Corporate Presentation

July 2025

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We report certain financial information using non-IFRS financial measures, as we believe these measures provide information that is useful to management and investors to assess financial performance. These non-IFRS financial measures do not have any standardized meaning and may not be comparable with similar measures used by other companies. For certain non-IFRS financial measures, there are no directly comparable amounts under IFRS. These non-IFRS financial measures should not be viewed as alternatives to measures of financial performance determined in accordance with IFRS. Please see slides 103-104 for a reconciliation of these measures to the most comparable IFRS measure.

This document and the Presentation contain statements that are or may be forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995. We intend such forward-looking statements to be covered by the safe harbor provisions for forward looking statements contained in Section 27A of the U.S. Securities Act of 1933, as amended and Section 21E of the Exchange Act of 1934, as amended. These statements are based on our management's current beliefs, expectations and assumptions about future events, conditions and results, and on information currently available to us. This document and the Presentation also contain estimates and other statistical data made by independent parties and by us relating to market size and growth and other data about our industry. This data involves a number of assumptions and limitations, and you are cautioned not to give undue weight to such estimates. In addition, projections, assumptions and estimates of our future performance and the future performance of the markets in which we operate are necessarily subject to a high degree of uncertainty and risk.

All statements other than statements of historical facts included in this document and the Presentation should be considered forward-looking statements, including without limitation, statements that relate to our expectations around our and our Founded Entities' therapeutic candidates and approach towards addressing major diseases, operational plans, future prospects, objectives, developments, strategies and expectations, the progress and timing of clinical trials and data readouts, the timing of regulatory approvals or clearances from the FDA, our future results of operations and financial outlook, including our anticipated cash runway and our forecasted cash, cash equivalents and short-term investments, and our ability to realize value for our shareholders.

Words such as "expect," "anticipate," "intend," "plan," "believe," "seek," "estimate," "think," "may," "could," "will," "would," "should," "continue," "potential," "likely," "opportunity" and similar expressions or variations of such words are intended to identify forward-looking statements, but are not the exclusive means of identifying forward-looking statements. Additionally, statements concerning future matters such as our expectations of business and market conditions, development and commercialization of new products, enhancements of existing products or technologies, and other statements regarding matters that are not historical are forward-looking statements.

The forward-looking statements are based on current expectations and currently available operating, financial and competitive information and are subject to known and unknown risks, uncertainties and other important factors that could cause actual results, performance and achievements to differ materially from current expectations, including, but not limited to, the following: our history of incurring significant operating losses since our inception; our ability to realize value from our Founded Entities; our need for additional funding to achieve our business goals, which may not be available and which may force us to delay, limit or terminate certain of our therapeutic development efforts; our limited information about and limited control or influence over our Non-Controlled Founded Entities; the lengthy and expensive process of preclinical and clinical drug development, which has an uncertain outcome and potential for substantial delays; potential difficulties with enrolling patients in clinical trials, which could delay our clinical development activities; side effects, adverse events or other safety risks which could be associated with our therapeutic candidates and delay or halt their clinical development; our ability to obtain regulatory approval for and commercialize our therapeutic candidates; our ability to compete with companies currently marketing or engaged in the development of treatments for indications within our programs are designed to target; our ability to realize the benefits of our collaborations, licenses and other arrangements; the impact of government laws and regulations; our ability to maintain and protect our intellectual property rights; our reliance on third parties, including clinical research organizations, clinical investigators and manufacturers; our vulnerability to natural disasters, global economic factors, geo-political actions and unexpected events; and the risks, uncertainties and other important factors described under the caption "Risk Factors" in our Annual Report on Form 20-F for the year ended December 31, 2024 filed with the SEC and in our other regulatory filings. These forward-looking statements are based on assumptions regarding the present and future business strategies of the Company and the environment in which it will operate in the future.

Given these risks, uncertainties and other factors, many of which are beyond the Company's control, you should not place undue reliance on these forward-looking statements.

Each forward-looking statement speaks only as at the date of this document. Except as required by law and regulatory requirements, we disclaim any obligation to update or revise these forward-looking statements, whether as a result of new information, future events or otherwise.

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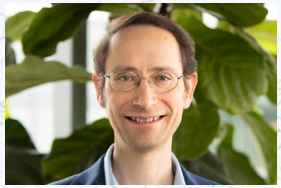
Our Founded Entities are comprised of Founded Entities we control and Founded Entities we do not control, all of which are incorporated in the United States. We formed each of our Founded Entities and have been involved in development efforts in varying degrees. In the case of Founded Entities we control, we continue to maintain majority voting control. With respect to Founded Entities we do not control, we may benefit from appreciation in our minority equity investment as a shareholder of such companies.

Our Proven and Seasoned Team

Bharatt Chowrira, PhD, JD

Chief Executive Officer

30+ years of leadership roles as CEO, President, COO, and GC held in multiple biotechs; including former COO at Auspex (acq. by Teva $3.5B), COO at Nektar, GC at SIRNA (acq. by Merck $1.1B), VP at Merck & Co.; Board Member



Eric Elenko, PhD

Co-founder & President

Co-founder and acting C-level executive of multiple PureTech founded entities (e.g., Karuna Therapeutics.) Leading innovation and development of internal PureTech programs in PureTech's "hub." Former consultant at McKinsey & Company.

Michael Inbar, CPA, MBA

Chief Accounting Officer

Former CFO at Acronis Inc.; Previously interim CFO at Wallarm, Inc.,; Held several leadership roles at Solid Biosciences, Inc., Syros Pharmaceuticals, Inc., and GlassHouse Technologies, Inc.

Robert Lyne, JD

Chief Portfolio Officer

Former CEO at Arix Bioscience (acq. by RTW Biotech $250M); Previously at Touchstone Innovations, Bird & Bird; worked on >80 VC financings as well as multiple trade exits & IPOs.

Charles Sherwood, JD

General Counsel

Former VP, Corporate Legal Counsel at Anika Therapeutics with extensive expertise in strategic transactions, IP, product & brand marketing, financing, securities compliance.

Spencer Ball

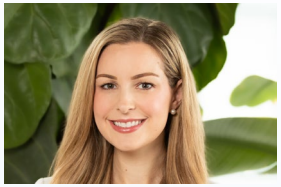
Executive VP, HR

Former Director, Talent Acquisition/Executive Search at PAREXEL International; Previously at Ball & Company, J. Robert Scott/Fidelity Investments, PAR Associates, and The Onstott Group.

Frank Salisbury

Senior VP, Commercial & Product Strategy

Held leadership roles at Acceleron, Sage Therapeutics, Genentech, and Actelion, among others; Oversaw the launch of ESBRIET (pirfenidone) for IPF in the US.



Allison Mead Talbot

Senior VP, Communications

Former leader at award-winning PR agencies, TogoRun (FleishmanHillard) & Feinstein Kean Healthcare (Ogilvy); Extensive experience in healthcare, tech, policy, and patient advocacy.

Anita Terpstra, PhD, JD

Senior VP, IP

Former Sr. Patent Counsel, and later as Associate General Counsel at Synlogic; Previously at Sigma-Aldrich, McDonnell, Boehnen, and Hulbert & Berghoff.

Luba Greenwood, JD

Entrepreneur-in-Residence

Currently serves as the Founder & Managing Partner of the Dana Farber Cancer Institute Venture Fund, Binney Street Capital (BSC) & Board of several biopharmaceutical companies; Former CEO & Chair of the Board at Kojin Therapeutics.

Sven Dethlefs, PhD

Entrepreneur-in-Residence

Former Executive Vice President & CEO at Teva North America; A pharmaceutical leader with 25+ years of experience in P&L leadership, R&D strategy, manufacturing, M&A, business transformation, capital markets, and board management.

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Our World Class Board of Directors

Our board has contributed to **regulatory approvals of over 20 drugs** and has led multi-billion-dollar strategic transactions

Sharon Barber-Lui

Interim Board Chair

CFO & Senior VP of Teva Pharma, Former CFO of Merck & Co. Inc. U.S. Oncology & Senior VP of EQRx

Robert Langer, ScD

Board

MIT, Award winning materials science pioneer, Former member of the US FDA's SCIENCE Board, Co-founder of multiple biotech companies incl. Moderna & PureTech

John LaMattina, PhD

Board

Former President of Pfizer Global R&D, Forbes Contributor

Kiran Mazumdar-Shaw

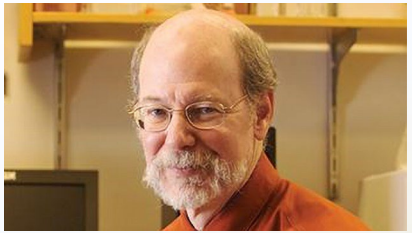
Board

Founder & Chairperson of Biocon, Board of Trustees Member at MIT, Member of National Academy of Engineering

Michele Holcomb, PhD

Board

Former EVP, Chief Strategy and Business Development Officer at Cardinal Health, SVP of Strategy, Portfolio, Search & Partnership of Teva, McKinsey & Company



Robert Horvitz, PhD

Board Observer & Chair of R&D Committee

Nobel Prize in Medicine, MIT, HHMI, neurobiologist at MGH, Former Novartis Scientific Advisory Board Member

Daphne Zohar

Senior Advisor & Board Observer

Founder & CEO of Seaport Therapeutics, BIO Board Member, Founding CEO of PureTech, Named to STAT's 2025 STATUS list, amongst other top industry recognitions

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2024 & Early 2025 Highlights

2 Successful clinical trial readouts

ELEVATE IPF STUDY

GALLOP ONCOLOGY

1 FDA approval

COBENFY™

$339.1M

PureTech Level Cash, Cash Equivalents and Short-term Investments as of March 31, 2025[1]

$397.5M

Amount of funding secured for Founded Entities[2]
(>88% came from 3rd parties)

SEAPORT THERAPEUTICS

VEDANTA BIOSCIENCES

VOR

$327.4M

Proceeds generated from Founded Entity monetization events[3]

KARUNA THERAPEUTICS™

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[1] PureTech level cash, cash equivalents and short-term investments excludes cash and cash equivalents at non-wholly owned subsidiary of $0.4m. PureTech level cash, cash equivalents and short-term investments is a non-IFRS measure;
[2] Founded Entities represent companies founded by PureTech in which PureTech maintains ownership of an equity interest and/or, in certain cases, is eligible to receive sublicense income, milestone payments and royalties on product sales. References to Founded Entities include PureTech's ownership interests in Gallop Oncology, Inc., Seaport Therapeutics, Inc., Vedanta Biosciences, Inc., Vor Bio, Inc., Entrega, Inc., Sonde Health, Inc., for all dates prior to July 2, 2024, Akili Interactive Labs, Inc., for all dates prior to March 18, 2024, Karuna Therapeutics, Inc., for all dates prior to October 30, 2023, Gelesis, Inc., for all dates prior to December 21, 2023, Follica, Incorporated, and for all dates prior to December 18, 2019, resTORbio.; [3] In 2024, we generated cash proceeds of approximately $327 million from the acquisitions of two of our Founded Entities (Karuna Therapeutics and Akili Interactive) and milestone payments related to the FDA approval of Cobenfy.

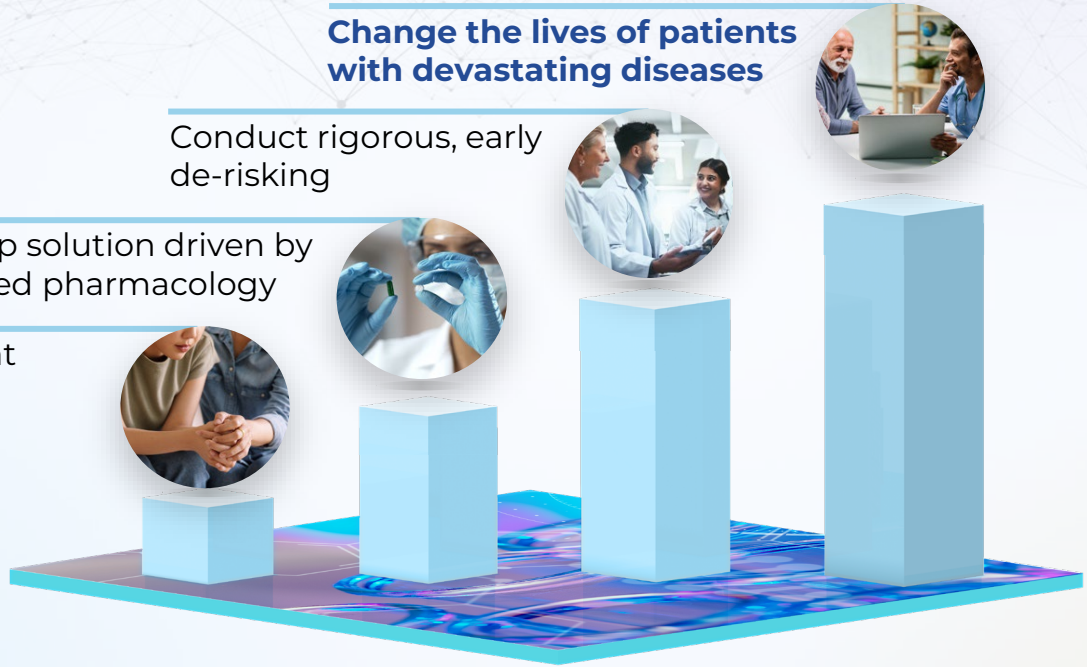
Our Innovative R&D Approach with Track Record of Success

Change the lives of patients with devastating diseases

Conduct rigorous, early de-risking

Develop solution driven by validated pharmacology

Identify significant patient need



>80%

Clinical trial success rate[1]

3

FDA Approvals

Including the most recent landmark approval of

COBENFY™

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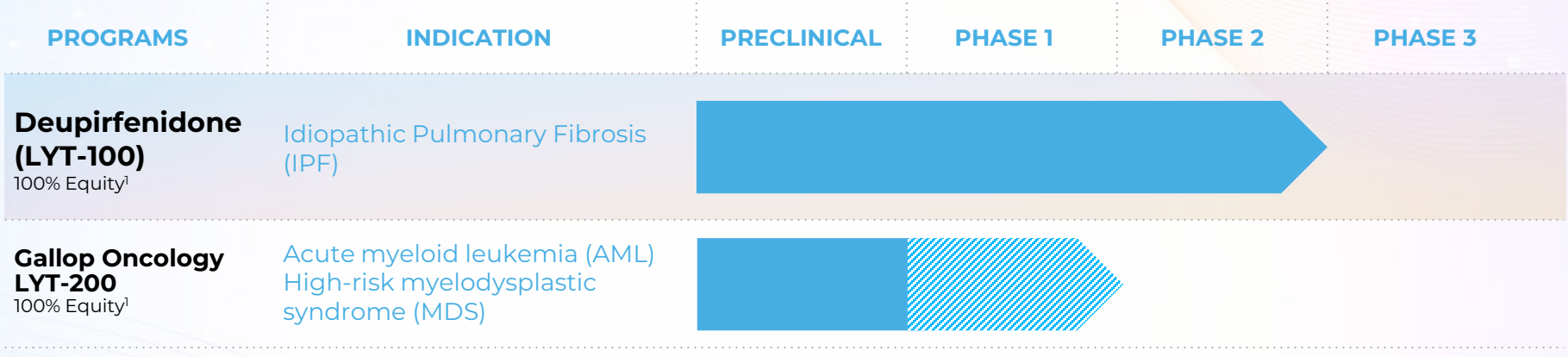
[1] The percentage includes number of successful trials out of all trials run for all therapeutic candidates advanced through at least Phase 1 by PureTech or its Founded Entities from 2009 onward.

Our Portfolio of First & Best-in-Class Medicines

Robust portfolio of new medicines balances risk with potential for tremendous growth



PURETECH-FOUNDED PROGRAMS[2]

Karuna Therapeutics[3]
Acquired by Bristol Myers Squibb for $14B

COBENFY® FDA approved for schizophrenia in adults

Seaport Therapeutics
35.6% Equity

Neuropsychiatric conditions

Vedanta
35.8% Equity

C. Difficile Ulcerative colitis

Entrega
73.8% Equity

Peptide therapeutics (e.g., GLP-1 agonists)

Sonde
34.8% Equity

Voice-based AI platform

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[1] Wholly-Owned Programs are comprised of the Company's current and future therapeutic candidates and technologies that are developed by the Company's wholly-owned subsidiaries, whether they were announced as a Founded Entity or not, and will be advanced through with either the Company's funding or non-dilutive sources of financing. As of December 31 ,2024, Wholly-Owned Programs were developed by the wholly-owned subsidiaries including PureTech LYT, Inc., PureTech LYT 100, Inc. and Gallop Oncology, Inc. and included primarily the programs deupirfenidone (LYT-100) and LYT-200.; [2] Founded Entities represent companies founded by PureTech in which PureTech maintains ownership of an equity interest and, in certain cases, is eligible to receive sublicense income and royalties on product sales. Relevant ownership interests were calculated on a partially diluted basis (as opposed to a voting basis) as of December 31, 2024, including outstanding shares, options and warrants, but excluding unallocated shares authorized to be issued pursuant to equity incentive plans. PureTech controls Gallop Oncology, Inc.; [3] As of March 22, 2023, PureTech has sold its right to receive a 3% royalty from Karuna to Royalty Pharma on net sales up to $2 billion annually, after which threshold PureTech will receive 67% of the royalty payments and Royalty Pharma will receive 33%. Additionally, under its license agreement with Karuna/BMS, PureTech retains the right to receive milestone payments upon the achievement of certain regulatory approvals. Note: Certain third-party trademarks are included here; PureTech does not claim any rights to any third-party trademarks. COBENFY™ (xanomeline and trospium chloride) is indicated for the treatment of schizophrenia in adults. For Important Safety Information, see U.S. Full Prescribing Information, including Patient Information on COBENFY.com. Following the acquisition of Karuna, KarXT is now under the stewardship of Bristol Myers Squibb and will be marketed as Cobenfy.

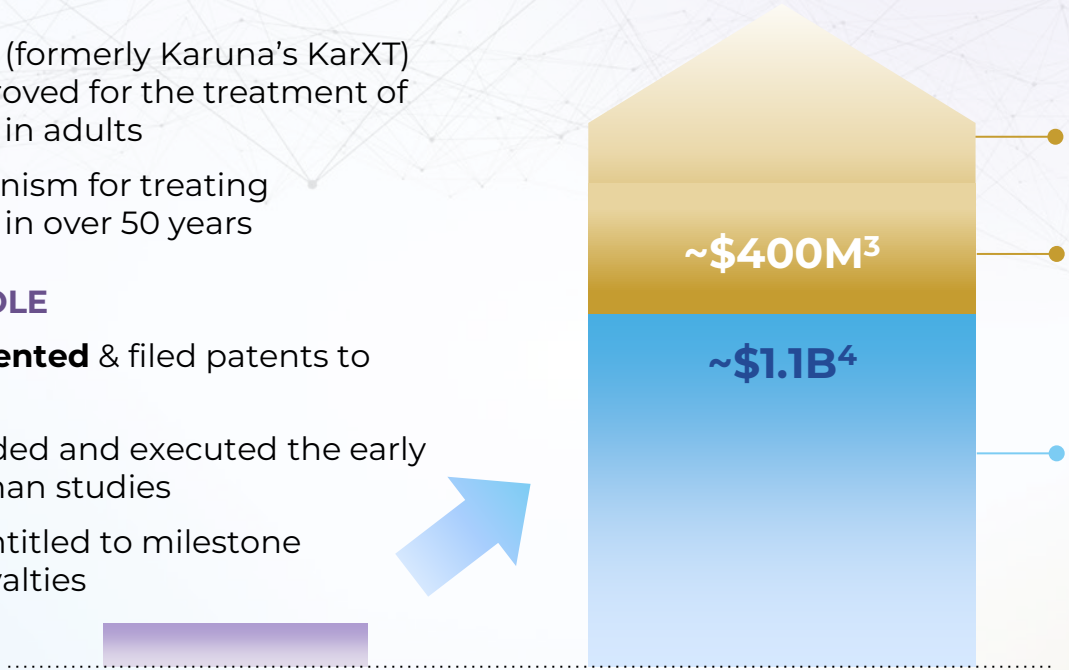
Karuna Therapeutics Case Study

A wholly owned subsidiary of Bristol Myers Squibb as of March 18, 2024

- **COBENFY**™ (formerly Karuna's KarXT) now FDA approved for the treatment of schizophrenia in adults
- 1st new mechanism for treating schizophrenia in over 50 years

PURETECH'S ROLE

- **PureTech invented** & filed patents to cover KarXT
- PureTech funded and executed the early derisking human studies
- PureTech is entitled to milestone payments/ royalties



Additional economics including milestone payments from Karuna/BMS and 2% royalty on annual sales above $2B[5]

Regulatory & commercial milestones under Royalty Pharma transaction

Cash generated to date through equity sales, milestone payments, and upfront payment from the Royalty Pharma transaction

$18.5M
Total PRTC spend[1]

~$1.5B
Potential Upside Value[2]

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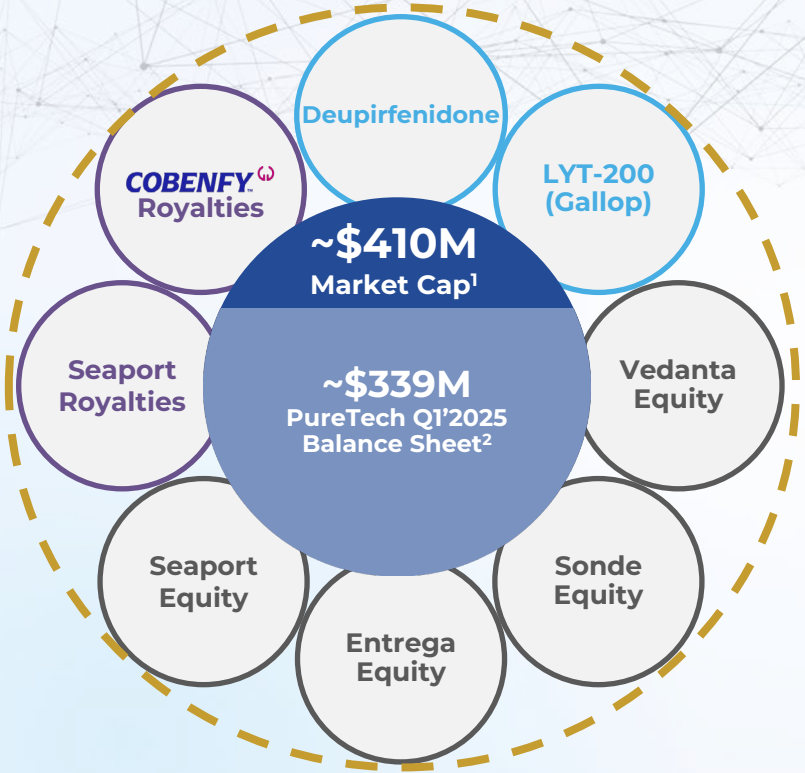
[1] Represents total PureTech principal investment in Karuna; [2] Represents the amounts described in footnote 3 plus the amounts described in footnote 4; [3] Represents the $400 million in potential milestone payments included in PureTech's transaction with Royalty Pharma. PureTech also may not receive the totality of the milestone payments under its transaction with Royalty Pharma; [4] Represents cash generated to date through sales of KRTX common stock and the $100 million in upfront consideration from PureTech's transaction with Royalty Pharma; [5] As of March 22, 2023, PureTech has sold its right to receive a 3% royalty from Karuna to Royalty Pharma on net sales up to $2 billion annually, after which threshold PureTech will receive 67% of the royalty payments and Royalty Pharma will receive 33%. Additionally, under its license agreement with Karuna/BMS, PureTech retains the right to receive milestone payments upon the achievement of certain regulatory approvals.

Significant Upside Potential Across PureTech's Portfolio

PureTech's Intrinsic Value



WHOLLY-OWNED PROGRAMS

Deupirfenidone (LYT-100): Potential new SOC for IPF in a >$10B TAM[3]

LYT-200: First-in-class monoclonal antibody for AML and other leukemias in a >$5B TAM[4]

FOUNDED ENTITIES EQUITY STAKES

Substantial equity holdings across **4 Founded Entities**

ROYALTIES, MILESTONES & SUBLICENSE INCOME

COBENFY™

- **Up to $400M** in milestone payments from Royalty Pharma
- **2% royalties** on annual sales > $2B (**up to $125M/year** based on analyst estimates of $4-11B[5] peak sales through 2033)
- Milestone payments on certain Cobenfy™ regulatory approvals

SEAPORT THERAPEUTICS

- **3-5% royalties** on Glyph product sales
- Milestone and sublicense payments
- 35.6% equity stake following >$325M raised in 2024

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SOC = Standard of care; IPF= Idiopathic pulmonary fibrosis; PPF = Progressing pulmonary fibrosis; AML = Acute myeloid leukemia; Note: Certain third-party trademarks are included here; PureTech does not claim any rights to any third-party trademarks. COBENFY™ (xanomeline and trospium chloride) is indicated for the treatment of schizophrenia in adults. For Important Safety Information, see U.S. Full Prescribing Information, including Patient Information on COBENFY.com. Following the acquisition of Karuna, KarXT is now under the stewardship of Bristol Myers Squibb and will be marketed as Cobenfy. [1] As of June 2025; [2] PureTech level cash, cash equivalents and short-term investments excludes cash and cash equivalents at non-wholly owned subsidiary of $0.4m. PureTech level cash, cash equivalents and short-term investments is a non-IFRS measure. [3] Straits Research Report, Idiopathic Pulmonary Fibrosis Market Size, Share & Trends Analysis Report By Drug Type (Nintedanib, Pirfenidone, Other Drug Types), By Mode of Action (Antifibrotic Agents, Tyrosine Kinase Inhibitors, Other Modes of Action), By End-User (Hospitals and Clinics, Pharmacies, Other end-users) and By Region (North America, Europe, APAC, Middle East and Africa, LATAM) Forecasts, 2025-2033; [4] Research and Markets; Aute Myeloid Leukemia Market Report 2025; [5] Based on various equity research as of December 31, 2024.

2025 Capital Allocation Overview

Our hub-and-spoke model enables self-funding operation & disciplined capital allocation

SOURCE OF CAPITAL

WHOLLY-OWNED PROGRAMS[1]

Deupirfenidone (LYT-100) (Phase 3 Ready)

- Exploring various financing mechanisms to support funding the Phase 3 trial (e.g., spin-out, project/royalty-based financing, strategic partnerships)
- PureTech will continue to fund the program in the interim

LYT-200 (Phase 1b ongoing)

- Pursuing external financing; PureTech will continue to fund the program in the interim

FOUNDED ENTITIES[2]

- Continued support for Founded Entities to the extent helpful with their financing, as well as to maintain certain equity ownership

NEW INNOVATIONS

- Initial expenditures on any new innovation/sourcing to be relatively low

OPERATIONAL & TAX EXPENSES

- Continued public company operating expense & US tax obligations

Additionally, potential capital returns to maximize shareholder value

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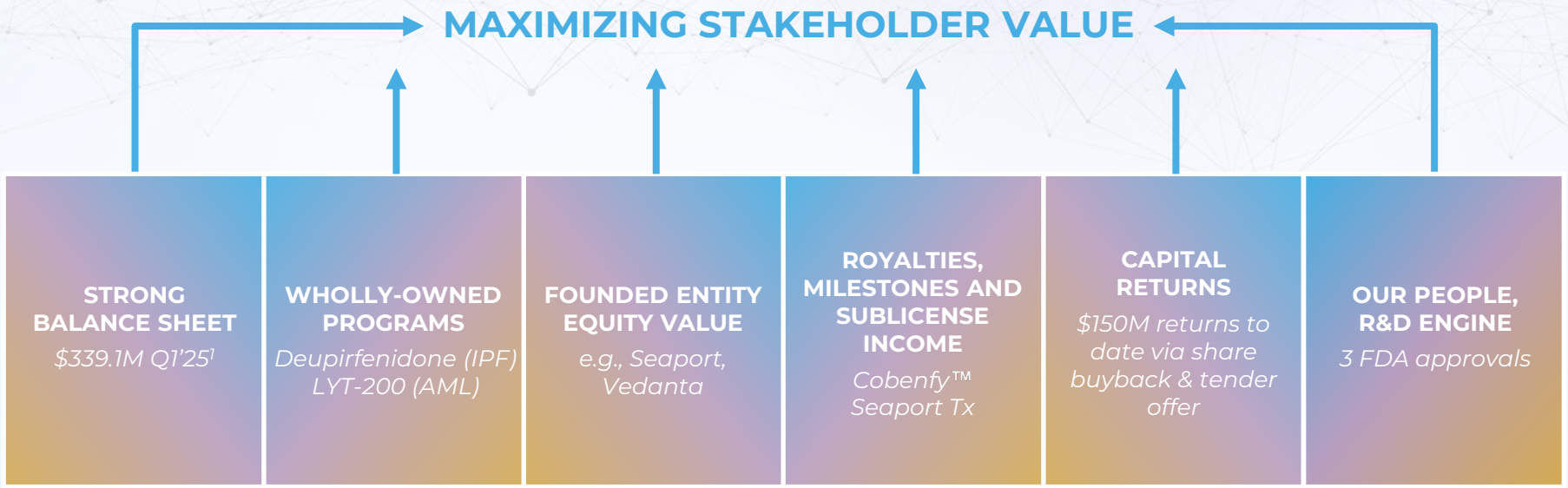
Our Key Components of Value



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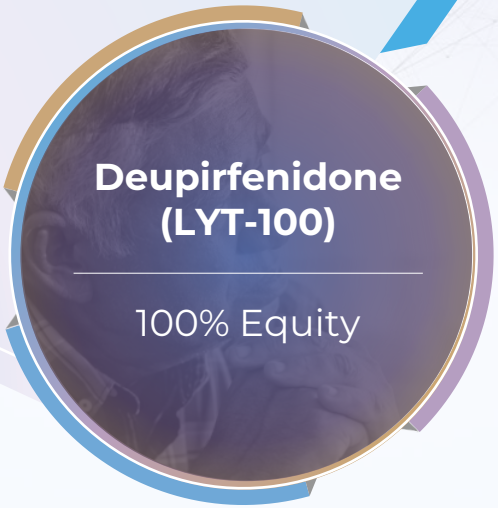
Wholly-Owned Program



Successful completion of Phase 2b ELEVATE IPF trial

Initiation of Phase 3 trial by YE 2025

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Deupirfenidone (LYT-100): Potential New Standard-of-care (SOC) for IPF and other PPFs

Lung Disease with High Patient Need	**Debilitating, fatal disease;** current SOC agents **cannot be taken in high doses due to poor tolerability,** resulting in **suboptimal efficacy**
Ideal Treatment Goal in IPF	**Stabilization of lung function without compromising on safety and tolerability**
Robust Deupirfenidone Data	Potential to set a new standard for IPF treatment: Phase 2b study **showed dose dependent lung function stabilization** with a **favorable tolerability profile**
Significant Commercial Opportunity	**Blockbuster potential** in a **multi-billion dollar market**
Strong Intellectual Property (IP)	**Broad and layered IP protection** with **exclusivities into at least 2043**[1]

Initiation of pivotal Phase 3 trial expected by the end of 2025

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SOC = standard-of-care; IPF = idiopathic pulmonary fibrosis; PPF = progressive pulmonary fibrosis
[1] Independent of possible adjustments or extensions.

Unmet Needs in IPF

Idiopathic Pulmonary Fibrosis (IPF) Overview

IPF is a **progressive and fatal disease** with a **significantly unaddressed** patient population

>232,000

IPF patients in the US & EU5[1]

Involves scarring of the lungs, leading to shortness of breath and loss of lung function[2]

~2-5 years

Life expectancy of IPF ***without treatment***[3]

Two

FDA-approved agents to treat IPF[4]

For most patients, tolerability challenges outweigh suboptimal efficacy

~25%

IPF patients ever start antifibrotic treatment

...of which >40% eventually discontinue[5]

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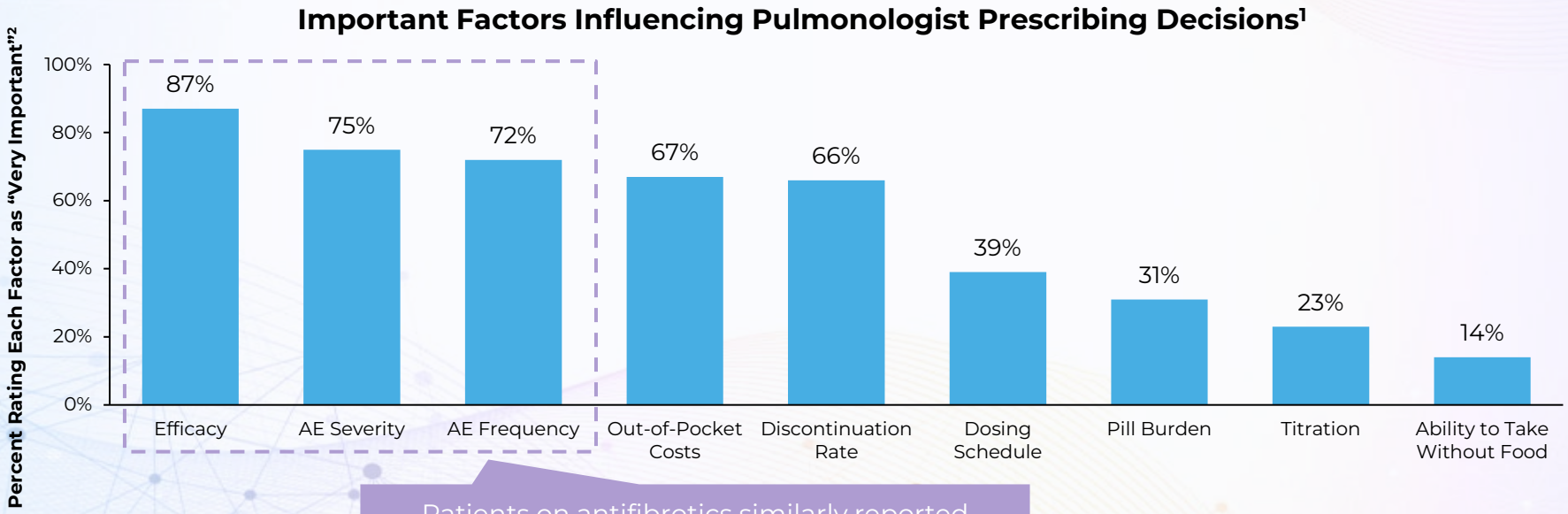
[1] GlobalData Epidemiology and Market Size Search, EU5=United Kingdom, France, Germany, Italy and Spain; [2] Barratt SL, Creamer A, Hayton C, Chaudhuri N. Idiopathic Pulmonary Fibrosis (IPF): An Overview. J Clin Med. 2018 Aug 6;7(8):201; [3] Fisher, M., Nathan, S. D., Hill, C., Marshall, J., Dejonckheere, F., Thuresson, P., & Maher, T. M. (2017). Predicting Life Expectancy for Pirfenidone in Idiopathic Pulmonary Fibrosis. Journal of Managed Care & Specialty Pharmacy, 23(3-b Suppl), S17–S24. https://doi.org/10.18553/jmcp.2017.23.3-b.s17; [4] ESBRIET (pirfenidone) and OFEV (nintedanib) were approved in 2014; [5] Dempsey TM, Payne S, Sangaralingham L, Yao X, Shah ND, Limper AH. Adoption of the Antifibrotic Medications Pirfenidone and Nintedanib for Patients with Idiopathic Pulmonary Fibrosis. Ann Am Thorac Soc. 2021 Jul;18(7):1121-1128.

Pulmonologists Ranked Efficacy as the Top Driver for Prescribing Decisions in IPF, Followed By Tolerability

Balancing efficacy with tolerability is key to achieving improved disease management



Patients on antifibrotics similarly reported efficacy and GI side effects as the top reasons for selecting one treatment over another[3]

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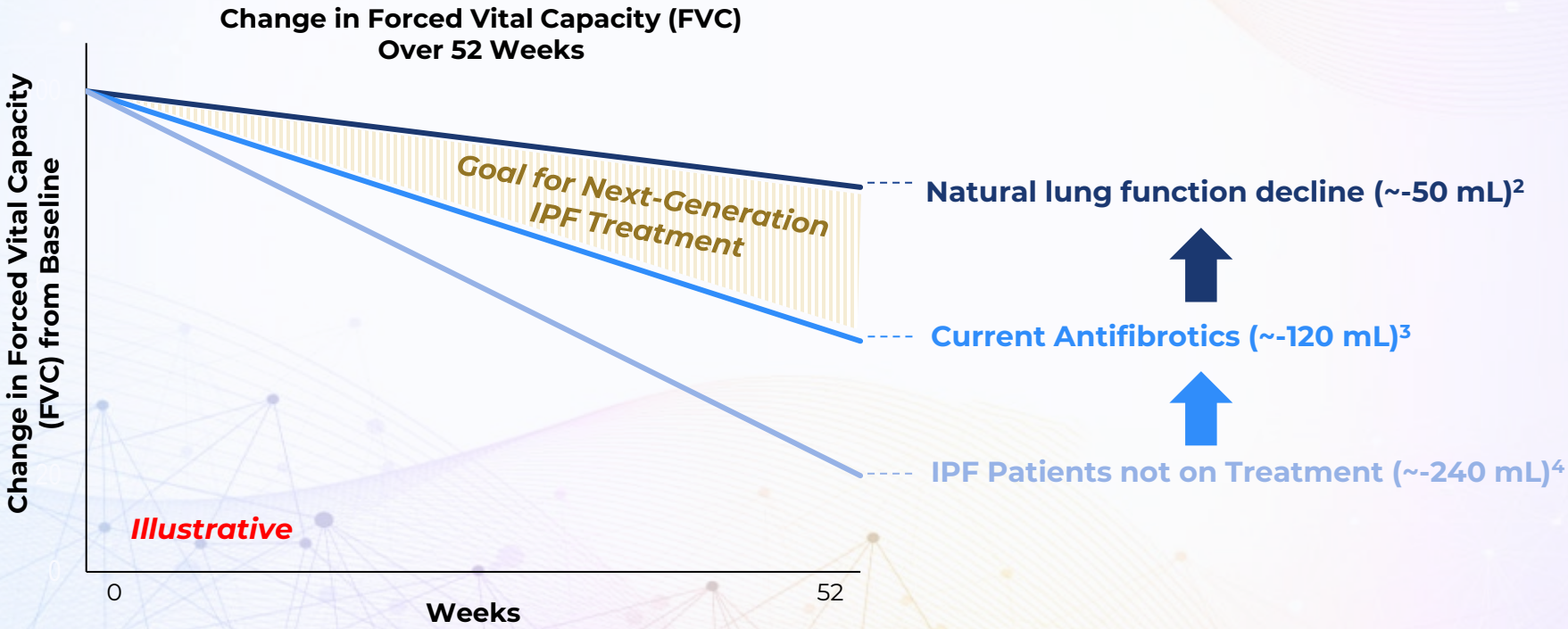
[1]Market research quantitative survey of 100 US pulmonologists conducted by Day & Associates. Research completed in September 2020. [2]Based on ratings from a 7-point scale (1 = Not at all important, 7 = Very important); [3]Market research quantitative survey of 90 participants with IPF conducted by Sago. Research completed in April 2024. AE = adverse event

Stabilization of Lung Function is the Ideal Treatment Goal in IPF

Pulmonologists and patients seek improved efficacy without sacrificing tolerability[1]



[1] Per market research survey of 50 pulmonologists conducted by Day & Associates. No pricing information/assumptions was shared. Research completed in October 2024 based on hypothetical product profiles using the results of the Phase 1 healthy older adult crossover study; [2]Per Valenzuela. Boehringer Ingelheim. ERS 2024 and Luoto. Eur Respir J. 2019. [3] Based on pirfenidone and nintedanib's pivotal studies. [4]Raman, Lavanya et al. "Nintedanib for non-IPF progressive pulmonary fibrosis: 12-month outcome data from a real-world multicentre observational study." ERJ open research vol. 9,2 00423-2022. 20 Mar. 2023, doi:10.1183/23120541.00423-2022.

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IPF Patients Need Better Treatment Options

Current standard-of-care treatments offer suboptimal efficacy with tolerability challenges

CHALLENGES WITH CURRENT SOC TREATMENTS

✗ SUBOPTIMAL EFFICACY

Current treatments only modestly slow lung function decline (by ~50%) and **do not stabilize lung function**

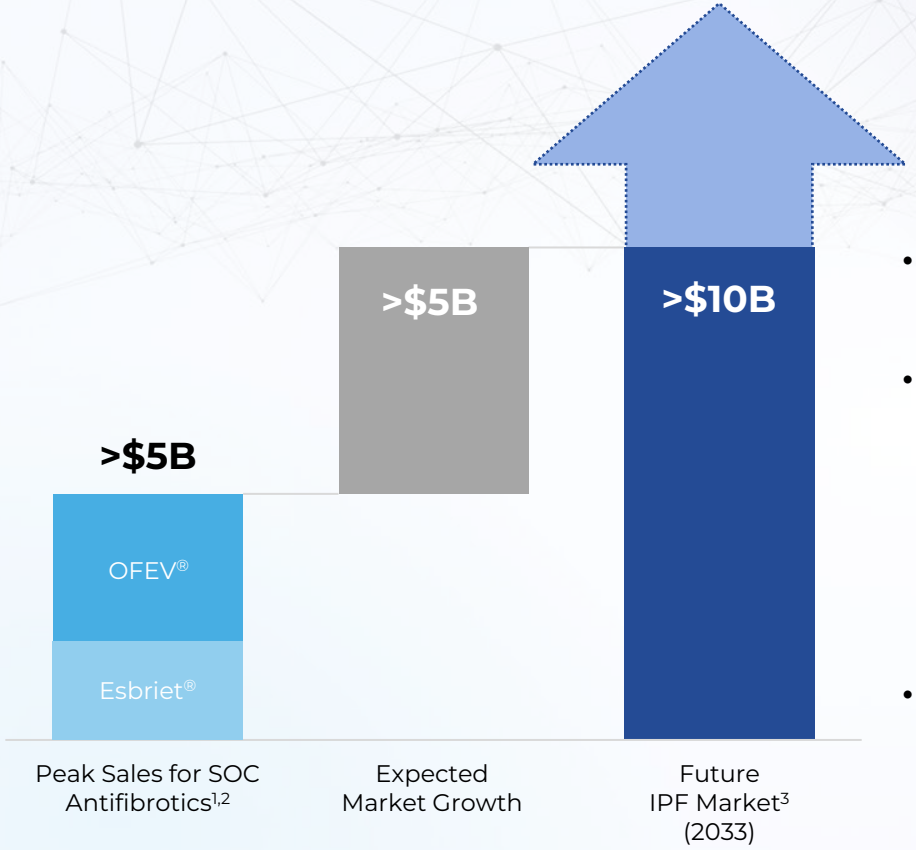
✗ POOR TOLERABILITY

For most patients and providers, **tolerability challenges outweigh suboptimal efficacy**

DEUPIRFENIDONE POTENTIAL

- ✓ **Potential to serve as a new standard-of-care treatment**
- ✓ **Lung function stabilization**
- ✓ **Favorable tolerability**

IPF Market Has the Potential for Substantial Market Growth



Global IPF Market:

- Despite **only ~25%** of IPF patients ever starting therapy[4], SOC agents have achieved blockbuster status
- Expected market growth in coming years is driven by:
  1) **Increased patient uptake & adherence** via the development of more efficacious and better tolerated therapies
  2) **Increased disease awareness / diagnosis**
- Beyond IPF, deupirfenidone has the potential to capture **additional markets** with expansion into non-IPF PF-ILDs

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Note: Certain third-party trademarks are included here; PureTech does not claim any rights to any third-party trademarks.. IPF = Idiopathic pulmonary fibrosis; SOC = Standard of care; PF-ILD = Progressive Fibrosing Interstitial Lung Disease. [1] Boehringer Ingelheim 2024 Financial Results. Ofev peak sales (2024) include those for all approved indications – IPF, PF-ILD, and systemic sclerosis-associated interstitial lung disease (SSc-ILD). [2] Roche 2021 Financial Results. Esbriet peak sales (2020). [3] Straits Research Report, Idiopathic Pulmonary Fibrosis Market Size, Share & Trends Analysis Report By Drug Type (Nintedanib, Pirfenidone, Other Drug Types), By Mode of Action (Antifibrotic Agents, Tyrosine Kinase Inhibitors, Other Modes of Action), By End-User (Hospitals and Clinics, Pharmacies, Other end-users) and By Region (North America, Europe, APAC, Middle East and Africa, LATAM) Forecasts, 2025-2033; [4] Dempsey TM, Payne S, Sangaralingham L, Yao X, Shah ND, Limper AH. Adoption of the Antifibrotic Medications Pirfenidone and Nintedanib for Patients with Idiopathic Pulmonary Fibrosis. Ann Am Thorac Soc. 2021 Jul;18(7):1121-1128.

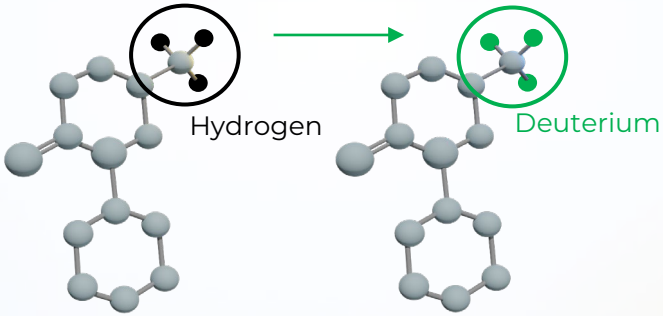
Introduction to Deupirfenidone

Deupirfenidone Enables Greater Drug Exposure Relative to Pirfenidone, Driving Improved Efficacy and Favorable Tolerability

PIRFENIDONE

- Clinically validated efficacy
- Higher exposure, and potentially greater efficacy, limited by tolerability

VS



DEUPIRFENIDONE

- Strategically replaced hydrogen with deuterium (heavy hydrogen) at site of metabolism
- Enhances the beneficial pharmacology and clinically-validated efficacy of pirfenidone with a favorable tolerability profile

Deupirfenidone Phase 1 Studies Established the Exposure of the Two Doses, 550 mg TID and 825 mg TID, Chosen for the Phase 2b Trial

KEY FINDINGS FROM PHASE 1 STUDIES[1]

- Deupirfenidone 550 mg TID had an AUC was **~13% lower** than pirfenidone 801 mg TID[1]
- Deupirfenidone 824 mg[2] TID had an AUC that was **43% higher** than deupirfenidone 550 mg TID
- Based on the above, deupirfenidone 550mg TID & 825mg TID were chosen to be studied in the Phase 2b ELEVATE trial where the 825mg TID dose demonstrated superior efficacy with a favorable tolerability profile

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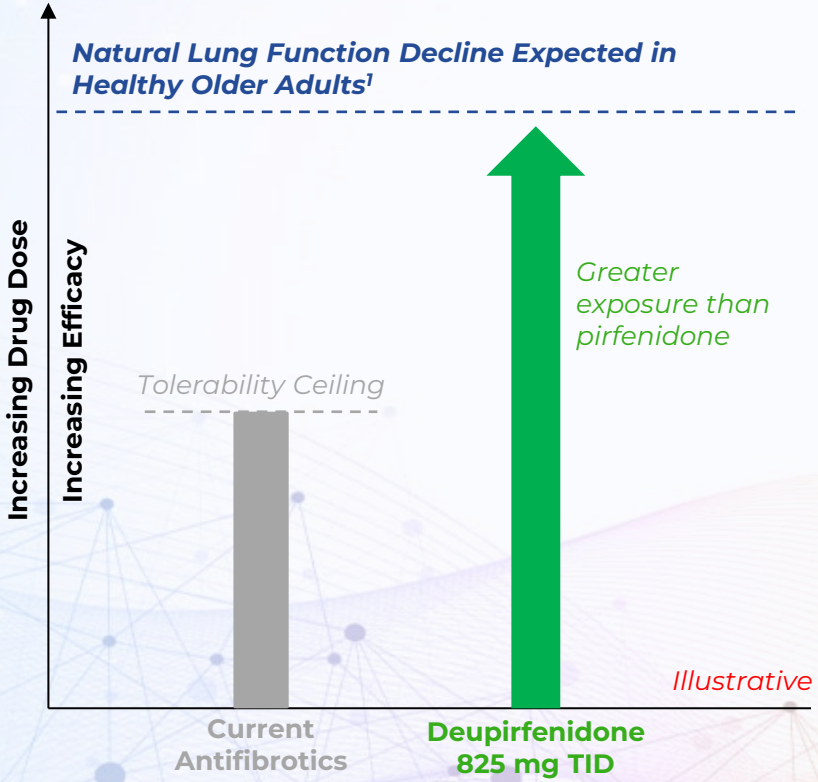
TID = three times a day; AUC = Area Under the Curve
[1]Toby M. Maher, Michael C. Chen, Chris C. Korth, Eric Elenko, Mark D. Harnett, Varun Garg, Camilla S. Graham, Wassim H. Fares, Julie Krop (2023), Deupirfenidone (LYT-100) dose-selection rationale for a Phase 2b idiopathic pulmonary fibrosis study — ELEVATE IPF; [2] Deupirfenidone 824 mg TID was used in PureTech's Phase 1 studies, whereas deupirfenidone 825 mg TID was used in PureTech's Phase 2b study.

Dose-limiting Tolerability Challenges Have Prevented Patients on SOC from Achieving Greater Efficacy



Commonly Reported Side Effects with Use of Current Antifibrotics*	Pirfenidone Label[2] (N=623)	Nintedanib Label[3] (N=723)
Nausea	36%	24%
Rash	30%	Not reported
URTI	27%	7%
Diarrhea	26%	62%
Fatigue	26%	<5%
Abdominal Pain	24%	15%
Liver enzyme elevation	<5%	14%
Vomiting	26%	12%

**Select, non-exhaustive list*

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[1]Per Valenzuela. Boehringer Ingelheim. ERS 2024 and Luoto. Eur Respir J. 2019; [2]Side effects for prifenidone reported in 3 randomized, double-blind, placebo-controlled trials (ASCEND, CAPACITY 004, and CAPACITY 006) in which a total of 623 patients received 2403 mg/day of pirfenidone; [3]Side effects for nintedanib reported in 3 randomized, double-blind, placebo-controlled trials in which a total of 723 patients received 150 mg/twice/day of nintedanib. URTI = upper respiratory tract infection

Deupirfenidone Hypothesis: Enable Higher Dose Exposure

Deuteration will enable higher dose exposure, in pursuit of better efficacy, with favorable tolerability

Deupirfenidone 825 mg TID arm demonstrates **improved efficacy** relative to pirfenidone, with favorable tolerability

Patients can tolerate **higher drug exposure** and **retain more lung function**

Potentially achieve **better patient outcomes without compromising tolerability**

ELEVATE Clinical Data

Key Takeaways from Successful Phase 2b ELEVATE IPF Trial

Deupirfenidone slowed lung function decline in people with IPF; achieved primary & key secondary endpoints

- **POTENTIAL FOR LUNG FUNCTION STABILIZATION**
  Deupirfenidone 825 mg TID achieved -21.5 mL decline in lung function as a monotherapy, approaching natural 6-month lung function decline (~-15 to ~-25 mL[1]) expected in healthy adults >60 years old
- **ENHANCED EFFICACY**
  Deupirfenidone 825 mg TID demonstrated strong, consistent and durable efficacy with ~50% greater treatment effect (80.9%) than pirfenidone (54.1%) vs placebo
- **DOSE-DEPENDENT RESPONSE**
  Both doses of deupirfenidone (550 mg TID[2] & 825 mg TID) successfully demonstrated dose-dependent response
- **FAVORABLE TOLERABILITY**
  Both doses of deupirfenidone demonstrated favorable tolerability

Data support potential for deupirfenidone to deliver improved efficacy vs current standard-of-care treatment for IPF

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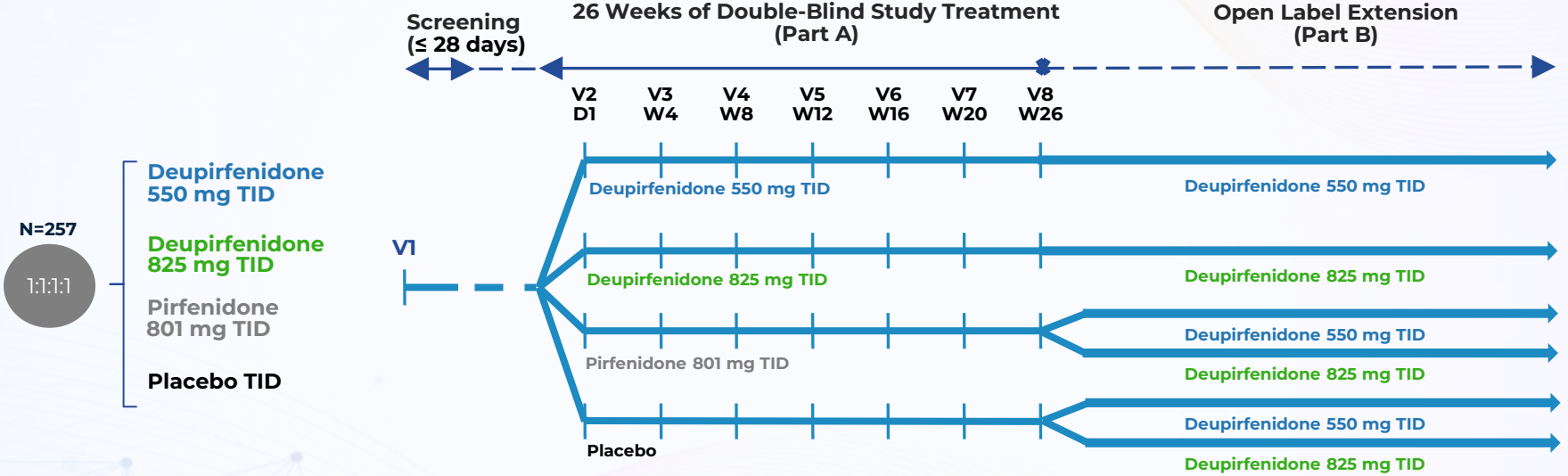
[1] FVC decline at 6 months was estimated assuming linear decline over time. Valenzuela, C., Bonella, F., Moor, C., Weimann, G., Miede, C., Stowasser, S., Maher, T. (2024). Decline in forced vital capacity (FVC) in subjects with idiopathic pulmonary fibrosis (IPF) and progressive pulmonary fibrosis (PPF) compared with healthy references. Poster presented at the European Respiratory Society International Congress, Vienna, Austria; and Luoto, J., Pihlsgård, M., Wollmer, P., & Elmståhl, S. (2019). Relative and absolute lung function change in a general population aged 60-102 years. The European Respiratory Journal, 53(3), 1701812. https://doi.org/10.1183/13993003.01812-2017; [2] Approximately equivalent exposure to pirfenidone 801 mg TID (Reference: Maher, T., Chen, M., Korth, C., Elenko, E., Harnett, M., Garg, V., Graham, C., Fares, W., Krop, J. (2023). Deupirfenidone dose-selection rationale for a Phase 2b idiopathic pulmonary fibrosis study — ELEVATE IPF. Poster presented at the CHEST Annual Meeting, Honolulu, HI).

ELEVATE: Global, Phase 2b, Multicenter, Randomized, Double-blind Clinical Trial



Primary Endpoint
(pooled deupirfenidone arms)

Rate of decline in FVC over 26 weeks

Key Secondary Endpoint
(pooled deupirfenidone arms)

Change in FVC percent predicted from baseline to Week 26

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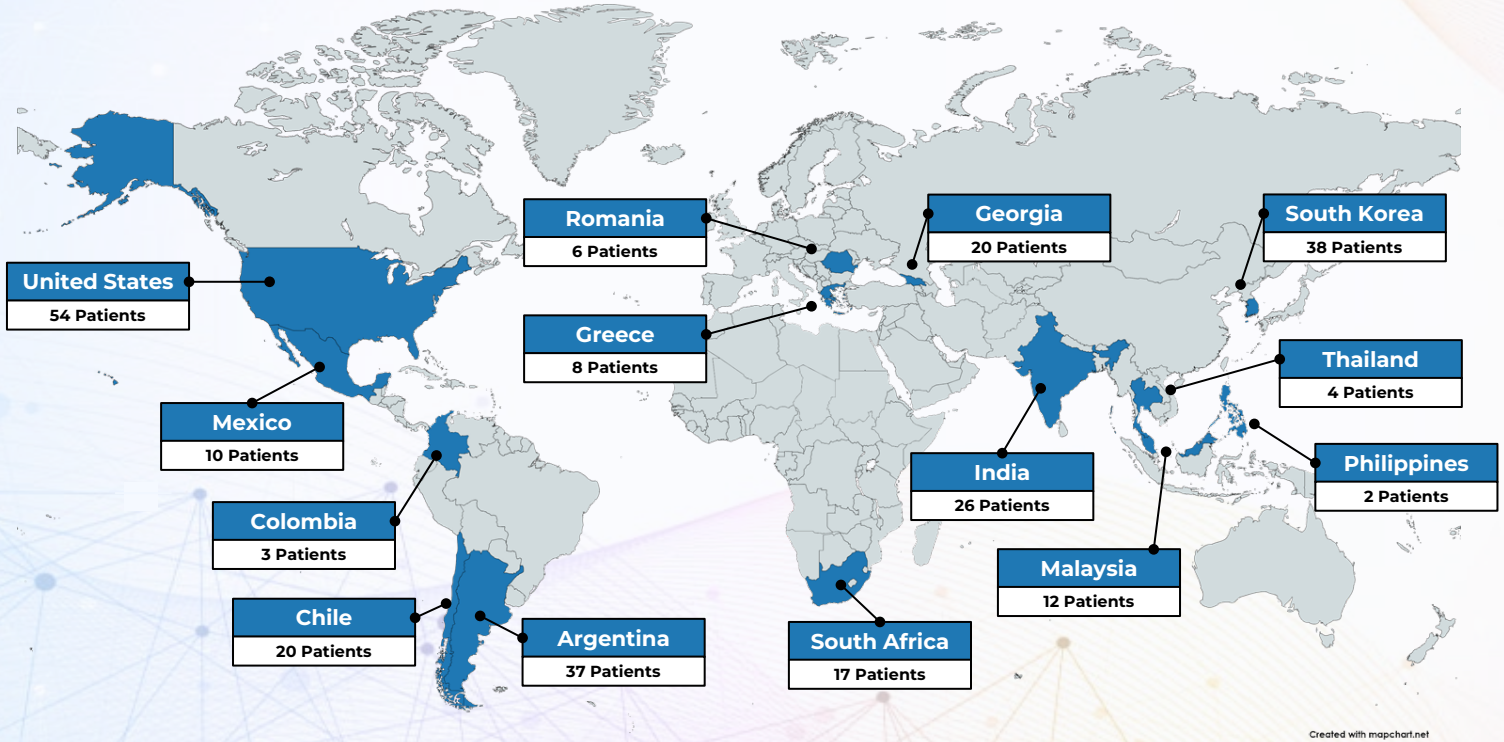
FVC = Forced Vital Capacity; TID = three times a day
Note: Patients in all arms were permitted to decrease and re-increase their assigned dose as tolerated

ELEVATE: Global, Phase 2b, Multicenter, Randomized, Double-blind Clinical Trial

257 patients were recruited from 87 sites across 14 countries



KEY DEMOGRAPHIC STATISTICS

- Median age: 72 years, 13.6% ≥ 80 years
- 71.2% Male, 28.8% Female
- 63% White or Caucasian, 33.5% Asian, 1.6% Black or African American, 1.9% Other
- 26.1% Hispanic or Latino

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Overview of ELEVATE Statistical Approach

Commonly used Bayesian[1] and frequentist analyses were applied

BAYESIAN STATISTICS

Used for Primary and Key Secondary Endpoints

FREQUENTIST ANALYSIS

Used for Primary and Key Secondary Endpoints

- We obtained FVC data per patient over time, commonly referred to as observed data
- Observed data doesn't account for missing data due to variety of reasons (e.g., drop-outs, missed visits, etc.)
- The gold standard is to use population-level models, such as mixed models for repeated measures (MMRM), that account for missing data
- The FDA mandates accounting for missing data in efficacy analyses

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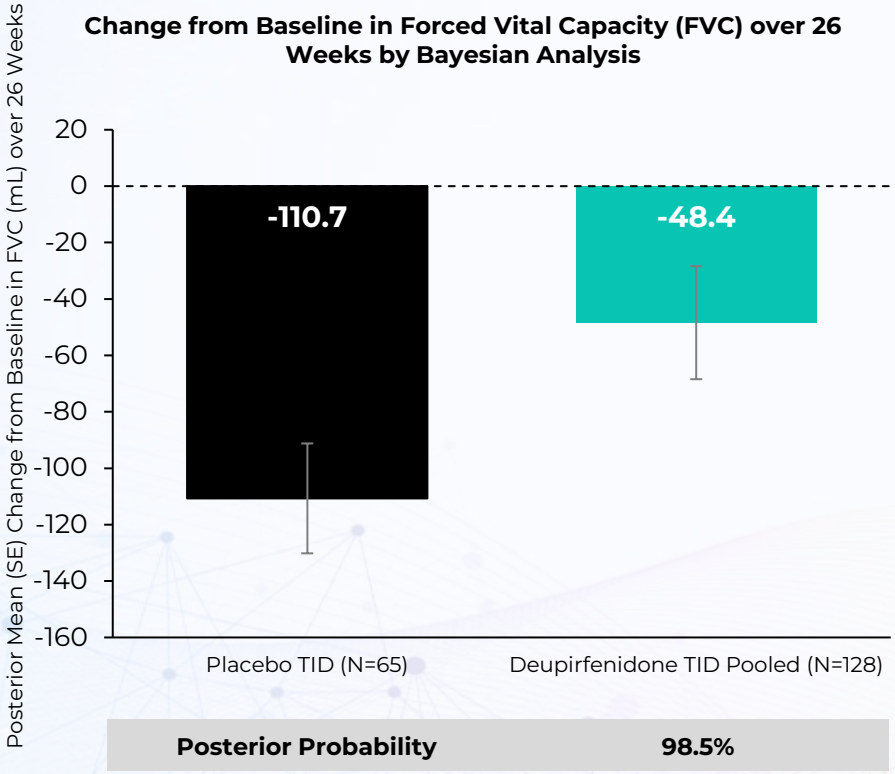
[1] Bayesian is a method that has been used by large pharmaceutical companies in the IPF space. The FDA has also acknowledged the benefits of this approach.
Efficacy analyses used a random coefficient regression model with absolute FVC or FVCpp including baseline as response variable and week, treatment and interaction between week and treatment as fixed effect. The analyses were performed based on the predefined Full Analysis Set. FVC = forced vital capacity

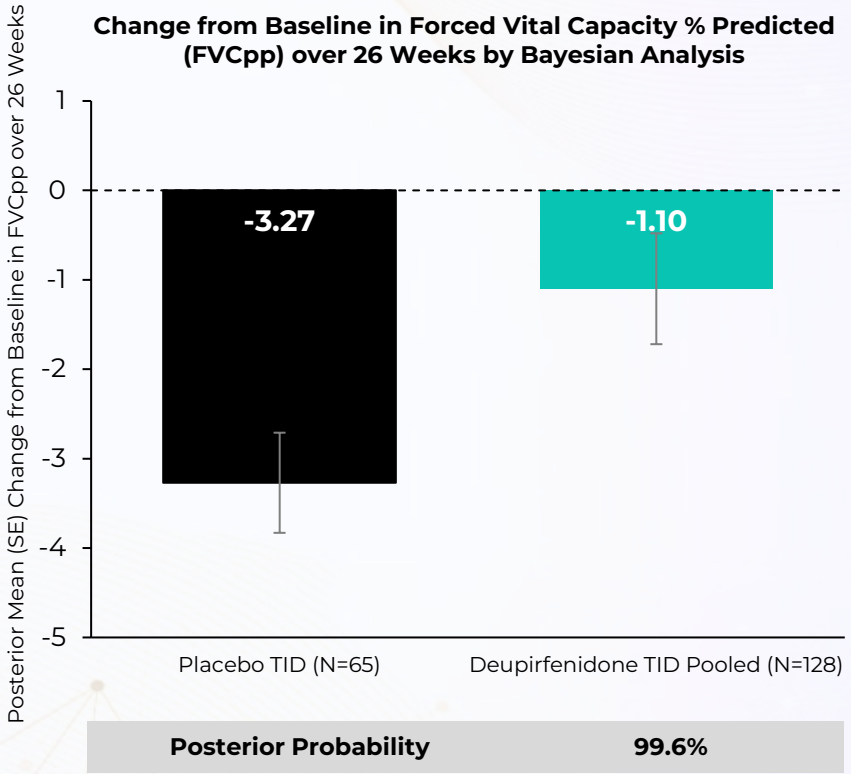
ELEVATE Achieved Primary and Key Secondary Endpoints

Change from Baseline in Forced Vital Capacity (FVC) over 26 Weeks by Bayesian Analysis



Posterior Probability	98.5%

Change from Baseline in Forced Vital Capacity % Predicted (FVCpp) over 26 Weeks by Bayesian Analysis



Posterior Probability	99.6%

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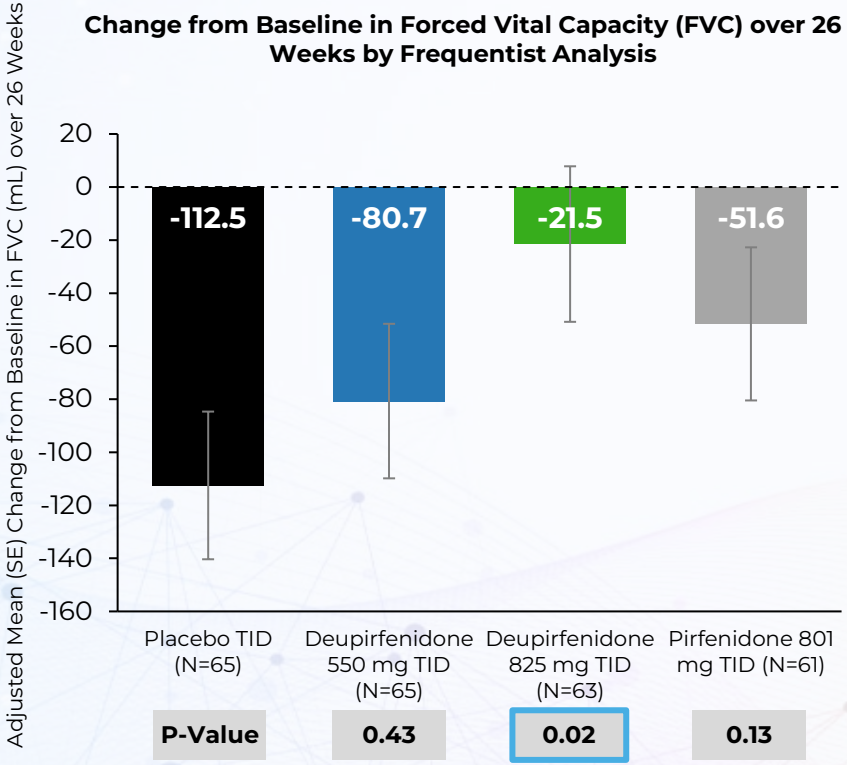
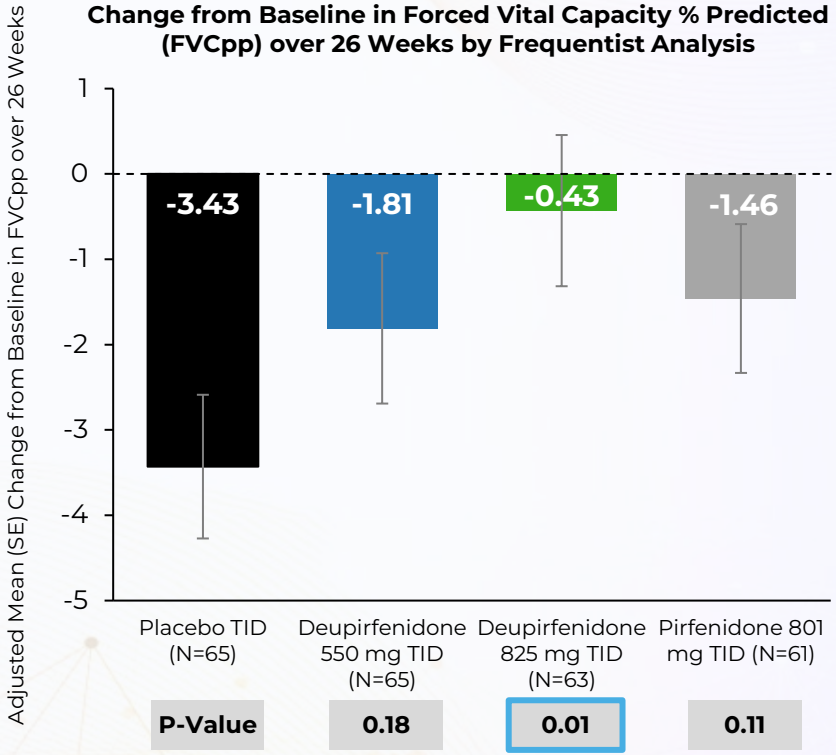
Efficacy analyses used a random coefficient regression model with absolute FVC or FVCpp including baseline as response variable and week, treatment (placebo, pirfenidone, deupirfenidone pooled arm) and interaction between week and treatment as fixed effect. The analyses were performed based on the predefined Full Analysis Set; Change from baseline FVC is not adjusted for patient characteristics such as height, age, race, or sex. TID = 3 times per day

Deupirfenidone Demonstrated Potential to Serve as a New Standard-of-Care Treatment for IPF

Change from Baseline in Forced Vital Capacity (FVC) over 26 Weeks by Frequentist Analysis



Change from Baseline in Forced Vital Capacity % Predicted (FVCpp) over 26 Weeks by Frequentist Analysis



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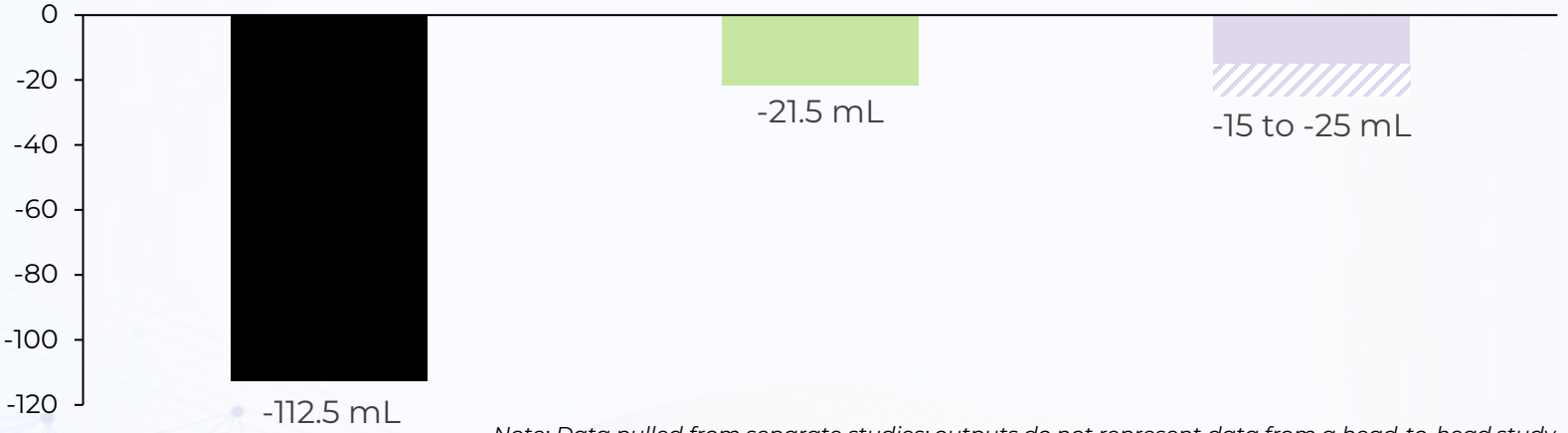
Efficacy analyses used a random coefficient regression model with absolute FVC or FVCpp including baseline as response variable and week, treatment and interaction between week and treatment as fixed effect. The analyses were performed based on the predefined Full Analysis Set. p values are two-sided and have not been corrected for multiplicity. Note: Change from baseline FVC is not adjusted for patient characteristics such as height, age, race, or sex.
TID = 3 times per day

Statistically Significant

Deupirfenidone 825 mg TID Significantly Slowed Decline and Stabilized Lung Function

FVC decline for deupirfenidone 825 mg TID at 26 weeks in ELEVATE approached the level of natural decline expected in healthy adults

Change from Baseline in Forced Vital Capacity (FVC) Over 26 Weeks (mL)



Note: Data pulled from separate studies; outputs do not represent data from a head-to-head study

Placebo	**Deupirfenidone**	Healthy Older Adults
ELEVATE Trial: IPF patients on placebo[1]	**ELEVATE Trial:** **IPF patients on deupirfenidone 825 mg TID[1]**	Healthy adults >60 years old[2]

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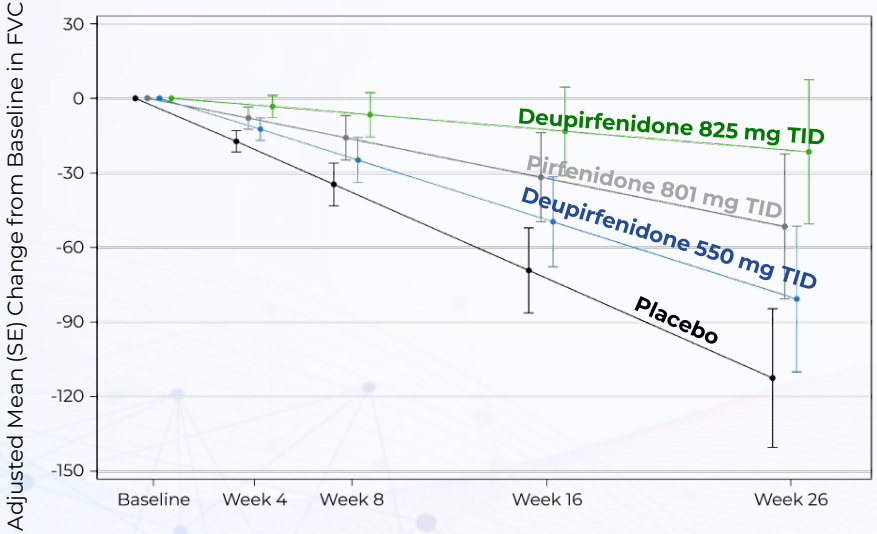
[1] Reflects outputs obtained via frequentist analysis; [2]Per Valenzuela. Boehringer Ingelheim. ERS 2024 and Luoto. Eur Respir J. 2019 (6-month decline in general population aged 60-102 years, estimated by taking reported 1-year decline and dividing by 2). Change from baseline FVC is not adjusted for patient characteristics such as height, age, race, or sex.

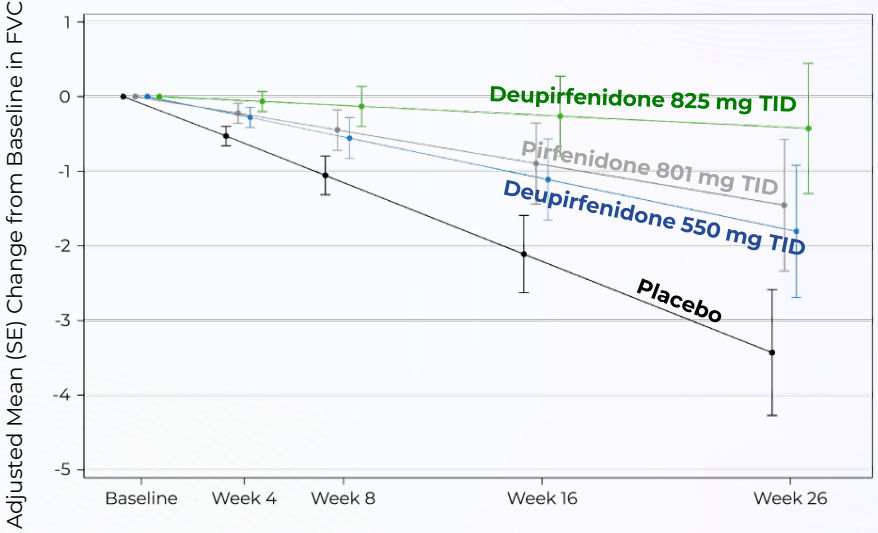
Deupirfenidone Demonstrated a Clear Dose-dependent Effect

Change from baseline in FVC and FVCpp (Mixed Model Repeated Measure with Random Slope Regression)

Adjusted Mean (SE) Change from Baseline in Forced Vital Capacity (FVC) Over Time by Frequentist Analysis



Adjusted Mean (SE) Change from Baseline in Forced Vital Capacity % Predicted (FVCpp) Over Time by Frequentist Analysis



Placebo TID | Pirfenidone 801 mg TID | Deupirfenidone 550 mg TID | Deupirfenidone 825 mg TID

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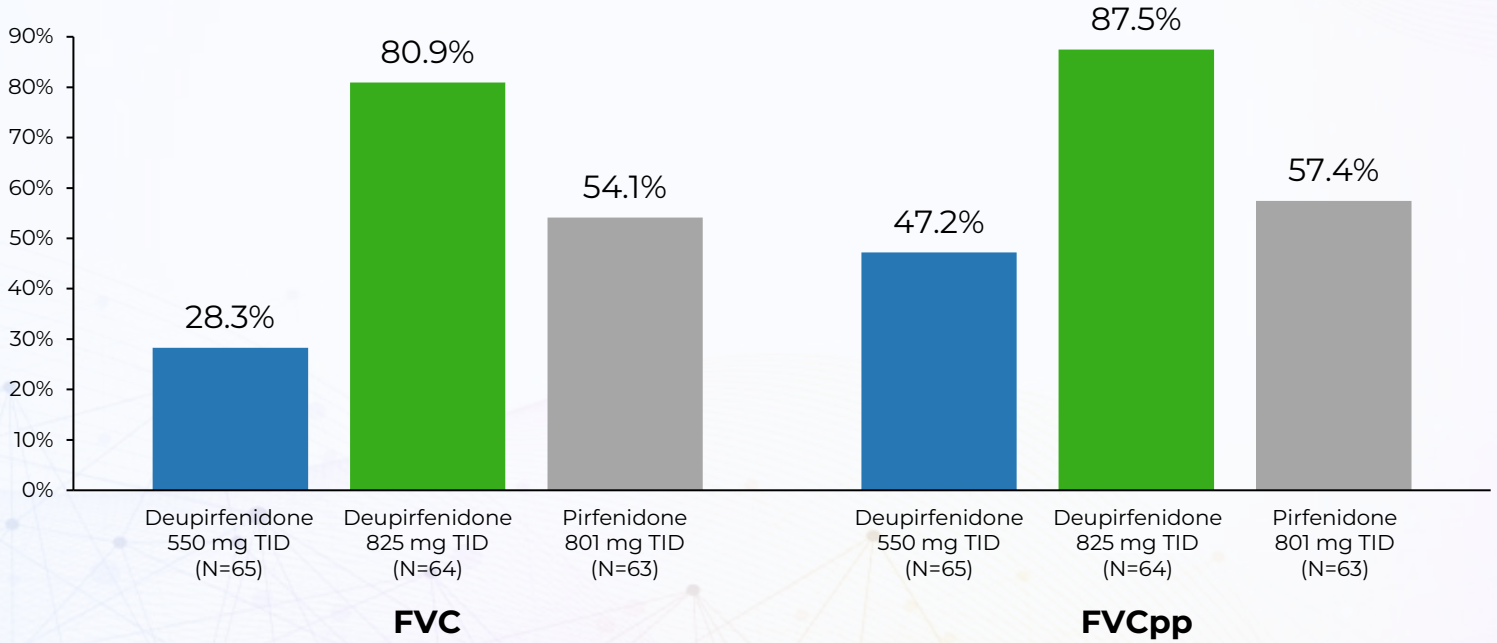
Efficacy analysis is based on pre-defined Full Analysis Set using a random coefficient regression model with absolute FVC as a response, including baseline. MMRM = mixed model for repeated measure; SE = standard error; TID = 3 times per day. Baseline is defined as the last available measurement performed before the first study drug administration in Part A. Adjusted mean (SE) by frequentist analysis is estimated based on a random coefficient regression model with absolute FVC over time, including baseline, as a response, and fixed effects for treatment(placebo, pirfenidone, deupirfenidone 550 mg or deupirfenidone 825 mg), visit (week), and treatment by visit interaction, as well as participant-level random effects for the intercept and slope.

Versus Placebo, Deupirfenidone 825 mg TID Had ~50% Greater Effect Size than Pirfenidone in ELEVATE Trial

Treatment Effect from Change in Forced Vital Capacity (FVC) and Percent Predicted Forced Vital Capacity (FVCpp) Across Arms



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Change from baseline FVC is not adjusted for patient characteristics such as height, age, race, or sex

Deupirfenidone Had Favorable Tolerability in ELEVATE Trial

Meaningful reduction in key GI-related adverse events

Key Predefined Gastrointestinal AEs from ELEVATE Study	Placebo TID (N=65) n (%)	Pirfenidone 801 mg TID (N=63) n (%)	Deupirfenidone 550 mg TID (N=65) n (%)	Deupirfenidone 825 mg TID (N=64) n (%)
Nausea	5 (7.7)	17 (27.0)	**11 (16.9)**	**13 (20.3)**
Dyspepsia	2 (3.1)	14 (22.2)	**8 (12.3)**	**9 (14.1)**
Diarrhea	6 (9.2)	7 (11.1)	7 (10.8)	**5 (7.8)**
Abdominal pain[1]	3 (4.6)	5 (7.9)	4 (6.2)	9 (14.1)
Constipation	1 (1.5)	4 (6.3)	**1 (1.5)**	3 (4.7)
Vomiting	0 (0)	2 (3.2)	5 (7.7)	**1 (1.6)**

BOLD: Met our pre-defined safety threshold relative to pirfenidone 801 mg TID arm, per market research and KOL feedback (25% less than the proportion of patients reporting in the pirfenidone arm)

Key GI AEs were predefined prior to unblinding data, based on market research and KOL feedback

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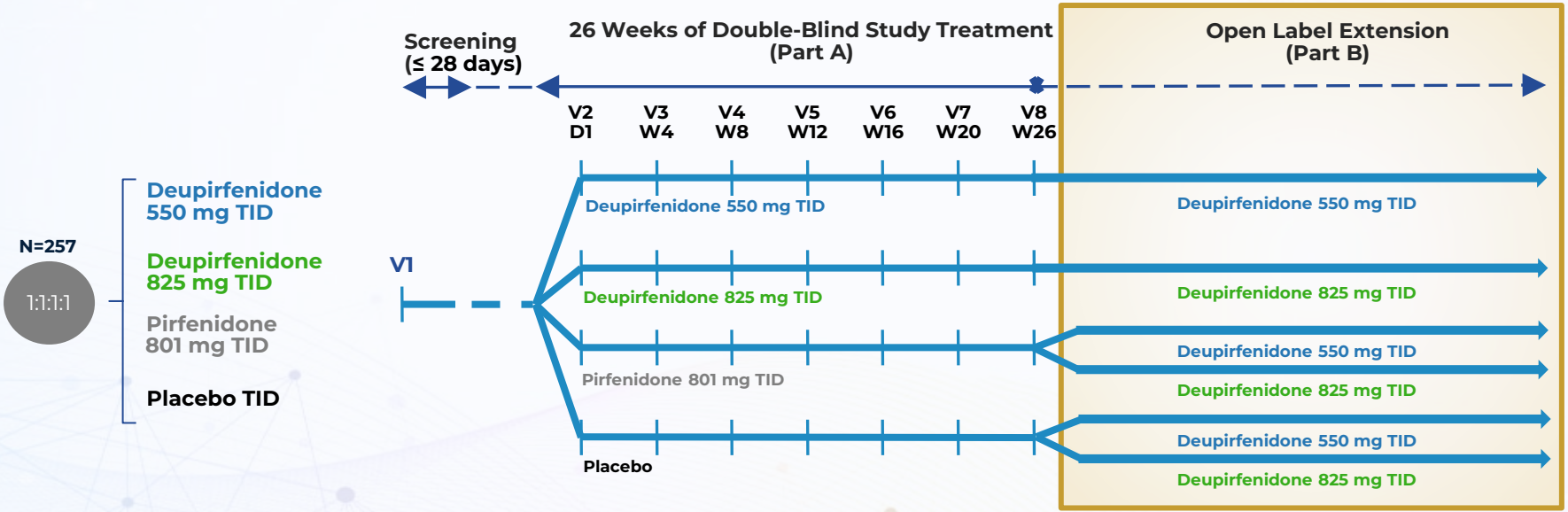
[1] 25% of patients in pirfenidone pivotal trials and 15% in nintedanib pivotal trials reported abdominal pain; AE= adverse event; TID = three times a day
Note: Differences between groups are determined by the difference between percentage of incidences observed.

Deupirfenidone's Favorable Tolerability Profile Allows for Higher Drug Exposure and Greater Efficacy

>90% of Patients Opted to Enroll in the Ongoing Open-label Extension



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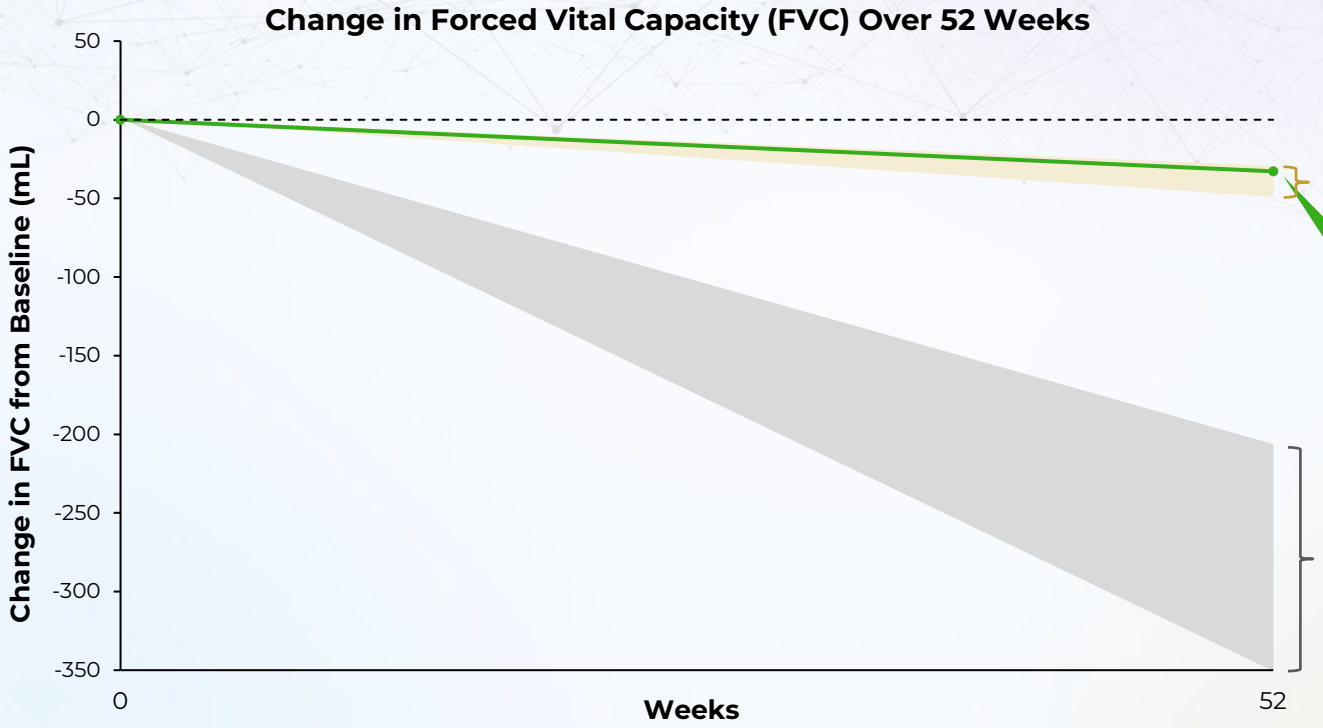
FVC = Forced Vital Capacity; TID = three times a day

Preliminary Open Label Extension Data Demonstrate Strong and Durable Efficacy with Deupirfenidone 825 mg TID over at Least 52 Weeks



-30 mL to -50 mL[1]

Healthy Older Adults
Expected natural lung function decline

-32.8 mL[2]

IPF Patients
Decline when treated with deupirfenidone 825 mg TID

-205 mL to -350 mL[3]

IPF Patients
Decline without treatment based on historical data

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[1] Per Valenzuela. Boehringer Ingelheim. ERS 2024 and Luoto. Eur Respir J. 2019.
[2] Integrated analysis of double-blind and preliminary open-label extension data from Phase 2b ELEVATE IPF trial as of May 9, 2025, using a random coefficient regression model with absolute FVC including baseline as response variable and week, treatment and interaction between week and treatment as fixed effect.
[3] Per placebo arm 48-week decline in pirfenidone CAPACITY 004 and CAPACITY 006 trials (Noble. Lanct. 2011.) and 52-week decline in nintedanib INPULSIS-1 and INPULSIS-2 trials (Richeldi. N Engl J Med. 2014)

Preliminary 52-week Data (Part A + Part B) Reaffirm Potential for Deupirfenidone to Become a New Standard of Care for IPF

FVC Change from Baseline Over 52 Weeks

Indirect comparison; not based on head-to-head data[1]

HEALTHY OLDER ADULTS	INVESTIGATIONAL IPF AGENTS	
Expected natural lung function decline	**Deupirfenidone 825 mg TID**	**Nerandomilast Monotherapy (9 mg; 18 mg BID)**
-30 to -50 mL[2]	**-32.8 mL[3]**	-70.4 mL; -79.2 mL[4,5]

Additional details from the ongoing open-label extension study are expected to be shared in a future scientific forum

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TID = Three times a day; BID = Twice a day; [1] Cross-trial comparisons are inherently limited, as these data are from separate studies with differing designs, patient populations, and methodologies. No direct, head-to-head trials have been conducted; [2] Per Valenzuela. Boehringer Ingelheim. ERS 2024 and Luoto. Eur Respir J. 2019; [3] Integrated analysis of double-blind (26 weeks) and preliminary open-label extension data from Phase 2b ELEVATE IPF trial as of May 9, 2025, using a random coefficient regression model with absolute FVC including baseline as response variable and week, treatment and interaction between week and treatment as fixed effect; [4] Per FIBRONEER-IPF trial (Richeldi. N Engl J Med. 2025.); [5] The FIBRONEER-IPF trial placebo arm without background treatment showed a 52-week FVC change from baseline of -148.7 mL (per Richeldi. N Engl J Med. 2025.) vs. a historical placebo arm change from baseline of -205 mL to -350 mL in the pirfenidone CAPACITY 004 and CAPACITY 006 trials (Noble. Lanct. 2011.) and nintedanib INPULSIS-1 and INPULSIS-2 trials (Richeldi. N Engl J Med. 2014.).

Historic IPF Trial Failures and PureTech Differentiation

Reasons for Historic IPF Trial Failures & PureTech Differentiation

	Reasons for Trial Failure	PureTech Differentiation
Idiopathic Nature of Disease	Evaluating a new mechanism of action for an idiopathic disease is inherently risky	Deupirfenidone efficacy builds on over a decade of established human efficacy data of pirfenidone
Short Phase 2 Trial Duration	Most Phase 2 IPF studies are 12-week trials that are not predictive of a 52-week trial (treatment duration required for pivotal)	Robust 26-week ELEVATE trial with deupirfenidone, with additional durable 52-week OLE data
Small Study Size	Smaller Phase 2 trials may not be representative of Phase 3 population	Deupirfenidone 825 mg TID arm had an adequate number of patients to achieve statistical significance
Study Quality	Variability (*e.g.*, outliers, decentralized FVC) in Phase 2 lead to false assumptions for Phase 3	No outliers observed in ELEVATE study. Phase 3 trial will include rigorous QC systems employed in ELEVATE
Lack of Active Control	IPF studies have not historically used an active control arm	First trial to compare an investigational drug to an approved antifibrotic; pirfenidone and placebo performed as expected, increasing data confidence
Deviation from Phase 2 Design	Phase 3 studies that deviate from their Phase 2 design (*e.g.*, change in dosing or background SOC use) increase technical risk	Phase 3 design will recapitulate key aspects of ELEVATE (*e.g.*, dose)

Examples:

Biogen Galápagos PLIANT HORIZON
Galecto FibroGen Roche / Promedior

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Example Phase 2 IPF Trial Failures: Biogen, Galecto, Horizon, Pliant; Example Phase 3 IPF Trial Failures: FibroGen, Galapagos, Roche/Promedior
OLE = open-label extension; TID = three times a day; FVC = forced vital capacity; QC = quality control; SOC = standard of care

Commercial Opportunity for Deupirfenidone

Broad and Layered Intellectual Property (IP) Coverage[1], Including Various Doses, Formulations, Methods of Treatment, and more

Composition of Matter Patent exclusivity up to 2033 with PTE; Additional IP coverage to ~2043

32 Active patents acquired from Auspex (exclusivity up to 2033 with PTE)

- **6** Issued US patents
- **26** Issued foreign patents

1 In-licensed US patent from Auspex

1 US patent application in-licensed from Auspex; directed to formulation of deuterated pirfenidone (exp. 2035)

Additional patents filed:

13 *Pending US patent applications*

39 *Foreign applications*

For the use of deuterated pirfenidone, including for the treatment of a range of conditions

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[1]As of December 31, 2024. PTE = Patent term extension

ELEVATE Data Suggests Multi-billion Dollar Revenue Potential

The ELEVATE data for 825 mg TID are a “home run” scenario for deupirfenidone as defined by stakeholder market research

Potential for Best-in-Class Efficacy

- Versus placebo, 825 mg TID dose **showed 50% better efficacy than pirfenidone**
- Stabilization of lung function will **set a new standard for IPF treatment**

Addresses Stakeholder Needs

- Pulmonologist market research conducted pre-ELEVATE readout suggested **~50% FVC improvement relative to pirfenidone would be highly attractive**

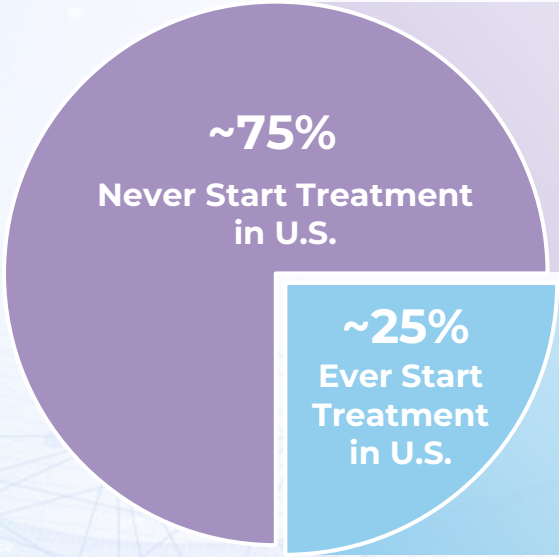
Potential for Significant Revenue

- 825 mg TID data suggests **blockbuster potential in IPF**, with **additional upside in other ILDs**

FVC = Forced vital capacity; IPF = Idiopathic pulmonary fibrosis; ILD = Interstitial Lung Disease

Deupirfenidone Has the Potential to Be Used Across Multiple Patient Segments

Potential to capture patients currently on SOC (~25%) AND expand to those who never start (~75%)



Patients Who Never Start Treatment
Tolerability risks outweigh modest efficacy benefits, discouraging patients from ever starting treatment

Patients Currently on Treatment
Current SOC agents provide suboptimal efficacy with significant tolerability challenges for certain patients

Patients Who Discontinue Treatment
Mean duration of treatment with SOC agents is <1 year; over 40% of patients eventually discontinue treatment[1]

✓ **Deupirfenidone has the potential for significantly improved efficacy without sacrificing tolerability, making it a treatment option for a wide range of IPF patients**

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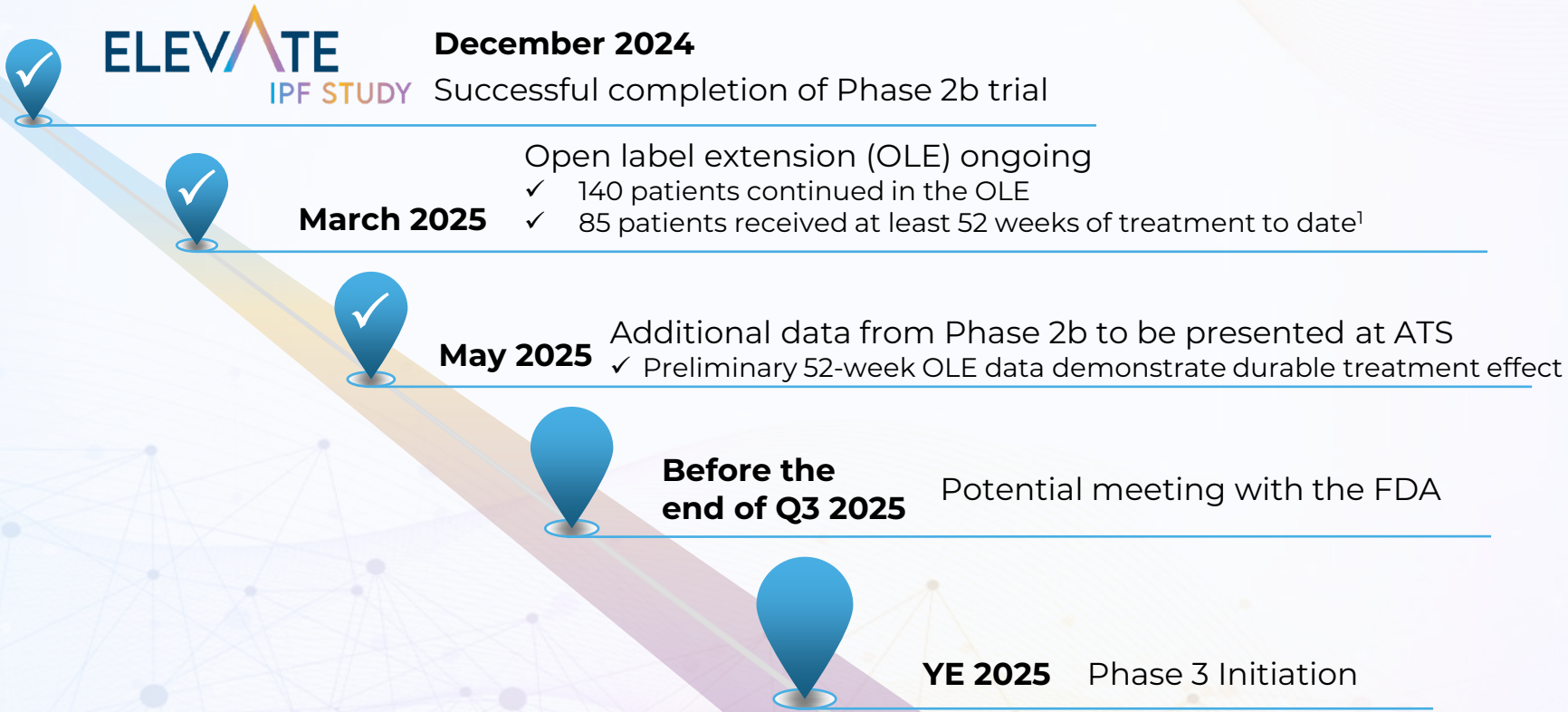
SOC = standard of care. [1]Retrospective cohort analysis using claims data for individuals enrolled in private and Medicare Advantage health plans from OptumLabs Data Warehouse (N=21,444,770); Dempsey TM, Payne S, Sangaralingham L, Yao X, Shah ND, Limper AH. Adoption of the Antifibrotic Medications Pirfenidone and Nintedanib for Patients with Idiopathic Pulmonary Fibrosis. Ann Am Thorac Soc. 2021;18(7):1121-1128.

Accelerating Program Advancement for Patients in Need



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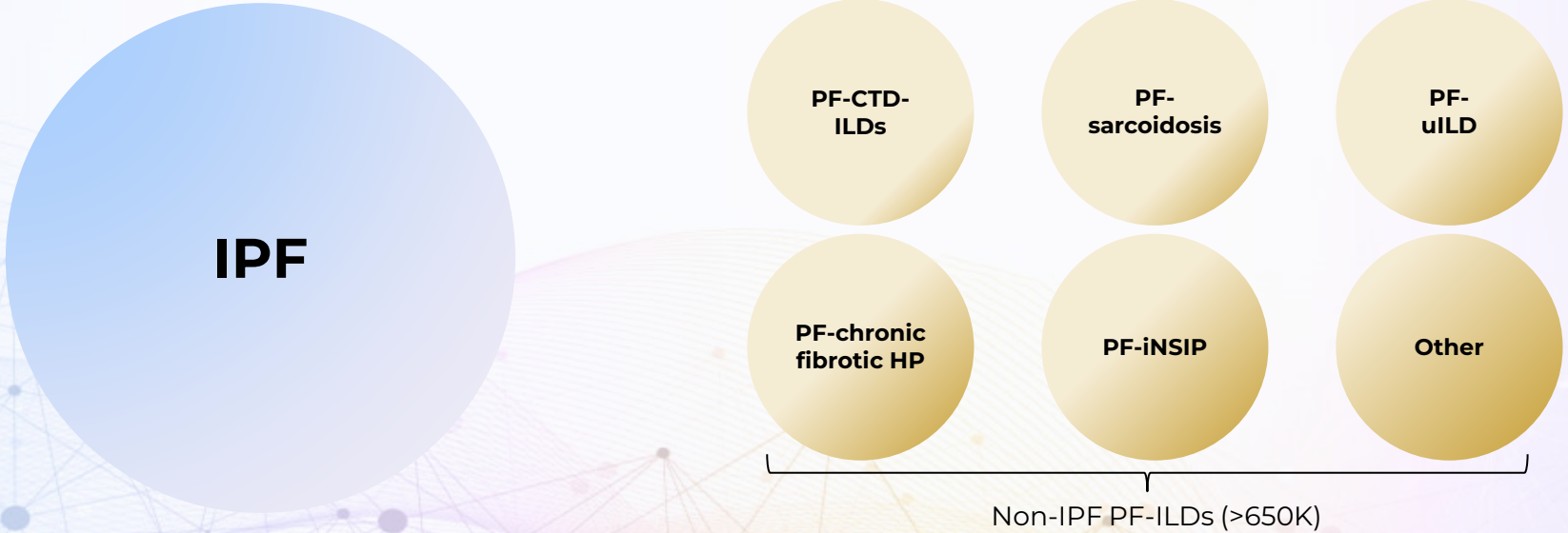
ATS = American Thoracic Society ; [1] As of March 14, 2025.

Potential to Expand into Other Progressive, Fibrotic Diseases with High Unmet Need

Progressive pulmonary fibrosis (PPF), also termed progressive fibrotic ILD (PF-ILD), is estimated to affect >1.3M patients in the US and 15 major markets[1,2,3]

CURRENT ADDRESSABLE MARKET: >720K

FUTURE ADDRESSABLE MARKET: >1.3M



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[1] Wong, A., et al. Respiratory Research (2020) 21:32; Sauleda, J., et al. Medical Sciences (2018) 6:110; 16 major markets: US, EU5 (Germany, Spain, Italy, France, UK), Australia, Brazil, Canada, China, India, Japan, Mexico, Russia, South Africa, South Korea; CTD: Connective Tissue Disease; iNSIP: Idiopathic Non-specific Interstitial Pneumonia; HP: Hypersensitivity Pneumonitis.; [2] GlobalData Epidemiology and Market Size Search; [3] Nintedanib is approved for PPF, also known as PF-ILD, in addition to IPF and SSc-ILD. Additional pipeline agents have demonstrated that mechanisms to treat IPF could also work for treating PPF.

Wholly-Owned Program

LYT-200

Topline results from Phase 1b trial in AML expected in Q3 2025

Phase 1b trial in solid tumors successfully completed

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Wholly-Owned Programs are comprised of the Company's current and future therapeutic candidates and technologies that are developed by the Company's wholly-owned subsidiaries, whether they were announced as a Founded Entity or not, and will be advanced through with either the Company's funding or non-dilutive sources of financing. As of December 31 ,2024, Wholly-Owned Programs were developed by the wholly-owned subsidiaries including PureTech LYT, Inc., PureTech LYT 100, Inc. and Gallop Oncology, Inc. and included primarily the programs deupirfenidone (LYT-100) and LYT-200.

Gallop Oncology: Advancing Galectin-9 Targeting mAb, LYT-200

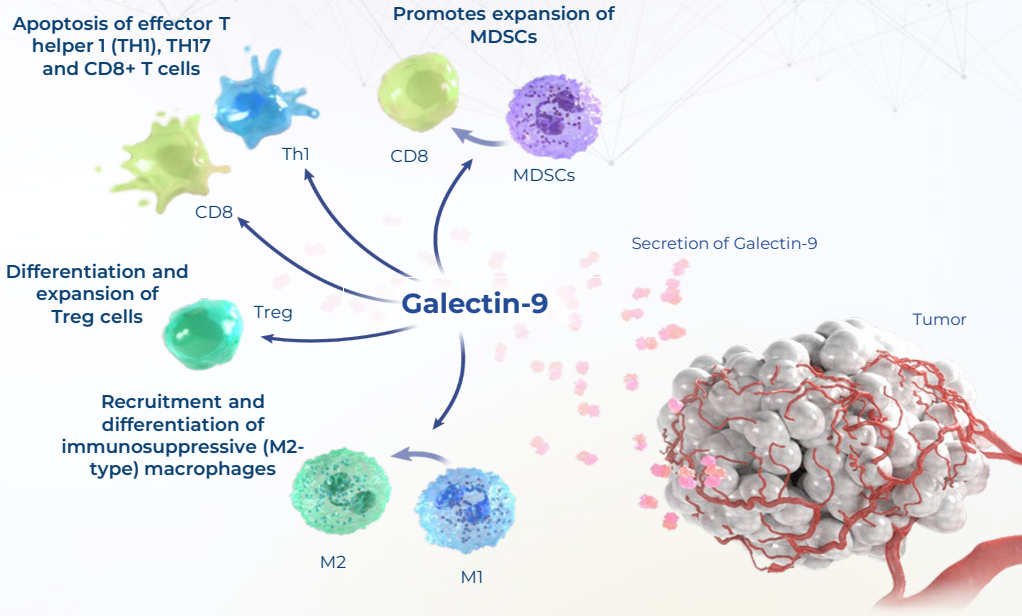
Driving immunosuppression through multiple pathways

HEMATOLOGIC MALIGNANCES (Phase 1b ongoing)

- Received **Orphan Drug designation** from the FDA for the treatment of AML
- Received **Fast Track designation** from the FDA for the treatment of AML
- Topline results from Phase 1b trial in AML expected in Q3 2025

SOLID TUMORS (Phase 1b completed)

- Received **Fast Track designation** from the FDA for the treatment of head and neck cancers
- Phase 1b trial in solid tumors successfully completed



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LYT-200 is an investigational drug not approved by any regulatory authority. mAb = monoclonal antibody; AML = acute myeloid leukemia; Treg = T regulatory cell; MDSC = myeloid derived suppressor cell; M1/M2 = tumor associated macrophage (TAM)1 (immunoactive) and 2 (immunosuppressed) cell; Th1 = T helper1 cell
https://www.nature.com/articles/s41573-023-00636-2; https://pubmed.ncbi.nlm.nih.gov/27038510/; https://www.nature.com/articles/s41388-020-1186-7.

GALLOP ONCOLOGY

LYT-200 Clinical Data to Date in AML & Solid Tumors

AML/MDS DOSE ESCALATION COHORTS[1] (ONGOING)

Favorable safety profile demonstrated to date, with no dose limiting toxicities

Monotherapy arm: 30 evaluable patients dosed, 2.0 mg/kg - 16.0 mg/kg

- At 7.5mg/kg and above: **1 patient achieved CR, 3 patients achieved PRs, and >50% of patients achieved SD**
- Average treatment duration of 3.5 months

Combination arm: 29 evaluable patients dosed, 4.0 mg/kg, 7.5mg/kg, and 12.0 mg/kg, with venetoclax/HMA

- **6 patients achieved CRs, 1 patient achieved MLFS, and >50% of patients achieved SD**
- Average treatment duration of 4 months

SOLID TUMORS ALL COHORTS (COMPLETED; N=44)

Favorable safety profile demonstrated in all cohorts, with no dose limiting toxicities; showed disease control & initial efficacy signals

Monotherapy cohorts: 20 patients dosed, 0.2 – 16.0 mg/kg every two weeks or 10 mg/kg every week

- **3 patients achieved SD**

Combination cohorts: 24 patients dosed, 6.3mg/kg or 16mg/kg every week, with tislelizumab

- In urothelial cancer patients, **2 patients achieved SD**
- In head and neck cancer patients, **1 patient achieved CR** lasting >2 years, **2 patients achieved PRs, 2 patients achieved SD**
- **33% Overall Response Rate**
- **50% and 43% disease control rate** at 6.3mg/kg and 16mg/kg, respectively

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AML = Acute myeloid leukemia; MDS = Myelodysplastic syndromes; PR = Partial response; CR = Complete response; SD = Stable disease; PD = Progressive disease; MLFS = Morphological leukemia-free state; ORR = Overall response rate; ELN (European Leukemia Network) guidelines 2017: for response assessment: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5291965; [1]Data as of 4/28/25.

GALLOP ONCOLOGY

Our Portfolio

Neuropsychiatric medicines

Advancing SPT-300 into potentially registration-enabling Phase 2b study

Advancing SPT-320 into Phase 1 studies

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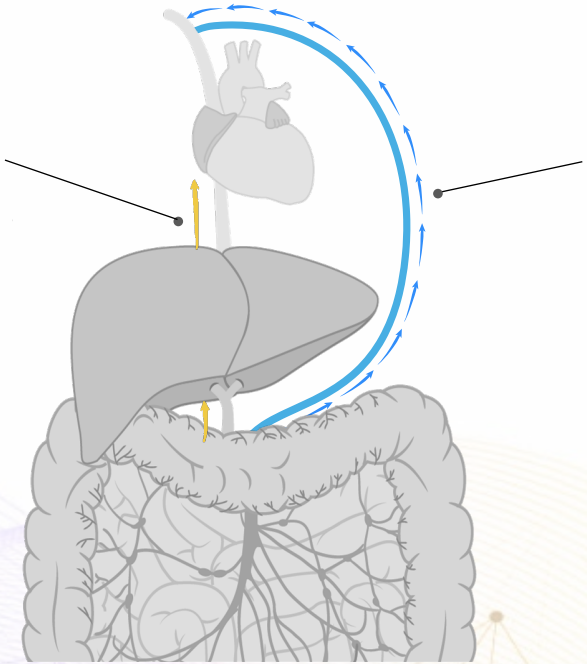
Founded Entities represent companies founded by PureTech in which PureTech maintains ownership of an equity interest and, in certain cases, is eligible to receive sublicense income and royalties on product sales. Relevant ownership interests were calculated on a partially diluted basis (as opposed to a voting basis) as of December 31, 2024, including outstanding shares, options and warrants, but excluding unallocated shares authorized to be issued pursuant to equity incentive plans. PureTech controls Gallop Oncology, Inc.

Glyph™: Leveraging the Lymphatic System to Unlock New Medicines

Proprietary platform advances active drugs previously limited by low oral bioavailability/hepatotoxicity

CONVENTIONAL

Oral drugs with high first-pass metabolism can have low bioavailability & hepatotoxicity

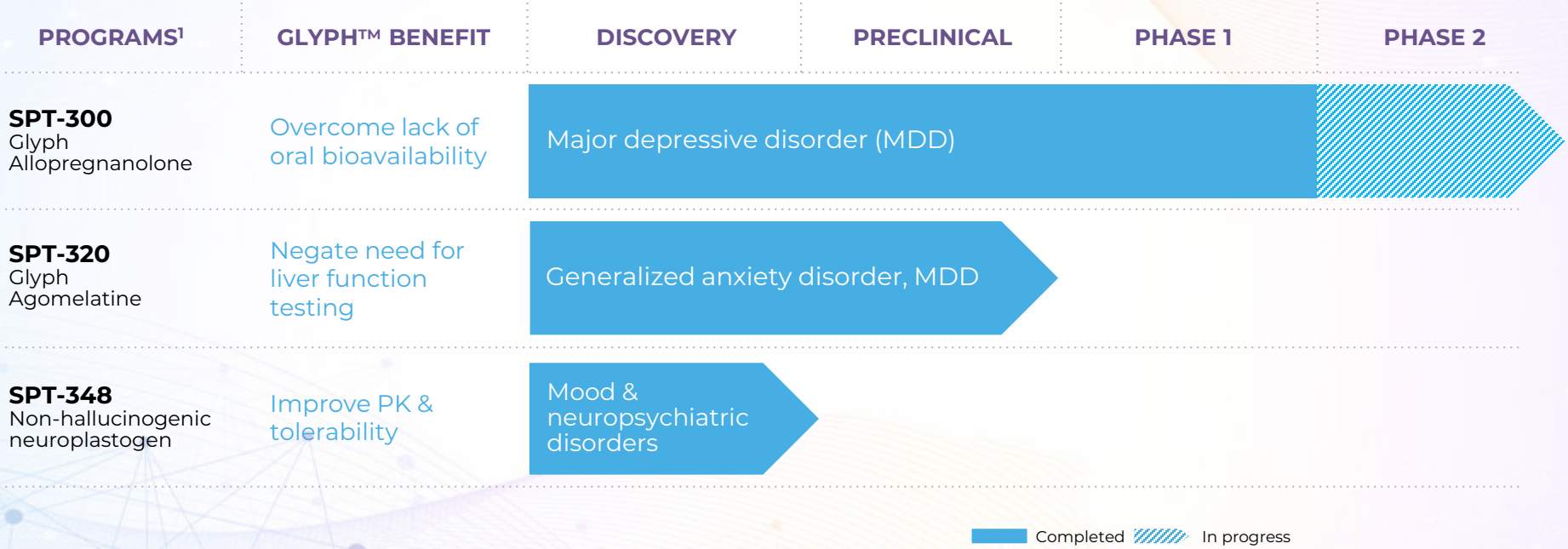


GLYPH™

Employ the lymphatic system's natural lipid absorption and transport process to bypass the liver, as a result:

- Enhances oral bioavailability
- Reduces dose
- Reduces first-pass hepatotoxicity
- Provides novel composition IP

Pipeline of First & Best-in-Class CNS Medicines



Multiple discovery/preclinical programs underway leveraging the Glyph™ platform

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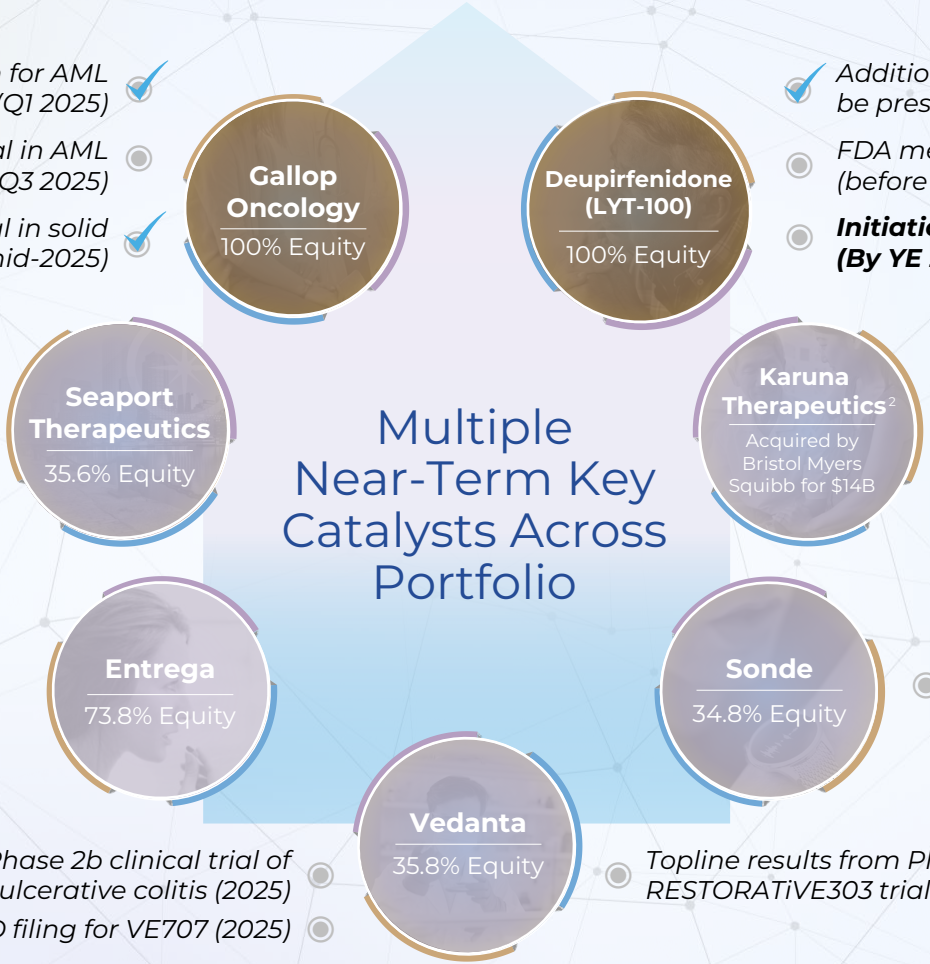
[1] The FDA and corresponding regulatory authorities will ultimately review Seaport's clinical results and determine whether their therapeutic candidates are safe and effective. No regulatory agency has made any such determination that our therapeutics are safe or effective for use by the general public for any indication.

SEAPORT THERAPEUTICS

Multiple Near-Term Key Catalysts Across Portfolio



Gallop Oncology
100% Equity

- *Received Fast Track Designation for AML (Q1 2025)* ✓
- *Topline results from Phase 1b trial in AML (Q3 2025)*
- *Topline results from Phase 1b trial in solid tumors (mid-2025)* ✓

Deupirfenidone (LYT-100)
100% Equity

- *Additional details from the Phase 2b trial to be presented at ATS (May 2025)* ✓
- *FDA meeting to discuss the Phase 2b data (before the end of Q3 2025)*
- ***Initiation of Phase 3 trial in IPF (By YE 2025)***

Seaport Therapeutics
35.6% Equity

- *Advancing SPT-300 into potentially registration-enabling Phase 2b study*
- *Advancing SPT-320 into Phase 1 studies*

Karuna Therapeutics[2]
Acquired by Bristol Myers Squibb for $14B

COBENFY™

PureTech retains rights to royalty and milestone payments upon the achievement of Cobenfy™ sales and certain regulatory approvals

Entrega
73.8% Equity

- *Developing oral administration of peptide therapeutics (e.g., GLP-1 agonists)*
- *Additional pre-clinical validation (2025)*

Sonde
34.8% Equity

- *Continue development of the voice-based artificial intelligence platform to detect changes in health*

Vedanta
35.8% Equity

- *Topline results from Phase 2b clinical trial of VE202 in ulcerative colitis (2025)*
- *IND filing for VE707 (2025)*
- *Topline results from Phase 3 pivotal RESTORATiVE303 trial (2026)*

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AML = acute myeloid leukemia; ATS = American Thoracic Society. Founded Entities represent companies founded by PureTech in which PureTech maintains ownership of an equity interest and, in certain cases, is eligible to receive sublicense income and royalties on product sales. Relevant ownership interests were calculated on a partially diluted basis (as opposed to a voting basis) as of December 31, 2024, including outstanding shares, options and warrants, but excluding unallocated shares authorized to be issued pursuant to equity incentive plans. PureTech controls Gallop Oncology, Inc.; [2] As of March 22, 2023, PureTech has sold its right to receive a 3% royalty from Karuna to Royalty Pharma on net sales up to $2 billion annually, after which threshold PureTech will receive 67% of the royalty payments and Royalty Pharma will receive 33%. Additionally, under its license agreement with Karuna, PureTech retains the right to also receive certain sublicense income. Note: Certain third-party trademarks are included here; PureTech does not claim any rights to any third-party trademarks. COBENFY™ (xanomeline and trospium chloride) is indicated for the treatment of schizophrenia in adults. For Important Safety Information, see U.S. Full Prescribing Information, including Patient Information on COBENFY.com. Following the acquisition of Karuna, KarXT is now under the stewardship of Bristol Myers Squibb and will be marketed as Cobenfy.

Nasdaq Global Market & LSE Main Market / FTSE-indexed: PRTC

Headquartered in Seaport, Boston

240,254,449 outstanding shares as of June 30, 2025

$339.1M PureTech Level Cash, Cash Equivalents & Short-Term Investments as of March 31, 2025[1]

ANALYST COVERAGE

Leerink Partners LLC

Faisal Khurshid

Jefferies

Benjamin Jackson

Peel Hunt LLP

Miles Dixon

Substantial shareholders include Invesco Asset Management, Baillie Gifford & Co., Lansdowne Partners LLP, Citigroup, Vanguard Group, Recordati S.p.A.

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[1] PureTech level cash, cash equivalents and short-term investments excludes cash and cash equivalents at non-wholly owned subsidiary of $0.4m. PureTech Level Cash, cash equivalents and short-term investments is a Non-IFRS measure

Appendix Contents

APPENDIX A: INTERNAL PROGRAM

- Deupirfenidone Clinical Advisory Board
- Deupirfenidone Preclinical Data
- Deupirfenidone Clinical Data
- Deupirfenidone Market Research
- Pirfenidone Data
- Case Study for Deuterium Benefits
- Case Study for Success in Genericized Markets

APPENDIX B: FOUNDED ENTITIES

- Gallop Oncology
- Seaport Therapeutics
- Sonde
- Vedanta
- Entrega

APPENDIX C: SUPPLEMENTAL MATERIALS

- PureTech's Proven Expertise
- PureTech is Executing & Delivering Results
- Financial Highlights/Non-IFRS Measures

Accelerating Momentum & Delivering Results

Key milestones in recent years

ELEVATE IPF STUDY

PureTech **completes successful Phase 2b trial** of deupirfenidone in IPF

KARUNA THERAPEUTICS™

Bristol Myers Squibb™

PureTech's Founded Entity Karuna Therapeutics **acquired by BMS for $14B**

COBENFY™

BMS/Karuna received **FDA Approval for Cobenfy™**

ROYALTY PHARMA

PureTech and Royalty Pharma entered into Cobenfy (KarXT) royalty transaction for **up to $500M**

GALLOP ONCOLOGY

PureTech's LYT-200 granted **Orphan Drug and Fast Track** Designations

VEDANTA BIOSCIENCES

PureTech's Founded Entity Vedanta Biosciences **initiated Phase 3 trial** of VE303

SEAPORT THERAPEUTICS

PureTech launched Founded Entity Seaport Therapeutics; **$325M raised** in 2024

Appendix A: Wholly-Owned Program Deupirfenidone

Registration-enabling Program in IPF Guided by Leading Experts

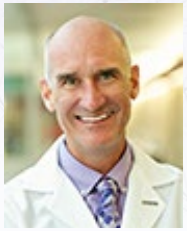
PureTech's clinical advisory board for IPF & related lung disorders

BILL BRADFORD, MD, PHD

Former SVP InterMune; developed pirfenidone for the treatment of IPF

VINCENT COTTIN, MD

Professor at Université Claude Bernard Lyon; Coordinator of Center for Rare Pulmonary Diseases at Louis Pradel Hospital; Section Editor of the *European Respiratory Journal*



KEVIN FLAHERTY, MD

Professor at University of Michigan; PhIII trial of nintedanib in pfILD *(NEJM)*

TOBY MAHER, MD, PHD

Professor & Director of ILD at Keck School of Medicine, USC; PhII trial of pirfenidone in uILDs *(Lancet RM)*

PAUL NOBLE, MD

Chair, Department of Medicine, Cedars-Sinai; results of two late-stage studies evaluating the effect of pirfenidone in patients w/ IPF *(Lancet)*

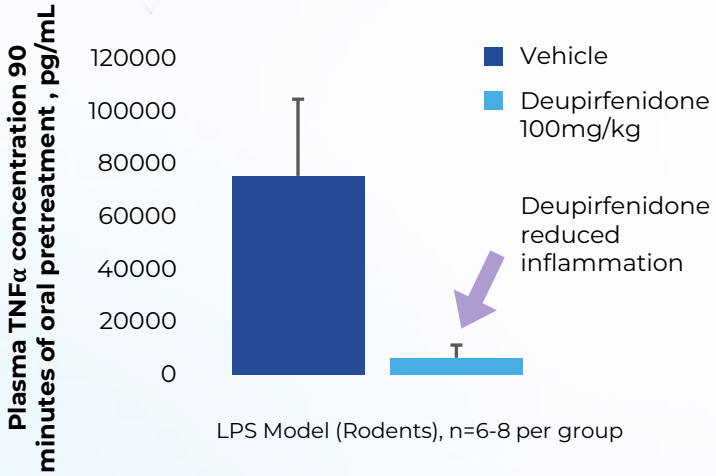
MARLIES WIJSENBEEK, MD, PHD

Chair of Erasmus Medical Center ILD program; PI on study to identify disease progression in patients with newly diagnosed pfILDs

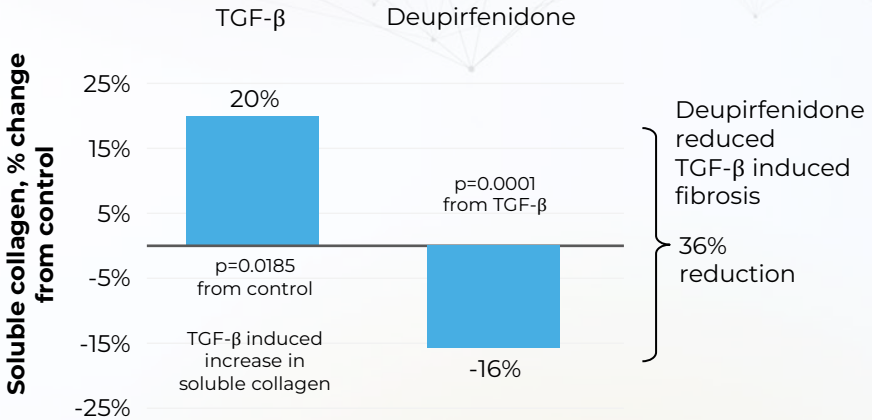
Deupirfenidone Preclinical Data

Deupirfenidone: Preclinical POC Demonstrates Anti-inflammatory & Anti-fibrotic Pharmacology

PRECLINICAL PLASMA CONCENTRATIONS OF TNFA WITH DEUPIRFENIDONE VERSUS CONTROL



IN VITRO REDUCTION OF TGF-B INDUCED SOLUBLE COLLAGEN PRODUCTION (MOUSE FIBROBLASTS)



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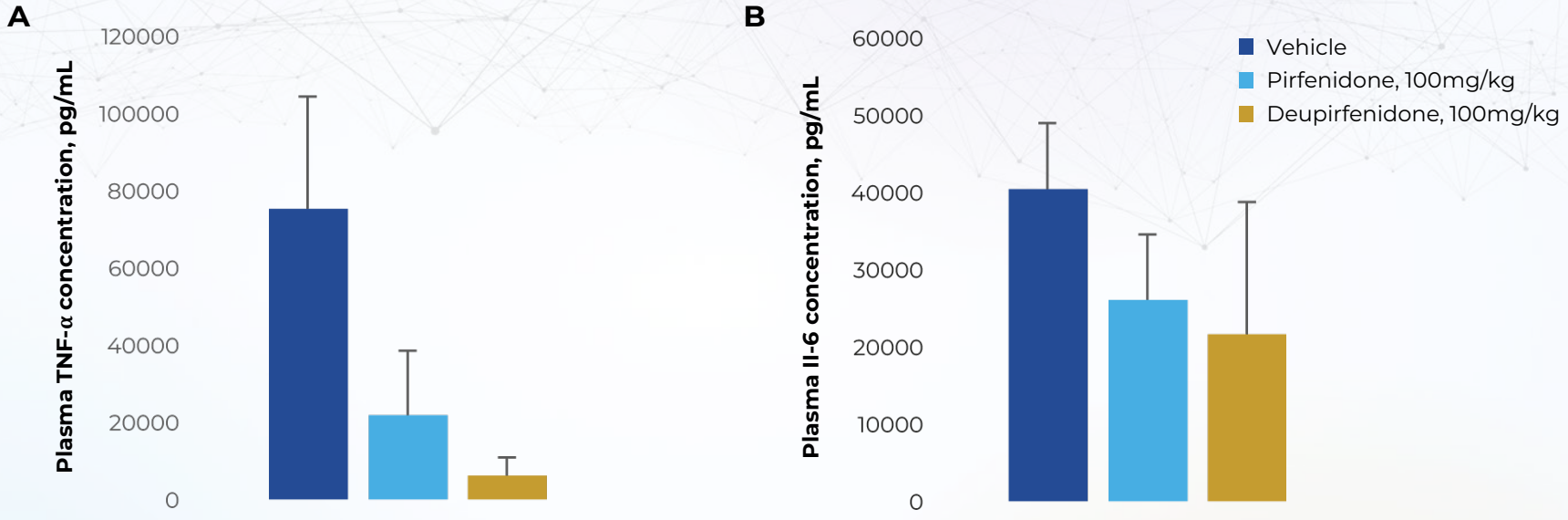
Source: Data on File

Deupirfenidone Preserves Pharmacologic Effect of Pirfenidone

Preclinical data shows improved anti-inflammatory and anti-fibrotic activity vs pirfenidone



Reduction in LPS-stimulated plasma concentrations of TNF-α and IL-6 by pirfenidone or deupirfenidone. Oral doses of vehicle, pirfenidone, or deupirfenidone (100mg/kg) administered 60 minutes prior to LPS (30 µg/kg intravenous): TNF-α (A) and IL-6 (B) measured 90 min after LPS stimulation: N=6-8 animals per group. Data are presented as mean +/- standard deviation.

Deupirfenidone Clinical Data

Deupirfenidone Phase 1 Clinical Trials

1. Initial PK studies

FOUNDATIONAL PK DATA

MAD 1.0

Multiple-dose safety, tolerability, and PK

Tolerable up to 1000mg BID, linear PK

PK

Determine dose with same exposure as pirfenidone

800 – 850 mg BID matches pirfenidone AUC

2. Head-to-head tolerability

TOLERABILITY ADVANTAGE VS. PIRFENIDONE

Older Adult

550 mg TID deupirfenidone vs. pirfenidone:
Comparable AUC[1]

Demonstrated tolerability advantage over pirfenidone

3. High-dose studies

EXPLORE FEASIBILITY OF HIGHER EXPOSURES

MAD 2.0

Safety and tolerability > 1000 mg BID

Tolerable up to 2000mg BID with no dose limiting toxicity

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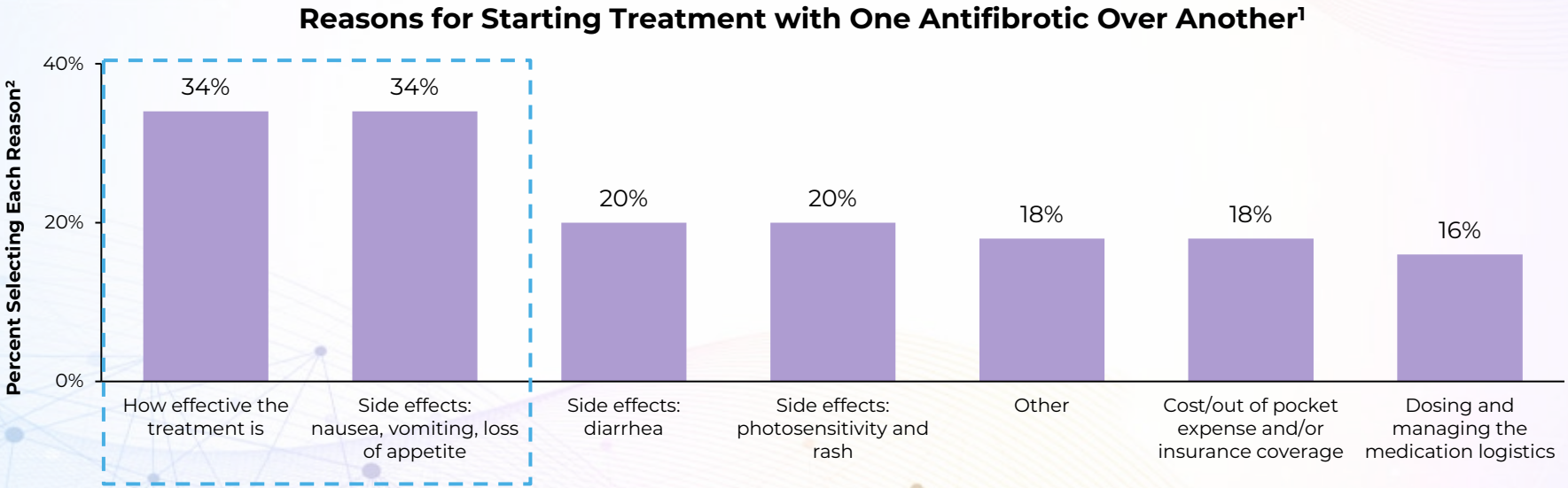
[1] Deupirfenidone 550 mg TID met the FDA-defined criteria for equivalent exposure (Geometric mean ratio and 90% CI (0.875 [0.842, 0.910]) were within the equivalence boundary of 0.8000 to 1.250) to pirfenidone 801 mg TID; the actual AUC was ~13% lower than pirfenidone 801 mg TID.

Market Research

IPF Patients Reported Efficacy and Tolerability as the Top Reasons for Selecting their Antifibrotic Treatment

Efficacy and GI tolerability were weighed equally when considering antifibrotic treatment



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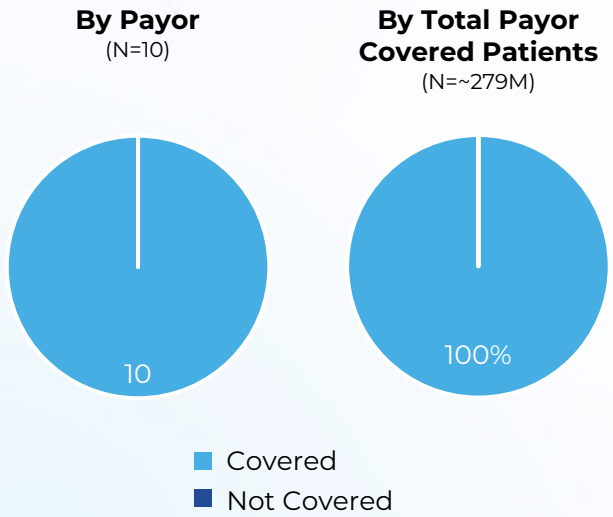
[1]Market research quantitative survey of 90 participants with IPF conducted by Sago. Research completed in March 2024. [2]This question was asked of N=44 participants who had ever taken an antifibrotic medication to manage their IPF. Participants were specifically asked about the decision for starting treatment with pirfenidone or nintedanib. Participant were allowed to select all reasons that applied to them.

Deupirfenidone Payor Market Research

Independent research indicates payors in favor of profile[1]

DEUPIRFENIDONE COVERAGE EXPECTATIONS[2]



- **Ten out of ten payors would put deupirfendone on formulary** if "clinically meaningful" differences compared to current SOC are demonstrated[3]
- Payers would view **20 – 50% improvement in FVC decline** over current SOCs as clinically meaningful, consistent with KOL perspectives that PureTech has received

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[1] 10 payors (mix of regional, national, PBM, and IDN) were qualitatively interviewed by a third party; Research completed in Q1 2023 based on a product profile using the results of the Phase 1 healthy older adult crossover study; the results here based on the UPSIDE product profile where LYT-100 results in improved efficacy; [2] Payors were asked: "how would your organization manage Product X"; [3] All payors expect to cover LYT-100 if LYT-100 result in improved efficacy outcomes for IPF patients.

Deupirfenidone in The Face of Generics & Novel MOAs

DEUPIRFENIDONE VS. GENERICS

- **The safety/tolerability of deupirfenidone remains attractive and meaningful to pulmonologists and payers** even in the face of generic competition[1]
- **Current SOC agents cannot be taken in high doses due to poor tolerability; Only ~25% of patients in the U.S. have ever initiated antifibrotic treatment**; Presence of generics is not likely to drive a dramatic increase in adoption
- Even if all US payers require step edits through a generic antifibrotic, **~50% of IPF patients will still be eligible for deupirfenidone** due to the significant tolerability challenges with current standard-of-care

DEUPIRFENIDONE VS. NOVEL MODE OF ACTIONS (MOAS)

- There are several Phase 3 & a handful of notable Phase 2 programs evaluating novel MOAs in IPF. If successful, **nearly all of these programs are expected to be used on top of or after current SOC**
- There is **potential for deupirfenidone to be positioned as the preferred backbone antifibrotic** for future combination regimens
- **Development of novel MOAs in IPF has proved difficult**, with many recent failures of late-phase programs. For many ongoing programs, it remains to be seen if **early Ph2 data can be replicated in Ph3 studies**

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[1] Generic pirfenidone is currently available in the US and most of EU; generic nintedanib is expected to be available within the next five years.

Deupirfenidone in The Face of Generics & Novel MOAs (Cont'd)

Base Case: deupirfenidone at equivalent dose to pirfenidone with favorable safety/tolerability

COMPETITOR	OVERVIEW	POSITIONING OF DEUPIRFENIDONE
Generic pirfenidone and nintedanib	▸ Both generic pirfenidone and generic nintedanib are expected to be on the market at time of deupirfenidone launch[1] ▸ Assume all payers add generics to generic Tier[2]; some payers require step edits[3] of generics before allowing treatment with branded agents	▸ **Deupirfenidone will compete for new patient starts in plans without step edits** ▸ In plans with step edits, deupirfenidone will be used as second line of treatment for **patients who fail on generic antifibrotics** ▸ Even if all payers require step edits, **~50% of patients will be eligible for deupirfenidone**
Reformulated pirfenidone and nintedanib	▸ A few reformulated pirfenidone and nintedanib approaches, including inhaled and sustained release, are in early development	▸ Deupirfenidone will offer oral systemic delivery of the medication, **without the AEs associated with inhaled (e.g., cough) and other reformulations of the currently approved drugs** ▸ None of the localized delivery candidates have demonstrated the same evidence of efficacy as systemic therapies
Novel Mechanisms	▸ Nearly all new mechanisms are being studied on top of/or after the standard-of-care (currently pirfenidone & nintedanib)	▸ **Potential for deupirfenidone to be the backbone standard-of-care for future combination regimens** ▸ Pirfenidone and nintedanib remain key competitors for deupirfenidone

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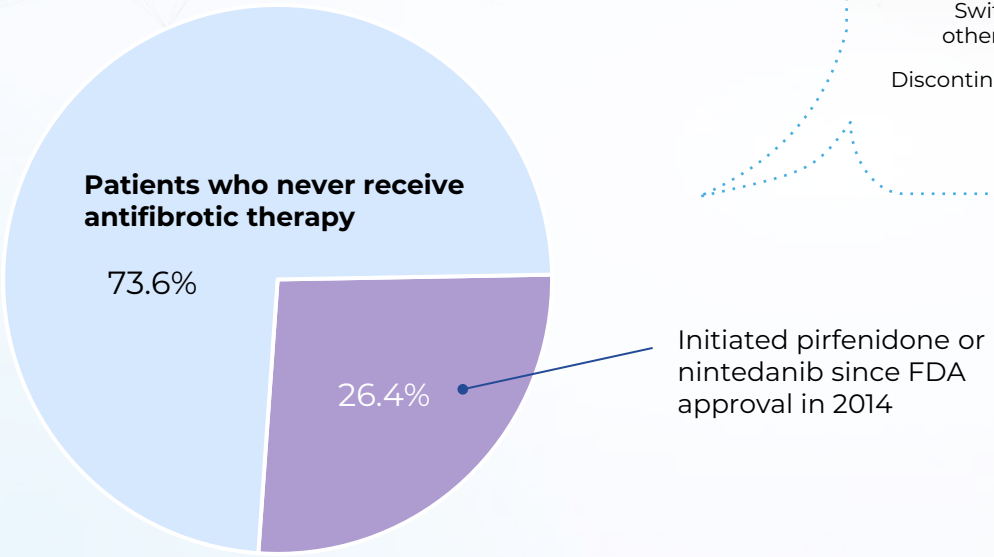
[1] Generic pirfenidone is currently available in the U.S. and most of EU; generic nintedanib is expected to be available within the next five years; [2] Tiering = List of prescription drugs that are covered under a healthcare plan drugs are usually divided into tiers or levels based on cost, type of medication, clinical effectiveness; [3] Step edit = When payers require patients to try a certain medication before allowing access to another.

Only ~25% of IPF Patients in the U.S. Have Ever Initiated Antifibrotic Treatment

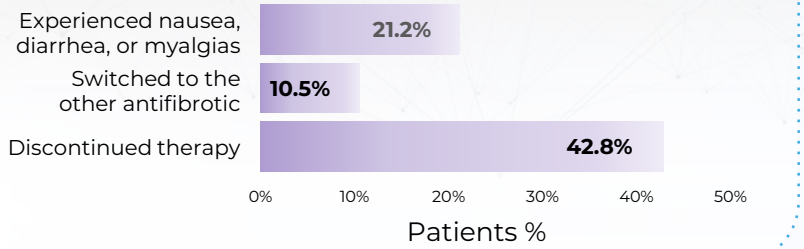
OPTUM Study of 11,000 Patients with IPF[1]

October 2014 to July 2019

10,996 patients with IPF in a US health claims database (OPTUM)



Initiated pirfenidone or nintedanib since FDA approval in 2014



Mean duration of treatment

302

days

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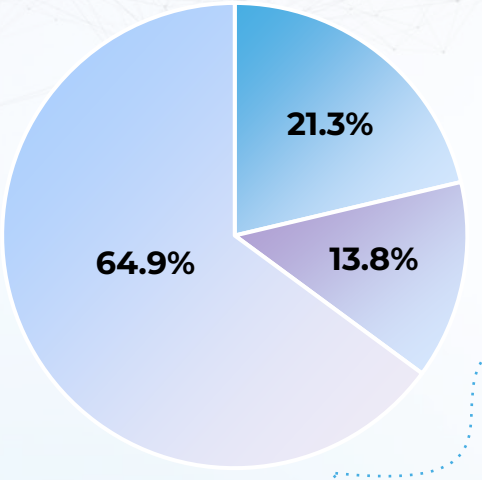
*Retrospective cohort analysis using claims data for individuals enrolled in private and Medicare Advantage health plans from OptumLabs Data Warehouse (N=21,444,770).

[1] Dempsey TM, Payne S, Sangaralingham L, Yao X, Shah ND, Limper AH. Adoption of the Antifibrotic Medications Pirfenidone and Nintedanib for Patients with Idiopathic Pulmonary Fibrosis. Ann Am Thorac Soc. 2021;18(7):1121-1128.

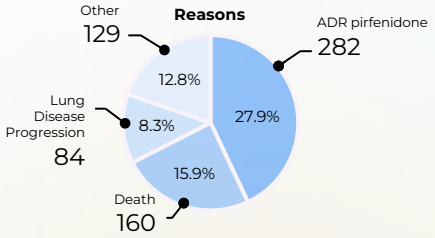
Prospective Registry Found Only 21% of Patients Who Started Pirfenidone Remained on Full Dose After 2 Years



21.3% — Patients 215 — Completed
No dose adjustment

13.8% — Patients 139 — Completed
Dose adjustment

64.9% — Patients 655 — Discontinued



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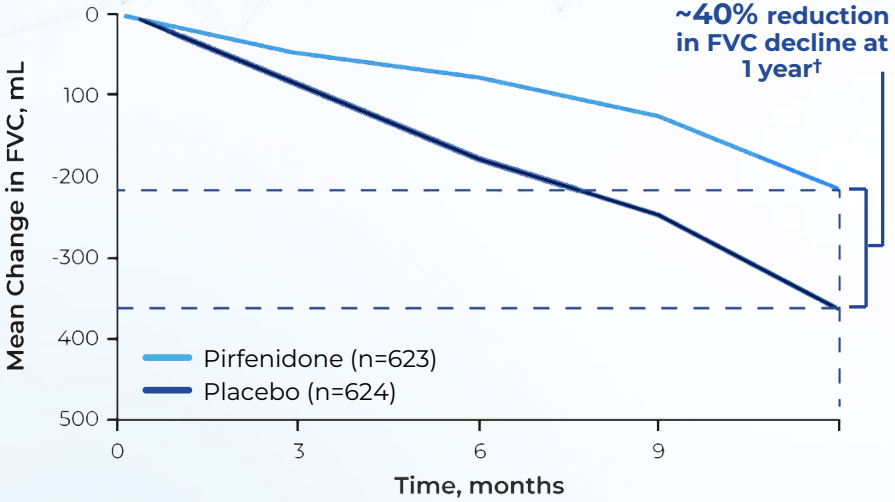
Cottin V, Koschel D, Günther A, et al. Long-term safety of pirfenidone: results of the prospective, observational PASSPORT study. ERJ Open Res. 2018;4(4):00084-2018. Published 2018 Oct 19. doi:10.1183/23120541.00084-2018.

Pirfenidone: A Clinically Validated Treatment for IPF

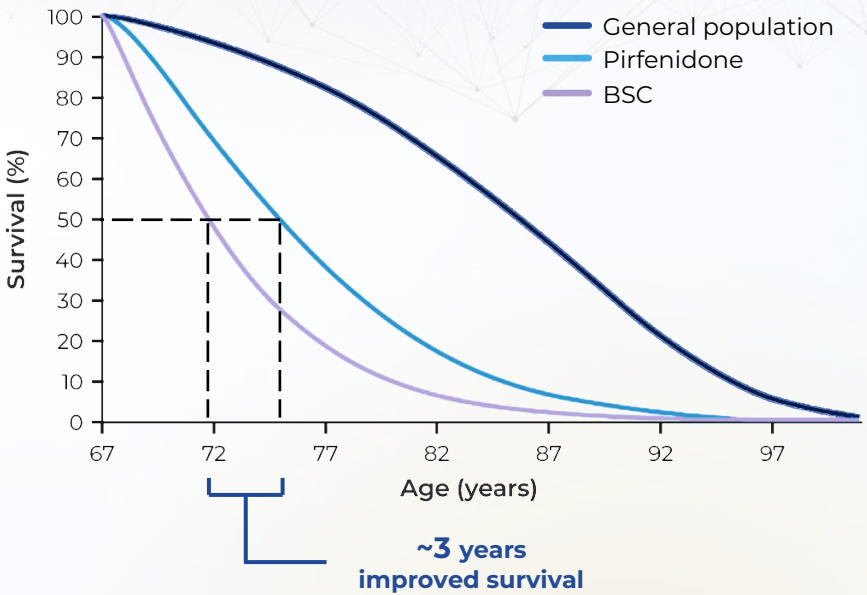
Pirfenidone: A Clinically Validated Treatment for IPF with Beneficial Effects on FVC and Survival

POOLED MEAN CHANGE FROM BASELINE IN FVC FROM THE **ASCEND** AND **CAPACITY** TRIALS[1]*



*FVC assessed at weeks 12, 24, 36, and 48 in CAPACITY and weeks 13, 26, 39, and 52 in ASCEND. †Mean change from baseline in FVC.

~3 YEAR IMPROVEMENT IN SURVIVAL WITH PIRFENIDONE VS BEST SUPPORTIVE CARE IN A MATCHED POPULATION FROM THE UK[2]



BSC, best supportive care; FVC, forced vital capacity; IPF, idiopathic pulmonary fibrosis.
[1] Noble PW, et al. Eur Respir J. 2016;47:27-30; [2] Fisher M, et al. J Manag Care Spec Pharm. 2017;23(3-b):S17-S24.

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Design & Tolerability Findings of Pirfenidone Studies

Pirfenidone discontinuations often related to gastrointestinal (GI) adverse events (AEs)[1]

Pirfenidone GI AEs:
- Require titration in IPF and other studies
- More common in women[2]

	PIRFENIDONE FOOD EFFECT/ANTACID STUDY[2]	PIRFENIDONE FOOD EFFECT AND BIOEQUIVALENCE STUDY[3]	PIRFENIDONE PHASE 3 STUDIES[1]
Design	801mg single-dose in healthy older adults, 44% women	801mg single-dose in healthy adults, 36% women	2403mg per day, IPF patients 26% women

Most common AEs

Most common AEs	Pirfenidone N=16
Nausea	43.8%
Dizziness	37.5%

AEs more frequent in the fasted state
AE rate higher in women

Most common AEs	Pirfenidone N=44
Nausea	29.5%
Dizziness	18.2%
Headache	9.1%
Constipation	9.1%
Vomiting	4.5%
Dyspepsia	4.5%

AEs more frequent in the fasted state

Most common GI AEs^	Pirfenidone N=623	Placebo N=624
Nausea	36%	16%
Rash	30%	10%
Ab. pain	24%	15%
Diarrhea	26%	20%
Headache	22%	19%
Dyspepsia	19%	7%
Dizziness	18%	11%
Vomiting	13%	6%
Anorexia	13%	5%

^Other most common AEs observed in the Phase 3 studies (pirfenidone vs. placebo) include upper resp. infect (27% vs. 25%), fatigue (26% vs. 19%), GERD (11% vs. 7%), sinusitis (11% vs. 10%), insomnia (10% vs. 7%), weight decrease (10% vs. 5%), arthalgia (10% vs. 7%)

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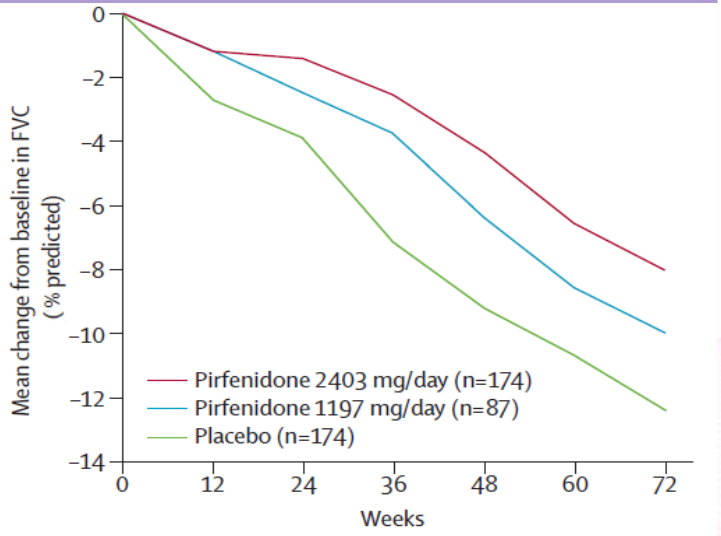
[1] InterMune, Inc., Pirfenidone [package insert]. U.S. Food and Drug Administration website; [2] Rubino, C. M., et al. Pulmonary pharmacology & therapeutics 22.4 (2009): 279-285 https://doi.org/10.1016/j.pupt.2009.03.003;
[3] Pan, Lin, et al. Advances in therapy 34.9 (2017): 2071-2082. https://doi.org/10.1007/s12325-017-0594-8.

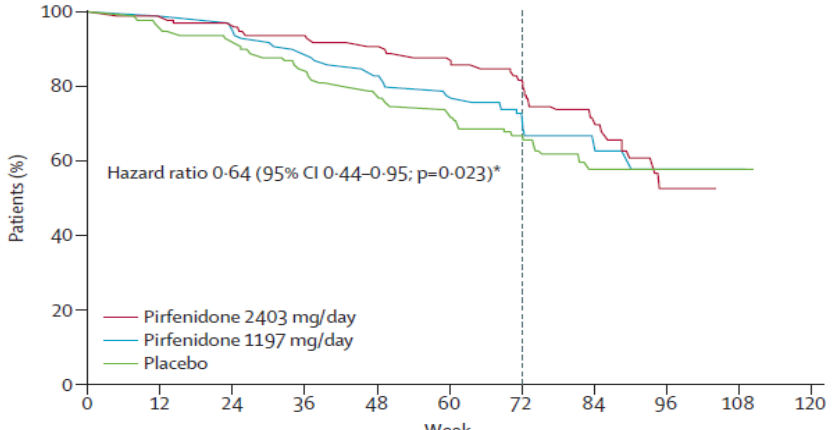
Full-dose Pirfenidone Produces Greatest Effect on FVC Decline and Survival in IPF

Analysis From Study 004 From CAPACITY Study Program

Mean Change from Baseline in Percent Predicted FVC



Kaplan-Meier Distribution of Progression-free Survival Time



Number at risk									
Pirfenidone 2403 mg/day	171	167	160	157	148	138	55	23	5
Pirfenidone 1197 mg/day	87	86	79	74	68	64	27	11	5
Placebo	173	162	150	136	126	116	44	21	4

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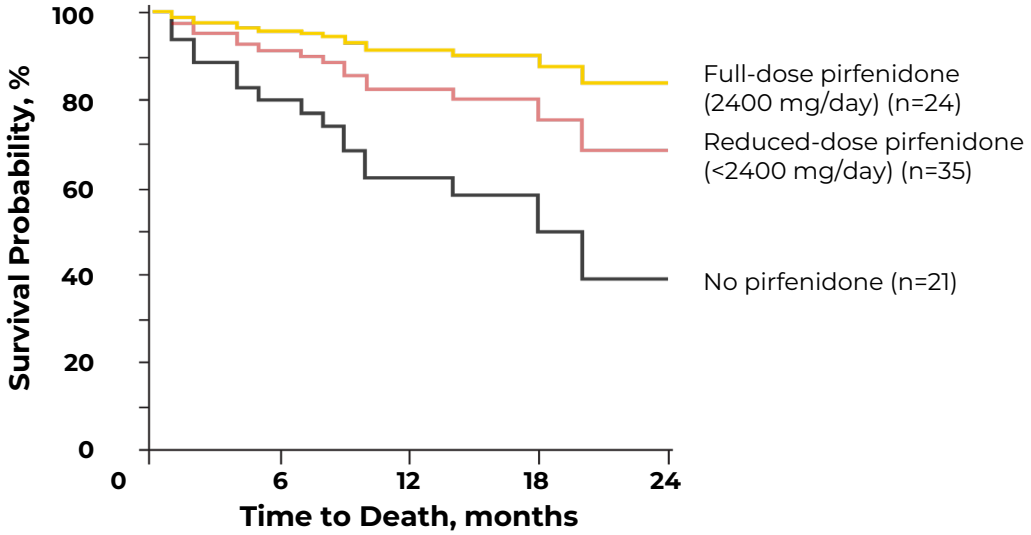
95% CIs were only calculated for absolute differences for the week 72 time point in study 004 (0.7 to 9.1) and study 006 (–3.5 to 4.7). ANCOVA, analysis of covariance; CI, confidence interval; FVC = forced vital capacity; IPF = idiopathic pulmonary fibrosis. Noble PW, et al. Lancet. 2011;377:1760-1769.

Maximal Survival Benefit With Full-dose Pirfenidone

Real-world Study of the Dosing and Tolerability of Pirfenidone

Three-group Analysis

The hazard for death was reduced only with the use of full-dose pirfenidone (HR [IQR], 0.19 [0.04-0.96]; P=0.045)



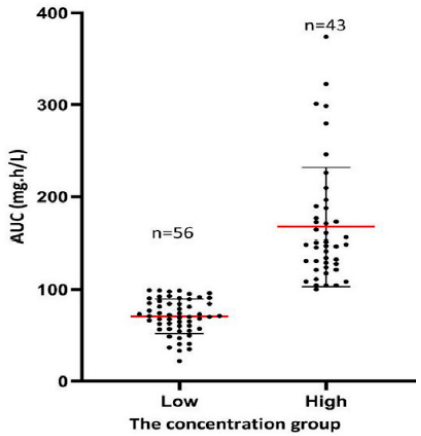
HR, hazard ratio; IQR, interquartile range.

Dhooria S, et al. Sarcoidosis Vasc Diffuse Lung Dis. 2020;37:148-157.

Higher Plasma Concentrations of Pirfenidone are Associated with Improved Clinical Outcomes

Used the natural distribution in plasma levels to assign patients to “low” versus “high” concentrations of pirfenidone

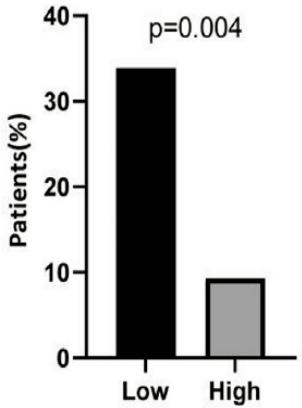
Distribution for two different pirfenidone concentrations*



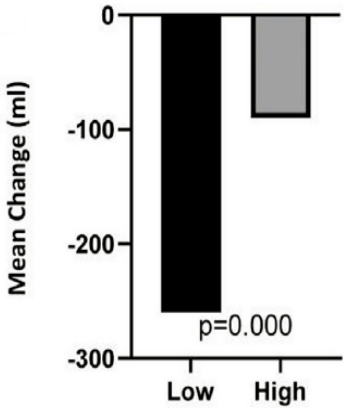
*Patients treated with pirfenidone ≥1,200 mg/day

Horizontal red lines represent the mean value, and the lower and upper black lines represent the SD value, respectively.

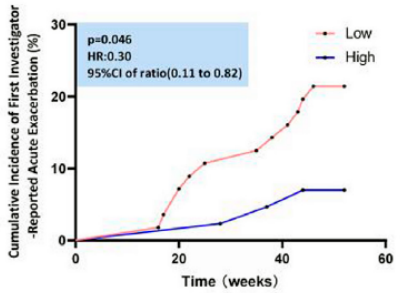
Efficacy Outcomes during the 52-Week Study Period



Proportion decreased % predicted FVC≥ 10% or who died



Mean change in FVC from baseline



Time to First Investigator-Reported Acute Exacerbation

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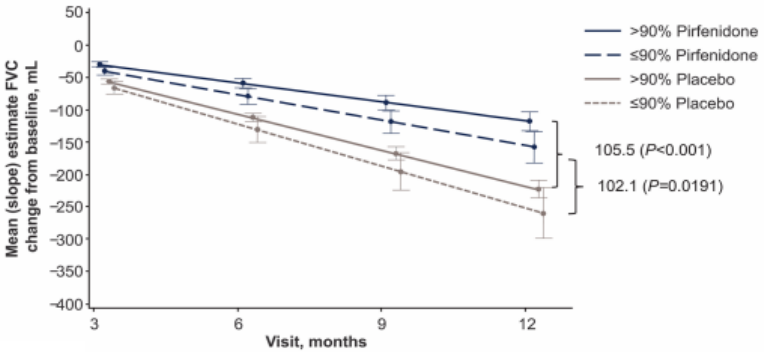
Li H et al. Front. Pharmacol. 2022; 13:1055702. [Chinese patients with IPF]

Lower Dose Intensity of Pirfenidone Leads to Worse Outcomes

In pirfenidone registration studies, IPF patients who took ≤90% pirfenidone had faster FVC decline

CAPACITY Study 004, 006 and ASCEND: Modelled mean (SEM) observed forced vital capacity (FVC) volume change from baseline (mL) over time by dose intensity (>90%, ≤90%)[1]



- Patients' change from baseline in FVC was stratified by dose intensity (i.e., patients who took >90% of their intended dose of pirfenidone vs patients who took ≤90%)
- **Patients who took ≤90% of their intended dose of pirfenidone had faster decline in FVC** as compared to patients who took >90%

[1] Nathan, S. D., Lancaster, L. H., Albera, C., Glassberg, M. K., Swigris, J. J., Gilberg, F., ... & Noble, P. W. (2018). Dose modification and dose intensity during treatment with pirfenidone: analysis of pooled data from three multinational phase III trials. *BMJ open respiratory research*, 5(1), e000323.; Modelled mean (SEM) observed forced vital capacity (FVC) volume change from baseline (mL) over time by dose intensity (>90%, ≤90%), based on actual dose (modified intention-to-treat population). No imputation for missing values and deaths. Months 3, 6, 9 and 12 correspond to weeks 12, 24, 36 and 48 for CAPACITY (004 and 006) studies and weeks 13, 26, 39 and 52 for ASCEND (016), respectively. The annual rate of decline was estimated from the linear mixed-effects model comparing pirfenidone with placebo for each of the dose intensity groups (>90%, ≤90%), with change from baseline as the outcome variable. Study (CAPACITY 004 and 006 and ASCEND 016), treatment, sex, age and height were evaluated as fixed effects, and patient and assessment time were evaluated as random effects in an unstructured variance–covariance matrix.

Case Study for Deuterium Benefits

A Case Study for Deuterium Benefits: Austedo®, a Deuterated Tetrabenazine

TETRABENAZINE

- Tetrabenazine is a generic drug indicated for the treatment of chorea associated with Huntington's disease
- Side effects prevent patients from achieving optimal dosing and efficacy

VS

The introduction of deuterium into the tetrabenazine molecule led to the creation of Austedo® by Teva Pharmaceuticals[1]

DEUTETRABENAZINE

- Significant efficacy and tolerability benefits due to the achievement of higher drug exposure
- Increased treatment rates and treatment duration
- Significant expansion of prescriber base; Teva predicts ~$2.5B in Austedo® sales by 2027[2]

[1] Certain third-party trademarks are included here; PureTech does not claim any rights to any third-party trademarks. [2]Teva Pharmaceuticals presentation at Leerink's Global Healthcare Conference 2025

Case Study for Success in Genericized Markets

Case Studies of Blockbuster Brands in Genericized Markets

Branded drugs that demonstrate clinically meaningful differentiation can achieve blockbuster commercial success, despite generic competition

PULMONARY ARTERIAL HYPERTENSION (PAH) MARKET

Opsumit® (macitentan)
Endothelin Receptor Antagonists

Opsumit® (macitentan) gained FDA approval in 2013

↓

Tracleer® (bosentan) and Letairis® (ambrisentan) lost patent exclusivity in 2019

↓

Opsumit® (macitentan)
$2.4B sales in 2024[1]
despite generic entrants

Uptravi® (selexipag)
Prostacyclins

Generic versions of Flolan® (epoprostenol) available

↓

Remodulin® (IV treprostinil) lost patent exclusivity in 2019

↓

Uptravi® (selexipag)
$2.2B sales in 2024[1]
despite generic competition

Winrevair™ (sotatercept)
Activin Signaling Inhibitors

Winrevair™ (sotatercept) gained FDA approval in 2024 as an add-on to background SOC therapies

↓

Winrevair™ (sotatercept)
Peak sales estimate of $3-5B[2]
despite its primary use as a combination therapy with generics

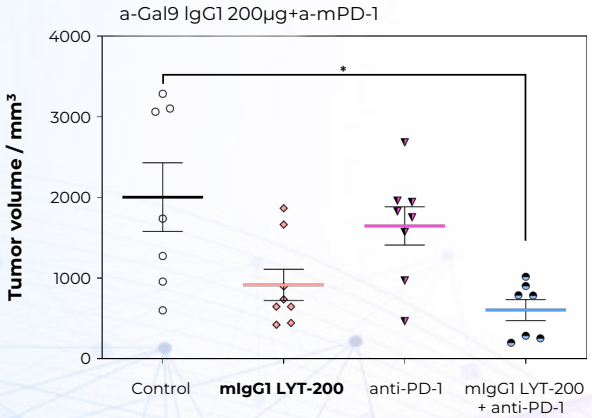
 [1]Johnson & Johnson Q4 and Full-Year 2024 Results; [2]Credit Susse, J.P. Morgan

Appendix A: Wholly-Owned Program LYT-200

Gallop Oncology: LYT-200

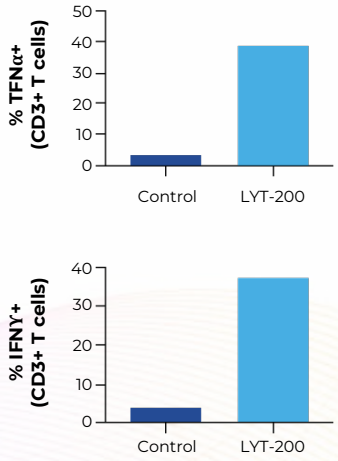
Multiple lines of preclinical data supporting therapeutic potential

SINGLE AGENT ACTIVITY IN B16F10 MELANOMA MODEL



n = 8 / arm; *p < 0.001; **p < 0.05; NS = not significant

T CELL ACTIVATION WITH LYT-200 IN PATIENT-DERIVED ORGANOID[1] MODEL



LYT-200 DRUG PROPERTIES MAKE IT AN EXCELLENT CLINICAL CLONE:

High affinity & specificity for galectin-9

Robust activity in preclinical studies:

- Single agent causes tumor reduction in pancreatic models where anti-PD-1s don't work
- ~50% tumor reduction with LYT-200 vs. ~22% tumor reduction with anti-PD-1 in melanoma model
- Increase in intra-tumoral CD8 T cells in combination with anti-PD-1
- Activation of intra-tumoral immunity in patient-derived tumor models

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[1] For patient-derived organoids, n = 20 tumor samples; Success defined as: >20% upregulation of at least two out of three T cell activation markers; Success achieved in 60% of tumors with majority showing >2 fold activation.

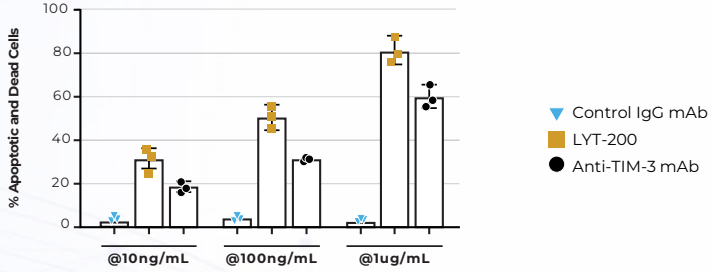
GALLOP ONCOLOGY

LYT-200

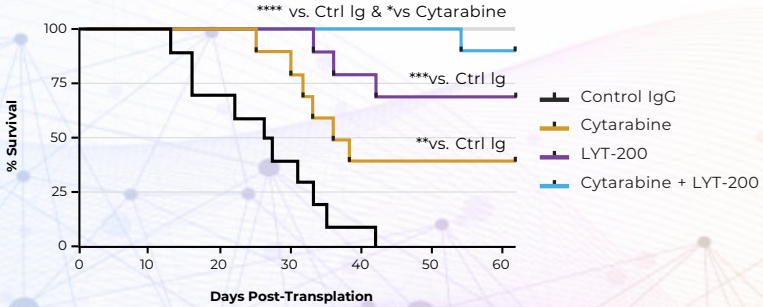
Administration induces apoptosis of leukemia cells & extends survival of leukemia cell engrafted animals

AML MODEL[1]

LYT-200 cause apoptosis of AML cells and is superior to anti-TIM-3 mAb

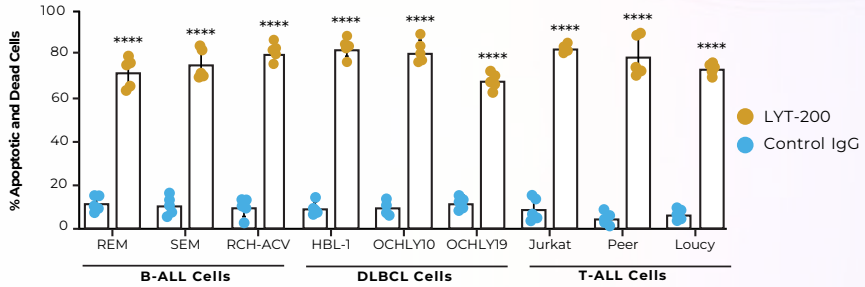


OCI-AML5 Xenograft Experiment

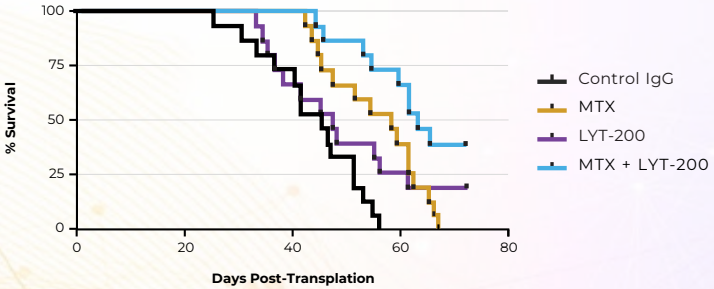


T-ALL, B-ALL & DLBCL MODEL

LYT-200 cause apoptosis of B-ALL, T-ALL and DLBCL cells



PDX Experiment for T-ALL[2]



[1] Statistical Significance (Log-rank [Mantel-Cox] test): Ctrl Ig vs. Cytarabine: **p=0.0090; Ctrl Ig vs. LYT-200: ****p<0.000; Ctrl Ig vs. Cytarabine + LYT-200: ****p<0.0001; Cytarabine vs. LYT-200 + Cytarabine: *p=0.0134; [2] Ctrl Ig vs. MTX= 0.062 (ns); Ctrl Ig vs. LYT-200= 0.021 (*); Ctrl Ig vs. LYT-200 + MTX= 0.0006 (***); MTX vs. LYT-200= 0.01 (**); MTX vs. LYT-200 + MTX= 0.0009 (***); LYT-200+LYT-200 + MTX= 0.008 (**).

Phase 1b Clinical Trial in AML/MDS Ongoing

DOSE ESCALATION TRIAL

Safety, tolerability, PK/PD, RP2D, Safety & efficacy + exploratory endpoints

PATIENT POPULATION

AML R/R to at least one line of prior therapy with or without allogeneic system cell transplant

OR

Patients with a document-ed diagnosis of R/R, high-risk MDS after at least one line of treatment

AND

For whom no standard therapy that may provide clinical benefit is available

DOSE FINDING (4+2 DESIGN)

If clinical benefit is observed & safety is maintained in any cohort, patients may be added to cohort(s) to further expand on safety/efficacy (Up to additional 6 patients)

Topline results from Phase 1b trial in AML in Q3 2025

PK= pharmacokinetic; PD = pharmacodynamics; RP2D = recommended Phase 2 dose; R/R = relapsed refractory.

Phase 1b Clinical Trial in Solid Tumors Completed

SOLID TUMOR DOSE ESCALATION & DOSE EXPANSION TRIAL

Dose Finding (CRM)
(all comers), safety, tolerability, RP2D, PK/PD, exploratory

Up to 26 patients

- Completed bi-monthly, monotherapy dose escalation portion of Phase 1b/2a trial (no dose limiting toxicities)
- Completed evaluation of weekly dosing

CLINICAL INVESTIGATORS

UCLA
PI - Zev Wainberg

Beth Israel Deaconess Medical Center
Daniel Fein

Health ONE
Gerald Falchook

The University of Texas MD Anderson Cancer Center
Making Cancer History®
Siqing Fu

Columbia University Medical Center
Manji Gulam

Memorial Sloan Kettering Cancer Center
Eric Sherman

Other sites: Mayo, START, Sarah Cannon

Appendix B: Founded Entities

Karuna Case Study

Wholly owned subsidiary of Bristol Myers Squibb as of March 18, 2024
1st new mechanism for treating schizophrenia in over 50 years

(PureTech entitled to Milestone Payments/ Royalties & up to $400M in milestone payments from agreement w/Royalty Pharma[1])

PATIENT NEED

~2.8M **living with schizophrenia in the US**

~3.2M **with Alzheimer's disease psychosis in the US**

Current antipsychotics **have significant side effects and poor adherence**

Xanomeline: clinical efficacy but was sitting on a shelf at Eli Lilly

PURETECH ROLE

Built top team of CNS experts & leaders

- ✓ **PureTech invented & filed patents** to cover the agonist/antagonist concept
- ✓ **Completed tolerability POC**
- ✓ Planned Phase 2 EMERGENT-1 study

Xanomeline
CNS active agonist

Trospium chloride
Peripheral antagonist blocks side effects of agonist

VALUE REALIZATION

- ✓ Phase 2 EMERGENT- 1, Phase 3 EMERGENT-2 & Phase 3 EMERGENT-3 trials **met primary endpoint** with clinically meaningful & significant **reduction in PANSS total score** vs. placebo
- ✓ Ongoing Phase 3 programs in **psychosis in Alzheimer's disease**
- ✓ Karuna Therapeutics acquired by Bristol Myers Squibb for **$14B**
- ✓ **Cobenfy™ (formerly known as KarXT) FDA approval on September 26, 2024**

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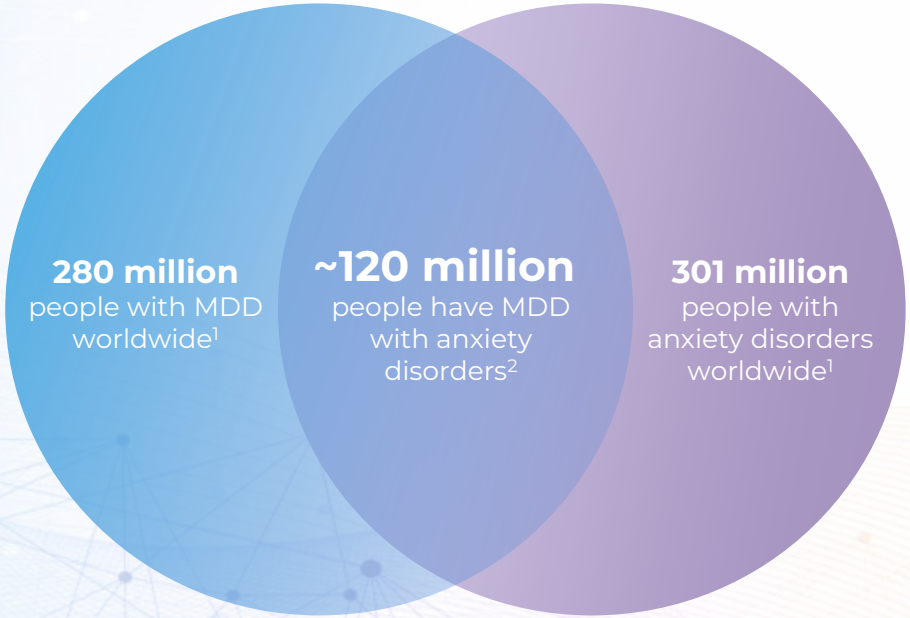
COBENFY™ (xanomeline and trospium chloride) is indicated for the treatment of schizophrenia in adults. For Important Safety Information, see U.S. Full Prescribing Information, including Patient Information on COBENFY.com.
[1] As of March 22, 2023, PureTech has sold its right to receive a 3% royalty from Karuna to Royalty Pharma on net sales up to $2 billion annually, after which threshold PureTech will receive 67% of the royalty payments and Royalty Pharma will receive 33%. Additionally, under its license agreement with Karuna, PureTech retains the right to also receive certain sublicense income.

Seaport Therapeutics: SPT-300, First Tailored Treatment for MDD

Large unmet need for new therapies to address multiple mental health disorders



MDD WITH ANXIETY

- MDD patients with anxiety, compared with MDD patients without anxiety[3]:
  - Less likely to achieve remission
  - Slower to respond to treatment
  - Poorer quality of life

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[1] Depressive disorder (depression); World Health Organization; [2] Kessler et al., 2015. Anxious and non-anxious major depressive disorder in the World Health Organization World Mental Health Surveys. Epidemiol Psychiatr Sci. 2015 Jun;24(3):210-26; [3] Compared to patients with MDD without anxiety: Hopwood M. (2023). Anxiety Symptoms in Patients with Major Depressive Disorder: Commentary on Prevalence and Clinical Implications. Neurology and therapy, 12(Suppl 1), 5–12.

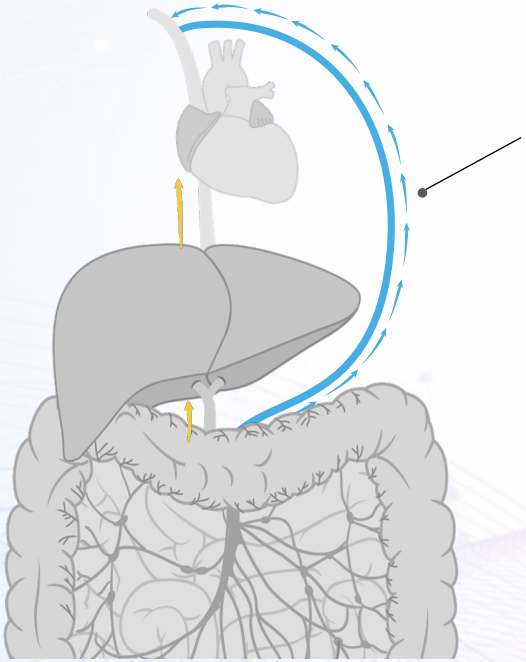
SEAPORT THERAPEUTICS

SPT-300 (Glyph Allopregnanolone)

For major depressive disorder

- Allopregnanolone is an endogenous (natural) neurosteroid with clinical validation in postpartum depression
- Lower levels of allopregnanolone have been documented in patients with mood disorders
- ...BUT method of administration (IV form) significantly limits patient uptake
- Oral chemical analogs have different composition than endogenous (natural) allopregnanolone and may not capture its full therapeutic potential
- **SPT-300 retains the activity & potency of endogenous allopregnanolone in an oral form**

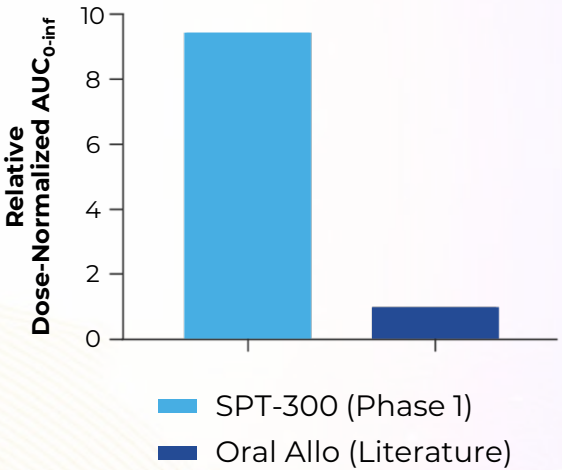
SPT-300 (Glyph Allopregnanolone)



GLYPH SPT-300 PHASE 1

- >9X drug delivery to target vs. oral allopregnanolone[1]
- Generally well-tolerated, AEs generally mild and transient
  - Most common AE was somnolence (on-target effect of $GABA_A$)
- No treatment-related severe or serious AEs
- No sudden loss of consciousness observed

SPT-300 ORAL SYSTEMIC EXPOSURE (HUMAN) VS LITERATURE DATA[1,2]



[1] Not a head-to-head; comparative values from brexanolone NDA 211371 Multi-disciplinary Review and Evaluation, FDA CDER, 2018. [2] AUC(0-inf) of LYT300 and Study 547-CLP-107 (in ref 1: Brexanolone NDA) were divided by mg allopregnanolone dosed, then both values divided by that dose-normalized AUC of 547-CLP-107 to show relative exposure at an equivalent dose.

Phase 2a Trial Design in Acute Anxiety

Randomized, placebo-controlled trial in the Trier Social Stress Test (TSST)

PRIMARY AIM:

To characterize pharmacology of SPT-300 for potential anxiety indications

PRIMARY ENDPOINT:

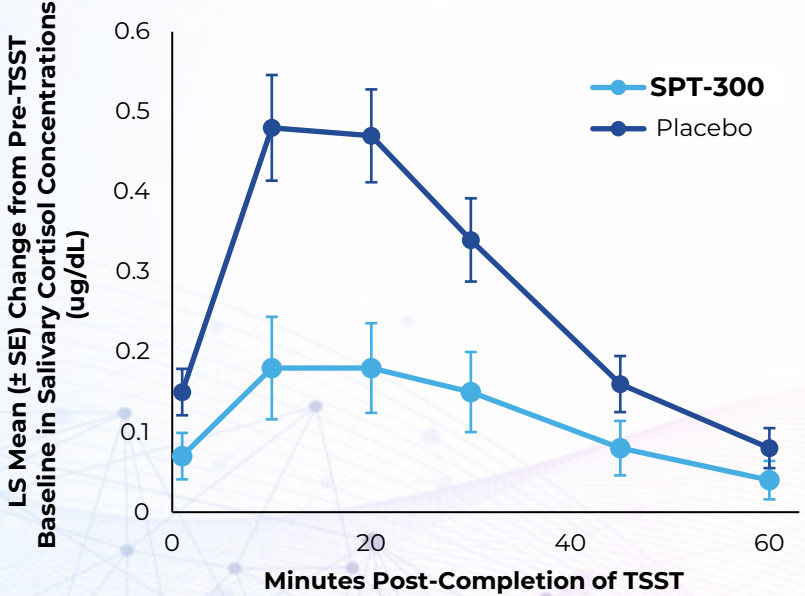
Reduction in salivary cortisol, a stress hormone

TRIAL DESIGN:

N=80 randomized to SPT-300 or placebo

Positive Phase 2a Study for SPT-300 in The Trier Social Stress Test

SPT-300 achieved primary endpoint (p=0.0001) in stress hormone response[1]



POSITIVE DATA

- SPT-300 had an effect size (Cohen's d = 0.72)[2]
- Generally well tolerated: All treatment-related adverse effects were transient, mild or moderate

VALIDATION

- Further supports the potential of SPT-300 for anxiety disorders
- Further validates the Glyph platform

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[1] SPT-300 vs. placebo log(10) LS Mean Change from Pre-TSST Baseline to Maximal Salivary Cortisol Concentration (ug/dL); [2] Fries, Eva, et al. (2006). Psychoneuroendocrinology, 31(10), 1278–1288. https://doi.org/10.1016/j.psyneuen.2006.09.009.

SEAPORT THERAPEUTICS

SPT-320 (Glyph Agomelatine)

For generalized anxiety disorder

- Clinically validated and approved for MDD in the EU and MDD & GAD in Australia
- Differentiated mechanism of action
- Consistent and statistically significant against placebo in GAD (4/4 studies)
- Superior efficacy and tolerability vs. standard-of-care[1,2]
- ...BUT it has low oral bioavailability and is associated with hepatoxicity necessitating liver function monitoring
- **SPT-320 has the potential to greatly reduce the risk of clinically significant liver enzyme elevations[3]**

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MDD=Major depressive disorder. GAD=Generalized anxiety disorder

[1] Cipriani, A., et al.(2018). Comparative efficacy and acceptability of 21 antidepressant drugs for the acute treatment of adults with major depressive disorder: a systematic review and network meta-analysis. The Lancet, 391(10128), 1357–1366. https://doi.org/10.1016/s0140-6736(17)32802-7; [2] Slee, A., et al.(2019). Pharmacological treatments for generalised anxiety disorder: a systematic review and network meta-analysis. The Lancet, 393(10173), 768–777. https://doi.org/10.1016/s0140-6736(18)31793-8; [3] In silico modeling using the FDA-licensed DILIsym platform shows potential to greatly reduce risk of clinically significant liver enzyme elevations.

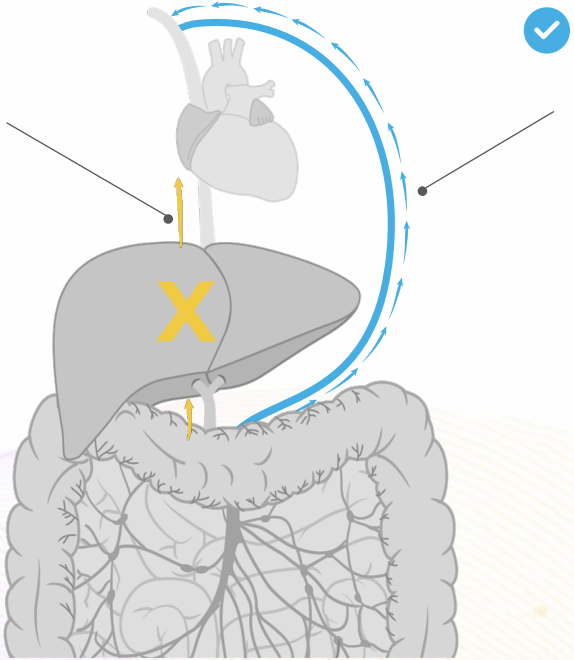
SEAPORT THERAPEUTICS

SPT-320: First-In-Class Potential for GAD & MDD

AGOMELATINE

- Low oral bioavailability (~1%)
- Most of the drug does not reach the brain
- Liver enzymes increase likely linked to hepatic first-pass metabolism:

  ~1.0% – 1.4% agomelatine vs. 0.7% with placebo[1]



SPT-320

- SPT-320 potential for therapeutic exposure with reduced risk of liver enzyme elevations

Data on file; N=6 (3M/3F);[1] AUSPAR review of Valdoxan (agomelatine).

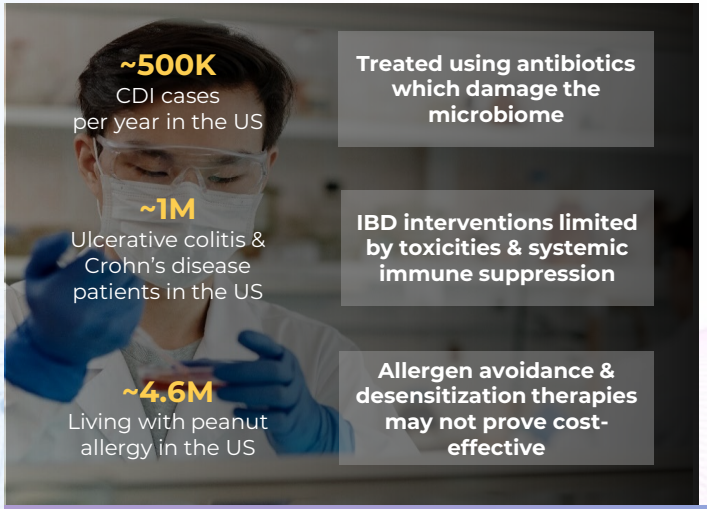
Vedanta

Developing a new class of drugs to modulate the human microbiome

(PRTC Ownership: 35.8%[1])

INNOVATION

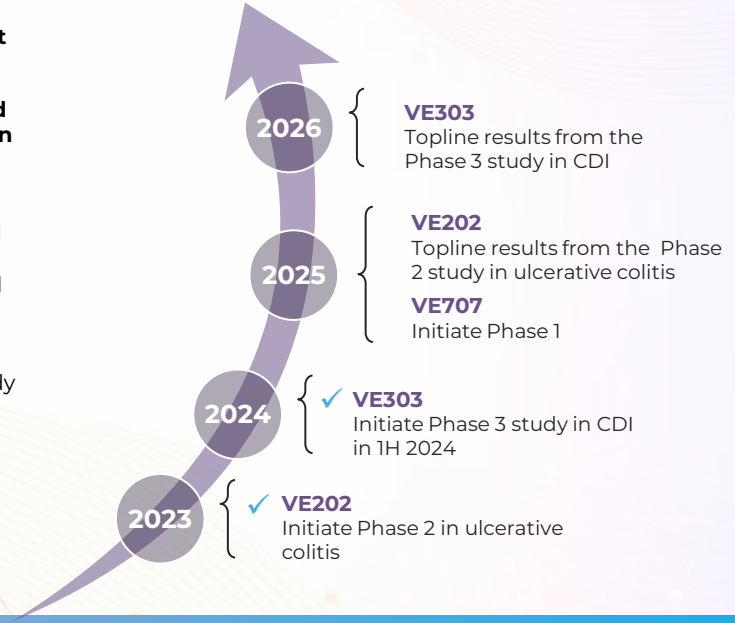
Rationally-defined consortia of **gut bacteria**; manufactured from **pure cell banks** to produce drug product of **known bacterial isolates; orally administered** to modulate microbial communities and immune responses



VALIDATION

- **Four clinical-stage programs in development**
- VE303 (C. difficile) demonstrated **accelerated gut microbiota restoration** after antibiotics in a **Phase 1a/1b study**
- VE202 (IBD) demonstrated durable & dose dependent colonization in Phase 1 trial in healthy volunteers
- VE416 (food allergy) being evaluated in Phase 1/2 study
- Strong IP portfolio
- $71.1M in total Series C

UPCOMING MILESTONES & VALUE REALIZATION



VE303 & VE202 received Fast Track designation from the U.S. FDA

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[1] As of December 31, 2024, PureTech's percentage ownership of Vedanta Biosciences was approximately 35.8 percent on a diluted basis. This calculation includes issued and outstanding shares, options, and warrants, but excludes unallocated shares authorized to be issued pursuant to equity incentive plans. PureTech ownership reflects current ownership and does not take into account any potential future dilution, if applicable, as a result of conversion of that debt amount.

Entrega

Engineering hydrogels to enable the oral administration of peptide therapeutics (e.g., GLP-1 agonists)

(PRTC Ownership: 73.8%[1])

Entrega is focused on the oral administration of biologics, vaccines and other drugs that are otherwise not efficiently absorbed when taken orally.

The vast majority of biologic drugs, including peptides, proteins and other macromolecules are currently administered by injection, which can present challenges for healthcare administration and compliance with treatment regimes.

MILESTONES ACHIEVED

- To validate its technology, Entrega generated preclinical proof-of-concept data demonstrating administration of therapeutic peptides into the bloodstream of large animals.

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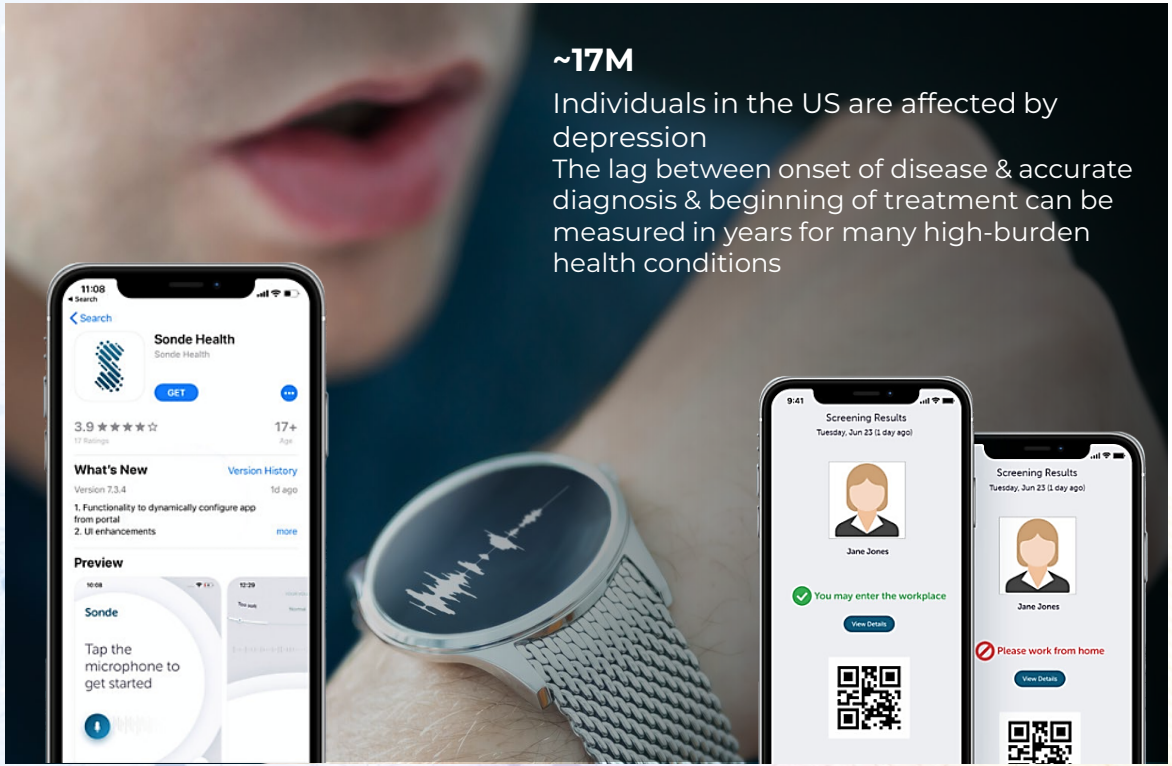
[1] As of December 31, 2024, PureTech's percentage ownership of Entrega was approximately 73.8 percent on a diluted basis. This calculation includes outstanding shares, options, and warrants, but excludes unallocated shares authorized to be issued pursuant to equity incentive plans.

Sonde

Voice-based artificial intelligence (AI) platform with the potential to transform how we monitor health

(PRTC Ownership: 34.8%[1])



SONDE

Developing proprietary technology to sense & analyze subtle changes in the voice to create a range of persistent brain, muscle & respiratory health measurements that provide a more complete picture of health in just seconds

KEY HIGHLIGHTS

- Technology has demonstrated the **potential to screen & monitor for diseas**e in individuals from brief samples of speech
- **Ongoing collaborations** with multiple US & ex-US hospitals, clinics & academic medical centers
- Partnership with Qualcomm Technologies for vocal biomarker technology
- Collected **voice data** from over 80,000 subjects as part of ongoing validation of platform
- Expanded development of its proprietary technology into respiratory & other **health & wellness conditions, including mental health**

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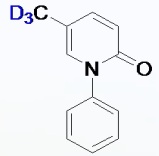
[1] As of December 31, 2024, PureTech's percentage ownership of Sonde was approximately 34.8 percent on a diluted basis. This calculation includes outstanding shares, options, and warrants, but excludes unallocated shares authorized to be issued pursuant to equity incentive plans.

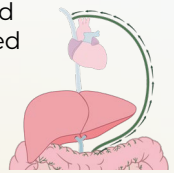
Appendix C: Supplemental Materials

PureTech's Proven Expertise

We give life to classes of medicine with proven efficacy by addressing key limitations

PROGRAM	VALIDATED EFFICACY	PROBLEM	PURETECH INSIGHT/IP
BMS's Cobenfy (fka KarXT) FDA approved for schizophrenia in adults	Xanomeline is highly effective in reducing psychosis	Xanomeline has GI tolerability issues	Pairing xanomeline with peripherally-restricted muscarinic antagonist improved AE profile and unlocked 1st new class in 50+ years
LYT-100 for inflammation and fibrosis, including IPF	Pirfenidone extends life in patients with IPF by an average of ~2.5 years[1]	GI tolerability issues negatively impact patient compliance & efficacy	Retain clinically-validated activity of pirfenidone w/ favorable tolerability & potential for improved efficacy
SPT-300 for neuropsychiatric & rare CNS conditions	Allopregnanolone has demonstrated efficacy in mental health conditions	Marketed allopregnanolone requires 60-hr IV infusion & chemical analogs may have different pharmacological effects than endogenous allopregnanolone	Using proprietary Glyph technology, achieved blood levels of allopregnanolone at/above those associated w/ therapeutic effect & demonstrated exposure-dependent target engagement w/ $GABA_A$ receptors[2]. Approach may have advantages vs. oral chemical analogs





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COBENFY™ (xanomeline and trospium chloride) is indicated for the treatment of schizophrenia in adults. For Important Safety Information, see U.S. Full Prescribing Information, including Patient Information on COBENFY.com. [1] Fisher, M., Nathan, S. D., Hill, C., Marshall, J., Dejonckheere, F., Thuresson, P., & Maher, T. M. (2017). Predicting Life Expectancy for Pirfenidone in Idiopathic Pulmonary Fibrosis. Journal of Managed Care & Specialty Pharmacy, 23(3-b Suppl), S17–S24. https://doi.org/10.18553/jmcp.2017.23.3-b.s17; [2] Brexanolone NDA 211371 Multi-disciplinary Review and Evaluation, FDA CDER, 2018; FXTAS = Fragile X-associated Tremor/Ataxia Syndrome.

PureTech is Executing & Delivering Results

REGULATORY

FDA Clearance

COBENFY™ (KarXT)

EndeavorRx® (AKL-T01)

Plenity® (Gelesis100)

R&D & DATA PRESENTATIONS

- ✓ **Phase 2b results for** deupirfenidone
- ✓ **Phase 2 & Phase 3 results for** Karuna's KarXT
- ✓ **Phase 1 results** for Vedanta's VE303 & VE202
- ✓ **Phase 2 results** for Vedanta's VE303
- ✓ Pivotal data for AKL-T01 ADHD study published in ***Lancet Digital Health***
- ✓ Vedanta's IO candidate selected & being **advanced with BMS**
- ✓ PureTech programs published in ***Nature*** & ***Nature Neuroscience***
- ✓ POC study for Vor published in ***PNAS***
- ✓ Presentations on PureTech's LYT-200 at **ESMO & ASH & SITC & AACR**
- ✓ Presentations on PureTech's deupirfenidone at **CHEST & ATS & ERS**
- ✓ PureTech's deupirfenidone MAD study published in **Clinical Pharmacology in Drug Development**

PARTNERSHIPS

- ✓ **PureTech's partnership with Imbrium Therapeutics to advance LYT-503/IMB-150**
  $6.5 million in upfront payment and eligible to receive up to $53 million in additional development milestone payments for this program as well as royalties on product sales
- ✓ **PureTech's royalty agreement with Royalty Pharma for up to $500M**
  $100 million up front and up to $400 million in additional payments for PureTech's 3% royalty in BMS's Cobenfy (formerly known as KarXT). After $2 billion sales threshold, PureTech to retain 67% of royalty payments

FINANCINGS

- ✓ **Seaport's $100M Series A financing; $225M Series B financing**
  Key investors include ARCH Venture Partners, Sofinnova Investments, Third Rock Ventures, General Atlantic with participation from T. Rowe Price Associates, Foresite Capital, Invus Capital, Goldman Sachs, Canada Pension Plan Investment Board (CPP Investments)
- ✓ **Karuna's $124M Series A+B financings; $103M IPO; $14B acquisition by BMS**
  Key investors include ARCH Venture Partners, Fidelity, Eventide, Pivotal bioVenture Partners, Partner Fund
- ✓ **Vor's $153M Series A+B financings; $203.4M IPO**
  Key investors include RA Capital Management, Fidelity Management & Research Company, Pagliuca Family Office, Alexandria Venture Investments, 5AM Ventures, Johnson & Johnson Innovation—JJDC, Inc. (JJDC), Osage University Partners, Novartis Institutes for BioMedical Research
- ✓ **Vedanta's $71M Series C financing; $68M Series D financing**
  Key investors include Bill & Melinda Gates Foundation, Bristol-Myers Squibb, Rock Springs Capital, affiliates of Magnetar Capital
- ✓ **Sonde's $16M Series A financing**
  Key investors include M Ventures, MP Healthcare Venture Management, Neoteny 4
- ✓ **Vedanta's $106.5M financing**
  Syndicate led by new investors AXA IM Alts and The AMR Action Fund along with existing investors Bill & Melinda Gates Foundation, Skyviews Life Science, and others

Financial Highlights

	March 31, 2025 $ millions	March 31, 2024 $ millions
Cash Flow and Liquidity		
Cash and Cash Equivalents	289.7	453.0
Short-term investments	49.8	121.4
Consolidated Cash, cash equivalents and short-term investments	**339.5**	**574.4**
Less: Cash and Cash Equivalents held at non-wholly-owned subsidiaries	(0.4)	(1.1)
PureTech Level Cash, cash equivalents and short-term investments[1]	**339.1**	**573.3**

[1] PureTech level cash, cash equivalents and short-term investments excludes cash and cash equivalents at non-wholly owned subsidiary of $0.4m. PureTech level cash, cash equivalents and short-term investments is a non-IFRS measure.

Non-IFRS Measures

Reported Performance

Reported performance considers all factors that have affected the results of our business, as reflected in our consolidated financial statements.

Core Performance

Core performance measures are alternative performance measures (APM) which are adjusted and non-IFRS measures. These measures cannot be derived directly from our Consolidated Financial Statements. We believe that these non-IFRS performance measures, when provided in combination with reported performance, will provide investors, analysts and other stakeholders with helpful complementary information to better understand our financial performance and our financial position from period to period. The measures are also used by management for planning and reporting purposes. The measures are not substitutable for IFRS financial information and should not be considered superior to financial information presented in accordance with IFRS.

Cash flow and liquidity

PureTech Level Cash, cash equivalents and short-term investments

Measure type: Core performance.

Definition: Cash and cash equivalents, and Short-term investments held at PureTech Health plc and only wholly-owned subsidiaries.

Why we use it: PureTech Level Cash, cash equivalents and short-term investments is a measure that provides valuable additional information with respect to cash, cash equivalents and short-term investments available to fund the Wholly Owned Programs and make certain investments in Founded Entities.