TOURMALINE

Corporate Overview

March 2024

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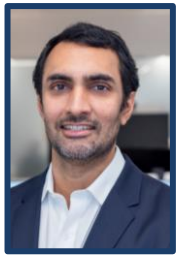
Our mission

We are driven by our mission to develop transformative medicines that dramatically improve the lives of patients with life-altering immune and inflammatory diseases

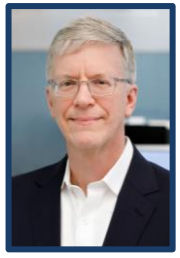
Experienced leadership team

Management Team



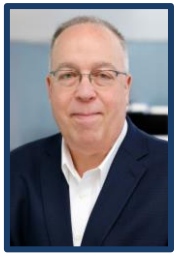
Sandeep Kulkarni, MD
Co-founder and Chief Executive Officer

Yung Chyung, MD
Chief Medical Officer



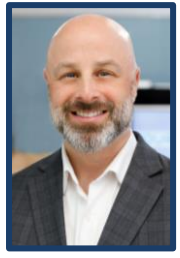
Brad Middlekauff, JD
Chief Business Officer and General Counsel

Susan Dana Jones, PhD
Chief Technology Officer



Kevin Johnson, PhD
Chief Regulatory Officer

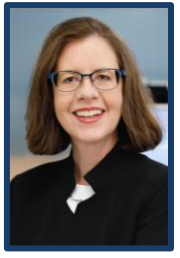
Ryan Robinson, CPA
Interim Chief Financial Officer



Ryan Iarrobino
Senior Vice President, Product Development

Gerhard Hagn
Senior Vice President, Head of Commercial & BD

Emil deGoma, MD
Senior Vice President, Medical Research



Dora Rau
Senior Vice President, Head of Quality

Board of Directors

Clay Siegall, PhD
Chairman

Caley Castelein, MD

Aaron Kantoff

Mark McDade

Sapna Srivastava, PhD

Parvinder Thiara

Sandeep Kulkarni, MD

Key highlights

An IL-6 renaissance is underway: new insights emerging about a broad range of indications where IL-6 may be clinically validated

TOUR006 has demonstrated best-in class potential: long-acting, low immunogenicity, and low-volume subcutaneous administration observed in clinical trials to date

Two strategic paths to significant value creation: (1) FcRn+ and (2) cardiovascular inflammation

A late-stage clinical company: topline data from pivotal Phase 2b spiriTED trial and Phase 2 CV trial both expected in H1 2025, pivotal Phase 3 TED trial also expected to commence in H2 2024

Accomplished leadership team: extensive experience developing and commercializing antibodies for immune and inflammatory diseases

Well-financed: cash expected to fund operations into 2027, enabling the delivery of key anticipated milestones for both strategic paths

We are in an IL-6 renaissance

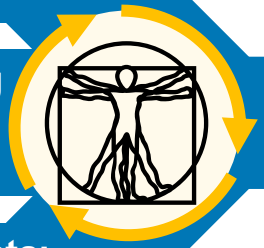
First wave of IL-6 inhibition: focus on rheumatology

2010 – 2023

- RA
- GCA
- sJIA
- CRS
- pJIA
- NMOSD
- MCD
- SSc-ILD
- COVID19
- PMR

Sources of emerging insights:

- Sustained academic and investigator enthusiasm for IL-6
- Hypothesis-generating success from off-label experimentation
- Human translational data: genetic, biomarker, epidemiologic



Second wave of IL-6 Inhibition: driven by emerging insights

2024: Late-stage programs

- AE
- AMI
- AMR
- ASCVD
- HFpEF
- MG
- MOGAD
- TED
- UME

2024+: Large body of potential indications

Cardio:	AAA	AM
	Stroke	
Derm:	BP	PV
Endo:	Graves'	
GI:	CD	UC
Hem:	ITP	TTP
Neph:	IgAN	MN
Neuro:	CIDP	IBM
	PPMS	RRMS
Ophth:	DME	NIU
Resp:	CHP	IPF
	PAP	Sarcoid
Rheum:	AAV	IgG4-RD
	SjS	

Tourmaline-Selected Indications Key

- Cardiovascular Inflammation
- FcRn+

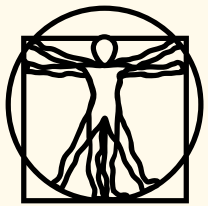
AAA: Abdominal aortic aneurysm; AAV: ANCA-associated vasculitis; AE: Autoimmune encephalitis; AM: Acute myocarditis; AMI: Acute myocardial infarction; AMR: Antibody mediated rejection; ASCVD: Atherosclerotic cardiovascular disease; BP: Bullous pemphigoid; CD: Crohn's disease; CHP: Chronic hypersensitivity pneumonitis; CIDP: Chronic inflammatory demyelinating polyneuropathy; COVID19: Coronavirus disease 2019; CRS: Cytokine release syndrome; DME: Diabetic macular edema; GCA: Giant cell arteritis; FcRn: neonatal Fc receptor; HFpEF: Heart failure with preserved ejection fraction; IBM: Inclusion body myositis; IgAN: IgA nephropathy; IgG4-RD: IgG4 related disease; IPF: Idiopathic pulmonary fibrosis; ITP: Idiopathic thrombocytopenic purpura; MCD: Multicentric castleman's disease; MG: Myasthenia gravis; MN: Membranous nephropathy; MOGAD: Myelin oligodendrocyte glycoprotein antibody-associated disease; NIU: Non-infectious uveitis; NMOSD: Neuromyelitis optica spectrum disorder; PAP: Pulmonary alveolar proteinosis; pJIA: Polyarticular juvenile idiopathic arthritis; PMR: Polymyalgia rheumatica; PPMS: Primary progressive multiple sclerosis; PV: Pemphigus vulgaris; RA: Rheumatoid arthritis; RRMS: Relapsing remitting multiple sclerosis; Sarcoid: Sarcoidosis; sJIA: Systemic juvenile idiopathic arthritis; SjS: Sjögren's syndrome; SSc-ILD: Systemic sclerosis interstitial lung disease; TED: Thyroid eye disease; TTP: Thrombotic thrombocytopenic purpura; UC: Ulcerative colitis; UME: Uveitic macular edema

TOUR006: an anti-IL-6 antibody with the potential to deliver significant value to patients

TOUR006 attributes observed to date	Potential value to patients
Long-acting with terminal half-life of ~7 weeks[1]	Dosing every 8 weeks[5] or quarterly[6]
>90% pathway inhibition after single 10mg dose[2]	Fast, deep, and durable impact across diseases
Fully human with ADAs in only 0.5% of pt[3]	Durable benefit without need to increase dose
High affinity to IL-6[4]	Volume of ≤1ml for SC injection[5]
Existing data from 448 study participants[1]	Generally well-tolerated safety profile observed to date

1) Across six clinical trials in healthy volunteers and RA, SLE, and CD patients
2) Data on file; single intravenous 10mg dose in Ph1 MAD study in RA patients; as measured by C-reactive protein (CRP), a pharmacodynamic marker of IL-6 signaling
3) Generated from Medarex transgenic mouse platform; across 448 subjects dosed with TOUR006, only 2 subjects generated anti-drug antibodies (ADAs) following treatment
4) Data on file
5) To be assessed based on data from prior Phase 2 trials
6) To be evaluated in CV Phase 2 trial

Two strategic paths to unlock major value creation



IL-6 Renaissance

Emerging insights implicating IL-6 in a wide range of rare & large diseases

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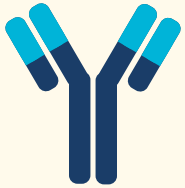


TOUR006

✓ Long-acting
✓ Low immunogenicity
✓ Low volume, SC

FcRn+

TOUR006 has the potential to be a superior therapy for a wide range of autoantibody-driven diseases vs. FcRn inhibitors

Key expected readouts

- ❑ **H1 2025:** spiriTED Phase 2b topline data
- ➢ **H1 2024:** Satra MG Phase 3 (LUMINESCE) topline data
- ➢ **2025:** Satra AE Phase 3 (CIELO) topline data

Cardiovascular Inflammation

TOUR006 has the potential to transform the care of high-risk patients by targeting key inflammatory pathways driving cardiovascular disease

Key expected readouts

- ❑ **H1 2025:** CV Phase 2 topline data
- ➢ **2025:** Zilti ASCVD in CKD Phase 3 (ZEUS) topline data
- ➢ **2026:** Zilti AMI Phase 3 (ARTEMIS) topline data

Milestones key: ❑ Internal ➢ External

The timing of regulatory and clinical trial milestones are subject to change and additional discussion with the FDA
AE: autoimmune encephalitis; AMI: acute myocardial infarction; ASCVD: atherosclerotic cardiovascular disease; CKD: chronic kidney disease; MG: myasthenia gravis; Satra: satralizumab; Zilti: ziltivekimab

Clinical development plan for TOUR006

Strategy	Indication	Preclinical	Phase 1	Phase 2	Phase 3	Expected key milestones
FcRn+	Thyroid Eye Disease (TED)	spiriTED				Phase 2b topline data expected in H1 2025
						Phase 3 expected to begin in H2 2024
	Additional autoantibody-mediated diseases					Evaluation ongoing*
Cardiovascular Inflammation	Atherosclerotic Cardiovascular Disease (ASCVD)					Phase 2 expected to begin in H1 2024 Phase 2 topline data expected in H1 2025

Note: Hatched bars represent trials that have not yet commenced.

The timing of regulatory submissions and clinical trial milestones are subject to change and additional discussion with the FDA
*Clinical development plan for additional indications subject to change upon indication selection and discussion with the FDA

FcRn+

FcRn inhibition has garnered substantial attention to date, however significant unmet need persists

What is FcRn?[1]

- Neonatal Fc receptor (FcRn) inhibition observed to lower IgG antibodies
- Mechanism relevant in disorders mediated by pathogenic IgG autoantibodies
- Two anti-FcRn therapies approved for myasthenia gravis with additional supportive data in CIDP, RA, and TED[2,3,4]

FcRn market adoption

- First approved FcRn inhibitor annualizing ~$1.5B sales in 2nd year of launch in MG[5]
- FcRn companies account for >$30B in market capitalization[6]

Key limitations of FcRn inhibition[7]

- **Efficacy limitations:** incomplete clinical response observed
- **Lack of durable efficacy:** clinical worsening occurs soon after cessation of therapy
- **High burden dosing profile:** burdensome weekly or biweekly IV or high-volume SC infusions/injections
- **Unknown long-term safety profile:** uncertain rate of infectious or other complications from sustained non-specific reduction of total IgG

1. Pyzik et al., Nat Rev Immunol (2023)
2. Chronic inflammatory demyelinating polyneuropathy (CIDP): ARGX, "argenx Reports Posit Topline Data from ADHERE study..." July 17, 2023
3. Rheumatoid arthritis (RA): Taylor et al., presentation at ACR Convergence (2023)
4. Thyroid eye disease (TED): Kahaly et al., J Clin Endocrinol Metab (2023)
5. ARGX company reports and filings
6. FactSet as of 12/29/23; assumes Momenta acquisition for $6.5B, UCB market capitalization not included
7. VYVGART, VYVGART HYTRULO, and RYSTIGGO FDA labels

TOUR006 has broad potential beyond autoantibody reduction

An FcRn+ opportunity

Modes of action for IL-6 inhibition[1,2]

IL-6 inhibition impacts:

- Pathogenic B-cell and plasma cell proliferation
- Pathogenic Th17 and Tfh cell proliferation and differentiation
- Acute phase proinflammatory signaling
- Circulation of pathogenic autoantibodies

Potential benefits of IL-6 inhibition versus FcRn inhibition

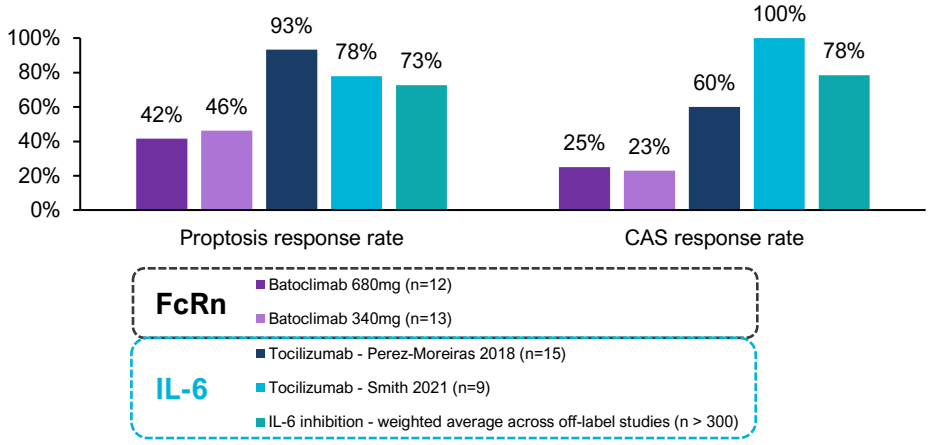
	IL-6 inhibition[1,2,3]	FcRn inhibition[4,5,6]
Autoantibody reductions	✓	✓
Inhibition of autoantibody production	✓	✗
Anti-inflammatory effects beyond autoantibody reduction	✓	✗
Durability of effect	✓	✗
Low administration burden	✓	✗
Favorable long-term safety profile observed to date	✓	?

1. Cabezas et al., Front Immunol (2022)
2. Dienz et al., J Exp Med (2009)
3. Tourmaline PK/PD modelling
4. Howard et al., Lancet Neurol (2021)
5. Patel and Bussel, J Allergy Clin Immunol (2020)
6. VYVGART, VYVGART HYTRULO, and RYSTIGGO FDA labels

IL-6 inhibition has demonstrated the potential to outperform FcRn inhibition

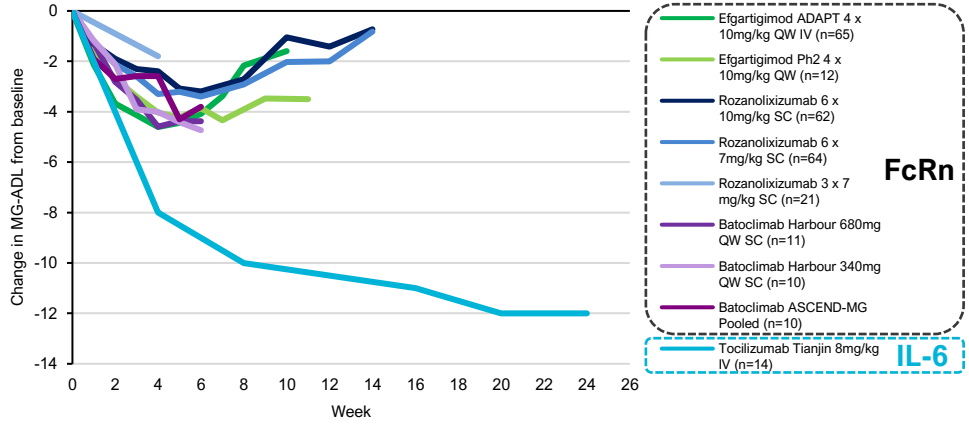
① TED

IL-6's upstream and anti-inflammatory mechanism provides deeper and broader benefit[1]



② MG

IL-6 pathway inhibition delivered the highest MG-ADL improvements ever reported in a prospective trial[2]



③ RA

IL-6:
- ✓ Two products approved with demonstration of efficacy in broad range of active RA patients[3,4]
- ✓ Superiority to anti-TNF in multiple H2H studies[5,6]

vs.

FcRn:
- × Single nipocalimab PoC study showed modest clinical efficacy[7]
- × No change observed on inflammatory markers like CRP[7] against placebo

④ NMOSD

IL-6:
- ✓ Product approved for prevention of relapse, demonstrating ~74-78% relapse risk reduction in two phase 3 studies.[8]
- ✓ Tocilizumab use for acute attacks reduced EDSS by ~65% at 6 months[9]

vs.

FcRn:
- × Open-label batoclimab study in acute attacks demonstrated ~33% 1-month EDSS reduction despite ~80% IgG & ~90% auto-ab reduction[10]
- × No ongoing industry-sponsored development

TOURMALINE

Certain data in this slide are based on a cross-trial comparison and are not based on head-to-head clinical trials. Cross-trial comparisons are inherently limited and may suggest misleading similarities or differences in outcomes. Results of head-to-head comparisons may differ significantly from those set forth herein. The information on this slide is based on Tourmaline-generated analysis of third-party data and is being presented for hypothesis generating purposes only. As a result, actual treatment responses hypothesized may be more or less than the data presented in this slide. Sources: 1. Batoclimab: Kahaly et al., J Clin Endocrinol Metab (2023); tocilizumab: Perez-Moreiras et. al., Am J Ophthalmol (2018); Smith et al., Ophthal Plast Reconstr Surg (2021); additional studies detailed on slide 19 and available upon request. Results represent a weighted average across all reported uses of IL-6 inhibition in TED where data for the presented endpoints are available. Proptosis response rate = proptosis reduction of 2mm or greater. Batoclimab response rate included no worsening (2mm or greater increase) in second eye. CAS response rate = ending CAS of 0 or 1. 2. MG: FcRn studies available upon request; TCZ: Jia et al., Aging Dis. (2023). 3. Actemra FDA label. 4. Kevzara FDA label. 5. Gabay et al., Lancet (2013). 6. Burmester et al., Ann Rheum Dis (2017). 7. Taylor et al., presentation at ACR Convergence (2023). 8. Enspryng FDA label. 9. Du et al., Front Immunol (2021). 10. Wang et al., Eur J Neurol (2023)

TED: our beachhead indication designed to validate TOUR006's FcRn+ potential in autoantibody-driven diseases

1. **High unmet medical need with significant market opportunity**
   - Potentially sight-threatening disease characterized by proptosis, double-vision, and pain
   - ~30k new patients each year in the U.S. (average age at diagnosis is ~45)[1,2]
   - ~80%[3] of eligible TED patients not receiving an FDA-approved treatment, which we believe may be related to significant limitations: risk of permanent hearing impairment / loss, limited durability, and inconvenience / complexity[4]

2. **Extensive third-party clinical support that IL-6 inhibition may address key unmet needs**
   - 40+ publications with 300+ patients demonstrate the therapeutic potential of IL-6 pathway inhibition in TED
   - IL-6 may play a more central and upstream role in TED pathogenesis than IGF-1R or FcRn

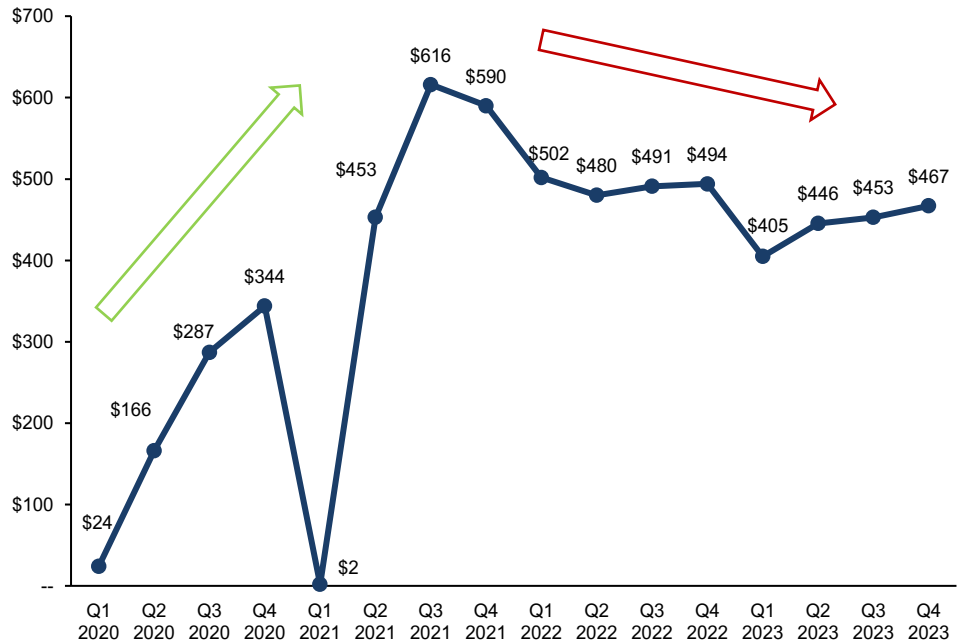
3. **TOUR006 has best-in-disease potential in TED**
   - Deep inhibition of IL-6 pathway observed to date offers potential for durable efficacy across many endpoints
   - Existing clinical database supports the potential for a well-tolerated profile at selected doses
   - Q8W dosing would allow for a patient-friendly, low burden treatment course

1. Lazarus, Best Pract. Res. Clin. Endocrinol. Metab. (2012)
2. Bartalena et al., Front. Endocrinol. (2020)
3. Horizon Q3 2022 earnings call
4. Tourmaline market research

IGF-1R class limitations present a significant opportunity for novel therapeutic approaches in TED

TEPEZZA U.S. revenues have been stagnating since 2021…

Sales ($M)[1]



…believed to be due to real-world experience

1. **Safety issues:** Risk of potentially permanent hearing loss[2]

> ----------WARNINGS AND PRECAUTIONS----------
>
> - Hearing Impairment Including Hearing Loss: TEPEZZA may cause severe hearing impairment including hearing loss, which in some cases may be permanent. Assess patients' hearing before, during, and after treatment with TEPEZZA and consider the benefit-risk of treatment with patients

2. **Limited durability:** Growing real-world effectiveness data reveals larger than anticipated number of non-responders / high relapse rate[3,4]

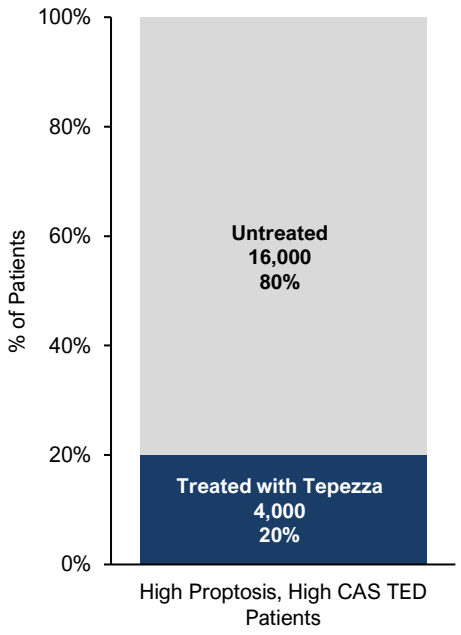
3. **High level of inconvenience & complexity:**
   - IV Q3W (n=8)[2] but limited access to infusion centers[5]
   - Numerous visits and high time commitment (HCPs and patients)[5]
   - Need for serial audiograms, as per label[2,6]
   - Burdensome reimbursement approval process[7]

1. Horizon and Amgen company reports and filings
2. TEPEZZA FDA label
3. Kahaly et al., Thyroid (2021) (ATA 2021 presentation)
4. Rosenblatt et al., Ophthalmic Plast Reconstr Surg (2023)
5. Tourmaline market research
6. Chow and Silkiss, BMJ Case Rep (2022)
7. Horizon Therapeutics Public Ltd. Co. Q2 2023 Form 10-Q

Despite an FDA-approved medicine, the vast majority of moderate-to-severe TED patients remain untreated

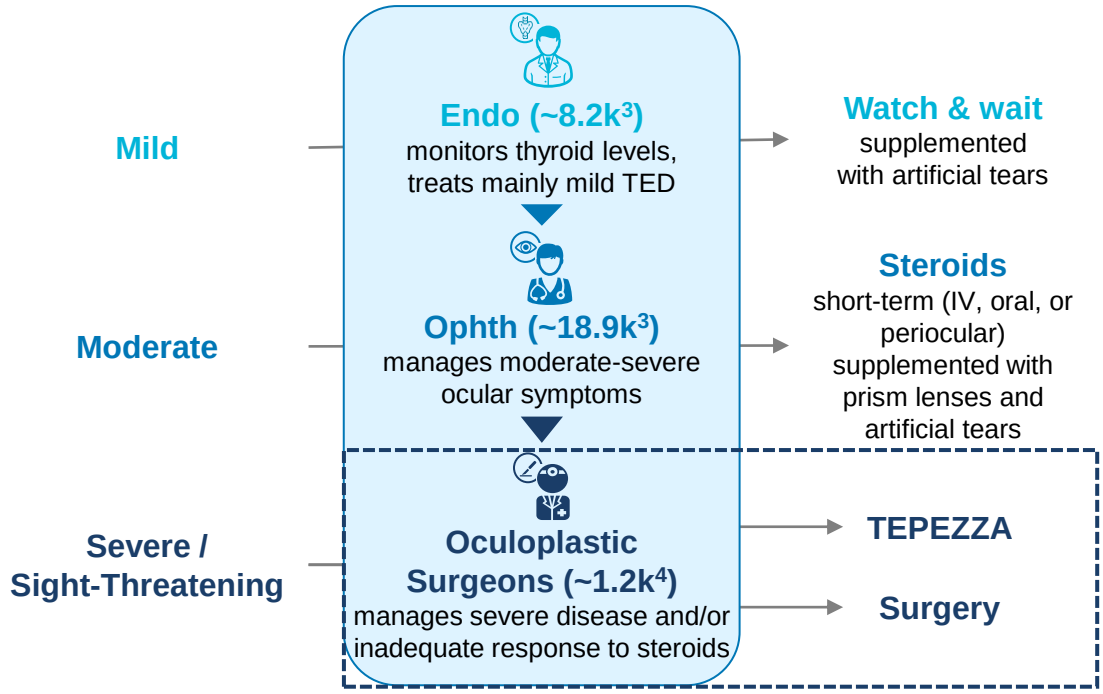
Most TED patients are not receiving TEPEZZA…

TEPEZZA US LTM penetration[1]



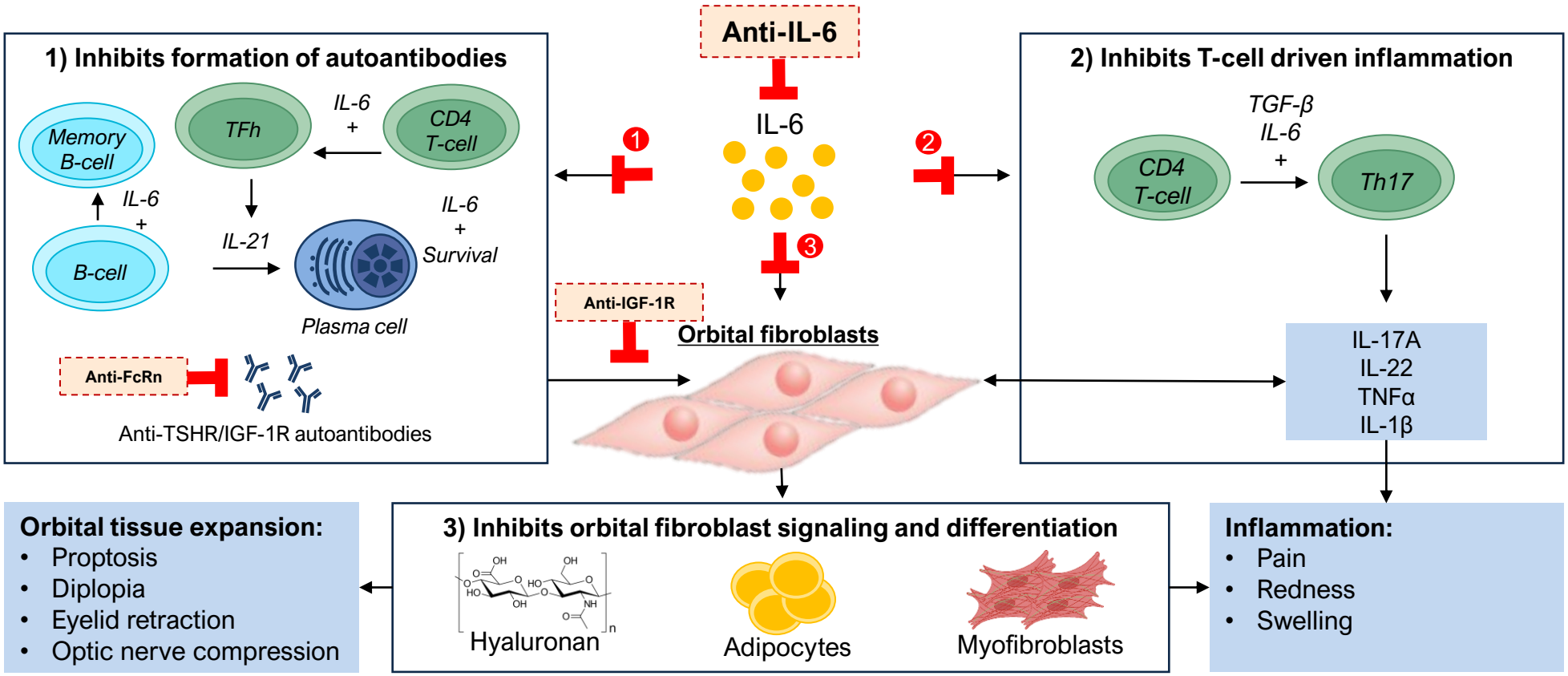
…or only get it relatively late in the treatment journey[2]

Simplified Treatment Journey[2]



1. Horizon Q3 2022 earnings call; LTM = last twelve months
2. Tourmaline market research; endo = endocrinologist; ophth = ophthalmologist
3. AAMC 2022 Physician Specialty Data Report
4. Hussey and Tao, Orbit (2022)

IL-6 inhibition has the potential to address a central and upstream driver of TED



Adapted from Huang et al., Eye (2018); Hodgson and Rajaii, Ophthalmol Ther (2020); Fang et al, Front Endocrinol (2021); Smith et al., Eye (2019); and Cabezas et al., Front. Immunol. (2022)

Over 40 publications support the therapeutic potential of IL-6 pathway inhibition in TED

Study Details				Key Endpoints		
First author	Year	Study type	N treated	Proptosis response rate	CAS response rate*	% autoantibody reduction
Pérez-Moreiras	2021	Retro	54	78	89	75
Sánchez-Bilbao	2020	Obs	48	NR	NR	NR
Atienza-Mateo	2018	Retro	29	NR	NR	NR
Pérez-Moreiras	2014	Prosp	18	72	100	76
Pérez-Moreiras	2018	RCT	15	93	60	NS
de la Fuente Bursón	2020	Retro	15	NR	NR	NR
Pereira	2023	Retro	14	NR	NR	NR
Boutzios	2023	Obs	12	NR	NR	84
Pampín-Sánchez	2022	Retro	11	75	73	NR
Moi	2022	Retro	10	CI	80	75
Cortez	2022	Prosp	10	10	100	81
Silkiss	2020	CS	9	CI	56	74
Smith	2021	Retro	9	78	100	54
Bielefeld	2019	Obs	8	NR	NR	NR
Ceballos-Marcias Jose	2020	CS	8	NR	75	41
Bennedjai	2020	Retro	7	NR	NR	73
Moás	2022	Obs	7	NR	NR	92
Toro-Tobon	2023	Retro	6	50	NR	NR
de Pablo Gomez	2018	CS	5	NR	60	NR
Navarrete	2022	Retro	5	NR	NR	NR
Ribi	2017	CS	3	33	67	NR
Maldiney	2020	CS	3	67	NR	NR
Stevens	2022	Retro	3	100	67	NR
Russell	2017	CS	2	NR	0	NR
Sy	2017	CS	2	CI	50	69

Study Details				Key Endpoints		
First author	Year	Study type	N treated	Proptosis response rate	CAS response rate*	% autoantibody reduction
Copperman	2019	CS	2	100	0	NR
Coy	2019	CS	2	NR	50	NR
Sierra Osorio	2020	CS	2	100	100	NR
Park	2021	CS	2	100	100	NR
Abeillon-du Payrat	2022	CS	2	100	50	NR
Butnaru	2013	CR	1	NR	100	NR
Gómez Rodríguez	2014	CR	1	NR	100	NR
Bielefeld	2017	CR	1	CI	NR	NR
Canas	2018	CR	1	100	NR	NR
Pascual-Camps	2018	CR	1	NR	NR	NR
Garreta Fontelles	2019	CR	1	NR	NR	93
Mehmet	2020	CR	1	0	NR	NR
Kaplan	2020	CR	1	NR	0	85
Cayon-Blanco	2020	CR	1	NR	100	NR
Tran	2020	CS	1	NR	NR	NR
Ruiz	2021	CR	1	NR	NR	NR
Albrashdi	2022	CR	1	100	NR	NR
Cezara	2022	CR	1	NR	0	NR
Mohamed	2022	CS	1	0	0	NR
Moleiro	2022	CR	1	100	NR	86
Almazrouei	2023	CR	1	NR	NR	NR
Cuculescu	2023	CR	1	CI	0	NR
Nirmalan	2023	CS	1	NR	NR	NR
Pramono	2023	CR	1	NR	NR	NR
Weighted Mean				**73%**	**78%**	**74%**
Smith 2017 (tepro Phase 2)				**71%**	**69%**	**N/A**
Douglas 2020 (tepro Phase 3)				**83%**	**59%**	**N/A**

We believe many of these reports may underestimate the true efficacy of IL-6 inhibition

- 300+ mostly steroid-refractory patients
- Late IL-6 inhibition (>9 months post symptom onset) when disease may have exited active phase
- Exposure to IL-6 inhibition may have been suboptimal (<6 months)

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Proptosis response rate is generally defined in the data outlined here as a ≥2 mm proptosis improvement in the worse eye at baseline without any worsening in the other eye. CAS response rate is generally defined in the data outlined here as a CAS of 0 or 1. Studies referenced in this table represent investigator-led studies and were not designed with the intent of generating evidence for an approval of tocilizumab or sarilumab in TED. The majority of these studies were not designed with power to detect statistical significance. Retro: retrospective. Obs: observational. Prosp: prospective. RCT: randomized controlled trial. CS: case series. CR: case report. NR: not reported. NS: not significant. CI: clear improvement. Tepro: teprotumumab. Publications available upon request

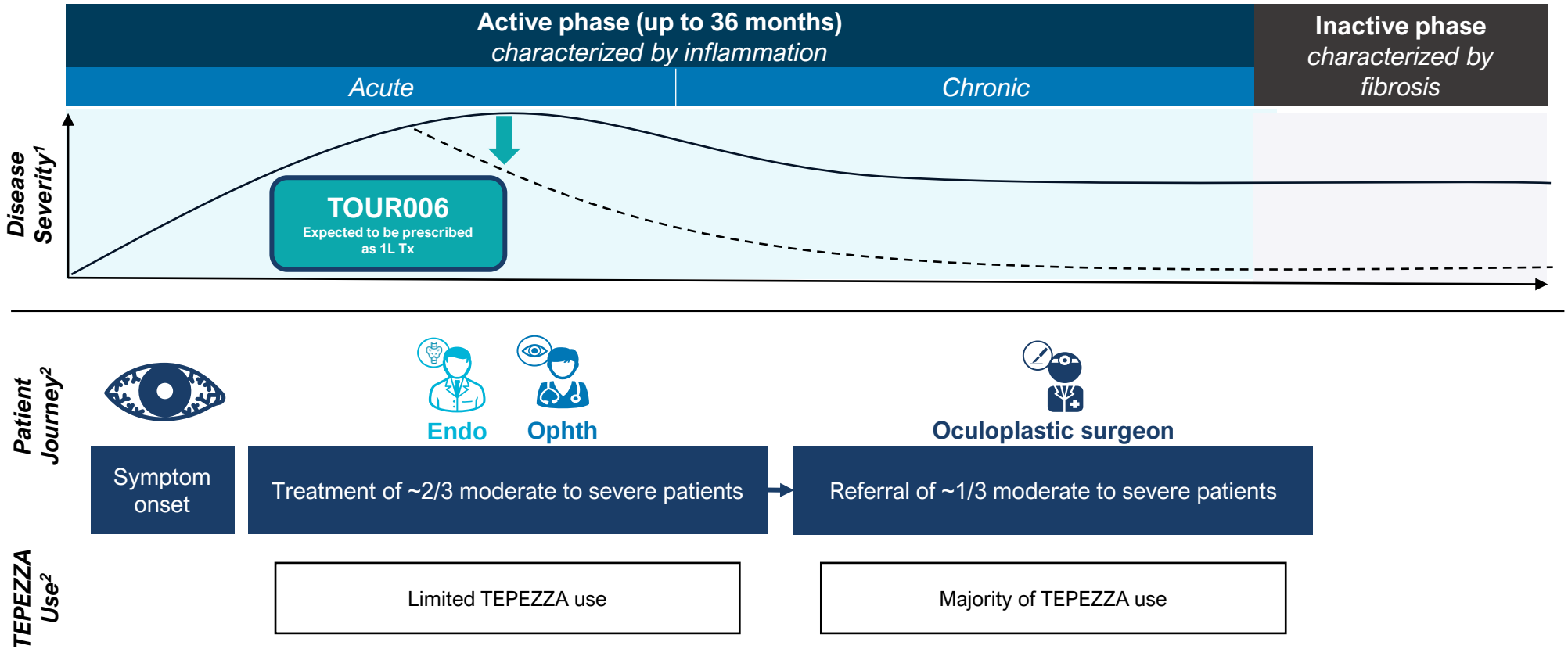
Market research indicates TOUR006's potential to become an optimal first-line TED therapy

Potential target profile of TOUR006

Deep & broad efficacy	• Meaningful reduction of proptosis • Important improvement of CAS and diplopia
Durable	• Inhibition of production of anti-TSHR auto-antibodies • Durable response, in part due to low immunogenicity
Well-tolerated	• Well-tolerated safety profile, manageable with routine monitoring • Lack of permanent or irreversible side effects
Patient-friendly	• SC, ≤1ml injections, every 8 weeks • Finite treatment for most of patients with flexibility where needed

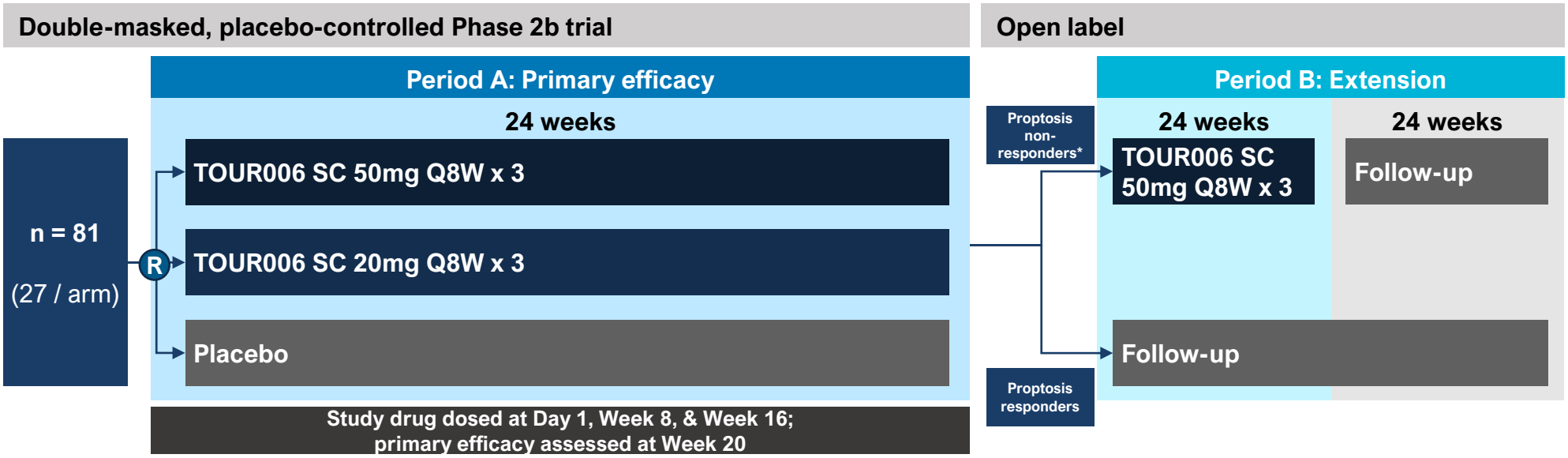
The characteristics presented reflect outcomes that may not be representative of TOUR006. The results of past clinical trials may not be indicative of future results, and the results of future or ongoing clinical trials may not demonstrate some or any of the characteristics presented.

TOUR006 offers the potential to stop disease progression in the inflammatory active phase



1. Adapted from Bartley, Arch Ophthalmol. (2011)
2. Tourmaline market research

spiriTED pivotal trial in first-line TED



Study population:
- Moderate-to-severe TED, with proptosis ≥ 3mm above normal (based on race and gender)
- Active phase, with symptom onset ≤ 12 months, CAS ≥ 4 and positive TSI
- First-line setting, with cap on prior corticosteroid use (< 1g methylprednisolone or equivalent)

Primary efficacy endpoint:
- Proptosis response rate at week 20

Additional endpoints:
- CAS
- Diplopia
- QoL, safety, PK/PD/ADA

*Any patient who receives rescue therapy/intervention in Period A will not receive TOUR006 in Period B and will instead undergo follow-up only

Cardiovascular Inflammation

TOUR006 is poised to capitalize on emerging insights into targeting IL-6-driven inflammation in cardiovascular diseases

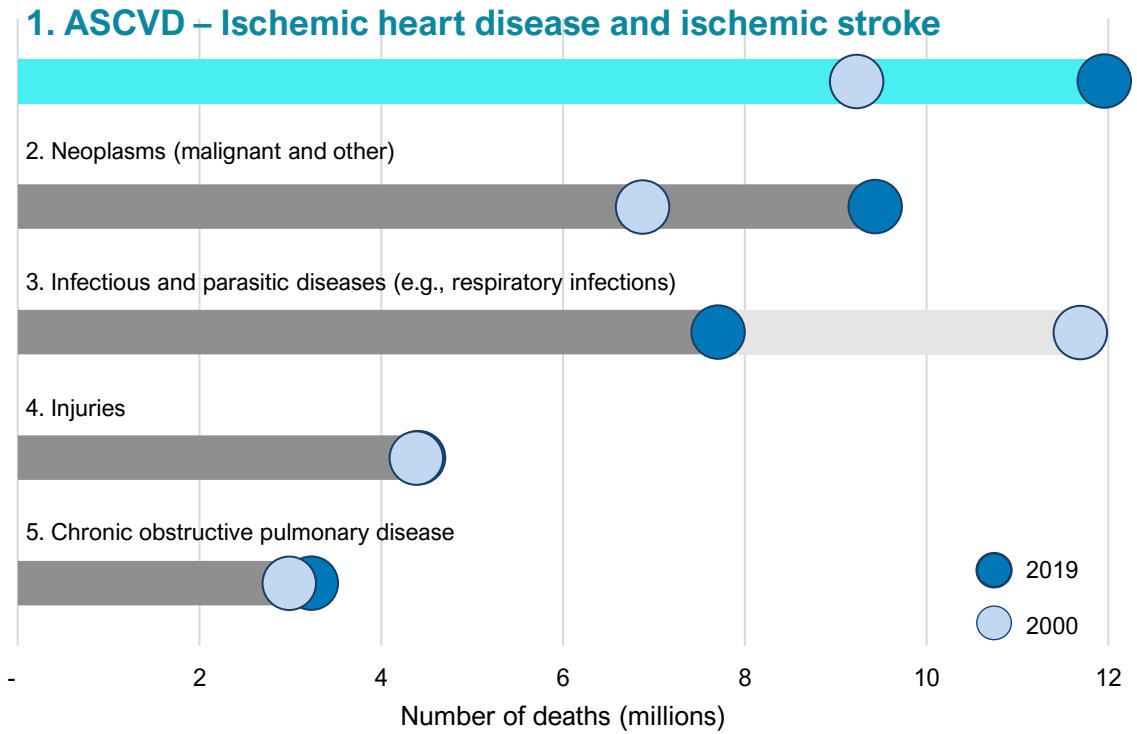
Emerging breakthrough insights support IL-6-driven inflammation as a key driver of CV diseases, particularly ASCVD, a leading cause of death worldwide

TOUR006's potentially best-in-class profile with quarterly subcutaneous administration will be evaluated in a Phase 2 study

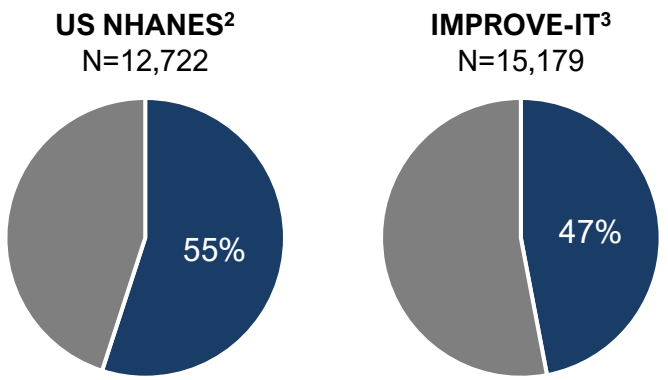
TOUR006 is anticipated to be Phase 3-ready for CV disease in 2025 and well-positioned to capitalize on key external de-risking events from competitors' clinical trials with IL-6 inhibitors

Burden of inflammatory risk in ASCVD is significant

Leading causes of death worldwide[1]



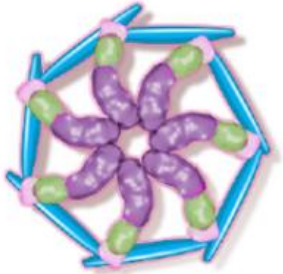
Prevalence of hsCRP≥2 mg/L among individuals with ASCVD



ASCVD: atherosclerotic cardiovascular disease. hsCRP: high-sensitivity C-reactive protein.

1. Global Health Estimates 2020: Deaths by Cause, Age, Sex, by Country and by Region, 2000-2019. Geneva, World Health Organization; 2020
2. Nanna et al., Circulation (2022)
3. Bohula et al., Circulation (2015)

IL-6 is central to inflammation driving ASCVD



Inflammasome

IL-1β
IL-18

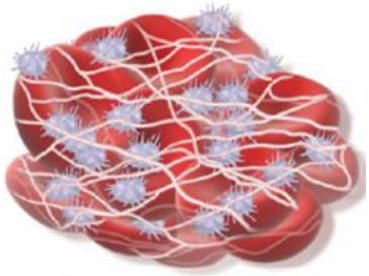
Pro-IL-1β
Pro-IL-18

Autoinduction

IL-1 → IL-1 → IL-6

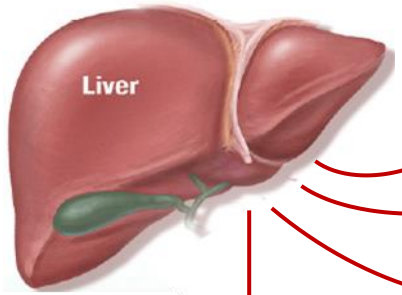
Pro-inflammatory responses

- Atherogenesis
- Leukocyte recruitment
- Activation of adaptive immunity



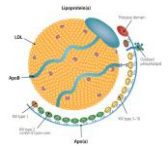
Thrombus formation and stabilization

Acute Phase Response



Fibrinogen
(promotes clotting)

Plasminogen activator inhibitor-1
(inhibits fibrinolysis)



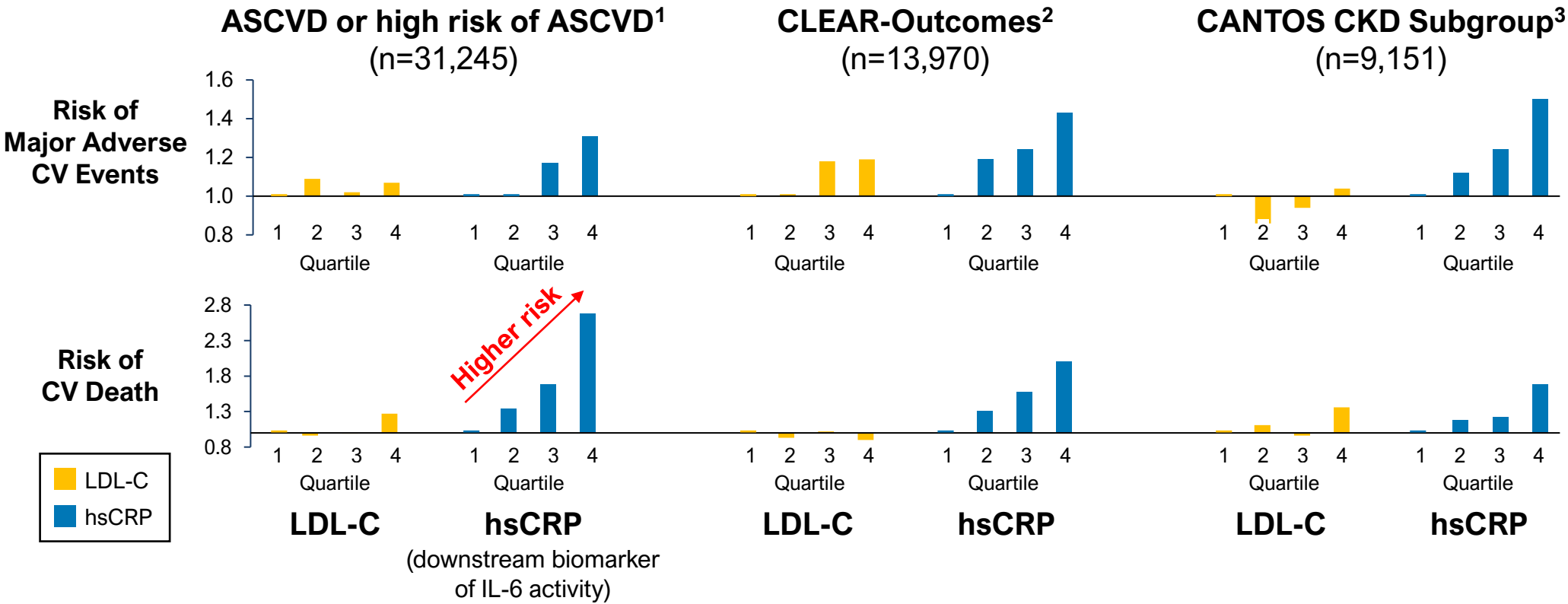
Lipoprotein(a)
(highly atherothrombotic LDL subpopulation)

C-reactive protein
(marker of inflammation)

Serum amyloid A
(remodels HDL)

ASCVD: atherosclerotic cardiovascular diseases. Figure adapted from Libby et al., Cells (2021), Libby et al., Int J Cardiol (2018), Muller et al., J Lipid Res (2015) and Svilaas et al., Tidsskr Nor Laegeforen. (2023)

Key insight #1: Inflammation predicts future MACE even better than cholesterol in high-risk populations



Hazard ratios shown. Major adverse cardiovascular events (MACE) include myocardial infarction, stroke, coronary revascularization, cardiovascular (CV) death.
CKD: chronic kidney disease. hsCRP: high-sensitivity C-reactive protein. LDL: low-density lipoprotein cholesterol. Certain data in this presentation are based on a cross-trial comparison and are not based on head-to-head clinical trials. Cross trial comparisons are inherently limited and may suggest misleading similarities or differences in outcomes. Results of head-to-head comparisons may differ significantly from those set forth herein.
1. Ridker et al., Lancet (2023) 2. Ridker et al., Circulation (2023) 3. Ridker et al., Eur Heart J (2022)

Key insight #2: Anti-inflammatory CV outcome trials highlight importance of IL-6 inhibition and lowering hsCRP

↔ No statistically significant reduction

↓ Statistically significant reduction

	Year	Drug	Class/Mechanism	hsCRP Reduction	MACE Reduction
	2007	pexelizumab	C5 inhibitor	↔	↔
	2008	succinobucol	antioxidant	↔	↔
	2014	darapladib	LpPLA2 inhibitor	↔	↔
	2014	varespladib	sPLA2 inhibitor	↔	↔
	2016	losmapimod	MAPK inhibitor	↔	↔
Indirect IL-6 inhibitor →	2017	canakinumab	**IL-1β inhibitor**	↓	↓
	2019	methotrexate	DHFR inhibitor	↔	↔
Indirect IL-6 inhibitor →	2019	colchicine	**NLRP3 inhibitor***	↓	↓
Direct IL-6 inhibitor →	2025E	ziltivekimab	***IL-6 inhibitor***	↓	***2025E***

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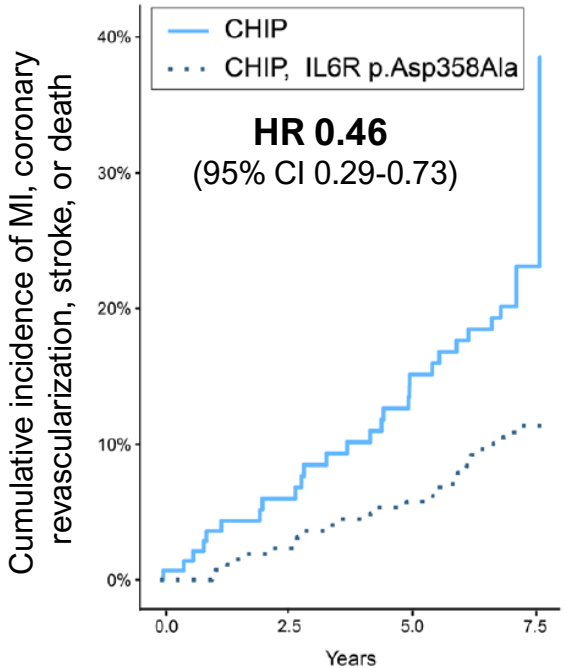
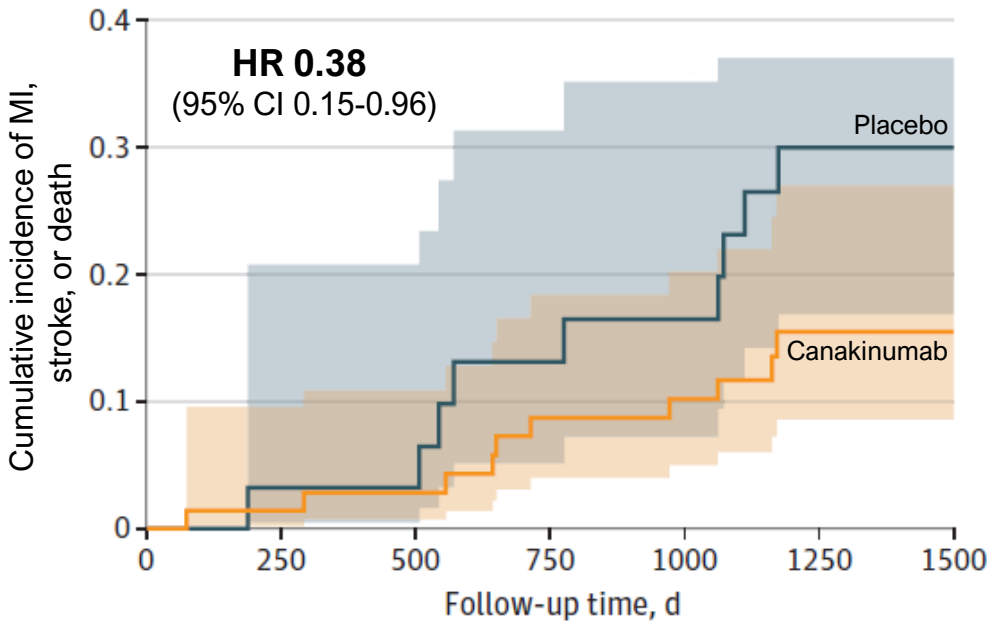
Certain data in this slide are based on a cross-trial comparison and are not based on head-to-head clinical trials. Cross-trial comparisons are inherently limited and may suggest misleading similarities or differences in outcomes. Results of head-to-head comparisons may differ significantly from those set forth herein. The information on this slide is based on Tourmaline-generated analysis of third-party data and is being presented for hypothesis generating purposes only. As a result, actual treatment responses hypothesized may be more or less than the data presented in this slide. Year: CVOT publication date or estimated completion date. DHFR: dihydrofolate reductase. LpPLA2: lipoprotein-associated phospholipase A2. MAPK: mitogen-activated protein kinase. NLRP3: NOD-, LRR- and pyrin domain-containing protein 3. sPLA2: secretory phospholipase A2. Pexelizumab: APEX AMI Armstrong et al., JAMA (2007). Martel et al., Am Heart J (2012). Succinobucol: ARISE Tardif et al., Lancet (2008). Darapladib: STABILITY White et al., NEJM (2014). SOLID-TIMI 52 O'Donoghue et al., JAMA (2014). Varespladib: VISTA-16 Nicholls et al., JAMA (2014). Losmapimod: LATITUDE-TIMI 60 O'Donoghue et al., JAMA (2016). Canakinumab: CANTOS Ridker et al., NEJM (2017). Methotrexate: CIRT Ridker et al, NEJM (2019). Colchicine: COLCOT Tardif et al., NEJM (2019). LoDoCo2 Nidorf et al., NEJM (2020). *Additional hypothesized mechanisms reviewed in Fiolet et al., Neth Heart J (2022). Ziltivekimab: RESCUE Ridker et al., Lancet (2021).

Key insight #3: Emerging precision medicine approaches may enhance potential CV benefit of IL-6 inhibition

Among high-risk patients with clonal hematopoiesis of indeterminate potential (CHIP), a genetic variant mimicking IL-6 inhibition was observed to lower risk of MACE ~50%[1]



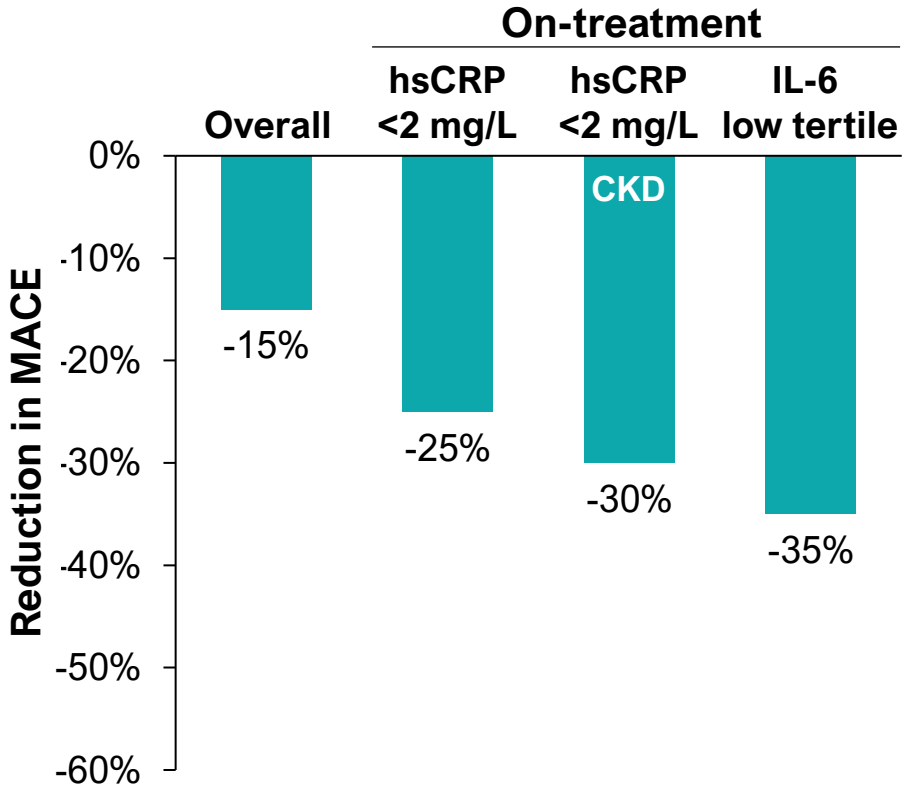
Among high-risk patients in CANTOS with CHIP (TET2), canakinumab was observed to lower risk of MACE ~60%[2]

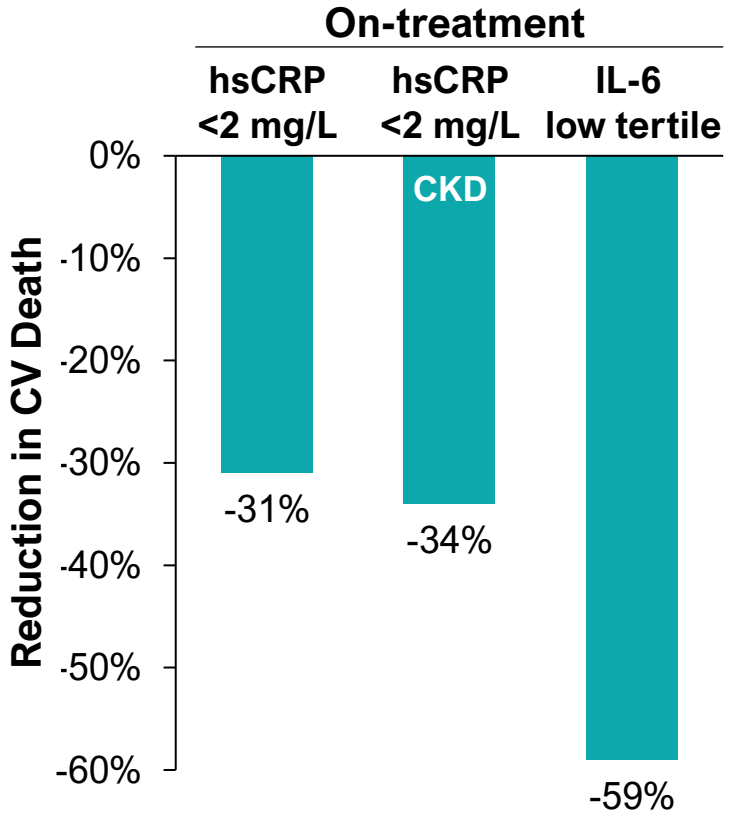


CANTOS: Canakinumab Anti-Inflammatory Thrombosis Outcomes Study. CHIP: clonal hematopoiesis of indeterminate potential. TET2: ten-eleven translocation-2. HR: hazard ratio. MACE: major adverse cardiovascular events. IL-6R p.Asp358Ala: IL-6 receptor gene variant associated with 7-8% lower hsCRP per allele (Sarwar et al., Lancet (2012), Swerdlow et al., Lancet (2012)).

1. Bick et al., Circulation (2020)
2. Svensson et al., JAMA Cardiol (2022). HR adjusted for age, time from last MI, baseline log2(hsCRP), sex, diabetes, total cholesterol, HDL-C, smoking, hypertension.

Lessons from canakinumab (anti-IL-1β mAb):
"Lower is better" for downstream biomarkers of IL-6 activity





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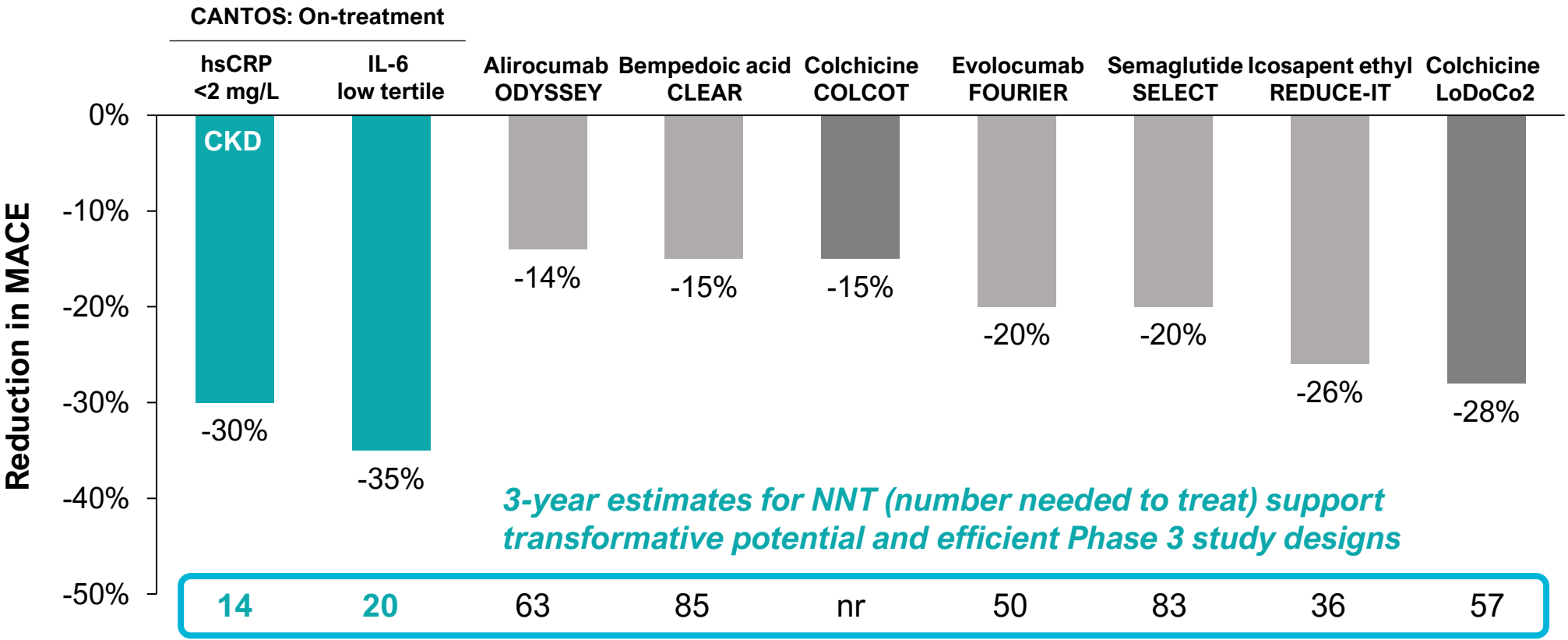
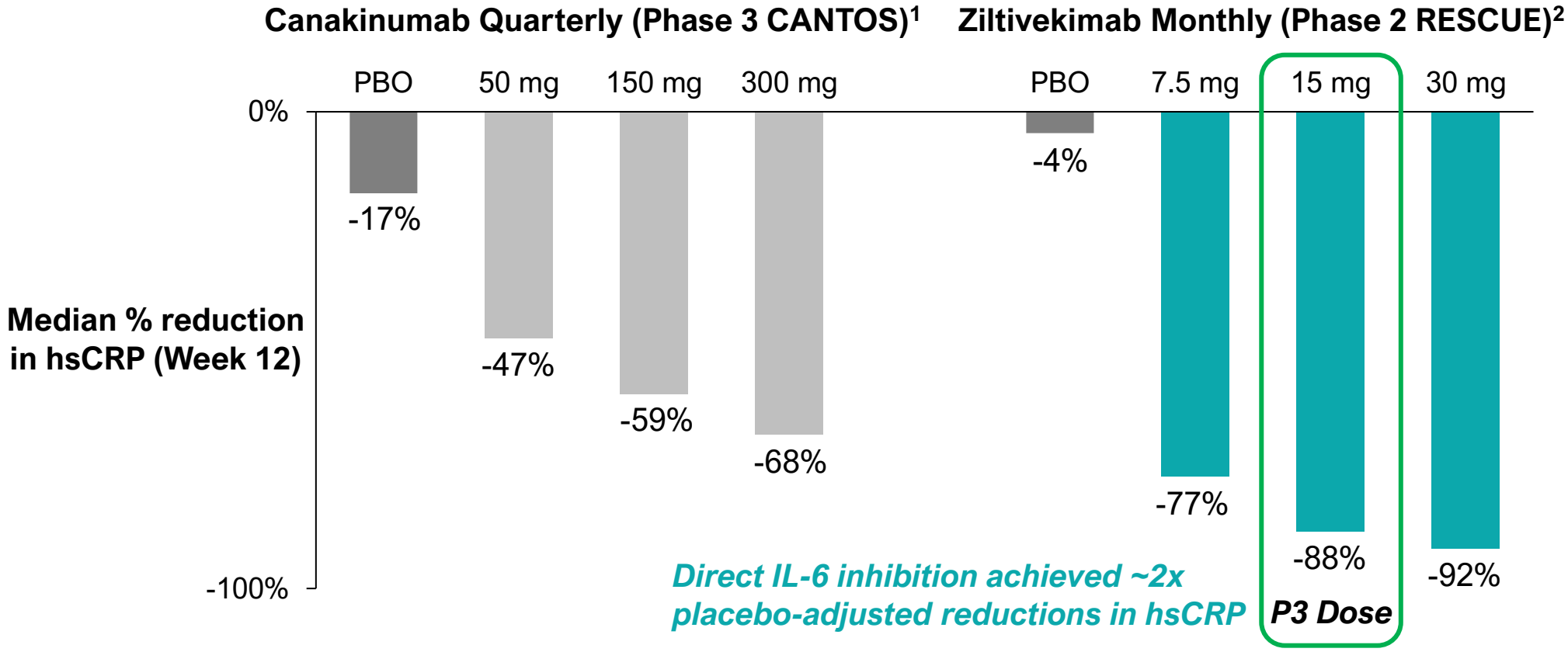
Reduction in MACE shown as 1-Hazard Ratio. MACE: major adverse cardiovascular events including CV death, myocardial infarction (MI), stroke. Overall CANTOS analysis presents data for 150mg dose group; values for CANTOS subanalyses combine all doses (50, 150, 300 mg). Ridker et al., NEJM (2017). Ridker et al., Lancet (2018). Adjusted for age, gender, smoking, hypertension, diabetes, BMI, baseline hsCRP, baseline LDL-C. Ridker et al., Eur Heart J (2018). Adjusted for age, gender, smoking, hypertension, diabetes, BMI, baseline IL-6, baseline LDL-C. Ridker et al., JACC (2018).

Lessons from canakinumab (anti-IL-1β mAb): Robust inhibition of IL-6 pathway has transformative potential in ASCVD



Reduction in MACE shown as 1-Hazard Ratio. MACE: major adverse cardiovascular events including CV death, myocardial infarction (MI), stroke except for: ODYSSEY OUTCOMES (all death, MI, ischemic stroke); COLCOT (CV death, MI, stroke, resuscitated cardiac arrest); LoDoCo2 (CV death, MI, ischemic stroke); main CANTOS analysis presents data for 150mg dose group; values for CANTOS subanalyses combine all doses (50, 150, 300mg); control arms were placebo + background SoC. Certain data in this slide are based on a cross-trial comparison and are not based on head-to-head clinical trials. Cross-trial comparisons are inherently limited and may suggest misleading similarities or differences in outcomes. Results of head-to-head comparisons may differ significantly from those set forth herein. NNT (number needed to treat) values obtained from absolute risk extracted from Kaplan-Meier figures via webplotdigitizer, unless directly reported. NNT for IL-6 < median shown; not reported for IL-6 low tertile. The information on this slide is based on Tourmaline-generated analysis of third-party data and is being presented for hypothesis generating purposes only. As a result, the actual MACE risk reduction hypothesized may be more or less than the data presented in this slide. Publications available upon request.

Lessons from ziltivekimab (monthly anti-IL-6 mAb): Directly inhibiting IL-6 lowers hsCRP more than upstream IL-1β blockade



1. Ridker et al., NEJM (2017)
2. Ridker et al., Lancet (2021)

Certain data in this presentation are based on a cross-trial comparison and are not based on head-to-head clinical trials. Cross trial comparisons are inherently limited and may suggest misleading similarities or differences in outcomes. Results of head-to-head comparisons may differ significantly from those set forth herein.

Lessons from ziltivekimab (monthly anti-IL-6 mAb):
Four concurrent Phase 3 CVOTs enrolling ~22,000 patients

ZEUS: ASCVD with CKD[1]

6,200 patients
- ASCVD
- CKD stage 3-4
- hsCRP ≥2 mg/L

1:1

- Ziltivekimab 15 mg QM + Standard of Care
- Placebo QM + Standard of Care

Primary endpoint:
Time to the first occurrence of MACE (CV death, non-fatal MI, or non-fatal stroke)

Secondary endpoints:
- Time to first occurrence of expanded MACE (above plus urgent coronary revascularization)
- Number of hospitalizations for HF or urgent HF visits
- Time to occurrence of CV death
- Time to first occurrence of composite CKD endpoint

ARTEMIS: acute MI[2]

10,000 patients
- Acute MI
- First dose within 24 or 48 hrs

1:1

- Ziltivekimab loading dose 1 followed by dose 2 QM + Standard of Care
- Placebo QM + Standard of Care

Primary endpoint:
Time to the first occurrence of MACE (CV death, non-fatal MI, or non-fatal stroke)

Secondary endpoints:
- Number of CV death, non-fatal MI, non-fatal stroke
- Time to first occurrence of composite MACE consisting of: all-cause mortality, non-fatal MI, and non-fatal stroke
- Time to first occurrence of MI (fatal and non-fatal)
- Time to occurrence of CV death

ATHENA: HFpEF[3]

680 patients
- HF Class II-III
- hsCRP ≥2 mg/L

1:1

- Ziltivekimab QM + Standard of Care
- Placebo QM + Standard of Care

Primary endpoint:
Change in KCCQ-CSS at 1 year

Secondary endpoints:
- Participant achieving threshold for clinically meaningful within-participant change in KCCQ CSS
- Participant achieving threshold for clinically meaningful within-participant change in 6-minute walk distance (6MWD)
- Participants improving 5 points or more in KCCQ-CSS

HERMES: HFpEF[4]

5,600 patients
- HF Class II-IV
- hsCRP ≥2 mg/L

1:1

- Ziltivekimab 15 mg QM + Standard of Care
- Placebo QM + Standard of Care

Primary endpoint:
Time to first occurrence of a composite HF endpoint (CV death, HF hospitalization, or urgent HF visit)

Secondary endpoints:
- Time to first occurrence of 4-point composite HF endpoint (CV death, HF hospitalization or urgent HF visit, non-fatal MI, non-fatal stroke)
- Number of CV deaths, HF hospitalizations or urgent HF visits
- Time to occurrence of CV death

Topline data readouts expected

2025 | **2026** | **2026** | **2027**

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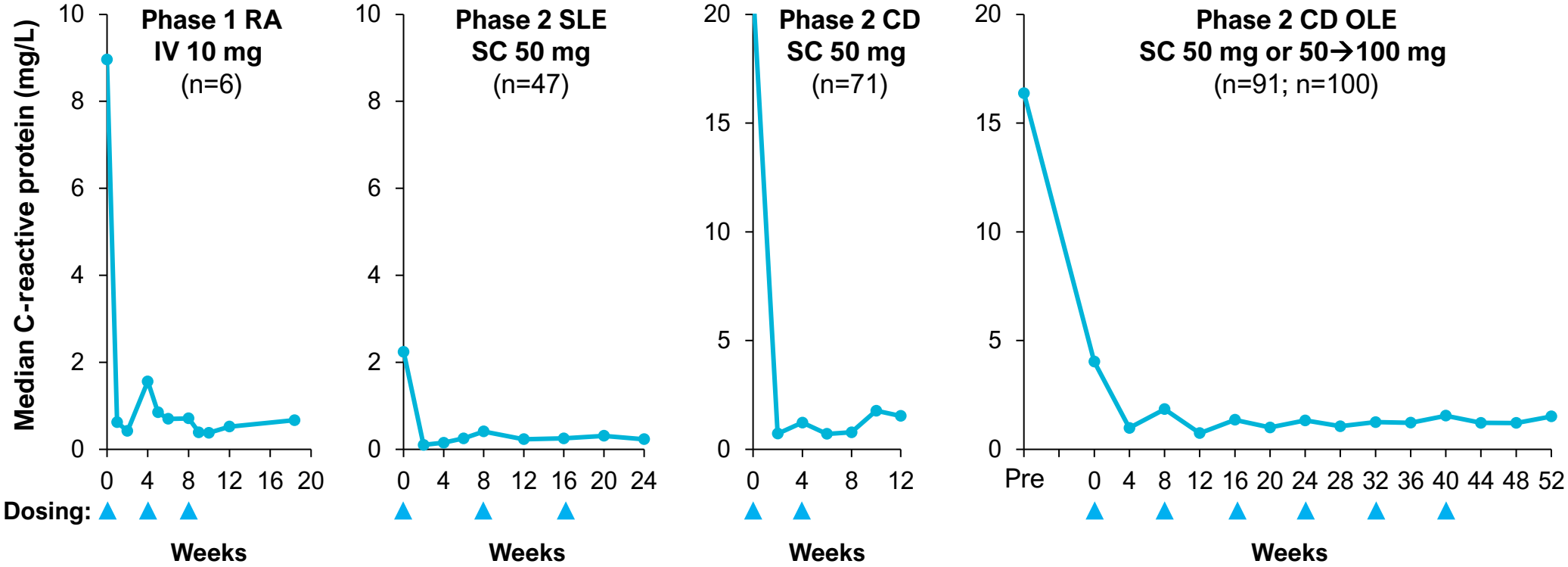
The timing of clinical trial milestones are subject to change.
ASCVD: atherosclerotic cardiovascular disease. CKD: chronic kidney disease. CVOT: cardiovascular outcome trial. HFpEF: heart failure with preserved ejection fraction. MACE: major adverse cardiovascular event. MI: myocardial infarction.
[1]Clinicaltrials.gov: NCT05021835. [2]Clinicaltrials.gov: NCT06118281. [3]Clinicaltrials.gov: NCT06200207 [4]Clinicaltrials.gov: NCT05636176.

TOUR006 designed to offer best-in-class potential profile in ASCVD

	TOUR006	Ziltivekimab	Clazakizumab
Company	TOURMALINE	novo nordisk	CSL
Monoclonal antibody	**fully human (IgG2) Medarex UltiMAb mouse**	fully human (IgG1k, YTE mutation) phage display	humanized rabbit (IgG1k)
Anti-drug antibodies[1]	**0-1%**	6-13%[3,4]	0-10%[7-9]
Route of administration[2]	**SC 0.6 mL**	SC[5,6] 1.0 mL	IV[10]
Longest dosing intervals in completed studies	**Q8W (SLE, CD)**	Q4W (NDD-CKD)[5,6]	Q4W[10] (HD-CKD)
Targeted dosing intervals	**Quarterly**	Monthly	Monthly

CD: Crohn's disease, CKD: chronic kidney disease, HD: hemodialysis, NDD: non-dialysis dependent, SLE: systemic lupus erythematosus. 1. Incidence of ADAs in repeat-dose studies calculated as reported per dosing arm. 2. Route of administration in planned or ongoing studies in patients with or at high-risk of ASCVD. 3. Clinicaltrials.gov NCT03926117. 4. Pergola et al., JASN (2021). 5. Ridker et al., Lancet (2021). 6. Wada et al., J Cardiol (2023). 7. Clinicaltrials.gov NCT01490450. 8. Clinicaltrials.gov NCT01545050. 9. Weinblatt et al., Arthritis Rheum (2015). 10. Clinicaltrials.gov NCT05485961. Data reported in publications or on clinicaltrials.gov as detailed above. No head-to-head studies have been conducted between the mabs shown here, which have each been evaluated in different populations.

TOUR006 achieved robust and durable suppression of CRP in patients with high-grade inflammatory autoimmune disorders

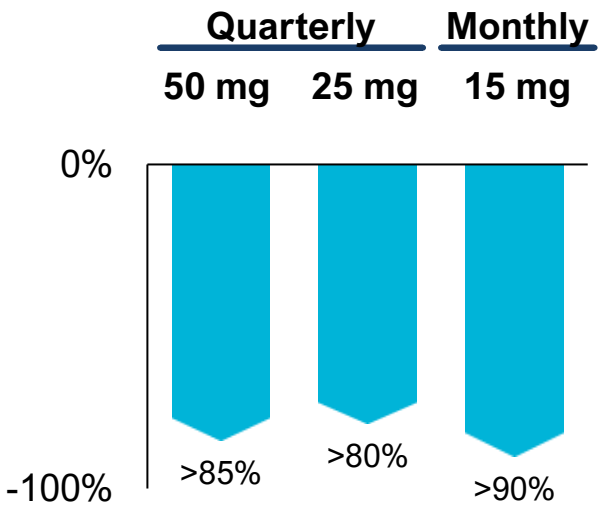


CRP: C-reactive protein, CD: Crohn's disease, OLE: open-label extension, RA: rheumatoid arthritis, SLE: systemic lupus erythematosus. Rheumatoid arthritis: B0151002 study report. Table 14.4.7.1.1. Median baseline CRP 9.0 mg/L. Key eligibility: active disease, background methotrexate. Crohn's disease: B0151003 study report. Table 14.2.4.1.3. Median baseline hsCRP 21.1 mg/L. Key eligibility: active disease, failed/intolerant to anti-TNFα. CD OLE B0151005 study report. Table 14.2.4.1. Median pre-baseline hsCRP 16.4 mg/L, baseline hsCRP 4.0 mg/L. Systemic lupus erythematosus: B0151006 study report. Table 14.3.4.1.5. Median baseline hsCRP 2.2 mg/L.

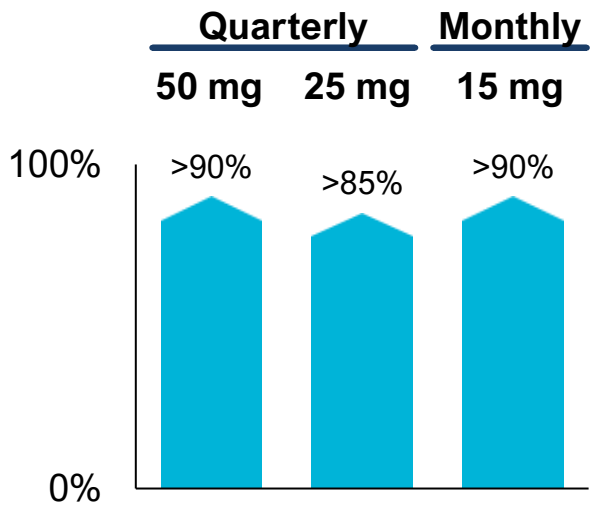
PK/PD modeling supports potential for quarterly dosing of TOUR006 SC in ASCVD

Results of PK/PD model developed from five studies in patients with RA, SLE, CD and healthy volunteers

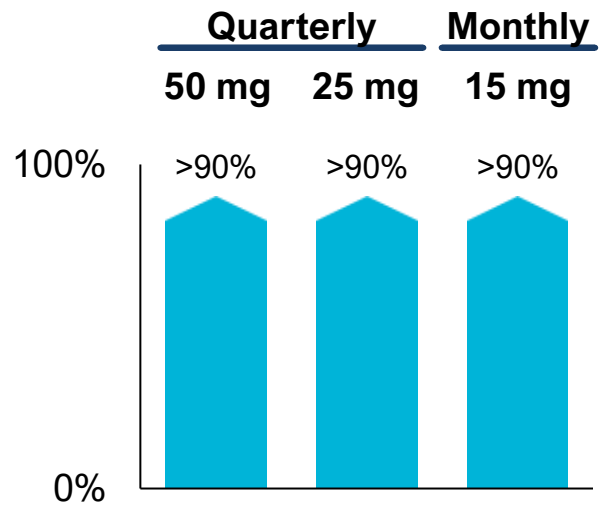
Median % reduction in hsCRP



% achieving hsCRP <2 mg/L



% achieving ↓hsCRP >50%



Ziltivekimab 15 mg monthly*
median % reduction: 88%

% achieving hsCRP<2 mg/L: 82%

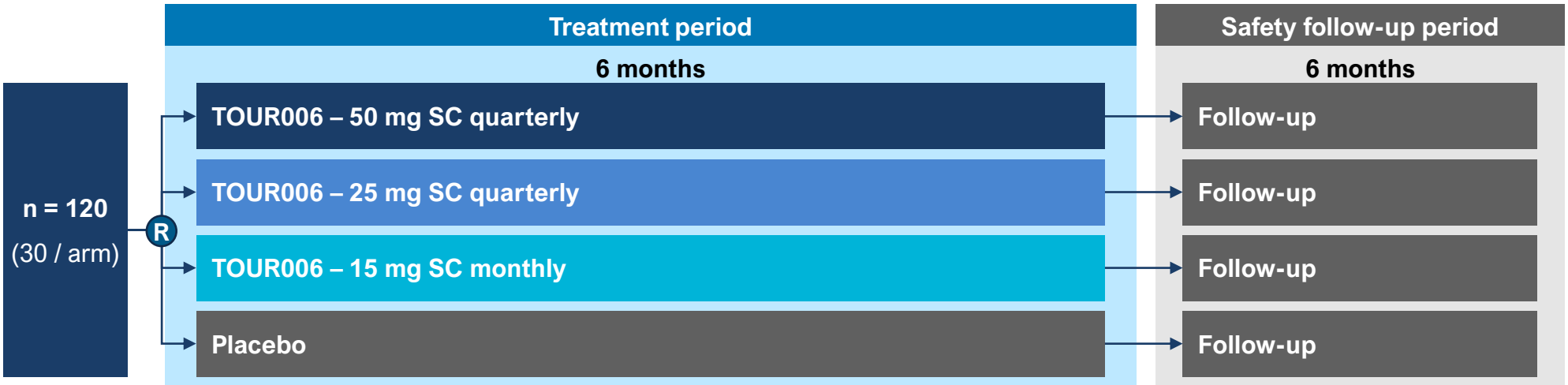
% achieving ↓hsCRP>50%: 89%

TOURMALINE

ASCVD: atherosclerotic cardiovascular disease, RA: rheumatoid arthritis, SLE: systemic lupus erythematosus, CD: Crohn's disease. The PK and PK/PD models for TOUR006 were developed based on the data from 5 clinical studies (two phase 1 studies in healthy volunteers, one phase 1 study in RA, one phase 2 study in SLE, and one phase 2 study in CD). A two-compartment model with first-order absorption and linear elimination and a mechanism-based indirect response model (in a relationship on CRP) adequately described the PK and PK/PD relationships, respectively. Simulations were performed assuming an RA-like population with baseline CRP >2 mg/L to 10 mg/L. Results at Day 90 are shown. *Ridker et al., Lancet (2021). Results after 12 weeks of treatment are shown. Certain data in this slide are based on a cross-trial comparison and are not based on head-to-head clinical trials. Cross-trial comparisons are inherently limited and may suggest misleading similarities or differences in outcomes. Results of head-to-head comparisons may differ significantly from those set forth herein.

TOUR006 CV Phase 2 study planned to initiate in H1 2024

Double-blinded, placebo-controlled Phase 2 trial – FDA aligned with overall study design*



Study population:

- CKD stage G3-4 (eGFR 15-59 ml/min/1.73m^2)
- hsCRP ≥ 2.0 mg/L
- Exclude patients at higher risk for safety complications (e.g., immunocompromised patients)

Key endpoints:

- Pharmacodynamics: hsCRP, serum amyloid A, fibrinogen, lipoprotein(a), and other biomarkers
- Pharmacokinetics, anti-drug antibodies
- Safety and tolerability

*Trial design to be finalized ahead of study start.

Key milestones expected through 2026

Cash runway expected into 2027

	2023	2024	2025	2026
FcRn+	☑ **Q3 2023:** Initiated pivotal Phase 2b spiriTED trial	❑ **H2 2024:** Initiate pivotal TED Phase 3 trial ➢ **H1 2024:** Satra Phase 3 MG (LUMINESCE) topline data	❑ **H1 2025:** spiriTED Phase 2b topline data ➢ **2025:** Satra TED Phase 3 (Satra-GO) topline data ➢ **2025:** Satra AE Phase 3 (CIELO) topline data	❑ **2026:** TED Phase 3 topline data ➢ **2026:** Satra MOGAD Phase 3 (METEOROID) topline data
Cardiovascular Inflammation	☑ **Q4 2023:** Received FDA alignment on proposed CV program	❑ **H1 2024:** Initiate CV Phase 2 trial	❑ **H1 2025:** CV Phase 2 topline data ➢ **2025:** Zilti ASCVD in CKD Phase 3 (ZEUS) topline data	➢ **2026:** Zilti AMI Phase 3 (ARTEMIS) topline data ➢ **2026:** Zilti HFpEF Phase 3 (ATHENA) topline data

Milestones key: ❑ Internal ➢ External

The timing of regulatory and clinical trial milestones are subject to change and additional discussion with the FDA

AE: autoimmune encephalitis; AMI: acute myocardial infarction; ASCVD: atherosclerotic cardiovascular disease; HFpEF: heart failure with preserved ejection fraction. MG: myasthenia gravis; MOGAD: myelin oligodendrocyte glycoprotein antibody-associated disease; Satra: satralizumab; TED: thyroid eye disease; Zilti: ziltivekimab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