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, objectives, goals, strategies, future events, future revenues or performance, financing needs, plans or intentions relating to product candidates, estimates of market size, business trends, efficacy of our proprietary half-life extension technology, the anticipated timing, costs, design and conduct of our current and planned clinical trials for APG777, APG808 and other potential programs, our ability to commercialize our product candidates, if approved, the pricing and reimbursement of our product candidates, if approved, the potential to develop future product candidates, our ability to retain the continued service of our key executives, the potential benefits of strategic collaborations and our intent to enter into any strategic arrangements, the timing and likelihood of success, plans and objectives of management for future operations, and future results of anticipated product development efforts. 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 Quarterly Report of 10-Q for the quarterly period ended September 30, 2023, filed with the SEC on November 13, 2023, 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.

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Engineering antibodies with potential best-in-class profiles in largest I&I indications with highly differentiated dosing

**APPROACH**

Technology approach proven to create antibodies with significantly extended half-life and other optimized properties

**EXPANSION**

Pipeline-in-a-product potential via indication expansion and combination approaches

---

**FOCUS**

Four programs leveraging well-established mechanisms and addressing I&I indications with multi-billion-dollar potential

<table>
<thead>
<tr>
<th>Program / Target</th>
<th>Discovery</th>
<th>Preclinical</th>
<th>Phase 1</th>
<th>Phase 2</th>
<th>Phase 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>APG777 IL-13</td>
<td></td>
<td></td>
<td>Atopic Dermatitis</td>
<td>✓ Aug 2023: Dosed first participant for Phase 1</td>
<td>Mid-2024: Initial SQ PK and safety data in HV</td>
</tr>
<tr>
<td>Same MOA as lebrikizumab</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>APG808 IL-4R(\alpha)</td>
<td></td>
<td></td>
<td>COPD</td>
<td>✓ 4Q 2023: Finalized candidate nomination</td>
<td>2024: Phase 1 initiation in HV</td>
</tr>
<tr>
<td>Same MOA as DUPIPENT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>APG990 OX40L</td>
<td></td>
<td></td>
<td>Atopic Dermatitis</td>
<td>2024: Nominate candidate</td>
<td>2025: Phase 1 initiation in HV</td>
</tr>
<tr>
<td>Same MOA as amlitelimab</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>APG222 Combination IL-13 and OX40L</td>
<td></td>
<td></td>
<td>Atopic Dermatitis</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(^1\) Pending data from our Phase 1 trial of APG777 in healthy participants, we may initiate a Phase 2 trial in asthma and expect to further evaluate opportunities to develop APG777 for other I&I indications, including alopecia areata, chronic rhinosinusitis with nasal polyps, chronic spontaneous urticaria, eosinophilic esophagitis and prurigo nodularis.
Apogee Therapeutics 2023 Year in Review
Advancing best-in-class antibodies in large I&I indications

**APG777 PHASE 1 INITIATED READOUT MID-2024**
Trial initiation beat guidance – Anticipated Phase 1 PK readout de-risks platform of half-life extended programs

**APG808 CANDIDATE FINALIZED**
Phase 1 initiation in healthy volunteers anticipated in 2024

**STRONG CASH POSITION* WITH RUNWAY INTO 4Q 2026**
Raised $345M in July IPO – One of the top-performing biotech IPOs of 2023 in a challenging year

**ENHANCED TEAM AND BOARD**
Attracted world-class talent and industry experts to our team and Board of Directors

* $423M total cash and marketable securities as of September 30, 2023
Apogee is pursuing the largest I&I markets with a highly de-risked approach

Population size, MM
Moderate or severe in 7 Major Markets

LARGE I&I INDICATIONS

<table>
<thead>
<tr>
<th>Large I&amp;I Indications</th>
<th>Apogee’s Potential Indications</th>
</tr>
</thead>
<tbody>
<tr>
<td>MG (Myasthenia gravis)</td>
<td>0.1</td>
</tr>
<tr>
<td>HS (Hidradenitis suppurativa)</td>
<td>0.4</td>
</tr>
<tr>
<td>IBD (Inflammatory bowel disease)</td>
<td>1.4</td>
</tr>
<tr>
<td>PsA (Psoriatic arthritis)</td>
<td>2.7</td>
</tr>
<tr>
<td>PsO (Psoriasis)</td>
<td>9.2</td>
</tr>
<tr>
<td>COPD (Chronic obstructive pulmonary disease)</td>
<td>9.4</td>
</tr>
<tr>
<td>Asthma</td>
<td>15.2</td>
</tr>
<tr>
<td>AD (Atopic dermatitis)</td>
<td>25.1</td>
</tr>
</tbody>
</table>

1 The 7 Major Markets are US, Japan, Germany, France, Italy, Spain, and UK. MG = Myasthenia gravis; HS = Hidradenitis suppurativa; IBD = Inflammatory bowel disease; PsA = Psoriatic arthritis; PsO = Psoriasis; COPD = Chronic obstructive pulmonary disease; AD = Atopic dermatitis.

Source: Company filings, annual reports, press releases, analyst forecasts, academic journals, GlobalData, EvaluatePharma, Clarivate.
Apogee mAbs are engineered for best-in-class properties, including half-life extension.

Based on clinically-validated epitopes with performance across five properties:

- **Backbone**: Designed to maximize antibody recycling. Drug exists at higher levels for longer effect.
- **Potency**: Optimizes exposures.
- **PK**: Decreases variability. Increases half-life.
- **Stability**: Drug exists at higher levels for longer effect.
- **Viscosity**: Potency

Viscosity
APG777 Phase 1 clinical trial objectives

- Establish **safety** and pharmacokinetic profile
- Set **Phase 2 induction regimen** to achieve at least equivalent exposures to lebrikizumab
- Determine **maintenance dosing regimens** to sustain exposures similar to lebrikizumab

**Mid-2024**: confirm potential for best-in-class dosing intervals

**Dosing Goal**: every 2 or 3 months (vs. every 2-4 weeks for current SoC)

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1 Exposure target based on C\textsubscript{trough} in maintenance, the minimal concentration of APG777 to have similar exposures to lebrikizumab
2 Based on FDA label for DUPIXENT\textsuperscript{TM} and ADBRY\textsuperscript{TM} and EMA public assessment report for EBGLYSS\textsuperscript{TM}
Phase 1 PK parameters including half-life will determine APG777’s potential differentiation.

**Illustrative modeled exposure levels at indicated dosing regimen over 24-weeks**

- **Every 8-week dosing**
- **Every 12-week dosing**

**Share preference for new initiations based on survey of practicing dermatologists**

- **APG777 Target Product Profile with 8- to 12-week dosing (assuming equivalent efficacy and safety to DUPIXENT™)**
- **Standard-of-care: 2-week dosing**

---

1. Based on steady state PK simulations made with parameters for APG777 identical to lebrikizumab except changes in dose and $k_{eardose}$; actual dosing interval tested in Ph2 will depend on multiple PK parameters from Ph1 including half-life
2. Exposure target was based on modeled $C_{\text{rough}}$ for lebrikizumab Q4W 250mg dosing (31 mg/L)
3. In 2023, Apogee conducted a single-blinded market research survey of practicing dermatologists (n=25) to determine intent to use a product with APG777 Target Product Profile assuming every 8- or 12-week maintenance dosing and equivalent efficacy and safety to DUPIXENT
4. Market research survey found that dermatologist share preference for new initiations was 91% assuming 8-week dosing and 92% assuming 12-week dosing
Mid-2024 Catalyst: APG777 PK readout is a key de-risking milestone

**Antibody Attributes**
- Clinically validated IL-13 target
- Epitope overlaps with lebrikizumab’s
- Equivalent or better potency vs. 1st generation mAbs across relevant pre-clinical assays
- Optimized and differentiated PK profile

**Commercial Potential**
- Precedent regulatory paths to approval
- Large, growing, underserved moderate-to-severe AD market
- Strong demand from physicians and patients for less-frequent administration

**Mid-2024: Initial SQ PK data may confirm best-in-class profile**
Phase 1 ongoing with key PK readout in mid-2024

Trial design elements

Double-blind, placebo-controlled, first-in-human trial

Single ascending dose component with a nested multiple ascending dose component

N ~40

8 per cohort with 6 participants treated with APG777 and 2 participants treated with placebo

Key inclusion criteria: healthy adult participants

Primary endpoint: safety

Secondary endpoints: PK, ADA

Single ascending dose¹

Dose 1 (SQ) x 1 dose

Dose 2 (SQ) x 1 dose

Dose 3 (SQ) x 1 dose

Multiple ascending dose²

Dose 1 (SQ) x multiple doses

Dose 2 (SQ) x multiple doses

Dose 3 (SQ) x multiple doses

Mid-2024: Present APG777 safety and PK, including potentially extended half-life, optimized exposures, and low variability

¹ SAD and MAD dose ascension will ultimately be determined by the SRC (Scientific Review Committee) based on available data.
² MAD doses will ultimately be determined by the SRC based on available data and pharmacokinetic needs. Different doses or schedules may be used at the discretion of the SRC and Sponsor.
AD represents a larger opportunity than psoriasis; AD biologics penetration mirrors early years of psoriasis

Population size, MM
Moderate or severe in 7 Major Markets¹, 2020

Psoriasis

Atopic dermatitis

9.2MM
$30B+ market²

25.1MM
~3x larger patient population

Psoriasis expected to be a $30B+ market; atopic dermatitis (AD) represents a larger opportunity

Penetration of approved systemic therapy in AD expected to ramp 8% → 25%+ by 2032

Penetration in years after launch (US)³

<table>
<thead>
<tr>
<th># Approved therapies:</th>
<th>Year 5</th>
<th>Year 20</th>
</tr>
</thead>
<tbody>
<tr>
<td>AD</td>
<td>8%</td>
<td>24%</td>
</tr>
<tr>
<td>Psoriasis</td>
<td>5%</td>
<td>21</td>
</tr>
</tbody>
</table>

More convenient dosing could potentially expand AD biologics’ penetration beyond projected 25%+

¹ The 7 Major Markets are US, Japan, Germany, France, Italy, Spain, and UK. ² $30B+ projected market size in 2028 and beyond, including both biologics and small molecules. ³ EvaluatePharma and Clarivate. Source: Company 10-K filings, annual reports, press releases, analyst forecasts, GlobalData.
Psoriasis, an analog to AD, represents an expanded market increasingly focused on improved dosing

Most patients respond (83-89% PASI 75)

Biologics with psoriasis approval year

Maintenance dosing for some new agents is Q8W – Q12W

Note: 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 and patient populations. As a result, cross-trial comparisons cannot be made. No head-to-head trials have been conducted among all biologics shown.

The AD market is where psoriasis was ~15 years ago

Note: Only Dupixent and Adbry are approved. Source: 1. Lebrikizumab 250mg Q2W Ph3 avg. Silverberg JI et al. AAD 2022 2. Dupilumab 300 mg Q2W mono Ph3 avg. DUXPIENT USPI 3. Tralokinumab 300 mg Q2W mono Ph3 avg. Adbry USPI 4. CBP-201 300 mg Q2W Ph2. Connect Biopharma Press Release Jan. 5, 2022 5. Nemolizumab 30 mg Q4W Ph3 avg. Silverberg J et al EADV 2023 6. Rocatinlimab 150mg Q4W Ph2b Guttman-Yassky E et al Lancet 2023 7. Amlitelimab 250mg Q4W Ph2b Weidinger S et al EADV oral presentation 2023. 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.
Apogee’s mAbs are designed to significantly improve therapeutic options for AD

Monotherapies engineered for highly-differentiated dosing potential

Combination therapy for potential greater clinical benefit

Note: *Positioning of Apogee programs is illustrative and not based on clinical trial data. These are based on pre-clinical results only and are illustrative of what we believe we can potentially achieve. Only Dupixent and Adbrly are approved. Source: 1. Lebrikizumab 250mg Q2W Ph3 avg. Silverberg J et al. AAD 2022 2. Dupilumab 300 mg Q2W mono Ph3 avg. DUPIXENT USPI 3. Tralokinumab 300 mg Q2W mono Ph3 avg. Adbrly USPI 4. CBP-201 300 mg Q2W Ph2. Connect Biopharma Press Release Jan. 5, 2022 5. Nemolizumab 30 mg Q4W Ph3 avg. Silverberg J et al EADV 2022 6. Rocatinlimab 150mg Q4W Ph2b Guttman-Yassky E et al Lancet 2023 7. Amlitelimab 250mg Q4W Ph2b Weidinger S et al EADV oral presentation 2023. 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.
APG777 leverages validated biology from lebrikizumab and is designed to be differentiated

- Epitope overlapping; equivalent potency to 1st gen
- $K_D \leq 100 \text{ pM}$
- Conserved MoA

- Novel IP into 2040s
  - Re-humanization on well-behaved human germlines
  - Improved manufacturability profile

- Low volume SQ delivery
  - Ability to formulate at 150 mg/mL with low viscosity

- Extended half-life
  - Prolonged exposure through YTE amino acid substitution for reduced dosing frequency

- Effector-silent backbone
  - hIG1 LALA Fc

Target Product Profile – Designed to be Best-in-Class:
- Efficacy and safety matches lebrikizumab
- $\leq 2 \text{ mL pre-filled autoinjector, same or smaller volume injection than lebrikizumab or DUPIXENT}$
- Every 2-month or every 3-month dosing
APG777 is designed to disrupt Th2 signaling by preventing formation of IL-13Rα1 / IL-4Rα heterodimer

- IL-13 signaling begins with binding of IL-13 to IL-13Rα1
- This forms an inactive complex that then binds to IL-4Rα to create a complete, active heterodimer
- Active IL-13Rα1 / IL-4Rα heterodimer sets off a signaling cascade that leads to:
  - Skin barrier defects
  - Immune cell recruitment
  - Tissue inflammation
  - Lichenification (skin thickening)
  - Pruritis (skin itching)
APG777's epitope overlaps with lebrikizumab, differentiating from other approaches to target IL-13

APG777’s mechanism of action disrupts Th2 signaling by blocking IL-4Rα binding and subsequent formation of the IL-13Rα / IL-4Rα heterodimer
Lebrikizumab and DUPIXENT have similar efficacy across key AD endpoints

Efficacy of biologics in AD (week 16)

- Lebrikizumab and DUPIXENT show consistently high results across all important efficacy parameters
  - Mechanistically, both target the key pathogenic step in AD, the heterodimerization of IL-4Rα and IL-13R1, which may explain the similar efficacy observed
- However, both are dosed every other week, a burden for patients
- Lebrikizumab showed, at minimum, equivalent maintenance efficacy for both Q2W and Q4W dosing, a main differentiator from DUPIXENT

Source: 1 Lebrikizumab 250mg Q2W Ph3 Avg. Silverberg JJ 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 In the 16-week induction phase
Note: 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. Only DUPIXENT and ADBRY are FDA approved.
Lebrikizumab showed greater efficacy with higher doses in Ph2b with no dose-dependent increases in AE rates

**Conjunctivitis rates by dose level in lebri Ph2b**

<table>
<thead>
<tr>
<th>Dose Level</th>
<th>Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placebo</td>
<td>0.0%</td>
</tr>
<tr>
<td>125mg Q4W</td>
<td>1.4%</td>
</tr>
<tr>
<td>250mg Q4W</td>
<td>3.8%</td>
</tr>
<tr>
<td>250mg Q2W</td>
<td>2.7%</td>
</tr>
</tbody>
</table>

**Response at 16 weeks (placebo-adjusted), % by dose level in lebri Ph2b**

- **EASI-75**
  - Placebo: 19%
  - 125mg Q4W: 32%
  - 250mg Q2W: 36%

- **EASI-90**
  - Placebo: 15%
  - 125mg Q4W: 25%
  - 250mg Q2W: 33%

- **IGA 0/1**
  - Placebo: 11%
  - 125mg Q4W: 18%
  - 250mg Q2W: 29%

**No dose-response for conjunctivitis or for other AEs of interest in Ph2b**

With no plateau in efficacy across doses, a higher dose and/or greater exposures could lead to better efficacy.


NOTE: Each regimen included one or more loading doses (LD): 125 mg every 4 weeks (250-mg LD), 250 mg every 4 weeks (500-mg LD), 250 mg every 2 weeks (500-mg LD at baseline and week 2).
Lebrikizumab Ph3 demonstrated a relationship between body weight and exposure and body weight and efficacy

Lebri Ph3 exposure (Ctrough) at 16 weeks, μg/mL

Lebri Ph3 response at 16 weeks (placebo-adjusted), %

Lebrikizumab exposure is inversely correlated with body weight

Relationships between body weight:exposure and body weight:efficacy in induction phase are suggestive of an exposure-response relationship

SOURCE: Lebrikizumab European Public Assessment Report
NOTE: Lebrikizumab 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)
APG777 is as potent as lebrikizumab and DUPIXENT in key preclinical assays

APG777 vs DUPIXENT, ADBRY, and lebrikizumab on key potency assay

<table>
<thead>
<tr>
<th>Assay</th>
<th>Affinity to human IL-13 by SPR</th>
<th>Inhibition of STAT-6 phosphorylation</th>
<th>Inhibition of TARC secretion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measurement</td>
<td>$K_D$ (pM)</td>
<td>$IC_{90}$ (nM)</td>
<td>$IC_{90}$ (nM)</td>
</tr>
<tr>
<td>APG777</td>
<td>78</td>
<td>0.56</td>
<td>1.40</td>
</tr>
<tr>
<td>ADBRY</td>
<td>116</td>
<td>1.34</td>
<td>27.96</td>
</tr>
<tr>
<td>DUPIXENT</td>
<td>0.58</td>
<td>13.41</td>
<td></td>
</tr>
<tr>
<td>Lebrikizumab</td>
<td>131</td>
<td>0.46</td>
<td>1.37</td>
</tr>
</tbody>
</table>

Note: TF-1 is a human erythroblast cell line that proliferates in response to IL-13 and is a widely used functional immune assay.
APG777 NHP half-life is significantly longer than lebrikizumab

APG777 has advantages over lebrikizumab in our NHP head-to-head studies

- **NHP average half-life**
  - **APG777**: 28 days
  - **Lebrikizumab**: 18 days

- APG777 shows extended half-life in NHPs
- APG777 had decreased PK variability with potential for greater consistency in response

APG777 can potentially achieve every 2- or 3-month maintenance dosing vs Q4W for lebrikizumab and Q2W for DUPIXENT

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*Note: N = 3 per group. 2 of 3 animals in the lebri. SQ arm developed ADAs by day 40 and those timepoints associated with ADAs are excluded. For APG777, the average half-life based on individual fits for each animal was 28.2 days IV group and 27.0 days SQ group. For lebri., the average half-life based on individual fits for each animal was 18.1 days IV group and 13.5 days SQ group. SOURCE: Zhu E et al EADV 2023.*
APG777 NHP half-life suggests potential for significant improvement over lebrikizumab in humans

### Indication

<table>
<thead>
<tr>
<th>Indication</th>
<th>NHP half-life, days</th>
<th>APG777 predicted human half-life vs. observed comparators, days</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Atopic Dermatitis</strong></td>
<td></td>
<td>Every 2 months</td>
</tr>
<tr>
<td>APG777 (YTE)*</td>
<td>28</td>
<td>33 (1.2x)</td>
</tr>
<tr>
<td>Lebrikizumab</td>
<td>13-18</td>
<td></td>
</tr>
<tr>
<td><strong>Comparable YTE mAbs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AstraZeneca Beyfortus</td>
<td>40</td>
<td>85-117</td>
</tr>
<tr>
<td>STAR-0215 (YTE) (Plasma Kallikrein)</td>
<td>34</td>
<td>83-117</td>
</tr>
<tr>
<td>Motavizumab-YTE (RSV)</td>
<td>21</td>
<td>70-100</td>
</tr>
<tr>
<td>Depemokimab (YTE) (IL-5)</td>
<td>19</td>
<td>90</td>
</tr>
<tr>
<td>GSK EVUSHELD (YTE) (SARS-CoV-2)</td>
<td>24</td>
<td>43</td>
</tr>
</tbody>
</table>

Note: Half-lives as reported in studies conducted by the sponsor of each of these product candidates or in the label of approved products. Half-lives are not based on head-to-head studies and are derived from different studies at different points in time, with differences in study design. As a result, cross-study comparisons cannot be made. *Based on steady state PK simulations made with parameters for APG777 identical to lebrikizumab except changes in dose and k_e.1

*Positioning of Apogee program is illustrative and not based on clinical trial data and is based only on pre-clinical study results.
Dermatologists view 8-week dosing as the bar for differentiation and adoption

Source: 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.

Note: For providers where likeliness to prescribe Product Y (equivalent efficacy and safety as DUPIXENT™) 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.

Intent to use a product with APG777 Target Product Profile
(Assuming every 2-, 3-, or 6-month maintenance dosing and equivalent efficacy and safety to DUPIXENT™)

<table>
<thead>
<tr>
<th>Dosage Interval</th>
<th>Proportion of new patients (biologic-naïve)</th>
<th>Proportion of switch patients (currently/formerly on a biologic)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Every 2 month</td>
<td>91%</td>
<td>56%</td>
</tr>
<tr>
<td>Every 3 month</td>
<td>92%</td>
<td>57%</td>
</tr>
<tr>
<td>Every 6 month</td>
<td>91%</td>
<td>68%</td>
</tr>
</tbody>
</table>

Source: 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.

Note: For providers where likeliness to prescribe Product Y (equivalent efficacy and safety as DUPIXENT™) 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.
**Strong historical correlation between Phase 2 and 3 data makes APG777 16-week AD data a key catalyst**

Advancing rapidly to 16-week data in 2H 2025 following Phase 1 PK readout in mid-2024

- **Phase 1 objectives**
  - Establish safety and pharmacokinetic profile
  - Set Phase 2 induction regimen to achieve at least equivalent exposures to lebrikizumab
  - Determine maintenance dosing regimens to sustain exposures similar to lebrikizumab

- **6-month GLP toxicology study has been completed** with no notable findings at any dose level tested
  - Enables maintenance dosing testing in our initial Phase 2 trial

**Strong correlation between Phase 2 and 3 results in AD for validated endpoints EASI-75 and IGA 0/1**

**Note:** While JAKi efficacy held up from Ph2 to Ph3, FDA applied a boxed warning to the class due to increased risk of CV events and death; patients must step through biologic to get to JAKi

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**Source:** Ph3 data for DUPIXENT, Rinvoq, Cibinqo, Adbrly is from USPI. Thaci et al Lancet 2016 (DUPIXENT Ph2). Guttmann-Yassky E et al JAMA Dermatol. 2020 (Lebri Ph2). Guttmann-Yassky E et al J All Clin Immunol. 2020 (Rinvoq Ph2). Gooderham MJ et al JAMA Dermatol. 2019 (Cibinqo Ph2). Exposure target based on Ctrough in maintenance, the minimal concentration of APG777 to have similar exposures to lebrikizumab
APG808 targets the same mechanism as Dupixent, which has been validated in COPD

COPD represents area of high unmet and a promising opportunity given recent positive DUPIXENT data

- 10% of the global population >40 yrs
- 3rd Leading cause of death in the US in 2019
- 150K+ People die each year in the US

No biologic therapies are approved for COPD, but DUPIXENT demonstrated promise in two Phase 3s:

- Significant, clinically meaningful reduction in moderate or severe acute COPD exacerbations
- Improved lung function from baseline at 12 weeks compared to placebo with separation from placebo as early as 2 weeks

DUPIXENT produced a significant and clinically meaningful reduction in exacerbations in two Phase 3 studies

- BOREAS
  - p=0.0005
  - 30%

- NOTUS
  - p=0.0002
  - 34%

Source: Bhatt SP et al NEJM 2023; Sanofi press release November 26, 2023, interim analysis, full results not yet disclosed
Treatments for moderate-severe COPD are limited

- **NOTE:** Positioning of Apogee program is illustrative and not based on clinical trial data. Dupixent is not approved for the treatment of COPD.

- **SOURCE:** 1Bhatt SP et al. NEJM 2023; 2Sanofi press release November 26, 2023, interim analysis, full results not yet disclosed

Other than Dupixent, no other late-stage biologic for the treatment of COPD has achieved its primary endpoint, leaving a vast unmet need for dosing beyond Q2W.

- **Highly-differentiated dosing potential and ability to test higher exposures**

**Reduction in COPD exacerbations over 52 weeks (%)**

- **Dosing Interval (weeks)**
  - 0 2 4 6 8

- **Consistent exacerbation reduction in two phase 3 trials in eos-high patients**
  - Dupixent (dupilumab)

- **APG808**

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Asthma, an analog for COPD, shows how biologics can be rapidly adopted when they address unmet needs

Xolair was the first approved biologic for severe asthma, but restrictive label and Black Box Warning limited adoption.

Over a decade later, the approval of biologics with better safety and broader labels drove rapid adoption of biologics in severe asthma.

- **Xolair** (omalizumab)
  - Approved in 2003
  - $3.8B est. peak revenue

- **Nucala** (mepolizumab)
  - Approved in 2015
  - $2.3B est. peak revenue

- **Dupixent** (dupilumab)
  - Approved in 2018
  - $20B+ est. peak revenue
  - (~$4B in asthma)

- **Fasenra** (benralizumab)
  - Approved in 2017
  - $2.8B est. peak revenue

2023: biologic penetration in severe asthma is estimated at >20%

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1 Analysts estimate ~20% of Dupixent revenue is from asthma
Source: Company 10-K filings, annual reports, analyst forecasts, Citeline; EvaluatePharma
APG808 is as potent as DUPIXENT in key preclinical assays

APG808 vs DUPIXENT on key potency assay

Additional in vitro assays support APG808 potency

<table>
<thead>
<tr>
<th>Assay</th>
<th>Affinity to human IL-4Rα</th>
<th>Inhibition of STAT-6 phosphorylation</th>
<th>Inhibition of TARC secretion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measurement</td>
<td>K_D (pM)</td>
<td>IC₉₀ (nM)</td>
<td>IC₉₀ (nM)</td>
</tr>
<tr>
<td>APG808</td>
<td>0.4</td>
<td>1.11</td>
<td>1.25</td>
</tr>
<tr>
<td>DUPIXENT</td>
<td>12</td>
<td>1.93</td>
<td>1.67</td>
</tr>
</tbody>
</table>

Additional preclinical assays demonstrate APG808 and DUPIXENT have an overlapping binding site on IL-4Rα

NOTE: TF-1 is a human erythroblast cell line that proliferates in response to IL-4 induced stimulation and is widely used in functional immune assays. ¹Affinity to human IL-4Rα by determined by KinExA. ²FDA MDR reports DUPIXENT affinity for human IL-4Rα for both monomeric (30 pM) and dimeric (12 pM) forms.
APG808 NHP half-life is significantly longer than DUPIXENT

NHP PK, SQ administration

<table>
<thead>
<tr>
<th>Serum Concentration (µg/mL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1000</td>
</tr>
<tr>
<td>100</td>
</tr>
<tr>
<td>10</td>
</tr>
<tr>
<td>0</td>
</tr>
</tbody>
</table>

Days Post-Injection

APG808 has advantages over DUPIXENT in our NHP head-to-head studies

- APG808 shows extended half-life in NHPs
  - APG808: ~26 days
  - DUPIXENT: ~12 days

- APG808 also showed decreased variability on PK and potential for greater consistency in response

APG808 can potentially achieve 6- or 8-week dosing vs Q2W for DUPIXENT

*NOTE: N = 5 animals per group. 3 of 5 animals in the dupilumab SQ arm developed ADAs by day 35 and those timepoints associated with ADAs are excluded from the half-life estimate based on data through day 56. APG808 and dupilumab preliminary SQ half-lives for 25 mg/kg were 26.4 days and 11.5 days, respectively, based on cumulative fit models across SQ groups for each compound using interim data through day 56. The NHP PK study is ongoing with final data expected out to day 91. Final NHP half-life estimates and PK parameters will be calculated based on full dataset out to day 91.
# APG808 NHP half-life suggests potential for significant improvement over DUPIXENT in humans

<table>
<thead>
<tr>
<th>Indication</th>
<th>NHP half-life, days</th>
<th>APG808 predicted human half-life vs. observed comparators, days</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Every 6 weeks</td>
</tr>
<tr>
<td></td>
<td></td>
<td>42 (1.6x)</td>
</tr>
<tr>
<td>COPD</td>
<td>APG808 (YTE)*</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>DUPIXENT (dupilumab)</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>CDX-0159 (YTE)</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>(c-KIT/CD117)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>VRDN-002 (YTE)</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>(IGF-1R)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>VRDN-003 (YTE)</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>(IGF-1R)</td>
<td></td>
</tr>
</tbody>
</table>

## Predicted half-life range based on comparable YTE mAbs

- Every 6 weeks: 42 (1.6x)
- Every 8 weeks: 59 (2.3x)

## Average of YTE mAbs for receptor targets (2.5x)

- APG808 dosing interval based on PK modeling

¹Positioning of Apogee program is illustrative and not based on clinical trial data and is based only on pre-clinical study results.

NOTE: Half-lives as reported in studies conducted by the sponsor of each of these product candidates or in the label of approved products. Half-lives are not based on head-to-head studies and are derived from different studies at different points in time, with differences in study design. As a result, cross-study comparisons cannot be made. Based on steady state PK simulations made with parameters for APG808 identical to Dupixent except changes in turnover.

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Dupixent was already a top fifteen drug five years into launch and is on track to be one of the largest drugs in the world

Dupixent has expanded its label into multiple blockbuster indications since its first approval in 2017

• DUPIXENT’s mechanism is clinically-validated with five approved indications
• DUPIXENT and APG808 both inhibit IL-4Rα, bind the target at overlapping sites, and have similar potency preclinically
• APG808 is initially being developed in COPD, an indication with few disease-modifying treatments
• APG808 has significant opportunity to expand; DUPIXENT’s approval precedents provide an established development path

**Source:** Drug Discovery & Development. ¹ Consensus estimates per Visible Alpha
APG990 blocks OX40L and potentially rebalances the immune system

OX40L blockade targets Th2, Th17, and Th22 pathways, which have been implicated in numerous I&I conditions.

Upcoming clinical trial readouts could provide PoC for OX40L beyond AD including asthma, hidradenitis suppurativa, alopecia areata, celiac disease, and systemic sclerosis.
OX40L and OX40 inhibition have shown similar efficacy, but OX40L has a clear advantage on safety

<table>
<thead>
<tr>
<th>IGA 0/1 response at Week 16</th>
<th>EASI-75 at Week 16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amlitelimab (OX40L)¹</td>
<td>22</td>
</tr>
<tr>
<td>Rocatinlimab (OX40)²</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>42</td>
</tr>
</tbody>
</table>

- In Phase 2b, rocatinlimab (OX40) was associated with pyrexia (17% of patients) and chills (11% of patients).
- In contrast, no pyrexia³ or chills for amlitelimab (OX40L) in Phase 2b.

Source: ¹Amlitelimab 250mg Q4W Weidinger et al. EADV oral presentation (2023). ²Rocatinlimab avg. of 150mg Q4W and 600mg Q4W Guttman-Yassky E et al. Lancet (2023). ³EADV presentation stated no pyrexia “within 72 hours of injection”. Note: 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.
APG222 combines two validated mechanisms and may enhance benefit in AD and other I&I indications

- OX40L treatment reduces circulating IL-13 levels supporting the potential for synergy with IL-13 blocker
- Combination potentially enables wider subset of patients to achieve deeper clinical responses and durable remission in AD and other I&I indications

Given strong mechanistic rationale, APG222 program will explore combination potential
Corporate
Experienced team with proven history of clinical development and commercial execution
Board of Directors with industry-leading development, commercial and management expertise
Executing a comprehensive strategy to address the significant opportunity in I&I indications

**OUR STRATEGY**

- Target known biologic drivers to advance candidates into and through clinical development for I&I indications
  - APG777 in AD & asthma
  - APG808 in COPD
  - Programs targeting OX40L and the dual inhibition of OX40L and IL-13 with broad application in I&I

- Maximize the potential of our programs through indication expansion

- Expand existing collaborations and evaluate new opportunities that broaden the impact of Apogee treatments for patients

**APOGEE OPPORTUNITY**

- Established paths to commercializing I&I products

- Multibillion dollar market opportunities in growing I&I indications

- Steady cadence of clinical and development milestones across broad pipeline

- Enthusiasm for Apogee approach among industry leaders and physicians
Multiple anticipated milestones in next two years, including 16-week POC data for APG777 in 2025

- **APG777 (IL-13)**
  - **2022**: AD
  - **2023**: ✓ Phase 1 first participant dosed
  - **2024**: Initial Phase 1 PK & safety data
  - **2025**: 16-week POC data

- **APG808 (IL-4Rα)**
  - **2022**: COPD
  - **2024**: ✓ Candidate nomination
  - **2025**: Phase 1 initiation

- **APG990 (OX40L)**
  - **2022**: AD
  - **2024**: Candidate nomination
  - **2025**: Phase 1 initiation

- **APG222 (IL-13 & OX40L)**
  - **2022**: AD
  - **2023**: ✓ Phase 1 initiation

**Founded by Fairmount & Venrock**
Feb 2022

**$149M Series B**
Nov 2022

**$345M IPO**
Jul 2023

**APG777 (IL-13)**

**Asthma**

**APG808 (IL-4Rα)**

**COPD**

**APG990 (OX40L)**

**AD**

**APG222 (IL-13 & OX40L)**

**AD**
Our programs have broad potential to disrupt the I&I space

- **Dermatology**
  - AD
  - AA
  - PN
- **Pulmonology / Immunology**
  - Asthma\(^1\)
  - COPD\(^1\)
  - CSU
  - CRSwNP
- **Gastroenterology**
  - EoE
  - UC\(^1\)
  - EGID

Note: \(^1\) Eosinophilic subtypes
AA = Alopecia Areata. PN = Prurigo Nodularis. CSU = Chronic Spontaneous Urticaria. CRSwNP = Chronic Rhinosinusitis with Nasal Polyps. EoE = Eosinophilic esophagitis. UC = Ulcerative Colitis. EGID = Eosinophilic Gastrointestinal Disorders (non-EoE)

- Planned Apogee Ph2 based on well-established mechanism
- 3\(^{rd}\) party clinical data supporting one or more Apogee targets
- Ongoing 3\(^{rd}\) party clinical trials which could validate one or more Apogee targets
Apogee plans to become a leader in I&I therapeutics

**Overall simplicity of strategy and path to commercializing potential highly differentiated therapeutics in I&I**

- Target known biologic drivers with well-established mechanisms
- First mover advantage in applying known half-life extension technology to validated targets
- Antibody engineering approach resulting in novel, proprietary compounds
- Clear unmet need to improve patient convenience and compliance, with enthusiasm for approach among industry leaders and physicians

**Multibillion dollar market** opportunities in growing AD market by expanding into other indications and broadening the reach of Apogee treatments

- APG777 in AD & asthma
- APG808 in COPD
- Programs targeting OX40L and the dual inhibition of OX40L and IL-13 with broad application in I&I
- Expand existing collaborations and evaluate new opportunities that increase the impact of treatments for patients

**Strong potential value creation** in near term with a steady cadence of meaningful clinical and development milestones across the pipeline

**Financial strength** with approximately $423M total cash and marketable securities as of September 30, 2023
Apogee /ˈapəjē/ noun

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