insmed

2025 Annual Report

Further.

Jane, living with non-cystic fibrosis bronchiectasis (NCFB)

Further
has no finish line.

It has no destination
or fixed endpoint.

Further means evolution—continuously setting bigger goals in service to patients.

This mindset matters. Patients cannot afford limits, so our science must have no bounds.

Progress on this scale demands reflection; the discipline to assess performance and adapt to change. To recalibrate and build on what we've learned. It calls for design with intention and agility in execution.

In 2025, we were ready—aligned on priorities and prepared for the opportunities ahead. In 2026, that readiness **will take us even further**: reaching more patients, expanding our scientific pursuits, and delivering the greatest possible impact.

"It's important to have a doctor who's not only very knowledgeable but also your advocate and supporter, as well as to stay active, eat right, and understand the treatments."

Julie, living with *Mycobacterium avium* complex (MAC) lung disease

"The most challenging thing about living with bronchiectasis is that I never knew when an exacerbation would hit or how awful it was going to be. It means a lot to me that I can make plans and do the things I love."

Jane, living with NCFB

To Our Shareholders:

In 2025, Insmed demonstrated what's possible when breakthrough science meets steadfast execution. As I look back on what we achieved last year, I feel a profound sense of gratitude for the remarkable progress our company has made and the positive impact we have had on patients.

The U.S. Food and Drug Administration (FDA) approval of BRINSUPRI® (brensocatib) on August 12, 2025, for the treatment of NCFB was one of the most highly anticipated drug approvals of the year. This medicine represents a first-in-class, first-in-disease therapy for a condition first identified more than 200 years ago, but for which no company had been able to deliver a dedicated, approved therapy until Insmed brought forward BRINSUPRI. The subsequent U.S. launch of BRINSUPRI has been exceptionally strong in just a few months' time, owing to the focus and urgency of the Insmed team.

The early success of this launch, coupled with our highly encouraging treprostinil palmitil inhalation powder (TPIP) data readout in pulmonary arterial hypertension (PAH), strong global ARIKAYCE® (amikacin liposome inhalation suspension) performance, and many other notable achievements, reinforces both the clinical potential of our growing portfolio and the remarkable discipline of our teams.

We had much to celebrate in 2025, but our greatest achievement is that we haven't lost an ounce of our culture. In the last two years, Insmed has grown from a company worth $4B with 900 employees to a company worth more than eight times that with nearly double the number of people. Maintaining and nourishing a culture through this type of growth isn't easy, but we firmly believe that nothing is more critical to the long-term success of Insmed than getting our culture right.

Importantly, that means bringing in individuals who embrace our patient-centered mission and feel a deep sense of accountability in what they do. We have assembled a highly capable group of people who are experts in their respective areas and are unafraid to challenge the status quo, and we empower them to make bold decisions and do their best work on behalf of patients. Our culture remains our greatest strength and differentiator and will propel Insmed's bright future ahead.

2025 was also a year to step back and reflect. We've already made a profound impact on

patients' lives, but our ambition is to go well beyond where we stand today. Our vision for the future is not simply about getting bigger; it's about creating an enterprise that can deliver first- or best-in-class medicines that transform patients' lives while setting the standard for how to do business the right way. Delivering that kind of progress takes careful contemplation of what's working well and how we need to evolve.

To support the growth of our commercial portfolio and clinical pipeline, we've reframed our business around three therapeutic areas: **Respiratory**, **Immunology & Inflammation**, and **Neuro & Other Rare**. While this structure is new, our strategy remains unchanged. We will continue to be guided by science, unmet need, and potential patient impact, while embracing a program-first mindset designed to empower decision-making closer to the programs, deepen cross-functional collaboration, and orient our collective expertise around what each program needs in order to advance.

We entered 2026 from a position of incredible strength, and over the next 12 to 18 months, we anticipate numerous catalysts across our three therapeutic areas. These include continuing to execute on the BRINSUPRI U.S. launch; reading out critical data milestones for ARIKAYCE in MAC lung disease and brensocatib in hidradenitis suppurativa (HS); sharing updates on our gene therapy programs; and initiating pivotal studies across multiple indications.

Achieving this next level of growth will take relentless execution, both commercially and clinically. What keeps us focused is knowing that each potential milestone translates into a greater number of patients who are counting on us to succeed. It's a weighty responsibility that we're proud to carry. Last year was monumental for Insmed, but now we intend to go further—reaching more patients, advancing our cutting-edge science, evolving how we work, and continuing to support our people as we explore the possibilities ahead.

"What keeps us focused is knowing that each potential milestone translates into a greater number of patients who are counting on us to succeed."

I am grateful, as always, to the many stakeholders who are part of our journey. Thank you to our talented employees for embracing our bold ambition, to our Board of Directors for your trust and guidance, to the researchers and healthcare professionals for sharing our mission, and to the investment community for believing in our work. My greatest thanks, as always, goes to the patients and families we serve. No matter what we achieve, we will keep going further for you.

Will Lewis
Chair & CEO

Putting People First

Patients

The patients we serve are our North Star—the reason we exist as a company and the guiding light for every decision we make.

Employees

Patients benefit the most when we trust and empower our people to do their best work. Our culture is grounded in mutual respect and a shared sense of urgency, and we give employees the support they need to deliver the greatest possible impact.

Medical community

Healthcare professionals are vital to helping patients make informed decisions about our approved products and advancing clinical trials for our investigational therapies. We consider their needs, seek their feedback, and operate with mutual trust and transparency.

Communities

Bringing positive change to the communities where we live and work is intrinsic to our culture and is one of the many ways employees feel energized to do their best work on behalf of patients.

Investors

Investors place a great deal of trust in us to make sound business decisions, take appropriate risks, and operate with strong governance. We believe that by creating value for patients, we create value for shareholders.

What Guides Us

At Insmed, our shared commitment to a set of core beliefs defines who we are and how we operate. Our mission and vision set the course, our values shape how we show up, and our To Be List keeps us on track in the moments that matter.

Our Mission

To transform the lives of patients with serious and rare diseases.

Our Vision

To be a globally recognized leading biotechnology company that empowers great people to deliver, with a profound sense of urgency and compassion, life-altering therapies to small patient populations experiencing big health problems.

Our Values

Collaboration: We check our egos at the door and share ideas openly and candidly. When we disagree, we do so with respect and a willingness to listen.

Accountability: We are each responsible for ensuring that our actions align with our values.

Passion: We are driven to expect more than others think is possible and deliver excellence to our patients, fellow employees, and stakeholders.

Respect: We embrace our colleagues' differences, recognize their contributions, and create a culture of empowerment and trust.

Integrity: We are committed to acting in an ethical, honest, and transparent manner in everything we do.

TO BE LIST

Be a champion for patients.
- → Operate as if a patient is in every conversation.
- → Act with initiative and stay impatient on behalf of patients.

Be you.
- → Bring your authentic self to work.
- → Take care in listening to and supporting your colleagues.

Be clear.
- → Communicate with intention and transparency.
- → Know that how and when you share information is just as important as what you share.

Be disciplined.
- → Deliver value through financial rigor, ruthless prioritization, and operational excellence.
- → Make data-informed decisions aligned to our strategic goals.

Be curious.
- → Ask why, challenge the status quo, and see every obstacle as an opportunity to learn.
- → Stay open and seek different perspectives, unbound by the org chart.

Be ready.
- → Empower our people through clear goals, decision-making authority, and fearless conversations.
- → Take responsibility for your actions and anticipate future risks and opportunities.

2025
Year in Review

In a standout year for Insmed, we're proud of all that we accomplished—both in our business and in how we showed up for patients, our communities, and each other. Here's a snapshot of our achievements in 2025 that will allow us to go further in 2026.

BRINSUPRI approved by U.S. FDA and European Commission for the treatment of patients ages 12 and older with NCFB

Reported **positive topline data from Phase 2b study of TPIP in patients with PAH** and **initiated Phase 3 study** in patients with pulmonary hypertension associated with interstitial lung disease (PH-ILD)

Initiated **Phase 1 ASCEND study of INS1201**, an intrathecally delivered gene therapy for patients with Duchenne muscular dystrophy (DMD)

Celebrated the opening of a **new research and development facility** in Cambridge, UK, attended by Her Royal Highness The Princess Royal

Received **investigational new drug (IND) clearance from the FDA for INS1202**, a gene therapy for the treatment of amyotrophic lateral sclerosis (ALS)

Completed enrollment in Phase 2b CEDAR study of brensocatib in patients with HS

AI at Insmed

Completed 12 AI initiatives
across drug discovery, drug development, commercialization, and enabling functions

No. 1 *Science* Top Employer
for fifth year in a row

Full-year 2025 ARIKAYCE revenues of **$433.8 million,** exceeding upper end of guidance range

Full-year 2025 BRINSUPRI revenues of **$172.7 million,** demonstrating strong early launch

Listed as one of the **Best Places to Work in the UK** by *The Sunday Times* for the second year in a row

ASPEN data published in the *New England Journal of Medicine*

Named one of **BioSpace's Best Places to Work** in the Large Employers category

Received **NJBIZ Business of the Year - Corporate Citizen of the Year award**

Received ***Handshake*** early talent award

Ranked No. 1 in the biotech sector on Extel's 2025 All-American Executive Team

~1,700
employees as of the end of 2025

U.S. Great Place to Work for fifth year in a row

Aspen study team recognized as **Clinical Research Team of the Year** at Citeline Awards

Our Culture

We're proud that even as we've driven extraordinary growth in our business, we've continued to uphold the culture that makes us uniquely Insmed. We've strengthened our approach to hiring and internal career development to ensure that our team members embrace the core competencies of their respective functions and operate in alignment with our values. In 2025, we launched a new careers website to better support our talent recruitment efforts and offer jobseekers an authentic look at what makes Insmed an employer of choice.

Year over year, our annual employee pulse survey reflects the strength of our culture.

97% of employees believe Insmed will be successful in the future

95% of employees are inspired by the work we do

95% of employees are proud to work at Insmed

92% recommend Insmed as a great place to work

91% overall engagement score, reflecting the strength of connection employees feel toward their work, each other, and Insmed

Employee Spotlights

As we grow and evolve as an organization, we asked employees:

What inspires you to go further?

"I'm inspired by the families who are hoping for therapies for diseases that currently have no treatments. In gene therapy process development and manufacturing, our rigor, scalability, and execution determine whether that hope becomes reality. I feel a deep responsibility to steward my expertise and talent fully, in service to the patients who are counting on us."

Joseph Oloo
Associate Director,
Upstream Process Development

"I am inspired by working in a positive culture where values are truly lived—an environment where the 'how' is every bit as important as the 'what.' Working collaboratively alongside like-minded and talented colleagues, I feel we are all part of one team working toward a single, patient-focused purpose...and that inspires me to go further."

Scott Hands
Head of Sales,
UK, Ireland, Belgium, Netherlands

"I'm inspired by the opportunity to build something enduring—where innovation, collaboration, and purpose come together to create meaningful impact for patients. The collective ambition to continuously redefine what's possible challenges us to think bigger and raise the bar for what we can achieve together."

Jamie Gordon
Global Commercial Lead,
ARIKAYCE

"'Further,' to me, reflects the limitless opportunities for growth and continued contribution at Insmed. All of my colleagues can enjoy these opportunities, regardless of role. I believe that by working together and collectively going further, we can deliver groundbreaking science that has the potential to transform lives."

Takahiro Senda
Senior Director,
Commercial Effectiveness, Japan

"What inspires me most is our unwavering commitment to patient-focused therapies, which helps ensure that every breakthrough we achieve directly translates into better care for those we serve. Our mission is fueled by our collaborative and supportive corporate culture, where a shared passion for innovation drives us to push boundaries and evolve together."

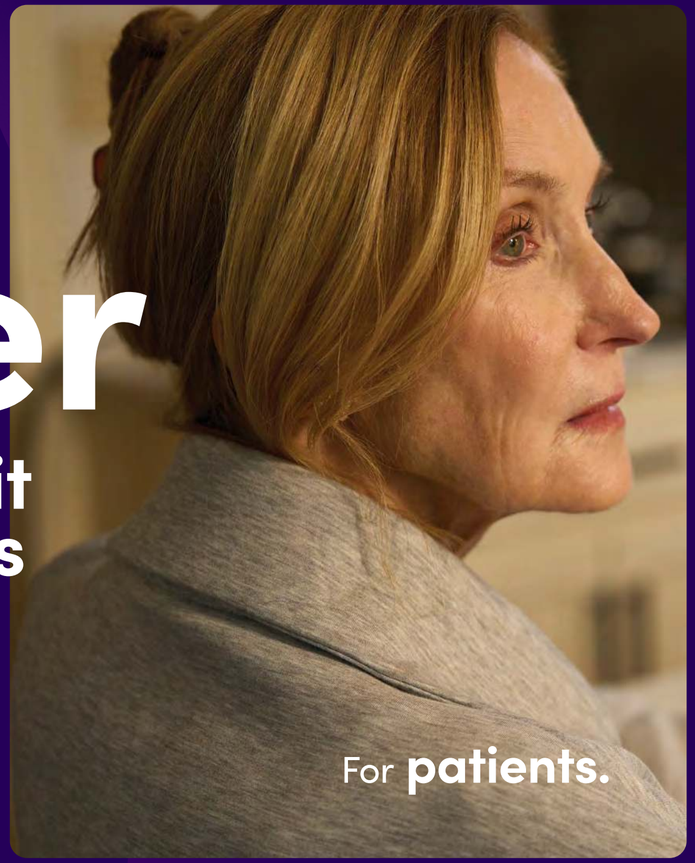
Lisa Schildhorn
Senior Manager,
Contracting Operations, Legal

We go further where it matters most.

If all assets are approved, we have the potential to reach significantly more patients with serious diseases.

Graphic includes Insmed assets that are Phase 2-ready or later in development, listed in order of planned development; size of ring does not represent size of opportunity. Figures represent the estimated number of diagnosed patients in the U.S., European 5, and Japan.

*Figure reflects upper end of estimated range



Our Business

2025 was a year of extraordinary execution across our portfolio, with clinical, regulatory, and commercial achievements that are making a profound impact on patients' lives. We continued to drive double-digit growth for our first marketed product, ARIKAYCE, and reported positive topline data from our Phase 2b study of TPIP in patients with PAH, setting the stage for a robust Phase 3 program across multiple potential indications.

Our proudest moment came in August with the U.S. FDA approval of BRINSUPRI, marking the first ever approval for a treatment indicated for patients with NCFB, followed shortly thereafter by approval from the European Commission.

Beyond these notable achievements, Insmed is advancing a robust portfolio and pipeline aligned to our three therapeutic areas, with numerous catalysts on the horizon that have the potential to significantly expand the number of patients we can reach with our therapies. Our commercial and later-stage clinical efforts are supplemented by our early-stage research engine, which is designed to produce an average of one to two IND filings per year.

Read on to learn more about what Insmed achieved in 2025 and how we plan to go further in 2026.

Our three therapeutic areas have one shared goal: to deliver first- and best-in-class medicines to patients in need.

Respiratory

- **BRINSUPRI®**
- **ARIKAYCE®**
- **TPIP:** PAH & PH-ILD
- **TPIP:** PPF & IPF
- **INS1148 (SCF248 Monoclonal Antibody):** ILD & Moderate to Severe Asthma
- **DPP1:** Other

Immunology & Inflammation

- **Brensocatib:** HS
- **INS1033 (DPP1):** Rheumatoid Arthritis (RA) & Irritable Bowel Disease (IBD)
- **Next-Gen Uricase:** Gout
- **IgG Protease**
- **INS1148 (SCF248 Monoclonal Antibody):** Other
- **Novel MoA**

Neuro & Other Rare

- **INS1201 (GTx):** DMD
- **INS1202 (GTx):** ALS
- **INS1203 (GTx):** Stargardt Disease
- **Synthetic Rescue (Antisense Oligonucleotide):** Ataxia Telangiectasia
- **Synthetic Rescue (Antisense Oligonucleotide):** Ataxia with Oculomotor Apraxia Type 1
- Other Rare Diseases

Research & Business Development

Respiratory

BRINSUPRI

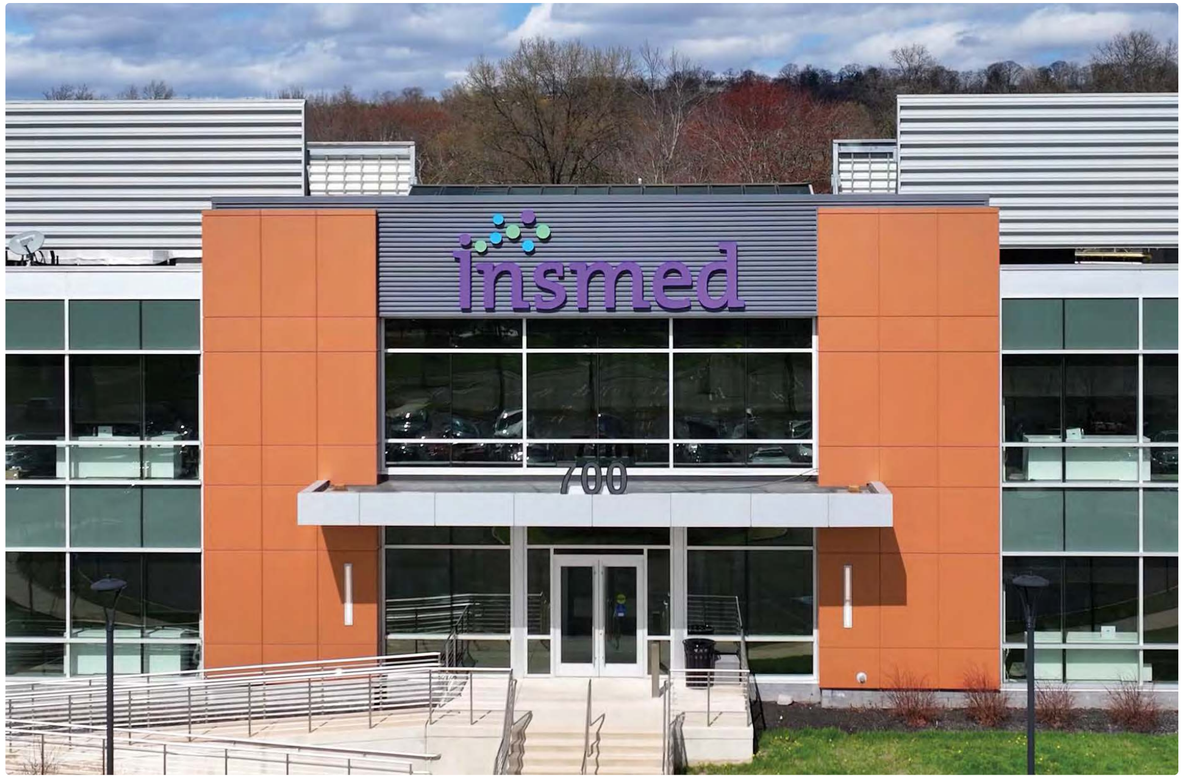
First and only treatment indicated for patients with bronchiectasis

On August 12, 2025, Insmed celebrated a transformative moment for the bronchiectasis community with the FDA approval of BRINSUPRI for patients ages 12 and older with NCFB. With this milestone, we were proud to deliver a long-awaited first-in-class, first-in-disease therapy. This achievement also marked the second FDA approval for Insmed, significantly expanding our potential to serve patients in need.

We moved rapidly to launch BRINSUPRI in the U.S. immediately after approval, with product reaching initial patients by early September. The U.S. launch of BRINSUPRI has been very strong, with 2025 revenues of $172.7 million in just a few months of availability. This early strength reflects the significant demand from a patient population that previously had to rely on therapies that did not address one of the key drivers of the disease.

Insmed also filed for approval of brensocatib in the UK, EU, and Japan in 2025. In November 2025, the European Commission granted approval of BRINSUPRI for the treatment of NCFB in patients 12 years of age and older with two or more exacerbations in the prior 12 months. In February 2026, approval was granted in the UK for the same indication.

We anticipate a regulatory decision for BRINSUPRI in Japan in 2026.



BRINSUPRI® (brensocatib) U.S. INDICATION AND IMPORTANT SAFETY INFORMATION

Indication in the U.S.
BRINSUPRI is indicated for the treatment of non-cystic fibrosis bronchiectasis (NCFB) in adult and pediatric patients 12 years of age and older.

Important Safety Information in the U.S.

WARNINGS AND PRECAUTIONS
Dermatologic Adverse Reactions
Treatment with BRINSUPRI is associated with an increase in dermatologic adverse reactions, including rash, dry skin, and hyperkeratosis. Monitor patients for development of new rashes or skin conditions and refer patients to a dermatologist for evaluation of new dermatologic findings.

Gingival and Periodontal Adverse Reactions
Treatment with BRINSUPRI is associated with an increase in gingival and periodontal adverse reactions. Refer patients to dental care services for regular dental checkups while taking BRINSUPRI. Advise patients to perform routine dental hygiene.

Live Attenuated Vaccines
It is unknown whether administration of live attenuated vaccines during BRINSUPRI treatment will affect the safety or effectiveness of these vaccines. The use of live attenuated vaccines should be avoided in patients receiving BRINSUPRI.

ADVERSE REACTIONS
The most common adverse reactions ≥2% in the ASPEN trial included upper respiratory tract infection, headache, rash, dry skin, hyperkeratosis, and hypertension. The safety profile for adult patients with NCFB in WILLOW was generally similar to ASPEN, except for a higher incidence of gingival and periodontal adverse reactions.

Less Common Adverse Reactions
Liver Function Test Elevations
In ASPEN, there was an increase from baseline in average ALT, AST, and alkaline phosphatase levels at all time points from Week 4 through Week 56 in both BRINSUPRI 10 mg and 25 mg arms compared to placebo. The incidence of ALT >3X upper limit of normal (ULN) was 0%, 1.2%, and 0.9%; the incidence of AST >3X ULN was 0.2%, 0.3%, and 0.5%; and the incidence of alkaline phosphatase >1.5X ULN was 2.5%, 4.1%, and 4.0% in patients treated with placebo and BRINSUPRI 10 mg and 25 mg, respectively.

Skin Cancers
In ASPEN, the incidence of skin cancers among patients treated with BRINSUPRI 10 mg and 25 mg was 0.5% and 1.9%, respectively, compared to 1.1% in placebo-treated patients.

Alopecia
In ASPEN, the incidence of alopecia among patients treated with BRINSUPRI 10 mg and 25 mg was 1.5% and 1.6% respectively, compared to 0.4% in placebo-treated patients.

USE IN SPECIFIC POPULATIONS
Pregnancy: There are no clinical data on the use of BRINSUPRI in pregnant women.

Lactation: There is no information regarding the presence of BRINSUPRI and/or its metabolite(s) in human milk, the effects on the breastfed infant, or the effects on milk production. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for BRINSUPRI and any potential adverse effects on the breastfed child from BRINSUPRI or from the underlying maternal condition.

Pediatric use: The safety and effectiveness of BRINSUPRI for the treatment of NCFB have been established in pediatric patients aged 12 years and older. Common adverse reactions in pediatric patients aged 12 years and older enrolled in ASPEN were consistent with those in adults. The safety and effectiveness of BRINSUPRI have not been established in pediatric patients younger than 12 years of age.

Please see full US Prescribing Information at https://insmed.com/pdf/brinsupri_full_prescribing_information.pdf.

ARIKAYCE

Continuing to drive double-digit growth

Seven years post-launch, our first commercial product, ARIKAYCE, continues to deliver double-digit growth year over year, underscoring the significant need for this therapy. Full-year ARIKAYCE revenues in 2025 were $433.8 million, exceeding the upper end of our guidance range. ARIKAYCE is currently approved in the U.S., Europe, and Japan as the first and only therapy for adults with refractory MAC lung disease with limited treatment options, in combination with their multidrug regimen.

Throughout 2025, Insmed continued to advance the Phase 3 ENCORE study of ARIKAYCE in diagnosed patients with a new occurrence of MAC lung infection who have not received antibiotics.

2025
Financial Highlights

Global annual net product revenues (in millions)

2023	$305.2
2024	$363.7
2025	**$606.4**

Cash, cash equivalents, and marketable securities (in millions)

2023	$780.4
2024	$1,433.8
2025	**$1,430.0**

In 2026, we anticipate BRINSUPRI revenues to be at least $1 billion and ARIKAYCE revenues to be between $450 million and $470 million.

IMPORTANT SAFETY INFORMATION AND BOXED WARNING FOR ARIKAYCE IN THE U.S.

WARNING: RISK OF INCREASED RESPIRATORY ADVERSE REACTIONS

ARIKAYCE has been associated with an increased risk of respiratory adverse reactions, including hypersensitivity pneumonitis, hemoptysis, bronchospasm, and exacerbation of underlying pulmonary disease that have led to hospitalizations in some cases.

Hypersensitivity Pneumonitis has been reported with the use of ARIKAYCE in the clinical trials. Hypersensitivity pneumonitis (reported as allergic alveolitis, pneumonitis, interstitial lung disease, allergic reaction to ARIKAYCE) was reported at a higher frequency in patients treated with ARIKAYCE plus background regimen (3.1%) compared to patients treated with a background regimen alone (0%). Most patients with hypersensitivity pneumonitis discontinued treatment with ARIKAYCE and received treatment with corticosteroids. If hypersensitivity pneumonitis occurs, discontinue ARIKAYCE and manage patients as medically appropriate.

Hemoptysis has been reported with the use of ARIKAYCE in the clinical trials. Hemoptysis was reported at a higher frequency in patients treated with ARIKAYCE plus background regimen (17.9%) compared to patients treated with a background regimen alone (12.5%). If hemoptysis occurs, manage patients as medically appropriate.

Bronchospasm has been reported with the use of ARIKAYCE in the clinical trials. Bronchospasm (reported as asthma, bronchial hyperreactivity, bronchospasm, dyspnea, dyspnea exertional, prolonged expiration, throat tightness, wheezing) was reported at a higher frequency in patients treated with ARIKAYCE plus background regimen (28.7%) compared to patients treated with a background regimen alone (10.7%). If bronchospasm occurs during the use of ARIKAYCE, treat patients as medically appropriate.

Exacerbations of underlying pulmonary disease has been reported with the use of ARIKAYCE in the clinical trials. Exacerbations of underlying pulmonary disease (reported as chronic obstructive pulmonary disease (COPD), infective exacerbation of COPD, infective exacerbation of bronchiectasis) have been reported at a higher frequency in patients treated with ARIKAYCE plus background regimen (14.8%) compared to patients treated with background regimen alone (9.8%). If exacerbations of underlying pulmonary disease occur during the use of ARIKAYCE, treat patients as medically appropriate.

Anaphylaxis and Hypersensitivity Reactions: Serious and potentially life-threatening hypersensitivity reactions, including anaphylaxis, have been reported in patients taking ARIKAYCE. Signs and symptoms include acute onset of skin and mucosal tissue hypersensitivity reactions (hives, itching, flushing, swollen lips/tongue/uvula), respiratory difficulty (shortness of breath, wheezing, stridor, cough), gastrointestinal symptoms (nausea, vomiting, diarrhea, crampy abdominal pain), and cardiovascular signs and symptoms of anaphylaxis (tachycardia, low blood pressure, syncope, incontinence, dizziness). Before therapy with ARIKAYCE is instituted, evaluate for previous hypersensitivity reactions to aminoglycosides. If anaphylaxis or a hypersensitivity reaction occurs, discontinue ARIKAYCE and institute appropriate supportive measures.

Ototoxicity has been reported with the use of ARIKAYCE in the clinical trials. Ototoxicity (including deafness, dizziness, presyncope, tinnitus, and vertigo) were reported with a higher frequency in patients treated with ARIKAYCE plus background regimen (17%) compared to patients treated with background regimen alone (9.8%). This was primarily driven by tinnitus (7.6% in ARIKAYCE plus background regimen vs 0.9% in the background regimen alone arm) and dizziness (6.3% in ARIKAYCE plus background regimen vs 2.7% in the background regimen alone arm). Closely monitor patients with known or suspected auditory or vestibular dysfunction during treatment with ARIKAYCE. If ototoxicity occurs, manage patients as medically appropriate, including potentially discontinuing ARIKAYCE.

Nephrotoxicity was observed during the clinical trials of ARIKAYCE in patients with MAC lung disease but not at a higher frequency than background regimen alone. Nephrotoxicity has been associated with the aminoglycosides. Close monitoring of patients with known or suspected renal dysfunction may be needed when prescribing ARIKAYCE.

Neuromuscular Blockade: Patients with neuromuscular disorders were not enrolled in ARIKAYCE clinical trials. Patients with known or suspected neuromuscular disorders, such as myasthenia gravis, should be closely monitored since aminoglycosides may aggravate muscle weakness by blocking the release of acetylcholine at neuromuscular junctions.

Embryo-Fetal Toxicity: Aminoglycosides can cause fetal harm when administered to a pregnant woman. Aminoglycosides, including ARIKAYCE, may be associated with total, irreversible, bilateral congenital deafness in pediatric patients exposed in utero. Patients who use ARIKAYCE during pregnancy, or become pregnant while taking ARIKAYCE should be apprised of the potential hazard to the fetus.

Contraindications: ARIKAYCE is contraindicated in patients with known hypersensitivity to any aminoglycoside.

Most Common Adverse Reactions: The most common adverse reactions in Trial 1 at an incidence ≥5% for patients using ARIKAYCE plus background regimen compared to patients treated with background regimen alone were dysphonia (47% vs 1%), cough (39% vs 17%), bronchospasm (29% vs 11%), hemoptysis (18% vs 13%), ototoxicity (17% vs 10%), upper airway irritation (17% vs 2%), musculoskeletal pain (17% vs 8%), fatigue and asthenia (16% vs 10%), exacerbation of underlying pulmonary disease (15% vs 10%), diarrhea (13% vs 5%), nausea (12% vs 4%), pneumonia (10% vs 8%), headache (10% vs 5%), pyrexia (7% vs 5%), vomiting (7% vs 4%), rash (6% vs 2%), decreased weight (6% vs 1%), change in sputum (5% vs 1%), and chest discomfort (5% vs 3%).

Drug Interactions: Avoid concomitant use of ARIKAYCE with medications associated with neurotoxicity, nephrotoxicity, and ototoxicity. Some diuretics can enhance aminoglycoside toxicity by altering aminoglycoside concentrations in serum and tissue. Avoid concomitant use of ARIKAYCE with ethacrynic acid, furosemide, urea, or intravenous mannitol.

Overdosage: Adverse reactions specifically associated with overdose of ARIKAYCE have not been identified. Acute toxicity should be treated with immediate withdrawal of ARIKAYCE, and baseline tests of renal function should be undertaken. Hemodialysis may be helpful in removing amikacin from the body. In all cases of suspected overdosage, physicians should contact the Regional Poison Control Center for information about effective treatment.

U.S. INDICATION
LIMITED POPULATION: ARIKAYCE® is indicated in adults, who have limited or no alternative treatment options, for the treatment of *Mycobacterium avium* complex (MAC) lung disease as part of a combination antibacterial drug regimen in patients who do not achieve negative sputum cultures after a minimum of 6 consecutive months of a multidrug background regimen therapy. As only limited clinical safety and effectiveness data for ARIKAYCE are currently available, reserve ARIKAYCE for use in adults who have limited or no alternative treatment options. This drug is indicated for use in a limited and specific population of patients.

This indication is approved under accelerated approval based on achieving sputum culture conversion (defined as 3 consecutive negative monthly sputum cultures) by Month 6. Clinical benefit has not yet been established. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials.

Limitation of Use:
ARIKAYCE has only been studied in patients with refractory MAC lung disease defined as patients who did not achieve negative sputum cultures after a minimum of 6 consecutive months of a multidrug background regimen therapy. The use of ARIKAYCE is not recommended for patients with non-refractory MAC lung disease.

Patients are encouraged to report negative side effects of prescription drugs to the FDA. Visit **www.fda.gov/medwatch,** or call 1-800-FDA 1088. You can also call the Company at 1-844-4-INSMED.

Please see Full Prescribing Information at https://www.arikayce.com/pdf/full_prescribing_information.pdf.

TPIP

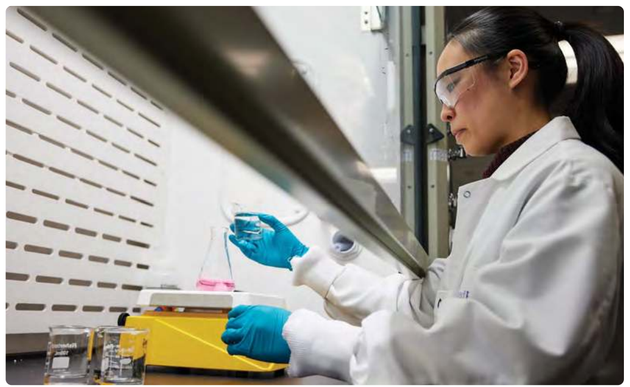
Key win in 2025 lays the foundation for robust pivotal program

2025 was a critical year for TPIP, with important efficacy data setting the stage for a robust clinical trial program across multiple indications. In June, Insmed announced positive topline results from our randomized, double-blind, placebo-controlled Phase 2b study of TPIP in patients with PAH. The study met its primary endpoint, with a 35% placebo-adjusted reduction in pulmonary vascular resistance at Week 16, as well as all secondary efficacy endpoints. These results showed the potential of TPIP's therapeutic effect as a once-daily therapy based on efficacy measures taken approximately 24 hours after therapy was administered. Importantly, TPIP was well tolerated in the study.

These compelling data provided the foundation to pursue pivotal programs in several potential indications. In 2025, we initiated a Phase 3 study of TPIP in patients with PH-ILD based on the strength of prior Phase 1/2 data in PH-ILD as well as the Phase 2b study in PAH. We plan to initiate a Phase 3 study in patients with PAH in the first half of 2026, followed by Phase 3 programs in PPF and IPF in the second half of the year.

Further Expanding Our Respiratory Portfolio

In December 2025, Insmed acquired INS1148, a monoclonal antibody targeting a specific isoform of Stem Cell Factor called Stem Cell Factor 248 (SCF248). We plan to advance Phase 2 development programs for INS1148 in ILD and moderate to severe asthma.



Immunology & Inflammation

Brensocatib

Exploring additional inflammatory diseases

Beyond bronchiectasis, Insmed is evaluating brensocatib for its potential role in HS, another neutrophil-mediated disease. In 2025, we completed enrollment in the Phase 2b CEDAR study of brensocatib in patients with HS. We expect to report topline results from this study in the second quarter of 2026. Also in 2025, we reported that the Phase 2b BiRCh study of brensocatib in patients with chronic rhinosinusitis without nasal polyps did not meet its primary or secondary efficacy endpoints and that this program has been discontinued.

INS1033

Advancing the next generation of DPP1 inhibition

Following the success of the clinical trial program for brensocatib in bronchiectasis, Insmed is working to design next-generation dipeptidyl peptidase 1 (DPP1) inhibitors with the potential to treat a range of neutrophil-mediated diseases. Our second such candidate, INS1033, is advancing toward the clinic in RA and IBD, with an IND filing expected in 2026.

Neuro & Other Rare

Gene Therapy

Bringing the first product candidate into the clinic

In 2025, Insmed made important clinical progress for our gene therapy candidates, which we are developing to address some of the most devastating and difficult-to-treat rare diseases.

We initiated the Phase 1 ASCEND study of INS1201, marking the first delivery of an Insmed gene therapy to a patient. INS1201 is an investigational, intrathecally delivered micro-dystrophin AAV9 gene therapy being developed for the treatment of patients with DMD. We are continuing to enroll patients in this study.

We also received IND clearance from the FDA for INS1202, an investigational, intrathecally delivered AAV9 short hairpin RNA construct targeting the human superoxide dismutase type 1 (SOD1) gene. Insmed is developing INS1202 as a potential treatment for patients with ALS who carry SOD1 mutations as well as those with sporadic ALS. In early 2026, we dosed the first patient in the Phase 1 ARMOR study of INS1202 in ALS.

Our third gene therapy candidate, INS1203, targeting Stargardt disease, is currently advancing toward the clinic.

inQuiry AI

Impact

Strengthening our community support

As a company dedicated to transforming lives, our responsibility to the world around us is ingrained in our culture. We continually aspire to serve as a role model within our industry, not only for how we operate our core business but also for the impact we strive to make on our communities and on the environment.

Throughout 2025, as our business grew, we significantly expanded our support for the communities where we live and work. Through both company- and employee-led efforts, we tackled some of the most pressing local needs in the areas of health, education, and human services. Our fourth annual Global Day of Good – Insmed's signature giveback event where employees step away from their day-to-day work to volunteer simultaneously around the world – took place in November and drew more than 1,200 employee volunteers, making it our largest event yet. We also launched Environment, a new employee resource group focused on environmental sustainability. The group has already begun working to support our local communities in improving environmental sustainability and educating employees around climate resilience and ways to incorporate environmental considerations into their business activities.

In December, we were honored that our efforts throughout the year led to us receiving the NJBIZ Corporate Citizen of the Year award. This recognition celebrates the companies making a meaningful impact in New Jersey through community service, stewardship, and commitment. We're proud that 92% of Insmed employees agree that giving back to the community is an important part of our organization's culture.

We encourage you to read our Responsibility Report, published annually, which provides more details on how Insmed upholds our commitments to all stakeholders.

Executive Perspectives

We asked our leaders:

How is Insmed going further in our mission in 2026?

"While 2025 was a year of milestones, our work is only just beginning. We will go further in 2026 by continuing to be a champion for patients in everything we do—anchoring ourselves in our guiding principles to bring additional meaningful treatments to those facing rare and serious diseases."

Christie Camelio
Chief Compliance Officer

From left to right: Christie Camelio, Kevin Mange, Gene Sullivan, Nicole Schaeffer, Will Lewis, Martina Flammer, Sara Bonstein, Mike Smith, Roger Adsett, Adele Deering

"In 2026 we look to build on our recent successes, exploring new indications and further expanding our ability to transform the lives of patients with serious and rare diseases."

Gene Sullivan
Chief Product Strategy Officer

"We are revolutionizing our approach by refusing to be limited by past assumptions. With our evolving operating model and AI capabilities as our foundation, we are ready to dream bigger and act bolder in 2026 than ever before."

Nicole Schaeffer
Chief People Strategy Officer

"We are building further on our successes and experiences to develop new medicines for patients that have the potential to make demonstrable differences in their lives."

Kevin Mange
Chief Development Officer

"Insmed is going further in our mission by expanding our reach to help significantly more patients across our three therapeutic areas. I feel privileged to work with colleagues who are passionate and committed to bringing ARIKAYCE and BRINSUPRI to patients while advancing our development programs and continuing to progress groundbreaking science in pursuit of new first- and best-in-class therapies. 2026 promises to be another exciting year."

Adele Deering
SVP, Portfolio Strategy & Operational Excellence

"In 2026, Insmed will continue to broaden our reach to patients with serious diseases while working to develop new therapies that have the potential to deliver meaningful impact to patients in need."

Mike Smith
Chief Legal Officer

"Now is the time to press our advantage on behalf of patients. Today, we are building upon our success, adding more first- or best-in-class therapies through both internal research and business development. We've also stepped back to organize the company around three therapeutic areas with dedicated teams for each program—allowing us to add new programs easily, staff them appropriately, and expand to new areas as compelling opportunities arise. We are now prepared for the expansion phase of Insmed."

Will Lewis
Chair and Chief Executive Officer

"In 2026, we have aligned our organization across three core therapeutic areas to ensure we have broader reach to patients who may benefit from our medicines while building a flexible infrastructure to add new programs as needed. Importantly, we've begun the year in a strong financial position, enabling us to pursue our ambitious goals."

Sara Bonstein
Chief Financial Officer

"This year, Insmed is going further by advancing more therapies into and through clinical development across our three therapeutic areas. At the same time, we are looking to broaden the impact of our two commercialized products, ARIKAYCE and BRINSUPRI, through potential expansion in MAC lung disease and appropriate diagnosis of bronchiectasis, respectively."

Roger Adsett
Chief Operating Officer

"We aim to go further in pursuing groundbreaking science where no treatments exist or current options fall short while supporting more patients across the diagnostic and treatment journey. Accelerating diagnosis gives patients clarity sooner and shortens the time to appropriate care, creating the opportunity for better disease outcomes and potentially changing the trajectory of the disease."

Martina Flammer
Chief Medical Officer

Going further for patients

"It took more than 30 years for me to be diagnosed with bronchiectasis, and it was a lonely journey. It's so important to advocate for yourself and keep trying to find answers."

Jane's Story

Living with Bronchiectasis

Jane first realized something was wrong with her lungs during a CPR course, when an instructor noticed her labored breathing. At the time, Jane was relatively healthy, but experienced frequent colds, flus, and bouts of bronchitis. After the CPR course, she visited a local doctor and was diagnosed with pulmonary sarcoidosis. Over the next several years, Jane cycled through multiple doctors, diagnoses, and treatments as her illness continued and her symptoms progressively worsened. It took more than 30 years for Jane to be diagnosed with bronchiectasis by a pulmonologist in New York.

Jane had never heard of bronchiectasis, but once she learned about it, she realized it explained everything she had been experiencing. She felt a sense of comfort in having a definitive diagnosis and knowing she was not alone.

Jane's doctor worked with her to manage her exacerbations with the therapies that were available, but her symptoms persisted and became more frequent. Within 10 years, Jane was experiencing exacerbations monthly, barely recovering from one before she had another. Her husband Dave was a "tremendous source of support," but it grew too difficult to do the things they loved, and they soon withdrew from their once-active social life.

When Jane's pulmonologist learned about the Phase 3 ASPEN study of brensocatib, he encouraged her to visit a different pulmonologist who was involved in the trial to see if she was eligible. It turned out she was—and once she carefully considered the opportunity and learned about the potential benefits and risks of participating in the study, she knew she wanted to give it a shot.

After completing the ASPEN study, Jane had a chance to receive brensocatib as part of a post-trial access program. Once that program began, her symptoms began to alleviate and she noticed a reduction in her pulmonary exacerbations. When BRINSUPRI was approved by the U.S. FDA in August of 2025, Jane's doctor worked with her to transition from post-trial access to commercial therapy, ensuring she was aware of the potential adverse events she could experience.

Now 80 years old, Jane shared that she feels "well" and is able to participate in many of her favorite activities with Dave—going to the ballet or opera, buying last-minute theater tickets, and taking walks.

"I'm enjoying being able to do the things I love," said Jane. "Even just taking a walk outside or making plans with friends and family—I feel very lucky to be able to do that."

Jane is a BRINSUPRI patient who has been compensated for her time.

Please see Important Safety Information on page 19.

Colleen's Story

Living with PAH

When Colleen was 26, she was thrilled to give birth to a healthy baby boy. But despite having a normal pregnancy and delivery, Colleen had a hard time bouncing back—she had trouble exercising and didn't feel fully functional.

Initially, Colleen chalked it up to typical postpartum symptoms and the stress of being a new mom, but she continued to struggle. When her son was about a year old, Colleen came down with multiple bouts of pleurisy over a few months, eventually landing in the emergency room. There, a chest X-ray showed she had an enlarged heart, which led to an EKG, echocardiogram, and right heart catheterization. Within two weeks, Colleen was diagnosed with PAH.

The news was devastating, and Colleen feared she would not be around to raise her son. For the first several months, Colleen was very sick physically and struggled emotionally with the blow of her diagnosis. After a few years, and through the support of other PAH patients, she realized: "I need to figure out how to live this life fully, no matter how long it is."

And live life she has. Although having PAH meant Colleen could not safely get pregnant again, she was able to foster and later adopt her daughter. Living with PAH also meant pivoting her career, as the demands of working full time were too challenging. Today, Colleen is a busy mom of a 19- and 11-year-old, works part-time running a self-publishing consulting firm, and has published and illustrated several books of her own. She also makes time for advocacy work, traveling the world speaking on patient-centered care and serving as the patient advocate for the Pulmonary Hypertension Association's Corporate Committee, the Awareness Committee Chair for the Connecticut Rare Disease Advisory Council, and the Secretary of a nonprofit that supports the mental health of PH patients, Sole of a PHoenix.

Colleen feels lucky to have a supportive care team that includes her pulmonary hypertension specialist and a nurse practitioner. Her hope for the future is that increased research into PAH and potential progress in the space allow the disease to become more manageable and better understood. Her advice to someone newly diagnosed with PAH is to make sure you are under the care of a pulmonary hypertension specialist, find support within the community, and know it's okay to allow the natural feelings of fear and sadness, but to work to move through them to action and education as soon as you can.

"My advocacy work is every bit as important as my medication," said Colleen. "It gives meaning to an impossible situation. I can't not have PAH but I can work to make it easier for myself and others."

Colleen has been compensated for her time.

"As Marko's mom and caregiver, I'm constantly balancing being his nurse, his therapist, his advocate, and simply just being his parent. It is extremely challenging and imperfect because he is still a teenager. I have to balance setting boundaries and enforcing consequences with the constant reminder that DMD is fatal.

Today, Marko knows pretty much everything about DMD and it empowers him to advocate for himself, as well. I always underscore our conversations about DMD by letting him know that what he reads online might be outdated because there are some very talented people working to better understand the disease and its management. I want him to know that his future might look very different and that motivates him to stay positive because he has a lot of goals for himself.

Hope, to us, means one day having a therapy that really can change the course of DMD. When you have a child, you celebrate every milestone. Your heart fills with joy when they take their first steps, when they learn to ride a bike. With DMD, after the age of six or seven, you have to watch this disease take away those milestones, one by one, with every passing year. These boys urgently need a different future."

Seda

Mother of a Son Living with DMD

Seda has been compensated for her time.

Julie's Story

Living with MAC Lung Disease

In December of 2011, just before her 60th birthday, Julie was running one of her many marathons when she started to feel more fatigued than usual. "At mile 20 I could barely go on, which was unusual for me," she said.

She pushed through and finished the race but that night she woke up coughing up blood. Given that Julie had been diagnosed in her thirties with pulmonary hemangioma, her doctor recommended she be hospitalized. Julie was admitted to the hospital and tested positive for tuberculous. Her pulmonologist, however, suspected MAC lung disease and referred her to an infectious disease specialist, who confirmed it by bronchoscopy.

When Julie received her diagnosis in 2011, there was limited information available on MAC lung disease and little consensus on the best treatment path. "With so little research available, even the doctors didn't have a complete picture of how best to manage MAC lung disease," said Julie.

Julie saw several specialists who prescribed multiple antibiotics, which she was told could clear her infection. However, she later learned through her own research that MAC lung disease was not easily treated and could damage her lungs over time.

Three years after her initial diagnosis, Julie tested negative for MAC and thought she was in the clear. But she later tested positive again. In 2021, after six months of unsuccessful treatment with a multidrug treatment regimen, Julie's doctor recommended she add ARIKAYCE to her treatment plan. She initially experienced some nausea, but was able to tolerate the treatment and continue. After completing a round of treatment with ARIKAYCE, Julie tested MAC-negative—a moment she says was just as exciting for her doctor as it was for her.

Today, Julie leads an active lifestyle, including playing tennis and practicing pilates, and is "enjoying every minute" of her retirement. Julie's advice to patients is: "Go to your doctor. Do your sputum samples. Don't be afraid to hear the news because there is hope."

Julie is an ARIKAYCE patient who has been compensated for her time.

Please see Important Safety Information on pages 22 & 23.

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-K

(Mark One)

☒ ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the fiscal year ended December 31, 2025

OR

☐ TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the transition period from _____ to _____

Commission File Number 0-30739

INSMED INCORPORATED

(Exact name of registrant as specified in its charter)

Virginia **(State or other jurisdiction of incorporation or organization)**	**54-1972729** **(I.R.S. employer identification no.)**
700 US Highway 202/206 **Bridgewater, New Jersey 08807** **(Address of principal executive offices)**	**(908) 977-9900** **(Registrant's telephone number including area code)**

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

Title of each class	Trading symbols	Name of each exchange on which registered
Common Stock, par value $0.01 per share	**INSM**	**Nasdaq Global Select Market**

Securities registered pursuant to Section 12(g) of the Act: None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or an emerging growth company (See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company" and "emerging growth company" in Rule 12b-2 of the Exchange Act). Large accelerated filer ☒ Accelerated filer ☐ Non-accelerated filer ☐ Smaller reporting company ☐ Emerging growth company ☐

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

Indicate by check mark whether the registrant has filed a report on and attestation to its management's assessment of the effectiveness of its internal control over financial reporting under Section 404(b) of the Sarbanes-Oxley Act (15 U.S.C. 7262(b)) by the registered public accounting firm that prepared or issued its audit report. ☒

If securities are registered pursuant to Section 12(b) of the Act, indicate by check mark whether the financial statements of the registrant included in the filing reflect the correction of an error to previously issued financial statements. ☐

Indicate by check mark whether any of those error corrections are restatements that required a recovery analysis of incentive-based compensation received by any of the registrant's executive officers during the relevant recovery period pursuant to §240.10D-1(b). ☐

Indicate by check mark whether the registrant is a Shell Company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant on June 30, 2025, was $21.1 billion (based on the closing price for shares of the registrant's common stock as reported on the Nasdaq Global Select Market on that date). In determining this figure, the registrant has assumed solely for this purpose that all of its directors, executive officers, persons beneficially owning 10% or more of the registrant's outstanding common stock and certain other stockholders of the registrant may be considered to be affiliates. This assumption shall not be deemed conclusive as to affiliate status for this or any other purpose.

On February 13, 2026, there were 215,551,896 shares of the registrant's common stock, $0.01 par value, outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant's definitive Proxy Statement for its 2026 Annual Meeting of Shareholders to be filed with the Securities and Exchange Commission no later than April 30, 2026 and to be delivered to shareholders in connection with the 2026 Annual Meeting of Shareholders, are herein incorporated by reference in Part III of this Annual Report on Form 10-K.

INSMED INCORPORATED

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Unless the context otherwise indicates, references in this Annual Report on Form 10-K to “Insmed Incorporated” refer to Insmed Incorporated, a Virginia corporation, and the “Company,” “Insmed,” “we,” “us” and “our” refer to Insmed Incorporated together with its consolidated subsidiaries. INSMED, PULMOVANCE, ARIKAYCE, and BRINSUPRI are trademarks of Insmed Incorporated. This Annual Report on Form 10-K also contains trademarks of third parties. Each trademark of another company appearing in this Annual Report on Form 10-K is the property of its owner.

CAUTIONARY NOTE REGARDING FORWARD-LOOKING STATEMENTS

This Annual Report on Form 10-K contains forward-looking statements that involve substantial risks and uncertainties. "Forward-looking statements," as that term is defined in the Private Securities Litigation Reform Act of 1995, Section 27A of the Securities Act of 1933 and Section 21E of the Securities Exchange Act of 1934 (the Exchange Act), are statements that are not historical facts and involve a number of risks and uncertainties. Words herein such as "may," "will," "should," "could," "would," "expects," "plans," "anticipates," "believes," "estimates," "projects," "predicts," "intends," "potential," "continues," and similar expressions (as well as other words or expressions referencing future events, conditions or circumstances) identify forward-looking statements.

Forward-looking statements are based on our current expectations and beliefs, and involve known and unknown risks, uncertainties and other factors, which may cause our actual results, performance and achievements and the timing of certain events to differ materially from the results, performance, achievements or timing discussed, projected, anticipated or indicated in any forward-looking statements. Such risks, uncertainties and other factors include, among others, the following:

- *failure to continue to successfully commercialize ARIKAYCE® in the United States (US), Europe or Japan (amikacin liposome inhalation suspension, Liposomal 590 mg Nebuliser Dispersion, and amikacin sulfate inhalation drug product, respectively) or failure to successfully commercialize BRINSUPRI® in the US or Europe, or to maintain US, European or Japanese approval for ARIKAYCE or US or European Union (EU) approval for BRINSUPRI;*
- *our inability to obtain full approval of ARIKAYCE from the US Food and Drug Administration (FDA), including the risk that we will not successfully or in a timely manner complete the confirmatory post-marketing clinical trial required for full approval of ARIKAYCE, or our failure to obtain regulatory approval to expand ARIKAYCE's indication to a broader patient population;*
- *failure to obtain, or delays in obtaining, regulatory approvals for our product candidates in the US, Europe or Japan, for ARIKAYCE outside of the US, Europe and Japan, including separate regulatory approval for the Lamira® Nebulizer System (Lamira) in each market and for each usage, or for BRINSUPRI outside of the US and the EU;*
- *failure to successfully commercialize our product candidates, if approved by applicable regulatory authorities, or to maintain applicable regulatory approvals for such product candidates, if approved;*
- *uncertainties or changes in the degree of market acceptance of our marketed products or, if approved, our product candidates, by physicians, patients, third-party payors and others in the healthcare community;*
- *our inability to obtain and maintain adequate reimbursement from government or third-party payors for our marketed products or, if approved, our product candidates, or acceptable prices for our marketed products or, if approved, our product candidates;*
- *inaccuracies in our estimates of the size of the potential markets for our marketed products and our product candidates or in data we have used to identify physicians, expected rates of patient uptake, duration of expected treatment, or expected patient adherence or discontinuation rates;*
- *failure of third parties on which we are dependent to manufacture sufficient quantities of our marketed products and our product candidates for commercial or clinical needs, as applicable, to conduct our clinical trials, or to comply with our agreements or laws and regulations that impact our business;*
- *risks and uncertainties associated with, and the perceived benefits of, our senior secured loan with certain funds managed by Pharmakon Advisors, LP (Pharmakon) and our royalty financing with OrbiMed Royalty & Credit Opportunities IV, LP (OrbiMed), including our ability to maintain compliance with the covenants in the agreements for the senior secured loan and royalty financing and the impact of the restrictions on our operations under these agreements;*
- *our inability to create or maintain an effective direct sales and marketing infrastructure or to partner with third parties that offer such an infrastructure for distribution of our marketed products or any of our product candidates that are approved in the future;*
- *failure to successfully conduct future clinical trials for our marketed products or our product candidates and our potential inability to enroll or retain sufficient patients to conduct and complete the trials or generate data necessary for regulatory approval of our product candidates or to permit the use of ARIKAYCE in the broader population of patients with Mycobacterium avium complex (MAC) lung disease, among other things;*
- *development of unexpected safety or efficacy concerns related to our marketed products or our product candidates;*
- *risks that our clinical studies will be delayed, that serious side effects will be identified during drug development, or that any protocol amendments submitted will be rejected;*
- *failure to successfully predict the time and cost of development, regulatory approval and commercialization for novel gene therapy products;*

- *risk that interim, topline or preliminary data from our clinical trials that we announce or publish from time to time may change as more patient data become available or may be interpreted differently if additional data are disclosed, or that blinded data will not be predictive of unblinded data;*
- *risk that our competitors may obtain orphan drug exclusivity for a product that is essentially the same as a product we are developing for a particular indication;*
- *our inability to attract and retain key personnel or to effectively manage our growth;*
- *our inability to successfully integrate our acquisitions and appropriately manage the amount of management's time and attention devoted to integration activities;*
- *risks that our acquired technologies, products and product candidates will not be commercially successful;*
- *inability to adapt to our highly competitive and changing environment;*
- *inability to access, upgrade or expand our technology systems or difficulties in updating our existing technology or developing or implementing new technology;*
- *risk that we are unable to maintain our significant customers;*
- *risk that healthcare legislation or other government action materially adversely affects our business;*
- *business or economic disruptions due to catastrophes or other events, including natural disasters or public health crises;*
- *risk that our current and potential future use of artificial intelligence (AI) and machine learning may not be successful;*
- *deterioration in general economic conditions in the US, Europe, Japan and globally, including the effect of prolonged periods of inflation, affecting us, our suppliers, third-party service providers and potential partners;*
- *risk that we could become involved in costly intellectual property disputes, be unable to adequately protect our intellectual property rights or prevent disclosure of our trade secrets and other proprietary information, and incur costs associated with litigation or other proceedings related to such matters;*
- *restrictions or other obligations imposed on us by agreements related to our marketed products or our product candidates, including our license agreements with PARI Pharma GmbH (PARI) and AstraZeneca AB (AstraZeneca), and failure to comply with our obligations under such agreements;*
- *the cost and potential reputational damage resulting from litigation to which we are or may become a party, including product liability claims;*
- *risk that our operations are subject to a material disruption in the event of a cybersecurity attack or issue;*
- *changes in laws and regulations applicable to our business, including any pricing reform and laws that impact our ability to utilize certain third parties in the research, development or manufacture of our product candidates, and failure to comply with such laws and regulations;*
- *our history of operating losses, and the possibility that we never achieve or maintain profitability;*
- *goodwill impairment charges affecting our results of operations and financial condition;*
- *inability to repay our existing indebtedness and uncertainties with respect to our ability to access future capital; and*
- *delays in the execution of plans to build out an additional third-party manufacturing facility approved by the appropriate regulatory authorities and unexpected expenses associated with those plans.*

We caution readers not to place undue reliance on any such forward-looking statements, which speak only as of the date they are made. Any forward-looking statement is based on information current as of the date of this Annual Report on Form 10-K and speaks only as of the date on which such statement is made. Actual events or results may differ materially from the results, plans, intentions or expectations anticipated in these forward-looking statements as a result of a variety of factors, many of which are beyond our control. More information on factors that could cause actual results to differ materially from those anticipated is included from time to time in our reports filed with the Securities and Exchange Commission (SEC), including, but not limited to, those described in the sections titled "Risk Factors" and "Management's Discussion and Analysis of Financial Condition and Results of Operations" included in this Annual Report on Form 10-K. We disclaim any obligation, except as specifically required by law and the rules of the SEC, to publicly update or revise any such statements to reflect any change in our expectations or in events, conditions or circumstances on which any such statements may be based, or that may affect the likelihood that actual results will differ from those set forth in the forward-looking statements.

PART I

ITEM 1. BUSINESS

Business Overview

We are a people-first global biopharmaceutical company striving to deliver first- and best-in-class therapies to transform the lives of patients facing serious diseases. Our commercial portfolio and clinical pipeline are organized around three therapeutic areas: Respiratory, Immunology & Inflammation, and Neuro & Other Rare. To complement our internal research and development, we also actively evaluate in-licensing and acquisition opportunities for commercial products, product candidates and technologies.

Our two commercial products, ARIKAYCE® and BRINSUPRI®, are both part of the Respiratory therapeutic area. ARIKAYCE is approved in the US as ARIKAYCE (amikacin liposome inhalation suspension), in Europe as ARIKAYCE Liposomal 590 mg Nebuliser Dispersion and in Japan as ARIKAYCE inhalation 590mg (amikacin sulfate inhalation drug product). ARIKAYCE received accelerated approval in the US in September 2018 for the treatment of MAC lung disease as part of a combination antibacterial drug regimen for adult patients with limited or no alternative treatment options in a refractory setting. In October 2020, the European Commission (EC) approved ARIKAYCE Liposomal for the treatment of nontuberculous mycobacterial (NTM) lung infections caused by MAC in adults with limited treatment options who do not have cystic fibrosis (CF). In March 2021, Japan's Ministry of Health, Labour and Welfare (MHLW) approved ARIKAYCE for the treatment of patients with NTM lung disease caused by MAC who did not sufficiently respond to prior treatment with a multidrug regimen. NTM lung disease caused by MAC (which we refer to as MAC lung disease) is a rare and often chronic infection that can cause irreversible lung damage and can be fatal.

BRINSUPRI (brensocatib 25 mg and 10 mg tablets), an oral, once-daily treatment for non-cystic fibrosis bronchiectasis (referred to as bronchiectasis or NCFB) in patients 12 years of age and older, was approved in the US in August 2025. In November 2025, the EC approved BRINSUPRI (brensocatib 25 mg tablets) for the treatment of NCFB in patients 12 years of age and older with two or more exacerbations in the prior 12 months. Bronchiectasis is a serious, chronic lung disease in which the bronchi become permanently dilated due to a cycle of infection, inflammation, and lung tissue damage.

Our Respiratory therapeutic area also includes the clinical-stage programs TPIP and INS1148. TPIP is an inhaled dry powder formulation of the treprostinil prodrug treprostinil palmitil which may offer a differentiated product profile for pulmonary hypertension associated with interstitial lung disease (PH-ILD), pulmonary arterial hypertension (PAH), progressive pulmonary fibrosis (PPF), and idiopathic pulmonary fibrosis (IPF). INS1148 is a monoclonal antibody targeting a specific isoform of Stem Cell Factor, called Stem Cell Factor 248 (SCF248).

The clinical-stage program in our Inflammation & Immunology therapeutic area is brensocatib, a small molecule, oral, reversible inhibitor of dipeptidyl peptidase 1 (DPP1), for the treatment of patients with hidradenitis suppurativa (HS).

The clinical-stage programs in our Neuro & Other Rare therapeutic area are INS1201, an intrathecally delivered gene therapy for patients with Duchenne muscular dystrophy (DMD), and INS1202, an intrathecally delivered gene therapy for patients with amyotrophic lateral sclerosis (ALS).

Our pre-clinical research programs encompass a wide range of technologies and modalities, including gene therapy, AI-driven protein engineering, protein manufacturing, RNA end-joining, and synthetic rescue.

A summary of our commercial products and clinical-stage pipeline is shown below:

*Brensocatib is approved in the US and Europe. Brensocatib remains under review by regulatory authorities in the UK and Japan.

The information below summarizes our updates and anticipated near-term milestones across our therapeutic areas.

Respiratory

BRINSUPRI

- In August 2025, BRINSUPRI (brensocatib 25 mg and 10 mg tablets), an oral, once-daily treatment for NCFB in adults and children 12 years and older, was approved in the US by the FDA. We launched BRINSUPRI in the US in the third quarter of 2025.
- In November 2025, the EC approved BRINSUPRI (brensocatib 25 mg tablets) for the treatment of NCFB in patients 12 years of age and older with two or more exacerbations in the prior 12 months.
- We anticipate regulatory decisions for brensocatib for the treatment of NCFB in the United Kingdom (UK) and Japan in 2026.
- We continue to evaluate the potential effect of evolving US policies which will then impact the timing for future potential international commercial launches.

ARIKAYCE

- Following the announcement of positive topline results from the ARISE trial, in June 2024, we met and aligned with the FDA on the primary endpoint for the ENCORE trial. If the data are positive, ENCORE may support a label expansion to include all MAC lung disease as well as support full approval for the current refractory indication.
- We completed enrollment in the ENCORE trial with 425 patients in the fourth quarter of 2024.
- We anticipate reporting topline data from the ENCORE trial by April 2026, with the submission of a US supplementary new drug application (sNDA) for ARIKAYCE in all patients with MAC lung disease projected for the second half of 2026. We also plan to review the data with the Pharmaceuticals and Medical Devices Agency to support potential label expansion in Japan.

TPIP

- In January 2026, the Office of Orphan Products Development of the FDA granted orphan drug designation to treprostinil palmitil for the treatment of patients with PAH. We plan to initiate a Phase 3 study of TPIP in patients with PAH in the first half of 2026.

- We initiated PALM-ILD, a Phase 3 study of TPIP in patients with PH-ILD in the fourth quarter of 2025 and are actively enrolling patients.
- We expect to report data from the open-label extension (OLE) of our Phase 2b study of TPIP in PAH in the second half of 2026.
- Additional Phase 3 studies of TPIP are anticipated to be initiated in patients with PPF and IPF in the second half of 2026.

INS1148

- In December 2025, we acquired INS1148, a Phase 2-ready monoclonal antibody targeting SCF248.
- We plan to advance Phase 2 development programs for INS1148 initially in interstitial lung disease and moderate to severe asthma.

We are exploring additional opportunities utilizing our various technologies within the Respiratory therapeutic area.

Immunology & Inflammation

Brensocatib

- In October 2025, we completed enrollment in the Phase 2b CEDAR study of brensocatib in patients with HS. We anticipate reporting topline data in the second quarter of 2026.

We are exploring additional opportunities utilizing our various technologies within the Immunology & Inflammation therapeutic area.

Neuro & Other Rare

INS1201

- We continue to enroll patients in the Phase 1 ASCEND clinical study of INS1201 for patients with DMD.

INS1202

- We continue to enroll patients in the Phase 1 ARMOR clinical study of INS1202 for patients with ALS.

We are exploring additional opportunities utilizing our various technologies within the Neuro & Other Rare therapeutic area.

Our Strategy

We strive to develop and commercialize first- and best-in-class therapies that serve patient communities where the need is greatest. Our commercial portfolio and clinical pipeline are organized around three therapeutic areas: Respiratory, Immunology & Inflammation, and Neuro & Other Rare. Our Respiratory therapeutic area includes our commercial products ARIKAYCE and BRINSUPRI and the clinical-stage product candidates TPIP and INS1148. Our first product, ARIKAYCE, is approved in the US as ARIKAYCE (amikacin liposome inhalation suspension), in Europe as ARIKAYCE Liposomal 590 mg Nebuliser Dispersion and in Japan as ARIKAYCE inhalation 590mg (amikacin sulfate inhalation drug product). We are not aware of any other approved inhaled therapies specifically indicated to treat MAC lung disease in North America, Europe or Japan. We believe that ARIKAYCE has the potential to prove beneficial in other patients with refractory MAC lung disease. Our second commercial product, BRINSUPRI, was approved in the US and EU in August 2025 and November 2025, respectively, for the treatment of NCFB. Regulatory submissions for brensocatib in the UK and Japan have been accepted. TPIP is our product candidate that may offer a differentiated product profile for patients with PH-ILD, PAH, PPF, and IPF. INS1148 is a monoclonal antibody targeting SCF248. Our Immunology & Inflammation therapeutic area includes brensocatib, which we are developing for HS. Our Neuro & Other Rare therapeutic area includes INS1201, our intrathecally delivered gene therapy product candidate for patients with DMD, and INS1202, our intrathecally delivered gene therapy product candidate for patients with ALS. We are also advancing pre-clinical research programs encompassing a wide range of technologies and modalities, including gene therapy, AI-driven protein engineering, protein manufacturing, RNA end-joining, and synthetic rescue.

Our key priorities are as follows:

- Ensure successful US commercial launch of BRINSUPRI;
- Continue to provide ARIKAYCE to appropriate patients and expand our label;
- Advance our pipeline and produce topline clinical data readouts in the near and long term; and
- Control spending, prudently deploying capital to support the best return-generating opportunities.

Respiratory

BRINSUPRI

BRINSUPRI (brensocatib 25 mg and 10 mg tablets), an oral, once-daily treatment for NCFB in adults and children 12 years and older, was approved in the US by the FDA in August 2025. In November 2025, BRINSUPRI (brensocatib 25 mg tablets), an oral, once-daily treatment for NCFB in adults and children 12 years and older with two or more exacerbations in the prior 12 months, was approved by the EC. Regulatory submissions for brensocatib in the UK and Japan have been accepted.

Brensocatib is a small molecule, reversible inhibitor of DPP1, which we licensed from AstraZeneca in October 2016. DPP1 is an enzyme responsible for activating neutrophil serine proteases (NSPs) in neutrophils when they are formed in the bone marrow. Neutrophils are the most common type of white blood cell and play an essential role in pathogen destruction and inflammatory mediation. Neutrophils contain the NSPs (including neutrophil elastase, proteinase 3, and cathepsin G) that have been implicated in a variety of inflammatory diseases. In chronic inflammatory lung diseases, neutrophils accumulate in the airways and result in excessive active NSPs that cause lung destruction and inflammation. Brensocatib may decrease the damaging effects of inflammatory diseases such as bronchiectasis by inhibiting DPP1 and its activation of NSPs.

In June 2020, the FDA granted breakthrough therapy designation for brensocatib for the treatment of adult patients with NCFB for reducing exacerbations. In November 2020, brensocatib was granted access to the PRIME scheme from the EMA for patients with NCFB. In October 2021, the EMA's Paediatric Committee approved the brensocatib Pediatric Investigational Plan (the PIP) for the treatment of patients with NCFB. As a result, the ASPEN trial included 41 adolescent patients between ages 12 to 17, which trial design satisfied the pediatric study requirements to support marketing applications in this patient population in the US, Europe and Japan. As a condition of BRINSUPRI's approval in the US, we agreed with the FDA to conduct a pediatric post marketing study of BRINSUPRI in children between ages 6 and 11. We are also required to continue to progress the PIP notwithstanding BRINSUPRI's approval in the EU.

The ASPEN Study

Based on positive results of our Phase 2b study of brensocatib in patients with NCFB (the WILLOW study), in December 2020 we commenced the ASPEN study, a global, randomized, double-blind, placebo-controlled Phase 3 study to assess the efficacy, safety, and tolerability of brensocatib in adult patients with bronchiectasis. Patients with bronchiectasis due to CF were not enrolled in the study. The primary endpoint was the rate of adjudicated pulmonary exacerbations (PEs) over the 52-week treatment period. Secondary endpoints included the time to first adjudicated PE, the proportion of subjects free of adjudicated PE by 52 weeks, the absolute change from baseline in post-bronchodilator FEV1, the reduction in annualized rate of severe adjudicated PE, and the change from baseline in the Bronchiectasis QOL-B Respiratory Symptoms Domain Score.

As part of the ASPEN study, more than 460 trial sites were engaged in nearly 40 countries. After excluding sites that did not enroll any patients and all sites in Ukraine, due to the ongoing conflict, the total number of active sites in ASPEN was 391 sites in 35 countries. Adult patients (ages 18 to 85 years) were randomized 1:1:1 and adolescent patients (ages 12 to <18 years) were randomized 2:2:1 for treatment with brensocatib 10 mg, brensocatib 25 mg, or placebo once daily for 52 weeks, followed by 4 weeks off treatment.

ASPEN Safety Information and Efficacy Data

We announced positive topline results from the ASPEN trial in May 2024. Results from the ASPEN trial were published in the NEJM in April 2025. The primary efficacy analysis included data from 1,680 adult patients and 41 adolescent patients. Brensocatib was well-tolerated in the study. In addition, the study met its primary endpoint, with both dosage strengths of brensocatib demonstrating statistically significant reductions in the annualized rate of adjudicated PEs versus placebo. The study also met several of its prespecified secondary endpoints with statistical significance.

Topline efficacy results from the ASPEN study were as follows:

	Brensocatib 10 mg compared to placebo		Brensocatib 25 mg compared to placebo	
Primary Endpoint				
Reduction in annualized rate of PEs	21.1%	p=0.0019*	19.4%	p=0.0046*
Secondary Endpoints				
Prolongation of time to first PE	18.7%	p=0.0100*	17.5%	p=0.0182*
Increase in odds of remaining exacerbation free over 52 weeks	41.2%	p=0.0059*	40.0%	p=0.0074*
Change from baseline in post-bronchodilator forced expiratory volume in 1 second (FEV1) at week 52	11 mL	p=0.3841	38 mL	p=0.0054*
Reduction in annualized rate of severe PEs	25.8%	p=0.1277	26.0%	p=0.1025
Change from baseline in the Quality of Life – Bronchiectasis (QOL-B) Respiratory Score at week 52	2.0 points	p=0.0594	3.8 points	p=0.0004^

* - Statistically significant

^ - Nominally significant p-value

Market Opportunity for BRINSUPRI

Bronchiectasis is a severe, chronic pulmonary disorder in which the bronchi become permanently dilated due to a cycle of infection, inflammation, and lung tissue damage. The condition is marked by frequent pulmonary exacerbations requiring antibiotic therapy and/or hospitalizations. Symptoms include chronic cough, excessive sputum production, shortness of breath, and repeated respiratory infections, which can worsen the underlying condition. Based on information from external sources, including market research funded by us and third parties, and internal analyses and calculations, we estimate the potential addressable market in bronchiectasis in the US, the European 5 (comprised of France, Germany, Italy, Spain and the UK) and Japan are as follows:

Potential Market	Estimated Number of Patients Diagnosed with Bronchiectasis
United States	500,000
European 5	600,000
Japan	150,000

We are not aware of any other approved therapies in the US, Europe, or Japan for the treatment of patients with bronchiectasis.

ARIKAYCE for Patients with MAC Lung Disease

ARIKAYCE is our first approved product. ARIKAYCE received accelerated approval in the US in September 2018 for the treatment of refractory MAC lung disease as part of a combination antibacterial drug regimen for adult patients with limited or no alternative treatment options. In October 2020, ARIKAYCE received approval in Europe for the treatment of NTM lung infections caused by MAC in adults with limited treatment options who do not have CF. In March 2021, ARIKAYCE received approval in Japan for the treatment of patients with NTM lung disease caused by MAC who did not sufficiently respond to prior treatment with a multidrug regimen. MAC lung disease is a rare and often chronic infection that can cause irreversible lung damage and can be fatal. Amikacin solution for parenteral administration is an established drug that has activity against a variety of NTM; however, its use is limited by the need to administer it intravenously and by toxicity to hearing, balance, and kidney function. Unlike amikacin solution for intravenous administration, our proprietary Pulmovance™ technology uses charge-neutral liposomes to deliver amikacin directly to the lungs where liposomal amikacin is taken up by the lung macrophages where the MAC infection resides. This technology also prolongs the release of amikacin in the lungs, while minimizing systemic exposure, thereby offering the potential for decreased systemic toxicities. ARIKAYCE's ability to deliver high levels of amikacin directly to the lung and sites of MAC infection via the use of our Pulmovance technology distinguishes it from intravenous amikacin. ARIKAYCE is administered once-daily using Lamira, an inhalation device developed and manufactured by PARI. Lamira is a portable nebulizer that enables aerosolization of liquid medications via a vibrating, perforated membrane, and was designed specifically for ARIKAYCE delivery.

The FDA has designated ARIKAYCE as an orphan drug and a Qualified Infectious Disease Product (QIDP) for NTM lung disease. Orphan designated drugs are eligible for seven years of exclusivity for the orphan indication. QIDP designation provides an additional five years of exclusivity for the designated indication. The FDA granted a total of 12 years of exclusivity in the indication for which ARIKAYCE was approved.

ARIKAYCE also has been included in the international treatment guidelines for NTM lung disease. The evidence-based guidelines, issued by the American Thoracic Society (ATS), European Respiratory Society (ERS), European Society of Clinical Microbiology and Infectious Diseases (ESCMID), and Infectious Diseases Society of America (IDSA), strongly recommend the use of ARIKAYCE for MAC lung disease as part of a combination antibacterial drug regimen for adult patients with limited or no alternative treatment options who have failed to convert to a negative sputum culture after at least six months of treatment.

In October 2020, the FDA approved a supplemental new drug application for ARIKAYCE, adding important efficacy data regarding the durability and sustainability of culture conversion to the ARIKAYCE label. The data, which are from the Company's Phase 3 study of ARIKAYCE (the CONVERT study), demonstrate that the addition of ARIKAYCE to guideline-based therapy (GBT) was associated with sustained culture conversion through the end of treatment as well as durable culture conversion three months post-treatment compared with GBT alone.

Accelerated Approval and Post-Marketing Confirmatory Clinical Trial

In September 2018, the FDA granted accelerated approval for ARIKAYCE under the Limited Population Pathway for Antibacterial and Antifungal Drugs (LPAD) for the treatment of refractory MAC lung disease as part of a combination antibacterial drug regimen for adult patients with limited or no alternative treatment options. LPAD, which was enacted as part of the 21st Century Cures Act, serves to advance the development of new antibacterial drugs to treat serious or life-threatening infections in limited populations of patients with unmet needs. As required for drugs approved under the LPAD pathway, labeling for ARIKAYCE includes certain statements to convey that the drug has been shown to be safe and effective only for use in a limited population.

As a condition of accelerated approval, we must conduct a post-marketing confirmatory clinical trial. In December 2020, we commenced the post-marketing confirmatory clinical trial program for ARIKAYCE in patients with MAC lung disease consisting of the ARISE trial, an interventional study designed to validate cross-sectional and longitudinal characteristics of a patient-reported outcome (PRO) tool in MAC lung disease, and the ENCORE trial, designed to establish the clinical benefits and evaluate the safety of ARIKAYCE in patients with newly diagnosed or recurrent MAC lung infection who have not started antibiotics using the PRO tool validated in the ARISE trial. In September 2023, we announced positive topline results from the ARISE trial. The study met its primary objective of demonstrating that the QOL-B respiratory domain works effectively as a PRO tool in patients with MAC lung disease. Based on feedback and in alignment with the FDA, we have determined that the primary endpoint for the ENCORE study will include eight questions from the QOL-B respiratory domain PRO. We completed enrollment of the ENCORE study in the fourth quarter of 2024, with 425 patients enrolled. We anticipate reporting topline data by April 2026. If the data are positive, ENCORE may support a label expansion to include all MAC lung disease as well as support full approval for the current refractory indication.

The ARISE Study

The ARISE trial was a global, randomized, double-blind, placebo-controlled Phase 3b study in adult patients with newly diagnosed or recurrent MAC infections that aimed to generate evidence demonstrating the domain specification, reliability, validity, and responsiveness of PRO-based scores, including a respiratory symptom score. The ARISE study met its primary objective of demonstrating that the QOL-B respiratory domain works effectively as a PRO tool in patients with MAC lung disease.

Patients in ARISE (N=99) were randomized 1:1 to treatment with ARIKAYCE plus macrolide-based background regimen (ARIKAYCE arm) or placebo plus macrolide-based background regimen (comparator arm) once daily for six months, followed by one month off treatment. ARIKAYCE-treated patients performed better than those in the comparator arm as measured by the QOL-B instrument, with 43.8% of patients achieving an improvement in QOL-B respiratory score above the estimated meaningful within-subject score difference of 14.8, compared with 33.3% of patients in the comparator arm. While the study was not powered to show a statistically significant difference between treatment arms, a strong trend toward significance was observed for improvement from baseline at Month 7 (12.24 vs. 7.76, p=0.1073). Patients in the ARIKAYCE arm also achieved nominally statistically significantly higher culture conversion rates at Month 7 versus patients in the comparator arm (78.8% vs. 47.1%, p=0.0010), and culture conversion was faster and more likely to persist through Month 7 for the ARIKAYCE arm, suggesting that ARIKAYCE-treated patients are more likely to remain negative.

Consistent with our expectations, the FDA and the Pharmaceuticals and Medical Devices Agency in Japan confirmed that they would not consider a label expansion for ARIKAYCE based on data from the ARISE study alone.

ARISE Culture Conversion

Consistent with prior clinical studies, a higher proportion of patients in the ARIKAYCE arm achieved culture conversion by Month 6 (defined as negative cultures at Months 5 and 6) compared to patients in the comparator arm (80.6% vs. 63.9%, p=0.0712). Among patients who achieved culture conversion by Month 6, more patients in the ARIKAYCE arm achieved the first of their two required monthly negative cultures for clinical conversion at Month 1 versus the comparator arm

(74.3% vs. 46.7%). As reported above, at Month 7 (one month following the cessation of treatment), 78.8% of patients in the ARIKAYCE arm vs. 47.1% of patients in the comparator arm were culture-converted, suggesting that ARIKAYCE-treated patients are more likely to remain negative.

Correlation Between ARISE Culture Conversion and QOL-B Performance

Patients in the ARIKAYCE arm who achieved culture conversion at both Month 6 and Month 7 had nominally statistically significantly greater improvements in QOL-B respiratory domain scores at Month 7 compared to patients in the ARIKAYCE arm who did not achieve culture conversion (15.74 vs. 3.53, p=0.0167 at Month 6 and 14.89 vs. 4.50, p=0.0416 at Month 7).

ARISE Safety and Tolerability

The discontinuation rate of ARIKAYCE or the placebo used in the comparator arm was 22.9% in the ARIKAYCE arm and 7.8% in the comparator arm. Study completion rates were 91.7% in the ARIKAYCE arm and 94.1% in the comparator arm. No new safety events were observed in the ARIKAYCE arm, and the safety profile in general was as expected in both treatment arms. Treatment-emergent adverse events (TEAEs) were reported by 91.7% of patients in the ARIKAYCE arm and 80.4% of patients in the comparator arm. The most common TEAEs were dysphonia (41.7% for the ARIKAYCE arm vs. 3.9% for the comparator arm), cough (27.1% vs. 7.8%), diarrhea (27.1% vs. 25.5%), and COVID-19 (12.5% vs. 9.8%). Of the treatment-emergent serious adverse events observed in the trial, none were determined to be related to ARIKAYCE by investigators.

The ENCORE Study

The ENCORE trial is a randomized, double-blind, placebo-controlled Phase 3b study to evaluate the efficacy and safety of an ARIKAYCE-based regimen in patients with newly diagnosed or recurrent MAC infection who have not started antibiotics. Patients are randomized 1:1 to receive ARIKAYCE plus background regimen or placebo plus background regimen once daily for 12 months. Patients will then discontinue all study treatments and remain in the trial for three months for the assessment of durability of culture conversion. The primary endpoint is change from baseline to Month 13 in respiratory symptom score. The key secondary endpoint is the proportion of subjects achieving durable culture conversion at Month 15. In June 2024, we met and aligned with the FDA on the primary endpoint for the ENCORE study. If the data are positive, ENCORE may support a label expansion to include all MAC lung patients as well as support full approval for the current refractory indication. Based on feedback and in alignment with the FDA, we have determined that the primary endpoint for the ENCORE study will include eight questions from the QOL-B respiratory domain PRO. We completed enrollment of the ENCORE study in the fourth quarter of 2024, with 425 patients enrolled. We anticipate reporting topline data by April 2026. Pending successful results from the ENCORE trial, we plan to submit a sNDA to the FDA for ARIKAYCE in all patients with MAC lung disease in the US in the second half of 2026. We also plan to review the data with the Pharmaceuticals and Medical Devices Agency to support potential label expansion in Japan.

Regulatory Approval Outside of the US

In October 2020, the EC granted marketing authorization for ARIKAYCE for the treatment of NTM lung infections caused by MAC in adults with limited treatment options who do not have CF. ARIKAYCE can now be prescribed for patients across the EU countries as well as in the UK. ARIKAYCE is reimbursed nationally in France, Belgium, the Netherlands, the UK and Ireland. To date, we have been unable to reach an acceptable agreement of a nationally reimbursed price with the Italian Medicines Agency; however, ARIKAYCE remains commercially available for physicians to prescribe in Italy under Class C, where we set the price and funding is agreed locally.

In March 2021, Japan's MHLW approved ARIKAYCE for the treatment of patients with NTM lung disease caused by MAC who did not sufficiently respond to prior treatment with a multidrug regimen. In July 2021, we launched ARIKAYCE in Japan.

Further Research and Lifecycle Management

We are currently exploring and supporting research and lifecycle management programs for ARIKAYCE beyond treatment of refractory MAC lung disease as part of a combination antibacterial regimen for adult patients who have limited or no treatment options. As noted above, we will continue to advance the post-marketing confirmatory MAC lung disease clinical trial program for ARIKAYCE, through the completed ARISE and ongoing ENCORE trials, which are intended to fulfill the FDA's post-marketing requirement to allow for the full approval of ARIKAYCE in the US, as well as to support the use of ARIKAYCE as a treatment for patients with MAC lung disease.

Subsequent lifecycle management studies could also potentially enable us to reach more patients. These initiatives may include new clinical studies sponsored by us and may also include investigator-initiated studies, which are independent clinical studies initiated and sponsored by physicians or research institutions, with funding from us.

Market Opportunity for ARIKAYCE in MAC Lung Disease

NTM lung disease is associated with increased rates of morbidity and mortality, and MAC is the predominant pathogenic species in NTM lung disease in the US, Europe and Japan. The prevalence of NTM lung disease has increased over the past two decades, and we believe it is an emerging public health concern worldwide. Based on an analysis using information from external sources, including market research funded by us and third parties, and internal analyses and calculations, we estimate the potential patient populations in the US, the European 5 and Japan are as follows:

Potential Market	Estimated Number of Patients with Diagnosed MAC Lung Disease	Estimated Number of Patients with Refractory MAC Lung Disease
United States	95,000-115,000	12,000-17,000
European 5	14,000	1,400
Japan	125,000-145,000	15,000-18,000

We are not aware of any other approved inhaled therapies specifically indicated for NTM lung disease in North America, Europe or Japan. Based on a burden of illness study that we conducted in the US with a major medical benefits provider, we previously concluded that patients with NTM lung disease are costly to healthcare plans, while a claims-based study in the US has shown that patients with NTM lung disease have higher resource utilization and costs than their age and gender-matched controls. Accordingly, we believe that a significant market opportunity for ARIKAYCE in NTM lung disease exists in the US and internationally.

Treprostinil Palmitil Inhalation Powder

TPIP is an investigational inhaled dry powder formulation of treprostinil palmitil that has the potential to address certain of the current limitations of existing prostanoid therapies. We believe that TPIP prolongs duration of effect and may provide patients with greater consistency in pulmonary arterial pressure reduction over time. Current inhaled prostanoid therapies must be dosed four to nine times per day. Reducing dose frequency has the potential to ease treatment burden for patients and improve compliance. Additionally, we believe that TPIP may be associated with fewer side effects, including severity and/or frequency of cough, headache, throat irritation, nausea, flushing and dizziness that are associated with high initial drug levels and local upper airway exposure when using current inhaled prostanoid therapies. We believe TPIP may offer a differentiated product profile for PH-ILD, PAH, PPF and IPF. In January 2026, FDA granted treprostinil palmitil orphan drug designation for the treatment of PAH, based on a plausible hypothesis that it may be clinically superior to treprostinil already approved for the treatment of the same indication.

In February 2021, we announced topline results from the Phase 1 study of TPIP in healthy volunteers. The objective of this first-in-human single ascending dose and multiple ascending dose study was to assess the pharmacokinetics and tolerability profile of TPIP. Data from the study demonstrated that TPIP was generally well tolerated, with a pharmacokinetic profile that supports continued development with once-daily dosing. The most common AEs across all cohorts in the study were cough, dizziness, headache, and nausea. Most AEs were mild in severity and consistent in nature with those typically seen with other inhaled prostanoid therapies. There were few moderate AEs and no severe or serious AEs. Subjects in the multiple dose panel that incorporated an up-titration approach beginning at 112.5 µg once-daily and progressing to 225 µg once-daily reported fewer AEs compared to the panel dosed with 225 µg once-daily from the first dose.

Overall pharmacokinetic results demonstrated that treprostinil exposure (AUC and Cmax) was dose-proportional, with low to moderate inter-subject variability. Treprostinil was detected in the plasma at 24 hours at all doses and throughout the 48-hour sampling period for the two highest doses. Compared with currently available inhaled treprostinil therapy, TPIP showed substantially lower Cmax and longer half-life.

In May 2024, we reported positive topline safety data and certain exploratory efficacy endpoints from the Phase 2a study of TPIP in patients with PH-ILD. A total of 39 patients were randomized 3:1 to receive either TPIP (n=29) or placebo (n=10) for 16 weeks. Patients started at a dose of 80 µg once daily (TPIP or matching placebo) and were titrated up to their maximum tolerated dose, or to the maximum allowable dose of 640 µg, once daily over a three-week period, with the possibility of a final dose increase occurring at Week 5. Of the patients treated with TPIP, 79.3% of patients were able to reach the maximum 640 µg dose by Week 5, compared to 100.0% of patients in the placebo arm. TEAEs which led to treatment discontinuation were reported in 13.8% of patients in the active treatment arm and 30.0% of patients in the placebo arm. Adverse events related to study drug were reported in 55.2% of TPIP patients and 40.0% of placebo patients. Serious adverse events were reported in 20.7% of TPIP-treated patients and 40.0% of placebo-treated patients. Deaths were reported in 6.9% of patients taking TPIP and 20.0% of patients taking placebo. All deaths were attributed to disease progression or comorbid causes, none of which were deemed related to study drug.

There were no meaningful changes in oxygenation levels compared to baseline for TPIP-treated patients at rest or at the lowest point during or after exercise. There was also no change in the use of supplemental oxygen for patients taking TPIP.

There was a small decrease in oxygenation levels observed after exercise for patients on TPIP, compared to a slight increase for patients taking placebo.

On the exploratory endpoint of change from baseline in 6-minute walk distance (6MWD), TPIP-treated patients demonstrated a 30-meter improvement compared to patients treated with placebo. However, this result was associated with a wide confidence interval. In addition, there was a directional improvement observed in N-terminal pro b-type natriuretic peptide (NT-proBNP) levels from baseline for patients taking TPIP and a directional worsening observed in patients on placebo, although no meaningful separation was observed between groups. Events of clinical worsening were reported in 10.3% of patients taking TPIP, compared to 50.0% of patients taking placebo. This difference was nominally significant (p=0.0164).

We initiated PALM-ILD, a Phase 3 study of patients with PH-ILD, in the fourth quarter of 2025.

In June 2025, we announced positive topline results from the Phase 2b study of TPIP in patients with PAH. The study met its primary endpoint and secondary efficacy endpoints. For the primary endpoint, the placebo-adjusted reduction from baseline in pulmonary vascular resistance (PVR) was 35% with Least Squares (LS) mean ratio of 0.65 (95% Confidence Interval (CI): 0.54, 0.79; p<0.001). For the secondary efficacy endpoints, the placebo-adjusted improvement in 6MWD was 35.5 meters (95% CI: 11.2, 60.7; p=0.003) and the placebo-adjusted reduction from baseline in NT-proBNP concentrations, a biomarker for cardiac stress, was 60% with LS mean ratio of 0.40 (95% CI: 0.27, 0.59; p<0.001). Efficacy of TPIP was evaluated approximately 24 hours after therapy was administered.

The TPIP PAH study was conducted at 44 sites globally, and a total of 102 patients were randomized 2:1 to receive either TPIP (n=69) or placebo (n=33) for 16 weeks. Demographics and baseline characteristics were similar in both study arms. Patients started at a dose of 80 µg once daily (TPIP or matching placebo) and were titrated up to their maximum tolerated dose, or to the maximum allowable dose of 640 µg, once daily over a three-week period, with the possibility of a final dose increase occurring at Week 5. Of the patients treated with TPIP, 84% titrated to at least 480 µg once daily (n=58) and 75% titrated to the maximum allowed dose of 640 µg once daily (n=52). Overall, 90% of patients receiving TPIP (n=62) and all patients receiving placebo completed the study.

Once-daily TPIP therapy was well-tolerated in the study. TEAEs occurred in 88.4% of patients who received TPIP versus 75.8% of patients who received placebo; serious TEAEs were observed in 7.2% of patients who received TPIP versus 3.0% of patients who received placebo; and severe TEAEs were observed in 5.8% of patients who received TPIP versus 3.0% of patients who received placebo. TEAEs leading to treatment discontinuation were experienced by 5.8% of patients taking TPIP; there were none in the placebo arm. There were no deaths in the study. The most common TEAEs occurring in at least 5.0% of patients in any study arm, and more frequently with TPIP than with placebo, were cough (40.6%, 21.2%), headache (31.9%, 15.2%), fatigue (10.1%, 3.0%), chest discomfort (8.7%, 0.0%), flushing (8.7%, 3.0%), upper respiratory tract infection (7.2%, 3.0%), and non-cardiac chest pain (5.8%, 3.0%) for TPIP and placebo, respectively.

Based on these results, we plan to initiate a Phase 3 study of TPIP in patients with PAH in the first half of 2026.

All patients who completed the Phase 2b study were eligible to enroll in the long-term OLE, which will evaluate TPIP up to a maximum allowable dose of 1,280 µg once daily. Of the patients who completed the Phase 2b study (n=95), 95% enrolled in the OLE. We expect to report data from the OLE of our Phase 2b study of TPIP in PAH in the second half of 2026.

Additional Phase 3 studies of TPIP are anticipated to be initiated in PPF and IPF in the second half of 2026.

Market Opportunity for TPIP in PH-ILD and PAH

We believe TPIP may be a highly effective therapy that has the potential to ease the treatment burden for patients with PH-ILD and PAH, improve compliance and be associated with fewer side effects compared to current therapies. Based on our assessment of information from external sources, including market research conducted by third parties, we estimate the

potential addressable market for TPIP at launch in the US, the European 5 and Japan will be as follows (approximately):

Potential Market	Estimated Number of Patients Diagnosed with PH-ILD	Estimated Number of Patients Diagnosed with PAH
United States	50,000	35,000
European 5	65,000	40,000
Japan	20,000	15,000

Brensocatib

In December 2025, we completed the Phase 2b BiRCh study of brensocatib in patients with chronic rhinosinusitis without nasal polyps (CRSsNP). The study did not meet its primary or secondary efficacy endpoints and we have discontinued our development program for brensocatib in CRSsNP.

INS1148

In December 2025, we acquired global rights to OpSCF (renamed INS1148) from Opsidio LLC (Opsidio). INS1148 is an investigational monoclonal antibody that we are developing as a potential first-in-class therapy to address respiratory and immunological and inflammatory diseases with high unmet need. Through its novel mechanism of action, INS1148 preferentially targets SCF248. Binding to SCF248 induces clearance of this SCF isoform and interrupts only the inflammatory cascade downstream of c-Kit signaling, while leaving the homeostatic and tissue healing c-Kit pathways intact. We plan to advance Phase 2 development programs for INS1148 initially in interstitial lung disease and moderate to severe asthma. See *Note 18 - Acquisitions* in this Annual Report on Form 10-K for further details.

Immunology & Inflammation

Brensocatib

We are conducting the Phase 2b CEDAR study to explore the efficacy and safety of brensocatib in HS. CEDAR is a randomized, double-blind study that enrolled adults with moderate to severe HS and assigned them 1:1:1 to brensocatib 10 mg once daily, brensocatib 40 mg once daily, or placebo for 16 weeks, followed by continued double-blind active treatment with brensocatib at the doses of 10 mg and 40 mg once daily for 36 weeks. The study will evaluate the efficacy and safety of brensocatib across clinically relevant endpoints in this population. CEDAR is fully enrolled, and we anticipate reporting topline data in the second quarter of 2026.

Neuro & Other Rare

INS1201

In the fourth quarter of 2024, we received clearance from the FDA for our IND application for INS1201, a micro-dystrophin adeno-associated virus gene therapy for patients with DMD. Administered intrathecally, this approach has the potential to target both skeletal and cardiac muscles at lower doses than intravenous DMD gene therapies. The FDA granted INS1201 Rare Pediatric Disease Designation in May 2024. We have initiated a Phase 1 study of INS1201, which we refer to as the ASCEND trial, and continue to enroll patients.

INS1202

In the third quarter of 2025, we received clearance from the FDA for our IND application for INS1202, an investigational adeno-associated virus (AAV9) short hairpin RNA (shRNA) construct targeting the human superoxide dismutase type 1 (SOD1) gene. We are developing INS1202 as a potential treatment for patients with ALS who carry SOD1 mutations and those who do not have SOD1 mutations. INS1202 is administered intrathecally as a one-time fixed (non-weight-based) dose. We have initiated a Phase 1 study of INS1202, which we refer to as the ARMOR trial, and continue to enroll patients.

Corporate Development

We plan to continue to develop, acquire, in-license or co-promote other commercial products, product candidates and technologies, including those that address serious diseases that currently have significant unmet needs. We are focused broadly on serious disease therapeutics and prioritizing those within our three therapeutic areas.

Manufacturing

We do not have any in-house manufacturing capability other than for small-scale pre-clinical development programs and we depend completely on a small number of third-party manufacturers and suppliers for the manufacture of our product candidates for use in clinical trials. We plan to rely primarily on third-party manufacturers and suppliers for the commercial manufacture and supply of most product candidates that we commercialize. ARIKAYCE is manufactured currently by

Resilience Biotechnologies Inc. (Resilience) (formerly Therapure Biopharma Inc.) in Canada at a 200 kilogram (kg) scale. For additional information about our agreement with Resilience, see *License and Other Agreements—ARIKAYCE-related Agreements*.

In October 2017, we entered into certain agreements with Patheon UK Limited (Patheon), a wholly-owned subsidiary of Thermo Fisher Scientific, Inc. (Thermo Fisher), related to increasing our long-term production capacity for ARIKAYCE commercial inventory. The agreements provide for Patheon to manufacture and supply ARIKAYCE for our anticipated long-term commercial needs. Under these agreements, we are required to deliver to Patheon the required raw materials, including active pharmaceutical ingredients, and certain fixed assets needed to manufacture ARIKAYCE. The aggregate investment to increase the long-term production capacity, including under these agreements, and related agreements or purchase orders with third parties for raw materials and fixed assets, is estimated to be approximately $127.7 million. In addition, we have a commercialization agreement with PARI, the manufacturer of our drug delivery nebulizer for ARIKAYCE, to address our commercial supply needs (the Commercialization Agreement).

In January 2024, we entered into certain agreements with Patheon Inc., a wholly-owned subsidiary of Thermo Fisher, related to the manufacture and supply of commercial brensocatib products, including BRINSUPRI, by Patheon Inc. for our long-term commercial needs. In addition, in September 2024, we entered into a commercial manufacturing and supply agreement with Esteve Química, S.A. (Esteve) for the manufacture and supply of active pharmaceutical ingredient for brensocatib. We are required to deliver to Patheon Inc. the active pharmaceutical ingredient needed to manufacture BRINSUPRI.

We expect to utilize contract manufacturing organizations (CMOs) to fulfill our future manufacturing requirements for TPIP. We are evaluating future in-house manufacturing capabilities.

Intellectual Property

We own or license rights to more than 1,400 issued patents and pending patent applications in the US and in foreign countries, including more than 400 issued patents and pending patent applications related to ARIKAYCE. Our success depends in large part on our ability to maintain proprietary protection surrounding our product candidates, technology and know-how; to operate without infringing the proprietary rights of others; and to prevent others from infringing our proprietary rights. We actively seek patent protection by filing patent applications, including on inventions that are important to the development of our business in the US, Europe, Japan, Canada, and selected other foreign markets that we consider key for our product candidates. These international markets generally include Australia, China, India, Israel and Mexico.

Our patent strategy includes obtaining patent protection, where possible, on compositions of matter, methods of manufacture, methods of use, dosing and administration regimens and formulations. We also rely on trade secrets, know-how, continuing technological innovation, in-licensing and partnership opportunities to develop and maintain our proprietary position.

We monitor for activities that may infringe our proprietary rights, as well as the progression of third-party patent applications that may have the potential to create blocks to our products or otherwise interfere with the development of our business. We are aware, for example, of US patents, and corresponding international counterparts, owned by third parties that contain claims related to treating lung infections using inhaled antibiotics. If any of these patents were to be asserted against us, we do not believe that our marketed product or development candidates would be found to infringe any valid claim of these patents.

Reflecting our commitment to safeguarding proprietary information, we require our employees, consultants, advisors, collaborators and other third-party partners to sign confidentiality agreements to protect the exchange of proprietary materials and information. We also seek to preserve the integrity and confidentiality of our data and trade secrets by maintaining physical security of our premises and physical and electronic security of our information technology systems.

ARIKAYCE (amikacin liposome inhalation suspension) Patents

Of the patents and applications related to ARIKAYCE, there are 13 in force issued US patents that cover the ARIKAYCE composition and its use in treating NTM that are listed in the FDA Orange Book. These patents and their expiration dates are as follows:

- US Patent No. 8,226,975 (expires August 15, 2028)
- US Patent No. 8,632,804 (expires December 5, 2026)
- US Patent No. 8,679,532 (expires December 5, 2026)
- US Patent No. 8,642,075 (expires December 5, 2026)
- US Patent No. 9,566,234 (expires January 18, 2034)
- US Patent No. 9,895,385 (expires May 15, 2035)
- US Patent No. 10,251,900 (expires May 15, 2035)

- US Patent No. 10,751,355 (expires May 15, 2035)
- US Patent No. 11,446,318 (expires May 15, 2035)
- US Patent No. 12,016,873 (expires May 15, 2035)
- US Patent No. 12,168,021 (expires May 15, 2035)
- US Patent No. 12,168,022 (expires May 15, 2035)
- US Patent No. 12,377,114 (expires May 15, 2035)

In addition, we own four pending US patent applications that cover the ARIKAYCE composition and/or its use in treating NTM lung disease, including those caused by MAC infections. One or more of the patent applications, if issued as patents in their current form, may be eligible for listing in the FDA Orange Book for ARIKAYCE. We also own a pending US application that covers methods for making ARIKAYCE. We anticipate that in the US, we will have patent coverage for ARIKAYCE and its use in treating NTM lung disease, including NTM lung disease caused by MAC, through at least May 15, 2035.

Ten patents are in force that have been granted by the European Patent Office (EPO) (European Patent Nos. 1909759, 1962805, 2852391, 3067046, 3142643, 3466432, 3766501, 4005576, 4122470, and 4331675) that relate to ARIKAYCE and its use in treating NTM lung disease, including those caused by MAC infections. In addition, we have additional patent applications pending before the EPO that relate to ARIKAYCE and its use in treating NTM lung disease. European Patent No. 1909759 (the ’759 patent), owned by us, was previously opposed by Generics (UK) Ltd. A hearing was held on October 19, 2015, during which we submitted amended claims. The European Patent Office Opposition Division (EPOOD) maintained the patent as amended and Generics (UK) Ltd appealed the decision. The EPO Technical Board of Appeals heard arguments related to the appeal on January 8, 2019 and the product claims of the patent were held invalid. The method of manufacture claims was remitted to the EPOOD for further consideration, and the EPO has since maintained the validity of these claims. European Patent Nos. 1962805 and 3067046, both of which expire approximately five months after the ‘759 patent (December 5, 2026 vs. July 19, 2026), also include claims related to ARIKAYCE and its use in treating NTM lung disease. European Patent Nos. 2852391, 4005576, and 4331675 each expire May 21, 2033 and include claims related ARIKAYCE together with a vibrating mesh nebulizer having certain properties. European Patent Nos. 3142643, 3466432, 3766501 and 4122470 each expire May 15, 2035 and include claims related to ARIKAYCE and its use for treating MAC lung infections.

More than 350 patents have also been issued and are in force in other foreign markets, e.g., Japan, China, Korea, Australia, and India, that relate to ARIKAYCE and/or methods of using ARIKAYCE for treating various pulmonary disorders, including NTM lung disease. More than 20 foreign patent applications are pending that relate to the ARIKAYCE composition and/or its use in treating various pulmonary disorders, including NTM lung disease.

Through our agreements with PARI, we have license rights to US and foreign patents and applications that cover the Lamira medical device through January 18, 2034. We have entered into a commercial supply agreement with PARI and we also have rights to use the nebulizers in expanded access programs and clinical trials.

BRINSUPRI (brensocatib) Patents

Through our agreement with AstraZeneca, we have licensed certain patent families that cover the BRINSUPRI drug substance, drug product and their use in treating bronchiectasis. There are 13 in-force US patents that are listed in the US FDA Orange Book. These patents and their expirations dates (not accounting for any patent term extension under 35 USC § 156 are as follows:

- US Patent No. 9,522,894 (expires March 12, 2035)
- US Patent No. 9,815,805 (expires January 21, 2035)
- US Patent No. 10,287,258 (expires January 21, 2035)
- US Patent No. 10,669,245 (expires January 21, 2035)
- US Patent No. 11,655,221 (expires January 21, 2035)
- US Patent No. 11,655,222 (expires January 21, 2035)
- US Patent No. 11,655,223 (expires January 21, 2035)
- US Patent No. 11,655,224 (expires January 21, 2035)
- US Patent No. 11,673,871 (expires January 21, 2035)
- US Patent No. 11,773,069 (expires January 21, 2035)
- US Patent No. 11,814,359 (expires January 21, 2035)
- US Patent No. 12,054,465 (expires February 21, 2040)
- US Patent No. 12,201,639 (expires March 1, 2039)

Counterpart patents to the aforementioned US drug substance patents have issued in Australia, Canada, Europe, China, Japan, South Korea, India, Israel, and Mexico and expire January 21, 2035, not accounting for any potential patent term extension. Counterpart patents to the aforementioned US drug product patents have issued in China, Europe and Japan and expire March 1, 2039. In addition, patent applications related to brensocatib and methods of using the same to treat indications of interest such as bronchiectasis and HS are pending in the US and throughout the world, including in Europe, China, and Japan.

TPIP Patents

We own US Patent Nos. 9,255,064, 9,469,600, 10,010,518, 10,526,274, 10,995,055 and 11,795,135, each expiring October 24, 2034 (not taking into account any potential patent term extensions or adjustments), each with claims covering treprostinil palmitil, the treprostinil prodrug component of TPIP, compositions comprising the same, and/or its use. US Patent No. 9,255,064 has claims directed to treprostinil palmitil, and other treprostinil prodrugs. US Patent No. 9,469,600 has claims related to TPIP and other treprostinil prodrug formulations. US Patent No. 10,010,518 has claims directed to methods of treating pulmonary hypertension, including PAH, using drug products comprising treprostinil palmitil. US Patent No. 10,526,274 has claims directed to methods for treating pulmonary fibrosis with treprostinil palmitil. US Patent No. 10,995,055 has claims directed to compositions comprising treprostinil palmitil in the form of a dry powder, and methods for treating pulmonary hypertension with the same. US Patent No. 11,795,135 has claims directed to methods for treating PH-ILD, with treprostinil palmitil. Counterpart patent applications to these US Patents have issued in Europe, Japan and other foreign jurisdictions. Counterpart patent applications to these US Patents are also pending in select jurisdictions, including the US, Europe and Japan.

We own pending patent applications that relate to treprostinil prodrug formulations, methods for using treprostinil prodrugs and formulations comprising the same, including the use of TPIP in treating patients with PAH, PH-ILD and other diseases, as well as methods for manufacturing such treprostinil prodrugs and formulations. Should the patent applications related to TPIP formulations and methods of using TPIP in pulmonary hypertension treatment methods issue, these patents would expire in October 2041.

INS1148 Patents

We own US Patent Nos. 11,939,373 and 12,410,246, expiring in October 2040 and September 2040, respectively, which have claims related to the INS1148 antibody. Counterpart patents have issued in select jurisdictions around the world, including in Europe and Japan, and will expire in September 2040.

INS1201 Patents

We own International Patent Application No. PCT/US2022/74622 and related patent applications, that cover INS1201 and its use in the treatment of DMD. Not taking into account any possible patent term extension under 35 U.S.C. § 156, patents stemming from this application family will expire on August 5, 2042. Patent applications in this family are pending in Australia, Brazil, China, Europe, Hong Kong, Japan, Korea, Mexico and the US.

INS1202 Patents

Through our agreement with the Research Institute at Nationwide Children's Hospital (NCH), we have licensed US Patent No. 10,793,861 and related patents and patent applications, that cover INS1202 and its use in the treatment of ALS. Not taking into account any possible patent term extension under 35 U.S.C. § 156, US Patent No. 10,793,861 will expire on November 16, 2034. A counterpart patent has issued in Europe and is pending in Canada.

We also own a pending provisional patent application that relates to certain methods for using INS1202 in treating patients with ALS. Should this patent application issue, the issued patent would expire in August 2046.

Trademarks

In addition to our patents and trade secrets, we have filed applications to register certain trademarks in the US and/or abroad, including INSMED, ARIKAYCE and BRINSUPRI. At present, we have received three registrations for the INSMED mark, one registration for the ARIKAYCE mark and one registration for the BRINSUPRI mark from the US Patent and Trademark Office (USPTO). We have also received notices of allowance or registrations in a number of countries abroad for the INSMED, ARIKAYCE and BRINSUPRI marks, among others. Our ability to obtain and maintain trademark registrations will in certain geographical locations depend on making use of the mark in commerce on or in connection with our products and approval of the trademarks for our products by regulatory authorities in each country.

License and Other Agreements

Multi-program Agreements

PPD Development, L.P. (a wholly-owned subsidiary of Thermo Fisher)

In April 2020, we entered into a master services agreement with PPD Development, L.P. (PPD) pursuant to which we retained PPD to perform clinical development services in connection with certain of our clinical research programs. The master services agreement has an initial term of five years. In March 2025, we amended the agreement to extend the term three years. Either party may terminate (i) any project addendum under the master services agreement for any reason and without cause upon 30 days' written notice, (ii) any project addendum in the event of the other party's breach of the master services agreement or such project addendum upon 30 days' written notice, provided that such breach is not cured within such 30-day period, (iii) the master services agreement or any project addendum immediately upon the occurrence of an insolvency event with respect to the other party or (iv) any project addendum upon 30 days' written notice if (a) the continuation of the services under such project addendum would post material ethical or safety risks to study participants, (b) any approval from a regulatory authority necessary to perform the applicable study is revoked, suspended or expires without renewal or (c) in the reasonable opinion of such party, continuation of the services provided under such project addendum would be in violation of applicable law. We have entered into project addenda with PPD to perform clinical development services over several years for, but not limited to, our PALM-ILD and PAH studies and other trials involving brensocatib and TPIP. The anticipated future cost of these project addenda is $295.7 million.

Brensocatib-related Agreements (including BRINSUPRI)

AstraZeneca

In October 2016, we entered into a license agreement with AstraZeneca (the AZ License Agreement), pursuant to which AstraZeneca granted us exclusive global rights for the purpose of developing and commercializing AZD7986 (renamed brensocatib). Following FDA approval, brensocatib was commercially designated as BRINSUPRI. In consideration of the licenses and other rights granted by AstraZeneca, we made an upfront payment of $30.0 million in late October 2016. In December 2020, we incurred a $12.5 million milestone payment obligation upon the first dosing in a Phase 3 clinical trial of brensocatib. In May 2024, upon our release of an official public statement that we intended to file an NDA, we incurred an additional $12.5 million milestone payment obligation. Upon regulatory approval by the FDA of an NDA, we paid AstraZeneca an additional $30.0 million. In November 2025, a $15.0 million milestone commitment became payable to AstraZeneca upon EC approval, and was paid in January 2026. Subsequent to this milestone, we are also obligated to make an additional $15.0 million contingent payment upon the achievement of a regulatory filing milestone. If we elect to develop brensocatib for a second indication, we will be obligated to make an additional series of contingent milestone payments totaling up to $42.5 million, the first of which occurs at the initiation of a Phase 3 trial in the additional indication. We are not obligated to make milestone payments for additional indications. In addition, we have agreed to pay AstraZeneca tiered royalties ranging from high single-digit to mid-teens on net sales of any approved product based on brensocatib and one additional payment of $35.0 million upon the first achievement of $1.0 billion in annual net sales. The AZ License Agreement provides AstraZeneca with the option to negotiate a future agreement with us for commercialization of brensocatib in chronic obstructive pulmonary disease or asthma. If we fail to comply with our obligations under our agreements with AstraZeneca (including, among other things, if we fail to use commercially reasonable efforts to develop and commercialize a product based on brensocatib, or we are subject to a bankruptcy or insolvency), AstraZeneca would have the right to terminate the license.

In March 2020, AstraZeneca exercised its first option pursuant to our October 2016 license agreement under which AstraZeneca can advance clinical development of brensocatib in the indications of chronic obstructive pulmonary disease (COPD) or asthma. Under the terms of the agreement, upon exercise of this option, AstraZeneca became solely responsible for all aspects of the development of brensocatib up to and including Phase 2b clinical trials in COPD or asthma. In March 2024, AstraZeneca exercised its second and final option under the agreement to further develop brensocatib beyond Phase 2b clinical trials and, if approved, commercialize brensocatib in the indications of COPD or asthma, upon reaching agreement after good faith negotiations resulting in terms, including financial terms, satisfactory to us and to AstraZeneca for such further development and commercialization. In June 2024, the negotiation period following such exercise of the final option expired. No agreement was reached between us and AstraZeneca to permit AstraZeneca to further develop and, if approved, commercialize brensocatib in the indications of COPD or asthma. As a result, we retain full worldwide development and commercialization rights for brensocatib in all indications other than COPD or asthma and AstraZeneca has no further development or commercialization rights for brensocatib in COPD, asthma or any other indication.

Patheon Inc. (a wholly-owned subsidiary of Thermo Fisher) and related agreements

In January 2024, we entered into certain agreements with Patheon Inc. related to the manufacture and supply of brensocatib by Patheon Inc. for our long-term commercial needs. Under these agreements, we are required to deliver to Patheon Inc. the active pharmaceutical ingredients needed to manufacture brensocatib. Our master commercial manufacturing services

agreement with Patheon Inc. will remain in effect for a fixed initial term, after which it will continue for successive renewal terms unless either we or Patheon Inc. have given written notice of termination. The agreements may also be terminated under certain other circumstances, including by either party due to a material uncured breach of the other party or the other party's insolvency. Patheon Inc.'s supply obligations are governed by individual product agreements entered into from time to time under the master commercial manufacturing services agreement. The product agreements specify, among other things, the term and pricing for Patheon Inc.'s supply obligations.

Esteve Química, S.A.

In September 2024, we entered into a commercial manufacturing and supply agreement with Esteve for the manufacture and supply of active pharmaceutical ingredient for brensocatib. The commercial manufacturing and supply agreement has an initial term of three years, after which it will continue for successive 12-month renewal terms unless either we or Esteve have given written notice of termination. The agreement may also be terminated under certain other circumstances, including by either party due to a material uncured breach of the other party or the other party's insolvency, the discontinue of specified dosages or changes in the regulatory landscape. Esteve's supply obligations are based on rolling forecasts of our anticipated demand for BRINSUPRI.

ARIKAYCE-related Agreements

PARI

We have a licensing agreement with PARI for use of the optimized Lamira Nebulizer System for delivery of ARIKAYCE in treating patients with NTM lung infections, CF and bronchiectasis. Under the licensing agreement, we have rights under several US and foreign issued patents and patent applications involving improvements to the optimized Lamira Nebulizer System, to exploit the system with ARIKAYCE for the treatment of such indications, but we cannot manufacture the nebulizers except as permitted under our Commercialization Agreement with PARI, which is described in further detail below. Lamira has been approved for use in the US (in combination with ARIKAYCE) and EU and is authorized for use in Japan. We also currently have rights to use the nebulizers in expanded access programs and clinical trials. Lamira must receive regulatory approval before we can market ARIKAYCE outside the US, EU and Japan, and it is labeled as investigational for use in our clinical trials outside of these regions.

We have certain obligations under this licensing agreement in relation to specified licensed indications. With respect to NTM, we met all obligations to achieve certain commercial, developmental and regulatory milestones by the required deadlines. With respect to bronchiectasis, we have satisfied our obligation to use commercially reasonable efforts to initiate a Phase 3 trial for bronchiectasis. With respect to CF, we are obligated to use commercially reasonable efforts to develop, obtain regulatory and reimbursement approval, market and sell ARIKAYCE in two or more major European countries, as well as to achieve certain milestones specified in the licensing agreement. Termination of the licensing agreement or loss of exclusive rights may occur if we fail to meet our obligations, including payment of royalties to PARI.

Under the licensing agreement, we paid PARI an upfront license fee and milestone payments. Upon FDA acceptance of our NDA and the subsequent FDA and EMA approvals of ARIKAYCE, we made additional milestone payments of €1.0 million, €1.5 million and €0.5 million, respectively, to PARI. In October 2017, we exercised an option to buy-down the royalties payable to PARI. PARI is entitled to receive royalty payments in the mid-single digits on annual global net sales of ARIKAYCE pursuant to the licensing agreement, subject to certain specified annual minimum royalties.

This licensing agreement will remain in effect on a country-by-country basis until the final royalty payments have been made with respect to the last country in which ARIKAYCE is sold, or until the agreement is otherwise terminated by either party. We have the right to terminate this licensing agreement upon written notice for PARI's uncured material breach, if PARI is the subject of specified bankruptcy or liquidation events, or if PARI fails to reach certain specified obligations. PARI has the right to terminate this licensing agreement upon written notice for our uncured material breach, if we are the subject of specified bankruptcy or liquidation events, if we assign or otherwise transfer the agreement to a third-party that does not agree to assume all of our rights and obligations set forth in the agreement, or if we fail to reach certain specified milestones.

In July 2014, we entered into a Commercialization Agreement with PARI for the manufacture and supply of the Lamira® Nebulizer Systems and related accessories (the Device), which is an e-Flow® nebulizer modified and optimized for use with ARIKAYCE. Under the Commercialization Agreement, PARI manufactures the Device except in the case of certain defined supply failures, when we will have the right to make the Device and have it made by third parties (but not certain third parties deemed under the Commercialization Agreement to compete with PARI). The Commercialization Agreement has an initial term of 15 years that began to run in October 2018 (the Initial Term). The term of the Commercialization Agreement may be extended by us for an additional five years by providing written notice to PARI at least one year prior to the expiration of the Initial Term.

Resilience

In February 2014, we entered into a contract manufacturing agreement with Therapure Biopharma Inc., which has been assumed by Resilience, for the manufacture of ARIKAYCE, on a non-exclusive basis, at a 200 kg scale. Pursuant to the agreement, we collaborated with Resilience to construct a production area for the manufacture of ARIKAYCE in Resilience's existing manufacturing facility in Mississauga, Ontario, Canada. The agreement had an initial term of five years, which began in October 2018, and renews automatically for successive periods of two years each, unless terminated by either party by providing the required two years' prior written notice to the other party. Under the agreement, we are obligated to pay a minimum of $6.0 million, subject to inflation, for commercial ARIKAYCE batches produced and certain manufacturing activities each calendar year. The agreement allows for termination by either party upon the occurrence of certain events, including (i) the material breach by the other party of any provision of the agreement or the quality agreement expected to be entered into between the parties, and (ii) the default or bankruptcy of the other party. In addition, we may terminate the agreement for any reason upon no fewer than 180 days' advance notice.

Patheon (a wholly-owned subsidiary of Thermo Fisher) and related agreements

In October 2017, we entered into certain agreements with Patheon related to the increase of our long-term production capacity for ARIKAYCE. The agreements provide for Patheon to manufacture and supply ARIKAYCE for our anticipated commercial needs. Under these agreements, we are required to deliver to Patheon the required raw materials, including active pharmaceutical ingredients, and certain fixed assets needed to manufacture ARIKAYCE. Patheon's supply obligations will commence once certain technology transfer and construction services are completed. Our manufacturing and supply agreement with Patheon will remain in effect for a fixed initial term, after which it will continue for successive renewal terms unless either we or Patheon have given written notice of termination. The technology transfer agreement will expire when the parties agree that the technology transfer services have been completed. The agreements may also be terminated under certain other circumstances, including by either party due to a material uncured breach of the other party or the other party's insolvency. These early termination clauses may reduce the amounts due to the relevant parties. The aggregate investment to increase our long-term production capacity, including under the Patheon agreements and related agreements or purchase orders with third parties for raw materials and fixed assets, is estimated to be approximately $127.7 million.

Cystic Fibrosis Foundation Therapeutics, Inc.

In 2004 and 2009, we entered into research funding agreements with Cystic Fibrosis Foundation Therapeutics, Inc. (CFFT) whereby we received $1.7 million and $2.2 million in research funding for the development of ARIKAYCE. As a result of the US approval of ARIKAYCE and in accordance with the CFFT agreements, as amended, we owed milestone payments to CFFT of $13.4 million in the aggregate, which have been paid as of December 31, 2025. Furthermore, if certain global sales milestones were met within five years of the commercialization of ARIKAYCE, we would have owed up to an additional $3.9 million. We met and paid $1.7 million of these additional global sales milestone payments.

INS1148-related Agreement

Opsidio

In December 2025, we entered into an asset purchase agreement with Opsidio, pursuant to which we acquired all rights, including all development and commercialization rights, to INS1148. At the closing of the transaction, we owed an upfront payment to Opsidio of $40.0 million, subject to a customary holdback. The Opsidio shareholders may also become entitled to receive contingent payments up to an aggregate of $382 million in cash upon the achievement of certain development, regulatory and sales milestones, as well as earnout payments based upon a low to mid single-digit percentage of net sales of certain products, in each case subject to the terms and conditions of the agreement.

University of Michigan

In connection with our purchase of INS1148, we became exclusive licensee to certain patents from the Regents of the University of Michigan (Michigan), including US Patent Nos. 9,353,178, 9,790,272 and 10,501,535. Pursuant to the license, we have exclusive rights under the licensed patents to develop and commercialize INS1148. Obligations under the Michigan license extend until the last to expire patent, which is January 10, 2032. If INS1148 is marketed prior to the Michigan agreement expiring, we will owe a low single-digit running royalty on net sales of INS1148.

INS1202-related Agreement

Research Institute at Nationwide Children's Hospital

In December 2023, we entered into a license agreement with NCH, pursuant to which we were granted an exclusive license under certain patents covering INS1202, to develop and commercialize INS1202 on a worldwide basis. In consideration for these rights, we made an upfront payment to NCH of $0.2 million and owe contingent milestones of up to $32.9 million. We also agreed to pay NCH a flat low single-digit royalty on net sales of INS1202 during the royalty term.

Competition

The biotechnology and pharmaceutical industries are highly competitive. We face potential competitors from many different areas including commercial pharmaceutical, biotechnology and device companies, academic institutions and scientists, other smaller or earlier stage companies and non-profit organizations developing anti-infective drugs and drugs for respiratory, inflammatory, immunology, oncology, and rare diseases. Many of these companies have greater human and financial resources and may have product candidates in more advanced stages of development and may reach the market before our product candidates. Competitors may develop products that are more effective, safer or less expensive or that have better tolerability or convenience. We also may face generic competitors where third-party payors will encourage use of the generic products. Although we believe that our formulation delivery technology, respiratory and anti-infective expertise, experience and knowledge in our specific areas of focus provide us with competitive advantages, these potential competitors could reduce our commercial opportunity. Additionally, there currently are, and in the future there may be, already-approved products for certain of the indications for which we are developing, or in the future may choose to develop, product candidates. For instance, PAH is a competitive indication with established marketed products, including other formulations of treprostinil.

In the lung disease market, our major competitors include pharmaceutical and biotechnology companies that have approved therapies or therapies in development for the treatment of chronic lung infections. There are other companies that are currently conducting clinical trials for the treatment of lung disease. While there are currently no approved treatments for bronchiectasis, other than BRINSUPRI, clinical studies in this disease state and specific endotypes (for instance, bronchiectasis with eosinophilic inflammation) have been initiated. Certain entities have expressed interest in studying other DPP1 inhibitors for the treatment of bronchiectasis and we are aware of several other entities currently conducting clinical trials for the treatment of bronchiectasis with a DPP1 inhibitor. Products developed by certain of our competitors may potentially be used in combination with brensocatib, if approved.

With regard to ARIKAYCE, we are not aware of any approved inhaled therapies specifically indicated for refractory NTM lung infections in North America, Europe or Japan, but there is a recommended treatment regimen that is utilized. The international treatment guidelines, which are issued by the ATS, ERS, ESCMID and IDSA, strongly recommend the use of ARIKAYCE for the treatment of patients with refractory NTM lung disease caused by MAC as a part of a combination antibacterial drug regiment for adult patients with limited or no alternative treatment options who have failed to convert to a negative sputum culture after at least six months of treatment. With regard to BRINSUPRI, we are not aware of any approved therapies for treating NCFB in the US, Europe or Japan, other than BRINSUPRI in the US and the EU.

The fields of gene therapy and protein engineering are rapidly advancing and highly competitive. While we believe our internal expertise provides a competitive advantage, we expect competition to intensify, including from other pharmaceutical companies, government agencies and public and private research institutions. If any of our gene therapy or protein engineering programs are approved for their indications, we expect to compete with other gene therapy products, protein engineering technologies and any other existing or new therapies or technologies that may become available in the future.

Government Regulation

Orphan Drug Designation

United States

Under the Orphan Drug Act (ODA), the FDA may grant orphan drug designation to drugs intended to treat a rare disease or condition, generally defined as a disease or condition that affects fewer than 200,000 people in the US or for which there is no reasonable expectation that the cost of developing and making available in the US a drug for such disease or condition will be recovered from US sales of such drug, if it meets certain criteria specified by the ODA and FDA. After the FDA grants orphan drug designation, FDA lists the drug and the designated rare disease in a publicly accessible database. The FDA designated liposomal amikacin as an orphan drug for treatment of NTM infections, bronchiectasis in patients with *Pseudomonas* aeruginosa or other susceptible microbial pathogens, and bronchopulmonary *Pseudomonas* aeruginosa infections in CF patients. However, the orphan drug designations for bronchiectasis in patients with *Pseudomonas* aeruginosa or other susceptible microbial pathogens and bronchopulmonary Pseudomonas aeruginosa infections in CF patients were withdrawn at our request in August 2023. The FDA granted INS1201 orphan drug designation in August 2025 for the treatment of DMD. In addition, in January 2026, FDA granted treprostinil palmitil orphan drug designation for the treatment of PAH, based on a plausible hypothesis that it may be clinically superior to treprostinil already approved for the treatment of the same indication.

Orphan drug designation qualifies the sponsor for various development incentives of the ODA, including tax credits for qualified clinical testing, a waiver of the PDUFA application fee (unless the application seeks approval for an indication not included in the orphan drug designation), and an exemption from pediatric study requirements under the Pediatric Equity Research Act (PREA) for the orphan indication. Orphan drug designation also may afford the company a period of exclusivity for the orphan indication upon approval of the drug. Specifically, an NDA or biologics license application (BLA) for a drug designated for a rare disease that receives FDA approval for an indication covered by the orphan designation is entitled to a seven-year exclusive marketing period, often referred to as orphan drug exclusivity, in the US for that drug in that indication. A product that has several separate orphan designations may have several separate exclusivities for separate orphan indications.

During the orphan drug exclusivity period, the FDA may not approve another sponsor's drug that is the same drug for the same approved indication or use, except in limited circumstances, such as a showing of clinical superiority to the product that has orphan drug exclusivity. Orphan drug exclusivity does not prevent the FDA from approving a different drug for the same disease or condition or the same drug for a different disease or condition, and it does not alter the timing or scope of the regulatory review and approval process; the sponsor must still demonstrate the safety and effectiveness of the drug.

In a decision issued in September 2021 (*Catalyst Pharmaceuticals, Inc. v. Becerra*), the US Court of Appeals for the Eleventh Circuit held that the FDA had erred by limiting the scope of orphan drug exclusivity for FIRDAPSE® (amifampridine) to the product's approved indication, an action that the FDA taken in accordance with its regulations interpreting the ODA. The court held that under the ODA, FIRDAPSE's orphan drug exclusivity instead protected the broader rare disease or condition that received orphan drug designation. Notwithstanding the Eleventh Circuit's decision in *Catalyst*, the FDA announced in January 2023 that it would continue to apply the FDA's regulations tying the scope of orphan drug exclusivity to a product's approved uses or indications. Since Catalyst, FDA's interpretation has been subject to additional litigation, which is currently pending appeal. The Mikaela Naylon Give Kids a Chance Act, which amends the statute to reflect FDA's longstanding interpretation, was signed into law on February 3, 2026.

European Union

The EC grants orphan drug designation to promote the development of drugs or biologics (1) for life-threatening or chronically debilitating conditions affecting not more than five in 10,000 people in the EU, or (2) for life threatening, seriously debilitating or serious and chronic condition in the EU where, without incentives, sales of the drug in the European Economic Area (the EU plus Iceland, Lichtenstein and Norway) (EEA) are unlikely to be sufficient to justify its development. Orphan drug designation is available either if no other satisfactory method of diagnosing, preventing or treating the condition is approved in the EEA or if such a method does exist but the proposed orphan drug will be of significant benefit to patients.

If a drug with an orphan drug designation subsequently receives an orphan drug marketing authorization from the EC for a therapeutic indication which is covered by such designation, the drug is entitled to orphan exclusivity. The EC has granted an orphan drug marketing authorization for ARIKAYCE for the treatment of NTM lung infections caused by MAC in adults with limited treatment options who do not have CF. Orphan exclusivity means that the EMA or a national medicines agency may not accept another application for authorization, or grant an authorization, for a same or similar drug for the same therapeutic indication. Competitors may receive such a marketing authorization despite orphan exclusivity, provided that they demonstrate that the existing orphan product is not supplied in sufficient quantities or that the 'second' drug or biologic is clinically superior to the existing orphan product. The 'second' drug may but need not have an orphan designation as well. The period of orphan exclusivity is 10 years, which can be extended by two years where an agreed pediatric investigation plan has been implemented. The exclusivity period may also be reduced to six years if the designation criteria are no longer met, including where it is shown that the product is sufficiently profitable not to justify maintenance of market exclusivity. Each orphan designated marketing authorization carries the potential for one market exclusivity for all the therapeutic indications that are covered by the designation. Market exclusivity is an orphan incentive awarded by the EC to a specific clinical indication with an orphan designation. Each indication with an orphan designation confers ten years of market exclusivity for the particular indication. A medicine that has multiple orphan designations for different conditions may benefit from separate market exclusivity periods pertaining to its different orphan designations.

Orphan drug designation also provides opportunities for free protocol assistance and fee reductions for access to the centralized regulatory procedure or fee exemptions for companies with a small and medium enterprises status. In addition, EU Member States may provide national benefits to orphan drugs, such as early access to the reimbursement procedure or exemption from any turnover tax imposed on pharmaceutical companies.

The orphan designation may be applied for at any time during the development of the drug but before the application for marketing authorization. At the time of marketing authorization, the criteria for orphan designation are examined again, and the EC decides on the maintenance of the orphan designation in granting an orphan drug marketing authorization. The non-maintenance of the orphan designation means that the drug loses its orphan status and thus no longer benefits from orphan exclusivity, fee reductions or exemptions, and national benefits.

Japan

The MHLW may, after hearing the opinion of the Pharmaceutical Affairs and Food Sanitation Council, grant orphan drug designation to a drug intended to treat a rare disease or condition if the drug meets the following conditions: (i) the number of target patients is less than 50,000 in Japan; (ii) the necessity of orphan drug designation is high from a medical point of view; and (iii) the plan for development of the drug is appropriate. Even if a drug is granted orphan drug designation, however, it does not always receive the manufacturing and marketing approval that is necessary for the drug to be sold or marketed in Japan. ARIKAYCE did not qualify for orphan drug designation in Japan due to the estimated number of NTM patients in Japan exceeding 50,000.

Rare Pediatric Disease Priority Review Voucher (PRV) Program

The FDA maintains a Rare Pediatric Disease PRV Program under Section 529 of the Federal Food, Drug, and Cosmetic Act (FDCA) to encourage the development of new drugs and biologics for the prevention or treatment of rare pediatric diseases. Under the program, a sponsor that obtains FDA approval of a marketing application for a product intended to treat such a disease may qualify for a PRV, which can be redeemed to obtain priority review of a subsequent marketing application for a different product or may be sold or transferred to another sponsor. A sponsor must meet certain procedural and substantive criteria, including obtaining rare pediatric disease designation from the FDA and satisfying eligibility requirements for the original product application in order to receive a voucher upon approval. The FDA granted INS1201 Rare Pediatric Disease Designation in May 2024. The Rare Pediatric Disease PRV program has historically been subject to statutory sunset provisions. The Mikaela Naylon Give Kids a Chance Act, which reauthorizes the program through 2029, was passed into law on February 3, 2026.

Drug Approval

United States

In the US, pharmaceutical products are subject to extensive regulation by the FDA and other government bodies. The US Federal Food, Drug, and Cosmetic Act (FDCA), the Public Health Services Act (PHSA) (in the case of biological products), and other federal and state statutes and regulations govern, among other things, the research, development, testing, manufacture, storage, recordkeeping, approval, labeling, promotion and marketing, distribution, post-approval monitoring and reporting, sampling and import and export of pharmaceutical products. Failure to comply with applicable US requirements at any time during product development, approval, or after approval may subject a company to a variety of administrative or judicial sanctions, such as imposition of clinical holds, FDA refusal to file or approve NDAs or BLAs, warning letters, product seizures, total or partial suspension of production or distribution, injunctions, fines, refusals of government contracts, restitution, disgorgement, civil penalties, and criminal prosecution. The description below summarizes the current approval process in the US for our product and product candidates.

Pre-clinical Studies

Pre-clinical studies may include laboratory evaluation of product chemistry, formulation and toxicity, and pharmacology, as well as animal trials to assess the characteristics and potential safety and efficacy of the product. The conduct of the pre-clinical tests must comply with federal regulations and requirements including the FDA's good laboratory practice (GLP) regulations and the US Department of Agriculture's regulations implementing the Animal Welfare Act. An IND sponsor must submit the results of the pre-clinical tests, together with manufacturing information, analytical data, any available clinical data or literature, and a proposed clinical trial protocol, among other things, to the FDA as part of an IND. Certain non-clinical tests, such as animal tests of reproductive toxicity and carcinogenicity, may continue even after the IND is submitted. An IND automatically becomes effective 30 days after receipt by the FDA, unless before that time the FDA raises concerns or questions related to one or more proposed clinical trials and places the clinical trial on a clinical hold. In such a case, the IND sponsor and the FDA must resolve any outstanding concerns before the clinical trial can begin. As a result, submission of an IND might not result in the FDA allowing clinical trials to commence.

Clinical Trials

Clinical trials involve the administration of the investigational new drug to human subjects (healthy volunteers or patients) under the supervision of a qualified investigator. Clinical trials must be conducted (i) in compliance with all applicable federal regulations and guidance, including those pertaining to good clinical practice (GCP) standards that are meant to protect the rights, safety, and welfare of human subjects and to define the roles of clinical trial sponsors, investigators, and monitors as well as (ii) under protocols detailing, among other things, the objectives of the trial, the parameters to be used in monitoring safety, and the effectiveness criteria to be evaluated. Each protocol involving testing of a new drug in the US (whether in patients or healthy volunteers) must be included as a submission to the IND, and the FDA must be notified of subsequent protocol amendments, including new protocols. In addition, the protocol must be reviewed and approved by an institutional review board (IRB), and all study subjects must provide informed consent. Typically, before any clinical trial, each institution participating in the trial will require review of the protocol before the trial commences at that institution. Progress reports detailing the results of the clinical trials must be submitted at least annually to the FDA and there are additional, more frequent reporting requirements for certain AEs.

A study sponsor might choose to discontinue a clinical trial or a clinical development program for a variety of reasons. The FDA may impose a temporary or permanent clinical hold, or other sanctions, if it believes that the clinical trial either is not being conducted in accordance with the FDA requirements or presents an unacceptable risk to the clinical trial subjects. An IRB also may require the clinical trial at the site to be halted, either temporarily or permanently, for failure to comply with the IRB's requirements, or may impose other conditions.

Clinical trials to support NDAs or BLAs for marketing approval are typically conducted in three sequential pre-approval phases, but the phases may overlap or be combined. In Phase 1, short term testing is conducted in a small group of

subjects (typically 20-100), who may be patients with the target disease or condition or healthy volunteers, to evaluate its safety, determine a safe dosage range, and identify side effects. In Phase 2, the drug is given to a larger group of subjects (typically up to several hundred) with the target condition to further evaluate its safety and gather preliminary evidence of efficacy. In Phase 3, the drug is given to a large group of subjects with the target disease or condition (typically several hundred to several thousand), often at multiple geographical sites, to confirm its effectiveness, monitor side effects, and collect data to support drug approval. Only a small percentage of investigational drugs complete all three phases of development and obtain marketing approval.

If a clinical trial includes sites and study subjects outside the US, that portion of the trial may be included under an IND or not included under an IND. If the site and subjects are not included under an IND, then any use of the data in the US is subject to special FDA consideration of whether the foreign data has been generated in accordance with appropriate ethical and scientific standards and is applicable to a US patient population. Local legal and regulatory requirements will also apply to the ex-US sites and study subjects.

NDAs and BLAs

After completion of the required clinical testing, an NDA or BLA can be prepared and submitted to the FDA. FDA approval of the NDA or BLA is required before marketing of the product may begin in the US. The NDA or BLA is a large submission that must include, among other things, the results of all pre-clinical, clinical and other testing and a compilation of data relating to the product's pharmacology, chemistry, manufacture, and controls. The application also includes representative samples, copies of the proposed product labeling, patent information, and a financial certification or disclosure statement. The cost of preparing and submitting an NDA or BLA is substantial. Additionally, under federal law (as amended by the most recent reauthorization of the Prescription Drug User Fee Act (PDUFA VII) in the FDA User Fee Reauthorization Act of 2022), most NDAs and BLAs are subject to a substantial application fee and, upon approval, the applicant will be assessed an annual prescription drug program fee, both of which are adjusted annually. NDAs and BLAs for orphan drugs are not subject to an application fee, unless the application includes an indication other than an orphan-designated indication. The FDA also has the authority to grant waivers of certain user fees, pursuant to the FDCA.

The FDA has 60 days from its receipt of an NDA or BLA to determine to accept the application for filing or issue a refuse to file determination based on the FDA's threshold determination of whether the application is sufficiently complete to permit substantive review. Once the submission is accepted for filing, the FDA begins a substantive review. The FDA may refer applications for novel drug or biological products or drug or biological products that present difficult questions of safety or efficacy to an advisory committee, typically a panel that includes outside clinicians and other experts, for review, evaluation and a recommendation as to whether the application should be approved. The FDA is not bound by the recommendation of an advisory committee, but it generally has followed such recommendations.

Before approving an NDA or BLA, the FDA will typically inspect one or more clinical sites to assure compliance with GCP. Additionally, the FDA will typically inspect the facility or the facilities at which the drug or biological product is manufactured. The FDA will not approve the product unless, among other requirements, compliance with current good manufacturing practice (cGMP) is satisfactory and the NDA or BLA contains data that provide substantial evidence of effectiveness for the proposed indication, generally consisting of adequate and well-controlled clinical investigations, and that the drug is safe for use under the conditions of use in the proposed labeling. The FDA also reviews the proposed labeling submitted with the NDA or BLA and typically requires changes in the labeling text.

After the FDA evaluates the NDA or BLA and the manufacturing and testing facilities, it issues an action letter; that is, a complete response letter, an approval letter, or a tentative approval letter (in the case of, for example, certain types of NDAs referred to as 505(b)(2) NDAs that rely in whole or in part on other company’s approvals). Complete response letters generally outline the deficiencies in the submission and delineate the additional testing or information needed in order for the FDA to reconsider the application. If and when those deficiencies have been addressed to the FDA's satisfaction in a resubmission of the NDA or BLA, the FDA will issue an approval letter. An approval letter, which may specify post approval requirements, authorizes commercial marketing of the drug or biological product for the approved indication or indications and the other conditions of use set out in the approved prescribing information. Once granted, product approvals may be withdrawn if compliance with regulatory standards is not maintained or problems are identified following initial marketing. A tentative approval letter is notification that an NDA otherwise meets the requirements for approval but cannot be approved because of exclusivity or patent reasons. A drug product that is granted tentative approval is not an approved drug and will not be approved until FDA issues an approval letter after any necessary additional review of the NDA. The FDA sets a goal date by which the FDA expects to issue an action letter, unless the review period is adjusted by mutual agreement between the FDA and the applicant or as a result of the applicant submitting a major amendment. The FDA's current performance goals call for the FDA to complete review of 90 percent of standard new molecular entity (NME) NDAs and original BLAs within 10 months of the end of the 60-day filing review period and NME NDAs and original BLAs within six months of the end of the 60-day filing review period. The FDA's current performance goals call for the FDA to complete review of 90 percent of standard non-NME) NDAs within 10 months of receipt and non-NME NDAs within 6 months of receipt.

As a condition of NDA or BLA approval, the FDA may require substantial post-approval testing, known as Phase 4 studies, to be conducted in order to gather additional information on the drug's effect in various populations and any side effects. Beyond routine post marketing safety surveillance, the FDA may require specific additional surveillance to monitor the drug's safety or efficacy and may impose other conditions, including labeling restrictions that can materially affect the potential market and profitability of the drug. As a condition of approval, or after approval, the FDA also may require submission, approval, and implementation of a risk evaluation and mitigation strategy (REMS), including a REMS with elements to assure safe use (ETASU) to mitigate any identified or suspected serious risks. The REMS may include medication guides, physician communication plans, assessment plans, and ETASU, such as restricted distribution methods, patient registries, or other risk minimization tools. Further post-approval requirements are discussed below.

Expedited Review and Approval of Eligible Drugs

Under the FDA's accelerated approval program, the FDA may approve certain drugs for serious or life-threatening conditions on the basis of a surrogate or intermediate endpoint that is reasonably likely to predict clinical benefit, which can substantially reduce time to approval. A surrogate endpoint used for accelerated approval is a marker—a laboratory measurement, radiographic image, physical sign or other measure that is thought to predict clinical benefit, but is not itself a measure of clinical benefit. An intermediate clinical endpoint is a clinical endpoint that can be measured earlier than irreversible morbidity and mortality (IMM) that is reasonably likely to predict an effect on IMM or other clinical benefit. The FDA bases its decision on whether to accept the proposed surrogate or intermediate clinical endpoint on the scientific support for that endpoint.

As a condition of accelerated approval, the FDA typically requires certain post-marketing clinical studies to verify and describe clinical benefit of the product, and may impose restrictions on distribution to assure safe use. Under the Consolidated Appropriations Act, 2023, Congress gave FDA the authority to require, as appropriate, that a confirmatory trial be underway prior to accelerated approval or within a specified time period after the date of accelerated approval. In addition, promotional materials for an accelerated approval drug to be used in the first 120 days post-approval must be submitted to the FDA prior to approval, and materials to be used after that 120-day period must be submitted 30 days prior to first use. If the required post-marketing studies fail to verify the clinical benefit of the drug, or if the applicant fails to perform the required post-marketing studies with due diligence, the FDA may withdraw approval of the drug under streamlined procedures in accordance with the FDCA, as amended by the Consolidated Appropriations Act, 2023. The agency may also withdraw approval of a drug if, among other things, the promotional materials for the product are false or misleading, or other evidence demonstrates that the drug product is not shown to be safe or effective under its conditions of use.

The FDA also has various programs—fast track designation, priority review and breakthrough designation—that are intended to expedite or streamline the process for the development and FDA review of drugs that meet certain qualifications. The purpose of these programs is to provide important new drugs to patients earlier than under standard FDA review procedures. The programs each have different eligibility criteria and provide different benefits, and can be applied either alone or in combination depending on an applicant's circumstances.

Fast track designation applies to a drug that is intended to treat a serious condition and for which nonclinical or clinical data demonstrate the potential to address unmet medical need. It should be requested at the time of IND submission or ideally no later than the pre-NDA or pre-BLA meeting. The FDA must respond to requests for fast track designation within 60 days of receipt of the request. If granted, the applicant is eligible for actions to expedite development and review, such as frequent interaction with the review team, as well as rolling review, meaning that the applicant may submit sections of the application as they are available. The timing of the FDA's review of these sections depends on a number of factors, and the review clock does not start running until the agency has received a complete NDA or BLA submission. The FDA may withdraw fast track designation if the agency determines that the designation is no longer supported by data emerging in the drug development process.

Priority review applies to an application (both original and efficacy supplement) for a drug that treats a serious condition and that, if approved, would provide a significant improvement in safety or effectiveness. It also applies to any supplement that proposes a labeling change pursuant to a report on a pediatric study conducted pursuant to section 505A of the FDCA. A request for priority review is submitted at the time of submission of an NDA or BLA, or supplemental NDA or BLA. The FDA must respond within 60 days of receipt of the request. If granted, the review time is shortened from the standard 10 months to 6 months, beginning either after the 60-day filing review period (in the case of NME NDA and original BLA submissions) or the date of receipt (in the case of non-NME original NDA submissions).

Breakthrough therapy designation applies to a drug that is intended to treat a serious condition and for which preliminary clinical evidence indicates that the drug may demonstrate substantial improvement on a clinically significant endpoint(s) over available therapies. It can be requested with the IND submission and ideally no later than the end-of-Phase 2 meeting. The FDA must respond within 60 days of receipt of the request. If granted, the applicant receives intensive guidance on efficient drug development, intensive involvement of senior managers and experienced review and regulatory health project

management staff in a proactive, collaborative, cross-disciplinary review, rolling review, and other actions to expedite review. Designation may be rescinded if the product no longer meets the criteria for breakthrough therapy designation.

Drugs that are designated as QIDPs may be eligible for priority review and will receive fast track designation upon the request of the sponsor, and also may be eligible for market exclusivity. A product is eligible for QIDP designation if it is an antibacterial or anti-fungal drug for human use that is intended to treat serious or life-threatening infections, including: those caused by an anti-bacterial or anti-fungal resistant pathogen, including novel or emerging infectious pathogens; or caused by qualifying pathogens listed by the FDA. A drug sponsor may request that the FDA designate its product as a QIDP at any time prior to NDA submission.

Additionally, the FDA may approve eligible drugs under the LPAD. A product is eligible if it is intended to treat a serious or life-threatening infection in a limited population of patients with unmet needs, the drug otherwise meets the standards of approval, and the FDA receives a written request from the sponsor to approve the drug under this pathway. An antibacterial or anti-fungal drug approved through this pathway may follow a streamlined clinical development program involving smaller, shorter, or fewer clinical trials. Approval is based on a benefit-risk assessment in the intended limited population, taking into account the severity, rarity, or prevalence of the infection the drug is intended to treat and the availability or lack of alternative treatment for the patient population. Such drugs might not have favorable benefit-risk profiles in a broader population. Drugs approved under LPAD are subject to additional regulatory requirements, including labeling and advertising statements regarding the limited population and submission of promotional materials to the FDA at least 30 days prior to dissemination. The FDA may remove these additional requirements if the agency approves the drug for a broader population.

The FDA’s Regenerative Medicine Advanced Therapy (RMAT) designation program, established under the 21st Century Cures Act, is intended to facilitate the development and expedite the review of certain regenerative medicine therapies, including cell therapies, gene therapies, therapeutic tissue engineering products, and combination products, that are intended to treat, modify, reverse, or cure a serious or life-threatening disease or condition and for which preliminary clinical evidence indicates the potential to address unmet medical needs. A product granted RMAT designation may be eligible for increased interactions with the FDA, including early discussions on clinical development, surrogate or intermediate endpoints, and potential accelerated approval pathways. However, RMAT designation does not change the standards for FDA approval, does not guarantee expedited review or approval, and the FDA may withdraw such designation if the product no longer meets the qualifying criteria.

Patent Term Extension and Non-Patent Exclusivities

In the US, after NDA or BLA approval of a drug containing an active ingredient that has not been previously approved, owners of relevant patents covering the drug or methods of manufacturing or using the drug may obtain up to a five-year patent term extension on a single patent. The allowable patent term extension is generally calculated as half of the drug's testing phase (the time between the date the IND becomes effective and the NDA or BLA submission date) and all of the review phase (the time between the NDA or BLA submission date and the approval date) up to a maximum of five years, to the extent such testing phase and approval phase occur after the issue date of the patent. The total post-NDA or BLA approval patent term including the extension may not exceed 14 years. The extension also can be shortened if the FDA determines that the NDA/BLA applicant did not pursue approval with due diligence. For patents that might expire while a patent term extension application is pending, the patent owner may request an interim patent term extension. The Director of the USPTO shall extend, until a final determination is made, the term of the patent for periods of up to one year if the Director determines that the patent is eligible for extension. An interim patent term extension may be renewed up to four times until a final determination is made, but only up to the amount of time for which the patent might be eligible for extension. Interim patent extensions may also be available for a patent that will expire before a drug is expected to be approved, but the NDA or BLA for the drug must have been submitted.

A variety of non-patent exclusivity periods are available under the FDCA that can delay the submission or approval of certain applications for competing products.

A five-year period of non-patent exclusivity within the US is granted to a new chemical entity (NCE). An NCE is a drug that contains no active moiety that has been approved by the FDA in any other application submitted under section 505(b) of the FDCA. During the exclusivity period for an NCE, the FDA may not accept for review an abbreviated NDA (ANDA) or a 505(b)(2) NDA submitted by another company that contains the same active moiety. However, an ANDA or 505(b)(2) NDA may be submitted after four years if it contains a certification of patent invalidity or non-infringement with respect to a patent listed with the FDA for the NCE drug.

A three-year period of non-patent exclusivity is granted for a drug product that contains an active moiety that has been previously approved, when the application contains reports of new clinical investigations (other than bioavailability studies) conducted or sponsored by the applicant that were essential to approval of the application, for example, for new indications, dosages, strengths or dosage forms of an existing drug. This three-year exclusivity covers only the conditions of approval associated with the new clinical investigations that are considered innovative, which means that the FDA may approve ANDAs and 505(b)(2) NDAs for other non-protected uses. Where this form of exclusivity applies, it prevents FDA approval of an

ANDA or 505(b)(2) NDA containing the same active moiety or combination of active moieties for the same conditions of approval for the three-year period; however, the FDA may accept and review ANDAs or 505(b)(2) NDAs during the three-year period.

These exclusivities also do not preclude FDA from accepting or approving a 505(b)(1) NDA.

Products with QIDP designation may receive a five-year extension of other non-patent exclusivities for which the drug is also eligible, subject to certain limitations. Depending upon the scope of the non-patent exclusivity that is extended, the five-year extension might not prevent the FDA from approving a subsequent application for a change to the QIDP-designated drug that results in, for example, a new indication, route of administration, dosing, schedule, dosage form, delivery system, delivery device, or strength. A drug that has been designated as both an orphan drug and a QIDP for the same indication, like ARIKAYCE, might be eligible for a combined 12 years of exclusivity for that indication.

Under the PHSA, the FDA recognizes reference product exclusivity starting from the first licensure of a biological product. Reference product exclusivity affects the timing of submission and approval of a BLA for a biosimilar product. Under section 351(k) of the PHSA, a BLA for a biosimilar product may be approved based upon a showing that the proposed product is highly similar to a previously licensed product, known as the reference product, notwithstanding minor differences in clinically inactive components; and there are no clinically meaningful differences between the proposed biosimilar product and the reference product in terms of safety, purity, and potency. Reference product exclusivity prevents the FDA from accepting a BLA submitted under section 351(k) of the PHSA for a proposed biosimilar product for 4 years after the date of first licensure of the reference product, and prevents the FDA from approving such BLA for a proposed biosimilar product for 12 years after such date of first licensure. An additional period of reference product exclusivity is not available upon approval of a supplemental BLA. Moreover, the PHSA limits the availability of reference product exclusivity for a subsequent BLA filed by the same sponsor or manufacturer of a biological product (or a licensor, predecessor in interest, or other related entity).

Certain periods of regulatory exclusivity are also available based on pediatric testing requested by FDA, as discussed below.

Medical Device Regulation

Medical devices, such as Lamira, may be marketed as stand-alone devices, or in some cases, as constituent parts of a drug/device combination product. In either case, the product will need to satisfy and comply with FDA requirements. Unless an exemption applies, each medical device commercially distributed in the US requires either FDA clearance of a 510(k) premarket notification, approval of a premarket approval application (PMA), or issuance of a de novo classification order. Medical devices are classified into one of three classes -- Class I, Class II or Class III -- depending on the degree of risk and the level of control necessary to assure the safety and effectiveness of each medical device. Medical devices deemed to pose lower risks are generally placed in either Class I or II.

While most Class I devices are exempt from the 510(k) premarket notification requirement, manufacturers of most Class II devices are required to submit to the FDA a pre-market notification. The FDA's permission to commercially distribute a device subject to a 510(k) premarket notification is generally known as 510(k) clearance. Devices deemed by the FDA to pose the greatest risk, such as life-sustaining, life-supporting, or many implantable devices, or devices that have been found not substantially equivalent to a legally marketed Class I or Class II predicate device, are placed in Class III, requiring approval of a PMA. De novo classification is a risk-based classification process to classify novel medical devices into Class I or Class II and authorize the device for commercial distribution.

Medical devices are also subject to certain postmarket requirements. Those requirements include, for example, establishment registration and device listing; compliance with the requirements of the Quality Management System Regulation (QMSR); medical device reporting regulations; correction and removal reporting regulations; compliance with requirements for Unique Device Identification; and, in certain cases, post-market surveillance activities and obligations. Device manufacturers must also comply with FDA requirements regarding promotion, which require that promotion is truthful, not misleading, and that all claims are substantiated, and prohibit the promotion of products for unapproved or "off-label" uses.

Medical device manufacturers must demonstrate and maintain compliance with the FDA's QSR. The QSR is a complex regulatory scheme that covers the methods and documentation of the design, testing, control, manufacturing, labeling, quality assurance, packaging, storage and shipping of medical devices. The FDA enforces the QSR through periodic inspections and unannounced "for cause" inspections. In January 2024, the FDA issued a final rule amending the QSR to align more closely with the international consensus standard for Quality Management Systems for medical devices used by many other regulatory authorities around the world, ISO 13485:2016. The revised regulation is referred to as the QMSR and became effective on February 2, 2026. The FDA made conforming edits to the combination product regulation to clarify the device Quality Management System (QMS) requirements for combination products.

The FDCA permits medical devices intended for investigational use to be shipped to clinical sites if such devices comply with prescribed procedures and conditions. All clinical investigations of devices to determine safety and effectiveness

must be conducted in accordance with the FDA's investigational device exemption, or IDE, regulations that govern investigational device labeling, prohibit promotion of the investigational device, and specify an array of study review and approval, informed consent, recordkeeping, reporting and monitoring responsibilities of study sponsors and study investigators.

Failure to comply with applicable regulations could result in enforcement actions such as: warning letters; fines; injunctions; civil penalties; inability to distribute products; recalls or seizures of products; delays in the introduction of products into the market; total or partial suspension of production; FDA refusal to grant, or delay in obtaining, marketing authorizations; and in the most serious cases, criminal penalties.

Combination Products

A combination product is a product comprising two or more regulated components (e.g., a drug and device) that are combined into a single product, co-packaged, or sold separately but intended only for use with each other, as evidenced by the labeling for the products. Drugs that are administered using a nebulizer or another device (and either co-packaged with the nebulizer or cross-labeled for use with a specific nebulizer), such as ARIKAYCE or TPIP, are examples of drug/device combination products.

The FDA is divided into various Centers, which each have authority over a specific type of product. NDAs are reviewed by personnel within the Center for Drug Evaluation and Research, while device PMAs, premarket notifications, and de novo classification requests are reviewed by the Center for Devices and Radiological Health. Combination products, such as drug/device combinations, are typically reviewed through a marketing submission that corresponds to the constituent part which provides the product's primary mode of action (PMOA), i.e., is the single mode of action that makes the greatest contribution to the overall therapeutic effect of the combination product. If the PMOA is unclear or in dispute, a sponsor may file a Request for Designation with the FDA's Office of Combination Products (OCP), which will render a determination and assign a lead Center based on the product's PMOA. If it is not possible to determine which one mode of action will provide a greater contribution than any other mode of action to the overall therapeutic effects of the combination product, the FDA makes a determination as to which Center to assign the product based on consistency with other combination products raising similar types of safety and effectiveness questions. When there are no other combination products that present similar questions of safety and effectiveness with regard to the combination product as a whole, the agency will assign the combination product to the Center with the most expertise in evaluating the most significant safety and effectiveness questions raised by the combination product. For combination products comprised of a drug and delivery device, the PMOA is typically that of the drug and the Center for Drug Evaluation and Research is assigned primary jurisdiction.

When evaluating an application or other marketing submission for a combination product, a lead Center may consult other Centers that will review relevant sections of the application. Depending on the type of combination product, approval or clearance could be obtained through submission of a single marketing application or through separate applications for the individual constituent parts (e.g., an NDA for the drug and a premarket notification for the device). The FDCA directs the FDA to conduct a review of a combination product under a single marketing application whenever appropriate. Applicants may choose to submit separate applications for constituent parts of a combination product (unless the FDA determines one application is necessary), and in limited situations, the FDA may determine an application for each constituent part is warranted. One reason to submit multiple applications is if the applicant wishes to receive some benefit that accrues only from approval under a particular type of application, like new drug product exclusivity. If multiple applications are submitted, each application is generally reviewed by the Center with authority over each application type. For combination products that contain an approved constituent part (such as a drug-device combination product in which the device has previously received clearance), the FDA may require that the application(s) include only such information as is necessary to meet the standard for clearance or approval, using a risk-based approach and taking into account any prior finding of safety or effectiveness for the approved constituent part.

Like their constituent products—e.g., drugs and devices—combination products are highly regulated and subject to a broad range of post marketing requirements including cGMP, adverse event reporting, periodic reports, labeling and advertising and promotion requirements and restrictions. Failure to comply with applicable requirements could result in enforcement actions.

Disclosure of Clinical Trial Information

Under US and certain foreign laws intended to improve clinical trial transparency, sponsors of clinical trials are required to register and disclose certain information about their clinical trials. This can include information related to the investigational drug, patient population, phase of investigation, study sites and investigators, and other aspects of the clinical trial. This information is then made publicly available. In the US, this information appears on ClinicalTrials.gov. Under US regulations, sponsors are obligated to disclose the results of these trials after completion. In the US, disclosure of the results of these trials can be delayed for up to two years if the sponsor is seeking initial approval of the product or approval of a new indication. Competitors may use this publicly available information to gain knowledge regarding the progress of development programs.

Other Post-approval Regulatory Requirements

Once an NDA or BLA is approved, a product will be subject to certain post-approval requirements, including those relating to advertising, promotion, adverse event reporting, recordkeeping, and cGMP, as well as registration, listing, and inspection. There also are continuing, annual user fee requirements.

The FDA regulates the content and format of prescription drug labeling, advertising, and promotion, including direct-to-consumer advertising and promotional Internet communications. The FDA also establishes parameters for permissible non-promotional communications between industry and the medical community, including industry-supported scientific and educational activities. The FDA and other agencies actively enforce the laws and regulations prohibiting the promotion for uses not consistent with the approved labeling, and a company that is found to have improperly promoted off-label uses or otherwise not to have met applicable promotion rules may be subject to significant liability under the FDCA, the PHSA, and other statutes, including the False Claims Act.

Manufacturers are subject to requirements for adverse event reporting and submission of periodic reports following FDA approval of an NDA or BLA.

All aspects of pharmaceutical manufacture must conform to cGMP after approval. Drug manufacturers and certain of their subcontractors are required to register their establishments with the FDA and certain state agencies, and are subject to periodic unannounced inspections by the FDA during which the FDA inspects manufacturing facilities to assess compliance with cGMP. Changes to the manufacturing process are strictly regulated and often require prior FDA approval before being implemented. FDA regulations also require investigation and correction of any deviations from cGMP and impose reporting and documentation requirements upon the sponsor and any third-party manufacturers that the sponsor may decide to use. Accordingly, manufacturers must continue to expend time, money and effort in the areas of production and quality control to maintain compliance with cGMP.

Drugs may be marketed only for the approved indications and in accordance with the provisions of the approved labeling. Changes to some of the conditions established in an approved application, including changes in indications, labeling, product formulation, or manufacturing processes or facilities, require submission and FDA approval of a new NDA or BLA or NDA or BLA supplement, in some cases before the change may be implemented. An NDA or BLA supplement for a new indication typically requires clinical data similar to that in the original application, and the FDA uses the same procedures and actions in reviewing NDA supplements as it does in reviewing NDAs or BLAs.

As previously mentioned, the FDA also may require Phase 4 studies and may require a REMS, which could restrict the distribution or use of the product.

In addition, the distribution of prescription pharmaceutical products is subject to the Prescription Drug Marketing Act (PDMA), which regulates the distribution of drugs and drug samples at the federal level, and sets minimum standards for the registration and regulation of drug distributors by the states. Both the PDMA and state laws limit the distribution of prescription pharmaceutical product samples and impose requirements to ensure accountability in distribution. The Drug Supply Chain Security Act (DSCSA) was enacted with the aim of building an electronic system to identify and trace certain prescription drugs distributed in the US. The DSCSA mandates phased-in and resource-intensive obligations for pharmaceutical manufacturers, wholesale distributors and dispensers over a 10-year period. FDA has exercised enforcement discretion and issued phased compliance policies to implement the law.

European Union

Marketing Authorization Application

To obtain approval of a drug under the EU regulatory system, an application for a marketing authorization may be submitted under a centralized, a decentralized or a national procedure. The centralized procedure, which is compulsory for medicines produced by certain biotechnological processes or for orphan drugs, provides for the grant of a single marketing authorization that is valid for all EU member states, which grants the same rights and obligations in each member state as a national marketing authorization. As a general rule, only one marketing authorization may be granted for drugs approved through the centralized procedure and the marketing authorization is also relevant for the EEA countries.

Under the centralized procedure, the Committee for Medicinal Products for Human Use (CHMP) is required to adopt an opinion on a valid application within 210 days, excluding clock stops when additional information is to be provided by the applicant in response to questions. More specifically, on day 80 of the procedure, the Rapporteur and Co-Rapporteur generate their draft assessment report. This is followed at day 120 by issuing to the applicant their formal report and a list questions. Applicants then have up to three months to respond to the questions (and can request a three-month extension). The Rapporteur, Co-Rapporteur and CHMP assess the applicant's replies and at day 150 generate their Joint Assessment Report. At day 180, the Joint Assessment Report along with a list of outstanding issues for unresolved matters (as needed) is provided to the applicant. Applicants then have one month to respond to the CHMP (and can request a one or two-month extension). At day 180 the

CHMP can also request the involvement of a Scientific Advisory Group (SAG), where the applicant is given the opportunity to present data supporting the application and addressing the specific questions addressed by the CHMP to the SAG. If the outstanding issues remain, an oral explanation may be requested by the EMA, where the applicant must attend the CHMP plenary session and address the Major Objections related to approval of the marketing authorization application (MAA). The CHMP members can then question the applicant on the key issues. At day 210, once its scientific evaluation is completed, the CHMP gives a favorable or unfavorable opinion as to whether to grant the marketing authorization. After the adoption of the CHMP opinion, a decision must be adopted by the EC, after consulting the Standing Committee of the Member States. The EC prepares a draft decision and circulates it to the member states; if the draft decision differs from the CHMP opinion, the Commission must provide detailed explanations. The EC adopts a decision within 15 days of the end of the consultation procedure.

Accelerated Procedure, Conditional Approval and Approval Under Exceptional Circumstances

Various programs, including accelerated assessment, conditional approval and approval under exceptional circumstances, are intended to expedite or simplify the approval of drugs that meet certain qualifications. The purpose of these programs is to provide important new drugs to patients earlier than under standard approval procedures.

For drugs which are of major interest from the point of view of public health, in particular from the viewpoint of therapeutic innovation, applicants may submit a substantiated request for accelerated assessment. If the CHMP accepts the request, the review time is reduced from 210 to 150 days.

Furthermore, for certain categories of medicinal products, marketing authorizations may be granted on the basis of less complete data than is normally required in order to meet unmet medical needs of patients or in the interest of public health. In such cases, the company may request, or the CHMP may recommend, the granting of a marketing authorization, subject to certain specific obligations; such marketing authorization may be conditional or under exceptional circumstances. The timelines for the centralized procedure described above also apply with respect to applications for a conditional marketing authorization or marketing authorization under exceptional circumstances.

Conditional marketing authorizations may be granted for products designated as orphan medicinal products, if all of the following conditions are met: (1) the risk-benefit balance of the product is positive, (2) the applicant will likely be in a position to provide the required comprehensive clinical trial data, (3) the product fulfills unmet medical needs, and (4) the benefit to public health of the immediate availability on the market of the medicinal product concerned outweighs the risk inherent in the fact that additional data are still required.

Conditional marketing authorizations are valid for one year, on a renewable basis until the holder provides a comprehensive data package. The granting of conditional marketing authorization depends on the applicant's ability to fulfill the conditions imposed within the agreed upon deadline. They are subject to "conditions", i.e., the holder is required to complete ongoing studies or to conduct new studies with a view to confirming that the benefit-risk balance is positive or to fulfill specific obligations in relation to pharmacovigilance. Once the holder has provided a comprehensive data package, the conditional marketing authorization is replaced by a 'regular' marketing authorization.

Marketing authorizations under exceptional circumstances may be granted where the applicant demonstrates that, for objective and verifiable reasons, they are unable to provide comprehensive data on the efficacy and safety of the drug under normal conditions of use. Such marketing authorizations are subject to certain conditions, in particular relating to safety of the drug, notification of incidents relating to its use or actions to be taken. They are valid for an indefinite period of time, but the conditions upon which they are based are subject to an annual reassessment in order to ensure that the risk-benefit balance remains positive.

Exclusivities

If an approved drug contains a new active substance, it is protected by data exclusivity for eight years from the notification of the Commission decision granting the marketing authorization and then by marketing protection for an additional two or three years. Overall, the drug is protected for ten or eleven years against generic competition, and no additional exclusivity protection is granted for any new development of the active substance it contains.

During the eight-year period of data exclusivity, competitors may not refer to the marketing authorization dossier of the approved drug for regulatory purposes. During the period of marketing protection, competitors may not market their generic drugs. The period of marketing protection is normally two years but may become three years if, during the eight-year data exclusivity period, a new therapeutic indication is approved that is considered as bringing a significant clinical benefit over existing therapies.

Medical Devices Regulations

In May 2017, the EU adopted a new Medical Devices Regulation (EU) 2017/745 (MDR), which repealed and replaced Directive 93/42/EEC on Medical Devices (Directive 93/42) on May 26, 2021. The MDR and its associated guidance documents

and harmonized standards, govern, among other things, device design and development, pre-clinical and clinical or performance testing, premarket conformity assessment, registration and listing, manufacturing, labeling, storage, claims, sales and distribution, export and import and post-market surveillance, vigilance, and market surveillance.

As of May 26, 2021, before a device can be placed on the market in the EU, compliance with the MDR requirements (i.e., the General Safety and Performance Requirements, or GSPRs, set out in Annex I of the MDR) must be demonstrated in order to affix the Conformité Européene mark, or CE Mark, to the product. The MDR provides recourse to harmonized European standards in order to facilitate compliance with the GSPRs. Harmonized standards provide a presumption of conformity with the GSPRs (although there are a limited number of standards harmonized currently). However, under transitional provisions provided for in the MDR, medical devices with Notified Body certificates issued under Directive 93/42 prior to May 26, 2021 may continue to be placed on the market for the remaining validity of the certificate, until December 31, 2027 at the latest for higher risk medical devices and until December 31, 2028 for other medical devices, in each case, so long as there is no significant changes in the design or intended purpose. After the expiry of any applicable transitional period, only devices that have been CE marked under the MDR may be placed on the market in the EU.

To demonstrate compliance with these requirements, a conformity assessment procedure is required. The MDR provides for several conformity assessment procedures, which depends on the type of medical device and the risks involved. Devices are divided in four groups based on risk: Class I, Class IIa, Class IIb, and Class III. Class I devices present the lowest level of risk so that, for most of these devices (other than those that are sterile and/or have measuring functionality) the manufacturer can self-certify the product plus affix the CE mark. For the other classes, the conformity assessment is carried out by an organization designated and supervised by a member state of the EEA to conduct conformity assessments, known as a Notified Body. The manufacturer initially classifies every device. However, when a device undergoes a conformity assessment with a Notified Body, the Notified Body may dispute the classification and assert that the device should be included in a class requiring stricter conformity assessment procedures. Specific rules apply to custom-made medical devices, medical devices that are used in clinical trials, and medical devices that incorporate a medicinal ingredient.

For classes of devices other than Class I, the Notified Body carries out the conformity assessment and issues a certificate of conformity, which entitles the manufacturer to affix the CE mark to its devices after having prepared and signed a related EU Declaration of Conformity. Affixing a CE mark allows the product to move freely within the EU and thus prevents EU Member States from restricting sales and marketing of the devices, unless such measure is justified on the basis of evidence of non-compliance. Ultimately, the manufacturer is responsible for the conformity of the device with the GSPRs and for the affixing of the CE mark. Lamira is CE marked by PARI, i.e., its manufacturer, in the EU.

Clinical evidence is required for most medium and high risk devices. In some cases, a clinical study may be required to support a CE marking application. A manufacturer that wishes to conduct a clinical study involving the device is subject to the clinical investigation requirements of the MDR, EU member state requirements, and current good clinical practices defined in harmonized standards and guidance documents.

After a device is placed on the market, it remains subject to significant regulatory requirements. The MDR prohibits misleading claims about devices and so devices may be marketed only for the uses and indications for which they are approved (although more detailed rules on marketing may be contained in national legislation). For CE marked devices, certain modifications to the device or quality system depending on the conformity assessment procedure used must be submitted to and approved by the Notified Body before placing the modified device on the market.

Economic Operators, include device manufactures, must register their establishments and devices in the EUDAMED database once available. Manufacturers of medical devices are subject to vigilance obligations that require reporting of incidents and are required to implement a post-marketing surveillance system (for monitoring data about the device and confirming the benefits of the device outweigh the risks). The vigilance obligations require that manufacturers must report serious incidents involving the device made available in the EU and any field safety corrective actions in respect of the device made available in the EU (including actions taken outside the EU) to relevant competent authorities. In addition, Notified Bodies regularly reassess the conformity of a medical device to the GSPRs and may from time to time audit the manufacturer and may, where needed, suspend or withdraw the manufacturer's certificate of conformity.

Japan

Under the Japanese regulatory system administered by the MHLW and the PMDA (which is responsible for product review and evaluations under the supervision of the MHLW), in principle, pre-marketing approval and clinical studies are required for all pharmaceutical products. The Law on Securing Quality, Efficacy and Safety of Products Including Pharmaceuticals and Medical Devices (Act No. 145 of 1960) requires a license for marketing authorization when importing to Japan and selling pharmaceutical products manufactured in other countries, a holder of such license is referred to as a marketing authorization holder. It also requires a foreign manufacturer to get each of its manufacturing sites certified as a manufacturing site of pharmaceutical products to be marketed in Japan. To receive a license for marketing authorization, the manufacturer or seller must, at the very least, employ certain manufacturing marketing, quality and safety personnel. A license for marketing

authorization may not be granted if the quality management methods and post marketing safety management methods applied with respect to the pharmaceutical product fail to conform to the standards stipulated in the ordinances promulgated by the MHLW. To obtain manufacturing/marketing approval for a new product, a Company must submit an application for approval to the MHLW with results of CMC, nonclinical and clinical studies to show the quality, efficacy and safety of the product candidate. A data compliance review, on-site inspection for good clinical practice, audit and detailed data review for compliance with current good manufacturing practices are undertaken by the PMDA. The application is then discussed by the committees of the Pharmaceutical Affairs and Food Sanitation Council. Based on the results of these reviews, the final decision on approval is made by the MHLW. The time required for the approval process varies depending on the product. PMDA's target review period (submission to approval) is twelve months (standard review) and nine months (priority review), although this is not a commitment. The product also needs approval for pricing in order to be eligible for reimbursement under Japan's National Health Insurance system. The medical products which, once they are approved and marketed, are subject to the continuing standards of Good Manufacturing Practice and Good Quality Practice and are also subject to regular post-marketing vigilance of safety and quality under the standards of Good Vigilance Practice and Good Post-marketing Study Practice. In Japan, the National Health Insurance system maintains a Drug Price List specifying which pharmaceutical products are eligible for reimbursement, and the MHLW sets the prices of the products on this list. After receipt of marketing approval, negotiations regarding the reimbursement price with the MHLW would begin. Price would be determined within 60 to 90 days following receipt of marketing approval unless the applicant disagrees, which may result in extended pricing negotiations. The government is currently introducing price cut rounds every year and mandates price decreases for specific products. New products judged innovative or useful, that are indicated for pediatric use, or that target orphan or small population diseases, however, may be eligible for a pricing premium. Price revisions after product launch based on Health Technology Assessment (HTA) and Cost-Effectiveness Analysis (CEA) were introduced in 2019. Products meeting the relevant criteria may have their prices adjusted according to the outcomes of the HTA/CEA evaluation. Additionally, certain rules for post-launch price reductions, such as Repricing for Market Expansion, are also applied. The government has also promoted the use of generics, where available.

Pediatric Information

United States

Under the PREA, as amended, certain NDAs, BLAs, and supplements must contain pediatric assessments, which are reports containing data to assess the safety and effectiveness of the drug for the claimed indications in all relevant pediatric subpopulations and to support dosing and administration for each pediatric subpopulation for which the drug is safe and effective. The FDA may, on its own initiative or at the request of an applicant, grant deferrals for submission of such assessments or full or partial waivers. Unless otherwise required by regulation, and subject to an exception for certain oncology drugs, PREA does not apply to any drug for an indication for which orphan designation has been granted.

Under the Best Pharmaceuticals for Children Act (BPCA), pediatric research is incentivized by the possibility of six months of pediatric exclusivity. For non-biological drugs, if pediatric exclusivity is granted, it attaches to existing statutory and patent-based exclusivity periods listed for the applicable drug in the FDA's Orange Book at the time the FDA determines that the sponsor, among other things, fairly responded to the FDA's "written request" for pediatric research, provided that the FDA makes such determination at least nine months before the expiration of such exclusivity period. For biological products, pediatric exclusivity does not attach to patents; it only attaches to exclusivities listed in FDA’s Purple Book at the time FDA makes its pediatric exclusivity determination (provided FDA makes that determination at least nine months before expiration of such exclusivity). Sponsors may seek to obtain a written request by submitting a proposed pediatric study request to the FDA. While the sponsor of an orphan-designated drug may not be required to perform pediatric studies under PREA unless one of the above exceptions applies, they are eligible to participate in the incentives under the BPCA if the FDA issues a written request.

European Union

In the EU, new drugs (i.e., drugs containing a new active substance) for adults must also be tested in children. This can also include pediatric pharmaceutical forms, in all subsets of the pediatric population. The mandatory pediatric testing is carried out through the implementation of a pediatric investigation plan (PIP), which is proposed by the applicant and approved by the EMA. A PIP contains all the studies to be conducted and measures to be taken in order to support the approval of the new drug, including pediatric pharmaceutical forms, in all subsets of the pediatric population. Implementation of a PIP is a prerequisite to validation of an MAA. Following granting of the marketing authorization, post approval compliance is also reviewed through the life cycle of the product until the PIP is completed. A PIP may allow for one or more waivers or deferral for one or more of the studies or measures included therein in order not to delay the approval of the drug in adults, and, on another hand, the EMA may grant either a product-specific waiver for the (adult) disease/condition or one or more pediatric subsets or a class waiver for the disease/condition. PIPs are subject to potential modifications from time to time, when they no longer are workable, if approved by EMA. Any new indication as a variation to an existing marketing authorization requires a new PIP for that indication. In the case of orphan medicinal products, completion of an approved PIP can result in an extension of the market exclusivity period from ten to twelve years. To benefit from the additional exclusivity the PIP must be completed and content from the PIP must be included in the approved summary of product characteristics.

Japan

In Japan, there is no statutory rule which imposes any different obligation on pharmaceutical manufacturers engaging in pediatric drug development than on other pharmaceutical manufacturers. However, the guidelines of the MHLW (Handling of Pharmaceuticals during the Reexamination Interval Period (Issue No. 107, February 1, 1999) and Enforcement of the Ministerial Ordinance Partially Revising the Ministerial Ordinance on Standards for Post-marketing Surveillance of Pharmaceutical Products and Review of Post-marketing Surveillance for the Reexamination of Pharmaceutical Products (No. 1324, December 27, 2000)) state as follows: (i) since information on pediatric patients obtained in clinical trials may be limited, the MHLW recommends that pharmaceutical manufacturers conduct adequate post-marketing surveillance during the reexamination interval period and collect as much information as possible for proper use of drugs for pediatric patients; and (ii) if a pharmaceutical manufacturer plans to conduct a clinical trial to set the dose of a pediatric drug to prepare application for manufacturing/marketing approval or after receiving the same approval, the reexamination interval period may be extended up to ten years. The notification of MHLW (Partial Revision of Handling of Reexamination Period (Issue No. 0116/3, January 16, 2024)) states that ten years will be applied as the reexamination period for the "addition of clearly different dosage such as pediatric doses." In addition, since February 2010 the MHLW has convened a study group composed of physicians on a regular basis to discuss and promote the development of children's drugs that have been approved for use in Europe and the US but are not yet approved in Japan, so that they can be used as early as possible in Japan as well.

Regulation Outside the US, Europe and Japan

In addition to regulations in the US, Europe and Japan, we will be subject to a variety of regulations in other jurisdictions governing clinical studies of our candidate products, including medical devices. Regardless of whether we obtain FDA approval for a product candidate, we must obtain approval by the comparable regulatory authorities of countries outside the US before we can commence clinical studies or marketing of the product candidate in those countries. The requirements for approval and the approval process vary from country to country, and the time may be longer or shorter than that required for FDA approval. Under certain harmonized medical device approval/clearance regulations outside the US, reference to US clearance permits fast-tracking of market clearance. Other regions are harmonized with EU standards, and therefore recognize the CE mark as a declaration of conformity to applicable standards. Furthermore, we must obtain any required pricing approvals in addition to regulatory approval prior to launching a product candidate in the approving country. Although the UK is no longer part of the EU, its medicinal product and medical device regulations remain broadly aligned with the EU requirements.

Managed Access Programs

Certain countries allow the supply or use of investigational products within strictly regulated managed access programs (MAPs), such as post-trial access programs, compassionate use programs and named patient access programs. We provide BRINSUPRI, ARIKAYCE, and, with respect to post-trial access programs, certain of our product candidates, to patients through various of these MAPs.

Reimbursement of Pharmaceutical Products

In the US, many independent third-party payors, as well as the Medicare and state Medicaid programs, reimburse dispensers of pharmaceutical products. Medicare is the federal program that provides healthcare benefits to senior citizens and certain disabled and chronically ill persons. Medicaid is the need-based federal and state program administered by the states to provide healthcare benefits to certain persons.

As one of the conditions for obtaining Medicaid and, if applicable, Medicare Part B or Part D coverage for our marketed pharmaceutical products, we will need to agree to pay a rebate to state Medicaid agencies that provide reimbursement for those products. We will also have to agree to sell our commercial products under contracts with the Department of Veterans Affairs, Department of Defense, Public Health Service, and numerous other federal agencies as well as certain hospitals that are designated by federal statutes to receive drugs at prices that are significantly below the price we charge to commercial pharmaceutical distributors. These programs and contracts are highly regulated and will impose restrictions on our business. Failure to comply with these regulations and restrictions could result in adverse consequences such as civil money penalties, imposition of a Corporate Integrity Agreement and/or a loss of Medicare and Medicaid reimbursement for our drugs.

Private healthcare payors also attempt to control costs and influence drug pricing through a variety of mechanisms, including through negotiating discounts with the manufacturers and through the use of tiered formularies and other mechanisms that provide preferential access to certain drugs over others within a therapeutic class. Payors also set other criteria to govern the uses of a drug that will be deemed medically appropriate and therefore reimbursed or otherwise covered.

The Inflation Reduction Act (IRA) of 2022 (P.L. 117-169) has, for the first time, allowed Medicare to negotiate the price of certain high expenditure, single source Medicare Part B or Part D drugs. The Centers for Medicare & Medicaid Services has implemented a Medicare Drug Price Negotiation Program, and this program may affect future Medicare reimbursement for our drugs. The IRA also requires manufacturers of certain Part B and Part D drugs to issue to the US Department of Health and Human Services (HHS) rebates based on certain calculations and triggers (i.e., when drug prices increase and outpace the rate of inflation) which may influence the pricing of current and future products.

The Trump Administration issued a series of Executive Orders seeking to reduce prescription drug costs in the US by requiring manufacturers to sell certain drugs in the US at no higher than the lowest prices paid for those same drugs in other developed countries and directing the US Department of Health and Human Services (HHS) to facilitate direct-to-consumer (DTC) purchasing programs for prescription drugs at the most-favored-nation (MFN) price. In addition, in late 2025, HHS proposed three payment models that would test MFN pricing in Medicaid (the GENEROUS model), Medicare Part D (the GUARD model), and Medicare Part B (the GLOBE model). Under the GENEROUS model, manufacturers could provide MFN pricing to state Medicaid agencies on a voluntary basis. If GLOBE and GUARD are finalized, pharmaceutical manufacturers would be required to pay MFN-based rebates on eligible products for 25% of eligible Medicare beneficiaries during the applicable testing period. Drug pricing is an active area for regulatory reform at both the federal and state levels, and additional significant changes to current drug pricing and reimbursement structures in the US could be forthcoming.

Different pricing and reimbursement schemes exist in other countries. In the EU, governments influence the price of drugs through their pricing and reimbursement rules and control of national healthcare systems that fund a large part of the cost of those products to patients. Some jurisdictions operate positive and negative list systems under which drugs may only be marketed once a reimbursement price has been agreed. To obtain reimbursement or pricing approval, some of these countries may require the completion of clinical trials that compare the cost-effectiveness of a particular product candidate to currently available therapies. Other member states allow companies to fix their own prices for drugs, but monitor and control company profits. The downward pressure on healthcare costs in general, particularly prescription drugs, has become very intense. As a result, increasingly high barriers are being erected to the entry of new drugs. In addition, in some countries, cross-border imports from low-priced markets exert a commercial pressure on pricing within a country. There can be no assurance that any country that has price controls or reimbursement limitations for drugs will allow favorable reimbursement and pricing arrangements for any of our products.

In Japan, drugs can be sold on the market if they undergo the PMDA's review of quality, efficacy and safety and receive manufacturing/marketing approval. However, in order for drugs to be covered by the National Health Insurance, they must be included in a Drug Price List. The "Drug Pricing Organization," which is a division of the Central Social Insurance Medical Council (CSIMC), calculates the price of drugs, the general meeting of the CSIMC approves the calculated price, and the MHLW includes the drugs and the calculated price in the Drug Price List. After receiving manufacturing/marketing approval, drugs are included in the Drug Price List within 60 to 90 days unless the applicant disagrees, which may result in extended pricing negotiations. The MHLW updates the Drug Price List annually after taking into account the survey result of the actual sales price of drugs and hearing the opinion of the CSIMC.

Fraud and Abuse and Other Laws

Physicians and other healthcare providers and third-party payors (government or private) often play a primary role in the recommendation and prescription of healthcare products. In the US and most other jurisdictions, numerous detailed requirements apply to government and private healthcare programs, and a broad range of fraud and abuse laws, transparency laws, and other laws are relevant to pharmaceutical companies. US federal and state healthcare laws and regulations in these areas include the following:

- The federal Anti-kickback Statute;
- The federal civil False Claims Act;
- The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health Act;
- The federal criminal false statements statute;
- The price reporting requirements under the Medicaid Drug Rebate Program and the Veterans Health Care Act of 1992;
- The federal Physician Payment Sunshine Act, being implemented as the Open Payments Program; and
- Analogous and similar state laws and regulations.

Similar restrictions apply in the member states of the EU and Japan, which have been set out by laws or industry codes of conduct.

Employees

As of December 31, 2025, we had a total of 1,664 full-time employees: 736 in research, clinical, regulatory, medical affairs and quality assurance; 107 in technical operations, manufacturing and quality control; 266 in general and administrative functions; and 555 in commercial activities. We had 1,274 full-time employees in the US, 238 employees in Europe and 152 employees in Japan. We anticipate increasing our headcount in 2026.

None of our employees are represented by a labor union and we believe that our relations with our employees are generally good. Generally, our US employees are at-will employees; however, we have entered into employment agreements with our executive officers.

Human Capital

Employee Attraction, Retention and Development

We are dedicated to attracting and retaining the best possible talent. Our compensation program, including short- and long-term incentives and benefits, is designed to allow us to attract and retain individuals whose skills are critical to our current and long-term success. Total compensation is generally positioned within a competitive range of the peer market median, with differentiation based on market benchmarks, experience, skills, proficiency, and performance to attract and retain key talent. With our compensation program, we also aim to align the interests of our employees with those of our stockholders.

We believe that continued growth and development are essential to the professional well-being of our team, from onboarding through the employee lifecycle. We seek to develop our employee talent within the organization through access to internal and external training, continuous learning programs and other development initiatives. As our organization and capabilities grow, we aim to ensure we have provided our team members with the guidance and resources they need to develop as professionals and to support our business.

Our Values

Five core values—collaboration, accountability, passion, respect, and integrity—set the tone for our culture and guide the actions we take each day. In 2025, we introduced guiding principles, the 'To Be List', bringing our values and who we are as an organization to life. We strive to ensure that these values drive all of our human capital endeavors, including hiring, our annual employee feedback process, our Global Core Competencies, our Recognition Program, and our employee onboarding initiatives.

We are focused on maintaining an inclusive work environment that best supports the varied needs of the patient communities we serve. We continue to grow our list of employee resource groups and expand our sourcing for new talent to enhance our talent pipeline. We are also committed to equitable pay for all employees. We use industry benchmarks and annual internal equity reviews to make salary adjustments as needed in efforts to ensure a fair and bias-free compensation system. As we grow, we are continuing to implement initiatives to advance the development of our talent and ensure comprehensive succession plans both in our employee workforce and our Board of Directors.

In furtherance of our values, we have continued to integrate our responsibility and sustainability program. We are cognizant of our environmental impact, support several green measures and community service programs, and continue to explore options to improve and build upon our sustainability efforts. We are committed to ensuring the health and well-being of our employees and promoting patient advocacy and safety. Finally, we are driven by integrity and believe good corporate governance is important and necessary to maintain ethical and compliant business practices.

Available Information

We file electronically with the SEC our annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, and amendments to those reports filed or furnished pursuant to Section 13(a) or 15(d) of the Securities Exchange Act of 1934 (Exchange Act). We make available on our website at http://www.insmed.com, free of charge, copies of these reports as soon as reasonably practicable after filing them with, or furnishing them to, the SEC. The public can also obtain materials that we file with the SEC through the SEC's website at http://www.sec.gov.

Also available through our website's "Investors-Corporate Governance" page are charters for the Audit, Compensation, Nominations and Governance and Science and Technology Committees of our Board of Directors, our Corporate Governance Guidelines, and our Code of Business Conduct and Ethics. We intend to satisfy the disclosure requirements regarding any amendment to, or waiver from, a provision of the Code of Business Conduct and Ethics by making disclosures concerning such matters available on our website.

The references to our website and the SEC's website are intended to be inactive textual references only. Neither the information in or that can be accessed through our website, nor the contents of the SEC's website, are incorporated by reference in this Annual Report on Form 10-K.

Financial Information

The financial information required under this Item 1 is incorporated herein by reference to Item 8 of this Annual Report on Form 10-K.

ITEM 1A. RISK FACTORS

Our business is subject to substantial risks and uncertainties. Any of the risks and uncertainties described below, either alone or taken together, could materially and adversely affect our business, financial condition, results of operations, prospects for growth, and the value of an investment in our common stock. In addition, these risks and uncertainties could cause actual results to differ materially from those expressed or implied by forward-looking statements contained in this Annual Report on Form 10-K (please read the Cautionary Note Regarding Forward-Looking Statements appearing at the beginning of this Annual Report on Form 10-K).

Risk Factor Summary

An investment in our securities is subject to various risks, the most significant of which are summarized below.

- Our prospects are highly dependent on the success of our approved products, ARIKAYCE and BRINSUPRI. If we are unable to successfully market, commercialize and maintain approval for ARIKAYCE and BRINSUPRI, our business, financial condition, results of operations and prospects and the value of our common stock may be materially adversely affected.
- We may not be able to obtain regulatory approval for ARIKAYCE in front-line NTM lung disease, for ARIKAYCE or BRINSUPRI in additional markets or for our product candidates. Any such failure to obtain regulatory approvals may materially adversely affect us.
- The commercial success of ARIKAYCE and BRINSUPRI depend on market acceptance by physicians, patients, third-party payors and others in the healthcare community, and the commercial success of our product candidates, if approved, will similarly depend on market acceptance.
- We obtained regulatory approval of ARIKAYCE in the US through an accelerated approval process, and full approval will be contingent on successful and timely completion of a confirmatory post-marketing clinical trial. Failure to obtain full approval or otherwise meet our post-marketing requirements and commitments may have a material adverse effect on our business, prospects, and the value of our common stock.
- We are subject to substantial, ongoing regulatory requirements, including with respect to advertising and promotion, and failure to comply with these requirements may lead to enforcement action or otherwise materially harm our business.
- If we are unable to obtain or maintain adequate reimbursement from government or third-party payors for ARIKAYCE, BRINSUPRI or our product candidates, if approved, or if we are unable to obtain or maintain acceptable prices for ARIKAYCE, BRINSUPRI, or, if approved, our product candidates, our prospects for generating revenue and achieving profitability may be materially adversely affected.
- ARIKAYCE, BRINSUPRI, or any of our product candidates may develop unexpected safety or efficacy concerns, which may have a material adverse effect on us.
- If our estimates of the size of the potential markets for ARIKAYCE, BRINSUPRI, or our product candidates prove inaccurate, our ability to generate revenue may be materially adversely affected.
- Pharmaceutical research and development is very costly and highly uncertain, and we may not succeed in developing product candidates in the future.
- Interim, topline and preliminary data from our clinical trials that we announce or publish from time to time may change as more patient data become available, may be interpreted differently if additional data are disclosed, and are subject to audit and verification procedures that may result in material changes in the final data.
- As ARIKAYCE is a drug/device combination product, we cannot sell ARIKAYCE without Lamira. Any failure to secure or maintain regulatory approval in each market for Lamira as a delivery system for ARIKAYCE may limit our ability to successfully commercialize ARIKAYCE. Additionally, we plan to submit an NDA for TPIP as a drug/device combination product or as a stand-alone marketing application, as dictated by local regulations. Failure to obtain or maintain regulatory approval or clearance of any of our devices or drug-device combination products may materially harm our business.
- If our clinical studies do not produce positive results or our clinical trials are delayed, or if serious side effects are identified during drug development, we may experience delays, incur additional costs and ultimately be unable to obtain regulatory approval for and successfully commercialize our product candidates in the US, Europe, Japan or other markets.
- We may not be able to enroll enough patients to conduct and complete our clinical trials or retain a sufficient number of patients in our clinical trials to generate the data necessary for regulatory approval of our product candidates or to gain the approval of the use of ARIKAYCE in the broader population of patients with MAC lung disease.
- If another party obtains orphan drug exclusivity for a product that is considered the same or essentially the same as a product we are developing for a particular indication, we may be precluded from or delayed in commercializing the product in that indication.
- Our clinical and pre-clinical research activities include the research and development of novel gene therapy product candidates. It will be difficult to predict the time and cost of development and of subsequently obtaining regulatory

approval for any such gene therapy product candidates, or how long it will take to commercialize any gene therapy product candidates.

- If we are unable to form and sustain relationships with third-party service providers that are critical to our business, or if any third-party arrangements that we may enter into are unsuccessful, our ability to develop and commercialize our products may be materially adversely affected.
- We may not have, or may be unable to obtain, sufficient quantities of ARIKAYCE, Lamira, BRINSUPRI, or our product candidates to meet our required supply for commercialization or clinical studies, which may materially harm our business.
- Adverse consequences to our business may result if we or our manufacturing partners fail to comply with applicable regulations or maintain required approvals.
- We are dependent on retaining and attracting key personnel, the loss of whose services may materially adversely affect our business, financial condition, results of operations and prospects, and the value of our common stock.
- We expect to continue to expand our development, regulatory and sales and marketing capabilities, and as a result, may encounter difficulties in managing our growth, which may disrupt our operations.
- Any acquisitions we have made or may make in the future, or collaborative relationships we have entered into or may in the future enter into, may not be clinically or commercially successful, and may require financing or a significant amount of cash, which could adversely affect our business.
- We may be subject to product liability claims, and we have only limited product liability insurance.
- Our business and operations, including our drug development and commercialization programs, may be materially disrupted and/or subject to reputational harm in the event of system failures, security breaches, cyber-attacks, deficiencies in cybersecurity, violations of data protection laws or data loss or damage by us or third parties.
- We are subject to laws and regulations that govern how we can collect, process, store and transfer personal data and sensitive data, and violations may result in meaningful penalties, enforcement, and/or reputational harm and have a significant impact on our operations.
- Our inability to access, upgrade or expand our technology systems or difficulties in updating our existing technology or developing or implementing new technology may have a material adverse effect on our business or results of operations.
- We are subject to a number of risks associated with our international activities and operations and may not be successful in any efforts to further expand internationally.
- We operate in a highly competitive and changing environment, and if we are unable to adapt to our environment, we may be unable to compete successfully.
- We have a limited number of significant customers and losing any of them may have an adverse effect on our financial condition and results of operations.
- Deterioration in general economic conditions in the US, Europe, Japan and globally, including the effect of prolonged periods of inflation on our suppliers, third-party service providers and potential partners, may harm our business and results of operations.
- The emergence of a pandemic, and efforts to reduce its spread, may negatively impact our business and operations.
- Our current and potential future use of AI and machine learning may not be successful and presents new risks and challenges to our business.
- If we are unable to adequately protect our intellectual property rights, the value of ARIKAYCE, BRINSUPRI, and our product candidates may be materially diminished.
- If we fail to comply with obligations in our third-party agreements, our business may be adversely affected, including by the loss of license rights that are important to our business.
- Healthcare legislation or other government action may materially adversely affect our business, financial condition, results of operations and prospects and the value of our common stock.
- We are subject to anti-corruption laws and trade control laws, as well as other laws governing our operations. If we fail to comply with these laws, we may be subject to negative publicity, civil or criminal penalties, other remedial measures, and legal expenses, which may adversely affect our business, financial condition, results of operations and prospects and the value of our common stock.
- We have a history of operating losses, expect to incur operating losses in the near term, and may never achieve or maintain profitability.
- We may need to raise additional funds to continue our operations, and any failure to obtain capital when needed on acceptable terms, or at all, may force us to delay, reduce or eliminate our development programs, commercialization efforts, or other operations.
- We have outstanding indebtedness in the form of a term loan and a royalty financing arrangement and may incur additional indebtedness in the future, which may adversely affect our financial position, prevent us from implementing our strategy, and, in certain cases, dilute the ownership interest of our existing shareholders.
- We may be unable to use certain of our net operating losses and other tax assets.

- Goodwill impairment charges in the future may have a material adverse effect on our business, results of operations and financial condition.
- Our shareholders may experience dilution of their ownership interests because of the future issuance of additional shares of our common stock.
- Certain provisions of Virginia law, our articles of incorporation and amended and restated bylaws and arrangements between us and our employees may hamper a third party's acquisition of us or discourage a third party from attempting to acquire control of us.

Risks Related to the Commercialization and Continued Approval of ARIKAYCE and BRINSUPRI, and the Potential Approval and Commercialization of our Product Candidates

Our prospects are highly dependent on the success of our approved products, ARIKAYCE and BRINSUPRI. If we are unable to successfully market, commercialize and maintain approval for ARIKAYCE and BRINSUPRI, our business, financial condition, results of operations and prospects and the value of our common stock may be materially adversely affected.

Our long-term viability and growth depend on the successful commercialization of ARIKAYCE and BRINSUPRI. ARIKAYCE was approved in the US for the treatment of MAC lung disease as part of a combination antibacterial drug regimen for adult patients with limited or no alternative treatment options in a refractory setting, as defined by patients who do not achieve negative sputum cultures after a minimum of six consecutive months of a multidrug background regimen therapy. Subsequently, ARIKAYCE was approved in Europe for the treatment of NTM lung infections caused by MAC in adults with limited treatment options who do not have CF, and in Japan for the treatment of patients with NTM lung disease caused by MAC who did not sufficiently respond to prior treatments with a multidrug regimen. We refer to NTM lung disease caused by MAC as MAC lung disease. BRINSUPRI was approved in the US in August 2025 as an oral, once-daily treatment for NCFB in adults and children 12 years and older, and in the EU in November 2025 for NCFB in adults and children 12 years or older with two or more exacerbations in the prior 12 months. We have invested and continue to invest significant efforts and financial resources in the commercialization of ARIKAYCE and BRINSUPRI. Our ability to continue to generate revenue from ARIKAYCE will depend heavily on successfully commercializing and obtaining full regulatory approval for ARIKAYCE from the FDA by conducting an appropriate confirmatory post-marketing study. Our ability to generate revenue from BRINSUPRI will depend heavily on successfully commercializing BRINSUPRI in the US and the EU as well as obtaining additional regulatory approvals outside of the US and the EU.

In order to continue to commercialize ARIKAYCE and BRINSUPRI, we must continue to establish and maintain marketing, market access, sales and distribution capabilities on our own or make arrangements with third parties for its marketing, sale and distribution. We are commercializing ARIKAYCE in the US, Europe and Japan and BRINSUPRI in the US using our sales force, and we intend to use our sales force in any additional markets in which we commercialize BRINSUPRI, but we may not continue to be successful in these efforts. The establishment, development and maintenance of our own sales force is and will continue to be expensive and time-consuming. As a result, we may seek one or more partners to handle some or all of the sales and marketing of ARIKAYCE and/or BRINSUPRI in certain markets following approval by the relevant regulatory authority in those markets. In that case, we will be reliant on third parties to successfully commercialize ARIKAYCE and/or BRINSUPRI and will have less control over commercialization efforts than if we handled commercialization with our own sales force. However, we may not be able to enter into arrangements with third parties to sell ARIKAYCE and/or BRINSUPRI on favorable terms or at all. In the event that either our own marketing, market access, sales force or third-party marketing, and sales organizations are not effective, our ability to generate revenue would be adversely affected.

We may not be able to obtain regulatory approval for ARIKAYCE in front-line NTM lung disease, for ARIKAYCE or BRINSUPRI in additional markets or for our product candidates. Any such failure to obtain regulatory approvals may materially adversely affect us.

We are required to obtain various regulatory approvals prior to studying our products in humans and then again before we market and distribute our products, and the failure to obtain such approvals will prevent us from commercializing our products, which would materially adversely affect our business, financial condition, results of operations and prospects and the value of our common stock. While we have obtained accelerated approval for ARIKAYCE in the US, approval for ARIKAYCE in Europe and Japan and approval for BRINSUPRI in the US and the EU, seeking any future regulatory approvals for our product candidates, as well as approval for ARIKAYCE in front-line NTM lung disease or for ARIKAYCE or BRINSUPRI in other jurisdictions presents significant obstacles.

We are continuing to conduct our confirmatory clinical trial program for full approval of ARIKAYCE in the broader population of patients with MAC lung disease through our ENCORE trial, and this trial program, along with any other clinical trials of ARIKAYCE, may not be successful. Additional results from ongoing and recently completed studies may affect the FDA's benefit-risk analysis for the product. If we are unable to expand the indication for use of ARIKAYCE, our prospects and the value of our common stock may be materially adversely affected.

Approval processes in the US, Europe, Japan and other markets require the submission of extensive pre-clinical and clinical data, manufacturing and quality information regarding the manufacturing process and any manufacturing facility, scientific data characterizing our product and other supporting data in order to establish safety and effectiveness. These processes are complex, lengthy, expensive, resource intensive and uncertain. Regulators will also conduct a rigorous review of any trade name we intend to use for our products. Even after they approve a trade name, these regulators may request that we adopt an alternative name for the product if adverse event reports indicate a potential for confusion with other trade names and medication error. If we are required to adopt an alternative name, potential commercialization of our product candidates or continued commercialization of ARIKAYCE or BRINSUPRI may be delayed or interrupted. We have limited experience in submitting and pursuing applications necessary to obtain these regulatory approvals.

Data submitted to regulators are subject to varying interpretations that may delay, limit or prevent regulatory agency approval. Even if we believe our clinical trial results are promising, regulators may disagree with our interpretation of data, study design or execution and may refuse to accept our application for review or decline to grant approval.

In addition, the grant of an orphan designation by the FDA or EC or approval by the FDA, EC, MHRA or MHLW does not ensure a similar decision by the regulatory authorities of other countries, and a decision by one foreign regulatory authority does not ensure regulatory authorities in other foreign countries or the FDA will agree with the decision. For instance, although ARIKAYCE received orphan drug designation in the US for the treatment of infections caused by NTM, ARIKAYCE did not qualify for orphan drug designation in Japan due to the estimated number of NTM patients in Japan exceeding 50,000. Similarly, clinical studies conducted in one country may not be accepted by regulatory authorities in other countries. Approval procedures vary among countries and can involve additional product testing, including additional pre-clinical studies or clinical trials, and administrative review periods. The time required to obtain approval in these other territories might differ from that required to obtain FDA approval. We may never obtain approval for our product candidates in the US or other jurisdictions, for ARIKAYCE outside of the US, Europe and Japan, or for BRINSUPRI outside of the US and the EU, which would limit our market opportunities and may materially adversely affect our business. Even if any of our product candidates is approved, if ARIKAYCE is approved outside of the US, Europe and Japan, or if BRINSUPRI is approved outside of the US and the EU, regulators may limit the indications for which the product may be marketed, require extensive warnings on the product labeling, require other burdensome risk mitigation measures, such as distribution restrictions, or require expensive and time-consuming additional clinical trials or reporting as conditions of approval.

We may also encounter delays or rejections based on changes in regulatory agency policies or resources during the period in which we develop a product and the period required for review of any application for regulatory agency approval of a particular product. Resolving such delays may force us or third parties to incur significant costs, limit our allowed activities or the allowed activities of third parties, diminish any competitive advantages that we or our third parties may attain or adversely affect our ability to receive royalties, any of which may materially adversely affect our business, financial condition, results of operations and prospects and the value of our common stock.

The commercial success of ARIKAYCE and BRINSUPRI depend on market acceptance by physicians, patients, third-party payors and others in the healthcare community, and the commercial success of our product candidates, if approved, may similarly depend on market acceptance.

Despite receiving FDA, EC and Japan's MHLW approval of ARIKAYCE and FDA and EC approval of BRINSUPRI for the specified indications, market acceptance may vary among physicians, patients, third-party payors or others in the healthcare community and is dependent on a number of factors, including the following:

- The willingness of the target patient populations to use, and of physicians to prescribe, ARIKAYCE and BRINSUPRI;
- The efficacy and potential advantages of ARIKAYCE and BRINSUPRI over alternative treatments;
- The risk and safety profile of ARIKAYCE and BRINSUPRI, including, among other things: with respect to ARIKAYCE, physician and patient concern regarding the US boxed warning and other safety precautions resulting from its association with an increased risk of respiratory adverse reactions; whether patients experience adverse events, including adverse events that did not occur or went undetected or unreported in our clinical trials; and any adverse safety information that becomes available as a result of longer-term use of ARIKAYCE and BRINSUPRI;
- Relative convenience and ease of administration, including any requirements for hospital administration of ARIKAYCE;
- The ability of the patient to tolerate ARIKAYCE and BRINSUPRI;
- The pricing of ARIKAYCE and BRINSUPRI;
- The ability and willingness of the patient to pay out of pocket costs for ARIKAYCE and BRINSUPRI (for example, co-payments);
- Sufficient government or third-party insurance coverage and reimbursement;

- The strength of marketing and distribution support and timing of market introduction of competitive products and treatments; and
- Publicity concerning ARIKAYCE and BRINSUPRI or any potential competitive products and treatments.

Our efforts to educate physicians, patients, third-party payors and others in the healthcare community on the benefits of ARIKAYCE and BRINSUPRI have required and will continue to require significant resources, which may be greater than those required to commercialize more established technologies and these efforts may never be successful. If approved, the market acceptance of our product candidates may vary among physicians, patients, third-party payors or others in the healthcare community and will depend on substantially similar factors.

We obtained regulatory approval of ARIKAYCE in the US through an accelerated approval process, and full approval will be contingent on successful and timely completion of a confirmatory post-marketing clinical trial. Failure to obtain full approval or otherwise meet our post-marketing requirements and commitments may have a material adverse effect on our business, prospects and the value of our common stock.

The FDA approved ARIKAYCE under the LPAD and accelerated approval pathways, and full approval will be based on results from a post-marketing confirmatory clinical trial. FDA may grant accelerated approval to a product for a serious or life-threatening disease or condition upon a determination that the product has an effect on a surrogate endpoint that is reasonably likely to predict clinical benefit or on a clinical endpoint that can be measured earlier than or irreversible morbidity or mortality, that is reasonably likely to predict an effect on irreversible morbidity or mortality, or other clinical benefit, taking into account the severity, rarity, or prevalence of the condition and the availability or lack of alternative treatments. Accelerated approval of ARIKAYCE was supported by preliminary data from the Phase 3 CONVERT study, which evaluated the safety and efficacy of ARIKAYCE in adult patients with refractory MAC lung disease, using achievement of sputum culture conversion (defined as three consecutive negative monthly sputum cultures) by Month 6 as the primary endpoint.

As a condition of accelerated approval, we must conduct a post-marketing confirmatory clinical trial for ARIKAYCE in patients with MAC lung disease, which we commenced in the fourth quarter of 2020, and submit periodic reports on the progress of this clinical trial. The confirmatory clinical trial program consists of the ARISE trial, an interventional study designed to validate cross-sectional and longitudinal characteristics of a PRO tool in MAC lung disease, and the ENCORE trial, designed to establish the clinical benefits and evaluate the safety of ARIKAYCE in patients with newly diagnosed or recurrent MAC lung disease using the PRO tool validated in the ARISE trial.

The confirmatory clinical trial program is intended to fulfill the FDA's post-marketing requirement to allow for full approval of ARIKAYCE by the FDA, and verification and description of clinical benefit in the ENCORE trial will be necessary for full approval of ARIKAYCE.

In September 2023, we announced positive topline results from the ARISE trial. The study met its primary objective of demonstrating that the QOL-B respiratory domain works effectively as a PRO tool in patients with MAC lung disease. Based on feedback and in alignment with the FDA, we determined that the primary endpoint for the ENCORE trial would include eight questions from the QOL-B respiratory domain PRO. We completed enrollment of the ENCORE trial in the fourth quarter of 2024, with 425 patients enrolled. However, we may encounter substantial delays in conducting the ENCORE trial, and we may not be able to conduct the trial in a manner satisfactory to the FDA or within the time period required by the FDA. In addition, the use of the PRO tool in the ENCORE trial, which involves patients' subjective assessments of efficacy of the treatments they receive in the trial, may increase the uncertainty of, and adversely impact, the clinical trial outcomes.

The FDA could, among other things, withdraw its approval of ARIKAYCE using expedited procedures if the ENCORE trial is not successful or if the FDA concludes that we failed to conduct the ENCORE trial with due diligence, that other evidence demonstrates that ARIKAYCE is not shown to be safe and effective, or that we disseminated false or misleading promotional materials with respect to ARIKAYCE. Additionally, under the amendments to the FDCA made by the Consolidated Appropriations Act, 2023, the FDA could pursue administrative and judicial remedies for a violation of the FDCA if we were to fail to conduct the ENCORE trial with due diligence or not timely submit the required reports on the progress of the ENCORE trial. Separate from the confirmatory trial, additional results from ongoing and recently completed studies may affect the FDA's benefit-risk analysis for the product. Failure to meet all post-marketing commitments may raise additional regulatory challenges.

We are subject to substantial, ongoing regulatory requirements, including with respect to advertising and promotion, and failure to comply with these requirements may lead to enforcement action or otherwise materially harm our business.

We are subject to a variety of manufacturing, packaging, storage, labeling, advertising, promotion, record-keeping and reporting requirements in the US, Europe, and Japan, including requirements to:

- Conduct sales, marketing and promotion, scientific exchange, speaker programs, charitable donations and educational grant programs in compliance with federal and state laws;

- Disclose clinical trial information and payments to healthcare professionals and healthcare organizations on publicly available databases;
- Monitor and report complaints, AEs and instances of failure to meet product specifications;
- Comply with cGMP requirements for drugs and quality systems requirements for devices;
- Comply with requirements regarding the security and integrity of the distribution supply chain;
- Acquire licenses for marketing authorization and certifications for our third-party manufacturers when importing and selling pharmaceutical products manufactured in one country into another country;
- Negotiate with national governments and other counterparties on pricing and reimbursement status;
- Carry out post-approval confirmatory clinical trials;
- Comply with ongoing pharmacovigilance requirements;
- Seek supplemental approvals for changes in product labeling or manufacturing; and
- Disclose payments to healthcare professionals and healthcare organizations to national regulatory authorities and/or on publicly available websites.

In addition, advertising and promotion of any product candidate that obtains approval in the US is heavily scrutinized by the FDA, the Department of Justice, the Department of Health and Human Services' Office of Inspector General, state attorneys general, members of Congress, other government agencies and the public. While physicians may prescribe products for off-label uses as the FDA and other regulatory agencies do not regulate a physician's choice of drug treatment made in the physician's independent medical judgment, they do restrict promotional communications from companies or their sales force with respect to off-label uses of products for which marketing authorization has not been obtained. Companies may only share truthful and not misleading information that is otherwise consistent with a product's FDA-approved labeling. Violations, including promotion of our products for unapproved (or off-label) uses, may be subject to untitled or warning letters, inquiries and investigations, and civil and criminal sanctions by the government. Additionally, foreign regulatory authorities will heavily scrutinize advertising and promotion of any product candidate that obtains approval in their respective jurisdictions.

Furthermore, on September 9, 2025, President Trump issued a Memorandum directing the US Department of Health and Human Services, or HHS, to "ensure transparency and accuracy in direct-to-consumer prescription drug advertising, including by increasing the amount of information regarding any risks associated with the use of any such prescription drug required to be provided in prescription drug advertisements." The same day, the FDA declared that it will no longer tolerate what it characterized as "deceptive practices" in prescription drug advertising and that the agency would "aggressively deploy" its available enforcement tools with "heightened scrutiny" of fair balance and disclosures in social media promotions. The FDA issued a generic "notice letter" to all holders of approved drug and biologic applications, including us, directing such companies to "remove any noncompliant advertising and bring all promotional communications into compliance." Any failure by us to comply with any of these requirements may lead to onerous government investigations or enforcement action or otherwise materially harm our business.

If we ultimately receive approval for ARIKAYCE, BRINSUPRI or any of our product candidates in jurisdictions other than the US, Europe, or Japan, we expect to be subject to similar ongoing regulatory oversight by the relevant foreign regulatory authorities, including the requirement to negotiate with national governments and other counterparties on pricing and reimbursement prices for each new jurisdiction.

Failure to comply with these ongoing regulatory obligations could have significant negative consequences, including:

- Issuance of warning letters or untitled letters by the FDA asserting that we are in violation of the law;
- Imposition of injunctions or civil monetary penalties or pursuit by regulators of civil or criminal prosecutions and fines against us or our responsible officers;
- Suspension or withdrawal of regulatory approval;
- Suspension or termination of ongoing clinical trials or refusal by regulators to approve pending marketing applications or supplements to approved applications;
- Seizure of products, required product recalls or refusal to allow us to enter into supply contracts, including government contracts, or to import or export products;
- Enforcement actions, such as a product recalls, or product shortages due to failure to meet certain manufacturing or regulatory requirements, including the successful completion and results of quality control or release testing;
- Suspension of, or imposition of restrictions on, our operations, including costly new manufacturing requirements with respect to ARIKAYCE, BRINSUPRI, or any of our product candidates; and

- Negative publicity, including communications issued by regulatory authorities, which may negatively impact the perception of us or ARIKAYCE, BRINSUPRI, or any of our product candidates by patients, physicians, third-party payors or the healthcare community.

We provide financial assistance with out-of-pocket costs to patients enrolled in commercial health insurance plans. In addition, independent foundations may assist with out-of-pocket financial obligations. The ability of these organizations to provide assistance to patients is dependent on funding from external sources, and we cannot guarantee that such funding will be available at adequate levels, if at all. Patient assistance programs, whether provided directly by manufacturers or charitable foundations, have come under recent government scrutiny. If we are deemed to have failed to comply with relevant laws, regulations or government guidance with respect to these programs, we may be subject to significant fines or penalties.

In addition, the policies of the FDA, the EMA, the MHLW, and other comparable regulatory authorities may change and additional government regulations may be enacted that could prevent, limit or delay regulatory approval of our products. Costs arising out of any regulatory developments could be time-consuming and expensive and could divert management resources and attention and, consequently, may adversely affect our business, financial condition and results of operations. If we are slow or unable to adapt to changes in existing requirements or the adoption of new requirements or policies, or if we are not able to maintain regulatory compliance, we may lose any marketing approval that we may have obtained, which may adversely affect our business, prospects and ability to achieve or sustain profitability.

If we are unable to obtain or maintain adequate reimbursement from government or third-party payors for ARIKAYCE, BRINSUPRI or our product candidates, if approved, or if we are unable to obtain or maintain acceptable prices for ARIKAYCE, BRINSUPRI or our product candidates, if approved, our prospects for generating revenue and achieving profitability may be materially adversely affected.

Our prospects for generating revenue and achieving profitability depend heavily upon the availability of adequate reimbursement for the use of ARIKAYCE, BRINSUPRI or, if approved, our product candidates, from governmental and other third-party payors, both in the US and in other markets. A significant portion of our current ARIKAYCE and BRINSUPRI revenues in the US are dependent on Medicare reimbursement, and we expect that trend to continue. Reimbursement by a third-party payor depends upon a number of factors, including the third-party payor's determination that use of a product is:

- A covered benefit under its health plan;
- Safe, effective and medically necessary;
- Appropriate for the specific patient;
- Cost-effective; and
- Neither experimental nor investigational.

Obtaining a determination of coverage and reimbursement for a product from each relevant governmental or other third-party payor is a time-consuming and costly process that could require us to provide supporting scientific, clinical and cost-effectiveness data for the use of our products to each payor. Payors in the US have evaluated ARIKAYCE for inclusion on formularies. Going forward, we may not be able to provide data that are sufficient to gain positive coverage and reimbursement determinations or we might need to conduct post-marketing studies in order to demonstrate the cost-effectiveness of ARIKAYCE to such payors' satisfaction. Such studies might require us to commit a significant amount of management time and financial and other resources. Payors in the US continue to evaluate BRINSUPRI and/or write policies related to access. If access requirements adopted by third-party payors or the prior authorization process prove too onerous, physicians and patients may develop a belief that BRINSUPRI is difficult to access, which, in turn, may affect our ability to successfully commercialize BRINSUPRI and adversely impact our business, financial condition, results of operations and prospects and the value of our common stock.

Even when a payor determines that a product is eligible for reimbursement, the payor may impose coverage limitations that preclude payment for some uses that are approved by the FDA or non-US regulatory authorities and/or may set a reimbursement rate that is too low to support a profitable sales price for the product. For example, in France we agreed with the French authorities to a reimbursed price for ARIKAYCE that was lower than the price in our temporary authorization for use (Autorisation Temporaire d'Utilisation or ATU) and are required to refund the difference. As a result, we recorded a revenue reversal in the fourth quarter of 2022, related to revenue recorded in prior periods. In addition, in 2023, we experienced a one-time, prospective price decrease for ARIKAYCE in Japan of 9.4%. In the US, payors have restricted and continue to restrict coverage of ARIKAYCE by using a variable co-payment structure that imposes higher costs on patients for drugs that are not preferred by the payor and by imposing requirements for prior authorization or step edits, and payors may similarly restrict coverage of BRINSUPRI as they continue to evaluate BRINSUPRI for coverage and write coverage policies. Additionally, if the results from our ENCORE trial support a label expansion for ARIKAYCE to include all MAC lung patients, payors may nonetheless restrict reimbursement for ARIKAYCE's use to refractory MAC patients, despite regulatory approval. Subsequent approvals of competitive products could result in a detrimental change to the reimbursement of our products. The occurrence of

any of these events likely would adversely impact market acceptance and demand for ARIKAYCE and/or BRINSUPRI, which, in turn, may affect our ability to successfully commercialize ARIKAYCE and/or BRINSUPRI and adversely impact our business, financial condition, results of operations and prospects and the value of our common stock.

There is a significant focus in the US healthcare industry and elsewhere on drug prices and value, and public and private payors are taking increasingly aggressive steps to control their expenditures for pharmaceuticals by, among other things, negotiating manufacturer discounts and placing restrictions on reimbursement for, and patient access to, medications. These pressures could negatively affect our business. We expect changes in the Medicare program and state Medicaid programs, as well as managed care organizations and other third-party payors, to continue to put pressure on pharmaceutical product pricing. One significant example of applicable legislative action is the IRA, which was signed into law on August 16, 2022. The IRA gives the HHS the ability and authority to directly negotiate with manufacturers the price that Medicare will pay for certain high-priced drugs and set caps on the negotiated price of such drugs, among other changes. The IRA also requires manufacturers of certain Part B and Part D drugs to issue to HHS rebates based on certain calculations and triggers (i.e., when drug prices increase and outpace the rate of inflation), which may influence the pricing of current and future products. At this time, we believe that ARIKAYCE will be excluded from price negotiation under the IRA due to its orphan drug designation, but BRINSUPRI is likely to be subject to IRA price negotiation in the future. We cannot predict other potential implications the IRA provisions will have on our business or the pricing of our product candidates, if approved. Similarly, we cannot predict the impact on our business of the Trump Administration's proposed "most favored nation" drug pricing policies. These types of laws may have a significant impact on our ability to set a product price we believe is fair or market and sell our approved products in certain jurisdictions and may adversely affect our ability to generate revenue and achieve or maintain profitability, as well as on our decisions about whether to launch our products in additional markets. We expect further federal and state proposals and healthcare reforms to continue to be proposed, which could limit the prices that can be charged for the products we develop or may otherwise limit our commercial opportunity. In addition, in connection with various government programs, we are required to report certain pricing information to the government, and the failure to do so may subject us to penalties. For further discussion of related risks, see "Risks Related to Government Regulation - Healthcare legislation or other government action may materially adversely affect our business, financial condition, results of operations and prospects and the value of our common stock."

In markets outside the US, including countries in Europe, Japan and Canada, pricing of pharmaceutical products is subject to governmental control. Evaluation criteria used by many government agencies in European countries for the purposes of pricing and reimbursement typically focus on a product's degree of innovation and its ability to meet a clinical need unfulfilled by currently available therapies. The Patient Protection and Affordable Care Act (ACA) created a similar entity, the Patient-Centered Outcomes Research Institute, designed to review the effectiveness of treatments and medications in federally-funded healthcare programs. An adverse result could lead to a treatment or product being removed from Medicare or Medicare coverage. The decisions of such governmental agencies could affect our ability to sell our products profitably.

We continue to have discussions with third-party payors regarding our price for ARIKAYCE and BRINSUPRI, and our pricing may meet resistance from them and the public generally. If we are unable to maintain adequate reimbursement for ARIKAYCE in the US, Europe and Japan, or for BRINSUPRI in the US and the EU, the adoption of ARIKAYCE and/or BRINSUPRI by physicians and patients may be limited. If we are unable to negotiate acceptable prices for ARIKAYCE and BRINSUPRI, we may be unable to generate sufficient revenue to achieve profitability. Both of these risks, in turn, may affect our ability to successfully commercialize ARIKAYCE and BRINSUPRI and adversely impact our business, financial condition, results of operations and prospects and the value of our common stock.

ARIKAYCE, BRINSUPRI, or any of our product candidates may develop unexpected safety or efficacy concerns, which may have a material adverse effect on us.

ARIKAYCE and BRINSUPRI are now being used by larger numbers of patients and, with respect to ARIKAYCE, for longer periods of time than during our clinical trials (including in the CONVERT study), and we and others (including regulatory agencies and private payors) are collecting extensive information on the efficacy and safety of ARIKAYCE and BRINSUPRI by monitoring its use in the marketplace. In addition, we are conducting a confirmatory trial to assess and describe the clinical benefit of ARIKAYCE in patients with MAC lung disease. We may also conduct additional trials in connection with lifecycle management programs for ARIKAYCE, BRINSUPRI, and, if approved, our product candidates. New safety or efficacy data from both market surveillance and our clinical trials may result in negative consequences including the following:

- Modification to product labeling or promotional statements, such as additional boxed or other warnings or contraindications, or the issuance of additional "Dear Doctor Letters" or similar communications to healthcare professionals;
- Required changes in the administration of ARIKAYCE, BRINSUPRI, or our product candidates;

- Imposition of additional post-marketing surveillance, post-marketing clinical trial requirements, distribution restrictions or other risk management measures, such as a risk evaluation and mitigation strategy (REMS) or a REMS with elements to assure safe use in the US;
- Suspension or withdrawal of regulatory approval;
- Suspension or termination of ongoing clinical trials or refusal by regulators to approve pending marketing applications or supplements to approved applications;
- Suspension of, or imposition of restrictions on, our operations, including costly new manufacturing requirements with respect to ARIKAYCE, BRINSUPRI, or our product candidates; and
- Voluntary or mandatory product recalls or withdrawals from the market and costly product liability claims.

Any of these circumstances could reduce ARIKAYCE's or BRINSUPRI's market acceptance or, if approved, the market acceptance of our product candidates and may materially adversely affect our business.

If our estimates of the size of the potential markets for ARIKAYCE, BRINSUPRI, or our product candidates prove inaccurate, our ability to generate revenue may be materially adversely affected.

We have relied on external sources, including market research funded by us and third parties, and internal analyses and calculations to estimate the potential market opportunities for ARIKAYCE, BRINSUPRI, and our product candidates. The externally sourced information used to develop these estimates has been obtained from sources we believe to be reliable, but we have not verified the data from such sources, and their accuracy and completeness cannot be assured. With respect to ARIKAYCE, our internal analyses and calculations are based upon management's understanding and assessment of numerous inputs and market conditions, including, but not limited to, the projected increase in prevalence of MAC lung disease, Medicare patient population growth and ongoing population shifts to geographies with increased rates of MAC lung disease.

In addition, we are relying on third-party data to identify the physicians who treat the majority of MAC lung disease patients in the US and to determine how to deploy our resources to market to those physicians; however, we may not be marketing to the appropriate physicians and may therefore be limiting our market opportunity.

With regard to BRINSUPRI, our estimated number of total diagnosed bronchiectasis patients in the US was derived from an external source. A similar per capita prevalence was used to calculate the estimated prevalence in the European 5 and Japan.

Our estimates of the potential addressable market for TPIP in PAH and PH-ILD in the US, the European 5 and Japan were also derived from external sources. However, the studies we reviewed indicate a lack of consensus on prevalence rates.

Furthermore, professional societies, practice management groups, private health and science foundations and other organizations publish guidelines or recommendations to the healthcare and patient communities relating to such matters as usage, dosage, route of administration and use of concomitant therapies. Recommendations or guidelines suggesting the reduced use of our products or the use of competitive or alternative products that are followed by patients and healthcare providers could result in decreased use of our products.

In addition to the foregoing reasons for caution, these understandings and assessments necessarily require assumptions subject to significant judgment and may prove to be inaccurate. As a result, our estimates of the size of these potential markets for ARIKAYCE, BRINSUPRI, and our product candidates could prove to be overstated, perhaps materially.

In the future, we may develop additional estimates with respect to market opportunities for our other product candidates, and such estimates are subject to similar risks. In addition, a potential market opportunity could be reduced if a regulator limits the proposed treatment population for one of our product candidates, similar to the limited population for which ARIKAYCE was approved. In either circumstance, even if we obtain regulatory approval, we may be unable to commercialize the product on a scale sufficient to generate significant revenue from such product candidates, which may have a material adverse effect on our business, financial condition, results of operations and prospects and the value of our common stock.

Risks Related to the Development and Regulatory Approval of Our Product Candidates Generally

Pharmaceutical research and development is very costly and highly uncertain, and we may not succeed in developing product candidates in the future.

Product development in the pharmaceutical industry is an expensive, high-risk, lengthy, complicated, resource intensive process. In order to develop a product successfully, we must, among other things:

- Identify potential product candidates;
- Submit for and receive regulatory approval to perform clinical trials;

- Design and conduct appropriate pre-clinical and clinical trials, including confirmatory clinical trials, according to good laboratory practices and good clinical practices and disease-specific expectations of the FDA and other regulatory bodies;
- Select and recruit clinical investigators and subjects for our clinical trials;
- Obtain and correctly interpret data establishing adequate safety of our product candidates and demonstrating with statistical significance that our product candidates are effective for their proposed indications, as indicated by satisfaction of pre-established endpoints;
- Submit for and receive regulatory approvals for marketing; and
- Manufacture the product candidates and device constituent parts according to cGMP and other applicable standards and regulations.

There is a high rate of failure inherent in this process, and potential products that appear promising at early stages of development may fail for a number of reasons. Importantly, positive results from pre-clinical studies of a product candidate may not be predictive of similar results in human clinical trials, promising results from earlier clinical trials of a product candidate may not be replicated in later clinical trials, and observations from ongoing trials, including observations based on interim, preliminary, or blinded data, may not be representative of results after the trials are completed and all data are collected and analyzed. Many companies in the pharmaceutical and biotechnology industries have suffered significant setbacks in late-stage clinical trials even after achieving positive results in earlier stages of development and have abandoned development efforts or sought partnerships in order to continue development.

In addition, there are many other difficulties and uncertainties inherent in pharmaceutical research and development that could significantly delay or otherwise materially impair our ability to develop future product candidates, including the following:

- Conditions imposed by regulators, ethics committees or institutional review boards for pre-clinical testing and clinical trials relating to the scope or design of our clinical trials, including selection of endpoints and number of required patients or clinical sites;
- Challenges in designing our clinical trials to support potential claims of superiority over current standard of care or future competitive therapies;
- Restrictions placed upon, or other difficulties with respect to, clinical trials and clinical trial sites, including with respect to potential clinical holds or suspension or termination of clinical trials due to, among other things, potential safety or ethical concerns or noncompliance with regulatory requirements;
- Delayed or reduced enrollment in clinical trials, high discontinuation rates or overly concentrated patient enrollment in specific geographic regions;
- Failure by third-party contractors, contract research organizations (CROs), clinical investigators, clinical laboratories, or suppliers to comply with regulatory requirements or meet their contractual obligations in a timely manner;
- Greater than anticipated cost of our clinical trials; and
- Insufficient product supply or inadequate product quality.

We cannot state with certainty when or whether our product candidates now under development will be approved or launched; whether, if initially granted, such approval will be maintained; whether we will be able to develop, license, or otherwise acquire additional products or product candidates; or whether our products, once launched, will be commercially successful. Failure to successfully develop future product candidates for any of these reasons may materially adversely affect our business, financial condition, results of operations and prospects and the value of our common stock.

Interim, topline and preliminary data from our clinical trials that we announce or publish from time to time may change as more patient data become available, may be interpreted differently if additional data are disclosed, and are subject to audit and verification procedures that may result in material changes in the final data.

From time to time, we may publicly disclose preliminary or topline data from our clinical trials, which may be based on a preliminary analysis of then-available data in a summary or topline format, and the results and related findings may change as more patient data become available, may be interpreted differently if additional data are disclosed at a later time and are subject to audit and verification procedures that could result in material changes in the final data. If additional results from our clinical trials are not consistent with topline data or other previously released data or are not viewed favorably, our ability to obtain approval for and commercialize our approved drug and drug candidates, our business, operating results, prospects, or financial condition may be harmed and our stock price may decrease.

We also make assumptions, estimates, calculations, and conclusions as part of our analyses of data, and we may not have received or had the opportunity to fully and carefully evaluate all data. As a result, the preliminary or topline results that we report may differ from future results of the same trials, or different conclusions or considerations may qualify such results,

once additional data have been disclosed and/or are received and fully evaluated. Such data also remain subject to audit and verification procedures that may result in the final data being materially different from the preliminary data we previously published. As a result, preliminary and topline data should be viewed with caution until the final data are available. We may also disclose interim data from our clinical trials. Interim data from clinical trials that we may complete are subject to the risk that one or more of the clinical outcomes may materially change as patient enrollment continues and more patient data become available. Differences between preliminary or interim data and final data could significantly harm our business prospects. In addition, blinded data may not be predictive of unblinded data.

Further, other parties, including regulatory agencies, may not accept or agree with our assumptions, estimates, calculations, conclusions, or analyses or may interpret or weigh the importance of data differently, which could impact the value of the particular program, the approvability or commercialization of the particular drug candidate or product, and our business in general. In addition, in regards to the information we publicly disclose regarding a particular study or clinical trial, such as topline data, you or others may not agree with what we determine is the material or otherwise appropriate information to include in such disclosure, and any information we determine not to disclose, or to disclose at a later date, such as at a medical meeting may ultimately be deemed significant with respect to future decisions, conclusions, views, activities, or otherwise regarding a particular drug, drug candidate, or our business. If the topline data that we report differ from actual results or are interpreted differently once additional data are disclosed at a later date, or if others, including regulatory authorities, disagree with the conclusions reached, our ability to obtain approval for and commercialize our drug candidates, our business, operating results, prospects, or financial condition may be harmed or our stock price may decline.

As ARIKAYCE is a drug/device combination product, we cannot sell ARIKAYCE without Lamira. Any failure to secure or maintain regulatory approval in each market for Lamira as a delivery system for ARIKAYCE may limit our ability to successfully commercialize ARIKAYCE. Additionally, we plan to submit an NDA for TPIP as a drug/device combination product or as a stand-alone marketing application, as dictated by local regulations. Failure to obtain or maintain regulatory approval or clearance of any of our devices or drug-device combination products may materially harm our business.

Lamira must receive regulatory approval or clearance in connection with each approved product or product candidate it will be used to administer. In the US, the FDA granted accelerated approval of a drug/device combination product comprised of ARIKAYCE with Lamira, and Lamira is CE marked by PARI in Europe and authorized for use by MHLW in Japan. However, outside the US, Europe and Japan, Lamira is labeled as investigational for use in our clinical trials, including in Canada and Australia, and is not approved for commercial use in Canada or certain other markets in which we may seek to commercialize ARIKAYCE in the future.

In addition, we plan to submit a marketing application for TPIP as a drug/device combination product or as a stand-alone application, as dictated by local regulations. We will need to seek additional approvals in connection with the delivery device for TPIP in certain markets before we can market and commercialize TPIP in them.

We will continue to work closely with PARI to coordinate efforts regarding regulatory requirements for Lamira, including our proposed filings. If we and PARI are not successful in obtaining approval for each usage of Lamira in each market, our ability to commercialize ARIKAYCE in those markets would be materially impaired. In addition, failure to maintain regulatory approval or clearance of Lamira may result in increased development costs, withdrawal of regulatory approval, delays or otherwise materially harm our business. Finally, failure to obtain regulatory approval or clearance of the delivery device for TPIP would affect our ability to develop and commercialize TPIP.

If our clinical studies do not produce positive results or our clinical trials are delayed, or if serious side effects are identified during drug development, we may experience delays, incur additional costs and ultimately be unable to obtain regulatory approval for and successfully commercialize our product candidates in the US, Europe, Japan or other markets.

Before obtaining regulatory approval for the sale of our product candidates, we must conduct, at our own expense, extensive pre-clinical tests to demonstrate the safety of our product candidates in animals, and clinical trials to demonstrate the safety and efficacy of our product candidates in humans. If we experience delays in our clinical trials or other testing or the results of these trials or tests are not positive or are only modestly positive, including with respect to safety, we may:

- Experience increased product development costs;
- Be delayed in obtaining, or be unable to obtain, regulatory approval for one or more of our product candidates;
- Obtain approval for indications or patient populations that are not as broad as intended or entirely different than those indications for which we sought approval or with labeling with boxed warnings or other warnings or contraindications;
- Need to change the way the product is administered;
- Be required to perform additional clinical trials to support approval or be subject to additional post-marketing testing requirements;

- Have regulatory authorities withdraw, or suspend, their approval of the product or impose risk mitigation strategies such as a REMS or other restrictions on distribution;
- Face a shortened patent protection period during which we may have the exclusive right to commercialize our products;
- Have competitors that are able to bring similar products to market before us;
- Be sued for alleged injuries caused to patients using our products; or
- Suffer reputational damage.

Such circumstances would impair our ability to commercialize our products and harm our business and results of operations.

The risk of finding adverse side effects may be particularly heightened in the case of gene therapies. For instance, new gene copies may produce too much or too little of the desired protein or RNA, or the production of the desired protein or RNA may change over time. Because the treatment is irreversible, there may be challenges in managing side effects. Some adverse effects would not be able to be reversed or relieved and might require us to develop additional clinical safety procedures. Furthermore, new gene copies may disrupt other normal biological molecules and processes which could also result in undesirable adverse effects. Adverse side effects may also be experienced by patients as a result of the process for administering the therapy or related procedures.

There have been several significant adverse side effects in gene therapy treatments in the past, including reported cases of leukemia, immune-mediated responses, and death seen in other trials. Gene therapy is still a relatively new approach to disease treatment and additional adverse side effects could develop. For instance, possible adverse side effects that could occur include immunologic-mediated reactions early after administration, which could substantially limit the effectiveness of the treatment, and could lead to further adverse side effects, possibly including organ failure or death. Additional manufacturing, clinical, and pre-clinical testing may be required, as well as additional analyses, assessments, and potential long-term patient and clinical study subject monitoring, beyond what is currently required, and sample testing and associated regulatory reporting. Serious adverse events in our clinical trials, or other clinical trials involving gene therapy products or our competitors' products, even if not ultimately attributable to the relevant product candidates, and the resulting publicity, any claims that gene therapy is unsafe, or gene therapy being unable to gain the acceptance of the public or the medical community may further adversely impact our product candidates in the form of increased government regulation, unfavorable public perception, lack of physician adoption, the need for additional testing or monitoring, potential regulatory delays, stricter labeling requirements, and a decrease in demand.

We may not be able to enroll enough patients to conduct and complete our clinical trials or retain a sufficient number of patients in our clinical trials to generate the data necessary for regulatory approval of our product candidates or to gain approval of the use of ARIKAYCE in the broader population of patients with MAC lung disease.

The completion rate of our clinical trials is dependent on, among other factors, the patient enrollment rate. Patient enrollment is a function of many factors, including:

- Investigator identification and recruitment;
- Regulatory approvals to initiate study sites;
- Patient population size;
- The nature of the protocol to be used in the trial;
- Patient proximity to clinical sites;
- Eligibility criteria for the trial;
- Patient willingness to participate in the trial;
- Discontinuation rates; and
- Competition from other companies' potential clinical trials for the same patient population.

Delays in patient enrollment for our clinical trials could increase costs and delay commercialization and sales, if any, of our products. Once enrolled, patients may elect to discontinue participation in a clinical trial at any time. If patients elect to discontinue participation in our clinical trials at a higher rate than expected, including with respect to our ENCORE trial, we may be unable to generate the data required by regulators for approval of our product candidates.

If another party obtains orphan drug exclusivity for a product that is considered the same or essentially the same as a product we are developing for a particular indication, we may be precluded from or delayed in commercializing the product in that indication.

Under the ODA, the FDA may grant orphan drug designation to drugs intended to treat a rare disease or condition (i.e., that affects fewer than 200,000 persons in the US). In the EU, the EC grants orphan drug designation to products that are intended for the diagnosis, prevention or treatment of a life-threatening or chronically debilitating disease or condition affecting not more than five in 10,000 people in the EU. The company that obtains the first regulatory approval from the FDA for a designated orphan drug for an indication within the designated rare disease or condition generally receives marketing exclusivity for use of that drug for that indication for a period of seven years. Similar laws exist in the EU with a term of 10 years. See Business — Government Regulation — Orphan Drug Designation in Item 1 of Part I of this Annual Report on Form 10-K for additional information. If a competitor obtains approval of the same drug for the same indication before we obtain approval, and the FDA grants such orphan drug exclusivity, we would be prohibited from obtaining approval for our product for seven years (or longer if the seven-year exclusivity period is extended for a QIDP or due to pediatric exclusivity), unless our product can be shown to be clinically superior. In addition, even if we obtain our own period of orphan exclusivity, the FDA may approve another product during our orphan exclusivity period that is otherwise the same drug for the same indication under certain circumstances, including if it is clinically superior to our product.

If we fail to obtain or maintain regulatory exclusivity for our product candidates, our business may be materially harmed.

We may be unable to obtain, or may not be able to maintain, regulatory exclusivity for our products or product candidates, including exclusivity under the Hatch-Waxman Act, orphan drug exclusivity, Generating Antibiotic Incentives Now Act exclusivity, or pediatric exclusivity. Even if granted, such exclusivity may be limited in scope or duration and may not prevent competitors from developing or marketing competing products. For example, while BRINSUPRI is eligible for five-year new chemical entity exclusivity, which should block submission of an Abbreviated New Drug Application (ANDA) or 505(b)(2) with the same active moiety for five years (or four years, if a paragraph IV certification of patent invalidity, unenforceability, or non-infringement is filed), if another sponsor submits a 505(b)(1) application for a drug containing the same active moiety, BRINSUPRI's regulatory exclusivity would not block submission of that product. The loss or expiration of any exclusivity period could allow competitors to introduce generic or other competing products, which may significantly reduce our revenues and adversely affect our business, financial condition, and results of operations.

Generic competition following the expiration or loss of exclusivity may significantly reduce our revenues.

Our products may become subject to competition from generic or follow-on drug manufacturers who seek approval through the ANDA or 505(b)(2) application process. Manufacturers may file ANDAs or 505(b)(2) applications seeking approval to market follow-on versions of our products prior to the expiration of our patents or regulatory exclusivities, including by filing Paragraph IV certifications alleging that our patents are invalid, unenforceable, or not infringed. Such challenges could result in costly and time-consuming litigation, and if successful, could lead to earlier-than-anticipated generic competition, which may materially and adversely affect our revenues and profitability.

Our clinical and pre-clinical research activities include the research and development of novel gene therapy product candidates. It will be difficult to predict the time and cost of development and of subsequently obtaining regulatory approval for any such gene therapy product candidates, or how long it will take to commercialize any gene therapy product candidates.

In addition to our ongoing gene therapy clinical trials, we intend to continue to identify and develop novel gene therapy product candidates as part of our pre-clinical research efforts. We have limited experience in developing gene therapy programs and cannot be certain that any gene therapy product candidates that we develop will successfully complete pre-clinical studies and clinical trials, or that they will not cause significant adverse events or toxicities. Any such results could impact our ability to develop a gene therapy product candidate, including our ability to enroll patients in our clinical trials. Furthermore, there is the potential risk of delayed adverse events following exposure to gene therapy products due to persistent biological activity of the genetic material or other components of products used to carry the genetic material, which may adversely affect our ability to obtain and maintain regulatory approvals for and commercialize any gene therapy products we may develop.

In addition, to date, only a small number of gene therapy products have been approved in the US, Europe, Japan, or elsewhere, and regulatory requirements governing gene therapy products continue to evolve and may continue to change in the future. We may seek regulatory approval in territories outside the US, Europe, and Japan, which may have their own regulatory authorities along with frequently changing requirements or guidelines. The regulatory review committees and advisory groups in the US, Europe, Japan, and elsewhere, and any new guidelines they promulgate, may lengthen the regulatory review process, require us to perform additional studies, increase our development costs, lead to changes in regulatory positions and interpretations, delay or prevent approval and commercialization of our product candidates or lead to significant post-approval limitations or restrictions. Within the FDA, the Center for Biologics Evaluation and Research (CBER) regulates gene therapy products. Within CBER, the review of gene therapy and related products is consolidated in the Office of Therapeutic Products, and the FDA has established the Cellular, Tissue and Gene Therapies Advisory Committee to advise CBER on its reviews. CBER works closely with the National Institutes of Health (the NIH) in connection with the development of gene therapy.

CBER has experienced leadership changes and broad layoffs and departures under the Trump Administration, which may slow review times.

The FDA has published specific guidance documents with respect to the development and approval of gene therapy products. Amongst these guidance documents are final guidance documents that pertain to the development of gene therapies for the treatment of specific disease categories, including rare diseases of interest to Insmed, and to manufacturing and long-term follow-up issues relevant to gene therapy, among other topics. For example, the FDA issued a final guidance document in September 2021 describing the FDA's approach for determining whether two gene therapy products are the same or are different for the purpose of orphan-drug designation and orphan-drug exclusivity. On January 11, 2026, the FDA announced information about what the agency called its "flexible approach" to overseeing chemistry, manufacturing and control requirements for cell and gene therapies, although applicable requirements remain rigorous. The FDA has continued to issue additional draft and final guidance documents on the development and manufacture of gene therapy products.

As we advance gene therapy product candidates, we will be required to consult with these regulatory authorities and advisory groups, and comply with applicable guidelines. If we fail to do so, we may be required to delay or discontinue development of certain of our product candidates. These additional processes may result in a review and approval process that is longer than we otherwise would have expected. Delay or failure to obtain, or unexpected costs in obtaining, the regulatory approval necessary to bring a potential product to market could decrease our ability to generate product revenue.

Due to these factors, it is more difficult for us to predict the time and cost of gene therapy product candidate development, and we cannot predict whether the application of our approach to gene therapy, or any similar or competitive programs, will result in the identification, development and regulatory approval of any product candidates, or that the gene therapy programs of our competitors will not be considered better or more attractive or available in the market prior to ours. There can be no assurance that any development problems we experience in the future related to gene therapy product candidates will not cause significant delays or unanticipated costs, or that such development problems can be solved. We may also experience delays and challenges in achieving sustainable, reproducible and scalable production. Additionally, if a safety concern arises in connection with a gene therapy product from any sponsor, regulatory authorities might apply greater scrutiny to our gene therapy product candidates and any approved gene therapy products, and it might become more challenging to enroll patients in clinical trials and commercialize approved gene therapy products. Any of these factors may prevent us from completing our pre-clinical studies or clinical trials or commercializing any gene therapy product candidates we may develop on a timely or profitable basis, if at all.

Risks Related to Our Reliance on Third Parties

If we are unable to form and sustain relationships with third-party service providers that are critical to our business, or if any third-party arrangements that we may enter into are unsuccessful, our ability to develop and commercialize our products may be materially adversely affected.

We currently rely, and expect to continue to rely, on third parties for significant research, analytical services, pre-clinical development, clinical development and manufacturing of our product candidates and commercial scale manufacturing of ARIKAYCE, Lamira, and BRINSUPRI. For example, we do not own facilities for clinical-scale or commercial manufacturing of our product candidates, and we expect that our future supply requirements for TPIP will be manufactured by CMOs. We currently rely on Resilience and Patheon to provide our clinical and commercial supply of ARIKAYCE. We currently rely on Esteve and Patheon Inc. to provide our clinical supply of brensocatib and our commercial supply of BRINSUPRI. Additionally, almost all of our clinical trial work is done by CROs, such as PPD, our CRO for the ENCORE and TPIP trials, and clinical laboratories. In addition, we rely on third parties to manufacture clinical materials for our pre-clinical research programs. Reliance on these third parties poses a number of risks, including the following:

- The diversion of management time and cost of third-party advisers associated with the negotiation, documentation and implementation of agreements with third parties in the pharmaceutical industry;
- The inability to control whether third parties devote sufficient resources to our programs or products, including with respect to meeting contractual deadlines;
- The inability to control the regulatory and contractual compliance of third parties, including their quality systems, processes and procedures, systems utilized to collect and analyze data, and equipment used to test drug product and/or clinical supplies;
- The inability to establish and implement collaborations or other alternative arrangements on favorable terms;
- Disputes with third parties, including CROs, leading to loss of intellectual property rights, delay or termination of research, development, or commercialization of product candidates or litigation or arbitration;
- Contracts with our collaborators fail to provide sufficient protection of our intellectual property; and
- Difficulty enforcing our contractual rights if one of these third parties fails to perform.

We also rely on third parties to select and enter into agreements with clinical investigators to conduct clinical trials to support approval of our product candidates, and the failure of these third parties to appropriately carry out such evaluation and selection can adversely affect the quality of the data from these studies, compliance with applicable rules, and, potentially, the approval of our products. In particular, as part of future drug approval submissions to the FDA, we must disclose certain financial interests of investigators who participated in any of the clinical studies being submitted in support of approval, or must certify to the absence of such financial interests. The FDA evaluates the information contained in such disclosures to determine whether disclosed interests may have an impact on the reliability of a study. If the FDA determines that financial interests of any clinical investigator raise serious questions of data integrity, the FDA can institute a data audit, request that we submit further data analyses, conduct additional independent studies to confirm the results of the questioned study, or refuse to use the data from the questioned study as a basis for approval. A finding by the FDA that a financial relationship of an investigator raises serious questions of data integrity could delay or otherwise adversely affect approval of our products.

In December 2025, the BIOSECURE Act was enacted as part of the FY2025 National Defense Authorization Act and signed into law. The BIOSECURE Act prohibits US government contractors and subcontractors from using biotechnology equipment or services from biotechnology companies of concern (BCOC) in performance of a US government contract. BCOCs are: (1) entities on the 1260H List, (2) entities included on a list to be developed by the Office of Management and Budget (OMB) (the OMB List) based on certain criteria set out in the BIOSECURE Act, and (3) any subsidiary, parent, or successor of a BCOC, if that entity meets the criteria set out for the OMB List. We do business with companies in China. If we determine that we do business with a company that is currently or later determined to be a BCOC we may be prohibited from selling certain products to the US government following a five-year grandfathering period starting from the effective date of the BIOSECURE Act's prohibition. It is possible some of our contractual counterparties may be impacted by this legislation, causing delay in our manufacturing activities while we find replacements.

These risks may materially harm our business, financial condition, results of operations and prospects and the value of our common stock.

We may not have, or may be unable to obtain, sufficient quantities of ARIKAYCE, Lamira, BRINSUPRI, or our product candidates to meet our required supply for commercialization or clinical studies, which may materially harm our business.

We do not have any in-house manufacturing capability other than for small-scale pre-clinical development programs and depend completely on a small number of third-party manufacturers and suppliers for the manufacture of our products and product candidates for both clinical and commercial needs. For instance, we are and expect to remain dependent on Resilience and Patheon to supply ARIKAYCE both for our clinical trials and commercial sale. Resilience manufactures placebo for our clinical trials and our current supply of ARIKAYCE for commercial sale. In addition, Esteve manufactures the active pharmaceutical ingredient for brensocatib, and Patheon Inc. manufactures our current supply of BRINSUPRI. However, we may not be able to maintain adequate quantities to meet future demand, including as a result of manufacturing and/or quality issues experienced by our third-party manufacturers or higher customer demand than expected. If we encounter delays or difficulties in the manufacturing process that disrupt our ability to supply our distributors and others with ARIKAYCE, BRINSUPRI, or our product candidates, including as a result of any efforts to establish manufacturing relationships in the US, we may experience product stock-outs, which would likely have a material adverse effect on our business and reputation.

In addition, we have entered into certain agreements with Patheon related to increasing our long-term production capacity for ARIKAYCE commercial inventory, although Patheon's supply obligations will commence only after certain technology transfer and construction services are completed. Any delay in the commencement of Patheon's supply obligations, whether due to delays in technology transfer and construction or from adding Patheon to our NDA as a CMO, would increase the risks associated with Resilience being unable to provide us with an adequate supply of ARIKAYCE.

We are also dependent on PARI being able to provide an adequate supply of nebulizers for commercial sale of ARIKAYCE, any ongoing clinical trials, and future commercial sales of our product candidates that use Lamira as their delivery mechanism, as PARI is the sole manufacturer of Lamira. We have no alternative supplier for the nebulizer, and because significant effort and time were expended in the optimization of the nebulizer for use with ARIKAYCE, we do not intend to seek an alternative or secondary supplier. In the event PARI cannot provide us with sufficient quantities of the nebulizer, replication of the optimized device by another party would likely require considerable time and additional regulatory approval. In the case of certain specified supply failures, we have the right under our commercialization agreement with PARI to make the nebulizer and have it made by certain third parties, but not those deemed under the commercialization agreement to compete with PARI.

We also will be reliant on CMOs to manufacture supply of TPIP for our future requirements. We plan to enter into commercial agreements with CMOs for TPIP, and cannot guarantee that we will be able to locate adequate partners or enter into favorable agreements with them.

We are evaluating developing in-house clinical manufacturing capability for our gene therapy product candidates, but we expect to rely on third-party CMOs for manufacturing of all testing materials for the foreseeable future. Products intended

for use in gene therapies are novel, complex and difficult to manufacture. If we develop in-house clinical manufacturing capability for our gene therapy product candidates, we may encounter delays in obtaining regulatory approval of our manufacturing processes or in complying with ongoing manufacturing regulatory requirements and applicable cGMP, including challenges related to producing adequate quantities of clinical grade materials that meet FDA, EMA, MHLW or other applicable standards or specifications with consistent and acceptable production yields and costs.

We do not have long-term commercial agreements with all of our suppliers and if any of our suppliers are unable or unwilling to perform for any reason, we may not be able to locate suppliers or enter into favorable agreements with them.

An inadequate supply of ARIKAYCE, Lamira, BRINSUPRI, or our product candidates may harm our commercial efforts or delay or impair clinical trials of ARIKAYCE or our product candidates and adversely affect our business, financial condition, results of operations and prospects and the value of our common stock.

Adverse consequences to our business may result if we or our manufacturing partners fail to comply with applicable regulations or maintain required approvals.

Manufacturers of ARIKAYCE, Lamira, BRINSUPRI, and our product candidates are subject to cGMP, Quality System Regulations and similar standards. While we have policies and procedures in place to select third-party manufacturers for our product and product candidates that adhere, and monitor their adherence to, such standards, they may nonetheless fail to do so. Similarly, while we have entered into a Commercialization Agreement with PARI for the manufacture of Lamira for use with ARIKAYCE, PARI and its affiliates involved in manufacturing may fail to adhere to applicable standards. These manufacturers and their facilities will be subject to periodic review and inspections by the FDA and other regulatory authorities following regulatory approval of our products, as with ARIKAYCE and BRINSUPRI. For instance, to monitor compliance with applicable regulations, the FDA routinely conducts inspections of facilities and may identify potential deficiencies. The FDA issues what are referred to as "Form 483s" that set forth observations and concerns identified during its inspections. Failure to satisfactorily address the concerns or potential deficiencies identified in a Form 483 could result in the issuance of a warning letter, which is a notice of the issues that the FDA believes to be significant regulatory violations requiring prompt corrective actions. Failure to respond adequately to a warning letter, or to otherwise fail to comply with applicable regulatory requirements may result in enforcement, remedial and/or punitive actions by the FDA or other regulatory authorities.

If one of these manufacturers fails to maintain compliance with regulatory requirements or experiences supply problems, including in the scale-up of commercial production, the production of ARIKAYCE, Lamira, BRINSUPRI, and our product candidates could be interrupted, resulting in delays, additional costs or restrictions on the marketing or sale of our products. An alternative manufacturer would need to be qualified, through regulatory filings, which could result in further delay. The regulatory authorities may also require additional testing if a new manufacturer is relied upon for commercial production. In addition, with respect to our product candidates, our manufacturers and their facilities are subject to pre-approval cGMP inspection by the FDA and other regulatory authorities, and the findings of the cGMP inspection may result in a failure to obtain, or a delay in obtaining, regulatory approval for future product candidates.

Risks Related to the Operation of our Business

We are dependent on retaining and attracting key personnel, the loss of whose services may materially adversely affect our business, financial condition, results of operations and prospects and the value of our common stock.

We depend heavily on our management team and our principal commercial and clinical personnel, the loss of whose services might significantly delay or prevent the achievement of our research, development or commercialization objectives. Our success depends, in large part, on our ability to attract and retain qualified management, clinical and commercial personnel, including those who join us through our business development activities. Our inability to retain and attract personnel could also negatively impact our ability to develop and maintain important relationships with commercial partners, leading research institutions and key distributors.

Competition for skilled personnel in our industry and market is intense because of the numerous pharmaceutical and biotechnology companies that seek similar personnel. These companies may have greater financial and other resources, offer a greater opportunity for career advancement and have a longer history in the industry than we do. We also experience competition for the hiring of our commercial and clinical personnel from universities, research institutions, and other third parties. We cannot assure that we will attract and retain such personnel or maintain such relationships. Our inability to retain and attract qualified employees may materially harm our business, financial condition, results of operations and prospects and the value of our common stock.

We expect to continue to expand our development, regulatory and sales and marketing capabilities and, as a result, may encounter difficulties in managing our growth, which may disrupt our operations.

In connection with our commercialization of ARIKAYCE in the US, Europe, and Japan and BRINSUPRI in the US, our continued international expansion efforts, and our ongoing development and planned commercialization of our product

candidates, if approved, we expect to continue to experience significant growth in the number of our employees and the scope of our operations, particularly in the areas of drug development, regulatory affairs, quality, commercial compliance, medical affairs, and sales and marketing. For example, we plan to continue to hire additional personnel to support ARIKAYCE and BRINSUPRI and advance our clinical and pre-clinical programs. To manage our anticipated future growth, we must continue to implement and improve our managerial, operational and financial systems, expand our facilities and continue to recruit and train additional qualified personnel, all while seeking to maintain our culture. Due to the limited experience of our management team in managing a company with this anticipated growth, we may not be able to effectively manage the expansion of our operations or recruit and train additional qualified personnel. The physical expansion of our operations may lead to significant costs and may divert our management and business development resources. We may not be able to effectively manage the expansion of our operations, which may delay the execution of our business plans or disrupt our operations.

Any acquisitions we have made or may make in the future, or collaborative relationships we have entered into or may enter into in the future, may not be clinically or commercially successful, and may require financing or a significant amount of cash, which may adversely affect our business.

As part of our business strategy, we may effect acquisitions or licenses to obtain additional businesses (or rights therein), products, technologies, capabilities and personnel. For example, we acquired Motus Biosciences, Inc. (Motus) and AlgaeneX, Inc. (AlgaeneX) in August 2021 (together, the Business Acquisition), Vertuis Bio, Inc. (Vertuis) in January 2023, and Adrestia Therapeutics Ltd. (Adrestia) in June 2023, each a privately-held, pre-clinical stage company. In December 2025, we acquired INS1148, an investigational monoclonal antibody, which we plan to advance into Phase 2 development programs in interstitial lung disease and moderate to severe asthma. Acquisitions involve a number of operational risks, including:

- Failure to achieve expected synergies;
- The possibility that our acquired technologies, products and product candidates may not be commercially successful;
- Difficulty and expense of assimilating the operations, technology and personnel of any acquired business;
- The inability to retain the management, key personnel and other employees of any acquired business;
- The inability to maintain any acquired company's relationship with key third parties, such as alliance partners;
- Exposure to legal claims or other liabilities for activities of or related to any acquired business or asset prior to acquisition;
- Diversion of our management's attention from our core business; and
- Potential impairment of intangible assets, adversely affecting our reported results of operations and financial condition.

We also may enter into collaborative relationships that would involve our collaborators conducting proprietary development programs. Disagreements with collaborators may develop over the rights to our intellectual property, and any conflict with our collaborators could limit our ability to obtain future collaboration agreements and negatively influence our relationship with existing collaborators.

If we make one or more significant acquisitions or enter into a significant collaboration in which the consideration includes cash, we may be required to use a substantial portion of our available cash and/or need to raise additional capital, which may adversely affect our financial condition.

We may be subject to product liability claims, and we have only limited product liability insurance.

The manufacture and sale of human therapeutic products involve an inherent risk of product liability claims, particularly as we continue to commercialize ARIKAYCE and BRINSUPRI and look to commercialize our product candidates, if approved. Regardless of merit or eventual outcome, liability claims may result in:

- Decreased demand for ARIKAYCE, BRINSUPRI, and any other products that we may commercialize, and a corresponding loss of revenue;
- Substantial monetary awards to patients or trial participants;
- Significant time and costs to defend the related litigation;
- Withdrawal or reduced enrollment of clinical trial participants; and
- Reputational harm and significant negative media attention.

We have limited product liability insurance for our products. We do not know if we will be able to maintain existing, or obtain additional, product liability insurance on acceptable terms or with adequate coverage against potential liabilities. This type of insurance is expensive and may not be available on acceptable terms. If we are unable to obtain or maintain sufficient insurance coverage on reasonable terms or to otherwise protect against potential product liability claims, we may be unable to commercialize our products. A successful product liability claim brought against us in excess of our insurance coverage, if any, may require us to pay substantial amounts and may materially adversely affect our business, financial condition, results of operations and prospects and the value of our common stock.

Our business and operations, including our drug development and commercialization programs, may be materially disrupted and/or subject to reputational harm in the event of system failures, security breaches, cyber-attacks, deficiencies in cybersecurity, violations of data protection laws or data loss or damage by us or third parties.

We are dependent on information technology systems, infrastructure, and data to operate our business. In the ordinary course of our business, we collect and store sensitive data, including intellectual property, our proprietary business information and that of our suppliers, as well as personally identifiable information, including health information, of clinical trial participants, patients and employees. Despite the implementation of security measures, our internal computer systems and those of our CROs, CMOs and other contractors and consultants are vulnerable to damage from computer viruses, unauthorized access, natural disasters, terrorism, war and telecommunication and electrical failures. Such an event could have a material adverse effect on our business operations, including a material disruption of our drug development and commercialization programs.

It is critical that we maintain such sensitive data in a manner that preserves its confidentiality and integrity. Unauthorized use or disclosure of or access to sensitive patient or employee data, including personally identifiable information, whether through breach of computer systems, systems failure, employee negligence, fraud or misappropriation, or otherwise, or whether by our employees or third parties, could result in negative publicity, legal liability and damage to our reputation. Unauthorized use or disclosure of or access to personally identifiable information could also expose us to sanctions for violations of data privacy laws and regulations around the world. In addition, the loss of clinical trial data for our product candidates could result in delays in our regulatory submissions and approval efforts and significantly increase our costs to recover or reproduce the data, if such recovery or reproduction is possible. To the extent that any disruption or security breach resulted in a loss of or damage to data or applications, or unauthorized disclosure of confidential or proprietary information, we could incur liability and the further development of our product candidates could be delayed. For example, the loss of or damage to clinical trial data, such as from completed or ongoing clinical trials, for any of our product candidates could result in delays in our regulatory approval efforts and significantly increase our costs to recover or reproduce the data. Likewise, we rely on third parties for the manufacture of our drug candidates or any future drug candidates and to conduct clinical trials, and similar events relating to their systems and operations may also have a material adverse effect on our business.

We have previously been, and expect to remain, the target of cyber-attacks. We may not be able to anticipate all types of security threats, and we may not be able to implement preventive measures effective against all such security threats. The techniques used by cyber criminals change frequently, may not be recognized until launched, and can originate from a wide variety of sources, including outside groups such as external service providers, organized crime affiliates, terrorist organizations, or hostile foreign governments or agencies. Notifications and follow-up actions related to a security incident could impact our reputation or cause us to incur substantial costs, including legal and remediation costs, in connection with these measures and otherwise in connection with any actual or suspected security breach. Although we have general liability insurance coverage, including coverage for errors and omissions and potential cybersecurity breaches, our insurance may not cover all claims, continue to be available on reasonable terms or be sufficient in amount to cover one or more large claims; additionally, the insurer may disclaim coverage as to any claim. The successful assertion of one or more large claims against us that exceed or are not covered by our insurance coverage or changes in our insurance policies, including premium increases or the imposition of large deductible or co-insurance requirements, may have a material adverse effect on our business, financial condition, results of operations and prospects and the value of our common stock.

We are subject to laws and regulations that govern how we can collect, process, store, and transfer personal data and sensitive data, and violations may result in meaningful penalties, enforcement, and/or reputational harm and have a significant impact on our operations.

Laws and regulations governing personal data and sensitive data continue to develop at a rapid pace, and jurisdictions around the world continue to propose new legislation and rules. For example, a number of US states have passed consumer privacy laws, consumer health data laws, and genetic privacy laws. Other jurisdictions outside of the US either have data protection laws in place or continue to advance proposals for similar legislation and regulation. In the US, the Department of Justice also has adopted rules for bulk US sensitive data, including health and genomic data. These laws place restrictions on how we collect, use, and transfer data, and they result in increased compliance and operational costs, especially if we continue to expand our international operations. Noncompliance with data protection laws and regulations can result in meaningful penalties, enforcement, and/or reputational harm and have a significant impact on our operations.

Our inability to access, upgrade or expand our technology systems or difficulties in updating our existing technology or developing or implementing new technology may have a material adverse effect on our business or results of operations.

If we are unable to successfully continue upgrading or expanding our technological capabilities to support our growth or if there are deficiencies in the design or implementation of such capabilities, we may not be able to take advantage of market opportunities, manage our costs effectively, manage our inventory, maintain a secure data environment, file timely reports with the SEC, or otherwise efficiently manage our internal controls. In addition, costs, potential problems and interruptions associated with the implementation of new or upgraded systems and technology, or with maintenance or adequate support of existing systems, could also disrupt or reduce the efficiency of our operations. Moreover, many of our vendors provide their

services to us via a cloud-based model instead of software that is installed on our premises. As a result, we depend upon our vendors to provide us with services that are always available and are free of errors or defects that could cause disruptions in our business processes. Any failure by such vendors to do so, or any disruption in our ability to access the Internet, may materially and adversely affect our ability to manage our operations.

We are subject to a number of risks associated with our international activities and operations and may not be successful in any efforts to further expand internationally.

As of December 31, 2025, we had 238 employees located in Europe and 152 employees located in Japan, although we have clinical trial sites and suppliers located around the world. In order to meet our long-term goals, we may further expand our international operations over the next several years, including in Europe and Japan, and continue to source material used in the manufacture of our product candidates from abroad. Additionally, a substantial portion of our commercial supply of ARIKAYCE is currently manufactured in Canada, our commercial supply of BRINSUPRI is also manufactured in Canada, and our supply of treprostinil palmitil, the treprostinil prodrug present in TPIP, is currently dependent on a single supplier located in Taiwan. Consequently, we are and will continue to be subject to risks related to operating in foreign countries, including:

- Difficulties ensuring compliance with international regulatory requirements;
- An inability to achieve optimal pricing and reimbursement for ARIKAYCE and/or BRINSUPRI, if approved in another jurisdiction, or subsequent changes in reimbursement, pricing and other regulatory requirements;
- Any implementation of, or changes to, tariffs, trade barriers and other import-export regulations in the US or other countries in which we, or our third-party partners, operate;
- Unexpected AEs related to ARIKAYCE, BRINSUPRI or our product candidates occurring in foreign markets that we have not experienced in the US, Europe or Japan;
- Scrutiny from customers, regulators, investors and other stakeholders related to environmental, health and safety, diversity, labor conditions, human rights and other concerns in the countries in which we, or our third-party partners, operate;
- Economic and political conditions, including foreign currency fluctuations, and inflation, could result in reduced revenue, increased or unpredictable operating expenses and other obligations incident to doing business in, or with a company located in, another country;
- Geopolitical events, such as conflicts, war and terrorism, could cause disruptions in our international operations, including our supply chain and planned or ongoing clinical studies, such as the geopolitical risks with respect to China and Taiwan, which could impact our ability to manufacture TPIP drug substance; and
- Compliance with foreign or US laws, rules and regulations, including data privacy requirements, labor relations laws, tax laws, anti-competition regulations, import, export and trade restrictions, anti-bribery/anti-corruption laws, regulations or rules, which could lead to actions by us or our distributors, manufacturers, other third parties who act on our behalf or with whom we do business in foreign countries or our employees who are working abroad that could subject us to investigation or prosecution under such foreign or US laws.

These and other risks associated with our international operations may materially adversely affect our business, financial condition, results of operations and prospects and the value of our common stock.

We operate in a highly competitive and changing environment, and if we are unable to adapt to our environment, we may be unable to compete successfully.

Biotechnology and related pharmaceutical technology have undergone and are likely to continue to experience rapid and significant change. Our future success will depend in large part on our ability to maintain a competitive position with respect to these technologies and to obtain and maintain protection for our intellectual property. Compounds, products or processes that we develop or that are developed on our behalf may become obsolete before we recover any expenses incurred in connection with their development. We face substantial competition from pharmaceutical, biotechnology and other companies, universities and research institutions with respect to NTM lung disease, bronchiectasis, PAH, PH-ILD, PPF, and IPF, and our gene therapy indications, and will face substantial competition with respect to future product candidates we may develop in these and other disease areas. Relative to us, some of these entities have substantially greater capital resources, research and development staffs, facilities and experience in conducting clinical studies, obtaining regulatory approvals, and manufacturing and marketing pharmaceutical products. Many of our competitors may achieve product commercialization or obtain patent protection earlier than us. Furthermore, we believe that our competitors have used, and may continue to use, litigation and patent office challenges to gain a competitive advantage. Our competitors may also use different technologies or approaches to develop products similar to ARIKAYCE, BRINSUPRI, and our product candidates.

We expect that competing successfully will depend on, among other things, the relative speed with which we can develop products, complete the clinical testing and regulatory approval processes and supply commercial quantities of the product to the market, as well as product efficacy, safety, reliability, availability, timing and scope of regulatory approval and

price. We expect competition to increase as technological advances are made and commercial applications broaden. There are potential competitive products, both approved and in development, which include oral, systemic, or inhaled antibiotic products to treat chronic respiratory infections. For instance, certain entities have expressed interest in studying their products for lung disease and are seeking to advance studies in lung disease, including NTM lung disease caused by mycobacterial species other than MAC. We are not aware of any entities currently conducting clinical trials for the treatment of refractory MAC lung disease or of any other approved inhaled therapies specifically indicated for NTM lung disease in North America, Europe or Japan. If any of our competitors develops a product that is more effective, safe, tolerable or convenient, or less expensive than ARIKAYCE, BRINSUPRI, or our product candidates, if approved, it would likely materially adversely affect our ability to generate revenue. We also may face lower priced generic competitors if third-party payors encourage use of generic or lower-priced versions of our product or if competing products are imported into the US or other countries where we may sell ARIKAYCE or BRINSUPRI. In addition, in an effort to put downward pressure on drug pricing, Congress and the FDA are working to facilitate generic competition, which could result in our experiencing competition earlier than otherwise would be the case.

There are also other amikacin products that have been approved by the FDA, MHLW and other regulatory agencies for use in other indications, and physicians may elect to prescribe those products rather than ARIKAYCE to treat the indications for which ARIKAYCE has received approval, which is commonly referred to as off-label use. Although regulations prohibit a drug company from promoting off-label use of its product, the FDA and other regulatory agencies do not regulate the practice of medicine and cannot direct physicians as to what product to prescribe to their patients. As a result, we would have limited ability to prevent any off-label use of a competitor's product to treat diseases for which we have received FDA or other regulatory agency approval, even if this use violates our patents or any statutory exclusivities that the FDA may grant for the use of amikacin to treat such diseases.

In addition, based in part on our successful Phase 2b WILLOW and Phase 3 ASPEN trials in bronchiectasis, certain entities have expressed interest in studying other DPP1 inhibitors for the treatment of bronchiectasis. We are aware of several other entities currently conducting clinical trials for the treatment of bronchiectasis with a DPP1 inhibitor. If any of these competitors develops a DPP1 inhibitor product that is more effective, safe, tolerable or convenient, it would likely materially adversely affect our ability to generate revenue through sales of BRINSUPRI. Additionally, based in part on our Phase 2b trial of TPIP in PAH, we have also initiated, or plan to initiate, Phase 3 trials of TPIP in PAH, PH-ILD, PPF, and IPF, for each of which indications there exist approved commercial therapies. If TPIP is approved for any of these indications, we will face substantial competition, and physicians may elect to prescribe, or patients may prefer, our competitors' products rather than TPIP. If we are unable to compete successfully, it would materially adversely affect our business, financial condition, results of operations and prospects and the value of our common stock.

We have a limited number of significant customers and losing any of them may have an adverse effect on our financial condition and results of operations.

Our three largest customers as of December 31, 2025 accounted for 74% and 85% of our total gross product revenue for the years ended December 31, 2025 and 2024, respectively. The degree to which a limited number of customers make up a significant portion of our gross product revenue may change as we continue to commercialize ARIKAYCE, BRINSUPRI, and, if approved, our product candidates in additional markets. There can be no guarantee that we will be able to sustain our accounts receivable or gross sales levels from our key customers. If, for any reason, we were to lose, or experience a decrease in the amount of business with our largest customers, whether directly or through our distributor relationships, our financial condition and results of operations may be negatively affected.

Deterioration in general economic conditions in the US, Europe, Japan and globally, including the effect of prolonged periods of inflation on our suppliers, third-party service providers and potential partners, may harm our business and results of operations.

Our business and results of operations may be adversely affected by changes in national or global economic conditions. These conditions include but are not limited to inflation, rising interest rates, limited availability of financing, energy availability and costs, the negative impacts caused by public health crises, negative impacts resulting from the military conflict between Russia and Ukraine or the instability in the Middle East, relations between the US and China, and the effects of governmental initiatives to manage economic conditions. Impacts of such conditions may be passed on to our business in the form of higher costs for labor and materials, possible reductions in pharmaceutical industry-wide spending on research and development and acquisitions and higher costs of capital.

The emergence of a pandemic, and efforts to reduce its spread, may negatively impact our business and operations.

Our global operations expose us to risks associated with public health crises and pandemics, particularly as the patients we seek to treat suffer from serious diseases that may make them especially vulnerable. A pandemic may also have an adverse impact on our operations and supply chain as a result of (i) our or our third-party manufacturers' employees or other key personnel becoming infected, (ii) preventive and precautionary measures that governments and we and other businesses,

including our third-party manufacturers, are taking, such as border closures, prolonged quarantines and other travel restrictions, (iii) shortages of supplies necessary for the manufacture of ARIKAYCE or BRINSUPRI, including as a result of government orders providing for the requisition of personal protective equipment and other medical supplies and equipment, and (iv) cold-chain storage and shipping limitations resulting from the need to prioritize delivery of vaccines, which could cause disruptions or delays in our ability to distribute ARIKAYCE due to lack of sufficient cold-chain storage and shipping capacity. Any of these circumstances could impact the ability of third parties on which we rely to manufacture ARIKAYCE and BRINSUPRI or their components and our ability to perform critical functions, which could significantly hamper our ability to supply ARIKAYCE and BRINSUPRI to patients. While we have experienced no disruption to date in our supply chain due to a pandemic, if we encounter delays or difficulties in the manufacturing process that disrupt our ability to supply ARIKAYCE or BRINSUPRI, we may not be able to satisfy patient demand or we may experience a product stock-out, which may have a material adverse effect on our business.

The emergence of a pandemic could also require us to delay the start of new clinical trials or otherwise impair our ability to complete those trials. For instance, our ability to enroll patients and retain principal investigators and site staff could be impaired due to an outbreak in their geography or prioritization of hospital resources toward the outbreak, or as a result of quarantines and other travel restrictions that interrupt healthcare services. Furthermore, patients, investigators, or site staff may be unwilling or unable to comply with clinical trial protocols due to illness, concerns about a pandemic, or quarantines or other travel restrictions that impede their movement. Additionally, any interruption in the supply of the study drug might delay our ability to start or complete clinical trials. Significant delays in the timing and completion of our clinical trials are costly and may adversely affect our ability to satisfy our post-marketing requirements for ARIKAYCE and to obtain regulatory approval for and to commercialize our product candidates.

Our current and potential future use of AI and machine learning may not be successful and presents new risks and challenges to our business.

We currently integrate AI and machine learning in certain of our research and development activities, including identification of potential product candidates, and are seeking to further integrate AI and machine learning throughout our business. We are exploring additional opportunities to incorporate AI and machine learning into our processes for drug discovery, drug development, drug commercialization, and in connection with our enabling functions. For example, we are using AI to explore potential business development opportunities. Such efforts may not be successful. Issues relating to the use of new and evolving technologies such as AI and machine learning may cause us to experience brand or reputational harm, competitive harm, legal liability, and new or enhanced governmental or regulatory scrutiny, and we may incur additional costs to resolve such issues.

As with many innovations, AI presents risks and challenges that could undermine or slow its adoption, and therefore harm our business. Developing, testing and deploying AI systems may also increase our operating costs due to the nature of the computing costs involved in such systems, which could adversely affect our business, financial condition and results of operations. The use of AI by us and our business partners may lead to novel and urgent cybersecurity risks, which could have a material adverse effect on our operations and reputation as well as the operations of any of our business partners. We may also face increased competition from other companies that are using AI, some of whom may develop more effective methods than we and any of our business partners have, which could have a material adverse effect on our business, results of operations, or financial condition. In addition, our efforts to develop, acquire or integrate these technologies will involve significant time, costs, and other resources, and may divert our management team's attention and focus from executing on other elements of our strategy. Furthermore, laws and regulations governing the use of AI continue to develop at a rapid pace, and jurisdictions around the world continue to propose new legislation and rules. Uncertainties regarding developing legal and regulatory requirements and standards may require significant resources to modify and maintain business practices to comply with US and non-US laws concerning the use of AI.

Risks Related to Our Intellectual Property

If we are unable to protect our intellectual property rights adequately, the value of ARIKAYCE, BRINSUPRI, and our product candidates may be materially diminished.

The patent position of biotechnology and pharmaceutical companies generally is highly uncertain and involves complex legal, technical, scientific and factual questions, and our success depends in large part on our ability to protect our proprietary technology and to obtain and maintain patent protection for our products, prevent third parties from infringing our patents, both domestically and internationally. We have sought to protect our proprietary position by filing patent applications in the US and abroad related to our novel technologies and products that are important to our business. This process is expensive and time-consuming, and we may not be able to file and prosecute all necessary or desirable patent applications at a reasonable cost or in a timely manner. It is also possible that we will fail to identify patentable aspects of our research and development output before it is too late to obtain patent protection. Our existing patents and any future patents we obtain may

not be sufficiently broad to prevent others from using our technologies or from developing competing products and technologies.

Even if our owned and licensed patent applications issue as patents, they may not issue in a form that will provide us with any meaningful protection or otherwise provide us with any competitive advantage. Any conclusions we may reach regarding non-infringement, inapplicability or invalidity of a third party's intellectual property vis-à-vis our proprietary rights, or those of a licensor, are based in significant part on a review of publicly available databases and other information. There may be information not available to us or otherwise not reviewed by us that could render these conclusions inaccurate. Our competitors may also be able to circumvent our owned or in-licensed patents by developing similar or alternative technologies or products in a non-infringing manner.

Additionally, patents issued to us or our licensors may be challenged, narrowed, invalidated, held to be unenforceable or circumvented through litigation, either in district court, the US international trade commission (ITC) or US patent office (USPTO), or in analogous foreign courts and patent offices, which could limit our ability to stop competitors from marketing similar products or reduce the term of patent protection for ARIKAYCE, BRINSUPRI, or our product candidates. US patents and patent applications may also be subject to interference or derivation proceedings, and US patents may be subject to re-examination proceedings, reissue, post-grant review and/or *inter partes* review in the USPTO. Our foreign patents have been and may be in the future subject to opposition or comparable proceedings in the corresponding foreign patent office, which could result in either loss of the patent or denial of the patent application or loss or reduction in the scope of one or more of the claims of the patent or patent application. See *Intellectual Property—ARIKAYCE Patents* in Item 1 of Part I of this Annual Report on Form 10-K for more information on our European patents that have been previously opposed.

Changes in either patent laws or in interpretations of patent laws in the US and other countries may also diminish the value of our intellectual property or narrow the scope of our patent protection, including making it easier for competitors to challenge our patents. For example, the America Invents Act included a number of changes to established practices, including the transition to a first-inventor-to-file system and new procedures for challenging patents and implementation of different methods for invalidating patents.

If we do not obtain patent term extension for BRINSUPRI or our product candidates, if needed, our business may be harmed.

Under the Drug Price Competition and Patent Term Restoration Act of 1984 (the Hatch-Waxman Amendments), which amended the FDCA, one or more of our US patents that we may own in the future may be eligible for limited patent term extension, depending upon the timing, duration and specifics of any FDA marketing approval of our product candidates and our technology. The Hatch-Waxman Amendments permit a patent extension term of up to five years as compensation for patent term lost during the FDA regulatory review process. A patent term extension cannot extend the remaining term of a patent beyond a total of 14 years from the date of product approval. Only one patent may be extended and only those claims covering the approved product, a method for using it for its approved use, or a method for manufacturing it may be extended. In addition, patent term extension is only applicable for the first approved indication for a product. The application for the extension must be submitted prior to the expiration of the patent for which extension is sought, and, in the US, within 60 days of product approval. A patent that covers multiple products for which approval is sought can only be extended in connection with one of the approvals. However, we may not be granted an extension because of, for example, failing to exercise due diligence during the testing phase or regulatory review process, failing to apply within applicable deadlines, failing to apply prior to expiration of relevant patents or otherwise failing to satisfy applicable requirements. Moreover, the applicable time period or the scope of patent protection afforded could be less than we request. If we are unable to obtain patent term extension or the term of any such extension is less than we request, our competitors may obtain approval of competing products following our patent expiration, and our revenue could be reduced. Any of the foregoing may have a material adverse effect on our business, financial condition, results of operations and prospects.

If we are not able to adequately prevent disclosure of trade secrets and other proprietary information, the value of ARIKAYCE, BRINSUPRI, and our product candidates may be materially diminished.

We rely on trade secrets to protect our proprietary technologies, especially where we do not believe patent protection is appropriate or obtainable. However, trade secrets are difficult to protect. We rely in part on confidentiality and restrictive covenant agreements with our employees, consultants, advisors, collaborators, and other third parties and partners to protect our trade secrets and other proprietary information. These agreements may not effectively prevent disclosure of confidential information or may not provide an adequate remedy in the event of unauthorized disclosure of confidential information. In addition, third parties may independently develop or discover our trade secrets and proprietary information. Regulators also may disclose information we consider to be proprietary to third parties under certain circumstances, including in response to third-party requests for such disclosure under the Freedom of Information Act or comparable laws. Additionally, the FDA, as part of its Transparency Initiative, has made additional information publicly available on a routine basis, including information that we may consider to be trade secrets or other proprietary information, and it is not clear at the present time whether and how the FDA's disclosure policies may change further in the future. Further, several states have limited or prohibited the use of post-employment non-compete agreements, and the Federal Trade Commission is challenging non-compete agreements on a

targeted, case-by-case basis, which could increase the difficulty of protecting trade secrets and other proprietary information. There are similar risks outside the US, such as the risk that a foreign regulatory agency would make available information we consider to be proprietary to third parties or the public, and the risks arising from other factors making it difficult to protect trade secrets, such as prohibitions or restrictions on post-employment non-compete agreements and other rules and regulations.

We may not be able to enforce our intellectual property rights throughout the world, which may harm our business.

The legal systems of some foreign countries, particularly developing countries, do not favor the enforcement of patents and other intellectual property protection, especially those relating to life sciences. Many companies have encountered significant problems in protecting and defending intellectual property rights in such foreign jurisdictions. For example, certain foreign countries have compulsory licensing laws under which a patent owner may be required to grant licenses to third parties. In addition, many countries limit the enforceability of patents against third parties, including government agencies or government contractors. In these countries, patents may provide limited or no benefit. This legal environment could make it difficult for us to stop the infringement of our patents or in-licensed patents or the misappropriation of our other intellectual property rights. Proceedings to enforce our patent rights in foreign jurisdictions may result in substantial costs and divert our efforts and attention from other aspects of our business, and our efforts to protect our intellectual property rights in such countries may be inadequate.

The drug research and development industry has a history of intellectual property litigation, and we may become involved in costly intellectual property disputes, which may delay or impair our product development efforts or prevent us from, or increase the cost of, commercializing ARIKAYCE, BRINSUPRI, or any other product candidates, if approved.

Third parties may claim that we have infringed upon or misappropriated their proprietary rights. Any existing third-party patents, or patents that may later issue to third parties, could negatively affect our commercialization of ARIKAYCE, BRINSUPRI, or any product candidate that receives regulatory approval. For instance, PAH is a competitive indication with established products, including other formulations of treprostinil. Our supply of treprostinil palmitil, the treprostinil prodrug present in TPIP, is dependent on a single supplier located in Taiwan. The supplier owns patents on its manufacturing process and crystalline drug product, and we have filed patent applications for TPIP; however, a competitor in the PAH or PH-ILD indication may claim that we or our supplier have infringed upon or misappropriated its proprietary rights. Moreover, in the event that we pursue approval of one of our product candidates via the 505(b)(2) regulatory pathway, we will be required to file a certification of non-infringement or invalidity against any unexpired patents listed in the Orange Book for the third-party drug we reference as part of our regulatory submission. This certification process may lead to litigation and could also delay approval and launch of a product candidate, if approved by regulators.

In the event of successful litigation or settlement of claims against us for infringement or misappropriation of a third party's proprietary rights, we may be required to take actions including, but not limited to, the following:

- Paying damages, including up to treble damages, royalties, and the other party's attorneys' fees, which may be substantial;
- Ceasing development, manufacture, marketing and sale of products or use of processes that infringe the proprietary rights of others;
- Expending significant resources to redesign our products or our processes so that they do not infringe the proprietary rights of others, which may not be possible, or may result in significant regulatory delays associated with conducting additional clinical trials or other steps to obtain regulatory approval; and/or
- Acquiring one or more licenses from third parties, which may not be available to us on acceptable terms or at all.

We may also have to undertake costly litigation or engage in other proceedings, such as interference or *inter partes* review, to enforce or defend the validity of any patents issued or licensed to us, to confirm the scope and validity of our or a licensor's proprietary rights or to defend against allegations that we have infringed a third party's intellectual property rights. Any proceedings regarding our intellectual property rights are likely to be time consuming and may divert management attention from operation of our business, and may have a material adverse effect on our business, financial condition, results of operations and prospects and the value of our common stock.

If we fail to comply with obligations in our third-party agreements, our business may be adversely affected, including by the loss of license rights that are important to our business.

We are a party to various agreements related to ARIKAYCE, BRINSUPRI, and our product candidates, including licensing agreements with PARI and AstraZeneca, which we view as material to our business. For additional information regarding the terms of these agreements, see *Business—License and Other Agreements* in Item 1 of Part I of this Annual Report on Form 10-K. These agreements impose a number of obligations on us and our business, including restrictions on our ability to freely develop or commercialize our products and product candidates and requirements to make milestone and royalty payments to our counterparties upon certain events. For example, under our license agreement with AstraZeneca, AstraZeneca retains a right of first negotiation pursuant to which it may exclusively negotiate with us before we can negotiate with a third party

regarding any transaction to develop or commercialize brensocatib, subject to certain exceptions. While this right of first negotiation is not triggered by a change of control, it may impede or delay our ability to consummate certain other transactions involving brensocatib.

If we fail to comply with our obligations under these agreements, our counterparties may have the right to take action against us, up to and including termination of a relevant license. For instance, under our license agreement with AstraZeneca, AstraZeneca may terminate our license to brensocatib if we fail to use commercially reasonable efforts to develop and commercialize a product based on brensocatib, or we are subject to a bankruptcy or insolvency. Reduction or elimination of our licensed rights may result in our having to negotiate new or reinstated licenses with less favorable terms and may materially harm our business.

Risks Related to Government Regulation

Healthcare legislation or other government action may materially adversely affect our business, financial condition, results of operations and prospects and the value of our common stock.

Our industry is highly regulated and changes in or revisions to laws and regulations that make gaining regulatory approval, reimbursement and pricing more difficult or subject to different criteria and standards may adversely impact our business, operations or financial results.

Changes to the ACA, to the Medicare or Medicaid programs, or to the ability of the federal government to negotiate or otherwise affect drug prices, or other federal legislation regarding healthcare access, financing or legislation in individual states, may affect our business, financial condition, results of operations and prospects and the value of our common stock. We may face similar challenges to gaining regulatory approval and sufficient reimbursement and pricing due to government healthcare reform in the EU, Japan and other jurisdictions where ARIKAYCE, BRINSUPRI, or any of our product candidates are approved. The Trump Administration has discussed several changes to the reach and oversight of the FDA, which may affect its relationship with the pharmaceutical industry, transparency in decision making and ultimately the cost and availability of prescription drugs.

Drug pricing is an active area for regulatory reform at both the federal and state levels, and additional significant changes to current drug pricing and reimbursement structures in the US and in other jurisdictions could be forthcoming. On May 12, 2025, the Trump Administration issued Executive Order 14297, “Delivering Most-Favored-Nation Prescription Drug Pricing to American Patients” (Executive Order 14297). Executive Order 14297 seeks to reduce prescription drug costs in the US by requiring manufacturers to sell certain drugs in the US at no higher than the lowest prices paid for those same drugs in other developed countries. Executive Order 14297 directs HHS to facilitate direct-to-consumer (DTC) purchasing programs for prescription drugs at the most-favored-nation (MFN) price that may bypass traditional supply chain intermediaries. The Trump Administration has warned that manufacturers that fail to make “significant progress” toward MFN pricing will face enumerated regulatory and enforcement consequences, and it sent a group of manufacturers a letter requesting engagement on such pricing. In September 2025, the Trump Administration began announcing deals with specific manufacturers to address its MFN goals. In addition, in late 2025, HHS proposed three payment models that would test MFN pricing in Medicaid, Medicare Part D, and Medicare Part B. On November 6, 2025, the Centers for Medicare & Medicaid Services (CMS) announced the “GENErating cost Reductions fOr U.S.” (GENEROUS) model under which manufacturers can provide MFN pricing to state Medicaid agencies on a voluntary basis, and on December 19, 2025, CMS published as a proposed rule the “Guarding U.S. Medicare Against Rising Drug Costs” (GUARD) model for products covered under Medicare Part D. If GUARD is finalized, pharmaceutical manufacturers would be required to pay MFN-based rebates on eligible products for 25% of eligible Medicare beneficiaries during the applicable testing period. MFN pricing pressures and DTC mechanisms could lead to voluntary or involuntary manufacturer price changes, which could be either temporary or long term, but all of which may adversely affect our business. Additionally, if our products are deemed subject to GUARD, we may determine to forego commercializing our products outside of the US, which may adversely affect our business.

The Trump Administration has also entered into agreements with several large pharmaceutical companies to reduce or offer discounts on the prices of certain of their products, and efforts by the Trump Administration to expand the number of companies entering into such agreements may result in us entering into such an agreement, which may adversely affect our business.

It also remains unclear how GENEROUS, GUARD or any other new legislation or regulation might affect the prices we may obtain for ARIKAYCE, BRINSUPRI, or any of our product candidates for which regulatory approval is obtained.

If we are found in violation of federal or state “fraud and abuse” laws, we may be required to pay a penalty or may be suspended from participation in federal or state healthcare programs, which may adversely affect our business, financial condition, results of operations and prospects and the value of our common stock.

In the US, we are subject to various federal and state healthcare “fraud and abuse” laws, including anti-kickback laws, false claims laws and other laws intended to reduce fraud and abuse in federal and state healthcare programs. Although we seek

to structure our business arrangements in compliance with all applicable requirements, these laws are broadly written, and it is often difficult to determine precisely how the law will be applied in specific circumstances. Accordingly, it is possible that our practices may be challenged under these laws. Violations of fraud and abuse laws may be punishable by criminal and/or civil sanctions, including fines or exclusion or suspension from federal and state healthcare programs such as Medicare and Medicaid and debarment from contracting with the US government, and our business, financial condition, results of operations and prospects and the value of our common stock may be adversely affected. Our reputation could also suffer. In addition, private individuals have the ability to bring actions on behalf of the government under the federal False Claims Act as well as under the false claims laws of several states.

Under the ACA and certain state laws, we are required to report information on payments or transfers of value to any US physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, or certified nurse-midwives (in each case who are not bona fide employees of the applicable manufacturer that is reporting the payment) and teaching hospitals, which is posted in searchable form on a public website. Failure to submit required information may result in civil monetary penalties.

Several states also impose other marketing restrictions or require pharmaceutical companies to make marketing or price disclosures to the state. In addition to the federal government, some states, as well as other countries, including France, require the disclosure of certain payments to healthcare professionals. The Health Insurance Portability and Accountability Act of 1996 (HIPAA), state, and foreign privacy laws may limit access to information identifying those individuals who may be prospective users or limit the ability to market to them. Some of these laws are new or ambiguous as to what is required to comply with their requirements, and we could be subject to penalties if it is determined that we have failed to comply with an applicable legal requirement.

We are subject to anti-corruption laws and trade control laws, as well as other laws governing our operations. If we fail to comply with these laws, we could be subject to negative publicity, civil or criminal penalties, other remedial measures, and legal expenses, which may adversely affect our business, financial condition, results of operations and prospects and the value of our common stock.

Our operations are subject to anti-corruption laws, including the US Foreign Corrupt Practices Act (FCPA), the UK Bribery Act and other anti-corruption laws that apply in countries where we do business. The FCPA, UK Bribery Act and these other laws generally prohibit us, our employees and our intermediaries from making prohibited payments to government officials or other persons to obtain or retain business or gain some other business advantage. We have conducted various studies at a broad range of trial sites around the world. Certain of these jurisdictions pose a risk of potential FCPA violations, and we have relationships with third parties whose actions could potentially subject us to liability under the FCPA or local anti-corruption laws. In addition, we cannot predict the nature, scope or effect of future regulatory requirements to which our international operations might be subject or the manner in which existing laws might be administered or interpreted.

We are also subject to other laws and regulations governing our international operations, including regulations administered by the US Department of Commerce’s Bureau of Industry and Security, the US Department of Treasury’s Office of Foreign Assets Control, and various non-US government entities, including applicable export control regulations, economic sanctions on countries and persons, customs requirements, currency exchange regulations and transfer pricing regulations (collectively, Trade Control laws).

We may not be effective in ensuring our compliance with all applicable anti-corruption laws, including the FCPA or other legal requirements, including Trade Control laws. If we are not in compliance with the FCPA and other anti-corruption laws or Trade Control laws, we may be subject to criminal and civil penalties, disgorgement and other sanctions and remedial measures, and legal expenses, which may have an adverse impact on our business, financial condition, results of operations and prospects and the value of our common stock. Likewise, even an investigation by US or foreign authorities of potential violations of the FCPA other anti-corruption laws or Trade Control laws may have an adverse impact on our reputation, business, financial condition, results of operations and prospects and the value of our common stock.

Our research, development and manufacturing activities used in the production of ARIKAYCE, BRINSUPRI, and our product candidates involve the use of hazardous materials, which may expose us to damages, fines, penalties and sanctions and materially adversely affect our results of operations and financial condition.

We are subject to numerous environmental, health and safety laws and regulations, including those governing laboratory procedures and the handling, use, storage, treatment and disposal of hazardous materials and wastes. Our research and development program and manufacturing activities for ARIKAYCE, BRINSUPRI, and our product candidates involve the controlled use of hazardous materials and chemicals. We generally contract with third parties for the disposal of these materials and wastes.

Although we strive to comply with all pertinent regulations, the risk of environmental contamination, damage to facilities or injury to personnel from the accidental or improper use or control of these materials remains. In addition to any

liability we could have for any misuse by us of hazardous materials and chemicals, we may also potentially be liable for activities of our CMOs or other third parties. Any such liability, or even allegations of such liability, may materially adversely affect our results of operations and financial condition. We also may incur significant costs as a result of civil or criminal fines and penalties.

In addition, we may incur substantial costs to comply with current or future environmental, health and safety laws and regulations. These current or future laws and regulations may impair our research, development or production efforts. Failure to comply with these laws and regulations also may result in substantial fines, penalties or other sanctions.

Inadequate funding for the FDA and other government agencies and/or shifting perspectives and/or priorities under the Trump Administration could continue to hinder the FDA's and/or those other government agencies' ability to hire and retain key leadership and other personnel or otherwise continue to negatively impact staffing, prevent new products and services from being developed or commercialized in a timely manner, or otherwise prevent those agencies from performing normal business functions on which the operation of our business may rely, which may negatively impact our business.

The ability of the FDA to review and approve new products, provide feedback on clinical trials and development programs, meet with sponsors and otherwise review regulatory submissions can be affected by a variety of factors, including government budget and funding levels; ability to hire and retain personnel and accept the payment of user fees; and statutory, regulatory, and policy changes, among other factors. Average review times at the agency may fluctuate as a result. In addition, government funding of other government agencies on which our operations may rely is subject to the political process, which is inherently fluid and unpredictable.

Disruptions or decreased staffing at the FDA and other agencies may also increase the time necessary for new drugs to be reviewed and/or approved by necessary government agencies or to otherwise respond to regulatory submissions which may adversely affect our business. In 2025, the FDA also experienced significant reductions in force that have impacted, and may continue to impact, the agency's ability to review applications in a timely manner. Additionally, over the last several years, the US government has shut down multiple times and certain regulatory agencies, such as the FDA, have had to furlough critical FDA and other government employees and stop critical activities. If funding for the FDA is reduced, agency staff continue to depart voluntarily or involuntarily, FDA priorities change, or a prolonged government shutdown occurs, it could significantly impact the ability of the FDA to timely review and process our regulatory submissions, which may have a material adverse effect on our business.

Risks Related to Our Financial Condition and Need for Additional Capital

We have a history of operating losses, expect to incur operating losses in the near term, and may never achieve or maintain profitability.

Since 2010, we have incurred losses in each year of our operation. As of December 31, 2025, our accumulated deficit was $5.6 billion. For the years ended December 31, 2025, 2024 and 2023, our consolidated net loss was $1,276.8 million, $913.8 million and $749.6 million, respectively. Our ability to generate revenue depends on the success of commercial sales of ARIKAYCE and BRINSUPRI; however, we do not anticipate achieving profitability for the foreseeable future. Despite commercialization of ARIKAYCE in the US, Europe, and Japan and BRINSUPRI in the US, we expect to continue to incur substantial operating expenses, and resulting operating losses, in the near term, as we:

- Initiate or continue clinical studies of our product candidates;
- Complete a post-marketing clinical trial of ARIKAYCE, consisting of the completed ARISE and ongoing ENCORE trials, as required by the FDA;
- Seek to discover or in-license additional product candidates;
- Support the sales and marketing efforts necessary for the continued commercialization of ARIKAYCE and BRINSUPRI;
- Scale-up manufacturing capabilities for future production of ARIKAYCE and BRINSUPRI, including the increase of production capacity at our manufacturers and process improvements in order to manufacture at a larger commercial scale;
- Seek the approval of BRINSUPRI in the UK and Japan and, if approved, potentially support the commercial launch of BRINSUPRI in those jurisdictions;
- Seek the approval of our product candidates in various markets and, if approved, support their commercial launch;
- File, prosecute, defend, and enforce patent claims related to ARIKAYCE, BRINSUPRI, and our product candidates; and
- Enhance operational, compliance, financial, quality and information management systems and hire more personnel, including personnel to support our commercialization efforts and development of our product candidates.

Even if we do achieve profitability, we may not be able to sustain or increase profitability on a quarterly or annual basis.

We may need to raise additional funds to continue our operations, and any failure to obtain capital when needed on acceptable terms, or at all, may force us to delay, reduce, or eliminate our development programs, commercialization efforts or other operations.

Our operations have consumed substantial amounts of cash since our inception. We expect to expend substantial financial resources to continue to commercialize ARIKAYCE and BRINSUPRI and conduct the confirmatory post-marketing ENCORE trial, seek full regulatory approval for ARIKAYCE, as well as continue research and development of our product candidates. We may need to raise additional capital to fund these activities, including due to changes in our product development plans or misjudgment of expected costs, to fund corporate development, to maintain our intellectual property portfolio or for other purposes, including to resolve litigation. Our operating expenses and long-term investments were significantly higher in 2025 than in 2024, reflecting our continued investment in the build-out of our commercial organization to support global expansion activities for ARIKAYCE, preparation for and execution of the commercial launch of BRINSUPRI, the manufacture of commercial inventory, which includes capital and long-term investments, and continued investment in research and development, including asset acquisitions, as well as selling, general and administrative expenses. We do not know whether additional financing will be available when needed, or, if available, whether the terms will be favorable to us. If adequate funds are not available to us when needed, we may be forced to delay, restrict or eliminate all or a portion of our development programs or commercialization efforts.

We have outstanding indebtedness in the form of a term loan and a royalty financing arrangement and may incur additional indebtedness in the future, which may adversely affect our financial position, prevent us from implementing our strategy, and, in certain cases, dilute the ownership interest of our existing shareholders.

In October 2022, we entered into a loan agreement (the Loan Agreement) with certain funds managed by Pharmakon and a revenue interest purchase agreement (the Royalty Financing Agreement) with OrbiMed. In October 2024, we entered into an Amended and Restated Loan Agreement (as subsequently amended on July 10, 2025, the A&R Loan Agreement) and amended the Royalty Financing Agreement.

The A&R Loan Agreement provides for a senior secured term loan of $350.0 million (in addition to the accrual and capitalization of $46.8 million of paid-in-kind interest under the Loan Agreement), which we drew in full in connection with our entry into the Loan Agreement (the Tranche A Term Loan). The A&R Loan Agreement amends the Loan Agreement to, among other items, add a new $150.0 million senior secured term loan tranche (the Tranche B Term Loan and, together with the Tranche A Term Loan, the Term Loans). The Term Loans bear interest at a fixed rate of 9.60% per annum. The A&R Loan Agreement extends the maturity date of the Term Loans to September 30, 2029, subject to acceleration to February 1, 2028 on the occurrence of certain prespecified events. As consideration for the provision of the Tranche B Term Loan, we agreed to pay Pharmakon a fee equal to 2.00% of the Tranche B Term Loan at the closing date of the Tranche B Term Loan and an additional exit fee of 2.00% of the amount of each prepayment or repayment of the Term Loans. The Term Loans will be repaid in eight equal quarterly payments starting on January 3, 2028.

Under the Royalty Financing Agreement, OrbiMed paid us $150.0 million in exchange for the right to receive, on a quarterly basis, royalties (the Royalty Financing) in an amount equal to 4.0% of ARIKAYCE global net sales prior to September 1, 2025 and 4.5% of ARIKAYCE global net sales on or after September 1, 2025, as well as 0.75% of brensocatib global net sales, which includes global net sales of BRINSUPRI (the Revenue Interest Payments). In the event that OrbiMed has not received aggregate Revenue Interest Payments equal to or greater than $150.0 million on or prior to March 31, 2028, the royalty rate for ARIKAYCE will be increased for all subsequent fiscal quarters to a rate that, if applied retroactively, would have resulted in aggregate Revenue Interest Payments to OrbiMed for all fiscal quarters ended on or prior to March 31, 2028 equal to $150.0 million. In addition, we must make a one-time payment to OrbiMed in an amount that, when added to the aggregate amount of Revenue Interest Payments received by OrbiMed as of March 31, 2028, would equal $150.0 million. The total Revenue Interest Payments payable by us to OrbiMed are capped at 1.8x of the purchase price or up to a maximum of 1.9x of the purchase price under certain conditions.

Our debt service obligations and the degree to which we are leveraged could have negative consequences on our business, such as the following:

- We may be more vulnerable to economic downturns, less able to withstand competitive pressures, and less flexible in responding to changing economic conditions;
- Our ability to obtain financing in the future may be limited;
- We may be required to sell debt or equity securities or to sell some of our core assets, possibly on unfavorable terms, to meet payment obligations;
- We may be placed at a possible competitive disadvantage with less leveraged competitors and competitors that may have better access to capital resources; and

- A substantial portion of our cash flows from operations in the future may be required for the payment of our interest or principal payments under the A&R Loan Agreement or Revenue Interest Payments under the Royalty Financing Agreement when they or any additional indebtedness become due, thereby reducing the amount of our cash flow available for other purposes, including funds for clinical development or to pursue future business opportunities.

Our ability to pay principal or interest on or, if desired, to refinance our indebtedness, including the A&R Loan Agreement and the Royalty Financing Agreement, depends on our future performance, which is subject to economic, financial, competitive and other factors, some of which are beyond our control. Our business may not generate cash flow from operations in the future sufficient to satisfy any obligations under the A&R Loan Agreement and the Royalty Financing Agreement or our obligations under any future indebtedness we may incur. If we are unable to generate such cash flow, we may be required to delay, restrict or eliminate all or a portion of our development programs or commercialization efforts or refinance or obtain additional equity capital on terms that may be onerous or highly dilutive. If we do not meet our debt obligations, it may materially adversely affect our results of operations, financial condition and the value of our common stock.

The A&R Loan Agreement and the Royalty Financing Agreement each contain customary affirmative and negative covenants that restrict our operations, including, among other things, restrictions on our ability to incur liens, incur additional indebtedness, make investments, engage in certain mergers and acquisitions or asset sales, and declare dividends or redeem or repurchase capital stock. The A&R Loan Agreement includes certain customary events of default. If a default occurs and is continuing, we may be required to repay all amounts outstanding under the A&R Loan Agreement. The Royalty Financing Agreement gives OrbiMed the option (the Put Option) to terminate the Royalty Financing Agreement and to require us to repurchase future Revenue Interest Payments upon enumerated events such as a bankruptcy event, a payment default, an uncured material breach or a change of control. The triggering of the Put Option, including by our failure to comply with these covenants, could permit OrbiMed to declare certain amounts to be immediately due and payable. Further, if we are liquidated, Pharmakon's and OrbiMed's rights to repayment would be senior to the rights of the holders of our common stock. Any triggering of the Put Option or other event of default under the A&R Loan Agreement or Royalty Financing Agreement could significantly harm our financial condition, business and prospects and could cause the price of our common stock to decline.

We may also incur additional indebtedness in the future which may result in increased fixed payment obligations, dilute the ownership interests of our existing shareholders, or result in additional restrictive covenants, such as limitations on our ability to incur additional debt, limitations on our ability to acquire, sell or license assets or intellectual property rights and other operating restrictions that may adversely impact our ability to conduct our business.

We may be unable to use certain of our net operating losses and other tax assets.

We have substantial tax loss carry forwards in the US (both federal and state), Ireland, the UK, and Switzerland. In general, our net operating losses and tax credits have been fully offset by a valuation allowance due to uncertainties surrounding our ability to realize these tax benefits. In particular, our ability to fully use certain US tax loss carry forwards and general business tax credit carry forwards recorded prior to December 2010 to offset future income or tax liability is limited under section 382 of the Internal Revenue Code of 1986, as amended. Changes in the ownership of our stock, including those resulting from the issuance of shares of our common stock offerings or upon exercise of outstanding options, may limit or eliminate our ability to use certain net operating losses and tax credit carry forwards in the future.

Changes in our effective income tax rate and future changes to US and non-US tax laws may adversely affect our results of operations.

We are subject to income taxes in the US and various ex-US jurisdictions in which we operate globally. Various factors may have favorable or unfavorable impacts on our effective tax rate, including changes in tax rates and laws, interpretations of existing laws, changes in accounting standards, changes in the jurisdiction of our pre-tax earnings and examinations of our tax filings. Changes in our effective income tax rate and future changes to US and non-US tax laws may adversely affect our results of operations.

Goodwill impairment charges in the future may have a material adverse effect on our business, results of operations and financial condition.

We have recorded a significant amount of goodwill on our consolidated balance sheet as a result of acquisitions. We review the recoverability of goodwill annually and whenever events or circumstances indicate that the carrying value of a reporting unit may not be recoverable.

The impairment tests require us to make an estimate of the fair value of our reporting units. An impairment could be recorded as a result of changes in assumptions, estimates or circumstances, some of which are beyond our control. Since a number of factors may influence determinations of fair value of goodwill, we are unable to predict whether impairments of goodwill will occur in the future, and there can be no assurance that continued conditions will not result in future impairments of goodwill. The future occurrence of a potential indicator of impairment could include matters such as (i) a decrease in expected net earnings, (ii) adverse equity market conditions, (iii) a decline in current market multiples, (iv) a decline in our common stock price, (v) a significant adverse change in legal factors or the general business climate, and (vi) an adverse action

or assessment by a regulator. Any such impairment would result in us recognizing a non-cash charge in our consolidated financial statements, which may adversely affect our business, results of operations and financial condition.

Risks Related to Ownership of Our Common Stock

Our shareholders may experience dilution of their ownership interests because of the future issuance of additional shares of our common stock.

In the future, we may issue additional equity securities for capital raising purposes, in connection with hiring or retaining employees, to fund or as consideration for acquisitions, or for other business purposes. We have previously funded, and expect to continue to fund, acquisitions using shares of our common stock as consideration. The future issuance of any additional shares of common stock will dilute our current shareholders and may create downward pressure on the value of our shares.

The market price of our stock has been and may continue to be highly volatile, which may lead to shareholder litigation against us.

Our common stock is listed on the Nasdaq Global Select Market under the ticker symbol "INSM". The market price of our stock has been and may continue to be highly volatile and could be subject to wide fluctuations in price in response to various factors, including those discussed herein, many of which are beyond our control. In addition, the stock market has from time to time experienced extreme price and volume fluctuations, which have particularly affected the market prices for biotechnology and pharmaceutical companies like us, and which have often appeared unrelated to their operating performance.

Historically, when the market price of a stock has been volatile, shareholders are more likely to institute securities and derivative class action litigation against the issuer of such stock. We previously faced a shareholder suit following a decline in our stock price. If any of our shareholders bring a lawsuit against us in the future, it may have a material adverse effect on our business. We have insurance policies related to some of the risks associated with our business, including directors' and officers' liability insurance policies; however, our insurance coverage may not be sufficient and our insurance carriers may not cover all claims in a given litigation. If we are not successful in our defense of claims asserted in shareholder litigation, those claims are not covered by insurance or they exceed our insurance coverage, we may have to pay damage awards, indemnify our executive officers, directors and third parties from damage awards that may be entered against them and pay our and their costs and expenses incurred in defense of, or in any settlement of, such claims. In addition, such shareholder suits could divert the time and attention of management from our business.

Certain provisions of Virginia law, our articles of incorporation and amended and restated bylaws and arrangements between us and our employees may hamper a third party's acquisition of us or discourage a third party from attempting to acquire control of us.

Certain provisions of Virginia law, our articles of incorporation and amended and restated bylaws and arrangements with our employees may hamper a third party's acquisition of us or discourage a third party from attempting to acquire control of us, or limit the price that investors might be willing to pay for shares of our common stock. These provisions or arrangements include:

- The ability to issue preferred stock with rights senior to those of our common stock without any further vote or action by the holders of our common stock. The issuance of preferred stock could decrease the amount of earnings and assets available for distribution to the holders of our common stock or could adversely affect the rights and powers, including voting rights, of the holders of our common stock. In certain circumstances, such issuance could have the effect of decreasing the market price of our common stock.
- The existence of a staggered board of directors in which there are three classes of directors serving staggered three-year terms, thus expanding the time required to change the composition of a majority of directors.
- The requirement that shareholders provide advance notice when nominating director candidates to serve on our board of directors.
- The inability of shareholders to convene a shareholders' meeting without the chairman of the board, the president or a majority of the board of directors first calling the meeting.
- The prohibition against entering into a business combination with the beneficial owner of 10% or more of our outstanding voting stock for a period of three years after the 10% or greater owner first reached that level of stock ownership, unless certain criteria are met.
- In addition to severance agreements with our officers and provisions in our incentive plans that permit acceleration of equity awards upon a change in control, a severance plan for eligible full-time employees that provides such employees with severance equal to six months of their then-current base salaries in connection with a termination of employment without cause upon, or within 18 months following, a change in control.

Under Virginia law, our board of directors may implement a shareholders' rights plan or "poison pill" without shareholder approval. Our board of directors regularly considers this matter, even in the absence of specific circumstances or takeover proposals, to facilitate its future ability to quickly and effectively protect shareholder value.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 1C. CYBERSECURITY

We incorporate assessment of our cybersecurity initiatives into our Enterprise Risk Management program. The Enterprise Risk Management program evaluates risk areas including, but not limited to, operational risk, intellectual property theft, fraud, harm to employees, patients, or third parties, and violation of privacy or security-related laws or regulations. As part of our efforts to mitigate cyber risk, we have implemented cybersecurity processes, technologies, and controls designed to identify and manage potential material cyber risks and have obtained cyber-specific insurance coverage.

We employ a range of tools and services, including regular network and endpoint monitoring, managed detection and response, system patching, managed security services, server and endpoint scheduled backups, awareness training and testing, periodic vulnerability assessment and penetration testing, to update our ongoing risk identification and mitigation efforts. We have a cybersecurity assessment process, which helps identify our cybersecurity risks by comparing our processes to standards set by the National Institute of Standards and Technology. Our processes also assess cybersecurity risks associated with our use of third-party service providers. We proactively engage with key vendors, industry participants, and law enforcement/cyber threat intelligence communities as part of our continuing efforts to evaluate and enhance the effectiveness of our information security policies and procedures.

Our information security program is managed by a senior director who reports to the Chief Information Officer (CIO), providing routine security program updates and briefings. The current senior director has more than 25 years of experience in cybersecurity, federal law enforcement, and cyber investigations, while possessing the required subject matter expertise, skills, experience, and industry certifications expected of an individual assigned to these duties. Our information security team, which includes the CIO and senior director, as well as additional professionals, is responsible for leading enterprise-wide cybersecurity strategy, policy, standards, and processes. Our CIO provides regular updates to our Chief Executive Officer and other members of management. The Audit Committee of the Board of Directors is responsible for oversight of the Company's cybersecurity risk exposure and the CIO provides reports to the Audit Committee, as well as the full Board of Directors, at least annually. The reports to management and our Board include updates on the Company's cyber risks and threats, the status of projects to strengthen our information security systems, assessments of the information security program, and the emerging threat landscape.

Based on the information available to us as of the filing date of this Annual Report on Form 10-K, we are not aware of any cybersecurity incidents, directly or indirectly, that have materially affected or are reasonably likely to materially affect our business, results of operations, or financial condition. For more information regarding our risks from cybersecurity threats, see "Risk Factors — Risks Related to the Operation of our Business — Our business and operations, including our drug development and commercialization programs, may be materially disrupted and/or subject to reputational harm in the event of system failures, security breaches, cyber-attacks, deficiencies in cybersecurity, violations of data protection laws or data loss or damage by us or third parties."

ITEM 2. PROPERTIES

We currently lease 117,022 square feet of office space for our corporate headquarters in Bridgewater, New Jersey. The initial term of this lease will expire in 2030.

We lease laboratory space located in Bridgewater for which we exercised the renewal option to extend the lease term until December 2026. In July 2023, we expanded this lease to a total of 46,671 square feet and further extended the lease term until April 2027. We also lease facilities in California totaling 54,478 square feet and New Hampshire totaling 12,668 square feet. In addition, we lease space outside of the US in France, Ireland, the Netherlands, Switzerland, the UK, and Japan.

Furthermore, in 2025 we purchased a building intended for use as a laboratory space. The property is located in New Hampshire and consists of 60,000 square feet. The facility has not yet been placed into service.

ITEM 3. LEGAL PROCEEDINGS

From time to time, we are a party to various lawsuits, claims and other legal proceedings that arise in the ordinary course of business. While the outcomes of these matters are uncertain, management does not expect that the ultimate costs to resolve these matters will have a material adverse effect on our consolidated financial position, results of operations or cash flows.

ITEM 4. MINE SAFETY DISCLOSURES

Not applicable.

PART II

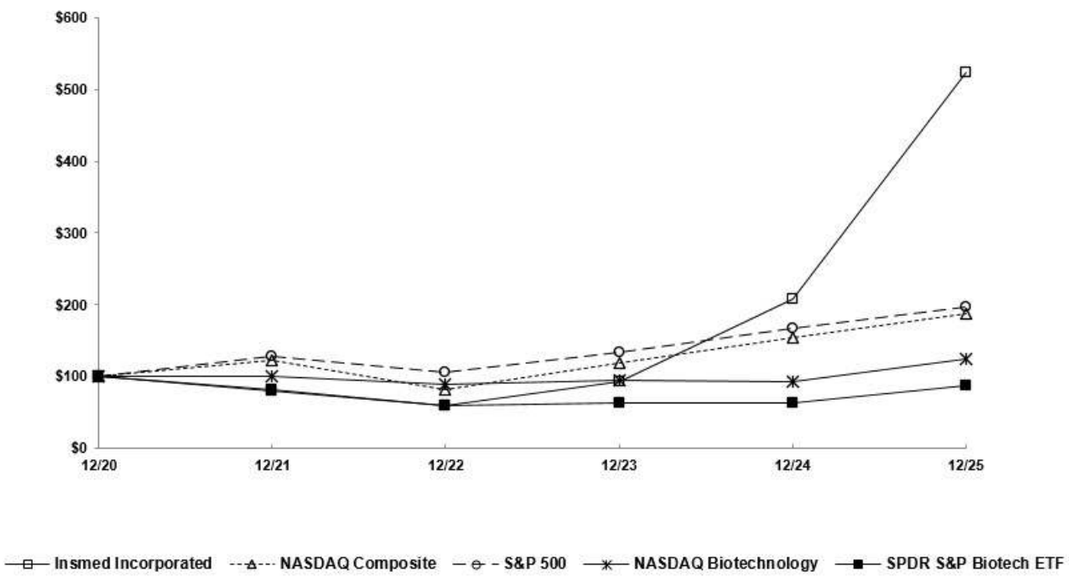
ITEM 5. MARKET FOR REGISTRANT'S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

Our trading symbol is "INSM." Our common stock currently trades on the Nasdaq Global Select Market. As of February 13, 2026, there were approximately 140 holders of record of our common stock.

We have never declared or paid cash dividends on our common stock. We anticipate that we will retain all earnings, if any, to support operations and to finance the growth and development of our business for the foreseeable future. Any future determination as to the payment of dividends will be dependent upon these and any contractual or other restrictions to which we may be subject and, to the extent permissible thereunder, will be at the sole discretion of our Board of Directors and will depend on our financial condition, results of operations, capital requirements and other factors our Board of Directors deems relevant at that time.

COMPARISON OF 5 YEAR CUMULATIVE TOTAL RETURN*

Among Insmed Incorporated, the NASDAQ Composite Index,
the S&P 500 Index, the NASDAQ Biotechnology Index and the SPDR S&P Biotech ETF Index



* $100 invested on 12/31/20 in stock or index, including reinvestment of dividends.
Fiscal year ending December 31.

ITEM 6. [RESERVED]

Not applicable.

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

The following discussion also should be read in conjunction with our consolidated financial statements and the notes thereto contained elsewhere in this Annual Report on Form 10-K. This discussion contains forward-looking statements that involve risks and uncertainties. As a result of many factors, such as those set forth under the section entitled Risk Factors, Cautionary Note Regarding Forward-Looking Statements and elsewhere herein, our actual results may differ materially from those anticipated in these forward-looking statements.

EXECUTIVE OVERVIEW

We are a people-first global biopharmaceutical company striving to deliver first- and best-in-class therapies to transform the lives of patients facing serious diseases. Our commercial portfolio and clinical pipeline are organized around three therapeutic areas: Respiratory, Immunology & Inflammation, and Neuro & Other Rare.

Our two commercial products, ARIKAYCE and BRINSUPRI, are both part of the Respiratory therapeutic area. ARIKAYCE is approved in the US as ARIKAYCE (amikacin liposome inhalation suspension), in Europe as ARIKAYCE Liposomal 590 mg Nebuliser Dispersion and in Japan as ARIKAYCE inhalation 590 mg (amikacin sulfate inhalation drug product). ARIKAYCE was approved in the US in September 2018, in the EU in October 2020 and in Japan in March 2021.

BRINSUPRI (brensocatib 25 mg and 10 mg tablets), an oral, once-daily treatment for NCFB in patients 12 years of age and older, was approved in the US in August 2025. In November 2025, the EC approved BRINSUPRI (brensocatib 25 mg tablets) for the treatment of NCFB in patients 12 years of age and older with two or more exacerbations in the prior 12 months.

Our Respiratory therapeutic area also includes the clinical-stage programs TPIP and INS1148. TPIP is an inhaled dry powder formulation of the treprostinil prodrug treprostinil palmitil that may offer a differentiated product profile for PH-ILD, PAH, PPF, and IPF. INS1148 is a monoclonal antibody targeting SCF248.

The clinical-stage program in our Inflammation & Immunology therapeutic area is brensocatib, a small molecule, oral, reversible inhibitor of DPP1, for the treatment of patients with HS.

The clinical-stage programs in our Neuro & Other Rare therapeutic area are INS1201, an intrathecally delivered gene therapy for patients with DMD, and INS1202, an intrathecally delivered gene therapy for patients with ALS.

Our pre-clinical research programs encompass a wide range of technologies and modalities, including gene therapy, AI-driven protein engineering, protein manufacturing, RNA end-joining, and synthetic rescue.

Refer to Part I, Item 1. "Business" for a detailed discussion of our ongoing commercial and clinical programs.

Prior to 2019, we had not generated significant revenue, and through December 31, 2025, we had an accumulated deficit of $5.6 billion. We have financed our operations primarily through the public offerings of our equity securities, debt financings and revenue interest financings. Although it is difficult to predict our future funding requirements, based upon our current operating plan, we anticipate that our cash and cash equivalents and marketable securities as of December 31, 2025 will enable us to fund our operations for at least the next 12 months.

Our ability to reduce our operating loss and begin to generate positive cash flow from operations depends on the continued success in commercializing our marketed products and achieving positive results from the ARIKAYCE confirmatory clinical trial program in order to obtain full approval of ARIKAYCE in the US and potentially reach more patients. Our continued success also depends on obtaining regulatory approval for brensocatib in an additional indication, bringing additional clinical stage products, such as TPIP, INS1148, INS1201, and INS1202, to market and advancing our pre-clinical research programs. We expect to continue to incur substantial expenses related to our research and development activities as we continue the ARIKAYCE confirmatory clinical program, conduct studies to explore the potential of brensocatib in HS, conduct trials of TPIP in PH-ILD, PAH, PPF, and IPF, and fund development of our pre-clinical research programs. We also expect to continue to incur significant costs related to the commercialization of our marketed products. Our financial results may fluctuate from quarter to quarter and will depend on, among other factors, the net sales of our marketed products; the scope and progress of our research and development efforts; and the timing of certain expenses. We cannot predict whether or when new products or new indications for marketed products will receive regulatory approval or, if any such approval is received, whether we will be able to successfully commercialize such products and whether or when we may become profitable.

KEY COMPONENTS OF OUR RESULTS OF OPERATIONS

Product Revenues, Net

Product revenues, net, consist of net sales of ARIKAYCE and BRINSUPRI. We recognize revenue for product received by our customers net of allowances for customer credits, including prompt pay discounts, service fees, estimated rebates, including government rebates, such as Medicaid rebates and Medicare Part D reimbursements in the US, and chargebacks.

Cost of Product Revenues (Excluding Amortization of Intangible Assets)

Cost of product revenues (excluding amortization of intangible assets) consist primarily of direct and indirect costs related to the manufacturing of ARIKAYCE and BRINSUPRI sold, including third-party manufacturing costs, packaging services, freight, and allocation of overhead costs, in addition to royalty expenses.

Research and Development (R&D) Expenses

R&D expenses consist of salaries, benefits and other related costs, including stock-based compensation, for personnel serving in our research and development functions. R&D expenses also include other internal operating expenses, the cost of manufacturing product candidates, including the medical devices for drug delivery, for clinical study, the cost of conducting clinical studies, and the cost of conducting pre-clinical and research activities. In addition, R&D expenses include payments to third parties for the license rights to products in development (prior to marketing approval), and may include the cost of asset acquisitions. Our R&D expenses related to manufacturing our product candidates and medical devices for clinical study are primarily related to activities at CMOs that manufacture our product candidates and early-stage research activities. Our R&D expenses related to clinical trials are primarily related to activities at contract research organizations (CROs) that conduct and manage clinical trials on our behalf. These contracts with CROs set forth the scope of work to be completed at a fixed fee or billed at a per-unit cost, and increase proportionally to the volume of services rendered. Payments under these contracts with CROs primarily depend on performance criteria such as the successful enrollment of patients or the completion of clinical trial milestones as well as time-based fees. Expenses are accrued based on contracted amounts applied to the level of patient enrollment and to activity according to the clinical trial protocol. Deposits for goods or services that will be used or rendered for future research and development activities are deferred and capitalized. Such amounts are then recognized as an expense as the related goods are delivered or the services are performed.

Selling, General and Administrative (SG&A) Expenses

SG&A expenses consist of salaries, benefits and other related costs, including stock-based compensation, for our non-employee directors and personnel serving in our executive, finance and accounting, legal and compliance, commercial and pre-commercial, corporate development, field sales, information technology and human resource functions. SG&A expenses also include professional fees for legal services, consulting services, including commercial activities, insurance, board of director fees, tax and accounting services.

Amortization of Intangible Assets

Upon commercialization of each of ARIKAYCE and BRINSUPRI, the related intangible assets began to be amortized over their estimated useful lives. The fair values assigned to our intangible assets are based on estimates and assumptions we believe are reasonable based on available facts and circumstances. Unanticipated events or circumstances may occur that require us to review the assets for impairment.

Change in Fair Value of Deferred and Contingent Consideration Liabilities

In connection with the Business Acquisition, we recorded deferred and contingent consideration liabilities related to potential future milestone payments. Adjustments to the fair value are due to changes in the probability of achieving milestones, our stock price, or certain other estimated assumptions. The change in fair value of deferred and contingent consideration liabilities is calculated quarterly with gains and losses recorded in the consolidated statements of comprehensive loss. Our deferred consideration liabilities were fully settled in the third quarter of 2024. As of December 31, 2025 and 2024, only contingent consideration liabilities exist.

Investment Income and Interest Expense

Investment income consists of interest and dividend income earned on our cash and cash equivalents and marketable securities. Interest expense consists primarily of contractual interest costs, Royalty Financing Agreement non-cash interest expense and the amortization of debt issuance costs related to our debt. Debt issuance costs are amortized to interest expense using the effective interest rate method over the term of the debt. Our consolidated balance sheets reflect debt, net of the debt issuance costs paid to the lender, and other third-party costs.

Change in Fair Value of Interest Rate Swap

We record derivative and hedge transactions in accordance with generally accepted accounting principles in the US (GAAP). In the fourth quarter of 2022, we entered into an interest rate swap contract (the Swap Contract) with a notional value of $350.0 million to economically hedge our variable rate-based term debt for three years, effectively changing the variable rate under the term debt to a fixed interest rate. Our interest rate swap was not designated as a hedging instrument for accounting purposes. We settled and terminated the Swap Contract in October 2024. All changes in the fair value of the Swap Contract were reported as change in fair value of interest rate swap in the consolidated statements of comprehensive loss.

RESULTS OF OPERATIONS

Comparison of the Years Ended December 31, 2025 and 2024

Product Revenues, Net

Product revenues, net, consist of net sales of ARIKAYCE and BRINSUPRI. The following table summarizes revenue by product and geography for the years ended December 31, 2025 and 2024 (in thousands):

	Years Ended December 31,		Increase (decrease)	
	2025	2024	$	%
ARIKAYCE				
US	$ 280,294	$ 254,800	$ 25,494	10.0 %
International	153,471	108,907	44,564	40.9 %
Total	$ 433,765	$ 363,707	$ 70,058	19.3 %
BRINSUPRI				
US	$ 172,658	$ —	$ 172,658	NA
Total	$ 172,658	$ —	$ 172,658	NA
Total				
US	$ 452,952	$ 254,800	$ 198,152	77.8 %
International	153,471	108,907	44,564	40.9 %
Total product revenues, net	$ 606,423	$ 363,707	$ 242,716	66.7 %

Product revenues, net for the year ended December 31, 2025 were $606.4 million as compared to $363.7 million for the year ended December 31, 2024, an increase of $242.7 million, or 66.7%. This increase was a result of $172.7 million of US commercial sales of BRINSUPRI following FDA approval in August 2025 and a 19.3% growth in sales of ARIKAYCE, driven primarily by a 40.9% growth in international sales.

Cost of Product Revenues (Excluding Amortization of Intangibles)

Cost of product revenues (excluding amortization of intangibles) for the years ended December 31, 2025 and 2024 were comprised of the following (in thousands):

	Years Ended December 31,		Increase (decrease)	
	2025	2024	$	%
Cost of product revenues (excluding amortization of intangibles)	$ 122,938	$ 85,742	$ 37,196	43.4%
Cost of product revenues, as % of revenues	*20.3 %*	*23.6 %*		

Cost of product revenues (excluding amortization of intangibles) were $122.9 million for the year ended December 31, 2025 as compared to $85.7 million for the year ended December 31, 2024, an increase of $37.2 million, or 43.4%. This increase was primarily attributable to the increase in total product revenues discussed above. Cost of product revenues as a percentage of revenues decreased in the current period due to sales of BRINSUPRI, which has lower manufacturing costs than ARIKAYCE.

All product costs for BRINSUPRI incurred prior to FDA approval on August 12, 2025 were expensed as R&D expenses. We expect our cost of product revenues (excluding amortization of intangible assets) to benefit during 2026 and beyond, as we sell through inventory that was expensed prior to FDA approval of BRINSUPRI.

R&D Expenses

R&D expenses for the years ended December 31, 2025 and 2024 were comprised of the following (in thousands):

	Years Ended December 31,		Increase (decrease)	
	2025	2024	$	%
External Expenses				
Clinical development and research	$ 178,037	$ 171,635	$ 6,402	3.7%
Manufacturing	140,245	94,766	45,479	48.0%
Regulatory, quality assurance, and medical affairs	43,742	36,476	7,266	19.9%
AstraZeneca milestone	—	12,500	(12,500)	(100.0)%
INS1148 asset acquisition	40,000	—	40,000	NA
Subtotal—external expenses	$ 402,024	$ 315,377	$ 86,647	27.5%
Internal Expenses				
Compensation and benefit-related expenses	$ 249,203	$ 194,907	$ 54,296	27.9%
Stock-based compensation	70,046	47,674	22,372	46.9%
Other internal operating expenses	49,820	40,409	9,411	23.3%
Subtotal—internal expenses	$ 369,069	$ 282,990	$ 86,079	30.4%
Total R&D expenses	$ 771,093	$ 598,367	$ 172,726	28.9%

R&D expenses were $771.1 million for the year ended December 31, 2025 as compared to $598.4 million for the year ended December 31, 2024, an increase of $172.7 million, or 28.9%. This increase was primarily due to the $76.7 million increase in compensation and benefit-related expenses and stock-based compensation costs due to an increase in headcount, a $45.5 million increase in manufacturing expense, and the $40.0 million up-front cash consideration in connection with the acquisition of INS1148, partially offset by the $12.5 million AstraZeneca milestone upon our release of an official public statement that we intended to file an NDA for brensocatib in 2024.

External R&D expenses by product for the years ended December 31, 2025 and 2024 were comprised of the following (in thousands):

	Years Ended December 31,		Increase (decrease)	
	2025	2024	$	%
ARIKAYCE external R&D expenses	$ 41,441	$ 60,269	$ (18,828)	(31.2)%
Brensocatib external R&D expenses	96,516	98,569	(2,053)	(2.1)%
TPIP external R&D expenses	94,201	65,935	28,266	42.9%
INS1148 asset acquisition	40,000	—	40,000	NA
AstraZeneca milestone	—	12,500	(12,500)	(100.0)%
Other external R&D expenses	129,866	78,104	51,762	66.3%
Total external R&D expenses	$ 402,024	$ 315,377	$ 86,647	27.5%

We expect R&D expenses to increase in 2026 relative to 2025 primarily due to our clinical trial activities and related spend, including our TPIP and brensocatib clinical trials, and other research efforts for our product candidates. INS1201 and INS1202 are included within other external R&D expenses.

SG&A Expenses

SG&A expenses for the years ended December 31, 2025 and 2024 were comprised of the following (in thousands):

	Years Ended December 31,		Increase (decrease)	
	2025	2024	$	%
Compensation and benefit-related expenses	$ 248,498	$ 168,498	$ 80,000	47.5%
Stock-based compensation	82,664	49,161	33,503	68.1%
Professional fees and other external expenses	281,187	173,631	107,556	61.9%
Facility related and other internal expenses	88,818	69,826	18,992	27.2%
Total SG&A expenses	$ 701,167	$ 461,116	$ 240,051	52.1%

SG&A expenses were $701.2 million during the year ended December 31, 2025 as compared to $461.1 million for the year ended December 31, 2024, an increase of $240.1 million, or 52.1%. This increase was primarily due to a $113.5 million

increase in compensation and benefit-related expenses and stock-based compensation costs due to an increase in headcount, and a $107.6 million increase in professional fees and other external expenses, both driven by commercial and commercial readiness activities for BRINSUPRI. We expect SG&A expenses to continue to increase in 2026 relative to 2025 due, in part, to commercial activities for BRINSUPRI.

Amortization of Intangible Assets

Amortization of intangible assets for the years ended December 31, 2025 and 2024 was $6.0 million and $5.1 million, respectively. This increase was due to amortization of the AstraZeneca milestones achieved upon FDA and EC approvals of BRINSUPRI in August 2025 and November 2025, respectively.

Change in Fair Value of Deferred and Contingent Consideration Liabilities

The change in fair value of deferred and contingent consideration liabilities for the year ended December 31, 2025 was $252.0 million and was primarily due to the increase in our share price. The change is related to the fair value of the potential future consideration to be paid to former equityholders of certain businesses we have acquired.

Investment Income

Investment income was $60.7 million for the year ended December 31, 2025 as compared to $53.3 million for the year ended December 31, 2024. The increase was primarily due to an increase in our average cash and cash equivalents and marketable securities balances in 2025 relative to 2024.

Interest Expense

Interest expense was $83.8 million for the year ended December 31, 2025 as compared to $84.9 million for the year ended December 31, 2024. This decrease was primarily due to a reduction in interest expense related to the redemptions of the outstanding 0.75% Convertible Senior Notes due 2028 (the 2028 Convertible Notes) in the second quarter of 2025 and the outstanding 1.75% Convertible Senior Notes due 2025 (the 2025 Convertible Notes) in the third quarter of 2024, partially offset by the interest income related to the Swap Contract in 2024. See *Note 10 - Debt* and *Note 11 - Royalty Financing Agreement* in this Annual Report on Form 10-K for further details.

Change in Fair Value of Interest Rate Swap

Prior to settlement and termination of the Swap Contract in October 2024, the change in fair value of interest rate swap was due to changes in interest rates during 2024 relative to the interest rate of the Swap Contract.

Provision for Income Taxes

The income tax provision was $5.0 million for the year ended December 31, 2025 as compared to $3.7 million for the year ended December 31, 2024. The income tax provision for the years ended December 31, 2025 and 2024 reflects the income tax expense recorded as a result of taxable income in certain of our subsidiaries in Europe and Japan, as well as a liability for certain state income taxes.

Comparison of the Years Ended December 31, 2024 and 2023

Please refer to the section titled "Management's Discussion and Analysis of Financial Condition and Results of Operations" in our Annual Report on Form 10-K for the fiscal year ended December 31, 2024 for a comparative discussion of our fiscal years ended December 31, 2024 and December 31, 2023.

LIQUIDITY AND CAPITAL RESOURCES

Overview

There is considerable time and cost associated with developing potential pharmaceutical products to the point of regulatory approval and commercialization. We commenced commercial shipments of ARIKAYCE in October 2018 and BRINSUPRI in August 2025. We expect to continue to incur consolidated operating losses, including losses at our US and certain international entities, as we plan to fund R&D for ARIKAYCE, TPIP, brensocatib, INS1148, INS1201, INS1202, and our other pipeline programs, continue commercialization and regulatory activities for ARIKAYCE and BRINSUPRI, and engage in other general and administrative activities.

In June 2025, we completed an underwritten offering of 8,984,375 shares of our common stock at a public offering price of $96.00 per share. 1,171,875 of the shares of common stock were issued pursuant to the exercise in full of the underwriters' option to purchase additional shares. Our net proceeds from the sale of the shares, after deducting the underwriting discounts and offering expenses of $39.2 million, were $823.3 million.

In May 2024, we completed an underwritten offering of 14,514,562 shares of our common stock at a public offering price of $51.50 per share. 1,893,203 of the shares of common stock were issued pursuant to the exercise in full of the

underwriters' option to purchase additional shares. Our net proceeds from the sale of the shares, after deducting underwriting discounts and offering expenses of $34.3 million, were $713.2 million.

In October 2022, we entered into a $350.0 million Tranche A Term Loan with Pharmakon that would have matured on October 19, 2027. The Tranche A Term Loan originally bore interest at a rate based upon the Secured Overnight Financing Rate (SOFR), subject to a SOFR floor of 2.5%, in addition to a margin of 7.75% per annum. Net proceeds from the Tranche A Term Loan, after deducting the lenders fees and deal expenses of $15.1 million, were $334.9 million. In October 2024, we entered into the A&R Loan Agreement, as amended July 10, 2025, with BioPharma Credit PLC, BPCR Limited Partnership and BioPharma Credit Investments V (Master) LP, which are funds managed by Pharmakon, and the guarantors party to such agreement. The A&R Loan Agreement, among other items, provides an additional $150.0 million senior secured Tranche B Term Loan. The A&R Loan Agreement extends the maturity of the Term Loans to September 30, 2029, subject to acceleration to February 1, 2028 on the occurrence of certain prespecified events, and amends the interest rate on the Term Loans to a fixed rate of 9.6% per annum. As consideration for the provision of the Tranche B Term Loan, we agreed to pay Pharmakon a fee equal to 2.0% of the Tranche B Term Loan at the closing date of the Tranche B Term Loan and an additional exit fee of 2.0% of the amount of each prepayment or repayment of the Term Loans. The Term Loans will be repaid in eight equal quarterly payments starting on January 3, 2028. Net proceeds from the Tranche B Term Loan, after deducting the lenders fees and administrative expenses of $3.7 million, were $146.3 million.

In October 2022, we entered into the Royalty Financing Agreement with OrbiMed, whereby OrbiMed paid us $150.0 million in exchange for the right to receive, on a quarterly basis, royalties in an amount equal to 4.0% of ARIKAYCE global net sales prior to September 1, 2025 and 4.5% of ARIKAYCE global net sales on or after September 1, 2025, as well as 0.75% of brensocatib global net sales, which includes BRINSUPRI. In the event that OrbiMed has not received aggregate Revenue Interest Payments equal to or greater than $150.0 million on or prior to March 31, 2028, the royalty rate for ARIKAYCE will be increased for all subsequent fiscal quarters to a rate which, if applied retroactively, would have resulted in aggregate Revenue Interest Payments to OrbiMed for all fiscal quarters ended on or prior to March 31, 2028 equal to $150.0 million. In addition, we must make a one-time payment to OrbiMed in an amount that, when added to the aggregate amount of Revenue Interest Payments received by OrbiMed as of March 31, 2028, would equal $150.0 million. The total Revenue Interest Payments payable by us to OrbiMed are capped at 1.8x of the purchase price or up to a maximum of 1.9x of the purchase price under certain conditions. Net proceeds from the Royalty Financing Agreement, after deducting the lenders fees and deal expenses of $3.6 million, were $146.4 million. The Royalty Financing Agreement was amended in October 2024 to, among other things, amend certain restrictions on the Company's ability to incur indebtedness.

In the first quarter of 2021, we entered into a sales agreement with SVB Leerink LLC (now known as Leerink Partners LLC) (Leerink Partners), to sell shares of our common stock, with aggregate gross sales proceeds of up to $250.0 million, from time to time, through an "at the market" equity offering program (the ATM program), under which Leerink Partners acted as sales agent. During the year ended December 31, 2023, we issued and sold an aggregate of 6,503,041 shares of common stock through the ATM program at a weighted-average public offering price of $24.12 per share and received net proceeds of $152.2 million. In the first quarter of 2024, we entered into a new sales agreement (the new sales agreement) with Leerink Partners to sell shares of our common stock, with aggregate gross sales proceeds of up to $500.0 million, from time to time, through a new "at the market" equity offering program (the new ATM program), under which Leerink Partners acted as sales agent. In connection with entering into the new ATM program, we terminated the ATM program. During the year ended December 31, 2024, we issued and sold an aggregate of 5,022,295 shares of common stock through the new ATM program at a weighted-average public offering price of $75.64 per share and received net proceeds of $371.3 million. On November 18, 2024, we terminated the new sales agreement.

Based on our current operating plan we anticipate that our cash and cash equivalents and marketable securities as of December 31, 2025 will enable us to fund our operations. While we believe we currently have sufficient funds to meet our financial needs for at least the next 12 months, we may raise additional capital to fund future development of our product candidates, and to develop, acquire, in-license or co-promote other products or product candidates, including those that address serious diseases with significant unmet need. Our cash requirements for the next 12 months will be impacted by a number of factors, the most significant of which we expect to be expenses related to our commercialization efforts for ARIKAYCE and BRINSUPRI and development costs for our clinical-stage assets, and, to a lesser extent, our pre-clinical research programs.

Cash Flows

We had cash and cash equivalents of $510.4 million as of December 31, 2025 as compared with $555.0 million as of December 31, 2024. In addition, as of December 31, 2025, we had marketable securities of $919.6 million as compared to $878.8 million as of December 31, 2024. Our working capital was $1.3 billion as of December 31, 2025 and 2024.

Net cash used in operating activities was $935.0 million and $683.9 million for the years ended December 31, 2025 and 2024, respectively, which was primarily driven by commercial, clinical, and manufacturing activities related to ARIKAYCE, commercial and commercial readiness activities for BRINSUPRI, as well as other SG&A expenses, clinical trial expenses related to brensocatib and TPIP, and the $40.0 million acquisition of INS1148. The increase in cash used in operating activities for the year ended December 31, 2025 as compared to 2024 was primarily due to the increase in net loss, excluding the adjustments to reconcile net loss to net cash used in operating activities.

Net cash used in investing activities was $64.6 million and $583.2 million for the years ended December 31, 2025 and 2024, respectively. During the year ended December 31, 2025, net cash used in investing activities consisted primarily of purchases of property and equipment. During the year ended December 31, 2024, net cash used in investing activities consisted primarily of purchases of marketable securities, partially offset by maturities of marketable securities.

Net cash provided by financing activities was $954.1 million and $1,341.0 million for the years ended December 31, 2025 and 2024, respectively. During the years ended December 31, 2025 and 2024, net cash provided by financing activities consisted primarily of proceeds from the issuance of common stock in our underwritten public equity offerings and proceeds from the exercise of stock options and the Employee Stock Purchase Plan (ESPP). During the year ended December 31, 2024, net cash provided by financing activities also included $150.0 million in proceeds from the Tranche B Term Loan.

Contractual Obligations

In December 2025, we acquired the global rights to OpSCF (renamed INS1148) from Opsidio. The Opsidio shareholders may become entitled to receive contingent payments up to an aggregate of $382 million in cash upon the achievement of certain development, regulatory and sales milestones, as well as earnout payments based upon a low to mid single-digit percentage of net sales of certain products, both subject to the terms and conditions of the agreement. See *Note 15 - Licenses and Other Agreements* in this Annual Report on Form 10-K for further details.

In June 2023, we acquired all of the issued and outstanding share capital of Adrestia, a privately held, pre-clinical stage company. Adrestia's former shareholders may also become entitled to receive contingent payments up to an aggregate of $326.5 million in cash upon the achievement of certain development, regulatory and commercial milestone events, as well as royalty payments based upon a low single-digit percentage of net sales of certain products, both subject to the terms and conditions of the agreement. See *Note 15 - Licenses and Other Agreements* in this Annual Report on Form 10-K for further details.

In January 2023, we acquired Vertuis, a privately held, pre-clinical stage company. The Company is obligated to pay the Vertuis equityholders up to an aggregate of $23.0 million in cash upon the achievement of certain development and regulatory milestone events, and up to an aggregate of $63.8 million in cash upon the achievement of certain net sales-based milestone events, in each case, subject to certain reductions. See *Note 15 - Licenses and Other Agreements* in this Annual Report on Form 10-K for further details.

In October 2022, we entered into financings resulting in aggregate gross proceeds of $500.0 million, comprised of the $350.0 million Tranche A Term Loan with funds managed by Pharmakon and the $150.0 million Royalty Financing Agreement with OrbiMed, which was subsequently amended in October 2024. Under the Royalty Financing Agreement, OrbiMed will be entitled to receive royalties of 4.0% on ARIKAYCE global net sales until September 1, 2025, and royalties of 4.5% on ARIKAYCE global net sales on or after September 1, 2025, as well as royalties of 0.75% on brensocatib global net sales, which includes BRINSUPRI. The total royalty payable to OrbiMed is capped at 1.8x of the $150.0 million purchase price or up to a maximum of 1.9x of the $150.0 million purchase price under certain conditions. See *Note 10 - Debt* and *Note 11 - Royalty Financing Agreement* in this Annual Report on Form 10-K for further details.

In October 2024, we entered into the A&R Loan Agreement, as amended July 10, 2025, with BioPharma Credit PLC, BPCR Limited Partnership and BioPharma Credit Investments V (Master) LP, which are funds managed by Pharmakon, and the guarantors party to such agreement. The A&R Loan Agreement amends and restates the Loan Agreement, dated as of October 19, 2022, pursuant to which the Tranche A Term Loan was provided. The A&R Loan Agreement, among other items, provides the Tranche B Term Loan. The A&R Loan Agreement extends the maturity of the Term Loans to September 30, 2029, subject to acceleration to February 1, 2028 on the occurrence of certain prespecified events, and amends the interest rate on the Term Loans to a fixed rate of 9.6% per annum. See *Note 10 - Debt* in this Annual Report on Form 10-K for further details.

In January 2024, we entered into certain agreements with Patheon Inc., a wholly-owned subsidiary of Thermo Fisher, related to the manufacture and supply of commercial brensocatib products, including BRINSUPRI, for our commercial needs and brensocatib for our clinical needs by Patheon Inc. Under these agreements, we are required to deliver to Patheon Inc. the active pharmaceutical ingredients needed to manufacture BRINSUPRI and brensocatib. In addition, in September 2024, we entered into a commercial manufacturing and supply agreement with Esteve for the manufacture and supply of BRINSUPRI's and brensocatib's active pharmaceutical ingredient.

In April 2020, we entered into a master services agreement with PPD pursuant to which we retained PPD to perform clinical development services in connection with certain of our clinical research programs. The master services agreement has an initial term of five years. In March 2025, we amended the agreement to extend the term three years. Either party may terminate (i) any project addendum under the master services agreement for any reason and without cause upon 30 days' written notice, (ii) any project addendum in the event of the other party's breach of the master services agreement or such project addendum upon 30 days' written notice, provided that such breach is not cured within such 30-day period, (iii) the master services agreement or any project addendum immediately upon the occurrence of an insolvency event with respect to the other party or (iv) any project addendum upon 30 days' written notice if (a) the continuation of the services under such project addendum would pose material ethical or safety risks to study participants, (b) any approval from a regulatory authority necessary to perform the applicable study is revoked, suspended or expires without renewal or (c) in the reasonable opinion of such party, continuation of the services provided under such project addendum would be in violation of applicable law. We have entered into project addenda with PPD to perform clinical development services over several years for, but not limited to, our PALM-ILD and PAH studies and other trials involving brensocatib and TPIP. The anticipated future cost of these project addenda is $295.7 million.

In September 2018, we entered into an agreement (the Lease) with Bridgewater Biotech Center LLC (assumed from Exeter 700 Route 202/206, LLC) to lease 117,022 square feet of office space located in Bridgewater, New Jersey for our corporate headquarters. Subject to certain conditions, we had the one-time option to expand the leased premises by up to 50,000 rentable square feet, exercisable prior to the fifth anniversary of the Commencement Date, which was October 1, 2019. We did not exercise this one-time option. The initial Lease term runs 130 months from the Commencement Date and we have the option to extend that term for up to three additional five-year periods. In addition, we are responsible for operating expenses and taxes pursuant to the Lease. Future minimum payments under the Lease during the initial Lease term are approximately $12.7 million. The Lease contains customary default provisions, including those relating to payment defaults, performance defaults and events of bankruptcy.

In October 2017, we entered into certain agreements with Patheon related to the increase of our long-term production capacity for ARIKAYCE. The agreements provide for Patheon to manufacture and supply ARIKAYCE for our anticipated commercial needs. Under these agreements, we are required to deliver to Patheon the required raw materials, including active pharmaceutical ingredients, and certain fixed assets needed to manufacture ARIKAYCE. Patheon's supply obligations will commence once certain technology transfer and construction services are completed. Our manufacturing and supply agreement with Patheon will remain in effect for a fixed initial term, after which it will continue for successive renewal terms unless either we or Patheon have given written notice of termination. The technology transfer agreement will expire when the parties agree that the technology transfer services have been completed. The agreements may also be terminated under certain other circumstances, including by either party due to a material uncured breach of the other party or the other party's insolvency. These early termination clauses may reduce the amounts due to the relevant parties. The aggregate investment to increase our long-term production capacity, including under the Patheon agreements and related agreements or purchase orders with third parties for raw materials and fixed assets, is estimated to be approximately $127.7 million.

In October 2016, we entered into the AZ License Agreement, pursuant to which AstraZeneca granted us exclusive global rights for the purpose of developing and commercializing AZD7986 (which we renamed brensocatib). Following FDA approval, brensocatib was commercially designated as BRINSUPRI. In consideration of the licenses and other rights granted by AstraZeneca, we made an upfront payment of $30.0 million, which was included as research and development expense in the fourth quarter of 2016. In December 2020, we incurred a $12.5 million milestone payment obligation upon first dosing in a Phase 3 clinical trial of brensocatib. In May 2024, upon our release of an official public statement that we intended to file an NDA, we incurred an additional $12.5 million milestone payment obligation. Upon regulatory approval by the FDA of an NDA, we paid AstraZeneca an additional $30.0 million. In November 2025, a $15.0 million milestone commitment became payable to AstraZeneca upon EC approval of BRINSUPRI. Subsequent to this milestone, we are also obligated to make an additional $15.0 million contingent payment upon the achievement of a regulatory filing milestone. If we elect to develop brensocatib for a second indication, we will be obligated to make an additional series of contingent milestone payments totaling up to $42.5 million, the first of which occurs at the initiation of a Phase 3 trial in the additional indication. We are not obligated to make payments for additional indications. In addition, we have agreed to pay AstraZeneca tiered royalties ranging from high single-digit to mid-teens on net sales of any approved product based on brensocatib and one additional payment of $35.0 million upon the first achievement of $1.0 billion in annual net sales. The AZ License Agreement provides AstraZeneca with

the option to negotiate a future agreement with us for commercialization of brensocatib in chronic obstructive pulmonary disease or asthma.

We have a licensing agreement with PARI for the use of optimized Lamira for delivery of ARIKAYCE in treating patients with NTM lung infections, CF and bronchiectasis. Under the licensing agreement, we have rights under several US and foreign issued patents, and patent applications involving improvements to optimized Lamira, to exploit the system with ARIKAYCE for the treatment of such indications, but we cannot manufacture the nebulizers except as permitted under our Commercialization Agreement with PARI, as described below. Lamira has been approved for use in the US (in combination with ARIKAYCE), the EU and Japan. Under the licensing agreement, we made an upfront license fee and milestone payments to PARI. Upon the FDA acceptance of our NDA and the subsequent FDA and EMA approvals of ARIKAYCE, we made additional milestone payments of €1.0 million, €1.5 million, and €0.5 million, respectively, to PARI. In October 2017, we exercised an option to buy-down the royalties payable to PARI, which was included within selling, general and administrative expenses in the fourth quarter of 2017. PARI is entitled to receive royalty payments in the mid-single digits on the annual global net sales of ARIKAYCE, pursuant to the licensing agreement, subject to certain specified annual minimum royalties.

In July 2014, we entered into a Commercialization Agreement with PARI for the manufacture and supply of Lamira, which is an e-Flow® nebulizer modified and optimized for use with ARIKAYCE. Under the Commercialization Agreement, PARI manufactures Lamira except in the case of certain defined supply failures, when the Company will have the right to make Lamira and have it made by third parties (but not certain third parties deemed under the Commercialization Agreement to compete with PARI). The Commercialization Agreement has an initial term of 15 years that began in October 2018. The term of the Commercialization Agreement may be extended by us for an additional five years by providing written notice to PARI at least one year prior to the expiration of the Initial Term.

In February 2014, we entered into a contract manufacturing agreement with Therapure Biopharma Inc., which has been assumed by Resilience, for the manufacture of ARIKAYCE, on a non-exclusive basis, at a 200 kg scale. Pursuant to the agreement, we collaborated with Resilience to construct a production area for the manufacture of ARIKAYCE in Resilience's existing manufacturing facility in Canada. The agreement has an initial term of five years, which began in October 2018, and renews automatically for successive periods of two years each, unless terminated by either party by providing the required two years' prior written notice to the other party. Under the agreement, we are obligated to pay certain minimum amounts for the batches of ARIKAYCE produced each calendar year.

Future Funding Requirements

Based on our current operating plan we anticipate that our cash and cash equivalents and marketable securities as of December 31, 2025 will enable us to fund our operations. We may raise additional capital to fund development of our future product candidates, and to develop, acquire, in-license or co-promote other products or product candidates, including those that address serious diseases with significant unmet need. We expect that our future capital requirements may be substantial and will depend on many factors, including:

- The timing, outcome, and cost of our ongoing and anticipated clinical trials for our product candidates;
- The cost of supporting the sales and marketing efforts necessary to support the continued commercial efforts of our marketed products;
- The cost of discovering or in-licensing additional product candidates;
- The costs of activities related to the regulatory approval process and the timing of approvals, if received;
- The timing and costs of supporting the commercial launch activities of BRINSUPRI in additional markets, if any;
- The cost of eventually supporting the commercial launches of TPIP and our other product candidates, if approved;
- The cost of filing, prosecuting, defending, and enforcing patent claims;
- The costs of our manufacturing-related activities;
- The cost of hiring more personnel to support our ongoing development and commercialization efforts; and
- The levels, timing and collection of revenue earned from sales of our marketed products and other products approved in the future, if any.

We have raised $2.2 billion in net proceeds from securities offerings and other financing transactions since January 1, 2023. We believe we currently have sufficient funds to meet our financial needs for at least the next 12 months. However, our business strategy may require us to raise additional capital at any time through equity or debt financing(s), strategic transactions or otherwise.

Off-Balance Sheet Arrangements

We do not have any off-balance sheet arrangements that have or are reasonably likely to have a current or future material effect on our financial condition, revenues or expenses, results of operations, liquidity, capital expenditures or capital resources. We do not have any interest in special purpose entities, structured finance entities or other variable interest entities.

CRITICAL ACCOUNTING ESTIMATES

Preparation of financial statements in accordance with GAAP requires us to make estimates and assumptions affecting the reported amounts of assets, liabilities, revenues and expenses and the disclosures of contingent assets and liabilities. We use our historical experience and other relevant factors when developing our estimates and assumptions and we regularly evaluate these estimates and assumptions. The amounts of assets and liabilities reported in our consolidated balance sheets and the amounts reported in our consolidated statements of comprehensive loss are affected by estimates and assumptions, which are used for, but not limited to, the accounting for revenue recognition and indefinite-lived intangible assets. The accounting estimates discussed below involve a significant level of estimation uncertainty and have had or are reasonably likely to have a material impact on our financial condition or results of operations. Actual results could differ materially from our estimates. See *Note 2 - Summary of Significant Accounting Policies* in this Annual Report on Form 10-K for our required disclosures on accounting policies and estimates.

Revenue Recognition

In accordance with Accounting Standards Codification (ASC) 606, Revenue from Contracts with Customers, we recognize revenue when a customer obtains control of promised goods or services, in an amount that reflects the consideration we expect to receive in exchange for the goods or services provided. To determine revenue recognition for arrangements within the scope of ASC 606, we perform the following five steps: (1) identify the contracts with a customer; (2) identify the performance obligations in the contract; (3) determine the transaction price; (4) allocate the transaction price to the performance obligations in the contract; and (5) recognize revenue when or as the entity satisfies a performance obligation. At contract inception, we assess the goods or services promised within each contract and determine those that are performance obligations and assess whether each promised good or service is distinct. We then recognize as revenue the amount of the transaction price that is allocated to the respective performance obligation when or as the performance obligation is satisfied. For all contracts that fall into the scope of ASC 606, we have identified one performance obligation: the sale of marketed products to our customers. We have not incurred or capitalized any incremental costs associated with obtaining contracts with customers.

Product revenues, net, consist of global net sales of ARIKAYCE and US net sales of BRINSUPRI. Our customers in the US include specialty pharmacies and a specialty distributor. Product revenues are recognized once we perform and satisfy all five steps of the revenue recognition criteria mentioned above.

Revenue is recorded at net selling price (transaction price), which includes estimates of variable consideration for which reserves are established for (a) customer credits, such as invoice discounts for prompt pay, (b) estimated government rebates, such as Medicaid and Medicare Part D reimbursements, and estimated managed care rebates, (c) estimated chargebacks, and (d) estimated costs of co-payment assistance. These reserves are based on the amounts earned or to be claimed on the related sales and are classified as reductions of accounts receivable (prompt pay discounts and chargebacks), prepaid expenses (co-payment assistance), or as a current liability (rebates). Where appropriate, these estimates take into consideration a range of possible outcomes which are probability-weighted for relevant factors such as our historical experience, current contractual and statutory requirements, and forecasted customer buying and payment patterns. Overall, these reserves reflect our best estimates of the amount of consideration to which we are entitled based on the terms of the applicable contract. The amount of variable consideration included in the transaction price may be constrained and is included in the net sales price only to the extent that it is probable that a significant reversal in the amount of the cumulative revenue recognized will not occur in a future period. Actual amounts of consideration ultimately received may differ from our estimates. If actual results in the future vary from estimates, we adjust these estimates, which would affect net product revenue and earnings in the period such variances become known.

Rebates: We contract with certain government agencies and managed care organizations, or collectively, third-party payors, so that our marketed products will be eligible for purchase by, or partial or full reimbursement from, such third-party payors. We estimate the rebates we will provide to third-party payors and deduct these estimated amounts from total gross product revenues at the time the revenues are recognized. These reserves are recorded in the same period in which the revenue is recognized, resulting in a reduction of product revenue and the establishment of a current liability. The current liability is included in accounts payable and accrued liabilities on the consolidated balance sheets. We estimate the rebates that will be provided to third-party payors based upon (i) our contracts with these third-party payors, (ii) the government mandated discounts applicable to government-funded programs, (iii) a range of possible outcomes that are probability-weighted for the estimated payor mix, and (iv) information obtained from our specialty pharmacies.

If any, or all, of our actual experience vary from the estimates above, we may need to adjust prior period accruals, affecting revenue in the period of adjustment.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

As of December 31, 2025, our cash and cash equivalents were in cash accounts or were invested in money market funds. Our investments in money market funds are not insured by the federal government. As of December 31, 2025, our marketable securities were invested in US treasury securities with an original maturity of six months or less.

As of December 31, 2025, we had our $500.0 million Term Loans outstanding. The Term Loans accrue interest quarterly at a fixed rate of 9.6% per annum. The Royalty Financing Agreement required us to pay a Revenue Interest Payment of 4.0% of ARIKAYCE global net sales prior to September 1, 2025 and to pay 4.5% thereafter, as well as 0.75% of brensocatib global net sales, which includes BRINSUPRI. If a 10% change in interest rates had occurred on December 31, 2025, it would not have had a material effect on the fair value of our debt as of that date, nor would it have a material effect on our future earnings or cash flows.

The majority of our business is conducted in US dollars. However, we do conduct certain transactions in other currencies, including Euros, British Pounds, Swiss Francs and Japanese Yen. Historically, fluctuations in foreign currency exchange rates have not materially affected our results of operations. During the years ended December 31, 2025, 2024 and 2023, our results of operations were not materially affected by fluctuations in foreign currency exchange rates.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

The information required by Item 8 is included in our Financial Statements and Supplementary Data set forth in Item 15 of Part IV of this Annual Report on Form 10-K.

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

None.

ITEM 9A. CONTROLS AND PROCEDURES

Evaluation of Disclosure Controls and Procedures

Our management, under the supervision and with the participation of our Chief Executive Officer and Chief Financial Officer, evaluated the effectiveness of our disclosure controls and procedures as of December 31, 2025. The term "disclosure controls and procedures," as defined in Rules 13a-15(e) and 15d-15(e) under the Exchange Act means controls and other procedures that are designed to ensure that information required to be disclosed by us in the reports that we file or submit with the SEC is recorded, processed, summarized and reported, within the time periods specified in the SEC's rules and forms, and to ensure that such information is accumulated and communicated to our management, including our Chief Executive Officer and Chief Financial Officer, as appropriate, to allow timely decisions regarding required disclosure. Based on that evaluation our Chief Executive Officer and Chief Financial Officer have concluded that our disclosure controls and procedures were effective as of December 31, 2025 at the reasonable assurance level.

Management's Report on Internal Control Over Financial Reporting

Our management is responsible for establishing and maintaining adequate internal control over financial reporting. Internal control over financial reporting is defined in Rule 13a-15(f) and 15d-15(f) under the Exchange Act, as a process designed by, or under the supervision of, our principal executive and principal financial and accounting officers and effected by our board of directors and management to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles and includes those policies and procedures that:

- Pertain to the maintenance of records that in reasonable detail accurately and fairly reflect the transactions and dispositions of our assets;
- Provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with US generally accepted accounting principles, and that receipts and expenditures of our company are being made only in accordance with authorizations of our management and board of directors; and
- Provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of our assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Projections of any evaluation of effectiveness to future periods are subject to the risks that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate. Our management assessed the effectiveness of our internal control over financial reporting as of December 31, 2025, based on the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission (COSO) in Internal Control—

Integrated Framework. Based on management's assessment, management concluded that the Company's internal control over financial reporting was effective as of December 31, 2025.

Changes in Internal Control Over Financial Reporting

There were no changes in our internal control over financial reporting identified in connection with the evaluation required by Rule 13a-15(d) and 15d-15(d) of the Exchange Act that occurred during the quarter ended December 31, 2025 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Attestation Report on Internal Control over Financial Reporting

Ernst & Young LLP, our independent registered public accounting firm, issued an attestation report on our internal control over financial reporting. The report of Ernst & Young LLP is contained in Item 15 of Part IV of this Annual Report on Form 10-K.

ITEM 9B. OTHER INFORMATION

Our policy governing transactions in our securities by our directors, officers and employees permits our directors, officers and employees to enter into trading plans complying with Rule 10b5-1 under the Exchange Act. The following table describes the written plans for the sale of our securities adopted or terminated by our officers and directors (each as defined in Rule 16a-1(f) of the Exchange Act) during the fourth quarter of 2025, each of which was entered into or terminated, as applicable, during an open trading window and is or was intended to satisfy the affirmative defense conditions of Rule 10b5-1(c) (each, a Trading Plan).

Name and Title	Date of Adoption of Trading Plan	Scheduled Start Date of Trading Plan	Scheduled Expiration Date of Trading Plan [1]	Maximum Shares Subject to Trading Plan	Date Plan Terminated
Michael Smith Chief Legal Officer	02/27/2025	05/30/2025	12/31/2025	109,462	11/04/2025
Michael Smith Chief Legal Officer	11/07/2025	02/23/2026	02/12/2027	150,172	N/A
Sara Bonstein Chief Financial Officer	11/10/2025	02/24/2026	04/08/2026	159,511	N/A
S. Nicole Schaeffer Chief People Strategy Officer	11/12/2025	02/24/2026	08/28/2026	55,400	N/A
Elizabeth McKee Anderson, Director	11/14/2025	03/04/2026	09/30/2026	20,000	12/11/2025
Roger Adsett Chief Operating Officer	12/03/2025	03/04/2026	06/16/2026	194,727	N/A
Elizabeth McKee Anderson, Director	12/11/2025	03/12/2026	09/30/2026	5,000	N/A

[1] A Trading Plan may expire on an earlier date if all contemplated transactions are completed before such Trading Plan's expiration date, upon termination by broker or the holder of the Trading Plan, or as otherwise provided in the Trading Plan.

ITEM 9C. DISCLOSURE REGARDING FOREIGN JURISDICTIONS THAT PREVENT INSPECTIONS

Not applicable.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

The information required by this Item is incorporated by reference from our definitive proxy statement for our 2026 annual meeting of shareholders to be filed with the SEC no later than 120 days after the close of the fiscal year covered by this Annual Report on Form 10-K.

ITEM 11. EXECUTIVE COMPENSATION

The information required by this Item is incorporated by reference from our definitive proxy statement for our 2026 annual meeting of shareholders to be filed with the SEC no later than 120 days after the close of the fiscal year covered by this Annual Report on Form 10-K.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS

The information required by this Item is incorporated by reference from our definitive proxy statement for our 2026 annual meeting of shareholders to be filed with the SEC no later than 120 days after the close of the fiscal year covered by this Annual Report on Form 10-K.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS AND DIRECTOR INDEPENDENCE

The information required by this Item is incorporated by reference from our definitive proxy statement for our 2026 annual meeting of shareholders to be filed with the SEC no later than 120 days after the close of the fiscal year covered by this Annual Report on Form 10-K.

ITEM 14. PRINCIPAL ACCOUNTANT FEES AND SERVICES

The information required by this Item is incorporated by reference from our definitive proxy statement for our 2026 annual meeting of shareholders to be filed with the SEC no later than 120 days after the close of the fiscal year covered by this Annual Report on Form 10-K.

PART IV

ITEM 15. EXHIBITS AND FINANCIAL STATEMENT SCHEDULES

(a) Documents filed as part of this report.

1. FINANCIAL STATEMENTS. The following consolidated financial statements of the Company are set forth herein, beginning on page 95:

(i) Reports of Independent Registered Public Accounting Firm (PCAOB ID: 42)

(ii) Consolidated Balance Sheets as of December 31, 2025 and 2024

(iii) Consolidated Statements of Comprehensive Loss for the Years Ended December 31, 2025, 2024 and 2023

(iv) Consolidated Statements of Shareholders' Equity for the Years Ended December 31, 2025, 2024 and 2023

(v) Consolidated Statements of Cash Flows for the Years Ended December 31, 2025, 2024 and 2023

(vi) Notes to Consolidated Financial Statements

2. FINANCIAL STATEMENT SCHEDULES.

None required.

3. EXHIBITS.

The exhibits that are required to be filed or incorporated by reference herein are listed in the Exhibit Index.

EXHIBIT INDEX

3.1	Articles of Incorporation of Insmed Incorporated, as amended through June 14, 2012 (incorporated by reference from Exhibit 3.1 to Insmed Incorporated's Annual Report on Form 10-K filed on March 18, 2013).
3.2	Amended and Restated Bylaws of Insmed Incorporated (incorporated by reference from Exhibit 3.1 to Insmed Incorporated's Current Report on Form 8-K filed on May 11, 2023).
4.1	Specimen stock certificate representing common stock, $0.01 par value per share, of the Registrant (incorporated by reference from Exhibit 4.2 to Insmed Incorporated's Registration Statement on Form S-4/A (Registration No. 333-30098) filed on March 24, 2000).
4.2	Description of Securities Registered Under Section 12 of the Securities Exchange Act of 1934 (incorporated by reference from Exhibit 4.5 of Insmed Incorporated’s Annual Report on Form 10-K filed on February 25, 2021).
10.1**	Insmed Incorporated 2015 Incentive Plan (incorporated by reference from Exhibit 99.1 to Insmed Incorporated's Registration Statement on Form S-8 filed on May 28, 2015).
10.1.1**	Form of Award Agreement for Non-Qualified Stock Options pursuant to the Insmed Incorporated 2015 Incentive Plan (incorporated by reference from Exhibit 10.2 to Insmed Incorporated’s Quarterly Report on Form 10-Q filed May 3, 2017).
10.2**	Insmed Incorporated 2017 Incentive Plan (incorporated by reference from Exhibit 10.3 to Insmed Incorporated’s Quarterly Report on Form 10-Q filed August 3, 2017).
10.2.1**	Form of Award Agreements for Restricted Stock Units pursuant to the Insmed Incorporated 2017 Incentive Plan (incorporated by reference from Exhibit 10.4 to Insmed Incorporated’s Quarterly Report on Form 10-Q filed August 3, 2017).
10.2.2**	Amendment to Form of Award Agreement for Restricted Stock Units pursuant to the Insmed Incorporated 2017 Incentive Plan (incorporated by reference from Exhibit 10.4.2 to Insmed Incorporated's Annual Report on Form 10-K filed on February 17, 2022).
10.2.3**	Form of Award Agreement for Non-Qualified Stock Options pursuant to the Insmed Incorporated 2017 Incentive Plan (incorporated by reference from Exhibit 10.5 to Insmed Incorporated’s Quarterly Report on Form 10-Q filed August 3, 2017).

10.3**	Insmed Incorporated Amended and Restated 2019 Incentive Plan (incorporated by reference from Appendix A to Insmed Incorporated's Proxy Statement on Schedule 14A filed on March 31, 2023).
10.3.1**	Amendment No. 1 to Insmed Incorporated Amended and Restated 2019 Incentive Plan (incorporated by reference from Appendix A to Insmed Incorporated's Proxy Statement on Schedule 14A filed on April 1, 2024).
10.3.2**	Amendment No 2. to Insmed Incorporated Amended and Restated 2019 Incentive Plan (incorporated by reference from Appendix A to Insmed Incorporated's Proxy Statement on Schedule 14A, filed on April 4, 2025).
10.3.3**	Form of Award Agreement for Restricted Stock Units pursuant to the Insmed Incorporated Amended and Restated 2019 Incentive Plan (incorporated by reference from Exhibit 10.1.3 to Insmed Incorporated's Quarterly Report on Form 10-Q filed on August 8, 2024).
10.3.4**	Form of Award Agreement for Restricted Stock Units to non-US employees pursuant to the Insmed Incorporated Amended and Restated 2019 Incentive Plan (incorporated by reference from Exhibit 10.1.4 to Insmed Incorporated's Quarterly Report on Form 10-Q filed on August 8, 2024).
10.3.5**	Form of Award Agreement for Non-Qualified Stock Options pursuant to the Insmed Incorporated Amended and Restated 2019 Incentive Plan before December 4, 2025 (incorporated by reference from Exhibit 10.1.1 to Insmed Incorporated's Quarterly Report on Form 10-Q filed on August 8, 2024).
10.3.6**	Form of Award Agreement for Non-Qualified Stock Options issued to non-US employees pursuant to the Insmed Incorporated Amended and Restated 2019 Incentive Plan before December 4, 2025 (incorporated by reference from Exhibit 10.1.2 to Insmed Incorporated's Quarterly Report on Form 10-Q filed on August 8, 2024).
10.3.7**	Form of Award Agreement for Restricted Stock Units issued to directors pursuant to the Insmed Incorporated Amended and Restated 2019 Incentive Plan (incorporated by reference from Exhibit 10.1.5 of Insmed Incorporated's Quarterly Report on Form 10-Q filed on August 3, 2023).
10.3.8**	Form of Award Agreement for Non-Qualified Stock Options pursuant to the Insmed Incorporated Amended and Restated 2019 Incentive Plan for awards granted on or after December 4, 2025 (filed herewith).
10.3.9**	Form of Award Agreement for Non-Qualified Stock Options issued to non-US employees pursuant to the Insmed Incorporated Amended and Restated 2019 Incentive Plan for awards granted on or after December 4, 2025 (filed herewith).
10.3.10**	Form of Award Agreement for Performance-Based Restricted Stock Units pursuant to the Insmed Incorporated Amended and Restated 2019 Incentive Plan (filed herewith).
10.3.11**	Form of Award Agreement for Performance-Based Restricted Stock Units to non-US employees pursuant to the Insmed Incorporated Amended and Restated 2019 Incentive Plan (filed herewith).
10.4**	Insmed Incorporated 2025 Inducement Plan (incorporated by reference from Exhibit 4.1 to Insmed Incorporated's Registration Statement on Form S-8 filed on February 20, 2025).
10.4.1**	Form of Award Agreement for Restricted Stock Units pursuant to the Insmed Incorporated 2025 Inducement Plan (incorporated by reference from Exhibit 10.2 to Insmed Incorporated's Quarterly Report on Form 10-Q filed on May 8, 2025.
10.4.2**	Form of Award Agreement for Restricted Stock Units to non-US employees pursuant to the Insmed Incorporated 2025 Inducement Plan (incorporated by reference from Exhibit 10.3 to Insmed Incorporated's Quarterly Report on Form 10-Q filed on May 8, 2025.
10.4.3**	Form of Award Agreement for Non-Qualified Stock Options pursuant to the Insmed Incorporated 2025 Inducement Plan before December 4, 2025 (incorporated by reference from Exhibit 10.4 to Insmed Incorporated's Quarterly Report on Form 10-Q filed on May 8, 2025).

10.4.4**	Form of Award Agreement for Non-Qualified Stock Options issued to non-US employees pursuant to the Insmed Incorporated 2025 Inducement Plan before December 4, 2025 (incorporated by reference from Exhibit 10.5 to Insmed Incorporated's Quarterly Report on Form 10-Q filed on May 8, 2025).
10.4.5**	Form of Award Agreement for Non-Qualified Stock Options pursuant to the Insmed Incorporated 2025 Inducement Plan for awards granted on or after December 4, 2025 (filed herewith).
10.4.6**	Form of Award Agreement for Non-Qualified Stock Options issued to non-US employees pursuant to the Insmed Incorporated 2025 Inducement Plan for awards granted on or after December 4, 2025 (filed herewith).
10.5**	Insmed Incorporated 2018 Employee Stock Purchase Plan (incorporated by reference from Appendix A to Insmed Incorporated's Proxy Statement on Schedule 14A filed on April 5, 2018).
10.6**	Omnibus Amendment to Insmed Incorporated Incentive Plans, dated December 10, 2020 (incorporated by reference from Exhibit 10.6 of Insmed Incorporated's Annual Report on Form 10-K filed on February 25, 2021).
10.6.1**	Omnibus Amendment to Insmed Incorporated Incentive Awards and Inducement Awards, dated May 8, 2024 (incorporated by reference from Exhibit 10.2 to Insmed Incorporated's Quarterly Report on Form 10-Q filed on August 8, 2024).
10.7**	Insmed Incorporated Senior Executive Bonus Plan (incorporated by reference from Exhibit 10.2 to Insmed Incorporated's Quarterly Report on Form 10-Q filed on November 5, 2013).
10.8**	Form of Non-Qualified Stock Option Inducement Award Agreement (incorporated by reference from Exhibit 10.3 to Insmed Incorporated's Quarterly Report on Form 10-Q filed August 8, 2024).
10.9**	Form of Non-Qualified Stock Option Inducement Award Agreement for non-U.S. employees (incorporated by reference from Exhibit 10.4 to Insmed Incorporated's Quarterly Report on Form 10-Q filed August 8, 2024).
10.10**	Form of Indemnification Agreement entered into with each of the Company's directors and officers (incorporated by reference from Exhibit 10.1 to Insmed Incorporated's Current Report on Form 8-K filed on January 16, 2014).
10.11**	Employment Agreement, effective as of September 10, 2012, between Insmed Incorporated and William Lewis (incorporated by reference from Exhibit 10.1 to Insmed Incorporated's Current Report on Form 8-K filed on September 11, 2012).
10.11.1**	Amendment to Employment Agreement, effective as of July 31, 2019, between Insmed Incorporated and William Lewis (incorporated by reference from Exhibit 10.5 to Insmed Incorporated's Quarterly Report on Form 10-Q filed on August 1, 2019).
10.12**	Amended and Restated Employment Agreement, effective as of April 1, 2022, between Insmed Incorporated and S. Nicole Schaeffer (incorporated by reference from Exhibit 10.4 to Insmed Incorporated's Quarterly Report on Form 10-Q filed on May 5, 2022).
10.13**	Amended and Restated Employment Agreement, effective as of April 1, 2022, between Insmed Incorporated and Roger Adsett (incorporated by reference from Exhibit 10.1 to Insmed Incorporated's Quarterly Report on Form 10-Q filed May 5, 2022).
10.13.1**	Side Letter to Amended and Restated Employment Agreement, effective as of August 8, 2022, between Insmed Incorporated and Roger Adsett (incorporated by reference from Exhibit 10.3 to Insmed Incorporated's Quarterly Report on Form 10-Q filed October 27, 2022).
10.14**	Amended and Restated Employment Agreement, effective as of April 1, 2022, between Insmed Incorporated and Sara Bonstein (incorporated by reference from Exhibit 10.2 to Insmed Incorporated's Annual Report on Form 10-Q filed May 5, 2022).
10.15**	Amended and Restated Employment Agreement, effective as of April 1, 2022, by and between Insmed Incorporated and Martina Flammer, M.D. (incorporated by reference from Exhibit 10.3 of Insmed Incorporated's Quarterly Report on Form 10-Q filed May 5, 2022).

10.16**	Amended and Restated Employment Agreement, effective as of April 1, 2022, by and between Insmed Incorporated and Michael Smith (incorporated by reference from Exhibit 10.5 of Insmed Incorporated's Quarterly Report on Form 10-Q filed May 5, 2022).
10.17**	Consulting Agreement, effective as of April 17, 2025, between Insmed Incorporated and J. Drayton Wise (incorporated by reference from Exhibit 10.1 to Insmed Incorporated's Quarterly Report on Form 10-Q filed on August 7, 2025).
10.18*	License Agreement, dated April 25, 2008, between Transave, Inc. and PARI Pharma GmbH, and Amendments No. 1-4 thereto (incorporated by reference from Exhibit 10.1 to Insmed Incorporated's Quarterly Report on Form 10-Q filed on October 29, 2020).
10.18.1*	Amendment No. 5 to License Agreement between Insmed Incorporated and PARI Pharma GmbH, effective as of October 5, 2015 (incorporated by reference from Exhibit 10.14.1 to Insmed Incorporated's Annual Report on Form 10-K filed on February 25, 2016).
10.18.2*	Amendment No. 6 to License Agreement between Insmed Incorporated and PARI Pharma GmbH, effective as of October 9, 2015 (incorporated by reference from Exhibit 10.14.2 to Insmed Incorporated's Annual Report on Form 10-K filed on February 25, 2016).
10.18.3*	Amendment No. 7 to License Agreement between Insmed Incorporated and PARI Pharma GmbH, effective as of July 21, 2017 (incorporated by reference from Exhibit 10.1 to Insmed Incorporated's Quarterly Report on Form 10-Q filed on November 2, 2017).
10.18.4*	Amendment No. 8 to License Agreement between Insmed Incorporated and PARI Pharma GmbH, effective as of December 19, 2018 (incorporated by reference from Exhibit 10.15.4 to Insmed Incorporated's Annual Report on Form 10-K filed on February 22, 2019).
10.19*	Contract Manufacturing Agreement, dated February 7, 2014, between Insmed Incorporated and Resilience Biotechnologies Inc. (successor to Therapure Biopharma Inc.) (incorporated by reference from Exhibit 10.2.1 to Insmed Incorporated's Quarterly Report on Form 10-Q filed on October 29, 2020).
10.19.1*	Amending Agreement, dated March 13, 2014, between Insmed Incorporated and Resilience Biotechnologies Inc. (successor to Therapure Biopharma Inc.) (incorporated by reference from Exhibit 10.2.2 to Insmed Incorporated's Quarterly Report on Form 10-Q filed on October 29, 2020).
10.20*	Commercialization Agreement dated July 8, 2014 between Insmed Incorporated and PARI Pharma GmbH (incorporated by reference from Exhibit 10.5 to Insmed Incorporated's Quarterly Report on Form 10-Q filed on August 8, 2024).
10.20.1*	Amendment No. 1 to Commercialization Agreement between Insmed Incorporated and PARI Pharma GmbH, effective as of July 21, 2017 (incorporated by reference from Exhibit 10.5.1 to Insmed Incorporated's Quarterly Report on Form 10-Q filed on August 8, 2024).
10.20.2*	Amendment No. 2 to Commercialization Agreement between Insmed Incorporated and PARI Pharma GmbH, effective as of July 20, 2018 (incorporated by reference from Exhibit 10.19.2 to Insmed Incorporated's Annual Report on Form 10-K filed on February 20, 2025).
10.21*	Manufacturing and Supply Agreement between Insmed Incorporated and Patheon UK Limited, dated as of October 20, 2017 (incorporated by reference from Exhibit 10.39 to Insmed Incorporated's Annual Report on Form 10-K filed February 23, 2018).
10.22*	Technology Transfer Agreement between Insmed Incorporated and Patheon UK Limited, dated as of October 20, 2017 (incorporated by reference from Exhibit 10.40 to Insmed Incorporated's Annual Report on Form 10-K filed February 23, 2018).
10.22.1*	Amendment to the Technology Transfer Agreement and to the Manufacturing and Supply Agreement, by and between Insmed Incorporated and Patheon UK Limited, dated as of March 11, 2021 (incorporated by reference from Exhibit 10.3 to Insmed Incorporated's Quarterly Report on Form 10-Q filed May 6, 2021).
10.23*	License Agreement, dated October 4, 2016, between Insmed Incorporated and AstraZeneca AB (incorporated by reference from Exhibit 10.29 to Insmed Incorporated's Annual Report on Form 10-K filed February 23, 2017).

10.24	Lease Agreement, dated September 11, 2018, by and between Insmed Incorporated and Bridgewater Biotech Center LLC (assumed from Exeter 700 Route 202/206, LLC) (incorporated by reference from Exhibit 10.1 to Insmed Incorporated's Current Report on Form 8-K filed on September 17, 2018).
10.25*	Master Commercial Manufacturing Services Agreement, dated January 8, 2024, by and between Insmed Incorporated and Patheon Inc. (incorporated by reference from Exhibit 10.24 to Insmed Incorporated's Annual Report on Form 10-K filed on February 20, 2025).
10.25.1*	Product Agreement pursuant to the Master Commercial Manufacturing Services Agreement, dated September 29, 2024, by and between Insmed Incorporated and Patheon Inc. (incorporated by reference from Exhibit 10.24.1 to Insmed Incorporated's Annual Report on Form 10-K filed on February 20, 2025).
10.25.1.1*	Amendment No. 1 to Product Agreement pursuant to the Master Commercial Manufacturing Services Agreement, dated January 23, 2025, by and between Insmed Incorporated and Patheon Inc. (filed herewith).
10.26*	Revenue Interest Purchase Agreement, dated October 19, 2022, between Insmed Incorporated and OrbiMed Royalty & Credit Opportunities III, LP (incorporated by reference from Exhibit 10.1 to Insmed Incorporated's Quarterly Report on Form 10-Q filed on October 27, 2022).
10.26.1*	First Amendment to Revenue Interest Purchase Agreement, dated October 31, 2024, between Insmed Incorporated and OrbiMed Royalty & Credit Opportunities III, LP (incorporated by reference from Exhibit 10.25.1 to Insmed Incorporated's Annual Report on Form 10-K filed on February 20, 2025).
10.27*	Amended and Restated Loan Agreement, dated October 31, 2024, between Insmed Incorporated, BioPharma Credit PLC, BPCR Limited Partnership and BioPharma Credit Investments V (Master) LP (incorporated by reference from Exhibit 10.26 to Insmed Incorporated's Annual Report on Form 10-K filed on February 20, 2025).
10.27.1*	Amendment No. 1 to Amended and Restated Loan Agreement, dated July 10, 2025, between Insmed Incorporated, BioPharma Credit PLC, BPCR Limited Partnership and BioPharma Credit Investments V (Master) LP (incorporated by reference from Exhibit 10.1 to Insmed Incorporated's Quarterly Report on Form 10-Q filed on October 30, 2025).
10.28*	Commercial Manufacturing and Supply Agreement, dated September 5, 2024, between Insmed Incorporated and Esteve Química, S.A. (incorporated by reference from Exhibit 10.27 to Insmed Incorporated's Annual Report on Form 10-K filed on February 20, 2025).
19.1	Insmed Incorporated Insider Trading Policy (incorporated by reference from Exhibit 19.1 to Insmed Incorporated's Annual Report on Form 10-K filed on February 20, 2025).
21.1	Subsidiaries of Insmed Incorporated (filed herewith).
23.1	Consent of Ernst & Young LLP (filed herewith).
31.1	Certification of William H. Lewis, Chair and Chief Executive Officer (Principal Executive Officer) of Insmed Incorporated, pursuant to Rules 13a-14(a) and 15d-14(a) promulgated under the Securities Exchange Act of 1934, as adopted pursuant to Section 302 of the Sarbanes Oxley Act of 2003 (filed herewith).
31.2	Certification of Sara Bonstein, Chief Financial Officer (Principal Financial Officer and Principal Accounting Officer) of Insmed Incorporated, pursuant to Rules 13a-14(a) and 15d-14(a) promulgated under the Securities Exchange Act of 1934, as adopted pursuant to Section 302 of the Sarbanes Oxley Act of 2003 (filed herewith).
32.1	Certification of William H. Lewis, Chair and Chief Executive Officer (Principal Executive Officer) of Insmed Incorporated, pursuant to 18 USC Section 1350, as adopted pursuant to Section 906 of the Sarbanes Oxley Act of 2003 (filed herewith).
32.2	Certification of Sara Bonstein, Chief Financial Officer (Principal Financial Officer and Principal Accounting Officer) of Insmed Incorporated, pursuant to 18 USC Section 1350, as adopted pursuant to Section 906 of the Sarbanes Oxley Act of 2003 (filed herewith).
97	Compensation Recovery Policy (incorporated by reference from Exhibit 97 to Insmed Incorporated's Annual Report on Form 10-K filed on February 22, 2024).

101	The following materials from Insmed Incorporated's Annual Report on Form 10-K for the year ended December 31, 2025 formatted in iXBRL (Inline eXtensible Business Reporting Language): (i) Consolidated Balance Sheets as of December 31, 2025 and 2024, (ii) Consolidated Statements of Comprehensive Loss for the years ended December 31, 2025, 2024 and 2023, (iii) Consolidated Statements of Shareholders' Equity for the years ended December 31, 2025, 2024 and 2023, (iv) Consolidated Statements of Cash Flows for the years ended December 31, 2025, 2024 and 2023, and (v) Notes to the Consolidated Financial Statements, and (vi) Cover Page.
104	The cover page from the Annual Report on Form 10-K for the year ended December 31, 2025, formatted in iXBRL and contained in Exhibit 101.
*	Certain portions of this exhibit have been redacted.
**	Management contract or compensatory plan or arrangement.

ITEM 16. FORM 10-K SUMMARY

Not applicable.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the Registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized on February 19, 2026.

INSMED INCORPORATED
a Virginia corporation
(Registrant)

By: /s/ WILLIAM H. LEWIS
William H. Lewis
Chair and Chief Executive Officer
(Principal Executive Officer)

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the Registrant and in the capacities indicated on February 19, 2026.

Signature	Title
/s/ WILLIAM H. LEWIS William H. Lewis	Chair and Chief Executive Officer (Principal Executive Officer)
/s/ SARA BONSTEIN Sara Bonstein	Chief Financial Officer (Principal Financial and Accounting Officer)
/s/ DAVID R. BRENNAN David R. Brennan	Lead Independent Director
/s/ ELIZABETH MCKEE ANDERSON Elizabeth McKee Anderson	Director
/s/ CLARISSA DESJARDINS, PH.D. Clarissa Desjardins, Ph.D.	Director
/s/ LEO LEE Leo Lee	Director
/s/ DAVID W.J. MCGIRR David W.J. McGirr	Director
/s/ CAROL A. SCHAFER Carol A. Schafer	Director
/s/ MELVIN SHAROKY, M.D. Melvin Sharoky, M.D.	Director

Report of Independent Registered Public Accounting Firm

To the Shareholders and the Board of Directors of Insmed Incorporated

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheets of Insmed Incorporated (the Company) as of December 31, 2025 and 2024, the related consolidated statements of comprehensive loss, shareholders' equity and cash flows for each of the three years in the period ended December 31, 2025, and the related notes (collectively referred to as the "consolidated financial statements"). In our opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the Company at December 31, 2025 and 2024, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2025, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2025, based on criteria established in Internal Control—Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework), and our report dated February 19, 2026 expressed an unqualified opinion thereon.

Basis for Opinion

These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's financial statements based on our audits. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that our audits provide a reasonable basis for our opinion.

Critical Audit Matter

The critical audit matter communicated below is a matter arising from the current period audit of the financial statements that was communicated or required to be communicated to the audit committee and that: (1) relates to accounts or disclosures that are material to the financial statements and (2) involved our especially challenging, subjective or complex judgments. The communication of the critical audit matter does not alter in any way our opinion on the consolidated financial statements, taken as a whole, and we are not, by communicating the critical audit matter below, providing a separate opinion on the critical audit matter or on the account or disclosure to which it relates.

	Variable consideration in contracts with customers
Description of the Matter	As discussed in Note 4 of the consolidated financial statements, the transaction price for product sales is typically adjusted for variable consideration, which includes rebates paid to government agencies, specifically Medicaid. The Company estimates Medicaid rebates based upon a range of possible outcomes that are probability-weighted for the estimated payor mix. Auditing the Company's estimate of Medicaid rebates was complex and judgmental due to uncertainty about the estimated payor mix at the time of shipment to the specialty pharmacies as well as the complexity of governmental pricing calculations. The transaction price is sensitive to assumptions used in Medicaid rebate calculations.
How We Addressed the Matter in Our Audit	We identified, evaluated and tested controls over management's review of the calculated reductions to gross product prices related to Medicaid rebates including management's review of the significant assumptions and the data utilized in its calculations. To test the revenue adjustments related to Medicaid rebates our audit procedures included, among others, using internal government pricing specialists to assist with our evaluation of management's methodology and calculations used to measure Medicaid rebates. We also tested the underlying data and inputs used by the Company in its determination of the estimated payor mix. We compared the inputs used by management to historical trends, evaluated the change in the estimated rebates amounts recorded throughout the year and assessed the historical accuracy of management's estimates against actual results.

/s/ Ernst & Young LLP

We have served as the Company's auditor since at least 1999, but we are unable to determine the specific year.

Iselin, New Jersey

February 19, 2026

Report of Independent Registered Public Accounting Firm

To the Shareholders and the Board of Directors of Insmed Incorporated

Opinion on Internal Control Over Financial Reporting

We have audited Insmed Incorporated's internal control over financial reporting as of December 31, 2025, based on criteria established in Internal Control—Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) (the COSO criteria). In our opinion, Insmed Incorporated (the Company) maintained, in all material respects, effective internal control over financial reporting as of December 31, 2025, based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated balance sheets of the Company as of December 31, 2025 and 2024, the related consolidated statements of comprehensive loss, shareholders' equity and cash flows for each of the three years in the period ended December 31, 2025, and the related notes and our report dated February 19, 2026 expressed an unqualified opinion thereon.

Basis for Opinion

The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying Management's Report on Internal Control Over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects.

Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and Limitations of Internal Control Over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ Ernst & Young LLP

Iselin, New Jersey

February 19, 2026

INSMED INCORPORATED
Consolidated Balance Sheets
(in thousands, except par value and share data)

	As of December 31, 2025	2024
Assets		
Current assets:		
Cash and cash equivalents	$ 510,445	$ 555,030
Marketable securities	919,602	878,796
Accounts receivable	140,857	52,012
Inventory	132,068	98,578
Prepaid expenses and other current assets	91,236	37,245
Total current assets	1,794,208	1,621,661
Fixed assets, net	102,942	80,052
Finance lease right-of-use assets	15,561	18,273
Operating lease right-of-use assets	20,708	17,257
Intangibles, net	97,651	58,652
Goodwill	136,110	136,110
Other assets	97,378	93,226
Total assets	$ 2,264,558	$ 2,025,231
Liabilities and shareholders' equity		
Current liabilities:		
Accounts payable and accrued liabilities	$ 456,060	$ 285,209
Finance lease liabilities	3,345	2,961
Operating lease liabilities	9,469	9,358
Total current liabilities	468,874	297,528
Debt, long-term	540,964	1,103,382
Royalty financing agreement	162,865	161,067
Contingent consideration	314,340	144,200
Finance lease liabilities, long-term	20,719	24,064
Operating lease liabilities, long-term	12,174	9,112
Other long-term liabilities	5,646	499
Total liabilities	1,525,582	1,739,852
Shareholders' equity:		
Common stock, $0.01 par value; 500,000,000 authorized shares, 214,255,853 and 179,382,635 issued and outstanding shares at December 31, 2025 and December 31, 2024, respectively	2,143	1,794
Additional paid-in capital	6,372,064	4,645,791
Accumulated deficit	(5,636,692)	(4,359,917)
Accumulated other comprehensive gain (loss)	1,461	(2,289)
Total shareholders' equity	738,976	285,379
Total liabilities and shareholders' equity	$ 2,264,558	$ 2,025,231

See accompanying notes to consolidated financial statements

INSMED INCORPORATED
Consolidated Statements of Comprehensive Loss
(in thousands, except per share data)

	Years Ended December 31,		
	2025	2024	2023
Product revenues, net	$ 606,423	$ 363,707	$ 305,208
Operating expenses:			
Cost of product revenues (excluding amortization of intangible assets)	122,938	85,742	65,573
Research and development	771,093	598,367	571,011
Selling, general and administrative	701,167	461,116	344,501
Amortization of intangible assets	6,001	5,052	5,052
Change in fair value of deferred and contingent consideration	251,993	91,682	28,697
Total operating expenses	1,853,192	1,241,959	1,014,834
Operating loss	(1,246,769)	(878,252)	(709,626)
Investment income	60,656	53,307	42,132
Interest expense	(83,795)	(84,913)	(81,694)
Change in fair value of interest rate swap	—	(236)	320
Other (expense) income, net	(1,841)	29	1,856
Loss before income taxes	(1,271,749)	(910,065)	(747,012)
Provision for income taxes	5,026	3,707	2,555
Net loss	$ (1,276,775)	$ (913,772)	$ (749,567)
Basic and diluted net loss per share	$ (6.42)	$ (5.57)	$ (5.34)
Weighted average basic and diluted common shares outstanding	199,014	164,043	140,433
Net loss	$ (1,276,775)	$ (913,772)	$ (749,567)
Other comprehensive income (loss):			
Foreign currency translation gains (losses)	3,306	(1,855)	(2,214)
Unrealized gain on marketable securities	444	311	713
Total comprehensive loss	$ (1,273,025)	$ (915,316)	$ (751,068)

See accompanying notes to audited consolidated financial statements

INSMED INCORPORATED
Consolidated Statements of Shareholders' Equity
(in thousands)

	Common Stock		Additional Paid-in Capital	Accumulated Deficit	Accumulated Other Comprehensive Income (Loss)	Total
	Shares	Amount				
Balance at December 31, 2022	135,654	$ 1,357	$ 2,782,416	$ (2,696,578)	$ 756	$ 87,951
Comprehensive loss:						
Net loss				(749,567)		(749,567)
Other comprehensive loss					(1,501)	(1,501)
Exercise of stock options and ESPP share issuance	1,142	12	18,387			18,399
Net proceeds from issuance of common stock	6,531	65	152,410			152,475
Issuance of common stock for vesting of RSUs	543	5				5
Deferred payments for Business Acquisition	177	2	3,895			3,897
Issuance of common stock for asset acquisitions	3,931	39	81,601			81,640
Stock-based compensation expense			74,778			74,778
Balance at December 31, 2023	147,978	$ 1,480	$ 3,113,487	$ (3,446,145)	$ (745)	$ (331,923)
Comprehensive loss:						
Net loss				(913,772)		(913,772)
Other comprehensive loss					(1,544)	(1,544)
Exercise of stock options and ESPP share issuance	5,026	50	113,193			113,243
Net proceeds from issuance of common stock	19,537	195	1,083,929			1,084,124
Issuance of common stock upon conversion of convertible notes	5,744	58	224,267			224,325
Issuance of common stock for vesting of RSUs	901	9				9
Deferred payments for Business Acquisition and Vertuis Bio, Inc.	197	2	14,080			14,082
Stock-based compensation expense			96,835			96,835
Balance at December 31, 2024	179,383	$ 1,794	$ 4,645,791	$ (4,359,917)	$ (2,289)	$ 285,379
Comprehensive loss:						
Net loss				(1,276,775)		(1,276,775)
Other comprehensive income					3,750	3,750
Exercise of stock options and ESPP share issuance	5,769	58	135,659			135,717
Net proceeds from issuance of common stock	8,984	90	823,192			823,282
Issuance of common stock upon conversion of convertible notes	17,923	179	565,962			566,141
Issuance of common stock for vesting of RSUs	1,172	11				11
Issuance of common stock for vesting of PSUs	660	7				7
Contingent payments for Business Acquisition	365	4	48,750			48,754
Stock-based compensation expense			152,710			152,710
Balance at December 31, 2025	214,256	$ 2,143	$ 6,372,064	$ (5,636,692)	$ 1,461	$ 738,976

See accompanying notes to audited consolidated financial statements

INSMED INCORPORATED
Consolidated Statements of Cash Flows
(in thousands)

	Years Ended December 31,		
	2025	**2024**	**2023**
Operating activities			
Net loss	$(1,276,775)	$ (913,772)	$ (749,567)
Adjustments to reconcile net loss to net cash used in operating activities:			
Depreciation	10,449	5,961	5,527
Amortization of intangible assets	6,001	5,052	5,052
Stock-based compensation expense	152,710	96,835	74,778
Amortization of debt issuance costs	6,216	6,884	7,320
Paid-in-kind interest capitalized	—	19,233	23,372
Royalty financing non-cash interest expense	20,675	20,044	18,846
Accretion of discount on marketable securities, net	(38,348)	(19,160)	(9,383)
Finance lease amortization expense	2,712	2,712	2,712
Non-cash operating lease expense	9,652	3,588	9,206
Change in fair value of deferred and contingent consideration liabilities	251,993	91,682	28,697
Change in fair value of interest rate swap	—	236	(320)
Vertuis acquisition	—	—	10,250
Adrestia acquisition	—	—	76,481
Changes in operating assets and liabilities:			
Accounts receivable	(88,307)	(12,932)	(11,963)
Inventory	(31,519)	(17,044)	(13,613)
Prepaid expenses and other current assets	(53,431)	(14,182)	2,265
Other assets	(2,123)	8,335	(20,074)
Accounts payable and accrued liabilities	100,073	44,592	15,155
Other liabilities	(4,992)	(11,946)	(10,988)
Net cash used in operating activities	(935,014)	(683,882)	(536,247)
Investing activities			
Purchase of fixed assets	(32,561)	(21,923)	(13,288)
Payment of AZ milestone	(30,000)	—	—
Purchase of marketable securities	(2,092,014)	(1,577,252)	(588,733)
Cash acquired in asset acquisition	—	—	3,417
Maturities of marketable securities	2,090,000	1,016,000	375,000
Net cash used in investing activities	(64,575)	(583,175)	(223,604)
Financing activities			
Proceeds from exercise of stock options and ESPP	135,717	113,243	18,399
Proceeds from issuance of common stock, net	823,282	1,084,124	152,475
Proceeds from issuance of Term Loan	—	150,000	—
Payments of principal of 0.75% convertible senior notes due 2028	(1,965)	—	—
Payment of debt issuance costs	—	(3,737)	(1,218)
Payments of finance lease principal	(2,961)	(2,610)	(1,217)
Net cash provided by financing activities	954,073	1,341,020	168,439
Effect of exchange rates on cash and cash equivalents	931	(1,307)	(250)
Net (decrease) increase in cash and cash equivalents	(44,585)	72,656	(591,662)

INSMED INCORPORATED
Consolidated Statements of Cash Flows (Continued)
(in thousands)

Cash and cash equivalents at beginning of period	555,030	482,374	1,074,036
Cash and cash equivalents at end of period	$ 510,445	$ 555,030	$ 482,374
Supplemental disclosures of cash flow information:			
Cash paid for interest	$ 55,353	$ 40,567	$ 35,787
Cash paid for income taxes	$ 4,141	$ 2,499	$ 1,955

See accompanying notes to audited consolidated financial statements

1. *The Company and Basis of Presentation*

Insmed is a people-first global biopharmaceutical company striving to deliver first- and best-in-class therapies to transform the lives of patients facing serious diseases. The Company's commercial portfolio and clinical pipeline are organized around three therapeutic areas: Respiratory, Immunology & Inflammation, and Neuro & Other Rare. To complement the Company's internal research and development, the Company also actively evaluates in-licensing and acquisition opportunities for commercial products, product candidates and technologies.

The Company's first two commercial products, ARIKAYCE® and BRINSUPRI®, are both part of the Respiratory therapeutic area. ARIKAYCE is approved in the US as ARIKAYCE (amikacin liposome inhalation suspension), in Europe as ARIKAYCE Liposomal 590 mg Nebuliser Dispersion and in Japan as ARIKAYCE inhalation 590 mg (amikacin sulfate inhalation drug product). ARIKAYCE received accelerated approval in the US in September 2018 for the treatment of MAC lung disease as part of a combination antibacterial drug regimen for adult patients with limited or no alternative treatment options in a refractory setting. In October 2020, the European Commission approved ARIKAYCE Liposomal for the treatment of nontuberculous mycobacterial lung infections caused by MAC in adults with limited treatment options who do not have cystic fibrosis. In March 2021, Japan's Ministry of Health, Labour and Welfare approved ARIKAYCE for the treatment of patients with NTM lung disease caused by MAC who did not sufficiently respond to prior treatment with a multidrug regimen. NTM lung disease caused by MAC (which the Company refers to as MAC lung disease) is a rare and often chronic infection that can cause irreversible lung damage and can be fatal.

BRINSUPRI (brensocatib 25 mg and 10 mg tablets), an oral, once-daily treatment for non-cystic fibrosis bronchiectasis (referred to as bronchiectasis or NCFB) in patients 12 years of age and older, was approved in the US in August 2025. In November 2025, the EC approved BRINSUPRI (brensocatib 25 mg tablets) for the treatment of NCFB in patients 12 years of age and older with two or more exacerbations in the prior 12 months. Bronchiectasis is a serious, chronic lung disease in which the bronchi become permanently dilated due to a cycle of infection, inflammation, and lung tissue damage.

The Company's Respiratory therapeutic area also includes clinical-stage programs for TPIP and INS1148. TPIP is an inhaled dry powder formulation of the treprostinil prodrug treprostinil palmitil which may offer a differentiated product profile for PH-ILD, PAH, PPF, and IPF. INS1148 is a monoclonal antibody targeting SCF248 for patients with interstitial lung disease and moderate to severe asthma. The Company is also exploring additional opportunities utilizing its various technologies within the Respiratory therapeutic area.

The Company's Inflammation & Immunology therapeutic area includes the development of brensocatib, a small molecule, oral, reversible inhibitor of DPP1, for the treatment of patients with HS. The Company is also exploring additional opportunities utilizing its various technologies within the Inflammation & Immunology therapeutic area.

The Company's Neuro & Other Rare therapeutic area includes the clinical-stage programs INS1201, an intrathecally delivered gene therapy for patients with DMD, and INS1202, an intrathecally delivered gene therapy for patients with ALS. The Company is also exploring additional opportunities utilizing its various technologies within the Neuro & Other Rare therapeutic area.

The Company's pre-clinical research programs encompass a wide range of technologies and modalities, including gene therapy, AI-driven protein engineering, protein manufacturing, RNA end-joining, and synthetic rescue.

The Company was incorporated in the Commonwealth of Virginia on November 29, 1999 and its principal executive offices are located in Bridgewater, New Jersey. The Company has legal entities in the US, France, Germany, Ireland, Italy, the Netherlands, Switzerland, the UK, and Japan.

The Company had $510.4 million of cash and cash equivalents and $919.6 million of marketable securities as of December 31, 2025 and reported a net loss of $1,276.8 million for the year ended December 31, 2025. The Company has funded its operations through public offerings of equity securities, debt financings, revenue interest financings and revenues generated from ARIKAYCE and BRINSUPRI. The Company expects to continue to incur consolidated operating losses, including losses in its US and certain international entities, while funding research and development activities for ARIKAYCE, TPIP, brensocatib, INS1148, INS1201, INS1202 and its other pipeline programs, and commercialization and regulatory activities for BRINSUPRI and ARIKAYCE.

The Company expects its future cash requirements to be substantial. While the Company currently has sufficient funds to meet its financial needs for at least the next 12 months, the Company may raise additional capital in the future to fund its operations, its ongoing commercialization and clinical trial activities, and its future product candidates, and to develop, acquire,

1. *The Company and Basis of Presentation (Continued)*

in-license or co-promote other products or product candidates, including those that address serious diseases with significant unmet need. The source, timing and availability of any future financing or other transaction will depend principally upon continued progress in the Company's commercial, regulatory and development activities. Any future financing will also be contingent upon market conditions. If the Company is unable to obtain sufficient additional funds when required, the Company may be forced to delay, restrict or eliminate all or a portion of its development programs or commercialization efforts.

The consolidated financial statements include the accounts of the Company and its wholly-owned subsidiaries, Celtrix Pharmaceuticals, Inc., Insmed France SAS, Insmed Gene Therapy LLC, Insmed Germany GmbH, Insmed Godo Kaisha, Insmed Holdings Limited, Insmed Innovation UK Limited, Insmed Ireland Limited, Insmed Italy S.R.L., Insmed Limited, Insmed Netherlands B.V., Insmed Netherlands Holdings B.V., and Insmed Switzerland GmbH.

2. *Summary of Significant Accounting Policies*

Use of Estimates—The preparation of the consolidated financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying notes. The Company bases its estimates and judgments on historical experience and on various other assumptions. The amounts of assets and liabilities reported in the Company's balance sheets and the amounts of revenues and expenses reported for each period presented are affected by estimates and assumptions, which are used for, but not limited to, the accounting for revenue allowances, stock-based compensation, income taxes, loss contingencies, acquisition related intangibles including in process research and development (IPR&D) and goodwill, fair value of contingent consideration, the revenue interest purchase agreement, and accounting for R&D costs. Actual results could differ from those estimates.

Cash and Cash Equivalents—The Company considers cash equivalents to be highly liquid investments with maturities of three months or less from the date of purchase.

Accounts Receivable—Accounts receivable are recorded net of customer allowances for prompt pay discounts, chargebacks, and any estimated expected credit losses. The Company's measurement of expected credit losses is based on relevant information about past events, including historical experience, current conditions, and reasonable and supportable forecasts that affect the collectability of the reported amount. To date, credit losses have not been material.

Concentration of Credit Risk—Financial instruments that potentially subject the Company to concentrations of credit risk consist primarily of cash and cash equivalents and marketable securities. The Company places its cash equivalents and marketable securities with high credit-quality financial institutions and may invest its investments in US treasury securities, mutual funds and government agency bonds. The Company has established guidelines relative to credit ratings and maturities that seek to maintain safety and liquidity.

The Company is exposed to risks associated with extending credit to customers related to the sale of products. The Company does not require collateral to secure amounts due from its customers. The Company uses an expected loss methodology to calculate allowances for trade receivables. The Company's measurement of expected credit losses is based on relevant information about past events, including historical experience, current conditions, and reasonable and supportable forecasts that affect the collectability of the reported amount. The Company does not currently have a material allowance for uncollectible trade receivables.

The following table presents the customers representing 10% or more of the Company's gross product revenues for the year ended December 31, 2025 and their respective percentages for the years ended December 31, 2024 and 2023:

	Years Ended December 31,		
	2025	**2024**	**2023**
Customer A	31%	30%	34%
Customer B	26%	34%	35%
Customer C	17%	21%	19%
Customer D	12%	8%	7%

The Company relies on third-party manufacturers and suppliers for manufacturing and supply of its products. The inability of the suppliers or manufacturers to fulfill supply requirements of the Company could materially impact future operating results. A change in the relationship with the suppliers or manufacturers, or an adverse change in their business, could materially impact future operating results.

2. Summary of Significant Accounting Policies (Continued)

Marketable Securities—Marketable securities consist of available-for-sale investments in US Treasury securities. Marketable securities under this classification are recorded at fair value and unrealized gains and losses are recorded within accumulated other comprehensive gain (loss). The estimated fair value of available-for-sale marketable securities is determined based on quoted market prices. Marketable securities maturing in one year or less are classified as current assets and marketable securities maturing in more than one year are classified as non-current assets. The Company did not have available-for-sale securities with a maturity of more than one year as of December 31, 2025 and December 31, 2024.

Fixed Assets, Net—Fixed assets are recorded at cost and are depreciated on a straight-line basis over the estimated useful lives of the assets. Estimated useful lives of three years to five years are used for computer hardware and software. Estimated useful lives of seven years are used for laboratory equipment, office equipment, manufacturing equipment and furniture and fixtures. Estimated useful lives of 39 years are used for building and building improvements. Leasehold improvements are amortized over the shorter of the lease term or the estimated useful life of the asset. Land is not depreciated.

Finite-lived Intangible Assets—Finite-lived intangible assets are measured at their respective fair values on the date they were recorded. The fair values assigned to the Company's intangible assets are based on reasonable estimates and assumptions given available facts and circumstances. See *Note 6 - Intangibles, Net and Goodwill* for further details.

Impairment Assessment—The Company reviews the recoverability of its finite-lived intangible assets and long-lived assets for indicators of impairments. Events or circumstances that may require an impairment assessment include negative clinical trial results, a significant decrease in the market price of the asset, or a significant adverse change in legal factors or the manner in which the asset is used. If such indicators are present, the Company assesses the recoverability of affected assets by determining if the carrying value of such assets is less than the sum of the undiscounted future cash flows of the assets. If such assets are found to not be recoverable, the Company measures the amount of the impairment by comparing the carrying value of the assets to the fair value of the assets. The Company determined that no indicators of impairment of finite-lived intangible assets or long-lived assets existed at December 31, 2025.

Business Combinations and Asset Acquisitions—The Company evaluates acquisitions of assets and other similar transactions to assess whether or not the transaction should be accounted for as a business combination or asset acquisition by first applying a screen to determine if substantially all of the fair value of the gross assets acquired is concentrated in a single identifiable asset or group of similar identifiable assets. If the screen is met, the transaction is accounted for as an asset acquisition. If the screen is not met, further determination is required as to whether or not the Company has acquired inputs and processes that have the ability to create outputs, which would meet the requirements of a business. If determined to be a business combination, the Company accounts for the transaction under the acquisition method of accounting as indicated in Business Combinations (Topic 805).

The consideration for the Company's business acquisitions may include future payments that are contingent upon the occurrence of a particular event or events. The obligations for such contingent consideration payments are recorded at fair value on the acquisition date. The contingent consideration obligations are then evaluated each reporting period. Changes in the fair value of contingent consideration, other than changes due to payments, are recognized as a gain or loss and recorded within change in the fair value of deferred and contingent consideration liabilities in the consolidated statements of comprehensive loss.

If determined to be an asset acquisition, the Company recognizes the assets acquired and liabilities assumed based on the relative fair value basis, which includes transaction costs in addition to consideration given. No gain or loss is recognized as of the date of acquisition unless the fair value of non-cash assets given as consideration differs from the assets' carrying amounts on the acquiring entity's books. Consideration transferred that is non-cash will be measured based on either the cost (which shall be measured based on the fair value of the consideration given) or the fair value of the assets acquired and liabilities assumed, whichever is more reliably measurable. Goodwill is not recognized in an asset acquisition and any excess consideration transferred over the fair value of the net assets acquired is allocated to the identifiable assets based on relative fair values. If the in-licensed agreement for IPR&D does not meet the definition of a business and the assets have not reached technological feasibility and therefore have no alternative future use, the Company expenses payments made under such license agreements as acquired IPR&D expense within R&D expense in its consolidated statements of comprehensive loss.

Contingent consideration payments in asset acquisitions are recognized when the contingency is resolved and the consideration is paid or becomes payable, unless the contingent consideration meets the definition of a derivative, in which case the amount becomes part of the basis in the asset acquired. None of the Company's contingent consideration met the definition of a derivative. Upon recognition of the contingent consideration payment, the amount is included in the cost of the acquired asset or group of assets.

2. Summary of Significant Accounting Policies (Continued)

Indefinite-lived Intangible Assets—Indefinite-lived intangible assets consist of IPR&D. IPR&D acquired directly in a transaction other than a business combination is capitalized if the projects will be further developed or have an alternative future use; otherwise, they are expensed. The fair values of IPR&D project assets acquired in business combinations are capitalized. The Company generally utilizes the Multi-Period Excess Earning Method to determine the estimated fair value of the IPR&D assets acquired in a business combination. The projections used in this valuation approach are based on many factors, such as relevant market size, patent protection, and expected pricing and industry trends. The estimated future net cash flows are then discounted to the present value using an appropriate discount rate. These assets are treated as indefinite-lived intangible assets until completion or abandonment of the projects, at which time the assets are amortized over the remaining useful life or written off, as appropriate. Intangible assets with indefinite lives, including IPR&D, are tested for impairment if impairment indicators arise and, at a minimum, annually. However, an entity is permitted to first assess qualitative factors to determine if a quantitative impairment test is necessary. Further testing is only required if the entity determines, based on the qualitative assessment, that it is more likely than not that an indefinite-lived intangible asset's fair value is less than its carrying amount. The indefinite-lived intangible asset impairment test consists of a one-step analysis that compares the fair value of the intangible asset with its carrying amount. If the carrying amount of an intangible asset exceeds its fair value, an impairment loss is recognized in an amount equal to that excess. The Company considers many factors in evaluating whether the value of its intangible assets with indefinite lives may not be recoverable, including, but not limited to, expected growth rates, the cost of equity and debt capital, general economic conditions, the Company's outlook and market performance of the Company's industry and recent and forecasted financial performance. The Company performs a qualitative test for its indefinite-lived intangible assets annually as of October 1. During the year ended December 31, 2025, the Company concluded that no impairment exists.

Goodwill—Goodwill represents the amount of consideration paid in excess of the fair value of net assets acquired as a result of the Company's business acquisitions accounted for using the acquisition method of accounting. Goodwill is not amortized and is subject to impairment testing at a reporting unit level on an annual basis or when a triggering event occurs that may indicate the carrying value of the goodwill is impaired. An entity is permitted to first assess qualitative factors to determine if a quantitative impairment test is necessary. Further testing is only required if the entity determines, based on the qualitative assessment, that it is more likely than not that the fair value of the reporting unit is less than its carrying amount. As of December 31, 2025, the Company concluded that it continues to operate as one reporting unit. As of October 1, 2025, the Company performed a qualitative impairment test for goodwill and concluded that no impairment exists.

Leases—A lease is a contract, or part of a contract, that conveys the right to control the use of explicitly or implicitly identified property, plant or equipment in exchange for consideration. Control of an asset is conveyed to the Company if the Company obtains the right to obtain substantially all of the economic benefits of the asset or the right to direct the use of the asset. The Company recognizes right-of-use (ROU) assets and lease liabilities at the lease commencement date based on the present value of future, fixed lease payments over the term of the arrangement. ROU assets are amortized on a straight-line basis over the term of the lease or are amortized based on consumption, if this approach is more representative of the pattern in which benefit is expected to be derived from the underlying asset. Lease liabilities accrete to yield and are reduced at the time when the lease payment is payable to the vendor. Variable lease payments are recognized at the time when the event giving rise to the payment occurs and are recognized in the consolidated statements of comprehensive loss in the same line item as expenses arising from fixed lease payments.

Leases are measured at present value using the rate implicit in the lease or, if the implicit rate is not determinable, the lessee's incremental borrowing rate. As the implicit rate is not typically available, the Company uses its incremental borrowing rate based on the information available at the lease commencement date to determine the present value of future lease payments. The incremental borrowing rate approximates the rate the Company would pay to borrow on a collateralized basis over a similar term an amount equal to the lease payments. See *Note 9 - Leases* for further details.

Debt Issuance Costs—Debt issuance costs are amortized to interest expense using the effective interest rate method over the term of the debt. Unamortized debt issuance costs paid to the lender and third parties are reflected as a discount to the debt in the consolidated balance sheets. Unamortized debt issuance costs associated with extinguished debt are expensed in the period of the extinguishment.

Foreign Currency—The Company has operations in the US, France, Germany, Ireland, Italy, the Netherlands, Switzerland, the UK, and Japan. The results of the Company's non-US dollar based functional currency operations are translated to US dollars at the average exchange rates during the period. Assets and liabilities are translated at the exchange rate prevailing at the balance sheet date. Equity is translated at the prevailing exchange rate at the date of the equity transaction.

2. Summary of Significant Accounting Policies (Continued)

Translation adjustments are included in total shareholders' equity, as a component of accumulated other comprehensive gain (loss).

The Company realizes foreign currency transaction gains and losses in the normal course of business based on movements in the applicable exchange rates. These gains and losses are included as a component of other (expense) income, net.

Inventory and Cost of Product Revenues (excluding amortization of intangible assets)—Inventory is stated at the lower of cost and net realizable value. Inventory is sold on a first-in, first-out (FIFO) basis. The Company periodically reviews inventory for expiry and obsolescence and, if necessary, writes down accordingly. If quality specifications are not met during the manufacturing process, such inventory is written off to cost of product revenues (excluding amortization of intangible assets) in the period identified.

Cost of product revenues (excluding amortization of intangible assets) consist primarily of direct and indirect costs related to the manufacturing of our marketed products sold, including third-party manufacturing costs, packaging services, freight, and allocation of overhead costs, in addition to royalty expenses. Cost is determined using a standard cost method, which approximates actual cost, and assumes a FIFO flow of goods. Inventory used for clinical development purposes is expensed to R&D expense when consumed. Prior to FDA approval of a product, the Company expenses all inventory related costs in the period incurred.

Research and Development—R&D expenses consist primarily of salaries, benefits and other related costs, including stock-based compensation, for personnel serving in the Company's research and development functions. R&D expenses also include other internal operating expenses, the cost of manufacturing a product candidate, including the medical devices for drug delivery, for clinical study, the cost of conducting clinical studies, and the cost of conducting pre-clinical and research activities. In addition, R&D expenses include payments to third parties for the license rights to products in development (prior to marketing approval), and may include the cost of asset acquisitions (as described further above). The Company's expenses related to manufacturing its product candidates and medical devices for clinical study are primarily related to activities at CMOs that manufacture its clinical product supply of ARIKAYCE, TPIP, brensocatib, INS1148, INS1201, INS1202, and pre-clinical research. The Company's expenses related to clinical trials are primarily related to activities at CROs that conduct and manage clinical trials on the Company's behalf. These contracts set forth the scope of work to be completed at a fixed fee or billed on a per-unit cost, and increase proportionally to the volume of services rendered. Payments under these contracts primarily depend on performance criteria such as the successful enrollment of patients or the completion of clinical trial milestones as well as time-based fees. Expenses are accrued based on contracted amounts applied to the level of patient enrollment and to activity according to the clinical trial protocol. Deposits for goods or services that will be used or rendered for future research and development activities are deferred and capitalized. Such amounts are then recognized as an expense as the related goods are delivered or the services are performed.

Stock-based Compensation—The Company recognizes stock-based compensation expense for awards of equity instruments to employees and directors based on the grant-date fair value of those awards. The grant-date fair value of the award is recognized as compensation expense ratably over the requisite service period, which generally equals the vesting period of the award. The Company may also grant performance-based stock options and performance stock units (PSUs) to employees from time to time. The grant-date fair value of performance-based stock options is recognized as compensation expense over the implicit service period once it is probable that the performance condition will be achieved. The grant-date fair value of PSUs is recognized as compensation expense on the date(s) the performance conditions become probable. Stock-based compensation expense is included in both R&D and SG&A expenses in the consolidated statements of comprehensive loss.

Investment Income and Interest Expense—Investment income consists of interest income earned on the Company's cash and cash equivalents and marketable securities. Interest expense consists primarily of contractual interest costs related to the Company's debt, non-cash interest expense related to the Company's Royalty Financing Agreement and amortization of debt issuance costs related to the Company's debt. See *Note 10 - Debt* and *Note 11 - Royalty Financing Agreement* for further details.

Income Taxes—The Company accounts for income taxes under the asset and liability method. Deferred tax assets and liabilities are recognized for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases and operating loss carry forwards. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax rates is recognized in income in the period that includes the enactment date.

2. Summary of Significant Accounting Policies (Continued)

A valuation allowance is recorded to reduce the deferred tax assets to the amount that is expected to be realized. In evaluating the need for a valuation allowance, the Company takes into account various factors, including the expected level of future taxable income and available tax planning strategies. If actual results differ from the assumptions made in the evaluation of a valuation allowance, the Company records a change in valuation allowance through income tax expense in the period such determination is made.

The Company may recognize the tax benefit from an uncertain tax position only if it is more likely than not that the tax position will be sustained on examination by taxing authorities, based solely on the technical merits of the position. The tax benefits recognized in the financial statements from such a position should be measured based on the largest benefit that is more likely than not to be sustained upon ultimate settlement. As any adjustment to the Company's uncertain tax positions would not result in a cash tax liability, it has not recorded any accrued interest or penalties related to its uncertain tax positions.

The Company's policy for interest and penalties related to income tax exposures is to recognize interest and penalties as a component of the provision for income taxes in the consolidated statements of comprehensive loss.

Net Loss Per Share—Basic net loss per share is computed by dividing net loss by the weighted average number of common shares outstanding during the period. Diluted net loss per share is computed by dividing net loss by the weighted average number of common shares and other dilutive securities outstanding during the period. Potentially dilutive securities from stock options, restricted stock units (RSUs), PSUs and convertible debt securities would be anti-dilutive as the Company incurred a net loss in all periods presented. Potentially dilutive common shares resulting from the assumed exercise of outstanding stock options and from the assumed conversion of the Company's previously outstanding convertible notes are determined based on the treasury stock method.

The following table sets forth the reconciliation of the weighted average number of common shares used to compute basic and diluted net loss per share for the years ended December 31, 2025, 2024 and 2023:

	Years Ended December 31,		
	2025	2024	2023
	(in thousands, except per share amounts)		
Numerator:			
Net loss	$ (1,276,775)	$ (913,772)	$ (749,567)
Denominator:			
Weighted average common shares used in calculation of basic net loss per share:	199,014	164,043	140,433
Effect of dilutive securities:			
Common stock options	—	—	—
RSUs	—	—	—
PSUs	—	—	—
Convertible debt securities	—	—	—
Weighted average common shares outstanding used in calculation of diluted net loss per share	199,014	164,043	140,433
Net loss per share:			
Basic and diluted	$ (6.42)	$ (5.57)	$ (5.34)

2. Summary of Significant Accounting Policies (Continued)

The following potentially dilutive securities have been excluded from the computations of diluted weighted average common shares outstanding as of December 31, 2025, 2024 and 2023 as their effect would have been anti-dilutive (in thousands):

	As of December 31,		
	2025	**2024**	**2023**
Common stock options	17,376	21,927	22,513
RSUs	3,889	3,320	2,750
PSUs	184	660	666
Convertible debt securities	—	17,690	23,438

Recently Adopted Accounting Pronouncements—In December 2023, the Financial Accounting Standard Board (FASB) issued ASU 2023-09, Income Taxes—Improvements to Income Tax Disclosures, in order to enhance the transparency and decision usefulness of income tax disclosures. ASU 2023-09 requires greater disaggregation of income tax disclosures related to the income tax rate reconciliation and income taxes paid. The Company adopted this new standard for the year ended December 31, 2025. These amendments have been applied retrospectively to all prior periods presented in the financial statements. The required disclosure enhancements of ASU 2023-09 did not have a material impact on the Company's consolidated financial statements. See *Note 14 - Income Taxes* for further details.

Recent Accounting Pronouncements (Not Yet Adopted)—In November 2024, the FASB issued ASU 2024-03, Income Statement (Subtopic 220-40)—Expense Disaggregation Disclosures, which requires disclosure of disaggregated income statement expense information about specific categories (including purchases of inventory, employee compensation, depreciation, and intangible asset amortization) in the notes to financial statements. ASU 2024-03 will be effective for fiscal years beginning after December 15, 2026 and interim periods beginning after December 15, 2027. The guidance is applied on a prospective basis, with a retrospective option, and early adoption is permitted. The Company is currently evaluating the impact of adoption of ASU 2024-03 on its consolidated financial statements.

In July 2025, the FASB issued ASU 2025-05, Financial Instruments-Credit Losses (Topic 326)—Measurement of Credit Losses for Accounts Receivable and Contract Assets. The amendments provide an optional practical expedient for estimated expected credit losses on current accounts receivable and current contract assets arising from ASC 606 revenue transactions, allowing entities to assume that economic conditions at the balance sheet date will remain unchanged over the remaining life of the receivable. The amendments are effective for annual periods beginning after December 15, 2025, and are to be applied prospectively. The Company is currently evaluating the impact of adoption of ASU 2025-05 on its consolidated financial statements.

In September 2025, the FASB issued ASU 2025-07, Derivatives and Hedging (Topic 815) and Revenue from Contracts with Customers (Topic 606)—Derivatives Scope Refinements and Scope Clarification for Share-Based Noncash Consideration from a Customer in a Revenue Contract. The amendments clarify the scope of derivative accounting and the application of the revenue recognition guidance to share-based noncash consideration received from customers. The Company will early adopt ASU 2025-07 on January 1, 2026, using a prospective transition method, as permitted by the standard. The adoption of ASU 2025-07 will not have a material impact on the Company's consolidated financial statements.

3. Fair Value Measurements

The Company categorizes its financial assets and liabilities measured and reported at fair value in the financial statements on a recurring basis based upon the level of judgment associated with the inputs used to measure their fair value. Hierarchical levels, which are directly related to the amount of subjectivity associated with the inputs used to determine the fair value of financial assets and liabilities, are as follows:

- Level 1—Inputs are unadjusted, quoted prices in active markets for identical assets or liabilities at the measurement date.
- Level 2—Inputs (other than quoted prices included in Level 1) are either directly or indirectly observable for the assets or liability through correlation with market data at the measurement date and for the duration of the instrument's anticipated life.

3. Fair Value Measurements (Continued)

- Level 3—Inputs reflect management's best estimate of what market participants would use in pricing the asset or liability at the measurement date. Consideration is given to the risk inherent in the valuation technique and the risk inherent in the inputs to the model.

Each major category of financial assets and liabilities measured at fair value on a recurring basis is categorized based upon the lowest level of significant input to the valuations. The fair value hierarchy also requires an entity to maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value. Financial instruments in Level 1 generally include US treasuries and mutual funds listed in active markets. The Company's cash and cash equivalents permit daily redemption and the fair values of these investments are based upon the quoted prices in active markets provided by the holding financial institutions.

The following table shows assets and liabilities that are measured at fair value on a recurring basis and their carrying value (in millions):

	As of December 31, 2025			
		Fair Value		
	Carrying Value	**Level 1**	**Level 2**	**Level 3**
Assets				
Cash and cash equivalents	$ 510.4	$ 510.4	$ —	$ —
Marketable securities	$ 919.6	$ 919.6	$ —	$ —
Liabilities				
Contingent consideration	$ 372.1	$ —	$ —	$ 372.1

	As of December 31, 2024			
		Fair Value		
	Carrying Value	**Level 1**	**Level 2**	**Level 3**
Assets				
Cash and cash equivalents	$ 555.0	$ 555.0	$ —	$ —
Marketable securities	$ 878.8	$ 878.8	$ —	$ —
Liabilities				
Contingent consideration	$ 168.9	$ —	$ —	$ 168.9

During the year ended December 31, 2025, $2.1 billion of marketable securities were purchased and $2.1 billion of marketable securities matured, each consisting of US Treasury Bills.

As of December 31, 2025, the Company held $919.6 million of available-for-sale securities, including an unrealized gain of $0.4 million recorded in accumulated other comprehensive gain (loss). As of December 31, 2024, the Company held $878.8 million of available-for-sale securities, including an unrealized gain of $0.3 million in accumulated other comprehensive gain (loss).

The Company recognizes transfers between levels within the fair value hierarchy, if any, at the end of each quarter. There were no transfers in or out of Level 1, Level 2 or Level 3 during the years ended December 31, 2025 and 2024. During the year ended December 31, 2025, new Level 1 assets were added in connection with the Company's purchase of available-for-sale securities.

The Company reviews the status of each security quarterly to determine whether an other-than-temporary impairment has occurred. In making its determination, the Company considers a number of factors, including: (1) the significance of the decline; (2) whether the security was rated below investment grade; (3) failure of the issuer to make scheduled interest or principal payments; and (4) the Company's ability and intent to retain the investment for a sufficient period of time for it to recover. The Company has determined that there were no other-than-temporary impairments during the year ended December 31, 2025.

Contingent Consideration Liabilities

3. Fair Value Measurements (Continued)

The contingent consideration liabilities arose from the Business Acquisition in August 2021. The contingent consideration liabilities consist of developmental and regulatory milestones, a priority review voucher milestone, and net sales milestones. Upon the achievement of certain development and regulatory milestone events, the Company is obligated to issue to Motus equityholders up to 4,979,705 shares of the Company's common stock in the aggregate and AlgaeneX equityholders up to 368,867 shares of the Company's common stock in the aggregate as of December 31, 2025. The fair value of the development and regulatory milestones are estimated utilizing a probability-adjusted approach. The weighted average probability of success of the remaining development and regulatory milestones was 39% as of December 31, 2025. The development and regulatory milestones, if achieved, will be settled in shares of the Company's common stock. As such, there is no discount rate applied in the fair value calculation. During the third quarter of 2025, a development milestone in connection with the Motus acquisition was achieved, resulting in the issuance of 364,566 shares of the Company's common stock in October 2025.

If the Company were to receive a priority review voucher from the FDA, the Company would be obligated to pay to the Motus equityholders a portion of the value of the priority review voucher, subject to certain reductions. The potential payout would be either 50% of the after-tax net proceeds received by the Company from a sale of the priority review voucher or 50% of the average of the sales prices for the last three publicly disclosed priority review voucher sales, less certain adjustments. The fair value of the priority review voucher milestone is estimated utilizing a probability-adjusted discounted cash flow approach. This obligation would be settled in cash. On December 20, 2024, the FDA's priority review voucher program expired. As of December 31, 2025 and 2024, the Company determined that the likelihood of receiving a priority review voucher was remote and the milestone had no fair value.

The contingent consideration liabilities for net sales milestones were valued using an option pricing model with Monte Carlo simulation. As of December 31, 2025, the fair value of these net sales milestones were deemed immaterial to the overall fair value of the contingent consideration.

The contingent consideration liabilities have been classified as a Level 3 recurring liability as its valuation requires substantial judgment and estimation of factors that are not currently observable in the market. If different assumptions were used for the inputs to the valuation approach, the estimated fair value could be significantly different than the fair value the Company determined. Contingent consideration liabilities expected to be settled within twelve months are classified as a current liability within accounts payable and accrued liabilities in the consolidated balance sheet. Contingent consideration expected to be settled in more than twelve months is classified as a non-current liability. As of December 31, 2025, the fair value of the current and non-current contingent consideration was $57.8 million and $314.3 million, respectively.

A valuation of the contingent consideration liabilities is performed quarterly with gains and losses included within change in fair value of deferred and contingent consideration liabilities in the consolidated statements of comprehensive loss. The following significant unobservable inputs were used in the valuation of the contingent consideration liabilities as of December 31, 2025 and 2024:

Contingent Consideration Liabilities	Fair Value as of December 31, 2025 (in millions)	Valuation Technique	Unobservable Inputs	Values
Development and regulatory milestones	$366.9	Probability-adjusted	Probabilities of success	14% - 90%

Contingent Consideration Liabilities	Fair Value as of December 31, 2024 (in millions)	Valuation Technique	Unobservable Inputs	Values
Development and regulatory milestones	$166.7	Probability-adjusted	Probabilities of success	14% - 97%

3. Fair Value Measurements (Continued)

A rollforward of the Company's valuations for the contingent consideration liabilities for the years ended December 31, 2025 and 2024 follows (in thousands):

	Contingent Consideration (Level 3 Liabilities)
Balance as of December 31, 2023	$ 84,600
Additions	—
Change in fair value	84,300
Payments	—
Balance as of December 31, 2024	168,900
Additions	—
Change in fair value	251,993
Payments	(48,754)
Balance as of December 31, 2025	$ 372,139

The change in fair value of contingent consideration liabilities are due to changes in factors such as the probability of achieving milestones, the Company's stock price, or certain other estimated assumptions. Payments are made in shares of the Company's common stock.

Royalty Financing Agreement

The fair value of the Royalty Financing Agreement at the time of the transaction was based on the Company's estimates of future royalties expected to be paid to OrbiMed over the life of the arrangement, which was determined using forecasts from market data sources, which are considered Level 3 inputs. This liability is being amortized using the effective interest method over the life of the arrangement, in accordance with ASC 470, Debt and ASC 835, Interest. The Company will utilize the prospective method to account for subsequent changes in the estimated future payments to be made to OrbiMed and will update the effective interest rate on a quarterly basis. The carrying value of the Royalty Financing Agreement approximates fair value. See *Note - 11 Royalty Financing Agreement* for further details.

Secured Senior Term Loan

The carrying value of the Term Loans are measured at amortized cost using the effective interest method and the carrying value approximates fair value. See *Note - 10 Debt* for further details.

4. Product Revenues, Net

In accordance with ASC 606, Revenue from Contracts with Customers, the Company recognizes revenue when a customer obtains control of promised goods or services, in an amount that reflects the consideration the Company expects to receive in exchange for the goods or services provided. To determine revenue recognition for arrangements within the scope of ASC 606, the Company performs the following five steps: (1) identify the contracts with a customer; (2) identify the performance obligations in the contract; (3) determine the transaction price; (4) allocate the transaction price to the performance obligations in the contract; and (5) recognize revenue when or as the entity satisfies a performance obligation. At contract inception, the Company assesses the goods or services promised within each contract to determine which are performance obligations and to assess whether each promised good or service is distinct. The Company then recognizes as revenue the amount of the transaction price that is allocated to the respective performance obligation when or as the performance obligation is satisfied. For all contracts that fall into the scope of ASC 606, the Company has identified one performance obligation: the sale of its marketed products to its customers. The Company has not incurred or capitalized any incremental costs associated with obtaining contracts with customers.

Product revenues, net consist of global net sales of ARIKAYCE and US net sales of BRINSUPRI. The Company's customers in the US include specialty pharmacies and a specialty distributor. Product revenues are recognized once the Company performs and satisfies all five steps of the revenue recognition criteria described above.

4. Product Revenues, Net (Continued)

The following table presents a geographic summary of the Company's product revenues, net for the years ended December 31, 2025, 2024 and 2023 (in thousands):

	Years Ended December 31,		
	2025	2024	2023
ARIKAYCE			
US	$ 280,294	$ 254,800	$ 224,195
International	153,471	108,907	81,013
Total	$ 433,765	$ 363,707	$ 305,208
BRINSUPRI			
US	$ 172,658	$ —	$ —
Total	$ 172,658	$ —	$ —
Total			
US	$ 452,952	$ 254,800	$ 224,195
International	153,471	108,907	81,013
Total product revenues, net	$ 606,423	$ 363,707	$ 305,208

During the years ended December 31, 2025, 2024 and 2023, sales of ARIKAYCE in Japan comprised 80%, 81% and 81% of international ARIKAYCE revenues, respectively.

Revenue is recorded at net selling price (transaction price), which includes estimates of variable consideration for which reserves are established for (a) customer credits, such as invoice discounts for prompt pay, (b) estimated government rebates, such as Medicaid and Medicare Part D reimbursements, and estimated managed care rebates, (c) estimated chargebacks, and (d) estimated costs of co-payment assistance. These reserves are based on the amounts earned or to be claimed on the related sales and are classified as reductions of accounts receivable (prompt pay discounts and chargebacks), prepaid expenses (co-payment assistance), or as a current liability (rebates). Where appropriate, these estimates take into consideration a range of possible outcomes which are probability-weighted for relevant factors such as the Company's historical experience, current contractual and statutory requirements, and forecasted customer buying and payment patterns. Overall, these reserves reflect the Company's best estimates of the amount of consideration to which it is entitled based on the terms of the applicable contract. The amount of variable consideration included in the transaction price may be constrained and is included in the net sales price only to the extent that it is probable that a significant reversal in the amount of the cumulative revenue recognized will not occur in a future period. Actual amounts of consideration ultimately received may differ from the Company's estimates. If actual results in the future vary from estimates, the Company adjusts these estimates, which would affect net product revenue and earnings in the period such variances become known.

Customer credits: Certain of the Company's customers are offered various forms of consideration, including prompt payment discounts. The payment terms for sales to specialty pharmacies and specialty distributors for prompt payment discounts are based on contractual rates agreed with the respective specialty pharmacies and distributors. The Company anticipates that its customers will earn these discounts and, therefore, deducts the full amount of these discounts from total gross product revenues at the time such revenues are recognized.

Rebates: The Company contracts with certain government agencies and managed care organizations, or collectively, third-party payors, so that its marketed products will be eligible for purchase by, or partial or full reimbursement from, such third-party payors. The Company estimates the rebates it will provide to third-party payors and deducts these estimated amounts from total gross product revenues at the time the revenues are recognized. These reserves are recorded in the same period in which the revenue is recognized, resulting in a reduction of product revenue and the establishment of a current liability. The current liability is included in accounts payable and accrued liabilities on the consolidated balance sheets. The Company estimates the rebates that it will provide to third-party payors based upon (i) the Company's contracts with these third-party payors, (ii) the government mandated discounts applicable to government-funded programs, (iii) a range of possible outcomes that are probability-weighted for the estimated payor mix, and (iv) information obtained from the Company's specialty pharmacies.

4. Product Revenues, Net (Continued)

Chargebacks: Chargebacks are discounts that occur when certain contracted customers, currently public health service institutions and federal government entities purchasing via the Federal Supply Schedule, purchase directly from the Company's specialty distributor. Contracted customers generally purchase the product at a discounted price and the specialty distributor, in turn, charges back to the Company the difference between the price the specialty distributor initially paid and the discounted price paid by the contracted customers. The Company estimates chargebacks provided to the specialty distributor and deducts these estimated amounts from gross product revenues, and from accounts receivable, at the time revenues are recognized.

Co-payment assistance: Patients who have commercial insurance and meet certain eligibility requirements may receive co-payment assistance. Based upon the terms of the program and information regarding programs provided for similar specialty pharmaceutical products, the Company estimates the average co-pay mitigation amounts and the percentage of patients that it expects to participate in the program in order to establish accruals for co-payment assistance. These reserves are recorded in the same period in which the related revenue is recognized, resulting in a reduction of product revenue. The Company adjusts its accruals for co-pay assistance based on actual redemption activity and estimates of future redemptions related to sales in the current period.

If any, or all, of the Company's actual experience varies from its estimates, the Company may need to adjust prior period accruals, affecting revenue in the period of adjustment.

The Company also recognizes revenue related to various MAPs in Europe. During the fourth quarter of 2022, the Company agreed with French authorities on the final reimbursement price related to the temporary authorization for use (Autorisation Temporaire d'Utilisation or ATU) program in France. The accrued France ATU reimbursement payable as of December 31, 2025 relates to current year sales and is recorded within accounts payable and accrued liabilities in the consolidated balance sheets. See *Note 8 - Accounts Payable and Accrued Liabilities* for further details.

The following table provides a summary rollforward of the Company's sales allowances and related accruals for the years ended December 31, 2025 and 2024, which have been deducted in arriving at product revenues, net (in thousands):

	Customer Credits, Fees and Discounts	Rebates, Chargebacks and Co-pay Assistance	Total
Balance as of December 31, 2023	$ 15,482	$ 10,177	$ 25,659
Allowances for current period sales	14,410	41,082	55,492
Allowances for prior period sales	100	3,380	3,480
Payments and credits	(22,415)	(39,958)	(62,373)
Balance as of December 31, 2024	$ 7,577	$ 14,681	$ 22,258
Allowances for current period sales	23,746	111,829	135,575
Allowances for prior period sales	—	500	500
Payments and credits	(19,876)	(59,102)	(78,978)
Balance as of December 31, 2025	$ 11,447	$ 67,908	$ 79,355

5. *Inventory*

The Company's inventory balance consists of the following (in thousands):

	As of December 31,	
	2025	2024
Raw materials	$ 30,623	$ 19,682
Work-in-process	41,346	39,932
Finished goods	60,099	38,964
	$ 132,068	$ 98,578

Inventory is stated at the lower of cost and net realizable value and consists of raw materials, work-in-process, and finished goods. The Company has not recorded any significant inventory write-downs. The Company currently uses a limited number of third-party CMOs to produce its inventory.

6. *Intangibles, Net and Goodwill*

Intangibles, Net

Finite-lived Intangible Assets

As of December 31, 2025, the Company's finite-lived intangible assets consisted of acquired ARIKAYCE R&D, the milestones paid to PARI for the license to use Lamira for the delivery of ARIKAYCE to patients as a result of the FDA and EC approvals of ARIKAYCE in September 2018 and October 2020, respectively, the milestone paid to AstraZeneca as a result of the FDA approval of BRINSUPRI in August 2025, and the milestone payable to AstraZeneca as a result of the EC approval of BRINSUPRI in November 2025. The Company began amortizing its acquired ARIKAYCE R&D and PARI milestone-related intangible assets in October 2018, over ARIKAYCE's initial regulatory exclusivity period of 12 years, and began amortizing its AstraZeneca milestone-related intangible assets in August and November 2025 over BRINSUPRI's regulatory exclusivity period of approximately 14 years. Amortization expense is estimated to be $8.3 million per year for the years 2026 through 2029, and approximately $7.1 million for 2030.

Indefinite-lived Intangible Assets

As of December 31, 2025, the Company's indefinite-lived intangible assets consisted of acquired IPR&D from the Business Acquisition. Indefinite-lived intangible assets are not amortized.

A rollforward of the Company's intangible assets for the years ended December 31, 2025 and 2024 follows (in thousands):

Intangible Asset	December 31, 2024	Additions	Amortization	December 31, 2025
Acquired ARIKAYCE R&D	$ 27,888	$ —	$ (4,850)	$ 23,038
PARI milestones	1,164	—	(202)	962
AstraZeneca milestones	—	45,000	(949)	44,051
Acquired IPR&D	29,600	—	—	29,600
	$ 58,652	$ 45,000	$ (6,001)	$ 97,651

Intangible Asset	December 31, 2023	Additions	Amortization	December 31, 2024
Acquired ARIKAYCE R&D	$ 32,738	$ —	$ (4,850)	$ 27,888
PARI milestones	1,366	—	(202)	1,164
Acquired IPR&D	29,600	—	—	29,600
	$ 63,704	$ —	$ (5,052)	$ 58,652

Goodwill

The Company's goodwill balance of $136.1 million as of December 31, 2025 and 2024 resulted from the August 2021 Business Acquisition.

7. *Fixed Assets, Net*

Fixed assets are stated at cost and depreciated using the straight-line method, based on useful lives as follows (in thousands):

Asset Description	Estimated Useful Life (years)	As of December 31, 2025	2024
Building	39	$ 10,437	$ —
Land	NA	1,963	—
Laboratory equipment	7	39,127	26,753
Furniture and fixtures	7	6,428	6,428
Computer hardware and software	3 - 5	8,425	6,485
Office equipment	7	171	171
Manufacturing equipment	7	1,336	1,336
Leasehold improvements	2 - 10	53,400	38,058
Construction in progress	—	42,410	51,127
		163,697	130,358
Less accumulated depreciation		(60,755)	(50,306)
		$ 102,942	$ 80,052

Depreciation expense was $10.4 million, $6.0 million and $5.5 million for the years ended December 31, 2025, 2024 and 2023, respectively.

8. *Accounts Payable and Accrued Liabilities*

Accounts payable and accrued liabilities consist of the following (in thousands):

	As of December 31, 2025	2024
Accounts payable and other accrued operating expenses	$ 79,907	$ 73,033
Accrued clinical trial expenses	34,329	26,068
Accrued professional fees	23,658	17,895
Accrued technical operation expenses	22,533	18,388
Accrued compensation and employee related costs	111,514	80,312
Accrued royalty and milestones payable	17,101	6,324
Accrued interest payable	—	359
Revenue Interest Payments payable	6,449	4,177
Accrued sales allowances and related costs	70,869	16,762
Accrued French rebate payable	6,960	5,988
Contingent consideration	57,799	24,700
Accrued milestone payment to AstraZeneca	15,000	—
Other accrued liabilities	9,941	11,203
	$ 456,060	$ 285,209

In November 2025, a $15.0 million milestone commitment became payable to AstraZeneca upon EC approval of BRINSUPRI. See *Note 6 - Intangibles, Net and Goodwill* for further details.

9. *Leases*

The Company's lease portfolio consists primarily of office and laboratory space, manufacturing facilities, research equipment and fleet vehicles. All of the Company's leases are classified as operating leases, except for the Company's leases of its corporate headquarters and a research facility in San Diego, which are classified as finance leases. The terms of the Company's lease agreements that have commenced range from less than one year to ten years, ten months. In its assessment of the term of each such lease, the Company has not included any options to extend or terminate the lease due to the absence of economic incentives in its lease agreements. Leases that qualify for treatment as a short-term lease are expensed as incurred. These short-term leases are not material to the Company's financial position. Furthermore, the Company does not separate lease and non-lease components for all classes of underlying assets. The Company's leases do not contain residual value guarantees and it does not sublease any of its leased assets.

The Company outsources its manufacturing operations to CMOs. Upon review of the agreements with its CMOs, the Company determined that these contracts contain embedded leases for dedicated manufacturing facilities. The Company obtains substantially all of the economic benefits from the use of the manufacturing facilities, the Company has the right to direct how and for what purpose the facility is used throughout the period of use, and the supplier does not have the right to change the operating instructions of the facility. The operating lease right-of-use assets and corresponding lease liabilities associated with the manufacturing facilities is the sum of the minimum guarantees over the life of the production contracts.

The Company records variable consideration for variable lease payments in excess of fixed fees or minimum guarantees. Variable costs related to CMO manufacturing agreements are direct costs related to the manufacturing of ARIKAYCE and are capitalized within inventory in the Company's consolidated balance sheet, while the variable costs related to other leasing arrangements, not related to the manufacturing of ARIKAYCE, have been classified within operating expenses in the Company's consolidated statements of comprehensive loss. The following table below summarizes the Company's total lease costs included in its consolidated financial statements, as well as other required quantitative disclosures (in thousands):

	As of December 31, 2025	2024
Finance lease cost:		
Amortization of right-of-use assets	$ 2,712	$ 2,712
Interest on lease liabilities	2,005	2,230
Total finance lease cost	$ 4,717	$ 4,942
Operating lease cost	10,880	10,415
Variable lease cost	24,764	25,818
Total lease cost	$ 40,361	$ 41,175
Other information:		
Cash paid for amounts included in the measurement of lease liabilities		
Operating cash flows for finance leases	$ 2,006	$ 2,230
Operating cash flows for operating leases	$ 11,040	$ 10,389
Financing cash flows for finance leases	$ 2,961	$ 2,610
Right-of-use assets obtained in exchange for new finance lease liabilities	$ —	$ —
Right-of-use assets obtained in exchange for new operating lease liabilities	$ 12,762	$ 8,995
Weighted average remaining lease term - finance leases	5.7 years	6.6 years
Weighted average remaining lease term - operating leases	2.4 years	2.9 years
Weighted average discount rate - finance leases	7.8 %	7.9 %
Weighted average discount rate - operating leases	8.9 %	9.0 %

9. Leases (Continued)

The following table below presents the maturity of lease liabilities on an annual basis for the remaining years of the Company's commenced lease agreements (in thousands):

Year Ending December 31,	Finance Leases	Operating Leases
2026	$ 5,097	$ 11,058
2027	5,228	9,376
2028	5,361	2,565
2029	5,496	954
2030	4,413	—
Thereafter	4,248	—
Total	29,843	23,953
Less: present value discount	5,779	2,310
Present value of lease liabilities	$ 24,064	$ 21,643
Balance Sheet Classification at December 31, 2025:		
Current lease liabilities	$ 3,345	$ 9,469
Long-term lease liabilities	20,719	12,174
Total lease liabilities	$ 24,064	$ 21,643

In addition to the Company's lease agreements that have previously commenced and are reflected in the consolidated financial statements, the Company has entered into additional lease agreements that have not yet commenced. The Company entered into certain agreements with Patheon related to increasing its long-term production capacity for ARIKAYCE commercial inventory. The Company has determined that these agreements with Patheon contain an embedded lease for the manufacturing facility and the specialized equipment contained therein. As of December 31, 2025, costs of $69.5 million incurred by the Company under these additional agreements have been classified within other assets in the Company's consolidated balance sheet. Upon the commencement date, prepaid costs and minimum guarantees specified in the agreement will be combined to establish an operating lease ROU asset and operating lease liability.

10. Debt

Debt, long-term consists of the following commitments as of December 31, 2025 and 2024 (in thousands):

	As of December 31,	
	2025	2024
Convertible notes	$ —	$ 567,164
Term Loans	540,964	536,218
Debt, long-term	$ 540,964	$ 1,103,382

2028 Convertible Notes

In May 2021, the Company completed an underwritten public offering of $575.0 million aggregate principal amount of the 2028 Convertible Notes, including the exercise in full of the underwriters' option to purchase an additional $75.0 million in aggregate principal amount of 2028 Convertible Notes. The Company's net proceeds from the offering, after deducting underwriting discounts and commissions and other offering expenses of $15.7 million, were approximately $559.3 million. The 2028 Convertible Notes bore interest payable semiannually in arrears on June 1 and December 1 of each year, beginning on December 1, 2021. The fair value of the liability component of the 2028 Convertible Notes on the date of issuance was estimated at $371.6 million using an effective interest rate of 7.1% and, accordingly, the residual equity component on the date of issuance was $203.4 million.

As of December 31, 2024, holders of seventy-seven thousand dollars of aggregate principal amount of 2028 Convertible Notes elected to convert their notes, resulting in an issuance of an aggregate of 2,362 shares of the Company’s common stock. The 2028 Convertible Notes would have matured on June 1, 2028 but, on April 24, 2025, the Company issued a redemption notice for the 2028 Convertible Notes with a redemption date of June 6, 2025 (the Redemption Date). The

10. Debt (Continued)

Company elected to settle any conversions of the 2028 Convertible Notes that occurred on or before the business day prior to the Redemption Date in shares of the Company’s common stock.

Through April 24, 2025, holders of $5.5 million of aggregate principal amount of 2028 Convertible Notes elected to convert their notes into shares of the Company’s common stock at a conversion rate of 30.7692 shares of common stock per $1,000 principal amount of notes (equivalent to a conversion price of approximately $32.50 per share of common stock), resulting in an issuance of an aggregate of 168,944 shares of the Company's common stock. After April 24, 2025, holders of $567.5 million of aggregate principal amount of the then outstanding 2028 Convertible Notes elected to convert their notes into shares of the Company's common stock at a conversion rate of 31.2861 shares of common stock per $1,000 principal amount of notes (equivalent to a conversion price of approximately $31.96 per share of common stock), resulting in the issuance of an aggregate of 17,756,196 shares of the Company’s common stock. On the Redemption Date, all then outstanding 2028 Convertible Notes were redeemed at a redemption price equal to 100% of the principal amount of such 2028 Convertible Notes, plus accrued and unpaid interest on such 2028 Convertible Notes to, but excluding, the Redemption Date (the Redemption Price). For each $1,000.00 principal amount of 2028 Convertible Notes, the Redemption Price was equal to approximately $1,000.10.

2025 Convertible Notes

In January 2018, the Company completed an underwritten public offering of $450.0 million aggregate principal of the 2025 Convertible Notes, including the exercise in full of the underwriters' option to purchase an additional $50.0 million in aggregate principal amount of 2025 Convertible Notes. The Company's net proceeds from the offering, after deducting underwriting discounts and commissions and other offering expenses of $14.2 million, were approximately $435.8 million. The 2025 Convertible Notes bore interest payable semiannually in arrears on January 15 and July 15 of each year, beginning on July 15, 2018. The fair value of the liability component of the 2025 Convertible Notes on the date of issuance was estimated at $309.1 million using an effective interest rate of 7.6% and, accordingly, the residual equity component on the date of issuance was $140.9 million.

The 2025 Convertible Notes would have matured on January 15, 2025 but on June 27, 2024, the Company called the outstanding 2025 Convertible Notes for redemption, which was completed on August 9, 2024. The Company elected to settle any conversions of the 2025 Convertible Notes that occurred on or before the business day prior to the Redemption Date in shares of the Company’s common stock. Holders of $224.8 million aggregate principal amount of the then outstanding 2025 Convertible Notes elected to convert their notes into shares of the Company's common stock at a conversion rate of 25.5384 shares of common stock per $1,000 principal amount of 2025 Convertible Notes (equivalent to an initial conversion price of approximately $39.16 per share of common stock). These conversions resulted in the issuance of an aggregate of 5,741,063 shares of the Company’s common stock.

The remaining $0.2 million aggregate principal amount of 2025 Convertible Notes outstanding were redeemed by the Company on the Redemption Date at a redemption price equal to 100% of the principal amount of the 2025 Convertible Notes, plus accrued and unpaid interest on the 2025 Convertible Notes to, but excluding, the Redemption Date (the Redemption Price). For each $1,000 principal amount of 2025 Convertible Notes, the Redemption Price was approximately $1,001.17.

The following table presents the carrying value of the Company’s convertible notes balance (in thousands):

	As of December 31,	
	2025	2024
Face value of outstanding convertible notes	$ —	$ 574,923
Debt issuance costs, unamortized	—	(7,759)
Convertible notes	$ —	$ 567,164

The $567.2 million carrying value of the 2028 Convertible Notes as of December 31, 2024 is net of $7.8 million of unamortized debt issuance costs.

Secured Senior Term Loan

In October 2022, the Company entered into the $350.0 million Tranche A Term Loan with Pharmakon that would have matured on October 19, 2027. The Tranche A Term Loan originally bore interest at a rate based upon the SOFR, subject to a SOFR floor of 2.5%, in addition to a margin of 7.75% per annum. Up to 50% of the interest payable during the first 24 months from the closing of the Tranche A Term Loan could have been paid-in-kind at the Company's election. If elected, paid-in-kind

10. Debt (Continued)

interest would have been capitalized and added to the principal amount of the Tranche A Term Loan. The Tranche A Term Loan, including the paid-in-kind interest, would have been repaid in eight equal quarterly payments starting in the 13th quarter following the closing of the Tranche A Term Loan (i.e., the quarter ending March 31, 2026), except that the repayment start date could have been extended at the Company's option for an additional four quarters, so that repayments start in the 17th quarter following the closing of the Tranche A Term Loan, subject to the achievement of specified ARIKAYCE data thresholds and certain other conditions. Net proceeds from the Tranche A Term Loan, after deducting the lenders fees and deal expenses of $15.1 million, were $334.9 million.

Amended and Restated Loan Agreement

In October 2024, the Company entered into the A&R Loan Agreement, as amended on July 10, 2025, with BioPharma Credit PLC, BPCR Limited Partnership and BioPharma Credit Investments V (Master) LP, which are funds managed by Pharmakon, and the guarantors party to such agreement. The A&R Loan Agreement amended and restated the Loan Agreement, dated as of October 19, 2022, pursuant to which the Tranche A Term Loan was provided. The A&R Loan Agreement, among other items, provides an additional $150.0 million senior secured term loan tranche. The A&R Loan Agreement extends the maturity of the Term Loans to September 30, 2029, subject to acceleration to February 1, 2028 on the occurrence of certain prespecified events, and amends the interest rate on the Term Loans to a fixed rate of 9.6% per annum. As consideration for the provision of the Tranche B Term Loan, the Company agreed to pay Pharmakon a fee equal to 2.0% of the Tranche B Term Loan at the closing date of the Tranche B Term Loan and an additional exit fee of 2.0% of the amount of each prepayment or repayment of the Term Loans. The Term Loans will be repaid in eight equal quarterly payments starting on January 3, 2028. Net proceeds from the Tranche B Term Loan, after deducting the lenders fees and administrative expenses of $3.7 million, were $146.3 million.

The Company evaluated whether the A&R Loan Agreement represented a debt modification or extinguishment in accordance with ASC 470-50, Debt – Modifications and Extinguishments. As the present value of the cash flows under the terms of the A&R Loan Agreement was less than 10% different from the remaining cash flows under the terms of the Tranche A Term Loan, the A&R Loan Agreement was accounted for as a debt modification. The unamortized balance of debt issuance costs incurred in connection with the Term Loans are being amortized through September 2029 utilizing the effective interest rate method. The effective interest rate of the Term Loans was 10.6% at modification.

The following table presents the carrying value of the Company's Term Loans balance as of December 31, 2025 and 2024 (in thousands):

	As of December 31,	
	2025	2024
Principal	$ 500,000	$ 500,000
Paid-in-kind interest capitalized	46,770	46,770
Debt discount, net	(5,806)	(10,552)
Term Loans	$ 540,964	$ 536,218

As of December 31, 2025, future principal repayments of debt for each of the fiscal years through maturity were as follows (in thousands):

Year Ending December 31:	
2026	$ —
2027	—
2028	341,731
2029	205,039
2030	—
2031 and thereafter	—
	$ 546,770

10. Debt (Continued)

The estimated fair value of the debt (categorized as a Level 2 liability for fair value measurement purposes) is determined using current market factors and the ability of the Company to obtain debt at comparable terms to those that are currently in place.

Interest expense for the years ended December 31, 2025, 2024, and 2023, is as follows (in thousands):

	Years Ended December 31,		
	2025	2024	2023
Convertible debt contractual interest expense	$ 1,680	$ 6,397	$ 8,250
Term Loans contractual interest expense	53,219	51,587	46,743
Royalty Financing Agreement non-cash interest expense	20,675	20,044	18,846
Amortization of debt issuance costs	6,216	6,884	7,320
Swap interest income	—	(2,229)	(1,882)
Total debt interest expense	$ 81,790	$ 82,683	$ 79,277
Finance lease interest expense	2,005	2,230	2,417
Total interest expense	$ 83,795	$ 84,913	$ 81,694

11. Royalty Financing Agreement

In October 2022, the Company entered into the Royalty Financing Agreement with OrbiMed. Under the Royalty Financing Agreement, OrbiMed paid the Company $150.0 million in exchange for the right to receive, on a quarterly basis, royalties in an amount equal to 4.0% of ARIKAYCE global net sales prior to September 1, 2025 and 4.5% of ARIKAYCE global net sales on or after September 1, 2025, as well as 0.75% of brensocatib global net sales, which includes BRINSUPRI. In the event that OrbiMed has not received aggregate Revenue Interest Payments of at least $150.0 million on or prior to March 31, 2028, the Company must make a one-time payment to OrbiMed for the difference between the $150.0 million and the aggregated Revenue Interest Payments that have been paid. In addition, the royalty rate for ARIKAYCE will be increased beginning March 31, 2028 to the rate which would have resulted in aggregate Revenue Interest Payments as of March 31, 2028 equaling $150.0 million. The total Revenue Interest Payments payable by the Company to OrbiMed are capped at 1.8x of the purchase price or up to a maximum of 1.9x of the purchase price under certain conditions. Net proceeds from the Royalty Financing Agreement, after deducting the lenders fees and deal expenses of $3.6 million, were $146.4 million. The Royalty Financing Agreement was amended in October 2024 to, among other things, amend certain restrictions on the Company's ability to incur indebtedness.

The fair value of the Royalty Financing Agreement at the time of the transaction was based on the Company's estimates of future royalties expected to be paid to OrbiMed over the life of the arrangement, which was determined using forecasts from market data sources, which are considered Level 3 inputs. This liability is being amortized using the effective interest method over the life of the arrangement, in accordance ASC 470, Debt and ASC 835, Interest. The initial annual effective interest rate was determined to be 12.4%. The Company is utilizing the prospective method to account for subsequent changes in the estimated future payments to be made to OrbiMed and updates the effective interest rate on a quarterly basis.

11. Royalty Financing Agreement (Continued)

The following table presents the activity of the Company's Royalty Financing Agreement balance for the years ended December 31, 2025 and 2024 (in thousands):

	As of December 31,	
	2025	2024
Royalty Financing Agreement liability - beginning balance	$ 163,671	$ 158,162
Revenue Interest Payments paid and payable	(19,401)	(14,535)
Interest expense recognized	20,675	20,044
Royalty Financing Agreement liability - ending balance	$ 164,945	$ 163,671
Royalty issuance costs, unamortized - beginning balance	$ (2,604)	$ (3,128)
Amortization of issuance costs	524	524
Royalty issuance costs, unamortized - ending balance	$ (2,080)	$ (2,604)
Royalty Financing Agreement	$ 162,865	$ 161,067

The Revenue Interest Payments payable in connection with the royalty financing agreement were $6.4 million and $4.2 million as of December 31, 2025 and 2024, respectively, which were recorded within accounts payable and accrued expenses on the consolidated balance sheets. Non-cash interest expense is recorded within interest expense in the consolidated statements of comprehensive loss.

12. Shareholders' Equity

Common Stock—As of December 31, 2025, the Company had 500,000,000 shares of common stock authorized with a par value of $0.01 per share and 214,255,853 shares of common stock issued and outstanding. In addition, as of December 31, 2025, the Company had reserved 17,375,581 shares of common stock for issuance upon the exercise of outstanding common stock options, 3,889,230 shares of common stock for issuance upon the vesting of RSUs and 266,443 shares for issuance upon the vesting of PSUs. In connection with the Business Acquisition, the Company reserved 9,406,112 shares of the Company's common stock, subject to certain closing-related reductions.

Of the 9,406,112 shares reserved, subject to certain closing-related reductions, the Company issued 2,889,367 shares of the Company's common stock in connection with the Business Acquisition in the third quarter of 2021, after certain closing-related deductions. 171,427, 177,203, and 182,182 shares of the Company's common stock reserved in connection with the Motus acquisition were issued as acquisition consideration on the first, second and third anniversaries of the closing date of the acquisition, respectively, in each case subject to certain reductions. During the third quarter of 2025, a development milestone in connection with the Motus acquisition was achieved, resulting in the issuance of 364,566 shares of the Company's common stock in October 2025. In February 2026, a development milestone in connection with the Motus acquisition was achieved, pursuant to which 368,867 shares of the Company's common stock, subject to certain reductions, became issuable. Additional shares of the Company's common stock will also be issued upon the achievement of certain development and regulatory milestone events, subject to certain reductions. The shares of the Company's common stock reserved in connection with the AlgaeneX acquisition will be issued upon the achievement of a development milestone event, subject to certain reductions. As of December 31, 2025, 5,348,572 shares of the Company's common stock remain reserved for the Business Acquisition.

In June 2025, the Company completed an underwritten offering of 8,984,375 shares of the Company's common stock at a public offering price of $96.00 per share. 1,171,875 of the shares of common stock were issued pursuant to the exercise in full of the underwriters' option to purchase additional shares. The Company's net proceeds from the sale of the shares, after deducting the underwriting discounts and offering expenses of $39.2 million, were $823.3 million.

In May 2024, the Company completed an underwritten offering of 14,514,562 shares of the Company's common stock at a public offering price of $51.50 per share. 1,893,203 of the shares of common stock were issued pursuant to the exercise in full of the underwriters' option to purchase additional shares. The Company's net proceeds from the sale of the shares, after deducting the underwriting discounts and offering expenses of $34.3 million, were $713.2 million.

In the second quarter of 2023, in connection with the Company's acquisition of Adrestia, the Company issued 3,430,867 shares of the Company's common stock as consideration at closing. See *Note 18 - Acquisitions* for further details.

In connection with the Company's acquisition of Vertuis, the Company reserved 550,000 shares of the Company's common stock, subject to future adjustment. An aggregate of 500,000 of the reserved shares were issued as acquisition

12. Shareholders' Equity (Continued)

consideration at closing. In July 2024, the Company issued the Vertuis equityholders an additional 14,773 shares of common stock. See *Note 18 - Acquisitions* for further details.

In the first quarter of 2021, the Company entered into a sales agreement with Leerink Partners, to sell shares of the Company's common stock, with aggregate gross sales proceeds of up to $250.0 million, from time to time, through the ATM program, under which Leerink Partners acts as sales agent. During the year ended December 31, 2023, the Company issued and sold an aggregate of 6,503,041 shares of common stock through the ATM program at a weighted-average public offering price of $24.12 per share and received net proceeds of $152.2 million. In the first quarter of 2024, the Company entered into the new sales agreement with Leerink Partners to sell shares of the Company's common stock, with aggregate gross sales proceeds of up to $500.0 million, from time to time, through the new ATM program, under which Leerink Partners acted as sales agent. In connection with entering into the new ATM program, the Company terminated the ATM program. During the third quarter of 2024, the Company issued and sold an aggregate of 5,022,295 shares of common stock through the new ATM program at a weighted-average public offering price of $75.64 per share and received net proceeds of $371.3 million. In November 2024, the Company terminated the new sales agreement.

Preferred Stock—As of December 31, 2025 and 2024, the Company had 200,000,000 shares of preferred stock authorized with a par value of $0.01 and no shares of preferred stock were issued and outstanding.

13. Stock-Based Compensation

The Company's current equity compensation plan, the Insmed Incorporated Amended and Restated 2019 Incentive Plan (the 2019 Incentive Plan), was approved by shareholders at the Company's Annual Meeting of Shareholders on May 13, 2023. The 2019 Incentive Plan replaced the Insmed Incorporated 2019 Incentive Plan, as amended, pursuant to which the Company was authorized to grant incentive awards up to an aggregate of 13,750,000 shares. At the Company's 2023 Annual Meeting of Shareholders, in connection with approval of the 2019 Incentive Plan, the Company's shareholders approved the issuance of an additional 10,500,000 shares under the 2019 Incentive Plan. At the Company's 2024 Annual Meeting of Shareholders, the Company's shareholders approved Amendment No. 1 to the 2019 Incentive Plan, which provides for the issuance of an additional 3,000,000 shares under the plan. At the Company's 2025 Annual Meeting of Shareholders, the Company's shareholders approved Amendment No. 2 to the 2019 Incentive Plan, which provides for the issuance of an additional 10,000,000 shares under the 2019 Incentive Plan. As of December 31, 2025, 11,674,577 shares remain available for future issuance under the 2019 Incentive Plan.

The 2019 Incentive Plan is administered by the Compensation Committee of the Board of Directors of the Company. Under the terms of the 2019 Incentive Plan, the Company is authorized to grant a variety of incentive awards based on its common stock, including stock options (both incentive stock options and non-qualified stock options), RSUs, performance options/shares and other stock awards to eligible employees and non-employee directors. The 2019 Incentive Plan will terminate on April 3, 2029 unless it is extended or terminated earlier pursuant to its terms.

In addition, from time to time, the Company makes inducement grants of stock options and RSUs to new hires, which awards are made pursuant to the Nasdaq's inducement grant exception to the shareholder approval requirement for grants of equity compensation. The Company granted inducement stock options and RSUs covering 522,517, 1,444,850 and 2,674,290 shares of the Company's common stock to new employees during the years ended December 31, 2025, 2024 and 2023, respectively. In February 2025, the Company adopted the Insmed Incorporated 2025 Inducement Plan, under which the Company is authorized to grant a variety of inducement awards, including stock options and RSUs, up to an aggregate of 1,000,000 shares, as an inducement to become an employee of the Company or any of its subsidiaries. As of December 31, 2025, 700,233 shares remain available for future issuance under the Insmed Incorporated 2025 Inducement Plan.

On May 15, 2018, the 2018 Employee Stock Purchase Plan was approved by shareholders at the Company's 2018 Annual Meeting of Shareholders. The ESPP allows eligible employees to acquire an ownership interest in the Company by purchasing common stock, at a discount, through payroll deductions. As of December 31, 2025, 4,359,032 shares remain available for future issuance under the ESPP. The ESPP is compensatory under GAAP and the Company recorded stock-based compensation expense of $4.5 million, $3.3 million and $1.9 million for the years ended December 31, 2025, 2024 and 2023, respectively.

Stock Options—The Company calculates the fair value of stock options granted using the Black-Scholes valuation model. The following table summarizes the grant date fair value and assumptions used in determining the fair value of all stock options granted, including grants of inducement options, during the years ended December 31, 2025, 2024 and 2023.

13. Stock-Based Compensation (Continued)

	2025	2024	2023
Volatility	61% - 65%	61% - 69%	62% - 70%
Risk-free interest rate	3.59% - 4.45%	3.51% - 4.64%	3.36% - 4.72%
Dividend yield	0.0%	0.0%	0.0%
Expected option term (in years)	5.89	6.11	6.05
Weighted average fair value of stock options granted	$42.52	$20.11	$13.12

The volatility factor was based on the Company's historical volatility during the expected option term. The Company accounts for forfeitures as they occur.

From time to time, the Company has granted performance-conditioned options to certain of its employees. Vesting of these options is subject to the Company achieving certain performance criteria established at the date of grant and the grantees fulfilling a service condition (continued employment). As of December 31, 2025 and December 31, 2024, the Company had performance-conditioned options covering 114,780 shares outstanding. As of December 31, 2025 and December 31, 2024, the performance conditions are not probable and therefore no stock-based compensation was recorded in the consolidated statements of comprehensive loss.

The following table summarizes stock option activity for stock options granted for the year ended December 31, 2025 as follows:

	Number of Shares	Weighted Average Exercise Price	Weighted Average Remaining Contractual Life in Years	Aggregate Intrinsic Value (in '000)
Options outstanding at December 31, 2024	21,927,128	$ 23.89		
Granted	1,361,710	$ 68.55		
Exercised	(5,597,272)	$ 22.20		
Forfeited and expired	(315,985)	$ 36.58		
Options outstanding at December 31, 2025	17,375,581	$ 27.82	6.60	$ 2,540,642
Exercisable at December 31, 2025	9,976,481	$ 22.75	5.62	$ 1,509,208

The total intrinsic value of stock options exercised during the years ended December 31, 2025, 2024 and 2023 was $534.9 million, $173.4 million and $6.0 million, respectively.

As of December 31, 2025, there was $132.3 million of unrecognized compensation expense related to unvested stock options, which is expected to be recognized over a weighted average period of 1.9 years.

Restricted Stock Units—The Company may grant RSUs to employees and non-employee directors. Each RSU represents a right to receive one share of the Company's common stock upon the completion of a specific period of continued service.

RSU awards granted are valued at the market price of the Company's common stock on the date of grant. The Company recognizes non-cash compensation expense for the fair values of RSUs on a straight-line basis over the requisite service period of the awards.

13. Stock-Based Compensation (Continued)

The following table summarizes RSU awards granted during the year ended December 31, 2025:

	Number of RSUs	Weighted Average Grant Price
Outstanding at December 31, 2024	3,320,341	$ 23.67
Granted	1,896,360	$ 72.62
Released	(1,183,350)	$ 23.59
Forfeited	(144,121)	$ 38.28
Outstanding at December 31, 2025	3,889,230	$ 46.96

The total grant-date fair value of RSU awards vested during the years ended December 31, 2025, 2024 and 2023 was $27.9 million, $19.6 million, and $13.1 million, respectively.

As of December 31, 2025, there was $140.7 million of unrecognized compensation expense related to unvested awards, which is expected to be recognized over a weighted average period of 2.4 years.

Performance Stock Units—In December 2025, the Company granted 91,877 PSUs (the 2025 PSUs) to certain of its employees. The 2025 PSUs are subject to a performance condition and a service condition. The performance condition is the number of INDs cleared by the FDA through December 31, 2028. The service condition is continuous employment with the Company through February 1, 2029. The potential payout of the award ranges from 0% to 200% of the target, dependent on the number of INDs cleared through December 31, 2028. The Company will begin recognizing compensation cost on the date that performance condition becomes probable, with an initial recording of the cumulative expense that would have been recognized if the PSU expense had been recognized on a straight-line basis since the date of grant. The remaining unrecognized compensation cost will then be expensed prospectively on a straight-line basis over the remaining service period. Any forfeitures of unvested awards that occur after compensation cost recognition commences will result in the cumulative reversal of expense in the period in which the forfeiture occurs. As of December 31, 2025, no performance condition was probable and therefore no stock-based compensation was recorded in the consolidated statements of comprehensive loss. As of December 31, 2025, there was an unrecognized expense related to the 2025 PSUs of $18.1 million, which assumes a 100% payout.

In January 2022, the Company issued 271,612 PSUs (the 2022 PSUs). The 2022 PSUs were subject to two performance conditions based on brensocatib milestones, both of which had been achieved as of March 31, 2025, and a service condition, which was three years of continued employment. The Company achieved the first performance condition by issuing a press release announcing certain topline results from the ASPEN trial by June 30, 2024. The Company achieved the second performance condition in February 2025 upon the FDA's notification that the new drug application had been accepted for brensocatib. During the second quarter of 2024, the Company's total shareholder return was compared to the Company's Peer Group and the payout of the awards was determined to be 250% of the target. During the year ended December 31, 2025, 660,466 shares were issued upon vesting of the 2022 PSUs and $10.3 million of stock-based compensation expense was recognized.

13. Stock-Based Compensation (Continued)

The following table summarizes the aggregate stock-based compensation expense recorded in the consolidated statements of comprehensive loss related to stock options, RSUs, PSUs and ESPP during the years ended December 31, 2025, 2024 and 2023 (in thousands):

	Years Ended December 31,		
	2025	2024	2023
Research and development expenses	$ 70,046	$ 47,674	$ 35,880
Selling, general and administrative expenses	82,664	49,161	38,898
Total stock-based compensation expense	$ 152,710	$ 96,835	$ 74,778

There was no stock-based compensation expense recorded in the consolidated statements of comprehensive loss related to the 2022 PSUs during the years ended December 31, 2024 and 2023, as the performance conditions associated with the 2022 PSU awards were not probable as of these dates.

14. Income Taxes

For the years ended December 31, 2025, 2024 and 2023, the Company recorded a provision for income taxes of $5.0 million, $3.7 million and $2.6 million, respectively.

The Company's loss before income taxes in the US and globally was as follows (in thousands):

	Years Ended December 31,		
	2025	2024	2023
US	$ (1,118,491)	$ (814,531)	$ (666,181)
Foreign	(153,258)	(95,534)	(80,831)
	$ (1,271,749)	$ (910,065)	$ (747,012)

The Company's provision for income taxes consisted of the following (in thousands):

	Years Ended December 31,		
	2025	2024	2023
Current:			
Federal	$ —	$ —	$ —
State	577	356	378
Foreign	4,476	3,380	2,231
Total current provision	5,053	3,736	2,609
Deferred:			
Federal	—	—	(13)
State	(27)	(29)	(41)
Foreign	—	—	—
Total deferred benefit	(27)	(29)	(54)
Provision for income taxes	$ 5,026	$ 3,707	$ 2,555

14. Income Taxes (Continued)

The reconciliation between the federal statutory tax rate and the Company's effective tax rate, after the retrospective adoption of ASU 2023-09, is as follows (in thousands):

	Years Ended December 31,					
	2025		2024		2023	
	$	%	$	%	$	%
Statutory federal taxes and tax rate	$ (267,067)	21.0 %	$ (191,114)	21.0 %	$ (156,873)	21.0 %
State and local income taxes, net of federal income tax effect [1]	552	— %	321	— %	338	— %
Foreign tax effects						
Switzerland						
Changes in valuation allowance	12,746	(1.0)%	9,056	(1.0)%	8,462	(1.1)%
Other	9,843	(0.8)%	7,955	(0.9)%	5,308	(0.7)%
Other foreign jurisdictions	14,071	(1.1)%	6,432	(0.7)%	4,813	(0.6)%
Effects of cross-border tax laws	—	— %	—	— %	—	— %
Tax credits						
Research and development tax credits	(38,872)	3.1 %	(30,861)	3.4 %	(22,330)	3.0 %
Changes in valuation allowances	271,336	(21.3)%	185,366	(20.4)%	131,040	(17.5)%
Nontaxable or nondeductible items						
Stock-based compensation, net of nondeductible compensation	(59,412)	4.7 %	(12,574)	1.4 %	2,443	(0.3)%
Change in fair value of contingent consideration	52,919	(4.2)%	19,253	(2.1)%	6,026	(0.8)%
Asset acquisition	—	— %	—	— %	18,217	(2.4)%
Other	729	(0.1)%	309	— %	865	(0.1)%
Changes in unrecognized tax benefits	—	— %	—	— %	—	— %
Effect of changes in tax laws or rates enacted in the current period	—	— %	—	— %	—	— %
Other adjustments	8,181	(0.6)%	9,564	(1.1)%	4,246	(0.6)%
Provision for income taxes and effective tax rate	$ 5,026	(0.3)%	$ 3,707	(0.4)%	$ 2,555	(0.1)%

[1] The state that contributed to the majority (greater than 50%) of the tax effect in this category was Texas.

The provisions recorded for the years ended December 31, 2025, 2024 and 2023 are primarily a result of the Company’s international subsidiaries that had taxable income during the periods and certain state taxes in the US which impose

14. Income Taxes (Continued)

income tax on modified gross revenues. There was a full valuation allowance recorded against the Company's deferred tax assets and therefore no tax benefit was recorded.

The amounts of cash paid for income taxes by the Company are as follows:

	Years Ended December 31,		
	2025	2024	2023
Federal	$ —	$ —	$ —
State			
Texas	315	340	201
Other state [1]	64	62	117
Foreign			
Japan	2,189	1,238	742
Netherlands	1,034	267	474
Germany	—	300	214
Italy	—	197	—
Switzerland	—	—	110
Other foreign [1]	539	95	97
	$ 4,141	$ 2,499	$ 1,955

[1] In a period in which income taxes paid in a jurisdiction do not exceed 5% of total income taxes paid, the taxes paid to that jurisdiction are reported in other state or other foreign.

Deferred tax assets and liabilities are determined based on the difference between financial statement and tax bases using enacted tax rates in effect for the year in which the differences are expected to reverse. The components of the deferred tax assets and liabilities consist of the following:

	As of December 31,	
	2025	2024
Deferred tax assets:		
Net operating loss and other carryforwards	$ 956,032	$ 672,735
General business credits	267,818	217,859
Capitalized R&D	167,487	178,021
Stock-based compensation	30,852	30,701
Other [1]	41,635	38,533
Deferred tax assets	1,463,824	1,137,849
Valuation allowance	(1,456,726)	(1,125,370)
Deferred tax assets, net of valuation allowance	$ 7,098	$ 12,479
Deferred tax liabilities:		
Intangibles	$ —	$ (5,581)
Right-of-use assets	(7,127)	(6,953)
Deferred tax liabilities	$ (7,127)	$ (12,534)
Net deferred tax liabilities	$ (29)	$ (55)

[1] Prior period amounts have been reclassified for consistency with the current period presentation.

The deferred tax assets, net of valuation allowance, of $7.1 million and $12.5 million at December 31, 2025 and 2024, respectively, primarily consisted of net operating loss, tax credit carryforwards and capitalized R&D for income tax purposes. As required by the 2017 Tax Cuts and Jobs Act, effective January 1, 2022, and through the year ended December 31, 2024, the Company's research and development expenditures were capitalized, resulting in a deferred tax asset. As amended by the One

14. Income Taxes (Continued)

Big Beautiful Bill Act (OBBBA), effective January 1, 2025, the Company's current year US research and development expenditures are no longer required to be capitalized. Due to the Company's history of operating losses, the Company recorded a valuation allowance on its net deferred tax assets by increasing the valuation allowance by $331.4 million and $221.3 million in 2025 and 2024, respectively, as it was more likely than not that such tax benefits will not be realized.

At December 31, 2025, the Company had federal net operating loss (NOL) carryforwards for income tax purposes of approximately $3.3 billion and federal tax credit carryforwards of $270.1 million. Due to the limitation on NOLs as more fully discussed below, $3.1 billion of the NOLs are available to offset future taxable income, if any. The NOL carryovers and general business tax credits expire in various years beginning in 2026. For state tax purposes, the Company has approximately $2.1 billion of NOLs in various states available to offset against future taxable income and state tax credit carryforwards of $23.1 million, expiring in various years beginning in 2026. The Company has $301.1 million of non-trading loss carryforwards in Ireland and loss carryforwards in the UK and Switzerland of $95.7 million and $277.1 million, respectively. The loss carryforwards in Ireland and the UK carry forward indefinitely while the loss carryforward in Switzerland begins to expire in 2030. The Company has disallowed interest expense carryover of $47.7 million which carries forward indefinitely.

The Company completed an Internal Revenue Code Section 382 (Section 382) analysis in order to determine the amount of losses that are currently available for potential offset against future taxable income, if any. It was determined that the utilization of the Company's NOL and general business tax credit carryforwards generated in tax periods up to and including December 2010 were subject to substantial limitations under Section 382 due to ownership changes that occurred at various points from the Company's original organization through December 2010. In general, an ownership change, as defined by Section 382, results from transactions increasing the ownership of shareholders that own, directly or indirectly, 5% or more of a corporation's stock, in the stock of a corporation by more than 50 percentage points over a testing period (usually 3 years). Since the Company's formation in 1999, it has raised capital through the issuance of common stock on several occasions which, combined with the purchasing shareholders' subsequent disposition of those shares, have resulted in multiple changes in ownership, as defined by Section 382. These ownership changes resulted in substantial limitations on the use of the Company's NOLs and general business tax credit carryforwards up to and including December 2010. The Company continues to track all of its NOLs and tax credit carryforwards but has provided a full valuation allowance to offset those amounts.

Law Changes

On July 4, 2025, H.R. 1 – OBBBA was signed into law. OBBBA provides for US tax law changes and modifications including effective beginning in 2025, the ability to deduct US based research and development expenditures, a more favorable interest expense limitation and the reinstatement of 100% bonus depreciation on qualified property. OBBBA also includes several changes to the US taxation of foreign activity, including changes to foreign tax credits, global intangible low-taxed income and foreign derived intangible income, among other things. Given the Company's history of net operating losses, OBBBA did not have a significant impact on the Company's financial statements.

The Organisation for Economic Co-operation and Development (OECD) recently published a framework to implement a global corporate minimum income tax rate of 15% on income arising in low-tax jurisdictions (Pillar Two). The Pillar Two proposed legislation is applicable to multinational corporations with global revenue exceeding €750 million for at least two years of the preceding four years. Over 140 countries have agreed in principle to implement Pillar Two and many have, or are in the process of, enacting related legislation. In January 2026, the OECD released a "side-by-side" package introducing new safe harbors and providing an exemption for US-based multinational companies from parts of the global minimum tax framework. The Pillar Two legislation is not anticipated to be effective for the Company until the Company's annual global revenues have exceeded the €750 million threshold for at least two years of the preceding four years. The Company will continue to evaluate the potential consequences of Pillar Two on its longer-term financial position.

The financial statement recognition of the benefit for a tax position is dependent upon the benefit being more likely than not to be sustainable upon audit by the applicable taxing authority. If this threshold is met, the tax benefit is then measured and recognized at the largest amount that is greater than 50% likely of being realized upon ultimate settlement. If such unrecognized tax benefits were realized and not subject to valuation allowances, the Company would recognize a tax benefit of $24.7 million. The following table summarizes the gross amounts of unrecognized tax benefits (in thousands):

14. Income Taxes (Continued)

	2025	2024
Balance as of January 1,	$ 19,014	$ 14,753
Additions related to prior period tax positions	—	—
Additions related to current period tax positions	5,649	4,261
Balance as of December 31,	$ 24,663	$ 19,014

The Company is subject to US federal and state income taxes and the statute of limitations for tax audit is open for the federal tax returns for the years ended 2022 and later, and is generally open for certain states for the years 2021 and later. The Company has incurred net operating losses since inception, except for the year ended December 31, 2009. Such loss carryforwards would be subject to audit in any tax year in which those losses are utilized, notwithstanding the year of origin.

The Company's policy is to recognize interest accrued related to unrecognized tax benefits and penalties in income tax expense. The Company has recorded no such expense. As of December 31, 2025 and 2024, the Company has recorded reserves for unrecognized income tax benefits of $24.7 million and $19.0 million, respectively. As any adjustment to the Company's uncertain tax positions would not result in a cash tax liability, it has not recorded any accrued interest or penalties related to its uncertain tax positions. If any of these unrecognized tax benefits were released, there would be no impact to the Company's effective tax rate.

15. License and Other Agreements

In-License Agreements

PARI Pharma GmbH—In April 2008, the Company entered into a licensing agreement with PARI for use of the optimized Lamira Nebulizer System for delivery of ARIKAYCE in treating patients with NTM lung infections, CF and bronchiectasis. Under the licensing agreement, the Company has rights under several US and foreign issued patents and patent applications involving improvements to the optimized Lamira Nebulizer System, to exploit the system with ARIKAYCE for the treatment of such indications, but the Company cannot manufacture the nebulizers except as permitted under the commercialization agreement with PARI, which is described in further detail below. The Lamira Nebulizer System has been approved for use in the US (in combination with ARIKAYCE), the EU and Japan. Under the licensing agreement, the Company paid PARI an upfront license fee and certain milestone payments. Upon FDA acceptance of the Company's NDA and the subsequent FDA and EMA approval of ARIKAYCE, the Company paid PARI additional milestone payments of €1.0 million, €1.5 million and €0.5 million, respectively. In October 2017, the Company exercised an option to buy-down the royalties that will be paid to PARI on ARIKAYCE net sales. As a result, PARI is entitled to receive royalty payments in the mid-single digits on the annual global net sales of ARIKAYCE, pursuant to the licensing agreement, subject to certain specified annual minimum royalties. See below for information related to the commercialization agreement with PARI.

Other Agreements

Adrestia Therapeutics Ltd.—In June 2023, the Company acquired all of the issued and outstanding share capital of Adrestia, a privately held, pre-clinical stage company. At the closing of the transaction, the Company issued an aggregate of 3,430,867 shares of the Company's common stock to Adrestia's former shareholders (collectively, the Adrestia shareholders). The closing share price on the date of the transaction was $21.10, resulting in a purchase price of $72.4 million. The Adrestia shareholders may also become entitled to receive contingent payments up to an aggregate of $326.5 million in cash upon the achievement of certain development, regulatory and commercial milestone events, as well as royalty payments based upon a low single-digit percentage of net sales of certain products, both subject to the terms and conditions of the agreement. The Company recognized $76.5 million as IPR&D expense for the year ending December 31, 2023, after adjusting for working capital assumed in connection with the asset acquisition.

Vertuis Bio, Inc.—In January 2023, the Company acquired Vertuis, a privately held, pre-clinical stage company. At the closing of the transaction, the Company issued an aggregate of 500,000 shares of the Company's common stock to Vertuis' former stockholders and an individual who are entitled to receive a portion of the acquisition consideration (collectively, the Vertuis equityholders). The closing share price on the date of the transaction was $18.50. In July 2024, the Company issued the Vertuis equityholders an additional $1.0 million of shares of the Company's common stock, or 14,773 shares of common stock, based on the share price on June 28, 2024. The Company is obligated to pay the Vertuis equityholders up to an aggregate of $23.0 million in cash upon the achievement of certain development and regulatory milestone events, and up to an aggregate of

15. License and Other Agreements (Continued)

$63.8 million in cash upon the achievement of certain net sales-based milestone events, in each case, subject to certain reductions. The Company recognized $10.3 million as IPR&D expense for the year ending December 31, 2023.

PPD Development, L.P.—In April 2020, the Company entered into a master services agreement with PPD pursuant to which it retained PPD to perform clinical development services in connection with certain of its clinical research programs. The master services agreement has an initial term of five years. Either party may terminate (i) any project addendum under the master services agreement for any reason and without cause upon 30 days' written notice, (ii) any project addendum in the event of the other party's breach of the master services agreement or such project addendum upon 30 days' written notice, provided that such breach is not cured within such 30-day period, (iii) the master services agreement or any project addendum immediately upon the occurrence of an insolvency event with respect to the other party or (iv) any project addendum upon 30 days' written notice if (a) the continuation of the services under such project addendum would post material ethical or safety risks to study participants, (b) any approval from a regulatory authority necessary to perform the applicable study is revoked, suspended or expires without renewal or (c) in the reasonable opinion of such party, continuation of the services provided under such project addendum would be in violation of applicable law. The Company entered into project addenda with PPD to perform clinical development services over several years for, but not limited to, its PALM-ILD and PAH studies and other trials involving brensocatib and TPIP.

Patheon UK Limited—In October 2017, the Company entered into certain agreements with Patheon related to the increase of its long-term production capacity for ARIKAYCE commercial inventory. The agreements provide for Patheon to manufacture and supply ARIKAYCE for its anticipated commercial needs. Under these agreements, the Company is required to deliver to Patheon the required raw materials, including active pharmaceutical ingredients, and certain fixed assets needed to manufacture ARIKAYCE. Patheon's supply obligations will commence once certain technology transfer and construction services are completed. The Company's manufacturing and supply agreement with Patheon will remain in effect for a fixed initial term, after which it will continue for successive renewal terms unless either party has given written notice of termination. The technology transfer agreement will expire when the parties agree that the technology transfer services have been completed. The agreements may also be terminated under certain other circumstances, including by either party due to a material uncured breach of the other party or the other party's insolvency. These early termination clauses may reduce the amounts due to the relevant parties.

AstraZeneca AB—In October 2016, the Company entered into a license agreement (AZ License Agreement) with AstraZeneca, a Swedish corporation. Pursuant to the terms of the AZ License Agreement, AstraZeneca granted the Company exclusive global rights for the purpose of developing and commercializing AZD7986 (renamed brensocatib). In consideration of the licenses and other rights granted by AstraZeneca, the Company made an upfront payment of $30.0 million. In December 2020, the Company incurred a $12.5 million milestone payment obligation upon the first dosing in a Phase 3 clinical trial of brensocatib. In May 2024, upon the Company's release of an official public statement that the Company intended to file an NDA, the Company incurred an additional $12.5 million milestone payment obligation. Upon regulatory approval by the FDA of an NDA, the Company paid AstraZeneca an additional $30.0 million. In November 2025, a $15.0 million milestone commitment became payable to AstraZeneca upon EC approval of BRINSUPRI. Subsequent to this milestone, the Company is also obligated to make an additional $15.0 million contingent payment upon the achievement of a regulatory filing milestone. If the Company elects to develop brensocatib for a second indication, the Company will be obligated to make an additional series of contingent milestone payments to AstraZeneca totaling up to $42.5 million, the first of which occurs at the initiation of a Phase 3 trial in the additional indication. The Company is not obligated to make milestone payments for additional indications. In addition, the Company will pay AstraZeneca tiered royalties ranging from high single-digit to mid-teens on net sales of any approved product based on brensocatib and one additional payment of $35.0 million upon the first achievement of $1.0 billion in annual net sales. The AZ License Agreement provided AstraZeneca with the option to negotiate a future agreement with the Company for commercialization of brensocatib in chronic obstructive pulmonary disease or asthma. In June 2024, the negotiation period following such exercise of the final option expired. No agreement was reached between the Company and AstraZeneca to permit AstraZeneca to further develop and, if approved, commercialize brensocatib in the indications of COPD or asthma. As a result, the Company retains full worldwide development and commercialization rights for brensocatib in all indications other than COPD or asthma and AstraZeneca has no further development or commercialization rights for brensocatib in COPD, asthma or any other indication.

PARI Pharma GmbH—In July 2014, the Company entered into the Commercialization Agreement for the manufacture and supply of the Device, which is an e-Flow® nebulizer modified and optimized for use with ARIKAYCE. Under the Commercialization Agreement, PARI manufactures the Device except in the case of certain defined supply failures, when the Company will have the right to make the Device and have it made by third parties (but not certain third parties deemed under

15. License and Other Agreements (Continued)

the Commercialization Agreement to compete with PARI). The Commercialization Agreement has an initial term of fifteen years from the first commercial sale of ARIKAYCE in October 2018. The term of the agreement may be extended by the Company for an additional five years by providing written notice to PARI at least one year prior to the expiration of the Initial Term. Notwithstanding the foregoing, the parties have certain rights and obligations under the agreement prior to the commencement of the Initial Term.

Resilience Biotechnologies Inc. (successor to Therapure Biopharma Inc.)—In February 2014, the Company entered into a contract manufacturing agreement with Therapure Biopharma Inc., which was assumed by Resilience for the manufacture of ARIKAYCE, on a non-exclusive basis, at a 200 kg scale. Pursuant to the agreement, the Company and Resilience collaborated to construct a production area for the manufacture of ARIKAYCE in Resilience's existing manufacturing facility in Canada. The agreement had an initial term of five years, which began in October 2018, and renews automatically for successive periods of two years each, unless terminated by either party by providing the required two years prior written notice to the other party. Notwithstanding the foregoing, the parties have rights and obligations under the agreement prior to the commencement of the initial term. Under the agreement, the Company is obligated to pay a minimum of $6.0 million, subject to inflation increases, for commercial ARIKAYCE batches produced and certain manufacturing activities each calendar year.

Patheon Inc.—In January 2024, the Company entered into certain agreements with Patheon Inc. related to the manufacture and supply of brensocatib by Patheon Inc. for the Company's anticipated long-term commercial needs. Under these agreements, the Company is required to deliver to Patheon Inc. the active pharmaceutical ingredient needed to manufacture brensocatib. The master commercial manufacturing services agreement with Patheon Inc. will remain in effect for a fixed initial term, after which it will continue for successive renewal terms unless either the Company or Patheon Inc. has given written notice of termination. The agreements may also be terminated under certain other circumstances, including by either party due to a material uncured breach of the other party or the other party's insolvency. Patheon Inc.'s supply obligations are governed by individual product agreements entered into from time to time under the master commercial manufacturing services agreement. The product agreements specify, among other things, the term and pricing for Patheon Inc.'s supply obligations.

Esteve Química, S.A—In September 2024, the Company entered into a commercial manufacturing and supply agreement with Esteve for the manufacture and supply of brensocatib's active pharmaceutical ingredient. The commercial manufacturing and supply agreement has an initial term of three years, after which it will continue for successive 12-month renewal terms unless either the Company or Esteve has given written notice of termination. The agreement may also be terminated under certain other circumstances, including by either party due to a material uncured breach of the other party or the other party's insolvency, the discontinue of specified dosages or changes in the regulatory landscape. Esteve's supply obligations are based on rolling forecasts of the Company's anticipated demand for brensocatib.

16. Commitments and Contingencies

Commitments

In September 2018, the Company entered into a lease for its new corporate headquarters in Bridgewater, New Jersey. The initial lease term commenced in October 2019 and expires in September 2030. In July 2016, the Company signed an operating lease for laboratory space, also located in Bridgewater, for which the initial lease term was extended through December 2026. In July 2023, the Company signed an amendment to expand the laboratory space in Bridgewater until 2027. In January 2022, the Company entered into a lease for research activities in San Diego, California. The lease term commenced in February 2022 and expires in June 2032. In February 2023, the Company signed an agreement to lease warehouse space in San Diego through March 2029. Future minimum rental payments under the Bridgewater leases and San Diego leases are $14.6 million and $18.0 million, respectively.

Rent expense charged to operations was $13.6 million, $11.9 million and $9.2 million for the years ended December 31, 2025, 2024 and 2023, respectively. Rent expense is recorded on a straight-line basis over the term of the applicable leases.

In addition to rent, the Company has several firm purchase commitments, primarily related to the manufacturing of ARIKAYCE and annual minimum royalties on global net sales of ARIKAYCE. Future firm purchase commitments under these agreements, the last of which ends in 2034, total $63.0 million. These amounts do not represent the Company's entire anticipated purchases in the future, but instead represent only purchases that are the subject of contractually obligated minimum

16. Commitments and Contingencies (continued)

purchases. The minimum commitments disclosed are determined based on non-cancelable minimum spend amounts or termination amounts. Additionally, the Company purchases products and services as needed with no firm commitment.

Legal Proceedings

From time to time, the Company is a party to various lawsuits, claims and other legal proceedings that arise in the ordinary course of business. While the outcomes of these matters are uncertain, management does not expect that the ultimate costs to resolve these matters will have a material adverse effect on the Company's consolidated financial position, results of operations or cash flows.

17. Retirement Plan

The Company has a 401(k) defined contribution plan for the benefit of most US employees and permits voluntary contributions by employees subject to IRS-imposed limitations. During the year ended December 31, 2025, the Company matched 100% of eligible employee contributions on the first 5% of employee compensation (up to the IRS maximum). During the years ended December 31, 2024 and 2023, the Company matched 100% of eligible employee contributions on the first 4% of employee compensation (up to the IRS maximum). Employer contributions for the year ended December 31, 2025, 2024 and 2023 were $12.8 million, $7.4 million and $5.5 million, respectively.

18. Acquisitions

Asset Acquisitions

INS1148

In December 2025, the Company acquired the global rights to OpSCF (renamed INS1148) from Opsidio. At the closing of the transaction, the Company owed an upfront payment of $40.0 million, subject to a holdback. The Opsidio shareholders may also become entitled to receive contingent payments up to an aggregate of $382 million in cash upon the achievement of certain development, regulatory and sales milestones, as well as earnout payments based upon a low to mid single-digit percentage of net sales of certain products, both subject to the terms and conditions of the agreement.

The Company evaluated the acquisition under ASC 805 and ASU 2017-01 and concluded that substantially all of the fair value of the gross assets acquired are concentrated in a single identifiable asset or a group of similar identifiable assets and accounted for the transaction as an asset acquisition. The Company determined that the asset acquired did not have any future alternative use and, in accordance with ASC 730, Research and Development, expensed the assets within research and development in the consolidated statement of comprehensive loss as of the date of the acquisition. The Company recognized $40.0 million as IPR&D expense for the year ending December 31, 2025.

19. Segment Reporting

The Company manages its business activities on a consolidated basis and operates as a single operating segment. The Company derives its revenues from the development and commercialization of therapies for patients facing serious diseases. The accounting policies of the segment are the same as those described in Note 2 – *Summary of Significant Accounting Policies*.

The Company has a single management team that reports to the Chief Executive Officer, the chief operating decision maker (CODM), who comprehensively manages the entire business. When evaluating the Company's financial performance, the CODM regularly reviews total revenues, total expenses, and expenses by function, and makes decisions using this information on a global basis. The CODM uses net loss, as reported in the consolidated statements of comprehensive loss, in evaluating the performance of the segment. Decisions regarding resource allocation are made primarily during the annual budget planning process and augmented as needed throughout the year. The measure of segment assets is reported on the balance sheet as total assets. The Company does not operate separate lines of business with respect to its products or product candidates. Accordingly, the Company has one reportable segment.

19. Segment Reporting (Continued)

Segment loss, including significant segment expenses, for the years ended December 31, 2025, 2024 and 2023 is as follows (in thousands):

	For the Years Ended December 31,		
	2025	**2024**	**2023**
Product revenues, net	$ 606,423	$ 363,707	$ 305,208
Less:			
Cost of product revenues (excluding amortization of intangible assets)	122,938	85,742	65,573
ARIKAYCE external R&D expenses	41,441	60,269	62,418
Brensocatib external R&D expenses	96,516	98,569	108,556
TPIP external R&D expenses	94,201	65,935	50,185
INS1148 asset acquisition	40,000	—	—
Other external R&D expenses	129,866	90,604	132,652
R&D compensation and benefit-related expenses	249,203	194,907	140,861
SG&A compensation and benefit-related expenses	248,498	168,498	117,926
Other segment items[(a)]	563,927	374,947	295,211
Depreciation	10,449	5,961	5,527
Amortization of intangible assets	6,001	5,052	5,052
Change in fair value of deferred and contingent consideration liabilities	251,993	91,682	28,697
Investment income	(60,656)	(53,307)	(42,132)
Interest expense	83,795	84,913	81,694
Provision for income taxes	5,026	3,707	2,555
Segment net loss	$ (1,276,775)	$ (913,772)	$ (749,567)

[(a)] Other segment items include stock-based compensation, professional fees, and facility-related expenses.

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Executive Committee

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Chair and Chief Executive Officer

Roger Adsett, MBA
Chief Operating Officer

Sara M. Bonstein, MBA
Chief Financial Officer

Christie Camelio
Chief Compliance Officer

Adele Deering, MBA, MSc
SVP, Portfolio Strategy & Operational Excellence

Martina Flammer, M.D., MBA
Chief Medical Officer

Kevin C. Mange, M.D., MSCE
Chief Development Officer

S. Nicole Schaeffer, MBA
Chief People Strategy Officer

Michael A. Smith, J.D.
Chief Legal Officer

Eugene J. Sullivan, M.D.
Chief Product Strategy Officer

Board of Directors

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Chair and Chief Executive Officer,
Insmed Incorporated
Chair of the Board,
NewAmsterdam Pharma

David R. Brennan[3]
Lead Independent Director,
Insmed Incorporated
Former Chief Executive Officer,
AstraZeneca PLC

Elizabeth McKee Anderson[1,2]
Former Worldwide Vice President,
Global Strategic Marketing and
Market Access, Infectious Diseases and
Vaccines, Janssen Pharmaceuticals, Inc.

Clarissa Desjardins, Ph.D.[4]
Founder and Chief Executive Officer,
Congruence Therapeutics

Leo Lee[3,4]
President, China, Novartis Pharma

David W.J. McGirr[1*]
Former Chief Financial Officer,
Cubist Pharmaceuticals, Inc.
(acquired by Merck & Co., Inc.)

Carol A. Schafer[1,2]
Managing Partner, Hyphen Advisors, LLC

Melvin Sharoky, M.D.[2,4]
Former President and Chief Executive Officer,
Somerset Pharmaceuticals, Inc.

Committee Legend

1: Audit; 2: Nominations & Governance;
3: Compensation; 4: Science & Technology
*(chairpersons in **blue**)*

[*]David W.J. McGirr, who is currently serving as a Class II director, will not stand for re-election at the Annual Meeting of Shareholders.

Annual Meeting of Shareholders

To be held on May 13, 2026, at 9:00 a.m. ET

Shareholders may receive without charge a copy of our Annual Report on Form 10-K for the year ended December 31, 2025, by going to investor.insmed.com or by sending a written request to Mr. Michael A. Smith, Corporate Secretary, Insmed Incorporated, 700 US Highway 202/206, Bridgewater, New Jersey, 08807, (908) 977-9900. In connection with any such request, we will provide a list of exhibits to the Annual Report on Form 10-K for the year ended December 31, 2025, and will provide copies of any such exhibit upon the payment of a reasonable fee.

Global Headquarters

700 US Highway 202/206
Bridgewater, NJ 08807
(908) 977-9900

Trading Symbol

The common stock of Insmed Incorporated is listed on the Nasdaq Global Select Market under the symbol INSM.

Transfer Agent & Registrar

Broadridge Corporate
Issuer Solutions
P.O. Box 1342
Brentwood, NY 11717

shareholder@broadridge.com
(866) 321-8022

Independent Auditors

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99 Wood Avenue South
Iselin, NJ 08830

Investor Relations

Bryan Dunn
Vice President, Investor Relations

investor.relations@insmed.com
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www.insmed.com

Various statements in this annual report are "forward-looking statements," as that term is defined in the Private Securities Litigation Reform Act of 1995. Words herein such as "may," "will," "should," "could," "would," "expects," "plans," "anticipates," "believes," "estimates," "projects," "predicts," "intends," "potential," "continues," and similar expressions (as well as other words or expressions referencing future events, conditions or circumstances) identify forward-looking statements. Forward-looking statements are based on our current expectations and beliefs, and involve known and unknown risks, uncertainties and other factors, which may cause our actual results, performance and achievements and the timing of certain events to differ materially from the results, performance, achievements or timing discussed, projected, anticipated or indicated in any forward-looking statements. For additional information, see Item 1A – Risk Factors of the Form 10-K included in this Annual Report. We undertake no obligation to update or revise publicly any forward-looking statements.