Eledon Pharmaceuticals

Phase 2 BESTOW Clinical Trial Results

November 7, 2025

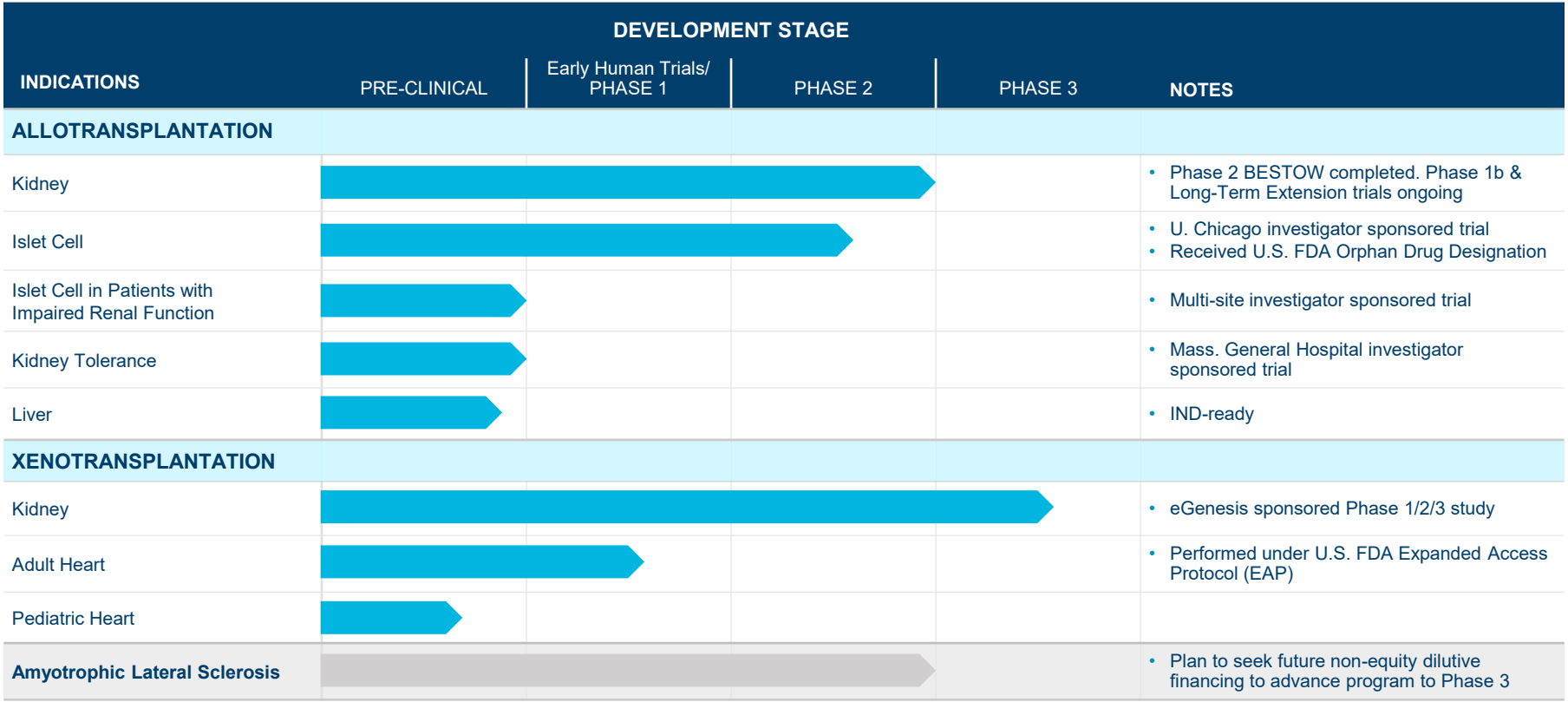
Forward-Looking Statements

This presentation contains forward-looking statements that involves substantial risks and uncertainties. Any statements about the company's future expectations, plans and prospects, including statements about its strategy, future operations, development of its product candidates, and other statements containing the words "believes," "anticipates," "plans," "expects," "estimates," "intends," "predicts," "projects," "targets," "could," "may," and similar expressions, constitute forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995, although not all forward-looking statements include such identifying words. Forward-looking statements include, but are not limited to statements regarding: expectations regarding the timing for the commencement and completion of product development or clinical trials; the rate and degree of market acceptance and clinical utility of the company's products; the company's commercialization, marketing and manufacturing capabilities and strategy; the company's intellectual property position and strategy; the company's ability to identify additional products or product candidates with significant commercial potential; the company's estimates regarding expenses, future revenue, capital requirements and needs for additional financing; developments relating to the company's competitors and industry; and the impact of government laws and regulations.

Actual results may differ materially from those indicated by such forward-looking statements as a result of various important factors, including: the ability to develop commercially viable product formulations; the sufficiency of the company's cash resources; the ability to obtain necessary regulatory and ethics approvals to commence additional clinical trials; whether data from early clinical trials will be indicative of the data that will be obtained from future clinical trials; whether the results of clinical trials will warrant submission for regulatory approval of any investigational product; whether any such submission will receive approval from the United States Food and Drug Administration or equivalent foreign regulatory agencies and, if we are able to obtain such approval for an investigational product, whether it will be successfully distributed and marketed. These risks and uncertainties, as well as other risks and uncertainties that could cause the company's actual results to differ significantly from the forward-looking statements contained herein, are discussed in our annual report on Form 10-K for the year ended December 31, 2024, and other filings with the SEC which can be found at www.sec.gov. Any forward-looking statements contained in this presentation speak only as of the date hereof and not of any future date, and the company expressly disclaims any intent to update any forward-looking statements, whether as a result of new information, future events or otherwise.

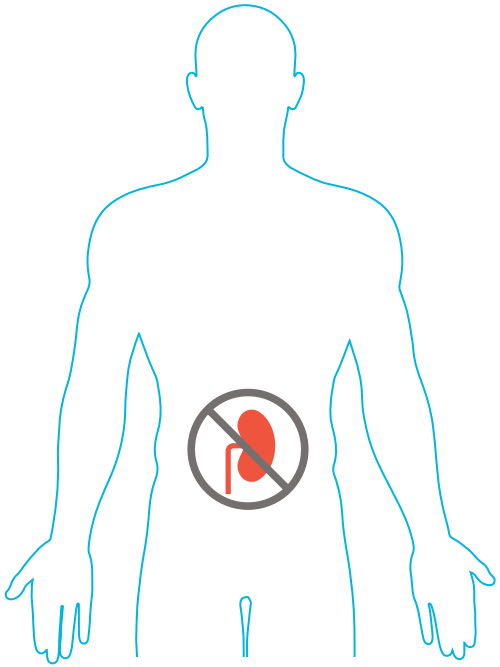
Photo: Gertrude "Trudy" Elion, inventor of azathioprine and recipient of Nobel Prize in Medicine in 1988.

Tegoprubart is a Pipeline in a Product Opportunity



Note: As of November 7, 2025. Development plans and timelines may change, including based on U.S. and global regulatory interactions.

Life-long Maintenance Immunosuppression is Necessary to Protect Transplanted Organs



Without immunosuppression, the **host** sees **donor** kidney as “foreign” and attacks (i.e., rejects) it

Induction immunosuppression (e.g. ATG) **is given at the time of transplant** to rapidly suppress the graft recipient’s immune system

Chronic, maintenance immunosuppression must then be taken for life or the organ will be rejected even years after the transplant

Source: U.S. NIH *Research Matters*, 2012.

Unmet Need in Kidney Transplantation

Tacrolimus, a calcineurin inhibitor (CNI), is the most common core of immunosuppression used in kidney transplant recipients, and the current standard of care

Tacrolimus presents several challenges:

1. **Limited long-term graft survival**: although tacrolimus significantly reduces the rate of acute rejection, long-term graft survival has not improved over time[1,2]
2. **Toxicity:** nephrotoxicity, neurotoxicity, hypertension, and increased risk of new-onset diabetes are all side effects associated with tacrolimus[3]
3. **Complexity and adherence:** the narrow therapeutic index of CNIs leads to a high pill burden with constant monitoring and dose adjustments, impacting adherence and complicating disease management[3]

Novel immunosuppressive strategies are needed to reduce toxicity, to maintain efficacy, and to improve long-term graft survival

CNI, calcineurin inhibitor.

1. Poggio E et al. Am J Transplantation 2021;21:2824–32. 2. Fitzsimmons WE, Naesens M. Transplantation 2024;108:593–7.
3. Leas BF et al. Comparative Effectiveness Reviews, No. 166. Rockville, MD: Agency for Healthcare Research and Quality, 2016

BESTOW Overview

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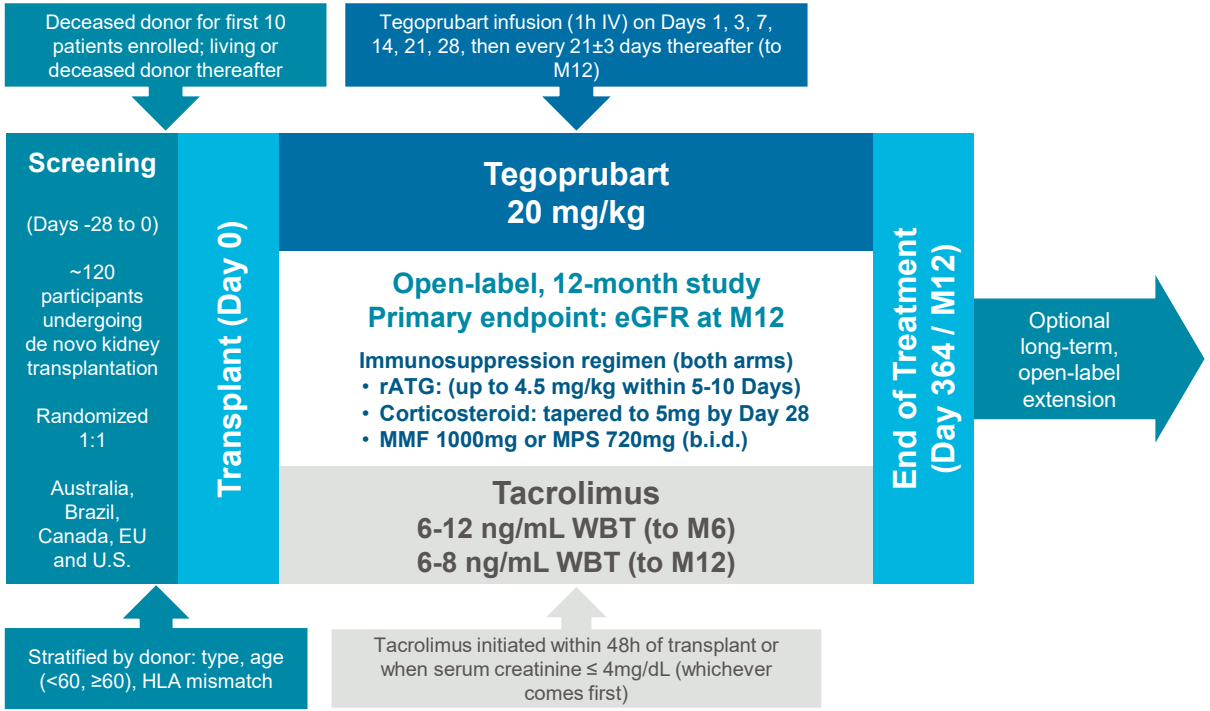
BESTOW Trial Overview

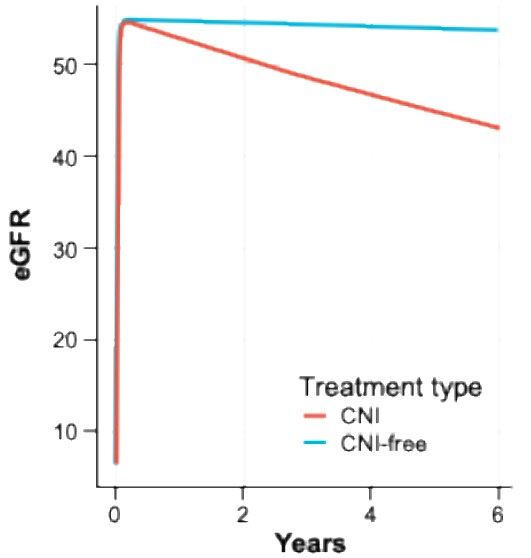
- **BESTOW** is the **first-ever** clinical trial comparing head-to-head tacrolimus to CD40L antibody (tegoprubart) in de novo kidney transplantation recipients
- A **prospective**, multicenter, **active-controlled, randomized, open-label** Phase 2 trial
- **Aim:** to determine the efficacy and safety of tegoprubart as the **core immunosuppressant regimen** in de novo kidney transplant recipients



b.i.d., twice daily; eGFR, estimated glomerular filtration rate (CKD-EPI creatinine criterion); HLA, human leukocyte antigen; i.v., intravenous; M, month; MMF, mycophenolate mofetil; MPS, mycophenolate sodium; rATG, rabbit anti-thymocyte globulin; WBT, whole blood trough concentration

BESTOW Key Efficacy Endpoints

Primary Endpoint of eGFR as a Proxy of Potential Long-Term Graft Function



Historical Mean eGFR of ~53 mL/min/1.73m2 After 12 Months Using CNIs

Secondary Endpoints Include Historical Approvable Endpoint of Non-Inferiority

- **Since the 1990's the primary US FDA approvable endpoint has been non-inferiority based on a composite of efficacy failure using:**
  - Biopsy Proven Acute Rejection
  - Graft Loss
  - Death
  - Loss to follow-up
- All transplant immunosuppressants are approved for "prophylaxis of organ rejection"
- Acute rejection is generally treatable and not predictive of long-term graft survival

Note: **n = 4,868 patients**. eGFR estimated using MDRD 4-variable GFR Equation. US FDA, United States Food & Drug Administration..
Source: Kosinski et al. *Clin Transl Sci*. 2023 Nov; 00:1–11.

BESTOW Conclusions

1. Observed composite endpoint (death, graft loss, BPAR, LTFU) failure rate in BESTOW was within the range reported in previous late-phase trials of approved immunosuppressive agents and demonstrated non-inferiority for tegoprubart vs. tacrolimus, using a 20% non-inferiority margin

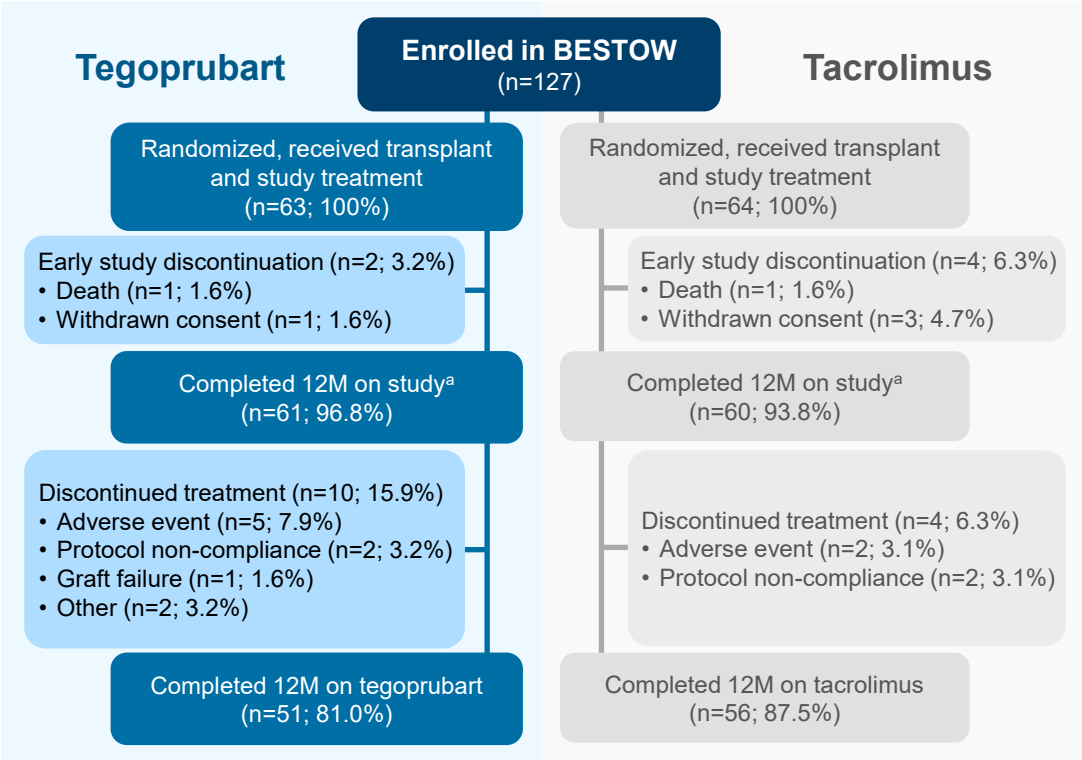
2. Tegoprubart demonstrated excellent graft function. Kidney graft function, as assessed by eGFR, stabilized after the first month and remained higher on tegoprubart across all timepoints, in the range of ~69 mL/min/1.73 m^2 through month 12, vs. ~66 mL/min/1.73 m^2 on tacrolimus

3. Tegoprubart demonstrated a favorable safety profile with significant reductions observed in prominent side effects associated with tacrolimus including new onset diabetes, tremor, hypertension, and delayed graft function

4. Results support advancement into Phase 3 and position tegoprubart as the potential next-generation cornerstone of kidney transplant immunosuppression

Note: BPAR, Biopsy Proven Acute Rejection. LTFU, Loss to Follow Up..

Participant Flow



[a]study completion includes discontinuation of randomized treatment and completing follow up period.
CMV, cytomegalovirus; HLA, human leukocyte antigen; KDPI, kidney donor profile index; M, months; SD, standard deviation.

Donor Characteristics

Mean (SD), unless stated otherwise	TEGO N=63	TAC N=64
Donor age, years	43.5 (15.3)	43.0 (14.64)
Donor type		
Living, n (%)	18 (28.6)	17 (26.6)
Deceased, n (%)	45 (71.4)	47 (73.4)
KDPI score	44.0 (24.3)	35.2 (25.5)
KDPI <35, n (%)	17 (37.8)	27 (57.4)
KDPI ≥35, n (%)	27 (60.0)	20 (42.6)
Cold ischemia time, (h)	13.4 (8.5)	12.6 (8.1)
HLA mismatches, n (%)		
≤3	29 (46.0)	20 (31.3)
>3	34 (54.0)	44 (68.8)
CMV risk, n (%)		
High	16 (25.4)	13 (20.3)
Intermediate	33 (52.4)	43 (67.2)
Low	13 (20.6)	8 (12.5)

Recipient Characteristics

Mean (SD), unless stated otherwise	TEGO N=63	TAC N=64
Recipient age, years	50.1 (14.0)	48.3 (12.8)
Recipient sex, n (%)		
Male	42 (66.7)	44 (68.8)
Female	21 (33.3)	20 (31.3)
ESRD, n (%)[a]		
Diabetes	16 (25.4)	20 (31.3)
Hypertension	41 (65.1)	32 (50.0)
Glomerulonephritis	24 (38.1)	13 (20.3)
Dialysis		
Yes at screening, n (%)	46 (73.0)	54 (84.4)
Duration in months	36.8 (33.4)	45.0 (41.5)
cPRA score, n (%)		
0%	44 (69.8)	43 (67.2)
>0%, ≤20%	7 (11.1)	8 (12.5)
>20%, ≤80%	11 (17.5)	11 (17.2)
>80%	1 (1.6)	1 (1.6)

Additional Immunosuppression

Mean (SD), unless stated otherwise	TEGO N=63	TAC N=64
Days on treatment	324.8 (98.5)	331.8 (91.1)
Total mg/kg rATG at induction, median (min, max)	4.3 (2.9, 8.7)	4.2 (2.0, 6.0)
Percentage of days on-treatment with full dose MPA	59.4 (35.3)	54.3 (37.22)
Days to first MPA reduction below full dose	92.2 (72.49)	91.9 (86.9)
Corticosteroids		
Total induction bolus, mg	758.3 (313.8)	848.9 (320.1)
Days to stable 5mg dose	23.1 (13.5)	31.5 (41.6)
Corticosteroid discontinuation, n (%)	3 (4.8)	5 (7.8)

[a]participants can be counted in more than one category.
cPRA, calculated panel reactive antibody; CMV, cytomegalovirus; ESRD, end stage renal disease; h, hours; HLA, human leukocyte antigen; KDPI, kidney donor profile index; MPA, mycophenolic acid; rATG, rabbit anti-thymocyte globulin; SD, standard deviation.

BESTOW Efficacy

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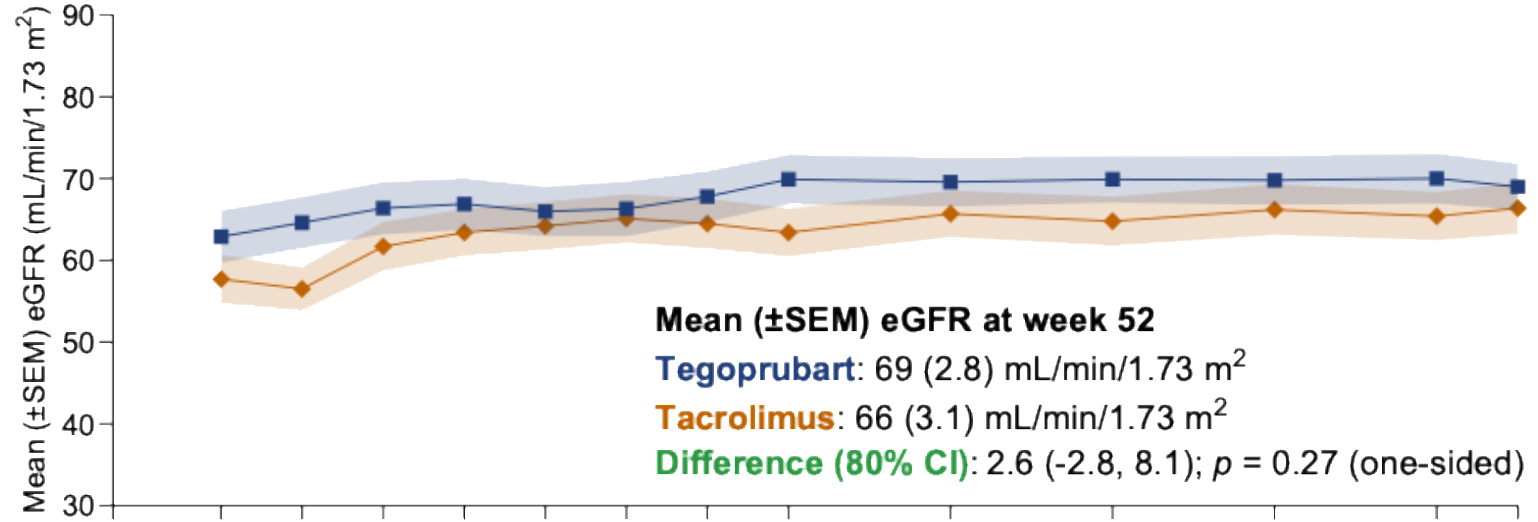
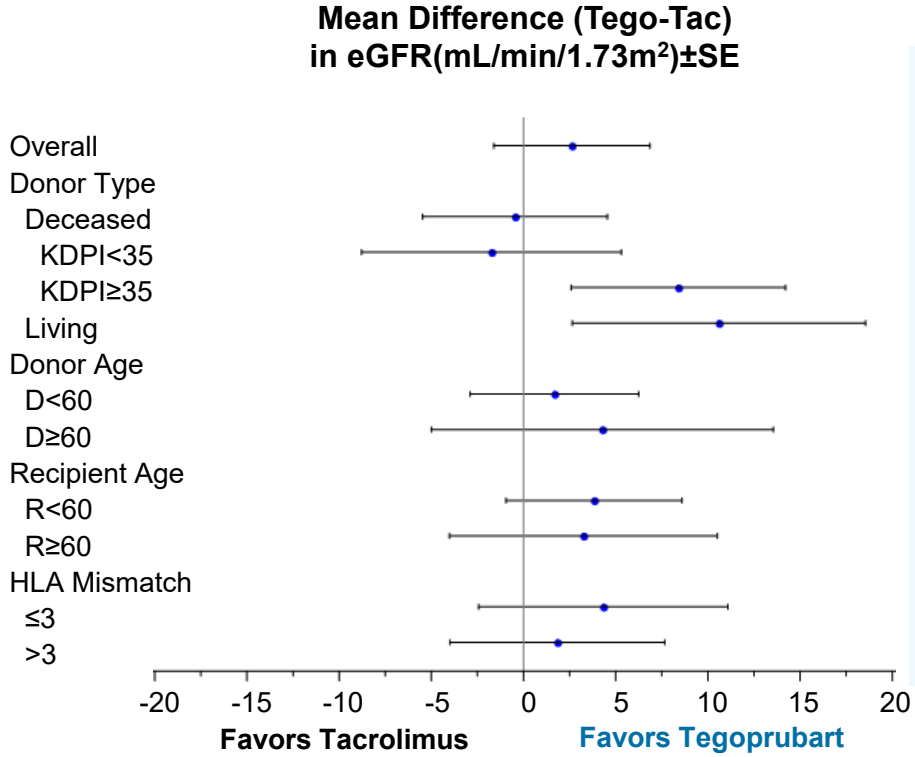
Mean eGFR Over 52 Weeks in Patients Who Completed Treatment



Tego (n)	51	51	51	51	51	51	51	51	51	51	51	51	51
Tac (n)	56	55	55	56	54	56	56	56	54	54	54	56	56

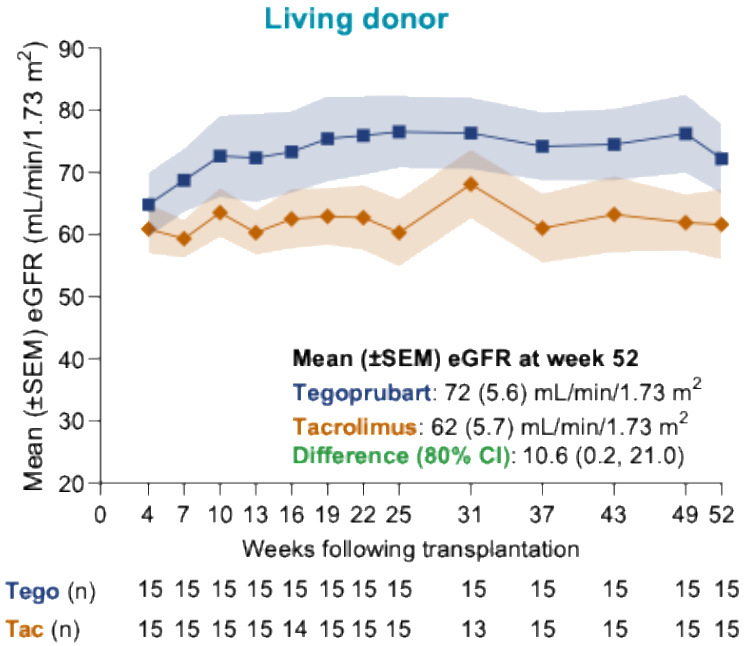
Note: Patients who completed treatment were those patients who completed 52 weeks of the study and received all planned doses of the randomized study drug. CI, confidence interval; eGFR, estimated glomerular filtration rate; SEM, standard error of the mean.

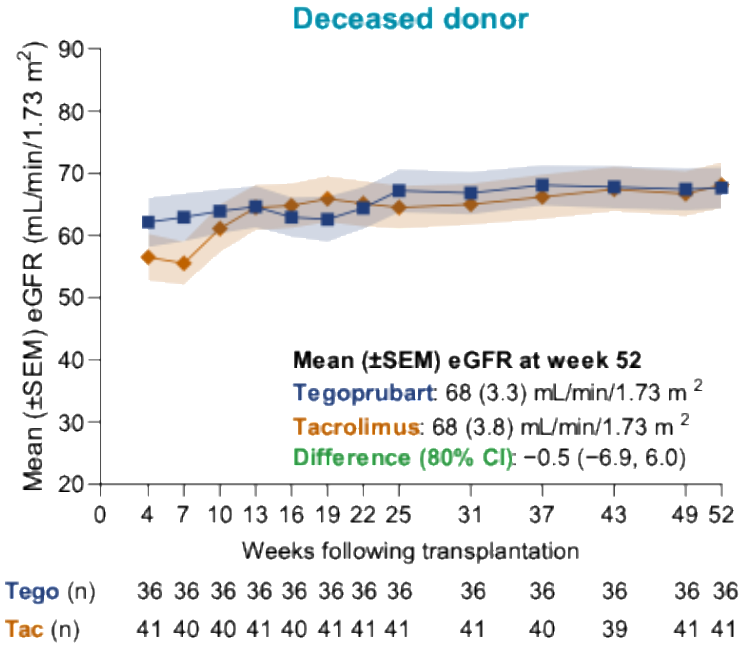
Subgroup Analysis of eGFR at 12 Month in Patients Who Completed Treatment



	Mean (SE)	
	Tegoprubart	Tacrolimus
Overall	69 (2.8)	66 (3.1)
Donor Type		
Deceased	68 (3.3)	68 (3.8)
KDPI<35	78 (5.8)	80 (4.0)
KDPI≥35	62 (2.9)	53 (5.0)
Living	72 (5.6)	62 (5.7)
Donor Age		
D<60	70 (3.1)	69 (3.4)
D≥60	58 (5.2)	54 (7.7)
Recipient Age		
R<60	73 (3.2)	69 (3.5)
R≥60	58 (4.8)	54 (5.4)
HLA Mismatch		
≤3	69 (3.5)	64 (5.8)
>3	69 (4.5)	67 (3.8)

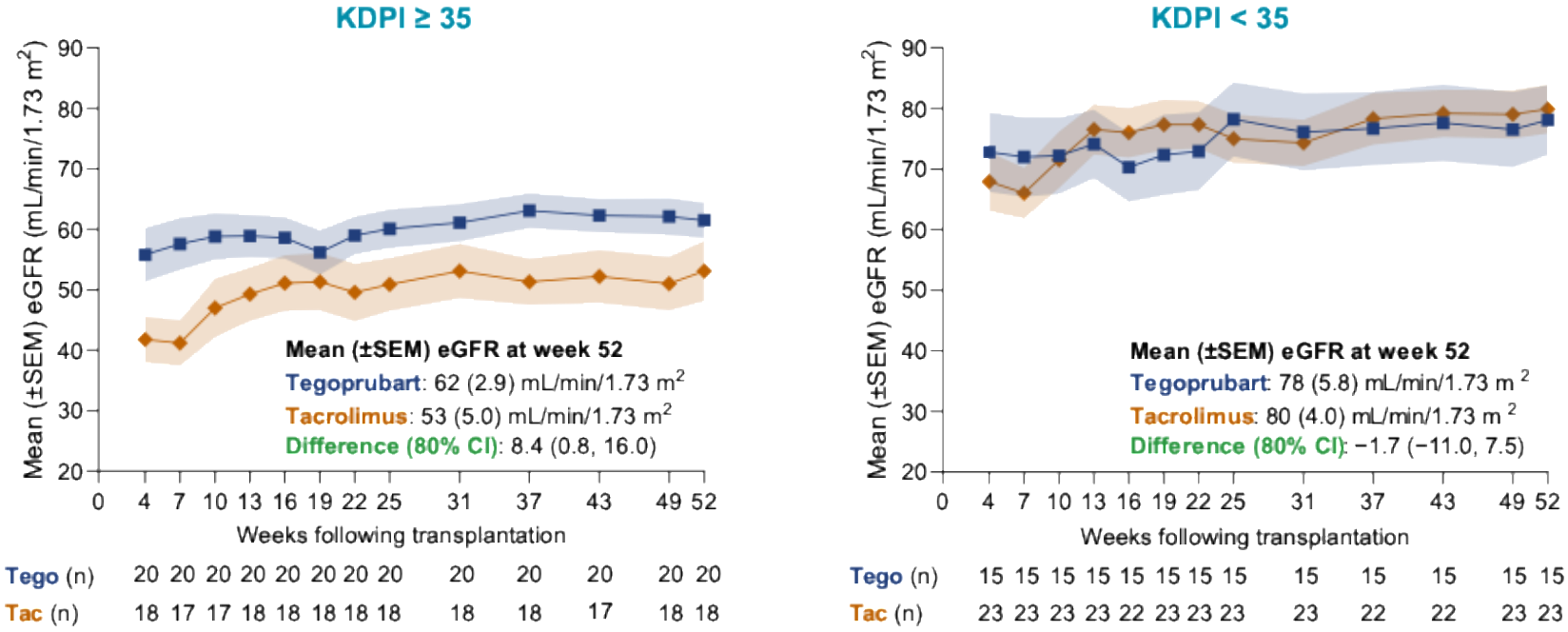
Mean eGFR by Donor Type in Patients Who Completed Treatment





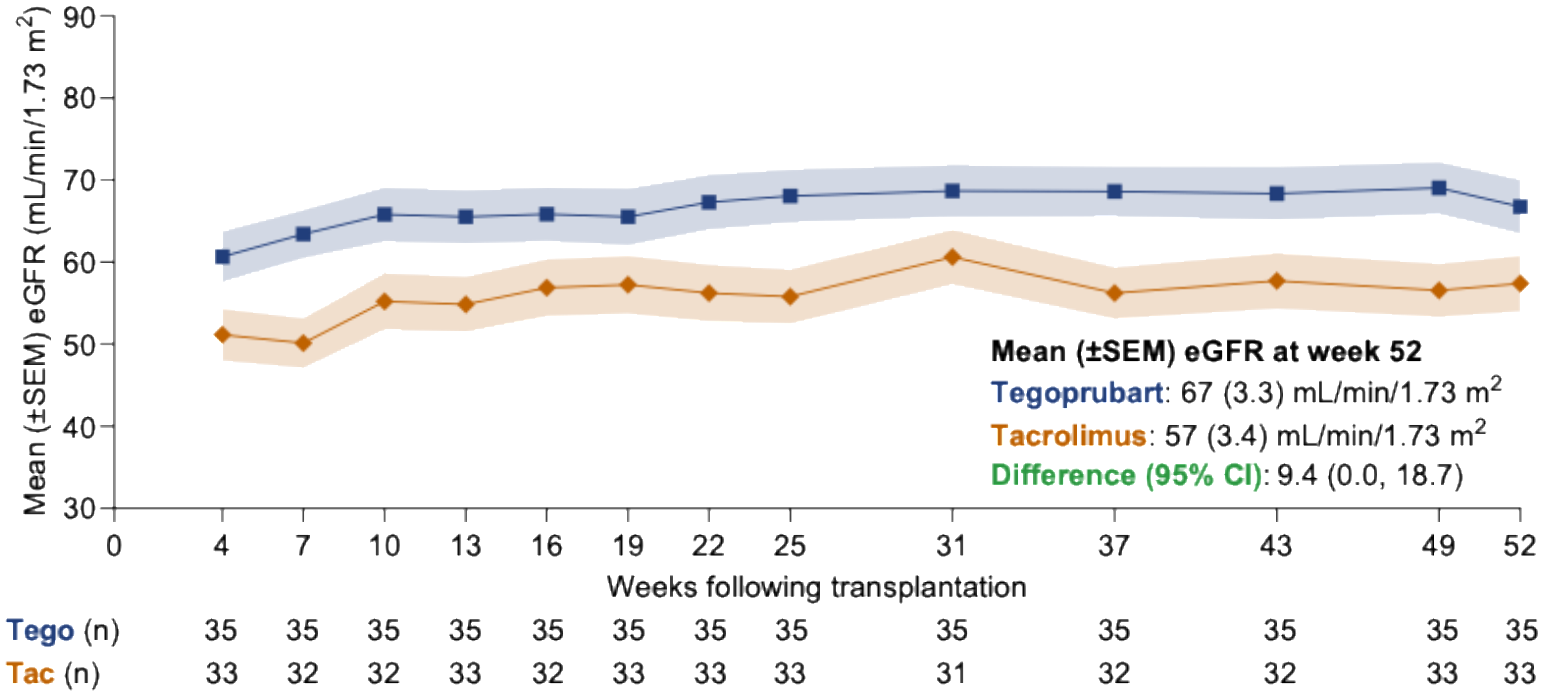
Note: Patients who completed treatment were those patients who completed 52 weeks of the study and received all planned doses of the randomized study drug. Rejection was determined by BPAR. BPAR, Biopsy Proven Acute Rejection; eGFR, estimated glomerular filtration rate; SEM, standard error of the mean.

Mean eGFR by KDPI Score in Deceased Donor Recipients Who Completed Treatment



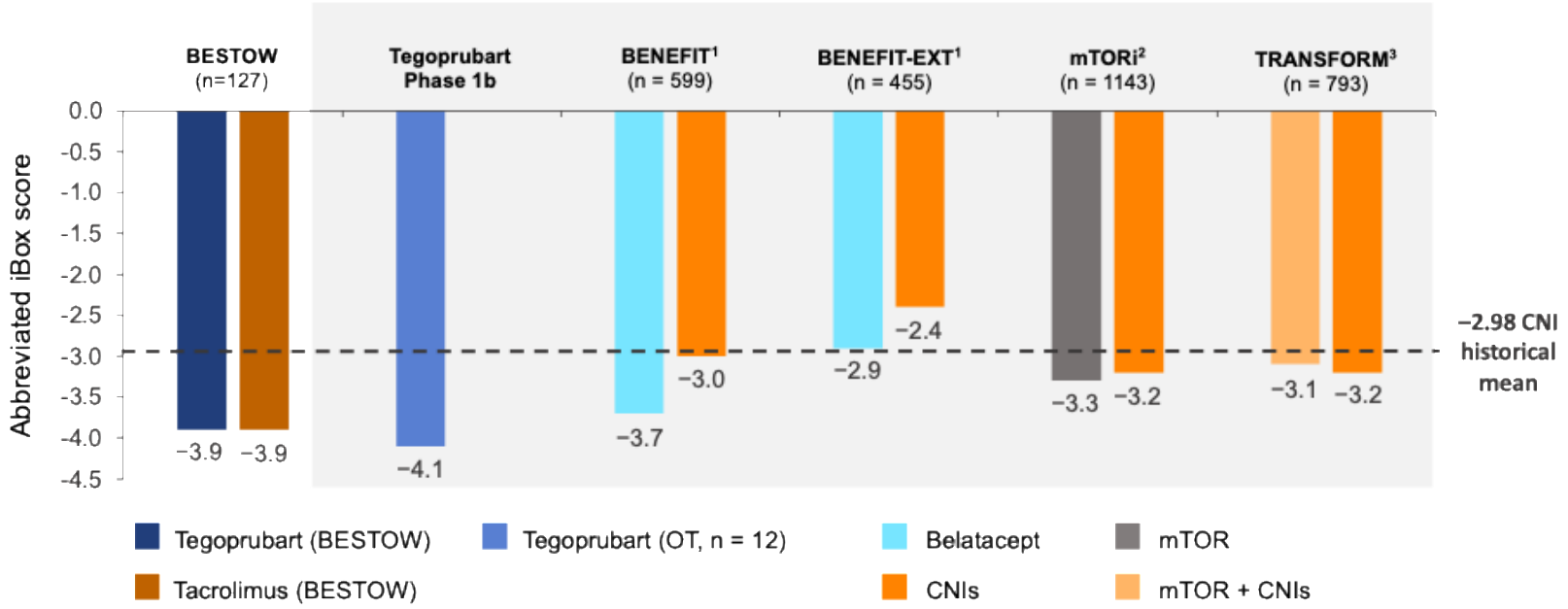
Note: Patients who completed treatment were those patients who completed 52 weeks of the study and received all planned doses of the randomized study drug. Rejection was determined by BPAR. BPAR, Biopsy Proven Acute Rejection; eGFR, estimated glomerular filtration rate; SEM, standard error of the mean.

Mean eGFR at 12-months for Subjects Who Received a Living Donor Kidney or a Deceased Donor Kidney With KDPI ≥ 35



Note: Patients who completed treatment were those patients who completed 52 weeks of the study and received all planned doses of the randomized study drug.

Comparative Abbreviated iBox Scores at 12 Months

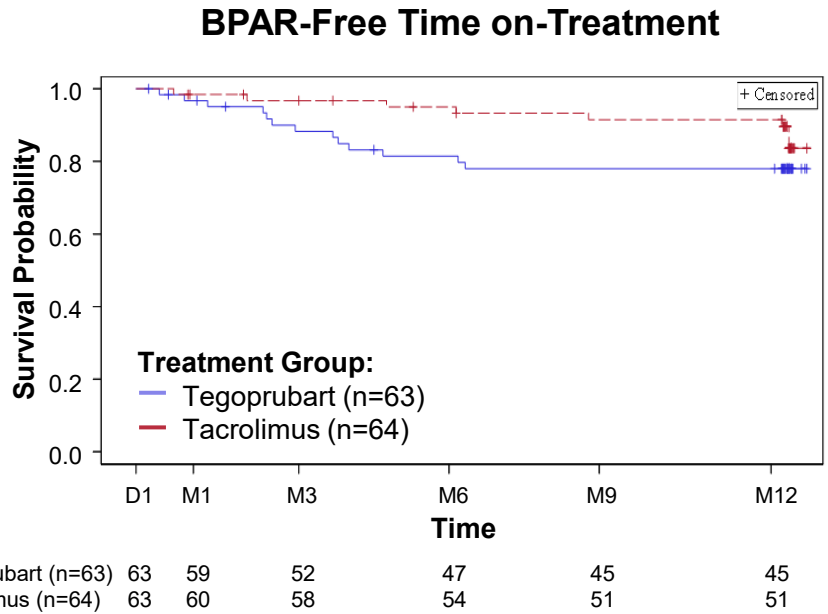


CNI, calcineurin inhibitor; ITT, intent to treat; mTOR, mammalian target of rapamycin; mTOR, mTORi, mammalian target of rapamycin inhibitor; OT, on treatment.

1. Klein A et al. Am J Transplant 2023;23:1496–506. 2. European Medicines Agency (EMA) Scientific Opinion-Qualification. Briefing Dossier. https://www.ema.europa.eu/en/documents/scientific-guideline/qualification-opinion-applicant-revised-briefing-book-ibox-scoring-system-composite-biomarker-panel_en.pdf (Accessed 24 Jul 2025) 3. Aubert O et al. BMJ Open 2021;11:e052138

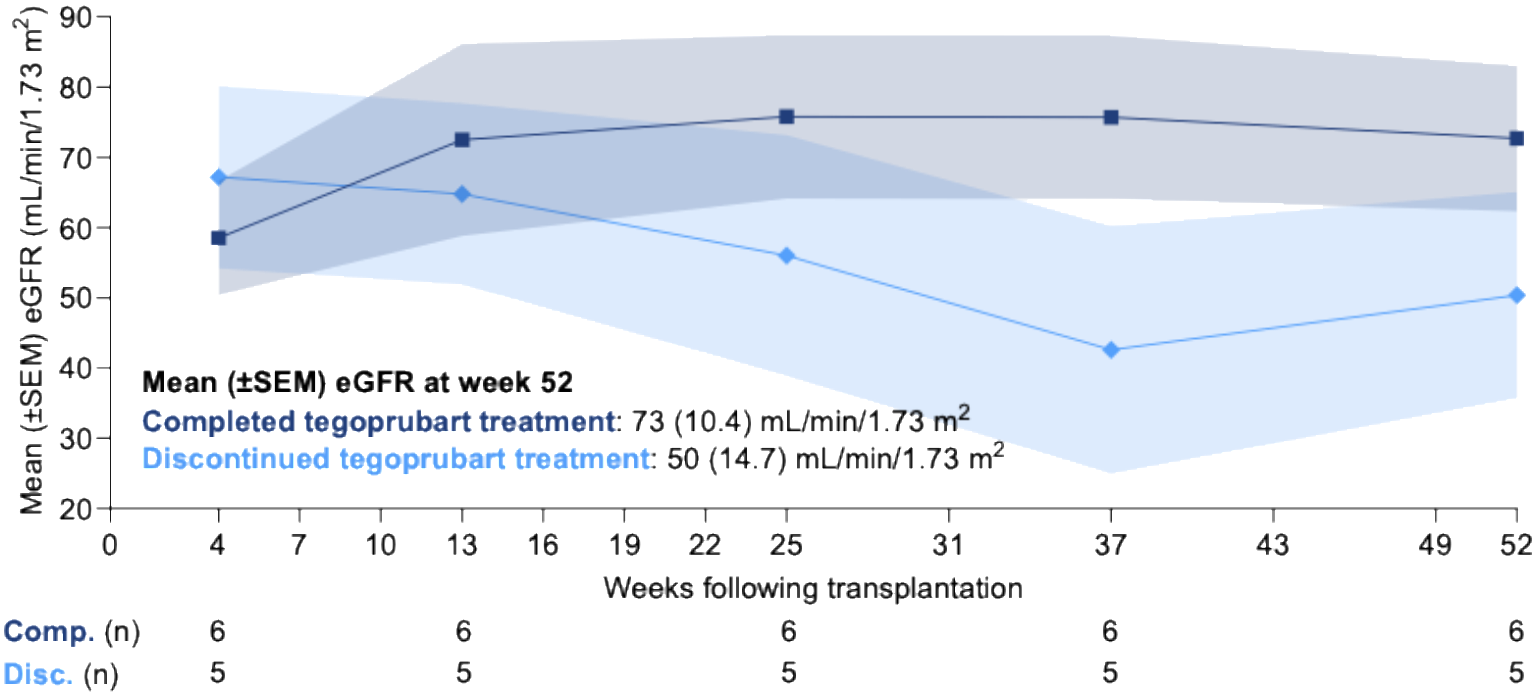
BPAR Based on ALL BIOPSIES Through 12 Months

Acute Parameters	Tegoprubart 20 mg/kg (N=63) n (%)	Tacrolimus (N=64) n (%)
Total biopsies	58 (92.1)	51 (79.7)
Acute Rejection	13 (20.6)	9 (14.1)
Acute AMR	2 (3.2)	1 (1.6)
Acute TCMR	13 (20.6)	8 (12.5)
Acute TCMR		
IA	2 (3.2)	5 (7.8)
IB	5 (7.9)	2 (3.1)
IIA	4 (6.3)	1 (1.6)
IIB	2 (3.2)	0
III	0	0



Note: All biopsies centrally reviewed by a blinded reference pathologist (Banff criteria). 'All cause' includes acute TCMR ≥ 1A and/or active AMR, and uses data from all biopsies.
[d]Participants with TCMR and AMR were only counted once in BPAR calculation. AMR, antibody mediated rejection; BPAR, biopsy proven acute rejection; CI, confidence interval; M, months; Tac, tacrolimus; TCMR, T cell-mediated rejection; Tego, tegoprubart.

Mean eGFR by Tegoprubart Treatment Completion in Patients Who Experienced Rejection



Note: Patients who completed treatment were those patients who completed 52 weeks of the study and received all planned doses of the randomized study drug. Rejection was determined by BPAR (biopsy proven acute rejection); Comp., completed tegoprubart treatment; Disc., discontinued tegoprubart treatment; eGFR, estimated glomerular filtration rate; SEM, standard error of the mean

Composite Efficacy Failure & Donor-Specific Antibodies

All biopsy, aAMR+aTCMR	Tegoprubart (N=63) n (%)	Tacrolimus (N=64) n (%)	Difference (Tegoprubart – Tacrolimus) % (95% CI)
BPAR	13 (20.6)	9 (14.1)	6.6 (-7.0, 20.3)
Graft loss	1 (1.6)	1 (1.6)	0
Death	1 (1.6)	1 (1.6)	0
LTFU	0	0	0
EF rate through 12 months	**14 (22.2)**	**11 (17.2)**	**5.0 (-9.5, 19.4)**

At end of treatment, 1 tegoprubart subject and 2 tacrolimus subjects were positive for Donor-Specific Antibodies

BPAR is defined as acute TCMR or acute AMR rejection while on randomized treatment as assessed by central pathologist.
BPAR, Graft Loss, Death and LTFU are not all mutually exclusive; participants are counted within each category that applies.
BPAR: biopsy proven acute rejection; EF: Efficacy failure; LTFU: Lost of follow-up. Composite efficacy failure defined as graft loss, BPAR, death and LTFU

BESTOW Safety

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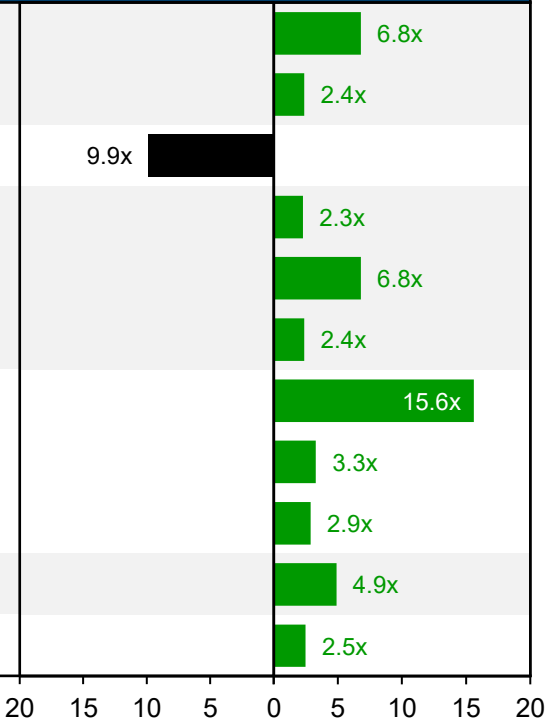
Overall Summary of Treatment-Emergent Adverse Events

	Tegoprubart (N=63) n (%)	Tacrolimus (N=64) n (%)	Risk Difference (95% CI)[1]
Any AE	61 (96.8)	64 (100)	-3.2 (-11.1, 2.9)
AE by Max Severity[2]			
G1: Mild	5 (7.9)	8 (12.5)	
G2: Moderate	20 (31.7)	23 (35.9)	
G3: Severe	31 (49.2)	28 (43.8)	
G4: Life-threatening	4 (6.3)	4 (6.3)	
G5: Death	1 (1.6)	1 (1.6)	
Related AEs	32 (50.8)	35 (54.7)	-3.9 (-21.4, 14.2)
Serious AEs (SAE)	33 (52.4)	36 (56.3)	-3.9 (21.3, 13.9)
Related SAEs	11 (17.5)	8 (12.5)	5.0 (-7.9, 18.3)
AE of Special Interest	47 (74.6)	49 (76.6)	-2.0 (-17.3. 13.4)
AE leading to study drug withdrawal	4 (6.3)	3 (4.7)	1.7 (-7.9, 11.4)

[1]Tegoprubart rate to Tacrolimus rate
[2]Participants are counted only once at their highest grade of AE, so risk difference is not presented.
On-treatment: first dose through last dose + 30 days (includes early discontinuations).

AEs ≥5% with ≥2 Times Risk Observed with a Therapy

		Tegoprubart (N=63) n (%)	Tacrolimus (N=64) n (%)	Relative Difference
Opportunistic Infections	Bacteremia	1 (1.6)	7 (10.9)	6.8x
	Sepsis	2 (3.2)	5 (7.8)	2.4x
Renal	Proteinuria	10 (15.9)	1 (1.6)	9.9x
Metabolic	Hyperglycemia	6 (9.5)	14 (21.9)	2.3x
	New Onset Diabetes (NODAT)	1 (1.6)	7 (10.9)	6.8x
	Hyperkalemia	7 (11.1)	17 (26.6)	2.4x
CNS	Tremors	1 (1.6)	16 (25.0)	15.6x
	Muscle Spasms	3 (4.8)	10 (15.6)	3.3x
	Pruritis	2 (3.2)	6 (9.4)	2.9x
Cardiovascular	Hypertensive Crisis	1 (1.6)	5 (7.8)	4.9x
Blood	Lymphopenia	4 (6.3)	10 (15.6)	2.5x



Note: Excludes select non-specific AEs (e.g., abdominal pain).

Opportunistic Infections

	Tegoprubart (N=63) n (%)	Tacrolimus (N=64) n (%)	Risk Difference (95% CI)[1]
Opportunistic Infections	**43 (68.3)**	**44 (68.8)**	**-0.5 (-17.2, 15.8)**
Viral Infections	**33 (52.4)**	**31 (48.4)**	**3.9 (-13.8, 21.6)**
CMV	25 (39.7)	23 (35.9)	3.7 (-13.3, 20.7)
CMV disease	**1 (1.6)**	**3 (4.7)**	**-3.1 (-11.7, 4.7)**
CMV DNA-emia	24 (38.1)	20 (31.3)	6.8 (-9.9, 23.5)
BKV (Polyomavirus)	14 (22.2)	13 (20.3)	1.9 (-12.7, 16.7)
Polyomavirus-associated nephropathy	**2 (3.2)**	**3 (4.7)**	**1.6 (−5.7, 9.6)**
Polyomavirus DNA-emia	14 (22.2)	13 (20.3)	1.9 (-12.7, 16.7)
EBV DNA-emia	1 (1.6)	1 (1.6)	0.0 (-7.1, 7.2)
Sepsis and Bacteremia	**3 (4.8)**	**11 (17.2)**	**-12.4 (-24.9, -1.4)**
Bacteremia	1 (1.6)	7 (10.9)	-9.4 (-20.0, -0.7)
Sepsis	2 (3.2)	5 (7.8)	-4.6 (-14.5, 4.3)
Fungal Infections	2 (3.2)	2 (3.1)	0.0 (-8.1, 8.3)
Other Opportunistic Infections	**22 (34.9)**	**26 (40.6)**	**-5.7 (-22.6, 11.4)**
PML	**0**	**0**	**0.0**

[1] Tegoprubart rate to Tacrolimus rate.

Note: Excludes select non-specific AEs.

AEs ≥5%: Renal & Metabolic

	Tegoprubart (N=63) n (%)	Tacrolimus (N=64) n (%)	Risk Difference (95% CI)[1]
Renal			
Delayed Graft Function	**9 (14.3)**	**16 (25.0)**	**-10.7 (-25.0, 3.4)**
Mean Days on Dialysis for DGF (SD)	**4.6 (4.19)**	**6.1 (7.71)**	
Oliguria	0	5 (7.8)	-7.8 (-17.3, -1.4)
Proteinuria	10 (15.9)	1 (1.6)	14.3 (4.7, 25.9)
Metabolic			
Hyperglycemia	**6 (9.5)**	**14 (21.9)**	**-12.4 (-25.7, 0.6)**
New Onset Diabetes (NODAT)	**1 (1.6)**	**7 (10.9)**	**-9.4 (-20.0, -0.7)**
Hyperkalemia	**7 (11.1)**	**17 (26.6)**	**-15.5 (-29.4, -1.4)**
Hypokalemia	7 (11.1)	6 (9.4)	1.7 (-9.6, 13.5)
Hypophosphatemia	19 (30.2)	10 (15.6)	14.5 (-0.4, 29.4)
Metabolic Acidosis	10 (15.9)	6 (9.4)	6.5 (-5.6, 19.0)

Difference in DGF occurrence and time on dialysis correspond to an estimated ~115 additional days on dialysis per 100 deceased donor recipients on tacrolimus vs. tegoprubart

[1] Tegoprubart rate to Tacrolimus rate.
Note: Excludes select non-specific AEs.

AEs ≥5%: CNS and Cardiovascular

	Tegoprubart (N=63) n (%)	Tacrolimus (N=64) n (%)	Risk Difference (95% CI)[1]
CNS			
Tremors	**1 (1.6)**	**16 (25.0)**	**-23.4 (-35.8, -11.5)**
Muscle Spasms	**3 (4.8)**	**10 (15.6)**	**-10.9 (-22.7, 0.1)**
Neurocognitive & Psychiatric Disorders	14 (22.2)	22 (34.4)	-12.2 (-27.9, 3.8)
Headache	**7 (11.1)**	**14 (21.9)**	**-10.8 (-24.4, 2.5)**
Dizziness	**3 (4.8)**	**6 (9.4)**	**-4.6 (-15.3, 5.1)**
Fatigue	7 (11.1)	5 (7.8)	3.3 (-7.9, 14.8)
Insomnia	6 (9.5)	11 (17.2)	-7.7 (-20.3, 4.8)
Pruritus	2 (3.2)	6 (9.4)	-6.2 (-16.6, 3.2)
Cardiovascular			
Heart Failure	**0 (0.0)**	**3 (4.7)**	**-4.7 (-13.1, 1.6)**
Hypertension	**10 (15.9)**	**16 (25.0)**	**-9.1 (-23.5, 5.3)**
Hypertensive Crisis	**1 (1.6)**	**5 (7.8)**	**-6.2 (-15.8, 1.8)**
Hypotension	8 (12.7)	7 (10.9)	1.8 (-10.2, 14.2)
Peripheral Edema	10 (15.9)	7 (10.9)	4.9 (-7.8, 17.6)
Thromboembolic Events	6 (9.5)	4 (6.3)	3.3 (-7.0, 14.2)

[1] Tegoprubart rate to Tacrolimus rate.

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Note: Excludes select non-specific AEs.

AEs ≥5%: Blood, Cancer & Gastro-Intestinal

	Tegoprubart (N=63) n (%)	Tacrolimus (N=64) n (%)	Risk Difference (95% CI)[1]
Blood			
Anemia	20 (31.7)	19 (29.7)	2.1 (-14.2, 18.8)
Leukopenia	26 (41.3)	15 (23.4)	17.8 (1.4, 33.9)
Lymphopenia	4 (6.3)	10 (15.6)	-9.3 (-21.4, 2.0)
Neutropenia	9 (14.3)	10 (15.6)	-1.3 (-14.3, 11.8)
Cancer			
Non-Melanoma Skin Cancer	3 (4.8)	1 (1.6)	3.2 (-4.3, 12.0)
PTLD	0	0	
Gastro-Intestinal			
Constipation	19 (30.2)	16 (25.0)	5.2 (-11.1, 20.9)
Diarrhea	14 (22.2)	22 (34.4)	-12.2 (-27.9, 3.8)
Dyspepsia	4 (6.3)	7 (10.9)	-4.6 (-15.7, 6.4)

[1] Tegoprubart rate to Tacrolimus rate.

Note: Excludes select non-specific AEs.

Conclusion

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BESTOW Conclusions

1. Observed composite endpoint (death, graft loss, BPAR, LTFU) failure rate in BESTOW was within the range reported in previous late-phase trials of approved immunosuppressive agents and demonstrated non-inferiority for tegoprubart vs. tacrolimus, using a 20% non-inferiority margin

2. Tegoprubart demonstrated excellent graft function. Kidney graft function, as assessed by eGFR, stabilized after the first month and remained higher on tegoprubart across all timepoints, in the range of ~69 mL/min/1.73 m^2 through month 12, vs. ~66 mL/min/1.73 m^2 on tacrolimus

3. Tegoprubart demonstrated a favorable safety profile with significant reductions observed in prominent side effects associated with tacrolimus including new onset diabetes, tremor, hypertension, and delayed graft function

4. Results support advancement into Phase 3 and position tegoprubart as the potential next-generation cornerstone of kidney transplant immunosuppression

Note: BPAR, Biopsy Proven Acute Rejection. LTFU, Loss to Follow Up..

Eledon Financial Profile and Expected Milestones

Strong Financial Profile

- **$93.4M* in cash**, cash equivalents and short-term investments as of September 30, 2025
- Forecasted **sufficient to fund operations to late 2026**

Expected 12 Month Milestones

- Guidance from FDA on Phase 3 design / path to market for kidney transplantation
- Long Term data in kidney transplantation
- Launch of Phase 3 in Kidney Transplantation in late 2026
- Enroll an additional 3 patients in investigator sponsored Phase 2 trial in islet cell transplantation for Type 1 diabetes by year end 2025, and report on initial 9 patients of data in 1H2026
- Launch Phase 2 islet cell transplant in patients with kidney dysfunction study as well as transplant tolerance study
- Guidance from FDA on Phase 3 design / path to market for islet cell transplantation & xenotransplantation

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* Preliminary, unaudited financial information as of September 30, 2025. The unaudited, preliminary cash, cash equivalents and short-term investments figure is based on current expectations and remains subject to the completion of financial closing procedures and internal reviews.

Eledon Pharmaceuticals

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