

Phase 2b REZOLVE-AA 52-Week Topline Results: 16-Week Extension Treatment Period

*Rezpegaldesleukin in Patients with
Severe-to-Very-Severe Alopecia Areata*



Forward-Looking Statements

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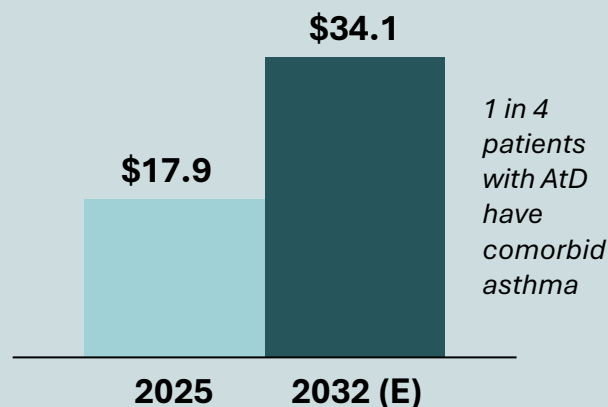
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Rezpegaldesleukin (REZPEG) Phase 2 Program Spans Immune-Mediated Diseases to Evaluate the Causal Biology of Tregs

Atopic Dermatitis (REZOLVE-AD) Inflammatory Skin Disease

- Achieved TPP with data indicating strong clinical efficacy and safety profile with differentiation to IL-13, IL-31, JAKi and OX-40 MoAs^{1,2}
- Only biologic in development to demonstrate positive efficacy data in comorbid asthma³

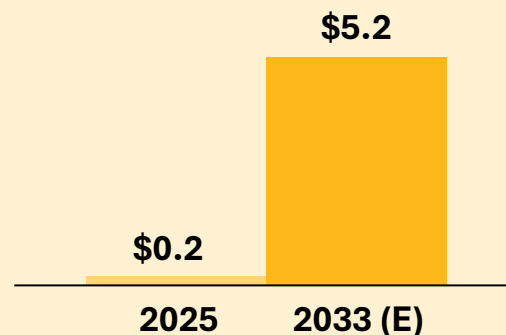
G7 Market Size (\$B)⁴



Alopecia Areata (REZOLVE-AA) Inflammatory Skin Disease

- Achieved TPP with data indicating clinical efficacy similar to low-dose Olumiant® (JAK inhibitor) and a superior differentiated safety profile
- First biologic to demonstrate clear proof-of concept in severe-to-very-severe AA

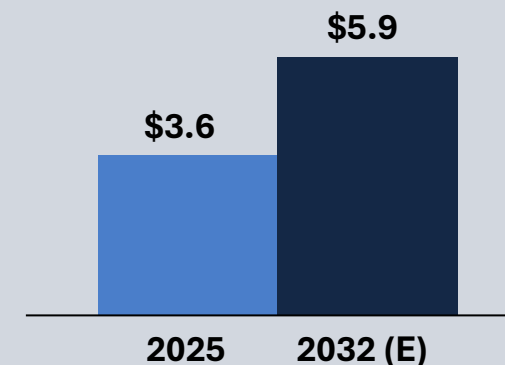
G7 Market Size (\$B)⁵



Type 1 Diabetes (T1D) Metabolic Disease

- Ongoing phase 2 placebo-controlled clinical trial in patients with new onset Stage 3 T1D
- Sponsored and funded by TrialNet (NIH/NIDDK) Type 1 Diabetes Consortium
- Initial data expected in 2027

G7 Market Size (\$B)⁴

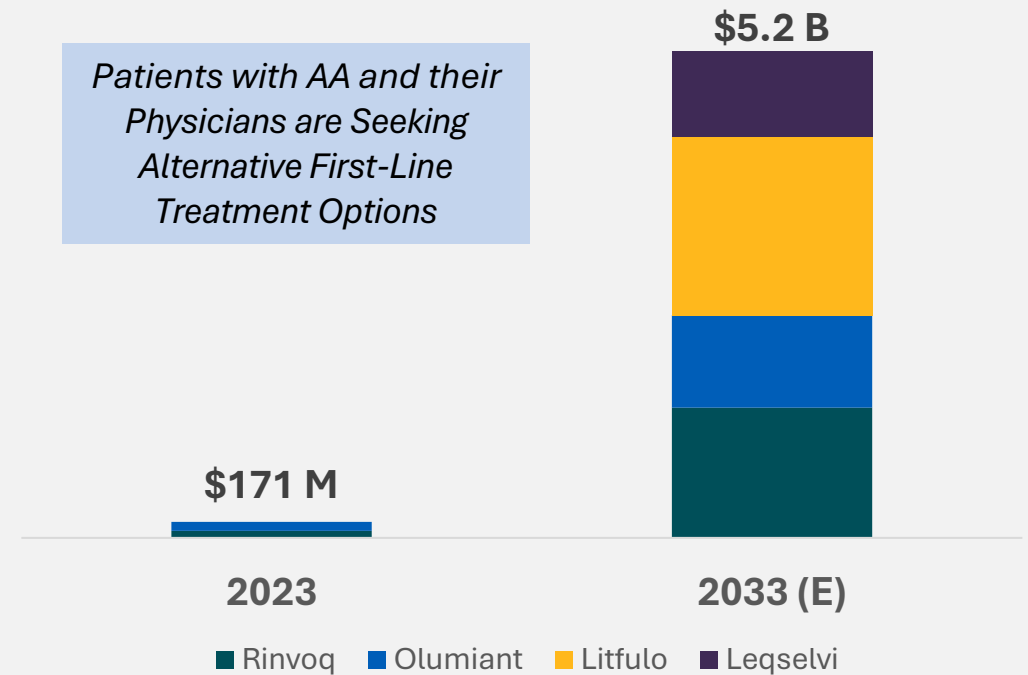


Sources: 1. Silverberg J, et al. Nature Communications (2025); 2. Silverberg J, et al. EADV (2025); 3. Corren J, et al. ACAAI (2025); 4. Evaluate Pharma WW Market Size Estimates; 5. Decision Resources Group
 TPP: Target Product Profile; (E): Estimate; Olumiant® is a registered trademark owned or licensed by Eli Lilly and Company, its subsidiaries, or affiliates.

Opportunity for REZPEG in Alopecia Areata (AA)

- **~160 million people worldwide are affected by alopecia areata (AA)**, including those who currently have it, have had it, or are expected to develop it¹
- In the US, **~6.7 million people will have AA** at some point in their lifetime, with **~700,000 individuals currently living with the condition**¹
- Notably, **80% of patients show signs of AA before 40**¹
- **Many patients are refractory to available therapies**, and long-term use is associated with troublesome side effects and safety risks²
- Currently, the only approved systemic treatments for AA are JAK inhibitors, which **carry multiple boxed warnings** and are also associated with high relapse rates upon discontinuation

Actual and Projected Sales of JAK inhibitors in AA² (WW Sales in USD, 2023 – 2033)



Sources: 1. National Alopecia Areata Foundation; 2. DRG – Unmet Needs of Alopecia Areata (accessed: 4.9.2026)

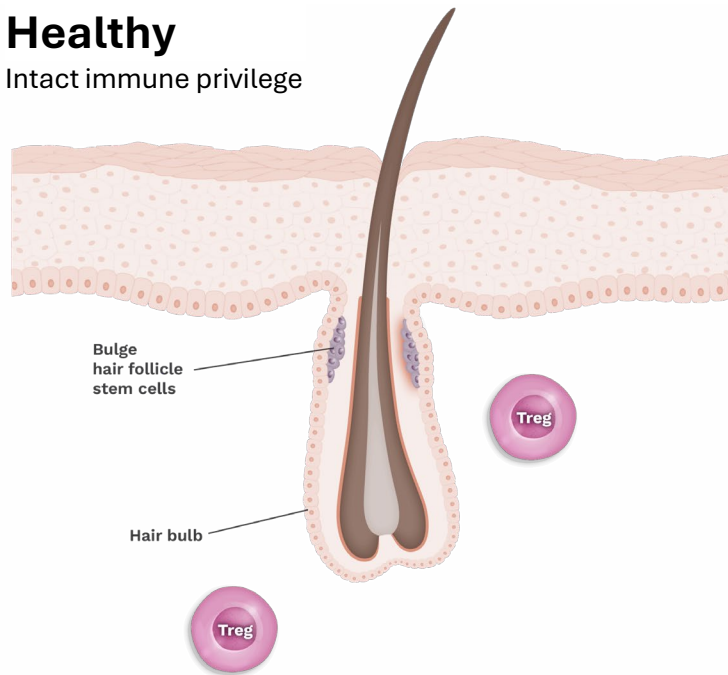
WW: worldwide; (E): Estimate; RINVOQ® (upadacitinib) is a registered trademark of AbbVie Biotechnology Ltd; Olumiant® (baricitinib) is a registered trademark (Registration #5745831) owned by Eli Lilly and Company; LITFULO® (ritlecinib) is a registered trademark owned by Pfizer Inc.; Leqselvi™ (deuruxolitinib) is a registered trademark of Pharmaceutical Industries, Inc.

Collapse of Immune Privilege in Alopecia Areata

Alopecia Areata is a Disease that Occurs When the Immune System Attacks Hair Follicles Causing Hair Loss

Healthy

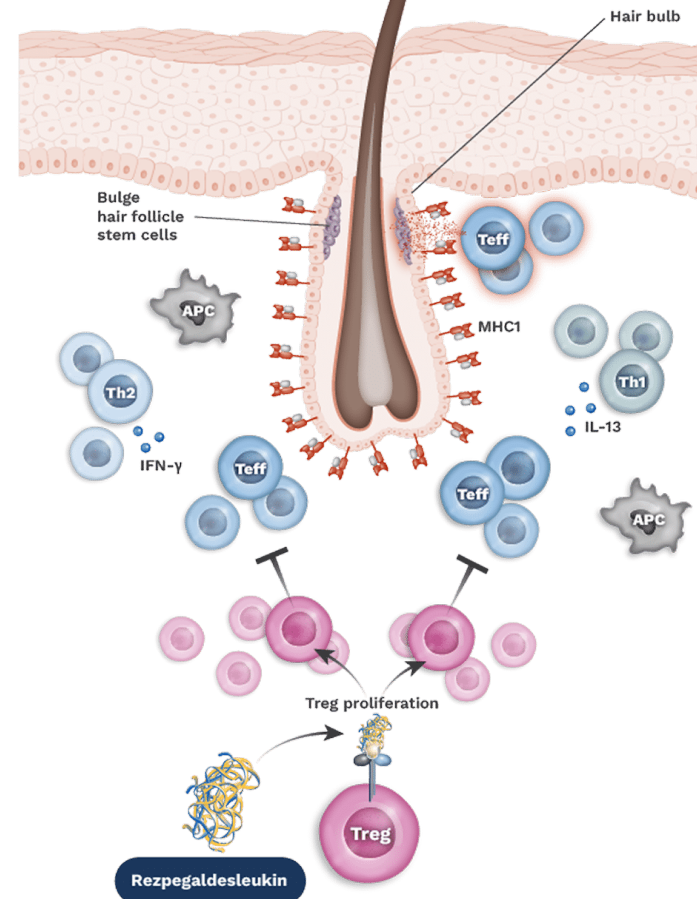
Intact immune privilege



Healthy anagen hair follicles are normally considered immune privileged, meaning they suppress immune responses to protect themselves.

Alopecia Areata

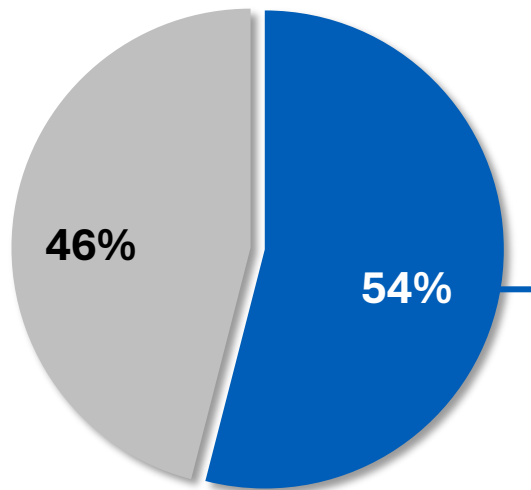
Collapse of immune privilege



Source: Adapted from Paus et al., *Journal of Investigative Dermatology* 2003

Majority of Physicians Report They Would Try Patients on Alternate Therapies for AA Before Prescribing JAK inhibitors

54% of physicians report they would try patients on alternate therapies for AA before prescribing JAKi¹



Challenges with JAKi Class

- **Boxed warnings** for serious infections, mortality, malignancy, major adverse cardiovascular events (MACE), and thrombosis
- Class-related risks such as cytopenias, hepatic enzyme elevations, and lipid changes require **routine safety monitoring**
- **Extensive testing** required prior to initiating therapy and while on therapy to monitor TB, CBC, LFTs, and lipids
- 80% of patients who go off low-dose Olumiant eventually rebound (90% SALT Score \leq 20 responders rebound)²

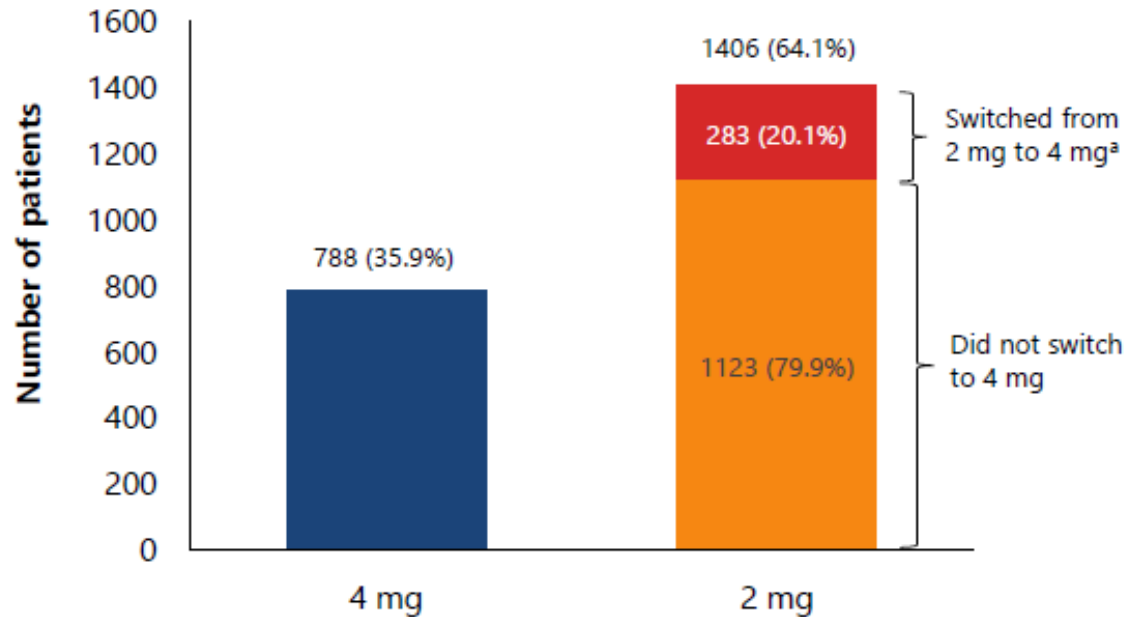
Source: 1. Adapted from Nohria et al., *Journal of the American Academy of Dermatology* 2024; 2. King et al., *JAMA Dermatol.* 2024

Unmet Need for Patients with Alopecia Areata

AAD 2025: Baricitinib Real World Claims Data

“Poor persistence observed among patients treated with baricitinib suggest there is an unmet need for effective treatment for patients with AA”¹

Dose Patterns Among Patients With AA Treated With Baricitinib



Dosage at baricitinib initiation

^aOnly switches from 2 to 4 mg are shown. A total of 775 (98.4%) of the 788 patients who initiated on baricitinib 4 mg remained on 4 mg during treatment; 13 (1.6%) patients who initiated on baricitinib 4 mg had a claim during the follow-up period for baricitinib 2 mg.

	Initiated on baricitinib 4 mg ^a n = 788	Initiated on baricitinib 2 mg n = 1406	Initiated on baricitinib 2 mg, did not switch to 4 mg n = 1123
TTD using Kaplan-Meier analysis ^{b,c} (months), median (IQR)	5.3 (2.1, 10.9)	5.0 (2.0, 11.8)	3.7 (1.2, 8.7)

^aA total of 775 (98.4%) of the 788 patients who initiated on baricitinib 4 mg remained on 4 mg during treatment; 13 (1.6%) of the patients who initiated on baricitinib 4 mg had a claim during the follow-up period for baricitinib 2 mg.

^bThe discontinuation date was defined as the date of the last claim (or last claim before a large gap) + days supply + 1. Patients who did not discontinue treatment were censored at the end of clinical activity.

^cDiscontinuation was defined as twice the amount of typical days of supply following each claim date, determined by the most frequent days supply. Specifically, 97.0% of baricitinib claims had a supply of 30 days.

Source: 1. Mostaghimi et al., AAD 2025

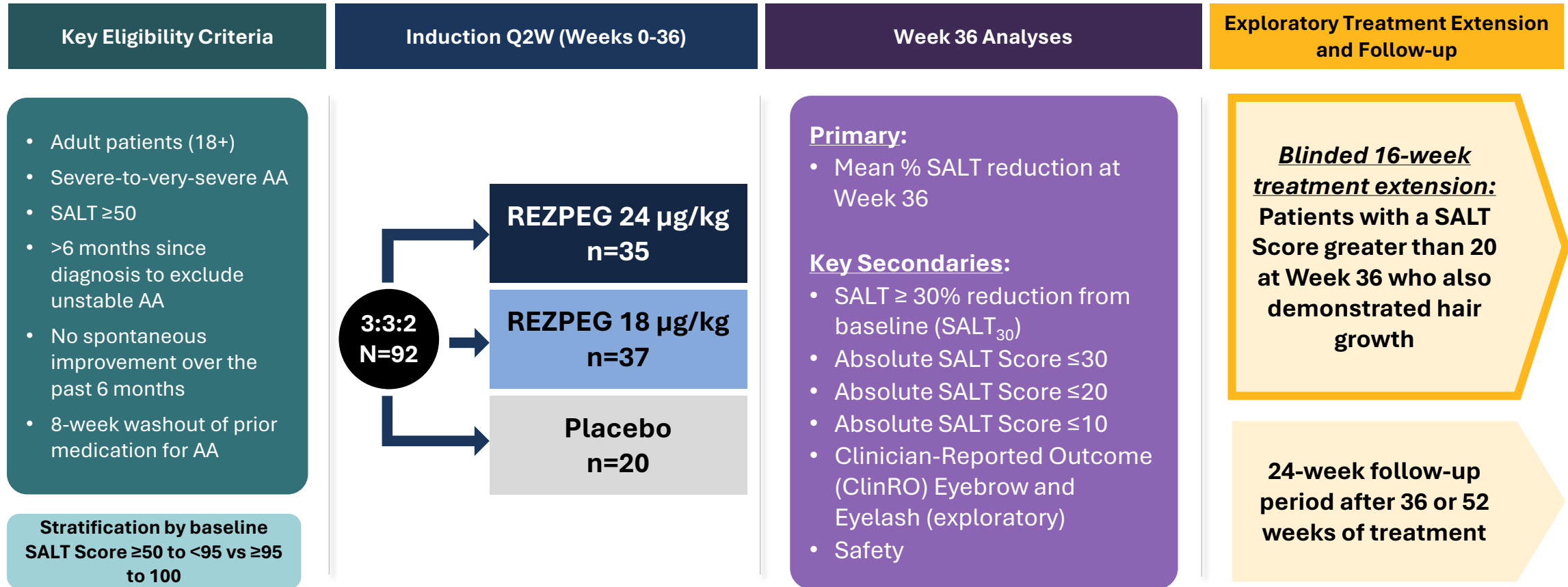
An Efficacious and Safe Biologic with Novel MoA Could Redefine First-line Systemic Therapy in Alopecia Areata

We believe there is a strong need for a non-JAKi based Sub-Q biologic to treat patients with AA, which could provide:

- **Better suitability for chronic use:** Circumvents JAKi class safety issues, including boxed warnings, that limit JAKi use in AA
- **Easier adherence:** Infrequent twice-monthly dosing of a biologic may be advantageous over oral daily dosing for long-term treatment
- **Extended biologic pharmacodynamic effect:** Opportunity for more durable and stable efficacy even in the setting of non-compliance
- **No need for lab monitoring:** Simplifies prescribing in dermatology clinics, which are not optimized for chronic lab management
- **Payer-friendly profile:** Fewer restrictions and risk-based exclusions; more straightforward access and broader eligibility

Phase 2b REZOLVE-AA Study Evaluating REZPEG for Alopecia Areata

Severe-to-Very-Severe Alopecia Areata (NCT06340360) - Granted Fast Track Designation in July 2025



Severity of Alopecia Tool (SALT) is a validated endpoint to assess the extent of scalp-hair loss in patients with alopecia areata

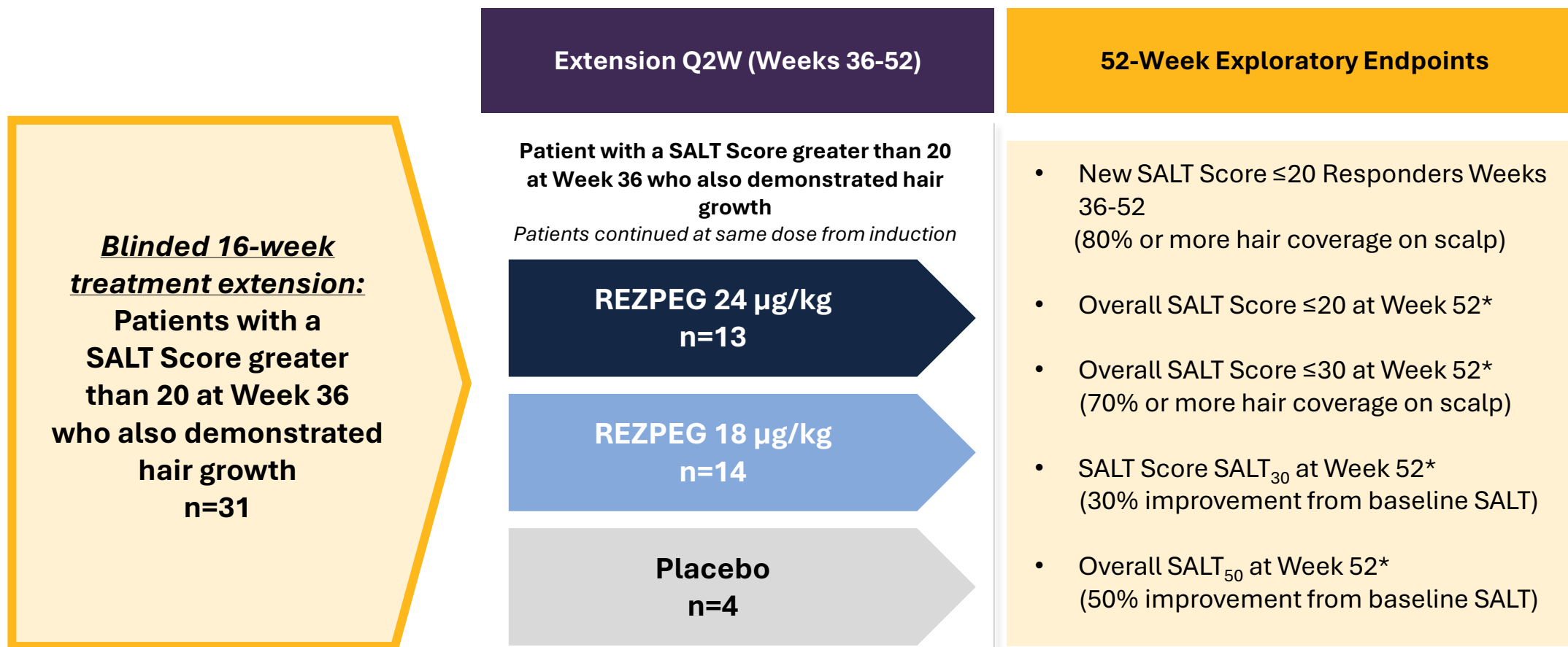
Goals of 16-week Treatment Extension in REZOLVE-AA

- Assess if additional dosing beyond 36 weeks enables more patients to achieve SALT Score ≤ 20
 - SALT Score ≤ 20 is the registrational endpoint for Phase 3 in alopecia areata
- REZOLVE-AA allowed 31 patients with a SALT Score >20 at week 36 to continue treatment for an additional 16 weeks (if they demonstrated hair growth)*
- Allow for evaluation of safety for twice-monthly dosing over 52 weeks
- Establish whether a 36-week or 52-week treatment induction should be used for Phase 3

**Patients who achieved SALT Score ≤ 20 at week 36 were not eligible to enter treatment extension; one placebo patient with a SALT Score ≤ 20 at week 36 entered into extension based on investigator's request, which was granted as an exception*

Blinded 16-Week Exploratory Treatment Extension for REZOLVE-AA

A Total of 31 Patients Entered into Treatment Extension



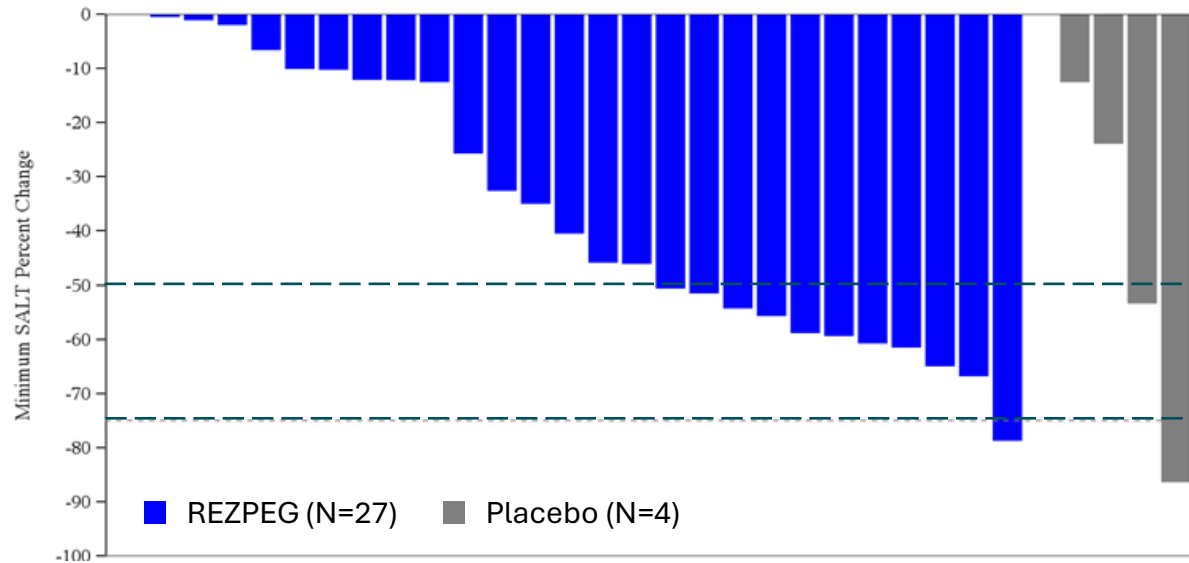
*Modified intent-to-treat adapted (mITT^A): excludes 4 patients with major study eligibility violations (post-hoc); No patient with study eligibility violations entered into the 16-week treatment extension

REZPEG-Treated Patients in Extension Achieved Deepening of Response

Best Percent Improvement in SALT Score from Baseline While on Study Treatment

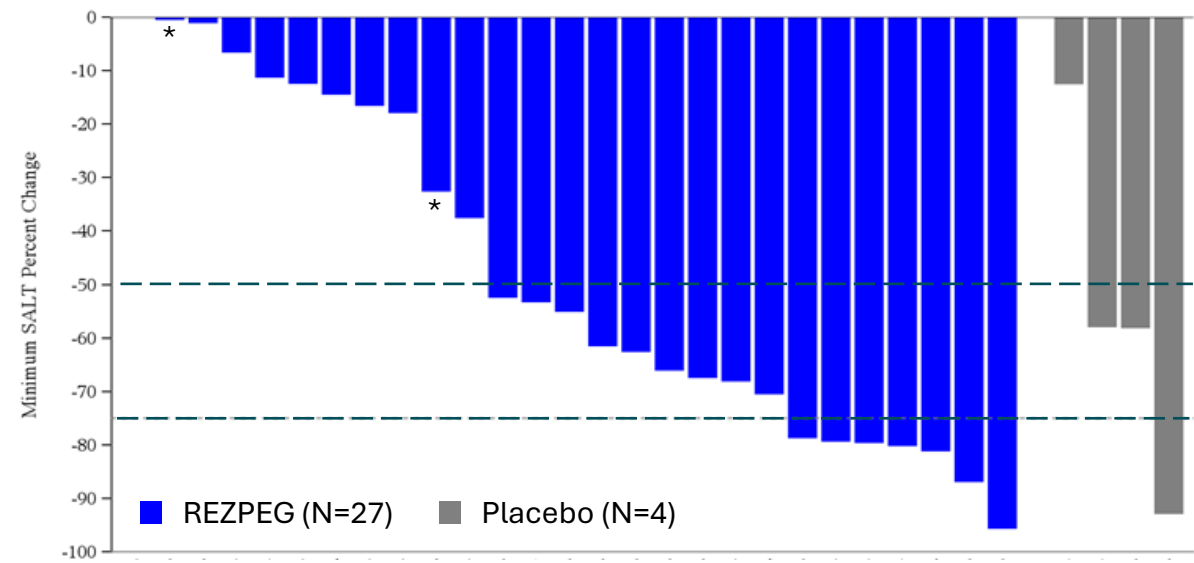
94% of patients in extension completed treatment to week 52

Extension Patients
36-week Induction (N=31)



4% (1/27) achieved $\geq 75\%$ reduction from baseline SALT

Extension Patients
52-week Treatment (N=31)

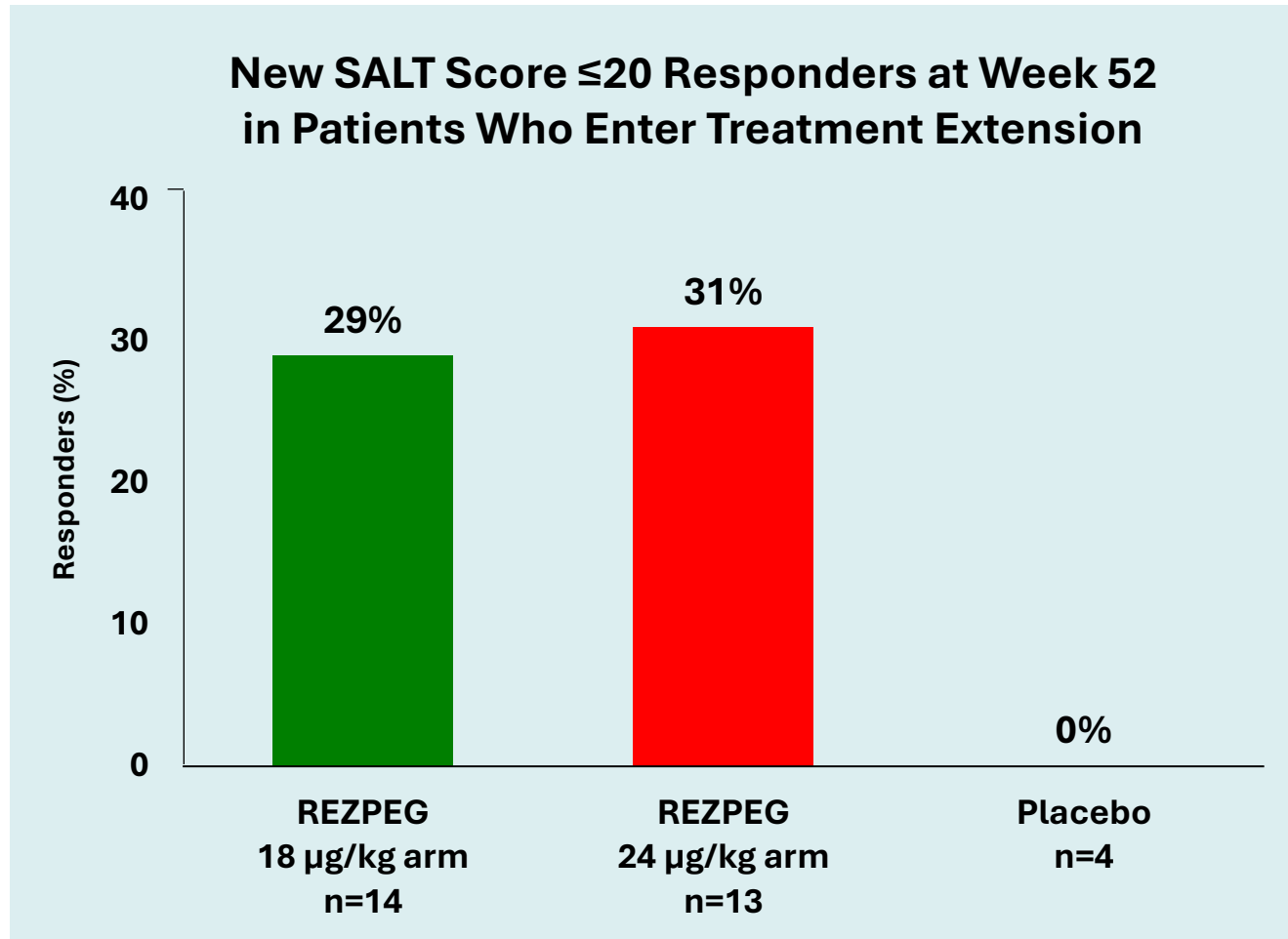


26% (7/27) achieved $\geq 75\%$ reduction from baseline SALT

*Discontinued prior to week 52 due to patient decision; one placebo patient with a SALT Score ≤ 20 at week 36 entered into extension based on investigator's request, which was granted as an exception

Conversions to SALT Score ≤ 20 with Additional 16 Weeks of Treatment

A Total of 31 Patients Entered into Treatment Extension



- There were 8 new SALT Score ≤ 20 responses in 27 patients treated with REZPEG
- There were no new SALT Score ≤ 20 responses in placebo
- Data strongly support a 52-week dosing induction in Phase 3

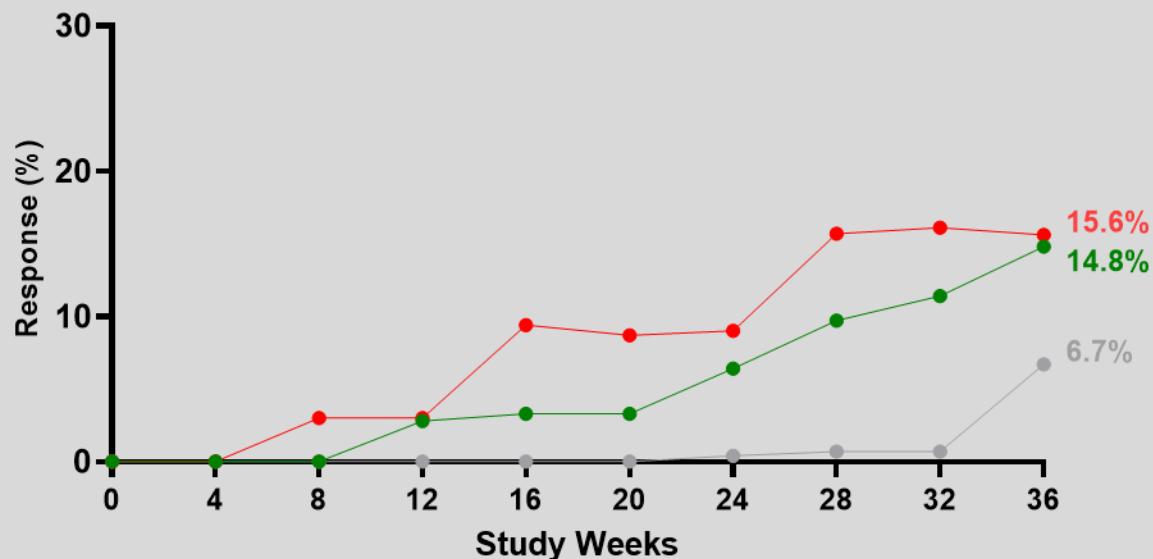
Analysis by multiple imputation (slide 31); two patients discontinued prior to week 52 due to patient decision

More Patients Treated with REZPEG Achieved SALT Score ≤ 20 at Week 52

Overall SALT Score ≤ 20 (80% or more hair coverage on scalp)

36-week Treatment Data

SALT Score ≤ 20 at Week 36 (mITT^A)



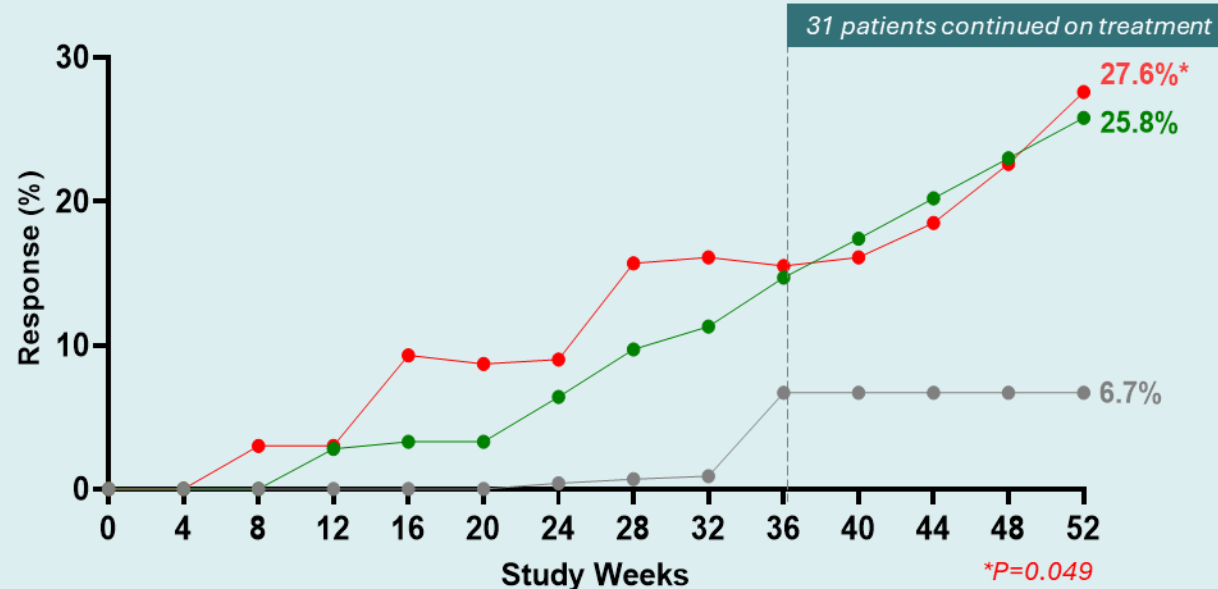
- REZPEG 24 µg/kg, Q2W (N=33)
- REZPEG 18 µg/kg, Q2W (N=36)
- Placebo (N=19)

mITT^A: excludes 4 patients with major study eligibility violations (post-hoc)

Rosmarin et al., AAD 2026

52-week Treatment Data

SALT Score ≤ 20 at Week 52 (mITT^A)



- REZPEG 24 µg/kg, Q2W (N=33)
- REZPEG 18 µg/kg, Q2W (N=36)
- Placebo (N=19)

*P=0.049

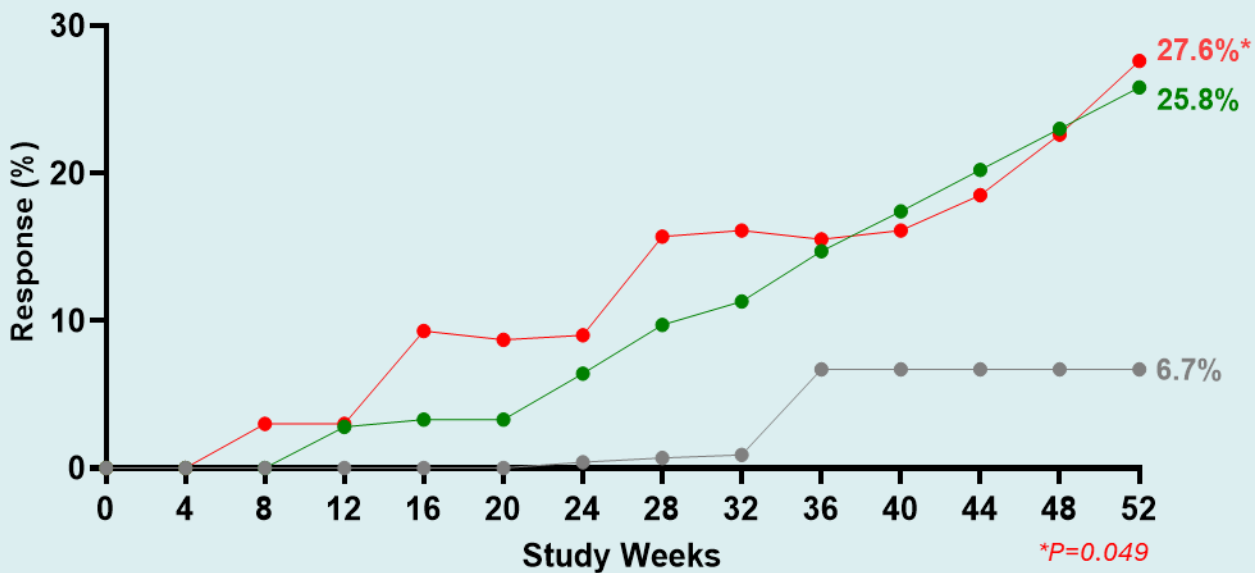
31 patients continued on treatment

Data for mITT^A analysis set are imputed from week 0 to week 36 following primary estimand. Data for patients in non-treatment extension set in week 40, 44, 48 and 52 are carried forward from week 36 data. Missing data for patients in treatment extension set for week 40, 44, 48 and 52 are imputed using the multiple imputation method.

REZPEG Met Our Target Product Profile

52-week Treatment Data

SALT Score ≤ 20
REZPEG in AA (mITT^A)



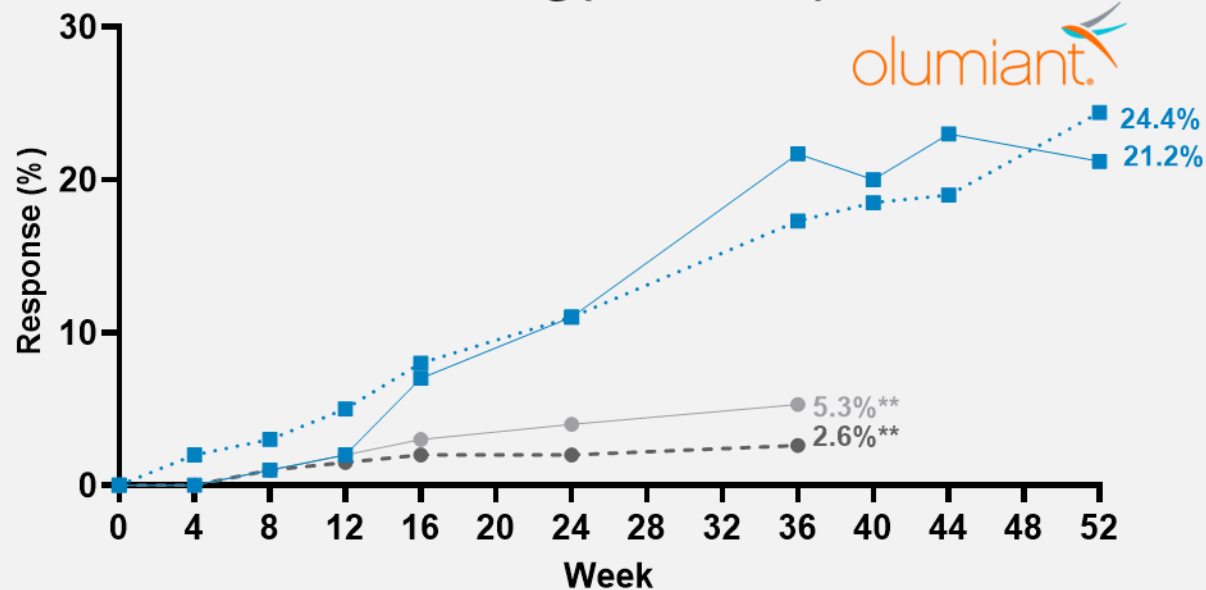
- REZPEG 24 µg/kg, Q2W (N=33)
- REZPEG 18 µg/kg, Q2W (N=36)
- Placebo (N=19)

mITT^A: excludes 4 patients with major study eligibility violations (post-hoc)

*P=0.049

Olumiant® Reference

SALT Score ≤ 20
Baricitinib 2mg (Low-Dose) in AA



- AA1: Baricitinib 2 mg, QD (N=184)
- AA2: Baricitinib 2 mg, QD (N=156)
- AA1: Placebo (N=189)
- AA2: Placebo (N=156)

Results from P3 BRAVE-AA-1/
BRAVE-AA-2 Studies

Redrawn from Figure 1
Kwon et al., American Journal of
Clinical Dermatology 2023

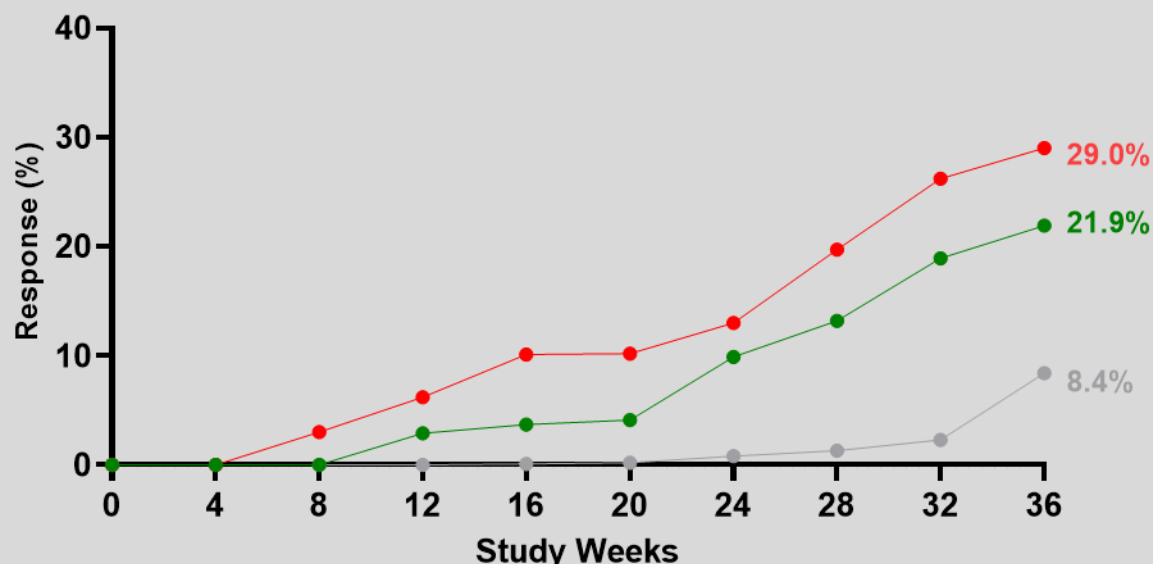
Olumiant® is a registered trademark owned or licensed by Eli Lilly and Company, its subsidiaries, or affiliates. **Placebo data based on Figure S9 from King et al., NEJM 2022

More Patients Treated with REZPEG Achieved SALT Score ≤ 30 at Week 52

SALT Score ≤ 30 (70% or more hair coverage on scalp)

36-week Treatment Data

SALT Score ≤ 30 at Week 36 (mITT^A)



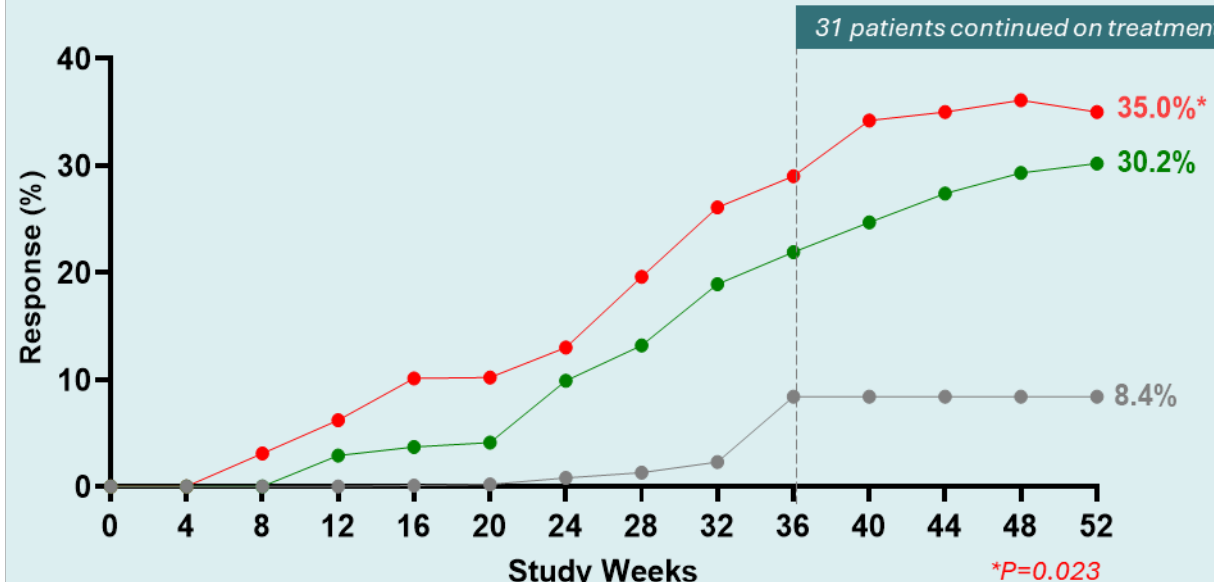
- REZPEG 24 µg/kg, Q2W (N=33)
- REZPEG 18 µg/kg, Q2W (N=36)
- Placebo (N=19)

mITT^A: excludes 4 patients with major study eligibility violations (post-hoc)

Rosmarin et al., AAD 2026

52-week Treatment Data

SALT Score ≤ 30 at Week 52 (mITT^A)



- REZPEG 24 µg/kg, Q2W (N=33)
- REZPEG 18 µg/kg, Q2W (N=36)
- Placebo (N=19)

Olumiant NA at Week 52

*P=0.023

31 patients continued on treatment

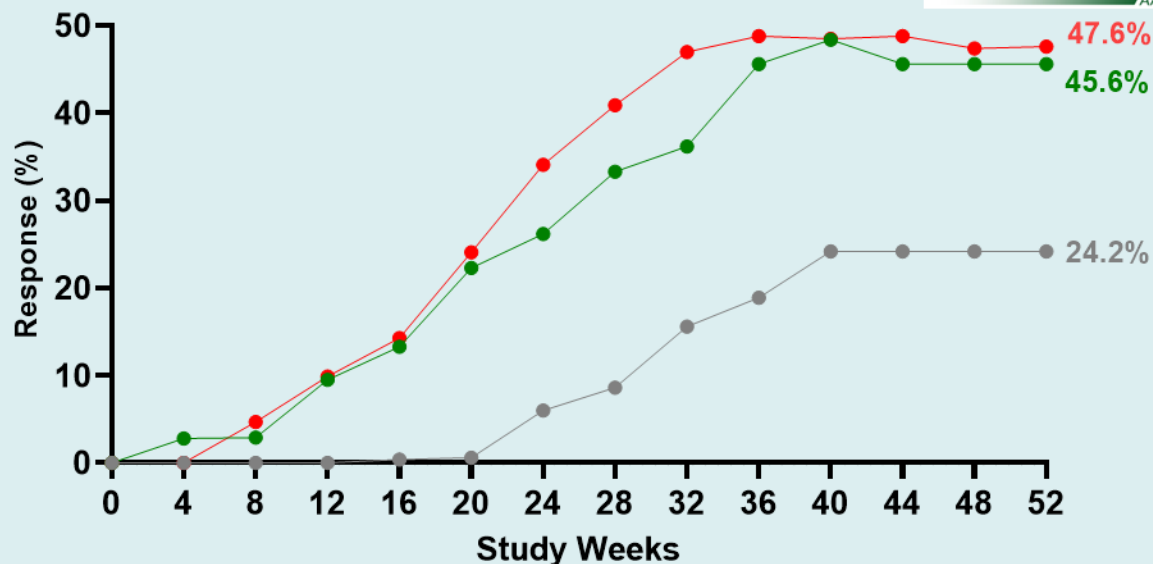
Data for mITT^A analysis set are imputed from week 0 to week 36 following primary estimand. Data for patients in non-treatment extension set in week 40, 44, 48 and 52 are carried forward from week 36 data. Missing data for patients in treatment extension set for week 40, 44, 48 and 52 are imputed using the multiple imputation method.

Promising Data for a Biologic in AA

SALT₃₀ (At Least 30 Percent Improvement from Baseline in SALT)

52-week Treatment Data

SALT₃₀ REZPEG Twice-Monthly Phase 2 Study in AA (mITT^A)

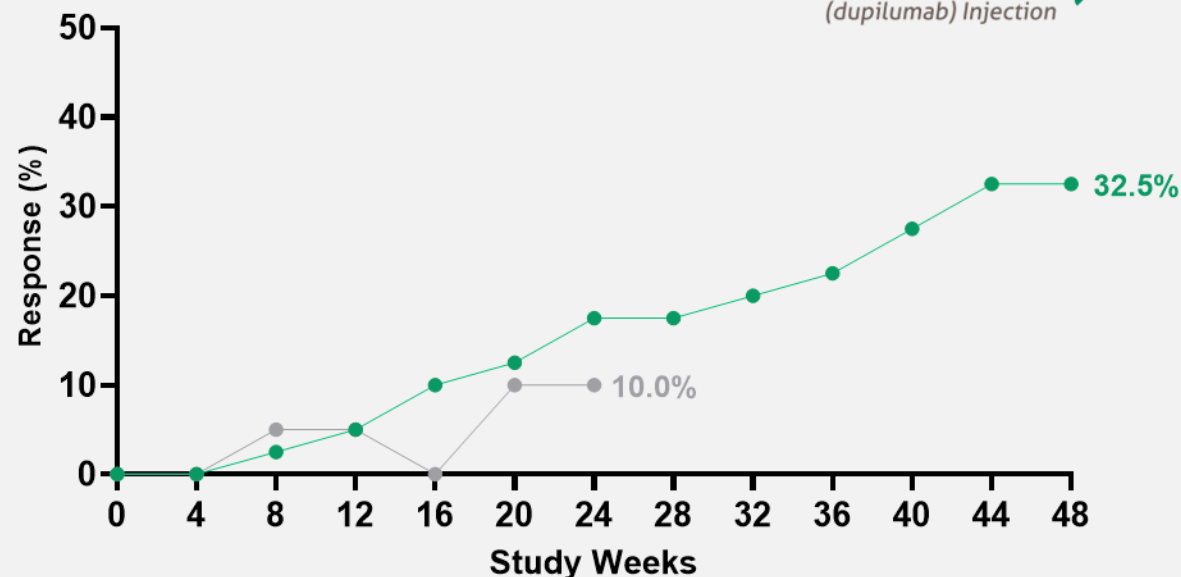


- REZPEG 24 µg/kg, Q2W (N=33)
- REZPEG 18 µg/kg, Q2W (N=36)
- Placebo (N=19)

mITT^A: excludes 4 patients with major study eligibility violations (post-hoc)

Dupixent® Reference

SALT₃₀ Dupixent® Once-Weekly Phase 2 Study in AA



- Dupilumab 300 mg, QW (N=40)*
- Placebo (N=20)**

Single site Phase 2 IST study
Adapted from Guttman et al.,
Allergy 2022

DUPIXENT is a registered trademarks of Sanofi or an affiliate. Study went to 48 weeks of treatment with SALT₅₀ at 22.5%; *Two 300 mg doses administered on cycle one as a loading dose; **Placebo patients not available past week 24

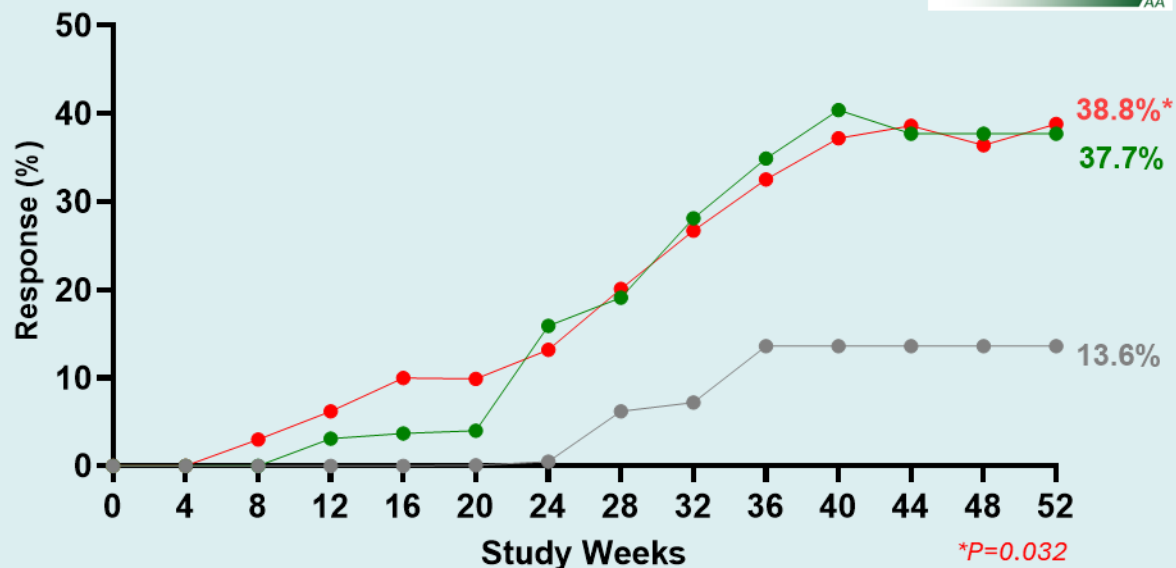
US DELPHI Consensus Guidelines “In patients with active atopy or history of atopic dermatitis, dupilumab may be considered as a long-term AA treatment” (Dec’25)

Promising Data for a Biologic in AA

SALT₅₀ (At Least 50 Percent Improvement from Baseline in SALT)

52-week Treatment Data

SALT₅₀ REZPEG Twice-Monthly Phase 2 Study in AA (mITT^A)



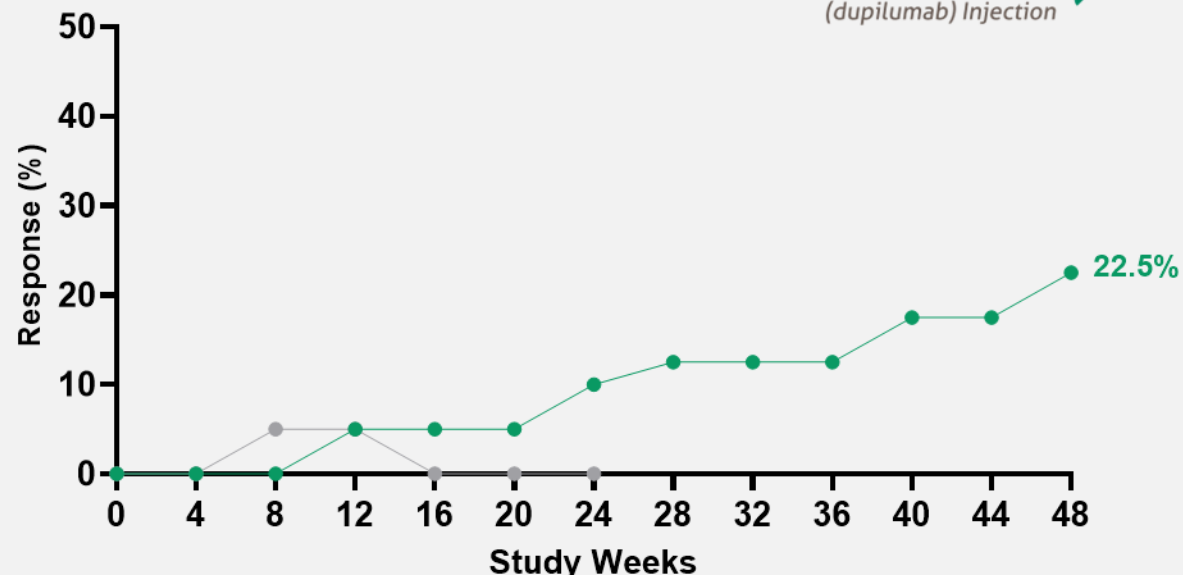
- REZPEG 24 µg/kg, Q2W (N=33)
- REZPEG 18 µg/kg, Q2W (N=36)
- Placebo (N=19)

mITT^A: excludes 4 patients with major study eligibility violations (post-hoc)

*P=0.032

Dupixent[®] Reference

SALT₅₀ Dupixent[®] Once-Weekly Phase 2 Study in AA



- Dupilumab 300 mg, QW (N=40)*
- Placebo (N=20)**

Single site Phase 2 IST study
Adapted from Guttman et al.,
Allergy 2022

DUPIXENT is a registered trademarks of Sanofi or an affiliate. Study went to 48 weeks of treatment with SALT₅₀ at 22.5%; *Two 300 mg doses administered on cycle one as a loading dose; **Placebo patients not available past week 24

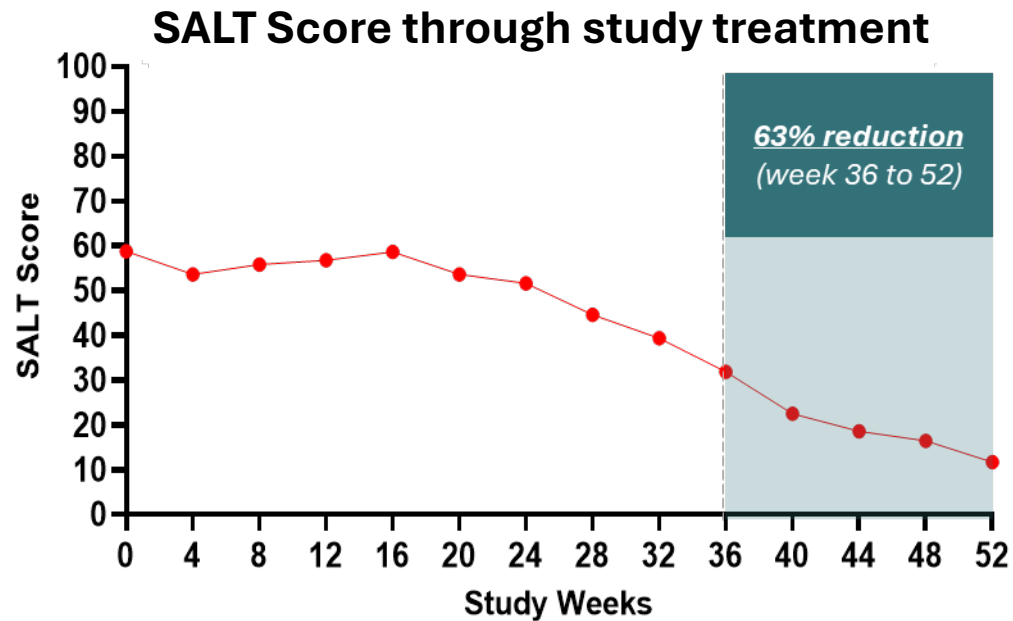
US DELPHI Consensus Guidelines “In patients with active atopy or history of atopic dermatitis, dupilumab may be considered as a long-term AA treatment” (Dec’25)

REZOLVE-AA: Safety Profile in Alopecia Areata at 52 Weeks Consistent With Previously Reported Studies

- ❑ No new safety findings observed with longer Q2W dosing out to 52 weeks
- ❑ Nearly all AEs were mild to moderate in severity and self-resolved
- ❑ No patients discontinued during 16-week extension due to an adverse event
 - Discontinuation rate due to AEs over 52 weeks of treatment was low (1.4%) for all REZPEG-exposed patients
- ❑ No patients discontinued treatment due to an ISR over 52 weeks of treatment
 - Lower frequency of ISRs observed over longer dosing duration in extension
 - Majority of ISRs were mild to moderate (erythema) and self-resolved within 5 days
- ❑ No observed increased risk or safety signal for: oral herpes, conjunctivitis, facial swelling or erythema, oral (aphthous) ulcers, myocardial infarction, pulmonary embolus, deep venous thrombosis and malignancy
- ❑ No AEs observed that could require JAKi-like laboratory testing and monitoring

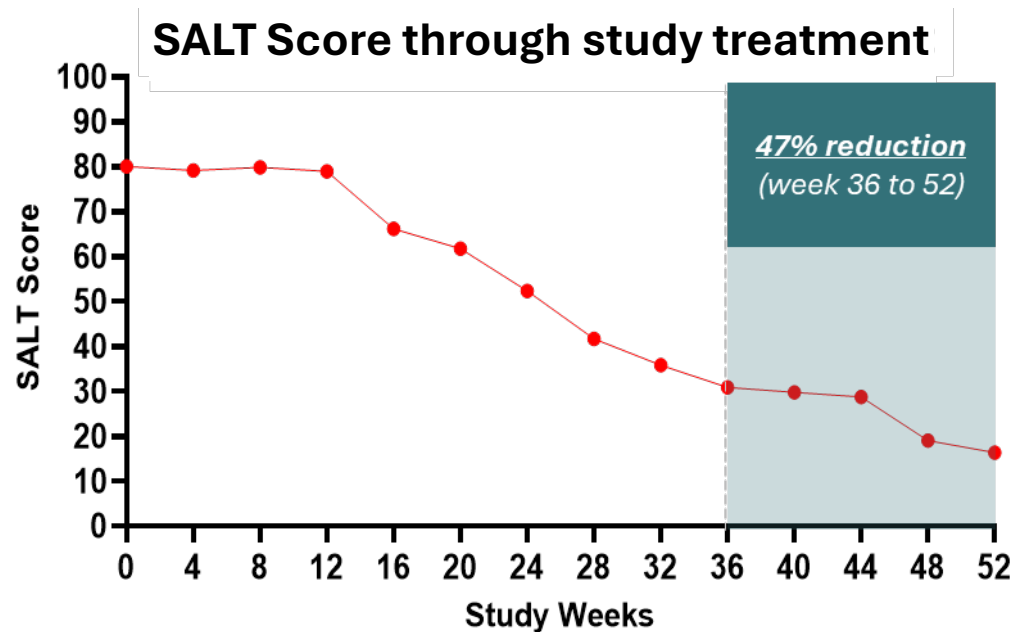
Case Study #1: Patient Achieved SALT Score ≤ 20 by Week 44

- 40-year-old white male
- Diagnosis 8 months prior to treatment
- 52 weeks of 24 $\mu\text{g}/\text{kg}$ REZPEG treatment



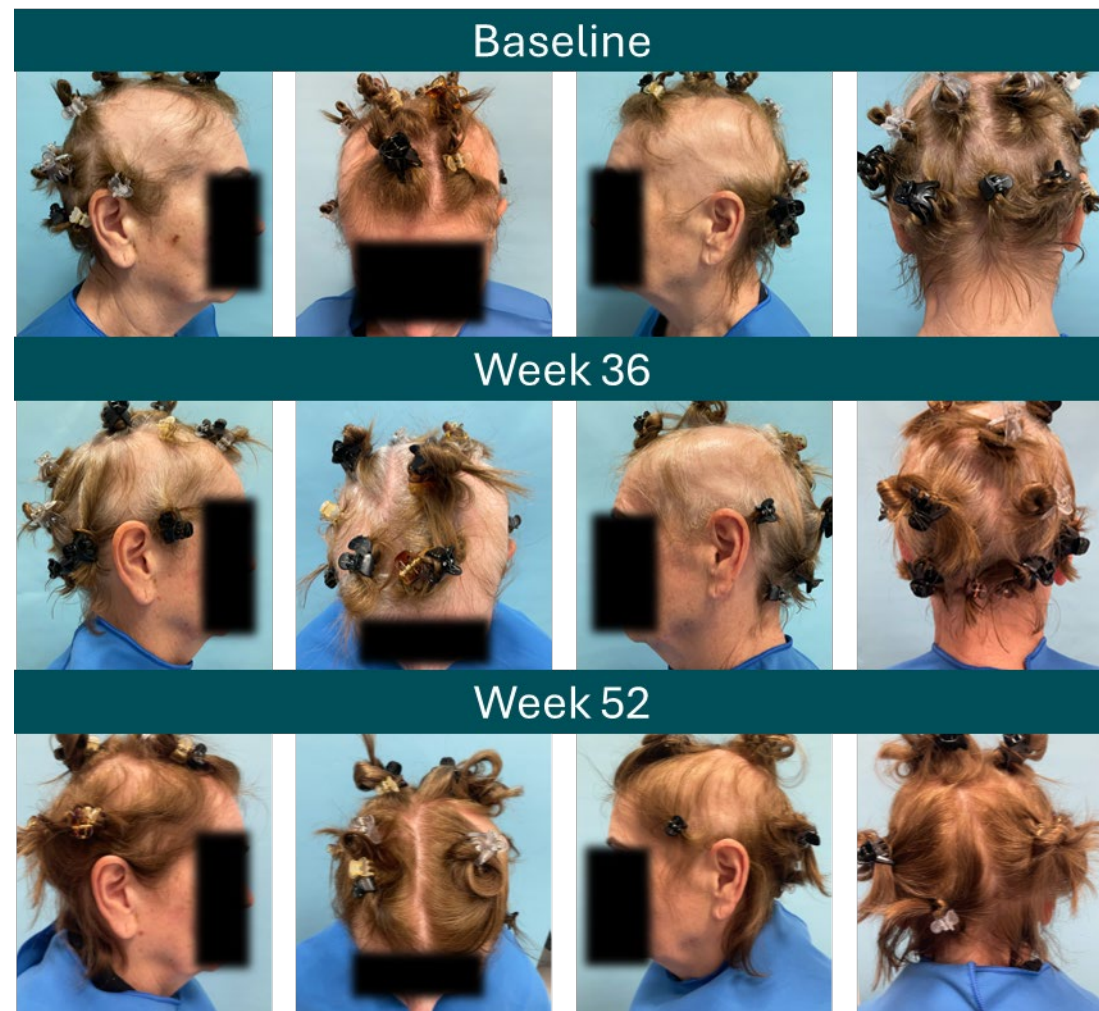
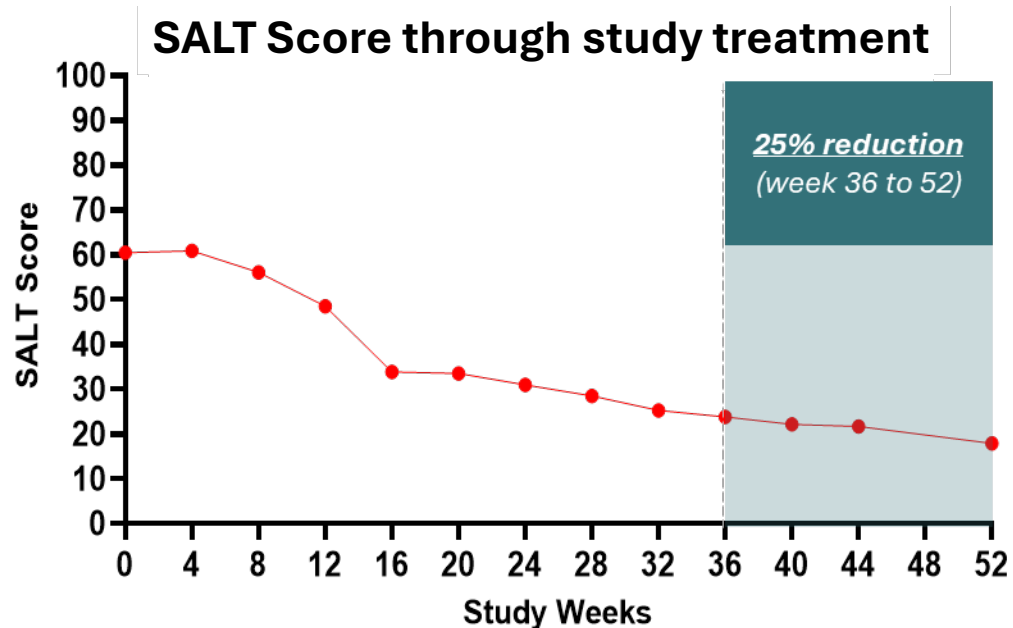
Case Study #2: Patient Achieved SALT Score ≤ 20 by Week 48

- 20-year-old white female
- Diagnosed 6 years prior to treatment
- 52 weeks of 24 $\mu\text{g}/\text{kg}$ REZPEG treatment



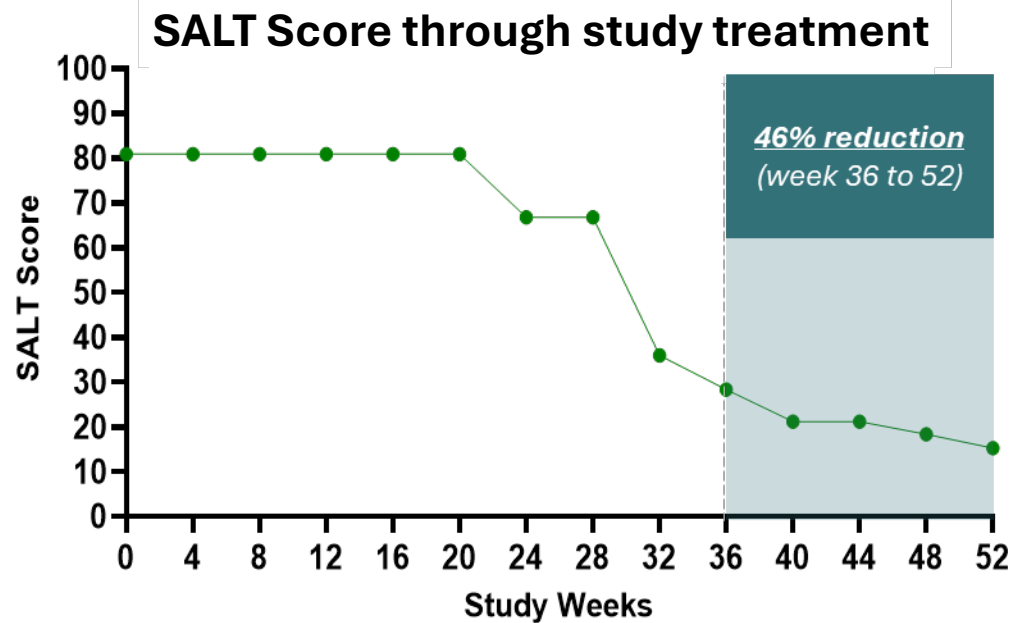
Case Study #3: Patient Achieved SALT Score ≤ 20 by Week 52

- 64-year-old white female
- Diagnosed 13 years prior to treatment
- 52 weeks of 24 $\mu\text{g}/\text{kg}$ REZPEG treatment



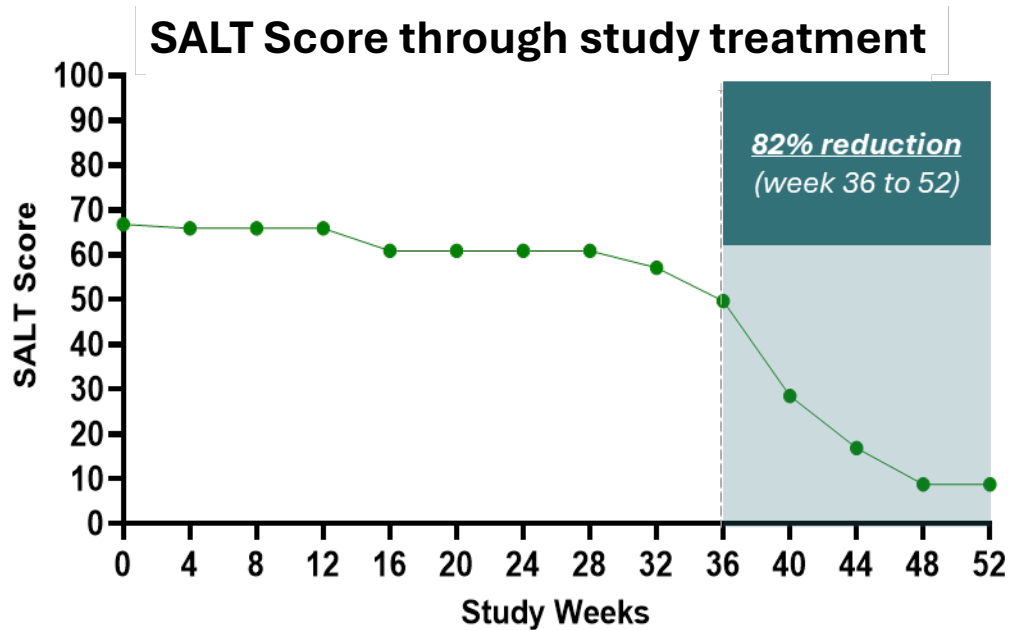
Case Study #4: Patient Achieved SALT Score ≤ 20 by Week 48

- 50-year-old white female
- Diagnosed 2.1 years prior to treatment
- 52 weeks of 18 $\mu\text{g}/\text{kg}$ REZPEG treatment




Case Study #5: Patient Achieved SALT Score ≤ 20 by Week 44

- 64-year-old white female
- Diagnosed 10 months prior to treatment
- 52 weeks of 18 $\mu\text{g}/\text{kg}$ REZPEG treatment



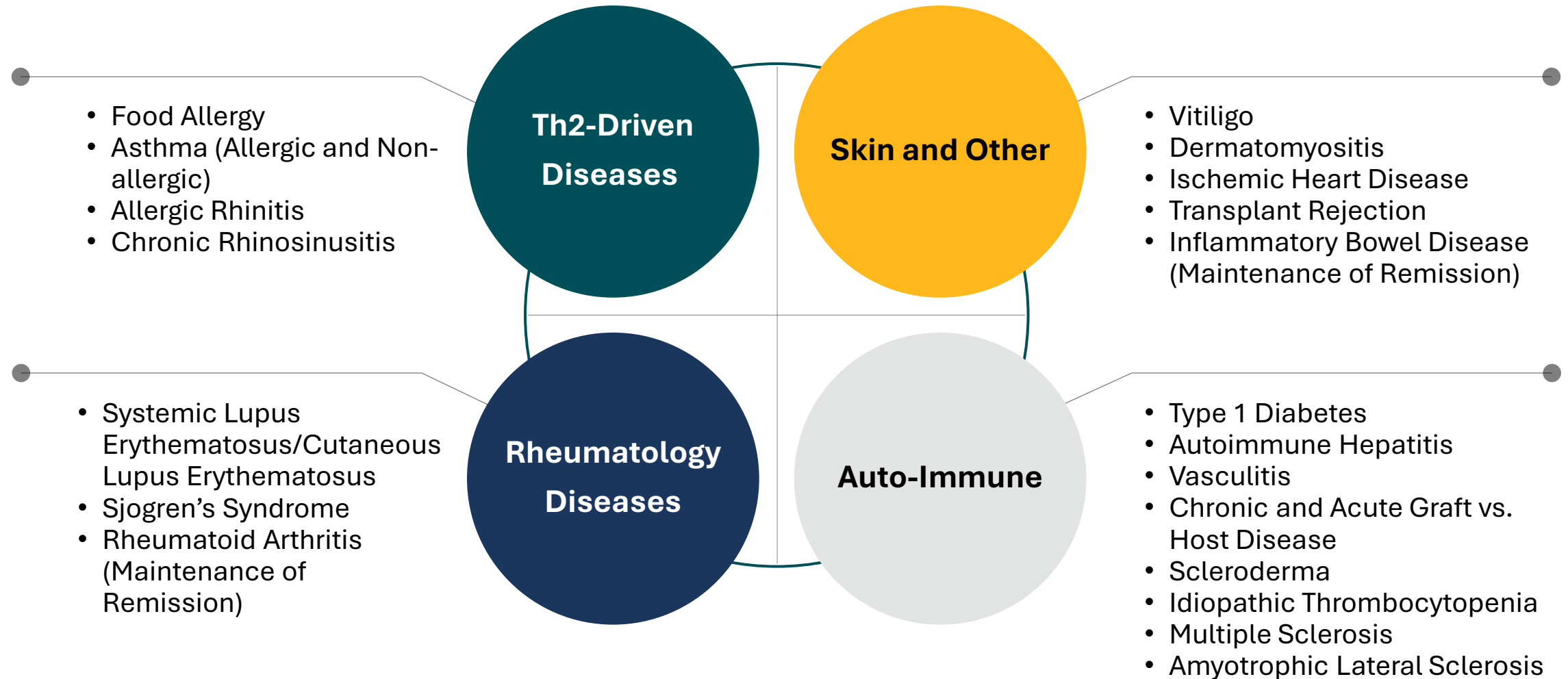
Key Questions Answered With Clinical Study Design Elements of the Phase 2b REZOLVE-AA Program

	Key Questions	Findings
<p style="text-align: center;">Phase 2 REZOLVE-AA Study</p>  <p style="text-align: center;">Represents first study to evaluate whether REZPEG has favorable clinical activity and safety profile in patients with severe-to-very-severe AA</p>	<p>Can a Treg biologic drug with infrequent dosing offer meaningful clinical benefit and a robust safety profile compared to available therapies?</p>	<ul style="list-style-type: none"> • Sub-Q Q2W dosing of REZPEG demonstrates clear and consistent separation from placebo on all measures of efficacy • Safety profile consistent with prior studies and highly differentiated from previously reported data on JAKi
	<p>What are the kinetics of hair regrowth with a Treg mechanism at 36 weeks? At 52 weeks?</p>	<ul style="list-style-type: none"> • Most profound increase in hair regrowth begins after week 16 and continues beyond the 36-week induction • Phase 3 induction endpoint planned to be at 52 weeks
	<p>What is the optimal dose for Phase 3?</p>	<ul style="list-style-type: none"> • Phase 3 dose established at 24 µg/kg Q2W
	<p>Should a 52-week induction be used in Phase 3 in order to achieve the SALT Score ≤20 registrational endpoint?</p>	<ul style="list-style-type: none"> • Data support 52-week induction for Phase 3 SALT Score ≤20 registrational endpoint

Anticipated Next Steps in Alopecia Areata and for REZPEG

Alopecia Areata	<ul style="list-style-type: none">• Conduct End of Phase 2 meeting with FDA in Q2 2026 to align on Phase 3 registrational strategy• Additional data readout from REZOLVE-AA Study: 24-week off treatment data in Q4 2026
Atopic Dermatitis	<ul style="list-style-type: none">• Initiation of ZENITH-AD Phase 3 program in patients with moderate-to-severe atopic dermatitis in June/July 2026• Additional data readout from REZOLVE-AD Study: 52-week off treatment data in Q1 2027
Type 1 Diabetes	<ul style="list-style-type: none">• Initial data in Type 1 diabetes in 2027
Other Indications	<ul style="list-style-type: none">• Initiation of proof-of-concept study for a potential new indication for REZPEG in 2H 2026

Expanding Potential Opportunities for REZPEG (Treg MOA Activity)



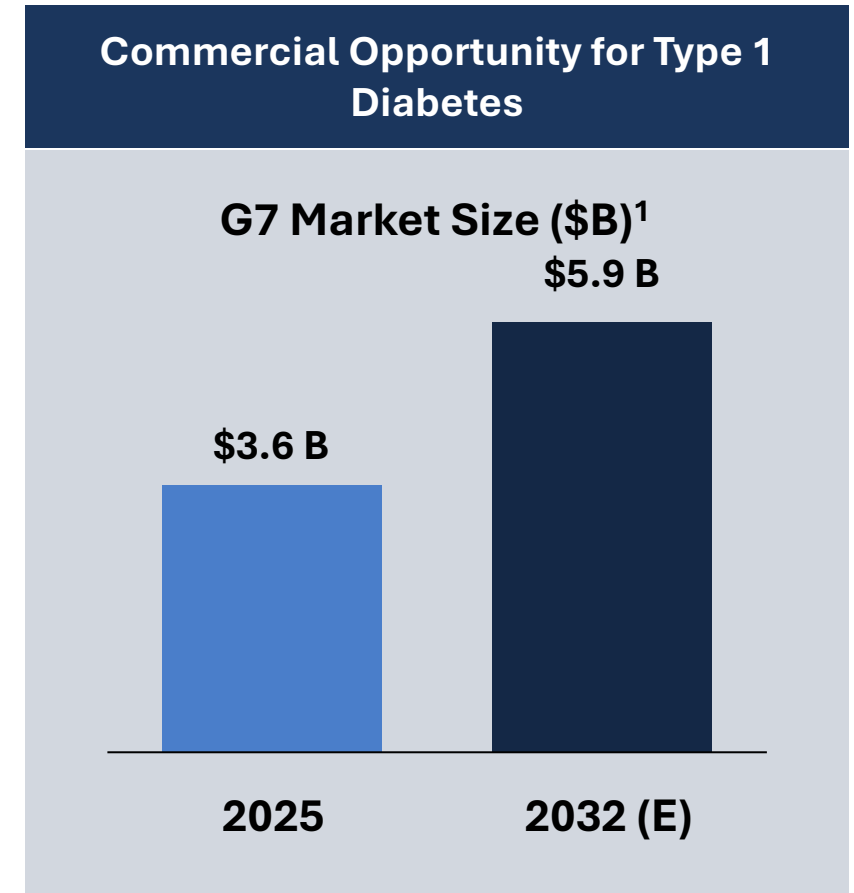
Ongoing Phase 2 Study Sponsored and Funded by TrialNet (NIH/NIDDK) Type 1 Diabetes Consortium

About the Study:

- Ongoing phase 2 placebo-controlled clinical trial in approximately 66 adults and children with new onset stage 3 T1D
- Evaluating REZPEG's Treg MoA for preservation of beta cell function in Stage 3 New Onset T1D
- Initial data expected in 2027

Scientific Rationale

- ✓ In T1D, the destruction of insulin-producing pancreatic beta cells is caused by T cells of the immune system
- ✓ Regulatory T cells (Tregs) act upstream of these T cell and pro-inflammatory cytokines to reduce their activity; by increasing the number and functionality of regulatory T cells, this investigational therapy aims to slow the progression of new onset T1D.

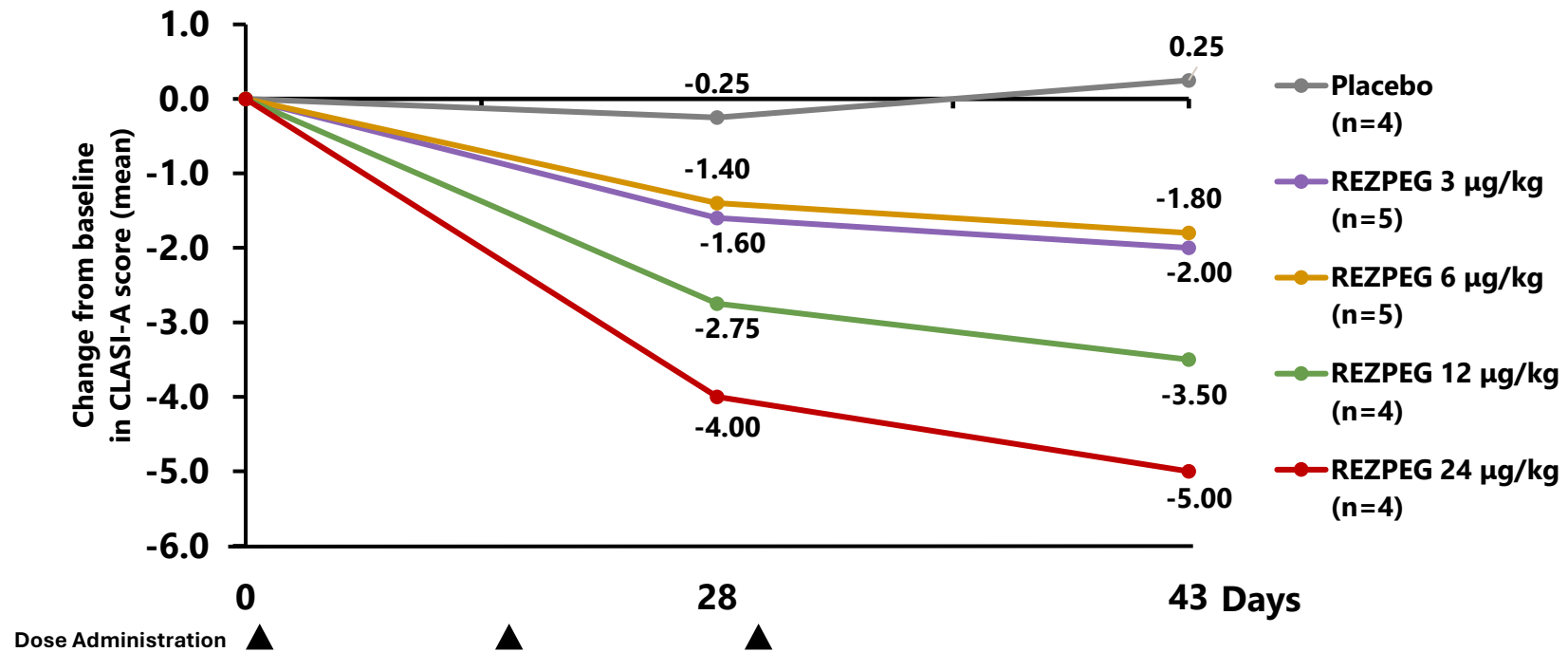


Sources: 1. Evaluate Pharma WW Market Size Estimates
(E): Estimate

Opportunity in Cutaneous Lupus Erythematosus

REZPEG Demonstrated a Dose-Dependent Reduction in CLASI-A Score in Patients with Lupus

Patients with Systemic Lupus Erythematosus and Cutaneous Involvement
Mean Change in CLASI-A Score from Phase 1 Study
Patients with a CLASI-A score of ≥ 4 at baseline (N=22)



Source: 1. Fanton et al., *Journal of Translational Autoimmunity* 2022

CLASI-A, cutaneous lupus erythematosus disease area and severity index-activity; SLE: systemic lupus erythematosus



Jonathan Silverberg, MD, PhD, MPH

Professor of Dermatology at The George Washington University School of Medicine and Health Sciences
Director of Clinical Research and Contact Dermatitis

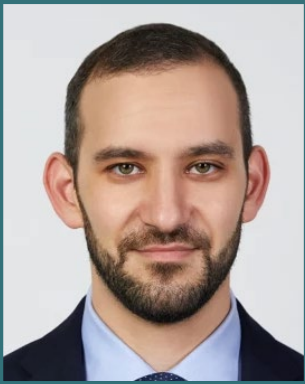
Dr. Silverberg is the Director of Clinical Research and Contact Dermatitis. Dr. Silverberg's area of clinical subspecialty is inflammatory skin disease. Dr. Silverberg has also been a local, national and/or international principal investigator for numerous clinical trials for novel treatments in inflammatory skin disorders. Dr. Silverberg's research interests include drug development, clinical trial design, biomarkers, dermato-epidemiology, health services research, patient-reported outcomes, comorbidities and burden of inflammatory skin disease and evidence-based dermatology. His publications include more than 1,000 peer-reviewed articles, abstracts and book chapters. He is an associate editor for the Journal of the American Academy of Dermatology, British Journal of Dermatology and Current Dermatology Reports.



David Rosmarin, MD

Chair of the Department of Dermatology at Indiana University School of Medicine
Kampen-Norins Scholar in Dermatology

Dr. Rosmarin is nationally recognized and serves as a referral for physicians with difficult to manage inflammatory diseases such as alopecia areata. Previously, Dr. Rosmarin served as the Director of the Clinical Trials Unit in the Department of Dermatology at Tufts Medical Center. His research interests focus on development of novel therapeutics and investigating novel uses of established therapies, with a particular focus on chronic skin diseases such as alopecia areata, atopic dermatitis, vitiligo, discoid lupus, and hidradenitis suppurativa. Dr. Rosmarin went to medical school at NYU, dermatology residency at Boston University-Tufts combined training program, and fellowship at Brigham and Women's Hospital.



Benjamin N. Ungar MD

Assistant Professor, Waldman Department of Dermatology, Icahn School of Medicine at Mount Sinai
Director of the Alopecia Center of Excellence and as Director of the Rosacea & Seborrheic Dermatitis Clinic

Dr. Ungar's clinical and research focus specialization is in inflammatory skin diseases, as well as how the immunology of the skin relates to the systemic components of the diseases he studies. His research is centered on atopic dermatitis and alopecia areata, as well as diseases such as seborrheic dermatitis. Dr. Ungar has authored or coauthored more than 75 original articles and more than 45 abstracts. He has led various talks on alopecia areata both in the United States and abroad. Dr. Ungar received his medical degree from the Icahn School of Medicine at Mount Sinai. He completed his internship at NYU Winthrop Hospital in Mineola, New York, followed by a residency in dermatology at the Icahn School of Medicine at Mount Sinai, from which he graduated as the chief resident.



**Appendix
(Data tables,
additional materials)**

REZOLVE-AA: Week 52 Data Readout - Statistical Methods

Exploratory Analyses Including Data During Treatment Extension Period

- **Week 0 up to Week 36 for mITT patients: Follow Primary Estimand Analysis used at time of Week 36 DBL**
 - mITT patients who used prohibited medications for the treatment of AA or who discontinued treatment due to lack of efficacy were considered **NONRESPONDERS** (using baseline observation carry forward (BLOCF) for continuous endpoints, and nonresponder imputation for binary endpoints), regardless of observed clinical response
 - Data after patients who discontinued due to other reasons are set to missing and all missing data are imputed using the multiple imputation method.
- **Week 40 to Week 52 for non-treatment extension patients:** Carry forward imputed data from Week 36 to Week 40, 44, 48, and 52
- **Week 40 to Week 52 for treatment extension patients:** Data after patients who discontinued due to other reasons are set to missing and all missing data are imputed using the multiple imputation method.
 - Only two patients discontinued before week 52 in treatment extension. (one on 18 µg/kg Q2W and one on 24 µg/kg Q2W)

Statistical Analysis Methods

- Descriptive summary statistics including p-values are all exploratory in nature

Patient Disposition in REZOLVE-AA

	REZPEG 18 µg/kg Q2W N = 37	REZPEG 24 µg/kg Q2W N = 35	REZPEG Total N = 72	Placebo N=20
Completed Study Treatment at W36	24 (64.9%)	21 (60.0%)	45 (62.5%)	11 (55.0%)
Entered the treatment extension period	14 (37.8%)	13 (37.1%)	27 (37.5%)	4 (20.0%)
Completed Treatment at W52	13 (92.9%)	12 (92.3%)	25 (92.6%)	4 (100.0%)
Discontinue treatment before W52	1 (7.1%)	1 (7.7%)	2 (7.4%)	0
Withdrawal by Subject/Patient Decision ¹	1 (7.1%)	1 (7.7%)	2 (7.4%)	0
Discontinued Treatment before W36				
Discontinued during weeks 0 – 16	7 (18.9%)	8 (22.9%)	15 (20.8%)	5 (25.0%)
Discontinued during weeks 16 - 36	6 (16.2%)	6 (17.1%)	12 (16.7%)	4 (20.0%)
Reasons for Discontinuations before W36				
Withdrawal by Subject/Patient Decision	10 (27.0%)	10 (28.6%)	20 (27.8%)	7 (35.0%)
New pregnancy during treatment ²	0	1 (2.9%)	1 (1.4%)	0
Eosinophilia	0	1 (2.9%)	1 (1.4%)	0
Worsening of AA	0	0	0	1 (5.0%)
Lost to Follow-up	2 (5.4%)	1 (2.9%)	3 (4.2%)	0
Lack of Efficacy to Study Treatment	0	1 (2.9%)	1 (1.4%)	1 (5.0%)
Other	1 (2.7%)	0	1 (1.4%)	0

1. Two patients discontinued prior to week 52 without a SALT Score ≤20 response (one from each dose arm)

2. Patient discontinued treatment and had a delivery of a healthy infant.

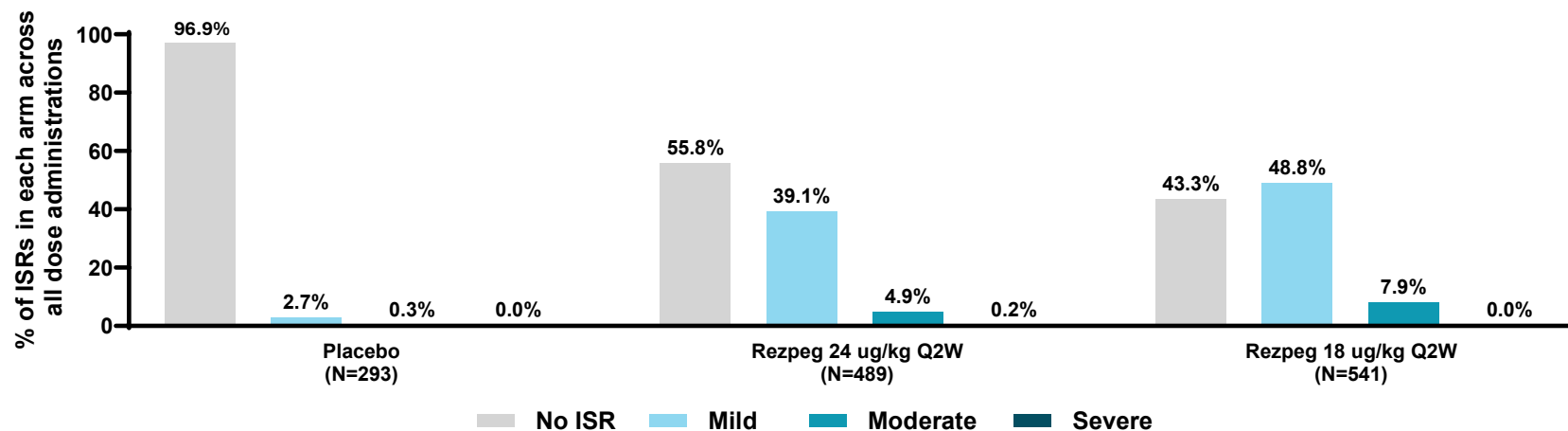
Summary of Treatment Emergent Adverse Events (TEAEs) *Safety Analysis Set - Overall Period: ≥ 10% REZPEG Total or Placebo Arm*

System Organ Class Preferred Term	REZPEG 18 µg/kg Q2W N = 37	REZPEG 24 µg/kg Q2W N = 35	REZPEG Total N = 72	Placebo N=20
Patients With at Least One TEAE¹	35 (94.6%)	35 (100.0%)	70 (97.2%)	15 (75.0%)
General disorders and administration site conditions	35 (94.6%)	32 (91.4%)	67 (93.1%)	7 (35.0%)
Injection site reaction	34 (91.9%)	32 (91.4%)	66 (91.7%)	6 (30.0%)
Infections and infestations	18 (48.6%)	17 (48.6%)	35 (48.6%)	9 (45.0%)
Upper respiratory tract infection	6 (16.2%)	5 (14.3%)	11 (15.3%)	1 (5.0%)
Nasopharyngitis	5 (13.5%)	6 (17.1%)	11 (15.3%)	2 (10.0%)
Oral herpes	2 (5.4%)	3 (8.6%)	5 (6.9%)	2 (10.0%)
Urinary tract infection	2 (5.4%)	3 (8.6%)	5 (6.9%)	2 (10.0%)
Musculoskeletal and connective tissue disorders	10 (27.0%)	10 (28.6%)	20 (27.8%)	5 (25.0%)
Arthralgia	4 (10.8%)	6 (17.1%)	10 (13.9%)	2 (10.0%)
Nervous system disorders	7 (18.9%)	9 (25.7%)	16 (22.2%)	3 (15.0%)
Headache	4 (10.8%)	6 (17.1%)	10 (13.9%)	3 (15.0%)
Blood and lymphatic system disorders	6 (16.2%)	10 (28.6%)	16 (22.2%)	1 (5.0%)
Eosinophilia	0	5 (14.3%)	5 (6.9%)	0
Gastrointestinal disorders	6 (16.2%)	10 (28.6%)	16 (22.2%)	3 (15.0%)
Gastroesophageal reflux disease	0	0	0	2 (10.0%)
Skin and subcutaneous tissue disorders	6 (16.2%)	9 (25.7%)	15 (20.8%)	6 (30.0%)
Alopecia	0	1 (2.9%)	1 (1.4%)	2 (10.0%)
Respiratory, thoracic and mediastinal disorders	4 (10.8%)	8 (22.9%)	12 (16.7%)	2 (10.0%)
Investigations	3 (8.1%)	7 (20.0%)	10 (13.9%)	2 (10.0%)
Injury (all deemed unrelated)¹	3 (8.1%)	5 (14.3%)	8 (11.1%)	0
Eye disorders	3 (8.1%)	2 (5.7%)	5 (6.9%)	2 (10.0%)

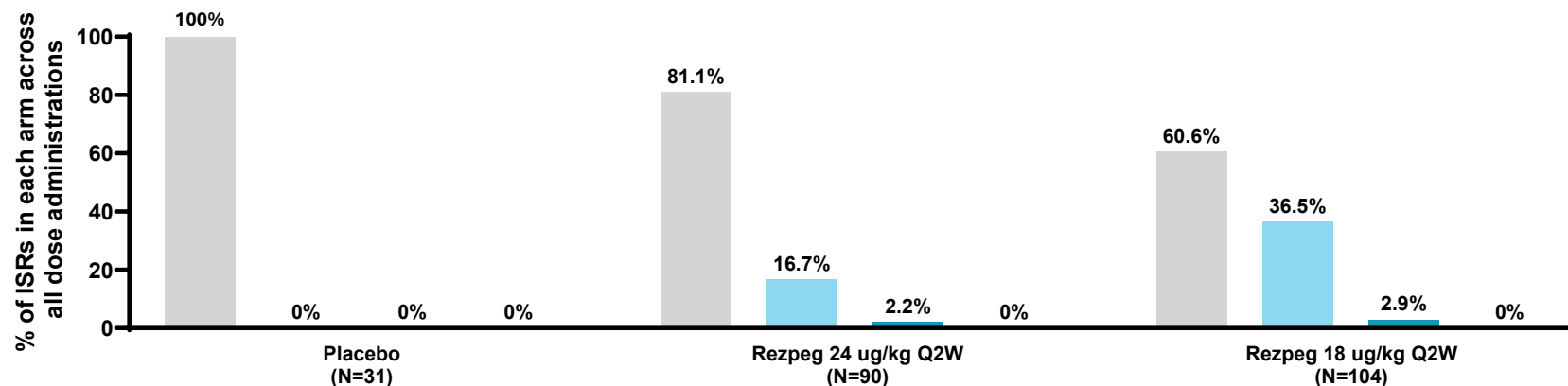
1. One patient in the 18 µg/kg had a serious AE of a gun shot wound and continued in the study. One patient in the 24 µg/kg had a severe ISR and continued treatment. One patient in the 24 µg/kg in the treatment extension had a serious AE of craniofacial fracture, and continued in the study.

Lower Frequency of ISRs Observed Over Longer Dosing Duration in Extension

Induction Period



Extension Period



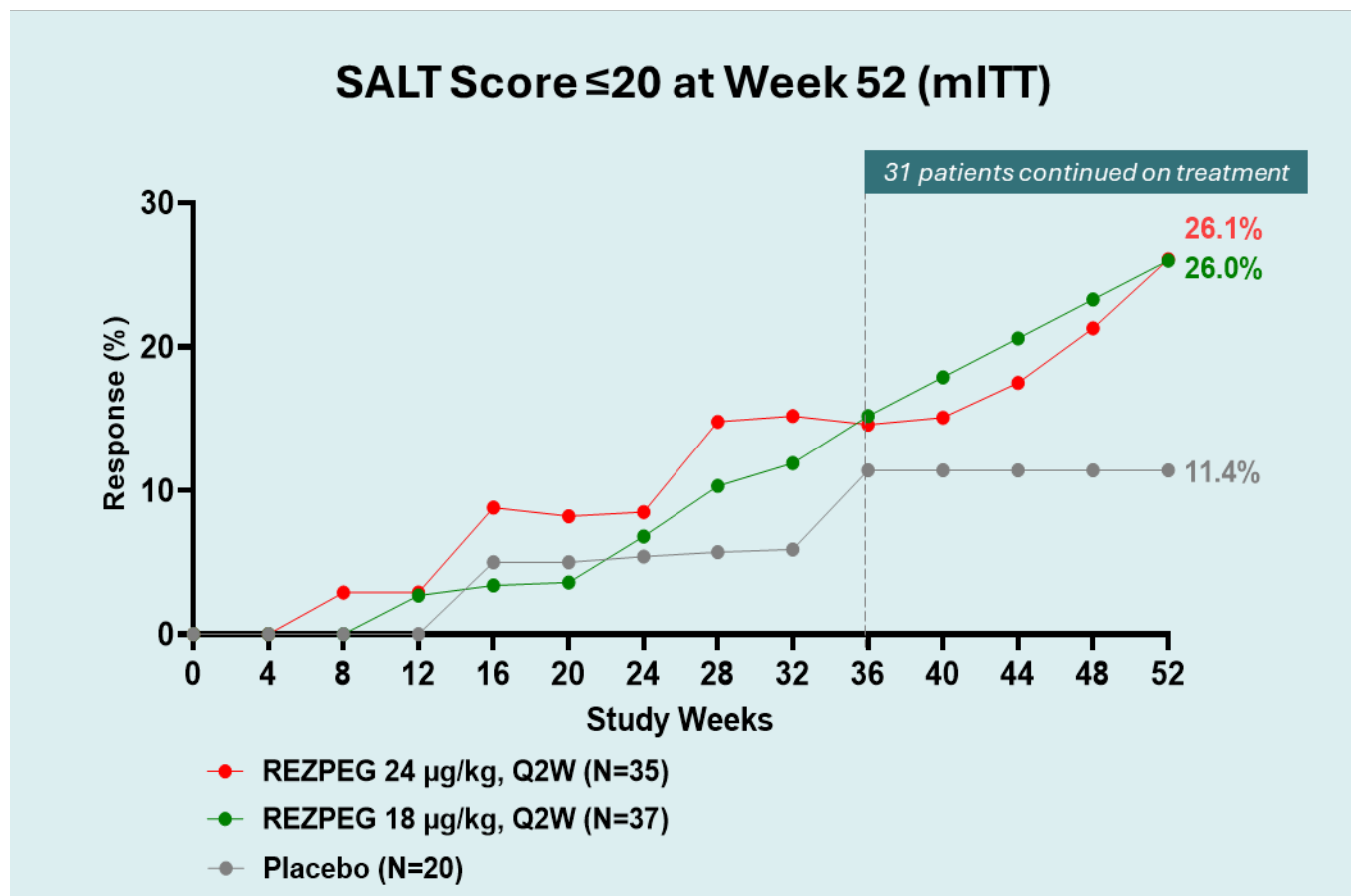
N= number of REZPEG administrations in REZPEG arms and number of placebo administrations in placebo arms

Mild: Faint erythema, asymptomatic, no or mild itch, no or mild tenderness

Moderate: Notable/great erythema, widespread itch, readily apparent induration, moderate pain

Severe: Widespread and constant itch limiting daily life, gross deviation of normal anatomic contour for induration, severe pain

REZPEG mITT Population Achieved High SALT Score ≤ 20 at Week 52



- **92 patients** in modified Intent to Treat (mITT population)
- **4 patients** are included in the mITT analysis who had major study eligibility violations and did not meet study inclusion/exclusion criteria (these patients did not enter treatment extension)

Data for mITT Analysis Set are imputed from Week 0 to Week 36 following Primary Estimand. Data for patients in non-Treatment Extension Set in Week 40, 44, 48 and 52 are carried forward from Week 36 data. Missing data for patients in Treatment Extension Set for Week 40, 44, 48 and 52 are imputed using Multiple Imputation.