Company Overview

November 2025

NASDAQ: JBIO

Disclaimers

Forward Looking Statements

Certain statements in this presentation, other than purely historical information, may constitute "forward-looking statements" within the meaning of the federal securities laws, including for purposes of the "safe harbor" provisions under the Private Securities Litigation Reform Act of 1995. These forward-looking statements include, but are not limited to, express or implied statements relating to the expectations, hopes, beliefs, intentions or strategies of Jade Biosciences, Inc. ("Jade") regarding the future of its pipeline and business including, without limitation, expectations with respect to cash runway, Jade's ability to achieve the expected benefits or opportunities with respect to JADE101, JADE201 and JADE-003, expected timelines for clinical trials and for interim data from the phase 1 clinical trial of JADE101, the expected timelines for initiating phase 1 clinical trials of JADE201 and JADE-003, the potential for JADE101 healthy volunteer data to be predictive of clinical efficacy, the potential of surrogate endpoints to support IgAN approval, the potential for the anti-APRIL class to become frontline treatment for IgAN, the potential of JADE101, JADE201 and any product candidate from the JADE-003 program to become best-in-class drugs and their potential therapeutic uses, mechanisms of action, efficacy, dosing, durability, safety profile and market opportunities. The words "opportunity," "potential," "milestones," "pipeline," "can," "goal," "strategy," "target," "anticipate," "achieve," "believe," "contemplate," "continue," "could," "estimate," "expect," "intends," "may," "plan," "possible," "project," "should," "will," "would" and similar expressions (including the negatives of these terms or variations of them) may identify forward-looking statements, but the absence of these words does not mean that a statement is not forward-looking. These forward-looking statements are based on current expectations and beliefs concerning future developments and their potential effects. There can be no assurance that future developments affecting Jade will be those that have been anticipated. These forward-looking statements involve a number of risks, uncertainties (some of which are beyond Jade's control) or other assumptions that may cause actual results or performance to be materially different from those expressed or implied by these forward-looking statements. These risks and uncertainties include, but are not limited to, the risks that the ongoing trial of JADE101 and any future clinical trials may not demonstrate safety and/or efficacy; Jade may experience unanticipated costs, difficulties or delays in the product development process; JADE101, JADE201 and Jade's future product candidates may fail in development, may not receive required regulatory approvals, or may be delayed to a point where they are not commercially viable; regulatory agencies may impose additional requirements or delay the initiation of clinical trials; risks associated with Jade's dependence on third-party vendors for the development, manufacture and supply of its product candidates; risks relating to market conditions and the satisfaction of closing conditions of the additional financing; and the other risks, uncertainties and factors more fully described in Jade's most recent filings with the Securities and Exchange Commission (including its most recent Quarterly Report on Form 10-Q), as well as risk factors associated with companies, such as Jade, that operate in the biopharma industry. Should one or more of these risks or uncertainties materialize, or should any of Jade's assumptions prove incorrect, actual results may vary in material respects from those projected in these forward-looking statements. Nothing in this communication should be regarded as a representation by any person that the forward-looking statements set forth herein will be achieved or that any of the contemplated results of such forward-looking statements will be achieved. You should not place undue reliance on forward-looking statements in this communication, which speak only as of the date they are made and are qualified in their entirety by reference to the cautionary statements herein. Jade does not undertake or accept any duty to release publicly any updates or revisions to any forward-looking statements. This communication does not purport to summarize all of the conditions, risks and other attributes of an investment in Jade.

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

Well-capitalized to deliver on key milestones with $326 million in cash [1], and runway into 1H 2028

MOA	Program	Discovery	IND-enabling	Phase 1	Expected Milestones	Potential Indications
anti-APRIL	JADE101				• Interim Data: 1H 2026	IgAN
anti-BAFF-R	JADE201				• Planned FIH: 1H 2026	Multiple systemic AI diseases
Undisclosed	JADE-003				• Planned FIH: 1H 2027	Undisclosed

Development candidates from Paragon

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

1. Pro forma cash, cash equivalents, and marketable securities includes $198.9M as of September 30, 2025, plus net proceeds before expenses, of $126.7M from October 2025 equity financing.

Notes: Jade has entered into exclusive license agreements with Paragon Therapeutics for JADE101 and JADE201. Jade holds an exclusive option to license JADE-003 from Paragon. Jade has not yet entered into a license agreement with respect to JADE-003.

MOA – mechanism of action; FIH – First-in-Human, IgAN - IgA nephropathy; AI – autoimmune; BAFF-R – B cell-activating factor receptor

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

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

Estimated $10B+ branded market in the U.S. alone

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

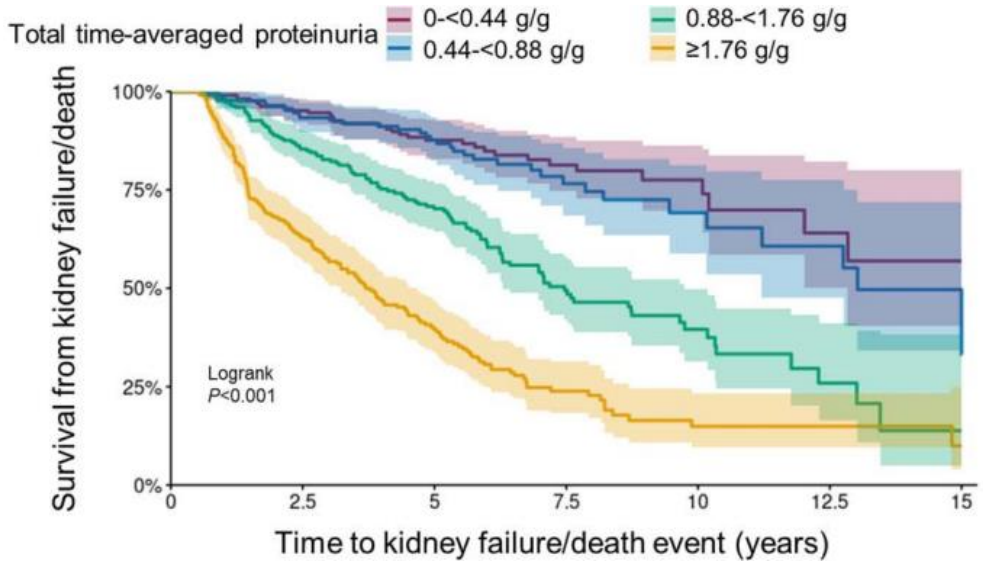
Biomarker-rich and highly translational HV data expected in 1H26; potential for **surrogate endpoints in future trials to support IgAN approval**

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

IgAN is a $10B+ potential market, with a need for effective and convenient therapies for life-long treatment

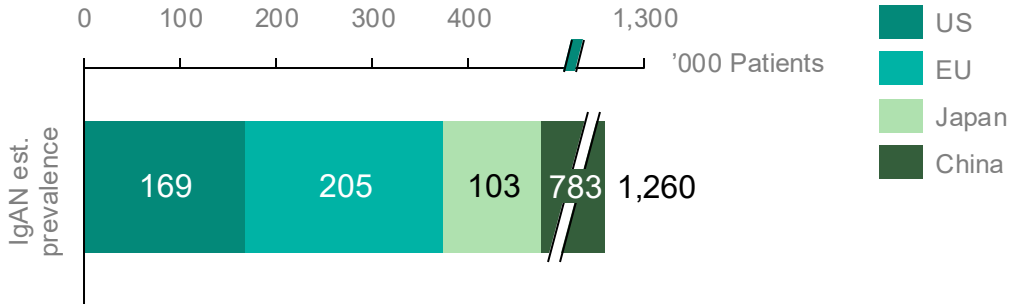
IgAN is typically diagnosed in young adults; **higher proteinuria** is associated with **greater risk of kidney failure**

Lifetime risk of progression to end-stage kidney disease begins at low proteinuria thresholds.



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

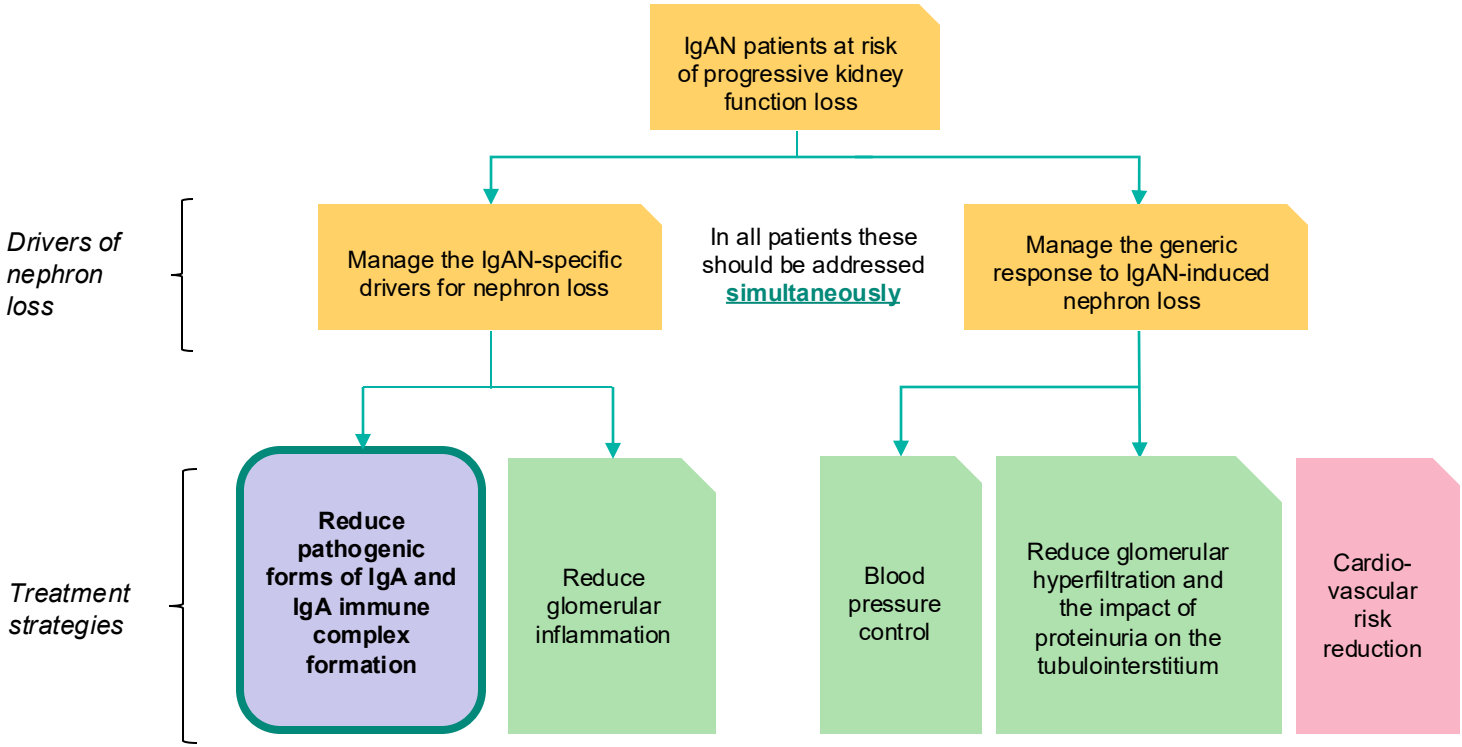
~1M+ global patients,
significant ex-U.S. market potential



IgAN is a **progressive autoimmune kidney disease** requiring **lifelong treatment**, with significant need for **well-tolerated, disease-modifying therapies** that offer **convenient dosing.**

Notes: Per KDIGO guidelines, treatment should be initiated in all cases where patients have proteinuria ≥0.5 g/day. 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

Updated 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 2025 Guidelines; 2023 Mathur (NEJM); Jade analysis
KDIGO – Kidney Disease Improving Global Outcomes

JADE101: Ultra-high affinity, half-life extended mAb with potential for best-in-class activity and patient convenience

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

Potential for ≤ 6 injections per year

Minimizes burden in a typically young IgAN patient population potentially requiring life-long therapy (no more than Q8W or less)

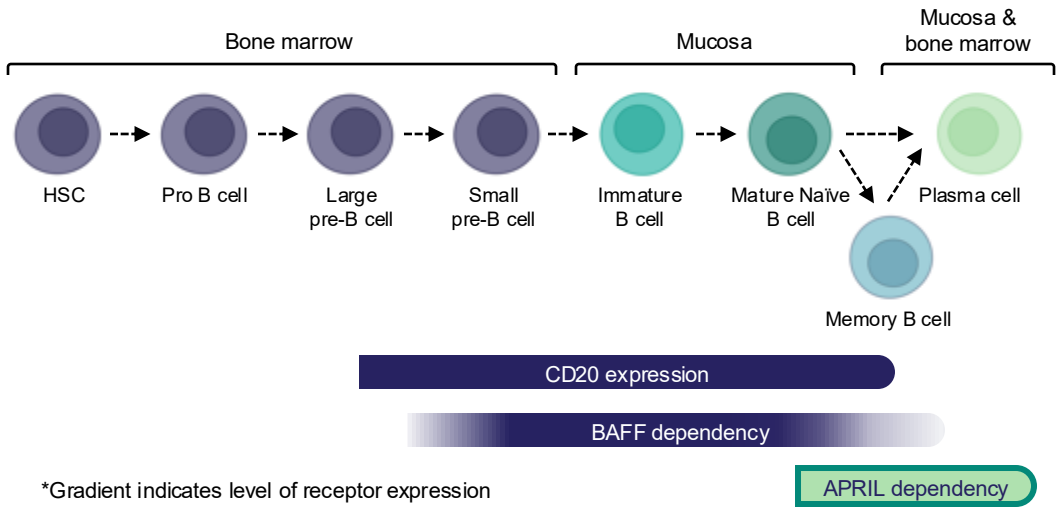
Avoids unnecessary immunosuppression

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

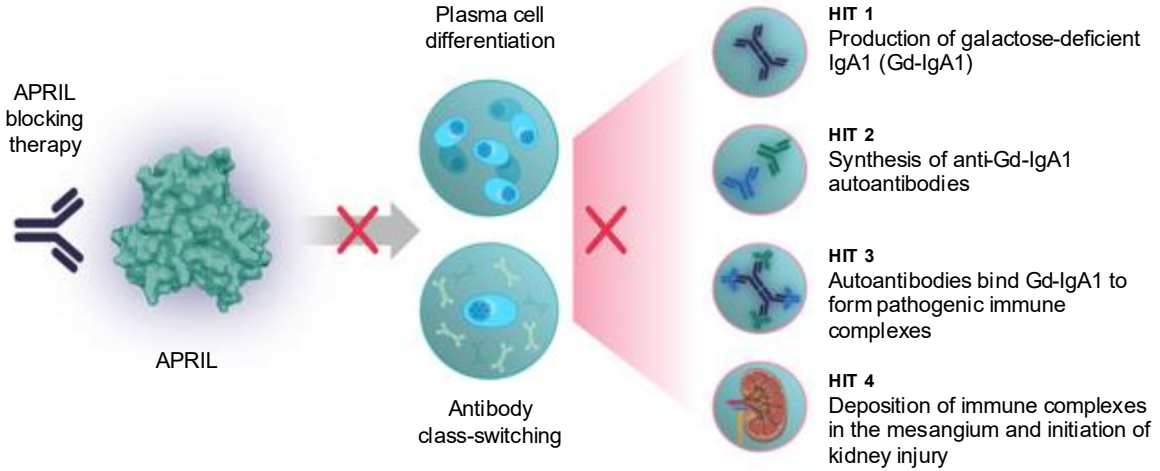
Broad **B-cell depletion is ineffective** in IgAN…

- 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.**



…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.

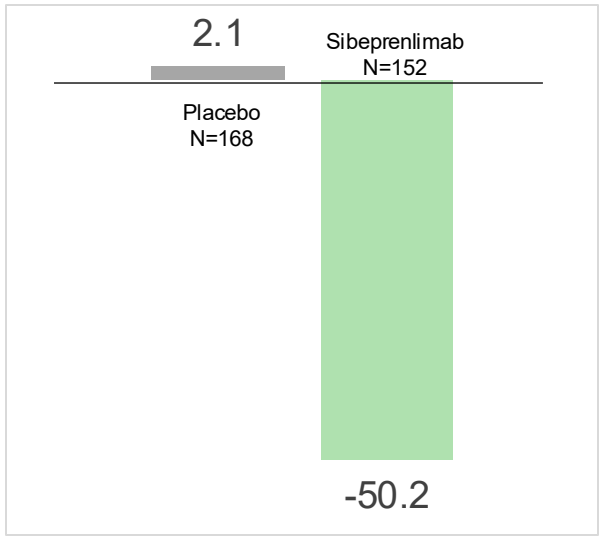
Sources: 2024 Cheung (Front Nephrol); 2023 Mathur (J Clin Med)

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

UPCR Δ from baseline (%, W36)

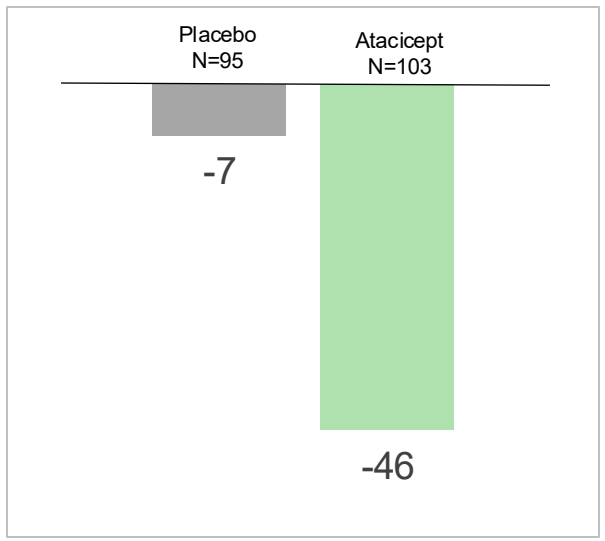
Sibeprenlimab

Δ -51%
(p < 0.0001)



Atacicept

Δ -42%
(p < 0.0001)



Studies enrolled 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)

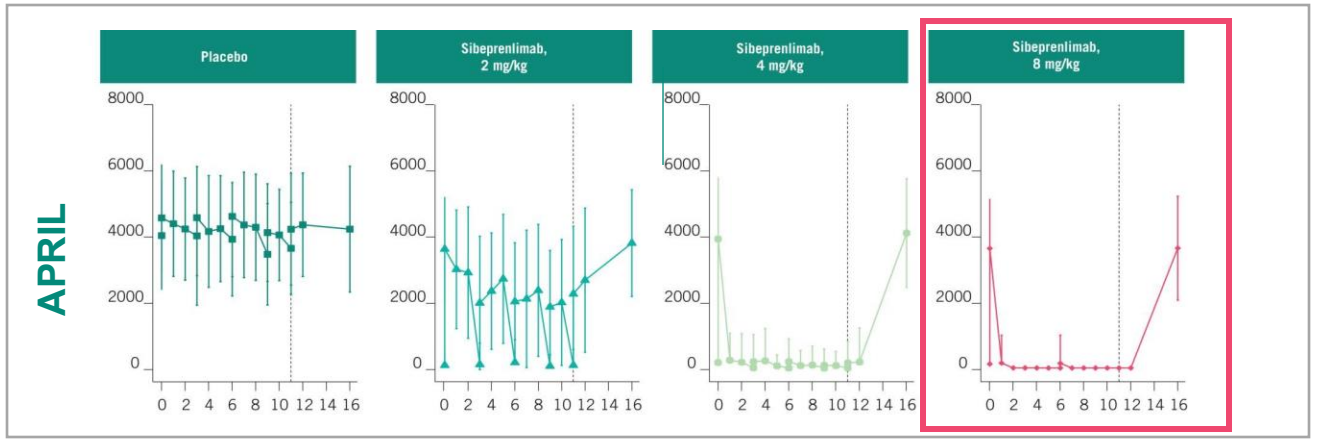
Deeper APRIL suppression drives superior clinical efficacy

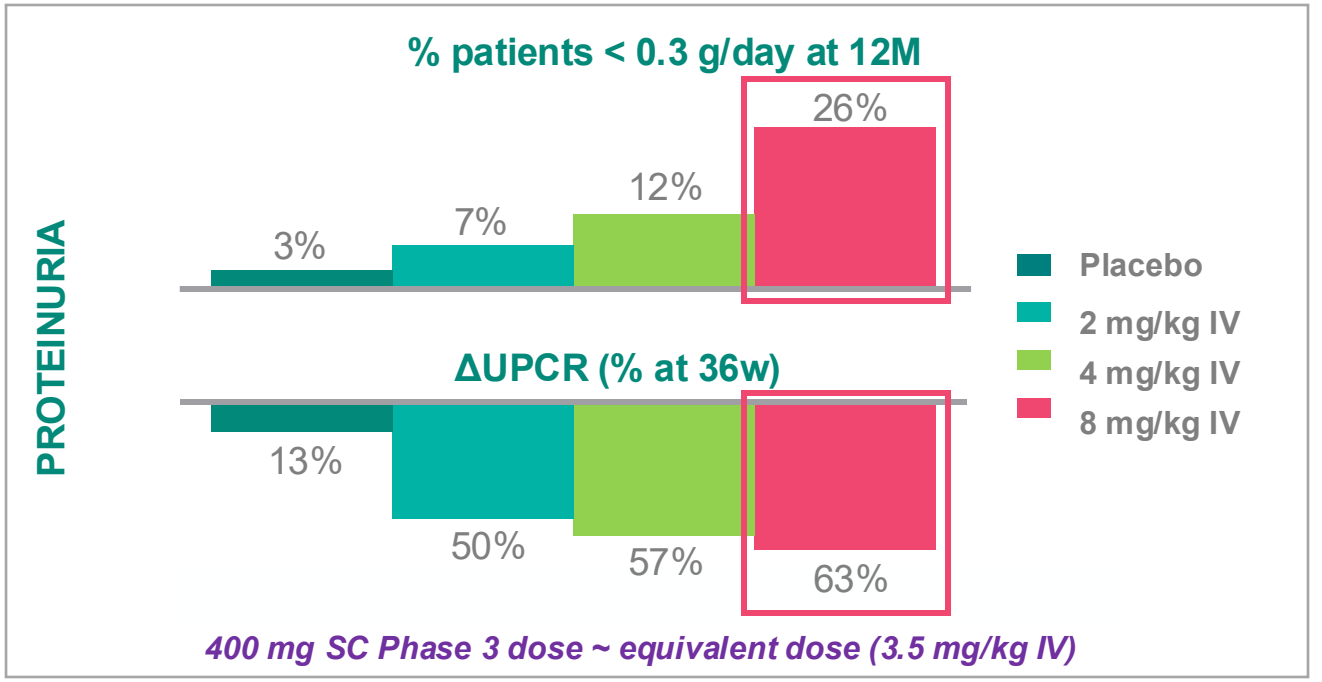
- Highest **proteinuria reduction** and rates of **clinical remission** (proteinuria <0.3 g/day) for sibeprenlimab were accompanied by the **deepest levels of APRIL suppression.**
- **Safety profile consistent** across dose levels, with **no increase in overall infections**.
- **Sibeprenlimab Phase 3** 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

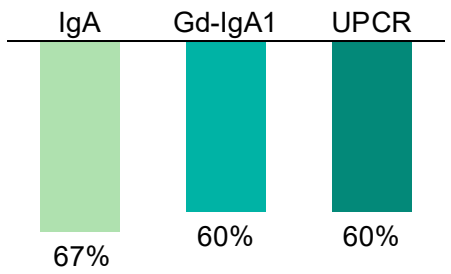
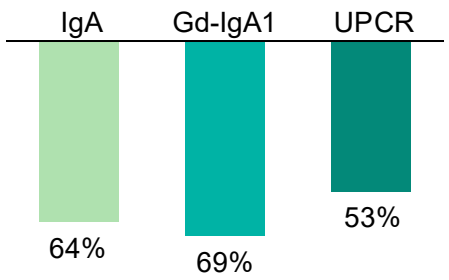
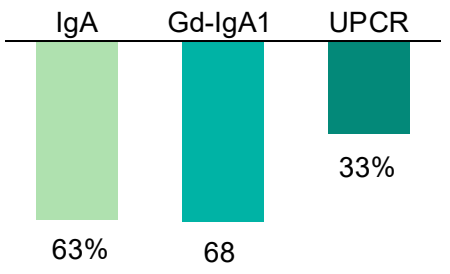
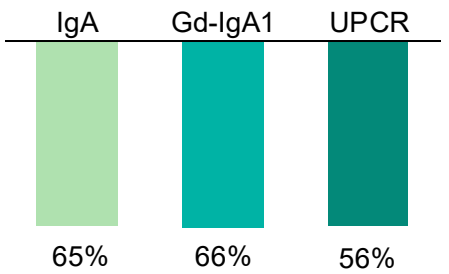
The NEW ENGLAND JOURNAL of MEDICINE





Note: Estimated sibeprenlimab Phase 3 dose (400 mg SC) based on average 85 kg IgAN patient (95% CI ~50-120 kg) and 75% bioavailability. SC – subcutaneous, IV – Intravenous
Source: 2023 Mathur (NEJM)

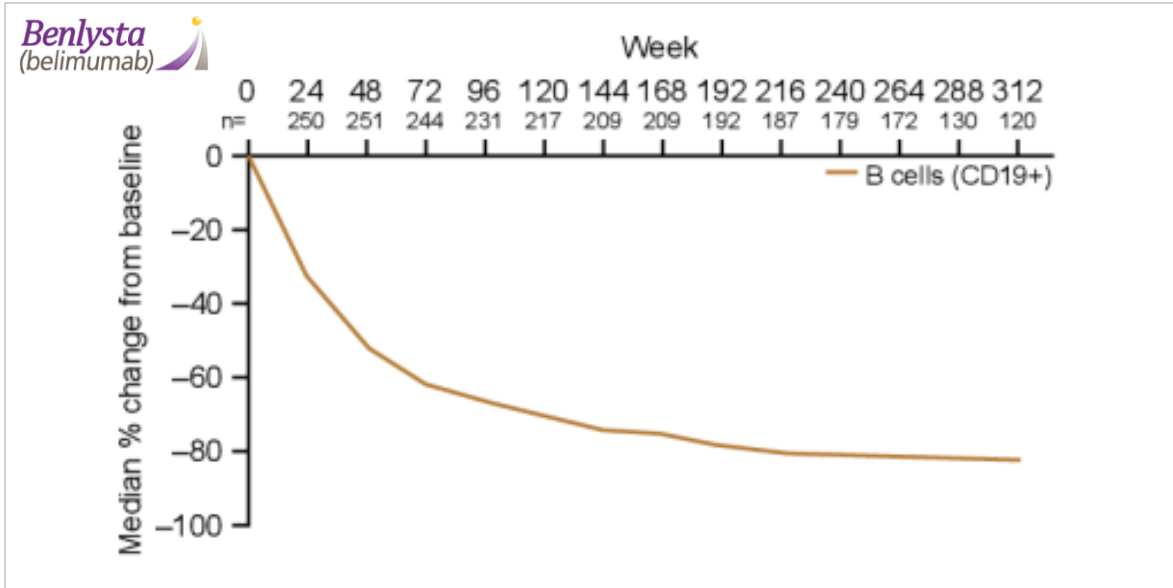
No clinical evidence that inhibiting BAFF provides additional efficacy beyond APRIL alone in IgAN Phase 2 clinical trials

	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=18 (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

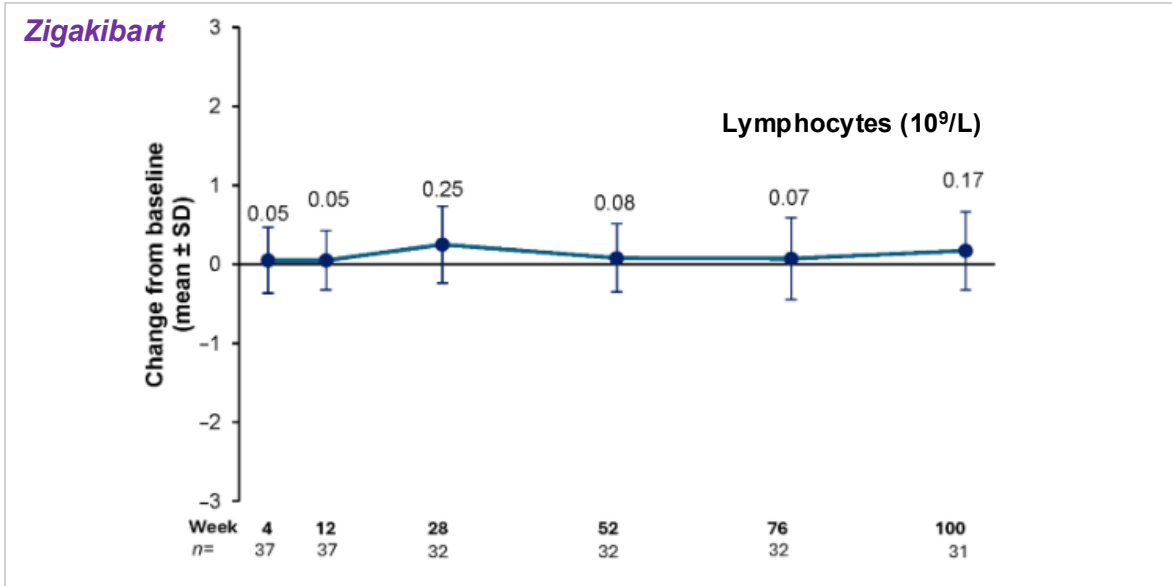
Notes: Cross-trial comparisons are inherently limited and presented for hypothesis-generating purposes only. Zigakibart IgA / Gd-IgA data at W40; UPCR data at W52 (only timepoint available); change from baseline is not placebo-controlled; N represents patients on dose(s) for which data is shown. Atacicept 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%.Gd-IgA1 (n=9) and UPCR data at W36; UPCR based on digitized plot. IgA (n=8). 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); 2025 Jiahua (ASN Presentation)

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

Long-term BAFF inhibition
significantly depletes B cells…



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



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

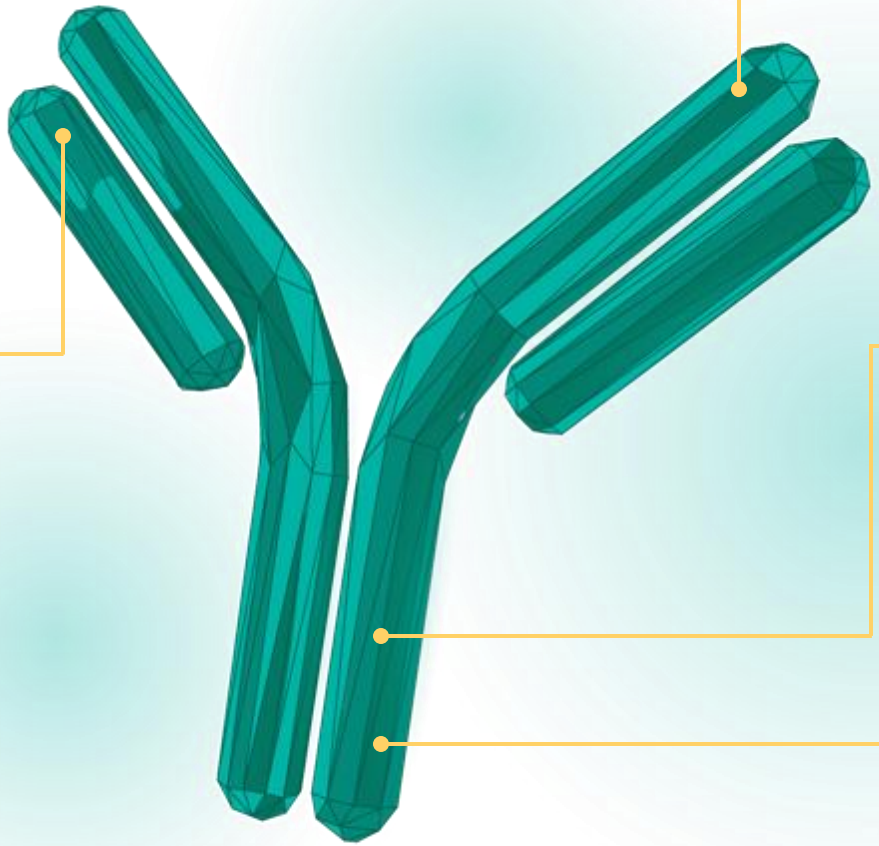
Long-term BAFF suppression, in an otherwise young and healthy patient population, **is unnecessary** given equivalent efficacy in IgAN from anti-APRILs and TACI-Fcs observed to date.

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

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

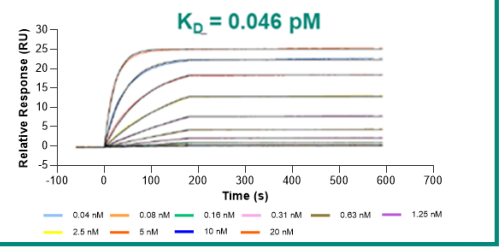
- Longer exposure intended to maximize efficacy and reduce dosing frequency

Effector-null human IgG1 Fc

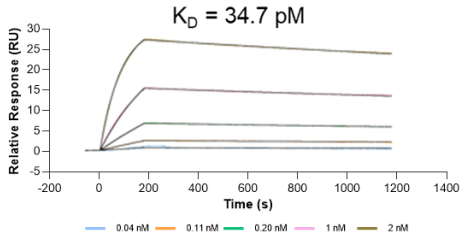
Notes; Paragon has filed provisional patent applications covering the subject matter of JADE101, which we have exclusively licensed from Paragon. No head-to-head clinical trials have been conducted between JADE101 and the referenced drug candidates. Cross-trial comparisons are inherently limited and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

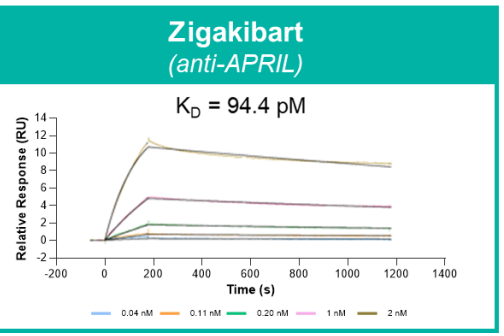
JADE101
(anti-APRIL)



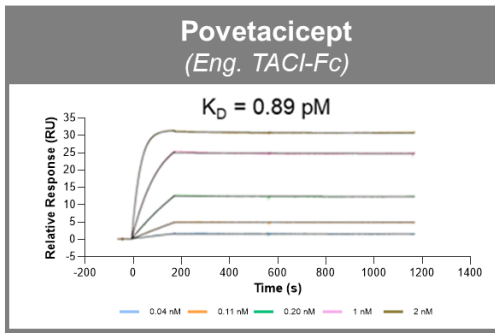
Sibeprenlimab
(anti-APRIL)



Zigakibart
(anti-APRIL)

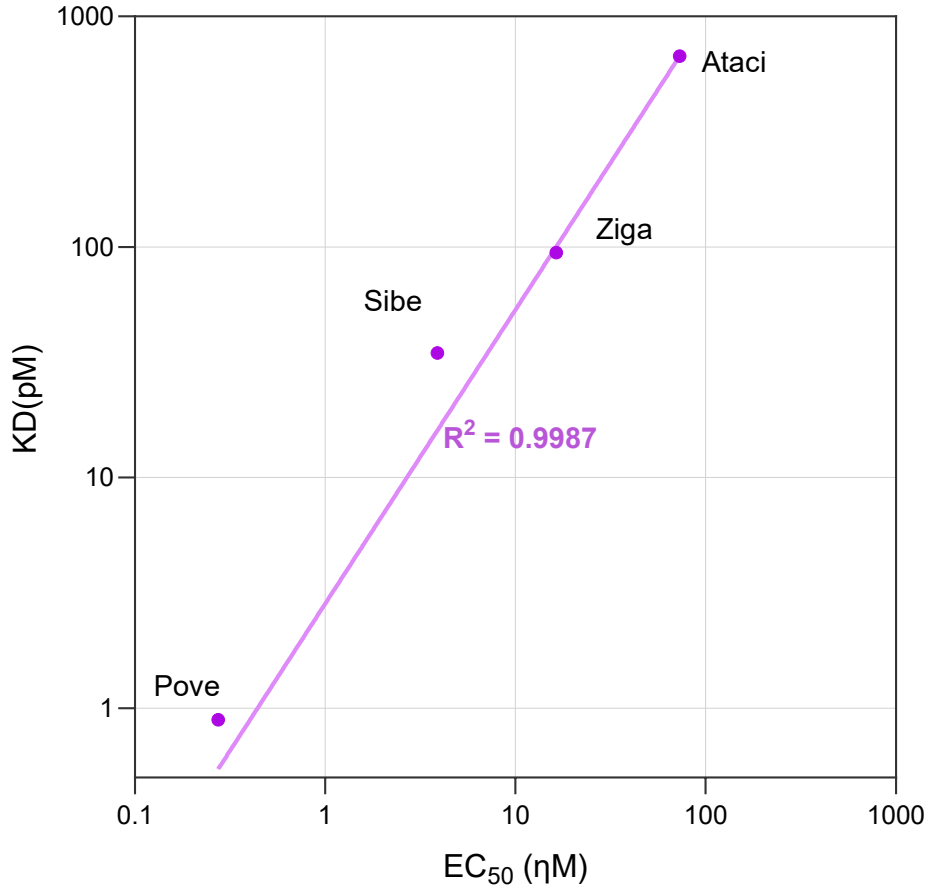


Povetacicept
(Eng. TACI-Fc)



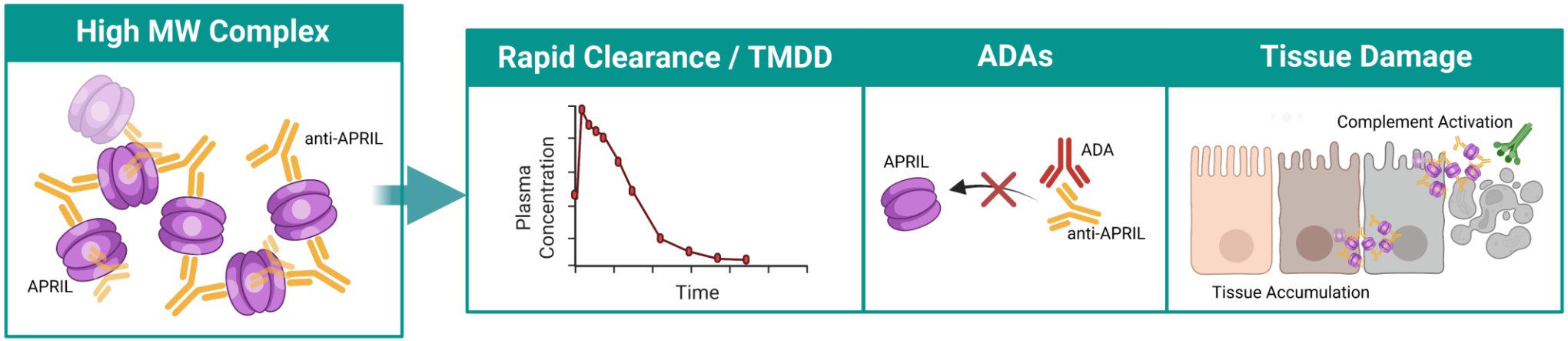
	K_a (1/Ms)	K_d (1/s)	K_D (pM)	Affinity vs JADE-001
Sibeprenlimab	3.9E+06	1.4E-04	34.7	**~755x↓**
Zigakibart	2.5E+06	2.4E-04	94.4	**~2,050x↓**
Povetacicept	1.2E+07	1.1E-05	0.89	**~20x↓**
JADE101	**2.3E+06**	**1.1E-07**	**0.046**	**-**

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

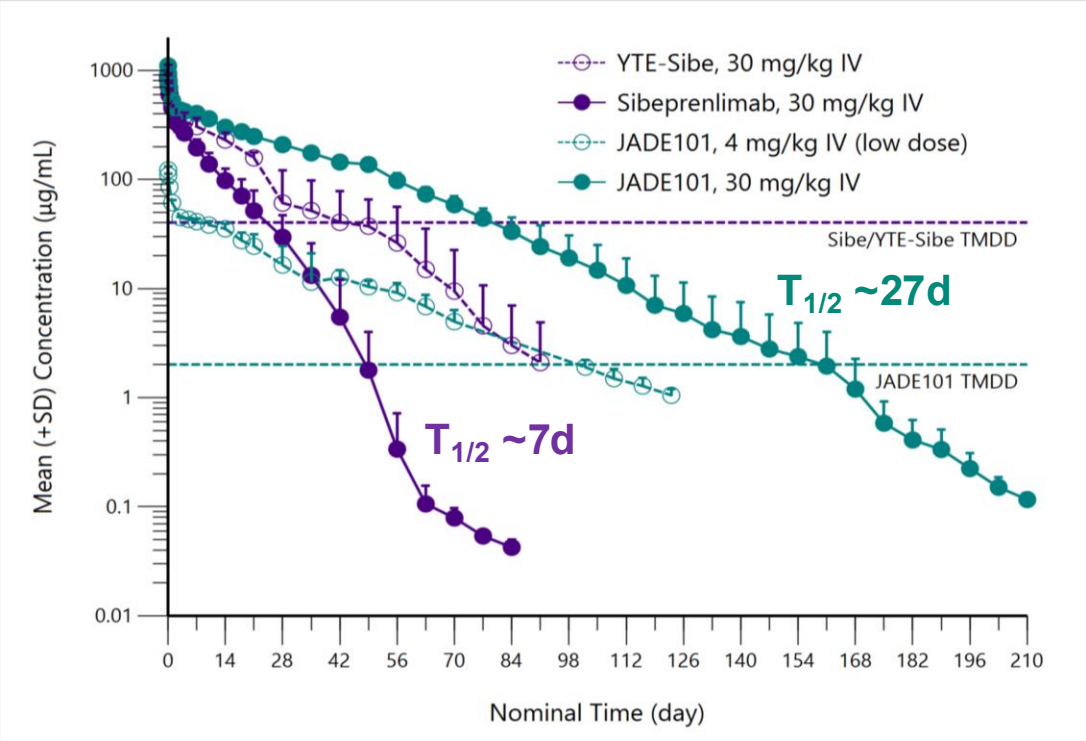


High MW complex formation can occur with mAbs binding trimeric proteins, such as APRIL. Avoiding high MW complexes potentially mitigates risks of immunogenicity and target mediated drug disposition (TMDD).

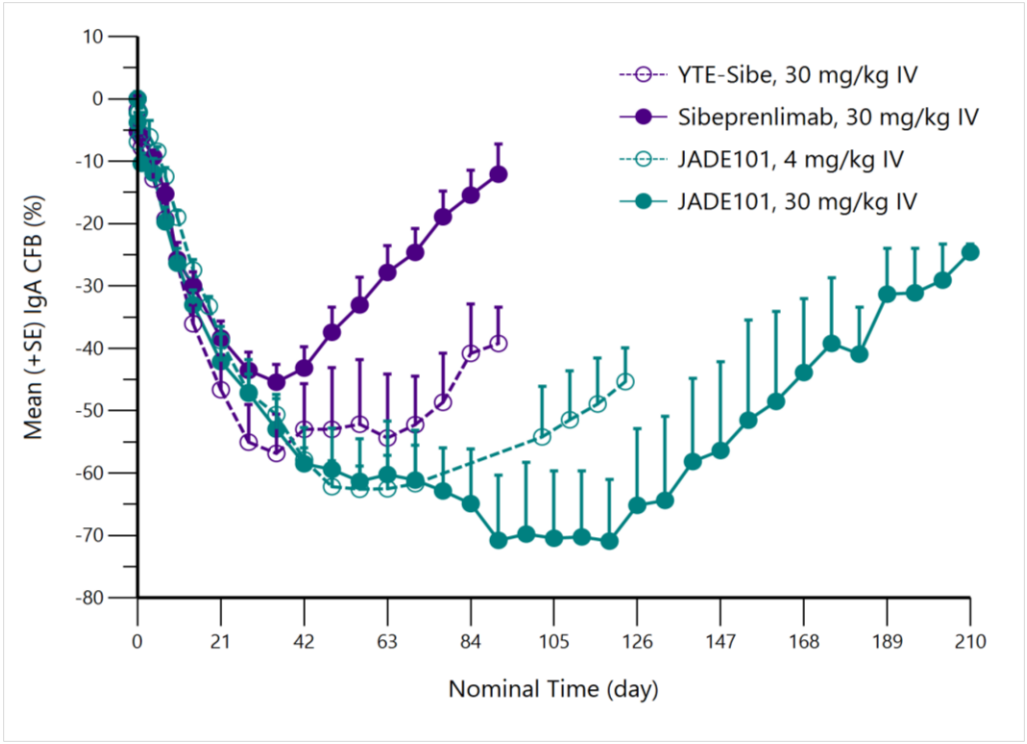
MW - molecular weight, mAbs – monoclonal antibodies
Source: Filbert et al. ERA 2025 (JADE101)

JADE101 exhibits a highly differentiated NHP PK/PD profile

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



Accompanied by **deep and prolonged IgA reduction**



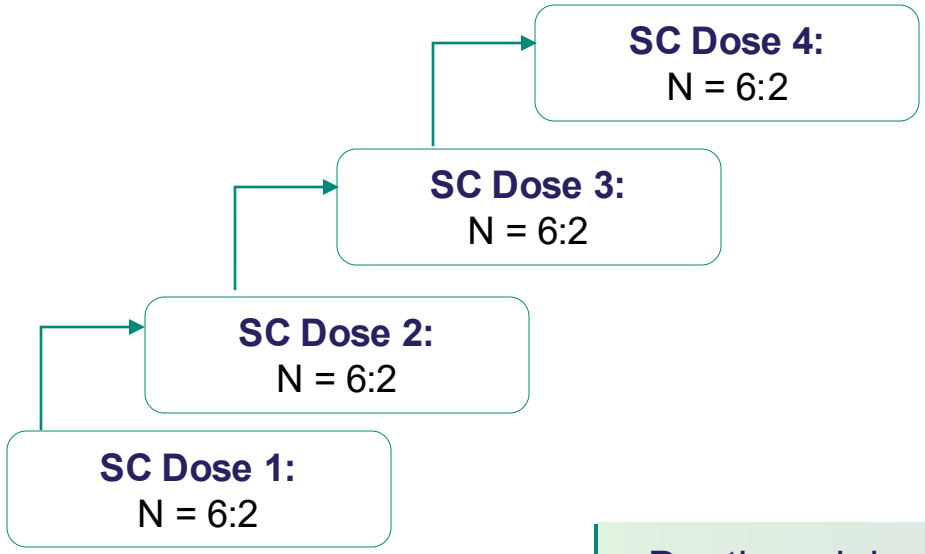
JADE101 has the potential to extend dosing interval through low clearance via half-life extension, target-mediated drug disposition mitigation & ultra-high (fM) human affinity.

*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. NHP- Non-human Primates, IV – Intravenous

Phase 1 JADE101 healthy volunteer trial ongoing; interim, biomarker-rich clinical data expected in H1 2026

Phase 1 Study Design

Randomized, double-blind, placebo-controlled SAD study
SC administration in healthy adult volunteers (n=32)



Endpoints

Primary

- Safety and tolerability

Secondary & Exploratory

- Pharmacokinetics
- Pharmacodynamics (APRIL, IgA, immunoglobulins)
- Immunogenicity

Follow Up

Half-life extended antibodies require extended follow up for full characterization (~1-year) and provide exposures that exceed those observed in MAD studies with typical mAbs.

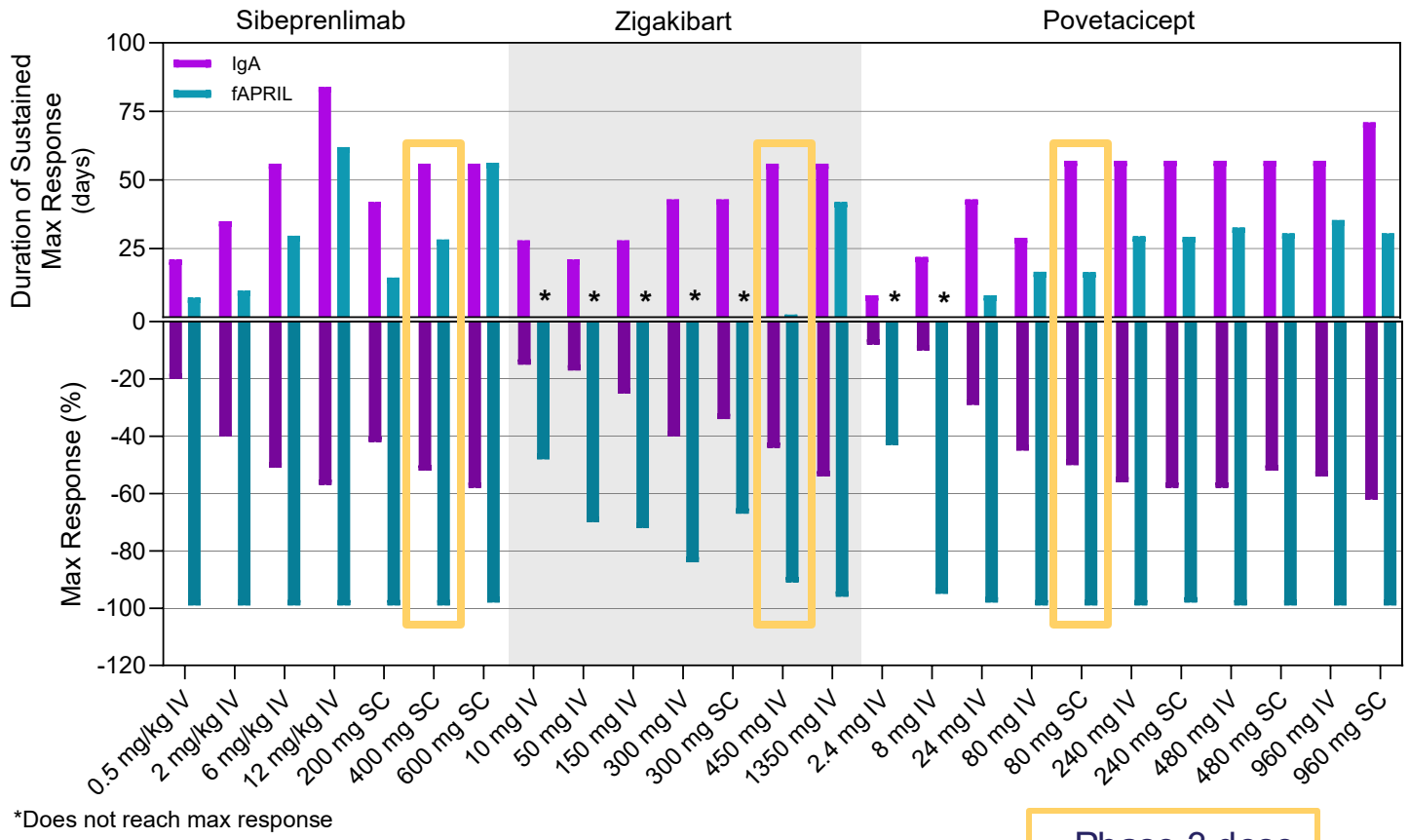
Depth and duration of APRIL inhibition anticipated to **predict clinical activity**, reflect **disease-modifying potential**, and **define dose and dose interval for IgAN patient trials**

Notes: ClinicalTrials.gov ID: NCT07059312. Numbers presented as subjects receiving JADE101 relative to placebo. Each cohort to include a sentinel group, n = 2 (1 JADE101, 1 placebo); remainder dosed after safety clearance.
SAD – Single Ascending Dose, MAD – Multiple Ascending Dose, SC - Subcutaneous

Anticipated 1H26 HV expected to enable JADE101 dose and dose interval selection for IgAN patients

- Anti-APRIL MOA provides **biomarker rich-data** in HVs **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
- **Depth and duration of APRIL** and **IgA suppression** in HVs will determine **dose and dose interval** for JADE101 in IgAN patients

IgA reduction and APRIL neutralization in HVs



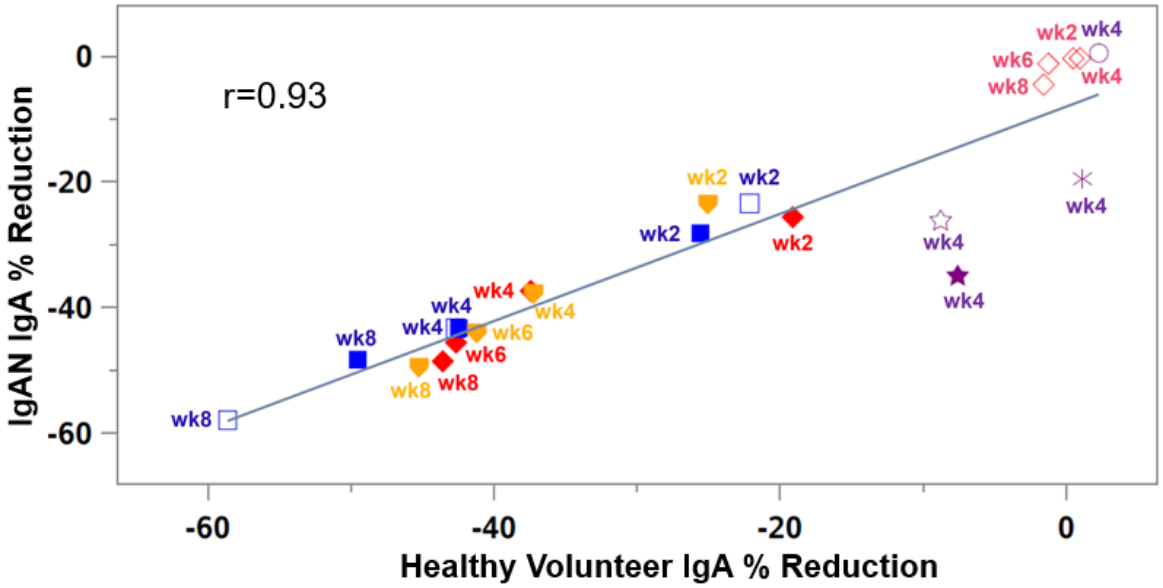
*Does not reach max response

~Phase 3 dose

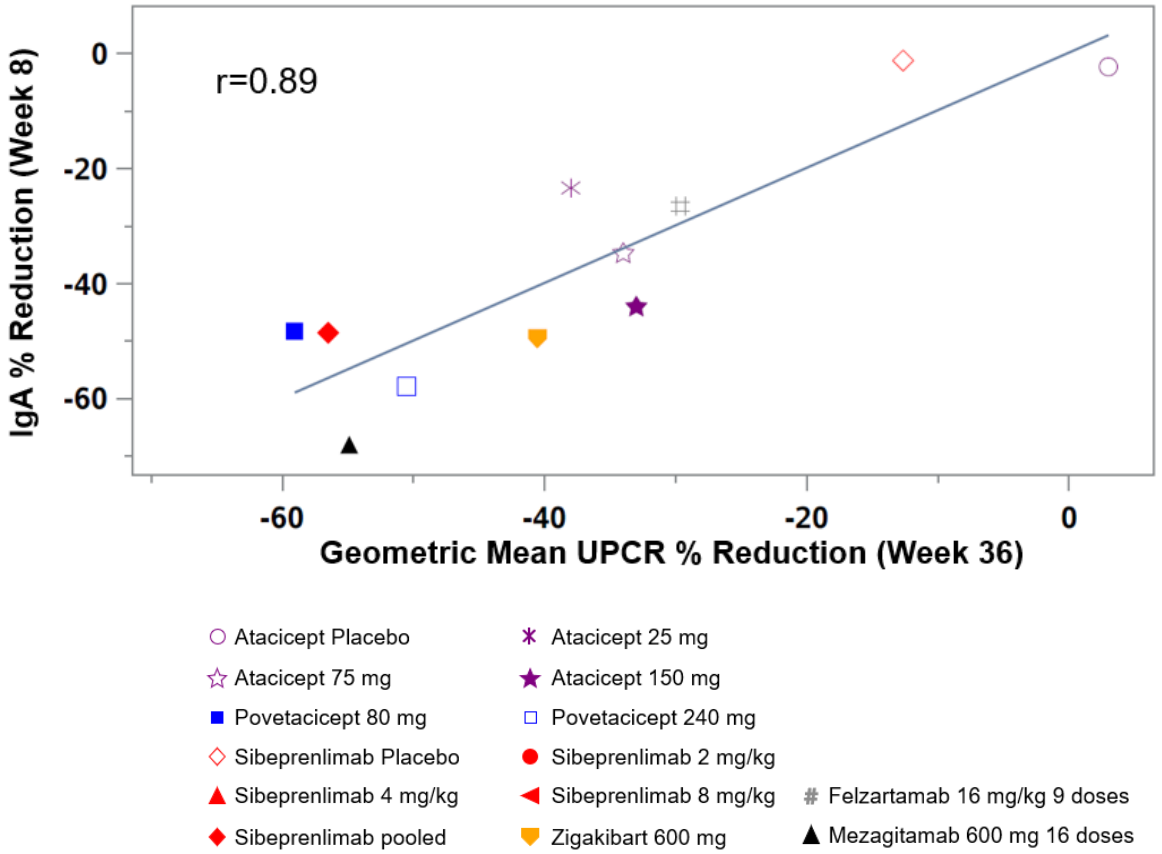
PD – pharmacodynamics, UPCR - urine protein-to-creatinine ratio. These data are derived from different trials at different points in time, with differences in methodology, design and populations. As a result, cross-trial comparisons cannot be made.
Source: 2025 Gufford (ASN Presentation)

IgA responses are consistent between HVs and IgAN patients and predictive of clinical efficacy

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

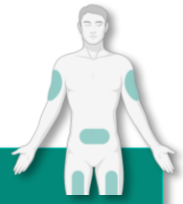


…and **early IgA reduction** further correlates with **W36 UPCR reduction**, in IgAN patients



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. These data are derived from different trials at different points in time, with differences in methodology, design and populations. As a result, cross-trial comparisons cannot be made.
Source: 2025 Gufford (ASN Presentation)

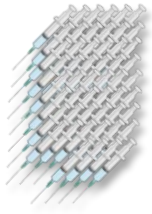
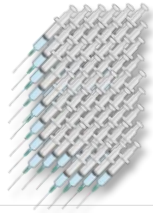
Minimizing injection burden for patients is a critical advantage in lifelong IgAN treatment



- IgAN typically affects young adults who may require lifelong therapy
- Fewer subcutaneous injections ease burden, improve adherence, and give patients more freedom
- Dose and dose frequency driven by potency, half-life, and TMDD threshold

With ultra-high affinity and extended half-life, **JADE101 has potential to offer best-in-class efficacy with the fewest injections.**

Reducing injection frequency 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)

JADE201: a potentially best-in-class afucosylated anti-BAFF-R mAb

JADE201, a potentially best-in-class afucosylated anti-BAFF-R mAb with dual MOA B cell depletion to treat autoimmune diseases

- B cell depletion has proven effective in autoimmune disease, but existing therapies like rituximab and anti-CD19 agents face limits:

Incomplete B cell depletion due to low target receptor expression on some B cell subsets or paucity of effector cells to mediate killing[1]

Sparing pathogenic autoantibody producing cells, including plasmablasts

Residual B cells in secondary lymphoid tissues and/or **ineffective depletion of B cells in ectopic lymphoid tissue** after treatment[2]

Resistance mechanisms, including increased BAFF expression following treatment with rituximab[3]

- Resistance mechanisms, particularly elevated BAFF after anti-CD20 therapy, enable autoreactive B cells to repopulate, undermining durability
- Ianalumab, an afucosylated anti-BAFF-R, provided proof-of-concept for overcoming these barriers, including clinical tissue B cell depletion[4]

JADE201 builds on ianalumab's proof-of-concept, adding HLE for expected improved durability, less frequent dosing, and potentially best-in-class profile.

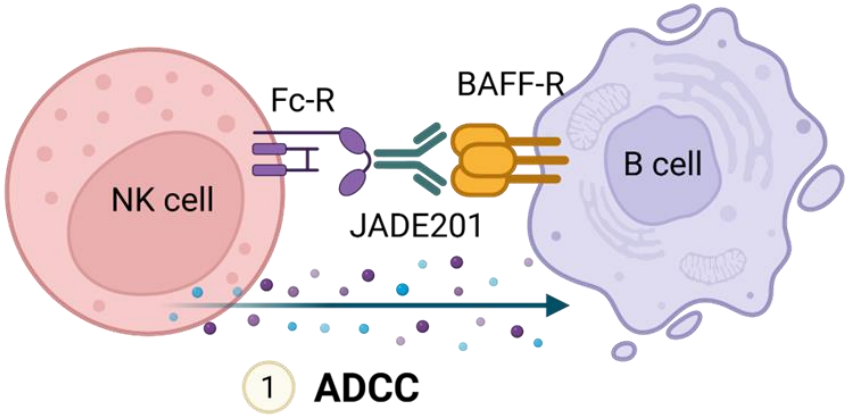
Jade BIOSCIENCES

Sources: 1. Merino-Vico Euro J Immunol 2023; 2. Ramwadhdoebe Rheumatology 2019; 3. Daneshvar E Int J Derm 2023; 4. Cornec, ACR Convergence 2025.
HLE – half-life extension.

JADE201's dual MOA expected to deliver deeper, more durable B cell depletion

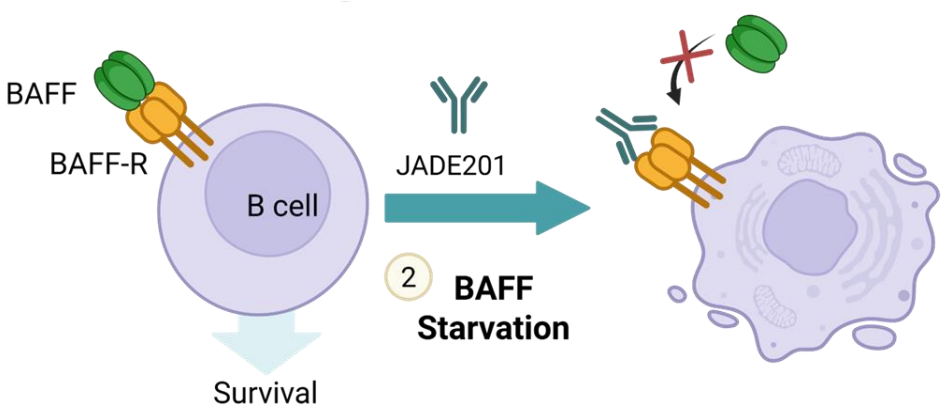
Direct Cytotoxicity via Enhanced Effector Function

- Validated mechanism that induces rapid B cell depletion
- Enhanced cytotoxicity by ADCC
- Potent depletion of circulating B cells



B Cell Inhibition and Depletion by BAFF Starvation

- Mechanism works in context of low receptor expression
- Relevant in secondary and ectopic lymphoid tissues where effector cells may be scarce
- Avoids B cell repopulation and resistance due to increased BAFF expression following B cell depletion with anti-CD20 agents

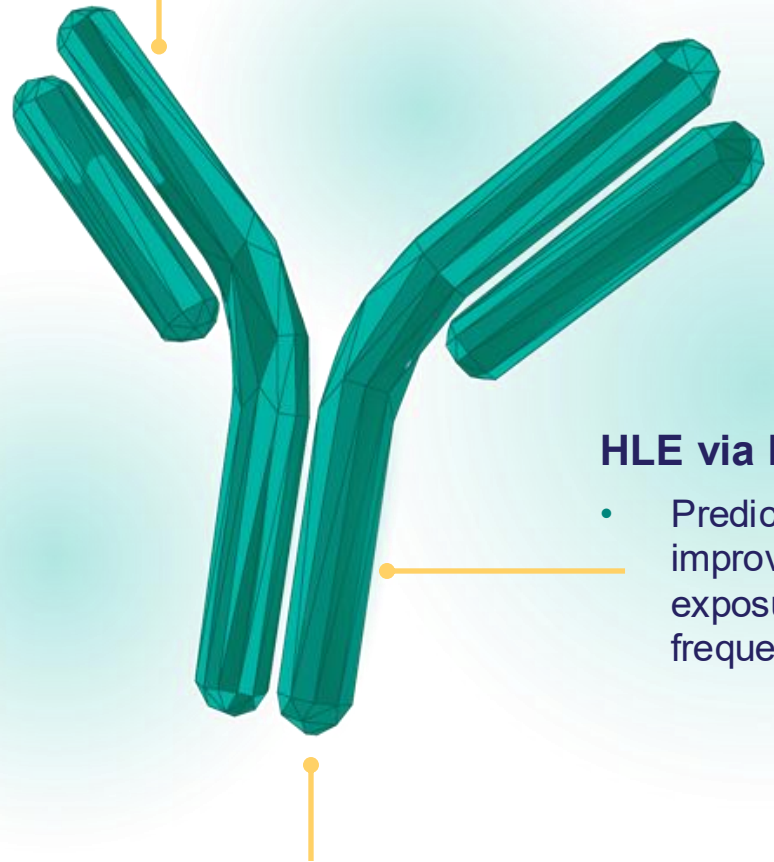


ADCC – antibody-dependent cellular cytotoxicity

Potentially best-in-class properties of JADE201

Binds BAFF-R broadly expressed on B cells

- Enhanced **ADCC activity** on B cells similar to ianalumab
- **Blocks BAFF activity** similar to ianalumab



HLE via Fc LS mutation

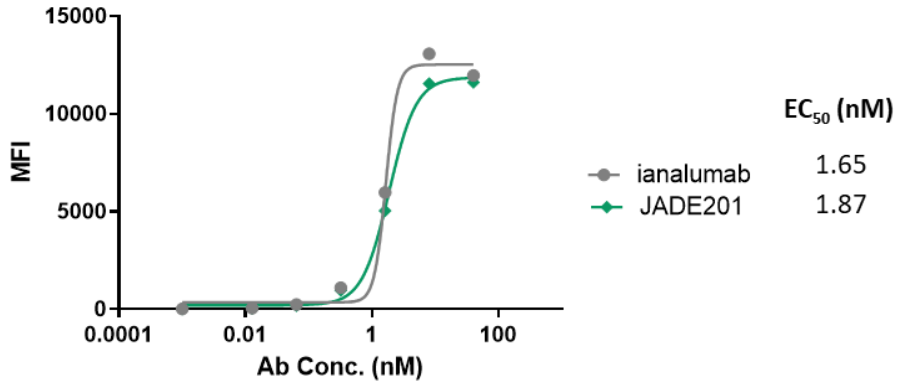
- Predicted to match, with potential for improved clinical activity due to increased exposure compared to ianalumab with less frequent dosing

Novel IP for COM into mid 2040s

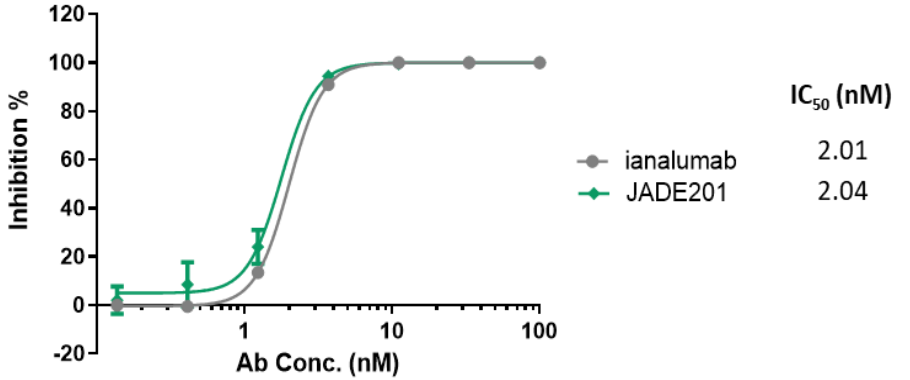
afucosylated for enhanced ADCC

JADE201 retains high BAFF-R binding affinity and functional activity in preclinical studies

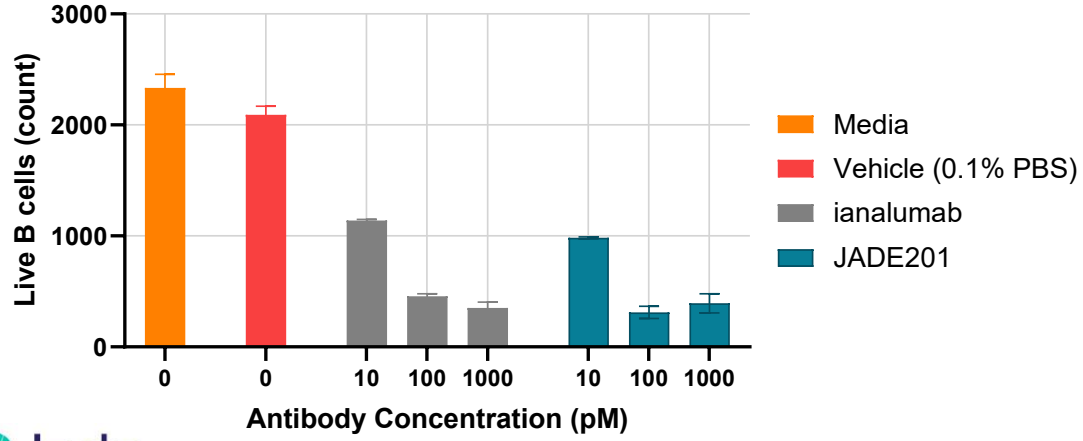
BAFF-R Binding (HEK Cells)



BAFF-R Blockade (Competition ELISA)



ADCC Activity – Primary human CD19+ B Cells



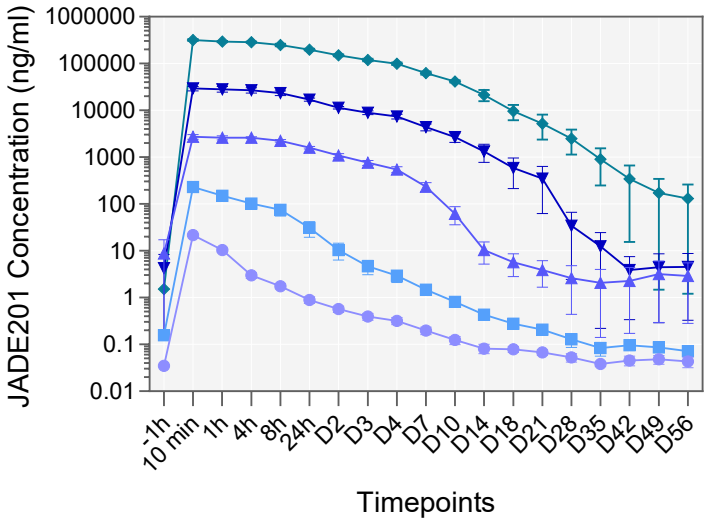
Additional Attributes Similar Between Clones

- Affinity to human/cyno BAFF-R by SPR
- BAFF-R binding (Raji B cells)
- FcR binding (excluding FcRn*)
- C1q binding
- ADCC activity on Raji B cells

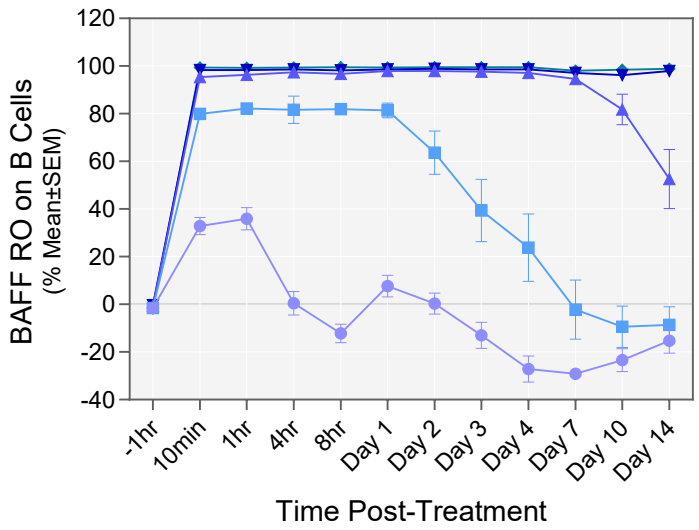
*LS mutation ~10x higher affinity to FcRn. Note: These data are derived from different studies at different points in time, with differences in methodology, design and populations. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials of JADE201 and other agents have been conducted.

JADE201 demonstrates deep B cell depletion in NHPs

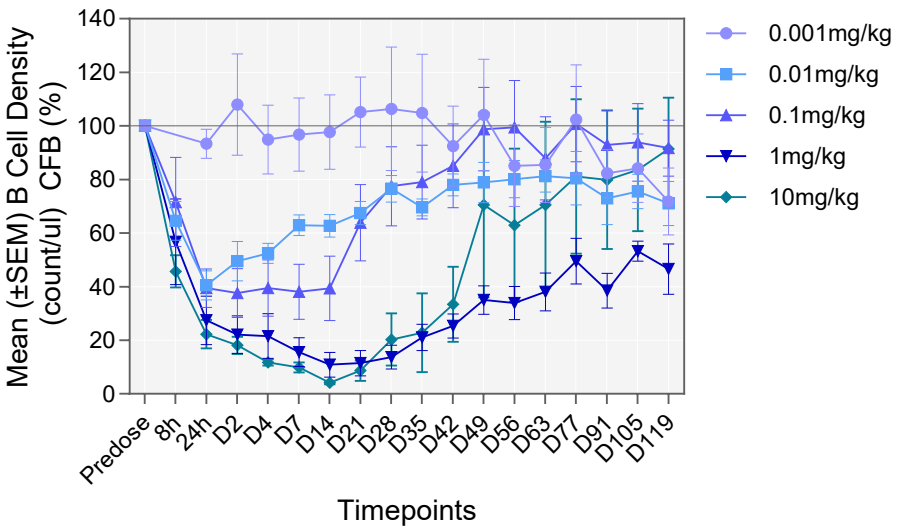
JADE201 PK



BAFF-Receptor Occupancy



B Cell Depletion

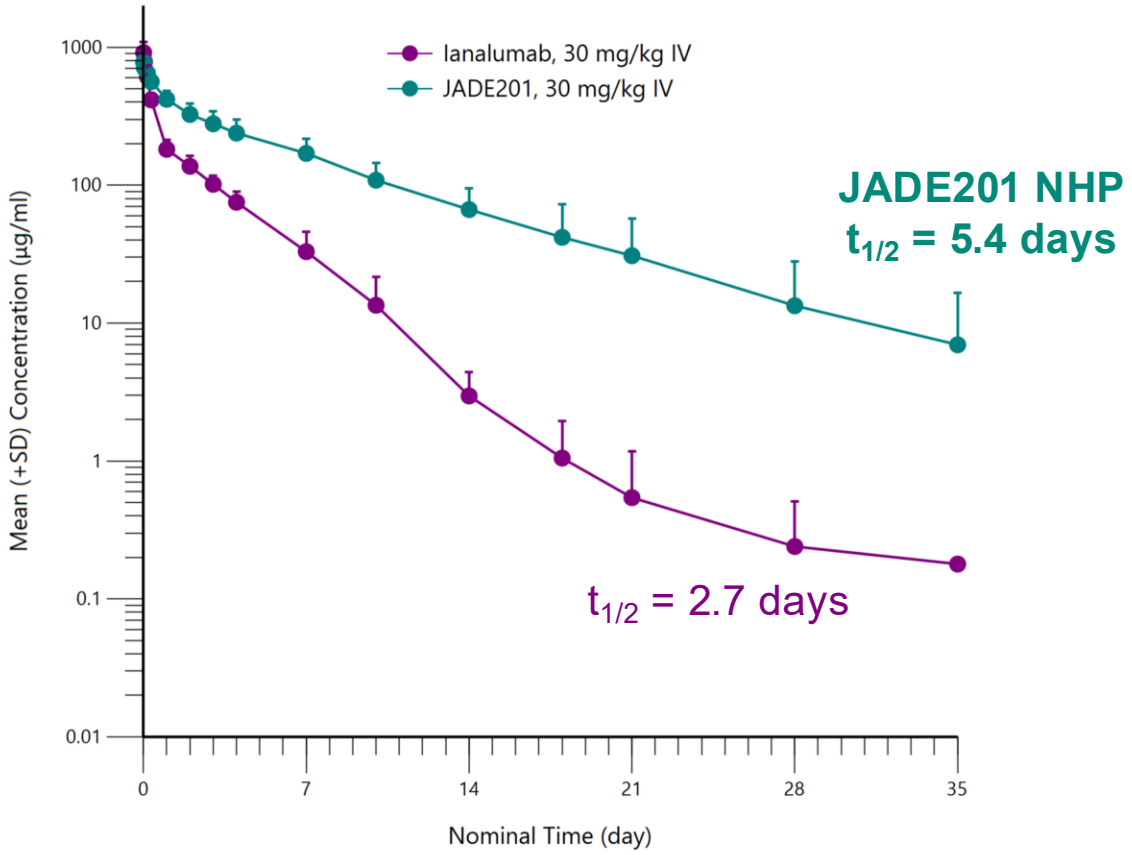


JADE201 demonstrates dose-dependent PK. Rapid RO observed with complete RO achieved at doses above 1 mg/kg. Deep and sustained B cell depletion achieved after single dose of JADE201 in NHPs.

Notes: ADA+ not yet ID and excluded. Accelerated recovery at 10 mg/kg v 1 mg/kg potentially related to ADA or hook effect.

JADE201 demonstrates a differentiated NHP PK profile from ianalumab

>2X HLE demonstrated in NHPs



HLE has potential to provide sustained BAFF receptor occupancy and improved clinical response

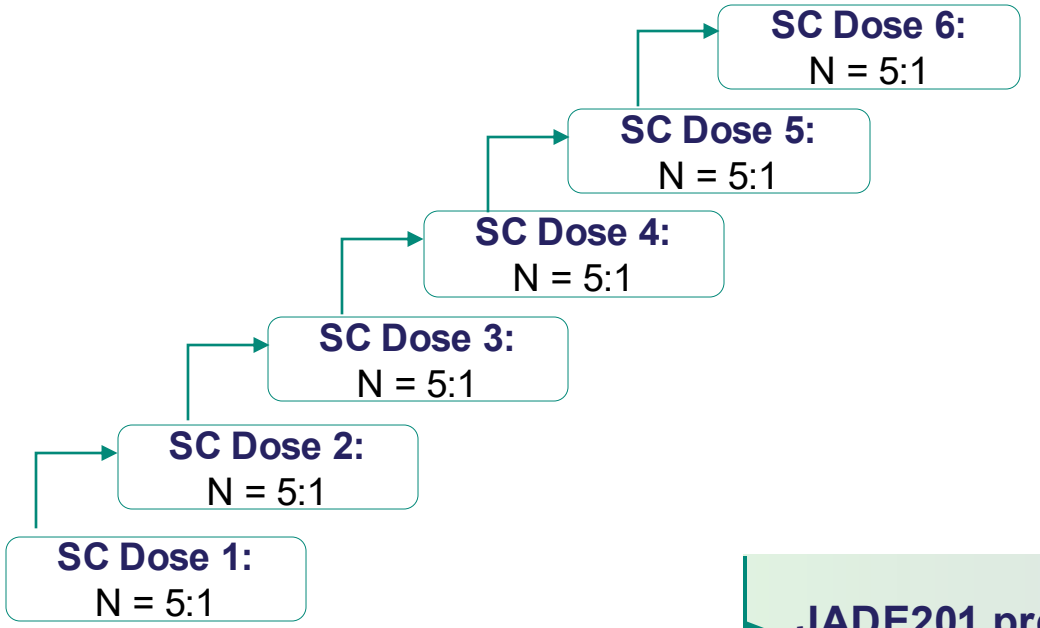
- Ianalumab has an observed human $T_{1/2}$ ~ 10 days
- JADE201 with HLE has the potential to provide complete BAFF-R coverage for an extended duration
  - Potential for deeper, more durable clinical responses
  - Extended dosing interval providing a more convenient, infrequent SC dosing profile

Note: Individual NHP time points that appear to be impacted by ADA excluded from half-life determinations and mean concentration-time plots.
These data are derived from different studies at different points in time, with differences in methodology, design and populations. As a result, cross-trial comparisons cannot be made, and No head-to-head clinical trials of JADE201 and other agents have been conducted.

JADE201 first-in-human trial in rheumatoid arthritis patients on track to begin in H1 2026

Phase 1 Study Design

Randomized, double-blind, placebo-controlled SAD study
SC administration in adults (n=36) with rheumatoid arthritis.



Endpoints

Primary

- Safety and tolerability

Secondary & Exploratory

- Pharmacokinetics
- Pharmacodynamics
- Immunogenicity
- B-cell depletion
- DAS28

JADE201 preclinical profile supports potential for best-in-class clinical efficacy with convenient, patient-friendly dosing

Notes: Numbers presented as subjects receiving JADE201 relative to placebo. Each cohort to include a sentinel group, n = 2 (1 JADE201, 1 placebo); remainder dosed after safety clearance.
DAS – Disease Activity Score

JADE201 profile expected to enable broad opportunity in multiple indications, including potential best-in-class and first-in-class

Rheumatology

- ANCA – Associated Vasculitis
- Autoimmune Myositis
- Rheumatoid Arthritis
- Sjogren's Disease*
- Systemic Lupus Erythematosus*
- Systemic Sclerosis *

Neurology

- Multiple Sclerosis
- Myasthenia Gravis
- Neuromyelitis Opica Spectrum Disorder

Nephrology

- Primary Membranous Nephropathy
- Lupus Nephritis*

Hematology

- Idiopathic Thrombocytopenic Purpura (ITP)*
- Warm AIHA*

Gastroenterology

- Autoimmune Hepatitis
- Primary Biliary Cholangitis

Dermatology

- Hidradenitis Suppurativa
- Bullous Pemphigoid
- Pemphigus

Endocrinology

- Grave's Disease
- Thyroid Eye Disease

Approximately 17 million patients and a total addressable market of over $80bn across potential indications

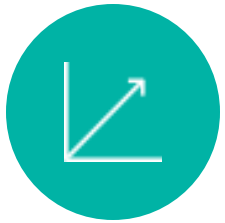
Source: GlobalData and other publicly available sources (2025 forecasted sales for approved systemic advanced therapies in US/EU5/JP). *Ianalumab ongoing phase 3 study; Primary endpoint met in ianalumab Phase 3 studies in Sjogren's Disease and ITP.

Pipeline beyond JADE101 & JADE201

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

Well-capitalized to deliver on key milestones with $326 million in cash [1], and runway into 1H 2028

MOA	Program	Discovery	IND-enabling	Phase 1	Expected Milestones	Potential Indications
anti-APRIL	JADE101				• Interim Data: 1H 2026	IgAN
anti-BAFF-R	JADE201				• Planned FIH: 1H 2026	Multiple systemic AI diseases
Undisclosed	JADE-003				• Planned FIH: 1H 2027	Undisclosed

Development candidates from Paragon

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

1. Pro forma cash, cash equivalents, and marketable securities includes $198.9M as of September 30, 2025, plus net proceeds before expenses, of $126.7M from October 2025 equity financing.
Notes: Jade has entered into exclusive license agreements with Paragon Therapeutics for JADE101 and JADE201. Jade holds an exclusive option to license JADE-003 from Paragon. Jade has not yet entered into a license agreement with respect to JADE-003.
MOA – mechanism of action; FIH – First-in-Human, IgAN - IgA nephropathy; AI – autoimmune; BAFF-R – B cell-activating factor receptor

Current capitalization

		Number of Shares*
Common stock	Shares outstanding	45,994,894
Common stock equivalents	Preferred stock (as converted to common stock)	12,622,000
	Pre-funded warrants	8,777,486
Common stock & common stock equivalents	**Total outstanding**	**67,394,380**

*As of October 6, 2025

Thank you

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