APOGEE THERAPEUTICS®

Corporate overview

March 2026

Disclaimers and Forward-looking statements

Other than statements of historical facts, all statements included in this presentation are forward-looking statements, including statements about our plans for our current and future product candidates and programs, the anticipated timing of initiation of our clinical trials, including a Phase 3 trial of zumilokibart (APG777) in atopic dermatitis (AD); the anticipated timing of its clinical trials, including the APEX 52-week Part A in AD, APEX 16-week Part B in AD, APG279 Phase 1b head-to-head readout against DUPIXENT in AD, the potential Phase 3 trial of zumilokibart and the potential launch of zumilokibart; our plans for current and future clinical trials; the potential clinical benefit and half-life of zumilokibart, APG333, APG990, APG808, our other product candidates, including the combination therapies APG279 and APG273, and any other potential programs; our expected timing for future pipeline updates; the potential to expand zumilokibart for other indications; our potential path to regulatory approval; our expectations regarding the time period over which our capital resources will be sufficient to fund our anticipated operations, our cash runway, and estimates of market size. In some cases, you can identify forward-looking statements by terms such as “anticipate,” “believe,” “can,” “could,” “design,” “estimate,” “expect,” “intend,” “likely,” “may,” “might,” “plan,” “potential,” “predict,” “suggest,” “target,” “will,” “would,” or the negative of these terms, and similar expressions intended to identify forward-looking statements. The forward-looking statements are based on our beliefs, assumptions and expectations of future performance, taking into account the information currently available to us. These statements are only predictions based upon our current expectations and projections about future events. The data included in this presentation may be subject to change following the availability of additional data or following a more comprehensive review of the data. Forward-looking statements are subject to known and unknown risks, uncertainties and other factors that may cause our actual results, level of activity, performance or achievements to be materially different from those expressed or implied by such forward-looking statements, including those risks described in “Risk Factors” and “Management’s Discussion and Analysis of Financial Condition and Results of Operations” in our Annual Report on Form 10-K for the year ended December 31, 2024, filed with the U.S. Securities and Exchange Commission (SEC) on March 3, 2025, our Quarterly Report on Form 10-Q for the three months ended March 31, 2025, filed with the SEC on May 12, 2025, Quarterly Report on Form 10-Q for the quarterly period ended June 30, 2025, filed with the SEC on August 11, 2025, Quarterly Report on Form 10-Q for the quarterly period ended September 30, 2025, filed with the SEC on November 10, 2025, and subsequent disclosure documents we have filed any may file with the SEC. Although we have attempted to identify important factors that could cause actual results to differ materially from those contained in forward-looking statements, there may be other factors that cause results not to be as anticipated, estimated or intended. We claim the protection of the Safe Harbor contained in the Private Securities Litigation Reform Act of 1995 for forward-looking statements.

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

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

This presentation also uses estimates and other statistical data made by independent parties and us relating to the data and analysis about our industry. The data involves a number of assumptions and limitations, and you are cautioned not to give undue weight to such estimates. In addition, projections, assumptions and estimates of our future performance and the future performance of the markets in which we operate are necessarily subject to a high degree of uncertainty and risk.

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

Apogee aims to deliver transformative impact for patients

Serial Innovation in AD

Zumilokibart (APG777) on path to planned **2029 launch with every 3-month or better dosing**

- Part A demonstrated potentially best-in-class profile
- 60% of surveyed physicians would make zumilokibart their biologic of choice in AD

APG279 (IL-13+OX40L) being tested H2H against DUPIXENT with **potential for improved efficacy and dosing vs. SOC[1]**

Significant expansion possible

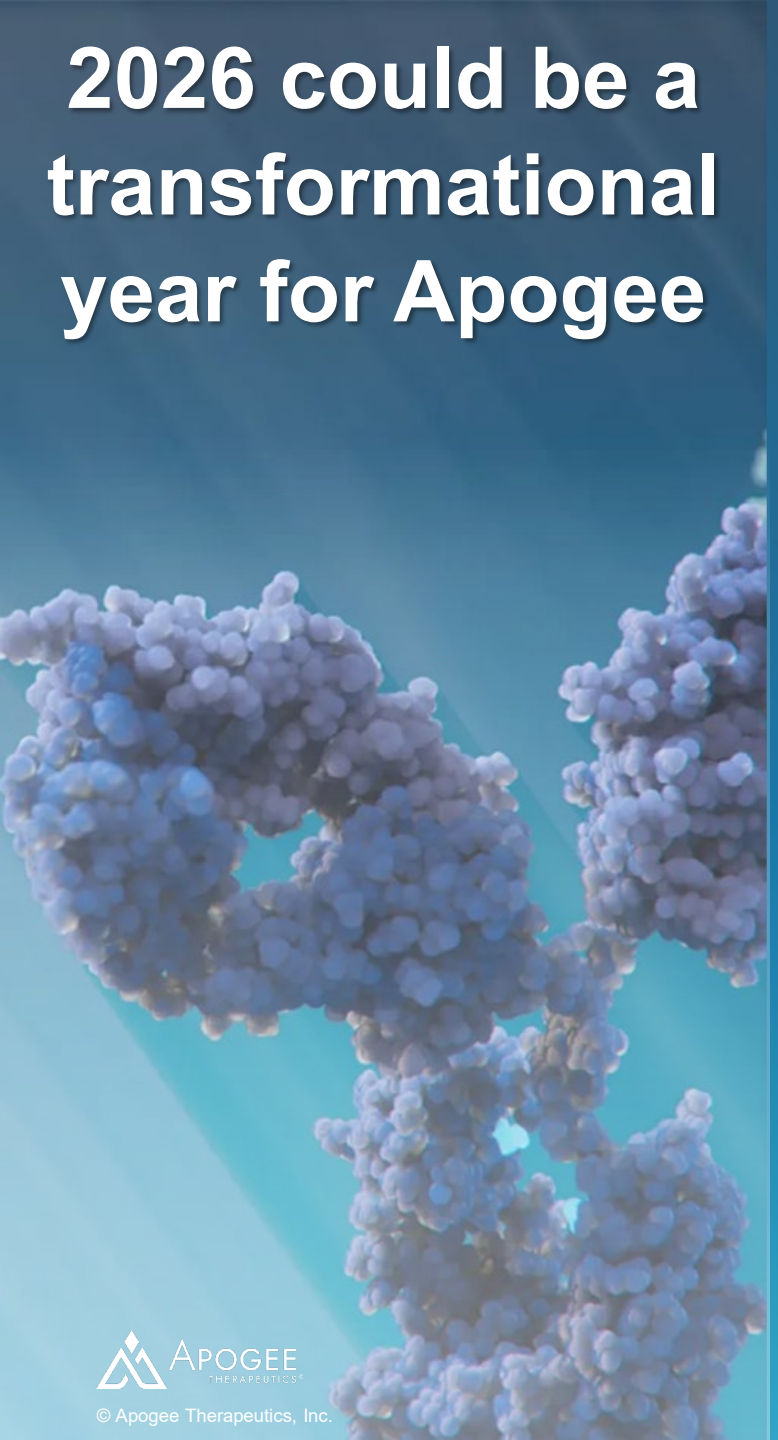
Zumilokibart (APG777) has a path to leadership in **8+ potential expansion indications**

- **Positive asthma Phase 1b data,** demonstrating potential beyond AD

Combos rapidly advancing behind zumilokibart with potential for improved efficacy and dosing vs. SOC

NOTE: [1] APG279 is a combination of zumilokibart (APG777) and APG990. APG279 will be co-administered in the proof-of-concept Phase 1b trial; coformulation planned for future clinical studies and commercialization. AD = atopic dermatitis, H2H = head-to-head, SOC = standard of care.

2026 could be a transformational year for Apogee



Expected Key 2026 Milestones:

Q1

- ✓ **Zumilokibart (APG777) Asthma Phase 1b positive data**

  UPDATE: Robust effect on FeNO comparable to DUPIXENT; sustained FeNO suppression after a single dose for 16 weeks, with continued FeNO suppression through 32 weeks for patients with available follow-up

- **Zumilokibart AD Phase 2: Part A (52-week readout)**

Q2

- **Zumilokibart AD Phase 2: Part B (16-week readout)**

  UPDATE: Part B enrollment complete and on track for Q2 2026 readout; overenrolled (N=347) due to strong interest from physicians and patients

2H

- **APG279 AD Phase 1b POC readout (vs DUPIXENT)[1]**

  UPDATE: On track for 2H 2026 readout with expanded enrollment (N ~80) due to strong interest from physicians and patients

- **Zumilokibart AD Phase 3 initiation**

NOTE: [1]APG279 is a combination of APG777 and APG990. APG279 will be co-administered in the proof-of-concept Phase 1b trial; coformulation planned for future clinical studies and commercialization. FeNO = fractional exhaled nitric oxide.

Apogee is advancing optimized novel biologics with potential for best-in-class differentiation in the largest I&I markets

STRATEGY	PROGRAM	PRECLINICAL	FIRST-IN-HUMAN (Phase 1 HV)	CLINICAL POC (Phase 1b/2)	REGISTRATIONAL (Phase 3)
Potential best-in-class monotherapy	**Zumilokibart** (APG777) IL-13	Atopic Dermatitis *(Positive Part A 16-week data; Part B enrollment complete)*			**Q1 2026:** Part A 52-week readout **Q2 2026:** Part B 16-week readout **2H 2026:** Phase 3 initiation
		Asthma *(Positive Ph1b data)*			**2026:** ASPIRE trial plans to be announced
		Eosinophilic Esophagitis			**2026:** Additional trial plans to be announced
Potential first- or best-in-class combination approaches	**APG279**[1] IL-13 + OX40L	Atopic Dermatitis			**2H 2026:** Phase 1b PoC readout (against DUPIXENT)
	APG273[2] IL-13 + TSLP	Asthma / COPD			**2026:** Additional trial plans to be announced

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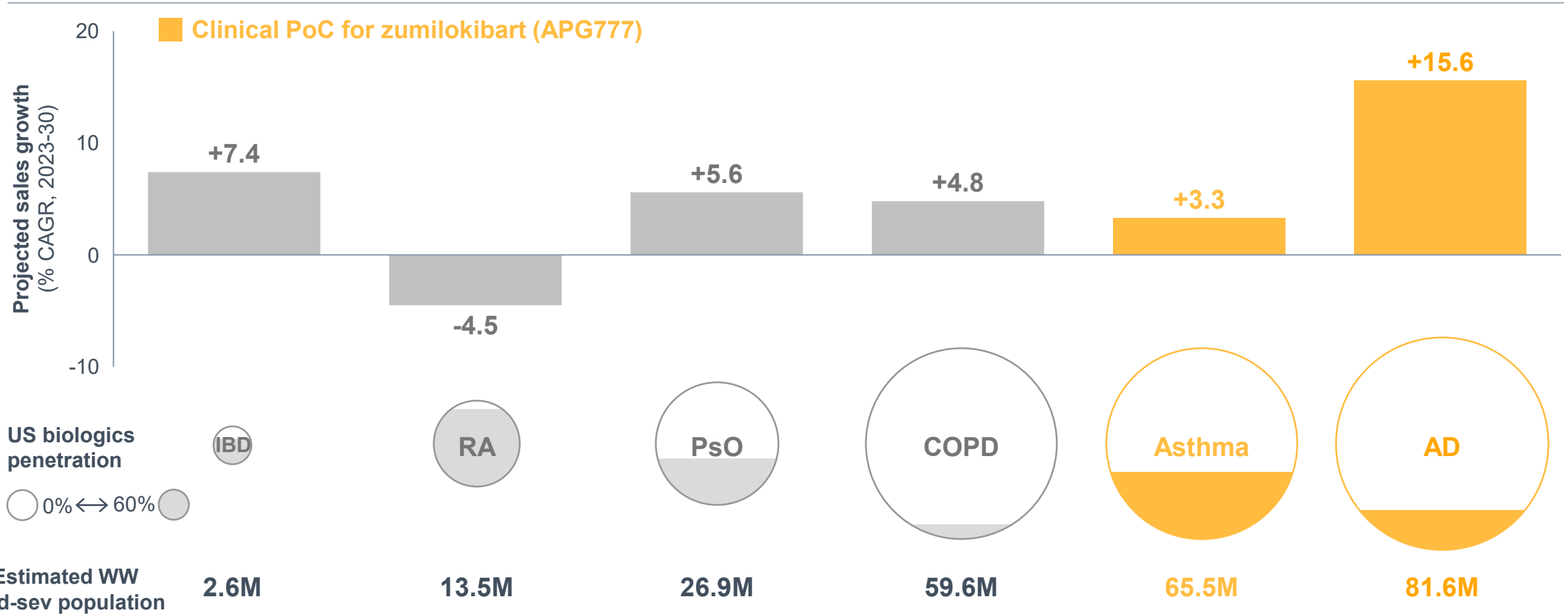
The agents listed above are currently under investigation. Their safety and effectiveness have not yet been established by any regulatory authority. APG808 (not shown) is a novel half-life extended IL-4Rα antibody. Apogee announced positive interim results from the Phase 1b trial of APG808 in patients with mild-to-moderate asthma in May 2025.
[1] APG279 is a combination of zumilokibart (APG777) and APG990. APG279 will be co-administered in the proof-of-concept Phase 1b trial; coformulation planned for future clinical studies and commercialization. [2] APG273 is a combination of zumilokibart and APG333.

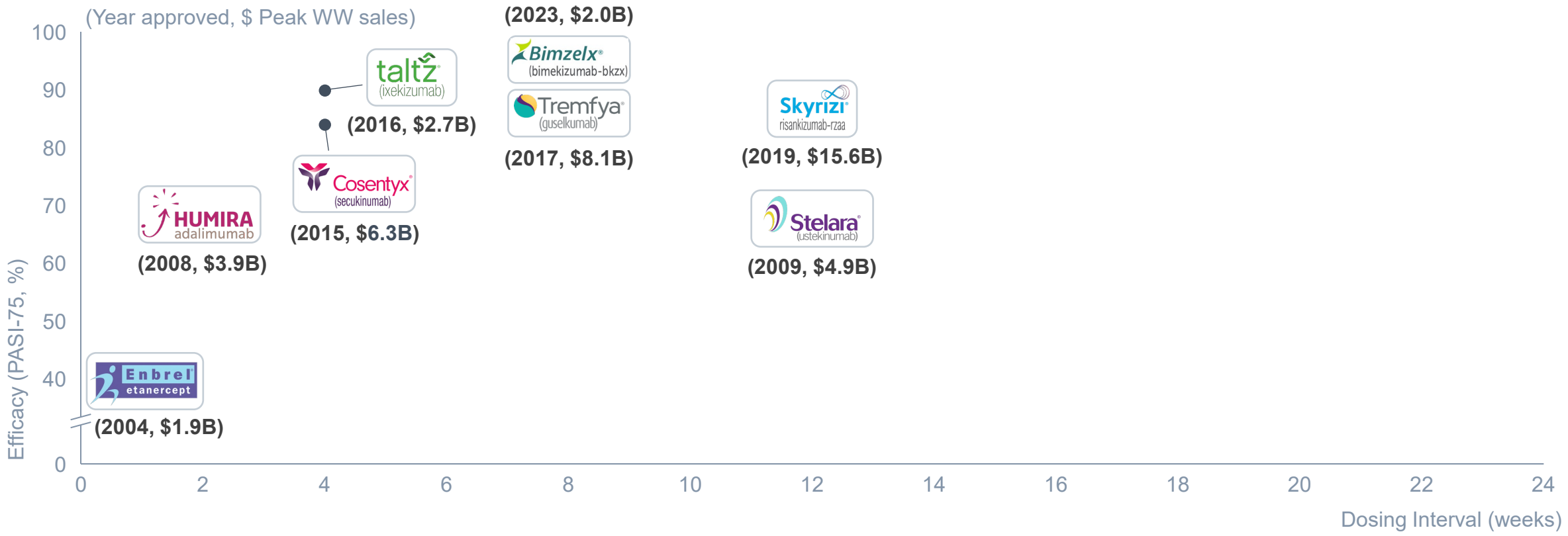
Apogee is entering late-stage development in the two largest I&I markets

Projected growth for key I&I markets (2023-2030)



NOTE: Market growth is in terms of global annual revenue. IBD = Inflammatory bowel disease, moderate-severe population shown; RA = Rheumatoid arthritis, progressive population shown; PsO = Psoriasis, moderate-severe population shown; COPD = Chronic obstructive pulmonary disease, population at high risk for exacerbations shown; moderate-severe asthma population shown; AD = Atopic dermatitis, moderate-severe population shown.
SOURCE: Academic journals, disease foundations, WHO, CDC, census data, EvaluatePharma, analyst research. Projected sales growth based on Evaluate Pharma figures as of 1/2/2026.

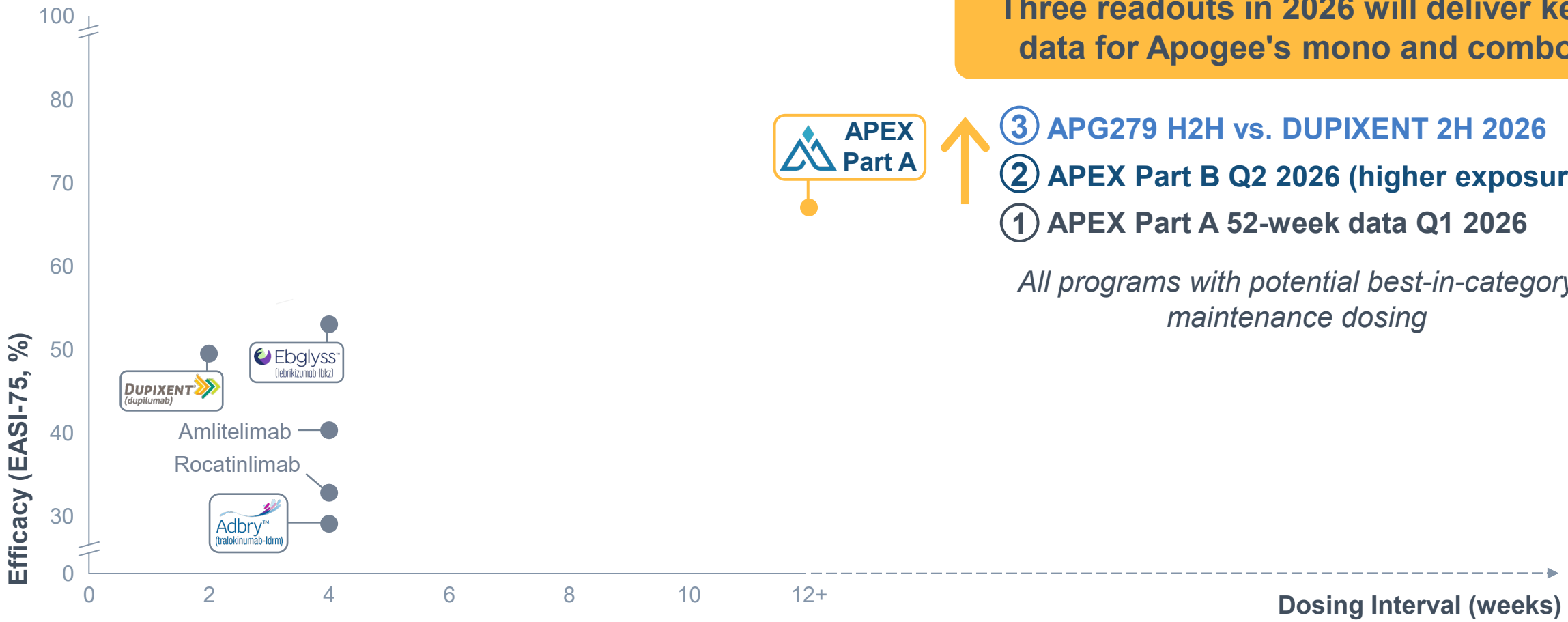
Psoriasis, a market analog to atopic dermatitis, has seen improved dosing drive market success



- **Psoriasis is not a winner take all market — 8 blockbusters**
- **SKYRIZI, a late entrant, leads the market with 40% share due to quarterly dosing which improves adherence[1]**

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.

Apogee could similarly reshape the future $50B atopic dermatitis market



Three readouts in 2026 will deliver key data for Apogee's mono and combo

APEX Part A

③ **APG279 H2H vs. DUPIXENT 2H 2026**

② **APEX Part B Q2 2026 (higher exposures)**

① **APEX Part A 52-week data Q1 2026**

All programs with potential best-in-category maintenance dosing

NOTE: Positioning of Apogee programs is illustrative and based on Phase 2 Part A results for zumilokibart only and illustrates what we believe we can potentially achieve. Only DUPIXENT, ADBRY, and EBGLYSS are approved in the US. Efficacy data are derived from different clinical trials conducted at different times, with differences in trial design and patient populations. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted. Future $50B AD market size based on EvaluatePharma and company projections. Maintenance dosing intervals are as per label or published data. For some agents, longer dosing intervals are currently being evaluated in ongoing clinical trial(s). All efficacy data shown based on non-responder imputation for rescue medication (topical or systemic) use (i.e., data subsequent to the use of rescue medication categorized as non-response). Statistical treatment of missing data varies across studies shown.

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

APOGEE THERAPEUTICS

Zumilokibart could substantially decrease annual injections for patients

Zumilokibart

2-4

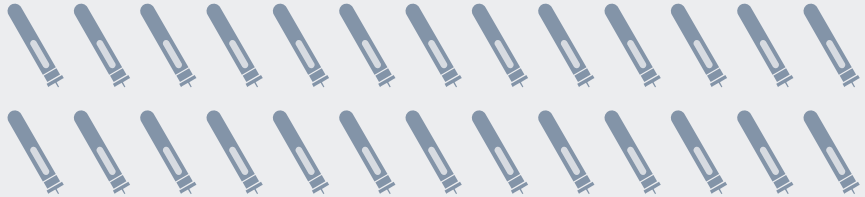
Injections

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

DUPIXENT

26

Injections



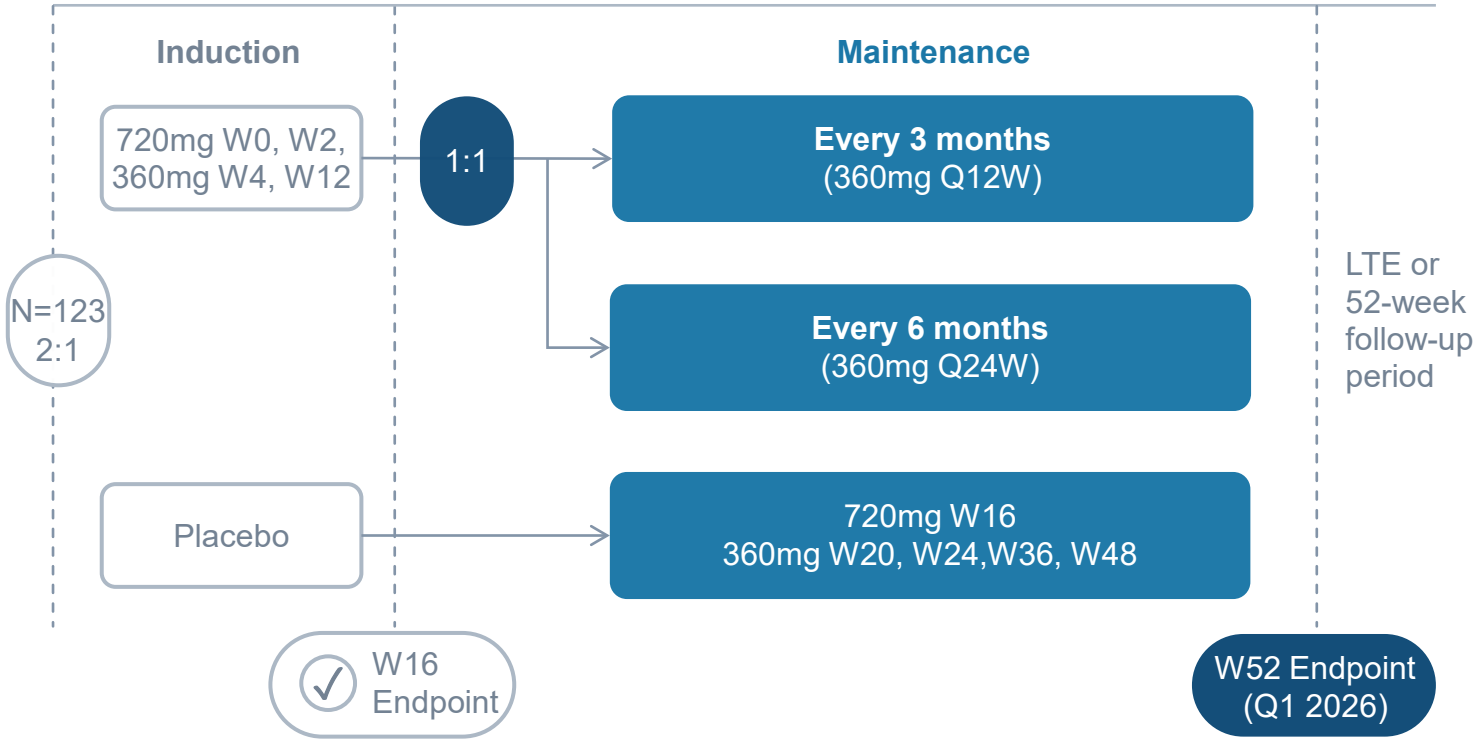
One injection every **2 weeks**[1]

NOTE: Zumilokibart injections per year based on preliminary PK data and PK simulations. [1] Injections per year in maintenance after an induction regimen lasting up to 16 weeks.
SOURCE: DUPIXENT USPI.

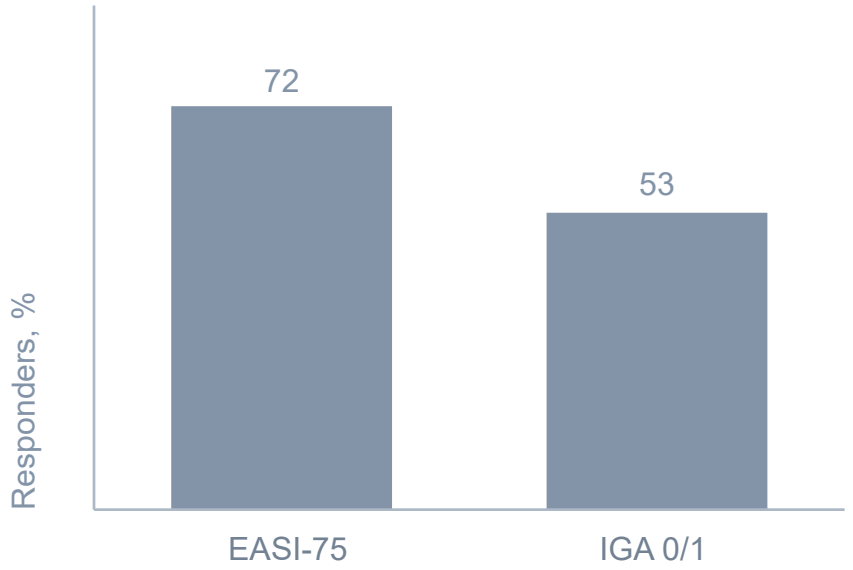
Part A 52-week data in Q1 2026 will show maintenance results for zumilokibart every 3- and 6-month dosing regimens

Zumilokibart (APG777) Part A trial design

Mod-Sev AD: EASI ≥16, vIGA ≥3, BSA ≥10%



DUPIXENT maintenance of response at Week 52 (every 2-week dosing)



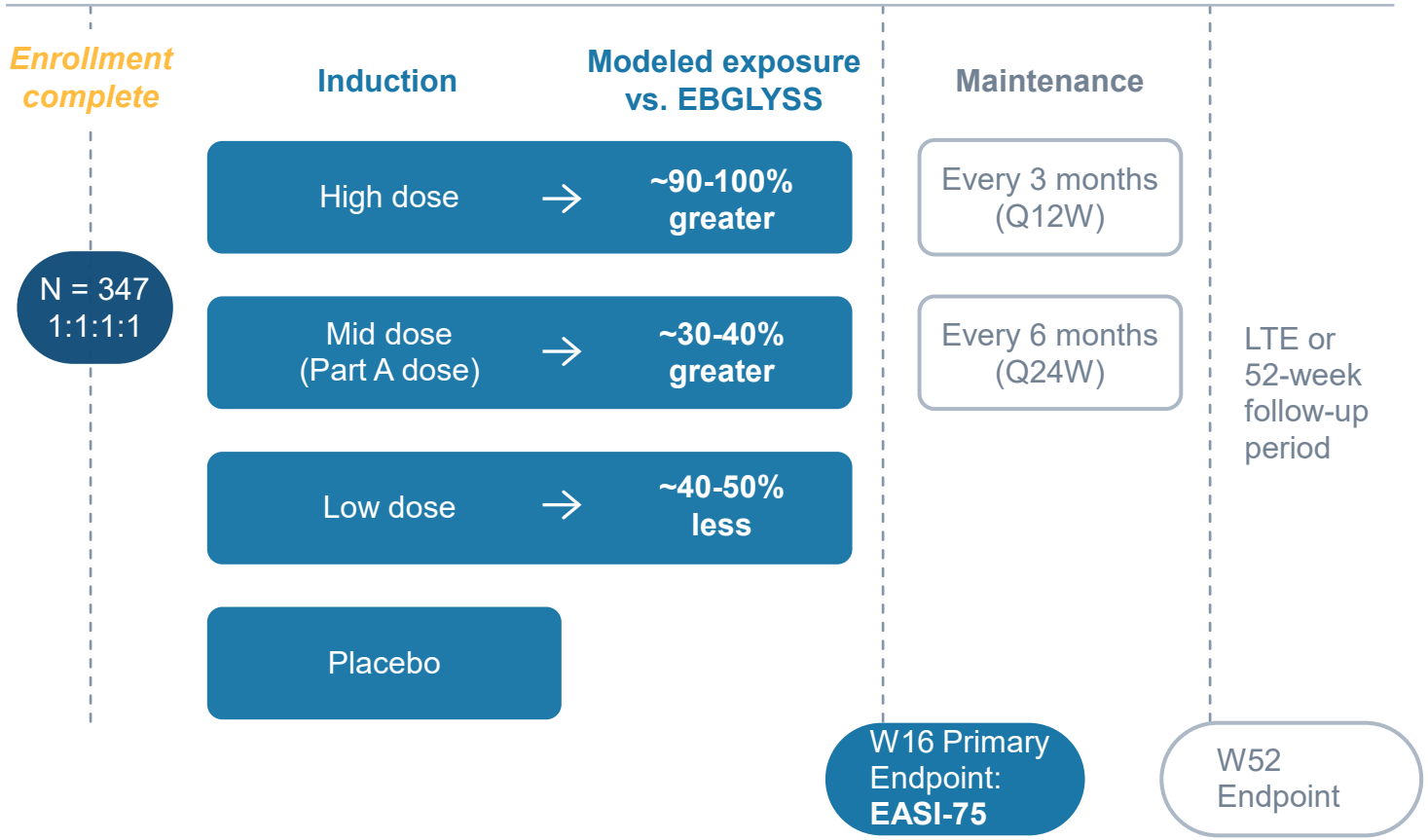
Part A 52 Week goal is to maintain responses similar to or better than DUPIXENT with quarterly or better dosing

NOTE: During maintenance all patients will receive active treatment with additional placebo injections given to maintain blinding. DUPIXENT EASI 75-week 52 data from pooled responders at week 16 in SOLO 1&2 who entered SOLO-CONTINUE where QW/Q2W and QW/Q2W performed similarly; IGA data for Q2W regimen from USPI. vIGA = Validated Investigator Global Assessment. EASI = Eczema Area and Severity Index.
SOURCE: Worm, M, et al, JAMA Derm, 2020, DUPIXENT USPI.

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

Zumilokibart (APG777) Part B trial design

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



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

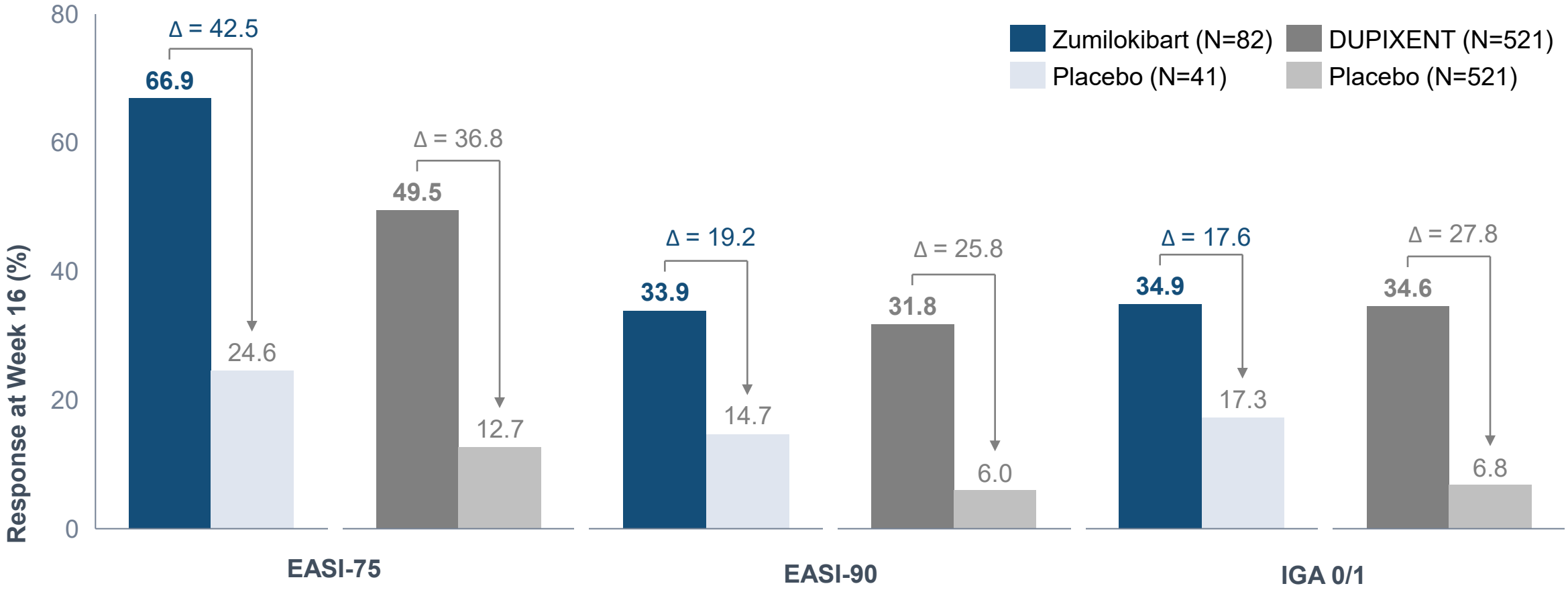
Phase 3 studies expected to initiate in 2026

Zumilokibart launch planned in 2029

NOTE: EASI = Eczema Area and Severity Index. vIGA = validated Investigator Global Assessment for Atopic Dermatitis.
SOURCE: EBGLYSS USPI, DUPIXENT USPI.

Zumilokibart Part B aims to replicate the competitive profile demonstrated in Part A across key lesional endpoints

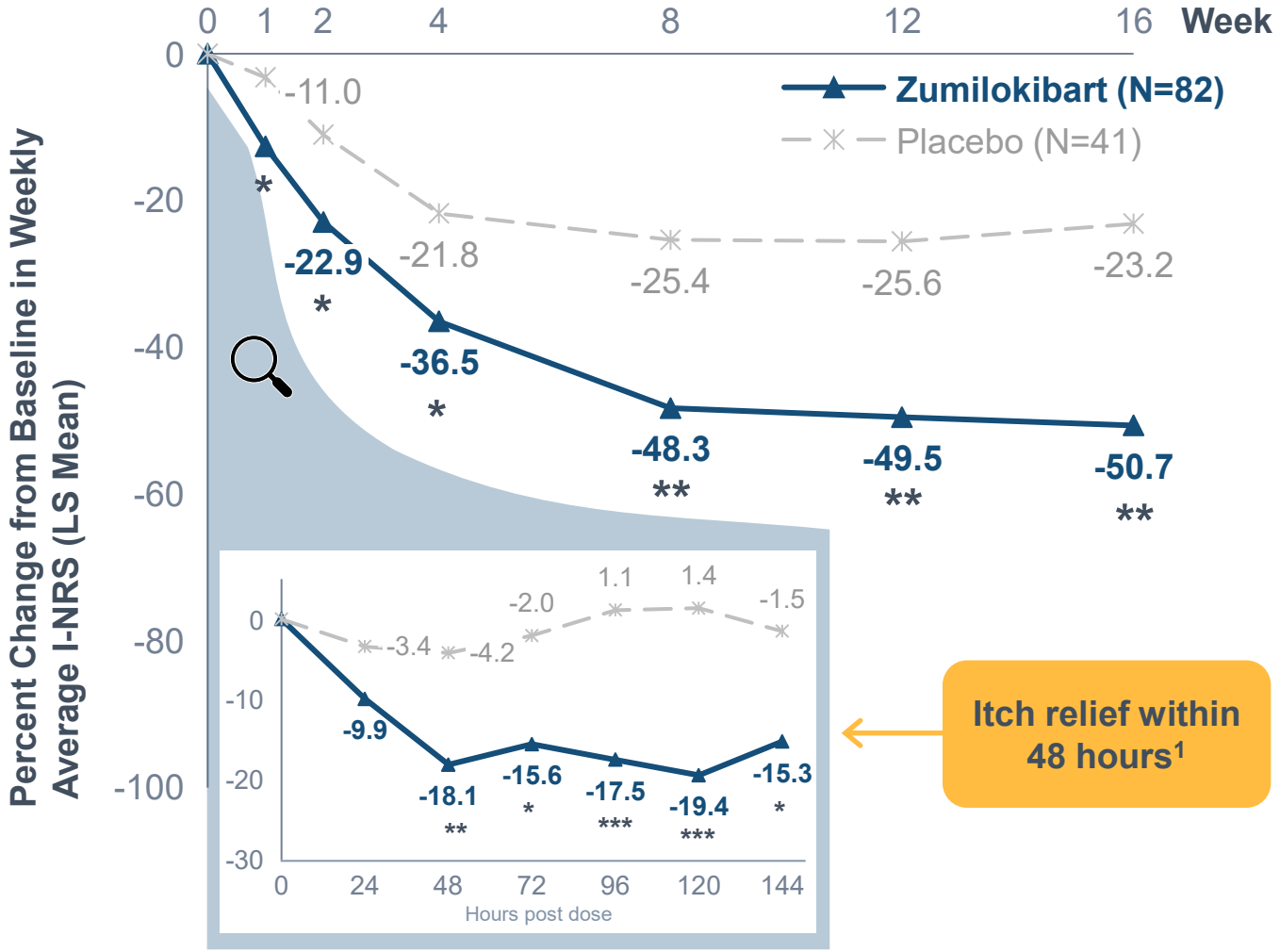
Zumilokibart (APG777) Part A: lesional endpoints



NOTE: For illustrative purposes only. Efficacy data are derived from different clinical trials conducted at different times, with differences in trial design and patient populations. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted. All efficacy data shown based on non-responder imputation for rescue medication (topical or systemic) use or treatment discontinuation due to lack of efficacy (i.e., data subsequent to the use of rescue medication or discontinuation due to lack of efficacy are categorized as non-response). Statistical treatment of missing data varies across studies shown.
SOURCE: **DUPIXENT** (average of Ph3 SOLO-1&2 and Ph2b; 300 mg Q2W regimen; non-responder imputation for missing values).

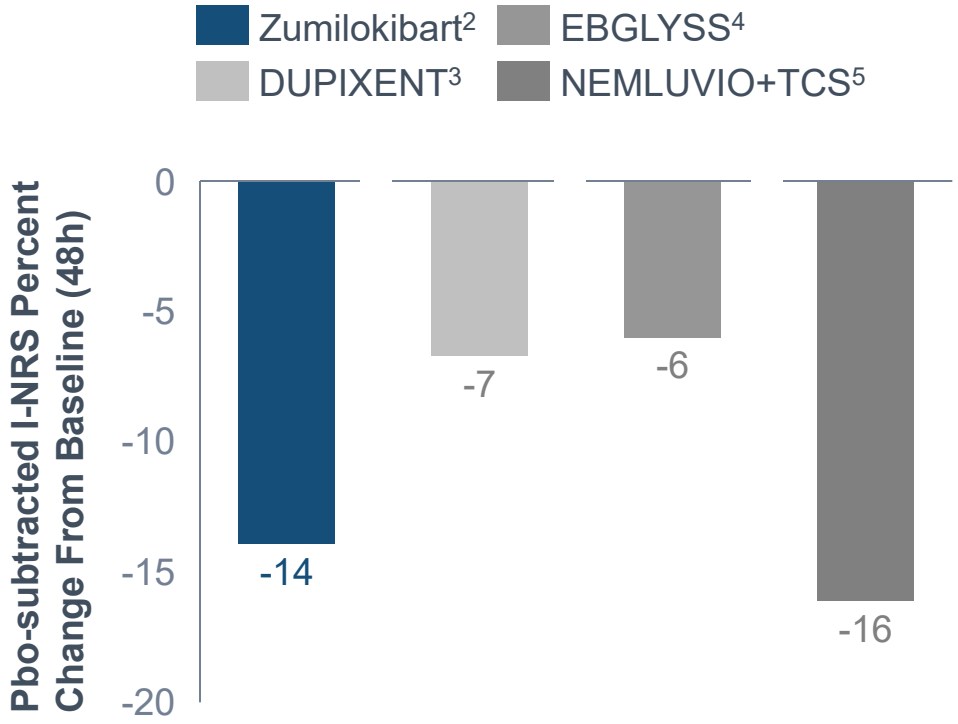
Zumilokibart also led to rapid, deep itch relief

Zumilokibart (APG777) Part A: Itch Numerical Rating Scale (I-NRS)



Itch relief within 48 hours[1]

Zumilokibart demonstrated rapid itch relief similar to NEMLUVIO + TCS

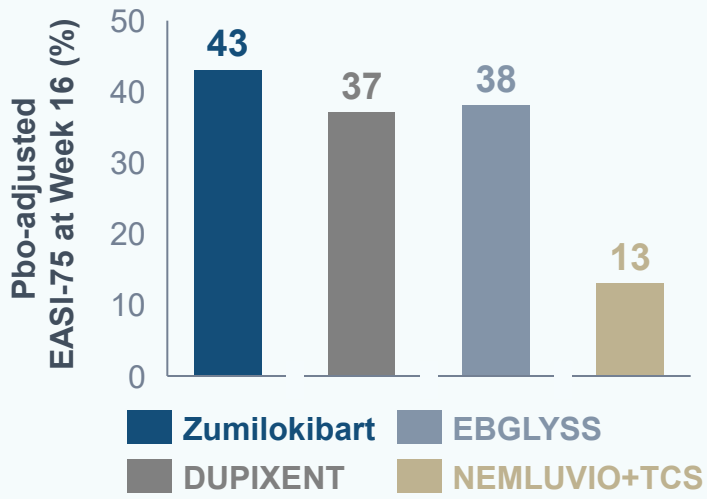


NOTE: For illustrative purposes only. Efficacy data are derived from different clinical trials conducted at different times, with differences in trial design and patient populations. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted. Daily change in I-NRS in Week 1 was evaluated as-observed without imputation for missing data. Weekly I-NRS based on non-responder imputation for rescue medication (topical or systemic) use or treatment discontinuation due to lack of efficacy (i.e., data subsequent to the use of rescue medication or discontinuation due to lack of efficacy are categorized as non-response). Statistical treatment of missing data varies across studies shown. Zumilokibart vs placebo: *p<0.05, **<0.01, ***p<0.001. LS = Least squares. [1] Based on Daily I-NRS score. [2] Placebo rate at hour 48 for zumilokibart = -4.2 (N=41). [3] DUPIXENT hour 48 I-NRS based on digitized pooled SOLO 1&2 data for 300mg Q2W (N=457) vs. placebo (N=460). SOURCE: Silverberg, JI et al. J. Am Acad. Dermatol. (2020) [4] EBGLYSS hour 48 I-NRS based on digitized pooled ADvocate 1&2 data for 250mg Q4W (N=564) vs. placebo (N=287). SOURCE: Yosipovitch, G et al, BJD (2023). [5] NEMLUVIO hour 48 I-NRS based on digitized plot for 30 mg Q4W (N=50) vs placebo (N=44); mixed model for repeated measures for missing values SOURCE: Silverberg, JI et al J. EADV 2021, Ph2b.

Zumilokibart Part A demonstrated lesion control similar to DUPIXENT and itch relief similar to NEMLUVIO, with potential to demonstrate SKYRIZI-like dosing

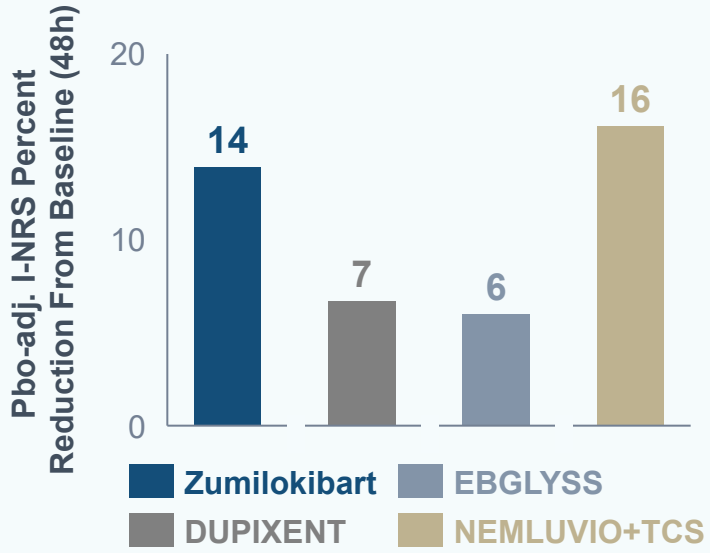
Lesion Control

Zumilokibart demonstrated lesion control similar to **DUPIXENT** and **EBGLYSS**



Itch Relief

Zumilokibart demonstrated rapid itch relief similar to **NEMLUVIO + TCS**



Dosing

Zumilokibart could provide transformational dosing similar to **SKYRIZI**

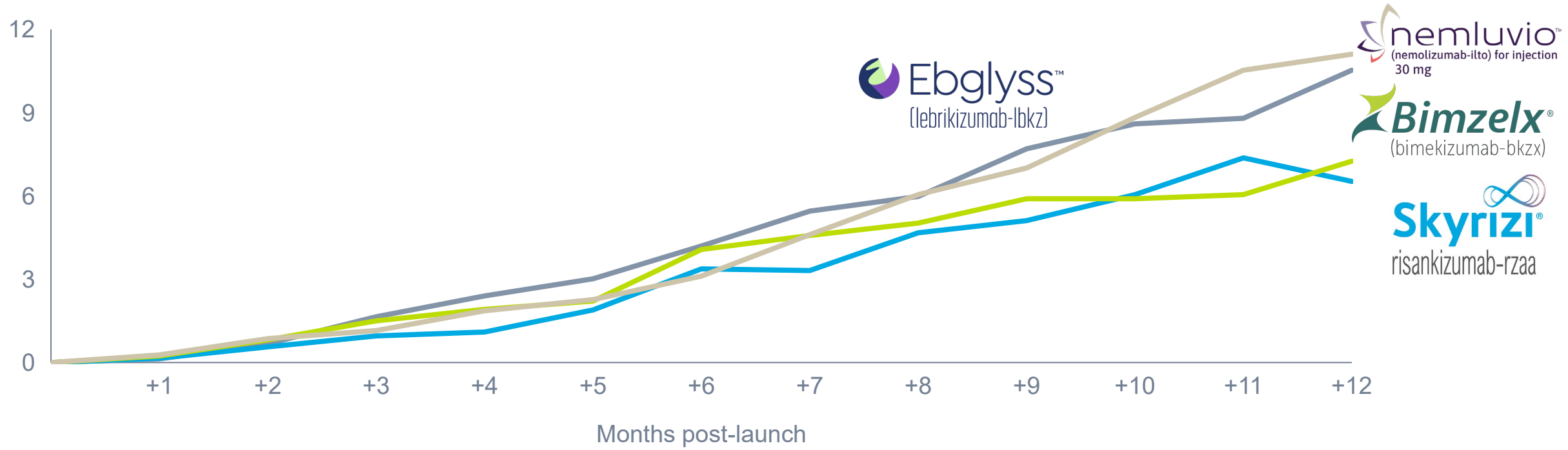
Zumilokibart	DUPIXENT
2-4	**26**
Injections	**Injections**
	
One injection every **3-6 months**[5]	One injection every **2 weeks**

Zumilokibart could transform the standard of care in AD

SOURCE: [1] **DUPIXENT** (average of Ph3 SOLO-1&2 and Ph2b; 300 mg Q2W regimen; non-responder imputation for missing values). [2] **DUPIXENT** (Silverberg et al JAAD 2020, average of Ph3 SOLO-1&2; 300 mg Q2W regimen; non-responder imputation for missing values). [3] **EBGLYSS** (average of Ph3 ADVOCATE-1&2 (multiple imputation (MCMC-MI) for missing values) and Ph2b (sensitivity analysis 3: NRI for rescue medication use and LOCF for other missing values); 250mg Q2W regimen). [4] **NEMLUVIO** (Silverberg, JI et al J. EADV 2021, Ph2b; 30 mg Q4W regimen; Mixed Model for Repeated Measures for missing values). [5] Injections per year in maintenance after an induction regimen lasting up to 16 weeks for zumilokibart and 2 initiation doses at week 0 and week 4 for SKYRIZI. Zumilokibart injections per year based on preliminary PK data and PK simulations.

EBGLYSS and NEMLUVIO are off to strong launches despite limited differentiation – highlighting demand for new treatment options in AD

U.S. Monthly Total TRx Volume (thousands)



- **EBGLYSS[1] and NEMLUVIO[2] are each annualizing over $500M** less than 1-year into launch with **40%+ sales growth in Q3 2025**
- **AD market growth[3]** (defined as annual growth in NBRx volume[4]) **in 2025 has accelerated to ~49% from just ~15% in 2024**

SOURCE: IQVIA (October 2025), company filings and press releases
NOTE: Based on NBRx counts for each product for all prescriber categories. NBRx = New to brand prescriptions.
[1] EBGLYSS recorded US sales of ~$127M in Q3 2025 representing a ~41% increase over Q2. Almirall reports EU sales on November 10th, 2025. [2] NEMLUVIO recorded WW sales of $132M in Q3 2025 across AD and PN representing a ~44% increase over Q2 2025. [3] AD biologics market consists of DUPIXENT, EBGLYSS, ADBRY, NEMLUVIO. [4] Based on prescription volume in January through September for indicated year relative to the same period in the previous year.

Zumilokibart: potentially the next clearly differentiated product to launch in AD

Today: ~$18B[1]

AD is the largest and fastest growing I&I market[2]

Future $50B+ market

Projected new approved AD biologics

DUPIXENT (dupilumab)

- Only ~1 of 2 patients respond[3]
- ~50% discontinue by year 2[4]
- Every 2-week dosing

Ebglyss (lebrikizumab-lbkz) · nemluvio (nemolizumab-ilto) for injection 30 mg · Adbry (tralokinumab-ldrm)

Similar / lower efficacy compared to DUPIXENT

Zumilokibart (APG777)

Physician's biologic of choice per market research based on efficacy, safety, and dosing profile

Rocatinlimab · Amlitelimab · Rezpeg

Lower efficacy compared to DUPIXENT

APG279

Potential for best-in-class efficacy and dosing

Potential novel MoAs/bispecifics

Today | **This decade (by 2029)** | **2030+**

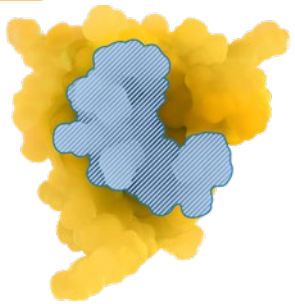
NOTE: Zumilokibart and APG279 are currently under investigation. Their safety and effectiveness have not yet been established by any regulatory authority. [1]Projected 2025 AD market size based on Evaluate Pharma as of 1/2/2026. [2] Largest based on patient population, fastest growing based on projected market size (EvaluatePharma). [3] Based on 49.5% EASI-75 response for DUPIXENT averaged from Ph3 SOLO-1&2 and Ph2b (300 mg Q2W regimen). [4] Symons et al. AAD 2024 (poster presentation).

APG279 (zumilokibart+APG990) combines validated mechanisms for potentially best-in-class efficacy and dosing in atopic dermatitis

OVERLAPPING EPITOPE

Zumilokibart (APG777)

HUMAN IL-13

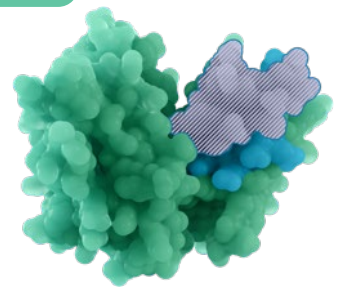


Overlapping region

(vs. EBGLYSS)

APG990

HUMAN OX40L



Overlapping region

(vs. amlitelimab)

OPTIMIZED PK AND FORMULATION

APG279

77-day human half-life

Coformulated at ≥180 mg/mL for potential 2 mL commercial presentation

~60-day human half-life

BROAD & ROBUST INHIBITION

Ex vivo human ALR assay[1]

	Type 1	Type 2	Type 3
	IFNγ	TARC	IL-22
APG279[2] IL-13 + OX40L	45	17	76
Dupilumab[2] IL-4Rα	123	16	389

Clinical data: Durable biomarker suppression through 6 months after single dose

(e.g.,TARC for zumilokibart; IgE for APG990)

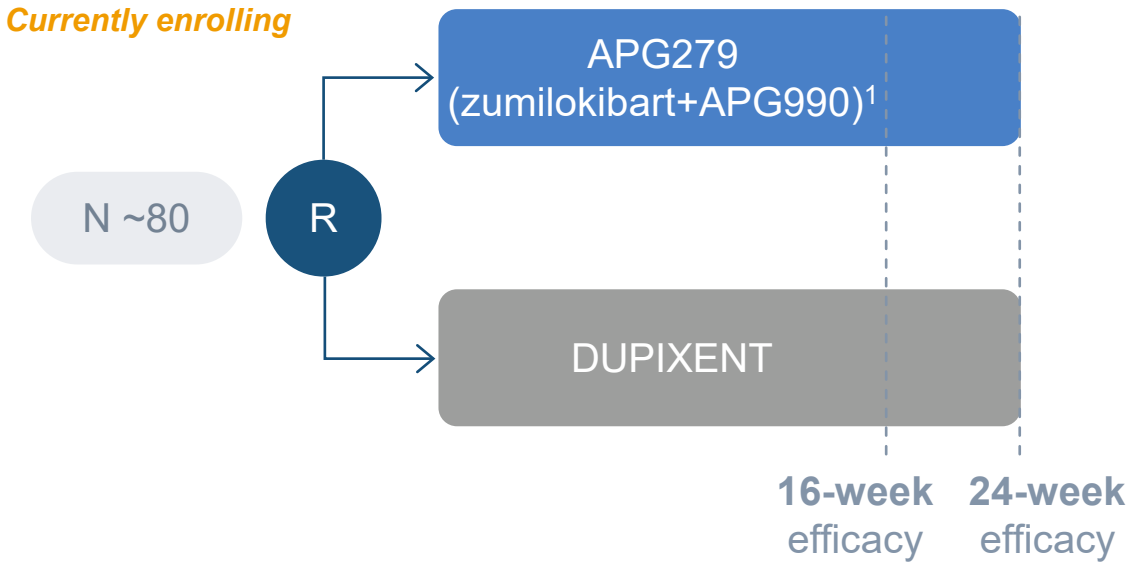
Cytokine level (% of untreated)[3]

0 20 40 60 80 100

NOTE: [1] The ALR was performed using TSLP-primed mDCs paired with allogeneic CD4 cells for 5 days. [2] Dupilumab and APG279 (tested as co-administered zumilokibart +APG990) were tested at 45 μg/mL that is comparable to DUPIXENT steady-state trough concentrations for the approved dose (300mg Q2W) in atopic dermatitis. [3] Cytokine levels for dupilumab and APG279 are reported as the mean percent of isotype control across four donor pairs.

APG279 is currently enrolling a POC head-to-head trial vs DUPIXENT, with readout expected in 2H 2026

Phase 1b trial in moderate-to-severe AD



Phase 1b POC readout against DUPIXENT in 2H 2026 could demonstrate potential for improved efficacy and dosing

Study objectives

Safety

Confirm safety profile to enable additional combination trials

PD biomarkers

Demonstrate broader pharmacodynamic effect vs. SoC

Efficacy

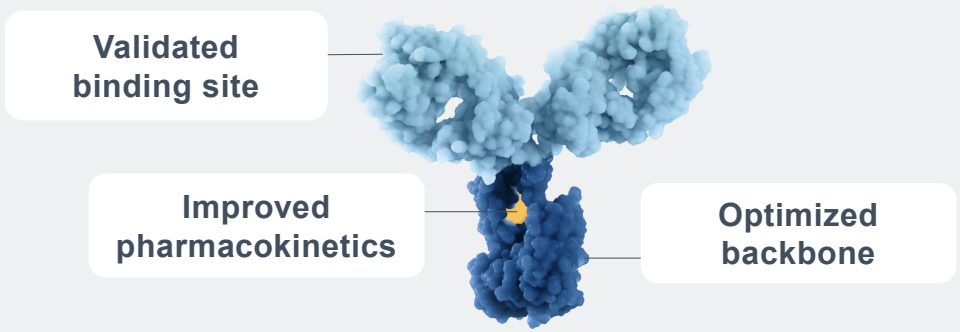
Demonstrate improved efficacy vs. SoC on key endpoints (e.g., EASI-75, IGA0/1)

NOTE: [1] APG279 (APG777+APG990) will be co-administered in the proof-of-concept Phase 1b trial; coformulation planned for future clinical studies and commercialization.
R = Randomization. SoC = Standard of Care. EASI = Eczema Area and Severity Index. vIGA = Validated Investigator Global Assessment.

Apogee is advancing optimized antibodies enabled for coformulation

Apogee's antibodies are designed to enable both best-in-class monotherapies and fixed-dose coformulations

Optimized antibody platform



Platform produces antibodies enabled for coformulation

APG279 is a potential first-in-class and best-in-class anti-IL-13 + anti-OX40L coformulation

Stability

Stable at high concentrations (≥180 mg/mL)

Injectability

Expected injection time comparable to SoC

Presentation

Compatible with commercial presentation (e.g., AI)

Potency

Equivalent to each component tested individually

NOTE: SoC = Standard of Care. AI = autoinjector.

Beyond zumilokibart in AD, multiple potential blockbuster expansions in dermatology, respiratory and GI with prioritization to start ASPIRE asthma trial

Atopic dermatitis

- Bullous Pemphigoid
- Chronic Spontaneous Urticaria
- Cold Inducible Urticaria
- Prurigo Nodularis

Multiple potential expansions in respiratory and GI

- Asthma
- Allergic Rhinitis (perennial)
- Chronic Obstructive Pulmonary Disease
- Chronic Rhinosinusitis with Nasal Polyps
- Eosinophilic esophagitis

Next steps:

APEX AD Ph 2

APEX AD Part A 52-week
Q1 2026 expected readout

APEX AD Part B 16-week
Q2 2026 expected readout

ASPIRE

ASPIRE asthma trial
Plans to be announced later this year

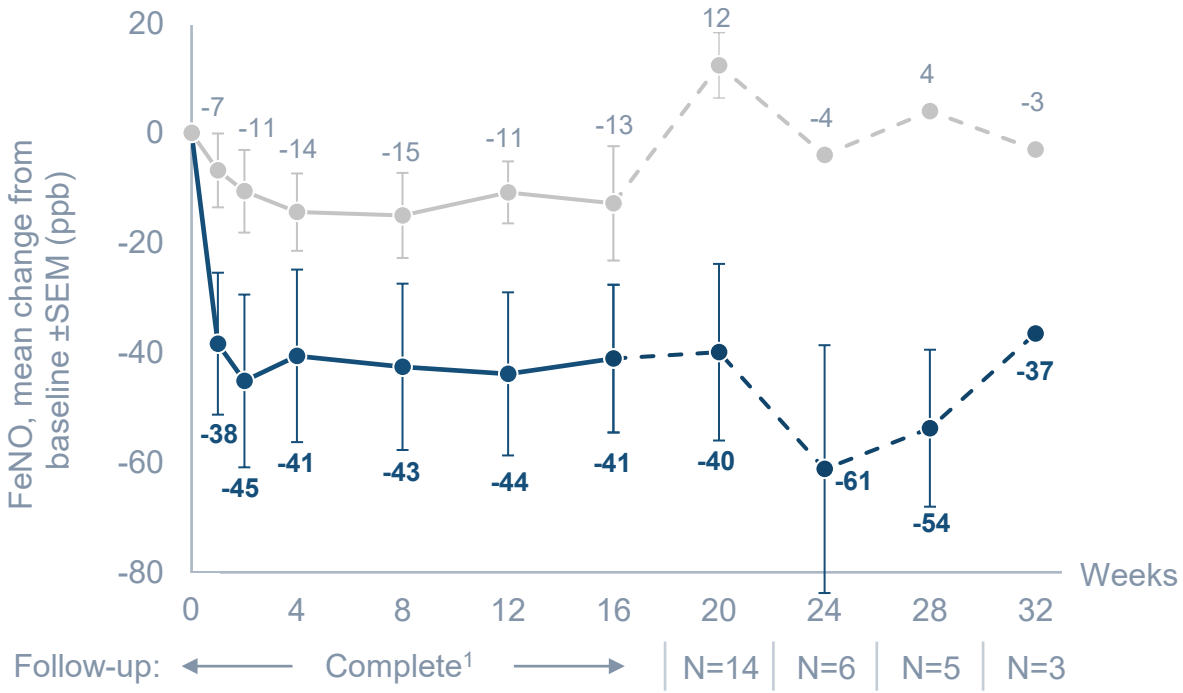
APOGEE THERAPEUTICS

Zumilokibart Phase 1b in asthma demonstrated durable FeNO suppression

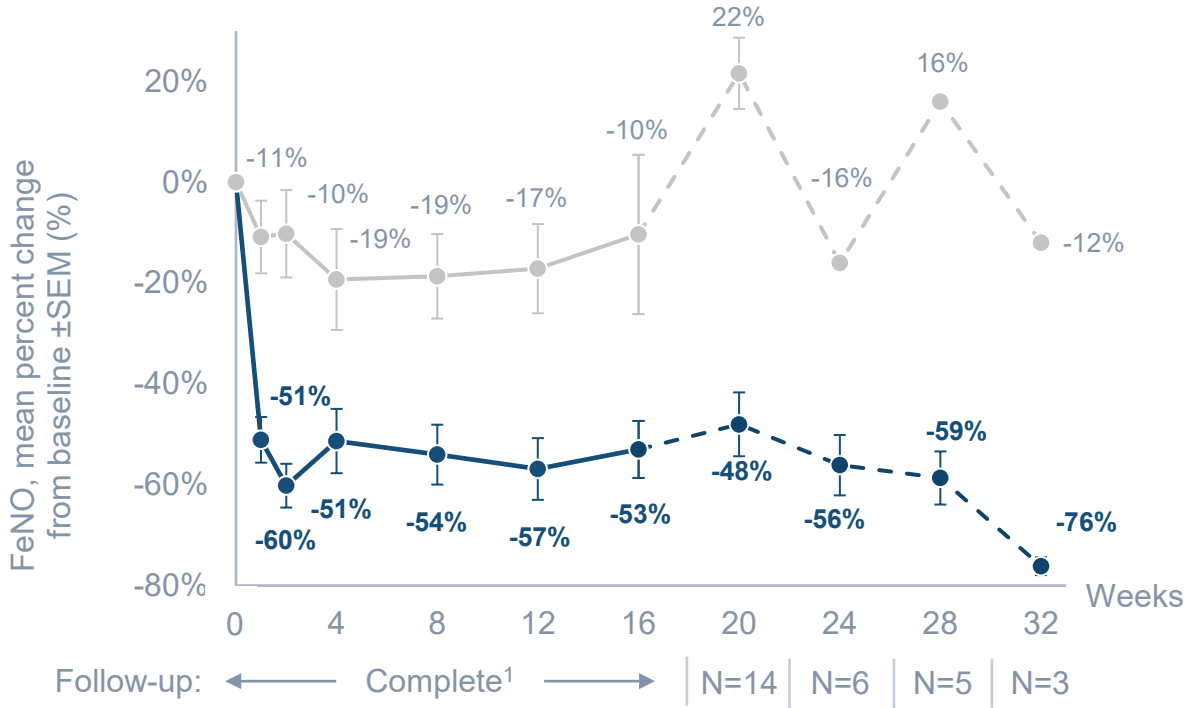
Zumilokibart 720 mg — Complete follow-up (N=14)[1] — Incomplete follow-up

Placebo — Complete follow-up (N=5) — Incomplete follow-up[2]

FeNO mean absolute change from baseline



FeNO mean percent change from baseline

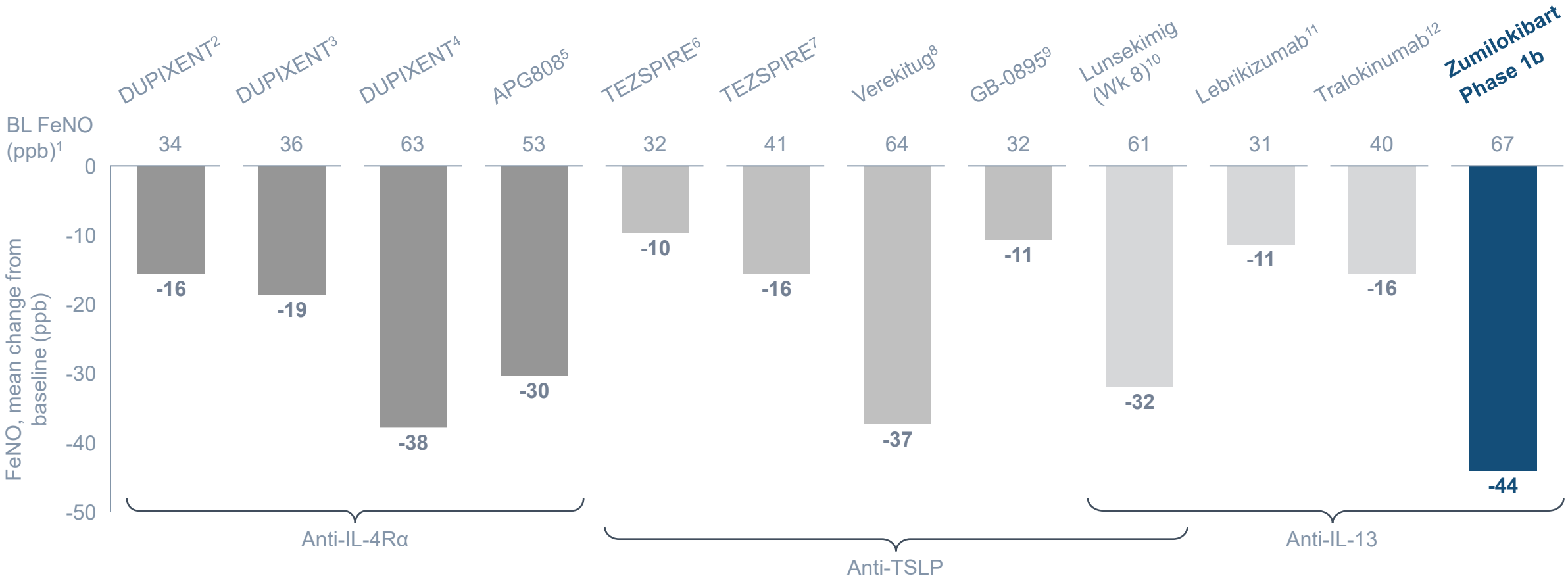


Single dose of zumilokibart demonstrated durable FeNO suppression through 32-weeks (for patients with available follow-up), supporting the potential for **every 3- or 6-month dosing**

NOTE: [1] One patient discontinued following the Week 12 visit (lost to follow-up). [2] Error bars cannot be generated for placebo beyond Week 20 due to small N.
FeNO = fractional exhaled nitric oxide.

Single dose of zumilokibart achieved competitive FeNO reduction

FeNO mean absolute change from baseline at 12 weeks (ppb)

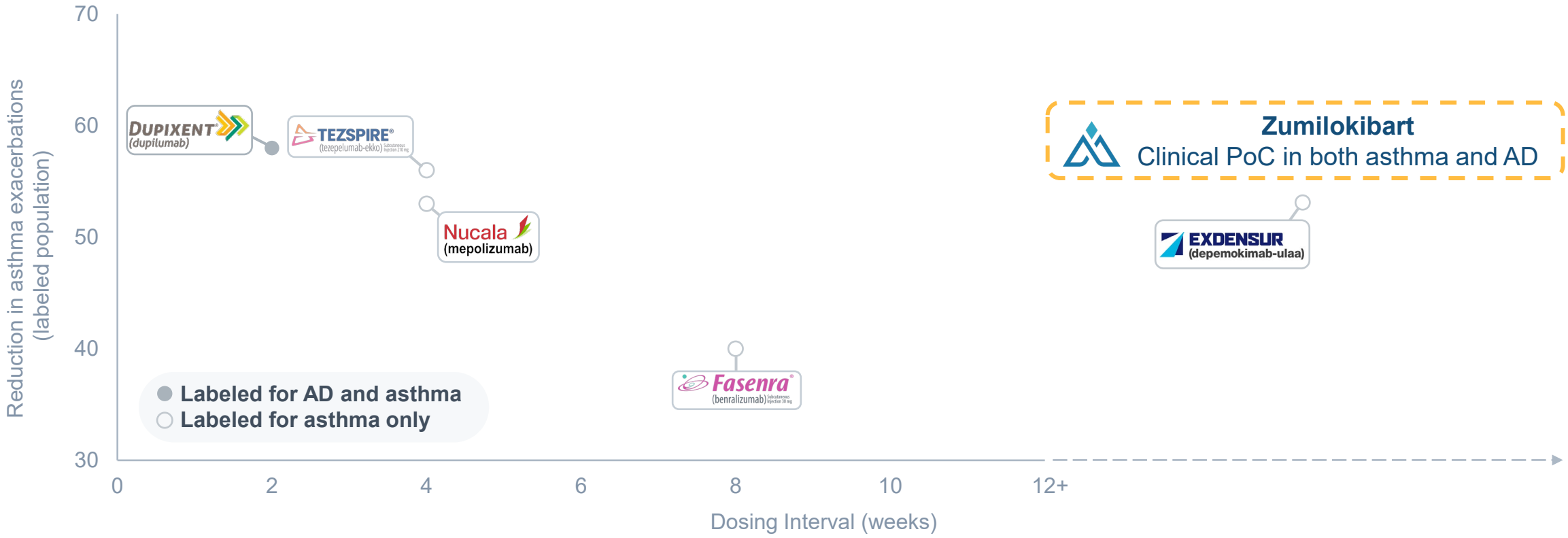


FeNO has shown the strongest correlation with asthma exacerbations of any biomarker[13,14]

NOTE: Data are derived from different clinical trials conducted at different times, with differences in trial design and patient populations. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted. FeNO level reflects data from marketed dose, where available. Lunsekimig data is from D57 (week 8; week 12 data not available). Lebrikizumab data is for 125mg Q4W dose (highest tested dose in Phase 3 trials). BL = baseline. FeNO = fractional exhaled nitric oxide.

SOURCE: [1] Baseline indicated refers to treatment group(s) only. [2]Castro M, et al. NEJM, 2018. [3]Rabe KF et al. NEJM, 2018 (digitized). [4]Castro M, et al. Lancet Resp Med, 2025 (difference of baseline mean FeNO of 63.1 ppb and Week 12 mean FeNO of 25.3 ppb). [5]Kamboj A, et al. ACAAI, 2025. [6]Corren JC, et al. NEJM, 2019 (digitized). [7]Menzies-Gow A, et al. NEJM, 2021 (digitized). [8]Deykin A et al. ERS 2024 (straight average of 100mg Q4W, 200mg Q4W, and 300mg Q12W cohorts). [9]Singh et al ERS 2025 (straight average of 100mg, 300mg, 600mg, and 1200mg cohorts, digitized). [10]Deiteren A et al. ATS 2023 (digitized). [11]Hanania NA, et al. Thorax, 2015 (125mg Q4W, weighted average of biomarker-high and biomarker low cohorts, digitized). [12]Russell RJ, et al. Lancet Respir Med, 2018 (digitized). [13]Mansur AH, et al. Respiratory Medicine, 2018. [14]Kraft M, et al. Eur Respir J. 2021.

Zumilokibart has the potential to be a differentiated drug for Type 2 inflammatory conditions including AD and asthma



Zumilokibart could become a leading therapy in the $15B+ future asthma biologics market

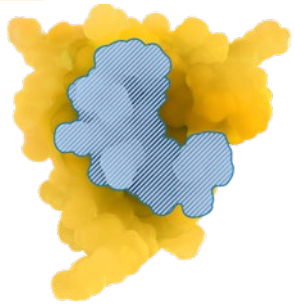
NOTE: Positioning of zumilokibart is illustrative and based on Phase 2 Part A results in AD and Phase 1b interim results in asthma for zumilokibart only and illustrates what we believe we can potentially achieve. Only DUPIXENT, TEZSPIRE, NUCALA, FASENRA, and EXDENSUR are approved in the US. Efficacy data are derived from different clinical trials conducted at different times, with differences in trial design and patient populations. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted. Maintenance dosing intervals are as per label or published data. For some agents, longer dosing intervals are currently being evaluated in ongoing clinical trial(s).
SOURCE: FDA labels. 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. EXDENSUR data from two Phase 3 trials in patients with eos ≥150 at screening or ≥300 in prior year

APG273 (zumilokibart+APG333) combines validated mechanisms for potentially best-in-class efficacy and dosing in obstructive airway disease

OVERLAPPING EPITOPE | OPTIMIZED PK AND FORMULATION | BROAD & ROBUST INHIBITION

Zumilokibart (APG777)

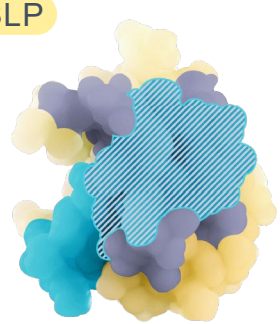
HUMAN IL-13



Overlapping region (vs. EBGLYSS)

APG333

HUMAN TSLP



Overlapping region (vs. TEZSPIRE)

APG273

77-day human half-life

Potential for APG273 every 3-month dosing or better

~55-day human half-life

Preclinical data

	Airway remodeling: Periostin[1]	Eosinophil recruitment: IL-5[2]
APG273 (IL-13 + TSLP)	23	7
Tezepelumab (TSLP)	65	7
Lebrikizumab (IL-13)	19	51

Cytokine level (% of untreated)[3]

0 | 20 | 40 | 60 | 80 | 100

Clinical data: Durable biomarker suppression through 6 months after single dose
(e.g.,TARC for zumilokibart; IL-5 for APG333)

Clinical POC for IL-13 + TSLP inhibition via lunsekimig (IL-13/TSLP NANOBODY) asthma Phase 2b data in 1H 2026

NOTE: [1] Human airway epithelial cells from one COPD donor were cultured at the air-liquid interface and treated with TSLP+IL-13. After 7 days, cytokines were measured in the basal supernatants. [2] ALR performed using four donor pairs of TSLP-primed mDCs plus allogeneic CD4 cells for 5 days. [3] Responses are reported as mean percent of control across all donors.

2026 could be a transformational year for Apogee

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

Expanding zumilokibart beyond atopic dermatitis

✓ Q1 2026: Asthma Phase 1b positive data

Establishing potential best-in-class dosing for zumilokibart in future $50B+ atopic dermatitis market

- Q1 2026: APEX Phase 2 Part A 52-week expected readout

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

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

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

- 2H 2026: AD Phase 1b POC expected readout (against DUPIXENT)

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

APOGEE THERAPEUTICS

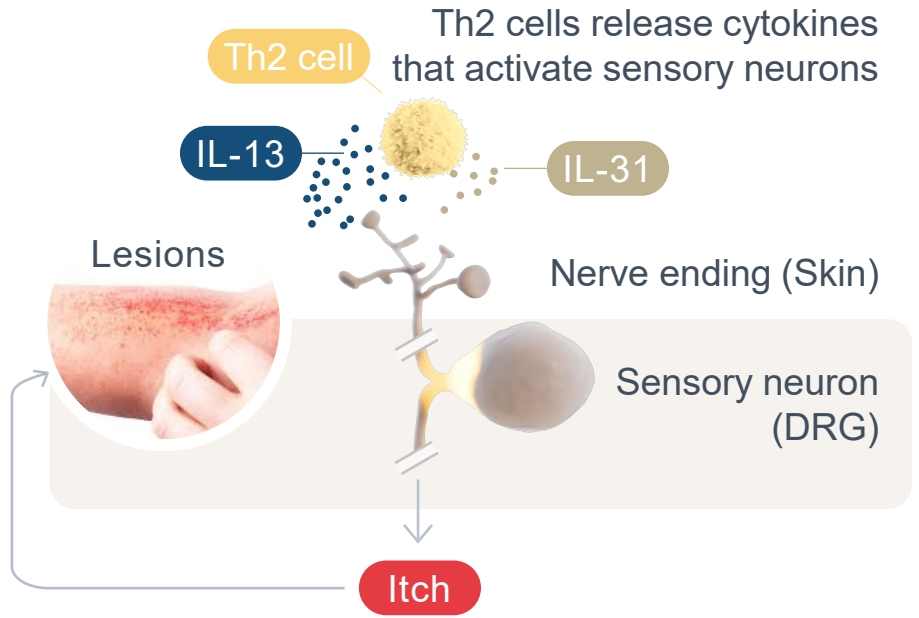
NOTE: [1] As of Dec 31, 2025, Apogee had cash, cash equivalents, marketable securities, and long-term marketable securities of $902.9M. [2] APG279 is a combination of APG777 (zumilokibart) and APG990. APG279 will be co-administered in the proof-of-concept Phase 1b trial; coformulation planned for future clinical studies and commercialization.

Apogee /ˈapəjē/ *noun*

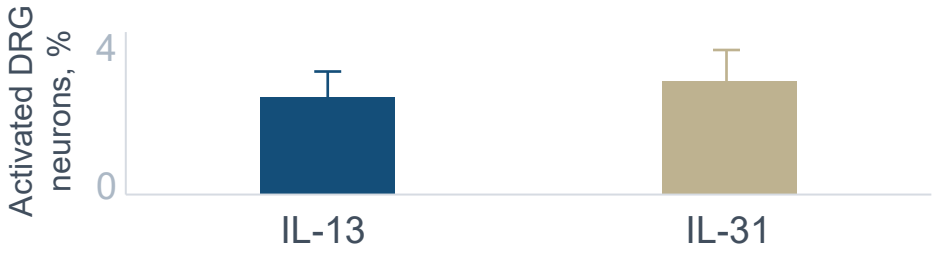
The highest point in the development of something; a climax or culmination

Zumilokibart blocks activation of sensory neurons for rapid itch relief

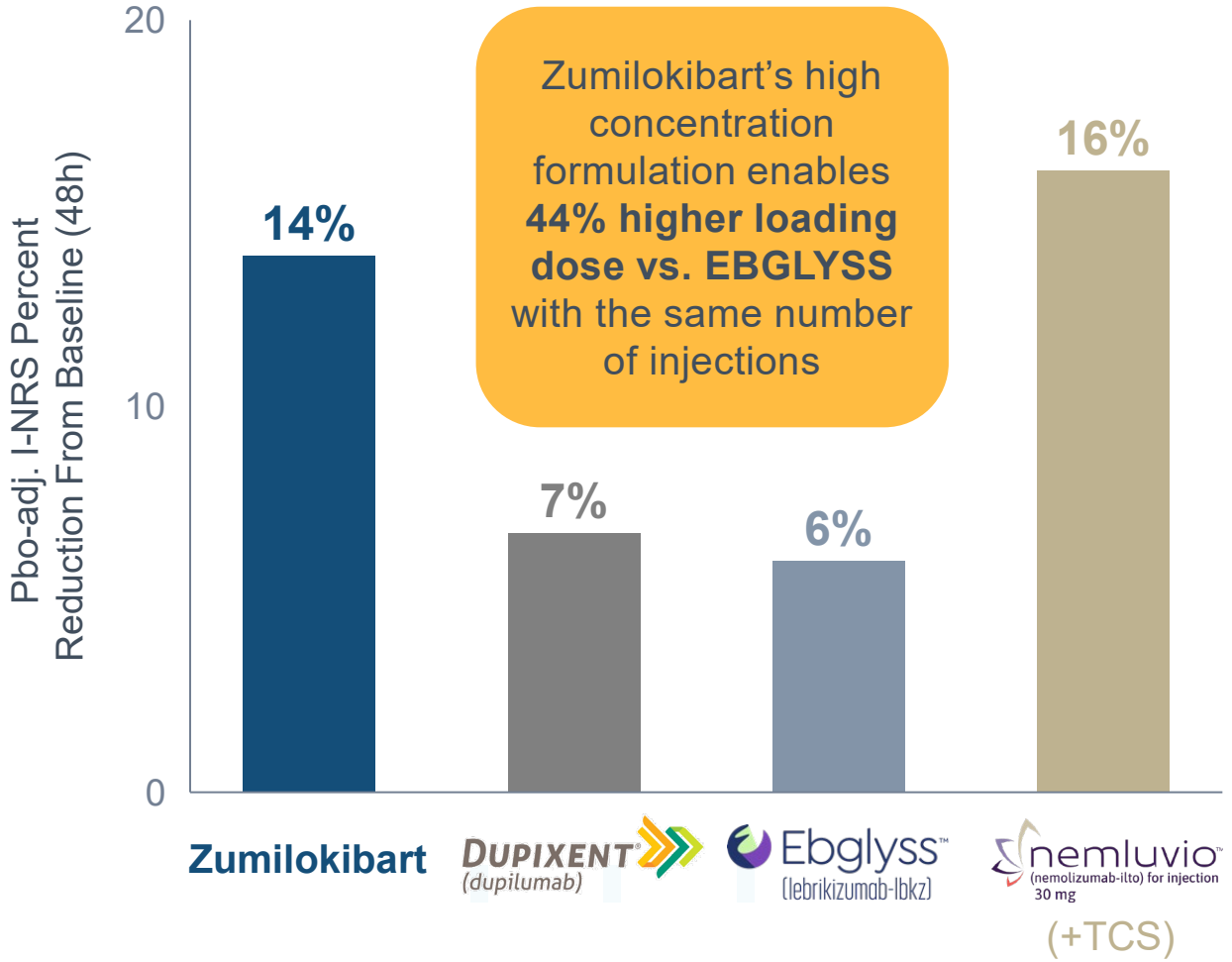
IL-13 induces sensory neuron activation at levels comparable to IL-31[5]



Percent of sensory neurons activated following cytokine stimulation[5]



Zumilokibart demonstrated rapid itch relief similar to NEMLUVIO + TCS

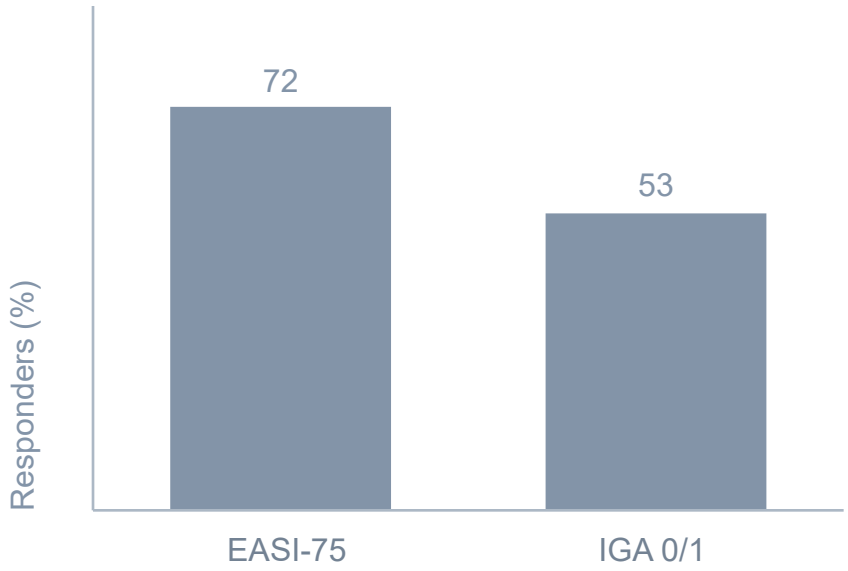


NOTE: DRG = Dorsal root ganglion (primary sensory neurons located in clusters along the spinal cord that transmit sensory information including itch).

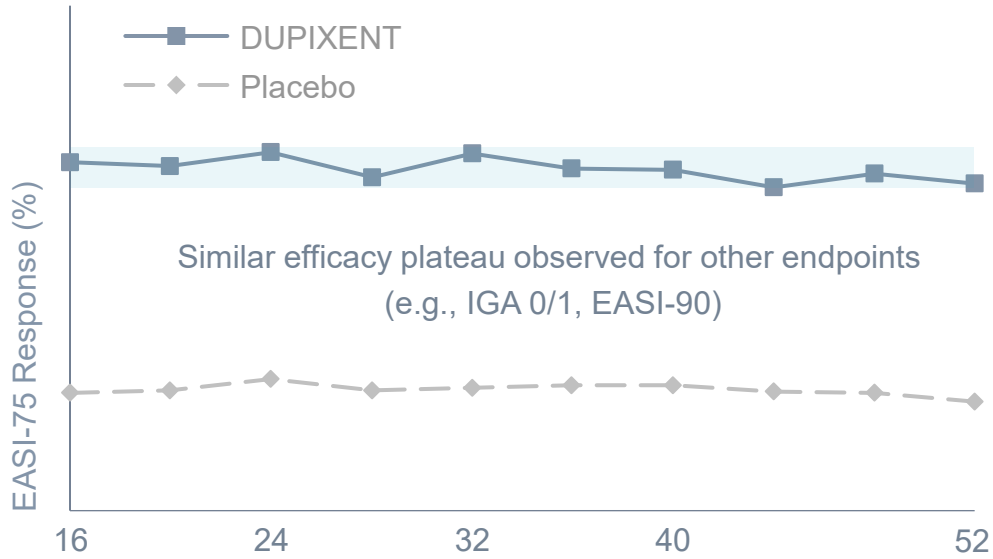
SOURCE: [1] **DUPIXENT** (average of Ph3 SOLO-1&2 and Ph2b; 300 mg Q2W regimen; non-responder imputation for missing values). [2] **DUPIXENT** (Silverberg et al JAAD 2020, average of Ph3 SOLO-1&2; 300 mg Q2W regimen; non-responder imputation for missing values). [3] **EBGLYSS** (average of Ph3 ADVOCATE-1&2 (multiple imputation (MCMC-MI) for missing values) and Ph2b (sensitivity analysis 3: NRI for rescue medication use and LOCF for other missing values); 250mg Q2W regimen). [4] **NEMLUVIO** (Silverberg, JI et al J. EADV 2021, Ph2b; 30 mg Q4W regimen; Mixed Model for Repeated Measures for missing values). [5] Oetjen et al. Cell. 2018.

Part A 52-week goal is to maintain responses similar to or better than DUPIXENT with quarterly or better dosing

DUPIXENT maintenance of response at Week 52 (monotherapy, every 2-week dosing)



DUPIXENT EASI-75 response through Week 52 (TCS combo; every 2-week dosing)



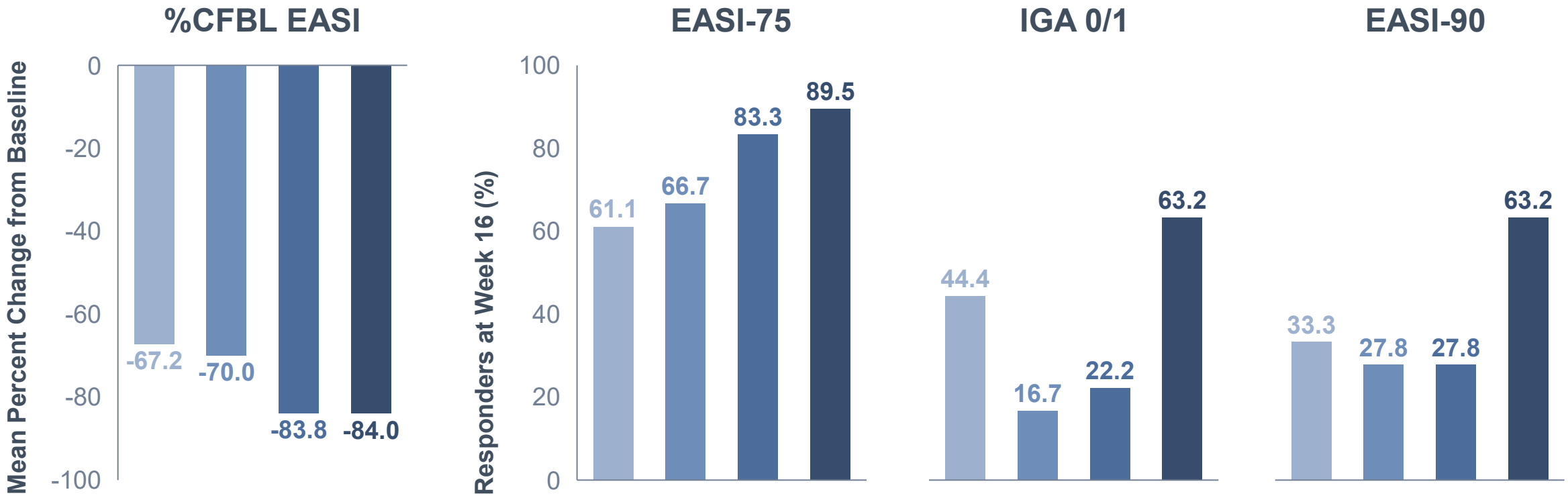
DUPIXENT achieves max response by Week 16 with no further deepening of response

NOTE: DUPIXENT EASI 75-week 52 data from pooled responders at week 16 in SOLO 1&2 who entered SOLO-CONTINUE where QW/Q2W and QW/Q2W performed similarly; IGA data for Q2W regimen from USPI. vIGA = Validated Investigator Global Assessment. EASI = Eczema Area and Severity Index. Longitudinal data from CHRONOS TCS trial
SOURCE: Worm, M, et al, *JAMA Derm*, 2020, DUPIXENT USPI, Blauvelt A et al, *Lancet*, 2017

Exposure-response relationship demonstrated across multiple endpoints

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

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



Zumilokibart Part B top dose has similar modeled exposure as Quartile 4[2]; Part B 16-week data expected Q2 2026

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

Zumilokibart was well tolerated

n (%) Safety summary through Week 16	Zumilokibart (N=82)	Placebo (N=41)
Patients reporting ≥1 TEAE	46 (56.1)	26 (63.4)
Patients reporting ≥1 serious TEAE	1 (1.2)	1 (2.4)
Patients who discontinued due to TEAE	2 (2.4)	0
Most frequent TEAEs by PT through Week 16 (≥5%)		
Noninfective conjunctivitis	12 (14.6)	1 (2.4)
Upper respiratory tract infection	7 (8.5)	5 (12.2)
Nasopharyngitis	4 (4.9)	5 (12.2)
Pain in extremity	0	3 (7.3)

- Total conjunctivitis rate of 18.3%[1], the most common adverse event, consistent with DUPIXENT and EBGLYSS in AD[2]
  - Transient and led to no discontinuations, dose interruptions, or dose adjustments
  - 3.7% of treated patients had conjunctivitis ongoing at Week 16 (similar to 4.2% for DUPIXENT[3]); median time to resolution of 29 days
  - No relationship between exposure and conjunctivitis, consistent with EBGLYSS and DUPIXENT
- No injection site reactions occurred (0%)
- No imbalance in infections between arms

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

Conjunctivitis is most commonly mild eye redness which has limited impact on physician use of DUPIXENT

Based on independent market research (N=75 HCPs):

About 1 in 5 AD patients experience conjunctivitis on DUPIXENT

Most cases resolve without need for treatment or are treated with OTC drops (e.g. Visine)

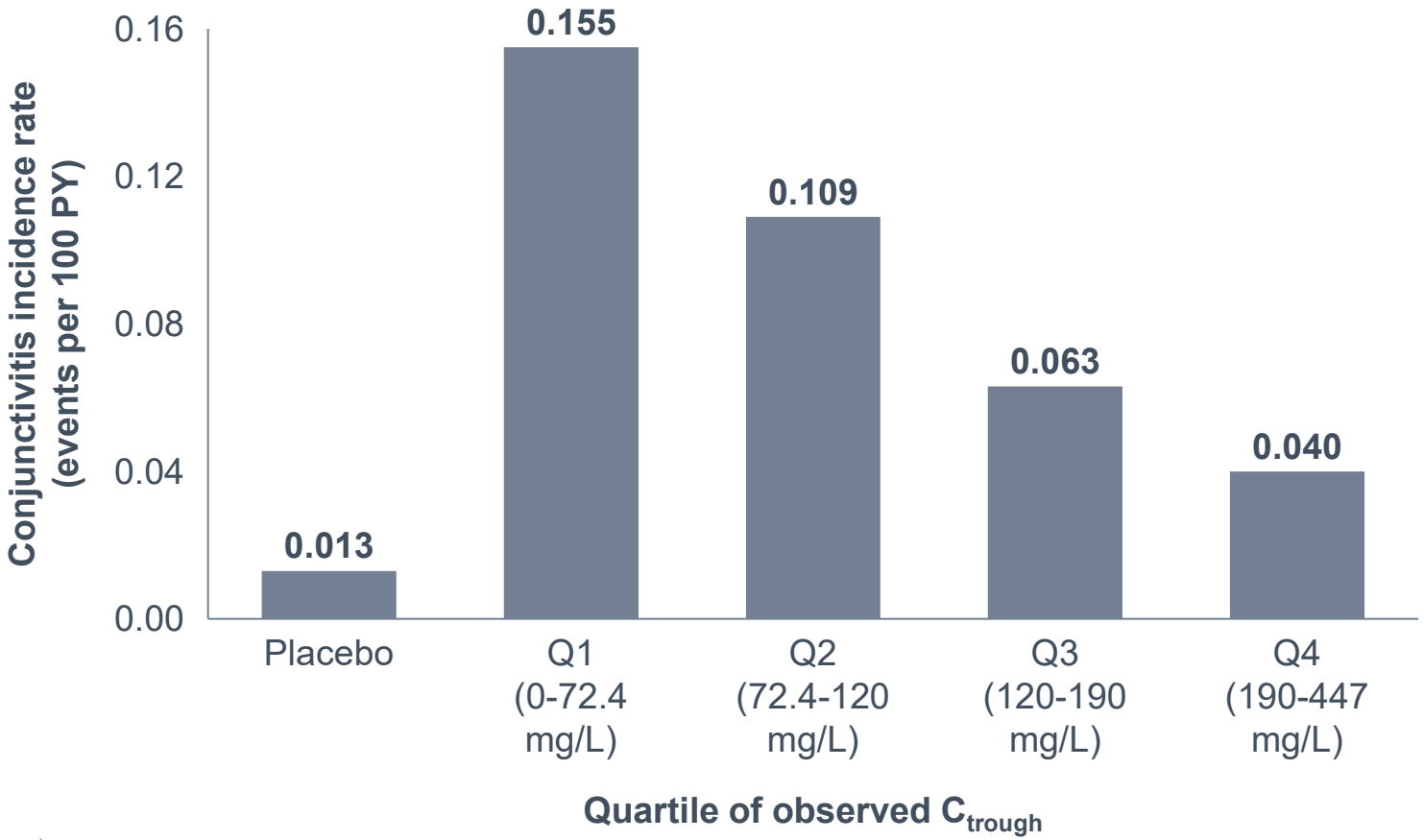
Patients very rarely discontinue DUPIXENT due to conjunctivitis; ISRs are the most common AE leading to discontinuation of DUPIXENT

[1]Independent market research carried out by TRINITY Quantitative Research (July 2025). N=75 dermatologists, allergists, and immunologists (treating both adult and pediatric AD patients). ISRs = Injection Site Reactions

Higher exposures have not increased risk of conjunctivitis for DUPIXENT, EBGLYSS, and zumilokibart

DUPIXENT conjunctivitis incidence rate across Phase 3 studies[1]

(baseline to Week 16 in pooled data from SOLO 1, SOLO 2, and CHRONOS)



- **DUPIXENT conjunctivitis rate is inversely correlated with exposure[1]**
- **EBGLYSS and ADBRY showed no relationship between exposure and conjunctivitis[2,3]**
- **Zumilokibart Part A showed no relationship between exposure and conjunctivitis**

SOURCE: [1] Akinlade et al. Br J Dermatol. 2019. (Supplemental Table S4). [2] EBGLYSS (lebrikizumab) Phase 2b saw similar rates of conjunctivitis across dose regimens (250mg Q4W = 3.8%; 250mg Q2W = 2.7%). Both FDA and EMA noted the safety profile was consistent between EBGLYSS Q2W and Q4W doses in the maintenance phase. [3] ADBRY FDA integrated review found no relationship between quartiles of exposure for tralokinumab and the incidence of conjunctivitis was observed.

Zumilokibart was well-tolerated in mild-to-moderate asthma patients

n (%)	Placebo N=5	Zumilokibart N=14
≥1 TEAE	4 (80.0%)	7 (50.0%)
≥1 serious TEAE	0	0
≥1 Grade 3 or 4 TEAE	0	0
≥1 drug-related TEAE	0	0
≥1 drug-related serious TEAE	0	0
≥1 drug-related Grade 3 or 4 TEAE	0	0
Discontinued study due to TEAE	0	0

- No conjunctivitis or injection site reactions observed
- Only TEAE occurring in >1 patient on zumilokibart was GERD (2 patients, 14.3%)
- Safety profile is in line with expectations for therapies targeting IL-13 in asthma
- No ADAs; PK in line with previous studies

NOTE: TEAE = Treatment-Emergent Adverse Event. GERD = gastroesophageal reflux disease. ADA = anti-drug antibody. Data cut off date: November 28th, 2025.
In full safety population (N=31) that were on treatment (N=23), TEAE occurring in >1 patient on zumilokibart were upper respiratory tract infection (N=3), nasopharyngitis (N=2), gastroesophageal reflux disease (N=2), and arthralgia (N=2); there were no Grade 3 or 4 AEs or SAEs.

Most surveyed physicians indicate zumilokibart would be their biologic of choice and most surveyed patients indicate they would start or switch to zumilokibart

Zumilokibart Part A profile was tested vs approved biologics[1,2]

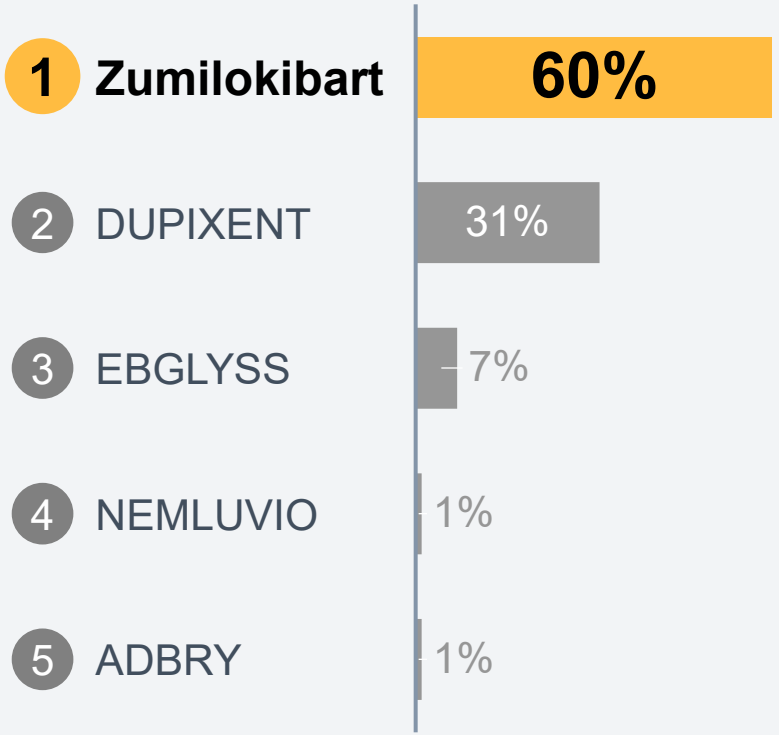
Independent market research (N=75 HCPs[1], N=90 patients[2])

Efficacy: EASI-75, EASI-90, IGA 0/1, I-NRS, etc. (absolute and pbo-adjusted)

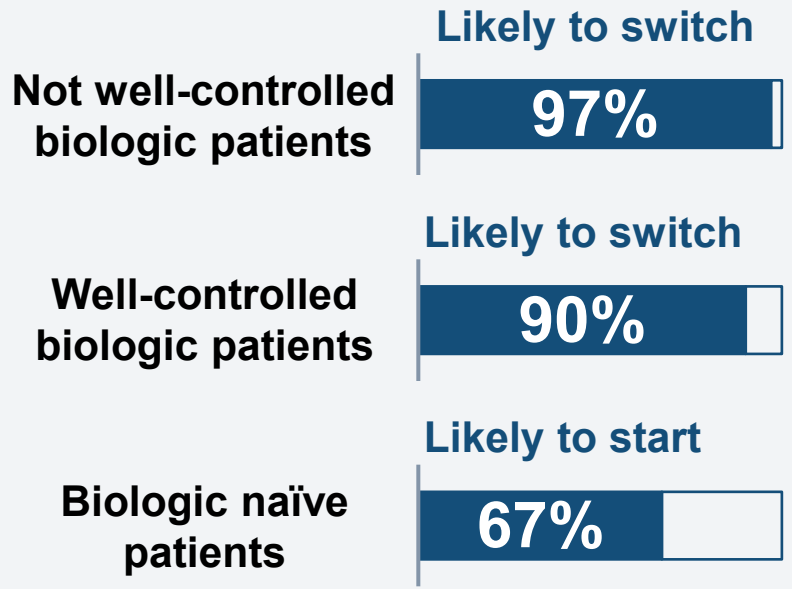
Dosing: Induction / maintenance regimen (Q3M for APG777 vs. Q2-8W for competitors)

Safety: Rates of conjunctivitis, ISRs, etc.

Physicians ranking treatment as their top biologic for AD (%)[1,3]



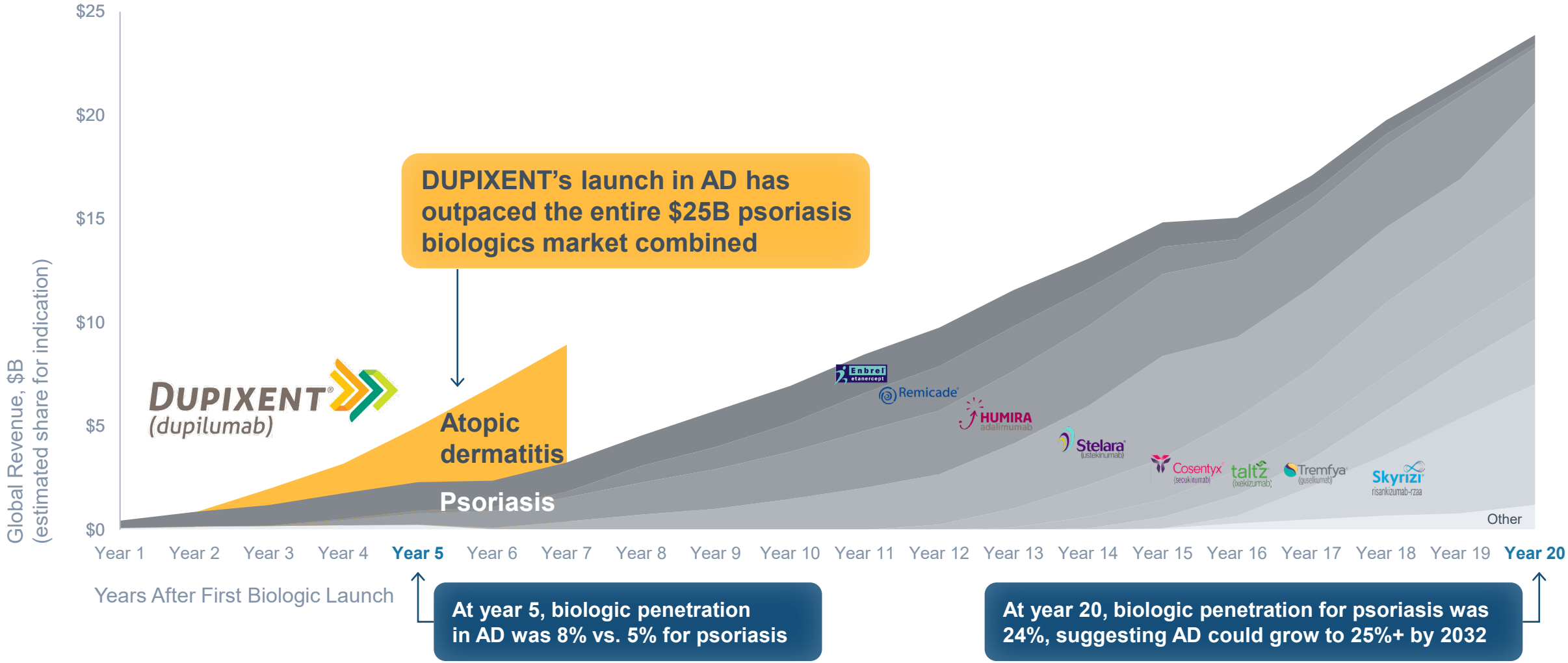
Most surveyed patients are likely to start or switch to zumilokibart profile[2]



>3X more biologic naïve patients are willing to start a biologic with zumilokibart dosing profile vs. DUPIXENT

[1] Independent market research carried out by TRINITY Quantitative Research (July 2025). N=75 dermatologists, allergists, and immunologists (treating both adult and pediatric AD patients). ISRs = Injection Site Reactions
[2] TRINITY Quantitative Research (September 2025). N=90 atopic dermatitis patients (N=30 biologic naïve, N=30 biologic well-controlled, N=30 biologic not well-controlled).
[3] HCPs were asked to force rank each biologic by preference for treating moderate-to-severe atopic dermatitis.

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



SOURCE: EvaluatePharma
NOTE: Year 1 for DUPIXENT in AD is 2017 and for Biologics in PsO is 2004 (i.e., ENBREL approval). Other includes SILIQ, ILLUMYA, and CIMZIA, which all launched prior to SKYRIZI.