PURETECH

GIVING LIFE TO SCIENCE®

DEUPIRFENIDONE:
A potential new standard of care for idiopathic pulmonary fibrosis (IPF) and other rare lung diseases

Supplemental Slides

Table of Contents

Executive Summary

Deupirfenidone: A Potential New Standard-of-care for IPF and other PPFs

Deupirfenidone
Orphan Drug Designation *for IPF granted by the FDA and European Commission*

High Patient Need	• **Debilitating, fatal disease;** current SOC agents **cannot be taken in high doses due to poor tolerability,** resulting in **suboptimal efficacy**
De-risked MOA	• Builds on **established human efficacy and safety** of FDA-approved pirfenidone
Powerful Phase 2b Data	• **Large, well-controlled trial** over 26 weeks with **active comparator** (pirfenidone) • 52-week OLE data showing **durable efficacy**
Best-in-Class	• **Potential for superior efficacy vs SOC** with favorable tolerability
Attractive & Established Market	• **Established multi-billion-dollar** market with **high unmet need**

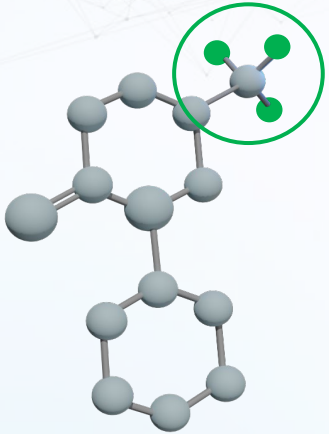
Initiation of pivotal Phase 3 trial expected in 1H 2026

PURETECH
GIVING LIFE TO SCIENCE®

SOC = standard of care; sMOA = mechanism of action.; OLE = open-label extension. Note: Certain third-party trademarks are included here; PureTech does not claim any rights to any third-party trademarks.

Deupirfenidone is a Novel Compound

STRUCTURE



DEUTERIUM SUBSTITUTION

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

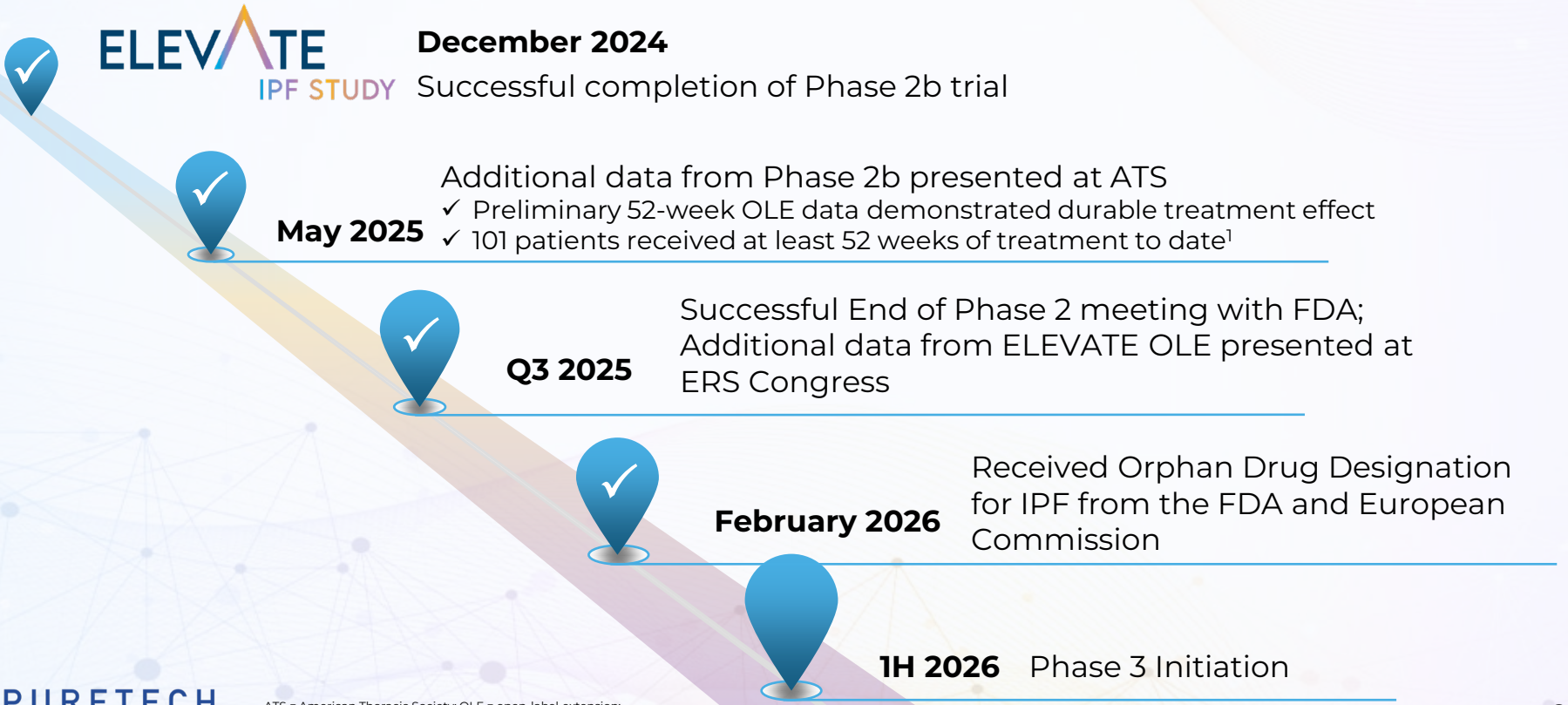
OVERVIEW

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

Orphan Drug Designation for IPF granted by the FDA & European Commission

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

Milestones Achieved and Catalysts



PURETECH
GIVING LIFE TO SCIENCE®

ATS = American Thoracic Society; OLE = open-label extension; ERS = European Respiratory Society. [1] As of May 9, 2025.

Idiopathic Pulmonary Fibrosis (IPF): Rare Lung Disease with High Unmet Need

Idiopathic Pulmonary Fibrosis (IPF) Overview

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

>232,000

IPF patients in the US & EU5[1]

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

~2-5 years

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

Three

FDA-approved agents to treat IPF[4]

Historically, tolerability challenges have outweighed suboptimal efficacy for most patients

~25%

of IPF patients have ever started antifibrotic treatment

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

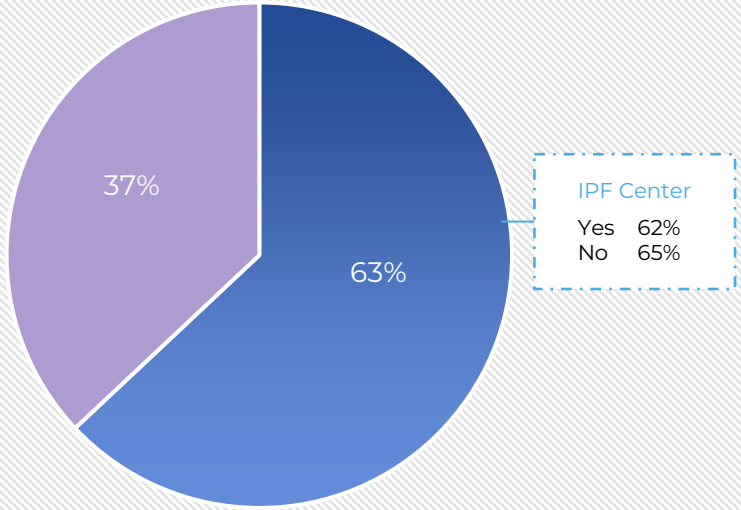
PURETECH
GIVING LIFE TO SCIENCE®

[1] GlobalData Epidemiology and Market Size Search, EU5=United Kingdom, France, Germany, Italy and Spain; [2] Barratt SL, Creamer A, Hayton C, Chaudhuri N. Idiopathic Pulmonary Fibrosis (IPF): An Overview. J Clin Med. 2018 Aug 6;7(8):201; [3] Fisher, M., Nathan, S. D., Hill, C., Marshall, J., Dejonckheere, F., Thuresson, P., & Maher, T. M. (2017). Predicting Life Expectancy for Pirfenidone in Idiopathic Pulmonary Fibrosis. Journal of Managed Care & Specialty Pharmacy, 23(3-b Suppl), S17–S24. https://doi.org/10.18553/jmcp.2017.23.3-b.s17; [4] ESBRIET (pirfenidone) and OFEV (nintedanib) were approved in 2014; JASCAYD (nerandomilast) was approved in 2025; [5] Dempsey TM, Payne S, Sangaralingham L, Yao X, Shah ND, Limper AH. Adoption of the Antifibrotic Medications Pirfenidone and Nintedanib for Patients with Idiopathic Pulmonary Fibrosis. Ann Am Thorac Soc. 2021 Jul;18(7):1121-1128.

Efficacy is the Key Prescribing Focus for Pulmonologists

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

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



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

(n=30)

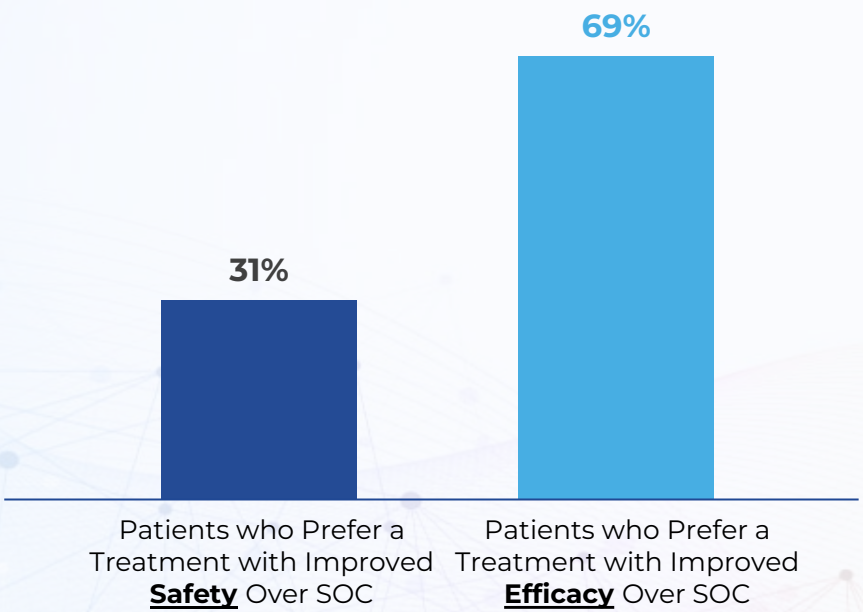
PURETECH
GIVING LIFE TO SCIENCE®

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

Improved Efficacy is Key Treatment Priority for People Living with IPF

The majority of survey participants indicated they would prefer a treatment with improved efficacy over one with improved safety

Patient Preferences for New IPF Therapies[1]



"Efficacy is far more important to me than anything else…I would even put up with greater side effects, because there are certainly stuff out there that you can take to manage side effects."

Female, Age 72

"The side effects go away. Give me a longer time to live…that would be good for me."

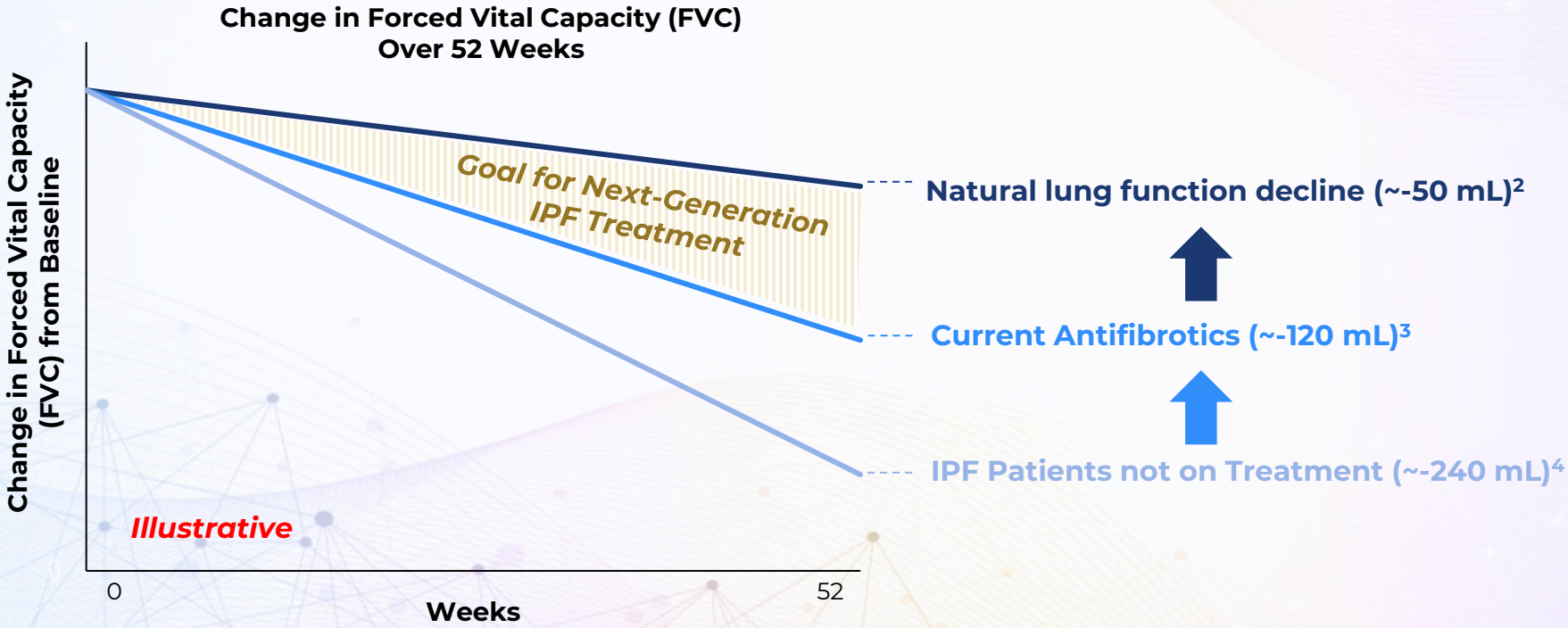
Male, Age 70

PURETECH
GIVING LIFE TO SCIENCE®

SOC = standard of care; [1] Per qualitative market research with N=16 participants with IPF, conducted by third party (Sago) in August 2023; Participants with IPF were presented with two hypothetical treatment profiles, and asked to describe which they would prefer: Treatment X with similar efficacy to approved antifibrotics but improved safety/tolerability, or Treatment Y with similar safety/tolerability to approved antifibrotics but improved efficacy.

Stabilizing Lung Function is the Ultimate Treatment Goal in IPF

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



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

PURETECH
GIVING LIFE TO SCIENCE®

Phase 2b ELEVATE IPF Trial

ELEVATE Trial Demonstrated Unprecedented Efficacy for Deupirfenidone 825 mg TID

POTENTIAL FOR LUNG FUNCTION STABILIZATION

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

ENHANCED EFFICACY VERSUS CURRENT STANDARD OF CARE

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

DURABLE EFFICACY RESPONSE OUT TO 52 WEEKS

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

SUPPORTING PHARMACOKINETIC (PK) DATA

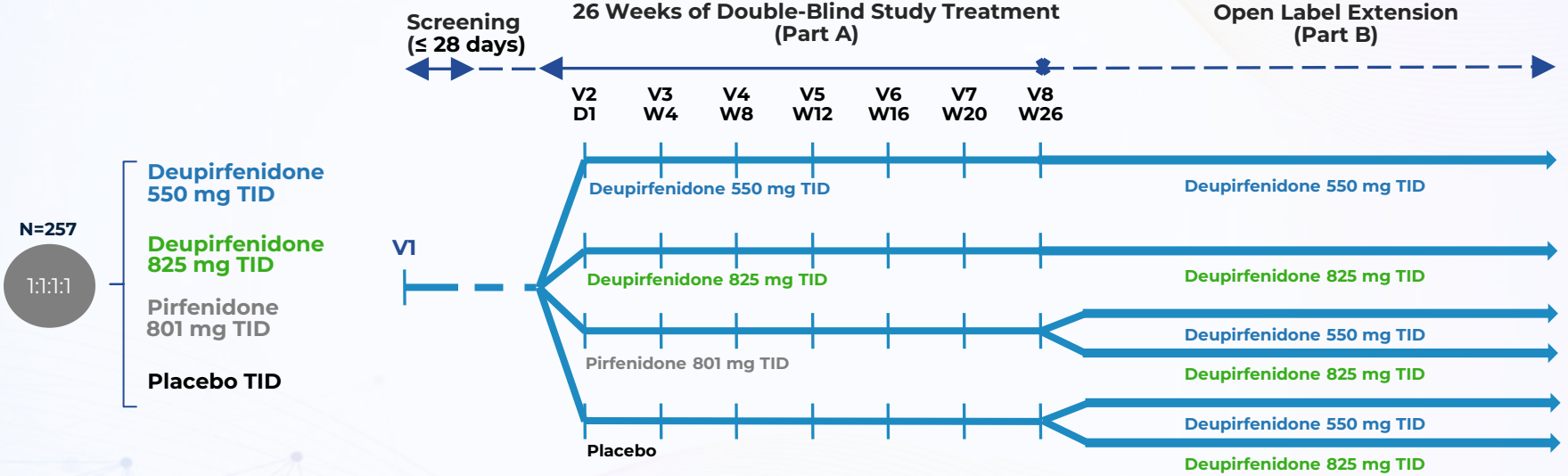
*Deupirfenidone 825 mg TID had **~50% greater exposure vs. pirfenidone**, which may have driven the greater efficacy observed*

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

PURETECH
GIVING LIFE TO SCIENCE®

[1] FVC decline at 6 months was estimated assuming linear decline over time. Valenzuela, C., Bonella, F., Moor, C., Weimann, G., Miede, C., Stowasser, S., Maher, T. (2024). Decline in forced vital capacity (FVC) in subjects with idiopathic pulmonary fibrosis (IPF) and progressive pulmonary fibrosis (PPF) compared with healthy references. Poster presented at the European Respiratory Society International Congress, Vienna, Austria; and Luoto, J., Pihlsgård, M., Wollmer, P., & Elmståhl, S. (2019). Relative and absolute lung function change in a general population aged 60-102 years. The European Respiratory Journal, 53(3), 1701812. https://doi.org/10.1183/13993003.01812-2017; [2] Per integrated analysis of double-blind and preliminary open-label extension data from Phase 2b ELEVATE IPF trial as of May 9, 2025, using a random coefficient regression model with absolute FVC including baseline as response variable and week, treatment and interaction between week and treatment as fixed effect.
FVC: Forced Vital Capacity.

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



Primary Endpoint
(pooled deupirfenidone arms)

Rate of decline in FVC over 26 weeks

Key Secondary Endpoint
(pooled deupirfenidone arms)

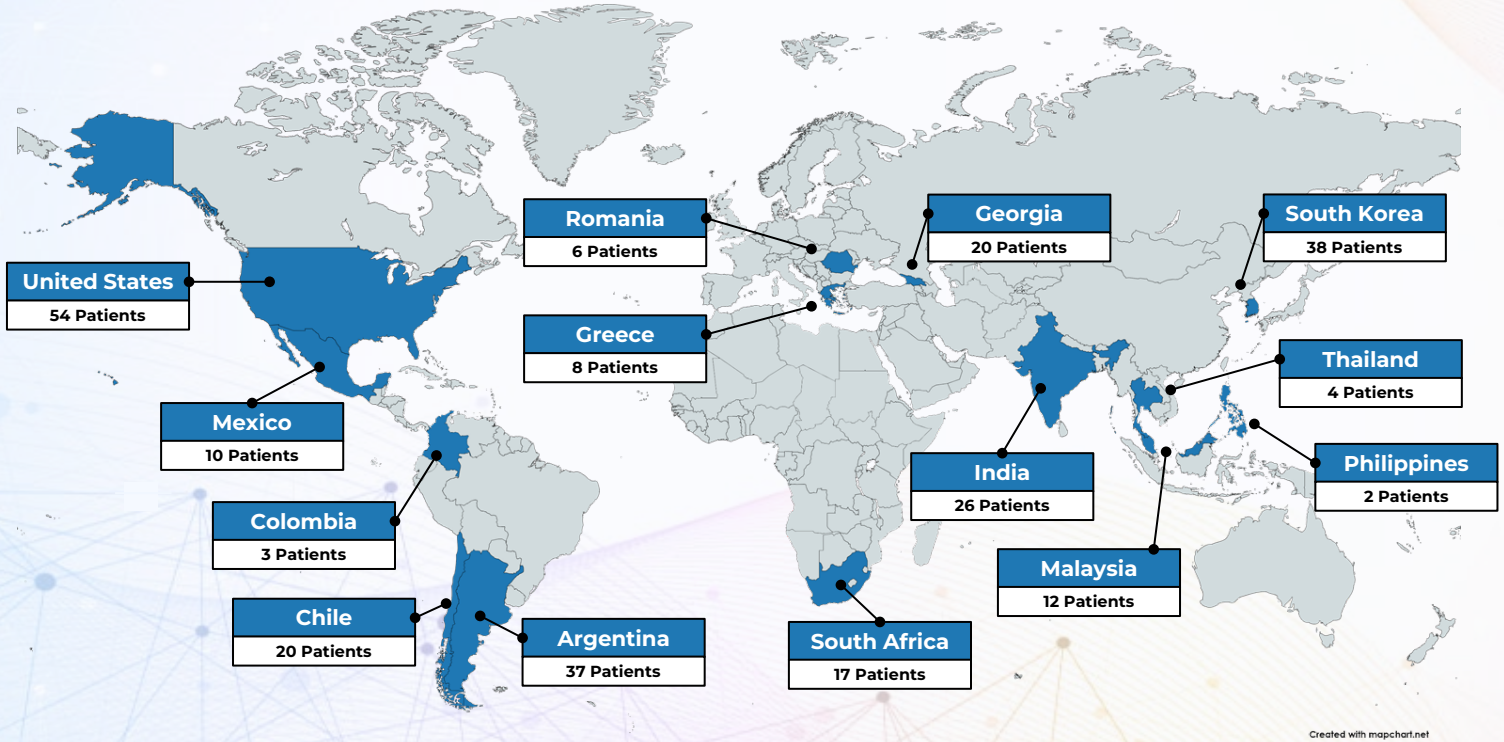
Change in FVC percent predicted from baseline to Week 26

PURETECH
GIVING LIFE TO SCIENCE®

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

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

257 patients were recruited from 87 sites across 14 countries



KEY DEMOGRAPHIC STATISTICS

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

PURETECH
GIVING LIFE TO SCIENCE®

Overview of ELEVATE Statistical Approach

Commonly used Bayesian[1] and frequentist analyses were applied

BAYESIAN STATISTICS

Used for Primary and Key Secondary Endpoints

FREQUENTIST ANALYSIS

Used for Primary and Key Secondary Endpoints

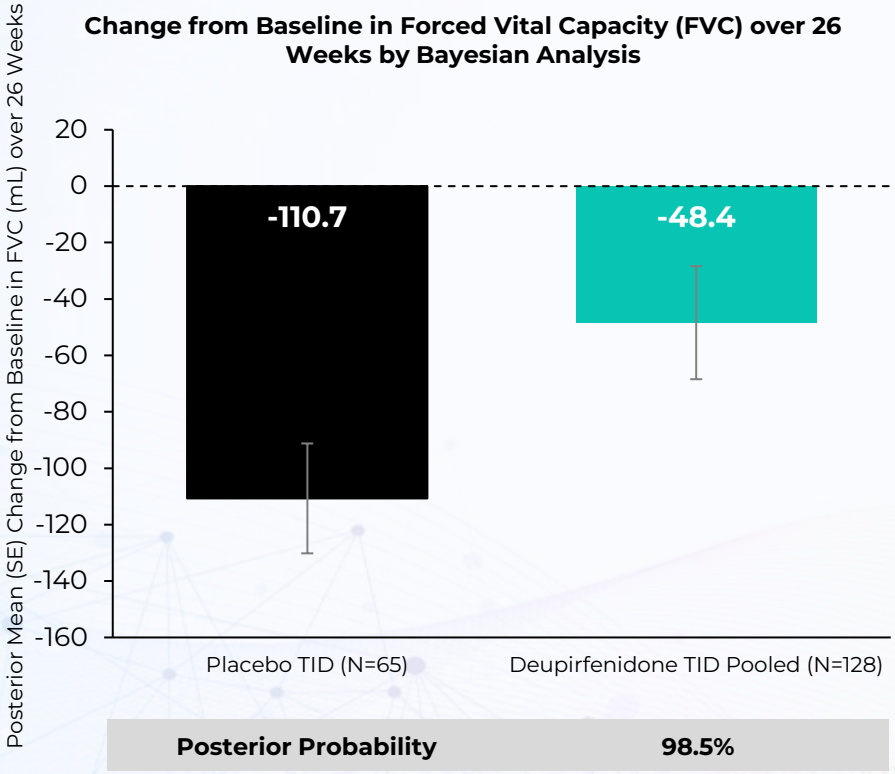
- We obtained FVC data per patient over time, commonly referred to as observed data
- Observed data doesn't account for missing data due to variety of reasons (e.g., drop-outs, missed visits, etc.)
- The gold standard is to use population-level models, such as mixed models for repeated measures (MMRM),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

PURETECH
GIVING LIFE TO SCIENCE®

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

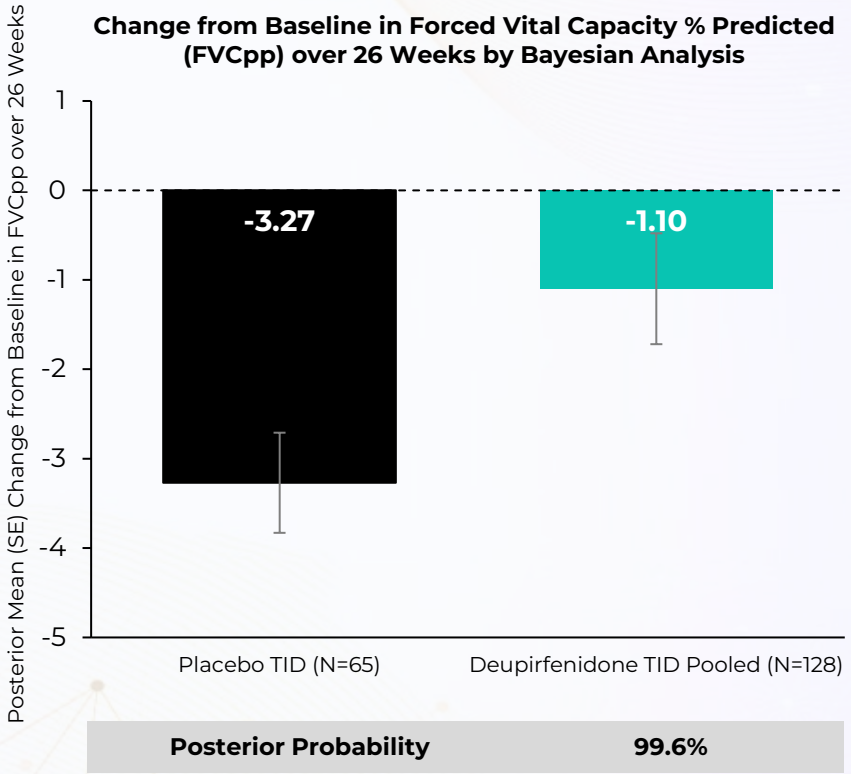
ELEVATE Achieved Primary and Key Secondary Endpoints

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



Posterior Probability	98.5%

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



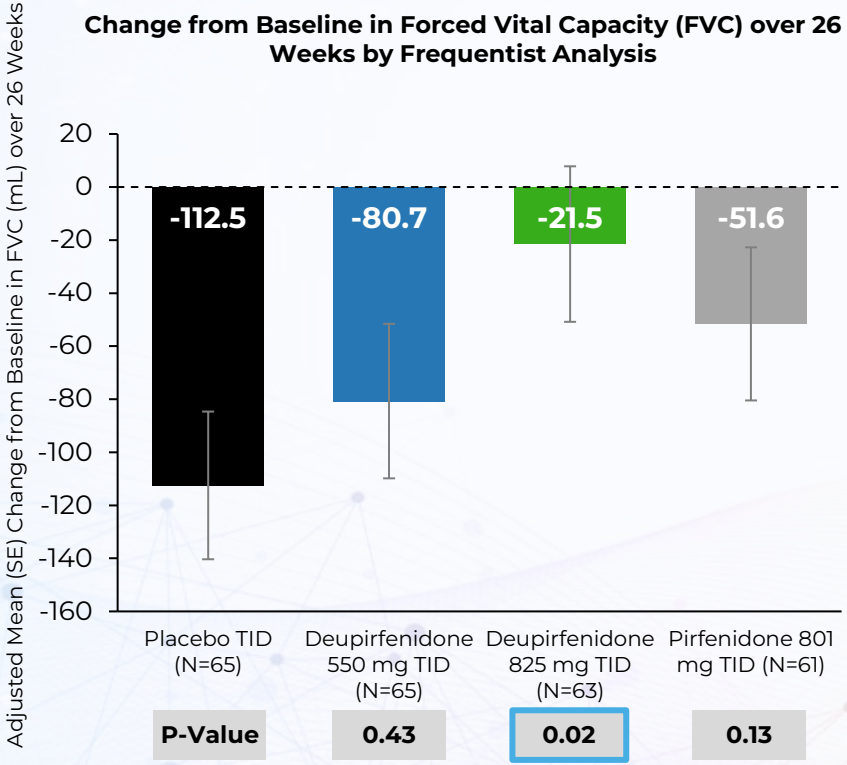
Posterior Probability	99.6%

PURETECH
GIVING LIFE TO SCIENCE®

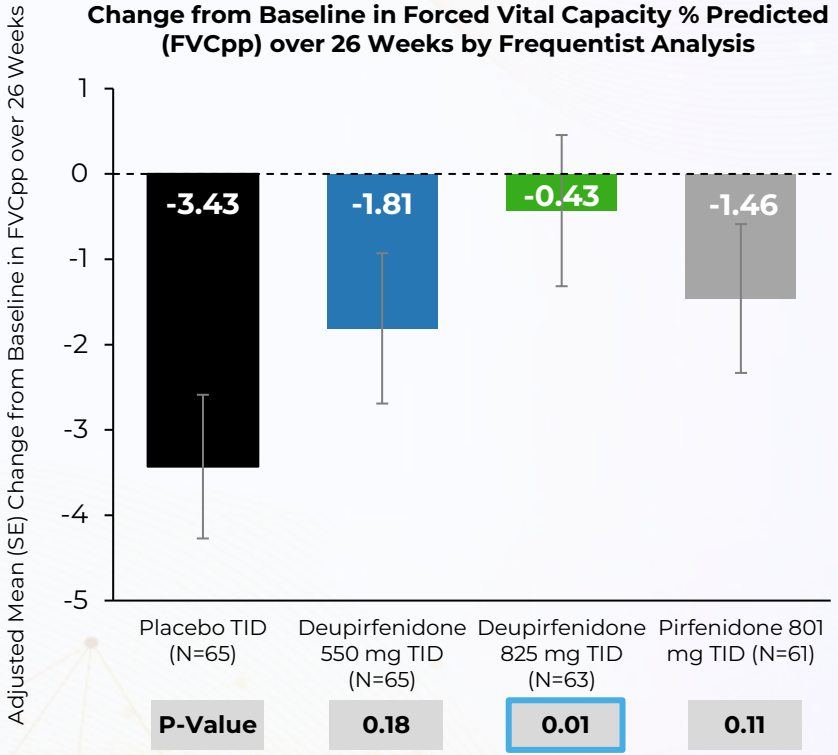
Efficacy analyses used a random coefficient regression model with absolute FVC or FVCpp including baseline as response variable and week, treatment (placebo, pirfenidone, deupirfenidone pooled arm) and interaction between week and treatment as fixed effect. The analyses were performed based on the predefined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

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

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



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

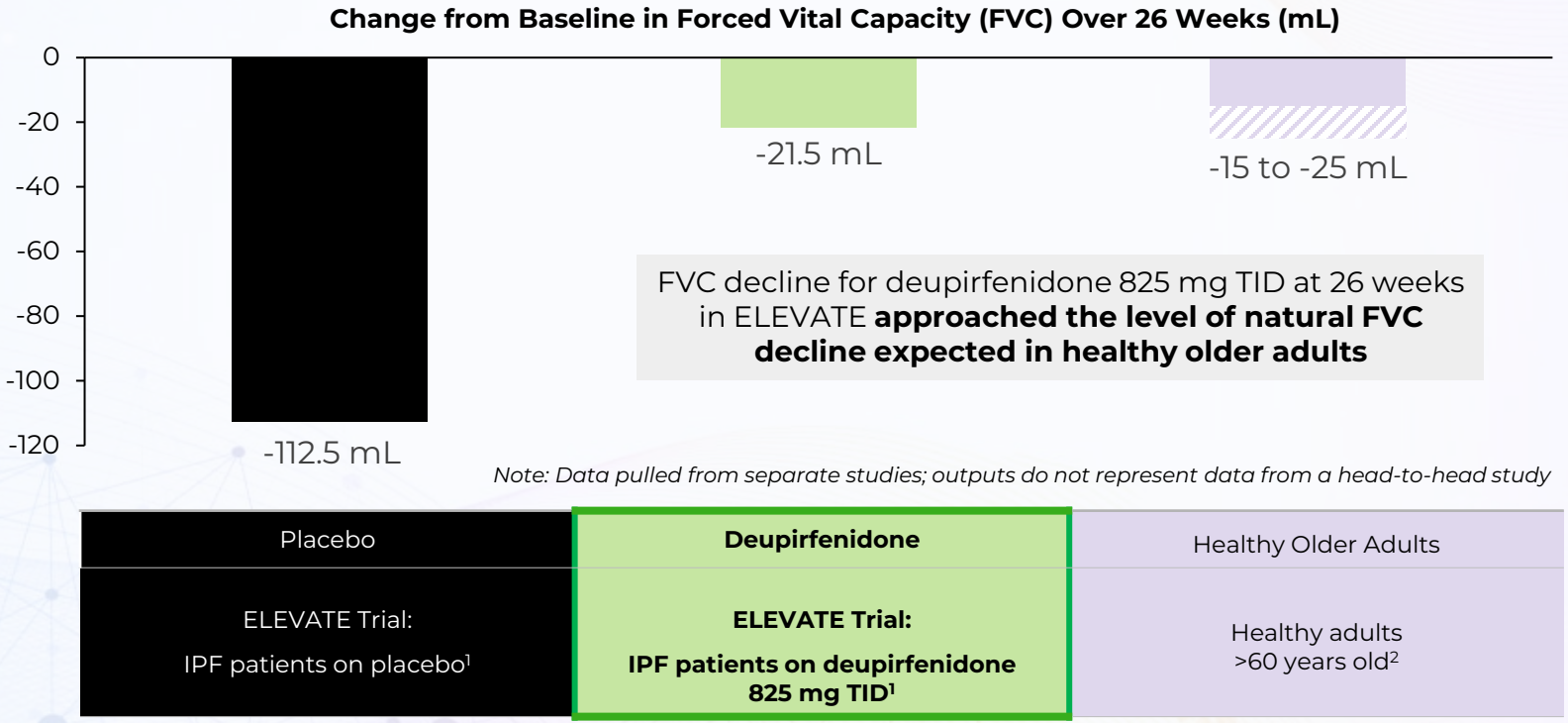


PURETECH
GIVING LIFE TO SCIENCE®

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

Statistically Significant

Deupirfenidone 825 mg TID Stabilized Lung Function; Rate of Decline Similar to Healthy Older Adults

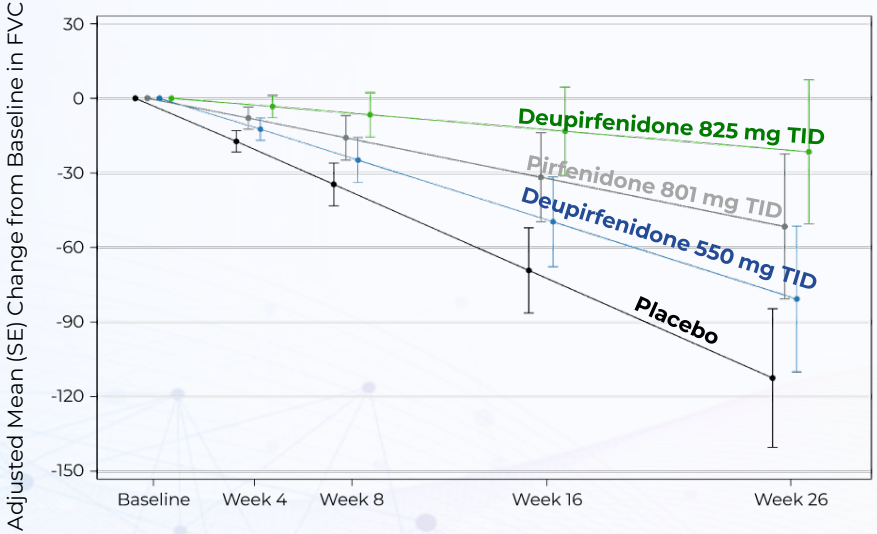


[1] Reflects outputs obtained via frequentist analysis; [2]Per Valenzuela. Boehringer Ingelheim. ERS 2024 and Luoto. Eur Respir J. 2019 (6-month decline in general population aged 60-102 years, estimated by taking reported 1-year decline and dividing by 2). Change from baseline FVC is not adjusted for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

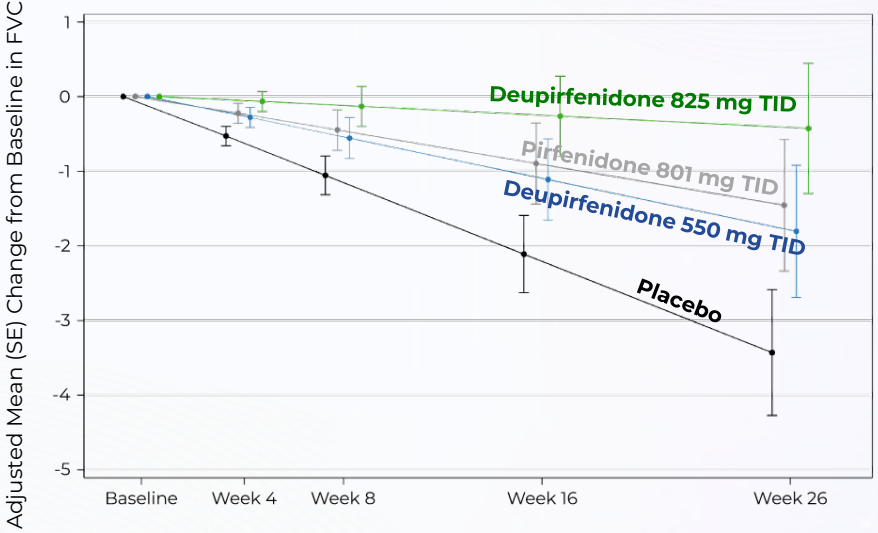
Deupirfenidone Demonstrated a Clear Dose-dependent Effect

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

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



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



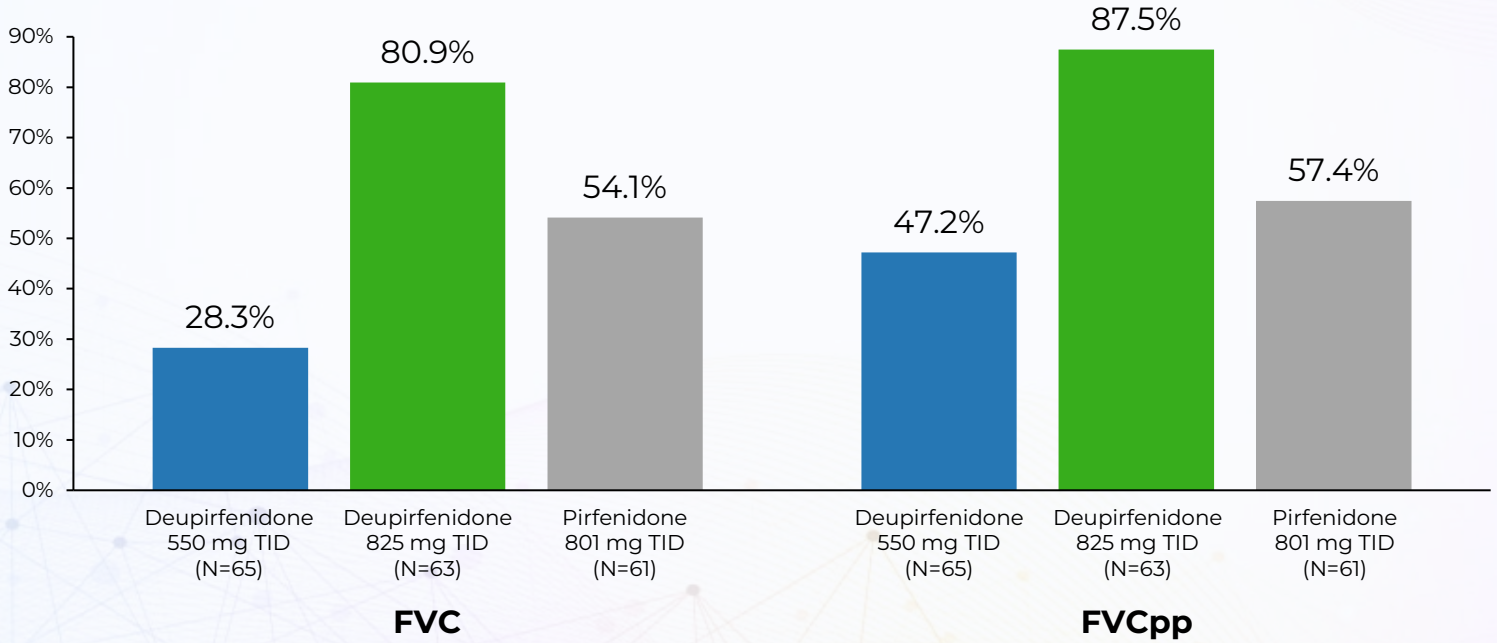
Placebo TID | Pirfenidone 801 mg TID | Deupirfenidone 550 mg TID | Deupirfenidone 825 mg TID

PURETECH
GIVING LIFE TO SCIENCE®

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

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

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



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

PURETECH
GIVING LIFE TO SCIENCE®

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

Analysis of Estimated AUC for Deupirfenidone and Pirfenidone

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

ELEVATE PK Summary

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

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

Deupirfenidone Had Favorable Tolerability in ELEVATE Trial

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

SOC/PT	Placebo TID (N=65) n (%)	Pirfenidone 801 mg TID (N=63) n (%)	Deupirfenidone 550 mg TID (N=65) n (%)	Deupirfenidone 825 mg TID (N=64) n (%)
Nausea	5 (7.7)	17 (27.0)	11 (16.9)	13 (20.3)
Dyspepsia	2 (3.1)	14 (22.2)	8 (12.3)	9 (14.1)
Diarrhea	6 (9.2)	7 (11.1)	7 (10.8)	5 (7.8)
Abdominal pain	3 (4.6)	5 (7.9)	4 (6.2)	9 (14.1)
Upper Respiratory Infections	6 (9.2)	9 (14.3)	8 (12.3)	6 (9.4)
Urinary tract infection	2 (3.1)	5 (7.9)	4 (6.2)	3 (4.7)
Cough	7 (10.8)	3 (4.8)	1 (1.5)	8 (12.5)
IPF (acute exacerbation)	10 (15.4)	2 (3.2)	3 (4.6)	4 (6.3)
Dyspnoea	4 (6.2)	3 (4.8)	2 (3.1)	1 (1.6)
Rash	1 (1.5)	6 (9.5)	3 (4.6)	6 (9.4)
Photosensitivity reaction	0	5 (7.9)	4 (6.2)	5 (7.8)
Pruritus	0	3 (4.8)	5 (7.7)	5 (7.8)
Decreased appetite	5 (7.7)	9 (14.3)	12 (18.5)	13 (20.3)
Dizziness	2 (3.1)	5 (7.9)	6 (9.2)	8 (12.5)
Headache	3 (4.6)	8 (12.7)	5 (7.7)	2 (3.1)
Fatigue	1 (1.5)	7 (11.1)	5 (7.7)	6 (9.4)

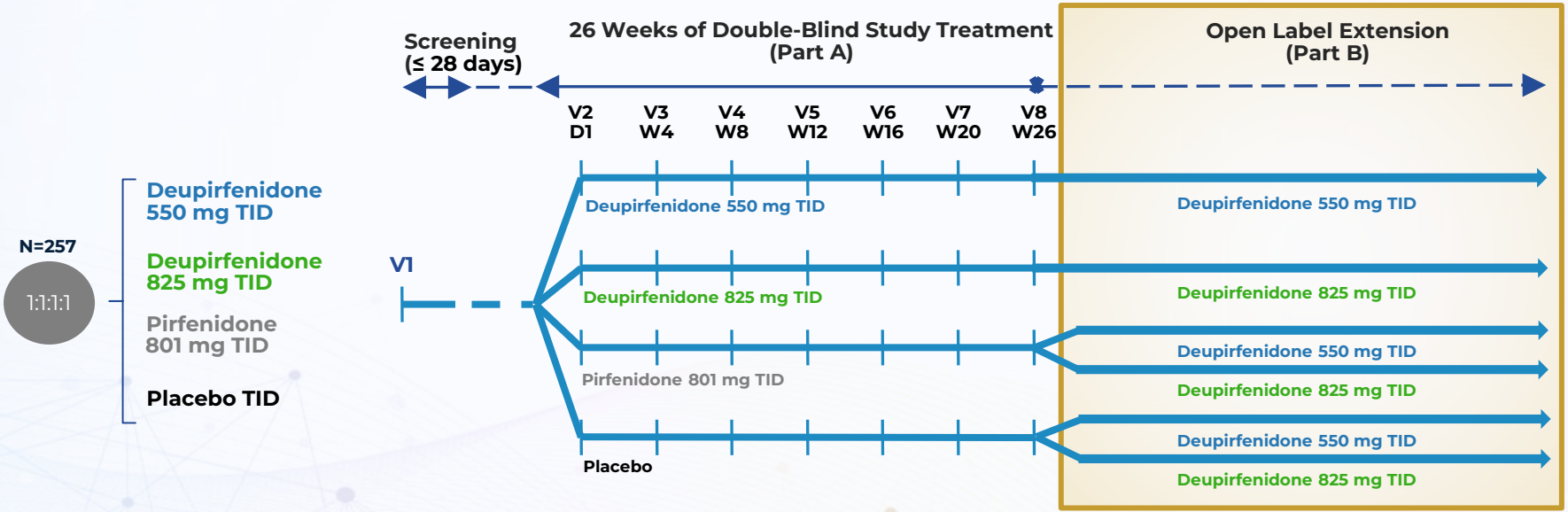
Orange = Higher reported incidence than pirfenidone arm
Green = Lower reported incidence than pirfenidone arm

PURETECH
GIVING LIFE TO SCIENCE®

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

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

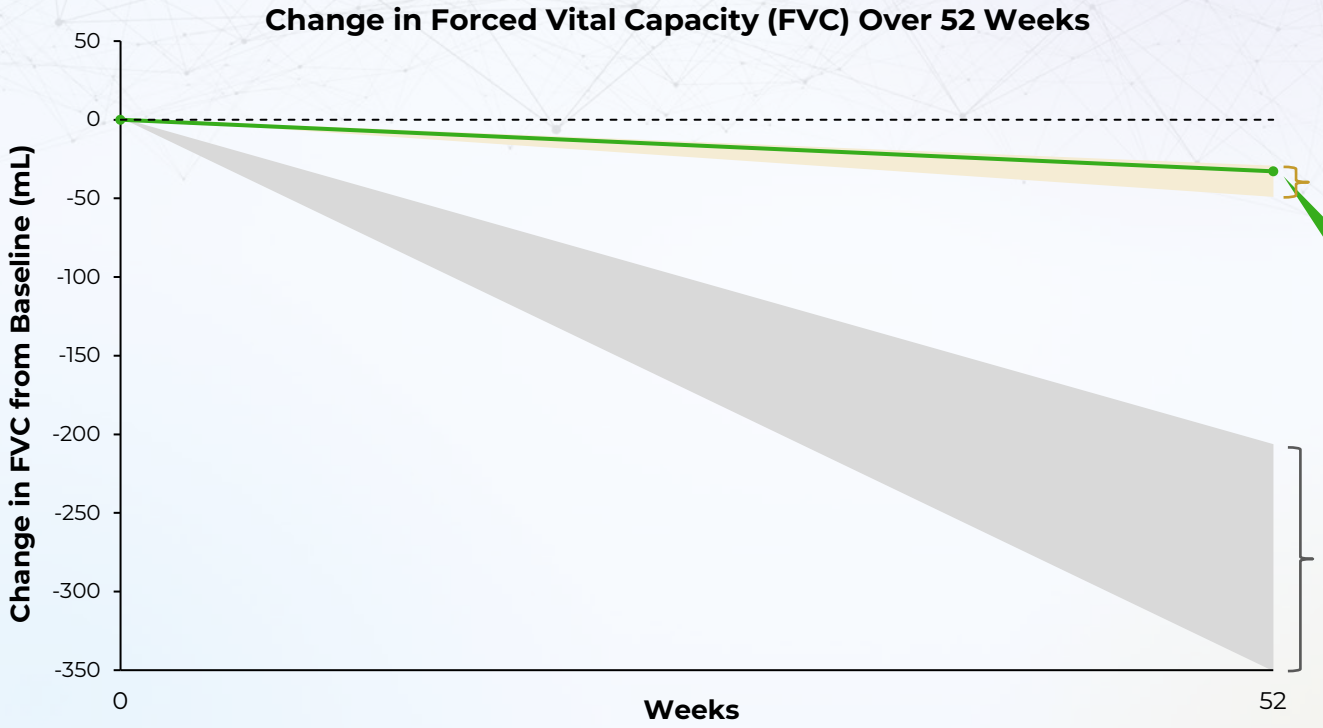
>90% of Patients Opted to Enroll in the Ongoing Open-label Extension



PURETECH
GIVING LIFE TO SCIENCE®

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

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



-30 mL to -50 mL[1]

Healthy Older Adults
Expected natural lung function decline

-32.8 mL[2]

IPF Patients
Decline when treated with deupirfenidone 825 mg TID

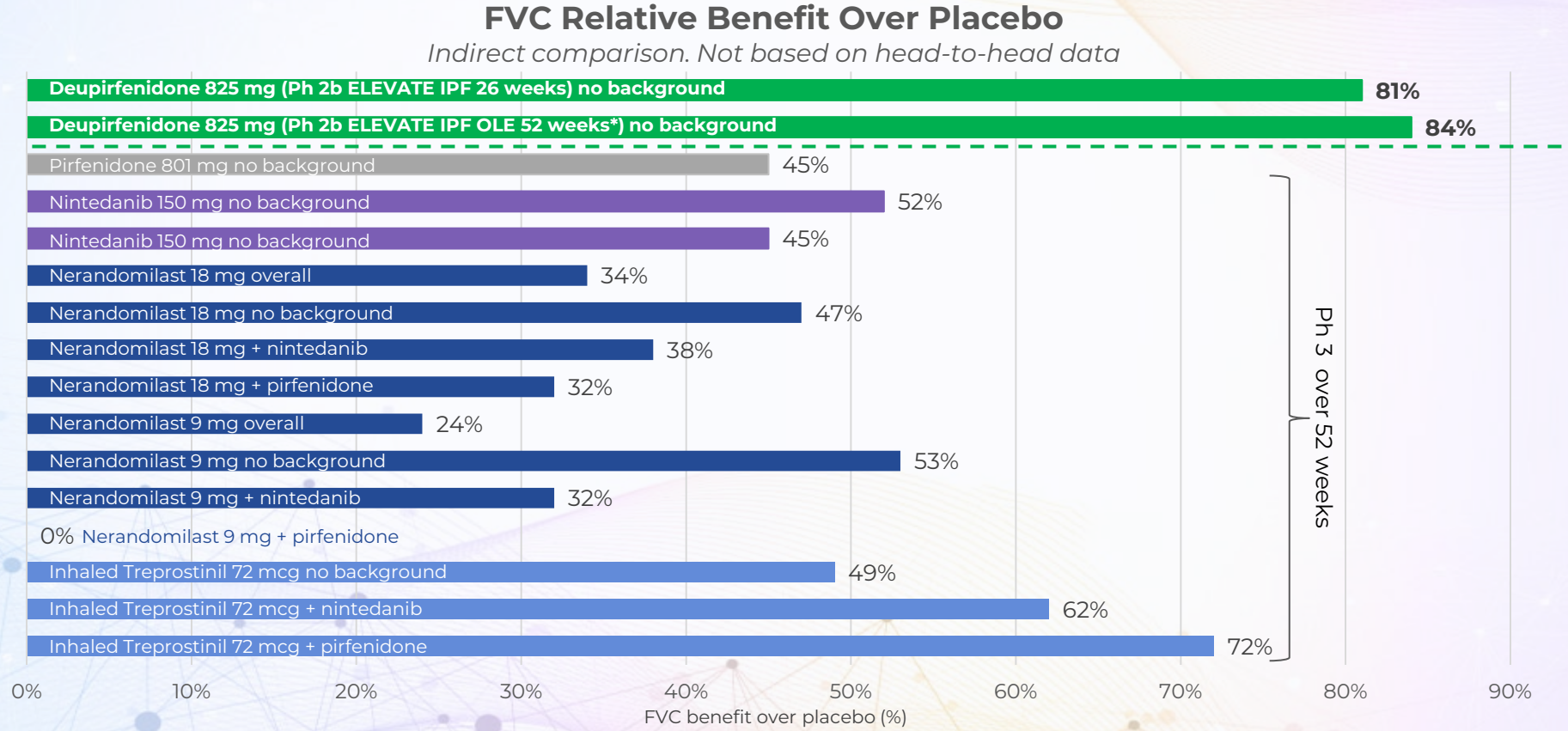
-205 mL to -350 mL[3]

IPF Patients
Decline without treatment based on historical data

PURETECH
GIVING LIFE TO SCIENCE®

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

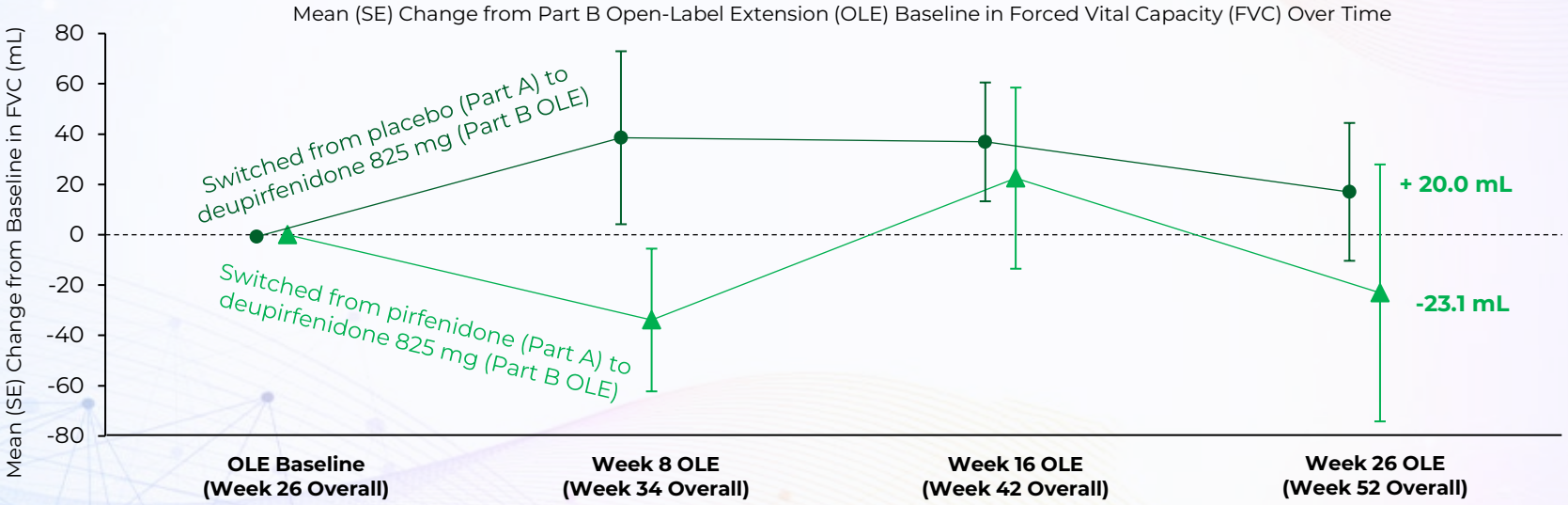
Deupirfenidone Has Demonstrated Potential for Best-in-class Efficacy



NOTE: Cross-trial comparisons are inherently limited, as these data are from separate studies with differing designs, patient populations, and methodologies. No direct, head-to-head trials have been conducted.
*In the ELEVATE IPF Open-Label Extension (OLE) study, the decline in FVC over 52 weeks with deupirfenidone 825 mg was -32.8 mL. The ELEVATE IPF OLE did not include a placebo arm, so the relative improvement over placebo was calculated assuming a -200mL decline in FVC at 52 weeks for placebo, based on a meta-analysis of the placebo decline from the ASCEND, INPULSIS-1, INPULSIS-2, AND TOMORROW trials..

Lung Function Stabilized in Patients who Switched from Placebo or Pirfenidone to Deupirfenidone 825 mg TID

Patients completed 26 weeks of placebo or pirfenidone treatment in Part A and then opted to be re-randomized to deupirfenidone for an additional 26 weeks in the open-label extension (Part B)



Part A (26 weeks)		Part B/OLE (26 weeks)	
Placebo (n=65)	-112.5 mL*	Deupirfenidone 825mg (n=17)	+20.0 mL†
Pirfenidone (n=61)	-51.6 mL*	Deupirfenidone 825mg (n=16)	-23.1 mL†

*Part A analysis is based on pre-defined Full Analysis Set using a random coefficient regression model with absolute FVC as a response, including baseline. Baseline is defined as the last available measurement performed before the first study drug administration in Part A. Adjusted mean (SE) by frequentist analysis is estimated based on a random coefficient regression model with absolute FVC over time, including baseline, as a response, and fixed effects for treatment (placebo, pirfenidone), visit (week), and treatment by visit interaction, as well as participant-level random effects for the intercept and slope.
† Part B analysis is based on switch patients (those who completed 26 weeks of placebo or pirfenidone in Part A and then initiated deupirfenidone 825 mg TID in Part B). Patients were re-baselined to the last available FVC measurement obtained prior to the first administration of deupirfenidone 825 mg TID in Part B. Observed mean (SE) values are presented over time as of May 9, 2025.

PURETECH
GIVING LIFE TO SCIENCE®

Phase 3 SURPASS-IPF Trial Design

Phase 3 Trial will be Head-to-head vs. Pirfenidone

	Design Overview
Comparator	**Head-to-head vs. pirfenidone; no background therapy**
Arms	Deupirfenidone 825 mg TID Pirfenidone 801 mg TID
Primary Endpoint	Change from baseline in absolute forced vital capacity (FVC) at 52 weeks
Additional Details	Based on feedback from the FDA, Celea believes that the results from this one trial, if successful and supported by the totality of data from the program, would complete the data package required to support potential registration

Commercial Opportunity

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

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

Why Deupirfenidone?

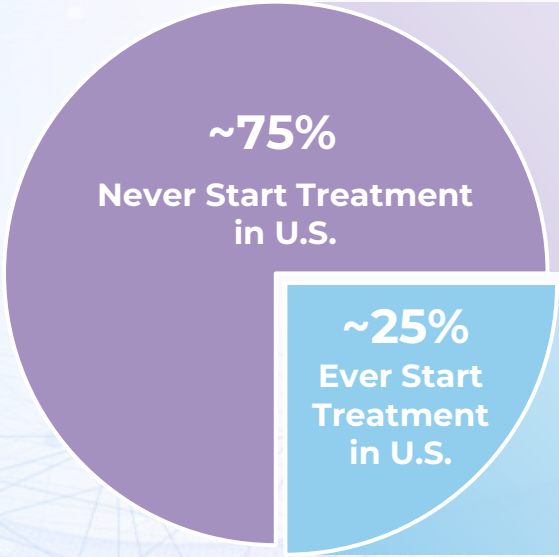
- ✓ **Broad potential to be the new SOC** for IPF patients
- ✓ Estimated total addressable market of **>$10B** by 2033[1]
- ✓ Potential to **capture additional markets** with expansion into non-IPF PF-ILDs
- ✓ **Broad** and **layered IP** protection

PURETECH
GIVING LIFE TO SCIENCE®

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

Deupirfenidone Has the Potential to Be Used Across Multiple Patient Segments

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



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

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

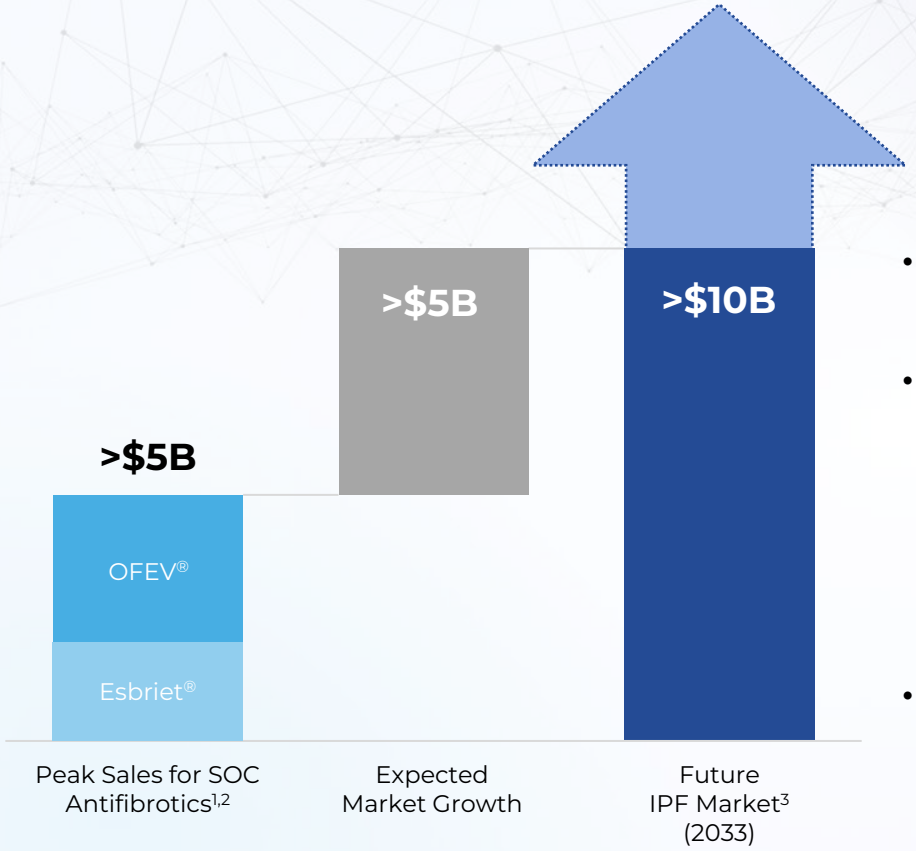
Patients Who Discontinue Treatment
Mean duration of treatment with SOC agents is <1 year; over 40% of patients eventually discontinue treatment[1]

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

PURETECH
GIVING LIFE TO SCIENCE®

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

IPF Market Has the Potential for Substantial Growth



Global IPF Market:

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

PURETECH
GIVING LIFE TO SCIENCE®

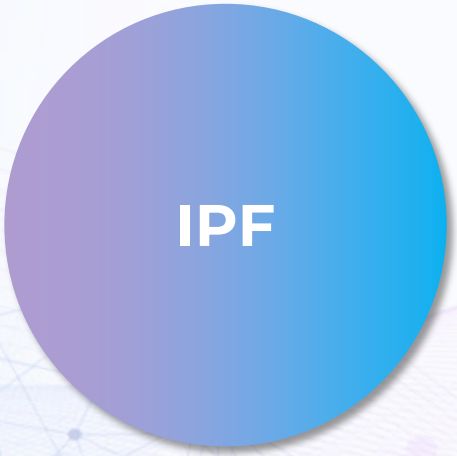
Note: Certain third-party trademarks are included here; PureTech does not claim any rights to any third-party trademarks.. IPF = Idiopathic pulmonary fibrosis; SOC = Standard of care; PF-ILD = Progressive Fibrosing Interstitial Lung Disease. [1] Boehringer Ingelheim 2024 Financial Results. Ofev peak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

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

Progressive pulmonary fibrosis (PPF), also termed progressive fibrotic ILD (PF-ILD), is estimated to affect ~675,000 patients in the US and EU5

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

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



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

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

PURETECH
GIVING LIFE TO SCIENCE®

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

Appendix

Deupirfenidone is Differentiated from Other IPF Programs

	Observations From IPF Trial Failures	Deupirfenidone Differentiation
Idiopathic Nature of Disease	Evaluating a **new mechanism of action** for an idiopathic disease is inherently risky	Deupirfenidone builds on >10 years of **established human efficacy** and safety data for pirfenidone
Short Phase 2 Trial Duration	Many Phase 2 IPF studies are **12-week trials** that may not be predictive of a 52-week trial (treatment duration required for pivotal)	Robust **26-week ELEVATE trial** with deupirfenidone, with additional durable **52-week OLE** data
Small Study Size	Smaller Phase 2 trials may not be representative of Phase 3 population	257 patients in 4 arms; High Dose achieved **statistical significance** vs placebo
Study Quality	**Variability** (e.g., outliers, decentralized FVC) in Phase 2 lead to false assumptions for Phase 3	**No outliers** observed in ELEVATE study. Phase 3 trial will include rigorous QC systems employed in ELEVATE
Lack of Active Control	**IPF studies have not historically used an active control arm**	**First trial to compare an investigational drug to an approved antifibrotic**; pirfenidone and placebo performed as expected, increasing data confidence
Deviation from Phase 2 Design	**Phase 3 studies that deviate from their Phase 2** design (e.g., change in dosing or background SOC use) increase technical risk	**Phase 3 design will recapitulate key aspects of ELEVATE** (e.g., dose)

Examples:

Biogen Galápagos PLIANT HORIZON
Galecto FibroGen Roche / Promedior

PURETECH
GIVING LIFE TO SCIENCE®

PURETECH
GIVING LIFE TO SCIENCE®

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