Corporate Presentation

April 2024

Forward-Looking Statements

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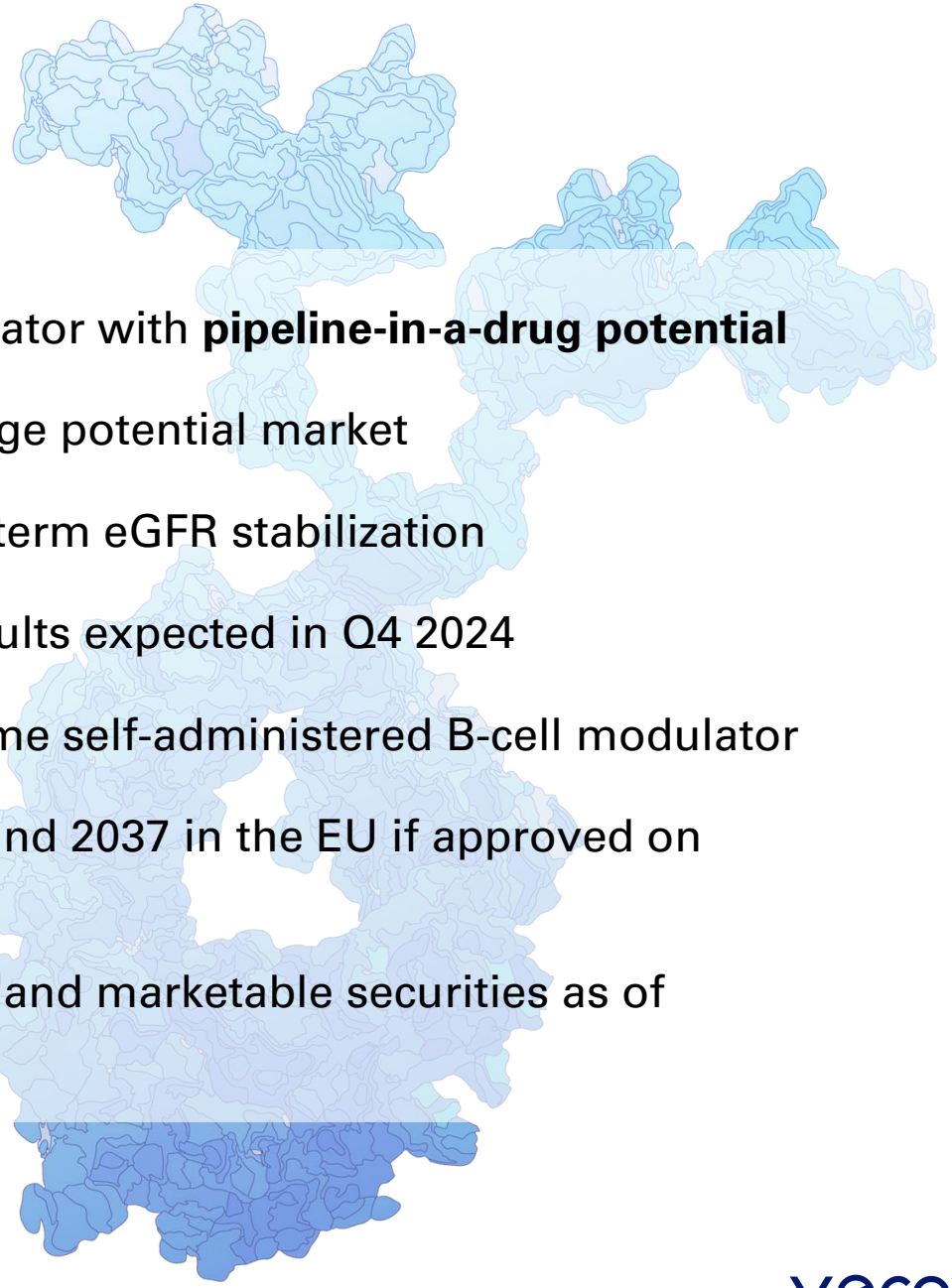
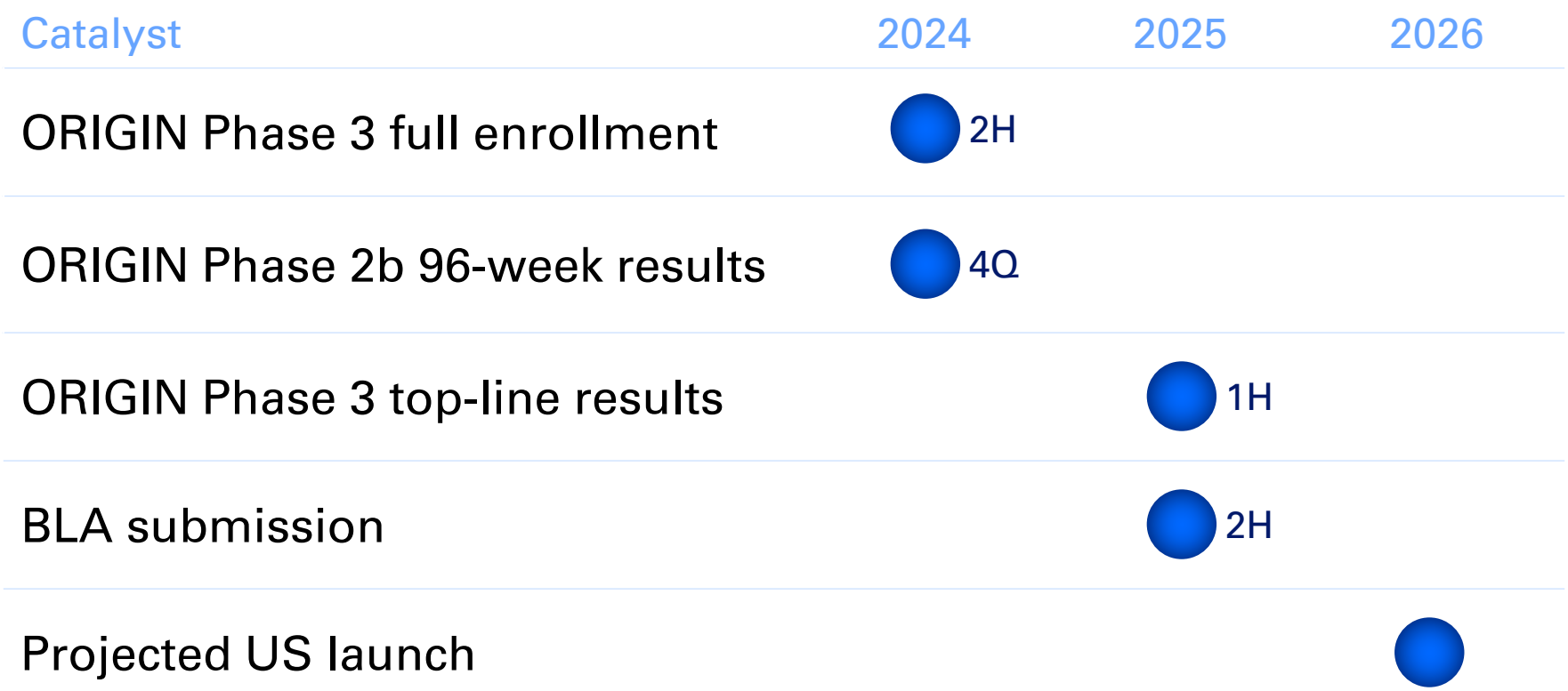
Corporate Highlights



- **Atacicept** is a potential first-in-class dual BAFF/APRIL B cell modulator with **pipeline-in-a-drug potential**
- Currently in Phase 3 pivotal trial for **IgA Nephropathy (IgAN)**, a large potential market
- Differentiation based on **disease-modifying MOA**, evident in long-term eGFR stabilization
- ORIGIN Phase 2b 72-week results **presented Q1 2024;** 96-week results expected in Q4 2024
- Phase 3 readout expected 1H 2025, potential **first-to-market** at home self-administered B-cell modulator
- Regulatory data exclusivity expected to extend to 2038 in the US and 2037 in the EU if approved on anticipated timeline
- Strong financial profile, ~$431M *pro forma* cash, cash equivalents and marketable securities as of December 31, 2023[1]

1. The Company has not yet completed its quarter- or year-end financial close process for the quarter ended December 31, 2023; includes ~$161M of cash, cash equivalents and marketable securities as of December 31, 2023 and additional ~$270M in net proceeds from February 2024 follow-on equity offering. This estimate of the Company's cash, cash equivalents and marketable securities as of December 31, 2023 is preliminary, has not been audited and is subject to change upon completion of the Company's financial statement closing procedures.
APRIL = A proliferation-inducing ligand; BAFF = B-cell activating factor; eGFR = estimated glomerular filtration rate; MOA = mechanism of action.

Atacicept: Expected Value Creation Catalysts Over Next 18 Months



Vera holds worldwide, exclusive rights to develop and commercialize atacicept

Based on management's current assumptions.

Management Team: Successful Clinical and Commercial Track Record

Marshall Fordyce, MD
President and CEO

- >15 years drug dev leadership
- 7 new drug approvals, Project Lead for tenofovir alafenamide program

GILEAD

Sean Grant, MBA
Chief Financial Officer

- >15 years in corporate strategy, finance, and capital raising
- Former healthcare banker with capital raising and M&A experience

CareDx® Your Partner in Transplant Care™ citi

Robert Brenner, MD
Chief Medical Officer

- Nephrologist with >25 years biotech leadership supporting multiple drug approvals

AMGEN amag PHARMACEUTICALS

William Turner
Chief Development Officer

- ~30 years drug dev and commercialization leadership in multiple therapeutic areas

SIERRA ONCOLOGY DYNAVAX aimmune THERAPEUTICS

Lauren Frenz, MBA
Chief Business Officer

- >15 years industry experience, including global commercial planning and multiple blockbuster launches at Gilead
- Strategic advisory at Leerink

GILEAD LEERINK PARTNERS

Kelly Rauber
VP, Head of HR

- >18 years in-depth HR experience from multiple industries

CYTOMX ORIC

vera therapeutics

Strong Financial Position

~$431M

Cash, cash equivalents, and marketable securities
(unaudited as of 12.31.23)[1]

~54M

Shares outstanding
(as of 2.1.24)

1. The Company has not yet completed its quarter- or year-end financial close process for the quarter ended December 31, 2023; includes ~$161M of cash, cash equivalents and marketable securities as of December 31, 2023 and additional ~$270M in net proceeds from February 2024 follow-on equity offering. This estimate of the Company's cash, cash equivalents and marketable securities as of December 31, 2023 is preliminary, has not been audited and is subject to change upon completion of the Company's financial statement closing procedures.

Vera Pipeline: Compelling Late-Stage Opportunities For Patient Benefit

Atacicept

Lead Indication: **IgAN**	Phase 3 Ongoing
IgAN extended dosing	Phase 2/3 potential
LN	Phase 3 ready
SLE	Phase 3 ready
Sjogren's syndrome	Phase 3 potential
Myasthenia gravis	Phase 3 potential
Membranous nephropathy	Phase 3 potential

MAU868

BK virus in transplantation	Phase 2/3 potential

LN = lupus nephritis; SLE = systemic lupus erythematosus.

MAU868: Novel Investigational Neutralizing Antibody Targeting BK Virus

Phase 2 Trial in Kidney Transplantation: Markedly decreased BK viral load and stable eGFR

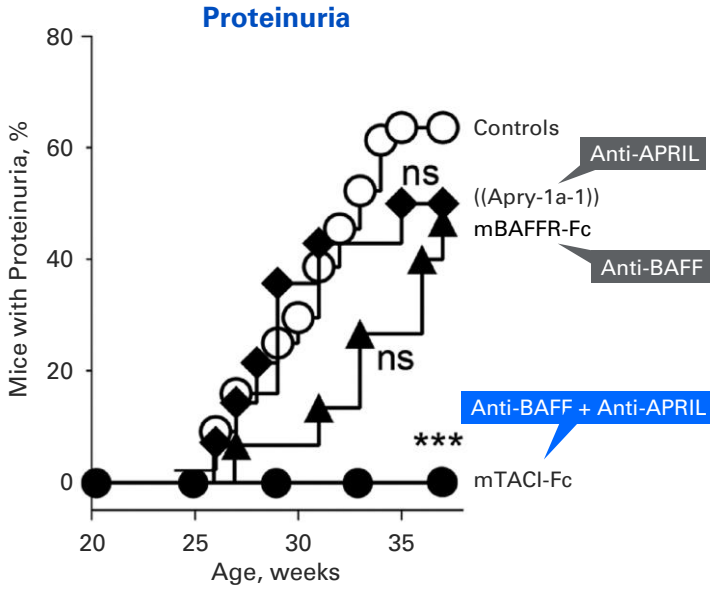
	MAU868 n=20	Placebo n=8	P-value
Log reduction in BK viremia, median (IQR) DNA copies/mL	-1.14 (-1.88, -0.50)	0.37 (-0.72, 0.04)	0.051
Patients with reduction in BK plasma viral load, n (%)			
by ≥1 log	11 (55)	1 (13)	0.040
to <lower limit of quantification	4 (20)	0	0.172
to $<10^4$ DNA copies/mL	15 (75)	3 (38)	0.061
Change in eGFR, median (IQR) mL/min/1.73m^2	2.0 (-5.0, 4.0)	-6.0 (-8.5, -0.5)	0.217

Jordan S, et al. Am J Transplant 2022.

Ataicept Dual Cytokine Inhibition of BAFF and APRIL:

Superior Potential B cell Modulation vs Single Pathway Intervention

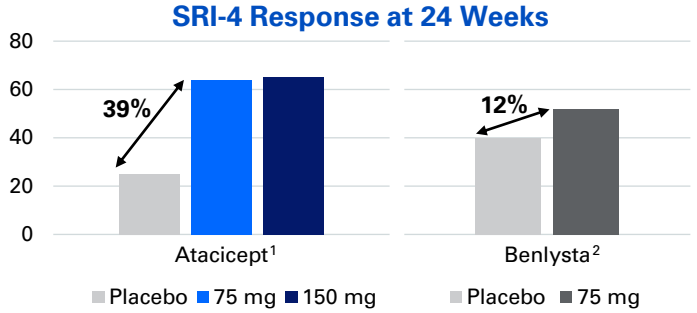
Pre-Clinical Evidence:
BAFF-APRIL >> BAFF or APRIL alone



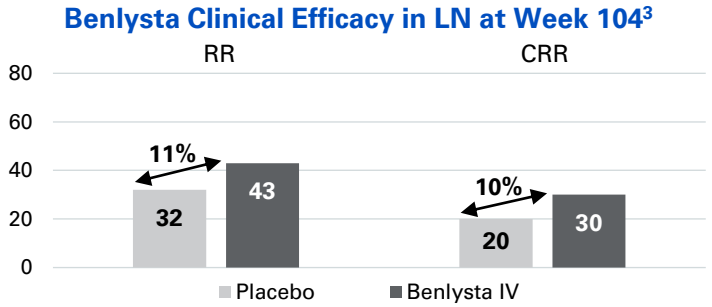
In mouse model of LN, ataicept prevented proteinuria compared to BAFF or APRIL alone

***p<0.001. Haselmayer P, et al. Eur J Immunol 2017.

Clinical Evidence:
BAFF-APRIL >> BAFF or APRIL alone



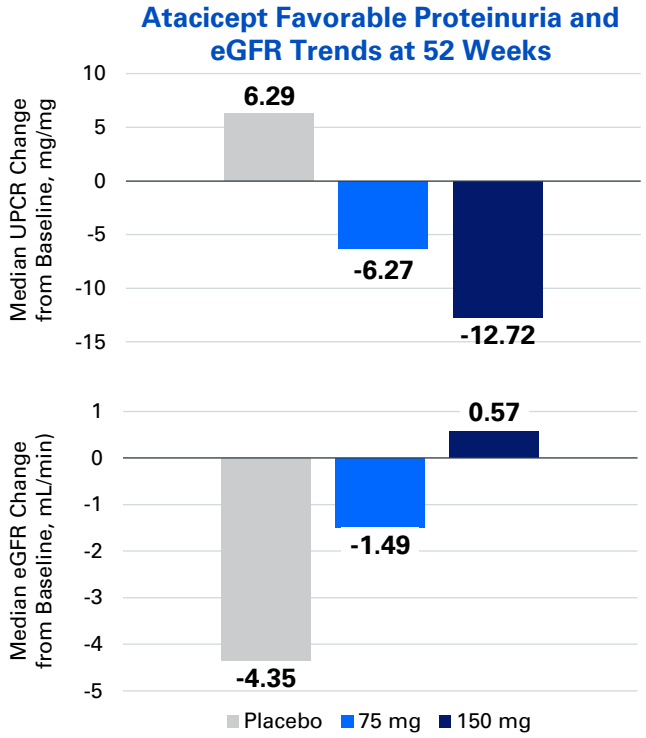
In similar serologically active SLE patients, BAFF/APRIL inhibition may provide better efficacy vs BAFF alone*



BENLYSTA approved in LN, but RR still <50%; we believe there is room for improvement with dual blockade[3]

1. Merrill JT, et al. Arthritis Rheumatol 2018; 2. van Vollenhoven RF, et al. Ann Rheum Dis 2012; 3. Furie R, et al. N Engl J Med 2020.

Clinical Evidence:
Improved kidney function in SLE



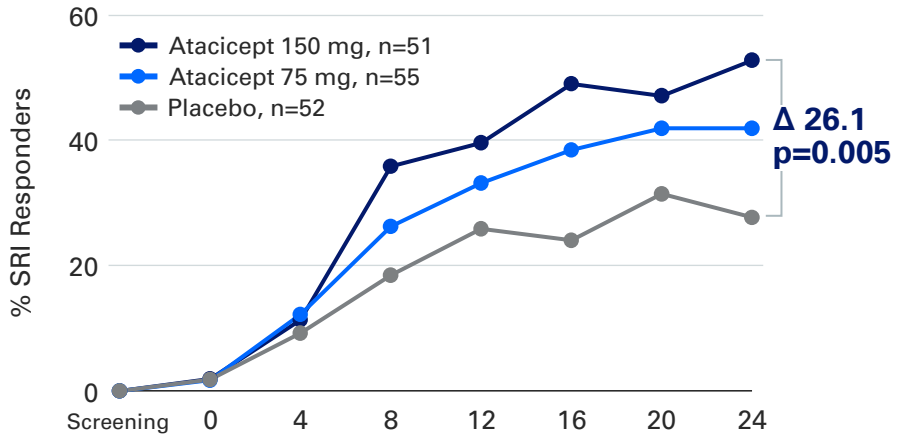
Phase 2 ataicept APRIL-SLE trial showed improved eGFR and proteinuria trends at 1 year in moderate–severe SLE

Isenberg D, et al. ERA-EDTA 2022 oral.

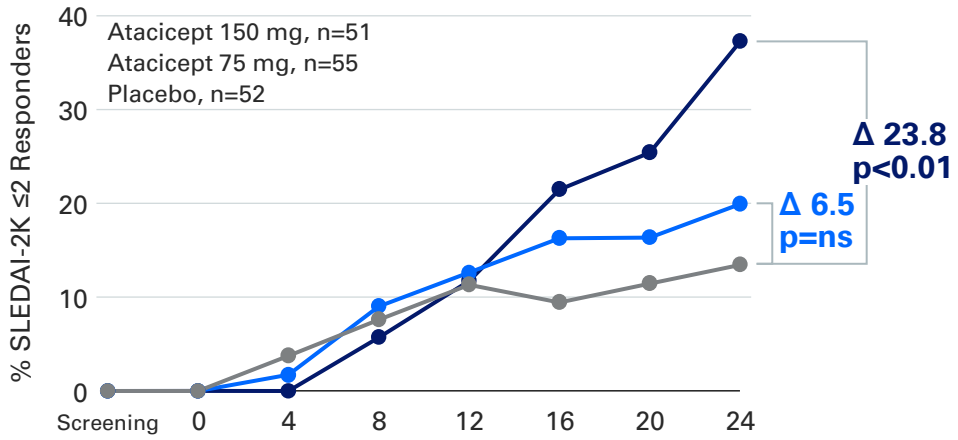
***Based on a cross-trial comparison and not a head-to-head clinical trial, such data may not be directly comparable due to differences in study protocols, conditions and patient populations.**
CRR = complete renal response; RR = renal response; SRI-4 = SLE responder index 4; UPCR = urine protein:creatinine ratio.

Atacicept Phase 2 Results in SLE Potentially Best-In-Class Clinical Activity

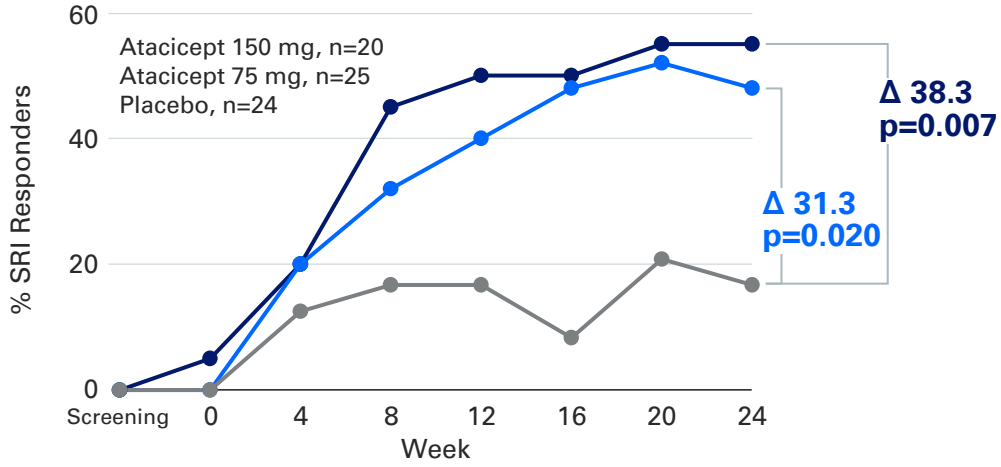
SRI-6 Response in HDA Patients (n=158)[1,2]



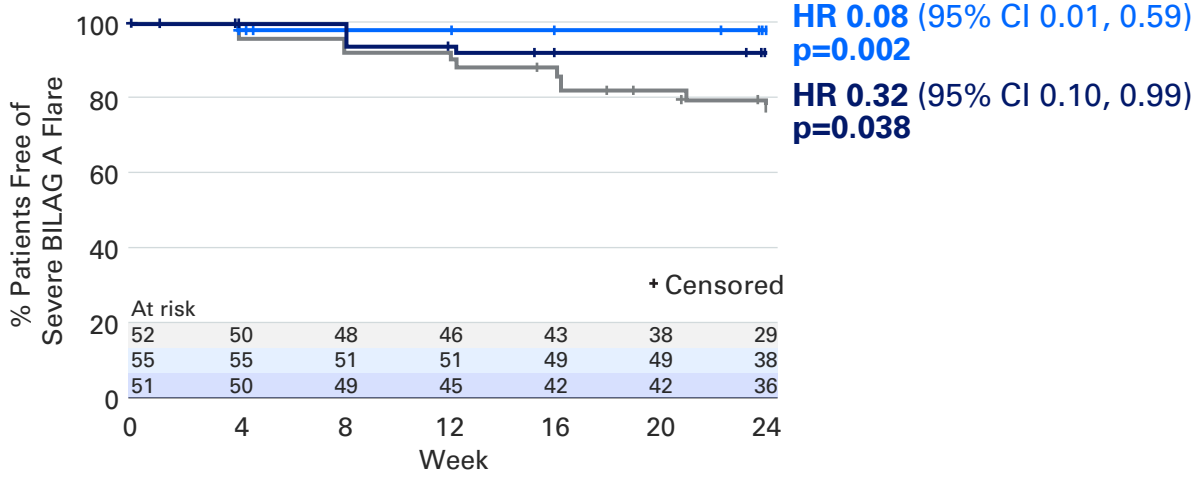
HDA Patients Reaching LDA (n=158)[3]



SRI-6 Response in HDA, Serologically Active Patients (n=69)[1,2]



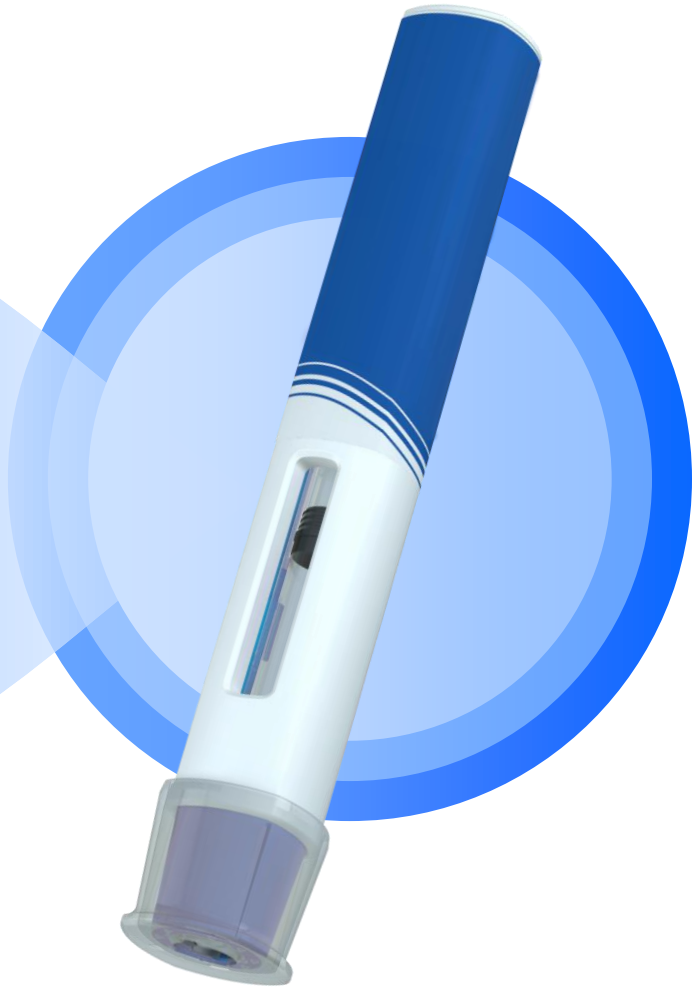
Severe BILAG A Flare in HDA Patients (n=158)[2]



HDA = High Disease Activity (SLE Disease Activity Index 2000 [SLEDAI-2K] ≥10); LDA = Low Disease Activity (SLEDAI-2K ≤2). 1. SLE responder index 6 (SRI-6) response defined as ≥6-point reduction in Safety of Estrogens in Lupus Erythematosus National Assessment version of SLEDAI score, no new British Isles Lupus Assessment Group (BILAG) A organ domain score or 2 new BILAG B organ domain scores, and no worsening (<0.30-point increase) in Physician's Global Assessment (PGA) score; 2. Merrill JT, et al. Arthritis Rheumatol 2018; 3. Morand EF, et al. Rheumatology 2020.

Attractive Target Commercial Atacicept Product Profile

- At home self-administration (subcutaneous) of small volume (1 mL) once weekly via autoinjector at commercial launch
- Smallest volume among B-cell modifying drugs in Phase 3 development (2–4 mL with APRIL-only)
- Large subcutaneous injection volumes are associated with pain and may affect tolerability and adherence[1]



1. Usach I, et al. Adv Ther 2019;36:2986-96. Atacicept is investigational and has not been approved by any regulatory authorities for any use.

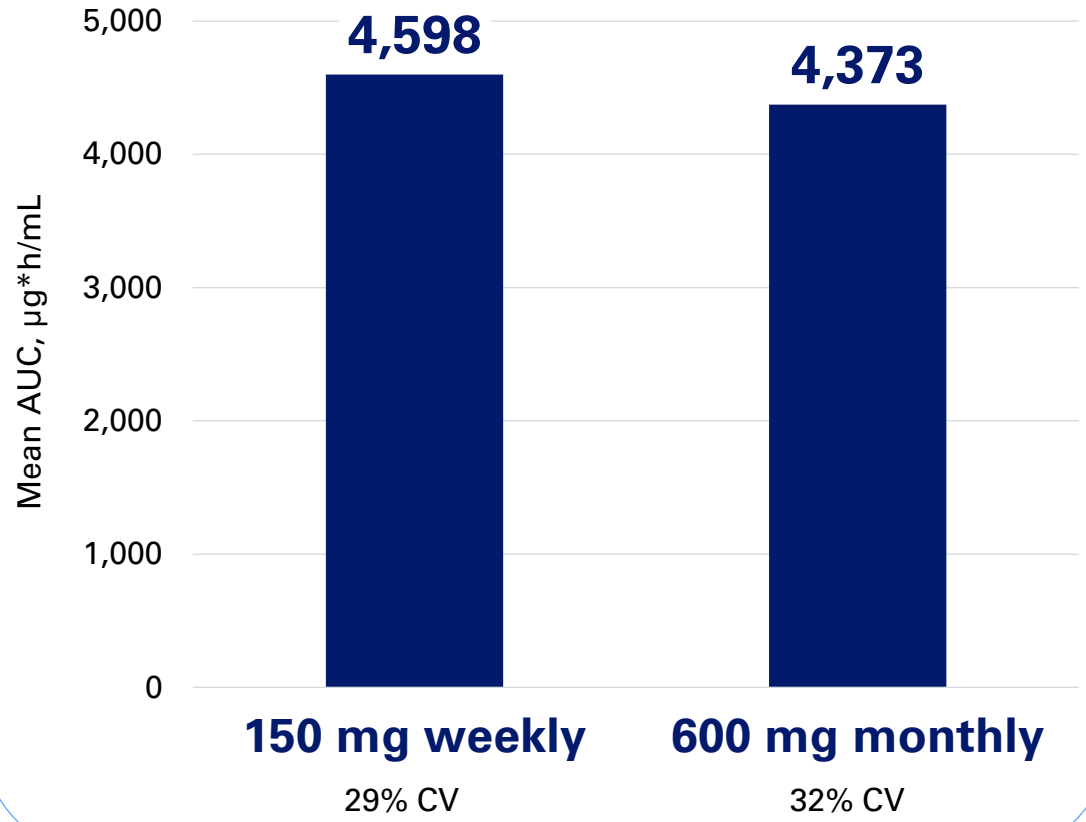
Atacicept PK/PD Supports Once-Monthly Dosing

Plan to Evaluate as Part of Life Cycle Management

Atacicept 150 mg weekly (Phase 2/3 dosing)

52 Week Simulation

Atacicept 600 mg monthly



Simulation of N=500 for each dosing scenario. AUC = area under curve; CV = coefficient of variation; PK/PD = pharmacokinetics/pharmacodynamics.

IgAN: High Unmet Need and Significant Commercial Opportunity

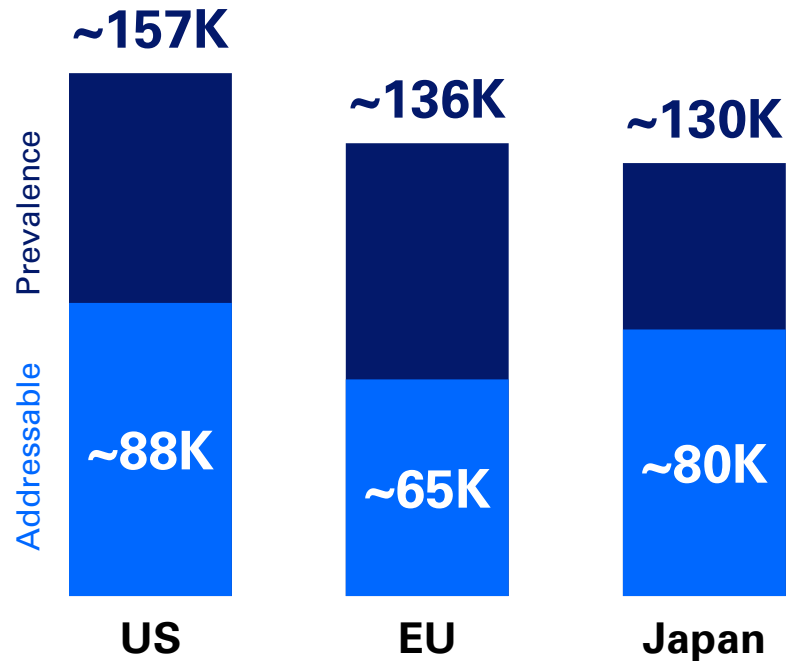
Serious and progressive autoimmune disease of the kidney; average age of diagnosis ~35 years old, severely impacting quality of life[1]

Orphan disease indication in the US and EU[2]

Up to 50% of IgAN patients progress to **ESKD**, resulting in need for **dialysis or transplant**[3,4]

Current SOC includes RASi and supportive care[5]; high unmet need for **disease-modifying therapy that targets the source**[5,6]

~$6–10B Annual Market Opportunity in US, EU, and Japan for Novel IgAN Therapeutics[7]



ESKD = end-stage kidney disease; RASi = renin-angiotensin system inhibitor; SOC = standard of care.
1. Jarrick S, et al. J Am Soc Nephrol 2019; 2. Orphan Disease Designation not yet obtained for atacicept in IgAN; 3. Kwon CS, et al. J Health Econ Outcomes Res 2021; 4. Pitcher D, et al. Clin J Am Soc Nephrol 2023;
5. Maixnerova D, et al. J Clin Med 2022; 6. Huang X, Xu G. Front Pharmacol 2021; 7. ClearView Healthcare Partners Analysis. US estimates based on 2032 projected population; EU and Japan estimates based on peak year forecast.

IgAN Epidemiology Considerations and Treatment Paradigm

Estimated IgAN Epidemiology in 2032E

IgAN Prevalence: ~0.04% of US Pop (360.5M)[1]

157K pts

High Risk (~56% of pts)[2]	Moderate Risk (~20%)[2]	Low Risk (~24%)[2]
~88K pts	**~31K pts**	**~38K pts**

ORIGIN P3 Population

Potential near-term expansion opportunity supported by ORIGIN P2b Results

Diagnosis and Treatment Paradigm

IgAN Natural History

IgAN-specific disease pathophysiology
→ **Turn off faucet of immune complex generation *with atacicept***

Non-IgAN-specific mechanism of nephron loss
→ **Treat CKD *with RAS and SGLT2 inhibition*[3]**

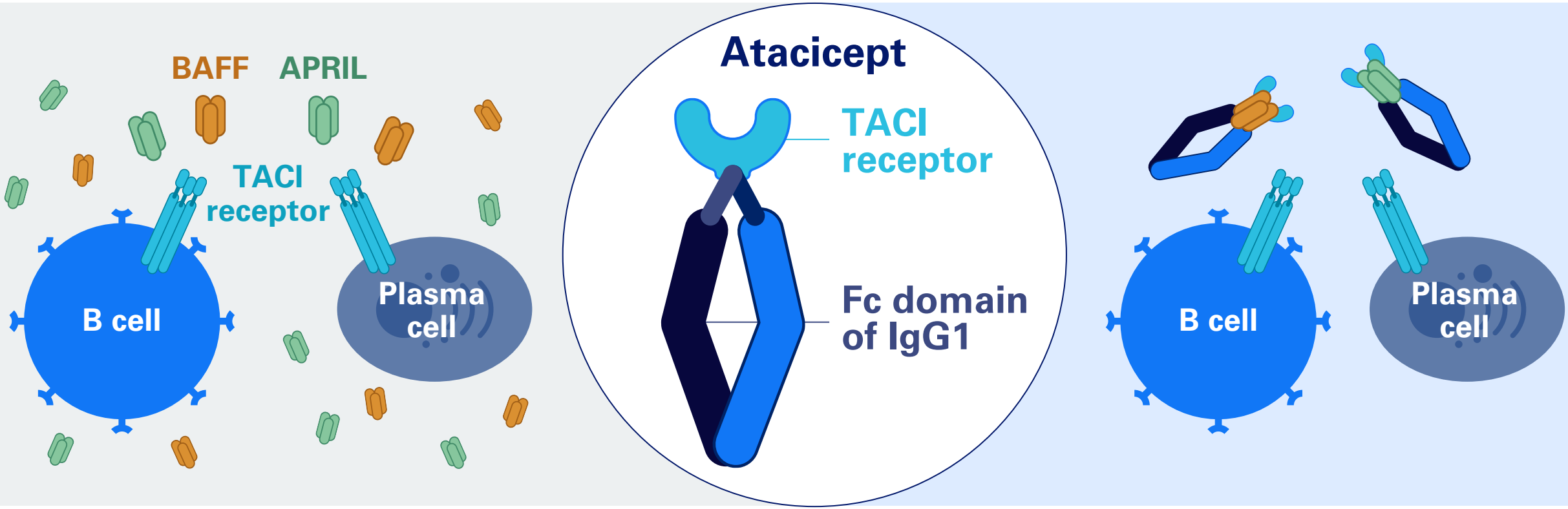
Treatment Considerations

- **~50%** of patients receiving standard of care progress to ESKD
- Patients with high proteinuria and/or hematuria often receive **immunosuppressive therapy**, frequently resulting in **adverse side effects with high dropout rates** in randomized controlled trials[4,5]
- **We project the initiation of disease modifying therapy with atacicept (dual BAFF/APRIL B cell modulation)** for prevalent IgAN patients, and first line disease modifying therapy for patients with a fresh biopsy
- Disease modifying therapy possibly **eliminates rationale for steroids and complement inhibitors**

Patient counts rounded to nearest 1,000. CKD = chronic kidney disease; SGLT2 = sodium-glucose cotransporter-2.
1. ClearView Partners Analysis; 2. Pitcher D, et al. Clin J Am Soc Nephrol 2023. Low Risk assumed to be 0–0.44 g/g UPCR, Mod Risk assumed to be 0.44–0.88 g/g, High Risk assumed to be >0.88 g/g; percentage of patients per risk group in overall study population applied to estimated US IgAN prevalence; 3. Kidney Disease: Improving Global Outcomes 2021 Clinical Practice Guideline for the Management of Glomerular Diseases; 4. Rauen T, et al. N Engl J Med 2015; 5. Lv J, et al. JAMA 2022.

Atacicept Is An Example Of Rational Drug Design

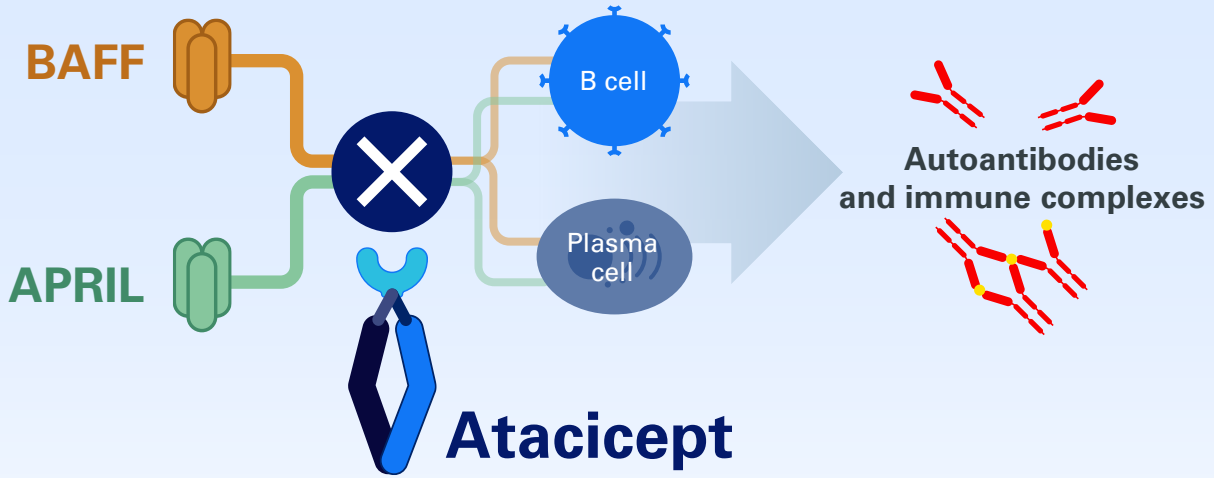
Native TACI Receptor Fused to Fc – Soluble Fusion Protein Designed To Bind Both BAFF and APRIL



Fc = fragment crystallizable; TACI = transmembrane activator and calcium-modulator and cyclophilin ligand interactor.

Thesis That Drove Vera Acquisition of Atacicept in 2020…

Rationale for Dual Inhibition of BAFF + APRIL with Atacicept



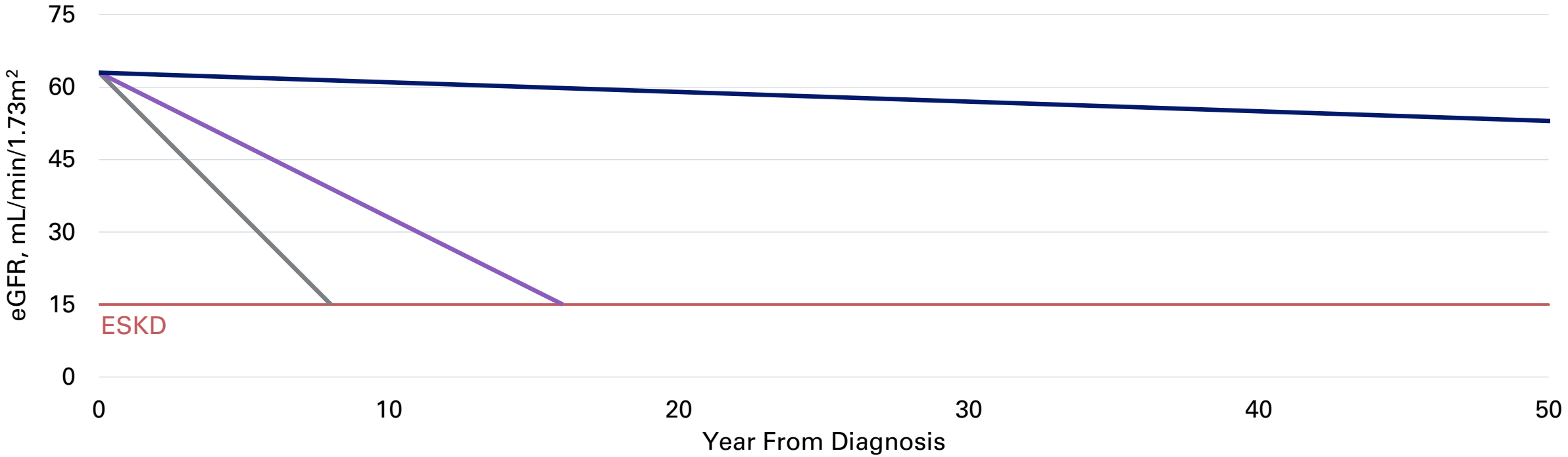
- Elevated BAFF plays **key role in IgAN pathogenesis**
  - BAFF and APRIL levels are both elevated in patients with IgAN and are each associated with clinical severity[1-3]
  - In preclinical models, overexpression of BAFF alone can lead to the development of kidney IgA deposits and IgA-like nephritis[4]
  - BAFF can directly increase the expression of factors associated with fibrosis and inflammation in mesangial cells[2]
  - Dual blockade of BAFF and APRIL decreased renal damage in an immunologic animal model more than individual blockade of either pathway alone[5]
- Dual inhibition offers the potential for **sustained clinical efficacy**
  - BAFF or APRIL alone are each capable of independently supporting plasma cell survival[5,6]
  - Blocking both biologic targets may avoid compensatory increase in parallel signal[7,8]
  - Blocking APRIL alone may lead to upregulation of BAFF signaling with potential consequences on efficacy[9]

1. Xin G, et al. J Nephrol 2013; 2. Cao Y, et al. Mol Med Rep 2020; 3. Zhai Y, et al. Medicine (Baltimore) 2016; 4. McCarthy D, et al. J Clin Invest 2011; 5. Haselmayer P, et al. Eur J Immunol 2017; 6. Benson M, et al. J Immunol 2008; 7. Yeh T, et al. J Allergy Clin Immunol 2020; 8. Vallerskog T, et al. Arthritis Res Ther 2006.

… Included Bold Projections for IgAN Disease Modification

Atacicept Potential to Convert eGFR Rate of Decline to That of the General Population

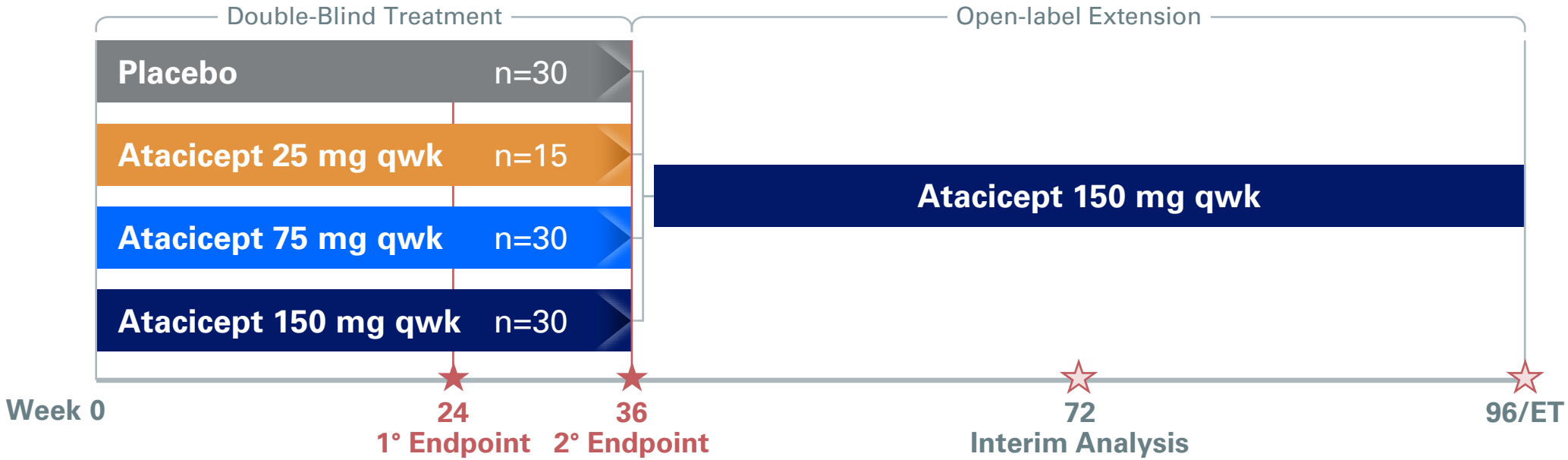
	Supportive CKD therapy[1]	New approved non-disease modifying therapies[2]	Atacicept
eGFR slope, mL/min/1.73m^2/y	~ -6	~ -3	~0



Projected eGFR trajectories do not represent clinical data and assume a constant eGFR slope over time.
Average slope estimates were applied to mean baseline eGFR of 63 mL/min/1.73m^2 in the ORIGIN Phase 2b study population and projected to ESKD (eGFR 15 mL/min/1.73m^2).
1. Average historical placebo (including chronic kidney disease standard of care) data from 7 clinical trials[3-11]; 2. Average data from clinical trials of two therapies[3,4,10]; 3. Lafayette R, et al. Lancet 2023; 4. Rovin BH, et al. Lancet 2023; 5. Li PK-T, et al. Am J Kidney Dis 2006; 6. Manno C, et al. Nephrol Dial Transplant 2009; 7. Lv J, et al. JAMA 2017; 8. Wheeler DC, et al. Kidney Int 2021; 9. Lv J, et al. JAMA 2022; 10. Zhang H, et al. ASN Kidney Week 2023, poster TH-PO1123; 11. Mathur M, et al. N Engl J Med 2023.

ORIGIN Phase 2b IgAN Trial: Study Design and Objectives

Multinational, randomized, placebo-controlled trial



Inclusion Criteria

- Participants ≥18 years old with IgAN on renal biopsy and high risk of disease progression
- Stable and optimized RAASi for ≥12 weeks
- Use of SGLT2i allowed
- UPCR-24h >0.75 g/g or UP >0.75 g per 24h
- eGFR ≥30 mL/min/1.73 m^2
- Blood pressure ≤150/90 mmHg

Endpoints

- Primary efficacy: UPCR-24h at week 24 ★
- Key secondary: UPCR-24h at week 36 ★
- eGFR change up to week 96 ☆
- Gd-IgA1 change
- Safety

ET = end of treatment; Gd-IgA1 = galactose-deficient immunoglobulin A1; RAASi = renin-angiotensin-aldosterone system inhibitor; UPCR = urine protein:creatinine ratio.

Summary of Positive Phase 2b Week 36 Results

- **Gd-IgA1 reduction of 64% from baseline with atacicept 150 mg**
- **Hematuria resolution in 80% of participants on atacicept 150 mg vs 5% on placebo**
- **Met primary endpoint, with statistically significant UPCR reductions on atacicept 150 mg**

PP Analysis	ITT Analysis	
Δ 43%*	**Δ 35%***	*p<0.05

- **Stable eGFR observed for participants on atacicept, with clinically meaningful and statistically significant difference vs placebo**

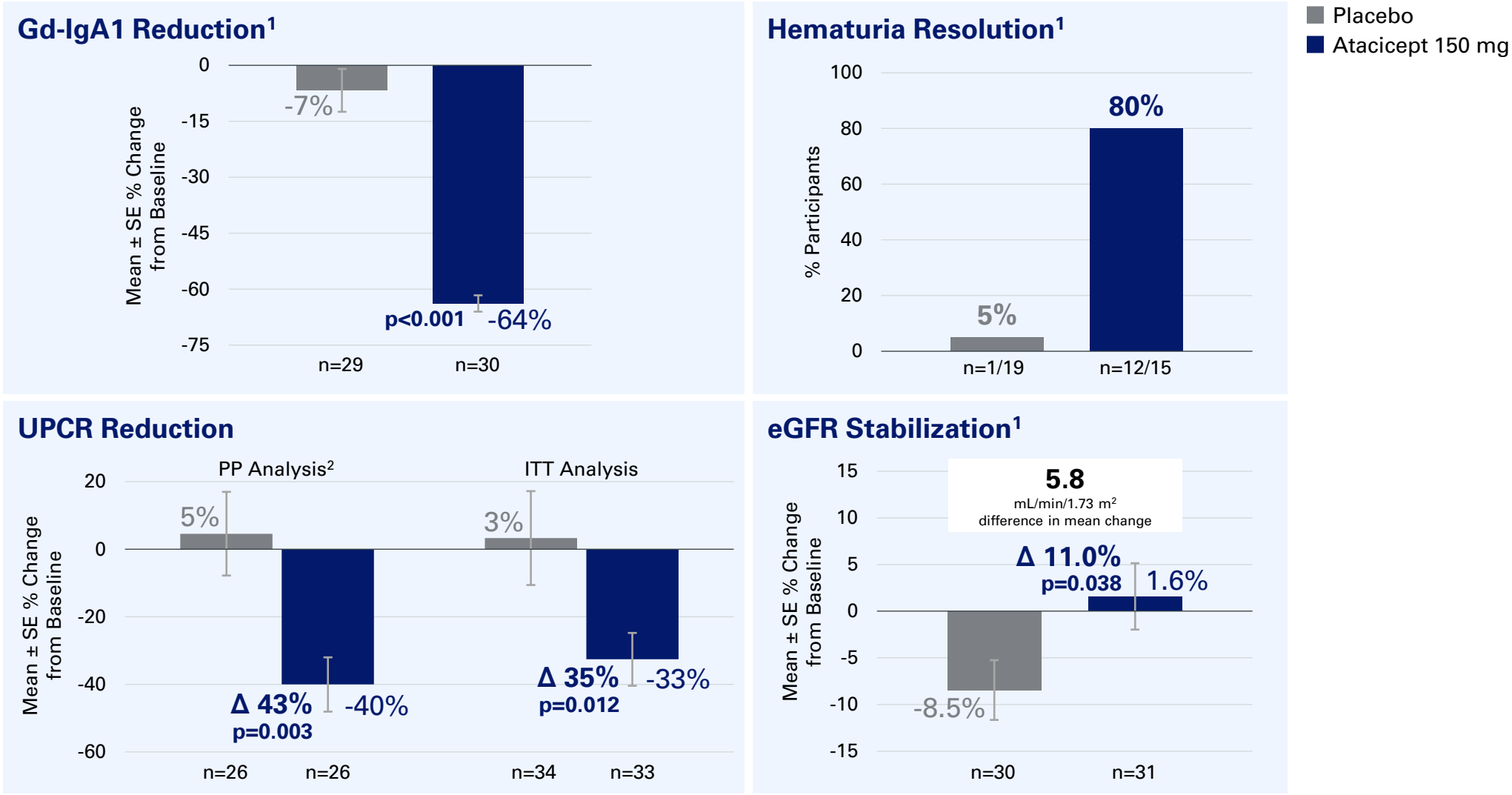
Mean eGFR % change with atacicept 150 mg vs placebo was **11% (p=0.038)**, approximating to an absolute difference of **5.8 mL/min/1.73 m^2**

- **Clinical safety profile similar between atacicept and placebo**

Atacicept 150 mg dose selected for Phase 3 clinical trial, initiated in June 2023

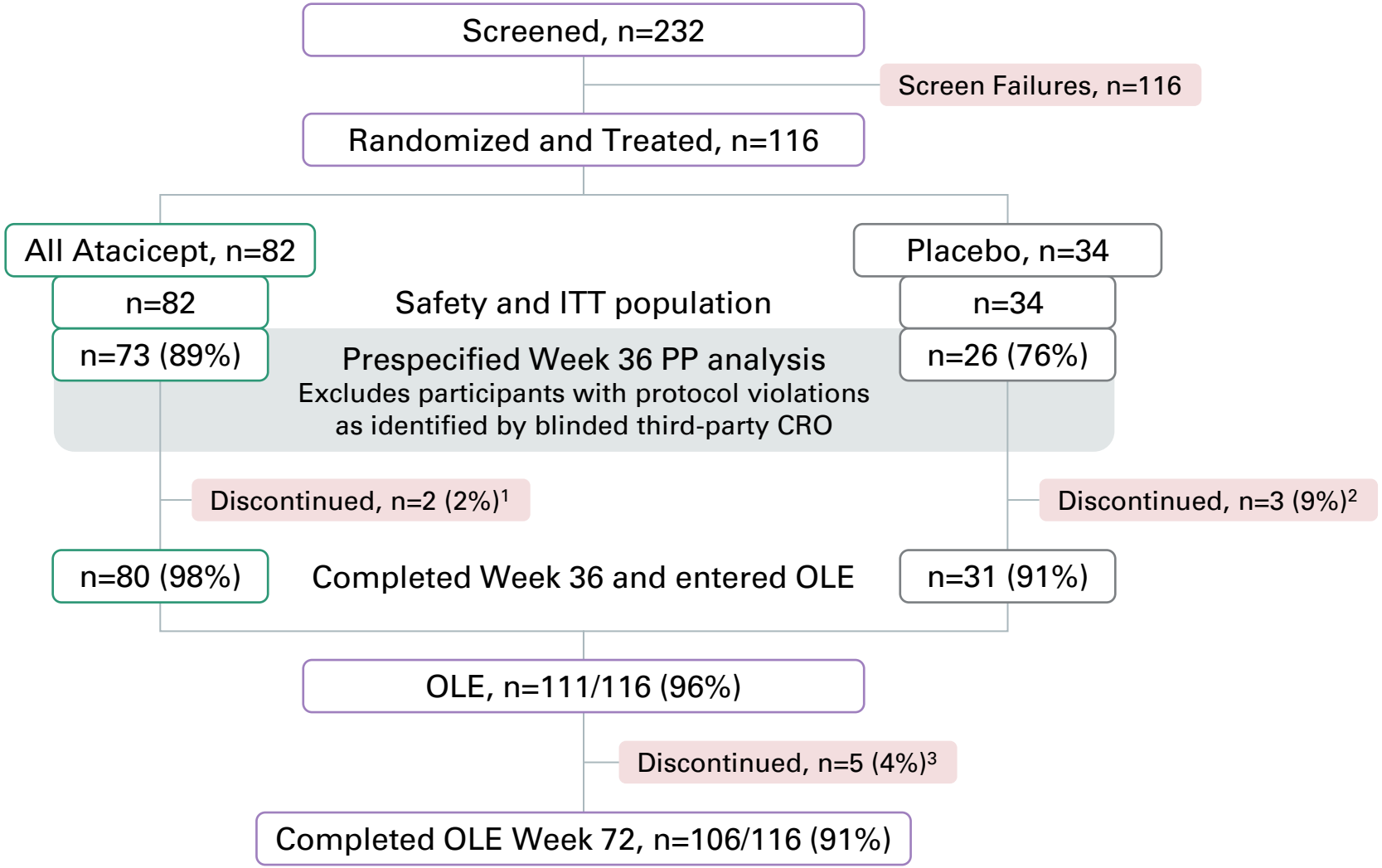
ITT = intent to treat; PP = per-protocol. Hematuria resolution defined as decrease to negative/trace levels in participants with baseline hematuria 1+ or higher.
Lafayette R, et al. ERA 2023 late breaking clinical trial oral presentation, June 17 2023; Barratt J, et al. ASN 2023, SA-PO887.

Disease Modification Observed in Phase 2b Week 36 Results



1. ITT analysis; 2. Prespecified Week 36 PP analysis excluded participants with protocol violations through week 36 as identified by blinded third-party CRO. Hematuria resolution defined as decrease to negative/trace levels in participants with baseline hematuria 1+ or higher. Lafayette R, et al. ERA 2023 late breaking clinical trial oral presentation, June 17 2023; Barratt J, et al. ASN 2023, SA-PO887.

ORIGIN 2b Participant Disposition



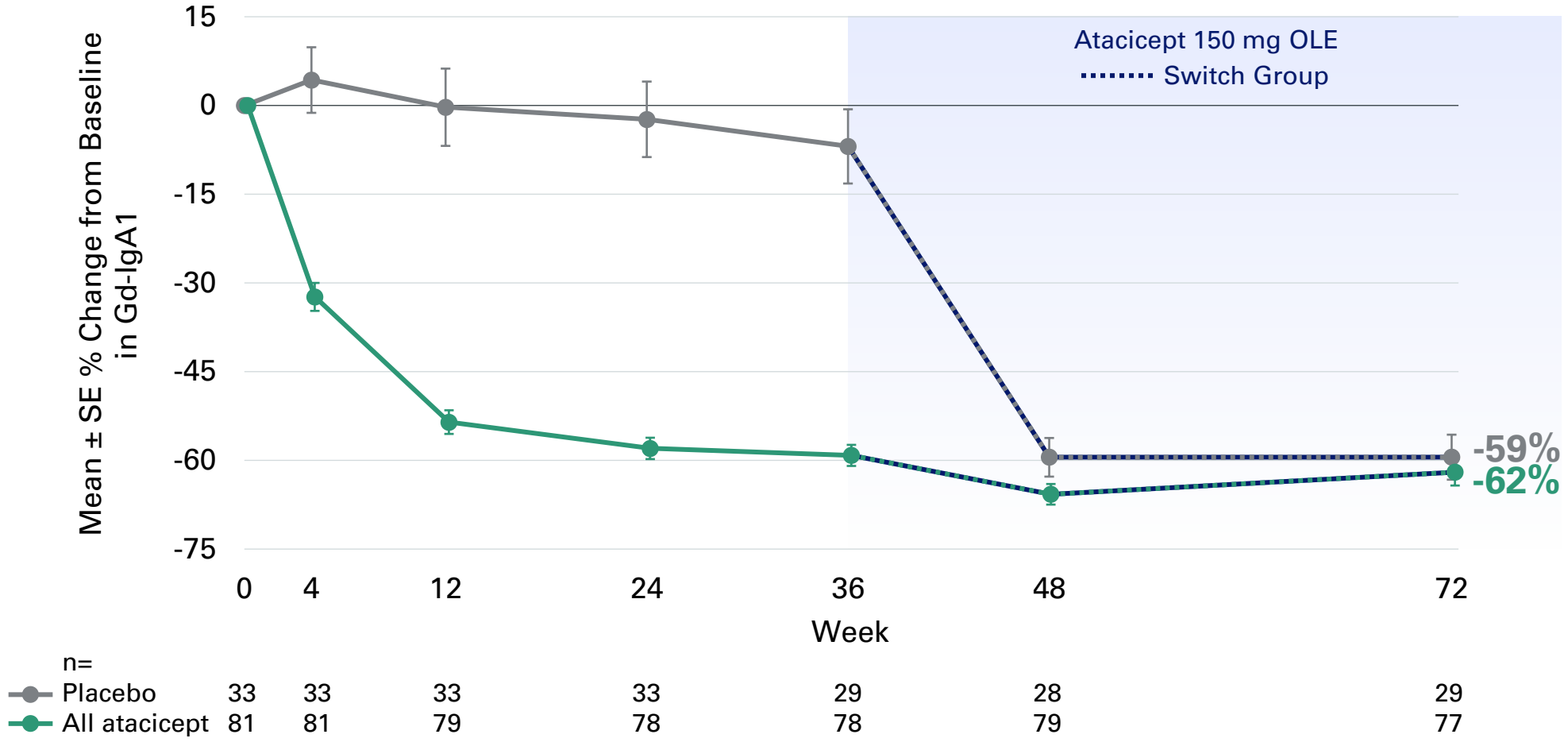
Vera data on file. OLE = open label extension.
1. Discontinued to pursue elective surgery (1), discontinued due to positive hepatitis B DNA and adverse event (1).
2. Initiated prohibited medication for concomitant disease (1), discontinued due to plan to start prohibited medication for concomitant disease (1) and adverse event (1).
3. Discontinued to pursue surgery (1), discontinued due to serious adverse event of pneumonia in a heavy smoker, resolved (1), investigator decision (1), pregnancy (1), and participant withdrawal (1).

ORIGIN 2b Demographics and Baseline Characteristics

Mean ± SD or n (%)	Overall n=116	Atacicept 25 mg n=16	Atacicept 75 mg n=33	Atacicept 150 mg n=33	Placebo n=34
Age, y	39	40	41	38	39
Male sex	69 (59)	9 (56)	19 (58)	22 (67)	19 (56)
Race					
White	62 (53)	7 (44)	12 (36)	17 (52)	26 (76)
Asian	51 (44)	7 (44)	20 (61)	16 (48)	8 (24)
Other	3 (3)	2 (12)	1 (3)	0	0
eGFR, mL/min/1.73 m^2	63 ± 27.3	71 ± 28.7	64 ± 25.4	56 ± 22.7	66 ± 31.7
UPCR by 24h urine, g/g	1.6 ± 0.9	1.6 ± 0.8	1.7 ± 0.9	1.7 ± 1.0	1.6 ± 0.8
Time from biopsy, y	2.8 ± 2.8	1.7 ± 1.6	3.4 ± 2.8	3.3 ± 3.4	2.1 ± 2.4

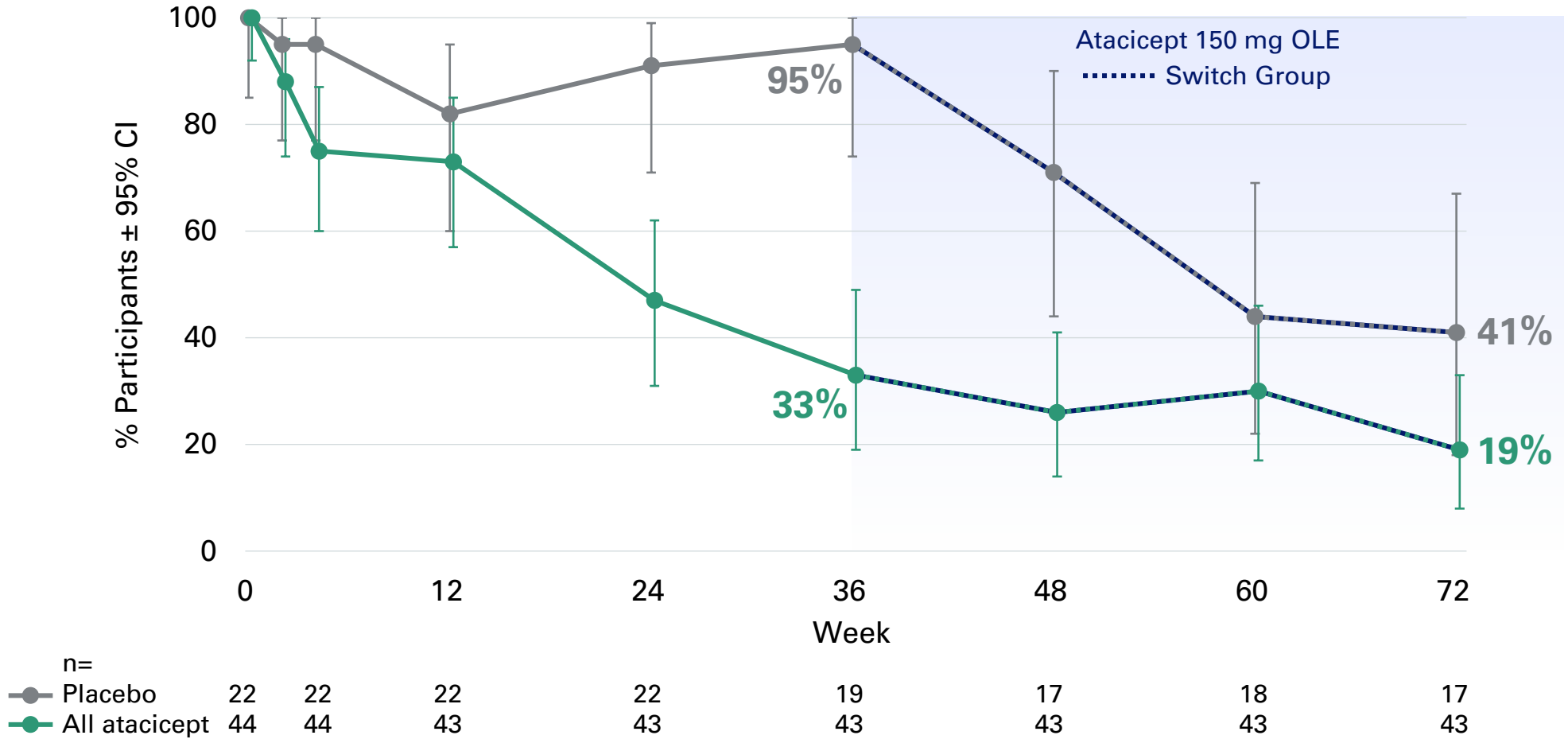
Consistent and Sustained Gd-IgA1 Reduction Through Week 72

Placebo → Atacicept Switch Group Had Similar Reduction as Randomized Atacicept Group



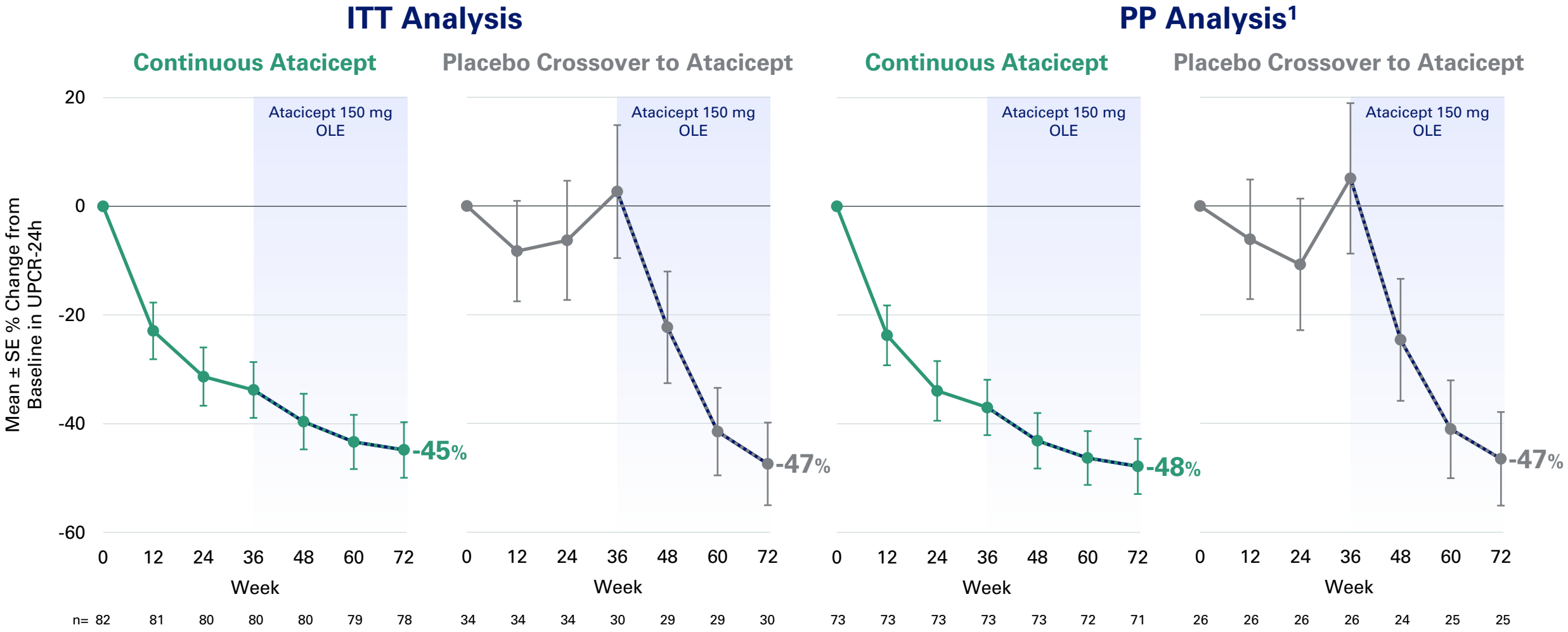
Vera data on file.
Percentage changes from baseline were analyzed using FDA-endorsed mixed-effects modeling; all atacicept group includes participants originally randomized to any atacicept group in the double-blind period; ITT analysis.

Consistent and Sustained Reductions in Percentage of Participants with Hematuria Through Week 72



Percentages represent number of participants with hematuria at each visit out of those with baseline hematuria; microscopic hematuria was evaluated via urine dipstick at a centralized lab, and hematuria levels were graded negative/trace, 1+, 2+, or 3+. All atacicept group includes participants originally randomized to any atacicept group in the double-blind period; ITT analysis. CI = confidence interval.

Consistent and Sustained Reductions in UPCR Over 72 Weeks

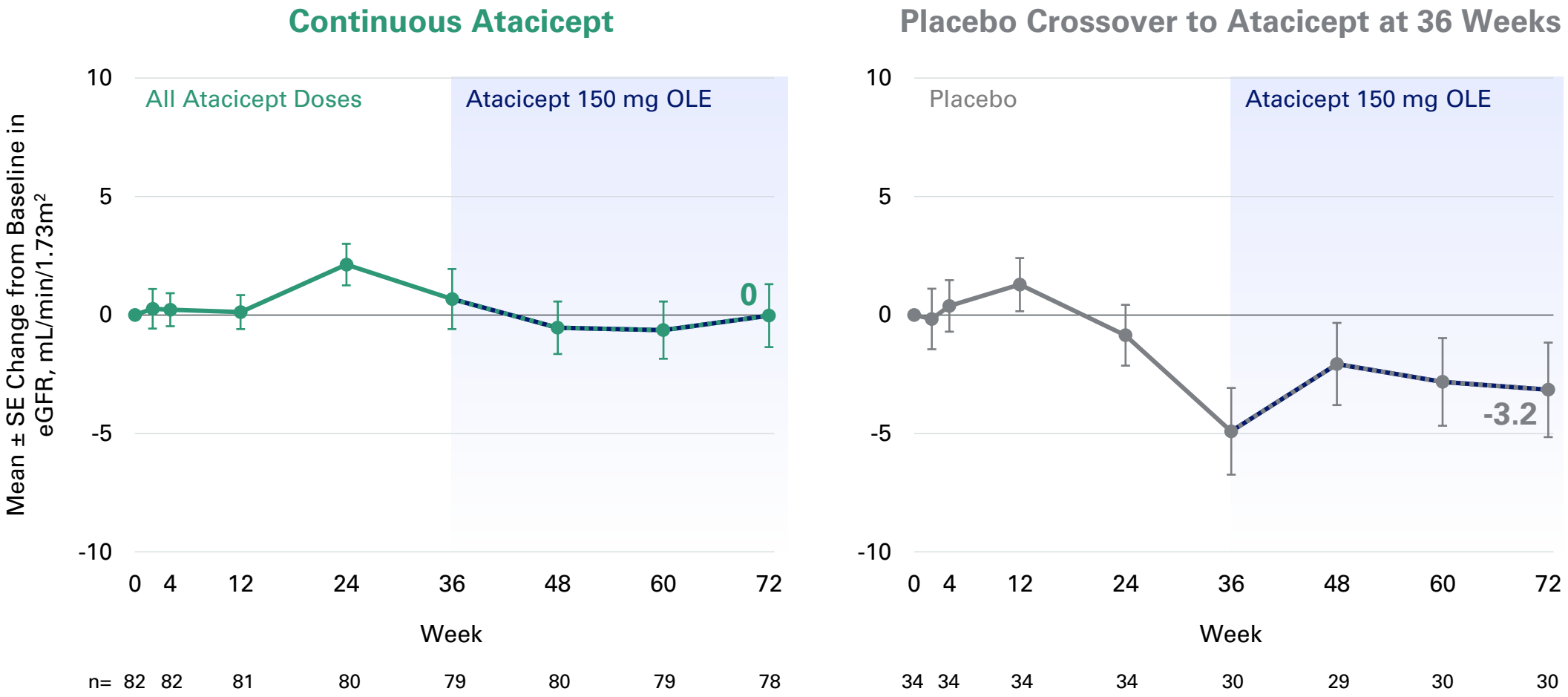


Vera data on file. Percentage changes from baseline were analyzed using FDA-endorsed mixed-effects modeling which takes into account the effects of baseline UPCR and eGFR and implicitly imputes missing data as missing at random. All atacicept group includes participants originally randomized to any atacicept group in the double-blind period.

1. Prespecified Week 36 PP analysis excluded participants with protocol violations through week 36 as identified by blinded third-party CRO.

Atacicept Resulted in eGFR Stabilization Through 72 Weeks

Atacicept Switch Halted eGFR Decline in Randomized Placebo Cohort



Vera data on file. Percentage changes from baseline were analyzed using FDA-endorsed mixed-effects modeling which takes into account the effects of baseline UPCR and eGFR and implicitly imputes missing data as missing at random; geometric least squares (LS) means, ratio of geometric LS means, and standard errors (SE), were transformed back into the original scale from model estimates. All atacicept group includes participants originally randomized to any atacicept group in the double-blind period; ITT analysis.

OLE Adverse Events Profile Consistent with Randomized Period

Double-Blind Data Through Week 36; OLE Data Through 12/2023[1]

	Double-blind BL to Week 36				Week 36 to 72	BL to Week 72
Participants, n (%)	Placebo n=34	Atacicept 25 mg n=16	Atacicept 75 mg n=33	Atacicept 150 mg n=33	Total OLE Atacicept 150 mg n=111	Atacicept 150 mg n=33
TEAEs	28 (82)	11 (69)	24 (73)	25 (76)	77 (69)	26 (79)
Infections and infestations	11 (32)	6 (38)	16 (48)	13 (39)	33 (30)	15 (45)
Study drug-related TEAEs[2]	14 (41)	6 (38)	17 (52)	19 (58)	51 (46)	22 (67)
Serious TEAEs	3 (9)	0	1 (3)	1 (3)	8 (7)	2 (6)
TEAEs leading to study drug discontinuation	1 (3)[3]	0	0	1 (3)[4]	1 (1)[5]	1 (3)[4]
Deaths	0	0	0	0	0	0

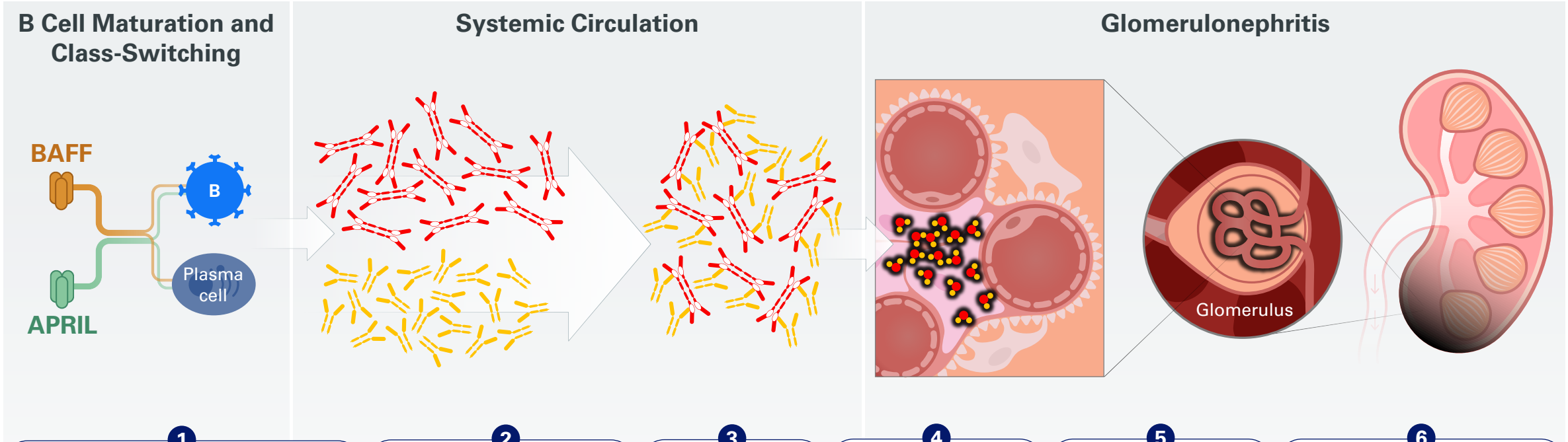
- Total patient exposure:
  - OLE through 12/05/23: mean 48.8 weeks, median 47.7 weeks (range 10.7 – 62.7)
  - Double-blind BL to 12/05/23: mean 82.0 weeks, median 83.4 weeks (range 3.0 – 99.0)

Vera data on file.
1. Week 72 cut-off includes all safety data as of 12/05/23, including visits past Week 72. AEs considered treatment-emergent during OLE period if they start after first dose of open-label atacicept 150 mg through end of study.
2. Majority of study drug-related TEAEs were injection site reactions and one contributed to drug discontinuation during double-blind period.
3. Discontinued due to worsening flank pain that was not resolved; unrelated to study treatment.
4. Discontinued due to injection site reaction and positive hepatitis B DNA that resolved without treatment 3 weeks later, normal liver function throughout.
5. Discontinuation due to pneumonia in a heavy smoker, resolved.

Summary of ORIGIN 2b Week 72 Results

- Participants treated with atacicept for 72 weeks demonstrated:
  - Consistent and sustained reductions in Gd-IgA1, hematuria and UPCR
  - Consistent and stable eGFR
  - **In aggregate, these data provide evidence of long-term, comprehensive IgAN disease modification**
- Participants switched from placebo to atacicept demonstrated similar results (Gd-IgA1, hematuria, UPCR, eGFR) to those originally randomized to atacicept during the first 36 weeks of ORIGIN 2b
- The cumulative safety profile is consistent with that observed during the randomized 36 weeks of ORIGIN 2b
- Week 72 data provide additional confidence in the ongoing ORIGIN 3 study

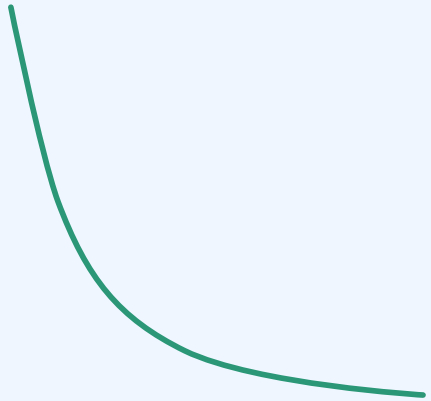
IgAN is a Disease of B Cell Origin With Kidney Pathology



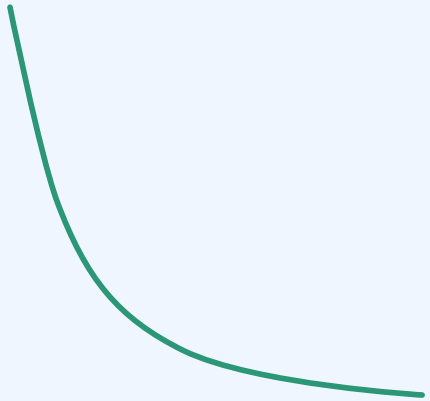
1. BAFF and APRIL are upregulated, causing B cells to increase production of Gd-IgA1…
2. …autoantibodies bind to exposed Gd-IgA1 hinge region…
3. …and form immune complexes…
4. …which deposit in the mesangium…
5. …resulting in glomerular inflammation (nephritis)…
6. …and progressive kidney injury with hematuria, proteinuria, and eGFR decline

An Ideal IgAN Disease Modifying Therapy Would be Expected To…

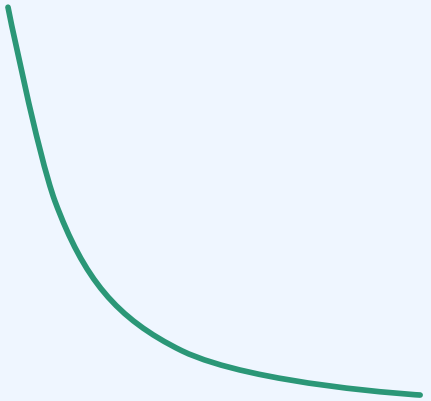
Reduce Gd-IgA1



Reduce hematuria



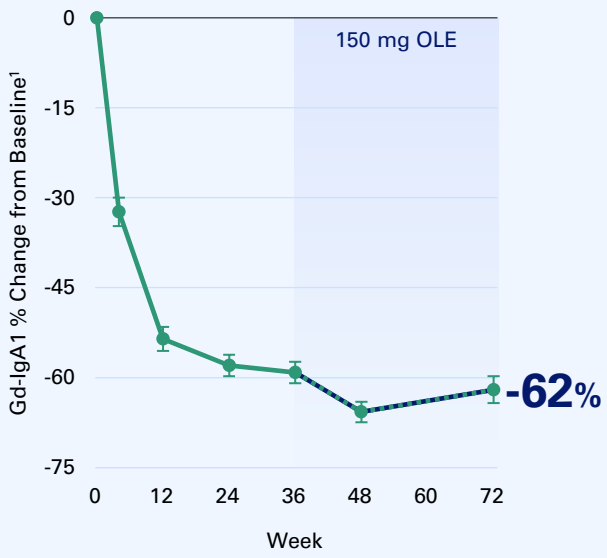
Reduce proteinuria



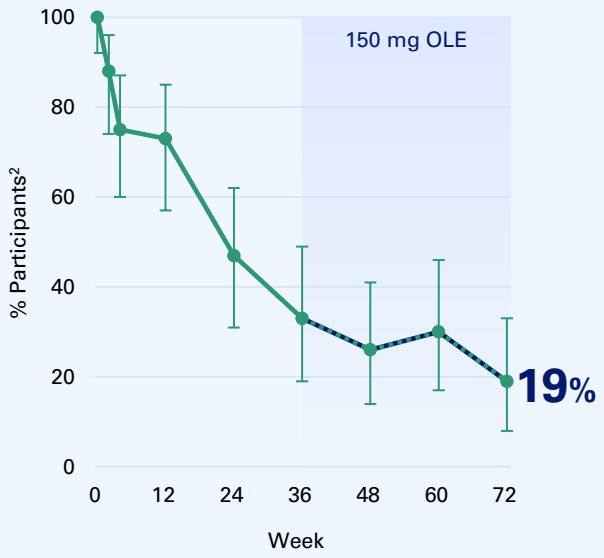
Stabilize eGFR

… And the Atacicept ORIGIN Phase 2b 72 Week Results Are Consistent With a Disease Modifying IgAN Profile

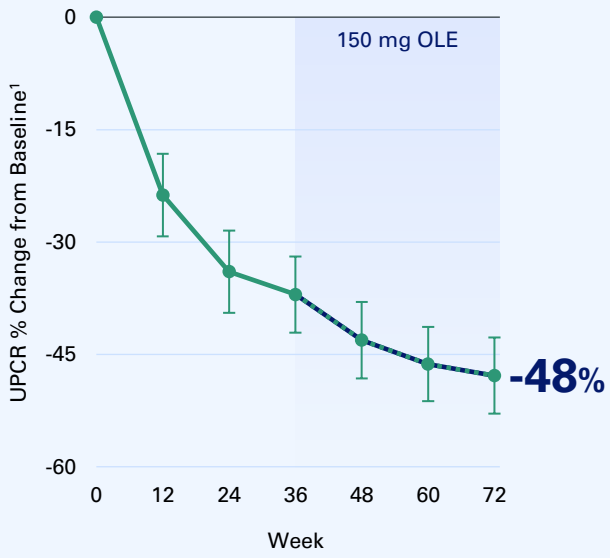
Reduction in Gd-IgA1



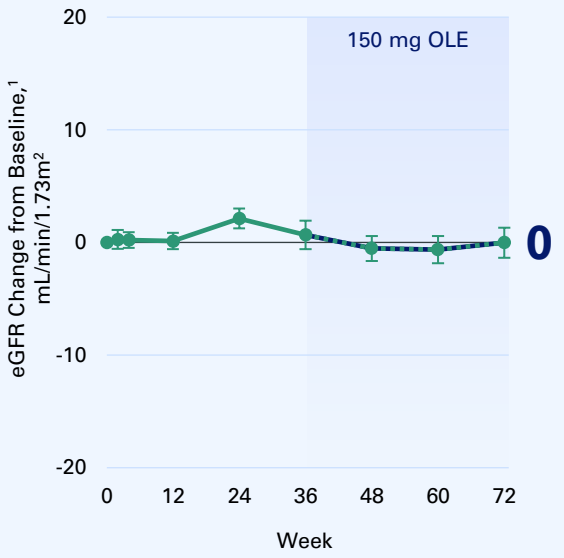
Reduction in participants with hematuria



Reduction in proteinuria

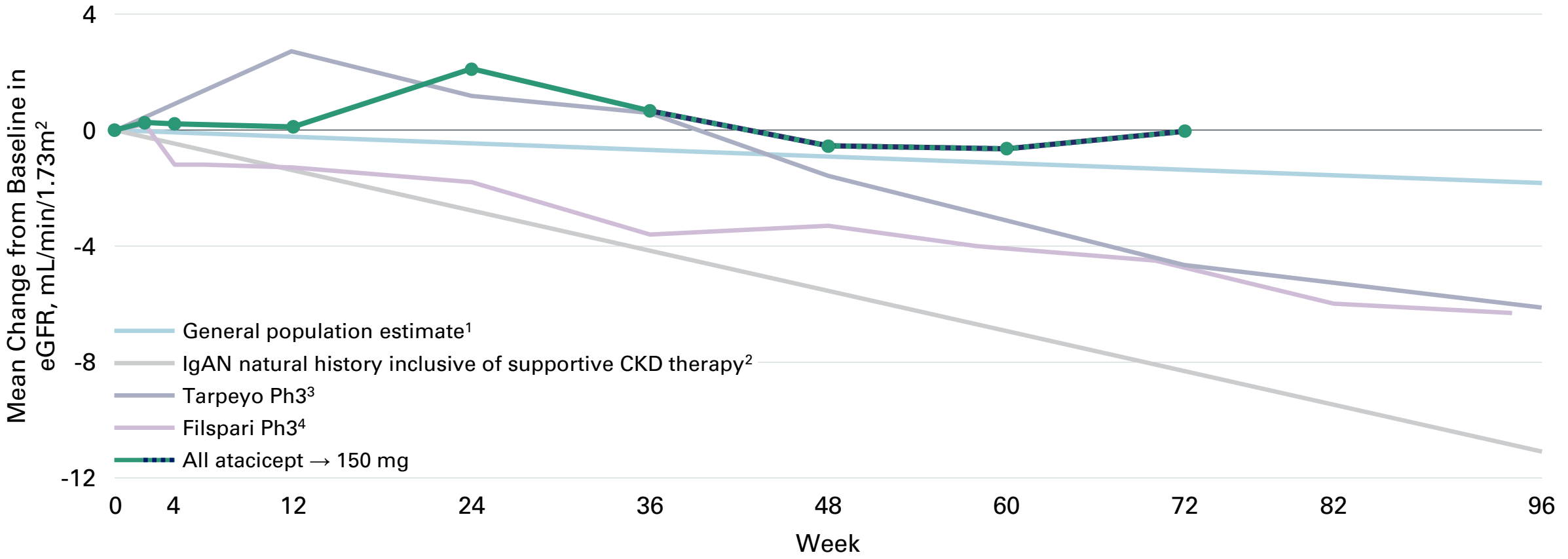


Stabilization of eGFR



Vera data on file. 1. Mean ± SE; 2. Percentages represent number of participants with hematuria at each divided by number with baseline hematuria.
Data from participants originally randomized to any atacicept group in the double-blind period in the ITT analysis for Gd-IgA1, hematuria, and eGFR, and in week 36 PP analysis for UPCR.

Atacicept Treated Participants Have an eGFR Profile Akin to the *General Population;* Dissimilar to Historical IgAN



This data is based on a cross-trial comparison and not a head-to-head clinical trial; such data may not be directly comparable due to differences in study protocols, conditions and patient populations.
Projected eGFR trajectories for general population and IgAN natural history do not represent clinical data and assume a constant eGFR slope over time. Figure cut at week 96 for consistency with Tarpeyo data.

1. Slope estimate from Baba M, et al. PLOS ONE 2015; 2. Average historical placebo slope from 7 clinical trials[3-11]; 3. Lafayette R, et al. Lancet 2023; 4. Rovin BH, et al. Lancet 2023; 5. Li PK-T, et al. Am J Kidney Dis 2006; 6. Manno C, et al. Nephrol Dial Transplant 2009; 7. Lv J, et al. JAMA 2017; 8. Wheeler DC, et al. Kidney Int 2021; 9. Lv J, et al. JAMA 2022; 10. Zhang H, et al. ASN Kidney Week 2023, poster TH-PO1123; 11. Mathur M, et al. N Engl J Med 2023.

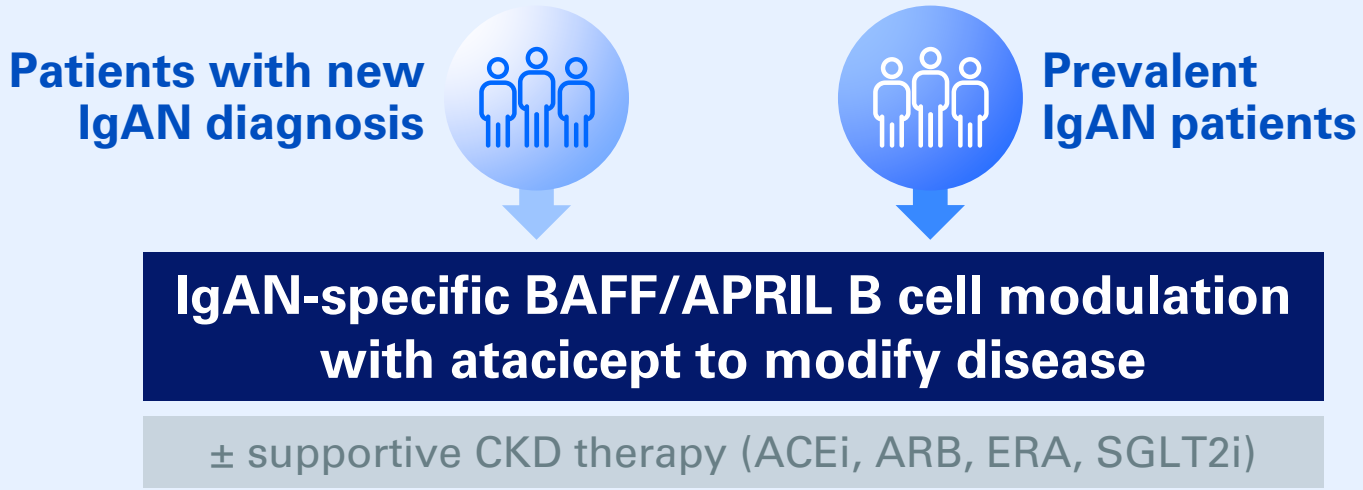
Cumulative Atacicept Data Offers Promise For Best-In-Class Potential…

…And Further Supports ORIGIN Phase 3 Design

	Atacicept	Sibeprenlimab[1]	Zigakibart[2]	Telitacicept[3]	Povetacicept[4]
Mechanism	BAFF/APRIL inhibition	APRIL inhibition only	APRIL inhibition only	BAFF/APRIL inhibition	BAFF/APRIL inhibition
Dosing & Administration	25/75/150 mg SC QW (Ph2) 150 mg SC QW (Ph3) 1 x 1 mL self-administered	2/4/8 mg/kg IV (Ph2) 400 mg SC QM (Ph3) 1 x 2 mL in-clinic injection	450 mg IV Q2W (Ph2) 600 mg SC Q2W (Ph3) 2 x 2 mL in-clinic injection	160/240 mg SC QW (Ph2) 3 x 1 mL injection	80/240 mg SC QM (Ph1b) 1 x TBD mL injection
Development Stage	Ph3	Ph3	Ph3	Ph2 discontinued in US no global development planned	Ph1b
Randomized Controlled Trial Data	✓	✓	✗	✓	✗
N (total pre-Phase 3)	132	155	40	44	20
Gd-IgA1 Reduction	62% at W72	~60% at W52	~70% at W40	50% at W24	~60% at W12
Hematuria	80% resolution at W36	Not reported	Not reported	Not reported	Not reported
UPCR Reduction vs Placebo	Δ 43% (p=0.003) at W36	Δ 43% at W36	No placebo controlled data	No UPCR data (different measure used)	No placebo controlled data
eGFR Duration Data	18 months 24 month pending	12 months	Not reported	6 months	6 months
Projected Commercial Launch	2026	2026	2027	Unknown	Unknown

This data is based on a cross-trial comparison and not a head-to-head clinical trial; such data may not be directly comparable due to differences in study protocols, conditions and patient populations.
Atacicept 150 mg data shown for W36, all-atacicept switch to 150 mg data shown for W72. 1. Mathur M, et al. NEJM 2023, Ph2 4 mg/kg IV Gd-IgA1 data, and Kooienga ASN 2022, TH-PO991, Ph2 pooled sibeprenlimab UPCR data; 2. Barratt J, et al. ERA-EDTA 2023, Ph2 combined cohort data; 3. Lv J, et al. Kidney Int Rep 2023 and Zan J, et al. Kidney Int Rep 2023, Ph2 240 mg data; 4. Tumlin J, et al. ASN 2023, TH-PO1125, Ph1b 80 mg data.

Potential Framework for a Future Treatment Paradigm in IgAN



- In prevalent IgAN patients, initiate disease modifying therapy with dual BAFF/APRIL B cell modulation using atacicept
- In incident IgAN patients with a fresh biopsy, initiate first line disease modifying therapy with dual BAFF/APRIL B cell modulation using atacicept
- Add/continue nonspecific supportive CKD therapy (ACEi, ARB, ERA and SGLT2i) for additional benefit
- With disease modifying therapy, the rationale for steroids and complement inhibitors may not exist

ARB = ERA = endothelin receptor antagonist.

Congruency with ORIGIN 2b Instills Greater Confidence in ORIGIN 3; Enrollment On Track

origin3

Initiated in 2023

Inclusion Criteria

- Patients ≥18 years old with IgAN on kidney biopsy and high risk of disease progression
- Stable and optimized RASi for ≥12 weeks
- Use of SGLT2i allowed
- UPCR-24h ≥1.0 g/g or UP ≥1.0 g per 24h
- eGFR ≥30 mL/min/1.73 m^2
- Blood pressure ≤150/90 mmHg

Endpoints

- Primary efficacy: UPCR-24h at week 36 ★ to support potential accelerated approval
  - >90% power at week 36
- Key secondary: eGFR change up to week 104 ☆
  - 90% power for eGFR Δ 4 mL/min at week 104
- Safety

- Operational efficiency leveraging similar study design and worldwide sites as ORIGIN 2b
- Same self-administered SC formulation and dose as used in ORIGIN 2b

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2024 Poised To Be An Impactful Year Of Community Engagement

Q1 Q2 Q3 Q4

Q1

ISN WCN'24 Hosted by SAN SLANH

- Encore posters
- Industry sponsored symposium
- Community engagement

Q2

NATIONAL KIDNEY FOUNDATION®
SCM24
SPRING CLINICAL MEETINGS

- Community engagement

Q3

61ST ERA CONGRESS
STOCKHOLM & VIRTUAL
MAY 23-26, 2024

- Data submission
- Industry sponsored symposium
- Community engagement
- Medical Affairs booth presence

Q4

AMERICAN SOCIETY OF NEPHROLOGY · ASN ·
KIDNEY WEEK

- Data submission
- Community engagement
- Sponsorship of GN CME course
- Medical Affairs booth presence

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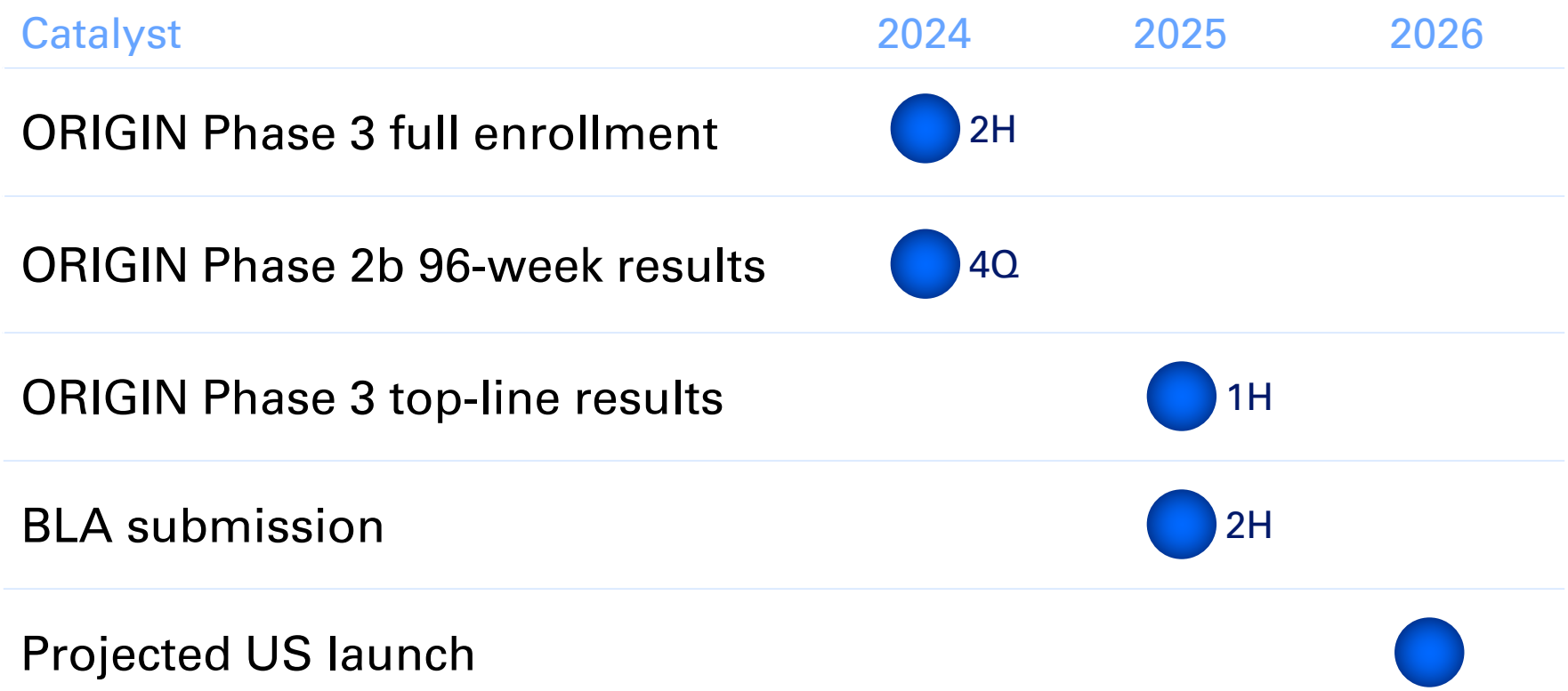
Atacicept: Expected Value Creation Catalysts Over Next 18 Months



Vera holds worldwide, exclusive rights to develop and commercialize atacicept

Based on management's current assumptions.

vera therapeutics™