NEKTAR® THERAPEUTICS

# Nektar Therapeutics Corporate Presentation

April 2026

Bold immune science.
Transformative immune health.

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# Strong opportunities exist within the I&I market

***Blockbuster Potential Across I&I Markets***

- **Over 70% of advanced therapies launched by 2022 have achieved over $1 billion in annual revenue within a single indication**, particularly in large, high-burden disease areas such as asthma, atopic dermatitis, Crohn's disease, psoriasis, rheumatoid arthritis, and ulcerative colitis

***Attractive Market Dynamics within I&I Indications***

- Multiple blockbuster therapies can **successfully coexist within the same indication**, reflecting the large patient population, heterogenous disease presentation, and evolving unmet needs
- **High-prevalence indications support sustained market expansion**, even in the presence of entrenched competitors

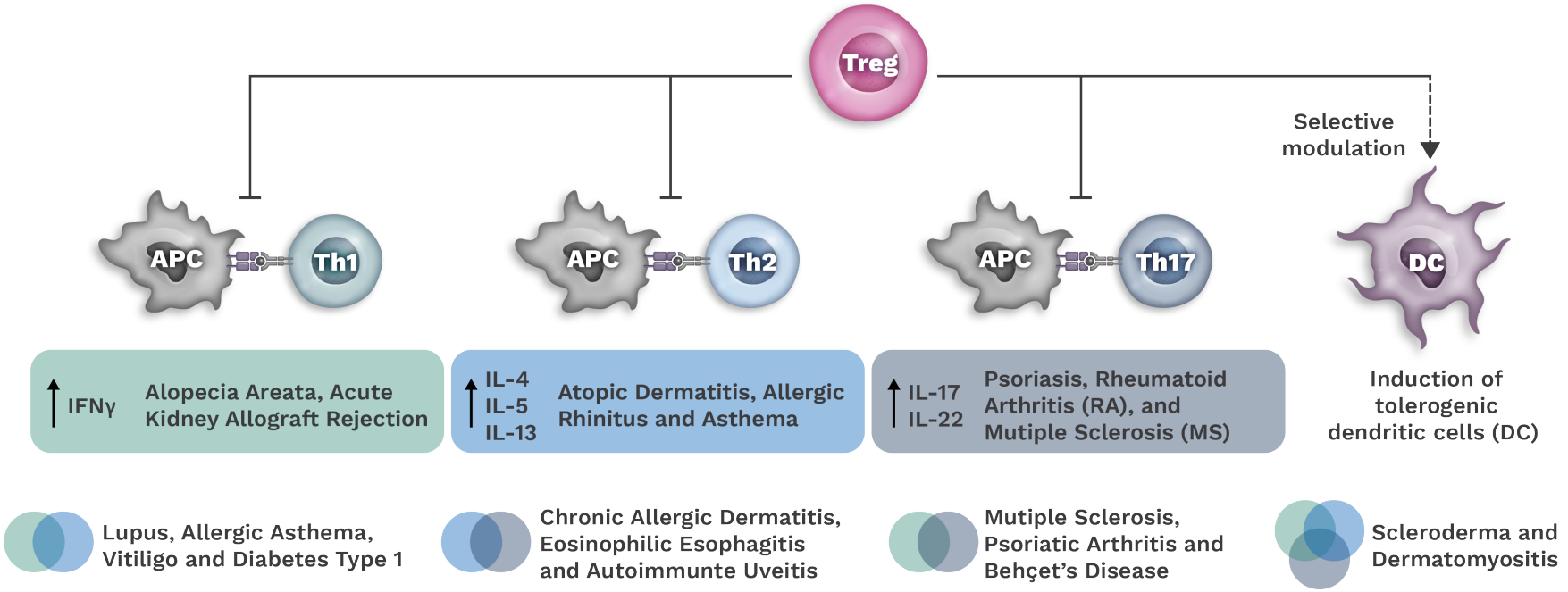
***Innovation Drives Penetration and Pipeline Value***

- **Novel mechanisms of action** continue to drive increased biologic penetration, particularly in traditionally underpenetrated indications like atopic dermatitis
- New entrants offering **improved efficacy, safety, or convenience** are capturing share despite competition from incumbent products
- Strong potential for **“pipeline-in-a-product” strategies**, with many agents demonstrating activity across **multiple autoimmune and inflammatory indications**

# Nektar pipeline

| | Program | Indication | Stage | Preclinical | Phase 1 | Phase 2 | Phase 3 | Partner |
|---|---|---|---|---|---|---|---|---|
| Immunology | Rezpegaldesleukin *(IL-2 T Regulatory Cell Stimulator)* | Moderate-to-Severe Atopic Dermatitis | Completed Enrollment in Phase 2b Study (REZOLVE-AD) | | | Phase 2; Fast Track Designation | | Off-treatment Data Q1 2027 |
| | | Severe-to-Very-Severe Alopecia Areata | Enrollment Completion in March 2025 (REZOLVE-AA) | | | Phase 2; Fast Track Designation | | Off-treatment Data Q4 2026 |
| | | New Onset Stage 3 Type 1 Diabetes (Stage 3) | TrialNet P2 Study | | | Phase 2 | | Potential Initial Data 2027 |
| | NKTR-0165 *(TNFR2 Agonist Antibody)* | Multiple Sclerosis & Other I&I Indications | Preclinical | | Preclinical | BiolojicDesign | | |
| | NKTR-0166 *(Bispecific Antibody)* | I&I Indications | Preclinical | | Preclinical | | | |
| Oncology | NKTR-422 *(PEG-CSF)* | Fibrotic Diseases & Other Indications | Preclinical | | Preclinical | | | |
| | NKTR-288 *(Interferon Gamma)* | Oncology | Preclinical | | Preclinical | | | |

# The central role of regulatory T cells in immune homeostasis




APC=Antigen-presenting cell; Th1 = Mature helper T cell (Th1); Th2 = Mature helper T cell (Th2); Th17 = Mature helper T cell (Th17)

**Tregs are crucial for immune homoeostasis and the prevention of autoimmune conditions**[1]

- ***IL-2 pathway agonism***
- ***TNFR2 agonism***

*Sources: 1 Lykhopiy V, et al. Genes Immun. (2023)*

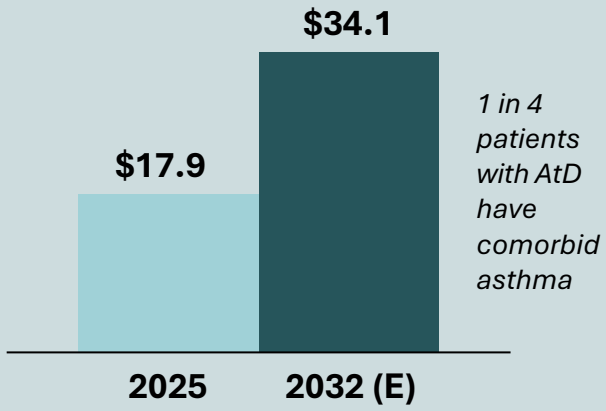
# Rezpegaldesleukin in Atopic Dermatitis

# 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 asthma[3]

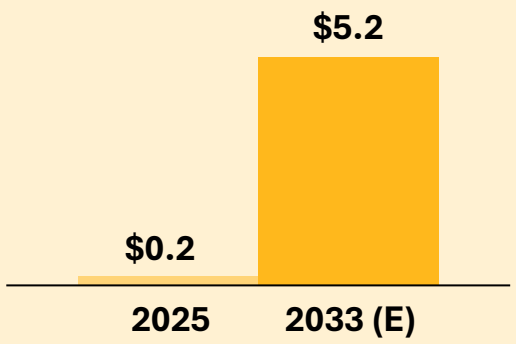
**G7 Market Size ($B)[4]**




## 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

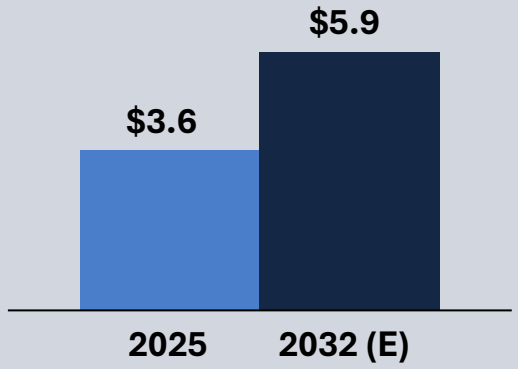
**G7 Market Size ($B)[5]**




## 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.*

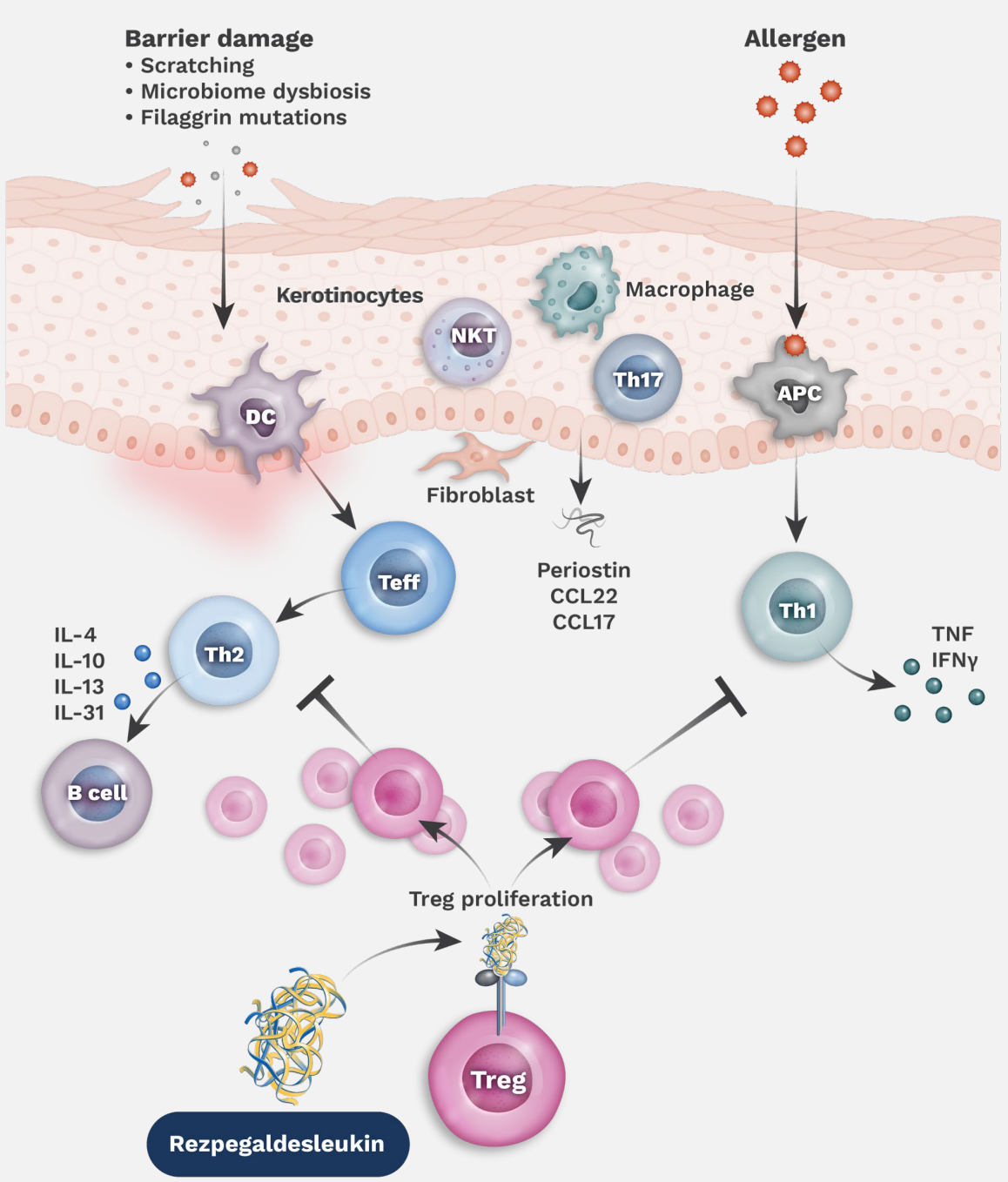
# Rezpegaldesleukin
# Atopic Dermatitis MOA

## Scientific rationale

- By targeting receptors on regulatory T cells (Tregs), rezpegaldesleukin stimulates the proliferation of these cells, including FOX-P3+ Tregs

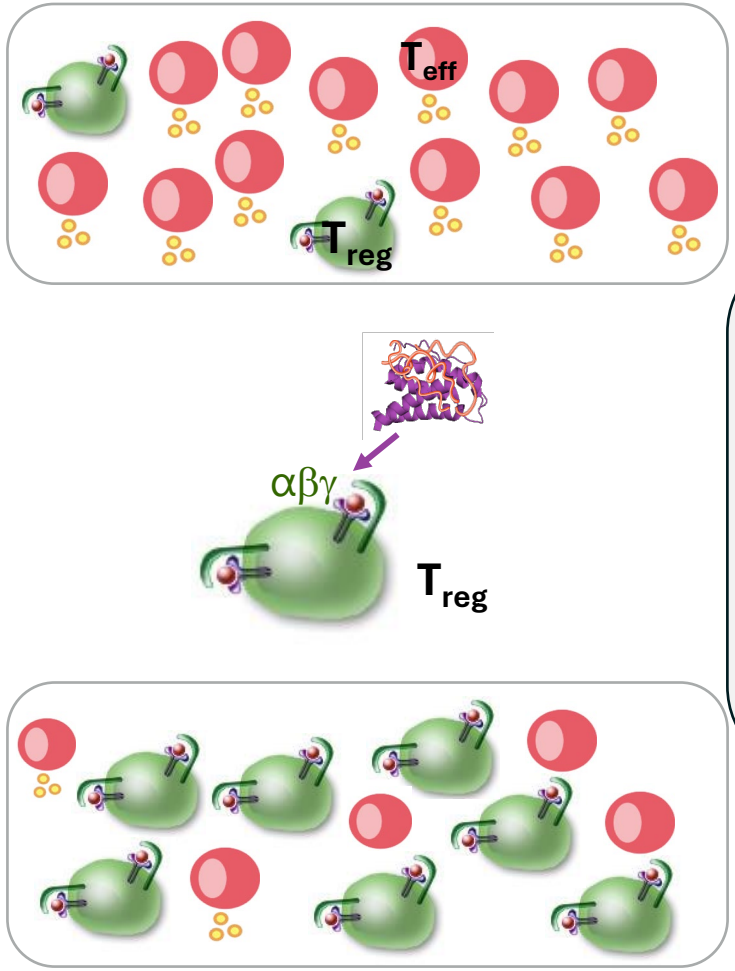
- Regulatory T cells act as a master immune-modulator upstream of the pro-inflammatory cytokine pathways, which drive Th1, Th2, Th17-mediated inflammatory disorders, such as atopic dermatitis

- By increasing the number and functionality of regulatory T cells, this investigational therapy aims to reduce inflammation more effectively than specific antagonist mechanisms that may target only one pathway



# Rezpegaldesleukin is a potential first-in-class regulatory T cell mechanism to restore balance in immune system

- Many patients with moderate-to-severe atopic dermatitis (AD) **do not adequately achieve disease control** or have safety/tolerability issues with current therapies
- **Tregs play a central role in controlling AD** by dampening inflammatory cytokines and overactive T cells[1]
- **Granted Fast Track designation in Feb 2025** for treatment of adult and pediatric patients ≥12 years of age with moderate-to-severe AD whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable




*Increased activity and number of T effector cells shift the balance toward inflammation*

**Rezpegaldesleukin** is a potential T-cell balancing therapy that acts on IL2 receptors and has been shown to[2,3]:

- **Proliferate** regulatory T cells
- **Restore** their functionality, reducing proinflammatory cytokines
- **Offer potential long-term control** of overactive immune responses

*Treg expansion and activation restores the immunoregulatory balance*

*Sources: 1. Silverberg et al. 2024 Nature Communications, 15:9230; 2. Fanton et al. 2022 J. Translational Autoimmunity, 5:100152; 3. Dixit et al. 2021 J Translational Autoimmunity, 4:100103*

# Atopic dermatitis presents a multi-billion dollar market opportunity

## Still high unmet need, especially for new therapies with potential for remittive effect

***Atopic dermatitis (AD) is a chronic autoimmune condition that causes inflammation, redness and irritation of the skin. Moderate-to-severe AD is associated with unbearable itching that can result in significant negative impact to quality of life.***

**~30 million**[1]

Adults with AD in U.S.

**~220 million**[2]

Adults with AD globally

**~50%**[3]

Adults with AD have moderate-to-severe disease

**~8%**[4]

Patients with moderate/severe AD are treated with a biologic

***There is a high unmet need for a novel mechanism of action to:***

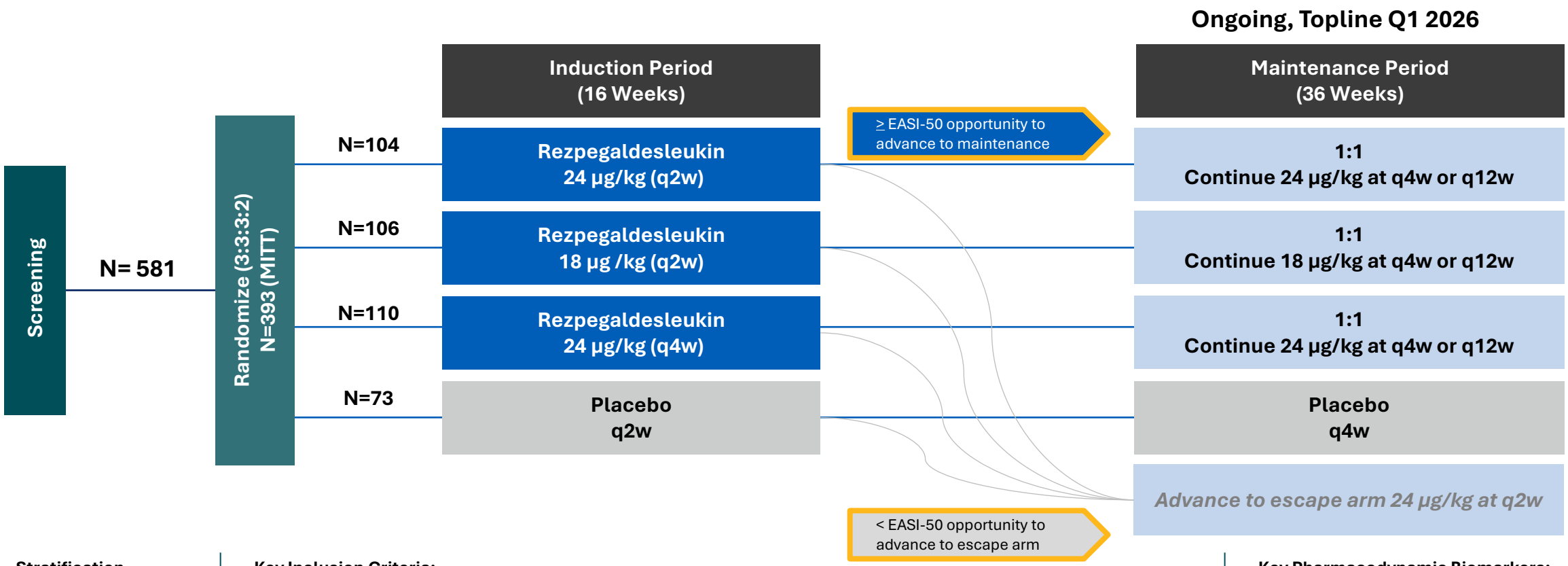
- **Offer dosing schedules without rebound effect**
- **Induce deep and potentially therapy-free remission**
- **Favorable safety and tolerability profile as compared to standard-of-care**

Dupixent: current market leader in atopic dermatitis exceeding $10.5 B in annual sales, **but 50% of patients fail on therapy**[5, 6]

*Sources: 1. Eczema stats. National Eczema Association. (September 2022). https://nationaleczema.org/research/eczema-facts/; 2. Eczema council. (n.d.). https://www.eczemacouncil.org/assets/docs/global-report-on-atopic-dermatitis-2022.pdf; 3. ClarivateTM DRG Mature Markets Data 2023.; 4. DRG Epidemiology; 5. N Engl J Med 2016; 375:2335-2348 DOI: 10.1056/NEJMoa1610020; 6. EvaluatePharma, accessed January 2025*

# REZOLVE-AD: Phase 2b trial design

## Patients with Moderate-to-Severe Atopic Dermatitis




**Stratification**

- ✓ Geographic region
- ✓ Disease severity by vIGA-AD

**Key Inclusion Criteria:**

- ✓ Age: ≥18 years
- ✓ Moderate/severe AD diagnosis for ≥ 12 months
  - EASI ≥ 16
  - vIGA-AD of 3 or 4
  - BSA ≥ 10%
- ✓ Biologic-naive (no prior biologic systemic therapy) and systemic JAKi-naïve
- ✓ Failure of prior therapy, including TCS of medium or higher potency, within last 6 months

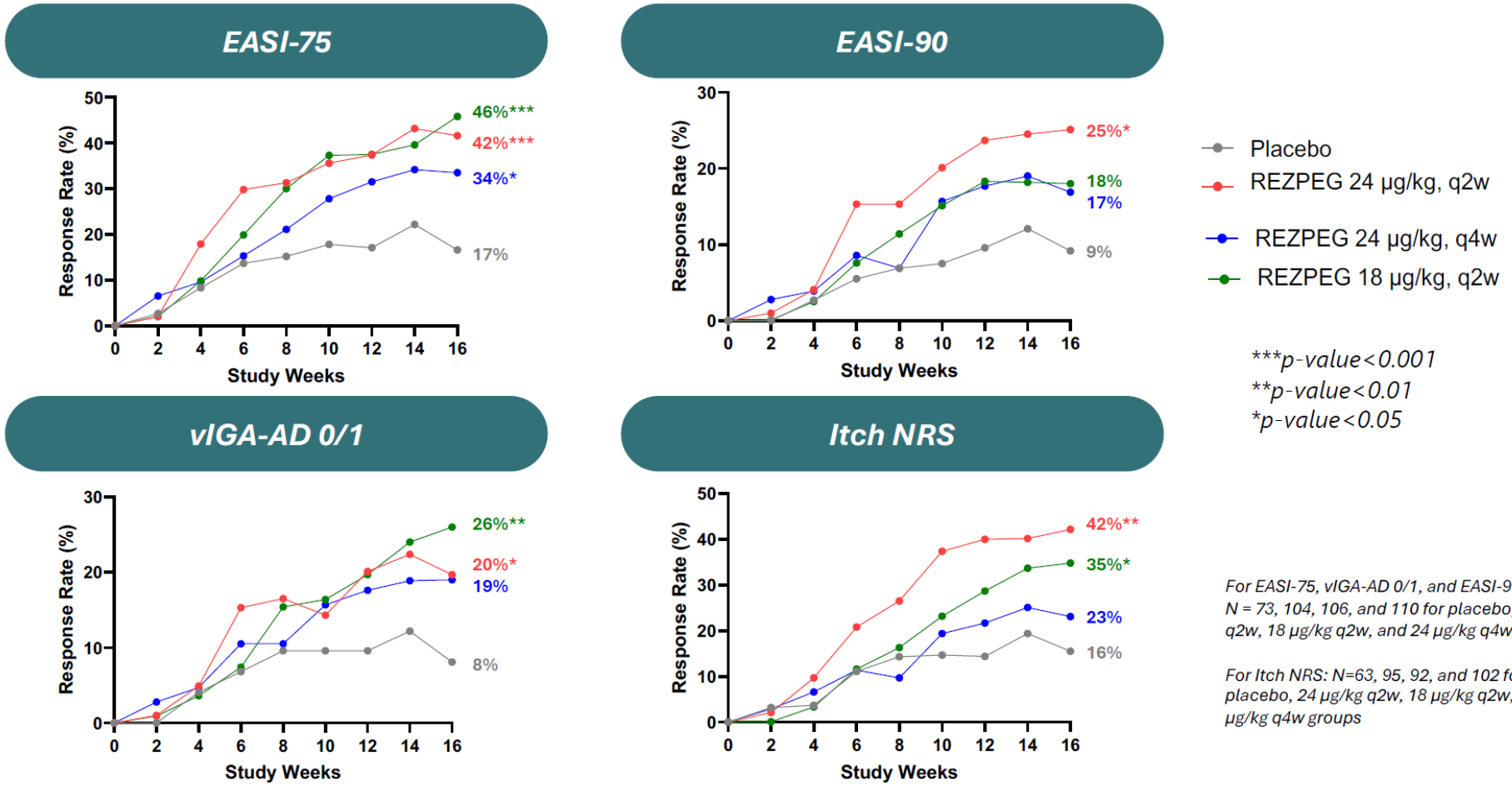
**Key Pharmacodynamic Biomarkers:**

- T regulatory cell
- TARC/CC17
- Periostin
- MDC/CCL22
- IL-19

MITT is defined as patients who were randomized and received at least one dose of study treatment or placebo.

# Fast Onset of Action Across All Key Secondary Endpoints

## EASI-75, EASI-90, vIGA-AD 0/1, and Itch NRS (≥ 4-point Reduction) Responses Seen Early and Sustained Throughout

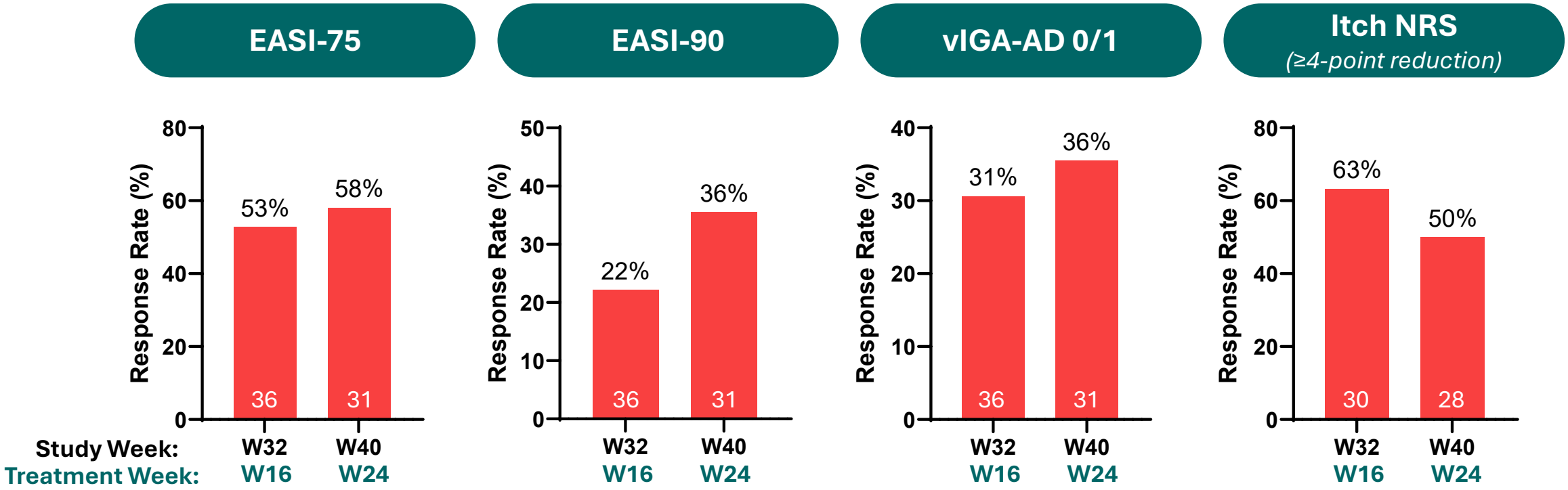



*For EASI-75, vIGA-AD 0/1, and EASI-90: N = 73, 104, 106, and 110 for placebo, 24 µg/kg q2w, 18 µg/kg q2w, and 24 µg/kg q4w*

*For Itch NRS: N=63, 95, 92, and 102 for the placebo, 24 µg/kg q2w, 18 µg/kg q2w, and 24 µg/kg q4w groups*

The Primary Estimand analysis for binary endpoints use logistic regressions. Data after use of rescue therapy outside protocol specifications or discontinued treatment due to lack of efficacy were imputed as non-responders; data after patients who discontinued due to other reasons were set to missing and all missing data are imputed using the multiple imputation method.
Source: Nektar Investor and Analyst Event (June 2025)

# Rezpeg 24 µg/kg Q2W for 24 Weeks Compared to 16 Weeks Achieved Superior Response Rates in Placebo Crossover Arm

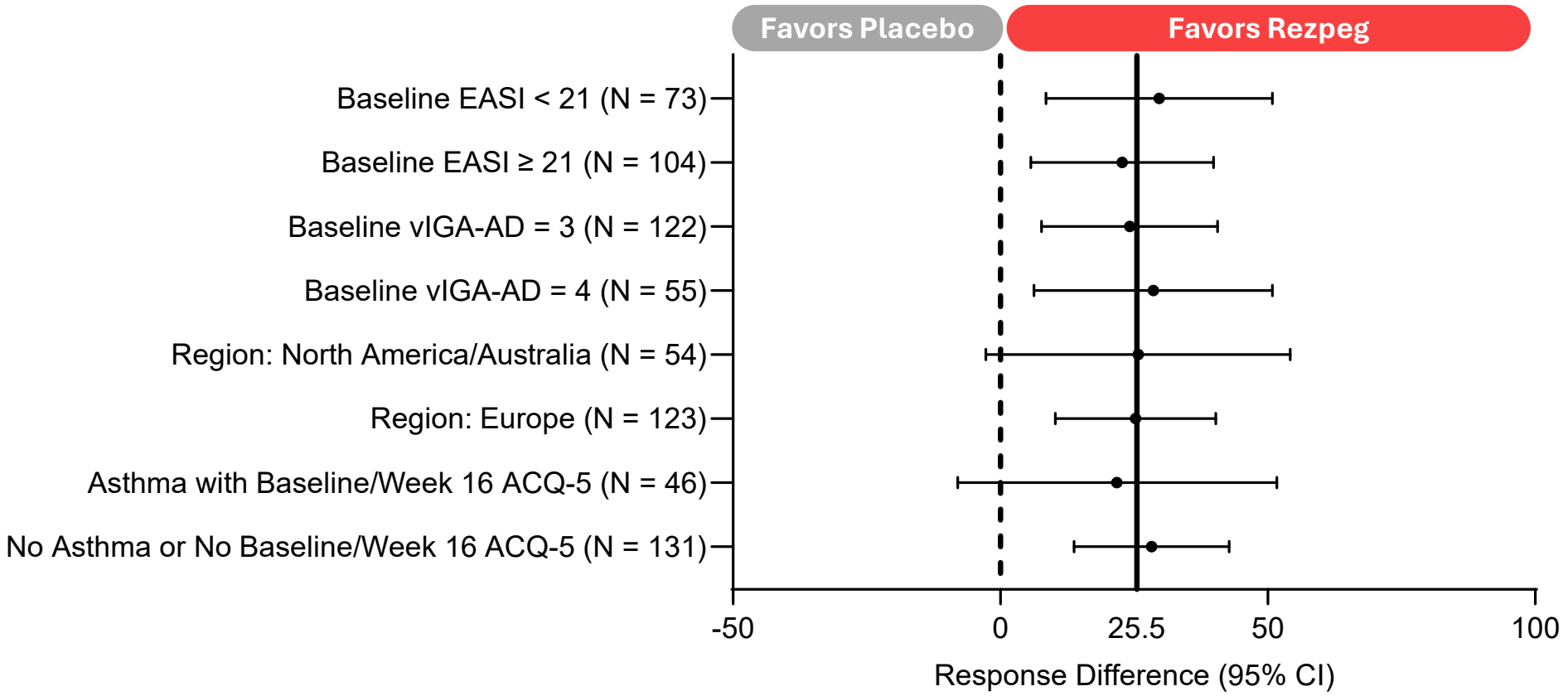



**Data Support Induction Dose of 24 µg/kg Q2W for 24 Weeks in Phase 3 Program**

The analysis of binary endpoints (EASI-75, EASI-90, vIGA-AD 0/1, and Itch NRS response) for the crossover patients uses descriptive summaries and number of patients with observed data as denominator.

# EASI-75 Response for Rezpegaldesleukin 24 µg/kg q2w vs. Placebo

## Consistent Treatment Effect Observed Across Baseline Severity of Disease, Geographical Region and Comorbidity of Asthma




The Primary Estimand analysis for binary endpoints use logistic regressions. Data after use of rescue therapy outside protocol specifications or discontinued treatment due to lack of efficacy were imputed as non-responders; data after patients who discontinued due to other reasons were set to missing and all missing data are imputed using the multiple imputation method.

# Asthma in Atopic Dermatitis

Asthma commonly co-occurs with Atopic Dermatitis, reflecting substantial overlap in type 2 inflammatory disease

***Patients with Atopic Dermatitis, particularly those with impaired skin-barrier function and a genetic predisposition toward IgE-mediated sensitization, are at increased risk of progressing to asthma as part of the "atopic march"***

## US Prevalence

**~21 M** ***Diagnosed AtD pts.***

***~34% moderate-severe***

**~7.1 M** ***Mod.-severe patients***

***~26% asthmatic***

**~1.9 M** ***Mod.-severe AtD / asthma patients***

## Treatment Approach & Biologic Use

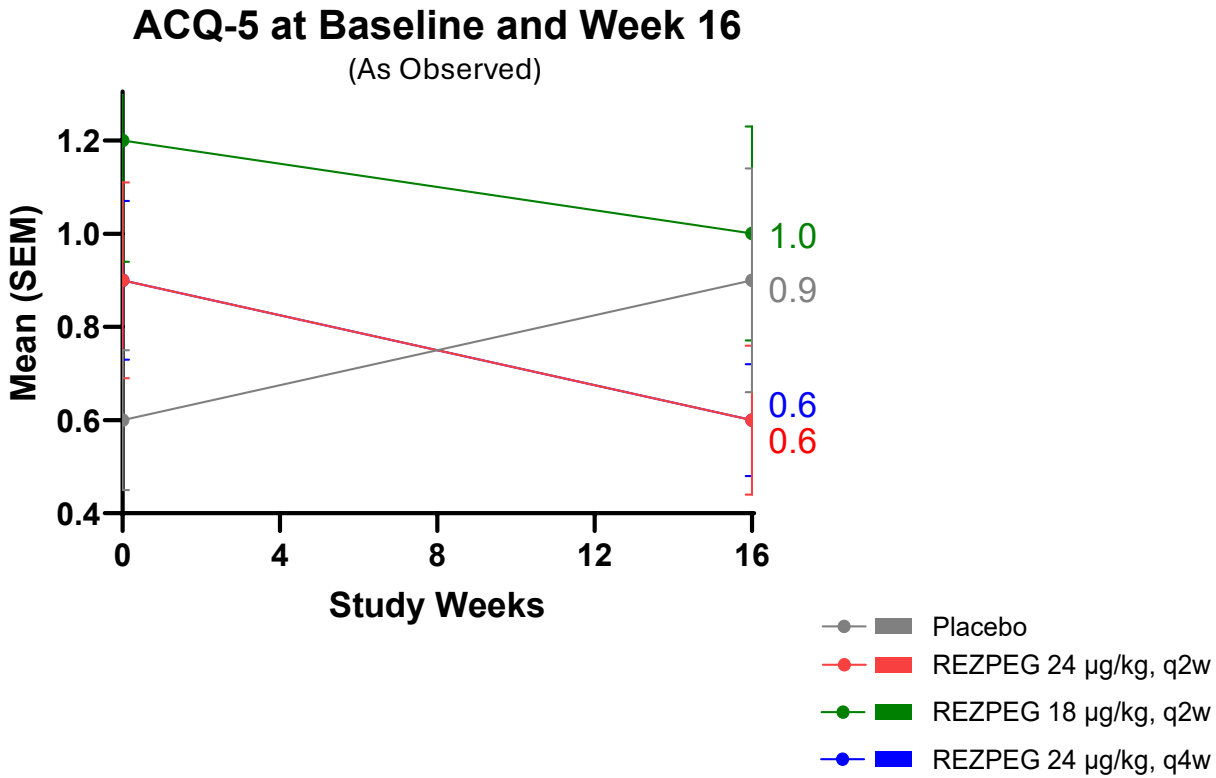
***Dupilumab is the only biologic approved for both AtD and asthma; AtD guidelines highlight its benefits for patients with comorbid conditions such as asthma, and multiple peer-reviewed studies support its use as a first-line option in these patients***

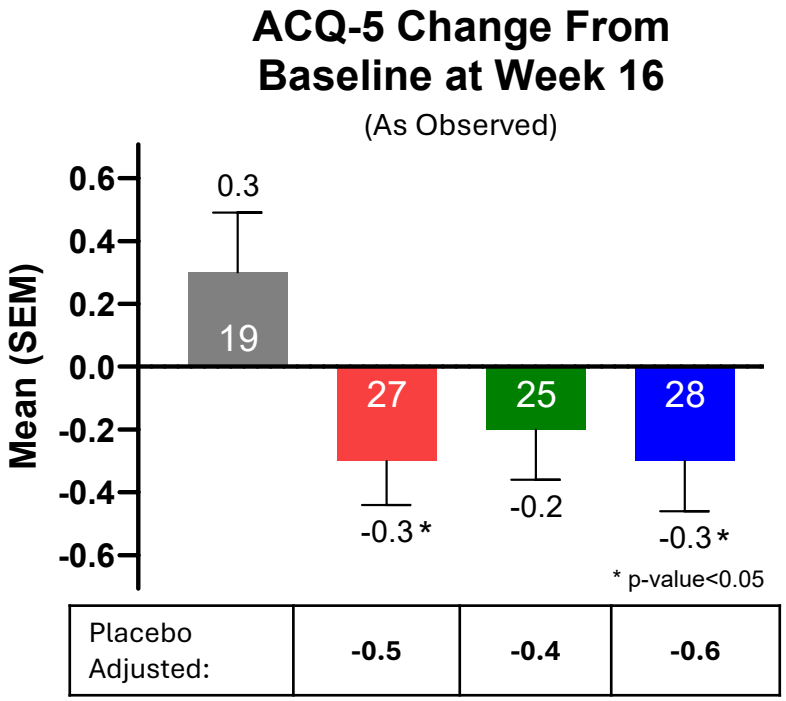
| Indication | Treatment Landscape |
|---|---|
| ***Atopic Dermatitis*** | Approved biologics: **dupilumab**, tralokinumab, lebrikizumab, nemolizumab |
| | Guidelines recommend biologics for mod-severe patients who are refractory, intolerant, or unable to use topical treatments |
| ***Asthma*** | Approved biologics: **dupilumab**, omalizumab, tezepelumab, mepolizumab, benralizumab, reslizumab |
| | Biologics are recommended for mod-severe uncontrolled patients; several, including dupilumab, are indicated specifically for patients characterized by an eosinophilic phenotype |

*Sources: 1. Clarivate DRG Epidemiology (Diagnosed Population) 2. J Am Acad Dermatol 2025 DOI: 10.1016/j.jaad.2025.10.022 3. I Inv Dermatol 2019 DOI: 10.1016/j.jid.2018.08.028 4. Dermatitis 2014 DOI: 10.1097/DER.0000000000000034 5. J Am Acad Dermatol 2021; 84:471-478 DOI: 10.1016/j.jaad.2020.02.055 6. Ann Allergy Asthma Immunol 2023 DOI: 10.1016/j.anai.2023.11.009 7. Prim Care Respir Med 2023 DOI: 10.1038/s41533-023-00330-1 8. J Clin Med 2025 DOI: 10.3390/jcm14134749 9. UpToDate (Nov 2025)*

# ACQ-5 Response in Patients with Self-Reported Asthma History

## Improvement in ACQ-5 Scores From Baseline to Week 16 in Rezpegaldesleukin Treated Patients with Asthma Comorbidity



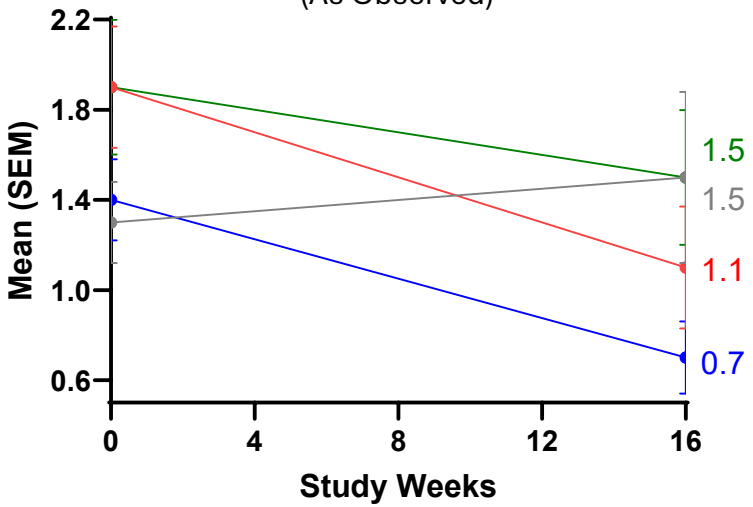

Only patients with both Baseline and Week 16 ACQ-5 data are included. The analysis for ACQ-5 data uses descriptive summary measures on observed data. P-value for change from baseline is from two-sample t-test.

# Patients with Self-Reported Asthma History and Baseline ACQ-5 ≥0.5

Improvement in ACQ-5 From Baseline to Week 16 in Rezpegaldesleukin Treated Patients with Baseline ACQ-5 Score ≥ 0.5

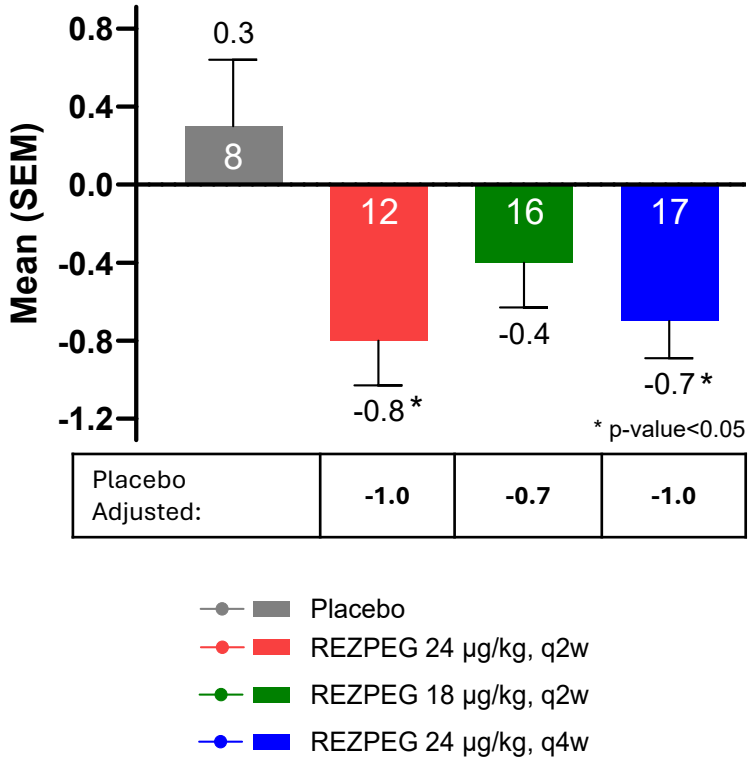
## ACQ-5 at Baseline and Week 16

(As Observed)




## ACQ-5 Change From Baseline at Week 16

(As Observed)

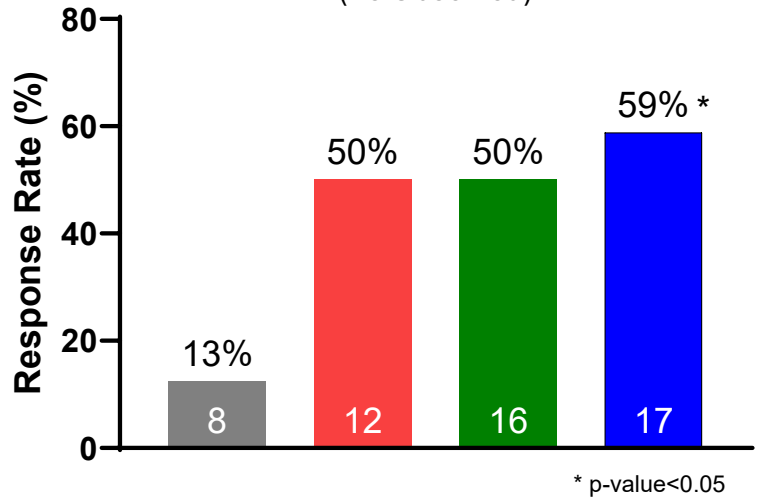



| Placebo Adjusted: | -1.0 | -0.7 | -1.0 |
|---|---|---|---|

Placebo
REZPEG 24 µg/kg, q2w
REZPEG 18 µg/kg, q2w
REZPEG 24 µg/kg, q4w

## Proportion of Patients with ACQ-5 Improvement of ≥ 0.5 at Week 16

(As Observed)



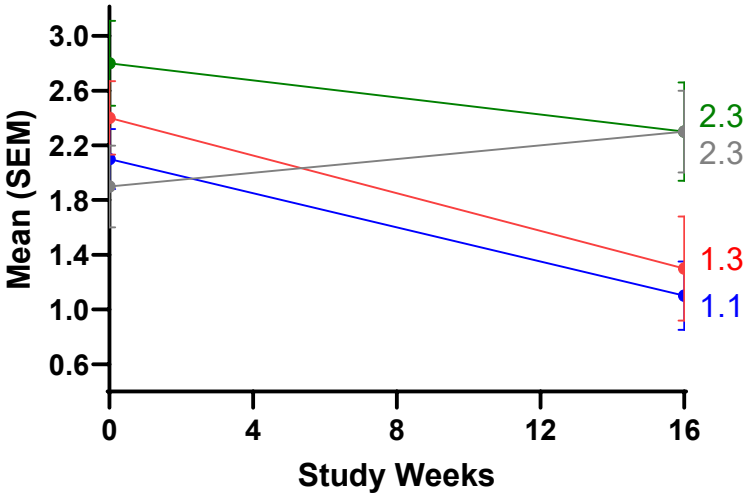

Only patients with both Baseline and Week 16 ACQ-5 data and baseline ACQ-5 ≥ 0.5 are included. The analysis for ACQ-5 data uses descriptive summary measures on observed data. P-value for change from baseline is from two-sample t-test and p-value for response is from Cochran-Mantel-Haenszel test.

# ACQ-5 Response in Patients with Self-Reported *Uncontrolled* Asthma at Baseline

## Improvement in ACQ-5 From Baseline to Week 16 in Rezpegaldesleukin Treated Patients with Baseline ACQ-5 Score ≥ 1.5

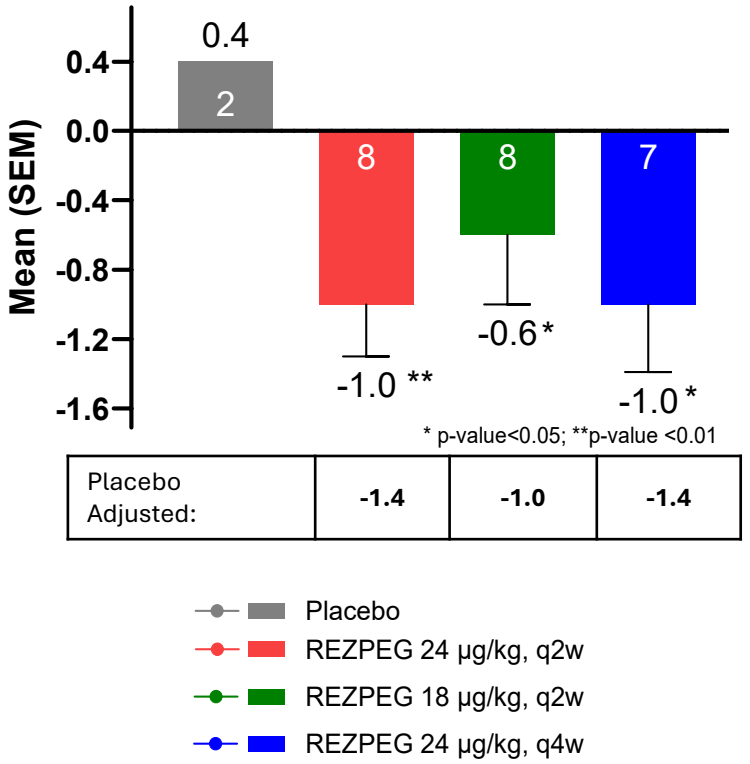
### ACQ-5 at Baseline and Week 16

(As Observed)




### ACQ-5 Change From Baseline at Week 16

(As Observed)

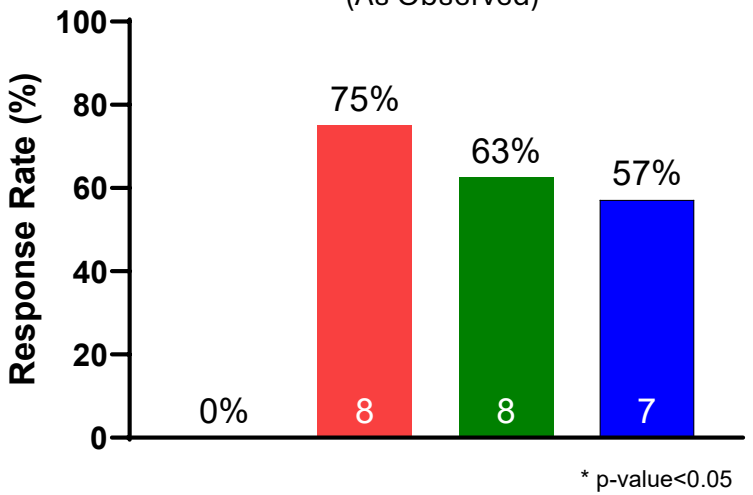



| Placebo Adjusted: | -1.4 | -1.0 | -1.4 |
|---|---|---|---|

Placebo
REZPEG 24 µg/kg, q2w
REZPEG 18 µg/kg, q2w
REZPEG 24 µg/kg, q4w

### Proportion of Patients with ACQ-5 Improvement of ≥ 0.5 at Week 16

(As Observed)

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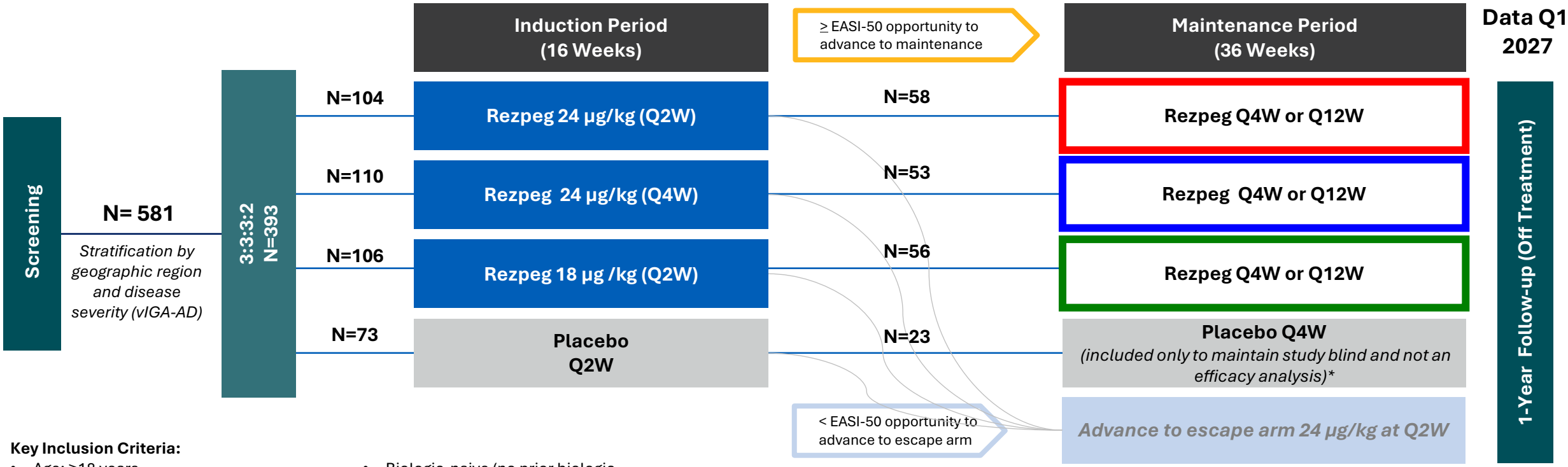
# Goals for Maintenance Phase of REZOLVE-AD Study

- Maintenance periods following an induction regimen are designed to establish a longer-term treatment dose and regimen that demonstrates durability of efficacy
  - In REZOLVE-AD, the maintenance phase provides an opportunity to establish a patient-centric lower frequency dosing regimen for optimal long-term chronic treatment
- Assess the ability of monthly (Q4W) and quarterly (Q12W) regimens during weeks 16-52 to:
  - Maintain and improve efficacy responses **and** convert nonresponders to responders
- Establish favorable long-term safety profile
  - Over 1,000 patients treated with Rezpeg to date (= 381 patient-years of exposure)

# REZOLVE-AD: Phase 2b Maintenance Designed to Evaluate Monthly and Quarterly Dosing

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- Age: ≥18 years
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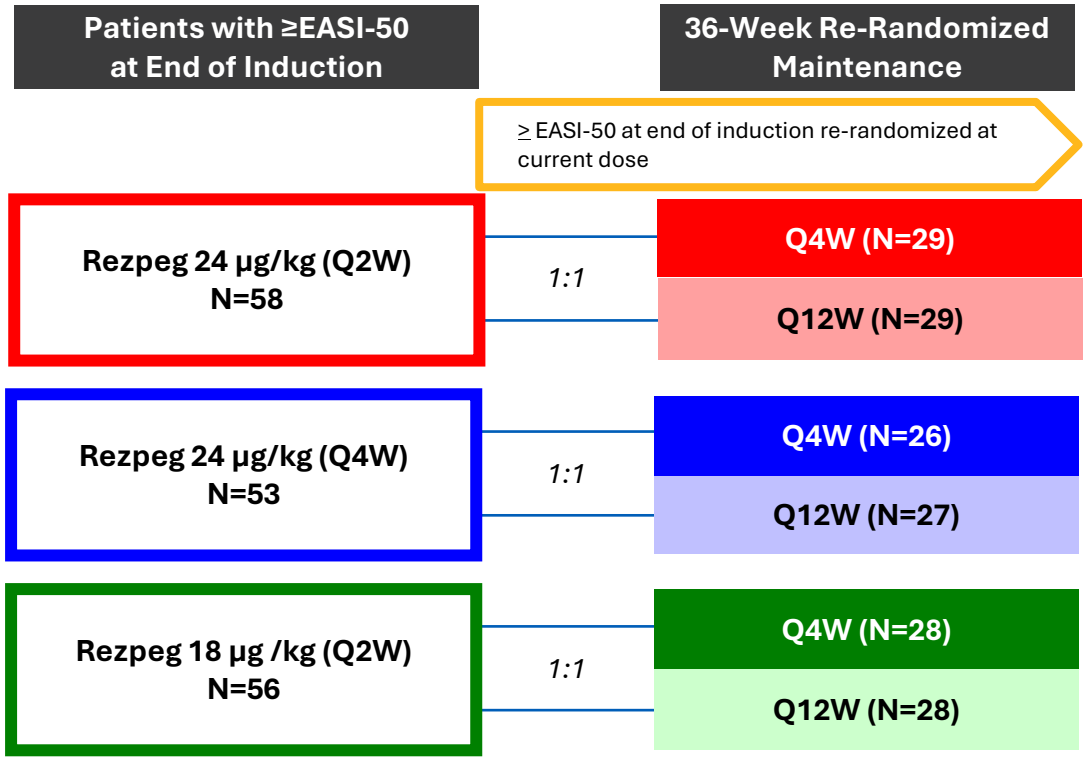
  - BSA ≥ 10%
- Biologic-naive (no prior biologic systemic therapy) and systemic JAKi-naïve
- Failure of prior therapy, including TCS of medium or higher potency, within last 6 months

*Placebo-treated clinical responders are not included in the efficacy analyses after week 16; however, they continued receiving placebo to maintain blinding (as was done in dupilimab Phase 3 SOLO-CONTINUE Study, amlitelimab Phase 2 STREAM-AD program, and tralokinimab Phase 3 ECZTRA Program)

# Multiple Efficacy Endpoints Assessed in Maintenance Portion of Trial




**Efficacy Endpoints at Week 52 Among Patients with Responses at Week 16**

- Maintaining EASI-75
- Maintaining vIGA-AD 0/1 (Clear/Almost Clear)
- Maintaining EASI-90
- Maintaining Itch NRS (≥4-point reduction)

**Assess New and Deepening Responses at Week 52 Among Patients Without Response at Week 16**

- New EASI-75 responders
- New EASI-90 responders
- New vIGA-AD 0/1 responders

**Conversions to EASI-100 from Week 16 to Week 52**

# Durability of Effect: Maintaining Responses

# All Monthly and Quarterly Arms Demonstrated Durability of Responses Over 36 Weeks of Maintenance Dosing Following Induction

*At Week 52*

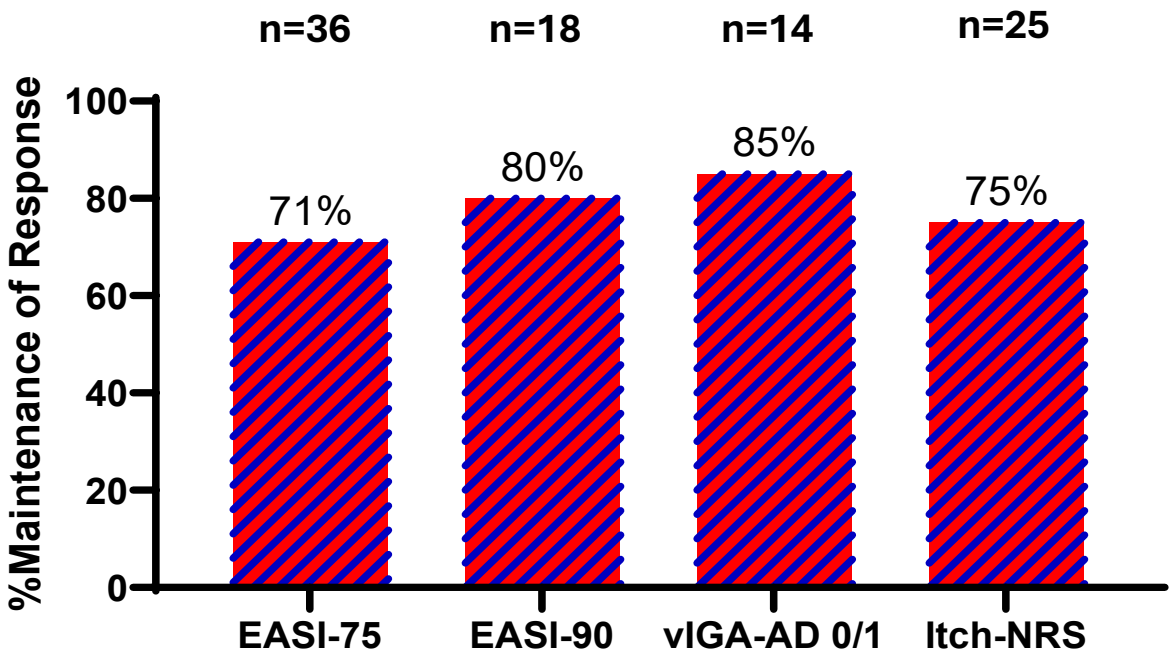
| 16-Week Induction Dose: | Rezpeg 24 µg/kg Q2W | | Rezpeg 24 µg/kg Q4W | | Rezpeg 18 µg/kg Q2W | |
|---|---|---|---|---|---|---|
| **36 -Week Maintenance Dose:** | **24 µg/kg Q4W N=29** | **24 µg/kg Q12W N=29** | **24 µg/kg Q4W N=26** | **24 µg/kg Q12W N=27** | **18 µg/kg Q4W N=28** | **18 µg/kg Q12W N=28** |
| **Maintaining EASI-75** | 74% (n=19) | 74% (n=18) | 67% (n=17) | 92% (n=17) | 81% (n=20) | 76% (n=19) |
| **Maintaining EASI-90** | 80% (n=10) | 77% (n=11) | 81% (n=8) | 78% (n=9) | 57% (n=8) | 57% (n=7) |
| **Maintaining vIGA-AD 0/1** | 83% (n=8) | 59% (n=8) | 86% (n=6) | 65% (n=13) | 81% (n=12) | 62% (n=9) |
| **Maintaining Itch NRS (≥4-point reduction)** | 71% (n=18) | 85% (n=9) | 85% (n=7) | 68% (n=8) | 56% (n=14) | 61% (n=6) |

(N=xx) is the entire maintenance population
(n=xx) is the denominator which equals the number of responders at Week 16
% represents proportion of patients who maintained that response at Week 52
Missing data is imputed using multiple imputation

# Maintenance of Responses in the Pooled Monthly and Quarterly High Dose Maintenance Arms

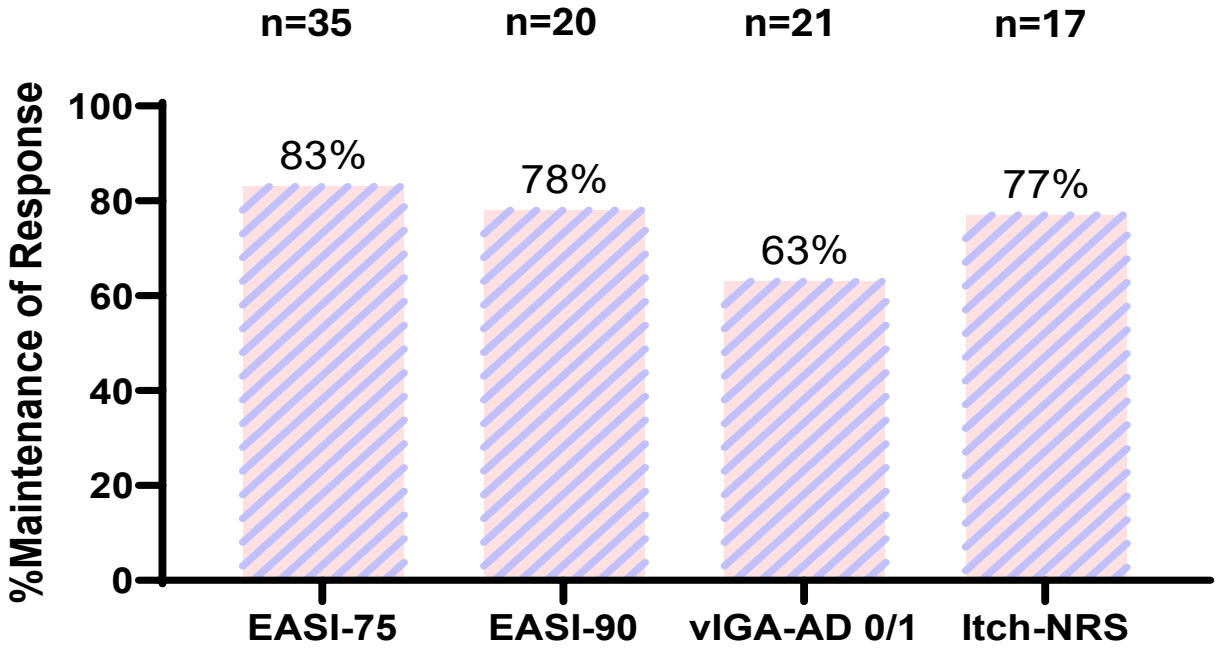
**Maintenance at Week 52 in the Q4W Cohorts**

24 µg/kg




**Maintenance at Week 52 in the Q12W Cohorts**

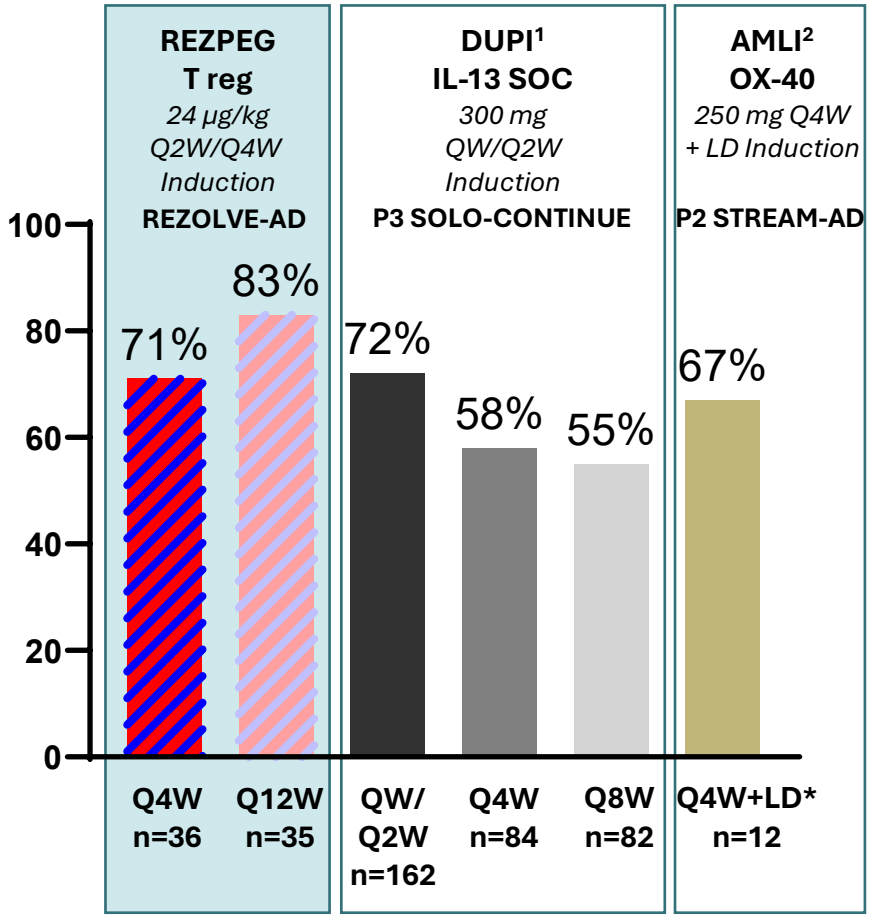
24 µg/kg



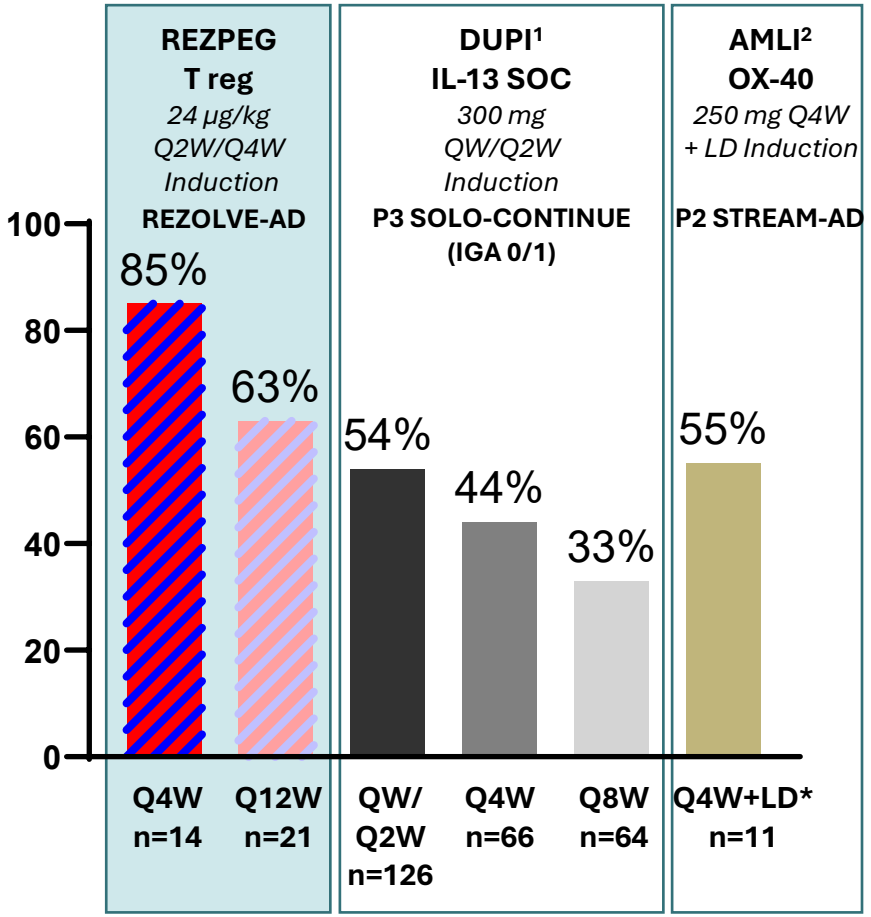

(n=xx) is the denominator which equals the number of responders at Week 16

# Maintenance of EASI-75 and vIGA-AD 0/1

## Percent Maintaining EASI-75 at Week 52



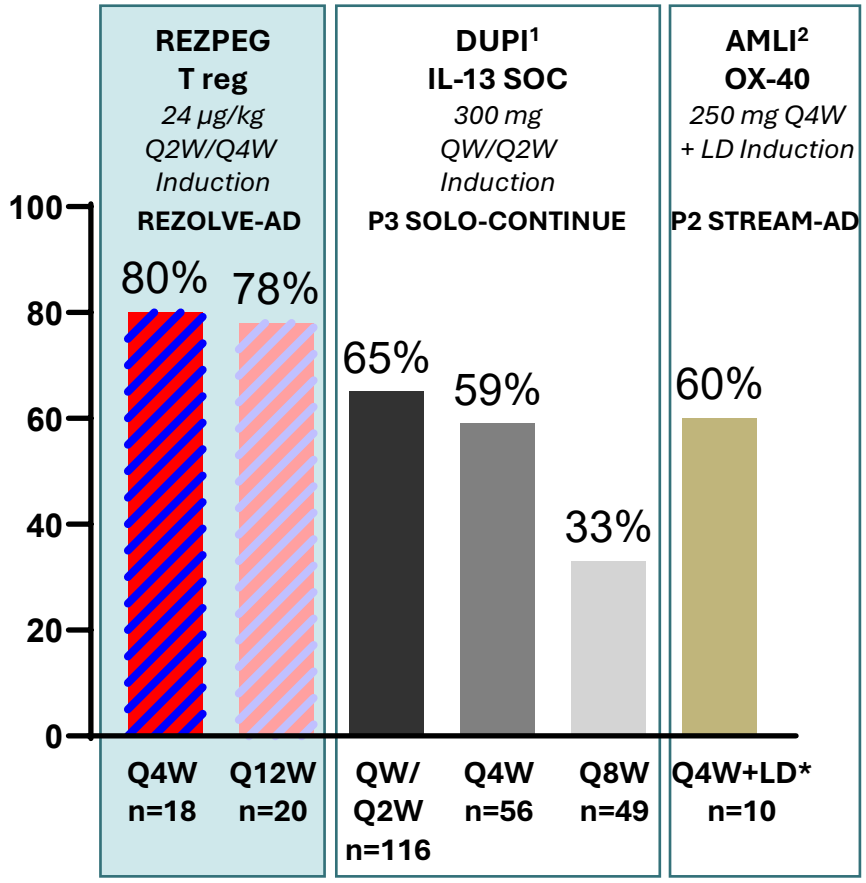

## Percent Maintaining vIGA-AD 0/1 at Week 52



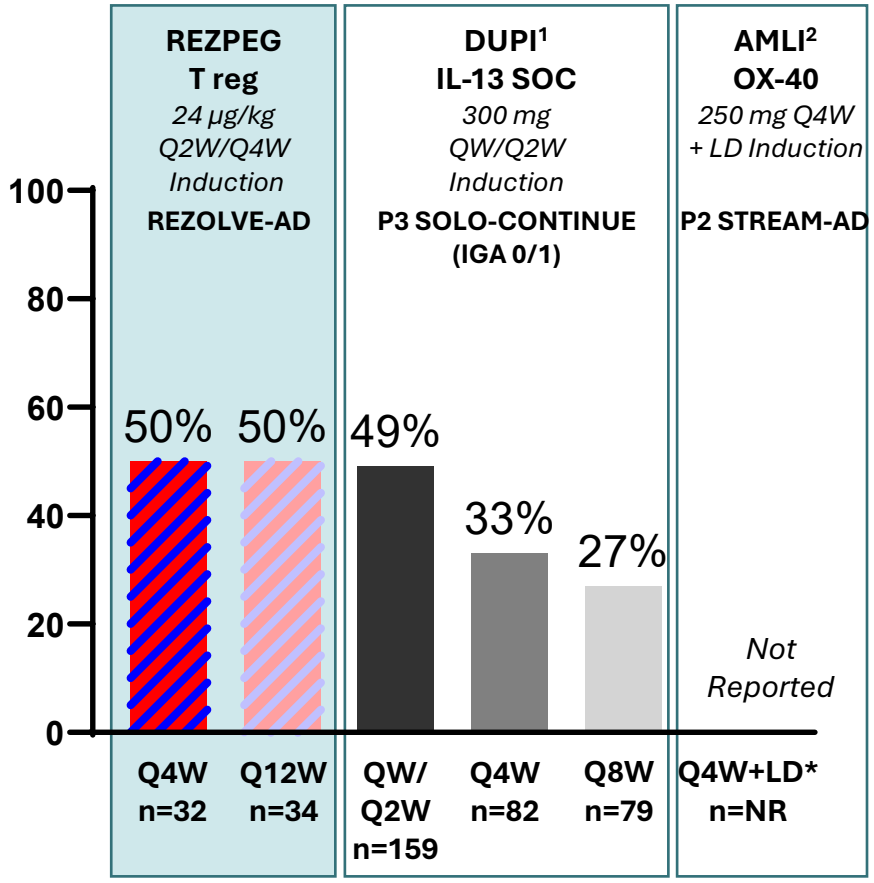

For REZOLVE-AD, data after escape are set to be missing. All other data regardless of rescue medication use and/or treatment discontinuation are used as is. Missing data is imputed using multiple imputation.
*Amlitelimab dose evaluated in Phase 3; Sources: 1. Phase 3 SOLO-CONTINUE Trial (Worm et al. 2019, JAMA Derm 156:131-143); 2. Phase 2 STREAM-AD (Weidinger et al. 2025, JACI 155:1264-75)

# Maintenance of EASI-90 and the Itch Response Rate at End of Maintenance

## Percent Maintaining EASI-90 at Week 52




## Percent Itch NRS (≥4-point reduction) Response Among EASI-75 or vIGA Responders at Re-Randomization



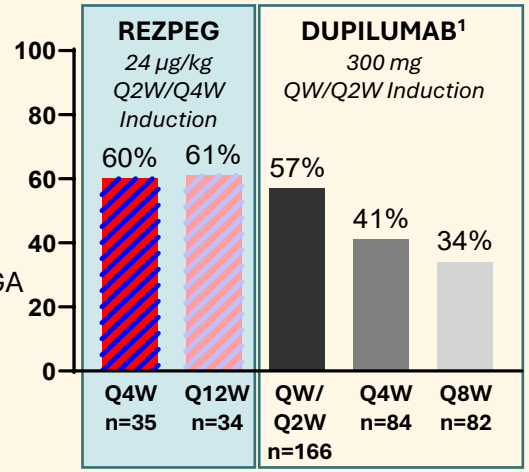

For REZOLVE-AD, data after escape are set to be missing. All other data regardless of rescue medication use and/or treatment discontinuation are used as is. Missing data is imputed using multiple imputation.
*Amlitelimab dose evaluated in Phase 3; Sources: 1. Phase 3 SOLO-CONTINUE Trial (Worm et al. 2019, JAMA Derm 156:131-143); 2. Phase 2 STREAM-AD (Weidinger et al. 2025, JACI 155:1264-75)
For percent itch NRS, SOLO-CONTINUE reported only 35 weeks of maintenance dosing

# Measurements of Improvements and Worsening for Itch and vIGA/IGA

## Improving

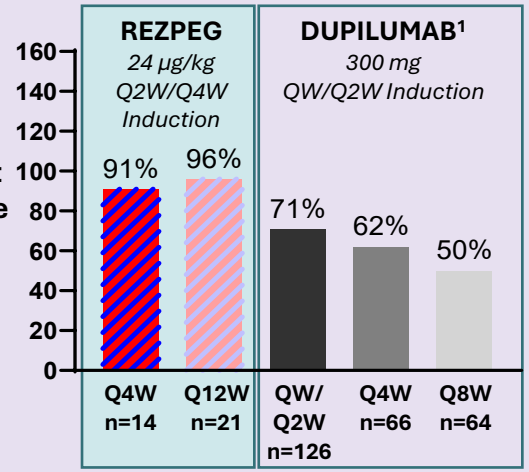
***Itch NRS***

**≥3-pt reduction from induction baseline**
at end of maintenance among EASI-75 or vIGA/IGA Responders at Re-Randomization




***vIGA/IGA***

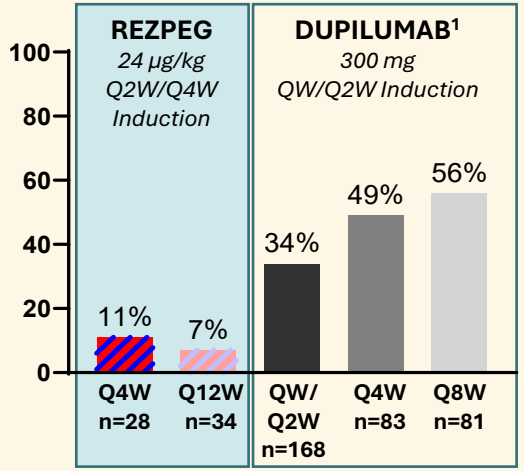
**Maintained within 1 point from start of maintenance**
at end of maintenance among vIGA/IGA Responders at Re-Randomization




## Worsening

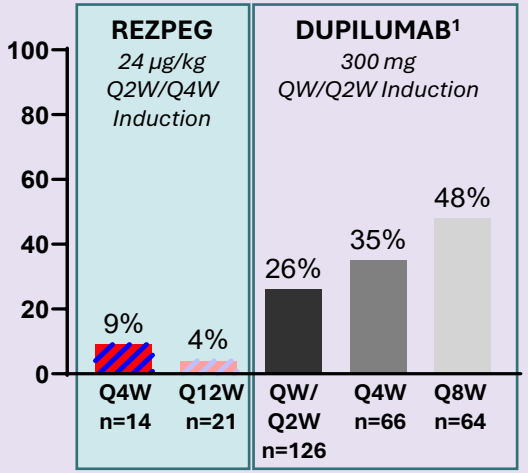
***Itch NRS***

**≥3-pt increase from start of maintenance**
at end of maintenance among EASI-75 or vIGA/IGA Responders at Re-Randomization after Induction




***vIGA/IGA***

**Worsening to 3/4**
at end of maintenance among vIGA/IGA Responders at Re-Randomization




For REZOLVE-AD, data after escape are set to be missing. All other data regardless of rescue medication use and/or treatment discontinuation are used as is. Missing data is imputed using multiple imputation.

Sources: 1. Phase 3 SOLO-CONTINUE Trial (Worm et al. 2019, JAMA Derm 156:131-143)

For percent itch NRS, SOLO-CONTINUE reported only 35 weeks of maintenance dosing

## *New* and *Deepening* Responses in Maintenance Among Re-Randomized Patients with ≥ EASI-50

# Rezpeg Monthly and Quarterly Induced *New* and *Deepening* Responses

*At Week 52*

| Induction Dose: | Rezpeg 24 µg/kg Q2W | | Rezpeg 24 µg/kg Q4W | | Rezpeg 18 µg/kg Q2W | |
|---|---|---|---|---|---|---|
| **Maintenance Dose:** | **24 µg/kg Q4W N=29** | **24 µg/kg Q12W N=29** | **24 µg/kg Q4W N=26** | **24 µg/kg Q12W N=27** | **18 µg/kg Q4W N=28** | **18 µg/kg Q12W N=28** |
| New EASI-75 Responders | 43% (n=10) | 35% (n=11) | 59% (n=9) | 44% (n=10) | 17% (n=8) | 62% (n=9) |
| New EASI-90 Responders | 33% (n=19) | 12% (n=18) | 33% (n=18) | 40% (n=18) | 37% (n=20) | 33% (n=21) |
| New vIGA-AD 0/1 Responders | 38% (n=21) | 35% (n=21) | 44% (n=20) | 46% (n=14) | 23% (n=16) | 36% (n=19) |
| New Itch Responder (≥4-point improvement) | 13% (n=9) | 9% (n=17) | 44% (n=17) | 29% (n=15) | 31% (n=13) | 18% (n=17) |

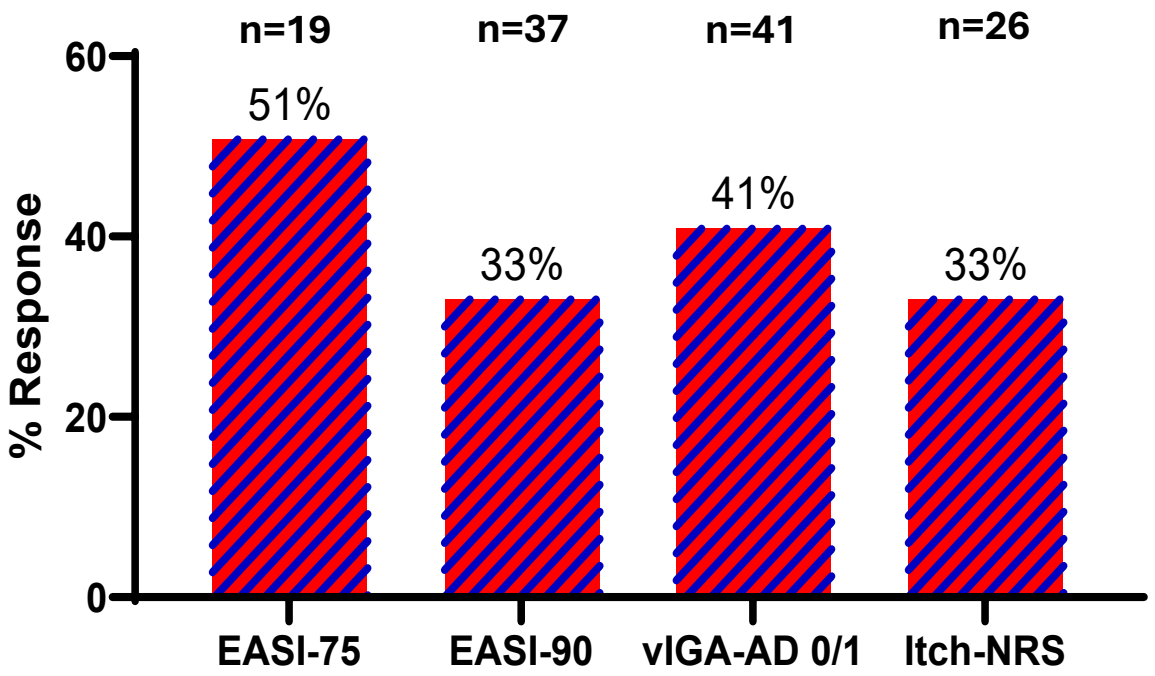
**New and deepening responses among re-randomized patients achieving EASI-50 in 16-week induction**

(N=xx) is the entire maintenance population; (n=xx) is the denominator which equals the number of non-responders for each endpoint at re-randomization; % represents proportion of patients who achieved that response at Week 52; missing data is imputed using multiple imputation

# *New* and *Deepening* Responses at Week 52 in Pooled Monthly and Quarterly Rezpeg (High Dose) Maintenance Arms

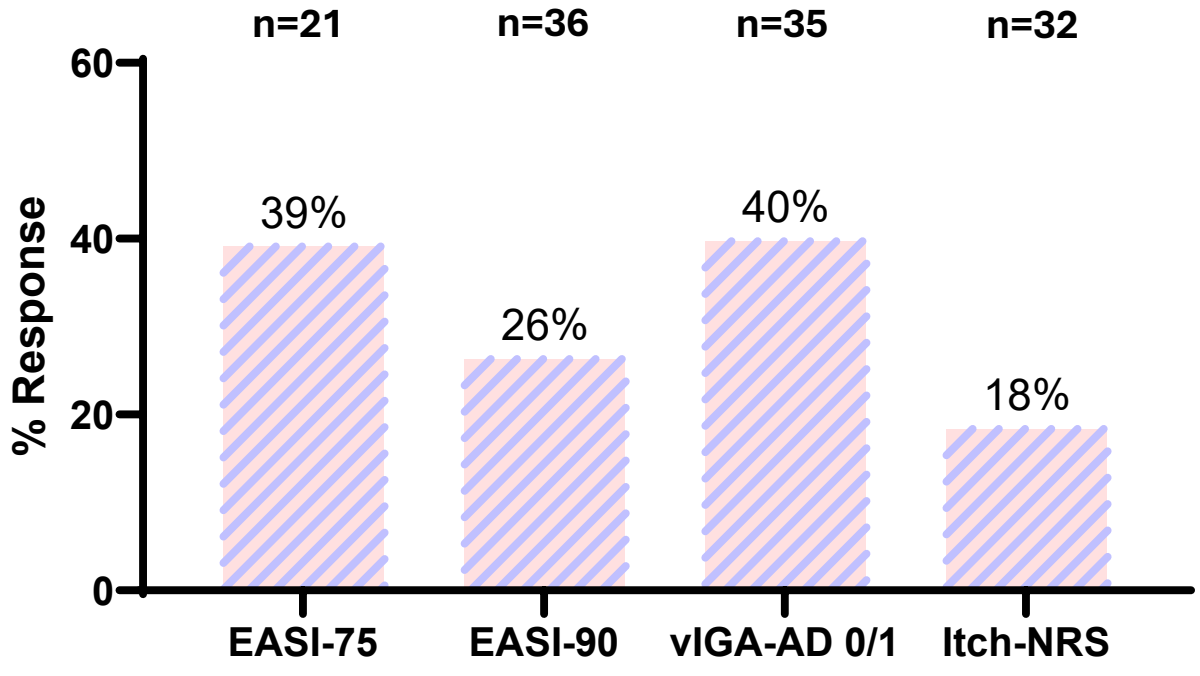
## New Responses at Week 52 in Q4W Cohorts

24 µg/kg




## New Responses at Week 52 in Q12W Cohorts

24 µg/kg



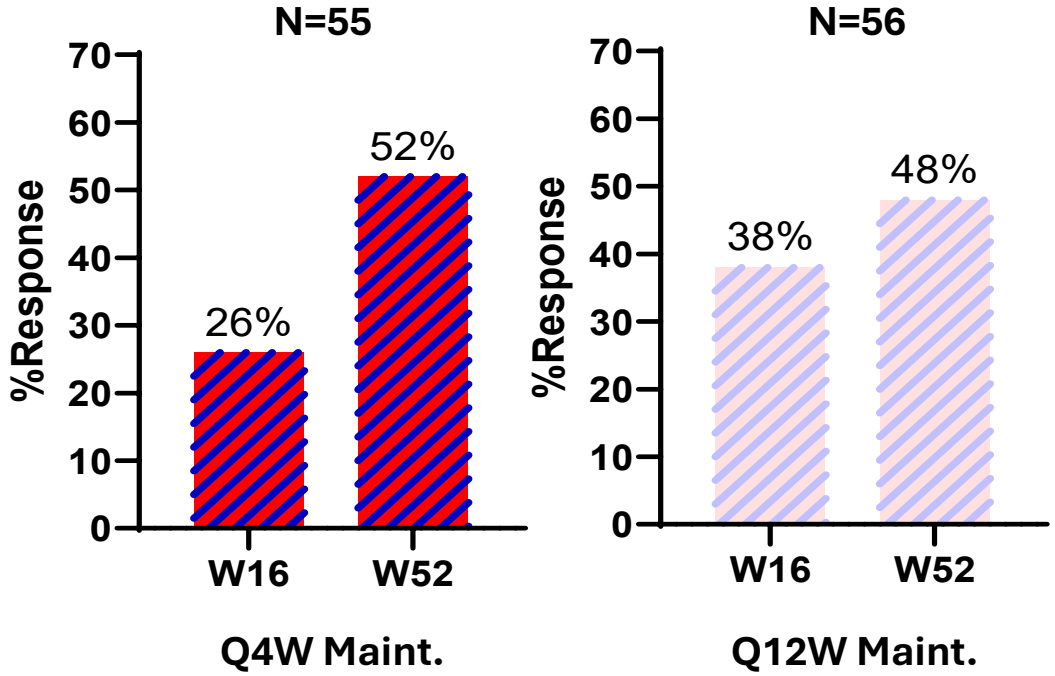

**New and deepening responses among re-randomized patients achieving EASI-50 in 16-week induction**

(n=xx) is the denominator which equals the number of non-responders for each endpoint at re-randomization

# vIGA-AD 0/1 Response Rates Increased at Week 52 in Pooled Monthly and Quarterly Rezpeg (High Dose) Maintenance Arms

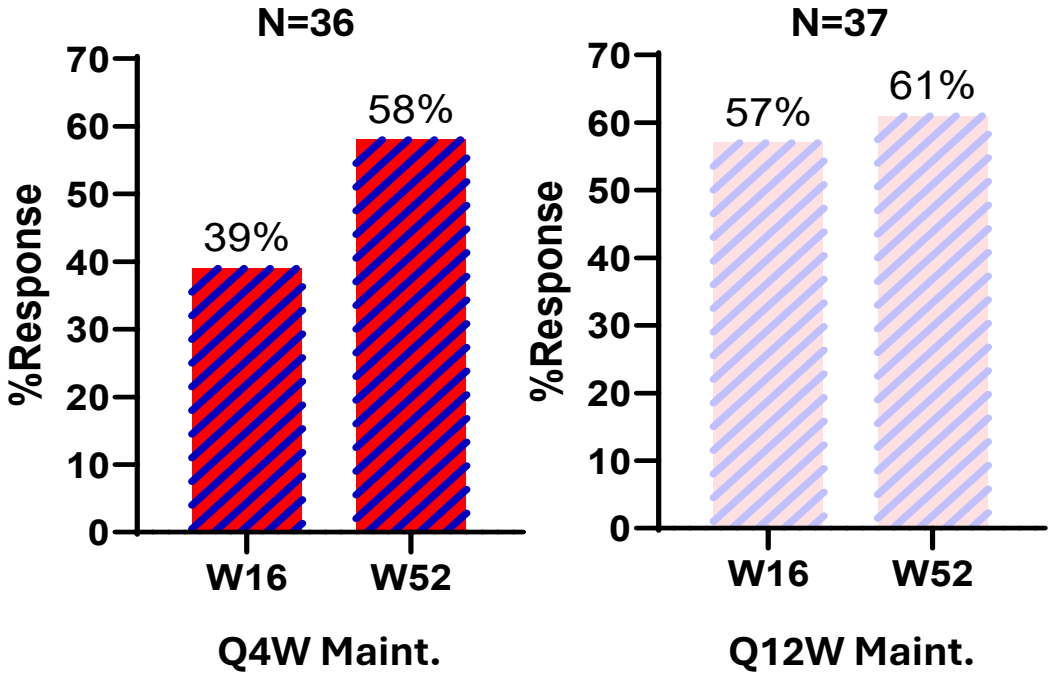
**vIGA-AD 0/1 Response Rate at Week 52 Among ≥ EASI-50 Responders at Re-Randomization**

24 µg/kg




**vIGA-AD 0/1 Response Rate at Week 52 Among ≥ EASI-75 or vIGA-AD 0/1 Responders at Re-Randomization**

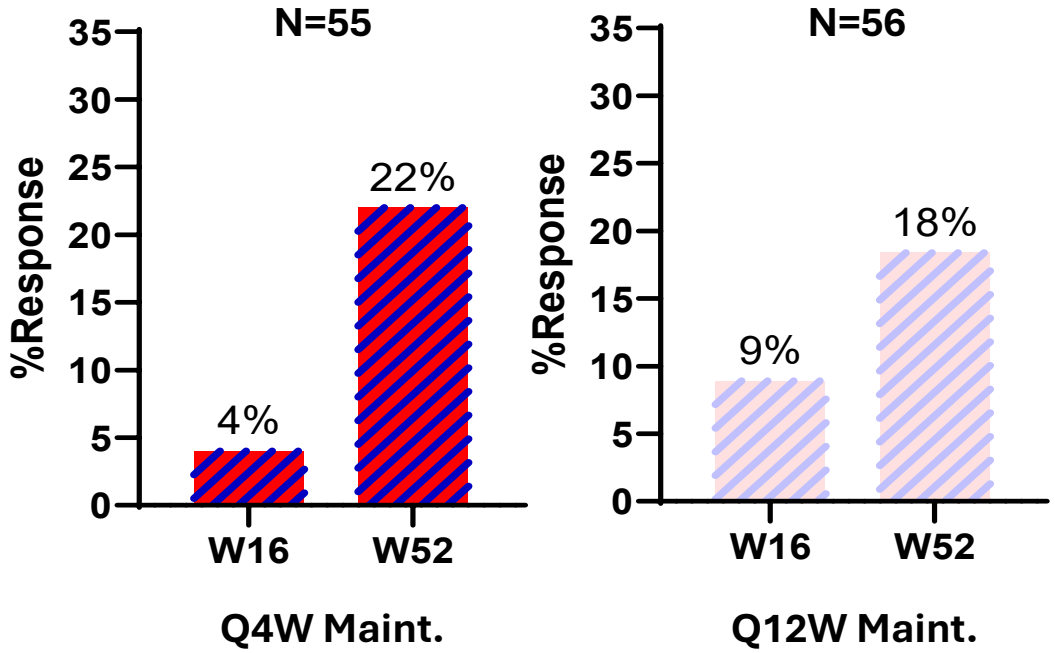
24 µg/kg



# EASI-100 Response Rates Increased at Week 52 in Pooled Monthly and Quarterly Rezpeg (High Dose) Maintenance Arms

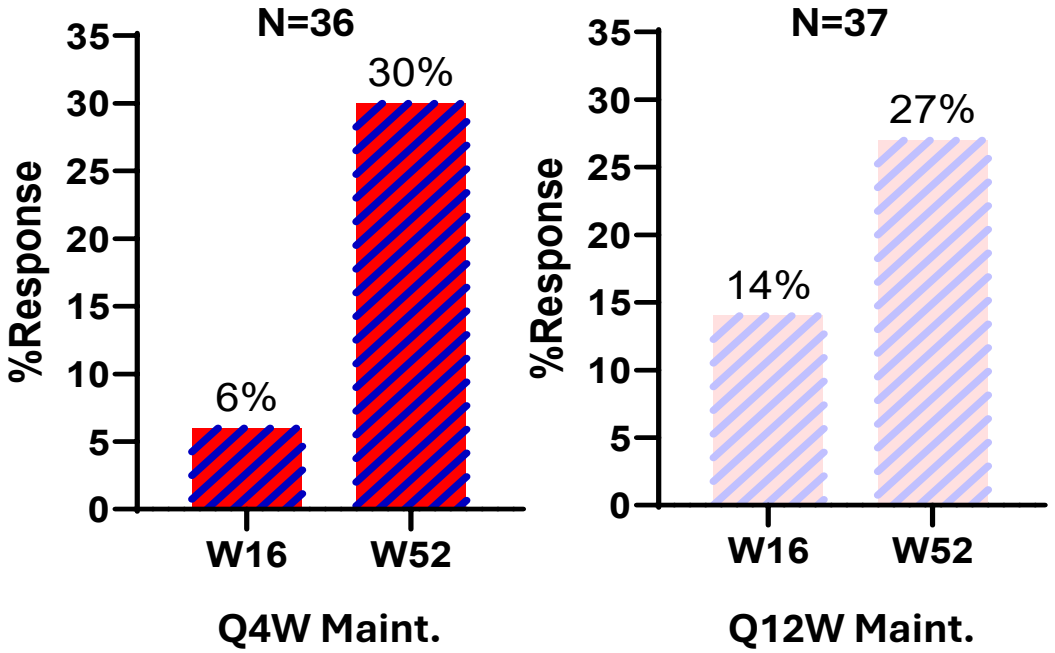
**EASI-100 Rate at Week 52 Among ≥ EASI-50 Responders at Re-Randomization**

24 µg/kg




**EASI-100 Rate at Week 52 Among ≥ EASI-75 or vIGA-AD 0/1 Responders at Re-Randomization**

24 µg/kg



# Safety Profile at 52-Weeks Consistent with Previously Reported Results

**52-week safety of Rezpeg across maintenance and escape patient populations is consistent with previously observed and reported safety profile**

- Discontinuation rate due to AEs was low (3.5%) for Rezpeg-exposed patients and was within the range of rates seen in contemporary Phase 2b studies
- No imbalance to suggest an increased risk of infection over placebo

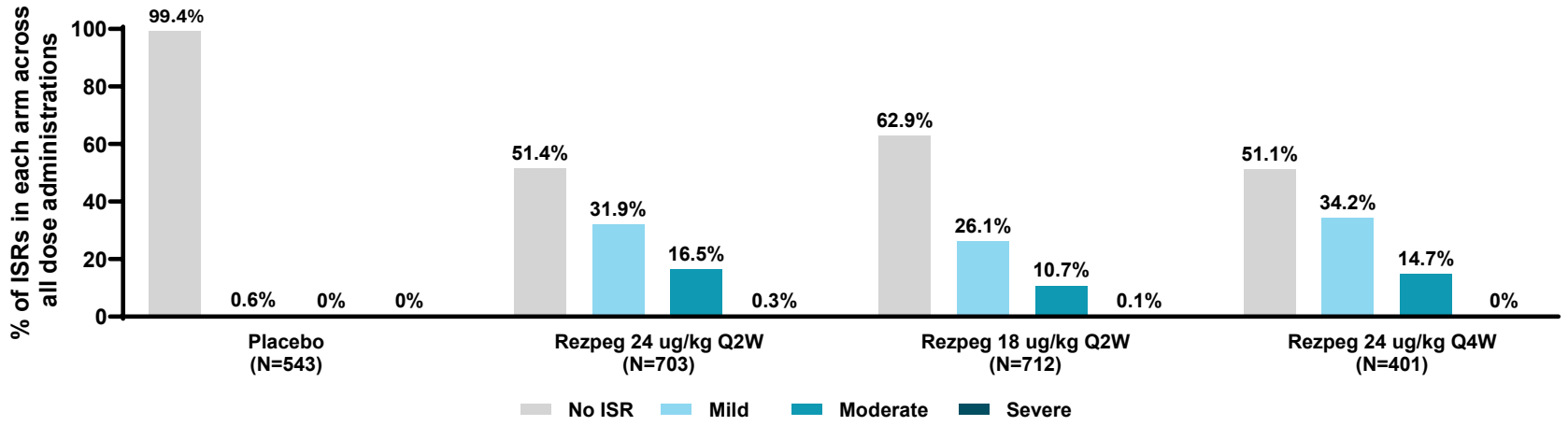
**No observed increased risk or safety signal for:** conjunctivitis, facial swelling or erythema, oral (aphthous) ulcers, myocardial infarction, pulmonary embolus, deep venous thrombosis and malignancy

**Most frequently observed adverse event was injection site reactions (ISRs)**

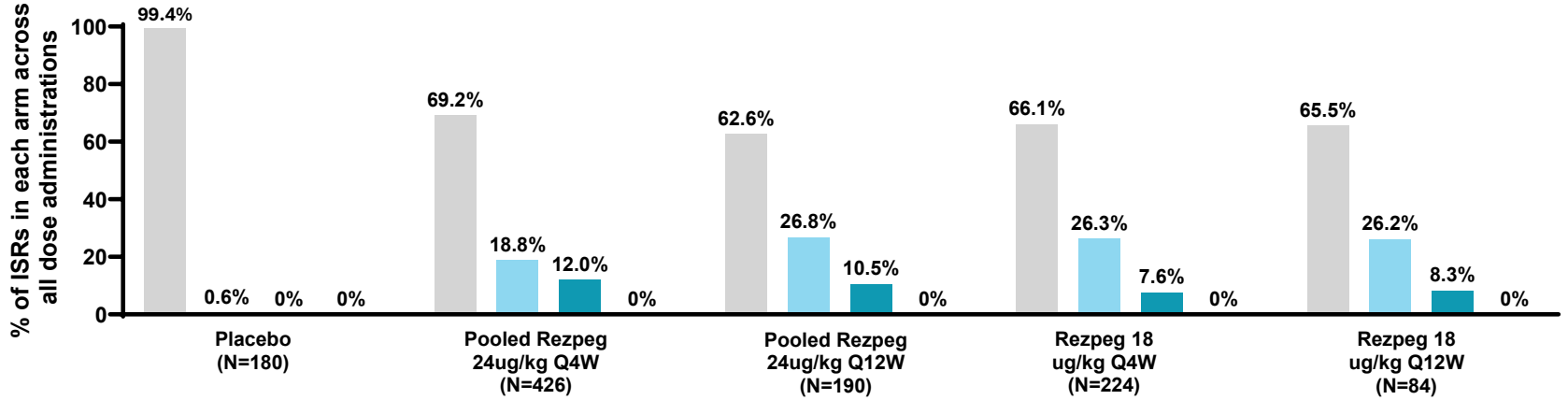
- Nearly all were mild-moderate in severity and self-resolving
- The treatment discontinuation rate due to ISRs overall was very low (0.7%) for Rezpeg exposed patients
- Lower frequency of ISRs observed over longer dosing duration in maintenance

# Lower Frequency of ISRs Observed Over Longer Dosing Duration in Maintenance

## Induction Period




## Maintenance 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*

# REZOLVE-AD Phase 2 Validates Rezpeg as First-in-Class Novel Treg Mechanism in Atopic Dermatitis

## Novel Treg MoA differentiates from existing and in-development biologics

- **Up to 6-fold increase in Tregs**
- **Clear dose-dependent reduction in multiple AD biomarkers: IL-19, TARC/CCL17, Periostin, MDC/CCL22**
- **Mechanistic validation translating into sustained clinical efficacy**

## All 3 dose arms met primary endpoint

- **% improvement in EASI at 16 weeks** ($p<0.001$)
- **Clear dose-dependent response**
- **Rapid onset of action** (early separation from placebo)
- **Similar efficacy data observed in severe patients as in moderate**

## Highest dose achieved all 6 key secondaries and durable maintenance

- **Met all six key secondary endpoints EASI-75, vIGA-AD 0/1, Itch-NRS, EASI-90, BSA**
- **Q4W and Q12W maintenance regimens durable through Week 52**
- **Continued deepening of responses from Week 16 to Week 52**

## Long-term safety consistent with previously-reported safety profile with no new safety concerns

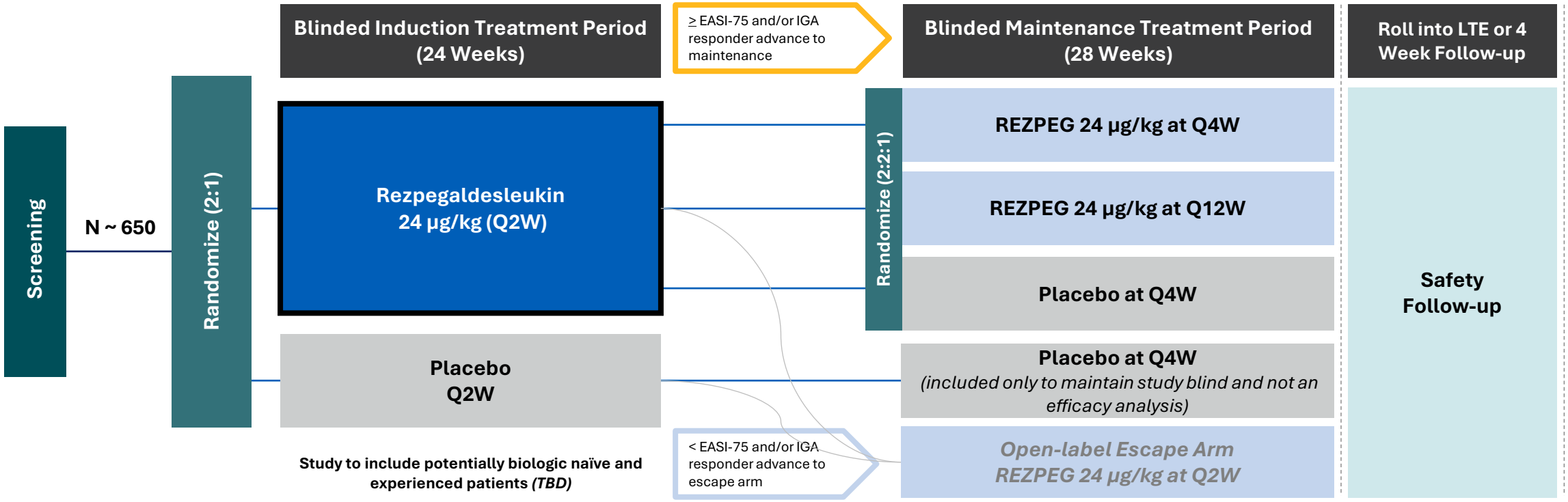
- No increased risk of conjunctivitis, oral ulcers, or infections, including oral herpes, in study treatment arms
- Most frequent AEs were mild injection site reactions (ISRs) that were self-resolving (<1% discontinuations due to ISRs)
- Over 1,000 patients treated to date (~381 patient-years of exposure)

Source: Nektar Investor and Analyst Event (June 2025); EASI-75: Eczema Area and Severity Index ≥ 75; vIGA-AD: validated Investigator Global Assessment of Atopic Dermatitis; Itch-NRS: Itch Numerical Rating Scale; EASI-90: Eczema Area and Severity Index ≥ 90; BSA: Body Surface Area

# Differentiating Features of Rezpeg for Atopic Dermatitis

- **Treg MoA validated** for deep and durable efficacy in patients with moderate-to-severe atopic dermatitis with extended dosing out to 52 weeks
- **Rapid onset of action** for both EASI-75 and itch relief with Rezpeg arm separating from placebo early in treatment
- Demonstrated **control of asthma (ACQ-5 endpoint)** in patients with moderate-to-severe atopic dermatitis and co-morbid asthma (25% of population)
- **Maintenance regimens achieved durability and demonstrated a deepening of responses**
- **Extended dosing regimens with Rezpeg compare favorably** to historically reported longer term maintenance data across Phase 2/Phase 3 trials
- **Extended dosing regimens with Rezpeg resulted in new and deepening of responses** achieved from Week 16 to Week 52
- **Long-term Safety Profile Established** for 52 weeks of dosing
  - Consistent with previously-reported safety profile with no new safety concerns identified in study treatment arms

# Proposed Phase 3 Trial Design in Atopic Dermatitis




**Key Inclusion Criteria**
- Age: ≥12 years
- Moderate/severe AD diagnosis for ≥ 12 months
  - EASI ≥ 16
  - IGA of 3 or 4
  - BSA ≥ 10%

**Stratification**
Induction:
- Age
- Geographic region
- Disease severity by IGA
- Prior biologic/oral JAKi

**Stratification**
Maintenance:
- Age
- Disease severity by IGA

**Endpoints**
Co-Primary
- IGA-related endpoint (Use of IGA, vIGA, rIGA TBD)
- EASI-75

Key Secondary
- EASI-90
- Itch NRS, ≥ 4-point reduction

# Rezpegaldesleukin in Alopecia Areata

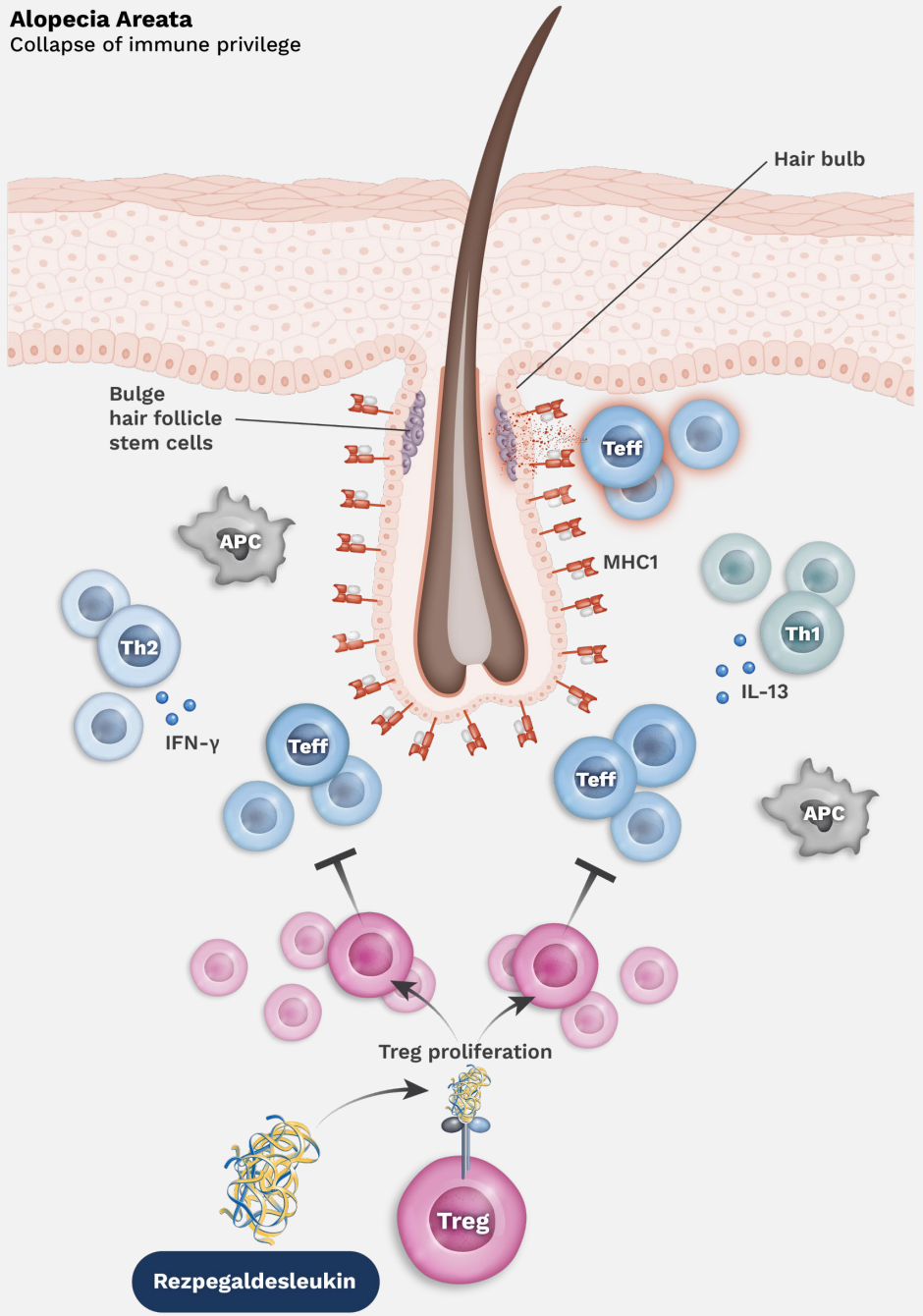
# Rezpegaldesleukin
# Alopecia Areata MOA

## Scientific rationale

- By targeting receptors on regulatory T cells, rezpegaldesleukin stimulates the proliferation of regulatory T cells (Tregs), including FOX-P3+ Tregs

- In alopecia, a pro-inflammatory environment causes the collapse of immune privilege around the anagen hair bulb leading to hair follicle focal inflammation driven by NKG2D + T cells, NK cells, as well as auto-reactive CD8+ T cells

- Regulatory T cells act upstream of these inflammatory cytokines to reduce their activity; by increasing the number and functionality of regulatory T cells, rezpegaldesleukin aims to reduce the hair follicle local inflammation and restore immune privilege.



# Rezpegaldesleukin in Alopecia Areata Overview

Topline data from Phase 2b study in severe-to-very severe alopecia areata in December 2025

**Alopecia areata (AA)** is a disease that happens when the immune system attacks hair follicles and causes hair loss[1]

- Nearly 6.7 million people in the US have had it or will have it in their lifetime. ~700,000 people currently have alopecia areata in US. [2]
- ~160 million people worldwide have alopecia areata or have had, or will have it[2]
- 80% of patients show signs of alopecia before 40[2]
- Many patients are refractory to available therapies, and long-term use is associated with troublesome side effects and safety risks[3]
- Only systemic treatments approved for alopecia are JAK inhibitors with multiple Blackbox warnings. High relapse rates upon discontinuation of these therapies[3]

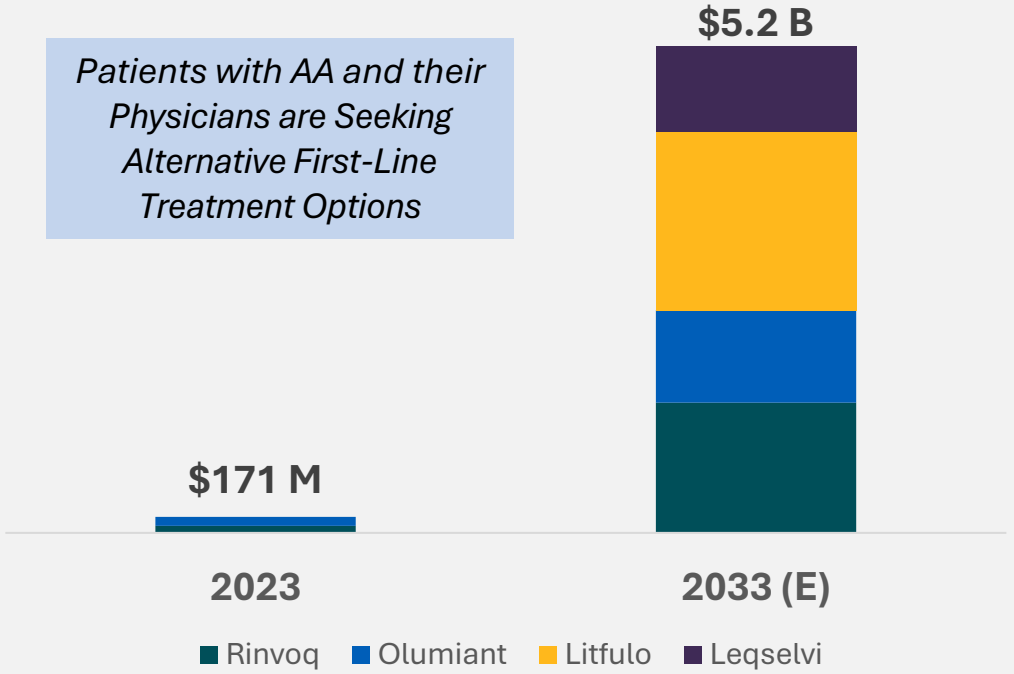
***Represents additional opportunity to expand Rezpeg***

*Sources: 1. NIH; 2. National Alopecia Areata Foundation; 3. DRG – Unmet Needs of Alopecia Areata*

# 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 it[1]
- 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 risks[2]
- 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 AA[2] (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® (ritlecitinib) is a registered trademark owned by Pfizer Inc.; Leqselvi™ (deuruxolitinib) is a registered trademark of Pharmaceutical Industries, Inc.*

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

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

| Key Eligibility Criteria | Induction Q2W (Weeks 0-36) | Week 36 Analyses | Exploratory Treatment Extension and Follow-up |
|---|---|---|---|

- Adult patients (18+)
- Severe-to-very-severe AA
- SALT ≥50
- >6 months since diagnosis to exclude unstable AA
- No spontaneous improvement over the past 6 months
- 8-week washout of prior medication for AA

**Stratification by baseline SALT Score ≥50 to <95 vs ≥95 to 100**

**3:3:2 N=92**

- **REZPEG 24 µg/kg n=35**
- **REZPEG 18 µg/kg n=37**
- **Placebo n=20**

**Primary:**
- Mean % SALT reduction at Week 36

**Key Secondaries:**
- SALT ≥ 30% reduction from baseline ($SALT_{30}$)
- Absolute SALT Score ≤30
- Absolute SALT Score ≤20
- Absolute SALT Score ≤10
- Clinician-Reported Outcome (ClinRO) Eyebrow and Eyelash (exploratory)
- Safety

***Blinded 16-week treatment extension:*** **Patients with a SALT Score greater than 20 at Week 36 who also demonstrated hair growth**

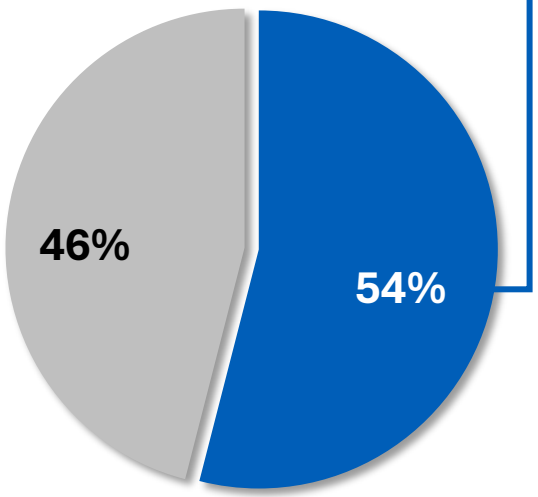
**24-week follow-up period after 36 or 52 weeks of treatment**

Rezolve AA

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

# 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 JAKi[1]***




## 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 ≤20 responders rebound)[2]

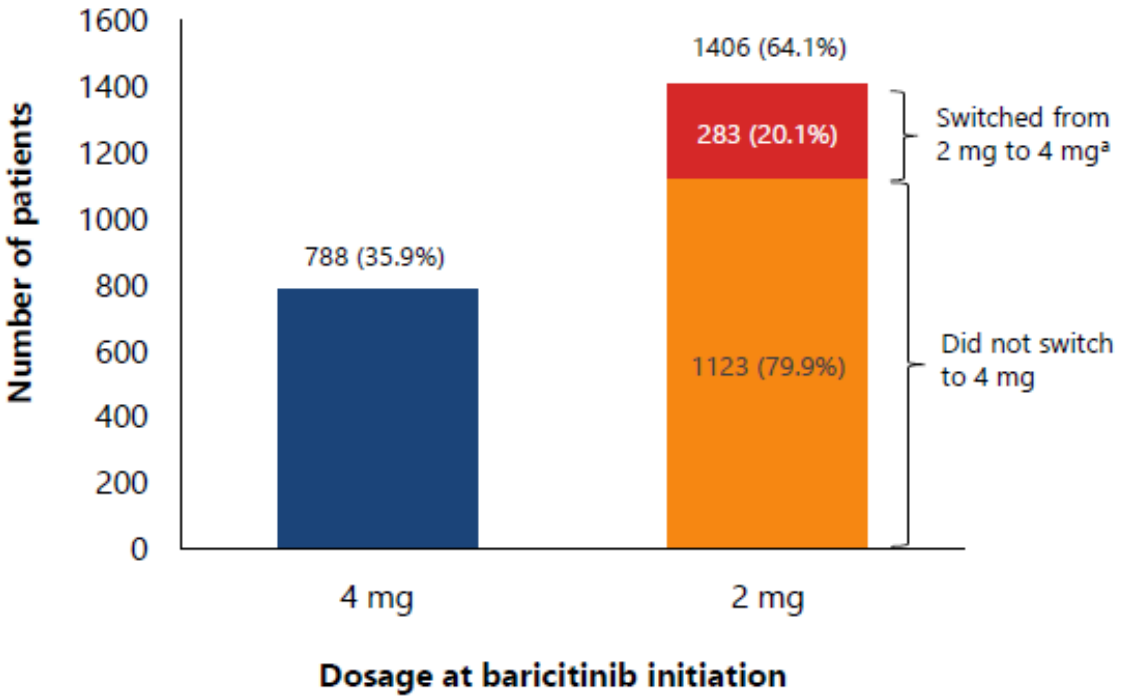
*Source: 1. Adapted from Nohria et al., Journal of the American Academy of Dermatology 2024; 2. King et al., JAMA Dermatol. 2024*

# 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




[a]Only 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) |

[a]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%) of the patients who initiated on baricitinib 4 mg had a claim during the follow-up period for baricitinib 2 mg.
[b]The 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.
[c]Discontinuation 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

# Blinded 16-Week Exploratory Treatment Extension for REZOLVE-AA

## A Total of 31 Patients Entered into Treatment Extension

***Blinded 16-week treatment extension:***
**Patients with a SALT Score greater than 20 at Week 36 who also demonstrated hair growth**
**n=31**

**Extension Q2W (Weeks 36-52)**

**Patient with a SALT Score greater than 20 at Week 36 who also demonstrated hair growth**
*Patients continued at same dose from induction*

- **REZPEG 24 µg/kg n=13**
- **REZPEG 18 µg/kg n=14**
- **Placebo n=4**

**52-Week Exploratory Endpoints**

- New SALT Score ≤20 Responders Weeks 36-52 (80% or more hair coverage on scalp)
- Overall SALT Score ≤20 at Week 52*
- Overall SALT Score ≤30 at Week 52* (70% or more hair coverage on scalp)
- SALT Score $SALT_{30}$ at Week 52* (30% improvement from baseline SALT)
- Overall $SALT_{50}$ at Week 52* (50% improvement from baseline SALT)

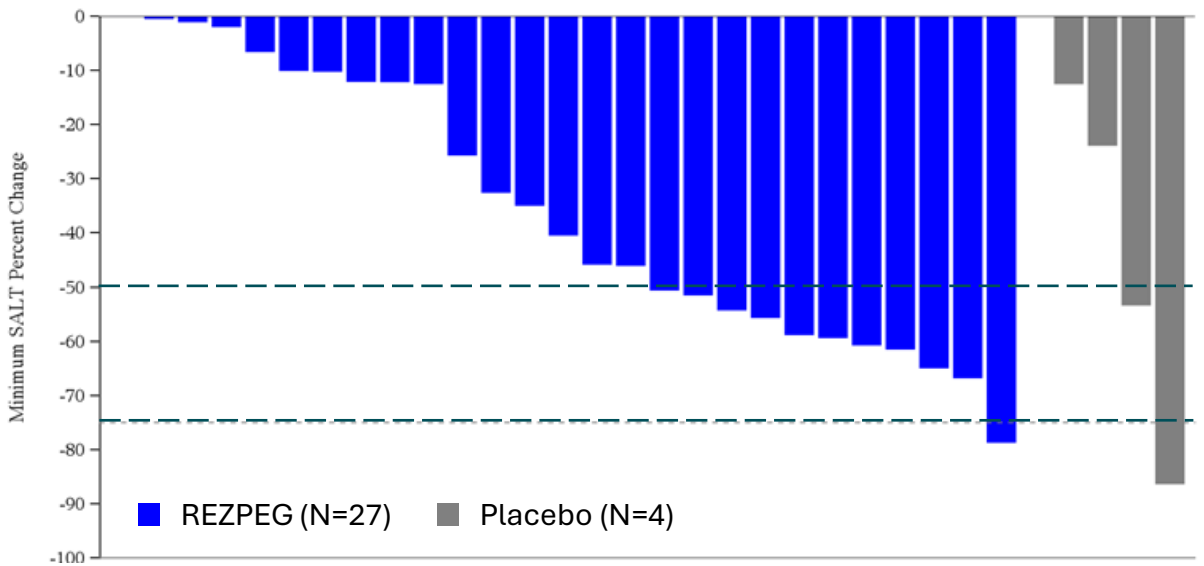
**Modified intent-to-treat adapted (mITT$^{A}$): excludes 4 patients with major study eligibility violations (post-hoc); No patient with study eligibility violations entered into the 16-week treatment extension*

# REZPEG-Treated Patients in Extension Achieved Deepening of Response

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

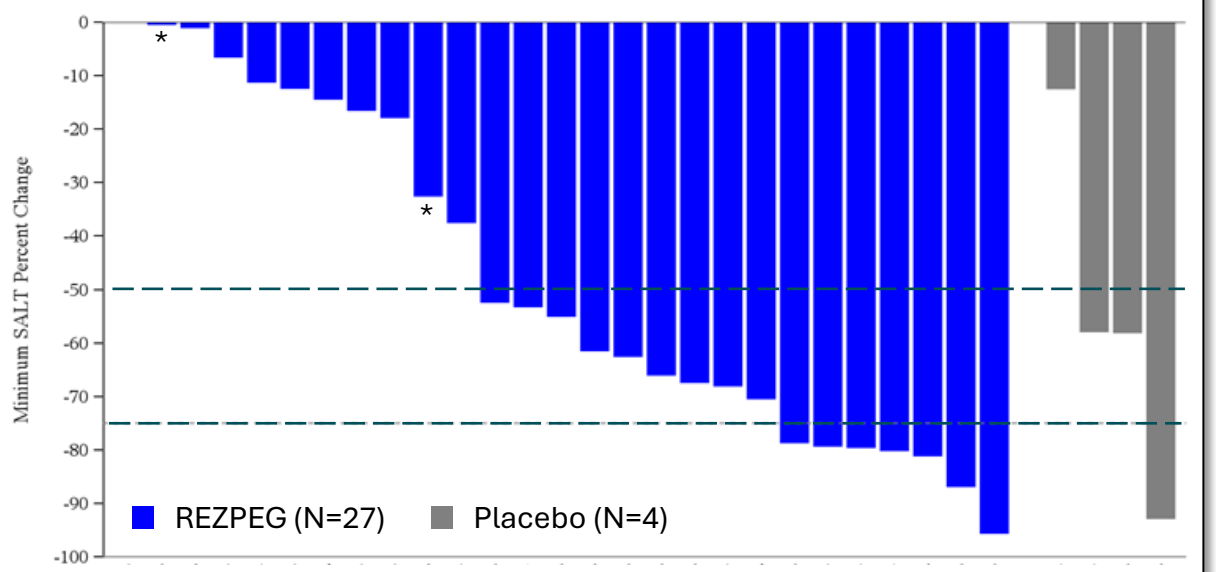
**94% of patients in extension completed treatment to week 52**

***Extension Patients***
***36-week Induction (N=31)***




**4% (1/27) achieved ≥75% reduction from baseline SALT**

***Extension Patients***
***52-week Treatment (N=31)***

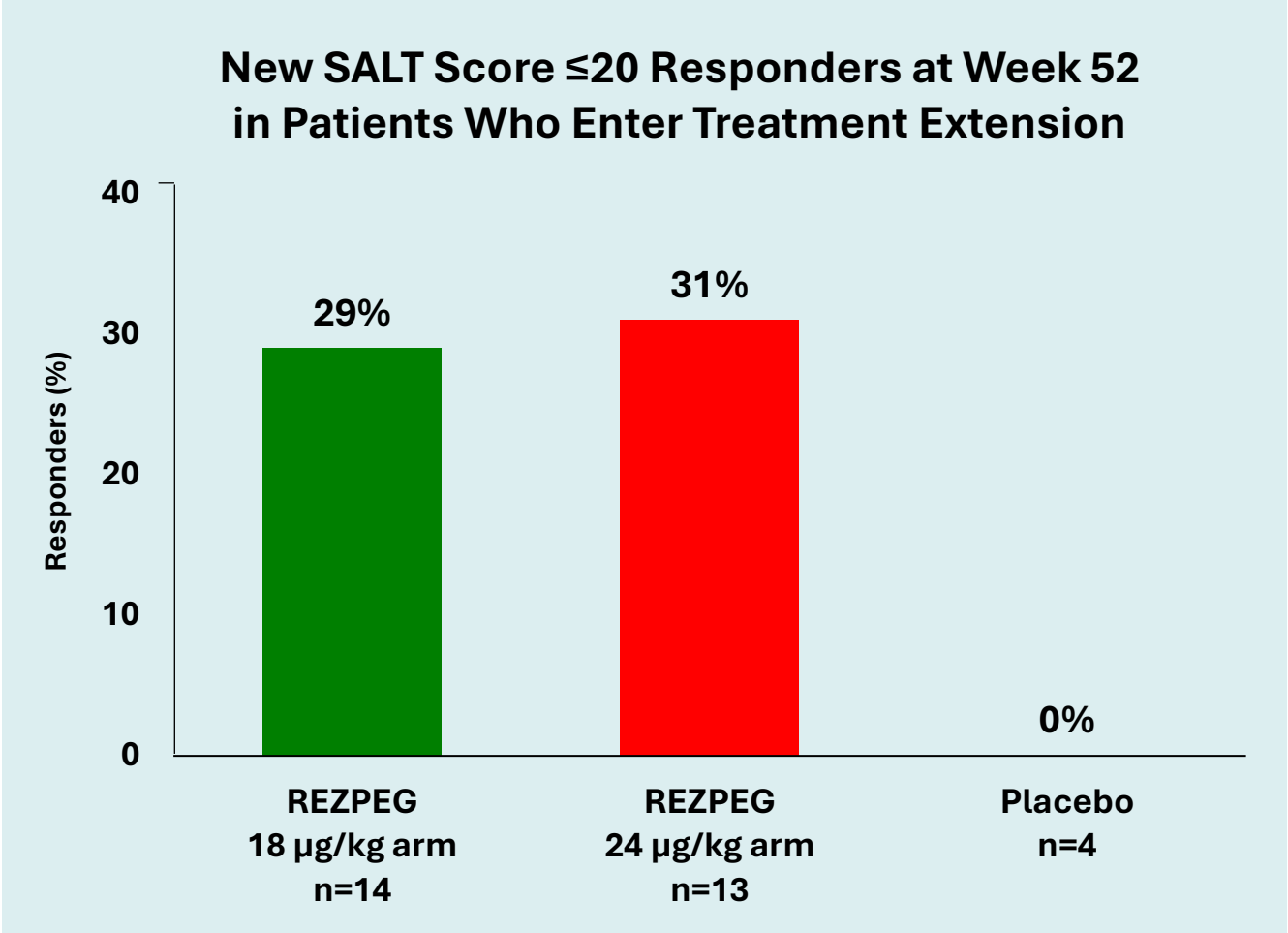



**26% (7/27) achieved ≥75% reduction from baseline SALT**

**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

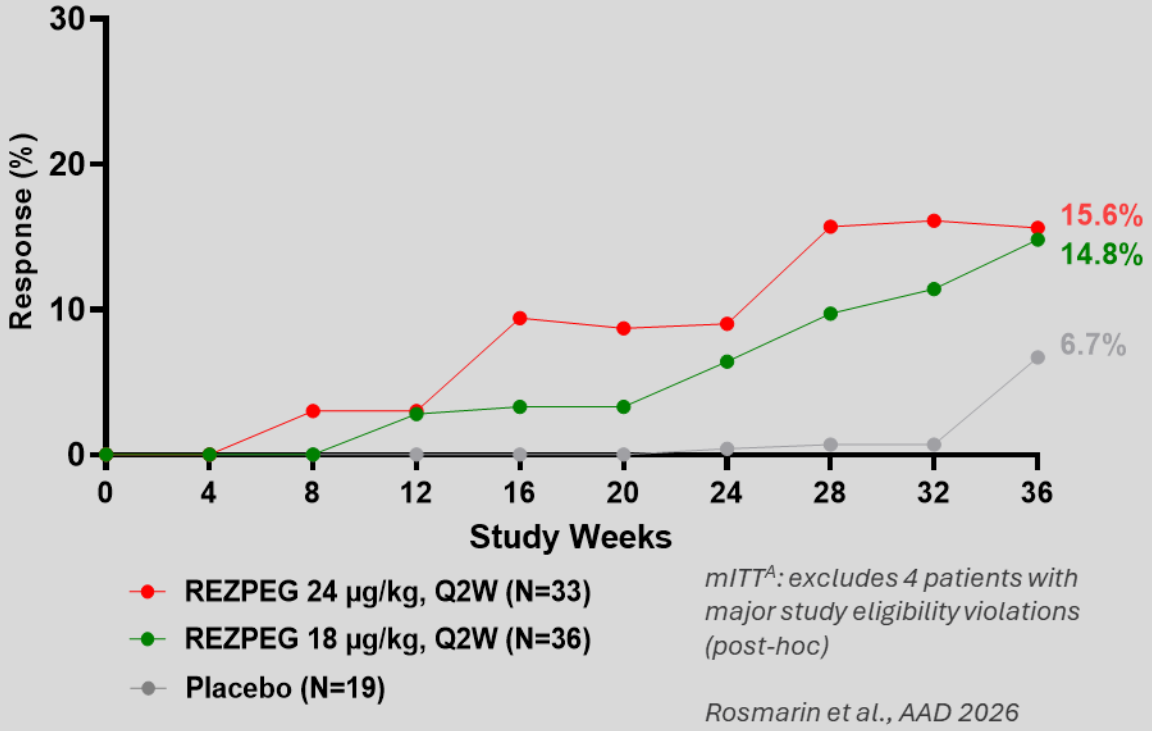
*Analysis by multiple imputation (slide 31); two patients discontinued prior to week 52 due to patient decision*

# 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])

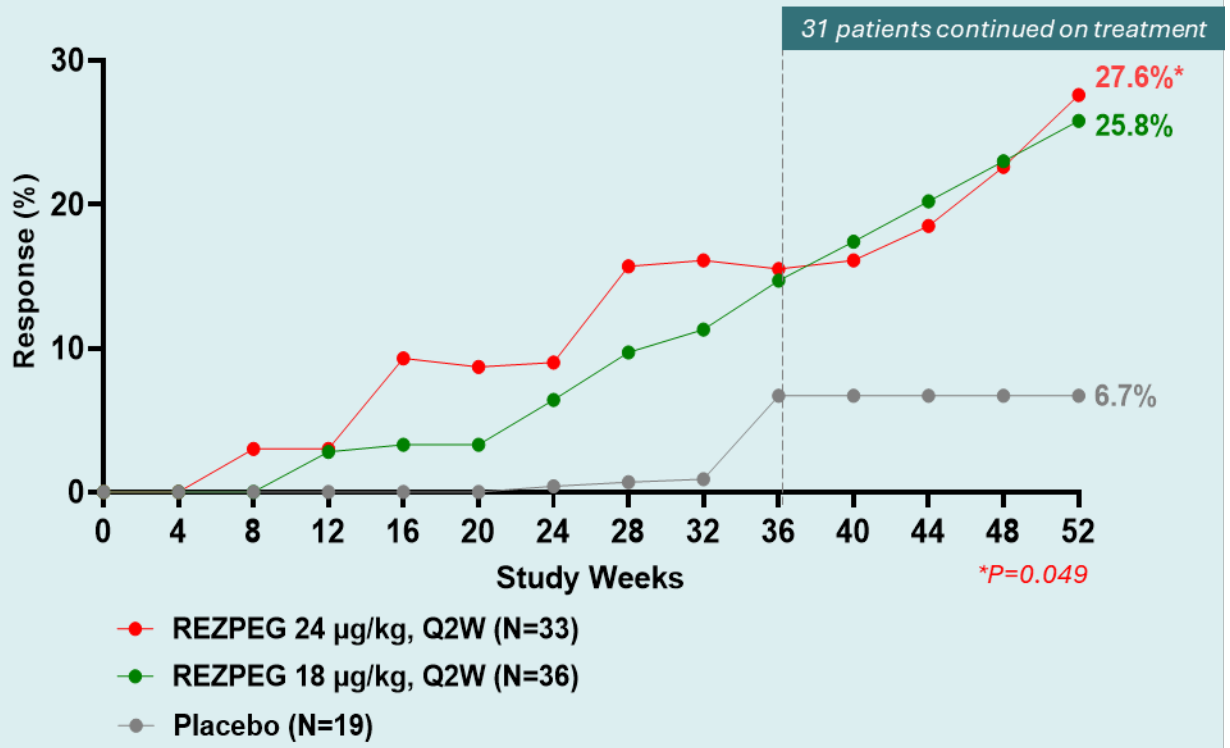



*mITT[A]: excludes 4 patients with major study eligibility violations (post-hoc)*

*Rosmarin et al., AAD 2026*

**52-week Treatment Data**

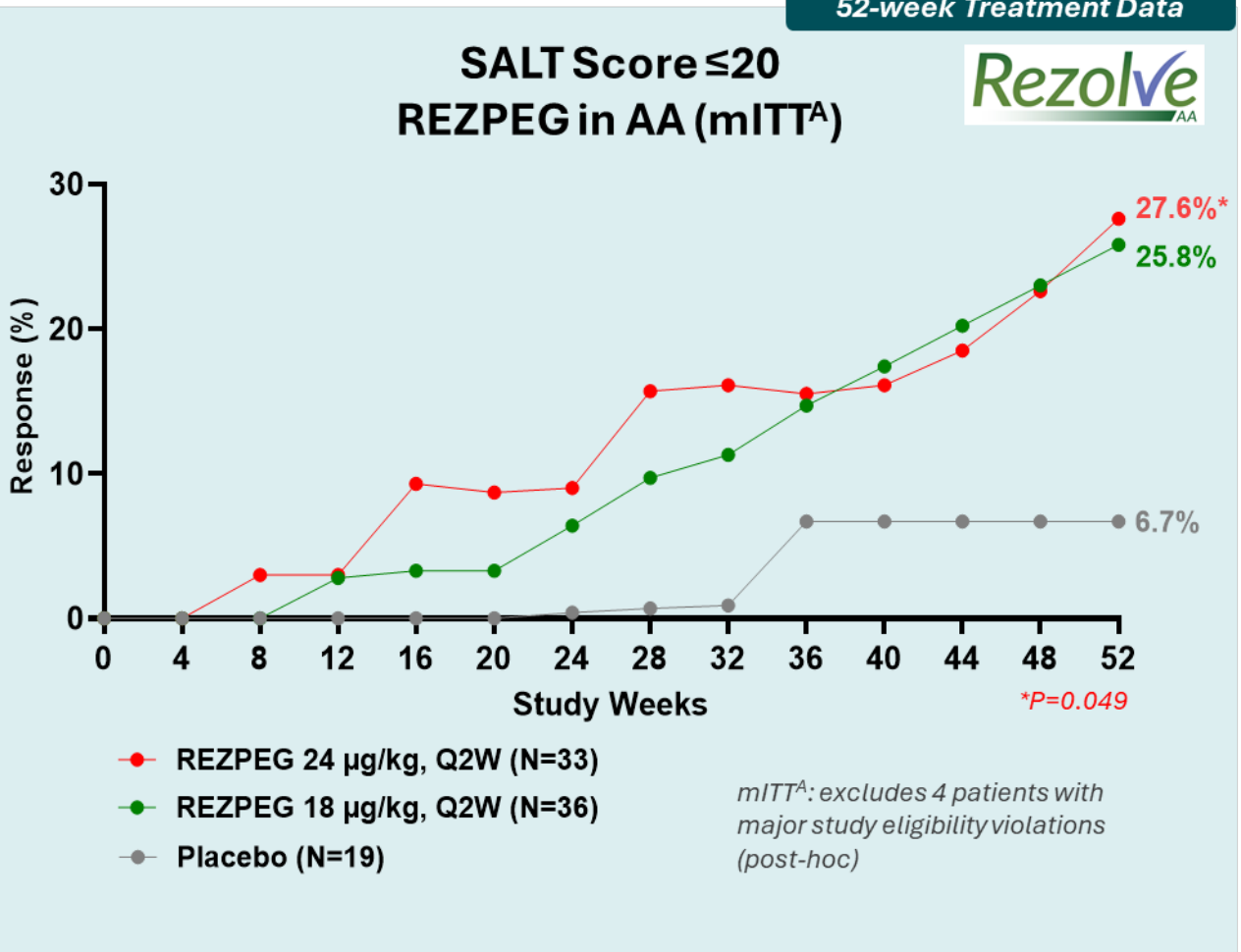
### SALT Score ≤20 at Week 52 (mITT[A])



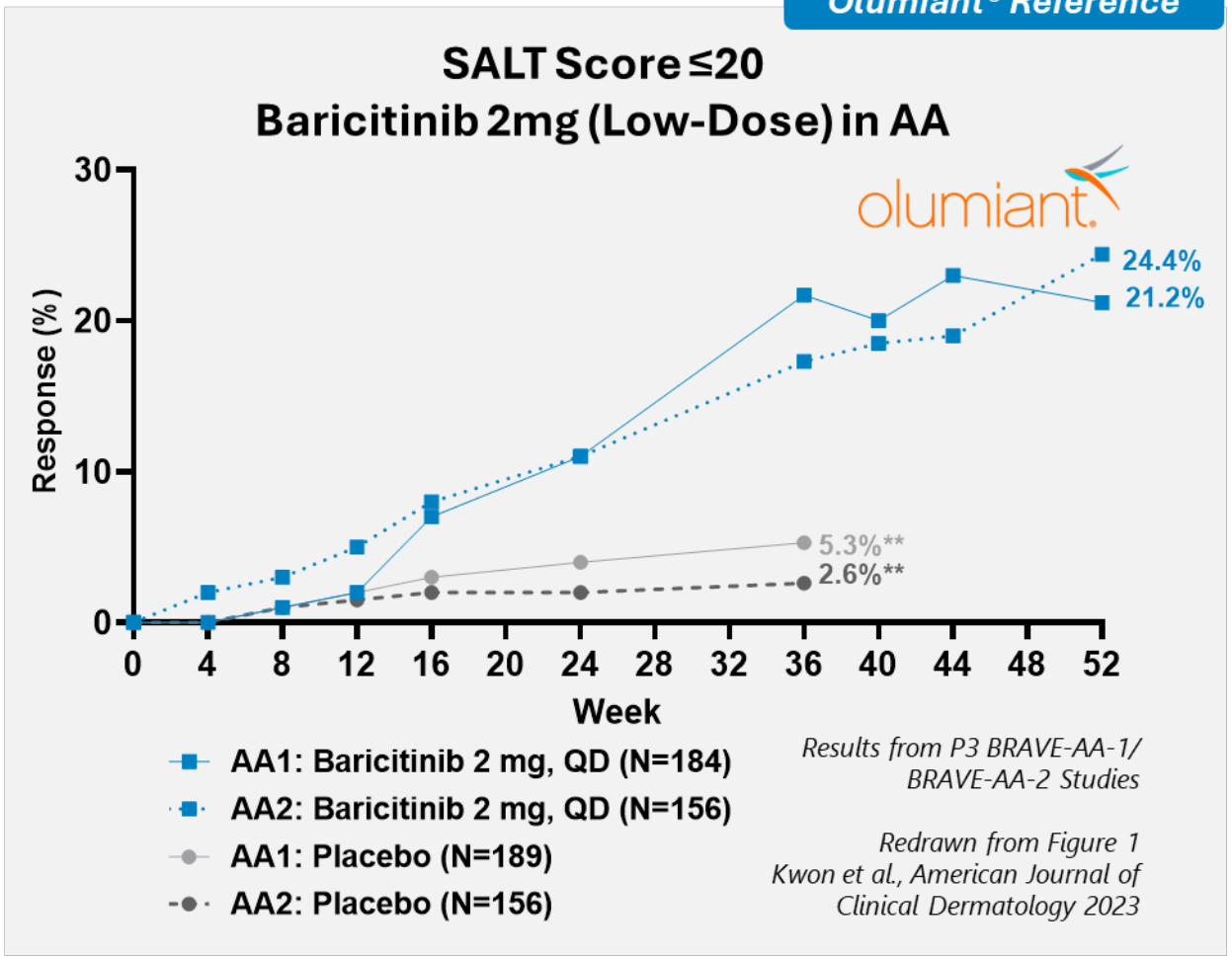

*Data for mITT[A] analysis set are imputed from week 0 to week 36 following primary estimand. Data for patients in non-treatment extension set in week 40, 44, 48 and 52 are carried forward from week 36 data. Missing data for patients in treatment extension set for week 40, 44, 48 and 52 are imputed using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

# REZPEG Met Our Target Product Profile

**52-week Treatment Data**




**Olumiant® Reference**




*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*

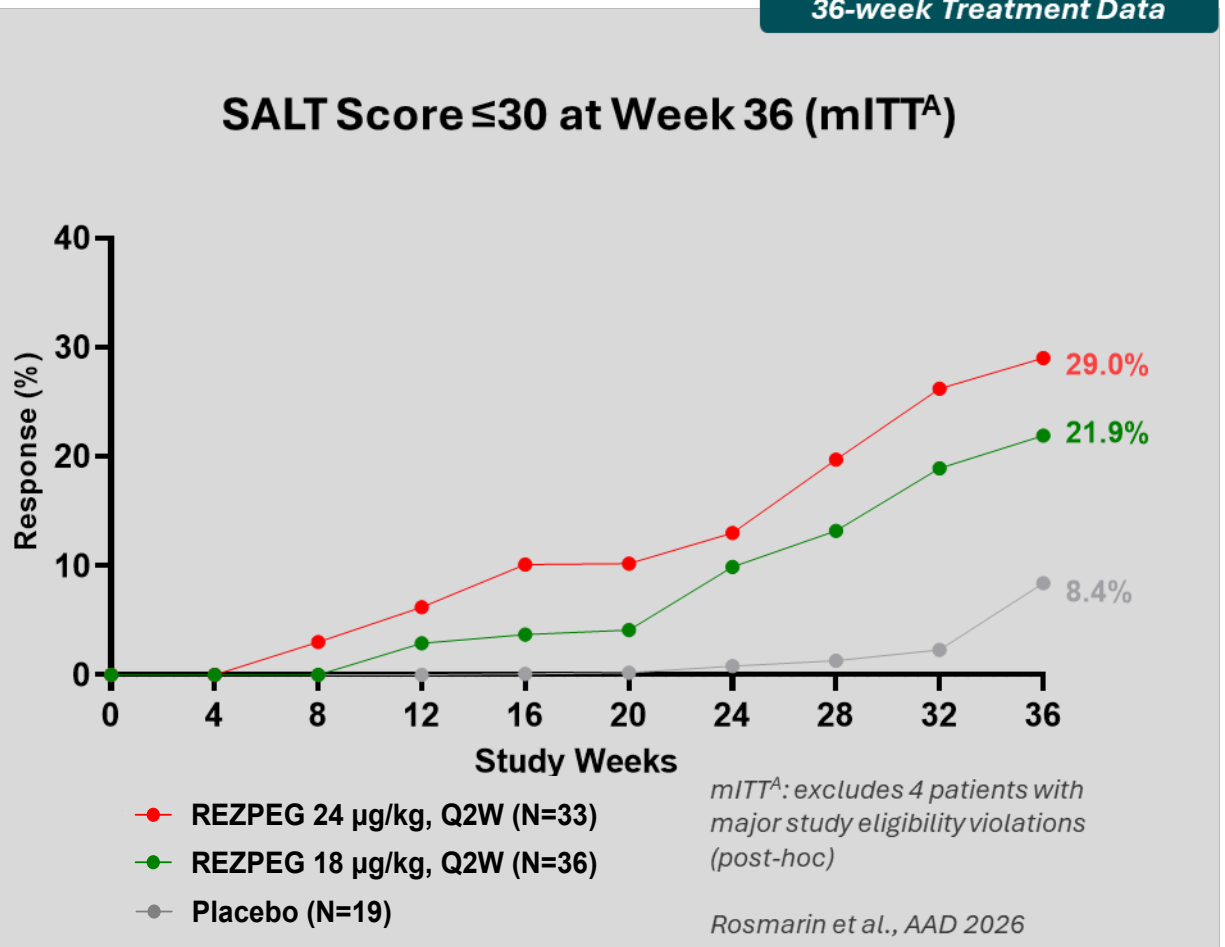


*This is a cross-trial comparison and includes data from different clinical studies and is not a head-to-head comparison.*

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

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

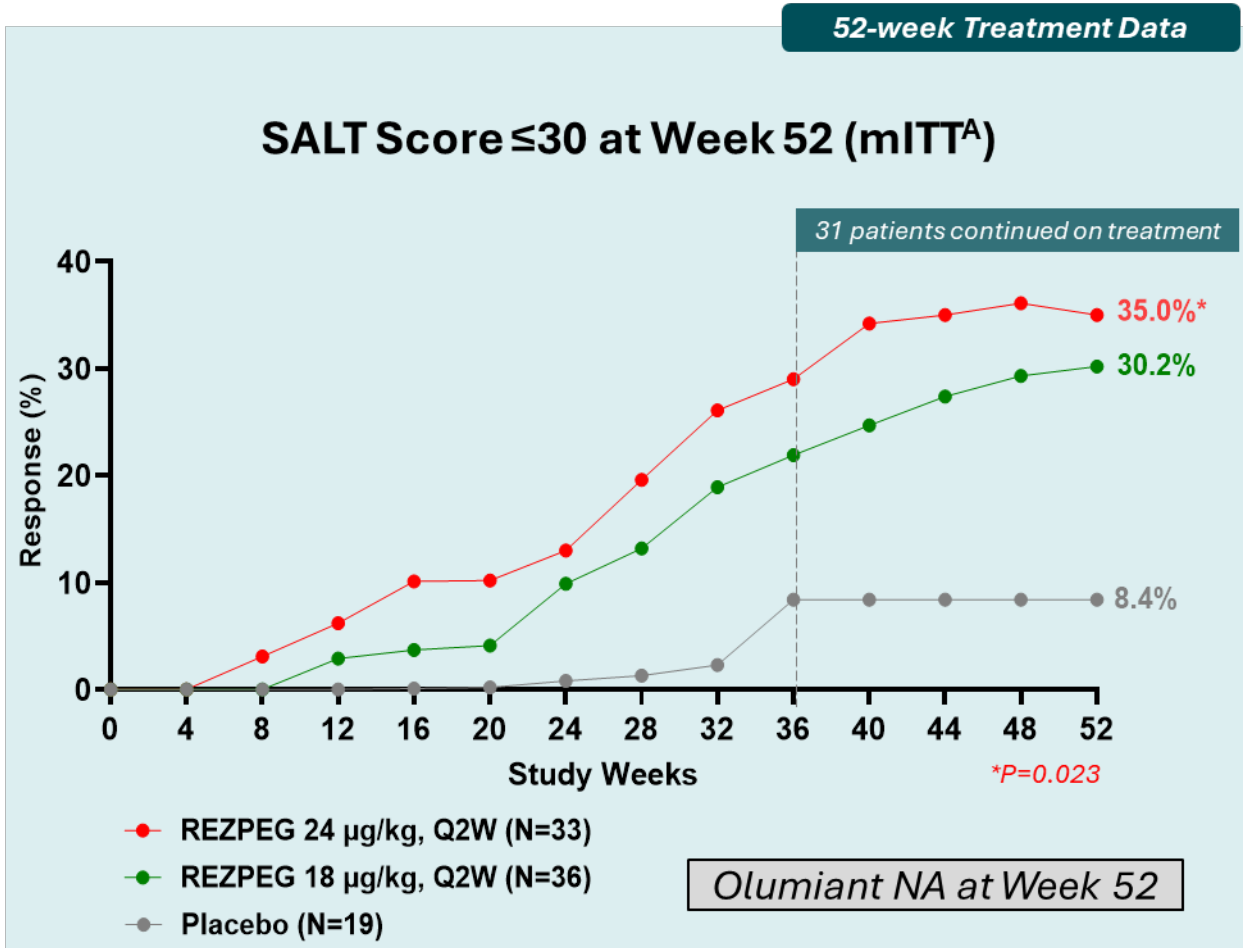
**36-week Treatment Data**




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

*Rosmarin et al., AAD 2026*

**52-week Treatment Data**



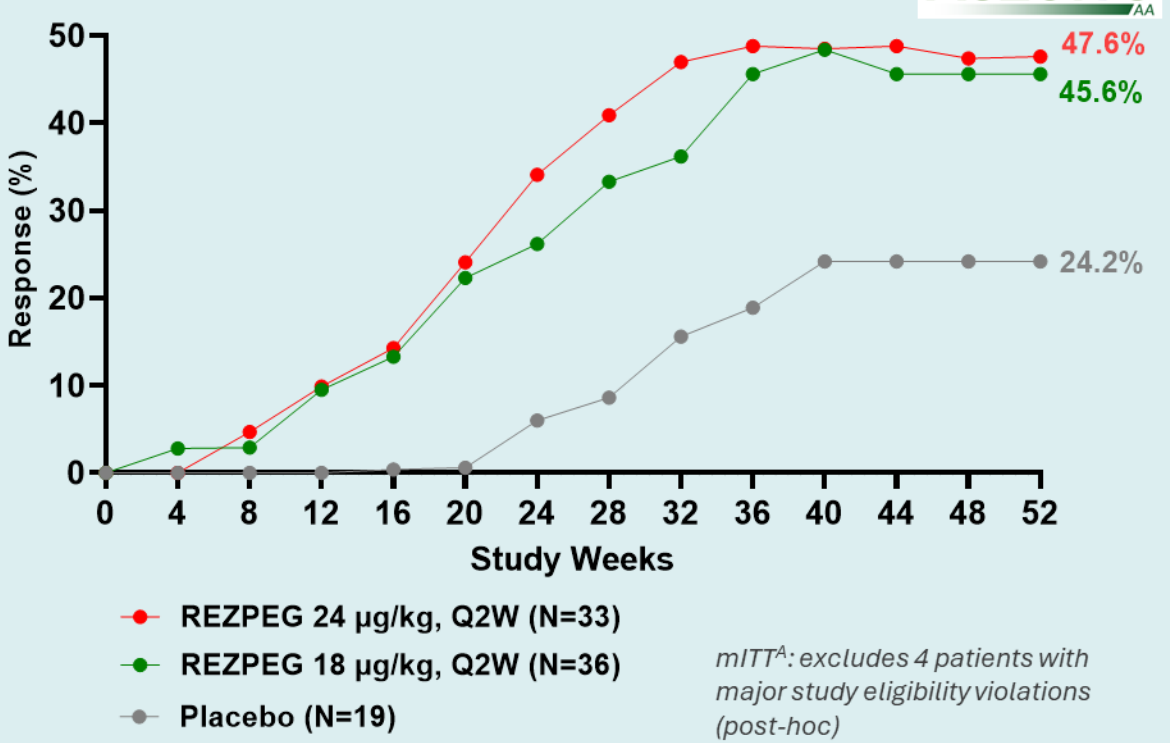

*Data for mITT^A analysis set are imputed from week 0 to week 36 following primary estimand. Data for patients in non-treatment extension set in week 40, 44, 48 and 52 are carried forward from week 36 data. Missing data for patients in treatment extension set for week 40, 44, 48 and 52 are imputed using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

# Promising Data for a Biologic in AA

## $SALT_{30}$ (At Least 30 Percent Improvement from Baseline in SALT)

**52-week Treatment Data**

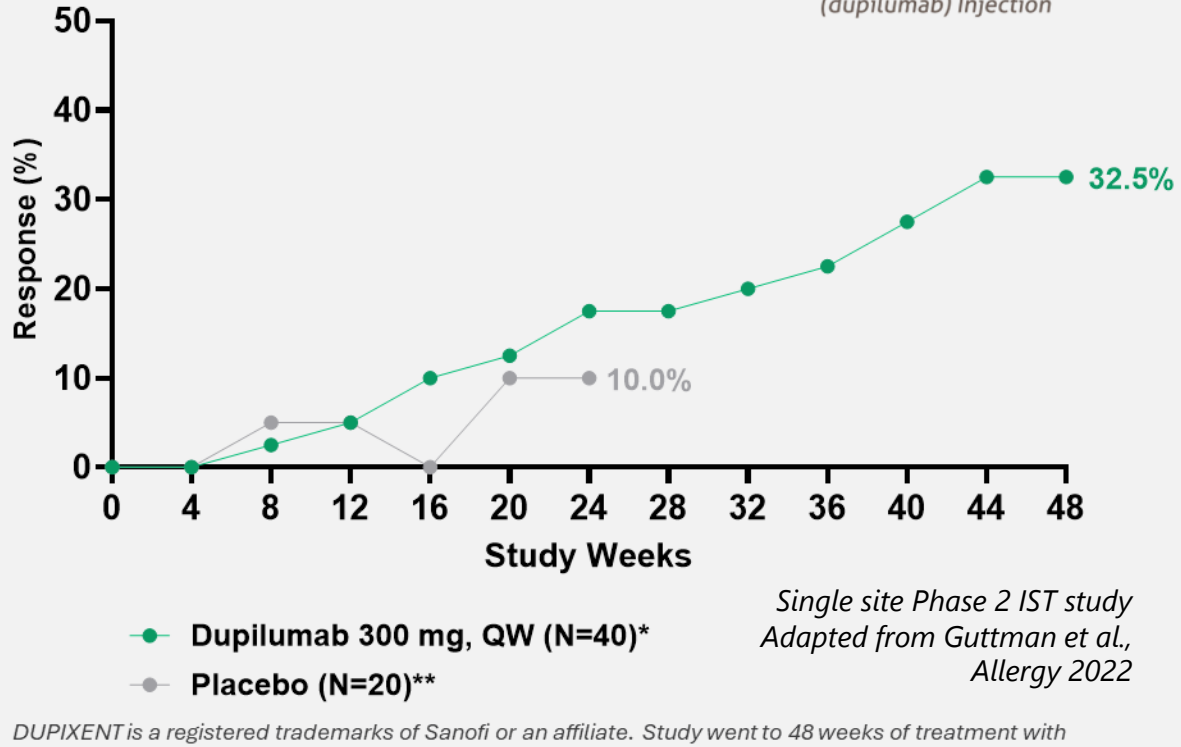
### $SALT_{30}$ REZPEG Twice-Monthly Phase 2 Study in AA (mITT[A])




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

**Dupixent® Reference**

### $SALT_{30}$ Dupixent® Once-Weekly Phase 2 Study in AA




*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 $SALT_{50}$ 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)**



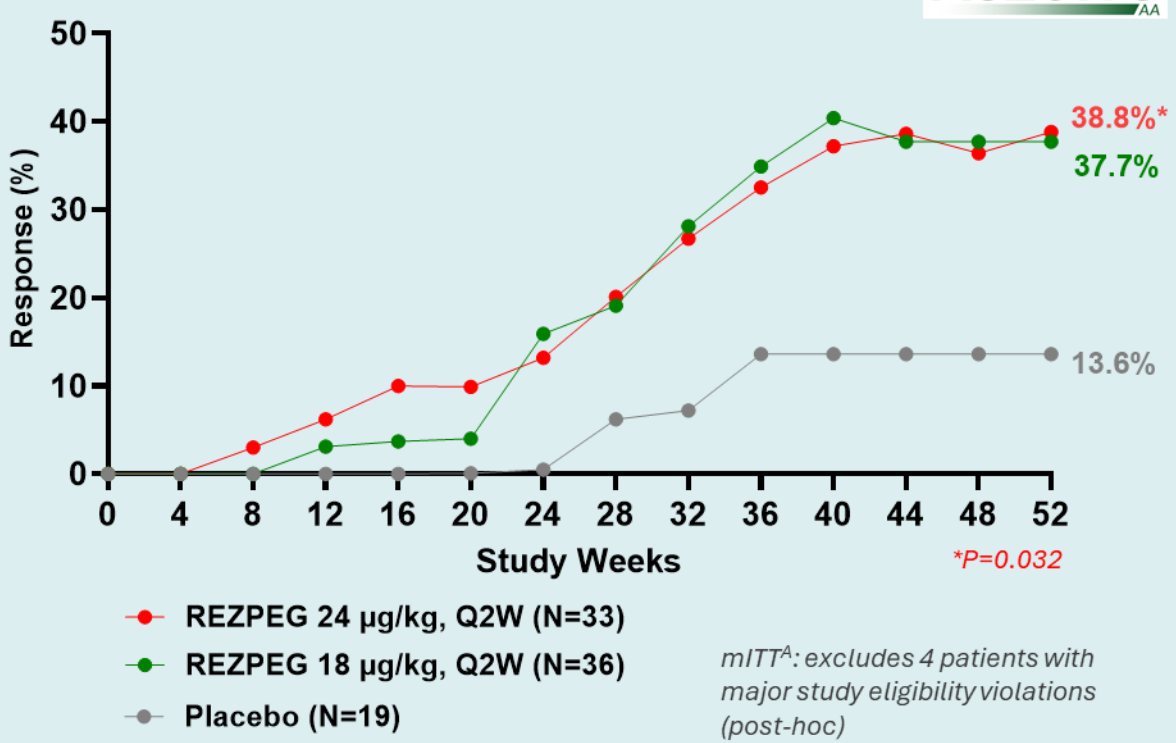
*This is a cross-trial comparison and includes data from different clinical studies and is not a head-to-head comparison.*

# Promising Data for a Biologic in AA

## $SALT_{50}$ (At Least 50 Percent Improvement from Baseline in SALT)

*52-week Treatment Data*

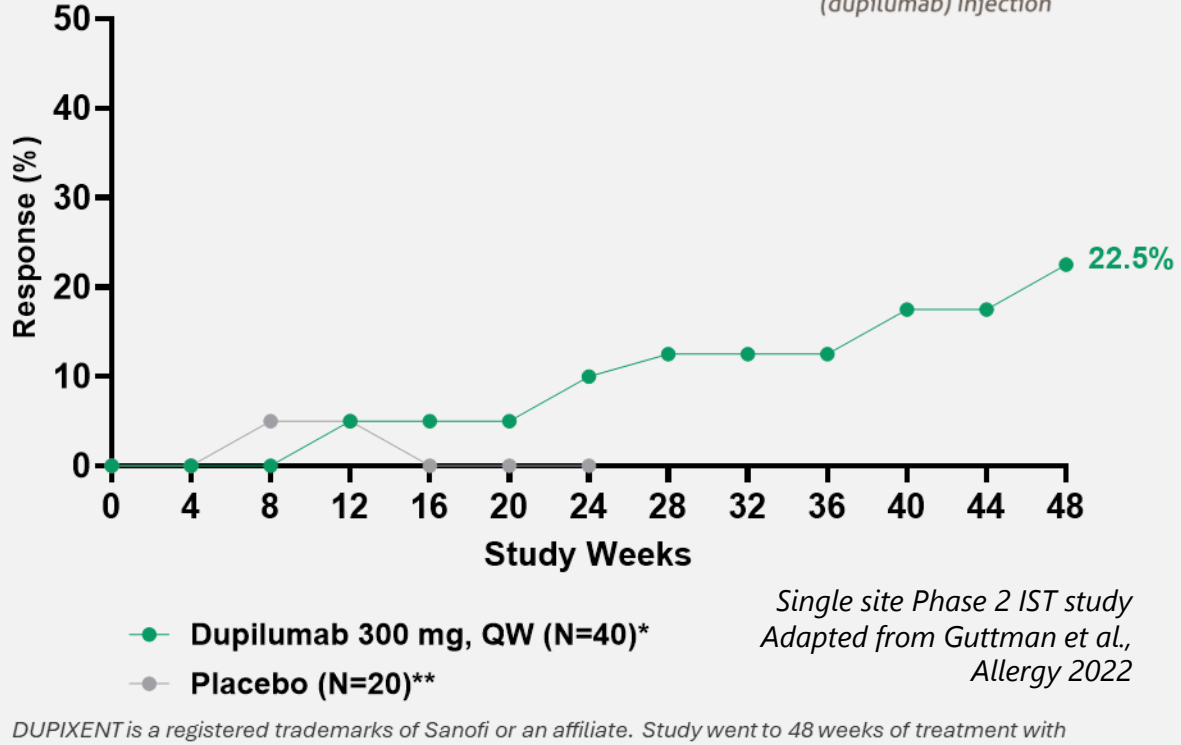
### $SALT_{50}$ REZPEG Twice-Monthly Phase 2 Study in AA (mITT[A])




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

*Dupixent® Reference*

### $SALT_{50}$ Dupixent® Once-Weekly Phase 2 Study in AA




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

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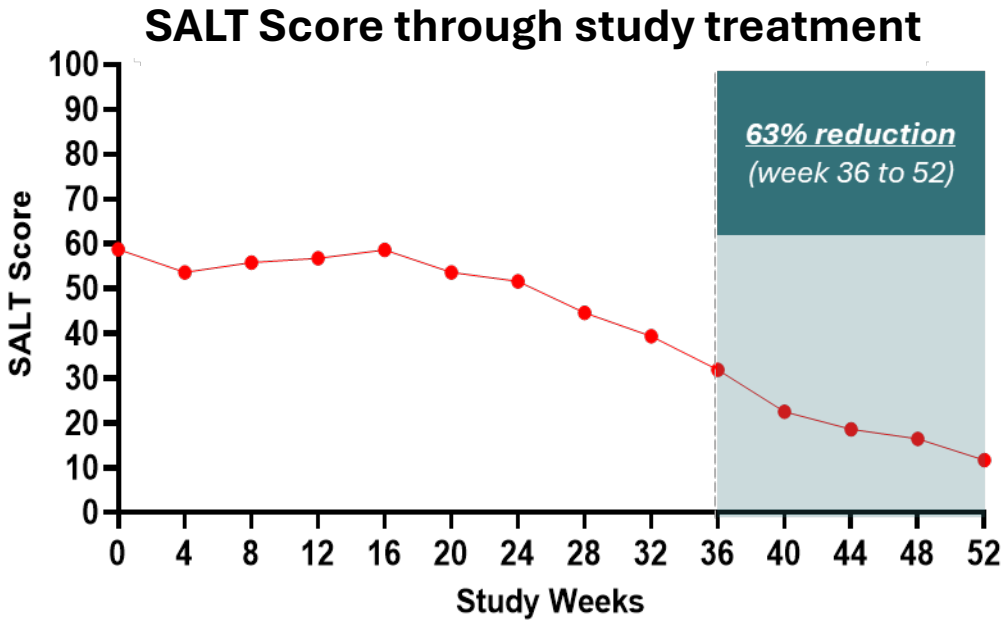
*This is a cross-trial comparison and includes data from different clinical studies and is not a head-to-head comparison.*

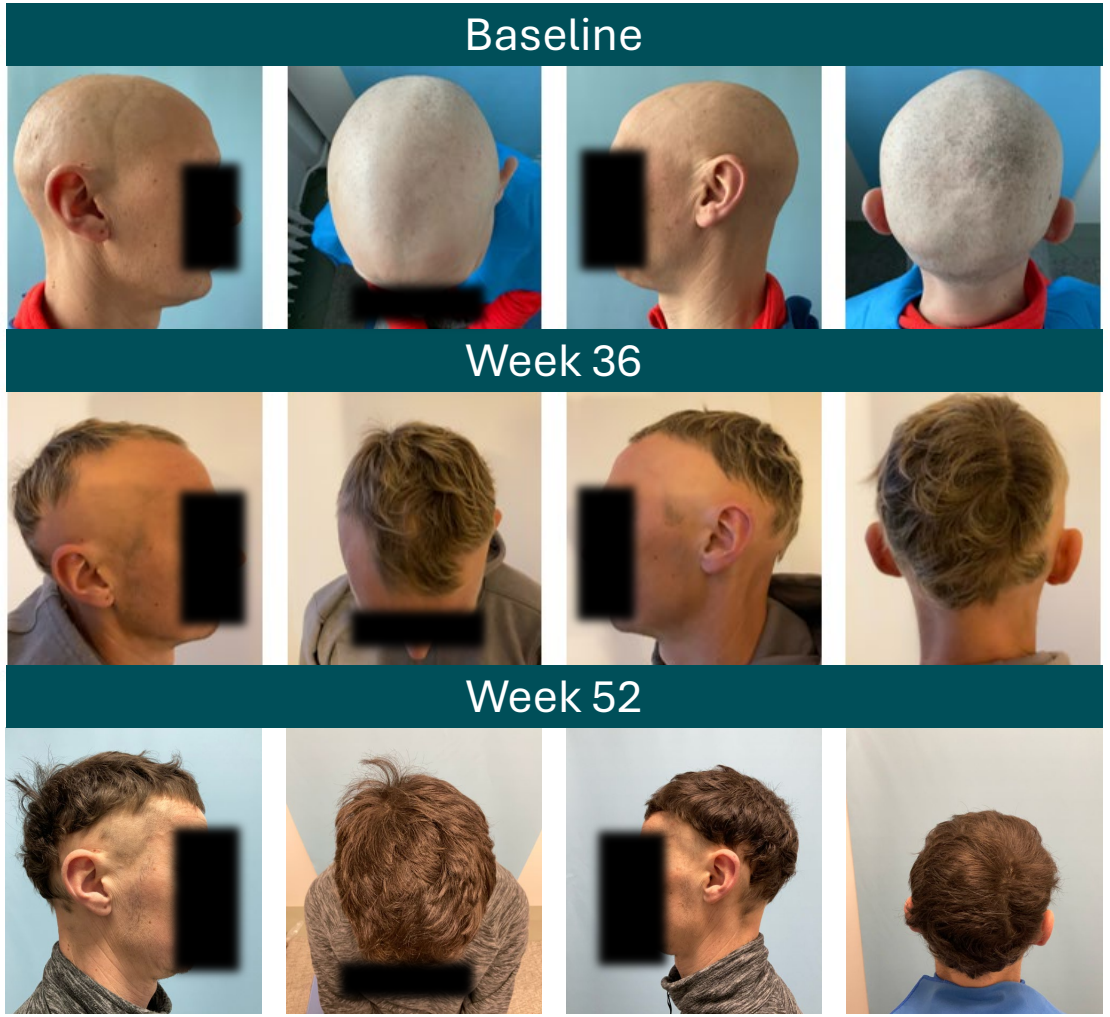
# REZOLVE-AA: Safety Profile in Alopecia Areata at 52 Weeks Consistent With Previously Reported Studies

- 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

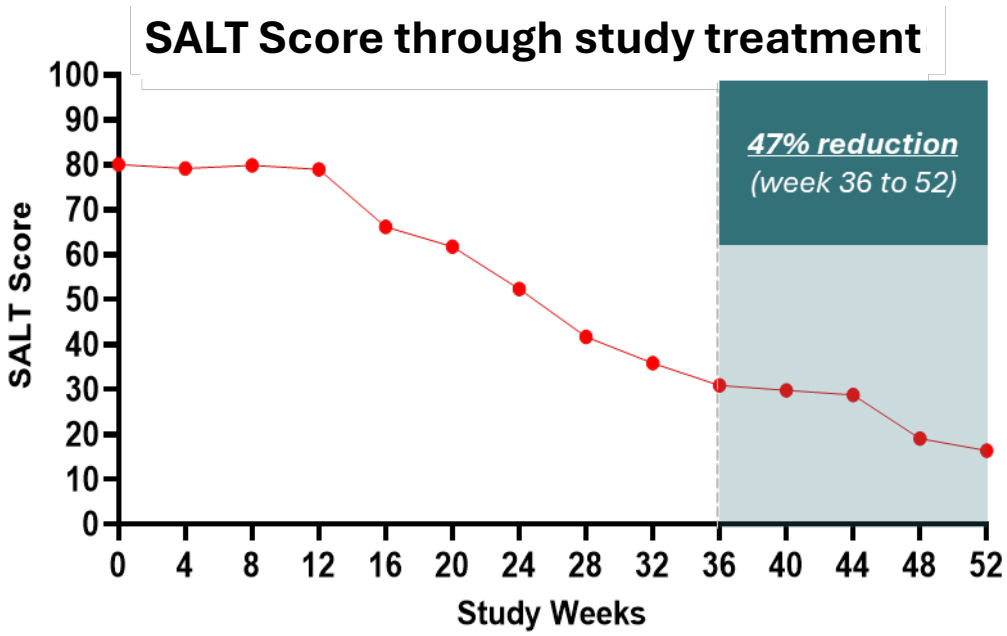
- 40-year-old white male
- Diagnosis 8 months prior to treatment
- 52 weeks of 24 µg/kg REZPEG treatment

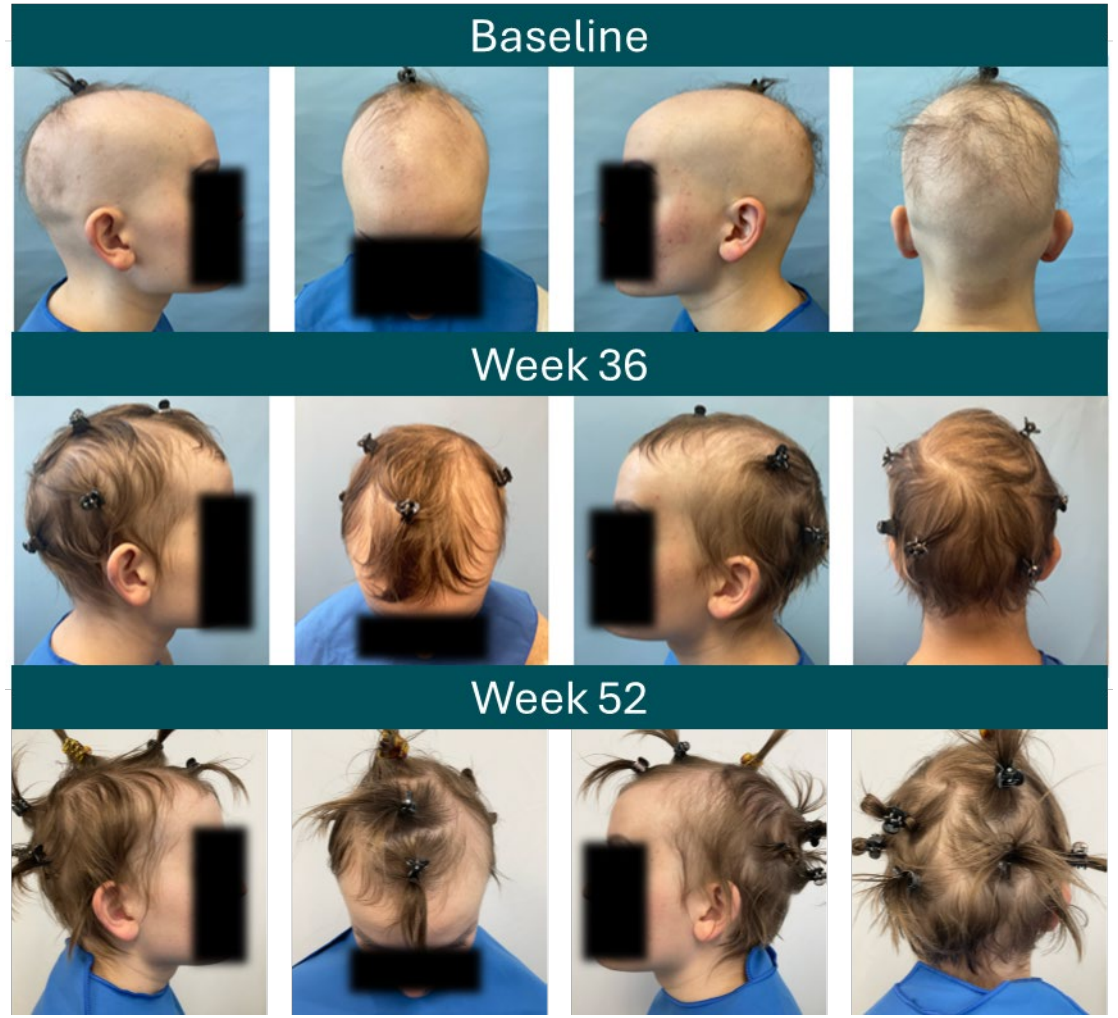


# Case Study #2: Patient Achieved SALT Score ≤20 by Week 48

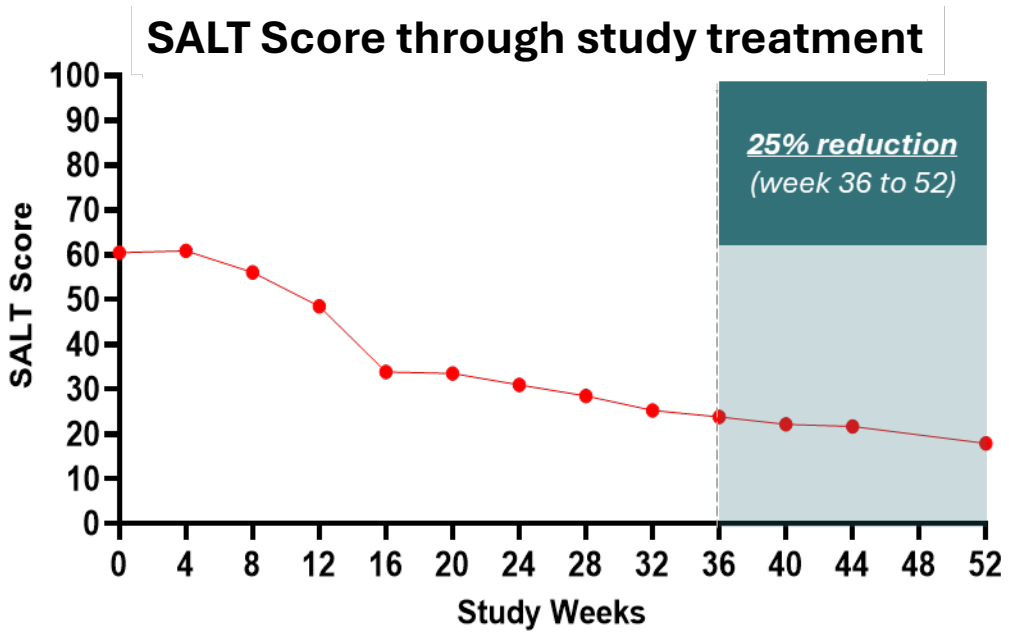
- 20-year-old white female
- Diagnosed 6 years prior to treatment
- 52 weeks of 24 µg/kg REZPEG treatment

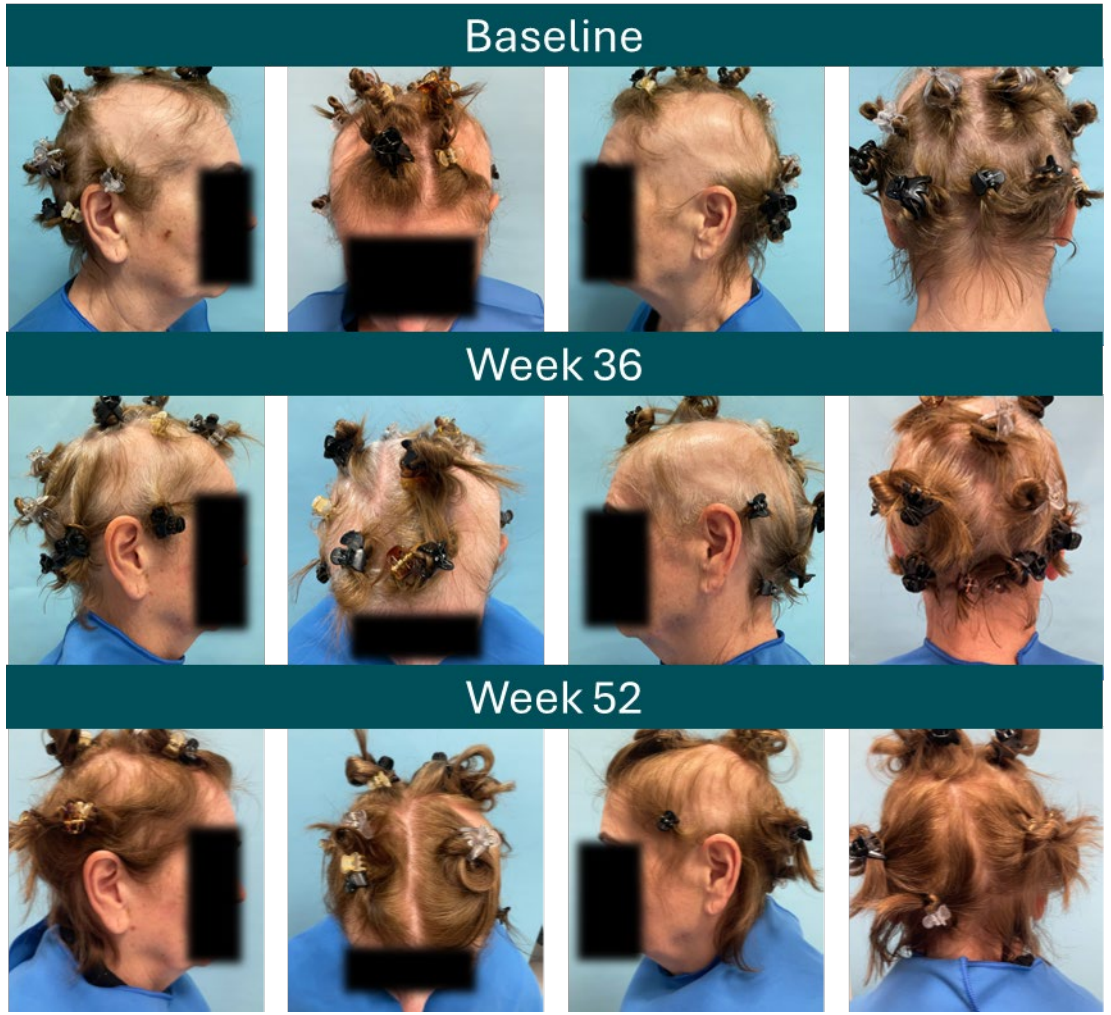


# Case Study #3: Patient Achieved SALT Score ≤20 by Week 52

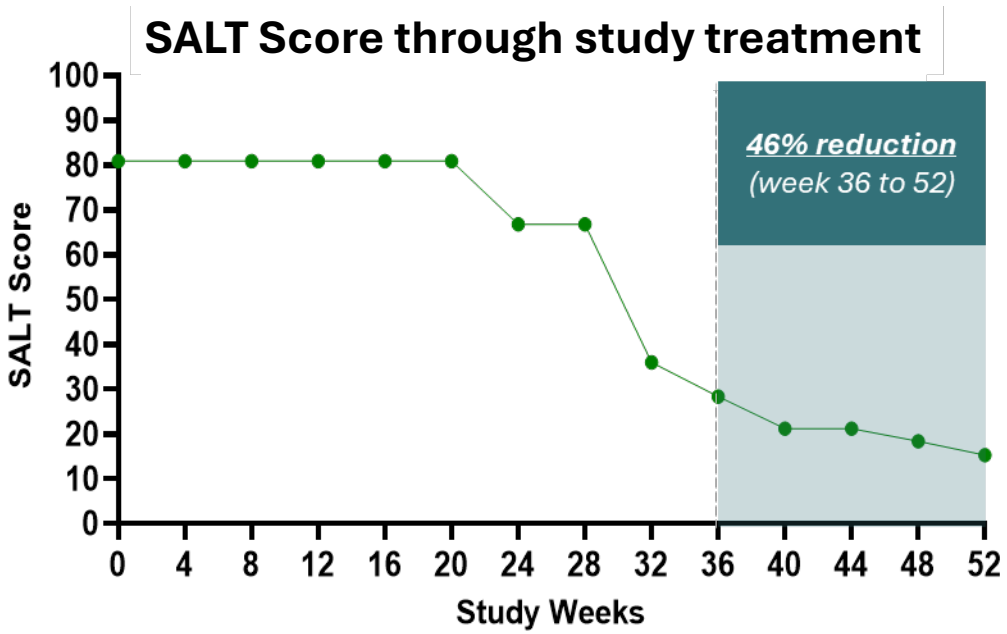
- 64-year-old white female
- Diagnosed 13 years prior to treatment
- 52 weeks of 24 µg/kg REZPEG treatment

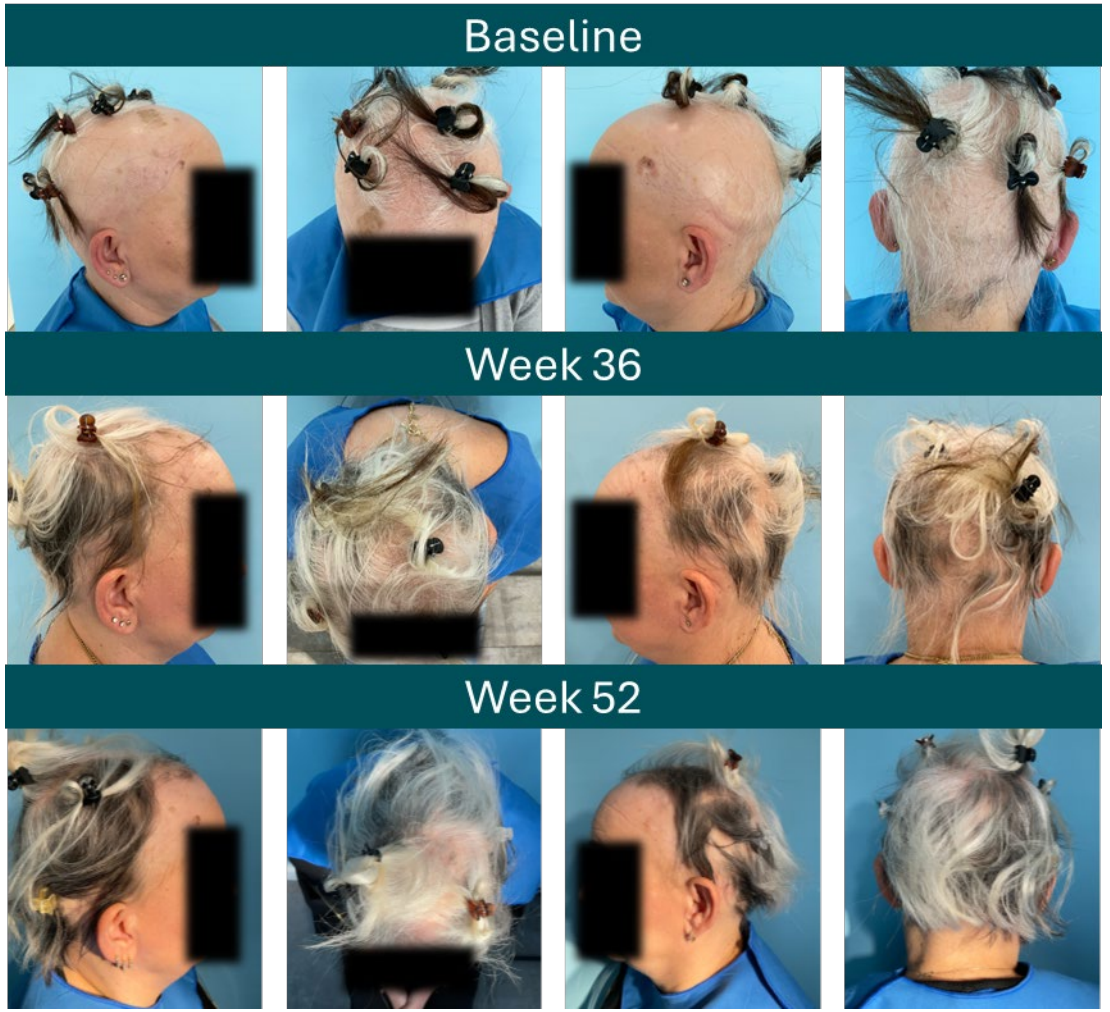


# Case Study #4: Patient Achieved SALT Score ≤20 by Week 48

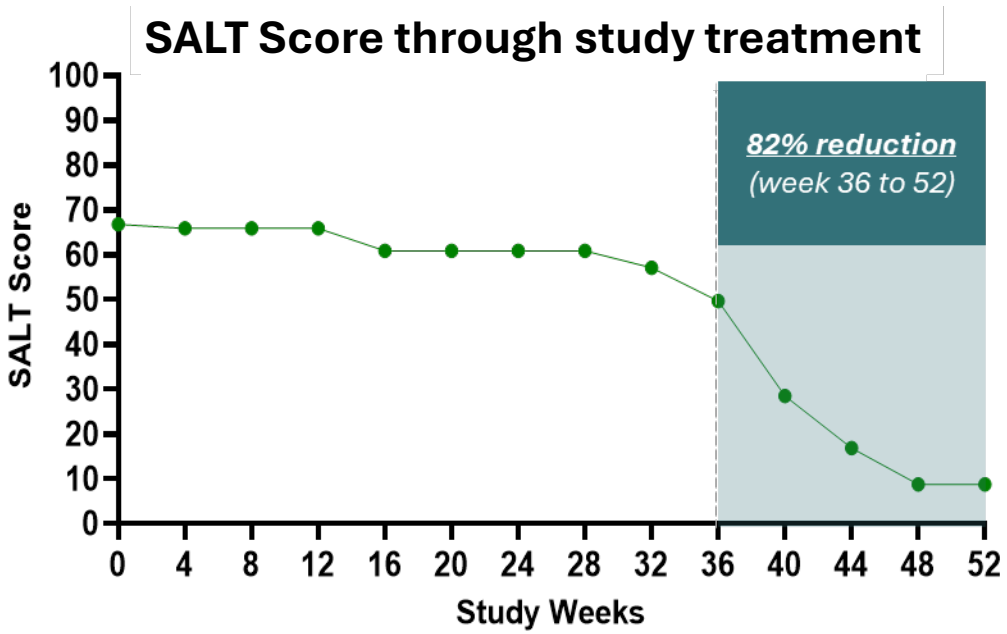
- 50-year-old white female
- Diagnosed 2.1 years prior to treatment
- 52 weeks of 18 µg/kg REZPEG treatment

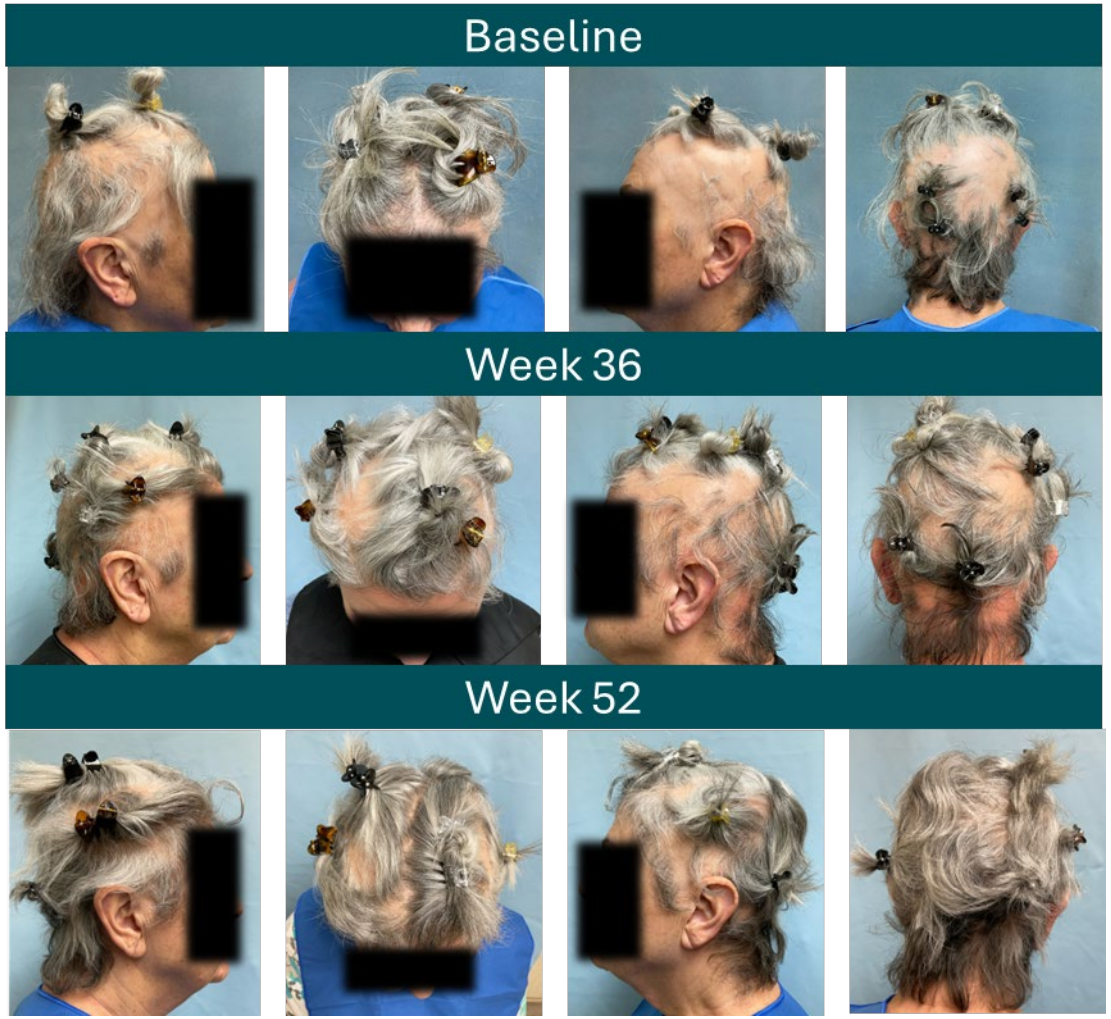


# Case Study #5: Patient Achieved SALT Score ≤20 by Week 44

- 64-year-old white female
- Diagnosed 10 months prior to treatment
- 52 weeks of 18 µg/kg REZPEG treatment



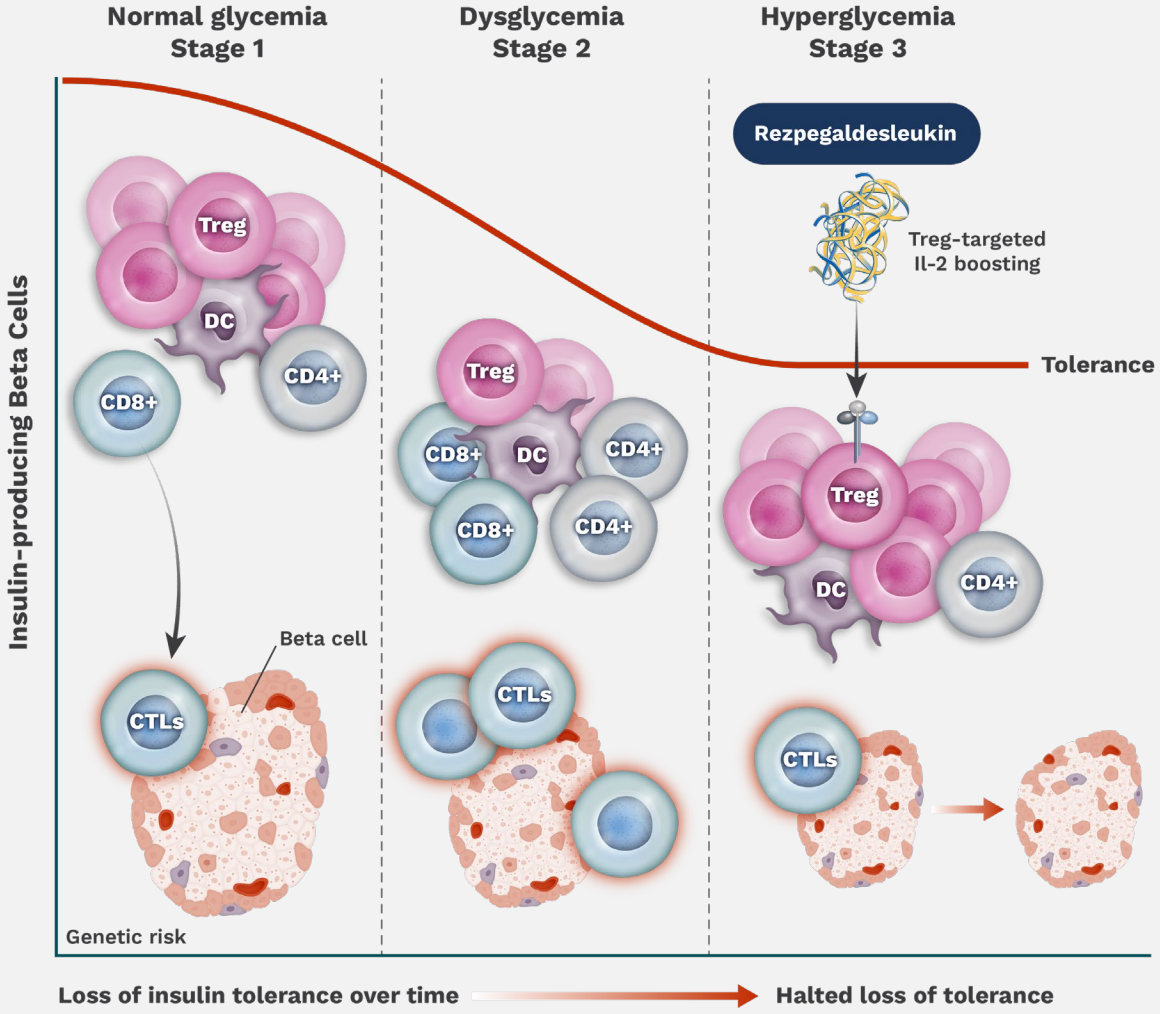



# Rezpegaldesleukin in Type 1 Diabetes

# Rezpegaldesleukin
# Type 1 Diabetes MOA

## Scientific rationale

- By targeting receptors on regulatory T cells, rezpegaldesleukin stimulates the proliferation of regulatory T cells (Tregs), including FOX-P3+ Tregs
- In Type 1 diabetes, the destruction of insulin-producing pancreatic beta cells is caused by T cells of the immune system
- Regulatory T cells 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 Type 1 diabetes.



# Proposed study design

*Type 1 Diabetes (Stage 3)*

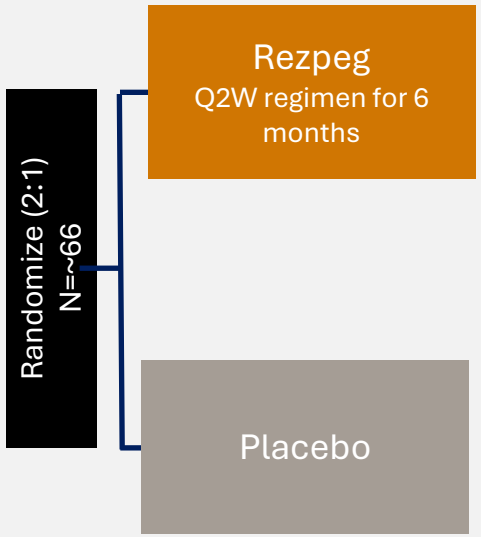
Type 1 Diabetes TrialNet

## Eligibility

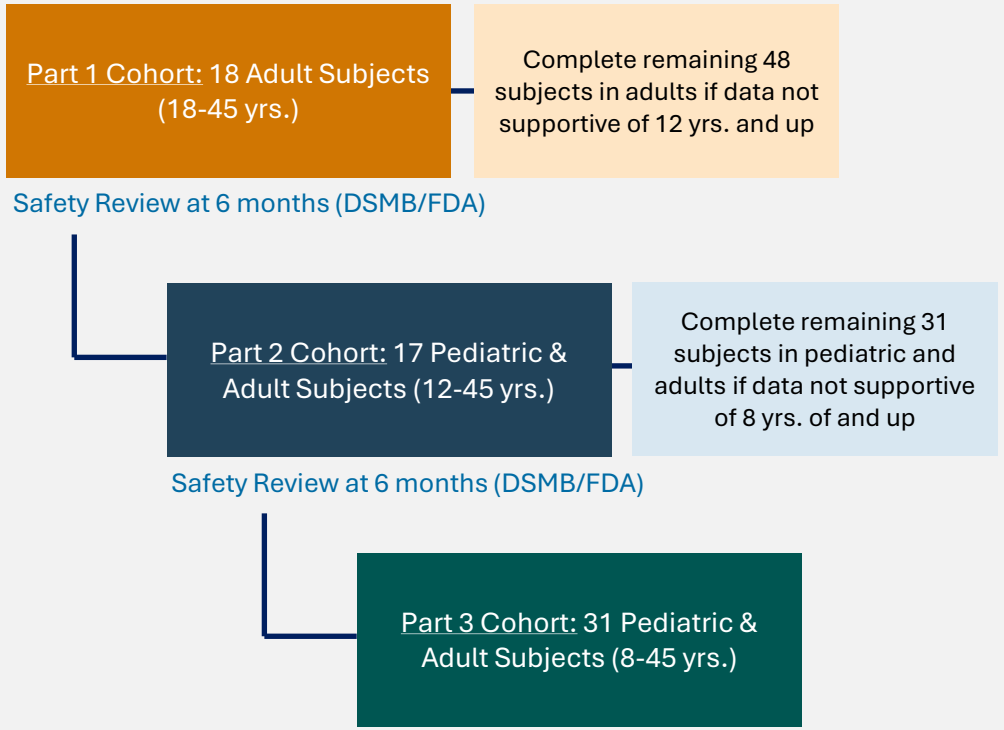
Key Inclusion:

- ✓ Ages starting at minimum of 18 and then decreasing to 12 and then 8 pending data review
- ✓ New onset T1D within 100 days
- ✓ Positive for ≥1 autoantibody (+AAB)
- ✓ Peak C-peptide >0.2pmol/mL

## Treatment




## Patient Enrollment




## Outcome Measures

ENDPOINTS:

Primary:
C-peptide response to Mixed Meal Tolerance Test (MMTT) compared to placebo at 12 months

Secondary/Exploratory:

- Comparisons of MMTT-stimulated C-peptide and glucose AUCs at 3 and 6 months to placebo
- Comparisons of MMTT-stimulated C-peptide at 3, 6, and 12 months to historical model-adjusted placebo controls
- Glucose monitoring data and hypoglycemia events
- Adverse Events

Additional Assessments:

- Metabolic Assessments (HbA1c, insulin usage, etc.)
- Immunologic Assessments

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

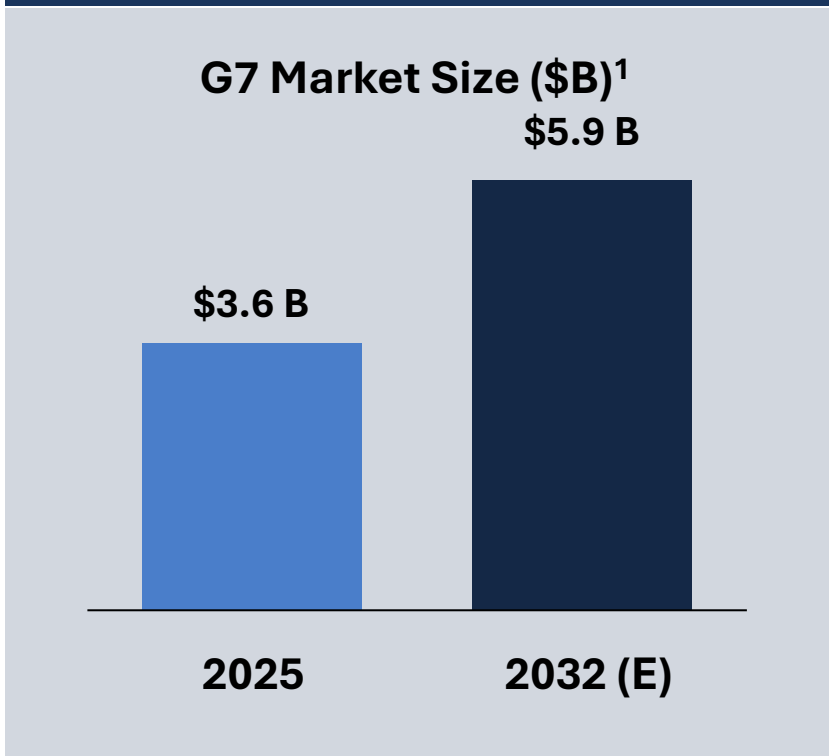
**About the Study:**

- 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**

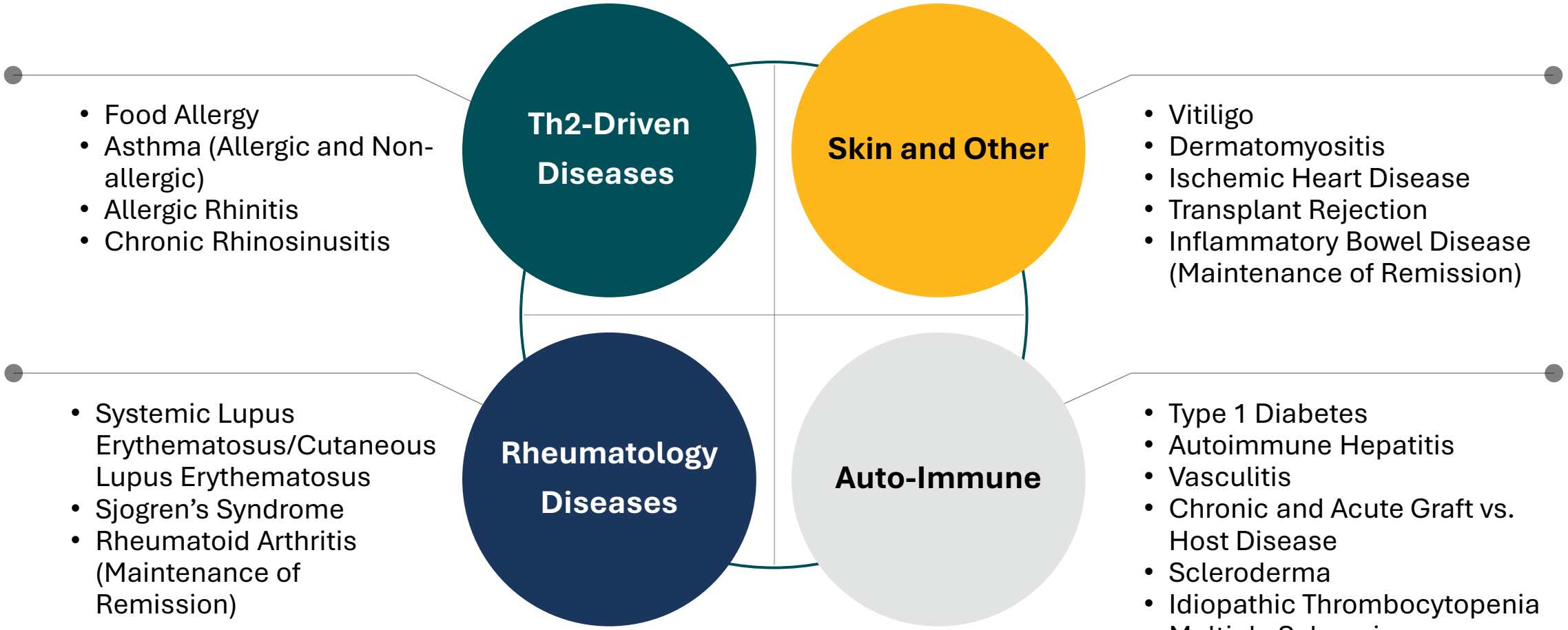
- In T1D, the destruction of insulin-producing pancreatic beta cells is caused by T cells of the immune system
- Regulatory T cells (Tregs) act upstream of these T cell and pro-inflammatory cytokines to reduce their activity; by increasing the number and functionality of regulatory T cells, this investigational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

**Commercial Opportunity for Type 1 Diabetes**




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

# Expanding Potential Opportunities for REZPEG (Treg MOA Activity)




- Food Allergy
- Asthma (Allergic and Non-allergic)
- Allergic Rhinitis
- Chronic Rhinosinusitis

- Vitiligo
- Dermatomyositis
- Ischemic Heart Disease
- Transplant Rejection
- Inflammatory Bowel Disease (Maintenance of Remission)

- Systemic Lupus Erythematosus/Cutaneous Lupus Erythematosus
- Sjogren's Syndrome
- Rheumatoid Arthritis (Maintenance of Remission)

- Type 1 Diabetes
- Autoimmune Hepatitis
- Vasculitis
- Chronic and Acute Graft vs. Host Disease
- Scleroderma
- Idiopathic Thrombocytopenia
- Multiple Sclerosis
- Amyotrophic Lateral Sclerosis

# Anticipated Next Steps in Alopecia Areata and for REZPEG

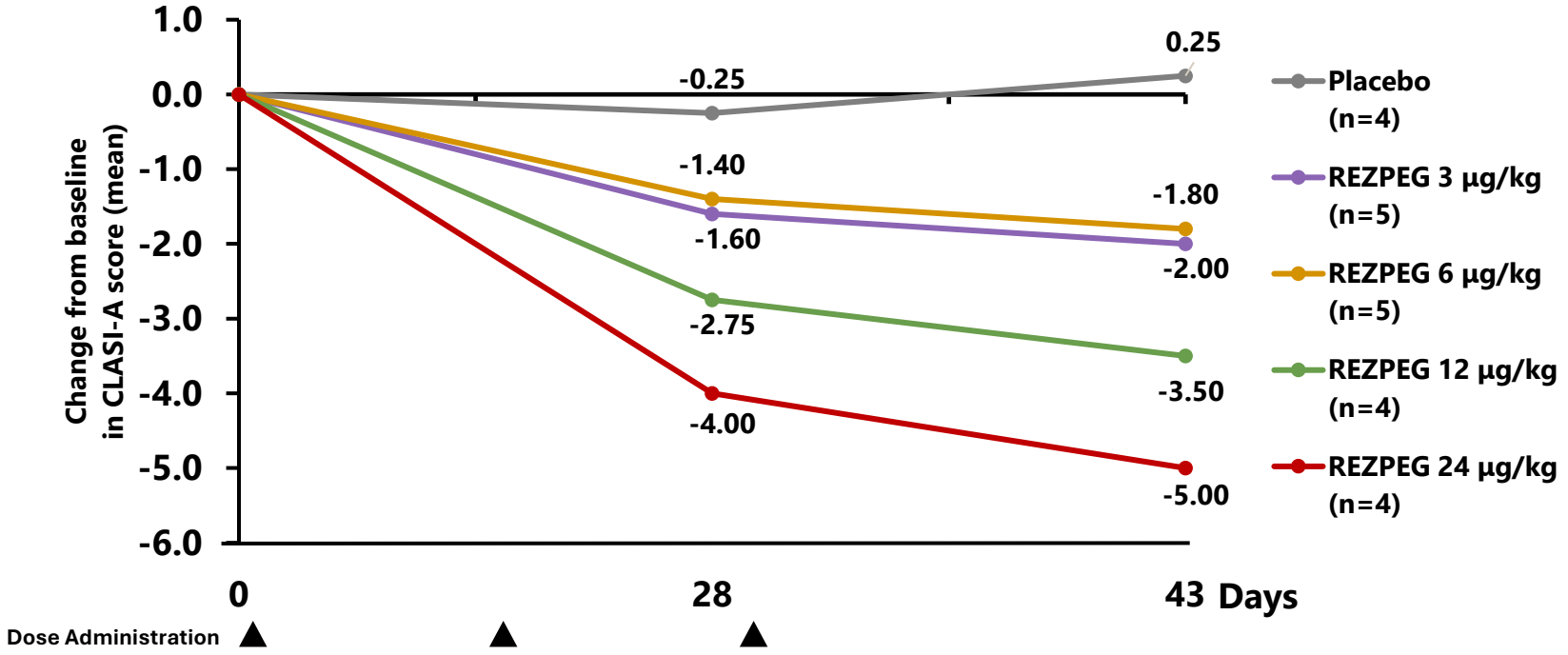
***$741.7M in cash and investments at start of Q2 2026***

| | |
|---|---|
| **Alopecia Areata** | • Conduct End of Phase 2 meeting with FDA in Q2 2026 to align on Phase 3 registrational strategy<br>• Additional data readout from REZOLVE-AA Study: 24-week off treatment data in Q4 2026 |
| **Atopic Dermatitis** | • Initiation of ZENITH-AD Phase 3 program in patients with moderate-to-severe atopic dermatitis in June/July 2026<br>• Additional data readout from REZOLVE-AD Study: 52-week off treatment data in Q1 2027 |
| **Type 1 Diabetes** | • Initial data in Type 1 diabetes in 2027 |
| **Other Indications** | • Initiation of proof-of-concept study for a potential new indication for REZPEG in 2H 2026 |

# 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*

# NKTR-0165

## TNFR2 Agonist Antibody

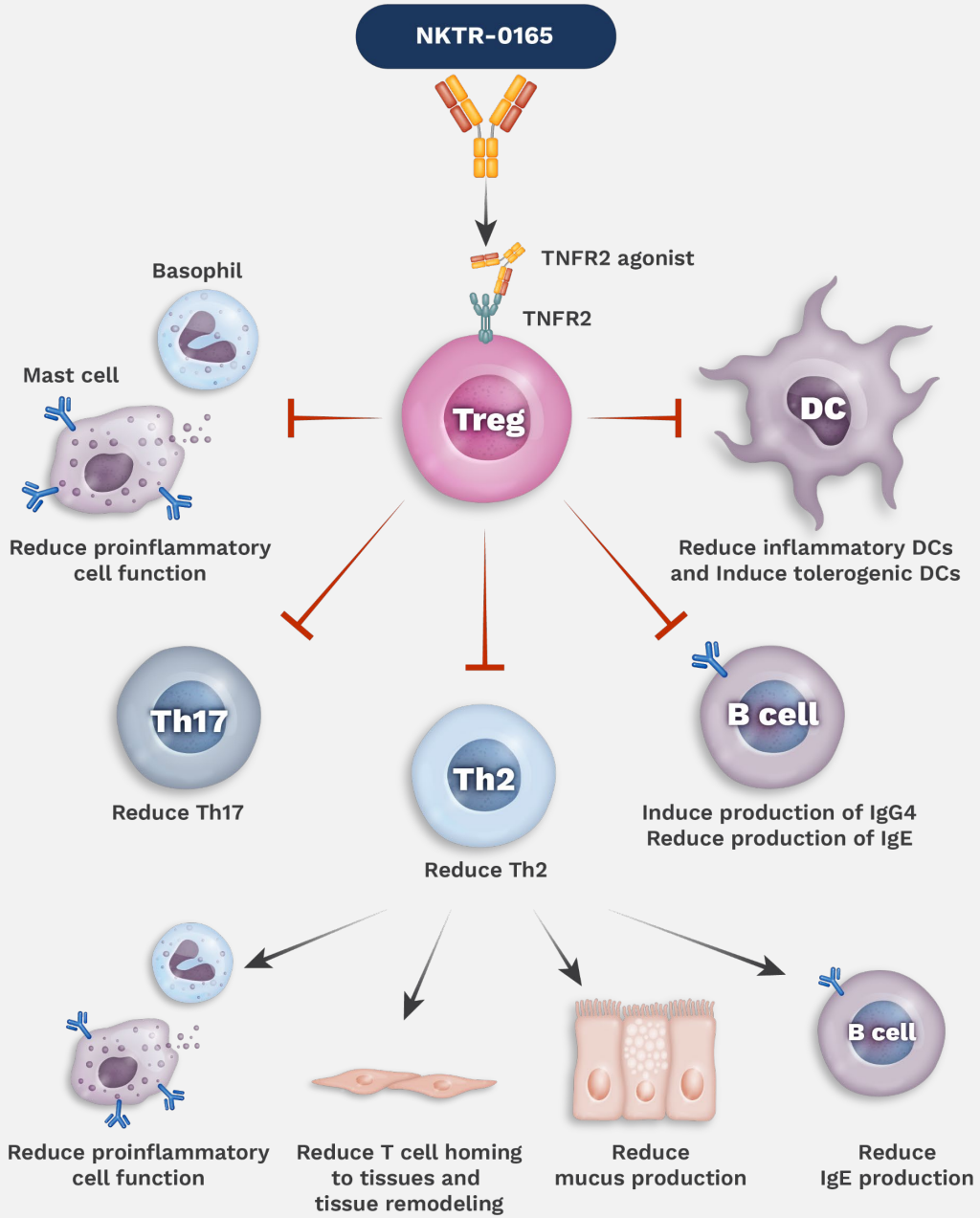
# NKTR-0165/TNFR2 Agonist Bivalent Antibody

## Scientific rationale

- By targeting TNFR2, a co-stimulatory receptor preferentially expressed on the surface of highly suppressive tissue-specific regulatory T cells, B-regulatory cells, neuronal cells and endothelial cells, NKTR-0165 has been shown to promote the activation, function, proliferation, and phenotypic stability of these cells

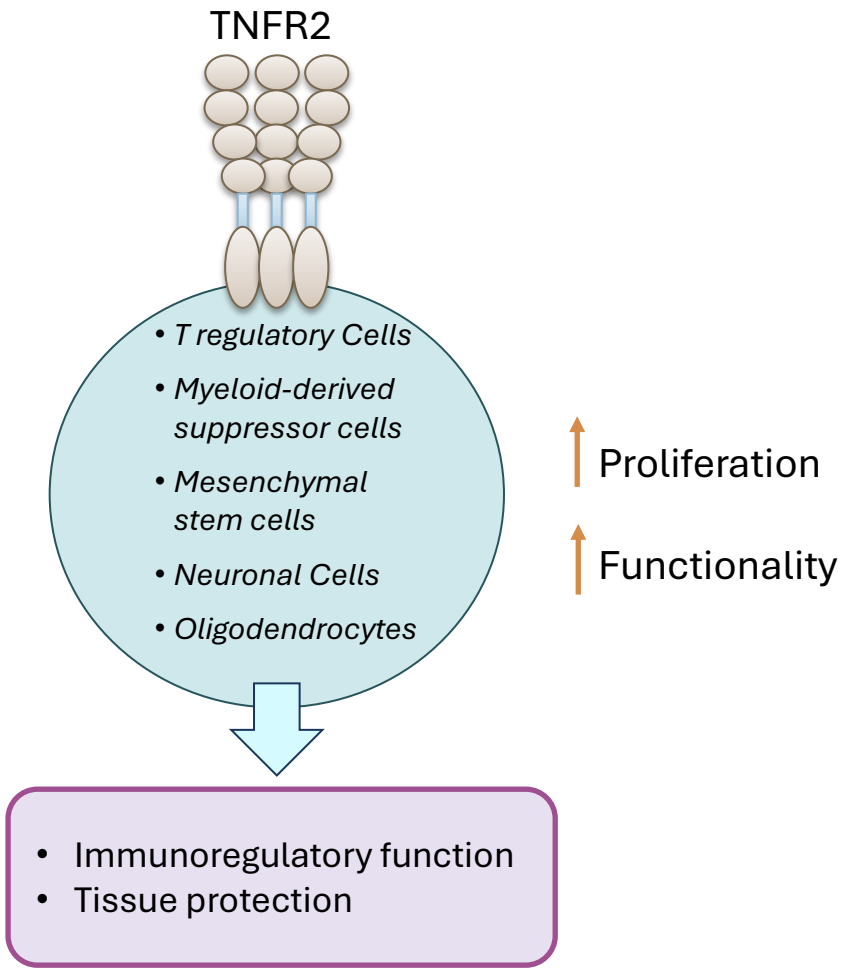
- TNFR2 signaling is an important gatekeeper of inflammation and its absence or deficit is associated with a broad range of autoimmune diseases

- As a monomeric bivalent antibody with a unique epitope, NKTR-0165 selectively stimulates TNFR2 receptor activity, without modulation of TNFR1 signaling; this novel first-in-class compound has the potential to modulate acute exacerbations and chronic trajectory of a number of autoimmune diseases



# NKTR-0165: TNFR2 agonist antibody program

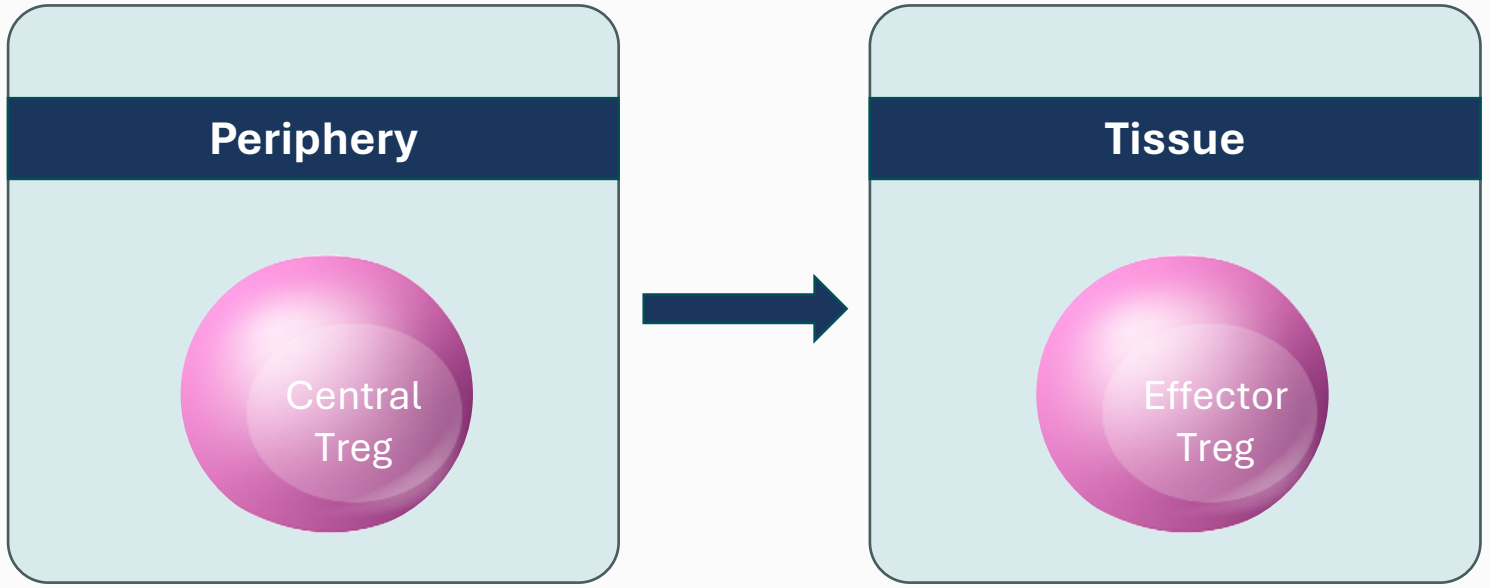
## Targeting TNF Receptor 2 (TNFR2) for the treatment of autoimmune conditions



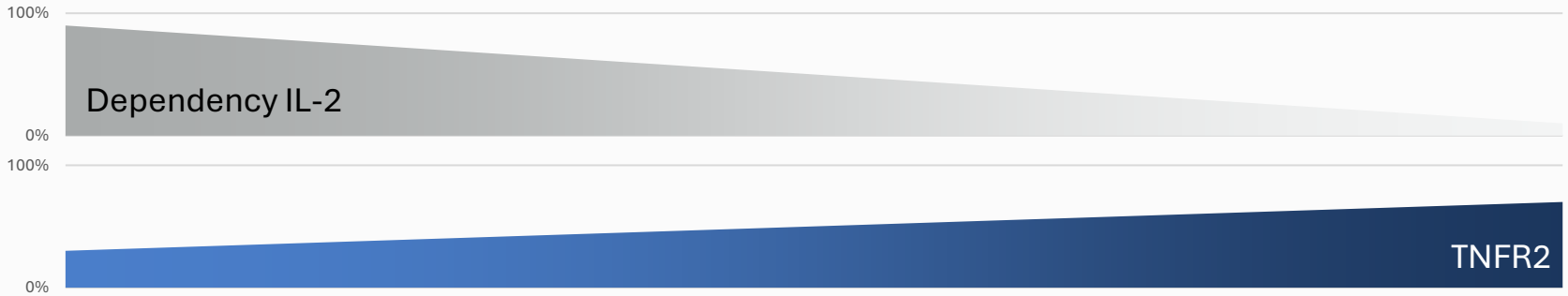

- TNFR2 signaling drives immunoregulatory function could provide direct protective effect for tissue cells
- Unique Nektar antibody candidates show selective T regulatory cell binding and signaling profiles enabling it to be developed for the treatment of autoimmune conditions
- Program targets multiple MOAs including suppression of inflammation, regrowth of myelin after demyelination (MS) and promotion of immune resolution.
    - Examples include Ulcerative Colitis, Multiple Sclerosis (i.e. myelin regrowth), Vitiligo and other autoimmune conditions

# TNFR2/NF-kB Axis is critical to maintain effector and tissue regulatory T cells

***Rezpegaldesleukin*** (IL-2 T Regulatory Cell Stimulator)




***NKTR-0165*** (Bivalent Agonistic Antibody Targeting TNFR2)

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