CORPORATE PRESENTATION

OCTOBER 2026

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INVESTMENT HIGHLIGHTS

Rare disease focused, clinical-staged biotechnology company developing a novel, once-daily, inhaled, disease modifying rapamycin formulation (LAM-001) across multiple Phase 2 programs:

- **PH-ILD** (~200K US/EU)[1] –Current therapies are limited to vasodilation, not disease modifying[2]. Promising Ph 2a data on top of standard of care presented ATS 2026; Ph 2b expected to initiate mid-2026.
- **BOS** (~30K US/EU)[3] - Severe complication of and leading cause of death post lung transplantation[4]. Positive, retrospective data from clinical utilization of oral rapamycin support an ongoing Ph 2 trial with data expected 1Q 2027.
- **SAPH** (~60K US/EU)[5] - Severe complication of sarcoidosis with no approved therapy (PH WHO group 5). Ph 2 trial expected to initiate in 4Q 2026, supported by proof-of-concept clinical efficacy data from completed PH study.

Efficient 505(b)2 development pathway for lead program (LAM-001), with strong IP coverage expected to the mid 2040's

US/EU **Orphan Disease Status** granted for multiple indications

Supportive FDA feedback from end of Phase 2 and pre-IND meetings

1. Represents estimated patient population in the US and EU: Wijsenbeek 2020 DOI: 10.1056/NEJMra2005230, Ang 2024 https://doi.org/10.1016/j.chest.2024.04.025
2. Shlobin 2024 https://doi.org/10.1002/pul2.12310
3. Represents estimated patient population in the US and EU at projected launch: US HRSA Data, Kulkarni 2018:doi: 10.1016/j.healun.2018.09.016 and Company estimates
4. Ehrsam 2021 doi.org/10.1016/j.healun.2021.01.887
5. Represents estimated patient population in the US and EU: American Lung Association Data, Duong 2018, https://doi.org/10.1097/CPM.0000000000000252

IRULYA PIPELINE AND ANTICIPATED MILESTONES

LAM-001	2026	2027	2028	ESTIMATED US/EU MARKET	ANTICIPATED DATA READOUTS
Pulmonary Hypertension-Interstitial Lung Disease (PH-ILD)	Phase 2B (PH-ILD)			~200k	1Q-28
Bronchiolitis Obliterans Syndrome (BOS)	Phase 2 (IIT)			~30k	1Q-27
Sarcoidosis Associated PH (SAPH)		Phase 2 (IIT)		~60k	4Q-28

◆ Anticipated Data Readout

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LIMITATIONS OF ORAL RAPAMYCIN

SYSTEMIC EXPOSURE WITH SIGNIFICANT SAFETY RISKS:
Oral Rapamune® Key Label Warnings and Precautions: Angioedema, Fluid Accumulation and Impairment of Wound Healing, Hyperlipidemia, Decline in Renal Function, Proteinuria, Latent Viral Infections, Male Infertility, Embryo-Fetal Toxicity

LIMITED LUNG EXPOSURE:
Systemic toxicity limits oral dosing levels and may preclude sufficient lung exposure

LOW AND VARIABLE ORAL BIOAVAILABILITY*:
Requiring inconvenient plasma monitoring and frequent dose adjustments

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We believe these limitations preclude the adoption of oral rapamycin in pulmonary diseases where the mTOR pathway has been clearly implicated

* Systemic bioavailability of 14 – 18% due to poor aqueous solubility, high molecular weight, extensive first-pass metabolism, variable gastrointestinal conditions, food effects, and P-glycoprotein-mediated efflux Sirolimus (Rapamycin) prescribing information, NIH NLM; Revised 5/2026

SOLUTION: LAM-001 DESIGNED FOR IMPROVED PULMONARY DELIVERY OF RAPAMYCIN

- **TARGETED DELIVERY:**
  Direct lung delivery → higher local exposure versus oral or nebulized formulations
- **IDEAL PHYSICAL CHEMICAL PROPERTIES FOR LUNG DELIVERY:**
  Enhanced lung exposure and potential improved efficacy in pulmonary diseases
- **MINIMIZED SYSTEMIC EXPOSURE AND WELL-TOLERATED SAFETY PROFILE:**
  Reduced systemic side effects compared to oral rapamycin
- **CONVENIENT ADMINISTRATION:**
  Easy-to-use once-a-day dry powder inhaler (DPI) designed to enhance patient compliance; fixed dose with no need for blood level monitoring (required with oral rapamycin due to low and variable oral bioavailability)

Based on non-clinical and clinical studies conducted by the Company, Sirolimus (Rapamycin) prescribing information. NIH NLM; Revised 5/2026
No head-to-head clinical trials have been conducted evaluating LAM-001 and Rapamycin. Differences exist between study or trial designs and participant characteristics, and caution should be exercised when comparing data across studies

LAM-001: INHALED RAPAMYCIN ADVANTAGES OVER ORAL

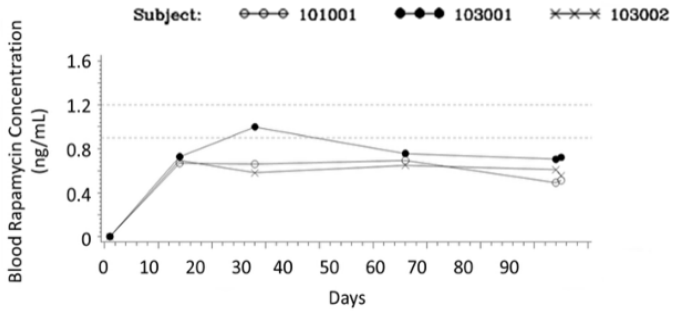
LAM-001 vs oral rapamycin: designed to deliver higher drug exposure in lungs where needed for clinical activity with lower systemic exposure where most toxicities arise

- Total dose delivered via inhalation = 20x lower (100 µg/day vs 2 mg/day)
- ~5-15x lower systemic exposure (<1 ng/ml vs 5-15 ng/ml for oral)
- > 90% mTOR inhibition at 24 hours after a single QD dose in rats comparable to 100 µg QD in humans

Human studies support improved safety profile of LAM-001 vs. oral

- LAM-001 is well tolerated across indications, up to 2.5 yrs of daily treatment
  - All AEs mild or moderate
  - No drug related: SAEs, withdrawals, or Grade 3/4 AEs

Phase 1/2 in LAM Patients



Steady state target of <1 ng/mL achieved at 100 µg QD

>> Reduced systemic exposure with clinically relevant lung exposure

ILD = interstitial lung disease
Based on non-clinical and clinical studies conducted by the Company
No head-to-head clinical trials have been conducted evaluating LAM-001 and Rapamycin. Differences exist between study or trial designs and participant characteristics, and caution should be exercised when comparing data across studies

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LAM-001: GROUP 3 PULMONARY HYPERTENSION (PH-ILD)

PULMONARY HYPERTENSION (PH-ILD)

DISEASE:

- Rare, progressive disorder characterized by smooth muscle cell proliferation and endothelial cell dysfunction, leading to thickening and narrowing of the pulmonary blood vessels
- Group 3 Pulmonary Hypertension due to underlying interstitial lung disease (ILD) characterized by fibrosis of the lung tissue*
- Worse prognosis than Group 1 PAH or ILD alone[1]
- 5-year survival 23%[2]
- No cure
- Only two approved drugs Tyvaso & Yutrepia

Estimated Addressable Patient Population[3]
Group 3 (PH-ILD) — US: ~86K | EU: ~120K

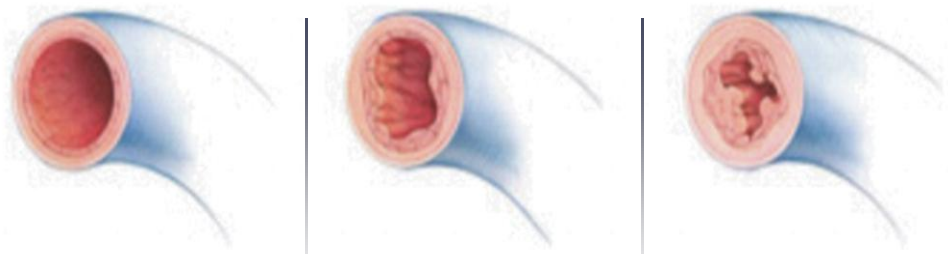

Figure 2 – Narrowing of the pulmonary arteries associated with PH[4]

ILD = interstitial lung disease,
* PH is categorized into 5 groups (Group1-5) based on disease etiology; Group 1: Pulmonary arterial hypertension, Group 2: PH due to left heart disease, Group 3: PH due to chronic lung disease (such as ILD or COPD) and/or hypoxia , Group 4: PH due to pulmonary artery obstructions, Group 5: PH due to other conditions including sarcoidosis, sickle cell anemia, chronic hemolytic anemia, splenectomy, and metabolic disorders)

[1]Kacprzak 2023 https://doi.org/10.3390/diagnostics13142354
[2]Gall 2017 http://dx.doi.org/10.1016/j.healun.2017.02.016
[3]Wijsenbeek 2020 DOI: 10.1056/NEJMra2005230, Ang 2024 https://doi.org/10.1016/j.chest.2024.04.025
[4]Pulmonary Hypertension Singapore

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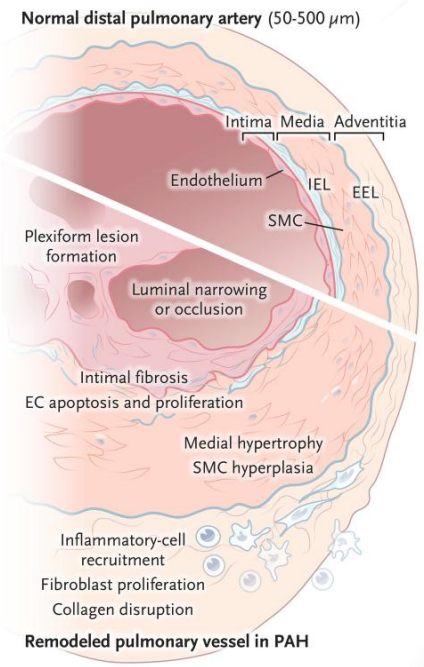
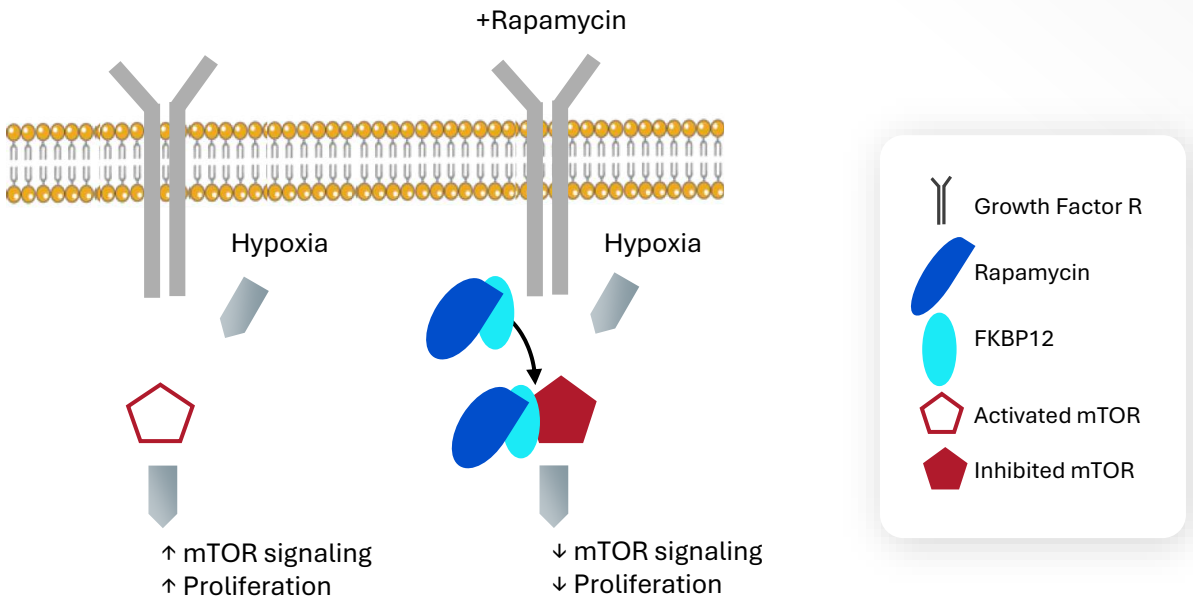
RAPAMYCIN TARGETS PH PATHOLOGY



Hassoun NEJM 2021

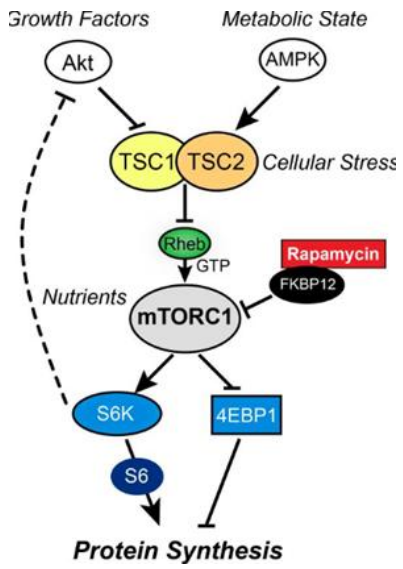


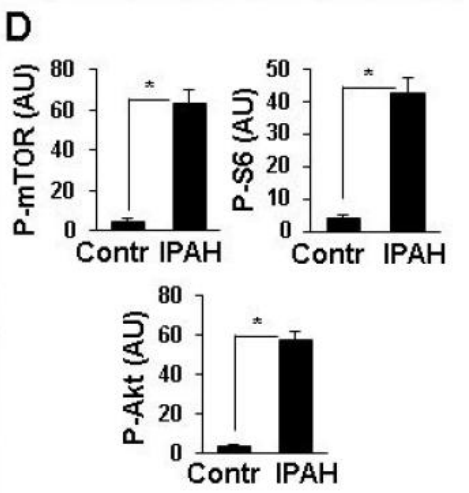
Krymskaya, et. al., FASEB (2011)

LAM-001 has been shown to reverse pulmonary arterial smooth muscle cell proliferation, remodeling the arterial damage which is central to PH disease process

RAPAMYCIN INHIBITS MTOR AND REVERSES PULMONARY ARTERIAL SMOOTH MUSCLE CELL (PASMC) PROLIFERATION[1,2]

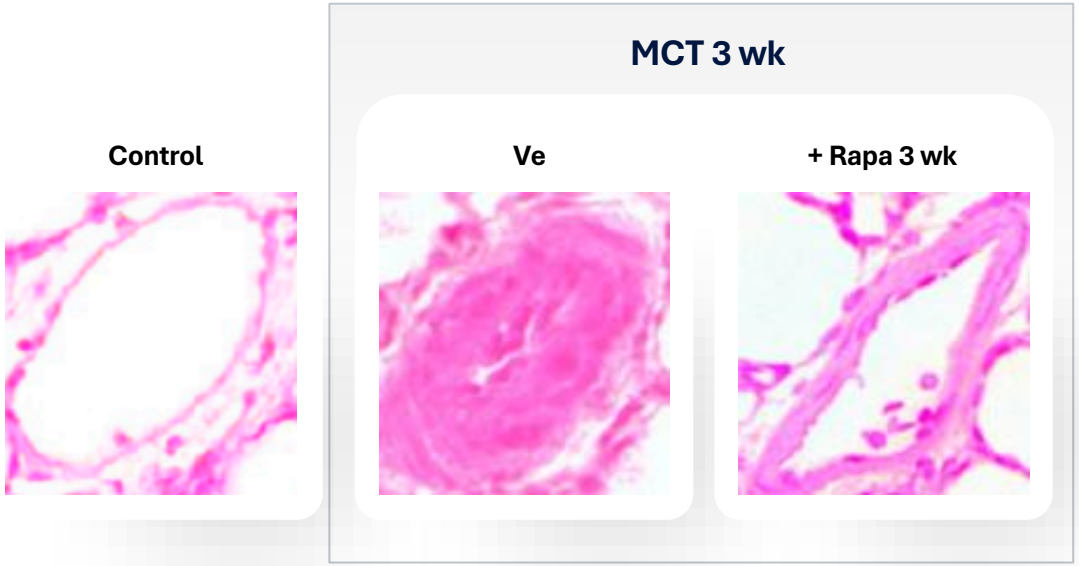
RAPAMYCIN INHIBITS mTOR, WHICH IS ACTIVATED IN PH[1]





[1] Based on Goncharov, Circulation. 2014 129: 864.
Contr = Control IPAH = Idiopathic Pulmonary Hypertension

RAPAMYCIN REVERSES PASMC PROLIFERATION[2]



[2] Based on Houssaini, Am J Resp Cell Mol Bio 2013
PASMC = Pulmonary Artery Smooth Muscle Cell, MCT = monocrotaline rat model

COMPETITIVE LANDSCAPE PH-ILD PRODUCTS AND PRODUCT CANDIDATES

		Company	Once-daily dosing	Vasodilation MOA	Antiproliferative MOA	Antifibrotic MOA	Status
LAM-001		IRulya	✓	--	+++	+++	Ph 2
Treprostinils	Tyvaso[1]	United Therapeutics	X	+++	--	+	Launched
	Yutrepia	Liquidia	X	+++	--	+	Launched
	TPIP	Insmed	✓	+++	--	+	Ph 3
	L606	Liquidia	X	+++	--	+	Ph 3
	Tresmi	United Therapeutics	X	+++	--	+	PR[2]
Ralinepag DPI		United Therapeutics	✓	+++	--	+	PC
ROC-101		AllRock Bio	✓	++	++	++	Ph 2
Mosliciguat		Pulmovant	✓	+++	+	+	Ph 3

1 Tyvaso nebulized or dry powder administrations
2 PR = Preregistration. Commercial launch anticipated 2027.
+++ = Higher activity | ++ = Medium activity | + = Lower activity

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PHASE 2a TRIAL OF LAM-001 IN GROUP 1 PAH AND GROUP 3 PH

AARON B. WAXMAN, MD, PhD
Principal Investigator

Brigham and Women's Hospital
Founding Member, Mass General Brigham

DESIGN	• Open Label; 24 wks; 4 sites; Invasive Cardiopulmonary Exercise Testing (iCPET)[1]
INCLUSION	• >18 yo; WHO Functional Class III; Group 1 PAH and Group 3 PH; symptomatic despite background Rx
PRIMARY ENDPOINTS	• Peak oxygen uptake (VO2 max), Safety, Tolerability
SECONDARY ENDPOINTS	• PVR, 6MWD, WHO functional class
EXPLORATORY ENDPOINT	• NT-proBNP

DATA PRESENTED AT ATS MAY 2026

1iCPET is a diagnostic procedure in which patients undergo pulmonary and radial artery catheterization in conjunction with a bicycle exercise test to directly measure cardiac and pulmonary function during exercise. Bradley A. Maron, Barbara A. Cockrill, Aaron B. Waxman, David M. Systrom "Invasive Cardiopulmonary Exercise Test" Circulation 2013, 1157-1164
PVR = Pulmonary Vascular Resistance, 6MWD = 6 Minute Walk Distance, NT-proBNP = N-terminal pro-B-type natriuretic peptide

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PHASE 2a BASELINE CHARACTERISTICS

	PAH	PH-ILD	Completers	All Enrolled
N per group	**5**	**5**	**6**	**10**
Female	4	2	2	6
Male	1	3	4	4
Age (median yr)	63	65	64	65
ILD				
IPF[1]		1	0	1
NSIP[1]		2	2	2
SSc- ILD[1]		1	1	1
PS[1](Grp 5)		1	1	1
Background PH Meds				
Ambrisentan	2	0	1	2
Macitentan	3	1	2	4
Riociguat	1	0	0	1
Selexipag	1	0	0	1
Sildenafil	1	3	2	4
Tadalafil	3	2	4	5
Treprostinil[2]	3	5	5	8
Discontinuations[3]	3	1	-	4

- **Majority of patients on triple background therapy:** All PH-ILD patients on background treprostinil
- **Patients on stable background therapy prior to enrollment and throughout study**
- **All discontinuations deemed unrelated to study drug**

[3]Discontinuations (all deemed unrelated to drug):

PAH

- *Respiratory failure/GI infection at ~month 5 lead to hospitalization, unrelated to study drug, developed aspiration pneumonia in hospital and died*
- *Widowmaker lesion identified mid-study (unrelated to study drug) and withdrew from study*
- *for immediate stenting*
- *Terminated following vaping induced lung injury*

PH-ILD

- *Multiple complications and hospitalizations unrelated to study drug and withdrew*

[1] IPF = Interstitial Pulmonary Fibrosis, NSIP = Non-specific Interstitial Pneumonia, SSc-ILD = Systemic Sclerosis ILD, PS = Pulmonary Sarcoidosis
[2] Inhaled, oral or SubQ
Data on file

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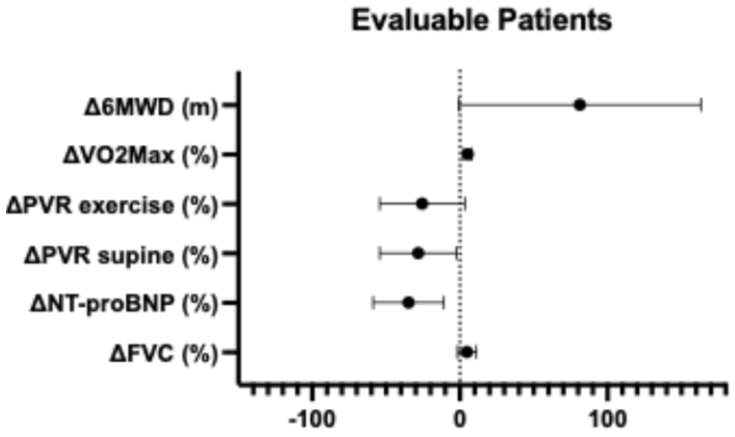
PHASE 2a 24 WEEK DATA SUMMARY

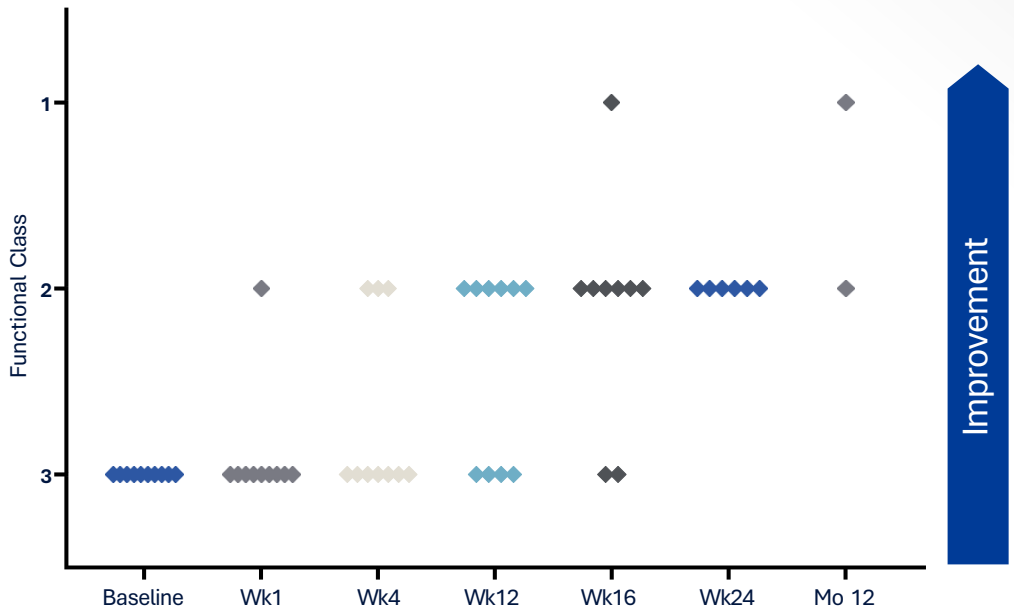
	Evaluable Population Mean | N = 6	PH-ILD Subgroup Mean | N = 4
Δ 6MWD (m)	+81.3	+67.4
Δ VO_2 Max (% Predicted)	+5.4%	+6.7%
% Δ PVR (exercise)	-25.5%	-35.3%
% Δ PVR (supine)	-28.1%	-33.9%
% Δ NT-proBNP	-29.0%	-28.8%
Δ FVC (% Predicted)	+4.8%	+1.8%

- Consistent, clinically relevant improvement from baseline observed across multiple endpoints
- In addition to SOC therapy in heavily pre-treated population
- Data support potential benefit across exercise capacity, pulmonary hemodynamics, cardiac stress and lung function



6MWD = 6 Minute Walk Distance, VO_2Max, PVR = Pulmonary Vascular Resistance, NT-proBNP = N-terminal pro-B-type natriuretic peptide, FVC = Forced Vital Capacity
Data on file

PHASE 2a FUNCTIONAL CLASS ENDPOINT



	Baseline	Wk1	Wk4	Wk12	Wk16	Wk24	Mo 12
FC 1						1	1
FC 2		1	3	6	6	6	1
FC 3		9	7	4	2		
Total	10	10	10	10	9	6	2

Data on file

100%
of completers improved to FC II by Week 24

- All ten patients FC III at baseline
- Six of ten improved to FC II by week twelve
- Two patients improved to FC I

WHO Functional Class Definition*

Class I	Symptom-free when physically active or resting
Class II	No symptoms at rest, but normal activities such as climbing stairs, grocery shopping or making the bed cause some discomfort and shortness of breath
Class III	Resting may be symptom-free, but normal chores around the house are greatly limited due to shortness of breath or feeling tired
Class IV	Symptoms at rest and severe symptoms with an activity

*https://www.phaeurope.org/about-ph/classification-and-who-functional-class/

SAFETY SUMMARY THROUGH 24-WEEKS

DRUG RELATED AEs

- Grade 1 Productive Cough (n = 1) - Resolving
- Grade 2 Cough (n = 1) - Not Resolved
- Grade 1 Gingivitis (n = 1) - Resolving

LAM-001 WAS WELL TOLERATED

NO DOSE INTERRUPTIONS DUE TO AEs

NO DISCONTINUATIONS DUE TO DRUG

NO DRUG-RELATED SAEs

AEs = Adverse Events, SAEs = Serious Adverse Event
Data on file

PHASE 2a EFFICACY AND SAFETY SUMMARY

COMPELLING CLINICAL ACTIVITY

- **PH-ILD patients +67m improvement observed in 6MWD compares favorably to existing therapies[1]**
- **Benefit seen on top of standard of care in heavily pretreated population**
- **Consistent signals of patient benefit seen across multiple measures**

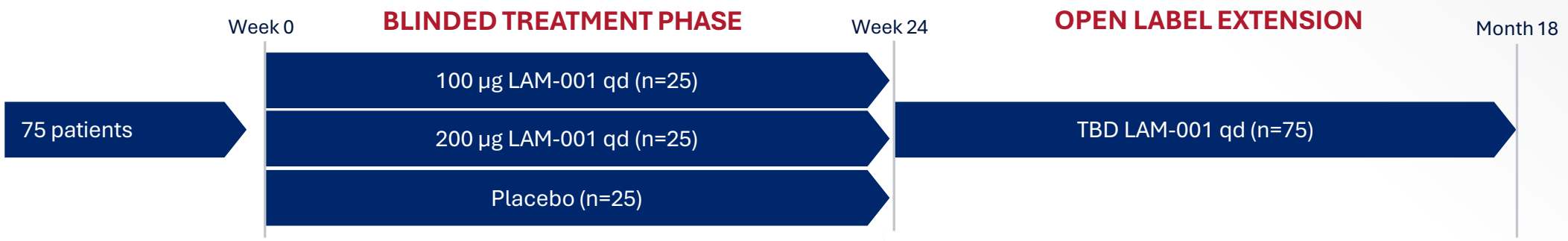
FAVORABLE TOLERABILITY

LAM-001 well tolerated

- No dose interruptions due to AE
- No discontinuations due to drug
- No drug related SAE
- Drug related AEs
  - N = 2 cough (Grade 1, 2)
  - N = 1 gingivitis (Grade 1)

[1]Compared to +31.1m placebo adj. improvement in the Tyvaso INCREASE Phase 3 study: Waxman 2021 DOI: 10.1056/NEJMoa2008470
No head-to-head clinical trials have been conducted evaluating LAM-001 and Tyvaso. Differences exist between study or trial designs and participant characteristics, and caution should be exercised when comparing data across studies

PHASE 2b TRIAL OF LAM-001 IN PH-ILD



DESIGN	• Placebo-controlled; Double Blind; Randomized 1:1:1; Multi-center (~60 sites); 24 wks; 12 mo open-label extension
INCLUSION	• 18-85 y/o; WHO FC II and III; PVR ≥4, PH-ILD Group 3; symptomatic despite stable background rx
PRIMARY ENDPOINTS	• Δ PVR
SECONDARY ENDPOINTS	• Δ 6MWD; Incidence of Clinical Worsening; Time to Clinical Worsening, % of pts maintain or improve WHO functional class, Δ NT-proBNP, Safety/Tolerability
EXPLORATORY ENDPOINT	• HRCT, Δ FVC, Δ DLCO, emPHasis 10, KBILD

Trial Ongoing, Data Anticipated 1Q 2028

Clinical Worsening defined as the occurrence of one of the following: 1) Death, 2) Lung or heart lung transplantation, 3) Hospitalization related to worsening respiratory status/respiratory decompensation (>24 hrs), 4) Addition of or increase in dose of greater than 10% of PH-specific therapy, 5) Worsened WHO Functional class AND symptomatic ≥ 15% decline in 6MWD from baseline (at two consecutive visits at least 24 hrs apart) 6) Symptomatic >10% decline from baseline FVC

PVR = Pulmonary Vascular Resistance, 6MWD = 6 minute walk distance, HRCT = High resolution CT, NT-proBNP = N-terminal pro-B-type natriuretic peptide, FVC = Forced Vital Capacity, DLCO = Diffusing Capacity of the Lungs for Carbon Monoxide, emPHasis 10 = pulmonary hypertension health related quality of life score, KBILD = King's Brief Interstitial Lung Disease Questionnaire

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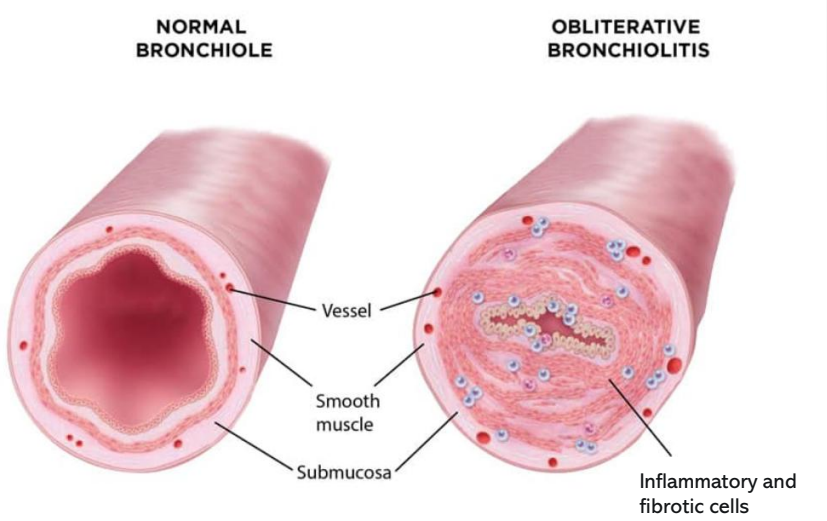
LAM-001: BRONCHIOLITIS OBLITERANS (BOS)

BRONCHIOLITIS OBLITERANS (BOS)

DISEASE:

- Leading cause of death post lung transplantation (LT)[1]
- Orphan Drug Designation granted US and Europe
- No FDA approved drugs
- ~4,000 lung transplants performed annually in US[2]

Estimated Addressable Patient Population[2]
BOS Post LT — US: ~17K | EU: ~11K



[1] Ehrsam 2021 doi.org/10.1016/j.healun.2021.01.887
[2] Estimated population at projected launch, US HRSA Data, Kulkarni 2018:doi: 10.1016/j.healun.2018.09.016 and Company estimates
[3] Adapted from researchoutreach.org

BOS MAJOR UNMET NEED

6.2 YEARS

Median survival post lung transplantation[1]

11%

BOS free survival at 10 yrs[2]

#1

BOS is the leading cause of death post lung transplantation[3]

2.5 YEARS

Median survival (or re-transplantation) post development of BOS post lung transplantation[4]

[1]ISHLT Factsheet: https://www.ishlt.org/docs/default-source/default-document-library/ishlt_fast-facts.pdf Accessed 7/6/26
[2]Kulkarni 2018 https://doi.org/10.1016/j.healun.2018.09.016
[3]Ehrsam 2021 doi.org/10.1016/j.healun.2021.01.887
[4]Copeland 2010 doi: 10.1164/rccm.201002-0211OC

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FEV1 IS KEY MEASURE OF BOS PROGRESSION AND SURVIVAL

PROGRESSION TO ADVANCED BOS IS MEASURED BY FEV1 DECLINE*

*Baseline = best post-transplant FEV1
Meyer 2014: DOI: 10.1183/09031936.00107514

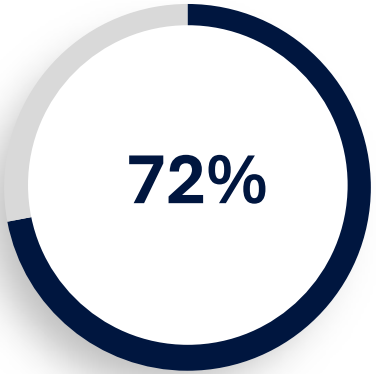
BOS Gr 0	BOS Gr 1	BOS Gr 2	BOS Gr 3
FEV1 > 80% Baseline	FEV1 66 - 80% Baseline	FEV1 51 - 65% Baseline	FEV1 ≤50% Baseline

1% ↓ in FEV1

3.4% ↑ Mortality
(p < 0.001)

1% decrease in FEV1 is associated with a 3.4% increase in Mortality (p < 0.001)

Kneidinger 2022 doi: 10.3389/fmed.2022.897581



- **72% of surveyed physicians ranked decline in FEV1 as the most important criterion for escalating BOS therapy**
- **Improvement in the rate of FEV1 decline should drive market uptake**

Based on a survey conducted with 48 BOS physicians, data on file

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RAPAMYCIN STABILIZES PULMONARY FUNCTION IN PATIENTS WITH BOS[1]

Oral rapamycin administered to patients with progressive BOS post lung transplant who had not responded to other treatments

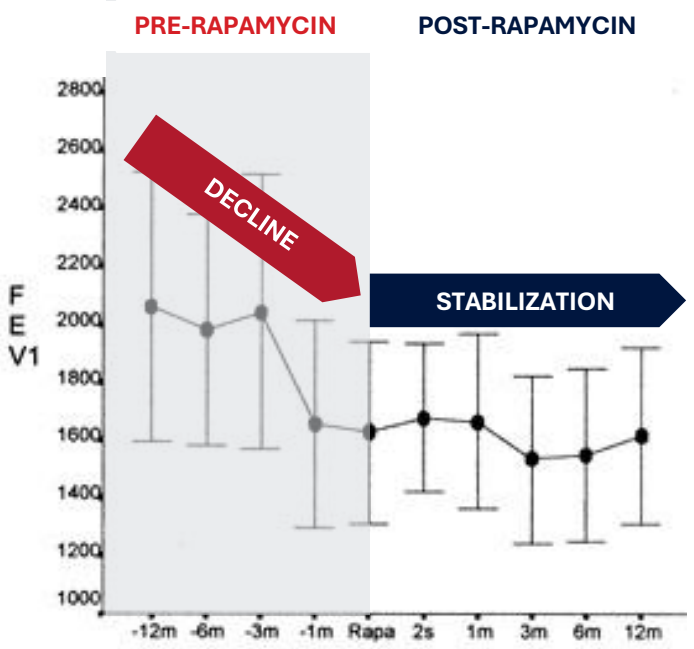
Prior to initiation of rapamycin:

Decline in FEV1 over the course of 12 months

Post introduction of rapamycin:

Eight of eleven patients (73%) showed improved or stabilized FEV1

Mean FEV1 Values Before and After Rapamycin



[1]Based on Hernandez, et. al. Transplantation Proceedings, 2005. DOI: 10.1016/j.transproceed.2005.09.191

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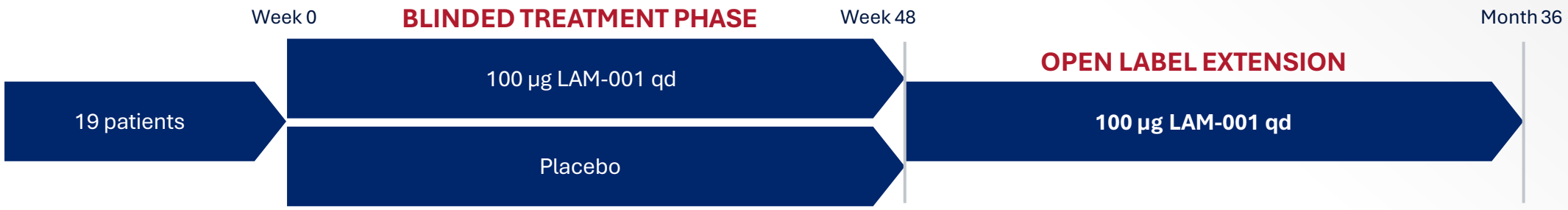
PHASE 2 TRIAL OF LAM-001 IN BOS



DESIGN	• Randomized 1:1, Double Blind, Placebo controlled, 25 mo open-label extension, Investigator-initiated trial
INCLUSION	• >18 yo; Newly diagnosed BOS (FEV1 51-85% of baseline, ≤ 12 mo from BOS diagnosis); ≥ 12 mo post Double lung transplant
PRIMARY ENDPOINTS	• % Δ in FEV1 @ 48 wks (or at termination of therapy, whichever occurs first)
SECONDARY ENDPOINTS	• Absolute Δ in FEV1 @ 48 wks*, Δ rate of progression in FEV1 @ 48 wks* vs pre-enrollment, PFS Level 1 (time to earliest to occur of: >10% decline in FEV1, death from respiratory failure or re-transplantation), Safety/Tolerability
EXPLORATORY ENDPOINT	• 6MWD @ 48 wks*, PFS Level 2 (time to earliest to occur of: >20% decline in FEV1,death from respiratory failure or re-transplantation), Δ FEV1/FVC @ 48 wks*, SGRQ-C, PK, CLAD signature gene profiling @ 3 mo, mTOR pathway activation via BAL
STATUS**	• Enrollment completed January 2026. An interim safety review was conducted in February 2026. Five of 19 subjects enrolled in the ongoing blinded study experienced a decline*** in FEV1 >10% at that time. Dosing continues.

TRIAL FULLY ENROLLED, DATA ANTICIPATED 1Q 2027

*Measured at 48 wks or at termination or treatment, whichever occurs first
** The interim clinical data presented herein are derived from an ongoing blinded study. Because the study remains blinded, the Company is unable to determine which patients received LAM-001 versus placebo. These interim data are preliminary, should be interpreted with caution, and are not indicative of the final results of the study. No conclusions regarding the efficacy or safety of LAM-001 should be drawn from these interim results. The actual results following unblinding may differ materially from the interim data presented herein.
*** As measured in two consecutive visits
FEV1 = Forced Expiratory Volume in 1 Second, PFS = Progression Free Survival, FVC = Forced Vital Capacity, SGRQ-C = St. George's Respiratory Quesitonnaire, COPD, BAL = Bronchioalveolar Lavage

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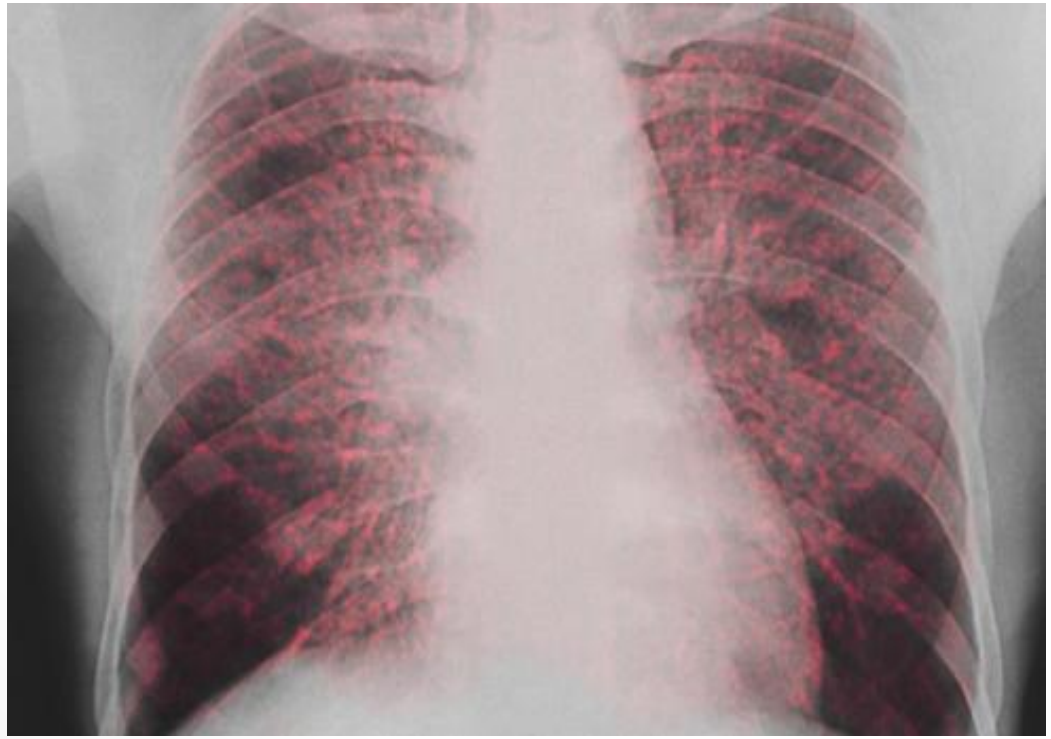
LAM-001: SARCOIDOSIS ASSOCIATED PULMONARY HYPERTENSION (SAPH)

SARCOIDOSIS ASSOCIATED PULMONARY HYPERTENSION (SAPH)

DISEASE:

- Sarcoidosis is a disease characterized by the growth of abnormal masses of cells called granulomas
  - Lungs are affected in 90% of cases (pulmonary sarcoidosis)
  - SAPH: a severe complication that occurs in 15% of cases[1]
- 55% 5 yr survival: 8-10x increase in mortality vs Sarcoidosis without PH[2]
- Median time from diagnosis to death or hospitalization 6 mo[3]
- No approved medications
  - PAH drugs approved for Group 1 PH used commonly off-label but of limited benefit (sildenafil, ERAs, prostacyclins)
- **Proof of concept from LAM-001 Phase 2a PH study**
  - *(N = 1: 6MWD + 161.5m, PVR – 41.0% @ 24 wks)*

Estimated Addressable Patient Population[1,4]
SAPH — US: ~26K | EU: ~34K



Pulmonary Sarcoidosis

1 Duong 2018 doi.org/10.1097/CPM.0000000000000252
2 Boucly 2017 https://doi.org/10.1183/13993003.00465-2017
3 Parikh 2019 https://doi.org/10.1038/s41598-019-40030-w
4 Lung.org accessed 10/16/26
ERAs = Endothelin Receptor Antagonists

Sarcoidosis is a multiorgan disease with specific organ involvement suggested by physical examination (skin, eye, etc.) or suggested by imaging (x-ray, MRI, or PET scan). Diagnosis is confirmed by biopsy of affected tissue identifying non caseating granulomas with no alternative cause identified

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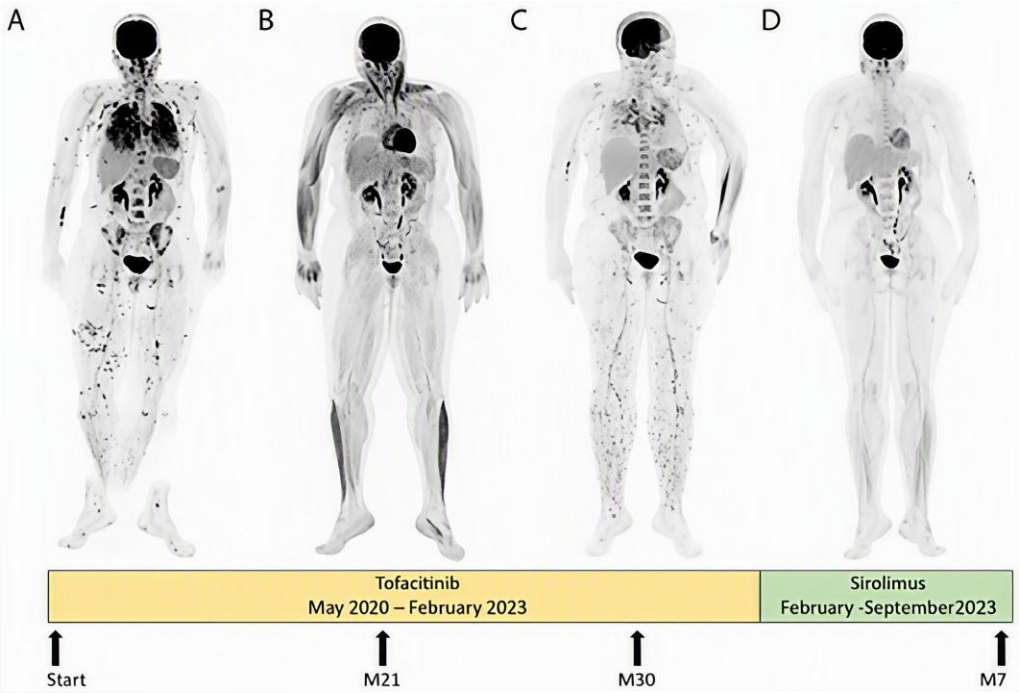
CLINICAL CASE STUDY (RAPAMYCIN): PULMONARY SARCOIDOSIS

COMPLETE RESPONSE IN SEVERE PULMONARY SARCOIDOSIS

- Patient with severe pulmonary sarcoidosis failed to respond to prednisone, azathioprine, methotrexate, hydroxychloroquine, infliximab and adalimumab
- JAK inhibitor (JAKi) started due to progressive skin lesions, worsening FVC, new pulmonary hypertension. 30 mo after initiation of treatment, skin lesions, respiratory decline and multi-organ relapse resumed.
- Oral rapamycin (sirolimus), 2mg QD initiated, then titrated to 4mg per day. After 7 mo:
  - 10% gain in FVC
  - 330-meter improvement in 6MWD
  - Weaning of supplemental Oxygen
- At 12 months:
  - FVC reached 54% predicted up from 40% before introduction of oral rapamycin
  - Complete response on FDG-PET

Patient PET scans before and after JAKi and Rapamycin (sirolimus) treatment



Hindre 2024: https://doi.org/10.1016/j.pulmoe.2024.03.002
JAKi = Janus kinase inhibitor, FVC = Forced vital capacity, 6MWD = 6 minute walk distance, PET = Positron emission tomography, FDG-PET = fluorodeoxyglucose PET

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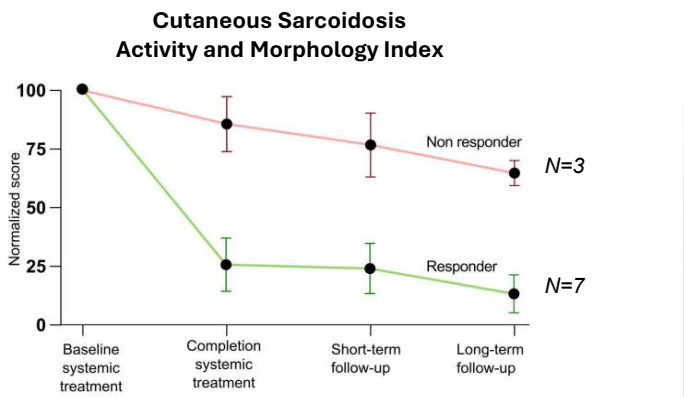
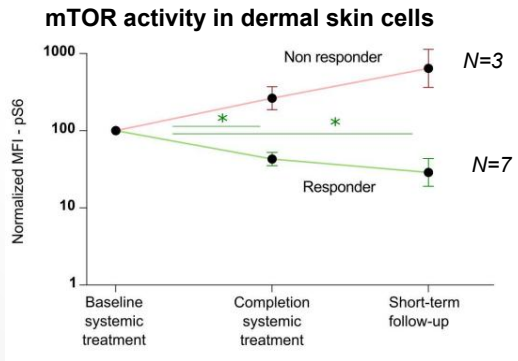
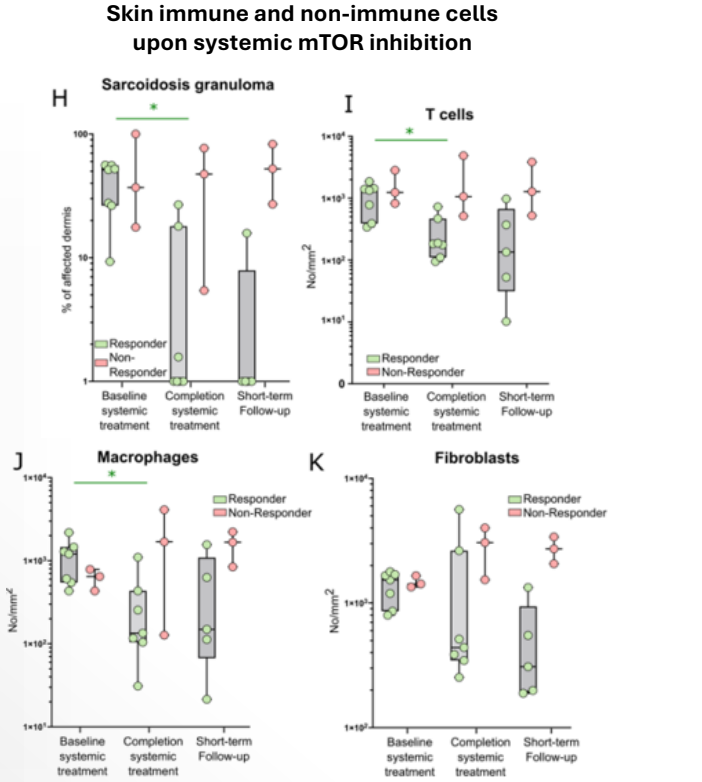
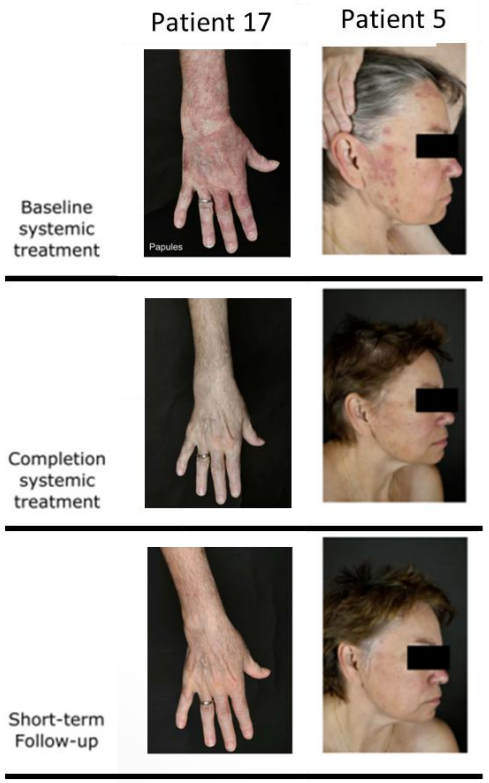
mTOR INHIBITION DEMONSTRATES ACTIVITY IN CUTANEOUS SARCOIDOSIS









Subjects with Cutaneous Sarcoidosis treated with Oral Rapamycin for 4 months

12 patients started systemic treatment, 10 completed 4 months of treatment
7/10 patients were classified as **"responders"** (decrease in CSAMI > 5 points)

Redl, et al. 2024, Lancet Rheumatology. Efficacy and safety of mTOR inhibition in cutaneous sarcoidosis: a single-centre trial. https://doi.org/10.1016/s2665-9913(23)00302-8

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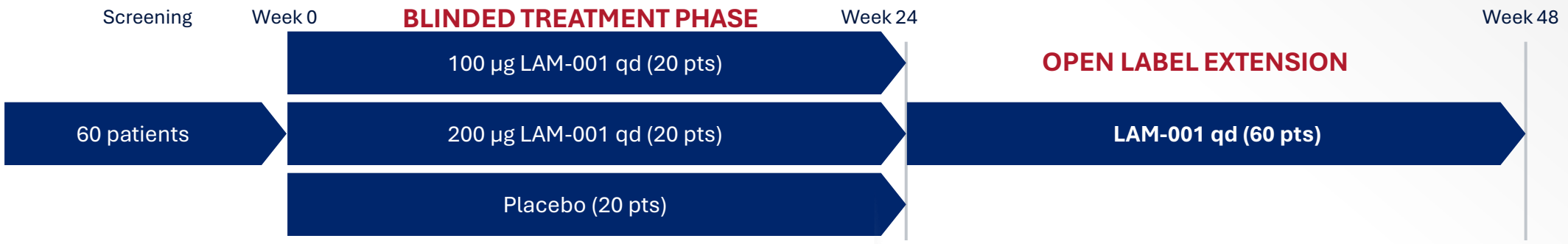
PHASE 2 TRIAL OF LAM-001 IN SAPH[1]



DESIGN	•	Placebo-controlled, double-blind, R1:1:1, 24 wks, up to 50 sites (ww), 6-mo open-label extension
INCLUSION	•	18 – 85 yrs; FC II or III; symptomatic despite stable background rx (≥ 3 mo) , no new PH or anti-inflammatory sarcoidosis drugs (< 6 mo, PH or sarcoidosis therapies not required for inclusion), PVR ≥ 4.0 WU
PRIMARY ENDPOINT[2]	•	Δ PVR
SECONDARY ENDPOINTS[2]	•	Δ 6MWD, Δ NT-proBNP, Time to Clinical Worsening[3], # Clinical Worsening events, Δ FVC, Δ TLV/TLC, Δ DLCO, # death/transplants, KSQ-L/GH, PGA, FAS, emPHasis-10, Safety/Tolerability
EXPLORATORY ENDPOINTS[2]	•	% pts maintain or improve WHO FC, Δ HRCT (fibrosis, vascular blood distribution), Δ 6MWD @ 48 wks, Biomarkers (ACE, s-IL2R, calcitriol), Δ Cough Severity VAS, PK

Anticipated Start 4Q 2026

1 Proposed study design
2 All secondary endpoints at 24 wks unless otherwise specified
3 Clinical Worsening defined as first of the following: 1) Death, 2) Lung or heart-lung transplantation, 3) Hospitalization related to worsening respiratory status/respiratory decompensation (>24 hrs), 4) PH symptoms that require the addition of or increase in dose > 10% of a PH disease-specific medication, 5) Symptomatic >10% decline from baseline FVC confirmed with repeat testing, 6) Worsened WHO functional class AND Symptomatic >15% decline in 6MWD from baseline directly related to the disease (at two consecutive visits at least 24 hrs apart)
PVR = pulmonary vascular resistance, 6MWD = 6-minute walk distance, NT-proBNP = N-terminal pro-B-type natriuretic peptide, DLCO = diffusion capacity of carbon monoxide, FVC = forced vital capacity, TLV/TLC = total lung volume / total lung capacity, KSQ-L/GH = King's Sarcoidosis Questionnaire, Lung/General Health, PGA = Patient Global Assessment, FAS = Fatigue Assessment Score, HRCT = High Resolution CT Scan, ACE = Angiotensin Converting Enzyme, s-IL2R = soluble Interleukin-2 Receptor, VAS = visual analogue scale

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IP, FINANCIAL, & MILESTONES

BROAD IP STRATEGY SUPPORTING LAM-001 EXCLUSIVITY

FDA ORANGE BOOK AFFORDS PROTECTION FOR 3 TYPES OF PATENTS

COMPOSITION CLAIMS

Drug Substance (DS)

- Particle size

Drug Product (DP)

- Formulation
- Delivery
- Dosage

METHOD CLAIMS

Method of Treatment (MoT)

- Use of composition
- Defined dosing regimens
- Specific indications

9 US AND 25 INTERNATIONAL PATENTS ISSUED* – EXPECTED EXCLUSIVITY INTO 2035

- Pharmaceutical compositions on DPI formulation
- Methods of treating PH and chronic lung disease

Pending Applications – Expected Exclusivity Into 2047

MULTIFACETED IP AND EXCLUSIVITY STRATEGY

- Broad claims in all 3 categories
  - Drug substance, drug product, and method
- Multiple patents expected to be Orange Book-listable
- Device exclusivity for the use of rapamycin in the RS01 dry powder inhaler device

ORPHAN DRUG EXCLUSIVITY IN ADDITION TO PATENTS | 7 YEARS US / 10 YEARS EU

* Australia, Canada, Europe, Hong Kong, Israel, Japan, Mexico, New Zealand and South Korea.

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WELL-CAPITALIZED WITH FUNDING FROM LEADING HEALTHCARE INVESTORS

MAY 2026 FINANCING

OVERSUBSCRIBED $115M UPFRONT FINANCING

LED BY

Balyasny

INCLUDING

AFFINITY ASSET ADVISORS

COASTLANDS CAPITAL

COLUMBIA THREADNEEDLE INVESTMENTS

Cormorant Asset Management

EVENTIDE

FORESITE CAPITAL

Janus Henderson INVESTORS

LIFESCI VENTURE PARTNERS

LOGOS CAPITAL

PERCEPTIVE ADVISORS

SILVERARC CAPITAL

WOODLINE PARTNERS

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ANTICIPATED MILESTONES

1Q27	1Q28	4Q28
LAM-001 BOS **Phase 2 Data**	LAM-001 PH-ILD **Phase 2b Data**	LAM-001 SAPH **Phase 2 Data**

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THANK YOU

OCTOBER 2026