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, objectives, goals, strategies and future events, the efficacy, safety, tolerability, PK and PD profile of APG777, the potential dosing regimen of APG777, the potential superiority of APG777 compared to current therapies, our expectations regarding plans for our current and future product candidates and programs, our plans for our current and future clinical trials, our plans for clinical trial design, the anticipated timing of the initiation of and results from our clinical trials, the potential clinical benefit and half-life of APG777, APG908, APG990, APG222 and any other potential programs including combinations, 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, 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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Apogee plans to reshape the current standard of care for I&I diseases

<table>
<thead>
<tr>
<th>Program</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</td>
<td></td>
<td></td>
<td>Atopic Dermatitis</td>
<td>2H 2025: 16-week proof-of-concept data</td>
<td></td>
</tr>
<tr>
<td>IL-13</td>
<td>IL-13</td>
<td>Same MOA as lebrikizumab</td>
<td>Atopic Dermatitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>APG808</td>
<td></td>
<td></td>
<td>COPD</td>
<td>2H 2024: Initial Phase 1 PK and safety in HV</td>
<td></td>
</tr>
<tr>
<td>IL-4Ra</td>
<td>IL-4Ra</td>
<td>Same MOA as DUPLEXENT</td>
<td>COPD</td>
<td>2025: Proof-of-concept trial initiation in COPD</td>
<td></td>
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<tr>
<td>APG990</td>
<td></td>
<td></td>
<td>Atopic Dermatitis</td>
<td>2H 2024: Phase 1 initiation in HV</td>
<td></td>
</tr>
<tr>
<td>OX40L</td>
<td>OX40L</td>
<td>Same MOA as amlitelimab</td>
<td>Atopic Dermatitis</td>
<td></td>
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</tr>
<tr>
<td>APG222</td>
<td></td>
<td></td>
<td></td>
<td>2025: Initial Ph1 PK &amp; safety in HV</td>
<td></td>
</tr>
<tr>
<td>Combination IL-13 + OX40L</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**FOCUS**
Best-in-class mono- and first-in-class combo-therapies for the largest markets in I&I

**APPROACH**
Fully optimized antibodies incorporating advanced engineering

**EXPANSION**
Pipeline-in-a-product potential for each program with optionality for combination therapy

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 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 is pursuing the largest I&I markets with a highly de-risked approach and AD is the largest

Estimated population size, MM
Moderate or severe in 7 Major Markets

- **Psoriasis expected to be a $30B+ market; atopic dermatitis (AD) represents a larger opportunity expected to grow to $50B+ based on ~3x larger patient population**

- **AD biologics penetration is outpacing early years of psoriasis biologics (8% vs 5% at 5 years)**

- **AD market is projected to grow more than any other I&I market**

• Psoriasis expected to be a $30B+ market; atopic dermatitis (AD) represents a larger opportunity expected to grow to $50B+ based on ~3x larger patient population

Source: Company filings, annual reports, press releases, analyst forecasts, academic journals, GlobalData, EvaluatePharma, Clarivate.
Apogee is pursuing potentially best-in-class monotherapy and first-in-class combination in AD

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 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. 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 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.

Efficacy (EASI-75, %)

Dosing Interval (weeks)

Potential for best-in-class efficacy

Potential first-in-class IL-13 + OX40L combination

Testing ~30-40% higher exposures than lebrikizumab in induction

Potential for every 3- or 6-month maintenance dosing
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**

Potential for PK that:
- Optimizes exposures
- Decreases variability
- Increases half-life

Potential for PK that:
- Designed to maximize antibody recycling
- Drug exists at higher levels for longer effect

Based on clinically-validated epitopes with performance across five properties:
APG777 leverages lebrikizumab's mechanism to deliver a potentially best-in-class, pipeline-in-a-product antibody

APG777 disrupts Th2 signaling by preventing formation of IL-13Rα1 / IL-4Rα heterodimer

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

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

APG777 human half-life enables higher exposures and 3- or 6- month dosing

NOTE: MoA = Mechanism of Action.
In psoriasis, an analog to AD, Skyrizi has taken the lead with quarterly dosing.
Psoriasis analogs demonstrate the value of reaching quarterly dosing

Efficacy of anti-IL23 biologics in psoriasis

- PASI 90: 72% for Tremfya (Q8W), 75% for Skyrizi (Q12W)
- IGA-0/1: 85% for Tremfya (Q8W), 86% for Skyrizi (Q12W)

Sales of anti-IL23 biologics ($B)

- Psoriasis (2028E): 9.1B for Skyrizi (Q12W), 4.8B for Tremfya (Q8W)
- All indications (2028E): 17.9B for Skyrizi (Q12W), 6.2B for Tremfya (Q8W)

Skyrizi's best-in-class dosing translated to a market-leading position

SOURCE: Skyrizi and Tremfya USPIs. EvaluatePharma WW consensus sales estimates
There is significant whitespace in the landscape of approved and in-development biologics for AD

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. 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 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 is pursuing potentially best-in-class monotherapy and first-in-class combination in AD

Efficacy (EASI-75, %)

Dosing Interval (weeks)

- Dupixent (dupilumab)
- Lebrikizumab
- CBP-201
- Rocatinlimab
- Amlitelimab
- Nemolizumab
- Adbry

Potential for every 3- or 6-month maintenance dosing

Potential for best-in-class efficacy

Testing ~30-40% higher exposures than lebrikizumab in induction

Potential first-in-class IL-13 + OX40L combination

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 and ADBRY are approved.

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Dermatologists view every 3- or 6-month dosing as highly differentiated

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

Apogee plans to test every 3- or 6-month maintenance dosing in APG777 Phase 2

<table>
<thead>
<tr>
<th></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 3 month dosing</td>
<td>92%</td>
<td>57%</td>
</tr>
<tr>
<td>Every 6 month dosing</td>
<td>91%</td>
<td>68%</td>
</tr>
</tbody>
</table>

NOTE: For providers who prioritize 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 dermatologist’s practice.

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.
APG777’s best-in-class Phase 1 PK profile shows potential to be a leading product in the expected $50B+ AD market¹

Potential for improved clinical responses (e.g. EASI-75, EASI-90, IGA 0/1) based on ~30-40% greater modeled induction exposures than lebrikizumab²

Extended 3- and 6- month dosing interval addresses clear unmet need

Favorable product characteristics and COGS

Novel IP into mid-2040s

¹$50B projected AD market in 2035, based on projected growth of AD market at a similar rate to psoriasis.²APG777 has demonstrated equivalent potency to lebrikizumab in our head-to-head preclinical assays. SOURCE: EvaluatePharma.
APG777 Phase 1 initial data exceeded all trial objectives

**Establish safety & PK profile**
Well-tolerated with at least 33-day half-life

- Half life of ~75 days
- Doses up to 1200mg tested and well-tolerated
- Initial multiple-dose data consistent with PK & safety profile from SAD cohorts

**Set Ph2 induction regimen**
Achieve at least equiv. exposures to lebrikizumab with same or fewer injections

- Regimen modeled to exceed lebrikizumab exposure by ~30-40% with potential for improved clinical responses (e.g. EASI-75, EASI-90, IGA 0/1)
- ~50% fewer injections than lebrikizumab in induction (6 vs 11)

**Set Ph2 maintenance regimens**
Equal lebrikizumab exposure with every 2-month or longer dosing

- 3- or 6-month maintenance dosing enabled with modeled exposures similar to or greater than lebrikizumab

**Supplemental**
Demonstrate effect on biomarkers pSTAT6 or TARC

- Extended PD effect on both pSTAT6 and TARC for ~3 months with follow-up ongoing
APG777 exhibited a potentially best-in-class PK profile with a half-life of ~75 days

**Single-dose concentration-time profile**

- Slow clearance, resulting in half-life of ~75 days
- Dose-proportional increases in both Cmax and AUC

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

**Multi-dose concentration-time profile**

- Initial multiple-dose data consistent with PK profile from SAD cohorts
pSTAT6 and TARC are biomarkers of IL-13 target engagement and AD severity

1. pSTAT6 is one of the earliest markers of IL-13 receptor activation

2. TARC levels are the most strongly correlated to AD severity of any biomarker

Taken together, APG777’s reduction of these biomarkers confirms inhibition of IL-13 signaling and allows comparison to other agents
Single dose APG777 showed near complete pSTAT6 inhibition for ~3 months (limit of available follow-up)

Median percent pSTAT6

Weeks

% pSTAT6

300 mg (N=1)
600 mg (N=6)
1200 mg (N=6)
Placebo (N=4)

At ~3 months (longest available follow-up) pSTAT6 remained fully suppressed after single dose of APG777

100% pSTAT6 inhibition was demonstrated for approximately 3 months across all doses

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 lebrikizumab impact on pSTAT6 in HVs.
Single dose of APG777 led to deep + sustained TARC inhibition for ~3 months (limit of available follow-up)

- 300 mg APG777 showed similar maximum PD marker changes as DUPIXENT
- APG777 sustained TARC inhibition demonstrates the potential for better durability
- All doses tested of APG777 showed deep TARC inhibition for ~3 months (limit of available follow-up)

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 a Phase 1 trial 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. No data has been published showing lebrikizumab impact on TARC in HVs.
APG777 Phase 2 in Atopic Dermatitis
Ongoing integrated Phase 2 expected to have 16-week topline data in 2H’25

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

<table>
<thead>
<tr>
<th>Screening</th>
<th>Induction</th>
<th>Maintenance</th>
</tr>
</thead>
<tbody>
<tr>
<td>2:1</td>
<td>720mg W0 720mg W2 360mg W4</td>
<td>Every 3 mos (Q12W) Rollover to OLE or 52-week follow-up period</td>
</tr>
</tbody>
</table>

Integrated Phase 2 design has potential for significant timeline acceleration
- Combines Ph2a and Ph2b elements into a single protocol; All Part A sites are Part B sites (avoiding site startup delays between parts)
- Both Part A and Part B are >90% powered for the primary endpoint (%CFBL in EASI at Week 16)

Part B: Dose optimization (N ~360)

<table>
<thead>
<tr>
<th>Screening</th>
<th>Induction</th>
<th>Maintenance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:1:1:1</td>
<td>High Dose</td>
<td>Regimen A (TBD) Rollover to OLE or 52-week follow-up period</td>
</tr>
<tr>
<td></td>
<td>Medium Dose</td>
<td>Regimen B (TBD)</td>
</tr>
<tr>
<td></td>
<td>Low Dose</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Placebo</td>
<td></td>
</tr>
</tbody>
</table>

Primary Endpoint

Rollover to OLE or 52-week follow-up period

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

Modelled induction and maintenance dosing for APG777 and lebrikizumab

- **Induction exposure goal:** EXCEED
- **Maintenance exposure goal:** EQUAL

- Lebrikizumab data suggests an exposure-response (E-R) for efficacy in induction that underpins our goal to EXCEED lebrikizumab induction exposures
- There was no E-R observed in maintenance for lebrikizumab; our aim is to EQUAL its exposure in maintenance

**Graphical representation:**
- APG777
  - Median
  - 95% PI
- Lebrikizumab
  - Median
  - 95% PI

**Planned APG777 induction regimen:** 720 mg in weeks 0 and 2 and 360 mg in weeks 4 and 12. Maintenance regimen shown is 360 mg every 12 weeks. The above graph is illustrative only with respect to plans for dosing of APG777 and does not present comparative data.
Lebrikizumab Ph3 appears to show an E-R relationship for efficacy in induction that has not been maximized

Lebrikizumab Ph3 response at Week 16 (Placebo-adjusted), %

- **EASI-75**
  - ~45-50% higher exposure: 29%
  - ~35-40% higher exposure: 36%
  - ~30% higher exposure: 49%

- **EASI-90**
  - ~45-50% higher exposure: 18%
  - ~35-40% higher exposure: 23%
  - ~30% higher exposure: 38%

- **IGA 0/1**
  - >100 kg (N = 100): 8%
  - 60-100 kg (N = 569): 26%
  - <60 kg (N = 180): 38%

**Bodyweight vs. Exposure**

- Lebrikizumab exposure and induction efficacy are both inversely correlated with body weight.
- Relationships suggest an exposure-response for efficacy in induction and support testing higher exposures with APG777.
- In lebrikizumab Ph2b and Ph3, there has been no dose-AE or exposure-AE relationship.
- APG777 plans to test ~30-40% higher exposures in induction with ~50% fewer injections.

**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).

**SOURCE:** Lebrikizumab European Public Assessment Report.
Modeled Phase 2 induction exposures exceed those of lebrikizumab by ~30-40%.

Modeled induction dosing for APG777 and lebrikizumab

NOTE: Planned APG777 induction regimen is 720 mg in weeks 0 and 2 and 360 mg in weeks 4 and 12. Exposure increase is based on modeled Caverage for APG777 vs lebrikizumab. The above graph is illustrative only with respect to plans for dosing of APG777 and does not present comparative data.

~30-40% increase in exposures

~50% decrease in injections
Modeled Phase 2 Q3M maintenance exposures equal those of lebrikizumab

**APG777 Q3M**

Aiming for annual maintenance injections:

4 vs 13-26 for lebrikizumab/DUPIXENT

**Modeled concentration in maintenance**

- APG777 Median and 95% PI
- Lebrikizumab Median and 95% PI

**NOTE:** The above graph is illustrative only with respect to plans for dosing of APG777 and does not present comparative data.
Modeled Phase 2 Q6M maintenance exposures equal those of lebrikizumab

APG777 Q6M
Aiming for annual maintenance injections:

2 vs 13-26 for lebrikizumab/DUPIXENT

Modeled concentration in maintenance

NOTE: The above graph is illustrative only with respect to plans for dosing of APG777 and does not present comparative data.
Strong historical correlation between Ph2 and Ph3 data makes APG777 16-week AD data a key catalyst

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

Phase 3 failure in AD is rare

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

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

## Phase 2 16-week data in atopic dermatitis is planned to readout in 2H 2025

<table>
<thead>
<tr>
<th>Safety</th>
<th>Efficacy primary endpoint</th>
<th>Efficacy key secondary endpoints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confirm well tolerated safety profile as seen in Phase 1 HV study and in line with other agents in class (e.g., DUPIXENT, lebrikizumab)</td>
<td>Primary endpoint of percent change from baseline in EASI at Week 16 in line with standard of care (approx. 65-70% absolute value)</td>
<td>Proportion of patients achieving key secondary endpoints at Week 16 (future approvable endpoints) in line with standard of care:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• EASI-75: approx. 45-50% (absolute value)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• IGA 0/1: approx. 35-40% (absolute value)</td>
</tr>
</tbody>
</table>

2H 2025 ➔ Phase 2 16-week PoC readout

NOTE: 1 Based on FDA label for DUPIXENT™
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.
With similar efficacy, dosing drives market share: Eylea (Q8W) significantly outsold Lucentis (Q4W) despite later launch.

### Efficacy in wAMD registrational trials

<table>
<thead>
<tr>
<th>% of patients meeting specified endpoint</th>
<th>&lt;15 letter BCVA loss</th>
<th>&gt;15 letter BCVA gain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lucentis (Q4W) – Approved in 2006 (LOE in 2020)</td>
<td>95</td>
<td>33</td>
</tr>
<tr>
<td>Eylea (Q8W) – Approved in 2011</td>
<td>95</td>
<td>31</td>
</tr>
</tbody>
</table>

### US sales ($B)

<table>
<thead>
<tr>
<th>Year</th>
<th>Lucentis (Q4W)</th>
<th>Eylea (Q8W)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>1.4</td>
<td>1.5</td>
</tr>
<tr>
<td>2020</td>
<td>3.4</td>
<td>4.9</td>
</tr>
</tbody>
</table>

Eylea’s success demonstrates how dosing differentiation can drive commercial success, even for a smaller biotech competing against an established incumbent (Eylea was Regeneron’s first major launch).
# 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>
<th>APG808 dosing interval based on PK modeling¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>COPD</td>
<td></td>
<td>Every 6 weeks</td>
<td>Average of YTE mAbs for receptor targets (2.5x)</td>
</tr>
<tr>
<td>APG808 (YTE)</td>
<td>26</td>
<td>42 (1.6x)</td>
<td></td>
</tr>
<tr>
<td>DUPIXENT (dupilumab)</td>
<td>11</td>
<td>59 (2.3x)</td>
<td></td>
</tr>
</tbody>
</table>

**Comparative YTE mAbs for other indications**

<table>
<thead>
<tr>
<th></th>
<th>NHP half-life, days</th>
<th>APG808 Predicted half-life range based on comparable YTE mAbs</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDX-0159 (YTE)</td>
<td>22</td>
<td>32 (~1.5X)</td>
</tr>
<tr>
<td>VRDN-002 (YTE)</td>
<td>14</td>
<td>30-43 (~1.5-3X)</td>
</tr>
<tr>
<td>VRDN-003 (YTE)</td>
<td>13</td>
<td>40-50 (~3-4X)</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. ¹Based on steady state PK simulations made with parameters for APG808 identical to Dupixent except changes in $k_{elim}$. *Positioning of Apogee program is illustrative and not based on clinical trial data and is based only on pre-clinical study results.
APG808 Phase 1 is underway with planned interim readout in 2H 2024

**Trial design elements**

- **Double-blind, placebo-controlled, first-in-human trial**
  - Single ascending dose in healthy participants

- **N ~ 32**
  - 8 per cohort (6:2 active:placebo)

- **Key inclusion criteria:** healthy adult participants

- **Primary endpoint:** safety

- **Secondary endpoints:** PK, ADA

**Single ascending dose**

- Dose 1 (SQ) x 1 dose
- Dose 2 (SQ) x 1 dose
- Dose 3 (SQ) x 1 dose
- Dose 4 (SQ) x 1 dose

**Asthma cohort**

- Dose or regimen TBD

**Ph1 readout in 2H 2024 will confirm potential for best-in-class dosing**

**Ph1b readout in 1H 2025 will demonstrate APG808 effect on FeNO in mild asthmatics**

NOTE: 1 SAD dose ascension will ultimately be determined by the SRC (Scientific Review Committee) based on available data. 2 Design for the expansion portion of the study in asthma patients is to be finalized.
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

2H 2024: confirm potential for best-in-class dosing intervals

Dosing Goal: every 6- or 8-weeks (vs. every 2 weeks for DUPIXENT®)

NOTE: PK = Pharmacokinetic. ¹ Based on FDA label for DUPIXENT™
APG990 leverages amlitelimab’s mechanism to deliver a potentially best-in-class, pipeline-in-a-product antibody.

APG990's epitope on OX40L overlaps with amlitelimab’s and leverages proven MoA and biology.

APG990 is as potent as amlitelimab across preclinical assays.

APG990 NHP half-life is extended relative to amlitelimab.

NOTE: MoA = Mechanism of Action.
APG990 blocks OX40L, inhibiting Type 1, 2, and 3 inflammation

**Upcoming amlitelimab (OX40L) POC readouts**

<table>
<thead>
<tr>
<th>Indication</th>
<th>PoC Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atopic dermatitis</td>
<td>PoC achieved</td>
</tr>
<tr>
<td>Asthma</td>
<td>Ph2b data in H2 2024</td>
</tr>
<tr>
<td>Hidradenitis suppurativa</td>
<td>Ph2 data in 2025</td>
</tr>
<tr>
<td>(0.4M eligible patient pop.)</td>
<td></td>
</tr>
<tr>
<td>Alopecia areata</td>
<td>Ph2 data in 2025</td>
</tr>
<tr>
<td>(0.6M eligible patient pop.)</td>
<td></td>
</tr>
<tr>
<td>Celiac disease</td>
<td>Ph2 start in 2024</td>
</tr>
<tr>
<td>(0.2M eligible patient pop.)</td>
<td></td>
</tr>
<tr>
<td>Systemic sclerosis</td>
<td>Ph2 start in 2024</td>
</tr>
<tr>
<td>(0.2M eligible patient pop.)</td>
<td></td>
</tr>
</tbody>
</table>

**OX40L blockade inhibits Type 1 (e.g. IFN), Type 2 (e.g. IL-13, IL-4Rα), and Type 3 (e.g. IL-22) inflammation implicated in numerous I&I conditions**
APG990 NHP half-life suggests potential for significant improvement over amlitelimab in humans

<table>
<thead>
<tr>
<th>Indication</th>
<th>NHP half-life, days</th>
<th>APG990 predicted human half-life vs. observed comparators, days</th>
<th>APG990 dosing interval based on PK modeling</th>
</tr>
</thead>
<tbody>
<tr>
<td>AD</td>
<td>26</td>
<td>Every 3 months²</td>
<td>Predicted half-life range based on comparable YTE mAbs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Every 6 months²</td>
<td>Average of YTE mAbs for receptor targets (2.5x)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amlitelimab</td>
<td>21-23²</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CDX-0159 (YTE) (c-KIT/CD117)</td>
<td>22</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VRDN-002 (YTE) (IGF-1R)</td>
<td>14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VRDN-003 (YTE) (IGF-1R)</td>
<td>13</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NOTE: Half-lives as reported in studies conducted by the sponsor of each of these product candidates. 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. 1Based on steady state PK simulations made with parameters for APG990 and amlitelimab derived from scaling initial NHP PopPK model based on Haraya & Tachibana BioDrugs 2023. 2Half-life thresholds based on Ctrough target of 10 µg/mL based on approximate steady state Ctrough of amlitelimab 62.5mg Q4W, which also exceed approximate exposures for amlitelimab 250mg Q12W dosing (~6 µg/mL) and Sanofi’s stated exposure target (~4 µg/mL). 3Amlitelimab Ph1 study publication reported NHP half-life of 23 days; in H2H NHP study with APG990, amlitelimab NHP half-life was 21 days. 4APG990 dosing interval based on PK modeling.

*Positioning of Apogee program is illustrative and not based on clinical trial data and is based only on pre-clinical study results.
IL-13 and OX40L are the two orthogonal mechanisms with greatest efficacy in AD

<table>
<thead>
<tr>
<th>Target</th>
<th>IL-13</th>
<th>IL-4Ra</th>
<th>OX40L</th>
<th>IL-22R</th>
<th>IL-31R</th>
<th>TSLP</th>
<th>IL-22</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agent Lebrikizumab</td>
<td>Lebrikizumab</td>
<td>Lebrikizumab</td>
<td>Amlitlimab</td>
<td>LEO138559</td>
<td>Nemolizumab</td>
<td>Fezakinumab</td>
<td>Not available</td>
</tr>
<tr>
<td>Inflammation targeted</td>
<td>Type 2</td>
<td>Type 2</td>
<td>Type 2</td>
<td>Type 3</td>
<td>Type 2</td>
<td>Type 3</td>
<td>Type 3</td>
</tr>
<tr>
<td>EASI-75 % responders pbo adjusted</td>
<td>49</td>
<td>38</td>
<td>34</td>
<td>29</td>
<td>28</td>
<td>13</td>
<td>15</td>
</tr>
<tr>
<td>IGA(0,1) % responders pbo adjusted</td>
<td>38</td>
<td>26</td>
<td>28</td>
<td>17</td>
<td>20</td>
<td>11</td>
<td>17</td>
</tr>
</tbody>
</table>

We are combining two of the most active and orthogonal MOAs with potentially first-in-class efficacy

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

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Coformulation approach</th>
<th>Bispecific approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dosing potential</td>
<td>Every 3-months or less frequently</td>
<td>Every 1-4 weeks</td>
</tr>
<tr>
<td>Potential to optimize stoichiometry of target inhibition</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>COGS</td>
<td>➡️</td>
<td>➴</td>
</tr>
<tr>
<td>Potential to deliver in simple presentation (e.g., single autoinjector)</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

**NOTE:** Coformulation characteristics are illustrative based on what we believe we can achieve. Bispecific characteristics based on properties of FDA approved bispecifics.
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

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, commercial and management expertise

Mark McKenna
Chairman & CEO, Mirador Therapeutics

Michael Henderson, MD
CEO, Apogee Therapeutics

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

Jennifer Fox
CFO & CBO, Zenas BioPharma

Andrew Gottesdiener, MD
Venrock

Peter Harwin
Managing Member, Fairmount

BJ Jones
CCO, NewAmsterdam Pharma

Tomas Kiselak
Managing Member, Fairmount

Nimish Shah
Venrock
Our programs have broad potential to disrupt the I&I space

**Dermatology**
- AD
- AA
- PN
- BP
- HS

**Pulmonology / Immunology**
- Asthma¹
- COPD¹
- CSU
- AR²
- ColdU
- CPUO
- Food allergy
- SS

**Gastroenterology**
- EoE
- Celiac Disease
- EGID
- UC¹

- Planned Apogee Ph2 based on well-established mechanism
- 3rd party clinical data supporting one or more Apogee targets
- Ongoing 3rd party clinical trials which could validate one or more Apogee targets
- Potential blockbuster expansion

**NOTE:**
- Eosinophilic subtypes ³
- 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)
Multiple anticipated milestones in next two years, including 16-week POC data for APG777 in 2025

<table>
<thead>
<tr>
<th></th>
<th>2024</th>
<th>2025</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>APG777</strong></td>
<td>✓ Positive Phase 1 PK &amp; safety in HVs</td>
<td>✓ 2H: 16-week PoC clinical data in AD</td>
</tr>
<tr>
<td>(IL-13)</td>
<td>✓ 1H: Phase 2 initiated in AD</td>
<td>• Phase 2 initiation in asthma</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Disclose additional indication</td>
</tr>
<tr>
<td><strong>APG808</strong></td>
<td>✓ Phase 1 initiated in HVs</td>
<td>✓ 1H: PoC clinical data in asthma</td>
</tr>
<tr>
<td>(IL-4Rα)</td>
<td>✓ 2H: Initial Ph1 PK &amp; safety in HVs</td>
<td>• PoC trial initiation in COPD</td>
</tr>
<tr>
<td><strong>APG990/222</strong></td>
<td>✓ Candidate nomination</td>
<td>✓ Initial Ph1 PK &amp; safety in HVs</td>
</tr>
<tr>
<td>(OX40L / IL-13+OX40L)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 2H: Phase 1 initiation in HVs</td>
<td></td>
</tr>
<tr>
<td><strong>Corporate</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Event</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• R&amp;D Day</td>
<td></td>
</tr>
</tbody>
</table>

$816M TOTAL CASH\(^1\) — EXPECTED RUNWAY INTO 2028

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\(^1\)As of March 31, 2024, Apogee had cash, cash equivalents and marketable securities of $816.2 million.
Apogee /ˈapəjē/ noun

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