
# Corporate Presentation

*March 2023*

# Forward Looking Statements

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*In some cases, you can identify forward-looking statements by terms such as "may," "will," "should," "expect," "plan," "anticipate," "could," "intend," "target," "project," "contemplates," "believes," "estimates," "predicts," "potential" or "continue" or the negative of these terms or other similar expressions. These statements involve known and unknown risks, uncertainties and other important factors that may cause our actual results, performance or achievements to be materially different from any future results, performance or achievements expressed or implied by the forward-looking statements. These known risks and uncertainties are described in detail in our filings with the Securities and Exchange Commission (the "SEC") from time to time. Because forward-looking statements are inherently subject to risks and uncertainties, some of which cannot be predicted or quantified and some of which are beyond our control, you should not rely on these forward-looking statements as predictions of future events. The events and circumstances reflected in our forward-looking statements may not be achieved or occur and actual results could differ materially from those projected in the forward-looking statements. Except as required by applicable law, we do not plan to publicly update or revise any forward-looking statements contained herein, whether as a result of any new information, future events, changed circumstances or otherwise. All forward-looking statements are qualified in their entirety by this cautionary statement, which is made under the safe harbor provisions of the Private Securities Litigation Reform Act of 1995 and we undertake no obligation to revise or update this presentation to reflect events or circumstances after the date hereof.*

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# Late-Stage Clinical Biotech Focused on Immunology

| 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) | Completed Phase 2 TORREY Study; Met Primary Endpoint; Well-Tolerated → Ph. 3 2H23* | WW |
| | | Pulmonary Hypertension Associated with Interstitial Lung Disease (PH-ILD) | Future Development | WW |
| GB5121 | CNS-Penetrant, BTK Inhibitor (Oral) | Primary CNS Lymphoma (PCNSL) | Phase 1b/2 Ongoing *Enrollment Paused^* | WW |
| GB7208 | CNS-Penetrant, BTK Inhibitor (Oral) | Multiple Sclerosis (MS) | Preclinical | WW |

*We expect to commence a Phase 3 PAH study in the second half of 2023.
^ Based upon the benefit / risk profile observed to date and a prioritization of resources to support the seralutinib program, Gossamer decided to pause enrollment in the Phase 1b/2 STAR CNS study in March 2023.
WW = worldwide; CNS = central nervous system.

# Seralutinib (GB002)

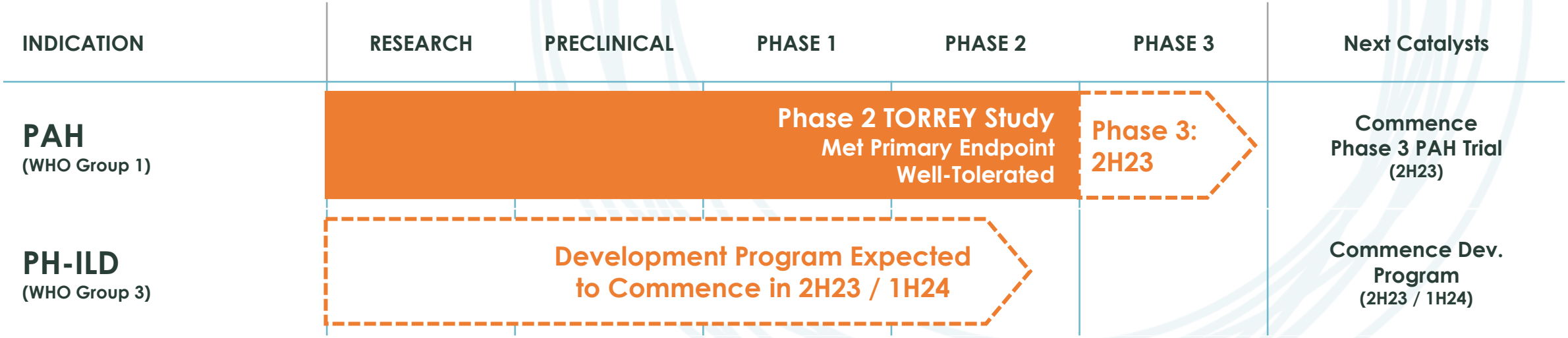
Inhaled PDGFR, CSF1R & c-KIT Inhibitor

Pulmonary Arterial Hypertension (PAH)

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

**Product Candidate Description**

- Inhaled PDGFR, CSF1R, and c-KIT kinase inhibitor designed for PAH
- Positive Phase 2 Clinical Trial Results in PAH Patients (TORREY Study)
  - Met primary endpoint (reduction in PVR v. placebo; p = 0.0310) and 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.

# 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

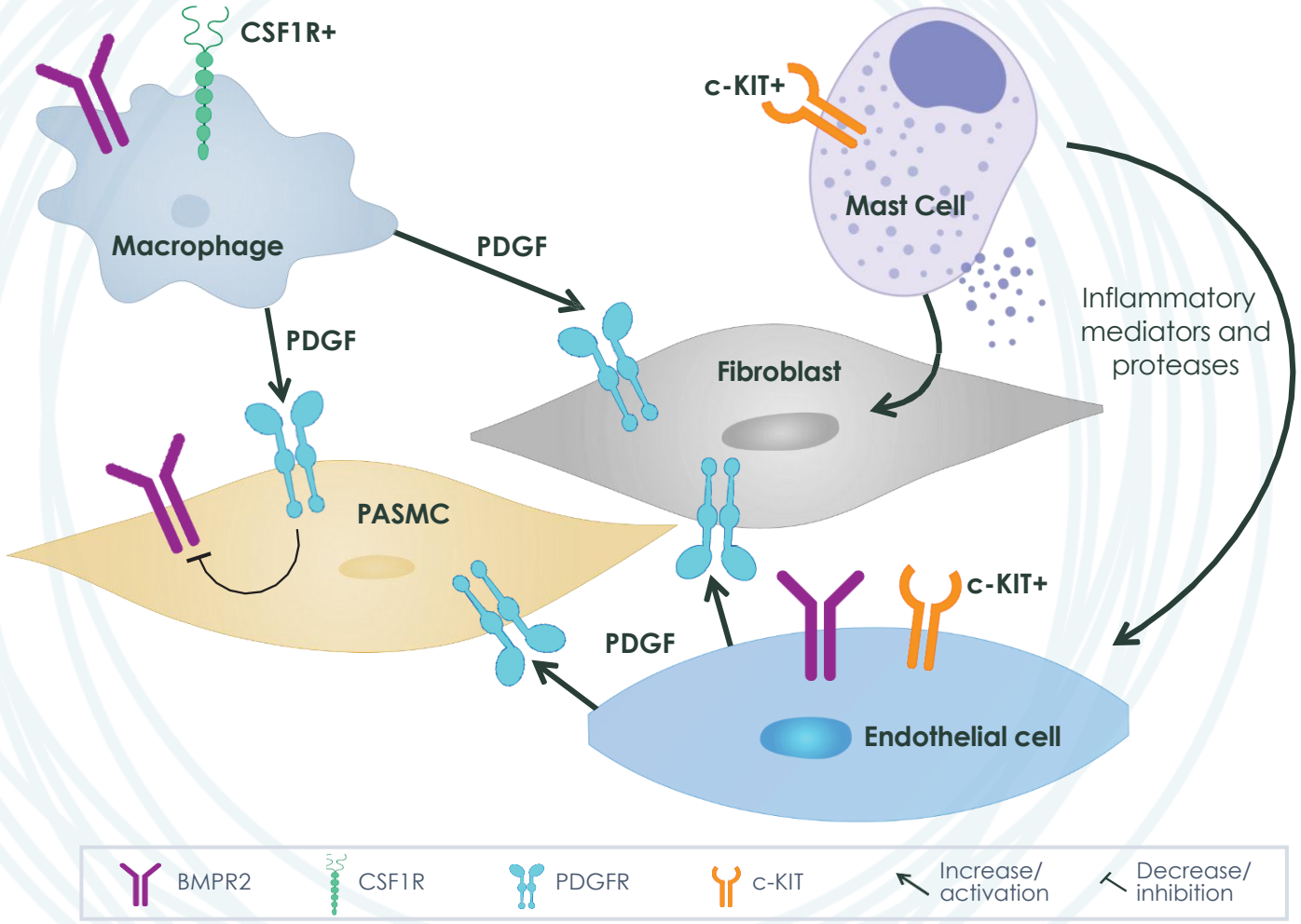
PDGF activation

↓ **BMPR2**

↓

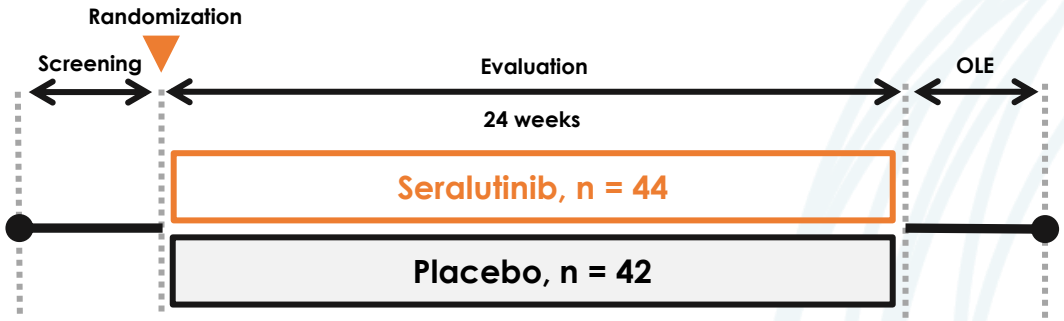
↑ PASMC

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.

# TORREY: 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<br>**Key Secondary:** Δ6MWD at Week 24†<br>**Exploratory:** Includes NT-proBNP, Echo |
| **Dosing Regimen** | **Titrated up to 90mg BID**<br>*(Starts 60mg BID; protocol allows 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; CTD = connective tissue disease; 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§

| Overall Study Population | | Functional Class III | | REVEAL 2.0 Risk Score ≥ 6 | |
|---|---|---|---|---|---|
| PVR | 6MWD | PVR | 6MWD | PVR | 6MWD |
| -14%* | +6.5m | -21%* | +37.3m* | -23%* | +21.9m |
| p = 0.0310 | p = 0.5972 | p = 0.0427 | p = 0.0476 | p = 0.0134 | p = 0.2482 |

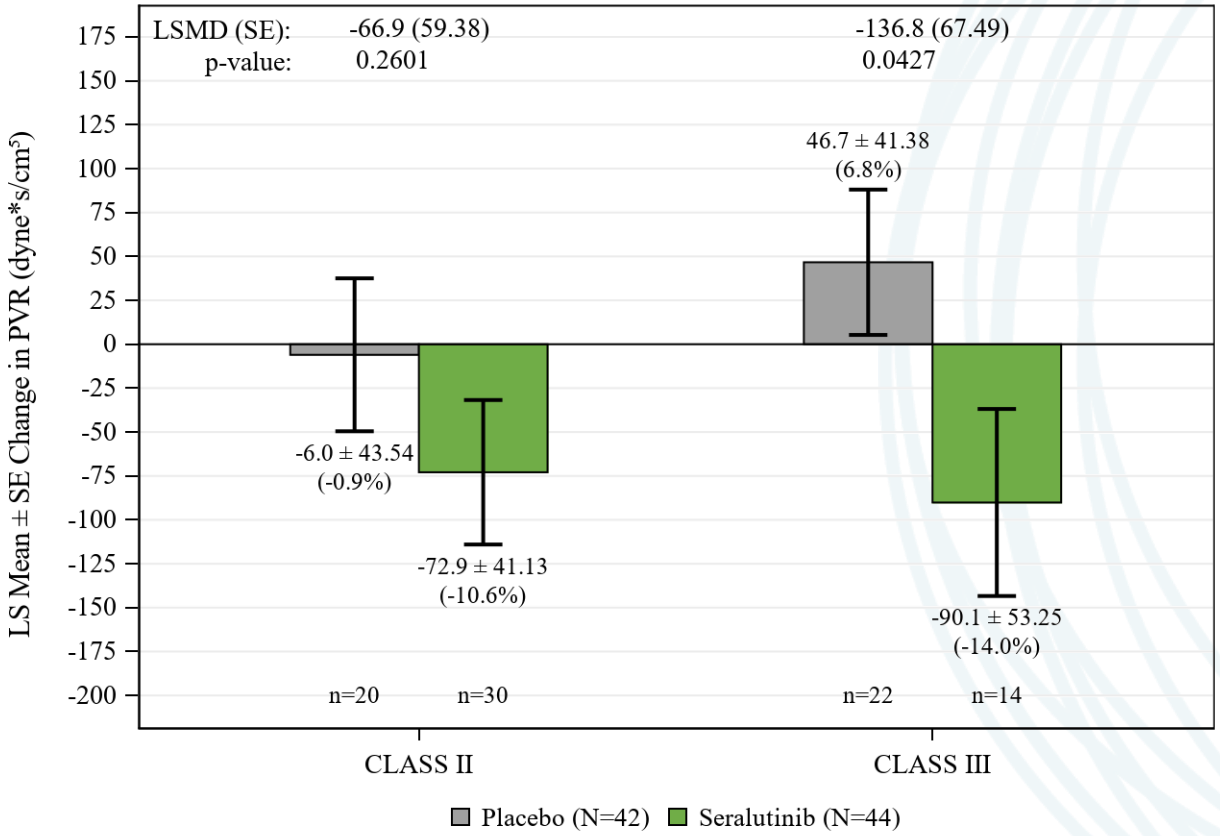
Primary Endpoint

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

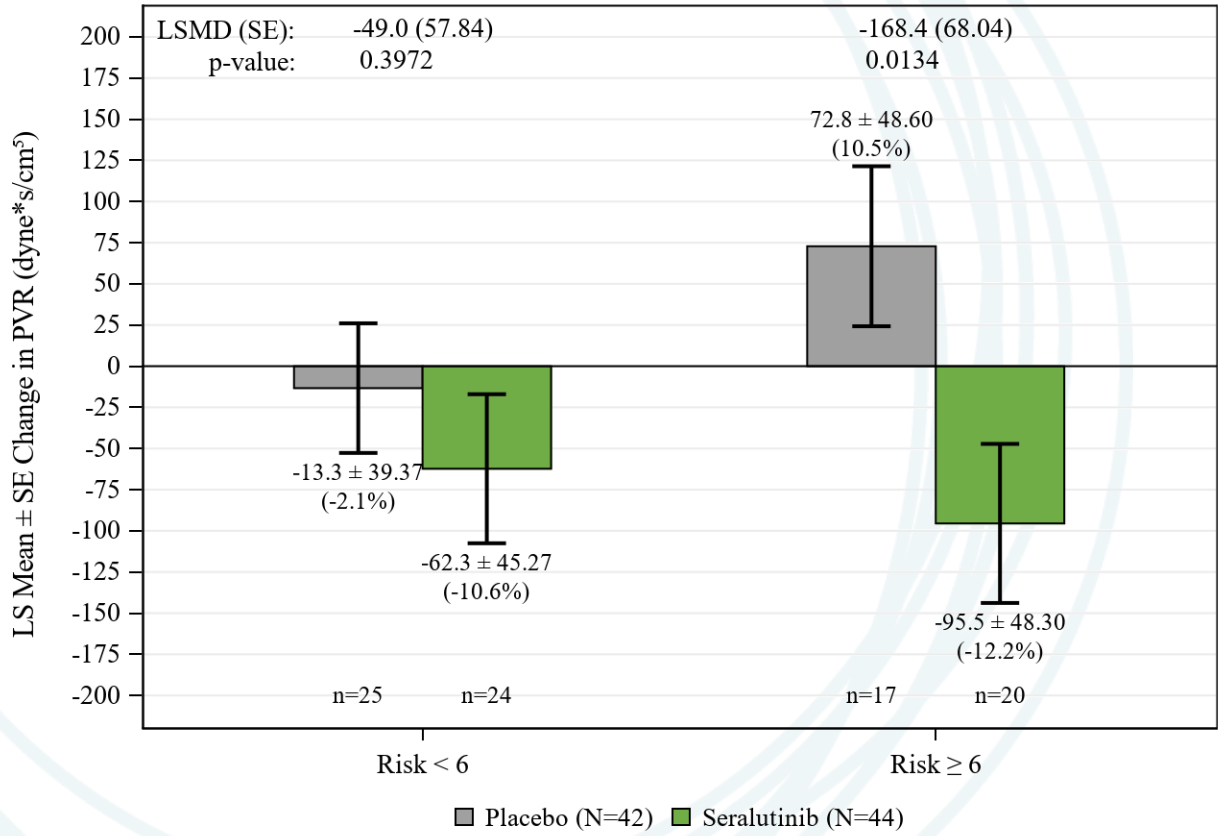
***** = p-value ≤ 0.05. All p-values in this presentation are nominal, aside from primary endpoint (Overall study population delta in PVR).
§ At baseline, as determined by Functional Class and REVEAL 2.0 Risk Score (pre-specified subgroups).

# 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



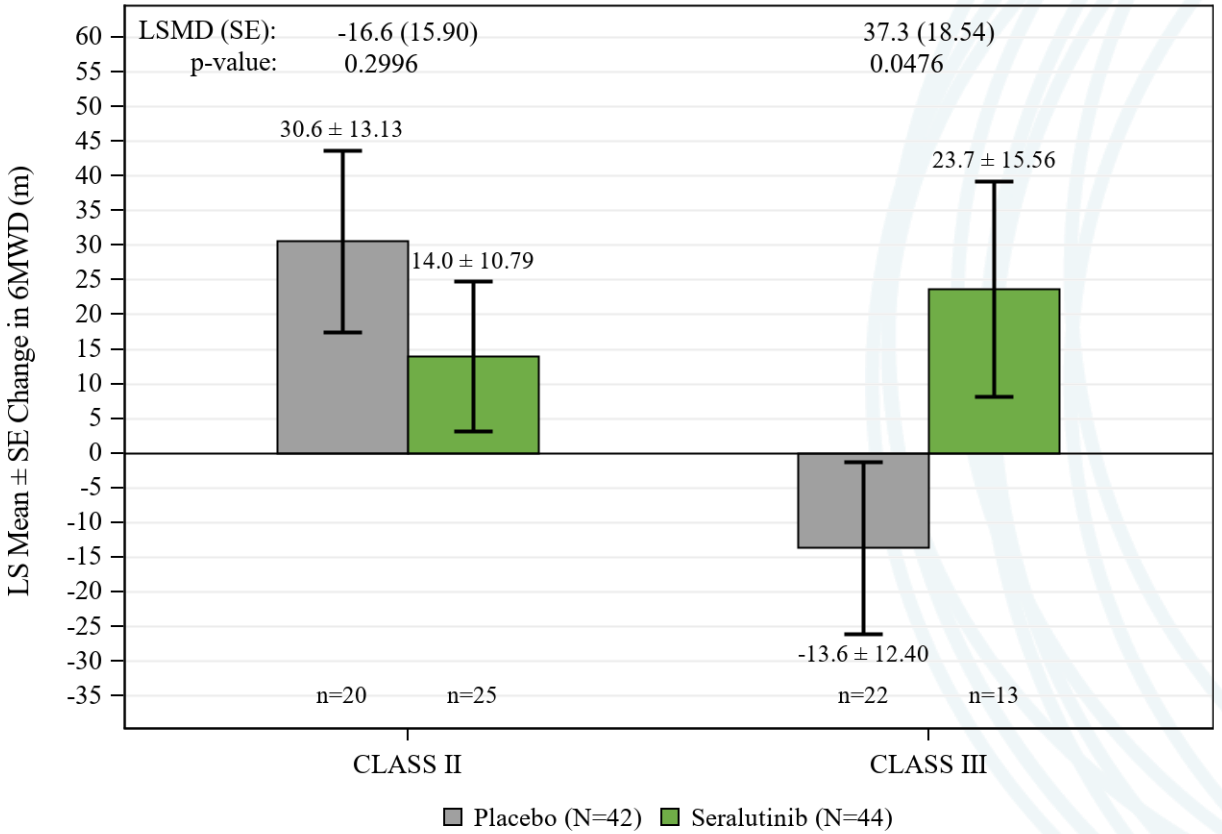

## REVEAL 2.0 Risk Score
Change in PVR, by Risk Score



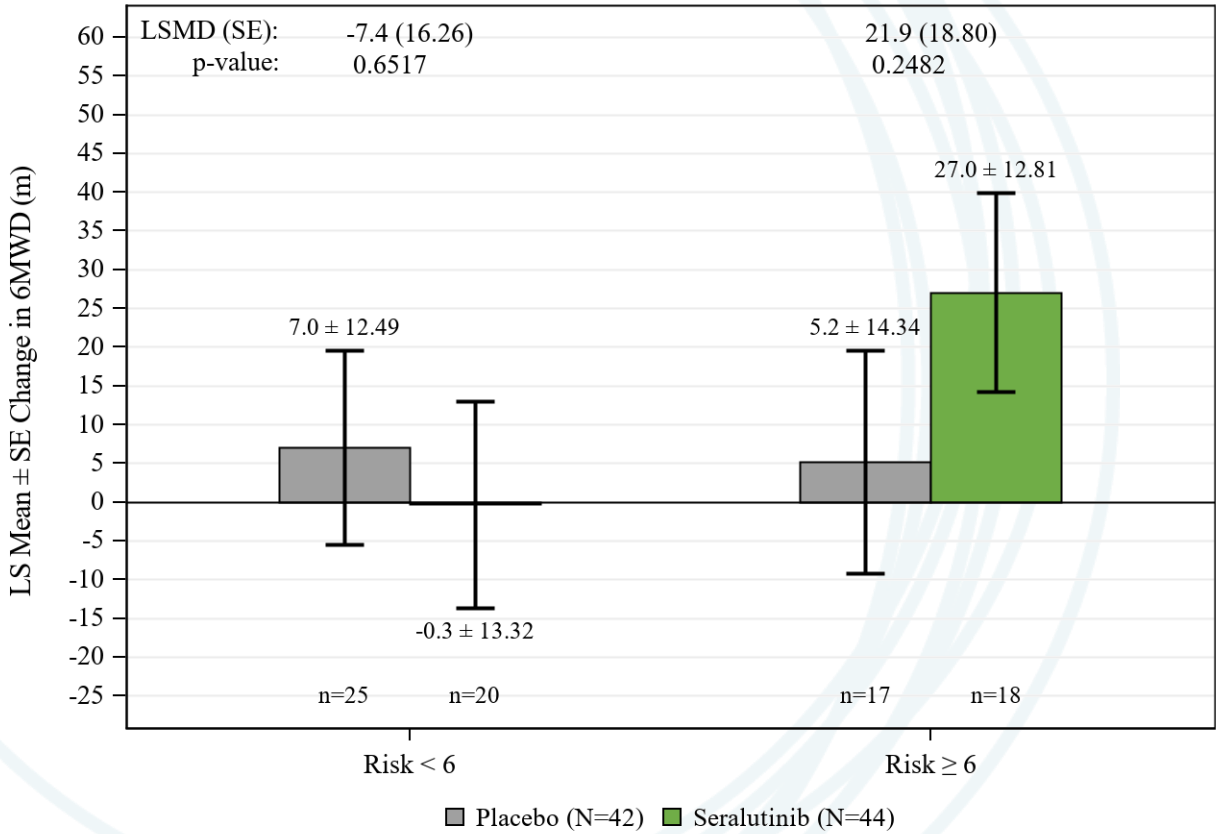

LS = least squares; LSMD = least squares mean difference; PVR = pulmonary vascular resistance; WHO = World Health Organization.
Based on ANCOVA modelling. Source: Data on file.

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

**Functional Class**
Change in 6MWD, by Functional Class

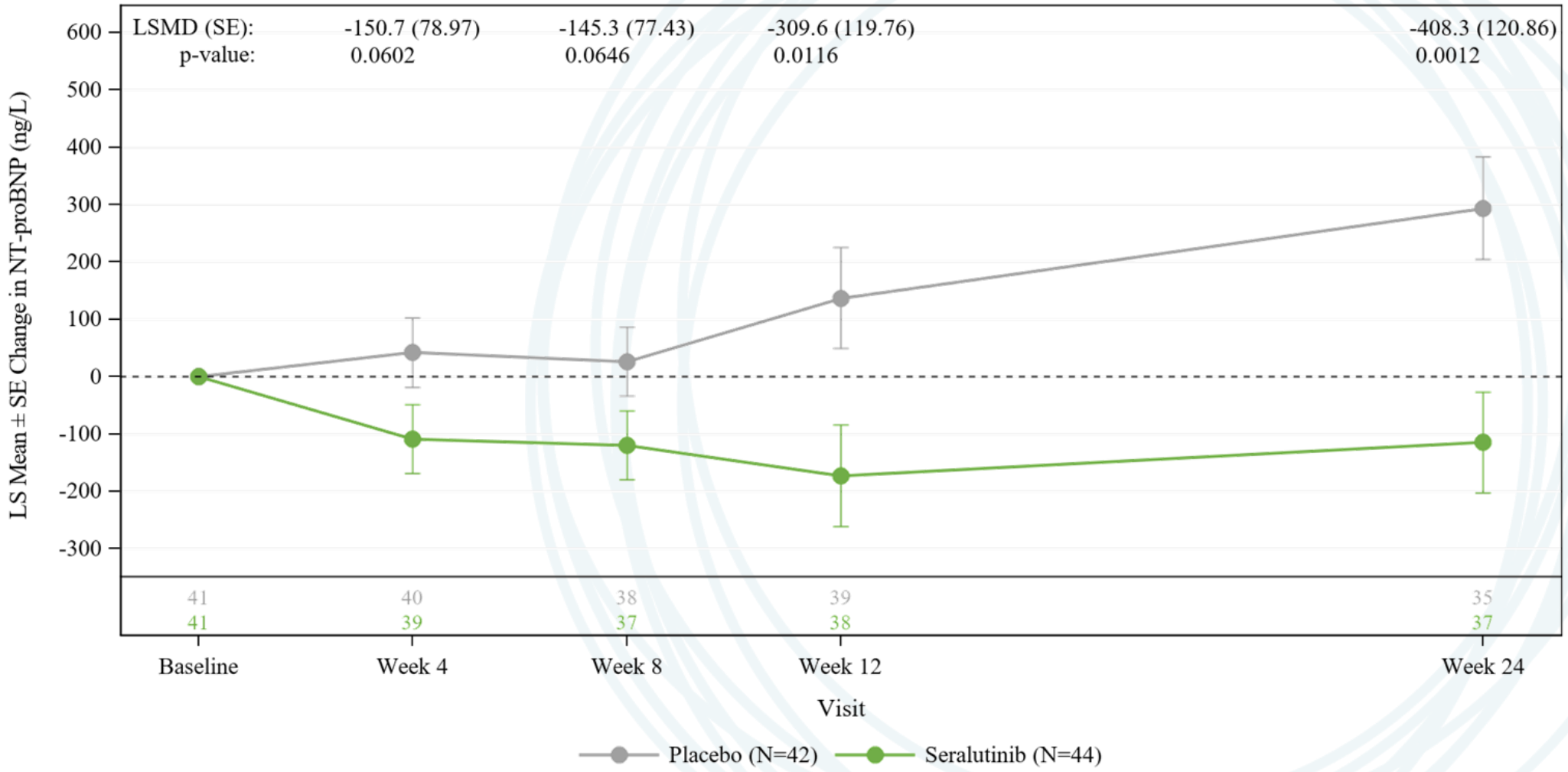



**REVEAL 2.0 Risk Score**
Change in 6MWD, by Risk Score




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)



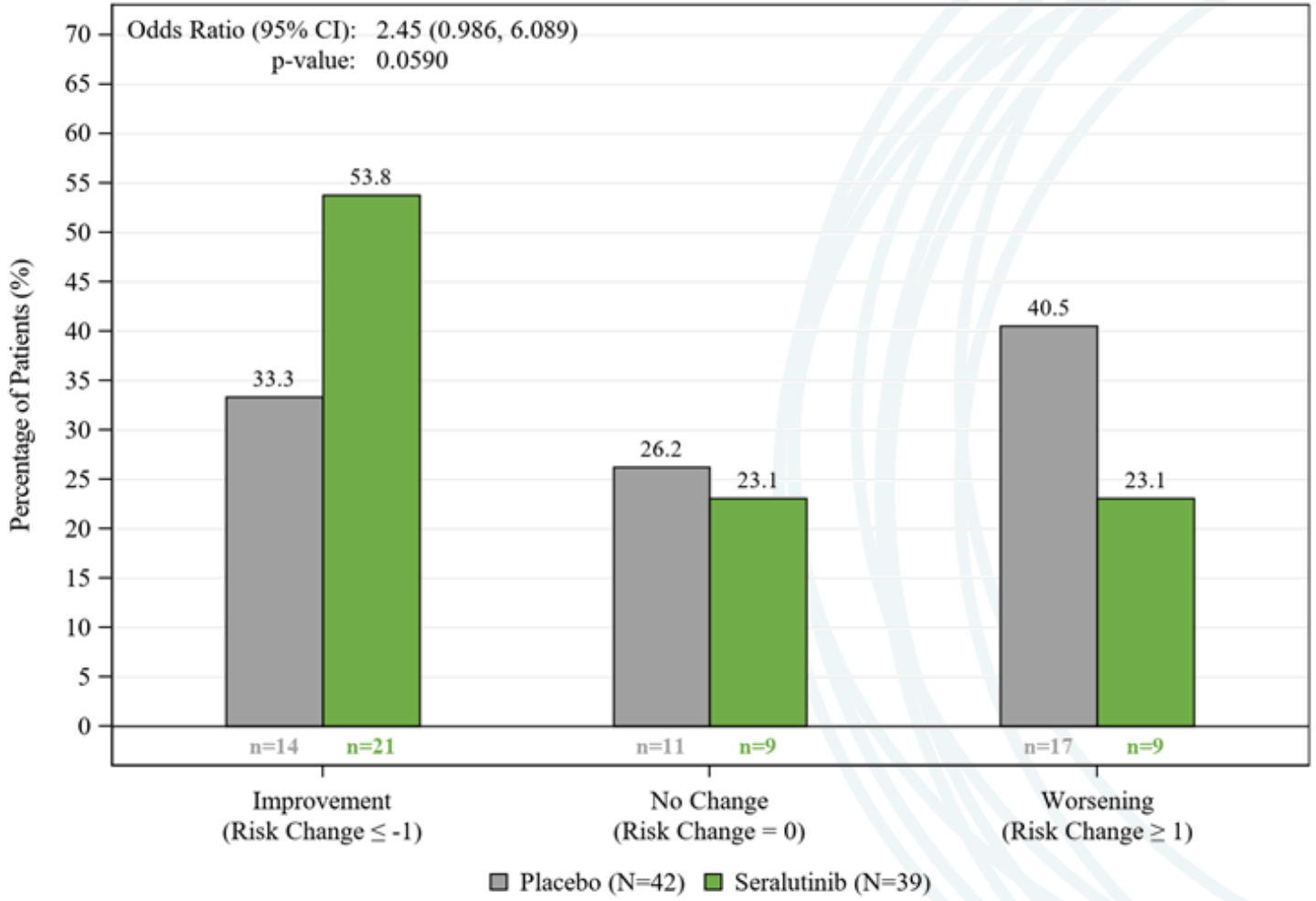

FC = functional class; LS = least squares; LSMD = least squares mean difference; MMRM = mixed-effects model with repeated measures; NT-proBNP = N-terminal pro B-type natriuretic peptide.
Based on a MMRM model. Source: Data on file.

# 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.

# The Majority of Patients Receiving Seralutinib Demonstrated an Improvement in REVEAL 2.0 Risk Score at Week 24




**1-point improvement in REVEAL 2.0 Risk Score at baseline associated with[1]:**

- **23% reduction in relative risk of death**
- **20% reduction in relative risk of clinical worsening**

**Seralutinib patients have 2.45 times the odds of achieving a REVEAL 2.0 Risk Score improvement compared to placebo patients**

**30 of 39 seralutinib patients improved or maintained baseline REVEAL 2.0 Risk Score**

Post hoc analysis. Odds ratio, 95% CI, and p-value from a stratified Cochran-Mantel-Haenszel chi-square test of improvement (yes vs. no).
1) A 1-point improvement in REVEAL 2.0 Risk Score (RRS) at PATENT-1 baseline was associated with a 23% reduction in the relative risk of death and a 20% reduction in the relative risk of clinical worsening in PATENT-2. Similarly, a 1-point improvement in RRS 2.0 at PATENT-1 Week 12 was associated with a 26% reduction in the relative risk of death and a 23% reduction in the relative risk of clinical worsening in PATENT-2. Source: https://doi.org/10.1016/j.ijcard.2021.03.034
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.

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

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

| Disease Process | Cell Type / Mechanism | Potential Relevant Pathway |
|---|---|---|
| Vascular Inflammation | Macrophages and ECs | • CSF1R<br>• 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<br>• BMPR2 |
| Parenchymal interstitial lung inflammation and fibrosis | Fibroblasts | • PDGFR<br>• CSF1R |
| | Epithelial-to-mesenchymal transition | • PDGFR |
| Shunt/hypoxia | V/Q mismatch | • Multiple |

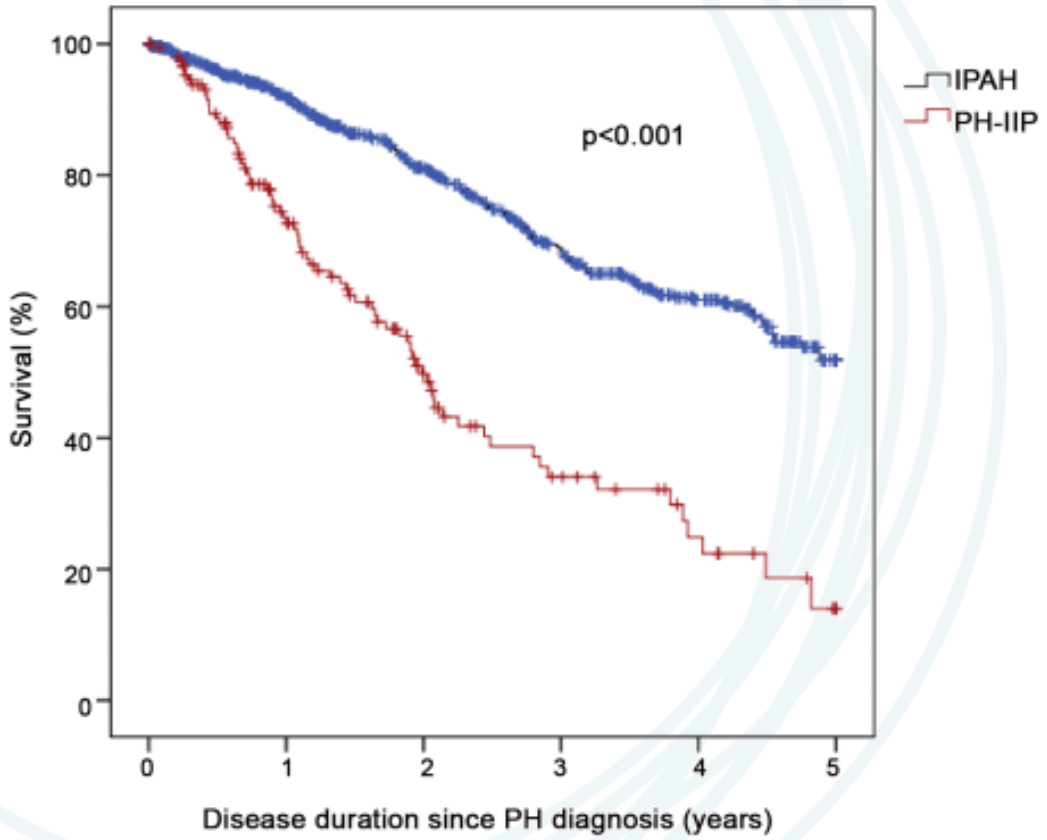


Source: Dotan, et al., BMC Open Res 2020; Yang, et al., Cell 2006; Song, et al., Cell Signal 2016; Wynn, J Pathol 2008; Tsutsumi, et al., PLoS One 2019.

# 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.

# Seralutinib Utilizes Convenient Dry Powder Inhaler

# GB5121 & GB7208

Covalent, CNS-Penetrant BTK Inhibitors

Primary CNS Lymphoma (PCNSL) and Multiple Sclerosis (MS)

# GB5121 & GB7208: CNS-Penetrant, BTK Inhibitors

**Product Candidates Description**

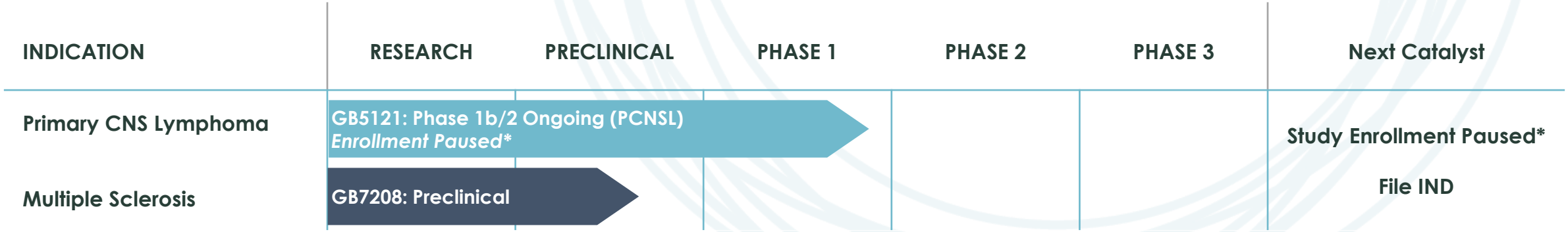
- 2 oral, small molecule, CNS-penetrant, irreversible BTK Inhibitors optimized for CNS penetration and kinase selectivity
- Developed in-house with patent protection expected to extend into 2040s

## GB5121: Lead Neuro-Oncology Candidate

- Initial indication, relapsed / refractory primary CNS lymphoma (PCNSL) provides a potential opportunity for an accelerated path to market
- Advanced into first-in-human clinical trial in 4Q21

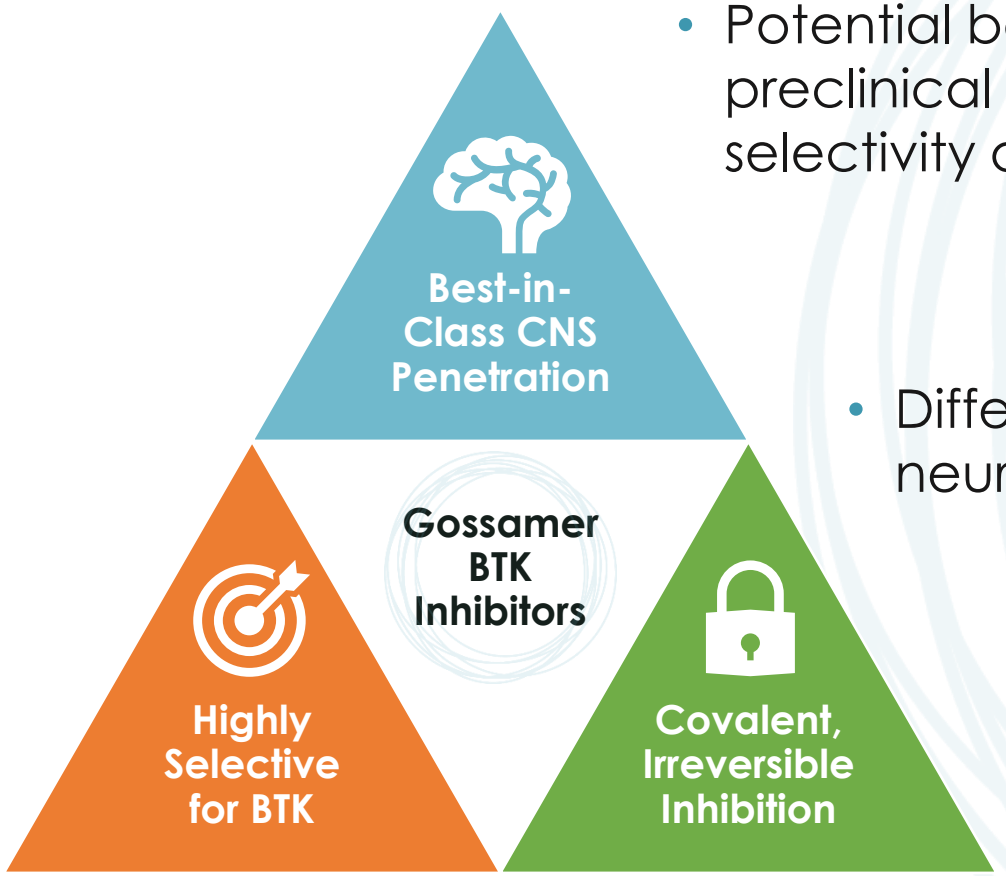
## GB7208: Lead Neuro-inflammatory / Neuro-degenerative Candidate

- Superior CNS penetration / results in preclinical mouse models vs. tolebrutinib at studied doses



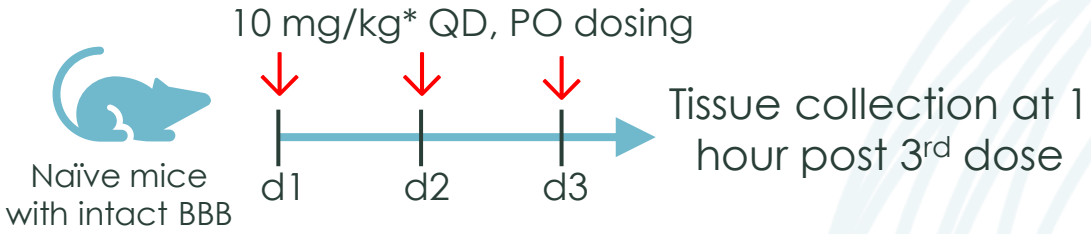

^ Based upon the benefit / risk profile observed to date and a prioritization of resources to support the seralutinib program, Gossamer decided to pause enrollment in the Phase 1b/2 STAR CNS study in March 2023.

# Gossamer's CNS-Penetrant BTK Inhibitors

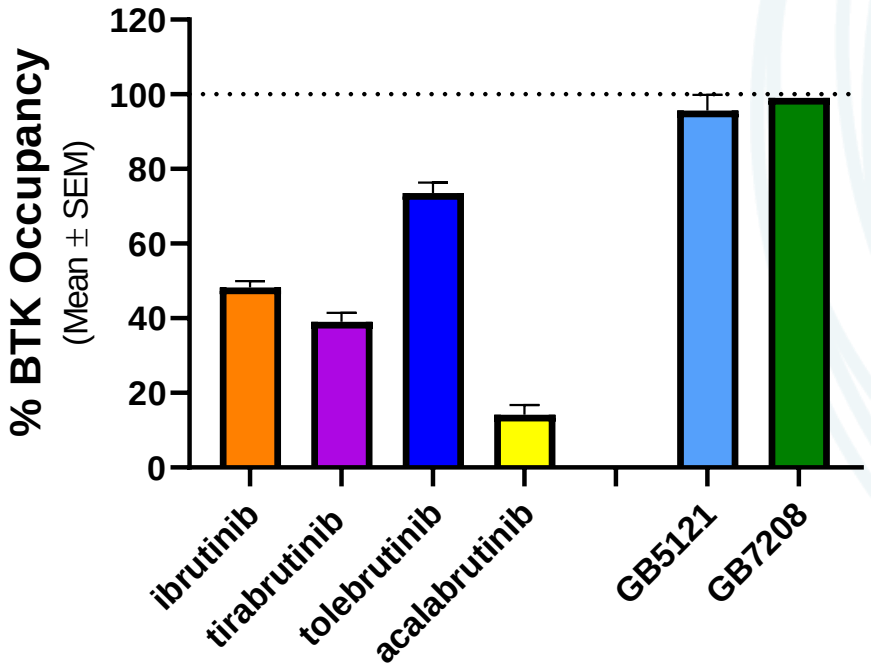



- Potential best-in-class preclinical CNS penetration based on preclinical mouse models, complemented by high degrees of selectivity and covalent binding profile
- Differentiated BTK inhibitors for neuro-oncology, neuroinflammatory, and neurodegenerative disorders
- Gossamer has significant clinical development expertise in both neuroinflammatory conditions and hematologic cancers

# GB5121 and GB7208 Demonstrate Superior Brain Penetration in Preclinical Mouse Models




## Brain Target Occupancy

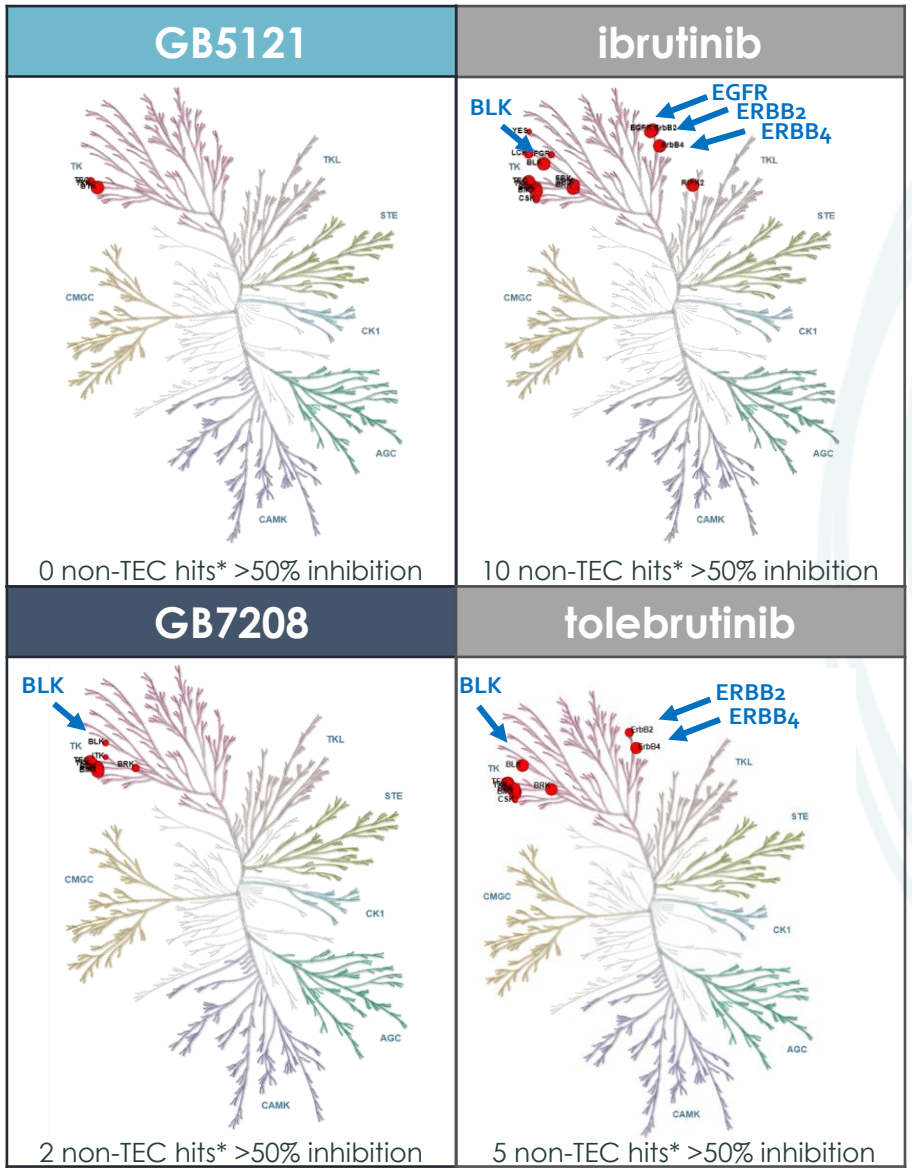


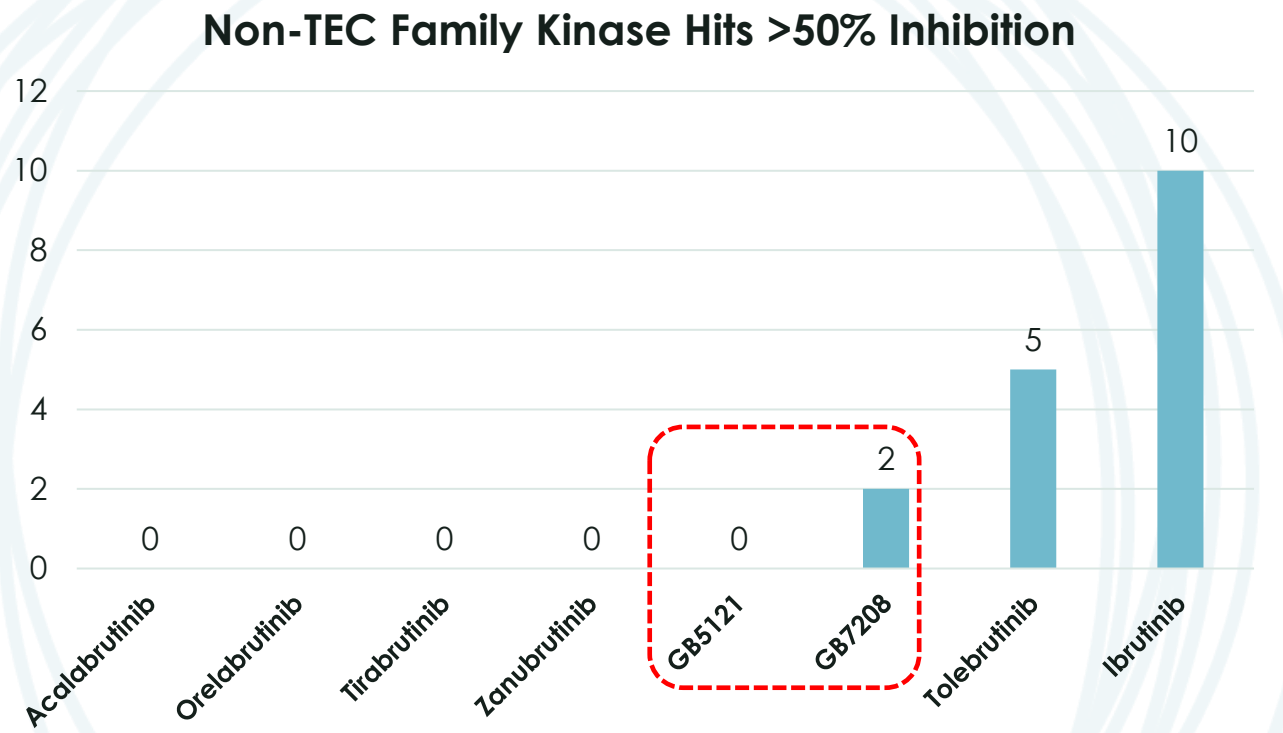

| Compound | Company / Phase | Mouse Brain Target Occupancy |
|---|---|---|
| **GB5121** | Gossamer Bio / Phase 1b/2 | |
| **GB7208** | Gossamer Bio / Preclinical | |
| **Tolebrutinib** | Sanofi (Principia) / Phase 3 | |
| **Ibrutinib** | Abbvie & J&J / Approved | |
| **Tirabrutinib** | Ono Pharma / Phase 2 (US), Approved (Japan) | |
| **Acalabrutinib** | AstraZeneca / Approved | |

*Based on internally generated data in naïve mice with intact BBB.*

*10 mg/kg = comparable to tolebrutinib clinical dose of 60mg QD in MS (based on allometric scaling).
QD = once-daily; PO = oral administration; BBB = blood brain barrier; SEM = standard error of the mean.

# GB5121 and GB7208 Are Highly Selective BTK Inhibitors Based on Kinome Scans



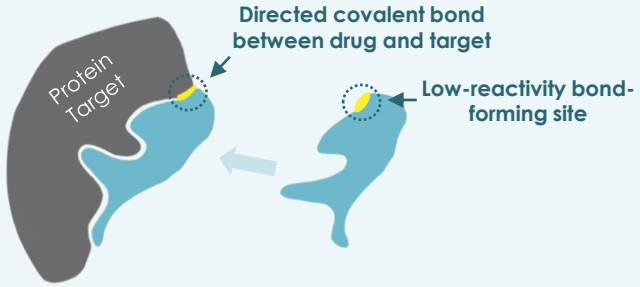

**Kinome scans suggest GB5121 and GB7208 are highly selective compounds**

* Non-TEC family kinases inhibited >50% at 1uM concentrations
**Red** denotes >50% inhibition, → denotes non-TEC covalent off-target interaction

Source: Internal data on hand.

# Covalent Inhibitors Provide Advantages Over Reversible Inhibitors

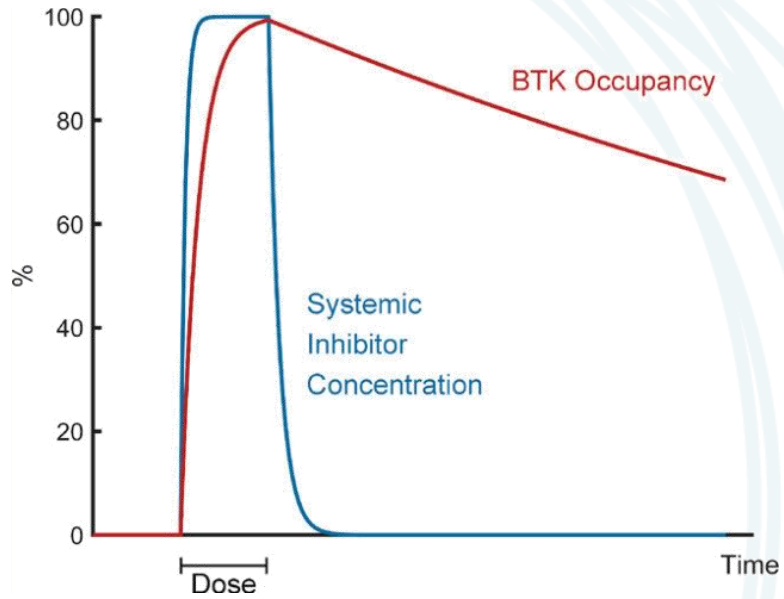
## Covalent Inhibitors




**Covalent irreversible drugs bind specifically to a drug target and form a precisely direct, permanent bond with their target**

## Reversible Inhibitors


**Traditional reversible drugs are in equilibrium with their target continually binding, unbinding and rebinding**




**Rapid, irreversible binding to BTK, coupled with fast clearance, enables achievement of high BTK occupancy for extended periods of time with faster systemic clearance of the inhibitor.**

**Advantages:**

- Enhanced Potency
- Selectivity
- Prolonged Duration of Action

Source: Singh, J. et al. Nat Rev Drug Discov 10, 307–317 (2011).

# Corporate Overview and Milestones

# Financial Overview

| | |
|---|---|
| Cash, Cash Equivalents and Marketable Securities<br>(As of 12/31/22) | ~$256mm |
| Debt, *Related to Line of Credit*<br>(As of 12/31/22; initial tranche of credit facility, announced 5/2/19) | ~$24mm |
| Principal of Convertible Notes Outstanding<br>(As of 12/31/22) | ~$200mm |
| Common Shares Outstanding<br>(As of 3/10/23) | ~95mm |

mm = millions.

# Upcoming Seralutinib Clinical Milestones

- 1H:23 – Complete End of Phase 2 Regulatory Interactions
- Middle of 2023 – TORREY Study Open Label Extension Data
- 2H:23 – Commence Global Registrational Phase 3 Program in PAH
- 2H:23-1H:24 – Commence Development Program in WHO Group 3 PH

# Appendix



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# 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.