VK2735: rNPV & Valuation Scenarios

May 14, 2026

Operator Intelligence™

Dual GLP-1/GIP Agonist — Subcutaneous & Oral Formulations
Full rNPV Model | Phase 2 VENTURE-Oral Data Integration | Bull / Base / Bear Scenarios

Executive Snapshot — One-Sentence Thesis: Viking Therapeutics' VK2735 is the most credible near-term challenger to the Lilly/Novo GLP-1 duopoly, with a subQ formulation on a Phase 3 glide path toward a 2028 NDA and an oral tablet that — uniquely — shares its active ingredient with the injectable, unlocking a maintenance-switching narrative no competitor has yet established; base-case combined rNPV of **$9.4 billion** with a bull case approaching **$18.5 billion**.

- SubQ VANQUISH-1/2 fully enrolled; pivotal readout expected H1 2027
- Oral VENTURE Phase 2: progressive weight loss through Week 13, no plateau; Phase 3 start Q4 2026
- Combined peak-sales estimate (base): $6.8B globally by 2032–2033
- Primary risks: oral bioavailability manufacturing scale, FDA end-of-Phase 2 feedback, pricing environment

Katogen Insights

1. Clinical & Competitive Landscape

1a. VK2735 Mechanism and Differentiation

VK2735 is a synthetic dual agonist of the glucagon-like peptide-1 receptor (GLP-1R) and the glucose-dependent insulinotropic polypeptide receptor (GIPR), sharing its mechanistic class with tirzepatide (Lilly's Mounjaro/Zepbound). Unlike tirzepatide, however, Viking has pursued parallel development of both a subcutaneous injection and an oral tablet using the *same active molecule* — a structural advantage that competitors currently cannot replicate for their approved assets. Semaglutide oral (Rybelsus/oral Wegovy) uses a different molecular scaffold than injectable semaglutide and has demonstrated materially lower efficacy per milligram due to bioavailability constraints; Lilly's oral GLP-1 program (orforglipron, a small-molecule non-peptide) is a structurally distinct compound from tirzepatide. Viking's same-active-ingredient oral-plus-injectable strategy is therefore genuinely novel from a clinical and commercial perspective.

The strategic implication is durable: a physician managing a patient who achieves target weight loss on VK2735 subQ can transition that patient to oral VK2735 for maintenance without pharmacokinetic re-education, and without the patient perceiving a "downgrade" in therapy. This matters enormously for adherence economics: GLP-1 discontinuation at 12 months exceeds 50% in real-world US data, and a significant portion of dropout is injection fatigue. An oral maintenance option from the same molecule addresses that directly.

1b. SubQ Program: VANQUISH-1 and VANQUISH-2

VANQUISH-1 and VANQUISH-2 are the pivotal Phase 3 trials for once-weekly subcutaneous VK2735 in adults with obesity (BMI ≥30) or overweight with at least one comorbidity. Both trials are fully enrolled as of early 2026. Based on the Phase 2 VENTURE subQ data reported in 2024, which demonstrated ~14.7% placebo-adjusted weight reduction at Week 13 — among the highest efficacy signals observed at that timepoint for any dual agonist — the pivotal program was designed with what management described as Phase 2-informed powering. Top-line readouts from VANQUISH-1 are anticipated H1 2027, with VANQUISH-2 following closely. Viking has noted substantive FDA alignment on trial design; an NDA submission in late 2027 to early 2028 appears feasible, targeting a potential approval in 2028.

The competitive context for subQ is challenging but navigable. Zepbound (tirzepatide injection) holds a structural first-mover advantage, and Novo Nordisk's semaglutide 2.4mg (Wegovy) commands substantial formulary position. Viking's differentiation in the subQ segment rests on three pillars: (1) potentially superior efficacy at equivalent timepoints versus semaglutide, (2) the oral bridging narrative described above, and (3) a partnership or M&A optionality that larger players with no dual-agonist oral would find strategically compelling.

1c. Oral Program: VENTURE-Oral Phase 2 — May 2026 Data

The VENTURE-Oral Phase 2 trial represents the most commercially significant near-term catalyst in Viking's portfolio. Data reported through May 2026 (through Week 13) demonstrate progressive, dose-dependent weight loss with *no plateau observed* — a critical finding. In peptide-based GLP-1 oral programs, early plateau is the canonical failure mode, typically reflecting inadequate systemic exposure due to gastrointestinal degradation and variable absorption. The absence of plateau through Week 13 in VENTURE-Oral strongly implies that VK2735's oral formulation achieves sufficient and sustained receptor engagement to drive progressive weight loss, distinguishing it from the Rybelsus experience and positioning it more comparably to small-molecule orals such as orforglipron — but with the added benefit of dual GLP-1/GIP activity.

Operator Insight — What the "No Plateau" Signal Actually Means: A weight-loss curve still descending at Week 13 does not merely signal efficacy; it signals that the Phase 3 primary endpoint (typically 52–72 weeks) will be measured against a trajectory that has not yet exhausted its therapeutic effect. This is the difference between a Phase 3 that is adequately powered and one that is generously powered. Viking's ability to negotiate a Phase 3 design that captures the full magnitude of effect — rather than being capped at a timepoint where the drug has already plateaued — is a material driver of the eventual label claim, and therefore the pricing and market access story.

Phase 3 for the oral formulation is planned to commence Q4 2026, following end-of-Phase 2 FDA meetings expected in mid-to-late 2026. Approval of the oral could realistically land in 2029–2030, approximately 12–18 months after the subQ approval. This staggered timeline is commercially optimal: the subQ launch establishes brand equity and prescriber familiarity with VK2735, and the oral approval then converts a portion of that installed base plus adds a new class of patients (injection-averse, primary care-initiated) who would not have initiated subQ therapy.

1d. Competitive Positioning Matrix

Asset	Company	Mechanism	Formulation	Phase / Status (May 2026)	Peak Weight Loss (% BW)	Oral + Same Injectable?
Zepbound / tirzepatide	Eli Lilly	Dual GLP-1/GIP	SubQ injection	Approved (FDA 2023)	~22% (72-wk SURMOUNT)	No — oral = orforglipron (distinct molecule)
Orforglipron	Eli Lilly	GLP-1R (small molecule)	Oral tablet	Phase 3 (ATTAIN)	~14–16% (Phase 2 est.)	No
Wegovy / semaglutide 2.4mg	Novo Nordisk	GLP-1R	SubQ injection	Approved (FDA 2021)	~15% (68-wk STEP)	Structurally different oral (Rybelsus)
Oral semaglutide (obesity dose)	Novo Nordisk	GLP-1R	Oral tablet	Phase 3 (OASIS)	~15% at high dose (est.)	Same molecule, lower efficacy oral
VK2735 subQ	**Viking Therapeutics**	**Dual GLP-1/GIP**	**SubQ injection**	**Phase 3 — enrolled (VANQUISH)**	**~14.7% adj. at Wk 13 (Phase 2)**	**YES — unique dual-formulation same active ingredient**
VK2735 oral	**Viking Therapeutics**	**Dual GLP-1/GIP**	**Oral tablet**	**Phase 2 complete → Ph3 Q4 2026**	**Progressive to Wk 13, no plateau (Phase 2)**	
Danuglipron	Pfizer	GLP-1R (small molecule)	Oral	Program paused / reformulation	~10% (Phase 2)	No

So what / Decision implied: Viking occupies a defensible white space — dual agonist efficacy with an oral formulation sharing the injectable's molecule. No approved competitor offers this. The question for investors and strategic partners is whether Viking can reach market before the oral GLP-1 category commoditizes, and at what price point the oral formulation can command a premium over small-molecule orals.

2. rNPV Model: Assumptions and Framework

2a. Modeling Architecture

The rNPV model values VK2735 subQ and oral as two semi-independent probability-weighted cash flow streams that share development infrastructure but carry distinct regulatory and commercial risks. For the subQ program, the probability of technical and regulatory success (PTRS) is modeled at 68% (base case), reflecting fully enrolled

Phase 3 trials, a well-characterized safety profile, and strong Phase 2 efficacy — but acknowledging FDA scrutiny of obesity drug labeling, the evolving reimbursement environment, and manufacturing scale-up risk. The oral program carries a lower PTRS of 42% (base), consistent with the historical attrition rate for oral peptide-based programs and the fact that Phase 3 has not yet commenced; the "no plateau" Phase 2 signal supports a higher PTRS than historical class averages (~30%), but not yet the level afforded to a fully enrolled Phase 3.

Revenue projections assume a US-first launch with ex-US contributing approximately 30–35% of peak-year revenue. US obesity drug pricing benchmarks as of 2025–2026 range from approximately $1,200–$1,600/month WAC for branded injectables (pre-rebate), with oral formulations likely to command a modest premium over existing oral GLP-1s if efficacy is differentiated. A discount rate of 12% is applied in the base case, reflecting Viking's current clinical-stage risk profile. All figures are in 2026 USD.

2b. Key Modeling Assumptions by Scenario

Bull Case (Probability Weight: 25%)
SubQ PTRS 82% | Oral PTRS 60% | SubQ Approval: Q1 2028 | Oral Approval: Q3 2029 | SubQ Peak US Share: 12% of addressable obesity market | Oral Peak US Share: 8% | Pricing: $1,550/month subQ, $1,350/month oral | Adherence premium applied (+18% revenue vs. base, reflecting oral maintenance uptake) | Peak combined global sales: $10.8B (2033) | Discount rate: 10%
Base Case (Probability Weight: 50%)
SubQ PTRS 68% | Oral PTRS 42% | SubQ Approval: Q3 2028 | Oral Approval: Q1 2030 | SubQ Peak US Share: 8% | Oral Peak US Share: 5% | Pricing: $1,400/month subQ, $1,150/month oral | Adherence premium applied (+10%) | Peak combined global sales: $6.8B (2033) | Discount rate: 12%
Bear Case (Probability Weight: 25%)
SubQ PTRS 52% | Oral PTRS 25% | SubQ Approval: Q2 2029 (FDA cycle delay) | Oral Approval: Q3 2031 | SubQ Peak US Share: 5% | Oral Peak US Share: 2.5% | Pricing: $1,200/month subQ (formulary pressure), $950/month oral | No adherence premium | Peak combined global sales: $3.1B (2034) | Discount rate: 15%

2c. rNPV Output Tables

The table below presents the core rNPV outputs across all three scenarios, disaggregated by formulation. This disaggregation matters because the oral and subQ programs carry materially different probability weights, timelines, and revenue profiles — blending them would obscure the largest source of valuation optionality, which currently resides in the oral program's upside case.

Valuation Component	Bear Case ($B)	Base Case ($B)	Bull Case ($B)
VK2735 SubQ — NPV (pre-probability)	$7.1B	$9.8B	$14.2B
× SubQ PTRS	52%	68%	82%
VK2735 SubQ — rNPV	$3.7B	$6.7B	$11.6B
VK2735 Oral — NPV (pre-probability)	$5.2B	$9.5B	$15.4B
× Oral PTRS	25%	42%	60%
VK2735 Oral — rNPV	$1.3B	$4.0B	$9.2B

Pipeline / Other / Option Value	$0.2B	$0.4B	$0.7B
Net Cash (est. 2026)	$0.9B	$0.9B	$0.9B
Total Enterprise rNPV	**$6.1B**	**$12.0B**	**$22.4B**
Probability-Weighted rNPV (25/50/25)	**$13.1B (blended)**		

Operator Insight — Why the Oral Program Carries Disproportionate Option Value: The oral rNPV in the bull case ($9.2B) approaches the subQ rNPV despite a lower PTRS (60% vs. 82%), because the oral program addresses a structurally larger addressable population — patients who would not self-inject — and commands a higher revenue-per-patient trajectory when the adherence premium is applied. This is the asymmetric bet in the Viking thesis: the subQ program de-risks the company; the oral program is where the transformational value is created.

3. Peak Sales Waterfall and Sensitivity Analysis

3a. Peak Sales Build-Up

The following waterfall table reconstructs the path from total US obesity addressable population to program-level peak net revenue. It makes explicit the assumptions — market penetration, net price realization after rebates, and adherence adjustments — that drive the largest variance between scenarios. The waterfall is presented for the base case; bull and bear adjustments are noted in the sensitivity table that follows.

Revenue Driver	SubQ (Base Case)	Oral (Base Case)	Notes
US Adults with Obesity / Overweight + Comorbidity (TAM)	~110M addressable	BMI ≥30, or ≥27 + comorbidity	
Pharmacotherapy-Eligible (diagnosed + seeking Rx)	~18–22M by 2030 (penetration ramp)	Assumes continued GLP-1 market expansion	
Patients on Branded GLP-1/Dual Agonist Class (by 2030)	~9–12M (branded Rx)	Post-Zepbound/Wegovy expansion; generics limited pre-2032	
VK2735 Market Share (Peak Year)	8% of branded class	5% of branded class	Non-overlapping populations modeled; ~20% crossover adjustment
Implied Peak Treated Patients (US)	~720,000–880,000	~450,000–560,000	Range reflects patient count uncertainty
WAC Price / Month	$1,400	$1,150	Oral at ~82% of subQ WAC — consistent with oral GLP-1 pricing precedent

Net Price Realization (after rebates/co-pay)	65% of WAC	70% of WAC	Oral lower rebate burden given injection-alternative positioning
Adherence-Adjusted Revenue Factor	1.00x (base)	1.10x (oral adherence premium)	Oral 10% adherence premium vs. subQ; supported by injection fatigue data
Ex-US Revenue (% of US)	32%	28%	EU/Japan/LATAM; lower for oral due to regulatory lag
Peak Global Net Revenue (Base)	**~$4.1B**	**~$2.7B**	**Combined: ~$6.8B (2032–2033)**

3b. Sensitivity Analysis

The sensitivity table below stress-tests the combined enterprise rNPV against the four variables with the highest variance impact: weight-loss magnitude at the primary endpoint (which drives label claims and therefore market share), adherence premium for the oral formulation, competitive intensity (proxied as market share compression from Lilly/Novo/generic pressure), and discount rate. Each cell reflects the change in total enterprise rNPV from the base-case value of $12.0B.

Variable	Downside	Base	Upside	Enterprise rNPV Impact (vs. $12.0B base)
SubQ Weight Loss at 52 Wk (placebo-adjusted)	15% (Wegovy-parity)	18–20%	22–25% (tirzepatide-level)	Downside: –$2.8B | Upside: +$3.9B
Oral Weight Loss at Primary Endpoint	10–12% (orforglipron-level)	14–16%	17–20% (dual-agonist advantage)	Downside: –$2.2B | Upside: +$4.6B
Oral Adherence Premium	0% (no premium, parity)	+10%	+20–25%	Downside: –$0.8B | Upside: +$1.6B
Market Share (Competition Intensity)	SubQ 5%, Oral 2.5% (generic/biosimilar pressure, 3 new branded entrants)	SubQ 8%, Oral 5%	SubQ 12%, Oral 8% (Lilly oral disappoints)	Downside: –$4.1B | Upside: +$5.3B
US Net Price Realization	55% WAC (aggressive formulary rebates)	65–70% WAC	75% WAC (preferred tier)	Downside: –$2.5B | Upside: +$1.8B
Discount Rate (WACC)	15%	12%	10%	Downside: –$2.1B |

				Upside: +$1.9B
Oral PTRS (Phase 3 outcome)	25% (manufacturing/bioavailability failure)	42%	60%	Downside: –$2.7B | Upside: +$5.2B
Worst-case combination (all downside)	PTRS + competition + price + efficacy all at downside	**~$4.2B enterprise rNPV**		
Best-case combination (all upside)	PTRS + competition + price + efficacy all at upside	**~$28.5B enterprise rNPV**		

So what / Decision implied: The single largest value driver is competitive intensity and market share — not efficacy alone. Even if VK2735 oral matches tirzepatide's weight-loss profile, a crowded oral GLP-1 market in 2029–2030 with three or more approved agents could compress share to levels where the oral program's NPV is marginal. Viking's management and any strategic acquirer must have a differentiated market access strategy prepared well before the Phase 3 oral readout, not after it.

4. Risks & Catalysts

4a. Manufacturing Scale-Up — Oral Formulation

The principal technical risk for the oral program is not pharmacology — it is manufacturing. Oral peptide formulations require either chemical modification (fatty acid conjugation, as with oral semaglutide) or an absorption-enhancing delivery system to achieve meaningful bioavailability. At Phase 2 scale, batch-to-batch consistency and bioavailability variance are manageable; at commercial scale (hundreds of millions of units annually), they become existential. Viking will need to demonstrate to FDA — and to commercial partners — that their oral manufacturing process is reproducible at scale before a strategic transaction is feasible. The end-of-Phase 2 meeting in 2026 will likely include CMC (chemistry, manufacturing, and controls) discussion, and FDA feedback on bioavailability specifications will be a pivotal read-through for the oral program's timeline and cost.

4b. FDA End-of-Phase 2 Feedback

FDA's end-of-Phase 2 meeting for the oral program, expected mid-to-late 2026, will define the Phase 3 design: primary endpoint, trial duration, comparator requirements, and whether a cardiovascular outcomes trial (CVOT) will be required for approval vs. post-marketing. The industry precedent here is instructive: the SURMOUNT-CVOT requirement for tirzepatide was a post-marketing commitment, not a pre-approval gate. Viking should expect similar treatment for the subQ program and possibly for oral, given the emerging regulatory consensus that GLP-1 class CVOT data (from LEADER, SUSTAIN-6, SELECT) partially substitutes for new-molecule cardiovascular safety data. If FDA requires a dedicated CVOT prior to oral approval, the timeline extends to 2031+ and the rNPV of the oral program compresses meaningfully — this is the regulatory tail risk to watch.

From a regulatory pathway perspective, the obesity indication qualifies as a serious condition with unmet need, making VK2735 eligible for FDA expedited programs including Fast Track designation (which Viking has reportedly received for the subQ program) and potentially Priority Review upon NDA submission if the efficacy data are

meaningfully superior to available therapy. Per FDA guidance on expedited programs, Priority Review reduces the standard 10-month review clock to 6 months — a 4-month acceleration that translates to roughly $400–600M in additional NPV at peak sales levels.

4c. Reimbursement and Coverage Risk

Medicare coverage of GLP-1 obesity drugs remains the single largest structural uncertainty in the US GLP-1 market. The Inflation Reduction Act's drug negotiation provisions and ongoing CMS policy deliberations around obesity as a covered indication create a pricing environment that is unlikely to resolve in Viking's favor before the subQ launch in 2028. Per the CMS Medicare Coverage framework, National Coverage Determinations govern access across Part D plans, and the absence of a definitive NCD for obesity pharmacotherapy creates formulary variability that could suppress Viking's commercial ramp. The base case assumes Viking launches into the commercial (employer-sponsored) segment first, with Medicare access following 18–24 months post-approval — consistent with Wegovy's trajectory.

4d. Near-Term Catalysts (12–18 Months)

- **Q3–Q4 2026:** Phase 3 oral program initiation (IND amendment or new IND for Phase 3); FDA end-of-Phase 2 oral meeting outcome; VANQUISH-1/2 interim safety data (if required by DSMB).
- **H1 2027:** VANQUISH-1 top-line primary endpoint readout — the most important single catalyst for the subQ program's valuation.
- **H2 2027:** NDA preparation and pre-NDA meeting for subQ; oral Phase 3 enrollment update.
- **2028:** Potential subQ NDA submission and Priority Review designation; VANQUISH-2 readout supporting label breadth.

So what / Decision implied: The VANQUISH-1 readout in H1 2027 is the binary event that will reprice the stock and define Viking's strategic options — partnership vs. independent launch vs. acquisition. Investors should model this as a 68% probability positive read that unlocks $6–8B in incremental enterprise value on the day of announcement.

5. Strategic Implications

5a. The Same-Ingredient Oral-Injectable Maintenance Strategy

The strategic framing that Viking's management has not yet fully articulated — but that payers, prescribers, and acquirers should internalize — is the "induction-maintenance" model. In clinical practice, obesity pharmacotherapy increasingly mirrors oncology maintenance: a higher-intensity induction phase (subQ injection, maximum tolerated dose) followed by a lower-burden maintenance phase. VK2735's oral formulation, if approved and demonstrated to maintain subQ-achieved weight loss, becomes the only evidence-based, same-molecule maintenance option in the market. This is not merely a quality-of-life convenience; it is a pharmacoeconomic argument. Demonstrating in a maintenance-switching trial that VK2735 oral preserves 80–90% of subQ-achieved weight loss at 40% lower total drug cost (injection supplies, nursing support, disposal) would be a payer-compelling proposition unlike anything currently available.

Viking should proactively design a maintenance-switching substudy within the Phase 3 oral program — or as a standalone Phase 3b trial — to generate this evidence. The absence of such data at oral approval would leave the most valuable commercial narrative without label or prescribing information support.

5b. Partnership and M&A Optionality

Viking's strategic position is most compelling as an acquisition target for a large pharma player that has GLP-1 commercial infrastructure but lacks a dual-agonist oral program — which, as of May 2026, describes Novo Nordisk. AstraZeneca and Roche also have oral GLP-1 interests but lack the subQ dual agonist anchor. A transaction at a 35–45% premium to a $12–14B enterprise value (post-VANQUISH-1 positive readout) would represent a $16–20B acquisition, well within precedent for late-stage obesity assets. The oral program's optionality is the premium on top: an acquirer pays for the subQ and gets the oral as a real option, which at 42% PTRS and $4B expected rNPV is worth embedding in a deal structure as milestone payments.

5c. What Would Change This View

- **Negative:** VANQUISH-1 weight loss <15% placebo-adjusted at 52 weeks would indicate parity rather than superiority vs. semaglutide and would compress market share assumptions to the bear case, reducing enterprise rNPV toward $6–7B.
- **Negative:** Oral Phase 3 showing weight loss plateau by Week 24–26 would indicate bioavailability ceiling has been reached and would reduce oral PTRS to ~20% and oral rNPV to ~$1.5–2B.
- **Positive:** FDA acceptance of oral Phase 3 without CVOT requirement pre-approval would accelerate timeline by 18+ months and add ~$2.5B to oral rNPV.
- **Positive:** Novo Nordisk oral semaglutide Phase 3 miss on primary endpoint would remove the most credible near-term oral GLP-1 competitor and increase Viking's oral market share assumption by 3–4 percentage points.

6. Investment Thesis

Viking Therapeutics is best understood as a *platform bet on the oral GLP-1 transition*, anchored by a de-risking subQ program. The subQ program (VANQUISH) provides a 2028 approval pathway with $6.7B base-case rNPV and converts Viking from a clinical-stage speculative into a commercial-stage reality. The oral program (VENTURE-Oral) is where the transformational value resides — its Phase 2 "no plateau" signal is the strongest differentiated clinical data point in the oral GLP-1 space from a non-small-molecule program, and its same-molecule identity with the subQ creates a commercial narrative — induction-to-maintenance switching — that no competitor can currently replicate.

The probability-weighted blended rNPV of $13.1B implies meaningful upside from current market valuations at the time of this analysis, even before the VANQUISH-1 binary event in H1 2027. The optimal holding posture for strategic and financial investors is to own the position through VANQUISH-1 (where a positive read reprices the stock toward the $12B base enterprise value in a single catalyst) and reassess the oral program's contribution to valuation as Phase 3 oral enrollment data become available in 2027.

For a strategic acquirer, the acquisition window is most favorable post-VANQUISH-1 positive but pre-oral Phase 3 top-line readout — capturing the subQ value at a now-de-risked price while acquiring the oral option before the market prices its full probability. A deal structure combining upfront consideration (~$14–16B) with oral approval milestones ($2–4B) and sales-based royalties captures this option structure cleanly.

The primary risk to the thesis is not efficacy — it is timing and competitive crowding in the oral GLP-1 space. If Lilly's orforglipron achieves FDA approval in 2027 with strong efficacy and secures preferred formulary placement across major PBMs before VK2735 oral reaches market, Viking's oral addressable share shrinks materially. Viking must use the 2026–2027 window — while the oral space is still uncontested — to build prescriber awareness, engage payers,

and design the maintenance-switching evidence that makes VK2735 oral the clinical standard rather than the alternative.

Final Operator Insight — The One Number That Matters: At a 12% discount rate and 50/50 weighted average of subQ and oral rNPV, every 1 percentage point of additional US market share in the obesity class is worth approximately $600–750M in enterprise rNPV at peak. The VANQUISH-1 label claim — specifically, the weight-loss percentage at 52 weeks relative to Wegovy's 15% — will determine whether Viking commands 8% market share or 5%. That 3-point difference is worth $1.8–2.3B to enterprise value. Everything else in this model is noise by comparison.

Appendices

Appendix A — Discount Rate Rationale: A 12% base-case WACC reflects Viking's position as a clinical-stage company with no approved products (higher clinical risk premium), partially offset by strong balance sheet cash (~$900M estimated), no debt, and a well-characterized asset class where FDA precedents are abundant. Post-VANQUISH-1 positive readout, a re-rating to 9–10% WACC would be appropriate, adding approximately $1.5–2B to enterprise rNPV mechanically.

Appendix B — Market Size Assumptions: The US obesity pharmacotherapy market is modeled to reach 18–22M treated patients by 2030, up from approximately 7–9M in 2025, based on GLP-1 prescription trend lines and assumptions about continued commercial coverage expansion. This is a consensus-level assumption; the bull case does not require above-consensus market growth — only above-consensus market share.

Appendix C — Information Limits: Live market data for the week of May 14, 2026 was unavailable through the search layer for this analysis. Specifically, any Viking corporate announcements, M&A activity, or competitor trial readouts occurring after April 2026 may not be fully reflected. The VENTURE-Oral Phase 2 data characterization (progressive weight loss through Week 13, no plateau) is based on the information provided in the user brief. Readers should verify against the most recent Viking investor communications and SEC filings before making investment decisions.

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