Corporate Presentation

June 2023

CorMedix™

Forward-Looking Statements

This presentation contains “forward-looking statements” within the meaning of the Private Securities Litigation Reform Act of 1995, Section 27A of the Securities Act of 1933, as amended, and Section 21E of the Securities Exchange Act of 1934, as amended, that are subject to risks and uncertainties. All statements, other than statements of historical facts, regarding management’s expectations, beliefs, goals, plans or CorMedix’s prospects, including, but not limited to, statements regarding the Prescription Drug User Fee Act (PDUFA) target action date, CorMedix’s commercial launch plans, CorMedix’s future financial position, financing plans, future revenues, projected costs and the sufficiency of our cash and short-term investments to fund our operations, should be considered forward-looking. Readers are cautioned that actual results may differ materially from projections or estimates due to a variety of important factors, including: the ability of the Company’s heparin supplier to address the manufacturing deficiencies identified in the warning letter for non-heparin API; the costs associated with CorMedix’s launch efforts; the expected regulatory exclusivity available for DefenCath; the risks and uncertainties of the relationships with the additional CMO and supplier of heparin; the risks and uncertainties associated with CorMedix’s ability to manage its limited cash resources; obtaining additional financing to support CorMedix’s research and development and clinical activities and operations; preclinical results are not indicative of success in clinical trials and might not be replicated in any subsequent studies or trials; and the ability to retain and hire necessary personnel to staff our operations appropriately. We continue to assess to what extent the uncertainty surrounding the Coronavirus pandemic may impact our business and operations. These and other risks are described in greater detail in CorMedix’s filings with the SEC, copies of which are available free of charge at the SEC’s website at www.sec.gov or upon request from CorMedix. CorMedix may not actually achieve the goals or plans described in its forward-looking statements, and investors should not place undue reliance on these statements. CorMedix assumes no obligation and does not intend to update these forward-looking statements, except as required by law.

Who is CorMedix?

- *CorMedix is a publicly listed (Nasdaq: CRMD), small cap pre-commercial stage biopharma company developing therapeutic products for the prevention and treatment of life-threatening conditions and diseases*
- *Our lead asset is DefenCath, a novel, first-in-class, non-antibiotic antimicrobial catheter lock solution designed to reduce catheter related bloodstream infections (CRBSIs) and maintain catheter patency in patients with central venous catheters (CVCs)*
- *Initial target indication for DefenCath is the reduction of CRBSIs in hemodialysis patients receiving chronic hemodialysis through a CVC, a critical unmet medical need with a high rate of incidence, and high rates of morbidity and mortality for the hemodialysis patient population*
- *CorMedix resubmitted the DefenCath NDA in May 2023, FDA has accepted the NDA for filing as a Class 2 resubmission with a 6-month review, and has granted a PDUFA target action date of November 15, 2023*
- *DefenCath is expected to serve a sizable commercial market opportunity spanning both the hospital inpatient as well as outpatient dialysis segments, with inpatient reimbursement already established upon FDA approval via NTAP*
- *DefenCath has the potential to receive 10 ½ years of market exclusivity pursuant to FDA approval of the NDA as a New Chemical Entity (NCE, 5 years) and Qualified Infectious Disease Product (QIDP, 5 years) with an additional 6 months upon completion of a pediatric hemodialysis study, as well as IP protection covering the product through 2042*

CorMedix Executive Leadership Team

	JOINED CORMEDIX	PRIOR EXPERIENCE
 **Joe Todisco** *Chief Executive Officer*	2022	• Chief Commercial Officer of Amneal Specialty • Co-founder and Chief Executive of Gemini Laboratories • Commercial Strategy and business development at Ranbaxy
 **Matt David, MD** *EVP, Chief Financial Officer*	2020	• Head of Strategy at Ovid Therapeutics • Life science focused investment banker at BofA, Thomas Weisel Partners and Piper Jaffray • Former Pharma research analyst at Lehman Brothers
 **Phoebe Mounts, PhD, JD** *EVP, General Counsel, Legal, Regulatory, Compliance*	2019	• Partner at Morgan Lewis, specializing in FDA law • Faculty at Johns Hopkins School of Public Health • Ph.D. in molecular biology
 **Liz Masson Hurlburt** *EVP, Clinical and Medical Affairs*	2017 *Led LOCK-IT-100 clinical study program*	• VP of Clinical Operations at Gemphire Therapeutics • Additional renal area experience from Rockwell Medical
 **Erin Mistry** *EVP, Chief Commercial Officer*	2020	• VP of Value Access at Intarcia Therapeutics • Senior Managing Director Syneos Health – global P&L of Value & Access Practice with 12 years consulting

The Problem: CRBSI

Catheter Related Bloodstream Infections

Catheter Related Bloodstream Infections (CRBSI) are a Common and Life-threatening Complication of CVC use

Disease Burden

~80% of patients starting HD (hemodialysis) will have a CVC inserted for vascular access [1]

CRBSIs can occur in 25%-33% [6] of CVC HD patients, and are caused by a wide range of pathogens-many of which are drug resistant [11]

Over 50% of CRBSIs occur within the first 3 months following CVC insertion [12]

The average time on a CVC is 220 days [2]

Health Economics

HD patients with CRBSIs have almost 2x more hospitalizations per year [4]

Length of hospital stays for HD CRBSI patients are 4x longer and cost 2x more than non-CRBSI patients [4,5]

Patients with CRBSI are 3x more likely to die within 90 days [12]

All-payer annual incremental costs of CRBSI is $2.3B [6]

CRBSI and related healthcare costs arise quickly

Key Takeaways from Inpatient HECON Analysis

9% to 13%

Observed incidence of CRBSI for **inpatients** with the diagnosis of AKI, CKD or ESRD

92% to 99%

All-cause readmission rate among CRBSI patients, ~80% within 30-days

60% to 72%

30-day readmission rate for **CRBSI recurrence** among CRBSI patients

3x to 5x

Greater 30-day readmission rates for **CRBSI vs non-infected patients** for AKI and CKD patients receiving inpatient hemodialysis

The data showed not only a high rate of CRBSI incidence, but significant readmissions at both 30-day and 90-day intervals for recurring CRBSIs.

CorMedix performed a retrospective database analysis of the largest hospital discharge database in the US, to assess the proportion of 381,336 HD-CVC patients between 2017-2021 with a diagnosis of AKI, CKD or ESRD among hospitalized inpatients, and to examine the incidence of CRBSIs among the respective hospitalized patient populations and 30-day and 90-day readmissions (for all-cause and for recurring CRBSIs).

*AKI/CKD/ESRD only cohorts

CRBSIs Can Increase Hospitalizations, Length of Stay and Negatively Impact Concomitant Conditions

Increases in Hospitalizations and LOS with CRBSIs

	CRBSI	Non CRBSI	P-value
Mean Number of Hospitalizations*	3.79	1.96	<0.05
Hospital Days*	25.0	5.86	<0.05

Increases in Major Complications with CRBSIs

CRBSIs resulted in **higher 1-year incremental rates** of[3,†]:

Dysrhythmia	26.7%
Congestive Heart Failure	13.4%
Endocarditis	9.4%
Myocardial Infarction	9.2%
Stroke	6.6%

*Both outcomes were significantly higher for CRBSI vs. non-CRBSI hospitalized patients ($p<0.05$) at 1-year post-CRBSI.
†HR for CRBSI patients were stroke (1.59, 95% CI 1.50-1.69), MI (2.47, 95% CI 2.30-2.64), CHF (1.89, 95% CI 1.79-2.00), endocarditis (14.46, 95% CI 12.21-17.13), and dysrhythmia (2.41, 95% CI 2.31-2.51).
BSI, bloodstream infection; CRBSI, catheter-related bloodstream infection; CVC, central venous catheter; ESRD, end-stage renal disease; HD-CVC, hemodialysis with central venous catheter; HR, hazard ratio.

References: 1. Rajagopalan K, et al. Presented at: the American Society of Nephrology (ASN) Kidney Week 2021; November 4-7, 2021; San Diego, California.
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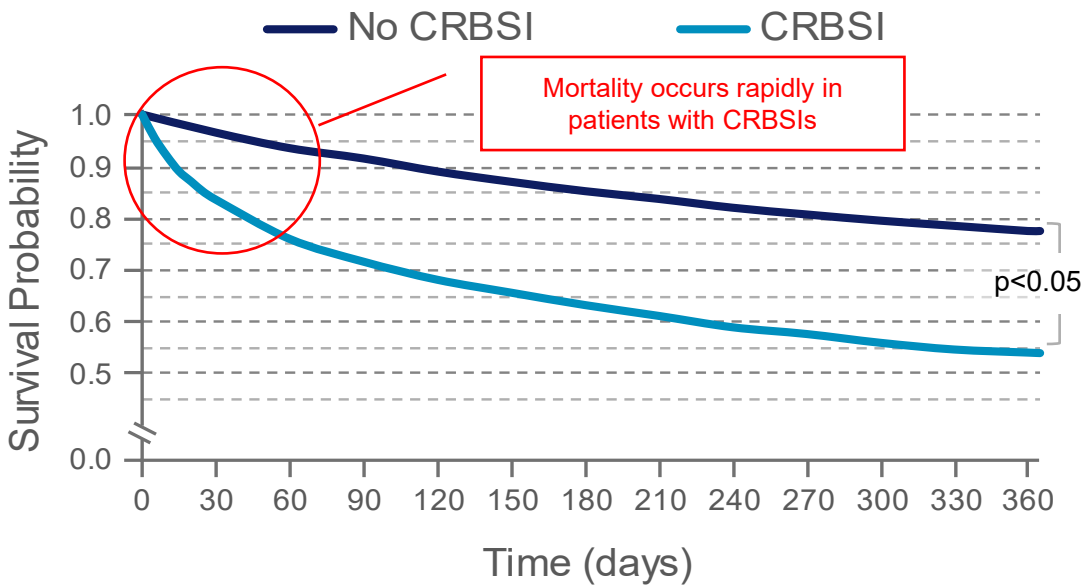
CRBSIs Significantly Increase the Risk of Death

- In an analysis of 55,727 CVC-dependent HD patients, mortality rates at **3 months** for HD-CVC patients with CRBSI was 3x higher than those without

Kaplan Meier Survival Estimate, Time to Death



Mortality Rates for CRBSI vs Non-CRBSI Patients

Mortality	CRBSI (%)	Non-CRBSI (%)
90 Days	28.4	8.9
180 Days	37.1	14.9
365 Days	46.5	22.9

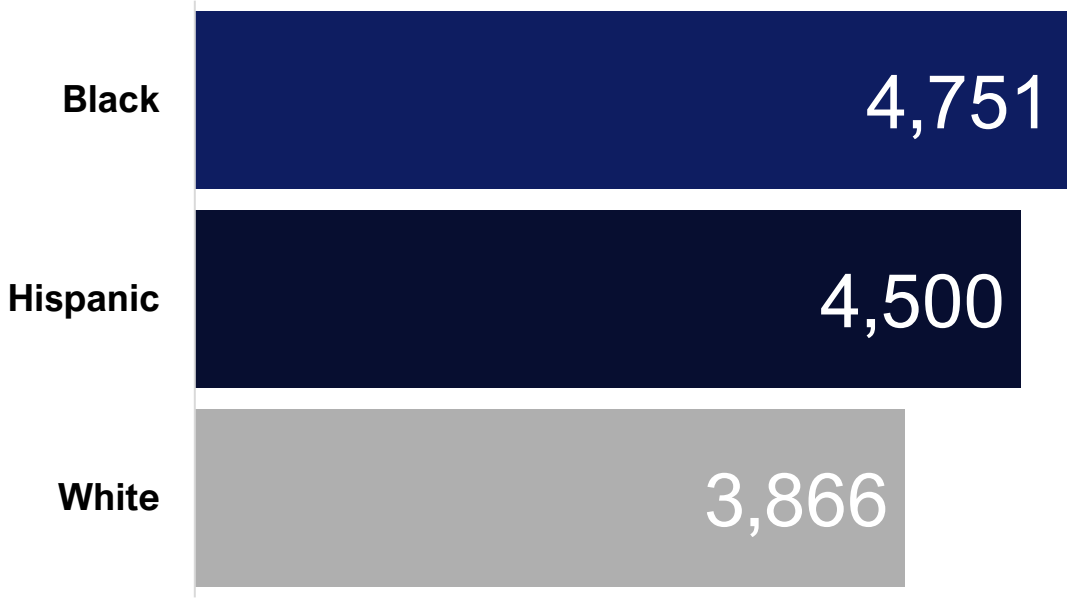
BSI, bloodstream infection; CRBSI, catheter-related bloodstream infection; CVC, central venous catheter; ESRD, end-stage renal disease; HD, hemodialysis; HD-CVC, hemodialysis with central venous catheter; HR, hazard ratio.

Reference: Massey K, et al. CRBSI incidence and associated mortality risk: Analysis of merged USRDS-Medicare claims. Presented at: the American Society of Nephrology (ASN) Kidney Week 2021; November 4-7, 2021.

CDC Reported Infection Rates and Health Equity Implications: CMS Proposed Policy Improvements for Infection Prevention

Race, Ethnicity, and Socioeconomic Factors Affect BSI Rates

S. aureus BSI Rates by Race/Ethnicity*
Rate per 100,000 patients on dialysis per year



*2017-2020 Emerging Infections Program surveillance data.
BSI, bloodstream infection.
Reference: Rha B, et al. MMWR Morb Mortal Wkly Rep. 2023;72:153-159.

CMS Proposes Policies to Improve Patient Safety and Promote Health Equity

CMS Announced on April 10th a proposed rule for inpatient and long-term care hospitals to advance health equity and support underserved communities

The rule would adopt hospital quality measures to foster safety, equity, and reduce preventable harm in the hospital setting

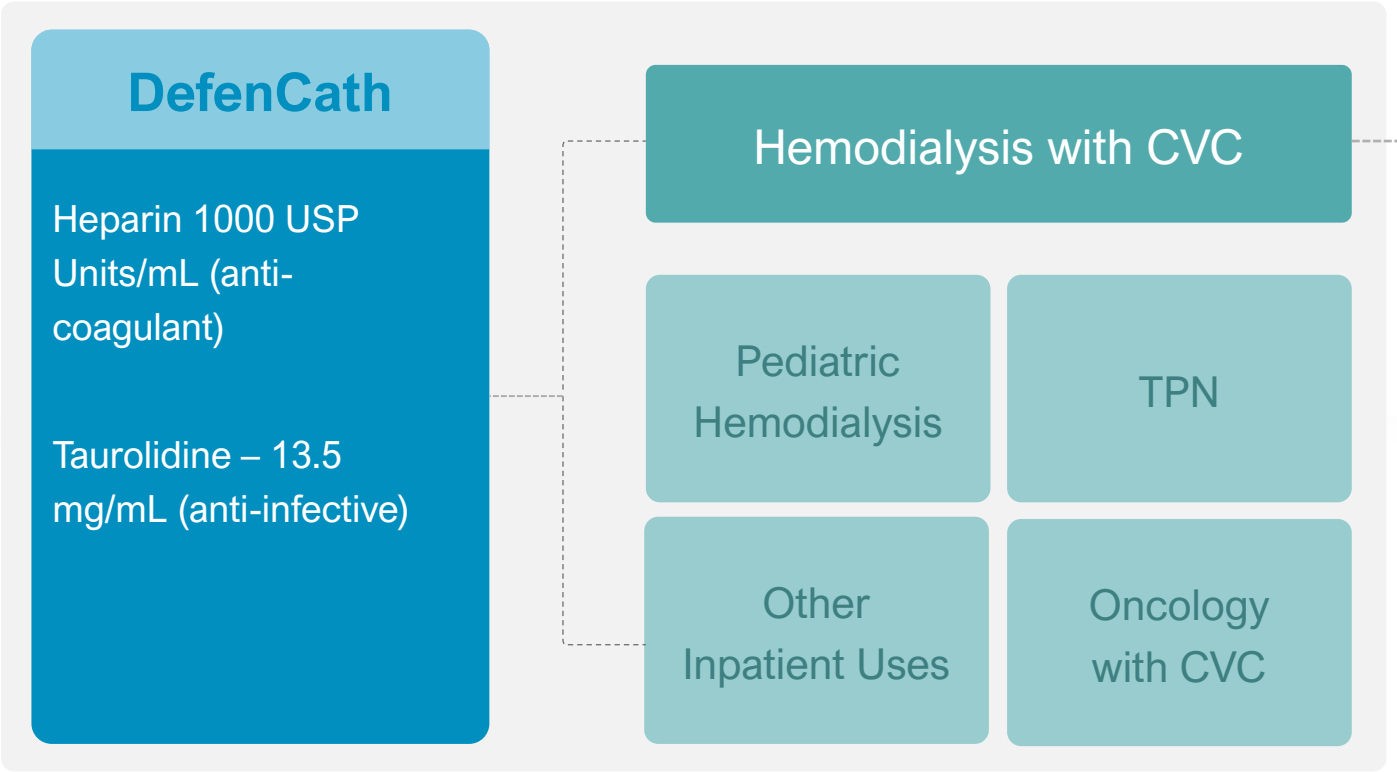
Infection prevention, especially in the disproportionately Black and Hispanic hemodialysis population, fits squarely within this initiative to both improve patient safety AND address health inequity

Our Proposed Solution: DefenCath™

A novel, first-in-class, antimicrobial catheter lock solution, with broad-spectrum antibacterial and antifungal activity, designed to reduce CRBSIs and maintain catheter patency in patients with central venous catheters (CVCs)

Targeting Multiple Potential Large Therapeutics Areas

- DefenCath is a novel, first in class, non-antibiotic catheter lock solution, designed to reduce CRBSIs and maintain catheter patency in patients with CVCs
- Our proprietary NCE Taurolidine demonstrates broad spectrum, antimicrobial activity against gram-negative and gram-positive bacteria, multi-drug resistant bacteria, and clinically relevant fungi
- No pharmacologic agents currently approved in the U.S. for the prevention or reduction of CRBSI in patients with CVCs
- DefenCath has the potential to receive 10.5 years of market exclusivity (NCE, QIDP + pediatric exclusivity) and IP coverage through 2042



Current Market and Clinical Program

- ~80% of HD patients begin treatment with a CVC inserted for vascular access [1]
- Outpatient: CVC patients receive hemodialysis an average of 3x per week
- Inpatient: market includes hospitalized HD-CVC patients and patients new to hemodialysis
- CorMedix aims to pursue other potential indications following an initial FDA approval, including a pediatric study under agreement with FDA

Phase 3 LOCK-IT-100 – Compelling Clinical Profile[3]

Objective: to demonstrate the efficacy and safety of DefenCath as a catheter lock solution for the prevention of CRBSI and the incidence of treatment-emergent adverse events compared to heparin standard of care

Primary endpoint met (time to occurrence of CRBSI) – highly statistically significant efficacy (p = 0.0006)

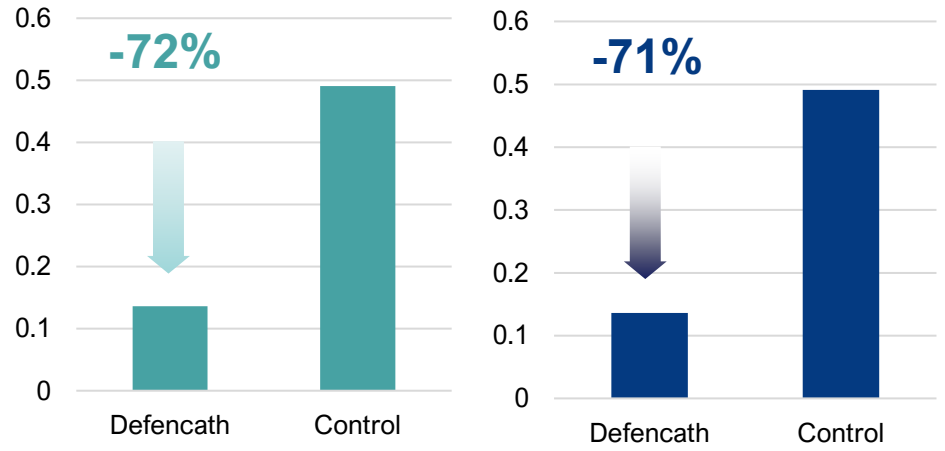
Secondary safety endpoints met - no statistically significant differences between DefenCath (D) & Heparin (H) control arm for loss of catheter patency and catheter removal

Study Design:

- Phase 3, multicenter, double-blind, randomized (1:1), active control (heparin)
- Event-driven: 56 CRBSI events required to complete the study; 28 CRBSI events at Interim Analysis met pre-specified efficacy endpoint without safety concerns and Data Safety Monitoring Board recommended early termination
- Statistical power based on 55% reduction of risk of CRBSI relative to the control arm
- Study conducted in outpatient clinics in a patient population representative of the current demographic of HD patients in terms of race and ethnicity

	Interim Analysis	Full Study
Total CRBSIs (D / H)	28 (6 D / 22 H)	41 (9 D / 32 H)
Total Subjects	653	795
Reduction in Risk of CRBSIs	**72%**	**71%**
p-value	0.0034	0.0006

Overall, fewer patients had catheters removed due to CRBSIs with DefenCath compared to control (2% vs. 7.3%; p=0.0008).



CorMedix™

Large Addressable Market Opportunity in Hemodialysis

(Inpatient + Outpatient)

Setting Of Care	Addressable Market		Reimbursement Dynamics
 Hospital Inpatient	• 3mm-5mm* 3ml vials per year • Net price point higher than outpatient setting		NTAP (New Technology Add-On Payment) is an additional payment for drugs that exceed a DRG payment amount by at least one standard deviation **CMS has issued the Inpatient Prospective Payment System ('IPPS") 2024 proposed rule that includes a revised NTAP of up to $17,111 per hospital stay for DefenCath, provided final NDA approval occurs before July 1, 2024**
 Outpatient Dialysis Clinics	• 30mm-80mm* 3ml vials per year • Variable net price depending on CMS reimbursement determination (separate reimbursement vs TDAPA)	**Base Case Utilization**	TDAPA is an add-on payment to the current bundled rate for certain new ESRD drugs TDAPA is a 2-year transitional payment after which the cost of therapy is included in the revised bundle payment amount
		Higher Utilization	CorMedix is partnering with key stakeholders to present evidence to CMS that DefenCath is not a renal dialysis service, including FDA label, clinical studies, MOA and FDA designation, and therefore should not be included in the ESRD bundle Company believes that DefenCath should be separately reimbursed with a unique J Code **Separate reimbursement would yield higher utilization in LDOs with longer-term sustainable value**

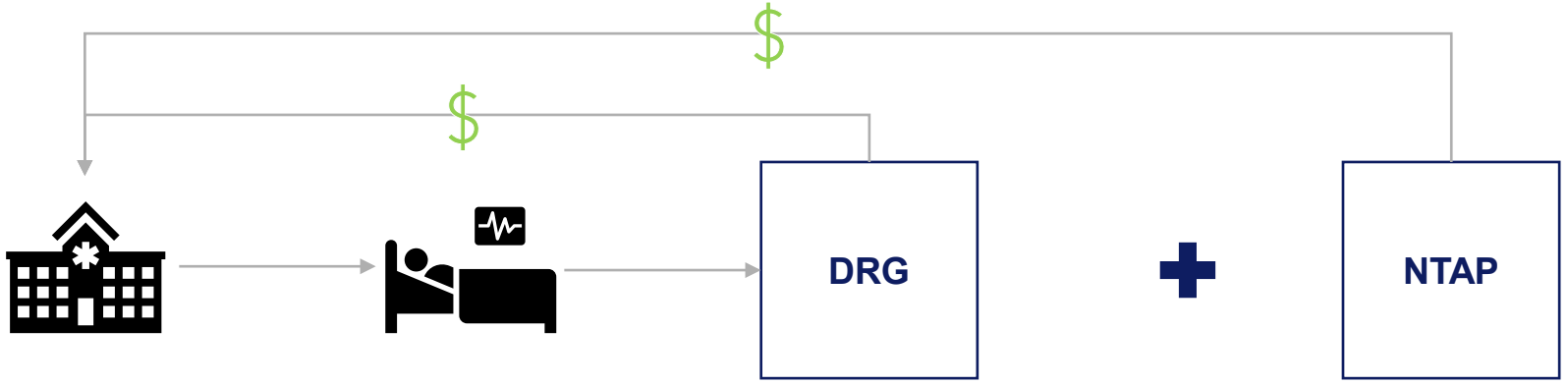
*Source: Internal Company Market Research

Note: NTAP represents reimbursement to inpatient facilities of 75% of the anticipated WAC price of $1,170 per 3 mL vial, and an average utilization of 19.5 vials per hospital stay. Each 3 ml vial expected to fill a single lumen lock, therefore 2 vials used per treatment.

NTAP Designation Provides Additional Reimbursement Possibility at Launch to Hospitals

New Technology Add-on Payment (NTAP) designation enables additional payment to hospitals above the standard Diagnosis-Related Group (DRG) payment amount for Medicare patients

How a hospital typically gets paid



Hospital

Inpatient Services Provided

The DRG system is used to classify diagnoses / services provided into groups and subgroups

How NTAP Factors In

With DefenCath NTAP designation, **hospitals** will receive an additional add-on payment for the use of the product

Add-on payment strengthens the value proposition & pharmacoeconomics of DefenCath

Add-on payment may not directly benefit the pharmacy budget, so benefit to full hospital P&L must be part of HEOR model

Key Customers Types and Settings of Care

Market channel segmentation and channel specific commercial strategy will be essential to a successful commercialization of DefenCath

Inpatient

Large National Health Systems

HCA Healthcare®

Cleveland Clinic

KAISER PERMANENTE®

Large Regional Hospital Networks

Mount Sinai

Indiana University Health

Independent Hospitals

TGH Tampa General Hospital®

Parkland

Government Hospitals and Agencies

VA | U.S. Department of Veterans Affairs

Outpatient

Large Dialysis Organizations (LDOs)

DaVita® Kidney Care

FRESENIUS MEDICAL CARE

MDOs (Mid) and SDOs (Small) Dialysis Providers

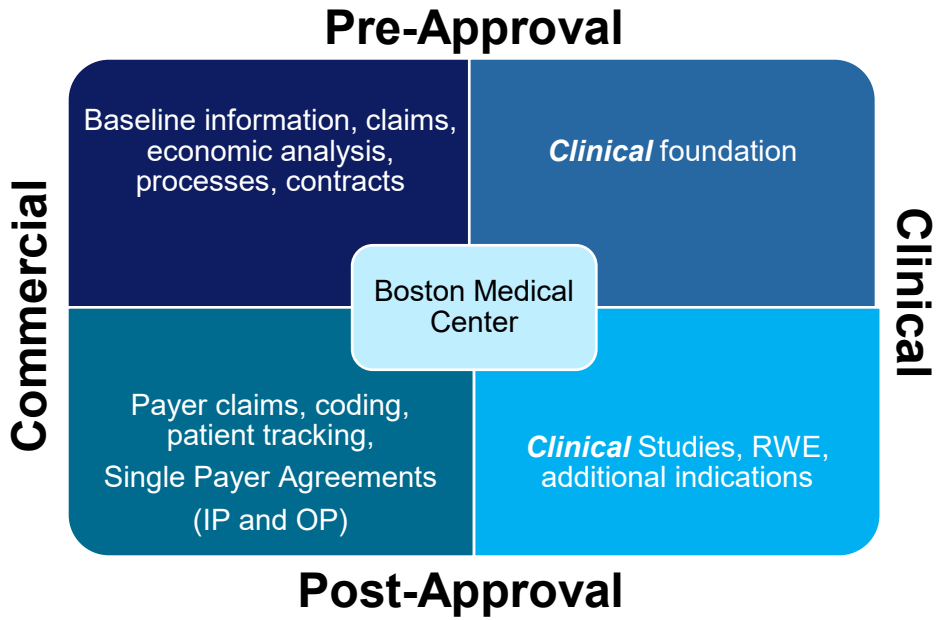
U.S. RENAL CARE®

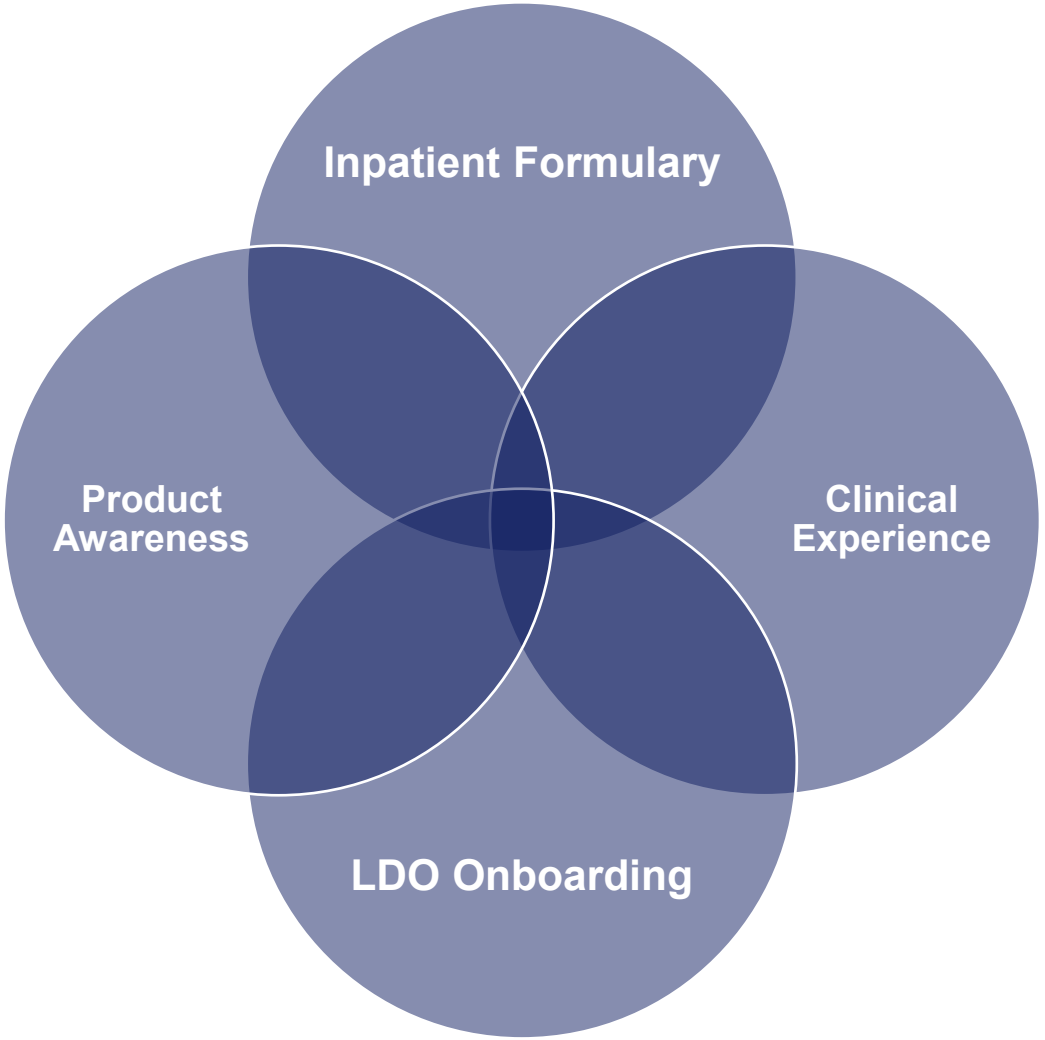
Powered by Physicians. Inspired by our Patients™

ARC DIALYSIS

Health System Strategic Partnerships

- BMC Partnership is a blueprint for other health systems from which we have a legitimate clinical or business need for data
- Pre-approval disease awareness
- DefenCath education and system implementation
- Demonstration of value across care continuum
- CorMedix brand awareness & value growth
- Regional IDN competition & interest in innovation





Commercial Execution & Strategy

CorMedix intends to launch first in the inpatient setting, while working simultaneously to obtain outpatient reimbursement clarity. Modest infrastructure required for both settings of care.

Hospital (Inpatient)

A commercial organization of ~30 can provide adequate coverage for launch

- ~6,100 hospitals in the US, per AHA statistics
- ~1,300 hospitals have more than 200 beds
- 70% of all hospitals are part of a hospital system, many of which centralizes decision and standardize protocols.
- CorMedix is actively reviewing options for a hybrid internal/external outsourced approach to prepare for launch in the Hospital market

Dialysis Facility (Outpatient)

A highly focused internal team of ~12 can provide adequate coverage for launch:

- There are ~7,600 dialysis facilities, ~10,000 nephrologists
- 2,500 to 3,000 dialysis facilities provide ~ 70% of the opportunity
- 5 large dialysis organizations* account for >85% of the dialysis patients; central decision making
- Top 15 states account for ~ 70% of the patients
- CorMedix has been laying the groundwork and building a highly experienced internal team to focus on the outpatient dialysis setting

Hospital size, standardization at system level, along with dialysis facility concentration and corporate owners allows for efficient deployment of resources (sales reps, medical affairs and market access)

* In US, the largest dialysis providers include DaVita, Fresenius, US Renal Care, Dialysis Clinic Inc., and American Renal Associates.

DefenCath Regulatory & Manufacturing Background

- CorMedix announced the completion of the DefenCath submission in July 2020, announced receipt of a complete response letter (CRL) in March of 2021. The NDA was subsequently resubmitted to FDA in February of 2022 and received a second CRL in August of 2022 related to deficiencies in compliance at the primary manufacturing site as well as supplier of heparin API for an unrelated API
- Since August 2022, the Company has worked to improve its supply chain, engaging compliance consultants to provide support to the primary CMO for the implementation of corrective actions, as well as securing an alternate supplier of heparin API, and engaging two back-up CMOs, Alcami and Seigfried Hameln
- The Company completed a Type A meeting in April 2023 with FDA to discuss guidance with respect to the DefenCath NDA re-submission, and following the receipt of FDA Meeting minutes in May 2023, resubmitted the DefenCath NDA. The NDA has been accepted for filing as a class 2 resubmission with a 6-month review, and a PDUFA target action date of November 15, 2023
- The FDA meeting minutes confirm FDAs guidance during the Type A Meeting:
    - FDA informed CorMedix that it is in receipt of the close out report for inspectional observations received from its existing contract manufacturing organization (“CMO 1”), and NDA resubmission with CMO 1 can be done at the Company’s discretion. The FDA may conduct a pre-approval inspection at the facility as part of the NDA review process
    - Based on guidance from FDA, CorMedix resubmitted the NDA application with manufacturing data generated at the existing CMO and utilizing both the existing source of heparin API (“API 1”) as well as a new supplier of heparin API (“API 2”)
    - As part of the validation of API 2, the Company will be adding a 3 mL single-dose vial to its 5 mL commercial presentation to meet market preferences and demand

Financial Highlights

Key Statistics

Exchange	NASDAQ Global Market
Common Stock	45.4 million shares as of 5/10/2023
Market cap***	~$250 million

Balance Sheet

Cash and short-term investments*	$55.6 million**
Debt	None

* Excluding restricted cash
** as of 3/31/2023
*** as of 6/20/2023

CorMedix's Key Investment Highlights

First in Class Therapy

DefenCath is a novel, broad-spectrum, antimicrobial catheter lock solution with the potential to change the standard of care in several large markets – there is no current pharmacologic agent approved to prevent or reduce the risk and incidence of catheter related bloodstream infections (CRBSI) associated with the use of central venous catheters (CVCs)

Taurolidine, the active ingredient, is a new molecular entity with broad spectrum antibacterial and antifungal activity, and two mechanisms of action, that does not lend itself to microbial resistance

Substantial Market Opportunity and Critical Unmet Medical Need

DefenCath initially targeted in hemodialysis patients. ~ **80%** of patients starting hemodialysis will have a CVC inserted for vascular access [1], with an average duration of 220 days [2], and roughly **25%-33%** will experience a CRBSI [6], with a significantly higher mortality rate vs. non-CRBSI HD patients

The Company estimates the inpatient market opportunity at 3mm-5mm 3ml vials per year, and the outpatient opportunity at 30mm-80mm vials per year, where two vials of 3 ml DefenCath would be utilized per catheter

CMS has proposed NTAP (inpatient reimbursement) with a maximum reimbursement per average hospital stay of ~$17K

Potential to receive 10.5 years of regulatory market exclusivity beginning upon NDA approval; plus IP to 2042

Pursuing Approval of the DefenCath NDA

Following an April Type A meeting with the FDA, CorMedix has resubmitted the DefenCath NDA, utilizing its existing CMO and including data from multiple suppliers of heparin API; The NDA has been accepted for filing as a class 2 resubmission with a 6-month review, and a PDUFA target action date of November 15, 2023

The Company intends to provide any necessary support to its existing CMO as it prepares for a potential pre-approval inspection at the facility

Compelling Safety & Efficacy Profile

LOCK-IT-100 trial of DefenCath demonstrated a 71% reduction in the risk of occurrence of CRBSI in 795 HD subjects [3]

Safety profile comparable to the heparin catheter lock control arm, which is the current standard of care designed to preserve catheter patency, but not infections [3]

Compelling HEOR and Health Equity Implications

HD patients with CRBSIs have 2x more hospitalizations per year, with 4x longer duration of stay [4], and 3x higher fatality rate [2]. HD patients with a CRBSI incur 2x higher per patient hospital cost [5], with an estimated 250,000 CRBSIs per year in U.S. [6]

African Americans make up 17% of the U.S. population but more than 35% of patients undergoing hemodialysis [7], disproportionately exposing them to higher risk for CRBSI

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