0) |
| TEAE related to drug | 143 (95) | 67 (60) |
| Serious TEAE | 0 (0) | 0 (0) |
| TEAE leading to discontinuation | 1 (1) | 1 (1) |
| Local Skin Reaction TEAE | 143 (95) | 67 (60) |

CAMP-1

ADVERSE EVENTS ⁽¹⁾

| PREFERRED TERM NAME | VP-102 (N=161) | | | Placebo (N=104) | | |
|--------------------------------|----------------|-----------|---------|-----------------|---------|---------|
| | n (%) | | | n (%) | | |
| | MILD | MOD | SEV | MILD | MOD | SEV |
| Application site vesicles | 79 (49.1) | 70 (43.5) | 8 (5.0) | 25 (24.0) | 4 (3.8) | 0 (0.0) |
| Application site pruritus | 85 (52.8) | 18 (11.2) | 1 (0.6) | 33 (31.7) | 5 (4.8) | 0 (0.0) |
| Application site pain | 58 (36.0) | 45 (28.0) | 7 (4.3) | 18 (17.3) | 2 (1.9) | 0 (0.0) |
| Application site erythema | 32 (19.9) | 37 (23.0) | 0 (0.0) | 21 (20.2) | 9 (8.7) | 0 (0.0) |
| Application site scab | 46 (28.6) | 16 (9.9) | 0 (0.0) | 24 (23.1) | 1 (1.0) | 0 (0.0) |
| Application site discoloration | 48 (29.8) | 5 (3.1) | 1 (0.6) | 16 (15.4) | 2 (1.9) | 0 (0.0) |
| Application site dryness | 23 (14.3) | 1 (0.6) | 0 (0.0) | 11 (10.6) | 0 (0.0) | 0 (0.0) |
| Application site edema | 15 (9.3) | 6 (3.7) | 0 (0.0) | 4 (3.8) | 2 (1.9) | 0 (0.0) |

(1) AEs occurring in >10% of subjects in any arm

Note: Data reported reflects AE information for CAMP-1 resulting from continued analysis of complete data set for CAMP-1 and CAMP-2 post release of topline Phase 3 results on 3 Jan 2019.

Copyright © 2019 Verrica Pharmaceuticals. All rights reserved.

CAMP-2 ADVERSE EVENTS ⁽¹⁾

| PREFERRED TERM NAME | VP-102 (N=150) | | | Placebo (N=112) | | |
|--------------------------------|----------------|-----------|---------|-----------------|---------|---------|
| | n (%) | | | n (%) | | |
| | MILD | MOD | SEV | MILD | MOD | SEV |
| Application site vesicles | 108 (72.0) | 30 (20.0) | 3 (2.0) | 34 (30.4) | 0 (0.0) | 0 (0.0) |
| Application site scab | 74 (49.3) | 11 (7.3) | 0 (0.0) | 20 (17.9) | 2 (1.8) | 0 (0.0) |
| Application site pruritus | 60 (40.0) | 5 (3.3) | 0 (0.0) | 29 (25.9) | 8 (7.1) | 0 (0.0) |
| Application site pain | 69 (46.0) | 14 (9.3) | 0 (0.0) | 16 (14.3) | 0 (0.0) | 0 (0.0) |
| Application site erythema | 41 (27.3) | 28 (18.7) | 1 (0.7) | 22 (19.6) | 6 (5.4) | 0 (0.0) |
| Application site dryness | 35 (23.3) | 4 (2.7) | 0 (0.0) | 19 (17.0) | 1 (0.9) | 0 (0.0) |
| Application site discoloration | 39 (26.0) | 7 (4.7) | 0 (0.0) | 9 (8.0) | 0 (0.0) | 0 (0.0) |

(1) AEs occurring in >10% of subjects in any arm

Our Opportunity in Common Warts

Copyright © 2019 Verrica Pharmaceuticals. All rights reserved.



VERRUCA VULGARIS (COMMON WARTS)

OVERVIEW

Caused by Human Papilloma virus (HPV)

Infects patients of all ages

Persistent infection, highly refractory

Typically 2-5 lesions

No FDA approved drug for the treatment of common warts

ETIOLOGY AND CLINICAL PRESENTATION

Transmission

- Skin to skin contact
- Sharing of infected articles of clothing

Diagnosis & Symptoms

- Dome shaped flesh-colored lesions commonly on the hands, fingers, knees or elbows
- Lesions may occur in groups or in a linear pattern
- Lesions can cause considerable pain and discomfort, may spread with skin trauma, and can be itchy



Complications

- Scarring may occur
- Dyspigmentation of affected areas
- Bacterial superinfection of lesions
- Irritation, pain, and redness of surrounding skin

PHASE 2 STUDY (COVE-1) IN COMMON WARTS IS ONGOING



Study Design

Open label, single center

Efficacy, safety & tolerability

Study has two cohorts



Endpoints

Primary

Percent of subjects with complete clearance of all treatable warts (baseline and new) at Day 84

Secondary

Percent of subjects achieving complete clearance of all treatable warts at Visits 2, 3, and 4



Patients

Cohort 1: 21 subjects 2+ years of age with common warts, who have not received any type of treatment within the past 14 days

Cohort 2: ~35 subjects 12+ years of age with common warts, who have not received any type of treatment within the past 14 days



Application

Study drug (VP-102) is administered topically to each treatable wart to a maximum of 4 applications or until complete clearance

Frequency of administration is at least 14 days (cohort 1) or 21 days (cohort 2)

VP-102 will be left on for 24 hours before removal with soap and warm water

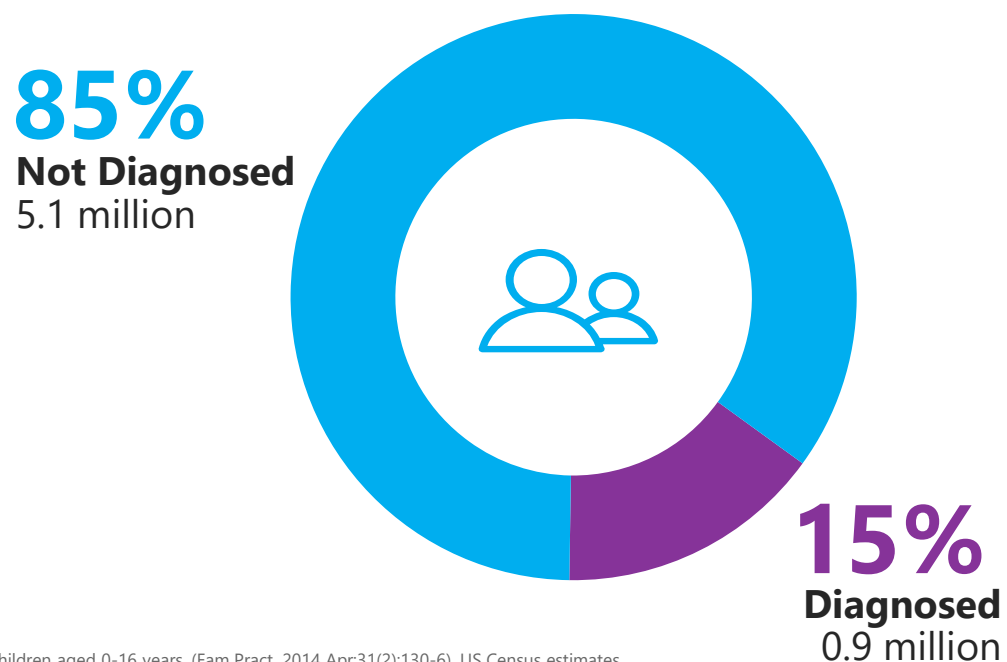
MC Commercial Opportunity

Copyright © 2019 Verrica Pharmaceuticals. All rights reserved.



REALIZING THE MOLLUSCUM OPPORTUNITY

US Prevalence of **~6 million in molluscum**⁽¹⁾ with **~1 million diagnosed annually**⁽²⁾

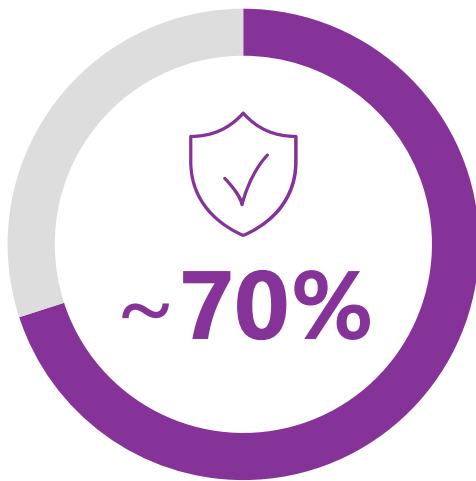


(1) Prevalence in the US of 5.1% to 11.5% in children aged 0-16 years. (Fam Pract. 2014 Apr;31(2):130-6). US Census estimates ~69.4MM children aged 0 to 16 years in 2016.

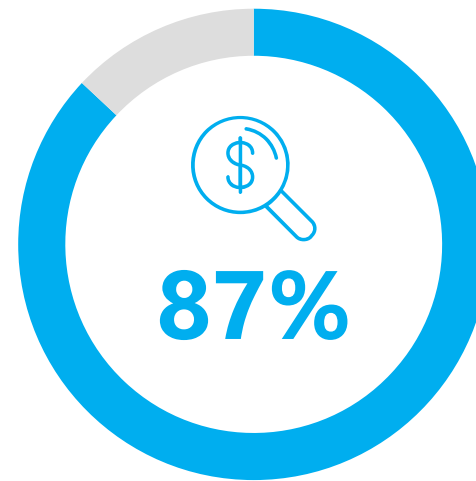
(2) IQVIA projected dataset for 12 months ending October 2017

Copyright © 2019 Verrica Pharmaceuticals. All rights reserved.

DERMATOLOGISTS ARE FAMILIAR WITH VP-102'S API & WOULD USE IF AVAILABLE



Physicians who do not use the API of VP-102 **stated inaccessibility as a primary reason why they are not using**⁽¹⁾



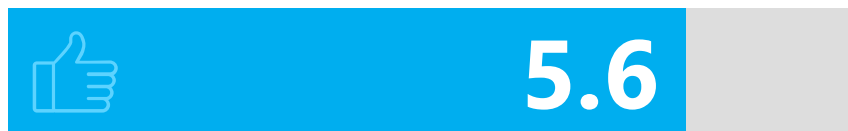
Physicians reported they **would use VP-102 if the cost of the drug was covered**⁽²⁾

(1) Pompei DT et al. Cantharidin Therapy: Practice patterns and attitudes of health care providers. Journal of the American Academy of Dermatology. 2013; 68(6). Survey of 400 healthcare providers, 87.7% of responders were US based dermatologists.

(2) Company survey of 40 physicians.

PHYSICIANS ARE HIGHLY FAVORABLE TO VP-102 PROFILE

Derms and Ped Derms ⁽¹⁾



KEY REASONS TO USE IF APPROVED

Efficacy

Precise and pain free application

FDA approval

Convenience of administration

Pediatricians ⁽¹⁾



KEY REASONS TO USE IF APPROVED

Efficacy

Fits into their current office model

Frustrated with not treating and having no viable options

Scale of 1 (unlikely to use at all) to 7 (highly likely to use)

(1) Physician Qualitative research- one-hour individual interviews [n=30 Pediatricians, 13 Dermatologist, 5 Pediatric Dermatologists]

INITIAL PAYER RESEARCH SUGGESTS FAVORABLE REIMBURSEMENT LANDSCAPE FOR VP-102

| | COHORT SIZE | AVERAGE LIVES COVERED |
|--------------------|-------------|-----------------------|
| Medical Directors | 7 | 9.8M |
| Pharmacy Directors | 6 | 4.2M |
| IDN Stakeholders | 2 | 6.5M |

Source: Third party study commissioned by the Company.

Copyright © 2019 Verrica Pharmaceuticals. All rights reserved.



The 15 Payer Organizations and
Plans Represented in the Interviews
**Cover a Total of 105 Million
Commercial & Medicaid Lives**

INITIAL PAYER RESEARCH SUGGESTS FAVORABLE REIMBURSEMENT LANDSCAPE FOR VP-102

Key Takeaways

- 1 Payers interviewed **recognize a significant unmet need** for molluscum contagiosum and lack of an effective treatment
- 2 Some of the **key concerns** mentioned about the undertreatment of the condition include the **risk of infection, scarring, or spread of the disease**
- 3 Payers **perceived VP-102 to be highly favorable** based on the majority of patients experiencing clearance within 12 weeks
- 4 Given the unmet need and favorable clinical outcomes in Phase 2 trials, **payers anticipate the majority of patients would have access to VP-102** with minimal to no restrictions



Source: Third party study commissioned by the Company.

Copyright © 2019 Verrica Pharmaceuticals. All rights reserved.

INTEGRATED COMMERCIAL APPROACH WITH MULTIPLE STRATEGIC LEVERS

Commercial Strategy



PRE-COMMERCIALIZATION ACTIVITIES ONGOING

ENGAGEMENT AT KEY CONFERENCES



WINTER CLINICAL
DERMATOLOGY

FALL CLINICAL
DERMATOLOGY
CONFERENCE®
Poster Presentation



American
Academy of
Pediatrics



National
and Regional
Meetings



National
and Regional
Meetings

South Beach
Symposium
clinical + aesthetic dermatology



DISEASE AWARENESS

Caregiver MC
education
through digital
and social tools

HCP MC education
through congresses,
speaker programs, and
professional journal space

OTHER

Trade distribution channel development

Customer segment insights

Brand strategy, customer segmentation, and targeting

Commercial systems infrastructure

VERRICA HAS SEVERAL POTENTIAL WAYS TO MAINTAIN EXCLUSIVITY



Regulatory Exclusivity

5.5 years of exclusivity for cantharidin as API potentially available upon approval (inclusive of potential for 6 months for pediatric indication)



Compounding Pharmacies

If VP-102 is approved, traditional compounding pharmacies will NOT be able to continue compounding cantharidin regularly or in inordinate amounts, except under patient specific circumstances as prescribed by a physician.

The FDA has the authority to regulate compounders. Improper compounding can result in monetary fines plus felony convictions in case of repeat offenses and intent to fraud/mislead.



Manufacturing

VP-102 has the potential to address stability issues with standard packaging and container/closure systems

Limited commercial CMOs with facilities for handling highly potent and highly flammable liquid products

Entered into a supply agreement for naturally-sourced cantharidin; subject to specified minimum annual purchase orders and forecasts, supplier agreed that it will not supply cantharidin, any beetles or other raw material from which cantharidin is derived to any other customer in North America



True Generic Unlikely

Unlikely to receive approval under an ANDA due to uniqueness from patent pending protection and significant differences likely between VP-102 and potential competitors

Cannot do traditional PK/bioequivalence study (no blood level profile for VP-102)

May require new clinical studies with new formulation and new delivery approach that shows equivalence without violating any of Verrica's IP

OVERVIEW OF INTELLECTUAL PROPERTY PORTFOLIO














KEY CLAIMS AND PATENT APPLICATIONS

VALUE TO VERRICA

| | | |
|----------|---|---|
| 1 | Our specific formulation (VP-102), key safety additions and novel cantharidin formulations (PCT/US2014/052184) Single use applicator containing cantharidin formulations (PCT/US2014/052184) | May prevent generics from copying our ether-free formulation or from making similar formulations May prevent generics from utilizing a single-use applicator for cantharidin that contains both a glass ampule to maintain product stability and a filter placed prior to dispensing tip, which helps increase administration accuracy and prevents direct contact with skin |
| 2 | Specific design of our commercial applicator (PCT/US2018/036353) | May prevent generics from utilizing a similar applicator |
| 3 | Methods of use for cantharidin in the treatment of molluscum (PCT/US2018/037808 and PCT/US2018/036353) | May prevent generics from a similar treatment regimen and label |
| 4 | Methods for purifying cantharidin and analyzing cantharidin or cantharidin solutions (PCT/US2016/14139) | May force generics to find alternative methodologies to produce GMP cantharidin or determine if their API or drug product is GMP compliant |
| 5 | Methods for complete cantharidin synthesis (PCT/US2015/066487) | Synthetic version would reduce risks of outside contaminants and environmental factors affecting the naturally-sourced API. May prevent generics competing with a synthetic version of cantharidin |

Any patents issued from our applications are projected to expire between 2034 and 2039, excluding any patent term adjustment and patent term extensions

SIGNIFICANT RECENT AND EXPECTED MILESTONES

| DATE | EVENT |
|--|--|
|  1Q 2018 | Received go ahead from FDA to initiate two Phase 3 trials, including SPA on pivotal trial |
|  1Q 2018 | Initiated Phase 3 trials for molluscum and Phase 2 trial for warts |
|  1Q 2018 | Executed purchase order for API that is expected to last through commercial launch |
|  1Q 2018 | Hired COO, CFO, CCO and CMO with significant commercial experience and track record of success |
|  2Q 2018 | Added dermatology veteran Mark Prygocki and KOL Dr. Gary Goldenberg to the Board of Directors |
|  3Q 2018 | Entered into a supply agreement for naturally-sourced cantharidin |
|  3Q 2018 | Completed enrollment in two pivotal Phase 3 trials in molluscum |
|  1Q 2019 | Positive topline results from two pivotal Phase 3 trials in molluscum |
|  1H 2019 | Initiate Phase 2 trial in genital warts |
|  2Q 2019 | Topline results from Phase 2 trial in common warts |
|  2H 2019 | VP-102 NDA submission in molluscum |
|  2H 2019 | VP-103 IND submission in plantar warts |
|  2H 2019 | Initiate pivotal trials in common warts |

INVESTMENT HIGHLIGHTS

★ Two of the Largest Unmet Needs in Dermatology

- Prevalence of ~6 million in molluscum contagiosum⁽¹⁾ and ~22 million in common warts in the U.S.⁽²⁾
- No FDA approved drugs to treat molluscum or warts

★ Positive Topline Phase 3 Results in Molluscum Contagiosum

- Achieved statistical significance for primary endpoints in our Phase 3 CAMP-1 and CAMP-2 pivotal trials for VP-102
- P-value <0.0001 for primary endpoint in both pivotal trials

★ Favorable Tolerability

- No serious adverse events in VP-102 treated patients

★ Physician Acceptance

- 95% of pediatric dermatologists have used API⁽³⁾

★ Innovative Product Candidate

- Drug-device combination of a proprietary formulation and a novel single-use applicator

★ Barriers to Competition

- New chemical entity regulatory exclusivity upon approval
- IP pending on product candidate, including on novel formulation, applicator and methods of use
- Drug-device combination makes a 'true generic' unlikely

★ Proven Team

- Industry-leading, experienced management team with extensive product launch experience

(1) Prevalence in the US of 5.1% to 11.5% in children aged 0-16 years. (Fam Pract. 2014 Apr;31(2):130-6). US Census estimates ~69.4MM children aged 0 to 16 years in 2016.

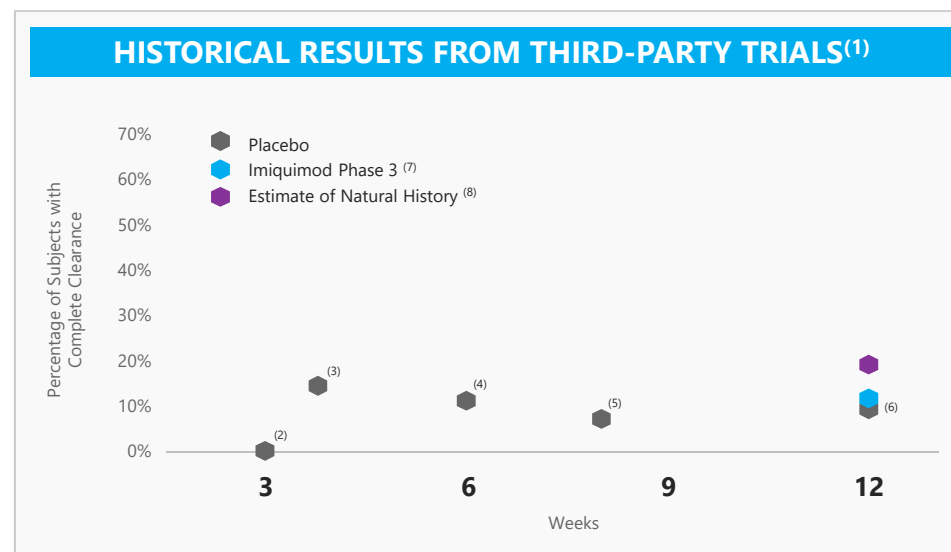
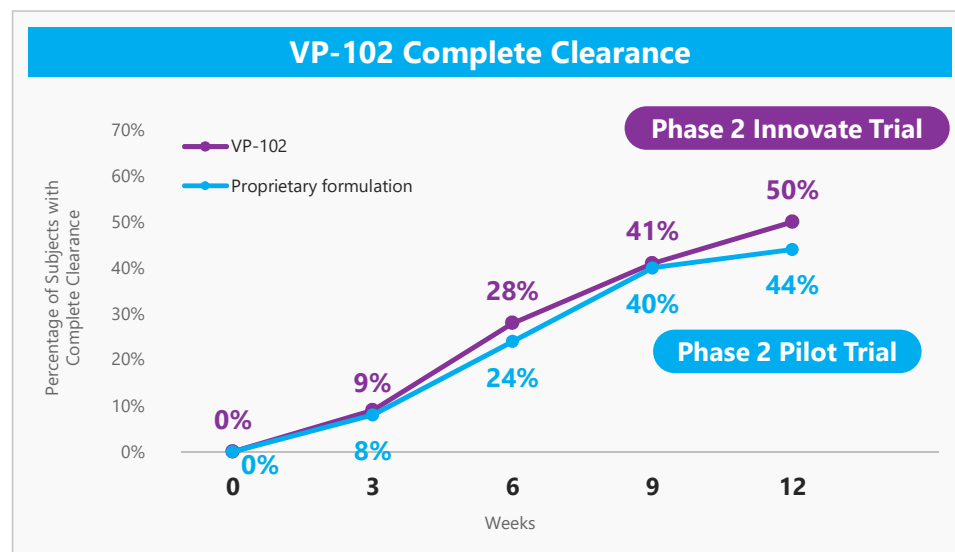
(2) IMS National Disease and Therapeutic Index (NDTI) Rolling 5 Years Ending June 2016. Nguyen et al, Laser Treatment of Nongenital Verrucae A Systemic Review. JAMA Dermatology. 2016; 152(9): 1025-1033

(3) Based on a survey of 115 dermatologists the results of which have been extrapolated to pediatric dermatologists.

Appendix

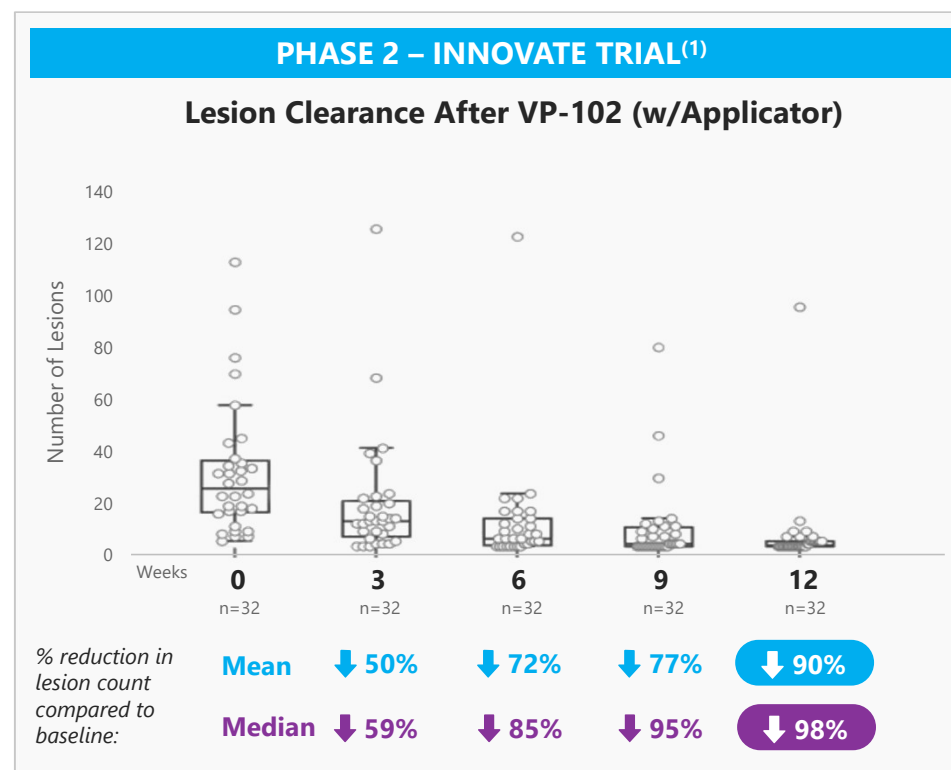
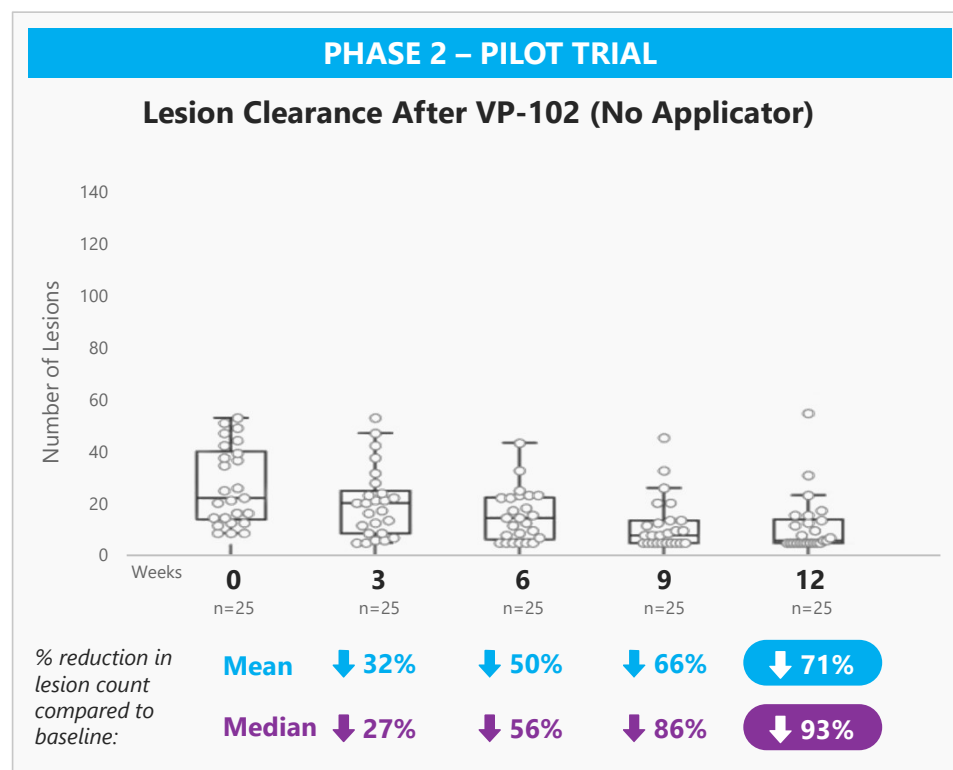


PHASE 2 TRIAL DATA DEMONSTRATES A FAVORABLE PROFILE FOR VP-102 IN MOLLUSCUM CLEARANCE



- (1) Historical placebo data from third-party trials with cantharidin; No head-to-head trials have been run against VP-102.
- (2) Burke BE, Baillie J, Olson RD. Essential oil of Australian lemon myrtle (*Backhousia citriodora*) in the treatment of molluscum contagiosum in children. *Biomedicine & Pharmacotherapy* 2004; 58: 245-247.
- (3) Syed TA, Lundin S, Ahmad M. Topical 0.3% and 0.5% podophyllotoxin cream for self-treatment of molluscum contagiosum in males. *Dermatology* 1994; 189:65-68.
- (4) Garelik J, Schairer D, Hwang H, Viola K, Cohen S. Safety and efficacy of topical cantharidin for the treatment of pediatric molluscum contagiosum: a prospective, randomized, double-blind, placebo-controlled trial. Unpublished.
- (5) Dosal C, Stewart PW, Lin JA, Williams CS, Morrell DS. Cantharidin for the treatment of molluscum contagiosum: a prospective, double-blinded, placebo-controlled trial. *Pediatric Dermatology* 2014;31(4):440-449.
- (6) Theos AU, Cummins R, Silverberg NB, Paller AS. Effectiveness of imiquimod cream 5% for treating childhood molluscum contagiosum: in a double-blind, randomized pilot trial. *Cutis* 2004 Aug;74(2):134-8, 141-2.
- (7) FDA Clinical Executive Summary for Imiquimod for Pediatric Molluscum. NDA Submission Number 20723. Submission Code SE8-020. Letter Date September 21, 2006.
- (8) Olsen JR, Gallacher J, Finlay AY, Piquet V, Francis NA. Time to resolution and effect on quality of life of molluscum contagiosum in children in the UK: a prospective community cohort study. *Lancet Infect Dis* 2015;15(2):190-195.
- Natural history point estimates for the percent resolution at Weeks 12 and 18 were derived using the steepest slope of the % resolution versus time (months) curve corresponding to a linear portion between months 8 to 17. This portion of the curve shows the highest rate of resolution and demonstrates 50% of patients resolved the infection over 9 months. This supports point estimates of 17% at 12 weeks and 25% at 18 weeks.

PHASE 2 TRIAL DATA DEMONSTRATES A FAVORABLE PROFILE FOR VP-102 IN MOLLUSCUM CLEARANCE



(1) Trial enrolled 33 subjects into either the exposure group (N=17) or the standard group (N=16) with 32 subjects completing the trial. Exposure group subjects were required to have 21 or more lesions at the baseline visit and standard group subjects had 1 to 20 lesions.

HISTORICAL COMPOUNDED CANTHARIDIN PRESENTS A NUMBER OF LIMITATIONS

1 Varying concentration

- Evaporation of volatile solvents leads to concentration increases
- Patients can receive more drug than clinically necessary resulting in excessive blistering

2 Inconsistent purity and lack of controlled product manufacturing

- Risk of impurities present such as residual solvents and pesticides

3 Lack of reimbursement

- Not FDA approved and therefore not eligible for drug reimbursement

4 Inconvenient and variable administration

- Application with the wooden stick part of a cotton-tipped swab can lead to patients receiving more drug than necessary
- Inability for physicians to identify where the drug has been applied

5 Limited availability

- Illegal to import formulated cantharidin
- Generally not available in hospitals and academic settings, which require FDA approved product
- Only an estimated 10% of 503B compounders produce formulations containing cantharidin⁽¹⁾



(1) Based on 57 503B facilities and 6 compounders of cantharidin per FDA database (July – December 2018).

MANAGEMENT TEAM WITH EXTENSIVE PRODUCT LAUNCH AND DERMATOLOGY EXPERIENCE



Ted White

President & Chief
Executive Officer



Chris Degnan

Chief Financial
Officer



Patrick Burnett

MD, PhD
Chief Medical Officer



Joe Bonaccorso

Chief Commercial
Officer



Selected Launched Products



BOARD OF DIRECTORS



Paul Manning
Chairman



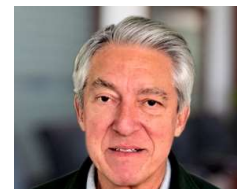
Ted White
President & Chief Executive Officer



Mark Prygocki
Director



Gary Goldenberg, MD
Director



Glenn Oclassen
Director



Sean Stalfort
Director



HIGHLY ACCLAIMED SCIENTIFIC ADVISORY BOARD



Mark Lebwohl, MD*

Waldman Chair of Dermatology, Icahn School of Medicine at Mount Sinai

Former President of the American Academy of Dermatology



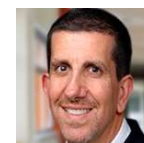
Steven Cohen, MD

Chief of Dermatology at the Albert Einstein School of Medicine



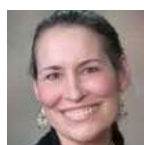
Elaine Siegfried, MD

Professor of Dermatology and Pediatrics at the St. Louis University School of Medicine



Anthony Mancini, MD

Head of the Division of Dermatology at Feinberg School of Medicine at Northwestern University



Janice Pelletier, MD

Professor at the University of Vermont College of Medicine



Dean Morrell, MD

Director of the residency training program and professor at UNC



Matt Davidson, PhD

Founder
Former Chief Scientific Officer of Verrica



(1)(*)We intend to engage Dr. Lebwohl as principal investigator for future clinical trial(s) in our common warts program.

Copyright © 2019 Verrica Pharmaceuticals. All rights reserved.