SYD-101 (0.01%)

for the Slowing of Myopia Progression in Children

October 30, 2026

Dermatologic and Ophthalmic Drugs Advisory Committee

Sydnexis, Inc.

SYD-101 (0.01%)

for the Slowing of Myopia Progression in Children

Patrick Johnson, PhD

President

Sydnexis, Inc.

Myopia Progresses Most Rapidly in Younger Children

Pediatric Progressive Myopia

- Progressive disease in which irreversible refractive error accumulates during childhood
- Worsening myopia increases lifetime risk of serious ocular complications

Natural History of Myopia Progression

- Progresses most rapidly in young children and slows in adolescence
- Earlier onset = faster initial progression and more years for irreversible accumulation

Low-Dose Atropine is an Established Treatment for Slowing Pediatric Myopia Progression

>3 decades
of randomized research

>30
placebo-controlled trials

Lower doses
Proven to optimize efficacy, tolerability, rebound risk

13 randomized trials
Evaluating atropine 0.01% for ≥ 24 months duration

Recognized by major medical associations
Established part of routine clinical practice

SYD-101 Developed to Address Need for a Stable, Standardized Formulation of Low-Dose Atropine

SYD-101 (0.01%)

Atropine sulfate ophthalmic solution

- **Stable, standardized, and quality-controlled**
- **Improves ocular exposure and protects from degradation**
- **Near-physiologic pH formulation improves tolerability**

European Union

United Kingdom

APPROVED INDICATION FOR USE

SYD-101 (0.01%)

Children 3 to 14 years of age with documented fast-progressing myopia

Study 001 Evaluated Which Concentration Optimized Benefit-Risk in Predominantly US Population

Study 001

Randomized controlled trial

- **N = 852** (92% United States)
- **Children 3–14 years old**
- **SYD-101 0.01%, 0.03% or Vehicle**
- **36 Months – Primary treatment**
  12 Months – Randomized withdrawal

FDA provided input into the population, duration, endpoints, and methods

Primary Endpoint Met

Confirmed progression worse than –0.75 D

Key Secondary Met

Slowing of mean annual progression rate

Expected Effects by Age

Consistent with natural history of myopia

Safe and Well-Tolerated

No safety deficiency identified by FDA

Today's Meeting Will Inform FDA's Formal Dispute Resolution Process

- NDA for SYD-101 (0.01%) submitted in Dec 2024
- Division issued CRL despite study meeting pre-specified endpoints
- Concluded substantial evidence of effectiveness not demonstrated
- Sydnexis requested review through FDA Formal Dispute Resolution

Study 001 Provides Substantial Evidence of SYD-101 Effectiveness

Supports approval as first standardized, FDA-approved pharmacologic option

CRL = Complete Response Letter

Pediatric Myopia: Evidence, Practice, and Unmet Need

Rahul Bhola, MD

Medical Director of Ophthalmology, Rady Children's Hospital Orange County

Division Chief, CHOC Specialists Ophthalmology

Associate Clinical Professor, UC Irvine School of Medicine

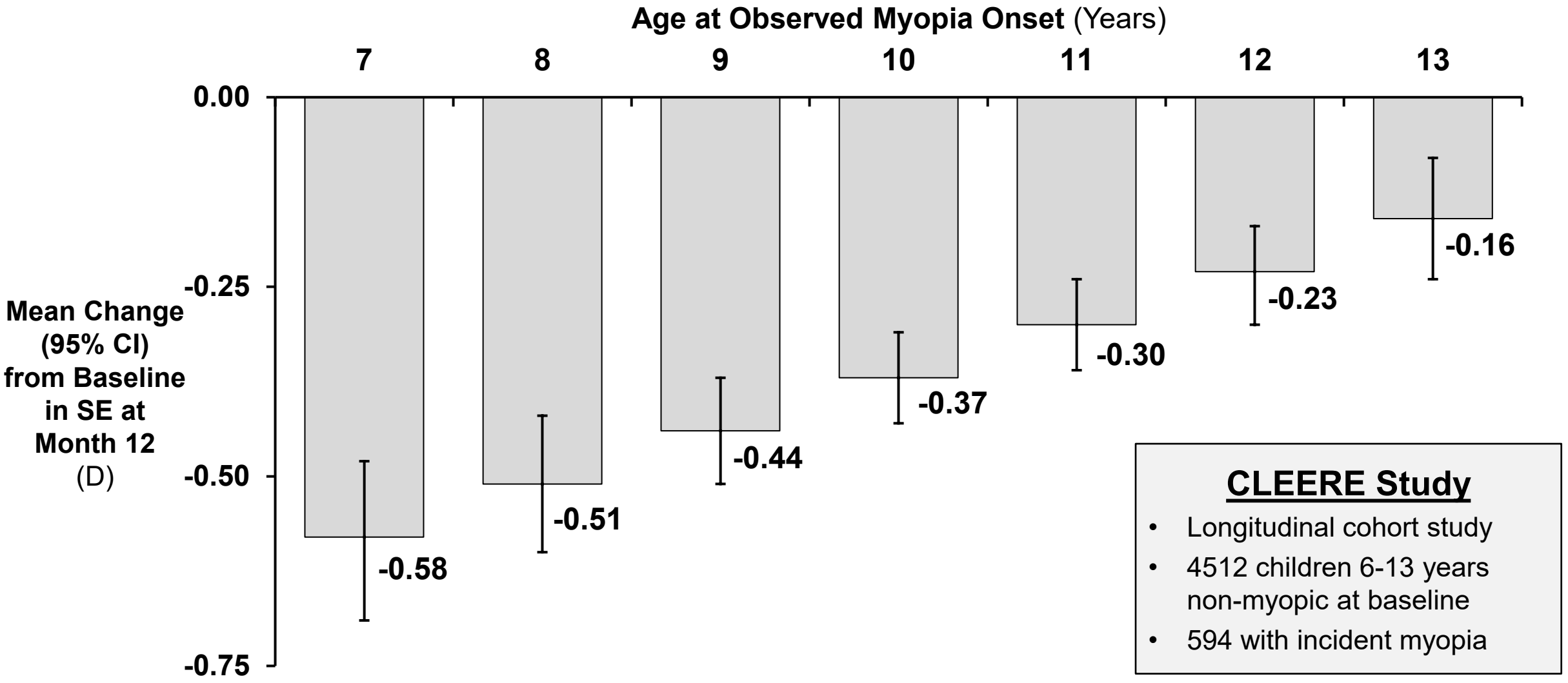
Pediatric Myopia is a Progressive, Irreversible Disease

- Myopia affects 1 in 3 children[1]
- Substantial increase in prevalence over past several decades[1]
- Irreversible refractive error accumulates throughout childhood and cannot be reversed
- Severe myopia associated with serious long-term complications

Treatment Goal	**Slow disease progression and reduce amount of irreversible refractive error carried into adulthood**

1. Liang et. al., Br J Ophthalmol. 2024

Myopia Progression is Fastest in Younger Children



CLEERE Study

- Longitudinal cohort study
- 4512 children 6-13 years non-myopic at baseline
- 594 with incident myopia

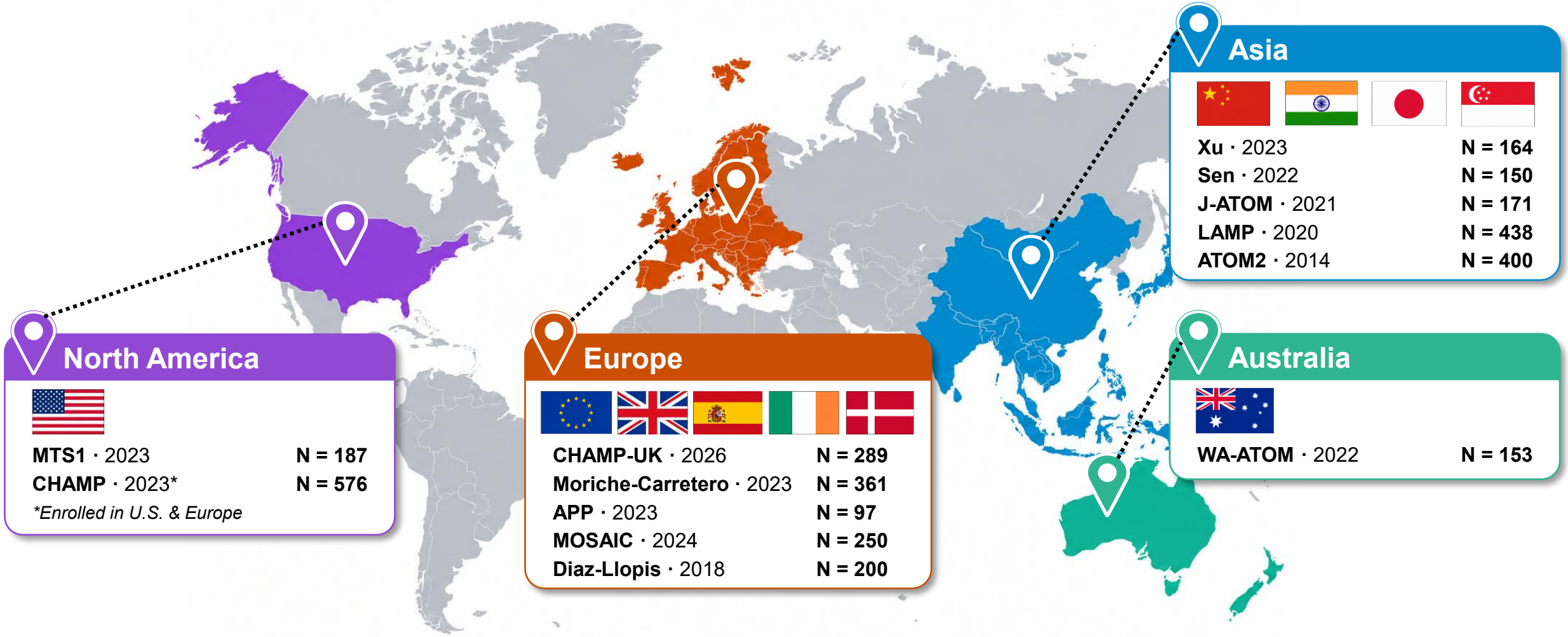
Zadnik et. al.; JAMA Ophthalmol. 2015;133:683. Jones-Jordan et. al., Invest Ophthalmol Vis Sci. 2021;62:36.

Safety and Efficacy of Atropine 0.01% Studied Around the World for More than 3 Decades

13 randomized-controlled trials

≥ 24 months follow-up

8 of 13 conducted outside Asia



North America

MTS1 · 2023	**N = 187**
CHAMP · 2023*	**N = 576**

**Enrolled in U.S. & Europe*

Europe

CHAMP-UK · 2026	**N = 289**
Moriche-Carretero · 2023	**N = 361**
APP · 2023	**N = 97**
MOSAIC · 2024	**N = 250**
Diaz-Llopis · 2018	**N = 200**

Asia

Xu · 2023	**N = 164**
Sen · 2022	**N = 150**
J-ATOM · 2021	**N = 171**
LAMP · 2020	**N = 438**
ATOM2 · 2014	**N = 400**

Australia

WA-ATOM · 2022	**N = 153**

Randomized Evidence Supports Atropine 0.01% Across Diverse Populations

Study	Timepoint (Months)	Age Range (Years)	Treatment Effect (0.01% vs Control)
Sen	24	5 – 15	0.58 D
Moriche-Carretero	36	6.7 ± 1.9	0.56 D
CHAMP-UK	24	6 – 12	0.33 D
APP	24	6 – 12	0.26 D
CHAMP	36	6 – 10	0.24 D
J-ATOM	24	6 – 12	0.22 D
LAMP	12	4 – 12	0.22 D
WA-ATOM	24	6 – 16	0.14 D
MOSAIC	24	6 – 16	0.10 D
MTS1	24	5 – 12	-0.02 D

Asian Populations

Western Populations

Consistency of Evidence Has Led to Broad Clinical Acceptance

American Academy of Ophthalmology®

> ***"Level I evidence supports the use of atropine to prevent myopic progression."***
> 0.01% atropine: more sustained effect with fewer adverse effects. – **AAO**

aapos | American Association for Pediatric Ophthalmology and Strabismus

> ***"0.01% atropine has consistently been shown to be effective at decreasing the rate of increasing myopia, with fewer side effects compared to the higher doses of atropine."*** **- AAPOS**

World Health Organization

aapos | American Association for Pediatric Ophthalmology and Strabismus

WSPOS
World Society of Paediatric Ophthalmology and Strabismus

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

INTERNATIONAL MYOPIA INSTITUTE

AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

AMERICAN OPTOMETRIC ASSOCIATION

AMERICAN ACADEMY of OPTOMETRY

~1 Million Compounded Prescriptions Written Annually for Children in the United States[1]

Key Risks with Compounded Products[2]

POTENCY	Concentration may vary across preparations
STABILITY	May degrade over time
STERILITY	Risk of contamination, which can lead to serious ocular infection and vision loss

FDA has identified serious deficiencies at facilities producing compounded low-dose atropine[3,4]

1. Numbers based on IQVIA data, Market Scope – Market Research, and data from a leading Electronic Medical Record system.
2. Richdale et. al., Eye & Contact Lens. 2023. 3. FDA Form 483, OSRX, April 2025. 4. FDA Warning Letter, OSRX, April 2025.

Low-Dose Atropine Use is Established, Yet U.S. Children Still Lack an FDA-Approved Treatment

- Myopia progression is irreversible and age-dependent
- Low-dose atropine efficacious for slowing of pediatric myopia
  - Recommended by guidelines
  - Approved products are available in many countries
- U.S. patients still dependent on compounded preparations
- **Children need a standardized, FDA-approved drug**

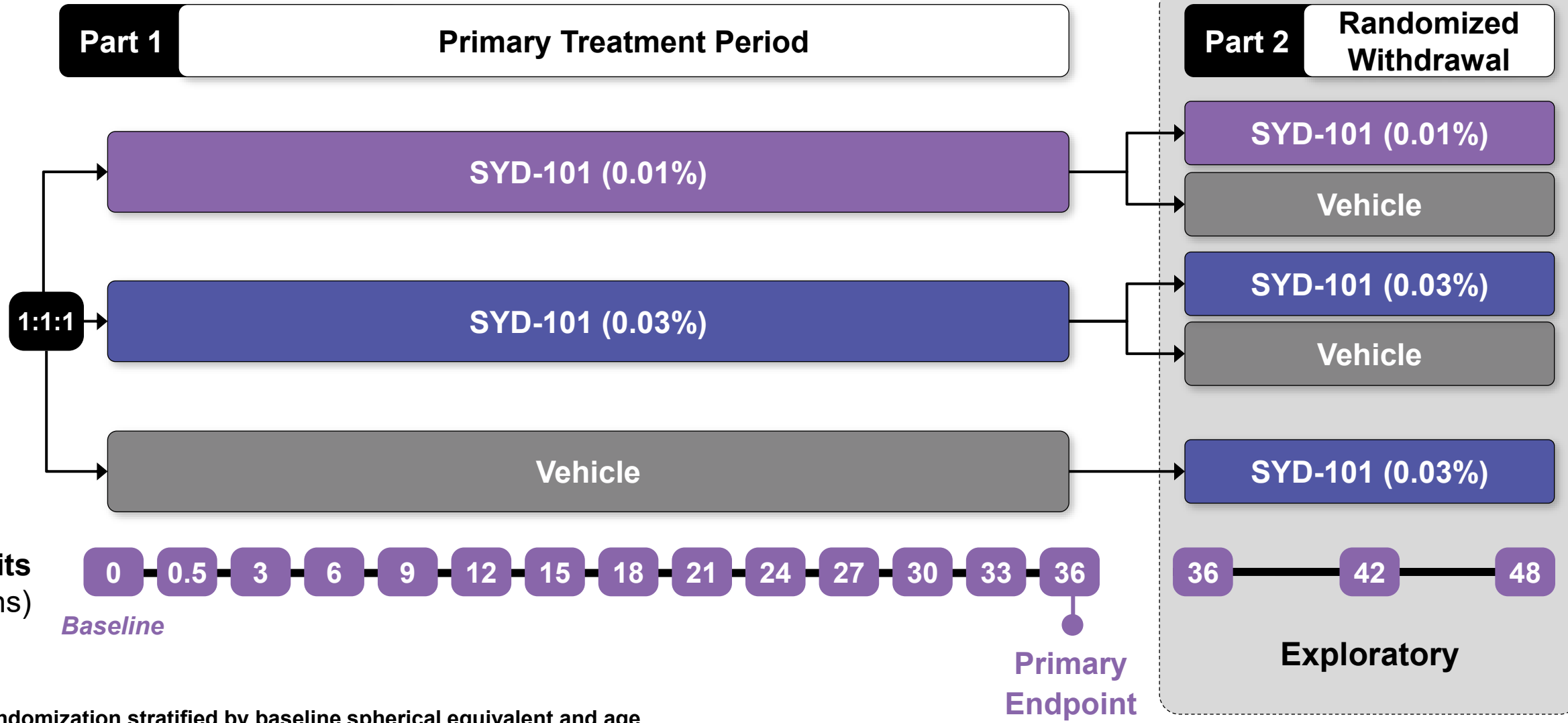
Study 001 Part 1 – Efficacy

Tina Rutar, MD

Pediatric Ophthalmologist

Cataract and Laser Institute of Southern Oregon

Study 001: Phase 3, Multicenter, Randomized, Double-Masked, Vehicle-Controlled Trial



Part 1: Randomization stratified by baseline spherical equivalent and age
Part 2: Re-randomization at Month 36 not stratified

Baseline Characteristics Well Balanced Across Treatment Groups

		SYD-101 (0.01%) N = 282	SYD-101 (0.03%) N = 283	Vehicle N = 282
Age, years; Mean (SD)		**10.4** (2.4)	**10.2** (2.5)	**10.4** (2.4)
Age Group	**3 to < 6**	**3%**	**3%**	**3%**
	6 to < 9	**22%**	**22%**	**22%**
	9 to < 12	**39%**	**39%**	**39%**
	12 to 14	**36%**	**36%**	**36%**
Sex	**Female**	**59%**	**55%**	**53%**
Ethnicity	**Non-Hispanic**	**74%**	**75%**	**71%**
Race	**White**	**67%**	**68%**	**70%**
	Black or African American	**12%**	**8%**	**7%**
	Asian	**16%**	**19%**	**17%**
Region	**United States**	**93%**	**91%**	**92%**
	Europe	**7%**	**10%**	**9%**
Fast Progressors (≤ -0.5 D in year before enrollment)		**34%**	**36%**	**32%**

Study 001 Used Complementary Responder and Continuous Measures of Myopia Progression

PRIMARY ENDPOINT

<–0.75 D

Proportion of participants with confirmed myopic progression at or before Month 36

Consistent with 2003 DODAC

-0.50 to -0.75 D over 2–3 years identified as clinically significant

Agreed with FDA

<–0.75 D threshold agreed during study design

KEY SECONDARY ENDPOINT

APR

Mean annual progression rate of myopia through Month 36

Continuous Measure

Captures the full range of myopia progression

SYD-101 (0.01%) Demonstrated a Statistically Significant Reduction in Myopia Progression Compared to Vehicle

Confirmed Myopic Progression < –0.75 D at or before Month 36	Full Analysis Set		
	SYD-101 (0.01%) N = 282	SYD-101 (0.03%) N = 283	Vehicle N = 282
Participants, %	**39.5%**	**43.1%**	**49.3%**
Difference vs vehicle, percentage points (95% CI)	**-9.6** (-17.9, -1.3)	**-6.2** (-14.2, 1.9)	
p-value	**0.0226**	**0.1319**	

SYD-101 (0.01%) Demonstrated Statistically Significant Reduction in Annual Progression Rate

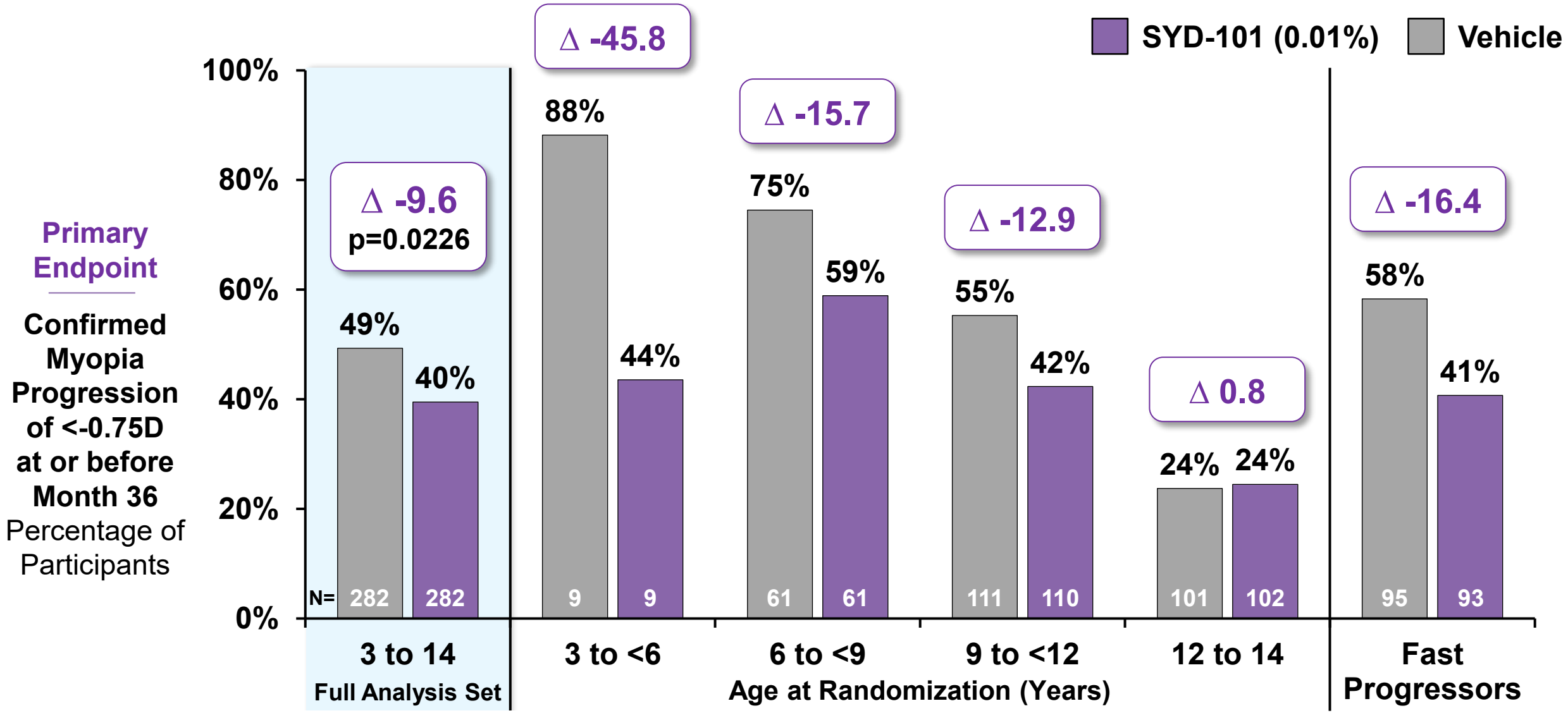
Annual Progression Rate, D/year	Full Analysis Set		
	SYD-101 (0.01%) N = 282	SYD-101 (0.03%) N = 283	Vehicle N = 282
LS Mean Rate	**-0.30**	**-0.32**	**-0.38**
Difference vs vehicle (95% CI)	**0.079** (0.038, 0.120)	**0.067** (0.025, 0.108)	
p-value	**0.0002**	**0.0018***	

*Nominal p-value

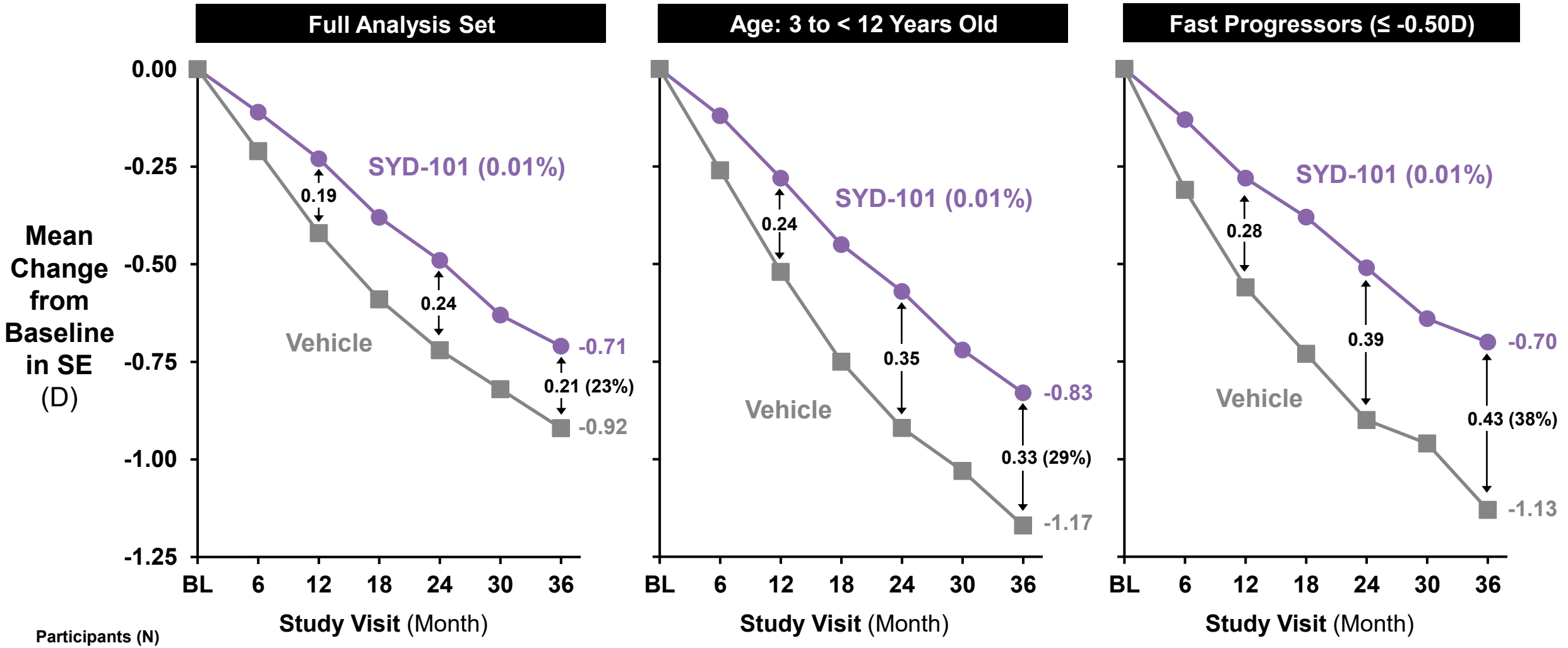
Study 001 Identified 0.01% as the Optimal Concentration of SYD-101

- SYD-101 0.03% did not provide greater efficacy than 0.01%
- Higher concentrations have not consistently produced larger treatment effects in low-dose atropine trials
  - CHAMP: 0.01% more effective than 0.02%
- Both SYD-101 concentrations showed benefit vs vehicle on continuous APR endpoint
- SYD-101 0.01% met both prespecified primary and key secondary endpoints

Treatment Effects Were Largest in Children at Greatest Risk of Progression



Cumulative Treatment Differences Were Larger in Children With More Active Disease



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SYD-101 (0.01%)	282	240	252	240	227	218	208
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SYD-101 (0.01%)	180	154	159	155	147	139	134
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	BL	6	12	18	24	30	36
SYD-101 (0.01%)	95	82	85	85	82	76	72
Vehicle	93	85	87	81	76	70	67

Treatment Effects in Study 001 Consistent with Prior Trials of Atropine 0.01%

Study	Timepoint (Months)	Age Range (Years)	Treatment Effect (0.01% vs Control)
Sen	24	5 – 15	0.58 D
Moriche-Carretero	36	6.7 ± 1.9	0.56 D
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MTS1	24	5 – 12	-0.02 D

Study 001 (36 Months)

- 0.43 D | Fast Progressors
- 0.33 D | 3 – <12 years
- 0.21 D | FAS (3 – 14 years)

Study 001 Part 2

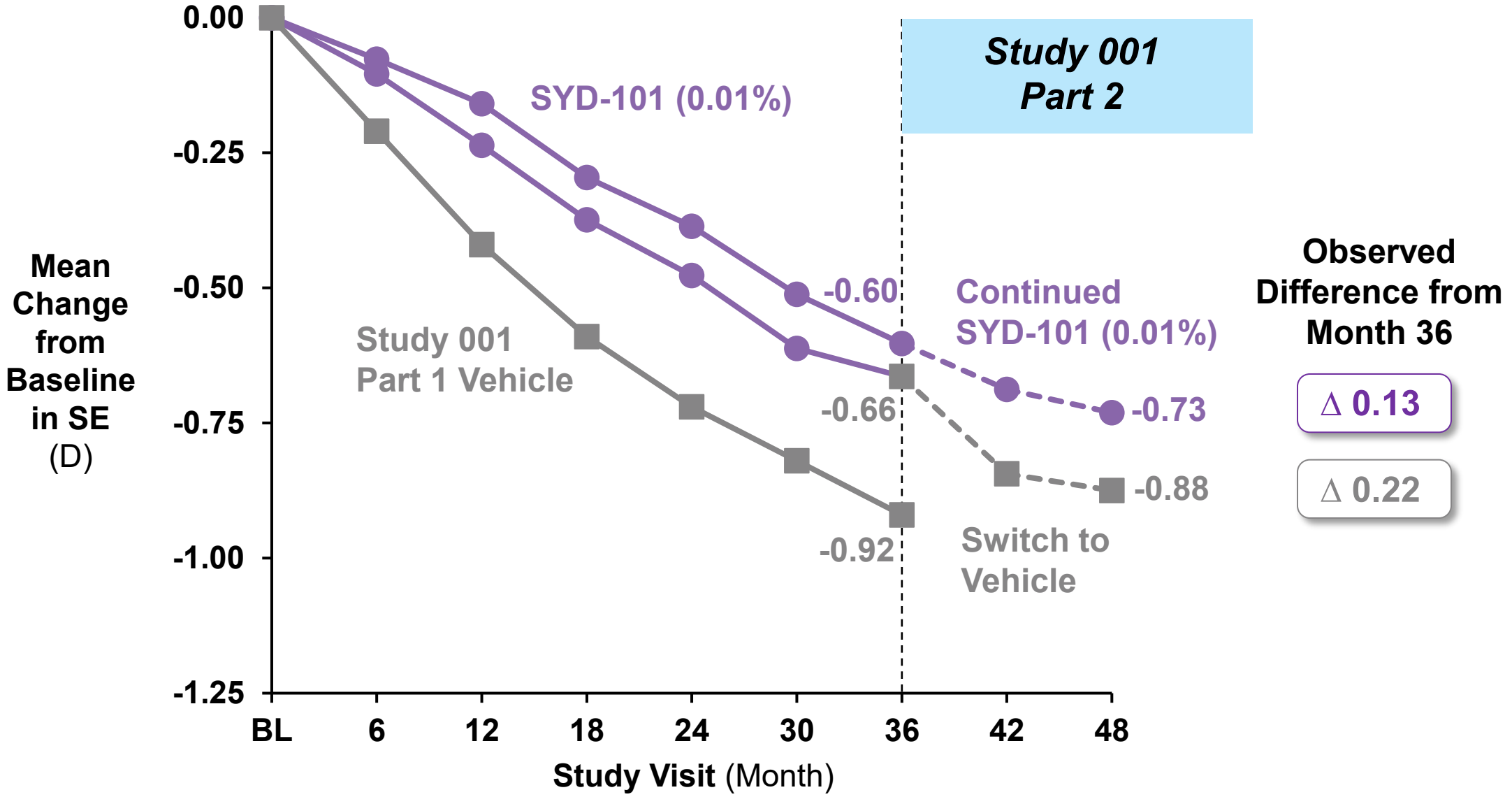
Randomized Withdrawal Phase

Part 2 of Study 001 Investigated Potential for Rebound After Treatment Withdrawal

Study 001 – Part 2

- No pre-specified imputation for missing data
- No formal hypothesis testing
- Rerandomization at Month 36 was not stratified
- All analyses were exploratory and performed using observed data
- Median age at 36 months = 13.4 years

Exploratory Part 2 Showed Modestly Greater Progression After 0.01% Withdrawal Than With Continued Treatment



Study 001 Part 1 – Safety

Overall Safety Profile Similar Between SYD-101 (0.01%) and Vehicle

	SYD-101 (0.01%) N = 282	SYD-101 (0.03%) N = 283	Vehicle N = 282
Any TEAE	64.9%	72.4%	68.8%
Ocular TEAE	44.7%	57.6%	44.7%
Severe Ocular TEAE	0.4%	0.4%	0.7%
Ocular SAE	0.4%	0.4%	0.4%
Related Ocular SAE	0	0	0

FDA AND SYDNEXIS AGREE

SYD-101 0.01% has a favorable safety profile consistent with the known effects of low-dose atropine

36-month primary treatment period

Fewer Children Receiving SYD-101 (0.01%) Required Escape Medication

	Full Analysis Set		
	SYD-101 (0.01%) N = 282	SYD-101 (0.03%) N = 283	Vehicle N = 282
Received Escape Medication, n (%)	**1.8% (5)**	**3.9% (11)**	**6.7% (19)**
Difference vs vehicle (95% CI)	**-5.0** (-8.7, -1.4)	**-2.9** (-6.9, 0.9)	
p-value	**0.0033**	**0.1377**	

- **Escape Criterion:** myopia progression ≤ -2.0 D between Month 18 and 36 and myopia progression confirmed 6 months later
- **Escape Dose:** 0.03% selected to support safety database for both doses

Clinical Perspective

Robert Clark, MD

Pediatric Ophthalmologist

Associate Clinical Professor

Stein Eye Institute, UCLA

Study 001 Added U.S. Phase 3 Evidence to an Established Treatment Effect

Already Established

- Effectiveness of low-dose atropine not in debate
- Incorporated into clinical guidance
- Commercial products available globally
- Widely used in practice

Study 001 Added

- Large Phase 3 trial in a primarily U.S. population
- Standardized formulation
- Met primary and key secondary endpoints with expected results by age
- No safety concerns

Low-Dose Atropine in Clinical Practice

- Treatment tailored based on age and rate of progression
- Younger children can achieve greatest benefit
- Regular monitoring for progression
- Consider withdrawing treatment as child ages and progression slows

Why Slowing Myopia Progression Matters

- Myopia progression is progressive and irreversible
  - Risk for serious complications
  - Permanent impairment of vision
- Vision is a core life function worth preserving

Any prevention of permanent loss of visual acuity is clinically meaningful

Sydnexis Responses to FDA Issues

Janet Cheetham, PharmD
Head of Clinical Operations, Sydnexis, Inc.

Jason Connor, PhD
ConfluenceStat, LLC

Robert Clark, MD
Stein Eye Institute, UCLA

Key Efficacy Issue #1: Small Effect Size and Borderline Statistical Significance for the Primary Endpoint

Study 001 Met the Prespecified Primary Endpoint

- Prespecified elements of primary endpoint analysis
  - Primary endpoint
  - Statistical model
  - Methods for handling missing data
  - Control for multiplicity

Primary Endpoint

Significance Threshold	Observed Result	Conclusion
$p < 0.025$	$p = 0.0226$	Endpoint Met

Key Secondary Endpoint Reinforces Primary Endpoint

- Primary endpoint responder definition (<-0.75 D progression)
  - No progression and -0.74 D treated identically
  - -0.74 and -0.76 treated as fundamentally different
- Key secondary endpoint (annual progression rate) reinforces that treatment effect on progression is real
  - Continuous endpoint with more statistical power

Key Secondary Endpoint

Significance Threshold	Observed Result	Conclusion
p < 0.025	**p = 0.0002**	**Endpoint Met**

Key Efficacy Issue #2: Sensitivity to Missing Data

Missing Data Were Similar Across Treatment Groups and Did Not Favor SYD-101

- Expected rate of dropout: 7% per year (~20% over 3 years)
- Observed missing data close to expectations
  - 24.3% in SYD-101 (0.01%) vs 21.2% in Vehicle
  - Reasons for missingness and discontinuation similar
- Tipping point analyses
  - Apply incrementally worse results to missing treatment group data until p-value “tips” from significant to not
  - Since primary p-value was 0.0226, only small amount needed to tip results across 0.025 threshold

Sensitivity Analyses in FAS Changed Statistical Significance More Than the Estimated Effect

	SYD-101 0.01% vs Vehicle			
	Primary (Percentage Points)		Key Secondary (LS Mean APR, D)	
	Difference	P-value	Difference	P-value
Primary analysis: observations after escape therapy, or discontinuation for a related AE considered progressors	-9.6	0.0226	0.079	0.0002
Treatment policy for escape therapy and treatment discontinuation; classify study discontinuation for a related AE as progressor	-10.0	0.0179	0.076	0.0004
Vehicle-based MNAR imputation after escape therapy or study discontinuation for any reason (both groups)	-9.1	0.0266	0.073	0.0005
Vehicle-based MNAR imputation after escape therapy (SYD-101 only) and after study discontinuation for any reason (both groups)	-8.9	0.0317	0.069	0.0011
Study discontinuation classified as progressor	-6.7	0.0924	*Not applicable*	
Mixed model for repeated measures analysis; observations after escape therapy set to missing (no MI)	*Not applicable*		0.077	0.0005

Key Efficacy Issue #3:
Lack of Clinically Meaningful Effect on Myopia Progression

Clinical Meaningfulness Difficult to Interpret Using Differences in Group Means

- FDA points to difference between groups in mean change from baseline in SE of 0.21 D at Month 36 as clinically negligible

> *"It will not result in a meaningful reduction in a child's corrective lens prescription, nor will it provide any noticeable improvement in daily visual function."*
>
> **- FDA Briefing Document, page 31**

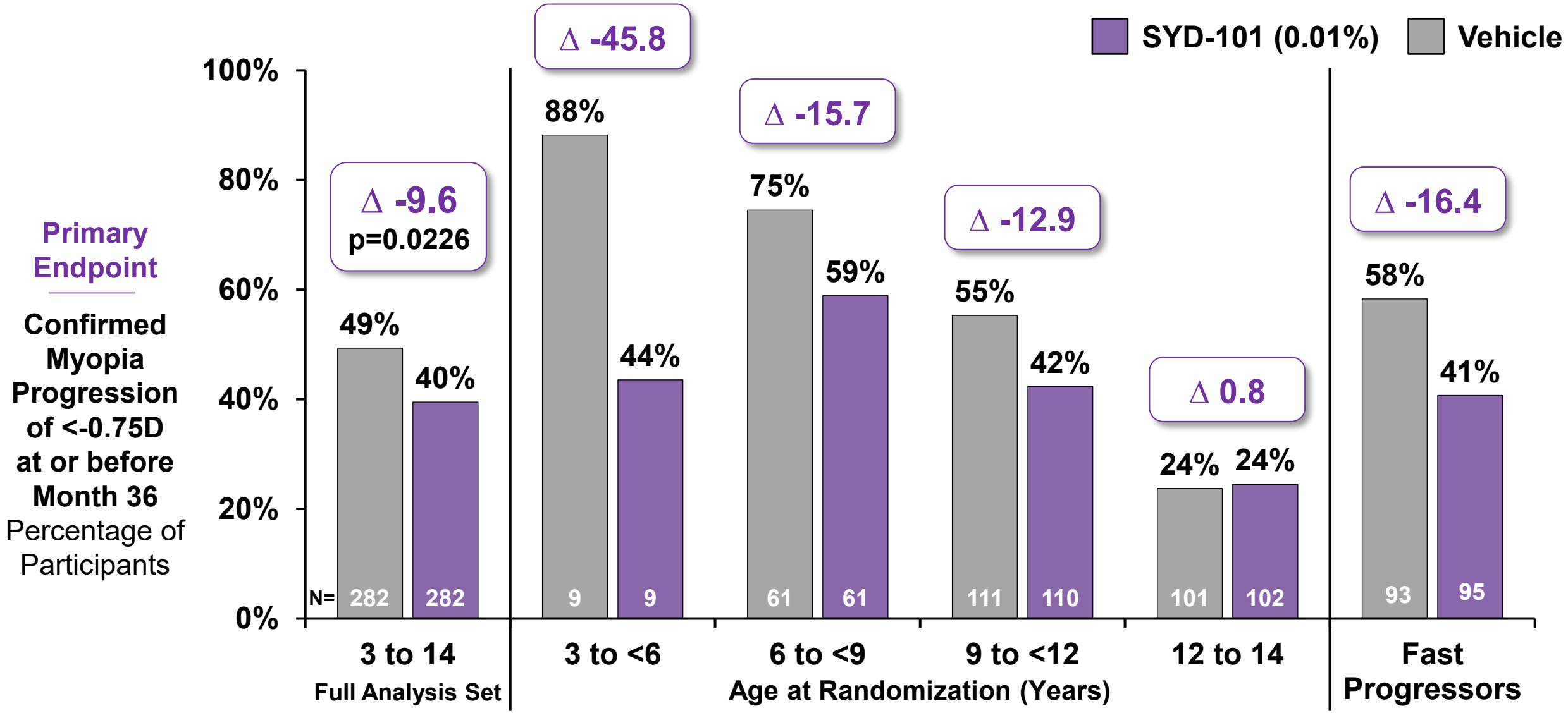
- Should not directly apply differences in mean values between groups to differences in clinical outcomes
- "Clinical meaningfulness" only has meaning at the patient level

SYD-101 Primary Endpoint Designed to Demonstrate Clinically Meaningful Benefit

- 2003 FDA Advisory Committee met to determine how to assess clinical meaningfulness in pediatric myopia trials
  - Define endpoint in meaningful terms at participant level
  - Recommendation: -0.5 to -0.75 D over 2-3 years
- Study 001 primary endpoint: Confirmed progression of worse than -0.75 D at or before Month 36
  - FDA agreed to threshold during study design

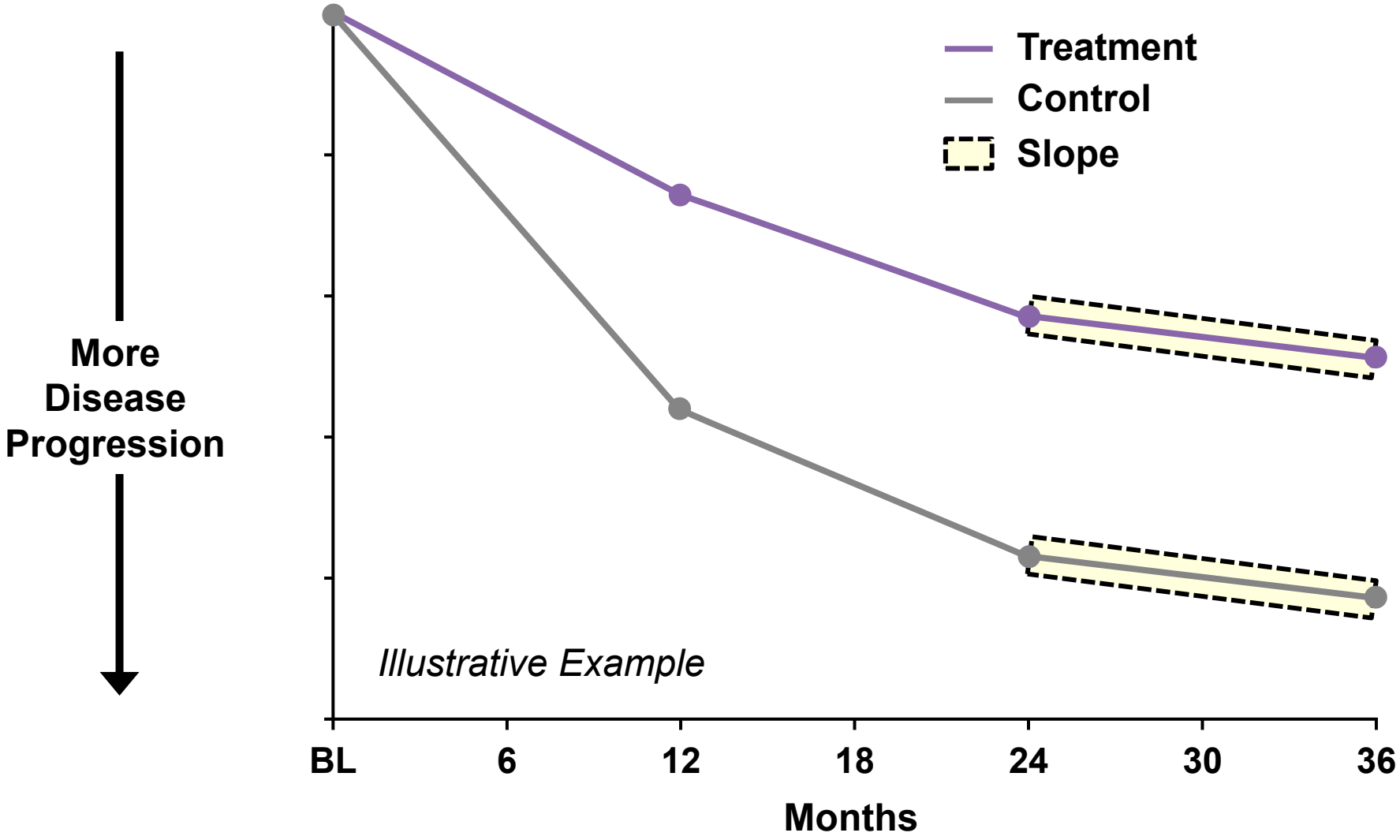
Responder analysis designed to avoid subjectivity of assessing "clinical meaningfulness" of mean changes

Treatment Effects Were Largest in Children at Greatest Risk of Progression



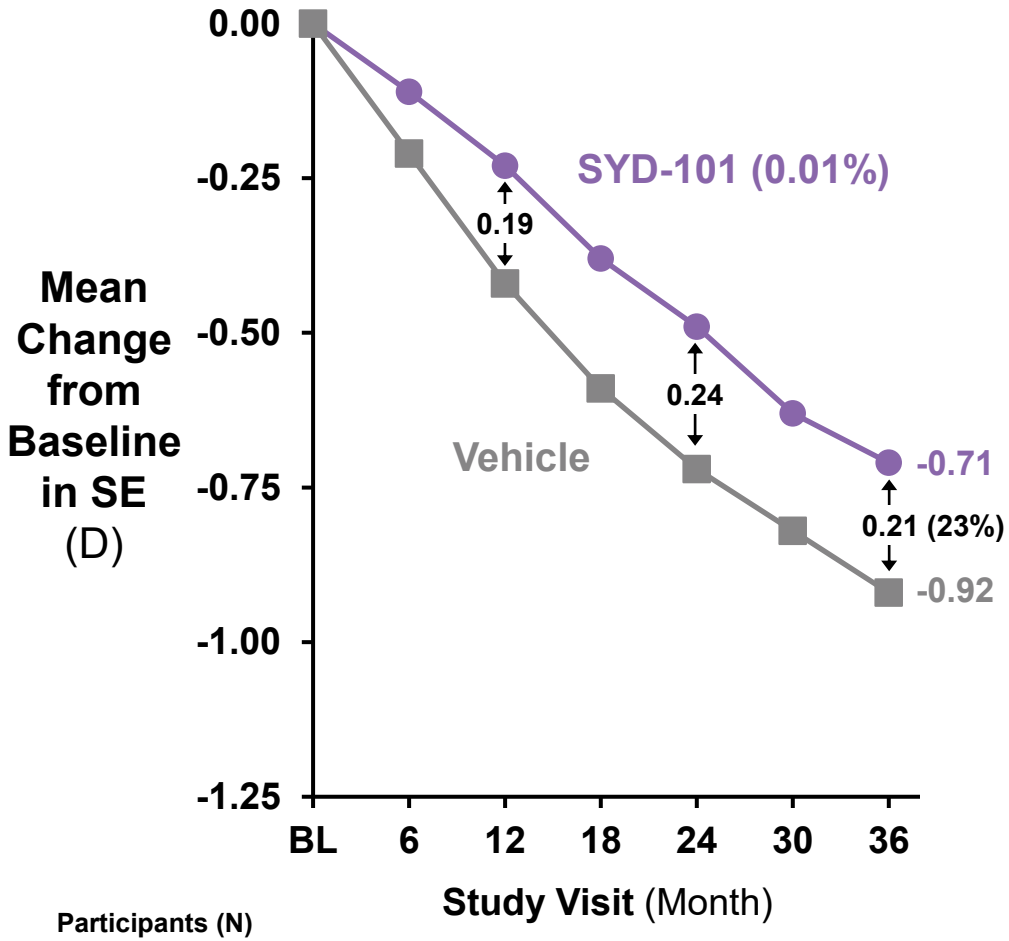
Key Efficacy Issue #4:
Declining Treatment Effect Over Time

FDA Assertion of Declining Treatment Effect Based on Changes in Annual Progression Rate



Treatment Effect Sustained Through 36 Months

Full Analysis Set



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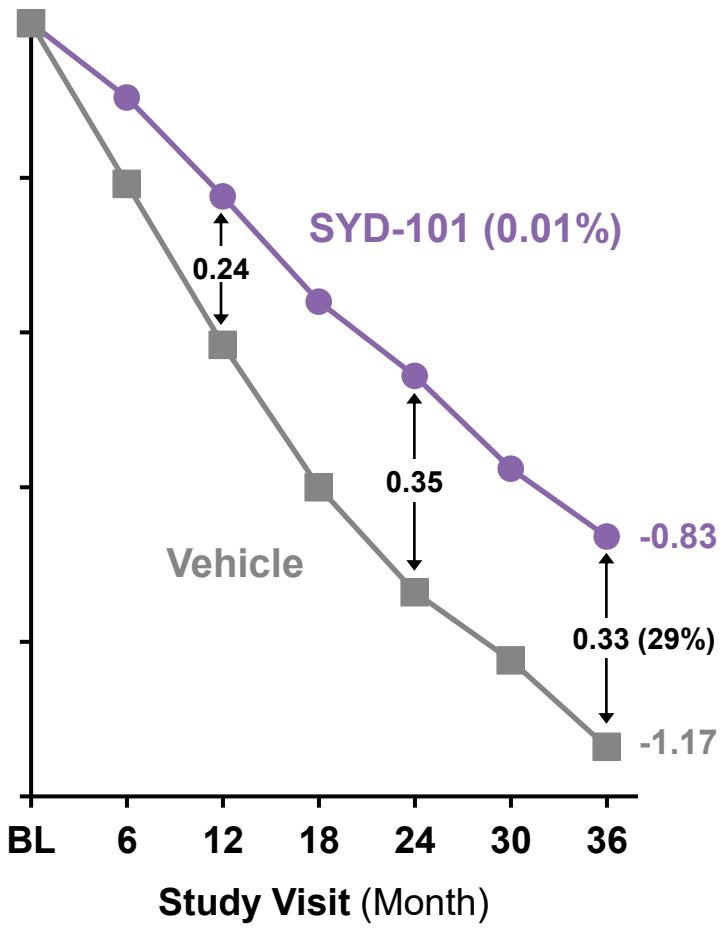
Age: 3 to < 12 Years Old



	BL	6	12	18	24	30	36
SYD-101 (0.01%)	180	154	159	155	147	139	134
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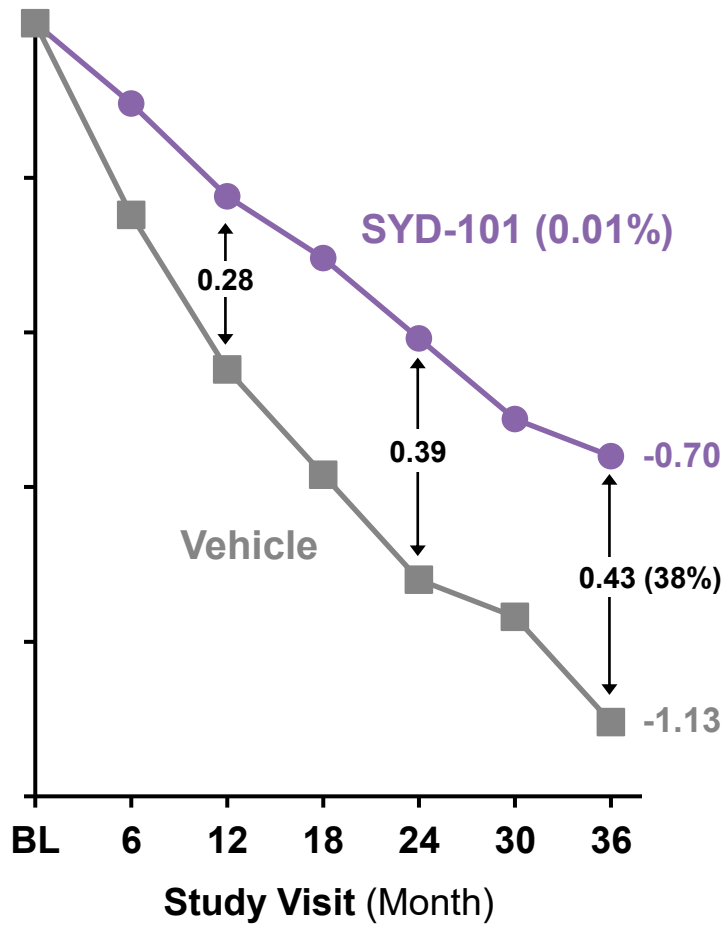
Fast Progressors (≤ -0.50D)



	BL	6	12	18	24	30	36
SYD-101 (0.01%)	95	82	85	85	82	76	72
Vehicle	93	85	87	81	76	70	67

Key Efficacy Issue #5: Lack of Effect on Axial Length and Biological Plausibility

Study 001 Axial Length Results in Context of the Literature

- Axial length recognized as important structural measure
  - Direct assessment of ocular growth
  - Associated with long-term risks for adverse ocular outcomes
- Strong correspondence between SE and axial length in atropine literature
- Study 001 showed no apparent effect with 0.01% dose
  - Mean effect: -0.01 (95% CI: -0.11, 0.08; p=0.79)

Limitations of Axial Length Data in Study 001

- In 2018, axial length not routinely incorporated in clinical practice[1] when Study 001 designed
- Potential reasons for inconclusive results
  - Only measured at sites with equipment (45% of participants)
  - No standardized approach for assessment across sites

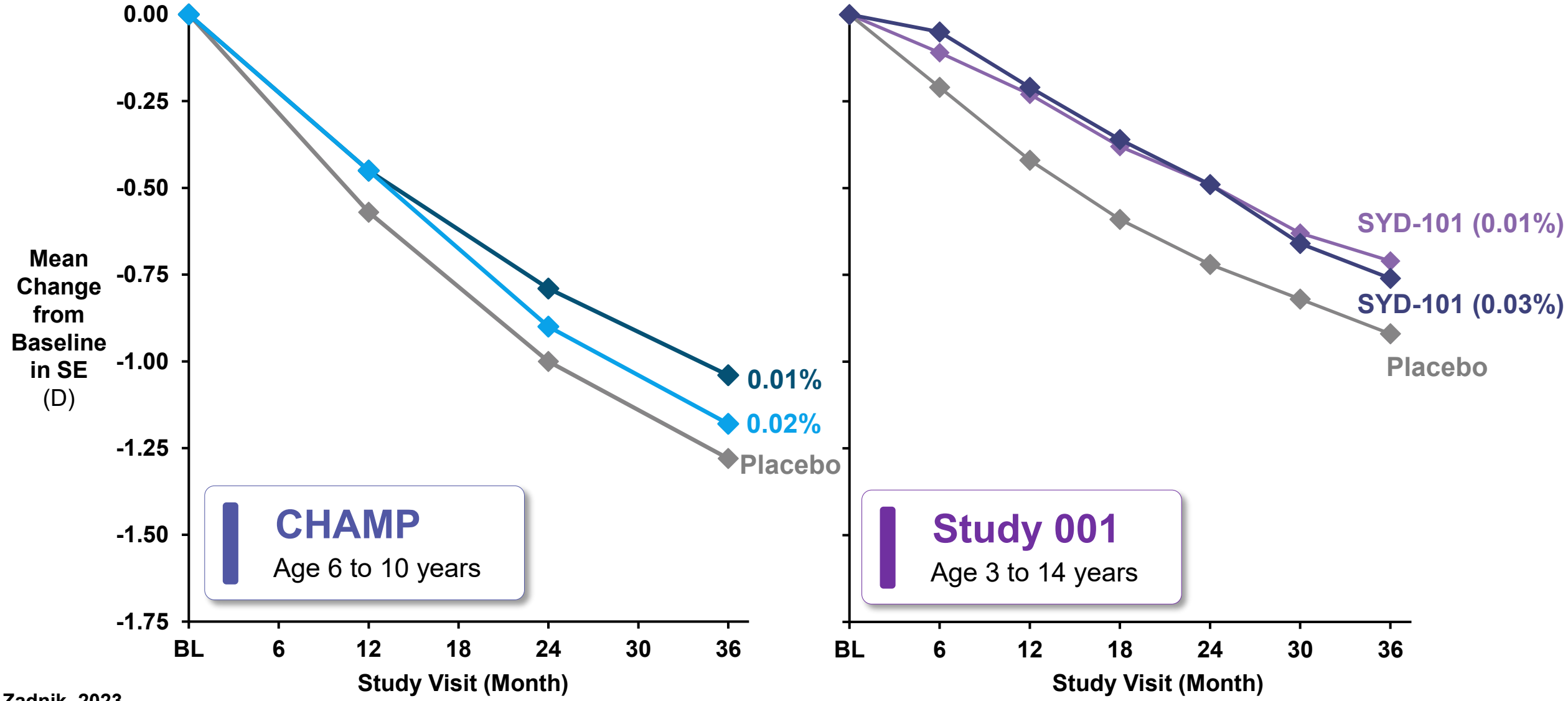
> *"The difficulty in accurately measuring an awake child's axial length is apparent in the Min, Max measurements: it is highly unlikely that any participant's axial length decreased from baseline while their eye was growing and their myopia progressing."*
>
> **- FDA Clinical Review of SYD-101 NDA**

Inconclusive result on axial length not sufficient to invalidate meaningful improvements in refractive error

1. Gifford et. al., IOVS 2019.

Key Efficacy Issue #6: Absence of a Dose-Response Relationship

Within the Low-Dose Range, Higher Atropine Concentrations Do Not Consistently Improve Efficacy



Zadnik, 2023.

Other Examples of Eye Drops Without Linear Dose-Response Relationship

- **Lumigan®** (bimatoprost ophthalmic solution, 0.03%)[1]
  - 0.03% dose lowered intraocular pressure more than 0.1%
- **Azopt®** (brinzolamide ophthalmic suspension, 1%)[2]
  - 1% and 2% concentrations more effective than 3%

1. NDA 021275. 2. NDA 020816.

Key Efficacy Issue #7: Unsupportive External Evidence and Generalizability

FDA's Four-Study Meta-Analysis Does Not Represent the Full Western Evidence Base

Study	Timepoint (Months)	Treatment Effect (0.01% vs Control)
Sen	24	0.58 D
Moriche-Carretero	36	0.56 D
CHAMP-UK	24	0.33 D
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WA-ATOM	24	0.14 D
MOSAIC	24	0.10 D
MTS1	24	-0.02 D

Asian Populations

Included in FDA meta-analysis

Relevant Western randomized evidence excluded by FDA

- **CHAMP-UK** | United Kingdom
- **APP** | Denmark
- **Moriche-Carretero** | Spain

Key Efficacy Issue #8:
Reliance on Exploratory Subgroup Analyses

ICH E9 Limits What Exploratory Subgroups Can Prove, Not Whether They Can Inform Interpretation

ICH E9:

- Exploratory subgroup analyses should be interpreted cautiously
- They should explore uniformity of treatment effects found overall
- Conclusions of efficacy or lack of efficacy should not be based solely on exploratory subgroups

- **Study 001 efficacy was established in the full analysis set, not in a subgroup**

Prespecified Subgroups Help Characterize Heterogeneity Within the Overall Treatment Effect

- Overall efficacy established in the full analysis set
- Responsible to investigate whether treatment effect is greater or lesser in particular patients
  - Federal regulations require efficacy results by age[1]
- Larger treatment effects in younger patients consistent with prior atropine trials and natural history

Subgroup analyses inform benefit-risk and guide clinical practice

1. 21 CFR 314.50

Conclusion

Patrick Johnson, Ph.D.

President

Sydnexis, Inc.

Requirements for Substantial Evidence of Effectiveness

- "*Substantial evidence of effectiveness*" is a defined regulatory term
- "*Substantial*" does *not* mean evidence needs to be "*overwhelming*"

Substantial = **1 Adequate and Well-Controlled Study** + **Confirmatory Evidence**

- Second trial
- External literature
- Other data sources

Extensive low-dose atropine literature serves as confirmatory evidence for the SYD-101 NDA

Attributes of a Single Highly Persuasive Trial to Establish Substantial Evidence of Effectiveness

Single Highly Persuasive Trial

- *"a design that provides information that is generalizable and relevant to clinical practice in the United States"*
- *"a design and analysis plan intended to provide clinically and statistically highly persuasive results"*
- *"the ability to generate primary analysis results that are clinically and statistically highly persuasive based on the clinical meaningfulness of the estimated magnitude of the benefit, the associated uncertainty, and the p-value"*
- *"the ability to demonstrate high-quality conduct, including comprehensive follow-up and minimal missing data, and demonstrate robustness of results to plausible violations in assumption"*

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Study 001 is Relevant and Generalizable to US Practice

Single Highly Persuasive Trial

> ***"a design that provides information that is generalizable and relevant to clinical practice in the United States"***

- Enrolled >90% patients from US
- 41 active sites across the country

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Study 001 Designed to Produce Persuasive Evidence

Single Highly Persuasive Trial

> ***"a design and analysis plan intended to provide clinically and statistically highly persuasive results"***

- Largest trial of 0.01% atropine to date
- Pre-specified methods, aligned in advance with FDA
- Primary endpoint measured clinically meaningful progression
- Key secondary endpoint was a continuous measure of disease

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Study 001 Produced Statistically Significant and Clinically Meaningful Results

Single Highly Persuasive Trial

- Primary endpoint showed significant effect on clinically meaningful level of progression
- Treatment effect consistent in sensitivity analyses
- Key secondary endpoint evaluating whether drug had an effect on continuous progression highly significant (p=0.0002)

> ***"the ability to generate primary analysis results that are clinically and statistically highly persuasive based on the clinical meaningfulness of the estimated magnitude of the benefit, the associated uncertainty, and the p-value"***

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Study 001 Was a High-Quality Trial

Single Highly Persuasive Trial

- Completion rate consistent with expectations for 3-year follow-up of children, despite conduct during COVID-19 pandemic
- Primary endpoint treatment effect stable across sensitivity analyses
- Key secondary endpoint treatment effect robust to all assumptions

> ***"the ability to demonstrate high-quality conduct, including comprehensive follow-up and minimal missing data, and demonstrate robustness of results to plausible violations in assumption"***

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SYD-101 Has Established Substantial Evidence of Effectiveness

Single Highly Persuasive Trial

> *"a design that provides information that is generalizable and relevant to clinical practice in the United States"*

> *"a design and analysis plan intended to provide clinically and statistically highly persuasive results"*

> *"the ability to generate primary analysis results that are clinically and statistically highly persuasive based on the clinical meaningfulness of the estimated magnitude of the benefit, the associated uncertainty, and the p-value"*

> *"the ability to demonstrate high-quality conduct, including comprehensive follow-up and minimal missing data, and demonstrate robustness of results to plausible violations in assumption"*

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Sponsor Perspective on Voting Question

SYD-101 (0.01%)

for the Slowing of Myopia Progression in Children

October 30, 2026

Dermatologic and Ophthalmic Drugs Advisory Committee

Sydnexis, Inc.