bridgebio

hope through
rigorous science

JP Morgan Presentation

January 9, 2023

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BridgeBio Pharma: Hope through rigorous science

We have created a sustainable engine for the systematic discovery, development, and commercialization of medicines for genetic diseases

Exome, genome sequencing (cost & quality)

Molecular biology and pathway mapping

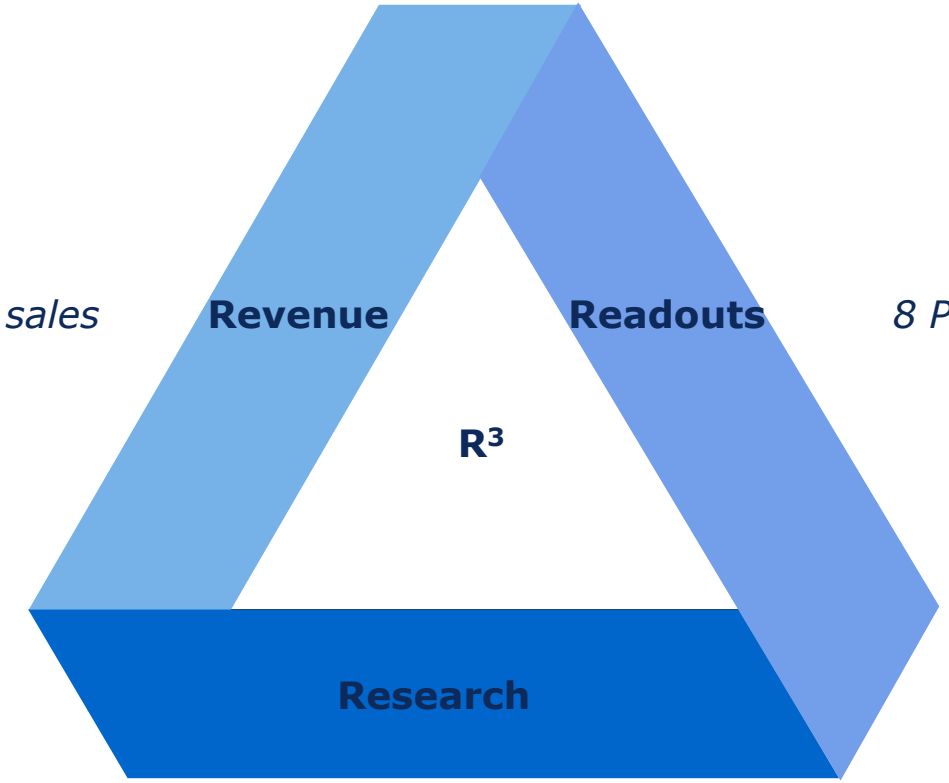
Big data and patient registries

- Find well described high unmet diseases that are *ripe for intervention*
- Develop *medicines that target genetic drivers* directly (at the source)
- Operate with *world-class* R&D capabilities and personnel that have developed significant, marketed products
- Employ a *scale-able and low cost corporate structure*

Real disease-modifying products that help patients with serious disease

Our R^3 5-year vision: We are building a distinctive product-focused genetic disease company

$2bn+ in product sales



8 Phase 3 readouts, 5 in large markets

1-2 INDs per year on average,
technology platforms spanning 4 modalities

Leadership team of world-renowned drug hunters

Scientific insight and judgment from industry leaders with a proven track record

Charles Homcy, MD
Founder and Chairman of Pharmaceuticals
MyoKardia GBT

Frank McCormick, PhD
Founder and Chairman of Oncology
ONYX PHARMACEUTICALS UCSF

Richard Scheller, PhD
Chairman of R&D
Genentech 23andMe

Len Post, PhD
Advisor
BIOMARIN LEAD THERAPEUTICS

Phil Reilly, MD, JD
Advisor
THIRD ROCK VENTURES bluebirdbio

Experienced team of R&D operators responsible for 100+ INDs and 20+ approved products

Mendelian / Cardiorenal

Uma Sinha, PhD
Chief Scientific Officer
GBT PORTOLA PHARMACEUTICALS

Robert Zamboni, PhD
Chemistry
MERCK FROSST

Jonathan Fox, MD, PhD
Chief Medical Officer, Cardiorenal
MyoKardia AstraZeneca

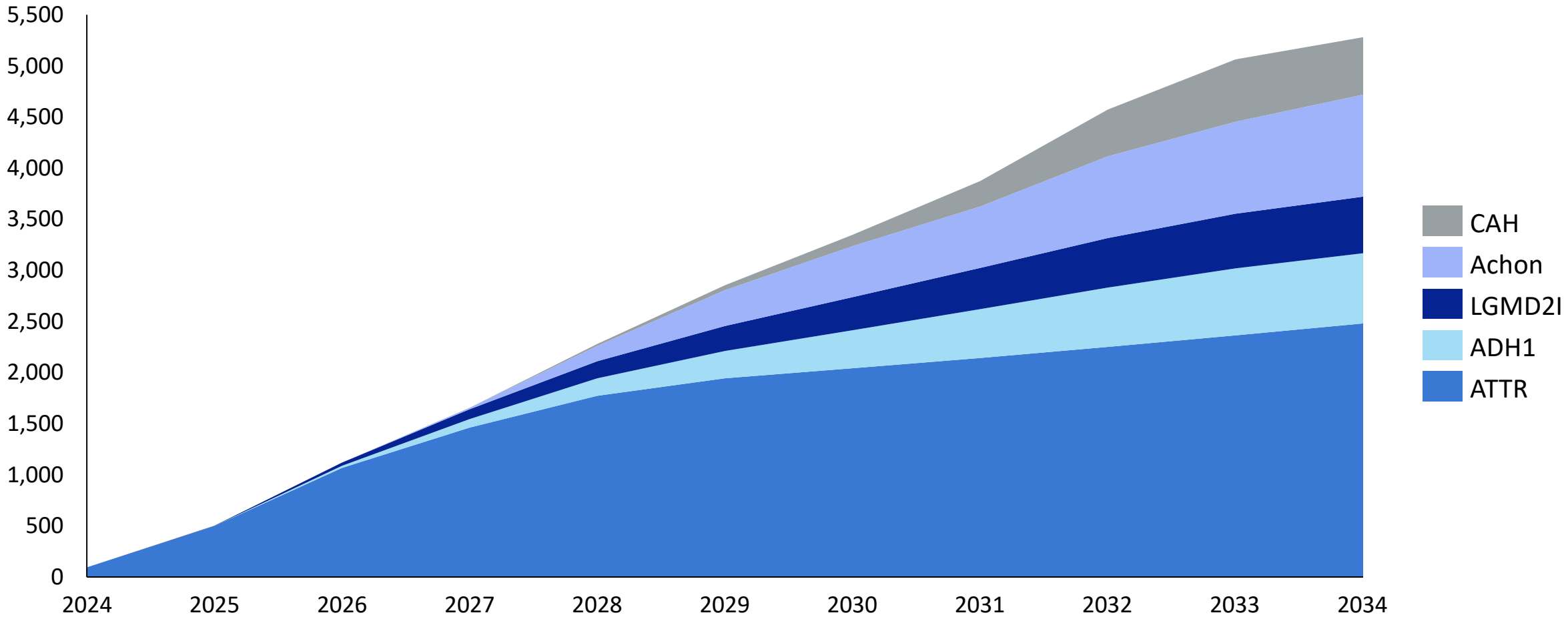
Oncology

Eli Wallace, PhD
Chief Scientific Officer, Oncology
Peloton Therapeutics ARRAY BIOPHARMA

Pedro Beltran, PhD
SVP, Oncology
AMGEN UNITY BIOTECHNOLOGY

Late-stage pipeline is poised to deliver significant risk-adjusted revenue and diversified top-line growth over following decade

Risk-adjusted revenue, $mn



Preliminary estimates

BBIO's catalyst map for 2023 – large potential value inflection points in the first 6 months of the year

Focus for today

Program	Stage	2023	
		1H	2H
Acoramidis for ATTR-CM	Phase 3		★ ATTRibute Ph3 topline data (July)
Low-dose infigratinib for achon. and hypochon.	Phase 2	★ Achon. Ph2 Cohort 5 topline data (March)	
Encaleret for ADH1	Phase 3		CALIBRATE Ph3 topline data (YE23) ★
AAV5 gene therapy for CAH (BBP-631)	Phase 2	Update: To date BBP-631 has been well-tolerated in 4 patients treated at the first two dose levels. We plan to collect data from additional patients including at the highest dose (cohort 3) which we expect will be available in 2H23	★ Ph2 data readout (2H23)
Ribitol for LGMD2i	Phase 3-ready		★ Ph3 initiation (2023)
RAS franchise: Next-gen G12Ci (BBO-8520)	Pre-IND		★ IND (2023)
RAS franchise: RAS:PI3Kα breaker	Lead-opt	★ Clinical candidate selection (1H23)	

★ Anticipated milestones

We are well-capitalized into 2024

Financial position as of 3Q22 report

Cash[1]	Shares outstanding[2]
~$558 Mn	~149 Mn

Anticipated burn trajectory

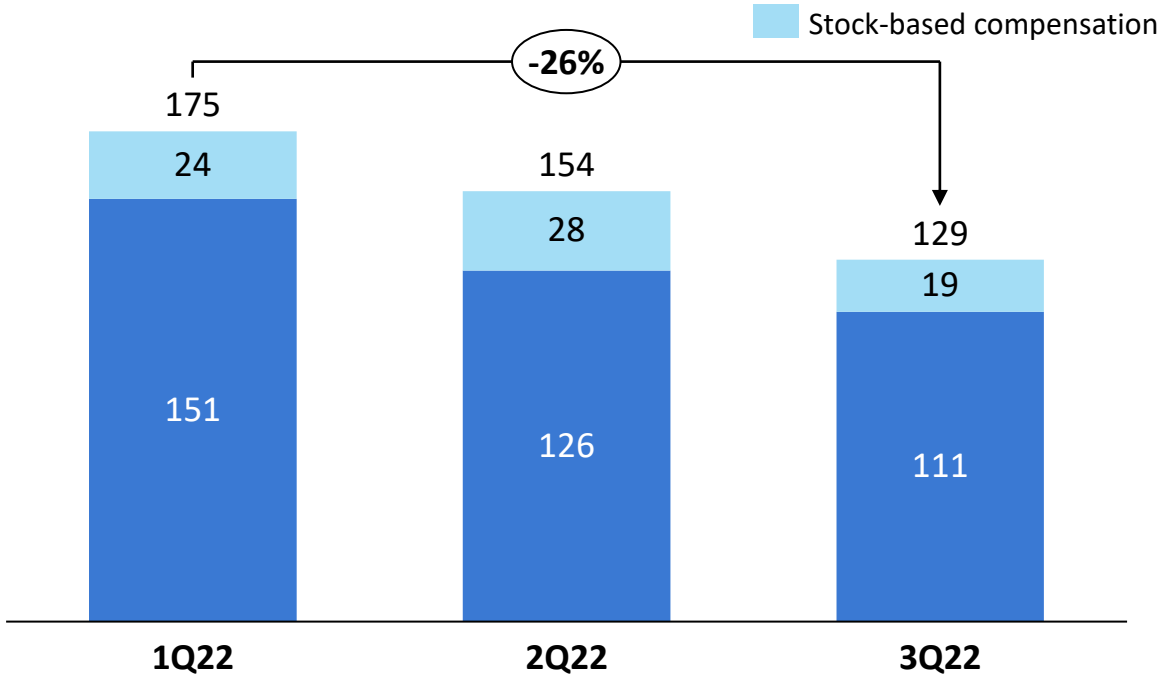
- ❑ **Runway into 2024** with cash on hand to read out: Achon cohort 5 data, ATTR Ph3 data, ADH1 Ph3 data, CAH POC, KRAS Clinical Data
- ❑ Anticipate OpEx and cash burn will continue to decline in Q4

Potential levers to further extend runway, given our 5 owned late-stage clinical assets

- ❑ Non-dilutive financings (i.e., royalty sales on late-stage assets)
- ❑ Upfronts and burn mitigation through BD deals

OpEx, $mn

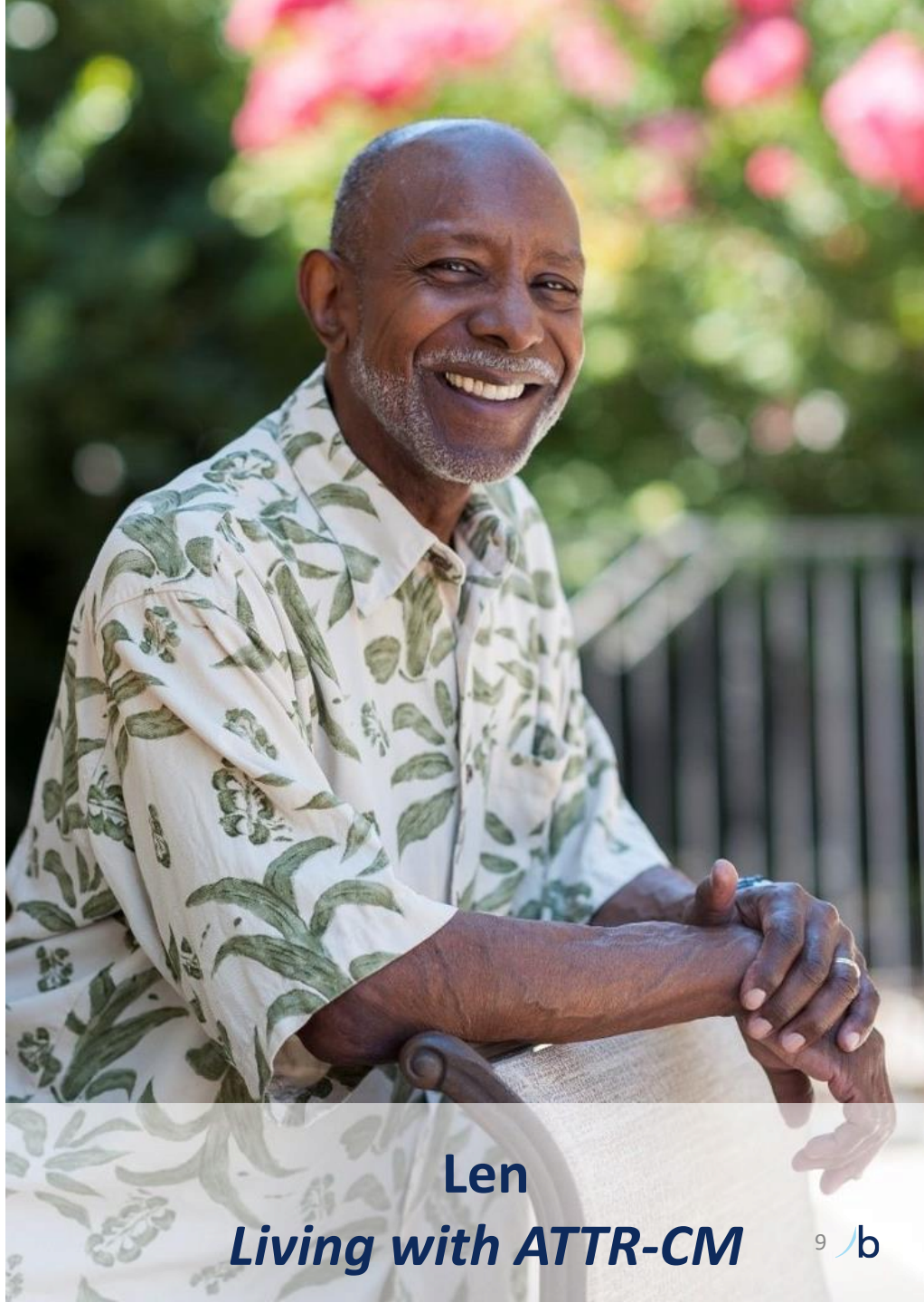
26% decrease in QoQ OPEX less SBC this year



1 Cash, cash equivalents and investments 2 Share amounts are absolute values

Acoramidis for transthyretin (TTR) amyloidosis (ATTR)

- Prevalence (US/EU): **400K**
- Stage: **Phase 3**
- Next Catalyst: **Phase 3 30-month all-cause mortality & CV hospitalization data expected mid-2023**



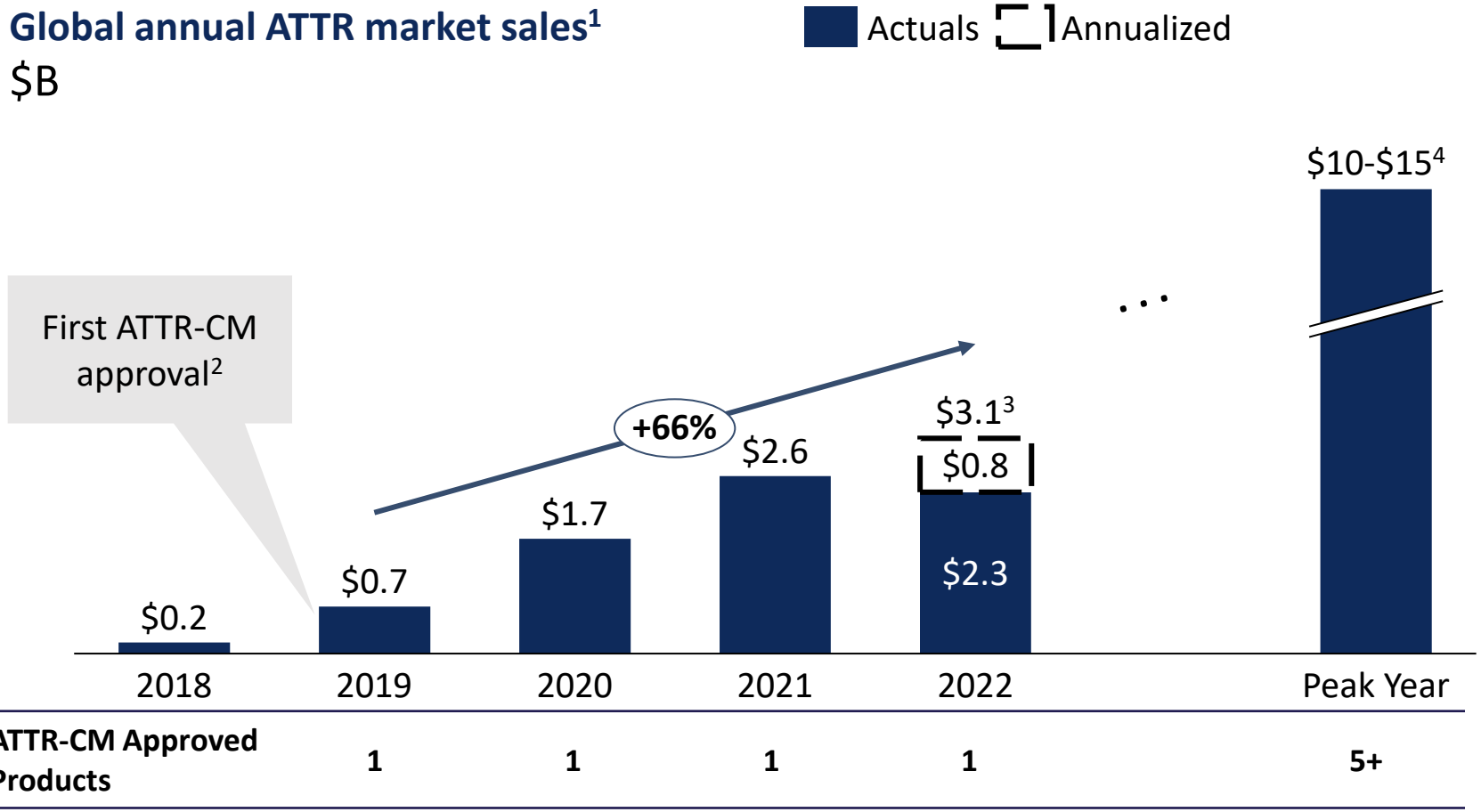
Len
Living with ATTR-CM

Acoramidis is well-positioned for success in the ATTR-CM market

- ATTR is a $3B global market today, **growing to $10-$15B**
- Acoramidis is a **2nd generation TTR stabilizer that has demonstrated a superior stabilization** profile ex vivo and in vitro
  - **Superior stabilization has been demonstrated to improve outcomes** – 20 mg v 80 mg in ATTR-ACT
- **Our Phase 3 patient population appears to be left-shifted in time**. Nevertheless, with the absolute magnitude of mortality being large and a more potent stabilizer, the trial remains well-powered
- In the contemporary ATTR-CM clinical context, **we believe best-in-class data is represented by patients living longer and going to the hospital less:**
  - **A better win ratio**
  - **Improved survival rates at 30 months**
  - **A meaningful separation in CV outcomes at 30 months**
  - **Superior treatment-related biomarkers as measured by serum NT-proBNP and TTR concentrations**

ATTR-CM has grown into a multi-billion dollar global market in 3 years and is primed for continued expansion

Global annual ATTR market sales[1]



Drivers of market growth include:

- Increased adoption of **non-invasive diagnostic tools**
- Earlier detection of disease
- **Growing market familiarity** with oral TTR stabilizers
- Tailwinds from the **Inflation Reduction Act** reducing patient out-of-pocket expenditure
- **Durable market growth** with Vyndamax polymorph patent protection through 2035[5]
- Precedent of **persistent brand sales** amidst 1st generation generic entry

[1]ATTR market includes all approved drugs for ATTR-PN and ATTR-CM
[2]First ATTR-CM sales occurred in Q2 2019
[3]Assumes linear annualization of Q4 2022 sales.
[4]Consensus estimates of $10B+ ATTR-CM market. Projection conducted prior to announcement of IRA market expansion opportunity for stabilizers.
[5]Orange Book

Acoramidis was designed to achieve maximal stabilization and preserve native TTR

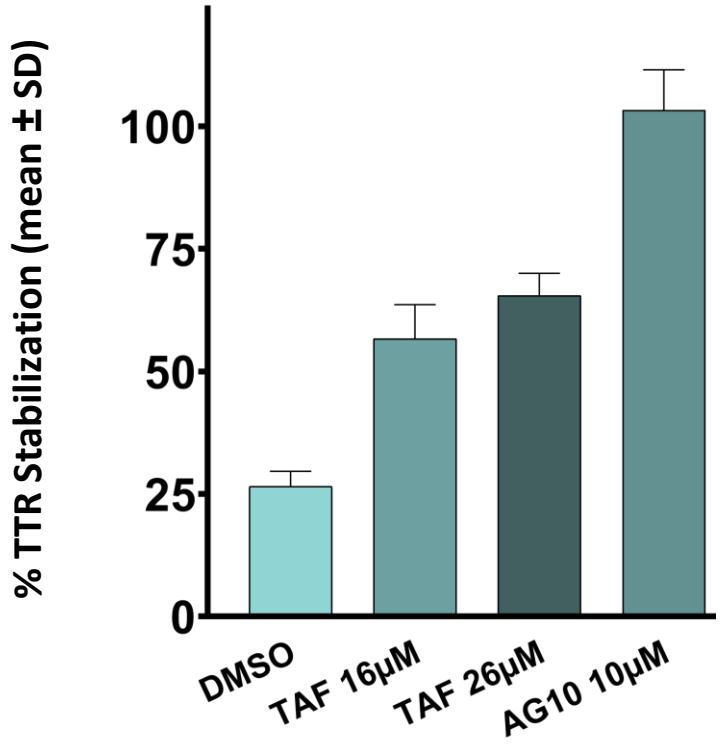
Design Objectives	Rationale
1 **Maximize TTR stabilization/minimize toxic monomer**	• Strong genotype/phenotype correlation between TTR stability and disease severity[1] • Observed dose-dependent improvements in both TTR stabilization and clinical outcomes demonstrated by tafamidis in ATTR-CM[2] • Extent of TTR stabilization or knockdown associated with degree of clinical benefit in ATTR-PN[3-6]
2 **Preserve circulating native TTR**	• TTR has been highly conserved throughout evolution[7] • TTR is an abundant plasma protein with relatively rapid turnover requiring sustained metabolic energy expenditure

We plan to enter the ATTR-CM market with acoramidis, a second generation, more potent TTR stabilizer

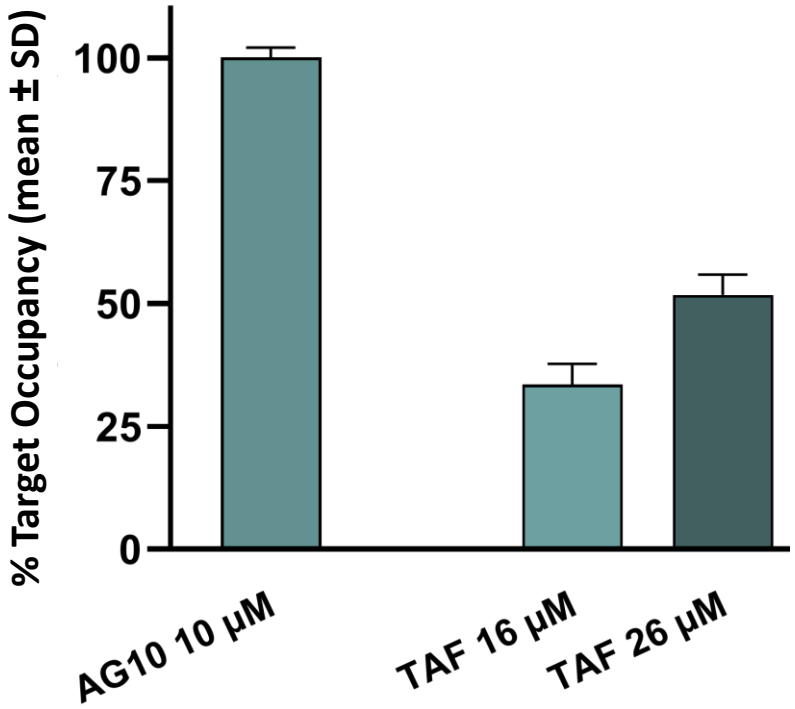
Source: [1]Hammarstrom, P et al., PNAS 2002, 99:16427-16432. [2]Damy, T., et al., Eur J Heart Fail. 2021;23(2):277-285. [3]Coelho, T. et al., Neurology 2012; 79:785–792. [4]Berk, JL et al , JAMA. 2013; 310:2658-2667. [5]Adams, DA. et al., N Engl J Med 2018;379:11-21. [6]Benson, M.D., et al., N Engl J Med 2018;379:22-31 [7]Richardson SJ, et al. Front Endocrinol. 2015;5:1-9.

TTR stabilization by acoramidis is *two-fold more potent* than tafamidis

TTR Stabilization by Western Blot Assay[1]



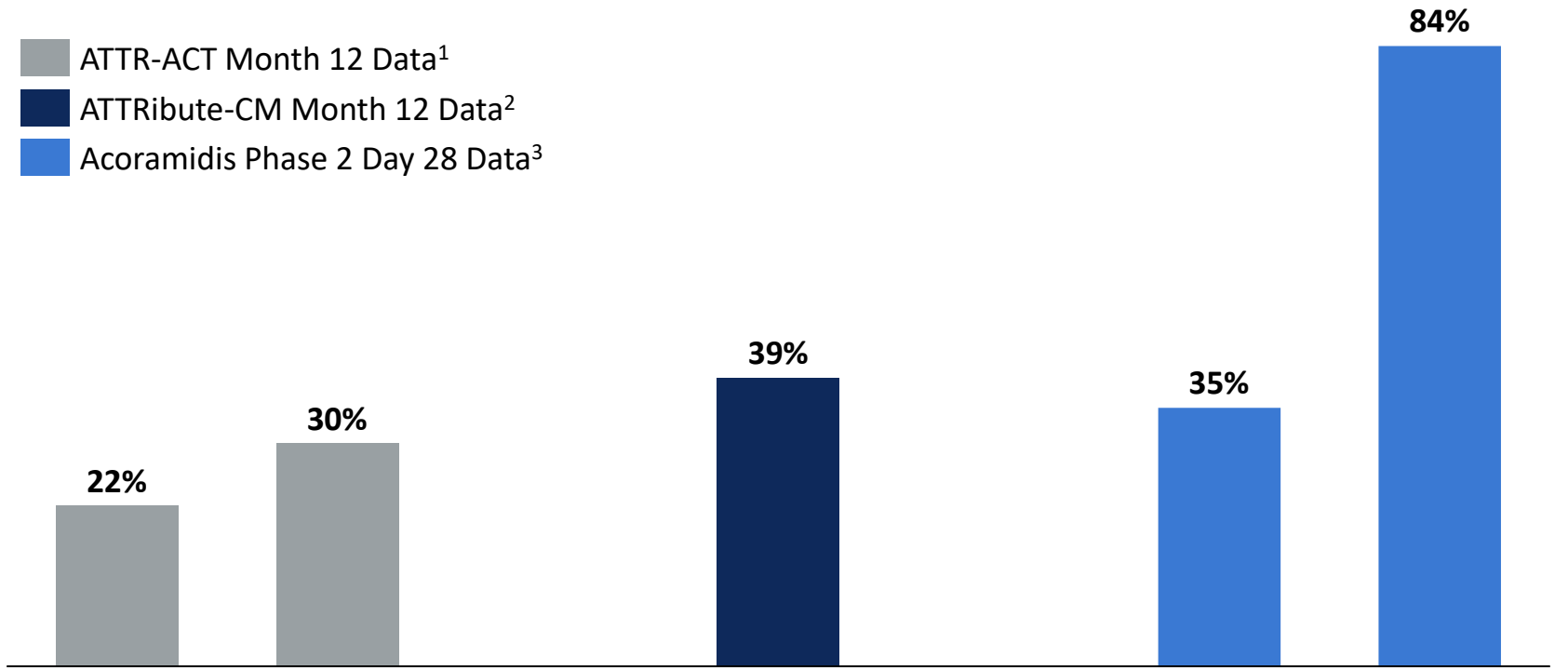
TTR Target Site Occupancy by FPE Assay[2]



Source: Ji, A.X., et al. American Heart Association Scientific Sessions 2019;140(1):13847.
[1]Western Blot quantitation of tetrameric TTR in plasma samples incubated with stabilizers. Each bar represents the percentage of tetrameric TTR remaining after 72 hr incubation at pH 3.8, n = 3 independent experiments. DMSO = control.
[2]FPE characterization of TTR binding site occupancy in serum incubated with stabilizer, n = 12 for each condition tested.

Acoramidis increases serum TTR significantly more than tafamidis

Serum TTR (mean % change from baseline)



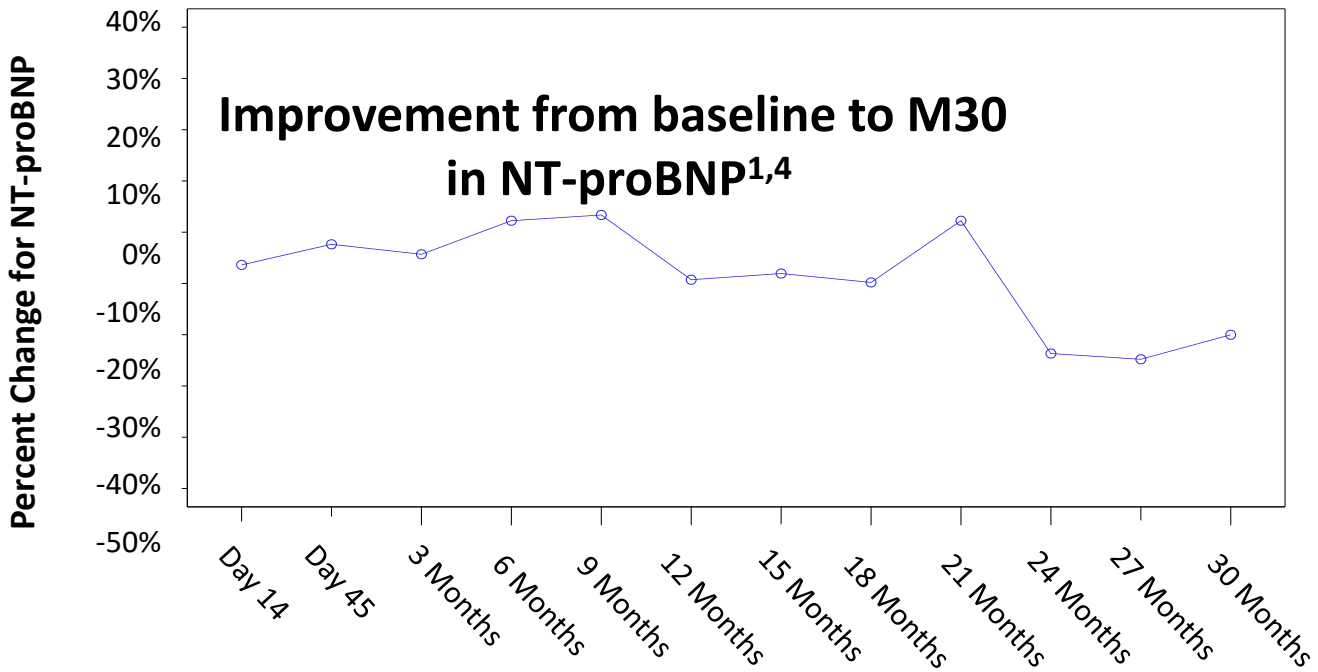
N	176	88	~421	11	5

Note: Direct cross-study comparisons may suggest misleading similarities or differences. The values shown are directional and do not report robust comparative analysis.

[1]Estimated from Damy, T., et al., Eur J Heart Fail. 2021;23(2):277-285; [2]BridgeBio Part A press release, December 27, 2021. [3]Heitner SB, et al. J Am Coll Cardiol. 2019, 73(9):660. Oral presentation at ACC 2019.

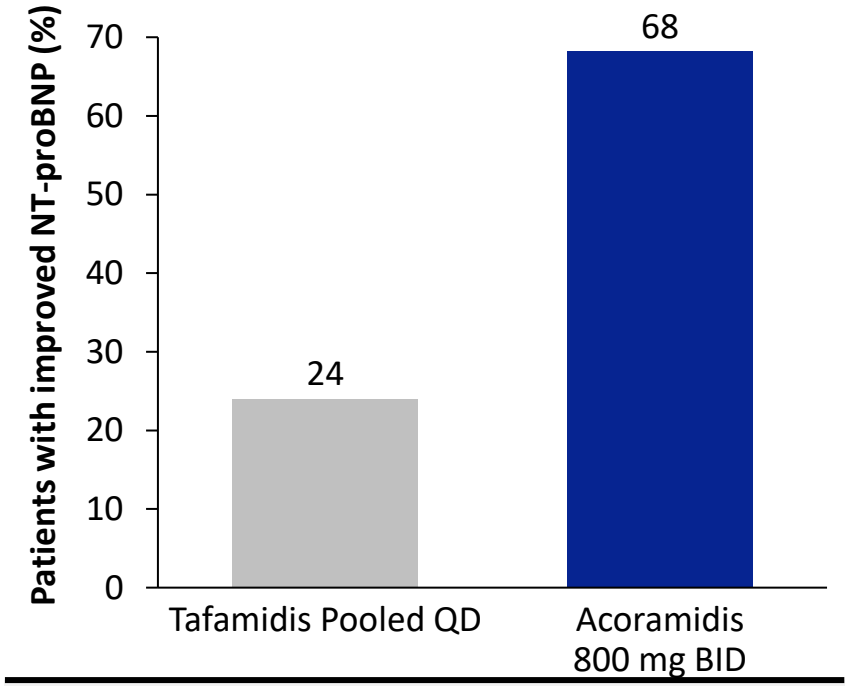
Acoramidis improves median NT-proBNP at 30 months

Median percent change from baseline in NT-proBNP[1,2]



N[3]	47	45	46	43	40	38	33	24	11	23	17	22

Improvement from baseline to M30 in NT-proBNP[1,4]



N	173	22

NT-proBNP is emerging as a leading predictive biomarker of mortality

Note: Direct cross-study comparisons may suggest misleading similarities or differences. The values shown are directional and do not report robust comparative analysis.
[1]Masri A, et al. J Am Coll Cardiol. 2022;79(9):227. Oral presentation at ACC 2022. [2]NT-proBNP was a reported laboratory parameter, not a pre-specified safety endpoint. Baseline defined as the date of the first dose of acoramidis. [3]Represents all evaluable data from participants who continued in the study. [4]Hanna M, et al. J Am Coll Cardiol. Adv. 2022;1(5):100148.

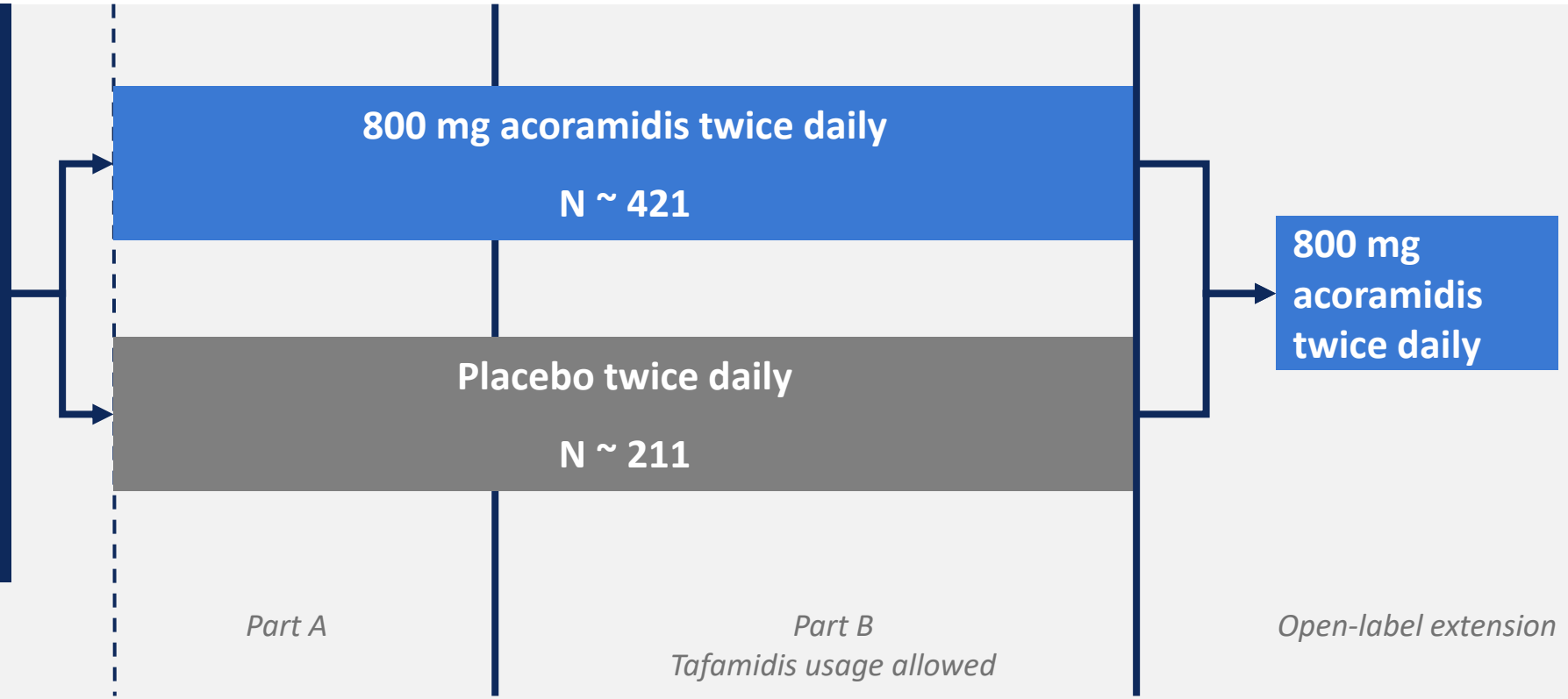
ATTRibute-CM is on track to provide Part B 30-month mortality and CV hospitalization results in mid 2023[1,2]

12-month endpoints:
Primary: Change in 6MWD
Select secondary: NT-proBNP, KCCQ

30-month endpoints:
Primary: Hierarchical composite[3] including all-cause mortality and CV-hospitalization
Select secondary: NT-proBNP, 6MWD, KCCQ

Key eligibility criteria

- Subjects with diagnosed ATTR-CM (WT or mutant)
- NYHA Class I-III
- ATTR-positive biopsy or ^{99m}Tc scan
- Light chain amyloidosis excluded if diagnosis by ^{99m}Tc



6MWD = Six-minute walk distance KCCQ = Kansas City Cardiomyopathy Questionnaire NYHA = New York Heart Association
^{99m}Tc = Technetium labeled pyrophosphate (PYP) or bisphosphonate (e.g., DPD) CV = cardiovascular-related
[1]ClinicalTrials.gov identifier: NCT03860935 [2]Gillmore JD et al. Circulation 2019;140(1):14214. Oral poster presented at AHA. [3]Primary analysis will use the Finkelstein-Schoenfeld method

Confidence in positive ATTRibute-CM Month 30 outcomes data based on Month 12 data

Month 12 | acoramidis vs. placebo		Month 30 | What gives us confidence
NT-proBNP Cardiac biomarker associated with survival in ATTR-CM	**+0.6%** vs. **+24.3%** on placebo[1]	■ Acoramidis nominally **improved quality-of-life** and **stabilized NT-proBNP** vs. placebo
Serum TTR Measure of TTR stabilization	**+38.5%** vs. **-0.7%** on placebo[1]	■ Acoramidis was **generally well-tolerated** and demonstrated **potent, sustained TTR stabilization**
KCCQ Quality-of-life measurement	**Observed improvement[2]**	■ **27% fewer treatment emergent adverse events leading to death** occurred in patients on acoramidis vs. placebo[3]

Source: BridgeBio Part A press release, December 27, 2021

[1]Nominal p<0.05 vs. placebo based on absolute change from baseline between groups

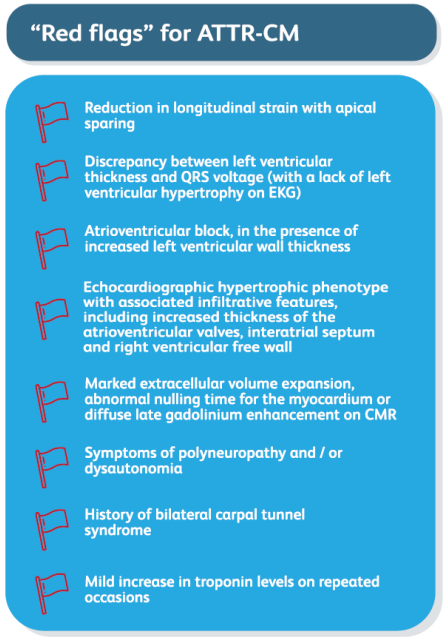
[2]Nominal P<0.05, mixed model repeated measures without imputation

[3]To protect the integrity of Part B, Sponsor's access to adverse event data for Part A excludes AEs leading to a cardiovascular hospitalization excepting events with the outcome of death

Patient standard of care has changed: Diagnosis, management, and prognosis of ATTR-CM have improved

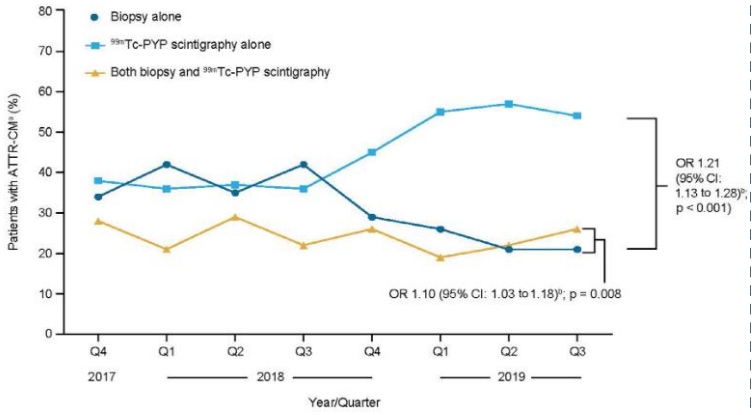
Elevated diagnostic suspicion & disease awareness

- **Rapid rise of ATTR-CM diagnoses**, particularly wildtype disease in recent years[1]



Increased adoption of non-invasive diagnostic modality[3]

- Grade 2/3 finding on bone scintigraphy **was >99% sensitive** & in the absence of a monoclonal protein **was 100% specific** in detecting ATTR-CM[2]

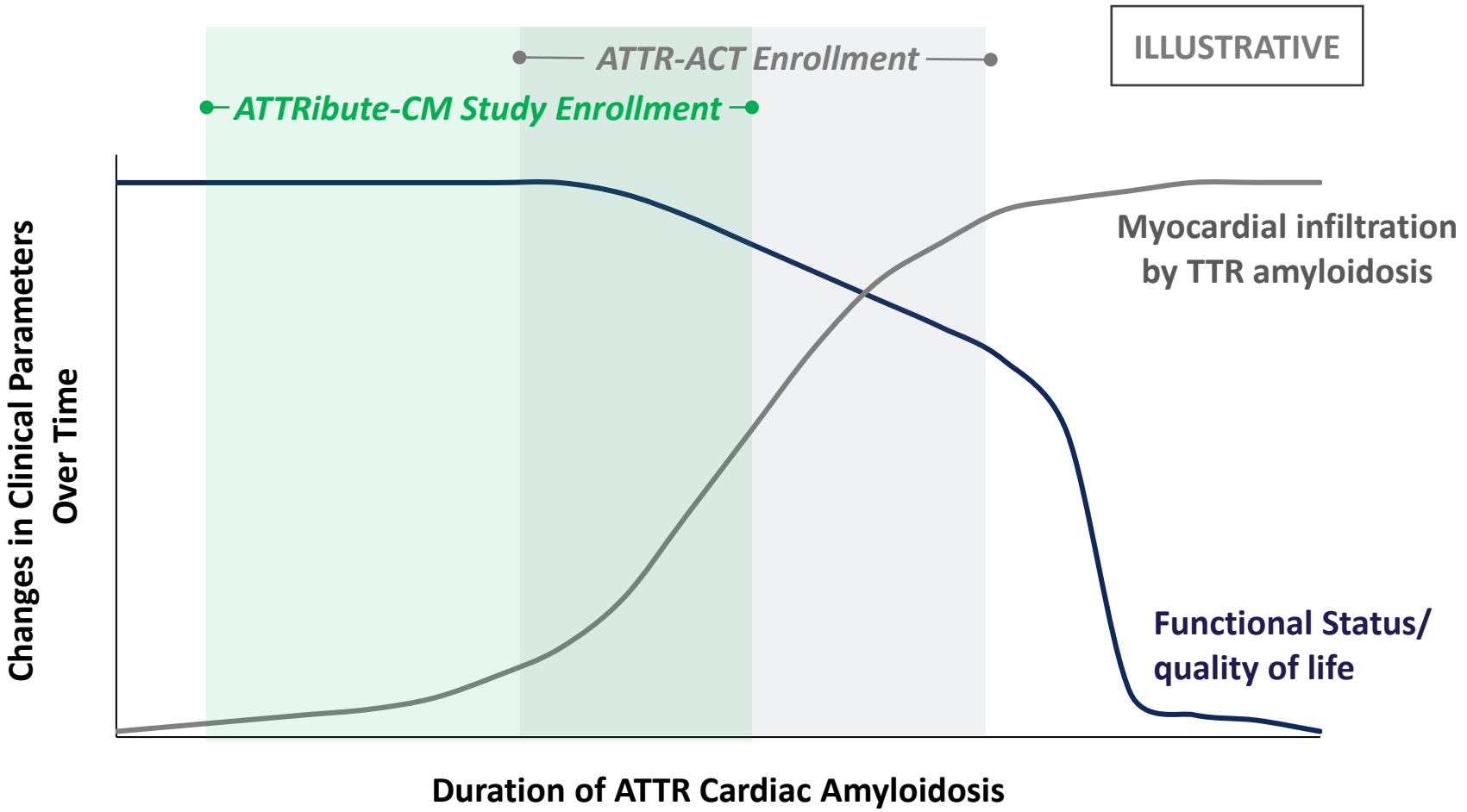


Evolving management with standard heart failure interventions[4]

- ATTR-CM patients generally have a **narrow therapeutic window for volume optimization with loop diuretics** due to stiff ventricles with limited stroke volume
- Guideline-directed medical therapy for heart failure can be **poorly tolerated due to restrictive physiology of ATTR-CM**

[1]Witteles RM, et al. JACC Heart Fail. 2019;7(8)709-716. [2]Gillmore JD, et al. Circulation. 2016;133(24):2404-2412. [3]Bourque J., et al., American Journal of Cardiology 2021; 167:98-103. [4]Stern L. et al., Methodist DeBakey Cardiovasc. Jour. 2022;18(2):59-72.

Bar for demonstrating efficacy has increased as patients are 'left-shifted' in time as compared with ATTR-ACT



Implications:

- Potential for later separation on survival
- Potential for smaller risk reduction
- Opportunity for more effective interventions given earlier presentation and residual unmet need

Source: Figure adapted from Grodin, J.L. et al., Circulation 2019;140:27-30.

ATTRibute-CM trial continues to have high operating fidelity as Part B of the study matures to 30-month outcomes readout

Ongoing fidelity of ATTRibute-CM remains high

- ✓ **Low tafamidis** drop-in rate in study participants
- ✓ **Maximum 18-month** duration on concomitant tafamidis allowed by protocol
- ✓ **Low study discontinuation** rate for reasons outside of mortality
- ✓ ATTRibute-CM was adequately powered to enroll 510 participants, and **over-enrolled by 24%** with 632 participants randomized

ATTRibute-CM Part B topline data are planned to be announced in mid-2023

Market research shows we have many ways to win

How will prescribers select which drug to use?[1]

Order of importance

1. Totality of benefit across CV outcomes (as measured by Win Ratio)
2. Absolute mortality rate on intervention – 80+% survival
3. Cardiovascular hospitalization on intervention
4. Favorable safety & tolerability profile
5. Ease of access

Best in class stabilizer adoption potential[2]

74% *of cardiologists surveyed would adopt a best-in-class stabilizer* ***within 1 year of approval*** *for newly diagnosed patients*

[1]BridgeBio market research, December 2022 (n=90)
[2]BridgeBio market research, May 2021 (n=141)

Low-dose oral FGFR inhibitor (infigratinib) for achondroplasia

- Prevalence (US & EU): **55k[1], ~10k treatable**
- Stage: **Phase 2**
- Next Catalyst: **Phase 2 update from cohort 5 (March 2023)**

Miguel
Living with achondroplasia

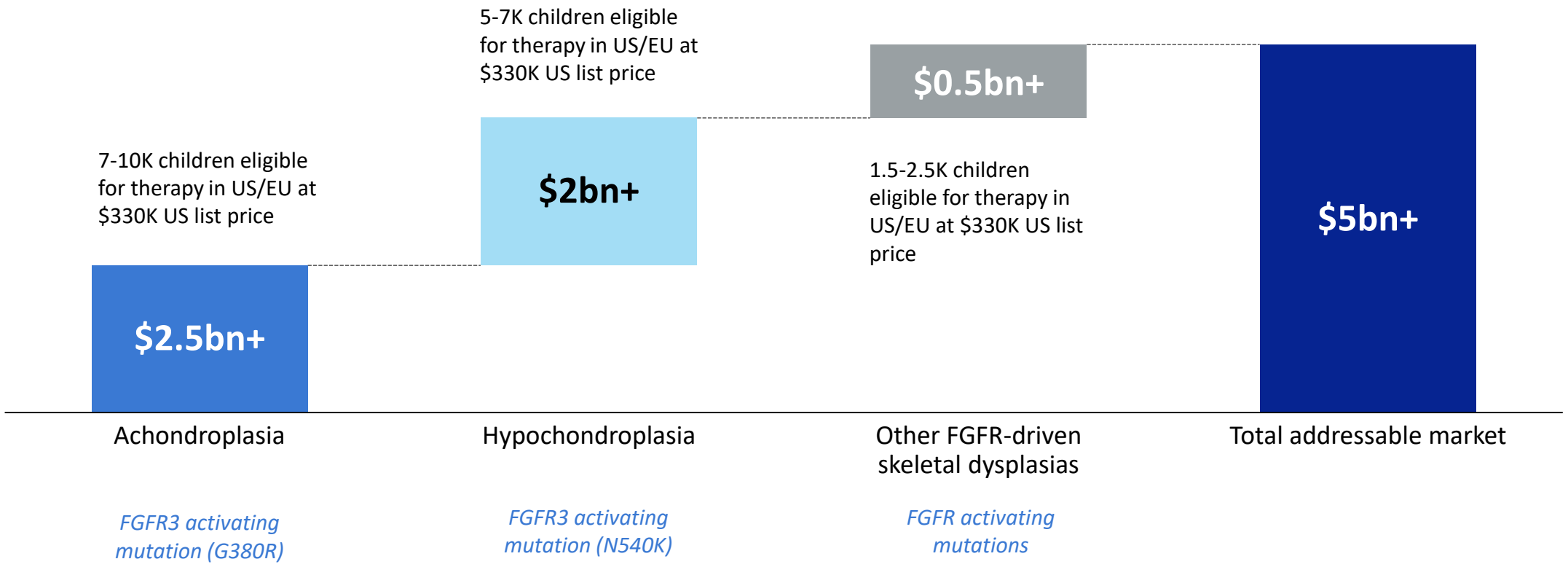
[1]55k prevalence in achondroplasia

Executive summary

- **Achondroplasia, hypochondroplasia, and other FGFR3-driven skeletal dysplasias represent a large, durable market**
  - Total addressable market greater than $5Bn
  - Vosoritide, the first approved treatment for Achondroplasia, is delivering strong sales and has seen increased guidance every quarter since launch
- **To address this market, BridgeBio is developing infigratinib as a potentially best in class product**, focusing on two design principles:
  - Target the condition at the source to maximize efficacy
  - Provide a safe oral option to avoid the need for injections
- **In preclinical mouse models infigratinib was shown to drive 3-5x greater skeletal growth** than other potential options
  - Infigratinib also demonstrated preclinical benefit in widening the foramen magnum
- **In clinical studies we have observed a clean safety profile and a +1.52 cm increase in annualized height velocity (AHV)** for cohort 4 compared to baseline
- **We expect to report on cohort 5 in mid-March** or earlier
  - Cohort 5 is twice the dose of cohort 4 (0.25 mg/kg/day vs 0.128 mg/kg/day)
  - We expect efficacy to be in line with or greater than cohort 4, with a continued clean safety profile

Achondroplasia and related FGFR-driven skeletal dysplasias represents a large durable total addressable market for infigratinib, with IP to at least 2041

Expansion of the achondroplasia opportunity into hypochondroplasia and other skeletal dysplasias could result in a total treatable population on par with other large genetic medicine franchises

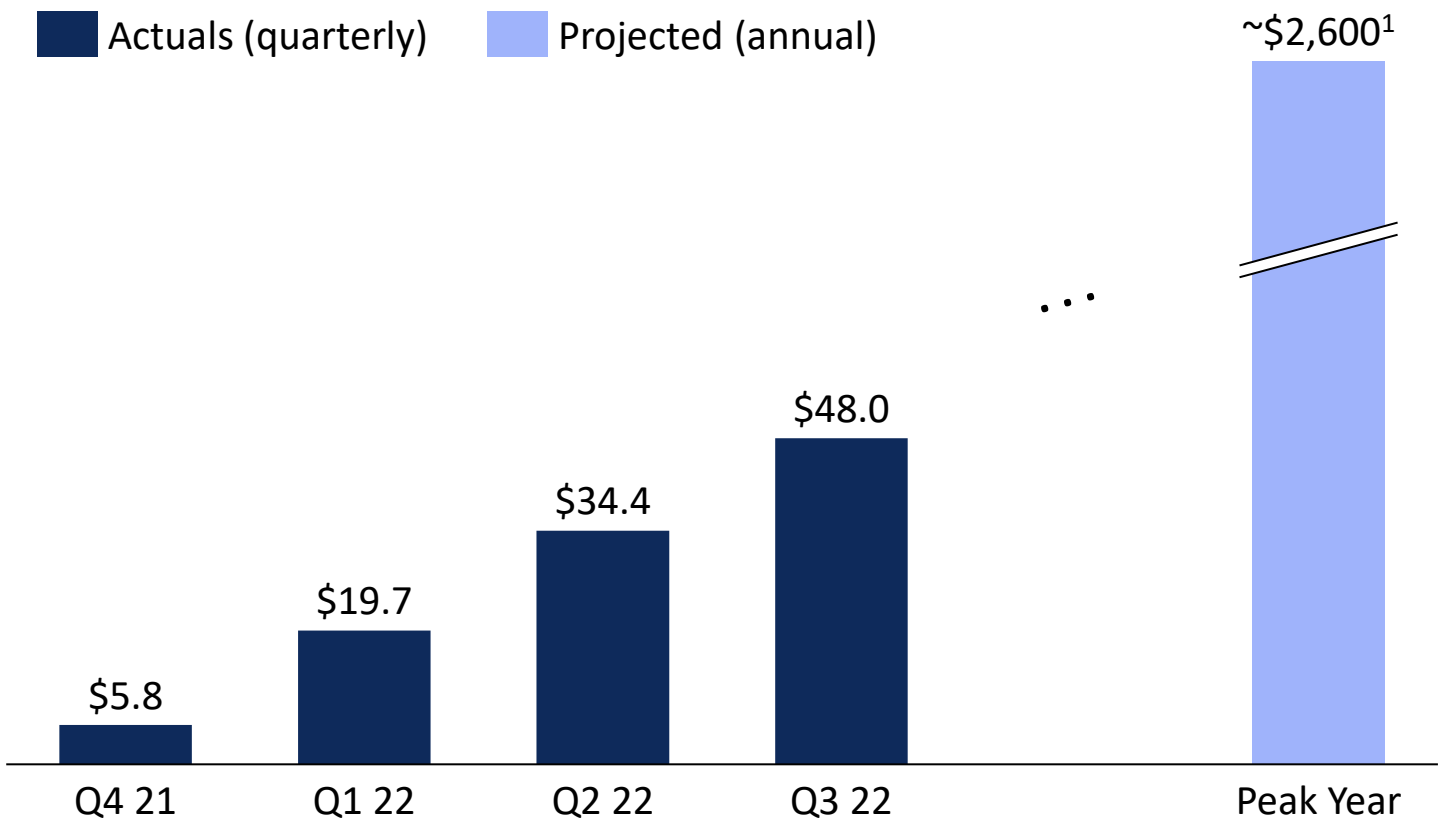


Source: [1]CDC estimates, Crisafulli, S., Sultana, J., Fontana, A. et al. Orphanet J Rare Dis. 2020, Farrell 2008 J Cystic Fibrosis. [2]Evaluate. DMD = duchenne muscular dystrophy. CF = cystic fibrosis

The achondroplasia market today is attractive and growing quickly

Global annual Achondroplasia market sales

$Mn



Drivers of market growth include:

- First available treatment increasing number of children seeking treatment
- Anticipated expansion of treatable population to include youngest children
- High enthusiasm for treatment among physicians and families has seen BioMarin increase guidance every quarter since launch
- Growing awareness among pediatric endocrinologists referred from geneticists

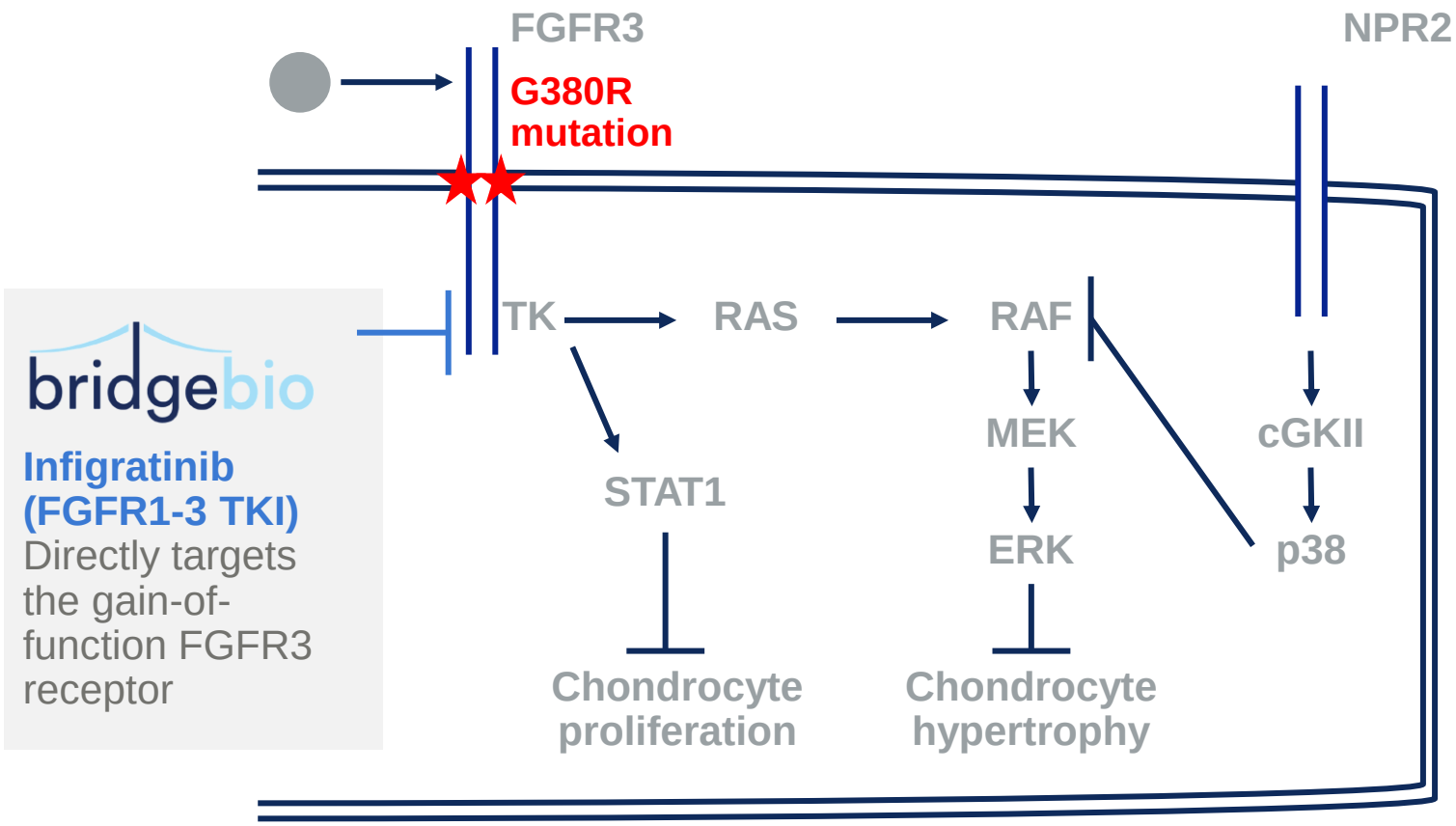
[1]FactSet consensus extended to peak year

Against this large market and unmet need, we are developing infigratinib based on two key design principles

Objectives	Design principles
✓ **Maximize efficacy** For all the manifestations of ACH—not just height– which matter for families and physicians	**Target the condition directly at the source (FGFR3)**
✓ **Avoid injections** For children and families, to reduce burden and pain of treatment	**Provide a safe oral treatment option**

Infigratinib is the only treatment option in development that incorporates both design principles

Infigratinib addresses the first design principle by directly targeting the underlying cause of achondroplasia, FGFR3 overactivity



bridgebio

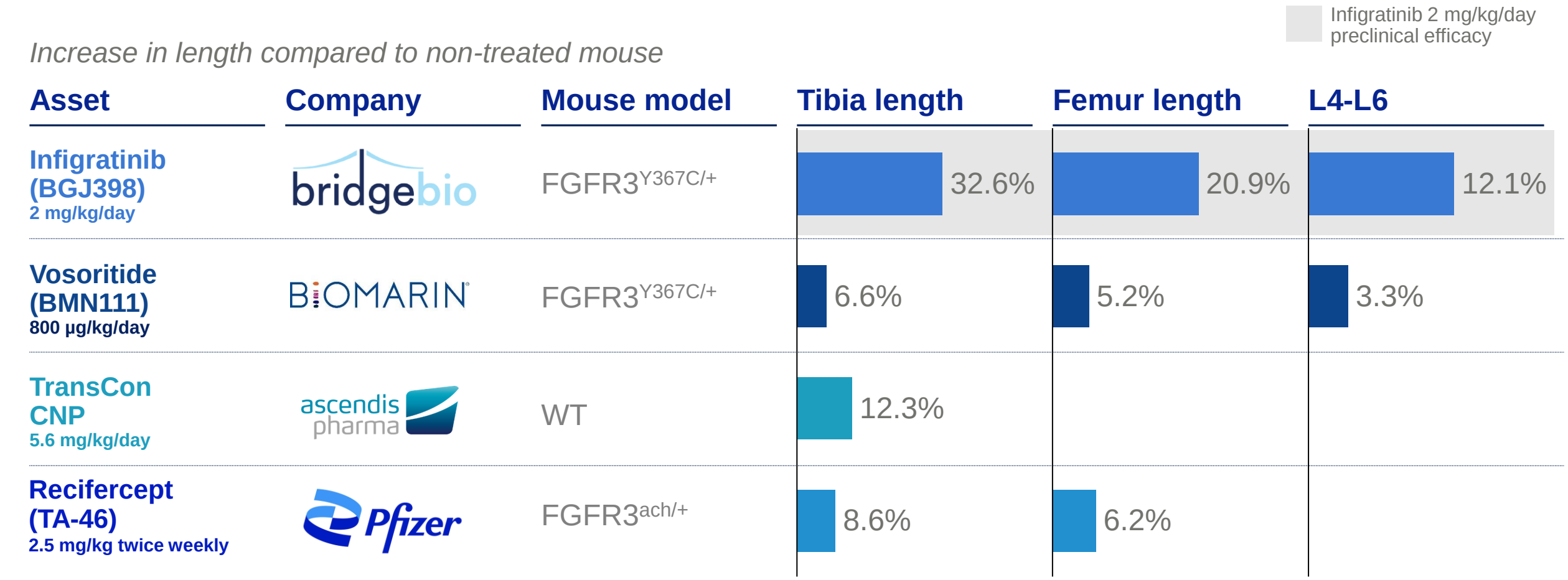
Infigratinib (FGFR1-3 TKI)
Directly targets the gain-of-function FGFR3 receptor

- Slight **gain-of-function mutation** in **FGFR3** leads to **disordered chondrocyte proliferation** and **clear genotype:phenotype**
  - **>95%** of cases **due to Gly380Arg substitution**
- Infigratinib **blocks FGFR signaling** from **inside the cell**
- Infigratinib **inhibits both pathways** responsible for the clinical phenotype associated with achondroplasia
- **Clear PD effects** in growth plate suggest **efficient penetration into target tissue**

SOURCE: Ornitz DM et al. Developmental Dynamic 2017; Richette Joint Bone Spine 2007; Unger Curr Osteoporos Rep 2017, Hoover-Fong Am J Gen Med 2017

By targeting the disease at its source, infigratinib has achieved impressive efficacy in mouse models

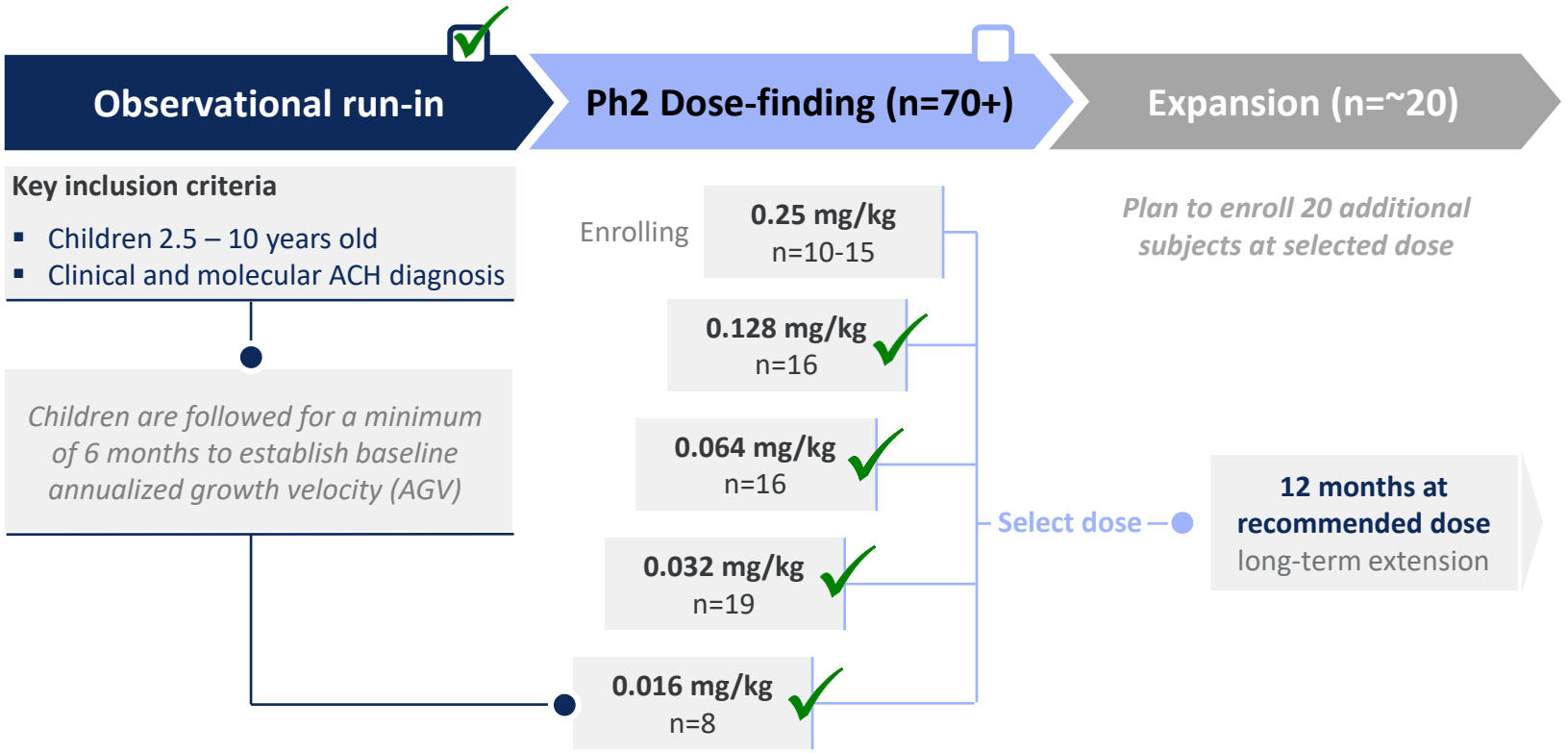
Increase in length compared to non-treated mouse



Preclinically, infigratinib has shown remarkable efficacy in bone length and a foramen magnum effect

SOURCE: Komla-Ebri J et al. Clin Inv 2016, Lorget et al. Am J Hum Genet 2012, Garcia et al. Science Trans Med 2013, Breinholt ENDO 2017.
NOTE: subcutaneous doses, percent increase compared to vehicle treated FGFR3$^{Y367C/+}$, FGFR3$^{ACH/+}$ mouse unless otherwise noted. Highest dose available for each compound is reported, this does not necessarily translate into the clinical doses

The PROPEL clinical program to evaluate infigratinib is approaching completion of Phase 2 and initiation of Phase 3



Primary objectives

- Collect baseline annualized height velocity (AHV)

- Identify safe therapeutic dose for expansion / pivotal study
- Safety and tolerability
- Change from baseline in AHV

- Confirmation of safety and efficacy at the identified dose

Next Steps

Phase 2 cohort 5 update

March 2023

Phase 3 trial initiation

2023

Future indications

- Exploring additional FGFR-driven skeletal dysplasias including hypochondroplasia
- Potential initiation of clinical studies in expansion indications in 2023

Interim Phase 2 clinical data from Cohort 4 suggests encouraging tolerability profile and potential for best-in-class efficacy at the Cohort 5 dose level

+1.52 cm/yr

mean increase in annualized height velocity (AHV) across all children 5 years or older in cohort 4

- 0.61 cm/yr mean increase in AHV across all children 3 to <5 years of age
- Baseline AHV of 4.01 cm/yr across all children in cohort 4

Well-tolerated with 0 SAEs

- No discontinuations due to AEs
- No dose dependent phosphate elevation
- No ocular AEs

64% responder rate

across all children 5 years or older in cohort 4

- Responses were consistently seen irrespective of baseline AHV

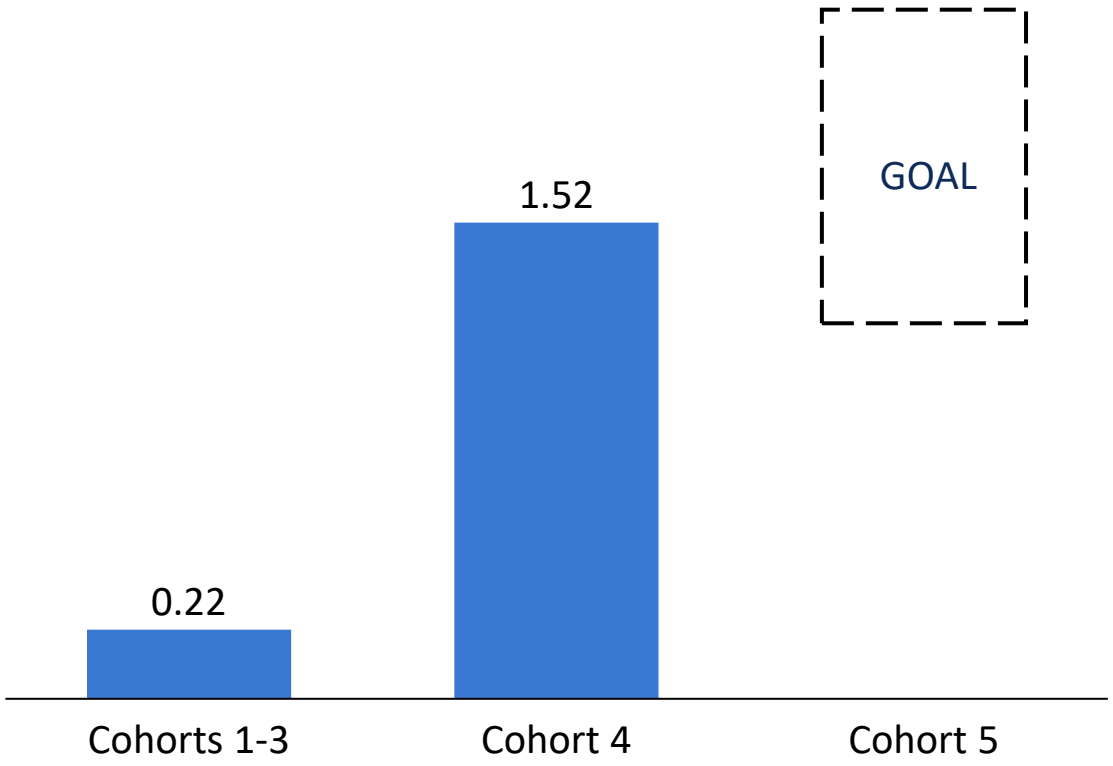
Statistically significant increase in biomarker

- Collagen X is an accepted biomarker for collagenous growth
- No previous cohort has demonstrated significant increases

Source: data on file
Data based on longest available follow-up at time of data cut

What are we looking for from our achondroplasia cohort 5 update?

Mean change from baseline in annual height velocity,
cm/yr



We are measuring and looking for:

- Clean safety, in-line with cohort 4 and prior disclosure on cohort 5 (no SAEs, no AEs requiring dose modification including hyperphosphatemia)
- Efficacy across 3 measures: change from baseline AHV, responder rate, and % of children getting to 7 cm/yr
- We believe it's essential to have clear baselines for growth and a range of ages to demonstrate compelling efficacy
    - A baseline is critical: Inter-patient variability is greater than intra-patient variability

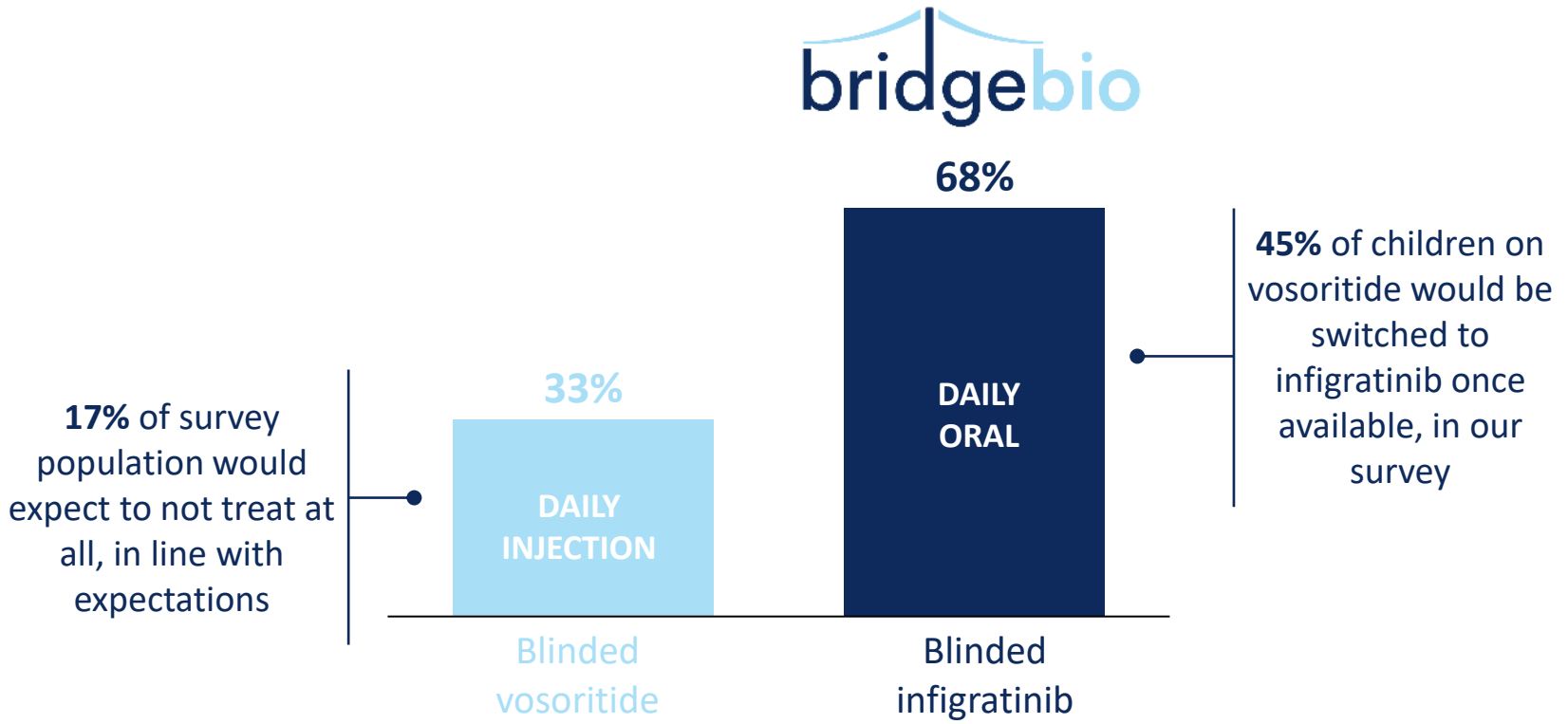
Market research validates the importance of infigratinib's oral route of administration, suggesting majority share even without an efficacy edge

- Blinded survey of a representative sample of 54 HCPs who treat ACH (50/50 academic/community)
- We tested preference for a blinded infigratinib TPP vs blinded vosoritide TPP ***with equivalent efficacy***
- The blinded infigratinib TPP closely matches the Cohort 4 profile, with upside potential for cohort 5
- Oral ROA is a major draw vs injectables

"Our daughter was in the BMRN trial, but we had to discontinue because of the trauma we experienced as a family due to the daily injections. How can I learn about enrolling in QED's trial?"

HCP survey of vosoritide vs. infigratinib showing equivalent efficacy

% of children with achondroplasia seeking treatment who would potentially receive each product



We see room for significant market share upside with a best-in-class efficacy profile

Source: US market research testing blinded product profiles for vosoritide and infigratinib among HCPs who treat children with achondroplasia; responses weighted by specialty (31 endos, 23 geneticists).

Quick hits on other value drivers – all $1bn+ markets

Program	Stage	Next update	Timing guidance
AAV5 gene therapy for CAH	Ph1/2	Ph2 data	2H23
Encaleret (CaSRi) for ADH1	Ph3	Ph3 topline data	YE23/1H24
Ribitol for LGMD2i	Ph3-ready	Ph3 initiation and FDA Feedback	2023
Next gen dual G12Ci (BBO-8520)	IND-enabling	Ph1 initiation	2023 (clinical data 2024)