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Corporate Presentation

March 2024

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I. Seralutinib Overview

Ongoing Phase 3 Registrational Study in PAH

PROGRAM	CLASS (Route of Admin.)	INDICATION	RESEARCH	PRE-CLINICAL	PHASE 1	PHASE 2	PHASE 3	RIGHTS
Seralutinib (GB002)	PDGFR, CSF1R, c-KIT Inhibitor (Inhaled)	Pulmonary Arterial Hypertension (PAH)	Phase 3 PROSERA Study Ongoing Completed Phase 2 TORREY Study Met Primary Endpoint Well-Tolerated					WW
		Pulmonary Hypertension Associated with Interstitial Lung Disease (PH-ILD)	Future Development					WW

WW = worldwide.

Seralutinib (GB002): Potential To Deliver Disease-Modifying Effects to Patients with PAH

- Inhaled PDGFR, CSF1R, and c-KIT kinase inhibitor designed for PAH
- Rationally designed as an inhaled therapy to treat PAH in wake of imatinib (Gleevec) PAH Phase 3 IMPRES results
- Positive Phase 2 Clinical Trial Results in PAH Patients (TORREY Study)
  - Met primary endpoint (reduction in PVR v. placebo; p = 0.0310) and generally well tolerated
  - Consistent, favorable treatment effect seen in 6MWD, Echo, NT-proBNP & Reveal 2.0 Risk Score
- Patent protection to 2039(1); Orphan Drug Designation from FDA and EMA

PVR = pulmonary vascular resistance; PDGFR = platelet derived growth factor; CSF1R = colony stimulating growth factor 1 receptor; 6MWD = 6-minute walk distance.

1) Includes assumption of maximum 5 years of patent term extension. Corresponding patent(s) and patent application(s) with compound-specific claims. Total patent life with patent term extension cannot exceed 14 years from approval.

PAH Has High Unmet Need & Significant Disease Burden

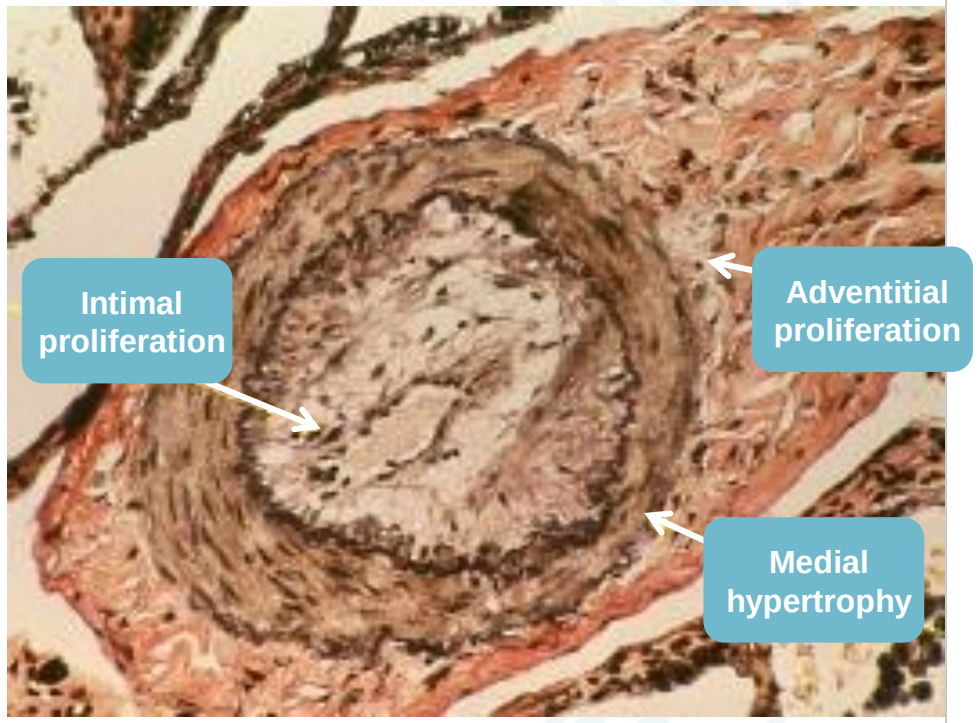
Pulmonary Arterial Hypertension (PAH)

- Rare, orphan disease
- Characterized by high blood pressure in the blood vessels carrying deoxygenated blood from the right side of the heart to the lungs
- Caused when the arteries in the lungs become narrowed, thickened and / or stiff as a result of pathological remodeling and vasoconstriction
- **Progressive disease and often fatal**
- **Heart works harder to pump blood to the lungs, potentially leading to right heart failure**

Symptoms

- Dyspnea
- Fatigue
- Dizziness
- Chest pressure / pain
- Edema in ankles, legs, abdomen
- Cyanosis
- Heart palpitations

PAH is Characterized by Vascular Remodeling



Muscular pulmonary artery from iPAH patient[1]

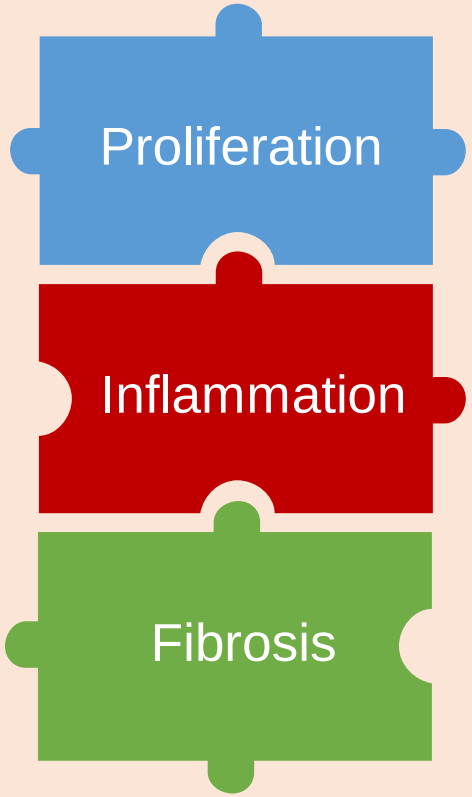
1) Gaine S and Rubin L: Lancet 1998; 352: 719-725.

What Do Currently Available Therapies Do?

- ERAs
- Prostacyclins
- PDE-5is
- sGC stimulators

Primarily work as vasodilators – dilating blood vessels

No approved therapy addresses underlying causes of disease



ERA = endothelin receptor agonist; PDE-5i = phosphodiesterase-5 inhibitor; sGC stimulators = soluble guanylate cyclase stimulators.
Source: Adapted from Humbert, et al., N Engl J Med 2004, 351:1425; LeVarge, et al. Ther Clin Risk Manag. 2015; Jing, et al. AJRCCM, 2011; Channick, et al. Lancet, 2001.

Contributing Factors to Vascular Remodeling

Role of PDGFR, CSF1R, c-KIT and Interactions with BMPR2

△ **PDGFR** signaling

↓

Proliferation

and

Fibrosis

c-KIT+ cells ↑

↓

Inflammation

and

Proliferation

CSF1R+ macrophages secrete PDGF

↓

Inflammation

and vascular remodeling

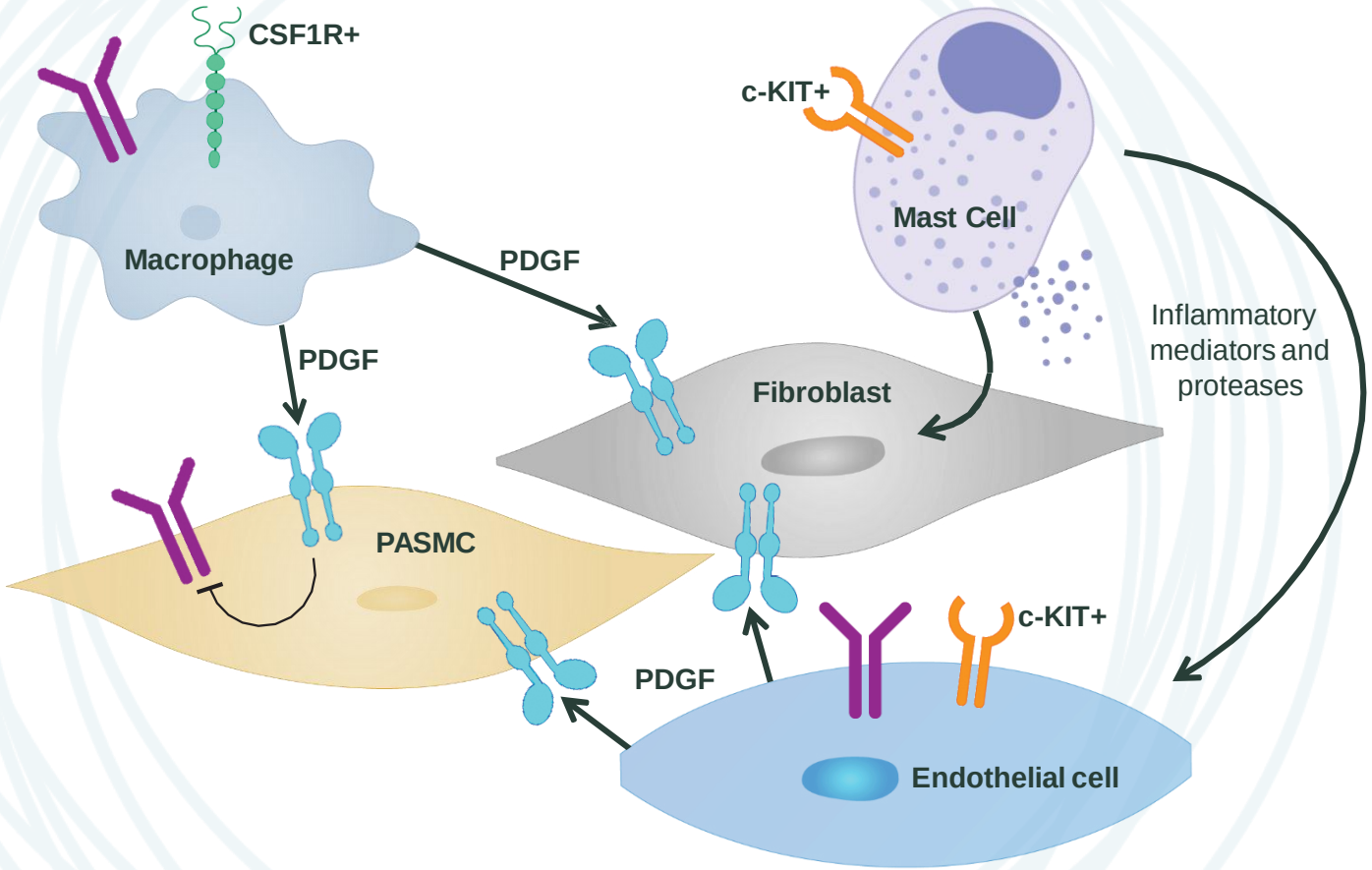
PDGF activation

↓**BMPR2**

↓

↑ PASMC

Proliferation



PDGFR = platelet derived growth factor receptor; CSF1R = colony stimulating factor 1 receptor; PASMC = pulmonary arterial smooth muscle cells.

Source: Grimminger et al dv Exp Med Biol 2010; 661:435; Zhou et al Cell 2018;172:744; Montani et al AJRCCM 2011; 184:116; Chen et al BMC Genomics 2016 17:781.

In the Phase 3 IMPRES Study of Imatinib in PAH, Safety Liabilities Outweighed Clinically Meaningful Efficacy

Clinical Efficacy Results
Phase 3 IMPRES Study

- Primary Endpoint:
  - 6-Minute Walk Distance (6MWD)
  - 32-meter improvement (pbo-adj.)*
- Secondary Endpoint:
  - Pulmonary Vascular Resistance (PVR)
  - 32% reduction (pbo-adj.)*

Clinical Safety / Tolerability
Phase 3 IMPRES Study

- Adverse Events:
  - High rate of GI side effects
  - 44% SAE rate for imatinib group
  - 8 subdural hematomas across study and extension
- Discontinuations:
  - 33% for imatinib group, with most occurring in first 8 weeks of trial

Source: Hoeper, Marius et al. “Imatinib mesylate as add-on therapy for pulmonary arterial hypertension: results of the randomized IMPRES study.” Circulation 127, no. 10 (2013): 1128 – 1138.
*Statistically significant result.
SAE = serious adverse event; pbo = placebo; pbo-adj. = placebo-adjusted; GI = gastrointestinal.

Seralutinib Employs Multiple Strategies to Mitigate Imatinib's Liabilities

Molecule Specifically Designed for PAH

- Imatinib was developed & approved as an anti-cancer therapy
- Seralutinib utilized Phase 3 IMPRES learnings and targets underlying biology of PAH, including PDGFRα/β, CSF1R and c-Kit
- Seralutinib avoids c-ABL inhibition

Improved Selectivity Against Targets of Interest

- Increased potency* across target kinases v. imatinib
  - Increased potency against the PDGFRα isoform
  - Greater than ten-fold higher potency against PDGFRβ, c-Kit, and CSF1R

Designed for Inhalation

- Inhalation limits systemic exposure to mitigate systemic AEs, while directly getting drug to site of disease
- As part of inhalation process, some drug product is inevitably swallowed
  - Swallowed / ingested drug can enter systemic concentration
  - Seralutinib designed to have limited oral bioavailability (~5%)

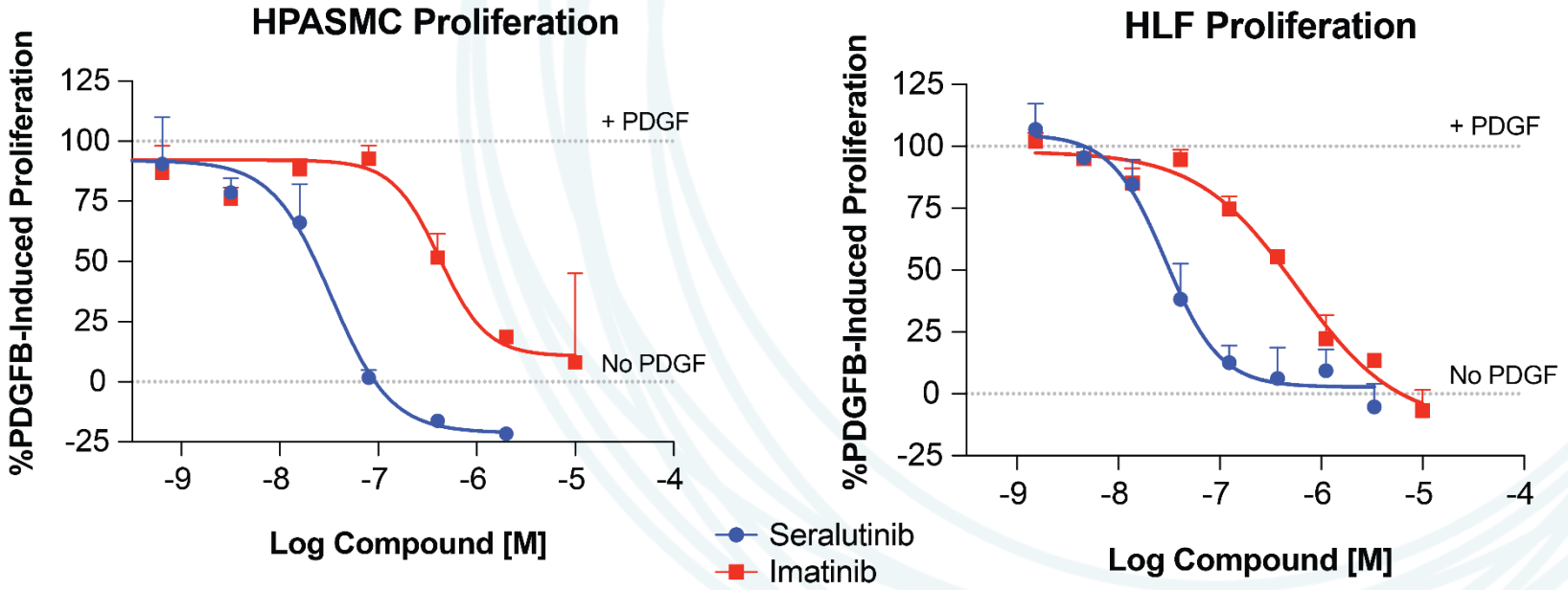
*Based upon cell based IC50 assays. Data on hand.
AE = adverse event.

Seralutinib In Vitro Profile

Seralutinib is a potent PDGFR, CSF1R and c-KIT inhibitor

Compound	Cell Based IC50 (nM)				
	H1703 PDGFRα	HLF PDGFβ>α	PASMC PDGFRα=β	CSF1R	c-KIT
Seralutinib	32	29	33	8	8
Imatinib	62	579	419	1032	301

Seralutinib is highly potent in PASMC and HLF proliferation assays

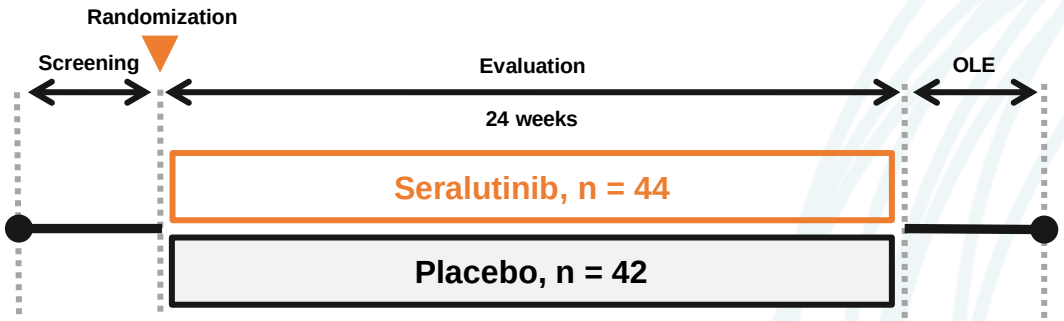


HPASMC: human pulmonary arterial smooth muscle cell; HLF: human lung fibroblast
Source: Galkin et al. Eur Respir J 2022; 60: 2102356.

Seralutinib Utilizes Convenient Dry Powder Inhaler

II. Completed TORREY Phase 2 Study

TORREY: Completed Phase 2 Study of Seralutinib in Patients With Functional Class II and III PAH



Patient Population	**Stable FC II & III PAH patients** on background therapy, including double & triple therapy
Endpoints	**Primary:** ΔPVR at Week 24 **Key Secondary:** Δ6MWD at Week 24† **Exploratory:** Includes NT-proBNP, Echo
Dosing Regimen	**Titrated up to 90mg BID** *(Started at 60mg BID; protocol allowed for down-titration to 45mg BID)*

TORREY STUDY

Enrolled relatively low-risk PAH patient population; most well-controlled PAH pop. to meet primary efficacy endpoint*

Met primary endpoint; seralutinib treatment benefit observed across primary, secondary and exploratory endpoints

Treatment well tolerated - vast majority of patients able to achieve and maintain 90mg BID dosing

*As determined by baseline PVR & 6MWD, we believe that TORREY enrolled the most well-controlled PAH patient trial population to meet its primary efficacy endpoint.
FC = Functional Class; OLE = open label extension; PVR = pulmonary vascular resistance; 6MWD = six-minute walk distance; BID = twice-daily dosing.
Source: clinical trials.gov/NCT04456998
†Trial was not powered to demonstrate a statistically significant difference in 6MWD.

Selected Baseline Disease Characteristics

(ITT Population)

Characteristic	Placebo (N=42)	Seralutinib (N=44)	Total (N=86)
Number of PAH background therapies – n (%)			
1	2 (4.8)	1 (2.3)	3 (3.5)
2	16 (38.1)	18 (40.9)	34 (39.5)
3	24 (57.1)	25 (56.8)	49 (57.0)
WHO FC – n (%)			
Class II	20 (47.6)	**30 (68.2)**	50 (58.1)
Class III	**22 (52.4)**	14 (31.8)	36 (41.9)
PVR (dyne*s/cm^5) – mean (SD)	661.3 (164.91)	675.8 (240.35)	**668.7 (205.90)**
6MWD (m) – mean (SD)	407.1 (107.02)	408.6 (75.11)	**407.9 (91.54)**
NT-proBNP (ng/L) – mean (SD)	645.6 (1158.75)	611.0 (714.58)	**628.3 (956.83)**

Heavily pre-treated patient population

Hit Primary Endpoint Despite **FC Imbalance in Drug & Pbo Arms**

Mildest baseline PAH disease to see treatment effect*

STELLAR Trial Phase 3 NT-proBNP mean baseline was 1,121.1ng/L; PVR was 763.7 dyne*s/cm^5 (1)

Full Baseline Characteristics Available in Appendix

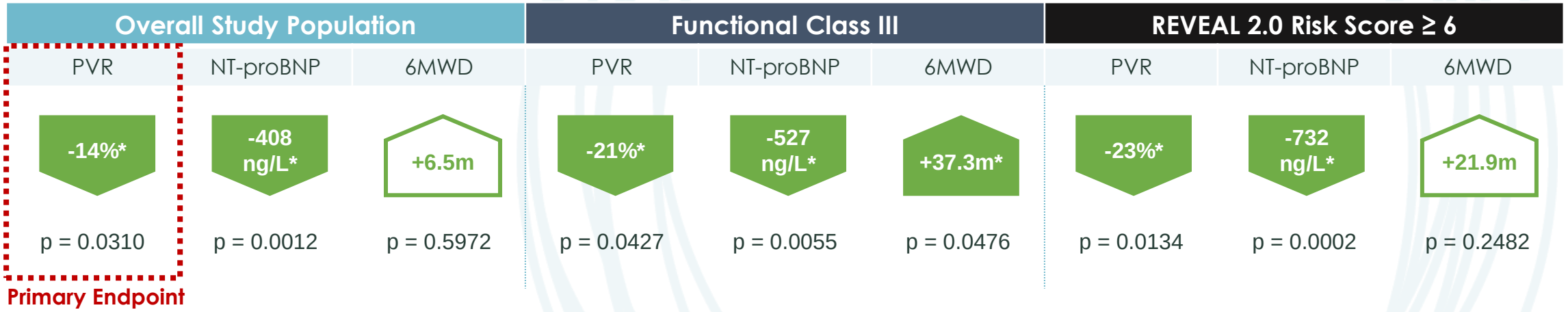
1) Source: https://doi.org/10.1056/NEJMoa2213558.

*As determined by baseline PVR & 6MWD, we believe that TORREY enrolled the most well-controlled PAH patient trial population to meet its primary efficacy endpoint.

6MWD = six-minute walk distance; FC = Functional Class; NT-proBNP = N-terminal pro B-type natriuretic peptide; PVR = pulmonary vascular resistance; WHO = World Health Organization; ITT = intention-to-treat; SD = standard deviation; Pbo = placebo.

TORREY Study Phase 2 Topline Results

- **Met Primary Endpoint:** Statistically significant reduction in PVR in heavily-treated study population
- **Consistent, favorable PVR benefit seen in all pre-specified sub-groups** in favor of seralutinib with **enhanced effects in patients with more severe disease** at baseline§

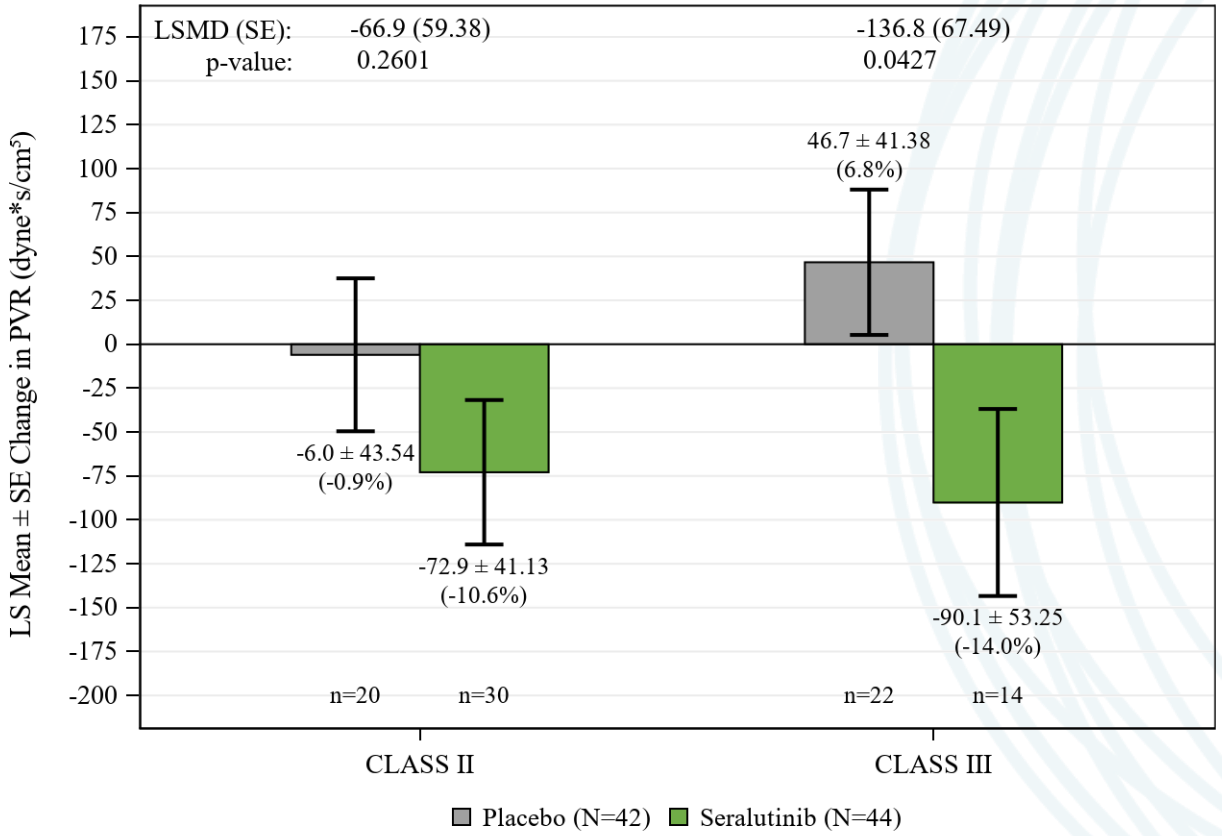


- Consistently favorable results for hemodynamic and ECHO endpoints
- **Well tolerated**, avoiding side effect profile associated with systemic imatinib in PAH

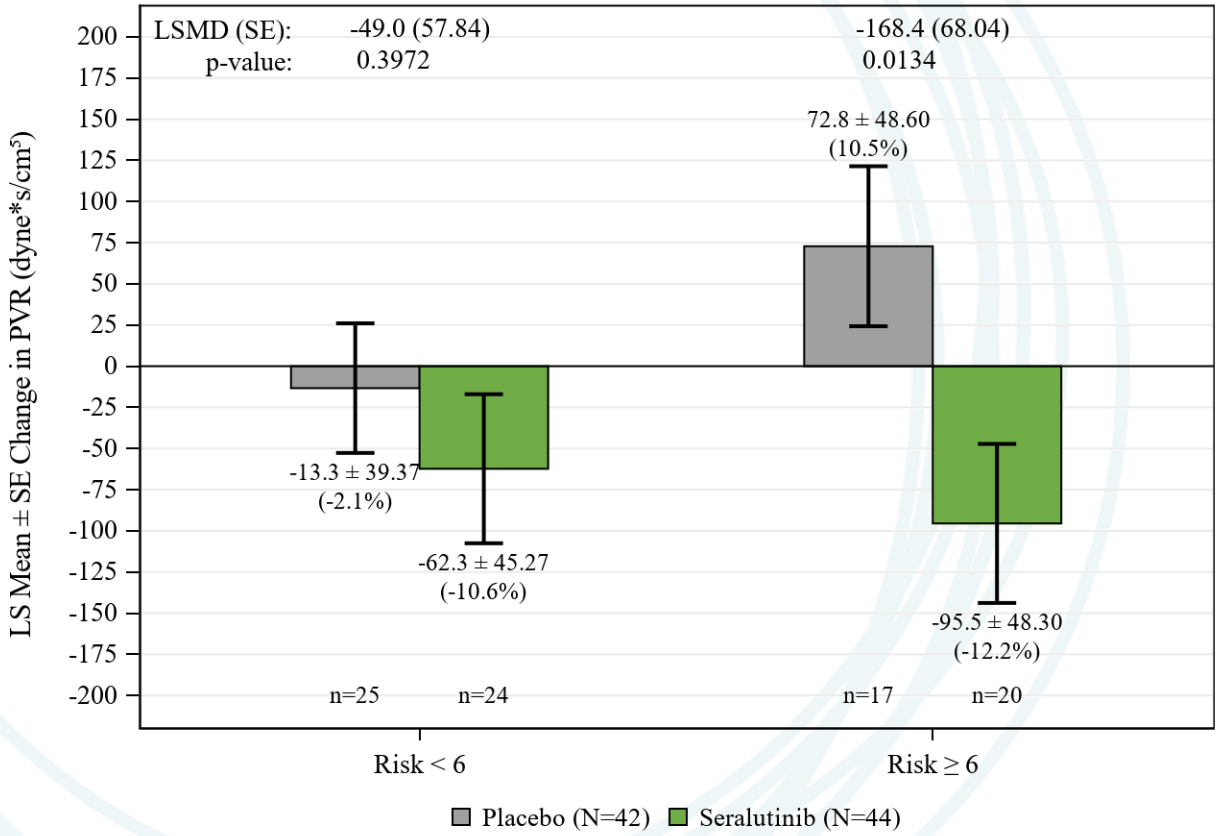
***** = p-value ≤ 0.05. All p-values in this presentation are nominal, aside from primary endpoint (overall study population delta in PVR).
§ At baseline, as determined by Functional Class and REVEAL 2.0 Risk Score (pre-specified subgroups).

Seralutinib's Effect on PVR was More Pronounced in Patients with More Severe Disease at Baseline (ITT Population)

WHO Functional Class
Change in PVR, by Functional Class



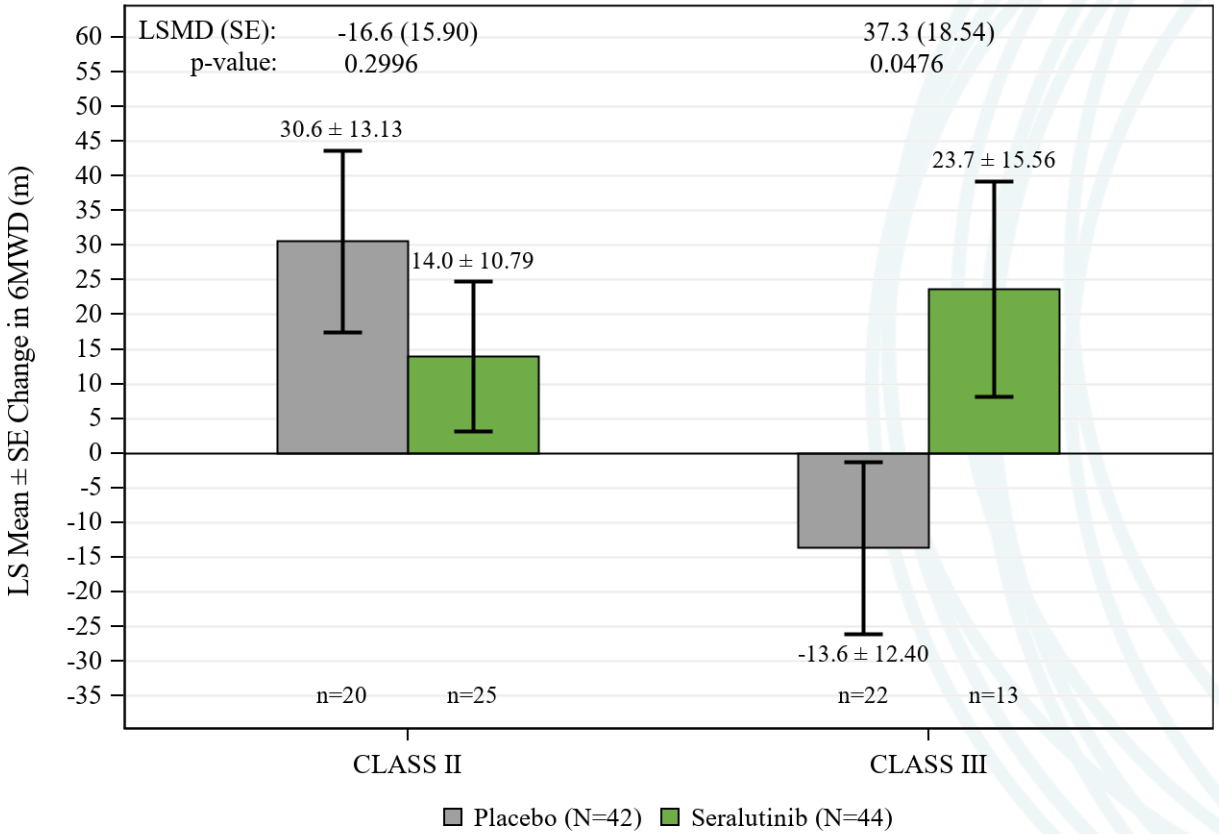
REVEAL 2.0 Risk Score
Change in PVR, by Risk Score



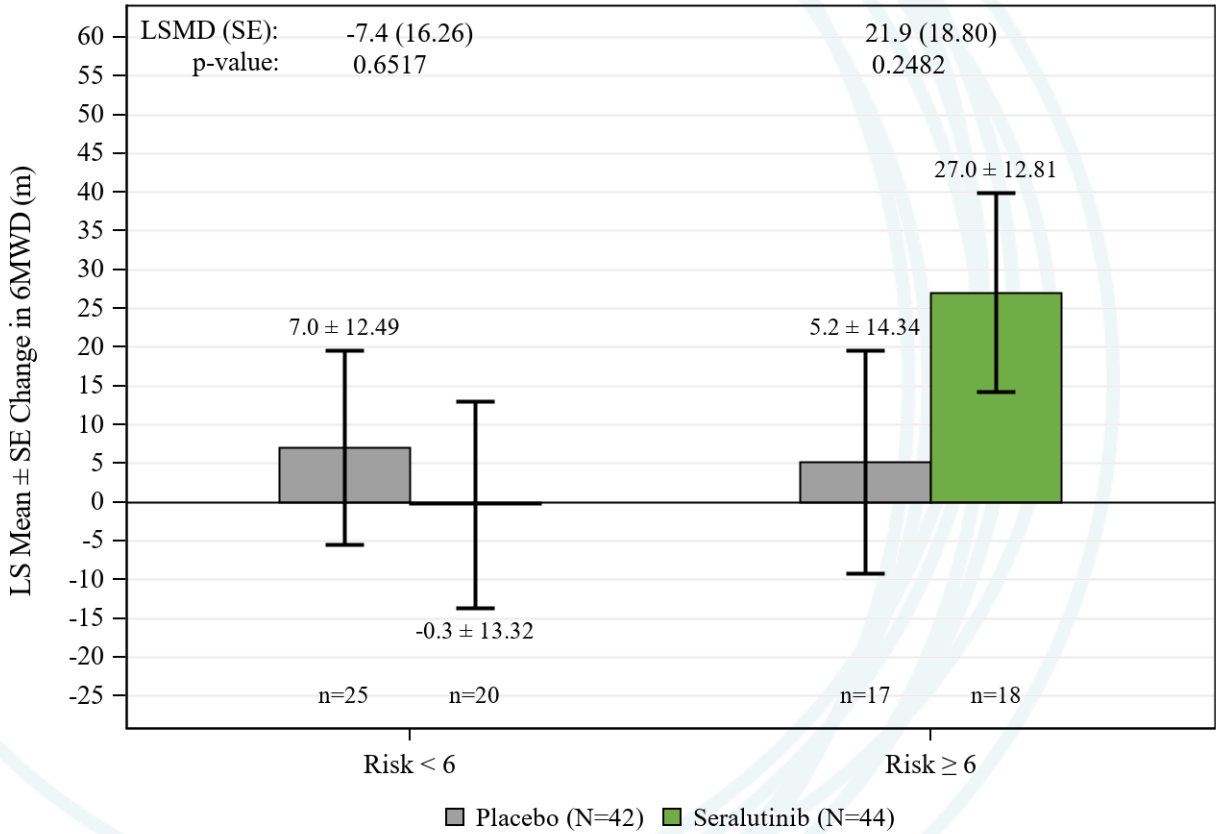
LS = least squares; LSMD = least squares mean difference; PVR = pulmonary vascular resistance; WHO = World Health Organization.
Based on ANCOVA modelling. Source: Data on file.

Change in 6MWD by Functional Class and REVEAL 2.0 Risk Score (ITT Population)

Functional Class
Change in 6MWD, by Functional Class

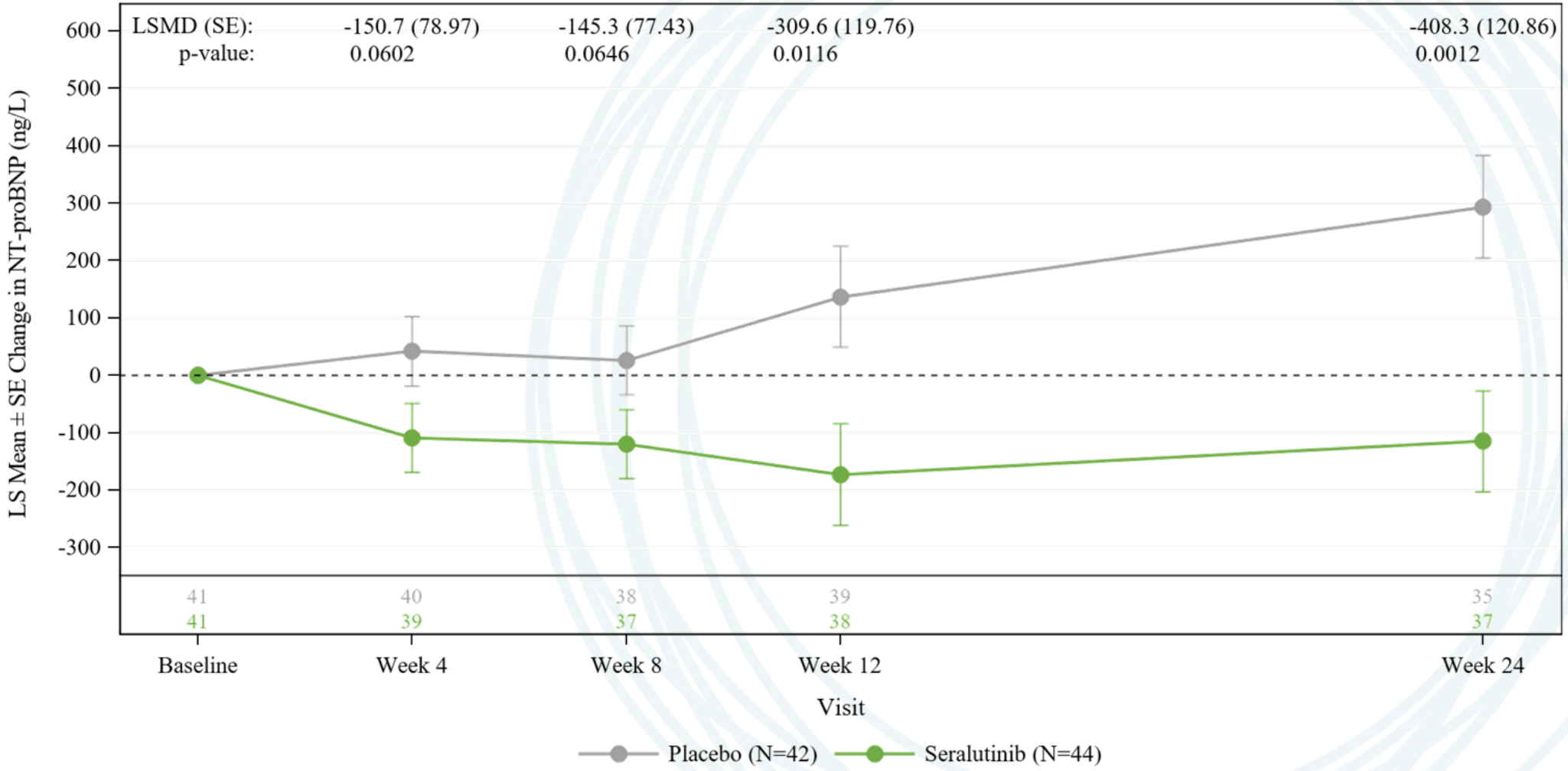


REVEAL 2.0 Risk Score
Change in 6MWD, by Risk Score



6MWD = six-minute walk distance; FC = Functional Class; LS = least squares; LSMD = least squares mean difference; MMRM = mixed-effects model with repeated measures; WHO = World Health Organization.
Based on MMRM modelling. Source: Data on file.

Seralutinib Treatment Led to Statistically Significant Reduction in NT-proBNP (ITT Population)



FC = functional class; LS = least squares; LSMD = least squares mean difference; MMRM = mixed-effects model with repeated measures; NT-proBNP = N-terminal pro B-type natriuretic peptide.
Based on a MMRM model. Source: Data on file.

Centrally-Read RHC and ECHO Results at Week 24 Consistently Favored Seralutinib (ANCOVA – Observed Cases)

Endpoint	LS Mean Difference (95% CI)	Statistically Significant Result Favoring Seralutinib (p ≤ 0.05)	Point Estimate Favoring Seralutinib	p-value
Right Atrium Area (cm^2)	**-1.99 (-3.783, -0.206)**	✓	✓	**0.0293***
RV Free Wall Strain (%)	**-2.64 (-5.172, -0.098)**	✓	✓	**0.0420***
PA Compliance (mL/mmHg)	**0.22 (0.009, 0.423)**	✓	✓	**0.0410***
RV Systolic Pressure (mmHg)	-8.10 (-13.877, -2.317)	✓	✓	0.0067*
PA Systolic Pressure (mmHg)	-6.98 (-12.774, -1.187)	✓	✓	0.0189*
PA Diastolic Pressure (mmHg)	-3.43 (-6.211, -0.643)	✓	✓	0.0165*
RV Fractional Area Change	2.62 (-1.405, 6.652)		✓	0.1983
PVR index (dyne*s/cm^5/m^2)	-160.42 (-333.970, 13.138)		✓	0.0695
mRAP (mmHg)	-0.99 (-2.350, 0.367)		✓	0.1503
Stroke Volume Index (mL/m^2)	2.19 (-0.917, 5.299)		✓	0.1644
Cardiac Index (L/min/m^2)	0.13 (-0.100, 0.359)		✓	0.2658

* p ≤ 0.05.
mRAP = mean right atrial pressure; PA = pulmonary artery; PVR = pulmonary vascular resistance; RV = right ventricle; LS = least squares; RHC = right heart catheterization; ECHO = echocardiography.
Source: Data on file.

Top AEs From Imatinib IMPRES Study Not Observed at High Incidence in TORREY

Preferred Term [a]	IMPRES Study (Phase 3) Imatinib		TORREY Study (Phase 2) Seralutinib	
	Placebo (N=98)	Imatinib (N=103)	Placebo (N=42)	Seralutinib (N=44)
Nausea	23 (24)	57 (55)	6 (14)	5 (11)
Peripheral edema [b]	20 (20)	45 (44)	1 (2)	2 (5)
Diarrhea	19 (19)	36 (35)	3 (7)	6 (14)
Vomiting	10 (10)	31 (30)	3 (7)	2 (5)
Periorbital edema [c]	7 (7)	30 (29)	0 (0)	1 (2)
Dyspnea	13 (13)	19 (18)	5 (12)	4 (9)
Hypokalemia	3 (3)	16 (16)	1 (2)	2 (5)
Anemia	3 (3)	14 (14)	0 (0)	1 (2)
Face edema [d]	1 (1)	10 (10)	0 (0)	1 (2)
Muscle spasms	2 (2)	10 (10)	0 (0)	1 (2)

AE = adverse event; MedDRA = Medical Dictionary for Regulatory Activities; PT = preferred term.
Note: AEs in IMPRES with an incidence ≥ 10% in Imatinib and ≥5% higher in Imatinib than Placebo are summarized for both IMPRES and TORREY.
Note: The above tables are for illustrative purposes only and are not a head-to-head comparison. Differences exist between study designs and methodologies, and caution should be exercised when comparing data across studies.
[a] Coded using MedDRA (v 24.0 in TORREY).
[b] Includes AE PTs of oedema, oedema peripheral, and peripheral swelling in TORREY.
[c] Includes AE PT of periorbital edema in IMPRES and AE PT of periorbital swelling in TORREY.
[d] Includes AE PT of face edema in IMPRES and AE PT of swelling face in TORREY.
Source: Data on file.

Incidence of TEAEs by Preferred Term: ≥ 5% in Seralutinib (Safety Population)

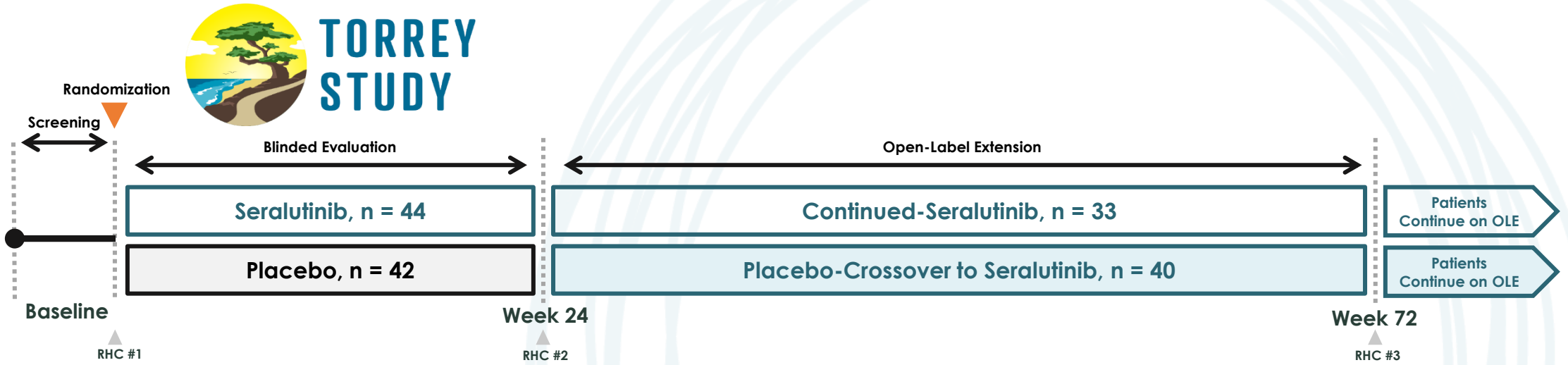
Preferred Term[a]	Placebo (N=42)	Seralutinib (N=44)
Number of subjects with a TEAE	36 (85.7)	41 (93.2)
Cough	16 (38.1)	19 (43.2)
COVID-19	7 (16.7)	6 (13.6)
Diarrhea	3 (7.1)	6 (13.6)
Headache	8 (19.0)	6 (13.6)
Dizziness	2 (4.8)	5 (11.4)
Fatigue	3 (7.1)	5 (11.4)
Nausea	6 (14.3)	5 (11.4)
Dyspnea	5 (11.9)	4 (9.1)
Nightmare	1 (2.4)	4 (9.1)
Abdominal pain lower	0	3 (6.8)
Arthralgia	1 (2.4)	3 (6.8)
Back pain	2 (4.8)	3 (6.8)
Chest discomfort	1 (2.4)	3 (6.8)
Nasal congestion	1 (2.4)	3 (6.8)
Nasopharyngitis	0	3 (6.8)
Rash	1 (2.4)	3 (6.8)
Throat irritation	0	3 (6.8)

All TEAEs in the table above were mild or moderate in severity.

MedDRA = Medical Dictionary for Regulatory Activities; TEAE = treatment-emergent adverse event.
[a] Coded using MedDRA v 24.0
Source: Data on file.

III. Ongoing TORREY OLE Trial

TORREY Open-Label Extension Interim Update



- Of 80 TORREY completers (38 seralutinib arm, 42 placebo arm), 73 (91.3%) elected to rollover into the open-label extension
  - 1 additional PAH patient from Phase 1b, who remains on drug as data cutoff, included in safety data
- PVR measured via right heart catheterization (RHC) at Baseline, Week 24, and Week 72 (approximately 1 year into OLE)
- **As of interim data cutoff date, Week 72 PVR data available for 52 patients**
  - **27 continued-seralutinib, 25 placebo-crossover**

RHC = right heart catheterization (PVR measurement); OLE = open-label extension; PVR = pulmonary vascular resistance.

Executive Summary of TORREY OLE Data to Date

- **PVR:** Updated results show consistent and continued deepening of PVR improvement
  - Roughly 3 out of every 4 “continued seralutinib” (“sera-cont.”) patients showing improvement in PVR at Week 72 (vs. 2 out of every 3 at end blinded study)
  - 72% of placebo-crossed (“pbo-cross”) patients show Week 72 PVR improvement vs. pre-TORREY baseline
- **6MWD:** Continued improvement in both treatment groups at Week 72
  - Driven by patients with elevated risk at TORREY baseline
- **Safety:** Profile is consistent with previously demonstrated profile
- ~60% of OLE patients continue on OLE study (as of data cutoff date)

Additional Week 72 PVRs Support Deepening Improvement with Long-Term Seralutinib Use

Baseline

- Week 72 PVRs available for 27 continued seralutinib patients

Median Baseline PVR:

620

dyne*s/cm^5

- Mean PVR at baseline: 621 dyne*s/cm^5
- 17 WHO Functional Class II, 10 WHO Functional Class III

End of TORREY

Week 24

Median Change in PVR vs. Baseline:

-89

dyne*s/cm^5

67% (18/27) with PVR improvement*

33% (9/27) with ≥ 20% PVR improvement*

22% (6/27) with ≥ 30% PVR improvement*

0% (0/27) with ≥ 50% PVR improvement*

OLE PVR Data Point

Week 72

Median Change in PVR vs. Baseline:

-146

dyne*s/cm^5

74% (20/27) with PVR improvement*

56% (15/27) with ≥ 20% PVR improvement*

37% (10/27) with ≥ 30% PVR improvement*

15% (4/27) with ≥ 50% PVR improvement*

Week 72 Median PVR: 475 dyne*s/cm^5

* Versus TORREY baseline PVR value

Majority of Placebo-Cross Patients Show PVR Improvement to Pre-TORREY Baseline at Week 72

- Week 72 PVRs available for 25 placebo-crossed patients
  - 11 WHO Functional Class II, 14 WHO Functional Class III
- Median PVR at Week 24 RHC: **647 dyne*s/cm^5**
  After 24 weeks of blinded placebo in TORREY (n = 25)
- Median PVR at Week 72 RHC: **603 dyne*s/cm^5**
  After 48 weeks of seralutinib treatment in TORREY OLE, preceded by 24 weeks of blinded placebo in TORREY (n = 25)
- 72% (18/25) had improved PVR at Week 72 vs. TORREY baseline
- 60% (15/25) had stable (no change) or improved PVR after starting seralutinib

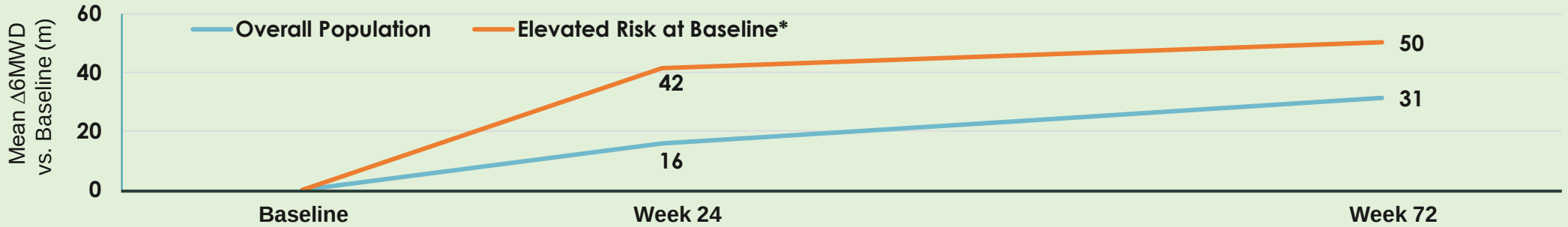
RHC = Right Heart Catheterization.

Further Improvements Seen in 6MWD during OLE, Driven by Patients with Elevated Risk at TORREY Baseline

Change in 6MWD at End of TORREY

Change in 6MWD at Week 72

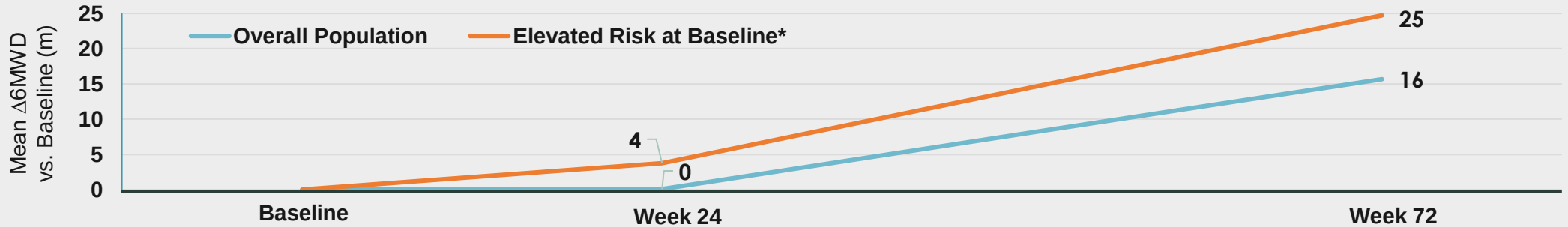
Seralutinib to Seralutinib



	Overall	Elevated Risk
N =	32	18
Baseline (m) =	409	377

	Overall	Elevated Risk
N =	26	15
Baseline (m) =	398	368

Placebo to Seralutinib



	Overall	Elevated Risk
N =	40	17
Baseline (m) =	408	337

	Overall	Elevated Risk
N =	23	10
Baseline (m) =	403	328

* REVEAL Lite 2 Risk Score ≥ 5 at TORREY baseline.
6MWD = six-minute walk distance.

Incidence of TEAEs by Preferred Term *(≥ 10%, Safety Population)*

Preferred term[a]	Total (N=74)
Number of subjects with a TEAE	71 (95.9)
Headache	18 (24.3)
COVID-19	16 (21.6)
Cough	16 (21.6)
Diarrhoea	13 (17.6)
Nausea	12 (16.2)
Dyspnoea	10 (13.5)
Arthralgia	9 (12.2)
Nasopharyngitis	8 (10.8)

Abbreviations: MedDRA, Medical Dictionary for Regulatory Activities; TEAE, treatment-emergent adverse event.
[a] Coded using MedDRA v 24.0

IV. Ongoing Phase 3 PROSERA Study

Ongoing PROSERA Phase 3 Study

PROSERA STUDY

Screening (up to 4 weeks)

Double Blind Placebo-Controlled Treatment Period (24 weeks)

Extended Double Blind Treatment Period (up to an additional 24 weeks)*

Seralutinib 90mg BID + Background PAH Therapy
N = 175

Placebo BID + Background PAH Therapy
N = 175

Week 24

Week 48

Primary Endpoint (6MWD) Evaluated at Week 24

Open-Label Extension (OLE)

Subjects who complete Week 24 who experience a clinical worsening event may proceed directly to OLE

PROSERA Key Inclusion Criteria

- Adults ≥ 18 and ≤ 75 years old
- WHO Group 1 PAH
- WHO Functional Class II or III
- PVR ≥ 400 dyne•s/cm^5
- Baseline 6MWD 150 - 450m*
- Either REVEAL Lite 2 Risk Score ≥ 5 **or** NT-proBNP ≥ 300 ng/L*
- Stable treatment with at least one SOC background therapy

* Key enrichment criteria.
WHO = World Health Organization; PVR = pulmonary vascular resistance; 6MWD = six-minute walk distance; NT-proBNP = N-terminal pro B-type natriuretic peptide; SOC = standard of care

V. Seralutinib in PH-ILD

Seralutinib's Next Frontier: What is PH-ILD?

- WHO Group 3 PH is PH due to lung diseases and / or hypoxia
  - PH due to interstitial lung disease (PH-ILD) is a subgroup of Group 3 PH
  - PH-ILD includes PH related to idiopathic pulmonary fibrosis (IPF) and PH related connective tissue disease-associated interstitial lung disease (CTD-ILD)
- Characterized by pulmonary vascular pathology associated with PH, in addition to thickening and scarring of the lung interstitium resulting from ILD
- Only Tyvaso is approved for PH-ILD, and only in the US
- **Patients have poor disease prognosis – increased mortality rate as compared to PAH patients**

~60-100K PH-ILD patients in the US(1)

One approved therapy (US only)

Callpoint overlap with PAH

1) Based on internal company estimates. Prevalence estimates of PH-ILD indicate the patient population is likely to be 1-2 times that of PAH.

Seralutinib Could Potentially Address the Pathophysiologic Mechanisms Underlying Group 3 Pulmonary Hypertension

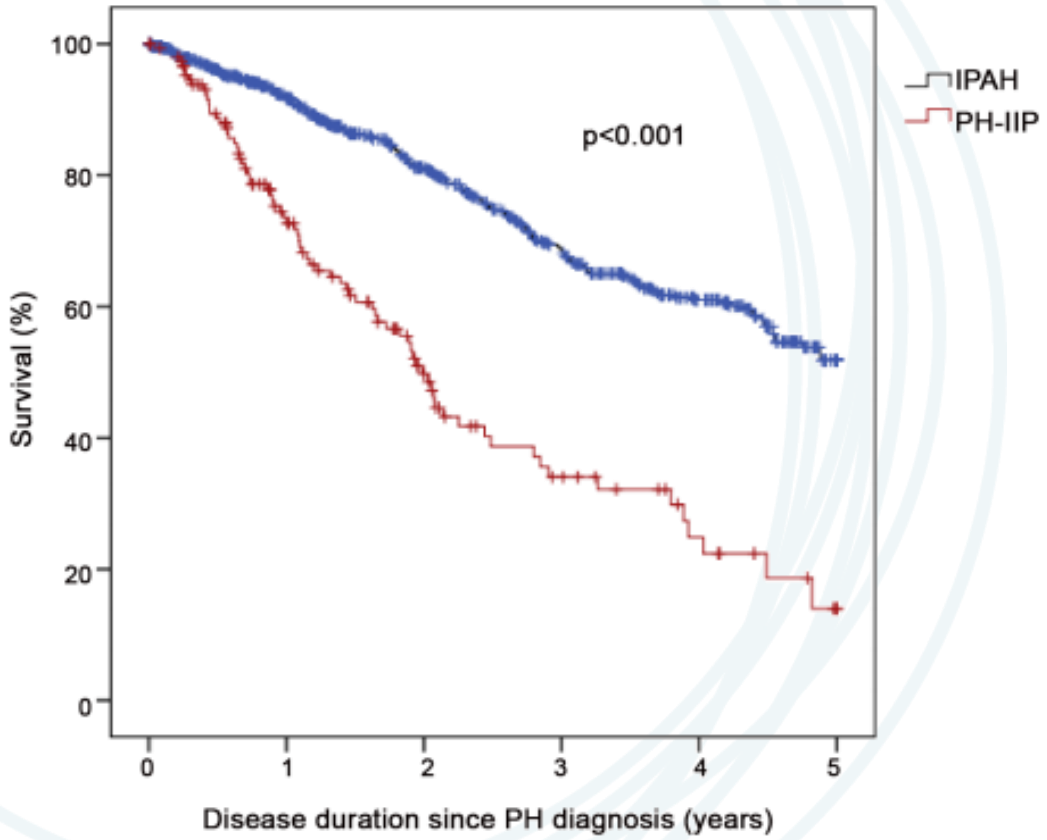
Disease Process	Cell Type / Mechanism	Potential Relevant Pathway
Vascular Inflammation	Macrophages and ECs	• CSF1R • KIT
Vascular fibrosis	Fibroblasts / myofibroblasts	• PDGFR
Pulmonary vasculopathy (plexiform lesions)	Endothelial-to-mesenchymal transition	• PDGFR
Pulmonary arteriolar hypertrophy / hyperplasia	Pulmonary arteriole vascular smooth muscle cells	• PDGFR • BMPR2
Parenchymal interstitial lung inflammation and fibrosis	Fibroblasts	• PDGFR • CSF1R
	Epithelial-to-mesenchymal transition	• PDGFR
Shunt/hypoxia	V/Q mismatch	• Multiple

Source: Dotan, et al., BMC Open Res 2020; Yang, et al., Cell 2006; Song, et al., Cell Signal 2016; Wynn, J Pathol 2008; Tsutsumi, et al., PLoS One 2019.

Given a Lack of Approved Treatments, Disease Prognosis is Poor, Even Relative to PAH

- Compared to ILD without PH or PH associated with other causes, development of PH-ILD is associated with:[1]
  - Increased need for supplemental oxygen
  - Reduced mobility (more FC IV symptoms and lower 6MWD)
  - Decreased survival
- Recent cohort analysis of PH patients (2002 – 2019) indicated that PH due to lung disease has a **3-fold increase in mortality compared to PAH**[3]

Kaplan-Meier survival estimates in patients with PH-IIP and patients with IPAH (COMPERA)[4]



IPF = Idiopathic pulmonary fibrosis, SSc = systemic sclerosis; CPFE = sarcoidosis combined pulmonary fibrosis and emphysema syndrome, PLCH = pulmonary Langerhans cell histiocytosis; LAM = lymphangioleiomyomatosis; PH-IIP = pulmonary hypertension associated with chronic fibrosing idiopathic interstitial pneumonias.

Source: 1. Panagiotou, et al., Eur Res Rev 2017; 2. King and Shlobin, Chest 2020; 3. Fauvel, et al., Arch Cardiovas Dis 2020; 4. Hoeper, et al., PLoS One 2015.

Financial Overview

Financial Overview

Cash, Cash Equivalents and Marketable Securities (As of 12/31/23)	~$296mm
Debt, *Related to Line of Credit* (As of 12/31/23)	~$12mm
Principal of Convertible Notes Outstanding (As of 12/31/23)	~$200mm
Common Shares Outstanding (As of 2/27/24)	~226mm

mm = millions.

Appendix

gossamerbio

FLUIDDA CT Sub-Study in Phase 2 TORREY Study: Assessing Pulmonary Vascular Remodeling in Patients Treated on Seralutinib

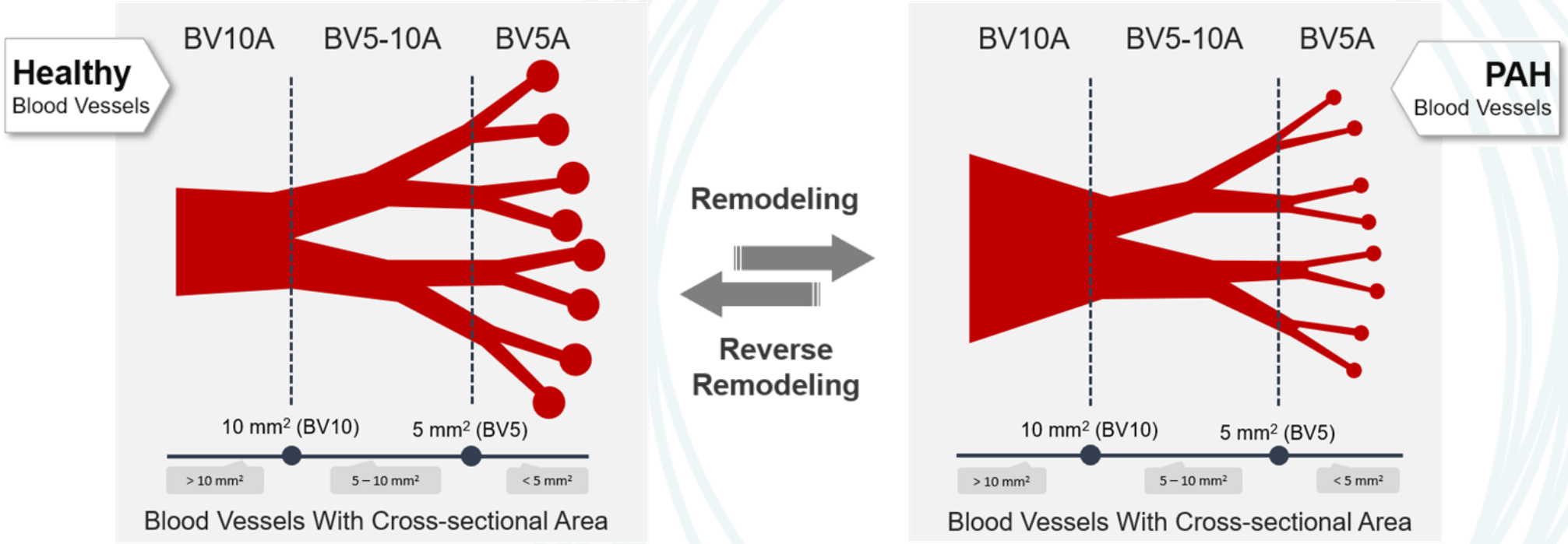
- **Purpose:** Provide evidence consistent with a reverse remodeling effect of seralutinib
- **Hypothesis:** volume of distal pulmonary arteries relative to volume of proximal pulmonary arteries will be increased by seralutinib as expressed by the ratio of BV5A to BV10A (BV510ARatio)
- **Available data:** Baseline and Week 24 HRCTs with pulmonary vascular reconstruction in 7 seralutinib-treated subjects and 12 placebo subjects

Thin Slice CTs with Pulmonary Vascular Segmentation at Baseline and Week 24

See publication - presented at ERS International Congress 2023 in Milan, Italy: "Seralutinib improves pulmonary arterial blood vessel volume distribution in pulmonary arterial hypertension (PAH): Results of the TORREY Phase 2 imaging substudy"

CT = computerized tomography; HRCT = high resolution computerized tomography

Pulmonary Vascular Volume of Small Distal Arterial Vessels is Decreased in PAH, Leading to Dilation of Larger Proximal Vessels



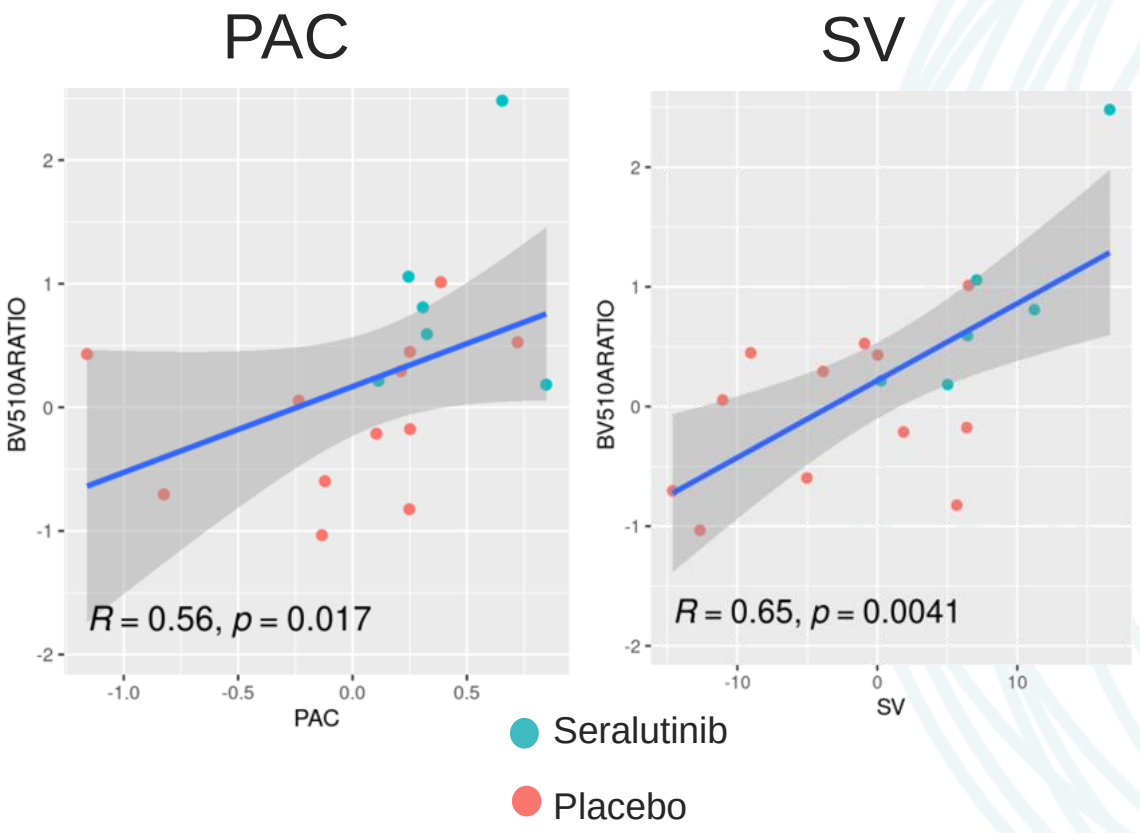
CT imaging can quantify these changes: BV5A: BVV of pulmonary arteries with a CSA < 5 mm2; BV5-10A: BVV of pulmonary arteries with a CSA between 5-10 mm2; BV10A: BVV of pulmonary arteries with a CSA > 10 mm2; BV510ARatio: BV5A/BV10A

- Pulmonary vascular pruning on CT correlates with histologic pulmonary vascular remodeling[1]

1. Synn AJ, et al. *Pulm Circ.* 2021;11(4):20458940211061284. Histologic remodeling correlation shown is based on a study in patients undergoing resection for early-stage adenocarcinoma.[1] Illustration adapted from FLUIDDA, Inc.
BV5A, blood vessel volume (BVV) of pulmonary arteries with a cross-sectional area (CSA) < 5 mm²; BV5-10A: BVV of pulmonary arteries with a CSA between 5-10 mm²; BV10A: BVV of pulmonary arteries with a CSA > 10 mm²; BV510ARatio: BV5A/BV10A; CT, computed tomography; PAH, pulmonary arterial hypertension.

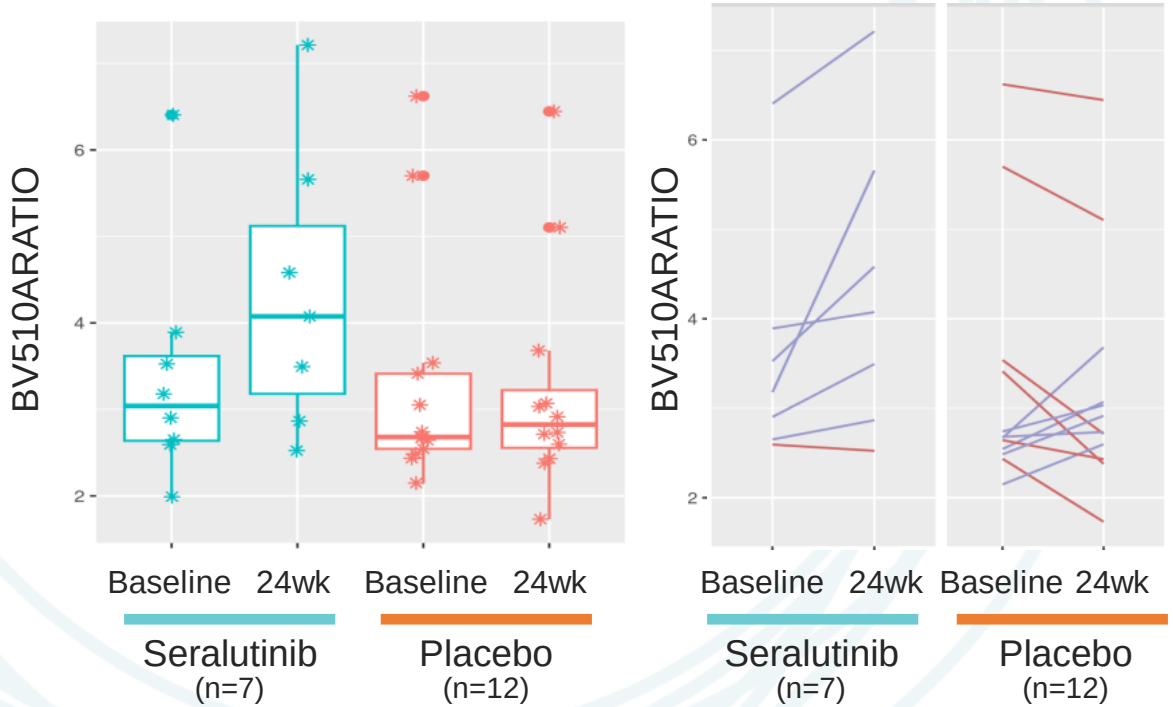
Seralutinib Treatment Increases BV510ARatio, Supporting Reverse Remodeling Hypothesis

BV510ARatio correlates with hemodynamics



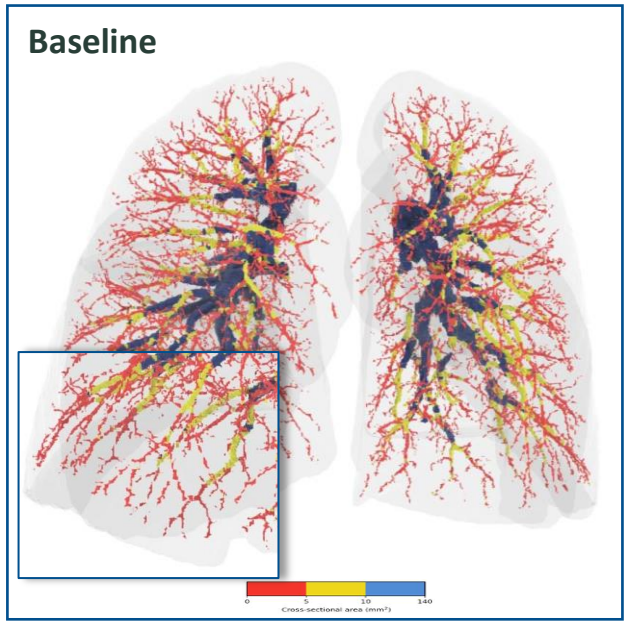
Seralutinib increases BV510ARatio

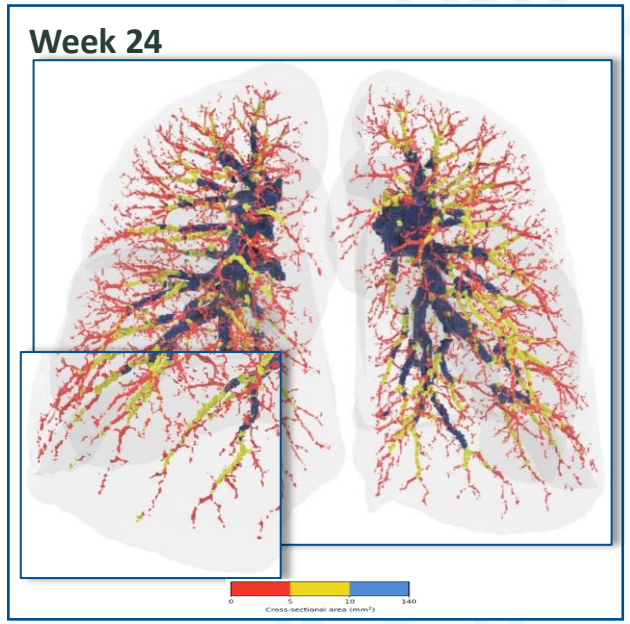
Parameter	LSMD Estimate (95% CI)	P-value
BV510ARATIO	0.845 (0.105,1.585)	0.028

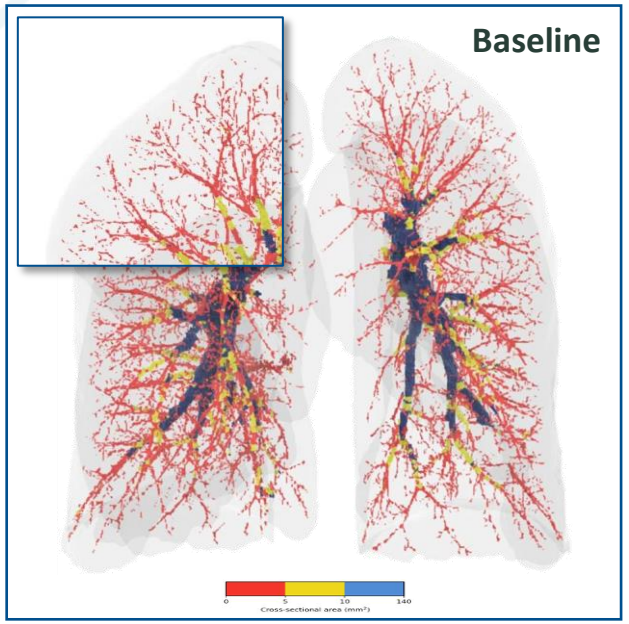


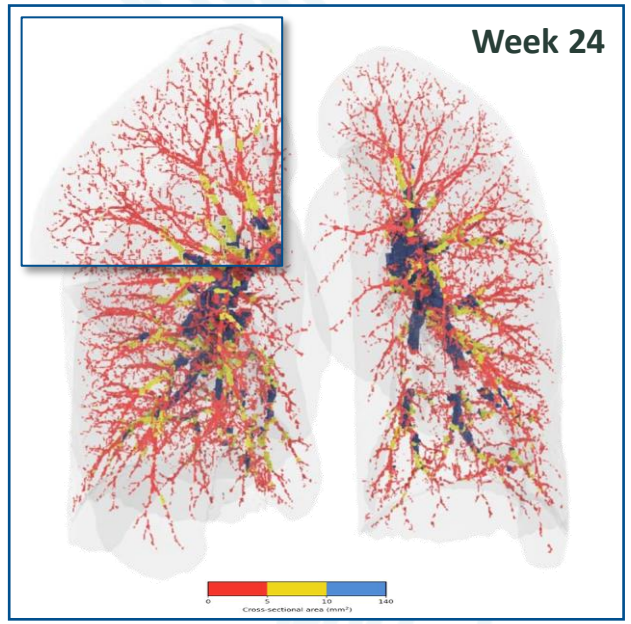
PAC=pulmonary artery compliance
SV=stroke volume
Linear regression models adjusted for baseline values and treatment arm; Abbreviations: LSMD, least squares mean difference; BV510ARATIO = Ratio of pulmonary arteries smaller than 5 mm^2 in cross sectional area (BV5A) compared to pulmonary arteries larger than 10 mm^2 in cross sectional area (BV10A)

Examples of Imaging: Placebo vs. Seralutinib









Placebo patient	
Female, 24 y, iPAH, FC II, treated with PDE5-i + prostacyclin	
PVR change, dyne*s/cm^5 (%)	283 (+65.4)
ΔBV510ARatio (% change)	-0.70 (-28.9)

Seralutinib patient	
Female, 58 y, iPAH, FC II, treated with ERA + PDE5-i + prostacyclin	
PVR change, dyne*s/cm^5 (%)	-159 (-39.0)
ΔBV510ARatio (% change)	+2.5 (+78.0)

Insets represent 1.3x magnification. ΔBV510ARatio, change in BV5A/BV10A ratio; ERA, endothelin receptor antagonist; FC, Functional Class; iPAH, idiopathic pulmonary arterial hypertension; PDE5-i, phosphodiesterase 5 (PDE5) inhibitor; PVR, pulmonary vascular resistance.

TORREY Phase 2 - Baseline Demographics (ITT Population)

Characteristic	Placebo (N=42)	Seralutinib (N=44)	Total (N=86)
Age (years) – mean (SD)	49.5 (11.81)	48.3 (12.70)	48.8 (12.22)
Sex – n (%)			
Female	38 (90.5)	40 (90.9)	78 (90.7)
Male	4 (9.5)	4 (9.1)	8 (9.3)
Race – n (%)			
White	37 (88.1)	37 (84.1)	74 (86.0)
Black or African American	1 (2.4)	0	1 (1.2)
Asian	2 (4.8)	4 (9.1)	6 (7.0)
Other	2 (4.8)	3 (6.8)	5 (5.8)
Ethnicity – n (%)			
Hispanic or Latino	6 (14.3)	8 (18.2)	14 (16.3)
Not Hispanic or Latino	34 (81.0)	36 (81.8)	70 (81.4)
Not reported	2 (4.8)	0	2 (2.3)
Region – n (%)			
North America	30 (71.4)	29 (65.9)	59 (68.6)
Western Europe	10 (23.8)	11 (25.0)	21 (24.4)
Asia Pacific	1 (2.4)	4 (9.1)	5 (5.8)
Eastern Europe	1 (2.4)	0	1 (1.2)

ITT = Intention-to-treat; SD = standard deviation.

TORREY Phase 2 - Baseline Background PAH Medication Use(ITT Population)

Characteristic	Placebo (N=42)	Seralutinib (N=44)	Total (N=86)
Number of background therapies – n (%)			
1	2 (4.8)	1 (2.3)	3 (3.5)
2	16 (38.1)	18 (40.9)	34 (39.5)
3	24 (57.1)	25 (56.8)	49 (57.0)
Prostacyclin/Prostacycin Receptor Agonist use – n (%)			
None	13 (31.0)	15 (34.1)	28 (32.6)
Monotherapy	1 (2.4)	1 (2.3)	2 (2.3)
Double therapy	4 (9.5)	3 (6.8)	7 (8.1)
Triple therapy	24 (57.1)	25 (56.8)	49 (57.0)
Parenteral Prostacyclin	19 (45.2)	19 (43.1)	38 (44.2)
Oral	10 (23.8)	10 (22.7)	20 (23.3)

ITT = Intention-to-treat.

TORREY Phase 2 - Baseline Disease Characteristics (ITT Population)

Characteristic	Placebo (N=42)	Seralutinib (N=44)	Total (N=86)
Age at PAH diagnosis (years) – mean (SD)	41.2 (11.65)	40.7 (15.84)	40.9 (13.87)
Years since PAH diagnosis – mean (SD)	8.78 (7.218)	8.07 (7.074)	8.41 (7.111)
PAH classification – n (%)			
Idiopathic	22 (52.4)	20 (45.5)	42 (48.8)
Heritable	5 (11.9)	10 (22.7)	15 (17.4)
Associated with:			
CTD	11 (26.2)	6 (13.6)	17 (19.8)
Anorexigen use	0	1 (2.3)	1 (1.2)
Methamphetamine use	4 (9.5)	4 (9.1)	8 (9.3)
Corrected congenital shunts	0	3 (6.8)	3 (3.5)
WHO FC – n (%)			
Class II	20 (47.6)	30 (68.2)	50 (58.1)
Class III	22 (52.4)	14 (31.8)	36 (41.9)
REVEAL 2.0 Risk Score ≥ 6 – n (%)	17 (40.5)	20 (45.5)	37 (43.0)
PVR (dyne*s/cm^5) – mean (SD)	661.3 (164.91)	675.8 (240.35)	668.7 (205.90)
6MWD (m) – mean (SD)	407.1 (107.02)	408.6 (75.11)	407.9 (91.54)
NT-proBNP (ng/L) – mean (SD)	645.6 (1158.75)	611.0 (714.58)	628.3 (956.83)

6MWD = six-minute walk distance; CTD = connective tissue disease; FC = functional class; NT-proBNP = N-terminal pro B-type natriuretic peptide; PAH = pulmonary arterial hypertension; PVR = pulmonary vascular resistance; WHO = World Health Organization; ITT = Intention-to-treat.

TORREY Phase 2 - Baseline Demographics and Disease Characteristics ***by Baseline WHO FC*** (ITT Population)

	Baseline WHO FC Class II			Baseline WHO FC Class III		
Characteristic	**Placebo (N=20)**	**Seralutinib (N=30)**	**Total (N=50)**	**Placebo (N=22)**	**Seralutinib (N=14)**	**Total (N=36)**
Age (years) – mean (SD)	47.6 (11.69)	47.7 (13.42)	47.7 (12.63)	51.1 (11.94)	49.4 (11.40)	50.4 (11.60)
Female – n (%)	19 (95.0)	27 (90.0)	46 (92.0)	19 (86.4)	13 (92.9)	32 (88.9)
Race, White – n (%)	19 (95.0)	24 (80.0)	43 (86.0)	18 (81.8)	13 (92.9)	31 (86.1)
Region, North America – n (%)	13 (65.0)	20 (66.7)	33 (66.0)	17 (77.3)	9 (64.3)	26 (72.2)
Years since PAH diagnosis – mean (SD)	9.60 (7.262)	8.40 (6.961)	8.88 (7.034)	8.02 (7.263)	7.36 (7.527)	7.76 (7.266)
PAH classification – n (%)						
Idiopathic	11 (55.0)	16 (53.3)	27 (54.0)	11 (50.0)	4 (28.6)	15 (41.7)
Heritable	4 (20.0)	6 (20.0)	10 (20.0)	1 (4.5)	4 (28.6)	5 (13.9)
Associated with CTD	5 (25.0)	5 (16.7)	10 (20.0)	6 (27.3)	1 (7.1)	7 (19.4)
REVEAL 2.0 Risk Score ≥ 6 – n (%)	**4 (20.0)**	**11 (36.7)**	**15 (30.0)**	**13 (59.1)**	**9 (64.3)**	**22 (61.1)**
PVR (dyne*s/cm^5) – mean (SD)	638.3 (161.85)	689.9 (265.72)	669.3 (229.34)	682.2 (168.62)	645.7 (179.29)	668.0 (171.25)
6MWD (m) – mean (SD)	**455.5 (63.96)**	**425.5 (62.98)**	**437.5 (64.45)**	**363.2 (120.05)**	**372.4 (87.97)**	**366.8 (107.43)**
NT-proBNP (ng/L) – mean (SD)	**406.8 (798.39)**	**609.9 (715.31)**	**525.3 (749.58)**	**873.0 (1403.06)**	**613.3 (742.17)**	**773.7 (1187.34)**
On 3 background therapies – n (%)	11 (55.0)	18 (60.0)	29 (58.0)	13 (59.1)	7 (50.0)	20 (55.6)
ERA + PDE-5i + Prostacyclins/PRA	8 (40.0)	16 (53.3)	24 (48.0)	10 (45.5)	6 (42.9)	16 (44.4)
ERA + sGC + Prostacyclins/PRA	3 (15.0)	2 (6.7)	5 (10.0)	3 (13.6)	1 (7.1)	4 (11.1)

ITT = Intention-to-treat; SD = standard deviation; CTD = connective tissue disease; PVR = pulmonary vascular resistance; 6MWD = 6-minute walk distance; NT-proBNP = N-terminal pro B-type natriuretic peptide; WHO = World Health Organization; FC = Functional Class.