APOGEE THERAPEUTICS®

APEX Part A 52-week readout

APEX AD Ph 2

March 23, 2026

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 3 trial of zumilokibart (APG777) in AD; the expected timing of results from our clinical trials, including the initial readout from Part B of our Phase 2 trial of zumilokibart in AD and the initial readout from our Phase 1b trial of APG279 in AD; planned clinical trial designs; our plans for current and future clinical trials and expansion indications; the potential launch timing of our product candidates, including zumilokibart in AD; the potential clinical benefit, treatment outcomes, dosing regimen, and safety of zumilokibart and 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, our planned business strategies; 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, 2025, filed with the U.S. Securities and Exchange Commission (the SEC) on March 2, 2026 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.

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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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 cross-study comparisons are directional and may not be directly comparable.

Agenda

Introduction		Michael Henderson, MD Chief Executive Officer
APEX Phase 2 Part A 52-Week Results		Carl Dambkowski, MD Chief Medical Officer
Unmet Need in Atopic Dermatitis		**Invited KOL: Ruth Ann Vleugels, MD, MPH, MBA** Mass General Brigham, Harvard Medical School
Zumilokibart 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 **Invited KOL: Ruth Ann Vleugels, MD, MPH, MBA**

Introduction

Michael Henderson, MD
Chief Executive Officer

Building a leading I&I company to address Type 2 inflammatory conditions

Atopic dermatitis (AD) is growing rapidly and could be the largest I&I market

- AD market is projected to reach **$50B+**
- New entrants with limited differentiation are quickly becoming blockbusters

Zumilokibart is a potentially best-in-class antibody targeting IL-13, the primary driver of AD and other Type 2 inflammatory diseases

- Zumilokibart's prior 16-week induction data showed **rapid reduction in itch and lesions**
- 52-week results now demonstrate zumilokibart **maintains those responses** and could be the **first every 6-month dosed drug** in dermatology, if approved
- **Both every 3- and 6-month dosing** led to **deepening across all endpoints**, in contrast to DUPIXENT

NOTE: Future $50B AD market size based on EvaluatePharma and company projections. Actual market size may differ materially.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.

APEX 52-week data demonstrated a potentially best-in-class profile with both every 3-month and every 6-month dosing

Durable maintenance of response at 52 weeks

Maintenance of EASI-75:

- 75% every 3-month dosing
- 85% every 6-month dosing

Maintenance of IGA 0/1:

- 86% every 3-month dosing
- 78% every 6-month dosing

Deepening responses through Week 52

- Deepening of response seen across all lesional and itch endpoints tested for both every 3- and 6-month dosing
- Up to 36 percentage points of deepening on the most stringent endpoints (IGA 0/1, EASI-90, EASI-100)

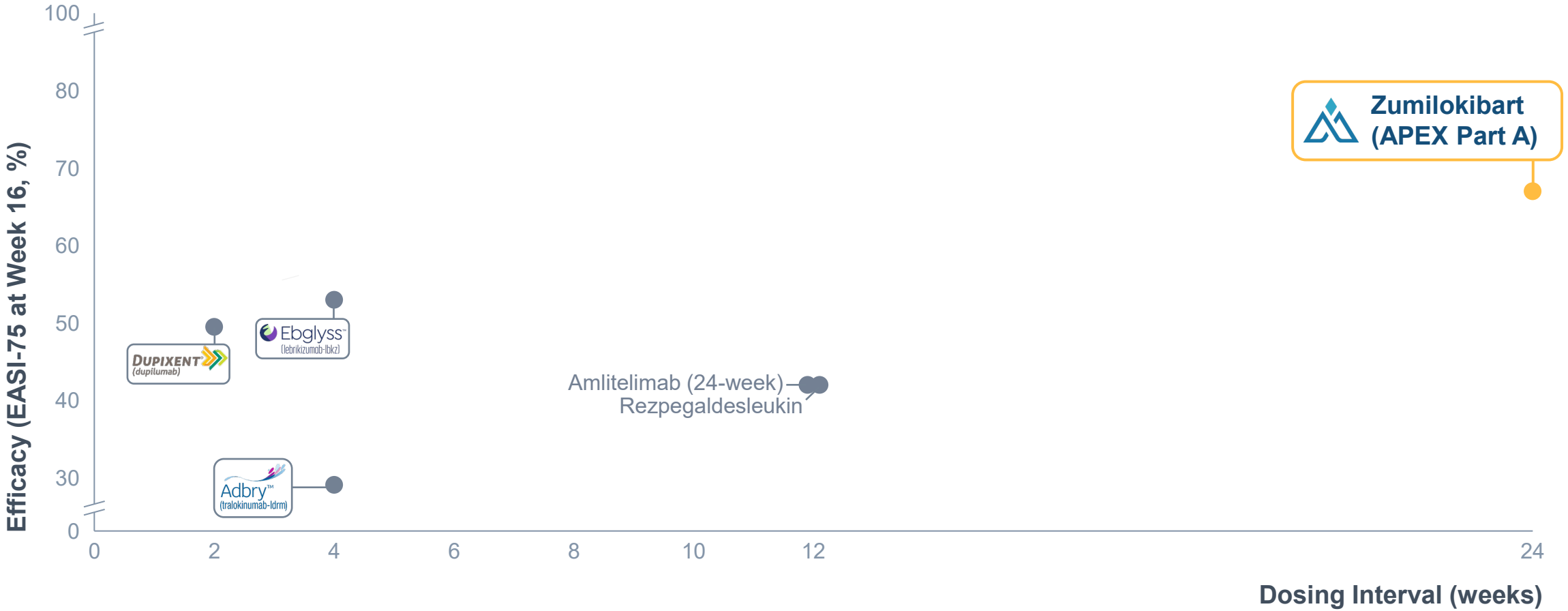
Well-tolerated safety profile consistent with class

- Both maintenance regimens well-tolerated
- Safety profile generally in line with class

Data support planned zumilokibart Phase 3 initiation in 2H 2026 with every 3- and every 6-month dosing regimens

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. IGA = Investigator Global Assessment. EASI = Eczema Area and Severity Index. Phase 3 plans subject to regulatory outcomes. Zumilokibart assessed Validated Investigator Global Assessment (vIGA) during APEX Part A.

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



NOTE: Positioning of Apogee programs is illustrative and based on Phase 2 Part A results for zumilokibart 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.

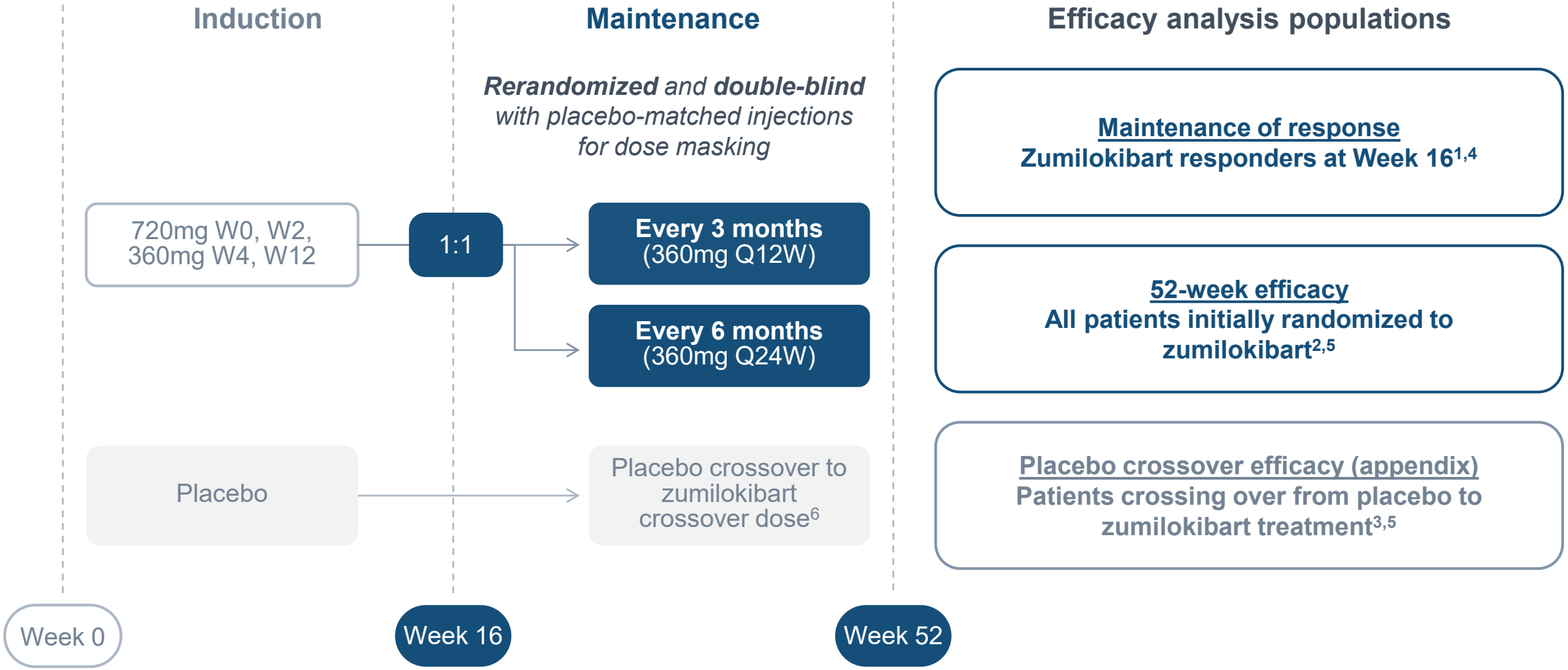
SOURCE: **DUPIXENT** (average of Ph3 SOLO-1&2 and Ph2b; 300 mg Q2W regimen; non-responder imputation for missing values). **EBGLYSS** (average of Ph3 ADVOCATE-1&2 (multiple imputation (MCMC-MI) for missing values) and Ph2b (sensitivity analysis 3: NRI for rescue medication use and LOCF for other missing values); 250mg Q2W regimen). **ADBRY** (average of Ph3 ECZTRA1&2; 300 mg Q2W regimen; non-responder imputation for missing values). **AMLITELIMAB** Sanofi press release (average of COAST-1 and COAST-2, 250mg Q4W + 500mg loading dose; non-responder imputation for missing values). **REZPEGALDESLEUKIN** Nektar press release (non-responder imputation for missing values).

APEX Part A 52-week results

Carl Dambkowski, MD
Chief Medical Officer

APEX Part A study design

APEX Part A schematic



NOTE: [1] Patients randomized to zumilokibart in induction that achieved a response at Week 16 (e.g., EASI-75) and received ≥1 dose of zumilokibart during maintenance. [2] Week 0-16 data: All patients randomized to zumilokibart in induction and received ≥1 dose of study drug in induction; Week 16-52 data: all patients randomized to zumilokibart in induction and received ≥1 dose of study drug in maintenance. [3] Patients randomized to placebo in induction and received ≥1 dose of zumilokibart in maintenance. [4] Evaluation method was Markov Chain Monte Carlo Multiple Imputation (MCMC-MI). Systemic rescue medication use or treatment discontinuation due to lack of efficacy was imputed as non-responder for all subsequent time points. Patients who received topical rescue medication or discontinued treatment for any other reasons had values set to missing subsequent to this time through to Week 52. [5] Efficacy data was evaluated as-observed without imputation for missing data or rescue medication use. [6] Placebo crossover zumilokibart dose regimen was: 720mg at W16; 360mg at W20, W24, W36, W48.

Baseline characteristics and demographics were in line with expectations

Baseline demographics and disease characteristics of all patients treated with zumilokibart

Characteristic	Study mITT population (all patients receiving ≥1 dose of zumilokibart; N=119)
Age, mean (SD), Y	37.9 (14.9)
Female, n (percent)	58 (48.7)
Weight, mean (SD), kg	83.4 (20.9)
Duration of AD from diagnosis, mean (SD), Y	24.3 (14.4)
Race, n (percent)	
White	82 (68.9)
Black or African American	17 (14.3)
Asian	16 (13.4)
Other	3 (2.5)
Baseline disease characteristics	
EASI, mean (SD)	25.3 (10.8)
vIGA (4), n (percent)	40 (33.6)
Weekly mean I-NRS, (SD)	6.5 (2.0)
BSA affected, mean (SD)	36.0 (22.5)

NOTE: Baseline refers to week 0 of the study. vIGA = Validated Investigator Global Assessment. EASI = Eczema Area and Severity Index. BSA = Body Surface Area. I-NRS = Itch Numeric Rating Scale. SD = standard deviation.

Zumilokibart was well-tolerated across the full 52-week treatment period

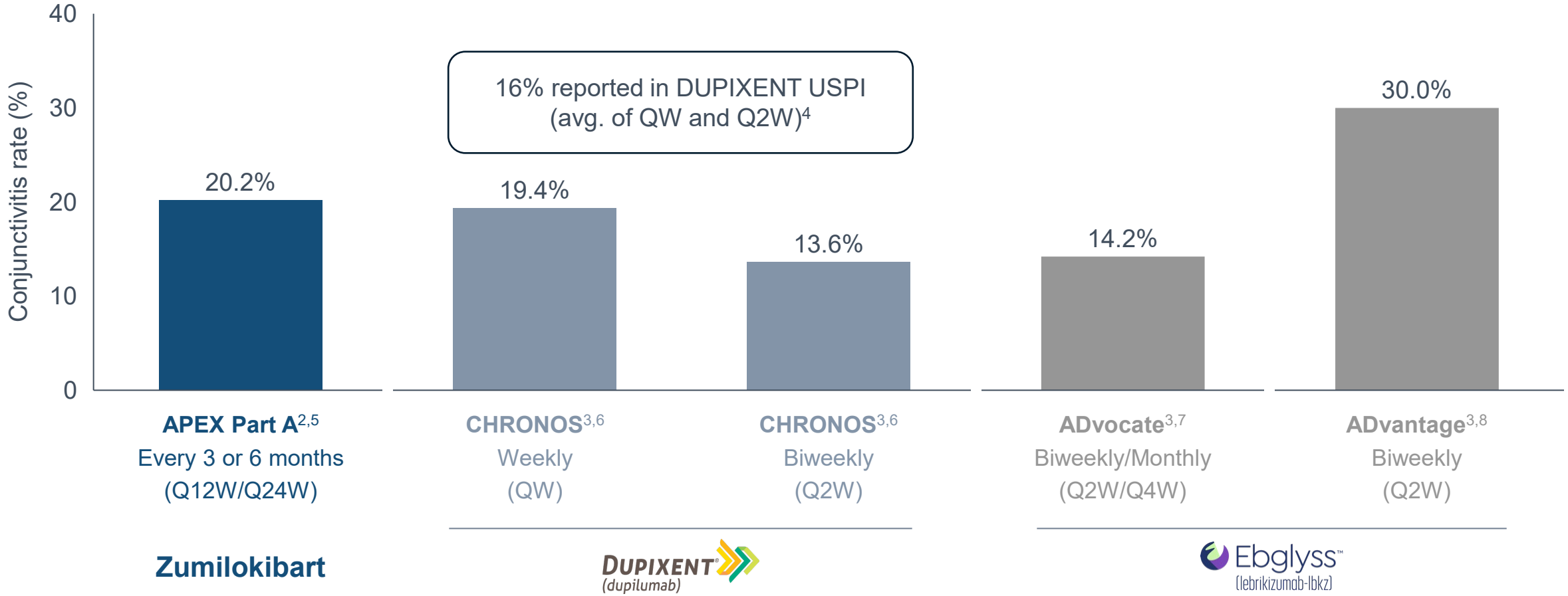
n (%)	**Study mITT population** (all patients receiving ≥1 dose of zumilokibart; N=119)
Safety summary for Week 0 to 52	
Patients reporting ≥1 TEAE	85 (71.4)
Patients reporting ≥1 serious TEAE	1 (0.8)
Patients who discontinued due to TEAE	4 (3.4)
Most frequent TEAEs by PT for Week 0 to 52 (≥5%)	
Noninfective conjunctivitis	16 (13.4)
Upper respiratory tract infection	15 (12.6)
Nasopharyngitis	11 (9.2)
Dermatitis atopic	6 (5.0)

- Pooled conjunctivitis rate (all PTs) of 20.2% with <1% discontinuations for full 52-week treatment period, generally in line with the IL-4Rα/13 class
- No effect of ADAs on PK, efficacy, or safety

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. ADA = anti-drug antibody. Pooled conjunctivitis rate of 20.2% includes the following preferred terms: noninfective conjunctivitis, conjunctivitis allergic, conjunctivitis bacterial and conjunctivitis viral.

APEX Part A conjunctivitis rate was comparable to DUPIXENT and EBGLYSS studies

Conjunctivitis rate for 52-week studies including all reported preferred terms (%)[1]



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.

[1] Conjunctivitis rate shown is the combined rate for all reported conjunctivitis-related MedDRA preferred terms including allergic conjunctivitis, atopic keratoconjunctivitis, bacterial conjunctivitis, conjunctivitis, noninfective conjunctivitis, and viral conjunctivitis.

[2] Conjunctivitis rate shown for zumilokibart includes all conjunctivitis-related preferred terms for study mITT population (all patients receiving ≥1 dose of zumilokibart; N=119).

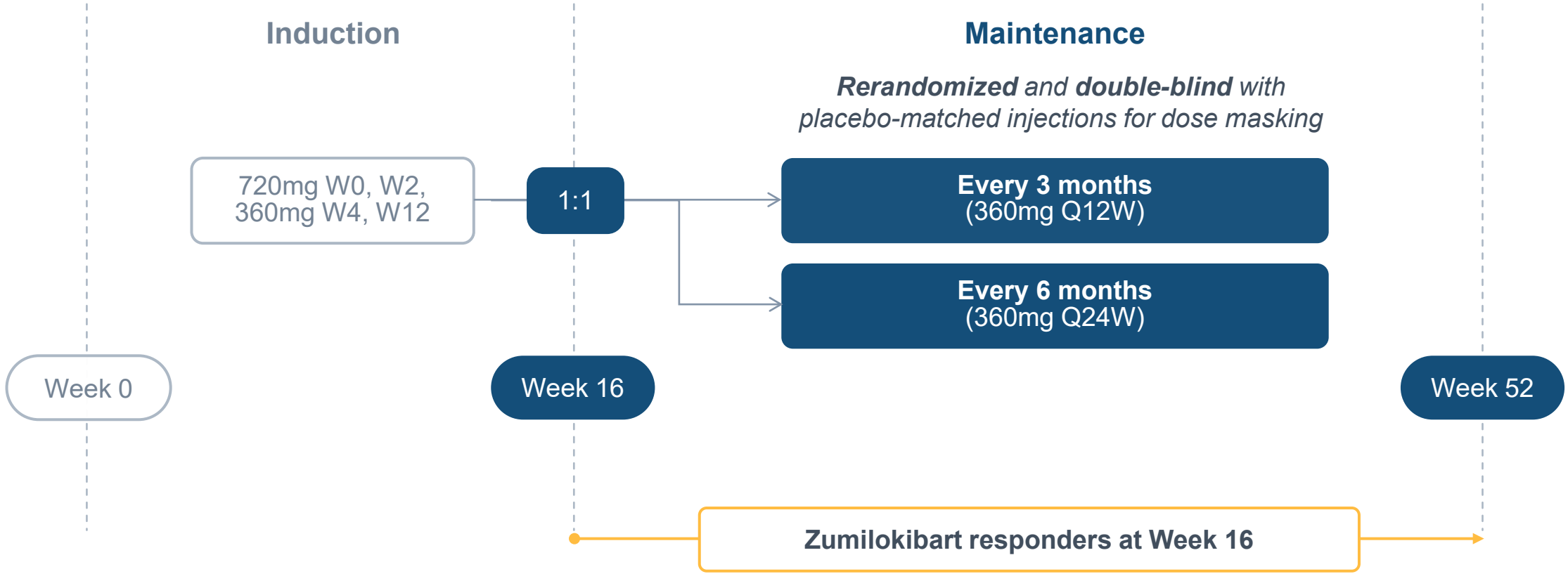
[3] Actual rate for all conjunctivitis-related preferred terms for DUPIXENT and EBGLYSS studies shown may differ due to missing and/or not reported data.

SOURCE: [4] DUPIXENT USPI. [5] APEX Phase 2 Part A. [6] Blauvelt A et al. Lancet 2017. [7] Blauvelt A et al. Br J Dermatol 2023. [8] Warren R.B. et al BJD 2025.

Zumilokibart achieved durable maintenance of Week 16 responses

Patients who achieved a response at Week 16 were assessed for maintenance of response at Week 52

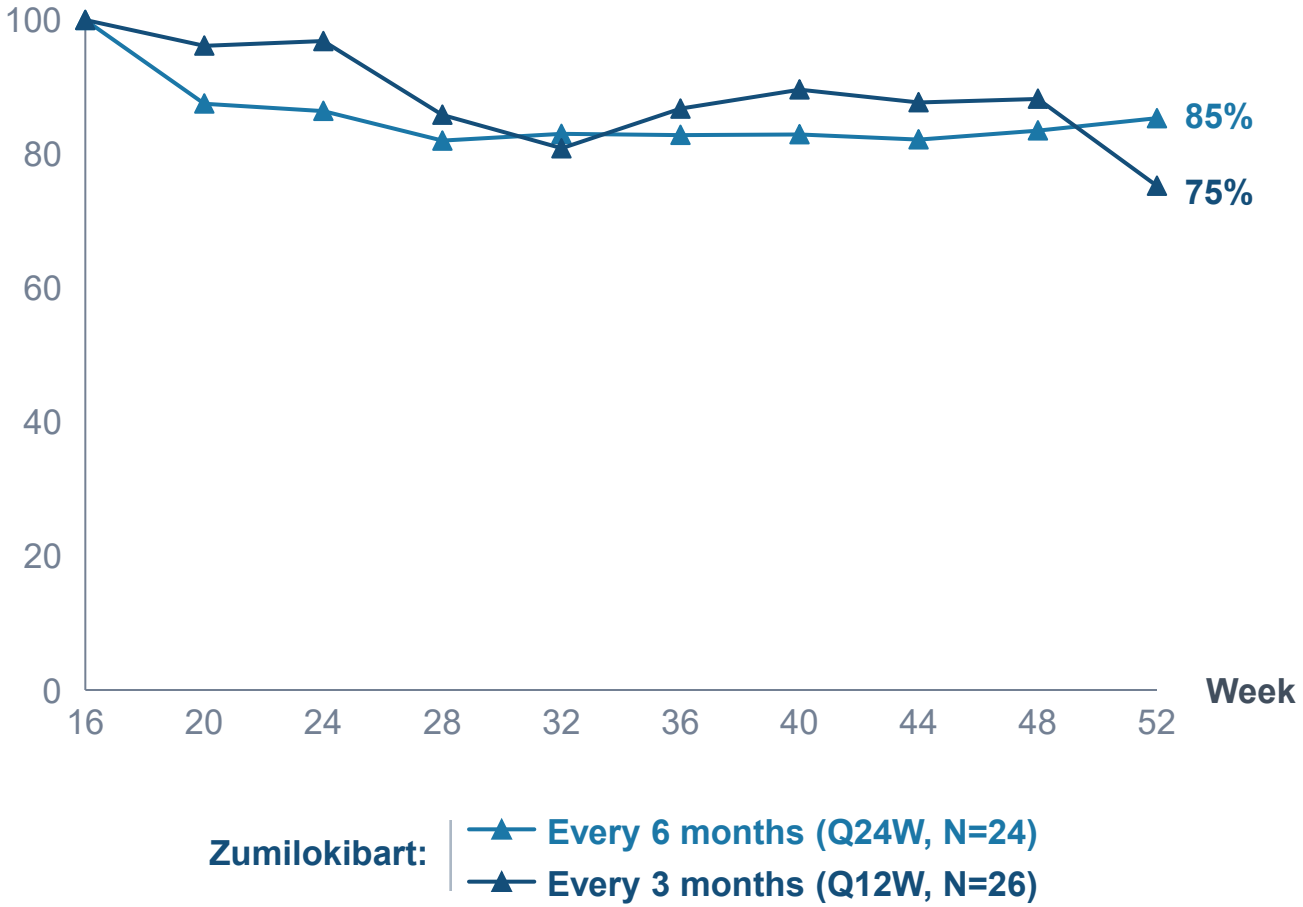
APEX Part A schematic

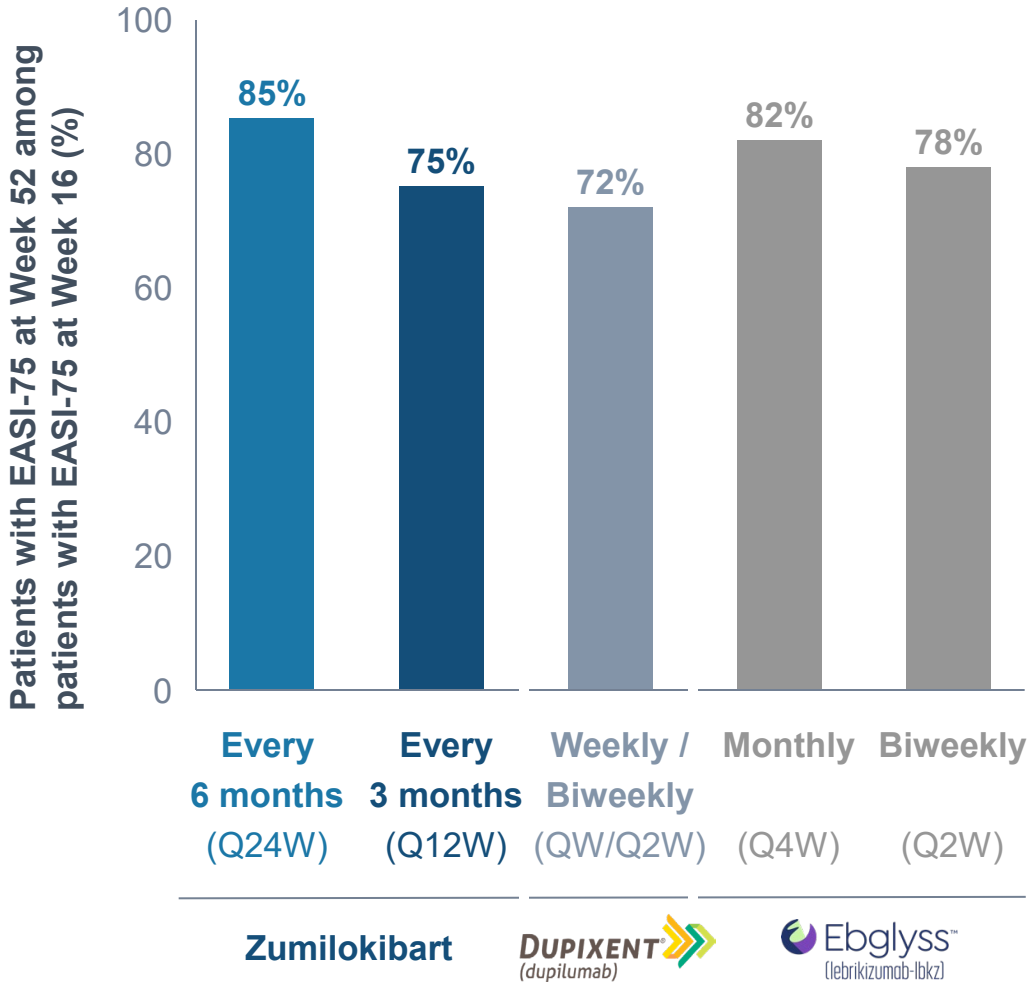


NOTE: Zumilokibart responders at Week 16 refers to patients randomized to zumilokibart in induction who achieved a response at Week 16 (e.g., EASI-75) and received ≥1 dose of zumilokibart during maintenance. Unless otherwise specified, maintenance of response was evaluated with Markov Chain Monte Carlo Multiple Imputation (MCMC-MI). Systemic rescue medication use or treatment discontinuation due to lack of efficacy was imputed as non-responder for all subsequent time points. Patients who received topical rescue medication or discontinued treatment for any other reasons had values set to missing subsequent to this time through to Week 52.

Zumilokibart demonstrated 75-85% maintenance of EASI-75 response

Maintenance of EASI-75 response among patients with EASI-75 at Week 16 (%)



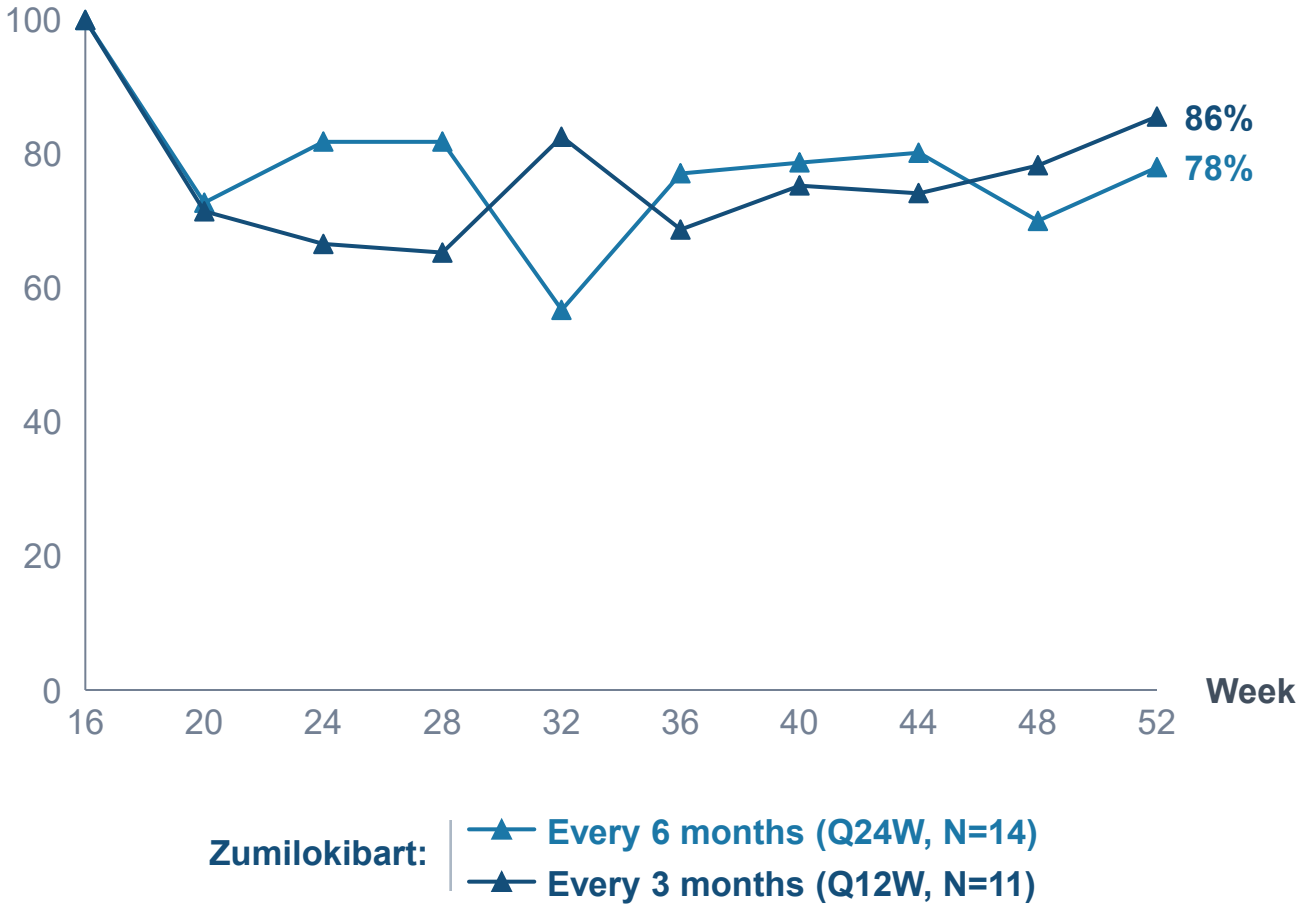


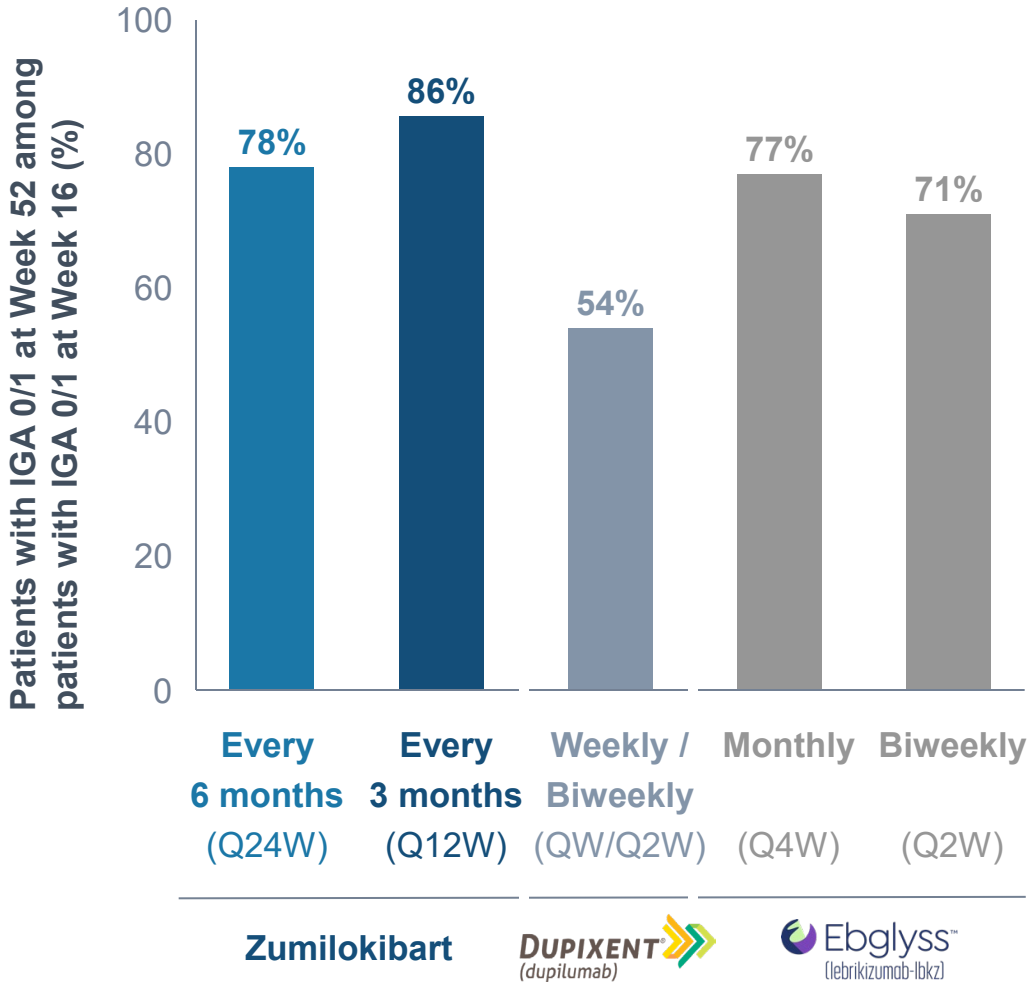
NOTE: For illustrative purposes only. Efficacy data are derived from different clinical trials conducted at different times, with differences in trial design and patient populations. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted. All efficacy data shown based on non-responder imputation for systemic rescue medication use or treatment discontinuation due to lack of efficacy. Statistical treatment of missing data varies across studies shown.

SOURCE: **DUPIXENT** Worm, M JAMA Dermatology 2019 (SOLO-CONTINUE). **EBGLYSS** Blauvelt A et al. Br J Dermatology 2023 (ADvocate 1/2).

Zumilokibart demonstrated 78-86% maintenance of IGA 0/1 response

Maintenance of IGA 0/1 response among patients with IGA 0/1 at Week 16 (%)



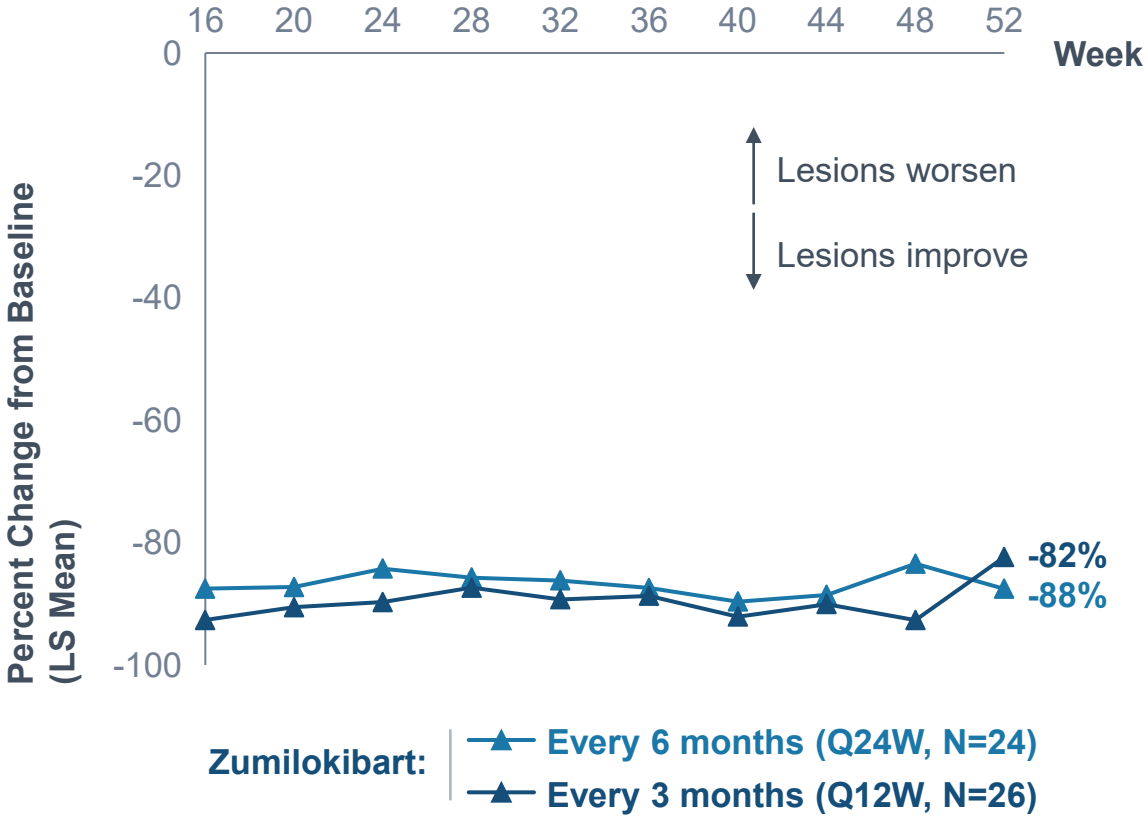


NOTE: For illustrative purposes only. Efficacy data are derived from different clinical trials conducted at different times, with differences in trial design and patient populations. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted. All efficacy data shown based on non-responder imputation for systemic rescue medication use or treatment discontinuation due to lack of efficacy. Statistical treatment of missing data varies across studies shown. Zumilokibart assessed vIGA 0/1 while DUPIXENT and EBGLYSS studies shown assessed IGA 0/1.

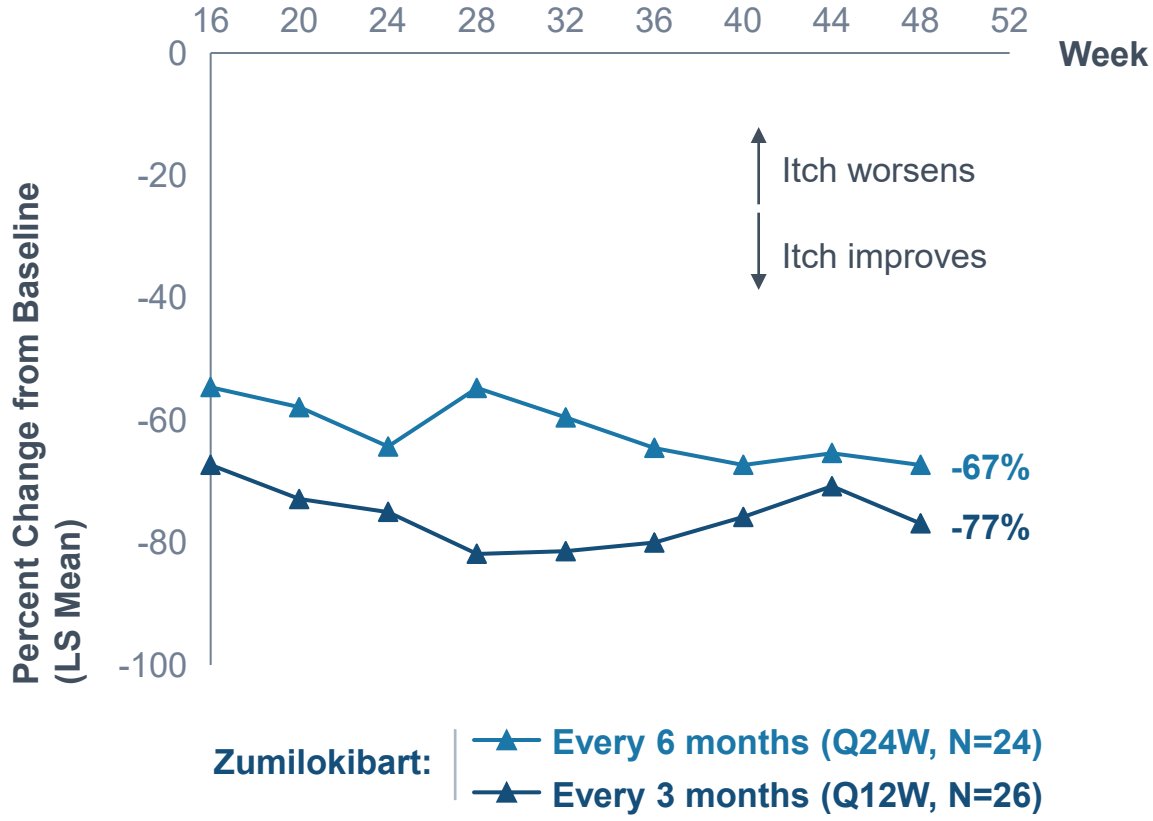
SOURCE: **DUPIXENT** Worm, M JAMA Dermatology 2019 (SOLO-CONTINUE). **EBGLYSS** Blauvelt A et al. Br J Dermatology 2023 (ADvocate 1/2).

Zumilokibart demonstrated 82-88% reduction in EASI and 67-77% reduction in Itch NRS score among EASI-75 responders

%CFBL EASI among EASI-75 responders (%)



%CFBL I-NRS among EASI-75 responders (%)

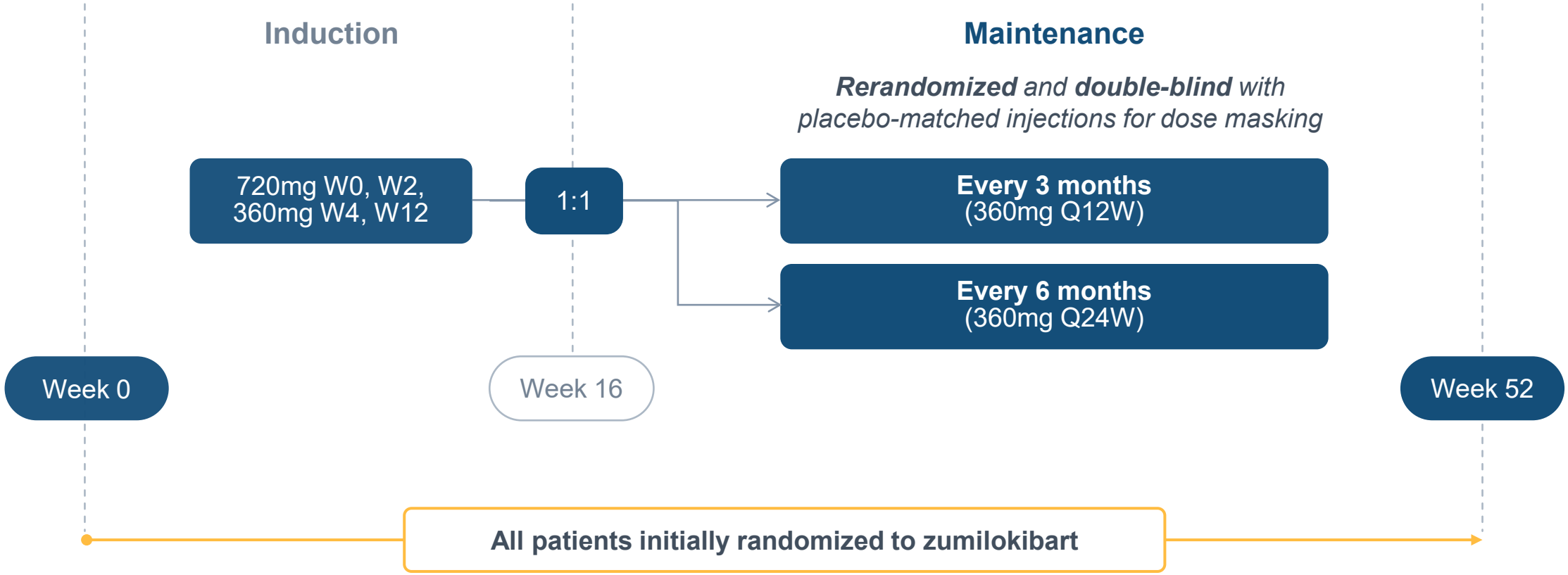


NOTE: For %CFBL EASI, missing data was imputed with Markov Chain Monte Carlo Multiple Imputation (MCMC-MI). Patients who received rescue medication or discontinued treatment had values set to missing subsequent to this time through to Week 52. For %CFBL I-NRS, data was evaluated as-observed without imputation for missing data or rescue medication use. Specified N for I-NRS data is based on patients per arm at Week 16.

Zumilokibart led to deepening responses over 52 weeks

Responses over 52 weeks were assessed for all patients who were initially randomized to zumilokibart

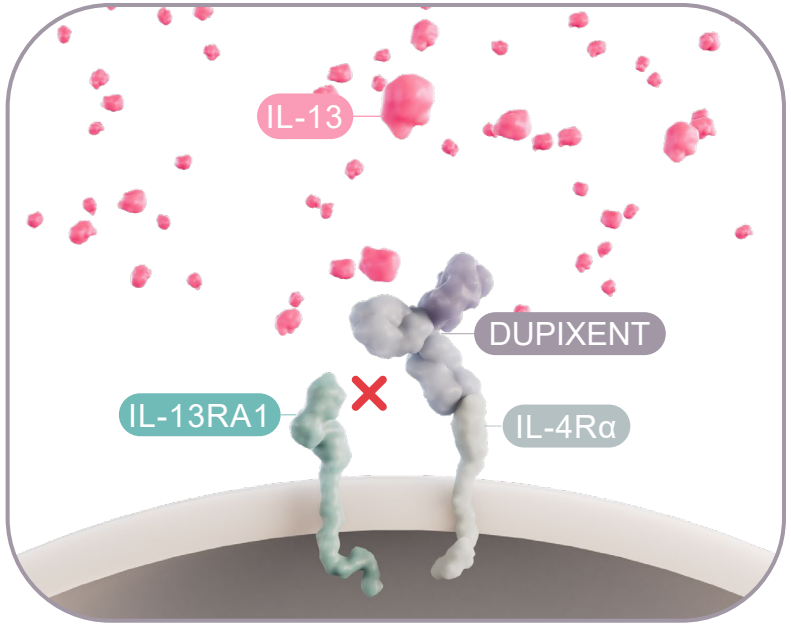
APEX Part A schematic



NOTE: Week 0-16 data: All patients randomized to zumilokibart in induction and received >1 dose of study drug in induction; Week 16-52 data: all patients randomized to zumilokibart in induction and received ≥1 dose of study drug in maintenance. Efficacy data was evaluated as-observed without imputation for missing data or rescue medication use. N=82 patients were randomized to zumilokibart for induction (Week 0-16), of which N=70 received ≥1 dose of study drug during maintenance period (16-52 weeks).

Zumilokibart achieves >99% IL-13 inhibition and demonstrates deepening of response on all endpoints

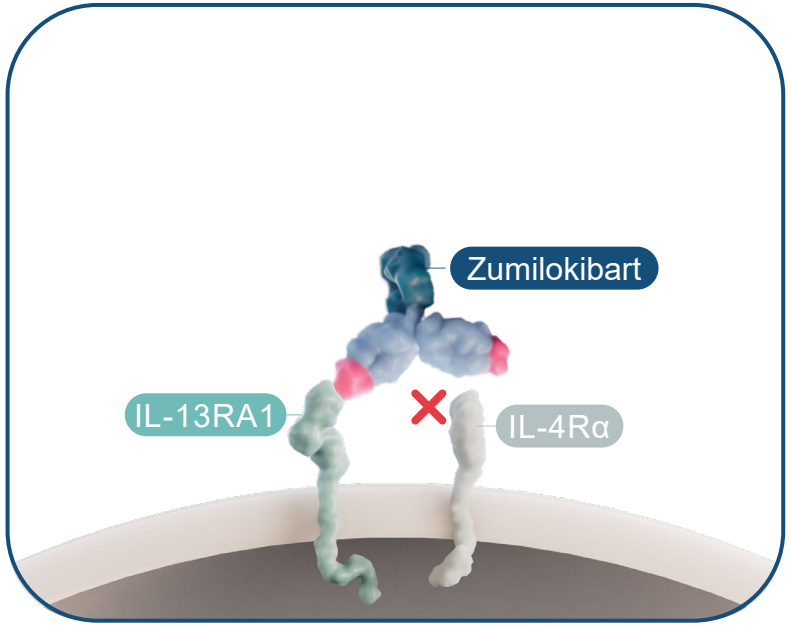
IL-4Rα inhibition does not reduce IL-13 or show deepening of response



IGA 0/1 response for DUPIXENT **+ TCS** (from label):

- **Week 16: 39%**
- **Week 52: 36%**

Zumilokibart neutralizes nearly all IL-13 and demonstrates deepening responses



IGA 0/1 response for zumilokibart (**monotherapy**):

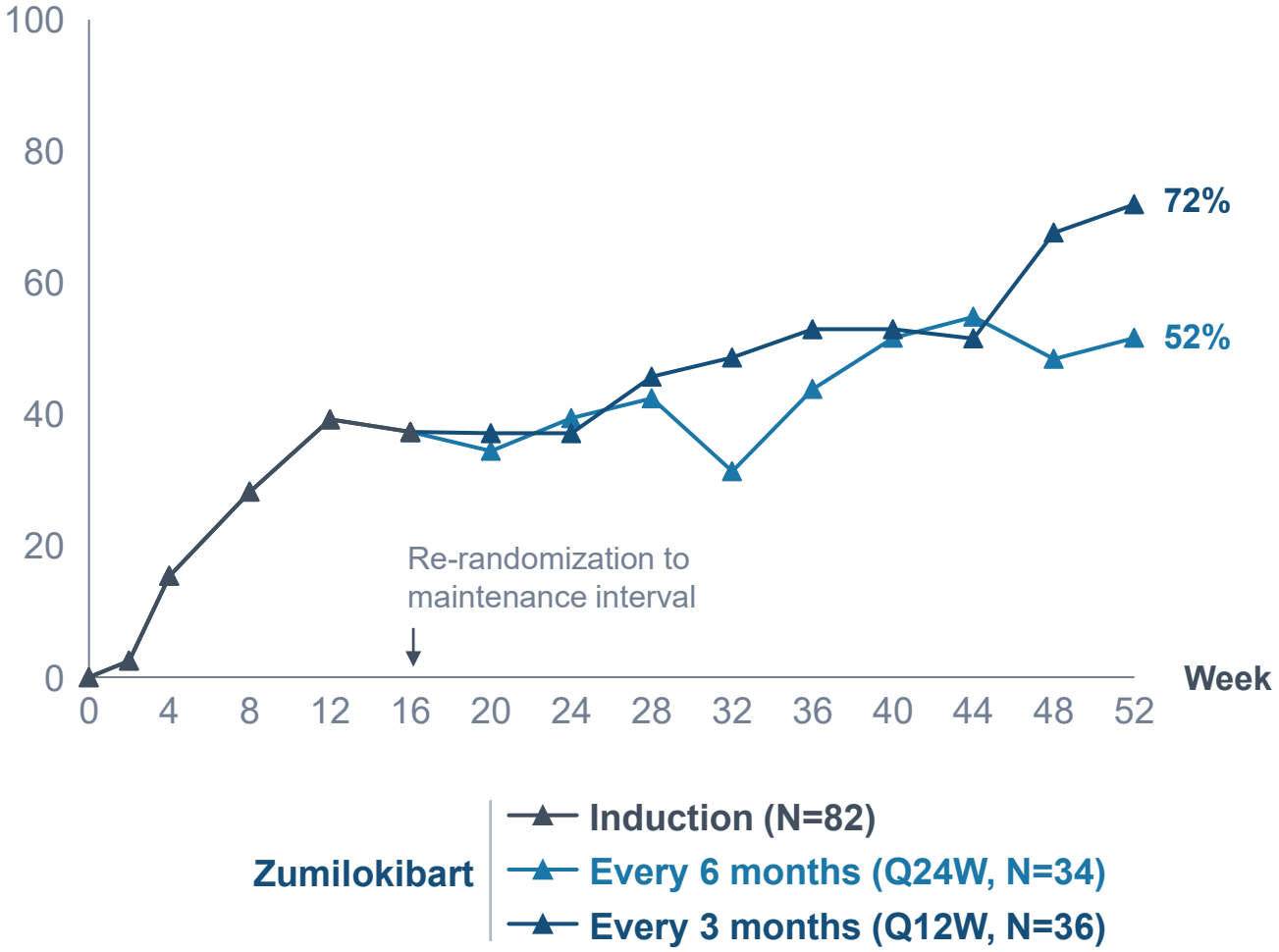
- **Week 16: 37%**
- **Week 52: 52-72%**

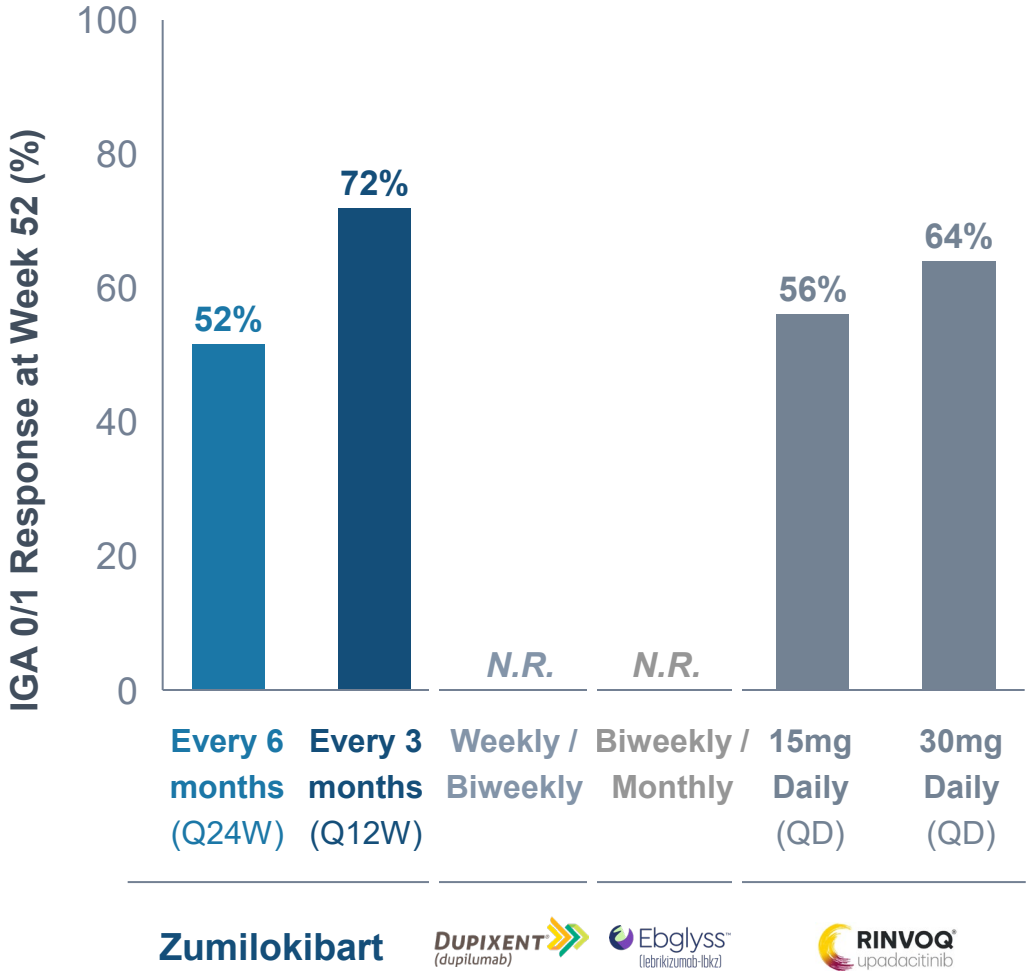
Both every 3- and 6-month dosing deepen across all endpoints tested

SOURCE: DUPIXENT USPI.
NOTE: 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. Zumilokibart assessed vIGA 0/1 while DUPIXENT studies shown assessed IGA 0/1.

Zumilokibart IGA 0/1 responses deepened by 14-35 percentage points

IGA 0/1 Response (%)



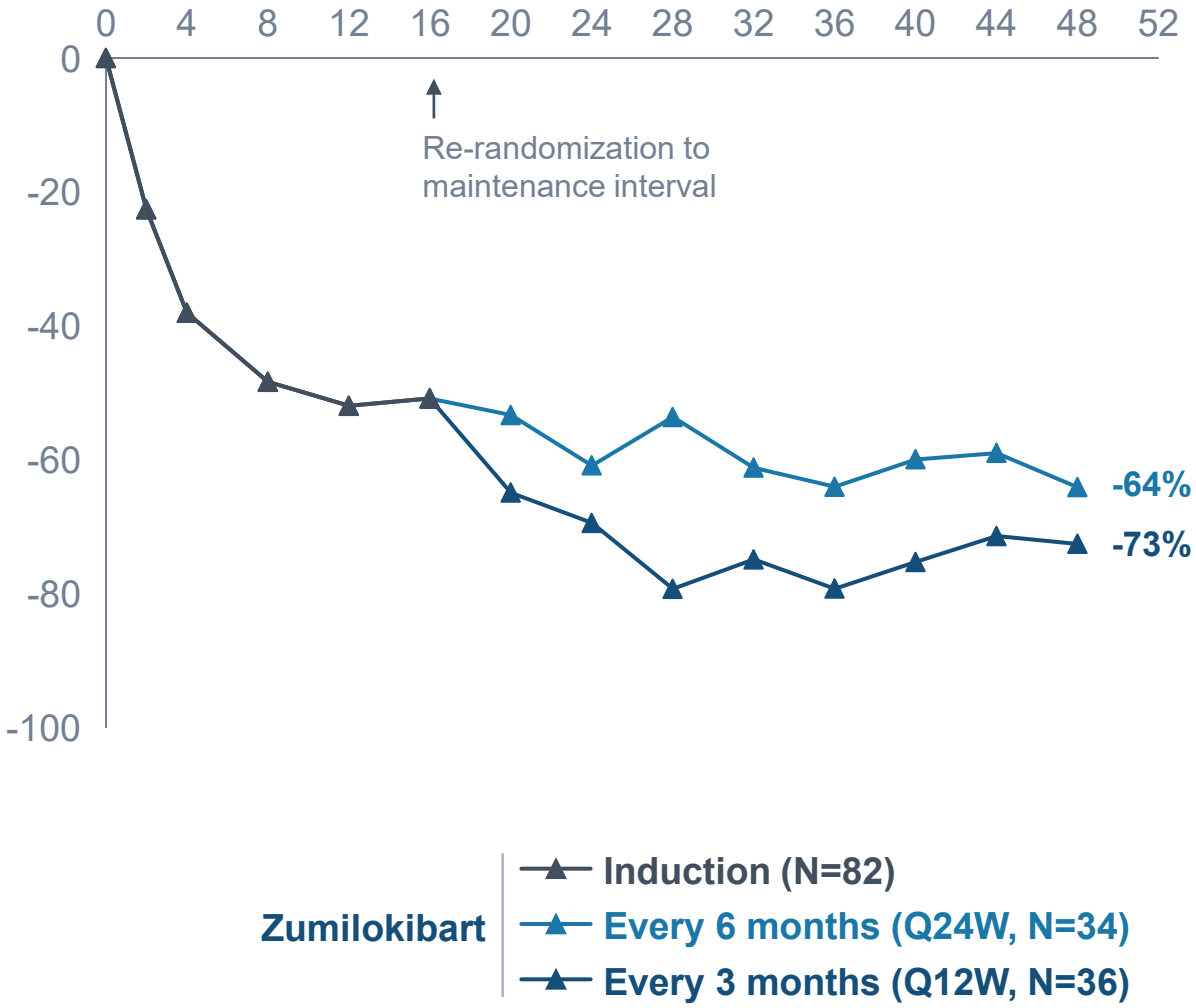


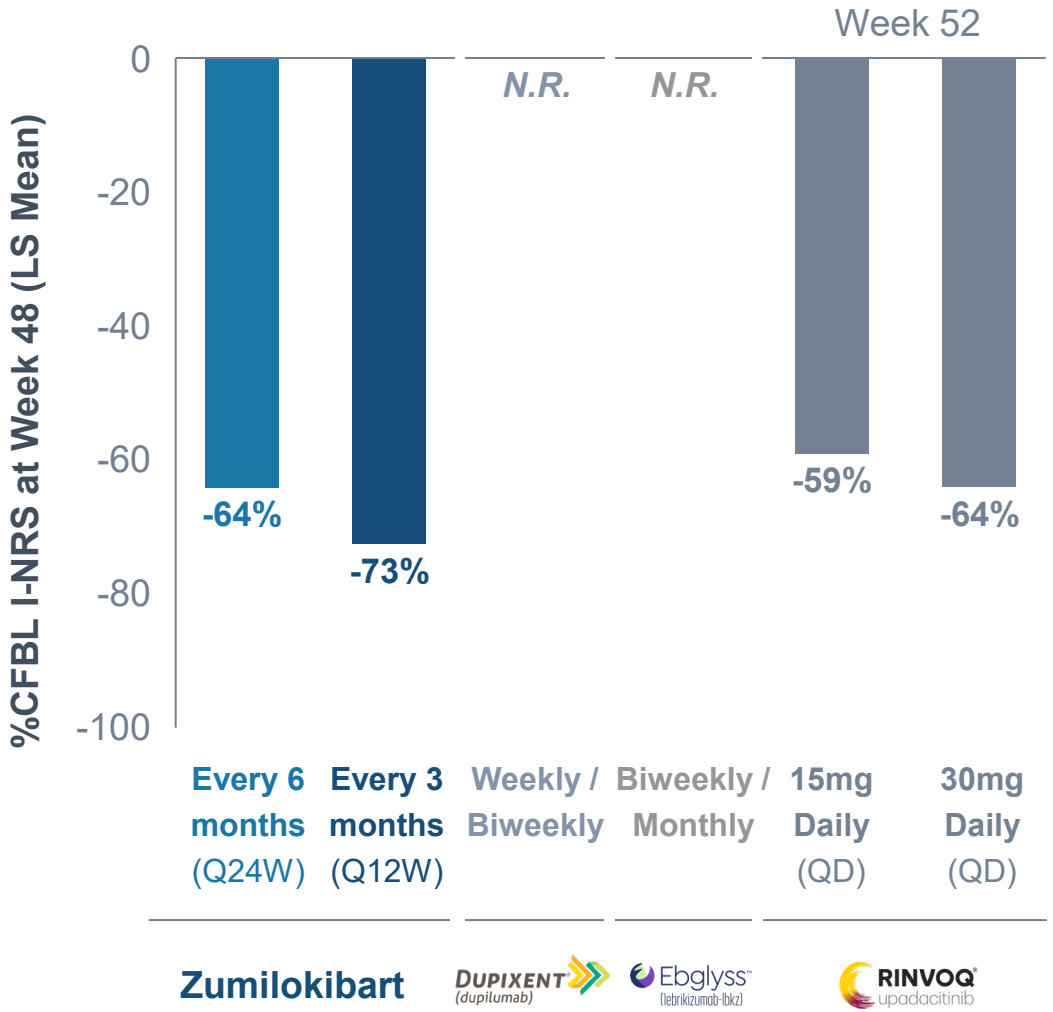
NOTE: For illustrative purposes only. Efficacy data are derived from different clinical trials conducted at different times, with differences in trial design and patient populations. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted. Efficacy data shown for zumilokibart and RINVOQ was evaluated as-observed without imputation for missing data or rescue medication use. Specified N is based on patients per arm at Week 16. Deepening of response was evaluated as observed based on the change in response rate from Week 16 (induction mITT population) to Week 52 (maintenance mITT population) for Q12W or Q24W cohorts.

SOURCE: **RINVOQ** Simpson et al Jama Dermatol 2022 (Measure Up 1/2, average across both trials; observed case (OC) analysis).

Zumilokibart Itch-NRS reduction deepened by 13-22 percentage points

%CFBL I-NRS (LS mean)



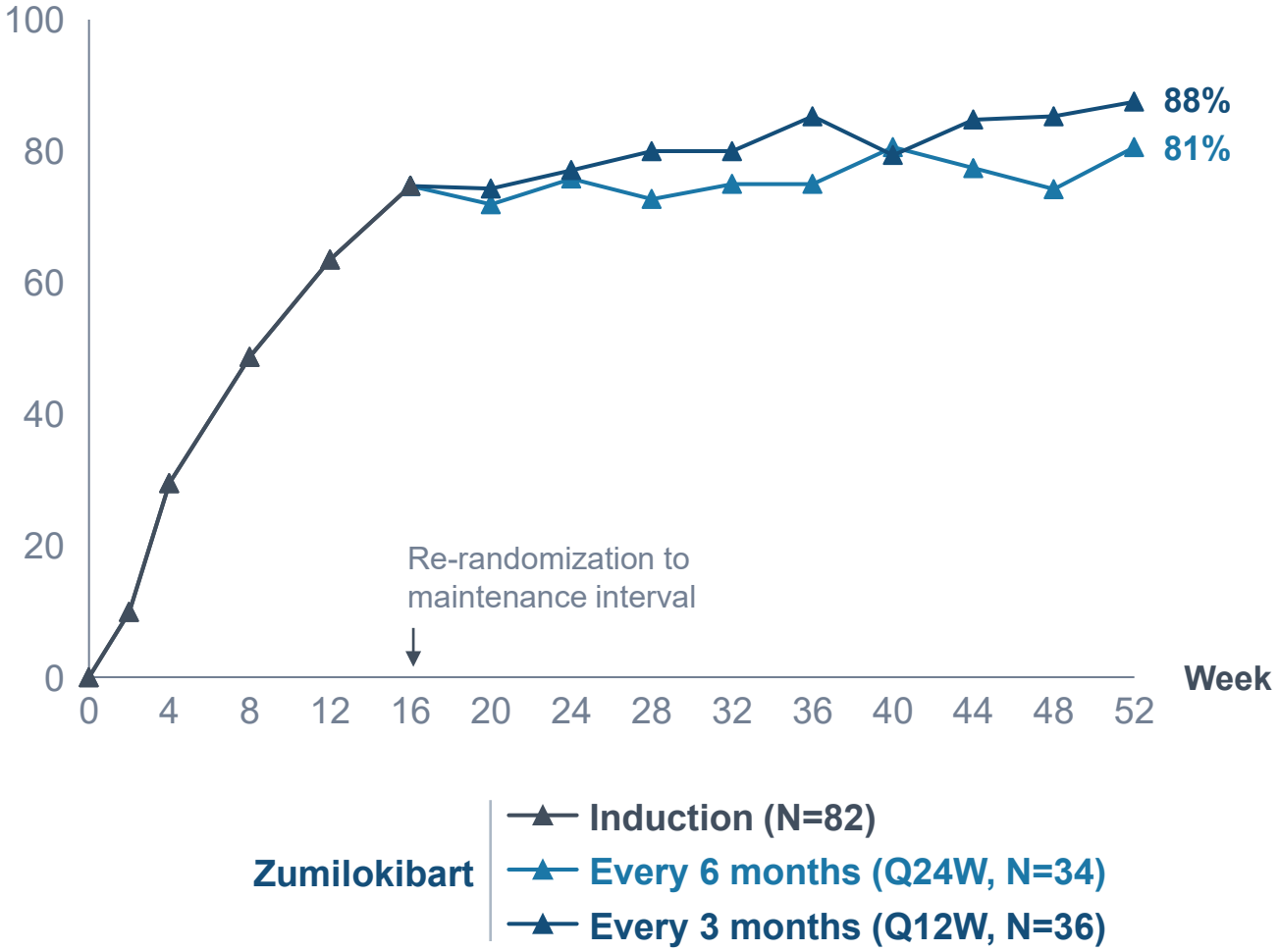


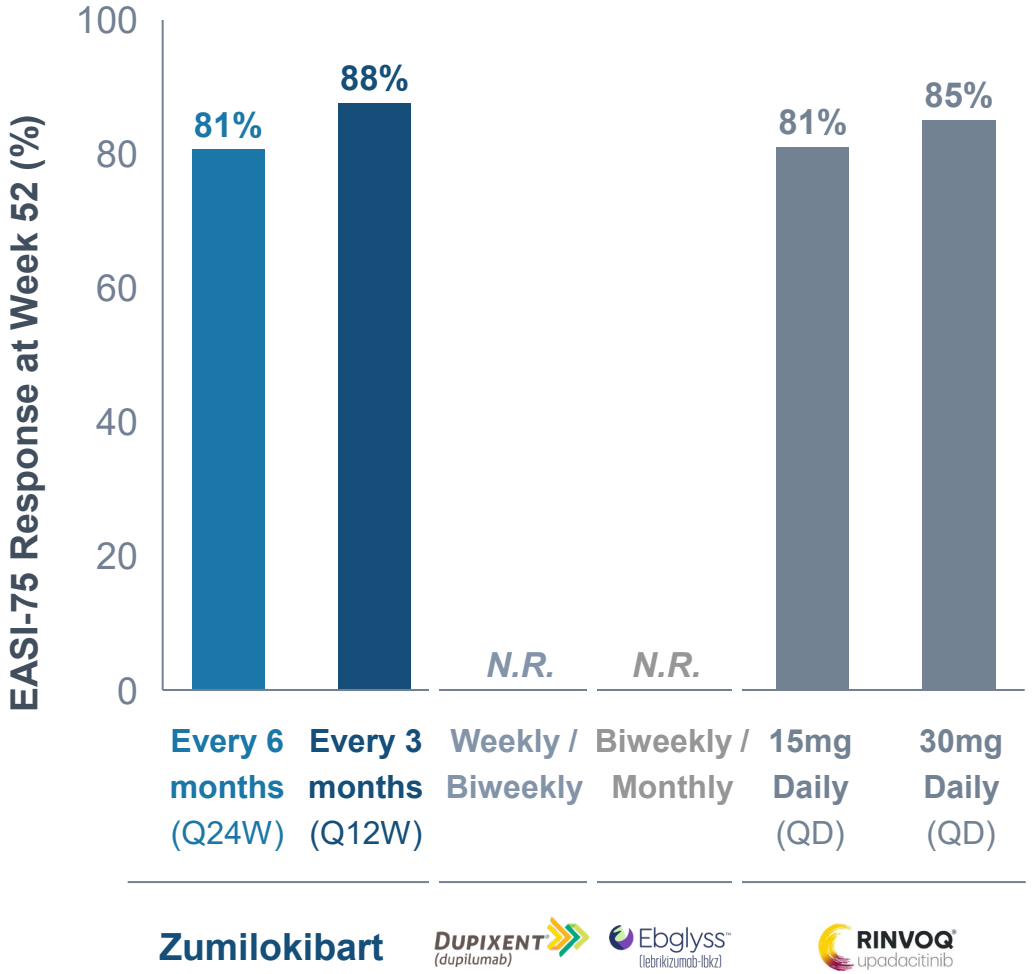
NOTE: For illustrative purposes only. Efficacy data are derived from different clinical trials conducted at different times, with differences in trial design and patient populations. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted. Efficacy data shown for zumilokibart and RINVOQ was evaluated as-observed without imputation for missing data or rescue medication use. Specified N is based on patients per arm at Week 16. Deepening of response was evaluated as observed based on the change in response rate from Week 16 (induction mITT population) to Week 48 (maintenance mITT population) for Q12W or Q24W cohorts.

SOURCE: **RINVOQ** Simpson et al Jama Dermatol 2022 (Measure Up 1/2, average across both trials; observed case (OC) analysis).

Zumilokibart EASI-75 responses deepened by 6-13 percentage points

EASI-75 Response (%)





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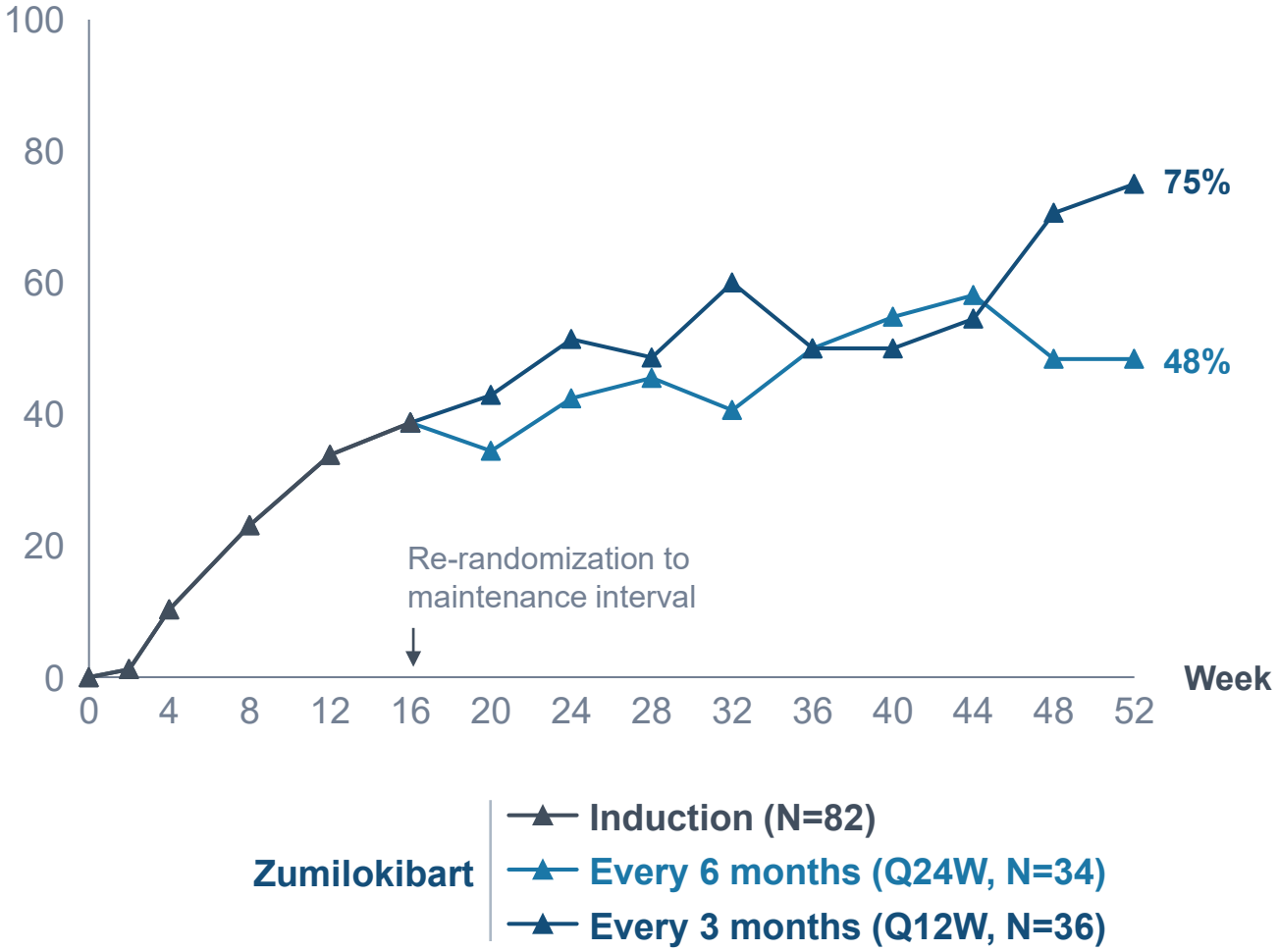
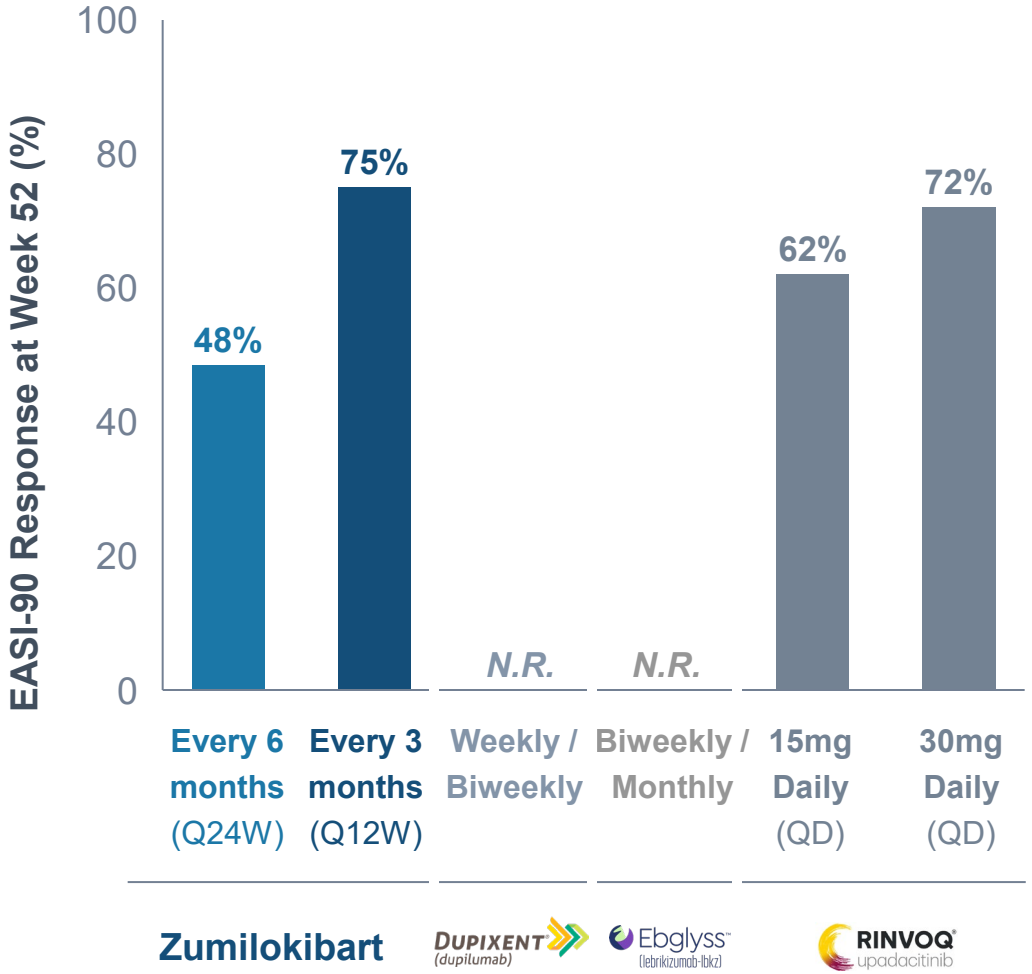
SOURCE: **RINVOQ** Simpson et al Jama Dermatol 2022 (Measure Up 1/2, average across both trials; observed case (OC) analysis).

Zumilokibart EASI-90 responses deepened by 10-36 percentage points

EASI-90 Response (%)



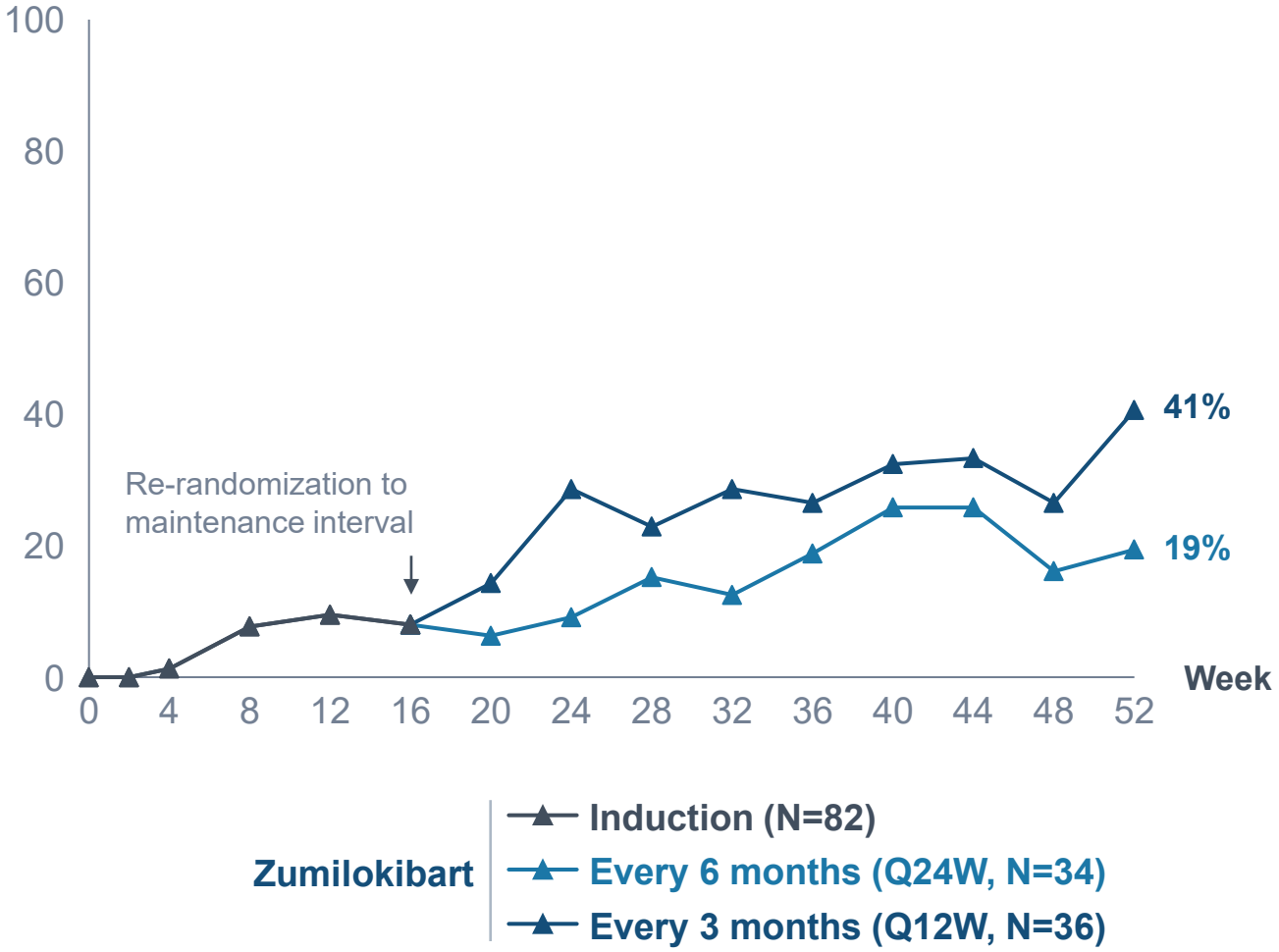


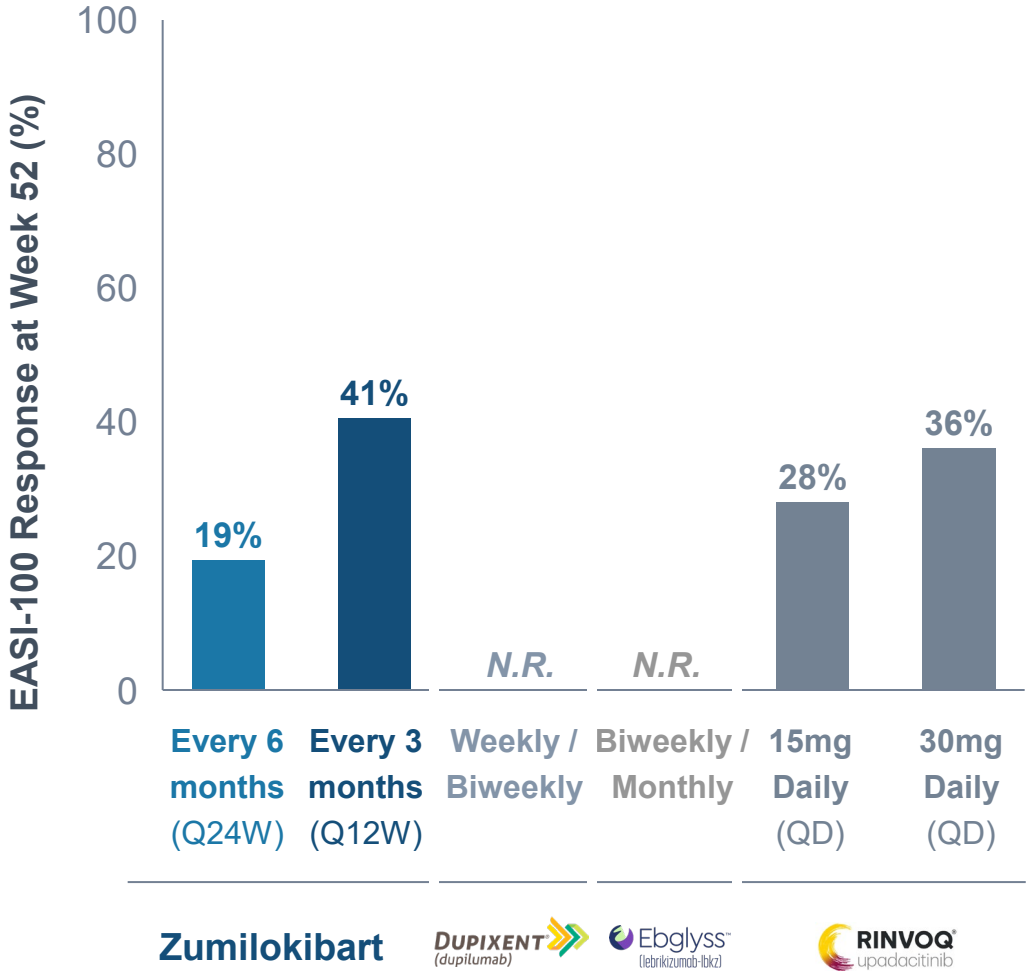
NOTE: For illustrative purposes only. Efficacy data are derived from different clinical trials conducted at different times, with differences in trial design and patient populations. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted. Efficacy data shown for zumilokibart and RINVOQ was evaluated as-observed without imputation for missing data or rescue medication use. Specified N is based on patients per arm at Week 16. Deepening of response was evaluated as observed based on the change in response rate from Week 16 (induction mITT population) to Week 52 (maintenance mITT population) for Q12W or Q24W cohorts.

SOURCE: **RINVOQ** Simpson et al Jama Dermatol 2022 (Measure Up 1/2, average across both trials; observed case (OC) analysis).

Zumilokibart EASI-100 responses deepened by 11-33 percentage points

EASI-100 Response (%)





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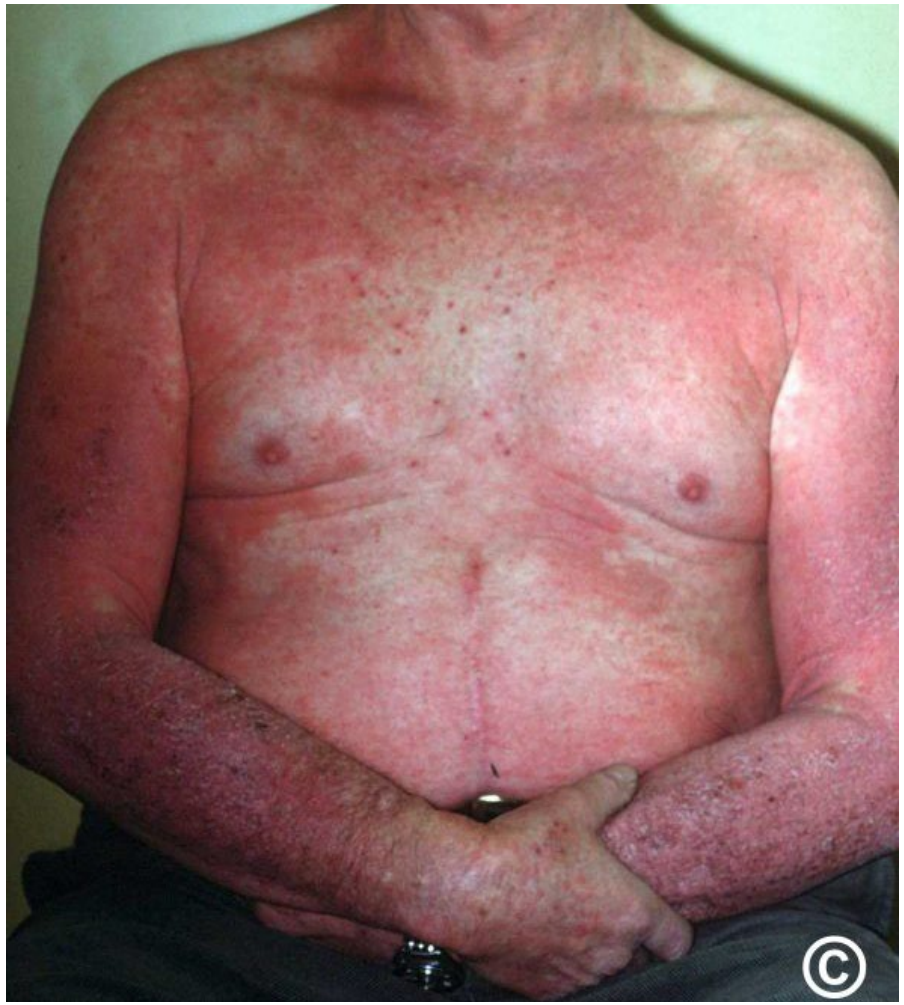
SOURCE: **RINVOQ** Simpson et al Jama Dermatol 2022 (Measure Up 1/2, average across both trials; observed case (OC) analysis).

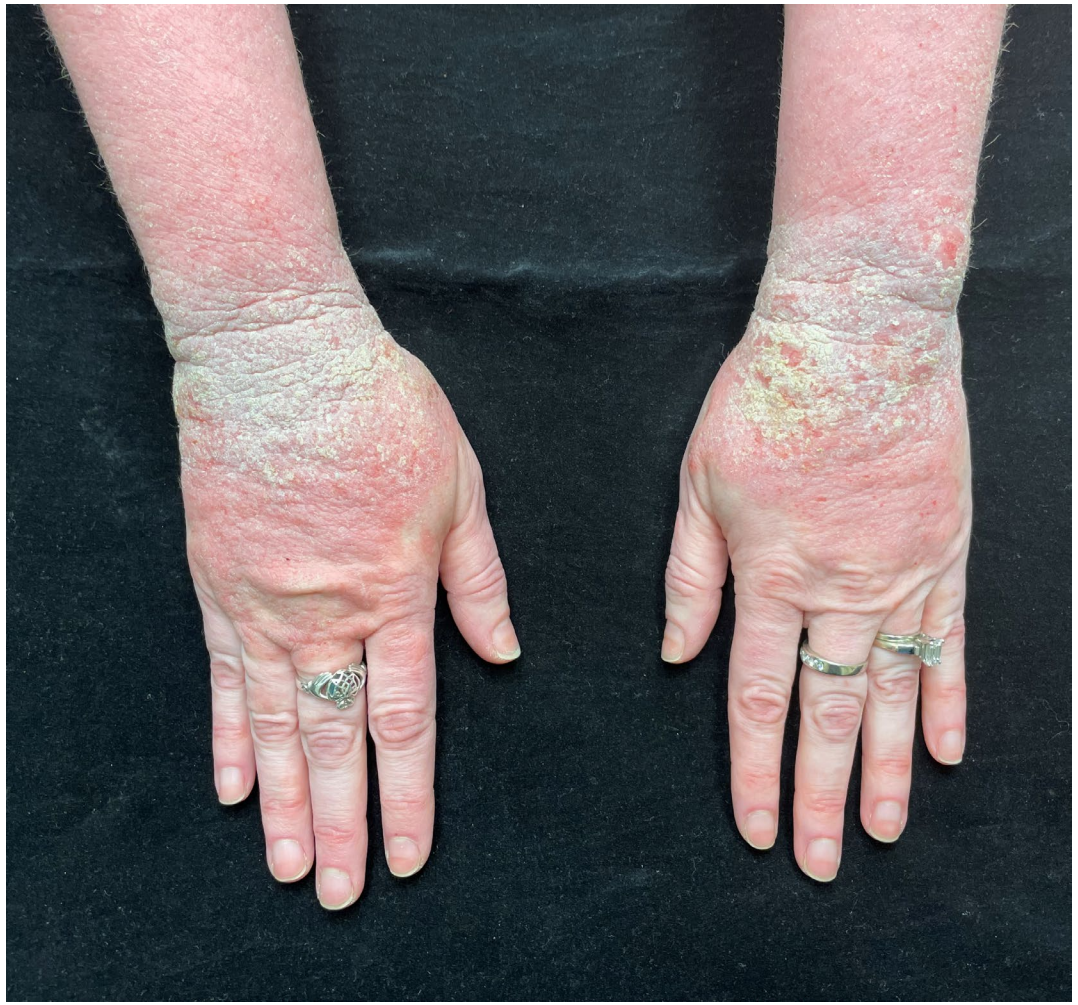
Mass General Brigham

Unmet Need in Atopic Dermatitis

Ruth Ann Vleugels, MD, MPH, MBA
Heidi and Scott C. Schuster Distinguished Chair in Dermatology
Director, Atopic Dermatitis Program
Brigham & Women's Hospital Department of Dermatology
Professor of Dermatology, Harvard Medical School

Atopic dermatitis is a severe, systemic disease



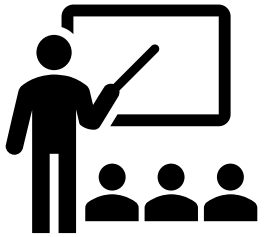


1) Primary Care Dermatology Society

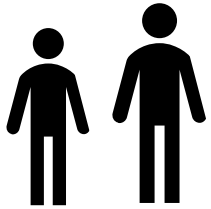
Atopic dermatitis has a profound impact on patient quality of life

Children

Loss of sleep



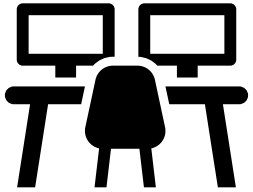
Absence from school



Growth restriction

Adults

Depression



Work sick leave

Reduced physical activity

Healthcare system

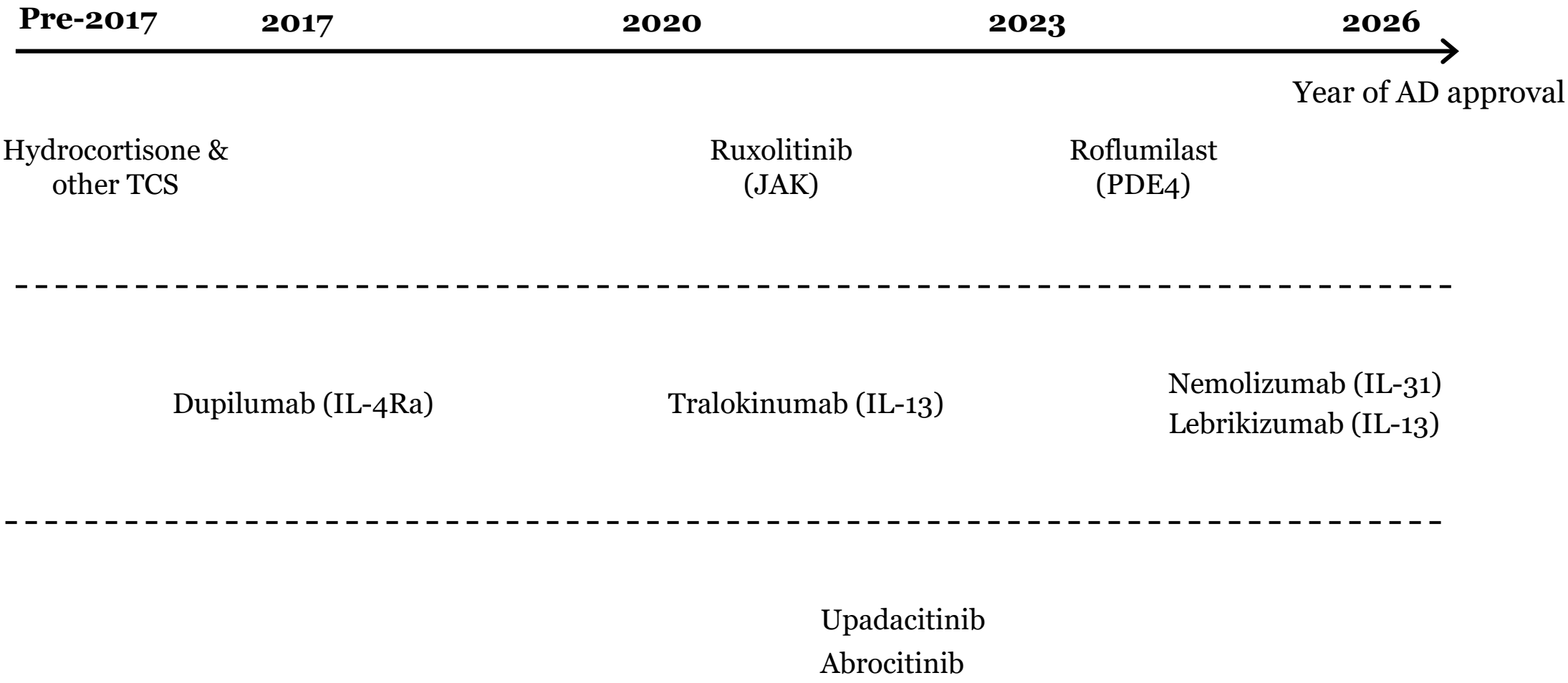
Specialist consultations

Hospitalizations

Annual cost burden

1) Bridgman et al., 2018. Ann Allergy Asthma Immunol. 2) Irish Skin Foundation.

Approval of new therapies has improved AD care



1) Symons et al., *Journal of Drugs in Dermatology* 2025

Despite multiple available treatment options for AD, unmet need remains significant

Therapy	Target	Strengths	Limitations
Dupilumab	IL-4Ra	• Significant lesion benefit • Well tolerated	• Dosing frequency (every 2 weeks)
Lebrikizumab	IL-13	• Significant lesion benefit • Well tolerated	• Dosing frequency (every 4 weeks)
Nemolizumab	IL-31	• Rapid and substantial itch relief • Well tolerated	• Limited improvement in rash
Upadacitinib/ Abrocitinib	JAK	• Rapid onset of action with substantial lesion benefit and itch relief • Oral route of administration	• Safety liabilities (boxed warning) • Dosing frequency (daily)

1) Dupixent USPI, 2) Ebglyss USPI, 3) Nemluvio USPI, 4) Rinvoq USPI

Zumilokibart could address several unmet needs in AD[1]

- Although newer therapies have greatly improved the lives of patients with AD, substantial unmet need still exists for therapies that are both safe and effective as well as have the ability to reduce injection burden
- Zumilokibart demonstrated strong clinical response at week 16 and responses were maintained with every 3-month and every 6-month dosing
- Deep responses on skin and itch were achieved in a substantial proportion of patients by week 52, including on EASI-100, which represents completely clear skin
- Zumilokibart was well-tolerated across both dosing regimens with a safety profile generally in line with the IL-4/13 class
- Zumilokibart has the potential to improve the lives of patients with AD by providing long-term disease control with only 2-4 maintenance injections per year

1) Safety and 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.

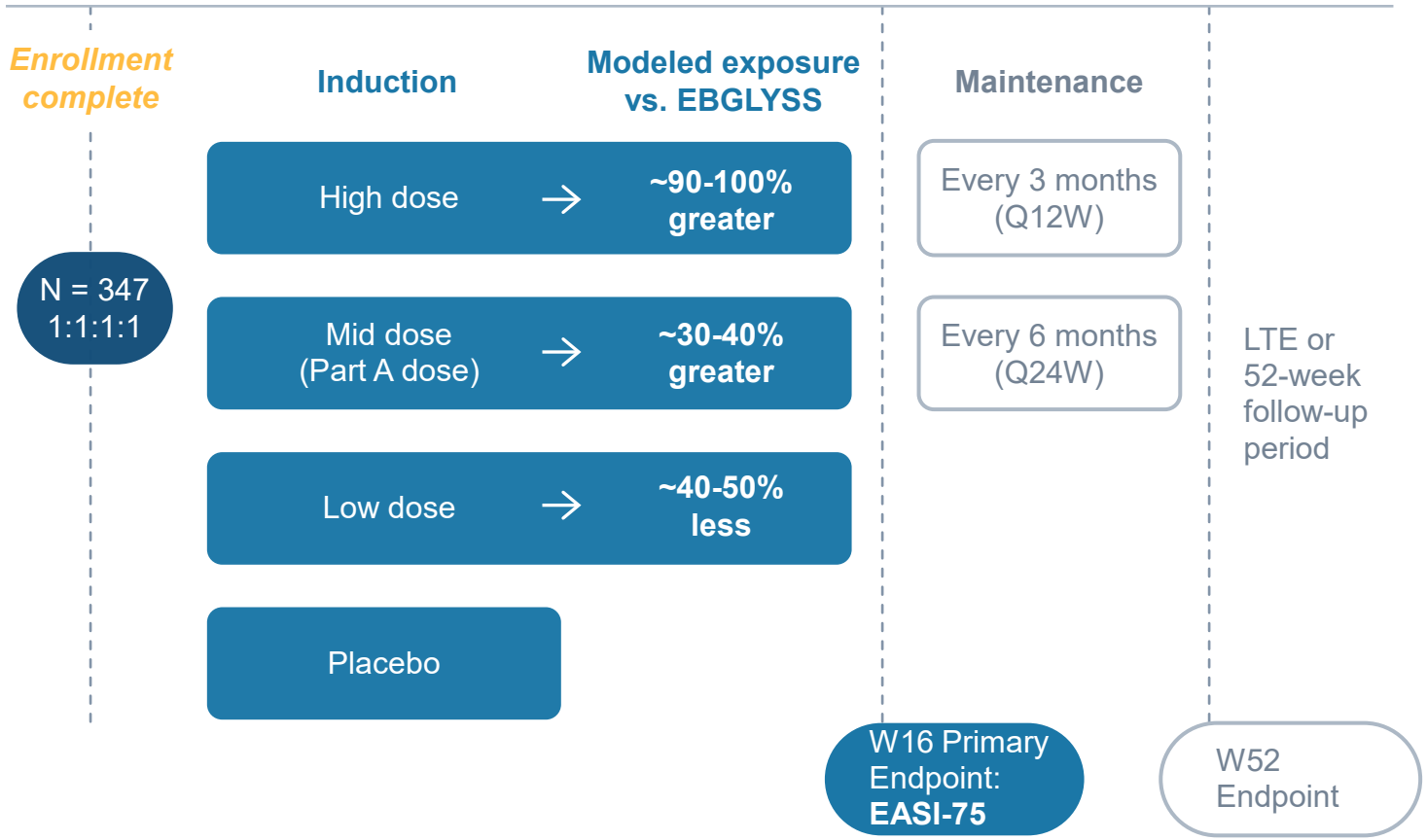
Zumilokibart Development Program

Kristine Nograles, MD
SVP, Clinical Development & Medical Affairs

Part B has completed enrollment; planned Q2 2026 readout potentially enables Phase 3 initiation in 2026

Zumilokibart Part B trial design

Mod-Sev AD: EASI ≥16, vIGA ≥3, BSA ≥10%, up to 20% biologic experienced



Week 16 readout expected in Q2 2026 to support Phase 3 dose selection

Phase 3 studies expected to initiate in 2H 2026

Zumilokibart launch planned in 2029

NOTE: Phase 3 and launch plans subject to clinical and regulatory outcomes. EASI = Eczema Area and Severity Index. vIGA = validated Investigator Global Assessment for Atopic Dermatitis. BSA = body surface area. LTE = long term extension.

Beyond zumilokibart in AD, ASPIRE and ELEVATE dose-ranging trials could enable Phase 3 for multiple blockbuster indication expansions

	Dermatology	Respiratory	Gastroenterology
TA PoC achieved	✓ Positive Phase 2 Part A data for **zumilokibart** in AD	✓ Positive Phase 1b data for **zumilokibart** in asthma	✓ Positive Phase 3 data for IL-13 inhibition in EoE[1]
Dose-ranging trial	**APEX AD Part B 16-week** Q2 2026 expected readout	**ASPIRE Asthma Phase 2** Plans TBA this year	**ELEVATE EoE Phase 2** Plans TBA this year
Expansion potential	• BP • CSU • Cold Inducible Urticaria • Prurigo Nodularis	• Allergic Rhinitis (perennial) • COPD • CRSwNP	• EGID (non-EoE)

Optimized dose in each TA could enable straight to Phase 3 approach for add'l expansions

NOTE: [1]Cendakimab positive Phase 3 in EoE (Dellon SE et al NEJM Evid 2025). Phase 3 and launch plans subject to clinical and regulatory outcomes. BP =Bullous Pemphigoid. CSU = Chronic Spontaneous Urticaria. COPD = Chronic Obstructive Pulmonary Disease. CRSwNP = Chronic Rhinosinusitis with Nasal Polyps. EGID = Eosinophilic Gastrointestinal Disorders.

Building a Leading I&I Company

Michael Henderson, MD
Chief Executive Officer

Zumilokibart could be the next clearly differentiated first line product to launch in AD

Transformative Dosing

Zumilokibart

2-4

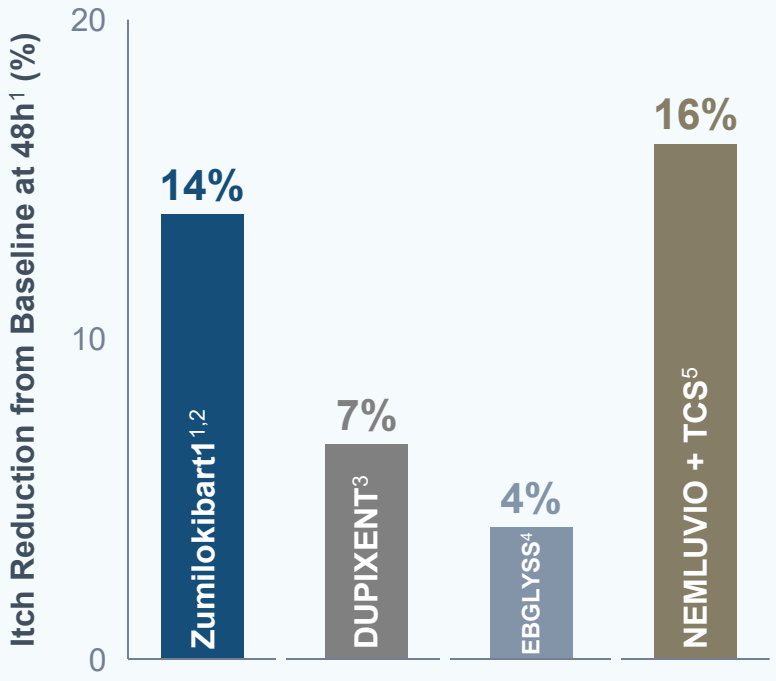
dosing days per year

DUPIXENT

26

dosing days per year

Rapid Itch Relief in 48 Hours



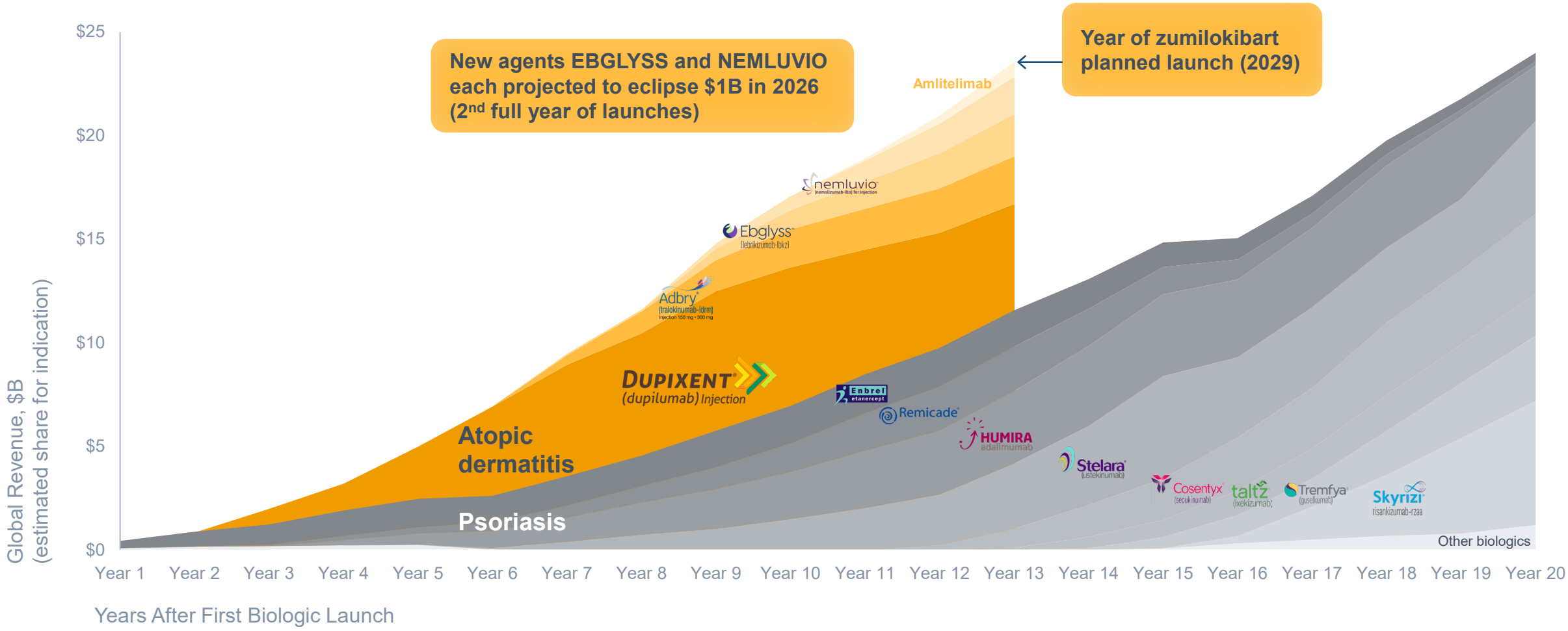
Robust Lesion and Itch Control that Deepens

	Week 52[6]
EASI-75	88%
IGA 0/1	72%
EASI-90	75%
EASI-100	41%
Itch-NRS	-73%

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. Zumilokibart data shown based on as-observed analysis without imputation for missing data. Expected launch subject to clinical outcomes and regulatory approval. I-NRS = itch numerical rating scale. TCS = topical corticosteroids.

SOURCE: [1] Placebo-adjusted I-NRS Percent Reduction From Baseline (LS mean, 48h). [2] **ZUMILOKIBART** APEX Part A (as observed). [3] **DUPIXENT** Silverberg et al. J. Am. Acad. Dermatol. 2020. (SOLO 1&2; digitized pooled data for 300mg Q2W vs placebo). [4] **EBGLYSS** Yosipovitch et al. BJD. 2024. (ADvocate 1&2, straight average of both trials based on digitized data for 250mg Q2W vs placebo). [5] **NEMLUVIO** Silverberg et al. J. EADV 2021 (Ph2b; digitized data for 30 mg Q4W vs placebo). [6] **ZUMILOKIBART** APEX Part A Q12W cohort (as observed analysis); Itch-NRS data is at Week 48.

Apogee has the potential to become a leader in a future $50B+ market



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. Future $50B AD market size based on EvaluatePharma and company projections. Actual market size may differ materially. Expected 2029 launch subject to clinical outcomes and regulatory approval.

2026 is becoming a transformational year for Apogee

Well-capitalized to deliver key milestones with $903M in cash[1] and runway into 2H 2028

Expanding zumilokibart beyond atopic dermatitis

- ✓ Q1 2026: Asthma Phase 1b positive data
- 2H 2026: Expect to announce clinical trial plans in asthma and EoE

Demonstrated potential best-in-class dosing for zumilokibart in a potential future $50B+ AD market

- ✓ Q1 2026: APEX Phase 2 Part A 52-week positive data

Optimizing Phase 3 dose to advance zumilokibart into late-stage development

- Q2 2026: APEX Phase 2 Part B 16-week expected readout
- 2H 2026: AD Phase 3 planned initiation

Serial innovation in atopic dermatitis with first-in-class APG279 combination[2]

- 2H 2026: AD Ph1b expected readout (vs DUPIXENT; fully enrolled)

Apogee poised for sustained leadership in AD starting with potential zumilokibart launch in 2029

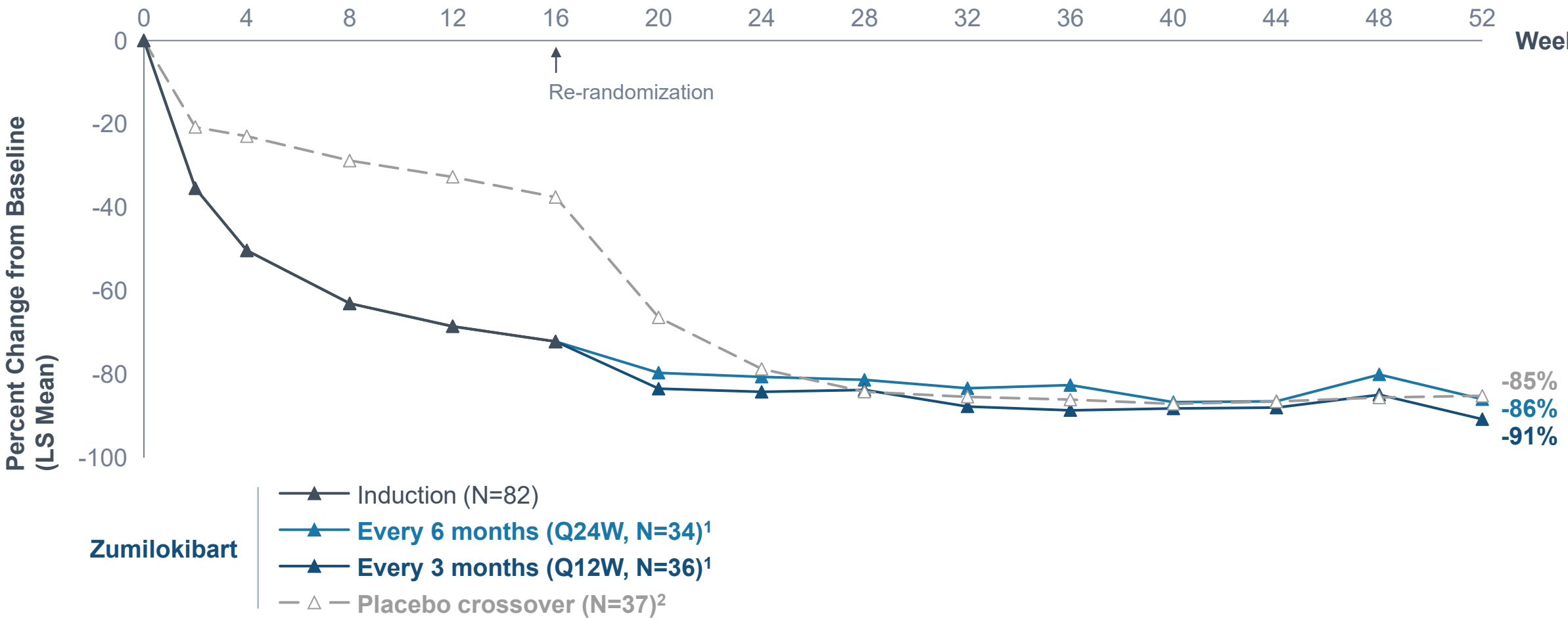
NOTE: [1] Cash, cash equivalents and marketable securities were $902.9 million as of December 31, 2025. [2] APG279 is a combination of zumilokibart and APG990. APG279 is co-administered in the proof-of-concept Phase 1b trial; coformulation planned for future clinical studies and commercialization. Future $50B AD market size based on EvaluatePharma and company projections. Actual market size may differ materially. AD Phase 3 planned initiation is subject to positive Part B clinical results and regulatory alignment. Expected 2029 launch subject to clinical outcomes and regulatory approval.

Apogee /ˈapəjē/ *noun*

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

Patients crossing over to zumilokibart achieved responses by week 52 similar to those of patients that received zumilokibart in induction

Eczema Area and Severity Index Score (percent change from baseline)



NOTE: Efficacy data shown was evaluated as-observed without imputation for missing data or rescue medication use. Specified N is based on patients per arm at Week 16, except for "Induction (N=82)" that is based on Week 0. Induction dose regimen was: 720mg at W0 and W2; 360mg at W4 and W12. Placebo crossover dose regimen was: 720mg at W16; 360mg at W20, W24, W36, W48.

[1] Week 0-16 data: All patients randomized to zumilokibart in induction and received ≥1 dose of study drug in induction; Week 16-52 data: all patients randomized to zumilokibart in induction and received ≥1 dose of study drug in maintenance.

[2] Week 0-16 data: All patients randomized to placebo in induction; Week 16-52 data: all patients randomized to placebo in induction and received ≥1 dose of study drug in maintenance.