2026年9月18日

Roth Capital Partners, LLC.による当社レポートの発表に関するお知らせ

現地時間の9月17日、米国カリフォルニア州に本拠を置く投資銀行Roth Capital Partners, LLC.のアナリストであるBoobalan Pachaiyappan氏による、当社レポートが発表されましたので、参考情報としてお知らせいたします。

なお、当該レポートは、恐れ入りますが、権利の都合上、英文のままでのご案内となりますので、ご了承ください。

【H.C. Wainwright & Co.公式webサイト】
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※当該レポートは、本書の下部にございますので、スクロールしてご確認ください。

MediciNova, Inc.（メディシノバ・インク）
東京事務所 IR担当
E-mail infojapan@medicinova.com
URL https://medicinova.jp/

MediciNova, Inc. (MNOV)

NASDAQ

Rating	Buy
Price (09/15/26)	$2.02
12-Mo.Price Target	$6.00

Stock Data

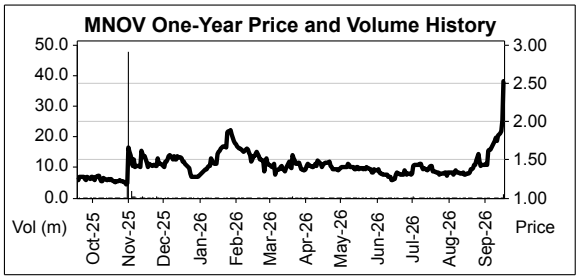
52-Week Range	$1.18- $2.02
Shares Out. (mil)	49.22
Mkt. Cap.(mil)	$92.04
3-Mo. Avg. Vol.	58,798
Cash (mil)	$25.4
Tot. Debt (mil)	$0.0

Rev ($M)

Yr Dec	Q1	Q2	Q3	Q4	FY
2025A	0.0A	0.1A	0.1A	0.2A	0.4A
2026E	0.2A	0.5A	0.0E	0.0E	0.6E
2027E	0.0E	0.0E	0.0E	0.0E	0.0E

EPS $

Yr Dec	Q1	Q2	Q3	Q4	FY
2025A	(0.06)A	(0.07)A	(0.06)A	(0.06)A	(0.24)A
2026E	(0.05)A	(0.05)A	(0.06)E	(0.07)E	(0.23)E
2027E	(0.08)E	(0.11)E	(0.16)E	(0.23)E	(0.58)E



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MNOV: Initiate at Buy, $6 PT; A Multimodal Mechanism to Power ALS Treatment

We initiate coverage of MediciNova with a Buy rating and 12-month PT of $6. Our optimism is predicated upon unmet needs in amyotrophic lateral sclerosis (ALS) treatment, Ph1b/2a study of Ibudilast (MN-166) showing evidence of disease stabilization & survival benefits (p=0.2) and a fully enrolled Ph2b/3 study (data in 4Q26). *Assuming positive results, MNOV could seek FDA approval in 2H27 and potentially launch the drug in 2H28.* We estimate MN-166 achieving a peak risk-unadjusted U.S. + EU5 revenue of ~$1.7B in 2035 (MNOV's share: $496M; flat royalty rate: 30%).

A new approach to ALS. MediciNova is a mid-stage biopharma developing oral, small molecules for multiple indications, including ALS (U.S. TAM: ~33K patients, per MNOV). The company's flagship asset (Ibudilast or MN-166; licensed from Kyorin Pharma; TYO: 4569-NC) is approved for use in Japan and South Korea for asthma and post-stroke dizziness). *MediciNova believes MN-166's multimodal mechanism could be repurposed to target neuroinflammation and aid the repair and survival of nerve cells in ALS patients.*

Unmet needs in ALS could favor regulatory flexibility. ALS is a fatal neurodegenerative disease impacting motor function and survival. Despite four FDA-approved drugs (Riluzole, Edaravone, Tofersen and Nuedexta), most patients die within 2–5 years post-diagnosis (reason: respiratory failure; source: Vasta *et al*., Neurology, 2025), suggesting disease severity. *Thus, demonstrating benefits in motor function and survival in a Ph2 study may qualify for a conditional approval, in our view.*

MN-166 differentiation. In Ph1b/2a (n=51), MN-166 demonstrated disease stabilization (21.2% vs. placebo's 12.5%; six months therapy) and higher survival (p=0.0025) when followed for 36 months without safety signals. A confirmatory Ph2b/3 study (n=234; 12 months) is fully enrolled, with top-line data slated for release in 4Q26. If positive, an NDA filing could occur in 2H27.

MN-166 could be a blockbuster ALS drug. We estimate MN-166 U.S. market entry in 2H28 (EU5 entry in 2030) and achieving a peak risk-unadjusted U.S. + EU5 revenue of ~$1.7B in 2035 (POA: 55%); MNOV's share: $496M (assumed royalty rate: 30%; no milestones applied).

Key debates. *(1) What is the bar for success in the ongoing Ph2b/3 study?* A higher mean combined assessment of function and survival (CAFS) score, benefiting the MN-166 group (relative benefit vs. placebo: ≥10%) without safety signals (pg 9); (2*) Is positive Ph2b/3 study sufficient for conditional approval?* We believe yes based on disease severity and past regulatory approvals; a separate Ph3 necessary (n=~600) for full approval (pg 15); *(3) How will MN-166 be commercialized?* Potentially through a strategic partnership in the U.S., EU5 and ROW (pg 22); and *(4) Is cash sufficient until Ph2b/3 readout?* Per MNOV, 2Q26-end cash is ~$25M (runway: 2H27).

Catalysts. (1) MN-001 Ph2 data; (2) 4Q26/1Q27: MN-166 Ph2b/3 ALS study data; (3) 2H27: MN-166 NDA filing; and (4) 2028: MN-166 FDA approval & U.S. launch.

Valuation. Our $6 PT is derived using a DCF analysis—12% discount rate; 5% terminal decline for MN-166 (ALS). Key risks include setbacks in clinical, regulatory and commercialization, financing and equity dilution.

Table of Contents

Corporate Compendious

Overview

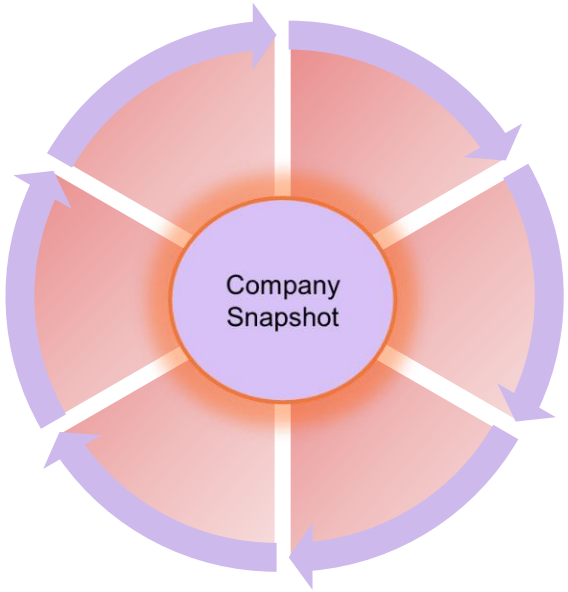
Sector: Healthcare
Industry: Biotech
Employees: 6
Headquarters: La Jolla, California
Founded in 2000

Business Focus

~ Clinical-stage biotech developing novel small molecule therapies to address unmet needs in neurodegenerative and inflammatory diseases
~ The company's lead asset, MN-166 (Ibudilast), a PDE4 inhibitor and MIF inhibitor, is designed to address key drivers of neuroinflammation across multiple neurodegenerative diseases, including ALS
~ Near-term stock narrative: Ph2b/3 (COMBAT-ALS) study topline data expected 4Q26
~ Long-term stock narrative: MN-166 regulatory approval in the U.S. in 2H28 and commercial adoption; EU launch: 2030

MN-166

~ MN-166 (Ibudilast) is a novel small molecule oral inhibitor targeting PDE4/PDE3/PDE10 and macrophage migration inhibitory factor (MIF) pathways
~ MN-166 is believed to attenuate CNS microglial activation and pro-inflammatory cytokine secretion (key drivers of ALS)
~ MNOV believes MN-166 could provide disease-modifying benefits to patients with ALS (POA: 55%), progressive MS (Ph3-ready; not valued), and glioblastoma (not valued)



Amyotrophic Lateral Sclerosis

~ Fatal disease characterized by loss of motor neurons, leading to muscle weakness, paralysis and respiratory failure (U.S. TAM: ~33K patients[1])
~ Ph1b/2a (ALS-1201; n=51): MN-166 demonstrated disease stabilization (21.2% vs. pbo's 12.5%) and higher survival (p=0.0025), in addition to acceptable safety/tolerability
~ Ph2b/3 COMBAT-ALS (n=234; 12 months): enrollment completed in 3Q25; top-line data assessing function + survival (CAFS) expected in 4Q26
~ If positive, we expect NDA filing in 2H27 and approval in 1H28

Other Programs (Not Valued)

~ MN-166 in Progressive multiple sclerosis (MS): Ph2 SPRINT-MS study (n=255; 96W) demonstrated a statistically significant reduction in whole-brain atrophy vs. pbo (48%; p=0.04)
~ MN-166 in Degenerative Cervical Myelopathy (DCM): Ph3 RECEDE study (Cambridge University Hospitals) is evaluating MN-166 as an adjunct to decompressive surgery (data timing: unknown)
~ MN-001 is being explored in a Ph2 study (n=40) for the treatment of liver diseases, including non-alcoholic steatohepatitis; top-line data in 2H26

Source of Capital & Ownership

Listing: Both on NASDAQ and TSE
Cash position: ~$25M (2Q26-end); runway: 2H27
Accumulated deficit: $443M (2Q26-end)
Top 3 institutional interests
Blackrock Fund Advisors – 1.42% | Citigroup Global Markets – 1.29% | Vanguard – 1.24%
Total institutional ownership: ~11%

Source: [1]MediciNova SEC Filings; FactSet.

Pipeline Chart

MN-166 (ibudilast)

Indication	Preclinical	Phase1	Phase II	Phase III	NDA	Designation	Partner
Amyotrophic Lateral Sclerosis (ALS) COMBAT-ALS	Phase2b/3				Topline expected 4Q 2026	Orphan disease Fast Track	In-house
Amyotrophic Lateral Sclerosis (ALS) SEANOBI-ALS	Expand Access Program					Orphan disease Fast Track	NIH MAYO CLINIC
Degenerative cervical Myelopathy (DCM) RECEDE	Phase2b/3					–	University of Cambridge NIHR
Chemotherapy-Induced Peripheral Neuropathy (CIPN) OXTOX	Phase2b					–	University of Sydney Concord Cancer Centre AGIT Group
Oncology (Glioblastoma) MN-166-GBM-1201	Phase2					Orphan disease	In-house Harvard University Dana-Farber Cancer Ins

MN-001 (tipelkast)

Indication	Preclinical	Phase1	Phase II	Phase III	NDA	Designation	Partner
Type2 DM + Hyper TG + NAFLD MN-001-NATG-202	Phase2			Topline expected 3Q 2026		Fast Track	In-house

Note: MN-166 ALS POA: 55% (U.S. & EU); we currently do not model revenue contributions for other clinical programs.

Source: Roth Capital Partners estimates; MediciNova Corporate Presentation (March 2026).

Scenario Assumptions and Catalyst Events

Base Case Assumptions

- MN-166 (ALS) FDA approval in 1H28 & U.S. launch in 2H28
- MN-166 (ALS) EMA approval & EU launch in 2030

Upside Scenario (Bull Case)

- Higher than expected global sales for MN-166 in ALS
- Development and commercialization of pipeline programs, including Progressive multiple sclerosis (PMS) and Degenerative Cervical Myelopathy (DCM)
- M&A interest

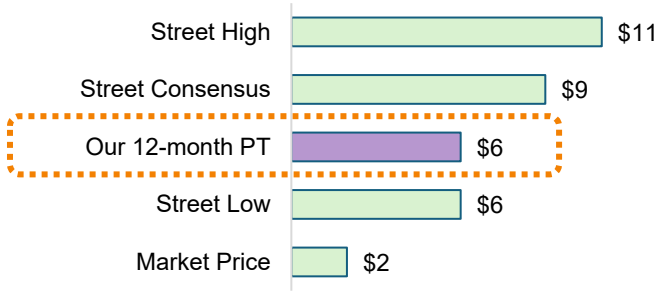
Downside Scenario (Bear Case)

- Lackluster Ph2b/3 COMBAT-ALS study clinical results of MN-166
- Less than anticipated market adoption of pipeline products in ALS
- Bear scenario could result in the stock price trading below cash if one or more of the clinical programs are culled

Catalyst Events

4Q26: Ph2b/3 COMBAT-ALS topline data
2027: SEA-NOBI-ALS Ph2 topline data (Roth estimates)
2H27: MN-166 for ALS NDA submission
1H28: MN-166 FDA approval
2H28: MN-166 U.S. commercial launch

Price Target: Us vs. The Street



Note: Market data as of 9/13/2026; MN-166 ALS POA: 55% (U.S. & EU); per MNOV, current cash (~$25M, 2Q26-end) is sufficient to cover operations into 2H27. Our 12-month PT is below consensus because we have included revenue contributions only from the ALS program.

Source: Roth Capital Partners estimates; MediciNova Corporate Presentation (March 2026).

DCF Valuation Summary

	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042
Revenue (risk-adjusted; $M)	**$0**	**$0**	**$3**	**$21**	**$61**	**$104**	**$146**	**$200**	**$243**	**$273**	**$170**	**$99**	**$86**	**$74**	**$70**	**$67**	**$62**
EBIT ($M)	**($13)**	**($35)**	**($39)**	**($17)**	**$22**	**$67**	**$109**	**$162**	**$205**	**$233**	**$129**	**$78**	**$67**	**$57**	**$54**	**$54**	**$49**
Less: Taxes ($M)	$0	$0	$0	$0	$0	$0	$0	$0	($59)	($68)	($37)	($23)	($19)	($16)	($16)	($16)	($14)
Debt-Free Earnings ($M)	**($13)**	**($35)**	**($39)**	**($17)**	**$22**	**$67**	**$109**	**$162**	**$145**	**$165**	**$92**	**$55**	**$47**	**$40**	**$38**	**$38**	**$35**
Less: Capital Expenditures ($M)	$0	$0	($0)	($1)	($2)	($3)	($4)	($6)	($7)	($8)	($5)	($3)	($3)	($2)	($2)	($2)	($2)
Less: Working Capital Changes ($M)	$0	$0	($0)	($1)	($1)	($1)	($1)	($2)	($1)	($1)	$3	$2	$0	$0	$0	$0	$0
Add: Depreciation and Amortization ($M)	$0	$0	$0	$1	$2	$3	$4	$6	$7	$8	$5	$3	$3	$2	$2	$2	$2
Total Net Investment ($M)	**$0**	**$0**	**($0)**	**($1)**	**($1)**	**($1)**	**($1)**	**($2)**	**($1)**	**($1)**	**$3**	**$2**	**$0**	**$0**	**$0**	**$0**	**$0**
Net Debt-Free Cash Flows: ($M)	**($13)**	**($35)**	**($39)**	**($17)**	**$21**	**$66**	**$107**	**$160**	**$144**	**$165**	**$95**	**$57**	**$48**	**$41**	**$38**	**$38**	**$35**
Discount Period	0.30	1.30	2.30	3.30	4.30	5.30	6.30	7.30	8.30	9.30	10.31	11.31	12.31	13.31	14.31	15.31	16.31
Discount Factor 12.0%	0.97	0.86	0.77	0.69	0.61	0.55	0.49	0.44	0.39	0.35	0.31	0.28	0.25	0.22	0.20	0.18	0.16
PV of Net Debt-Free Cash Flows ($M):	**($12)**	**($30)**	**($30)**	**($12)**	**$13**	**$36**	**$53**	**$70**	**$56**	**$57**	**$29**	**$16**	**$12**	**$9**	**$8**	**$7**	**$6**

DCF Assumptions	
Discount Rate	12.0%
Tax Rate	29.0%

PV of FCF ($M)	$287
PV of Terminal Value ($M)	$27
Enterprise value ($M)	$315
Cash ($M; 2Q27-end)	$49
Debt ($M)	$0
Equity value ($M)	$363
Diluted shares outstanding (M; 2Q27-end)	57.77
12-month PT per share ($)	$6

Perpetuity Growth Assumptions	
2043 Cash Flow (-5.0% Growth Rate)	$33.2
Growth Rate	-5%
Terminal Value ($M)	**$195**
Discount Period	17.31
Discount Factor @ 12.0%	0.14
PV of Terminal Value ($M)	**$27**

Distribution of Value	
Period Cash Flow	91.3%
Terminal Cash Flow	8.7%
Total	100.0%

Discount Rate \ Growth Rate	-9%	-7%	-5%	-3%	-1%
10%	380	384	389	395	404
11%	343	346	349	354	361
12%	309	312	315	318	323
13%	280	282	284	287	290
14%	253	255	257	259	261

DCF value (per share): $6

Note: Revenue represents risk-adjusted revenue in $M; All values in $M, except per share items; assumes D&A and CapEx as 3% and 3% of revenue; assumes changes in working capital as 3% of incremental revenue; DCF analysis date: 9/13/2026.

Source: Roth Capital Partners Estimates; MediciNova SEC Filings.

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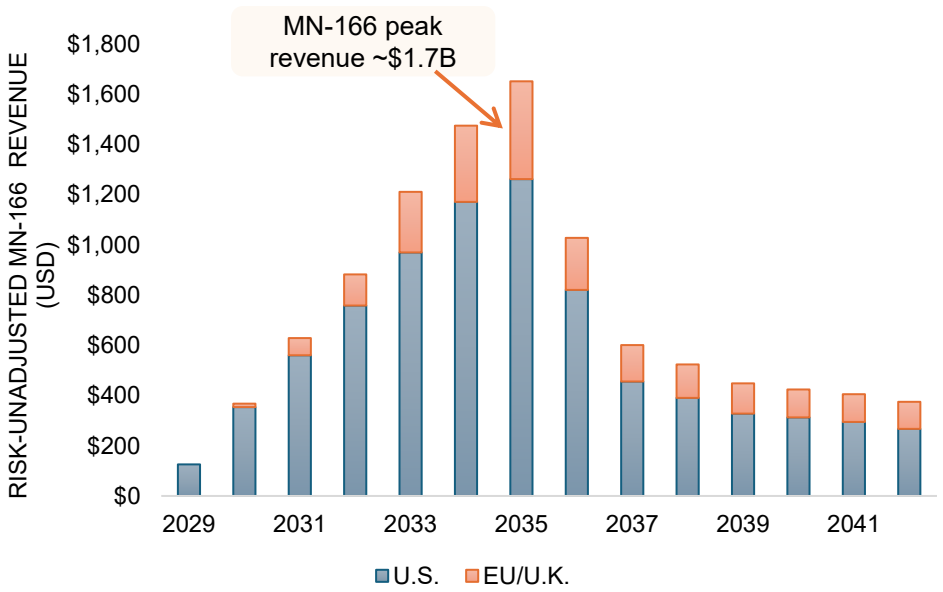
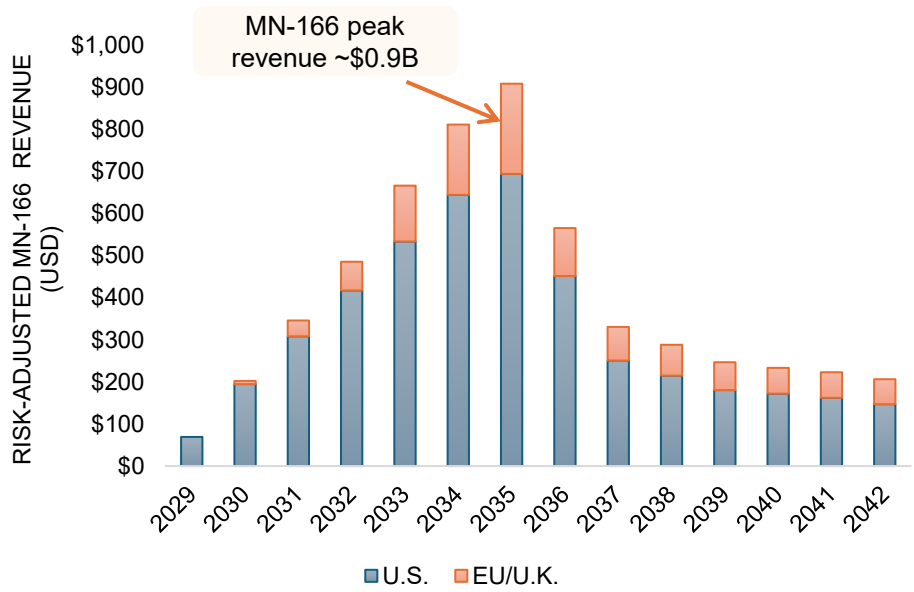
MN-166 Revenue Build in ALS (U.S. & EU5)

Risk-Unadjusted MN-166 Revenue



POA: 55% (U.S. & EU)

Risk-Adjusted MN-166 Revenue



For modeling purposes, we assumed a POA of 55% based on MN-166's favorable safety-efficacy profile generated from signal-finding Ph1b/2a (1201) study. Our above-average POA is predicated upon novel multimodal MoA, improvements in clinical outcome as reflected in ALS disease stabilization and increased survival without safety signals. Our estimates suggest that MNOV could receive FDA approval[1] in 1H28 and enter the U.S. market in 2H28 (EU entry in 2030) and achieve a peak revenue of ~$1.7B (left chart) and $0.9B (right chart) on a risk-unadjusted and risk-adjusted basis, respectively, assuming that the proposed Ph2b/3 COMBAT-ALS study (fully enrolled) generates positive data. Notably, assuming a flat royalty rate of 30%, we project $496M risk-unadjusted WW revenue to MNOV in 2035.

Note: [1]While the ongoing Ph2b/3 COMBAT-ALS is registration-enabling, full approval may require a large-scale Ph3 study (n= ~600 patients).

Source: Roth Capital Partners Estimates; MediciNova SEC Filings.

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Bull vs. Bear Analysis

Attribute	Bull Interpretation	Bear Interpretation
Valuation	~$89M market cap (9/11/2026) leaves substantial room for rerating upon positive Ph2b/3 COMBAT-ALS readout	Low valuation reflects a materially long development without commercialization
Cash/dilution concerns	2Q26-end: $25.4M cash; : 2H27	Positive Ph3 data may necessitate substantial financing for regulatory/commercialization purposes
MN-166 (Ibudilast) for ALS	Ph1b/2a (ALS-1201; n=51) demonstrated disease stabilization (21.2% vs. pbo's 12.5%) and higher survival (p=0.0025), in addition to acceptable safety/tolerability; Ph2b/3 study results is a bona fide value creation event (data: YE26)	ALS clinical development is complex due to inherent disease characteristics (>90% failure rate).
Ph2b/3 design	Improved design vs. Ph1b/2a namely: Symptom onset ≤18 months; pulmonary function ≥70% predicted; mean disease duration of 12.5 months; mean baseline ALSFRS-R of 40.6; 234 randomized patients vs. 51; 12-month controlled treatment vs. six months; CAFS incorporating both function and survival	ALS-1201 achieved its primary safety and tolerability endpoint; the exploratory ALSFRS-R responder comparison numerically favored MN-166 but was not statistically significant (p=0.2)
Ph2b/3 COMBAT-ALS endpoint	CAFS captures survival and function (ALSFRS-R)	CAFS can be hard to interpret vs. ALSFRS-R; prior Ph1b/2a did not show CAFS benefits
Supporting evidence	Beyond CAFS, signals of muscle strength, quality of life (QoL), safety/tolerability and expanded access program (EAP)	Without CAFS benefits, improvements in secondary measures may not rescue trial success
Other programs (not valued)	MN-001's potential in dyslipidemia and NAFLD/MAFLD is enormous	Crowded landscape; Ph2 biomarker efficacy doesn't establish commercial differentiation
Stock setup	Very small EV ($64M) suggests even modest POA improvement could produce disproportionate stock reaction	MNOV stock appreciated +28% during the preceding six months suggesting some catalyst anticipation is embedded (in-line with XBI)

While we are encouraged by the Ibudilast's multimodal biology and preliminary ALS data generated in the Ph1b/2a study, we believe COMBAT-ALS decides whether MN-166's exploratory responder and survival signals translate into a statistically robust, clinically meaningful function-and-survival benefit. Specifically, a statistically significant higher mean CAFS rank score (see pg 9) with evidence of pbo-adjusted ALSFRS-R benefits could significantly rerate MNOV stock, in our view. A marginal win could necessitate an additional ALS clinical trial, whereas a primary miss/safety signal could significantly impact the program and/or the company's operations.

Source: Roth Capital Partners; MediciNova SEC Filings.

Ph2b/3 COMBAT-ALS 4Q26 Readout Scenario Ladder

Scenario	Wt. Prob.	Decisive Efficacy Measures (Placebo-Adjusted, 12 Mo.)	Corroboration and Safety	Regulatory Implication	First-Day Stock Reaction
Super Bull	10%	CAFS p≤0.01; ≥3.0-pt ALSFRS-R benefit or ≥30% slowing of decline; favorable survival contribution	HHD, responder rate and ALSAQ-5 all consistent; no mortality imbalance; AE discontinuations in line with placebo	**Potential filing-quality; strongest FDA case**	+200% to +300%
Bull	20%	CAFS p<0.05; 2.0 – 3.0-pt pbo-adj ALSFRS-R benefit or 20% – 30% slowing; survival neutral to favorable;	Two or more key secondaries supportive, including muscle strength, QoL, safety; GI tolerability manageable; no serious-AE imbalance	**Strong regulatory case; FDA discussion becomes critical**	+100% to +180%
Base	35%	CAFS (p<0.05) with only a 1.0 – 2.0-pt pbo-adj ALSFRS-R benefit and weak survival contribution	Secondaries mixed; safety acceptable	**Positive program (Ibudilast works in ALS)**	+10% to +35%
Bear	25%	CAFS p>0.15; <1.0-pt benefit or <10% slowing; ALSFRS-R and survival effectively null	Safety acceptable but no secondary establishes efficacy; program needs redesign or partner funding	**Weak case; another controlled trial likely**	(15%) to (55%)
Heavy Bear	10%	Numerically worse on CAFS or ALSFRS-R, or an adverse death / permanent-ventilation imbalance	Material AE discontinuation or tolerability signal; development halted or economically stranded	**Program continuation uncertain**	(60%) to (80%)

A strong and internally consistent Ph2b/3 COMBAT-ALS results could support an NDA submission, pending FDA alignment. However, MNOV has not publicly disclosed its statistical analysis plan or formal FDA agreement that the current CAFS-based study alone will be sufficient for approval. Accordingly, in our view, a further randomized study remains a meaningful risk, particularly if the primary result is marginal or the secondary evidence is mixed.

Note: Probabilities, stock reactions are Roth Capital Partners estimates, not company guidance. HHD – Hand-held dynamometry. ALSAQ: ALS assessment questionnaire (five items/areas physical mobility, activities of daily living, eating and drinking, communication, and emotional functioning). Efficacy bars are placebo-adjusted 12-month deltas versus placebo, not within-group change from baseline. Stock reaction reflects the immediate catalyst reaction off the 9/11/26 close of $1.81, not a 12-month price target. Management guides top-line by YE26; ClinicalTrials.gov lists estimated primary completion of April 2027.

Source: Roth Capital Partners; MediciNova SEC filings and press releases; ClinicalTrials.gov (NCT04057898); S&P Capital IQ.

1. Building New Bridges to Address Unmet Needs in Neurological Diseases

Asset	Indication	Status	Mechanism	TAM (U.S.)	Next Milestone	POA	Comments
MN-166 (Ibudilast)	ALS	Ph2b/3	Suppresses neuroinflammation and oxidative stress	~33K patients[1]	Ph2b/3 top-line data by 4Q26	55%	Ph1b/2: demonstrated disease stabilization and survival benefits (p=0.2); if the ongoing Ph2b/3 is positive, NDA filing could occur in 2H27
	Progressive MS	Ph2 completed	Same as above	~100K to 150K patients[2]	Partnership update to begin Ph3	-	SPRINT-MS Phase 2b (NIH/NINDS-funded) demonstrated 48% reduction in whole brain atrophy vs pbo; clarity is awaited on financing/partnership
	Degenerative Cervical Myelopathy (DCM)	Ph3	Same as above	~500K patients[1]	Unknown	-	Ph3 trial ongoing (data timing: unknown); DCM has no approved disease-modifying therapy; investigator-sponsored
MN-001 (Tipelukast)	Hypertriglyceridemia / NAFLD (T2DM)	Ph2	Anti-fibrotic & anti-inflammatory	~37M patients[1]	Ph2 top-line data in 2H26	-	Ph2 (n=40; 24-wk DB): enrollment completed Nov 2025

MNOV Business Focus

MediciNova is a mid-stage biopharma developing novel small molecule therapies for neuroinflammatory and fibrotic diseases, (e.g., ALS, MS and NASH). The company's lead asset is MN-166 (Ibudilast), a first-in-class oral, brain-penetrating agent exhibiting anti-inflammatory and neuroprotective properties through inhibition of phosphodiesterase enzymes (PDE3,4,10 and 11) and Toll-Like Receptor 4 (TLR4). Ibudilast is approved for commercial use in Japan and South Korea for asthma and post-stroke complications for over 20 years; MNOV licensed the asset from Kyorin Pharma (Japan).

MNOV Near-Term Value

While MN-166 was initially evaluated in MS, MNOV ultimately prioritized the agent for development in ALS, given a clear pathway to accelerated approval and SOC inadequacies. In the Phase 1b/2a (ALS-1201) study (n=51 patients with ≤5 years onset; 30mg BID; 6 months), 21.2% of patients treated with MN-166 showed stable or improvement in ALS symptoms (vs. 12.5% in the placebo arm), without safety signals though we caveat that statistical significance was not met (p=0.2).* In addition, improvements in quality of life (51.5% vs. 25%) and muscle strength (33.3% vs. 25%) were also observed. A Ph2b/3 study (n=234 with ≤18 months onset; 50mg BID; 12 months) is in progress with top-line data slated for release in 4Q26.

MNOV Long-Term Value

Assuming the ongoing Ph2b/3 study is positive (i.e., MN-166 improves function and survival; 1° ep), MNOV could file for an NDA in 2H27, receive FDA approval in 1H28 and potentially launch in the U.S. 2H28 (a strategic partnership is assumed). Positive Ph3 study may be required for full approval. Separately, MNOV (through an academic partnership) is concurrently running a second ALS study (SEA-NOBI-ALS) involving late-stage ALS patients; enrollment complete4d in July (not valued in our DCF). If positive, MNOV could seek a broader label, in our view. Given MN-166's attractive revenue potential in ALS (risk-unadjusted WW revenue: ~$1.7B in 2035), we believe progress towards approval could rerate shares.

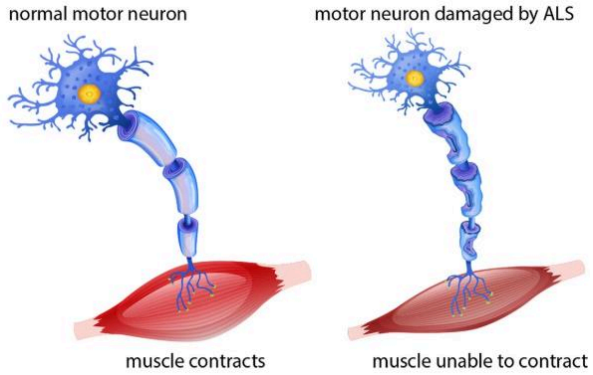
MediciNova is advancing MN-166 (ibudilast), a brain-penetrating small molecule targeting various biological pathways implicated in neuroinflammation—a key driver of ALS progression. Assuming MN-166 delivers survival and functional benefits in the ongoing Ph2b/3 study, it could receive an FDA approval in 1H28, be launched in the U.S. in 2H28 and achieve a peak risk-unadjusted WW revenue of $1.7B in 2035.

Note: *The Ph1b/2a study's primary endpoint (ALSFRS-R) was also not met; POA – Probability of approval; SOC – standard of care; ALSFRS-R – Revised ALS Functional Rating Scale.

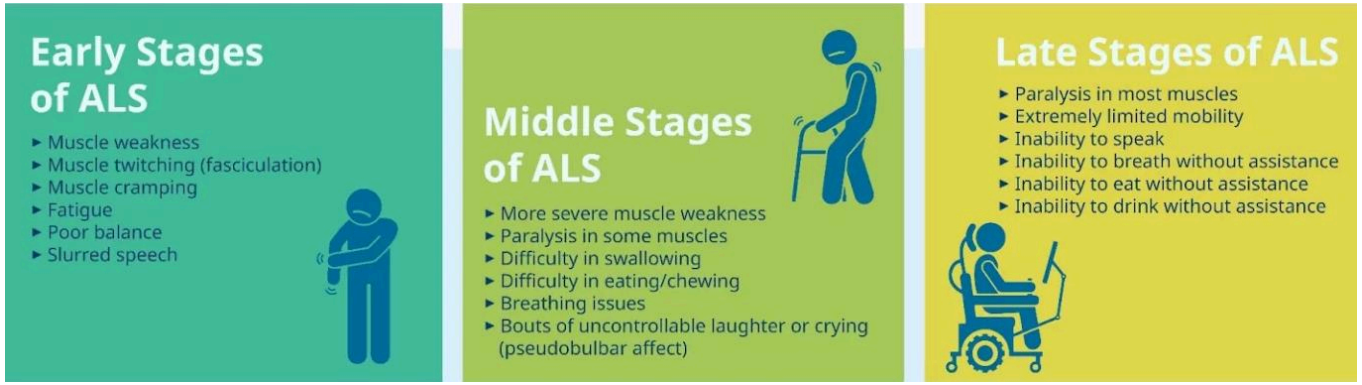
Source: [1]MediciNova SEC Filings and Corporate Presentation (March 2026); [2]National Multiple Sclerosis Society; [3]The Association for Frontotemporal Degeneration.

2. MN-166: A Potential New Standard of Care for ALS

Normal Neuron vs ALS Neuron[1]



Stages of ALS[2]



ALS is a Progressive Neurodegenerative Disorder

Amyotrophic lateral sclerosis (ALS) is a fatal neurodegenerative disease that progressively destroys motor neurons in the brain and spinal cord, ultimately leading to loss of voluntary muscle function. Affecting ~33K patients in the U.S.,[3] the disease manifests heterogeneously, with symptoms ranging from limb weakness and muscle cramps to dysphagia, dysarthria and respiratory decline.[4] While early signs often include twitching or clumsiness, disease progression results in the inability to perform essential tasks such as speaking, eating and breathing. Ultimately, paralysis and respiratory failure occurs leading to death (average life expectancy: two to five years post diagnosis).[4]

Diagnosis and Cause

ALS diagnosis remains largely clinical, as no single test confirms disease presence—clinicians undergo an exclusion process to rule out other overlapping indications (e.g., neuropathy). Diagnostic workup typically includes electromyography, MRI, blood biomarkers (e.g., neurofilament light) and exclusion of ALS mimics. To make the situation worse, diagnosis could take ~10 to 16 months post-onset during which time critical motor neuronal loss has already occurred.[4] Although ~10% of ALS cases are familial, the vast majority are sporadic, suggesting disease progression is driven by a complex interplay of genetic and environmental factors (e.g., toxin exposure, smoking, military service[5]).

Gaps in ALS Treatment

The etiology of ALS is complex and elusive though research has shown the involvement of multiple intersecting pathways, including oxidative stress, glutamate excitotoxicity, mitochondrial dysfunction and neuroinflammation, among others. Such a scenario complicates drug development as targeting multiple pathways at once using a single agent could be a Herculean challenge. Overall, four drugs were approved by the FDA (Riluzole, Edaravone, Nuedexta and Tofersen; see next slide for more details). While encouraging advancements were made on the biomarkers front—e.g., neurofilaments that serve as a proxy neuroaxonal injury and TDP-43 serving as a proxy for motor neuron degeneration—development of effective therapies for a broader set of ALS patients remains an ongoing challenge.

ALS is a fatal neurodegenerative disease that causes progressive muscle paralysis and respiratory failure, with most patients dying within 2–5 years of diagnosis.[4] Despite four FDA-approved therapies, treatment impact remains modest, with limited survival benefits and few options targeting the disease's multifactorial pathology.

Note: [5]U.S. Veterans are about 1.5 times more likely to get ALS compared to people who were never in the service (per ALS Association); a significant portion of this slide is repurposed from our NRSN initiation report.

Source: [1]https://www.fcneurology.net; [2]www.startstemcells.com; [3]MediciNova SEC Filings; [4]Bradford & Rodgers, Frontiers in Neuroscience (2024).

Available Therapies Provide Modest, Subset-Specific or Symptomatic Benefits, Leaving Major ALS Unmet Need

Attributes	Riluzole	Nuedexta	Edaravone	Relyvrio (Withdrawn)	Tofersen
Sponsor	Sanofi	Otsuka Pharma	Mitsubishi Tanabe Pharma	Amylyx Pharma	Biogen
Approval Year	1995	2010	2017	2022	2023
Setting	Broader ALS	Pseudobulbar effects	Broader ALS	Broader ALS	SOD1-ALS
Route of Administration	Oral tablet	Oral capsule	Injection; oral suspension	Oral suspension	Intrathecal injection
Dosing Regimen	50mg BID	DM 20 mg/Q 10 mg QD (Days 1–7); Maintenance dose BID thereafter	Injection – 60mg QD ORS – 105mg QD	1 packet daily (3g PB/ 1g TURSO) for 3 weeks; maintenance dose 1 packet BID	100mg (15ml) every 28 days, with initial loading doses every 14 days
Rationale/Mechanism	Glutamate-mediated excitotoxicity inhibition	Glutamate and serotonin signaling modulation	Oxidative stress reduction by scavenging free radicals	ER stress reduction; mitochondrial dysfunction targeting	Reduction of toxic SOD1 protein
Warning/ Precautions	Mild nausea/fatigue when starting Riluzole; hepatotoxicity in rare cases	Thrombocytopenia; hypersensitivity reactions; hepatitis and dizziness	Sulfite allergic reaction; hypersensitivity reaction; confusion; gait disturbance and headache	Generally well tolerated; GI-related AEs most common	Myelitis; radiculitis; papilledema; elevated intracranial pressure and aseptic meningitis
Comments	Limited to survival extension without significant muscle strength or function improvement; 1st FDA approved drug for ALS	Effectively reduces pseudobulbar episodes but offers only symptomatic relief without altering disease progression	Shionogi acquired the global rights to both Radicava ORS (oral) and IV Radicava for $2.5B	Received accelerated approval based on positive Ph2 data; withdrawn from the market after negative Ph3 PHOENIX study results	First ALS drug approved based on biomarker reduction rather than direct clinical function; limited to a small subset (~2%) of ALS patients

The FDA has approved multiple ALS therapies, though significant unmet needs remain. For context, Riluzole modestly extends survival (~2 to 3 mos; reduces mortality by ~35%) but offers no functional benefit.[1] Radicava may slow decline in early-stage patients by 33%, though its durability is limited and delivery could be burdensome.[2] Qalsody shows strong biomarker engagement (NfL, SOD1) but lacks significant functional benefit and is restricted to ALS patients with *SOD1* mutations (~2%). Nuedexta addresses pseudobulbar affect symptoms but has no impact on disease progression.[4] Relyvrio, despite receiving a full approval based on Ph2 data, was taken off the market due to a failed Ph3 study. In our view, while these therapies target select pathways and/or symptoms, none of them provide comprehensive or transformative benefits highlighting the need for novel disease-modifying agents.

Note: [1]Hinchcliffe & Smith, Degenerative Neurological and Neuromuscular Disease (2017); [2]https://www.radicava.com; [3]https://www.qalsodyhcp.com; [4]Smith et al., Neuro (2017); PBA – Pseudobulbar affect is a neurological condition that causes outbursts of uncontrolled or inappropriate laughing or crying; NfL – Neurofilament light chain; DM – Dextromethorphan; Q – Quinidine; a significant portion of this slide is repurposed from our NRSN initiation report.

Source: Roth Capital Partners; SEC Filings and Corporate websites of respective companies mentioned above; www. labels.fda.gov.

ALS Clinical Development Landscape is Filled With Failures, in Our View

Sponsor	Agent	Rationale	Status During the Time of Program Termination	Comments
Amylyx Pharma	Relyvrio	ER stress reduction; mitochondrial dysfunction targeting	Phase 3*	Withdrawn after negative Ph3 PHOENIX trial results (i.e., lack of efficacy)
Cytokinetics/Astellas	CK-2127107	Enhances skeletal muscle contractility by increasing troponin sensitivity to calcium	Phase 3	Failed to meet primary endpoint (ALSFRS-R change at 24 weeks); trial terminated for futility at interim; results favored placebo; no slowing of functional decline
European Commission	TUDCA	Reduces ER stress and stabilizes mitochondrial membranes	Phase 3	No statistically significant difference between TUDCA and pbo in slowing disease progression (ALSFRS-R)
AB Sciences	Masitinib	Inhibits tyrosine kinases involved in neuroinflammation	Phase 3	Masitinib has not received EMA approval for ALS due to insufficient evidence of clinical efficacy
Seelos Tx	SLS-005	Enhances autophagy and clearance of misfolded proteins	Phase 2/3	No statistically significant improvement in motor function or mortality vs. placebo in ~120 patients
AbbVie	ABBV-CLS-7262	Activates eIF2B and restores protein synthesis in motor neurons	Phase 2/3	Primary endpoint not met; no evidence of motor function improvement or survival benefits
Denali	DNL343	Activates eIF2B to restore protein synthesis in motor neurons	Phase 2/3	Failed to show clinical benefit at 24 wks; no evidence of disease slowing
PTC Tx	Utreloxastat	Inhibits 15-LO to reduce oxidative stress and preserve neuronal integrity	Phase 2	Provided modest clinical benefit that was not statistically significant
Investigator-initiated	Rapamycin	Inhibits mTOR to activate autophagy and reduce neuroinflammation	Phase 2	Primary endpoint of Treg elevation not met
Biogen	BIIB105	Reduce toxic protein accumulation (ATXN2)	Phase 1/2	Program terminated following lack of efficacy (i.e., no benefits on neurofilament light chain, function, breathing, and strength)

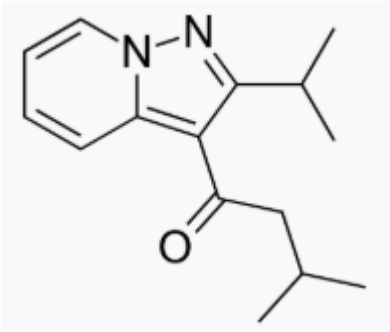
Over 90% of ALS agents explored in preclinical/clinical studies never made it to the market due to a combination of late diagnosis, poor understanding of ALS pathogenesis, a lack of disease-informing animal models that reflect human characteristics, inadequate clinical trial design and the lack of efficacy. We believe agents that broadly address multiple ALS mechanistic pathways have better chances of succeeding in clinical trials, given the disease's multifactorial etiology and variability of progression.

Note: *Received accelerated approval; TUDCA – Tauroursodeoxycholic acid; EMA – European Medicines Agency; NLRP3 levels are significantly elevated in the blood of ALS patients; It controls genes involved in cellular clearance and stress response—key mechanisms disrupted in neurodegenerative diseases like ALS; a significant portion of this slide is repurposed from our NRSN initiation report.

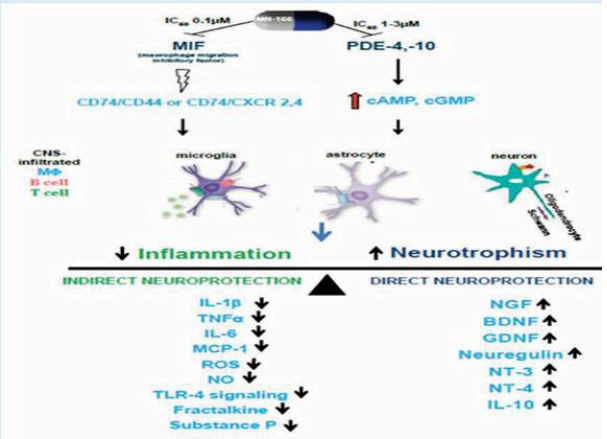
Source: Petrov et al., Frontiers in Aging Neuroscience (2017); MediciNova SEC Filings and Corporate Presentation (March 2026).

Through a Multimodal Mechanism, MN-166 Tackles Neuroinflammation and Promotes Repair and Survival of Nerve Cells

MN-166 (Ibudilast) Chemical Structure



Ibudilast Mechanism of Action



Ibudilast's Therapeutic Potential

Indication	Stage
ALS	Ph2b/3
Multiple sclerosis	Ph2 completed
Glioblastoma	Ph1/2 completed
COVID-19	Ph2
Degenerative Cervical Myelopathy	Unknown
Alzheimer's disease	Unknown

MN-166 Intro & MoA

MN-166 (ibudilast) is a novel, first-in-class oral agent originally developed by Kyorin Pharmaceuticals (Japan). The agent functions by inhibiting several inflammation-inducing targets such as phosphodiesterases (PDE3,4,10 and 11), macrophage migration inhibitory factor and toll-like receptors (TLR4) while also offering neuroprotection through upregulation of neurotrophic factors (e.g., GDNF, NGF and NT-4). We note that Ibudilast has been in clinical use for over 40 years as a treatment for bronchial asthma and post-stroke dizziness (i.e., the agent's safety and tolerability profile is well documented in ex-U.S. regions).

MN-166 Therapeutic Focus

In 2004, MediciNova in-licensed MN-166 from Kyorin to expand its use in neurological indications, including PMS and ALS. In brief, MN-166 has been shown to: (i) penetrate the blood-brain barrier; (ii) prevent memory impairment and spatial learning in Alzheimer's disease (AD) models; (iii) reduce brain atrophy in human multiple sclerosis (MS) patients; (iv) to protect against toxic protein (TDP-43) implicated in 97% of ALS cases; and (v) suppress the expression of Matrix Metalloproteinase-9 (MMP-9), significantly elevated in ALS cases causing degeneration of motor neurons.

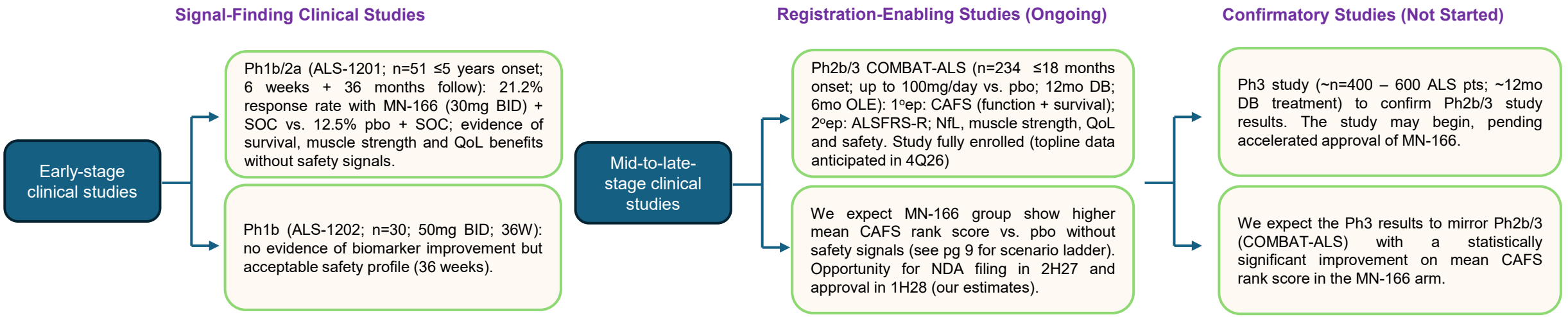
Opportunity in ALS

The company's belief is that MN-166 could slow down ALS disease progression by targeting neuroinflammation—a hypothesis that is not conclusively proven to date, in our view. Within ALS, MNOV is advancing the therapeutic utility of MN-166 in two sub-populations, namely, early-stage cases exhibiting disease onset within 18 months (Ph2b/3 COMBAT-ALS is ongoing; data in 4Q26) and late-stage patients who failed eligibility criteria for most ALS clinical studies. Positive results from both studies will likely solidify MN-166 labeling, though we have modeled revenue only from the early onset ALS cases.

Note: ALSFRS-R – The Revised Amyotrophic Lateral Sclerosis Functional Rating Scale; GDNF – glial cell-derived neurotrophic factor; NGF – Nerve growth factor; NT-4 – Neurotrophin-4.

Source: MediciNova SEC Filings and Corporate Presentation (March 2026); Babu et al., NeuroImage: Clinical (2021); Oskarsson et al., Neurodegenerative Disease Management (2021).

MN-166 Clinical Journey: A Glimpse



MNOV's ALS Program

MediciNova's ALS clinical program is composed of: (i) a signal-finding Ph1b/2a study (ALS-1201; n=51); (ii) an open-label Ph1b biomarker study (ALS-1202; n=35; (iii) a potential Ph2b/3 registrational study (COMBAT-ALS; n=234; 12 months) with combined assessment of function and survival (CAFS) as 1°ep (topline data in 4Q26); (iv) an expanded access (SEA-NOBI-ALS) study in late-stage ALS patients fully funded by the NIH; and (v) a potential confirmatory Ph3 study (n=~450).

Ph1b/2a Clinical Data Summary

In Ph1b/2a study (60 mg/day add-on to riluzole; single center study), MN-166 demonstrated safety, disease stabilization (21% vs. 13% pbo) and survival benefits, though statistical significance was not achieved on ALSFRS-R (p=0.2). The company has initiated a potential Ph2b/3 study that is slated to disclose top-line data in 4Q26. Our registrational-grade readout would involve: CAFS p<0.05; 2.0 – 3.0 pt pbo-adj ALSFRS-R benefit or 20% – 30% slowing; survival neutral to favorable (Bull) or CAFS p≤0.01; ≥3.0-pt ALSFRS-R benefit or ≥30% slowing of decline; favorable survival contribution (Super Bull).

Program Differentiation and Future Steps

We are bullish about MNOV's ALS program based on: (i) a multi-modal MoA that tackles neuroinflammation—a key driver of ALS pathology; (ii) evidence of disease stabilization and survival in Ph1b/2a study; and (iii) a defined pathway to accelerated approval, should Ph2b/3 yield positive data (1° ep: CAFS; an endpoint never used in past FDA approvals). Separately, positive data from SEA-NOBI-ALS study could further expand MN-166's label, given late-stage ALS cases are enrolled, in our view.

Note: HR=0.21 and post-cessation p-values from Brooks et al. conference abstract – not peer-reviewed; Ph1b/2a ALS-1201 – NCT02238626; Ph1b ALS-1202/MGH – NCT02714036; Ph2b/3 COMBAT-ALS – NCT04057898; SEA-NOBI-ALS EAP – NCT06743776; CAFS – Combined Assessment of Function and Survival; ALSFRS-R – ALS Functional Rating Scale-Revised; DB – Double-blind; OLE – Open-label Extension; NfL – Neurofilament Light Chain; EAP – Expanded Access Program; PBR28-PET – Translocator Protein PET (glial activation marker); AA – accelerated approval.

Source: MediciNova SEC Filings and Corporate Presentation (March 2026); Matsuda et al. AAN 2019 poster; Brooks et al. ALS-MND abstract; Babu et al., Neuroimaging Clinical (2021).

ALSFRS-R Score is a Widely Recognized Endpoint That Tracks Functional Changes Relevant to ALS Patients

BULBAR

Speech
- 4 Normal
- 3 Detectable speech disturbance
- 2 Intelligible with repeating
- 1 Speech combined with nonvocal communication
- 0 Loss of useful speech

Salivation
- 4 Normal
- 3 Slight but definite excess of saliva in mouth; may have nighttime drooling
- 2 Moderately excessive saliva; may have minimal drooling
- 1 Marked excess of saliva with some drooling
- 0 Marked drooling; requires constant tissue or handkerchief

Swallowing
- 4 Normal
- 3 Early eating problems—occasional choking
- 2 Dietary consistency changes
- 1 Needs supplemental tube feeding
- 0 NPO (exclusively parenteral or enteral feeding)

FINE MOTOR

Handwriting
- 4 Normal
- 3 Slow or sloppy; all words are legible
- 2 Not all words are legible
- 1 Able to grip pen but unable to write
- 0 Unable to grip pen

Cutting Food*
- 4 Normal
- 3 Somewhat slow and clumsy, but no help needed
- 2 Can cut most foods, although clumsy and slow; some help needed
- 1 Food must be cut by someone, but can still feed slowly
- 0 Needs to be fed

Dressing and Hygiene
- 4 Normal
- 3 Independent and complete self-care with effort or decreased efficiency
- 2 Intermittent assistance or substitute methods
- 1 Needs attendant for self-care
- 0 Total dependence

*There are different assessments for cutting food with gastrostomy.

GROSS MOTOR

Turning in Bed
- 4 Normal
- 3 Somewhat slow and clumsy, but no help needed
- 2 Can turn alone or adjust sheets, but with great difficulty
- 1 Can initiate, but not turn or adjust sheets alone
- 0 Helpless

Walking
- 4 Normal
- 3 Early ambulation difficulties
- 2 Walks with assistance
- 1 Non-ambulatory functional movement only
- 0 No purposeful leg movement

Climbing Stairs
- 4 Normal
- 3 Slow
- 2 Mild unsteadiness or fatigue
- 1 Needs assistance
- 0 Cannot do

RESPIRATORY

Dyspnea
- 4 None
- 3 Occurs when walking
- 2 Occurs with one or more of the following: eating, bathing, dressing (ADL)
- 1 Occurs at rest, difficulty breathing when either sitting or lying
- 0 Significant difficulty, considering using mechanical respiratory support

Orthopnea
- 4 None
- 3 Some difficulty sleeping at night due to shortness of breath. Does not routinely use more than two pillows
- 2 Needs extra pillow in order to sleep (more than two)
- 1 Can only sleep sitting up
- 0 Unable to sleep

Respiratory Insufficiency
- 4 None
- 3 Intermittent use of BiPAP
- 2 Continuous use of BiPAP
- 1 Continuous use of BiPAP during the night and day
- 0 Invasive mechanical ventilation by intubation or tracheostomy

The FDA approved Radicava based on improvements in ALSFRS-R (placebo-adjusted value: 2.49 points or 33% less decline; p=0.0013).*

For context, ALSFRS-R is a routinely deployed primary endpoint in ALS clinical trials that assesses bulbar (speech/salivation/swallowing), fine motor (upper extremity), gross motor (lower extremity/trunk), and respiratory functions. It is a 12-item questionnaire rated by HCPs that measures ALS disease progression/disability, with scores ranging from 0 (maximum disability) to 48 (normal).[1]

Despite its widespread use in ALS clinical trials, there remains a lack of consensus regarding what constitutes a clinically meaningful change in ALSFRS-R. Due to disease heterogeneity and progression variability, some patients could lose ~1 point each month (near stable) whereas others could lose up to 6 points per month (acute).[2] Accordingly, a 25% or greater change in the slope of ALSFRS-R is widely sought after.[3]

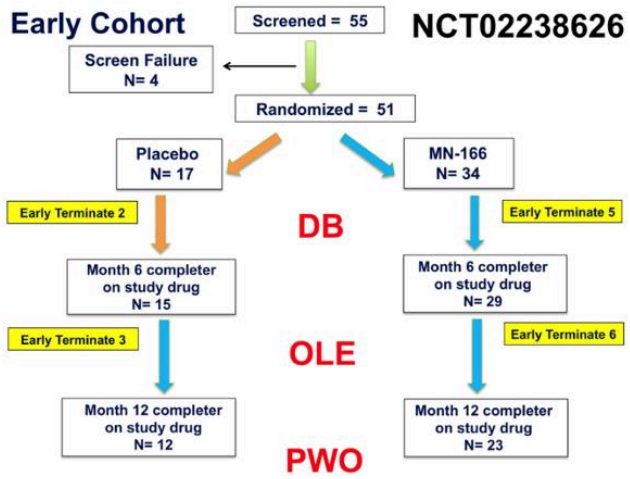
While ALSFRS-R poses several advantages, including correlation with measures of muscular strength and overall survival, limitations remain[4]: (1) a lack of sensitivity to early changes in symptoms, particularly in cases with slow progression; (2) equal weighting of all 12 items despite predictable sub-domain variability; (3) a low probability of observation for some item scores; and (4) an assumption of linear decline in function.

Note:*FDA label.

Source: [1]ALS Foundation; [2]Proudfoot et al., Amyotrophic Lateral Sclerosis and Frontotemporal Degeneration (2016); [3]Castrillo-Viguera et al., Amyotrophic lateral Sclerosis (2010); [4]Fournier et al., JAMA Neurology (2019); a significant portion of this slide is repurposed from our NRSN initiation report.

MN-166 Treatment Demonstrated Disease Stabilization and Survival Benefit in ALS-1201, Though Concerns Remain

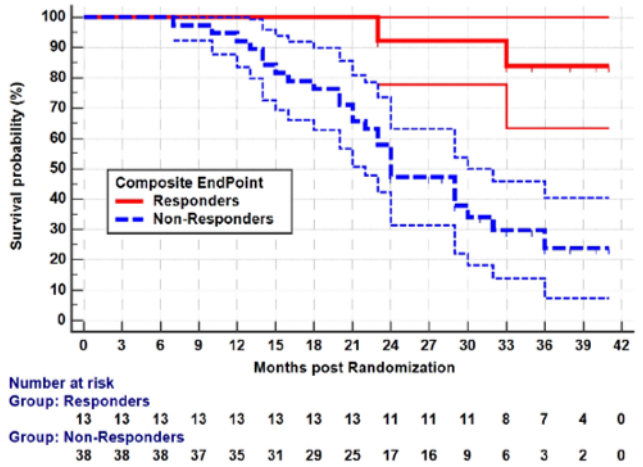
ALS-1201 Study Design



ALS-1201: Responder Analysis Data[3]

Parameter	Placebo (n=16)	MN-166 (n=33)
ALSFRS-R	2/16 (12.5%)	7/33 (21.2%)
ALSAQ-5	4/16 (25.0%)	17/33 (51.5%)
MMT	4/16 (25.0%)	11/33 (33.3%)

Survival Data



Ph1b/2a (1201) Study Design

In this slide, we review key elements of Ph1/2 ALS-1201 study (n=51; 2:1; 30mg BID) that demonstrated early signals of MN-166 efficacy in ALS patients. In brief, the 1201 study was conducted in a single-center and was designed as randomized, placebo-controlled trial involving six months of double-blinded treatment and six months of open-label period. Key objectives include ALSFRS-R (1°ep; proxy for functional decline), muscle strength and quality of life.

Disease Stabilization

While top-line results demonstrated no statistically significant difference between treatment and control groups (p=0.2), a *post hoc* analysis suggested disease stabilization/improvement[1] in 7/33 (21.2%) vs. 2/16 (12.5%) in the placebo group. In addition, 51.5% and 33.3% taking MN-166 showed improvements in hand strength (manual muscle testing) and better QoL vs. pbo, suggesting potential benefits.

Survival Enhancement

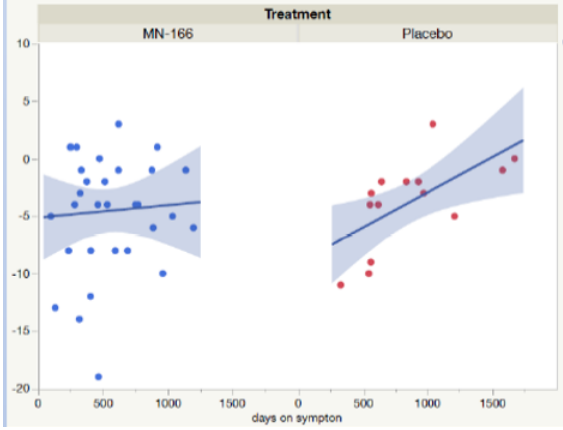
Separately, patients who demonstrated prior disease stabilization/improvement (colored in red) after completing 6- & 12-months treatment showed evidence of higher survival during the 30-month post-study follow-up (p=0.0025), suggesting additional functional benefits (for context, Riluzole increases survival by 2 to 3 months)[2] . While we acknowledge the 1201 study was conducted at a single site, it nevertheless informed preliminary therapeutic effects (disease stabilization & extended survival), warranting proof-of-concept testing.

Note: [1]<12 units (<1 unit per month) decrease in ALSFRS-R total score; [2]FDA; [3]given the early nature of the study, the sample size is smaller.

Source: MediciNova SEC Filings and Corporate Presentation (March 2026); Matsuda et al. AAN poster (2019); Brooks et al. ALS-MND abstract.

MN-166 Appears to Exhibit an Acceptable Safety Profile, Pending 100mg Tolerability/Discontinuation Data

ALSFRS-R vs. Disease History Correlation



MN-166: Safety Summary*

	Placebo (n=17)	MN-166 (n=34)
# of subjects with at least one TRAE	n=3	n=4
Total events # of TRAEs	5	8
Severe or life-threatening TRAEs	0	0
Serious TRAEs	0	0

MN-166: Adverse Event Profile

Event	Placebo (n=3)	MN-166 (n=4)
Gastrointestinal system	1	2
Nervous system disorder	3	0
Metabolism and nutrition	0	4
Investigation	1	1
Injury	0	1

Further Evidence of Disease Stabilization

In general, the ALSFRS-R score of ALS patients decline ~0.3 to 1.5 pts/month (average: ~0.9 to 1.1 pts/month) with faster progression occurring during the early stages of the disease vs. those with a longer history. It appears this inverse trend between ALSFRS-R decline at six months and ALS history was reflected in the placebo arm of the 1201 study (red dots; r=0.63; p<0.05).[1,2,3] In contrast, in the MN-166 arm, no correlation was observed (r=0.06; p=0.73), further suggesting disease stabilization and positive impact on patients with shorter ALS history/progressive disease.

Safety Summary

On the safety front, MN-166 exhibited an acceptable safety/tolerability without safety signals in ALS-1201 (30mg BID or 60mg total) and ALS-1202 (30–50mg BID or up to 100mg/day). Notably, no safety signals emerged from the DSMB's blinded interim analysis of the ongoing Ph2b/3 COMBAT-ALS study (50mg BID or 100mg total). Commonly reported events include: GI discomfort (nausea, diarrhea), insomnia, headache, and fatigue, consistent with Ibudilast's safety profile in bronchial asthma and post-stroke dizziness (ex-U.S. data).

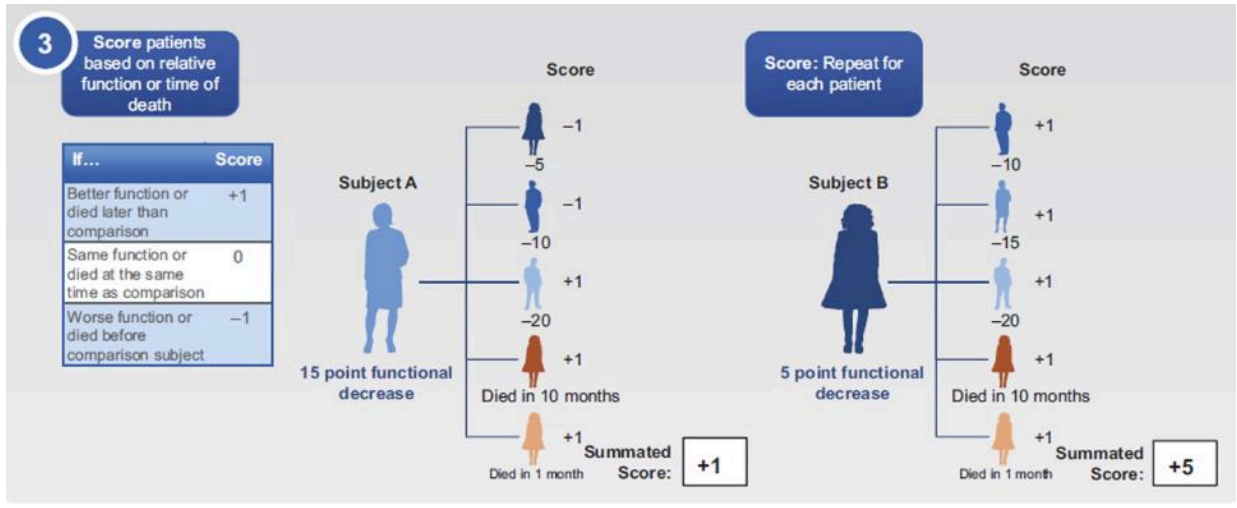
Adverse Events List

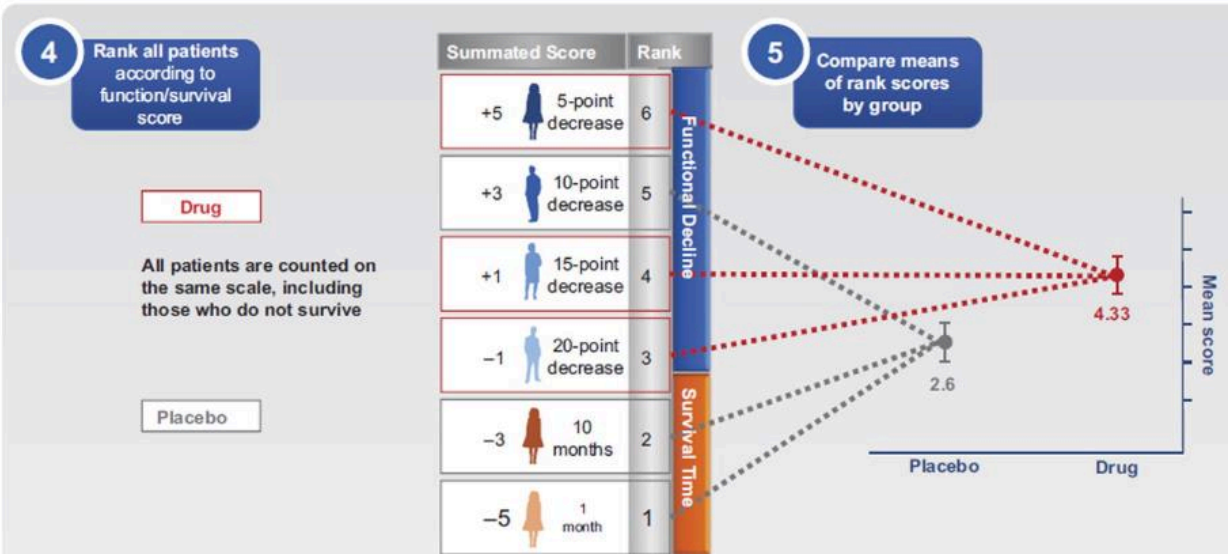
In ALS-1202 study (n=35), 13 (37%) participants experienced tolerability issues forcing a dose reduction from 100mg/day to 60–80mg/day; 11 (31%) participants discontinued study drug early due to drug related adverse events. However, this profile was not replicated in Ketas (brand name for Ibudilast or MN-166 in Japan & Korea) suggesting ALS patients may be sensitive to MN-166. Accordingly, we will keenly watch out for the discontinuation rate in the ongoing Ph2b/3 study.

Note: *Ketas is the branded commercial formulation of ibudilast (MN-166) marketed in Japan by Kyorin Pharmaceutical for approved indications (bronchial asthma and post-stroke dizziness; *given the early nature of the study, the sample size is smaller; SAE – serious adverse event; TRAE – treatment-related adverse event.

Source: [1]MediciNova SEC Filings and Corporate Presentation (March 2026); [2]Hamatani et al., Amyotrophic Lateral Sclerosis and Frontotemporal Degeneration (2024); [3]Matsuda et al., ALS International Symposium (2019).

CAFS: a Highly-Relevant Regulatory Endpoint That Captures Mortality and Functional Benefits





CAFS is a composite "statistical" endpoint that measures the impact of a therapeutic agent on survival time and functional decline (change in ALSFRS-R score). By combining two seemingly distinct physical functions and ranking each patient against every other patient in the study, CAFS aims to minimize mortality effects by ranking deaths below survivors without compromising data quality (death is a routine event in ALS clinical studies). A higher mean CAFS score reflects prolonged life and/or functional improvement.[1]

CAFS offers multiple advantages: (i) utilizes statistical analysis to rank patients (not a physical test); (ii) eliminates survivor bias by penalizing deaths (score: -1) vs. living patients (score: +1); (iii) increases the statistical power of short-term clinical studies (e.g., 6 or 12 months) particularly in rapid progressing diseases such as ALS, given the involvement of two variables; and (iv) approved by global regulators.

Source: [1]Berry et al., Amyotrophic Lateral Sclerosis and Frontotemporal Degeneration (2013).

CAFS in Practice: Hypothetical and Real Examples

How Does CAFS Scoring Work?[1]

Calculation: Worst rank = patient who dies first; best rank = survivor with least functional decline

- **Scenario 1.** If a patient dies and the counterpart lives, then the survivor is ranked favorably (e.g., +1 point) vs. the deceased (-1 point)
- **Scenario 2.** If both die, then the longest survivor scores favorably (+1) against the one with shorter survival (-1)
- **Scenario 3.** If both survive, the one with the least decline in their ALSFRS-R is ranked favorably (+1) vs. the counterpart
- **Scenario 4.** If both survive and exhibit similar functional decline, it would be a tie (no points)

Final ranking: Scores of every patient with respect to all their counterparts is summed and ranked.

Group mean: Mean rank score is calculated for both treatment and control groups (higher score suggests better "group" outcome; our benchmark for approval: ≥10%)

Dexpramipexole

Cudkowicz et al.[2]

Regimen	CAFS
50mg group	41.1
300mg group	52.4
Relative benefit	27%
p-value	0.046

NeuroNata-R

CorestemChemon Press Release[3]

Regimen	CAFS	Relative Benefit
Two doses	20.95	17% (p=0.024)
Five doses	24.78	38% (p=0.041)
Placebo	17.92	-

Mean CAFS Score: A "Hypothetical" Calculation (Our View)

	Study Drug	Control Group	Comments
Situation 1	489	438	Therapeutic outcome is better in the study drug
Situation 2	441	438	No significant difference between the group outcomes
Situation 3	438	475	Control group outperforms study drug; no efficacy

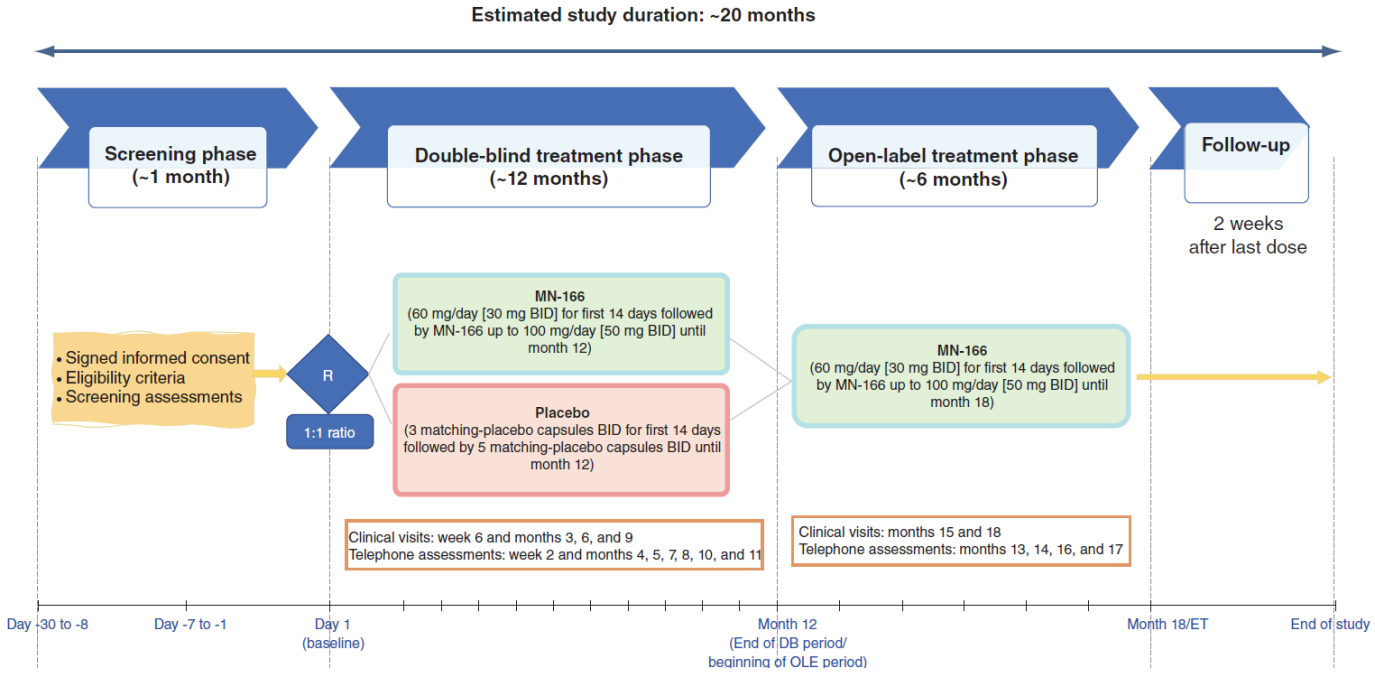
The objective of CAFS scoring was to calculate the mean CAFS scores of both treatment and control groups (see left), with higher scores signifying better group outcome. As shown in the Dexpramipexole example, the 300mg dose group (mean score: 52.4) showed better treatment outcome vs. the control group (41.1; relative benefit: 27%).

It is unclear what constitutes a clinically meaningful CAFS score, given such benchmark was never set. Given ALS' complex etiology, we believe an increase in mean rank score favoring the drug group ($p<0.05$) could qualify for FDA approval.

Source: [1]Berry et al., Amyotrophic Lateral Sclerosis and Frontotemporal Degeneration (2013); [2]Cudkowicz et al. Amyotrophic Lateral Sclerosis (2013); [3]CorestemChemon press release (September 17, 2025).

Phase 2b/3 (COMBAT-ALS) Study is Designed to Confirm MN-166 Efficacy in ALS Patients and Support Regulatory Submission

Ph2b/3 COMBAT-ALS Study Design



In our view, COMBAT-ALS prospectively enriches for earlier-stage patients with symptom onset ≤18 months, preserved pulmonary function and a mean baseline ALSFRS-R of 40.6. The larger sample and 12-month controlled period should reduce disease-progression variability and improve the ability to detect a clinically meaningful treatment effect. Our 'data-day' hierarchy: (1) Did CAFS hit p<0.05; (2) What was survival hazard ratio? (3) How many deaths/permanent ventilation events in each arm? (4) What is the pbo-adj ALSFRS-R improvements or % ALS disease slowing? (5) Were there secondary benefits (HHD/QoL); (6) What is the overall safety/tolerability profile of Ibudilast?

Note: Ph2b/3 COMBAT-ALS – NCT04057898.

Source: MediciNova SEC Filings and Corporate Presentation (March 2026).

On the heels of Ph1b data demonstrating signals of functional improvement (disease stabilization, survival extension) with an acceptable safety profile, MNOV initiated the registration-enabling Ph2b/3 COMBAT-ALS study (n=234; 1:1; 12 months; 100mg/day total vs. placebo). The study is fully enrolled with top-line data anticipated in 4Q26.

The study's primary endpoint is CAFS (a combined assessment of function and survival) upon 12 months of MN-166 therapy vs. pbo (sugar + Riluzole). Secondary objectives include muscle strength (HHD), QoL (ALSAQ-5) and responder analysis. If positive, MNOV could file for an FDA approval based on Ph2b/3 results (a strategy routinely used by ALS drug developers).

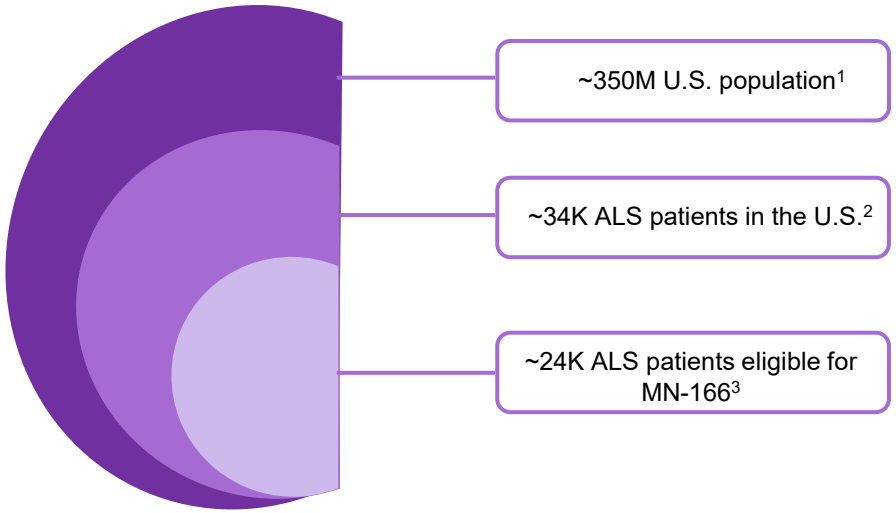
As outlined in pg-9, our base case is a CAFS nominal win with only a 1.0 – 2.0-pt pbo-adj ALSFRS-R benefit and weak survival contribution (mixed secondary and acceptable safety). However, a registrational-grade readout would involve: CAFS p<0.05; 2.0 – 3.0-pt pbo-adj ALSFRS-R benefit or 20% – 30% slowing; survival neutral to favorable (Bull) or CAFS p≤0.01; ≥3.0-pt ALSFRS-R benefit or ≥30% slowing of decline; favorable survival contribution (Super Bull).

3. Creating New Value in the ALS Treatment Landscape

MN-166 (ALS)

4Q26	2H27	1H28	2H28	2030	2033	2035
Ph2b/3 topline data readout	NDA filing	FDA accelerated approval*	U.S. launch	EMA approval and EU5 launch	>$1B in risk-unadjusted WW revenue	>$1.7B in risk-unadjusted sales

ALS U.S. Market Segmentation (2028)



- ~350M U.S. population[1]
- ~34K ALS patients in the U.S.[2]
- ~24K ALS patients eligible for MN-166[3]

MNOV's Commercialization Strategy

Of the estimated ~34K ALS patients in the U.S. in 2028, we believe ~24K may be eligible for MN-166 therapy.[3] Our base case assumes MN-166 FDA approval in 1H28 (POA: 55%) and launch in 2H28 (annual launch price: $200K per patient). Our models suggest ~5K U.S. patients on MN-166 therapy during peak year (2035) resulting in >$1.3B in peak revenue. Given that MNOV is a lean firm with six employees, we assumed a strategic partnership with an established firm for launch in 2H28 (flat royalty rate: 30% without any upfront payment).

Separately, we expect MN-166 to be approved by the EMA and be launched in EU5 in 2030 through a strategic partnership (POA: 55%; flat royalty rate: 30%; EU5 TAM: ~30K patients). With an annual launch price of $90K/patient, our models suggest MN-166 generating a peak risk-unadjusted revenue of $390M in 2035 (~3,700 patients on MN-166 therapy). We have not included ROW MN-166 revenue in our models.

Our models suggest MN-166 launch in the U.S. in 2H28 (EU launch: 2030), with a peak risk-unadjusted combined revenue of ~$1.7B in 2035 (MediciNova's share: $496M; flat royalty rate: 30%; POA: 55%). We projected generic competition entry in 2036, though there is a likelihood that this could occur later.

Note: [1]U.S. Census; [2]CDC, National ALS Registry, Company estimates based on current prevalence; [3]We currently assume ~70% of ALS patients have no respiratory difficulty and hence qualify for MN-166.*Our timeline/pricing assumptions were not confirmed by management; [4]MN-166 annual U.S. pricing based on Relyvrio's (Amylyx Pharma) launch price of $158K/patient in 2022; *Ph2 results could support approval subject to FDA alignment.

Source: Roth Capital Partners Estimates; MediciNova SEC Filings.

Competitive Landscape Analysis Highlights Mechanistic Differentiation

Selected ALS Agents in Clinical Trials

Sponsor	Agent	Modality	Rationale	Status	Comments
Clene Nanomedicine	CNM-Au8	Nanotherapeutic	Restores neuronal metabolism and reduces oxidative stress	Phase 3	Intends to submit an NDA (accelerated approval) in 4Q26 based on reductions in NfL and GFAP (key biomarkers)
MediciNova	MN-166	Oral small molecule	MIF inhibition to reduce inflammation	Phase 2b/3	A Ph2b/3 study (COMBAT-ALS) involving 234 pts is actively progressing; top-line data in 4Q26
AB Science	Masitinib	Oral small molecule	Tyrosine kinase inhibition	Phase 3	Ph3 study expected to resume in 2026; EMA and Health Canada previously issued negative opinions on conditional marketing authorization applications based on the previous Ph2b/3 single study
NeuroSense Tx	PrimeC	Oral small molecule	COX-2 inhibition; dicer upregulation	Phase 3	Ph3 PARAGON study to begin by mid-2026; ~70% increase in median survival observed with PrimeC vs. patients who were previously on placebo but later switched to PrimeC (total treatment: 36 mos)
Coya Tx	COYA 302	Cytokine and fusion protein immunomodulator	Regulatory T-cell modulation	Phase 2	Early biomarker signals; Ph2 (ALSTARS) study enrollment expected to complete in 2H26; top-line data in
CervoMed	Neflamapimod	Oral small molecule	p38 MAP kinase inhibitor	Phase 2-ready	Ph2 study initiation expected by 4Q26; initial ~35 ALS patients (expandable to 80); 18–24W; primary endpoint: change in blood NfL; funding by UK's NIHR designed to rapidly identify promising ALS therapies
LeonaBio	ATH-1105	Oral small molecule	Neurotrophic HGF system	Phase 2	Ph2 initiation of clinical trial of ATH-1105 in ALS patients in 1H26
Insmed	INS1202	Gene therapy	Reduce SOD1 production	Phase 1	In mouse models, INS1202 demonstrated a 70% improvement in median survival and significantly reduced human mutant SOD1 protein levels in the spinal cord; Ph1 study dosed first patient
Amylyx Pharma	AMX0114	Antisense oligonucleotide	Targets axonal degeneration in ALS	Phase 1	Ph1 Cohort 1 data found to be safe and tolerable; Cohort 2 dosing ongoing
Pasithea Tx	PAS-004	Small Molecule	Macrocyclic MEK inhibition	Phase 1	Nov '25: ALS Association has awarded ~$1M grant to evaluate PAS-004 in ALS patients

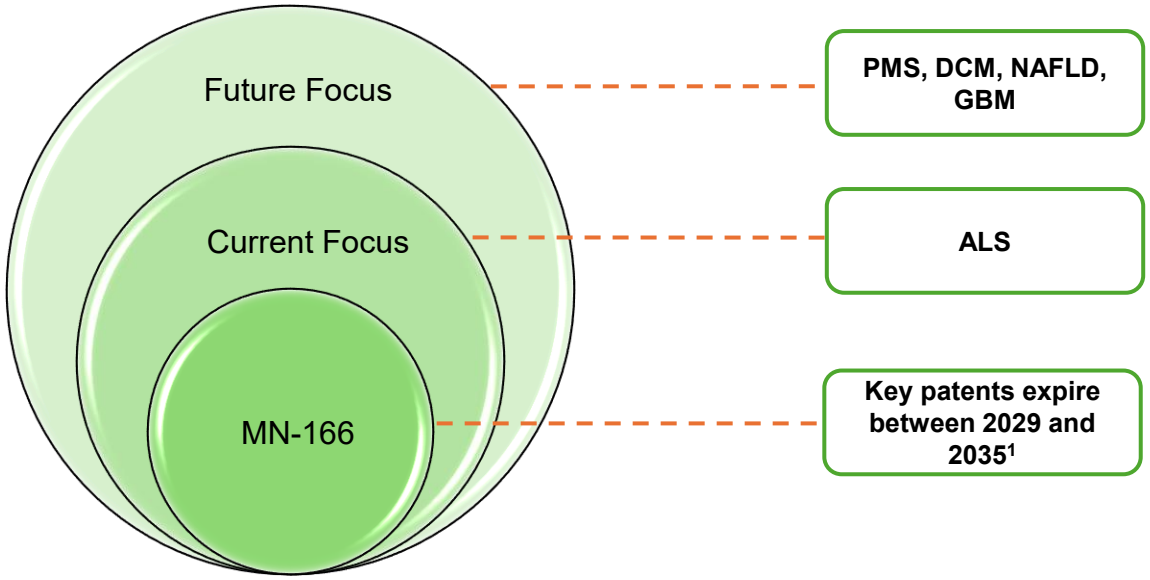
ALS is a fatal neurodegenerative disease that continues to present challenges from a drug development perspective. In fact, ALS clinical trials have a very high failure rate (>90%) vs. other indications, with only two drugs (Riluzole and Edaravone) approved for the broader ALS population among 125+ clinical trials studied.[1] Our analysis of ALS clinical landscape suggests that MN-166 could be the second-leading agent, with Clene's (CLNN-Buy; Aschoff, Ph.D.) CNM-Au8 expected to be filed under the accelerated approval pathway in 4Q26.

Note: [1]Petrov et al., Frontiers in Aging Neuroscience (2017); this slide was previously used in our NRSN initiation report.

Source: Roth Capital Partners; SEC filings of companies mentioned above.

4. IP Depth and Orphan Drug Exclusivity Create a Meaningful Competitive Moat

MNOV Patent Strategy



Selected Patents and Their Expiration Years

Patent Number	Indication	Anticipated Expiration Year[2]
US8338453	MS	2028
US9314452	ALS	2029
US11944607	PD	2028
US11083713	MS	2028
US10258611B2	ALS	2035
US11278531	ALS	2035
US11535670B2	Cancers	2042

IP Strategy

MediciNova's IP estate spans multiple in-licensed programs covering composition of matter, formulations and methods of treatment across neurological indications, ALS, MS and NASH, among others. We note that the core composition of matter patent for MN-166, in-licensed from Kyorin, is expired. If approved, MN-166 is eligible for orphan drug exclusivity (seven years in the U.S. and 10 years in the EU).

MN-166 Exclusivity in ALS

MediciNova has filed multiple method of use and formulation patents for MN-166 extending its runway between 2028 and 2035. The most relevant patent is US20210000804A1 that covers the combination regimen (MN-166 + Riluzole) for ALS treatment (slated expiration: 2035; generic entry in 2036; our view). We believe a 5-year patent extension may be granted, given MN-166 was never approved by the FDA.

IP-Guided Business Strategy

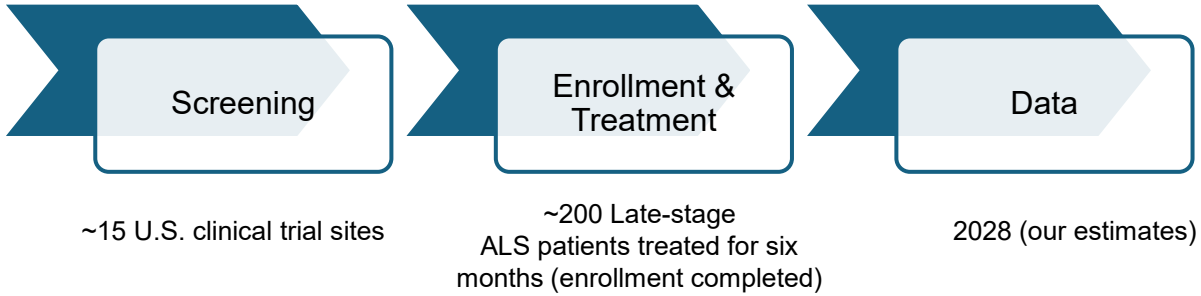
In our view, MNOV's broad therapeutic potential (particularly, the pipeline-in-a-molecule characteristics of MN-166) uniquely positions the company to prioritize core programs (e.g., ALS) vs. non-core programs that could be developed under strategic partnership (e.g., PMS and DCM). In our view, the comprehensive IP shield is an underappreciated component of the MNOV's investment thesis.

Note: PMS, DCM, NAFLD and GBM are not included in our valuation.

Source: [1]MediciNova SEC Filings; [2]Google Patents.

5. Advancements From SEA-NOBI-ALS Study Could Provide Optionality

Expanded Access Program (SEA-NOBI-ALS) Design



SEA-NOBI-ALS Endpoints

Endpoints	
Primary	Plasma NfL; ALSFRS-R change from baseline
Secondary	ALSAQ-5 (QOL), Neuro QOL, inflammatory cytokines assay
Criteria	
Inclusion	>18 yrs; onset: >36 months; SVC <50%
Exclusion	Abnormal liver enzymes; dropped out of the Ph2b/3 COMBAT-ALS study

In addition to the potential registration-enabling Ph2b/3 COMBAT-ALS study that is currently ongoing, MediciNova is jointly running an Expanded-Access Program, referred to as the SEA-NOBI-ALS study. In brief, the SEA-NOBI-ALS study is fully funded by the NIH ($22M) and has enrolled 200 late-stage ALS patients who would not qualify for any other clinical trials.

The study's primary endpoint is change from baseline in NfL levels (an endpoint used in the FDA approval of Tofersen in ALS patients exhibiting SOD1 mutations). While factors such as ALS progress, sub-type and genetic status could influence NfL levels in patients, with Clene's NDA of CNM-Au8 to be submitted in 4Q26, it is unclear whether NfL could be broadly applicable in ALS, in our view.

At this juncture, we have not included revenue contributions from the SEA-NOBI-ALS program for want of additional clarity (it is very difficult to show benefits in late-stage ALS patients). However, the study could provide additional safety, drug exposure, biomarker data that could be serve as external support for COMBAT-ALS, in our view.

Note: SEA-NOBI-ALS EAP – NCT06743776.

Source: MediciNova SEC Filings and Corporate Presentation (March 2026).

Financials

MN-166 (ALS) Revenue Model – U.S. & EU5

MN-166 (ALS, U.S.)	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042
U.S. Population ('000)	350,473	352,926	355,397	357,885	360,390	362,912	365,453	368,011	370,587	373,181	375,793	378,424	381,073	383,740	386,427
ALS patients	34,701	34,874	35,049	35,224	35,400	35,577	35,755	35,934	36,113	36,294	36,475	36,658	36,841	37,025	37,210
Growth rate	*0.5%*	*0.5%*	*0.5%*	*0.5%*	*0.5%*	*0.5%*	*0.5%*	*0.5%*	*0.5%*	*0.5%*	*0.5%*	*0.5%*	*0.5%*	*0.5%*	*0.5%*
ALS patients eligible for MN-166	24,290	24,412	24,534	24,657	24,780	24,904	25,028	25,153	25,279	25,406	25,533	25,660	25,789	25,918	26,047
Rate (%)	*70%*	*70%*	*70%*	*70%*	*70%*	*70%*	*70%*	*70%*	*70%*	*70%*	*70%*	*70%*	*70%*	*70%*	*70%*
MN-166 penetration	97	610	1,668	2,564	3,370	4,184	4,906	5,131	4,171	2,896	2,758	2,438	2,373	2,281	2,110
Market penetration rate (%)	*0.4%*	*2.5%*	*6.8%*	*10.4%*	*13.6%*	*16.8%*	*19.6%*	*20.4%*	*16.5%*	*11.4%*	*10.8%*	*9.5%*	*9.2%*	*8.8%*	*8.1%*
Net price of treatment ($)	$200,000	$206,000	$212,180	$218,545	$225,102	$231,855	$238,810	$245,975	$196,780	$157,424	$141,681	$134,597	$131,905	$129,267	$126,682
Annual price inflation rate (%)		*3%*	*3%*	*3%*	*3%*	*3%*	*3%*	*3%*	*-20%*	*-20%*	*-10%*	*-5%*	*-2%*	*-2%*	*-2%*
MN-166 revenue ($M)	$19	$126	$354	$560	$759	$970	$1,171	$1,262	$821	$456	$391	$328	$313	$295	$267
Risk-adjusted sales in the U.S. ($M)	**$11**	**$69**	**$195**	**$308**	**$417**	**$534**	**$644**	**$694**	**$451**	**$251**	**$215**	**$180**	**$172**	**$162**	**$147**
Revenue to MediciNova ($M)	$6	$38	$106	$168	$228	$291	$351	$379	$246	$137	$117	$98	$94	$88	$80
Risk-adjusted revenue to MediciNova ($M)	**$3**	**$21**	**$58**	**$92**	**$125**	**$160**	**$193**	**$208**	**$135**	**$75**	**$64**	**$54**	**$52**	**$49**	**$44**

MN-166 (ALS, EU)	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042
EU/U.K. ALS patients	30,452	30,605	30,758	30,911	31,066	31,221	31,377	31,534	31,692	31,850	32,010	32,170	32,330	32,492	32,655
Growth rate	*0.5%*	*0.5%*	*0.5%*	*0.5%*	*0.5%*	*0.5%*	*0.5%*	*0.5%*	*0.5%*	*0.5%*	*0.5%*	*0.5%*	*0.5%*	*0.5%*	*0.5%*
MN-166 penetration			153	738	1,298	2,454	2,997	3,734	2,649	2,472	2,389	2,273	2,059	2,004	1,917
Market penetration rate (%)			*0.5%*	*2.4%*	*4.2%*	*7.9%*	*9.6%*	*11.9%*	*8.4%*	*7.8%*	*7.5%*	*7.1%*	*6.4%*	*6.2%*	*5.9%*
Net price of treatment ($)			$90,000	$92,700	$95,481	$98,345	$101,296	$104,335	$78,251	$58,688	$55,754	$52,966	$54,025	$55,106	$56,208
Annual price inflation rate (%)			*3%*	*3%*	*3%*	*3%*	*3%*	*3%*	*-25%*	*-25%*	*-5%*	*-5%*	*2%*	*2%*	*2%*
MN-166 revenue ($M)			$14	$68	$124	$241	$304	$390	$207	$145	$133	$120	$111	$110	$108
Risk-adjusted sales in the EU ($M)			**$8**	**$38**	**$68**	**$133**	**$167**	**$214**	**$114**	**$80**	**$73**	**$66**	**$61**	**$61**	**$59**
Revenue to MediciNova ($M)			$4	$21	$37	$72	$91	$117	$62	$44	$40	$36	$33	$33	$32
Risk-adjusted revenue to MediciNova ($M)			**$2**	**$11**	**$20**	**$40**	**$50**	**$64**	**$34**	**$24**	**$22**	**$20**	**$18**	**$18**	**$18**

Note: Assumed royalty rate: 30%; MN-166 ALS POA: 55% (U.S. & EU); we currently do not model revenue contributions for other clinical programs/ROW regions; We estimate that there are ~33K ALS patients in the U.S. and ~30K in the EU5 (based on SEC filings of MOVO, COYA, NRSN); we currently assume 70% of ALS patients are initially eligible for MN-166 therapy based on our analysis of clinical trial criteria.

Source: Roth Capital Partners Estimates; MediciNova SEC filings.

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Income Statement: Historical and Projected

FY end December 31 $ in thousands, except per share data	2025A	2026E				2026E	2027E				2027E
		1Q26A	2Q26A	3Q26E	4Q26E		1Q27E	2Q27E	3Q27E	4Q27E	
Income Statement											
Revenue											
Product revenue											
License and other revenue	410	187	458	-	-	645					-
Total revenue	410	187	458	-	-	645	-	-	-	-	-
Operating expenses											
Cost of services	379	170	141	-	-	311	-	-	-	-	-
Research, development and patents	7,155	1,263	1,029	1,081	1,405	4,777	2,107	3,161	4,741	7,112	17,121
General and administrative	6,159	1,590	1,830	2,013	2,415	7,848	2,898	3,623	4,710	6,358	17,590
Total Operating Expenses	13,693	3,023	3,000	3,093	3,820	12,936	5,006	6,784	9,451	13,470	34,711
Gain (loss) from operations	(13,283)	(2,836)	(2,541)	(3,093)	(3,820)	(12,291)	(5,006)	(6,784)	(9,451)	(13,470)	(34,711)
Other income/expense											
Interest income	1,304	253	232	215	193	893	164	463	412	337	1,375
Other income (expenses), net	(13)	(3)	(5)		-	(8)	-	-	-	-	-
Total other income, net	1,291	250	227	215	193	885	164	463	412	337	1,375
Loss before provision for income taxes	(11,992)	(2,586)	(2,314)	(2,878)	(3,627)	(11,406)	(4,842)	(6,320)	(9,039)	(13,133)	(33,335)
Net income (loss)	(11,998)	(2,586)	(2,314)	(2,878)	(3,627)	(11,406)	(4,842)	(6,320)	(9,039)	(13,133)	(33,335)
Net loss per share (basic)	(0.24)	(0.05)	(0.05)	(0.06)	(0.07)	(0.23)	(0.08)	(0.11)	(0.16)	(0.23)	(0.58)
Net loss per share (diluted)	(0.24)	(0.05)	(0.05)	(0.06)	(0.07)	(0.23)	(0.08)	(0.11)	(0.16)	(0.23)	(0.58)
Weighted average number of shares outstanding (basic)	49,063	49,221	49,221	49,221	49,221	49,221	57,713	57,771	57,829	57,887	57,800
Weighted average number of shares outstanding (diluted)	49,063	49,221	49,221	49,221	49,221	49,221	57,713	57,771	57,829	57,887	57,800

Note: We assumed no revenue in 2H26 and 2027. We modeled $40M equity financing (8M shares; $5 per share) in assuming positive Ph2b/3 COMBAT-ALS study data.

Source: Roth Capital Partners Estimates; MediciNova SEC filings (2026).

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Leadership

Dr. Yuichi Iwaki
President & CEO

~ Founder, President and Chief Executive Officer of MediciNova
~ 30+ years of experience in transplantation immunology, immunogenetics, and advising biotech firms
~ Professor at USC (Urology, Surgery, Pathology); Director of Transplantation Immunology Lab since 1992; former Professor at University of Pittsburgh
~ Academics: M.D. and Ph.D. from Sapporo Medical School (Japan)

Dr. Kazuko Matsuda
CMO

~ Chief Medical Officer of MediciNova since 2010 (previously VP of Clinical Development)
~ Former Assistant Professor at USC Keck School of Medicine; prior tenure: Children's Hospital (Los Angeles)
~ M.D. and Ph.D. from Sapporo Medical School | MPH from Harvard School | Board-certified pediatrician (US & Japan)

Dr. David H. Crean
CBO

~ Chief Business Officer of MediciNova since May 2021
~ President & CEO of Coast BioVentures; Managing Partner at Cardiff Advisory (M&A and partnering focus)
~ Former Managing Director at Objective Capital; Board roles including Chairman at Histogen and Executive Committee member at CLSA
~ Ph.D. and M.S. from SUNY Buffalo | MBA from Pepperdine University | BS from Canisius College

Jason J. Kruger
CFO

~ Chief Financial Officer of MediciNova since June 2022
~ Founder and President of Signature Analytics (2008 – present)
~ Former Senior Manager at Deloitte & Touche; earlier roles at Moss Adams
~ BS from University of Arizona | CPA (inactive)

Source: MediciNova, Inc. Corporate Website.

Public Companies Mentioned in This Report

Company Name	Ticker	Rating
AbbVie Inc.	ABBV	Not Covered
Amylyx Pharmaceuticals, Inc.	AMLX	Not Covered
Astellas Pharma Inc.	ALPMF	Not Covered
AB Science S.A.	AB.PA	Not Covered
Biogen Inc.	BIIB	Not Covered
CervoMed Inc.	CRVO	Buy; Pachaiyappan, Ph.D.
Clene Inc.	CLNN	Buy; Aschoff, Ph.D.
Coya, Inc.	COYA	Buy; Pachaiyappan, Ph.D.
Cytokinetics, Inc.	CYTK	Not Covered
Denali Therapeutics, Inc.	DNLI	Not Covered
Insmed Inc.	INSM	Buy; Walsh M.D.
Kyorin Pharmaceutical Co Ltd	TYO: 4569	Not Covered
LeonaBio Inc.	LONA	Not Covered
Mitsubishi Tanabe Pharma Corp.	OTC: MTZPY	Not Covered
NeuroSense Therapeutics Ltd.	NRSN	Buy; Pachaiyappan, Ph.D.
Otsuka Holdings Co., Ltd.	OTSKY	Not Covered

Company Name	Ticker	Rating
Pasithea	KTTA	Not Covered
PharmAust Limited	ASX: PAA	Not Covered
PTC, Inc.	PTCT	Not Covered
Sanofi SA	SNY	Not Covered
Seelos, Inc.	SEEL	Not Covered

Valuation: MediciNova, Inc. (MNOV)

We derive our 12-month PT of $6 per share from a DCF analysis using a 12% WACC and 5% terminal growth of decline beginning in 2036. Notably, we assume a probability of approval (POA) of 55% for MN-166 in the ALS indication in both the U.S. and EU5 regions. Our higher-than-average POA reflects the novel disease-modifying potential of the asset and expected regulatory flexibility from the FDA for accelerated approval. We do not account for revenue contributions for other indications/regions.

Factors that could impede shares of MediciNova from achieving our price target include, but are not limited to: (1) clinical/regulatory setbacks; (2) slower-than-anticipated market penetration of MN-166 in ALS; (3) failure to generate positive efficacy in the ongoing or future clinical studies; (4) delays in securing funding; (5) a lack of regulatory alignment or failure to obtain approval in the U.S. and/or EU for pipeline programs; (6) potential partnership risks; and (7) potential near- and medium-term dilution risk.

Risks: MediciNova, Inc. (MNOV)

Clinical risk. MediciNova's agents could fail to deliver clinically meaningful and statistically significant results in clinical studies, substantially reducing the value of the company's product candidates and our target price.

Regulatory risk. Even if successful in the clinic, MediciNova's products could fail to be approved by domestic and/or foreign regulatory agencies, reducing their value and, therefore, our target price.

Commercialization risk. The company could face substantial challenges to commercialize its products. There is no guarantee MediciNova's products would be preferred by prescribers over competing products.

Reimbursement risk. The global drug pricing and reimbursement environment is constantly changing, which could have major ramifications for the company and the broader healthcare ecosystem.

Financing risk. MediciNova might need additional capital to fund its operations, and such financing may not occur, or it could be substantially dilutive to existing investors.

Competitive risk. Any future approved products of MediciNova may not be well adopted in a competitive marketplace, adversely affecting its value and, therefore, our target price.

Market risk. The market price of SMid-Cap stocks has been and may continue to be volatile without company-specific fundamental reasons, which may result in substantial losses for investors.

Company Description: MediciNova, Inc. (MNOV)

MediciNova is a mid-stage biopharmaceutical company focused on developing disease-modifying therapies for neurodegenerative diseases, with a primary emphasis on ALS. The company's flagship asset (MN-166) demonstrated positive Ph1b/2a (n=51) data demonstrating disease stabilization and survival benefits. A Ph2b/3 study (n=234) is fully enrolled; top-line data in 4Q26.

Regulation Analyst Certification ("Reg AC"): The research analyst primarily responsible for the content of this report certifies the following under Reg AC: I hereby certify that all views expressed in this report accurately reflect my personal views about the subject company or companies and its or their securities. I also certify that no part of my compensation was, is or will be, directly or indirectly, related to the specific recommendations or views expressed in this report.

For important disclosure information regarding the companies in this summary report, please contact the Director of Research at (800) 678-9147 or write to: ROTH Capital Partners, LLC, Attention: Director of Research, 888 San Clemente Drive, Newport Beach, CA 92660

Disclosures:

ROTH makes a market in shares of Clene, Inc. and as such, buys and sells from customers on a principal basis.
Shares of MediciNova, Inc., Clene, Inc., Coya Therapeutics, Inc. and CervoMed Inc may be subject to the Securities and Exchange Commission's Penny Stock Rules, which may set forth sales practice requirements for certain low-priced securities.

Distribution of IB Services Firmwide

			IB Serv./Past 12 Mos. as of September 16, 2026	
Rating	**Count**	**Percent**	**Count**	**Percent**
Buy [B]	**398**	**77.28**	**113**	**28.39**
Neutral [N]	**70**	**13.59**	**6**	**8.57**
Sell [S]	**1**	**0.19**	**0**	**0**
Under Review [UR]	**46**	**8.93**	**15**	**32.61**

Our rating system attempts to incorporate industry, company and/or overall market risk and volatility. Consequently, at any given point in time, our investment rating on a stock and its implied price movement may not correspond to the stated 12-month price target.

Ratings System Definitions - ROTH Capital employs a rating system based on the following:

Buy: A rating, which at the time it is instituted and or reiterated, that indicates an expectation of a total return of at least 10% over the next 12 months.

Neutral: A rating, which at the time it is instituted and or reiterated, that indicates an expectation of a total return between negative 10% and 10% over the next 12 months.

Sell: A rating, which at the time it is instituted and or reiterated, that indicates an expectation that the price will depreciate by more than 10% over the next 12 months.

Under Review [UR]: A rating, which at the time it is instituted and or reiterated, indicates the temporary removal of the prior rating, price target and estimates for the security. Prior rating, price target and estimates should no longer be relied upon for UR-rated securities.

Not Covered [NC]: ROTH Capital does not publish research or have an opinion about this security.

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