Eledon Pharmaceuticals

Corporate Overview

March 2026

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.

Eledon Company Highlights

Optimized & Differentiated Lead Asset: *Tegoprubart*

- **Novel anti-CD40L antibody with significant advantages vs. approved immunosuppressants to protect transplanted organs and cell**
  - 150+ subjects of safety data, including **100+ patients with transplant efficacy data** in kidney, islet cell, xeno-kidney, and xeno-heart transplantation
  - Data supports potentially **unprecedented safety profile** vs. currently available medicines
  - In kidney transplantation, among **highest levels of kidney function (eGFR) ever reported**
  - In pancreatic islet transplantation, 6 of 6 patients with Type 1 Diabetes transplanted to date functionally cured of their T1D

Strong Financial Profile

- **$93.4M in cash**, cash equivalents and short-term investments as of September 30, 2025
- **Completed $57.5M financing** in **November 2025**
- Forecasted **sufficient to fund operations into 2Q 2027**

Expected 12 Month Milestones

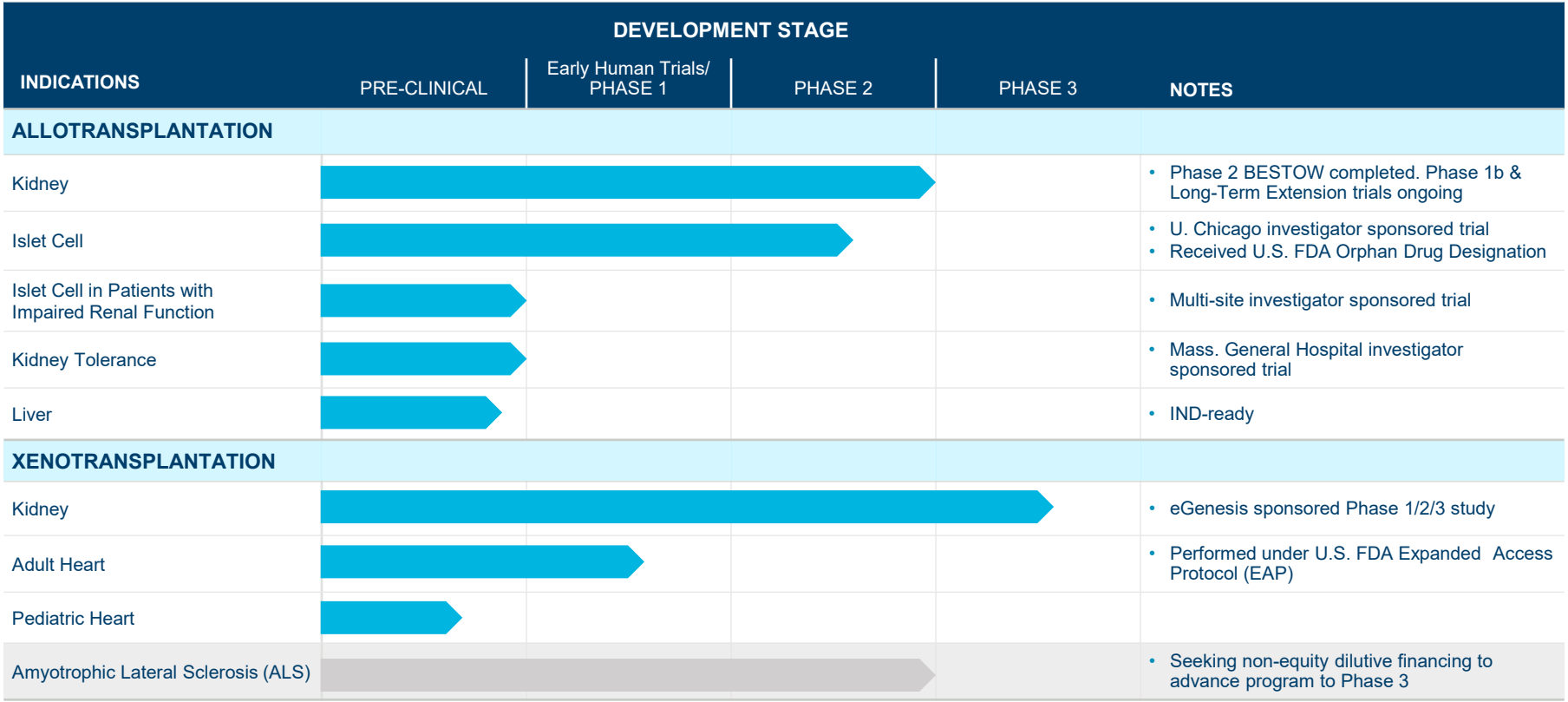
i. Agreement with FDA on Phase 3 design / path to market for kidney transplantation, islet cell transplantation & xenotransplantation

ii. Report long-term data in kidney transplantation

iii. Report 12 patients of data in investigator sponsored Phase 2 trial in islet cell transplantation for Type 1 diabetes

iv. Launch of multiple new investigator sponsored studies in liver transplantation, islet cell transplantation, xenotransplantation, and tolerance induction

Tegoprubart is a Pipeline in a Product Opportunity

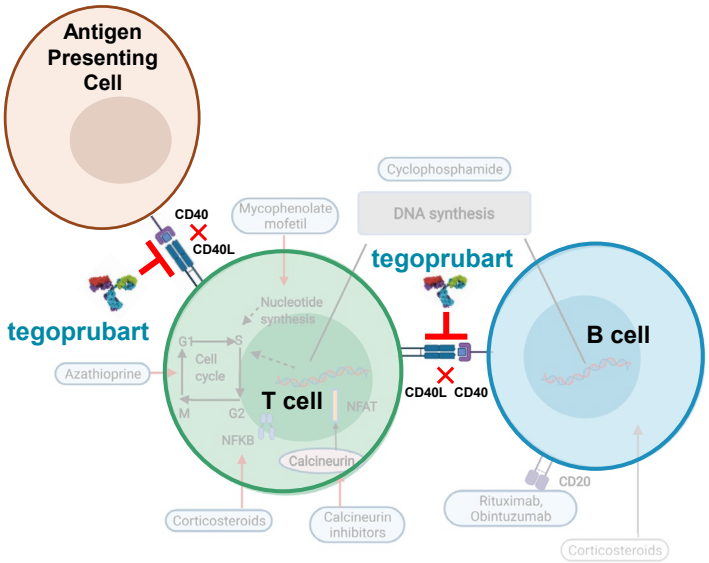


Eledon Pharmaceuticals

Note: As of March 15, 2026. Development plans and timelines may change, including based on U.S. and global regulatory interactions.

Mechanism Overview of CD40L Inflammatory Signaling

CD40/CD40L Pathway and Tegoprubart Site of Action



- Interaction of CD40 with CD40L on immune cells **mediates activation of the co-stimulatory immune pathway**, controlling "cross talk" between the adaptive and innate immune systems
- Maximal activation of inflammatory system is a 3-step process requiring co-stimulatory signaling
  - **Step 1:** Major histocompatibility complexes (MHC) and CD3/TCR engagement
  - **Step 2:** CD40 and CD40L binding resulting in cell division and clonal expansion
  - **Step 3:** Pro-inflammatory response by polarized T cells expressing inflammatory chemokines and cytokines
- **Blocking CD40L shifts polarization away from pro-inflammatory signaling** to T cell anergy, apoptosis, and polarization **to a Treg environment**
  - Blocking CD40L thus **does not generally result in lymphopenia** often seen with immunosuppressive agents

Source: Adapted from Kant, 2022.

Tegoprubart: Potential Best-in-Class Anti-CD40/CD40L Antibody

Targeting CD40 Ligand vs. CD40 Receptor	
CD40L and CD40	**CD40L only**
Targeting both anti-CD40L and anti-CD40 inhibits B cell polarization and class switching, as well as inhibits the pro-inflammatory polarization of $CD4^+$ Helper T cells	✓ Blocking anti-CD40L also inhibits CD11 costimulatory receptors on antigen presenting cells, thus blocking the pro-inflammatory polarization of $CD8^+$ Cytotoxic T cells
	✓ Blocking CD40L also polarizes $CD4^+$ lymphocytes to $FoxP3^+$ Regulatory T cells (Tregs), thus creating a potentially more tolerogenic environment
	✓ CD40L is more selectively expressed, providing the potential for additional safety and PK/PD/dosing advantages

IgG1 vs. fusion protein or pegylated FAB
✓ Up to over 2x times longer half-life
✓ Manufacturing advantages
✓ Less anti-drug antibodies

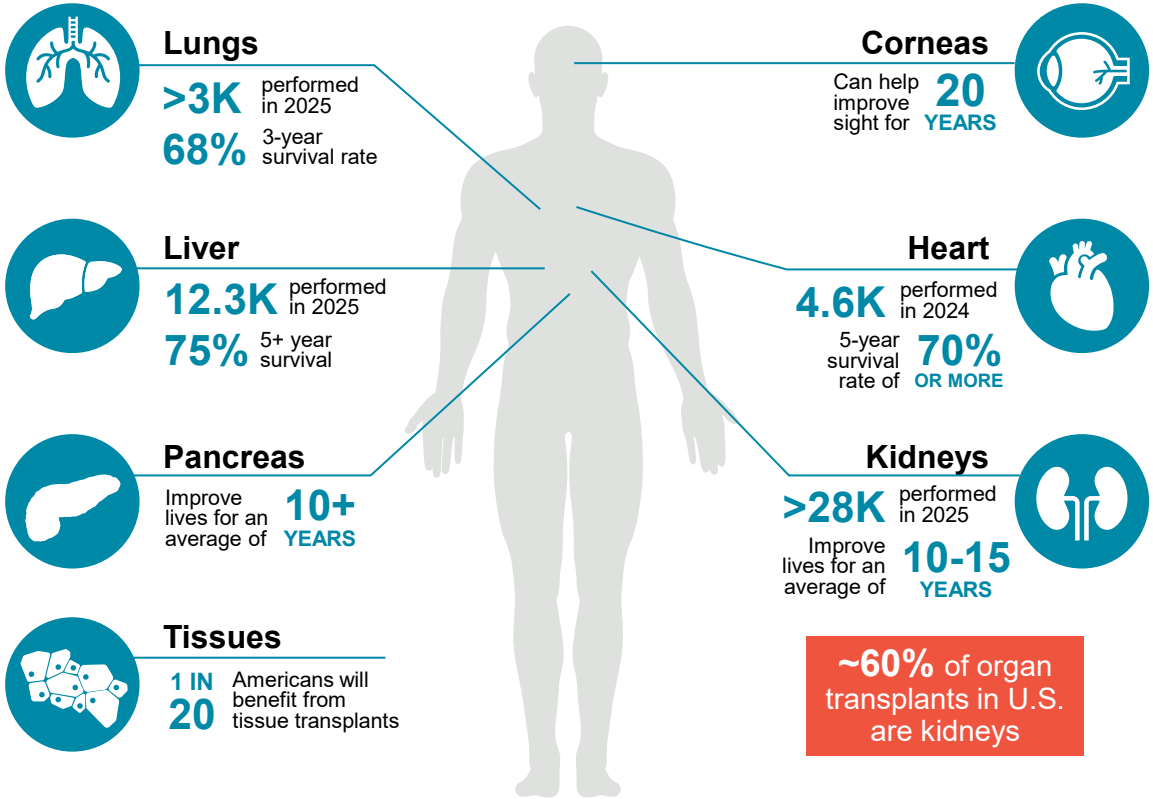
Eledon Pharmaceuticals

Note: Potential advantages versus selected other CD40/CD40L clinical programs; not based on head-to-head studies. Differences versus any individual competitive program may vary.

Kidney Transplantation: Overview

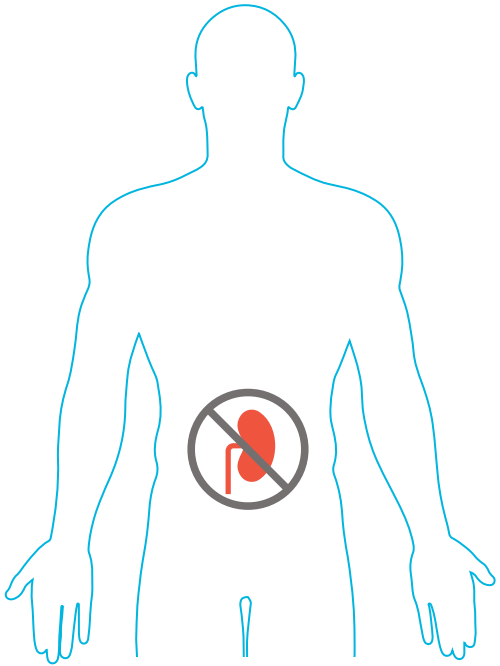
Eledon Pharmaceuticals

Over 49,000 Organs Were Transplanted in the United States in 2025



Note: Numbers are company estimates for the U.S. in 2025. 16.550 deceased donors in the US in 2025.
Sources: Adapted from baptisthealth.com; USDHHS; OPTN.

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

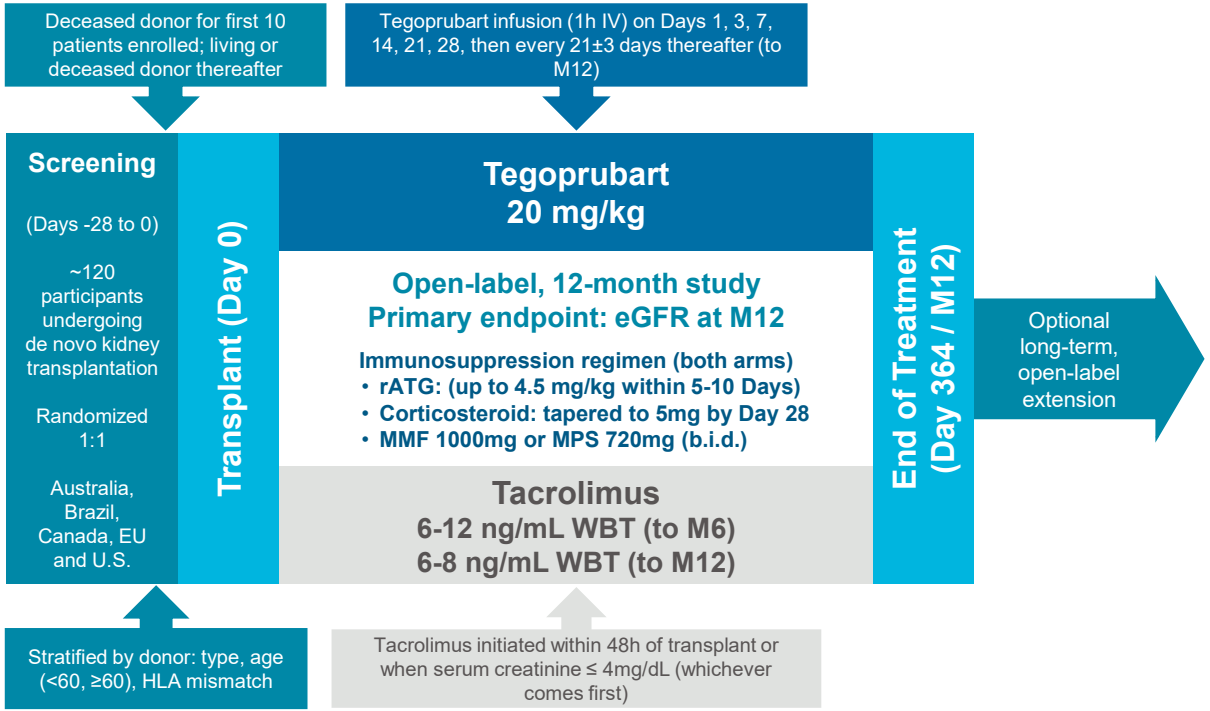
Source: U.S. NIH *Research Matters*, 2012.

Kidney Transplantation: Phase 2 BESTOW

Eledon Pharmaceuticals

BESTOW Trial Overview

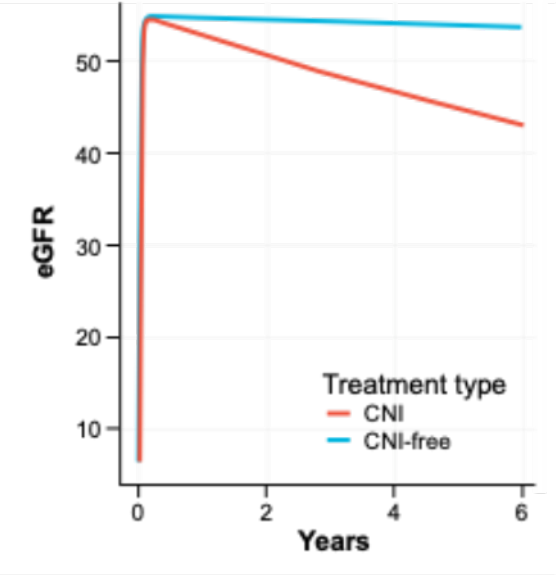
- **BESTOW** is the **first-ever** clinical trial comparing head-to-head tacrolimus to CD40L antibody (tegoprubart) in de novo kidney transplantation recipients
- A **prospective**, multicenter, **active-controlled, randomized, open-label** Phase 2 trial
- **Aim:** to determine the efficacy and safety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

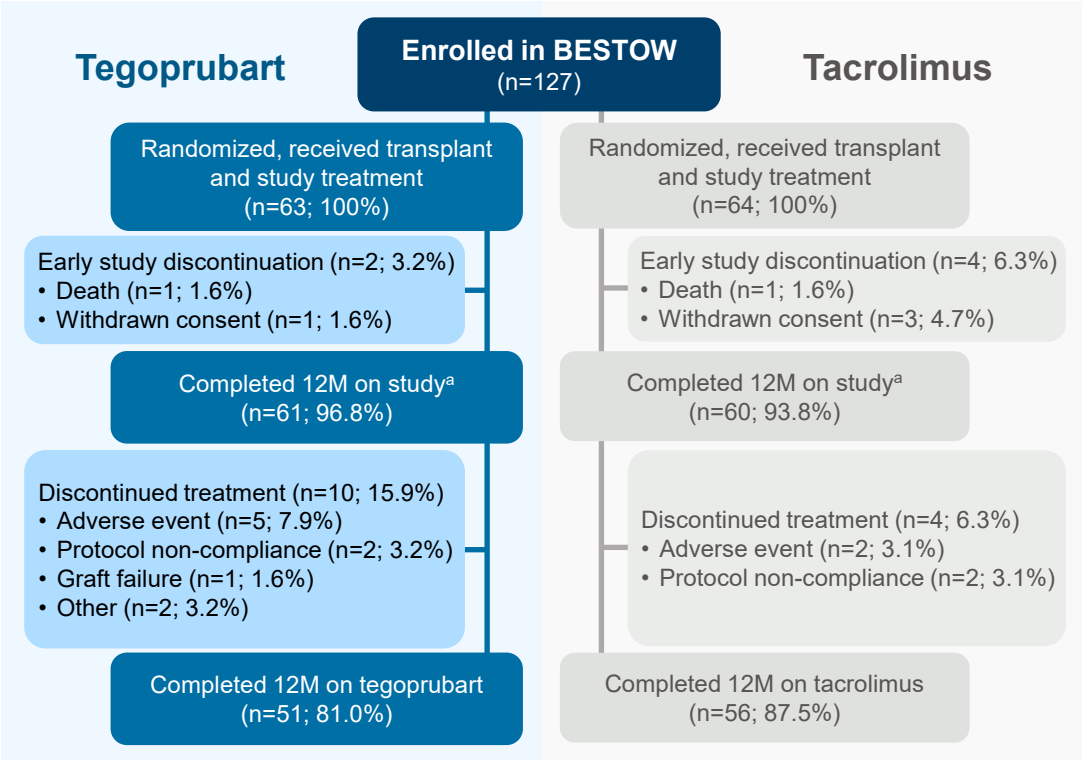
2. Tegoprubart demonstrated excellent graft function. Kidney graft function, as assessed by eGFR, stabilized after the first month and remained higher on tegoprubart across all timepoints, in the range of ~69 mL/min/1.73 m^2 through month 12, vs. ~66 mL/min/1.73 m^2 on tacrolimus

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

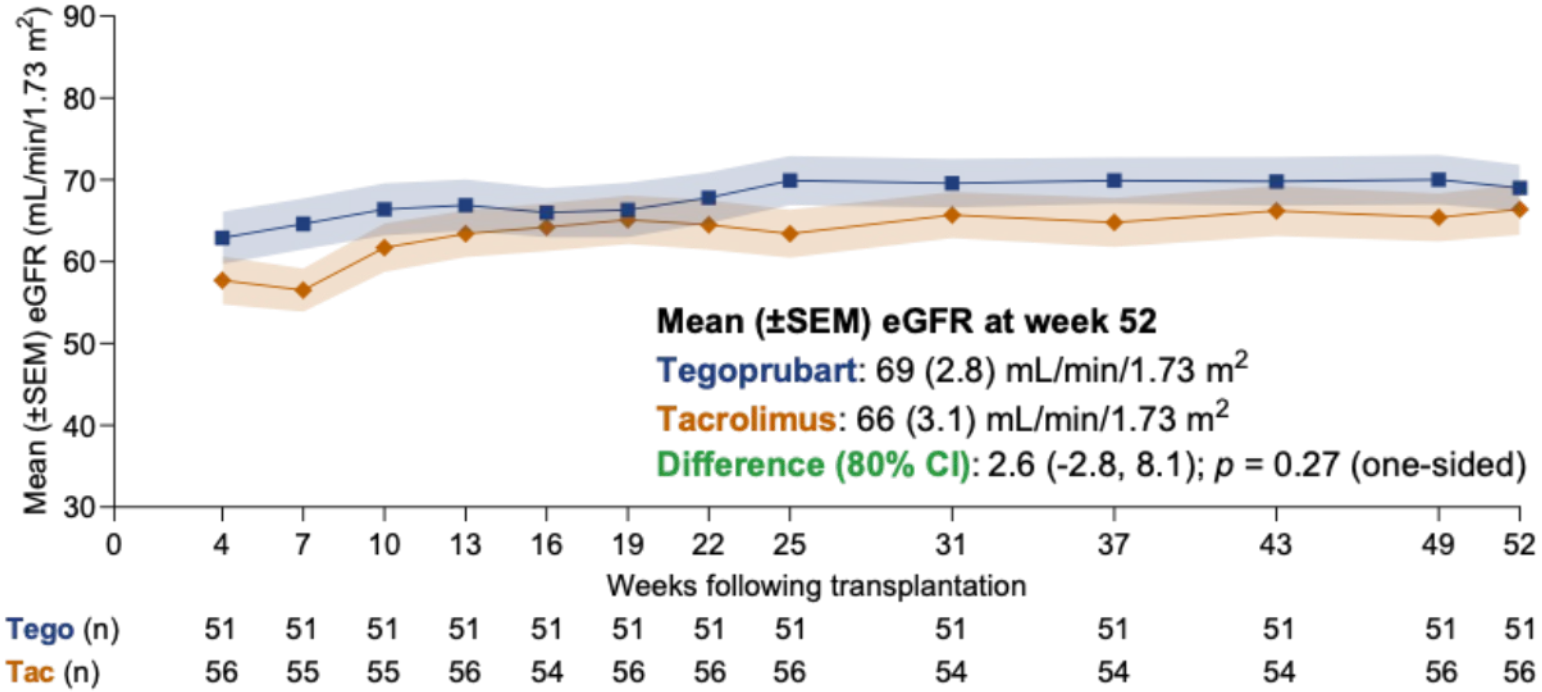
Mean (SD), unless stated otherwise	TEGO N=63	TAC N=64
Recipient age, years	50.1 (14.0)	48.3 (12.8)
Recipient sex, n (%)		
Male	42 (66.7)	44 (68.8)
Female	21 (33.3)	20 (31.3)
ESRD, n (%)[a]		
Diabetes	16 (25.4)	20 (31.3)
Hypertension	41 (65.1)	32 (50.0)
Glomerulonephritis	24 (38.1)	13 (20.3)
Dialysis		
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)

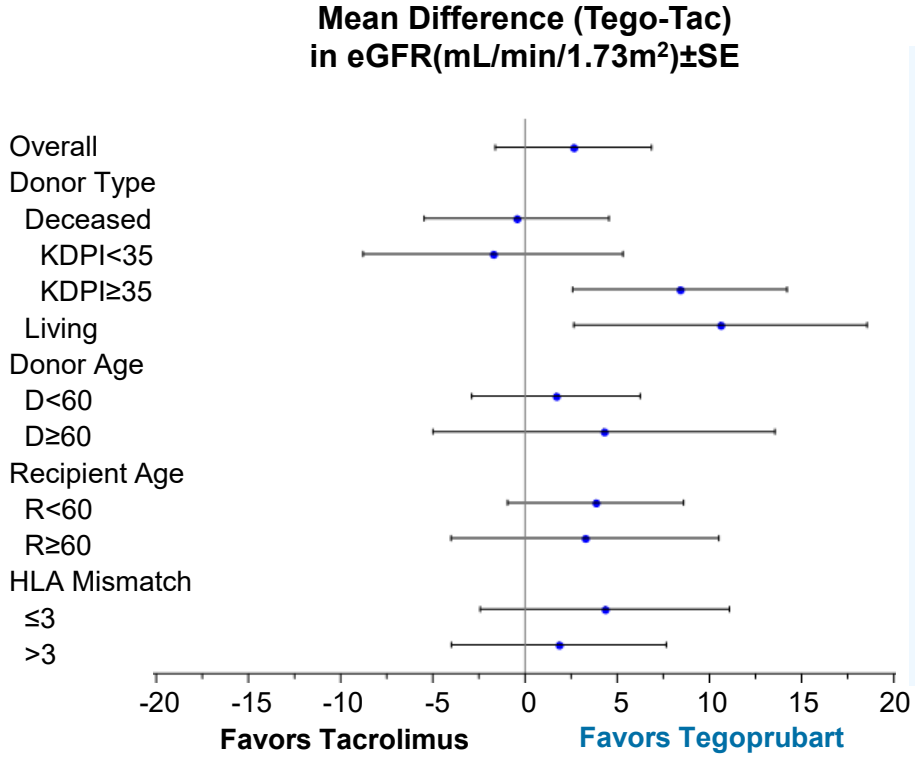
[a]participants can be counted in more than one category.
cPRA, calculated panel reactive antibody; CMV, cytomegalovirus; ESRD, end stage renal disease; h, hours; HLA, human leukocyte antigen; KDPI, kidney donor profile index; MPA, mycophenolic acid; rATG, rabbit anti-thymocyte globulin; SD, standard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

Mean eGFR Over 52 Weeks in Patients Who Completed Treatment



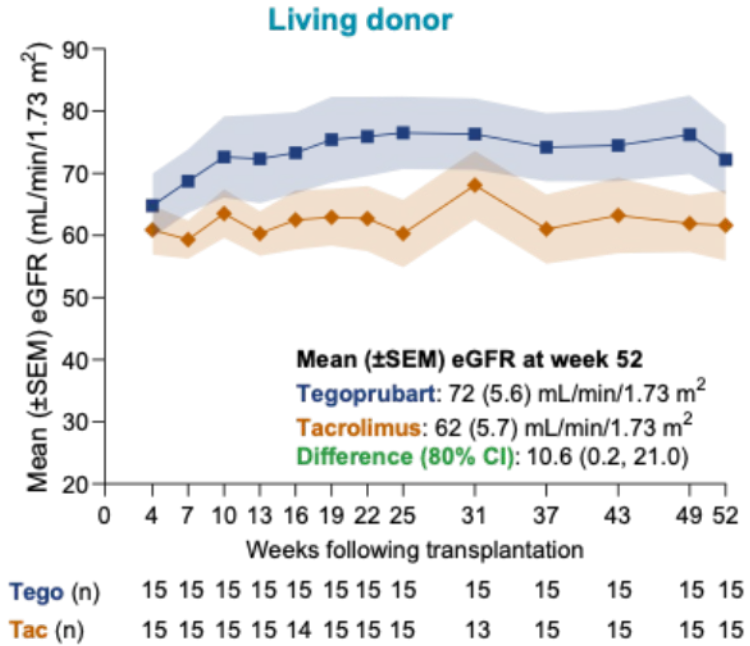
Note: Patients who completed treatment were those patients who completed 52 weeks of the study and received all planned doses of the randomized study drug. CI, confidence interval; eGFR, estimated glomerular filtration rate; SEM, standard error of the mean.

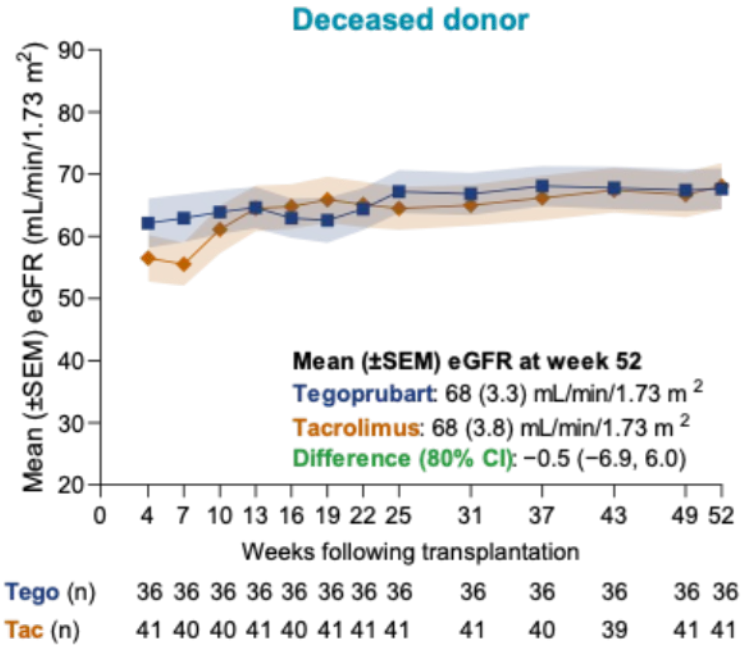
Subgroup Analysis of eGFR at 12 Month in Patients Who Completed Treatment



	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)

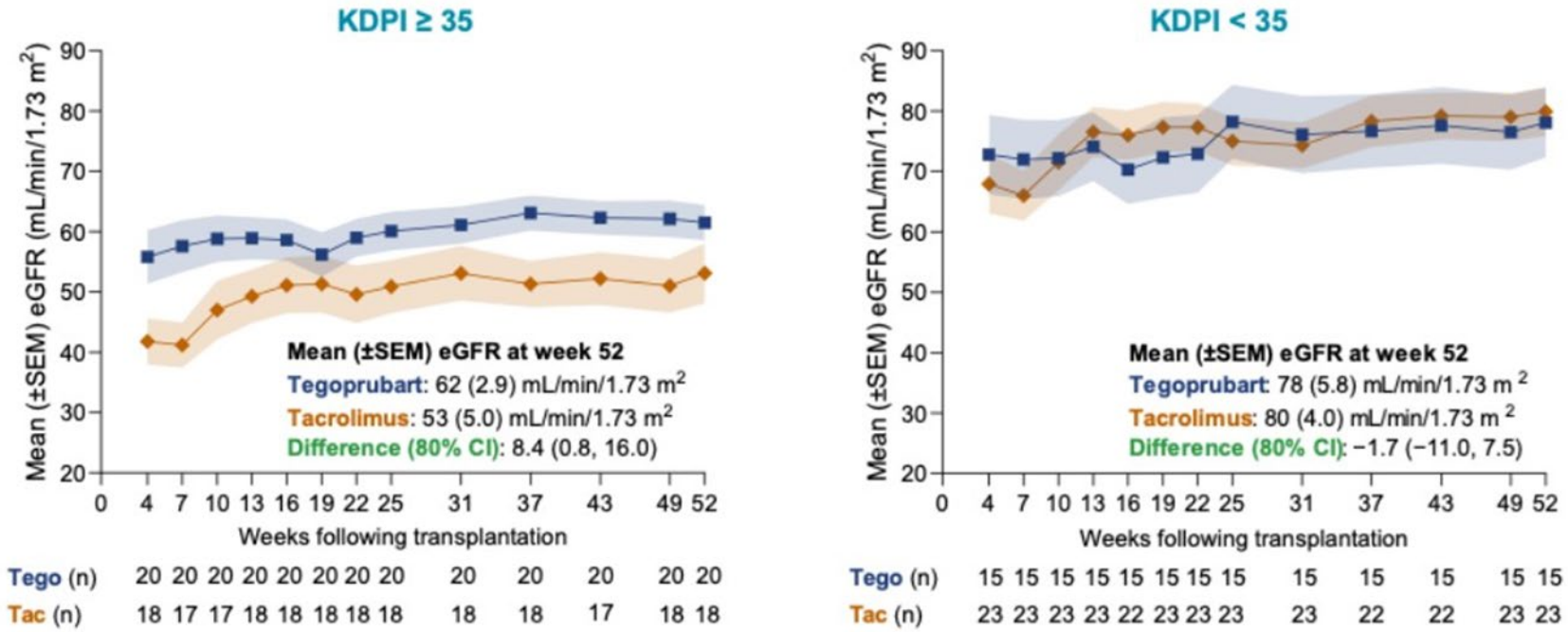
Mean eGFR by Donor Type in Patients Who Completed Treatment





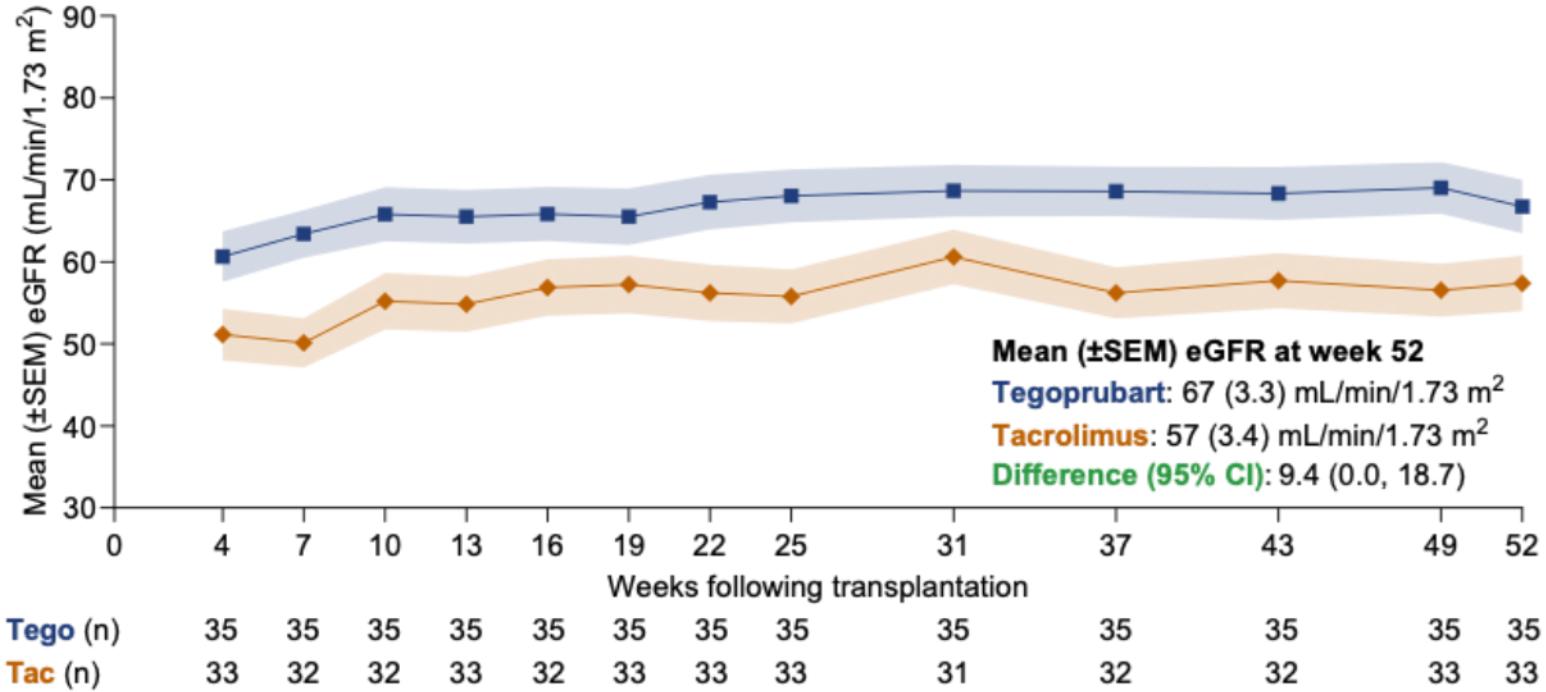
Note: Patients who completed treatment were those patients who completed 52 weeks of the study and received all planned doses of the randomized study drug. Rejection was determined by BPAR. BPAR, Biopsy Proven Acute Rejection; eGFR, estimated glomerular filtration rate; SEM, standard error of the mean.

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.

Composite Biomarker Panel (iBox)

- **iBox is a predictive model of 5-year kidney graft survival** developed **to estimate the risk of long-term graft loss following kidney transplantation** using kidney function and recipient immunological response, either with a 12-month biopsy (i.e., ‘full iBox’) or without histopathologic assessment (i.e., ‘abbreviated iBox’).
- **Abbreviated iBox** (without biopsy) includes:
  - eGFR
  - anti-HLA DSA
  - proteinuria
  - time since transplantation
- iBox is superior to BPAR as a surrogate for long-term graft loss and excludes BPAR, whose effectiveness as a predictor of long-term graft survival is close to random chance.

C-statistics (SE) at 1-year post transplantation

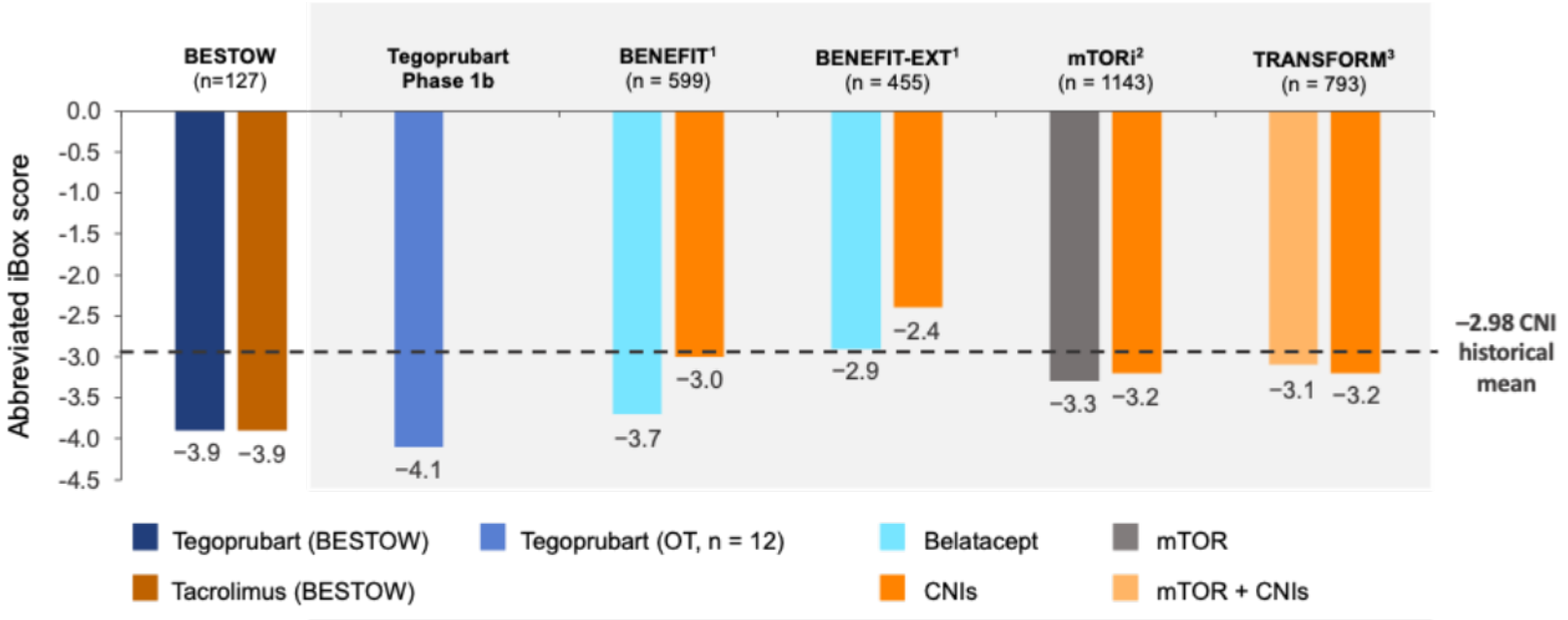
	Full iBox	Abbreviated iBox	BPAR
Combined validation (n = 1,534)	**0.81 (0.03)**	**0.80 (0.03)**	**0.57 (0.03)**

C-statistics ≥ 0.80 indicates a strong predictive model

A difference in abbreviated iBox score of −0.40 at 12 months is considered a minimum clinically important difference and is predictive of a 4–5% difference in 5-year graft survival

BPAR, biopsy-proven acute rejection; DSA, donor-specific antibodies; eGFR, estimated glomerular filtration rate; HLA, human leukocyte antigen; SE, standard error
Source: Klein A et al. Am J Transplant 2024;24:1784–93

Comparative Abbreviated iBox Scores at 12 Months

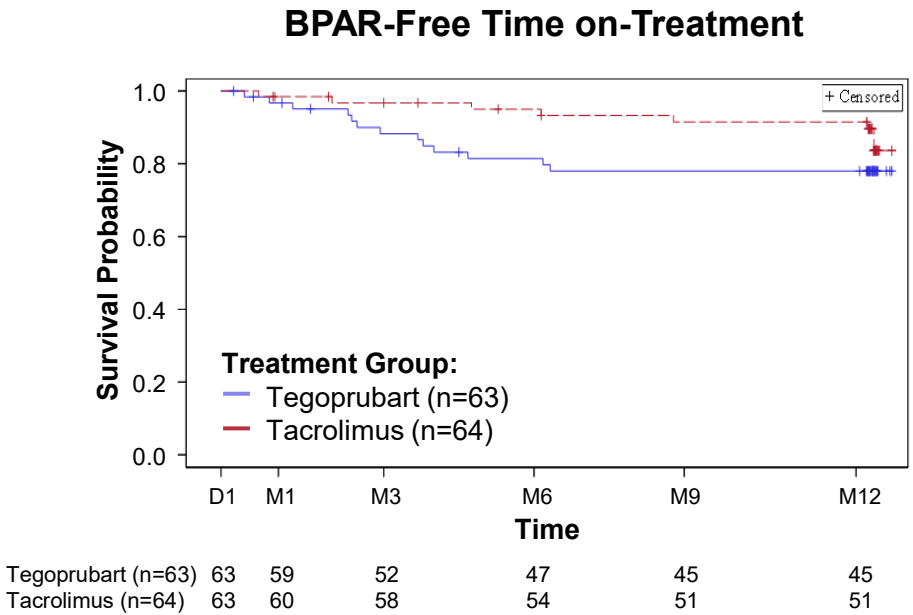


CNI, calcineurin inhibitor; ITT, intent to treat; mTOR, mammalian target of rapamycin; mTOR, mTORi, mammalian target of rapamycin inhibitor; OT, on treatment.

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

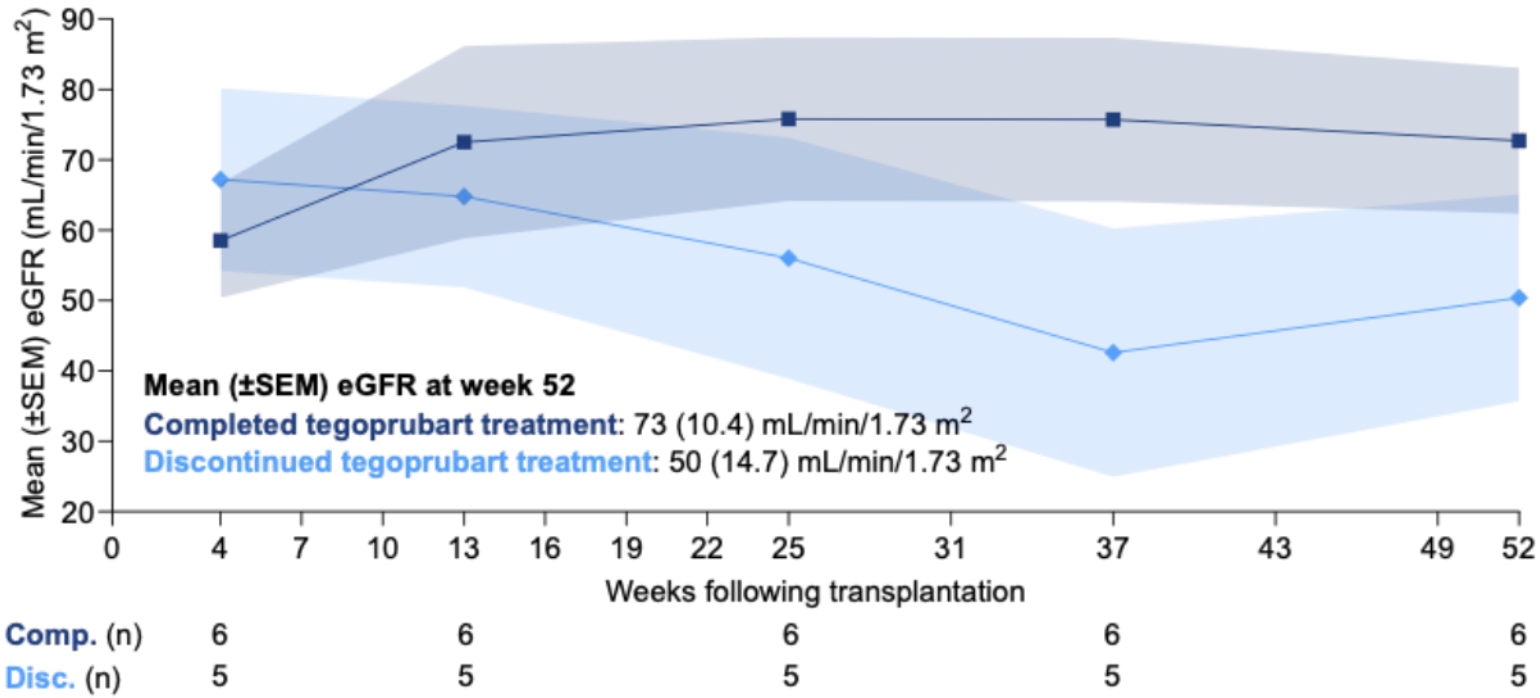
BPAR Based on All Biopsies Through 12 Months

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

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[1]
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**
	Pruritus	**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**

[1] Tegoprubart rate to Tacrolimus rate.
Note: May exclude 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)
BK 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: May exclude select non-specific AEs (e.g., abdominal pain).

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: May exclude select non-specific AEs (e.g., abdominal pain).

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

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: May exclude select non-specific AEs (e.g., abdominal pain).

Islet Cell Transplantation

Eledon Pharmaceuticals

Islet Cell Transplant Opportunity

~2 million Americans live with **Type 1 diabetes (T1D)**

~33% of people with T1D report **Impaired Awareness of Hypoglycemia regardless of CGM or Automated Pump (AID) usage**

~12% of people with T1D **experience recurrent severe hypoglycemic events** annually, putting them at higher risk for adverse outcomes

~5% to 8% of adults with T1D **experience Diabetic Ketoacidosis (DKA)** annually, often as a result of poor glycemic control

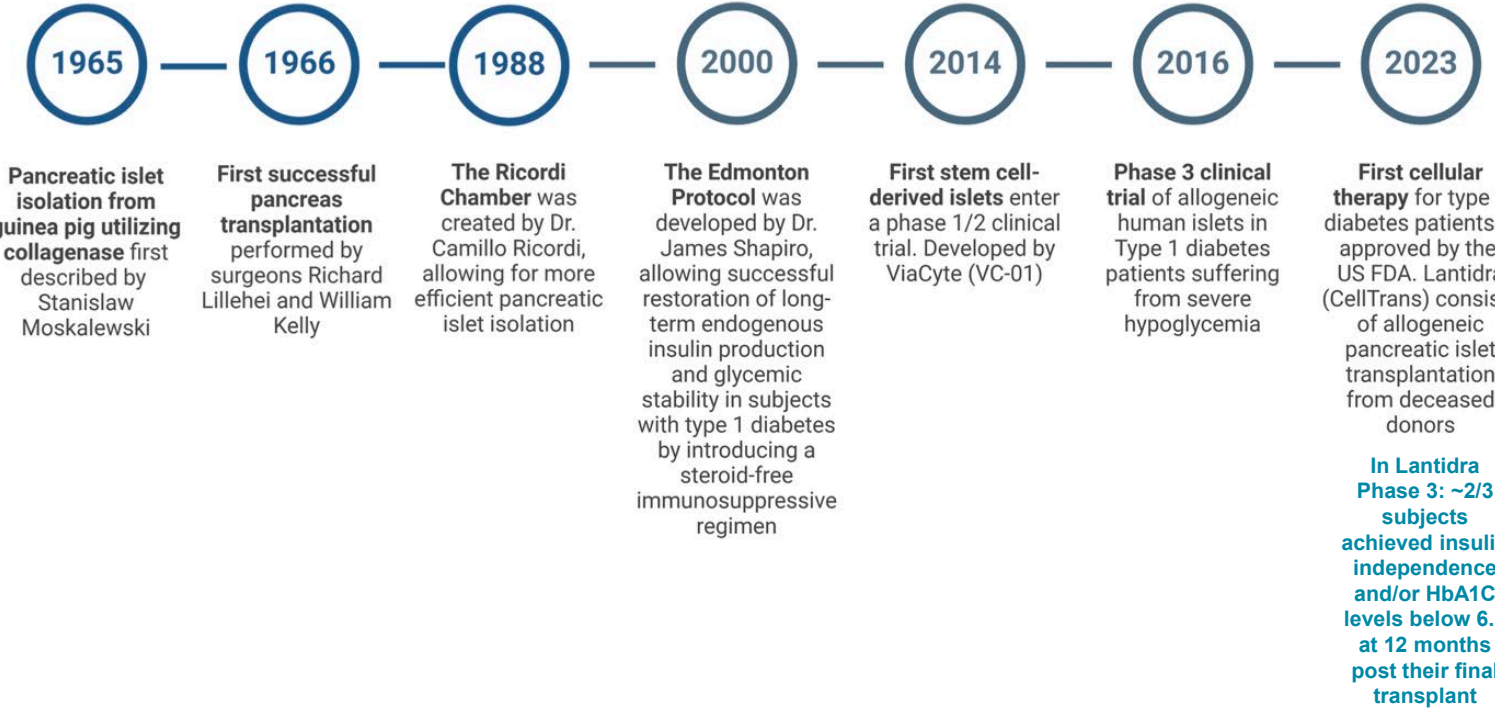
Currently, **islet cell transplantation is underutilized** in part due to immunosuppressive regimens with CNIs that may (i) be toxic to transplanted insulin producing islet cells resulting in the need for repeat transplants and (ii) cause significant side effects

Tegoprubart may unlock the islet cell transplant market by potentially:

1. Improving islet cell graft survival regardless of cell source (e.g., isolated from deceased donor pancreases or stem-cell derived) and/or the use of a pouch
2. Reducing side effects associated with standard of care regimens including islet cell death

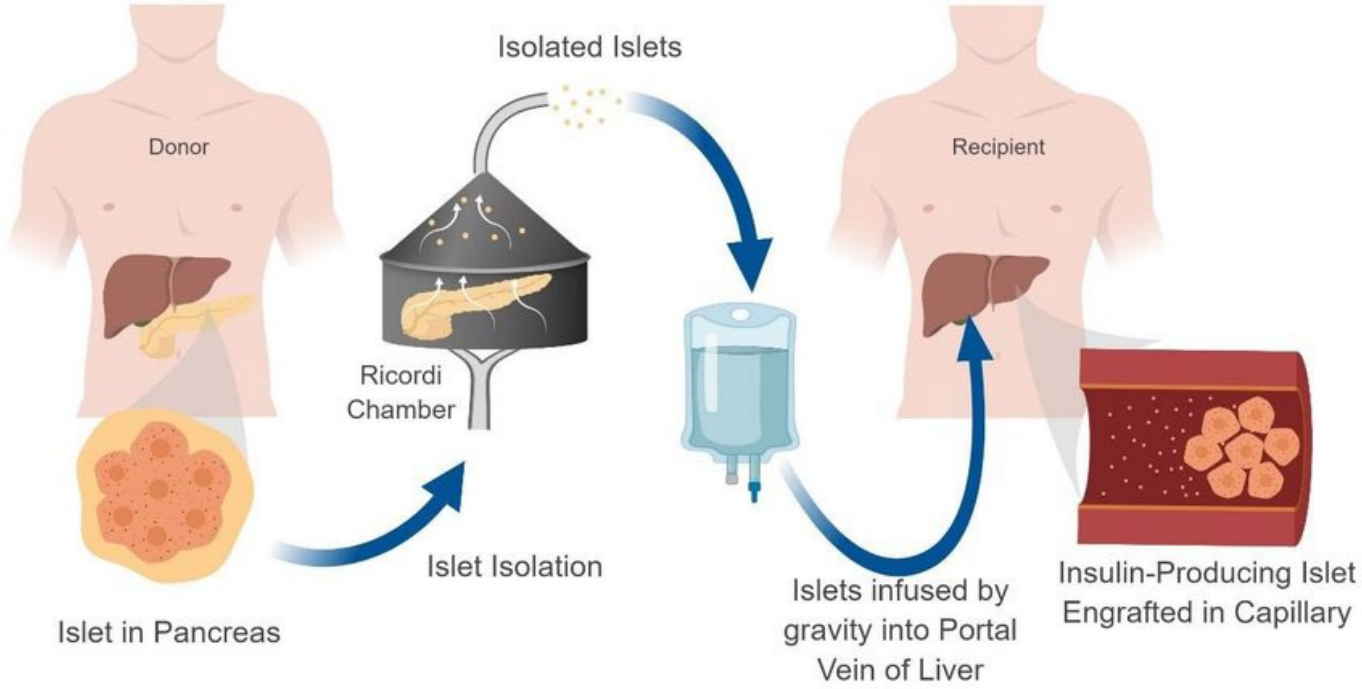
Source: Sherr et al. Severe Hypoglycemia & Impaired Awareness. *Diabetes Care*, 2024. Virdi et al. Prevalence, Cost, & Burden of DKA. *DT&T*, 2023; CDC 2024; Shapiro et al. Clinical pancreatic islet transplantation. *Nature Reviews. Endocrinology*. 2017;13(5):268–277.

60 Years of Milestones in Pancreatic Islet Transplantation But Better Immunosuppression Remains a Key Need



Source: Tondin and Lanzoni. "Islet Cell Replacement." *BioDrugs*, 2025.

Islet Cell Transplant Procedure



Source: Quintana et al. *OBM Transplantation*. 2018

Phase 1/2 Study Assessing the Use of Tegoprubart to Prevent Islet Cell Transplant Rejection in Participants with Type 1 Diabetes (T1D)

DESIGN

- 52-week, open label, single dose level study
- Initial group of 12 patients with T1D transplanted in an investigator sponsored trial at the University of Chicago
- Islet cell transplant combined with induction therapy plus tegoprubart and mycophenolate mofetil (MMF) every third week by IV infusion
- Financing principally from Breakthrough T1D (a.k.a. JDRF) and The Cure Alliance

PLANNED DATA GENERATION

- **Safety & tolerability**
- **Graft function**
  - e.g., HbA1C, C-peptide
- **Number of hypoglycemic events**
- **Insulin independence**
- **Need for repeat islet cell transplant(s)**

Note: Development plans may change, including based on U.S. and global regulatory interactions.

Subject Demographics and Transplanted Islet Dose(s)

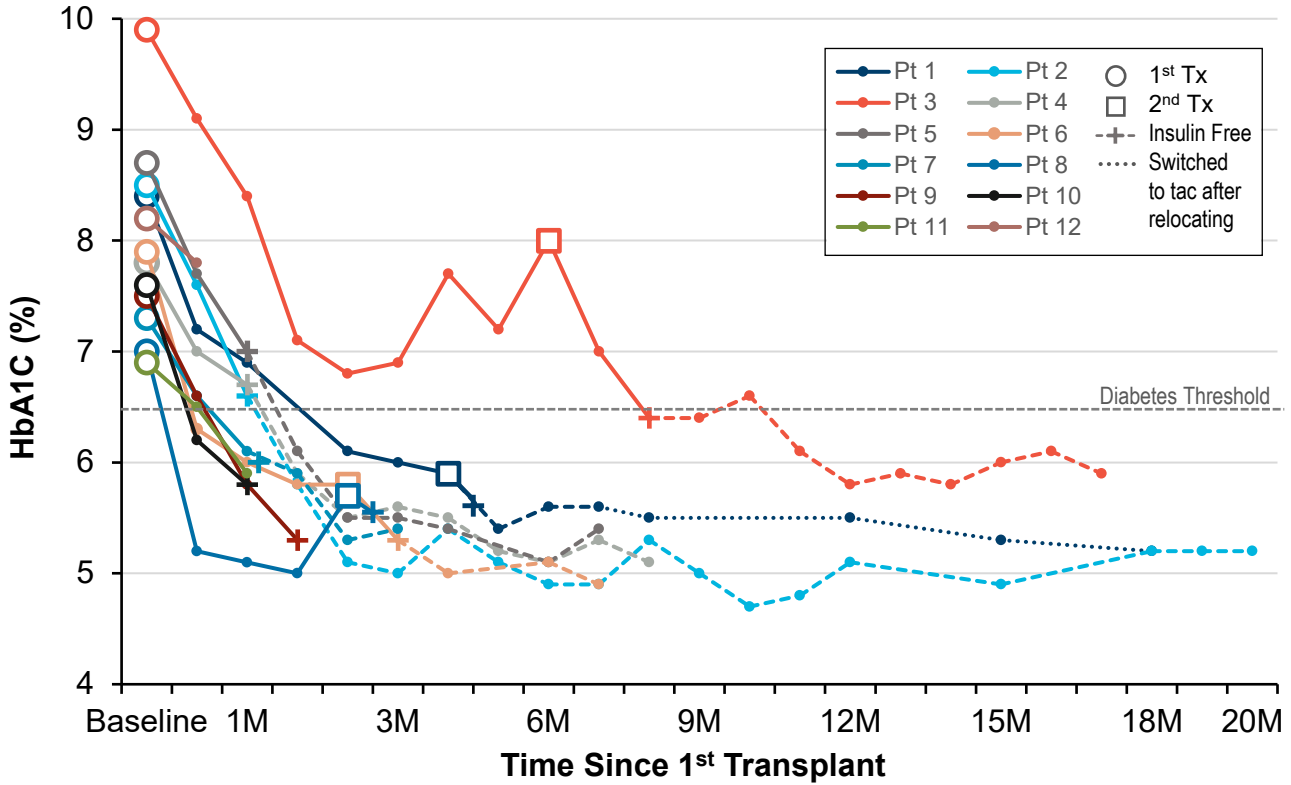
Subject	Gender	Age at Transplant	Years of T1D	BMI	Baseline HbA1C	Baseline Insulin (u)	1st Tx (IEQ/Kg)	2nd Tx (IEQ/Kg)
1	F	42	31	30	8.4	80	4,092	5,501
2	F	30	26	21	8.5	60	6,775	
3	M	37	19	30	9.9	90	4,086	4,211
4	F	51	40	19	7.8	35	5,569	
5	F	49	35	25	8.7	65	5,159	
6	M	19	9	29	7.9	90	5,491	7,096
7	F	59	41	26	7.3	40	6,519	
8	M	35	34	25	7.0	35	6,436	6,928
9	F	39	13	22	7.5	40	6,109	
10	F	49	32	24	7.6	40	6,684	
11	F	41	34	23	6.9	55	6,016	
12	M	57	39	25	8.2	35	7,731	
Average	**8F /4M**	**42**	**29**	**25**	**8.0**	**55**	**5,889**	**5,934**

All subjects have a history of recurrent severe hypoglycemic events as well as impaired awareness of hypoglycemia, despite standard of care diabetes management and education

Eledon Pharmaceuticals

Note: Tx=Transplant; IEQ = Islet Equivalents, at time of transplant, defined per standard as each equaling a single spherical islet of 150 µm in diameter.
Source: Witkowski, ATTD, March 2026.

Pre- and Post- Transplant HbA1C Levels & Timing of Independence from Exogenous Insulin

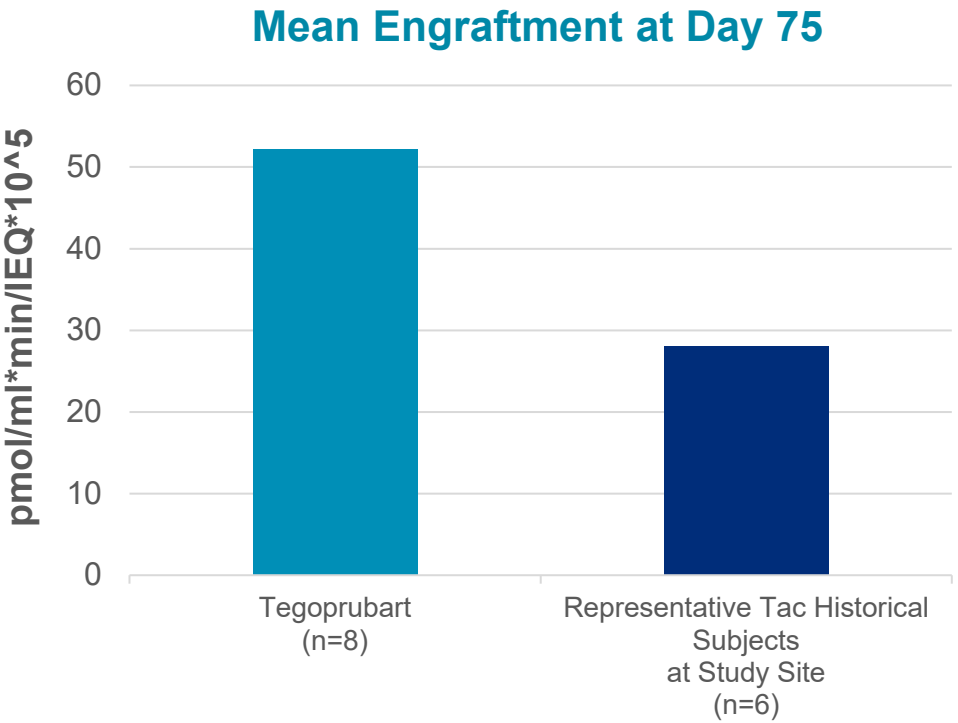


- **10 of 10 subjects >4 weeks post-transplant achieved insulin independence** and **an average ~2.65% reduction in HbA1c to date**
- 9 of 10 subjects >4 weeks post transplant achieved normal HbA1C levels within ~2 months after initial transplant, all within 12 months
- **No subjects experienced a severe hypoglycemic event post-transplant**

Eledon Pharmaceuticals

Note: Patient 1 discontinued tegoprubart after relocating to a geography too distant to continue receiving iv tegoprubart at the University of Chicago. Tac = tacrolimus.
Source: Witkowski, ATTD, March 2026.

Day 75 Calculated Islet Engraftment



- **Islet engraftment,** calculated based on c-peptide secretion during a Mixed Meal Tolerance Test on day 75 post transplant, **demonstrated higher levels of engraftment with tegoprubart vs. representative historical subjects on tacrolimus**
- **Single donor islet transplants** treated with tegoprubart permitted **lowering insulin requirements by up to ~65u of insulin per day**
- 4 subjects who required a second transplant were able to reduce their insulin doses by an average of ~66% after their initial transplant

Eledon Pharmaceuticals

Note: Tac = tarcrolimus treated. Note that data is approximate.
Source: Witkowski, ATTD, March 2026.

Islet Cell Transplant Safety Profile Summary To Date

- **All 12 subjects achieved stable islet graft function with rapidly improved blood glucose control**
- **No severe hypoglycemic events**
- **No signs of rejection or de novo donor specific antibodies (DSAs)**
- **No signs of kidney toxicity, neurotoxicity, GI toxicity, hypertension, or thromboembolic events**
- **No severe infections**
  - 2 subjects experienced transient, low titer CMV viremia that responded to lowered MPA
  - 1 subject experienced a superficial skin infection that responded to lowered MPA
  - 1 subject experienced episode of norovirus diarrhea
- Non-clinically significant anemia & leukopenia that responded to lowered MPA

Eledon

Source: Pharmacokinetics, March 2026.

Eledon Pharmaceuticals

Thank You!

19800 MacArthur Blvd., Suite 250
Irvine, California 92612, USA
info@eledon.com
+1 949-238-8090