



Corporate Presentation

November 11, 2024



Forward Looking Statements

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Spruce Bio: Transforming Care in Endocrinology and Neurology

**Large Markets with High Unmet Need
Primed for Innovation**

~\$3B+ market in **CAH**; ~\$8B+ market in **PCOS**, and ~\$10B+ market in **MDD**

**Potentially Transformative Treatment
Paradigm**

Tildacerfont is an oral, **second generation CRF-1 receptor antagonist** with validated MOA and favorable safety profile

Adult and Pediatric CAH Program Ongoing

CAHmelia-204 topline data (Adult CAH) and **CAHptain-205 topline data** (Adult and Pediatric CAH) expected in **Dec. 2024**

**Strategic Collaboration to Develop
Treatment for MDD**

Strategic collaboration with HMNC Brain Health; **initiation of Phase 2 study** of tildacerfont and Cortibon (CDx) for MDD in **Q1 25**

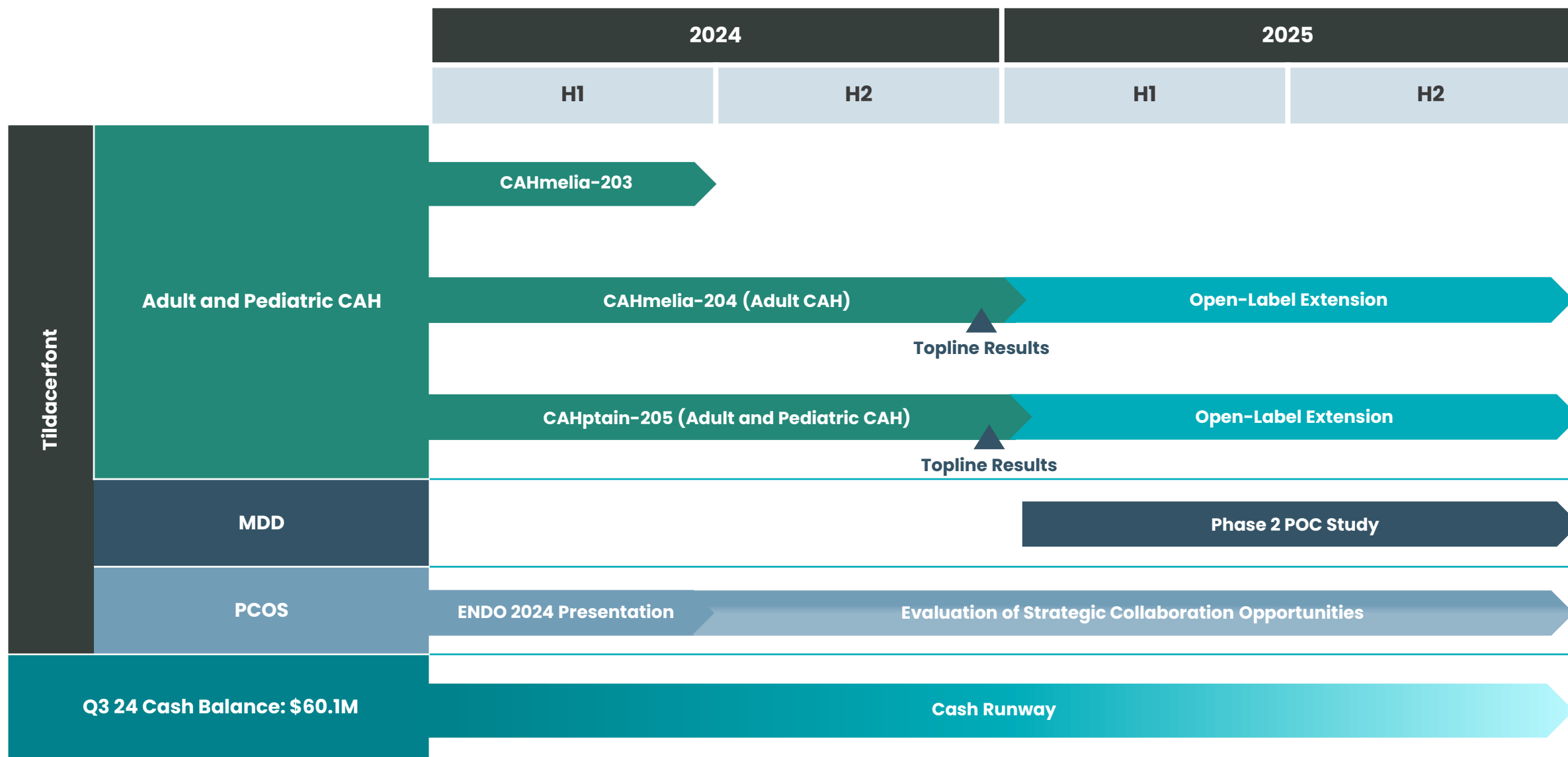
**Positive Ph2 POWER Study of Tildacerfont
in PCOS**

POWER study demonstrates **significant reduction in DHEAS**; evaluation of strategic collaboration opportunities underway

Strong IP Protection

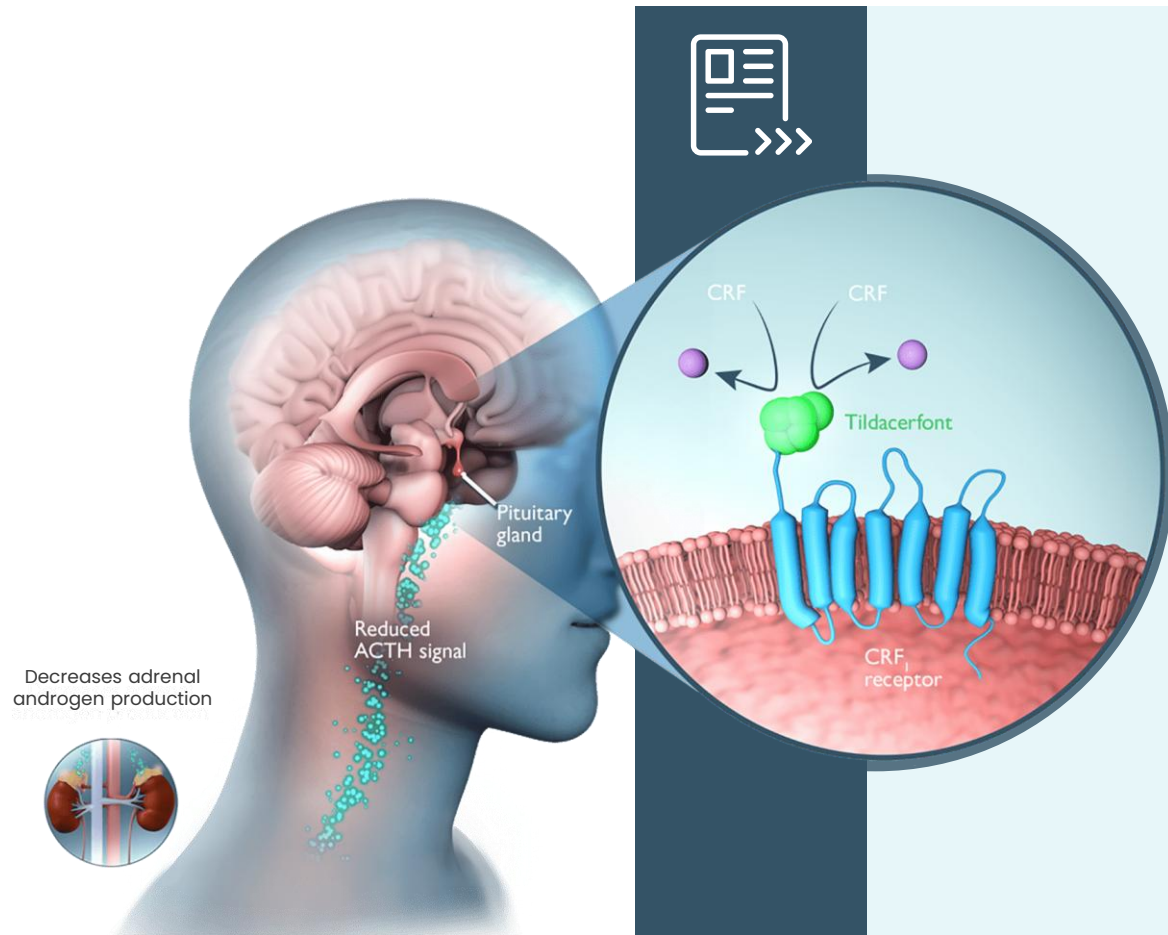
Comprehensive IP portfolio with **exclusivity to 2038** combined with **Orphan Drug Designation for CAH** in U.S. and E.U.

Overview of Anticipated Milestones and Cash Runway



Note: CAH is congenital adrenal hyperplasia, MDD is major depressive disorder; PCOS is polycystic ovary syndrome.

Tildacerfont is a Second-Generation CRF₁ Receptor Antagonist



Tildacerfont is an oral, second generation CRF₁ receptor antagonist¹



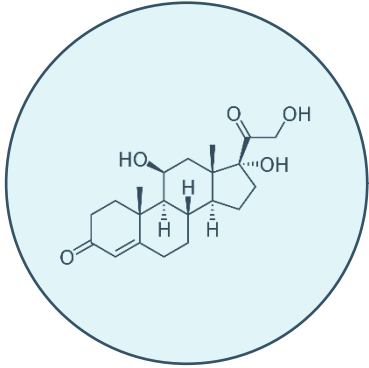
Tildacerfont binds to CRF₁ receptors in the pituitary gland, blocking receptor stimulation by the hypothalamus¹

Adult and Pediatric Congenital Adrenal Hyperplasia (CAH)



Classic CAH Disease Overview

Classic CAH is a chronic and potentially life-threatening rare disease



Classic CAH is an autosomal recessive disease characterized by an inability to produce cortisol, leading to a chronic imbalance of key hormones and an overproduction of adrenal androgens.



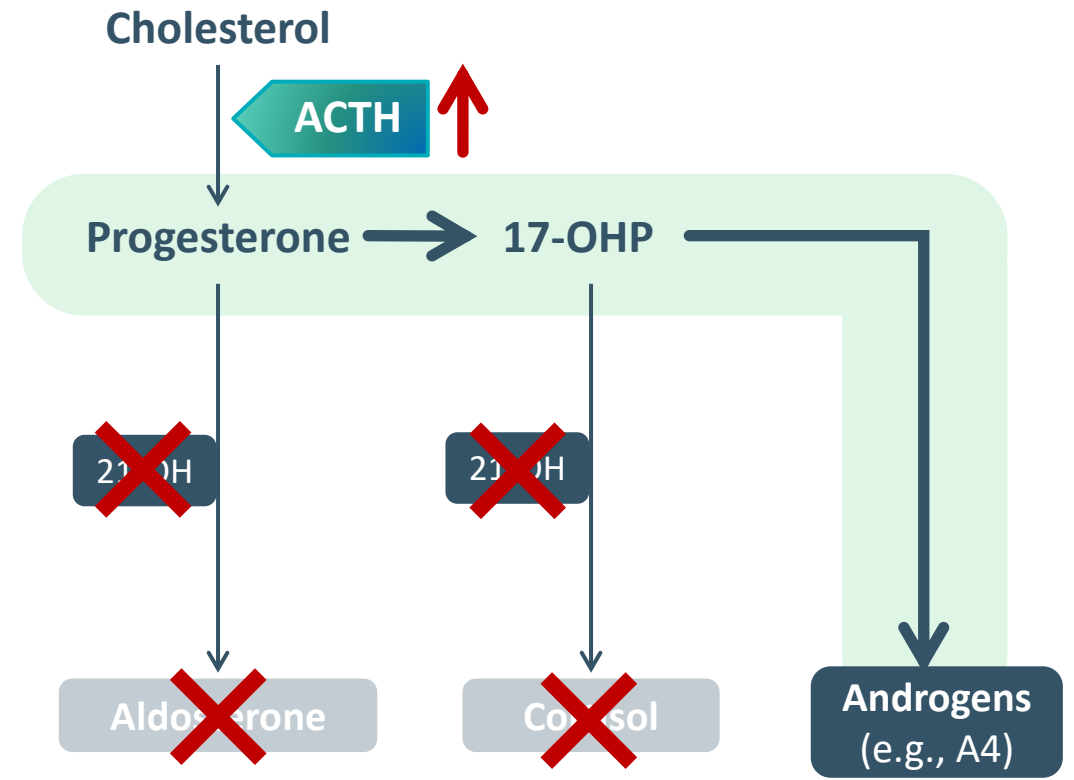
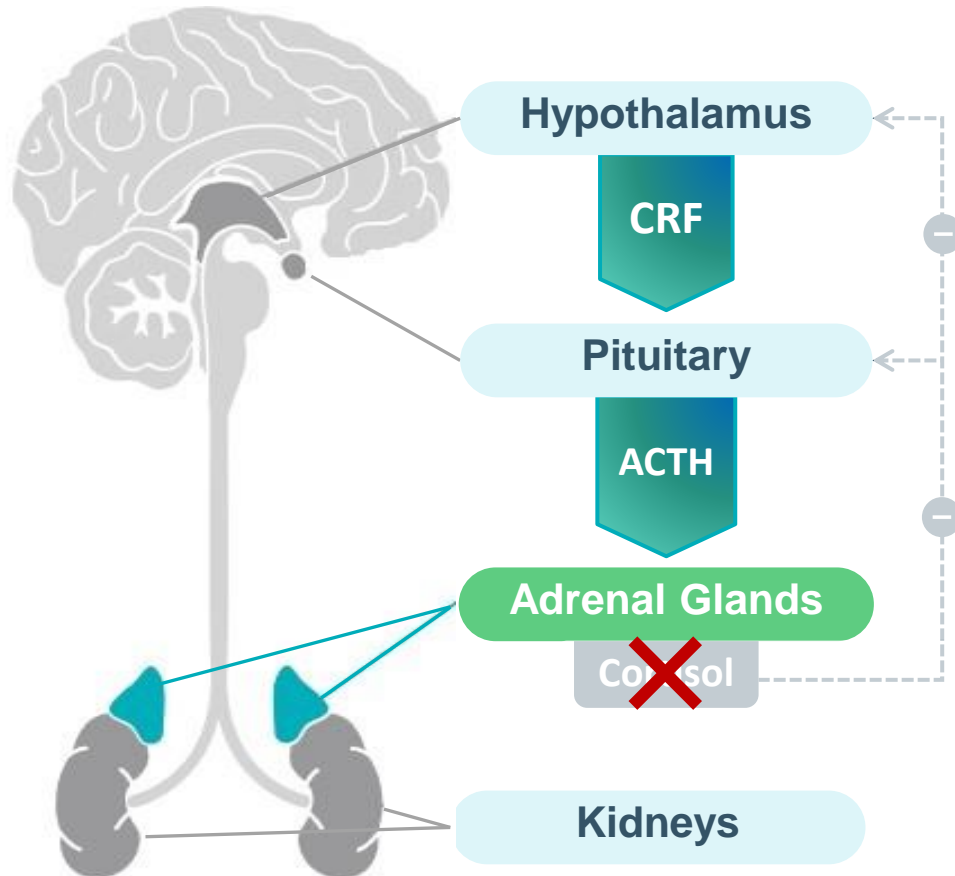
Due to the severity and high incidence of the disease, most developed countries have established newborn screening programs to test for classic CAH at birth.



We estimate the total classic CAH population to be approximately 20,000–30,000 people in the U.S., approximately 50,000 people in the EU, and at least 145,000 people in China.

HPA Axis Function in Classic CAH Patients

- Deficiency in 21-OH results in lack of cortisol & aldosterone production
- Lack of cortisol upregulates CRF & ACTH leading to overstimulation and hyperplasia of adrenal glands
- 17-OHP is routed to the androgen pathway, resulting in excess androgens



17-OHP, 17-hydroxyprogesterone; 21-OH, 21-hydroxylase; 21-OHD, 21-hydroxylase deficient; ACTH, adrenocorticotropic hormone; CAH, congenital adrenal hyperplasia; CRF, corticotropin releasing factor; HPA, hypothalamic-pituitary-adrenal.

Engels M, et al. *Endocr Rev.* 2019;40:973-87.

Classic CAH Presents in Infancy and Early Childhood

BEHAVIORAL

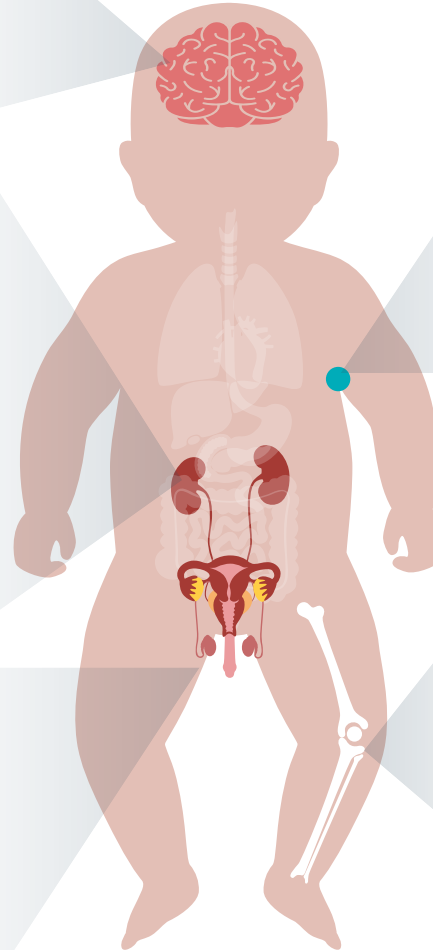
Increased prevalence of ADHD⁴

ADRENAL (SALT-WASTING) CRISIS

- Risk of potentially fatal electrolyte imbalance, acidosis, and shock begins at birth¹, precipitated by acute illness, often infection²
- Life-threatening hypoglycemia with seizures is more common in children^{1,2}

GENITOURINARY

- 46,XX genital atypia/sex misassignment at birth³
- 46,XY TARTs may begin in childhood⁵



PUBARCHE^{2,3}

- Early childhood virilization
- Early onset adult body odor

MUSCULOSKELETAL^{2,3}

- Early growth acceleration
- Advanced bone age
- Premature epiphyseal closure

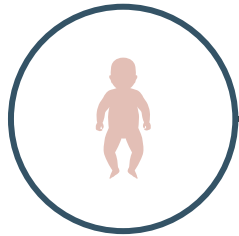
CAH, congenital adrenal hyperplasia

1. Falhammer H, et al. *J Clin Endocrinol Metab.* 2014; 99: E2715-E2721; 2. Claahsen-van der Grinten H, et al. *Endocr Rev.* 2021;bnab016. DOI: <https://doi.org/10.1210/edrv/bnab016> [Epub ahead of print];

3. Merke D, et al. *N Engl J Med.* 2020;383:1248-61; 4. Mueller S, et al. *Eur J Endocrinol.* 2010;163:801-10; 5. Claahsen-van der Grinten H, et al. *Best Pract Res Clin Endocrinol Metab.* 2009;23(2):209-20.

Management Goals of CAH Vary by Age

Early childhood to puberty



Goal of therapy:

Maximize androgen suppression for normal growth and pubertal development

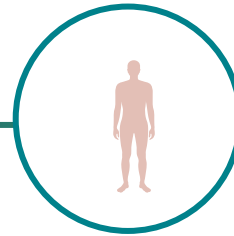
Challenges:

GC overdose may cause iatrogenic Cushing syndrome

Strategies to achieve balance:

Use only short-acting GCs
Avoid attempts to normalize 17-OHP levels

Puberty



Goal of therapy:

Maintain adequate androgen suppression despite rapid HC metabolism in puberty

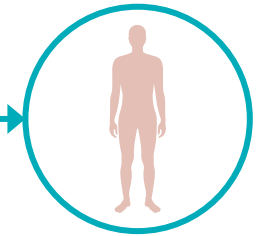
Challenges:

Higher GC doses are associated with shorter adult height

Strategies to achieve balance:

Use GC doses >17 mg/m²/d with care
Prioritize height over normalizing hormone levels

Post puberty to early adulthood



Goal of therapy:

Prevent morbidity & mortality from adrenal crisis, preserve fertility

Challenges:

MC requirements vary through adolescence
Medical needs vary by sex and gender

Strategies to achieve balance:

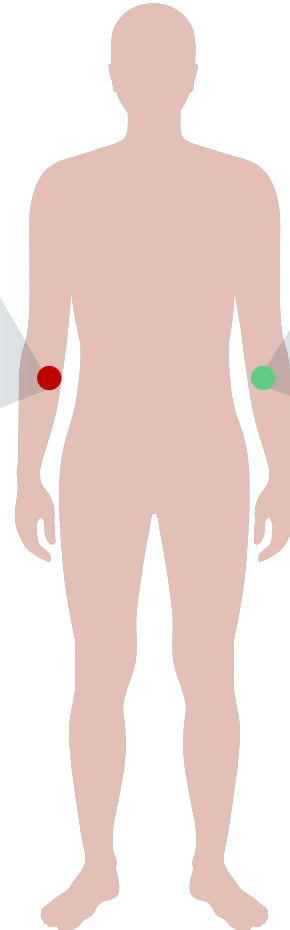
Continue GC & MC at transition to adulthood
Refer to multidisciplinary transition clinics

Unmet Need and Treatment Goals Vary By Disease Status

Management of classic CAH requires a balance between **adrenal androgen suppression** and **GC replacement**^{1,2}

Severe Hyperandrogenemia

- Elevated adrenal androgens
- Unmet need to **reduce adrenal androgens** and improve related clinical outcomes
- Poor GC Compliance



Supraphysiologic GCs

- Normal or near normal adrenal androgens
- Unmet need to **reduce GC dose** and improve related clinical outcomes
- Better adherence to GC therapy

Novel Therapies are Needed in CAH

Glucocorticoids have been the SoC since the 1950s¹ **but contribute to the burden of disease. Supraphysiologic doses** are required to **control elevated adrenal androgens** which result in **comorbidities linked to excessive chronic GC use**

Excess Androgens

HIRSUTISM,
AMENORRHEA
ACNE

PSYCHOLOGICAL
EFFECTS

ABNORMAL
AND/OR EARLY
PUBERTY

SHORT
STATURE

INFERTILITY

Goal of Therapy: To Control High Androgens and Symptoms of CAH While Avoiding Chronic Supraphysiologic GC

Excess GCs

CARDIOVASCULAR
DISEASE

SHORT
STATURE

INSULIN
RESISTANCE

OSTEOPOROSIS

OBESITY

P2a Study 202 in Adult CAH: Baseline Demographics

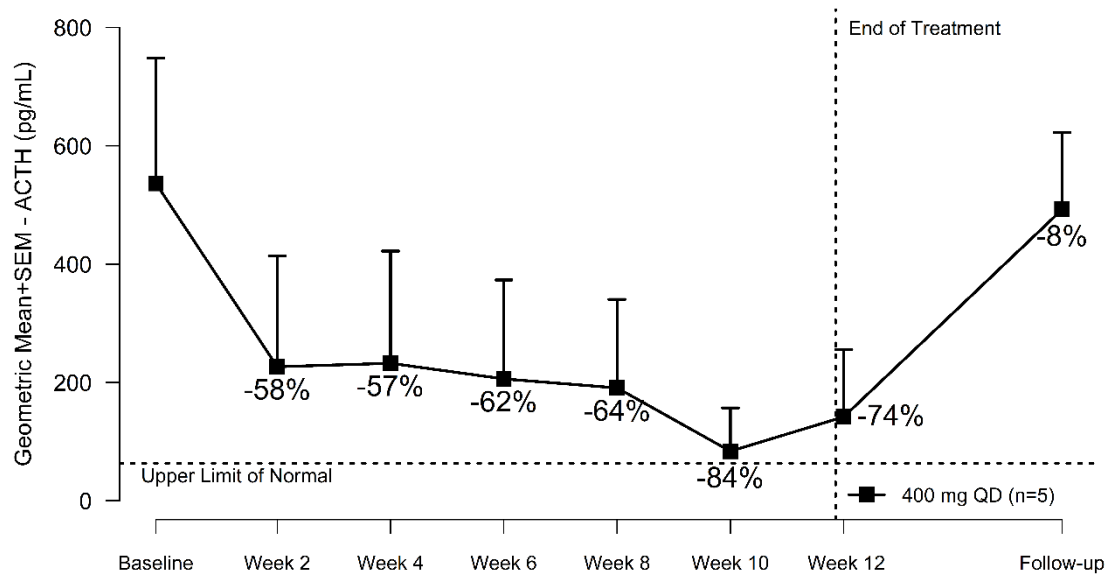
	Patients with A4 < 2x ULN (N=3)	Patients with A4 > 2x ULN (N=5)
Demographics		
Age (yrs), mean (SD)	48.0 (17.69)	42.4 (15.63)
Sex, Female, n (%)	3 (100%)	2 (40%)
Race, White n (%)	3 (100%)	4 (80%)
BMI (kg/m²), mean (SD)	35.5 (6.10)	27.8 (5.56)
Baseline Glucocorticoid dose		
Dose (mg) in Hydrocortisone equivalents	36.7 (11.6)	24.5 (11.5)
Baseline hormones		
ACTH (ng/mL), geometric mean (CV%)	12.2 (584.1%)	536.6 (108.5%)
17-OHP (ng/dL), geometric mean (CV%)	314.1 (1068.6%)	15323.3 (46.9%)
A4 (pg/dL), geometric mean (CV%)	28.8 (216.1%)	1001.1 (48.4%)

Subjects on dexamethasone (n=3), metabolized through CYP3A4, excluded from baseline and efficacy summaries due to observed increased in exposures but included in safety summary

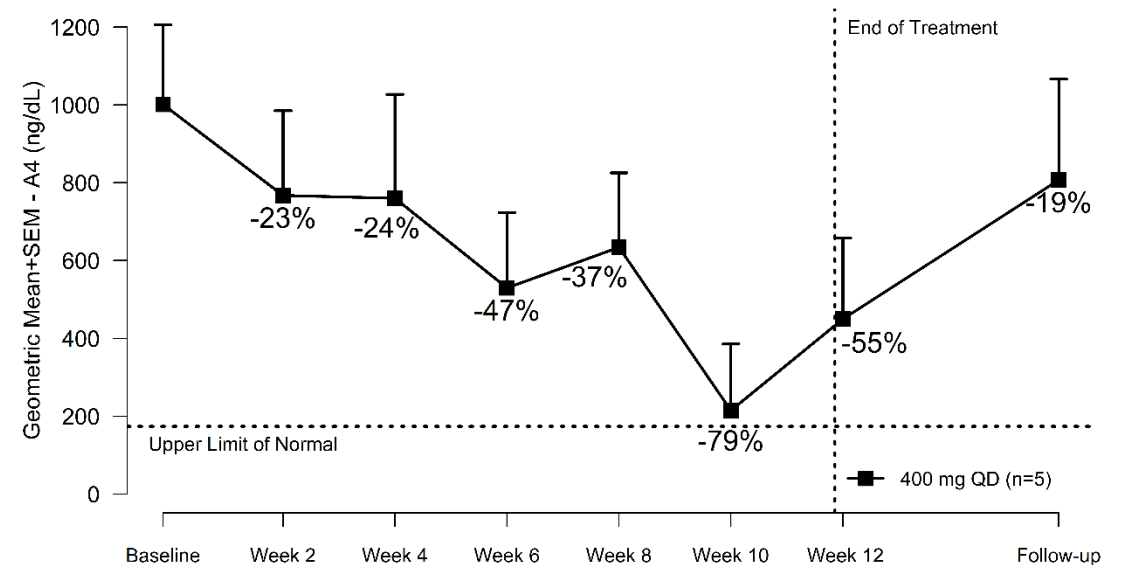
P2a Study 202 in Adult CAH: Robust Reduction in Adrenal Hormones

- Maximum reduction in **adrenocorticotrophic hormone (ACTH)** and **androstenedione (A4)** of **84% and 79%**, respectively, in patients with highly elevated androstenedione (A4) levels at baseline.

ACTH



A4



- Normalization of ACTH achieved in 60% of patients*

- Normalization of A4 achieved in 40% of patients

3 patients were on dexamethasone and excluded from analysis

*One subject at week 2 prior to discontinuation from the trial and two patient during month 3.

ACTH, adrenocorticotrophic hormone; QD, once daily.

Sarafoglou K, et al. *J Clin Endocrinol Metab*. 2021:dgab438. DOI: <https://doi.org/10.1210/clinem/dgab438> [Epub ahead of print].



CAHmelia
203 · 204



CAHmelia Baseline Characteristics

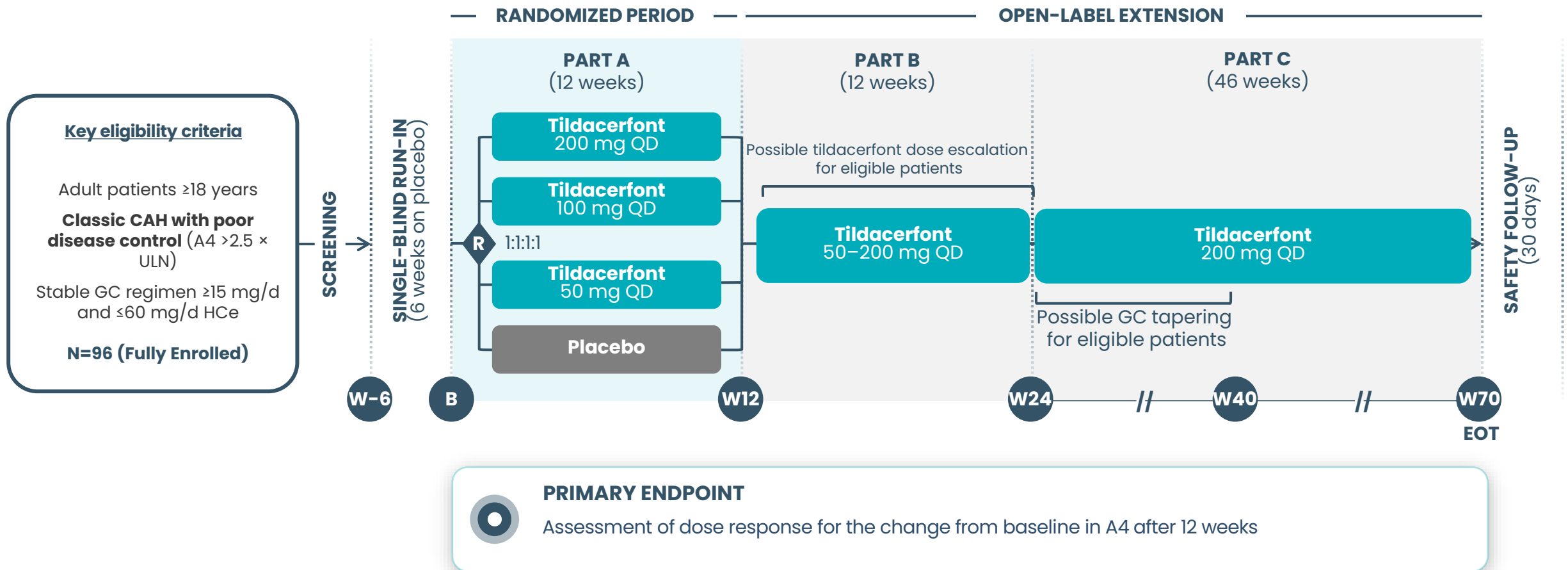
CAHmelia 203 and 204 Baseline Characteristics Highlight Two Distinct Patient Populations in Adult CAH with Differing Disease Status and Treatment Goals

Baseline Characteristics	CAHmelia-203	CAHmelia-204	Ph3 CRF ₁ Study in Adult CAH
Treatment Goal	Hyperandrogenemia Control	GC Reduction With Androgenic Control ³	GC Reduction <u>Without</u> Androgenic Control ⁴
Number of Subjects	96	100	182
Male/Female	47% Male 53% Female	47% Male 53% Female	51% Male 49% Female
Average Age Age Range	32 Years Old (18 – 65 Years Old)	33 Years Old (18 – 64 Years Old)	31 Years Old (18–58 Years Old)
Average Glucocorticoid (GC) Dose ¹	27 mg/day (14 mg/m ² /day)	37 mg/day (20 mg/m ² /day)	32 mg/d (18 mg/m ² /day)
Average Androstenedione (A4) Level ²	1,151 ng/dL (>5x ULN)	224 ng/dL (~ULN)	620 ng/dL (~3x ULN)
Average Baseline 17-Hydroxyprogesterone (17-OHP) Level ²	16,653 ng/dL (>80x ULN)	5,675 ng/dL (>28x ULN)	Not Disclosed
Average Baseline Adrenocorticotropic (ACTH) Level ²	435 pg/dL (>6x ULN)	168 pg/dL (>2x ULN)	Not Disclosed
Body Mass Index (BMI)	50% Obese (BMI ≥ 30 kg/m ²)	53% Obese (BMI ≥ 30 kg/m ²)	47% Obese (BMI ≥ 30 kg/m ²)

¹ In hydrocortisone equivalents (HCE) ² Pre-GC dose. ³ A4 <ULN for age and sex. ⁴ A4 <120% of the subject's baseline or <ULN for age and sex.

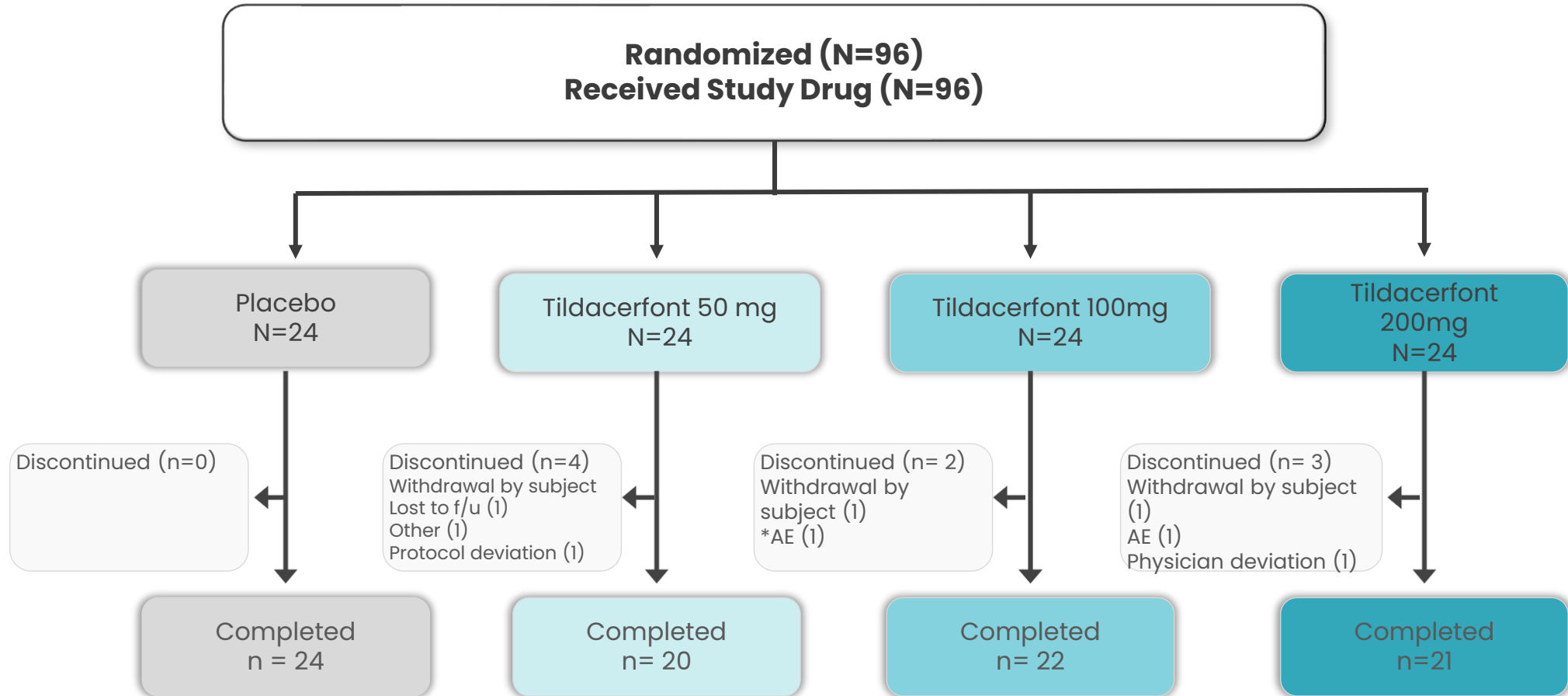
CAHmelia-203 Study in Adult CAH with Severe Hyperandrogenemia

A randomized, double-blind, placebo-controlled, dose-ranging Phase 2b study to evaluate the efficacy and safety of tildacerfont in adult classic CAH patients with **severe Hyperandrogenemia**



CAHmelia-203 Study Participant Disposition

91% of patients completed CAHmelia-203 through week 12



CAHmelia-203 Topline: No Dose Response or Reduction in A4

Data Highlights

The clinical trial did not achieve the primary efficacy endpoint of the assessment of dose response for the change in A4 from baseline to week 12.

200mg QD of tildacerfont demonstrated a placebo-adjusted reduction from baseline in A4 of -2.6% (p-value not significant) at week 12.

Compliance with study medication and GC was low with only 50% of patients reporting 80% or greater compliance.

Tildacerfont was generally safe and well tolerated at all doses with no treatment-related serious adverse events (SAEs). Most adverse events were reported as mild to moderate.

The CAHmelia-203 results underscore the complexities inherent in managing a patient group with challenges related to androgenic control and GC compliance. Based on my clinical experience, patients within this group may face difficulties adhering to any therapeutic interventions, potentially impacting treatment outcomes..." -

Irina Bancos, MD

Mayo Clinic

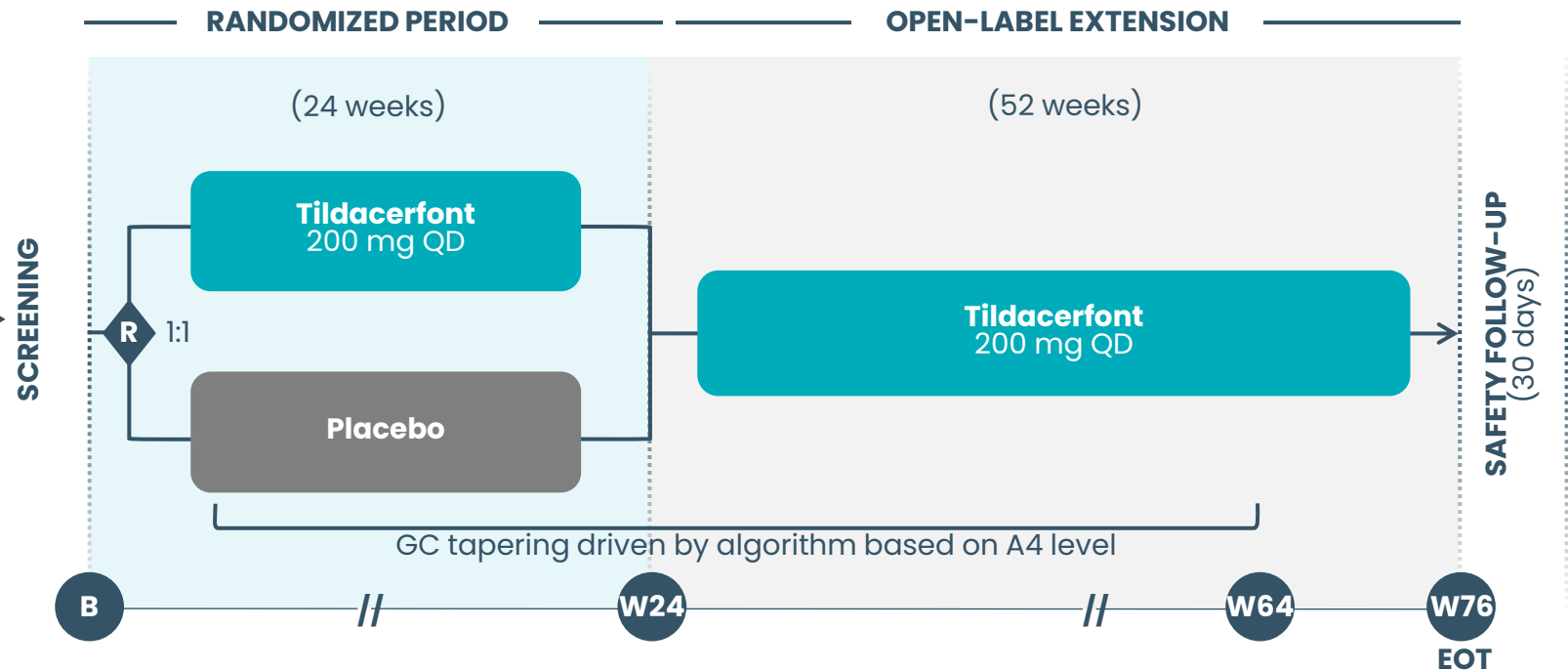
203 Investigator | CAH KOL

CAHmelia-204 Study in Adult CAH with Androgenic Control

A randomized, double-blind, placebo-controlled Phase 2b study to evaluate the efficacy and safety of tildacerfont in reducing supraphysiologic GC use in adult patients with classic CAH

Key eligibility criteria

Adult patients ≥18 years
Classic CAH with good disease control
(LLD ≤ A4 ≤ 2.5x ULN)
Stable GC regimen ≥30 mg/d and ≤60 mg/d HCe
N=100 (Fully Enrolled)



PRIMARY ENDPOINT

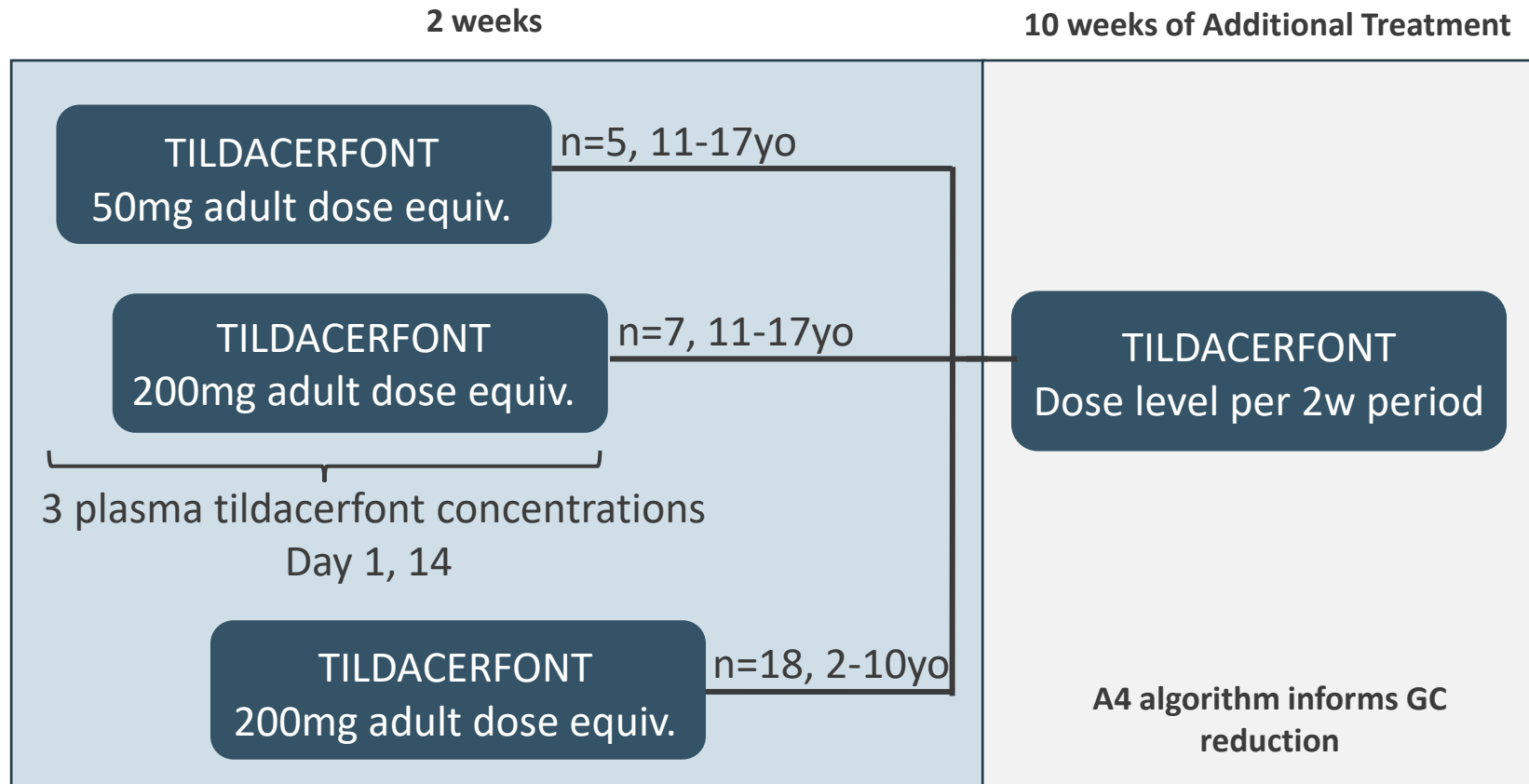
Absolute change in daily glucocorticoid dose (HCe) from baseline at Week 24



CAHptain
205

CAHptain Study in Pediatric CAH (Cohorts 1-3)

Open-Label study with staggered cohorts, sentinel dosing



Key eligibility criteria for Cohorts 1-3

- Male and female subjects aged 2 to 17 years old
- Diagnosis of CAH due to 21-hydroxylase deficiency
- Stable dose of GC
- N=30 (Cohorts 1-3)**

Opportunity to decrease GC dose at Weeks 4, 8, and 12

1 EP: Safety

**2 EP: Decrease in A4 or GC dose at w12
Decrease in A4 at w4***

SAFETY FOLLOW-UP (30d)
 Open-label extension
 All subjects 200mg adult dose equivalent

* In participants with elevated baseline A4. GC doses were not changed during first 4 weeks.

CAHptain-205 Topline: Safe and Well-Tolerated in Children

Pharmacodynamic responses were observed despite lower-than-projected exposures

Data Highlights

Tildacerfont is well-tolerated in children

- All AEs were mild to moderate
- No treatment-related SAEs or AEs leading to study withdrawal

Pediatric doses were determined based on modelling

- Conservative dosing assumptions were employed to ensure patient safety
- Model overestimated exposure in children
- Tildacerfont exposure was lower than expected
 - Adult equivalent doses did not provide the same exposure in children

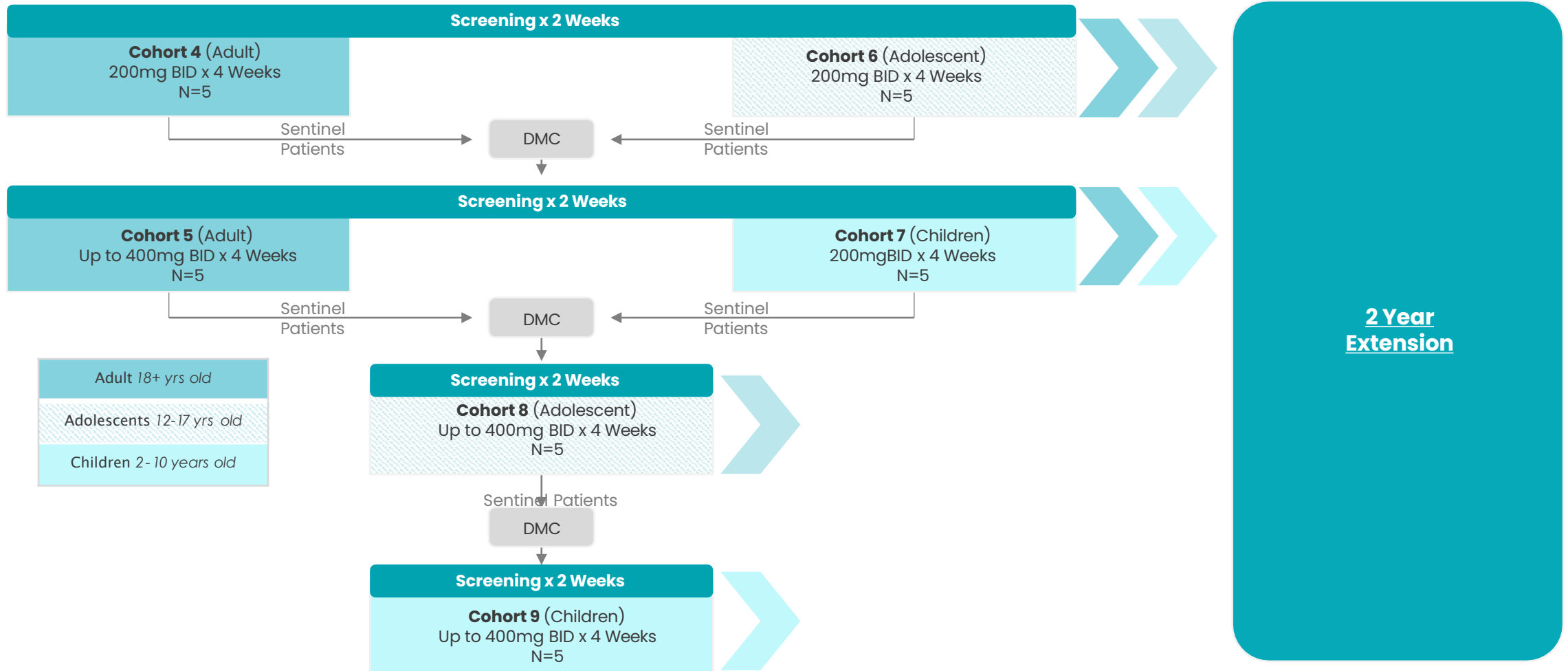
Target engagement was observed and led to improved CAH control despite suboptimal exposure

- 70% (16/23) of participants with elevated baseline A4 achieved A4 reductions at W4
- 73% (22/30) demonstrated A4 or GC reduction after 12 weeks of treatment
- No clear dose response observed- attributed to variable exposures

“These data are encouraging and suggest that tildacerfont at the right dose may enable clinically meaningful reduction of A4 and GC levels in children and adolescents....I am excited for next stage in identifying the optimal pediatric dose that may improve long-term clinical outcomes, such as short stature and obesity, which are related to both androgen excess and exposure to chronic supraphysiologic GC doses.”

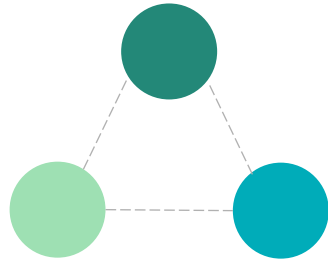
Paul Thornton, M.B.B.S., Principal Investigator and Medical Director of a CAH Center of Excellence

CAHptain-205 Dose Ranging Expanded into Adults and Pediatric

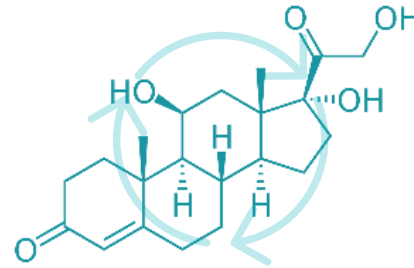


Polycystic Ovary Syndrome (PCOS)

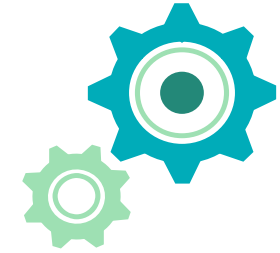
PCOS is a Common, Chronic Endocrine Disorder



Heterogeneous in nature: typically characterized by **hyperandrogenism, ovulatory dysfunction, and polycystic ovaries**¹



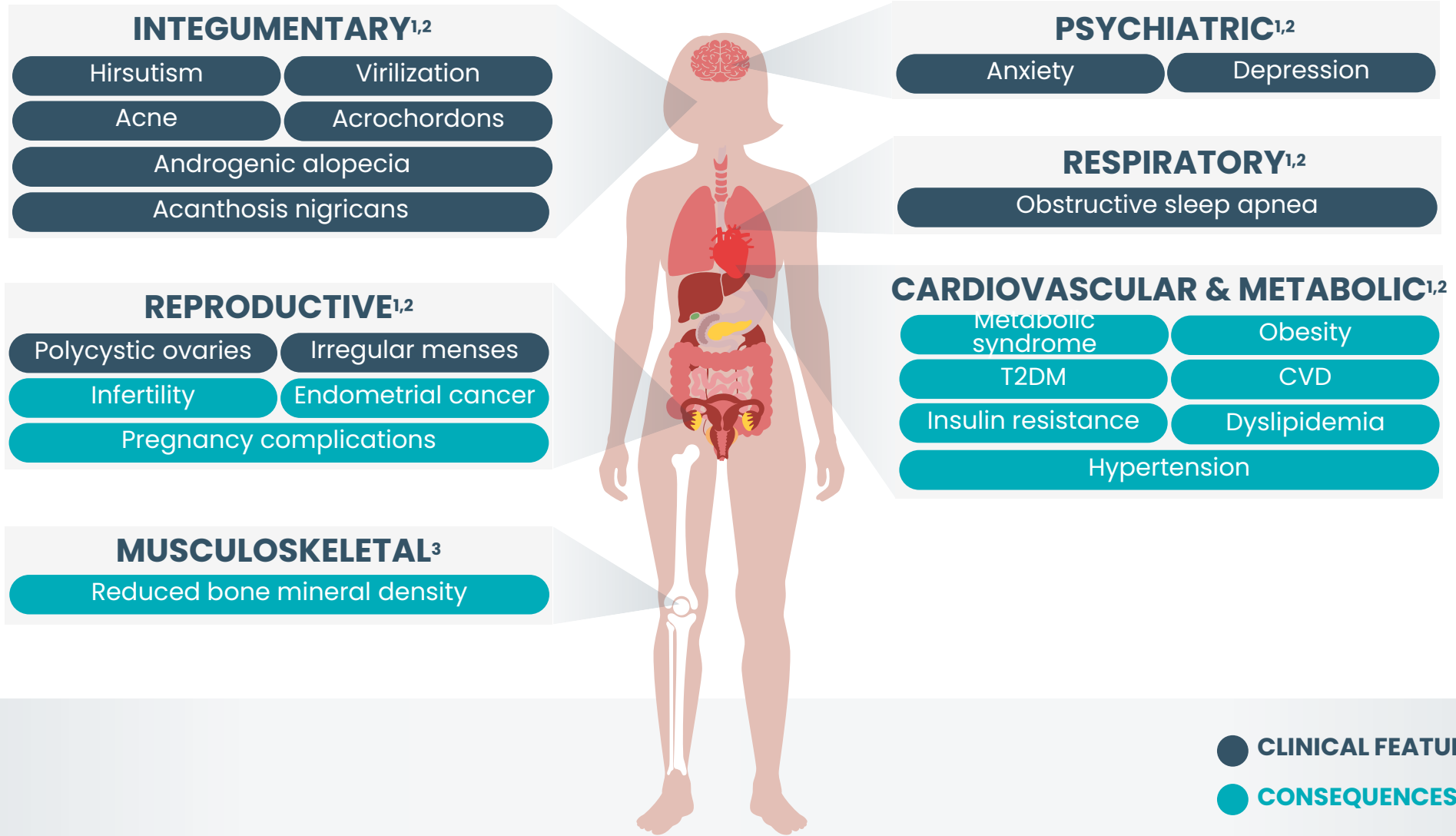
Symptoms are linked to **androgen excess** and **metabolic dysfunction**²



Results from a complex interplay of **hereditary and environmental factors**; exact cause is not fully elucidated³

Affects up to **12% of reproductive aged women** in the US; the **most common cause of anovulatory female infertility**³

PCOS Leads to Varied Symptomatology and Long-term Risks



- CLINICAL FEATURES OF PCOS
- CONSEQUENCES OF PCOS

CVD, cardiovascular disease; T2DM, type 2 diabetes mellitus; PCOS, polycystic ovary syndrome.

1. McCartney CR, et al. *New Engl J Med.* 2016;375:54-64. 2. Deswal R, et al. *J Hum Reprod Sci.* 2020;13:261-271. 3. Katulski K, et al. *J Endocrinol Invest.* 2014;37:1219-1224.

Currently, Only Symptomatic Treatment Exists for PCOS



HYPERANDROGENEMIA

Hormonal contraception: 1st line treatment for hirsutism and acne

Antiandrogens: typically used as an adjunct to hormonal contraception to treat hirsutism



INFERTILITY

Estrogen modulators (clomiphene, letrozole): 1st line for anovulatory infertility

Insulin sensitization (metformin): adjuvant to prevent OHSS during IVF



IRREGULAR MENSTRUATION

Hormonal contraception: 1st line treatment for menstrual irregularities

Insulin sensitization (metformin): alternative for women intolerant to hormonal contraception



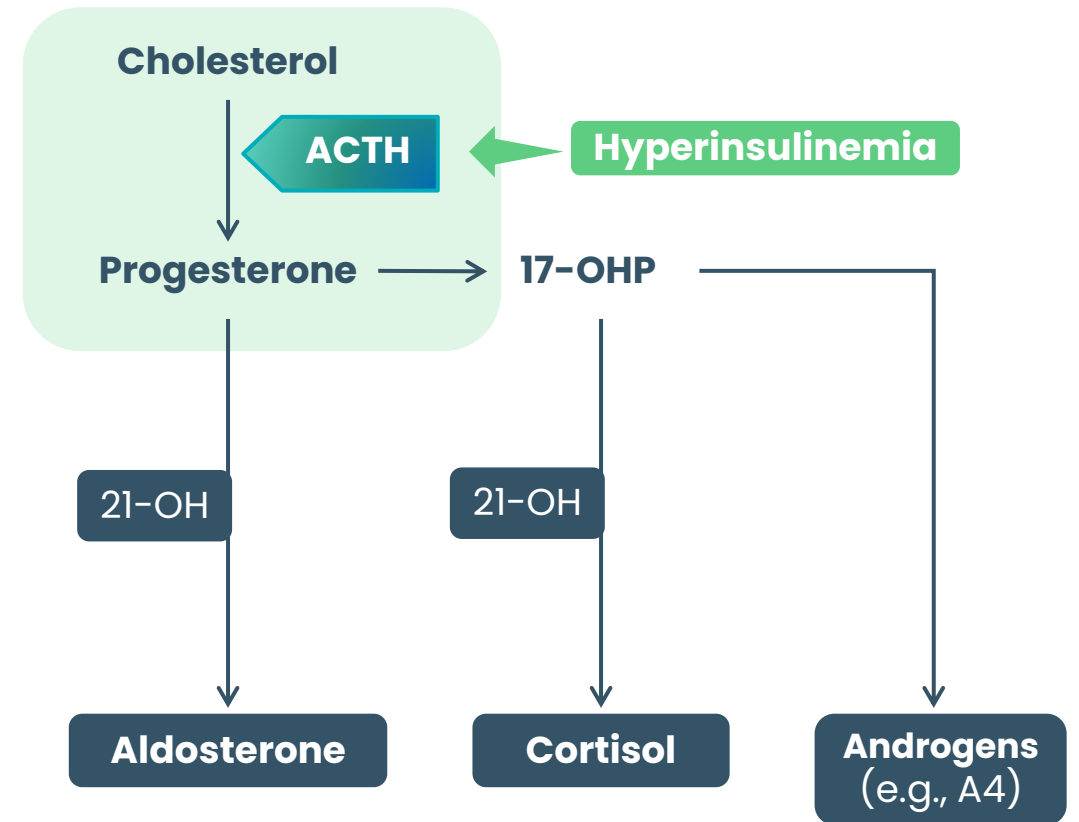
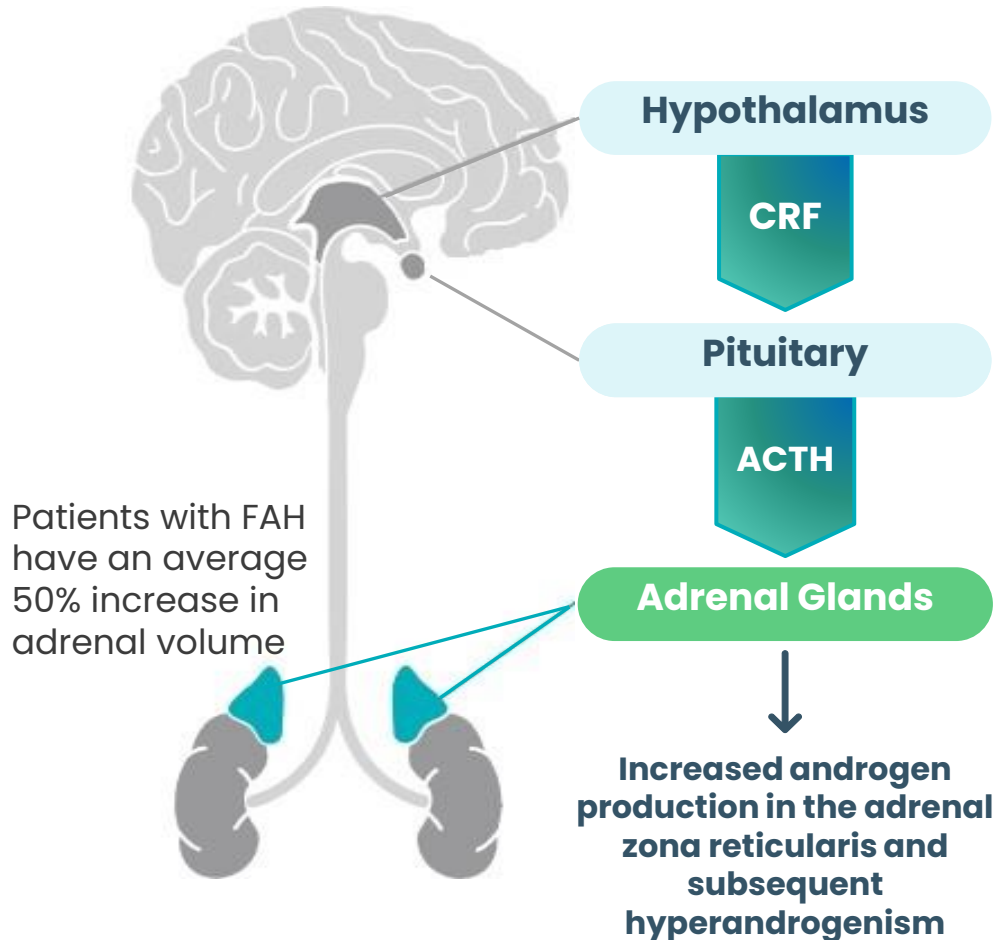
RISK MANAGEMENT

Lifestyle changes: weight loss via calorie restriction and exercise

Insulin sensitization (metformin): alternative option if lifestyle changes yield insufficient results

Adrenal Hypersensitivity to ACTH in PCOS

Hyperinsulinemia may potentiate corticotropin-mediated adrenal androgen production



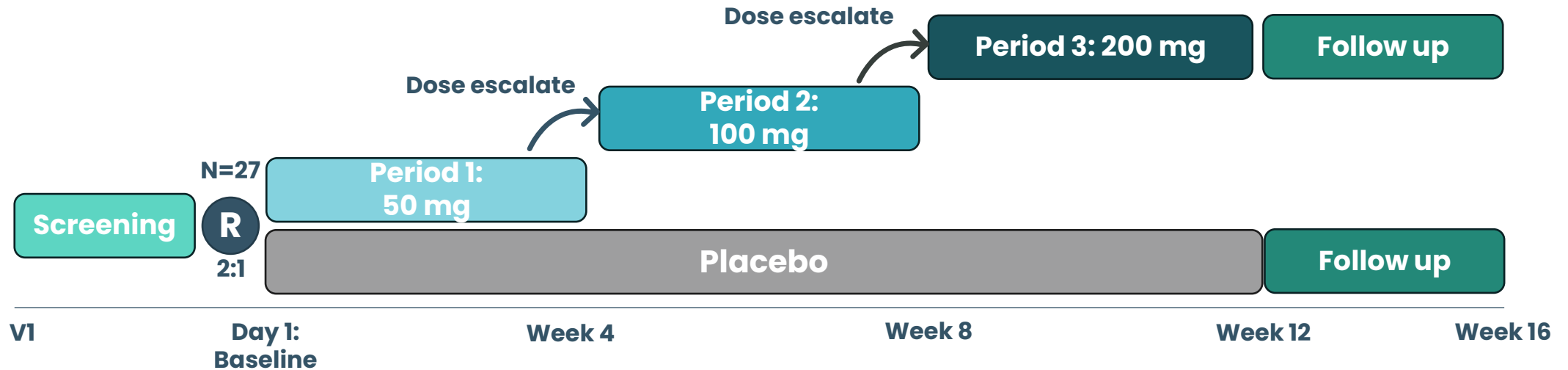


P. W.E.R. study


spruce BIOSCIENCES

Phase 2 Clinical Proof of Concept POWER Study Completed

A Randomized, Placebo-Controlled, Dose Escalation Study to Evaluate the Safety and Efficacy of Tildacerfont in Adult Subjects with PCOS and Elevated Adrenal Androgens



Key eligibility criteria

- Females 18–40 years old with PCOS
- DHEAS > ULN

Strata

- DHEAS (baseline DHEAS \leq 1.2xULN, DHEAS > 1.2xULN)

Primary endpoint

- Absolute change from baseline in DHEAS

Additional endpoints

- Safety and tolerability
- Proportion of subjects with: \geq 30% reduction from baseline in DHEAS and DHEAS \leq ULN
- Change from baseline in ACTH, 17OHP, T, A4, 11OHA4, 11OHT, 11KA4, and 11KT

POWER Study Baseline Characteristics

Key Variables Mean (SD)	Tildacerfont (n = 17)	Placebo (n = 10)	Total (n = 27)
Age	28.4 (5.6)	29.3 (5.5)	28.7 (5.4)
Age at PCOS Diagnosis	22.6 (6.3)	21.6 (6.0)	22.3 (6.1)
BMI (kg/m ²)	32.1 (5.8)	32.4 (12.5)	32.2 (8.6)
DHEAS (µg/dL)	351.3 (90.5)	387.8 (107.2)	364.8 (96.7)
17-OHP (ng/dL)	83.2 (86.3)	62.1 (54.1)	75.4 (75.5)
ACTH (pg/mL)	23.9 (11.9)	22.3 (12.0)	23.3 (11.7)
A4 (ng/dL)	185.2 (75.2)	130.0 (66.0)	166.8 (75.6)
T (ng/dL)	61.0 (22.0)	61.1(27.0)	61.0 (23.4)
Screening DHEAS > ULN, N (%)			
Yes	12 (70.6%)	7 (70.6%)	19 (70.4%)
No	5 (29.4%)	3 (29.4%)	8 (29.6%)

Significant Reduction in DHEAS Versus Placebo Observed

In women with elevated baseline DHEAS, a significant reduction in DHEAS versus placebo was observed ($p = 0.020$).

	Tildacerfont (n = 12)¹	Placebo (n = 7)¹
n	11 ²	5 ³
Mixed Model of Repeated Measures		
Least Squares (LS) Geometric Mean Ratio (% Change from Baseline)	0.876 (-12.4%)	1.057 (5.7%)
95% Confidence Interval (CI) of Geometric Mean Ratio	0.802, 0.955	0.931, 1.200
95% CI of Percent Change from Baseline	-19.8%, -4.5%	-6.9%, 20.0%
Difference LS Mean Ratio [tildacerfont/placebo]	0.828	N/A
95% CI of Difference LS Mean Ratio	0.709, 0.967	N/A
p-value	0.020	N/A

1. Eight subjects (five in the tildacerfont arm and three in the placebo arm) did not meet inclusion criteria #3 requiring DHEAS to be greater than the ULN and were excluded from the analyses.
2. One subject was excluded from the analyses due to no post-baseline DHEAS assessment.
3. Two subjects were excluded from the analyses due to concomitant glucocorticoid (GC) use, which confounded assessment of adrenal steroid reduction.

Increase in SHBG Versus Placebo Observed

In study participants, an increase in Sex Hormone Binding Globulin (SHBG) versus placebo was observed ($p = 0.012$), which may lower levels of free, bioactive sex hormones.

	Tildacerfont (n = 17)	Placebo (n = 10)
n	16 ¹	9 ¹
Mixed Model of Repeated Measures		
Least Squares (LS) Geometric Mean Ratio (% Change from Baseline)	1.329 (32.9%)	0.919 (-8.1%)
95% Confidence Interval (CI) of Geometric Mean Ratio	1.124, 1.571	0.735, 1.148
95% CI of Percent Change from Baseline	12.4%, 57.1%	-26.5%, 14.8%
Difference LS Mean Ratio [tildacerfont/placebo]	1.446	N/A
95% CI of Difference LS Mean Ratio	1.093, 1.913	N/A
p-value	0.012	N/A

- Two subjects (one in the tildacerfont arm and one in placebo arm) did not have a week 12 SHBG assessment completed.

Major Depressive Disorder (MDD)



Strategic Collaboration with HMNC to Develop Treatment for MDD



Collaboration

Pairs Spruce's **Tildacerfont** with **Cortibon** to treat MDD patients **responsive to CRF₁ receptor antagonism**



Tildacerfont

Tildacerfont may **mediate endocrine, behavioral, and autonomic responses to stress**, which may produce antidepressant action



Cortibon (CDx)

Genetic selection tool developed at the Max Planck Institute utilizing samples from P2 study of CRF₁ receptor antagonist in MDD



Phase 2 Proof of Concept (POC) Study

HMNC to initiate and fund **Phase 2 POC study** of tildacerfont and Cortibon for MDD in **Q1 25**



License Option

Option by Spruce to **in-license exclusive worldwide rights to Cortibon** following Phase 2 POC Study




Economics

Pursuant to license terms, **HMNC** entitled to **milestone payments and royalties on net sales** of tildacerfont in MDD

Treatment Options in MDD Demonstrate Suboptimal Efficacy

MDD biology and pathogenesis¹

Genetic environmental psychological and biological factors cause MDD




- I. HPA axis dysfunction hypothesis
- II. Monoamine hypothesis
- III. Inflammatory hypothesis
- IV. Genetic and Epigenetic anomaly hypothesis
- V. Structural and functional brain remodeling hypothesis
- VI. Social psychological hypothesis

HMNC focus

Pharmacotherapy is one of complementary treatment options, but shows suboptimal efficacy

Pharmacotherapy

Antidepressants cover a broad spectrum of **mechanisms of action**...




- ✓ Selective serotonin reuptake inhibitors
- ✓ Serotonin noradrenalin reuptake inhibitors
- ✓ Noradrenalin and dopamine reuptake inhibitors
- ✓ Noradrenalin and specific serotonergic antidepressants
- ✓ Melatonergic agonist
- ✓ Tricyclic antidepressants
- ✓ Second generation antipsychotics
- ✓ Monoamine oxidase inhibitors
- ✓ NMDA receptor modulator

Psychotherapy


Brain stimulation

Lifestyle change


...but out of **100** patients...



...**72** fail to achieve remission after first line of antidepressant treatment...

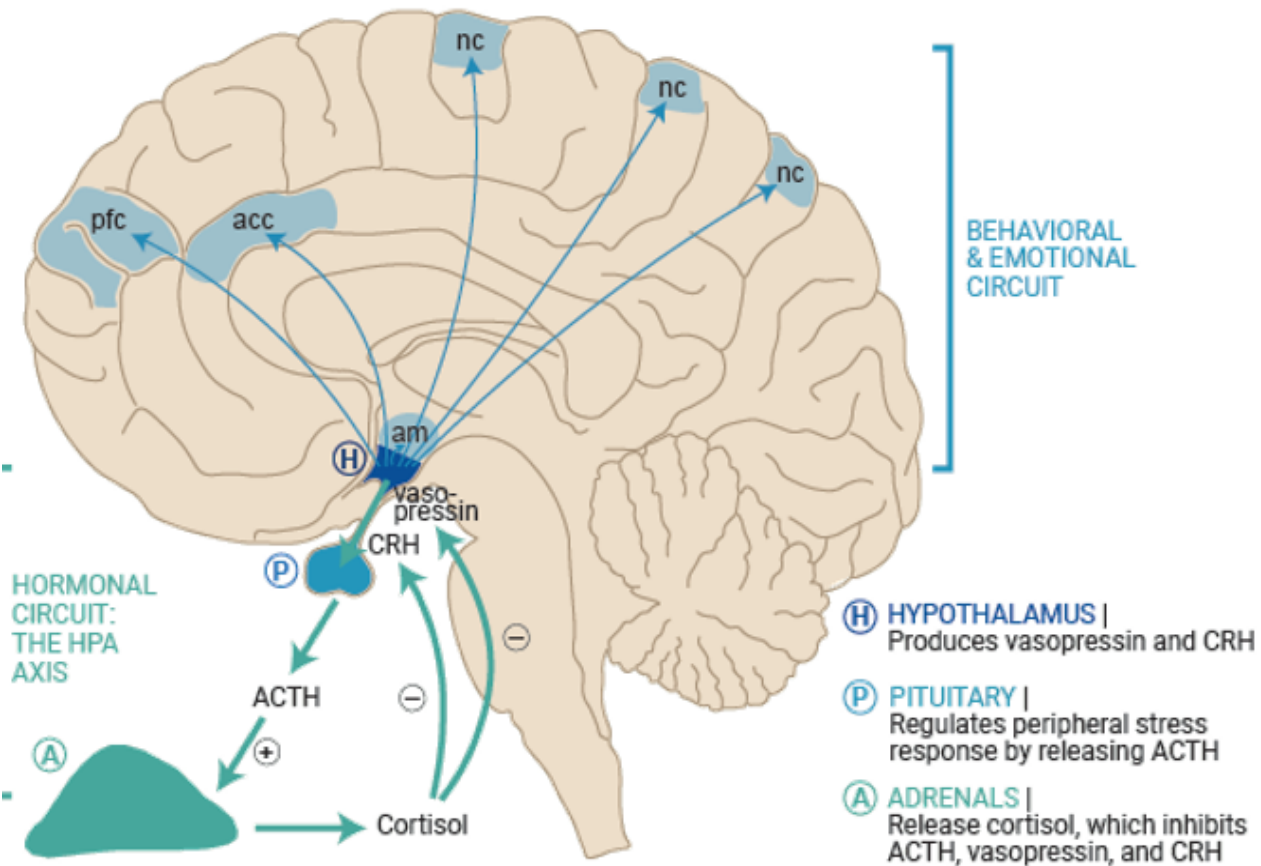


...and **34** fail to remit even after multiple lines of treatment²



¹Cui, Lulu, et al. (2024) ²Rush et al (2009)

Substantial Subset of MDD Patients Possess HPA-Axis Disturbance



Background

- A substantial subset (~30-50%) of all patients with MDD have a disturbance in vasopressin and/or CRH signaling, both key stress response regulators

Breakthrough

- Our CDxes have the potential to identify especially those patients, with high specificity and sensitivity
- Our pipeline antidepressants targeting the stress axis, e.g., HMNC's nelivaptan and Spruce's CRHR1 antagonist tildacerfont are expected to be highly efficacious in CDx-positive patients

CRHR1 Antagonists – Why were they shelved?

- Developmental programs that target the HPA axis were conducted in non-selected patient populations and therefore, did not show significant efficacy

"We reviewed a range of issues that may explain why CRHR1 antagonists have been challenging to translate from bench to bedside. These include potential specificity limitations of preclinical models and the fact that CRHR1 antagonists produced therapeutic-like results only under specific conditions, unlike some clinically effective compounds that act more generally." Reference: [Spierling, Zorrilla \(2017\)](#)

Note: Plus sign indicates stimulation, minus sign indicates inhibition, light blue-shaded brain areas contain CRHR1R and/or V1BR; acc, anterior cingulate cortex; ACTH, corticotropin; am, amygdala; CRH, corticotropin-releasing hormone; pfc, prefrontal cortex; nc, neocortex.

Financial Highlights



Financial Highlights

Capital Structure and Summary Financials as of September 30, 2024

Capital Structure	Shares (M)
Shares Outstanding	41.3
Equity Awards Issued and Outstanding	7.9
Common Stock Warrants	12.7
Fully Diluted Shares Outstanding	61.9

Financials	000's
Cash & Cash Equivalents	\$60,055
Debt ¹	\$2,163

1. Term loan, gross balance as of September 30, 2024.



spruceBIOSCIENCES

