VERRICA™ PHARMACEUTICALS

Reinventing Skin Science

Company Overview

June 29, 2022

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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, interactions with the FDA with regard to the resolution of the CRL, the timing of an NDA resubmission, potential approval of the NDA for VP-102, the potential benefits and potential commercialization of VP-102 for the treatment of molluscum, if approved, 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, future results of anticipated product candidates, and the potential payments and benefits to Verrica of the license agreement with Torii, 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.

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Investment Highlights

Focused on Clinician-Administered Therapies With Potential for Reimbursement as a Medical Benefit

YCANTH™ (VP-102)

- In Development to Address Two of the Largest Unmet Needs in Dermatology
  - U.S. prevalence of ~6 million in molluscum contagiosum[(1)] and ~22 million in common warts[(2)]
  - No FDA-approved drugs to treat molluscum or warts
- Innovative Product Candidate
  - Proprietary drug-device combination of formulation and single-use applicator
- Physician Acceptance
  - 95% of Pediatric Dermatologists have used API[(3)]
- Payer Research Suggests Favorable Reimbursement Landscape
- Exclusive License for Torii Pharmaceutical to Develop and Commercialize VP-102 in Japan
- NDA resubmission expected Q1 2023

Dermatological Oncology

- Worldwide rights for dermatological oncology, including basal cell and squamous cell carcinomas and non-metastatic melanoma, to LTX-315
  - First-in-class oncolytic peptide injected directly into tumor
- Positive tumor-specific immune cell responses in multi-indication Phase 1/2 oncology trials
- Verrica to focus initially on development to treat basal cell and squamous cell carcinomas
- 5.4 million diagnoses annually in the U.S. of basal and squamous cell skin cancers[(4)]; patients typically treated with surgery
- FDA acceptance of IND in November 2021; first patient dosed in Phase 2 study for treatment of Basal Cell Carcinoma in April 2022

Proven Team and Strong Balance Sheet

- Industry-leading, experienced management team with extensive dermatology product launch experience
- $21.9M cash, cash equivalents and marketable securities as of March 31, 2022 (excludes restricted cash)

(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.
(4) Rogers JAMA Derm 2015; https://www.aad.org/media/stats-skin-cancer; https://www.skincancer.org/skin-cancer-information/skin-cancer-facts/
(5) Timing of clinical trials subject to change.

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Verrica: Striving to Change the Game in Medical Dermatology

- Potential first and only FDA-approved product to treat Molluscum Contagiosum
- Innovative distribution model to eliminate physician cost of acquiring YCANTH
  - Forward-deployed based inventory model to allow physicians to pay for inventory only after the claim has been adjudicated and the patient agrees to treatment through RFID technology
- Enhanced physician revenue opportunity
  - Continued reimbursement under the CPT codes 11710 and 17111
  - Margin on sale of the product (typically 6%-10% of ASP dependent on health plan)
- HCP-administered procedure in office typically falls under the medical benefit with an assigned permanent J-Code
- Patient responsibility typically averages 20% co-insurance off list price, before manufacturer co-pay applied

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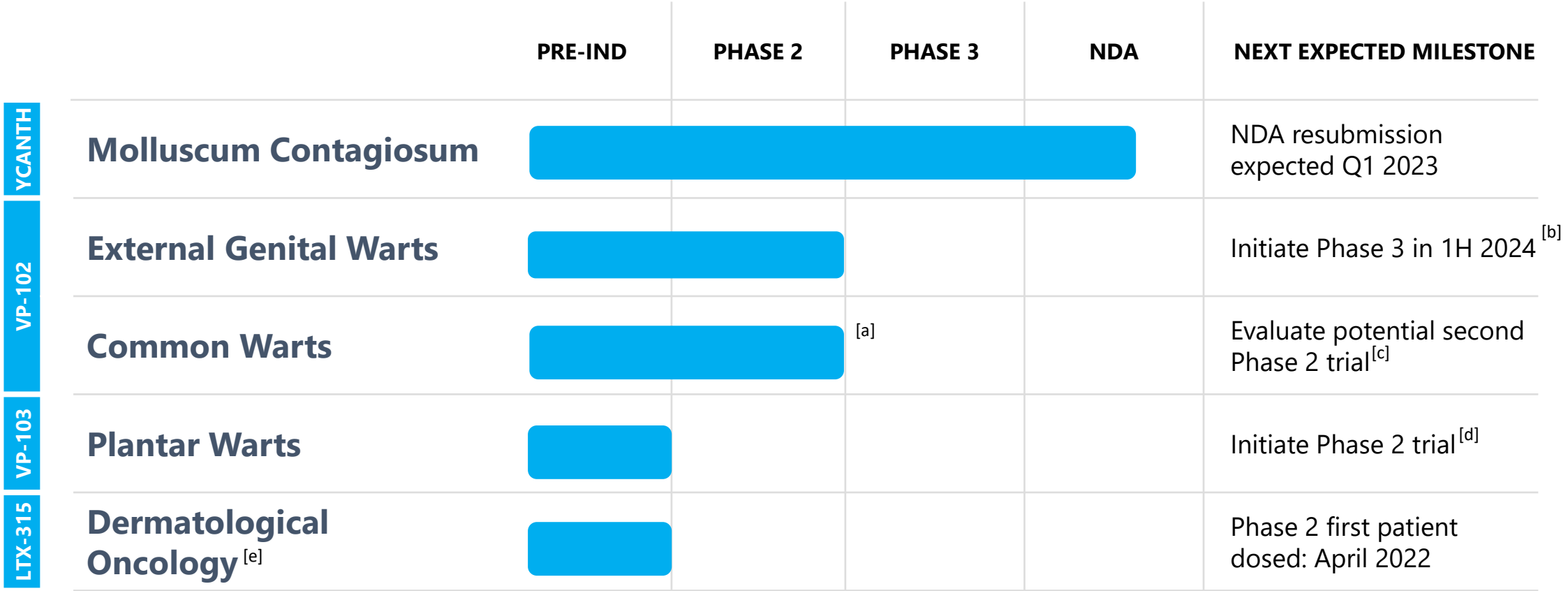
Our Product Portfolio



[a] Originally designed Phase 2 program completed.
[b] Timing of clinical trials for External Genital Warts may be subject to change.
[c] Company evaluating potential for conducting an additional Phase 2 trial based on FDA feedback for Phase 3 trial protocol.
[d] Timing for initiating clinical trials for Plantar Warts to be determined.
[e] License excludes metastatic melanoma and metastatic merkel cell carcinoma. Phase 2 study initiated in April 2022 for the treatment of Basal Cell Carcinoma.

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YCANTH™ in Development to Address Two of the Largest Unmet Needs in Dermatology

Molluscum

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

85%
Not Diagnosed
5.1 million

15%
Diagnosed
0.9 million

Common Warts

US Prevalence of **~22 million**(3) with **~1.5 million diagnosed annually**(4)

22M
Prevalence in U.S.

1.5M
Patients Diagnosed Annually

(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
(3) 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
(4) IQVIA Anonymous Longitudinal Patient Level Data (APLD) for 12 months ending September 2018

U.S. Regulatory Status of VP-102

- Verrica received a Complete Response Letter (CRL) from the FDA in May 2022 as a direct result of deficiencies identified at a general reinspection of a facility of Sterling Pharmaceuticals Services, LLC.
- None of the issues identified by the FDA during the reinspection were specific to the manufacturing of VP-102.
- Verrica held a Type A meeting with the FDA on June 27, 2022 to discuss the path forward for NDA resubmission and Verrica expects to resubmit the NDA in Q1 2023.
- Verrica remains confident in the path forward for VP-102 as the potential first and only FDA approved treatment option for molluscum.

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THE PROBLEM

Molluscum Contagiosum

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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

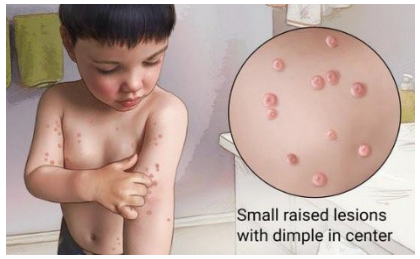
ETIOLOGY AND CLINICAL PRESENTATION

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

	DESCRIPTION	LIMITATIONS
Cryotherapy	Freezing the lesions with liquid nitrogen	• 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	• Pain and scarring • Unsuitable for use in children
Laser Surgery	Applying a laser to target and destroy the lesions	• 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	• Unproven efficacy
Off-Label Drugs	Retinoids, antiviral medicines, or immune modulating therapies	• Limited efficacy • Side-effects
Natural Remedies	Applying natural oils (e.g. tea tree oil) with antimicrobial properties	• Unproven efficacy • Pain, irritation and allergic reactions

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THE SOLUTION

YCANTH™ (VP-102)

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YCANTH™ (VP-102) Is a Proprietary Drug-Device Combination of Cantharidin Administered Through our Single-use Precision Applicator

GMP-controlled new formulation of 0.7% w/v cantharidin

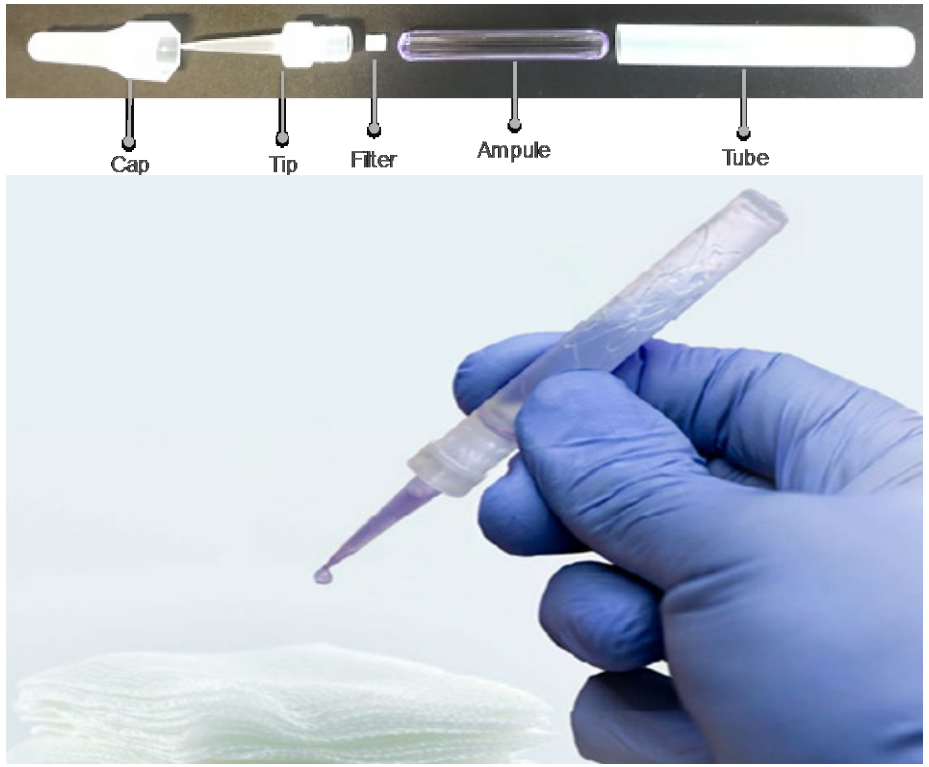
- Consistent and shelf-stable

Single-use applicator to reduce cross-contamination and allow for more effective application of drug by HCP

Visualization agent to identify treated lesions

Bittering agent to deter oral ingestion

Clinician administered, **In-Office** Procedure



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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, 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

Molluscum History for Subjects in Phase 3 Trials[1]

	VP-102 (n=310)	Vehicle (n=218)
Baseline Lesion Count		
Mean (SD)	20.5 ± 23.1	22.5 ± 22.3
Median	12.0	15.5
Range	1-184	1-110
Time Since Clinical Diagnosis (days)		
Mean (SD)	122.9 ± 200.9	126.2 ± 198.7
Median	25.0	31.5
Range	1-1247	1-1302
Previous Treatment for Molluscum - no. (%)		
Yes	89 (28.7)	72 (33.0)
Atopic Dermatitis (AD) – no. (%)		
History or Active AD	50 (16.1)	35 (16.1)
Active AD*	23 (7.4)	20 (9.2)

*Active AD was determined by concomitant medication usage of the following medications during the study: topical corticosteroids, topical calcineurin inhibitors, and/or PDE-4 inhibitors

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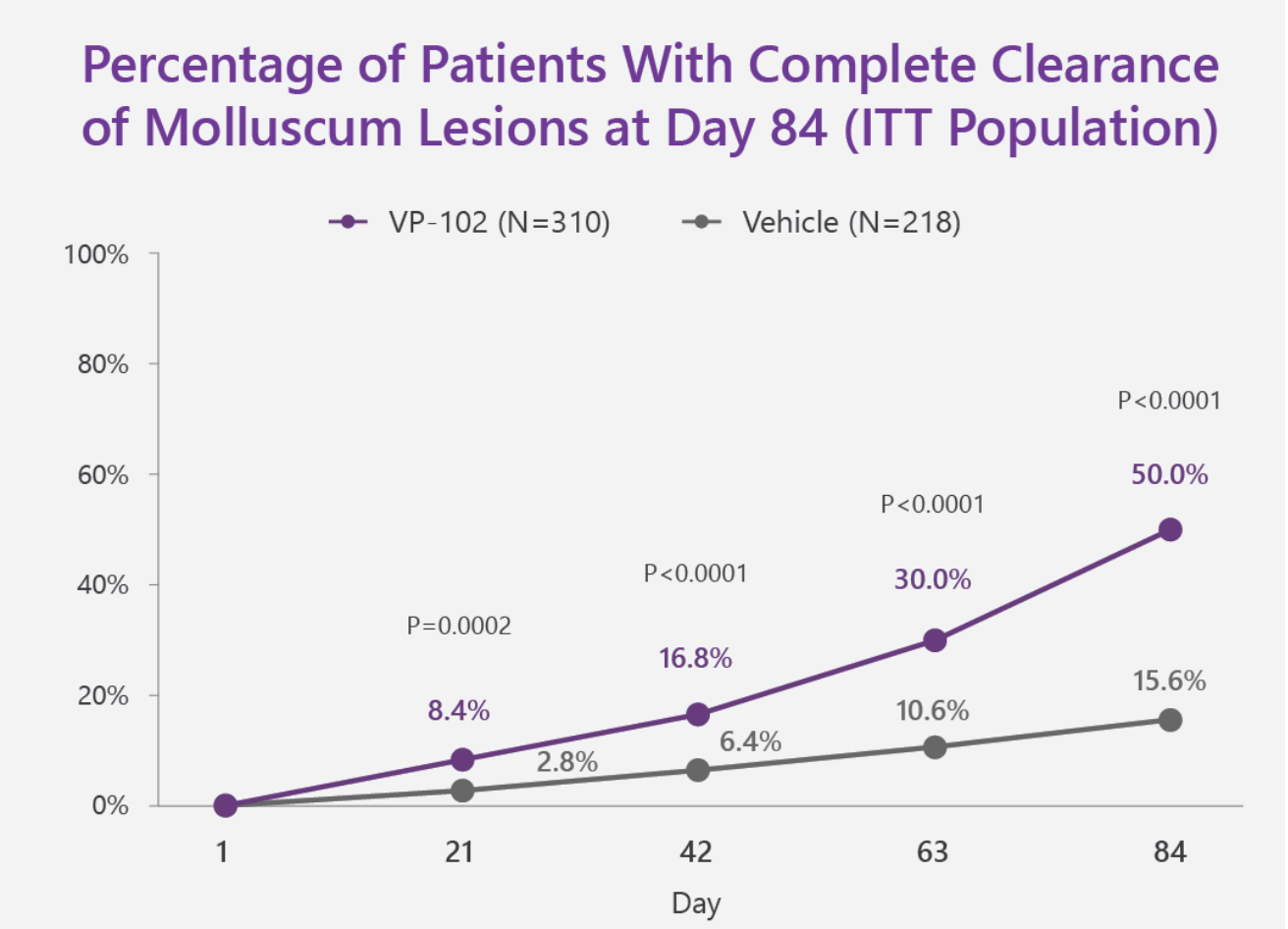
Note: Slide reflects pooled data from Phase 3 molluscum trials (CAMP-1 and CAMP-2)

(1) Eichenfield *Amer J Clin Derm* 2021

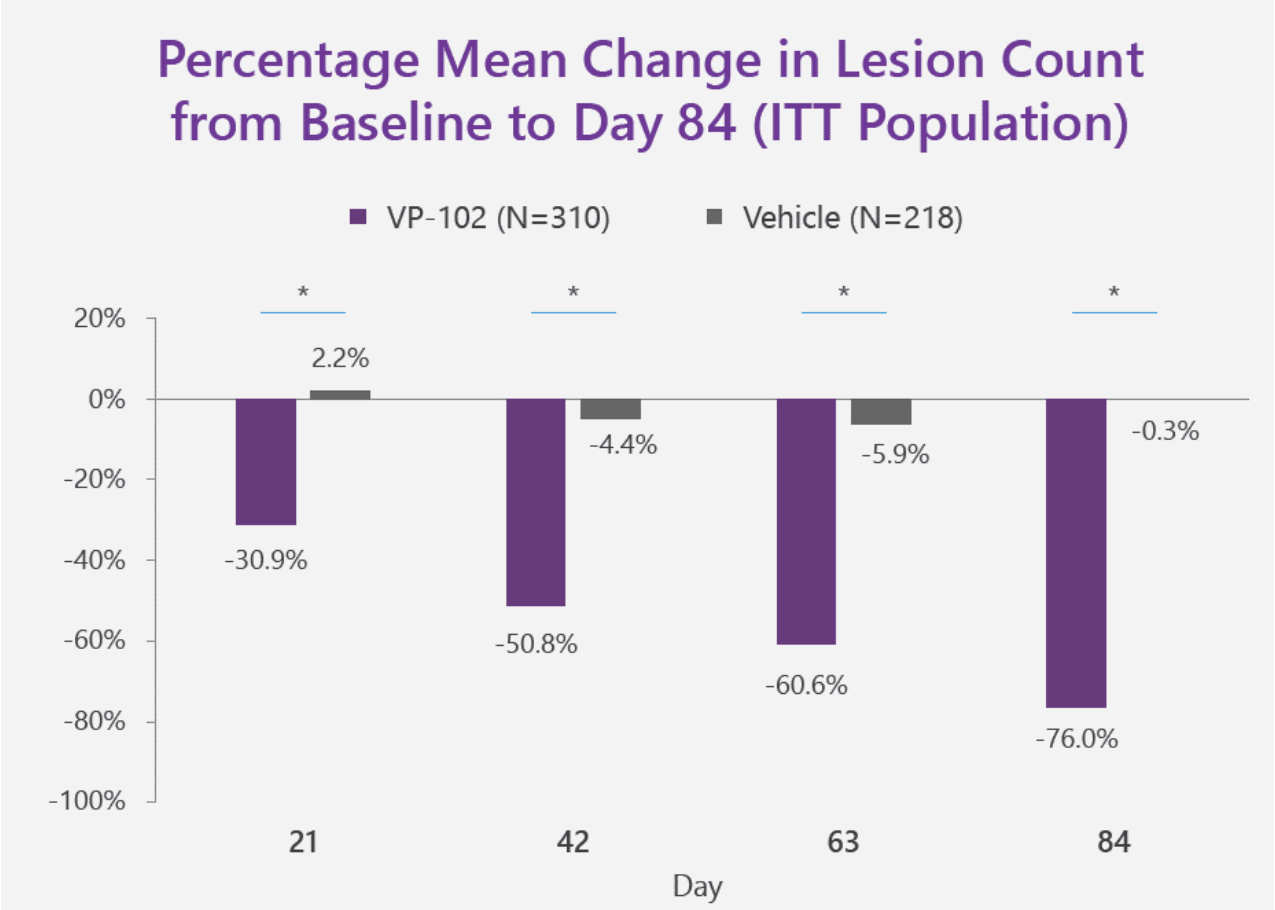
Phase 3 Studies in Molluscum Demonstrate Statistically Significant Efficacy on Primary Endpoint of Complete Clearance vs. Vehicle[1]



Note: Slide reflects pooled data from Phase 3 molluscum trials (CAMP-1 and CAMP-2)

(1) Eichenfield *Amer J Clin Derm* 2021

Phase 3 Studies in Molluscum Demonstrate Statistically Significant Efficacy on Percent Reduction of Lesions vs. Vehicle[1]



Note: Slide reflects pooled data from Phase 3 molluscum trials (CAMP-1 and CAMP-2)

(1) Eichenfield *Amer J Clin Derm* 2021

Phase 3 Discontinuation of Study Medication Due to Treatment-Related Adverse Events[1]

N (%)	VP-102 (N=311)	Vehicle (N=216)
Application Site Vesicles	5 (1.6)	0 (0)
Application Site Pain	3 (1.0)	0 (0)
Application Site Pruritus	1 (0.3)	0 (0)
Contact Dermatitis	1 (0.3)	0 (0)
Total Discontinuation Rate	**6 (1.9)**	**0 (0)**

Note: Slide reflects pooled data from Phase 3 molluscum trials (CAMP-1 and CAMP-2)

(1) Eichenfield *Amer J Clin Derm* 2021

MC Commercial Opportunity

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Realizing the Molluscum Opportunity

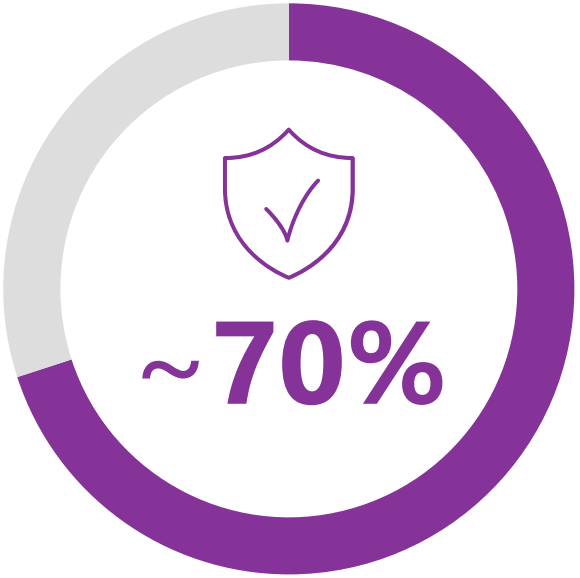
US Prevalence of **~6 million in molluscum**(1) with **~1 million diagnosed annually**(2)

85%
Not Diagnosed
5.1 million

15%
Diagnosed
0.9 million

(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

Dermatologists are Familiar with API Used in YCANTH™ (VP-102) & Would Use if Available



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

Physicians reported they **would use YCANTH™ (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 YCANTH™ (VP-102) Profile

Derms and Ped Derms (1)

Pediatricians (1)

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

KEY REASONS TO USE IF APPROVED

- Efficacy
- Precise and pain free application
- FDA approval
- Convenience of administration

- Efficacy
- Fits into their current office model
- Frustrated with not treating and having no viable options

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

Multiple Payer Research Studies Suggest Favorable Reimbursement Landscape for YCANTH™ (VP-102)

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

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

Source: Third party study commissioned by the Company.

Multiple Payer Research Studies Suggest Favorable Reimbursement Landscape for YCANTH™ (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 YCANTH™ (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 YCANTH™ (VP-102)** with minimal to no restrictions

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Source: Third party study commissioned by the Company.

Medical Benefit Advantages Over Pharmacy Benefit

	Medical Benefit	Pharmacy Benefit
Reimbursement for products administered in office by HCP	More common	Less common
Reimbursable upon launch prior to clinical review	More common	Less common
Subject to rebates and discounts in order to obtain formulary access	Less common	More common
Gross-to-Net Deductions	Typically, lower deductions than Pharmacy Benefit	Typically, higher deductions to meet rebate demands and costs of co-pay program
Patient obligation	Typically, averages 20% co-insurance off list price, before manufacturer co-pay applied	Prescription co-pay varies by plan

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Integrated Commercial Approach with Multiple Strategic Levers

Commercial Strategy

Disease Awareness

Increase treatment seekers through cost-efficient consumer advertising

KOL Engagement

Strong established relationships and support

Specialized Sales Team

Targeting office-based and institutional Dermatologists, and select Pediatricians

Dedicated Institutional Team

Specialists to promote to dermatologists in academic settings and group practices

Buy and Bill or Specialty Pharmacy

Forward Deployed Inventory

Supportive HUB services

Dedicated field reimbursement Team

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Physician Choice of Distribution Model

	Buy-and-Bill	Specialty Pharmacy
HCP Reimbursement		
Permanent J-code	Yes (within 1-2 quarters post-launch); Reimbursed under miscellaneous J-code until permanent J-code assigned	No
Office visit fee	Yes	Yes
Lesion destruction (CPT 17110, 17111)	Yes	Yes
Margin on sale of product	Yes, typically 6%-10% of ASP (dependent on health plan)	No
Distribution	**Forward-deployed Inventory Model**	**Specialty Pharmacy Model**
	▪ Verrica sells product to distributor ▪ Distributor supplies product on consignment basis to physicians ▪ Allow physicians to pay for inventory after the claim has been adjudicated and the patient agrees to treatment through RFID technology	▪ RX filled by pharmacy network ▪ The pharmacy will also support prior-authorizations, if applicable ▪ Pharmacy adjudicates claim with patients and applies co-pay program ▪ White bag delivery to physician

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Pre-Commercialization Activities Ongoing

Engagement at Premier Venues & Industry Channels

The Society for Pediatric Dermatology	Winter Clinical Dermatology	Fall Clinical Dermatology Conference® Poster Presentation
American Academy of Dermatology (AAD) 1938	American Academy of Pediatrics National and Regional Meetings	SDPA Society of Dermatology Physician Assistants National and Regional Meetings
South Beach Symposium clinical + aesthetic dermatology	MauiDerm The Dermatology Meetings	JAMA Network™

DISEASE AWARENESS

Caregiver Molluscum education through digital and social tools

HCP Molluscum 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

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VP-102 in External Genital Warts

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Condyloma Acuminatum (Genital Warts)

OVERVIEW

Caused by human papilloma virus (HPV)

Lesions on the surface of the skin in the genital and perianal regions

Highly contagious and recurrences are common

Treatment options have limitations

Approximately 500,000 to 1 million cases of EGW are newly diagnosed per year in the United States[1]

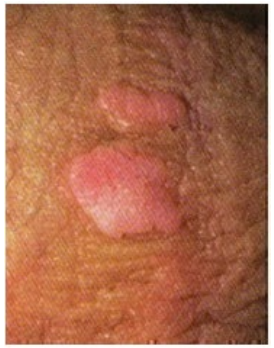
ETIOLOGY AND CLINICAL PRESENTATION

Transmission

- Skin to skin contact
- Spread through sexual contact

Diagnosis & Symptoms

- Can be flat, dome-shaped, keratotic, pedunculated and cauliflower-shaped
- Lesions may occur singularly, in clusters, or as plaques
- Lesions can be itchy, and can cause pain and discomfort



Complications

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

(1) Yanofsky, Valerie & Patel, Rita & Goldenberg, Gary. (2012). Genital warts: A comprehensive review. The Journal of clinical and aesthetic dermatology. 5. 25-36.

Phase 2 Study (CARE-1) in External Genital Warts (EGW)

Study Design

Multi-center, double-blind, vehicle-controlled

Dose regimen, efficacy, safety & tolerability

Study comprised of two parts (A and B)

Primary objective of Part A is to identify the two best dosing regimens for evaluation in Part B

Endpoints

Primary
Percent of subjects with complete clearance of all treatable warts at Day 84

Secondary
Percent of subjects achieving complete clearance of all treatable warts at days 21, 42, and 63

Patients

Part A: 18 subjects 18+ years of age with 2-30 external genital and/or perianal warts for ≥ 4 weeks at baseline visit

Part B: 87 subjects 18+ years of age with 2-30 external genital and/or perianal warts for ≥ 4 weeks at baseline visit

Application

Study drug (VP-102) is administered topically to each treatable wart every 21 days until complete clearance for a maximum of 4 treatments

Part A: Three treatment groups with a 2-hour, 6-hour, and 24-hour duration of skin exposure before removal with soap and warm water

Part B: 6- and 24-hour duration of treatment exposure (chosen based on Part A) with follow up period through Day 147

Frequency of administration is every 21 days

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Demographics (CARE-1, ITT Population)[1]*

	VP-102 6-hour (N=30)	Vehicle 6-hour (N=24)	VP-102 24-hour (N=27)	Vehicle 24-hour (N=18)
Age				
Mean (SD)	38.93 (9.9)	35.83 (7.8)	34.33 (7.1)	33.83 (6.3)
Min, Max	26, 59	26, 58	25, 53	25, 43
Gender, n (%)				
Male	17 (56.7)	14 (58.3)	15 (55.6)	11 (61.1)
Female	13 (43.3)	10 (41.7)	12 (44.4)	7 (38.9)
Race, n (%)				
White	24 (80.0)	13 (54.2)	24 (88.9)	12 (66.7)
Black or African American	6 (20.0)	8 (33.3)	2 (7.4)	6 (33.3)
American Indian or Alaska Native	0 (0)	1 (4.2)	0 (0)	0 (0)
Other	0 (0)	2 (8.3)	1 (3.7)	0 (0)
Ethnicity, n (%)				
Hispanic or Latino	6 (20.0)	1 (4.2)	2 (7.4)	5 (27.8)
Not Hispanic or Latino	24 (80.0)	23 (95.8)	25 (92.6)	13 (72.2)

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*Pooled data from Part A and B

(1) Guenthner 2020 Winter Clinical Dermatology Symposium

Baseline EGW Characteristics (CARE-1, ITT Population)[1*]

	VP-102 6-hour (N=30)	Vehicle 6-hour (N=24)	VP-102 24-hour (N=27)	Vehicle 24-hour (N=18)
Duration of Warts, No. (%)				
<1 year	15 (50.0)	12 (50.0)	14 (51.9)	9 (50.0)
1-2 years	3 (10)	1 (4.2)	2 (7.4)	0 (0.0)
>2-5 Years	4 (13.3)	5 (20.8)	8 (29.6)	3 (16.7)
>5 years	8 (26.7)	6 (25.0)	3 (11.1)	6 (33.3)
Wart Count				
Mean	8.5	6.71	9.48	7.56
SD	7.3	5.5	6.2	6.8
Median	6	5	9	4.5
Min, Max	2, 30	2, 26	2, 25	2, 28
Prior Wart Treatment, No. (%)				
Yes	17 (56.7)	13 (54.2)	14 (51.9)	9 (50)

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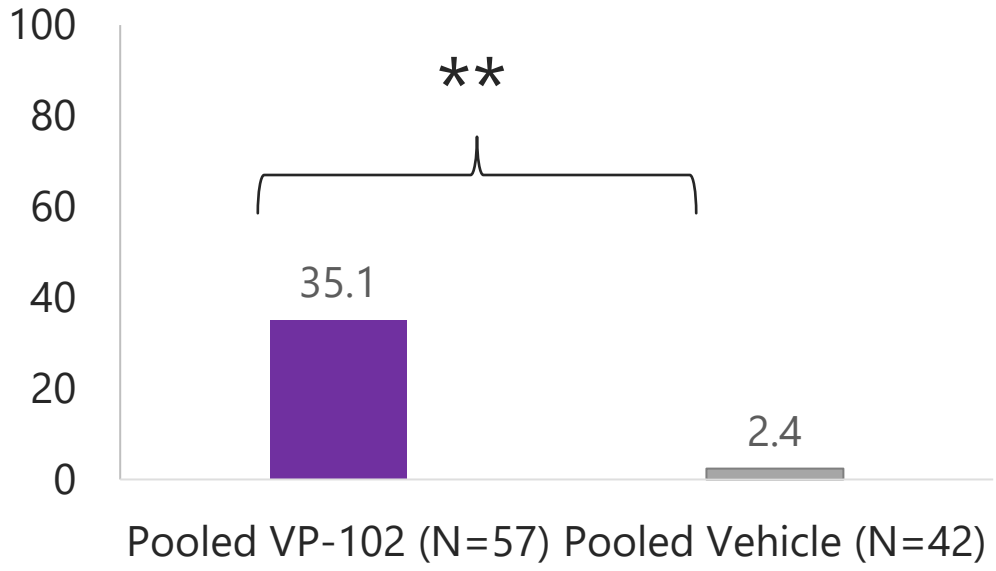
*Pooled data from Part A and B

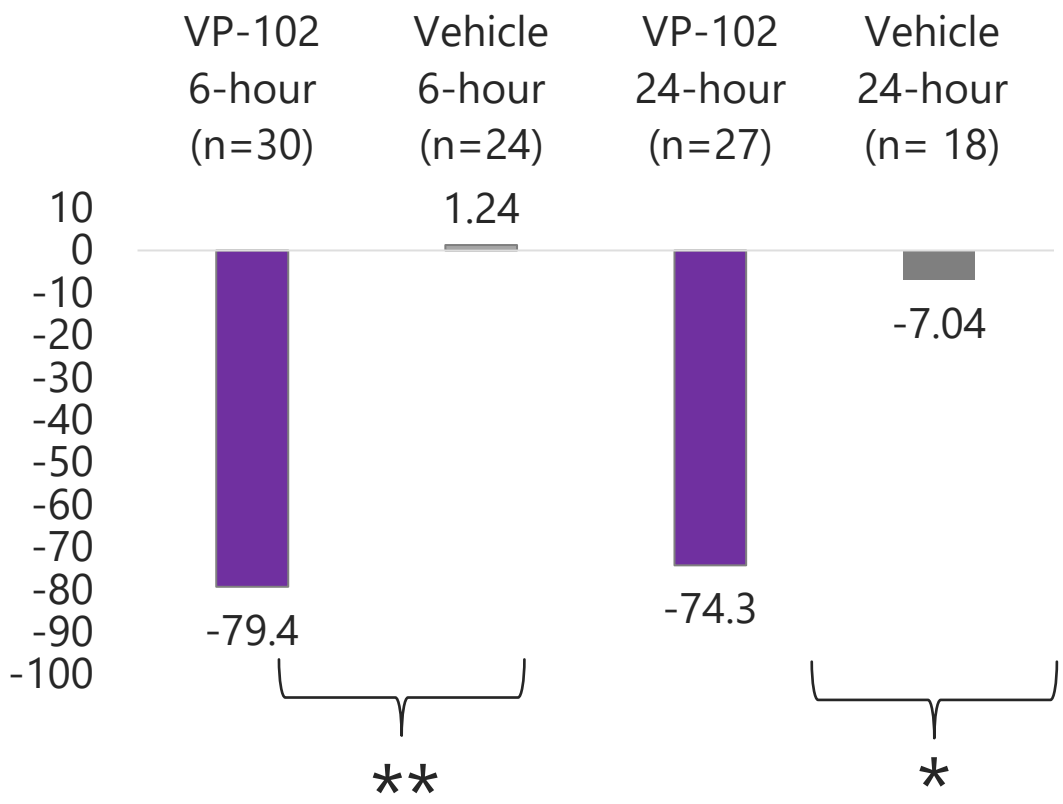
(1) Guenthner 2020 Winter Clinical Dermatology Symposium

Efficacy (CARE-1, ITT Population)

Percentage of Subjects with Complete Clearance of all Baseline and New Treatable EGW Lesions[ǂ]



Mean Percentage Change in EGW Lesions from Baseline[1]



ǂPooled data from Part A and B
*P<0.001
**P≤0.0001

(1) Guenthner 2020 Winter Clinical Dermatology Symposium

Safety: Treatment Emergent Adverse Events (CARE-1, Safety Population)[1,*,‡]

TEAEs, N (%)	VP-102 6-hour (N=29)	Vehicle 6-hour (N=22)	VP-102 24-hour (N=28)	Vehicle 24-hour (N=20)
Subjects reporting at least one TEAE	29 (100.0)	15 (68.2)	28 (100.0)	9 (45.0)
Application site vesicles	25 (86.2)	0 (0.0)	26 (92.9)	1 (5.0)
Application site pain	20 (69.0)	3 (13.6)	19 (67.9)	4 (20.0)
Application site erythema	14 (48.3)	3 (13.6)	19 (67.9)	1 (5.0)
Application site pruritus	14 (48.3)	5 (22.7)	10 (35.7)	1 (5.0)
Application site scab	13 (44.8)	1 (4.5)	14 (50.0)	0 (0.0)
Application site discoloration	7 (24.1)	4 (18.2)	6 (21.4)	0 (0.0)
Application site dryness	7 (24.1)	2 (9.1)	6 (21.4)	1 (5.0)
Application site erosion	6 (20.7)	0 (0.0)	7 (25.0)	0 (0.0)
Application site edema	3 (10.3)	1 (4.5)	7 (25.0)	1 (5.0)
Application site exfoliation	3 (10.3)	2 (9.1)	5 (17.9)	0 (0.0)

TEAEs = Treatment Emergent Adverse Events

*Pooled data from Part A and B. No subjects discontinued the study due to AEs.
‡No serious adverse events as deemed related to study drug by investigator.

(1) Guenthner 2020 Winter Clinical Dermatology Symposium

VP-102 in Common Warts

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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

U.S prevalence of 22 million[1], with 1.5 million[2] diagnosed annually

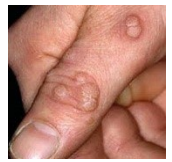
ETIOLOGY AND CLINICAL PRESENTATION

Transmission

- Skin to skin contact
- Touching of contaminated objects

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

(1) 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
(2) IQVIA Anonymous Longitudinal Patient Level Data (APLD) for 12 months ending September 2018

We Have Successfully Completed a Phase 2 Study (COVE-1) in Common Warts

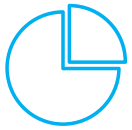
Study Design

Efficacy, safety & tolerability

Open label study with two cohorts

Cohort 1: one center

Cohort 2: four centers



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

Change from baseline in number (%) of treatable warts at Day 84

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

Cohort 1 is treated until clear, Cohort 2 receives one additional treatment at the first visit clearance was observed up to a maximum of 4 total applications

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

Paring was allowed in Cohort 2

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

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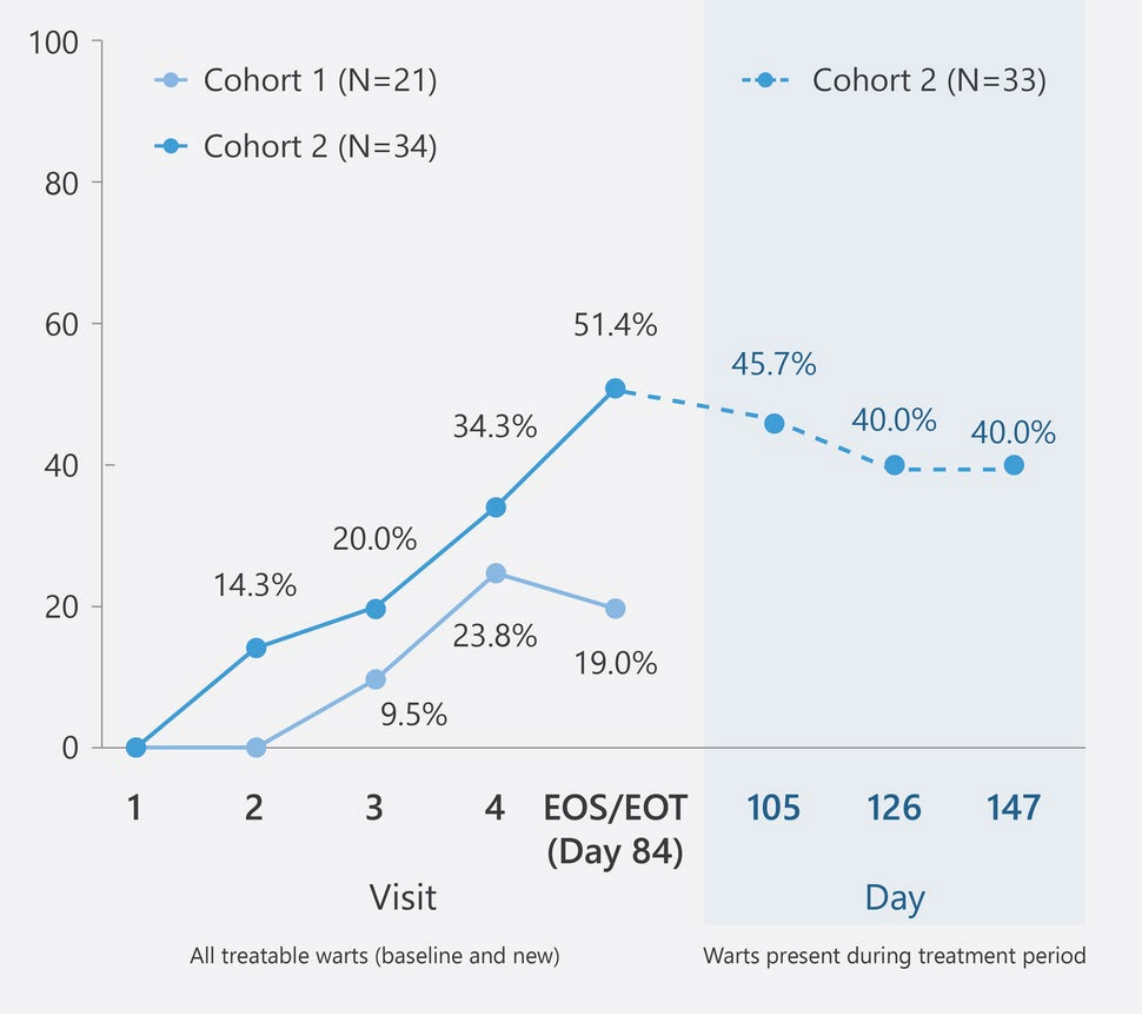
VP-102 Demonstrated Clinically Meaningful Efficacy on Primary Endpoint of Complete Clearance in COVE-1 Study[1]



(1) Guenthner 2019 Fall Clinical Dermatology Symposium

Adverse Events in COVE-1 Study (Incidence≥5%)[1,*]

	Cohort 1 N=21 (To Day 84)	Cohort 2 N=34 (To Day 147)
Incidence: N (%)		
Application Site Vesicles	20 (95.2)	27 (79.4)
Application Site Pain	15 (71.4)	26 (76.5)
Application Site Erythema	13 (61.9)	19 (55.9)
Application Site Pruritus	9 (42.9)	16 (47.1)
Application Site Scab	8 (38.1)	20 (58.8)
Application Site Dryness	6 (28.6)	13 (38.2)
Application Site Edema	4 (19.0)	6 (17.6)
Application Site Discoloration	1 (4.8)	8 (23.5)
Application Site Exfoliation	0	4 (11.8)
Application Site Erosion	0	3 (8.8)
Papilloma Viral Infection**	0	3 (8.8)

* Local skin reactions were expected due to the pharmacodynamic action of cantharidin. ** Warts reported with verbatim term of 'ring wart' and coded to MeDRA.

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(1) Guenthner 2019 Fall Clinical Dermatology Symposium

LTX-315

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LTX-315 Overview

Induces Immunogenic Cell Death and a Tumor-specific Immune Response[1]

OVERVIEW

First-in-class oncolytic peptide that is injected directly into a tumor to induce immunogenic cell death

Worldwide license in dermatological oncology[2] from Lytix Biopharma in August 2020

Verrica intends to focus initially on basal cell and squamous cell carcinomas as lead indications

FDA acceptance of IND in November 2021; First Patient Dosed in Phase 2 clinical trial for BCC in April 2022

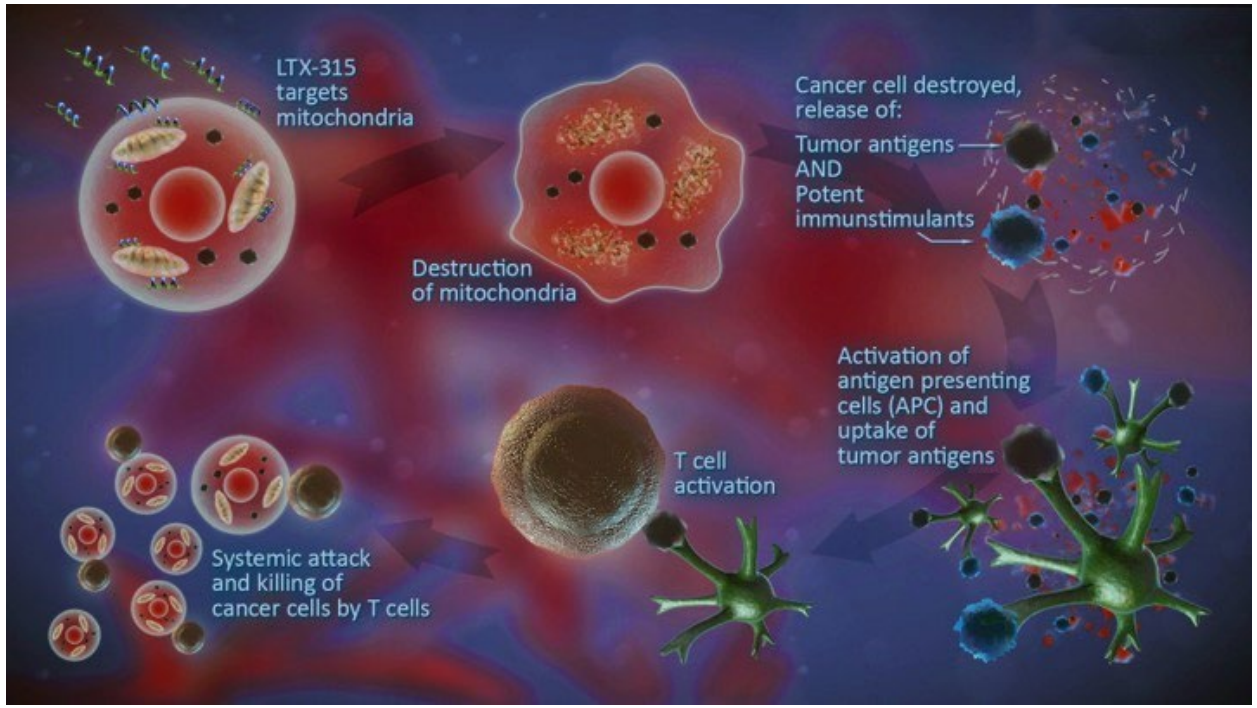
(1) Camilio *Oncoimmunology* 2014
(2) All malignant and pre-malignant dermatological indications, except for metastatic melanoma and metastatic merkel cell carcinoma

1 Kills the Tumor Cells

LTX-315 enters the cells and disturbs cell membranes, causing cell death and release of a patient's tumor specific antigens

2 Triggers Immune Responses Targeting Tumor Cells

This allows the immune system to recognize, infiltrate, and attack cancer cells via dendritic cells and cytotoxic T cells



Non-Melanoma Skin Cancer

OVERVIEW

Non-melanoma skin cancer includes basal cell and squamous cell carcinoma

Basal cell carcinoma is the most common malignancy in humans[1]

Common treatments are invasive, painful, can cause scarring, and may require destruction of healthy tissue

ETIOLOGY AND CLINICAL PRESENTATION

Patient population[1]

- Estimated 5.4 million diagnoses of basal cell (BCC) and squamous cell (SCC) carcinomas annually
- Increasing age and sun exposure are risk factors

Diagnosis & Symptoms[2,3]

- New or changing lesions on sun exposed skin
- Common on the head/neck
- BCC: Pink pearly papules with prominent blood vessels
- SCC: Pink, rough scaly papules, patches, or plaques
- Diagnosis through routine biopsy

Complications[3,4]

- Damage to healthy tissue, pain, permanent scarring
- Surgical complications include disfigurement, bleeding and infection
- Metastasis to other areas of the body/organs

(1) Rogers *JAMA Derm* 2015; https://www.aad.org/media/stats-skin-cancer; https://www.skincancer.org/skin-cancer-information/skin-cancer-facts/
(2) Combalia *Derm Practic & Concept* 2020
(3) Gruber *StatPearls* 2020
(4) Bailey *Int J of Wom Derm* 2019

Current Treatments For Non-Melanoma Skin Cancer[1-3]

Invasive procedures may lead to permanent scarring, pain, damage to healthy tissue, and recurrence

	DESCRIPTION	LIMITATIONS
Surgical Excision	Using a scalpel to remove diseased tissue and healthy skin	• Invasive • Can cause scarring/disfigurement, infection, pain
Mohs Surgery	Used in high risk NMSC or in special sites	• Invasive, may take several rounds • Can cause scarring, disfigurement and pain
Electrodessication and Curettage	Minor surgical procedure to remove diseased tissue with sharp tool and cauterize the area	• Invasive • Painful • Likely to cause scarring
Topical Agents	5-FU, ingenol mebutate, or imiquimod	• May only be efficacious in small, superficial tumors • Local inflammatory reactions, systemic size effects
Oral Therapy	ERIVEDGE® (vismodegib)[4]	• Approval limited to small subset of BCC and metastatic BCC • Systemic side effects
Oral Therapy	ODOMZO® (sonidegib)[5]	• Approval limited to small subset of BCC and metastatic BCC • Systemic side effects

(1) Camilio *Oncoimmunology* 2014
(2) Combalia *Derm Practic & Concept* 2020
(3) Bailey *Int J of Wom Derm* 2019

(4) Per Prescribing Information: a hedgehog pathway inhibitor indicated for the treatment of adults with metastatic basal cell carcinoma, or with locally advanced basal cell carcinoma that has recurred following surgery or who are not candidates for surgery and who are not candidates for radiation.
(5) Per Prescribing Information: a hedgehog pathway inhibitor indicated for the treatment of adult patients with locally advanced basal cell carcinoma (BCC) that has recurred following surgery or radiation therapy, or those who are not candidates for surgery or radiation therapy.

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Regulatory Exclusivity and Intellectual Property

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Verrica has Several Potential Ways to Maintain Exclusivity for VP-102

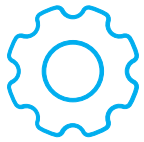
Regulatory Exclusivity

5 years of exclusivity for cantharidin as API potentially available upon approval (potential for additional 6 months for pediatric exclusivity for common warts and plantar warts indications)

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 YCANTH™ (VP-102) and potential competitors

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

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

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Overview of VP-102/103 Intellectual Property Portfolio

KEY CLAIMS AND PATENT APPLICATIONS	VALUE TO VERRICA
1 Our specific formulation, YCANTH™ (VP-102), key safety additions and novel cantharidin formulations (PCT/US2014/052184) (PCT/US2018/036353)	May prevent generics from copying our ether-free formulation or from making similar formulations
Single use applicator containing cantharidin formulations (PCT/US2014/052184) (PCT/US2018/037808)	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/US2018/037808) (US 29/607744)	May prevent generics from utilizing a similar applicator Design patent application allowed in the US
3 Methods of use for cantharidin in the treatment of molluscum (PCT/US2018/037808 and PCT/US2018/036353) (PCT/US2014/052184)	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) (PCT/US2018/054373)	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

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Overview of LTX-315 Intellectual Property Portfolio

Product	Description	EU	US	JP	Other (*, pending)
LTX-315 PCT/EP2009/006744	Composition-of-matter claims	Granted[1], expires 2029	Granted, expires 2032	Granted, expires 2029	AU, BR*, CA, CN, IN, NZ, KR, RU, SG
LTX-315 T cell clonality PCT/EP 2017/05229	Methods-of-use claims	Pending, expires 2037	Pending, expires 2037	Pending, expires 2037	AU*, CN*, KR*

[1] In force in: UK, Belgium, Denmark, Finland, France, Germany, Italy, Netherlands, Norway, Poland, Spain, Sweden, Switzerland and Turkey

Investor Relations—NASDAQ: VRCA

Analyst Coverage[1]
Ken Cacciatore, Cowen
Oren Livnat, H.C. Wainwright
Serge Belanger, Needham
Greg Renza, RBC Capital Markets
Kemp Dolliver, Brookline Capital Markets

As of March 31, 2022

- Cash and marketable securities: $21.9M (excludes restricted cash)
- Debt: $40M
- Outstanding shares: 27.5M
- Outstanding option shares and RSUs: 4.2M

(1) Disclaimer: Any opinions, estimates or forecasts regarding Verrica's performance made by the above-referenced analysts are theirs alone and do not represent opinions, forecasts or predictions of Verrica or its management, and no endorsement of such opinions, estimates or forecasts shall be implied.

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Investment Highlights

Focused on Clinician-Administered Therapies With Potential for Reimbursement as a Medical Benefit

YCANTH™ (VP-102)

- In Development to Address Two of the Largest Unmet Needs in Dermatology
  - U.S. prevalence of ~6 million in molluscum contagiosum[(1)] and ~22 million in common warts[(2)]
  - No FDA-approved drugs to treat molluscum or warts
- Innovative Product Candidate
  - Proprietary drug-device combination of formulation and single-use applicator
- Physician Acceptance
  - 95% of Pediatric Dermatologists have used API[(3)]
- Payer Research Suggests Favorable Reimbursement Landscape
- Exclusive License for Torii Pharmaceutical to Develop and Commercialize VP-102 in Japan
- NDA resubmission expected Q1 2023

Dermatological Oncology

- Worldwide rights for dermatological oncology, including basal cell and squamous cell carcinomas and non-metastatic melanoma, to LTX-315
  - First-in-class oncolytic peptide injected directly into tumor
- Positive tumor-specific immune cell responses in multi-indication Phase 1/2 oncology trials
- Verrica to focus initially on development to treat basal cell and squamous cell carcinomas
- 5.4 million diagnoses annually in the U.S. of basal and squamous cell skin cancers[(4)]; patients typically treated with surgery
- FDA acceptance of IND in November 2021; first patient dosed in Phase 2 study for treatment of Basal Cell Carcinoma in April 2022

Proven Team and Strong Balance Sheet

- Industry-leading, experienced management team with extensive dermatology product launch experience
- $21.9M cash, cash equivalents and marketable securities as of March 31, 2022 (excludes restricted cash).

(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.
(4) Rogers JAMA Derm 2015; https://www.aad.org/media/stats-skin-cancer; https://www.skincancer.org/skin-cancer-information/skin-cancer-facts/
(5) Timing of clinical trials subject to change.

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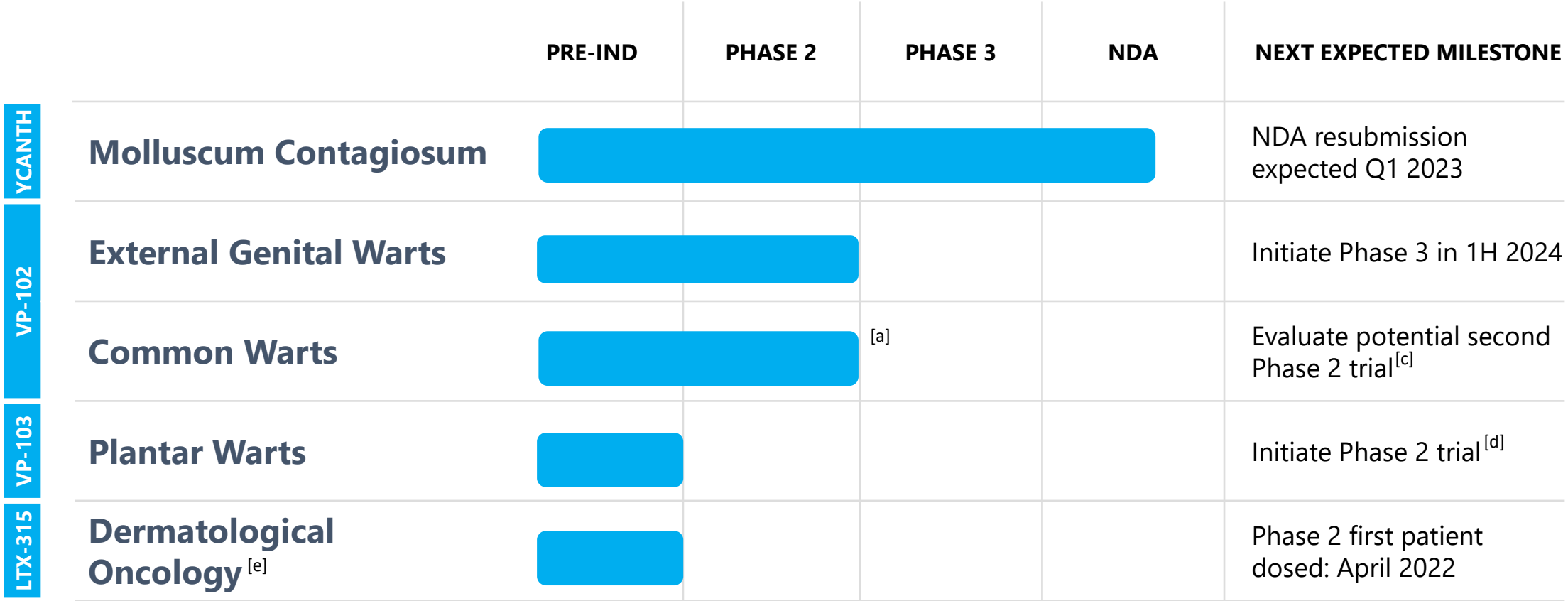
Our Product Portfolio



[a] Originally designed Phase 2 program completed.
[b] Timing of clinical trials for External Genital Warts may be subject to change.
[c] Company evaluating potential for conducting an additional Phase 2 trial based on FDA feedback for Phase 3 trial protocol.
[d] Timing for initiating clinical trials for Plantar Warts to be determined.
[e] License excludes metastatic melanoma and metastatic merkel cell carcinoma. Phase 2 study initiated in April 2022 for the treatment of Basal Cell Carcinoma.

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Management Team with Extensive Product Launch and Dermatology Experience

Ted White

President & Chief Executive Officer

NOVARTIS

AQUA PHARMACEUTICALS an Almirall company

Terry Kohler

Chief Financial Officer

endo

Johnson & Johnson

Gary Goldenberg, MD

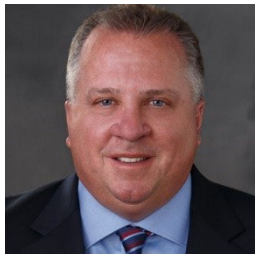
Chief Medical Officer

Icahn School of Medicine at Mount Sinai

GOLDENBERG DERMATOLOGY

TEMPLE UNIVERSITY

WAKE FOREST UNIVERSITY



Joe Bonaccorso

Chief Commercial Officer

NOVARTIS

Pierre Fabre

Selected Launched Products

Diovan 80 mg · 160 mg valsartan capsules

LAMISIL SINGELDOS

ELIDEL Pimecrolimus Cream 10 mg/g

Hemangeol PROPRANOLOL HYDROCHLORIDE

Acticlate (Doxycycline Hyclate USP) Tablets 75 mg 150 mg

Appendix

Late-stage dermatology therapeutics company

Reinventing dermatology therapeutics by focusing on development and commercialization

Molluscum Clinical Evidence

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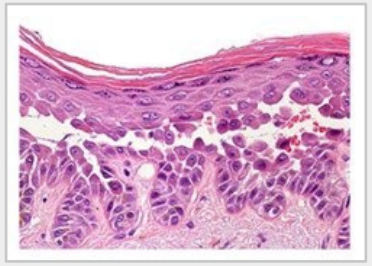
Cantharidin Elicits a Dual Response in the Skin

1 Superficial blistering of lesional skin

Cantharidin is a vesicant, causing the pharmacodynamic response of blistering in the skin.

Once applied, cantharidin activates neutral serine proteases that cause degeneration of the desmosomal plaque and intraepidermal blistering.(1)



Desmosome Cleavage and Blister Formation

2 Elicits Inflammation & Immune Response

Cantharidin stimulates leukocyte infiltration (e.g., neutrophils, macrophages, B and T cells and eosinophils) and the release of chemokines and cytokines including TNF-a, IL-8 and CXCL-5.(2)

Lymphocyte Neutrophil Eosinophil Macrophage

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(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 YCANTH™ (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	• N=266 • Conducted under SPA • Randomized, double blind, multi-center, placebo controlled	• 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 3	**Pivotal Trial CAMP-2** Complete	VP-102	• N=262 • Randomized, double blind, multi-center, placebo controlled	• 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	• Open-label, single-center • N=33	• To determine possible systemic exposure from a single 24-hour application of VP-102 • To confirm safety and efficacy with applicator
PHASE 2	**Pilot Trial** Complete	Our proprietary formula of cantharidin used in VP-102, applied with the wooden stick part of a cotton-tipped swab	• Open-label, single-center • N=30	• To evaluate safety and efficacy and determine optimal treatment duration

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Demographics in Phase 3 Trials[1]

	VP-102 (n=310)	Vehicle (n=218)
Age (years)		
Mean (SD)	7.5 ± 6.7	6.8 ± 5.8
Median	6.0	6.0
Range	2-60	2-54
Age Group - no.(%)		
≥ 2 to 5 yr	137 (44.2)	106 (48.6)
≥6 to 11 yr	140 (45.2)	89 (40.8)
≥12-18 yr	22 (7.1)	18 (8.3)
≥ 19 yr	11 (3.5)	5 (2.3)
Gender – no. (%)		
Female	154 (49.7)	107 (49.1)
Male	156 (50.3)	111 (50.9)
Race or Ethnic Group – no. (%)		
White	277 (89.4)	202 (92.7)
Black or African American	13 (4.2)	8 (3.7)
Asian	6 (1.9)	1 (0.5)
American Indian/Alaskan Native	0	1 (0.5)
Other	14 (4.5)	6 (2.8)

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Note: Slide reflects pooled data from Phase 3 molluscum trials (CAMP-1 and CAMP-2)

(1) Eichenfield *Amer J Clin Derm* 2021

Safety Summary for Molluscum Phase 3 Trials[1]

Incidence of Treatment Emergent Adverse Events (TEAEs) ≥5%

	VP-102 (N=311)	Vehicle (N=216)
At Least One Incidence: N (%)		
Application Site Vesicles	298 (95.8)	63 (29.2)
Application Site Pain	193 (62.1)	36 (16.7)
Application Site Pruritus	169 (54.3)	75 (34.7)
Application Site Scab	147 (47.3)	47 (21.8)
Application Site Erythema	139 (44.7)	58 (26.9)
Application Site Discoloration	100 (32.2)	27 (12.5)
Application Site Dryness	63 (20.3)	31 (14.4)
Application Site Edema	29 (9.3)	10 (4.6)
Application Site Erosion	22 (7.1)	2 (0.9)

Treatment Emergent Adverse Events (TEAEs) ≥5% by Severity

	VP-102 (N=311)			Vehicle (N=216)		
At Least One Incidence: N (%)	**Mild**	**Moderate**	**Severe**	**Mild**	**Moderate**	**Severe**
Application Site Vesicles	187 (60.1)	100 (32.2)	11 (3.5)	59 (27.3)	4 (1.9)	0
Application Site Pruritus	145 (46.6)	23 (7.4)	1 (0.3)	62 (28.7)	13 (6.0)	0
Application Site Pain	127 (40.8)	59 (19.0)	7 (2.3)	34 (15.7)	2 (0.9)	0
Application Site Scab	120 (38.6)	27 (8.7)	0	44 (20.4)	3 (1.4)	0
Application Site Discoloration	87 (28.0)	12 (3.9)	1 (0.3)	25 (11.6)	2 (0.9)	0
Application Site Erythema	73 (23.5)	65 (20.9)	1 (0.3)	43 (19.9)	15 (6.9)	0
Application Site Dryness	58 (18.6)	5 (1.6)	0	30 (13.9)	1 (0.5)	0
Application Site Edema	21 (6.8)	8 (2.6)	0	7 (3.2)	3 (1.4)	0
Application Site Erosion	20 (6.4)	2 (0.6)	0	2 (0.9)	0	0

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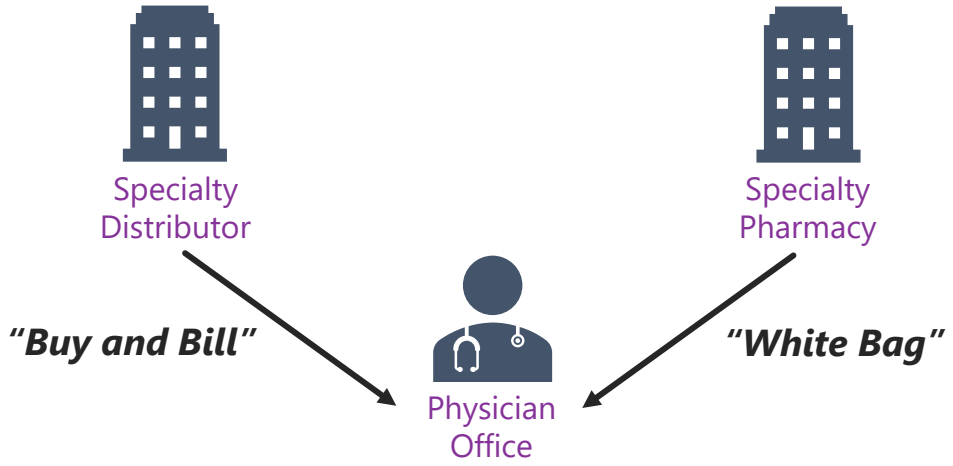
Note: Slide reflects pooled data from Phase 3 molluscum trials (CAMP-1 and CAMP-2)

(1) Eichenfield *JAMA Derm* 2020

YCANTH™ (VP-102) Designed to be Clinician-Administered and Intend to Distribute Through Specialty Product Channels, if Approved



Potential Physician Reimbursement Opportunities	
"Buy and Bill"	**"White Bag"**
Office visit	Office visit
Procedure for lesion destruction	Procedure for lesion destruction
YCANTH™ (VP-102) = (ASP + X%)	

Distribution model will be supported by a patient and HCP services platform (HUB)

- Benefits investigation/verification to determine coverage
- Full reimbursement support for miscellaneous J-code under medical benefit (1)
- Prior authorization support
- Co-pay/co-insurance assistance

Dedicated field reimbursement team to support physician offices

(1) Verrica intends to file for a product-specific J-code for VP-102

Note: For illustrative purposes only. If approved, actual distribution channels and support services may change as strategy is finalized.

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 7% of 503B compounders produce formulations containing cantharidin(1)

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Reinventing Skin Science

(1) Based on 57 503B facilities and 4 compounders of cantharidin per FDA database (January – June 2019).