Corporate Presentation

October 2024

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Jade Biosciences is developing potentially transformative therapies for high-value Inflammation and Immunology indications

Jade's mission is to deliver best-in-class therapies for patients living with autoimmune diseases.

- Developing potential **best-in-class therapies for the treatment of autoimmune diseases**, including IgA nephropathy (IgAN).
- Fourth company launched to research and develop **antibody candidates licensed from Paragon Therapeutics**, an antibody discovery engine founded by Fairmount.
- **Following in the footsteps of Apogee, Spyre, and Oruka**, which have collectively raised ~$1.8B and have generated clinical data utilizing Paragon's half-life extension technology.

MOA	Program	Discovery	IND-enabling	Planned Clinical FIH	Planned Healthy Volunteer Data
anti-APRIL	JADE-001			2H25	1H26
Undisclosed	JADE-002			1H26	
Undisclosed	JADE-003			1H27	

I&I – inflammation and immunology; MOA– mechanism of action; FIH – First-In-Human

Experienced Management Team with Backing from Paragon

Management

Tom Frohlich
CEO

Andrew King
CSO, Head of R&D

Hetal Kocinsky
CMO

Valerie Fauvelle
SVP, Regulatory & Quality

Jonathan Quick
SVP, Finance

Elizabeth Balta
GC & Corporate Secretary

Amy Sullivan
SVP, Development Operations

Sandy Lewis
SVP, Biometrics and Clinical Strategy

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PARAGON THERAPEUTICS

JADE-001: a potential best-in-class anti-APRIL mAb for IgAN

Jade is developing a potential best-in-class anti-APRIL mAb designed to have disease-modifying MoA in IgAN

Estimated $10B+ newly branded market

*Current approved treatments don't adequately address young patient population with need for **long-term disease-modifying** therapy*

Anti-APRIL mechanism is potentially disease-modifying

*Shown to reduce **pathogenic IgA** and proteinuria, and **preserve kidney function***

JADE-001 has potential best-in-class profile

*Designed to have superior potency and half-life for **maximal efficacy** & **convenient dosing** in young patient population requiring life-long therapy*

Efficient development path to PoC and market

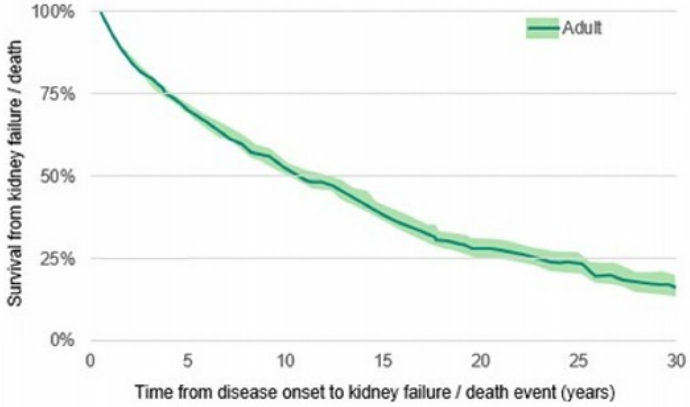
*HV IgA **biomarker closely correlated with efficacy in IgAN**; Potential **surrogate endpoints** support potential IgAN approval*

HV – Healthy Volunteers; PoC – proof of concept

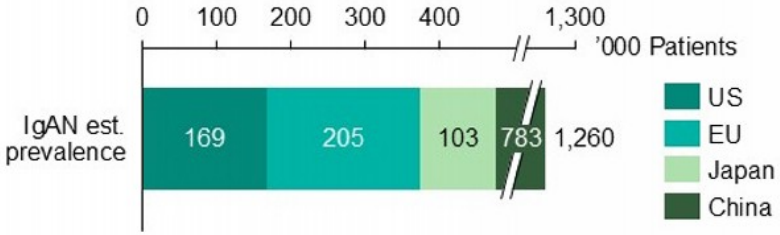
~169K+ IgAN patients in US, majority with persistent proteinuria, representing potential $10B+ market

IgAN patients with persistent proteinuria are **at risk of kidney failure**

- IgAN is an **autoimmune kidney disease**, typically diagnosed in 20- to 30-year-olds, **requiring life-long therapy**.



~1M+ global patients,
significant potential ex-US market potential



- At a prevalence of ~169K in the US, with **~60-75% of patients with persistent proteinuria** requiring treatment per international guidelines, along with pricing of branded IgAN agents, the **US TAM is estimated to exceed $10B annually**.

There is a high unmet need for **disease-modifying treatments that are safe, well-tolerated, and convenient** for life-long therapy in a **young patient population**.

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Notes: US prevalence estimate from FDA; EU prevalence estimate from EMA; Japan / China prevalence estimates from a Novartis presentation. Estimated pricing of ~$120K-$150K per year based on Filspari and Tarpeyo.
Sources: 2023 Pitcher (CJASN); FDA Reviews for Filspari / Tarpeyo; EMA; Novartis; 2018 Schena (Seminars in Nephrology); Reuters

Current IgAN treatments leave significant unmet need, with no disease-modifying (i.e., long-term GFR-stabilizing) approved therapeutics

	ACEi / ARB	Systemic glucocorticoids	SGLT2i	Filspari	Tarpeyo	Fabhalta	Ideal IgAN therapy
MoA	Renin-angiotensin system inhibition	General immunosuppression	SGLT2 inhibition	Dual endothelin / angiotensin inhibition	GI-released systemic glucocorticoid	Complement Factor B inhibitor	
Status	Used off-label	Used off-label	Approved for CKD	Approved	Approved	Accelerated approval	
Therapeutic rationale	Supportive therapy (reduce glomerular pressure)	Immunosuppression	Supportive therapy	Supportive therapy	Immunosuppression	Reduce complement-driven pathology	Disease-modifying (depletes Gd-IgA1, stabilizes GFR)
Proteinuria reduction	~↓30-40%	~↓30-50% at 6M; none at 3Y	↓26% pbo-adj (UACR)	↓35% control-adj at 36W	↓32% pbo-adj at 36W	↓38% pbo-adj at 36W	60%+, ideally to < 0.3-0.5 g per day
GFR stabilization	✗	✗	✗	✗	✗	No long-term data	✓
Safety	BBW (fetal tox), hyperkalemia, angioedema, AKI	Severe infections, edema, hypertension, bone density loss, etc.	UTIs, genital fungal infections, volume depletion	BBW + REMS (liver & pregnancy); hypotension, edema, AKI, hyperkalemia	Immunosuppression, edema, hypertension, weight increase, URTI	BBW + REMS (serious bacterial infections); URTI, abdominal pain	No notable safety issues, minimal immunosuppression
Annual dosing	365 x (or greater)	180-270 x (6 to 9-month course)	365 x	365 x	270 x (9-month course)	730 x	4-6 x (or fewer)

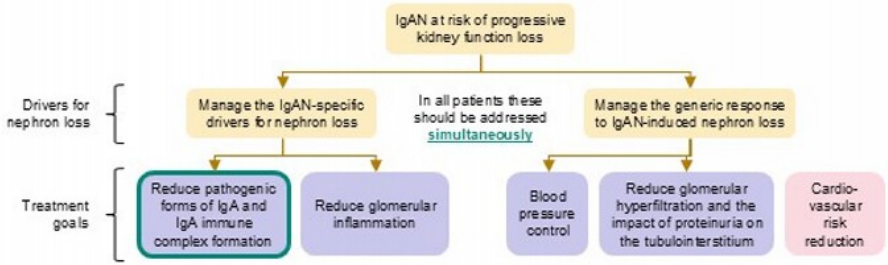
Notes: Proteinuria reduction based on UPCR. Data from Praga & Nakamura trials (ACEi / ARB), STOP-IgAN & TESTING (glucocorticoids), DAPA-CKD (SGLT2i), PROTECT (Filspari), NefIgArd (Tarpeyo), APPLAUSE-IgAN (Fabhalta).
Sources: UpToDate; 2003 Praga (J Am Soc Nephrol); 2006 Li (Am J Kidney Dis); 2000 Nakamura (Am J Nephrol); 2022 Lv (JAMA); 2023 Campbell (Dove Press); Filspari Label; Tarpeyo Label; Fabhalta Label; KOL interviews. CKD – chronic kidney disease; UACR –urine albumin to creatinine ratio; BBW – black box warning; REMS – risk evaluation and mitigation strategy; AKI – acute kidney injury; URTI – upper respiratory tract infection

Proposed updates to KDIGO guidelines highlight the need for therapies like JADE-001, which may reduce pathogenic IgA

Proposed guidelines expected to **increase IgAN diagnosis** and **redefine treatment goals**…

Patient population	• Recommends a **kidney biopsy in all adults with proteinuria ≥0.5 g/d** where IgAN is a possible diagnosis. • Recommends all patients be **enrolled in an IgAN registry**.
Risk of progression	• Redefines risk of progressive loss of kidney function for **patients with ≥0.5 g/d of proteinuria** on or off treatment (previously ≥0.75-1 g/d after maximal supportive care). • Recommends **additional treatment should be initiated in all cases** where patients have proteinuria ≥0.5 g/d.
Proteinuria target	• Establishes a new, ideal treatment goal: proteinuria should be maintained at <0.5 g/d, **preferably <0.3 g/d**. • 0.3 g/d is the highly **stringent cutoff for clinical remission** used in the sibeprenlimab Phase 2.

… and further underscore the **importance of reducing pathogenic IgA** in the treatment paradigm



- Proposed guidelines state, "reduction or prevention of IgA immune complex formation should incorporate treatments that have been **proven to reduce pathogenic forms of IgA**". Anti-APRILs and TACI-Fcs have **shown the best clinical data to date** for reducing pathogenic IgA.
- Guidelines also recommend therapies that prevent immune complex-mediated injury **should be used in combination with, and not as a replacement** for, therapies that reduce pathogenic IgA.

KDIGO updates are anticipated to increase **IgAN diagnosis**, expand the **at-risk patient population** requiring treatment, **lower proteinuria target** to clinical remission, and require **use of targeted therapies** that **reduce pathogenic IgA**

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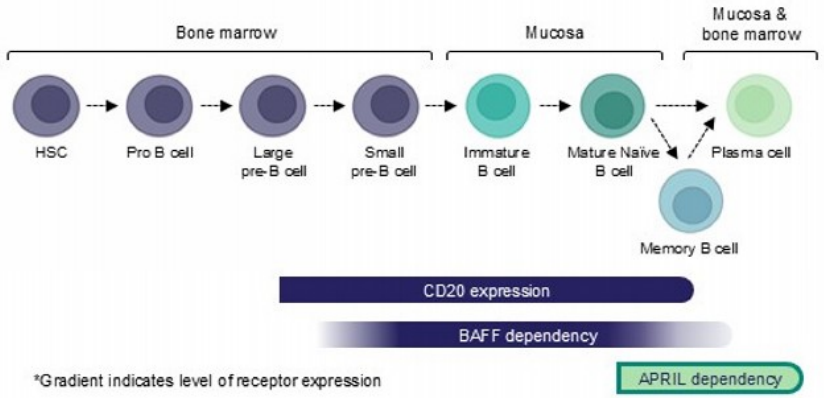
Sources: KDIGO Guidelines Public Review Draft; 2023 Mathur (NEJM); Jade analysis
KDIGO – Kidney Disease Improving Global Outcomes

Reducing pathogenic IgA production by plasma cells is a potentially disease-modifying approach for IgAN

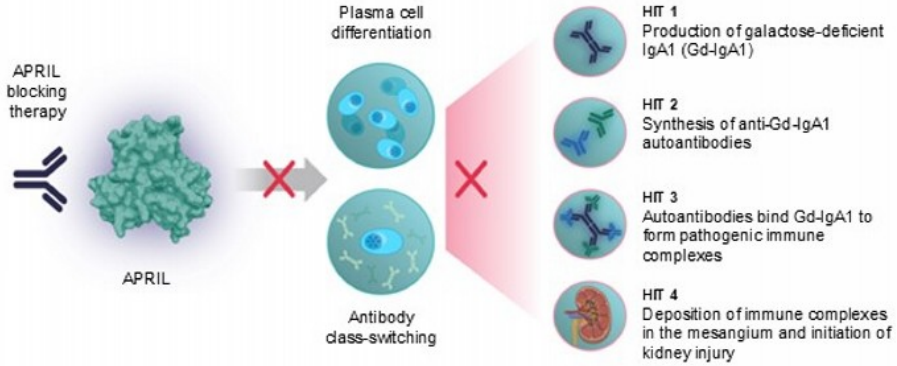
Broad **B-cell depletion is ineffective** in IgAN…

- B-cell depletion with rituximab (anti-CD20) **failed to reduce Gd-IgA1, anti-Gd-IgA1 autoantibody, or proteinuria** and **did not impact eGFR**.
- BAFF neutralization (blisibimod) **did not reduce IgA or proteinuria.**



…while **targeted plasma cell modulation is highly effective.**

- APRIL and dual APRIL/BAFF neutralization **result in significant and sustained depletion of Gd-IgA1, reduction in proteinuria, and eGFR stabilization.**



Neutralizing APRIL depletes Gd-IgA1, reduces proteinuria, and **preserves eGFR**, providing a **disease-modifying treatment** of IgAN without impacting B-cell development and maturation.

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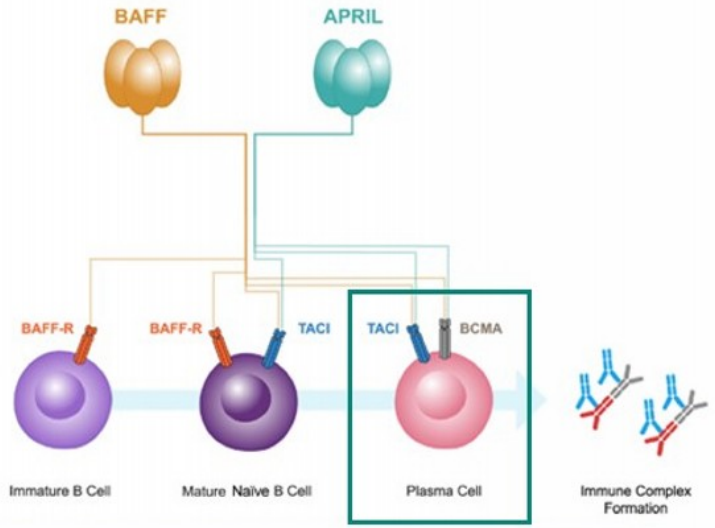
Sources: 2024 Cheung (Front Nephrol); 2023 Mathur (J Clin Med)

Selectively targeting APRIL potentially provides disease modification without added immunosuppression of BAFF inhibition

APRIL is the B cell survival factor **critically linked to IgAN pathogenesis and disease activity**

	APRIL	BAFF
Risk variant in IgAN GWAS	✓	✗
Elevated in IgAN patients and **associated with disease severity**	✓	✓/✗
Promotes **excess secretion of Gd-IgA1** in IgAN patient lymphocytes *ex vivo*	✓	No data
Drives **IgA class switching** via TACI *in vivo*	✓	✗
Overexpression in mouse model leads to glomerular IgA deposition	✓	✓
KO mouse model **decreases IgA levels / IgA+ plasma cells** in small intestine	✓	✗
Selective inhibition demonstrates preclinical / clinical efficacy in IgAN	✓	✗

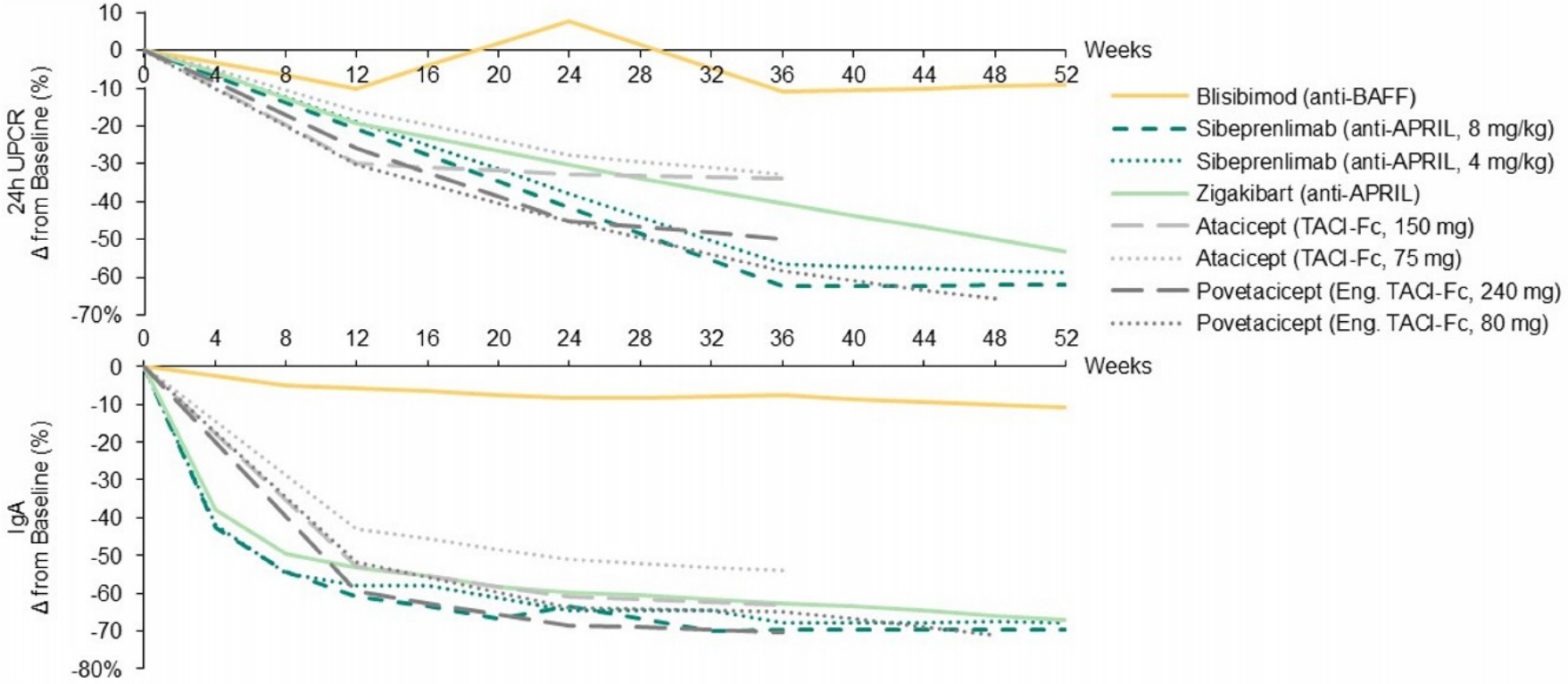
Targeting APRIL **selectively modulates plasma cells**, maintaining pool of mature B cells



Existing genomic, mechanistic, IgAN model, and clinical data **support the importance of APRIL over BAFF** in IgAN, and APRIL-only blockade **avoids the potential for unnecessary immunosuppression**.

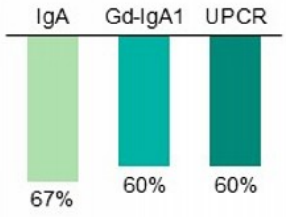
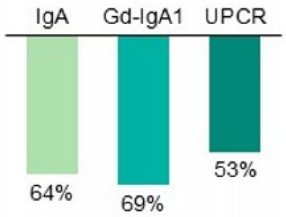
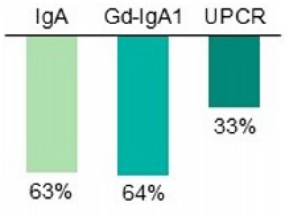
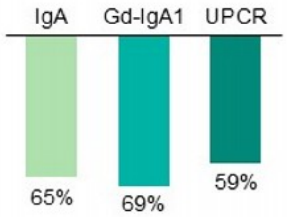
Sources: 2024 Cheung (Front Nephrol); Chinook 2022 CKD3 Presentation; 2004 Castigli (PNAS); 2001 Schiemann (Science)

Reductions in proteinuria and IgA in IgAN clinical studies indicate APRIL inhibition is the driving force behind TACI-Fc efficacy



Notes: Cross-trial comparisons are inherently limited and presented for hypothesis-generating purposes only. Data digitized from graphs where publications did not provide specific values. Values only included if N > 5. Blisibimod W52 data is from W60.
Sources: Anthera 2017 10-K; 2023 Mathur (NEJM); 2023 Barratt (ERA Poster); 2024 Lafayette (KI Reports); 2024 Tumlin (WCN Presentation); 2024 Madan (ASN Presentation)

Anti-APRILs have shown evidence of disease modification and clinical activity that matches or beats TACIs, with reduced immune suppression

	Sibeprenlimab	Zigakibart	Atacicept	Povetacicept
MoA	anti-APRIL	anti-APRIL	TACI-Fc	Engineered TACI-Fc
Status	P3	P3	P3	P3
Δ from baseline in critical disease markers *(W36 timepoint*)*	 N=79 (4/8 mg/kg pooled)	 N=35 (600 mg)	 N=32 (150 mg)	 N=9 (80 mg)
GFR stabilization	✓ (12 months)	✓ (18 months)	✓ (24 months)	✓ (12 months)
Hematuria resolution	✓	No data	✓	✓
Safety	✓ Well tolerated, no overall ↑ infections, slight ↑ in URTIs vs. pbo	✓ Well tolerated (no pbo), no drug discontinuations	✓ Well-tolerated, slight ↑ in infections (& URTIs) vs. pbo	✓ Well-tolerated (no pbo) 240 mg ↑ infections
P3 Dosing	400 mg SC, Q4W	600 mg SC, Q2W	150 mg SC, QW	80 mg SC, Q4W

*"The goal is to reduce pathogenic IgA and **get the disease under control right away**. The **APRIL class will be the backbone** [of therapy]. This class will **become first-line**."*

– European KOL

*"These therapies **may change the thinking in IgAN**. Instead of first starting with a hemodynamic agent and then going to prednisone… **now we would start with [anti-APRIL** and anti-APRIL/BAFF]."*

– US KOL

*"If I biopsy a patient and they have clear inflammation, **if these were available, I would use them immediately** with ACEi / ARBs."*

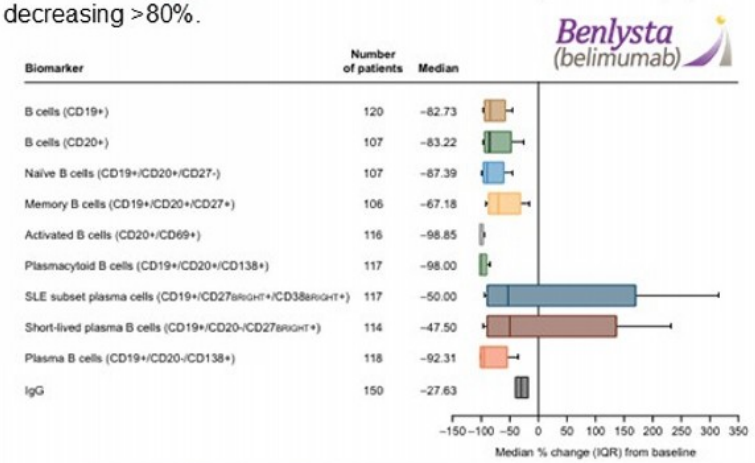
– US KOL

Notes: *Zigakibart IgA / Gd-IgA data at W40; UPCR data at W52 (only timepoint available); change from baseline is not pbo-controlled; N represents patients on dose(s) for which data is shown. Atacicept infections/URTIs placebo - (32%/0%), 25 mg (38%/0%), 75 mg (49%/9%), 150 mg (39%/6%). Povetacicept infection rates: Grade 1/2/≥3 – 80 mg 10%/5%/0%, 240 mg 18%/27%/3%. Sibe infections/URTIs placebo - (55%/0%), 2 mg/kg (39.5%/8%), 4 mg/kg (56%/12%), 8 mg /kg (53%/5%
Sources: 2023 Mathur (NEJM); 2024 Barratt (ERA Presentation); VERA January 2024 R&D Day; ALPN 2024 WCN Investor Update; 2024 Madan (ASN Presentation)

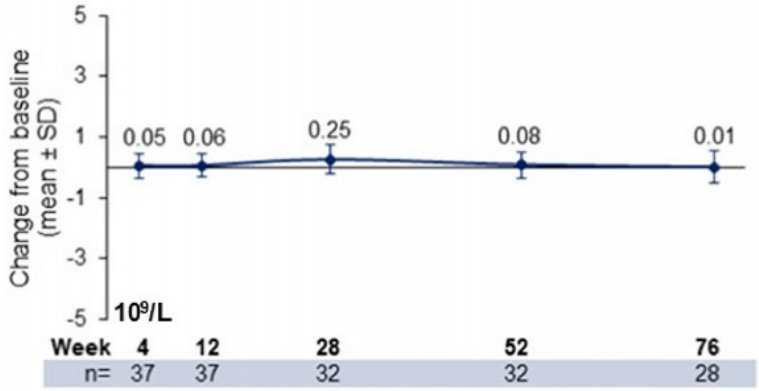
BAFF inhibition is accompanied by the potential for significant long-term B cell depletion

Long-term BAFF inhibition **significantly depletes all B cell populations**…

- ~7-year data from belimumab in SLE shows **continuous BAFF inhibition lowers B cell populations from ~50% to ~99%**, with most populations decreasing >80%.



… whereas chronic **APRIL inhibition does not impact circulating lymphocytes**



Long-term BAFF suppression, in an otherwise young and healthy patient population, **is unnecessary** given equivalent efficacy in IgAN from anti-APRILs and TACI-Fcs observed to date.

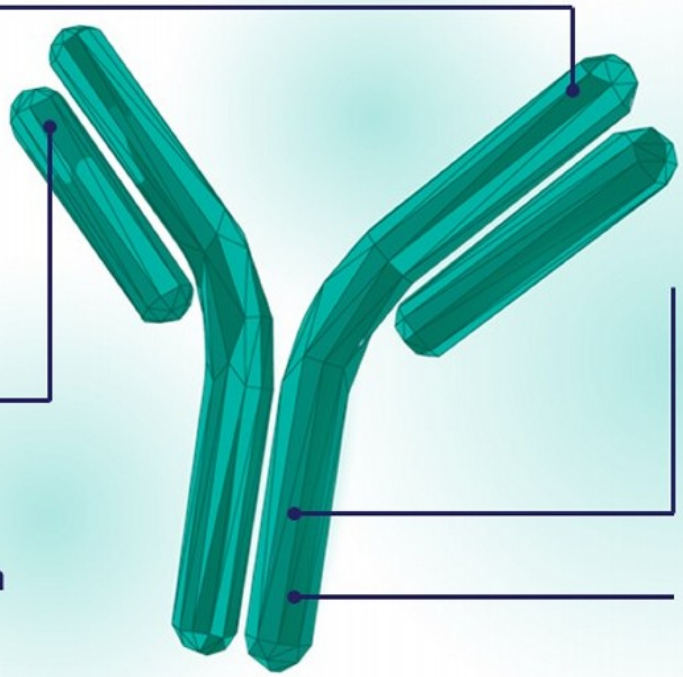
Sources: 2022 Struemper (Lupus Sci Med); Barratt ASN 2024

JADE-001 is a potential best-in-class anti-APRIL

Blocks APRIL with greater potency than clinical benchmarks

- Validated mechanism of action
- Binds **APRIL** to neutralize activity
- **Greater binding affinity** than sibeprenlimab (≥5x) and zigakibart (≥14x)

Multiple antibody discovery strategies pursued to achieve potential best-in-class mAb



Half-life extension through validated YTE Fc modification

- Longer exposure intended to reduce dosing frequency

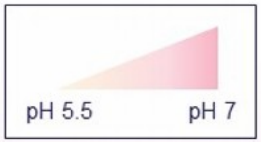
Effector-null human IgG1 Fc

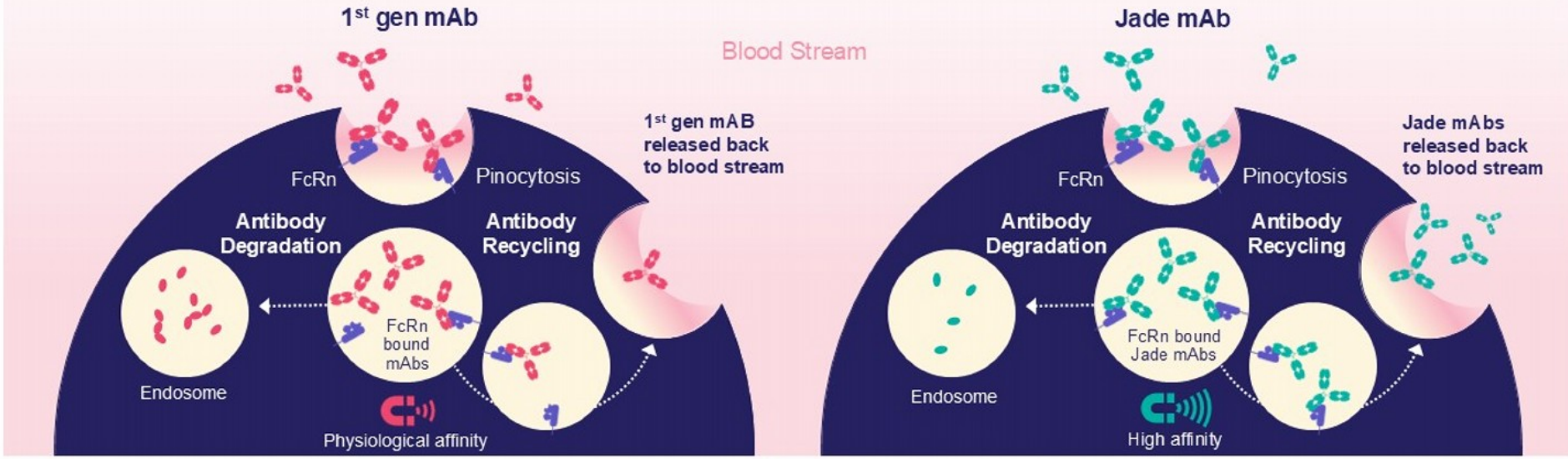
Novel IP for composition of matter into 2040s

Paragon has filed provisional patent applications covering the subject matter of JADE-001, which we will be entitled to under the license agreement with respect to JADE-001. We have exercised the Option with respect to JADE-001, but have not yet entered the license agreement.

Jade mAbs employ proven half-life extension (HLE) technology

- Jade mAbs designed to be recycled back into circulation more readily
- Drug exists at much higher levels for longer duration of effect
- Fewer injections decrease patient burden and can improve compliance and penetration



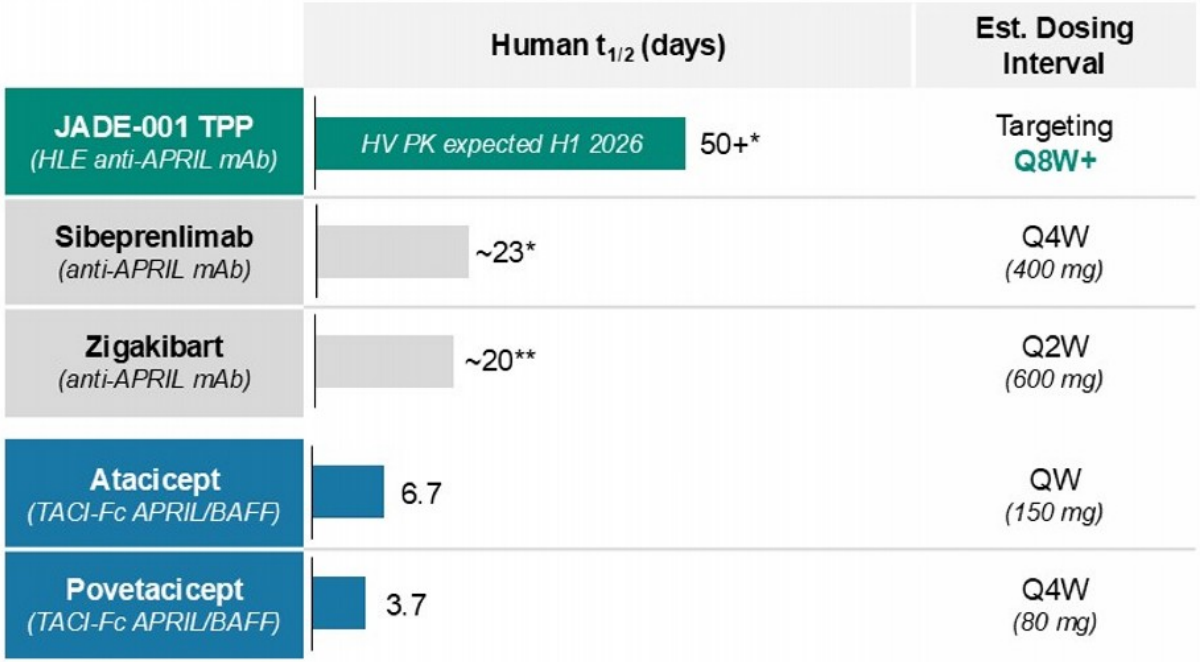


SOURCE: Adapted from Ko S et al BioDrugs 2021

JADE-001's goal is to introduce Q8W+ dosing for IgAN patients via HLE

- JADE-001 **employs well-established HLE technology**, with the **potential for Q8W+ dosing**.
- High **potency can potentially further drive lower dosing frequency** – which has **already been demonstrated for APRIL** by sibeprenlimab's Q4W dosing vs. zigakibart's Q2W dosing despite near-equivalent half-life.

Prior experience, **including with Paragon-generated mAbs**, indicates HLE could **significantly improve dosing over anti-APRILs in development**

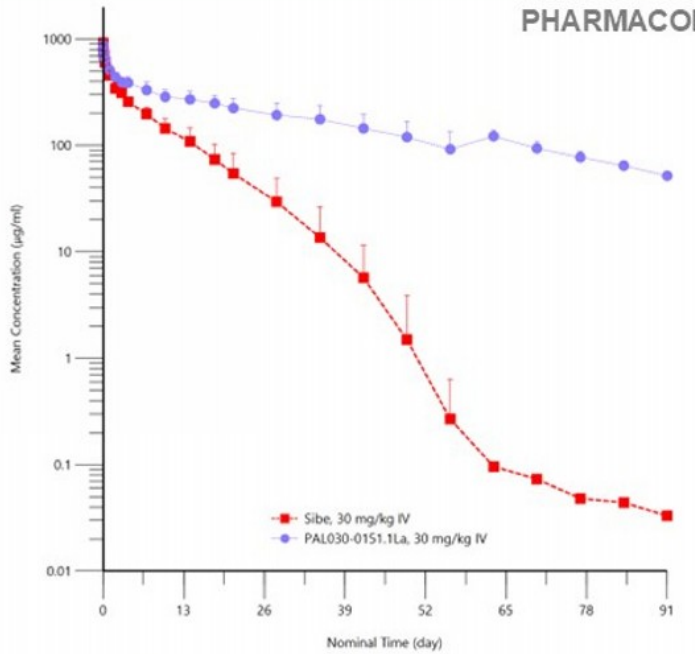


Sources: 2019 Myette (Kidney Intl); 2022 Mathur (KI Reports); 2018 Dulos (ASN Poster); 2020 Lo (ERA Poster); Apogee Corporate Presentation
*Based on single dose studies in NHPs dosed with JADE-001 initial clone. A development candidate will be selected from a pool of clones currently in profiling. We have exercised the Option with respect to JADE-001 under the Paragon Option Agreement but have not yet entered into the related license agreement.
**Available anti-APRIL therapeutics demonstrate appreciable TMDD resulting in dose and dose frequency dependent t1/2. Jade estimated t1/2 of benchmarks from publicly available data at the P3 dose and schedule via standard noncompartmental analysis of observed data bolstered with compartmental modelling approaches capturing clinically observed TMDD. Cross-trial comparisons are inherently limited and presented for hypothesis-generating purposes only.

JADE-001 HLE strategy and profile in NHPs shows promise with early clone*

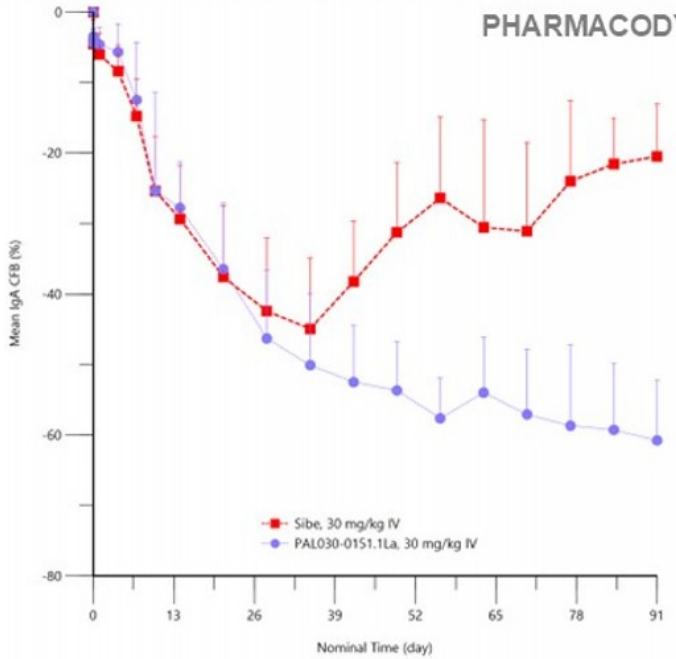
~3X increased half-life over sibeprenlimab in NHPs…

PHARMACOKINETICS



… which is **accompanied by prolonged IgA reduction** in NHPs following a single, saturating dose

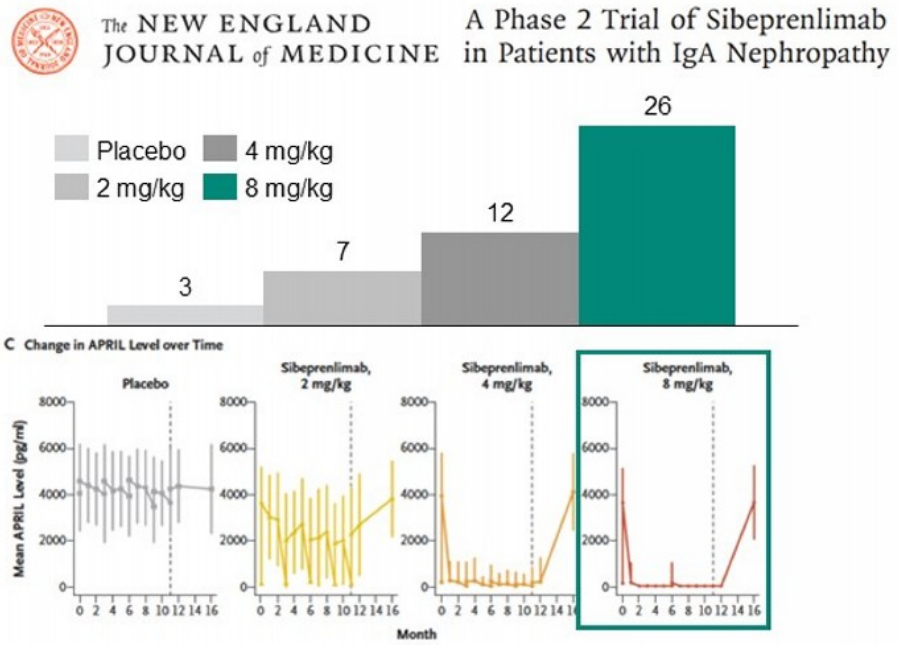
PHARMACODYNAMICS



Note: *Data shown is from an initial clone. A development candidate will be selected from a pool of clones currently in profiling. We have exercised the Option with respect to JADE-001 under the Paragon Option Agreement but have not yet entered into the related license agreement. Sibeprenlimab and JADE-001 lead clone dosed at 30 mg/kg (single dose), N=4 per group. Manufactured based on available sequences from patents / company releases. Studies are ongoing.
Sources: Internal data

Deeper APRIL suppression could drive superior efficacy

- The highest rates of **clinical remission** (<0.3 g/day urinary protein excretion) for sibeprenlimab were accompanied by the **deepest levels of APRIL suppression.**
- **Safety profile** was **consistent** across dose levels.
- Significant opportunity to drive **increased systemic exposure with HLE and maximize clinical remission**.
- JADE-001's **affinity** could further contribute to potential **best-in-class efficacy**.

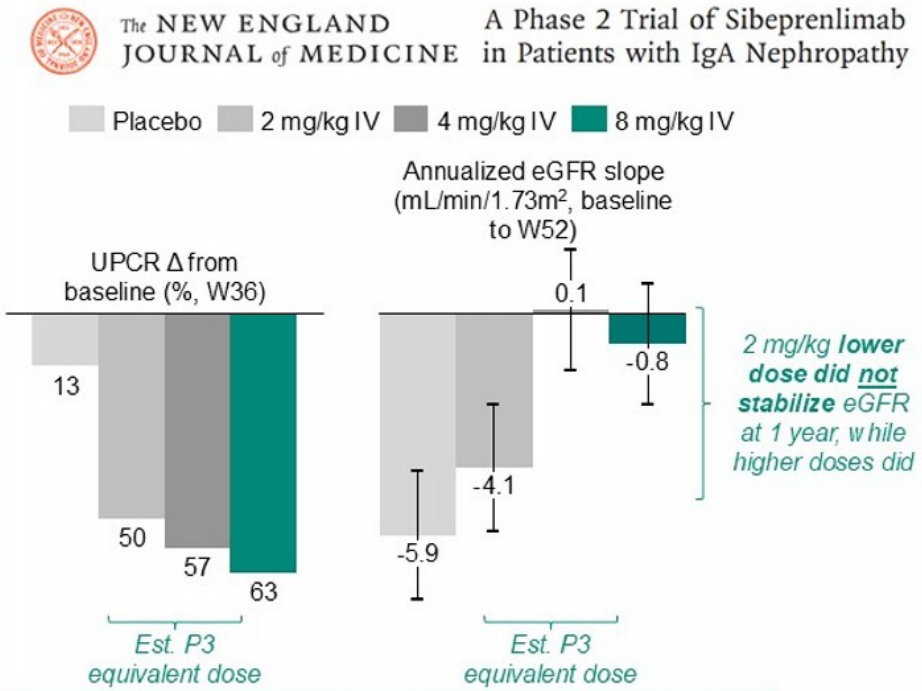


JADE-001 has potential to **demonstrate superior clinical activity by maximizing remission rates** in **significantly more patients than other anti-APRIL programs** in development.

Note: clinical remission definition of <0.3g/day urinary protein excretion.
Source: 2023 Mathur (NEJM)

Sibeprenlimab is potentially under-dosed in ongoing Phase 3 trial

- **Sibeprenlimab** is being dosed as a single **400mg SC injection Q4W** in ongoing **global Phase 3** VISIONARY trial.
- 400 mg SC Q4W is **equivalent to ~3.5 mg/kg IV for average IgAN patient (range 2.5-6 mg/kg).**
- The estimated Phase 3 equivalent dose range **demonstrated lower efficacy on key endpoints in Phase 2** ENVISION trial (as seen on right).
- **~50%** of healthy volunteers in P1 SAD demonstrated positive antidrug antibody activity following a single SC dose which may further **impact PK, efficacy, and safety profile** in Phase 3.



Potential under-dosing of sibeprenlimab creates **additional opportunity for JADE-001** to demonstrate potential best-in-class clinical activity for patients.

Notes: Estimated sibeprenlimab P3 dose based on average 85 kg IgAN patient (95% CI ~50-120 kg) and 75% bioavailability.
Sources: 2023 Mathur (NEJM); 2023 Zhang (Clin Pharm)
HV – healthy volunteers; ADA+ - antidrug antibody positive

Potential path to early clinical proof-of-concept and accelerated approval

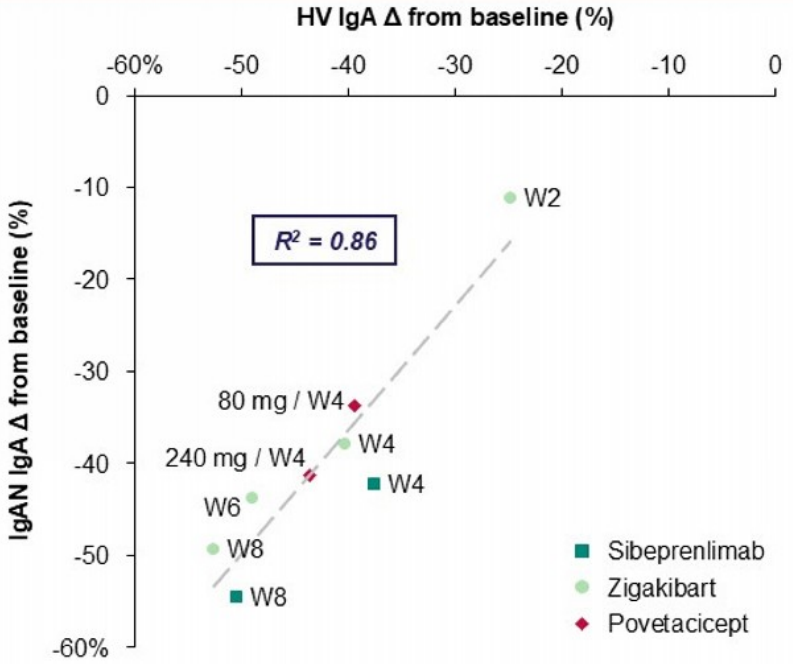
MOA	Program	Discovery	Phase 1 Initiation	Potential Healthy Volunteer Data	Potential Indications
anti-APRIL	JADE-001	Ongoing	2H25	1H26	IgAN

- **NHP and Phase 1 PK/PD** could provide early signals of clinical activity; **IgA reduction** in HVs has been observed to be **highly correlated** with **clinical activity**.
- 9-month proteinuria data, which we believe is highly **predictive of kidney function preservation**, provides support for US submission for **accelerated approval and potentially offers a faster path** to market prior to eGFR confirmatory data.

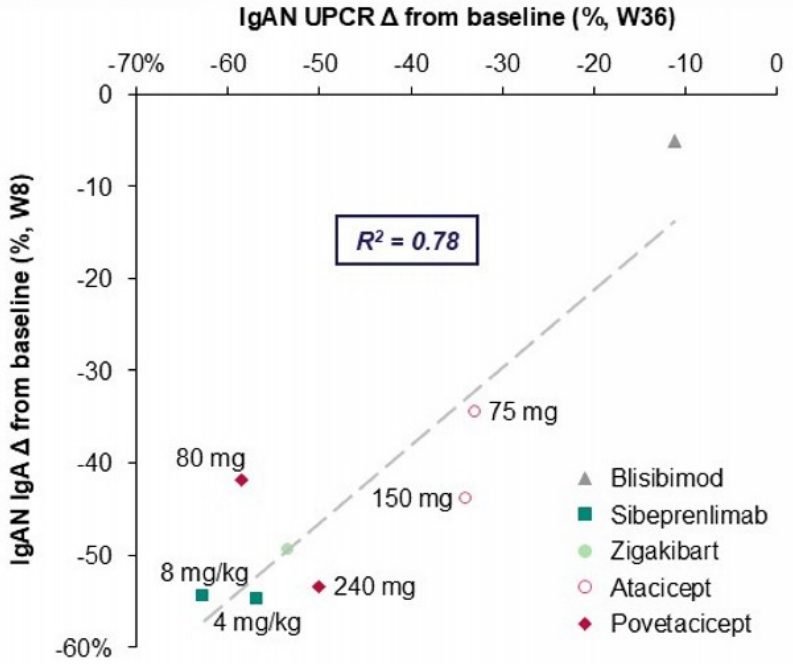
Proof-of-concept **IgA healthy volunteer data expected in 1H 2026**

IgA reduction in healthy volunteers is the critical inflection point for clinical development in IgAN

IgA reduction in HVs has been observed to be **highly correlated** with IgA reduction in IgAN patients



…and IgA reduction was observed to correlate with W36 UPCR reduction, the **endpoint for accelerated approval**



Notes: Sibeprenlimab IgAN IgA reductions (LHS) are average of 4 mg/kg and 8 mg/kg cohorts (HV data is from 6 mg/kg cohort); the two cohorts saw effectively equivalent IgA reduction at W4 and W8. Zigakibart UPCR data is at 52W. Atacicept IgAN W8 is average of W4 and W12 datapoints. Trend lines are best linear fit.
Sources: 2022 Mathur (KI Reports); 2023 Mathur (NEJM); 2020 Lo (ASN Presentation); 2023 Barratt (ERA Poster); 2024 Barratt (ERA Presentation); 2022 Dillon (ASN Poster); 2024 Tumlin (WCN Presentation); Anthera 2017 10-K; 2024 Lafayette (KI Reports); 2024 Madan (ASN Presentation)

Potential of JADE-001 in IgAN

Potential Disease-modifying MoA

Potential to deplete pathogenic IgA and avoids broad B-cell inhibition

More convenient dosing

Enabled by half-life extension technology

Potential best-in-class clinical activity

Designed for superior potency and half-life with potential to maximize clinical remission

Pipeline opportunities beyond IgAN

Additional Jade pipeline programs are expected to focus on best-in-class product profiles in high-value I&I indications

I&I indications with **significant market opportunity**

Potential **Best-in-class** and **best-in-indication** product profile

Potential **Rapid path** to clinical PoC

Expected minimal **competition**

Jade **team expertise**

Team is evaluating additional opportunities to **build pipeline of potentially best-in-class** I&I therapies.

Jade Biosciences is developing transformative therapies for high-value I&I indications

- Approximately $300 million raised to date, including anticipated proceeds from an oversubscribed pre-closing private financing, from syndicate of top tier healthcare investors, including:

FAIRMOUNT
venrock
FRAZIER LIFE SCIENCES
BRAIDWELL
DEEP TRACK CAPITAL
RACAPITAL
DRIEHAUS CAPITAL MANAGEMENT
SOLEUS CAPITAL
Great Point Partners

MOA	Program	Discovery	IND-enabling	Planned Clinical FIH	Planned Healthy Volunteer Data
anti-APRIL	JADE-001			2H25	1H26
Undisclosed	JADE-002			1H26	
Undisclosed	JADE-003			1H27	

Jade BIOSCIENCES

Estimated capitalization following close of transactions with Aerovate and pre-closing private placement

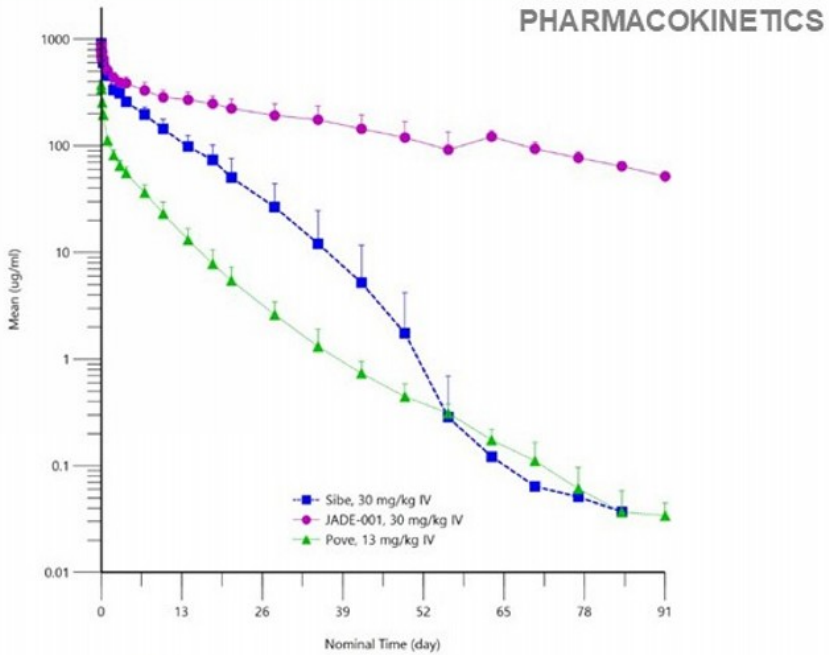
		Shares on an as-converted basis	Expected ownership of the combined company	Estimated dividend per share
Aerovate	• Shares of common stock outstanding	28,867,711	1.6%	$2.25[1]
Jade Biosciences	• Shares of common stock outstanding (including shares underlying option grants)	202,760,666	98.4%	N/A
	• Series A shares	428,776,000		
Pre-closing financing	• Shares of common stock	932,531,887		
	• Pre-funded warrants	262,898,748		
Estimated total shares of common stock of the combined company post-closing[2]		1,855,835,012		

[1] Prior to closing, Aerovate expects to declare a cash dividend to pre-merger Aerovate stockholders, distributing excess net cash estimated to be approximately $65 million.
[2] Please refer to AVTE's SEC filings for additional information, including the Registration Statement on Form S-4 that AVTE intends to file in connection with the transaction.

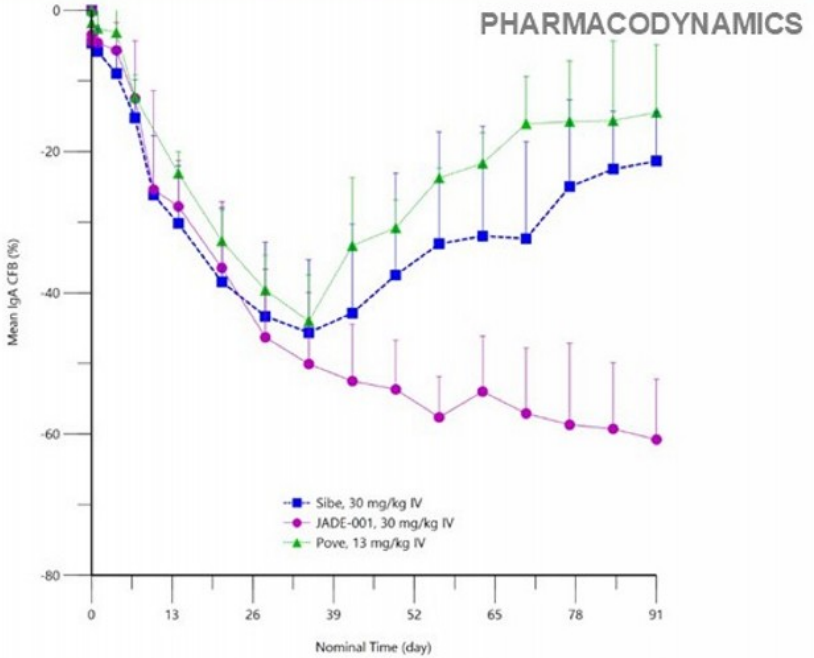
Thank you

JADE-001 HLE strategy and profile in NHPs shows promise*

~3X increased half-life over sibeprenlimab in NHPs…



… which is **accompanied by prolonged IgA reduction** in NHPs following a single, saturating dose



Note: *Data shown is from an initial clone. A development candidate will be selected from a pool of clones currently in profiling. We have exercised the Option with respect to JADE-001 under the Paragon Option Agreement but have not yet entered into the related license agreement. Sibeprenlimab (n=12) and JADE-001 (n=5) lead clone dosed at 30 mg/kg (single dose), Pove (n=4) dosed at 13 mg/kg (equimolar, single dose). Manufactured based on available sequences from patents / company releases. Studies are ongoing.
Sources: Internal data