APOGEE THERAPEUTICS

Corporate overview

DECEMBER 2024

Disclaimers and Forward-looking statements

This presentation contains certain "forward-looking statements" within the meaning of applicable securities laws. Other than statements of historical facts, all statements included in this presentation are forward-looking statements, including statements about our plans for our current and future product candidates and programs, our plans for current and future clinical trials, including a Phase 2 trial of APG 777 in atopic dermatitis, Phase1b and 2b trials of APG777 in asthma and a trial of APG777 in eosinophilic esophagitis, a Phase 1b trial of APG808 in asthma, a Phase 1 trial for APG990, a Phase 1 trial for APG333, and a clinical trial of the combination of APG777 and APG990; our plans for clinical trial design; the anticipated timing of the initiation of and results from our clinical trials, including data from our Phase 2 trial of APG777and our Phase 1 trial of APG990; the potential clinical benefit, half-life and dosing regimen of APG777, APG808, APG990, APG333 and any other potential programs, including the combinations of APG777 and APG990, and APG777 and APG333; our expected timing for future pipeline updates; our expectations regarding the time period over which our capital resources will be sufficient to fund our anticipated operations, and estimates of market size. In some cases, you can identify forward-looking statements by terms such as “anticipate,” “believe,” “can,” “could,” “design,” “estimate,” “expect,” “intend,” “likely,” “may,” “might,” “plan,” “potential,” “predict,” “suggest,” “target,” “will,” “would,” or the negative of these terms, and similar expressions intended to identify forward-looking statements. The forward-looking statements are based on our beliefs, assumptions and expectations of future performance, taking into account the information currently available to us. These statements are only predictions based upon our current expectations and projections about future events. Forward-looking statements are subject to known and unknown risks, uncertainties and other factors that may cause our actual results, level of activity, performance or achievements to be materially different from those expressed or implied by such forward-looking statements, including those risks described in “Risk Factors” and “Management’s Discussion and Analysis of Financial Condition and Results of Operations” in our Annual Report on Form 10-K for the year ended December 31, 2023, filed with the SEC on March 5, 2024, our Quarterly Report on Form 10-Q for the quarter ended September 30, 2024, filed with the SEC on November 12, 2024, and subsequent disclosure documents we may file with the U.S. Securities and Exchange Commission. Although we have attempted to identify important factors that could cause actual results to differ materially from those contained in forward-looking statements, there may be other factors that cause results not to be as anticipated, estimated or intended.

This presentation concerns drug candidates that are under clinical investigation, and which have not yet been approved by the U.S. Food and Drug Administration. These are currently limited by federal law to investigational use, and no representation is made as to their safety or effectiveness for the purposes for which they are being investigated.

The assumptions used in the preparation of this presentation, although considered reasonable by us at the time of preparation, may prove to be incorrect. You are cautioned that the information is based on assumptions as to many factors and that actual results may vary from the results projected and such variations may be material. Accordingly, you should not place undue reliance on any forward-looking statements contained herein or rely on them as predictions of future events. All forward-looking statements in this presentation apply only as of the date made and are expressly qualified by the cautionary statements included in this presentation. We do not undertake to update any forward-looking statements, except in accordance with applicable securities laws.

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Apogee plans to transform the standard-of-care for I&I diseases

Novel antibodies engineered against validated targets

- Potential higher exposures and longer half-lives could improve efficacy and transform dosing
- Expected novel IP into the mid-2040s[1]

First biotech to pursue combination approaches in the largest I&I markets

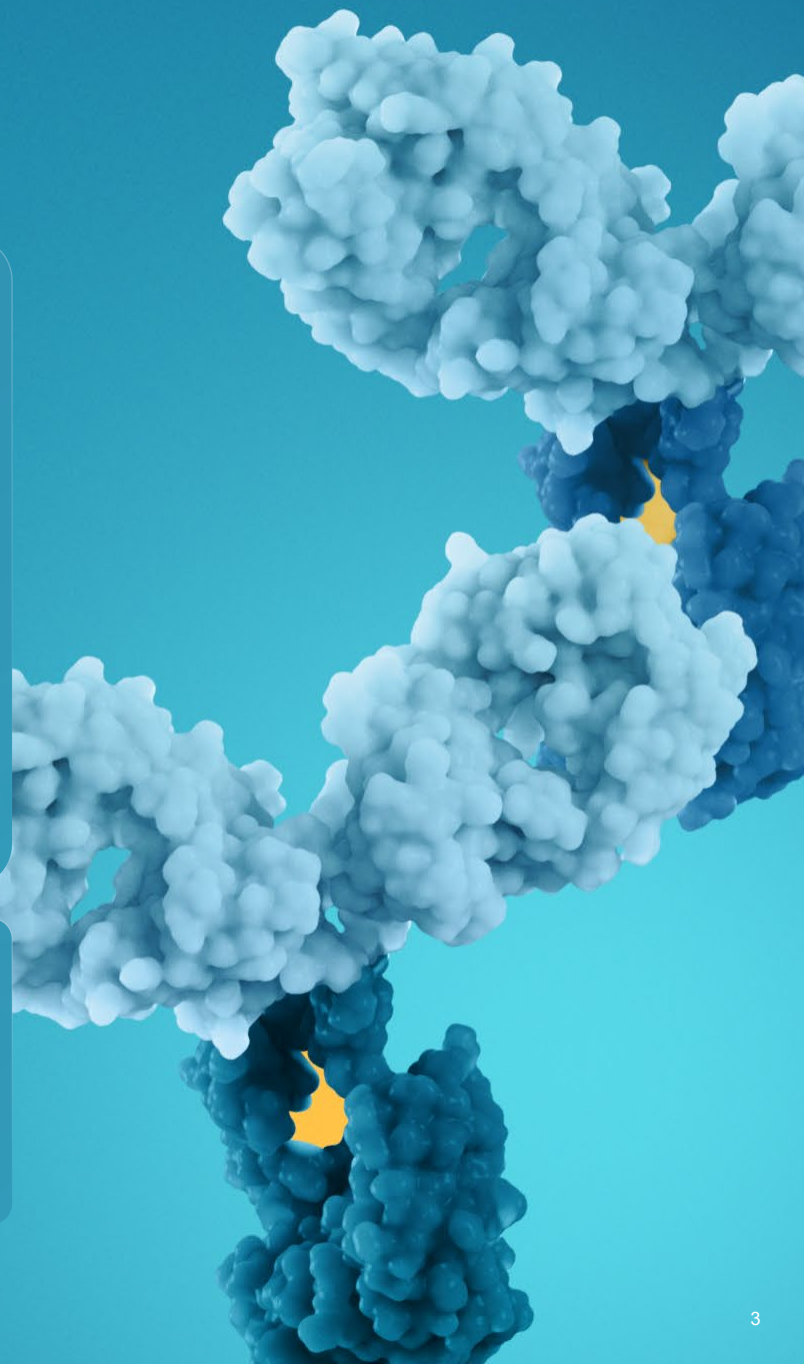
- AD combo trial expected to start 2025, asthma + COPD to follow

Potentially best-in-class therapy for future $50B+ atopic dermatitis market

- Market leader, DUPIXENT, is dosed every 2 weeks; nearly half of patients discontinue within 2 years
- APG777 Phase 2 Part A could demonstrate best-in-class efficacy signal in mid-2025 with potential for annual dosing

Strong financial position

- $754m total cash providing expected runway into 2028 with multiple near-term catalysts[2]



NOTE: [1] Based on current applications issuing as patents. [2] As of September 30, 2024, Apogee had cash, cash equivalents and marketable securities of $754M.

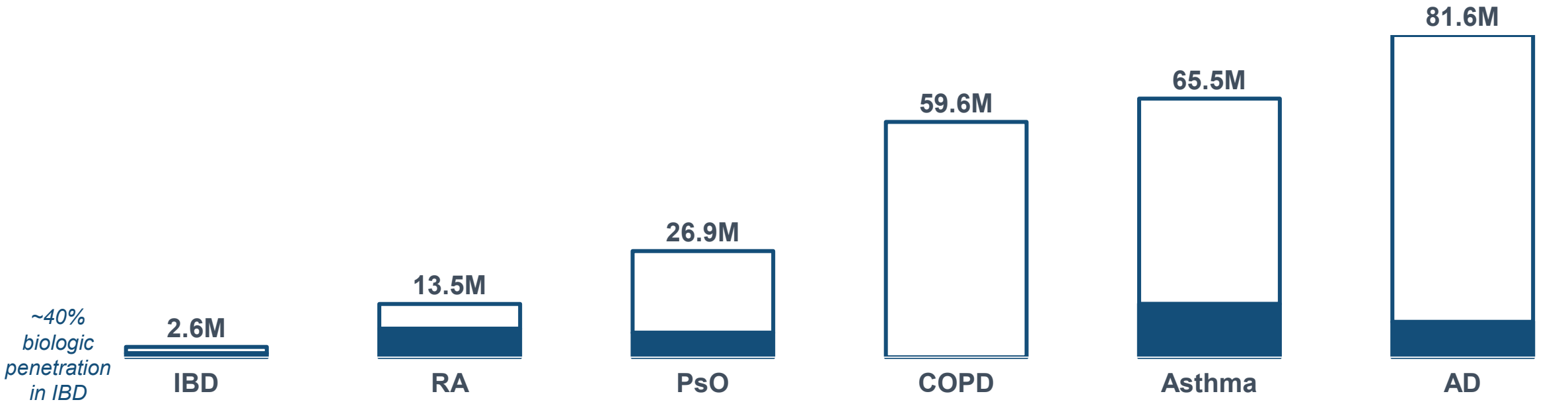
Apogee is focused on the largest I&I markets

Estimated population size. Moderate or severe, WW

US biologics penetration: 0% ⟷ 60%

Mature I&I markets have **consistently achieved high biologics penetration** (~25-60% after 15-20 years)

Apogee's current indications are the largest and least penetrated markets today

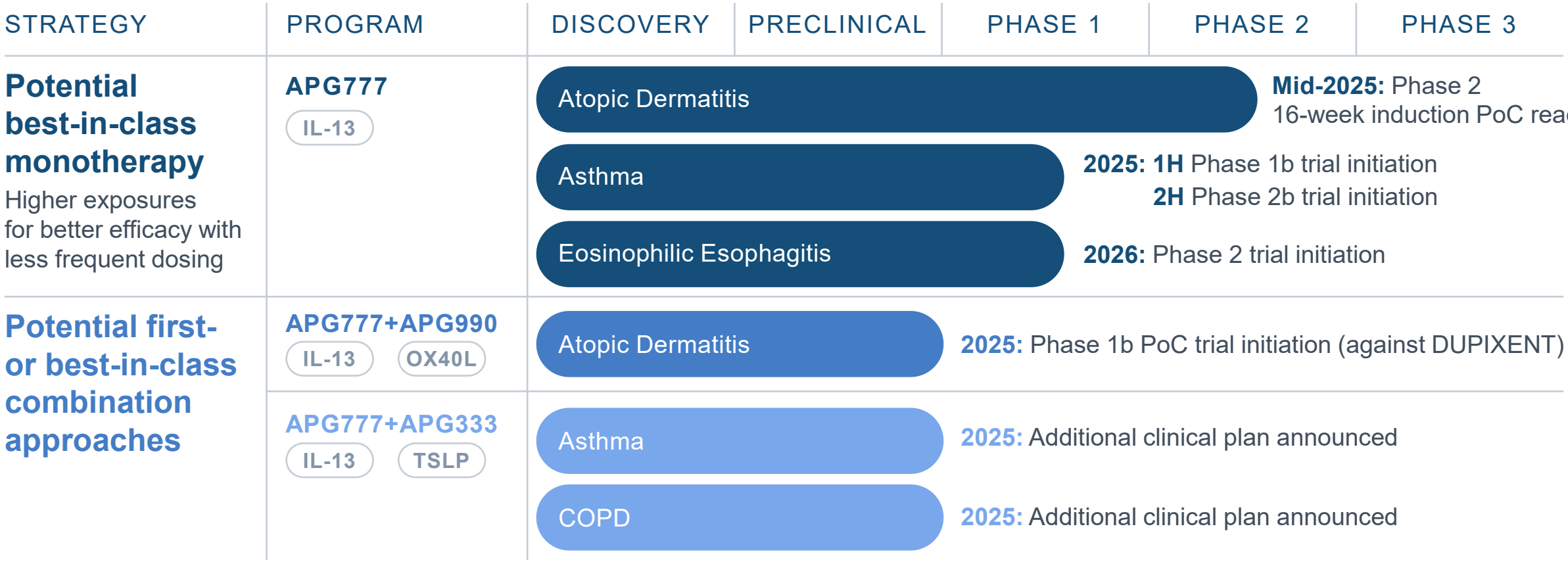


2023 WW Market Size: $23B $26B $27B

Significant future market opportunity

NOTE: IBD = Inflammatory bowel disease; RA = Rheumatoid arthritis; PsO = Psoriasis; COPD = Chronic obstructive pulmonary disease; AD = Atopic dermatitis
SOURCE: Academic journals, disease foundations, WHO, CDC, census data, EvaluatePharma, analyst research.

Apogee's approach is to achieve differentiated efficacy and dosing for validated targets



APG808 IL-4Rα → **Ph1b in asthma** readout expected in 1H 2025

APG990 OX40L → **Phase 1** healthy volunteer trial readout expected in 1H 2025

APG333 TSLP → **Phase 1** healthy volunteer trial readout expected in 2H 2025

The Apogee agents mentioned above are currently under investigation. Their safety and effectiveness for the listed target indications have not yet been established.

Apogee's antibodies are engineered for best-in-class properties against validated mechanisms

Platform	Results
Fully optimized antibodies	Multiple clinical readouts validate platform and de-risk pipeline
Improved pharmacokinetics	**Best-in-class PK** (3-5x current treatments) APG777: ~77-day half-life enables every 3- or 6-month dosing; path to annual dosing APG808: ~55-day half-life enables up to every 2-month dosing; path to every 3-months
Validated binding site	**Equivalent potency as leading agents** with expected novel IP to the mid-2040s[1]
Optimized backbone	**Improved formulation at high concentration and suitable for coformulation** e.g., APG777 180 mg/mL formulation (40% higher than EBGLYSS) enables higher exposures for potentially greater efficacy; coformulation PoC with APG990 achieved
Enhanced manufacturability	Improved manufacturability with potential for **low single digit COGS**

NOTE: [1] Based on current applications issuing as patents.

Our vision for building a next-gen biotech

APG777 in AD: Best-in-class monotherapy

- **Potential megablockbuster** in the future **$50B+ AD market**
- **Accelerated mid-2025 Ph2 POC readout** testing higher induction exposures for potentially better efficacy and every 3- or 6-month dosing
- **Path to annual dosing**

APG777: Pipeline-in-a-product

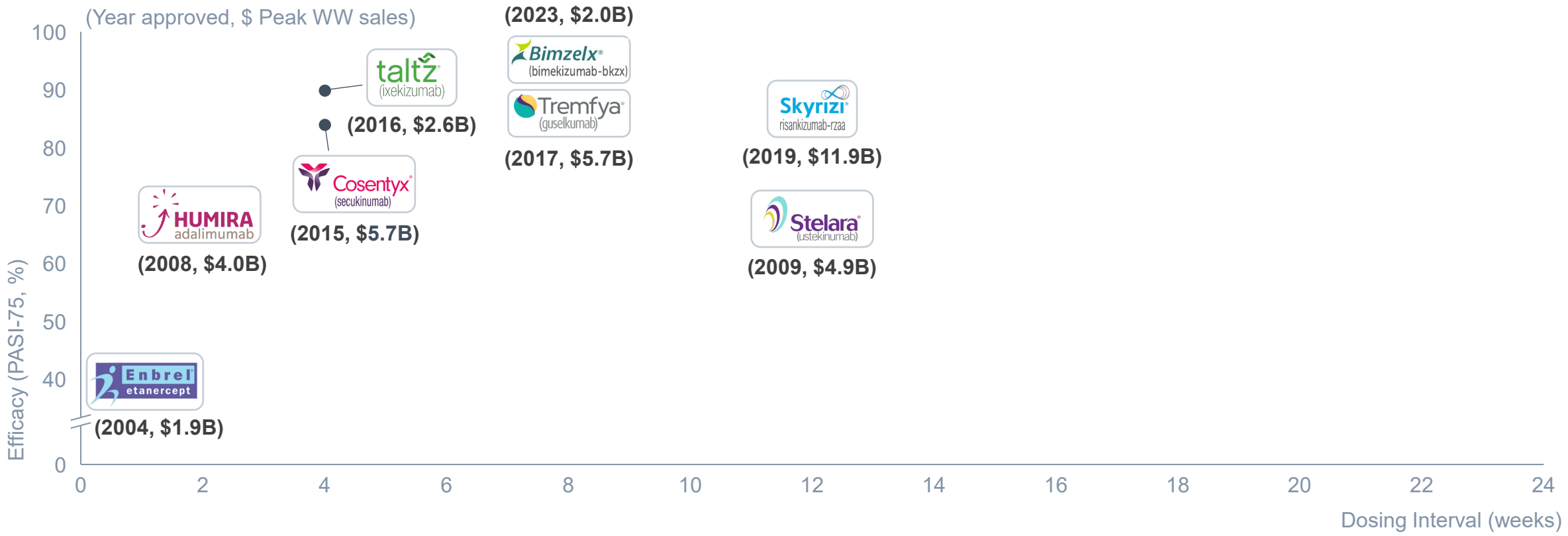
- Path to leadership in **10+ potential expansion indications** starting with:
  - **Asthma** Ph2b initiation expected **in 2025**
  - **EoE** Ph2 initiation expected **in 2026**

Best-in-class combinations

- **Potential to break through the monotherapy efficacy ceiling** via rational combos
- **Combos rapidly advancing** behind 777 mono with even greater **pipeline-in-a-product potential**:
  - **777+990: Ph1b against DUPIXENT** initiation expected in 2025; readout expected in 2H 2026
  - **777+333: asthma and COPD** clinical planning underway

APG777: Potential best-in-class monotherapy in AD

Psoriasis, a market analog to atopic dermatitis, has seen improved dosing and efficacy drive market success



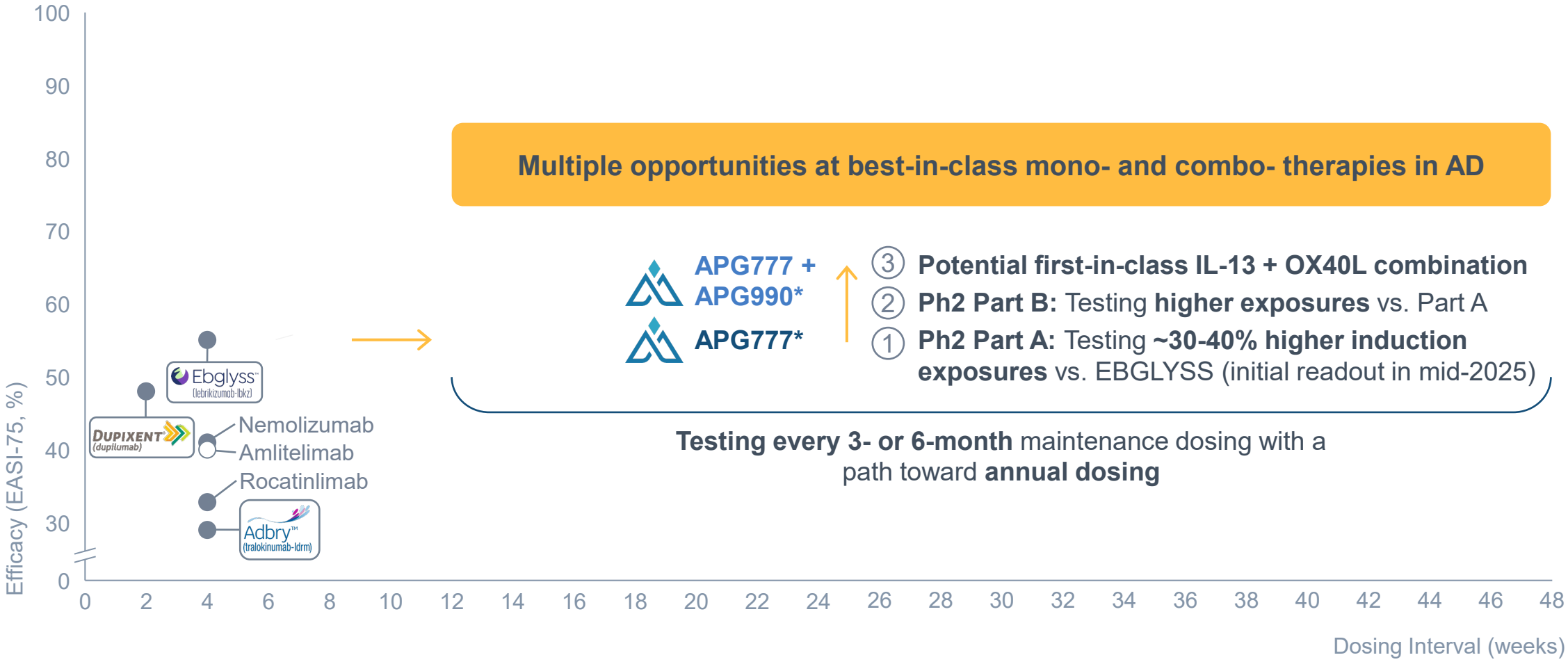
- **Psoriasis is not a winner take all market — 8 blockbusters**
- **SKYRIZI, a late entrant, has #1 share due to quarterly dosing which improves adherence[1]**

NOTE: PsO = Psoriasis. PsA = Psoriatic Arthritis. Year denotes US launch year for adults with moderate to severe plaque psoriasis. Efficacy data are derived from different clinical trials at different points in time, with differences in trial design, patient populations, and statistical analysis. As a result, cross-trial comparisons cannot be made. No head-to-head trials have been conducted among all biologics shown. Assumes 1 EUR = 1.07 USD.

[1] Real-world evidence shows SKYRIZI patients experienced fewer drug changes and a higher probability of drug survival compared with those treated with other biologic therapies for PsO and PsA.

SOURCE: Armstrong AW, et al JAMA Dermatol. 2020. Gordon KB, et al Lancet 2021. Reich K, et al Lancet 2021. GlobalData. EvaluatePharma. USPIs. Wall Street research and management projections. Erik L et al ACR Convergence 2023.

Apogee is potentially the first in atopic dermatitis to provide transformational dosing and efficacy

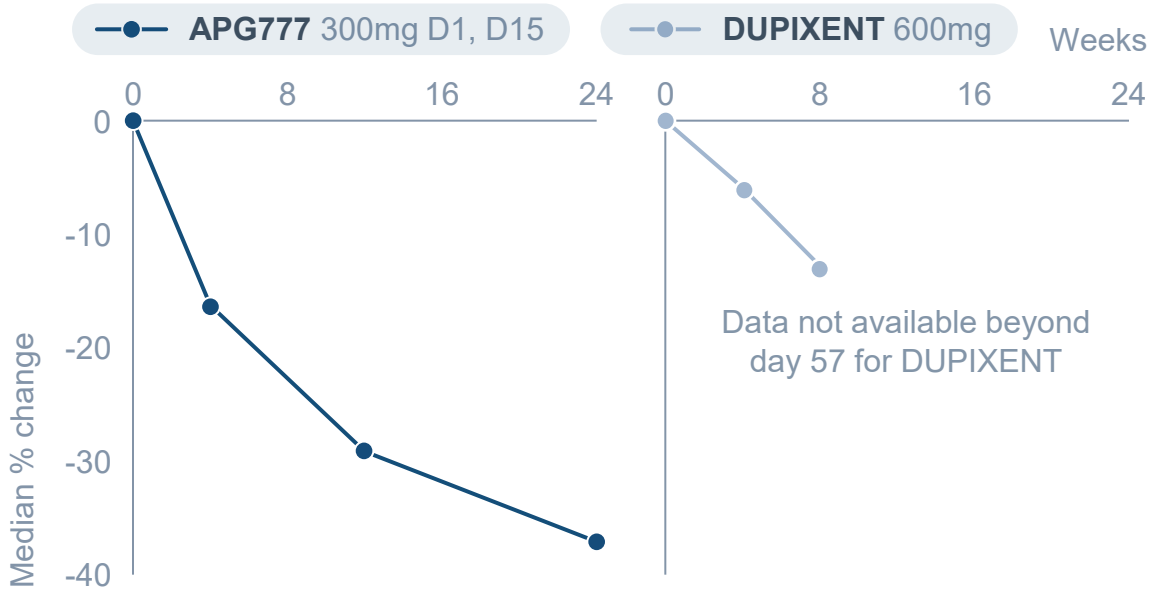


NOTE: *Positioning of Apogee programs is illustrative and based on interim Phase 1 results for APG777 only and illustrates what we believe we can potentially achieve. Only DUPIXENT, ADBRY, and EBGLYSS are approved in the US. Efficacy data are derived from different clinical trials at different points in time, with differences in trial design and patient populations. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted.

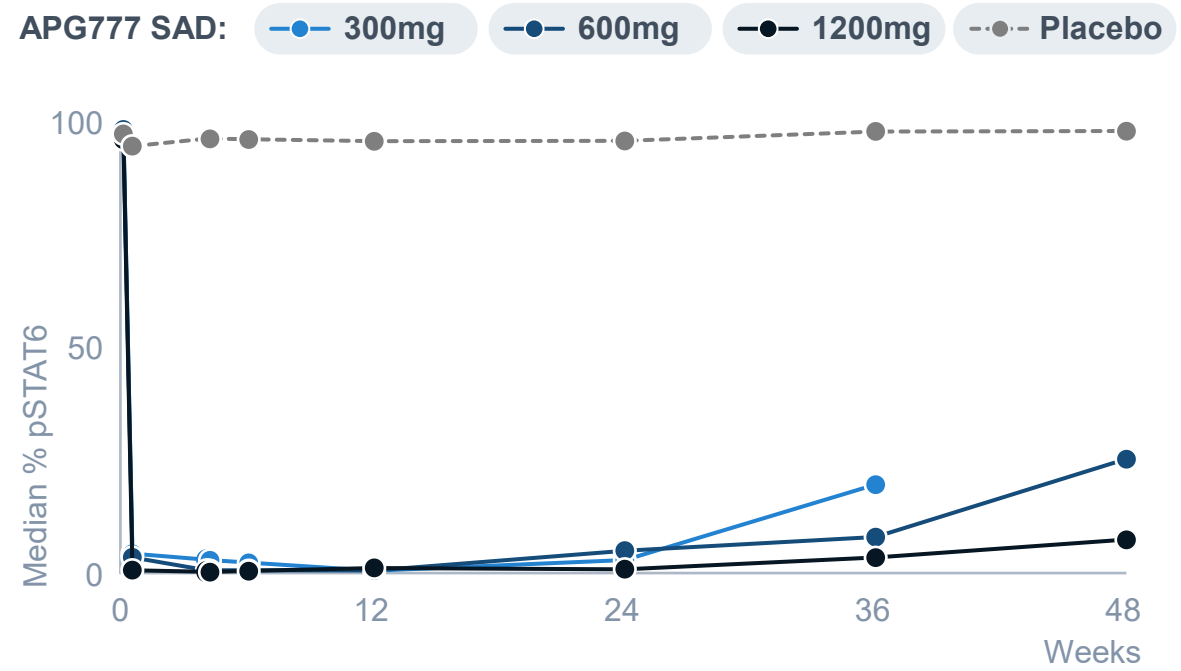
SOURCE: [1] EBGLYSS 250mg Q2W Ph3 avg. Silverberg JI et al. AAD 2022. [2] DUPIXENT 300 mg Q2W mono Ph3 avg. DUPIXENT USPI. [3] ADBRY 300 mg Q2W mono Ph3 avg. ADBRY USPI. [4] Nemolizumab 30 mg Q4W Ph3 avg. Silverberg J et al EADV 2023. [5] Rocatinlimab 150mg Q4W Ph2b Guttman-Yassky E et al Lancet 2023. [6] Amlitelimab 250mg Q4W Ph2b Weidinger S et al EADV oral presentation 2023.

APG777's optimized PK profile, including 77-day half-life, led to deep and sustained changes in key biomarkers TARC and pSTAT6

Median % changes from baseline in TARC



Median % pSTAT6



APG777 shows greater depth of TARC reduction compared to the same total dose of DUPIXENT

Near complete pSTAT6 inhibition up to ~12 months supports the potential for annual dosing

NOTE: N = 1 in cohort 1 (APG777 SAD 300mg) due to the accelerated timing of study enrollment relative to assay validation. No data has been published showing DUPIXENT or EBGLYSS impact on pSTAT6 in HVs. pSTAT6 measured using flow cytometry of whole blood samples stimulated with 10 ng/mL IL-13 (approximately 500 times the level of IL-13 present in lesional skin of moderate-to-severe AD patients). TARC data are derived from different clinical trials conducted at different points in time, with differences in trial design, dosing regimen and patient populations. DUPIXENT data derived from one Phase 1 trial with 6 healthy volunteers receiving a single SQ injection of 600 mg DUPIXENT. APG777 data derived from our Phase 1 trial in 6 healthy volunteers receiving two SQ injection of 300 mg of APG777. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted. APG777 is an investigational drug and has not been approved by the FDA as safe and effective. No data has been published showing EBGLYSS impact on TARC in HVs.
SOURCE: Li, Z, et al. ACCP, 2020. Data for time points on nominal day post dose 1, 29, 57 (TDU12265).

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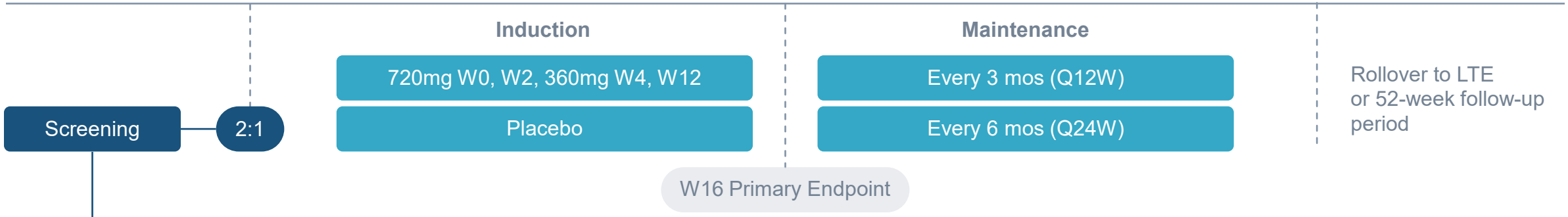
Ongoing integrated Phase 2 trial expected to have 16-week Part A topline data in mid-2025

Part A: Proof-of-concept

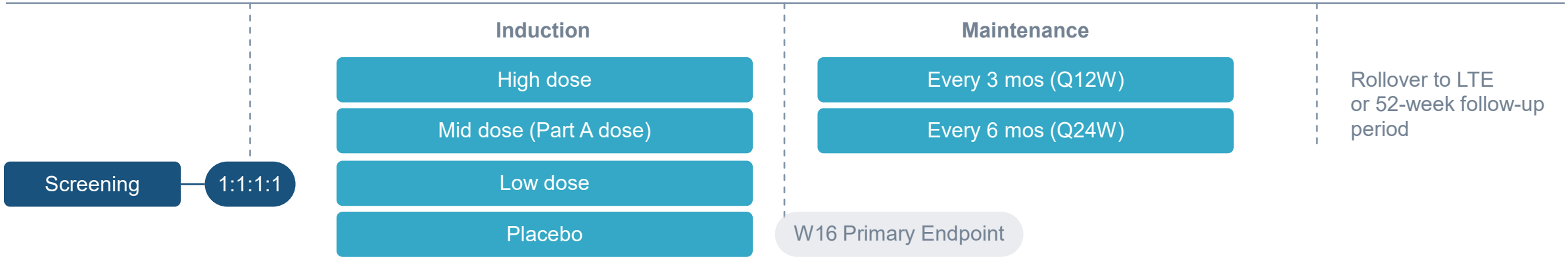
N ~110 *>90% powered*



Strong historical correlation between Ph2 and Ph3 data makes 16-week induction data a key catalyst[1]

Part B: Dose optimization

N ~280 *>90% powered*



NOTE: Induction regimen in Part A is two injections (720mg) week 0 and week 2 followed by a single injection (360mg) at week 4 and 12.
Number of and doses within induction and maintenance regimens to be tested in Part B are preliminary and will be confirmed based on emerging data from Part A.
SOURCE: [1] Agnihotri, G., et al. Clin Drug Investig 2020.

APG777 Phase 2 induction exposures designed to exceed EBGLYSS for potentially greater efficacy

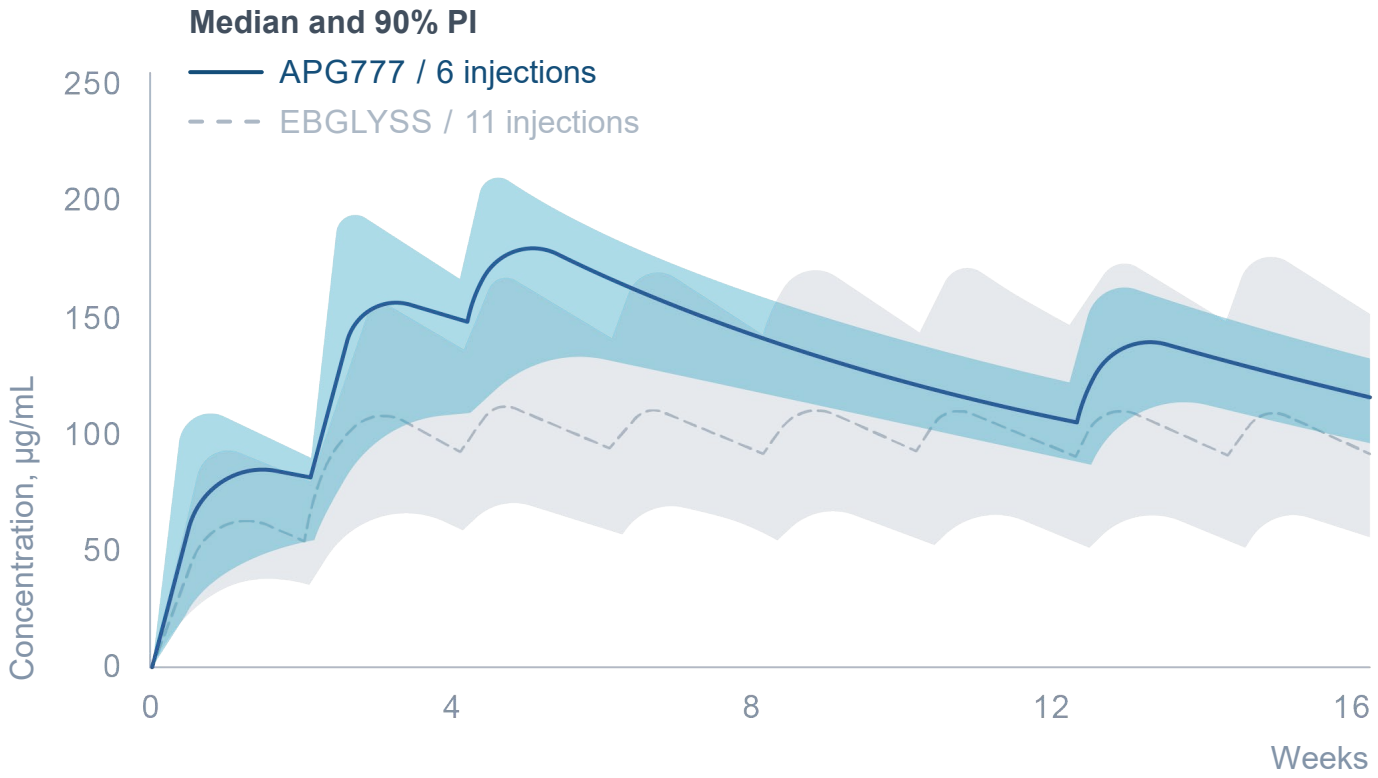
Evidence suggests additional benefit to higher exposures for EBGLYSS in induction

1. EBGLYSS Phase 2b showed dose-response that did not plateau with no dose-AE or exposure-AE relationship[1]

2. ~30% greater exposures in EBGLYSS low-bodyweight patients led to improved efficacy across endpoints[2]

3. EBGLYSS exposure-response model predicts better efficacy possible[2]

APG777 Phase 2 dose targets higher induction exposures than EBGLYSS[3]



~30-40% higher predicted exposure with ~half the number of injections

NOTE: The above graph is illustrative only with respect to plans for dosing of APG777 and does not present comparative data. [1] Guttman-Yassky E et al JAMA Dermatology 2020. [2] EBGLYSS (lebrikizumab) European Public Assessment Report. [3] Solid blue line represents population PK (PPK) model predicted median concentrations of APG777 at Phase 2 induction dose, shaded blue area represents 90% prediction interval (PI) (N=1000); Simulated EBGLYSS exposures (gray) based on PPK model reported in EPAR. Induction regimen in Part A is two injections (720mg) week 0 and week 2 followed by a single injection (360mg) at week 4 and 12.

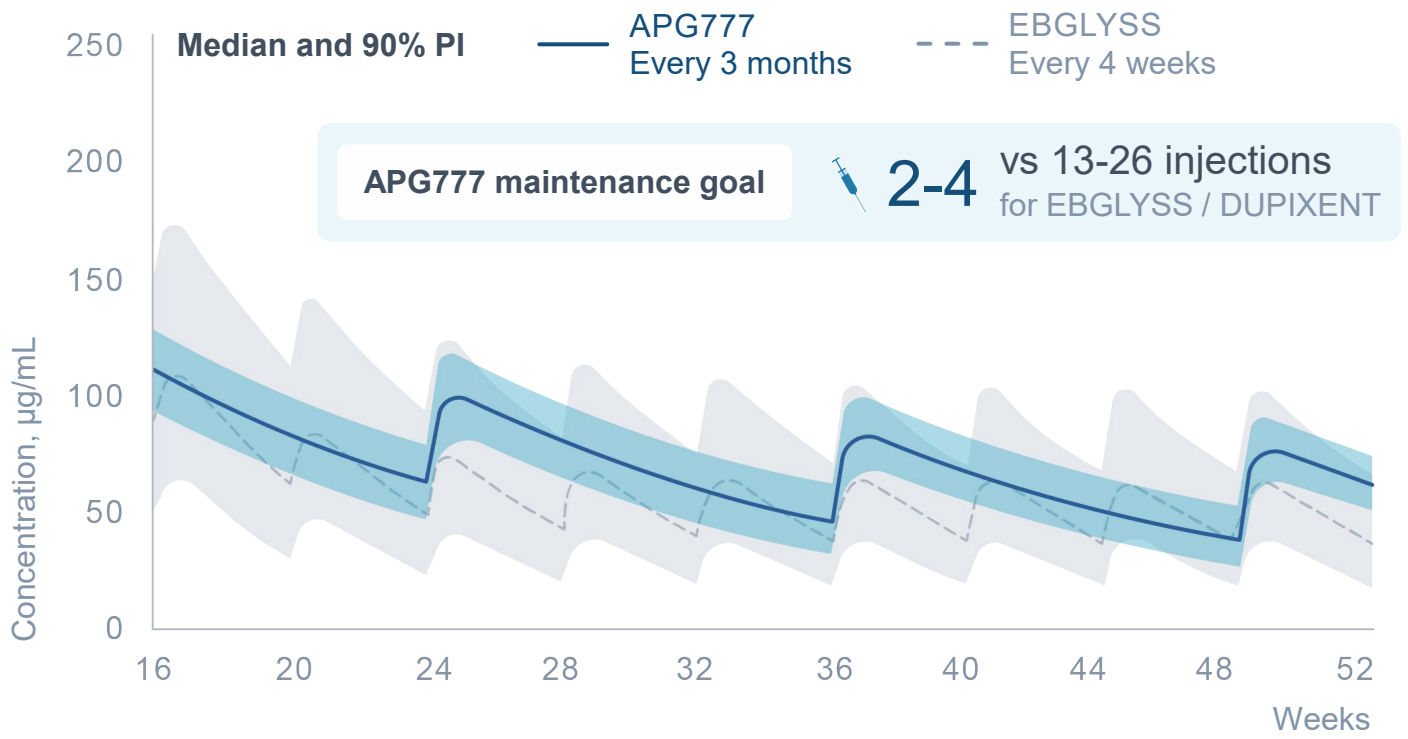
APG777 Phase 2 maintenance exposures designed to equal EBGLYSS

Evidence suggests no additional benefit to higher exposures for EBGLYSS in maintenance

1. EBGLYSS Q4W maintenance data compares favorably to DUPIXENT[1]

2. EBGLYSS Q2W and Q4W regimens had similar maintenance of response[1]

APG777 Phase 2 doses target similar maintenance exposures to EBGLYSS[2]



NOTE: Every 3-month maintenance dosing regimen shown. The above graph is illustrative only with respect to plans for dosing of APG777 and does not present comparative data. [1] EBGLYSS (lebrikizumab) European Public Assessment Report. [2] Solid blue line represents population PK (PPK) model predicted median concentrations of APG777 at Phase 2 maintenance dose, shaded blue area represents 90% prediction interval (PI) (N=1000); Simulated EBGLYSS exposures (Gray) based on PPK model reported in EPAR.

Phase 2 16-week Part A induction data in atopic dermatitis is planned to readout in mid-2025

Objectives

Safety

Confirm well tolerated safety profile as seen in Phase 1 HV study and **in line with other agents in class**

e.g., DUPIXENT, EBGLYSS

Efficacy (primary)

Primary endpoint of % change from baseline in EASI at Week 16 **in line with standard of care**

~ 65-70% decrease (topline)

Efficacy (key secondary)

Proportion of patients achieving key secondary endpoints at Week 16 (future approvable endpoints) **in line with standard of care:**

EASI-75: ~45-50% (topline)

IGA 0/1: ~35-40% (topline)

NOTE: Based on FDA label for DUPIXENT and EBGLYSS

APG777 could substantially decrease annual injections for patients

APG777

2-4

Injections

One injection every 3-6 months[1]
Future potential for annual dosing

EBGLYSS

13-26

Injections

One injection every 2-4 weeks[1]

DUPIXENT

26

Injections

One injection every 2 weeks[1]

NOTE: APG777 injections per year based on preliminary PK data and PK simulations. [1] Injections per year in maintenance after an induction regimen lasting up to 16 weeks. EBGLYSS may be dosed every two weeks until adequate clinical response is achieved.
SOURCE: EBGLYSS USPI, DUPIXENT USPI.

Beyond APG777 in AD, multiple potential blockbuster expansions in dermatology, respiratory, and GI

Dermatology

Atopic dermatitis

↓

- Bullous Pemphigoid
- Prurigo Nodularis

Respiratory

Asthma

↓

- Allergic Rhinitis (perennial)
- Chronic Obstructive Pulmonary Disease
- Chronic Rhinosinusitis with Nasal Polyps
- Chronic Spontaneous Urticaria
- Cold Inducible Urticaria

Gastroenterology

Eosinophilic esophagitis

↓

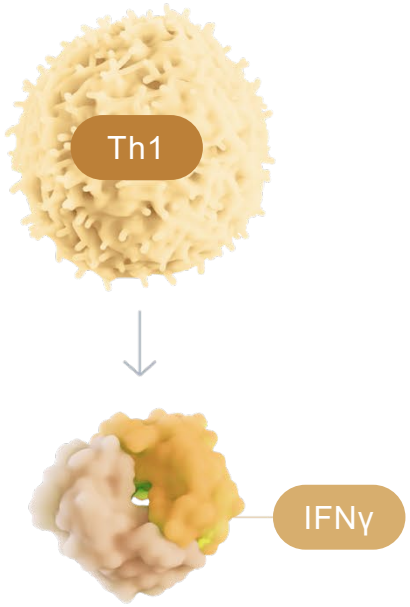
- Eosinophilic Gastrointestinal Disorders (non-EoE)
- Ulcerative Colitis (eosinophilic subtypes)

Option to launch directly to Phase 3 for most promising expansions after identifying a TA-specific Phase 2 dose

APG777+APG990: Raising the bar in AD via broader inhibition

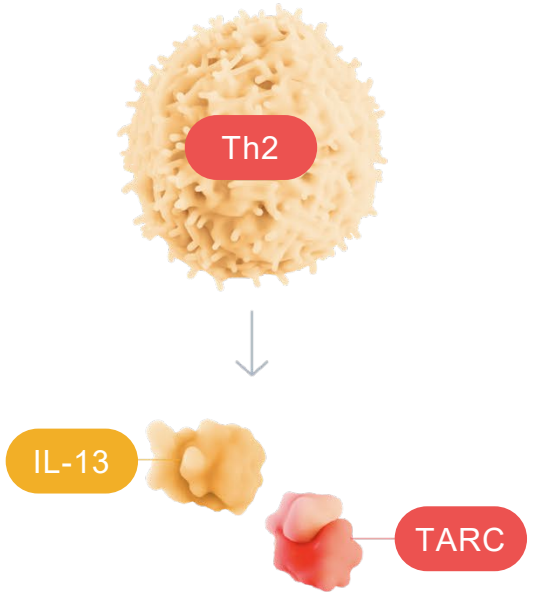
Type 1, 2, and 3 inflammation play distinct roles in AD with Type 2 inflammation being the core driver

Type 1



Chronic lesions

Type 2



Core inflammation, barrier disruption, and itch

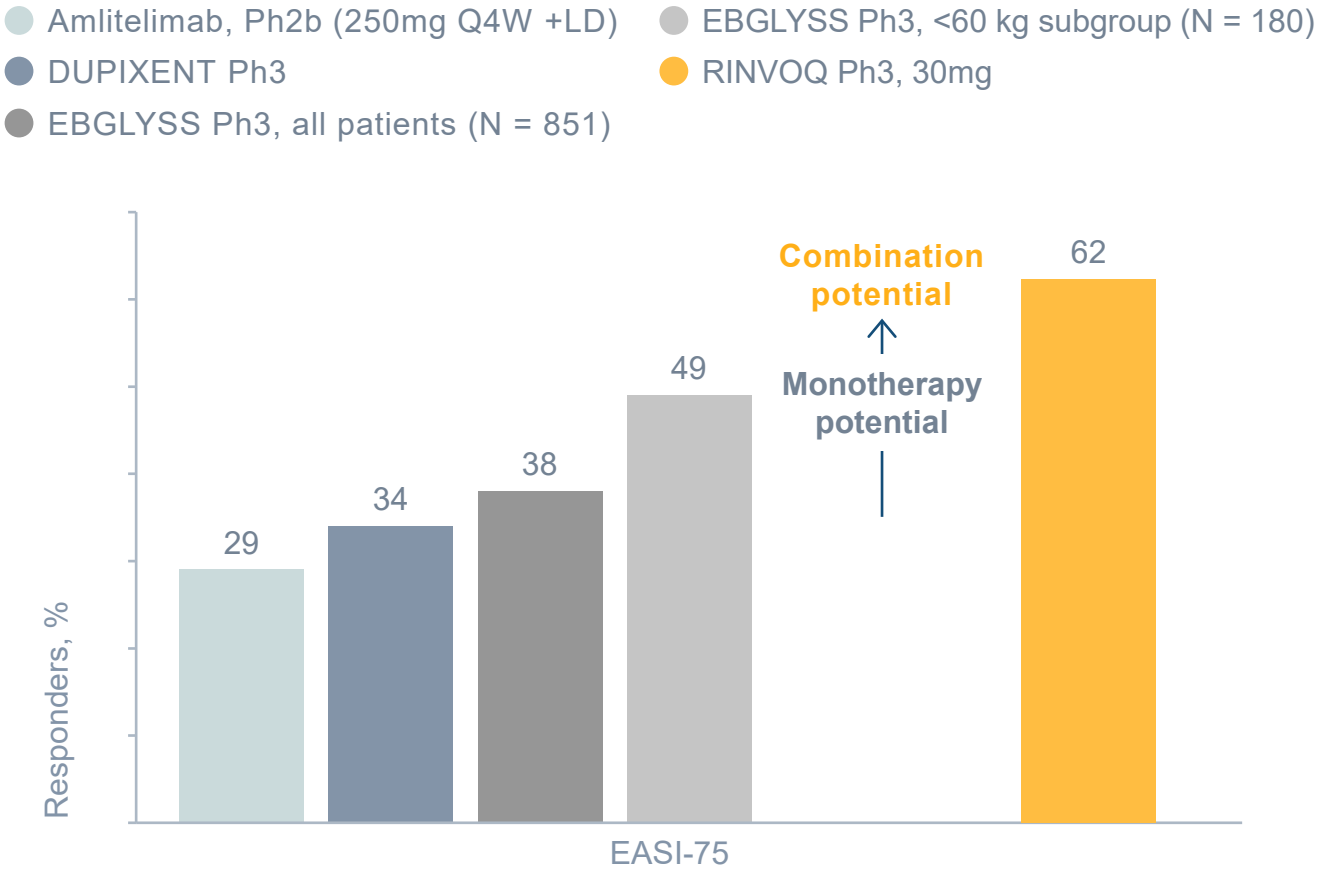
Type 3

Epidermal thickening, barrier disruption

SOURCE: Adapted from Guttman-Yassky et al. Br J Dermatol 2024; 00:1–9.

Targeting all inflammatory types may provide greater efficacy

Efficacy of advanced systemics in AD (Week 16, placebo-adjusted)



- **JAKs inhibit Type 1-3 inflammation** but carry a **black box warning** and require lab monitoring
- **DUPIXENT and EBGLYSS block Type 2 inflammation, the core driver of AD**
- **Amlitelimab partial inhibition of Type 1, 2, and 3** is well-tolerated, although less efficacious

APG777 shows near complete Type 2 inhibition
+
APG990 provides potential to address AD heterogeneity through Type 1-3 inhibition

NOTE: In EBGLYSS Ph2b and Ph3 there has been no dose-AE or exposure-AE relationship. EBGLYSS exposures and efficacy are for the Phase 3 dose (500 mg Loading Dose at Weeks 0 and 2, 250 mg Q2W Weeks 4 to 16). Efficacy data are derived from different clinical trials at different points in time, with differences in trial design and patient populations. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted.
SOURCE: EBGLYSS European Public Assessment Report. DUPIXENT USPI. RINVOQ USPI. Weindinger, S. Oral Presentation. AAD (2024).

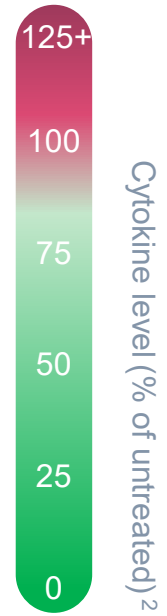
Potential first-in-class APG777+APG990 targets all inflammatory types, including near complete Type 2 inhibition

APG777+APG990 combines orthogonal mechanisms for potentially best-in-class efficacy and **every 3-month dosing or less frequent**

APG777+APG990 shows closer to JAK-like inhibition of Type 1, 2, and 3 signaling – but with potential for **better tolerability**

Ex vivo human allogeneic lymphocyte reaction (ALR) assay[1]

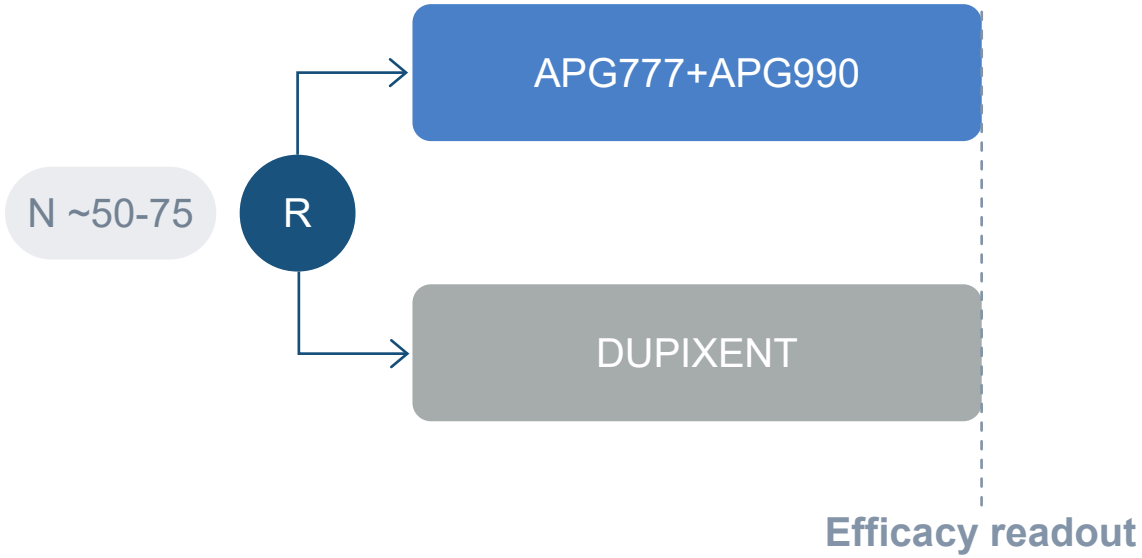
	Dosing	① Type 1 IFNγ	② Type 2 TARC	③ Type 3 IL-22
Lebrikizumab[3] IL-13	Q2W-Q4W	121	25	154
Dupilumab[3] IL-4Rα	Q2W	123	16	389
Amlitelimab[3] OX40L	Q4W	46	69	53
APG777+APG990[3] IL-13 OX40L	**Q12W+**	45	17	76
Upadacitinib[4] JAK	DAILY	8	10	30



NOTE: [1] The ALR was performed using TSLP-primed mDCs paired with allogeneic CD4 cells for 5 days. [2] Cytokine levels for lebrikizumab, dupilumab, amlitelimab, and APG777+APG990 are reported as the mean percent of isotype control across four donor pairs; upadacitinib reported as mean percent of DMSO control across four donor pairs. [3] Lebrikizumab, dupilumab, amlitelimab, and APG777+APG990 were tested at 45 µg/mL that is comparable to DUPIXENT steady-state trough concentrations for the approved dose (300mg Q2W) in atopic dermatitis. [4] Upadacitinib was tested at the Cmax concentration for RINVOQ 15mg (31 ng/mL), reflecting maximum inhibition achieved briefly after dosing.

Planned Phase 1b of APG777+APG990 against DUPIXENT expected to initiate in 2025

Phase 1b trial in moderate-to-severe AD



Phase 1b readout against DUPIXENT in 2026 could demonstrate potential for transformational efficacy and dosing

Study objectives

Safety

Confirm safety profile to enable additional combination trials

PD biomarkers

Demonstrate broader pharmacodynamic effect vs. SoC

Efficacy

Demonstrate improved efficacy vs. SoC on key endpoints (e.g., EASI-75, IGA0/1)

Coformulations could enable potentially best-in-class efficacy while maintaining best-in-class dosing

Characteristics	Coformulation approach	Bispecific approach
Dosing potential	Every 3-months or less frequently	Every 1-4 weeks
Potential to optimize dose for effective target inhibition	✓	✗
COGS	↓	↑
Potential to deliver in simple presentation (e.g., single autoinjector)	✓	✓
Approval precedent (total # of approvals in last 20 years)	134	10

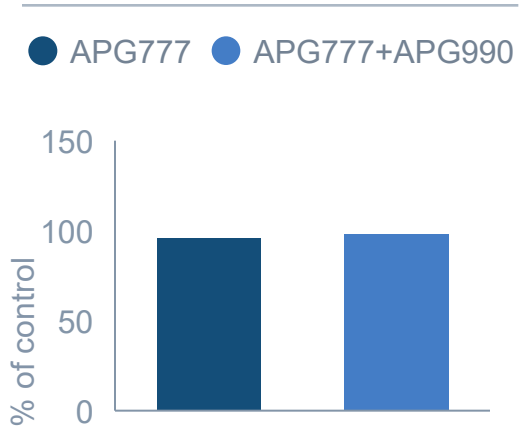
NOTE: Coformulation characteristics are illustrative based on what we believe we can achieve. Bispecific characteristics based on properties of FDA approved bispecifics. Coformulated drugs limited to FDA approved products 2004-2024.
SOURCE: FDA

APG777+APG990 coformulation proof-of-concept achieved

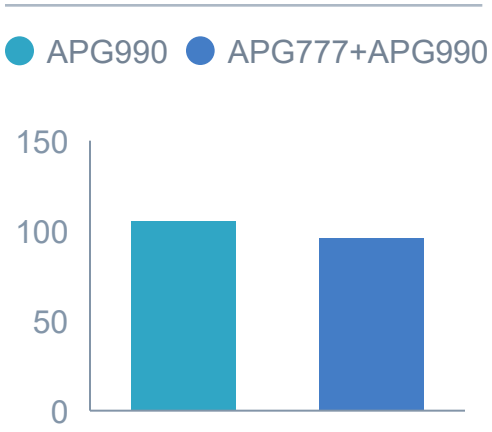
Stability	Stable at high concentrations (i.e., >150 mg/mL)
Injectability	Expected injection time comparable to DUPIXENT
Presentation	Compatible with commercial presentation (e.g., 2 mL PFS or AI)
Potency	Potency equivalent to each component tested individually

APG777+APG990 pre-filled syringe

APG777 potency[1,2]



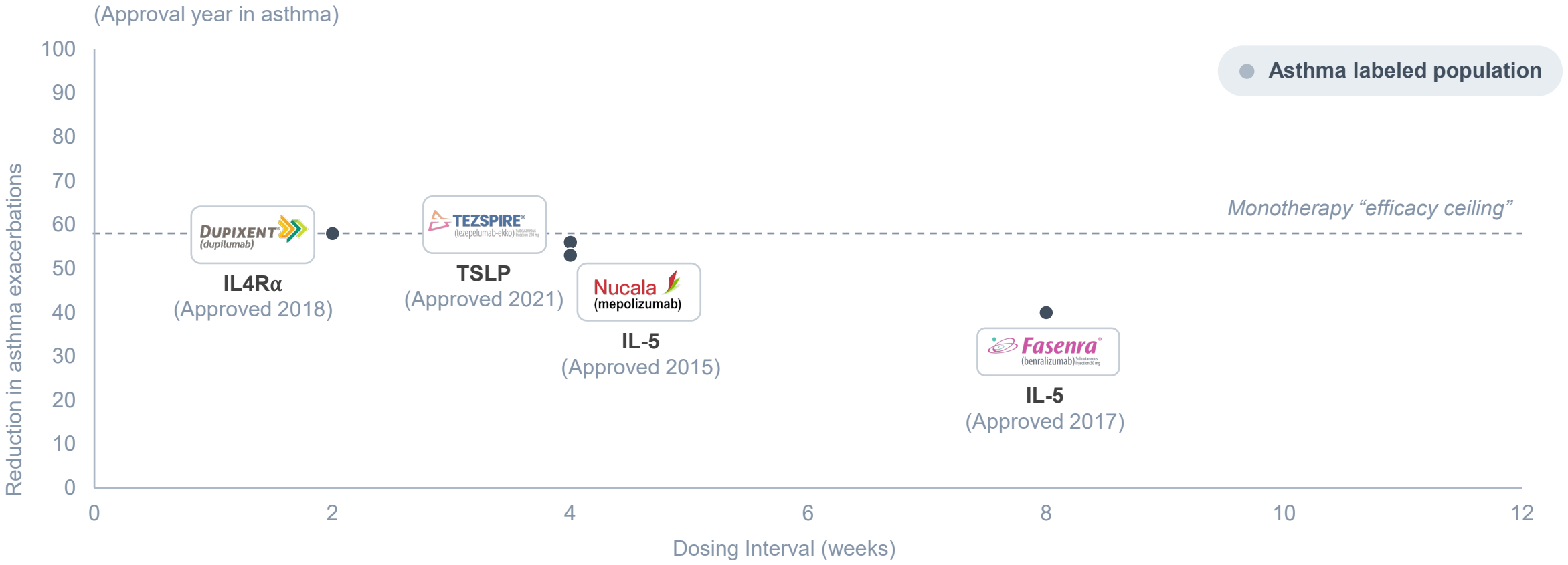
APG990 potency[1,3]



NOTE: PFS = pre-filled syringe. AI = autoinjector
[1] Potency for APG777, APG990, and APG777+APG990 (50:50 ratio) measured under accelerated storage conditions. [2] Direct binding of IL-13 to APG777 determined by ELISA.
[3] Direct binding of OX40L to APG990 determined by ELISA.

APG777+APG333: Breaking through the respiratory efficacy ceiling

Multiple novel treatments targeting alarmins or Type 2 cytokines have been approved in asthma, but efficacy has hit a ceiling



DUPIXENT (Ph3) and TEZSPIRE (Ph2) have shown lower AER reductions in COPD patients

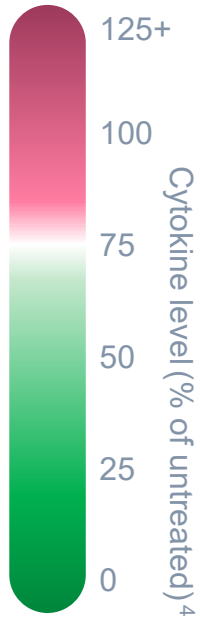
NOTE: AER = Annualized Exacerbation Rate. These data are derived from different clinical trials conducted at different points in time, with differences in trial design, dosing regimen and patient populations. DUPIXENT label indicates reductions in exacerbations were significant in those with eos ≥150. TEZSPIRE data from population without a biomarker requirement. NUCALA data from population with eos ≥150 at screening or ≥300 in prior year. FASENRA data from two Phase 3 trials in patients with eos ≥300. DUPIXENT COPD data reflective of two Ph3 trials in patients with eos ≥300. TEZSPIRE COPD data for patients with eos ≥150.
SOURCE: EvaluatePharma, FDA labels.

APG777+APG333 targets both central and local drivers of respiratory disease to potentially break through the monotherapy efficacy ceiling

APG777+APG333 combines orthogonal mechanisms for potentially best-in-class efficacy and **every 3-month dosing** or less frequent:

- **TSLP** inhibition to block **central inflammation**
- **IL-13** inhibition to address **local airway responses**

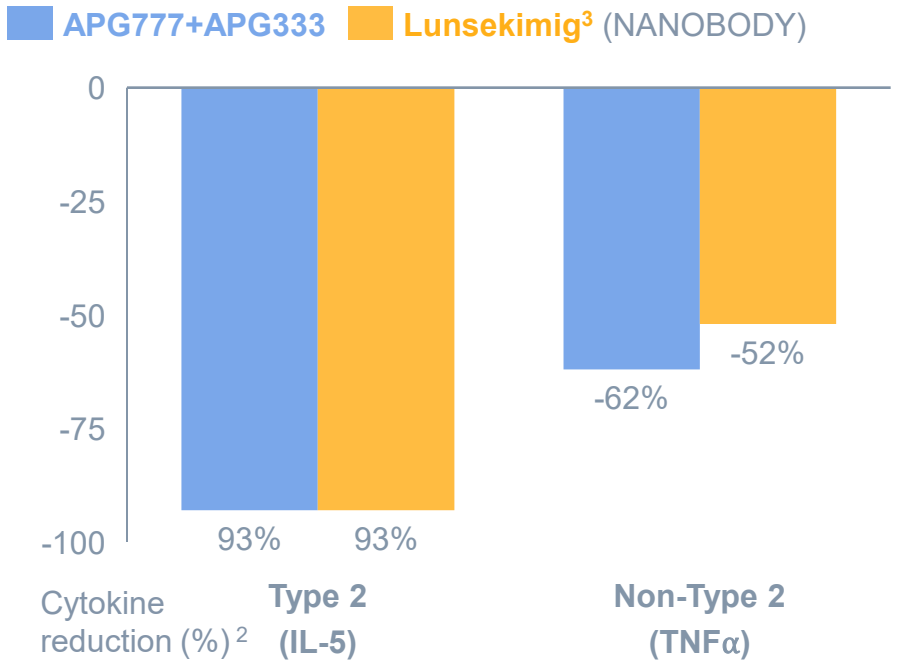
	Dosing	Central inflammation: Type 2[1] — IL-5	Central inflammation: Non-Type 2[1] — TNFα	Local airway responses (in COPD patient cells / tissue model): BSMC activation[2] — Periostin	Local airway responses (in COPD patient cells / tissue model): Epithelial dysfunction[3] — Barrier loss
Tezepelumab (TSLP)	Q4W	7	37	65	87
Lebrikizumab (IL-13)	Q2W-Q4W	51	129	19	18
Dupilumab (IL-4Rα)	Q2W	46	148	19	36
APG777+APG333 (IL-13, TSLP)	Q12W+	7	38	23	5



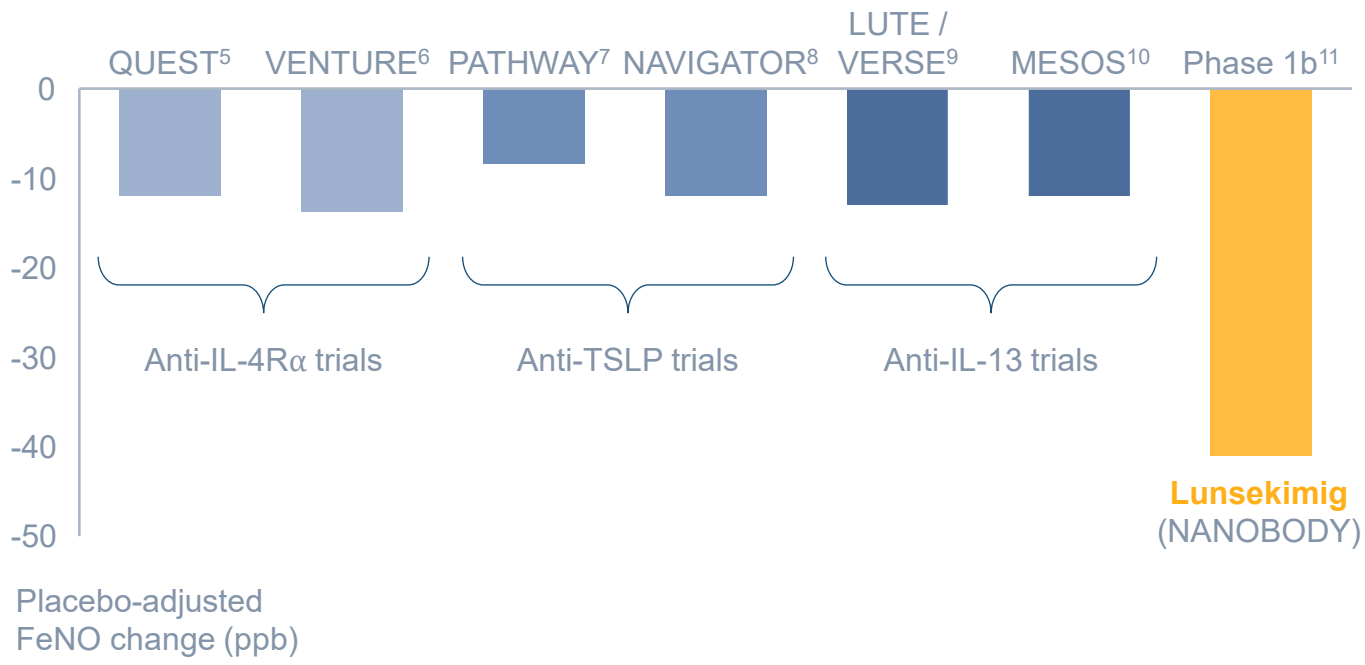
NOTE: [1] ALR performed using four donor pairs of TSLP-primed mDCs plus allogeneic CD4 cells for 5 days. [2] BSMCs from three COPD donors were stimulated with TSLP+IL-13 for 24 hours and cytokines were measured in the supernatant. [3] Human airway epithelial cells from one COPD donor were cultured at the air-liquid interface and treated with TSLP+IL-13. After 7 days, cytokines were measured in the basal supernatants and barrier integrity was measured using transepithelial electrical resistance. [4] Responses are reported as mean percent of control across all donors.

Lunsekimig has validated targeting IL-13 + TSLP in the clinic but is dosed every 2-4 weeks, which APG777+APG333 could significantly improve on

APG777+APG333 performs similar to lunsekimig preclinically[1]



FeNO data from lunsekimig Phase 1b in asthma demonstrated potential for additive efficacy[4]

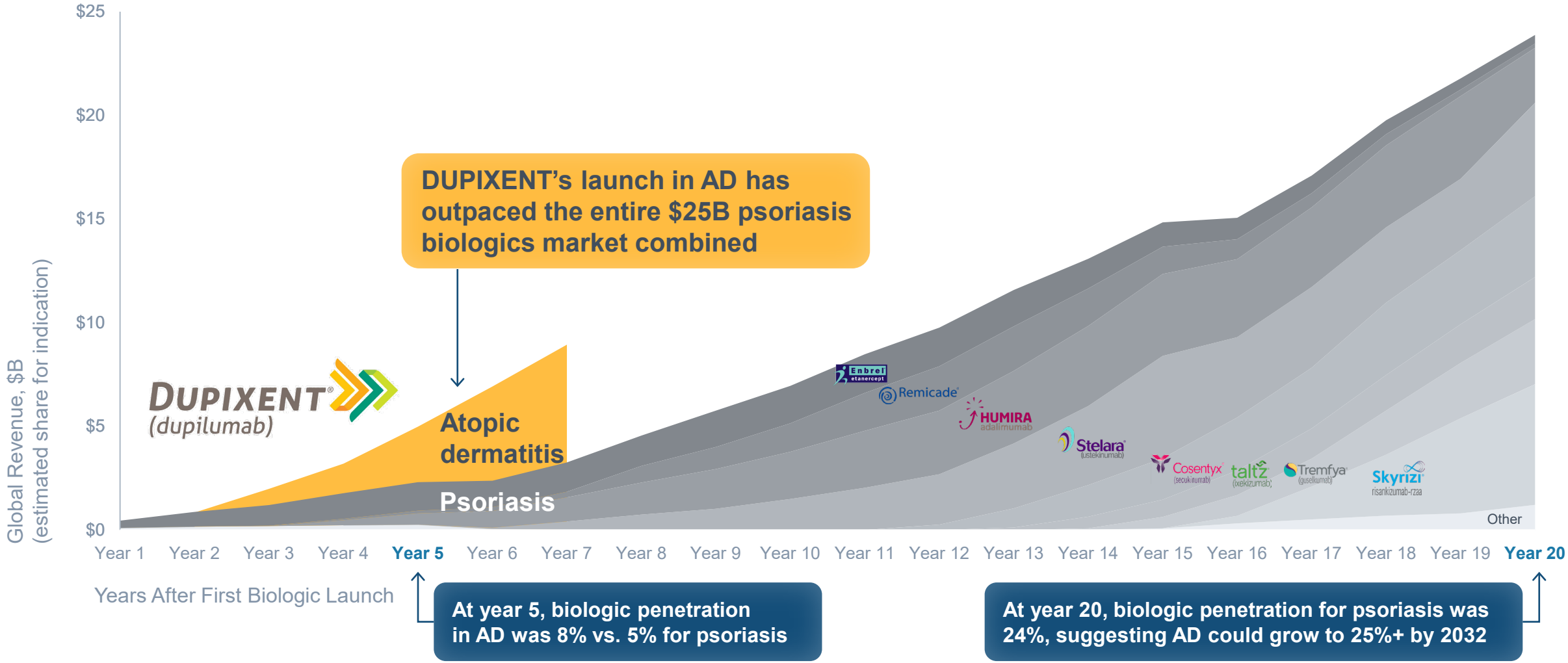


Combined blockade of IL-13 and TSLP demonstrates potential for broader and deeper impact on central and local drivers of respiratory disease not previously seen by monotherapies alone

NOTE: [1] ALR performed using four donor pairs of TSLP-primed mDCs plus allogeneic CD4 cells for 5 days. [2] Responses are reported as mean percent of control across all donors. [3] Lunsekimig produced and purified based on published sequence and evaluated at a concentration with an equivalent molarity of APG777+APG333. [4] FeNO level reflects data from marketed dose, where available. Data shown is placebo-adjusted reduction at 29d, with the exception of QUEST, where level was reported at 12 weeks. LUTE/VERSE data from was periostin-high enrollees.
SOURCE: [5] Castro M, et al. NEJM, 2018. [6] Rabe KF et al. NEJM, 2018. [7] Corren JC, et al. NEJM, 2017. [8] Menzies-Gow A, et al. NEJM, 2021. [9] Hanania NA, et al. Thorax, 2015. [10] Russell RJ, et al. Lancet Respir Med, 2018. [11] Deiteren A, et al. ATS, 2023.

Corporate & Commercial

Apogee has the potential of becoming a leader in a future $50B+ market that is in its early years and growing rapidly



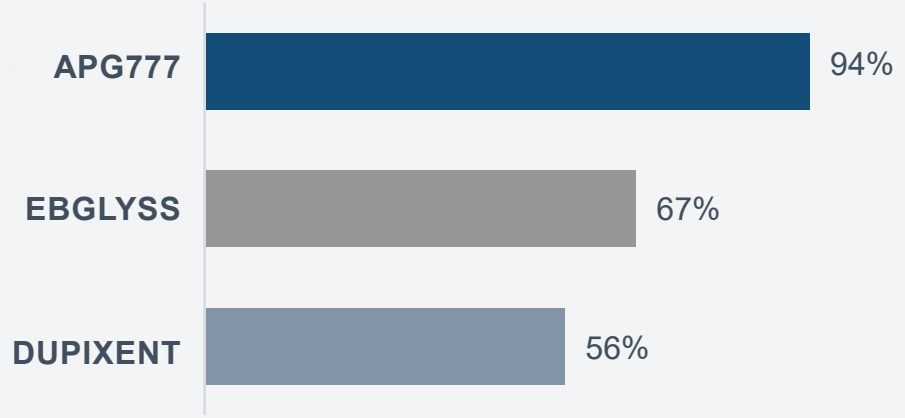
SOURCE: EvaluatePharma
NOTE: Year 1 for DUPIXENT in AD is 2017 and for Biologics in PsO is 2004 (i.e., ENBREL approval). Other includes SILIQ, ILLUMYA, and CIMZIA, which all launched prior to SKYRIZI.

Patients and physicians prefer APG777's quarterly dosing profile; payers support 1L biologic access

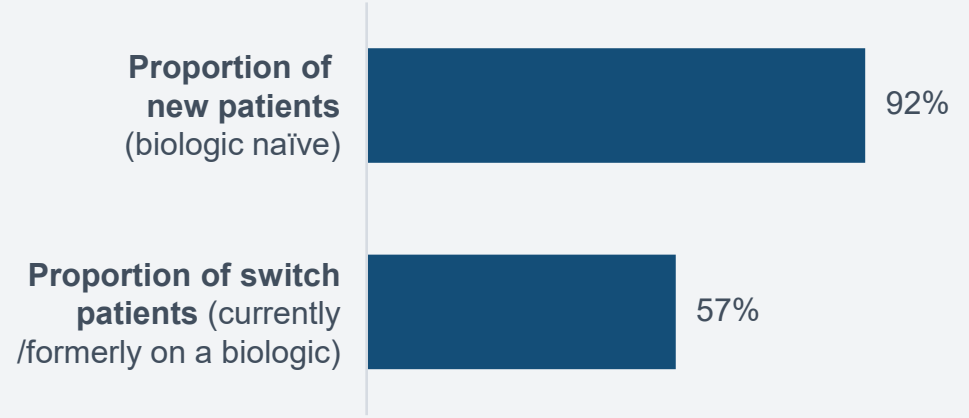
Market research supports APG777's differentiated profile

(based on blinded TPP with equivalent efficacy and safety as DUPIXENT but with every 3-month maintenance dosing)

Patient likelihood to take action for each treatment[1]



Physician intent to use a product with APG777 Target Product Profile[2]



Payer coverage expectations for APG777[3]

"Parity as DUPIXENT"	VP of Pharmacy, National PBM #1[3]
"Covered at parity… if [APG777] shifts the market, then it may move up to preferred"	VP of Pharmacy, National PBM #2[3]
"Parity and co-preferred alongside DUPIXENT and ADBRY"	VP of Pharmacy, National MCO[3]

SOURCE: Patients: TRINITY Qualitative Research with N=18 AD Patients, August 2024. Physicians: In 2023, Apogee conducted a single-blinded market research survey of 25 practicing dermatologists in 14 states in the United States, with the assistance of an expert search network. Payers: Real Endpoints Qualitative Research with N=6 payers, February 2024. Charles River Associates research with N=10 payers, August 2024.
NOTE: [1] AD patients responding 6 or 7 on a scale from 1 to 7 rating their likelihood to take action after reviewing a blinded TPP for each treatment. APG777 TPP based on equivalent efficacy and safety as DUPIXENT. [2] For providers where likeliness to prescribe Product Y (equivalent efficacy and safety as DUPIXENT, but with Q3M dosing) differs for pediatric and adult patients, a blended rate was calculated using the weighted average of the pediatric and adult rates based on the mix of AD patients in that dermatologists' practice. [3] Payer coverage expectations are based on a product with similar efficacy, safety, and net pricing as DUPIXENT, but with Q3M dosing.

Over the next 2 years, 8 clinical trial readouts expected across our pipeline

$754M in cash with runway into 2028

★ KEY READOUT		2025	2026
Potential best-in-class monotherapy in AD	**APG777** IL-13	★ **Mid-2025: AD Phase 2 16-week PoC readout** • 1H: Asthma Phase 1b initiation • 2H: Asthma Phase 2b initiation	★ **1H: AD Phase 2 Part A 52-week readout** ★ **2H: AD Phase 2 Part B 16-week readout** • Asthma Phase 1b readout • EoE Phase 2 initiation
Potential first- or best-in-class combination approaches	**APG777+APG990** IL-13 OX40L	• AD Phase 1b PoC trial initiation (against DUPIXENT)	★ **2H: AD Phase 1b PoC readout (against DUPIXENT)**
	APG777+APG333 IL-13 TSLP	• Additional clinical plan announced	
Potential best-in-class mAbs for combinations	**APG808** IL-4Rα	• 1H: Asthma Phase 1b readout	
	APG990 OX40L	• 1H: Initial Phase 1 PK & safety in HVs	
	APG333 TSLP	• 2H: Initial Phase 1 PK & safety in HVs	

NOTE: As of September 30, 2024, Apogee had cash, cash equivalents and marketable securities of $754M.

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Apogee /ˈapəjē/ *noun*

The highest point in the development of something; a climax or culmination