UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 8-K

CURRENT REPORT
Pursuant to Section 13 or 15(d) of
the Securities Exchange Act of 1934

Date of report (Date of earliest event reported): **October 22, 2020**

ORAMED PHARMACEUTICALS INC.
(Exact name of registrant as specified in its charter)

DELAWARE	**001-35813**	**98-0376008**
(State or Other Jurisdiction of Incorporation)	(Commission File Number)	(IRS Employer Identification No.)

1185 Avenue of the Americas, Third Floor, New York, New York	**10036**
(Address of Principal Executive Offices)	(Zip Code)

844-967-2633
(Registrant's telephone number, including area code)

Check the appropriate box below if the Form 8-K filing is intended to simultaneously satisfy the filing obligation of the registrant under any of the following provisions:

☐ Written communications pursuant to Rule 425 under the Securities Act (17 CFR 230.425)

☐ Soliciting material pursuant to Rule 14a-12 under the Exchange Act (17 CFR 240.14a-12)

☐ Pre-commencement communications pursuant to Rule 14d-2(b) under the Exchange Act (17 CFR 240.14d-2(b))

☐ Pre-commencement communications pursuant to Rule 13e-4(c) under the Exchange Act (17 CFR 240.13e-4(c))

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	**Trading symbol**	**Name of each exchange on which registered**
Common Stock, par value $0.012	ORMP	The Nasdaq Capital Market, Tel Aviv Stock Exchange

Indicate by check mark whether the registrant is an emerging growth company as defined in Rule 405 of the Securities Act of 1933 (§230.405 of this chapter) or Rule 12b-2 of the Securities Exchange Act of 1934 (§240.12b-2 of this chapter).

Emerging growth company ☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Item 7.01. Regulation FD Disclosure.

On October 22, 2020, Oramed Pharmaceuticals Inc. posted to its website an investor presentation, a copy of which is attached hereto as Exhibit 99.1.

Item 9.01. Financial Statements and Exhibits.

(d) Exhibits.

99.1	Investor Presentation dated October 22, 2020. (Furnished herewith.)

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned hereunto duly authorized.

ORAMED PHARMACEUTICALS INC.

By: /s/ Nadav Kidron
Name: Nadav Kidron
Title: President and CEO

October 22, 2020

Addressing the Multibillion-Dollar Injectable Drug Markets with Oral Formulations

October 2020

Safe Harbor

Certain statements contained in this material are forward-looking statements. These forward-looking statements are based on the current expectations of the management of Oramed only, including with respect to clinical trials, milestones and the potential benefits of Oramed's products, and are subject to a number of factors and uncertainties that could cause actual results to differ materially from those described in the forward-looking statements, including the risks and uncertainties related to the progress, timing, cost, and results of clinical trials and product development programs; difficulties or delays in obtaining regulatory approval or patent protection for our product candidates; competition from other pharmaceutical or biotechnology companies; and our ability to obtain additional funding required to conduct our research, development and commercialization activities, and others, all of which could cause the actual results or performance of Oramed to differ materially from those contemplated in such forward-looking statements. Except as otherwise required by law, Oramed undertakes no obligation to publicly release any revisions to these forward-looking statements to reflect events or circumstances after the date hereof or to reflect the occurrence of unanticipated events. For a more detailed description of the risks and uncertainties affecting Oramed, reference is made to Oramed's reports filed from time to time with the Securities and Exchange Commission, which involve known and unknown risks, uncertainties and other factors which may cause the actual results, performance or achievements of the company, or industry results, to be materially different from any future results, performance or achievements expressed or implied by such forward-looking statements. Please refer to the company's filings with the Securities and Exchange Commission for a comprehensive list of risk factors that could cause actual results, performance or achievements of the company to differ materially from those expressed or implied in such forward-looking statements. Oramed undertakes no obligation to update or revise any forward-looking statements.

Oramed Snapshot

- **Proprietary oral protein delivery platform**
- **Diabetes first** - initially targeting the lucrative insulin market
- **Robust pipeline** leveraging IP portfolio for additional significant market opportunities
- **Strong financial position** over $45.6M in cash and investments, no debt[1]
- **Experienced management** team backed by world-class scientific experts
- **Multiple value-creation events** for 2020
- **NASDAQ/TASE:** ORMP

[1] As of May 31, 2020

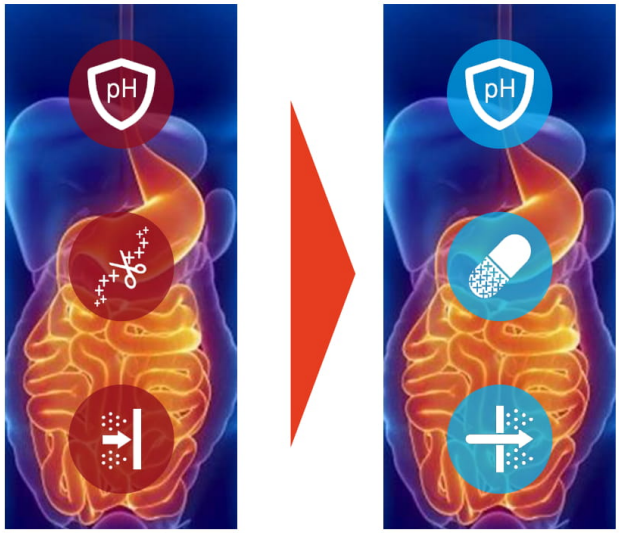
Proprietary Technology for Oral Drug Delivery

Proteins and Peptides do Not Survive the Digestive System

Harsh pH
Stomach acidity cleaves and shreds protein

Protease attack
Proteases attack and break down proteins

Absorption barrier
Therapeutic proteins fail to be absorbed via the intestinal wall (barrier)



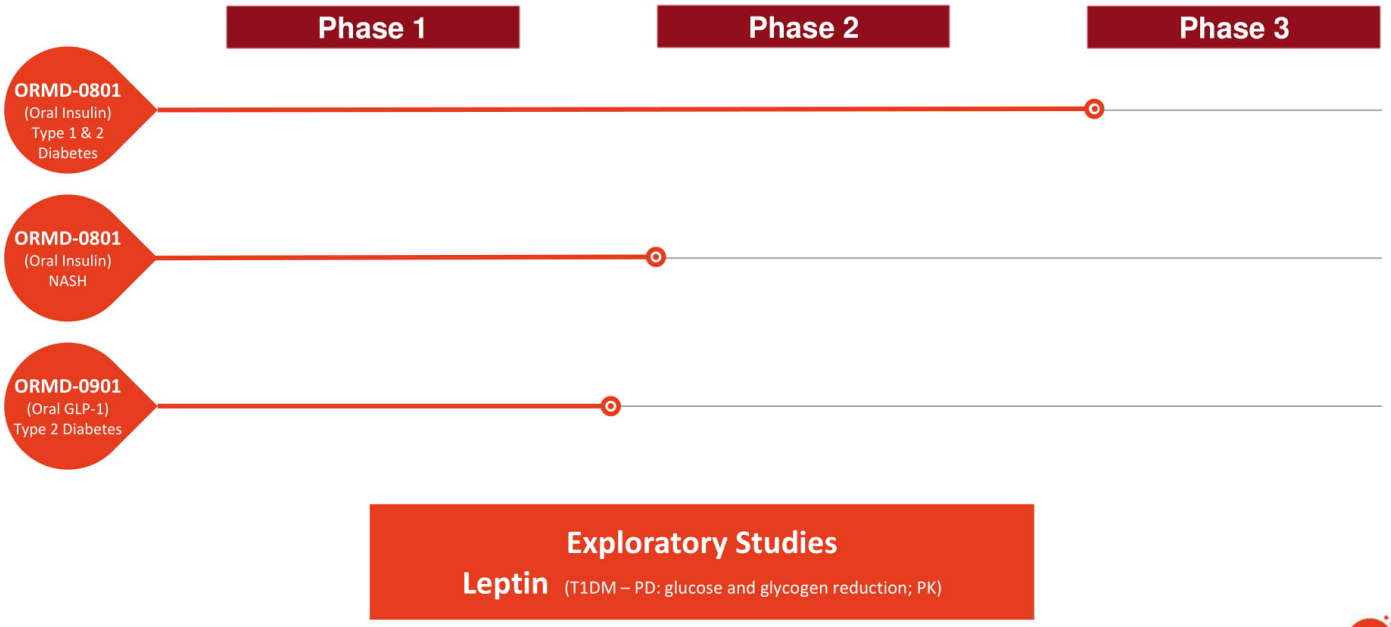
Oramed Technology Protects Drug Integrity and Increases Absorption

pH shield
Sensitive enteric coating protects capsule contents before entering small intestine

Protease protection
Protease inhibitors protect the active agent

Absorption enhancement
Assists the permeation of proteins/peptides across intestinal membrane and into bloodstream

Multiple Clinical-Stage Programs



Exploratory Studies

Leptin (T1DM – PD: glucose and glycogen reduction; PK)

Diabetes:
Millions of diabetics inject insulin today and wish for oral dosage

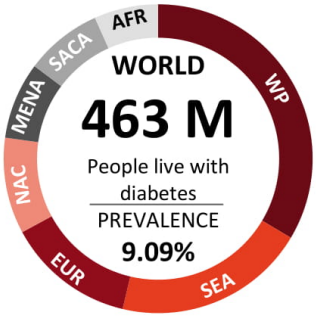
oramed Pharmaceuticals Inc

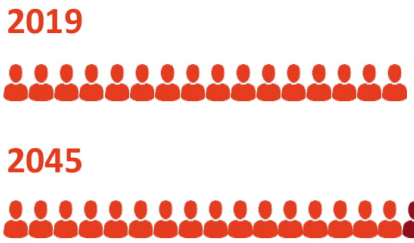
1 in 11 Adults on the Planet Have Diabetes

10% healthcare

spent on diabetes

In 2019 diabetes expenditure reached US $ 760 billion





expected increase:

+237

MILLION

https://www.idf.org/e-library/epidemiology-research/diabetes-atlas/159-idf-diabetes-atlas-ninth-edition-2019.html

ORMD-0801:
Oral Insulin

ORMD-0801 - Flagship Product for Oral Treatment of Diabetes

>900
study subjects

>10,000
human doses

No Serious Drug-Related Adverse Events

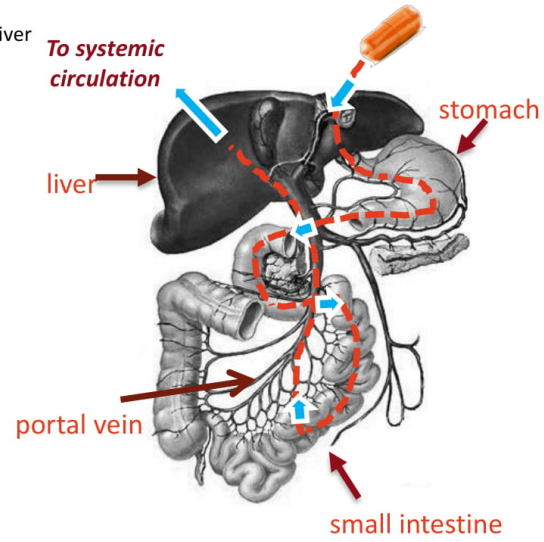
The Drawbacks of Injected Insulin vs. the Advantages of Oral Insulin

ENDOGENOUS INSULIN produced by the pancreas and delivered to the body via the liver

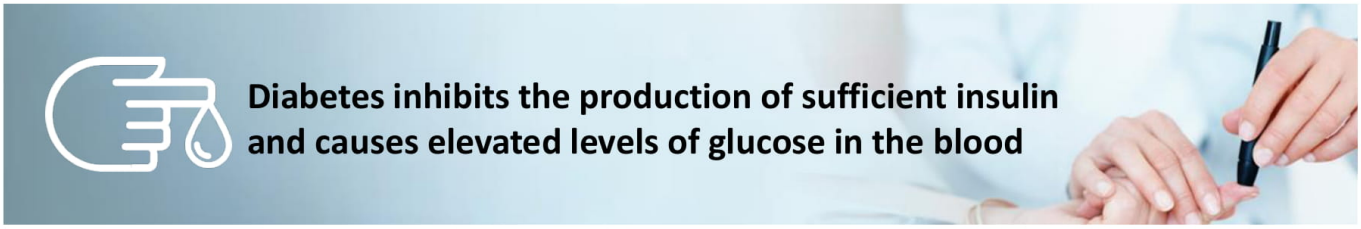
Injected Insulin introduced directly to the bloodstream, with only a fraction of it reaching the liver. This can cause excess sugar to be stored in fat and muscle which often results in weight gain and may also cause hypoglycemia.

Oral insulin, like natural insulin, is delivered first to the liver, resulting in:

- ✓ Better blood glucose control
  - ✓ Reduced hypoglycemia
  - ✓ Reduced hyperglycemia
- ✓ No weight gain



ORMD-0801 for Type 1 & Type 2 Diabetes



TYPE 1 Diabetes

- **T1DM is autoimmune:** The body destroys its own insulin-producing (beta) cells, leaving patients completely dependent on external insulin sources
- **10% of diabetics have T1DM:** Up to 37 million people worldwide have T1DM
- **Projected Market:** $13 billion by 2023

TYPE 2 Diabetes

- **T2DM is metabolic:** The body becomes insulin resistant. Injections may be used to make up for the pancreas's inability to create sufficient insulin to keep blood sugar at normal levels
- **371 million people worldwide need treatment**
- **Projected Market:** $59 billion by 2025

ORMD-0801 for Type 1 Diabetes (T1DM)

Potentially eliminating the need for insulin before each meal

T1DM patients are treated with various types of insulin replacement therapy

- Long-acting insulin (basal) helps maintain stable insulin levels during fasting periods
- Rapid-acting insulin (bolus) prior to each meal to stabilize blood sugar
- Administration is via injection or pump

Oramed oral insulin

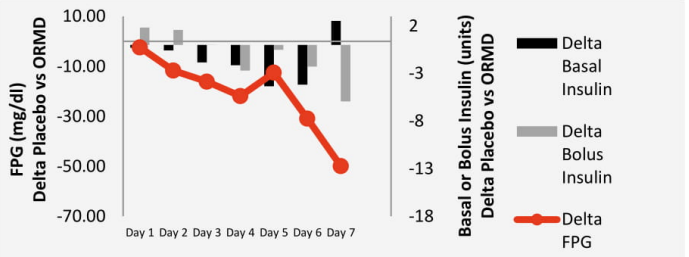
- Easier use and reduced systemic exposure
- Potentially reducing multiple daily injections
- Tighter regulation and control of blood sugar levels by directly targeting liver glucose (TiR), due to portal administration

Phase 2a T1DM Study

Consistent and Accumulative Effect of ORMD-0801 for Treating Type 1 Diabetes

Blood glucose levels lower day and night compared to control group

Reduction in FBG



25 T1DM patients

7 days of treatment

3 times a day (at mealtime)

Primary Endpoint: Evaluate change in exogenous insulin requirements in T1DM patients

Oral Insulin Reduces Exogenous Insulin Requirements

Decreased

- ✓ use of rapid-acting insulin
- ✓ levels of post-meal glucose
- ✓ levels of daytime glucose

Safe and Well Tolerated

Completed: 180 Patient Phase 2 Study for Type 2 Diabetes

33 US sites

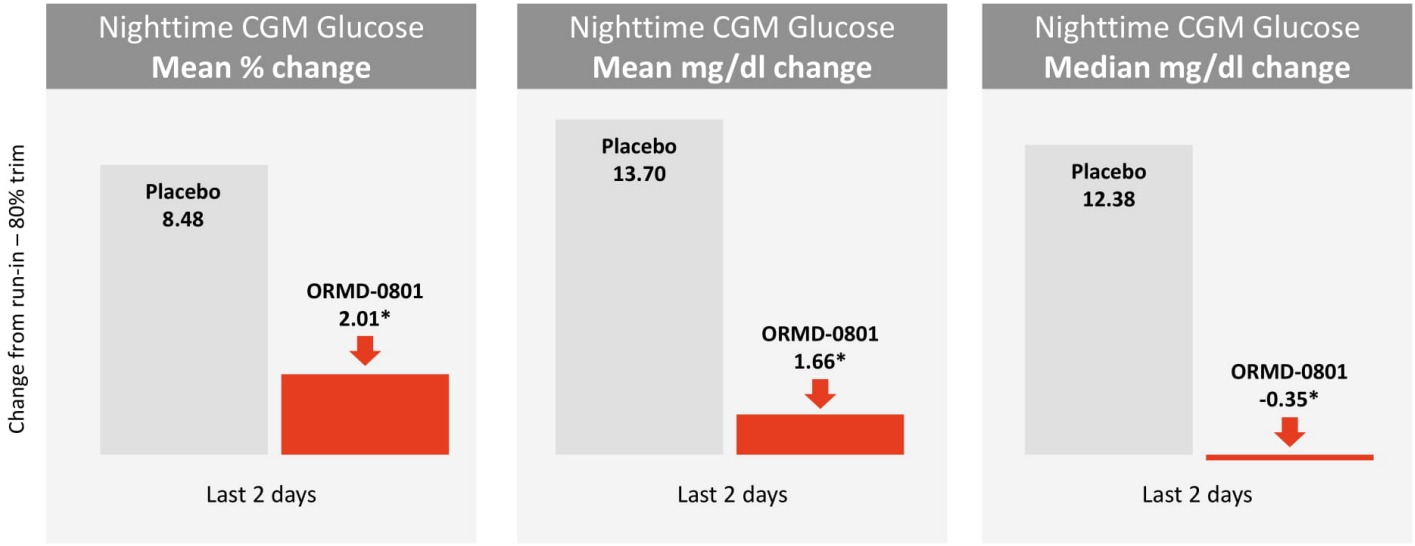
180 patients

28 day treatment

1 Dose (nightly)

FDA Phase 2 Study

Achieved Every Primary Endpoint with No Drug Related Serious Adverse Events



* Indicates Statistically Significant Difference versus Placebo (p-Value<0.05)

FDA Phase 2 Study

Exploratory Endpoints: CGM Parameters

* Indicates p-Value<0.05

Completed: 298 Patient Phase 2b Trial

34 US sites*

298 Patients*

90 Day treatment

7 Doses

*36 Sites: 2 sites (49 subjects) were excluded due to significant treatment by center interaction

- 347 subjects received primary treatment and had baseline A1c (included in ITT)
- **298** subjects included in primary analysis
- **266** included in final analysis (Week 12 A1C results)

Endpoints

01 Primary Endpoint

- Mean change in HbA1c from baseline to Week 12

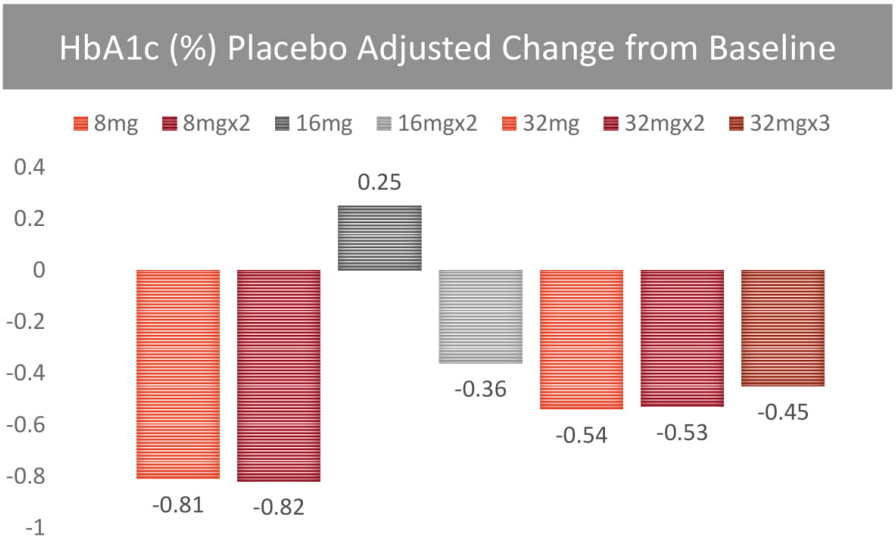
02 Secondary Endpoints

- Safety (AEs, hypoglycemic)
- Fasting Plasma Glucose (FPG) + CGM
- Weight

Dose Finding

- 96 mg/day (32 mg X 3/day)
- 32 mg/day (32 mg X 1/day)
- 32 mg/day (16 mg X 2/day)
- 64 mg/day (32 mg X 2/day)
- 16 mg/day (8 mg x 2/day)
- 16 mg/day (16 mg X 1/day)
- 8 mg/day (8 mg X 1/day)

Phase 2b: Primary Endpoint Successfully Met



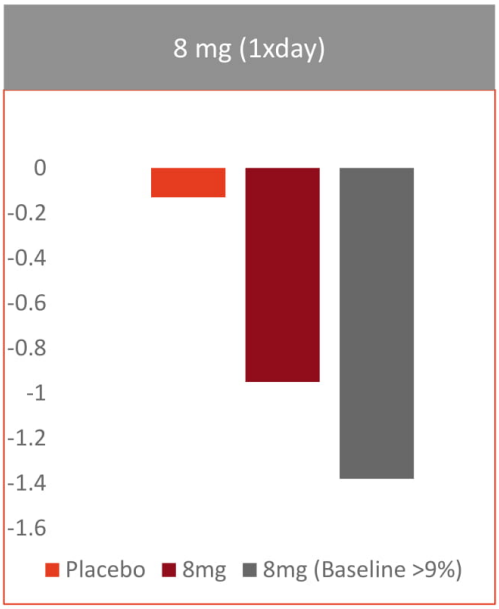
8 mg - 1/day
-0.95 (-0.81 placebo adjusted)

60-70% of the randomized patients were on 2 or more glucose lowering drugs

All Patients were on Metformin

Glucose lowering agents taken in addition to Metformin included:
Glibenclamide, Glipizide, Empagliflozin, Pioglitazone, Glimepiride, Dapagliflozin, Sitagliptin, Glibomet, Ertugliflozin

Phase 2b: 8 mg 1/day – HbA1c Change from Baseline at Week 12



- **0.95 (0.81 placebo adjusted) reduction**
  - **p-value: 0.0276**
  - **[1.29 A1C reduction (Observed Means)]**
- **1.26 placebo adjusted reduction (Baseline >9%)**

FDA Phase 2b Trial Results - Primary Endpoint Successfully Met

Safe and well tolerated

FDA BLA Pathway:
- Confirmatory Phase 3 Study
- Submission to FDA

Gain **12-year marketing** exclusivity upon FDA approval

Significant **HbA1c lowering with 1X/daily treatment:**
- ✓ No increase in Adverse Events compared to Placebo
- ✓ No increase in Hypoglycemic Events compared to Placebo
- ✓ No weight gain compared to Placebo

Pivotal Phase 3

Factors considered by the FDA in a pivotal Phase 3 program

1. ***Efficacy***: The study is powered, based on previous Phase 2 data, to include sufficient patients that will provide statistical significance for primary endpoint provided that the drug performs at least equally well in the Phase 3 study as it did in the Phase 2 study.
2. ***Safety***: The study has sufficient patients, as determined by the FDA, to demonstrate that the drug is safe in diabetic patients.
3. ***Exposure***: The study must show that the drug remains safe in patients exposed to the drug over a period of 6 and 12 months
4. ***Geographic variation***: USA, Israel and EU countries

Pivotal Phase 3: Two Protocols

ORA-D-013-1

A Double-Blinded, Placebo-Controlled, Double Dummy, Multi-Center Randomized, Phase 3 Study to Evaluate the Efficacy and Safety of ORMD-0801 in Subjects with Type 2 Diabetes Mellitus with **Inadequate Glycemic Control on One, Two or Three Oral Glucose-Lowering Agents**

ORA-D-013-2

A Double-Blinded, Placebo-Controlled, Multi-Center Randomized, Phase 3 Study to Evaluate the Efficacy and Safety of ORMD-0801 in Subjects with Type 2 Diabetes Mellitus with **Inadequate Glycemic Control on Diet Control Alone or on Diet Control and Metformin Monotherapy**

Pivotal Phase 3: Dosing (Selected from P2b study data)

- **ORA-D-013-01**
  - Double Blind, Double Dummy
  - 1:1:1 randomization
    - **8mg once-daily** at **night** and placebo 45 mins before breakfast
    - **8mg twice-daily** at **night** and 45 mins before **breakfast**
    - **Placebo twice-daily** at **night** and 45 mins before **breakfast**
- **ORA-D-013-02**
  - Double Blind
  - 1:1 randomization
    - **8mg** at **night**
    - **Placebo** at **night**

Pivotal Phase 3: Sample Size

	ORA-D-013-1	ORA-D-013-2
Sample size	675 adult male and female subjects	450 adult male and female subjects
Territory	US-based	US, Eastern and Western European and Israel-based
Number of Sites	75 US sites	36 US sites, 25 ex-US sites

ORA-D-013-1: Primary and Secondary Objectives

Primary Objective

- To compare the efficacy of ORMD-0801 to placebo in improving glycemic control as assessed by A1c in inadequately controlled T2DM subjects on one, two or three oral glucose-lowering agents.

Secondary Objective

- To assess the safety of repeat administration of ORMD-0801 in inadequately controlled T2DM subjects on one, two or three oral glucose-lowering agents.

ORA-D-013-2: Primary and Secondary Objectives

Primary Objectives

- **Active vs Placebo:**
  - To evaluate the efficacy of ORMD-0801 compared to placebo in improving glycemic control as assessed by A1c in inadequately controlled T2DM subjects on diet control alone or on diet control and metformin monotherapy over a 26-week treatment period.

Secondary Objectives

- **Active vs Placebo:**
  - To evaluate the efficacy of ORMD-0801 compared to placebo in maintaining glycemic control over a 52-week treatment period.

Pivotal Phase 3: Key Inclusion Criteria

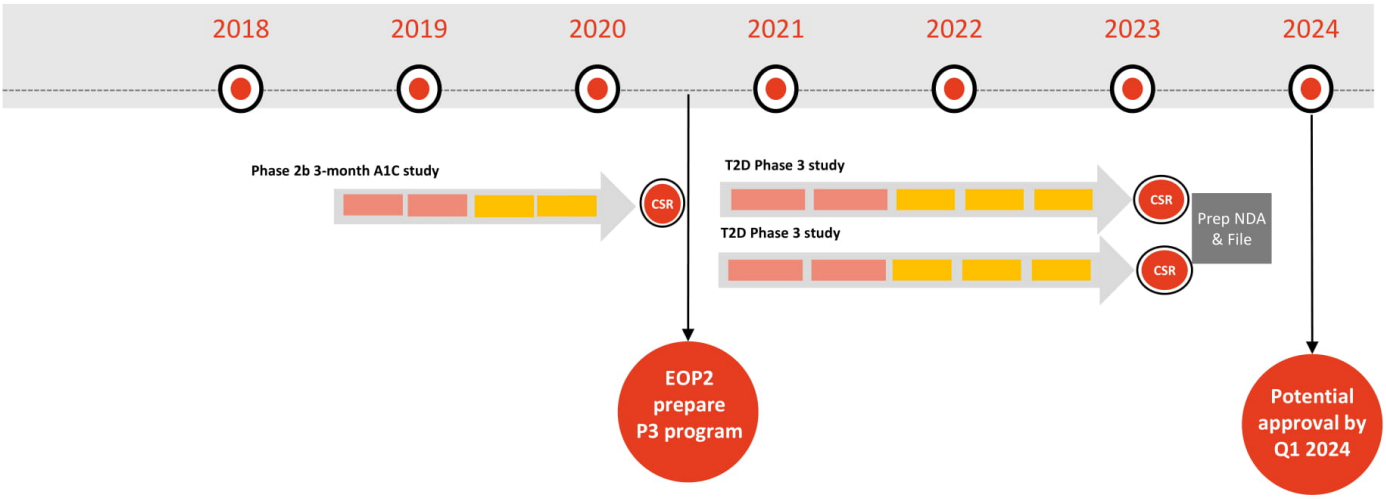
ORA-D-013-1

- HbA1c ≥ 7.5% but ≤ 11.0% at Screening.
- On a stable dose of at least one and up to three of the following oral glucose-lowering agents for a 3-month period prior to Screening:
  - Metformin
  - DPP-4 inhibitor
  - SGLT-2 inhibitor
  - Thiazolidinedione
  - Sulfonylurea

ORA-D-013-2

- HbA1c ≥ 7.5% but ≤ 11.0% at Screening.
- Subjects should be on:
  - Diet and exercise alone for a period of at least 3 months prior to Screening; OR
  - Diet and exercise with a stable dose of metformin only (≥ 1500 mg or MTD) for a period of at least 3 months prior to Screening.

Pivotal Phase 3: Anticipated Clinical Development Timelines



China License Deal: 500M patient potential

- **License: Exclusive right to ORMD-0801 in Greater China**
- **Licensee: Hefei Tianhui ("HTIT")**
  Owns with Sinopharm a state-of-the-art GMP API insulin manufacturing facility
  - HTIT clinical trials of ORMD-0801 underway
- **$50M Payments + Royalties:**
  - $12M in restricted stock (at premium)
  - $38M milestone payments
    - $33M received to date
    - $17M expected over the next 2-3 years
  - Up to 10% royalties on net sales

Chinese diabetes market*

114M **diabetic**
(10.9% of adult population)

~388M **prediabetic**
(35.7% of adult population)

* Journal of the American Medical Association

Commercial Positioning

SEAGROVE PARTNERS

Project Background

Seagrove Partners completed focus groups with 94 total participants including HCPs, Patients & Payers in July 2020.

Six Key Project Objectives:

1. Understand the Therapeutic Unmet Needs for PWD (Type 1 and Type 2)
2. Determine Total Addressable Market for Oral Insulin
3. Test Oral Insulin Target Product Profile with Payers, HCPs & Patients
4. Determine Preferred Patient Segments for Maximum Product Uptake
5. Understand Recommended Product Positioning
6. Gather Video Outtakes Highlighting Key Respondent

Key Findings

- **Prescribers value ancillary benefits of existing diabetes medications.** In addition to the solid A1C lowering impact, HCPs place a high value on weight loss, cardiovascular and renal benefits that existing medications provide.
- **Positive response with some uncertainty on positioning.** The initial response was a combination of excitement and skepticism ("too good to be true") for an oral insulin with no hypo risk. The majority of HCPs advocated use before the introduction of LAI and despite some disappointment in the A1C lowering capability, the quantitative scores were high with HCPs in total stating they would "strongly recommend oral insulin" for 33% of T2 patients who are insulin candidates.
- **Primary care physicians are attractive target.** Most T2 patients are in later stages of the progression of diabetes and are on high TDD of insulin when they see an endo. The value proposition of ORMD-0801 may be highest when prescribed earlier in the treatment protocol to introduce insulin without the need for training etc. on injectable insulin.
- **Oral insulin concept and physiologic MOA concept were positively received by Payers.** Payers were enthusiastic about the clinical potential of an oral insulin for T2 patients. Many commented on the physiologic MOA and ability to increase compliance but were less interested in the use for T1 patients. ~74% (14/19) of payers can see success in using for DPP-4, SGLT-2s/GLP-1s and LAI candidates.
- **63% of payers would be "very likely" or "likely" to recommend formulary coverage for T2D members in combination with other oral agents (metformin, SGLT-2s) or GLP-1s.**
- **Positioning oral insulin as a new class has benefits.** Positioning ORMD-0801 as a new class of medication (vs. being lumped in with insulins) allows more control over rebate levels and less (none initially) competition for preferred coverage.
- **Phase III design can bolster support for coverage.** It was clear from the FG discussion that the Payers will rely on outcomes data when determining coverage and rebate levels. The polling revealed that A1C improvement is still the gold standard and then the next group of important measures are a reduction in hypo, increased TIR and evidence of beta cell preservation.

Patient Segmentation

First Line After Metformin (before GLP-1s/SGTL-2s)

This will likely require showing comparable A1C improvement with Metformin to the GLP-1/SGLT-2 classes, improved TIR and long-term evidence of beta cell preservation (which would delay the need for injectable insulin). This assumes there is still no weight gain or increase in hypo risk. Key requirement: better A1C improvement that DPP-4s.

Second OR Third Line for Select Patient Segments

Identify segments where clinical improvement is the highest. 1) Patients who cannot take GLP-1s or SGLT-2s 2) Patients who are hypo unaware (particularly for overnight control with decreased hypo) 3) Patients who cannot/will not take injections. This may end up becoming the product sweet spot and may be easiest to brand and promote. This would include current DPP-4 users.

Third Line In Combination with GLP-1s/SGLT-2s

Given the ancillary CV, renal and weight gain benefits of the GLP-1/SGLT-2 classes, oral insulin will require strong A1C, additional clinical data (e.g. improved TIR or enhanced combo effect with another class) as well as evidence that oral insulin delays the need for injectable insulin to be broadly recommended. Keep in mind this will be viewed as added cost to the system.

4th Line Post GLP-1s/SGLT-2s

With similar (but longer-term) clinical results to today, ORMD-0801 can be positioned as a precursor or "training insulin" particularly in primary care. The value proposition can be strengthened by showing a delay to injectable insulin.

Possible Positioning and SWOT

Ancillary "Upside" Package

- QD Dosing
- No Hypos
- Weight Neutral
- Durable Beta Cell Preservation
- Much Better TIR
- Much Better Deviations
- Better Post Prandial Control
- Data Supporting MOAc

A1C	Patient Segmentation
>1.3	Frontline Therapy with Metformin
1.0-1.2	Frontline Therapy with Metformin
0.8-1.0	Replacement for 2nd Line Agents
0.6-0.8	Replacement for DPP4s
<0.6	3rd Line Therapy for Those Who Can't Tolerate GLP-1s/SGLTs

Ancillary "Base" Package

- QD Dosing
- No Hypos
- Weight Neutral
- Trend Towards Beta Cell Preservation
- Better TIR
- Much Better Deviations
- No Change on Post Prandial Control
- Data Supporting MOA

A1C	Patient Segmentation
>1.3	Frontline Therapy with Metformin
1.0-1.2	Replacement for 2nd Line Agents
0.8-1.0	Replacement for DPP4s
0.6-0.8	Replacement for DPP4s
<0.6	3rd Line Therapy for Those Who Can't Tolerate GLP-1s/SGLTs

S
- Oral administration allows earlier treatment with insulin by removing barriers to exogenous injectable insulin use
- Physiologic treatment by portal absorption & safety profile
- Clinical publications re: positive impact of using insulin earlier in the treatment pathway
- A1C & exogenous insulin reductions
- Once daily, simple dosing

W
- Other medications offer similar or better A1c improvements
- Cost may prevent earlier use in Tx pathway
- Lack of direct CV, renal or weight loss benefits
- Potential for BID dosing & capsule size
- Inability to titrate dose to achieve A1c goals

Greatest opportunity to show A1C reduction, reduced safety risk and explore other indications in Phase III (e.g. TIR, reduce std deviation of glucose fluctuations, beta cell preservation)

O
- DTC and PCP education given oral vs. injectable
- Patients who can't take/tolerate GLP-1s & SGLT-2s
- Development of new category for formulary coverage
- Phase III: Improved TIR, reduce STD, beta cell preservation
- Update ADA treatment guidelines to include oral insulin
- Adjunctive to LAI for T1DM to increase TIR and reduce TDD
- Potential treatment for NASH (no FDA approved Tx options)

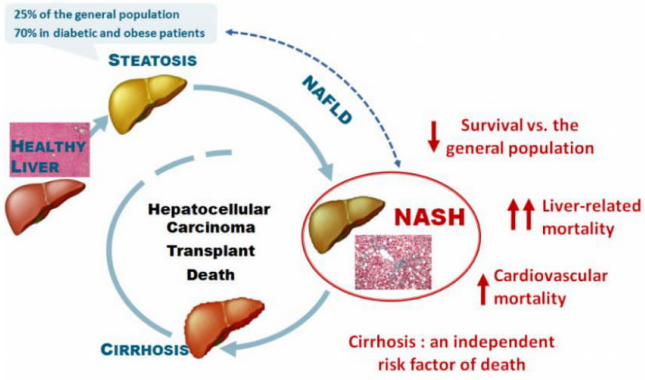
T
- GLP-1s and SGLT-2s moving forward in treatment continuum
- Rybelsus with best-in-class efficacy in an oral pill
- Once-weekly insulin and GLP-1s
- Generic options for DPP-4, GLP-1s, SGLT-2s & insulin
- Simpler AID system development geared toward T1 & T2
- Size of current payer rebates/pricing pressure for insulin & other medications
- More aggressive DM programs aimed at reversing T2D or stopping progression

NASH Study

Leveraging Oral Insulin for Nonalcoholic Fatty Liver Disease

Nonalcoholic Steatohepatitis (NASH)

- Chronic liver disease caused by excessive fat in liver (MoA not fully known)
- Leads to fibrosis, cirrhosis and liver failure (death)
- 25% of adults in the U.S. have NAFLD
- 5% of adults in the U.S. have NASH
  - 37% among patients with T2DM



Status

- Data from initial 8 patients presented at ADA 2020 :
  - Safety:
    - 12-week, once-daily treatment had no SAEs
  - Efficacy:
    - 30% relative reduction measured by MRI-PDFF
    - 6.9±6.8% mean reduction in liver fat content (p value: 0.035)
- Initiation of 10 additional patients in EU (ongoing)
- Initiation of Double-Blind Placebo-Controlled Study (n=30) in US and Israel (Q4;2020)

ORMD-0901:
Oral GLP-1 Analog

GLP-1 Analog:
ORMD-0901 for Oral GLP-1 (TD2M)

GLP-1 Analog

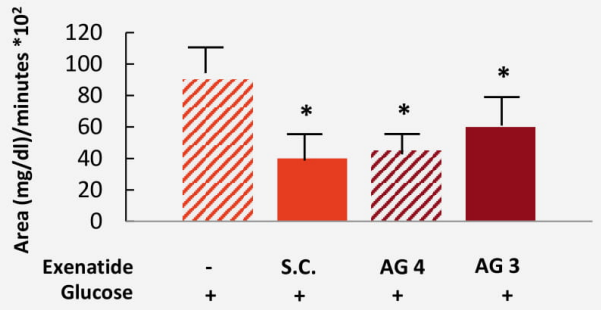
- T2DM medication
- Mimics the natural hormone in the body
- Compelling safety profile
- Decreases blood glucose levels
- Effectively reduces HbA1c
- Preserves beta cell function
- Promotes weight loss
- Current therapy via injection only

ORMD-0901 Clinical Status

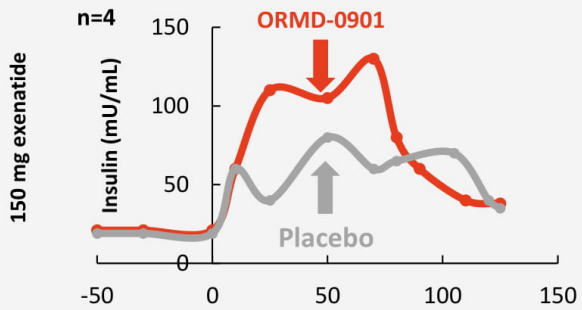
- IND
- Bioavailability study

Oral GLP-1 - ORMD-0901

Preclinical: Oral exenatide delivery amounted to a >50% reduction in mean glucose (similar to SC)



Human (4 healthy volunteers)



ORMD-0901 formulations

Preserved the biological activity of orally delivered exenatide. ORMD-0901 successfully curbed blood sugar excursions following glucose challenge

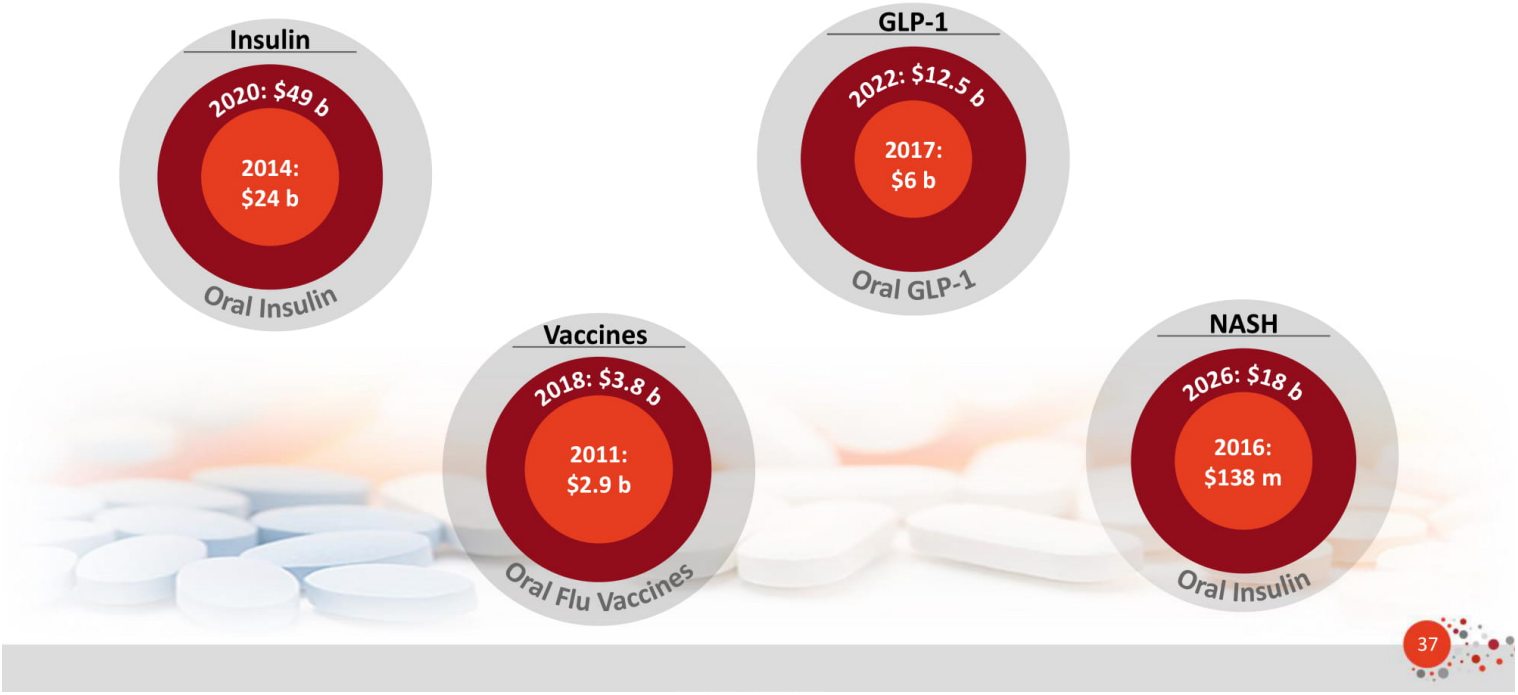
Anticipated Development Milestones

0801
- T2DM: Initiate Phase 3
- NASH: Initiate Phase 2

0901
- Bioavailability Study (T2DM) Initiation & Completion

Leptin
- Phase I ex-USA Initiation

Funneling Huge Injectable Drug Markets to Novel Oral Formulations



Management Team

Nadav Kidron, Esq, MBA - CEO & Director

Many years of business experience as well as corporate law and technology

Miriam Kidron, PhD - CSO & Director

Senior Researcher at the Diabetes Unit of Hadassah Medical Center for more than 25 years

Avi Gabay, CPA - CFO

Extensive experience in corporate financial management

Josh Hexter - Chief Operating & Business Officer

More than 18 years of prominent leadership roles in biotech and pharma

Roy Eldor, MD - Chief Medical Advisor

Head of the Diabetes Unit at Tel-Aviv Sourasky Medical Center

Board of Directors

Kevin Rakin - Chairman

Co-Founder and Partner at HighCape Partners; former President of Regenerative Medicine at Shire plc

Leonard Sank

Entrepreneur and business leader; Director of Macsteel Service Centres SA (Pty) Ltd

Aviad Friedman

Director of public and private companies including Maayan Ventures, Capital Point and Rosetta Green Ltd.

Arie Mayer

Managing Director and Chairman of the Board of Merck Life Science Israel (formerly Sigma-Aldrich Israel Ltd.)

Xiaoming Gao

Chairman of HTIT, China

Nadav Kidron

CEO, Oramed

Miriam Kidron

CSO, Oramed

Scientific Advisory Board

Roy Eldor, MD, PhD

Director, Diabetes Unit, Institute of Endocrinology, Metabolism & Hypertension, Tel-Aviv Medical Center

Ele Ferrannini, MD, PhD

Professor, Internal Medicine, University of Pisa School of Medicine. Past President of the EASD

Alexander Fleming, MD

Recognized authority in the metabolic and endocrine fields with extensive FDA experience.

Avram Herskho, MD, PhD; Nobel Laureate

Distinguished professor in the biochemistry unit in the B. Rappaport Facility of Medicine, Technion, Haifa, Israel

Harold Jacob, MD

Chief Medical Officer, NanoVibronix. Previously, Director, Medical Affairs at Given Imaging.

Julio Rosenstock, MD

Director, Dallas Diabetes Research Center, Professor, University of Texas Southwestern Medical Center; Associate Editor, *Diabetes Care*.

Jay Skyler, MD, MCAP

Professor or Medicine, Division of Endocrinology, Diabetes & Metabolism, Department of Medicine, University of Miami.

Oramed (NASDAQ/TASE: ORMP)

Addressing the Multibillion-Dollar Injectable Drug Markets with Oral Formulations

- **Proprietary oral protein delivery platform**
- **Primary Indication: Insulin** - initially targeting the lucrative insulin market; additional markets in the pipeline
- **Strong financial position** with over $45.6M in cash and investments, no debt, 23.3M shares outstanding (28.5M fully diluted)[1]
- **Strong management** team backed by world-class scientific experts
- **Multiple near-term value-creation catalysts** for this year
- **Robust IP Portfolio**
  - Methods and compositions for oral administration of proteins
  - Methods and compositions for oral administration of exenatide
  - Methods and compositions (insulin + exenatide)
  - Improved protease inhibitors

[1] As of May 31, 2020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