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ATTRibute-CM Part B Expectation Setting

1H 2023

Forward-looking statements

This presentation contains forward-looking statements. Statements in this presentation may include statements that are not historical facts and are considered forward-looking within the meaning of Section 27A of the Securities Act of 1933, as amended (the Securities Act), and Section 21E of the Securities Exchange Act of 1934, as amended (the Exchange Act), which are usually identified by the use of words such as “anticipates,” “believes,” “estimates,” “expects,” “intends,” “may,” “plans,” “projects,” “seeks,” “should,” “will,” and variations of such words or similar expressions. We intend these forward-looking statements to be covered by the safe harbor provisions for forward-looking statements contained in Section 27A of the Securities Act and Section 21E of the Exchange Act. These forward-looking statements, including statements relating to the clinical, therapeutic and market potential of our programs and product candidates, including our clinical development program for acoramidis for transthyretin amyloid cardiomyopathy (ATTR-CM), including the progress of our ongoing Phase 3 ATTRibute-CM trial of acoramidis and any other planned clinical trials of acoramidis, the availability and success of topline results from the month 30 endpoint of our Phase 3 ATTRibute-CM trial of acoramidis, the potential benefits of acoramidis for ATTR-CM, including any clinical expectation and market expectation, our planned interactions with regulatory authorities, and the timing of these events, among others, reflect our current views about our plans, intentions, expectations and strategies, which are based on the information currently available to us and on assumptions we have made. Although we believe that our plans, intentions, expectations and strategies as reflected in or suggested by those forward-looking statements are reasonable, we can give no assurance that the plans, intentions, expectations or strategies will be attained or achieved. Furthermore, actual results may differ materially from those described in the forward-looking statements and will be affected by a number of risks, uncertainties and assumptions, including, but not limited to, initial and ongoing data from our preclinical studies and clinical trials not being indicative of final data, the potential size of the target patient populations our product candidates are designed to treat not being as large as anticipated, the design and success of ongoing and planned clinical trials, difficulties with enrollment in our clinical trials, adverse events that may be encountered in our clinical trials, the United States Food and Drug Administration or other regulatory agencies not agreeing with our regulatory approval strategies, components of our filings, such as clinical trial designs, conduct and methodologies, or the sufficiency of data submitted, potential adverse impacts due to COVID-19, such as delays in regulatory review, manufacturing and supply chain interruptions, adverse effects on healthcare systems and disruption of the global economy, the impacts of current macroeconomic and geopolitical events, including changing conditions from hostilities in Ukraine, increasing rates of inflation and rising interest rates, on our overall business operations and expectations, as well as those risks set forth in the Risk Factors section of our Annual Report on Form 10-K for the year ended December 31, 2022 and our other filings with the U.S. Securities and Exchange Commission. Moreover, we operate in a very competitive and rapidly changing environment in which new risks emerge from time to time. These forward-looking statements are based upon the current expectations and beliefs of our management as of the date of this presentation and are subject to certain risks and uncertainties that could cause actual results to differ materially from those described in the forward-looking statements. Except as required by applicable law, we assume no obligation to update publicly any forward-looking statements, whether as a result of new information, future events or otherwise

Questions we will address today

Clinical expectations

- How do we compare to available therapy?
- What does superiority look like?
- What are our clinical expectations?

Market expectations

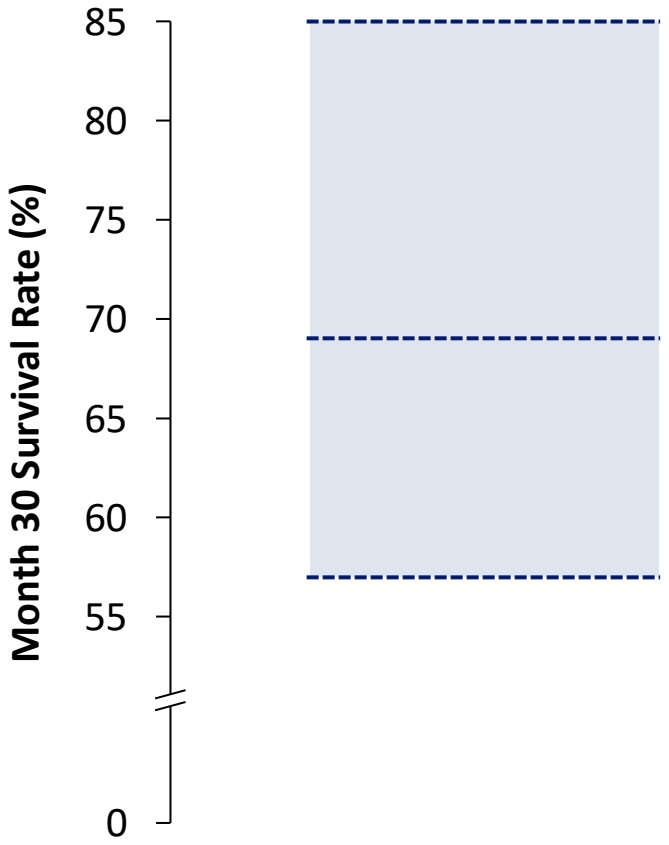
- How large and durable is this market?
- How much share do we expect?
- What are upside drivers?

Agenda

- **Expectations – toward the elimination of ATTR-CM survival risk, but with a higher bar**
- **Deep dive on population expectations**
- **Deep dive on commercial**
  - **This is a large market**
  - **This is a durable market**
  - **Market share expectations**
  - **Case studies in upside for share and market expansion with multiple brands**

Where we started (as a field)…

30-Month Survival Rate in ATTR-CM
Illustrative



'Life without ATTR-CM'
85% survival independent of ATTR-CM[1,2]

***ATTR-ACT* 'Partial stabilization'**
70% survival

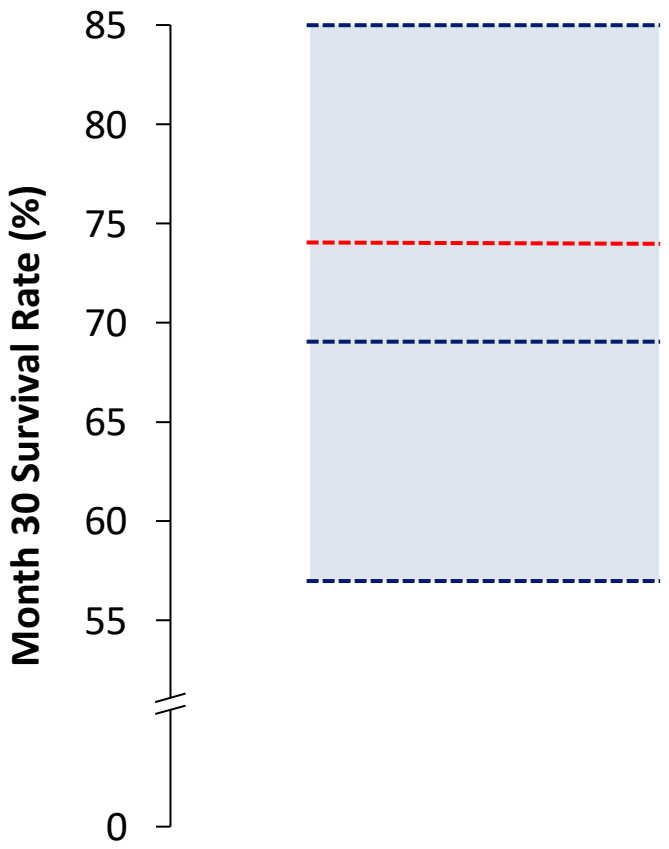
ATTR-ACT placebo
57% survival

Tafamidis, starting against a low baseline of survival, drives us ~45% toward the goal

[1]ssa.gov. Linearly extrapolated as annual survival probability of a 77 year-old male in the US for 30-months. 2 Miller et al., Am J Card 2021.
Source: Maurer et al., NEJM 2018.

...medical management improves survival dramatically…

30-Month Survival Rate in ATTR-CM
Illustrative



'Life without ATTR-CM'
85% survival independent of ATTR-CM

Contemporary ATTR-CM survival[2-6,*]
74% survival

***ATTR-ACT* 'Partial stabilization'[1]**
70% survival

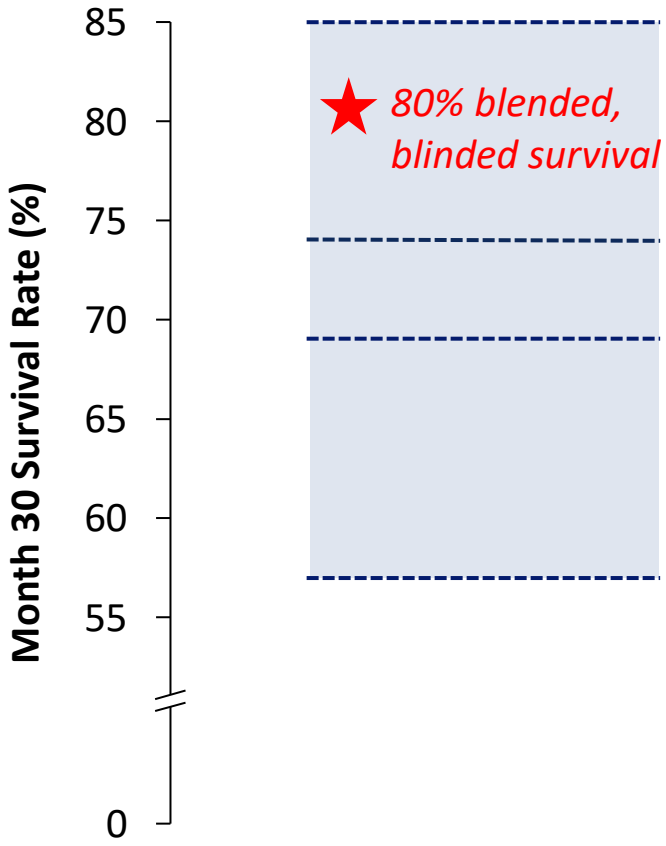
ATTR-ACT placebo[1]
57% survival

Improved medical management implies today's placebo will be better than the tafamidis arm of ATTR-ACT

Sources: [1]Maurer et al., NEJM 2018. [2]Gillmore et al., J Eur Heart 2018. [3]Hanson et al., Circulation 2018. [4]Lane et al., Circulation 2019. [5]Law S. et al., Heart 2021. [6]Ioannou et al., Circulation 2022.
[*]Adjusted for ATTRibute-CM NYHA distribution

…and leads us to ask: Can a more potent stabilizer now get us toward the elimination of ATTR survival risk?

30-Month Survival Rate in ATTR-CM
Illustrative



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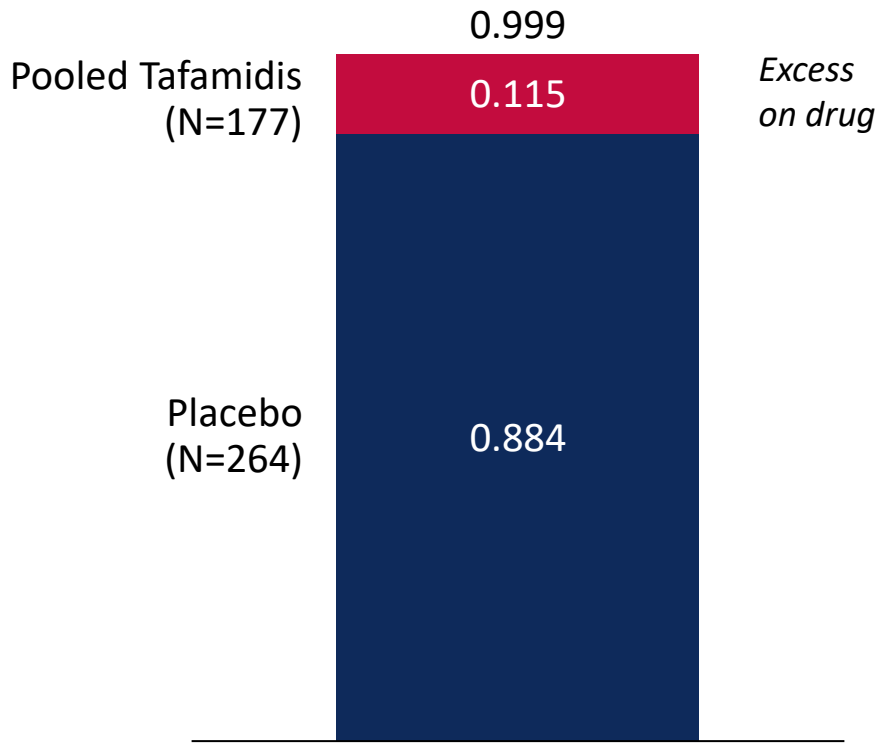
[*]Adjusted for ATTRibute-CM NYHA distribution

In addition to survival, there is ample room to improve on CV hospitalization rates, a key clinical and pharmacoeconomic parameter

Mean Frequency of CV Hospitalization Events per Year

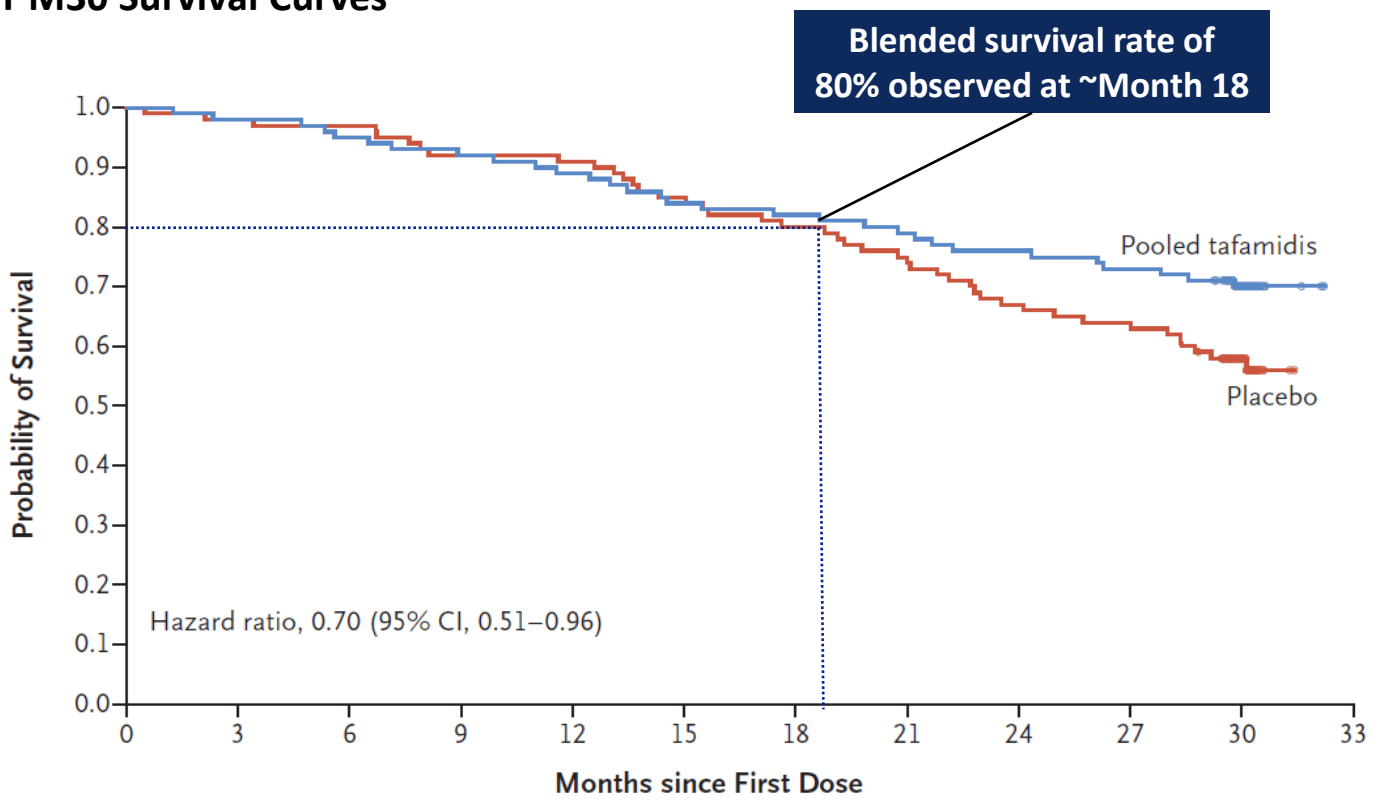


- **Mean Frequency of CV Hospitalization on Tafamidis is 0.999 which is greater than placebo (0.884)**
- **Average cost of ATTR-CM hospitalization is $16-20K**

Source: Tafamidis NDA Statistical Review, 2019.

The challenge: At these levels of blended survival, there was no separation observed in ATTR-ACT

ATTR-ACT M30 Survival Curves



No. at Risk (cumulative no. of events)

Pooled tafamidis	264 (0)	259 (5)	252 (12)	244 (20)	235 (29)	222 (42)	216 (48)	209 (55)	200 (64)	193 (71)	99 (78)	0 (78)
Placebo	177 (0)	173 (4)	171 (6)	163 (14)	161 (16)	150 (27)	141 (36)	131 (46)	118 (59)	113 (64)	51 (75)	0 (76)

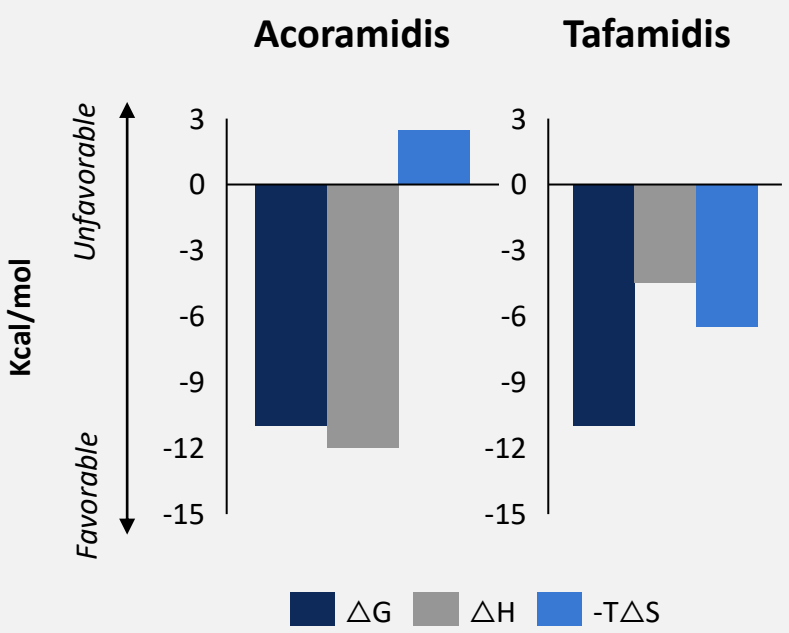
ATTRibute-CM is left-shifted in time by **~12 months** relative to ATTR-ACT

Acoramidis needs to be **more potent to separate** from placebo

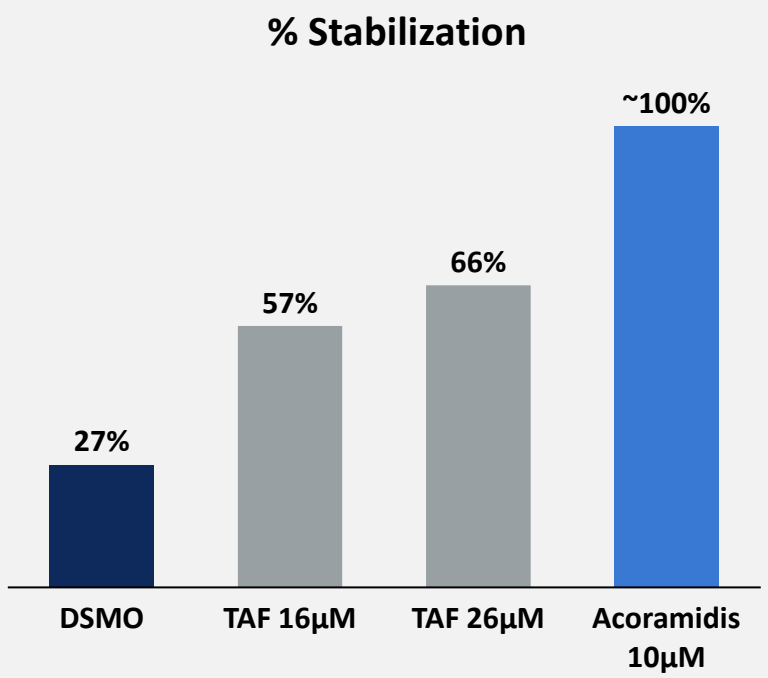
Figure adapted from: Maurer et al., NEJM 2018.

Reminder: A more potent drug is required and we have one

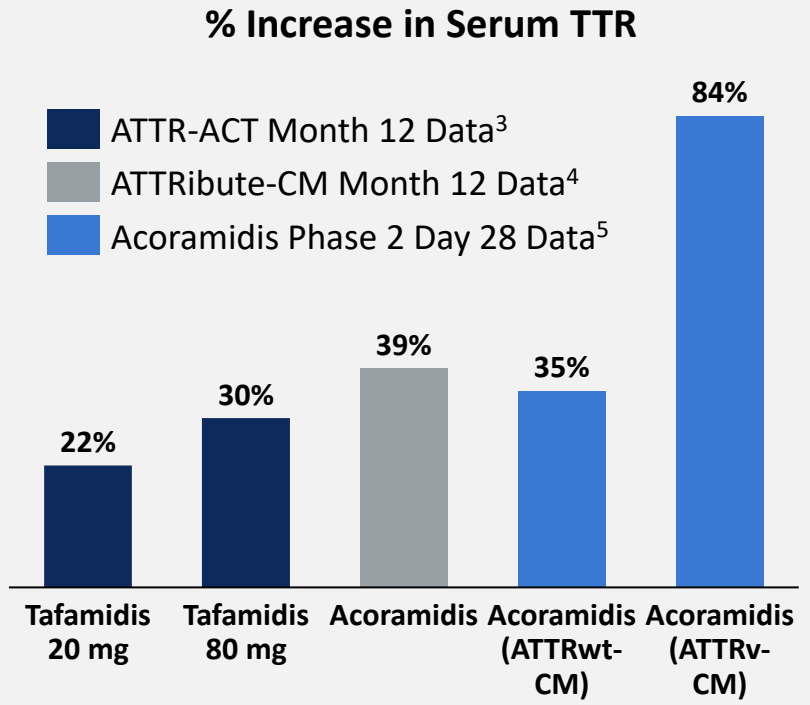
Superior Binding to TTR in vitro[1]
facilitated by enthalpic interactions



Near-Complete TTR Stabilization[2]
at target trough clinical concentrations



Rapid, durable increases in serum TTR
an in vivo marker of native tetramer stability



Acoramidis sees more target (superior %F), binds more target (superior kd2), and glues the target together stronger (enthalpic binding mode)

[1]Miller, M. et al. Jour Med Chem, 2018. [2]Ji, A.X., et al. American Heart Association Scientific Sessions, 2019. [3]Estimated from Damy, T., et al., Eur J Heart Fail. 2021;23(2):277-285; [4]BridgeBio Part A press release, December 27, 2021. [5]Heitner SB, et al. J Am Coll Cardiol. 2019, 73(9):660. Oral presentation at ACC 2019.

A higher bar but a more potent drug – our expectations

Base outcome – market share ~25%

- **Achieve statistical significance on primary endpoint:** p-value <0.04
- **Unprecedented survival**: Highest ever 30-month survival rate on drug (>80%) with clinically meaningful separation from placebo
- **Best-in-class serum biomarkers:** NT-proBNP, serum TTR, TTR stabilization

Best possible – market share ~40%+

- **Achieve statistical significance on primary endpoint:** p-value <0.04
- **Unprecedented survival**: Highest ever 30-month survival rate on drug (>80%) with clinically meaningful separation from placebo
- **Best-in-class serum biomarkers:** NT-proBNP, serum TTR, TTR stabilization
- **Best-in-class CV hospitalization data**: Profound reduction in event rates consistent across multiple analyses
- **Win-ratio better than 1.7**: Best-in-class with significant impacts on mortality and morbidity

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  - This is a durable market
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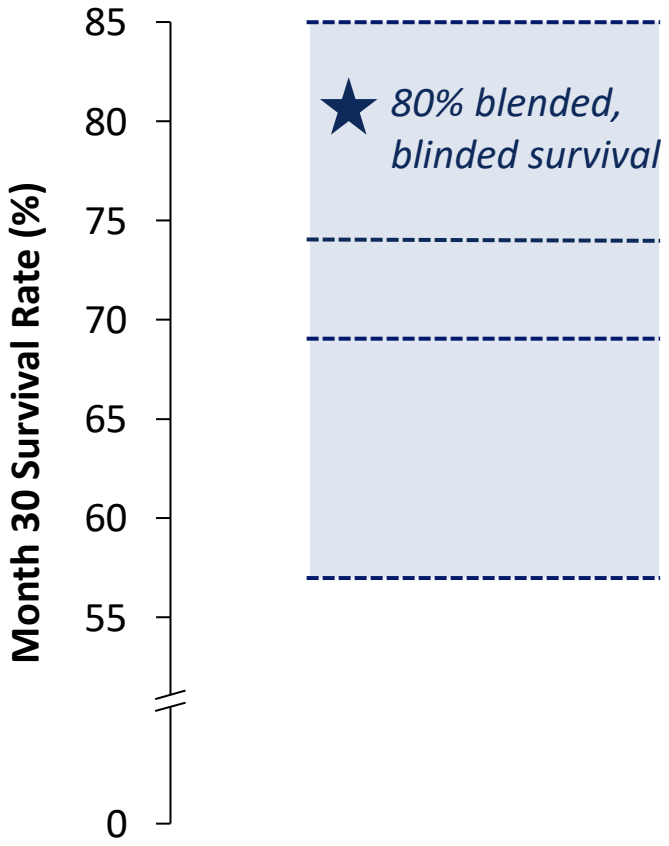
Can a more potent stabilizer now get us toward the elimination of ATTR survival risk?

30-Month Survival Rate in ATTR-CM
Illustrative



'Life without ATTR-CM'
85% survival independent of ATTR-CM 1

Contemporary ATTR-CM survival[2-6,*] 2
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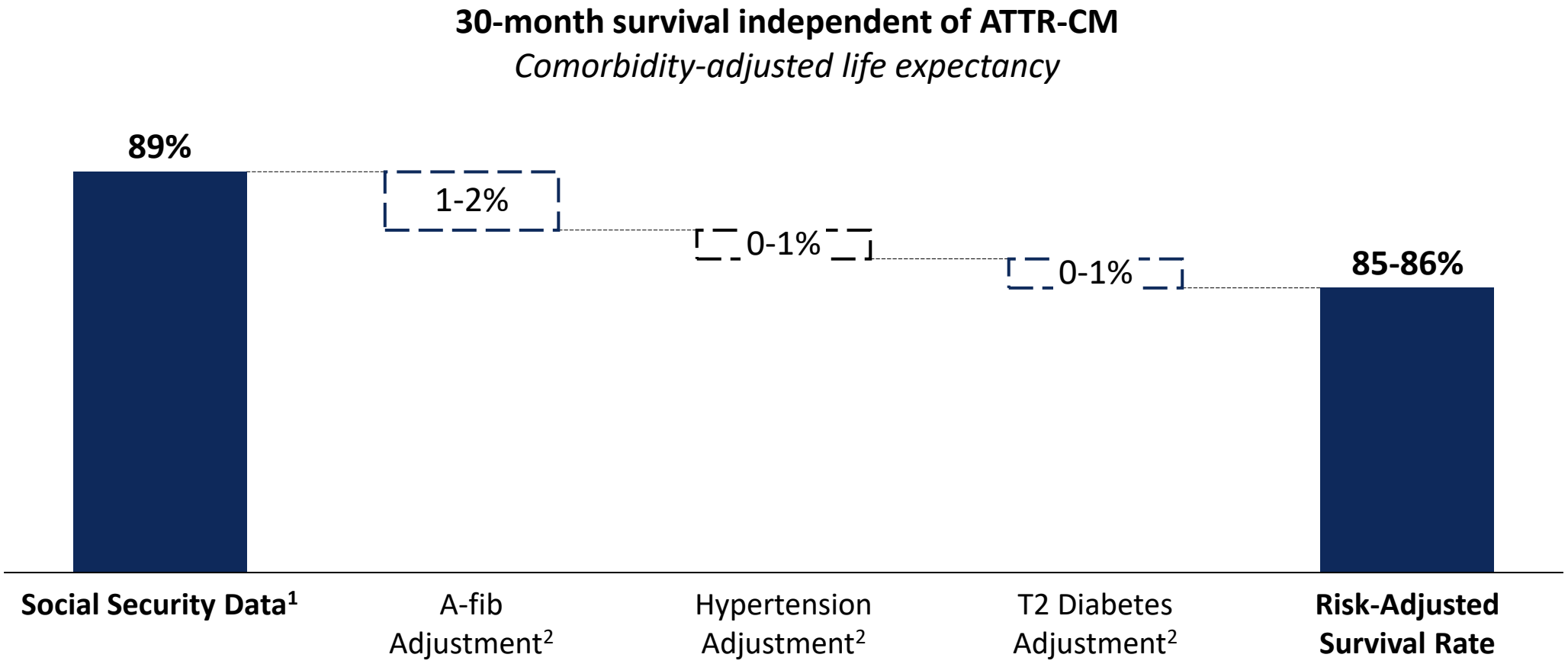
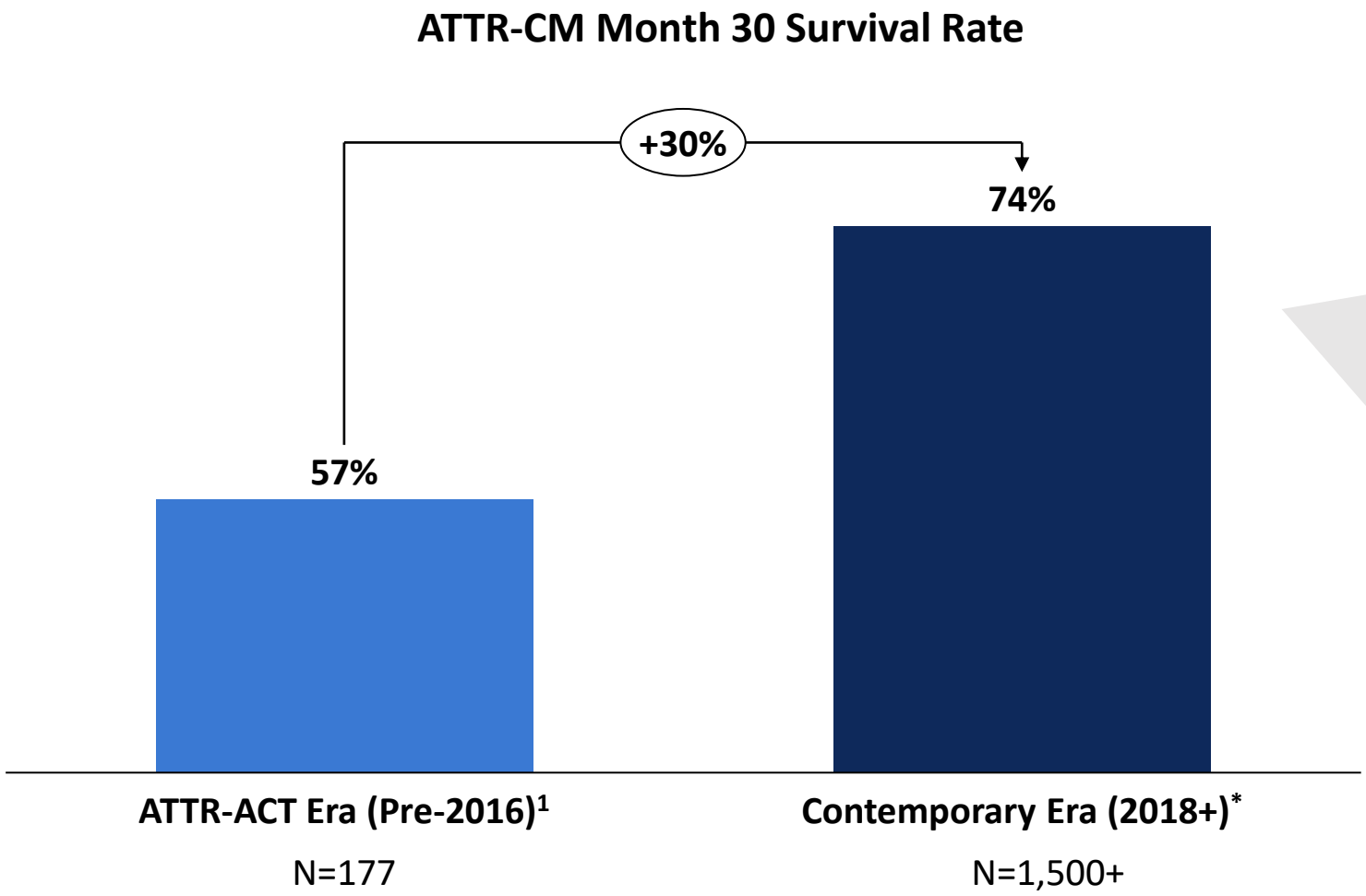
[*]Adjusted for ATTRibute-CM NYHA distribution

1 30-month survival rate, independent of ATTR-CM, in ATTRibute-CM study cohort is estimated to be 85-86%



[1]ssa.gov. Linearly extrapolated as annual survival probability of a 77 year-old male in the US for 30-months. 2 Miller et al., Am J Card 2021.
Note: a second method assessing survival probability triangulates to a similar estimate.
A-fib = atrial fibrillation/flutter; T2 Diabetes = Type 2 Diabetes Mellitus.

2 Survival rate in ATTR-CM has improved since ATTR-ACT



Representative of 5 observational ATTR-CM cohorts in the absence of disease-modifying intervention:

- Gillmore et al., J Eur Heart 2018
- Hanson et al., Circulation 2018
- Lane et al., Circulation 2019
- Law S. et al., Heart 2021
- Ioannou et al., Circulation 2022

Sources: [1]Maurer et al., NEJM 2018.
*Adjusted for ATTRibute-CM NYHA distribution

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Market expectations

- How large and durable is this market?
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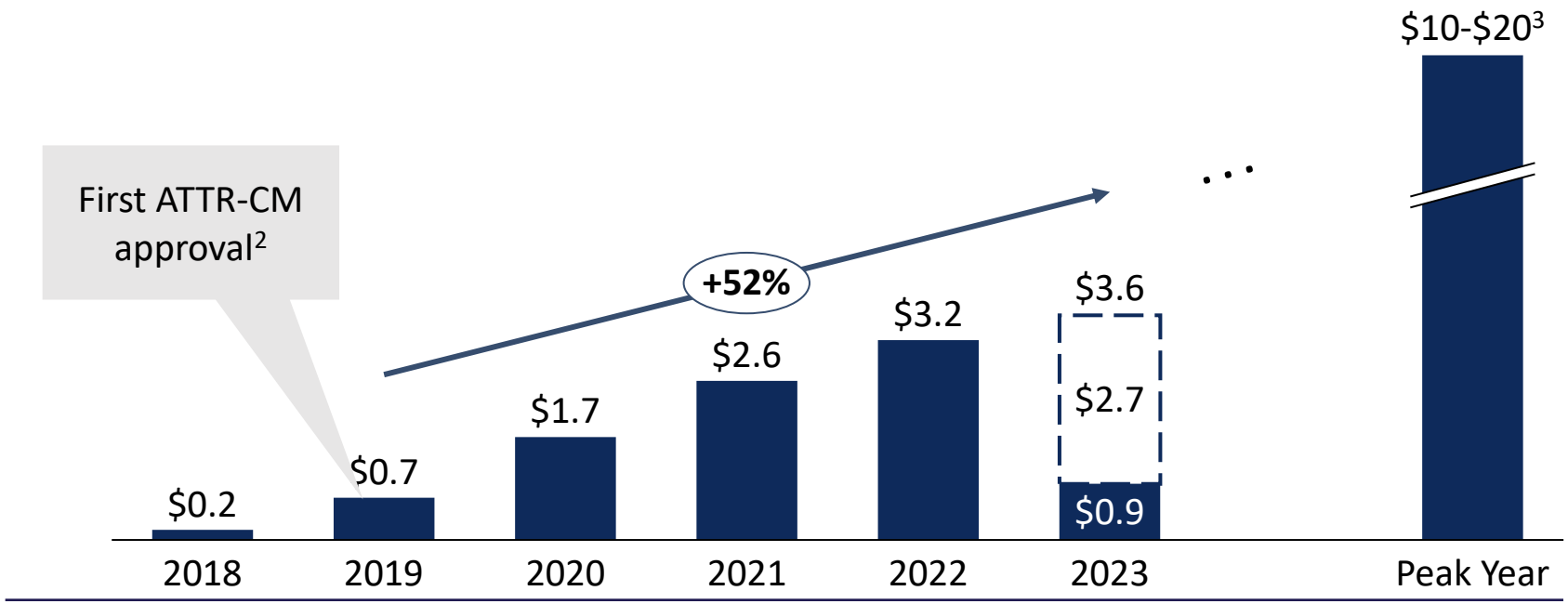
The market is large: ATTR-CM has grown into a multi-billion dollar global market in 3 years and is primed for continued expansion

Global annual ATTR market sales[1]

$B



ATTR-CM Approved Products	1	1	1	1	1	5+

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** anticipated to reduce patient out-of-pocket expenditure
- **Durable market growth** with Vyndamax polymorph patent protection through 2035[4]
- **Entrance of multiple brands** tends to drive diagnosis rates up

[1]ATTR market includes all approved drugs for ATTR-PN and ATTR-CM
[2]First ATTR-CM sales occurred in Q2 2019
[3]Consensus estimates of $10B+ ATTR-CM market; BBIO model (next page)
[4]Orange Book

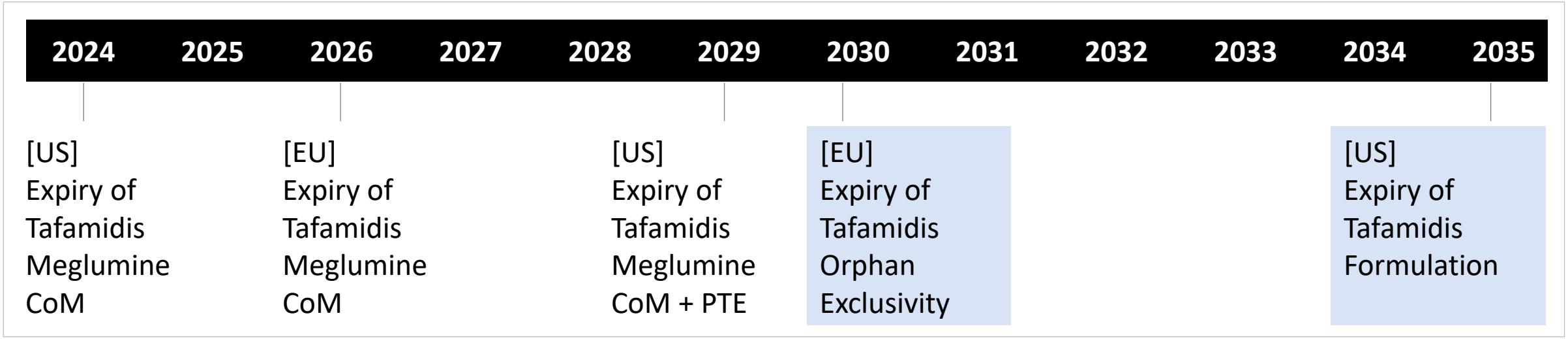
The market is large: TTR model supports $20B global market with improved IRA-driven access

	US	EU[1]	ROW	Methodology
Prevalent Population	240,000	250,000	480,000	*Epidemiology from leading literature*
(x) Diagnosis Rate at Peak	45%	45%	16%	
(x) Prescription Rate	85%	60%	45%	*Linear extrapolation from historical rates*
(x) Fulfillment Rate (US)/Reimbursement Rate (Ex-US)	66% *(prev. 61%)*	90%	90%	
(x) Paying Patients (% not receiving free drug)	80% *(prev. 75%)*	100%	100%	*BridgeBio internal calculation from IQVIA claims data*
(x) Annual Price	$200,000	$130,000	$80,000	
(=) Addressable Market	$9.7B	$7.9B	$2.5B	
(+) Total Addressable Market (Post-IRA)	**$20.1B**			
Benefit to US market from IRA	*$1.3B (+13%)*			

Note: Assumes peak year in 2035 per earliest ATTR-CM product expiry (Vyndamax)
[1]Represents broader Europe

The market is durable: IP and regulatory designations estimated to provide tafamidis market exclusivity to 2030 & 2035 in the EU & US, respectively

Estimated Tafamidis IP & Regulatory Exclusivity Timeline



Acoramidis expected to have market exclusivity until 2039

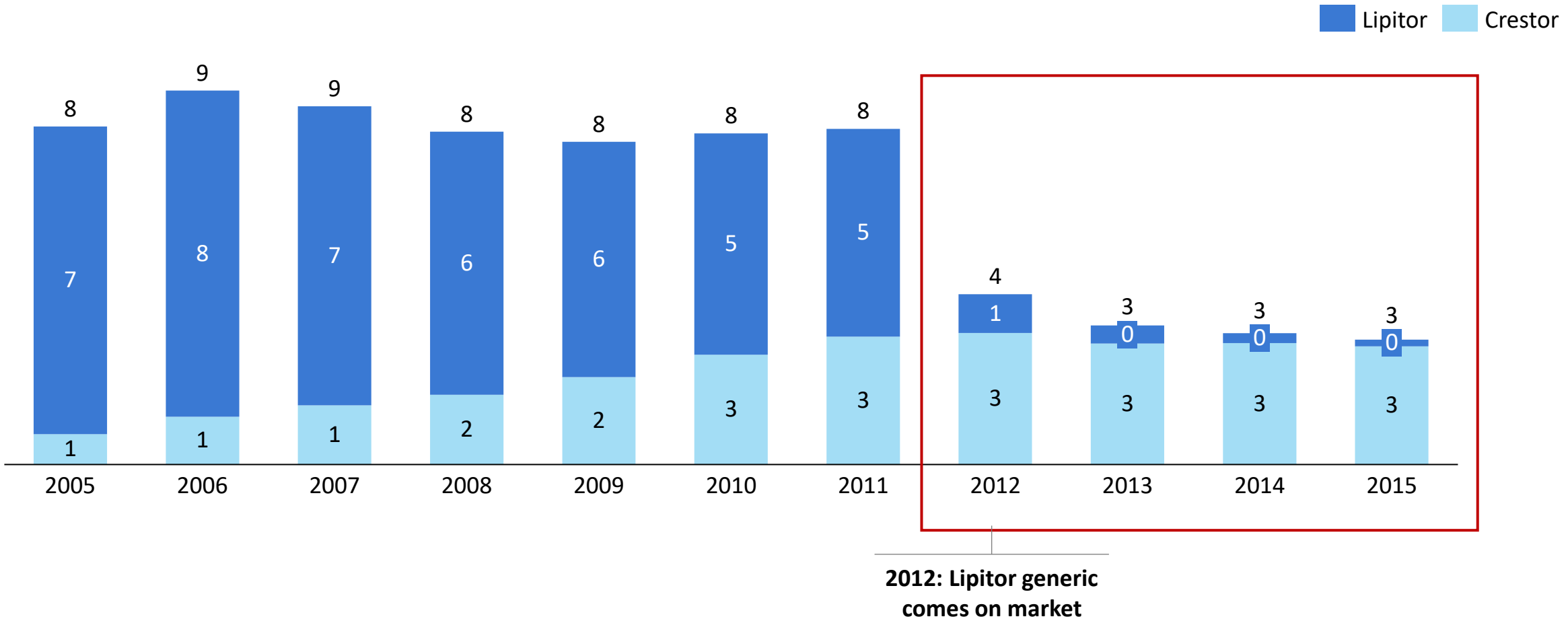
The market is durable: Genericization of Vyndamax prior to 2035 is challenged by the filing strength and thermodynamic profile of the solid form

Generic manufacturers have two primary strategies in challenging Vyndamax IP

Generic manufacturer strategy	Limitations in approach
1 Challenge IP for obviousness	• EU solid form filing (EP3191461) exemplifies strength of the filing • Litigation in US has historically favored inventors with Orange Book-listed solid form IP
2 Prepare a new solid form & establish bioequivalence	• Current tafamidis formulation limits evaluation of alternative solid forms given the physical stability of the claimed solid form (thermodynamics present a significant barrier to generics)

The market is durable: Market analogs suggest potent second entrants can maintain volume share – a statin example

Net revenues of Branded Statins, US, USD B



Source: EvaluatePharma

Market share expectations: Sources of insight for analysis

Source	Areas of insight
ATTR-CM specialists **N=15** expert interviews **N=184** survey respondents	• Factors for prescribing • Perceptions of existing and pipeline therapies • Scenarios for prescribing
Ex-Commercial executives **N=8** expert interviews	• Success factors for late launchers Leaders in the launches of: Eliquis (apixaban) tablets, EYLEA, VICTOZA, Jardiance (empagliflozin) tablets, ELOCTATE, Uptravi selexipag, LIPITOR, Opsumit macitentan tablets 10 mg, Nurtec ODT
HCP, GTM, and market access insights	• Cardiologist decision factors • Data sources and options for evaluation • Cardiologist distribution • Inflation Reduction Act and Reimbursement factors
Industry databases	Evaluate Pharma Commercial Intelligence — Sales data Symphony Health, A PRAHEALTHSCIENCES COMPANY — Pharmaceutical Audit Suite (PhAST) IQVIA — Prescription data
Public databases	NIH U.S. National Library of Medicine ClinicalTrials.gov FDA LABEL

Triangulating top-down and bottom-up estimation leads to a ~25-40% share estimate for Acoramidis in a 4-player ATTR-CM market

Bottom-up approaches (market research) to estimating Acoramidis potential share

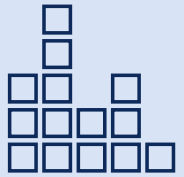
A  **HCP preference share survey** using hypothetical TPPs

B  **HCP interviews** using hypothetical TPPs

Triangulating top-down and bottom-up approaches leads to a consistent estimate of ~25-40% share for Acoramidis in a 4-player market

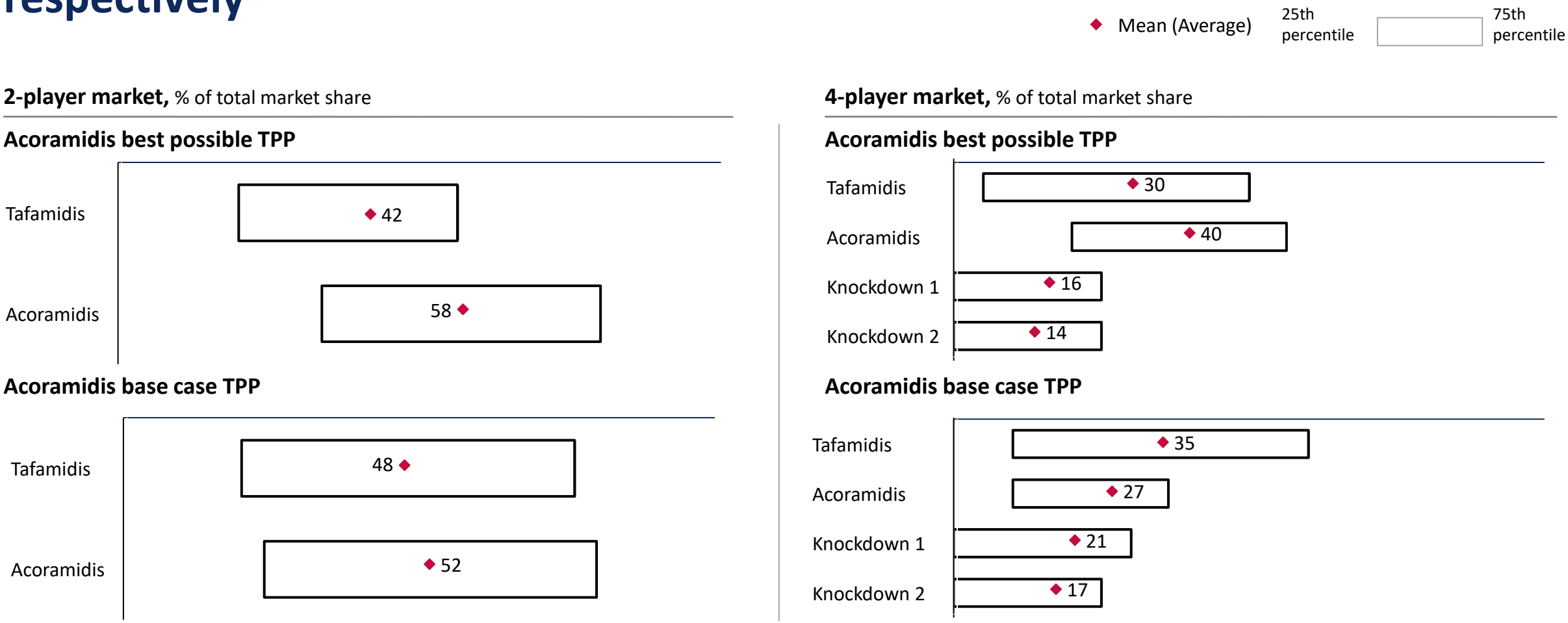
Top-down approaches (comparative analytics) to estimating Acoramidis potential share

C  **Benchmark steady-state sales share** for 2nd entrants

D  **Benchmark steady-state Rx volume share** for 2nd entrants

Source: HCP survey (N=184); HCP interviews (N=15); Evaluate Pharma sales data, April 2023; PhAST Rx data, April 2023.

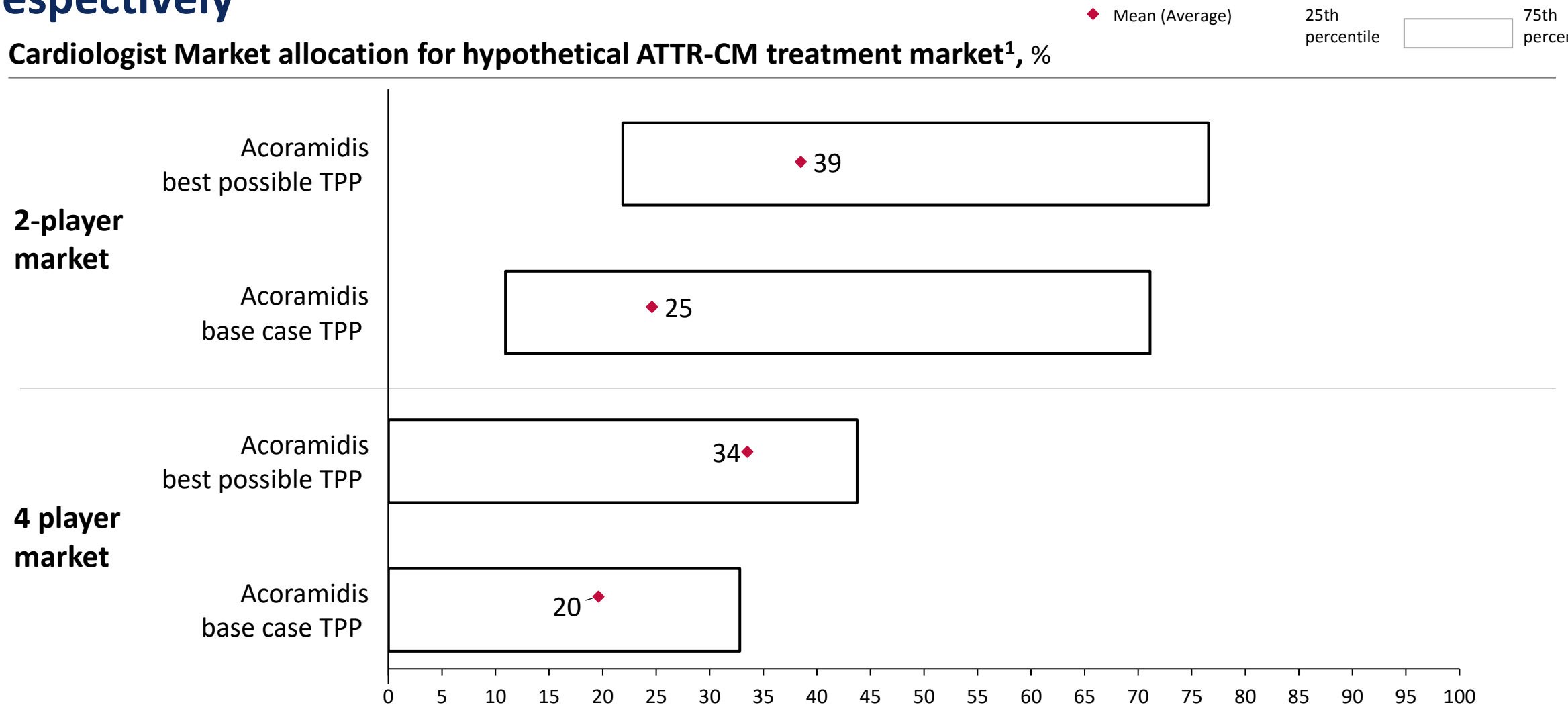
A: Cardiologists indicate they would allocate 58% and 40% share to Acoramidis' best possible profile in 2-player and 4-player markets, respectively



Source: HCP survey (N=184)

B: HCPs interviewed indicate they would allocate 39% and 34% share to Acoramidis' best possible profile in 2-player and 4-player markets, respectively

Cardiologist Market allocation for hypothetical ATTR-CM treatment market[1], %

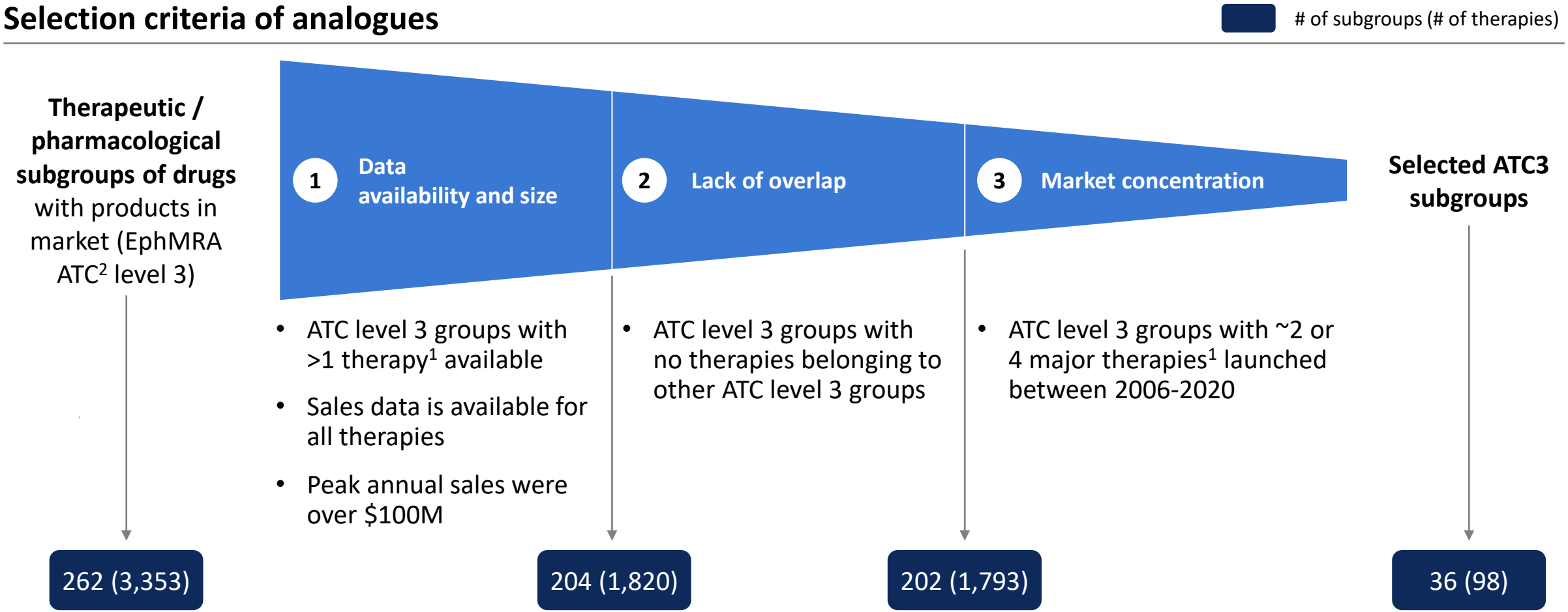


1. Majority of HCPs interviewed see ATTR-CM as a 1-of-2 market going forward, with knockdown therapies being potential add-ons in case of treatment failure

Source: Expert interviews (N=15)

C: Sales share benchmarking in 2 and 4 player markets was conducted across 36 analogues

Selection criteria of analogues



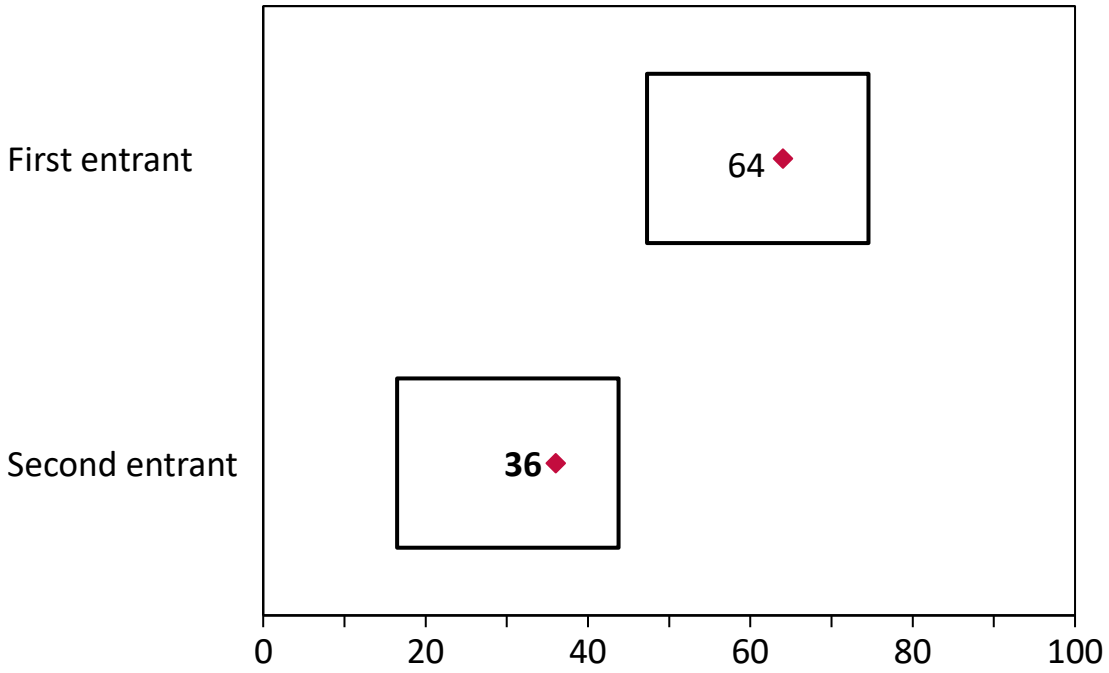
1. Includes only non-generic therapies
2. ATC system classifies drugs according to their main therapeutic use, with one code per administration form

Source: Evaluate Pharma sales data, April 2023

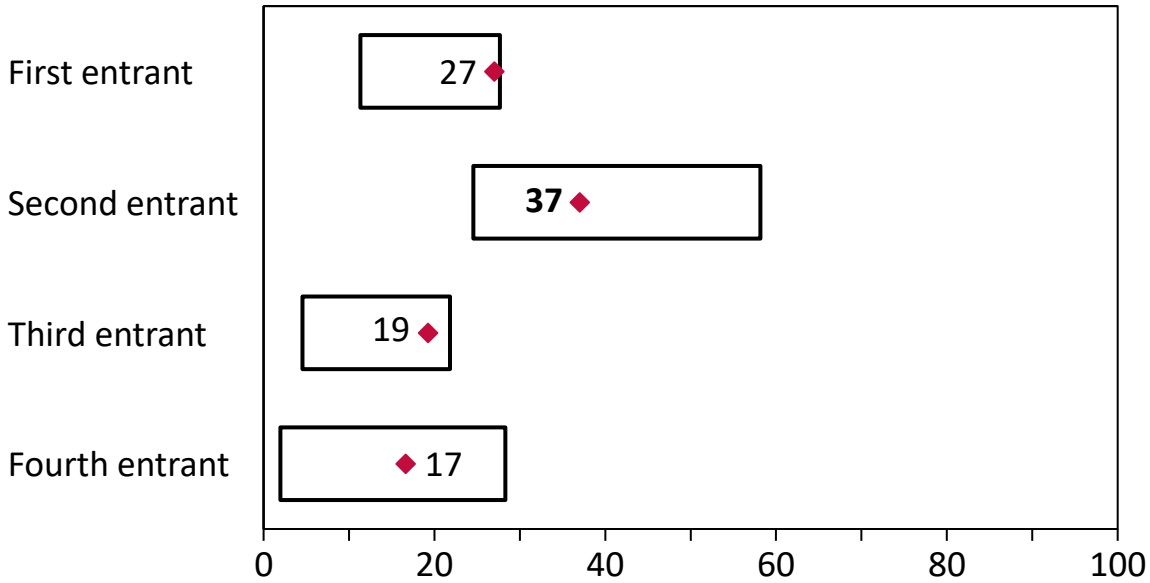
C: Analogues suggest 2nd-to-market entrants take ~36% and ~37% net revenue share in 2-player and 4-player markets, respectively

Market share in ATC Level 3, % ATC3 net revenue by order of launch, year 5 after last launch

2-player markets, N=23



4-player markets, N=14

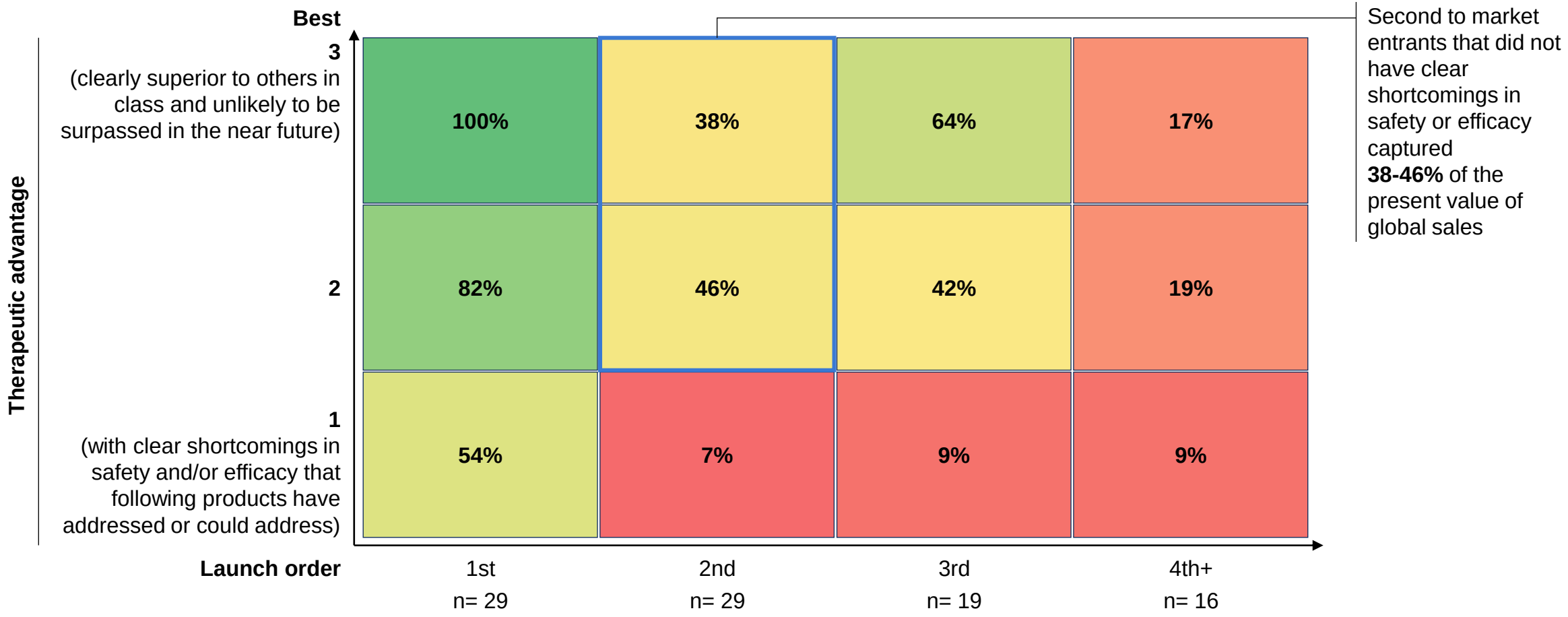


First entrants define early market dynamics based on their differentiation, and hence tend to be more significant outliers in either direction

Source: Evaluate Pharma sales data, April 2023

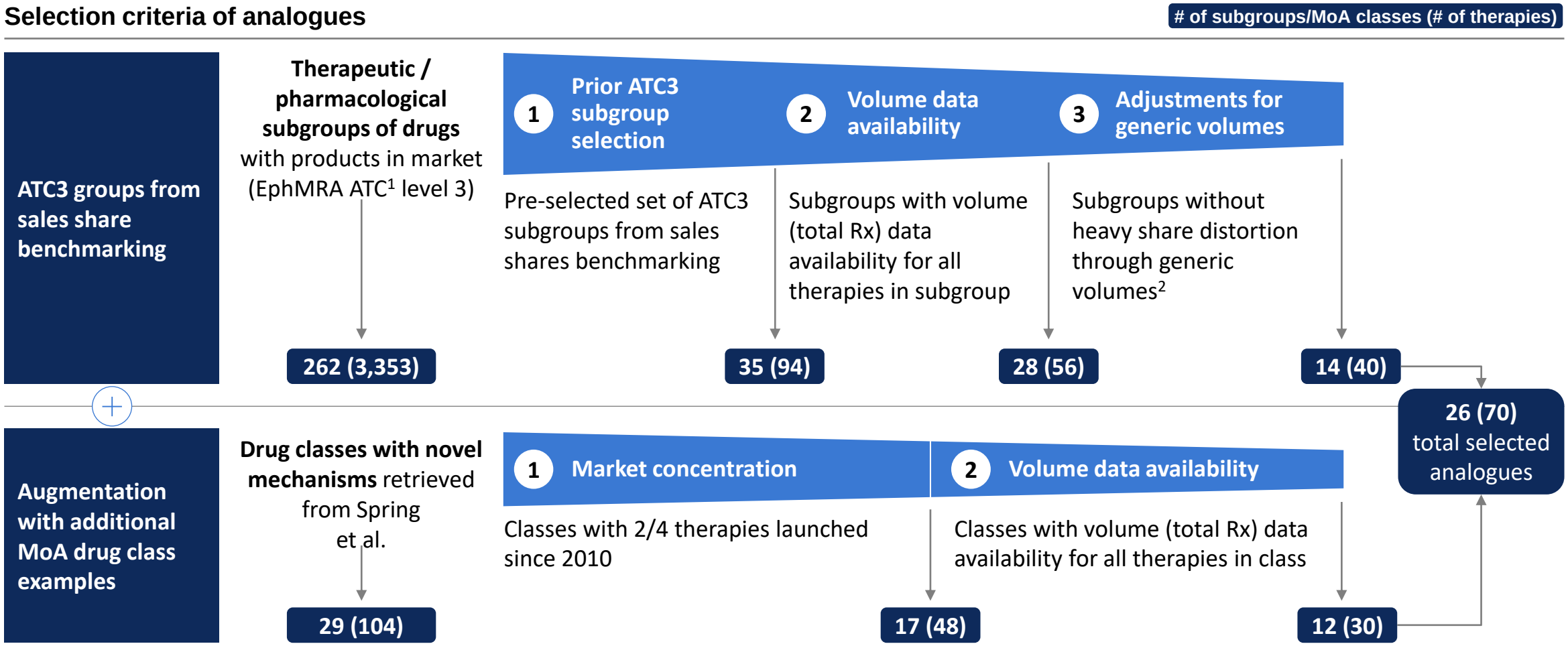
C: For comparison, Spring et al. (2023) show that 2nd-to-market assets without clear shortcomings captured 38-46% NPV share in past decade

Average percentage of the present value of global sales, Percentage
(normalized to the average for products that were first-to-launch and best-in-class)



Source: Spring, et al. "First-in-Class versus Best-in-Class: an Update for New Market Dynamics" Nature Reviews Drug Discovery

D: Volume share benchmarking in 2 and 4 player markets was conducted across 26 analogs

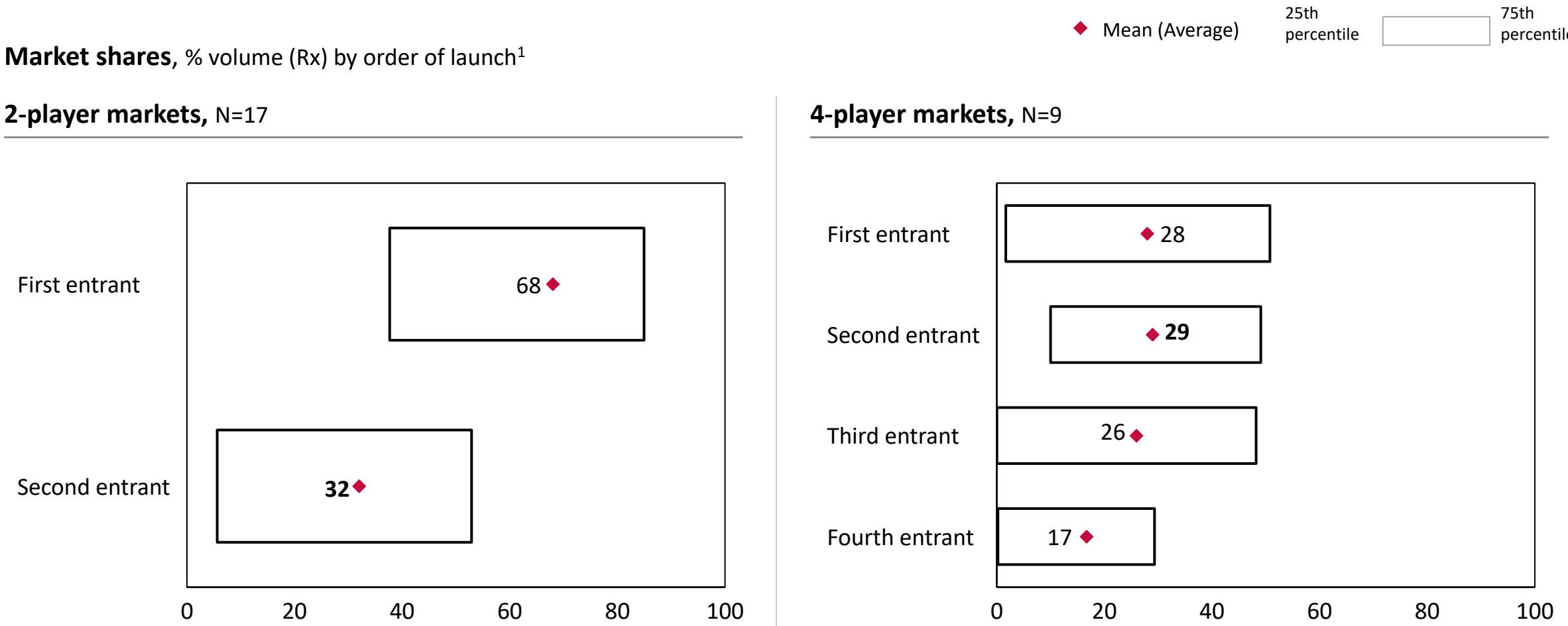


1. ATC system classifies drugs according to their main therapeutic use, with one code per administration form
2. ATC3 subgroups where generic volumes significantly distort the volume shares of branded drugs were removed by: (1) identifying therapies with LoE before launch of next entrant in group, (2) analyzing sales v. volume shares for extreme abnormalities. If both cases (1) + (2) were evident in data, subgroup was removed from dataset

Source: Evaluate Pharma sales data, PhAST Rx data, April 2023; Spring, Lindsay, et al. "First-in-Class versus Best-in-Class: an Update for New Market Dynamics - Supplementary Information." Nature Reviews Drug Discovery.

D: Analogues suggest 2nd-to-market entrants take ~32% and ~29% volume share in a 2-player and 4-player markets, respectively

Market shares, % volume (Rx) by order of launch[1]



1. Based on U.S. total yearly prescription volumes (total Rx). For ATC3 subgroups, shares are derived from the year 5 years after the last therapy launched. For MoA classes, shares are derived from 2022 Rx data

Source: Symphony Health Pharmaceutical Audit Suite (PhAST); April 2023

Upside drivers: Other therapies have broken through as late launchers

Entrant	Class	Incumbent	Differentiators to win
Eliquis (apixaban) tablets	Novel Oral Anti-Coagulants (NOACs)	Xarelto rivaroxaban	Using RWE for a "H2H" against Xarelto Clinical differentiation (based on safety) KOL strategy – activating goodwill from prior cardiovascular launches
Jardiance (empagliflozin) tablets 10 mg/25 mg	SGLT2 inhibitors	Invokana (canagliflozin) tablets	Pursuing innovative contracting (total cost of care) Differentiating based on RWE Expanding prescribers (to cardiologists)
Opsumit macitentan tablets 10 mg	Endothelin receptor antagonists (ERAs) for Pulmonary Arterial Hypertension (PAH)	Letairis ambrisentan 5 mg and 10 mg Tablets	Clinical differentiation via a H2H trial HCP and patient segmentation, focusing around gaining new patients vs switching Improving access through price matching and patient support
Uptravi selexipag tablets 200-1600 mcg	Prostacyclin Receptor Agonists (PRAs) for Pulmonary Arterial Hypertension (PAH)	orenitram treprostinil EXTENDED-RELEASE TABLETS	Establishing triple therapy clinical protocol Positioning therapy as add-on, using synergies with complementary portfolio Clinical differentiation (safety)
EYLEA	Anti-VEGF mAbs for age-related macular degeneration (AMD)	LUCENTIS RANIBIZUMAB INJECTION	Broadening prescribing base (including to non-retina surgeons) Focusing on smaller accounts to negate big Pharma's size advantage / rebating Focusing story on ease of administration
Nurtec ODT (rimegepant) orally disintegrating tablets 75 mg	CGRP inhibitors for migraines	aimovig (erenumab-aooe) injection UBRELVY (ubrogepant) tablets	Innovative DTC advertising (using social media influencers) Using digital channels to scale and coordinate impact

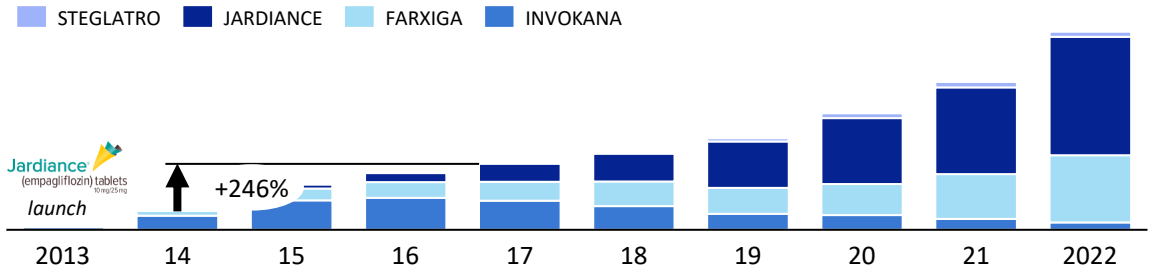
Source: Evaluate Pharma, press search

Upside drivers: Examples of market growth pursuant to novel entry

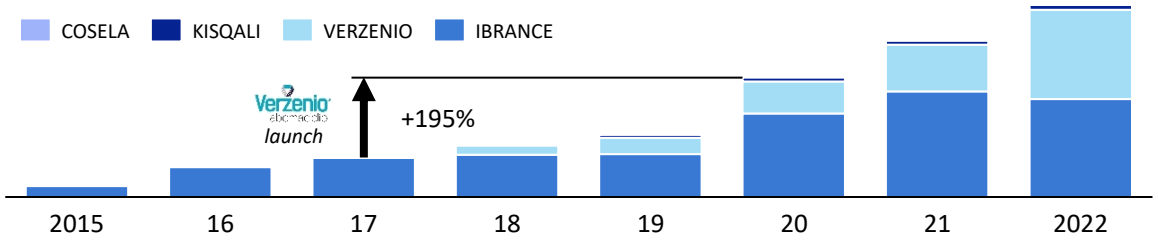
3-year volume lifts pursuant to entry in market

Patient volume growth (US)

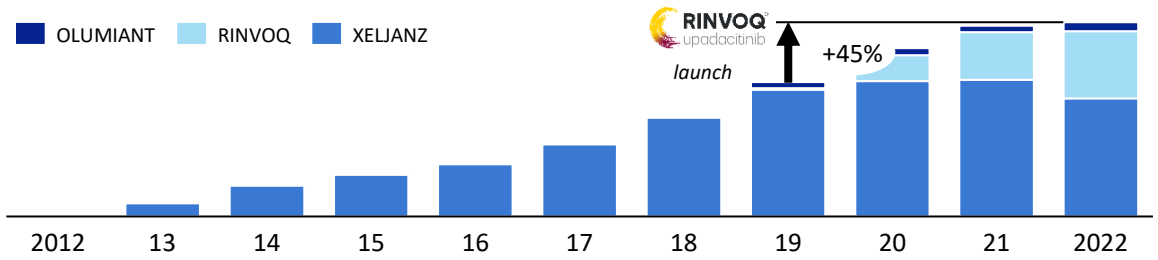
SGLT2 inhibitors



CDK4 & SDK6 inhibitors



JAK inhibitors



Reasons for market growth:

1. **Increased patient awareness** due to more intense competition for new starts (in indication or in class) vs switches, e.g., Opsumit focused on finding and treating treatment-naïve patients in PAH
2. **Increased proactive screening** from HCPs given multiple treatment option, e.g., Lipitor created narrative of “bad cholesterol”, and led to large-scale screening effort
3. **Increase in patient access** through competitive contracting with payers from all players in the market, e.g., Eliquis was welcomed by payers initially because competition from similar therapies could lower the barrier to patient access

Source: Symphony Health Pharmaceutical Audit Suite (PhAST); April 2023

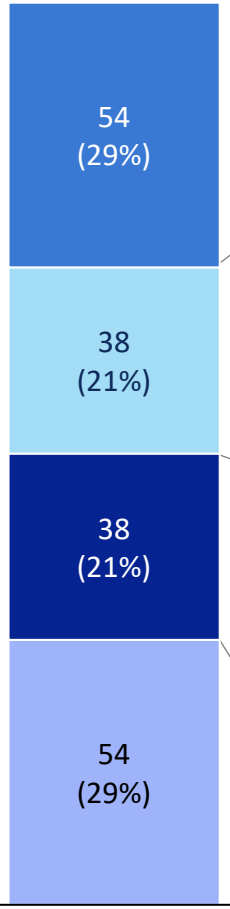
Key points

- Profound opportunity to improve survival (above 80%) and decrease hospitalization rates
- A higher bar exists today – separation requires a more potent drug (which we have)
- The market is large ($20 B TAM) and durable
- Market share estimates, employing multiple analytic methods, are consistently ~ 25-40%
- Other drug categories suggest commercial strategies and tactics that could help a second-mover take additional share

Appendix

A: Needs-based analysis of survey respondents reveals different cardiologist segments with respect to ATTR-CM

Share of survey respondents,% (N=184)



Attitudinal features

Segment 1

- **I am least concerned about my patients' ATTR Cardiomyopathy compared to their other health risks**
- **I will only try new medications after I have seen their efficacy and safety demonstrated by others in my field**
- I strongly believe that access to ATTR-CM therapy is extremely difficult for my patients after my diagnosis
- I am extremely satisfied with the current treatments for ATTR Cardiomyopathy

Segment 2

- **I consider myself an expert in the treatment of ATTR Cardiomyopathy**
- **I always prescribe the best medications for my ATTR Cardiomyopathy patients regardless of cost to the patient (i.e., copay or total prescription cost)**
- Other physicians often ask me for advice on treating their ATTR Cardiomyopathy patients
- I treat ATTR Cardiomyopathy very aggressively
- I proactively seek out the latest clinical trial results and journal articles on treatments for ATTR Cardiomyopathy

Segment 3

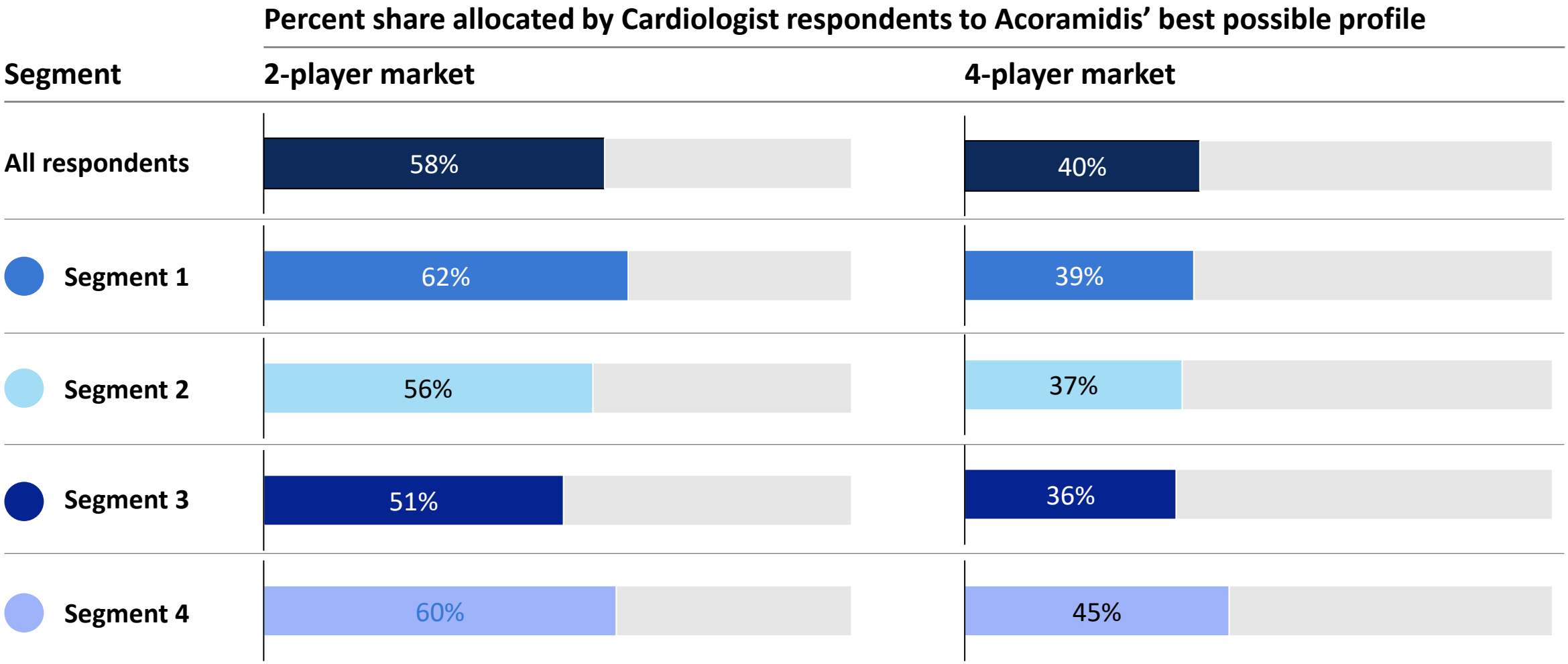
- **I strongly believe that access to ATTR-CM therapy is extremely difficult for my patients after my diagnosis**
- **I consider myself an expert in the treatment of ATTR Cardiomyopathy**
- When treating ATTR Cardiomyopathy, it is most important to me to stabilize and improve the patient's functional outcomes
- Our office always exhausts all channels to help patients negotiate access to costly treatment for ATTR Cardiomyopathy (e.g., prior s)

Segment 4

- **I will only try new medications after I have seen their efficacy and safety demonstrated by others in my field**
- **I am not the first of my peers to try a new medication**
- I do **not** treat ATTR Cardiomyopathy very aggressively
- I do **not** consider myself an expert in the treatment of ATTR Cardiomyopathy

Source: HCP survey (N=184)

A: Despite their differences, Cardiologists across segments allocate a similar share to the TPP with Acoramidis' (best possible) profile



Source: HCP survey (N=184)