

# Corporate Presentation

MAY 2026



# Forward Looking Statements

This presentation contains “forward-looking statements” within the meaning of the Private Securities Litigation Reform Act of 1995, including without limitation statements regarding: future expectations, plans and prospects for Climb Bio; expectations regarding the therapeutic benefits, clinical potential and clinical development of budoprutug and CLYM116; the anticipated timelines for initiating Climb Bio’s Phase 1b/2a clinical trial of budoprutug in systemic lupus erythematosus in China; the anticipated timelines for announcing data from Climb Bio’s ongoing and planned clinical trials and Beijing Mabworks Biotech Co., Ltd.’s (“Mabworks”) Phase 1/2 trial of CLYM116; the anticipated benefits of Climb Bio’s technology transfer and exclusive license agreement with Mabworks; the sufficiency of Climb Bio’s cash resources for the period anticipated; the impact of the proceeds from the April 2026 private placement on Climb Bio’s balance sheet; and other statements containing the words “anticipate,” “believe,” “continue,” “could,” “estimate,” “expect,” “intend,” “may,” “plan,” “potential,” “predict,” “project,” “should,” “target,” “would,” “will,” “working” and similar expressions. Forward-looking statements are based on management’s current expectations of future events and are subject to a number of risks and uncertainties that could cause actual results to differ materially and adversely from those set forth in, or implied by, such forward-looking statements. Climb Bio may not actually achieve the plans, intentions or expectations disclosed in these forward-looking statements, and you should not place undue reliance on these forward-looking statements. These risks and uncertainties include, but are not limited to, important risks and uncertainties associated with: the ability of Climb Bio to timely and successfully achieve or recognize the anticipated benefits of its technology transfer and exclusive license agreement with Mabworks; changes in applicable laws or regulation; the possibility that Climb Bio may be adversely affected by other economic, business and/or competitive factors; Climb Bio’s ability to advance budoprutug and CLYM116 on the timelines expected or at all and to obtain and maintain necessary approvals from the U.S. Food and Drug Administration and other regulatory authorities; obtaining and maintaining the necessary approvals from investigational review boards at clinical trial sites and independent data safety monitoring boards; replicating in clinical trials positive results found in early-stage clinical trials or nonclinical studies; competing successfully with other companies that are seeking to develop treatments for primary membranous nephropathy, immune thrombocytopenia, systemic lupus erythematosus, IgA nephropathy and other immune-mediated diseases; maintaining or protecting intellectual property rights related to budoprutug, CLYM116 and/or its other product candidates; the outcome of any legal proceedings or other disputes; managing expenses; and raising the substantial additional capital needed, on the timeline necessary, to continue development of budoprutug, CLYM116 and any other product candidates Climb Bio may develop. For a discussion of other risks and uncertainties, and other important factors, any of which could cause Climb Bio’s actual results to differ materially from those contained in the forward-looking statements, see the “Risk Factors” section, as well as discussions of potential risks, uncertainties and other important factors, in Climb Bio’s most recent filings with the U.S. Securities and Exchange Commission. In addition, the forward-looking statements included in this presentation represent Climb Bio’s views as of the date hereof and should not be relied upon as representing Climb Bio’s views as of any date subsequent to the date hereof. Climb Bio anticipates that subsequent events and developments will cause Climb Bio’s views to change. However, while Climb Bio may elect to update these forward-looking statements at some point in the future, Climb Bio specifically disclaims any obligation to do so, except as required by law.



OUR MISSION

**Deliver high impact, disease-modifying medicines for individuals living with immune-mediated diseases**



*Scaling New Heights in the Development of Transformative Immune Medicines*

# Delivering Clinical Results and Advancing Development

## Corporate Highlights



Developing **differentiated**, monoclonal antibody (mAb) therapeutics for **immune-mediated diseases**, including those affecting **kidney health**, with expansive commercial opportunities



Leveraging **clinically validated** B cell targets, **proven mAb modality**, and indications with **well-defined** endpoints and **established** regulatory pathways



Anticipating a **data-rich 2026** with **multiple clinical readouts** across both clinical-stage programs

- **Budoprutug** - anti-CD19 mAb in development for pMN, ITP, and SLE; Fast Track and Orphan Drug Designation granted for pMN
- **CLYM116** - anti-APRIL mAb in development for IgAN



**Well-resourced** to advance clinical programs through meaningful value-driving milestones, with **runway anticipated into 2028\***

# Climb Bio: Data-Rich 2026

Continuing the ascent with initial readouts anticipated from all ongoing trials

2026



## Budoprutug SC

*Initial Ph1 HV data  
PK, PD, bioavailability*

## Budoprutug SLE

*FPI China Ph1b – Q2*

## Budoprutug ITP

*Initial Ph1b data – June  
B cell and platelets, low dose cohort*

## CLYM116

*Initial Ph1 HV data – mid-year  
PK, PD*

## Budoprutug pMN

*Initial Ph2 data – Q4  
B cell and PLA2R, low dose cohort*

## Budoprutug SLE

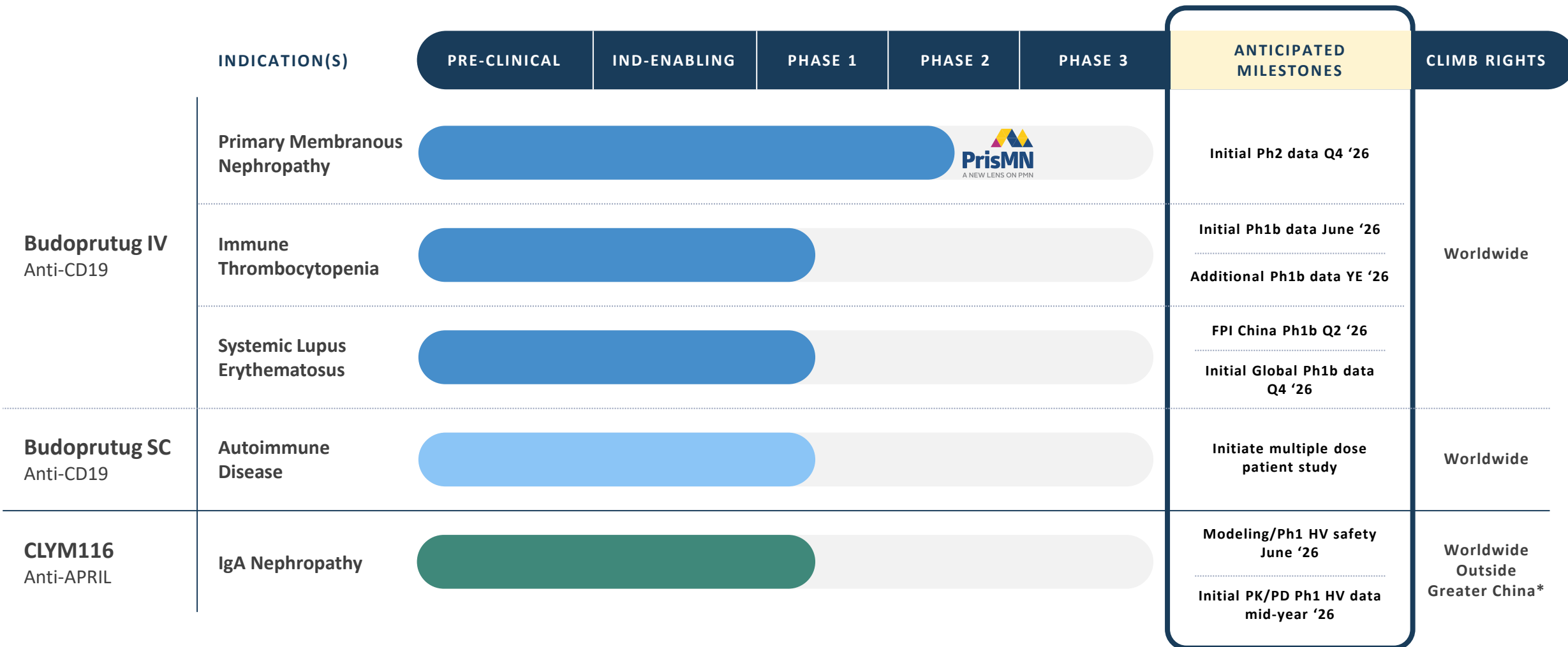
*Initial global Ph1b data – Q4  
B cell, low doses*

## Budoprutug ITP

*Additional Ph1b data – YE*

# Pipeline of Highly Differentiated mAbs

Anticipating initial readouts from all ongoing trials in 2026



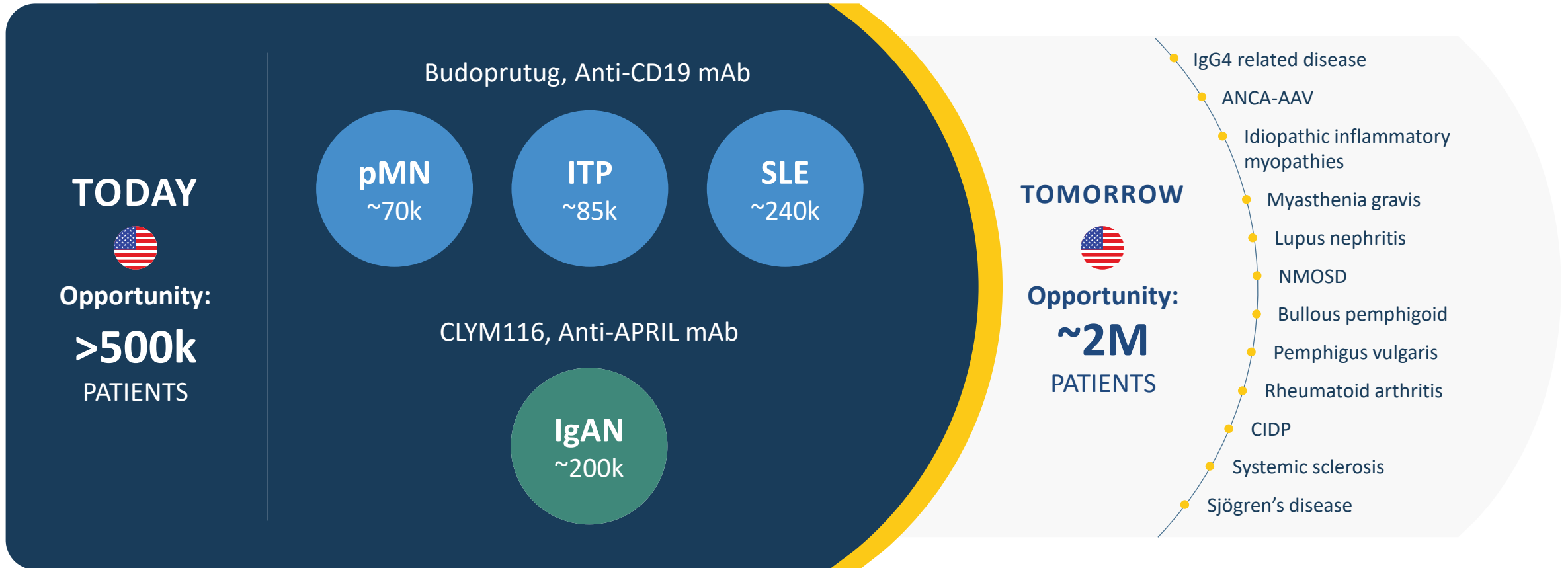
Budoprutug SC and CLYM116 Phase 1 trials conducted in healthy volunteers.

\*Greater China defined as mainland China, Hong Kong, Macau, and Taiwan; Partner: Beijing Mabworks Biotech Co., Ltd.

APRIL = a proliferation-inducing ligand, IV = intravenous, mAbs = monoclonal antibodies, SC = subcutaneous

# Pursuing Expansive Market Opportunities

Addressing the needs of patients living with B cell-mediated diseases



# Climb Bio Team Poised to Deliver for Patients



**Aoife Brennan, MB, ChB**  
*President and CEO*



**Perrin Wilson, PhD**  
*CBO*



**Susan Altschuller, PhD, MBA**  
*CFO*



**Edgar Charles, MD**  
*CMO*



**Ashley Jones**  
*SVP, People & Workforce  
Strategy*



**Adam Villa, MBA, MS**  
*SVP, Tech Ops*



**Chandra Adams, JD**  
*VP, General Counsel*

## BOARD OF DIRECTORS

**Douglas E. Williams, PhD**  
*Independent, Chairman*

**Aoife Brennan, MB, ChB**

**Bo Cumbo**  
*CEO, Solid Biosciences*

**Kim Drapkin, CPA**  
*Independent*

**Judith Dunn, PhD**  
*President, Head of R&D, Vima  
Therapeutics*

**Andrew Levin, MD, PhD**  
*Managing Director, RA Capital*

**Stephen Thomas, PhD**  
*CEO, Sera Medicines*

# Budoprutug

Anti-CD19

# Budoprutug: A Differentiated Anti-CD19 Approach

Durable B cell depletion, long dosing interval, with potential for IV and SC formulations

1

Rapid, deep and **durable B cell depletion** and favorable tolerability demonstrated in a **pilot clinical study**

2

## Potential Differentiating Benefits

**mAb modality** confers **distinct advantages**

- **Well-established manufacturing** and supply chains, favorable cost-of-goods and scalability
- **Minimal off-target** effects, with a **low risk of CRS and ICANS**; no lymphodepleting chemotherapy preconditioning requirement
- Ability to **dose in the community setting**; **no in-hospital** or special unit administration required

3

**Long dosing interval**, with potential to **formulate for both IV and SC** administration

## Clear Opportunity

- **Limited competition** in CD19 mAb space
- Administration profile intended to support **outpatient and community use**
- Potential to address **multiple B-cell mediated diseases**
- **Strong IP** protection extending to 2045+

# CD19: Attractive and Validated Target for B Cell-Mediated Disease

CD19 expression profile provides potential efficacy and safety advantages relative to other targets

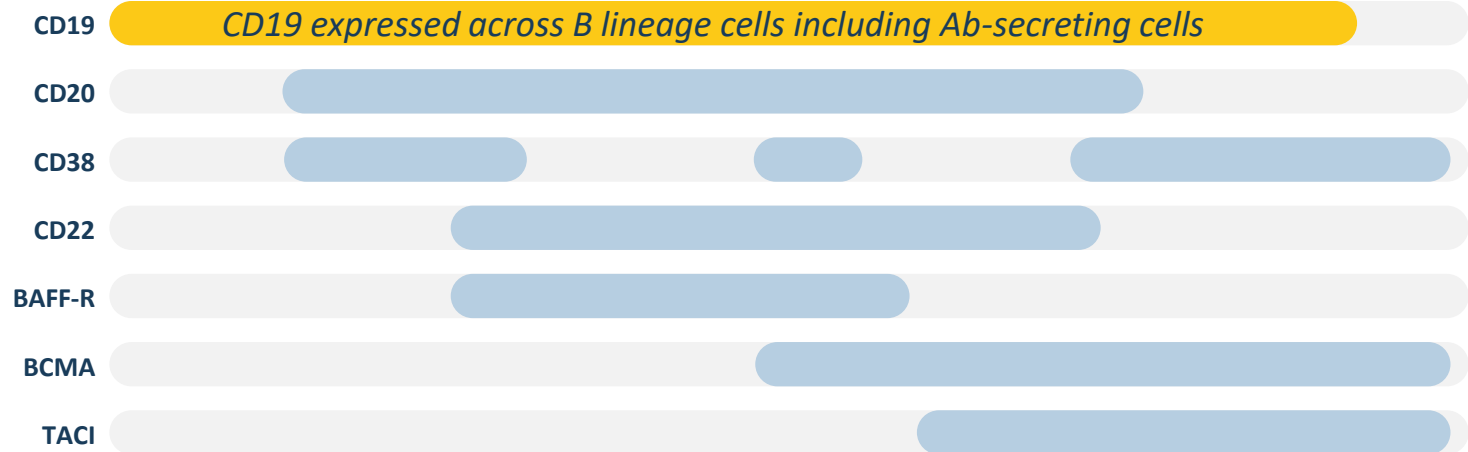
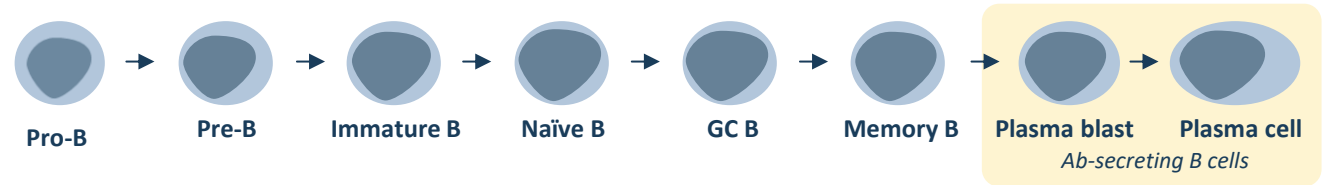
## Clinically Proven Approach

### CD19 CAR T Therapies

- Have demonstrated **potential for remission** in SLE patients

### CD19 mAb Therapy (inebilizumab)

- Approved for NMOSD, IgG4-RD, and gMG
- **Demonstrated benefit** in rituximab relapse and where rituximab has failed

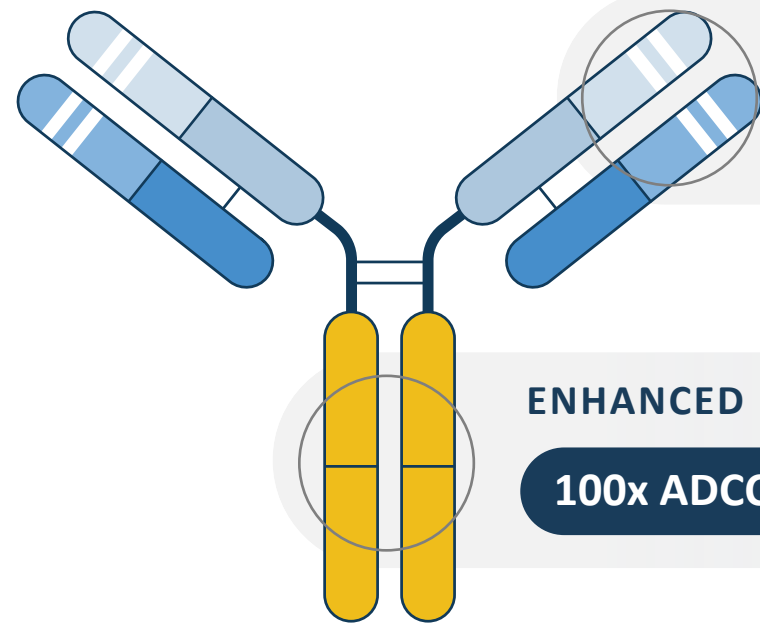


*Broad CD19 expression profile enables **comprehensive, rapid and durable depletion** of pathogenic B cells, while **preserving protective antibody responses** mediated by long-lived plasma cells*

# Budoprutug is a Highly Potent, Fc-Enhanced Anti-CD19 mAb

Designed for optimal biological activity, with potential for both IV and subcutaneous administration

## KEY FEATURES



### STRONG TARGET BINDING

**18 pM**

binding affinity to CD19  
counters low antigen density

### ENHANCED B CELL DEPLETION

**100x ADCC**

precisely-tuned, low-fucosylated Fc region  
increases potency vs wild-type Fc

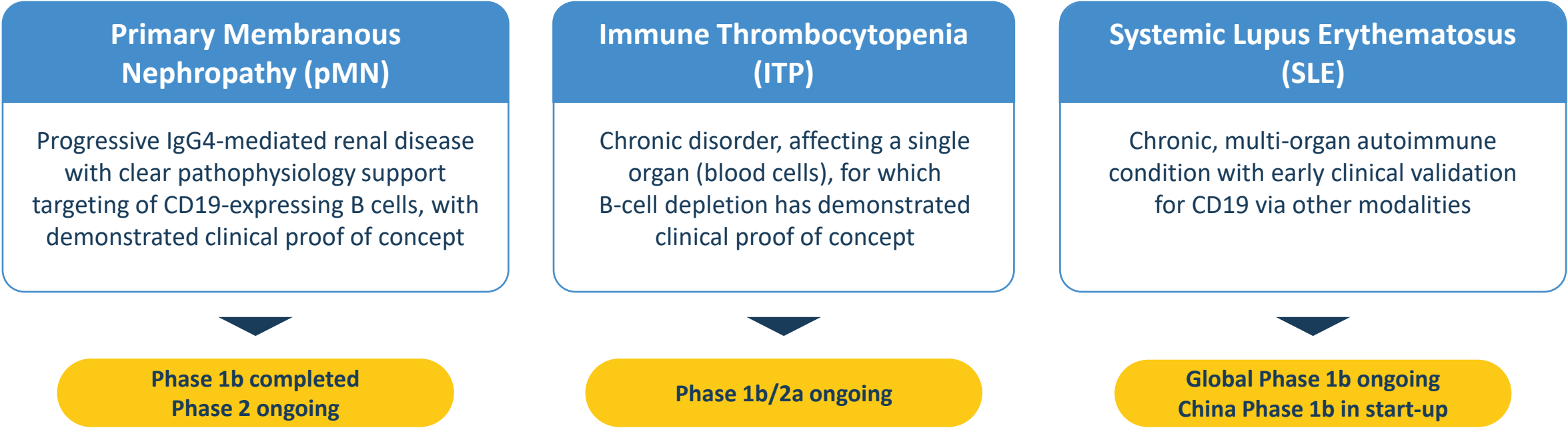
### SUBCUTANEOUS DOSING POTENTIAL

**≥175 mg/mL**

High concentration  
formulation with low  
viscosity

# Developing Budoprutug Across Multiple Diseases

Pursuing development in lead indications with high unmet need and clear B-cell driven pathology



## Ongoing Studies Designed to Answer Key Clinical Questions

Ability to achieve deep B-cell depletion • Optimal dose in renal and non-renal indications • Potential for long-term disease control

# Primary Membranous Nephropathy (pMN)

## Progressive renal disease

- **Autoantibody mediated** disease characterized by **proteinuria, nephrotic syndrome** and progressive **loss of renal function**
- Untreated, ~30% progress to **end-stage renal disease** within 10 years and another 30% develop chronic kidney disease

## No approved therapies

- **Rituximab used off-label** and considered **first-line**; 20-40% patients are refractory
- **Clear unmet need** for disease-modifying therapies that deliver **complete remission** of proteinuria

## Clear path to approval

- Early demonstration of efficacy and approval possible based on a **validated biomarker** indicative of kidney damage: **proteinuria**

## SIGNIFICANT OPPORTUNITY

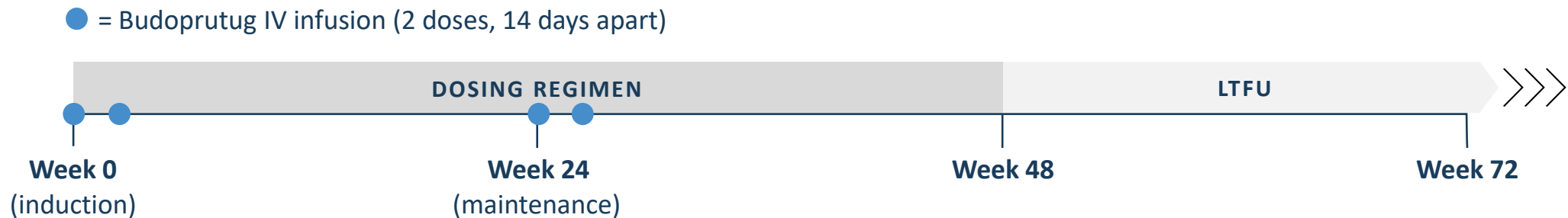
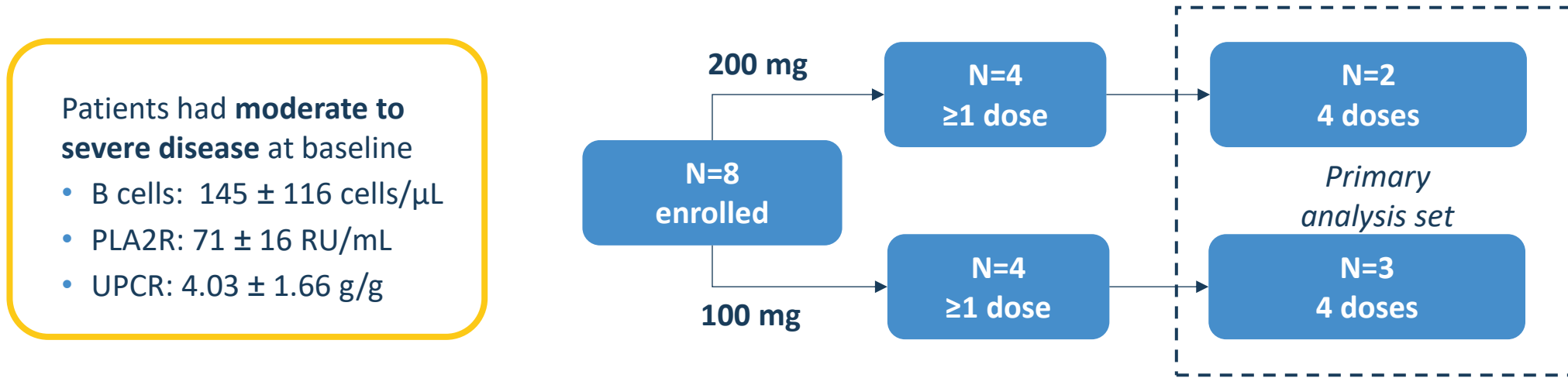
~**70,000** patients  
in the US alone

## THE CLIMB SOLUTION

**Budoprutug demonstrated compelling proof-of-concept in a pilot Phase 1b clinical study in pMN**

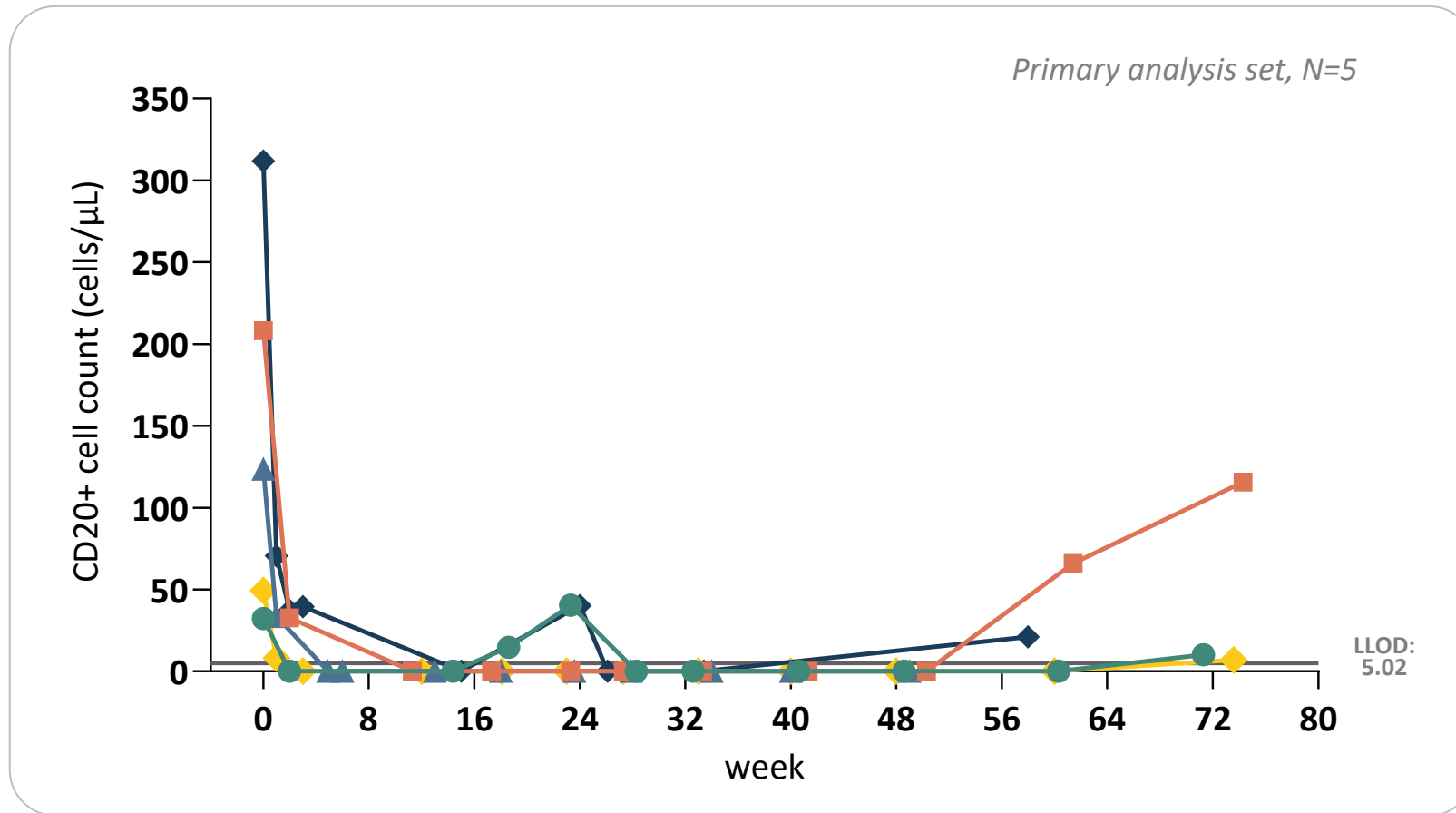
# Completed Phase 1b Study Established Proof of Concept in pMN

Budoprutug evaluated in an open-label, dose escalation study in adult patients with pMN (NCT04652570)



# Budoprutug Administration Resulted in Durable B Cell Depletion

Rapid and complete circulating B cell depletion observed in 100% of patients at doses of 100-200mg

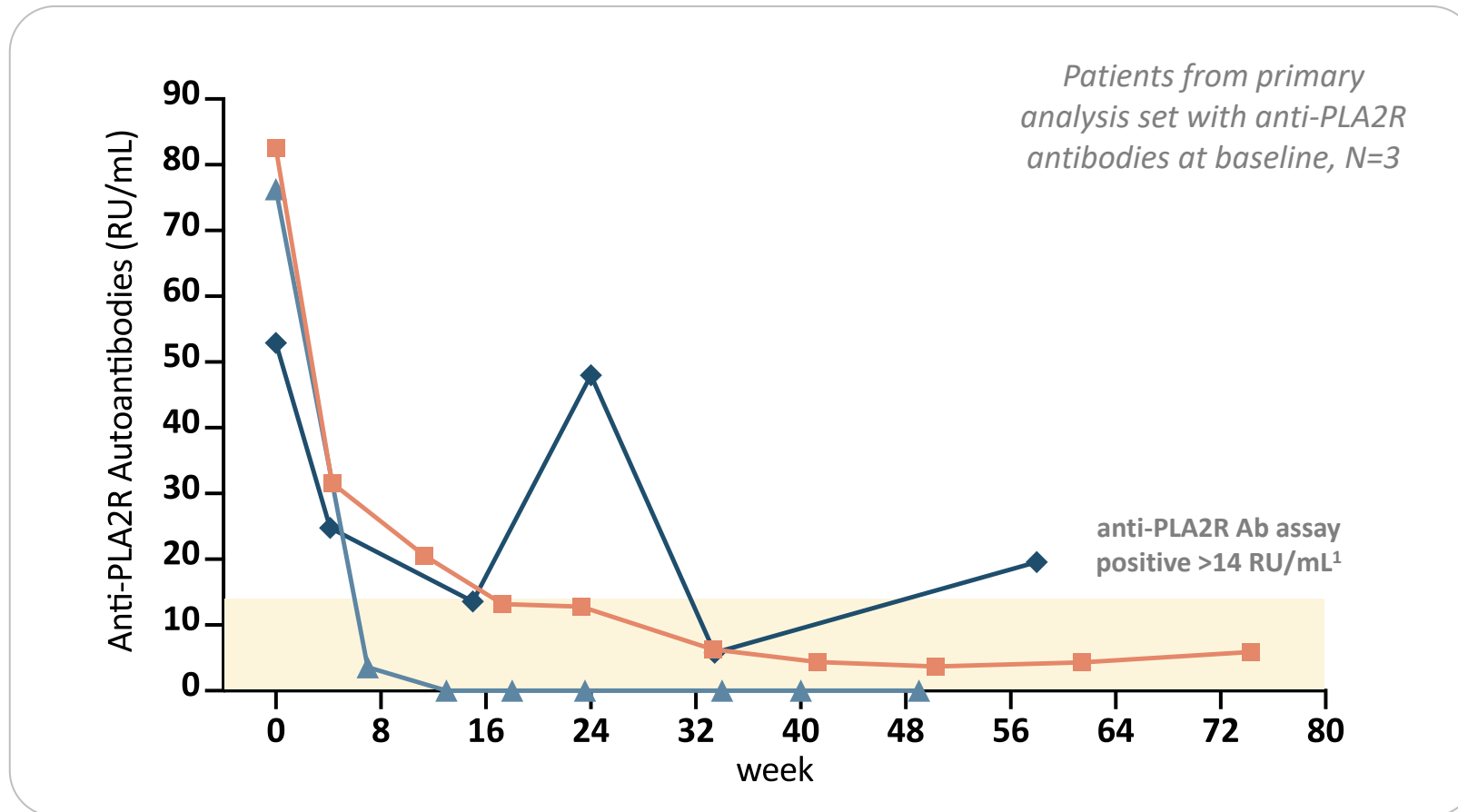


**Complete circulating B cell depletion** (CD20+ count < 5 cells/ $\mu$ L) achieved in all 5/5 patients

- **Rapid depletion:** LLOD reached as soon as 2 weeks after first dose
- **Sustained reductions** out to 1 year + after two dose cycles

# Budoprutug Administration Resulted in Serologic Remission

Anti-PLA2R antibody negativity achieved in 100% (3/3) evaluable patients

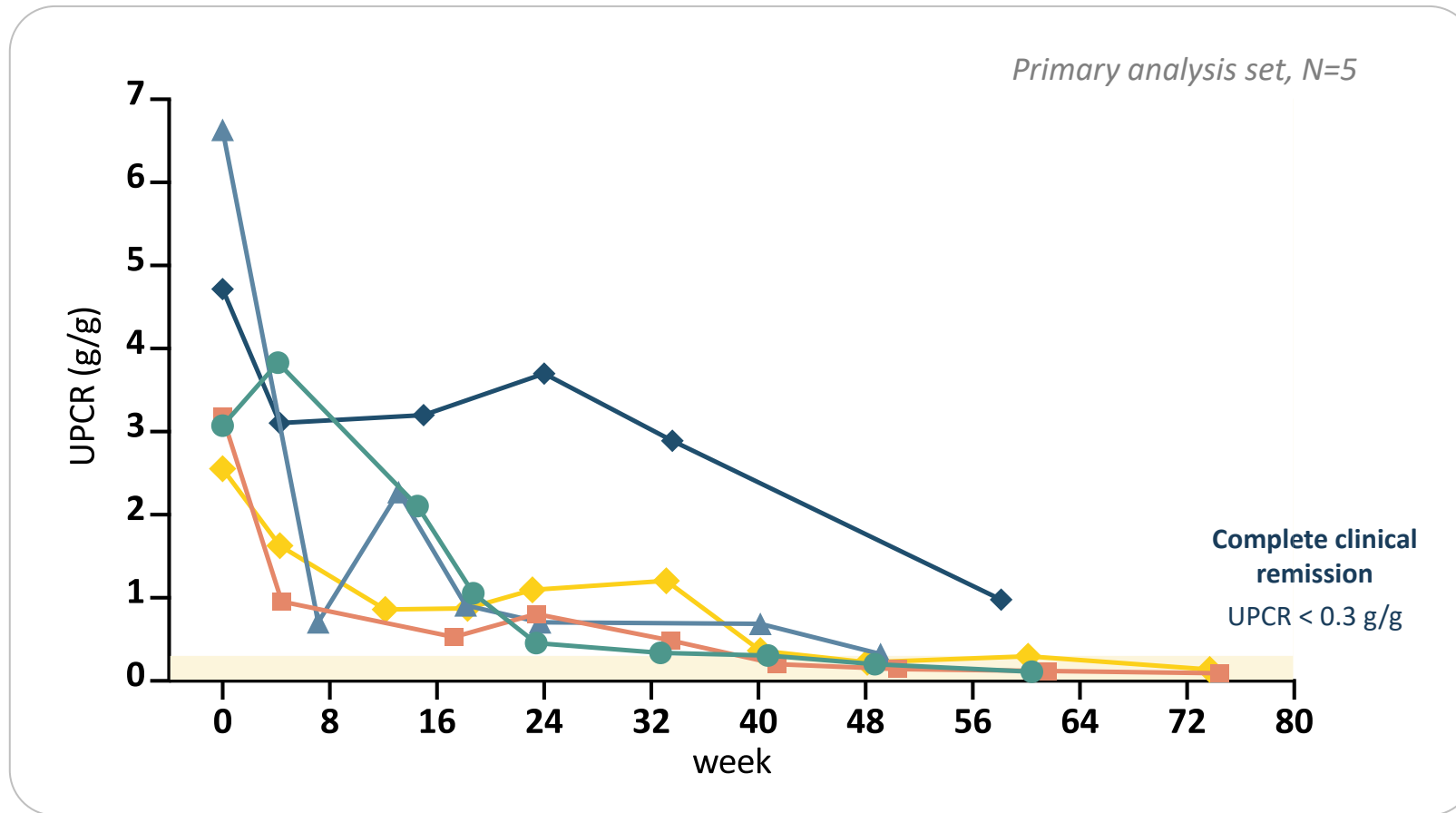


**PLA2R antibodies are the primary disease driver in pMN and a key biomarker of clinical response<sup>2</sup>**

- ~75% of pMN is mediated by anti-PLA2R autoantibodies
- Disappearance of anti-PLA2R antibodies precedes clinical remission

# Budoprutug Administration Led to Clinical Remission (Proteinuria)

All patients achieved complete or partial clinical remission by Week 48, as measured by UPCR



**All patients achieved complete (3/5) or partial (2/5) clinical remission by Week 48**

- 2 patients with partial clinical remission achieved serologic remission, suggesting further progress to full clinical remission may be possible

**Long-term control of proteinuria for up to 3 years after initial dosing was observed in 4 patients who received up to 4 doses of budoprutug**

- In 3 of these patients, no further immunosuppressive treatment was required

**Proteinuria (UPCR) is a key measure of kidney function and is the primary outcome measure in pMN**



## Safety

Budoprutug was generally well tolerated in the completed Phase 1b pMN trial at doses of up to 200mg, supporting exploration of higher doses in ongoing and future studies

**8 patients received at least one injection of budoprutug and were included in the safety analysis population in the completed Phase 1b pMN trial**

- ✓ There were no deaths on study
- ✓ There were 3 SAEs, none considered to be related to budoprutug by the investigator
- ✓ No discontinuations due to AE
- ✓ No dose limiting toxicities (DLTs) were observed
- ✓ 4 patients reported infections on study of which 3 were cases of COVID-19 and 1 was bacterial pneumonia

# Budoprutug Has a Highly Competitive Profile in pMN

High serologic remission (anti-PLA2R negativity) and complete clinical remission rates support a potentially strong and differentiated clinical profile

	<b>Budoprutug (based on completed pMN Ph1b)</b>	<b>Rituximab</b>	<b>Obinutuzimab</b>	<b>Povetacicept</b>	<b>Felzartamab</b>
Target	CD19	CD20	CD20	BAFF/APRIL	CD38
Serologic remission (anti-PLA2R negativity)	✓ <b>100%</b> (3/3) <sup>1</sup>	64–95% <sup>2</sup> (titer decrease)	90-92% <sup>6-7</sup>	100% (4/4) <sup>9</sup>	23% (6/26) <sup>10</sup>
Complete or partial clinical remission	✓ <b>100%</b> (5/5) <sup>1</sup>	60% (39/65) <sup>2</sup>	85% (50/59) to 95% (20/21) <sup>6-7</sup>	100% (5/5) <sup>9</sup>	35% (9/26) <sup>10</sup>
Complete remission	✓ <b>60%</b> (3/5) <sup>1</sup> UPCR ≤0.3 g/g	14-41% <sup>2-5</sup> UPCR ≤0.3 g/g	29-38% <sup>6-8</sup> UPCR ≤0.3 g/g	40% (2/5) <sup>9</sup> UPCR <0.5 g/g	0% (0/26) <sup>10</sup> UPCR <0.5 g/g
Dosing	✓ 2 IV doses administered 14 days apart, then q6m	2 x 1000 mg IV doses administered 7 days apart, then q6m	2 x 1000 mg IV doses administered 14 days apart, then q6m	80 mg SC every 4 weeks	9 IV doses over 6 months

Table above reflects cross-trial comparisons and not data from head-to-head studies; differences exist between trial designs and participant characteristics and caution should be exercised when comparing data across trials.

**Note: To date, there are no FDA-approved therapies for pMN**

IV = intravenous, PLA2R = phospholipase A2 receptor, pMN = primary membranous nephropathy, q6m = every 6 months, SC = subcutaneous. Serologic remission defined as <14 RU/mL, complete remission defined as UPCR ≤0.3 g/g for budoprutug, rituximab, obinutuzimab and UPCR <0.5 g/g for povetacicept and felzartamab, partial remission defined as UPCR between <3.5 g/g and ≥50% reduction from baseline. <sup>1</sup> Cortazar ASN 2024, <sup>2</sup> Fervenza NEJM 2019 - immunological remission not reported, <sup>3</sup> Fervenza Kid Int 2008, <sup>4</sup> Fervenza CJASN 2010, <sup>5</sup> Roccatello Autoimmun Rev 2016, <sup>6</sup> Hu CJASN 2024, <sup>7</sup> Su KI Reports 2024, <sup>8</sup> Lin Kid Med 2024, <sup>9</sup> Madan KI Reports 2025, <sup>10</sup> Rovin KI Reports 2024

# PrisMN: Budoprutug Phase 2 pMN Study Enrolling

Biomarker endpoint provides potential to rapidly identify dose to carry forward into Phase 3; initial B cell and PLA2R data from low dose cohort anticipated in Q4 2026

## Open-label, dose ranging study

### Population

- 18-70 years of age
- UPCR  $\geq$  2.0 g/g; designed to ensure adequate enrollment of patients with UPCR  $>$  5.0 g/g
- PLA2R antibody positive

### Primary Objective

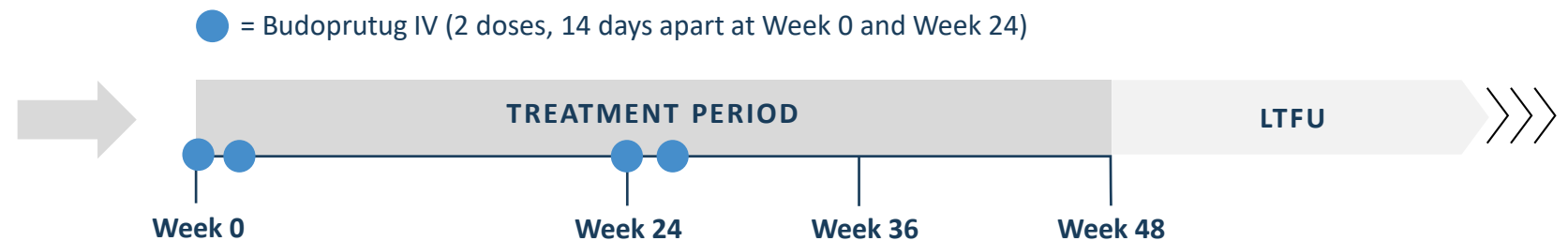
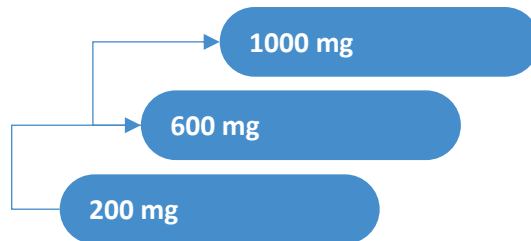
- Safety and tolerability

### Secondary Objectives

- Preliminary PK and PK/PD
- PD markers (B cells, anti-PLA2R, total Ig)
- Preliminary efficacy: complete and partial remission at week 48 (UPCR and eGFR)

### DOSE ESCALATION

15 patients per cohort, enrolled sequentially



# Immune Thrombocytopenia (ITP)

## Chronic bleeding disorder

- **Autoantibody mediated** disease characterized by the **destruction of platelets**
- **Results in bruising, bleeding episodes, hemorrhage** and fatigue

## Limited treatment options

- **~80% fail first line** glucocorticoids; **~40% progress** on second line TPO-RAs
- **Rituximab** has demonstrated the potential to achieve long-term disease remission, but **only ~20%** maintain remission
- **Surgical removal of the spleen** may be considered for chronic cases or when therapeutic interventions fail

## Defined endpoint

- **Platelet response** can demonstrate early proof-of-concept and served as primary endpoint measure for approvals in ITP

## SIGNIFICANT OPPORTUNITY

~85,000 patients  
in the US alone

## THE CLIMB SOLUTION

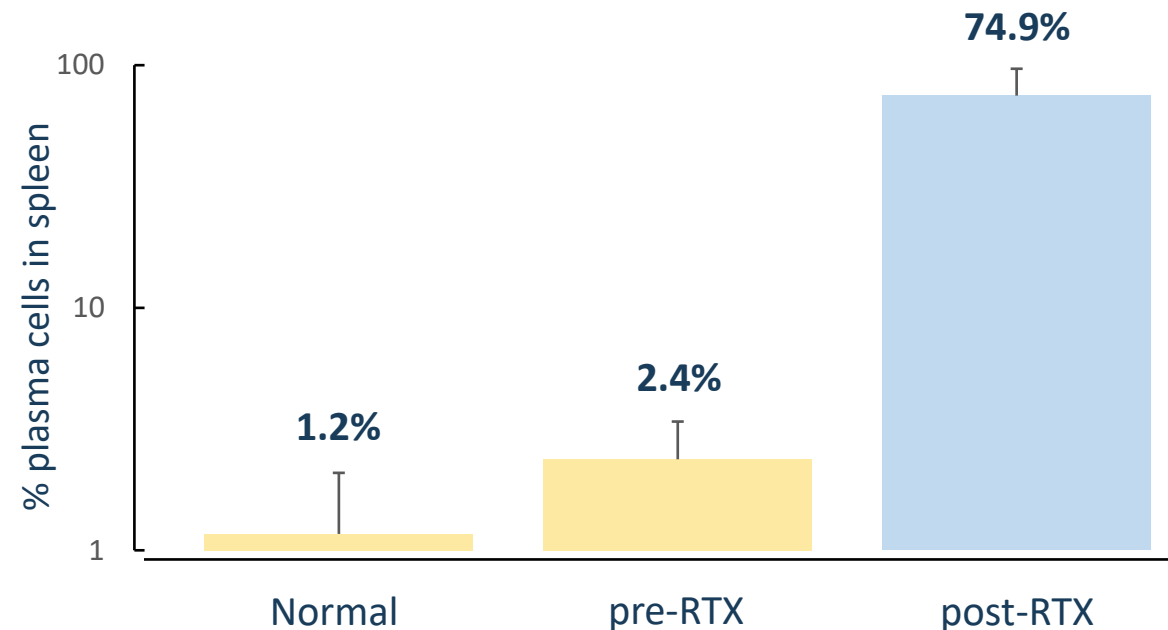
**Budoprutug has the potential to achieve disease remission in this high unmet need population**

# Strong Rationale for CD19 Approach in ITP

Potent anti-CD19 approach offers the promise of sustained elimination of pathogenic B cells

- B cell targeting via CD20 (rituximab) has demonstrated benefit in ITP, however up to 80% **fail rituximab, likely due to** the presence of **CD19+/CD20- B cells**<sup>1-3</sup>
- **Anti-CD20 mAbs do not eliminate plasmablasts or plasma cells**, which continue to drive anti-platelet antibody production, while **CD19 is expressed on plasmablasts and certain plasma cells**<sup>2</sup>

CD19<sup>+</sup>/CD20<sup>-</sup> plasma cells expand within B cell niches post anti-CD20 treatment<sup>1</sup>



*Broader expression of CD19 across B cell lineage may overcome limitations of anti-CD20 therapies*

# Budoprutug Phase 1b/2a ITP Trial Enrolling

Designed to define dose and regimen, and establish depth and duration of platelet response and B cell depletion; initial B cell and platelet data from low dose cohort anticipated in June 2026

## Open label, dose escalation and expansion study

### Population

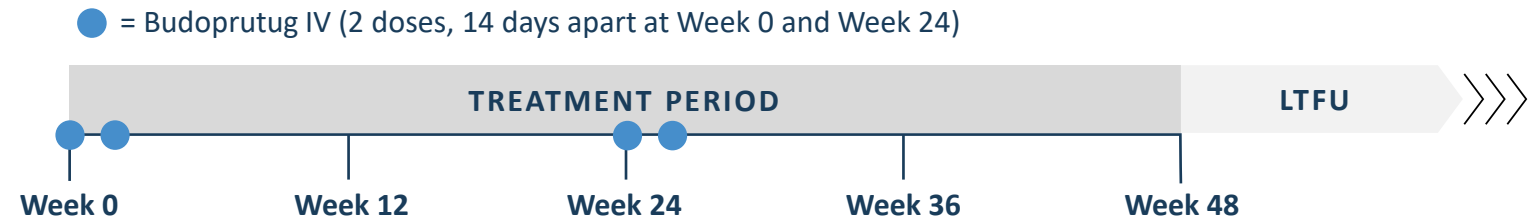
- N ~ 30 patients
- Insufficient response to 1 or more prior therapies
- Platelet count <30,000/ $\mu$ L

### Primary Objective

- Safety and tolerability

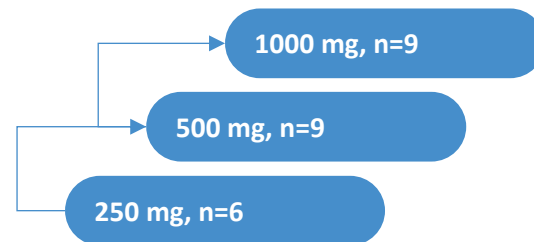
### Secondary Objectives

- Pharmacokinetic profile
- Effects on B cell depletion (pharmacodynamic response)
- Effects on platelet counts (ITP clinical response)



### DOSE ESCALATION

6-9 patients per cohort, enrolled sequentially



### DOSE EXPANSION

Up to 6 patients at dose identified during escalation period

**Dose selected;  
administered as 2 doses,  
14 days apart**

# Systemic Lupus Erythematosus (SLE)

Chronic  
autoimmune  
condition

- **Autoreactive lymphocytes and autoantibodies** mistakenly **attack tissues and organs** throughout the body
- Wide array of autoantibodies cause disease manifestations that can **affect virtually any organ system**; subset of patients have kidney involvement (lupus nephritis)
- **Relapses** may lead to **cumulative damage** and **organ failure**

High  
unmet need

- Steroids given first-line but are not a long-term solution
- ~50% of patients on approved biologics relapse
- **Off-label rituximab is a mainstay of treatment**, underscoring need for more effective therapies

Established PoC  
for CD19

- **CD19 CAR T-cell therapies** have demonstrated **potential for remission**; but **modality limits broad utility** and patient access

## SIGNIFICANT OPPORTUNITY

~**240,000** patients  
in the US alone

## THE CLIMB SOLUTION

**Budoprutug offers potential for broad B-cell targeting with the safety and convenience of a mAb**

# Strong Rationale for Anti-CD19 mAb in SLE

CD19 mAb approach could provide optimal profile of disease control, safety, and broad patient accessibility

## B-cell targeting has promise

Anti-BAFF mAb approved for SLE/LN<sup>1</sup>, anti-CD20 mAb filed for LN, rituximab used off-label

*but up to 55% of patients still fail to achieve disease control*

### Likely reasons for anti-CD20 treatment failure are addressable with CD19 targeting

- Persistence of CD19+ self-reactive B cell subsets
- Continued production of pathogenic autoantibodies by plasmablasts
- Rapid recovery of pathogenic B cell subsets

## CD19 CAR Ts demonstrate strong efficacy

8/8 SLE patients treated with anti-CD19 CAR T-cells achieved disease remission by 6 months

*but have significant risks and access challenges*

### mAb approach can overcome key CAR T-cell challenges

- Low risk of CRS and ICANS, no lymphodepletion required
- Long treatment interval with the ability to easily retreat as needed
- Administered in the community setting

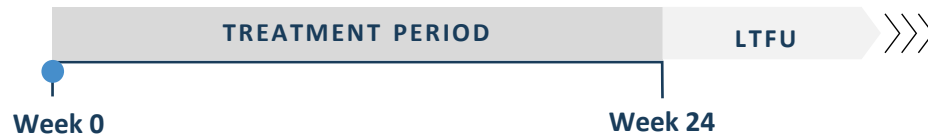
# Parallel Global and China SLE Studies

Designed to assess safety, tolerability, B-cell depletion, and kinetics of B-cell subset repopulation

## Global Phase 1b Study

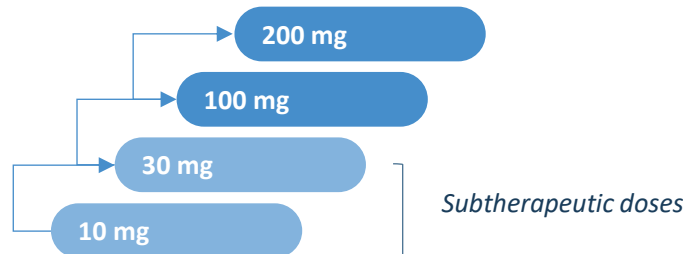
Enrolling adults with seropositive SLE; SLEDAI  $\geq 8$ ; refractory to adequate trials of at least 2 therapies

● = Budoprutug IV Day 1



### SINGLE ASCENDING DOSE COHORTS, N ~30

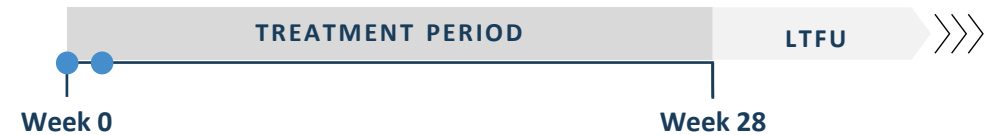
Up to 6 patients per cohort enrolled sequentially



## China Phase 1b/2a Study

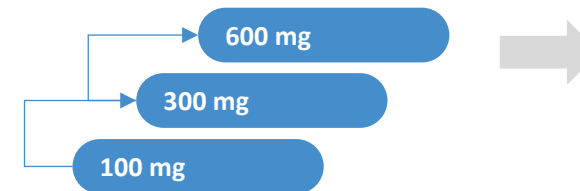
Enrolling adults with seropositive SLE; SLEDAI  $\geq 6$ ; refractory to adequate trial of at least 1 therapy

● = Budoprutug IV Day 1 and Day 15



### DOSE ESCALATION, N ~18

Up to 6 patients per cohort enrolled sequentially



### DOSE EXPANSION, N ~12

Up to 12 patients at dose identified in escalation period

Dose selected; administered as 2 doses, 14 days apart

Initial data from low dose cohorts in the Global Study anticipated in Q4, with FPI in China Study on track for Q2

# Budoprutug – Subcutaneous (SC) Formulation

Anti-CD19

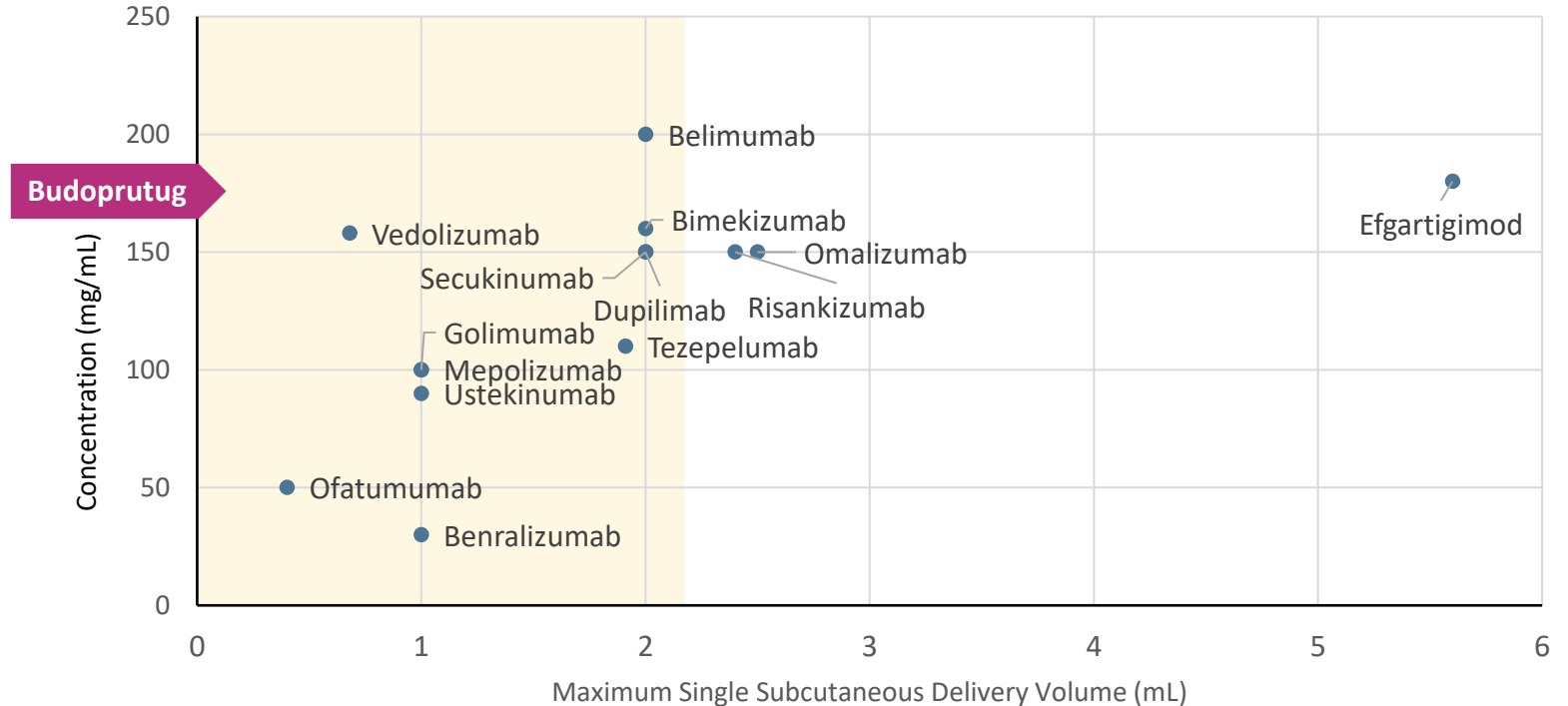
# Budoprutug SC Formulation Provides Optionality and Differentiation

Ability to formulate as both IV and SC provides optionality in development and may be a differentiating feature of budoprutug relative to other anti-CD19 mAbs

## Potential Value of SC Administration

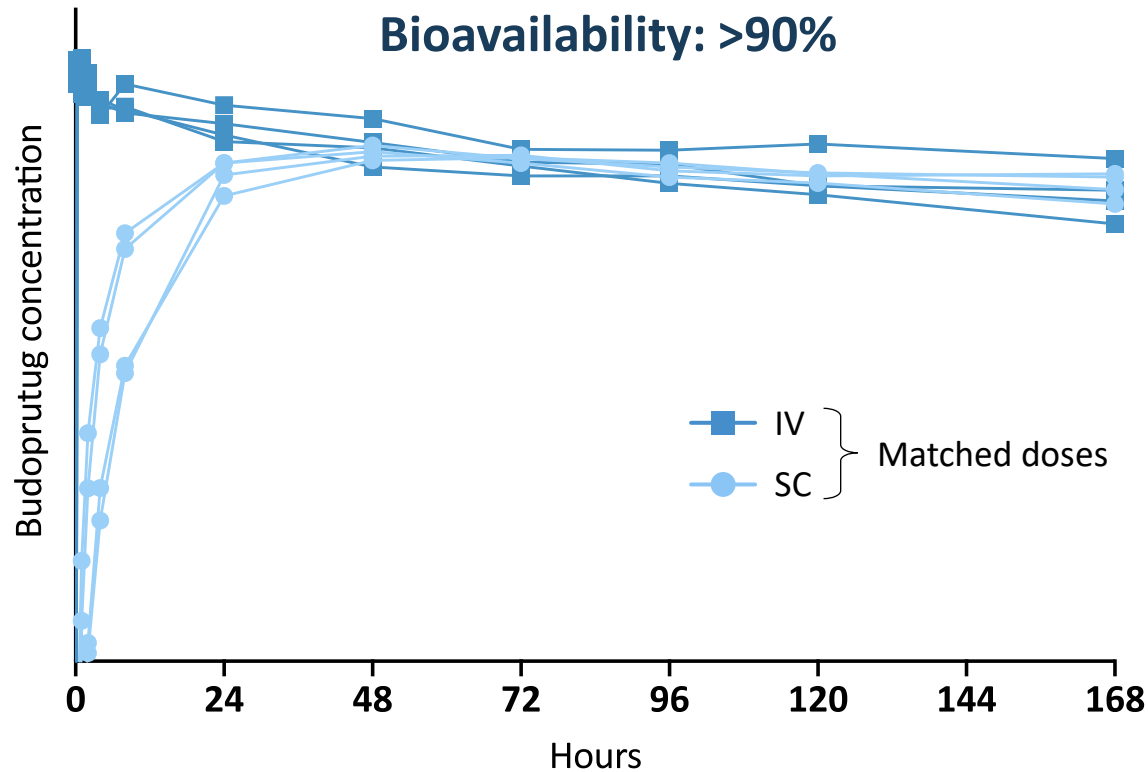
- Patient and provider flexibility
- Potential for at-home administration, reducing burden on healthcare facilities and improving patient convenience
- Potential to broaden target patient populations or indications

Budoprutug SC concentration and volume targets defined by benchmark immunology mAbs



# NHP Data Supports Viability of Budoprutug SC Formulation

Budoprutug SC formulation demonstrated high bioavailability and favorable tolerability



## Favorable Tolerability Profile

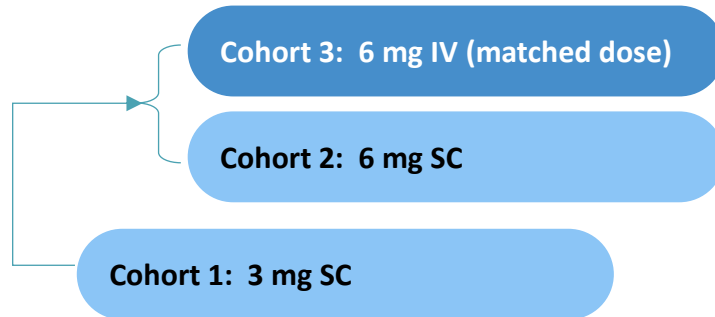
- No local tolerance issues identified on histopathology
- No safety findings
- No observed anti-drug antibodies (ADAs)

**High concentration, low viscosity, and high bioavailability provide potential for a high concentration, single SC injection**

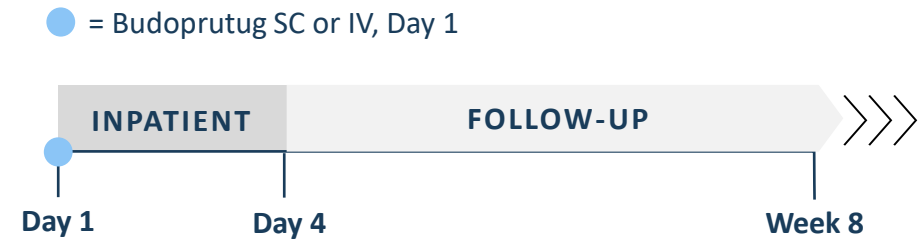
# Budoprutug SC Formulation Phase 1 Trial Completed

Evaluation of PD effects of budoprutug SC and IV in healthy volunteers

## SINGLE ASCENDING DOSE COHORTS



- 8 subjects per SC cohort (6 budoprutug: 2 placebo)
- 14 subjects in the IV cohort (12 budoprutug: 2 placebo)



### Primary Objective

- Safety and tolerability

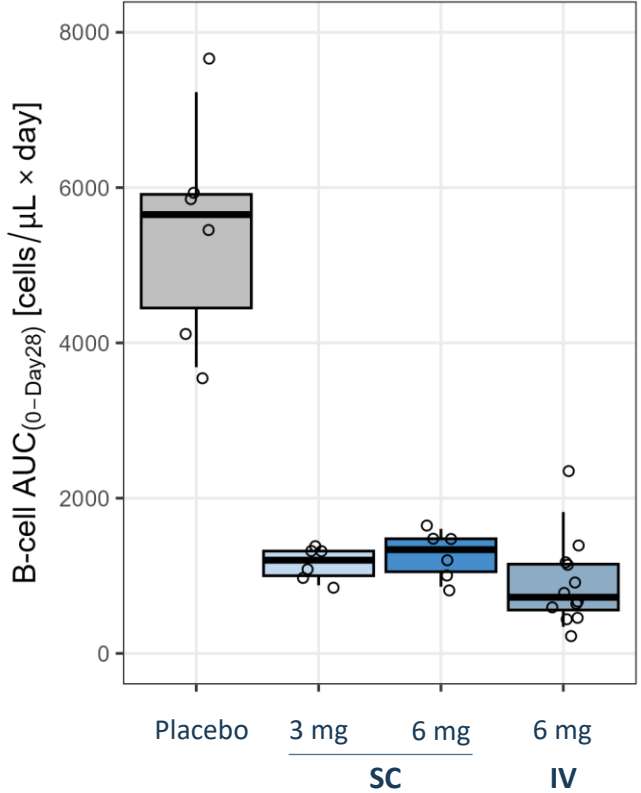
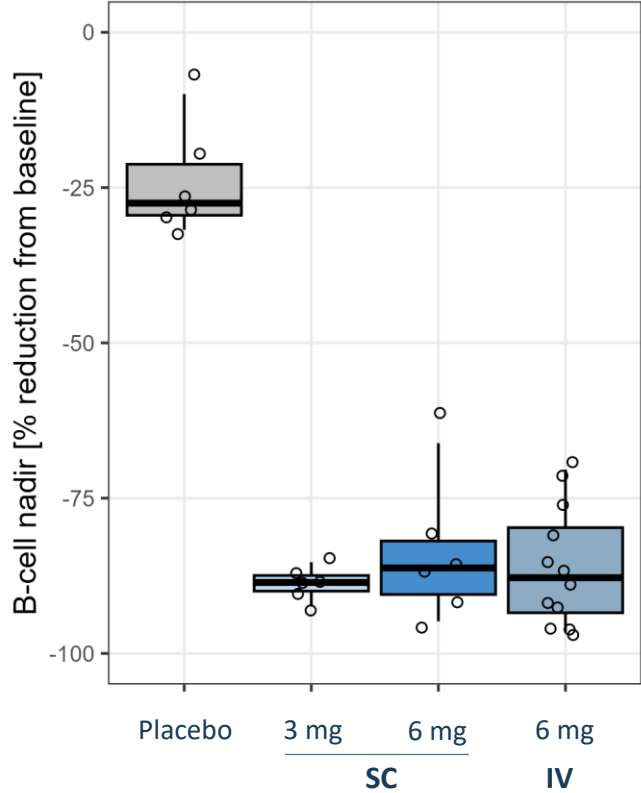
### Secondary Objectives

- Pharmacokinetic profile
- Effects on B-cell depletion (pharmacodynamic response)

*Low doses of budoprutug were chosen to achieve non-complete (~50%) peripheral B cell depletion in HV*

# Robust B-cell Depletion Observed with Budoprutug SC in HV

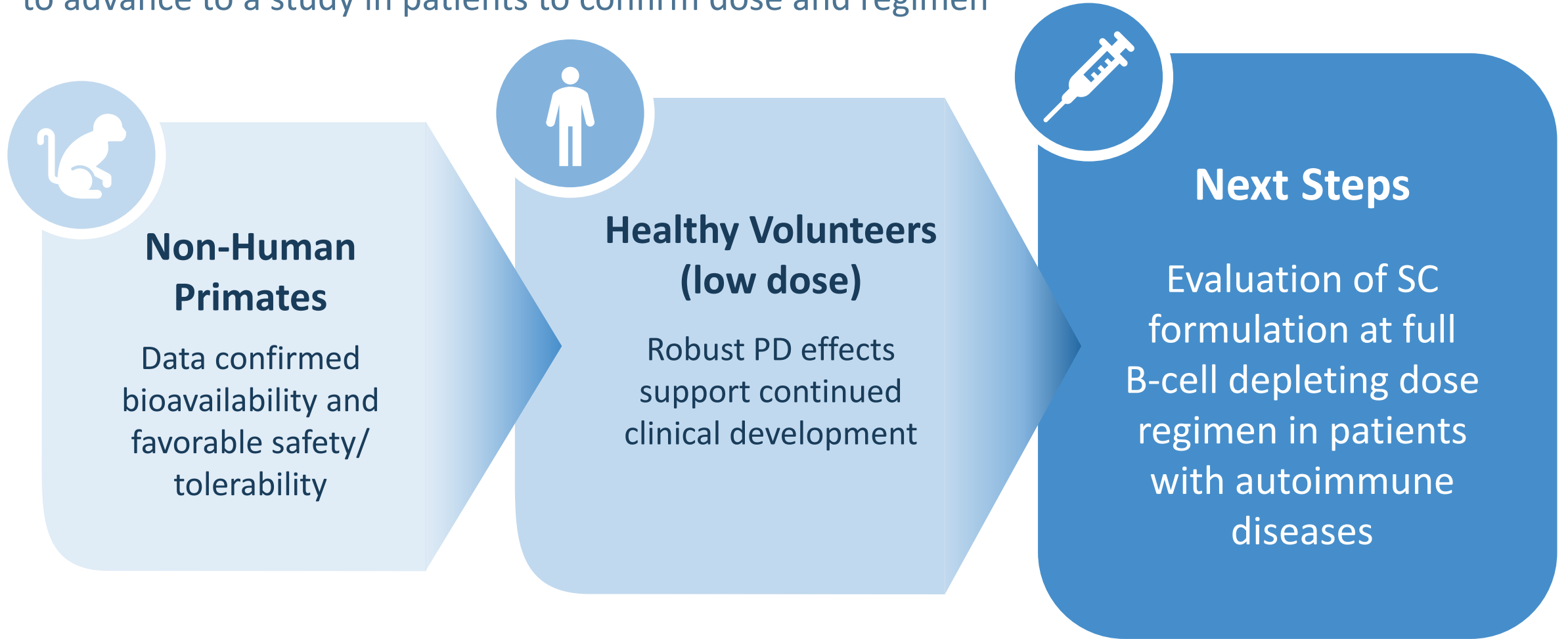
Budoprutug SC administration demonstrated ~80% B-cell depletion; similar magnitude and time course of depletion between SC and IV



*Budoprutug SC was well-tolerated; safety profile consistent between SC and IV*

# Budoprutug SC: Future Direction

Data in NHPs and healthy volunteers support continued development of SC formulation, with plans to advance to a study in patients to confirm dose and regimen



# CLYM116

Anti-APRIL mAb

# CLYM116: A Potential Best-in-Class anti-APRIL mAb

Initial clinical data expected mid-2026



- NHP data demonstrated potential for deep and durable IgA suppression, long half-life, and acceptable safety profile

- CLYM116 has the potential to provide:
  - ✓ Improved activity
  - ✓ Less frequent dosing
  - ✓ Favorable safety profile

- Phase 1 clinical trial in healthy volunteers to evaluate safety and PK/PD ongoing, with initial data expected mid-2026
- Mabworks Phase 1/2 trial in healthy volunteers and patients with IgAN in China also ongoing\*

# IgA Nephropathy (IgAN)

## Progressive, lifelong renal disease

- **Autoantibody mediated** disease caused by deposition of immune complexes in the glomeruli, which leads to proteinuria, kidney injury and loss of kidney function
- Diagnosed **early in life** (typically, ages 15-40)<sup>1</sup>; patients at **risk for renal failure** as disease progresses
- **Lifelong disease** – patients likely to require chronic therapy

## Growing market

- Treatment goals are to **normalize proteinuria and preserve kidney function** (stabilize eGFR)<sup>2</sup>
- KDIGO 2025 Guideline updates likely to increase diagnosis rates, expand patient population requiring treatment, and increase proportion of patients receiving potential disease-modifying therapy
- Market expected to reach ~ **\$10-20B annually**<sup>3-5</sup>

## Rapid and defined path to approval

- Accelerated approval based on **reduction in proteinuria** with full approval based on **stabilization of eGFR**
- **Biomarkers (APRIL, IgA)** enable rapid assessment of clinical profile during early development

## SIGNIFICANT OPPORTUNITY

Most common primary glomerular disease worldwide, ~**200,000** patients in the US alone

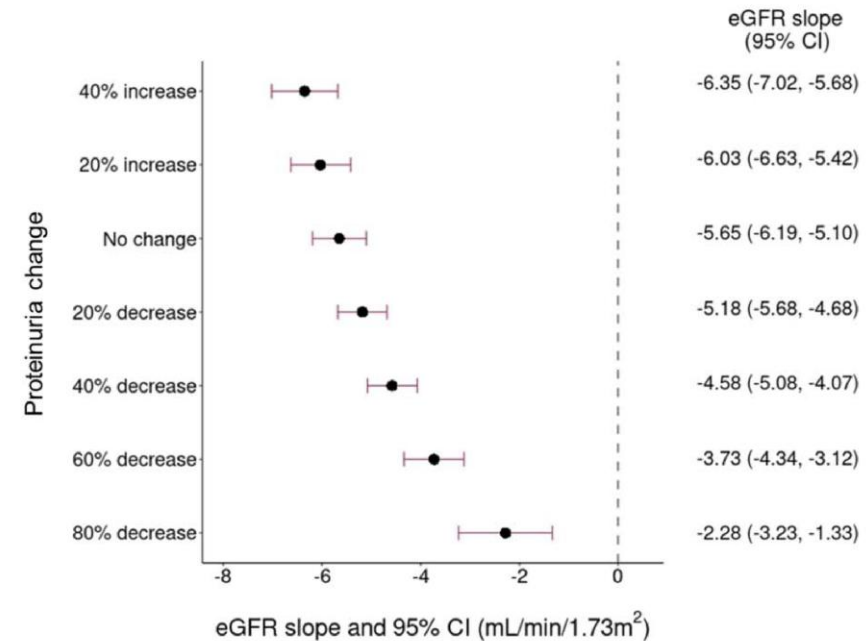
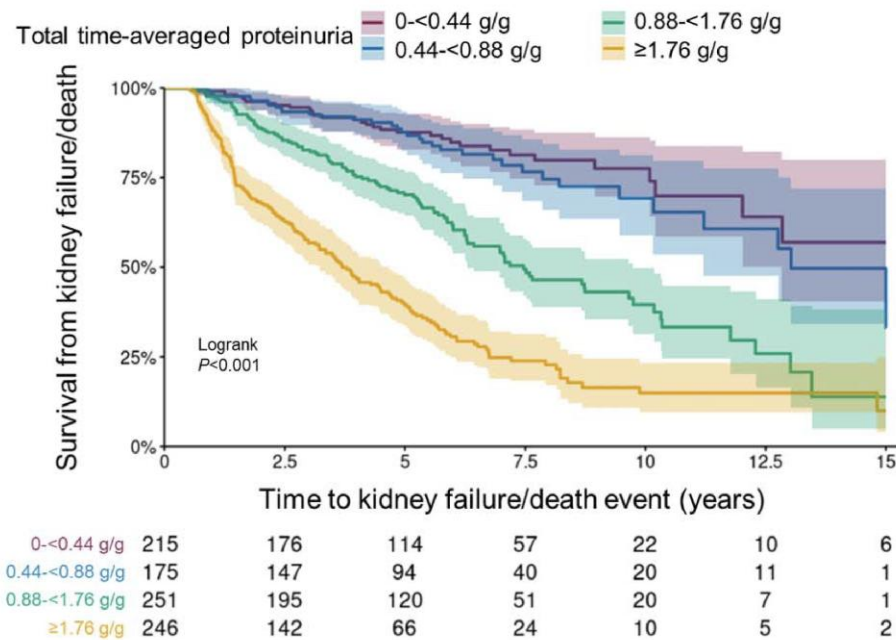
## THE CLIMB SOLUTION

**CLYM116 is a potential best-in-class anti-APRIL mAb, designed for improved activity and less frequent dosing**

# Proteinuria is an Established Surrogate Endpoint for IgAN

Prior approvals provide precedent regarding study design and registrational endpoints, including proteinuria at 9 months for accelerated approval and stabilization of eGFR at 2 years for full approval

## Proteinuria is associated with eGFR decline and kidney failure/death (UK RaDaR study)<sup>4</sup>



- Magnitude of proteinuria predicts development of kidney failure/death
- Proteinuria improvement (6-12 month) correlates with long-term (6-30 month) kidney function improvement

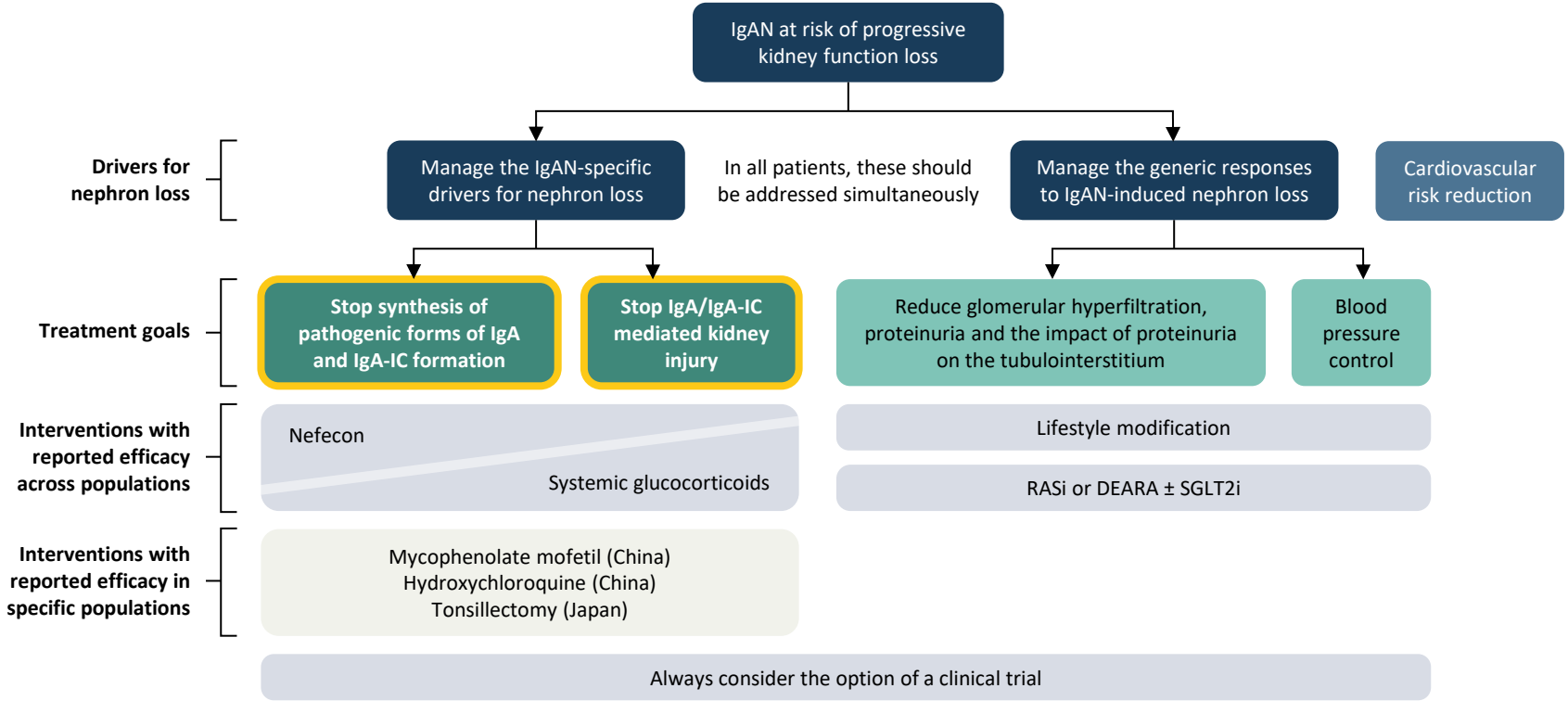
# KDIGO 2025 Guideline Highlights Role for IgA Reduction in IgAN

KDIGO updates reinforce need for disease modifying treatments that halt the production of pathogenic IgA, positioning anti-APRIL therapies as a core pillar in the treatment of IgAN

KDIGO 2025 Guidelines recommend important changes:

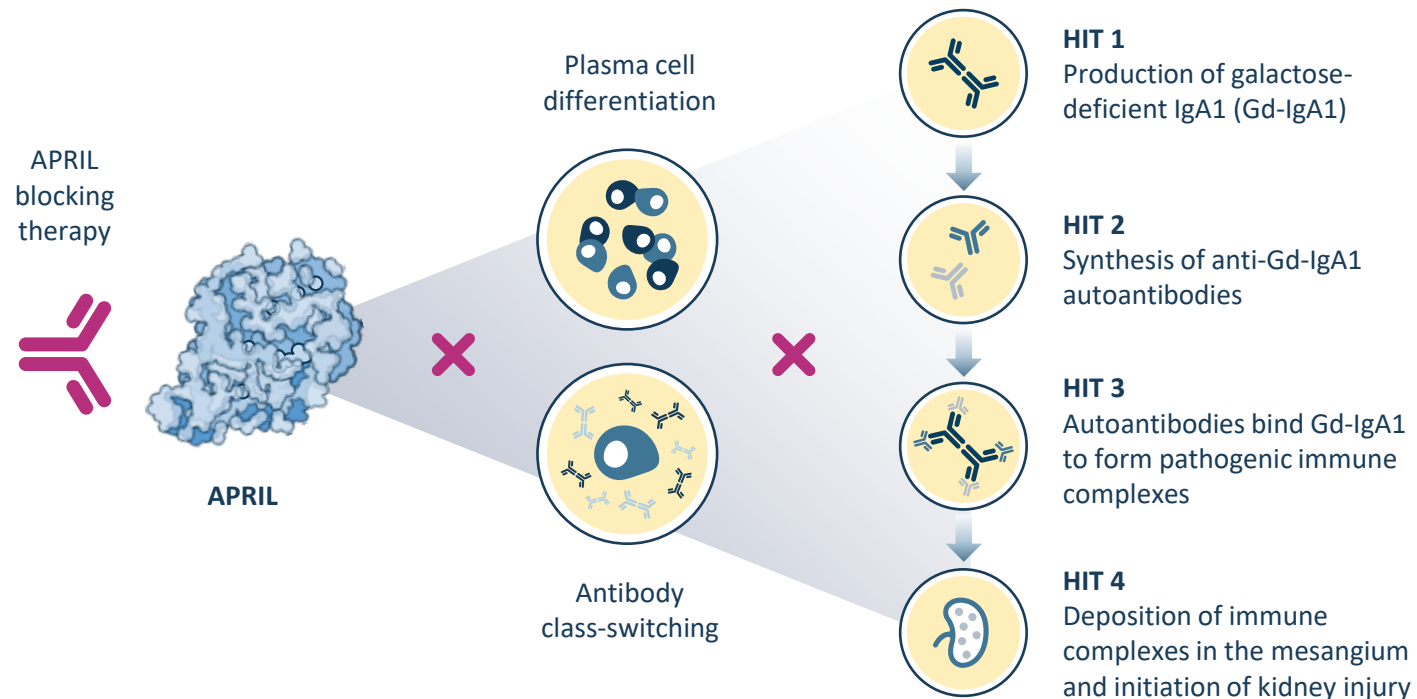
- Lower threshold for biopsy (**proteinuria  $\geq 0.5$  g/day**) to enable earlier diagnosis
- **Treatment initiation** in patients with **proteinuria  $\geq 0.5$  g/day**
- Revised **treatment goal**: proteinuria maintained at  $< 0.5$  g/day, preferably  $< 0.3$  g/day
- Use of multiple treatment strategies simultaneously

## Initiation of treatment with therapies that both prevent/reduce pathogenic IgA and immune complex formation and manage disease-induced nephron loss



# APRIL is a Potentially Disease Modifying Approach in IgAN

In IgAN, APRIL inhibition has been demonstrated to prevent the production of pathogenic IgA and the consequent immune complex formation that leads to kidney damage



**Clinical endpoints in IgAN assess key measures of disease activity**

**IgA and Gd-IgA1** serve as pharmacodynamic biomarkers in early clinical studies<sup>1-3</sup>

**Proteinuria** reductions and **eGFR** stabilization reflect potential to preserve kidney function and support accelerated and full approval, respectively<sup>4,5</sup>

# Selective APRIL Inhibition Has Been Clinically Validated in IgAN

In Phase 3 IgAN studies, anti-APRIL mAb, sibeprenlimab shows numerically better or similar proteinuria (UPCR) reductions compared to anti-BAFF/APRIL antagonists, atacicept and povetacept

	<b>Sibeprenlimab<sup>1</sup></b> (anti-APRIL mAb)	<b>Atacicept<sup>2</sup></b> (TACI-IgG Fc)	<b>Povetacept<sup>3</sup></b> (TACI-Fc Fusion)
Dose	400 mg SC, Q4W	150 mg SC, QW	80 mg SC, Q4W
N	320*	203**	199±
UPCR change at 9 months	-50.2% vs. +2.1% for placebo	-46% vs. +7% for placebo	-52.0% vs. -4.3% for placebo
UPCR reduction at 9 months (placebo-adjusted)	<b>51.2%</b> p<0.0001	<b>42%</b> p<0.0001	<b>49.8%</b> p<0.0001

- **Dual BAFF/APRIL inhibition does not appear to provide an efficacy benefit beyond APRIL inhibition alone in IgAN**
- **APRIL only approach avoids potential immunosuppression associated with BAFF inhibition**

*Table above reflects cross-trial comparisons and not data from head-to-head studies; differences exist between trial designs and participant characteristics and caution should be exercised when comparing data across trials.*

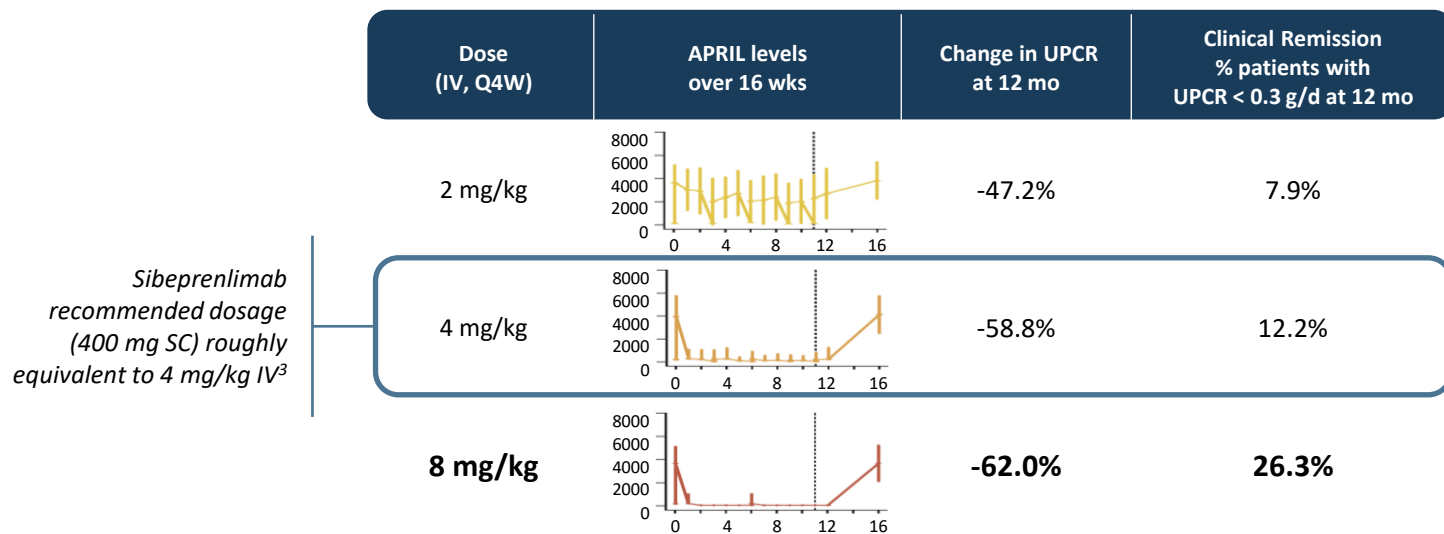
\*Interim analysis of 320 patients, total of 530 enrolled; \*\*Interim analysis of 203 patients, total of 431 enrolled; ±Interim analysis of 199 patients, total of 605 enrolled.

<sup>1</sup>Perkovic ERA 2025, 40 week endpoint, <sup>2</sup>Vera Corporate Presentation, June 2025, 36 week endpoint. <sup>3</sup>Vertex Press Release, March 9, 2026. APRIL = a proliferation-inducing ligand, BAFF = B-cell activating factor, IgAN = IgA nephropathy, mAb = monoclonal antibody, QW = once weekly, Q4W = once every four weeks, SC = subcutaneous, UPCR = urine protein creatinine ratio

# Next Gen Anti-APRILs Have Potential to Deliver Improved Profiles

Opportunity for next generation anti-APRIL agents to demonstrate improved efficacy, less frequent dosing, and reduced immunogenicity

Clinical data<sup>1</sup> suggest that sibeprenlimab recommended dosage<sup>2</sup> may not completely suppress APRIL or provide optimal proteinuria control



Immunogenicity was observed in the Phase 3 sibeprenlimab study, which resulted in an impact on drug exposure and proteinuria reductions<sup>2</sup>

34% evaluable patients developed ADA

In patients who developed ADA:

- Drug exposure was ~40% lower
- UPCR reductions at Month 9 were lower (41.6% vs. 52.7%)

## OPPORTUNITY FOR NEXT GENERATION APPROACH

**Improved efficacy:** more robust proteinuria reductions through deeper APRIL suppression, getting more patients to clinical remission

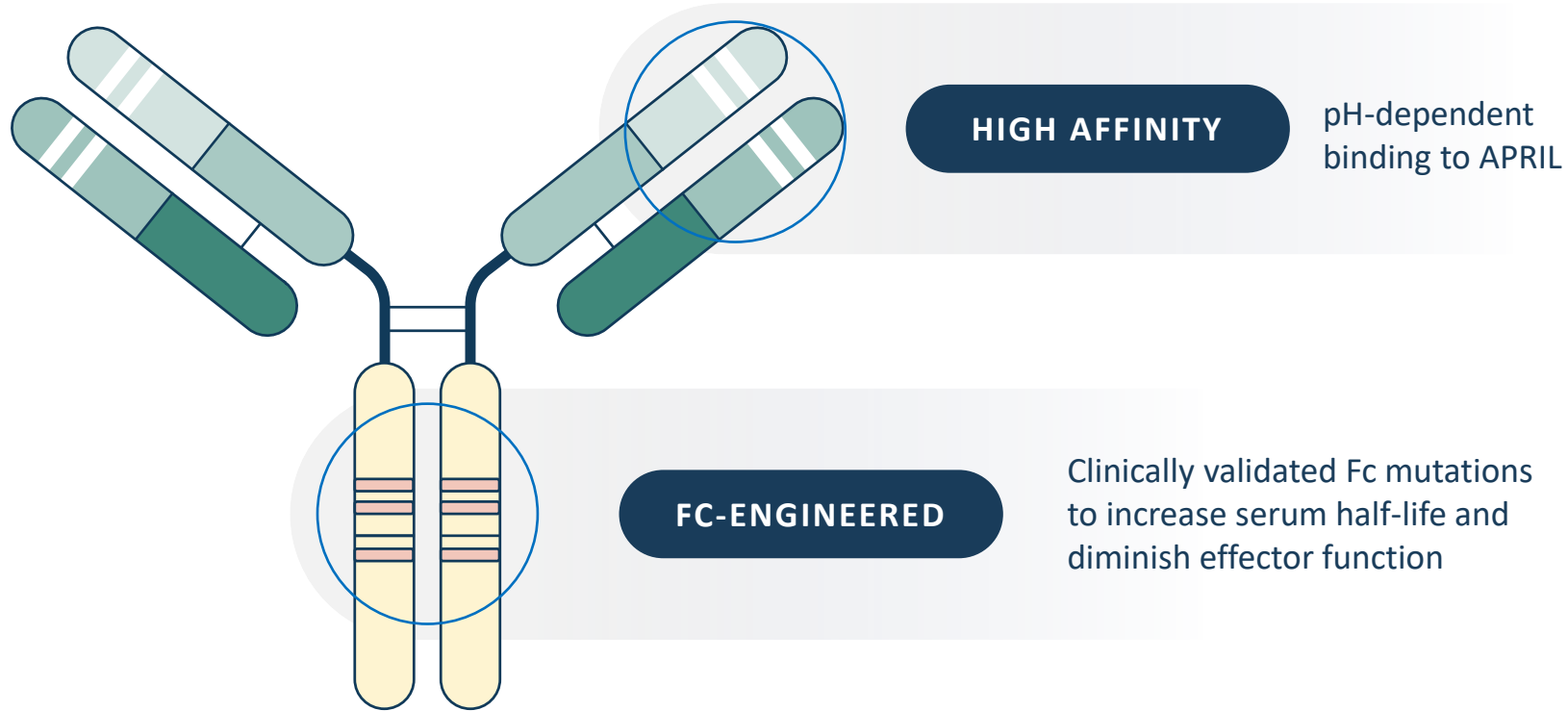
**Less frequent dosing:** reduced injection frequency through more prolonged APRIL suppression

**Favorable safety profile, with reduced immunogenicity:** supporting chronic administration

# CLYM116 Is The Only Known “Sweeper” Anti-APRIL In Development

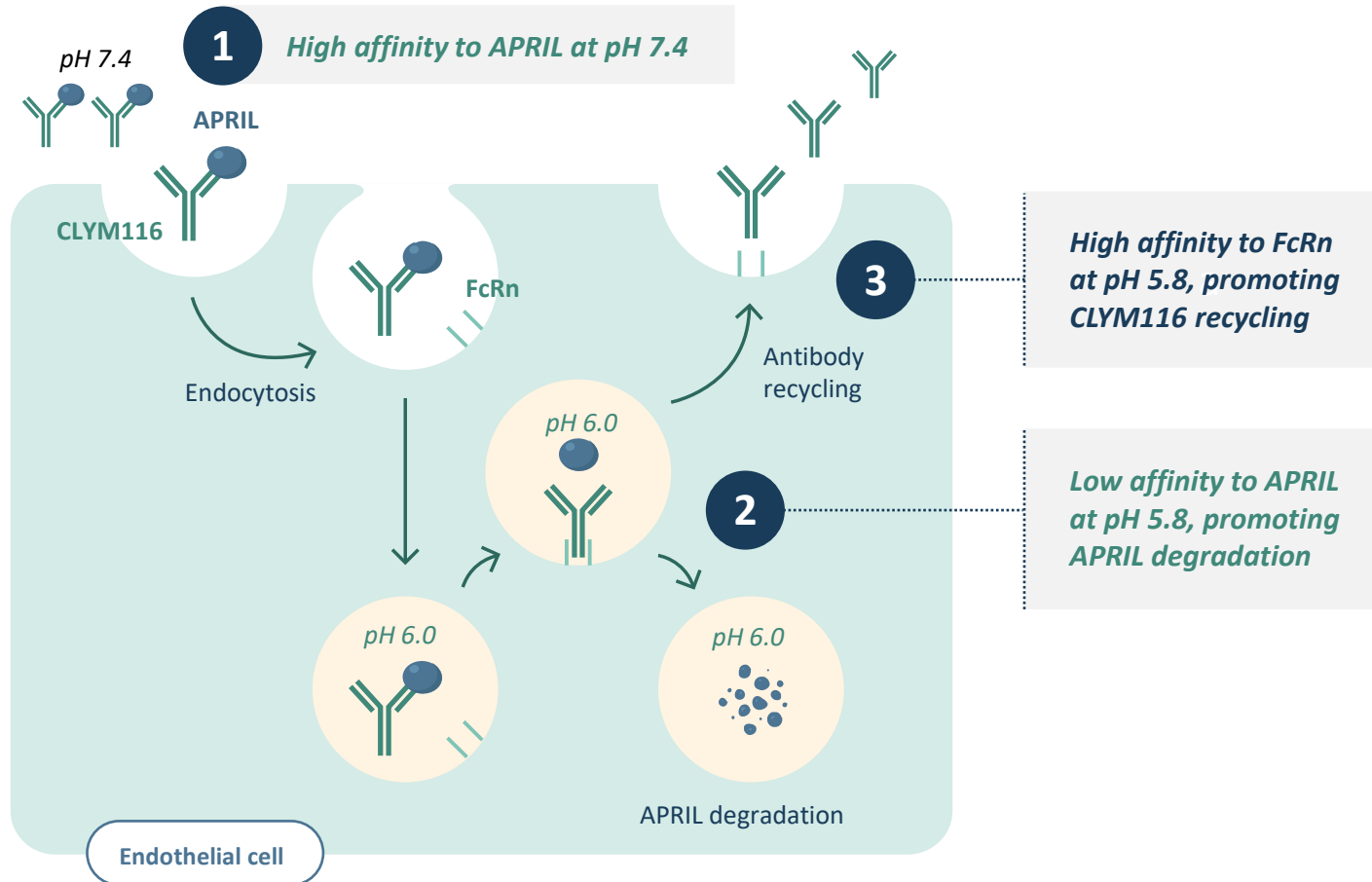
Potential best-in-class anti-APRIL mAb, designed for improved activity, less frequent dosing, and favorable safety profile

## KEY FEATURES



# CLYM116 “Sweeper” MoA Provides Potential for Clinical Benefits

CLYM116’s recycling degrader ‘sweeper’ mechanism of action provides potential for improved activity and less frequent dosing vs. first generation approaches or half-life extension alone



**pH-dependent binding to APRIL** provides potential for enhanced APRIL elimination through both:

- 1 potent blocking of APRIL binding to its receptors *and***
- 2 promotion of APRIL degradation in the lysosome**

**Efficient antibody recycling 3** reduces clearance of CLYM116, resulting in potentially longer half-life

# CLYM116 *In Vitro* and *In Vivo* Data Support Sweeper Mechanism

Preclinical data demonstrate the potential for CLYM116 to provide a differentiated activity profile

## CLYM116 demonstrated:

- ✓ **Potent, pH-dependent binding of APRIL** in an *in vitro* binding assay, as compared to first-generation anti-APRIL mAbs (sibeprenlimab and zigakibart) which did not demonstrate this profile
- ✓ **Fewer high molecular weight (HMW) complexes** vs sibeprenlimab in an HPLC (high performance liquid chromatography) analysis; HMW complexes may increase risk of immunogenicity
- ✓ **More effective APRIL depletion and clearance** as compared to first-generation anti-APRIL mAbs (sibeprenlimab and zigakibart) in APRIL degradation assay in a C57BL/6 mouse model
- ✓ **More efficient antibody recycling** as compared to first-generation anti-APRIL mAbs (sibeprenlimab and zigakibart) in an antibody exposure humanized FcRN transgenic mouse model

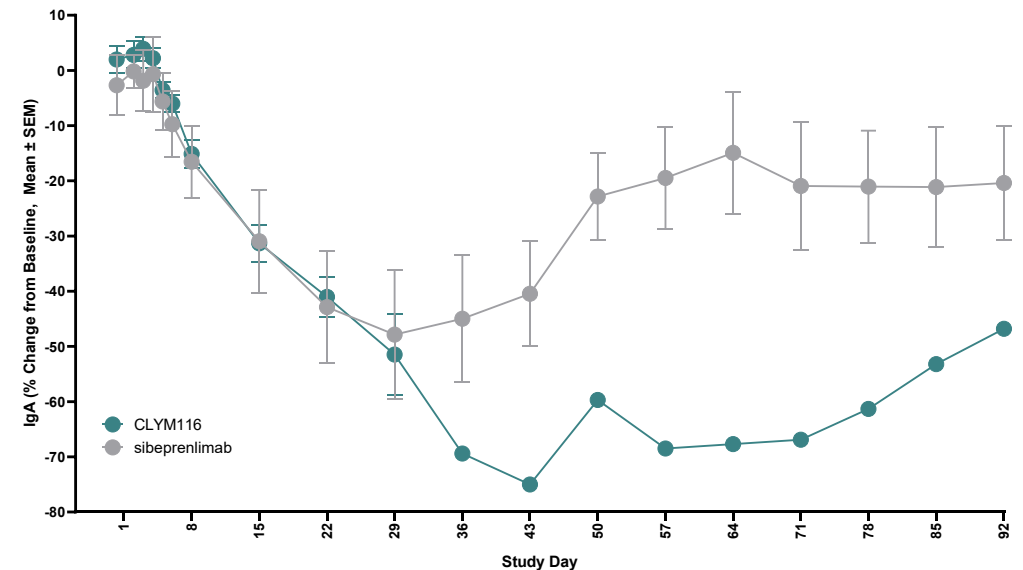
# CLYM116 Showed a Differentiated PK/PD Profile in NHPs

CLYM116 demonstrated high bioavailability, a ~2-3 fold longer half-life vs. sibeprnelimab and deep and durable suppression of IgA after a single SC dose in NHPs

In a head-to-head study in NHPs, CLYM116 SC demonstrated:

- ~85% bioavailability and favorable tolerability, with a formulation designed to support **potential for convenient, at-home dosing**
- ~2-3x longer half-life across doses as compared to sibeprnelimab, supporting **potential for improved exposure and less frequent dosing in humans**
- **Deeper and more prolonged IgA reduction** compared to sibeprnelimab after a single subcutaneous administration at equivalent doses (6 mg/kg), supporting **potential to demonstrate a differentiated activity profile**

**CLYM116 demonstrated >70% maximal reduction in IgA after a single 6 mg/kg SC dose, with >50% reduction in IgA maintained out to 3 months**



*Confirmed ADA+ animals were excluded from the analysis*

ADA = anti-drug antibody, NHPs = nonhuman primates, SC = subcutaneous

Data from a head-to-head study in nonhuman primates; single subcutaneous administration. Sibeprnelimab analog generated from publicly available sequence.

Beck ASN 2025

# Ph3 Data Supports Translatability from NHPs to HV to IgAN Patients

Data continue to support potential for CLYM116 to have a best-in-class profile in IgAN

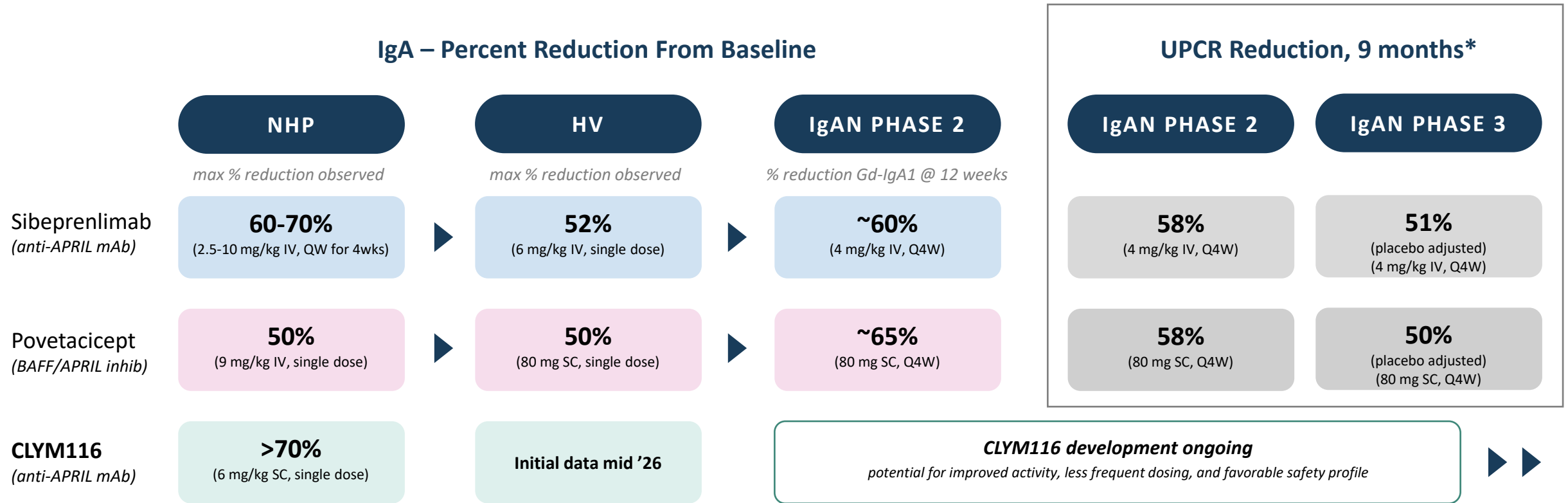


Table above reflects cross-study and cross-trial comparisons and not data from head-to-head studies; differences exist between trial designs and participant characteristics and caution should be exercised when comparing data across trials.

\*Primary endpoint for accelerated approval. Reported as 9 months and Week 40 for sibeprenlimab Phase 2 and Phase 3, respectively, and Week 36 for povetacicept Phase 2 and Phase 3. Sibeprenlimab: Myette Kid Intl 2019, Mathur Kid Intl Reports 2022, Mathur NEJM 2024. Povetacicept: Evans Arthritis & Rheumatology 2023, Davies Clin Transl Sci 2024, Madan KI Reports 2026, Vertex Press Release, Mar 9, 2026. APRIL = a proliferation-inducing ligand, BAFF = B-cell activating factor, HV = healthy volunteers, IgAN = IgA nephropathy, inhib = inhibitor, IV = intravenous, mAb = monoclonal antibody, NHPs = nonhuman primates, QW = once weekly, Q4W = once every 4 weeks, SC = subcutaneous, UPCR = urine protein creatinine ratio, wks = weeks.

# CLYM116 Phase 1 Study In Healthy Volunteers Enrolling

Pharmacodynamic biomarker data (APRIL, IgA) expected to guide dose and dose frequency for studies in IgAN patients; initial PK/PD data expected mid-2026

**Randomized, double-blind, placebo-controlled, ascending dose study**

**Population**

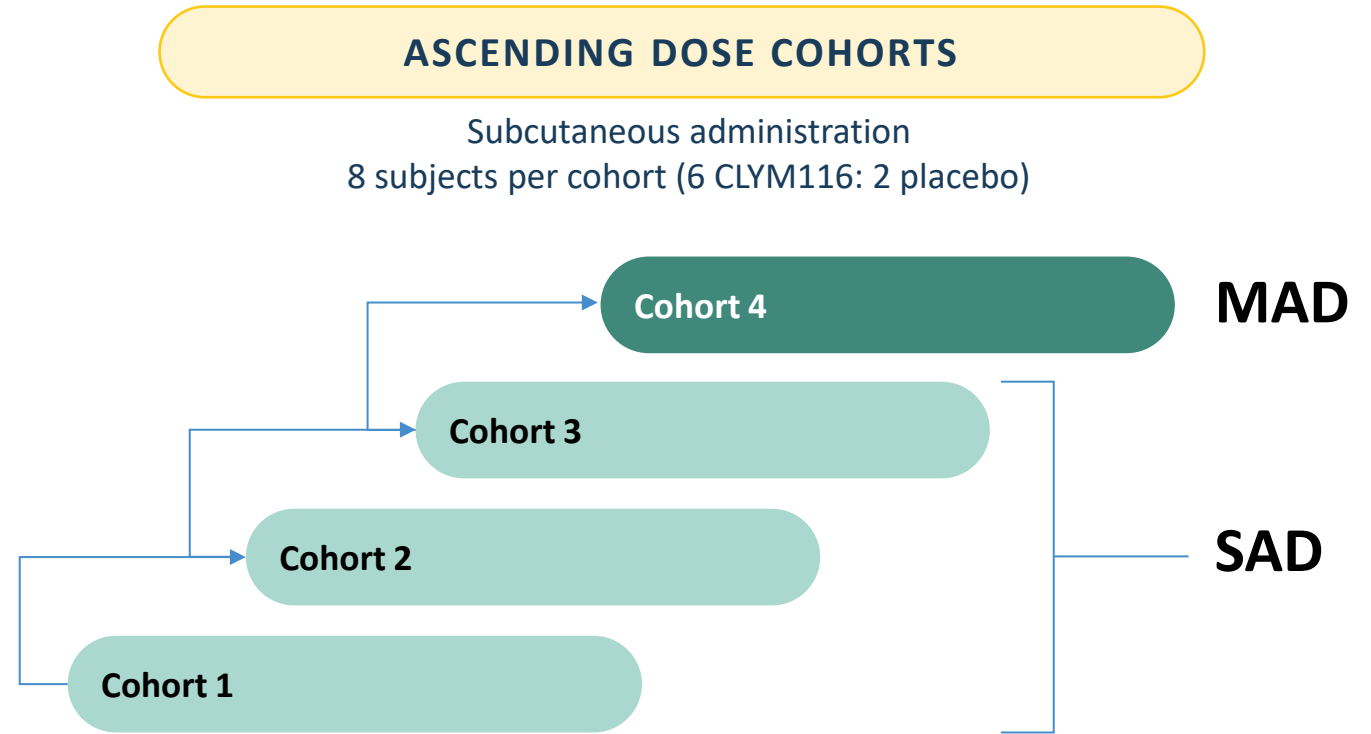
- Healthy volunteers

**Primary Objective**

- Safety and tolerability

**Secondary Objectives**

- Pharmacokinetic profile
- Effect on immunoglobulins (IgA, IgM, and IgG) and APRIL levels (pharmacodynamic response)

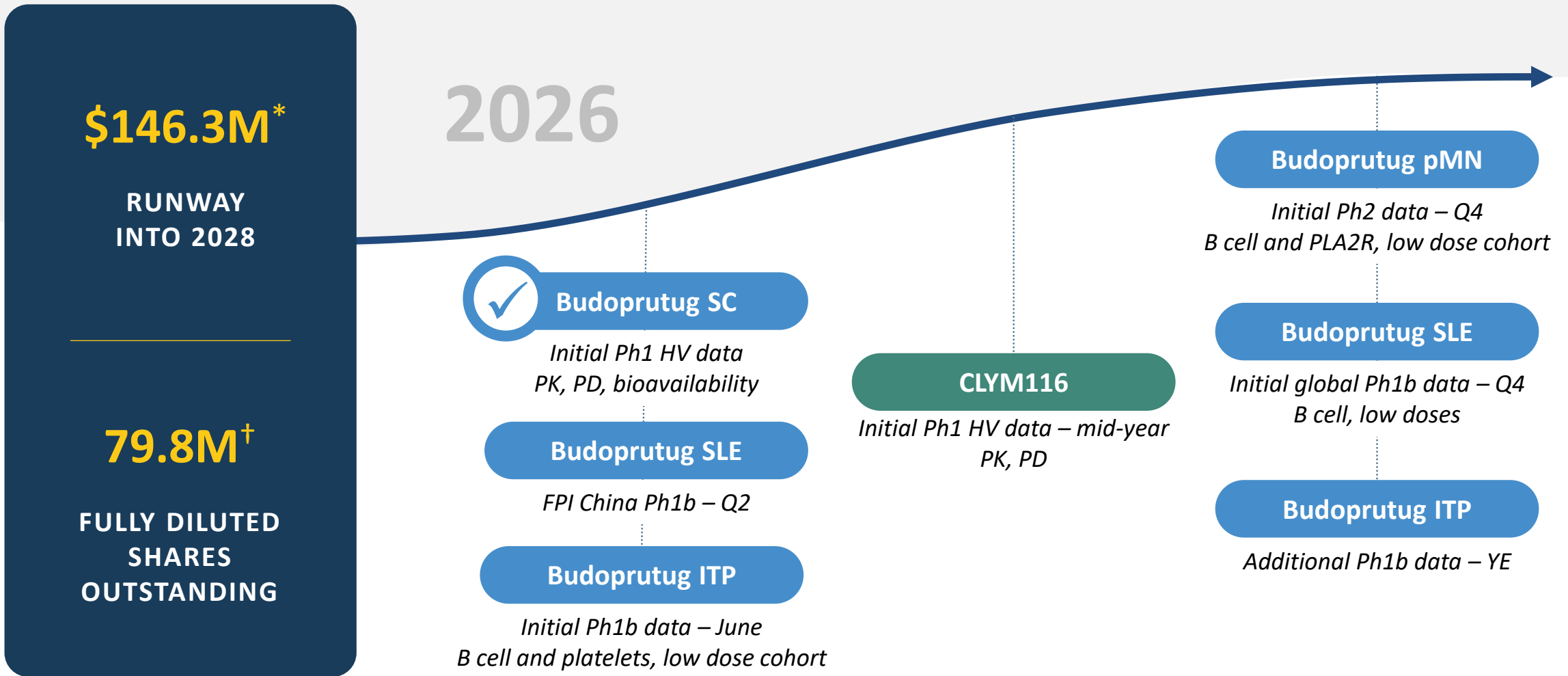


*(additional cohorts may be included as study progresses)*

# Looking ahead

# Climb Bio: Data-Rich 2026

Continuing the ascent with initial readouts anticipated from all ongoing trials



\*Cash, cash equivalents, and marketable securities as of March 31, 2026, excluding the proceeds received from the April 2026 private placement; †57.3 million common shares outstanding; ITP = immune thrombocytopenia; SLE = systemic lupus erythematosus; pMN = primary membranous nephropathy; SC = subcutaneous; HV = healthy volunteers; PK = pharmacokinetics, PD = pharmacodynamics; FPI = first patient in

# Climb Bio is Well Positioned for Success

Multiple clinical readouts within cash runway



Developing **differentiated**, monoclonal antibody (mAb) therapeutics for **immune-mediated diseases**, including those affecting **kidney health**, with expansive commercial opportunities



Leveraging **clinically validated** B cell targets, **proven mAb modality**, and indications with **well-defined** endpoints and **established** regulatory pathways



Anticipating a **data-rich 2026** with **multiple clinical readouts** across both clinical-stage programs

- **Budoprutug** - anti-CD19 mAb in development for pMN, ITP, and SLE; Fast Track and Orphan Drug Designation granted for pMN
- **CLYM116** - anti-APRIL mAb in development for IgAN



**Well-resourced** to advance clinical programs through meaningful value-driving milestones, with **runway anticipated into 2028\***