



*A Subsidiary of Quince Therapeutics*

# Corporate Presentation

July 2026

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# Quince Therapeutics / Orphai Transaction Highlights



***Acquisition closed  
on May 18, 2026***



## Transaction Overview & Financing

- ✓ The acquisition of Orphai was structured as a stock-for-stock transaction whereby all of Orphai's outstanding equity interests were exchanged for a combination of shares of Quince common stock and a newly created, Series C non-voting convertible preferred stock and all outstanding Orphai warrants were exchanged for warrants issuable to the investors in the private placement financing.
- ✓ Concurrent with the acquisition of Orphai, Quince executed subscription agreements for an up to \$187 million financing led by Balyasny and participation from the following institutional investors: Affinity Asset Advisors, LLC, Coastlands Capital, Columbia Threadneedle Investments, Cormorant Asset Management, Eventide Asset Management, Foresite Capital, Janus Henderson Investors, LifeSci Venture Partners, Logos Capital, Perceptive Advisors, SilverArc Capital, Woodline Partners LP and other investors

## Governance & Leadership

- ✓ Brigitte Roberts has joined Quince Board of Directors and will join existing Quince management team to provide continuing leadership for the combined company.

## Use of Proceeds

- ✓ The proceeds from the private placement are expected to be primarily used to advance LAM-001 and deliver the following anticipated milestones:
  - Phase 2 data in Bronchiolitis Obliterans Syndrome (BOS)
  - Phase 2 data in Pulmonary Hypertension-Interstitial Lung Disease (PH-ILD)
  - Phase 2 data in Sarcoidosis Associated Pulmonary Hypertension (SAPH)

# Investment Highlights



**Rare disease focused, clinical-staged biotechnology company developing a novel, once-daily, inhaled, disease modifying rapamycin formulation (LAM-001) across multiple Phase 2 programs:**

- **PH-ILD** (~200K US/EU)<sup>1</sup> –Current therapies are limited to vasodilation, not disease modifying<sup>2</sup>. Promising Ph 2a data on top of standard of care presented ATS 2026; Ph 2b expected to initiate mid-2026.
- **BOS** (~30K US/EU)<sup>3</sup> - Severe complication of and leading cause of death post lung transplantation<sup>4</sup>. Positive, retrospective data from clinical utilization of oral rapamycin support an ongoing Ph 2 trial with data expected 1Q 2027.
- **SAPH** (~60K US/EU)<sup>5</sup> - Severe complication of sarcoidosis with no approved therapy (PH WHO group 5). Ph 2 trial expected to initiate in 2026, supported by proof-of-concept clinical efficacy data from completed PH study.



Efficient 505(b)2 development pathway for lead program (LAM-001), with strong IP coverage expected to the mid 2040's



US/EU Orphan Disease Status granted for multiple indications



Supportive FDA feedback from end of Phase 2 and pre-IND meetings

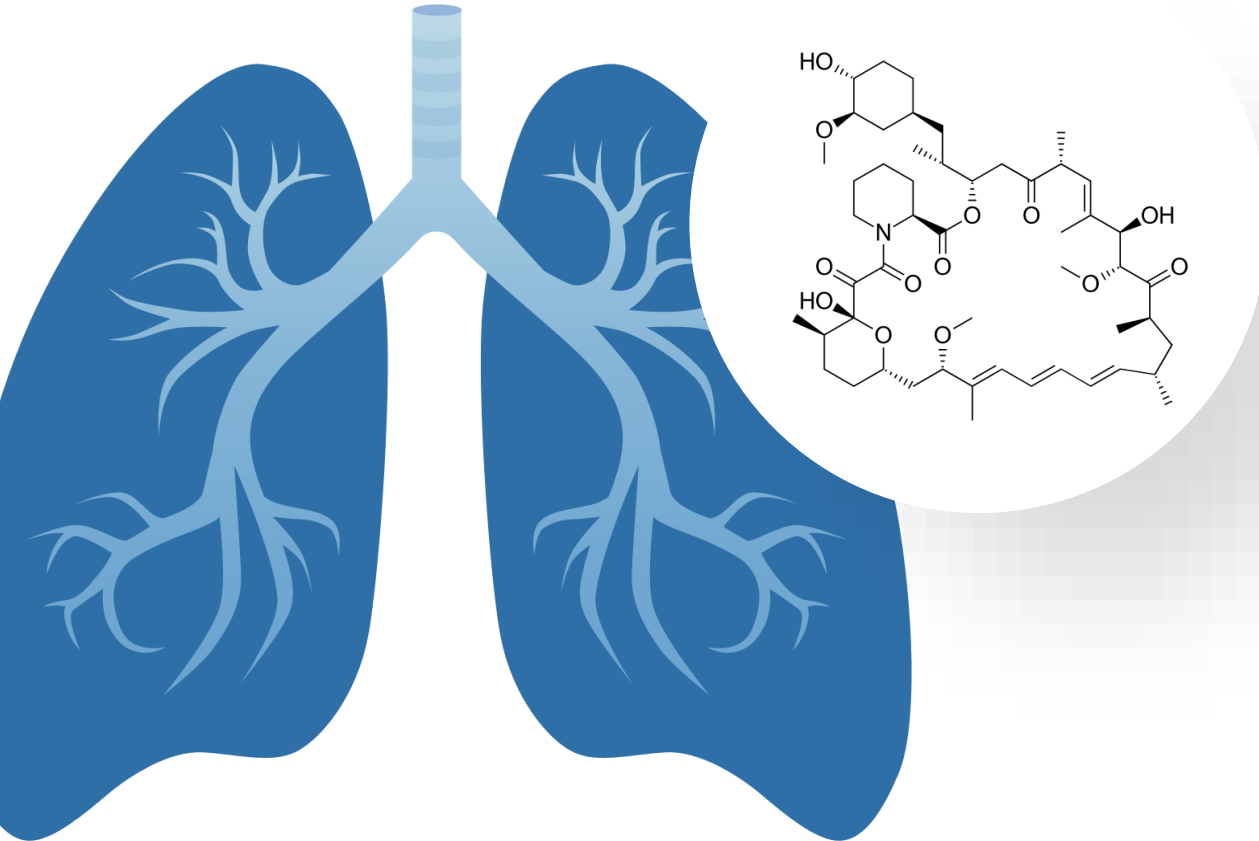
1. Represents estimated patient population in the US and EU: Wijsenbeek 2020 DOI: 10.1056/NEJMra2005230, Ang 2024 <https://doi.org/10.1016/j.chest.2024.04.025>  
2. Shlobin 2024 <https://doi.org/10.1002/pul2.12310>  
3. Represents estimated patient population in the US and EU at projected launch: US HRSA Data, Kulkarni 2018:doi: 10.1016/j.healun.2018.09.016 and Company estimates  
4. Ehrsam 2021 [doi.org/10.1016/j.healun.2021.01.887](https://doi.org/10.1016/j.healun.2021.01.887)  
5. Represents estimated patient population in the US and EU: American Lung Association Data, Duong 2018, <https://doi.org/10.1097/CPM.0000000000000252>

# Quince Pipeline and Anticipated Milestones

|                                                                  | 2026                         | 2027 | 2028 | Estimated US/EU Market | Anticipated Data Readouts |
|------------------------------------------------------------------|------------------------------|------|------|------------------------|---------------------------|
| <b>LAM-001</b>                                                   |                              |      |      |                        |                           |
| Pulmonary Hypertension-<br>Interstitial Lung Disease<br>(PH-ILD) | <div>Phase 2b (PH-ILD)</div> |      |      | ~200k                  | 1Q-28                     |
| Bronchiolitis Obliterans<br>Syndrome<br>(BOS)                    | <div>Phase 2 (IIT)</div>     |      |      | ~30k                   | 1Q-27                     |
| Sarcoidosis Associated PH<br>(SAPH)                              | <div>Phase 2</div>           |      |      | ~60k                   | 4Q-28                     |

 Anticipated Data Readout

# Limitations of Oral Rapamycin



## ✗ Systemic Exposure with Significant Safety Risks:

**Oral Rapamune® Key Label Warnings and Precautions:**  
Angioedema, Fluid Accumulation and Impairment of Wound Healing, Hyperlipidemia, Decline in Renal Function, Proteinuria, Latent Viral Infections, Male Infertility, Embryo-Fetal Toxicity

## ✗ Limited Lung Exposure:

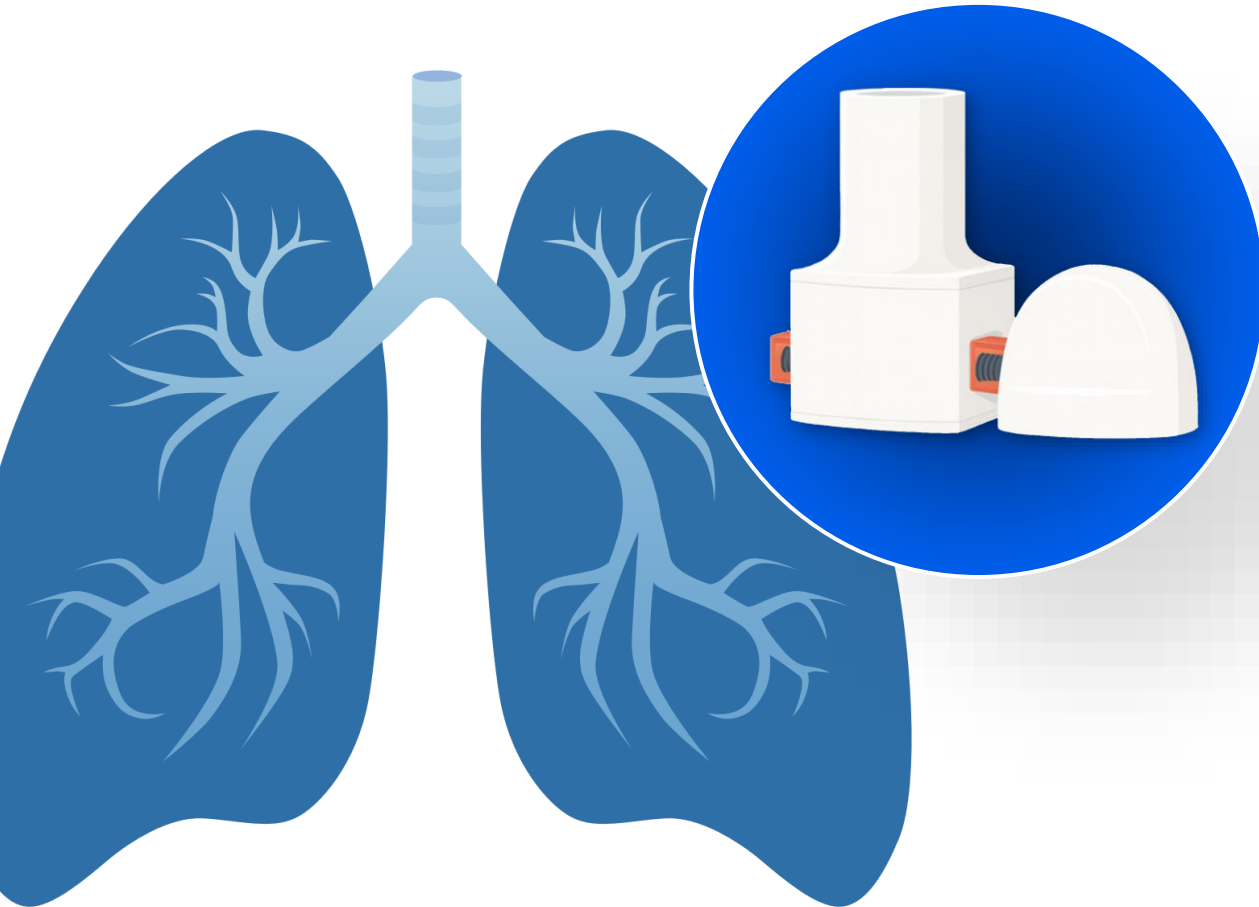
Systemic toxicity limits oral dosing levels and may preclude sufficient lung exposure

## ✗ Low and Variable Oral Bioavailability\*:

Requiring inconvenient plasma monitoring and frequent dose adjustments

**We believe these limitations preclude the adoption of oral rapamycin in pulmonary diseases where the mTOR pathway has been clearly implicated**

# Solution: LAM-001 Designed for Improved Pulmonary Delivery of Rapamycin



- ✓ **Targeted Delivery:** Direct lung delivery → higher local exposure versus oral or nebulized formulations
- ✓ **Ideal Physical Chemical Properties for Lung Delivery:** Enhanced lung exposure and potential improved efficacy in pulmonary diseases
- ✓ **Minimized Systemic Exposure and Well-Tolerated Safety Profile:** Reduced systemic side effects compared to oral rapamycin
- ✓ **Convenient Administration:** Easy-to-use once-a-day dry powder inhaler (DPI) designed to enhance patient compliance; fixed dose with no need for blood level monitoring (required with oral rapamycin due to low and variable oral bioavailability)

# LAM-001: Inhaled Rapamycin Advantages over Oral

**LAM-001 vs oral rapamycin: designed to deliver higher drug exposure in lungs where needed for clinical activity with lower systemic exposure where most toxicities arise**

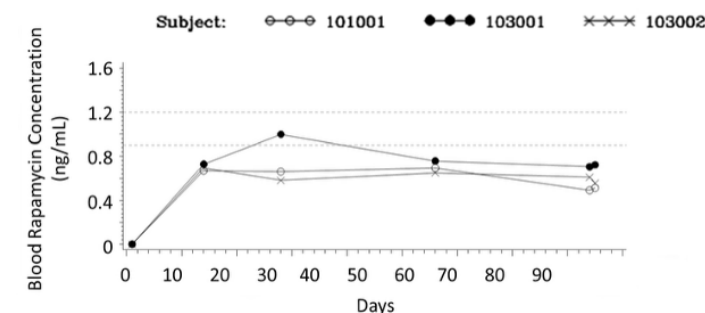
- Total dose delivered via inhalation = 20x lower (100 µg/day vs 2 mg/day)
- ~5-15x lower systemic exposure (<1 ng/ml vs 5-15 ng/ml for oral)
- > 90% mTOR inhibition at 24 hours after a single QD dose in rats comparable to 100 µg QD in humans

**Human studies support improved safety profile of LAM-001 vs. oral**

- LAM-001 is well tolerated across indications, up to 2.5 yrs of daily treatment
  - All AEs mild or moderate
  - No drug related: SAEs, withdrawals, or Grade 3/4 AEs

**Reduced systemic exposure with clinically relevant lung exposure**

**Phase 1/2 in LAM Patients**



Steady state target of <1 ng/mL achieved at 100 µg QD

# LAM-001: Group 3 Pulmonary Hypertension (PH-ILD)

# Pulmonary Hypertension (PH-ILD)

## DISEASE

- Rare, progressive disorder characterized by smooth muscle cell proliferation and endothelial cell dysfunction, leading to thickening and narrowing of the pulmonary blood vessels
- Group 3 Pulmonary Hypertension due to underlying interstitial lung disease (ILD) characterized by fibrosis of the lung tissue\*
- Worse prognosis than Group 1 PAH or ILD alone<sup>1</sup>
- 5-year survival 23%<sup>2</sup>
- No cure
- Only two approved drugs Tyvaso & Yutrepia

**Estimated Addressable Patient Population<sup>3</sup>**  
Group 3 (PH-ILD) — US: ~86K | EU: ~120K

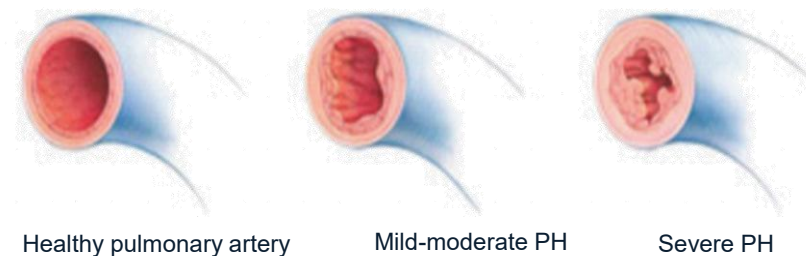


Figure 2 – Narrowing of the pulmonary arteries associated with PH<sup>4</sup>

ILD = interstitial lung disease,

\* PH is categorized into 5 groups (Group1-5) based on disease etiology; Group 1: Pulmonary arterial hypertension, Group 2: PH due to left heart disease, Group 3: PH due to chronic lung disease (such as ILD or COPD) and/or hypoxia, Group 4: PH due to pulmonary artery obstructions, Group 5: PH due to other conditions including sarcoidosis, sickle cell anemia, chronic hemolytic anemia, splenectomy, and metabolic disorders)

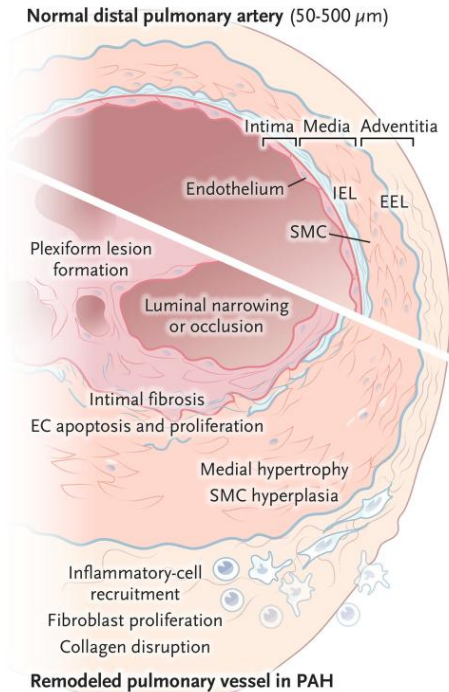
<sup>1</sup>Kacprzak 2023 <https://doi.org/10.3390/diagnostics13142354>

<sup>2</sup>Gall 2017 <http://dx.doi.org/10.1016/j.healun.2017.02.016>

<sup>3</sup>Wijssenbeek 2020 DOI: 10.1056/NEJMra2005230, Ang 2024 <https://doi.org/10.1016/j.chest.2024.04.025>

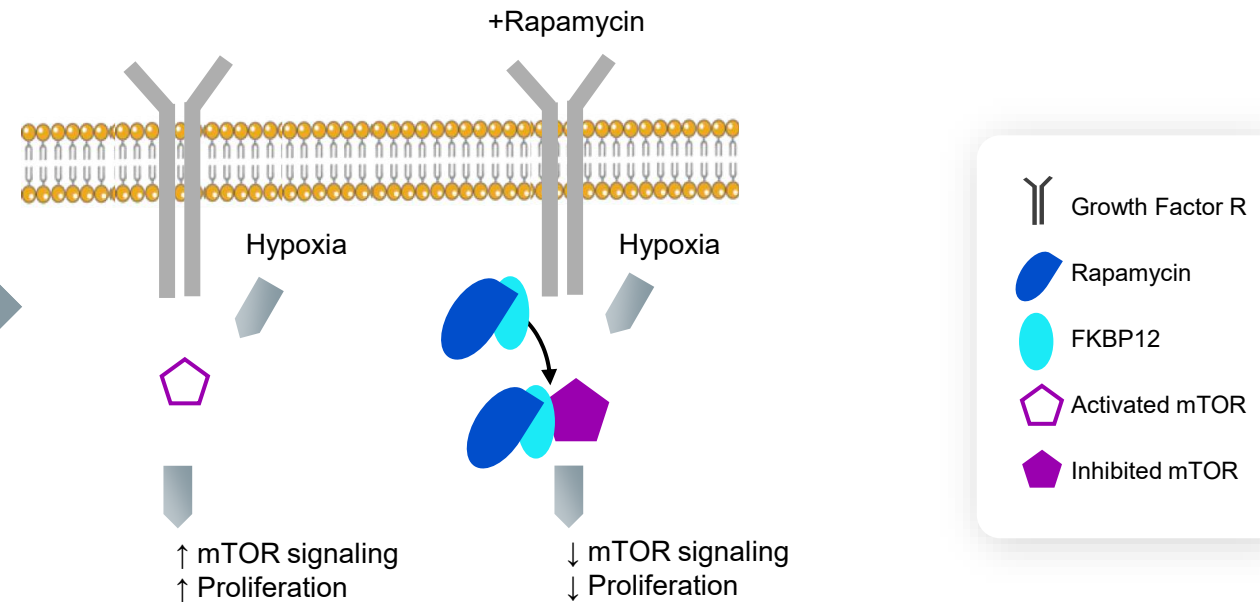
<sup>4</sup>Pulmonary Hypertension Singapore

# Rapamycin Targets PH Pathology



Hassoun NEJM 2021

## PH Smooth Muscle cells (*Hypoxia*)

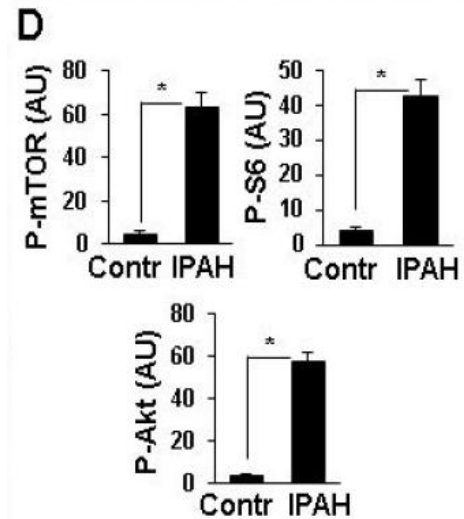
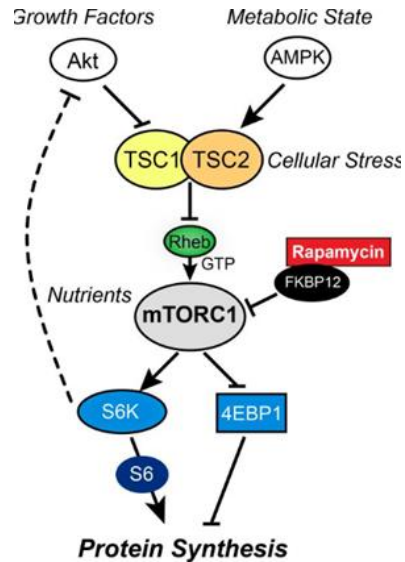


Krymskaya, et. al., FASEB (2011)

**LAM-001 has been shown to reverse pulmonary arterial smooth muscle cell proliferation, remodeling the arterial damage which is central to PH disease process**

# Rapamycin Inhibits mTOR and Reverses Pulmonary Arterial Smooth Muscle Cell (PASMC) Proliferation<sup>1,2</sup>

## Rapamycin inhibits mTOR, which is Activated in PH<sup>1</sup>



<sup>1</sup> Based on Goncharov, Circulation. 2014 129: 864.  
Contr = Control IPAH = Idiopathic Pulmonary Hypertension

## Rapamycin Reverses PASMC Proliferation<sup>2</sup>

**MCT 3 wk**



<sup>2</sup> Based on Houssaini, Am J Resp Cell Mol Bio 2013  
PASMC = Pulmonary Artery Smooth Muscle Cell, MCT = monocrotaline rat model

# Competitive Landscape PH-ILD Products and Product Candidates

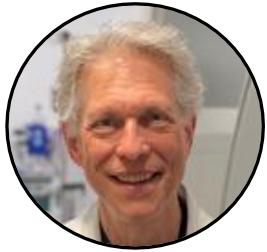
|               |                     | Company             | Once-daily dosing | Vasodilation MOA | Antiproliferative MOA | Antifibrotic MOA | Status          |
|---------------|---------------------|---------------------|-------------------|------------------|-----------------------|------------------|-----------------|
| LAM-001       |                     | Quince              | ✓                 | --               | +++                   | +++              | Ph 2            |
| Treprostinils | Tyvaso <sup>1</sup> | United Therapeutics | ✗                 | +++              | --                    | +                | Launched        |
|               | Yutrepia            | Liquidia            | ✗                 | +++              | --                    | +                | Launched        |
|               | TPIP                | Insmed              | ✓                 | +++              | --                    | +                | Ph 3            |
|               | L606                | Liquidia            | ✗                 | +++              | --                    | +                | Ph 3            |
|               | Tresmi              | United Therapeutics | ✗                 | +++              | --                    | +                | PR <sup>2</sup> |
| Ralinepag DPI |                     | United Therapeutics | ✓                 | +++              | --                    | +                | PC              |
| ROC-101       |                     | AllRock Bio         | ✓                 | ++               | ++                    | ++               | Ph 2            |
| Mosliciguat   |                     | Pulmovant           | ✓                 | ++               | +                     | +                | Ph 2            |

<sup>1</sup> Tyvaso nebulized or dry powder administrations

<sup>2</sup> PR = Preregistration. Commercial launch anticipated 2027.

+++ = higher activity, ++ = medium activity, + = lower activity

# Phase 2a Trial of LAM-001 in Group 1 PAH and 3 PH



Aaron B. Waxman, MD, PhD  
Principal Investigator

 **Brigham and Women's Hospital**  
Founding Member, Mass General Brigham



## Design

- Open Label; 24 wks; 4 sites; Invasive Cardiopulmonary Exercise Testing (iCPET)<sup>1</sup>

## Inclusion

- >18 yo; WHO Functional Class III; Group 1 PAH and Group 3 PH; symptomatic despite background Rx

## Primary Endpoints

- Peak oxygen uptake (VO<sub>2</sub> max), Safety, Tolerability

## Secondary Endpoints

- PVR, 6MWD, WHO functional class

## Exploratory Endpoint

- NT-proBNP

**Data Presented at ATS May 2026**

<sup>1</sup>iCPET is a diagnostic procedure in which patients undergo pulmonary and radial artery catheterization in conjunction with a bicycle exercise test to directly measure cardiac and pulmonary function during exercise. Bradley A. Maron, Barbara A. Cockrill, Aaron B. Waxman, David M. Systrom "Invasive Cardiopulmonary Exercise Test" *Circulation* **2013**, 1157-1164  
PVR = Pulmonary Vascular Resistance, 6MWD = 6 Minute Walk Distance, NT-proBNP = N-terminal pro-B-type natriuretic peptide

# Phase 2a Baseline Characteristics

|                                     | PAH      | PH-ILD   | Completers | All Enrolled |
|-------------------------------------|----------|----------|------------|--------------|
| <b>N per group</b>                  | <b>5</b> | <b>5</b> | <b>6</b>   | <b>10</b>    |
| Female                              | 4        | 2        | 2          | 6            |
| Male                                | 1        | 3        | 4          | 4            |
| Age (median yr)                     | 63       | 65       | 64         | 65           |
| <b>ILD</b>                          |          |          |            |              |
| IPF <sup>1</sup>                    |          | 1        | 0          | 1            |
| NSIP <sup>1</sup>                   |          | 2        | 2          | 2            |
| SSc-ILD <sup>1</sup>                |          | 1        | 1          | 1            |
| PS <sup>1</sup> (Grp 5)             |          | 1        | 1          | 1            |
| <b>Background PH Meds</b>           |          |          |            |              |
| Ambrisentan                         | 2        | 0        | 1          | 2            |
| Macitentan                          | 3        | 1        | 2          | 4            |
| Riociguat                           | 1        | 0        | 0          | 1            |
| Selexipag                           | 1        | 0        | 0          | 1            |
| Sildenafil                          | 1        | 3        | 2          | 4            |
| Tadalafil                           | 3        | 2        | 4          | 5            |
| Treprostinil <sup>2</sup>           | 3        | 5        | 5          | 8            |
| <b>Discontinuations<sup>3</sup></b> | <b>3</b> | <b>1</b> | <b>-</b>   | <b>4</b>     |



**Majority of patients on triple background therapy**

- **All PH-ILD patients on background treprostinil**



**Patients on stable background therapy prior to enrollment and throughout study**



**All discontinuations deemed unrelated to study drug**

<sup>3</sup>Discontinuations (all deemed unrelated to drug):

PAH

- Respiratory failure/GI infection at ~month 5 lead to hospitalization, unrelated to study drug, developed aspiration pneumonia in hospital and died
- Widowmaker lesion identified mid-study (unrelated to study drug) and withdrew from study for immediate stenting
- Terminated following vaping induced lung injury

PH-ILD

- Multiple complications and hospitalizations unrelated to study drug and withdrew

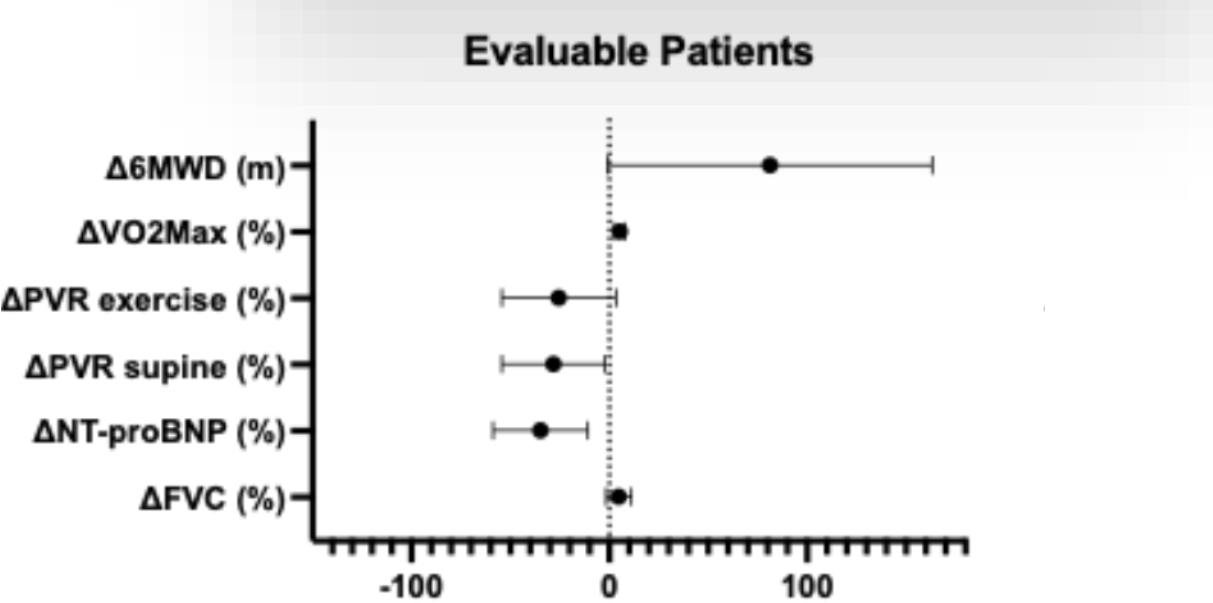
<sup>1</sup> IPF = Interstitial Pulmonary Fibrosis, NSIP = Non-specific Interstitial Pneumonia, SSc-ILD = Systemic Sclerosis ILD, PS = Pulmonary Sarcoidosis

<sup>2</sup> Inhaled, oral or SubQ  
Data on file

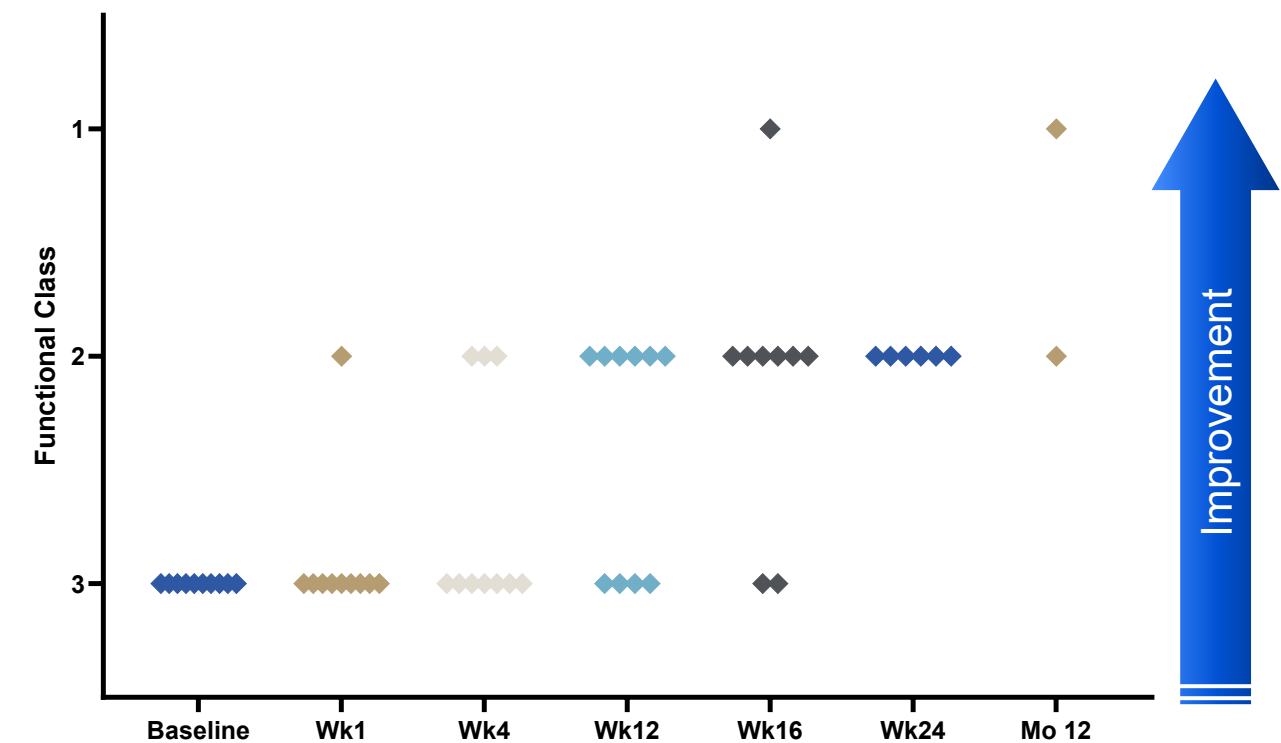
# Phase 2a 24 Week Data Summary

|                                     | Evaluable Population | PH-ILD Subgroup |
|-------------------------------------|----------------------|-----------------|
|                                     | Mean                 | Mean            |
|                                     | N = 6                | N = 4           |
| Δ 6MWD (m)                          | +81.3                | +67.4           |
| Δ VO <sub>2</sub> Max (% Predicted) | +5.4%                | +6.7%           |
| % Δ PVR (exercise)                  | -25.5%               | -35.3%          |
| % Δ PVR (supine)                    | -28.1%               | -33.9%          |
| % Δ NT-proBNP                       | -29.0%               | -28.8%          |
| Δ FVC (% Predicted)                 | +4.8%                | +1.8%           |

- Consistent, clinically relevant improvement from baseline observed across multiple endpoints
- In addition to SOC therapy in heavily pre-treated population
- Data support potential benefit across exercise capacity, pulmonary hemodynamics, cardiac stress and lung function



# Phase 2a Functional Class Endpoint



**100% of completers improved to FC II by Week 24**

- All 10 patients FC III at baseline
- 6/10 improved to FC II by Week 12
- 2 patients improved to FC I

## WHO Functional Class Definition\*

- Class: I** Symptom-free when physically active or resting
- Class: II** No symptoms at rest, but normal activities such as climbing stairs, grocery shopping or making the bed cause some discomfort and shortness of breath
- Class: III** Resting may be symptom-free, but normal chores around the house are greatly limited due to shortness of breath or feeling tired
- Class: IV** Symptoms at rest and severe symptoms with an activity

# Safety Summary through 24-Weeks

## Drug Related AEs

- Grade 1 Productive Cough (n = 1) - Resolving
- Grade 2 Cough (n = 1) - Not Resolved
- Grade 1 Gingivitis (n = 1) - Resolving



**LAM-001 was well tolerated**



**No dose interruptions due to AEs**



**No discontinuations due to drug**



**No drug related SAEs**

# Phase 2a Efficacy and Safety Summary

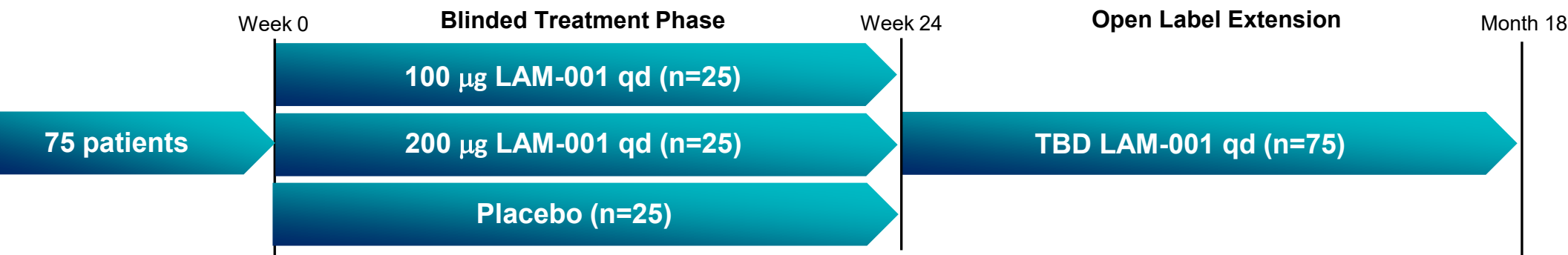
## Compelling Clinical Activity

- ✓ PH-ILD patients +67m improvement observed in 6MWD compares favorably to existing therapies<sup>1</sup>
- ✓ Benefit seen on top of standard of care in heavily pretreated population
- ✓ Consistent signals of patient benefit seen across multiple measures

## Favorable Tolerability

- ✓ LAM-001 well tolerated
  - No dose interruptions due to AE
  - No discontinuations due to drug
  - No drug related SAE
  - Drug related AEs
    - N = 2 cough (Grade 1, 2)
    - N = 1 gingivitis (Grade 1)

# Phase 2b Trial of LAM-001 in PH-ILD\*



|                       |                                                                                                                                                                                                                                     |
|-----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Design                | <ul style="list-style-type: none"><li>Placebo-controlled; Double Blind; Randomized 1:1:1; Multi-center (~50 sites); 24 wks; 12 mo open-label extension</li></ul>                                                                    |
| Inclusion             | <ul style="list-style-type: none"><li>18-70 y/o; WHO FC II and III; PVR <math>\geq 4</math>, PH-ILD Group 3; symptomatic despite stable background rx</li></ul>                                                                     |
| Primary Endpoints     | <ul style="list-style-type: none"><li><math>\Delta</math> PVR</li></ul>                                                                                                                                                             |
| Secondary Endpoints   | <ul style="list-style-type: none"><li><math>\Delta</math> 6MWD; Incidence of Clinical Worsening; Time to Clinical Worsening, <math>\Delta</math> WHO functional class, <math>\Delta</math> NT-proBNP, Safety/Tolerability</li></ul> |
| Exploratory Endpoints | <ul style="list-style-type: none"><li>HRCT, <math>\Delta</math> FVC, <math>\Delta</math> DLCO, emPHasis 10, KBILD</li></ul>                                                                                                         |

Anticipated Start Mid-2026

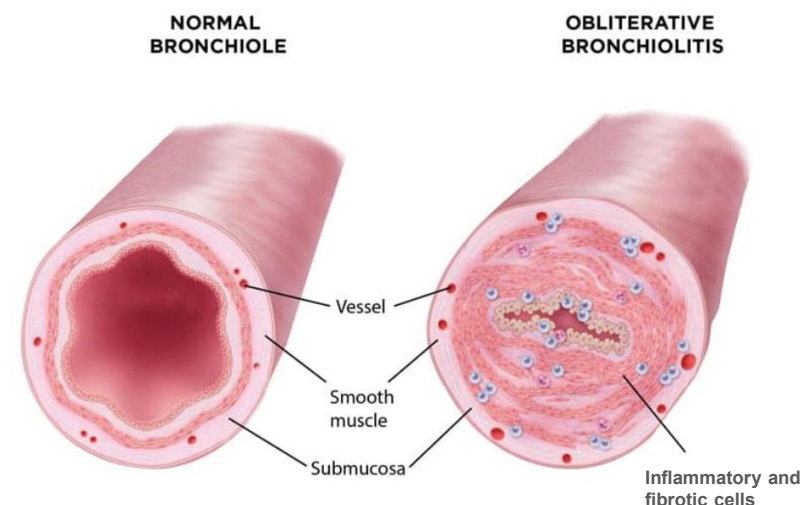
\*Proposed study design  
Clinical Worsening defined as the occurrence of one of the following: 1) Death, 2) Lung transplantation or heart-lung transplantation, 3) Hospitalization related to worsening respiratory status/respiratory decompensation (>24 hrs), 4) Worsened WHO Functional class 5)  $\geq 15\%$  decline in 6MWD from baseline 6)  $>10\%$  decline from baseline FVC  
PVR = Pulmonary Vascular Resistance, HRCT = High resolution CT, NT-proBNP = N-terminal pro-B-type natriuretic peptide, FVC = Forced Vital Capacity, DLCO = Diffusing Capacity of the Lungs for Carbon Monoxide, emPHasis 10 = pulmonary hypertension health related quality of life score, KBILD = King's Brief Interstitial Lung Disease Questionnaire

# LAM-001: Bronchiolitis Obliterans (BOS)

# LAM-001: Bronchiolitis Obliterans (BOS) Market

- Leading cause of death post lung transplantation (LT)<sup>1</sup>
- Orphan Drug Designation granted US and Europe
- No FDA approved drugs
- ~4,000 lung transplants performed annually in US<sup>2</sup>

**Estimated Addressable Patient Population<sup>2</sup>**  
**BOS Post LT — US: ~17K | EU: ~11K**



BOS = Bronchiolitis Obliterans Syndrome<sup>3</sup>

<sup>1</sup> Ehrt 2021 doi.org/10.1016/j.healun.2021.01.887

<sup>2</sup> Estimated population at projected launch. US HRSA Data, Kulkarni 2018:doi: 10.1016/j.healun.2018.09.016 and Company estimates.

<sup>3</sup> Adapted from Researchoutreach.org

# BOS Major Unmet Need

**6.2 years**

Median survival post lung transplantation<sup>1</sup>

**11%**

BOS free survival at 10 yrs<sup>2</sup>

**#1**

BOS is the leading cause of death post lung transplantation<sup>3</sup>

**2.5 years**

Median survival (or re-transplantation) post development of BOS post lung transplantation<sup>4</sup>

<sup>1</sup>ISHLT Factsheet: [https://www.isHLT.org/docs/default-source/default-document-library/isHLT\\_fast-facts.pdf](https://www.isHLT.org/docs/default-source/default-document-library/isHLT_fast-facts.pdf) Accessed 7/6/26

<sup>2</sup>Kulkarni 2018 <https://doi.org/10.1016/j.healun.2018.09.016>

<sup>3</sup>Ehram 2021 [doi.org/10.1016/j.healun.2021.01.887](https://doi.org/10.1016/j.healun.2021.01.887)

<sup>4</sup>Copeland 2010 doi: 10.1164/rccm.201002-0211OC

# FEV1 is Key Measure of BOS Progression and Survival

## Progression to Advanced BOS is Measured by FEV1 Decline\*

|          |                        |
|----------|------------------------|
| BOS Gr 0 | FEV1 > 80% Baseline    |
| BOS Gr 1 | FEV1 66 - 80% Baseline |
| BOS Gr 2 | FEV1 51 - 65% Baseline |
| BOS Gr 3 | FEV1 ≤50% Baseline     |

\*Baseline = best post-transplant FEV1  
Meyer 2014: DOI: 10.1183/09031936.00107514

**1% ↓ in FEV1**  
*is associated with a*  
**3.4% ↑ Mortality**  
( $p < 0.001$ )

Kneidinger 2022 doi: 10.3389/fmed.2022.897581

**72%**

Surveyed physicians ranked decline in **FEV1** as the most important criterion for escalating BOS therapy

---

Improvement in rate of FEV1 decline should drive market uptake

Based on a survey conducted with 48 BOS physicians, data on file

# Rapamycin Stabilizes Pulmonary Function in Patients with BOS<sup>1</sup>

Oral rapamycin administered to patients with progressive BOS post lung transplant who had not responded to other treatments

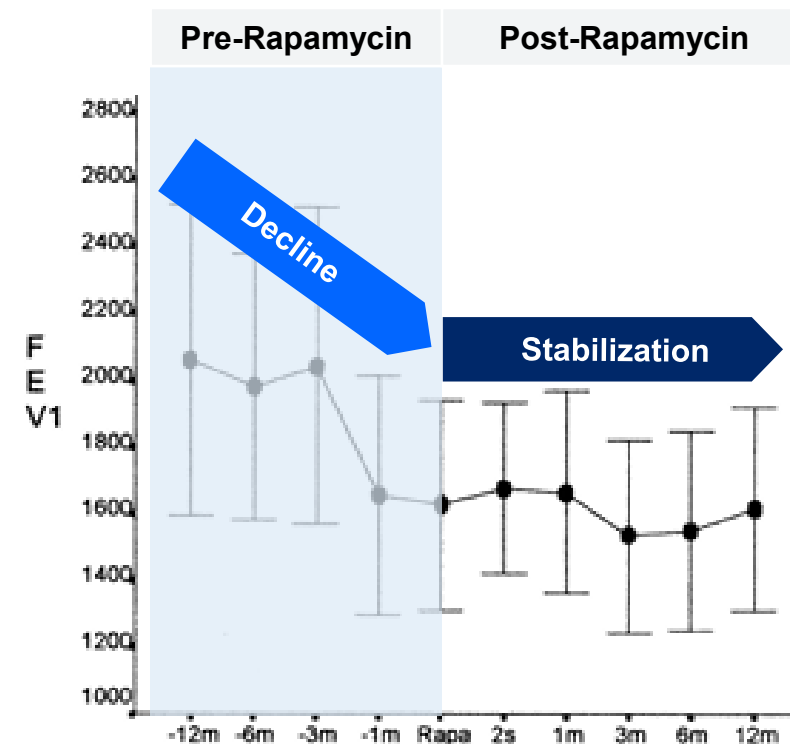
**Prior to initiation of rapamycin:**

Decline in FEV1 over the course of 12 months

**Post introduction of rapamycin:**

Eight of eleven patients (73%) showed improved or stabilized FEV1

**Mean FEV1 Values Before and After Rapamycin**



# Phase 2 Trial of LAM-001 in BOS



|                       |                                                                                                                                                                                                                                                                                                    |
|-----------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Design                | <ul style="list-style-type: none"><li>Randomized 1:1, Double Blind, Placebo controlled, 25 mo open-label extension, Investigator-initiated trial</li></ul>                                                                                                                                         |
| Inclusion             | <ul style="list-style-type: none"><li>&gt;18 yo; Newly diagnosed BOS (FEV1 51-85% of baseline, ≤ 12 mo from BOS diagnosis); ≥ 12 mo post Double lung transplant</li></ul>                                                                                                                          |
| Primary Endpoint      | <ul style="list-style-type: none"><li>% Δ in FEV1 @ 48 wks (or at termination of therapy, whichever occurs first)</li></ul>                                                                                                                                                                        |
| Secondary Endpoints   | <ul style="list-style-type: none"><li>Absolute Δ in FEV1 @ 48 wks*, Δ rate of progression in FEV1 @ 48 wks* vs pre-enrollment, PFS Level 1 (time to earliest to occur of: &gt;10% decline in FEV1, death from respiratory failure or re-transplantation), Safety/Tolerability</li></ul>            |
| Exploratory Endpoints | <ul style="list-style-type: none"><li>6MWD @ 48 wks*, PFS Level 2 (time to earliest to occur of: &gt;20% decline in FEV1, death from respiratory failure or re-transplantation), Δ FEV1/FVC @ 48 wks*, SGRQ-C, PK, CLAD signature gene profiling @ 3 mo, mTOR pathway activation via BAL</li></ul> |
| Status**              | <ul style="list-style-type: none"><li>Enrollment completed January 2026. An interim safety review was conducted in February 2026. Five of 19 subjects enrolled in the ongoing blinded study experienced a decline*** in FEV1 &gt;10% at that time. Dosing continues.</li></ul>                     |

**Trial Fully Enrolled, Data Anticipated 1Q 2027**

\* Measured at 48 wks or at termination or treatment, whichever occurs first

\*\* The interim clinical data presented herein are derived from an ongoing blinded study. Because the study remains blinded, the Company is unable to determine which patients received LAM-001 versus placebo. These interim data are preliminary, should be interpreted with caution, and are not indicative of the final results of the study. No conclusions regarding the efficacy or safety of LAM-001 should be drawn from these interim results. The actual results following unblinding may differ materially from the interim data presented herein.

\*\*\* As measured in two consecutive visits

FEV1 = Forced Expiratory Volume in 1 Second, PFS = Progression Free Survival, FVC = Forced Vital Capacity, SGRQ-C = St. George's Respiratory Questionnaire, COPD, BAL = Bronchioalveolar Lavage

# IP, Financial, & Milestones



# Broad IP Strategy Supporting LAM-001 Exclusivity

## FDA Orange Book Affords Protection for 3 Types of Patents

### Composition Claims

### Method Claims

#### Drug Substance (DS)

Particle size

#### Drug Product (DP)

Formulation

Delivery

Dosage

#### Method of Treatment (MoT)

Use of composition

Defined dosing regimens

Specific indications

### 9 US and 25 International Patents Issued\* – Expected Exclusivity Into 2035

- Pharmaceutical compositions on DPI formulation
- Methods of treating PH and chronic lung disease

### Pending Applications – Expected Exclusivity Into 2047

### Multifaceted IP and Exclusivity Strategy

- Broad claims in all 3 categories
  - Drug substance, drug product, and method
- Multiple patents expected to be Orange Book-listable
- Device exclusivity for the use of rapamycin in the RS01 dry powder inhaler device

### Orphan Drug Exclusivity in addition to patents

- 7 years US / 10 years EU

\* Australia, Canada, Europe, Hong Kong, Israel, Japan, Mexico, New Zealand and South Korea.

# Well-Capitalized with Funding from Leading Healthcare Investors

*May 2026 Financing*

**Oversubscribed  
\$115 M Upfront Financing**

*Led by*

**Balyasny** 

*Including*

  
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 LIFE**SCI**  
VENTURE PARTNERS

 LOGOS  
CAPITAL

 PERCEPTIVE  
ADVISORS

 SILVERARC  
CAPITAL

 WOODLINE  
PARTNERS

# Anticipated Milestones



**May '26    LAM-001 PH Phase 2a Data  
(Oral Presentation at ATS)**

**1Q27        LAM-001 BOS Phase 2 Data**

**1Q28        LAM-001 PH-ILD Phase 2b Data**

**4Q28        LAM-001 SAPH Phase 2 Data**

Thank You

