Investor Day Presentation

OCTOBER 2024

CLIMBBIO

Forward Looking Statement

This presentation contain “forward-looking statements” within the meaning of the Private Securities Litigation Reform Act of 1995, including without limitation statements regarding: future expectations, plans and prospects for Climb Bio, Inc. (“Climb Bio”); the anticipated benefits of the acquisition of Tenet Medicines, Inc.; expectations regarding budoprutug’s therapeutic benefits, clinical potential and clinical development; the trial design for planned clinical trials of budoprutug; plans to optimize the administration of budoprutug; the anticipated timelines for initiating clinical trials of budoprutug; the sufficiency of Climb Bio’s cash resources for the period anticipated and other statements containing the words “anticipate,” “believe,” “continue,” “could,” “estimate,” “expect,” “intend,” “may,” “plan,” “potential,” “predict,” “project,” “should,” “target,” “would,” “will,” “working” and similar expressions. Forward-looking statements are based on management’s current expectations of future events and are subject to a number of risks and uncertainties that could cause actual results to differ materially and adversely from those set forth in, or implied by, such forward-looking statements. Climb Bio may not actually achieve the plans, intentions or expectations disclosed in these forward-looking statements, and you should not place undue reliance on these forward-looking statements. These risks and uncertainties include, but are not limited to, important risks and uncertainties associated with: the ability of Climb Bio to timely and successfully achieve or recognize the anticipated benefits of its acquisition of Tenet Medicines, Inc.; changes in applicable laws or regulation; the possibility that Climb Bio may be adversely affected by other economic, business and/or competitive factors; Climb Bio’s ability to advance budoprutug on the timelines expected or at all and to obtain and maintain necessary approvals from the U.S. Food and Drug Administration and other regulatory authorities; obtaining and maintaining the necessary approvals from investigational review boards at clinical trial sites and independent data safety monitoring boards; replicating in clinical trials positive results found in early-stage clinical trials of budoprutug; competing successfully with other companies that are seeking to develop treatments for systemic lupus erythematosus, immune thrombocytopenia and membranous nephropathy and other immune-mediated diseases; maintaining or protecting intellectual property rights related to budoprutug and/or its other product candidates; managing expenses; and raising the substantial additional capital needed, on the timeline necessary, to continue development of budoprutug and any other product candidates Climb Bio may develop. For a discussion of other risks and uncertainties, and other important factors, any of which could cause Climb Bio’s actual results to differ materially from those contained in the forward-looking statements, see the “Risk Factors” section, as well as discussions of potential risks, uncertainties and other important factors, in Climb Bio’s most recent filings with the U.S. Securities and Exchange Commission. In addition, the forward-looking statements included in this presentation represent Climb Bio’s views as of the date hereof and should not be relied upon as representing Climb Bio’s views as of any date subsequent to the date hereof. Climb Bio anticipates that subsequent events and developments will cause Climb Bio’s views to change. However, while Climb Bio may elect to update these forward-looking statements at some point in the future, Climb Bio specifically disclaims any obligation to do so, except as required by law.

Introduction & Corporate Update

Aoife Brennan, MD | President & CEO

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Together We Can Reach Higher Ground

At Climb Bio, we believe elevating relationships leads to more meaningful insights, better answers, and ultimately, to more inspired medicines for patients living with immune-mediated diseases

More than 2.5 million Americans suffer from a B-cell mediated disease

Committed to enhancing the patient experience

Driven to becoming a leader in development for immune-mediated diseases

Team Highlights

Building a highly-credentialed and experienced development organization focused on execution

Aoife Brennan
President and CEO

Jan Hillson
Senior Clinical Advisor

William Bonificio
Interim CBO

Janaki M. Subramanyam
VP, Regulatory Affairs

Nishi Rampal
SVP, Clinical Development

Emily Pimblett
CAO

Brett Kaplan
COO

Stephen Thomas
Director & Interim CSO

Jay Mitchell
VP, Clinical Operations

Kate Hecht
SVP, Program Management

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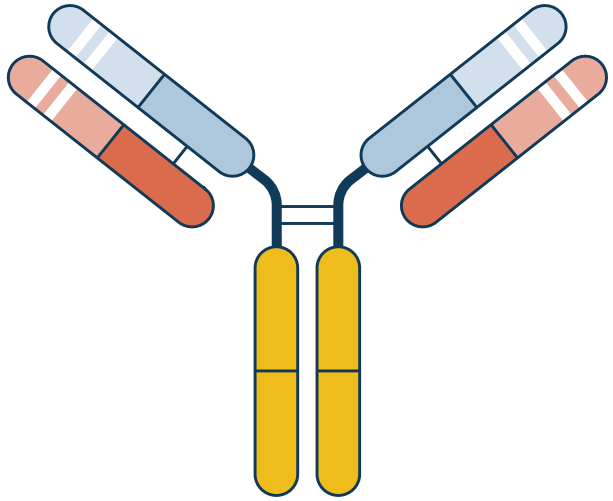
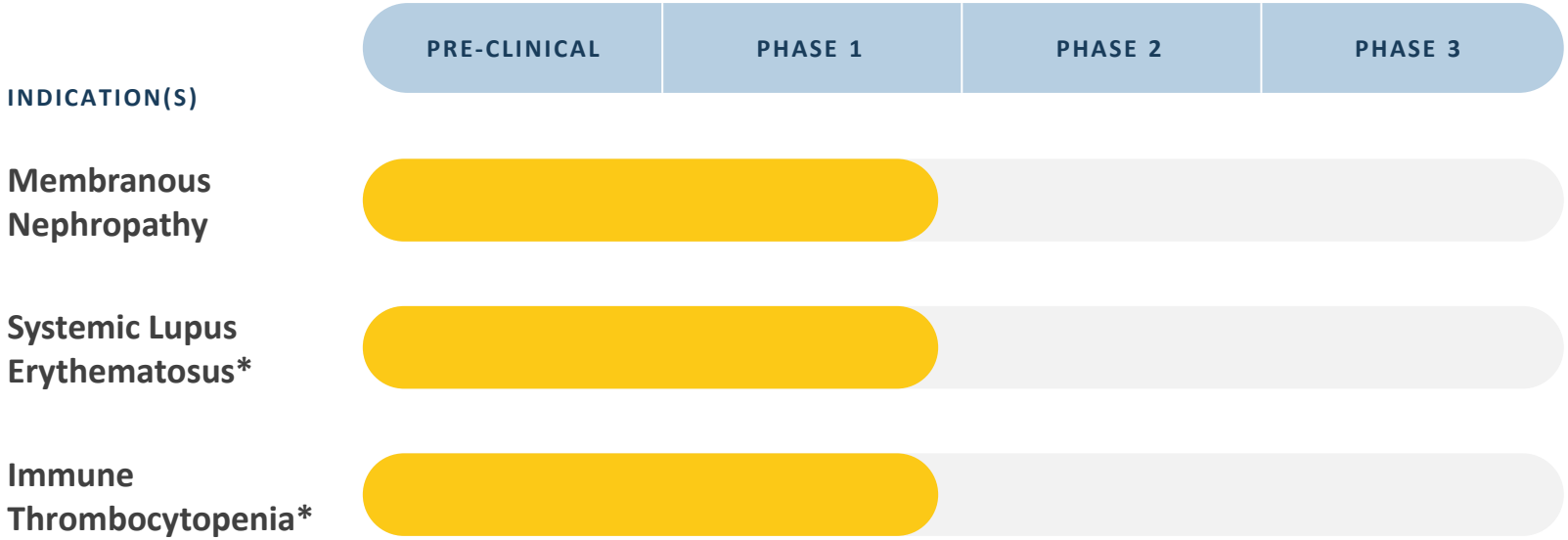
Budoprutug: Anti-CD19 mAb Designed to Treat a Broad Range of B-Cell Mediated Diseases



Budoprutug
Anti-CD19
Fc^+, mAb



CD19 is a promising target antigen for AAb-mediated diseases as a clinically-validated MoA

Additional potentially addressable indications across multiple therapeutic areas

Aiming to advance potentially best-in-class mAb to late-stage clinical trials

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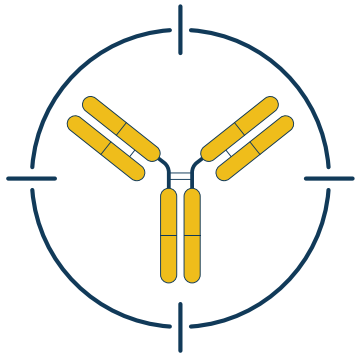
AAb = autoantibody, Fc+ = Fc-engineered, mAb = monoclonal antibody, MoA = mechanism-of-action
*Subject to investigational new drug application clearance

Corporate Strategy & Vision

Climb is well-positioned to advance budoprutug across three distinct opportunity sets

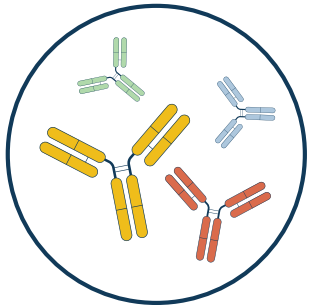


Primarily IgG4-Mediated

Clear pathophysiology supporting targeting of CD19-expressing B-cells

Lead indication
Membranous Nephropathy

Opportunity to Differentiate
Potential for “immune reset”, improved efficacy

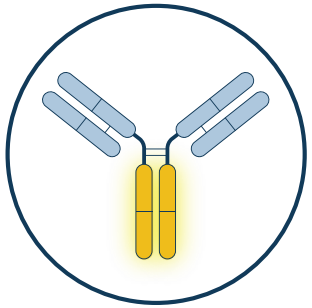


Complex Systemic

Multi-organ, systemic diseases with heterogenous patient populations

Lead indication
Systemic Lupus Erythematosus

Opportunity to Differentiate
Improve efficacy while balancing safety, tolerability, and convenience



Primarily Single Organ IgG1 - 3

Orphan diseases with compelling clinical proof-of-concept using B-cell depletion

Lead indication
Immune Thrombocytopenia

Opportunity to Differentiate
Demonstrate efficacy in relapsing and/or refractory patients

R&D Day Agenda

October 15, 2024 I 12.00 – 02.00 ET I Virtual Webcast

Introduction & Corporate Update
Aoife Brennan, President and CEO

Scientific Background
Stephen Thomas, Director and Interim CSO

IgG4-Mediated Disease Opportunity
Frank Cortazar, KOL, PI

Complex Rheumatologic Disease Opportunity
Jan Hillson, Senior Clinical Advisor

Validated Rare Disease Opportunity
Nishi Rampal, SVP, Clin Dev

Corporate Outlook
Brett Kaplan, COO

Q&A
Moderated by Aoife

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Scientific Background

Stephen Thomas, PhD | Director and Interim CSO

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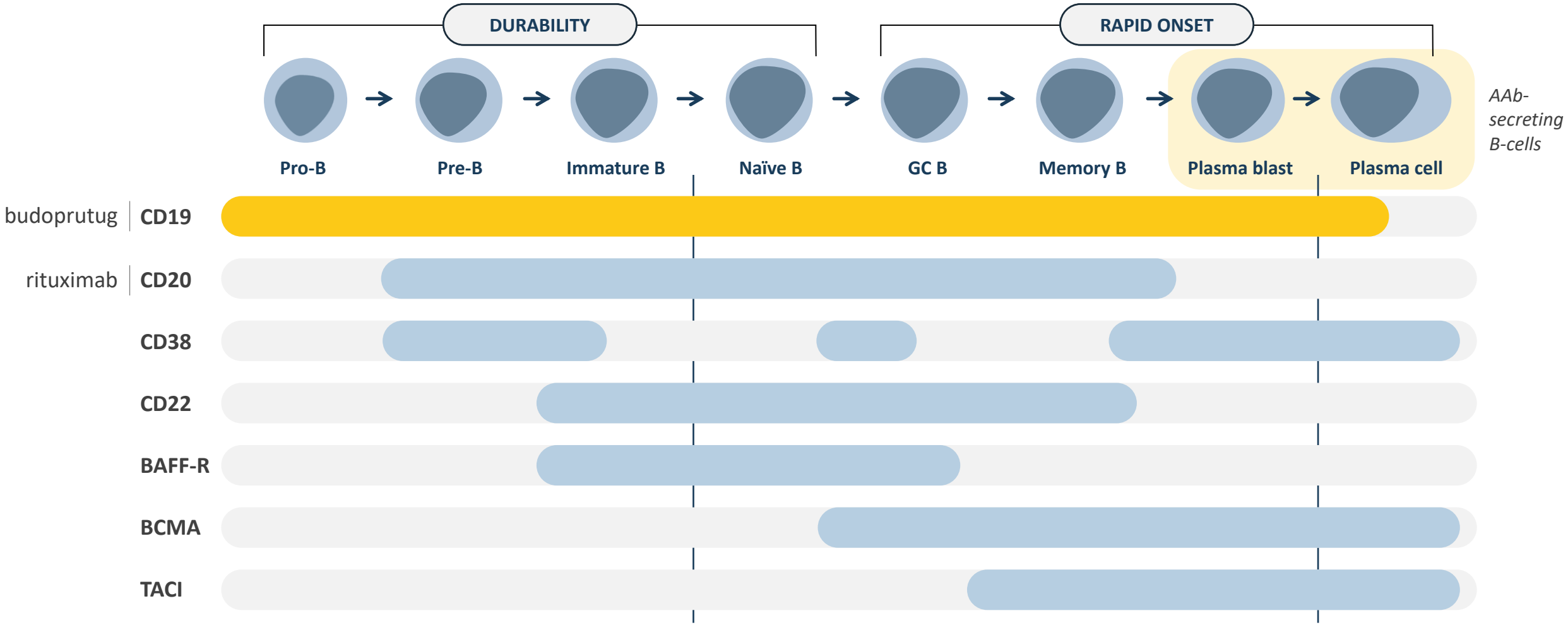
CD19 Expression on Autoantibody-Secreting Cells (ASCs)

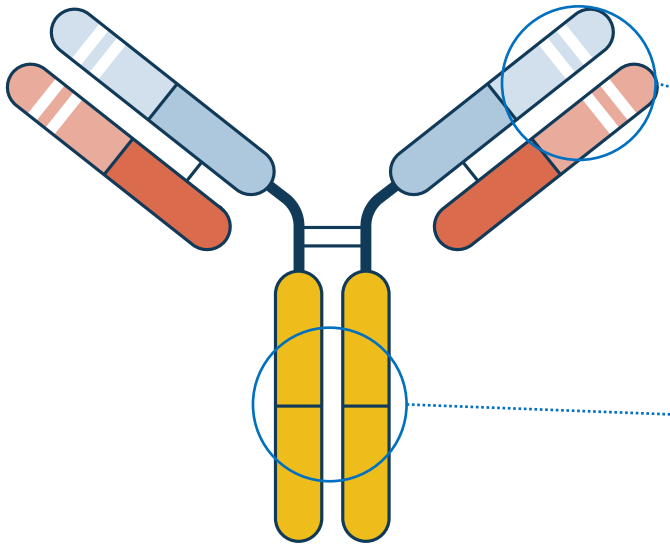
CD19-targeted therapy potentially enables rapid onset and durability



AAb = autoantibody, Zhang 2023

Budoprutug: Fc-Enhanced Anti-CD19 mAb

Designed to treat immune-mediated diseases



Budoprutug is a highly potent anti-CD19 mAb containing a low-fucosylated Fc region, leading to enhanced effector function and highly potent ADCC

Unique attributes driving differentiation & positioning

HIGH AFFINITY

18 pM

binding affinity to CD19 to counter low antigen density

ADCC-ENHANCED

>100x potency

vs. wild-type IgG1 to drive deep & durable B cell depletion

HIGH CONCENTRATION

≥175 mg/mL

with low viscosity for low volume, SC injection

- **Potential for best-in-class efficacy**
  Rapid, deep, and durable B cell depletion at doses as low as 100 mg
- **Opportunity for patient-tailored approach to treatment**
  Potential to provide IV and/or SC offerings where favorable to patient and point-of-care
- **Optimized dosing and tolerability**
  Potential for induction and maintenance dosing paradigm with favorable safety, tolerability profile
- **Pipeline-in-a-molecule potential**
  3 distinct opportunity sets:
  IgG4-Mediated, Complex Systemic, & Primarily Single Organ IgG1 – 3

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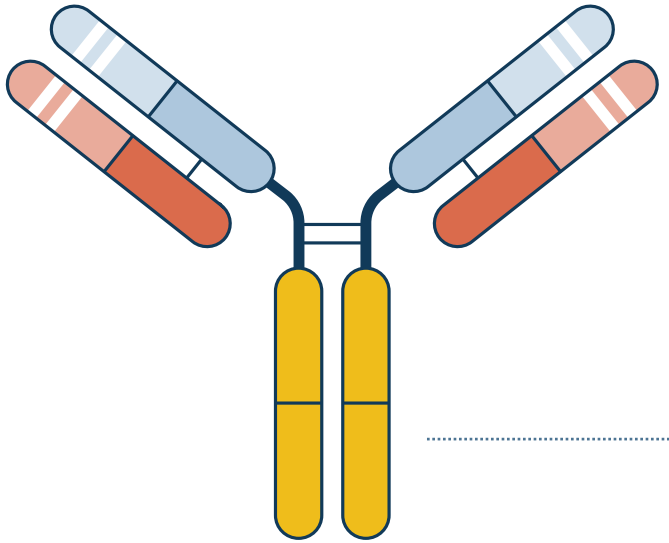
pM = picomolar, ADCC = antibody-dependent cellular cytotoxicity, IV = intravenous, SC = subcutaneous

Why a Monoclonal Antibody?

Key aspects of budoprutug potentially support a differentiated target product profile



Budoprutug is a highly potent anti-CD19 mAb containing a low-fucosylated Fc region, leading to enhanced effector function and highly potent ADCC

- **Manufacturability: *The Right Construct***

  Monoclonal antibodies typically have well-established manufacturing and supply chains, favorable cost-of-goods, & scalability

- **Efficacy: *The Right Target***

  CD19-targeted therapies have demonstrated impressive efficacy in controlled trials and case reports of patients with autoimmune diseases

- **Safety & Tolerability: *The Right Modality***

  Anti-CD19 mAbs have demonstrated a favorable safety and tolerability profile to date, comparable to anti-CD20s

- **Patient-Tailored: *The Right Dosing Regimen***

  Opportunity for induction and maintenance, treat-to-target approach is highly differentiated from typical biologics in I&I

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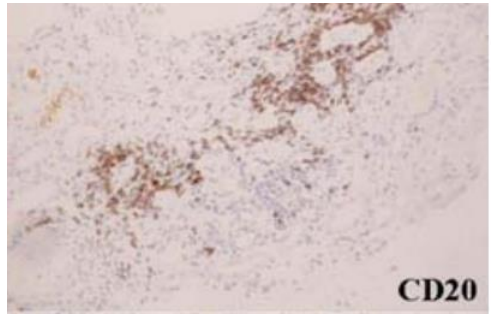
ADCC = antibody-dependent cellular cytotoxicity, I&I = Immunology and Inflammation

Naked mAbs Have Demonstrated Tissue-Level B-cell Depletion

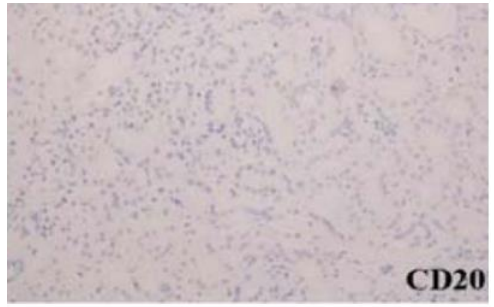
Rituximab (RTX) depleted B-cells in patient tissues, though left behind CD20-negative B-cells

KIDNEY

Before RTX

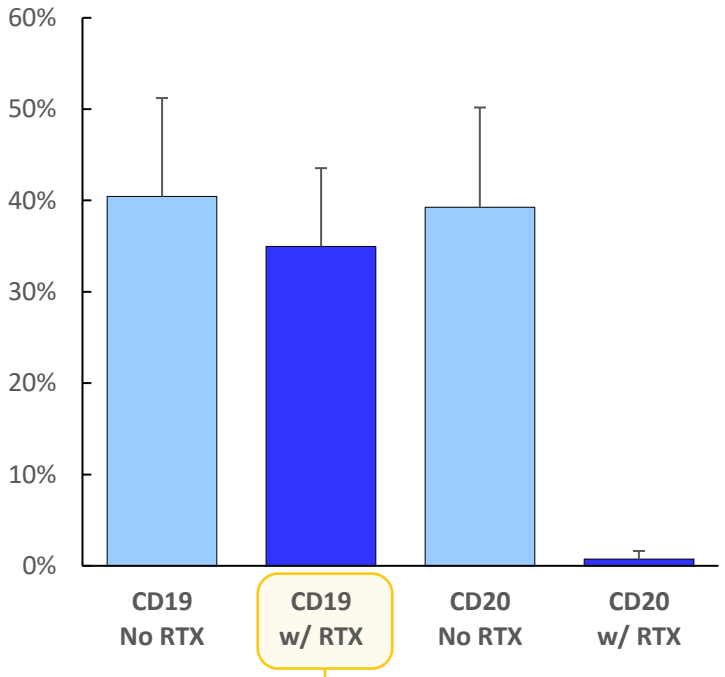


After RTX



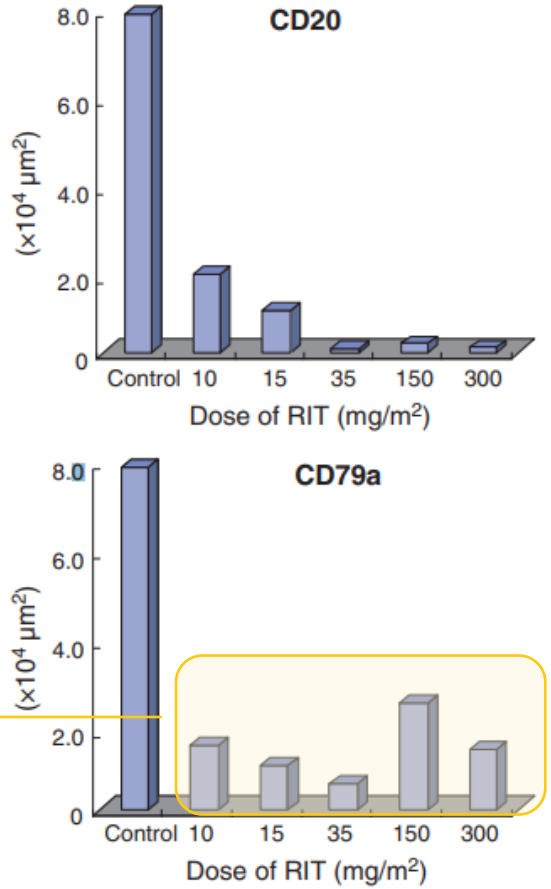
Lack of CD20⁺ B-cell staining in tissue after treatment with RTX

LYMPH NODE



CD19⁺ and CD79a⁺ B-cells are not effectively cleared from tissue after RTX, potentially due to low or no CD20 expression

SPLEEN



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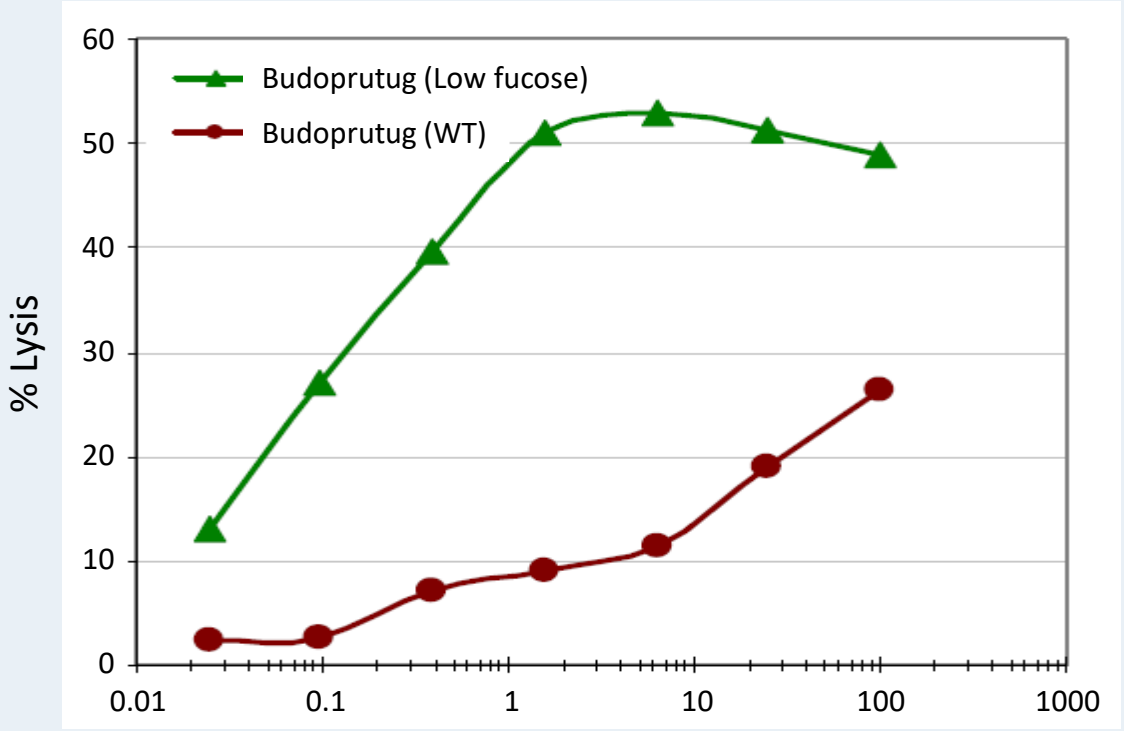
Genberg 2006, Kamburova 2013, Toki 2019, Crickx 2021

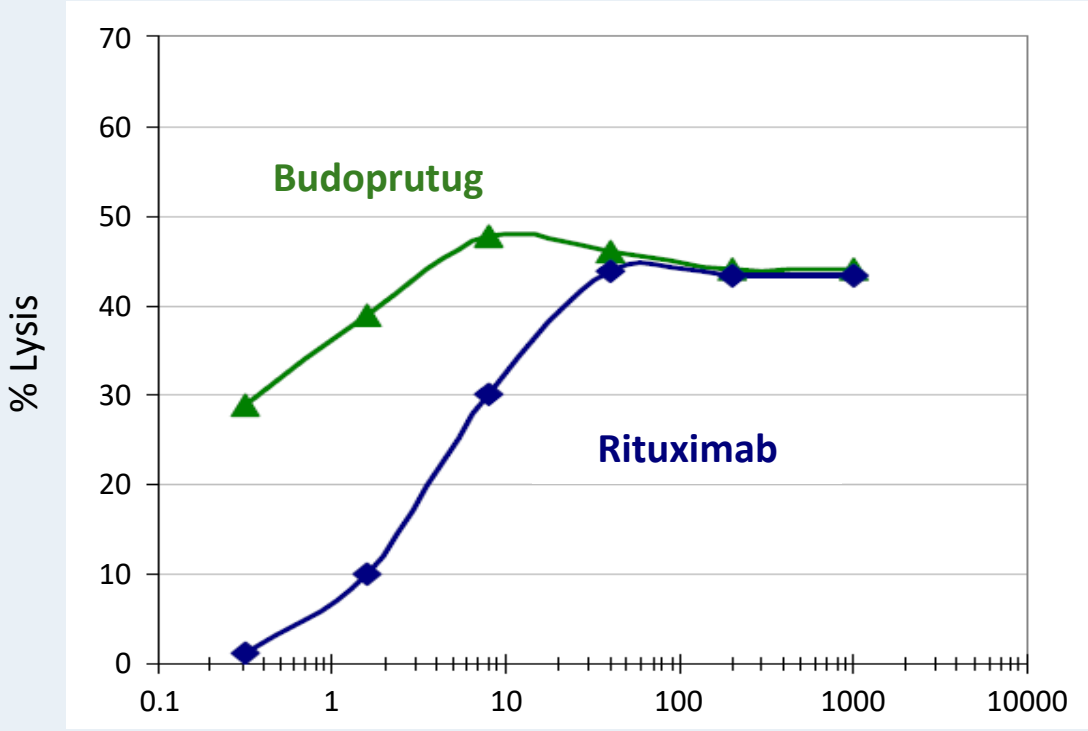
Low Fucosylation Dramatically Enhances Potency

Budoprutug demonstrates potent ADCC, with no detectable CDC in cell-based models

Comparison of in vitro ADCC of budoprutug with low-fucose vs wild-type (WT) IgG1



Comparison of in vitro ADCC of budoprutug vs. rituximab against Daudi lymphoma cells



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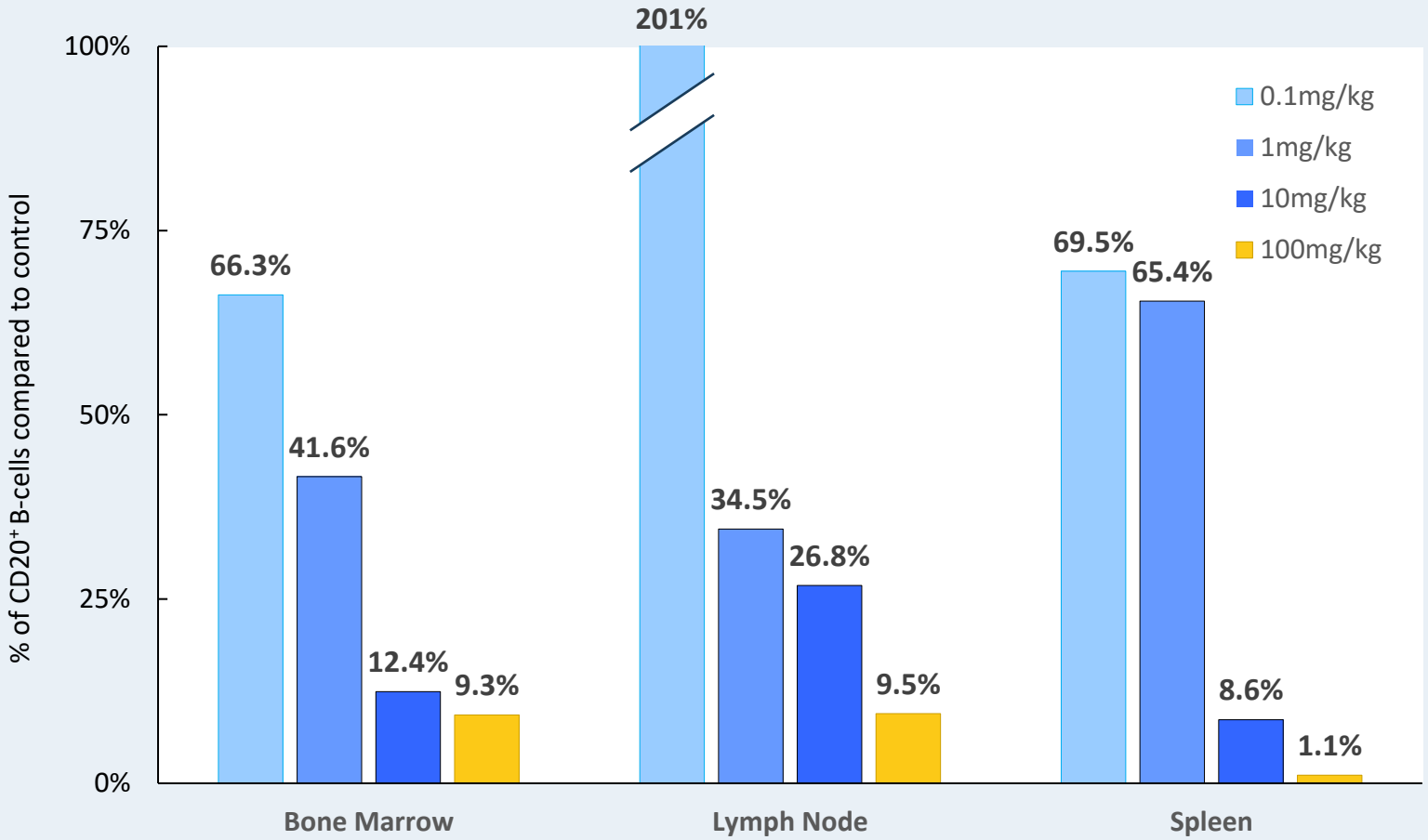
Budoprutug Achieved Depletion of Tissue-Resident B-cells In Vivo

huCD19 transgenic mice treated with weekly doses (QWx4) of budoprutug for 28 days

- B-cell measurements in tissue were taken 7 days post-dosing
- Dose-dependent B-cell depletion in all tissues analyzed at Day 28
- >90% depletion in all tissues at 100 mg/kg



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Budoprutug Biomarker Strategy

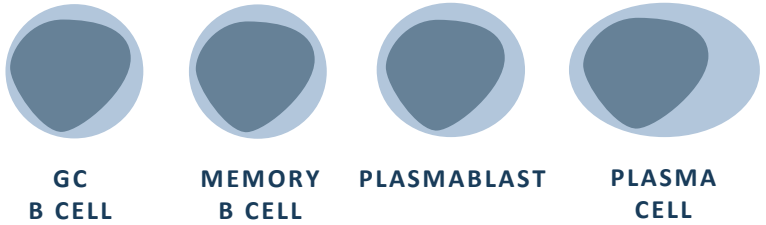
Opportunity to help accelerate proof-of-concept, benchmark within competitive landscape

Autoantibody Reduction

- Level, duration and breadth of disease-related autoantibody reduction

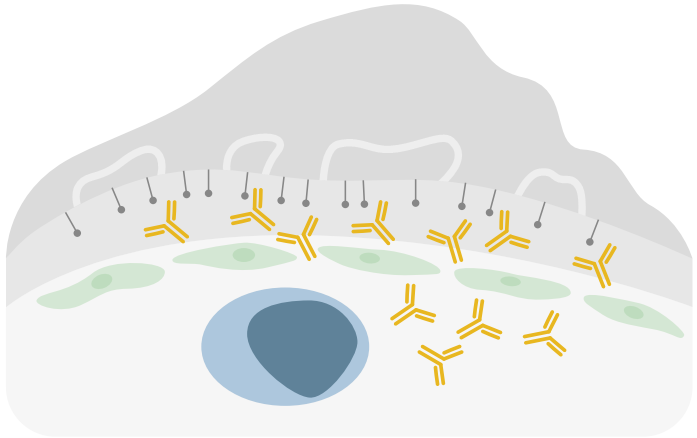
Peripheral B-cell Depletion (& Recovery)

- Level, duration and breadth of peripheral B-cell depletion
- Time to peripheral B-cell recovery (with immunophenotyping)



Tissue B-Cell Depletion

- Level, duration and breadth of tissue-level (i.e., lymph node, spleen, kidney) B-cell depletion



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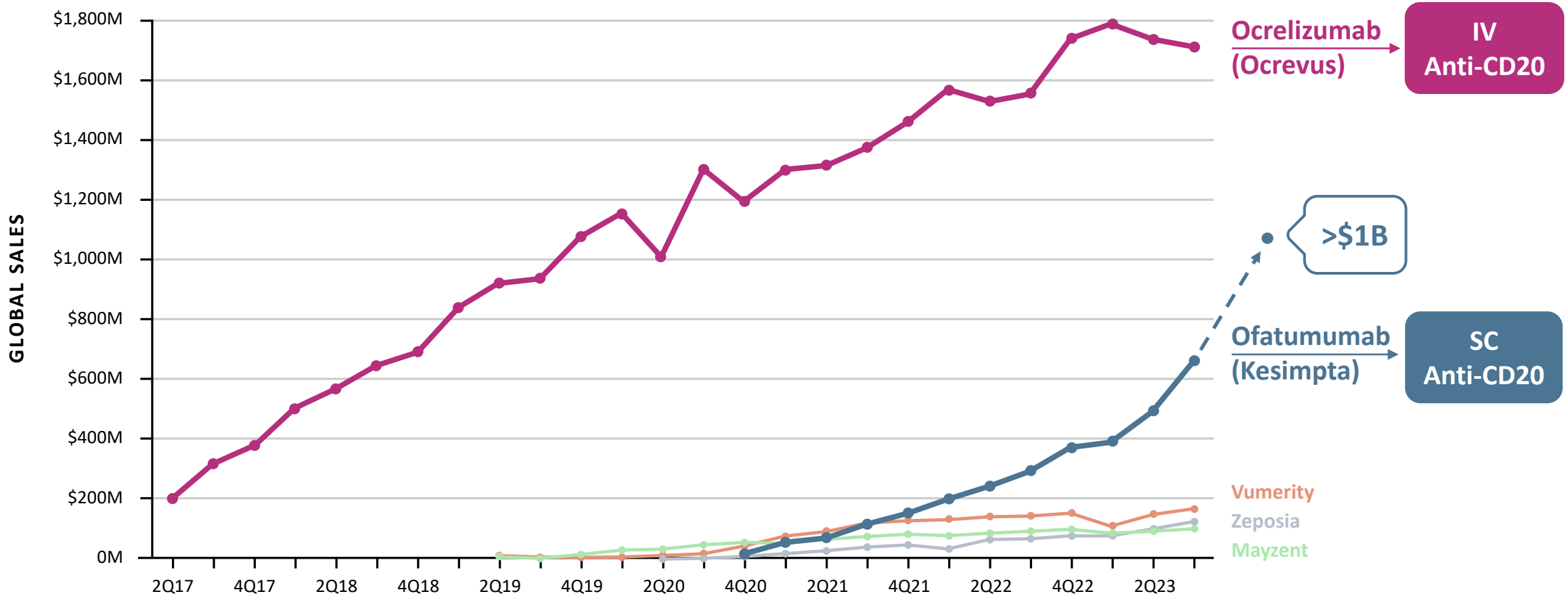
Subcutaneous Dose Form May Enable Further Differentiation

SC dosing presents the opportunity for product line extension and patient-tailored solution(s)

Real-world example showing SC dose form gaining appreciable market share relative to IV within same modality & MoA



Graphic adopted from BioCentury 2023; SC = subcutaneous

Targeting CD19 in autoantibody-mediated glomerular disease

Frank B Cortazar, MD

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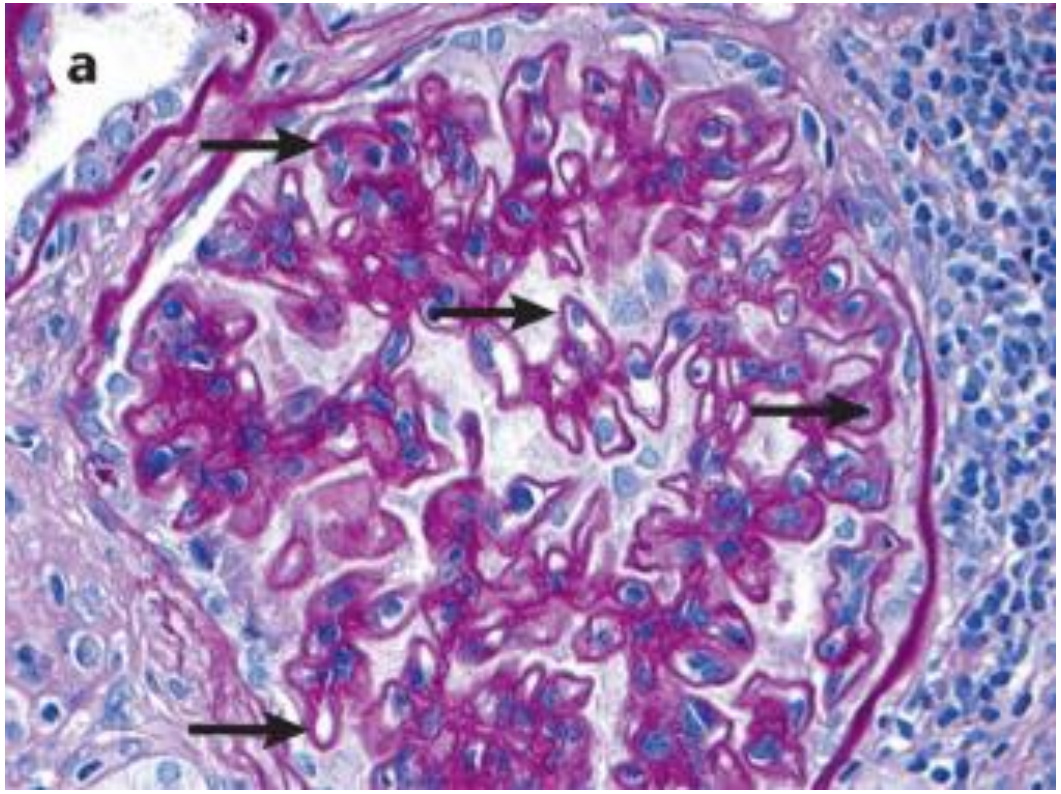
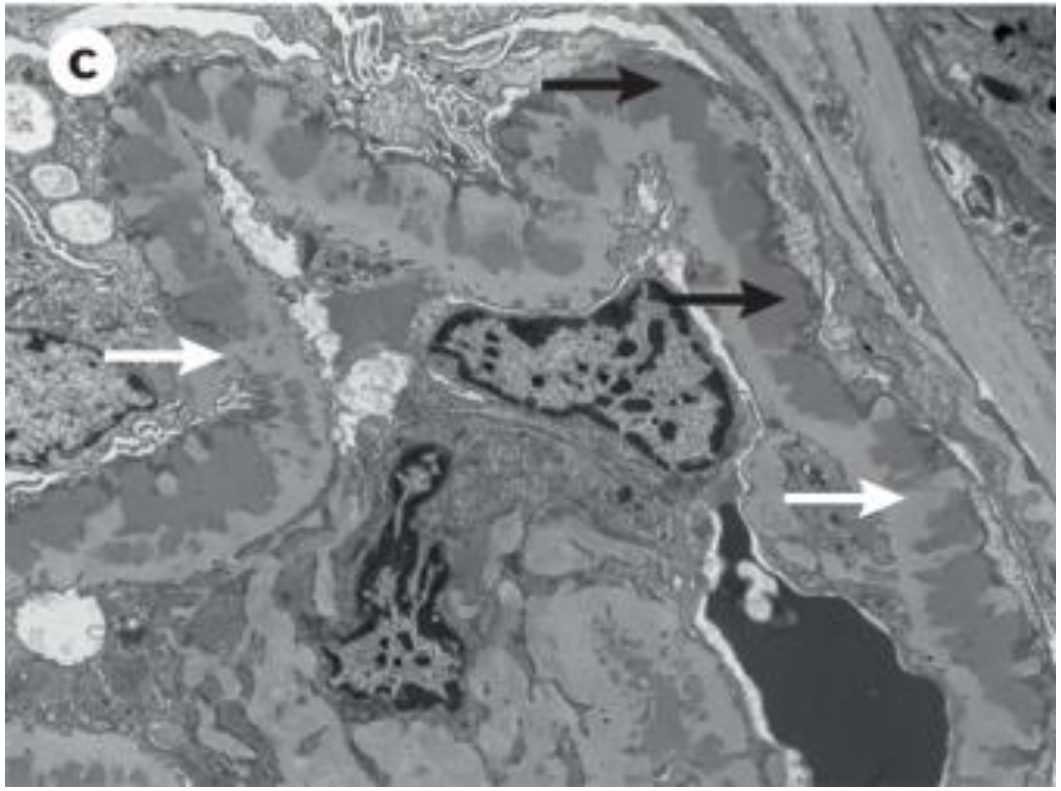
Vasculitis & Glomerular Center

Membranous Nephropathy





Nat Rev Dis Primers **7**, 69 (2021).

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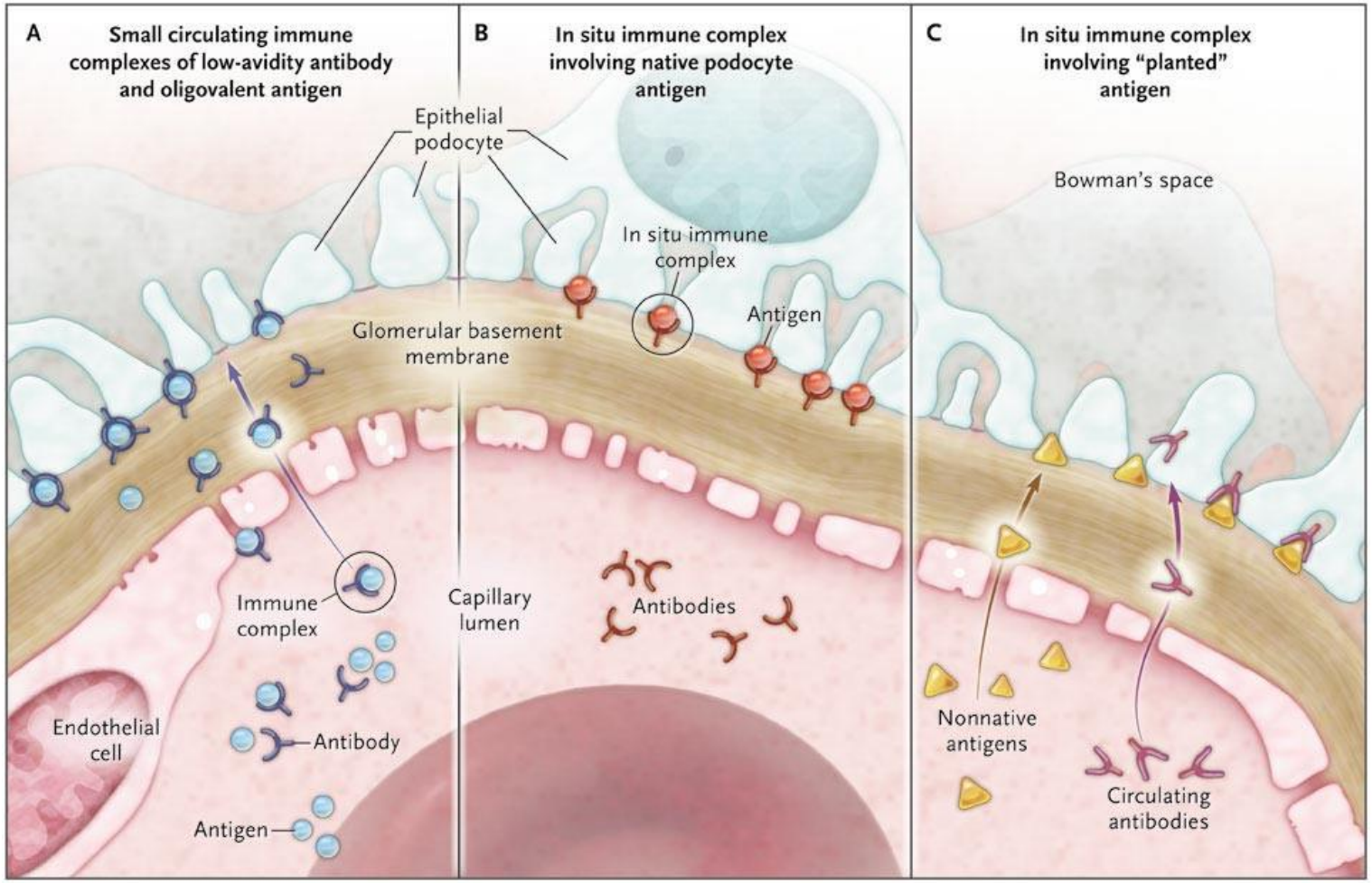
Membranous Nephropathy Epidemiology

- Most common cause of nephrotic syndrome in non-diabetic adults
  - Incidence 8-10 cases/million

- **"Primary" Membranous** (80%)
  - Phospholipase-A2 receptor (PLA2R): 70-80%
  - Thrombospondin type 1 domain-containing 7a (THSD7A): 2-5%
  - Others

- **Secondary Membranous** (20%)
  - Autoimmune
  - Infection
  - Drugs
  - Malignancy

Immune Complex Formation



N Engl J Med. 2009 Jul 2;361(1):81-3.

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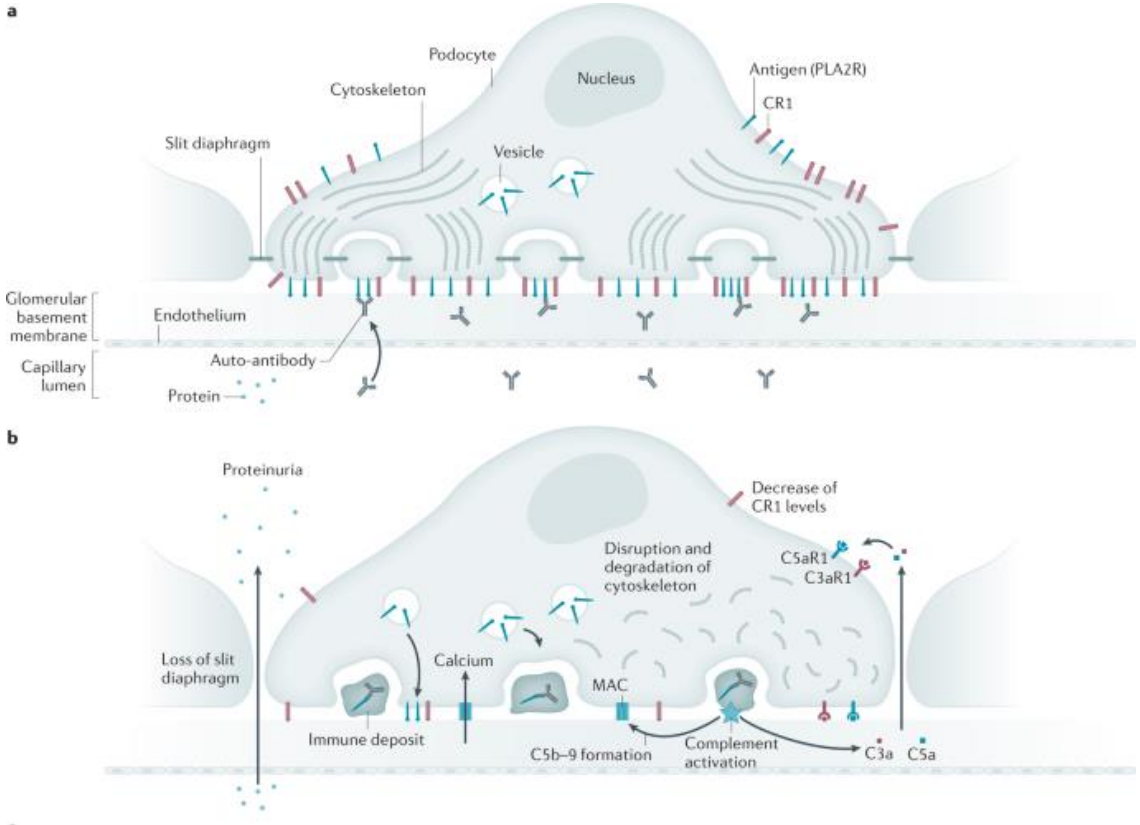
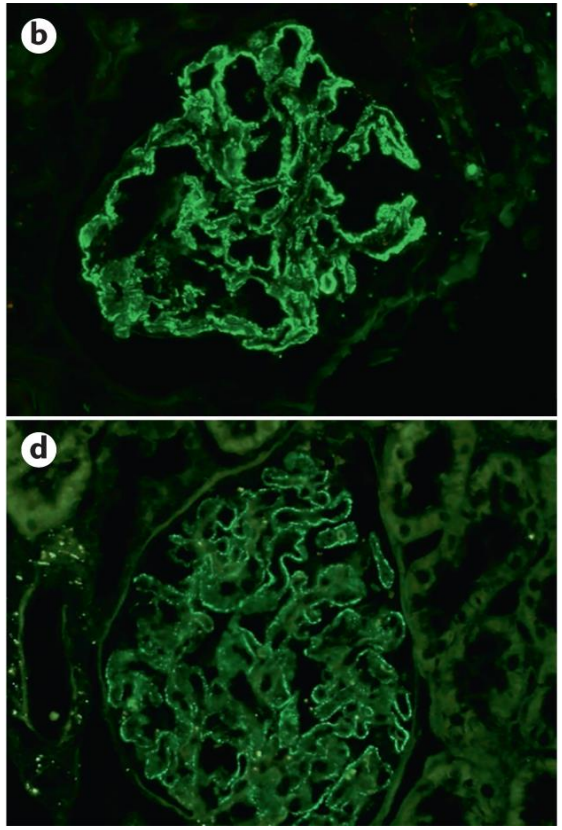
PLA2R-associated MN





Nat Rev Dis Primers **7**, 69 (2021).

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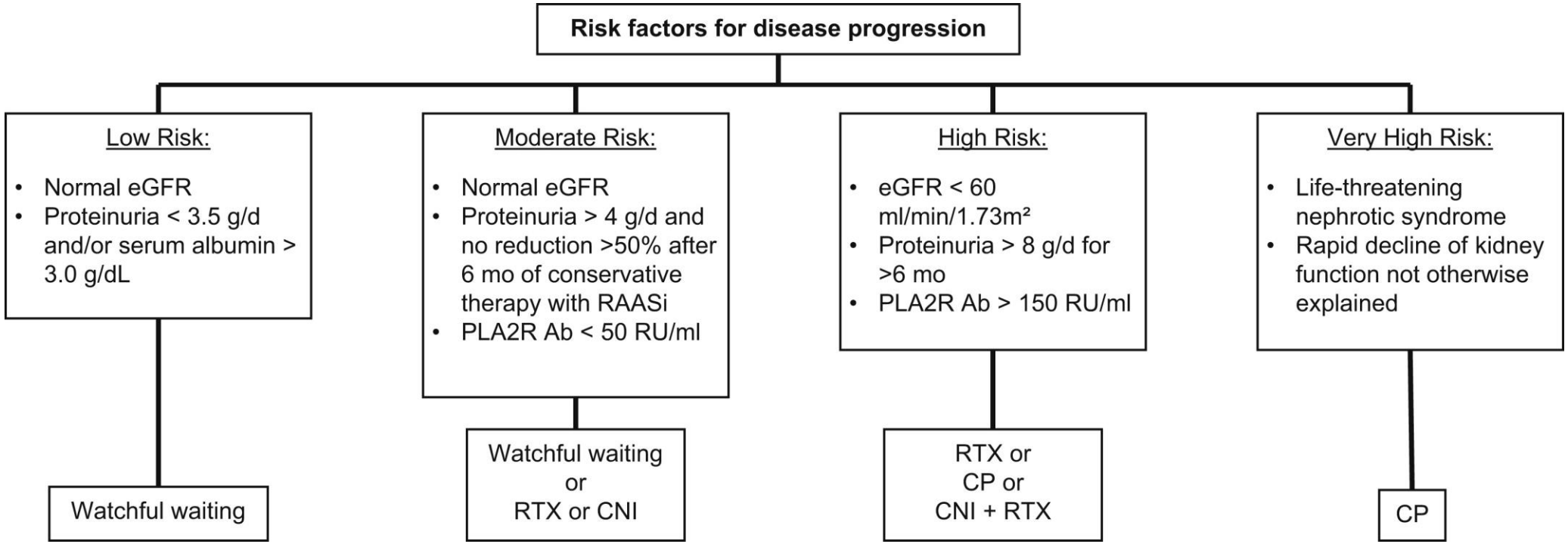
Membranous Nephropathy Presentation

- The majority of patients (~2/3) present with nephrotic syndrome
  - Proteinuria > 3.5 d/day and hypoalbuminemia

- Complications of nephrotic syndrome
  - Edema (can be debilitating)
  - Hyperlipidemia
  - Thrombosis (~ 10%)
  - Infection

Risk Stratification



AJKD, Volume 77, Issue 3, 440 - 453

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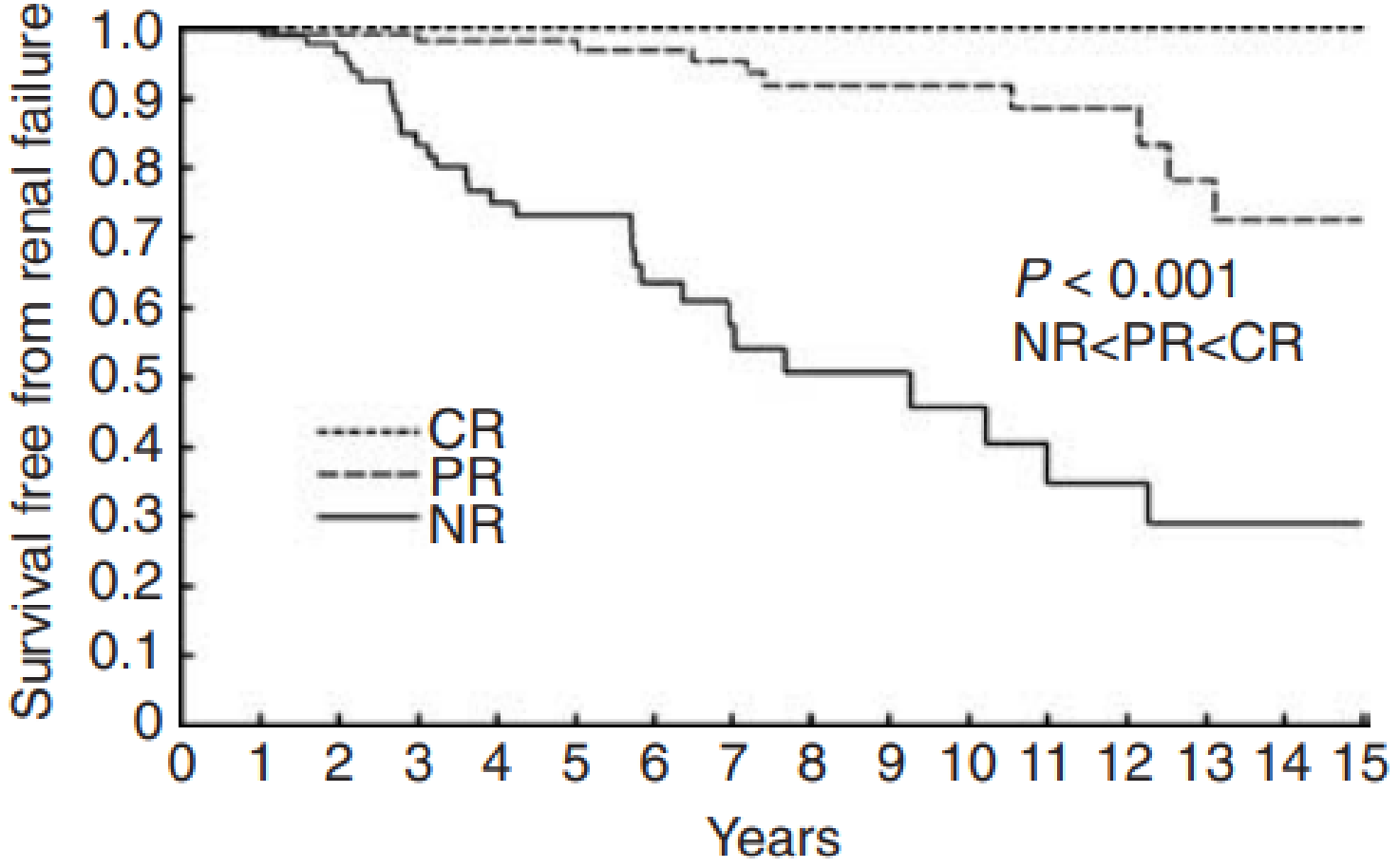
Importance of Remission

348 nephrotic patients with primary MN

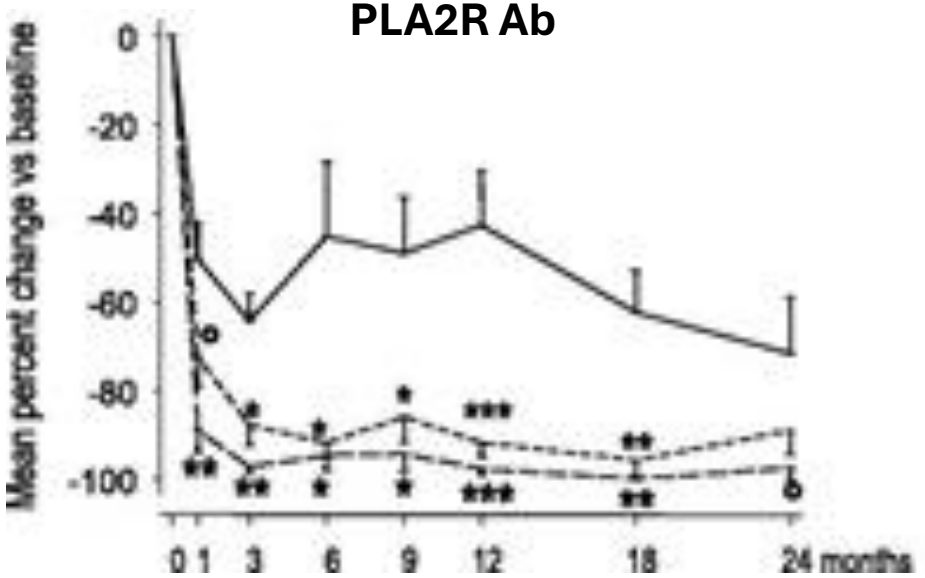


Kidney Int. 2004 Sep;66(3):1199-205.

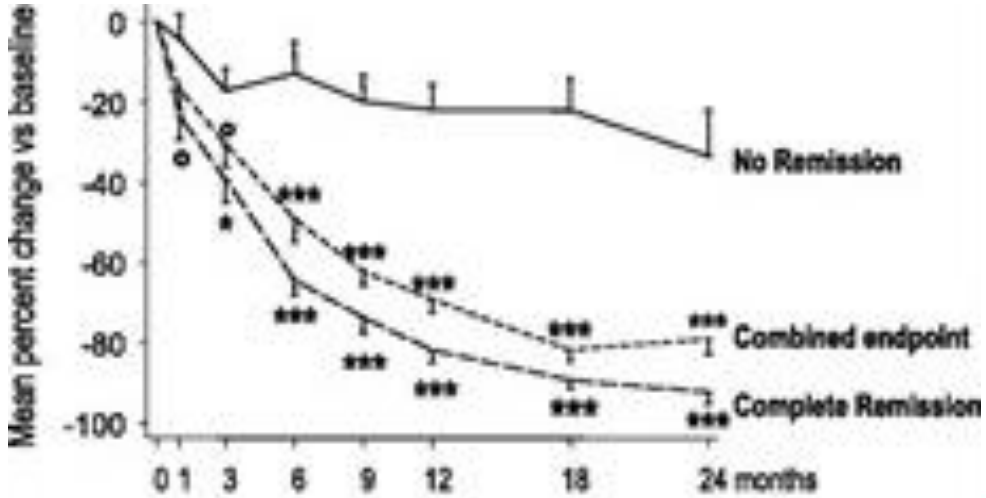
Immunologic Remission

81 nephrotic patients with PLA2R-associated MN treated with rituximab

PLA2R Ab



Proteinuria



J Am Soc Nephrol. 2015 Oct;26(10):2545-58.

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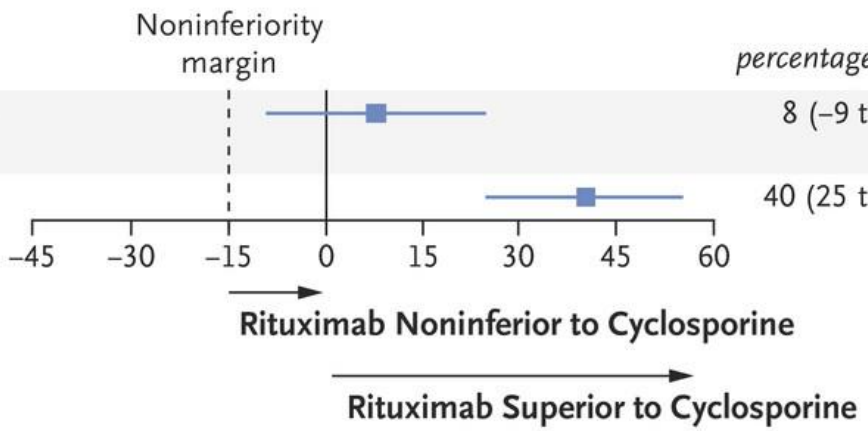
Rituximab for MN

MENTOR TRIAL: 130 patients with primary MN and proteinuria > 5 g/d

Evaluation Time Point	Rituximab (N=65)	Cyclosporine (N=65)	Risk Difference (95% CI)	P Value for Noninferiority	P Value for Superiority
	no. with complete or partial remission (%)		*percentage points*		
End of treatment period at 12 mo	39 (60)	34 (52)	8 (–9 to 25)	0.004	—
End of follow-up at 24 mo	39 (60)	13 (20)	40 (25 to 55)	<0.001	<0.001



40% of patients receiving rituximab had no remission

N Engl J Med. 2019 Jul 4;381(1):36-46.

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Rituximab for MN

Complete Remission

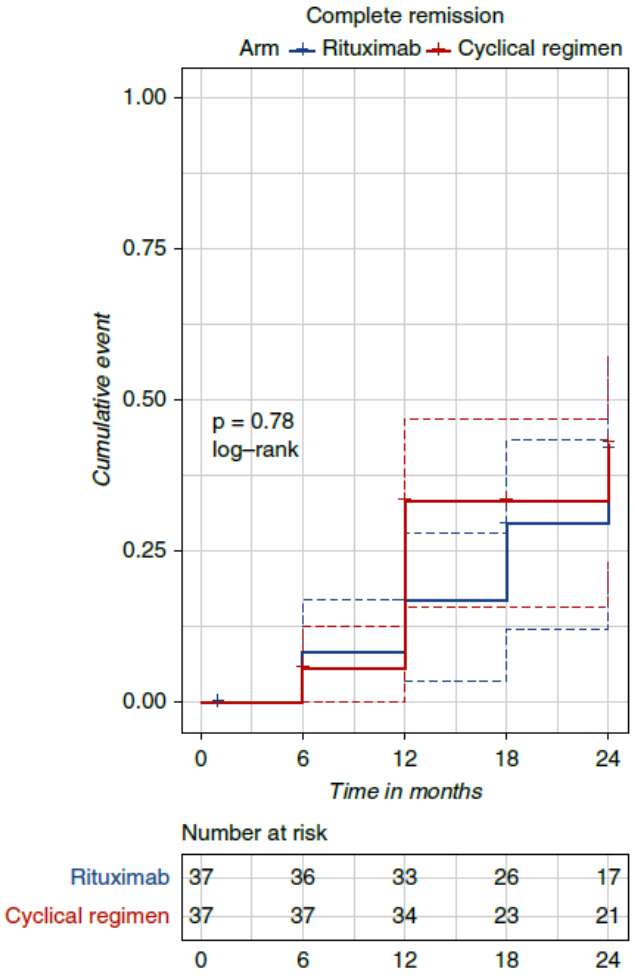
Time from randomization	Rituximab		Cyclosporine		Risk difference (95% CI)
	n	CR (%)	n	CR (%)	
ITT population					
6 months	65	0 (0.0)	65	1 (1.5)	-1.5 (-4.5 to 1.5)
12 months	65	9 (13.8)	65	3 (4.6)	9.2 (-0.6 to 19.1)
18 months	65	18 (27.7)	65	1 (1.5)	26.2 (14.9 to 37.4)
24 months	65	23 (35.4)	65	0 (0.0)	35.4 (23.8 to 47.0)

Immunological Remission (ELISA < 40 u/mL)

Time from randomization	Rituximab		Cyclosporine		Risk difference (95% CI)
	n	CR/PR (%)	n	CR/PR (%)	
Immunological response					
6 months	50	26 (52.0)	46	13 (28.3)	23.7 (4.7 to 42.7)
12 months	50	33 (66.0)	46	14 (30.4)	35.6 (16.9 to 54.3)
18 months	50	32 (64.0)	46	5 (10.9)	53.1 (37.1 to 69.2)
24 months	50	33 (66.0)	46	6 (13.0)	53.0 (36.6 to 69.3)

N Engl J Med. 2019 Jul 4;381(1):36-46.

Cyclophosphamide for MN



- RI-CYCLO Trial: 74 patients with primary MN and proteinuria > 3.5 g/day randomized to RTX vs CYC/Steroids
- At 12 months: CR in 32% of CYC and 16% in RTX
- At 24 months: CR ~ 40% of both groups
- **Concerns about toxicity and need for intensive monitoring limit cyclophosphamide use**

J Am Soc Nephrol. 2021 Apr;32(4):972-982.

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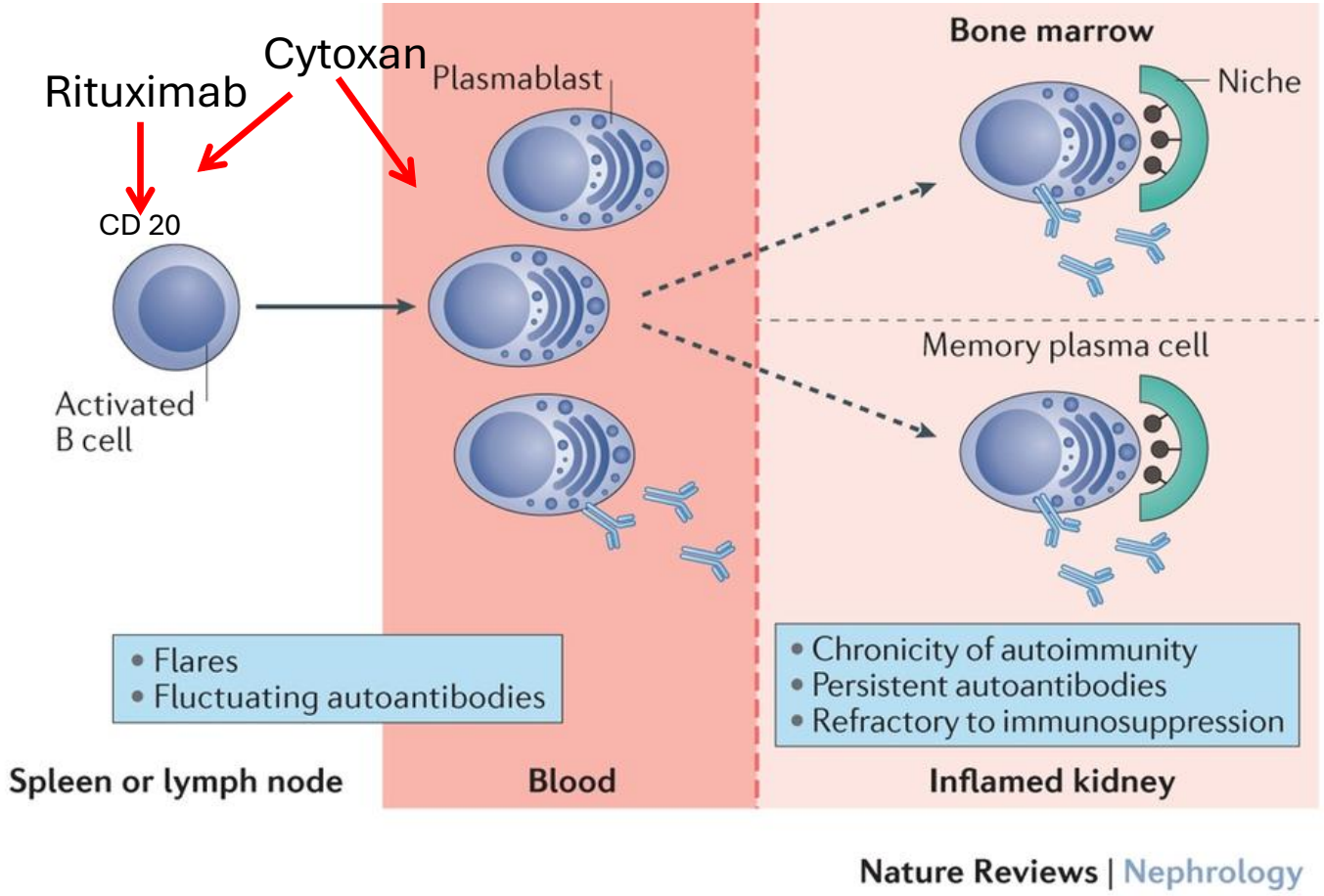
Combination Therapy for MN



Nat Rev Nephrol. 2016 Apr;12(4):232-40

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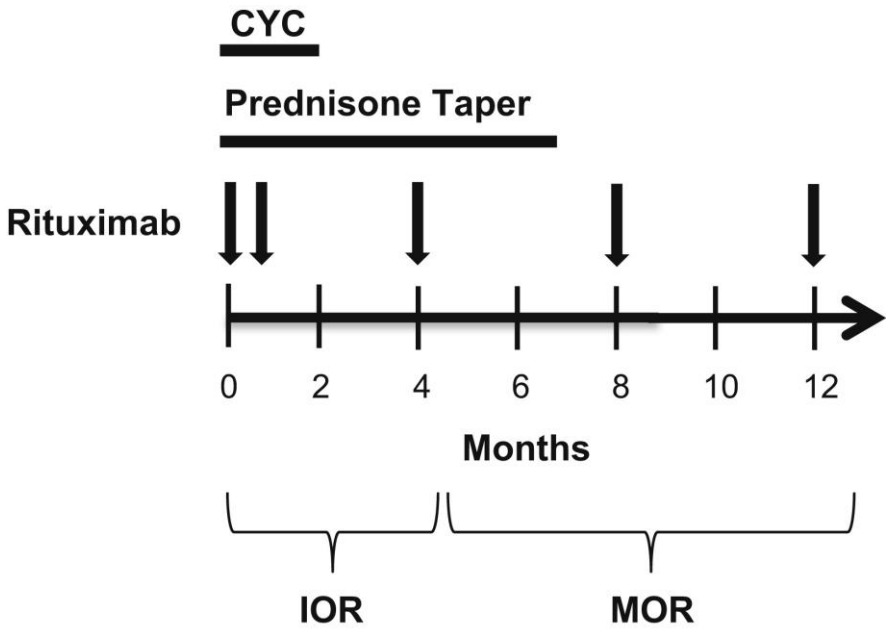
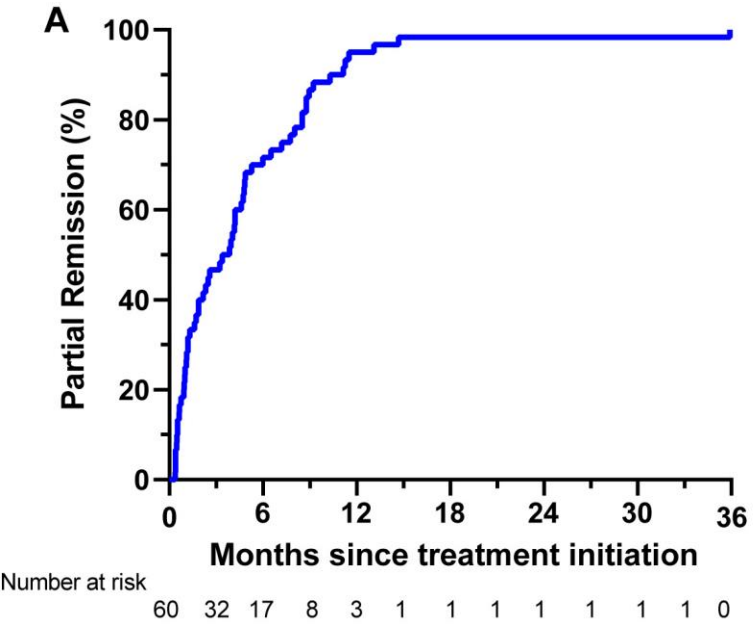
Combination Therapy for MN

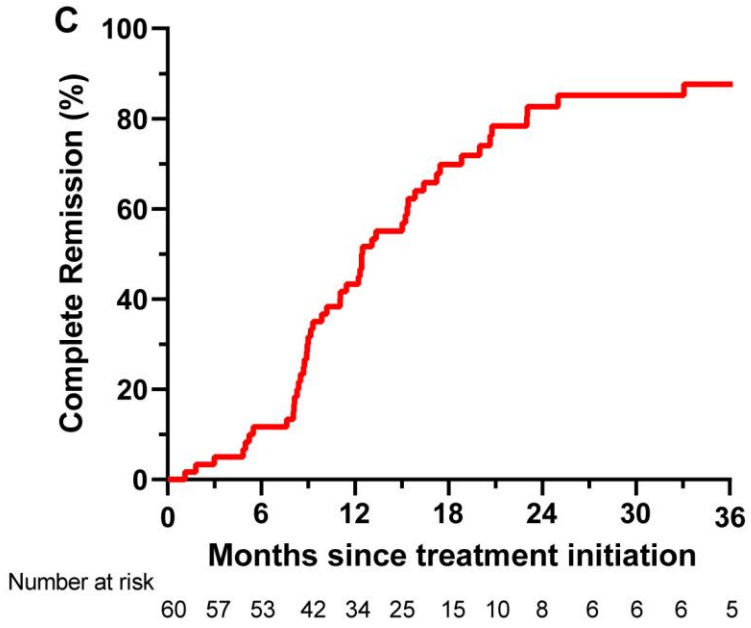


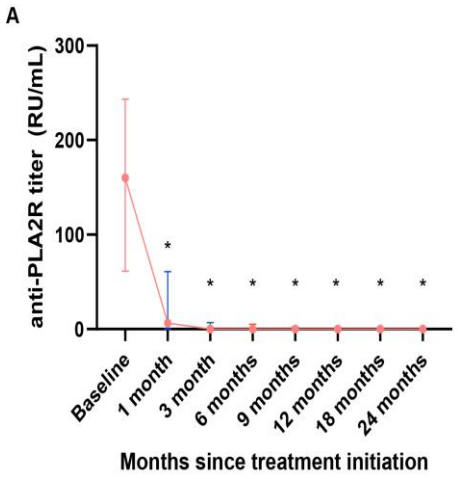
- Rituximab
  - 1 gm x 2
- Prednisone
  - Tapered to 15mg by day 30
  - Then tapered by 2.5 mg/month
- Cytoxan
  - 2.5 mg/kg for 1 week
  - 1.5 mg/kg for 7 weeks
  - **Adjusted for renal fx**

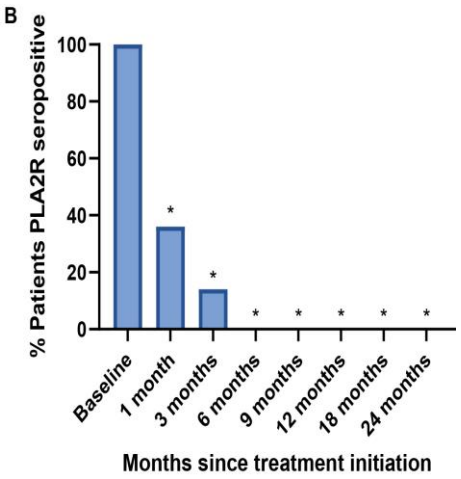
Cortazar, Frank B. et al. KI Reports 2018; 3(2):94 - 402

Combination Therapy for MN









Am J Kidney Dis. 2021 Dec;78(6):793-803.

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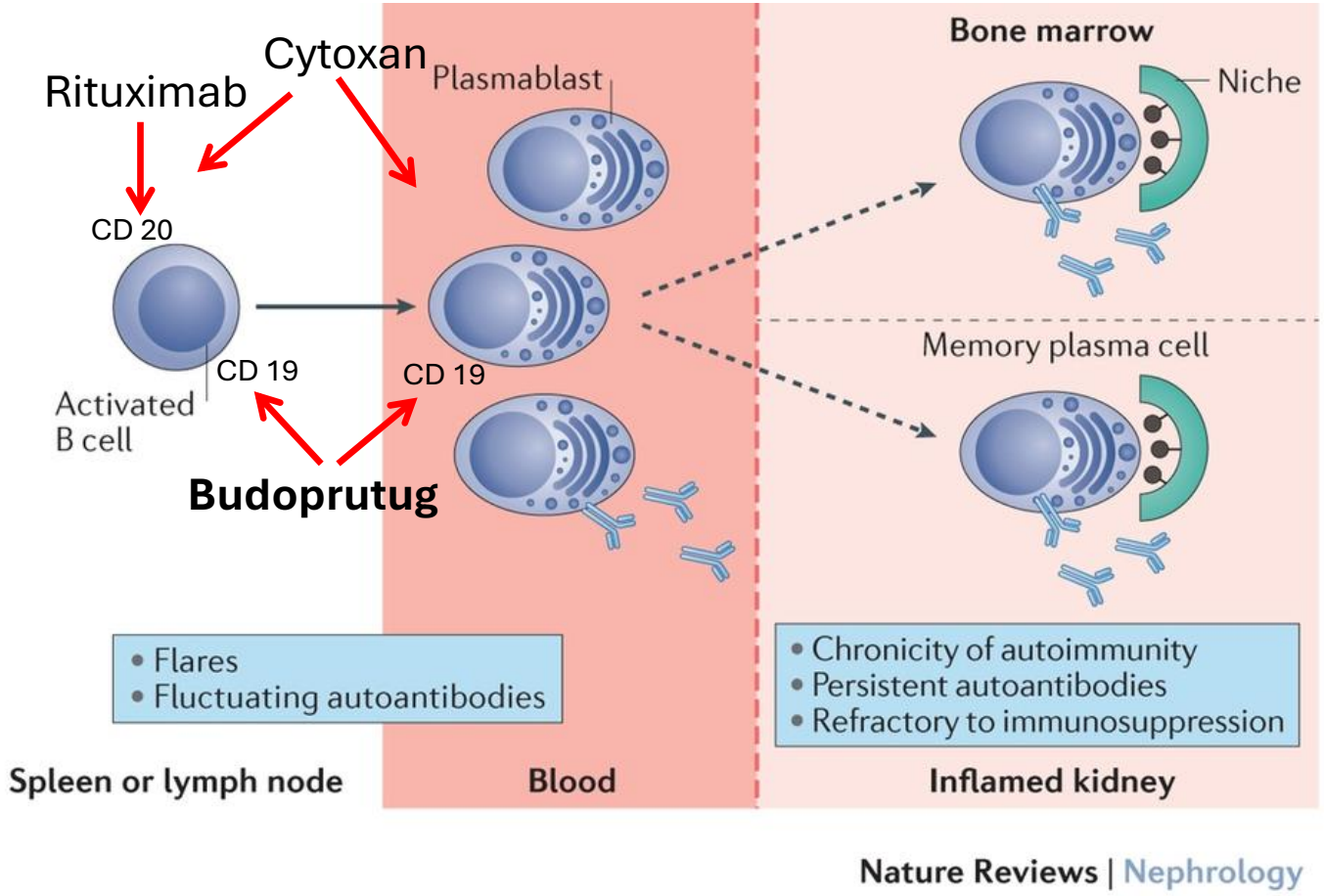
Combination Therapy for MN



Nat Rev Nephrol. 2016 Apr;12(4):232-40

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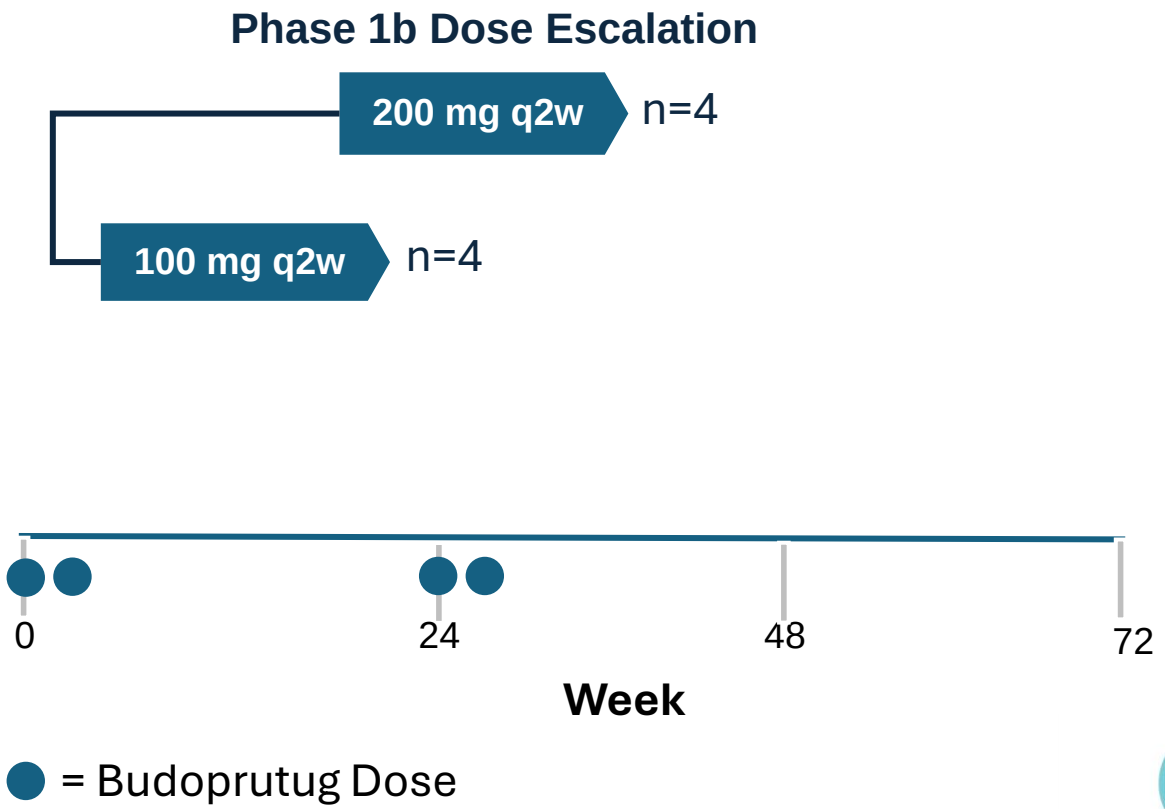
Budoprutug MN Phase 1b Study Design

ELIGIBILITY	• UPCR ≥2.0 g/g • B-cell count >LLN (80 cells/μL)
DESIGN	• Dose escalation & expansion • 18-month follow-up
ELIGIBILITY	• UPCR ≥2.0 g/g • B-cell count >LLN (80 cells/μL)
DESIGN	• Dose escalation & expansion • 18-month follow-up
DOSING	2 doses 14 days apart† • 100 mg • 200 mg
ENDPOINTS	• Safety, Tolerability & PK • PD markers (B-cells, PLA2R) • Proteinuria response



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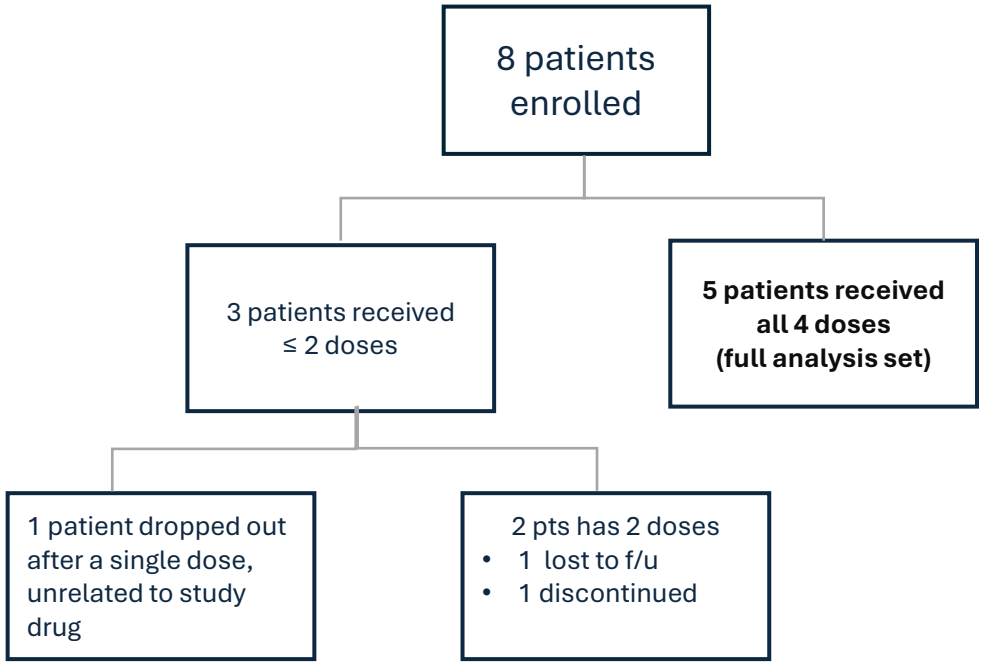
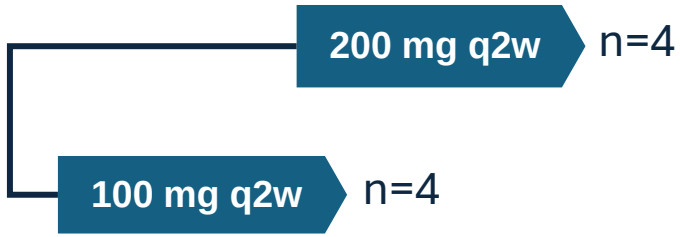
Budoprutug Phase 1b Study



PARAMETER	BASELINE (MEAN)
B-cells	145 cells/μL
PLA2R	71 RU/mL
UPCR	4.03 g/g

Phase 1b Dose Escalation



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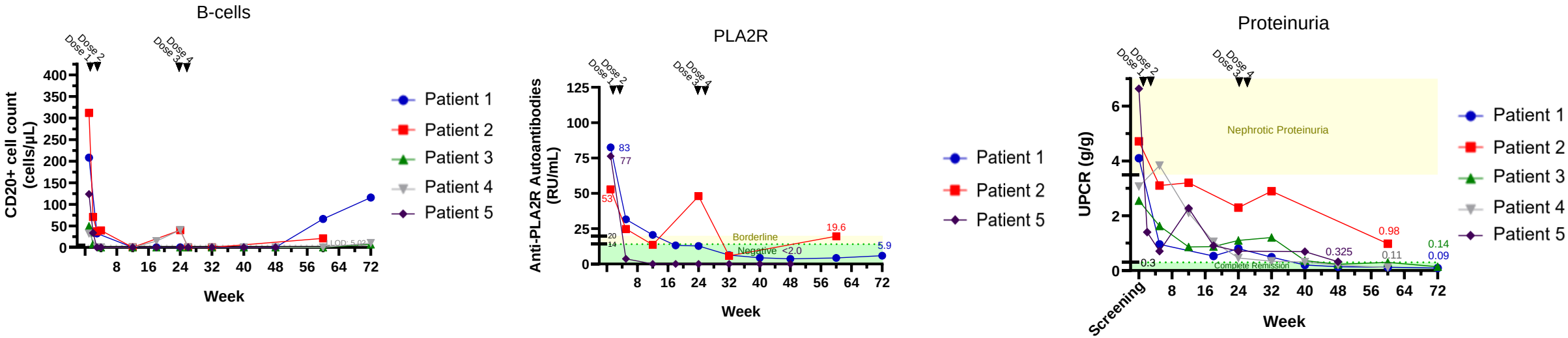
Budoprutug Phase 1b Study

Data for MN subjects (n = 5) who have completed ≥48-weeks



Complete remission achieved in 60% (3/5) of patients at Week 48

- Partial remission (>50% reduction in UPCR + UPCR <3.5 g/g) achieved in all (5/5) subjects
- Complete B-cell depletion ($CD20^+$ count <5 cells/µL) achieved in all (5/5) subjects
- Anti-PLA2R Ab negativity (<14 RU/mL) achieved in all (3/3) evaluable subjects
- 2 subjects on study that have not entered complete remission have achieved PLA2R negativity (serological remission)
- *Patient 1 remains in CR 2 yrs after last infusion*

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Budoprutug Safety

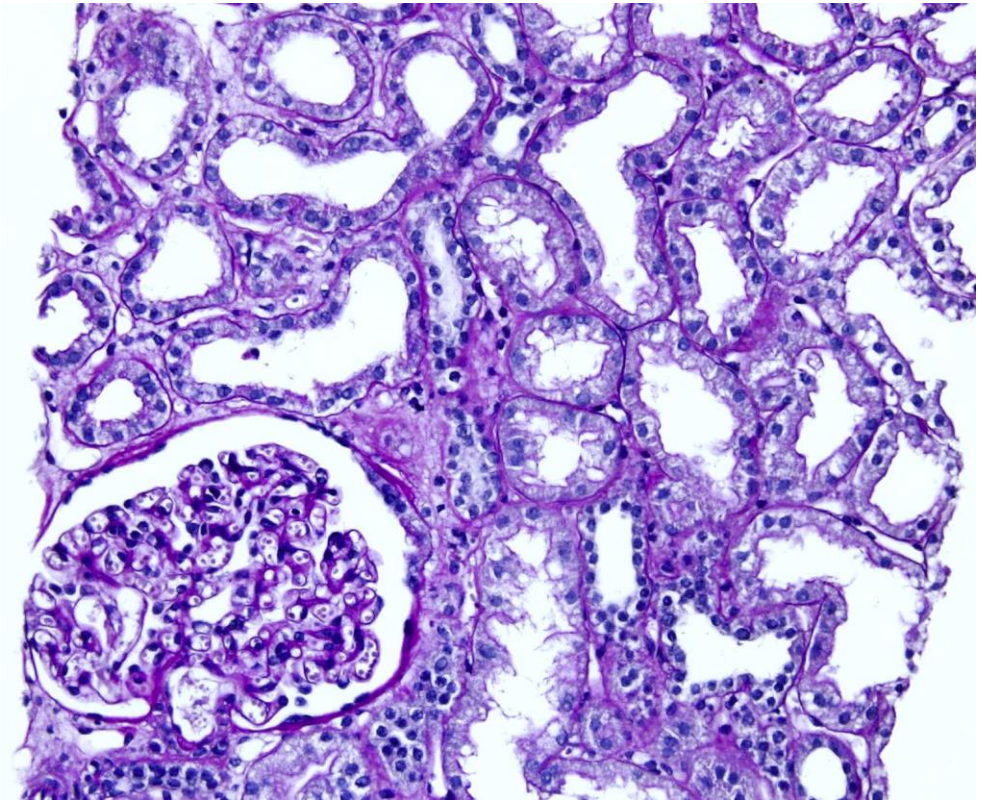
Budoprutug was generally well tolerated at doses of up to 200mg

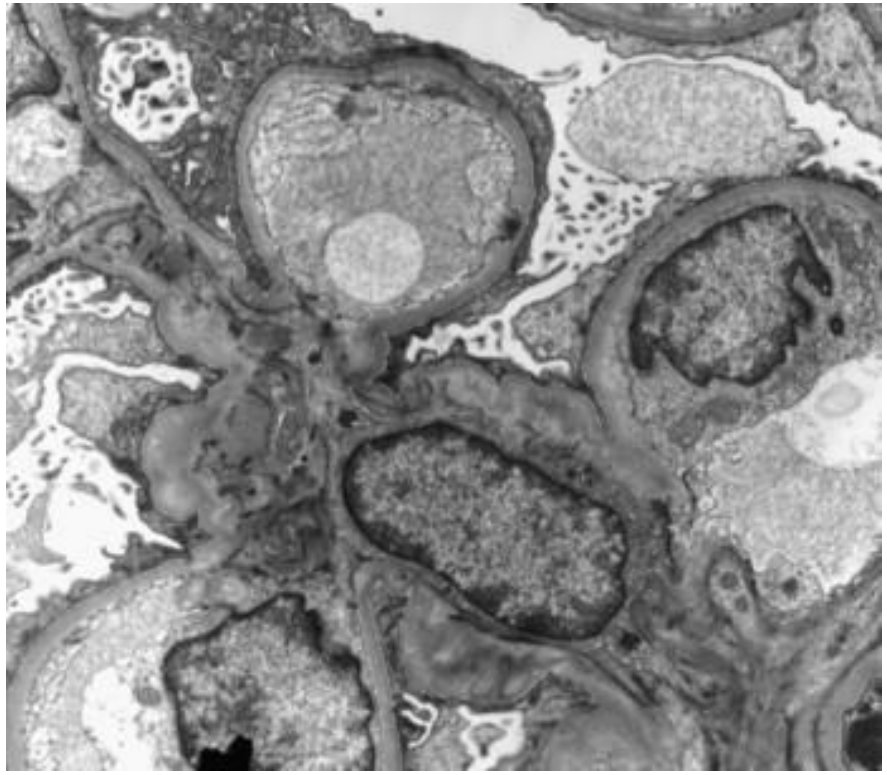
- 8 Patients received at least one injection of budoprutug and are included in the safety analysis population
  - There were no deaths on study
  - There were 3 SAEs, none of which were considered to be related to budoprutug by the investigator.
  - No discontinuations due to AE
  - No dose limiting toxicities (DLTs) were observed
  - 4 patients reported infections on study of which 3 were cases of COVID-19, 1 was bacterial pneumonia

Budoprutug in MN

- Well tolerated
- Demonstrated clinical and immunological remission rates superior to rituximab based on historical data

Minimal Change Disease





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MCD Overview

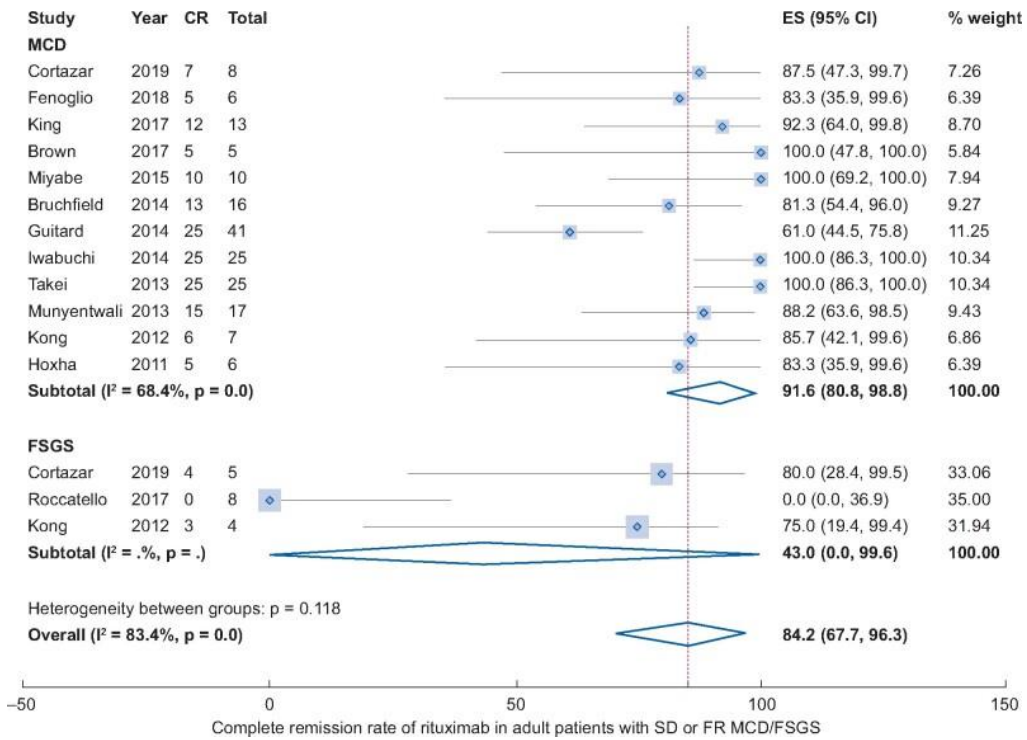
Pathophysiology	• Unknown etiology, though evidence suggests a circulating autoantibody (AAb) • Diffuse foot effacement on biopsy
Symptoms & Diagnosis	• Sudden onset of nephrotic syndrome • Edema, often profound
Epidemiology	• Incidence of 1/150k • 20k addressable patients in US
Natural History	• Uncontrolled disease results in complications of nephrotic syndrome & eventual kidney failure • Patients that respond to therapy can achieve long-term remissions
Standard of Care	• Steroids used to induce, maintain remission • No labeled, FDA-approved therapy

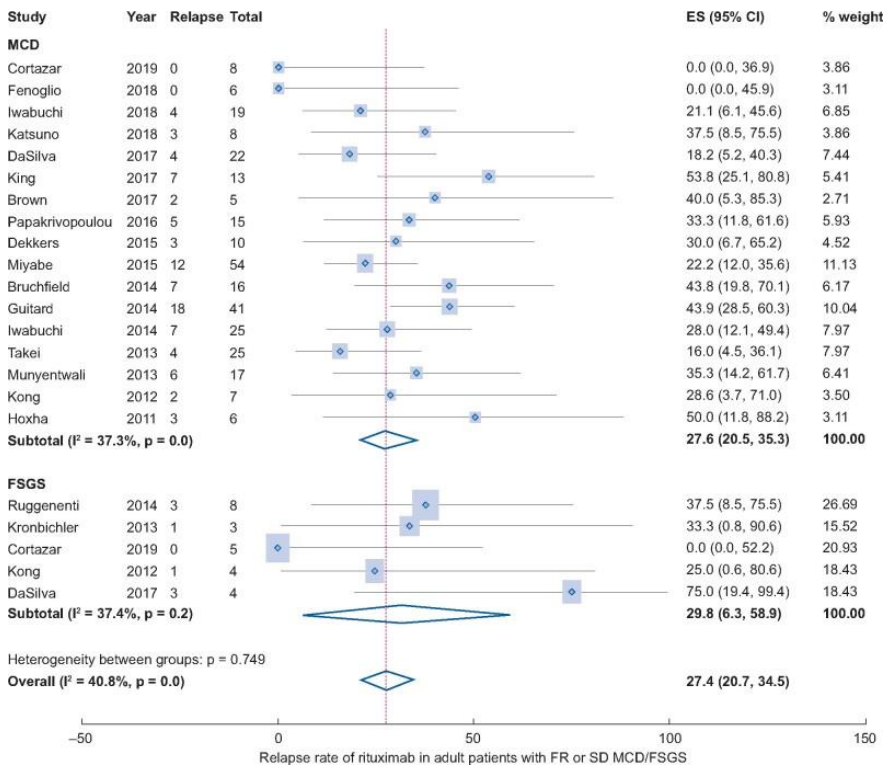
Treatment Challenges in MCD

- A significant number of patients have:
  - Steroid dependent (unable to taper steroids without a relapse)
  - Frequently relapsing disease (4 relapses/yr)

- Treatment options include
  - CNIs (nephrotoxicity/high relapse rate)
  - Cyclophosphamide (High toxicity)
  - **Rituximab**

Rituximab for complicated MCD





Clin Kidney J. 2020 Nov 21;14(4):1042-1054.

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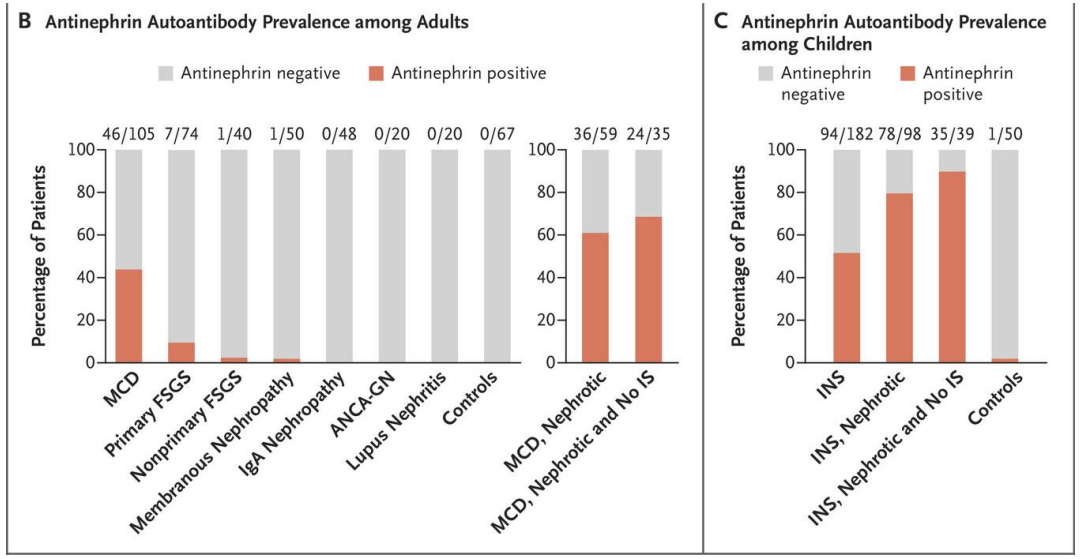
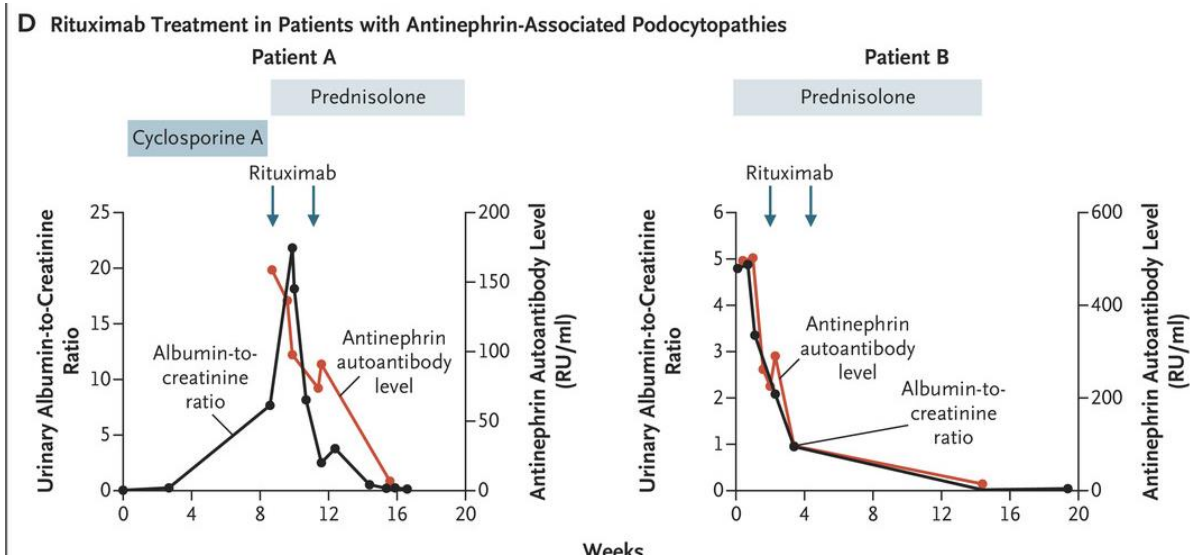
Antinephrin antibodies in MCD





N Engl J Med. 2024 Aug 1;391(5):422-433.

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Budoprutug for complicated MCD

- Phase 1b Study

- Enrolled a 57-year-old with frequently relapsing MCD
  - Relapsed on tacrolimus
  - Remission after steroid course; relapsed within 2 months and steroids reinitiated

- Received budoprutug: 2 induction doses and 2 maintenance doses
  - B cells effectively depleted
  - Steroids discontinued; remains in remission 18 months after last infusion
  - No safety signals

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Complex Systemic Disease Opportunity

Jan Hillson, MD | Senior Clinical Advisor

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Corporate Strategy & Vision

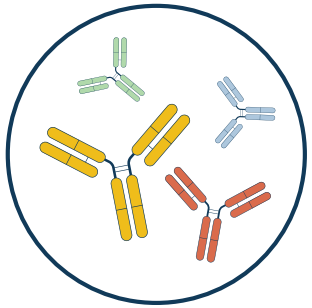
Climb is well-positioned to advance budoprutug across three distinct opportunity sets

Primarily IgG4-Mediated

Clear pathophysiology supporting targeting of CD19-expressing B-cells

Lead indication
Membranous Nephropathy

Opportunity to Differentiate
Potential for “immune reset”, improved efficacy



Complex Systemic

Multi-organ, systemic diseases with heterogenous patient populations

Lead indication
Systemic Lupus Erythematosus

Opportunity to Differentiate
Improve efficacy while balancing safety, tolerability, and convenience

Primarily single organ IgG1 - 3

Orphan diseases with compelling clinical proof-of-concept using B-cell depletion

Lead indication
Immune Thrombocytopenia

Opportunity to Differentiate
Demonstrate efficacy in relapsing and/or refractory patients

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Systemic Lupus Erythematosus (SLE): Indication Overview

Pathophysiology	• **SLE comprises a group of disorders** characterized by the generation and persistence of autoreactive lymphocytes and autoantibodies directly interfere with critical functions, target cells for destruction, and damage tissues through immune complex depositions
Symptoms & Diagnosis	• **Diagnosis is clinical**, based on serology and organ system involvement without other cause • **Symptoms and severity vary widely across patients.** Nephritis is the most common organ system threat; fatigue and cognitive dysfunction are the most common disabling manifestations
Epidemiology	• **US burden is ~240,000 active patients**; ~80,000 with lupus nephritis • Global prevalence is ~1-2 per 100,000 adults, with 9:1 female predominance
Standard of Care	• **Corticosteroids** to rapidly control inflammation • **Antimalarials** for rash and to reduce flares • **Small molecule immune suppressants** to reduce corticosteroid use • **Belimumab** (B cell activating factor blockade), **Anifrolumab** (type 1 interferon receptor blockade) for refractory disease • **Rituximab** used off label
Unmet Need	• **10% – 20% are refractory** to current therapies; much larger numbers are dependent on corticosteroids • **Relapses**, especially of nephritis, vasculitis, thrombosis, lead to cumulative damage and organ failure • **Fatigue and cognitive dysfunction** respond poorly, impairing participation and quality of life • **Treatment-associated burden** of cardiovascular mortality, infection, and neoplasm risk

Targeting B-Cells Has Shown Promise in SLE

DRUG	CO.	TARGET	ROUTE	STAGE	SLE CLINICAL DATA
Rituximab	Roche	CD20	IV, SC	Phase 3 SLE and LN (failed)	Phase 3 (vs. placebo, n=257) Week 52 SRI-4 27.2% (vs. 22.7%)
Obinutuzumab	Roche	CD20	IV	Phase 3 LN (completed; results pending)	Phase 2 (vs placebo, n=125) Week 52 CRR 35% (vs 23%) Week 104 CRR 41% (vs 23%)
Belimumab	GSK	BAFF	SC	SLE and LN (marketed)	Phase 3 (vs. placebo, n=836) Week 52 SRI-4 61% (vs. 48%)

Patients with poor response to depletion of CD20+ B cells are characterized by any among:

- Inadequate CD20+ B cell depletion
- Persistence of CD19+ self-reactive B cell subsets
- Continued production of pathogenic autoantibodies by plasma cells
- Rapid recovery of pathogenic B cell subsets

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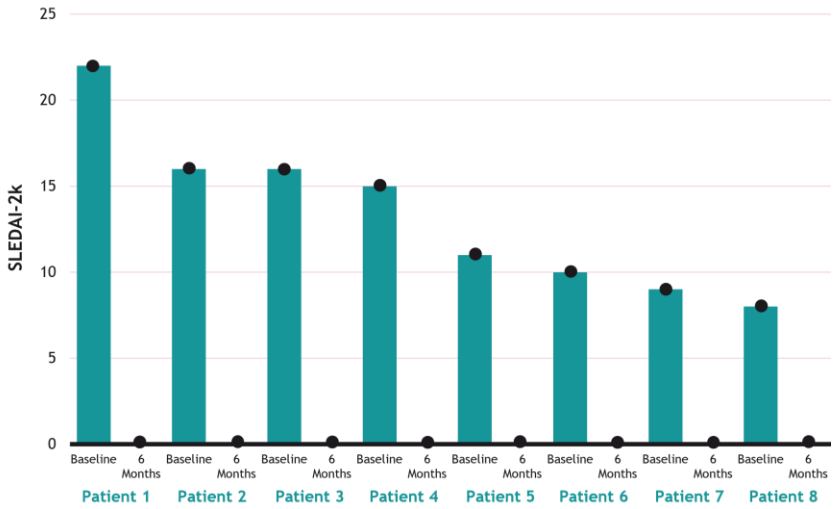
Arnold 2022; Furie 2022; Scherlinger 2019; Benlysta FDA label

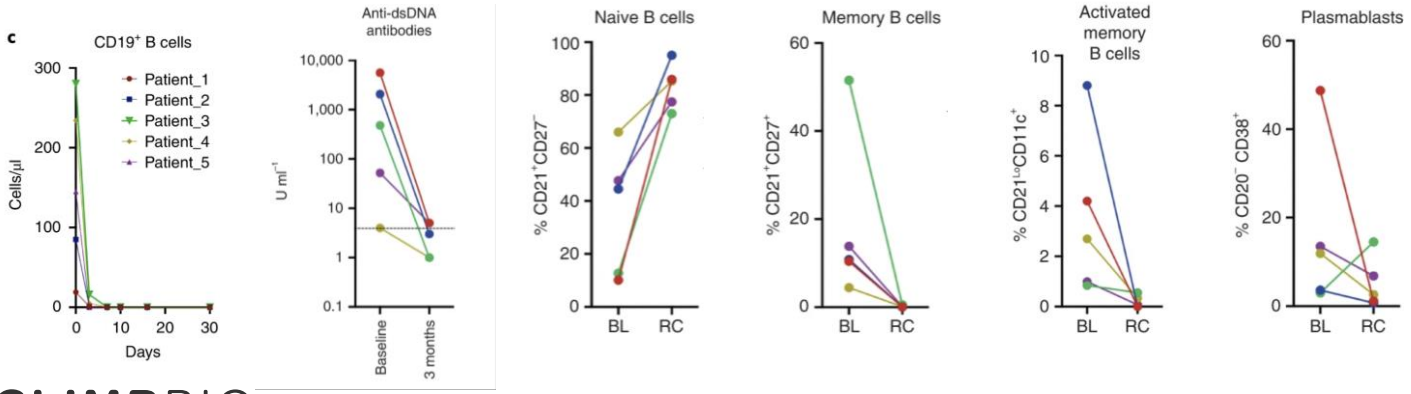
Targeting B-Cells Has Shown Promise in SLE

CD19 CAR-T potentially 'curative' at 6 months



SLE patient data from Müller 2024, Mackensen 2022, SLEDAI-2K = Systemic Lupus Erythematosus Disease Activity Index 2000

Response is associated with rapid depletion of circulating B cell and autoantibodies, followed by recovery of relatively benign B cell subsets



Depletion of CD19+ B cells with CD19+ CAR-T cells addresses some of the shortcomings of existing therapy. Limitations include:

- Challenging to make autologous cells from highly pre-treated patients
- Toxicity associated with required conditioning therapy
- Risk of cytokine release syndrome and immune effector cell associated neurotoxicity syndrome
- Access limited by complexity and cost

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SLE Trial Design & Objectives*

Planned open-label, dose escalation with augmented B cell and antibody analyses

POPULATION

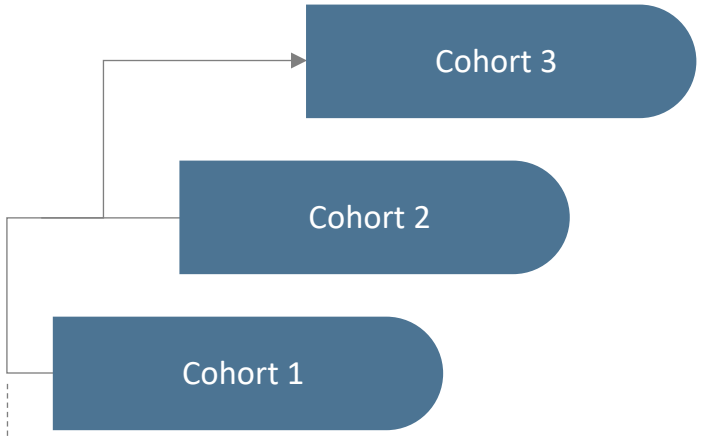
- Diagnosis of SLE, with active disease based on SLEDAI
- Seropositive, with elevated ANA, anti-dsDNA, ENA or APL
- <20 mg prednisone by Day -28; stable limited background

PRIMARY OBJECTIVE

- To evaluate the safety and tolerability of budoprutug in subjects with SLE

KEY SECONDARY/EXPLORATORY OBJECTIVES

- To evaluate the effects of budoprutug on B-cell depletion (prioritized pharmacodynamic [PD] response), autoantibody levels, and protective antibody levels
- To evaluate the PK and PK/PD (dose relationship) profile in patients with SLE
- To evaluate preliminary signs of clinical activity in patients with SLE
- To determine the kinetics of re-population of B-cell subsets and antibodies after depletion

Dose Escalation	Potential Dose Expansion
	Dose regimen selected based on Dose Escalation
Subjects with active SLE on stable limited background are eligible for dose escalation phase	*Subjects with active SLE despite adequate trial of two prior therapies* *Follow until B cells return toward baseline*

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*Subject to investigational new drug application clearance

SLEDAI = Systemic Lupus Erythematosus Disease Activity Index; ANA = antinuclear antibodies; anti-dsDNA = anti double-stranded DNA; ENA = extractable nuclear antigen

Corporate Outlook

Significant unmet needs across lead indications, >2.5M US patients with immune-mediated disease

Primarily IgG4-Mediated

- MG (MuSK) ~7k
- MN ~70k
- CIDP ~20k
- IgG4-RD ~20k
- PV ~15k

Complex Systemic

- RA ~1300k
- Sjogren's ~340k
- SLE ~240k
- SSc ~85k

Primarily single organ IgG1 - 3

- MS ~730k
- ANCA-AAV ~140k
- MG (AChR) ~68k
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Primarily Single Organ IgG1 – 3 Disease Opportunity

Nishi Rampal, MD | SVP Clinical Development

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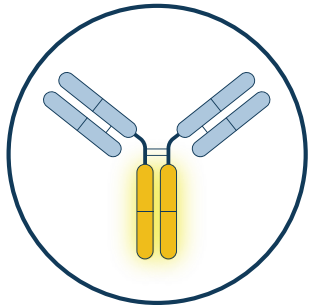

Primarily single organ IgG1 - 3

Orphan diseases with compelling clinical proof-of-concept using B-cell depletion

Lead indication
Immune Thrombocytopenia

Opportunity to Differentiate
Demonstrate efficacy in relapsing and/or refractory patients

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Immune thrombocytopenia (ITP): Indication Overview

Pathophysiology	• ITP is an autoimmune disease characterized by low platelets resulting in bruising and hemorrhage • **Antiplatelet autoantibodies** lead to **accelerated removal of platelets** by macrophages with bone marrow compensation
Symptoms & Diagnosis	• Symptoms: bruising (**petechiae and purpura**), bleeding episodes, and fatigue • Diagnosis: Low platelet count, supported by additional blood tests i.e., CBC and blood smear, antiplatelet antibody test, bone marrow aspiration if needed
Epidemiology	• The estimated global prevalence of ITP is around 200,000 patients worldwide • In the US, there are 81,000 adults with chronic ITP with >24,000 refractory to 2nd line treatment
Natural History	• Most children have spontaneous remission within a few weeks or months • While adults often stabilize on 1st line therapy, the majority eventually **relapse or become refractory**, necessitating treatment with 2nd and at times 3rd line therapies, **splenectomy** in hard-to-treat situations can be considered

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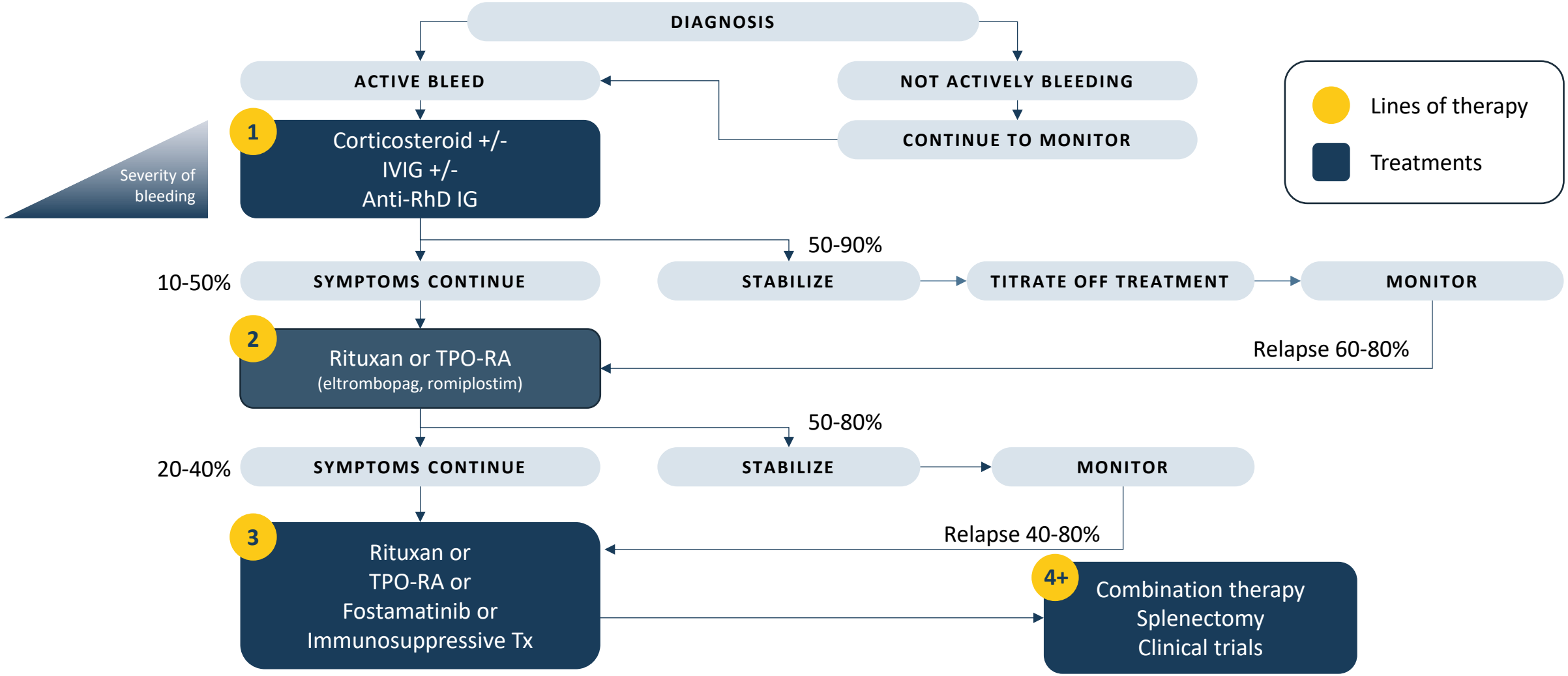
Statpearl ; Weycker D 2020; Moulis G 2021; Moulis G 2014; Jefferies Analyst Report For Rigel Pharmaceuticals from April 2,2024; DelveInsights Press Release for ITP report on Jan 11 2024; Gugenheim Securities Alpine report April 9, 2024

Current management guidelines



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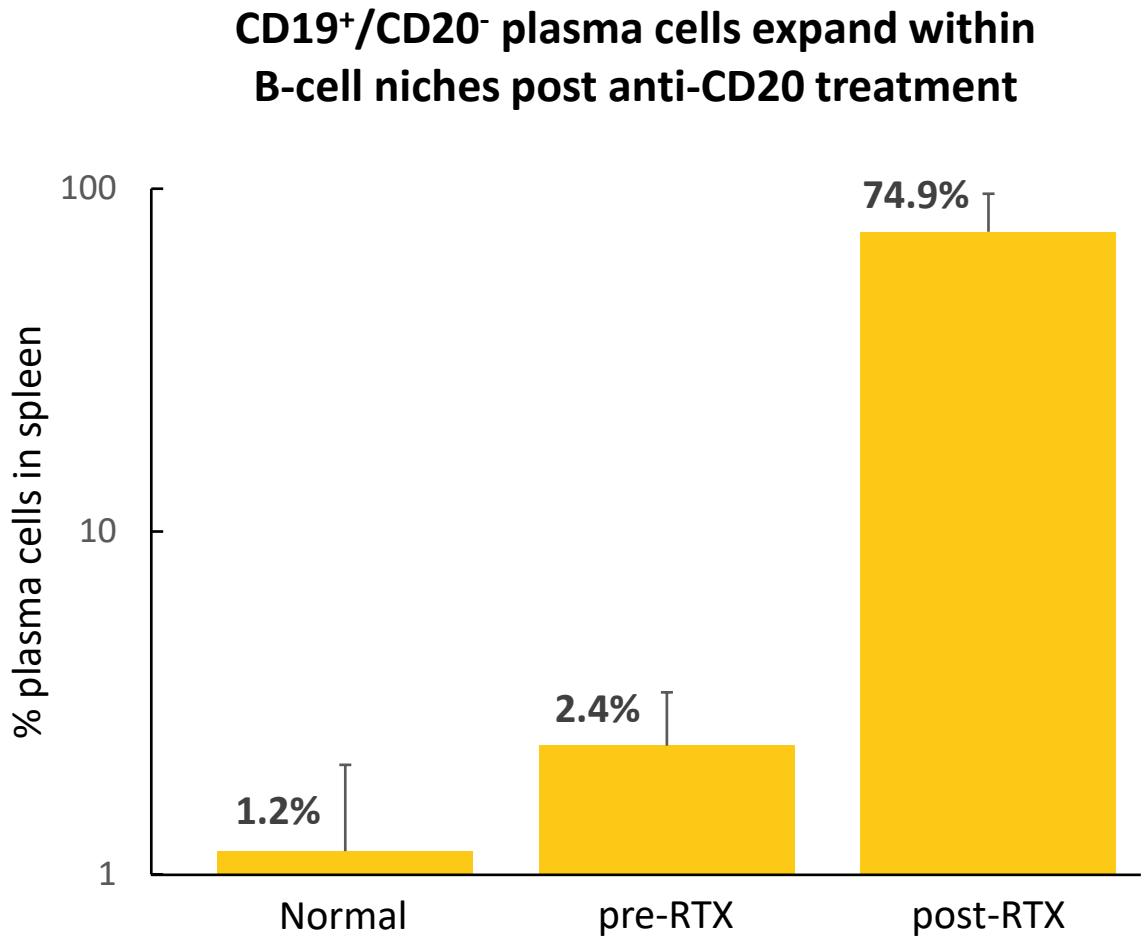
The International Working Group (IWG) on ITP and the American Society of Hematology (ASH) 2019 guidelines
Sources: Vianelli N 2022; Liu XG 2023; Bussel J 2021, Statpearl; Provan D 2019; Neunert C 2019

ITP patients likely fail rituximab due to the presence of CD19+CD20- B-cells

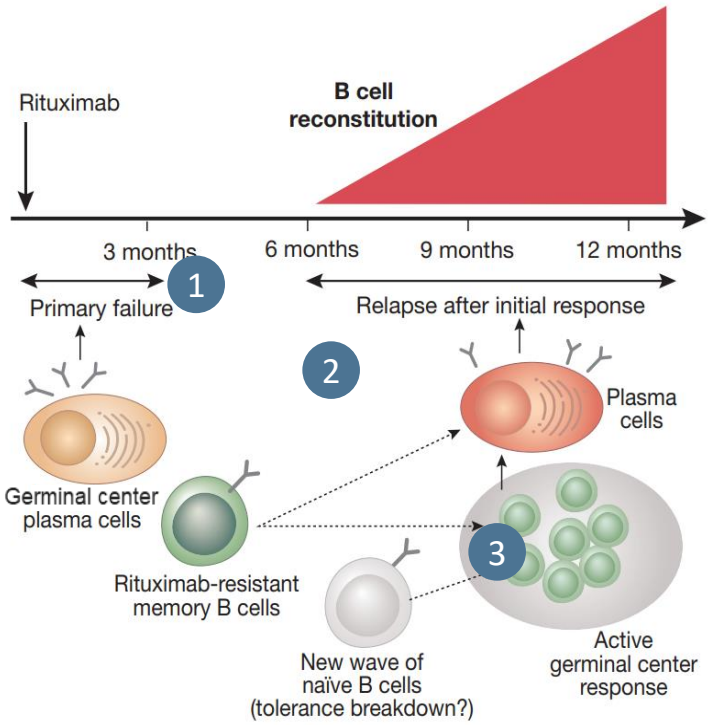


Primary failure

1. Pre-existing CD20⁻ PCs

Relapse after initial response

2. Pre-existing CD20⁻ B-cells
3. *De novo* CD20⁻ B-cells



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Mahevas et al. 2013

ITP Phase 2 Trial Design & Objectives*

Planned single arm, open-label study focused on platelet response and B-cell depletion

POPULATION

- Insufficient response to 1 or more prior therapies
- Platelet count <30,000/µL
- B cells > 40 /µL

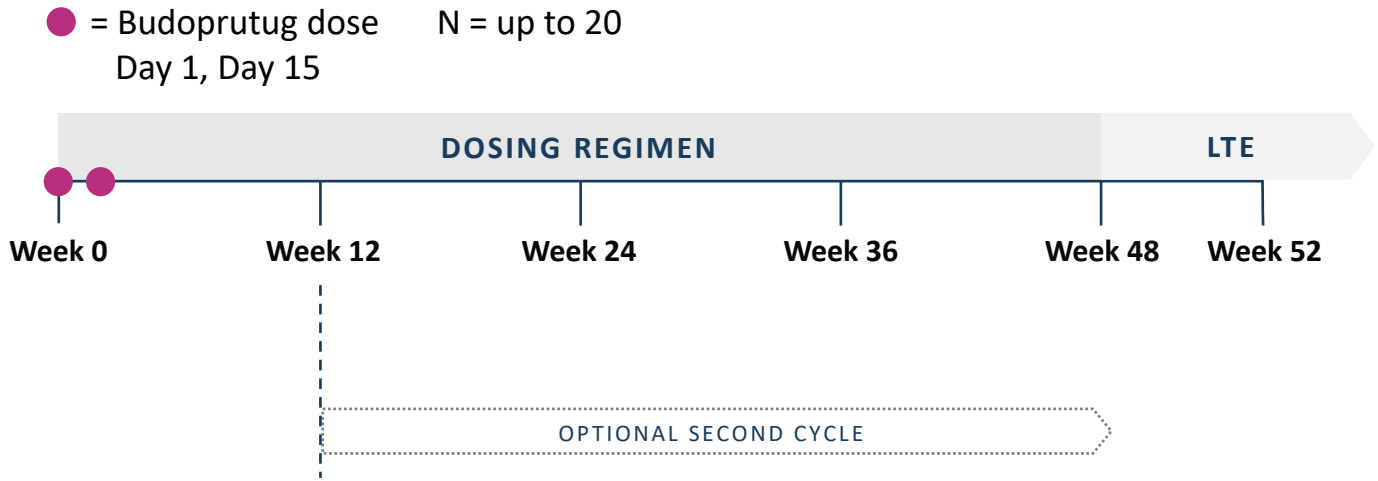
PRIMARY OBJECTIVE

- To evaluate the safety and tolerability of budoprutug in subjects with ITP
- To evaluate the efficacy of budoprutug on platelet counts

KEY SECONDARY/EXPLORATORY OBJECTIVES

- To evaluate subject reported outcomes/quality of life (QoL) measures
- To evaluate PK/PD (dose relationship) profile in subjects with ITP

Potential for treat to target approach



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*Subject to investigational new drug application clearance

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Corporate Outlook

Brett Kaplan, MD | COO

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Multiple Clinical and Regulatory Milestones Over Coming 12 Months

$218M*

RUNWAY THROUGH 2027

67.2M*

SHARES OUTSTANDING

Anticipated Milestones	Timing
Initiation of SLE global clinical trial with first patient in†	H1 2025
Initiation of ITP global clinical trial with first patient in †	H1 2025
Additional non-clinical data from subcutaneous program	H1 2025
Advance PMN program to late phase development	2025
Initiate clinical development of subcutaneous program	2025
Evaluate additional programs	2025

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* As of Sept 30, 2024
† Subject to investigational new drug clearance

Building A Leading Immune-Mediated Disease Focused Company

Immune-Mediated Disease Focus

Focused solely on immune-mediated disease with budoprutug, a potentially best-in-class anti-CD19 antibody, our cornerstone asset

Broad Potential

Budoprutug in development for SLE, ITP and MN with the prospect of expanding into additional indications as well as a potential subcutaneous formulation

Well Resourced

Funded through 2027 enabling delivery of key value inflection points through the initiation of multiple clinical programs and a subcutaneous formulation clinical trial

Experienced Team

Track record of execution and operational results

CLIMBBIO

Questions & Answers

CLIMBBIO