APEX Phase 2 Part A readout

JULY 7, 2025

Disclaimers and Forward-looking statements

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; the anticipated timing of initiation of our clinical trials, including the Phase 2b trials of APG777 in asthma, the Phase 2 trial of APG777 in eosinophilic esophagitis (EoE), and a Phase 3 trial of APG777 in AD; the expected timing of results from our clinical trials, including 52-week maintenance data from Part A, the initial readout from Part B of our Phase 2 trial of APG777 in AD, the initial readout from our Phase 1b trial of APG279 in AD, and the initial readout from our Phase 1 trial of APG333; planned clinical trial designs; our plans for current and future clinical trials; the potential clinical benefit and half-life of APG777, APG333, APG990, APG808, our other product candidates, including combination therapies, and any other potential programs; our expected timing for future pipeline updates; our potential path to regulatory approval; our expectations regarding the time period over which our capital resources will be sufficient to fund our anticipated operations, our cash runway, 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. The data included in this presentation may be subject to change following the availability of additional data or following a more comprehensive review of the data. 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, 2024, filed with the U.S. Securities and Exchange Commission (the SEC) on March 3, 2025 and subsequent disclosure documents we have filed and may file with the SEC. 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. We claim the protection of the Safe Harbor contained in the Private Securities Litigation Reform Act of 1995 for forward-looking statements.

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.

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This presentation contains data based on cross-study comparisons and not based on any head-to-head clinical trials. Cross-study comparisons are inherently limited and may suggest misleading similarities and differences. The values shown in the cross-study comparisons are directional and may not be directly comparable.

Agenda

Introduction		Michael Henderson, MD Chief Executive Officer
APEX Phase 2 Part A Results		Carl Dambkowski, MD Chief Medical Officer
APG777 Development Program		Kristine Nograles, MD SVP, Head of Clinical Development & Medical Affairs
Building a Leading I&I Company		Michael Henderson, MD Chief Executive Officer
Analyst Q&A		Michael Henderson, MD, CEO Carl Dambkowski, MD, CMO Jane Pritchett Henderson, CFO Jeff Hartness, CCO

Introduction

Michael Henderson, MD
Chief Executive Officer

APEX Part A delivers on a potentially best-in-class profile with promising efficacy results and path to quarterly or better dosing

APEX Part A met or exceeded all trial objectives

- **Part B** 16-week topline **accelerated to mid-2026**
- Planned **AD Phase 3 initiation in 2026**

APG777 has transformational dosing potential

- Part A regimen has **~50% fewer injections in induction** vs. DUPIXENT or EBGLYSS
- Path to best-in-class **quarterly or better dosing** in maintenance

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

- **APG279 (IL-13 + OX40L) Ph1b** in AD H2H against DUPIXENT **dosed first patient**; readout expected in 2H 2026

APEX Part A met or exceeded all trial objectives

ENDPOINT (WEEK 16)	OBJECTIVE (absolute)	**APG777** (absolute)	PLACEBO	SIGNIFICANCE
EASI % CFBL *(primary)*	~ -65-70%	**-71.0%**	-33.8%	p<0.001
EASI-75	~ 45-50%	**66.9%**	24.6%	p<0.001
vIGA 0/1	~ 35-40%	**34.9%**	17.3%	p<0.05
Itch NRS % CFBL		**-50.7%**	-23.2%	p<0.01

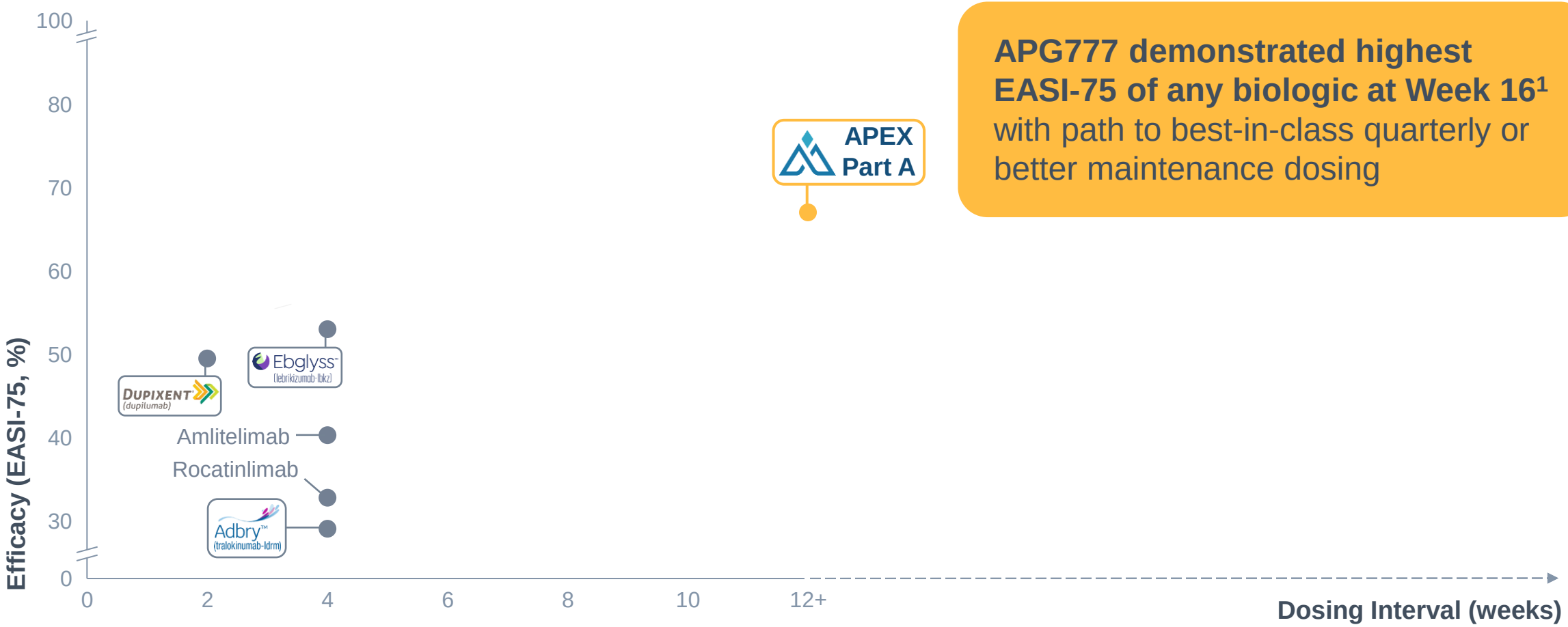
Highest EASI-75 (absolute *and* placebo-adjusted) of any biologic at Week 16[1]:

- **+14 points vs. EBGLYSS** (~25% higher)
- **+17 points vs. DUPIXENT** (~35% higher)

- **Efficacy results numerically higher** or in line **vs. SoC**; **exposure-response** relationship observed
- **Rapid onset of itch relief** (Week 1) and lesion reduction (Week 2)[2]
- **Well-tolerated** – safety profile consistent with class

NOTE: [1] APG777 achieved the highest EASI-75 absolute and placebo-adjusted of any biologic tested in a global placebo-controlled trial of moderate-to-severe atopic dermatitis. [2] Itch NRS percent change from baseline for APG777 vs. placebo statistically significant at Week 1 (p<0.05). EASI percent change from baseline for APG777 vs. placebo statistically significant at Week 2 (p<0.05). "% CFBL" = Percent Change From Baseline. SoC = Standard of Care. vIGA = Validated Investigator Global Assessment. EASI = Eczema Area and Severity Index. Itch NRS = Itch Numeric Rating Scale.

Apogee has the potential to transform the future $50B atopic dermatitis market

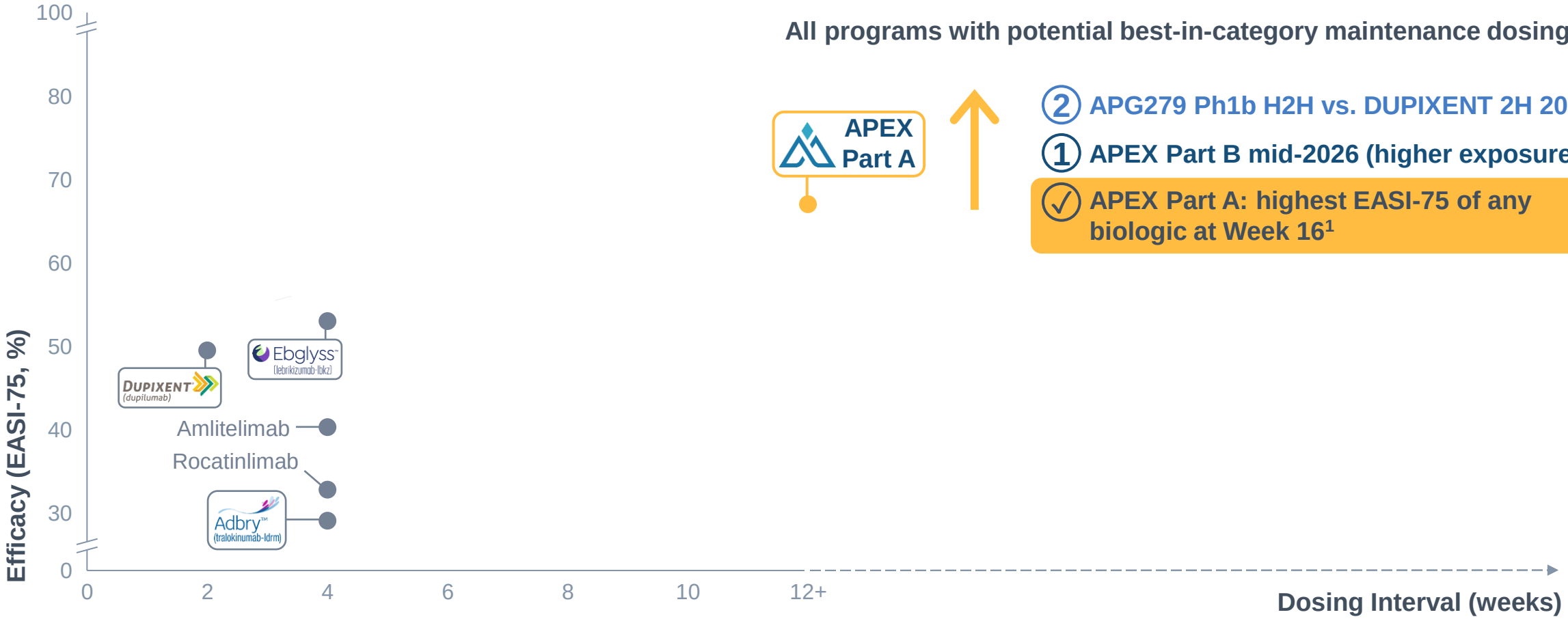


APG777 demonstrated highest EASI-75 of any biologic at Week 16[1] with path to best-in-class quarterly or better maintenance dosing

NOTE: Positioning of Apogee programs is illustrative and based on Phase 2 Part A 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 conducted at different times, 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. Future $50B AD market size based on EvaluatePharma and company projections. Maintenance dosing intervals are as per label or published data. For some agents, longer dosing intervals are currently being evaluated in ongoing clinical trial(s). All efficacy data shown based on non-responder imputation for rescue medication (topical or systemic) use (i.e., data subsequent to the use of rescue medication categorized as non-response). Statistical treatment of missing data varies across studies shown. [1] APG777 achieved the highest EASI-75 absolute and placebo-adjusted of any biologic tested in a global placebo-controlled trial of moderate-to-severe atopic dermatitis.

SOURCE: **DUPIXENT** (average of Ph3 SOLO-1&2 and Ph2b; 300 mg Q2W regimen; non-responder imputation for missing values). **EBGLYSS** (average of Ph3 ADVOCATE-1&2 (multiple imputation (MCMC-MI) for missing values) and Ph2b (sensitivity analysis 3: NRI for rescue medication use and LOCF for other missing values); 250mg Q2W regimen). **ADBRY** (average of Ph3 ECZTRA1&2; 300 mg Q2W regimen; non-responder imputation for missing values). **AMLITELIMAB** Weidinger et al EADV 2023 (Ph2b, 250mg Q4W + 500mg loading dose; non-responder imputation for missing values). **ROCATINLIMAB** AAD 2025 (Ph3 ROCKET Horizon, 300mg Q4W + Week 2 loading dose; statistical handling of missing data not specified).

Apogee has two additional opportunities to deliver higher efficacy results with key readouts anticipated in 2026



NOTE: Positioning of Apogee programs is illustrative and based on Phase 2 Part A 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 conducted at different times, 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. Maintenance dosing intervals are as per label or published data. For some agents, longer dosing intervals are currently being evaluated in ongoing clinical trial(s). All efficacy data shown based on non-responder imputation for rescue medication (topical or systemic) use (i.e., data subsequent to the use of rescue medication categorized as non-response). Statistical treatment of missing data varies across studies shown. [1] APG777 achieved the highest EASI-75 absolute and placebo-adjusted of any biologic tested in a global placebo-controlled trial of moderate-to-severe atopic dermatitis.

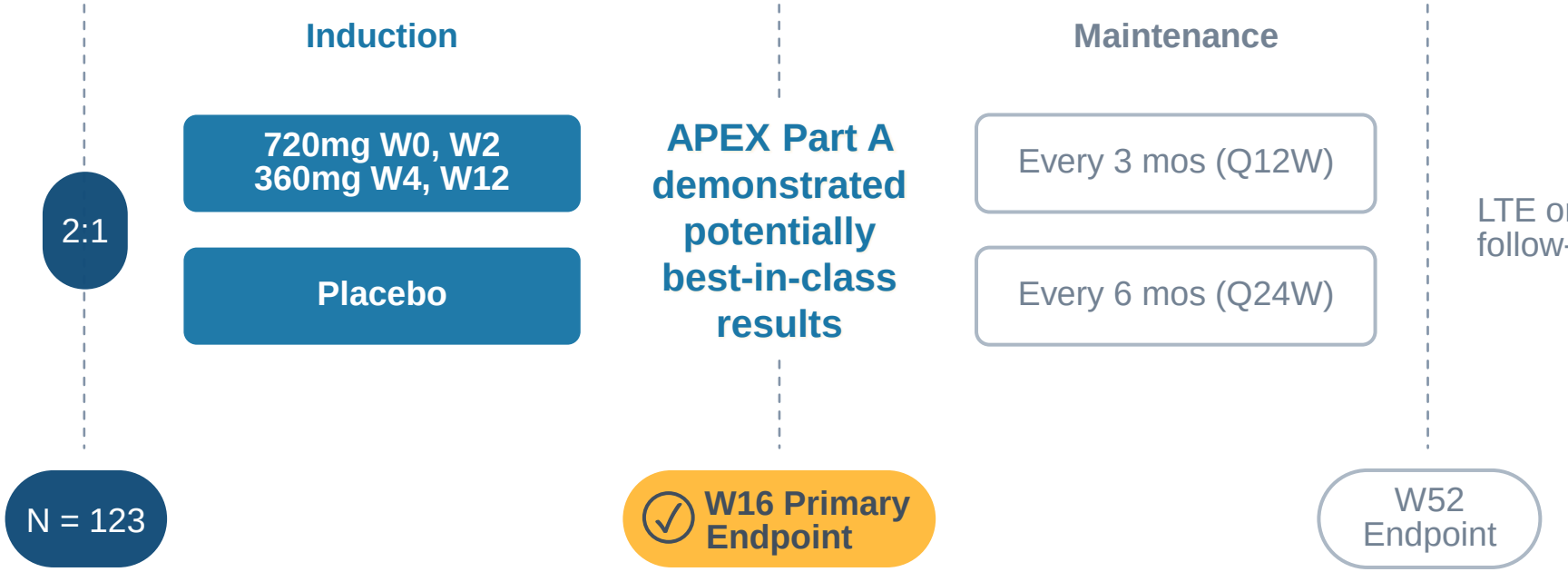
SOURCE: **DUPIXENT** (average of Ph3 SOLO-1&2 and Ph2b; 300 mg Q2W regimen; non-responder imputation for missing values). **EBGLYSS** (average of Ph3 ADVOCATE-1&2 (multiple imputation (MCMC-MI) for missing values) and Ph2b (sensitivity analysis 3: NRI for rescue medication use and LOCF for other missing values); 250mg Q2W regimen). **ADBRY** (average of Ph3 ECZTRA1&2; 300 mg Q2W regimen; non-responder imputation for missing values). **AMLITELIMAB** Weidinger et al EADV 2023 (Ph2b, 250mg Q4W + 500mg loading dose; non-responder imputation for missing values). **ROCATINLIMAB** AAD 2025 (Ph3 ROCKET Horizon, 300mg Q4W + Week 2 loading dose; statistical handling of missing data not specified).

APEX Phase 2 Part A Results

Carl Dambkowski, MD
Chief Medical Officer

APEX Part A 16-week topline data available for all patients

Part A enrolled moderate-to-severe atopic dermatitis patients (EASI ≥16, vIGA ≥3, BSA ≥10%)



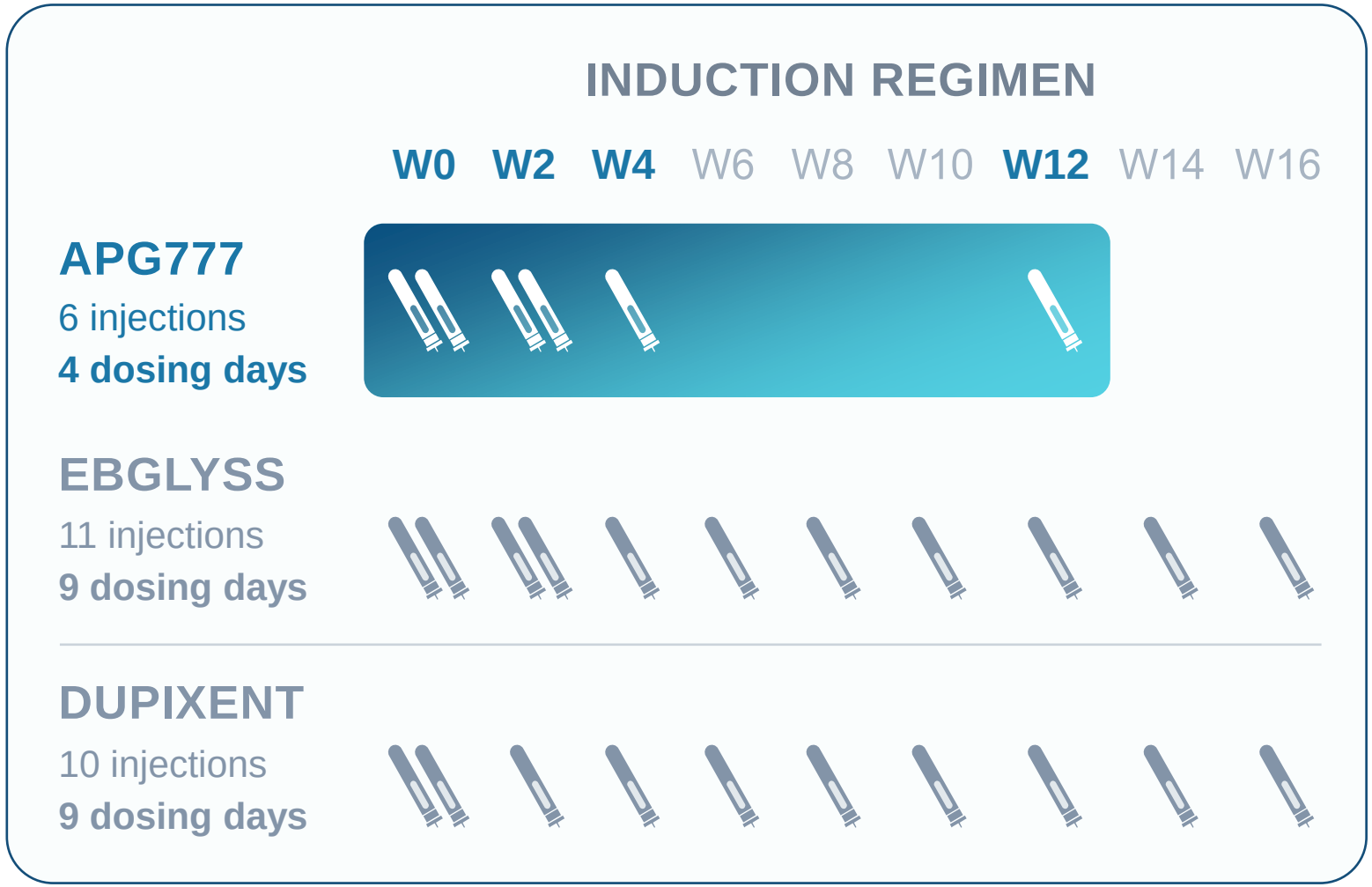
Primary analysis method:

- **Missing data** was imputed with Markov Chain Monte Carlo Multiple Imputation (MCMC-MI)
- **Rescue medication use** or treatment discontinuation due to lack of efficacy was imputed as non responder for all subsequent time points[1]

NOTE: [1] Data collected after the initiation of rescue medication or drug discontinuation will be set to missing for continuous variables (e.g. percent change from baseline in EASI score) before MCMC-MI. A patient will be counted as a non-responder for the dichotomous variables (e.g. EASI-75) for timepoints after rescue medication use or treatment discontinuation due to lack of efficacy

SOURCE: EBGLYSS USPI, DUPIXENT USPI.

APG777 could substantially decrease induction injections for patients



APG777 Part A induction regimen achieves higher exposures with ~50% fewer injections and dosing days[1]

NOTE: [1] Based on projected number of injections and dosing days with planned commercial presentation.
SOURCE: EBGLYSS USPI, DUPIXENT USPI.

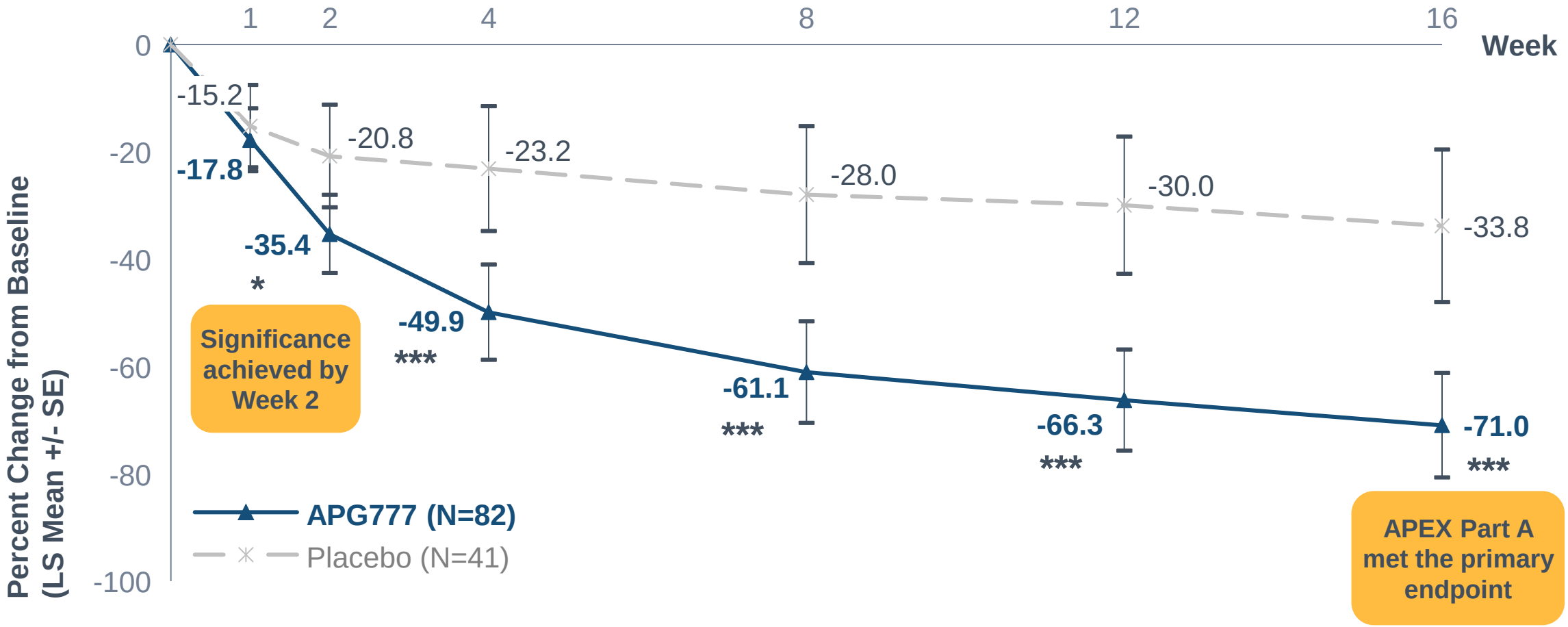
Baseline characteristics and demographics were generally well-balanced and in line with expectations

Characteristic	APG777 (N=82)	Placebo (N=41)
Age, mean (SD), Y	38.7 (15.6)	36.0 (13.7)
Female, n (percent)	41 (50.0)	19 (46.3)
Weight, mean (SD), kg	84.5 (22.5)	81.6 (16.9)
Duration of AD from diagnosis, mean (SD), Y	24.2 (14.5)	24.6 (14.1)
Race, n (percent)		
White	54 (65.9)	30 (73.2)
Black or African American	13 (15.9)	6 (14.6)
Asian	12 (14.6)	4 (9.8)
Other / Unknown	3 (3.7)	1 (2.4)
Baseline disease characteristics		
EASI, mean (SD)	25.2 (10.8)	25.3 (10.8)
vIGA (4), n (percent)	27 (32.9)	14 (34.1)
Weekly mean I-NRS, (SD)	6.4 (2.1)	6.7 (1.9)
BSA affected, mean (SD)	37.2 (22.3)	33.2 (22.6)

NOTE: vIGA = Validated Investigator Global Assessment. EASI = Eczema Area and Severity Index. BSA = Body Surface Area. I-NRS = Itch Numeric Rating Scale.

Treatment with APG777 reduced lesions as early as Week 2

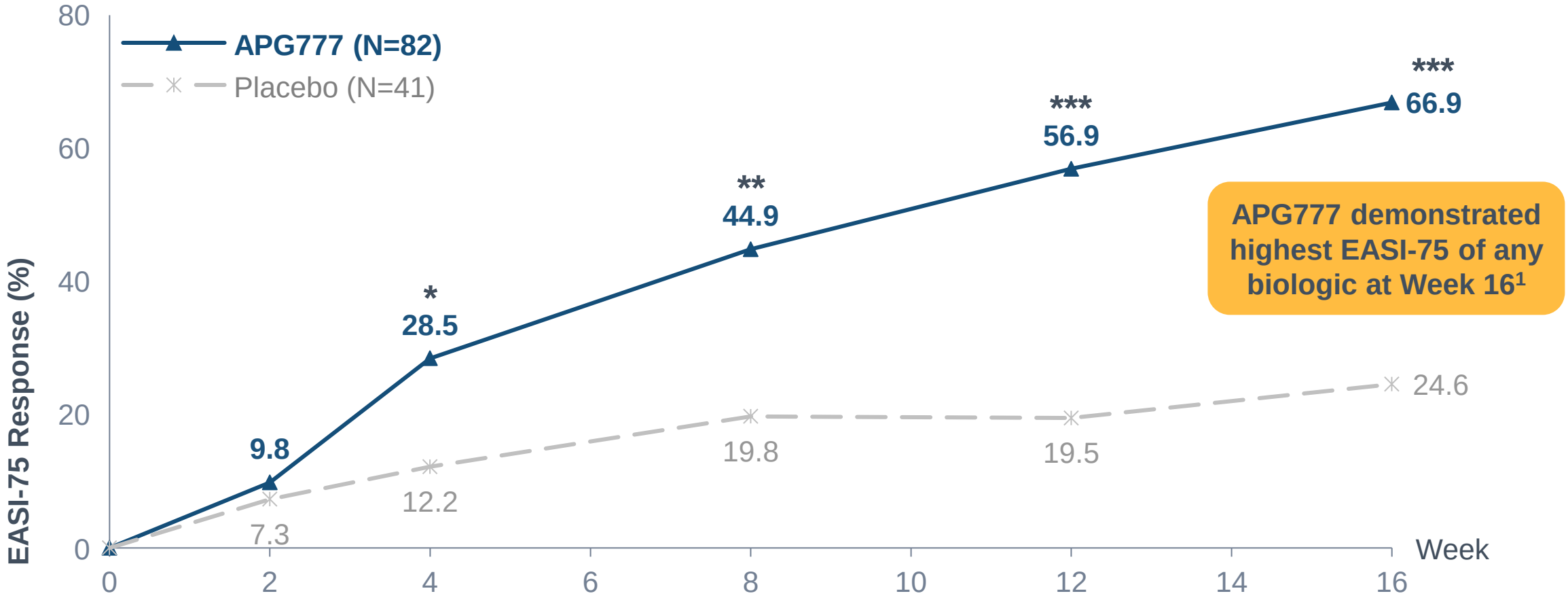
Eczema Area and Severity Index Score



*p<0.05, week 2; ***p<0.001 vs placebo, weeks 4–16.
NOTE: LS = Least squares. SE = Standard error.

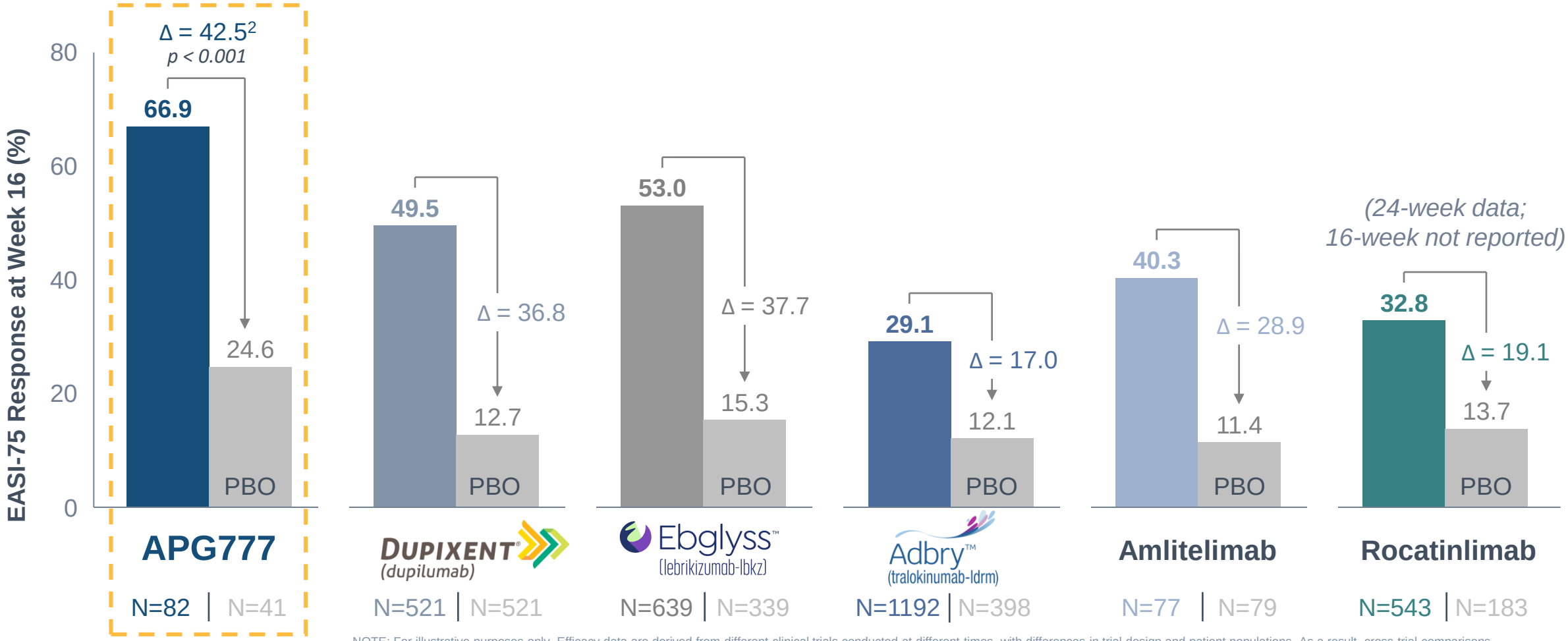
More than two-thirds of patients treated with APG777 achieved EASI-75 response at Week 16

EASI-75 Response



*p<0.05, week 4; **p<0.01 week 8; ***p<0.001 vs placebo, weeks 12, 16.
NOTE: [1] APG777 achieved the highest EASI-75 absolute and placebo-adjusted of any biologic tested in a global placebo-controlled trial of moderate-to-severe atopic dermatitis.

APG777 achieved highest EASI-75 absolute and placebo-adjusted of any biologic at Week 16[1]

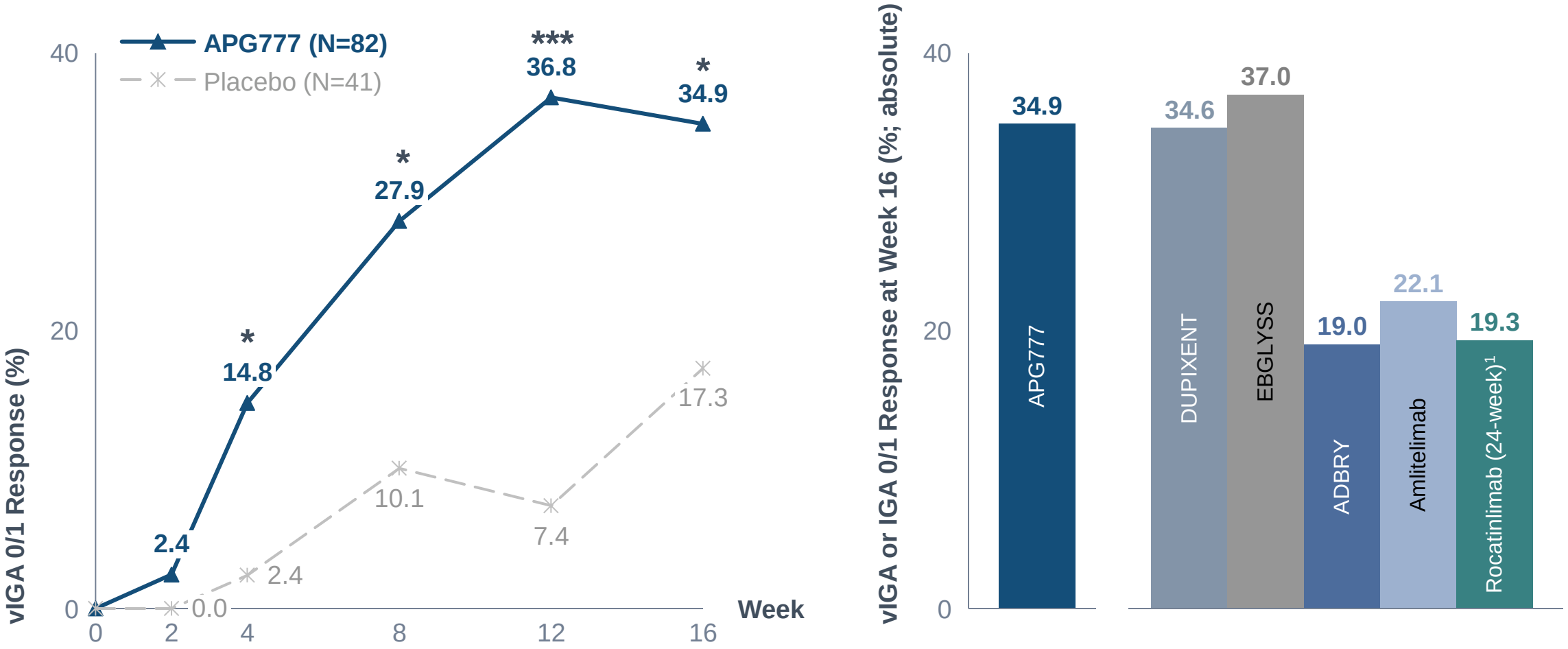


NOTE: For illustrative purposes only. Efficacy data are derived from different clinical trials conducted at different times, with differences in trial design and patient populations. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted. All efficacy data shown based on non-responder imputation for rescue medication (topical or systemic) use or treatment discontinuation due to lack of efficacy (i.e., data subsequent to the use of rescue medication or discontinuation due to lack of efficacy are categorized as non-response). Statistical treatment of missing data varies across studies shown. [1] APG777 achieved the highest EASI-75 absolute and placebo-adjusted of any biologic tested in a global placebo-controlled trial of moderate-to-severe atopic dermatitis. [2] Calculation of difference between APG777 and placebo is based on Cochran–Mantel–Haenszel (CMH) analysis adjusted by randomization stratification factors.

SOURCE: **DUPIXENT** (average of Ph3 SOLO-1&2 and Ph2b; 300 mg Q2W regimen; non-responder imputation for missing values). **EBGLYSS** (average of Ph3 ADVOCATE-1&2 (multiple imputation (MCMC-MI) for missing values) and Ph2b (sensitivity analysis 3: NRI for rescue medication use and LOCF for other missing values); 250mg Q2W regimen). **ADBRY** (average of Ph3 ECZTRA1&2; 300 mg Q2W regimen; non-responder imputation for missing values). **AMLITELIMAB** Weidinger et al EADV 2023 (Ph2b, 250mg Q4W + 500mg loading dose; non-responder imputation for missing values). **ROCATINLIMAB** AAD 2025 (Ph3 ROCKET Horizon, 300mg Q4W + Week 2 loading dose; statistical handling of missing data not specified).

Key secondaries were in line with standard of care

vIGA or IGA 0/1 with a Reduction of ≥2 Points from Baseline



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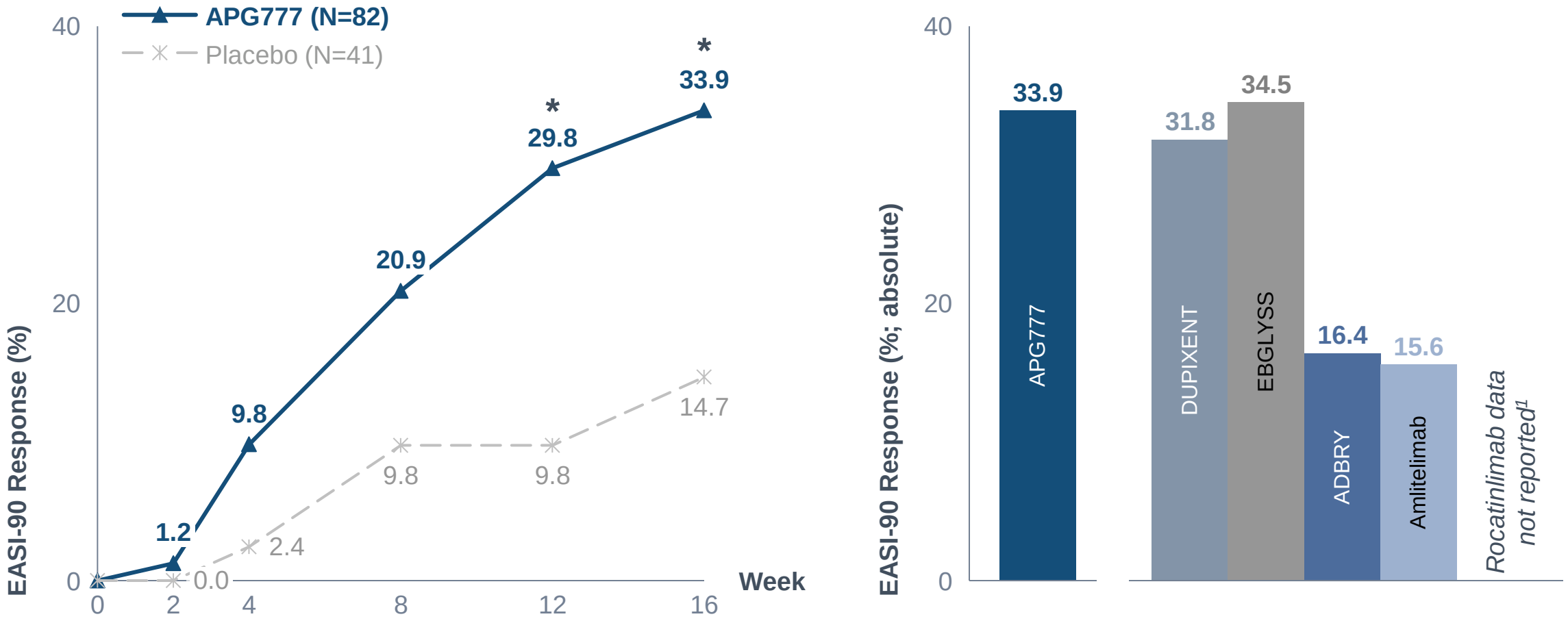
SOURCE: **DUPIXENT** (average of Ph3 SOLO-1&2 and Ph2b; 300 mg Q2W regimen; non-responder imputation for missing values). **EBGLYSS** (average of Ph3 ADVOCATE-1&2 (multiple imputation (MCMC-MI) for missing values) and Ph2b (sensitivity analysis 3: NRI for rescue medication use and LOCF for other missing values); 250mg Q2W regimen). **ADBRY** (average of Ph3 ECZTRA1&2; 300 mg Q2W regimen; non-responder imputation for missing values). **AMLITELIMAB** Weidinger et al EADV 2023 (Ph2b, 250mg Q4W + 500mg loading dose; non-responder imputation for missing values). **ROCATINLIMAB** AAD 2025 (Ph3 ROCKET Horizon, 300mg Q4W + Week 2 loading dose; statistical handling of missing data not specified).

Key secondaries were in line with standard of care

EASI-90 Response



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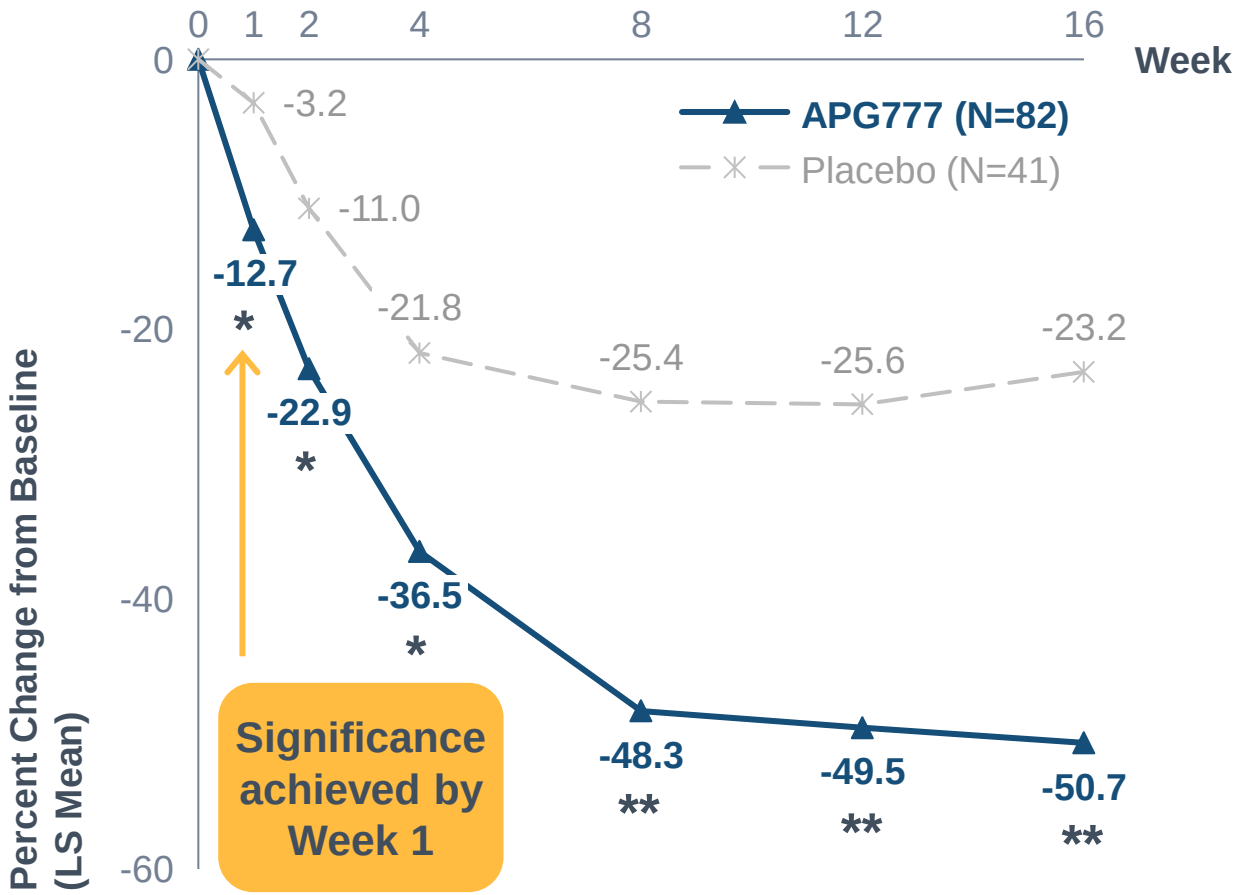
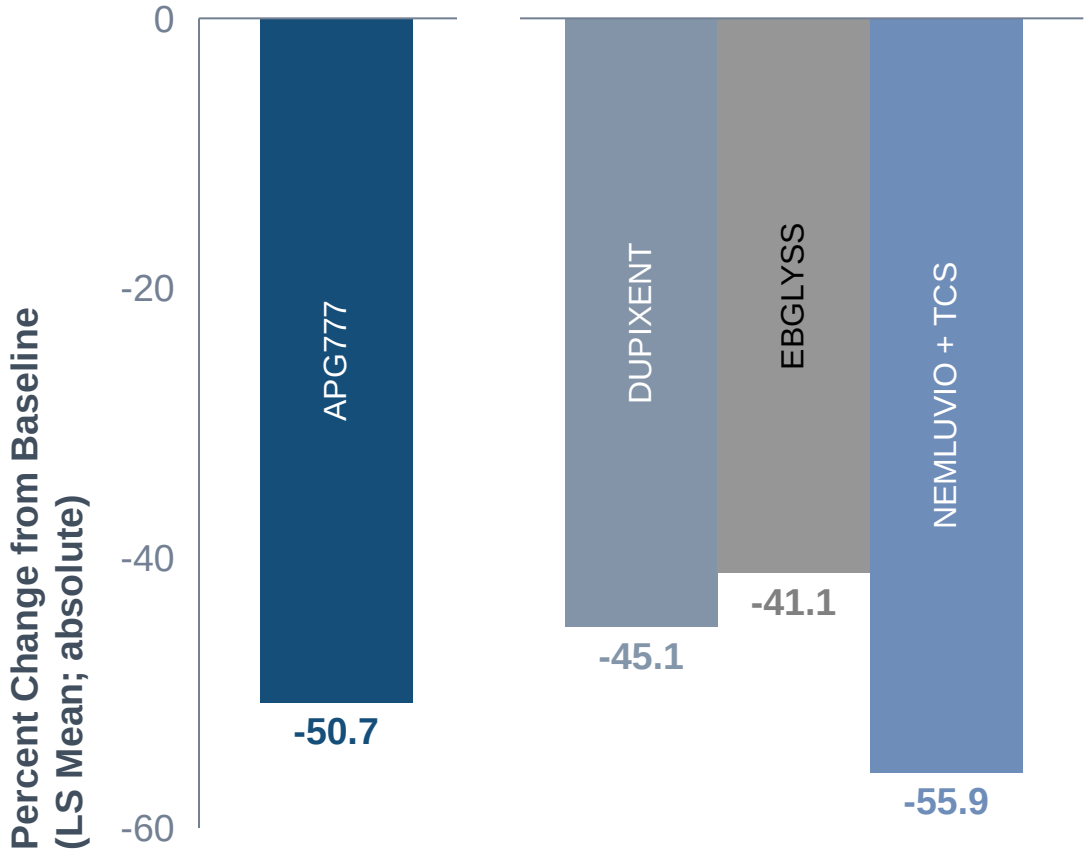
SOURCE: **DUPIXENT** (average of Ph3 SOLO-1&2 and Ph2b; 300 mg Q2W regimen; non-responder imputation for missing values). **EBGLYSS** (average of Ph3 ADVOCATE-1&2; 250mg Q2W regimen; multiple imputation (MCMC-MI) for missing values). **ADBRY** (average of Ph3 ECZTRA1&2; 300 mg Q2W regimen; non-responder imputation for missing values). **AMLITELIMAB** Weidinger et al EADV 2023 (Ph2b, 250mg Q4W + 500mg loading dose; non-responder imputation for missing values).

Treatment with APG777 led to itch relief in the first week

Itch Numerical Rating Scale (I-NRS)





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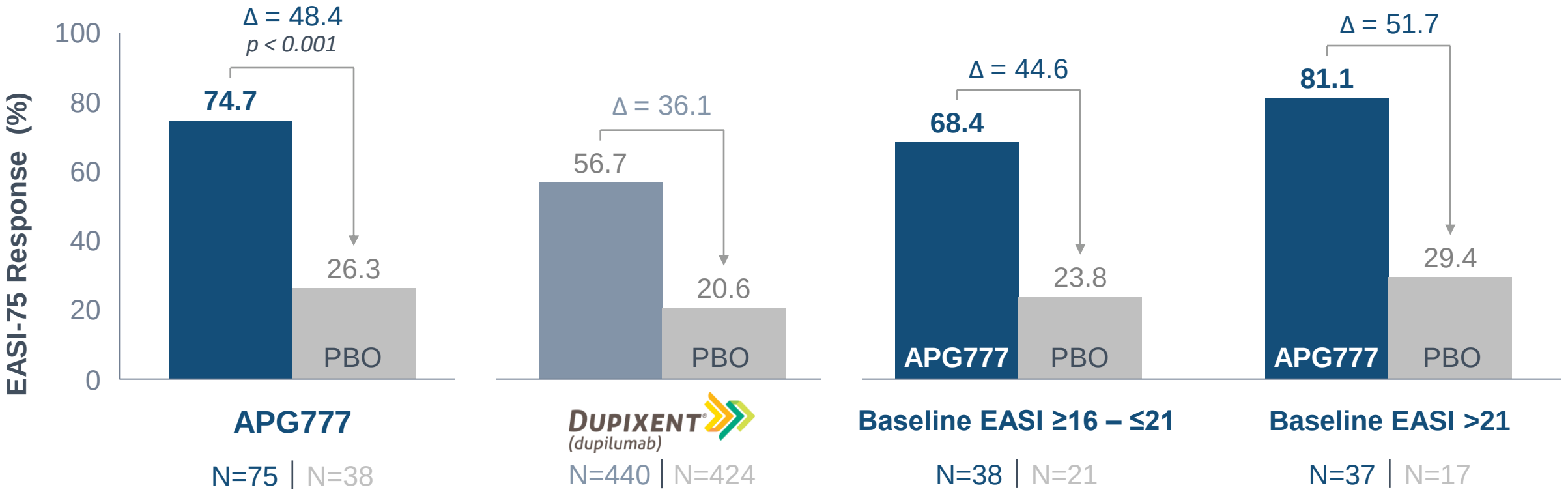
SOURCE: **DUPIXENT** (average of Ph3 SOLO-1&2 and Ph2b; 300 mg Q2W regimen; non-responder imputation for missing values). **EBGLYSS** (average of Ph3 ADVOCATE-1&2; 250mg Q2W regimen; multiple imputation (MCMC-MI) for missing values). **NEMLUVIO** (Ph3 ARCADIA1&2 average; 30 mg Q4W regimen; non-responder imputation for missing values).

Pre-specified sensitivity analysis demonstrate robustness of results

EASI-75 response at Week 16 (%; as observed, pre-specified analysis)



APG777

N=75 | N=38

DUPIXENT® (dupilumab)

N=440 | N=424

Baseline EASI ≥16 – ≤21

N=38 | N=21

Baseline EASI >21

N=37 | N=17

Absolute and pbo-adj. EASI-75 consistent across moderate and severe baseline severity subpopulations

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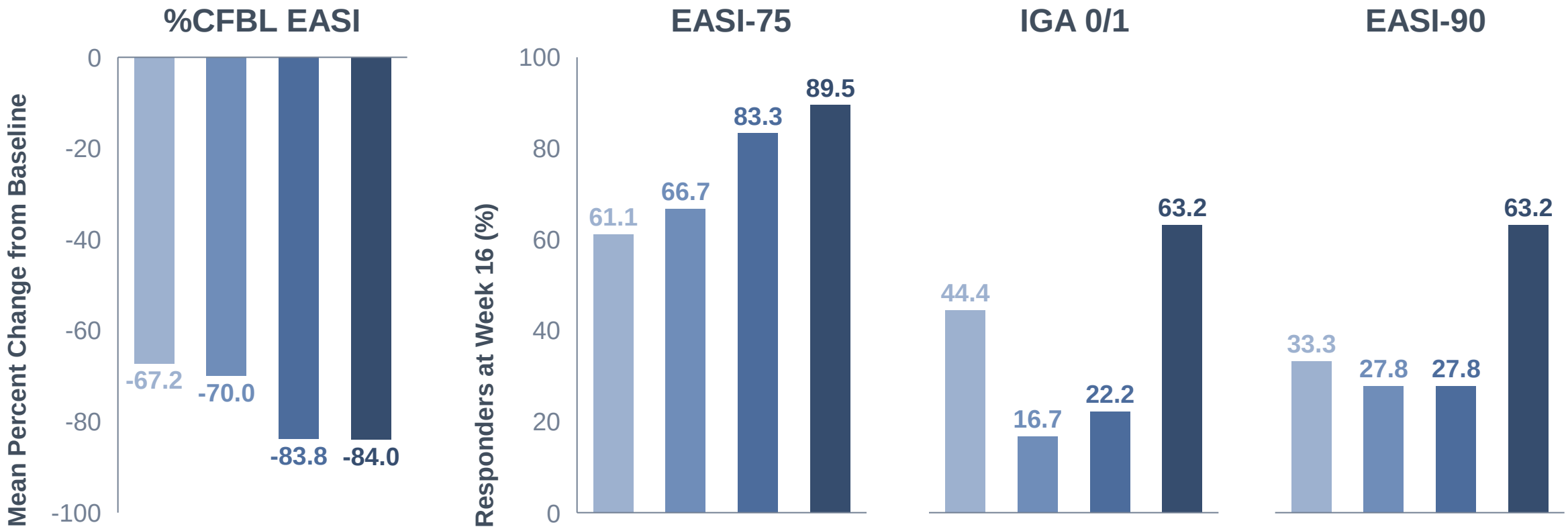
SOURCE: **DUPIXENT** Simpson et al NEJM 2016 (average of Ph3 SOLO-1&2 (sensitivity analysis 3: All observed values regardless of rescue treatment; missing data not imputed); 300 mg Q2W regimen).

Exposure-response relationship demonstrated across multiple endpoints

Key efficacy endpoints by APG777 exposure quartile at Week 16 (%; as observed, post-hoc analysis)

Exposure Quartile[1]: Q1 (n=18) Q2 (n=18) Q3 (n=18) Quartile 4 (n=19; highest exposure)



Part B top dose has similar modeled exposure as Quartile 4[2]

NOTE: [1] APG777 exposure quartiles based on average concentration (Cavg). Quartiles were constructed to have an equal number of patients. Total N = 73 based on availability of PK data at time of data cut.
[2] Based on modeled median exposure for Part B top dose.

APG777 was well tolerated

n (%)	APG777 (N=82)	Placebo (N=41)
Safety summary through Week 16		
Patients reporting ≥1 TEAE	46 (56.1)	26 (63.4)
Patients reporting ≥1 serious TEAE	1 (1.2)	1 (2.4)
Patients who discontinued due to TEAE	2 (2.4)	0
Most frequent TEAEs by PT through Week 16 (≥5%)		
Noninfective conjunctivitis	12 (14.6)	1 (2.4)
Upper respiratory tract infection	7 (8.5)	5 (12.2)
Nasopharyngitis	4 (4.9)	5 (12.2)

- Total conjunctivitis rate of 18.3%[1], the most common adverse event, consistent with DUPIXENT and EBGLYSS in AD[2]
  - Transient and led to no discontinuations, dose interruptions, or dose adjustments
  - 3.7% of treated patients had conjunctivitis ongoing at Week 16 (similar to DUPIXENT[3]); median time to resolution of 29 days
  - No relationship between exposure and conjunctivitis, consistent with EBGLYSS and DUPIXENT
- No injection site reactions occurred (0%)
- No imbalance in infections between arms

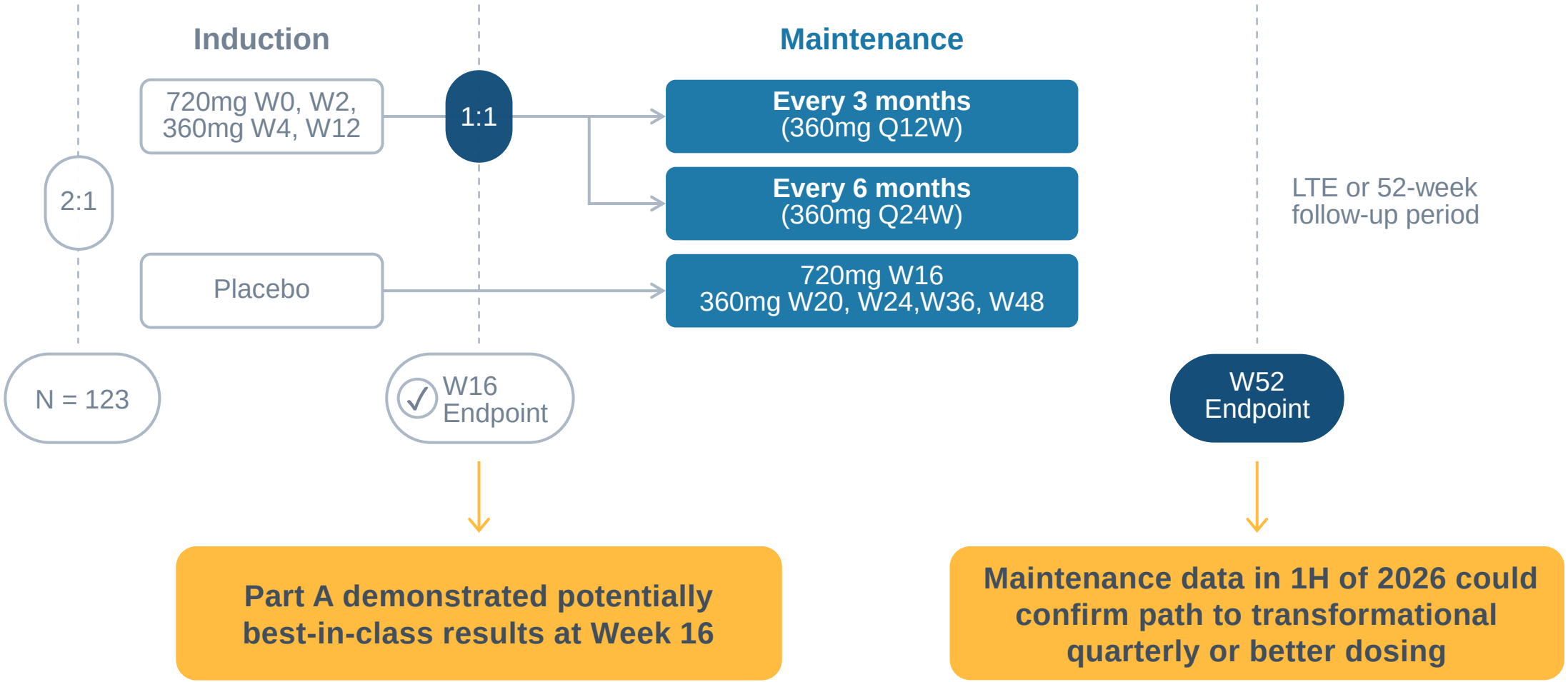
NOTE: Safety data are derived from different clinical trials conducted at different times, with differences in trial design and patient populations. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted. TEAE = treatment-emergent adverse event. PT = preferred term. N.R. = Not reported. AD = atopic dermatitis.
SOURCE: [1] Combined rate for all conjunctivitis-related MedDRA preferred terms including: allergic conjunctivitis, atopic keratoconjunctivitis, bacterial conjunctivitis, conjunctivitis, noninfective conjunctivitis, and viral conjunctivitis. [2] Based on combined conjunctivitis rate (all preferred terms) for DUPIXENT (~5-26%) and EBGLYSS (~3-27%) approved dose regimen across 16-week placebo-controlled trials in moderate-to-severe atopic dermatitis. [3] 4.2%, Akinlade B et al *Br J Dermatol.* 2019.

APG777 Development Program

Kristine Nograles, MD
SVP, Clinical Development
& Medical Affairs

Part A 52-week readout testing every 3- and 6-month maintenance dosing expected 1H 2026

Part A schematic



NOTE: During maintenance, all patients will receive active treatment with additional placebo injections given to maintain blinding.

APG777 could substantially decrease annual injections for patients

APG777

2-4

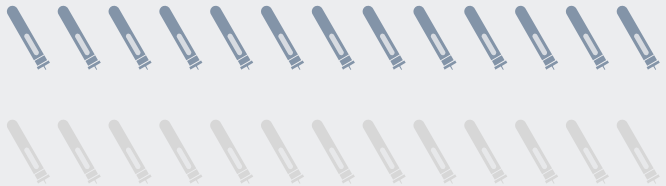
Injections

One injection every **3-6 months**[1]

EBGLYSS

13-26

Injections



One injection every **2-4 weeks**[1]

DUPIXENT

26

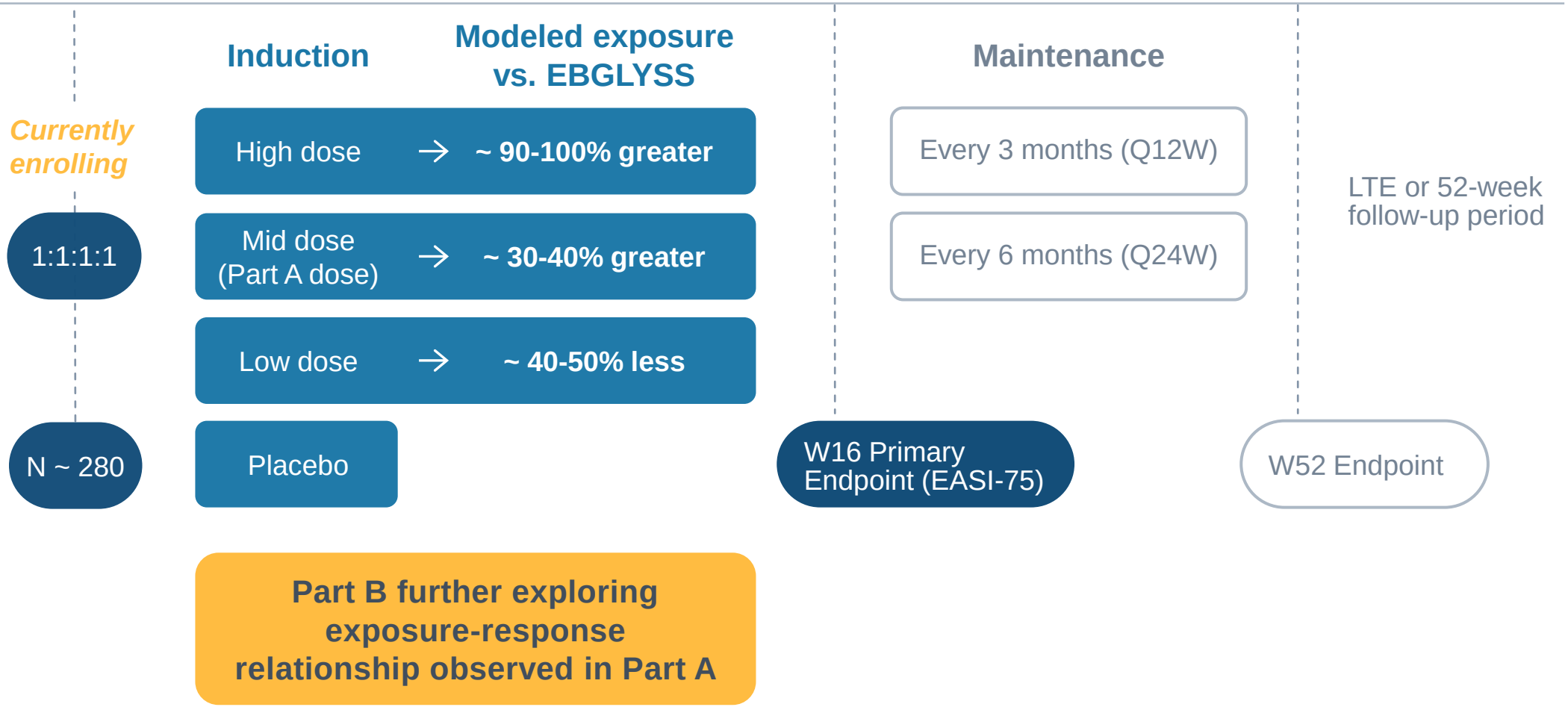
Injections

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.

Strong enrollment in APEX Part B, enabling acceleration of 16-week readout to mid-2026

Part B schematic (>90% powered for primary endpoint)

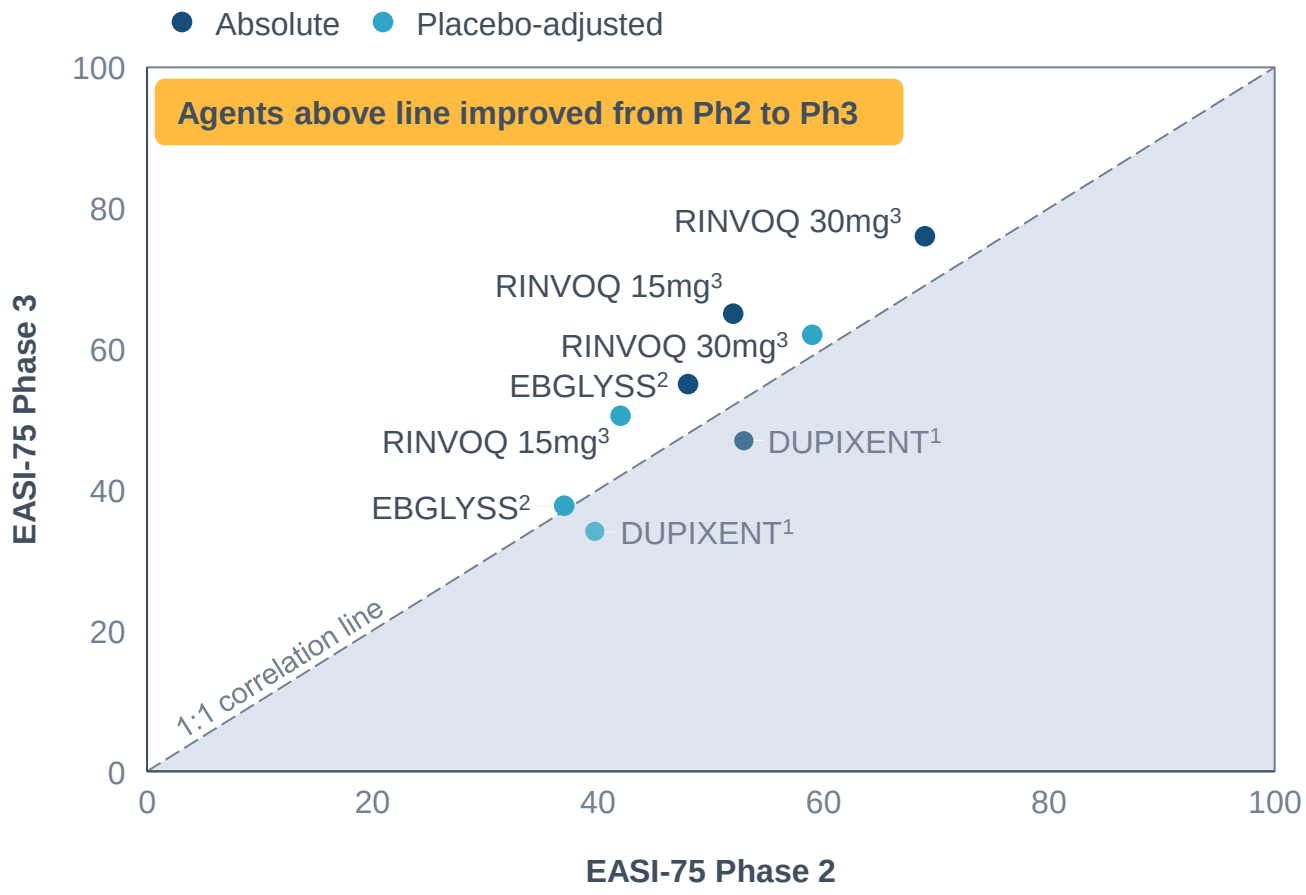


Building a Leading I&I Company

Michael Henderson, MD
Chief Executive Officer

Historical correlation data increases confidence APEX Phase 2 results will translate to Phase 3

Strong correlation between Phase 2 and 3 for key endpoints



- Historical correlation data increases confidence APEX Phase 2 results will translate to Phase 3
  - Phase 3 trials for biologics and small molecules in AD have a **100% historical success rate**[4]
- **Key efficacy endpoints** have **increased on average between Phase 2 and Phase 3** for analogous agents:
  - EASI-75: +5.6 ppt (+1.5 ppt pbo-adj.)
  - IGA 0/1 +7.5 ppt (+2.2 ppt pbo-adj.)
  - EASI-90 +12.4 ppt (+7.8 ppt pbo-adj.)

SOURCE: Ph3 data for DUPIXENT, EBGLYSS, RINVOQ is from USPI. [1] Thaci et al. *Lancet* 2016. [2] Guttman-Yassky E et al *JAMA* Dermatol. 2020. [3] Guttman-Yassky E et al *J All Clin Immunol.* 2020. 4 Agnihotri G et al *Clin Drug Investig* 2020.
NOTE: ppt = percentage point. Pbo-adj. = placebo-adjusted.

Apogee has multiple value-creating catalysts in the next 18 months

$681M in cash[1] with runway into Q1 2028

	★ UPDATES TODAY	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** ★ **Mid: AD Phase 2 Part B 16-week readout** ★ **AD Phase 3 initiation** • 1H: Asthma Phase 1b readout • EoE Phase 2 initiation
Potential first- or best-in-class combination approaches	**APG279[2]** IL-13 + OX40L	✓ ★ **AD Phase 1b PoC trial (against DUPIXENT) – First patient dosed**	• 2H: AD Phase 1b PoC readout (against DUPIXENT)
	APG777 + APG333 IL-13 + TSLP	• Additional clinical plans in asthma / COPD announced	
Potential best-in-class mAbs for combinations	**APG990** OX40L	✓ 1H: Initial Phase 1 PK & safety in HVs	
	APG808 IL-4Rα	✓ 1H: Asthma Phase 1b readout	
	APG333 TSLP	• 2H: Initial Phase 1 PK & safety in HVs	

NOTE: [1] As of March 31, 2025, Apogee had cash, cash equivalents, marketable securities, and long-term marketable securities of $681M.
[2] APG279 is a combination of APG777 and APG990. APG279 will be co-administered in the proof-of-concept Phase 1b trial; coformulation planned for future clinical studies and commercialization.

CORPORATE

Our vision for building a next-gen biotech

KEY UPDATE

APG777 in AD: Best-in-class monotherapy

- **Potential megablockbuster** in the future **$50B+ AD market**
- ★ **Demonstrated highest EASI-75 of any biologic at Week 16[1]** with path to best-in-class quarterly or better maintenance dosing
- ★ **Part B** 16-week topline, testing higher exposures, **accelerated to mid-2026**
- ★ **Planned Phase 3** initiation in 2026 and **launch this decade**

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**

KEY UPDATE

Best-in-class combinations

- **Potential to break through the monotherapy efficacy ceiling**
- **Combos rapidly advancing**:
  - ★ **279: Ph1b against DUPIXENT dosed first patient**; readout expected in 2H 2026
  - **777+333: respiratory** clinical planning underway

NOTE: [1] APG777 achieved the highest EASI-75 absolute and placebo-adjusted of any biologic tested in a global placebo-controlled trial of moderate-to-severe atopic dermatitis.

Apogee /ˈapəjē/ *noun*

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