Jade BIOSCIENCES

Company Overview

July 2025

NASDAQ: JBIO

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Forward Looking Statements

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Market and Industry Data

Certain information contained in this presentation and statements made orally during this presentation relate to or are based on studies, publications and other data obtained from third-party sources as well as our own internal estimates and research. While we believe these third-party sources to be reliable as of the date of this presentation, we have not independently verified, and make no representation as to the adequacy, fairness, accuracy or completeness of, any information obtained from third party sources. Forecasts and other forward-looking information obtained from these sources are subject to the same qualifications and uncertainties as the other forward-looking statements in this presentation. Statements as to our market and competitive position data are based on market data currently available to us, as well as management's internal analyses and assumptions regarding the Company, which involve certain assumptions and estimates. These internal analyses have not been verified by any independent sources, and there can be no assurance that the assumptions or estimates are accurate. While we are not aware of any misstatements regarding our industry data presented herein, our estimates involve risks and uncertainties and are subject to change based on various factors. As a result, we cannot guarantee the accuracy or completeness of such information contained in this presentation.

Jade Biosciences is advancing potentially best-in-class therapies for autoimmune diseases

Current funding expected to support operations through 2027, well beyond biomarker-rich JADE101 healthy volunteer data

MOA	Program	Candidate	Discovery	IND-enabling	Planned Clinical FIH	Interim FIH Data	Potential Indications
anti-APRIL	JADE-001	JADE101			2H25	1H26	IgAN
Undisclosed	JADE-002	JADE201			1H26		Multiple systemic AI diseases
Undisclosed	JADE-003	—			1H27		Undisclosed

Development candidates licensed from Paragon

Candidates designed to maximize clinical responses and allow patient friendly, infrequent dosing

Notes: Jade has entered into an exclusive JADE101 license agreement with Paragon Therapeutics. Jade holds an exclusive option to license JADE201 and JADE-003 from Paragon. Jade has not yet entered into a license agreement with respect to JADE201 or JADE-003.
MOA – mechanism of action; FIH – First-in-Human, IgAN - IgA nephropathy; AI - autoimmune

JADE101: a potentially best-in-class anti-APRIL mAb for IgAN

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Jade is developing a potentially best-in-class anti-APRIL mAb

Estimated $10B+ branded market

Current treatments do not adequately address the need for **long-term disease-modifying therapy** in a typically young IgAN patient population

Anti-APRIL class poised to be frontline treatment for IgAN

Mechanism has potential to be disease modifying, **reducing pathogenic IgA** and proteinuria, **stabilizing kidney function**

Potentially best-in-class profile

JADE101 is designed to have superior potency and an extended half-life for **maximal efficacy** & **convenient dosing**

Efficient path to PoC and market

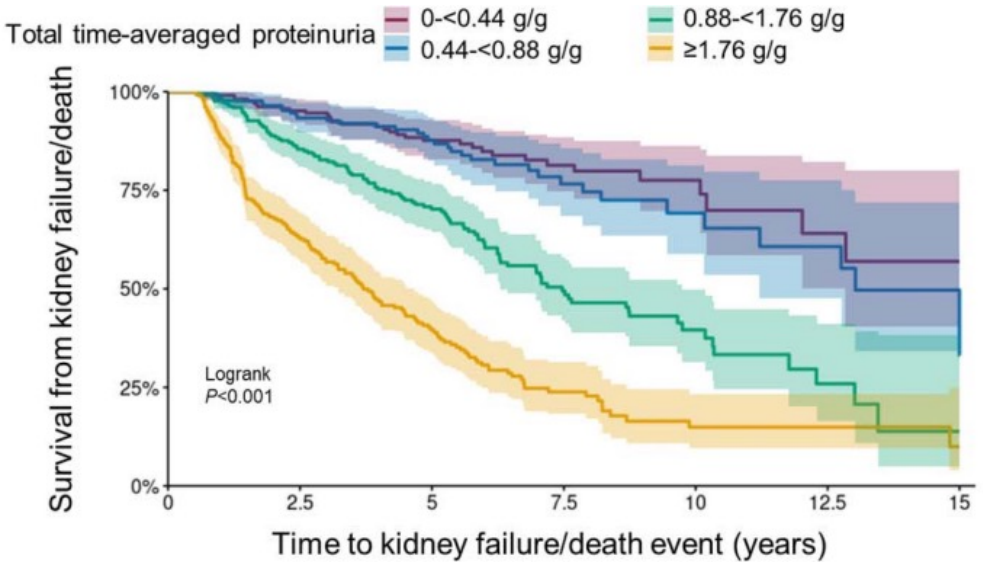
Biomarker-rich and highly translational HV data expected in 1H26; potential for **surrogate endpoints in future trials to support IgAN approval**

HV – healthy volunteer, mAb – monoclonal antibody, PoC – proof of concept

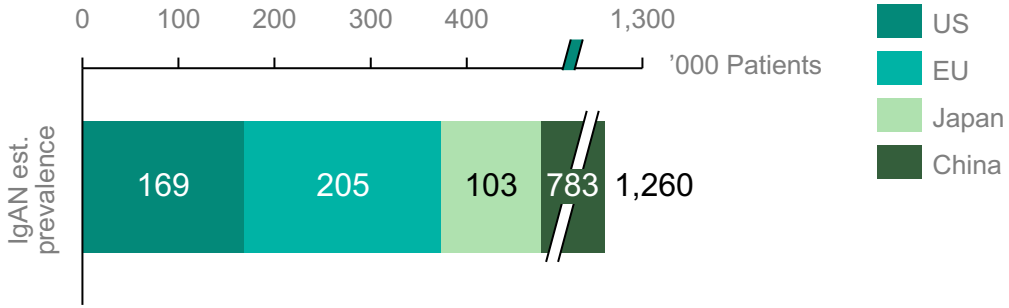
~169K+ IgAN patients in the U.S. with majority requiring treatment*, representing potential $10B+ market

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

IgAN patients are **at risk of kidney failure: Risk increases with higher proteinuria**



~1M+ global patients,
significant potential ex-U.S. market potential

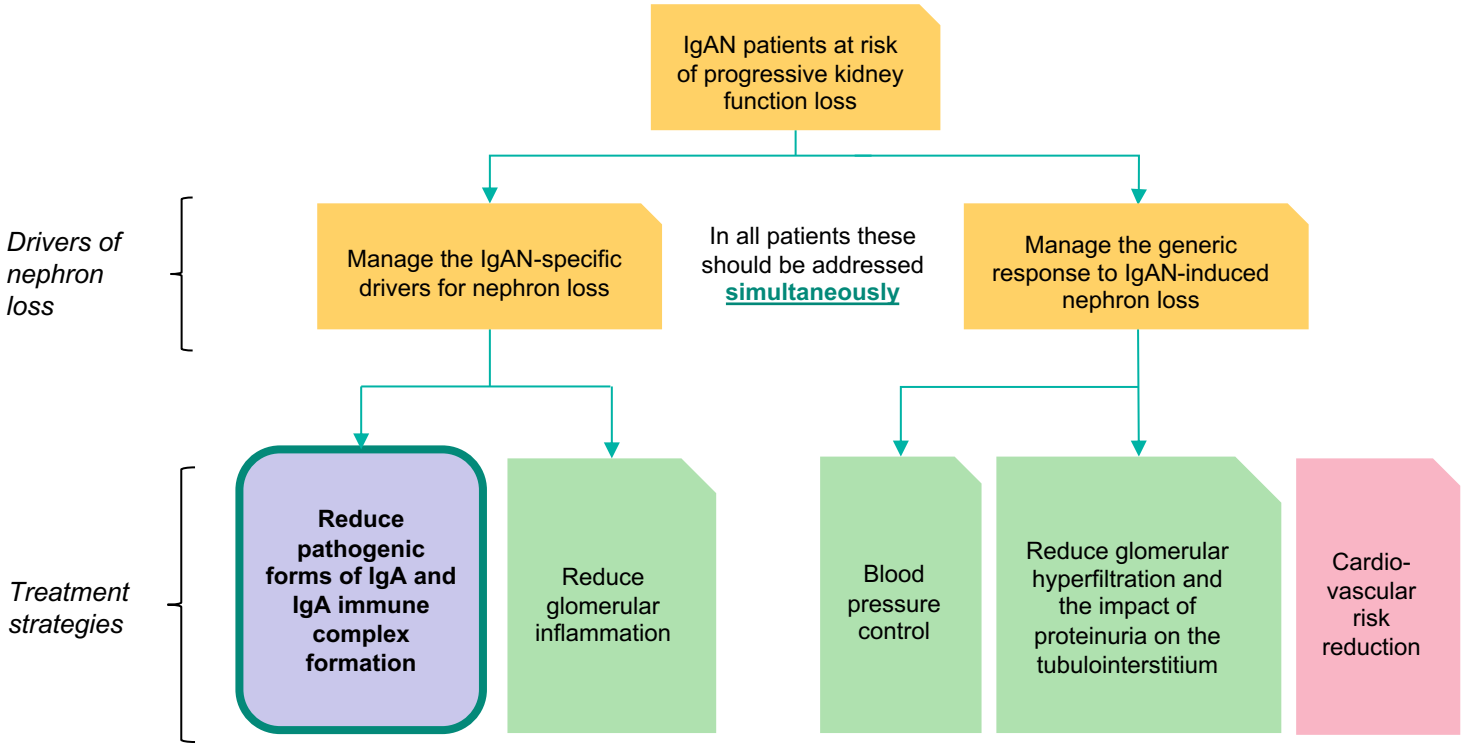


~169K+ patients with IgAN in the U.S., with **60-75%** requiring treatment per international guidelines

There is significant unmet need for therapies that provide **disease modifying impact,** are **well-tolerated** and are **conveniently dosed** given the typically early age of IgAN diagnosis

*Per KDIGO guidelines, treatment should be initiated in all cases where patients have proteinuria ≥0.5 g/day.
Notes: U.S. prevalence estimate from FDA; EU prevalence estimate from EMA; Japan / China prevalence estimates from a Novartis presentation. Estimated pricing of ~$120K-$150K per year based on Filspari and Tarpeyo.
Sources: 2023 Pitcher (CJASN); FDA Reviews for Filspari / Tarpeyo; EMA; Novartis; 2018 Schena (Seminars in Nephrology); Reuters

Proposed updates to KDIGO guidelines position the anti-APRIL class as the foundational therapy in IgAN



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

Expanding Patient Population

- Kidney biopsy recommended in all adults with proteinuria ≥0.5 g/d where IgAN is a possible diagnosis
- Recommends **additional treatment should be initiated in all cases** where patients have proteinuria ≥0.5 g/d

Lower Proteinuria Targets

- Establishes new treatment goal: proteinuria maintained at <0.5 g/day, **preferably <0.3 g/day**

Redefining Treatment Strategies

- New guidelines direct the use of treatments that have been **proven to reduce pathogenic forms of IgA**

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

Potentially best-in-class profile of JADE101

Femtomolar APRIL Affinity + Half Life Extension

Potentially best-in-class efficacy

APRIL inhibitors demonstrate greater proteinuria reduction and increased clinical remission rates with higher exposures and more complete APRIL suppression

Infrequent Q8W+ dosing

Minimizes burden in a typically young IgAN patient population potentially requiring life-long therapy (≤ 6 injections/year)

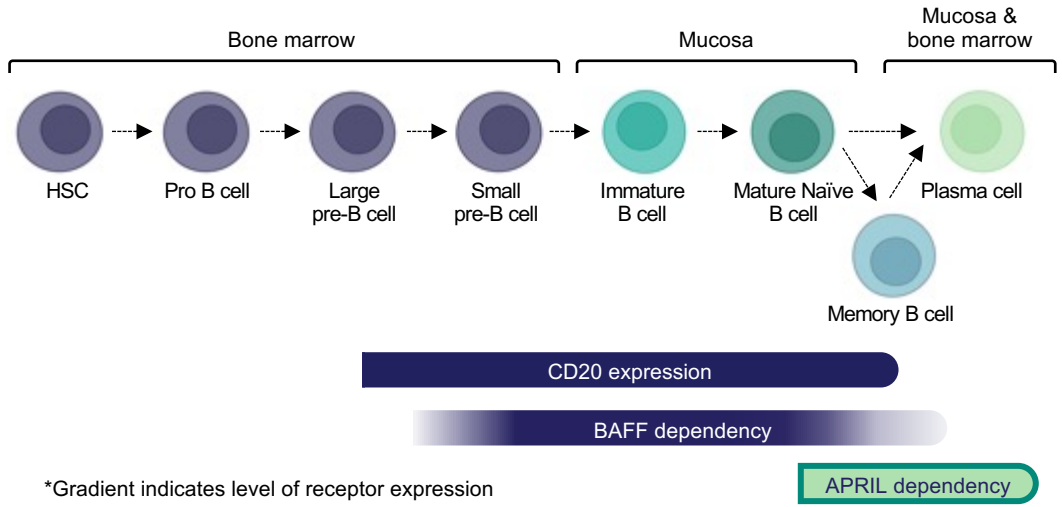
Avoids unnecessary immunosuppression

Selectively targeting APRIL provides disease modifying impact while avoiding B-cell depletion associated with BAFF inhibition

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

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

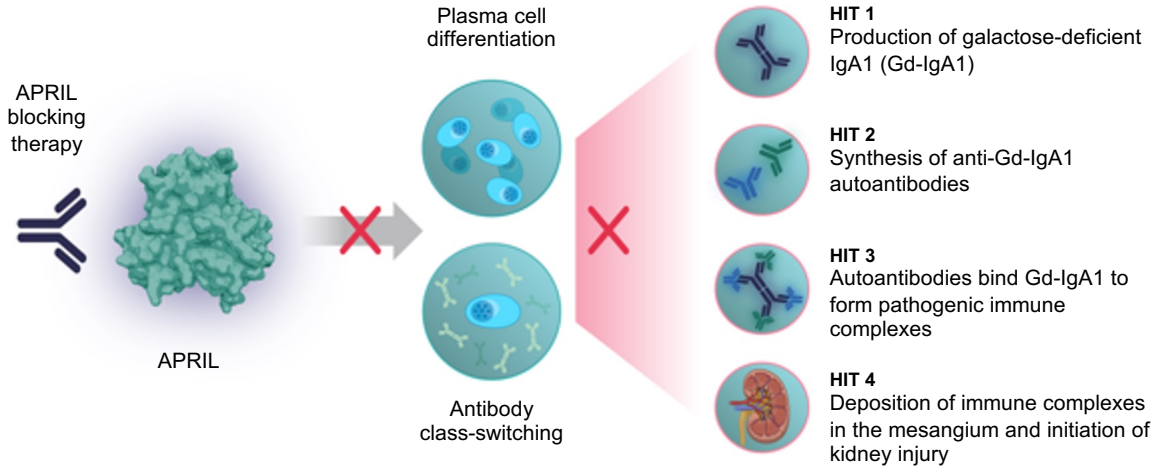
- B-cell depletion with rituximab (anti-CD20) **failed to reduce Gd-IgA1, anti-Gd-IgA1 autoantibody, or proteinuria** and **did not impact eGFR**.
- BAFF neutralization (blisibimod) **did not reduce IgA or proteinuria.**



*Gradient indicates level of receptor expression

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

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



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

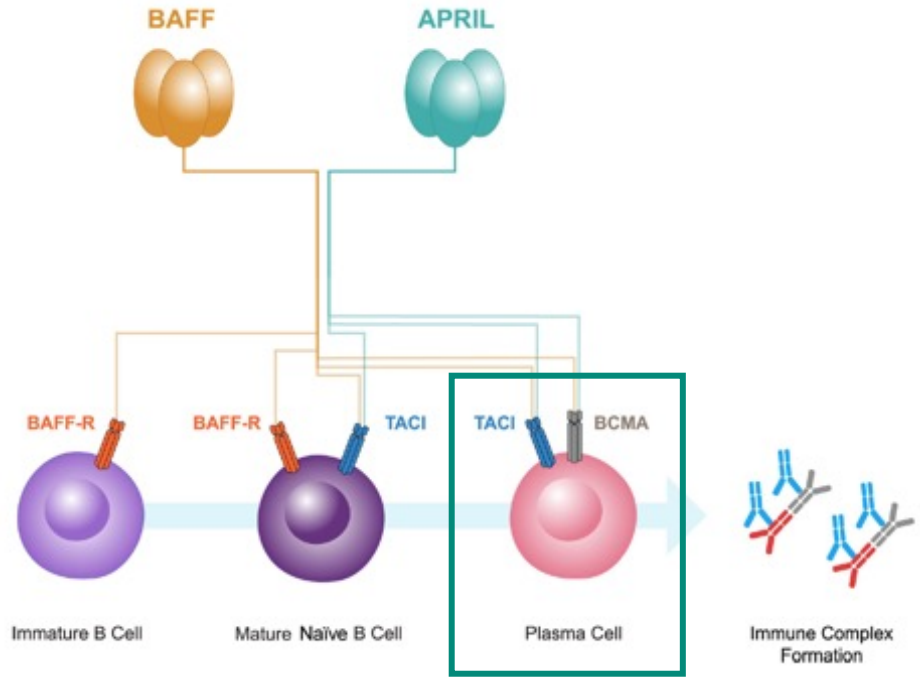
Sources: 2024 Cheung (Front Nephrol); 2023 Mathur (J Clin Med)

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

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

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

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



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

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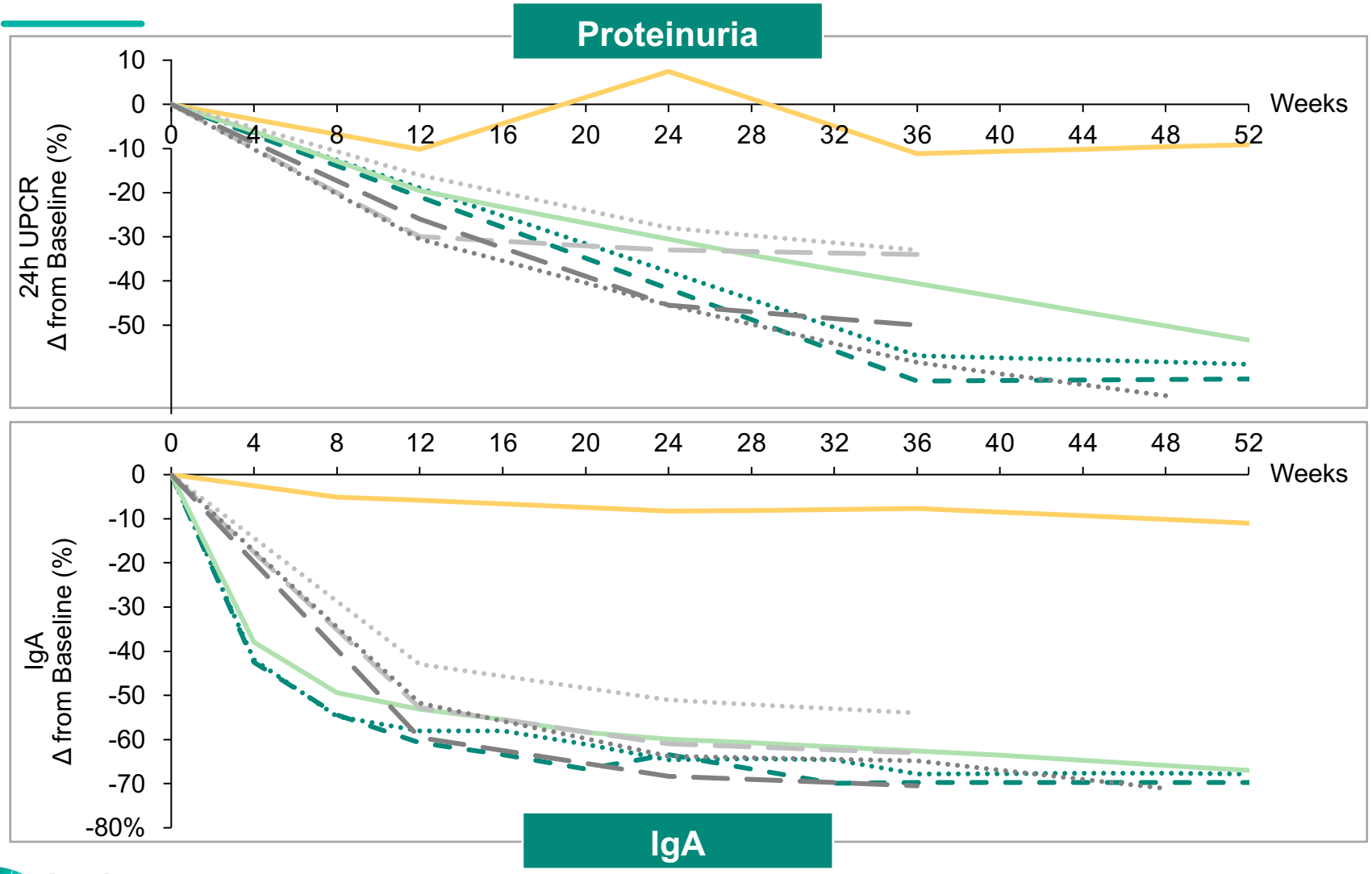
Sources: 2024 Cheung (Front Nephrol); Chinook 2022 CKD3 Presentation; 2004 Castigli (PNAS); 2001 Schiemann (Science)
GWAS - Genome-Wide Association Studies, KO – knockout

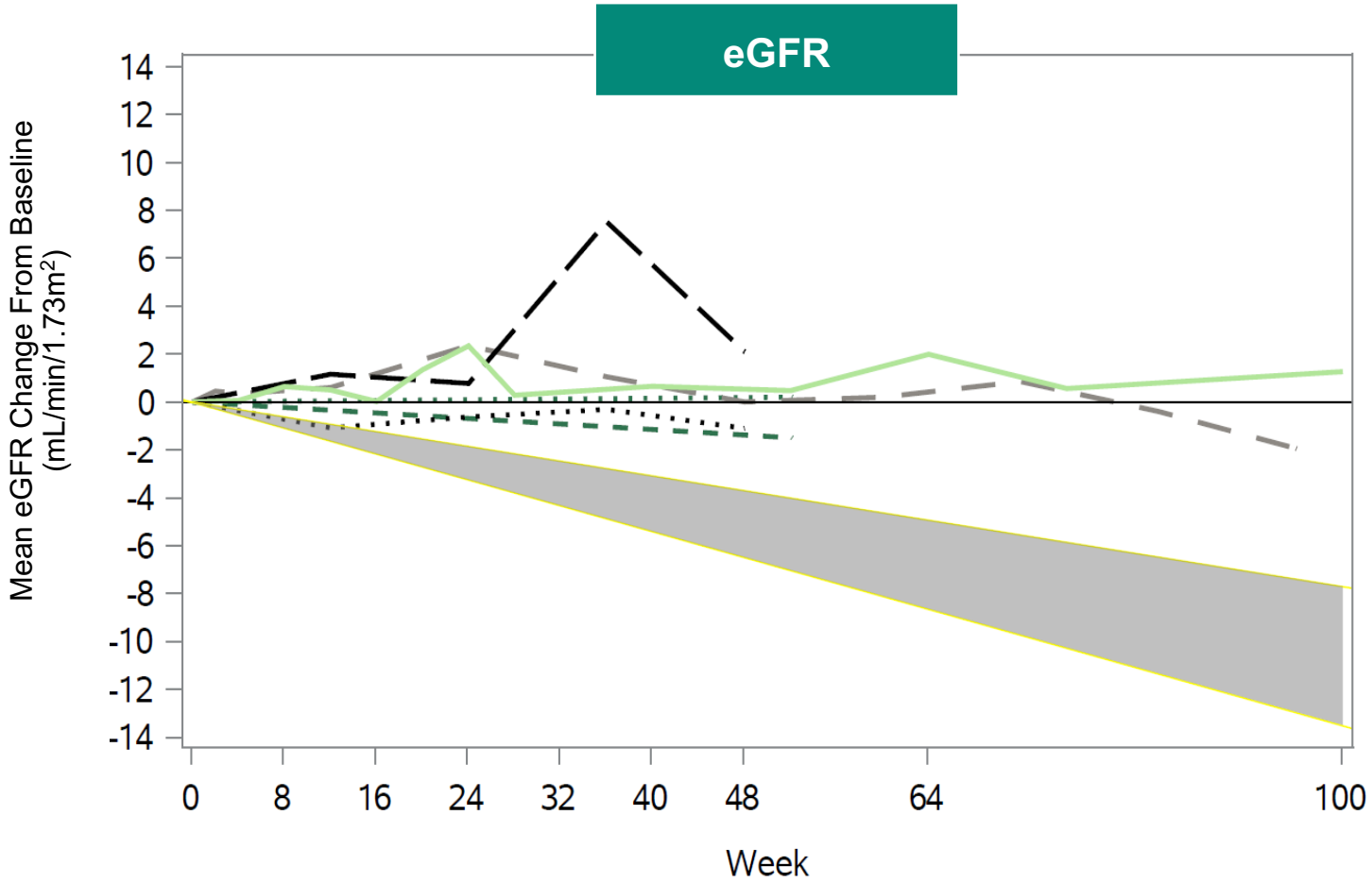
Reductions in proteinuria and IgA across Phase 2 clinical studies indicate APRIL inhibition is the driving force behind efficacy in IgAN



TACI-Fc fusion proteins inhibit APRIL & BAFF

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

Selective APRIL inhibition is sufficient to deliver the full disease modifying impact of eGFR stabilization in IgAN Phase 2 trials

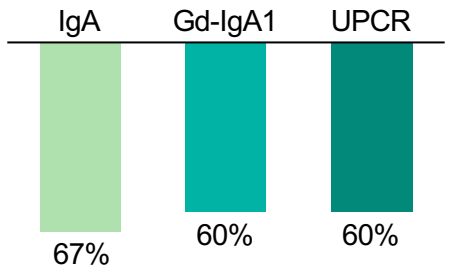
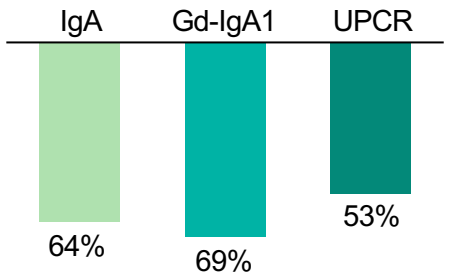
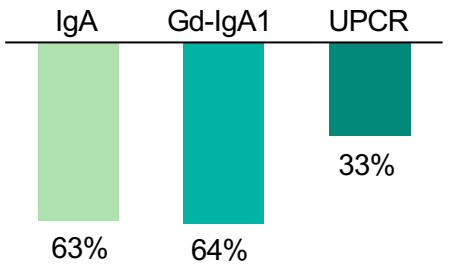
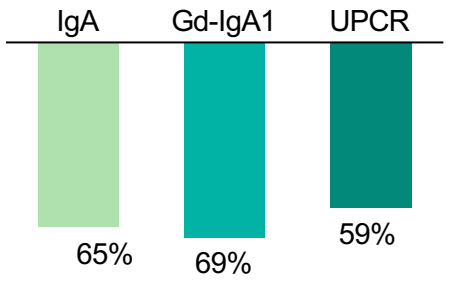


- Sibeprenlimab (anti-APRIL, 8 mg/kg)
- Sibeprenlimab (anti-APRIL, 4 mg/kg)
- Zigakibart (anti-APRIL)
- Atacicept (TACI-FC, Open Label)
- Povetacicept (Eng. TACI-Fc, 240 mg)
- Povetacicept (Eng. TACI-Fc, 80 mg)
- Control group (Range of expected decline: 4 – 7 mL/min/1.73m²/year)

TACI-Fc fusion proteins inhibit APRIL & BAFF

Notes: Cross-trial comparisons are inherently limited and presented for hypothesis-generating purposes only. Data digitized from graphs where publications did not provide specific values.
eGFR – Estimated Glomerular Filtration Rate
Sources: 2023 Mathur (NEJM); 2025 Barratt (ERA Poster); 2025 Barratt (JASN) (atacicept based on open-label treatment at 150 mg QW where baseline is the last value prior to receiving the first dose of atacicept at any dose level); 2024 Madan (ASN Presentation)

No clinical evidence that inhibiting BAFF provides additional efficacy beyond APRIL alone in IgAN Phase 2 clinical trials

	Sibeprenlimab	Zigakibart	Atacicept	Povetacicept
MoA	anti-APRIL	anti-APRIL	TACI-Fc	Engineered TACI-Fc
Status	Phase 3	Phase 3	Phase 3	Phase 3
Δ from baseline in critical disease markers *(W36 timepoint*)*	 N=79 (4/8 mg/kg pooled)	 N=35 (600 mg)	 N=32 (150 mg)	 N=9 (80 mg)
GFR stabilization	✓ (1 year)	✓ (2 years)	✓ (2 years)	✓ (1 year)
Hematuria resolution	✓	✓	✓	✓
Safety	✓ Well-tolerated, no overall ↑ infections, slight ↑ in URTIs vs. placebo	✓ Well-tolerated (no placebo), no drug discontinuations	✓ Well-tolerated, slight ↑ in infections (& URTIs) vs. placebo	✓ Well-tolerated (no placebo) 240 mg ↑ infections
Phase 3 Dosing	400 mg SC, Q4W	600 mg SC, Q2W	150 mg SC, QW	80 mg SC, Q4W

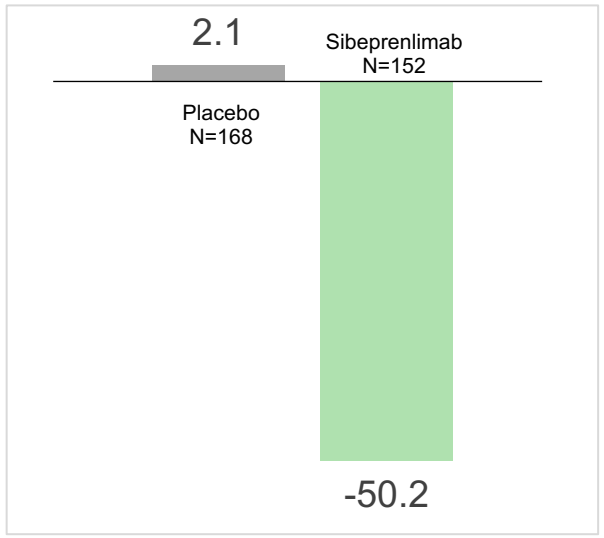
Notes: Cross-trial comparisons are inherently limited and presented for hypothesis-generating purposes only. Zigakibart IgA / Gd-IgA data at W40; UPCR data at W52 (only timepoint available); change from baseline is not placebo-controlled; N represents patients on dose(s) for which data is shown. Atacicept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

Selective APRIL inhibition resulted in numerically greater proteinuria reduction compared to dual APRIL/BAFF in Phase 3 IgAN trials

UPCR Δ from baseline (%, W36)

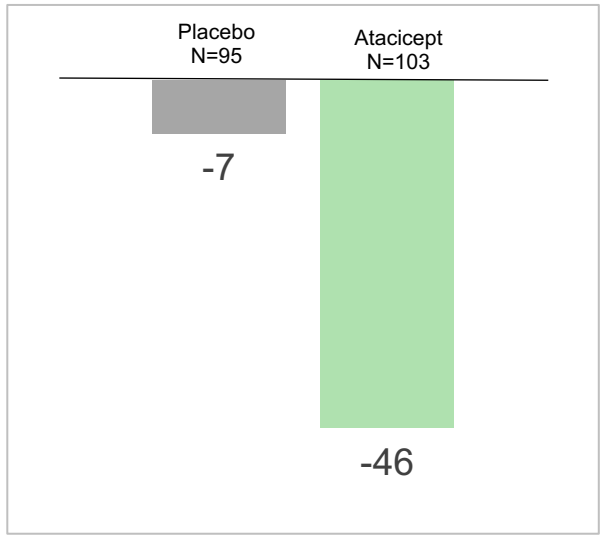
Sibeprenlimab

Δ -51%
(p < 0.0001)



Atacicept

Δ -42%
(p < 0.0001)



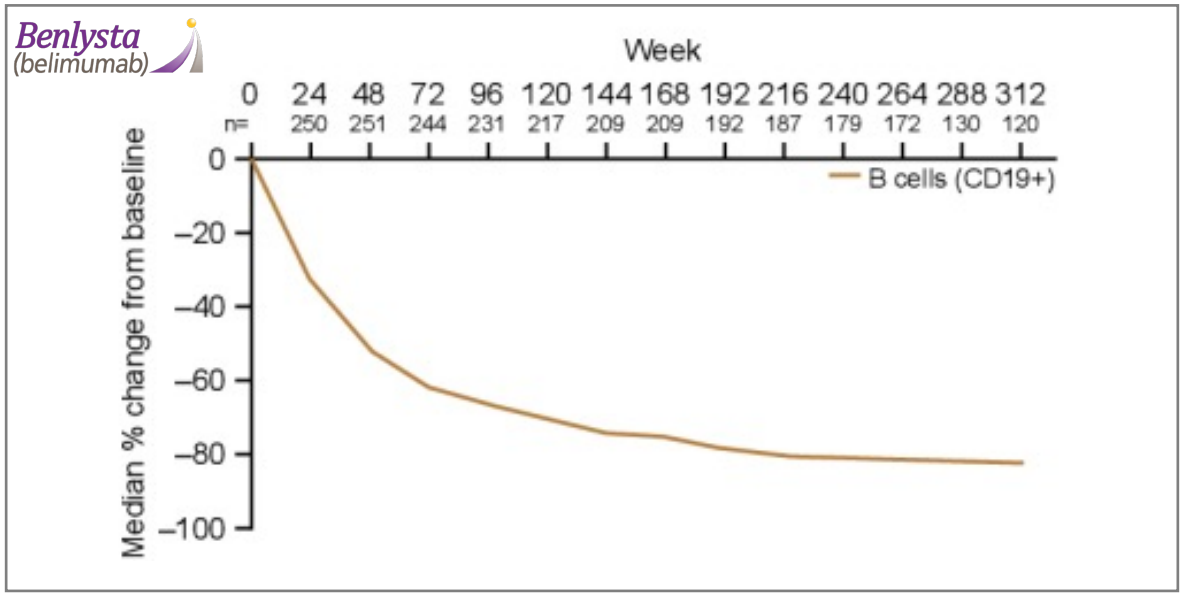
Study populations were consistent with a high-risk, global, IgAN patient population, similar to other pivotal studies.

Active treatments were well tolerated with favorable safety profiles comparable to placebo.

Notes: Cross-trial comparisons are inherently limited and presented for hypothesis-generating purposes only. Data digitized from graphs where publications did not provide specific values.
Sources: Perkovic et al. ERA 2025 (sibeprenlimab), ORIGIN 3 clinical trial (atacicept, NCT04716231)

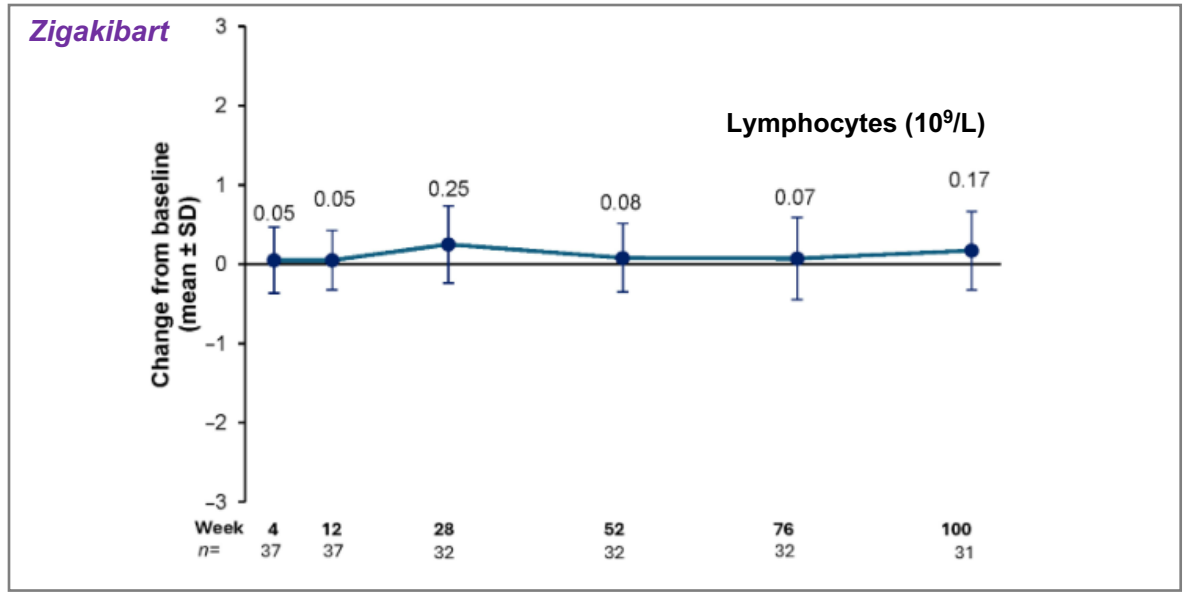
BAFF inhibition is accompanied by the potential for significant long-term B cell depletion

Long-term BAFF inhibition **significantly depletes B cells**…



~7-year belimumab data in SLE shows **long-term BAFF inhibition lowers CD19+ B cells by ~80%**

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



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

Sources: 2022 Struemper (Lupus Sci Med);2025 Barratt (Kidney International)

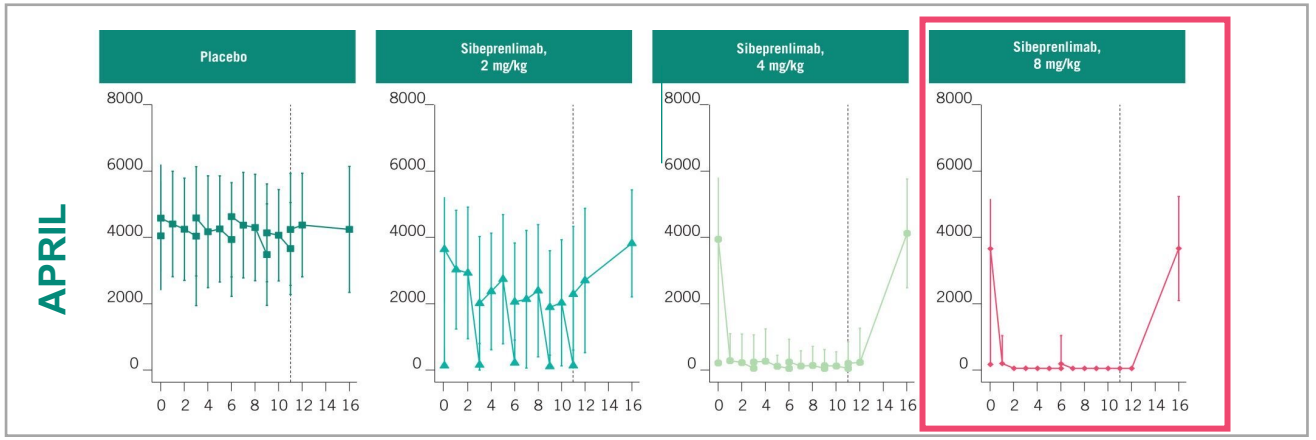
Deeper APRIL suppression drives superior clinical efficacy

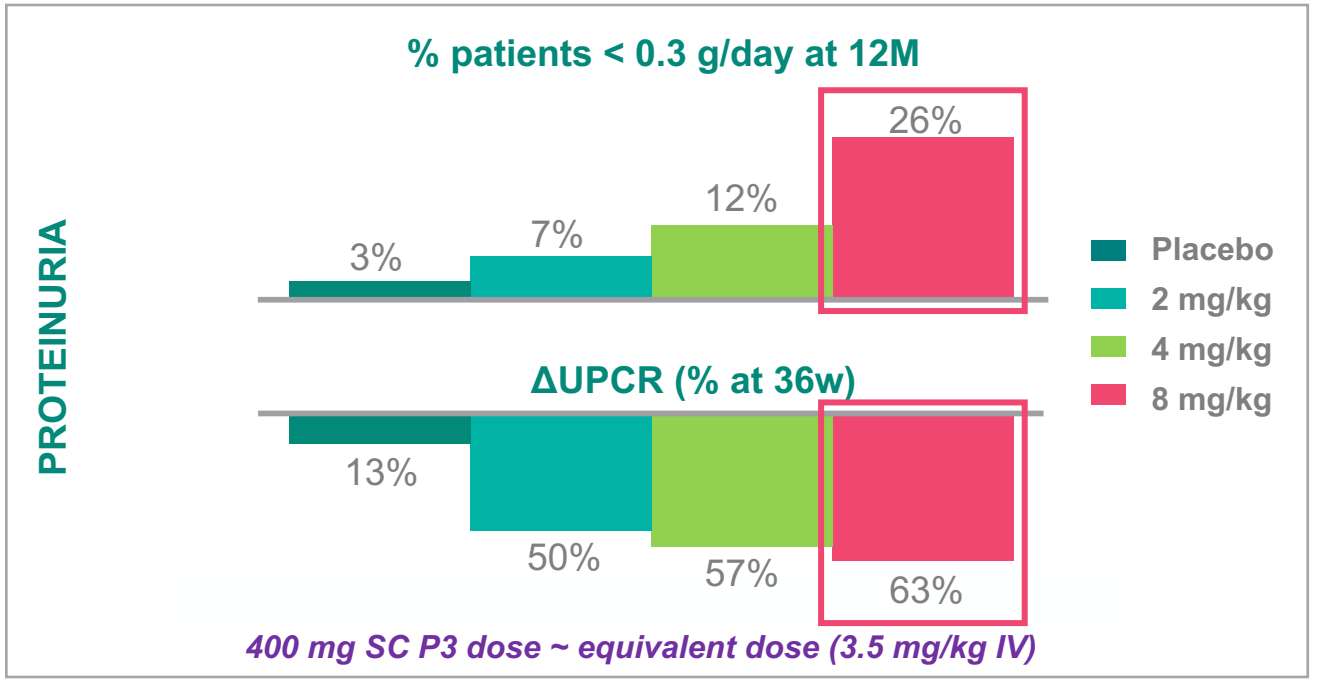
- Highest **proteinuria reduction** and rates of **clinical remission** (proteinuria <0.3 g/day) for sibeprenlimab were accompanied by the **deepest levels of APRIL suppression.**
- **Safety profile consistent** across dose levels, with **no increase in overall infections**.
- **Sibeprenlimab Phase 3** dose **approximates Phase 2 mid-dose**, which **did not capture the full efficacy** expected to be available to the mechanism of action

JADE101 has potential to **more completely suppress APRIL,** produce **larger proteinuria reductions** and **maximize remission rates** in **significantly more patients** than other anti-APRIL programs in development.

Sibeprenlimab Phase 2 Data

The NEW ENGLAND JOURNAL of MEDICINE



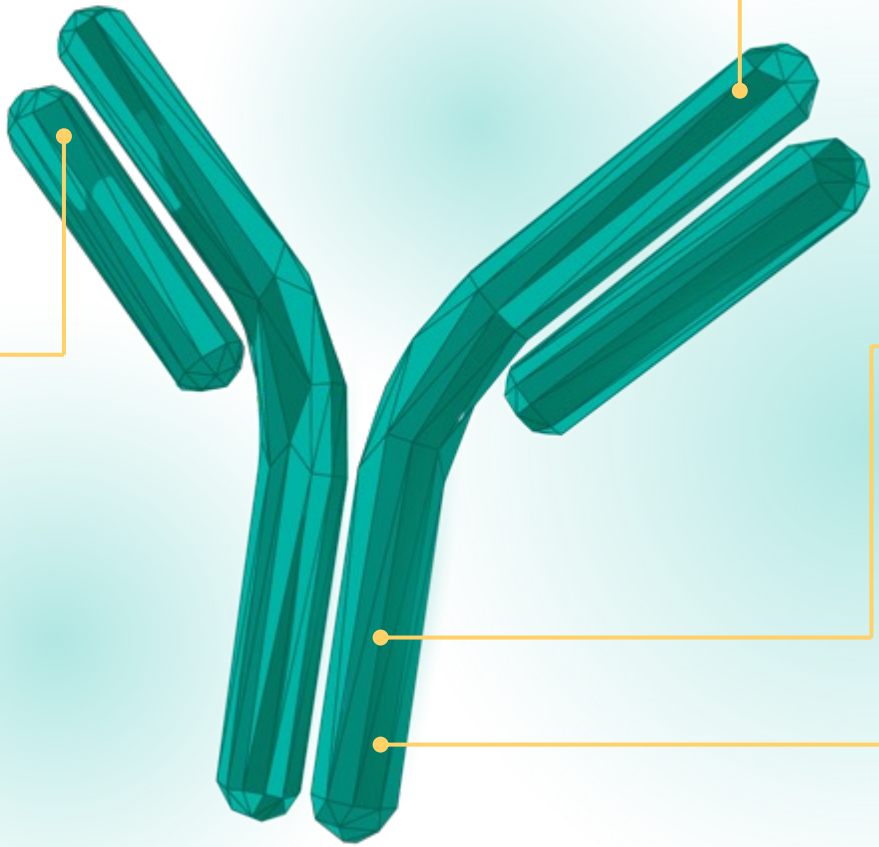


Note: Estimated sibeprenlimab P3 dose (400 mg SC) based on average 85 kg IgAN patient (95% CI ~50-120 kg) and 75% bioavailability.
Source: 2023 Mathur (NEJM)

Potentially best-in-class properties of JADE101

Novel IP for composition of matter into mid-2040s

***De novo* antibody discovery campaign** pursued to achieve fully-human, potentially best-in-class mAb



Ultra-high (fM) APRIL binding affinity

- Binds **APRIL** to neutralize activity
- **Greater APRIL binding affinity** than sibeprenlimab, zigakibart, povetacicept and atacicept

Half-life extension through validated YTE Fc modification

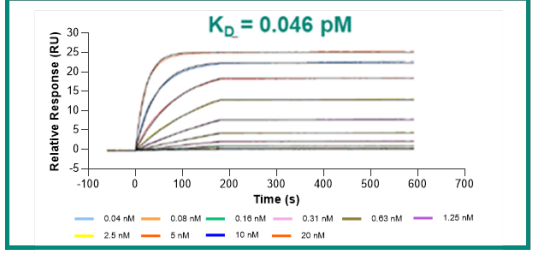
- Longer exposure intended to maximize efficacy and reduce dosing frequency

Effector-null human IgG1 Fc

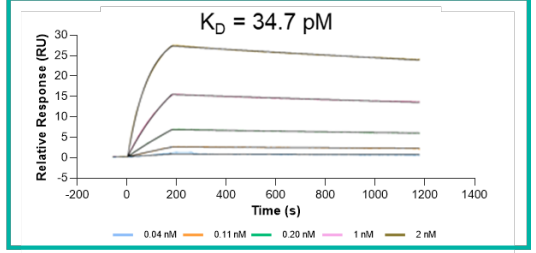
Notes; Paragon has filed provisional patent applications covering the subject matter of JADE101, which we have exclusively licensed from Paragon. No head-to-head clinical trials have been conducted between JADE101 and the referenced drug candidates. Cross-trial comparisons are inherently limited and presented for hypothesis-generating purposes only.
fM – femtomolar

JADE101 has femtomolar affinity and a slow off-rate that is superior to other anti-APRILs currently in development

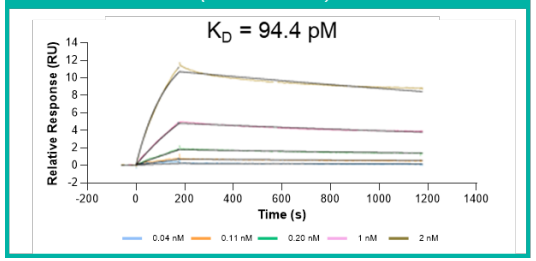
JADE101
(anti-APRIL)



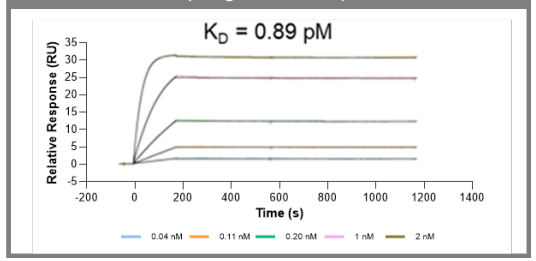
Sibeprenlimab
(anti-APRIL)



Zigakibart
(anti-APRIL)

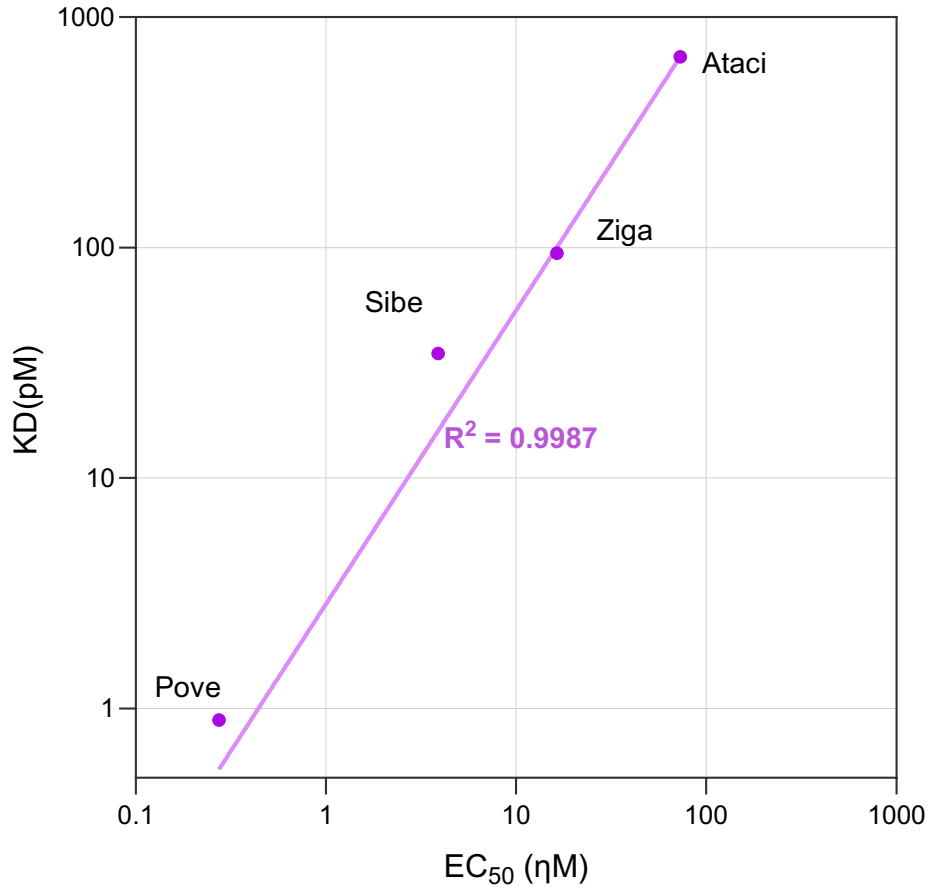


Povetacicept
(Eng. TACI-Fc)



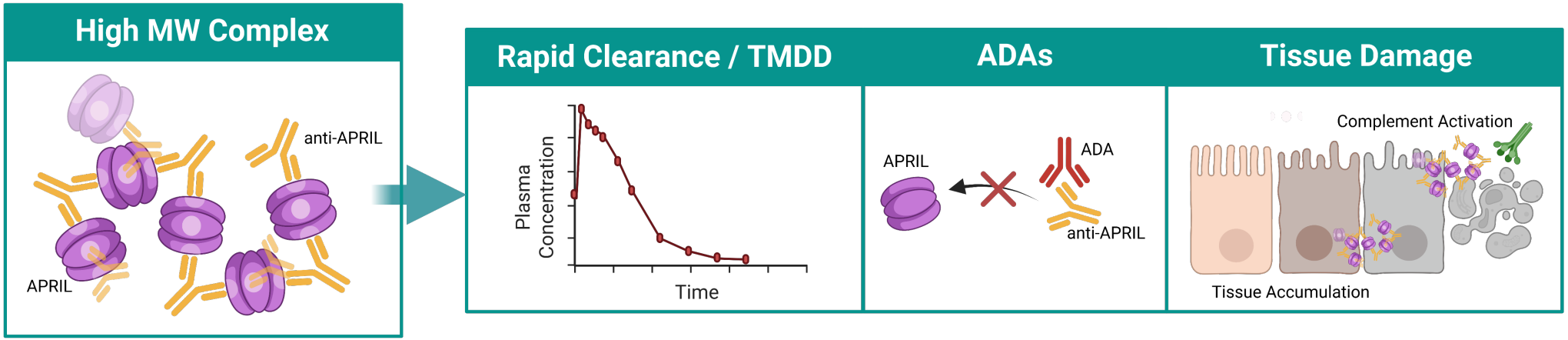
	K_a (1/Ms)	K_d (1/s)	K_D (pM)	Affinity vs JADE-001
Sibeprenlimab	3.9E+06	1.4E-04	34.7	**~755x↓**
Zigakibart	2.5E+06	2.4E-04	94.4	**~2,050x↓**
Povetacicept	1.2E+07	1.1E-05	0.89	**~20x↓**
JADE101	**2.3E+06**	**1.1E-07**	**0.046**	**-**

APRIL affinity by SPR is highly predictive of *in vivo* potency to lower serum IgA in humans



Source: Internal data; Benchmarks manufactured based on publicly available sequences. Atacicept APRIL KD 672 pM (Vera internal data). IgA EC_{50} estimates calculated using compartmental PK models linked to indirect response models to describe IgA kinetics built using published PK and IgA concentration-time profiles for each molecule. Sibeprenlimab: Mathur, 2022 and Zhang, 2023; Ziga: ASN, 2021/2022 and WCN, 2021; Povetacicept: Davies, 2024; Atacicept: Willen, 2020, Nestorov, 2008/2010, Munafo, 2007). These data are derived from different trials at different points in time, with differences in trial design and populations. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials of JADE101 and other agents have been conducted.

JADE101 avoids high molecular weight complex formation



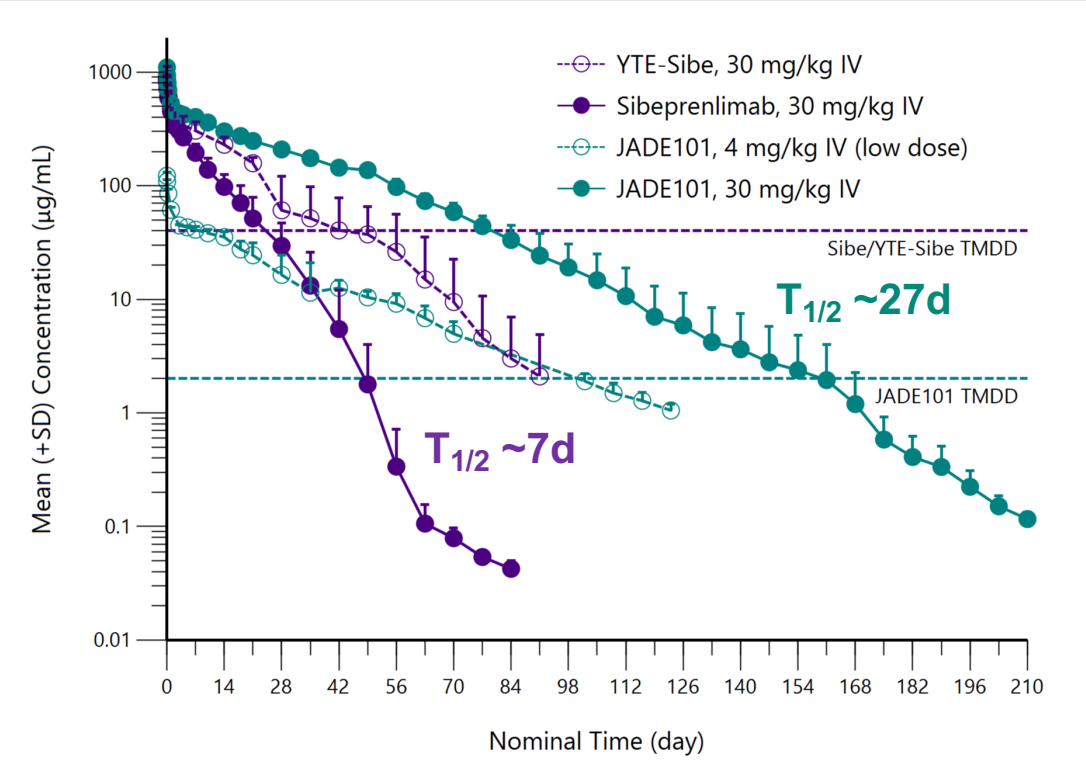
High MW complex formation can occur with mAbs binding trimeric proteins, such as APRIL. Avoiding high MW complexes potentially mitigates risks of immunogenicity and target mediated drug disposition (TMDD).

MW - molecular weight, mAbs – monoclonal antibodies
Source: Filbert et al. ERA 2025 (JADE101)

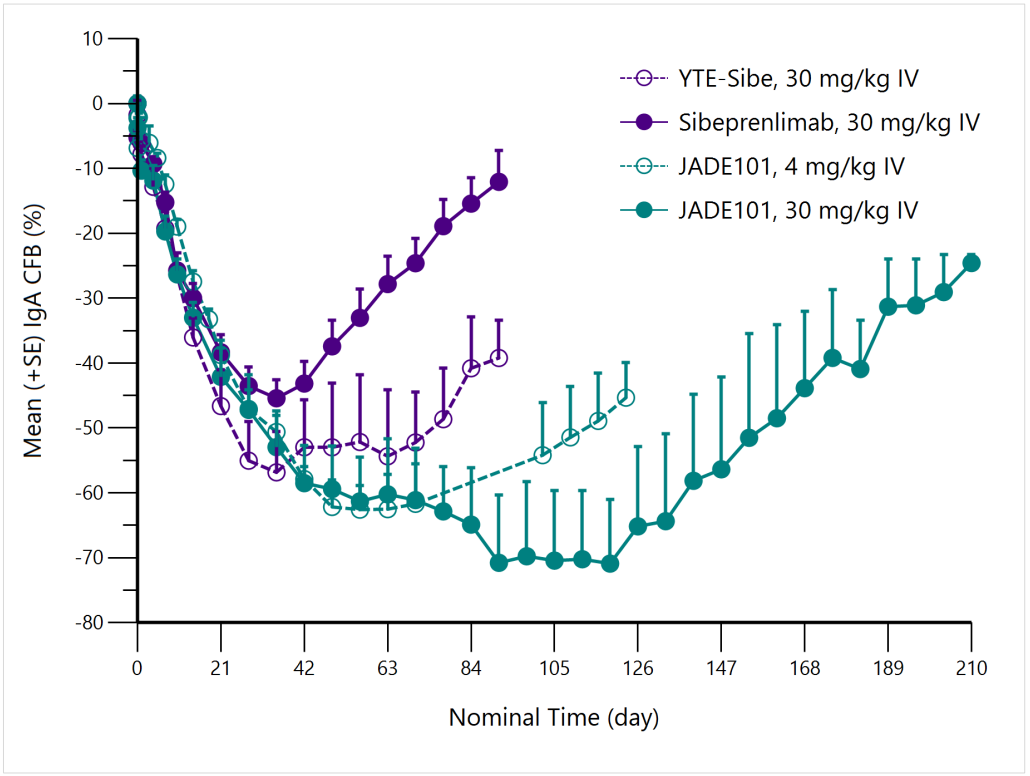
JADE101 exhibits a highly differentiated NHP PK/PD profile

Single IV Dose

>3X increased half-life compared to sibeprenlimab* in NHPs



Accompanied by deep and prolonged IgA reduction



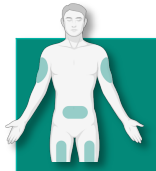
JADE101 has the potential to extend dosing interval through low clearance via half-life extension, target-mediated drug disposition mitigation & ultra-high (fM) human affinity.

*Sibeprenlimab generated from publicly available sequence. YTE-Sibe was engineered on the IgG1 framework. Confirmed ADA+ samples excluded.
No head-to-head clinical trials have been conducted between JADE101 and the referenced drug candidates.

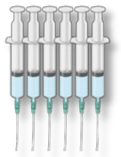
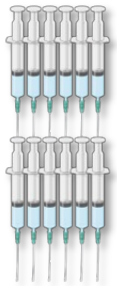
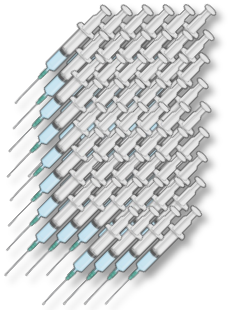
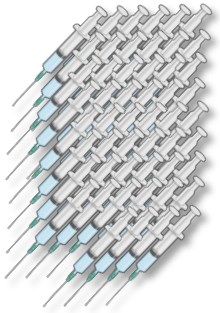
Minimizing patient burden

- IgAN patients are typically diagnosed as **young adults** and potentially require **lifelong treatment**
  - Fewer number of injections reduces patient burden, provides more freedom between doses & improves adherence
- Key determinants of dose and dose frequency: **Potency**, **half-life** and **TMDD** threshold

JADE101, with ultra-high affinity, extended half-life and anticipated mitigation of TMDD has **potential to provide best-in-class clinical activity with the least frequent dosing schedule.**



Frequent subcutaneous injections create significant burden for patients managing a chronic disease: Reducing the frequency of injections is anticipated to be a valuable choice driver

	JADE101	Sibeprenlimab	Atacicept	Povetacicept	Zigakibart
Target	APRIL	APRIL	APRIL + BAFF	APRIL + BAFF	APRIL
Format	mAb	mAb	Fc-fusion	Fc-fusion	mAb
APRIL K_D (pM)	0.046 pM	34.7 pM	672 pM	0.89 pM	94.4 pM
Human $T_{1/2}$ (days)	TBD	~23 days	~6.7 days	~3.7 days	~20 days
Dose (mg)	TBD	400 mg	150 mg	80 mg	600 mg
Dose Frequency	Anticipated to be Q8W+	Q4W	QW	Q4W	Q2W
Volume	Anticipated to be 2ml	2ml	1ml	1ml	2 x 2ml
Injections per year	6 injections or less 	12 injections 	52 injections 	12 injections 	52 injections 
Injections / 10 years	≤ 60	120	520	120	520

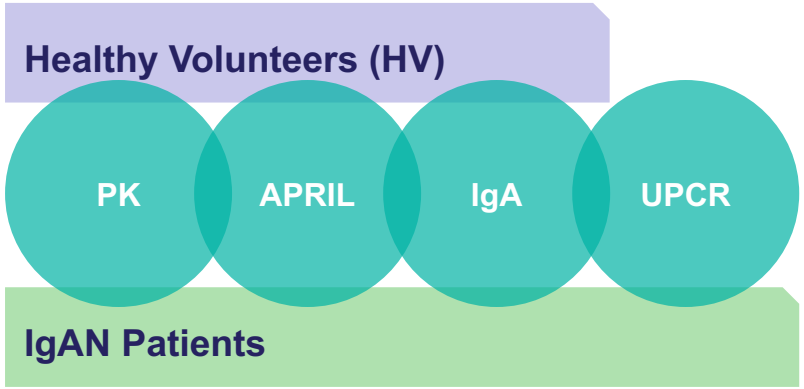
Source: Filbert et al. ERA 2025 (JADE101), Perkovic et al. ERA 2025 (sibeprenlimab), ORIGIN 3 clinical trial (atacicept, NCT04716231), Davies, 2024 (Povetacicept), Barratt et al. ERA 2025 (Zigakibart)

Anticipated 1H26 HV data potentially positions JADE101 for accelerated development

PK, APRIL and IgA HV data will define the dose and schedule designed to fully suppress APRIL throughout the dosing interval in IgAN patients.

MOA	Candidate	IND Enabling	Phase 1 Initiation	Interim Healthy Volunteer Data	Potential Indications
anti-APRIL	JADE101	Ongoing	2H 2025	1H 2026	IgAN

- Anti-APRIL MOA provides **biomarker rich-data expected to be predictive of clinical efficacy**
- **Consistent PK/PD** relationships in **HV and IgAN patients**
  - HV PK highly predictive of IgAN PK and directly linked to APRIL suppression
  - HV IgA reduction expected to highly correlate with IgAN IgA reduction
  - Early IgA response expected to highly correlate with future UPCR reduction in IgAN



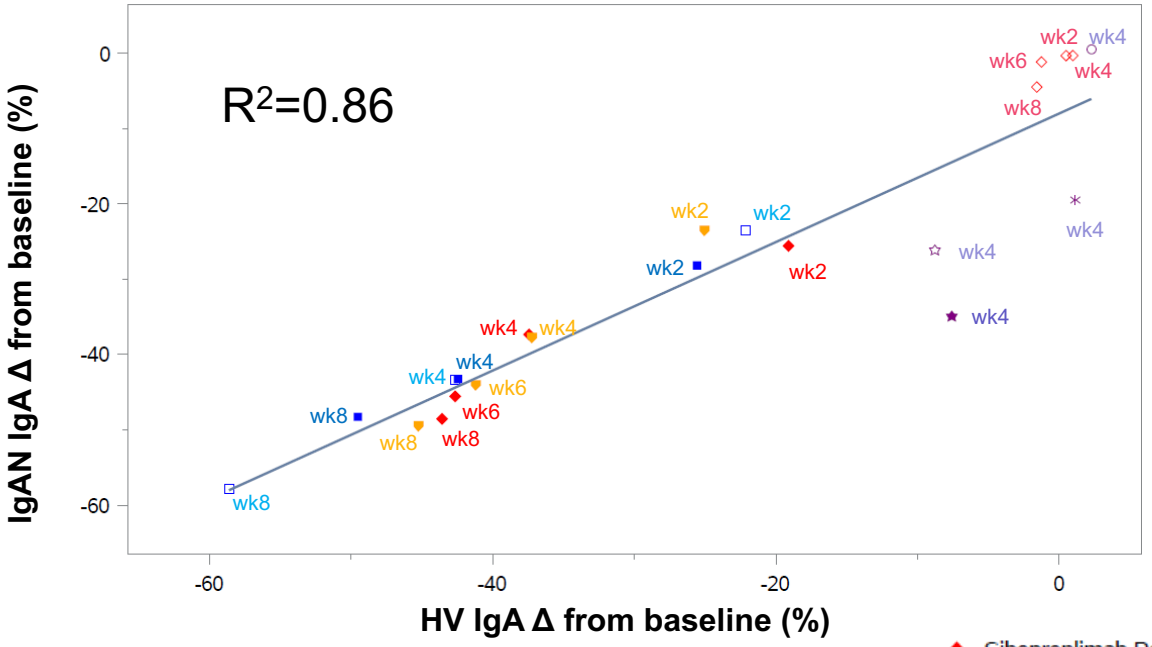
PD – pharmacodynamics, UPCR - urine protein-to-creatinine ratio

Sources: Zigakibart: (ASN 2021/2022 and WCN2021). Sibeprenlimab: Mathur 2022 (KI Reports) for Phase 1. Chan 2023 (KI Reports) for Phase 2 IgA; Mathur 2024 (NEJM) for Phase 2 UPCR. Povetacicept: Davies 2024 (Clin Transl Sci) for Phase 1. Madan 2024 (ASN) for Phase 2. Atacicept: Willen 2020 (European Journal of Drug Metabolism and Pharmacokinetics) for Phase 1. Zigakibart: Lo 2020 (ASN) for Phase 1. Barratt 2023 (ERA) for Phase 2 IgA, Barratt 2024 (ASN abstract) for Phase 2 UPCR. Floege 2024 (ERA) for Phase 2. Mezagitamab: December 2024 Takeda SEC from 6-K for Phase 2.

Biomarker-rich, directly translational HV data supports the potential to accelerate clinical development

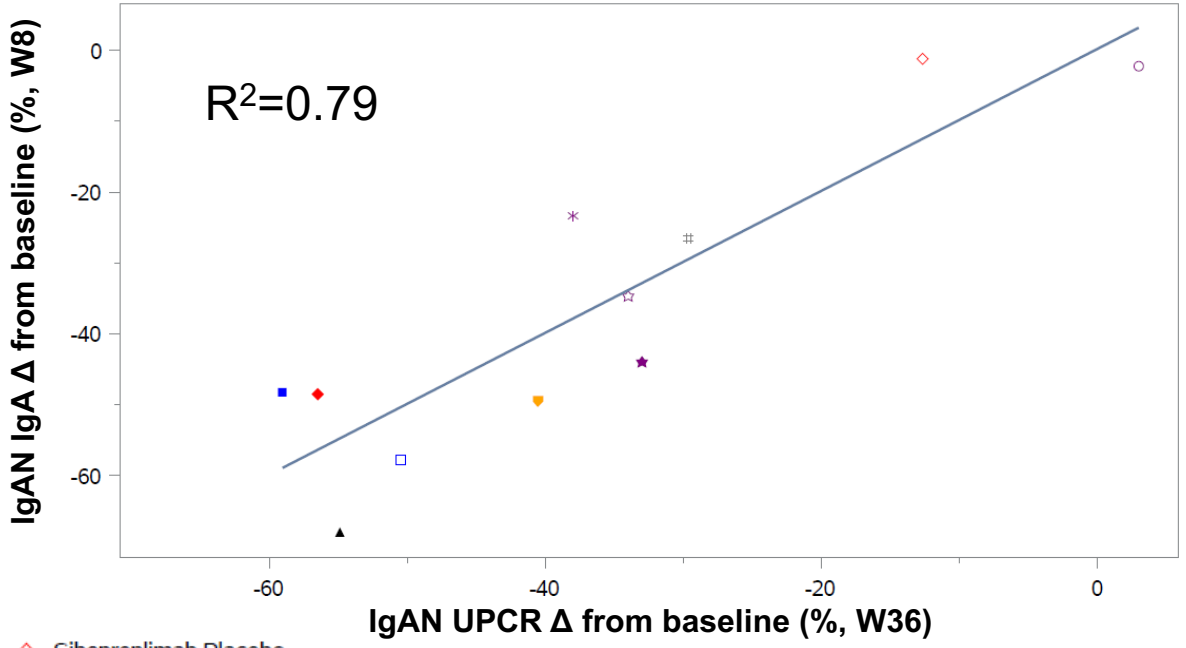
IgA reduction in HVs is **highly correlated** with IgA reduction in IgAN patients at **multiple time points**…

IgAN Patients vs **Healthy Volunteers**



…and **early IgA reduction** further correlates with **W36 UPCR reduction**, the anticipated endpoint for accelerated approval

IgAN Patients



- Sibeprenlimab Pooled
- Sibeprenlimab Placebo
- Povetacicept 80 mg
- Povetacicept 240 mg
- Atacicept Placebo
- Atacicept 25 mg
- Atacicept 75 mg
- Atacicept 150 mg
- Zigakibart 600 mg
- Felzartamab 16 mg/kg 9 doses
- Mezagitamab 600 mg 16 doses

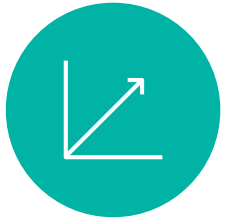
Notes: Sibeprenlimab IgAN IgA reductions (LHS) are average of 4 mg/kg and 8 mg/kg cohorts (HV data is from 6 mg/kg cohort); the two cohorts saw effectively equivalent IgA reduction at W4 and W8. Zigakibart UPCR data is at 52W. Atacicept IgAN W8 is average of W4 and W12 datapoints. Trend lines are best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

Pipeline beyond JADE101

Additional Jade programs expected to focus on best-in-class product profiles in high-value autoimmune indications

Autoimmune indications with **significant market opportunity**

Potentially **best-in-class** and **best-in-indication** product profile



Potential **rapid path** to clinical PoC

Limited competition expected

Jade **team expertise**

Evaluating additional opportunities to **build pipeline of potentially best-in-class** autoimmune therapies.

Jade Biosciences is advancing potentially best-in-class therapies for autoimmune diseases

Current funding expected to support operations through 2027, well beyond biomarker-rich JADE101 healthy volunteer data

MOA	Program	Candidate	Discovery	IND-enabling	Planned Clinical FIH	Interim FIH Data	Potential Indications
anti-APRIL	JADE-001	JADE101			2H25	1H26	IgAN
Undisclosed	JADE-002	JADE201			1H26		Multiple systemic AI diseases
Undisclosed	JADE-003	—			1H27		Undisclosed

Development candidates licensed from Paragon

Candidates designed to maximize clinical responses and allow patient friendly, infrequent dosing

Notes: Jade has entered into an exclusive JADE101 license agreement with Paragon Therapeutics. Jade holds an exclusive option to license JADE201 and JADE-003 from Paragon. Jade has not yet entered into a license agreement with respect to JADE201 or JADE-003.
MOA – mechanism of action; FIH – First-in-Human, IgAN - IgA nephropathy; AI - autoimmune

Capitalization following close of merger with Aerovate

$49.9M cash as of March 31, 2025
+$192.7M net proceeds from PIPE on April 28, 2025

		Number of Shares*
Common stock	Shares outstanding	32,235,926
Common stock equivalents	Preferred stock (as converted to common stock)	12,622,000
	Pre-funded warrants	7,766,247
Common stock & common stock equivalents	**Total outstanding**	**52,624,173**

Notes: Number of shares are on an as-converted basis and following the 1:35 reverse stock split effected in connection with the merger. The pro forma, post-split fully diluted share count, which includes equity incentives such as employee stock options, is approximately 60.6 million shares. Refer to AVTE and JBIO SEC filings for additional information.
*As of April 28, 2025

Thank you

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NASDAQ: JBIO