bridgebio

hope through
rigorous science

Bank of America Merrill Lynch Presentation

May 15th, 2024

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Today’s focus

Clinical bar for first line ATTR-CM treatment

Plans to share infigratinib Phase II long-term data

BBOT carveout in the context of our corporate strategy

Updates since January's JP Morgan presentation

- ATTR-CM landscape continues to evolve rapidly
  - Delivered additional acoramidis data across hard outcomes, imaging, biomarkers, and quality of life, including a pre-specified sensitivity analysis applied to the entire intention-to-treat study population demonstrating acoramidis significantly reduced all-cause mortality (p=0.04), with no safety signals of potential clinical concern[1]
  - Global tafamidis Q1 2024 sales increased 66% year-over-year and imply a $4.5B+ annualized run rate
  - HELIOS-B statistical analysis plan updated with topline readout delayed to late June/early July

- Delivered on commitment to strengthen our balance sheet to support a world-class acoramidis launch and fund our late-stage clinical trials
  - Negotiated a variety of deals across equity, royalty, debt, and licensing to secure up to $1.5B of funding

- Delivered on commitment to unlock value from early-stage pipeline and streamlined the firm
  - Launched BridgeBio Oncology Therapeutics with a $200 million private financing to accelerate the development of novel oncology pipeline

- Continued strong execution to fully enroll our phase three studies in Achondroplasia, LGDM2i, and ADH1
  - All clinical trials on target to complete enrollment in 2024 to setup 2025 readouts

1 ITT population. Poulsen et al., ESC HF 2024 "ATTRibute-CM: ITT Sensitivity Analysis and Sub-Analysis Comparing Acoramidis and Placebo in Stage 4 CKD"

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Thoughts on the evolving ATTR-CM clinical landscape

- We believe that patients deserve as many treatment options as possible. We are rooting for all drugs to demonstrate conclusive efficacy and safety

- Our aim is to clear up misinformation and to reiterate the acoramidis clinical data

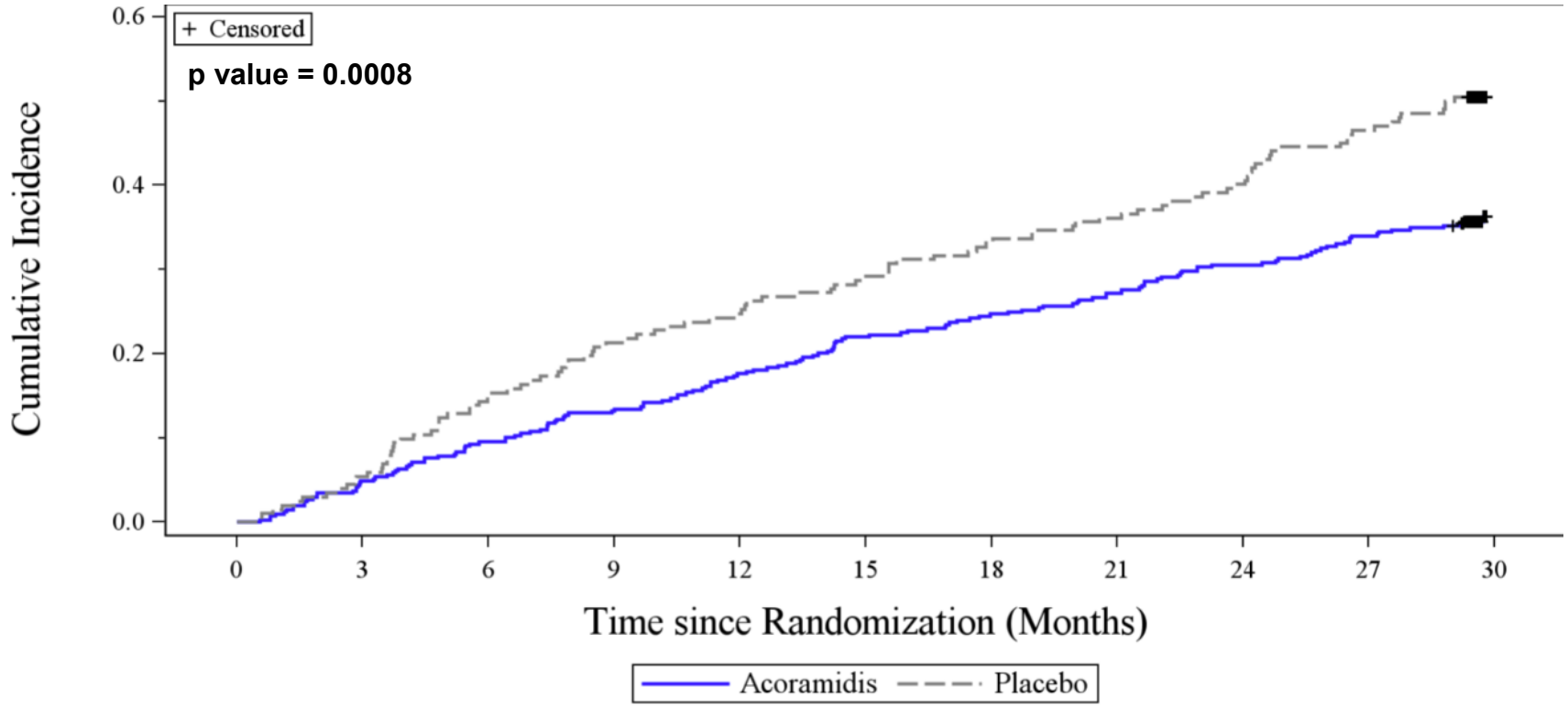
Acoramidis has established a compelling clinical profile

1	**42% & Month 3**	Acoramidis demonstrated a **42% reduction in frequency of composite ACM and CVH events** and with event curves **separating by Month 3**[1]
2	**Trends Favoring Acoramidis**	Intrastudy exploratory, post-hoc results comparing measures of efficacy to tafamidis **trended in favor of acoramidis**
3	**30-Month Endpoint**	ATTRibute-CM **did not require extension beyond 30 months**; additional 6 months estimated to yield a 5% increase in relative risk reduction in ACM[2]

Acoramidis is an investigational molecule. The safety and efficacy have not been established by regulatory authorities.
1 For this analysis, cardiovascular-related hospitalization included both adjudicated events and events of clinical interest and heart transplant and implantation of cardiac mechanical assistance device were treated as death. 2 Elliott P, Circ Heart Fail., 2022; 15(1):e008193. The extrapolation is based a gamma distribution model of survival in placebo-treated patients in ATTR-ACT beyond 30 months.
ACM = All-Cause Mortality. CVH = Cardiovascular-related Hospitalization.

ATTRibute-CM composite CV outcomes curves separated earlier with greater risk reduction than previously seen in field

Time to All-Cause Mortality or First Cardiovascular-Related Hospitalization Over 30 Months



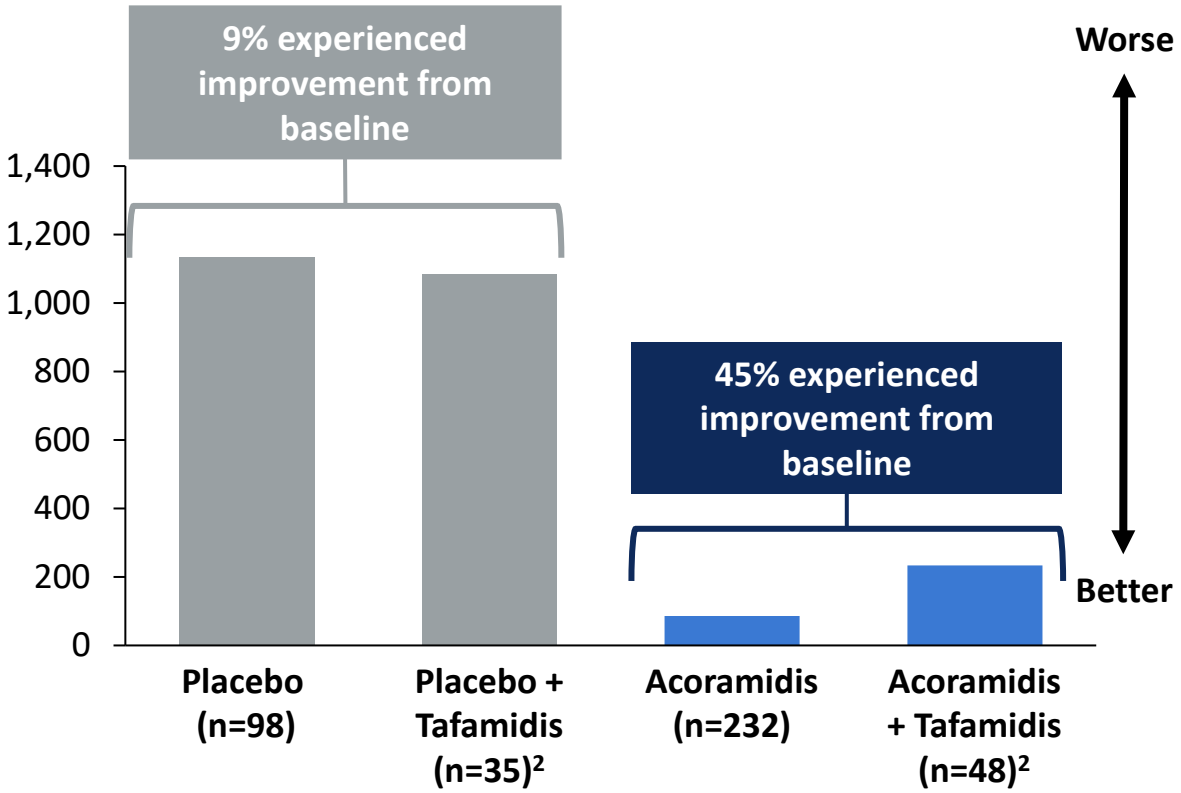
Subjects Remaining at Risk (Cumulative Events)

Acoramidis	409 (0)	389 (20)	370 (39)	355 (54)	337 (72)	319 (90)	308 (101)	298 (111)	284 (125)	270 (139)	0 (147)
Placebo	202 (0)	191 (11)	172 (30)	159 (43)	152 (50)	143 (59)	135 (67)	129 (73)	121 (81)	108 (94)	0 (102)

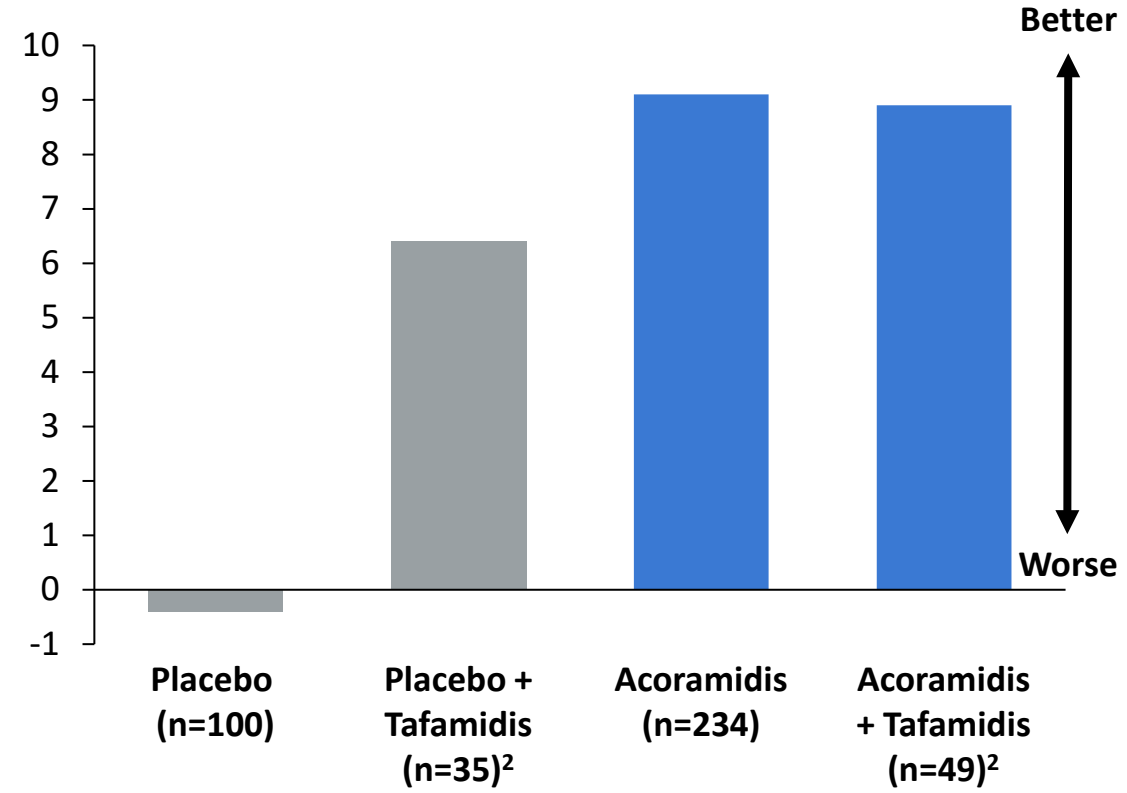
Note: mITT population. Heart transplant and implantation of cardiac mechanical assistance device were treated as death for this analysis. Cardiovascular-related hospitalization included both adjudicated events and events of clinical interest.

Within study exploratory, post-hoc results trended in favor of acoramidis

NT-proBNP, median change from baseline (pg/mL)[1]

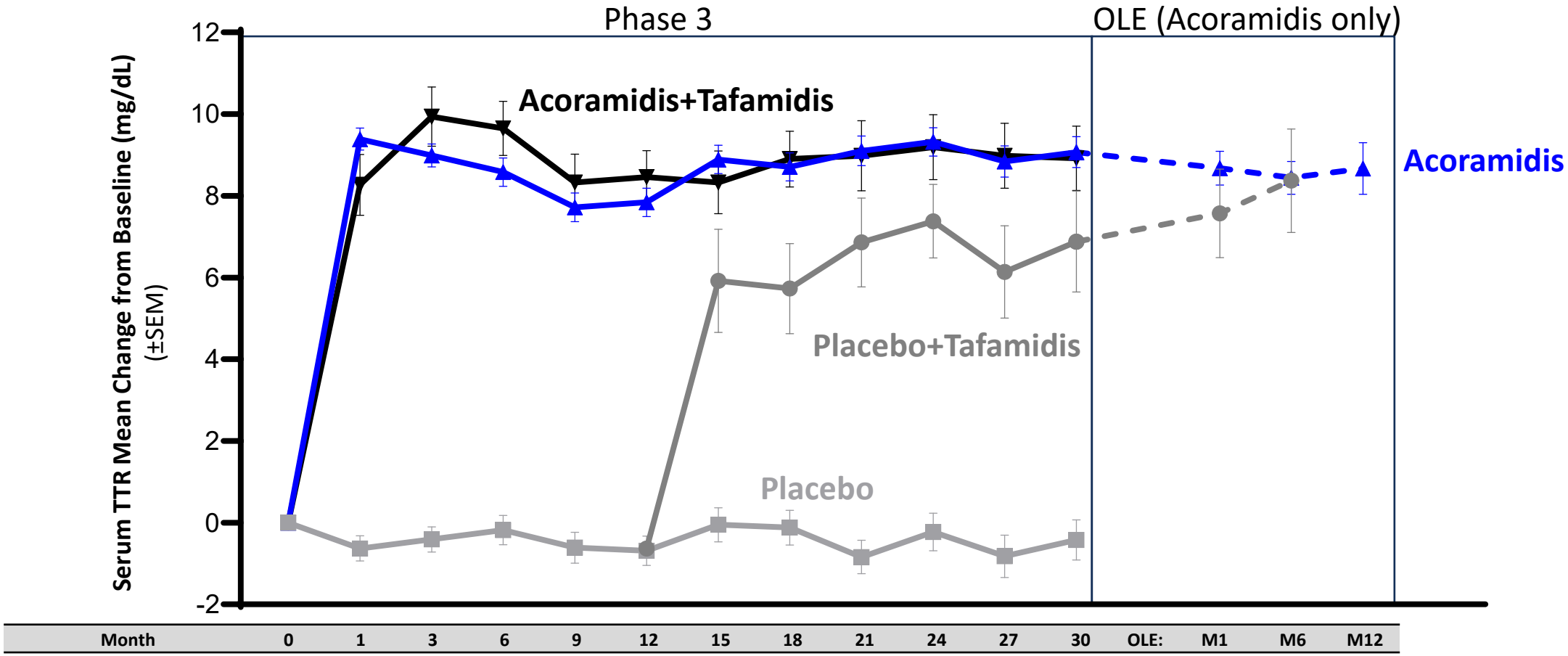


Serum TTR Level, mean change from baseline (mg/dL)[1]



1 Change from baseline at Month 30 in mITT population. 2 Tafamidis usage allowed after month 12 in ATTRibute-CM. Mean exposure on tafamidis = 11 months in mITT population.
Note: Within study exploratory, post-hoc results comparing acoramidis to placebo + tafamidis also trended in favor of acoramidis in the following measures: all-cause mortality, cardiovascular-related hospitalization, 6MWD (6-minute walk distance), and Kansas City Cardiomyopathy Questionnaire Overall Summary Score (KCCQ-OS).
NT-proBNP = N-terminal prohormone of brain natriuretic peptide.

Higher serum TTR levels may be available to patients who switch onto acoramidis regardless of baseline levels



Notes: All open-label extension (OLE) results are preliminary and are shown in dashed lines. OLE month 12 results are not shown for the Placebo+Tafamidis group due to insufficient data. OLE results are not shown for Acoramidis+Tafamidis or Placebo groups due to ongoing analyses. The Placebo+Tafamidis group was defined as: the sample collection date at least 14 days after tafamidis start date AND no more than 14 days after the tafamidis end date. In OLE, fraction of acoramidis only patients continuing was n=222 of n=234 at month 30, and fraction of Placebo+Tafamidis patients that qualify for OLE was n=21 of n=33.

ATTRibute-CM did not require extension beyond 30 months to observe a clinical benefit for acoramidis

Regardless of statistical model[1] employed (Andersen-Gill or Finkelstein-Schoenfeld), acoramidis demonstrated a highly statistically significant result <u>at 30 months</u>

A-G: p=0.0008

F-S (4-component): p<0.0001

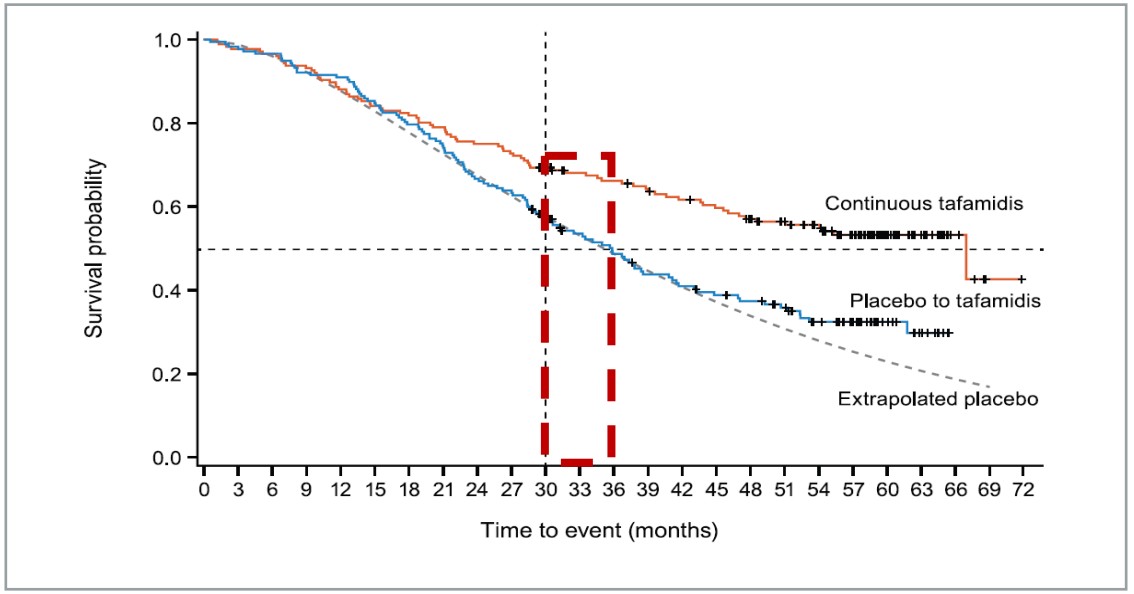
1 Andersen-Gill (A-G) model assessed composite of all-cause mortality and recurrent CVH events. Finkelstein-Schoenfeld (F-S) model hierarchically assessed all-cause mortality, cumulative frequency of CVH events, change from baseline in NT-proBNP, and change from baseline in 6MWD.

ATTRibute-CM was a shorter trial in more advanced ATTR-CM patients

Differences in study design:

- **Duration:** 30 Months (ATTRibute-CM) vs. Up to 36 Months (HELIOS-B)
- **Baseline Demographics:** ATTRibute-CM had no restriction on NYHA III and fewer ATTRv participants[1]
- **Statistical Methodology:** Finkelstein-Schoenfeld (ATTRibute-CM) vs. Andersen-Gill (HELIOS-B)

ATTR-ACT with open label extension



Relative risk reduction is correlated with study duration: **additional 6 months estimated to result in a 5% increase in relative risk reduction in ACM[2]**

1 Shilling R., J Am Coll Cardiol., 2020; 75(11_Suppl_1):3579. 2 Elliott P, Circ Heart Fail., 2022; 15(1):e008193.
Note: Direct cross-study comparisons may suggest misleading similarities or differences. The values shown are directional and do not report robust comparative analysis. The extrapolated placebo curve (dotted line) is a gamma distribution model-based extrapolation of survival in placebo-treated patients in ATTR-ACT beyond 30 months
ACM = All-Cause Mortality.

We continue to advance acoramidis evidence generation and development

Highlights from ESC HF 2024

- Acoramidis significantly reduced ACM (p=0.04) in a pre-specified sensitivity analysis of the entire ATTRibute-CM study population (N=632)[1]
- In participants Stage 4 chronic kidney disease (N=21), acoramidis was associated with proportionally fewer deaths compared with placebo[1]

Additional evidence of clinical differentiation
15+ abstracts @ ESC HF & ISA 2024

Advancement towards planned global launches
US PDUFA: November 29, 2024

Execution of lifecycle management
Initiate primary prevention study (ACT-EARLY)

1 Poulsen S et al., ATTRibute-CM: ITT Sensitivity Analysis and Sub-Analysis Comparing Acoramidis and Placebo in Stage 4 CKD; presented at ESC HF 2024 Meeting.
ESC HF = Heart Failure Association of the European Society of Cardiology; ISA = International Society of Amyloidosis; PDUFA = Prescription Drug User Fee Act action date.

Today’s focus

Clinical bar for first line ATTR-CM treatment

Plans to share infigratinib Phase II long-term data

BBOT carveout in the context of our corporate strategy

Long-term data on infigratinib cohort 5 will be available in early June

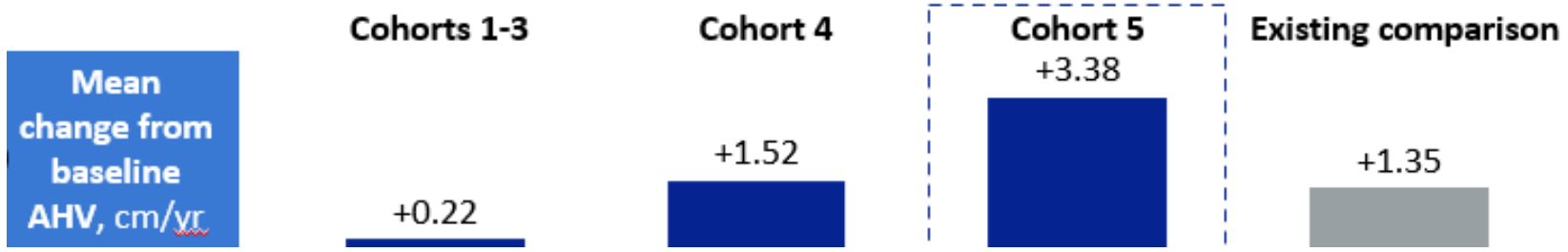
Context for data availability

- PROPEL2 has **two planned data cuts**: Month 6 and Month 18 (End of Study)
- We wanted to share the latest results with the broader community including investigators and families as soon as possible, which we anticipate to be in early June
- The aim is still to also publish the results in a top journal as previously communicated

What we hope to accomplish

- Continued safety: well tolerated, no SAEs
- Continued best-in-class efficacy with a change from baseline in AHV of greater than 1.35 cm/yr
- Potential trends in proportionality

Last year we shared a best-in-class profile for cohort 5 at month six



Cohort 5 demonstrated a well-tolerated safety profile, with:

- 0 severe adverse events
- 0 adverse events assessed as drug-related
- 0 discontinuations due to adverse events
- No accelerated advancement of bone age or worsening of body proportions

Cohort 5 baseline characteristics	
Female : Male ratio	**7:5**
Mean age (yr) <5 5 - <8 8 - <11 >=11	**7.24** 8% 58% 25% 8%
BL AHV (cm/yr) Mean (SD)	**3.52 (1.3)**

What we are looking to demonstrate in long-term cohort 5 follow up

1

Base Case: CNP-like efficacy in a safe and convenient oral

- **Well-tolerated** safety profile
- Change from baseline AHV of **>1.35** cm/yr out to **Month 18**

2

Upside Case: differentiated efficacy in a safe and convenient oral

- **Well-tolerated** safety profile
- Best-in-class change from baseline AHV of **≥2** cm/yr out to **at Month 18**

3

Aspirational: Additionally, signs of proportionality improvement

- **Well-tolerated** safety profile
- Best-in-class change from baseline AHV of **>2** cm/yr out to **at Month 18**
- **Trend on proportionality improvement**

Data to be available in early June

Next steps and future expansions for infigratinib

Full enrollment in PROPEL3

FPI for hypochondroplasia phase 2 study

Deliver on the full value of infigratinib for patients

- FGFR-driven syndromic craniosynostoses
- Label expansion for infant and toddlers

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Our objective function

1

Patient Impact

Objective = max $\int_0^t \sum_1^N Drug_i$*ΔQALY$_i$

De-centralized R&D model designed to scale

2

Sustainable value creation

Driven by two criteria:

- NPV+ (driven by ROIC, g, WACC) makes us sustainable
- Beautiful science (high POTS) makes us more of an engineering company – more predictable, less speculative

Our corporate strategy

Sustainable competitive advantage

- Proprietary knowledge built up through multiple reps improves returns (increases ROIC)
- Patient impact objective coupled with financing allows us to pursue more opportunities (increases g)
- Portfolio construction helps financing by allowing us to access cheaper cost of capital (decreases WACC)

Results to date

- 17 INDs, 2 approvals, positive acoramidis Phase 3, reading out 3 additional Phase 3 trials in 2025
- Substantial risk-adjusted NPV created by capital efficiency, portfolio growth, and WACC reduction

Key metrics

- $'s to IND: <$10M on average
- $'s to POC: ~$50M on average. ATTR-CM: $58M, Achon: $75M, ADH1: $31M, LGMD2i: $38M
- POTS: 50% above historic benchmarks
- Risk adjusted PYS: >$5B from late-stage assets alone

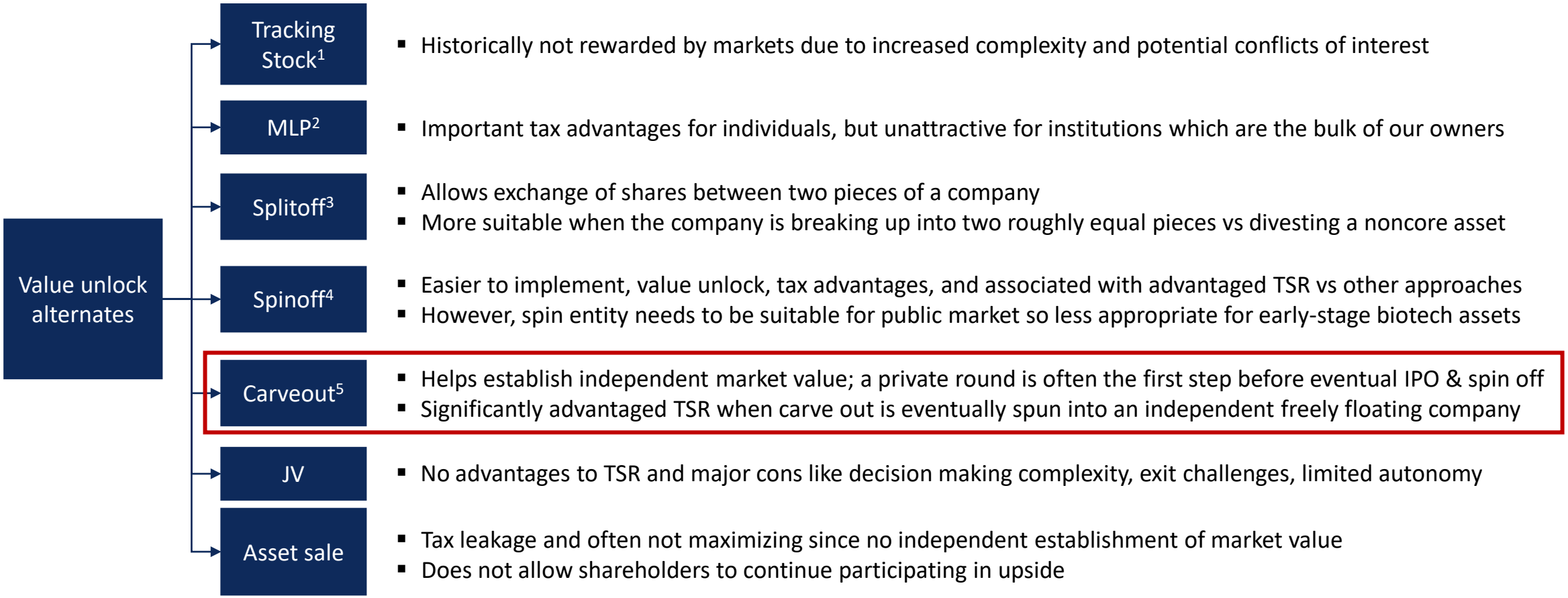
Complication:

But today we are out of step with a market that richly values pure plays and simplicity

We are adapting to the market environment to unlock value

Systematically analyzed >100 companies across several industries to examine ways to unlock value

- Conglomerate discounts seen across several sectors in rising interest rate environment: oil & gas, healthcare, industrials, communications
- History teaches us that carveouts / spinoffs to reduce WACC by creating pure plays can generate shareholder value at such moments

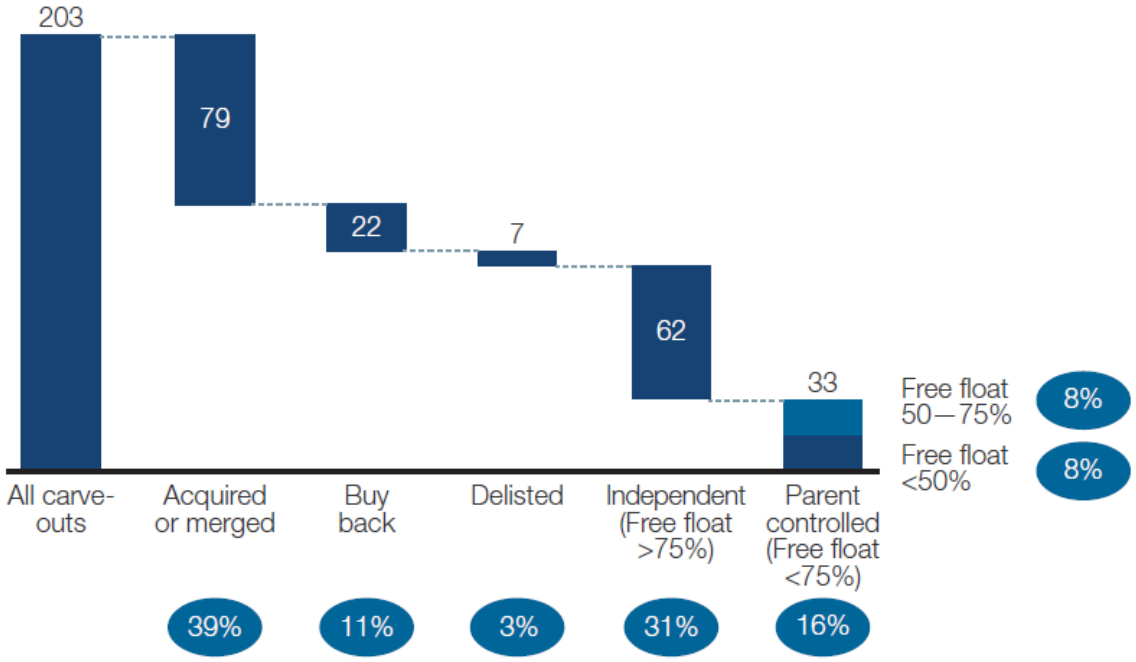


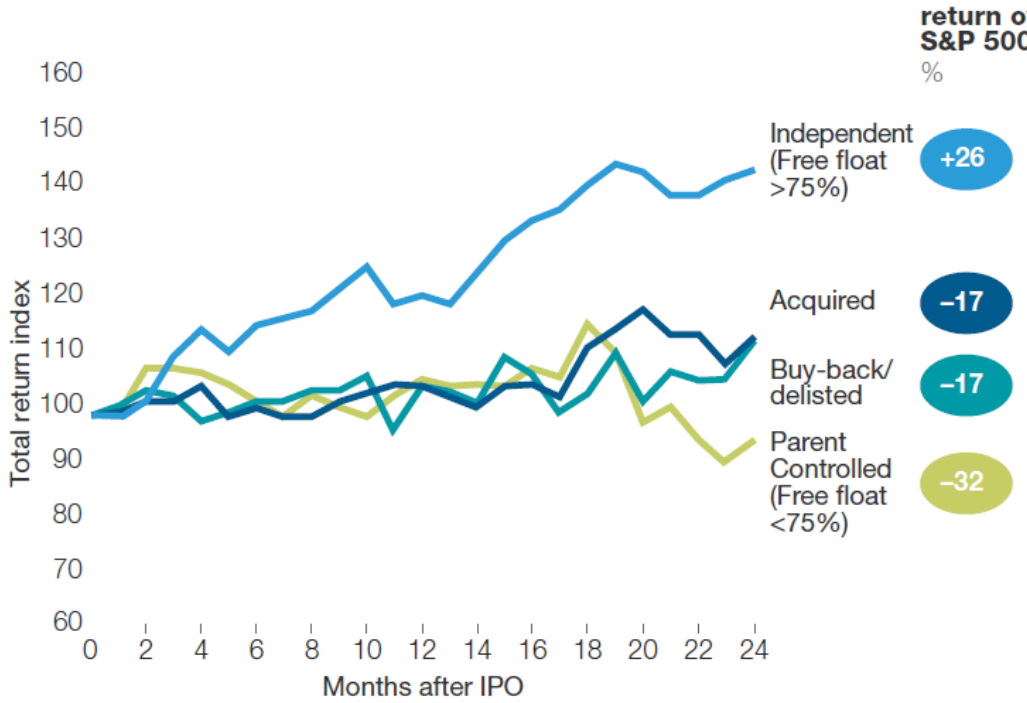
[1]**Tracking stock:** Special class of parent stock for which the dividends "track" a specific subsidiary's economic performance, either through an IPO for cash (tracking stock carve-out) or through a distribution to parent shareholders as dividends (tracking stock spin-off) [2]**MLP:** Master Limited Partnership [3]**Split-off:** Full flotation of a subsidiary by offering subsidiary shares to existing parent shareholders in exchange for parent shares [4]**Spin-off:** Full flotation of a subsidiary by distributing subsidiary shares in the form of dividends to existing parent shareholders [5]**Carve-out:** The flotation of a minority stake of usually less than 50% (in the United States) of a subsidiary's shares through an IPO for cash

Resolution: BridgeBio Oncology Therapeutics carveout

- Pure play KRAS company with G12Ci [on and off], pan KRASi [on and off], PI3Kα:RAS breaker entering clinic
- Launched with oversubscribed $200M financing to accelerate the development of our innovative precision oncology pipeline while retaining equity ownership
- Top quality investor syndicate
- Multiple paths to value realization – future dividend to shareholders or sale to strategic

Carve out trajectory and long term TSR by trajectory





Source: McKinsey Analysis

Up next in 2024

- Infigratinib for skeletal dysplasias
  - Long-term cohort 5 data from phase 2 study in achondroplasia in early June
  - FPI for hypochondroplasia phase 2 study
- BBP-631 for CAH
  - Phase 1/2 data readout with subsequent go/no-go for program
- BBP-418 for LGMD2I/R9
  - Regulatory and trial enrollment updates
- Encaleret for ADH1
  - Phase 3 enrollment updates
- Acoramidis for ATTR-CM
  - 11/29/2024 PDUFA