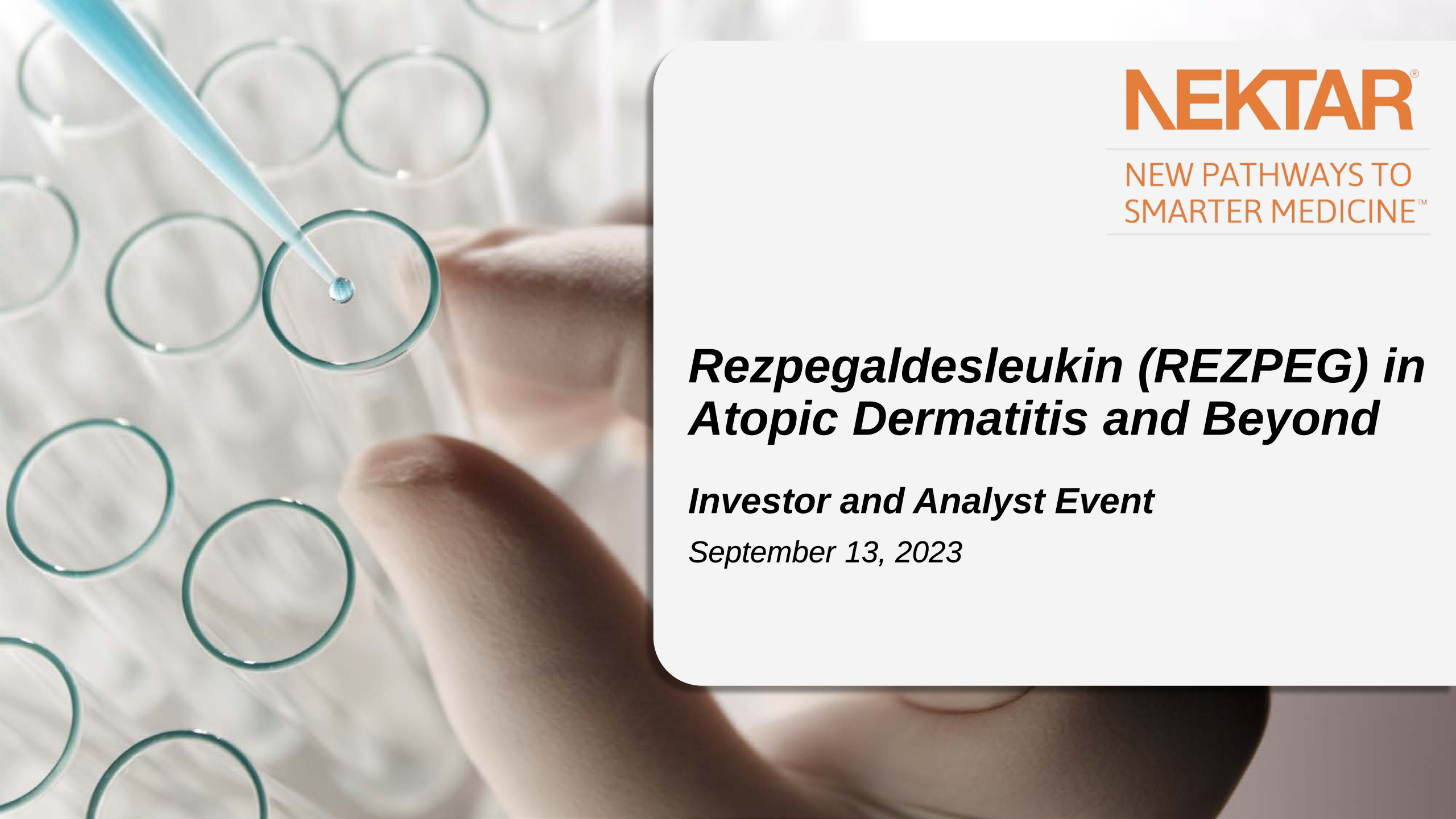

NEKTAR®

NEW PATHWAYS TO SMARTER MEDICINE™

Rezpegaldesleukin (REZPEG) in Atopic Dermatitis and Beyond

Investor and Analyst Event

September 13, 2023

This presentation includes forward-looking statements regarding Nektar's proprietary drug candidates, the timing of the start of and plans for ongoing or planned clinical trials with partners, the therapeutic potential of our drug candidates, the timing and outcome of regulatory decisions, and future availability of clinical trial data. Actual results could differ materially, and these statements are subject to important risks detailed in Nektar's filings with the SEC including the Form 10-Q filed on August 9, 2023. Nektar undertakes no obligation to update forward-looking statements as a result of new information or otherwise.

Today’s Invited Speakers

David Rosmarin, MD

Chair of the Department of Dermatology at Indiana University School of Medicine

Kampen-Norins Scholar in Dermatology

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

Raj Chovatiya, MD, PhD, MSCI

Assistant Professor of Dermatology at the Northwestern University Feinberg School of Medicine

Agenda

- ***Pathophysiology & Biology of Atopic Dermatitis***
  - *David Rosmarin, M.D., Indiana University*
- ***The Incidence and Categorization of Mild, Moderate and Severe Disease***
  - *Jonathan Silverberg, M.D., Ph.D., MPH, The George Washington University School of Medicine*
- ***Atopic Dermatitis Treatment Landscape***
  - *Raj Chovatiya, M.D., Ph.D., Northwestern University*
- ***REZPEG in Atopic Dermatitis and Future Program Plans***
  - *Jonathan Zalevsky, Ph.D., Chief R&D Officer at Nektar Therapeutics*
- ***Q&A Session***
  - *Speakers joined by Mary Tagliaferri, M.D., Chief Medical Officer at Nektar Therapeutics*

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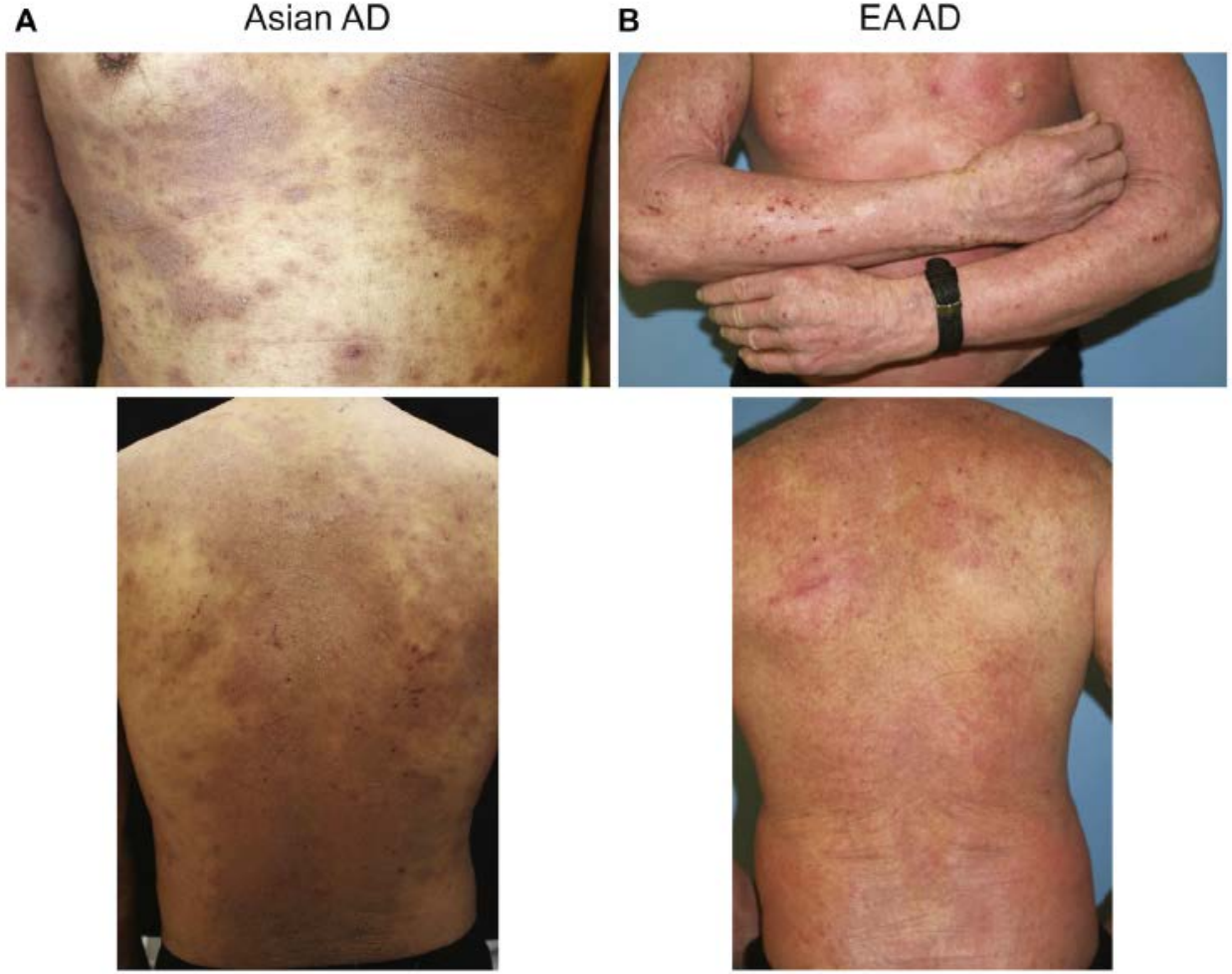
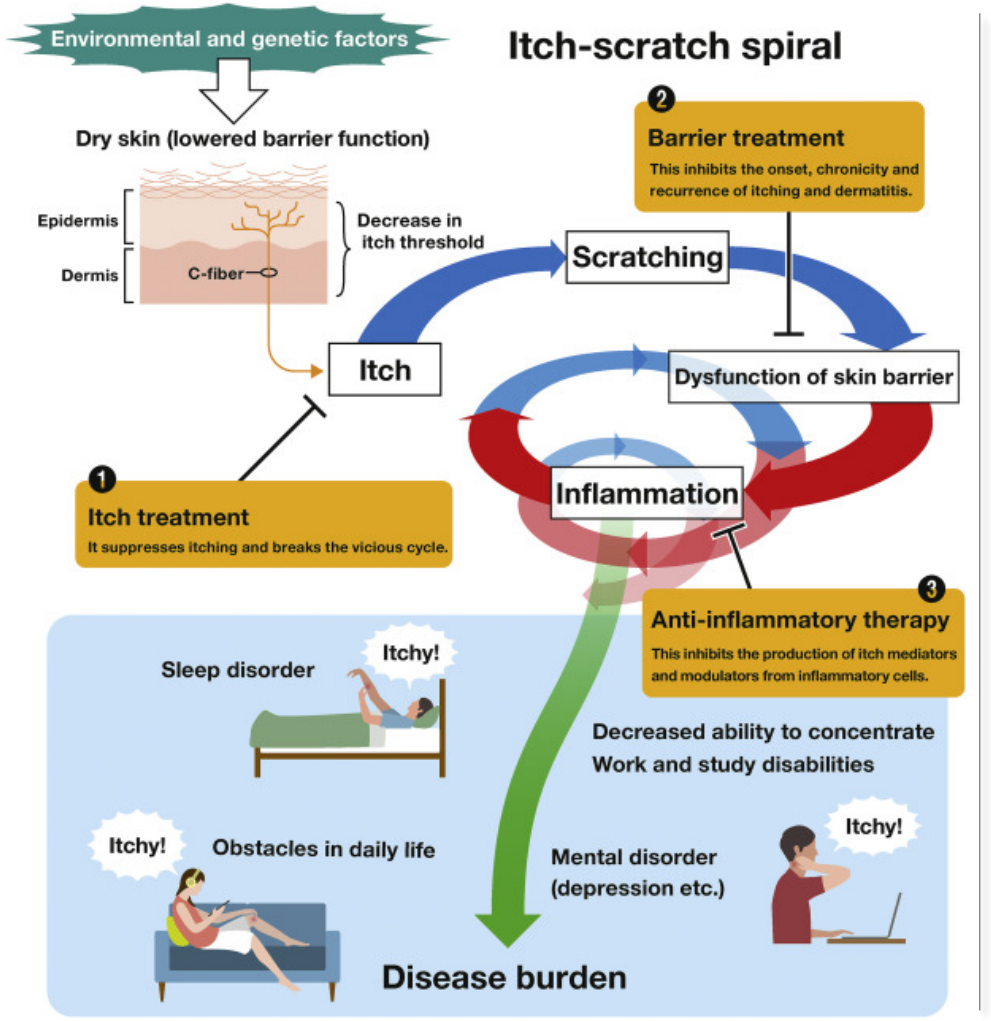
Atopic Dermatitis – Clinical Characteristics

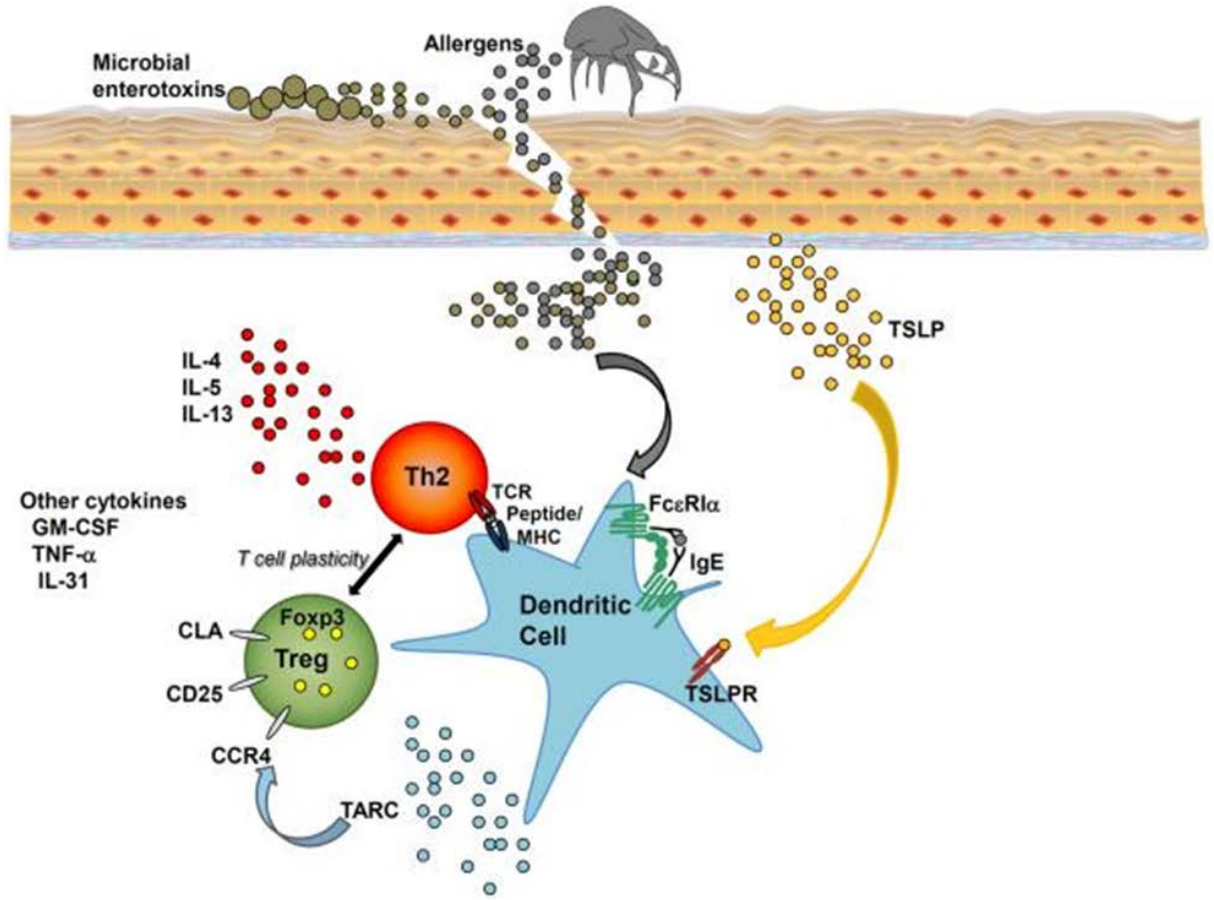


Dainichi T *et al Nature Immunol* 2018.
Noda S *et al J Allergy Clin Immunol* 2015.

Atopic Dermatitis Pathogenesis



Source: Tominaga M, et al. Allergol Int. (2022). 71(3): 265-277. has context menu



Source: Agrawal R, et al. Curr Probl Dermatol. (2011) 41: 112-124.

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US Prevalence: adults

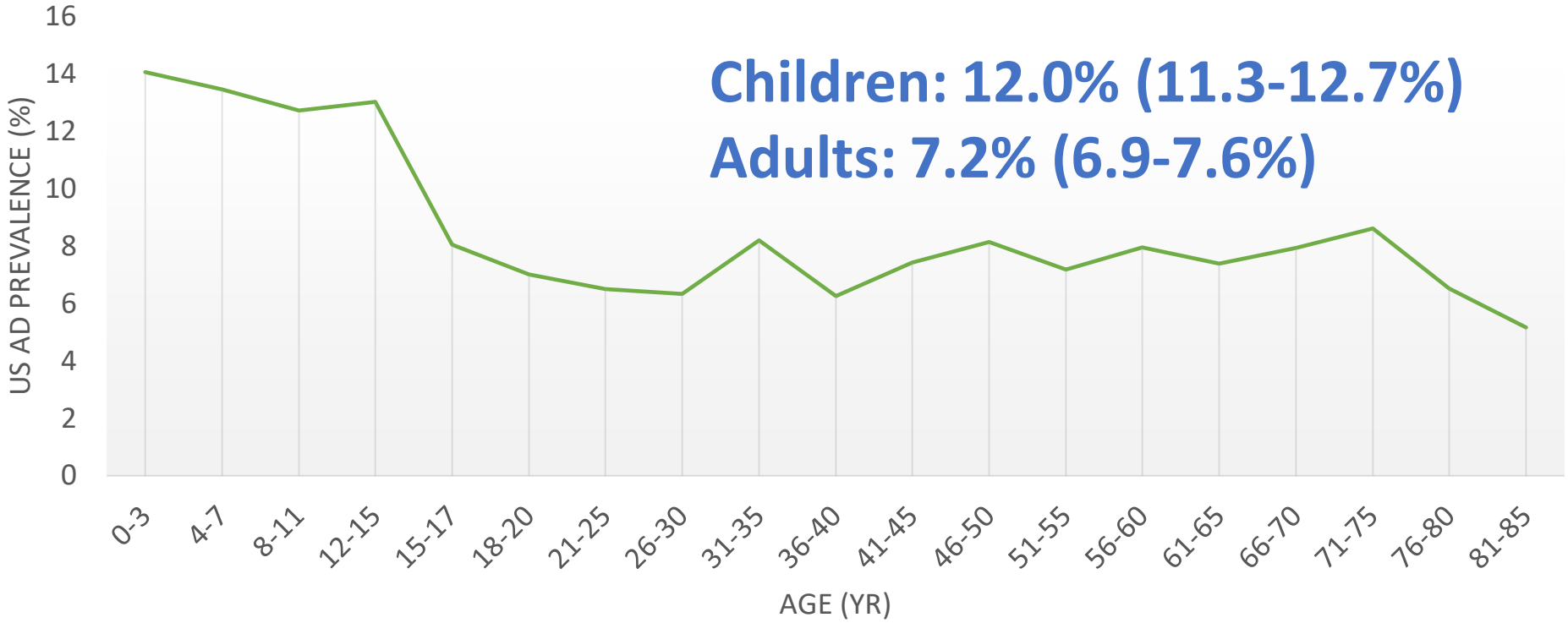
- National Health Interview Survey: US population-based household survey
  - AD defined by self-report of eczema or skin allergy
  - **Prevalence of AD in adults was 7.2%**
- Atopic Dermatitis in America survey: US population-based web panel
  - AD defined by the United Kingdom Working Party (UKWP) criteria
  - **Prevalence of AD in adults was 7.3%**
- **Estimated 16.5 million US adults with AD**

Silverberg JI, Gelfand JM, Margolis DJ, Boguniewicz M, Fonacier L, Grayson MH, Simpson EL, Ong PY, Chiesa Fuxench ZC. Patient-burden and quality of life in atopic dermatitis in US adults: A population-based cross-sectional study. *Annals of Allergy, Asthma and Immunology*. 2018. 121(3):340-347.

Hua T, **Silverberg JI**. Atopic dermatitis in US adults - epidemiology, association with marital status and atopy. *Annals of Allergy, Asthma and Immunology*. 2018. 121(5):622-624.

US Prevalence: adults

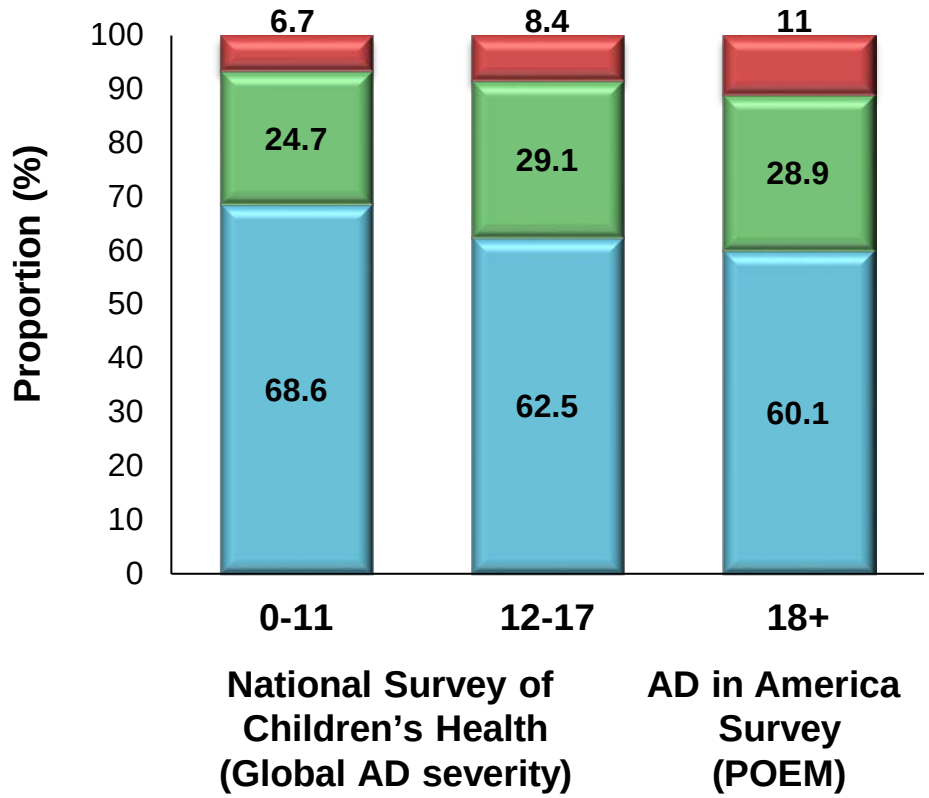
- 2012 National Health Interview Survey data of US adults aged 18–85[2]
  - Nationally representative cohort from all 50 states (n=34,613)



Silverberg JI. Public Health Burden and Epidemiology of Atopic Dermatitis. Dermatol Clin. 2017 Jul;35(3):283-289.

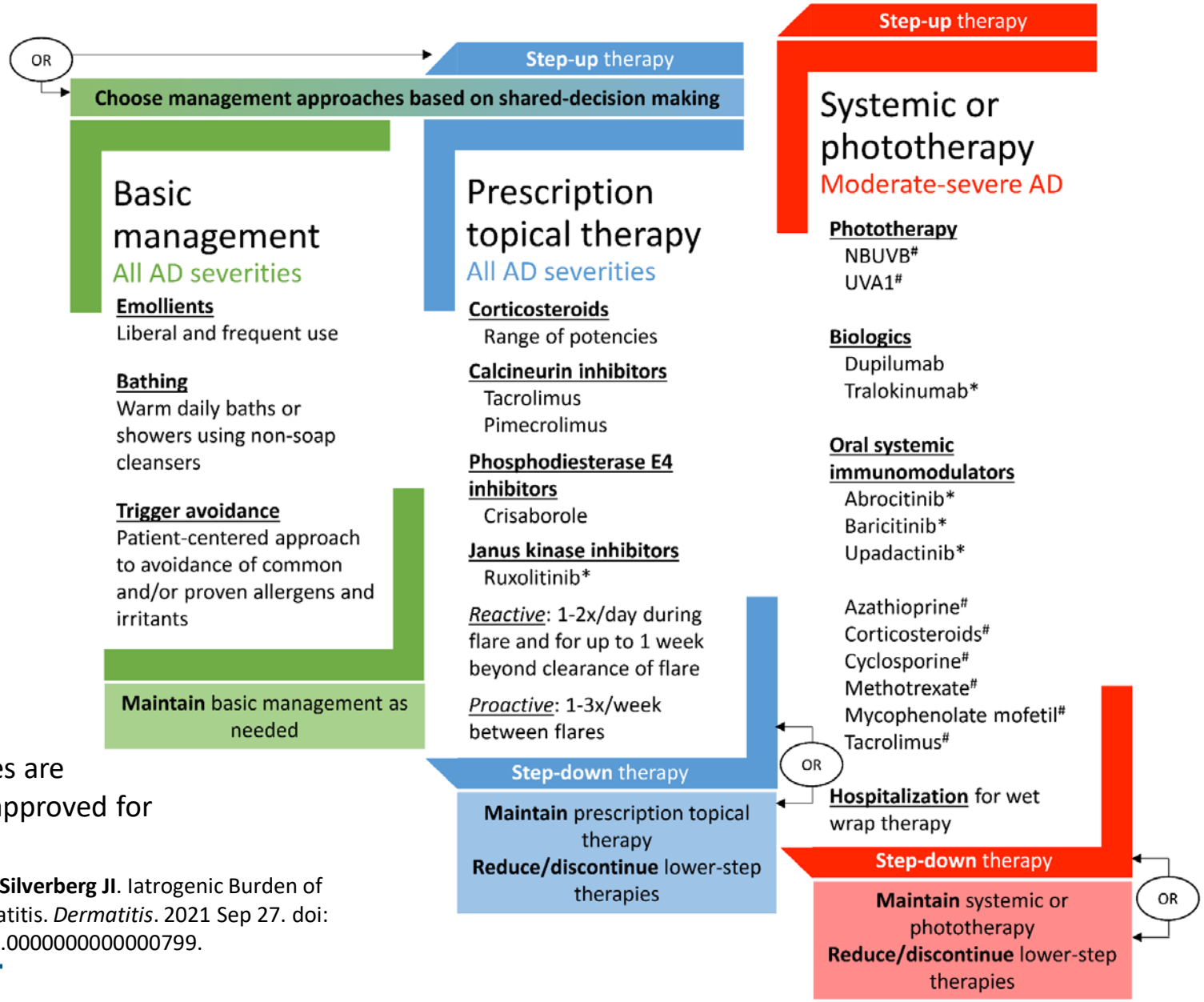
US Prevalence: adults

- Atopic Dermatitis in America survey
  - N=602 adults with data on AD severity
  - AD severity defined by the Patient-Oriented Eczema Measure (POEM)
  - **Estimated 5.9 million adults with moderate-severe AD**



Chiesa Fuxench ZC, Boguniewicz M, Fonacier L, Gelfand JM, Grayson MM, Margolis DJ, Ong P, Schwartz LB, **Silverberg J**, Simpson E. [6236] Prevalence and Impact of Disease Severity on Health Related Quality of Life in Adult Patients with Atopic Dermatitis. AAD 2018 Annual Meeting.
Silverberg JI, Simpson EL. Associations of childhood eczema severity: A US population based study. Dermatitis. 2014 May-Jun;25(3):107-14.

Management of AD



Some of the presented molecules are investigation assets or/and not approved for AD in Israel

Chovatiya R, **Silverberg JI**. Iatrogenic Burden of Atopic Dermatitis. *Dermatitis*. 2021 Sep 27. doi: 10.1097/DER.0000000000000799.

General remaining unmet needs in AD

- Undertreatment
- Overuse of steroids
- Low and delayed use of advanced systemics
- Long-term disease control (AD is chronic, thus control overtime matters)

Based on personal experience

Unmet needs for systemic and biologic therapy

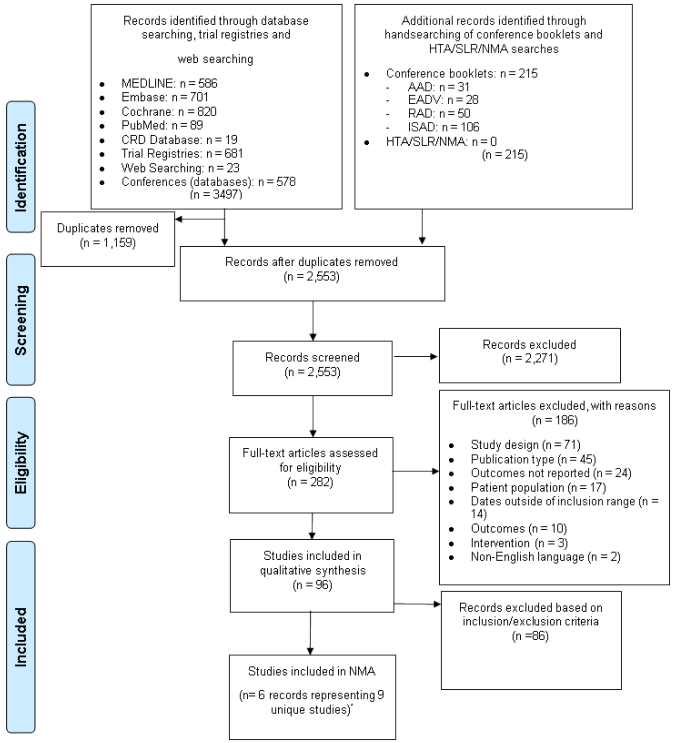
Compared to dupilumab as the benchmark, the following are needed:

- More reliable and robust efficacy without safety tradeoffs
- Less frequent dosing, i.e. fewer injections
- Flexible dosing options to allow tailoring of therapy for patients
- Treatments that are at least as safe and effective for long-term use
- Less/no conjunctivitis or red face
- Safe and effective options to use in patients who previously had inadequate response or adverse-events from dupilumab
- Safe and effective options to use in patients who had secondary loss of response to dupilumab

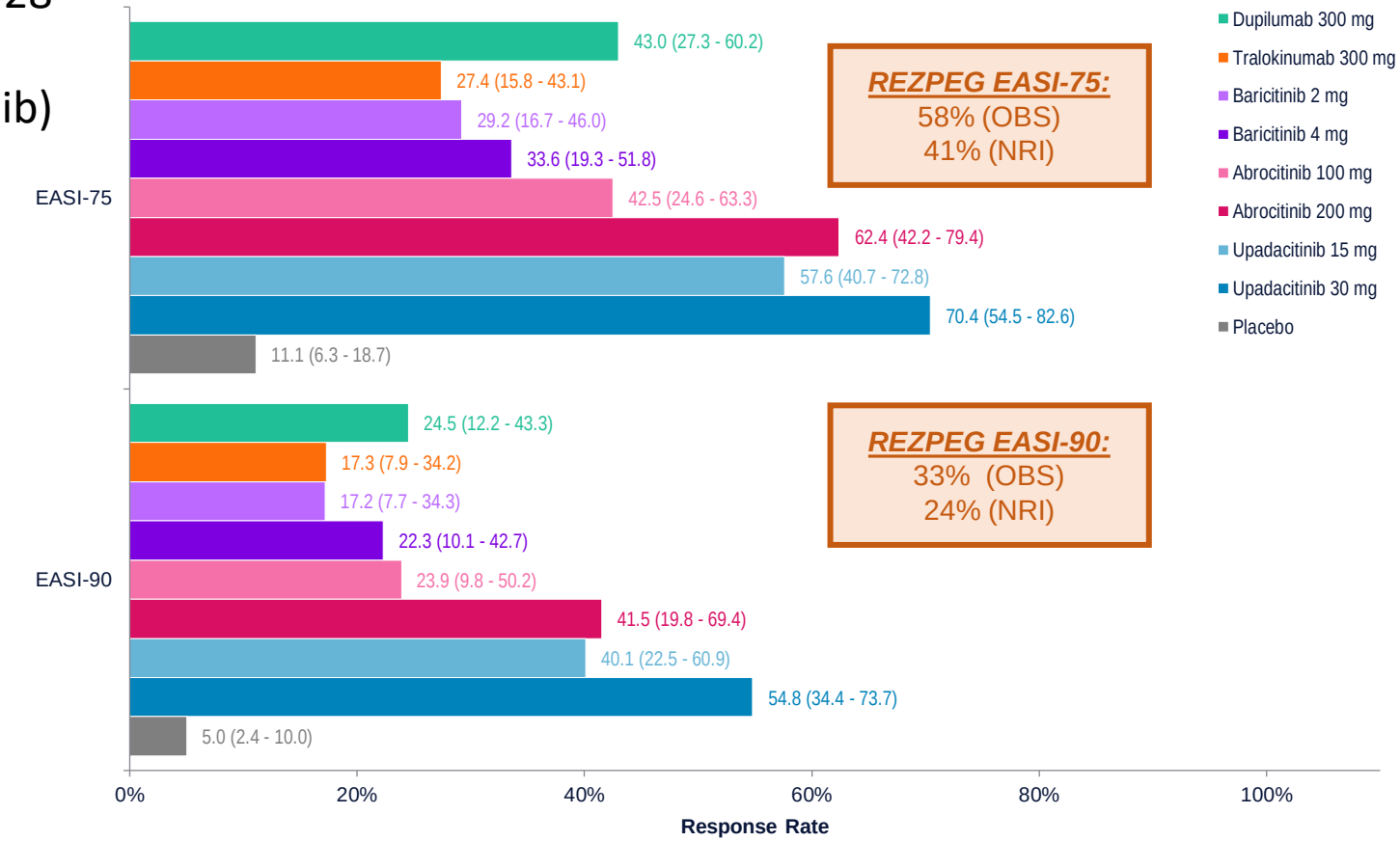
Comparative treatment effectiveness at W12-16

Systematic review and meta-analysis

The NMA analyzed 11 unique phase 3 placebo-controlled trials encompassing 6,254 patients in 28 arms across five targeted therapies (abrocitinib, baricitinib, dupilumab, tralokinumab, upadacitinib)



EASI-75 and EASI-90 response rate estimates and 95% credible intervals at primary endpoint timepoint (Bayesian NMA fixed-effects results)



REZPEG EASI-75:
58% (OBS)
41% (NRI)

REZPEG EASI-90:
33% (OBS)
24% (NRI)

Silverberg JI, et al. Comparison of efficacy of targeted therapies without topical corticosteroids for moderate to severe atopic dermatitis: systematic review and network meta-analysis. *Revolutionizing Atopic Dermatitis (RAD)* June 2021 Virtual Conference, Abstract 505.

Thank you

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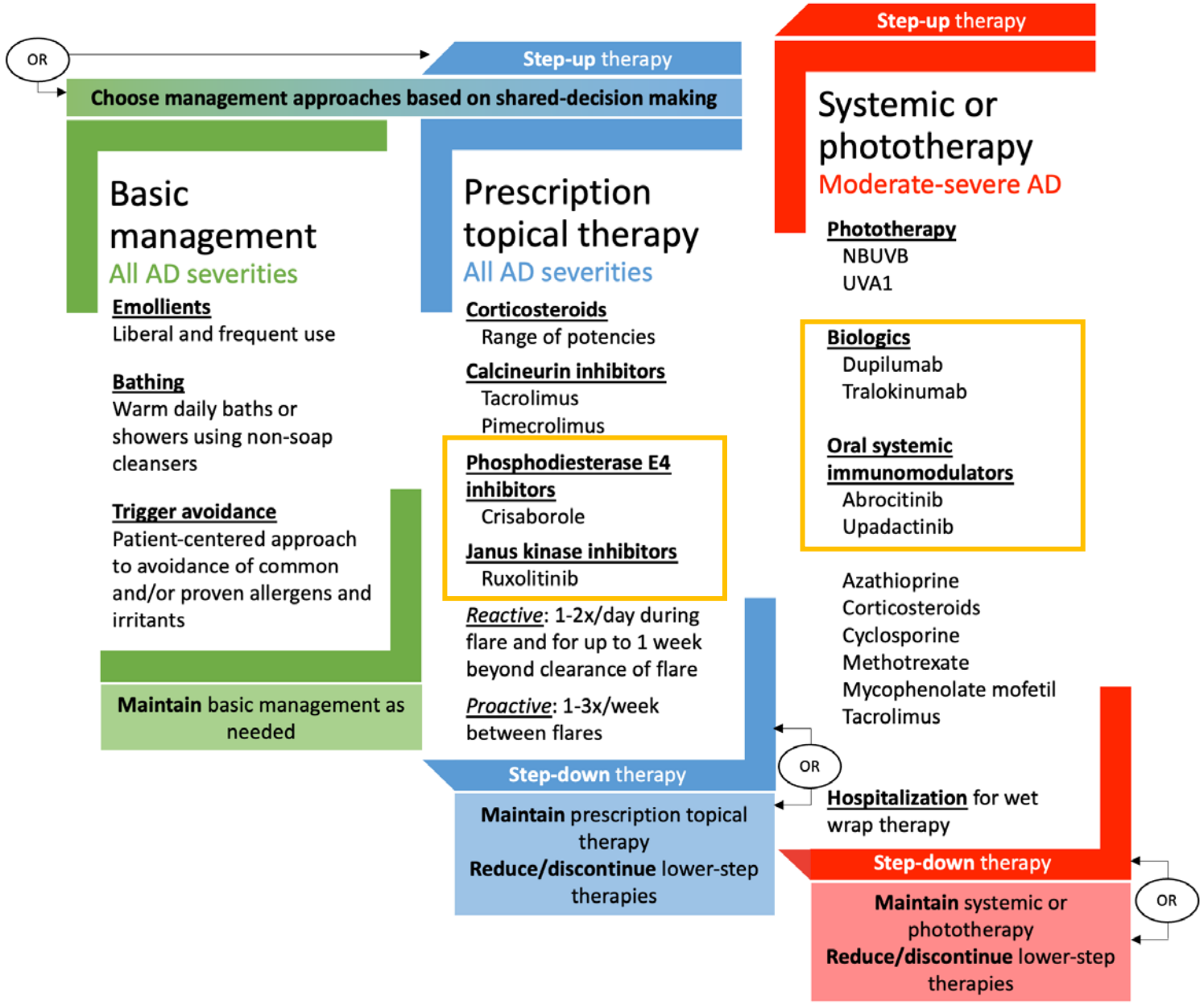
Treatment Approach Has Changed Considerably in Recent Years

- Mild-moderate (but practically, all severities)
  - Crisaborole (PDE4)
  - Ruxolitinib (JAK 1/2)
- Moderate-severe
  - Dupilumab (IL-4Rα)
  - Tralokinumab (IL-13)
  - Abrocitinib (JAK 1)
  - Upadacitinib (JAK 2)



Chovatiya R, Silverberg JI. Iatrogenic Burden of Atopic Dermatitis. Dermatitis. 2022 Nov-Dec 01;33(6S):S17-S23.

Biologic Therapies

Advantages

- First line systemic therapy after topicals
- No lab monitoring
- Safe and effective for long-term management
- Approvals for other atopic diseases (dupilumab)
- Multiple years of real-world data
- Approval at young ages and recommended in older age

Disadvantages

- Moderate-severe disease only
- Injections
- Refrigeration
- Slower onset
- Only one dose (can’t “step up”)
- Potential side effects
- Long-term control / immunogenicity
- Cost/Access

Oral JAK Inhibitors

Advantages

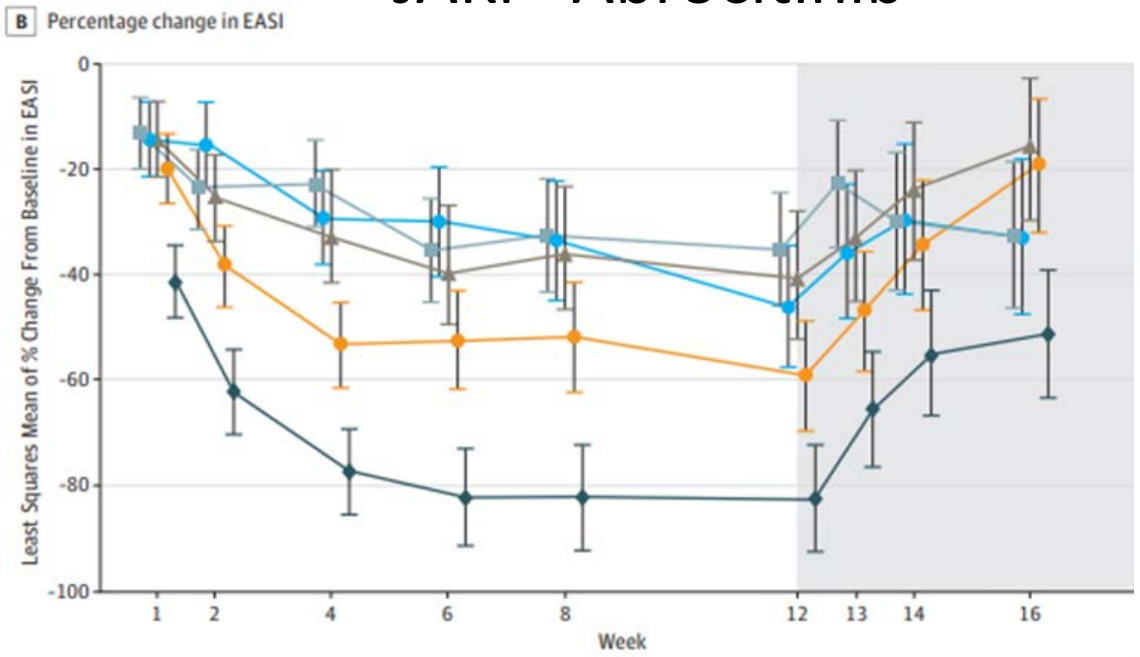
- Very rapid improvement of signs, symptoms, and other measures – days to weeks
- Higher levels of efficacy than previously measured at topline dosing
- Flexible dosing
- Minimal concerns about immunogenicity / intermittent use
- Safe and effective for long-term management based on RCT/LTE evidence so far
  - Majority of AEs across trials were mild-moderate
- Treatment of other inflammatory conditions (IBD, RA, AA, vitiligo…)

Disadvantages

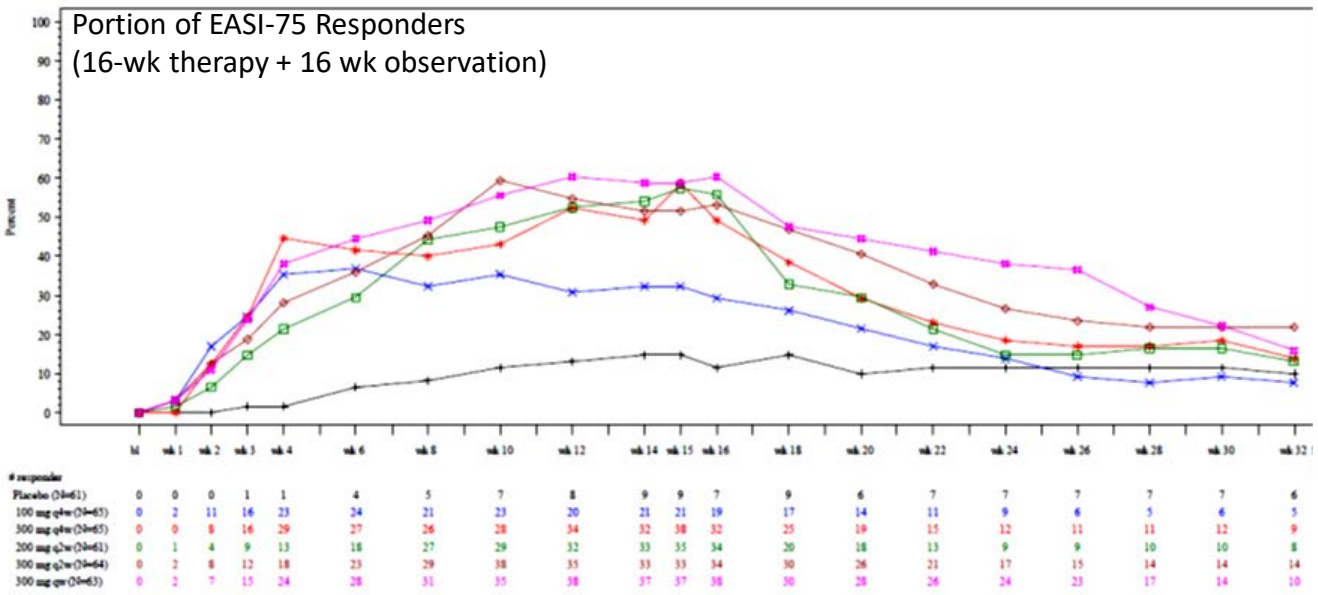
- Effectively second line option (after prior systemic therapy, which is often biologics)
- Boxed warning
- Limited use with age, comorbidities, other medications
- Lab monitoring
- More broadly acting on immune system
- Herpesvirus infection (VZV, HSV)
- Pregnancy / lactation

Loss of Disease Control after Cessation of Therapy

JAKi - Abrocitinib



Biologic - Dupilumab



Sources: Gooderham et al. *JAMA Derm* (2019) 155(12): 137101379; Blauvelt et al. *Am J Clin Dermatol*. (2022) 23(3): 365-383; https://www.tga.gov.au/sites/default/files/auspar-dupilumab-180612.docx

Despite current the current therapeutic revolution, remittance is still an elusive concept

Many HCPs ask for medications with remittive effect – what might that mean for AD?

- Complete clearance and medication discontinuation
- Complete clearance with infrequent medication use

- Near clearance and medication discontinuation
- Near clearance with infrequent medication use

- ”Control” (however you choose to define it) and medication discontinuation
- “Control” (however you choose to define it) with infrequent medication use

For a chronic disease like AD, what might be possible?

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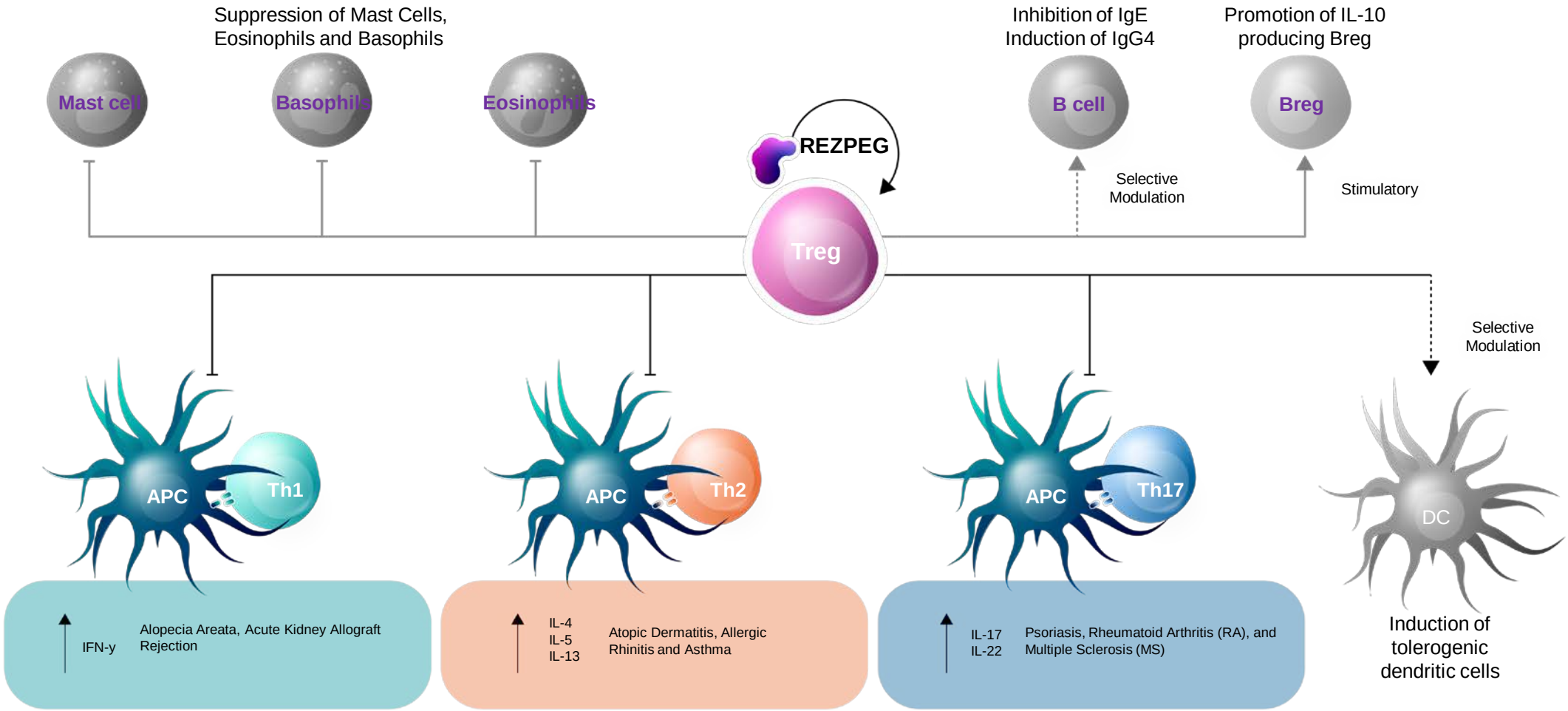
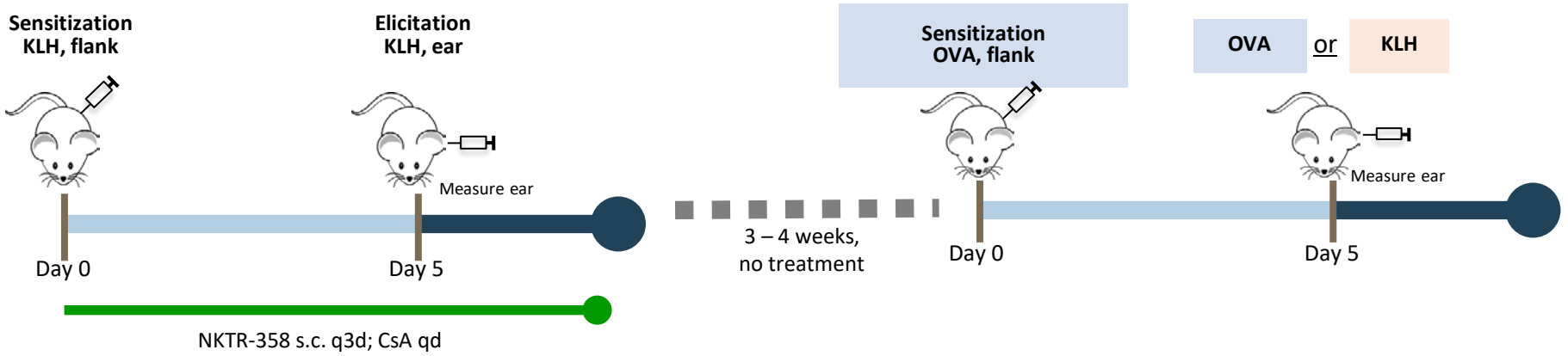
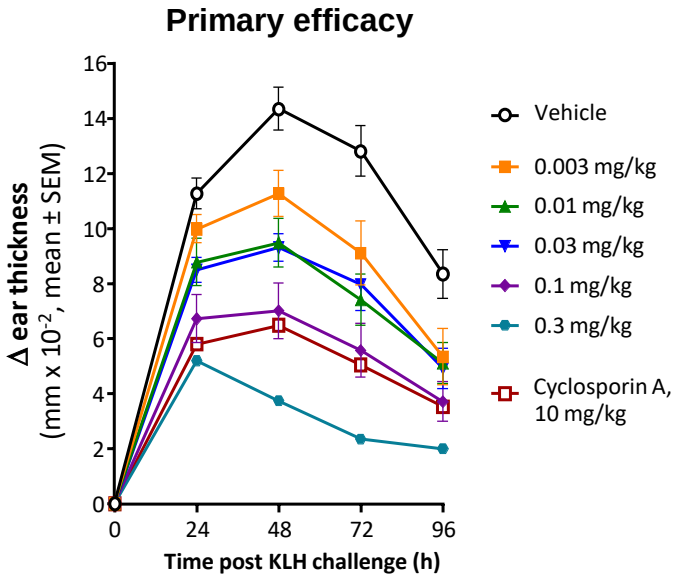
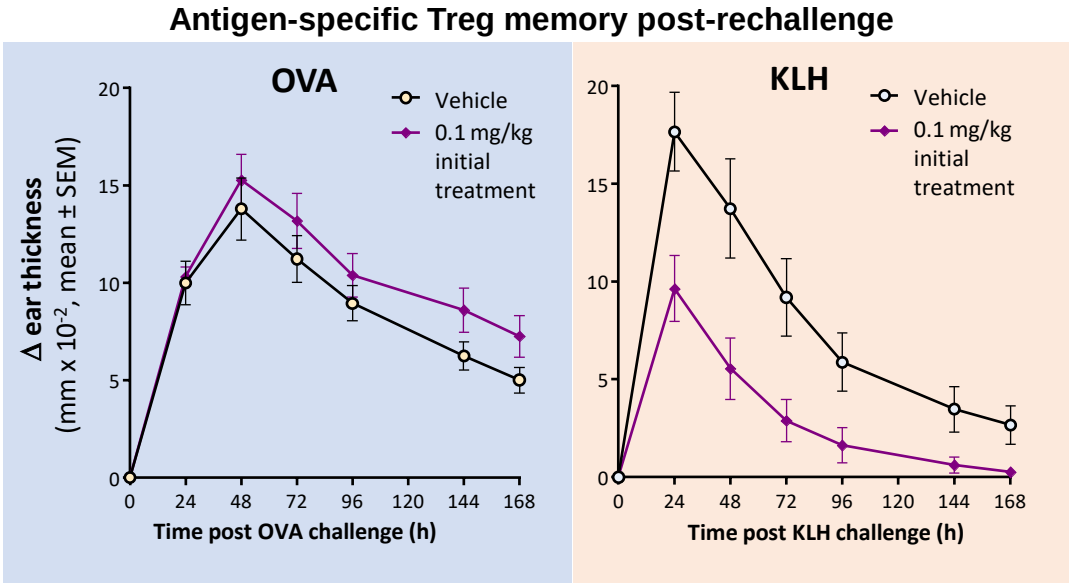
Role of Regulatory T Cells in Autoimmune Disease



REZPEG Reduces Inflammation in Dermal Pathologies while Increasing Treg Populations



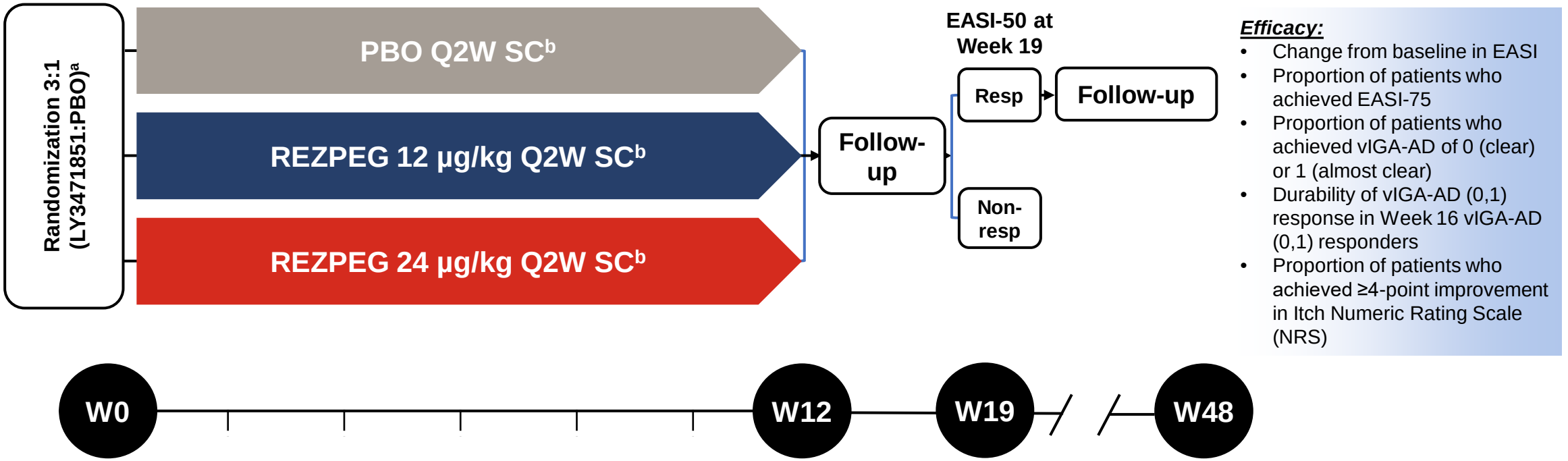




REZPEG Phase 1b, Double-Blind, Placebo-Controlled Study of Patients With Atopic Dermatitis (NCT04081350)

Key Eligibility Criteria

- Aged 18-70 years
- Moderate-to-severe AD involving ≥10% body surface area in the affected skin
- History of inadequate response or intolerance to topical medications
- vIGA-AD™ ≥3
- Eczema Area and Severity Index (EASI) ≥16



Efficacy:

- Change from baseline in EASI
- Proportion of patients who achieved EASI-75
- Proportion of patients who achieved vIGA-AD of 0 (clear) or 1 (almost clear)
- Durability of vIGA-AD (0,1) response in Week 16 vIGA-AD (0,1) responders
- Proportion of patients who achieved ≥4-point improvement in Itch Numeric Rating Scale (NRS)

Source: Schleicher et. al.: "*Efficacy and Safety of a Selective Regulatory T-Cell Inducing IL-2 Conjugate (LY3471851) in the Treatment of Atopic Dermatitis: A Phase 1 Randomised Study*"

[a] Full study design is not shown; the REZPEG 10 µg/kg cohort is not included in this analysis

[b] Total of 7 doses/patient

EASI-50=50% improvement from baseline in Eczema Area and Severity Index; PBO=placebo; Q2W=once every 2 weeks; SC=subcutaneous; W=Week

Study Demographics of Patients in Phase 1b Trial in Atopic Dermatitis

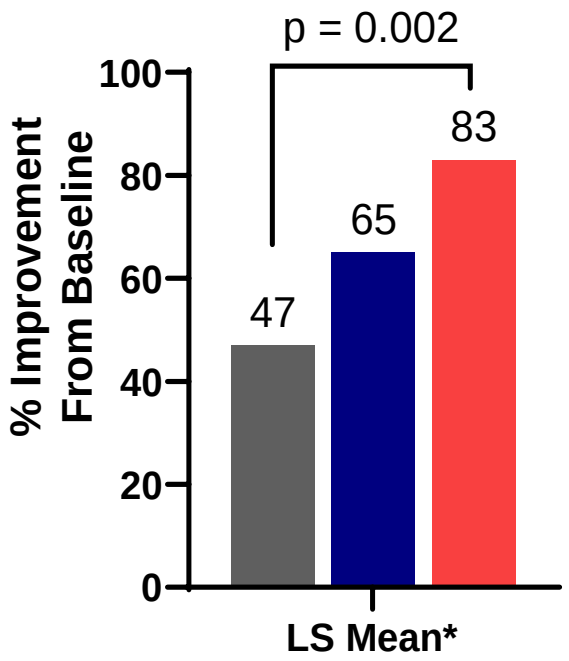
Characteristic	PBO (n=10)	REZPEG 12 µg/kg (n=16)	REZPEG 24 µg/kg (n=17)
Mean age, years (SD)	42.5 (19.8)	47.9 (17.5)	37.5 (16.4)
Sex, n (%)			
Female	6 (60.0%)	11 (68.8%)	7 (41.2%)
Male	4 (40.0%)	5 (31.3%)	10 (58.8%)
Race, n (%)			
White	6 (60.0%)	11 (68.8%)	14 (82.4%)
Black or African American	3 (30.0%)	3 (18.8%)	3 (17.6%)
Asian	1 (10.0%)	2 (12.5%)	0
Ethnicity, n (%)			
Hispanic or Latino	0	3 (18.8%)	7 (41.2%)
Not Hispanic or Latino	10 (100.0%)	13 (81.3%)	10 (58.8%)
Mean EASI score (SD)	23.7 (7.1)	23.5 (11.2)	21.9 (5.1)
Mean BSA score (SD)	39.0 (21.6)	33.8 (20.1)	33.5 (15.8)
vIGA score, n (%)			
3 (moderate)	5 (50.0%)	9 (56.3%)	11 (64.7%)
4 (severe)	5 (50.0%)	7 (43.8%)	6 (35.3%)
Mean Itch NRS score (SD)	8.5 (1.3)	7.8 (2.1)	7.4 (2.5)
Mean DLQI score (SD)	13.0 (5.9)	12.4 (6.7)	11.3 (7.2)
Mean POEM score (SD)	21.2 (5.7)	20.0 (5.2)	19.6 (7.0)

NEKTAR SD: Standard deviation

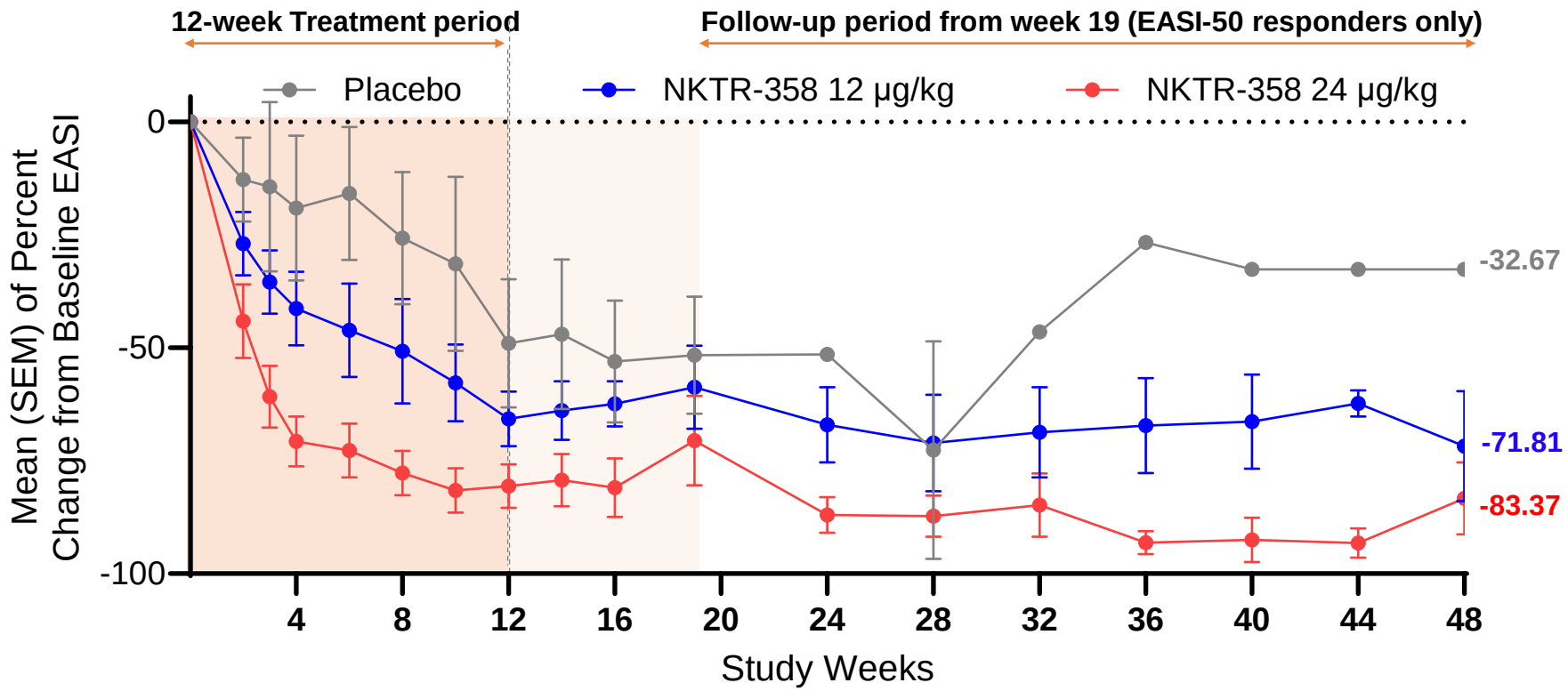
Phase 1b Study of REZPEG in Atopic Dermatitis

Percent Change From Baseline for EASI Score

EASI Improvement at Week 12



Percent Reduction from Baseline EASI



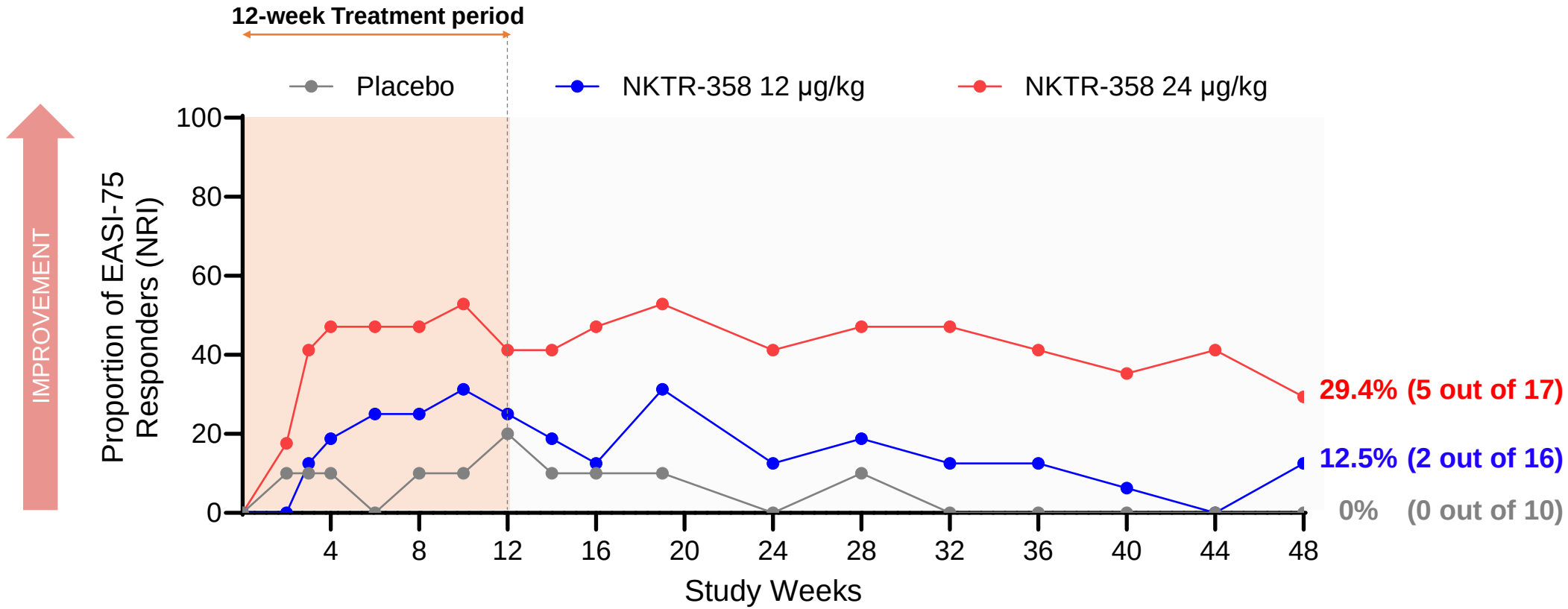
Weeks	0	2	3	4	6	8	10	12	14	16	19	24	28	32	36	40	44	48
PBO, n	10	8	6	8	6	8	5	7	5	5	6	1	2	1	1	1	1	1
REZPEG 12 µg/kg, n	16	16	15	15	14	14	12	12	12	12	12	7	5	5	5	4	3	4
REZPEG 24 µg/kg, n	17	16	16	15	15	14	13	12	13	13	13	8	9	9	7	7	7	7

n = number of participants who were evaluated at each defined timepoint

NEKTAR SEM: Standard error of the mean; continuous endpoint using observed data; *EASI Improvement results are least squares (LS) mean percent change from baseline obtained from Mixed Model for Repeated Measures (MMRM) as specified in the statistical analysis plan (SAP) defined in the protocol (generated by independent statistical audit firm)

EASI-75 (EASI Score Decreased by at Least 75%)

Proportion of EASI-75 Responders



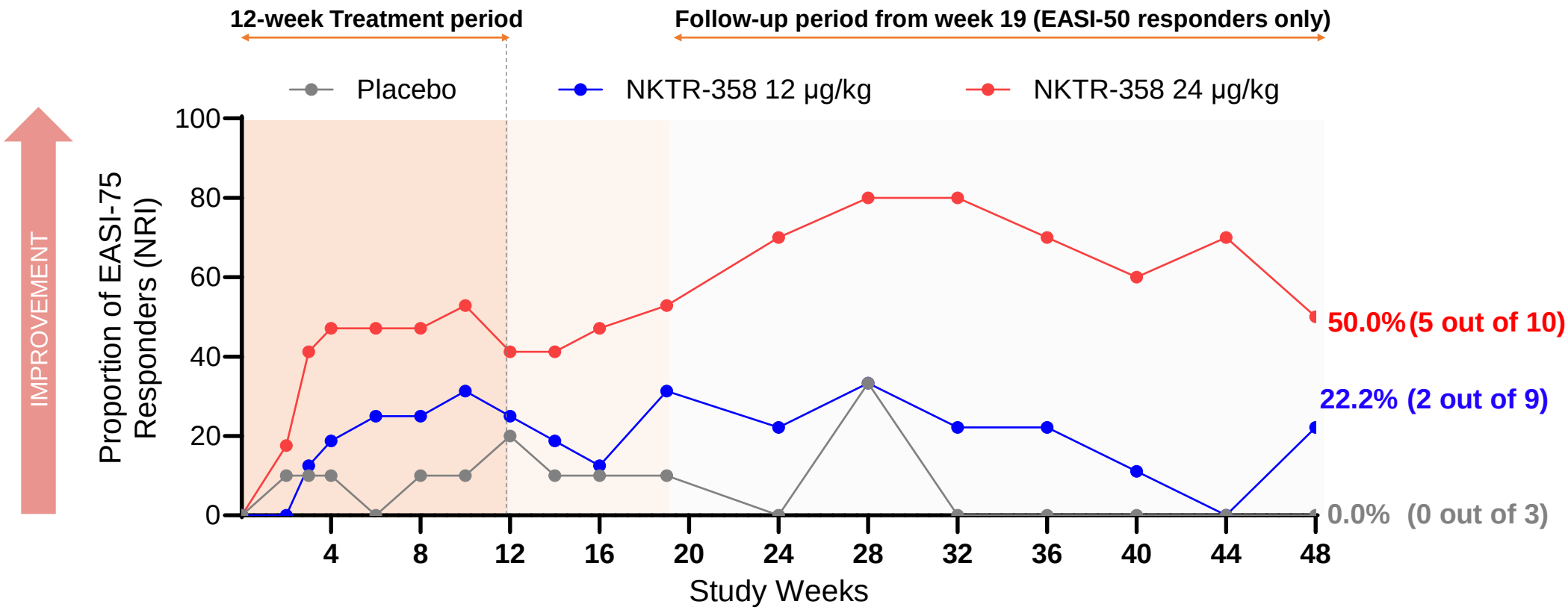
Weeks	0	2	3	4	6	8	10	12	14	16	19	24	28	32	36	40	44	48
PBO, n	N=10	1	1	1	0	1	1	2	1	1	1	0	1	0	0	0	0	0
REZPEG 12 µg/kg, n	N=16	0	2	3	4	4	5	4	3	2	5	2	3	2	2	1	0	2
REZPEG 24 µg/kg, n	N=17	3	7	8	8	8	9	7	7	8	9	7	8	8	7	6	7	5

n = number of participants who achieved an EASI-75 response at each defined timepoint

Patients were followed until Week 19 (17, 16, and 10 pts in the 24 µg/kg, 12 µg/kg, and PBO groups), and those with ≥EASI-50 response at Week 19 (10, 9, and 3 pts in the 24 µg/kg, 12 µg/kg, and PBO groups) were followed until Week 48 or until EASI-25 response criteria were no longer met; patients who were not EASI-50 responders at week 19 were imputed as non-responders for visits after week 19; NRI: non-responder imputation

EASI-75 (EASI Score Decreased by at Least 75%)

Proportion of EASI-75 Responders



Weeks	0	2	3	4	6	8	10	12	14	16	19	24	28	32	36	40	44	48
PBO, n	N=10	1	1	1	0	1	1	2	1	1	1	0	1	0	0	0	0	0
REZPEG 12 µg/kg, n	N=16	0	2	3	4	4	5	4	3	2	5	2	3	2	2	1	0	2
REZPEG 24 µg/kg, n	N=17	3	7	8	8	8	9	7	7	8	9	7	8	8	7	6	7	5

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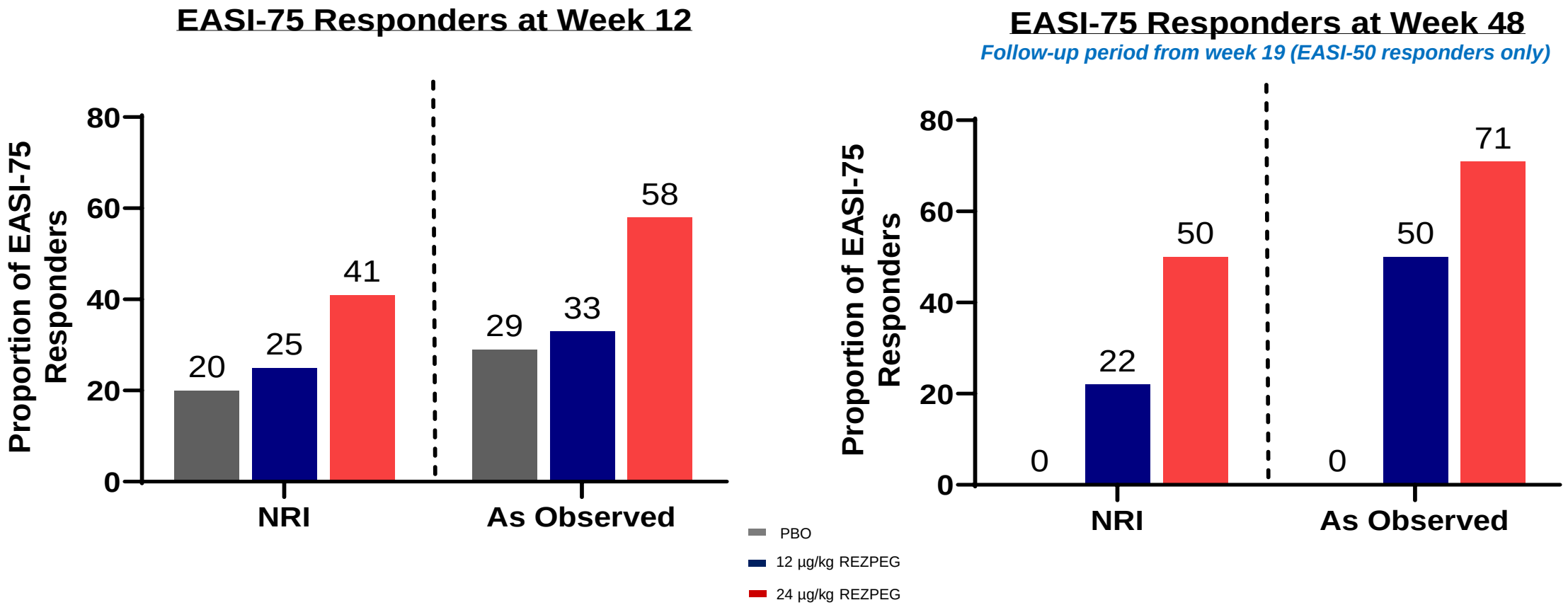
Phase 1b Study of REZPEG in Atopic Dermatitis

Proportion of EASI-75 Responders at Week 12 and at Week 48



Patients were followed until Week 19, and those with ≥EASI-50 response at Week 19 were followed until Week 48 or until EASI-25 response criteria were no longer met. NRI: non-responder imputation

Other Key Measurements of Disease in Atopic Dermatitis

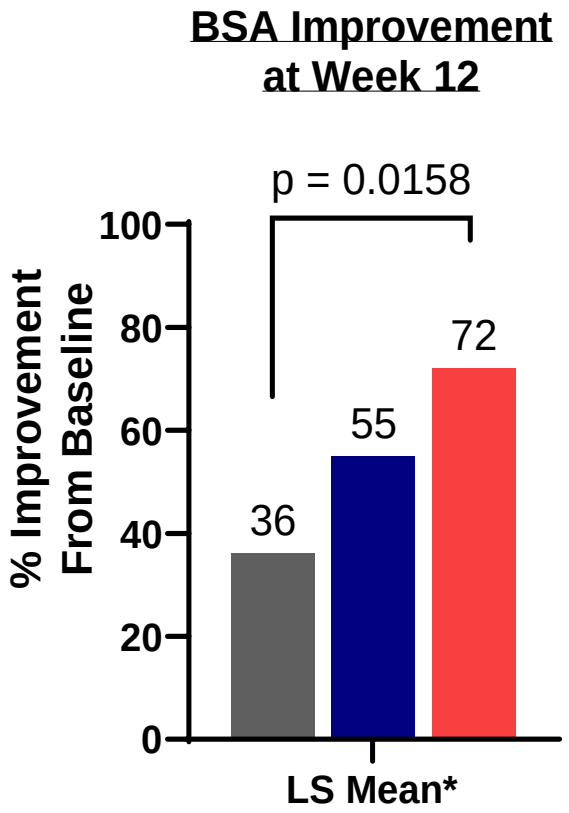
- **BSA: Affected body surface area (BSA) is a widely known and used measure of skin disease severity in clinical practice and many dermatologists prefer this tool for evaluating patient outcomes**
  - Patients with 10% or more of the BSA affected by disease are classified as moderate-to-severe atopic dermatitis patients

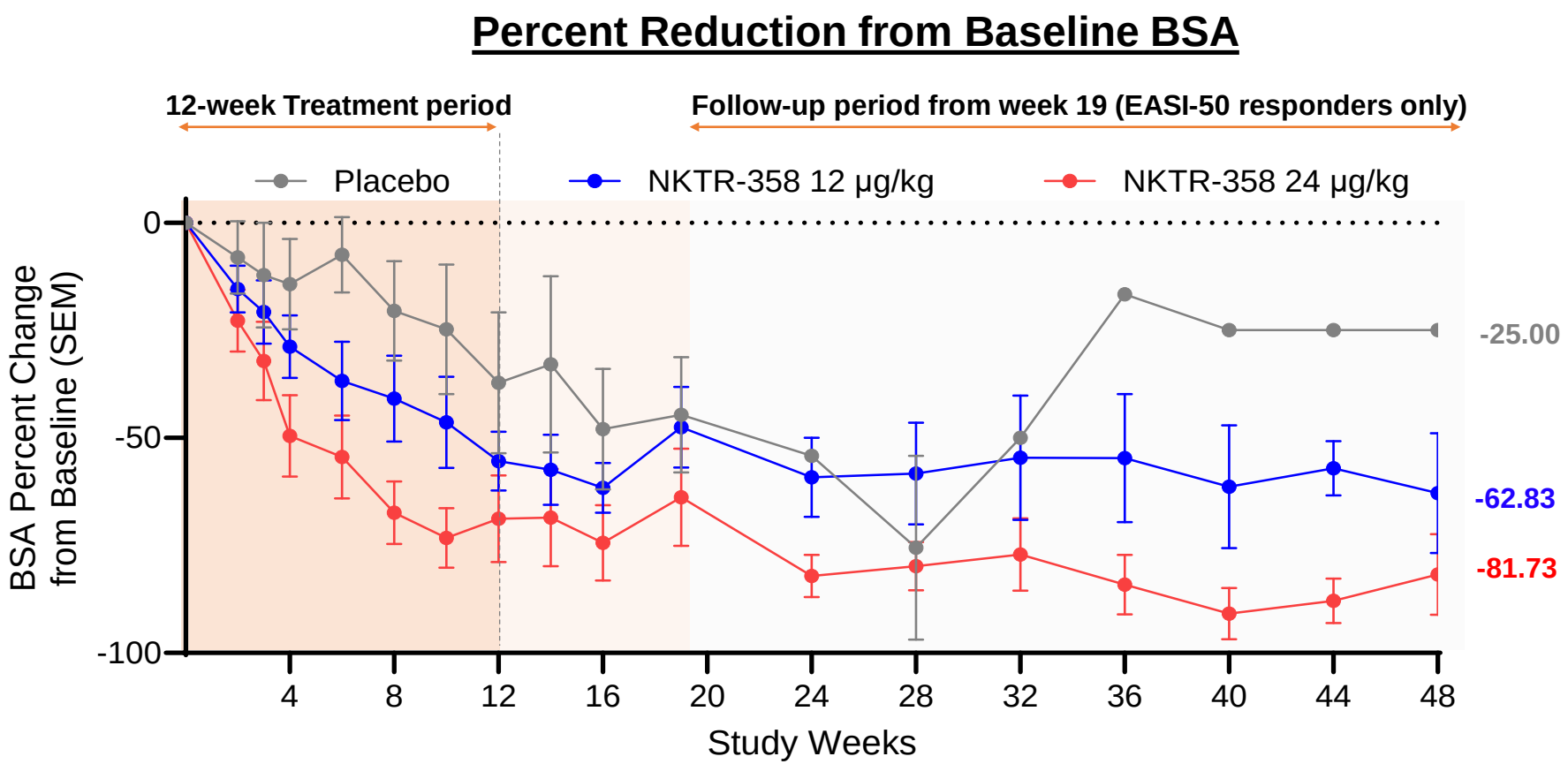
- **DLQI: The Dermatology Life Quality (DLQI) Index measures health-related quality of life for adult patients suffering from skin disease and is the most frequently used patient reported outcome measure in randomized controlled trials in dermatology**
  - Simple, self-administered and user-friendly validated 10-question questionnaire
  - Used in many different skin conditions in over 80 countries and is available in over 110 translations
  - Its use has been described in over 3,000 publications, including many multinational studies

- **POEM: The Patient Oriented Eczema Measure (POEM) is a tool used for monitoring atopic dermatitis severity that focuses on the illness as experienced by the patient**
  - POEM has been recommended for use by clinical guidelines including those issued by the National Institute for Health and Care Excellence (NICE)
  - POEM is recommended by the HOME (Harmonising Outcome Measures for Eczema) initiative as the core outcome instrument for measuring patient-reported symptoms in eczema trials

BSA (Body Surface Area)

Percent Change From Baseline for BSA





Weeks	0	2	3	4	6	8	10	12	14	16	19	24	28	32	36	40	44	48
PBO, N	10	8	6	8	6	8	5	7	5	5	6	1	2	1	1	1	1	1
REZPEG 12 µg/kg, N	16	16	15	15	14	14	12	12	12	12	12	7	5	5	5	4	3	4
REZPEG 24 µg/kg, N	17	16	16	15	15	14	13	12	13	13	13	8	9	9	7	7	7	7

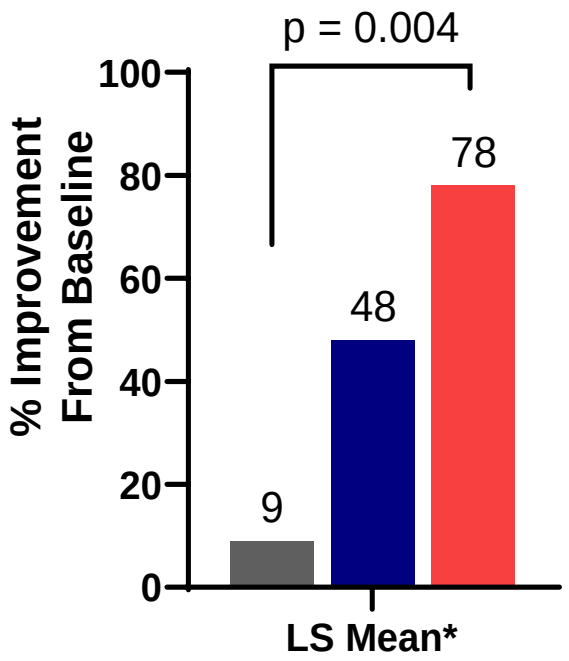
N = number of participants who were evaluated at each defined timepoint

SEM: Standard error of the mean; continuous endpoint using observed data; *BSA Improvement results are least squares (LS) mean percent change from baseline obtained from Mixed Model for Repeated Measures (MMRM) as specified in the statistical analysis plan (SAP) defined in the protocol

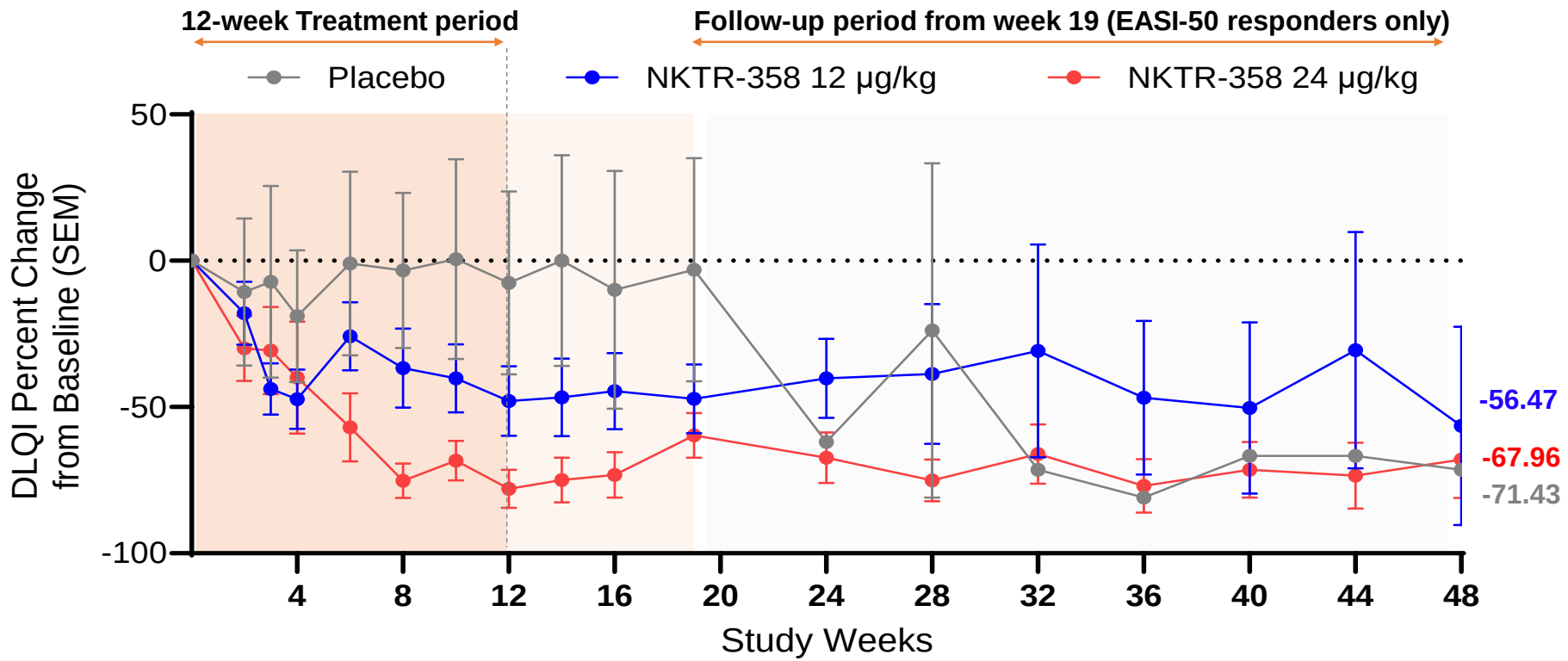
DLQI (Dermatology Life Quality Index)

Percent Change From Baseline for DLQI

DLQI Improvement at Week 12



Percent Reduction from Baseline DLQI



Weeks	0	2	3	4	6	8	10	12	14	16	19	24	28	32	36	40	44	48
PBO, N	10	8	6	8	6	8	5	7	5	5	6	1	2	1	1	1	1	1
REZPEG 12 µg/kg, N	16	16	15	15	14	14	12	12	12	12	12	7	5	5	5	4	3	4
REZPEG 24 µg/kg, N	17	16	16	15	15	14	13	12	13	13	13	8	9	9	7	7	7	7

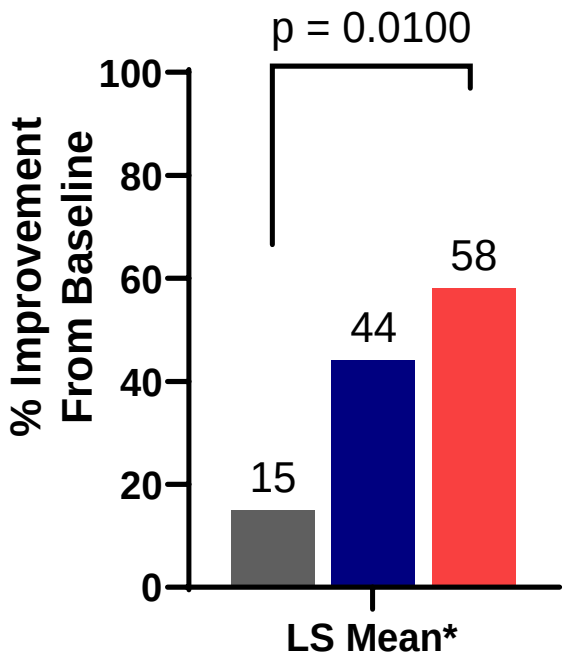
N = number of participants who were evaluated at each defined timepoint

NEKTAR SEM: Standard error of the mean; continuous endpoint using observed data; *DLQI Improvement results are least squares (LS) mean percent change from baseline obtained from Mixed Model for Repeated Measures (MMRM) as specified in the statistical analysis plan (SAP) defined in the protocol

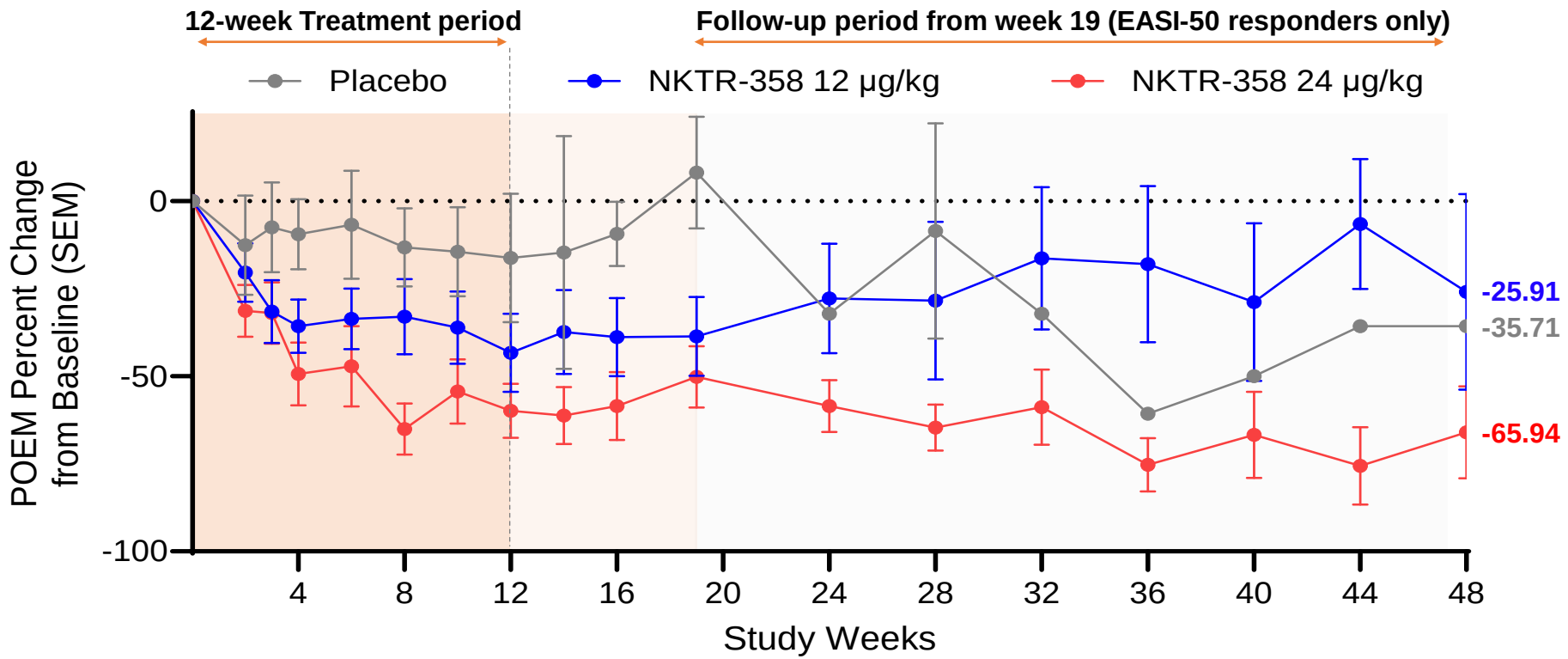
POEM (Patient-Oriented Eczema Measure)

Percent Change From Baseline POEM

POEM Improvement at Week 12



Percent Reduction from Baseline POEM



Weeks	0	2	3	4	6	8	10	12	14	16	19	24	28	32	36	40	44	48
PBO, N	10	8	6	8	6	8	5	7	5	5	6	1	2	1	1	1	1	1
REZPEG 12 µg/kg, N	16	16	15	15	14	14	12	12	12	12	12	7	5	5	5	4	3	4
REZPEG 24 µg/kg, N	17	16	16	15	15	14	13	12	13	13	13	8	9	9	7	7	7	7

N = number of participants who were evaluated at each defined timepoint

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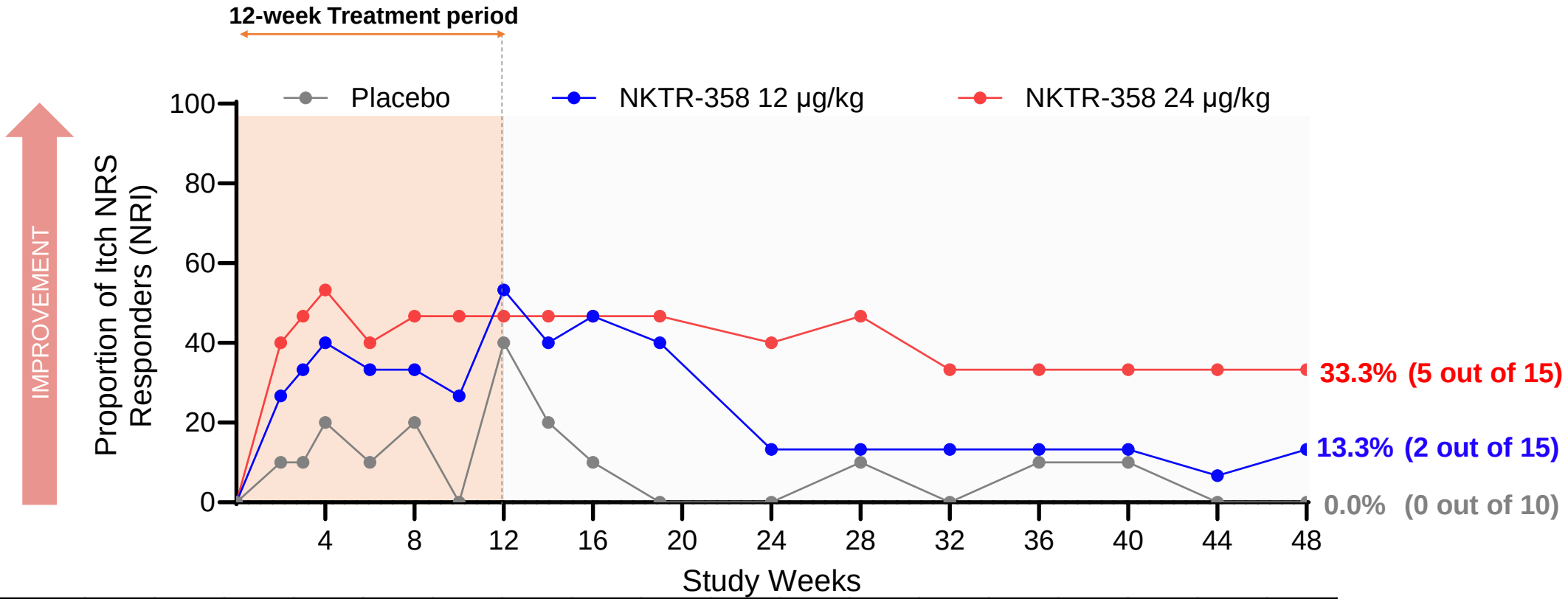
Itch NRS (Numeric Rating Scale)

Proportion of Itch NRS Responders; Responder defined as greater than or equal to a 4-point reduction from baseline – ***<u>Only patients with a baseline score of 4 points or greater included</u>***



Weeks	0	2	3	4	6	8	10	12	14	16	19	24	28	32	36	40	44	48
PBO, n	N=10	1	1	2	1	2	0	4	2	1	0	0	1	0	1	1	0	0
REZPEG 12 µg/kg, n	N=15	4	5	6	5	5	4	8	6	7	6	2	2	2	2	2	1	2
REZPEG 24 µg/kg, n	N=15	6	7	8	6	7	7	7	7	7	7	6	7	5	5	5	5	5

n = number of participants who achieved an Itch NRS response at each defined timepoint

Patients were followed until Week 19 (17, 16, and 10 pts in the 24 µg/kg, 12 µg/kg, and PBO groups), and those with ≥EASI-50 response at Week 19 (10, 9, and 3 pts in the 24 µg/kg, 12 µg/kg, and PBO groups) were followed until Week 48 or until EASI-25 response criteria were no longer met; patients who were not EASI-50 responders at week 19 were imputed as non-responders for visits after week 19; NRI: non-responder imputation

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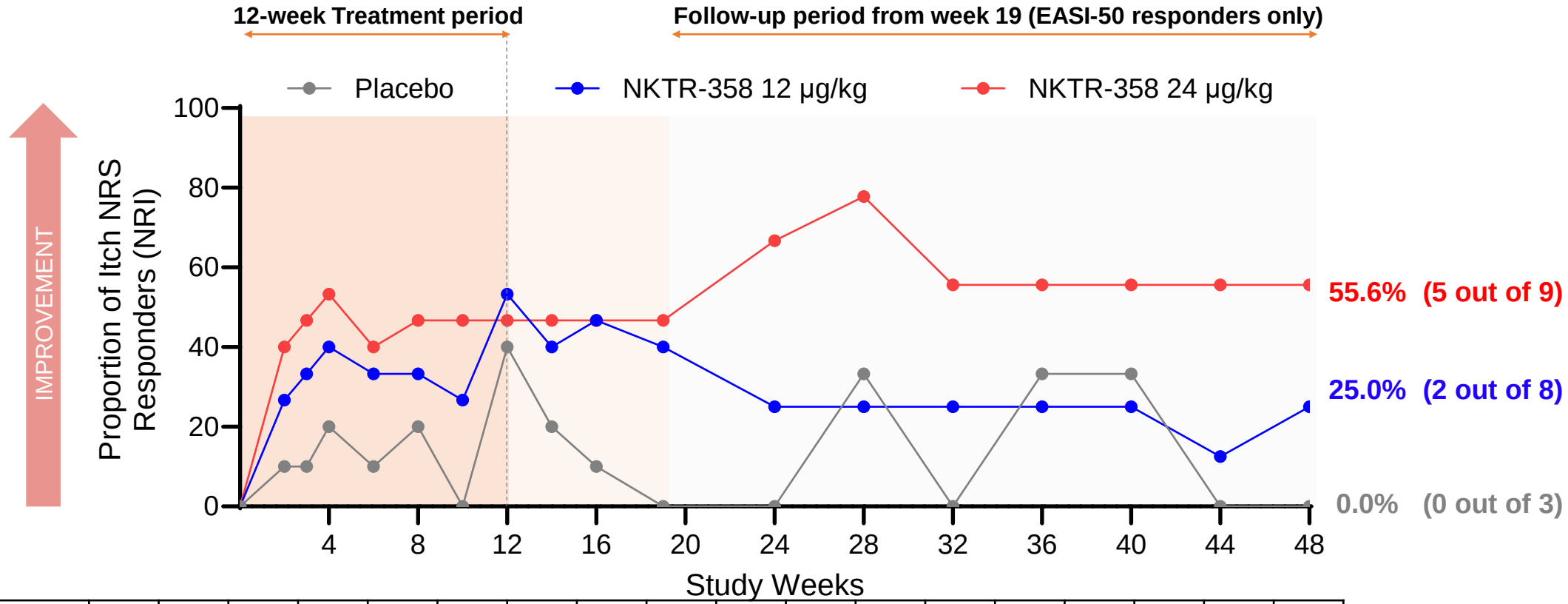

Weeks	0	2	3	4	6	8	10	12	14	16	19	24	28	32	36	40	44	48
PBO, n	N=10	1	1	2	1	2	0	4	2	1	0	0	1	0	1	1	0	0
REZPEG 12 µg/kg, n	N=15	4	5	6	5	5	4	8	6	7	6	2	2	2	2	2	1	2
REZPEG 24 µg/kg, n	N=15	6	7	8	6	7	7	7	7	7	7	6	7	5	5	5	5	5

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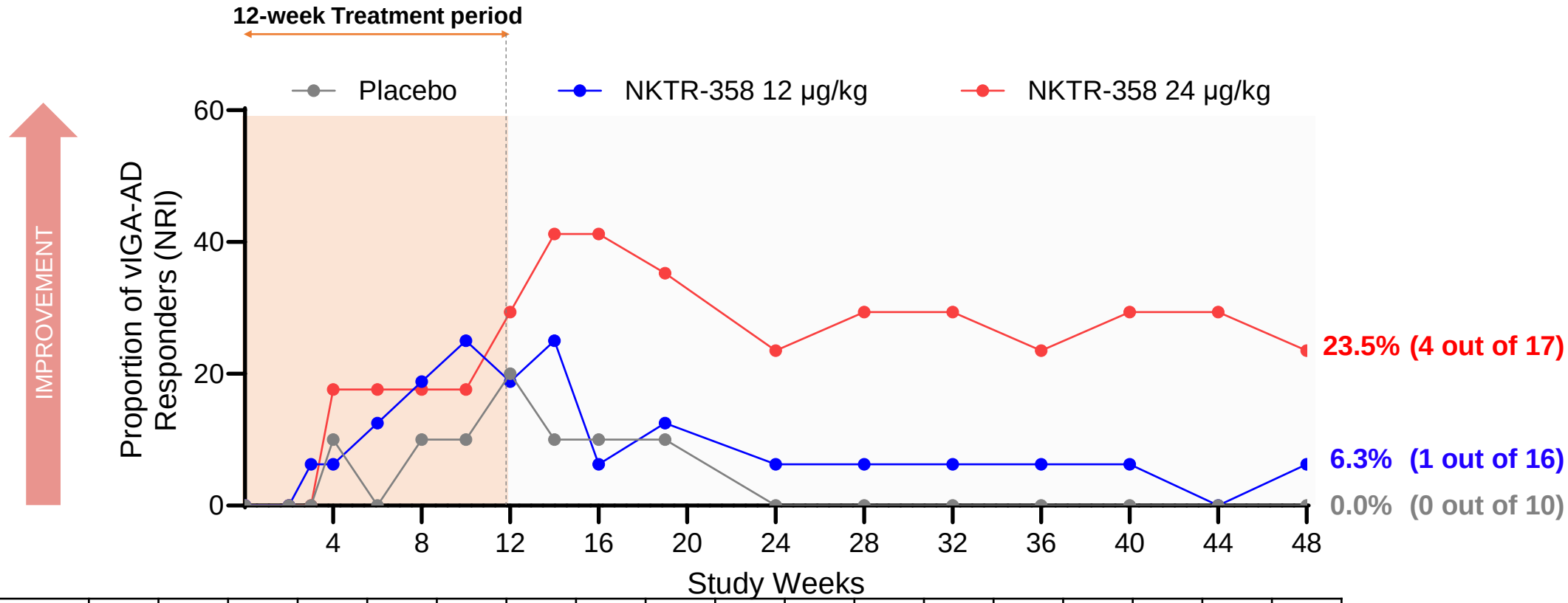
vIGA (Validated Investigator Global Assessment)

Proportion of vIGA Responders; Responder defined as a score of 0 or 1 and at least a 2-point reduction from baseline



Weeks	0	2	3	4	6	8	10	12	14	16	19	24	28	32	36	40	44	48
PBO, n	N=10	0	0	1	0	1	1	2	1	1	1	0	0	0	0	0	0	0
REZPEG 12 µg/kg, n	N=16	0	1	1	1	2	3	3	3	1	2	1	1	1	1	1	0	1
REZPEG 24 µg/kg, n	N=17	0	0	2	2	2	3	5	7	7	6	4	5	5	4	5	5	4

n = number of participants who achieved a vIGA response at each defined timepoint

Patients were followed until Week 19 (17, 16, and 10 pts in the 24 µg/kg, 12 µg/kg, and PBO groups), and those with ≥EASI-50 response at Week 19 (10, 9, and 3 pts in the 24 µg/kg, 12 µg/kg, and PBO groups) were followed until Week 48 or until EASI-25 response criteria were no longer met; patients who were not EASI-50 responders at week 19 were imputed as non-responders for visits after week 19; NRI: non-responder imputation

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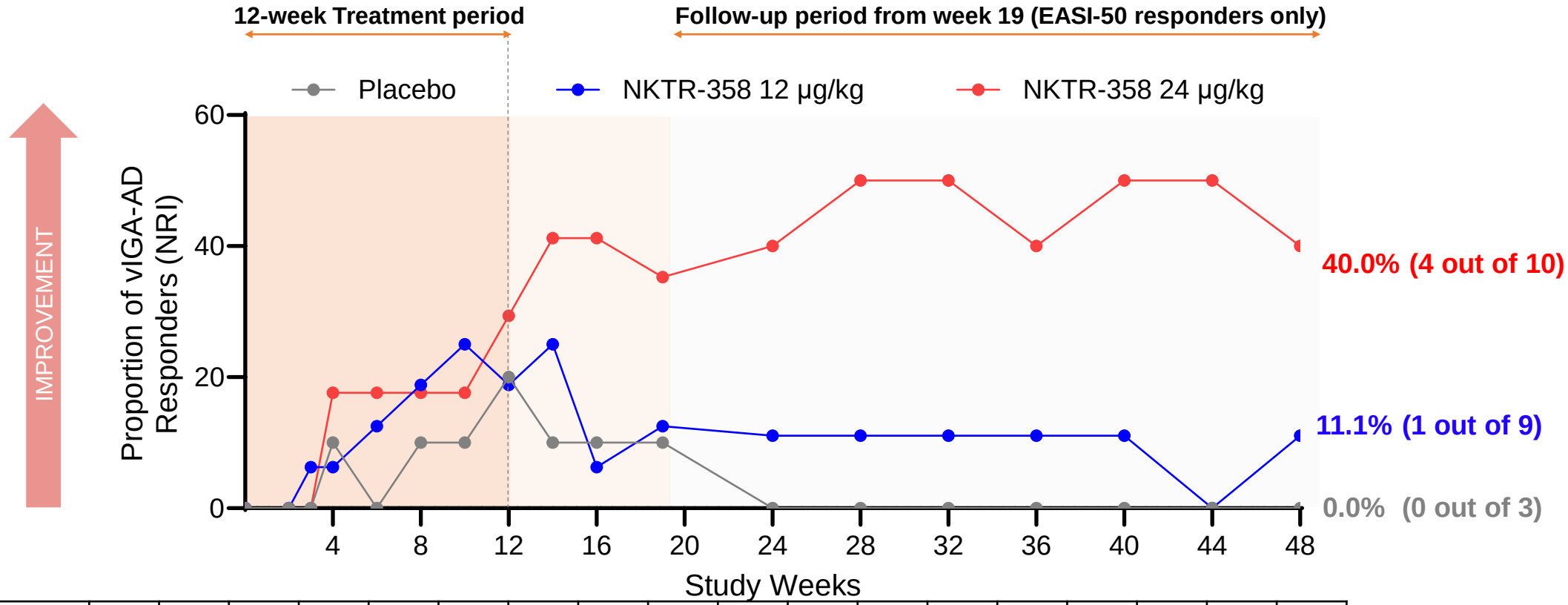


Weeks	0	2	3	4	6	8	10	12	14	16	19	24	28	32	36	40	44	48
PBO, n	N=10	0	0	1	0	1	1	2	1	1	1	0	0	0	0	0	0	0
REZPEG 12 µg/kg, n	N=16	0	1	1	1	2	3	3	3	1	2	1	1	1	1	1	0	1
REZPEG 24 µg/kg, n	N=17	0	0	2	2	2	3	5	7	7	6	4	5	5	4	5	5	4

n = number of participants who achieved a vIGA response at each defined timepoint

Patients were followed until Week 19 (17, 16, and 10 pts in the 24 µg/kg, 12 µg/kg, and PBO groups), and those with ≥EASI-50 response at Week 19 (10, 9, and 3 pts in the 24 µg/kg, 12 µg/kg, and PBO groups) were followed until Week 48 or until EASI-25 response criteria were no longer met; patients who were not EASI-50 responders at week 19 were excluded from the denominator for visits after week 19; NRI: non-responder imputation

Summary of Adverse Events Reported thru Week 48

Adverse Event	PBO (n=10)	REZPEG 12 µg/kg (n=16)	REZPEG 24 µg/kg (n=17)
Any Treatment Emergent Adverse Event (TEAE)	8 (80.0%)	10 (62.5%)	13 (76.5%)
TEAE in at least 5% of patients in the overall REZPEG group			
Infections and infestations	2 (20.0%)	7 (43.8%)	7 (41.2%)
Corona virus infection	0	2 (12.5%)	2 (11.8%)
Folliculitis	0	2 (12.5%)	0
Sinusitis	0	2 (12.5%)	0
Urinary tract infection	0	0	2 (11.8%)
Gastrointestinal disorders	3 (30.0%)	1 (6.3%)	3 (17.6%)
Nausea	0	1 (6%)	1 (6%)
General disorders and administration site conditions	1 (10.0%)	2 (12.5%)	2 (11.8%)
Pain	0	1 (6.3%)	1 (5.9%)
Investigations	0	0	4 (23.5%)
Nervous system disorders	0	2 (12.5%)	2 (11.8%)
Headache	0	2 (12.5%)	0
Blood and lymphatic system disorders	0	1 (6.3%)	1 (5.9%)
Eye disorders	0	2 (12.5%)	0
Respiratory, thoracic and mediastinal disorders	0	1 (6.3%)	1 (5.9%)
Skin and subcutaneous tissue disorders	1 (10.0%)	1 (6.3%)	1 (5.9%)
Any Adverse Events Related to Study Drug	3 (30.0%)	2 (12.5%)	5 (29.4%)
Any Severe Adverse Events	3 (30.0%)	0	0
Any Serious Adverse Events	2 (20.0%)	0	0
Deaths	0	0	0
Any Adverse Events Leading to Discontinuation of Study	0	1 (6.3%)	3 (17.6%)
Injection site reactions, # solicited patient reports	1	43	33

- *All TEAEs in study drug arms were mild to moderate in nature*
- *There were no severe or serious AEs in either of the drug arms*
- *No reports of conjunctivitis*
- *Most common AEs were mild to moderate injection site reactions*

NEKTAR

Efficacy Comparison of Biologics in Patients with Atopic Dermatitis – Phase 2 Clinical Trials Vs. Nektar Phase 1b

Endpoint	DUPIXENT (dupilumab) 300 mg Q2W[1] (approved)	ADBRY (Tralokinumab) 300mg Q2W[2] (approved)	Lebrikizumab 250mg Q2W[3]	Nemolizumab 30mg Q4W[4]	Rocatinlimab 300mg Q2W[5]	Rezpegaldesleukin (Phase 1b) 24 µg/kg Q2W
	Regeneron	*Leo Pharma*	*Lilly*	*Galderma*	*Amgen*	*Nektar*
Mechanism of Action	**IL-4 & IL-13 antagonist**	**IL-13 antagonist**	**IL-13 antagonist**	**IL-31 antagonist**	**OX40 antagonist**	**IL-2Rα agonist**
Drug: EASI LS Mean % reduction from baseline	68%	58%	72%	69%	61%	83%
Placebo: EASI LS Mean % reduction from baseline	18%	41%	41%	52%	15%	47%
EASI-75	~53%#	43%&	51%-61%+	46%	54%	58% (OBS) 41% (NRI)
EASI-90	~30%#	Not available	44%	30%	37%	33% (OBS) 24% (NRI)
IGA/vIGA-AD ≥ 2 pt (0, 1) Responders	30%	27%	45%	37%	31%	42% (OBS) 29% (NRI)
Itch NRS ≥ 4 pt Responders	36-41%**	20-25%**	70%	~50%^^	56%	64%* (OBS) 47%* (NRI)

*Analysis on patients with baseline score>=4; **Based on Phase 3 studies. # estimated from Figure 3 in manuscript 1. &excluded data after rescue medication and uses last observation carry forward (LOCF). +patients without baseline were excluded and missing data were imputed using Markov Chain Monte Carlo (MI-MCMC). ^^estimated from Figure 4 in manuscript 4

Acronyms: EASI = Eczema Area and Severity Index; LS = least squares; IGA = investigator global assessment; vIGA = validated investigator global assessment; pt = point; NRS = numerical rating scale; Q2W = every two weeks; Q4W = every four weeks; OBS = as observed; NRI = non-responder imputation. UNK=unknown. **References:** [1]Thaçi et al. *Lancet* (2016) 387(10013): 40-52; [2]Wollenberg et al. *J Allergy Clin Immunol (*2019) 143(1): 135-141; [3]Guttman-Yassky et al. *JAMA Dermatol.* (2020) 156(4): 411-420; [4]Silverberg et al. *J Allergy Clin Immunol*. (2020) 145(1): 173-182; [5]Guttman-Yassky et al. *Lancet (*2023) 401(10372): 204-214; [6] Weidinger et al. *Br J Derm* (2023), epub ahead (July 18, 2023); [7] https://classic.clinicaltrials.gov/ct2/show/results/NCT03568162?view=results.

NEKTAR

Phase 2b Study for Patients with Atopic Dermatitis

Screening	Induction Period (16 Weeks)	Maintenance Period (28 Weeks)	Follow-up (10 Weeks)

Key Inclusion:
- ✓ Age: 18-70 years
- ✓ Moderate/severe AD
  - EASI ≥ 16
  - vIGA-AD ≥ 3
  - BSA ≥ 10%
- ✓ Biologic-naive

Randomize (3:3:3:2) N=~400

- **Arm A: REZPEG Regimen A (q2w)**
  - **Arm A1: REZPEG Dose A q4w**
  - **Arm A2: REZPEG Dose A q12w**
- **Arm B: REZPEG Regimen B (q4w)**
  - **Arm B1: REZPEG Dose B q4w**
  - **Arm B2: REZPEG Dose B q12w**
- **Arm C: REZPEG Regimen C (q2w)**
  - **Arm C1: REZPEG Dose C q4w**
  - **Arm C2: REZPEG Dose C q12w***
- **Arm D: Placebo q2w**
  - **Arm D1: Placebo q4w**

EASI-50 responders advance to maintenance follow-up

At the end of induction, any patients with ≤ EASI-50 can move to the escape arm (Regimen A q2w).

In the maintenance period, acute exacerbation (< EASI-25) diverted to Escape Arm

ENDPOINTS:

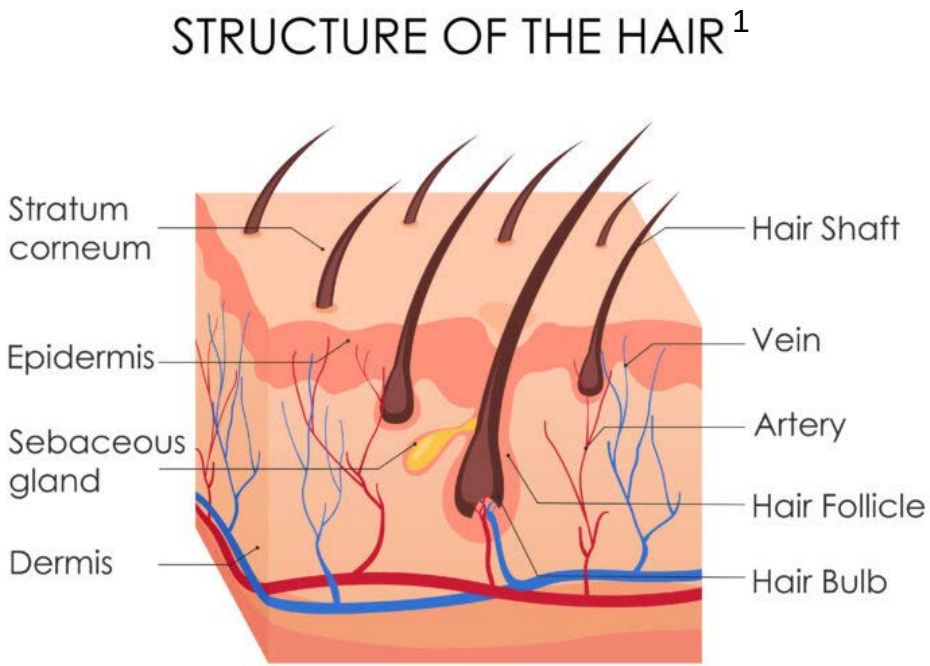
Primary:
Mean % EASI improvement at Week 16

Secondary/Exploratory:
- vIGA-AD 0/1, ≥ 2-point reduction
- EASI-75, -90, -50
- Itch NRS, ≥ 4-point reduction
- SCORAD
- PROs
- Safety
- PK/PD

Alopecia Areata – Disease Landscape

- About 700,000 people in the U.S. currently have some form of alopecia areata[1]
- Most individuals develop alopecia early in life. More than 80% show signs of the disease before age 40[1]
- Many patients, especially those with a longer duration of AA or greater BSA involvement, are refractory to available therapies and long-term use is associated with troublesome side effects and safety risks[2]
- High relapse rates upon discontinuation of current therapies make continuous treatment necessary for sustained hair growth, the primary goal of treatment[2]

Alopecia areata is a disease that happens when the immune system attacks hair follicles and causes hair loss[3]



Phase 2a Study for Patients with Alopecia Areata

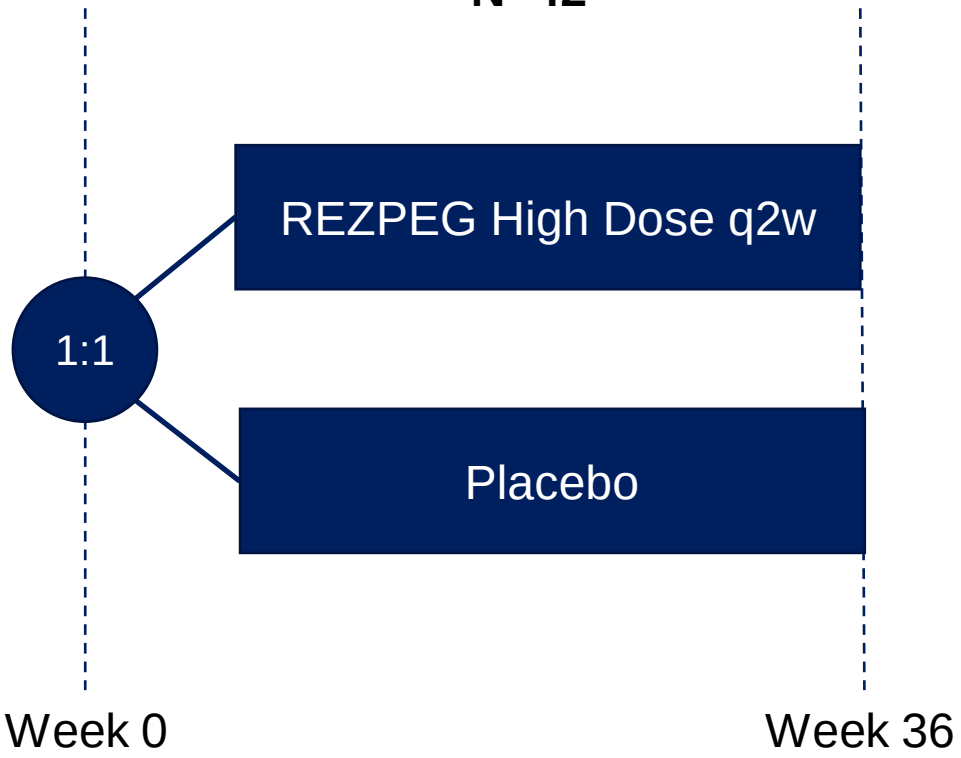
Screening

Induction (Weeks: 0-36) N=42

Follow-Up of 24 Weeks (Weeks: 36-60)

Key Inclusion:
- ✓ Age: 18+ years
- ✓ Severe-to-Very Severe AA
- ✓ SALT ≥50

Enrollment of patients with SALT 95-100 limited to 20 patients



ENDPOINTS:

Primary

Mean percent improvement in SALT at Week 36

Secondary/Exploratory
- Proportion with ≥ 50% reduction in SALT at Week 36 and other assessed timepoints
- Mean % improvement in SALT at other assessed timepoints
- Safety
- PK/PD

SALT: The Severity of Alopecia Tool is widely used to assess the extent of scalp-hair loss in patients with alopecia areata. Guidelines define treatment success as a 50% improvement in scalp hair.

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Q&A Session with Invited Speakers

David Rosmarin, MD

Chair of the Department of Dermatology at Indiana University School of Medicine

Kampen-Norins Scholar in Dermatology

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

Raj Chovatiya, MD, PhD, MSCI

Assistant Professor of Dermatology at the Northwestern University Feinberg School of Medicine

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