QUINCE THERAPEUTICS

Orphai THERAPEUTICS

A Subsidiary of Quince Therapeutics

Corporate Presentation

June 2026

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Quince Therapeutics / Orphai Transaction Highlights

Acquisition closed on May 18, 2026

Transaction Overview & Financing

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

Governance & Leadership

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

Use of Proceeds

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

Capitalization

As of 5/18/2026	
Pre-merger Quince common stock outstanding[1]	16,300,740
Merger consideration[2]	
Shares of common[3]	3,258,517
Shares of preferred	67,101.235
Preferred conversion ratio	1,000
Total pre-financing common equivalent	70,359,752
Concurrent financing (upfront portion)	
Shares of preferred	144,200.633
Common equivalent	144,200,633
Total Capitalization (Common, as converted)[2,4]	**230,861,125**

- Shares of common stock and preferred stock were issued to Orphai security holders in exchange for all of Orphai's outstanding equity interest and all outstanding warrants were exchanged for warrants issuable to investors in the private placement financing
- Shares of preferred stock are issuable to investors at the closing of the private placement
- The private placement provides $115M upfront, along with 50% warrant coverage. The warrants will be exercisable upon Phase 2 BOS readout and will be exercisable at a 25% premium to the deal price and have a 30-day exercise window. The anticipated warrant proceeds are approximately $72M (or approximately $83M including the warrants issued to former Orphai warrant holders).
- Shares of preferred stock will automatically convert into 1,000 shares of common stock, subject to certain beneficial restrictions set by each holder and approval of QNCX's stockholders
- Please refer to the company's SEC filings for additional information

1. Calculated using the treasury stock method
2. Excludes currently outstanding Orphai options that were assumed by Quince and warrants issued to Orphai warrant holders.
3. Represents shares of Quince common stock issued to Orphai stockholders in connection with the merger, equal to 19.99% of Quince's pre-merger common stock outstanding immediately prior to closing
4. Represents Quince pre-merger shares of common stock outstanding, shares of common stock issued to Orphai's stockholders at the closing of the merger, shares of common stock underlying the shares of preferred stock issued to Orphai's stockholders at the closing of the merger, and shares of preferred stock issuable to investors upon the closing of the private placement financing, all on an as converted basis and without regard to any beneficial ownership limitations

Investment Highlights

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

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

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

US/EU Orphan Disease Status granted for multiple indications

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

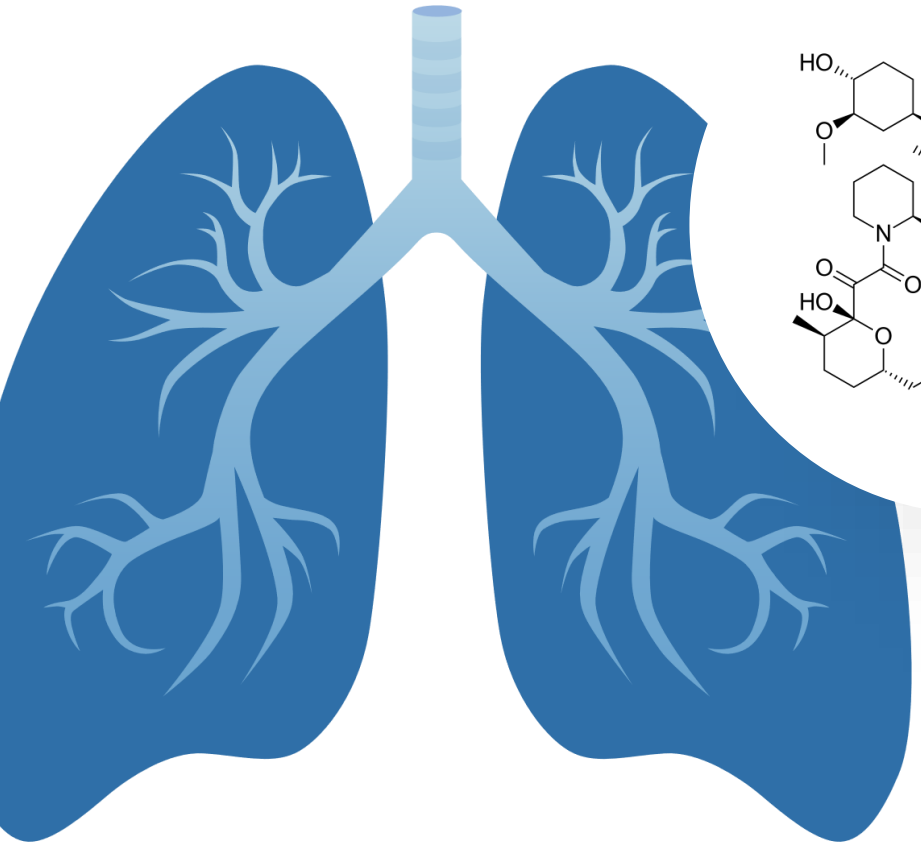
1. Represents estimated patient population in the US and EU: Wijsenbeek 2020 DOI: 10.1056/NEJMra2005230, Ang 2024 https://doi.org/10.1016/j.chest.2024.04.025
2. Shlobin 2024 https://doi.org/10.1002/pul2.12310
3. Represents estimated patient population in the US and EU: US HRSA Data, Kulkarni 2018:doi: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

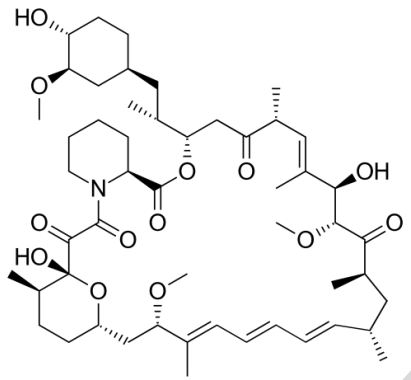
Quince Pipeline and Anticipated Milestones

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

◆ Anticipated Data Readout

Limitations of Oral Rapamycin





Systemic Exposure with Significant Safety Risks:

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

Limited Lung Exposure:

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

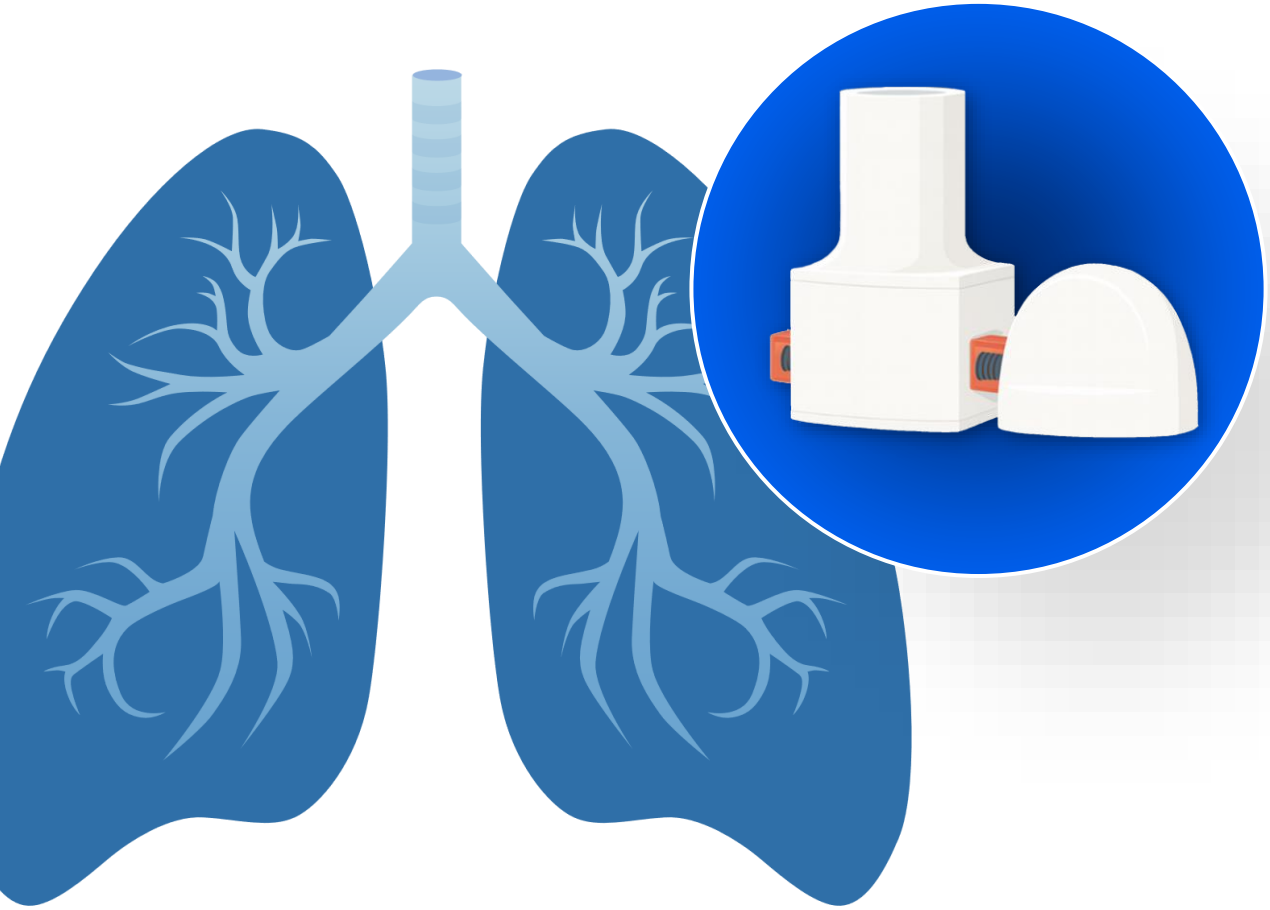
Low and Variable Oral Bioavailability*:

Requiring inconvenient plasma monitoring and frequent dose adjustments

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

* Systemic bioavailability of 14 – 18% due to poor aqueous solubility, high molecular weight, extensive first-pass metabolism, variable gastrointestinal conditions, food effects, and P-glycoprotein-mediated efflux *Rapamune (sirolimus) [prescribing information]. Pfizer Inc.; Revised 4/2017*

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



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

Based on non-clinical and clinical studies conducted by the Company, Rapamune (sirolimus) prescribing information. Pfizer Inc.; Revised 4/2017
No head-to-head clinical trials have been conducted evaluating LAM-001 and Rapamycin. Differences exist between study or trial designs and participant characteristics, and caution should be exercised when comparing data across studies

LAM-001: Inhaled Rapamycin **Advantages** over Oral

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

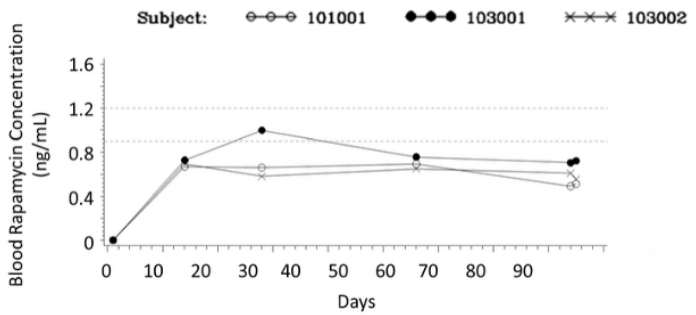
- Total dose delivered via inhalation = 20x lower (100 µg/day vs 2 mg/day)
- ~5-15x lower systemic exposure (<1 ng/ml vs 5-15 ng/ml for oral)
- > 90% mTOR inhibition at 24 hours after a single QD dose in rats comparable to 100 µg QD in humans

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

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

Reduced systemic exposure with clinically relevant lung exposure

Phase 1/2 in LAM Patients



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

ILD = interstitial lung disease
Based on non-clinical and clinical studies conducted by the Company
No head-to-head clinical trials have been conducted evaluating LAM-001 and Rapamycin. Differences exist between study or trial designs and participant characteristics, and caution should be exercised when comparing data across studies

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

Pulmonary Hypertension (PH-ILD)

DISEASE

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

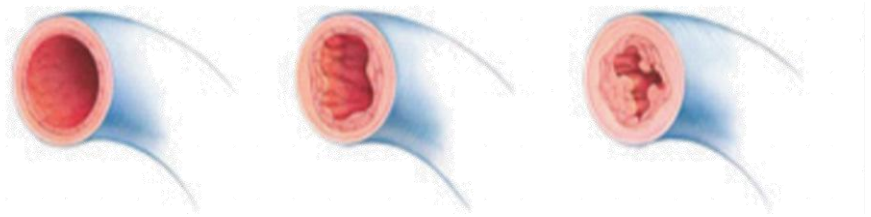


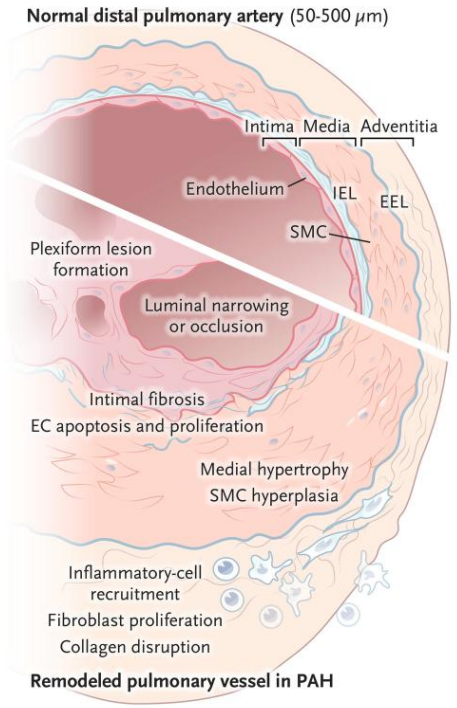
Figure 2 – Narrowing of the pulmonary arteries associated with PH[4]

Estimated Addressable Patient Population[3]
Group 3 (PH-ILD) — US: ~86K | EU: ~120K

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

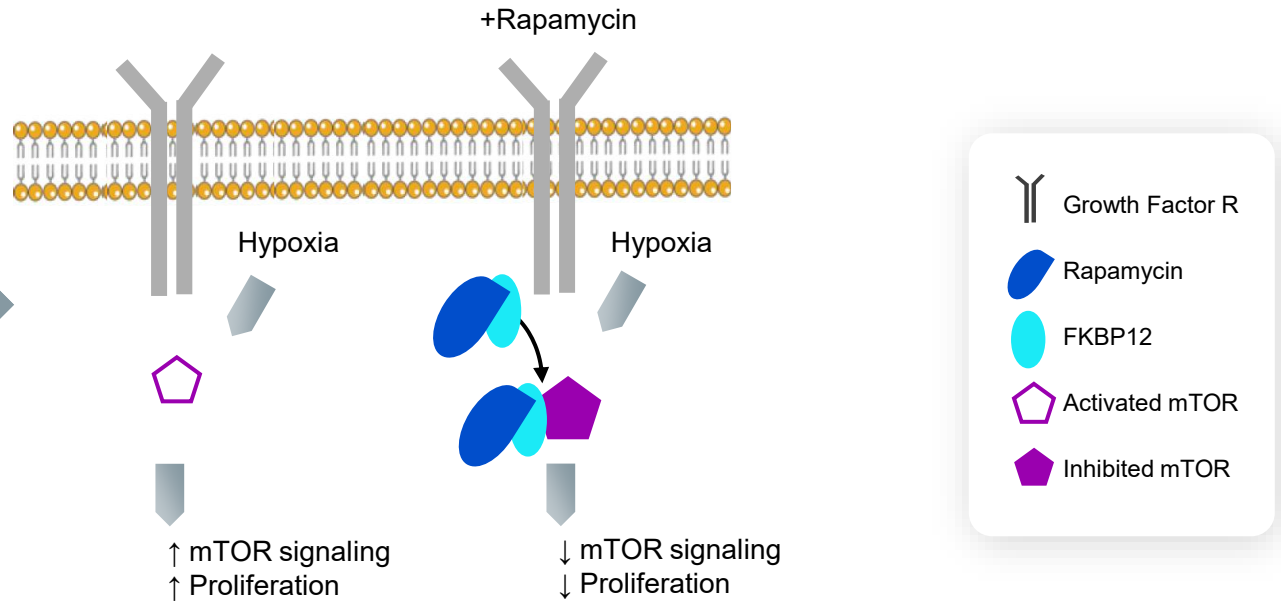
[1]Kacprzak 2023 https://doi.org/10.3390/diagnostics13142354
[2]Gall 2017 http://dx.doi.org/10.1016/j.healun.2017.02.016
[3]Wijsenbeek 2020 DOI: 10.1056/NEJMra2005230, Ang 2024 https://doi.org/10.1016/j.chest.2024.04.025
[4]Pulmonary Hypertension Singapore

Rapamycin Targets PH Pathology



Hassoun NEJM 2021

PH Smooth Muscle cells *(Hypoxia)*

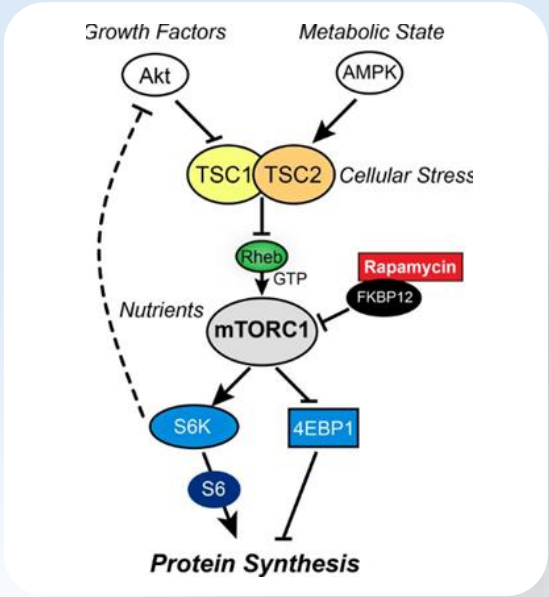


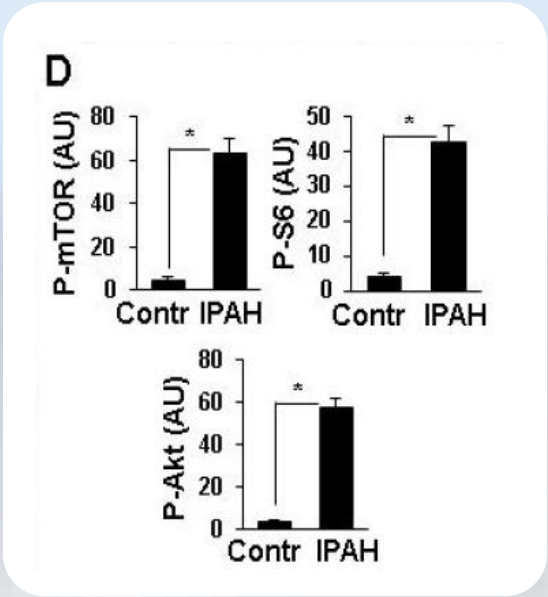
Krymskaya, et. al., FASEB (2011)

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

Rapamycin Inhibits mTOR and Reverses Pulmonary Arterial Smooth Muscle Cell (PASMC) Proliferation[1,2]

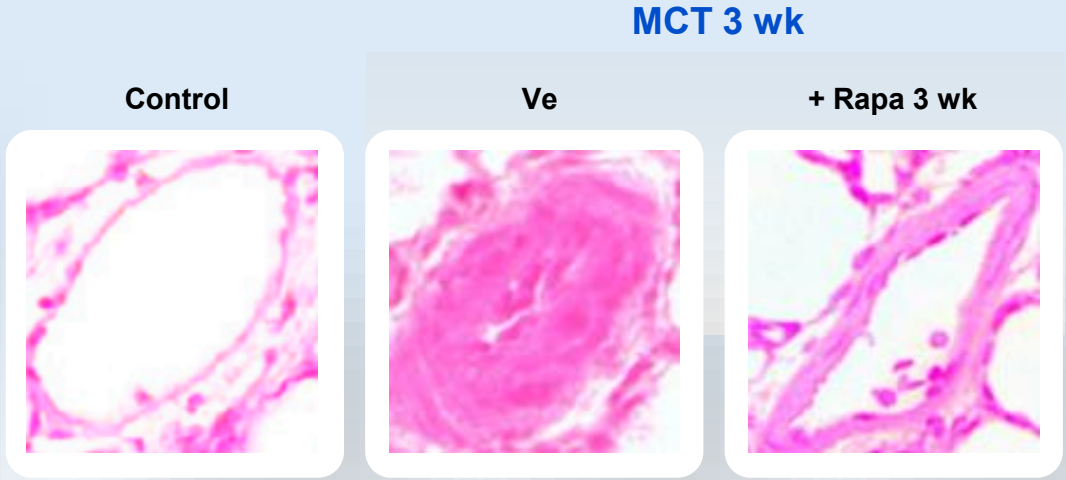
Rapamycin inhibits mTOR, which is Activated in PH[1]





[1] Based on Goncharov, Circulation. 2014 129: 864.
Contr = Control IPAH = Idiopathic Pulmonary Hypertension

Rapamycin Reverses PASMC Proliferation[2]



[2] Based on Houssaini, Am J Resp Cell Mol Bio 2013
PASMC = Pulmonary Artery Smooth Muscle Cell, MCT = monocrotaline rat model

Competitive Landscape PH-ILD Products and Product Candidates

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

1 Tyvaso nebulized or dry powder administrations
2 PR = Preregistration. Commercial launch anticipated 2027.
+++ = higher activity, ++ = medium activity, + = lower activity

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

Aaron B. Waxman, MD, PhD
Principal Investigator

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

Design	• Open Label; 24 wks; 4 sites; Invasive Cardiopulmonary Exercise Testing (iCPET)[1]
Inclusion	• >18 yo; WHO Functional Class III; Group 1 PAH and Group 3 PH; symptomatic despite background Rx
Primary Endpoints	• Peak oxygen uptake (VO2 max), Safety, Tolerability
Secondary Endpoints	• PVR, 6MWD, WHO functional class
Exploratory Endpoint	• NT-proBNP

Data Presented at ATS May 2026

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

Phase 2a Baseline Characteristics

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

Majority of patients on triple background therapy
- **All PH-ILD patients on background treprostinil**

Patients on stable background therapy prior to enrollment and throughout study

All discontinuations deemed unrelated to study drug

[3]Discontinuations (all deemed unrelated to drug):

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

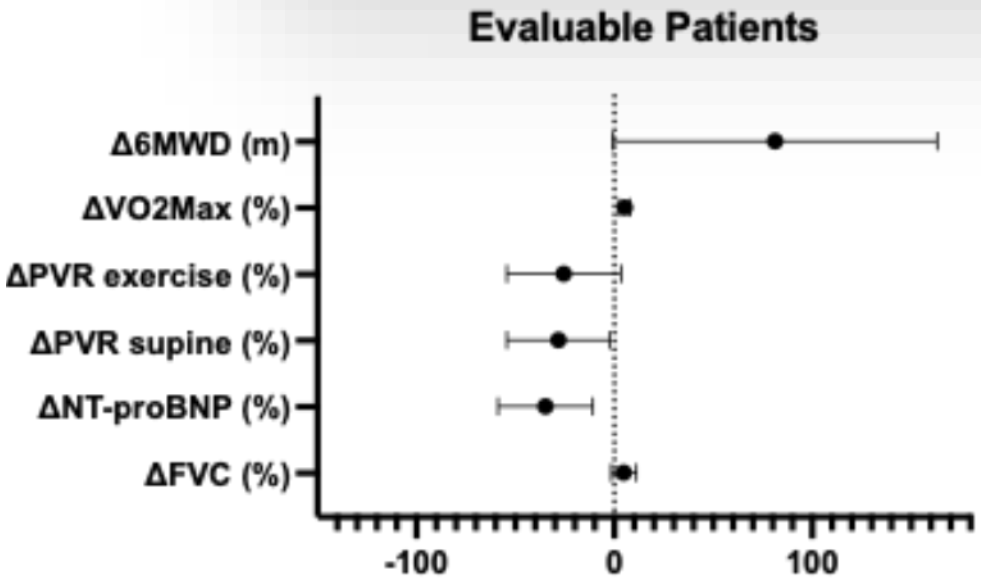
PH-ILD
- *Multiple complications and hospitalizations unrelated to study drug and withdrew*

[1] IPF = Interstitial Pulmonary Fibrosis, NSIP = Non-specific Interstitial Pneumonia, SSc-ILD = Systemic Sclerosis ILD, PS = Pulmonary Sarcoidosis
[2] Inhaled, oral or SubQ
Data on file

Phase 2a 24 Week Data Summary

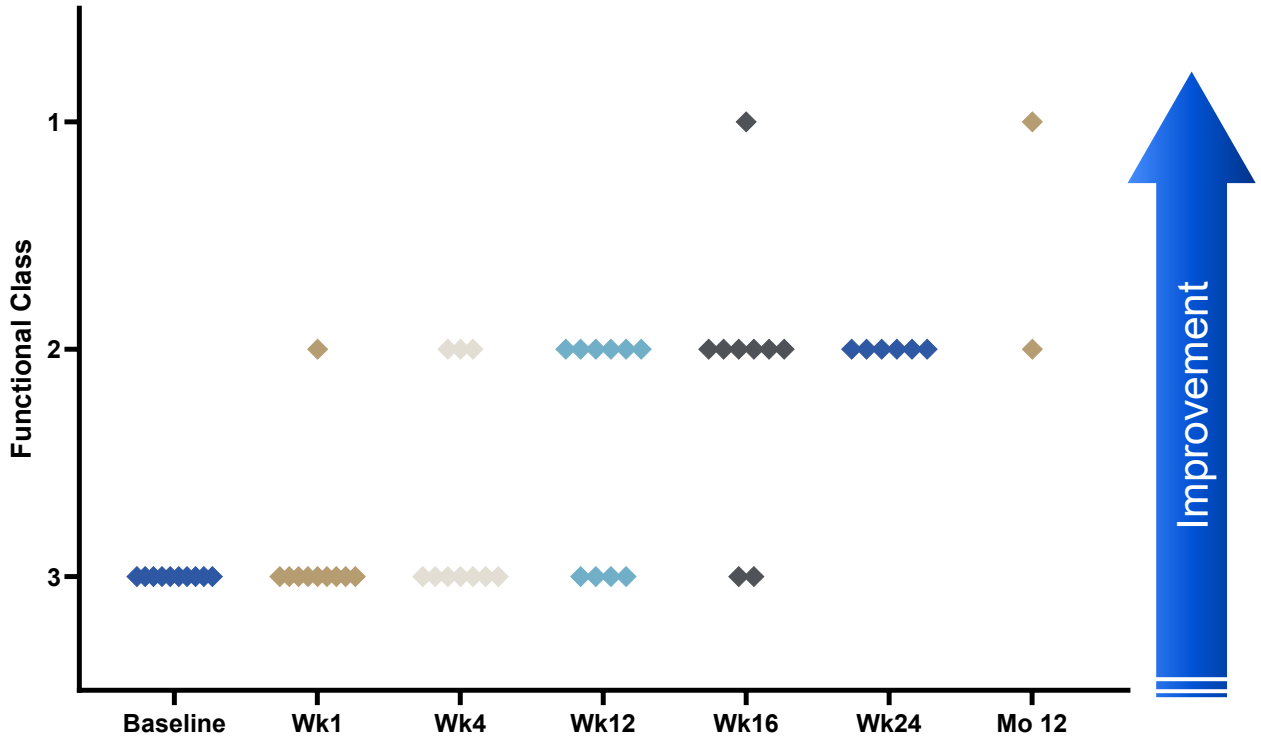
	Evaluable Population	PH-ILD Subgroup
	Mean	Mean
	N = 6	N = 4
Δ 6MWD (m)	+81.3	+67.4
Δ VO_2 Max (% Predicted)	+5.4%	+6.7%
% Δ PVR (exercise)	-25.5%	-35.3%
% Δ PVR (supine)	-28.1%	-33.9%
% Δ NT-proBNP	-29.0%	-28.8%
Δ FVC (% Predicted)	+4.8%	+1.8%

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



6MWD = 6 Minute Walk Distance, VO_2Max, PVR = Pulmonary Vascular Resistance, NT-proBNP = N-terminal pro-B-type natriuretic peptide, FVC = Forced Vital Capacity
Data on file

Phase 2a Functional Class Endpoint



	Baseline	Wk1	Wk4	Wk12	Wk16	Wk24	Mo 12
FC 1					1		1
FC 2		1	3	6	6	6	1
FC 3		9	7	4	2		
Total	10	10	10	10	9	6	2

100% of completers improved to FC II by Week 24

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

WHO Functional Class Definition*

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

*https://www.phaeurope.org/about-ph/classification-and-who-functional-class/

Data on file

Safety Summary through 24-Weeks

Drug Related AEs

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

LAM-001 was well tolerated

No dose interruptions due to AEs

No discontinuations due to drug

No drug related SAEs

AEs = Adverse Events, SAEs = Serious Adverse Event
Data on file

Phase 2a Efficacy and Safety Summary

Compelling Clinical Activity

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

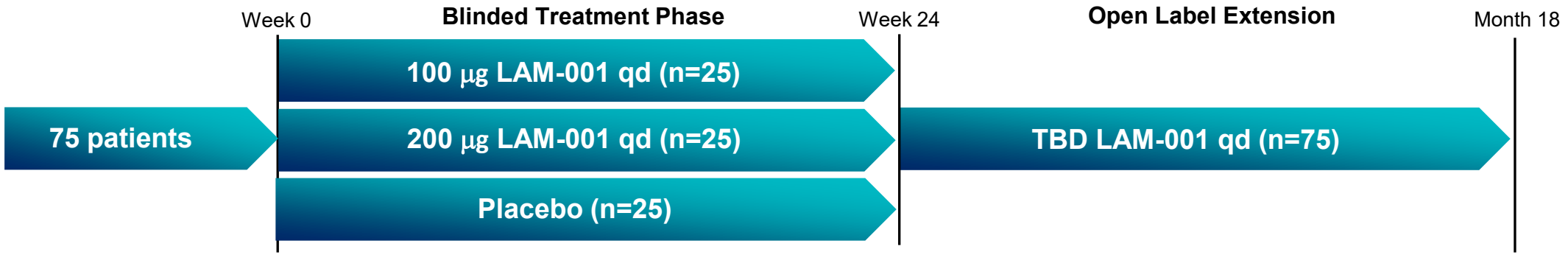
Favorable Tolerability

LAM-001 well tolerated

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

[1]Compared to +31.1m placebo adj. improvement in the Tyvaso INCREASE Phase 3 study: Waxman 2021 DOI: 10.1056/NEJMoa2008470
No head-to-head clinical trials have been conducted evaluating LAM-001 and Rapamycin. Differences exist between study or trial designs and participant characteristics, and caution should be exercised when comparing data across studies

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



Design	• Placebo-controlled; Double Blind; Randomized 1:1:1; Multi-center (40 sites); 24 wks; 12 mo open-label extension
Inclusion	• 18-70 y/o; WHO FC II and III; PVR ≥4, PH-ILD Group 3; symptomatic despite stable background rx
Primary Endpoints	• Δ PVR
Secondary Endpoints	• Δ 6MWD; Time to Clinical Worsening; Incidence of Clinical Worsening, Safety/Tolerability
Exploratory Endpoints	• Δ WHO functional class, Δ NT-proBNP, Δ FVC, Δ DLCO, KBILD, emPHasis 10

Anticipated Start Mid-2026

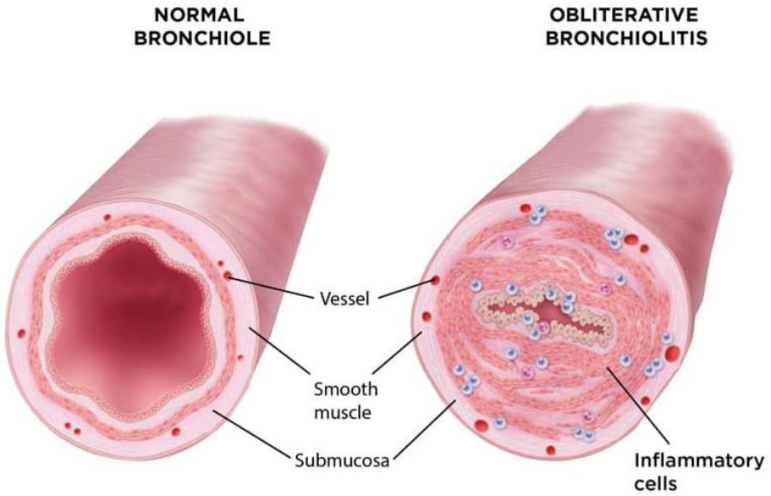
*Proposed study design
Clinical Worsening defined as the occurrence of one of the following: 1) Death, 2) Unplanned Lung or heart-lung transplantation, 3) PH specific hospitalization (>24 hrs), 4) Worsened Functional class 5) ≥ 15% decline in 6MWD from baseline
PVR = Pulmonary Vascular Resistance, NT-proBNP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

LAM-001: Bronchiolitis Obliterans (BOS)

LAM-001: Bronchiolitis Obliterans (BOS) Market

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

Estimated Addressable Patient Population[2]
BOS Post LT — US: ~17K | EU: ~11K



BOS = Bronchiolitis Obliterans Syndrome[3]

[1] Ehrsam 2021 doi.org/10.1016/j.healun.2021.01.887
[2] US HRSA Data, Kulkarni 2018:doi: 10.1016/j.healun.2018.09.016 and Company estimates
[3] Researchoutreach.org

BOS Major Unmet Need

6.2 years

Median survival post lung transplantation[1]

94%

Percent of lung transplant patients develop BOS within 10 years of lung transplantation[2]

#1

BOS is the leading cause of death post lung transplantation[3]

2.5 years

Median survival (or re-transplantation) post development of BOS post lung transplantation[4]

[1]ISHLT Factsheet: https://www.ishlt.org/docs/default-source/default-document-library/ishlt_fast-facts.pdf Accessed 5/15/26
[2]Weigt 2016 https://doi.org/10.1055/s-0033-1348467
[3] Ehrsam 2021 doi.org/10.1016/j.healun.2021.01.887
[4]Copeland 2010 doi: 10.1164/rccm.201002-0211OC

FEV1 is Key Measure of BOS Progression and Survival

Progression to Advanced BOS is Measured by FEV1 Decline*

BOS Gr 0	FEV1 > 80%	Baseline
BOS Gr 1	FEV1 66 - 80%	Baseline
BOS Gr 2	FEV1 51 - 65%	Baseline
BOS Gr 3	FEV1 35 - 50%	Baseline
BOS Gr 4	FEV1 ≤35%	Baseline

*Baseline = best post-transplant FEV1
Verleden 2019 doi.org/10.1016/j.healun.2019.03.009

1% ↓ in FEV1

is associated with a

3.4% ↑ Mortality

(p < 0.001)

Kneidinger 2022 doi: 10.3389/fmed.2022.897581

72%

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

Improvement in rate of FEV1 decline should drive market uptake

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

Rapamycin Stabilizes Pulmonary Function in Patients with BOS[1]

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

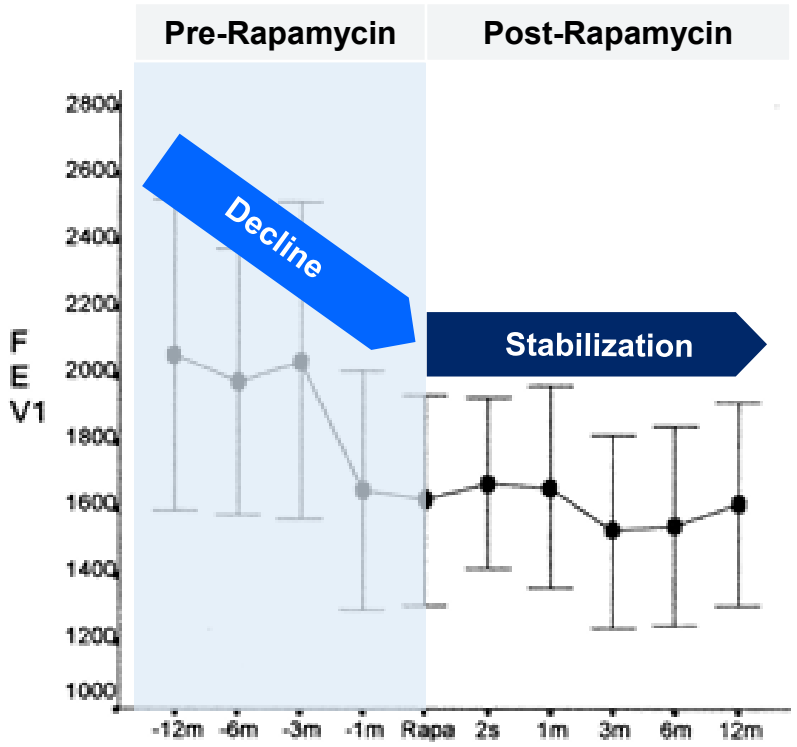
Prior to initiation of rapamycin:

Decline in FEV1 over the course of 12 months

Post introduction of rapamycin:

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

Mean FEV1 Values Before and After Rapamycin



[1]Based on Hernandez, et. al. Transplantation Proceedings, 2005. DOI: 10.1016/j.transproceed.2005.09.191

Phase 2 Trial of LAM-001 in BOS

Design	• Randomized 1:1, Double Blind, Placebo controlled, 25 mo open-label extension, Investigator-initiated trial
Inclusion	• >18 yo; Newly diagnosed BOS (grade 1-2); ≥200mL drop in FEV1 (moderate progressive BOS), Double lung transplant
Assessments	• Home spirometry; monthly PFTs & safety labs, monitor blood for cytokines and PK; BAL for SIR & biomarkers
Primary Endpoints	• % Δ from baseline in FEV1 @ 48 wks*
Secondary Endpoints	• Absolute Δ from baseline in FEV1 @ 48 wks*, Δ rate of progression in FEV1 vs pre-enrollment @ 48 wks*, PFS (defined as time to earliest to occur of: >10% decline in FEV1 or death from respiratory failure or retransplantation), Safety/Tolerability
Exploratory Endpoints	• PFS (defined as time to earliest to occur of: >20% decline in FEV1 or death from respiratory failure or retransplantation), 6MWD @ 48 wks* vs baseline, Δ FEV1/FVC @ 48 wks*, SGRQ-C, mTOR pathway activation via BAL
Status**	• Enrollment completed January 2026. An interim safety review was conducted in February 2026. Five of 19 subjects enrolled in the ongoing blinded study experienced a decline*** in FEV1 >10% at that time. Dosing continues.

Trial Fully Enrolled, Data Anticipated 1Q 2027

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

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

*** As measured in two consecutive visits

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

IP, Financial, & Milestones

Broad IP Strategy Supporting LAM-001 Exclusivity

FDA Orange Book Affords Protection for 3 Types of Patents

Composition Claims

Method Claims

Drug Substance (DS)

Particle size

Additional pending

Drug Product (DP)

Formulation

Delivery

Dosage

Method of Treatment (MoT)

Use of composition

Defined dosing regimens

Specific indications

9 Issued US Patents – Expected Exclusivity Into 2035

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

Pending Applications – Expected Exclusivity Into 2047

Multifaceted IP and Exclusivity Strategy

- Broad claims in all 3 categories
  - Drug substance, drug product, and method
- Multiple patents expected to be Orange Book-listable
- Orphan Drug Exclusivity in addition to patents
  - 7 years US / 10 years EU
- Device exclusivity for the use of rapamycin in the RS01 dry powder inhaler device

Well-Capitalized with Funding from Leading Healthcare Investors

May 2026 Financing

Oversubscribed

$115 M Upfront Financing

Led by

Balyasny

Including

AFFINITY ASSET ADVISORS

COASTLANDS CAPITAL

COLUMBIA THREADNEEDLE INVESTMENTS

Cormorant Asset Management

EVENTIDE

FORESITE CAPITAL

Janus Henderson INVESTORS

LIFESCI VENTURE PARTNERS

LOGOS CAPITAL

PERCEPTIVE ADVISORS

SILVERARC CAPITAL

WOODLINE PARTNERS

Anticipated Milestones

May ‘26	LAM-001 PH Phase 2a Data (Oral Presentation at ATS)
1Q27	LAM-001 BOS Phase 2 Data
1Q28	LAM-001 PH-ILD Phase 2b Data
4Q28	LAM-001 SAPH Phase 2 Data

Thank You