APOGEE THERAPEUTICS

CORPORATE OVERVIEW

November 2024

Disclaimers and Forward-looking statements

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

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

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

The trademarks, trade names and service marks appearing in this presentation are the property of their respective owners. Certain information contained in this presentation relate to or are based on studies, publications and other data obtained from third-party sources as well as our own internal estimates and research. While we believe these third-party sources to be reliable as of the date of this presentation, it has not independently verified, and makes no representation as to the adequacy, fairness, accuracy or completeness of, any information obtained from third-party sources.

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

Novel antibodies engineered against validated targets in some of the largest I&I markets

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

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

- Dupixent, current market leader, is dosed every 2 weeks and nearly half of patients discontinue within 2 years
- APG777 Phase 2 could demonstrate best-in-class efficacy signal in 2H 2025 with potential for every 3- or 6-month maintenance dosing

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

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

Strong financial position

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

APOGEE THERAPEUTICS

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

Apogee's approach is to achieve differentiated efficacy and dosing in the markets it is pursuing

Strategy	Program	Discovery	Preclinical	Phase 1	Phase 2	Phase 3
Potential best-in-class monotherapy in AD *Higher exposures for better efficacy with less frequent dosing*	**APG777** IL-13				**Atopic Dermatitis**	**2H 2025:** Phase 2 16-week induction PoC data
Potential best-in-class mAbs for combinations *Strategic optionality to combine orthogonal mechanisms across pipeline*	**APG808** IL-4Rα			**Healthy Volunteers**		**Q4 2024:** Initial Phase 1 PK and safety in HVs
	APG990 OX40L			**Healthy Volunteers**		**1H 2025:** Initial Phase 1 PK & safety in HVs
	APG333 TSLP			**Healthy Volunteers**		**Late 2024 / Early 2025:** Initiate Phase 1 PK & safety in HVs
Potential first- or best-in-class combination approaches *Rational combinations to drive broader + deeper responses*	**APG777 ± APG990** IL-13 ± OX40L			**Atopic Dermatitis**		**2025:** Clinical trial initiation
	APG777 ± APG333 IL-13 ± TSLP			**Asthma**		**TBD:** Clinical trial initiation[1]
	Additional combination(s) IL-13/IL-4Rα + OX40L/TSLP			**COPD**		**December 2, 2024:** Additional combination(s) to be announced at R&D Day

The Apogee agents mentioned above are currently under investigation. Their safety and effectiveness for the listed target indications have not yet been established. (1) Pending final data from our Phase 1 trials of APG777 and APG333 in healthy participants, we may initiate a Phase 2 trial in asthma and expect to further evaluate opportunities to develop APG777 and the APG777+APG333 combination for other I&I indications, including alopecia areata, chronic rhinosinusitis with nasal polyps, chronic spontaneous urticaria, eosinophilic esophagitis and prurigo nodularis.

Apogee mAbs are engineered for best-in-class properties, including half-life extension

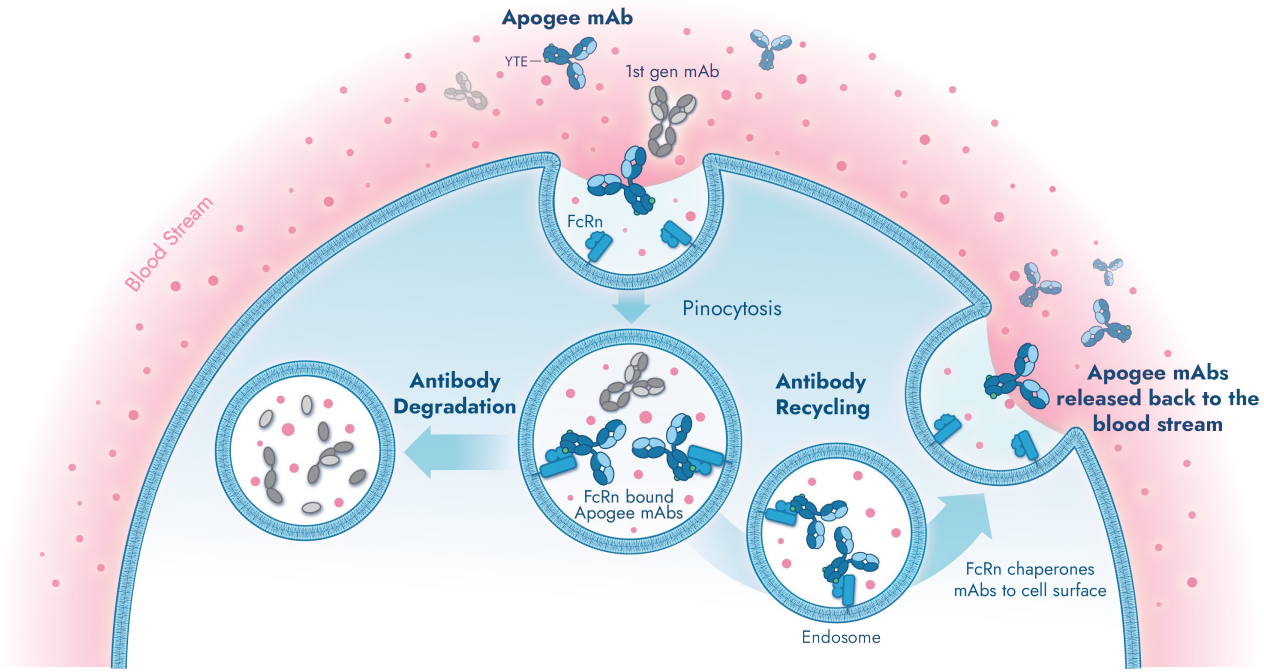
Based on clinically-validated epitopes with performance across five properties:

- **Backbone**
- **Potency**
- **PK**
- **Stability**
- **Viscosity**

- Designed to maximize antibody recycling
- Drug exists at higher levels for longer effect

Potential for PK that:

- *Optimizes exposures*
- *Decreases variability*
- *Increases half-life*



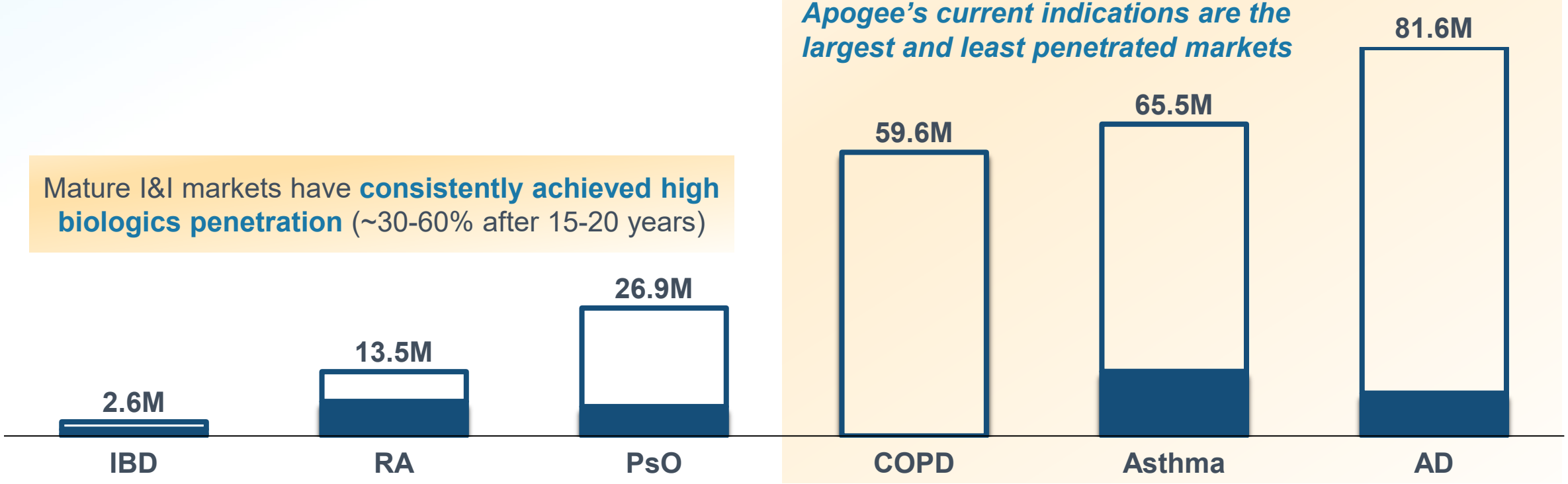
Beyond AD we initially expect to expand into asthma and COPD, the largest remaining I&I markets

Estimated population size
Moderate or severe, WW

US biologics penetration: 0% ⟷ 60%

Mature I&I markets have **consistently achieved high biologics penetration** (~30-60% after 15-20 years)

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



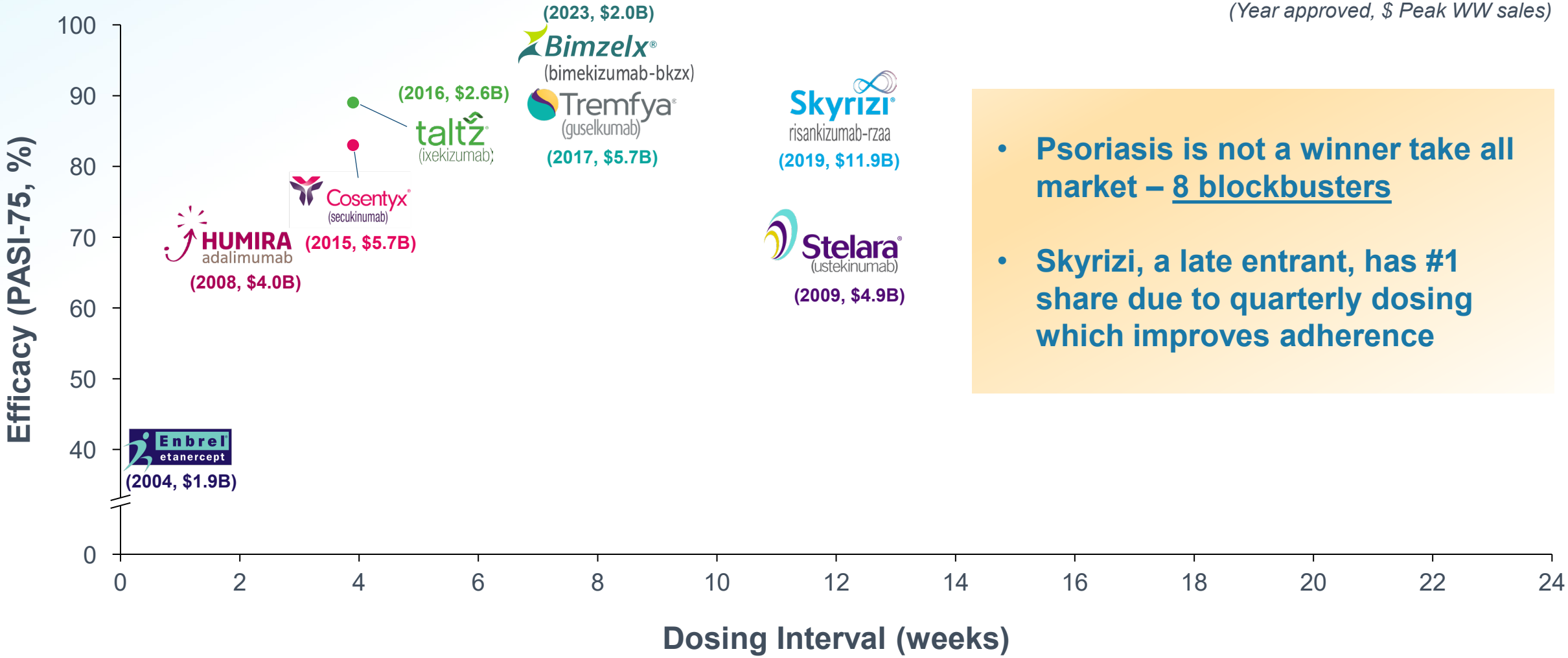
	IBD	RA	PsO	COPD	Asthma	AD
2023 WW Market Size:	$23B	$26B	$27B	← TBD →		

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

Potential best-in-class monotherapy in atopic dermatitis

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

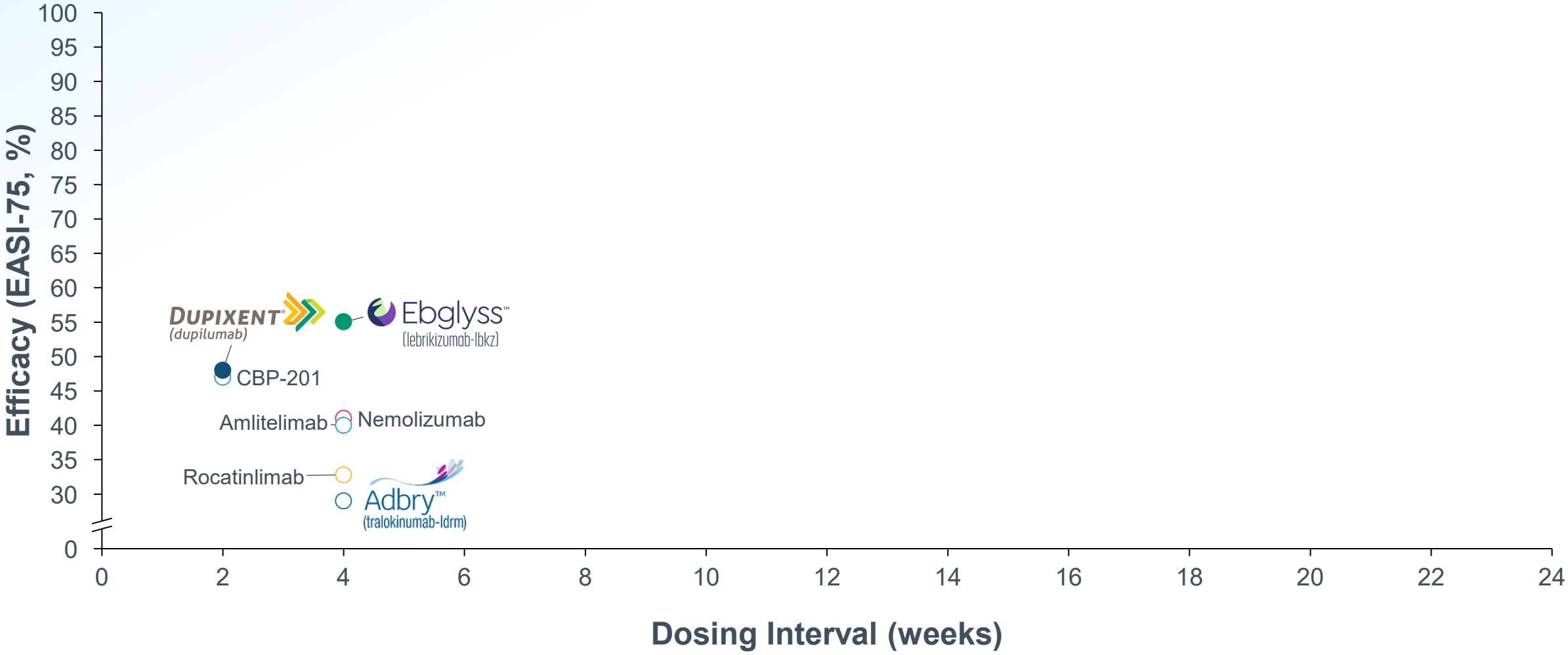
(Year approved, $ Peak WW sales)



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

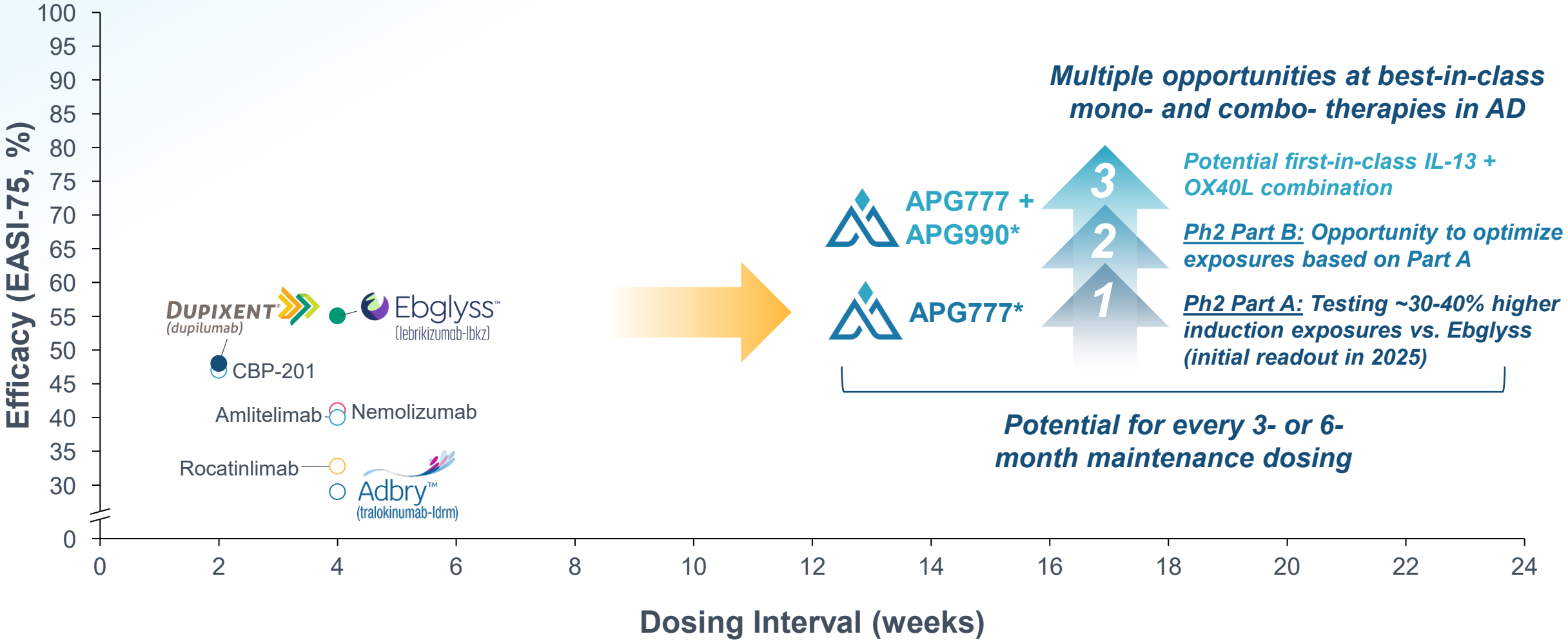
NOTE: Year denotes US launch year for adults with moderate to severe plaque psoriasis. Efficacy data are derived from different clinical trials at different points in time, with differences in trial design, patient populations, and statistical analysis. As a result, cross-trial comparisons cannot be made. No head-to-head trials have been conducted among all biologics shown. Assumes 1 EUR = 1.07 USD.
[1]Real-world evidence shows Skyrizi patients experienced fewer drug changes and a higher probability of drug survival compared with those treated with other biologic therapies for PsO and PsA
SOURCE: Armstrong AW, et al JAMA Dermatol. 2020, Gordon KB, et al Lancet 2021. Reich K, et al Lancet 2021. GlobalData. EvaluatePharma. USPIs. Wall Street research and management projections. Erik L et al ACR Convergence 2023. PsO = Psoriasis. PsA = Psoriatic Arthritis.

Atopic derm, in contrast to psoriasis, has far fewer options for patients



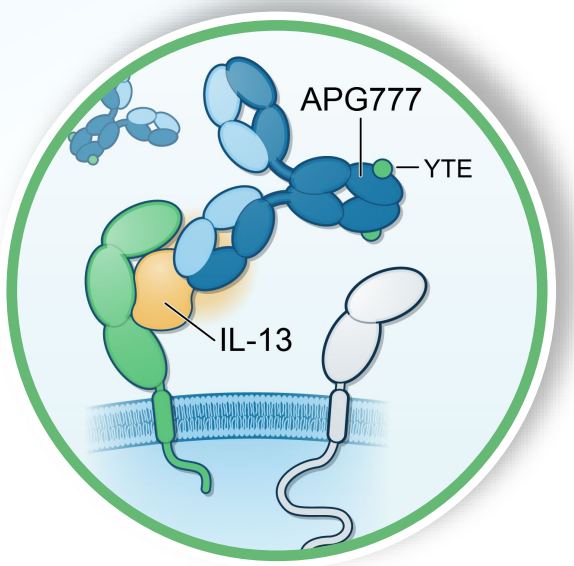
NOTE: Only DUPIXENT, ADBRY, and EBGLYSS are approved in the US. SOURCE: 1. EBGLYSS 250mg Q2W Ph3 avg. Silverberg JI et al. AAD 2022 2. Dupilumab 300 mg Q2W mono Ph3 avg. DUPIXENT USPI 3. Tralokinumab 300 mg Q2W mono Ph3 avg. Adbry USPI 4. CBP-201 300 mg Q2W Ph2. Connect Biopharma Press Release Jan. 5, 2022 5. Nemolizumab 30 mg Q4W Ph3 avg. Silverberg J et al EADV 2023 6. Rocatinlimab Q4W Ph3 EADV Amgen oral presentation 2024 (note: 24-week data) 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 has potential to be the first in atopic derm to provide both transformational dosing and efficacy

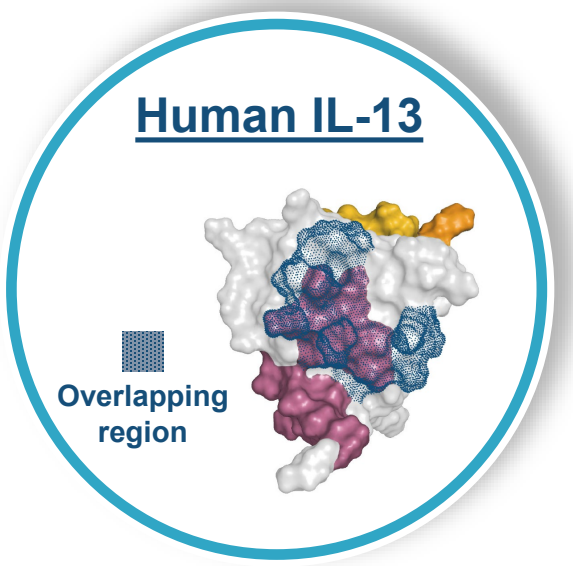


NOTE: *Positioning of Apogee programs is illustrative and based on interim Phase 1 results for APG777 only and illustrates what we believe we can potentially achieve. Only DUPIXENT, ADBRY, and EBGLYSS are approved in the US. SOURCE: 1. EBGLYSS 250mg Q2W Ph3 avg. Silverberg JI et al. AAD 2022 2. Dupilumab 300 mg Q2W mono Ph3 avg. DUPIXENT 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 Q4W Ph3 EADV Amgen oral presentation 2024 (note: 24-week data) 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.

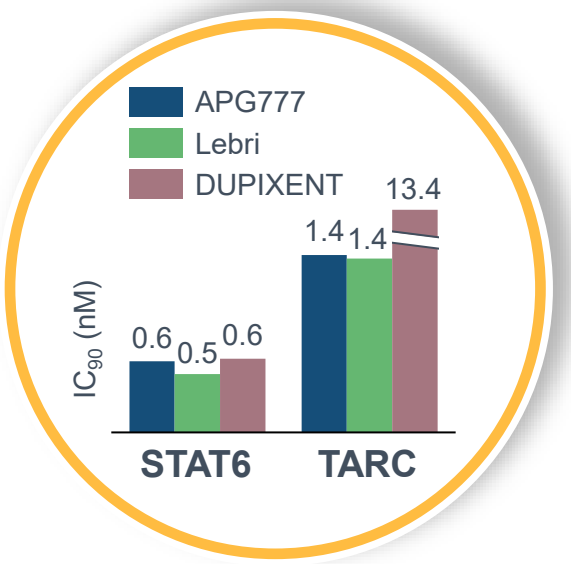
APG777 leverages EBGLYSS's mechanism to deliver a potentially best-in-class, pipeline-in-a-product antibody



APG777 disrupts Type 2 inflammation by preventing formation of IL-13Rα1 / IL-4Rα heterodimer



APG777's epitope on IL-13 overlaps with EBGLYSS's and leverages proven MoA and biology



APG777 is as potent as EBGLYSS and DUPIXENT in key preclinical assays

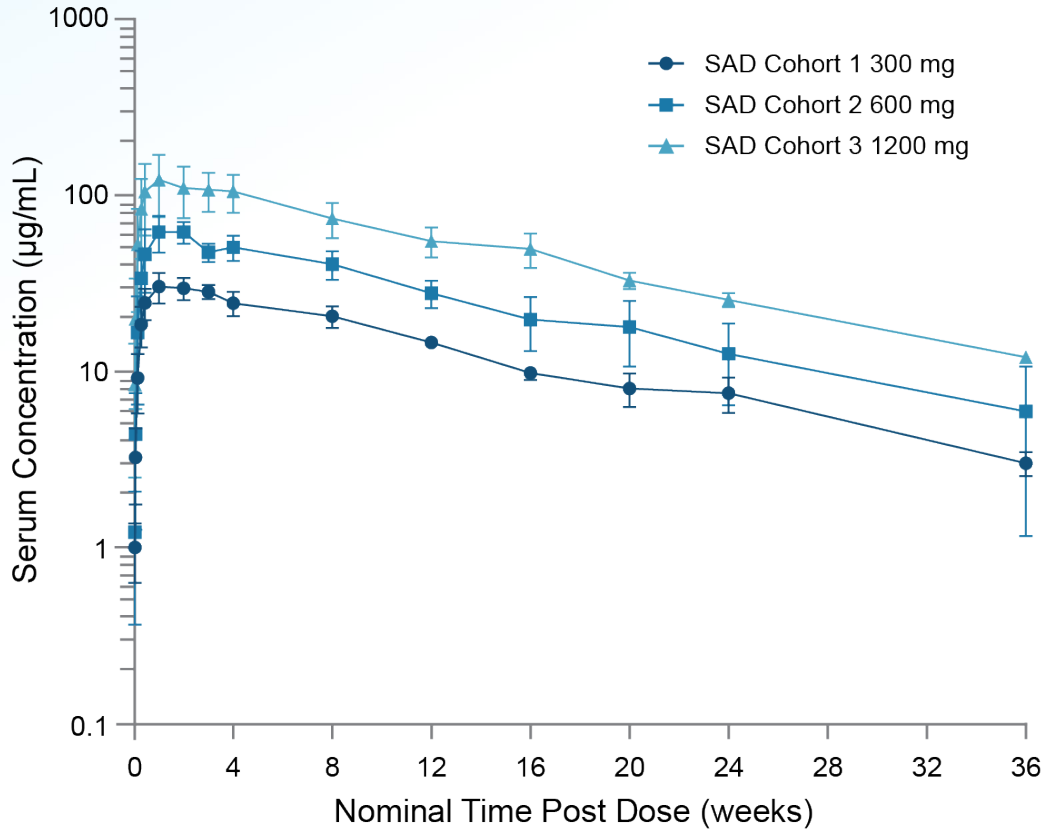
 NOTE: MoA = Mechanism of Action.

APG777 Clinical Data

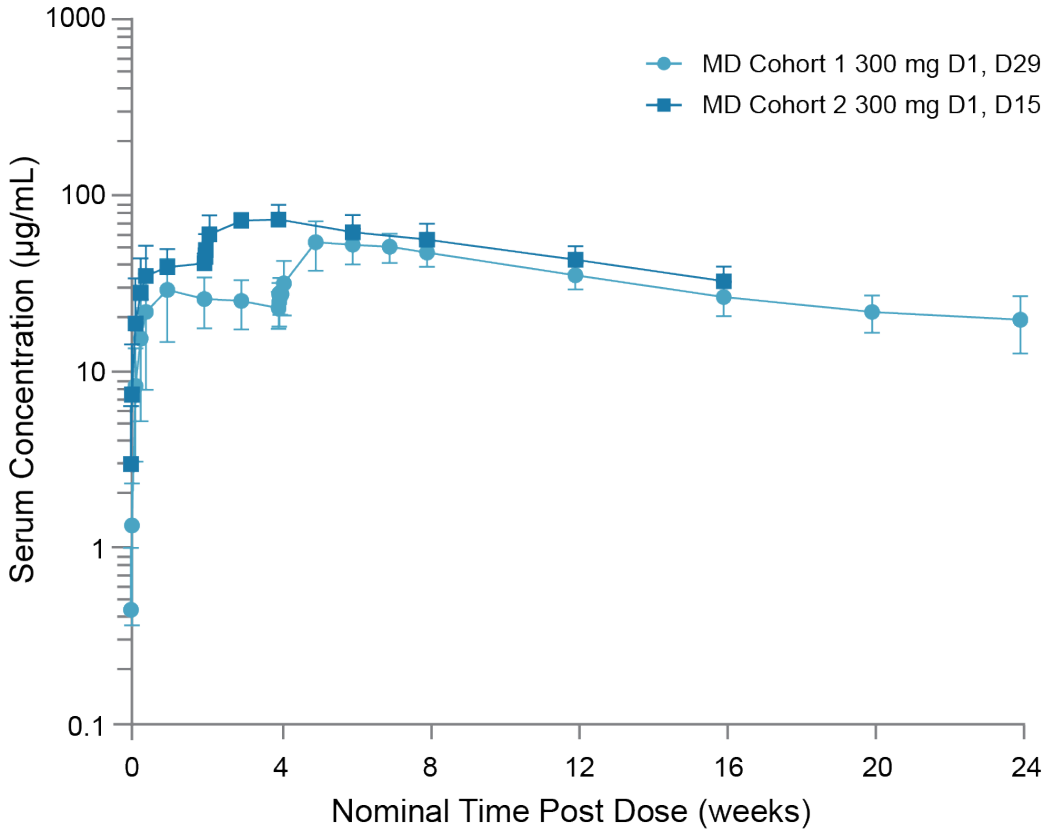
Phase 1

APG777 continues to exhibit a potentially best-in-class PK profile with a half-life of ~75 days

Single-dose concentration-time profile

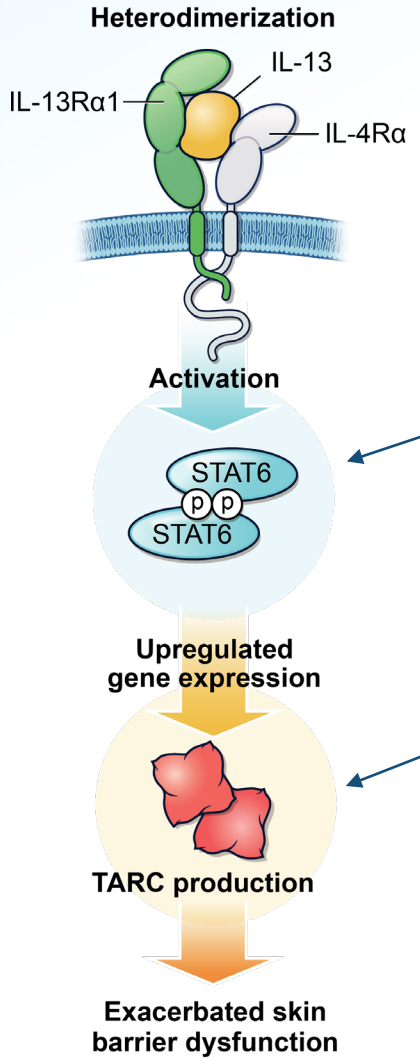


Multi-dose concentration-time profile



PK demonstrated dose-proportionality and half-life of ~75 days (approximately 3x EBGLYSS)

pSTAT6 and TARC are biomarkers of IL-13 target engagement and AD severity



APG777 Phase 1 biomarkers

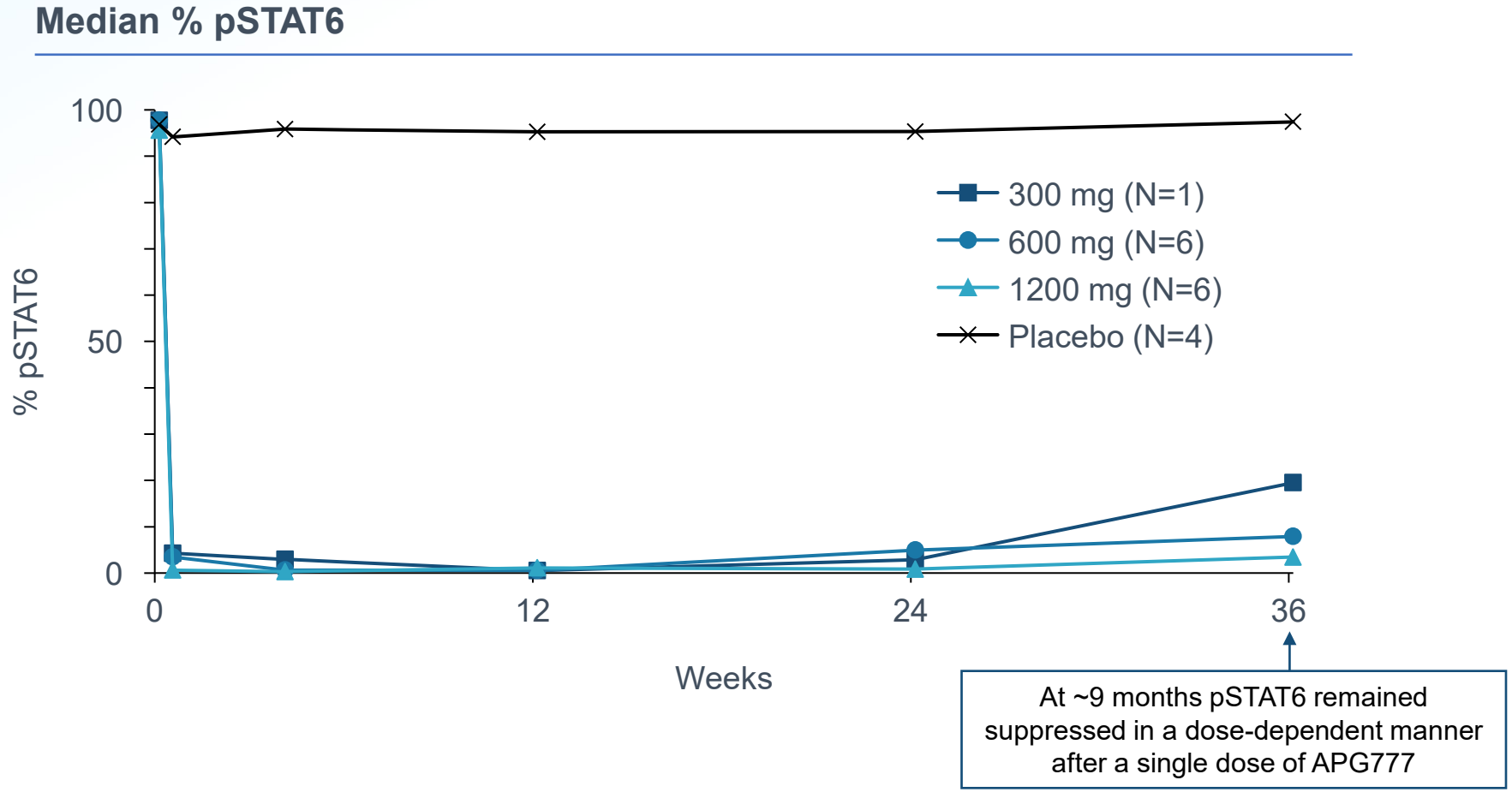
1. **pSTAT6 is a proximal and sensitive marker** of IL-13 receptor activation

2. **TARC is historically correlated with AD severity and initial treatment response**

Taken together, **APG777's reduction of these biomarkers confirms inhibition of IL-13 signaling** and allows comparison to other agents

Phase 1

Single dose APG777 showed extended pSTAT6 inhibition for ~9 months (limit of available follow-up)



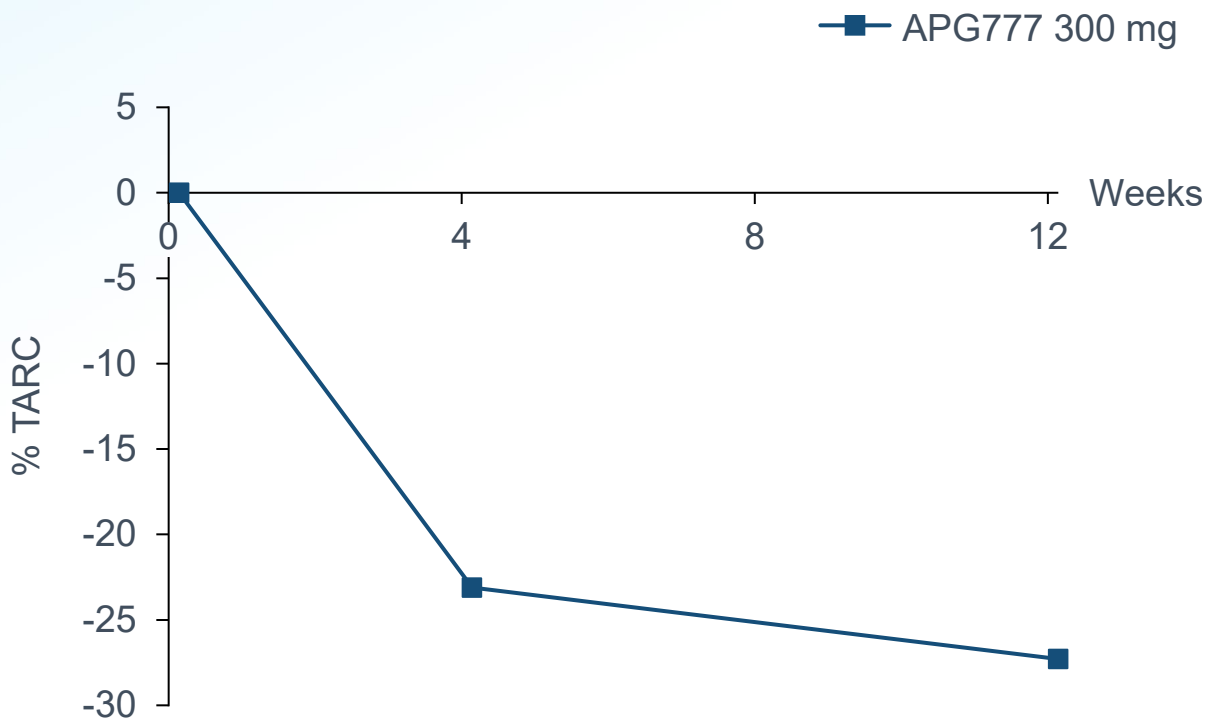
All doses demonstrated near-complete pSTAT6 inhibition for up to ~9 months

NOTE: N = 1 in cohort 1 due to the accelerated timing of study enrollment relative to assay validation. No data has been published showing DUPIXENT or EBGLYSS impact on pSTAT6 in HVs. pSTAT6 measured using flow cytometry of whole blood samples stimulated with 10 ng/mL IL-13 (approximately 500 times the level of IL-13 present in lesional skin of moderate-severe AD patients).
SOURCE: Szegedi K et. al. JEADV 2015

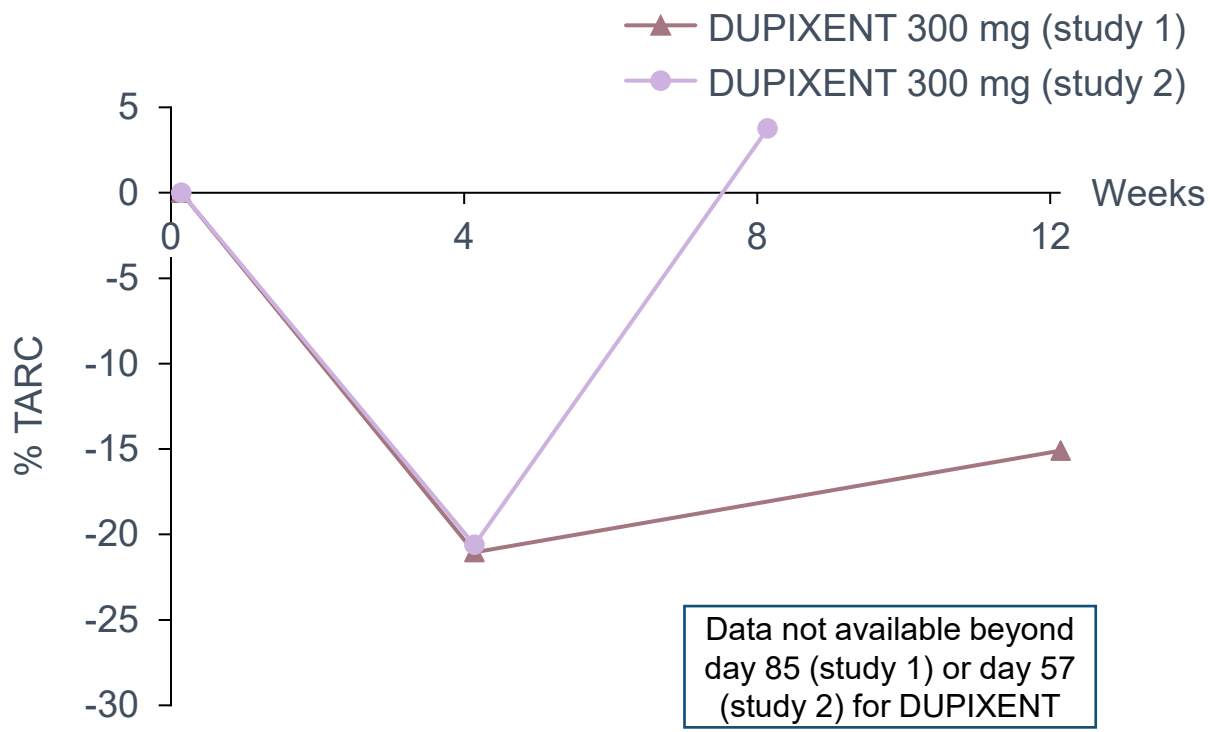
Phase 1

Single dose of APG777 led to deep and more sustained TARC inhibition vs DUPIXENT

Median % changes from baseline in TARC



Median % changes from baseline in TARC



- **300 mg APG777 showed similar maximum PD marker changes as DUPIXENT**
- **APG777 sustained TARC inhibition demonstrates the potential for better durability**

NOTE: These data are derived from different clinical trials conducted at different points in time, with differences in trial design, dosing regimen and patient populations. DUPIXENT data derived from two separate Phase 1 trials, each with 6 healthy volunteers receiving a single SC injection of 300 mg DUPIXENT. APG777 data derived from our Phase 1 trial in 6 healthy volunteers receiving a single SC injection of 300 mg of APG777. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted. APG777 is an investigational drug and has not been approved by the FDA as safe and effective. SOURCE: Li, Z, et al. ACCP, 2020. Data for time points on nominal day post dose 1, 29, 85 (study 1; R668-AS-0907) and 1, 29, 57 (study 2; TDU12265). No data has been published showing EBGLYSS impact on TARC in HVs.

APG777 Phase 2 in AD

APG777 Phase 2 regimen is designed to achieve two goals

Induction

EBGLYSS data suggests an **exposure-response for efficacy in induction**

Goal: *Exceed* EBGLYSS exposures

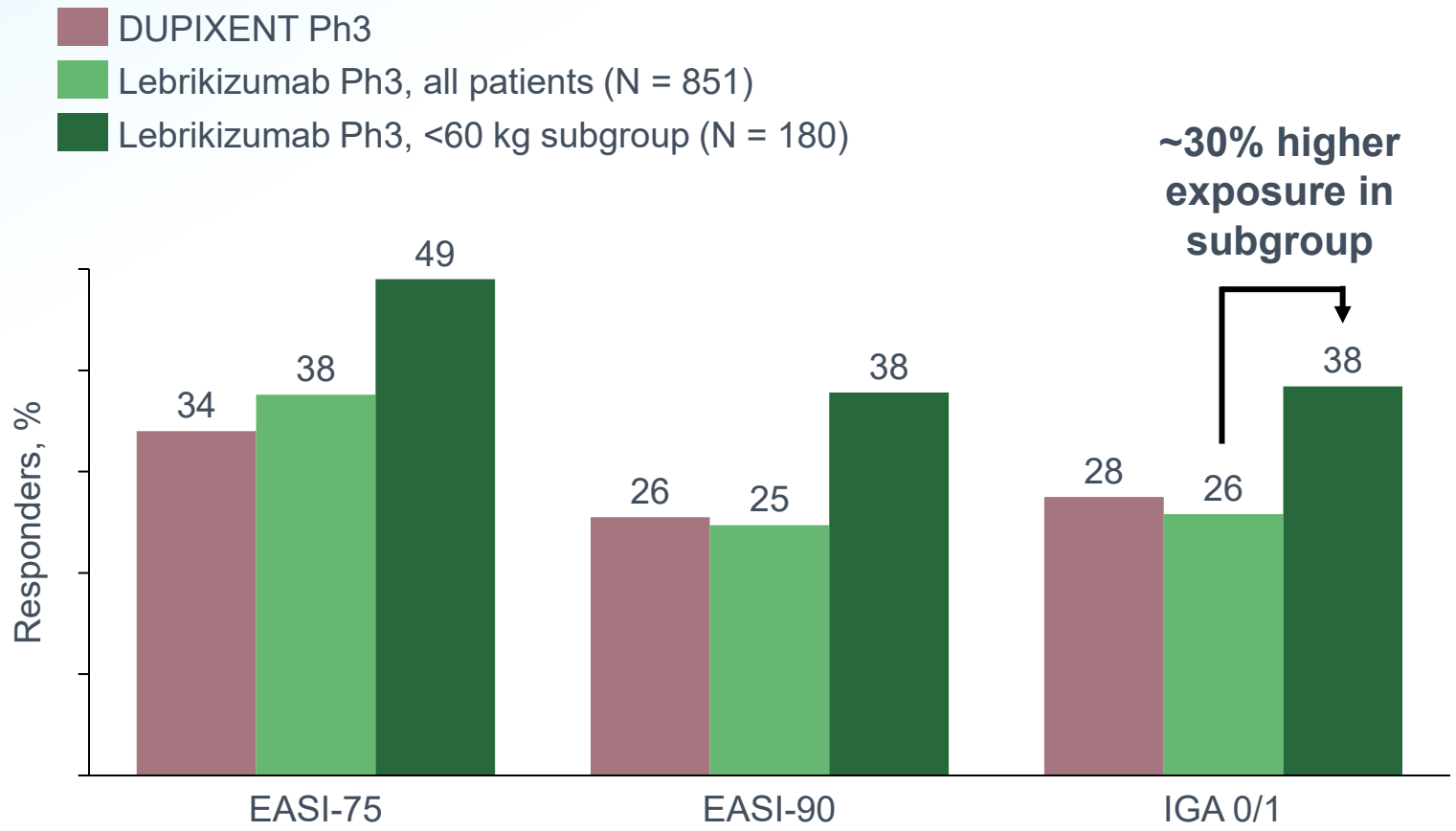
Maintenance

There was **no exposure-response observed in maintenance** for EBGLYSS

Goal: *Equal* EBGLYSS exposures

EBGLYSS Ph3 subgroup with higher exposures had consistently better efficacy across key endpoints

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



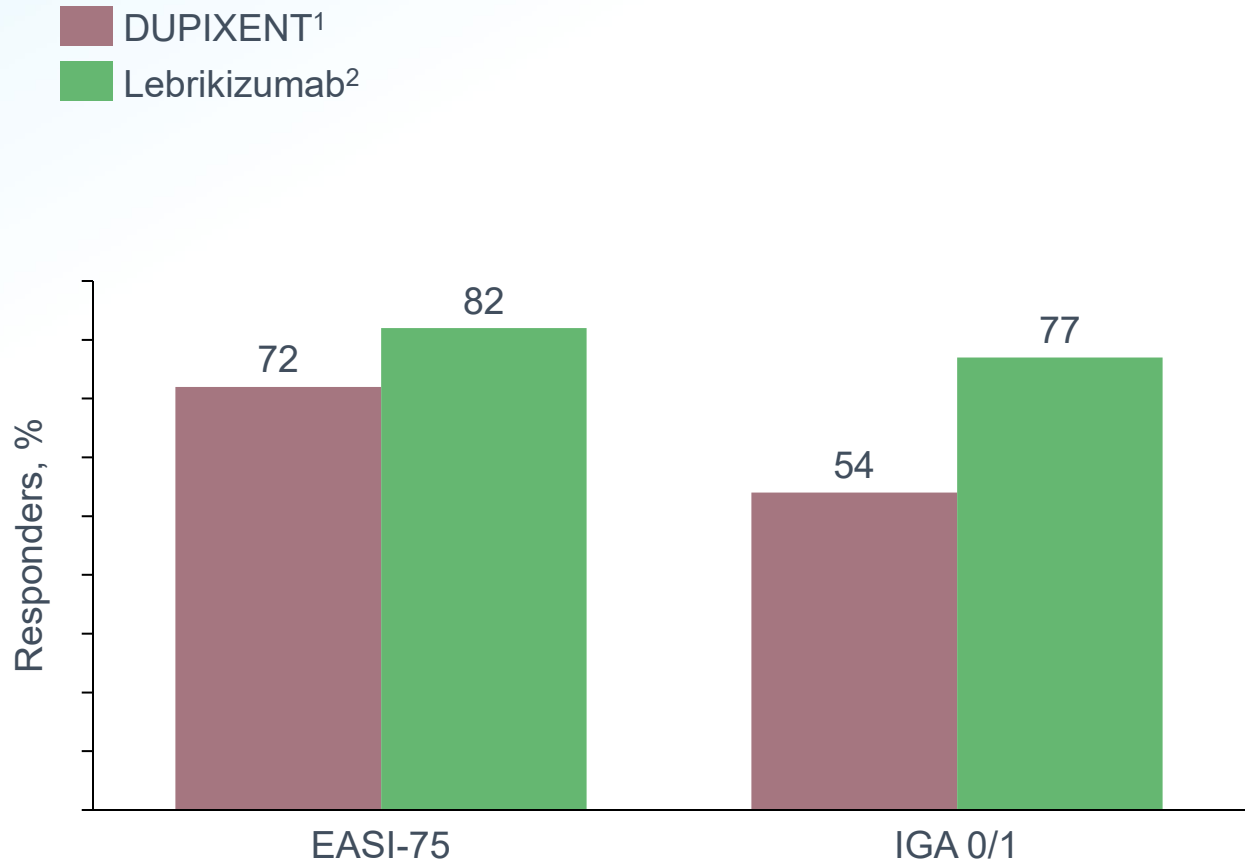
- **Exposure-response** in induction demonstrated by EBGLYSS
- **~30% higher exposures** in EBGLYSS low bodyweight subgroup led to **improved efficacy across endpoints**

APG777 Ph2 Part A targets ~30-40% higher exposure than EBGLYSS in induction with ~50% fewer injections

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

EBGLYSS has demonstrated superior maintenance compared to DUPIXENT

Maintenance of response in AD (Week 52)



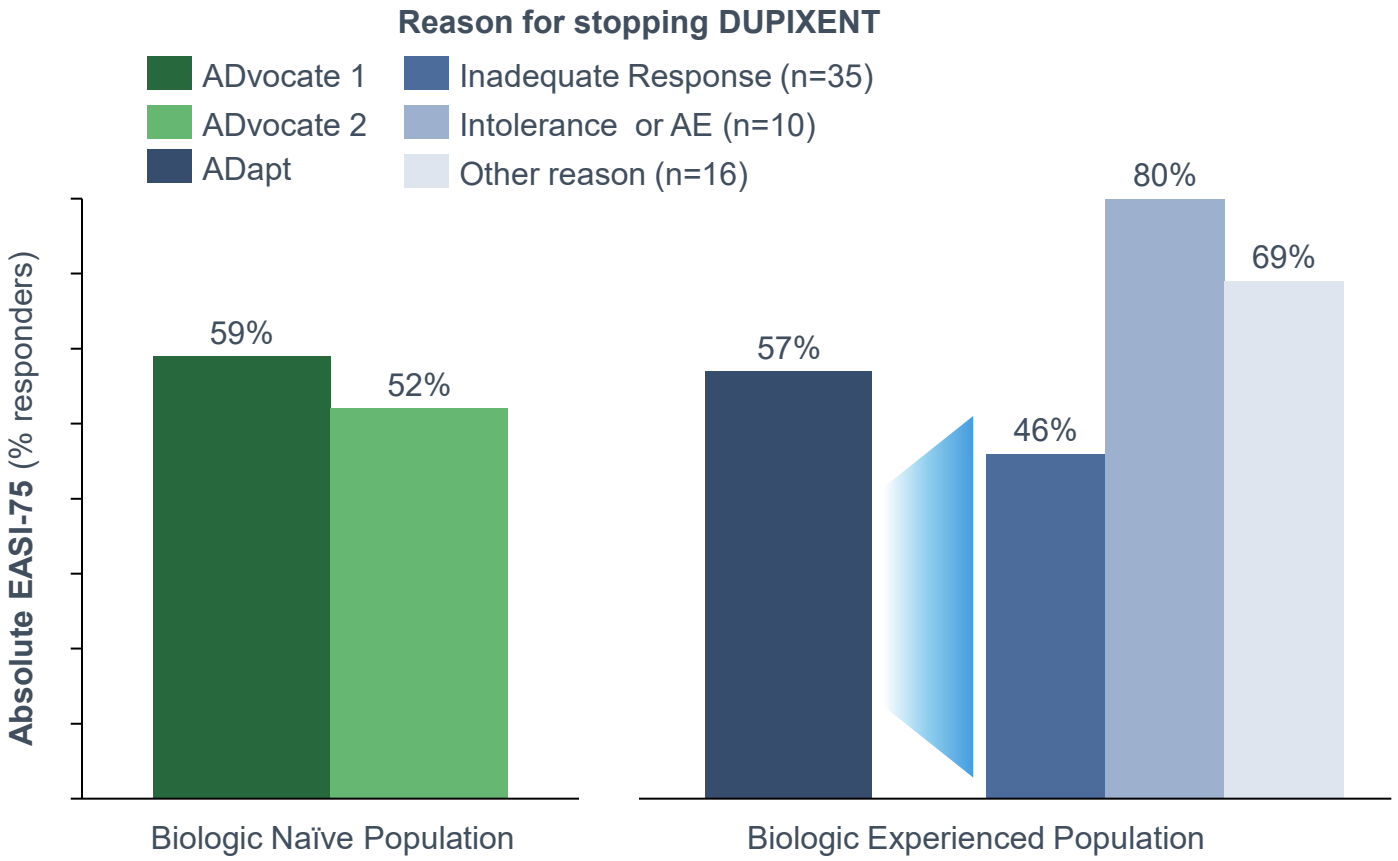
- **No dose-response or exposure-response in maintenance** was observed for EBGLYSS
- EBGLYSS has shown **superior maintenance responses compared to DUPIXENT**
- Real-world data for **DUPIXENT shows poor compliance;** ~50% of patients discontinue before two years[3]

APG777 maintenance regimens are designed to equal EBGLYSS exposures with only 2-4 injections per year *(vs. 13-26 injections per year)*

NOTE: The labeled dose of EBGLYSS is Q4W in maintenance. Efficacy data are derived from different clinical trials at different points in time, with differences in trial design and patient populations. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted.
SOURCE: 1) Worm, M, et al, JAMA Derm, 2020. 2) Blauvelt, A et al Br J Dermatol, 2023. 3) Symons et al. AAD 2024 (poster presentation)

EBGLYSS demonstrated similar results in biologic naïve and experienced patients

Efficacy of EBGLYSS in biologic naïve and experienced patient populations



- **EBGLYSS showed strong efficacy in patients that had an inadequate response to DUPIXENT** (46% EASI-75 at week 16)
- Of the ten patients that discontinued DUPIXENT due to **intolerance / AEs none experienced similar issues on EBGLYSS**

ADapt trial in DUPIXENT-experienced trial supports the broad use of IL-13 across both first- and second-line populations

NOTE: ADapt trial was open-label potentially limiting direct comparisons with placebo-controlled trials. AEs of note leading to discontinuation of DUPIXENT included eye irritation, facial dermatitis, and inflammatory arthritis. None were experienced on EBGLYSS.
SOURCE: 1) EBGLYSS USPI. 2) Silverberg, J, et al. Fall Clinical Poster Presentation (2024).

APG777 Phase 2 exposures are designed to exceed EBGLYSS in induction and equal in maintenance

Modeled concentration of APG777 in induction and maintenance (Q3M) vs EBGLYSS

Induction goal:

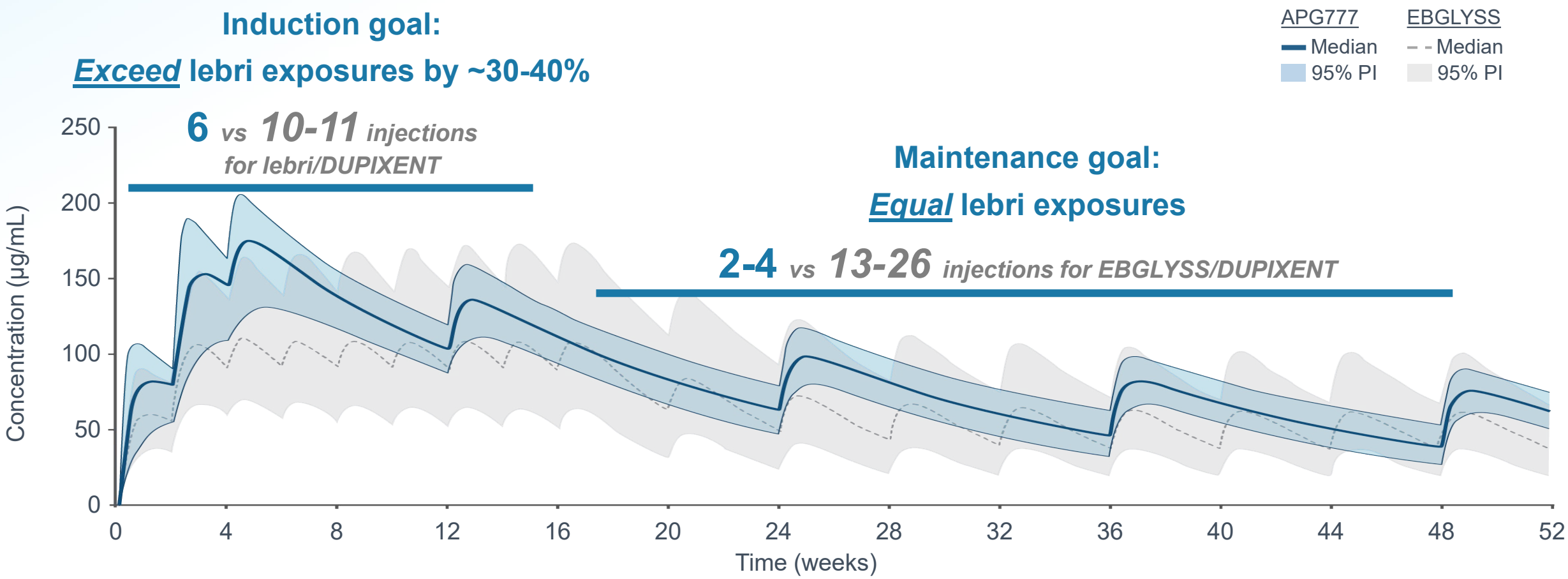
***Exceed* lebri exposures by ~30-40%**

6 vs 10-11 injections for lebri/DUPIXENT

Maintenance goal:

***Equal* lebri exposures**

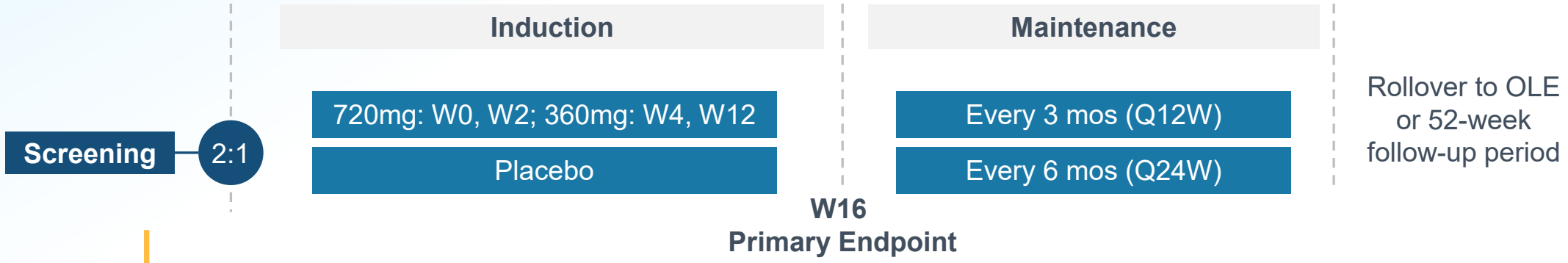
2-4 vs 13-26 injections for EBGLYSS/DUPIXENT



 NOTE: Every 3-month maintenance dosing regimen shown. The above graph is illustrative only with respect to plans for dosing of APG777 and does not present comparative data.

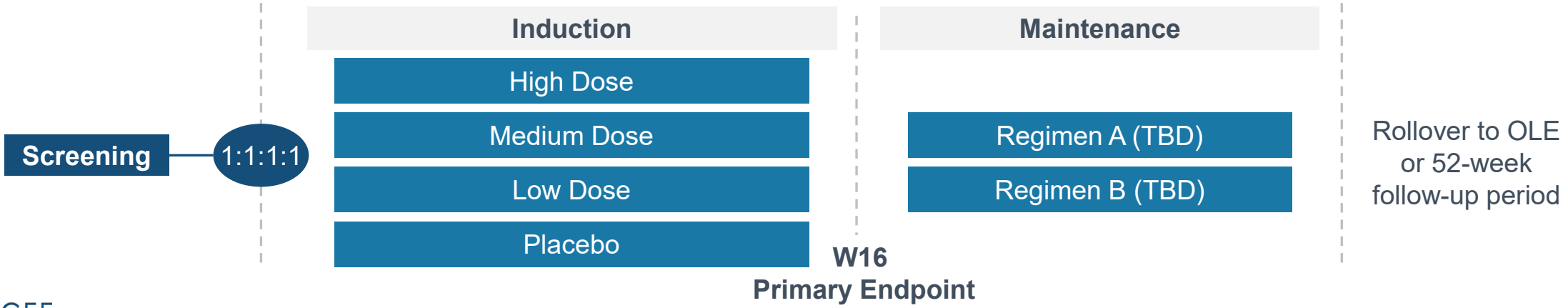
Ongoing integrated Phase 2 trial expected to have 16-week Part A topline data in 2H'25

Part A: Proof-of-concept (N ~110)



Phase 2 design is >90% powered in both Part A / B and has potential for significant acceleration

Part B: Dose optimization (N ~360)



NOTE: Number of and doses within induction and maintenance regimens to be tested in Part B are preliminary and will be confirmed based on emerging data from Part A.

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

OBJECTIVES

Safety

Confirm well tolerated safety profile as seen in Phase 1 HV study and **in line with other agents in class** (e.g., DUPIXENT, EBGLYSS)

Efficacy

primary endpoint

Primary endpoint of percent change from baseline in EASI at Week 16 **in line with standard of care (approx. 65-70% topline)**

Efficacy

key secondary endpoints

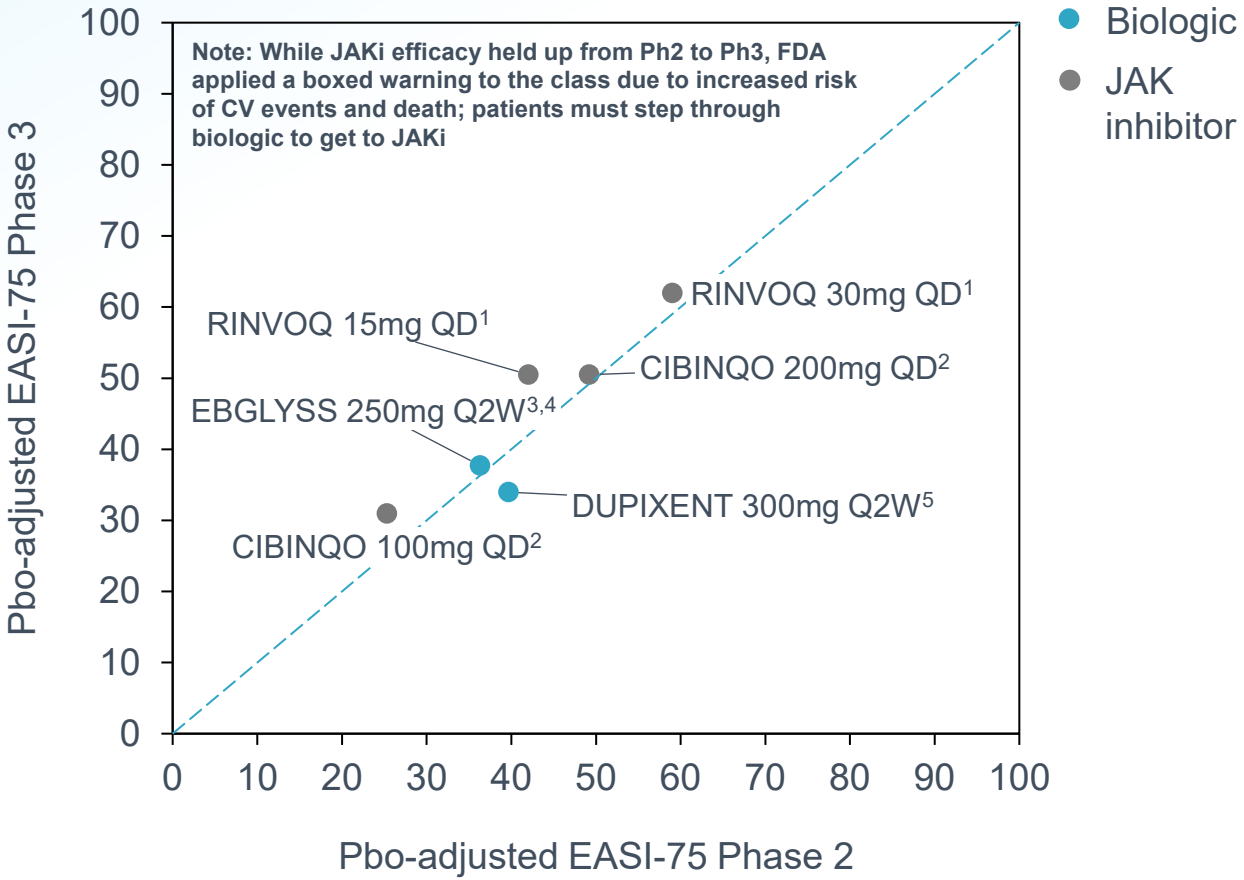
Proportion of patients achieving key secondary endpoints at Week 16 (future approvable endpoints) **in line with standard of care:**

- **EASI-75: approx. 45-50%** (topline)
- **IGA 0/1: approx. 35-40%** (topline)

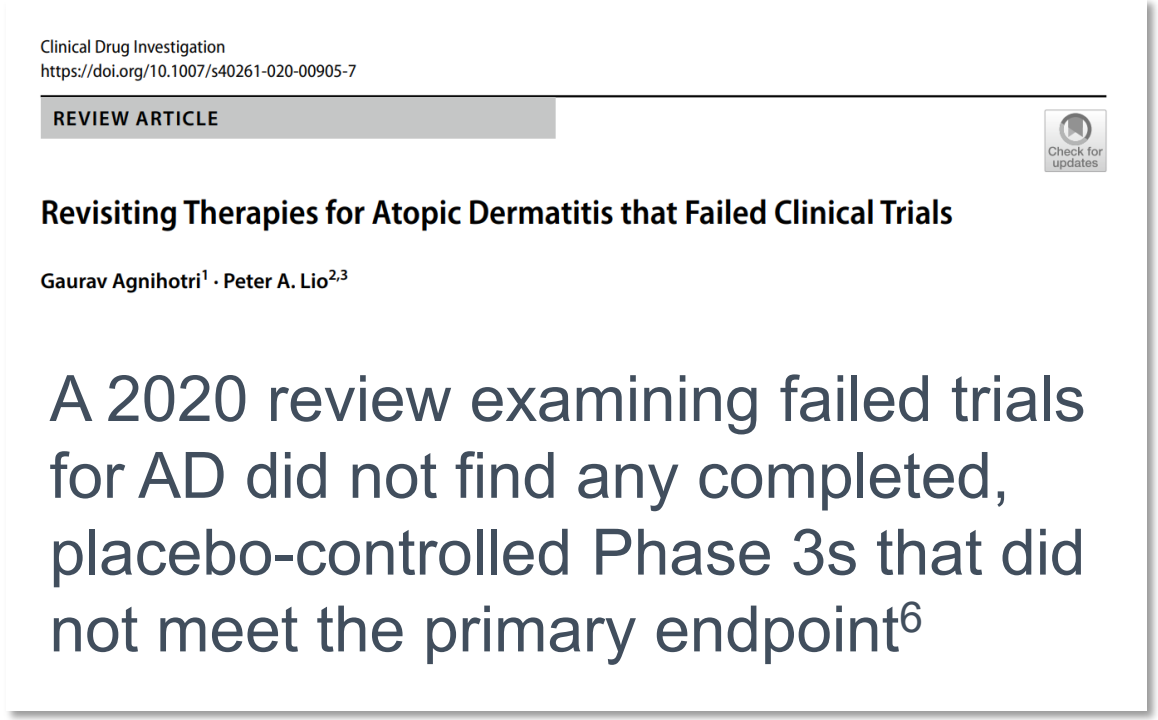
NOTE: [1] Based on FDA label for DUPIXENT™

Strong historical correlation between Ph2 and Ph3 data makes APG777 16-week induction data a key catalyst

Strong correlation between Phase 2 and 3 results in AD for validated endpoint EASI-75



Phase 3 failure in AD is rare



Clinical Drug Investigation
https://doi.org/10.1007/s40261-020-00905-7

REVIEW ARTICLE

Check for updates

Revisiting Therapies for Atopic Dermatitis that Failed Clinical Trials

Gaurav Agnihotri[1] · Peter A. Lio[2,3]

A 2020 review examining failed trials for AD did not find any completed, placebo-controlled Phase 3s that did not meet the primary endpoint[6]

SOURCE: Ph3 data for DUPIXENT, RINVOQ, and CIBINQO is from USPI. 1) Guttman-Yassky E et al *J All Clin Immunol.* 2020. 2) Gooderham MJ et al *JAMA* Dermatol. 2019. 3) Guttman-Yassky E et al *JAMA* Dermatol. 2020. 4) Silverberg JI et al. *NEJM* 2023 5) Thaci et al. *Lancet* 2016. 6) Agnihotri, G., et al. *Clin Drug Investig* 2020

Potential first-in-class combination therapy in atopic dermatitis

AD is heterogenous – Type 2 is the core pathway with varying involvement of Type 1 and Type 3

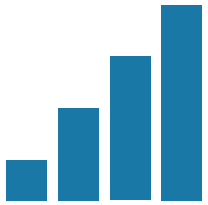
Age

Pediatric → Adult

Type 1

Type 2

Type 3



Severity

Moderate → Severe

Type 1

Type 2

Type 3

Ethnicity

Asian → European

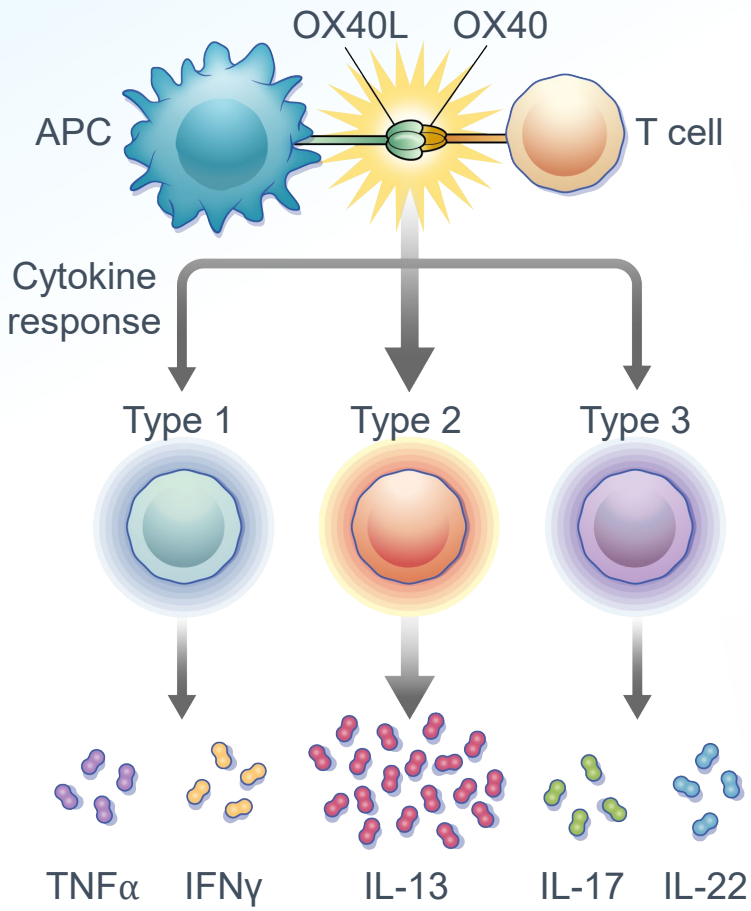
Type 1

Type 2

Type 3

SOURCE: Adapted from Fania et al. Int. J. Mol. Sci. 2022.

OX40L / OX40 interaction drives Type 1, 2, and 3 inflammation in atopic dermatitis



- **OX40L is expressed on antigen-presenting cells (APCs)**
- **OX40L / OX40 interaction promotes inflammatory T cell responses in AD**

+

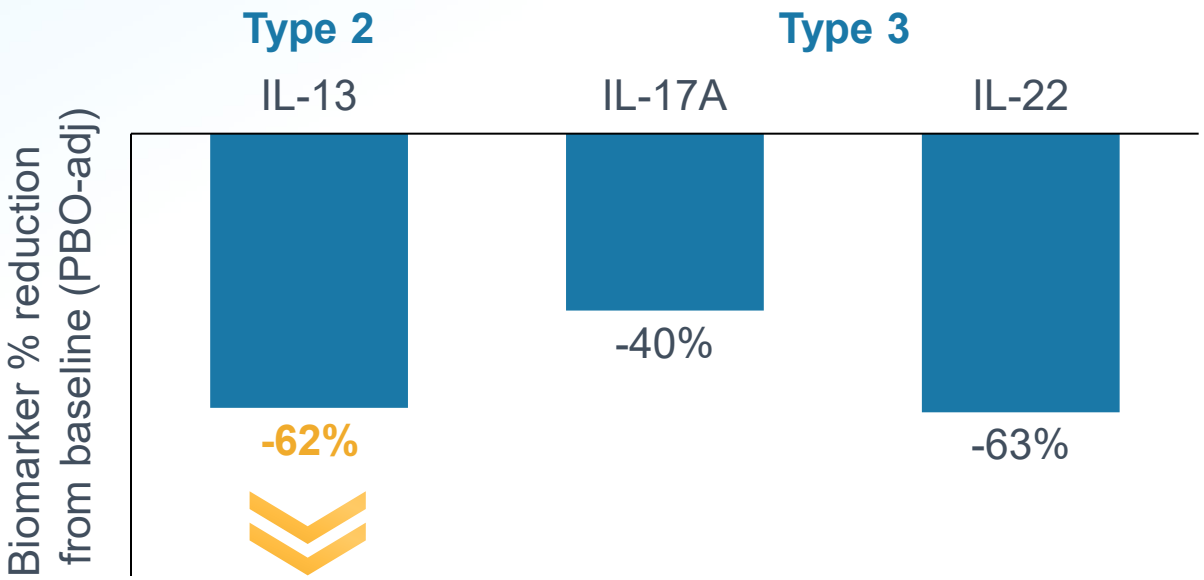
- **T cells produce Type 1, 2, and 3 cytokines** that drive inflammation and AD symptoms
- **Type 2 (IL-13) is the core pathway in AD;** Type 1 and 3 play a secondary role in specific subpopulations

Blocking OX40L / OX40 interaction has the potential to broadly inhibit Type 1, 2, and 3 inflammation

NOTE: Amlitelimab biomarker changes presented are average values across dose cohorts based on approximate data points from digitized charts. APC = antigen presenting cell
SOURCE: Sanofi 2023 R&D day presentation

OX40L inhibition is clinically validated in AD and has demonstrated broad cytokine suppression

Amlitelimab (OX40L) Phase 2b AD biomarker data



Potential additional benefit from deeper inhibition of Type 2 inflammation

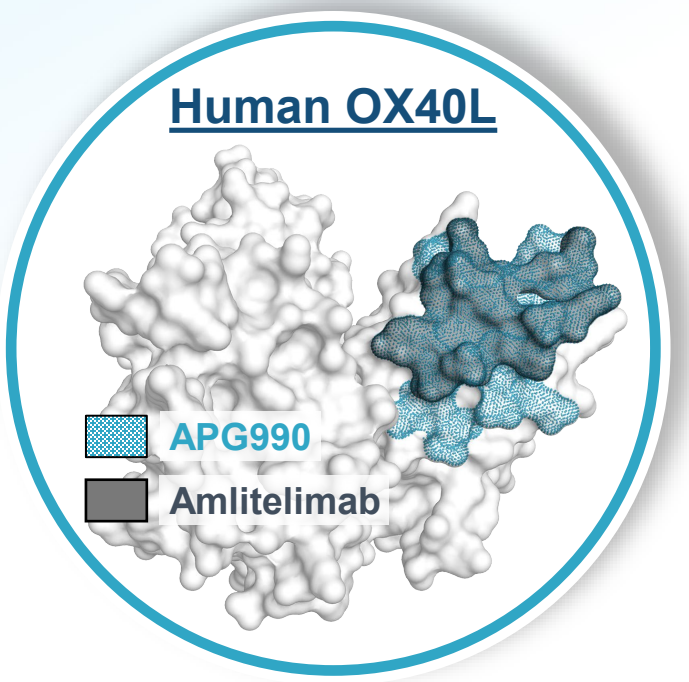
Upcoming amlitelimab (OX40L) POC readouts

☐ Indication where IL-13 / IL-4Rα inhibition also achieved PoC

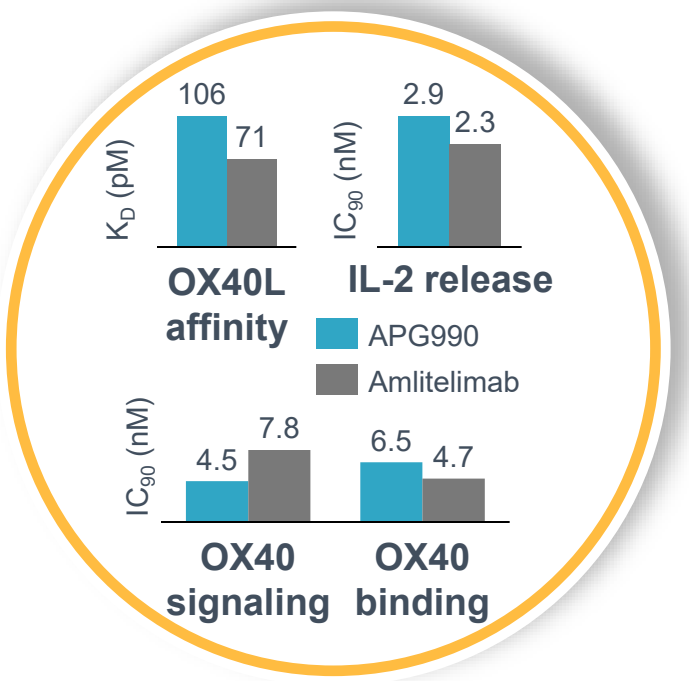
Atopic dermatitis	PoC achieved
Asthma	Ph2b data in 2025
Hidradenitis suppurativa *(0.4M eligible patient pop.)*	Ph2 data in 2025
Alopecia areata *(0.6M eligible patient pop.)*	Ph2 data in 2025
Celiac disease *(0.2M eligible patient pop.)*	Ph2 start in 2024
Systemic sclerosis *(0.2M eligible patient pop.)*	Ph2 start in 2024

NOTE: Eligible patient population for each indication is based on Sanofi estimates specific to amlitelimab
SOURCE: Sanofi 2023 R&D day presentation

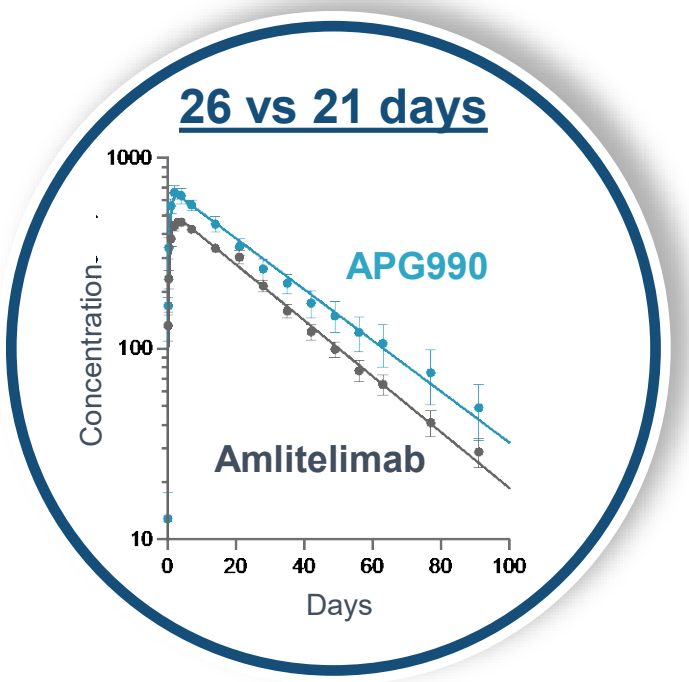
APG990 leverages amlitelimab's mechanism to deliver a potentially best-in-class, pipeline-in-a-product antibody



APG990 epitope overlaps with amlitelimab to leverage proven MoA



APG990 is as potent as amlitelimab across preclinical assays



APG990 NHP half-life is extended relative to amlitelimab

Phase 1 HV trial initiated in Q3 2024, with data expected in 2025

 NOTE: MoA = Mechanism of Action.

APG990 Phase 1 is underway with initial data readout in 2025

Trial design elements

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

Single ascending dose in healthy participants

N ~ 40

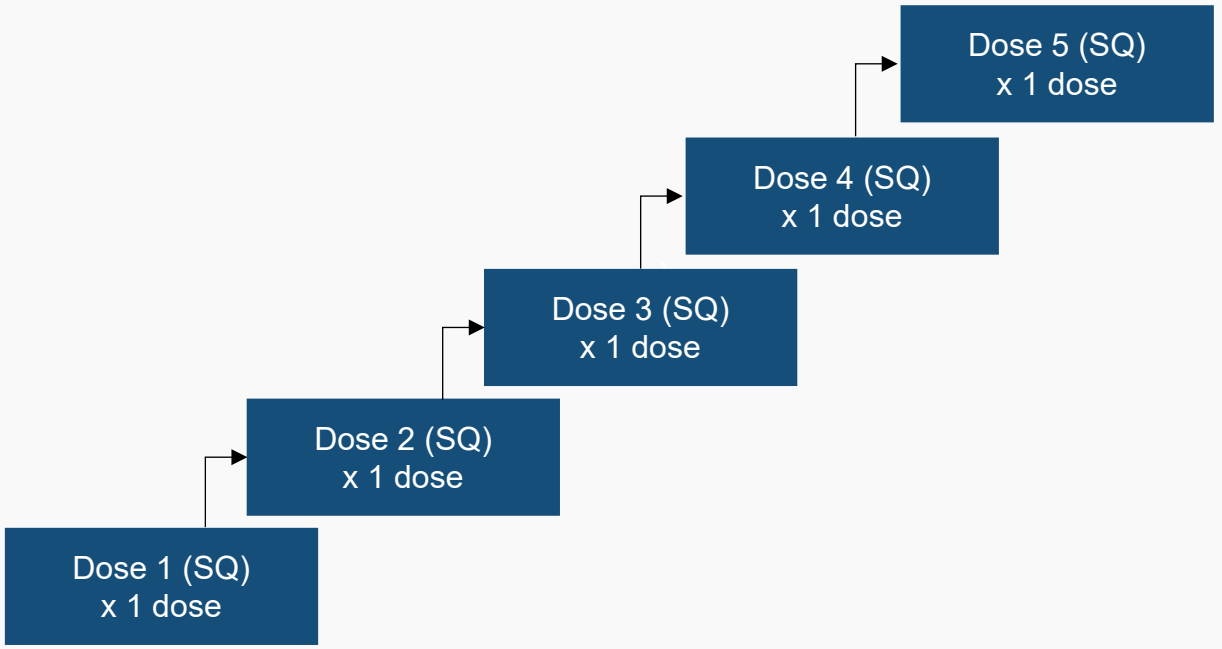
8 per cohort (6:2 active:placebo)

Key inclusion criteria: healthy adult participants

Primary endpoint: safety

Secondary endpoints: PK, ADA

Single ascending dose[1]



Phase 1 readout in 2025 will confirm potential for best-in-class dosing

NOTE: [1] SAD dose ascension will ultimately be determined by the SRC (Scientific Review Committee) based on available data.

APG990 Phase 1 clinical trial objectives

OBJECTIVES

Confirm tolerable **safety profile to enable future combination trials**

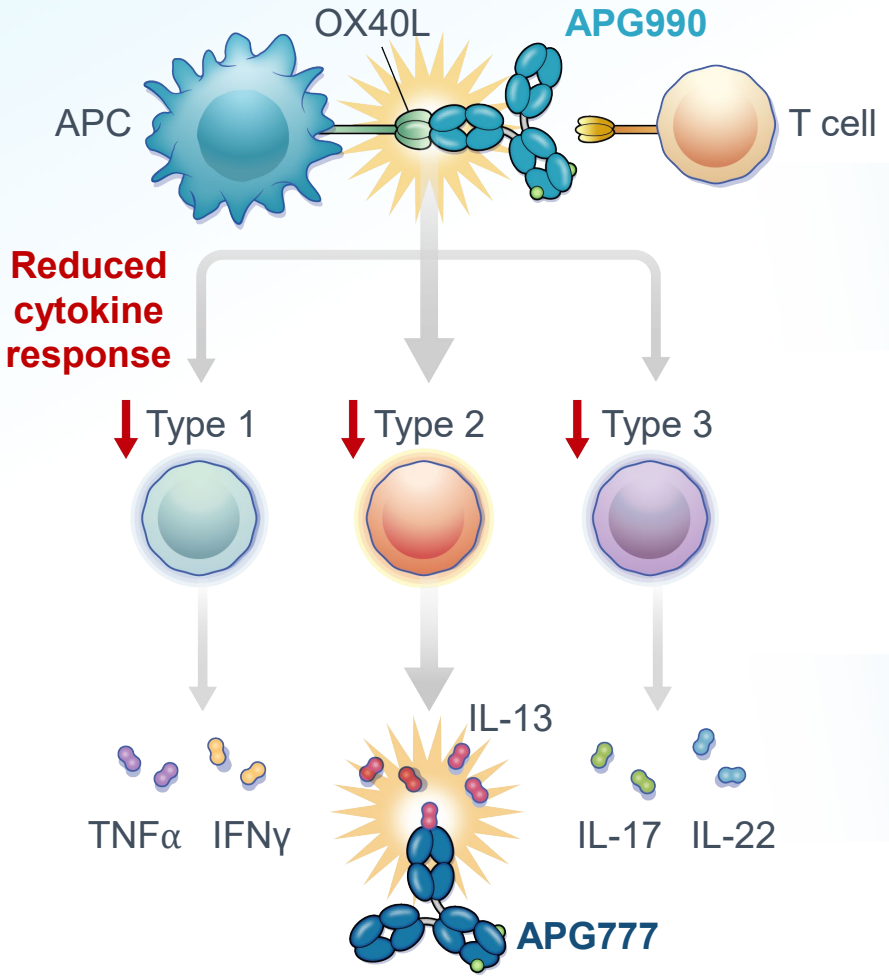
Establish **optimized PK profile** with a half-life of at least 21 days

Determine **dosing regimens** to sustain exposures similar to amlitelimab

2025: confirm potential for best-in-class dosing intervals » **Dosing Goal:** every 3- or 6-months

NOTE: PK = Pharmacokinetic.

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



- **APG990 targets upstream OX40L/OX40 interaction**
- **Potential for Type 1, 2 and 3 inhibition** without safety / tolerability issues associated with JAK inhibitors

+

- **APG777 targets downstream IL-13**
- APG777 Phase 1 demonstrated **near complete inhibition of Type 2** inflammatory biomarker pSTAT6

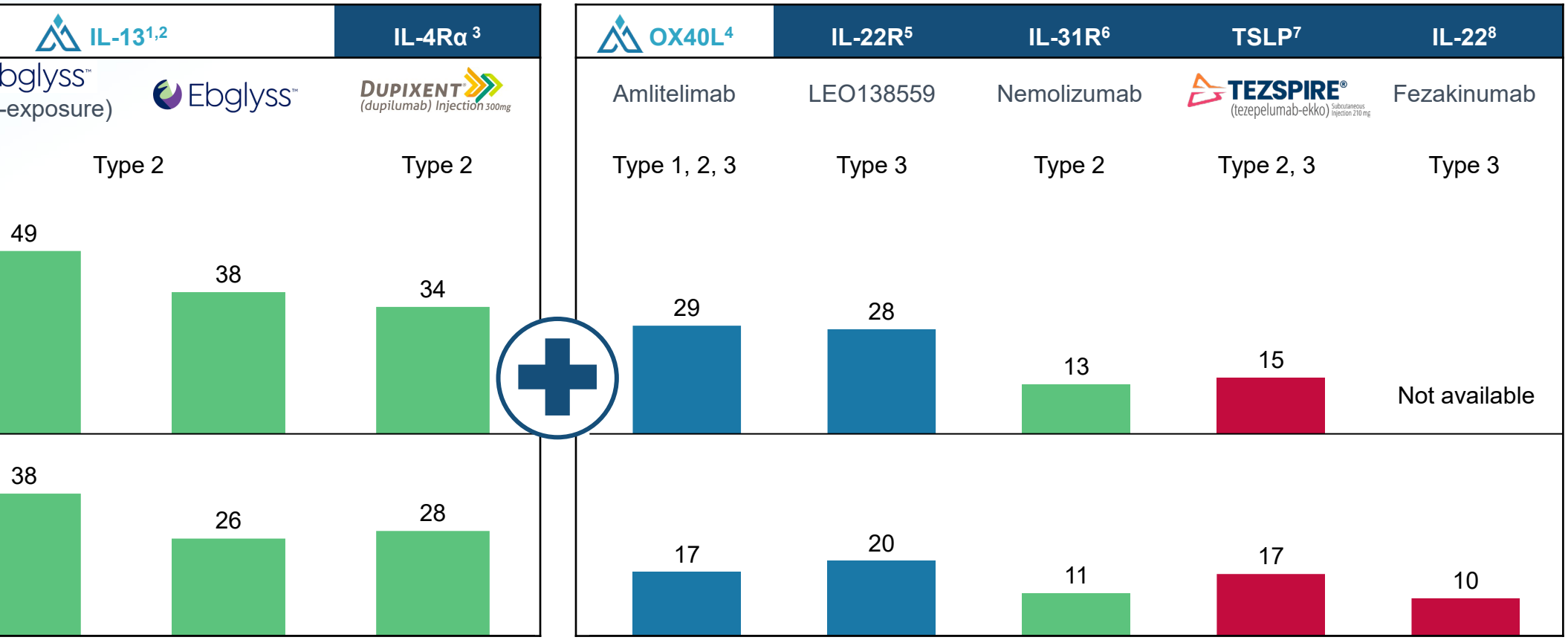
APG777+APG990 combination enables potentially best-in-class efficacy and dosing (Q3M+)

NOTE: Amlitelimab biomarker changes presented are average values across dose cohorts based on approximate data points from digitized charts. APC = antigen presenting cell
SOURCE: Sanofi 2023 R&D day presentation

IL-13 and OX40L are the two orthogonal mechanisms with greatest efficacy in AD

Selected targets for 777+990 combination

Status in AD: Approved | In development | Terminated



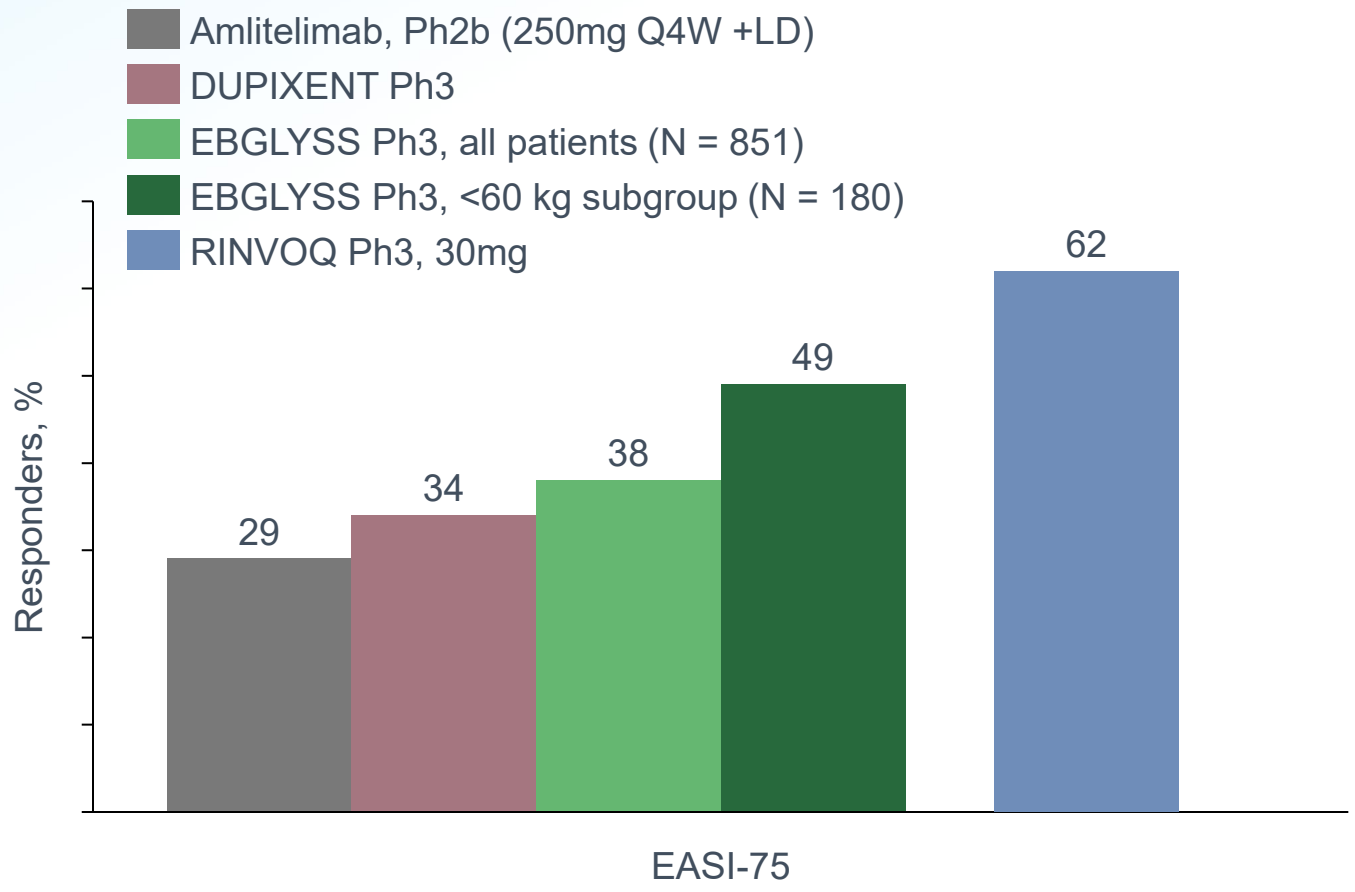
We are combining two of the most active and orthogonal MOAs with potential to exceed monotherapy efficacy

NOTE: MOA = Mechanism of Action. Tezspire and nemolizumab results are from combination trials with TCS. Fezakinumab data is from week 20 while all others are week 16. EBGLYSS, DUPIXENT, and nemolizumab values reflect the weighted average from phase 3 trials, all other values are from Ph2 trials. Nemolizumab is approved in Japan for itch associated with AD and marketed as Mitchga.

SOURCE: 1. Silverberg J et al. NEJM. (2023). 2. Ebglyss EMA Public Assessment Report. 3. Simpson E at al. NEJM. (2016) 4. Weidinger S et al. EADV oral presentation (2023). 5.Thaci et al. AAD oral presentation (2023). 6. Silverberg J. EADV oral presentation (2023) 7. Simpson E et al. J Am Acad Dermatol. (2019). 8. Guttman-Yassky E et al. J Am Acad Dermatol.(2018)

Targeting all inflammatory types may provide greater efficacy

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



- **JAKs inhibit Type 1, 2 and 3 inflammation** but carry a black box warning limiting uptake
- **DUPIXENT and EBGLYSS block Type 2 inflammation**
- **Amlitelimab partially inhibits Type 1, 2, and 3 inflammation** with an acceptable safety profile

APG777 shows near complete inhibition Type 2 inflammation – the core driver of AD

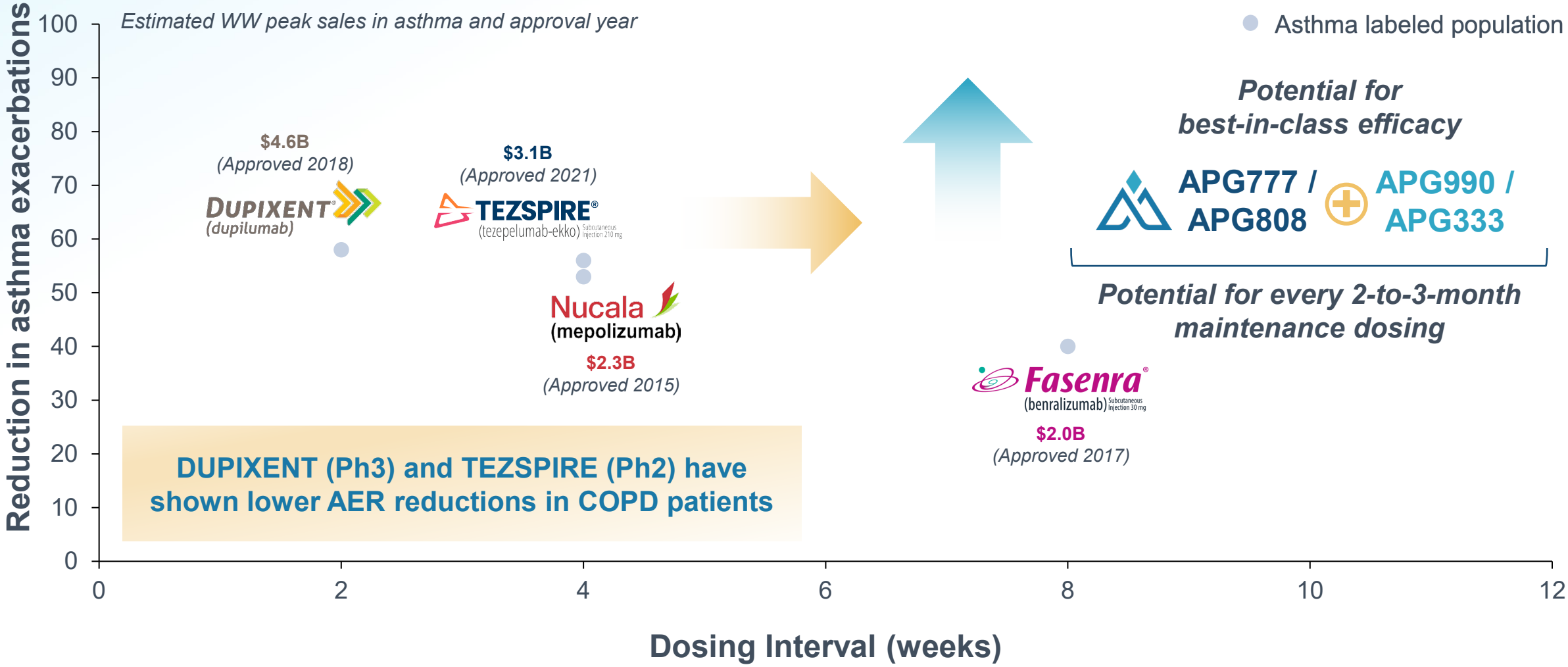
+

APG990 provides potential for broader inhibition to also address heterogenous Type 1 and Type 3 inflammation in AD

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

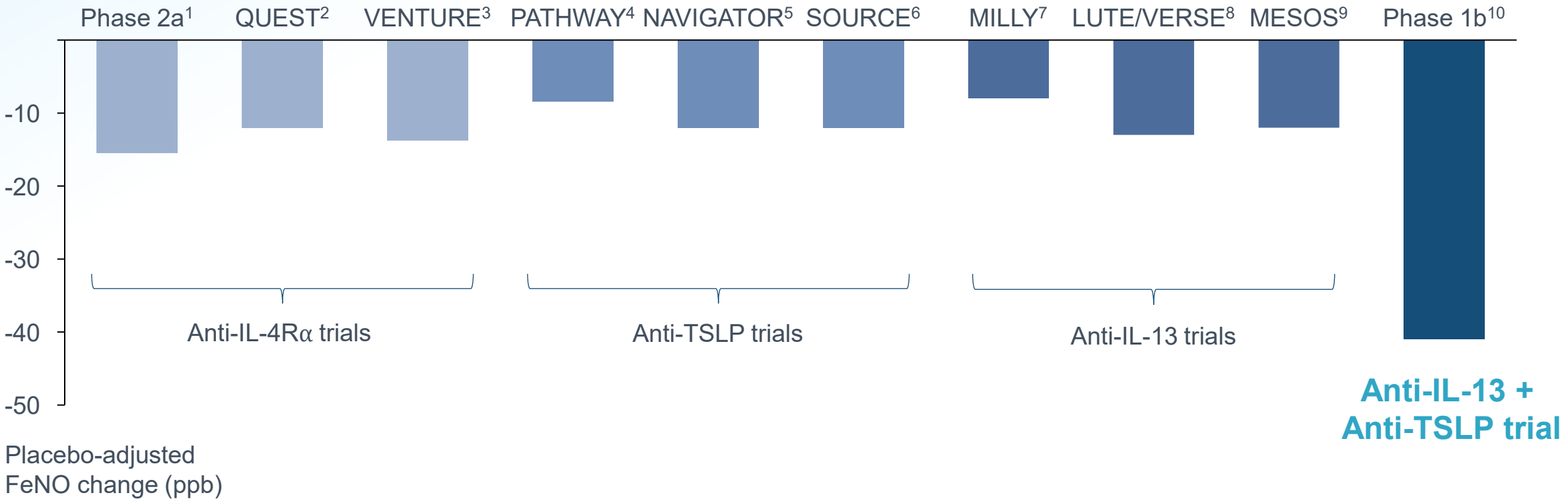
Potential best-in-class combination therapies in asthma and COPD

Apogee is pursuing potentially best-in-class combinations in respiratory diseases



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

Recent data has suggested combo inhibition can lead to additive efficacy in respiratory indications

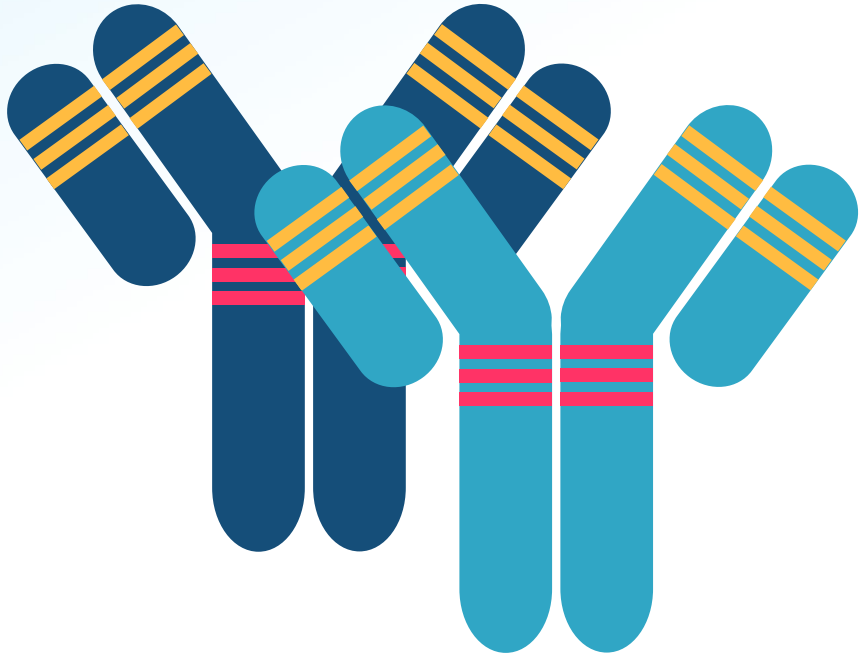


Combined blockade of Type 2 inflammation through IL-13 inhibition and disrupted alarmin signaling by TSLP neutralization demonstrates a potential increase in effect not previously seen by monotherapies alone

NOTE: FeNO level reflects data from marketed dose, where available. Data shown is placebo-adjusted reduction at 29d, with the exception of QUEST, where level was reported at 12 weeks. LUTE/VERSE data from was periostin-high enrollees.

SOURCE: 1) Wenzel S, et al. NEJM, 2013 2) Castro M, et al. NEJM, 2018 3) Rabe KF et al. NEJM, 2018 4) Corren JC, et al. NEJM, 2017 5) Menzies-Gow A, et al. NEJM, 2021 6) Weschler M, et al. Lancet Respir Med, 2022 7) Corren JC, et al. NEJM., 2011 8) Hanania NA, et al. Thorax, 2015 9) Russell RJ, et al. Lancet Respir Med, 2018 10) Deiteren A, et al. ATS, 2023

Apogee's portfolio uniquely enables multiple combos with best-in-class potential in respiratory indications



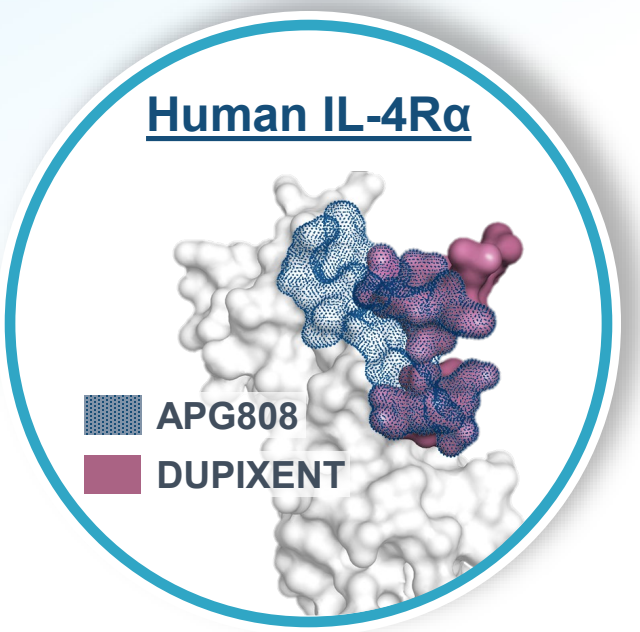
APG777 / APG808 ⊕ **APG990 / APG333**

- **Only known portfolio with IL-13, IL-4Rα, OX40L, and TSLP inhibitors** to enable optimal respiratory combination approaches
- **Potential to bring Q3M+ dosing to an IL-13 / TSLP combo approach** that has been validated by 3rd party data
- **Potential for deeper and broader responses** by targeting orthogonal mechanisms
- **Potential for best-in-class dosing** via coformulation approach

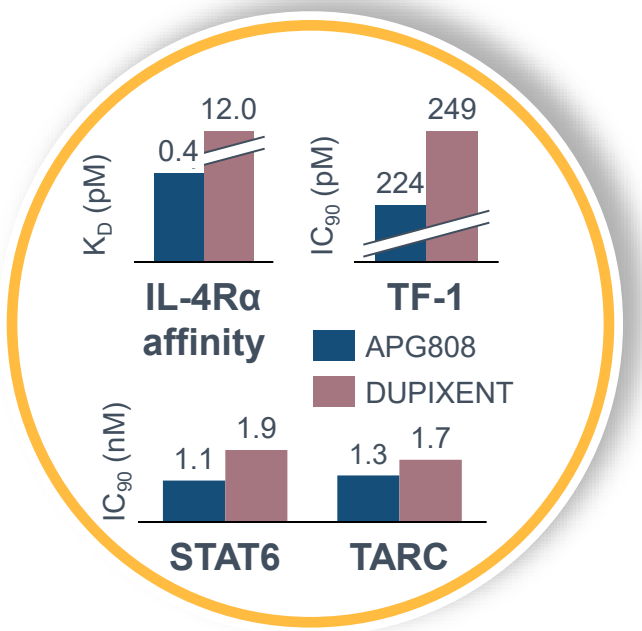
Apogee's TSLP combinations have potential to exceed monotherapy efficacy in a broader population

Differentiators	Potential monotherapies without TSLP		Potential best-in-class combos with TSLP	
	APG777 in asthma	APG808 in COPD	*APG777+APG333 in asthma*	*Best-in-class combo in COPD*
Potential patient population (% eligible)	**High EOS**		**Potential for broader population** *Based on TSLP MoA + data in all-comers asthma*	
Potential efficacy advantage	**TBD, based on optimizing exposure**		✓ *IL-13+TSLP has demonstrated additive FeNO benefit*	✓ *Potential to exceed monotherapy ceiling*

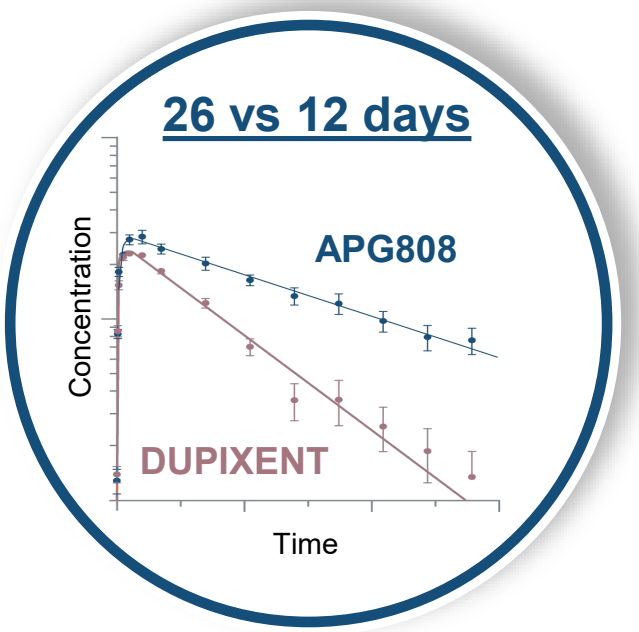
APG808 leverages DUPIXENT's mechanism to deliver a potentially best-in-class, pipeline-in-a-product antibody



APG808's epitope on IL-4Rα overlaps with DUPIXENT's and leverages proven MoA and biology



APG808 is as potent as DUPIXENT across preclinical assays



APG808 NHP half-life is more than 2x longer than DUPIXENT

 NOTE: MoA = Mechanism of Action.

APG808 Phase 1a clinical trial objectives

OBJECTIVES

Confirm tolerable **safety profile**

Establish **optimized PK profile** with a half-life of at least 42 days

Determine **dosing regimens** to sustain exposures similar to DUPIXENT

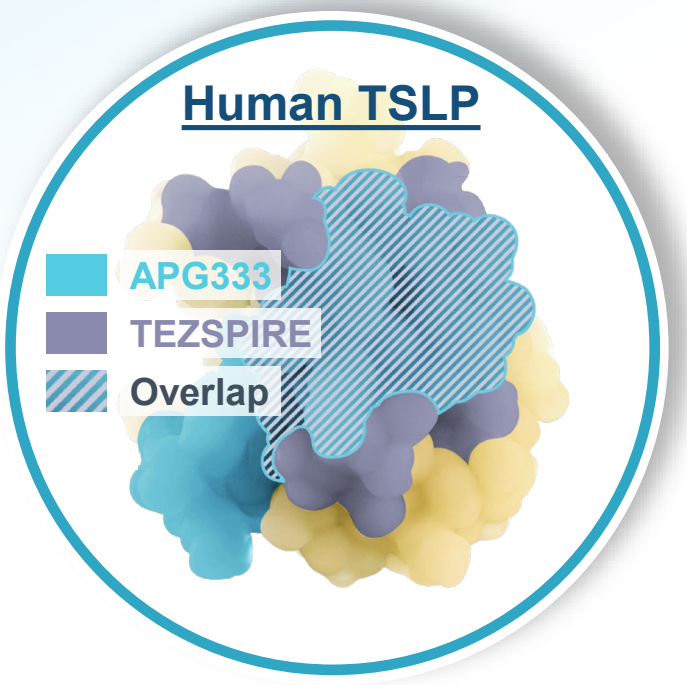
Q4 2024: confirm potential for best-in-class dosing intervals

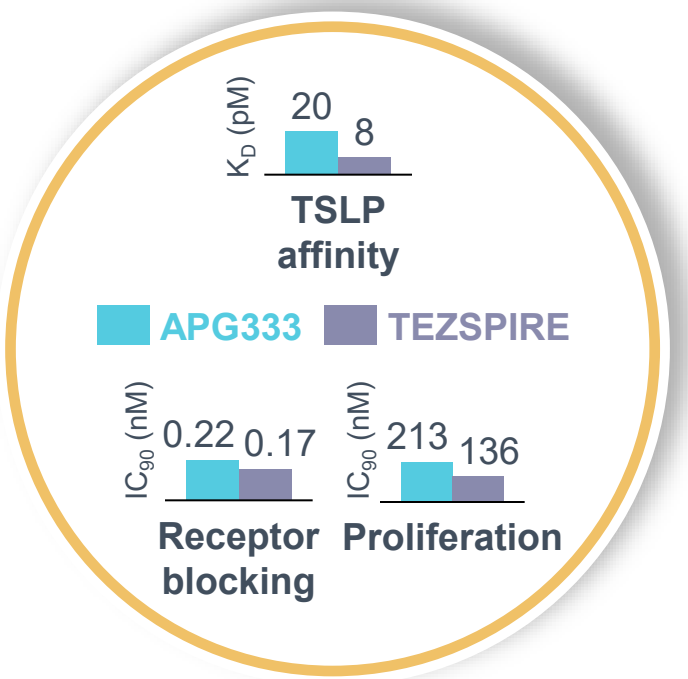
Dosing Goal: every 6- or 8-weeks

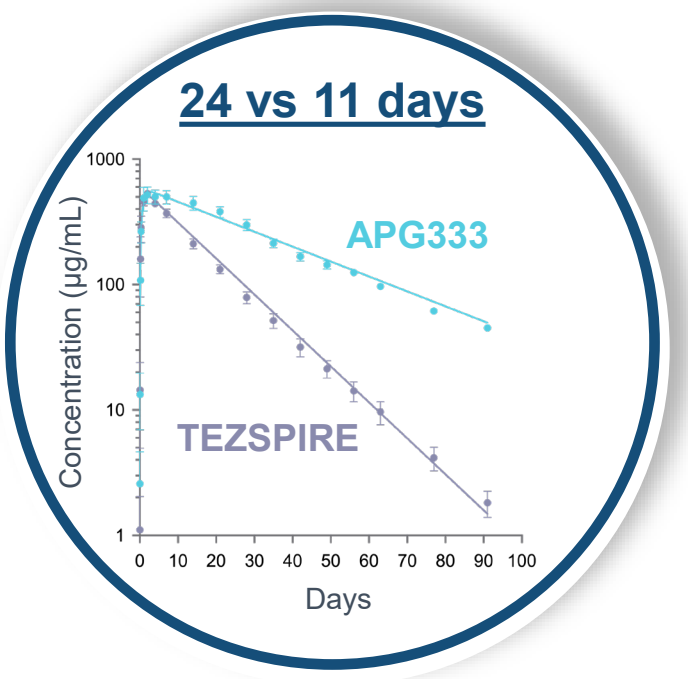
(vs. every 2 weeks for DUPIXENT[1])

NOTE: PK = Pharmacokinetic. [1] Based on FDA label for DUPIXENT™

APG333 leverages TEZSPIRE's mechanism to enable potentially best-in-class combination therapies







APG333's epitope on TSLP overlaps with TEZSPIRE's and leverages proven MoA and biology

APG333 demonstrates potency comparable to TEZSPIRE across preclinical assays

APG333 NHP half-life is extended relative to TEZSPIRE

NOTE: MoA = Mechanism of Action. APG333 preclinical data was generated using tezepelumab, which is the active ingredient in TEZSPIRE. The tezepelumab tested in these studies was made using the publicly-available sequence for tezepelumab

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

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

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

There are 134 FDA approved co-formulated drugs and several notable late-stage combos being actively pursued

Select FDA approved coformulated biologics

Company	Brand Name	Generic Drug Names	FDA Approval	Indication(s)
argenx	VYVGART® Hytrulo	efgartigimod alfa + hyaluronidase-qvfc	2023	GMG, CIDP
Bristol Myers Squibb	Opdualag	nivolimab + relatlimab-rmbw	2022	Melanoma
REGENERON	REGEN-COV™	casirivimab + imdevimab	2020*	COVID-19
REGENERON	Inmazeb®	atoltivimab/maftivimab/odesivimab-ebgn	2020	Ebola
Roche	PHESGO®	pertuzumab + trastuzumab + hyaluronidase-zzxf	2020	Breast cancer
sanofi	SOLIQUA®	insulin glargine + lixisenatide	2016	T2D

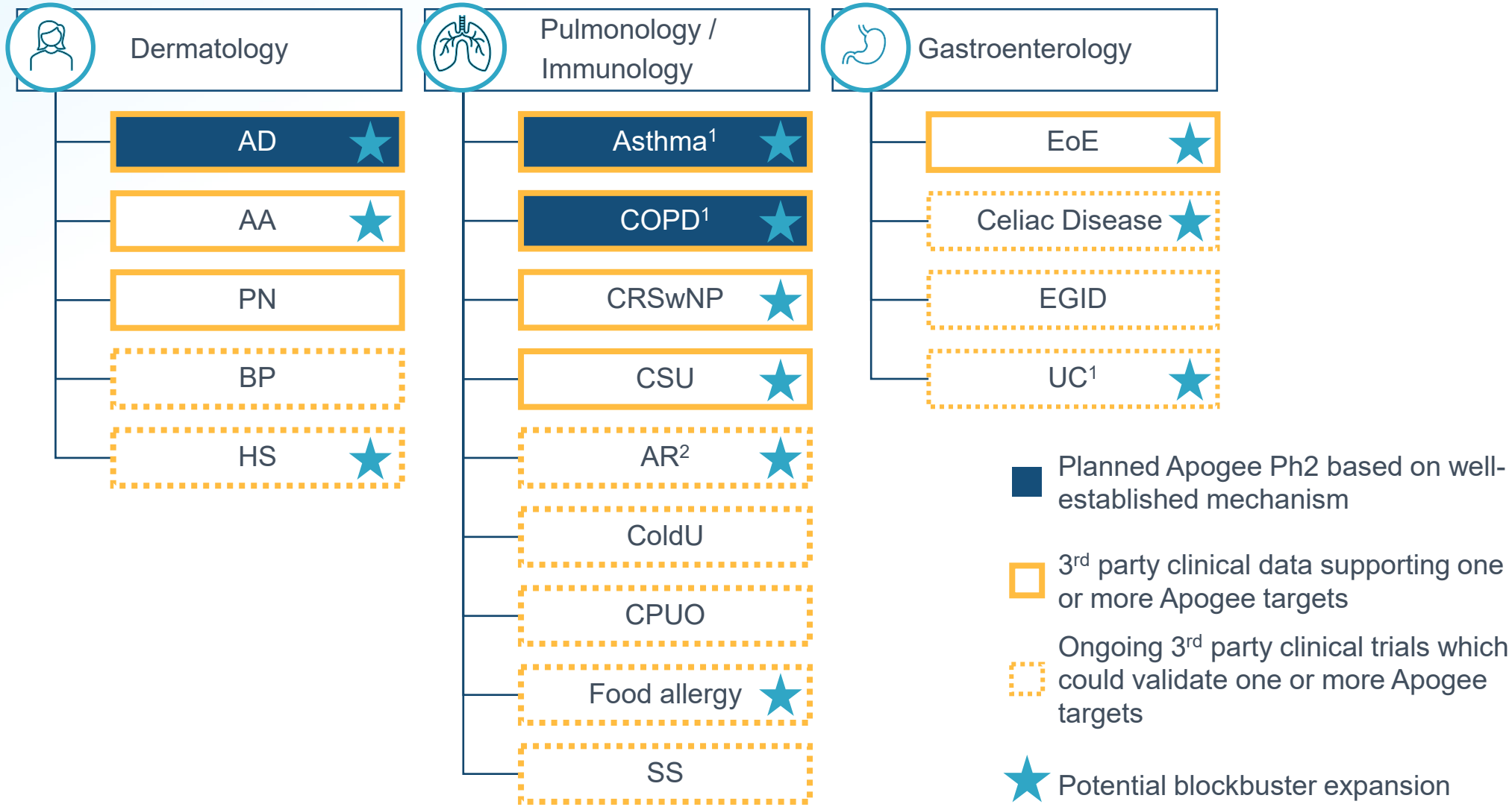
Select coformulated biologics in late-stage development

Company	Program	Generic Drug Names	Phase	Indication(s)
Johnson & Johnson	JNJ-4804	golimumab + guselkumab	Ph2b	IBD, PsA
novo nordisk®	CagriSema	cagrilintide + semaglutide	Ph3	T2D, obesity
REGENERON	REGN3918	pozelimab + cemdisiran	Ph3	GMG, PNH

NOTE: GMG = Generalized myasthenia gravis; CIDP = Chronic inflammatory demyelinating polyneuropathy; MM = Multiple myeloma; T2D = Type 2 diabetes; IBD = Inflammatory bowel disease; PsA: Psoriatic arthritis; PNH = Paroxysmal nocturnal hemoglobinuria
* REGEN-COV received Emergency Use Authorization from the FDA
SOURCE: FDA

Expansion indications

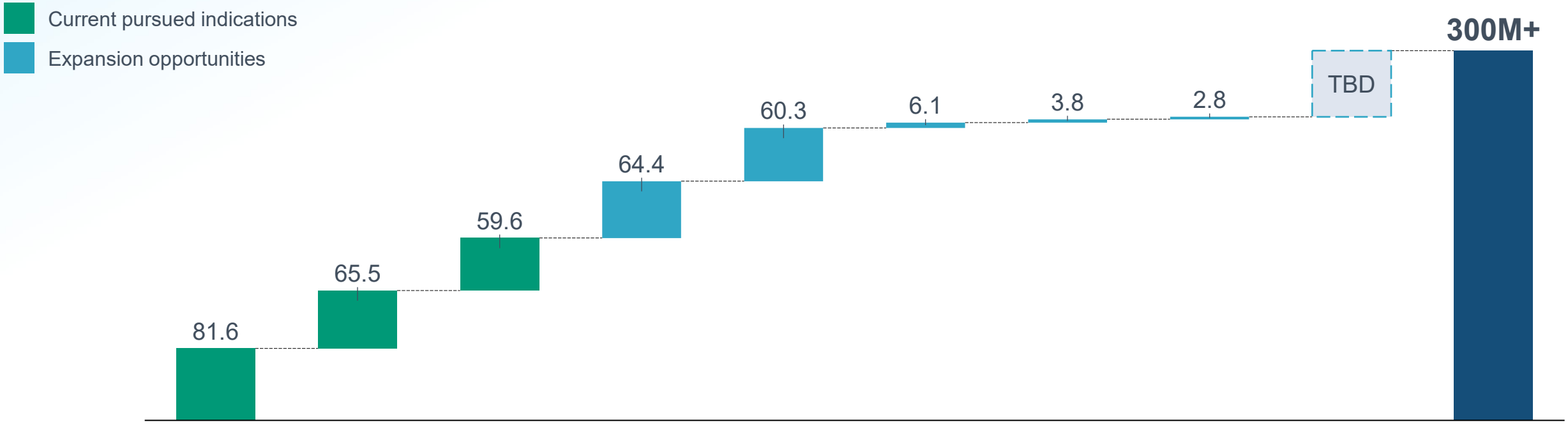
Our programs have broad potential to disrupt the I&I space



NOTE:[1] Eosinophilic subtypes [2] Perennial
AA = Alopecia Areata. PN = Prurigo Nodularis. BP= Bullous Pemphigoid. HS = hidradenitis suppurativa. CSU = Chronic Spontaneous Urticaria. CRSwNP = Chronic Rhinosinusitis with Nasal Polyps ColdU = Cold Inducible Urticaria. CPUO = Chronic Pruritis of Unknown Origin.. AR = Allergic Rhinitis. SS= Systemic Sclerosis. EoE = Eosinophilic esophagitis. UC = Ulcerative Colitis. EGID = Eosinophilic Gastrointestinal Disorders (non-EoE).

We are pursuing the largest markets in I&I with a total addressable population over 300M

WW addressable patient population across indications (in millions)

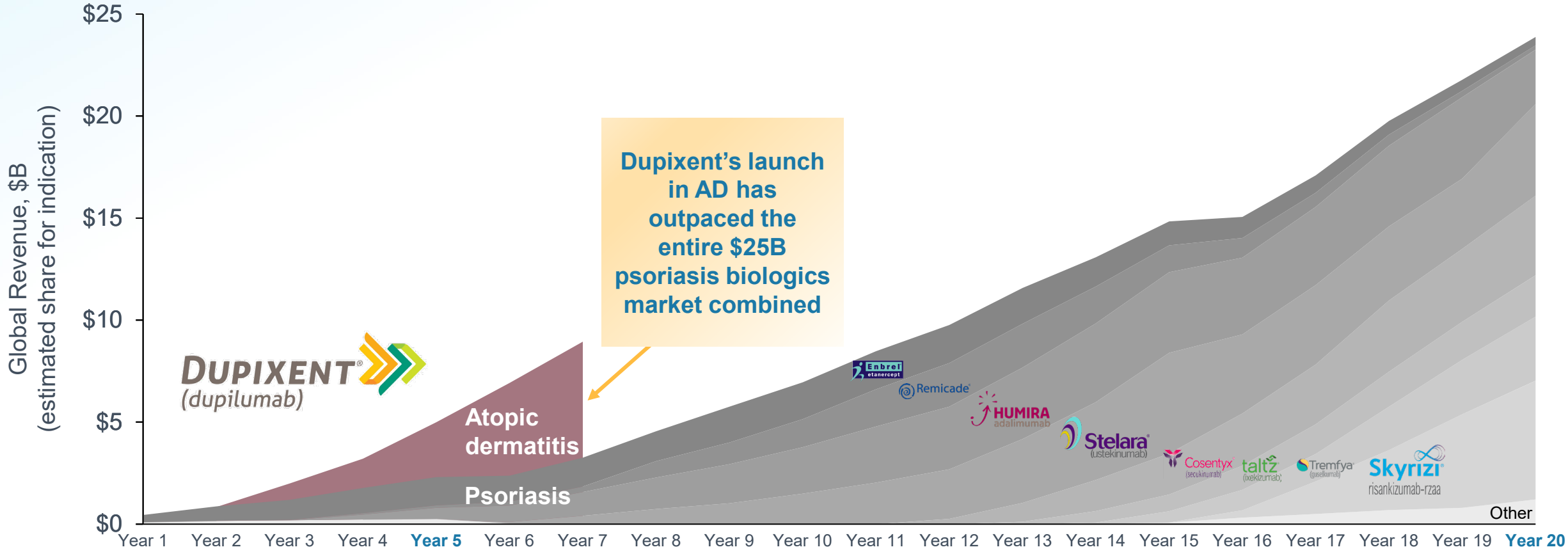


Indication	AD[1]	Asthma[1]	COPD[1]	CSU[2]	CRSwNP[2]	AA[2]	PN[2]	EoE[2]	EGID & AR	Total WW Addressable Population
2030E Market Size	$29.0B	$20.0B	$13.5B	$4.5B	$1.0B	$2.0B	$0.5B	$0.5B	TBD	$70B++

NOTE: AD = Atopic Dermatitis, COPD = Chronic Obstructive Pulmonary Disease, CSU = Chronic Spontaneous Urticaria, CRSwNP = Chronic Rhinosinusitis with Nasal Polyps, EoE = Eosinophilic Esophagitis, PN = Prurigo Nodularis, AA = Alopecia Areata, EGID = Eosinophilic Gastrointestinal Disorders (non-EoE), AR = Allergic Rhinitis.
[1] Encompasses moderate-to-severe population. [2] Encompasses prevalent population.
SOURCE: Academic journals, disease foundations, WHO, CDC, census data, analyst research, EvaluatePharma. 2030E market size rounded to nearest $0.5B.

Corporate & Commercial

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



Dupixent's launch in AD has outpaced the entire $25B psoriasis biologics market combined

At year 5, biologic penetration in AD was 8% vs. 5% for psoriasis

At year 20, biologic penetration for psoriasis was 24%, suggesting AD could grow to 25%+ by 2032

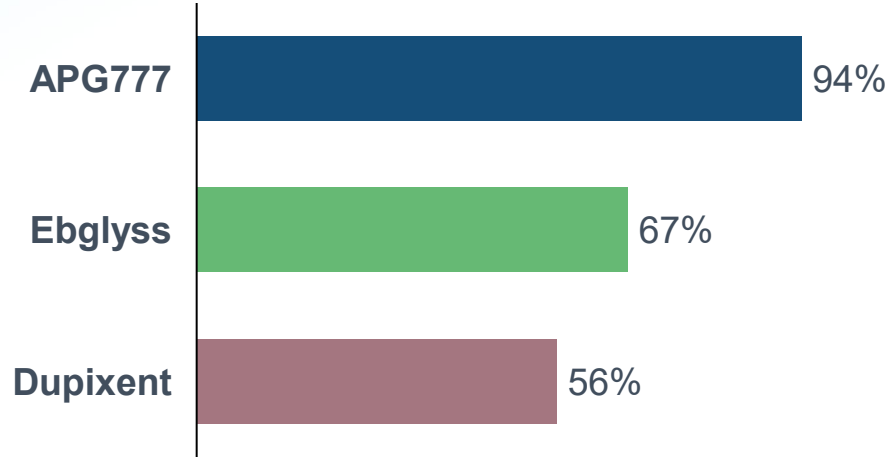
SOURCE: EvaluatePharma
NOTE: Year 1 for Dupixent in AD is 2017 and for Biologics in PsO is 2004 (i.e., Enbrel approval).

Patients and physicians like APG777's quarterly dosing profile; payors support 1L biologic access

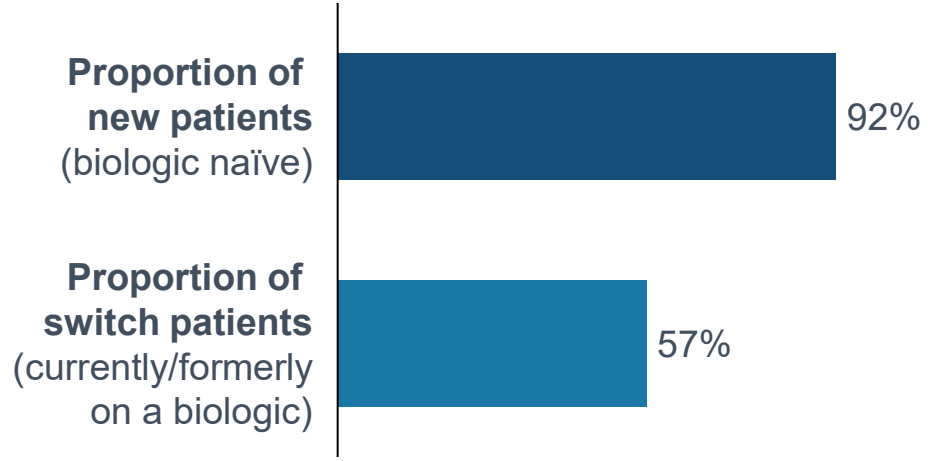
Market research supports APG777's differentiated profile

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

Patient likelihood to take action for each treatment[1]



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



> *[APG777] would be placed from a coverage perspective or a tiering perspective at parity as Dupixent*
>
> – VP of Pharmacy, Large National PBM #1[3]

> *[APG777] would be covered at parity… if [APG777] shifts the market, then it may move up to preferred*
>
> – VP of Pharmacy, Large National PBM #2[3]

SOURCE: **Patients:** TRINITY Qualitative Research with N=18 AD Patients, August 2024. **Physicians**: In 2023, Apogee conducted a single-blinded market research survey of 25 practicing dermatologists in 14 states in the United States, with the assistance of an expert search network. **Payors:** Real Endpoints Qualitative Research with N=6 payers, February 2024.

NOTE: [1]AD patients responding 6 or 7 on a scale from 1 to 7 rating their likelihood to take action after reviewing a blinded TPP for each treatment. APG777 TPP based on equivalent efficacy and safety as DUPIXENT. [2]For providers where likeliness to prescribe Product Y (equivalent efficacy and safety as DUPIXENT, but with Q3M dosing) differs for pediatric and adult patients a blended rate was calculated using the weighted average of the pediatric and adult rates based on the mix of AD patients in that dermatologists' practice. [3]Payor coverage expectations are based on a product with similar efficacy, safety, and net pricing as Dupixent, but with Q3M dosing

Multiple anticipated milestones through 2025 with $754M in cash providing expected runway into 2028

★ Key readout

		2024	2025
Potential best-in-class monotherapy in AD	**APG777** IL-13	✓ Positive Phase 1 PK & safety in HVs ✓ 1H: Phase 2 initiated in AD	★ **2H: Phase 2 16-week induction PoC data** • Disclose additional indication
Potential best-in-class mAbs for combinations	**APG808** IL-4Rα	✓ Phase 1 initiated in HVs ★ **4Q: Initial Phase 1 PK & safety in HVs**	★ **1H: Phase 1b clinical data in asthma**
	APG990 OX40L	✓ Candidate nomination ✓ 3Q: Phase 1 initiated in HVs	★ **1H: Initial Phase 1 PK & safety in HVs**
	APG333 TSLP	• Late 2024 / Early 2025: Initiate Phase 1 PK & safety in HVs	
Potential first- or best-in-class combination approaches	**APG777 ± APG990** IL-13 ± OX40L		• Clinical trial initiation in AD
	APG777 ± APG333 IL-13 ± TSLP		
	Additional combination(s) IL-13/IL-4Rα + OX40L/TSLP	• 4Q: Additional respiratory combination(s) to be announced at R&D Day December 2	

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

Experienced team with proven history of clinical development and commercial execution

Michael Henderson, MD
Chief Executive Officer, Director

Carl Dambkowski, MD
Chief Medical Officer

Jane Pritchett Henderson
Chief Financial Officer

Rebecca Dabora, PhD
Chief Development Officer

Jeff Hartness
Chief Commercial Officer

Matt Batters, JD
Chief Legal Officer

Wendy Aspden-Curran
SVP of Clinical Operations

Drew Badger, PhD
SVP of Regulatory Affairs & Toxicology

Dan Mulreany
SVP of Business Development & Strategy

Kristine Nograles, MD, MSc
SVP of Clinical Development

Board of Directors with industry-leading development, regulatory, commercial and management expertise

Mark McKenna
Chairman & CEO, Mirador Therapeutics

mirador THERAPEUTICS · Prometheus Biosciences · BAUSCH Health · Johnson & Johnson

Michael Henderson, MD
CEO, Apogee Therapeutics

bridgebio · QED therapeutics · pellepharm · McKinsey & Company

Lisa Bollinger, MD
CEO & President of Bollinger Regulatory Consulting, LLC

MERCK · AMGEN · FDA

Jennifer Fox
CFO & CBO, Zenas BioPharma

Zenas BioPharma · citigroup · Nuvation Bio

Andrew Gottesdiener, MD
Venrock

venrock

Peter Harwin
Managing Member, Fairmount

FAIRMOUNT · PARAGON THERAPEUTICS

BJ Jones
CCO, NewAmsterdam Pharma

New Amsterdam Pharma · biohaven · AstraZeneca · Takeda

Tomas Kiselak
Managing Member, Fairmount

FAIRMOUNT · PARAGON THERAPEUTICS

Nimish Shah
Venrock

venrock

Apogee /ˈapəjē/ *noun*

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