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Deupirfenidone Program

Supplemental Slides

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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.

Accelerating Program Advancement for Patients in Need

ELEVATE IPF STUDY

December 2024
Successful completion of Phase 2b trial

March 2025
Open label extension (OLE) ongoing
- ✓ 140 patients continued in the OLE
- ✓ 85 patients received at least 52 weeks of treatment to date[1]

May 2025
Additional data from Phase 2b to be presented at ATS
- ✓ Preliminary 52-week OLE data demonstrate durable treatment effect
- ✓ 101 patients received at least 52 weeks of treatment to date[2]

September 2025
Additional OLE data (including "switch data") at ERS International Congress

Before the end of Q3 2025
Expected meeting with FDA

H1 2026
Initiation of Phase 3

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ATS = American Thoracic Society; ERS = European Respiratory Society; [1] As of March 14, 2025; [2] As of May 9, 2025.

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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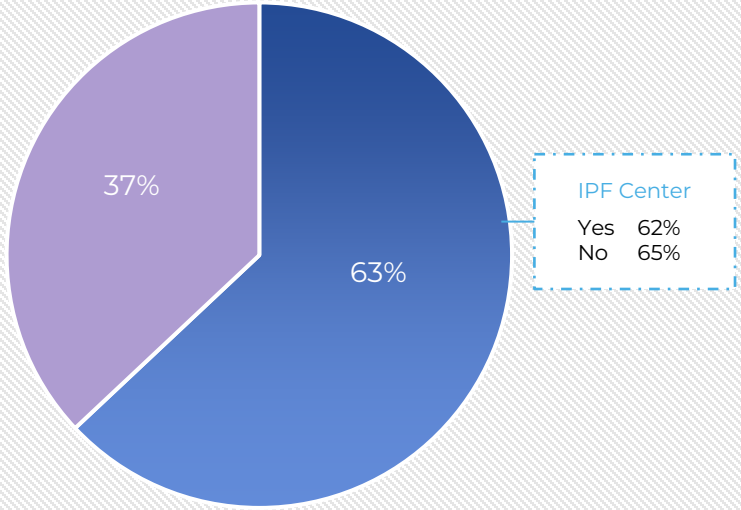
[1] GlobalData Epidemiology and Market Size Search, EU5=United Kingdom, France, Germany, Italy and Spain; [2] Barratt SL, Creamer A, Hayton C, Chaudhuri N. Idiopathic Pulmonary Fibrosis (IPF): An Overview. J Clin Med. 2018 Aug 6;7(8):201; [3] Fisher, M., Nathan, S. D., Hill, C., Marshall, J., Dejonckheere, 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.

Efficacy is the Key Prescribing Focus in IPF

The majority of respondents prioritize efficacy (over safety/tolerability) in trying to optimize therapy for IPF patients, regardless of practice setting (2025 analysis)

Recognizing the Tradeoffs Between Efficacy and Safety/Tolerability, If I Have to Choose One, I Most Prioritize…



- Pushing for Incremental Efficacy Even if There is a Slight Safety/Tolerability Disadvantage
- Optimizing for a Safe/Tolerable Treatment Even if There is a Slight Efficacy Disadvantage

(n=30)

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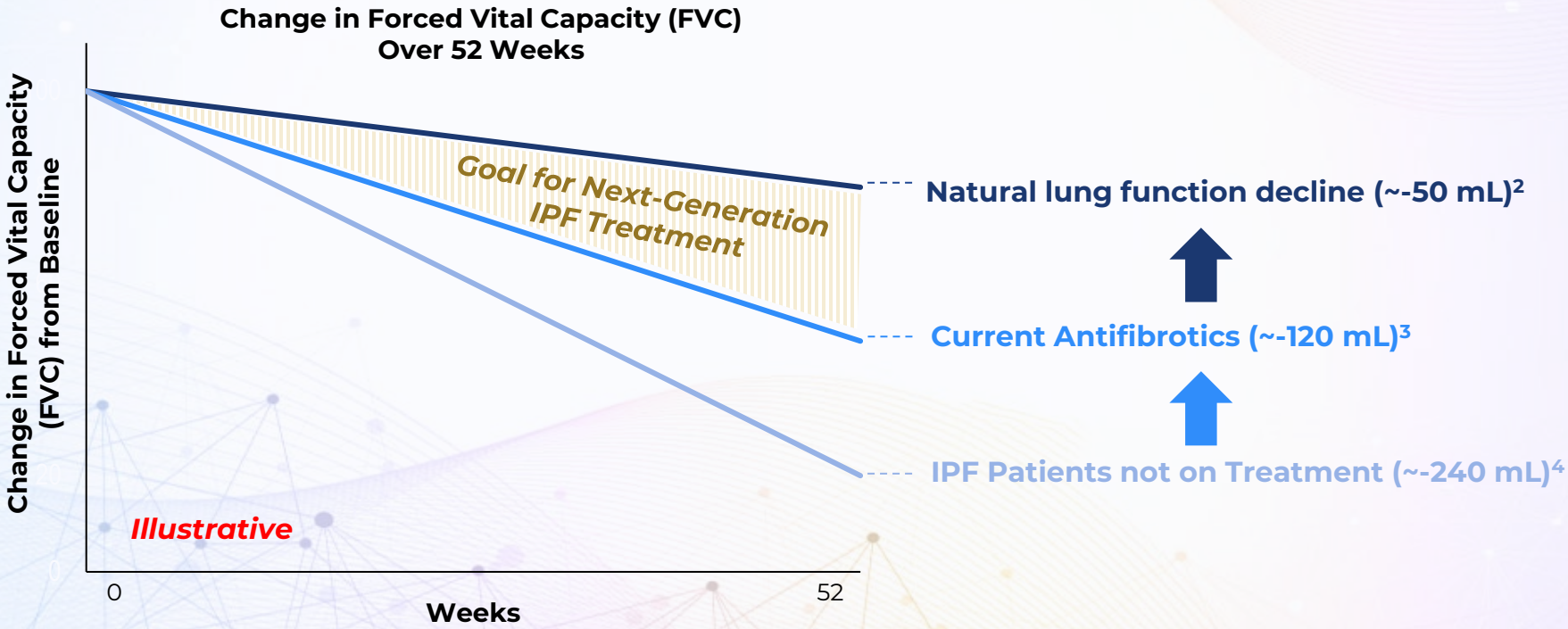
30 pulmonologists participated in a quantitative survey, conducted by a third party and completed in Q3 2025. Pulmonologists were asked "Which of the following best describes your approach when trying to optimize therapy for IPF patients?"

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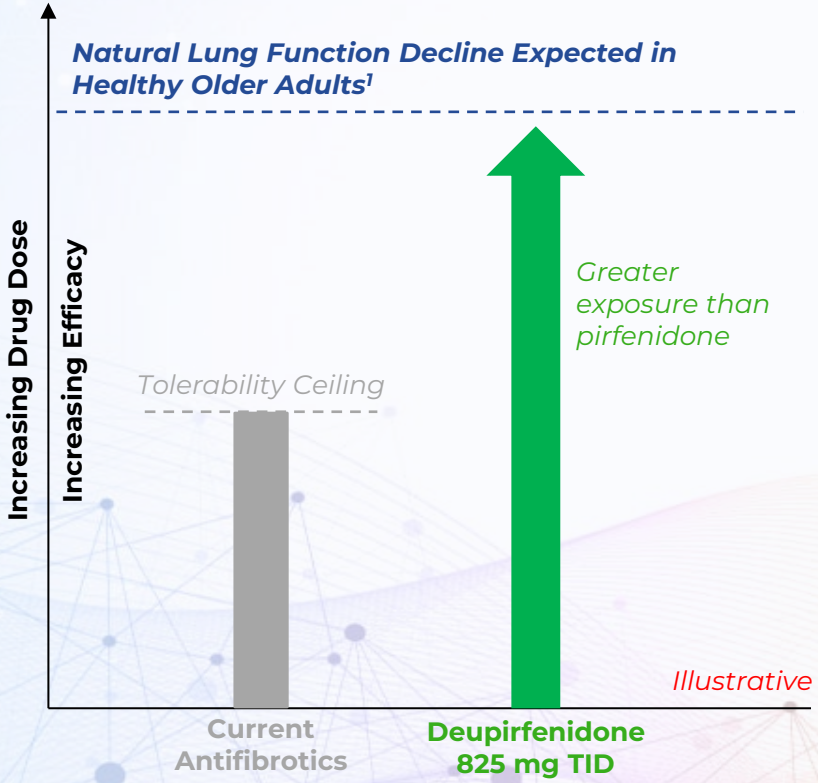
Dose-limiting Tolerability Challenges Have Prevented Patients on SOC from Achieving Greater Efficacy



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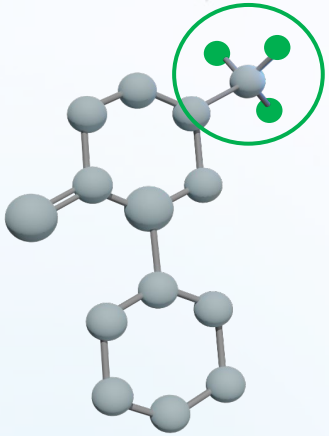
[1]Per Valenzuela. Boehringer Ingelheim. ERS 2024 and Luoto. Eur Respir J. 2019; [2]Side effects for prifenidone reported in 3 randomized, double-blind, placebo-controlled trials (ASCEND, CAPACITY 004, and CAPACITY 006) in which a total of 623 patients received 2403 mg/day of pirfenidone; [3]Side effects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

Introduction to Deupirfenidone

Deupirfenidone Is a Novel Compound with the Potential to Become the Next Standard-of-care Treatment in IPF

STRUCTURE



DEUTERIUM SUBSTITUTION

New chemical entity with strategically placed deuterium (heavy hydrogen) at site of metabolism

OVERVIEW

- Leverages clinically validated pirfenidone[1] with **potential for improved efficacy without sacrificing tolerability**
- Composition of matter patent exclusivity up to 2033 with PTE; Additional broad and layered IP coverage to ~2043

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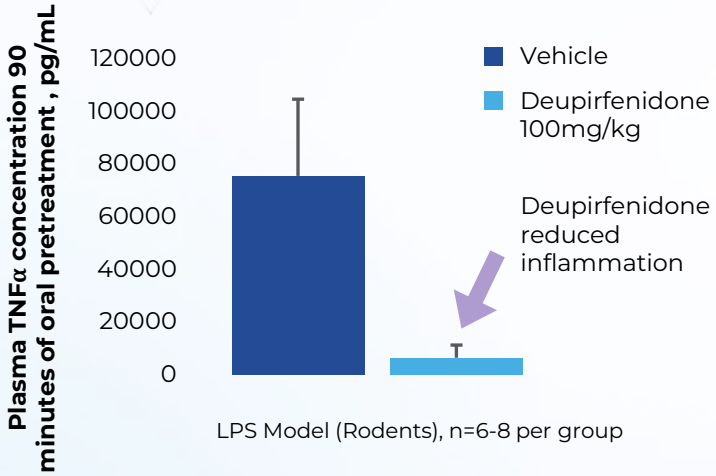
Deupirfenidone is an investigational drug not approved by any regulatory authority.
PTE: Patent Term Extension.
[1] Pirfenidone is one of the two FDA-approved standard-of-care treatments, with the other being nintedanib. Deupirfenidone is a deuterated form of pirfenidone.

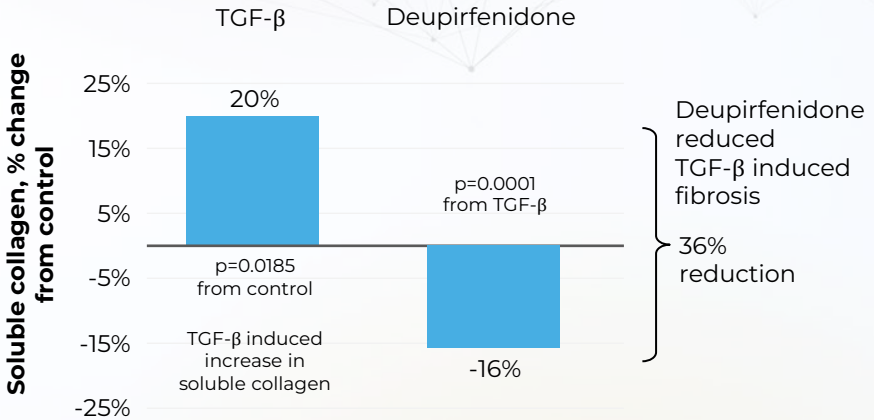
Preclinical Data

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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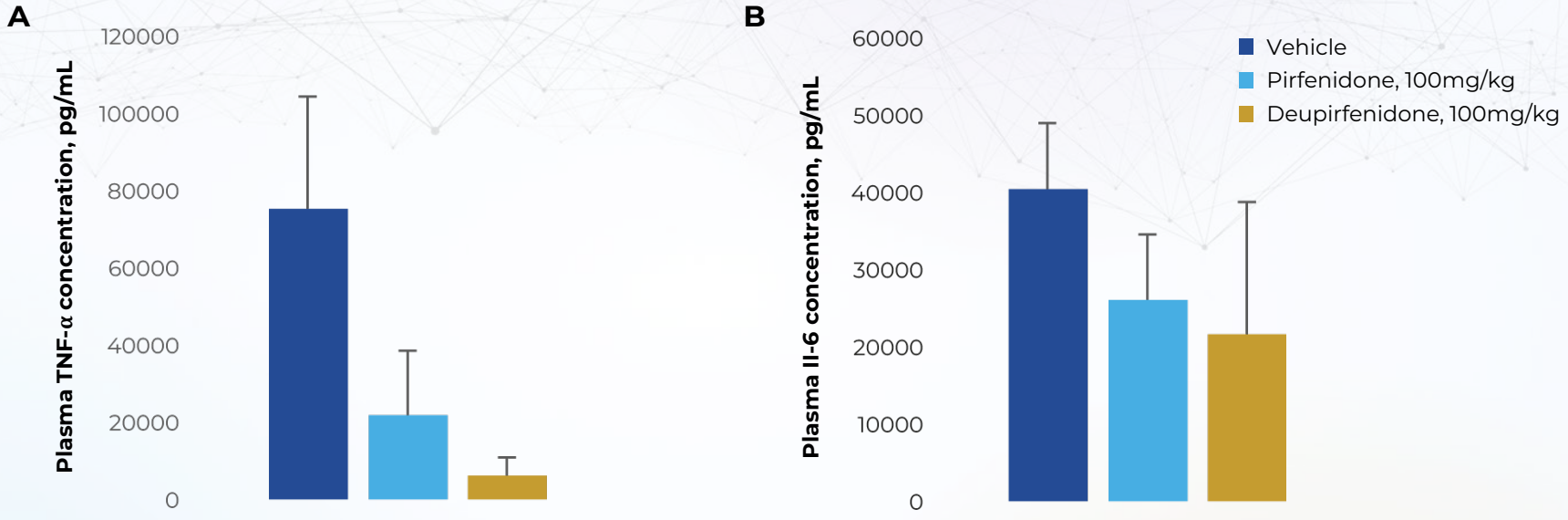
Source: Data on File

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.

Phase 2b ELEVATE Data

ELEVATE Trial Demonstrated Unprecedented Efficacy for Deupirfenidone 825 mg TID

POTENTIAL FOR LUNG FUNCTION STABILIZATION

*Deupirfenidone 825 mg TID monotherapy **approached the natural lung function decline expected in healthy older adults**[1]*

ENHANCED EFFICACY VERSUS CURRENT STANDARD OF CARE

*Deupirfenidone 825 mg TID demonstrated a ~**50% greater treatment effect than pirfenidone** vs placebo*

DURABLE EFFICACY RESPONSE OUT TO 52 WEEKS

*Ongoing open-label extension highlights **consistent effect of deupirfenidone** at 52 weeks[2]*

SUPPORTING PHARMACOKINETIC (PK) DATA

*Deupirfenidone 825 mg TID had **~50% greater exposure vs. pirfenidone**, which may have driven the greater efficacy observed*

Data support potential for deupirfenidone to set a new standard for efficacy in IPF

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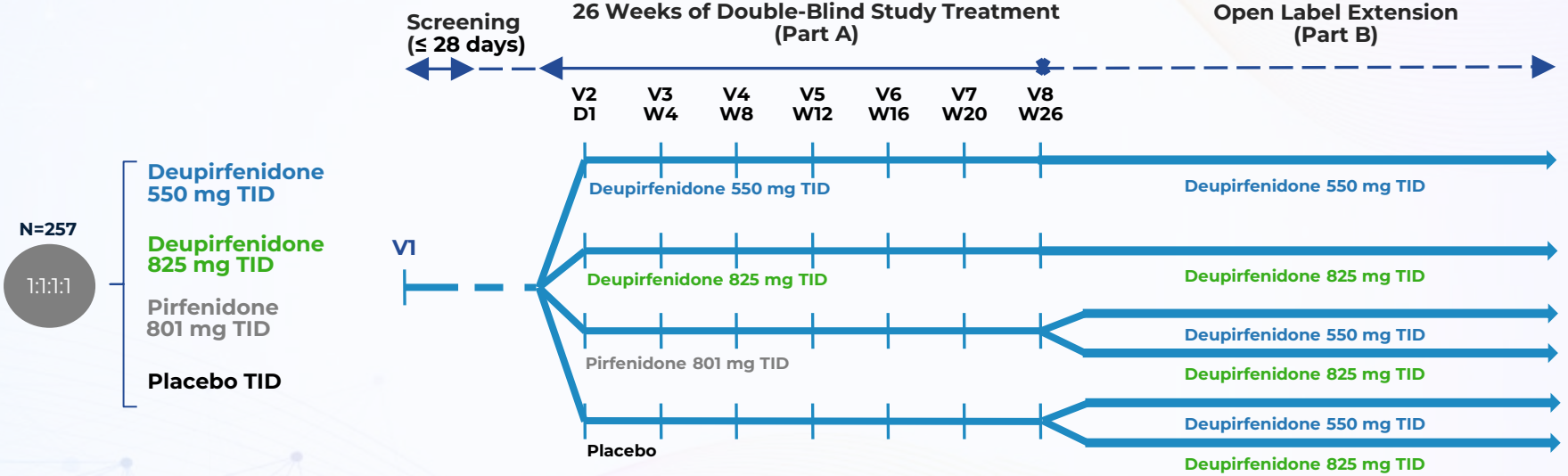
[1] FVC decline at 6 months was estimated assuming linear decline over time. Valenzuela, C., Bonella, F., Moor, C., Weimann, G., Miede, C., Stowasser, S., Maher, T. (2024). Decline in forced vital capacity (FVC) in subjects with idiopathic pulmonary fibrosis (IPF) and progressive pulmonary fibrosis (PPF) 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] Per 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.
FVC: Forced Vital Capacity.

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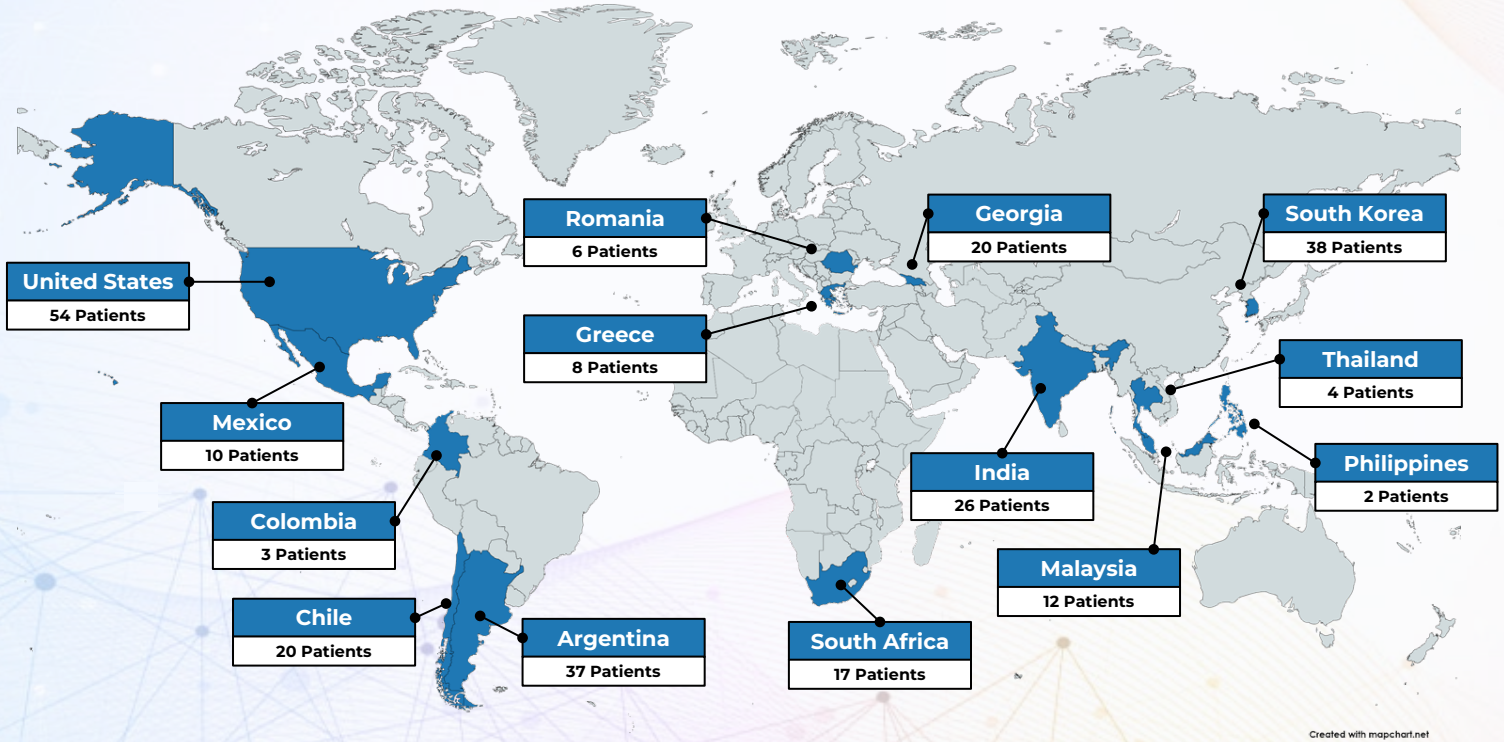
FVC = Forced Vital Capacity; TID = three times a day
Note: Patients in all arms were permitted to decrease and re-increase their assigned dose as tolerated

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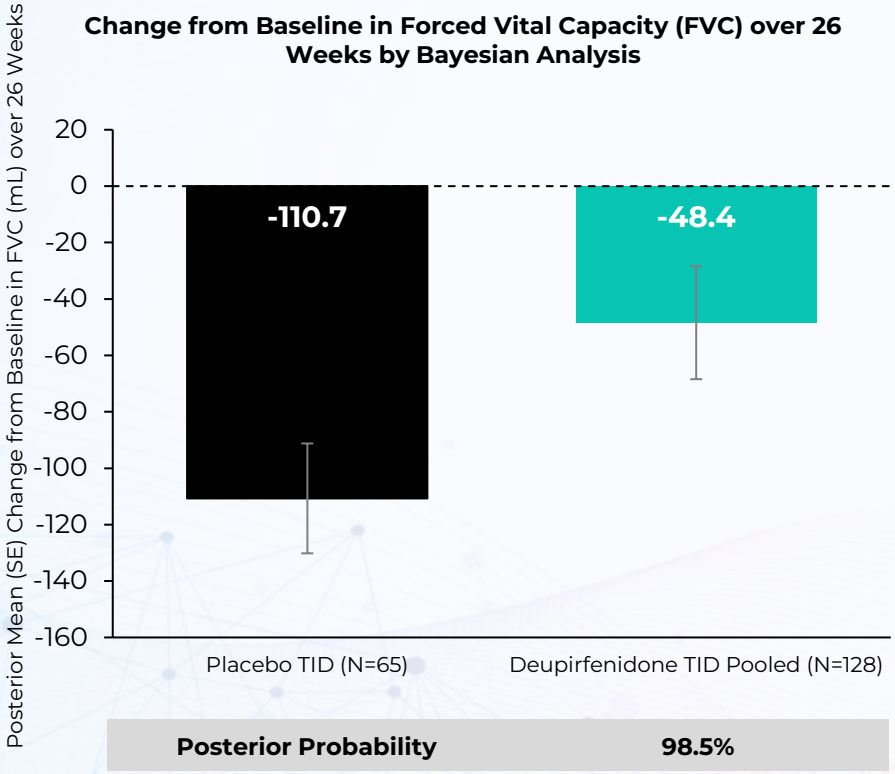
[1] Bayesian is a method that has been used by large pharmaceutical companies in the IPF space. The FDA has also acknowledged the benefits of this approach.
Efficacy analyses used a random coefficient regression model with absolute FVC or FVCpp including baseline as response variable and week, treatment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

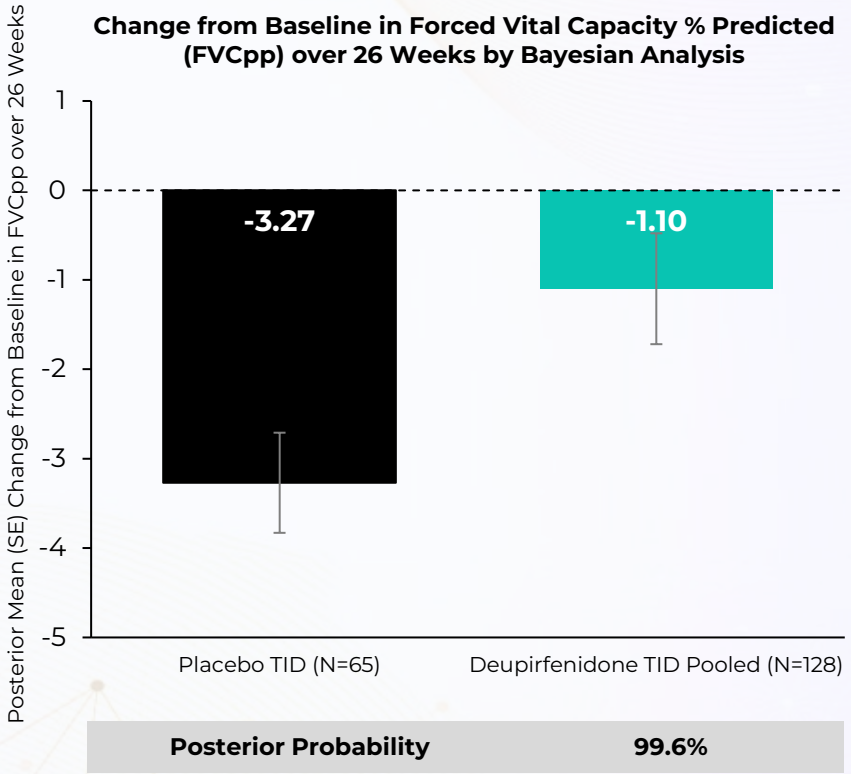
ELEVATE Achieved Primary and Key Secondary Endpoints

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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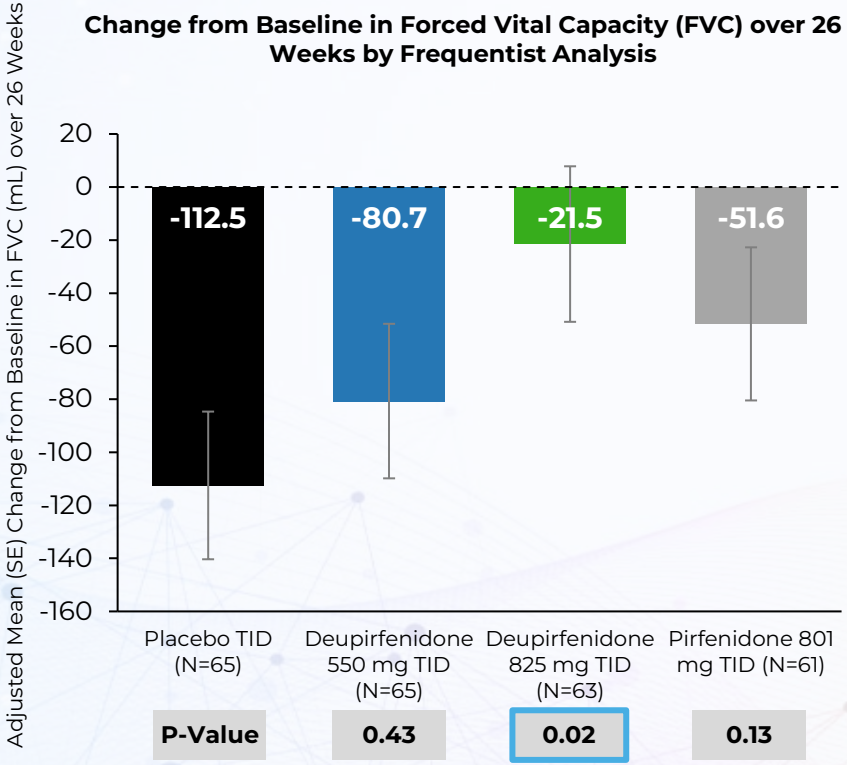
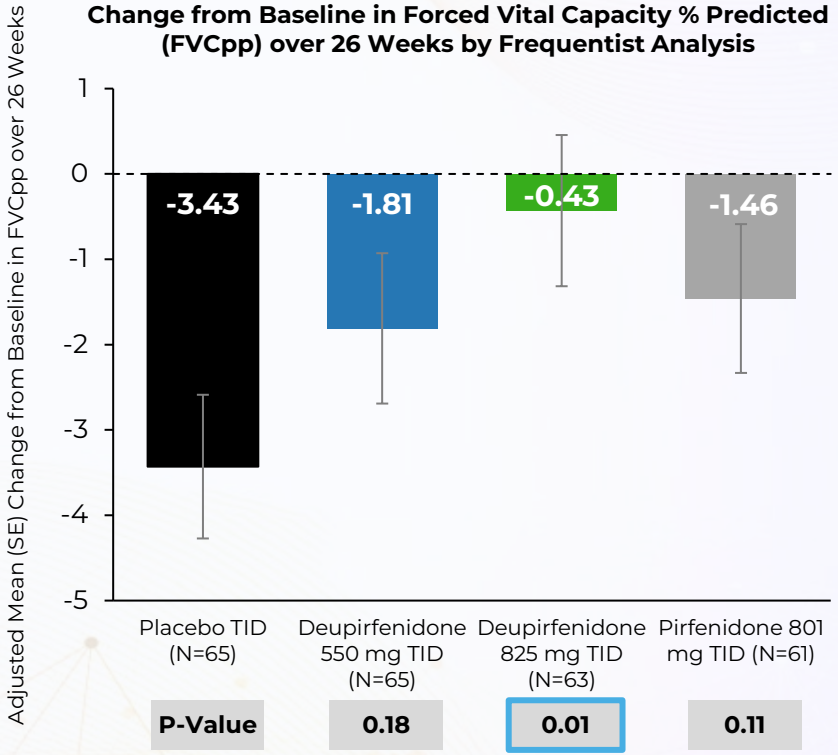
Efficacy analyses used a random coefficient regression model with absolute FVC or FVCpp including baseline as response variable and week, treatment (placebo, pirfenidone, deupirfenidone pooled arm) and interaction between week and treatment as fixed effect. The analyses were performed based on the predefined 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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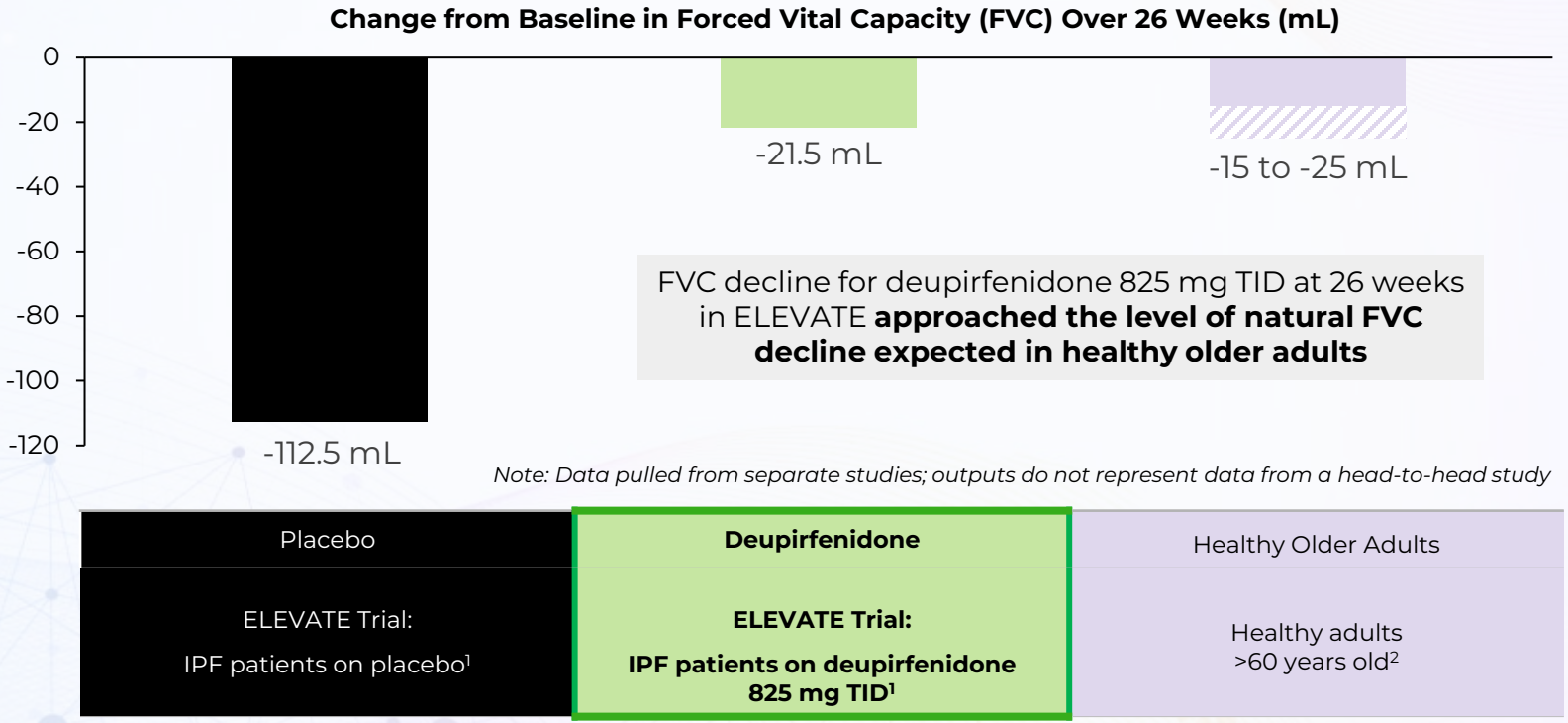
Efficacy analyses used a random coefficient regression model with absolute FVC or FVCpp including baseline as response variable and week, treatment and interaction between week and treatment as fixed effect. The analyses were performed based on the predefined Full Analysis Set. p values are two-sided 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 Preserved Lung Function; Rate of Decline Similar to Healthy Older Adults

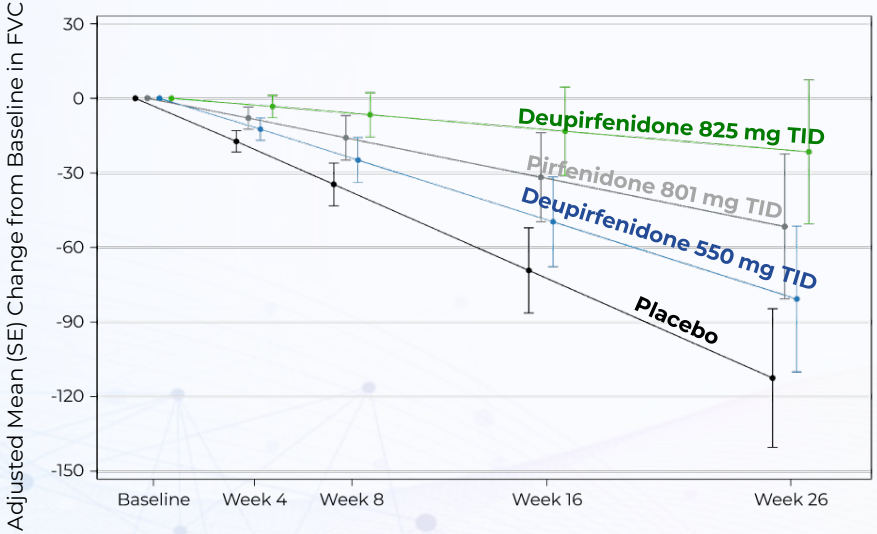


[1] Reflects outputs obtained via frequentist analysis; [2]Per Valenzuela. Boehringer Ingelheim. ERS 2024 and Luoto. Eur Respir J. 2019 (6-month decline in general population aged 60-102 years, estimated by taking reported 1-year decline and dividing by 2). Change from baseline FVC is not adjusted for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

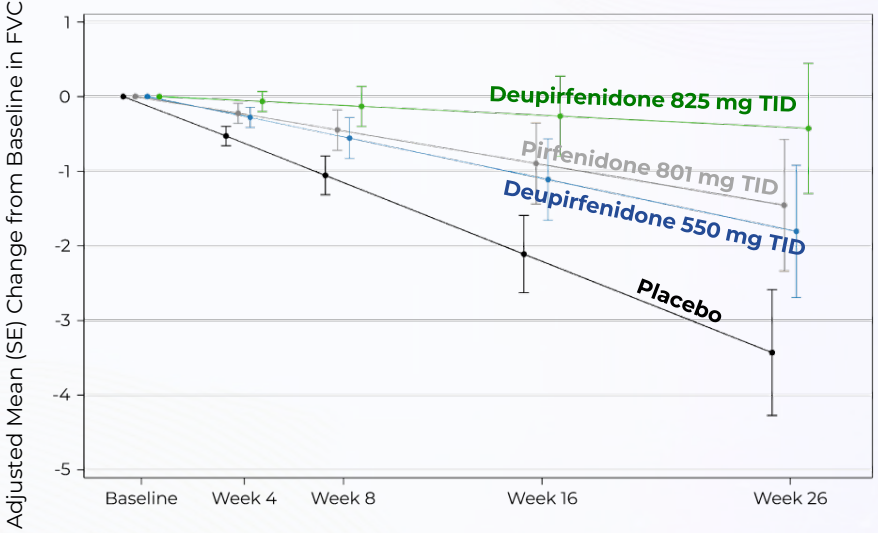
Deupirfenidone Demonstrated a Clear Dose-dependent Effect

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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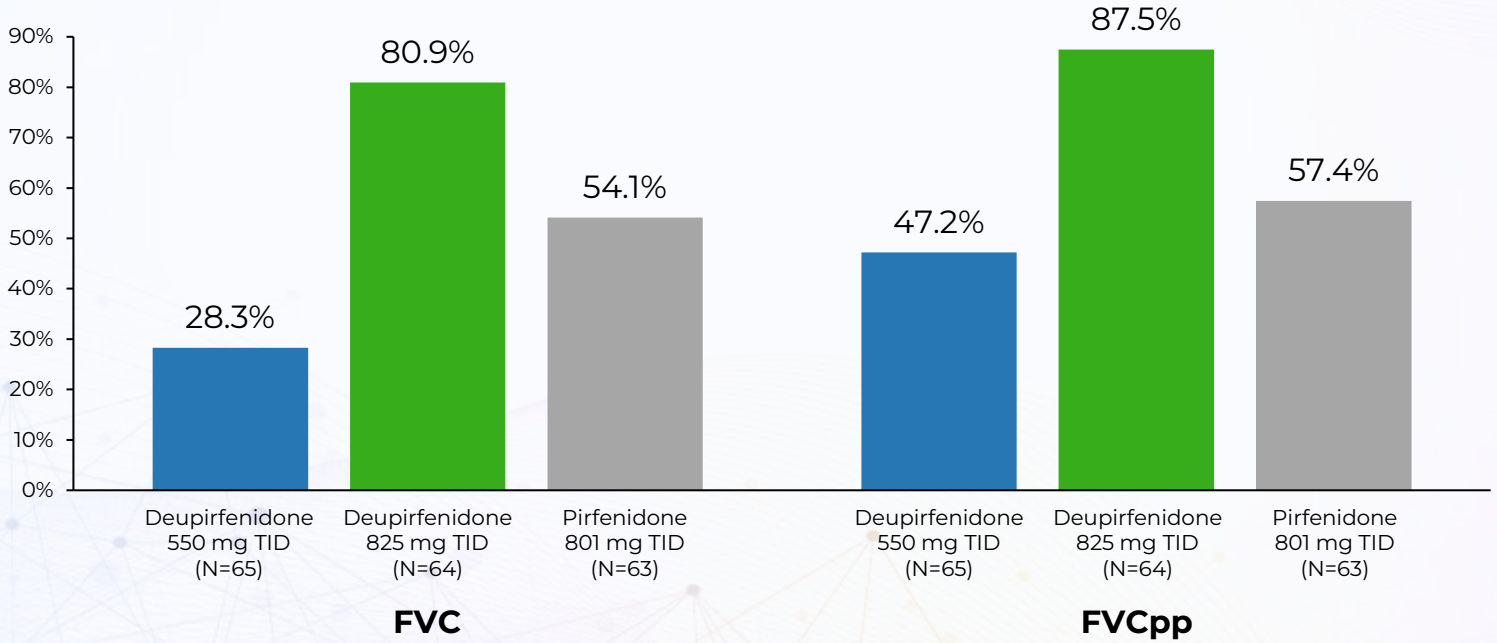
Efficacy analysis is based on pre-defined Full Analysis Set using a random coefficient regression model with absolute FVC as a response, including baseline. MMRM = mixed model for repeated measure; SE = standard error; TID = 3 times per day. Baseline is defined as the last available measurement performed 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



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

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PK Analysis From ELEVATE Showed That Deupirfenidone 825 mg TID Has ~50% Greater Exposure than Pirfenidone

Analysis of Estimated AUC for Deupirfenidone and Pirfenidone

	Deupirfenidone 550 mg TID vs. Pirfenidone 801 mg TID		Deupirfenidone 825 mg TID vs. Pirfenidone 801 mg TID	
	AUC Ratio	p-value	AUC Ratio	p-value
PK Population[1] (446 Samples)	~14% Lower	0.1493	~46% Greater	0.0002
Subjects with >95% Adherence[2] (221 Samples)	~19% Lower	0.0939	~50% Greater	0.0012

ELEVATE PK Summary

- Deupirfenidone 825 mg TID had **greater exposure** than pirfenidone 801 mg TID, which may have **driven the greater efficacy observed**
- Increased exposure of 825 mg TID **did not result in increased tolerability challenges**, suggesting the deuterated structure of deupirfenidone may **overcome the dose-limiting adverse events associated with pirfenidone**

AUC: Area Under the Curve.
Note: These results were generated using ANOVA models on natural log transformed estimated AUC0-24. The ANOVA used fixed effects for Visit, Treatment, and Visit*Treatment and a repeated statement for Visit. Estimates of the natural log transformed treatment differences were back transformed to derive the least square geometric mean ratios for each comparison. [1] PK samples were collected at any of the 3 pre-specified visits and shows drug exposure on an aggregate population level. [2] Took >95% of the capsules assigned to regimen and shows drug exposure between the relevant dose levels.

Deupirfenidone Had Favorable Tolerability in ELEVATE Trial

Summary of Most Common (≥5% in Any Treatment Group) TEAEs by SOC, PT, and Treatment Group (Safety Set)

SOC/PT	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	3 (4.6)	5 (7.9)	4 (6.2)	9 (14.1)
Upper Respiratory Infections	6 (9.2)	9 (14.3)	8 (12.3)	6 (9.4)
Urinary tract infection	2 (3.1)	5 (7.9)	4 (6.2)	3 (4.7)
Cough	7 (10.8)	3 (4.8)	1 (1.5)	8 (12.5)
IPF (acute exacerbation)	10 (15.4)	2 (3.2)	3 (4.6)	4 (6.3)
Dyspnoea	4 (6.2)	3 (4.8)	2 (3.1)	1 (1.6)
Rash	1 (1.5)	6 (9.5)	3 (4.6)	6 (9.4)
Photosensitivity reaction	0	5 (7.9)	4 (6.2)	5 (7.8)
Pruritus	0	3 (4.8)	5 (7.7)	5 (7.8)
Decreased appetite	5 (7.7)	9 (14.3)	12 (18.5)	13 (20.3)
Dizziness	2 (3.1)	5 (7.9)	6 (9.2)	8 (12.5)
Headache	3 (4.6)	8 (12.7)	5 (7.7)	2 (3.1)
Fatigue	1 (1.5)	7 (11.1)	5 (7.7)	6 (9.4)

Orange = Higher reported incidence than pirfenidone arm
Green = Lower reported incidence than pirfenidone arm

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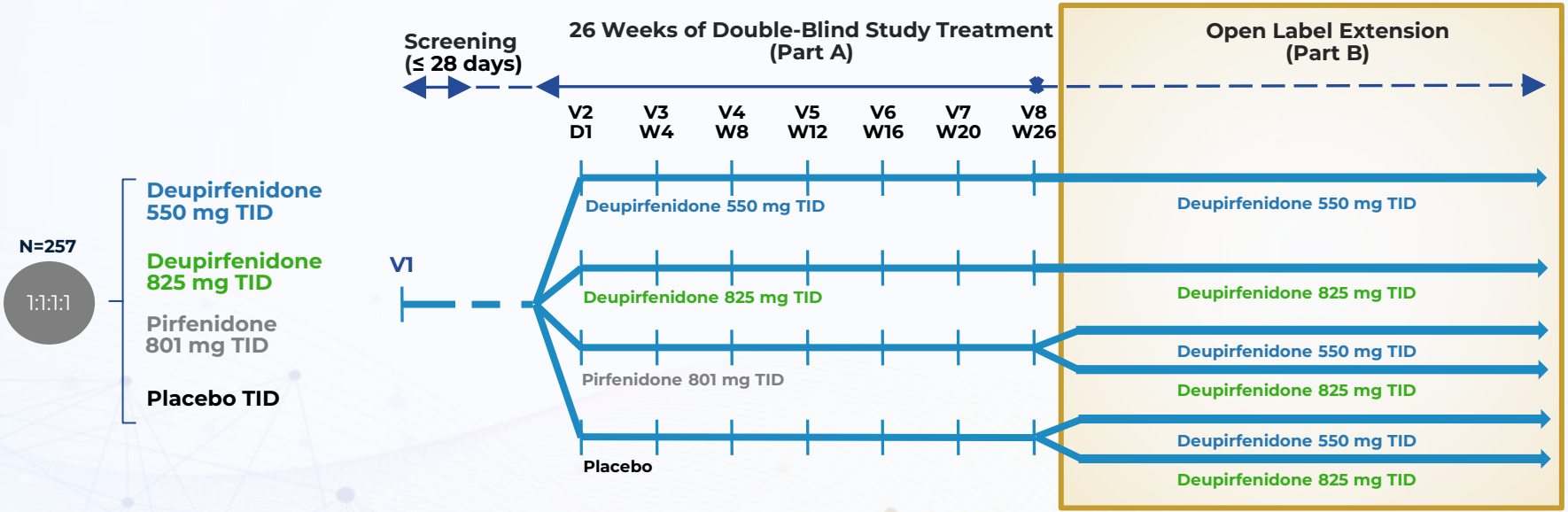
TEAE= treatment-emergent adverse event; SOC = System Organ Class; PT = Preferred Term; TID = three times a day

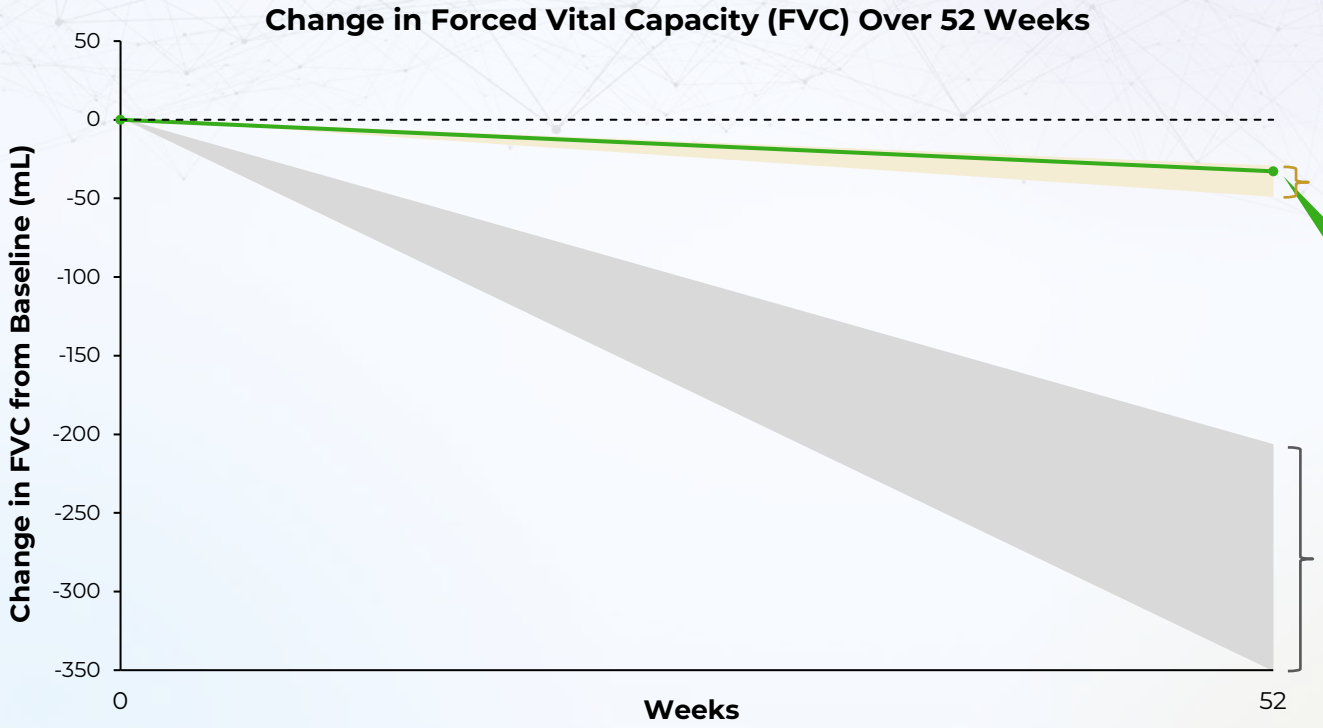
Deupirfenidone's Favorable Tolerability Profile Allows for Higher Drug Exposure and Greater Efficacy

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



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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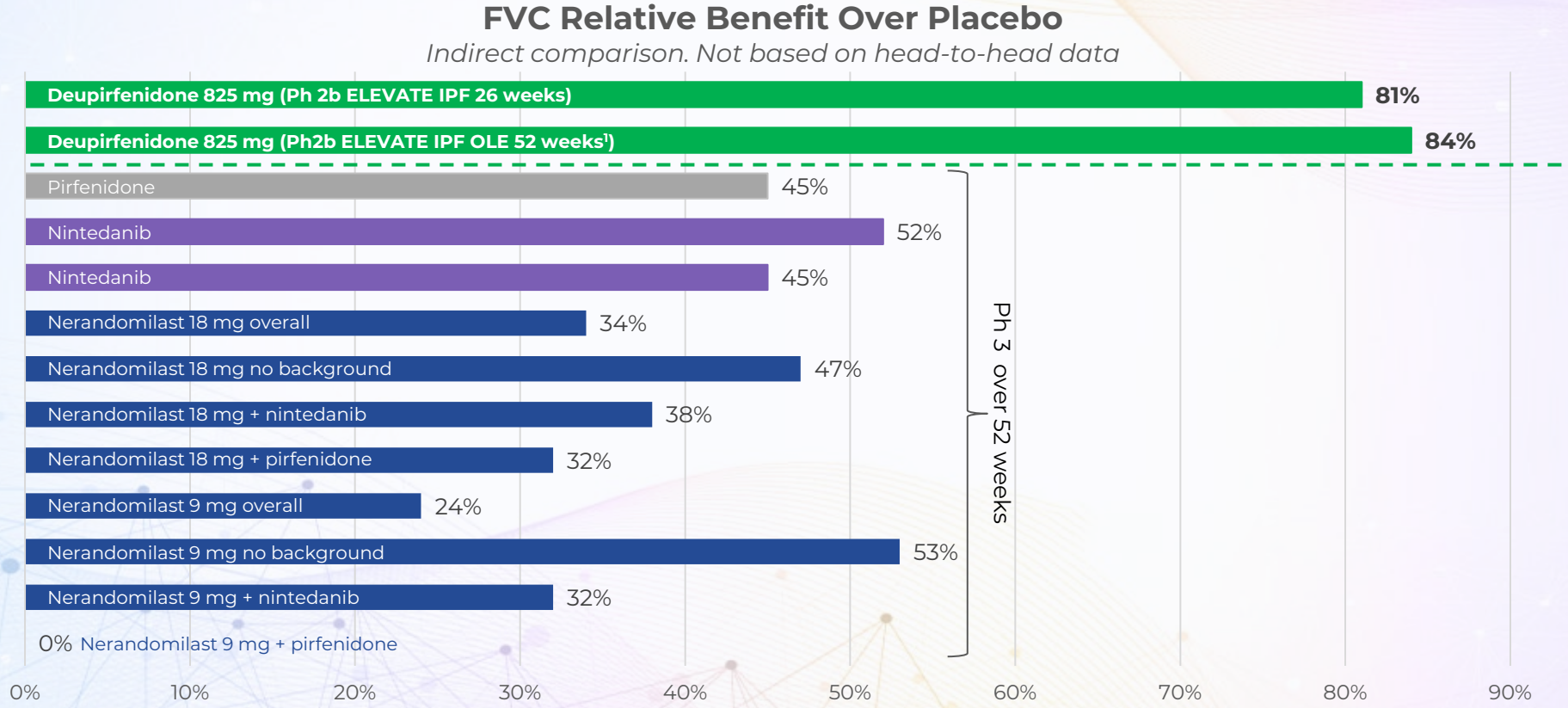
TID = Three times a day; BID = Twice a day; [1] Cross-trial comparisons are inherently limited, as these data are from separate studies with differing designs, patient populations, and methodologies. No direct, head-to-head trials have been conducted; [2] Per Valenzuela. Boehringer Ingelheim. ERS 2024 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.).

Deupirfenidone Has Demonstrated Potential for Best-in-class Efficacy



NOTE: 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.
[1] In the ELEVATE IPF open-label extension (OLE) study, the decline in FVC over 52 weeks with deupirfenidone 825 mg was -32.8 mL. The ELEVATE IPF OLE did not include a placebo arm, so the relative improvement over placebo was calculated assuming a -200 mL decline in FVC at 52 weeks for placebo.

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Historical IPF Trial Failures & PureTech Differentiation

Deupirfenidone Differentiates from Other IPF Programs

	Observations From IPF Trial Failures	Deupirfenidone Differentiation
Idiopathic Nature of Disease	Evaluating a **new mechanism of action** for an idiopathic disease is inherently risky	Deupirfenidone builds on >10 years of **established human efficacy** and safety data for pirfenidone
Short Phase 2 Trial Duration	Many Phase 2 IPF studies are **12-week trials** that may not be 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	257 patients in 4 arms. High Dose achieved **statistical significance** vs placebo
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

Deupirfenidone Has the Potential to be Best-in-class in IPF

- ✓ **Strong data package as a monotherapy**; first therapy to show potential lung function normalization in IPF
- ✓ **Best-in-class efficacy:** first and only IPF treatment to show improved efficacy over SOC treatment (pirfenidone)
- ✓ **Favorable tolerability**; increased efficacy without compromising tolerability
- ✓ **Promising Phase 3 translatability**; supported by the rigorous/well-run Phase 2b trial

Why Deupirfenidone?

- ✓ **Broad potential to be the new SOC** for IPF patients
- ✓ Estimated total addressable market of **>$10B** by 2033[1]
- ✓ Potential to **capture additional markets** with expansion into non-IPF PF-ILDs
- ✓ **Broad** and **layered IP** protection

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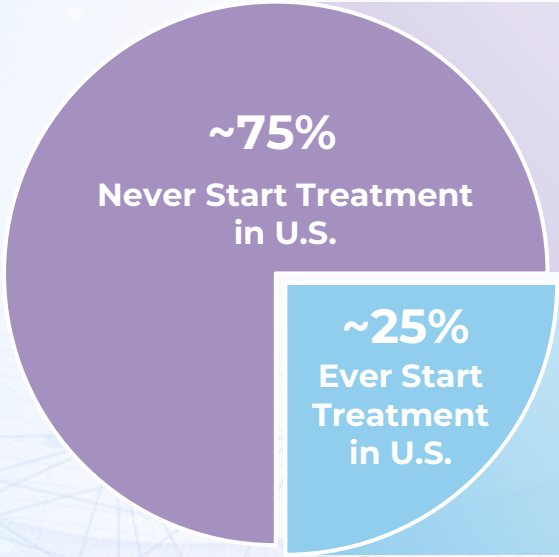
SOC = Standard of care; PF-ILD = Progressive Fibrosing Interstitial Lung Disease; IP = Intellectual Property
[1] Straits Research Report, Idiopathic Pulmonary Fibrosis Market Size, Share & Trends Analysis Report.

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.

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

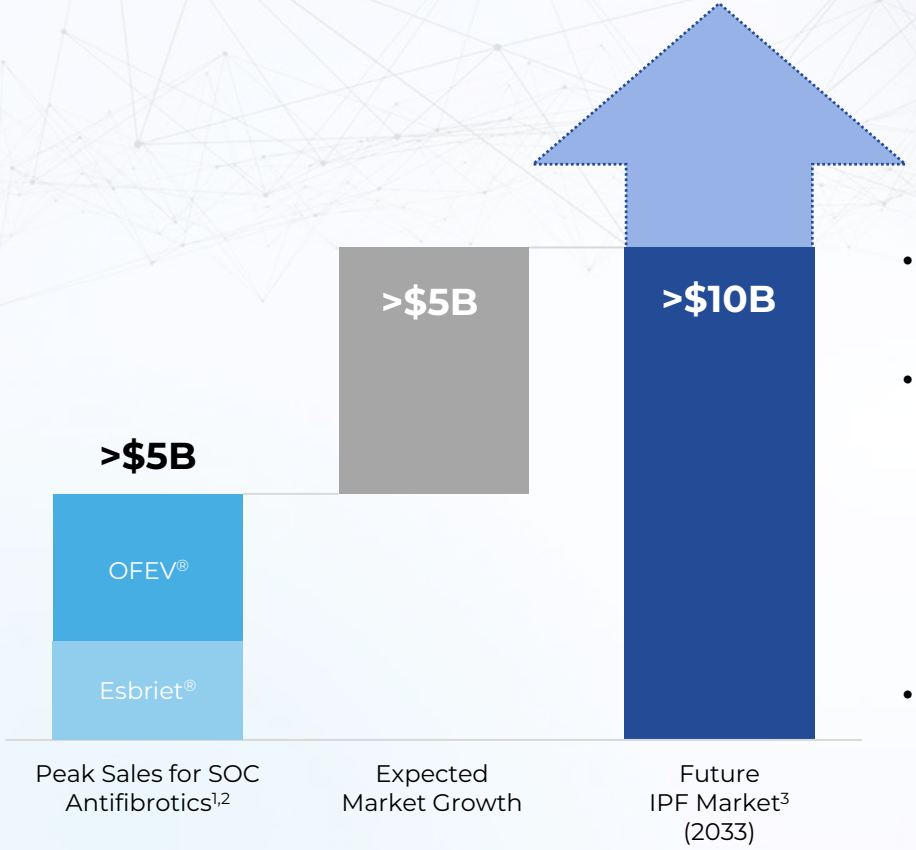
- Pulmonologist market research conducted pre-ELEVATE readout suggested **~50% FVC improvement relative to pirfenidone would be highly attractive**

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

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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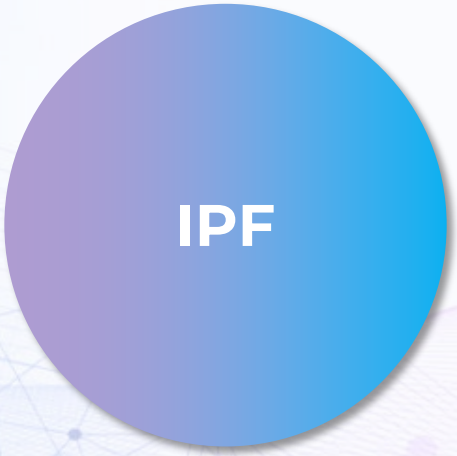
Note: Certain third-party trademarks are included here; PureTech does not claim any rights to any third-party trademarks.. IPF = Idiopathic pulmonary fibrosis; SOC = Standard of care; PF-ILD = Progressive Fibrosing Interstitial Lung Disease. [1] Boehringer Ingelheim 2024 Financial Results. Ofev peak 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.

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 ~675,000 patients in the US and EU5

CURRENT ADDRESSABLE MARKET:
US AND EU5 *>232,000 patients*[1]

FUTURE ADDRESSABLE MARKETS:
+ ~675,000 additional patients[2]



- PF-Connective Tissue Disease - ILD
- PF - Sarcoidosis
- Unclassifiable PF-ILD
- PF - Chronic Fibrotic Hypersensitivity Pneumonitis
- PF - Idiopathic Non-Specific Interstitial Pneumonia
- Other PPFs

TOTAL FUTURE ADDRESSABLE MARKET: *>900K IPF and other PPF Patients*

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[1] GlobalData Epidemiology and Market Size Search. EU5=United Kingdom, France, Germany, Italy and Spain. [2] Per Golchin. Value in Health. 2024. doi: 10.1016/j.jval.2024.10.1385; Hilberg. ERJ Open Res. 2022. doi: 10.1183/23120541.00597-2021; Chen. Front Pharmacol. 2021. doi: 10.3389/fphar.2021.754851; Nasser. Respir Res. 2021. doi: 10.1186/s12931-021-01749-1; Olson. Adv Ther. 2021. doi: 10.1007/s12325-021-01786-8.