



INVESTOR R&D DAY

July 16, 2025

KODIAK



WELCOME & INTRODUCTIONS

Forward-Looking Statements

These slides contain "forward-looking statements" within the meaning of Section 27A of the Securities Act of 1933, Section 21E of the Securities Exchange Act of 1934 and the Private Securities Litigation Reform Act of 1995. These forward-looking statements are not based on historical fact and include statements regarding: the progress and anticipated benefits of our ABC platform; the prospects and anticipated milestones of the candidates in our pipeline, including tarcocimab, KSI-501, and KSI-101; the timing and success of our planned Biologics License Application ("BLA") package; the timing of anticipated topline data readouts; the potential to provide sustainable revenue streams starting from 2027; the net sales potential of our clinical portfolio; and the addressable population of KSI-101. Forward-looking statements generally include statements that are predictive in nature and depend upon or refer to future events or conditions, and include words such as "may," "will," "should," "would," "could," "expect," "plan," "believe," "intend," "pursue," and other similar expressions among others. Any forward-looking statements are based on management's current expectations of future events and are subject to a number of risks and uncertainties that could cause actual results to differ materially and adversely from those set forth in or implied by such forward-looking statements. The risks and uncertainties include, but are not limited to: the risk that cessation or delay of any of the on-going clinical studies and our development of tarcocimab, KSI-501 or KSI-101 may occur; the risk that ongoing clinical trial results may not provide the evidence, insights, or benefits as anticipated; the risk that safety, efficacy, and durability data observed in our product candidates in current or prior studies may not continue or persist; the risk that the results of the tarcocimab Phase 3 studies may not be sufficient to support a single BLA submission for DR, RVO and wet AMD; the risk that a BLA may not be accepted by, or receive approval from, the FDA or foreign regulatory agencies when expected, or at all; future potential regulatory milestones of tarcocimab, KSI-501 or KSI-101, including those related to current and planned clinical studies, may be insufficient to support regulatory submissions or approval; the risk that a new formulation of tarcocimab, KSI-501 or other ABC Platform derived molecules may not provide the benefits expected; our research and development efforts and our ability to advance our product candidates into later stages of development may fail; the risk that KSI-501 may not inhibit VEGF and IL-6 or have an impact on the treatment of patients as expected; any one or more of our product candidates may not be successfully developed, approved or commercialized; our manufacturing facilities may not operate as expected; adverse conditions in the general domestic and global economic markets, which may significantly impact our business and operations, including our clinical trial sites, as well as the business or operations of our manufacturers, contract research organizations or other third parties with whom we conduct business; as well as the other risks identified in our filings with the Securities and Exchange Commission. For a discussion of other risks and uncertainties, and other important factors, any of which could cause our actual results to differ from those contained in the forward-looking statements, see the section entitled "Risk Factors" in our most recent Form 10-Q, as well as discussions of potential risks, uncertainties, and other important factors in our subsequent filings with the Securities and Exchange Commission. These forward-looking statements speak only as of the date hereof and Kodiak undertakes no obligation to update forward-looking statements, and readers are cautioned not to place undue reliance on such forward-looking statements.

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Today's Attendees

Presenters from Kodiak Management



Victor Perlroth, MD
Chairman and CEO



John Borgeson
Chief Financial Officer



Dolly S. Chang, MD, PhD
Chief Scientific Officer



Pablo Velazquez-Martin, MD
Chief Medical Officer

Industry Experts



Charles Wykoff, MD, PhD

- Director of Research, Retina Consultants of Texas
- Chairman of Research, Retina Consultants of America
- Professor of Clinical Ophthalmology and Deputy Chair of Ophthalmology, Blanton Eye Institute, Houston Methodist Hospital



Sumit Sharma, MD

- Enterprise Vice Chair, Integrated Surgical Institute
- Medical Director, Information Technology – Ophthalmology
- Vitreoretinal Surgery and Uveitis/Ocular Inflammatory Diseases, Cole Eye Institute, Cleveland Clinic

Guest Speakers and Industry Experts



Charles Wykoff, MD, PhD

Director of Research, Retina Consultants of Texas
Chairman of Research, Retina Consultants of America
Professor of Clinical Ophthalmology and Deputy Chair of Ophthalmology,
Blanton Eye Institute, Houston Methodist Hospital

- Medical and surgical retina specialist and an active clinical investigator for exudative and atrophic retinal diseases
- Major themes in his research are a translational focus, utilizing novel biomarkers and accelerating drug and device development
- 350+ publications and serves on multiple scientific and medical advisory boards, safety monitoring committees, and global steering committees for endeavors spanning the innovative process from early to late-stage developments
- A member of the NEI Audacious Goals Steering Committee and has been awarded multiple Achievement, Honor and Senior Honor Awards
- His guiding philosophy is to build and strengthen innovative, ethical teams focused on developing new approaches to improving outcomes for blinding diseases.

Guest Speakers and Industry Experts



Sumit Sharma, MD

Enterprise Vice Chair, Integrated Surgical Institute
Medical Director, Information Technology – Ophthalmology
Vitreoretinal Surgery and Uveitis/Ocular Inflammatory Diseases, Cole Eye
Institute, Cleveland Clinic

- Vitreoretinal Surgeon and Uveitis Specialist at Cole Eye Institute, Cleveland Clinic with a special interest in clinical trials and advanced imaging analysis
- Keen interest in designing new imaging based quantitative outcome metrics for both clinical practice and clinical trials in AMD, DME, RVO and uveitis
- Actively involved in clinical trials serving as the principal or co-investigator of over 80 clinical trials in all phases of development
- 100+ peer reviewed publications including as the first author of multiple clinical trials
- Serves as the Enterprise Vice Chair for Clinical Outcomes, Safety, Quality and Patient Experience for the Integrated Surgical Institute, including 7 surgical departments at Cleveland Clinic with oversight over all Cleveland Clinic locations in Ohio, Florida, London and Abu Dhabi

Welcome, Safe Harbor, Agenda

John Borgeson,
Chief Financial Officer

Key Messages, What to Expect Today

Victor Perloth, MD
Chief Executive Officer

Tarcocimab and KSI-501: Retinal Vascular Diseases

Charles Wykoff, MD, PhD

KSI-101: Macular Edema Secondary to Inflammation

What is MESI?
What causes MESI?
What is the unmet need?
How can this unmet need be addressed?
Phase 1b APEX Study – DME and MESI cohorts
How does KSI-101 fit into the emerging treatment landscape?
PEAK and PINNACLE: KSI-101 pivotal program

Sumit Sharma, MD

Charles Wykoff, MD, PhD

A patient's MESI journey

Dolly S. Chang, MD, PhD
Chief Scientific Officer

Commercial opportunity

Victor Perloth, MD
Chief Executive Officer

Summary, Q&A, Closing

Kodiak Management Team
and Industry Leaders



Victor Perloth, MD
Chairman and CEO

Key Messages & What to Expect

Kodiak Investor R&D Day July 2025 – Key Messages

Wholly Owned

KSI-101

- Strong 12-week data from Phase 1b APEX
- PEAK and PINNACLE – already enrolling
- Commercial opportunity of 150,000+ initial addressable patients with headroom

A potent reason to believe in Kodiak

Tarcocimab & KSI-501

- Science-based “heavyweights”?
- Tarcocimab: targeting BLA mid-2026 in wet AMD, RVO and diabetic retinopathy
- KSI-501: bispecific ABC[®] may be even better!



Pipeline, Digital Health, Manufacturing

- KSI-102, KSI-103: bispecifics for inflammation
- Duets for glaucoma and geographic atrophy
- VETi: AI headsets for commercial leadership
- URSUS: commercial manufacturing

Accelerating our technology and product leadership in retina

3 late-stage assets, in 4 Phase 3 studies, with topline data expected across 2026

For patients with retinal vascular diseases

For patients with MESI

Tarcocimab

Anti-VEGF ABC[®]

Mainstay biologic with science of immediacy and durability, on track for BLA filing in 2026 in 3 indications of wet AMD, DR and RVO

KSI-501

Anti-IL-6, VEGF trap bispecific ABC[®]

Mainstay biologic with potential for additional efficacy beyond anti-VEGF monotherapies while maintaining immediacy and signature durability of ABC platform

KSI-101

High-strength anti-IL-6, VEGF trap bispecific protein

High-strength, dual inhibition of IL-6 and VEGF, for safe and potent control of macular edema secondary to inflammation (MESI)

Quadrant of core unmet need

Quadrant of core unmet need

Greenfield market opportunity

Kodiak is a precommercial retina biotech with a portfolio of three Phase 3 assets, with BLA facing data expected across 2026, and a series of BLA filings possible in 2026 and then 2027

	MOA	Indication	Phase 3 Study	Complete	Q1 '26	Q2 '26	Q3 '26	Q4 '26	1Q '27	2Q '27	3Q '27	
Tarcocimab	Anti-VEGF Antibody Biopolymer Conjugate (ABC)	RVO	BEACON	✓			BLA*					
		DR	GLOW1	✓								
		Wet AMD	DAYLIGHT	✓								
		DR	GLOW2		🎯							
		Wet AMD	DAYBREAK				🎯					
KSI-501	Anti-IL-6, VEGF Trap ABC	Wet AMD	DAYBREAK				🎯					
		Wet AMD	2nd Pivotal							🎯	BLA*	
KSI-101	Anti-IL-6, VEGF Trap Protein	MESI	PEAK					🎯				
			PINNACLE						🎯	BLA*		

ABC: antibody biopolymer conjugate; DR: diabetic retinopathy; AMD: age-related macular edema; RVO: retinal vein occlusion; MESI: macular edema secondary to inflammation; BLA: biologics license application; GLOW2: NCT06270836. DAYBREAK: NCT06556368

* Based on expected timeline of clinical data

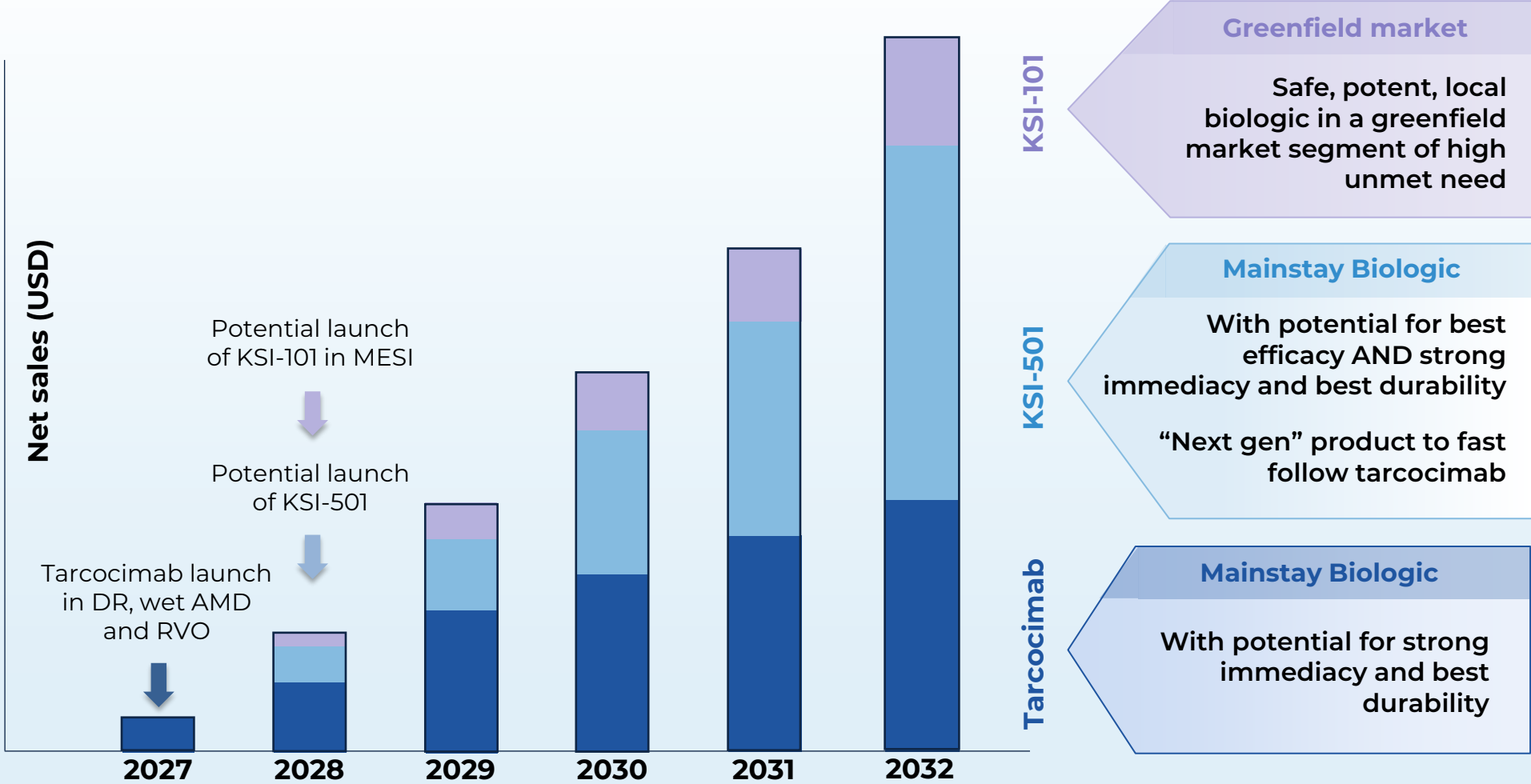
🎯 = BLA-facing topline data readouts (expected)

Kodiak’s pipeline has the potential to provide sustainable revenue streams starting from 2027, with built-in life cycle management, risk diversification and continuing technology and product leadership in retina

Kodiak’s assets are proprietary and wholly-owned.

We have the flexibility in our commercialization decisions to support adoption of our products in the marketplace.

Net Sales Potential of Kodiak Clinical Portfolio (Illustrative)



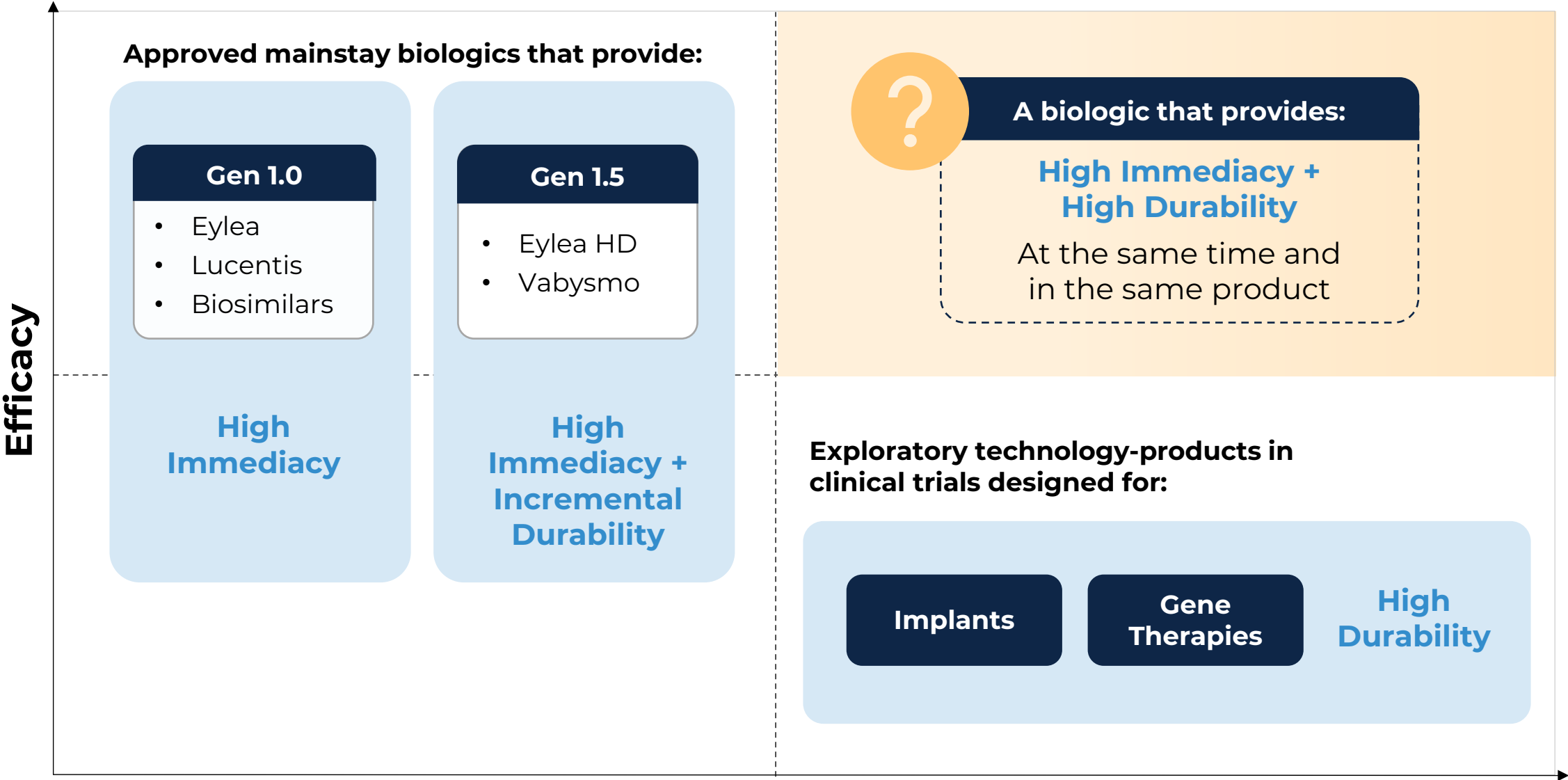


Charles Wykoff
MD, PhD

Tarcocimab & KSI-501

**The Retinal Vascular Diseases
and the Anti-VEGF Market:
Tarcocimab & KSI-501**

There remains valuable open space in the retinal vascular diseases market, despite the availability of approved biologics and clinical trials of new exploratory technologies

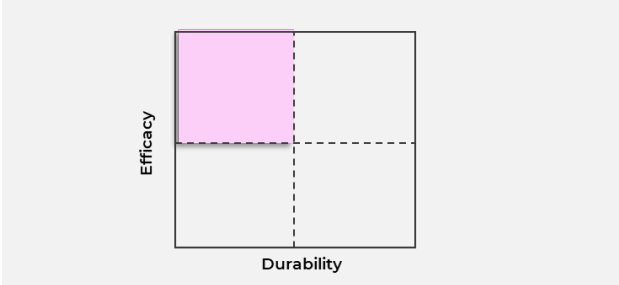
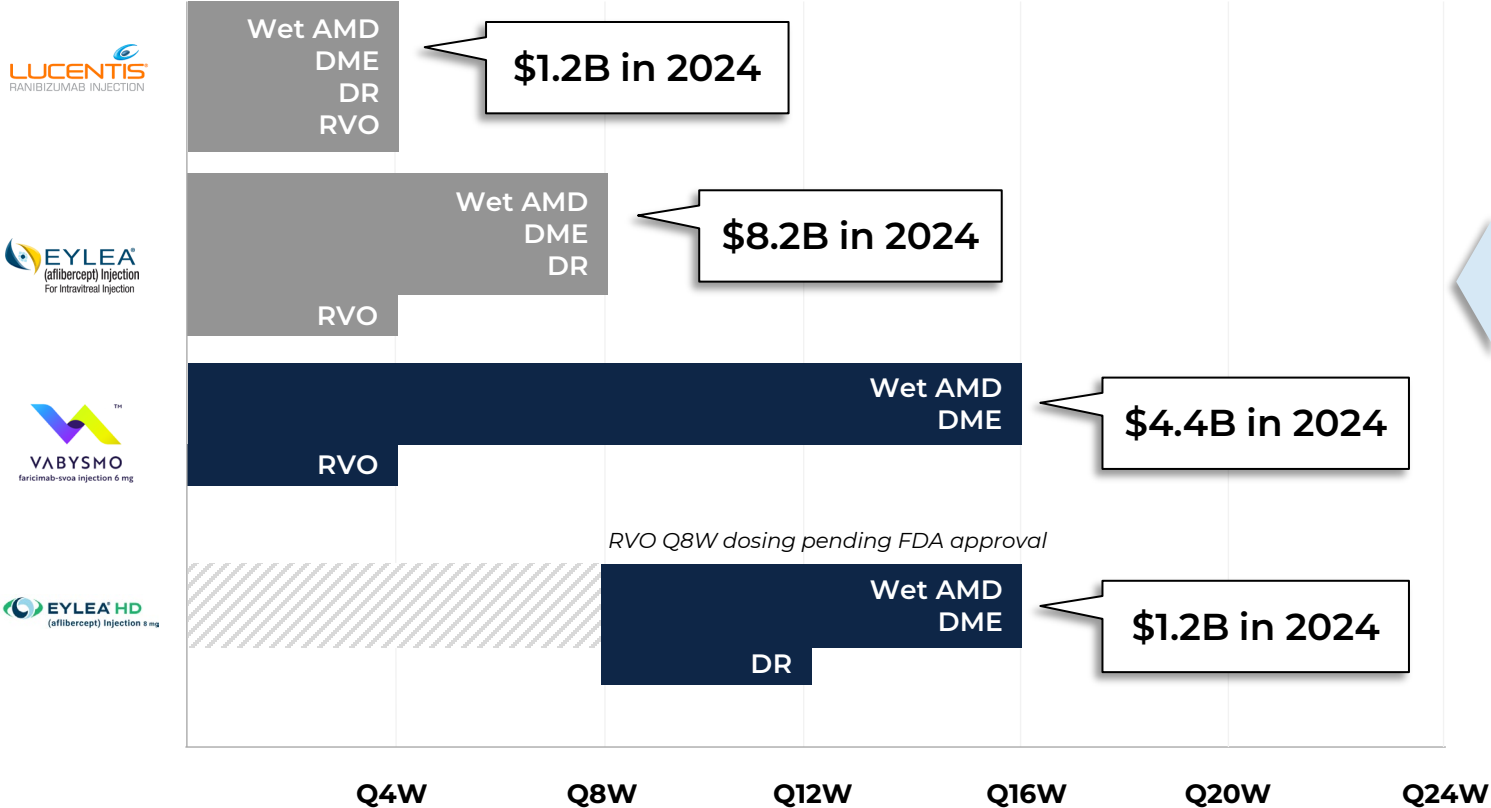


The Gen 1.0 biologics that provide **immediacy** and the Gen 1.5 biologics that provide **immediacy and incremental durability** are meaningful for patients and physicians

Dosing regimen per label for approved intravitreal biologics

Gen 1.0
Good efficacy, limited durability

Gen 1.5
Immediacy
Incremental durability

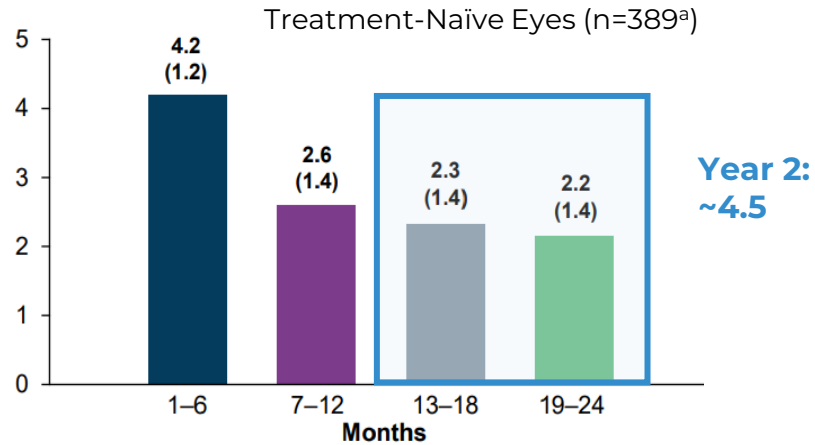


This sustained commercial success is a testament to:

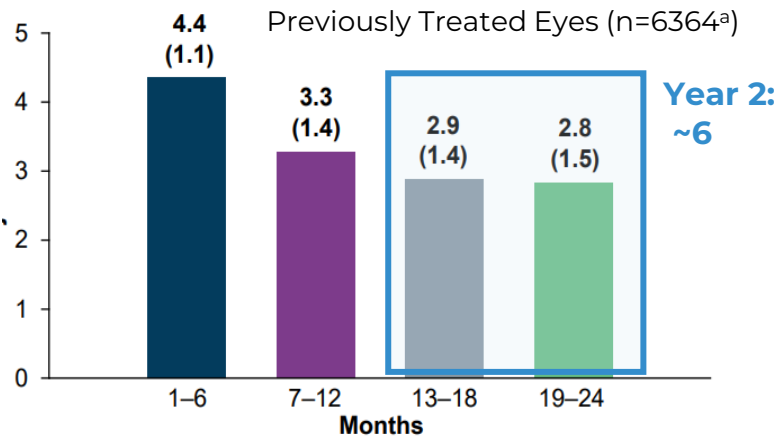
- The **power of the intravitreal biologic** as the mainstay of therapy
- The **unmet need** that remains for patients

Despite their commercial success, real-world data in wet AMD show that most patients are falling short of the durability promise of the Gen 1.5 labels

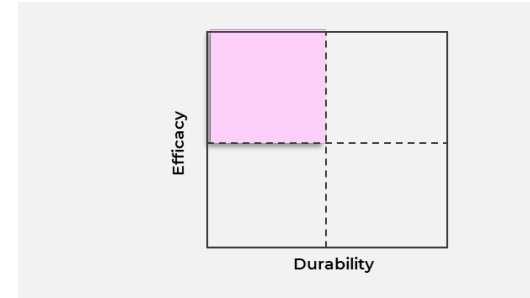
Faricimab injections observed after the first 6 months of treatment through Year 2 in the FARENTINA study²



In Year 2, patients received 4.5 injections which is an average dosing interval of every 11.5 weeks



In Year 2, patients received 6.0 injections which is an average dosing interval of every 8 weeks



Most patients are on a Q8W-Q12W schedule in the real world in Year 2

^a Only eyes with ≥ 1 injection after index and prior to censoring were included.

Technologies being explored in clinical trials, including implants and gene therapies, are engineering for high durability but are lacking immediacy

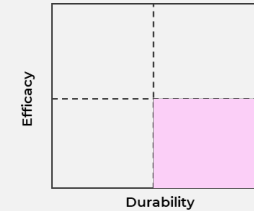
Implants

- Engineering for durability
- Long-term safety unknown

Gene Therapies

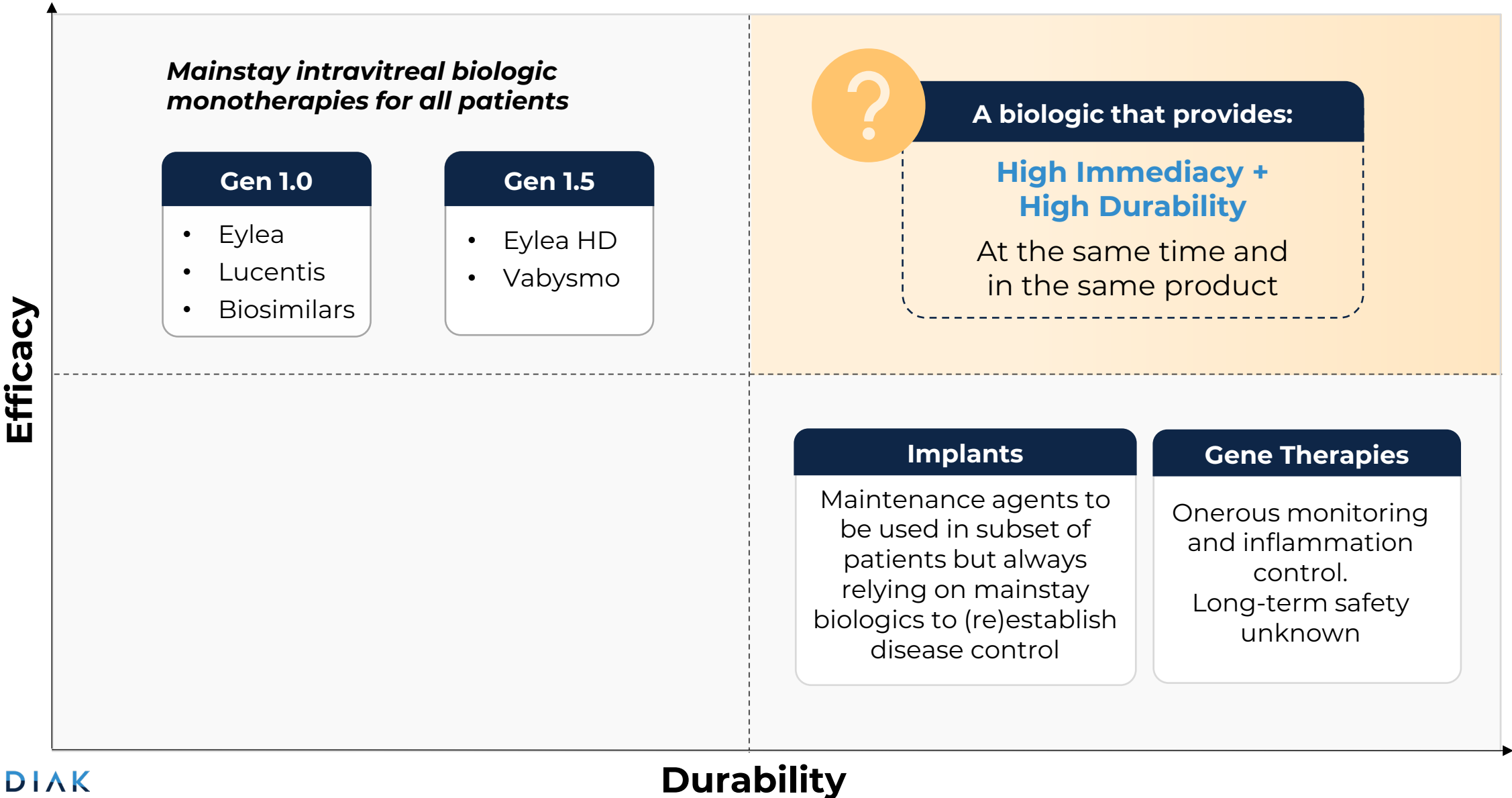
- Engineering for durability
- Onerous monitoring and inflammation control
- Long-term safety unknown

Implants and gene therapies are being tested **on top of mainstay biologics**, which are given during the **loading phase** and then as needed during the **maintenance phase**.



Maintenance agents to be used in subset of patients but always **relying on mainstay biologics to (re)establish disease control**

Therefore, the open space remains. A biologic that provides high immediacy and high durability *at the same time and in the same therapy* has the potential to be a heavy weight in this important \$15+ billion marketplace



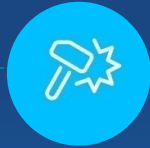
Kodiak's ABC[®] Platform Science in Retina

SCIENCE OF IMMEDIACY and DURABILITY



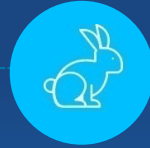
Designed-in Extended Tissue Residence Time

A proprietary phosphorylcholine-based polymer is conjugated to an antibody to increase molecular size which extends ocular half-life



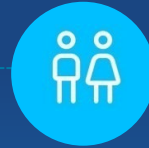
High in-Vitro Potency

Both unconjugated protein and conjugated protein demonstrate high binding affinity and potency *in vitro*



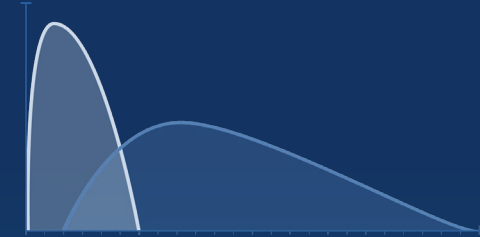
Extended Ocular Half-Life in Animals

3x the ocular $t_{1/2}$ of approved intravitreal biologics when measured in rabbits following an intravitreal injection



Extended Ocular Half-Life in Humans

3x the ocular $t_{1/2}$ of faricimab when measured from aqueous humor in patients following an intravitreal injection



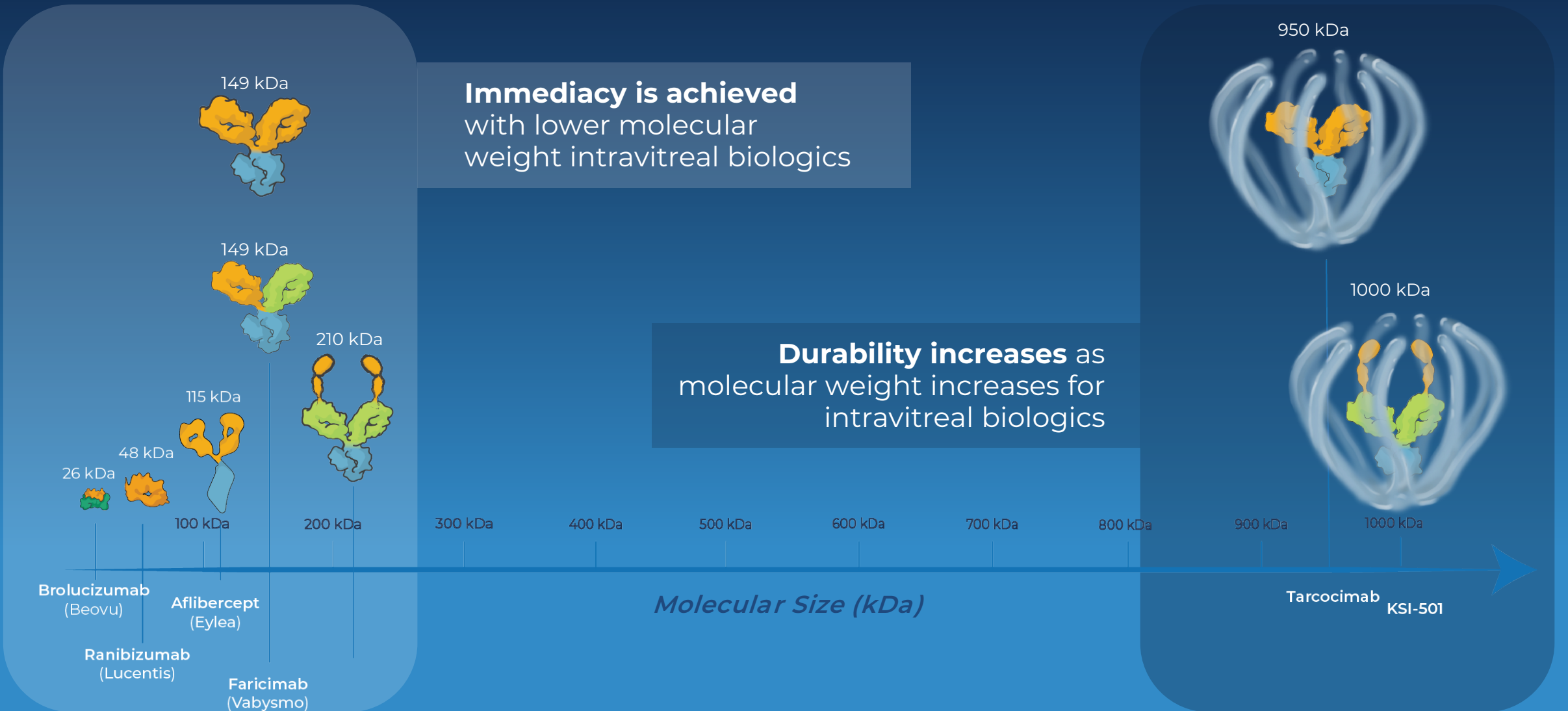
Powerful Immediacy via Unconjugated Antibody

The unconjugated protein delivers a strong "pulse" of anti-VEGF inhibition during the loading phase, or to recapture control of the disease in patients whose disease has reactivated

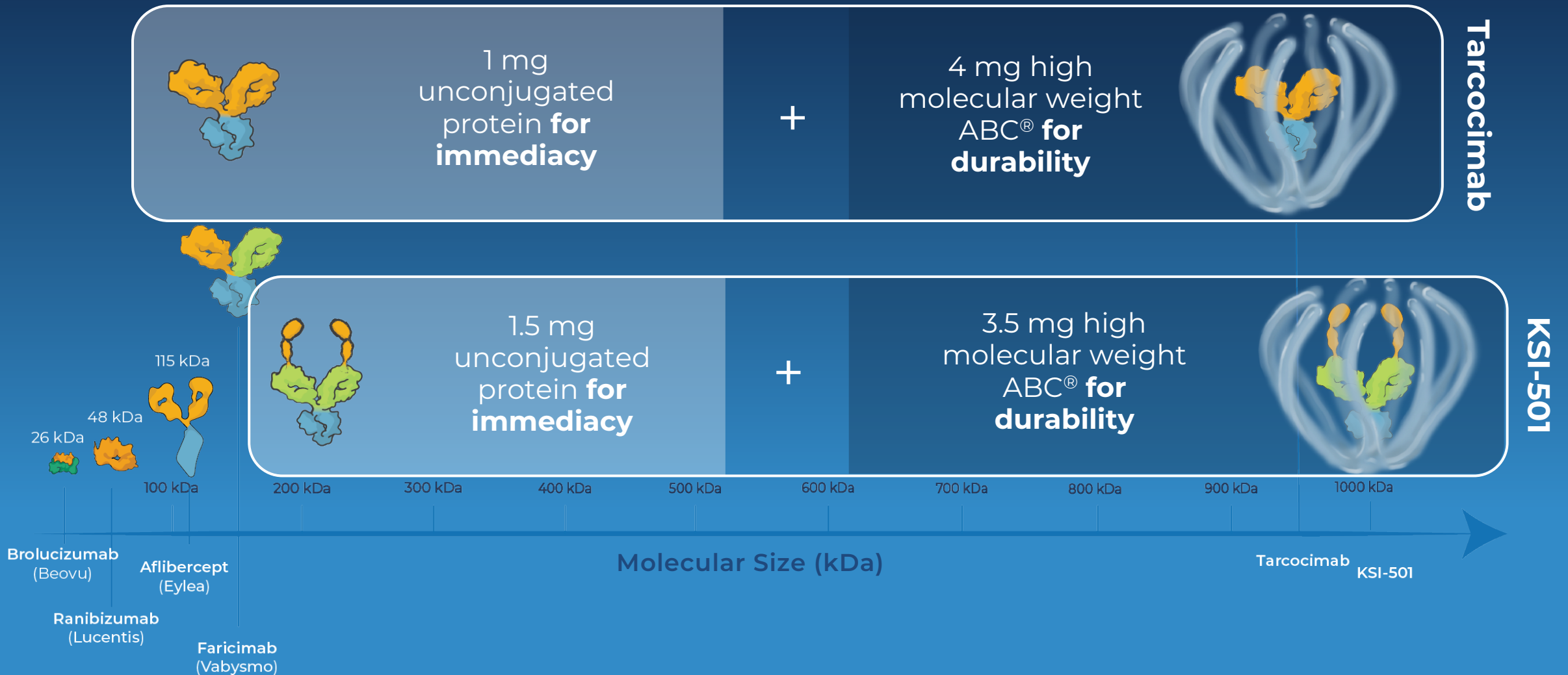
Extended Clinical Durability via Conjugated Antibody

The conjugated protein maintains the signature durability as seen in Kodiak's pivotal studies to date

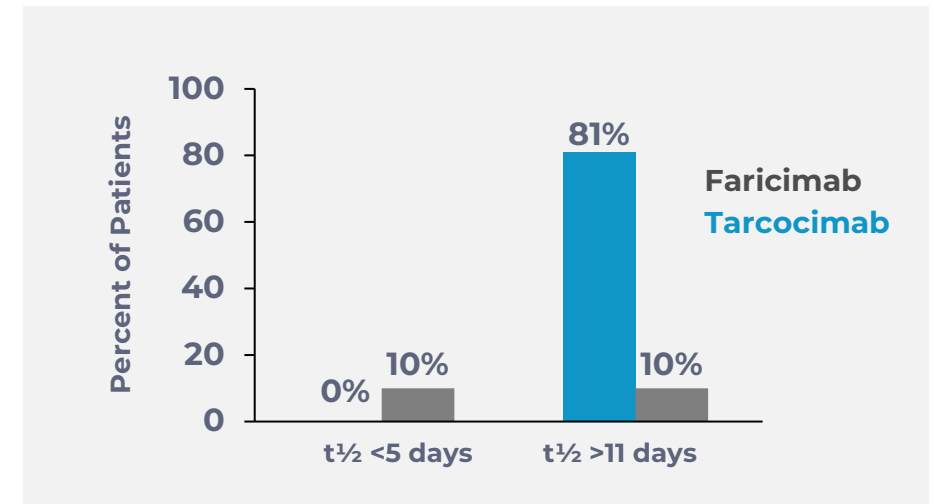
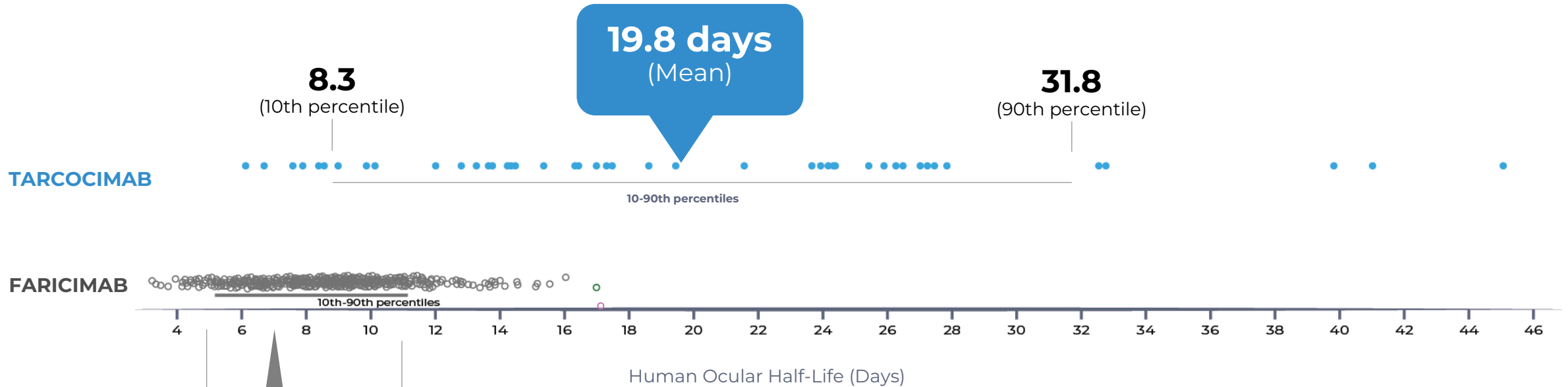
Tarcocimab and KSI-501 bring the best of both worlds – with a science of high immediacy and high durability at the same time in a single biologic



Tarcocimab and KSI-501 bring the best of both worlds – with a science of high immediacy and high durability at the same time in a single biologic

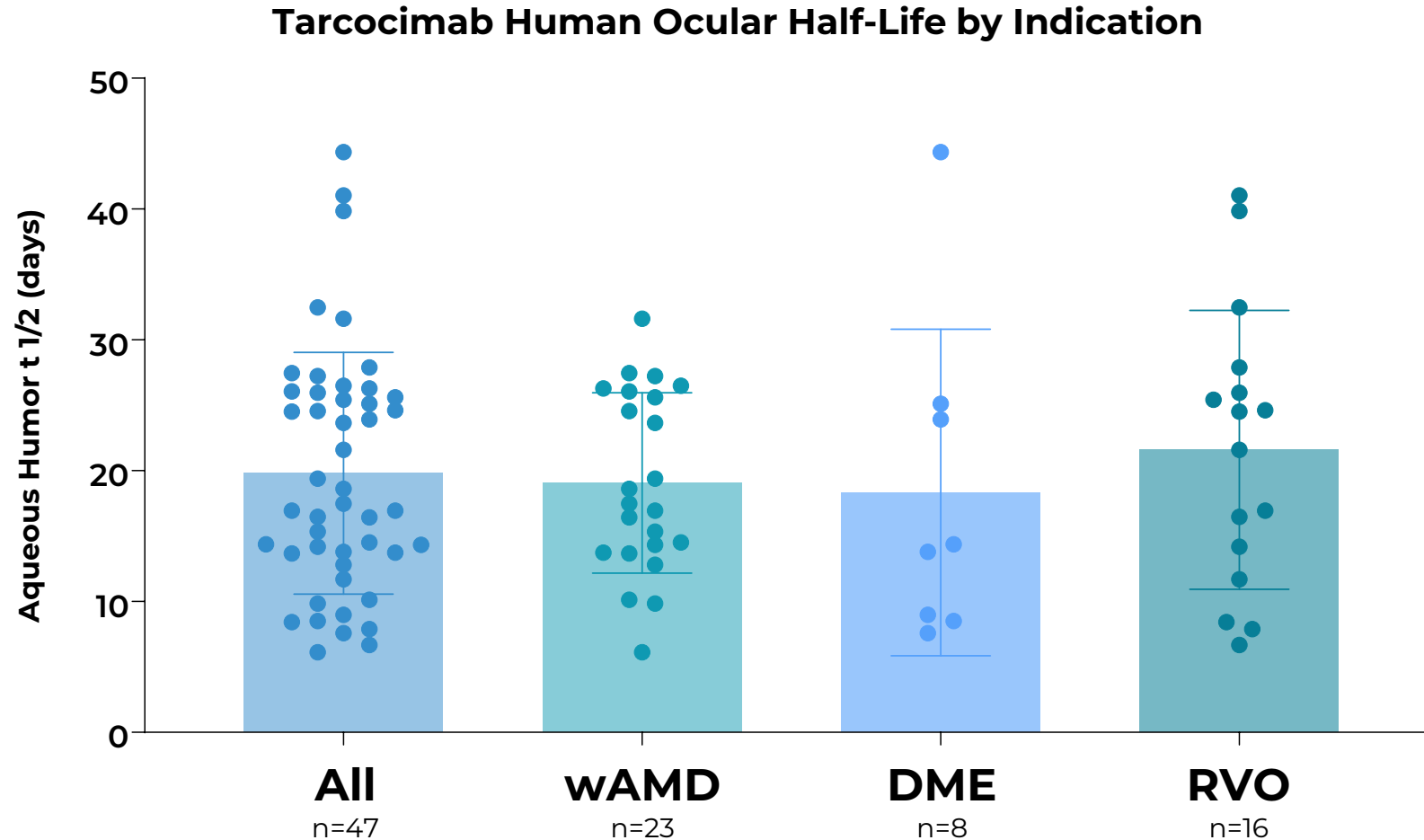


Tarcocimab has a mean ocular half-life in humans of 20 days, which is 3-fold longer than faricimab



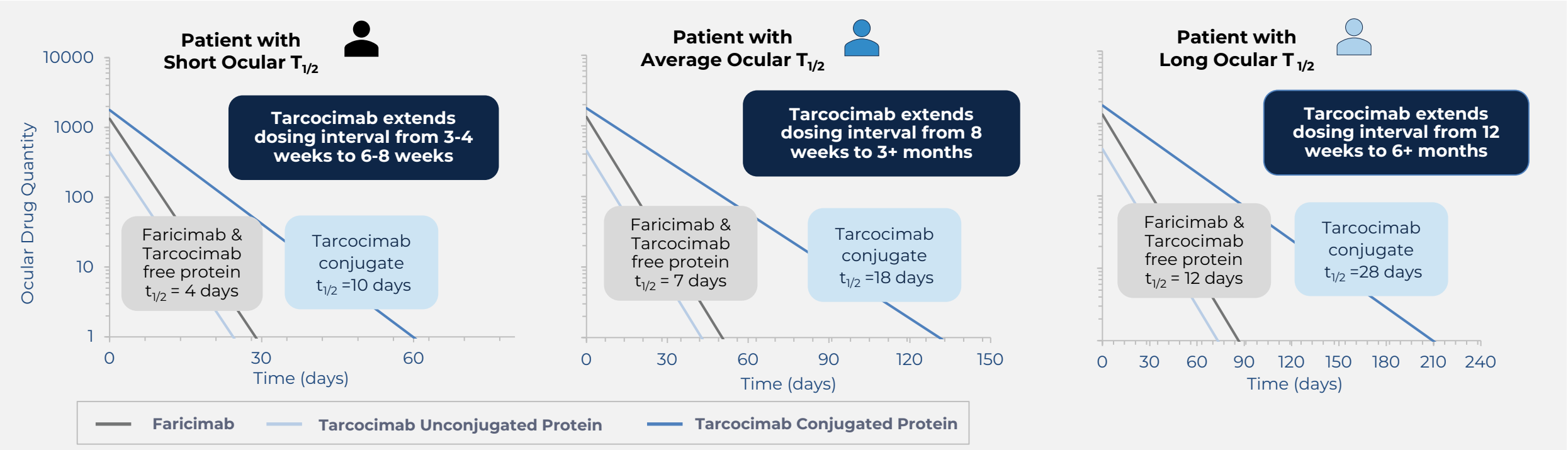
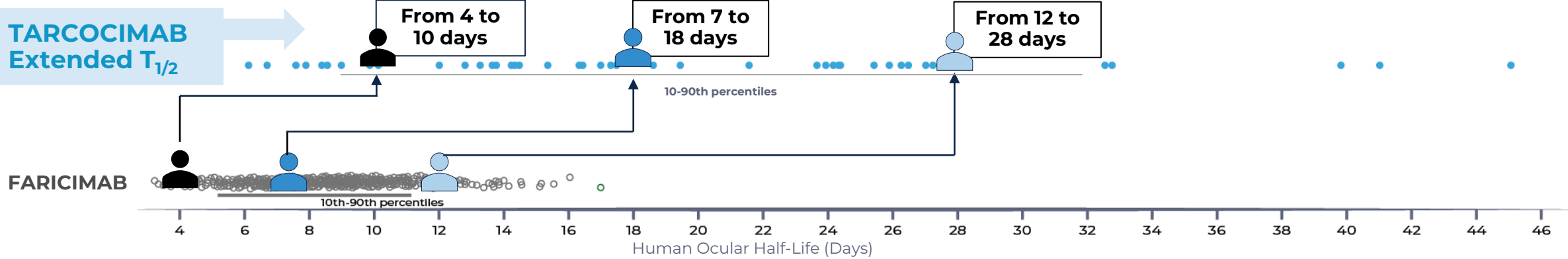
Each dot represents the ocular half-life from one individual patient. Blue dots are tarcocimab from the Phase 1b study of tarcocimab in patients with wet AMD, DME and RVO. Gray dots are faricimab from Genentech, Inc. PK and ER of faricimab, Report # 1105763

Tarcocimab demonstrated consistent 20-day ocular half-life across wet AMD, DME and RVO patients



Height of the box represents the mean; error bars represent standard deviation.

Modeling suggests tarcocimab may provide a similar immediacy of efficacy while meaningfully extending dosing intervals for all patient types



ABC[®] Enabled Mainstay Biologics

Tarcocimab

- Strong Immediacy
- Industry-leading Durability

KSI-501

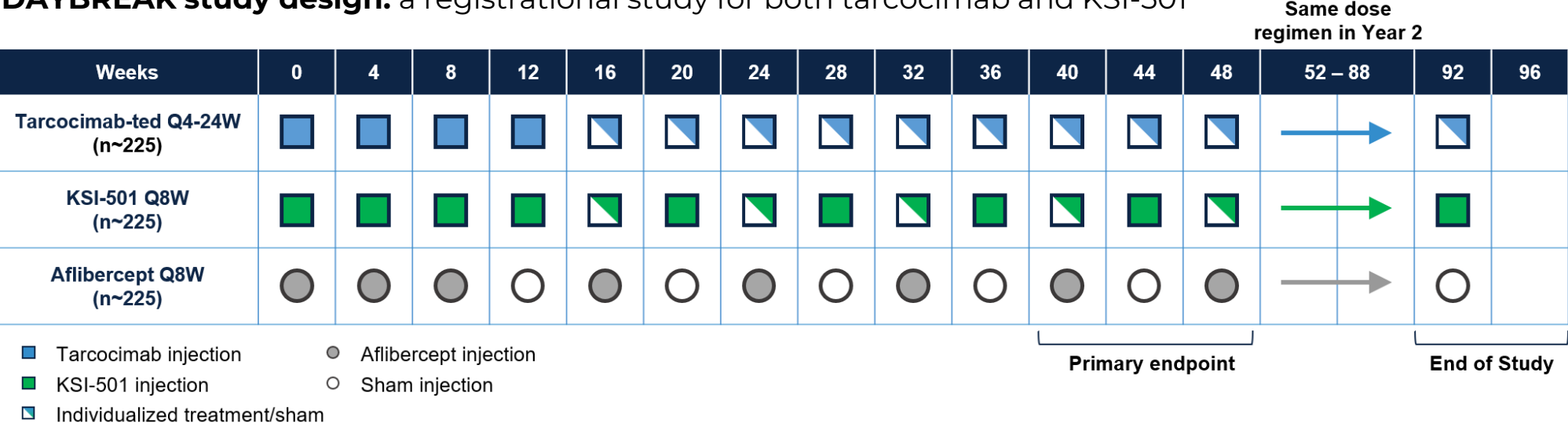
- Better Efficacy
- Strong Immediacy
- Industry-leading Durability

Kodiak's ongoing and planned clinical studies have a high probability of success to support a tarcocimab BLA in 2026 and a potential KSI-501 BLA in 2027 while supporting complementary and potentially differentiated commercial profiles

	Indication	Phase 3 Study		Primary Endpoint	6-Month Durability	Results / Progress
Tarcocimab	RVO	BEACON	Completed	✓	✓	• Doubled treatment interval (Q8W) at PE (month 6) and ~50% of tarcocimab treated patients on 6-month dosing at Year 1
	DR	GLOW1		✓	✓	• 100% of patients on 6-month dosing at Year 1
	Wet AMD	DAYLIGHT		✓	Not Applicable	• Monthly study of tarcocimab demonstrated favorable safety and non-inferior efficacy at Year 1
	DR	GLOW2	Ongoing	Superiority	✓	• Topline data on track for 1Q 2026 • Design mirrors successful GLOW1 study
	Wet AMD	DAYBREAK		Non-Inferiority	✓	• Expecting to close screening end of August • Topline data expected mid 2026
KSI-501	Wet AMD	DAYBREAK	Ongoing	Non-Inferiority	Not Applicable	• Expecting to close screening end of August • Topline data expected mid 2026
	Wet AMD	2nd Pivotal	Planned	TBD	TBD	• In planning • Exploring start in 4Q 2025 / 1Q 2026 • Targeting BLA mid-2027

Tarcocimab and KSI-501 in wet AMD: DAYBREAK study explores in a definitive manner immediacy through the loading phase and real-world durability and, in the case of KSI-501, the potential for better efficacy

DAYBREAK study design: a registrational study for both tarcocimab and KSI-501



DAYBREAK uses an AI-based tool to precisely measure fluid in the eye so that treatment is optimized for each patient

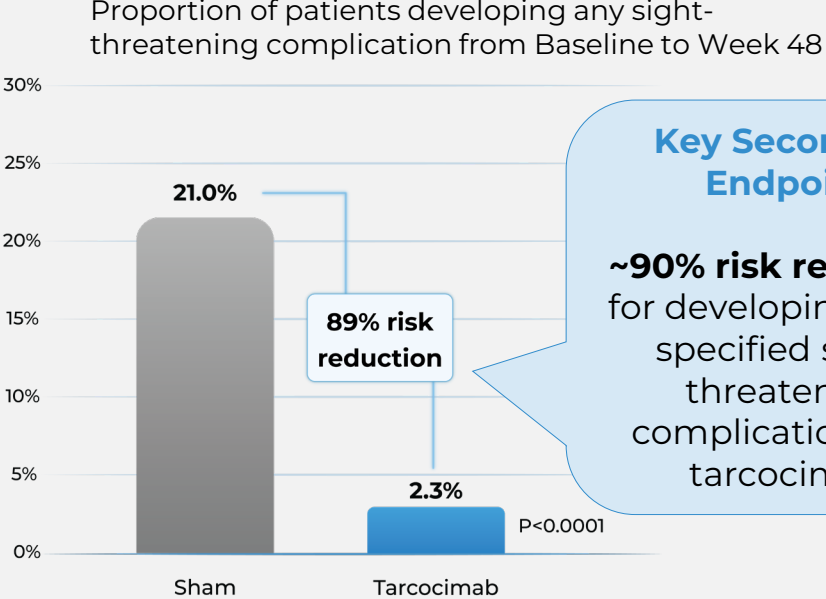
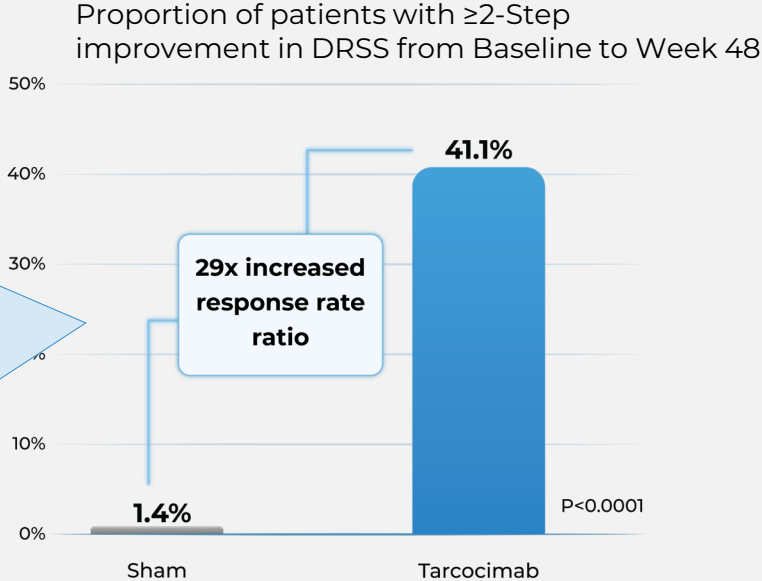
- **In high need patients,** treats until dry, enables monthly dosing and detects disease reactivations earlier.
- **In long durability patients,** allows patients without active disease to safely to 6-month dosing.

We are expecting to close screenings for DAYBREAK by the end of August

Tarcocimab in DR: the GLOW2 study in DR features a similar study design as the successful GLOW1 study, with the benefit of an additional 3rd initiating dose

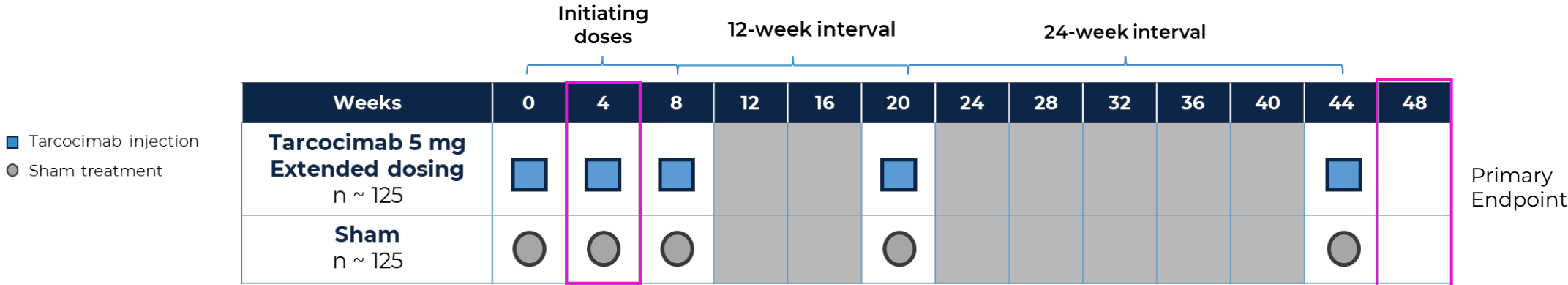
GLOW1 study results

Primary Endpoint
Tarcocimab demonstrated **superiority** in ≥ 2 -step and ≥ 3 -step improvement in DRSS

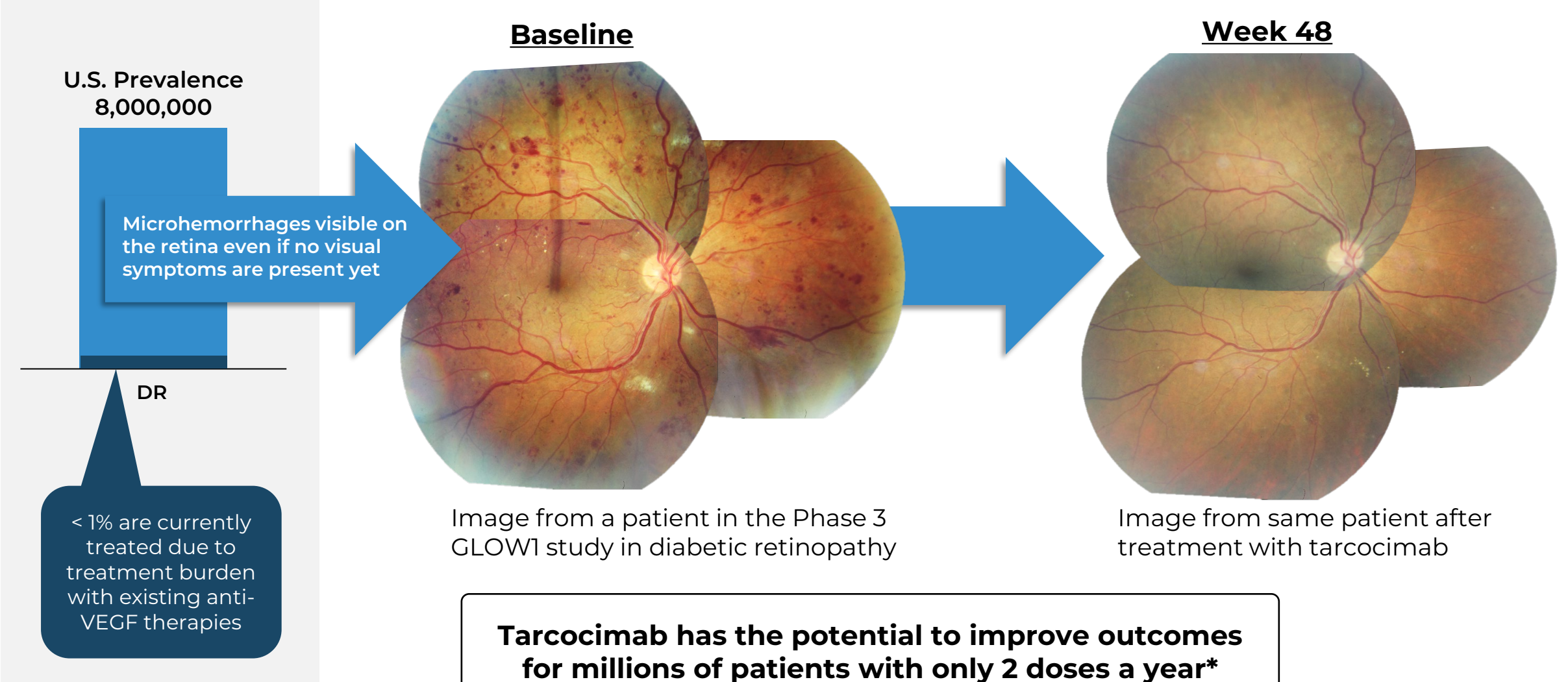


Key Secondary Endpoint
~90% risk reduction for developing a pre-specified sight-threatening complication with tarcocimab

GLOW2 study design



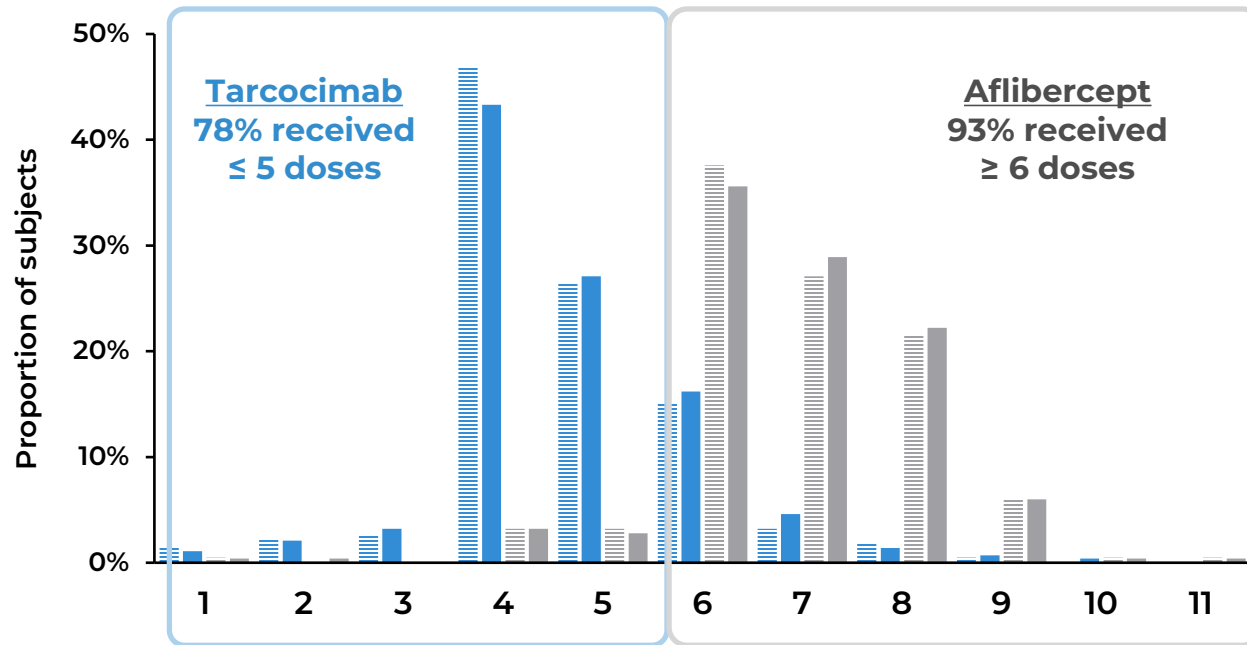
Tarcocimab in DR: the GLOW1 study shows that tarcocimab opens the door to earlier treatment with only 2 doses a year – a transformative potential for millions of patients



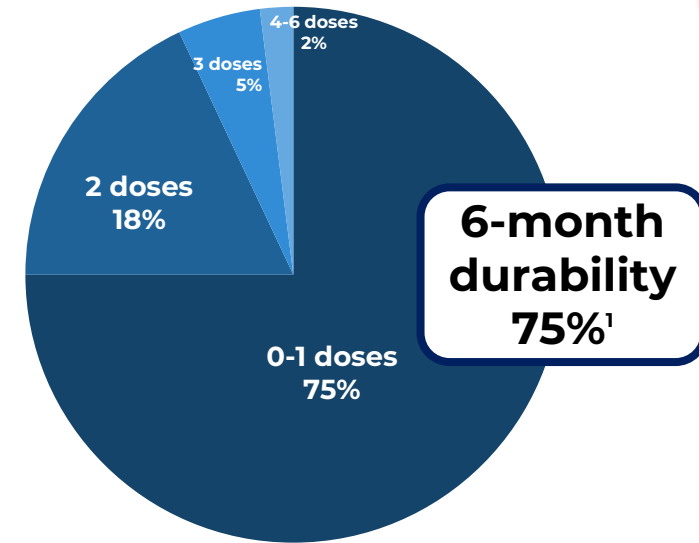
* after 3 initiating doses.

Tarcocimab is uniquely poised to address the core unmet need in RVO with high efficacy and best-in-class durability

Number of injections through Year 1



Tarcocimab
Number of doses
in the second 6 months of Year 1



Quadrant of core unmet need

■ Tarcocimab BRVO ■ Tarcocimab All RVO ■ Aflibercept BRVO ■ Aflibercept All RVO

RVO market size: ~\$3B

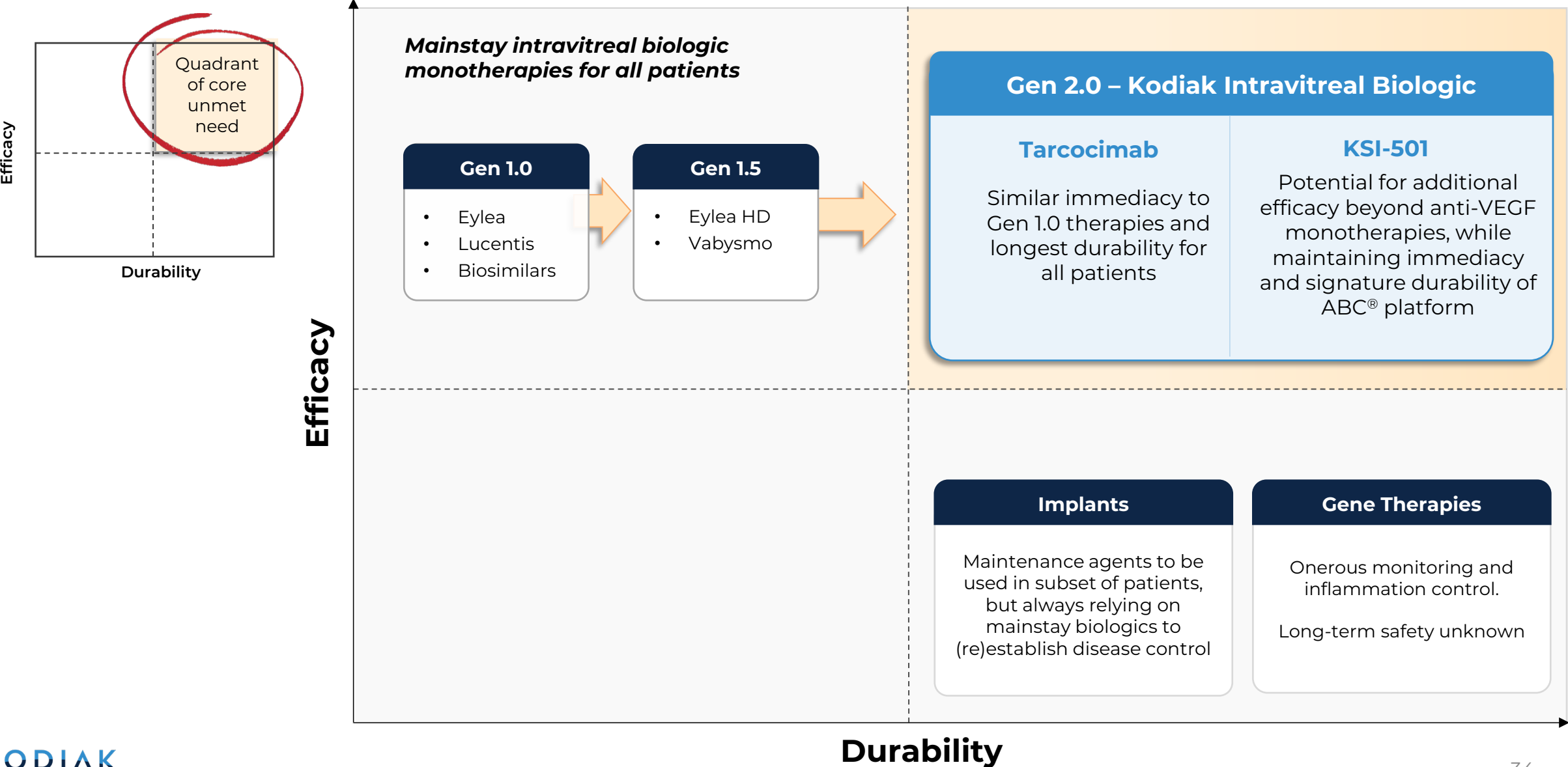
Gen 1.5 agents have failed to address the key unmet need for high efficacy with better durability in RVO. With built-in durability, tarcocimab delivered 6-month durability in 75% of RVO patients in BEACON and is uniquely poised to address key unmet needs for RVO patients

RVO: retinal vein occlusion; BRVO: branched retinal vein occlusion;

1. Durability interval calculated based on patients that received no injections (46%) or 1 injection (29%) over the second 6 months of Year 1.

2. RVO market size from imarc: RVO Market Size, Epidemiology, In-Market drug sales, pipeline therapies, and Regional Outlook

Revisiting the core unmet need: based on a science of high immediacy and high durability, tarcocimab and KSI-501 are poised to fill the 'golden quadrant'



Macular Edema
Secondary to
Inflammation
(MESI)

KSI-101



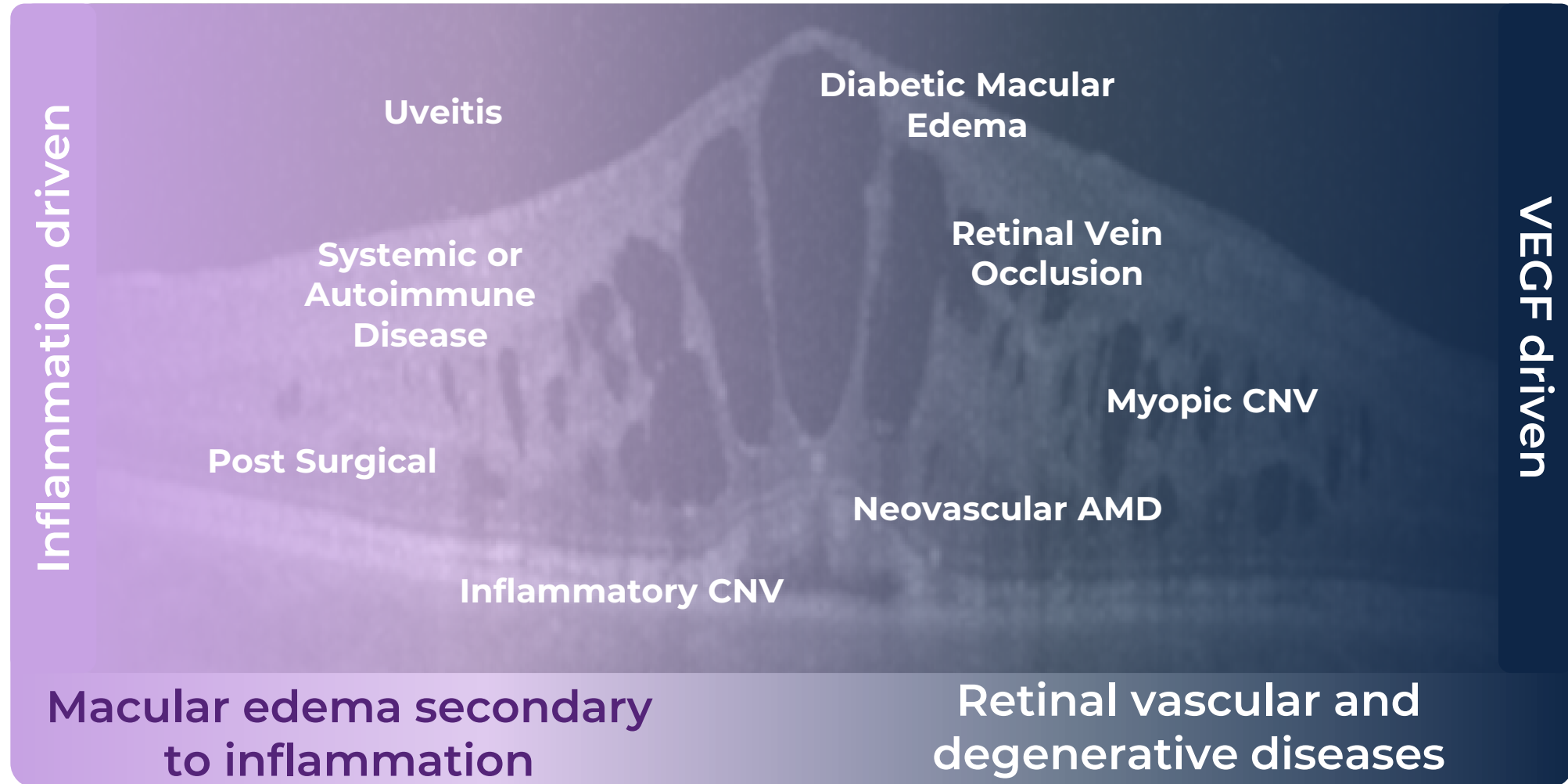
Sumit Sharma
MD

Macular Edema Secondary to Inflammation

What is MESI?

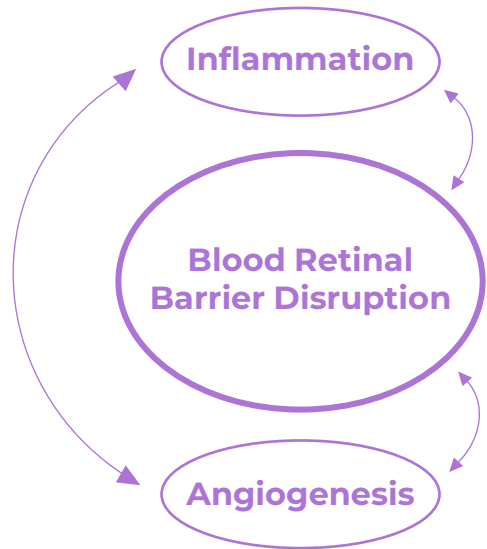
Macular edema, the common clinical presentation of a wide spectrum of diseases, can be caused by inflammation and/or by VEGF over-expression

Macular Edema Spectrum of Diseases

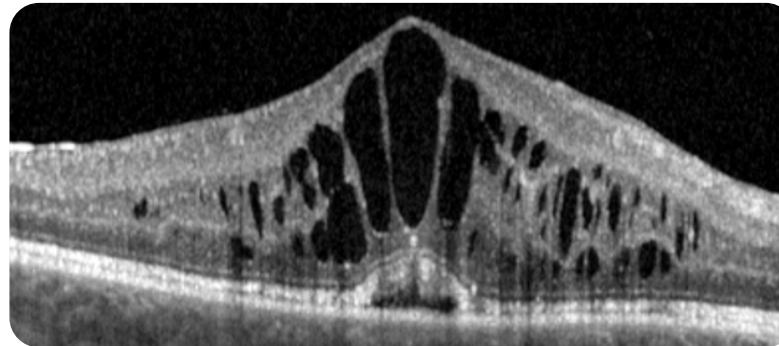


What is macular edema secondary to inflammation (MESI)?

Common Pathophysiology

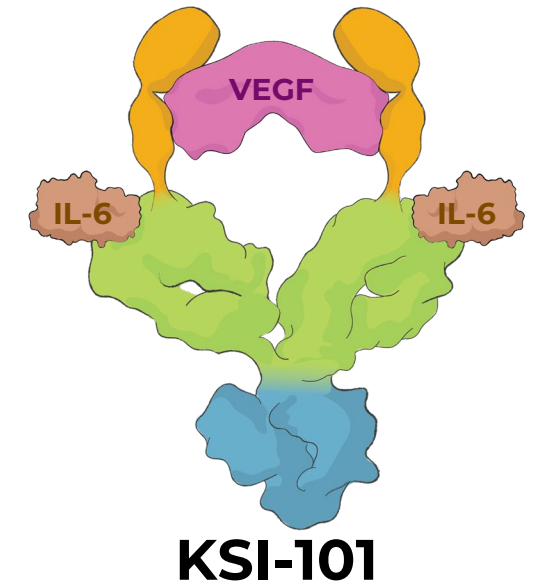


Common Clinical Presentation



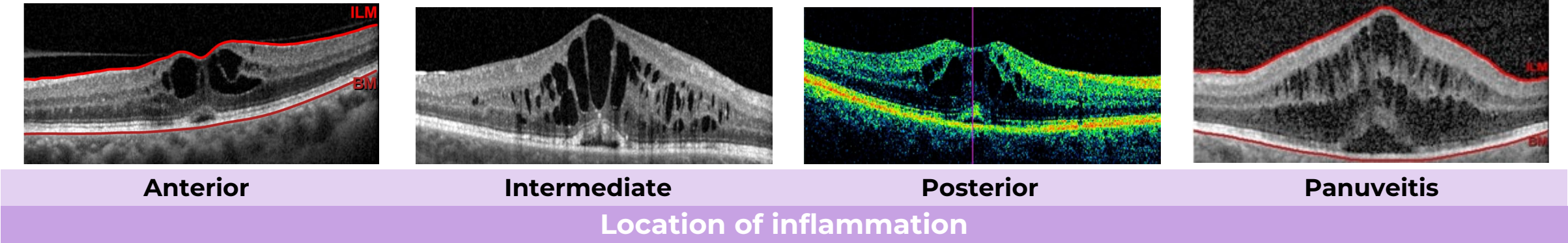
Macular Edema with visual impairment

Potential common therapy

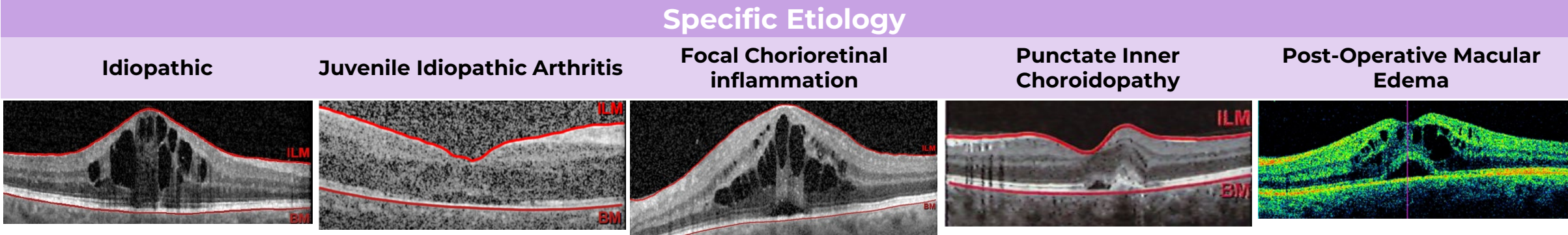


MESI is a heterogenous group of diseases that clinically present with macular edema and visual impairment, which are caused by a common pathophysiology: inflammation and blood retinal barrier disruption

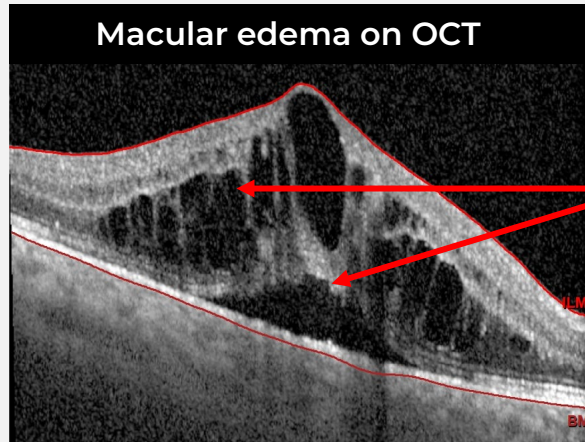
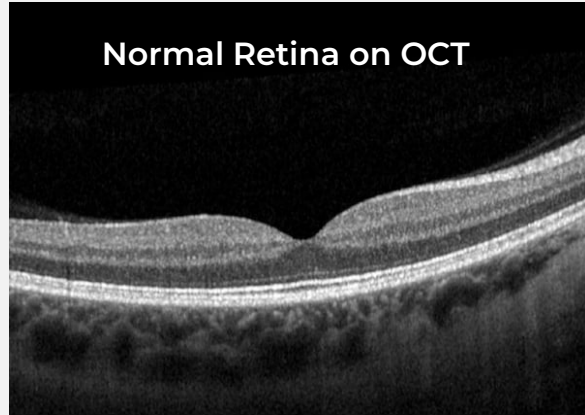
MESI comprises a heterogenous group of diseases with a common, readily identifiable clinical presentation: macular edema with visual impairment



Irrespective of the anatomical location of the inflammation or the specific etiology, the clinical presentation is the same: macular edema



Macular edema is the leading cause of vision loss among patients with ocular inflammation



Fluid that leaked into the retina causing macular edema

- **Noninfectious MESI represents a set of serious ocular inflammatory conditions that cause significant vision loss.**
- **Ocular inflammation is the 4th leading cause of vision loss among working aged adults in the developed world¹**
- **Approximately 1/3 of patients with ocular inflammation develop macular edema in the U.S.²**
- **Symptoms at diagnosis typically include distorted central vision, vitreous floaters, reduced visual acuity, and decreased color and contrast sensitivity**
- **MESI leads to photoreceptor damage and can result in permanent loss of visual acuity**



Sumit Sharma
MD

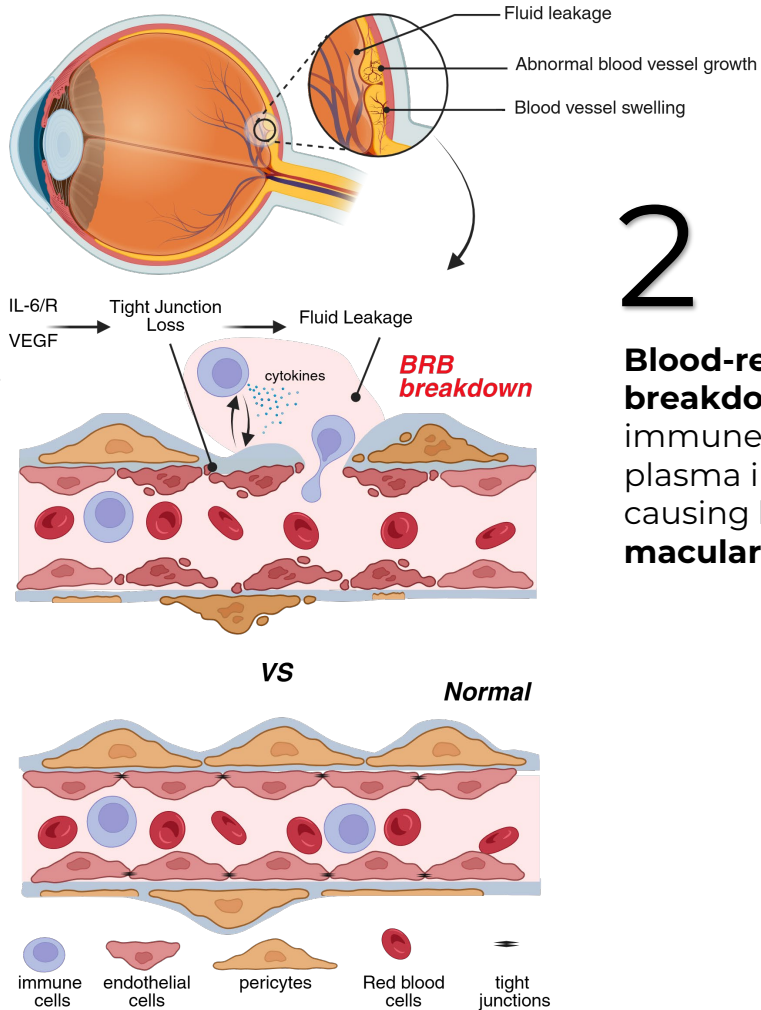
Macular Edema Secondary to Inflammation

What causes MESI?

Dysregulation of the immune system causes a series of insults to the blood-ocular barrier, leading to breakdown of the barrier and release of inflammatory mediators

1

Inflammatory insults (e.g., autoimmune disease) can trigger intraocular immune responses and **disrupt the blood-retinal barrier**

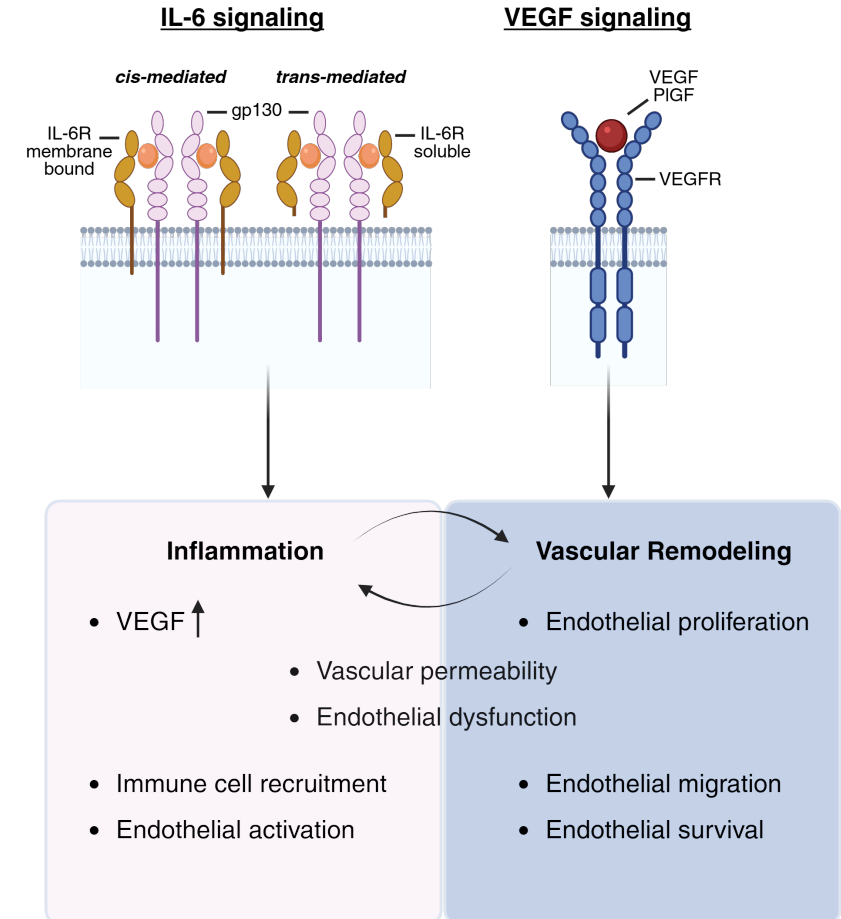


2

Blood-retinal barrier breakdown allows immune cells and plasma into the retina, causing **leakage and macular edema**

3

IL-6 and VEGF are co-induced: VEGF promotes vascular leak and neovascularization, while IL-6 sustains inflammation and upregulates VEGF

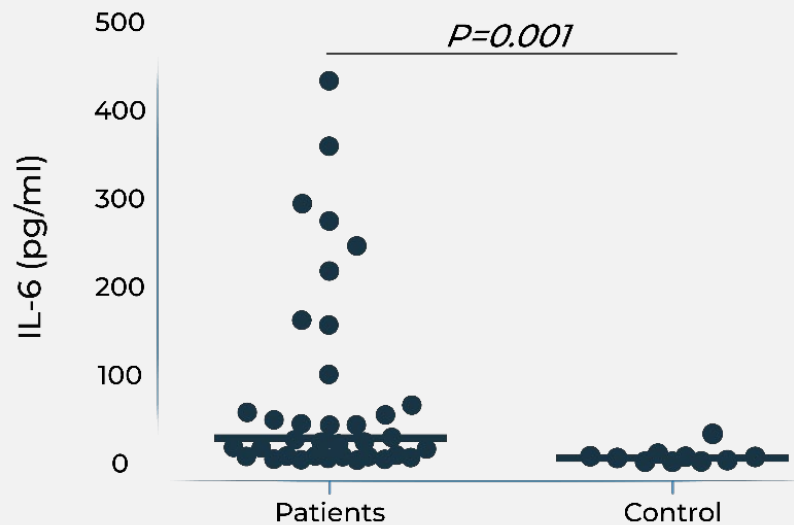


Both IL-6 and VEGF levels are elevated in patients who have ocular inflammation and macular edema

IL-6

- IL-6 levels are elevated in patients with ocular inflammation and further elevated in patients with inflammatory macular edema

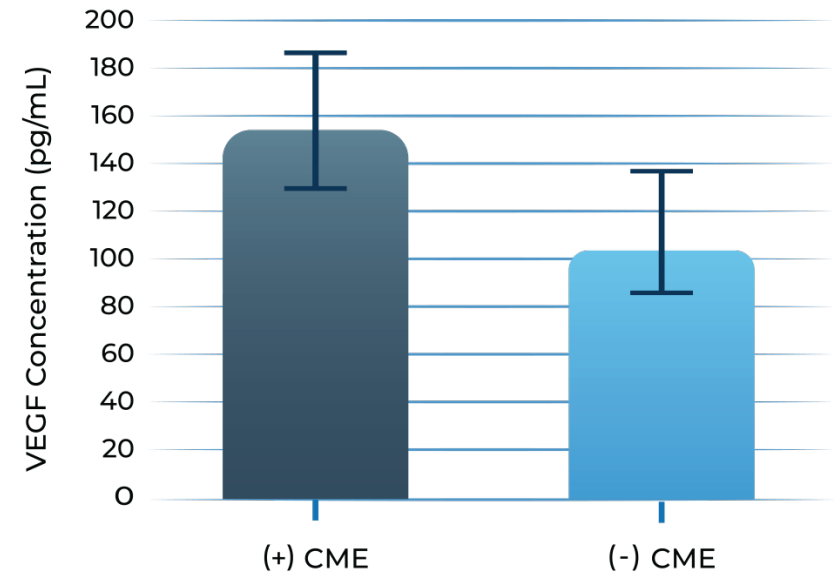
Aqueous humor IL-6 levels in patients with intermediate uveitis¹



VEGF

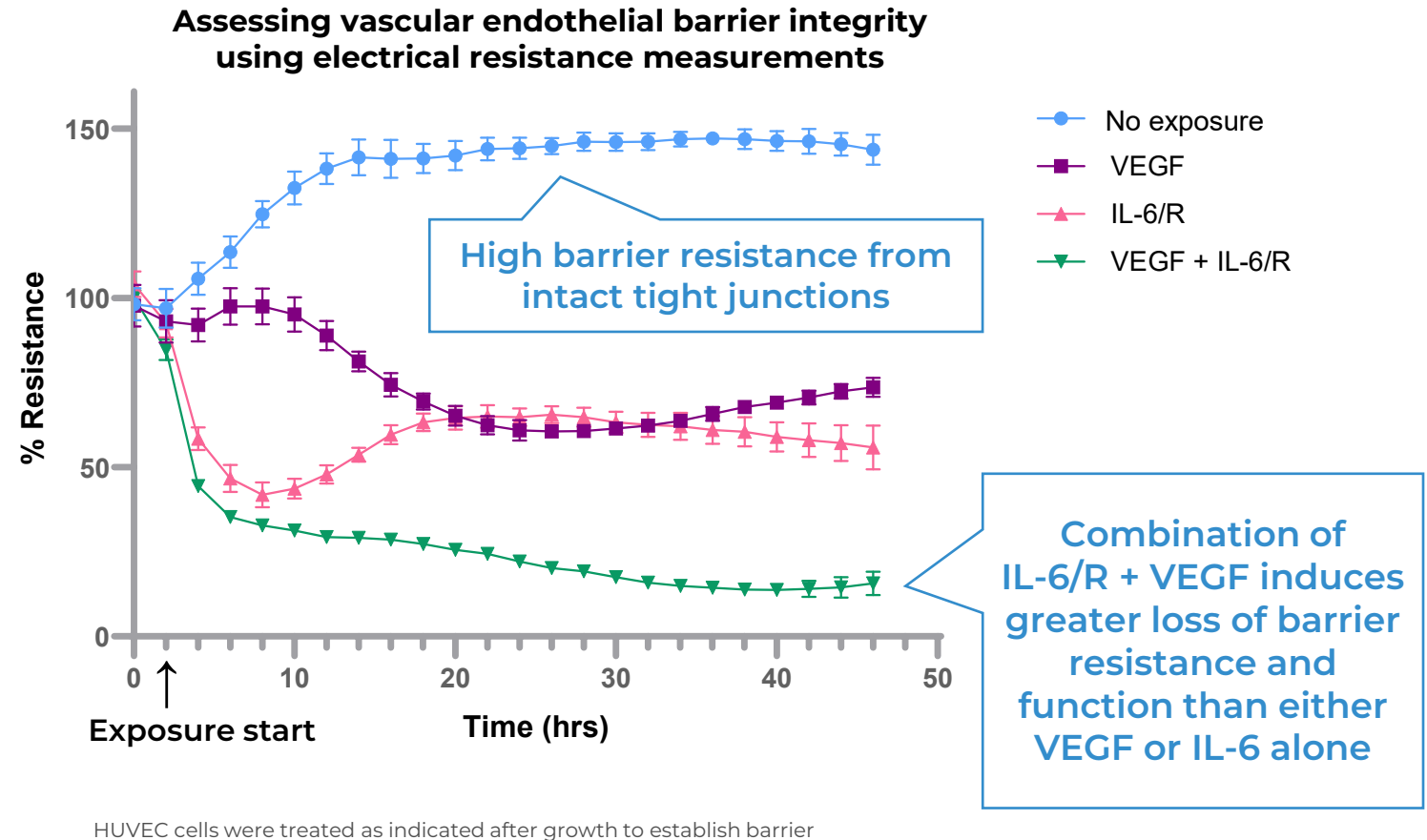
- Persistent inflammation triggers VEGF upregulation. VEGF levels are found to be elevated in eyes with inflammatory macular edema

VEGF levels in aqueous humor of uveitis patients with macular edema vs without macular edema²



IL-6 and VEGF each disrupt the blood-retinal barrier independently. When combined, they cause an even greater loss of barrier integrity

- Ocular inflammation damages tight junctions between endothelial cells, compromising the integrity of the blood retina barrier. This increases vascular permeability
- The integrity of the blood-retinal barrier can be measured by barrier resistance
- Exposure to both IL-6/R and VEGF **additively induces greater loss in barrier function**, as measured by decreased barrier resistance, than either IL-6 or VEGF alone, in human umbilical vein endothelial cells (HUVEC)





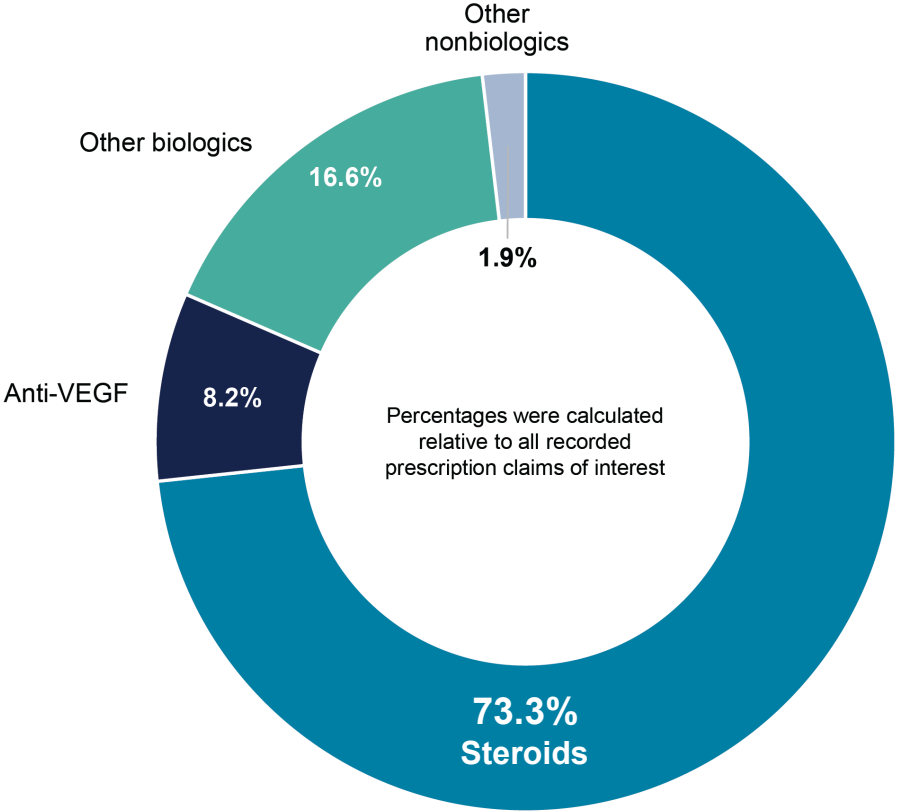
Sumit Sharma
MD

Macular Edema Secondary to Inflammation

**What is the unmet
need?**

Corticosteroids are used most often for MESI, but carry significant safety risks and efficacy can be limited

Most frequently prescribed medications in patients with macular edema due to noninfectious uveitis, across any line of therapy¹



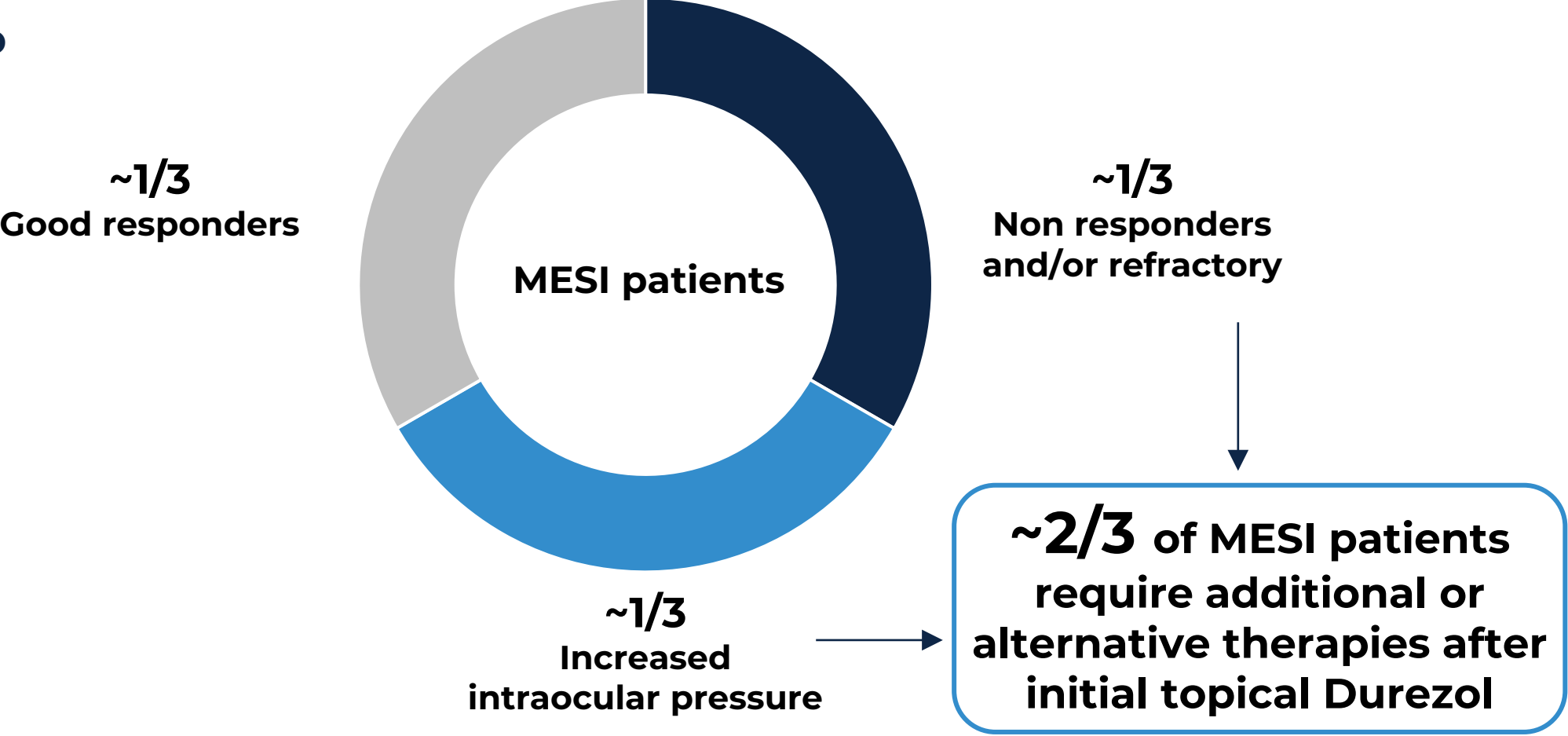
- Steroids were the most common medication class and remain the standard of care¹
- XIPERE® (suprachoroidal triamcinolone acetonide) is the only approved local ocular treatment in the U.S.
- **Approximately 30-40% of patients do not fully respond to intraocular steroids^{2,3}**
- Intraocular steroids are avoided in the pediatric population and **used with caution in adults due to high risk of permanent glaucoma damage and cataract formation**

My clinical experience: while topical steroids are the first line of therapy for MESI, only a third of patients achieve the treatment goal without the negative side effects



Sumit Sharma, MD

Response to topical steroid treatment (diflupredprednate, Durezol) as first line of treatment in MESI patients



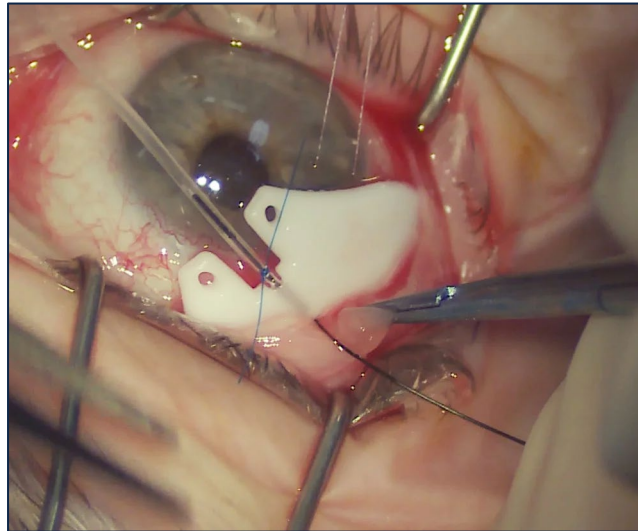
Adverse effects from today's treatments for MESI often require multiple surgical interventions, but surgeries are complicated in MESI patients and require complete control of inflammation before, during and after each procedure

Cataract repair in MESI patients is complex and can be contraindicated, leading to permanent vision loss



- Even with good inflammation control, surgeries can trigger intractable inflammation, often leaving the eyes with no intraocular lens implant and/or suboptimal results ((synechiae/scarring)

Visual damage from glaucoma is irreversible and can lead to legal blindness



- Concerns about permanent IOP elevation limit steroid use and dose
- Supplemental topical drops to control elevated IOP are often insufficient, requiring invasive glaucoma surgeries
- **Once the optic nerve is damaged due to glaucoma (high eye pressure), the visual loss is irreversible**

RETISERT® (fluocinolone acetonide intravitreal implant) label:

- **60% of patients will require chronic IOP lowering medications** to control intraocular pressure
- **37% will require filtering procedures** to control intraocular pressure
- Within an average post-implantation period of approximately 2 years, **nearly all phakic eyes are expected to develop cataracts and require cataract surgery**

RETISERT® (fluocinolone acetonide intravitreal implant)
Prescribing Information.

Patient journey: steroids induced glaucoma with recurrent MESI over the course of approximately 2 years

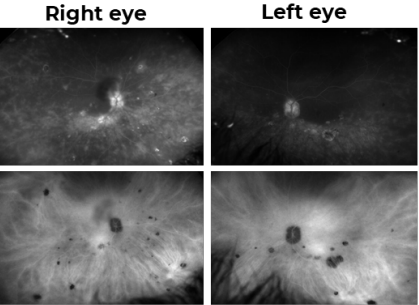
 Patient presented to uveitis specialist

1

Patient presented in August 2023 with a 12-year history of **panuveitis of both eyes** and **multiple failed treatments**



Minimum macular edema initially




- Failed treatments**
- Weekly adalimumab
 - Methotrexate
 - Cellcept
 - Azathioprine
 - Oral steroids
 - Difluprednate eyedrops

2

Developed worsening of chorioretinal lesions and **macular edema**

Intraocular pressure (IOP) spikes to 40s with any steroids (topical eyedrops and intravitreal)

Referred to a glaucoma specialist


 **Surgery #1:** A combined cataract surgery and glaucoma surgery (OMNI canaloplasty) of the right eye in Jan 2024

IOP continue to rise despite surgery

3

Worsening **macular edema** with taper of **difluprednate eyedrops**

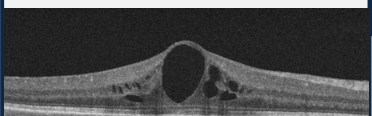
Referred to a rheumatologist

 For alternate **immunomodulatory therapy (IMT)**

Attempted authorization for tocilizumab but insurance denied twice. Unable to get authorization for infliximab either


4

Trial of bromfenac drops with initial improvement then worsening of **macular edema**



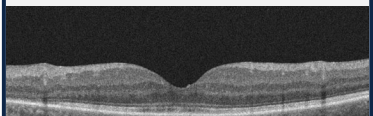
Place back on difluprednate drops QID with spike of IOP to 38

Referred to a glaucoma specialist

 **Surgery #2:** **Glaucoma tube shunt surgery** of the right eye in May 2025

IOP now stable

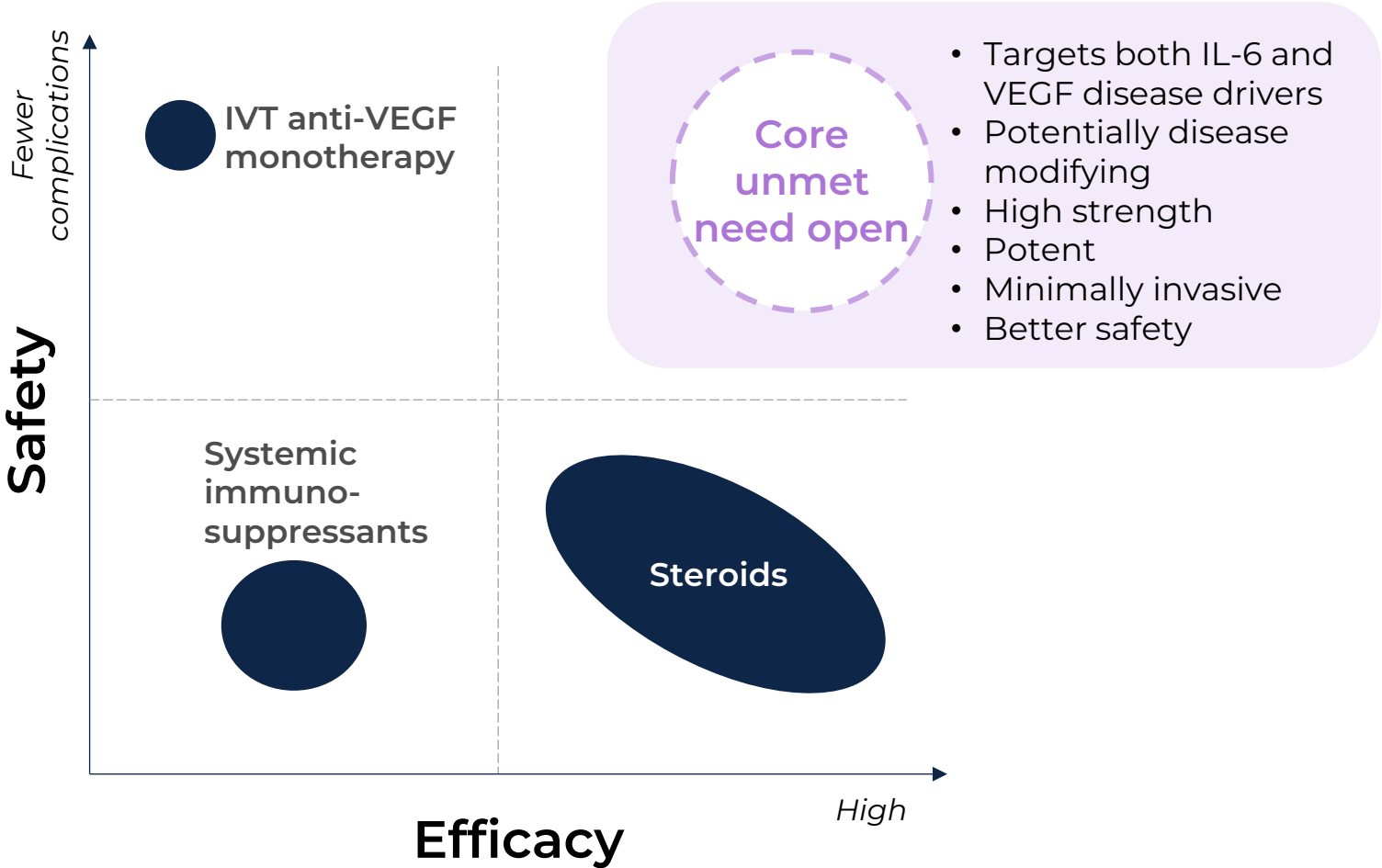
IOP stable and macular edema now resolved after **fluocinolone intravitreal injections**



Will evaluate further need for IMT next visit

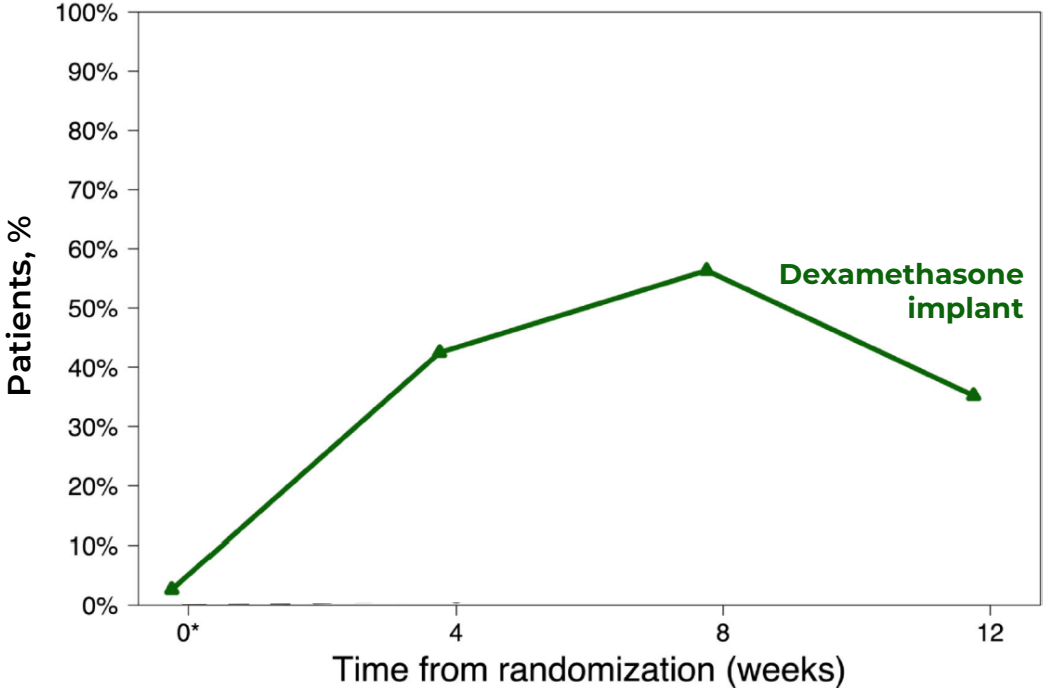
There is a core unmet need in MESI for a potent, high-strength, locally administered and safe therapy

Illustrative



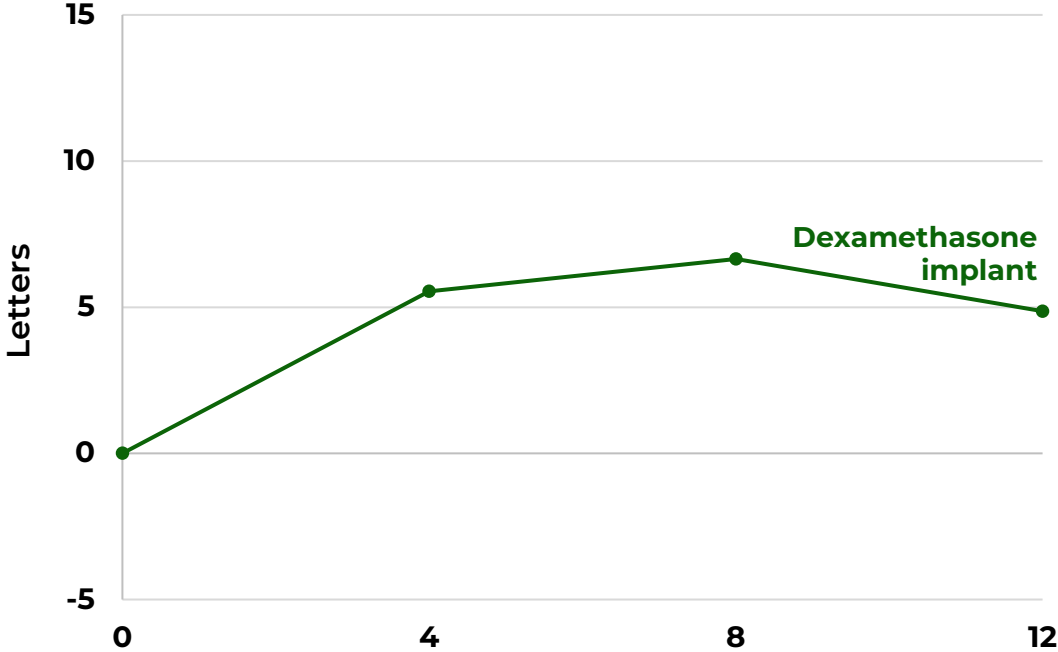
MERIT Study – Ozurdex (dexamethasone implant, Abbvie) does not resolve the edema in almost half of MESI patients at any point, and the treatment effect wanes by Week 12

Proportion of eyes with normalization of OCT CST



Dexamethasone:	76	73	71	71
Methotrexate:	76	74	71	66
Ranibizumab:	69	64	67	61

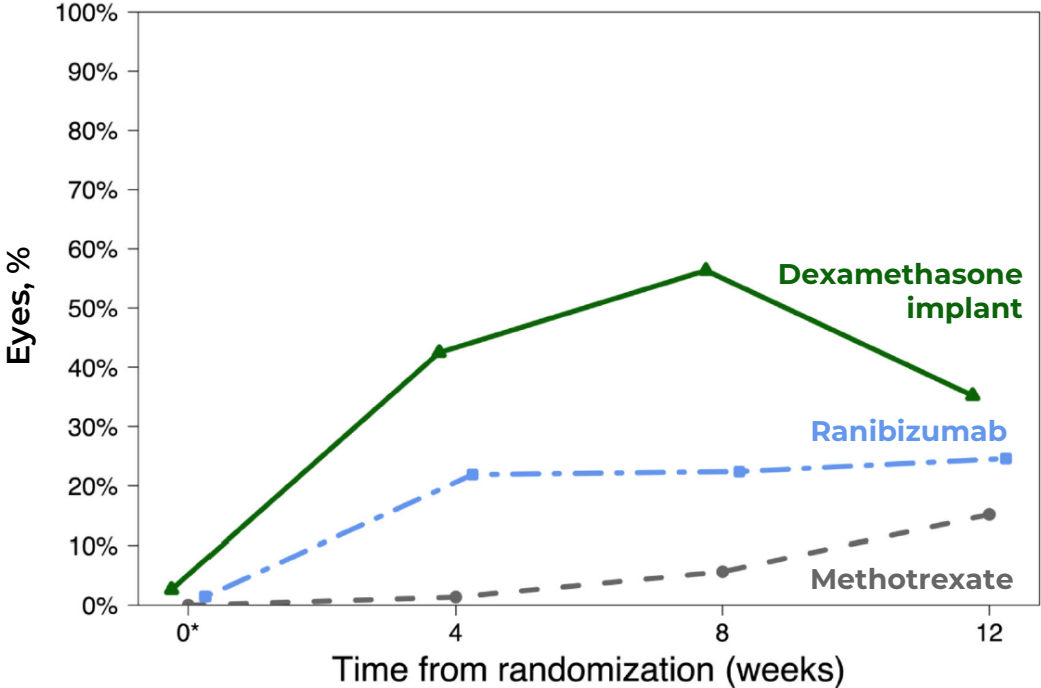
Mean change in BCVA



Even at the maximum drying effect of Ozurdex, which is observed at Week 8, the visual acuity gains are modest, and also wane by Week 12

MERIT Study –anti-VEGF monotherapy can provide a meaningful fluid response in a subset of MESI patients

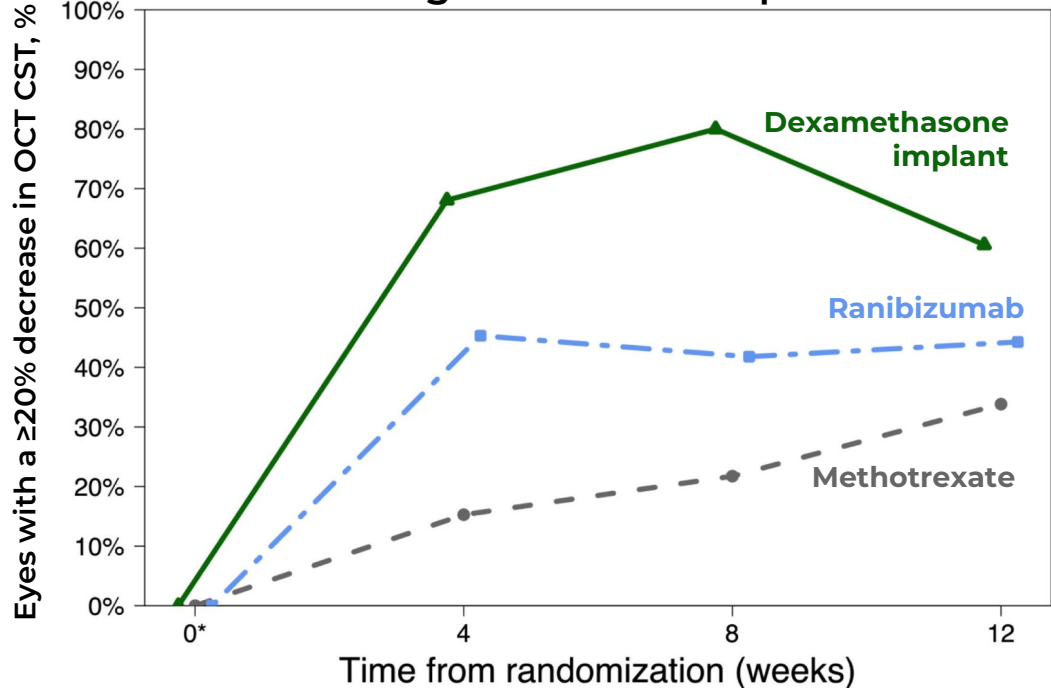
Proportion of eyes with normalization of OCT CST



Dexamethasone: 76
 Methotrexate: 76
 Ranibizumab: 69

Time from randomization (weeks)

Proportion of eyes with a meaningful OCT CST response



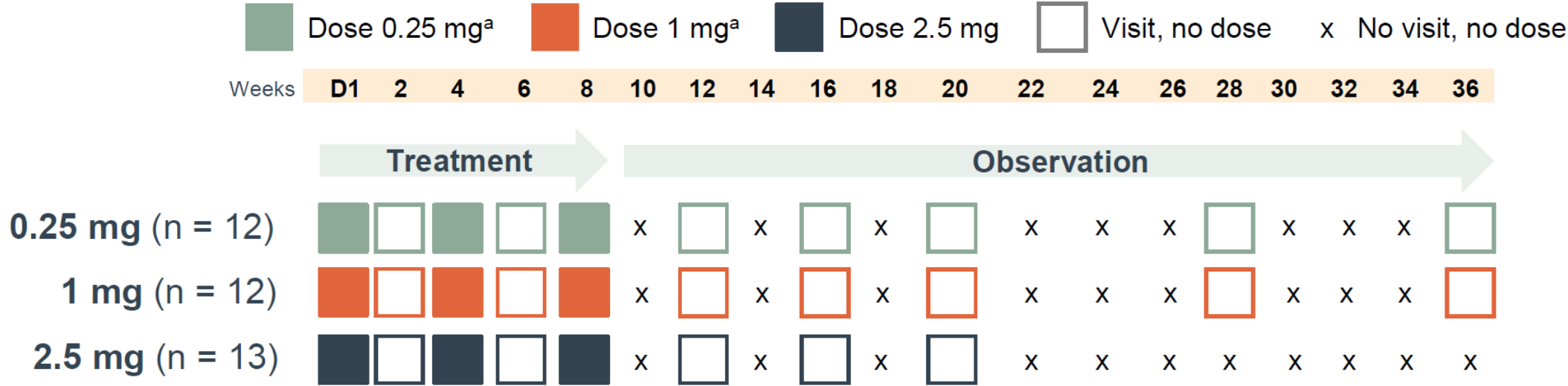
Dexamethasone: 76
 Methotrexate: 76
 Ranibizumab: 69

Time from randomization (weeks)

Anti-VEGF monotherapy (ranibizumab) can have a meaningful anatomical response in almost half of patients and completely resolve fluid in ~25% of patients

DOVETAIL Study - intravitreal anti-IL-6 monotherapy (Roche, vamikibart) has been studied as a potential therapy for patients with inflammatory macular edema

- DOVETAIL is a phase 1, multipart, multicenter, nonrandomized, open-label, multiple ascending dose study of intravitreal vamikibart



Primary objective: Safety and tolerability

Secondary objectives: PK, ADA formation, efficacy



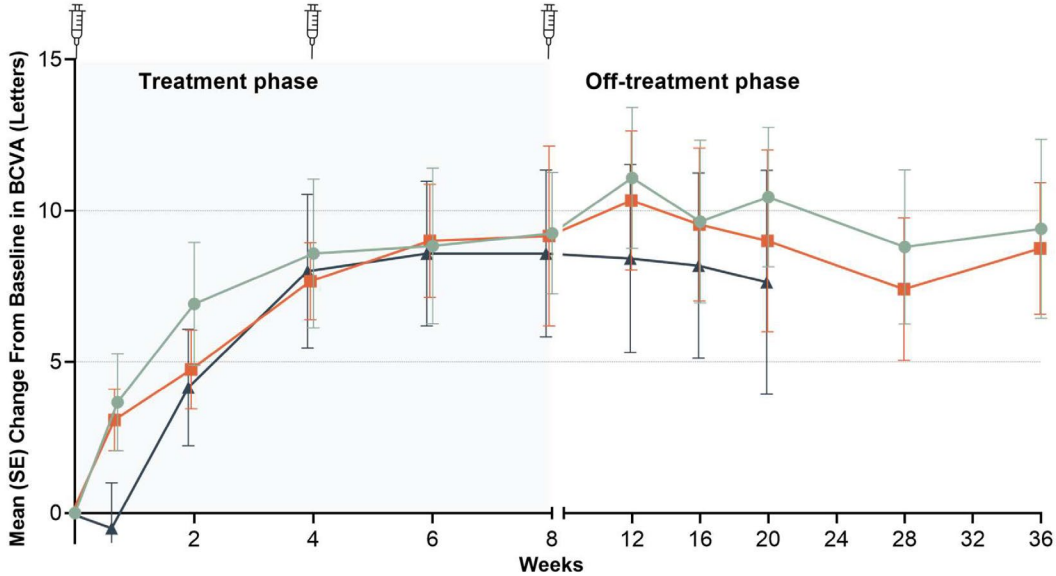
Age ≥ 18 years

Noninfectious uveitis and concurrent macular edema (CST ≥ 325 μm)

Vamikibart (Roche, anti-IL-6) has shown that anti-IL-6 monotherapy can provide visual and anatomical improvement in patients with inflammatory macular edema

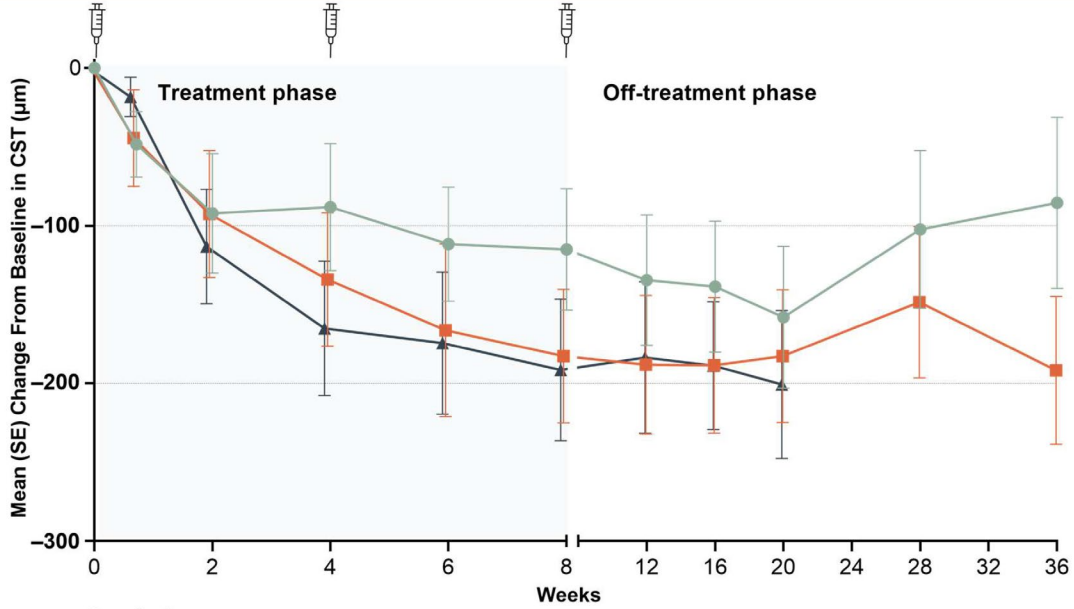
DOVETAIL

Change from Baseline in BCVA



DOVETAIL

Change from Baseline in OCT CST



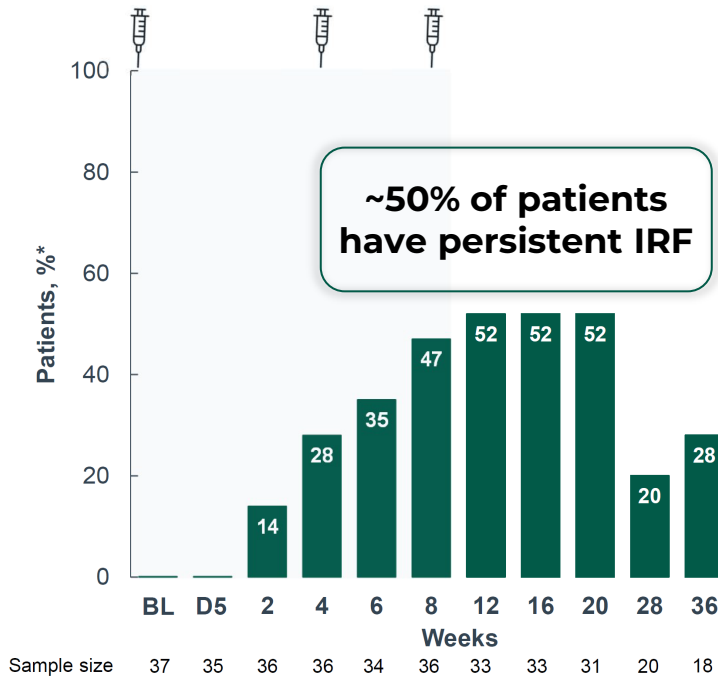
	0	2	4	6	8	12	16	20	28	36
0.25 mg (n)	12	12	12	12	12	12	11	11	10	10
1 mg (n)	12	12	12	12	11	12	11	11	10	8
2.5 mg (n)	13	12	13	12	12	12	11	11	2.5 mg cohort last F-up is W20	

	0	2	4	6	8	12	16	20	28	36
0.25 mg (n)	12	12	12	11	12	12	11	11	10	10
1 mg (n)	12	12	12	12	11	12	12	11	11	10
2.5 mg (n)	13	11	12	12	12	12	11	11	2.5 mg cohort last F-up is W20	

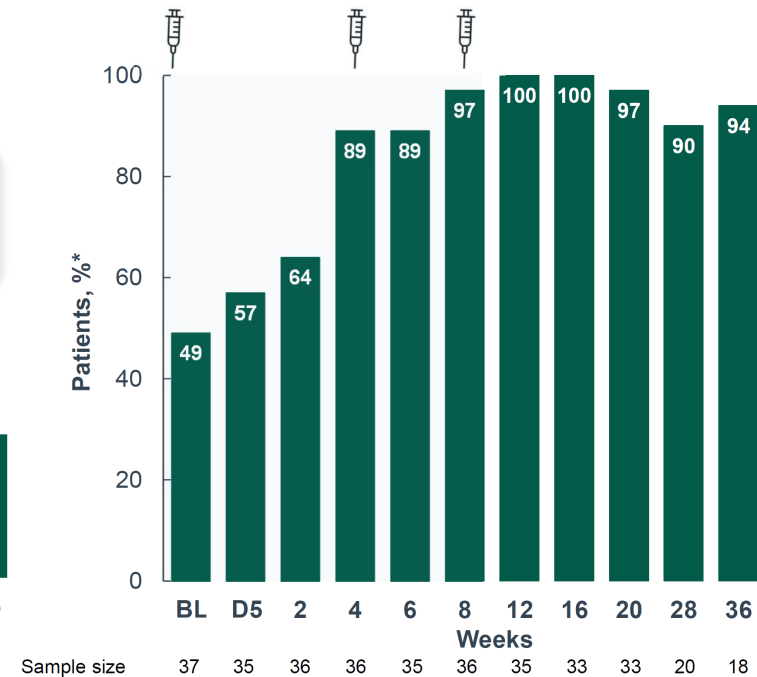
A clear dose response is seen with IL-6 monotherapy in patients with inflammatory macular edema

While intravitreal IL-6 monotherapy is helpful, 50% of patients have persistent IRF¹, similar to the overall failure rate of systemic adalimumab, leaving room for a more potent and/or broader spectrum biologic therapy

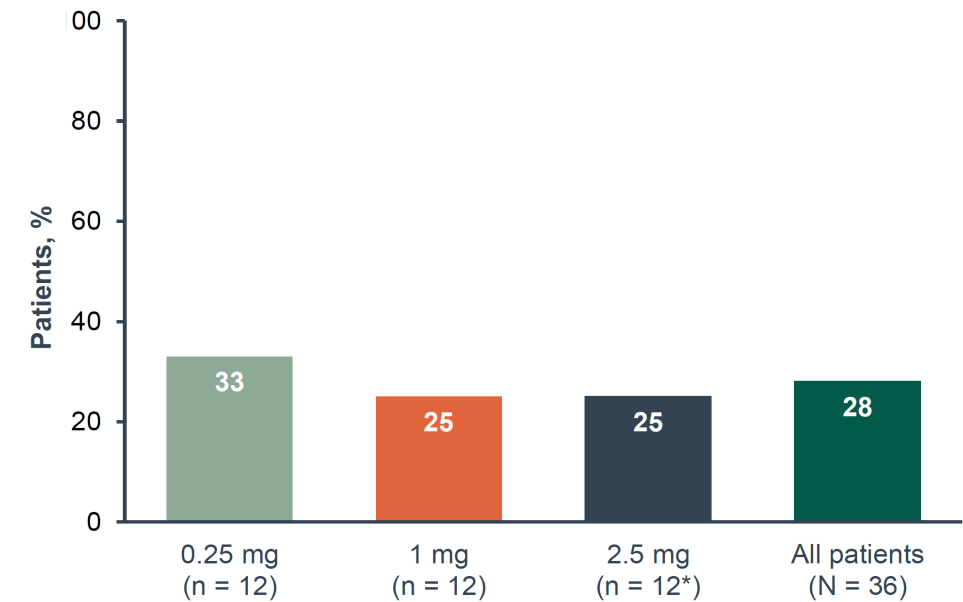
DOVETAIL
Absence of IRF



DOVETAIL
Absence of SRF



DOVETAIL
≥15-letter gainers at Week 12



Persistent intraretinal fluid (IRF) is known to cause permanent negative effects on visual function



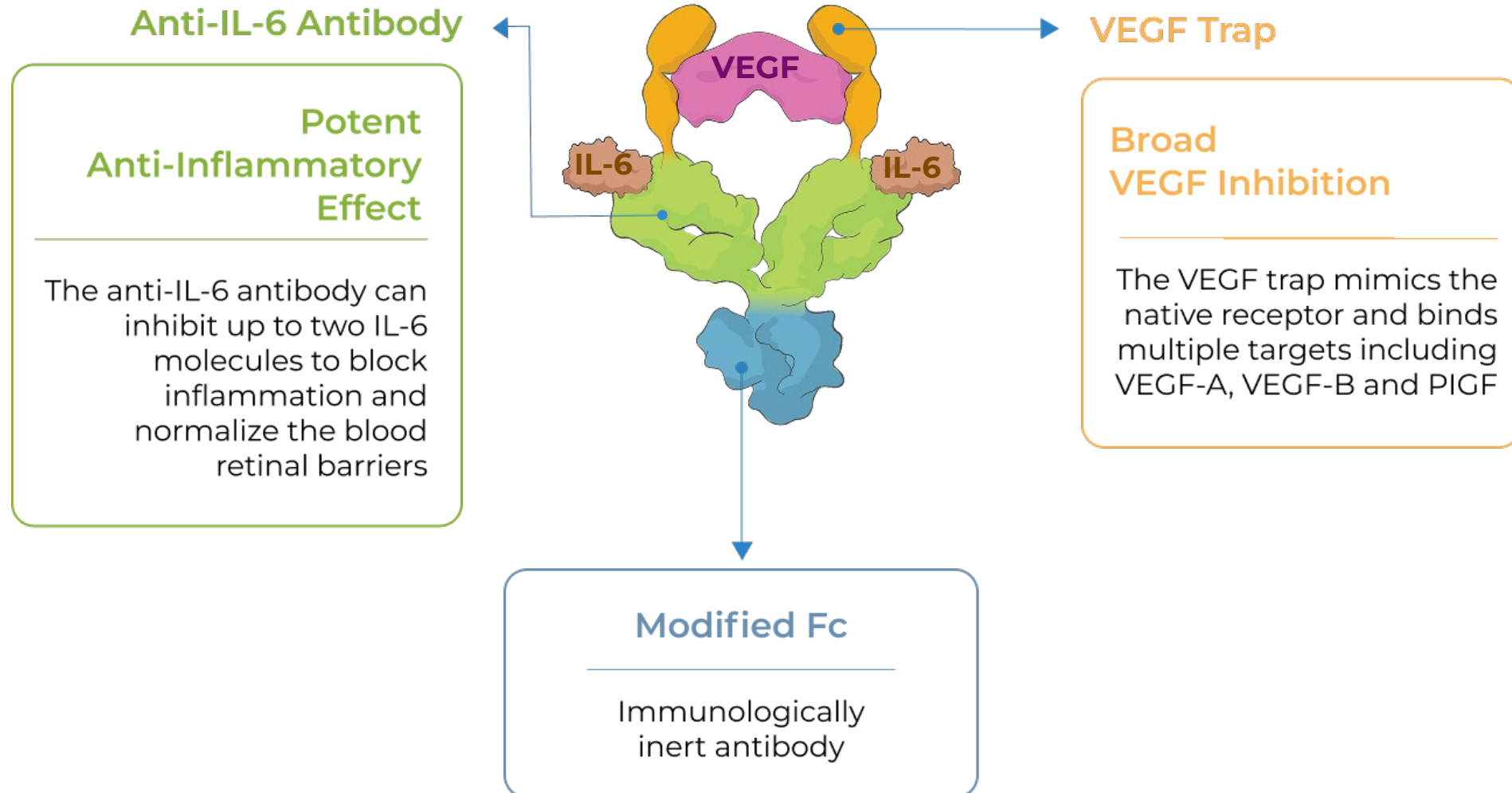
Sumit Sharma
MD

Macular Edema Secondary to Inflammation

**How can this unmet
need be addressed?**

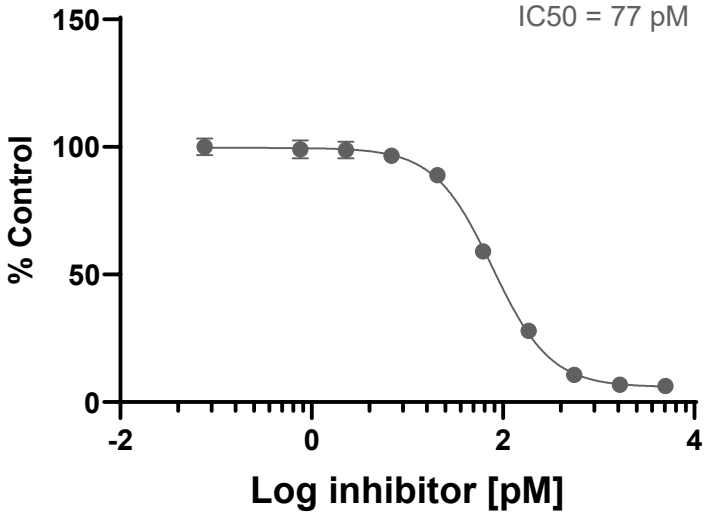
KSI-101 is a first-in-class, high-strength intravitreal biologic designed to target IL-6 mediated inflammation and VEGF-mediated vascular permeability simultaneously

KSI-101: high formulation strength (100 mg/mL)

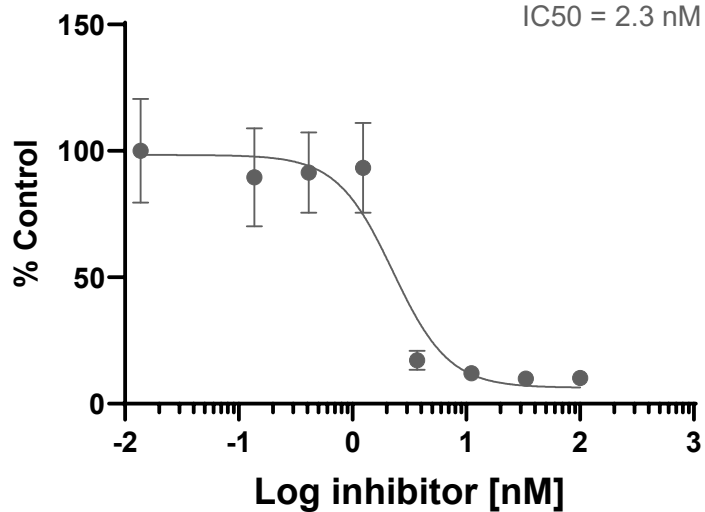


KSI-101 is a potent dual inhibitor of VEGF signaling and IL-6 classic (cis) and soluble (trans) receptor-mediated pathways

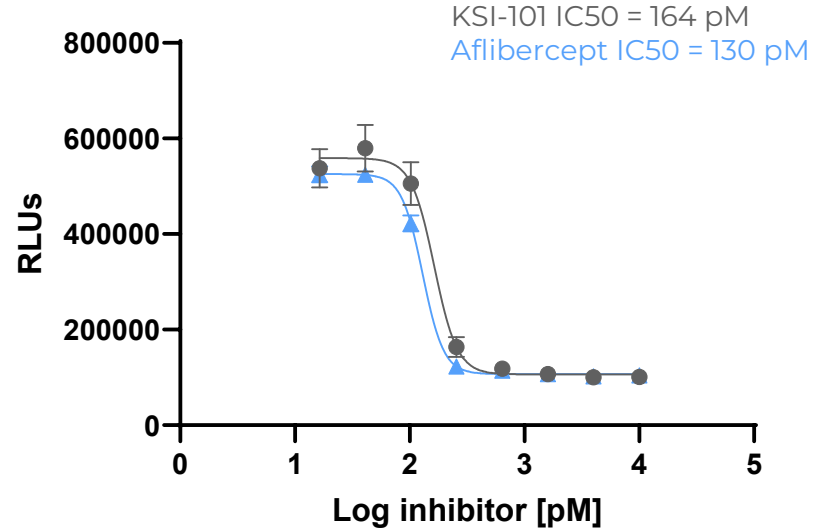
KSI-101 inhibits IL-6 classic signaling



KSI-101 inhibits soluble IL-6 receptor-mediated signaling

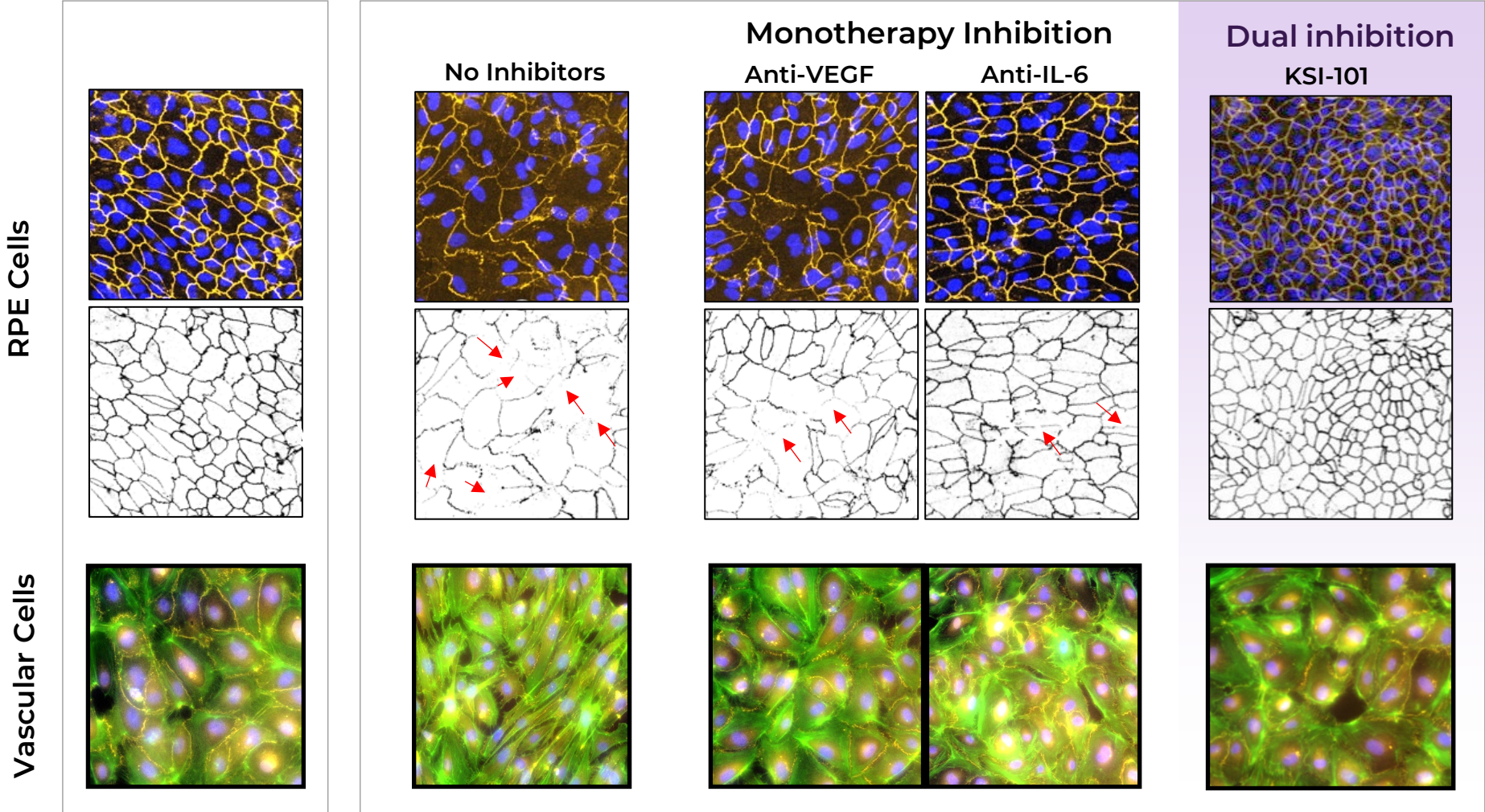


KSI-101 inhibits VEGF signaling



Bispecific KSI-101 improves barrier tight junctions greater than anti-IL-6 or anti-VEGF monotherapies alone

Exogenous VEGF and IL-6
Tight junction disruption and changes in cell morphology

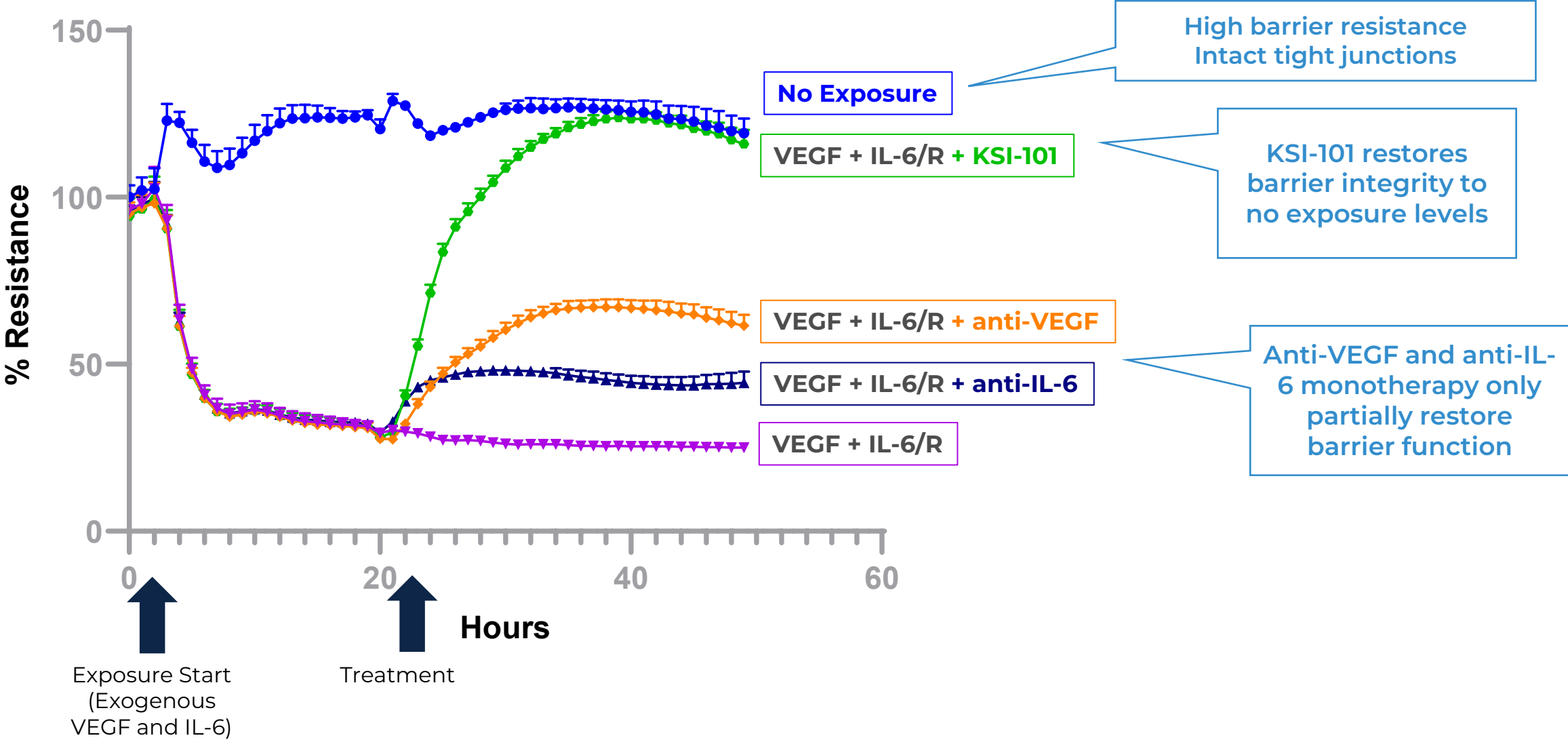


Dual inhibition by KSI-101 confers superior normalization of complex tight junction-mediated barrier biology compared to either anti-VEGF or anti-IL-6 monotherapy alone

Demonstrates the synergistic effect of IL-6 and VEGF dual inhibition

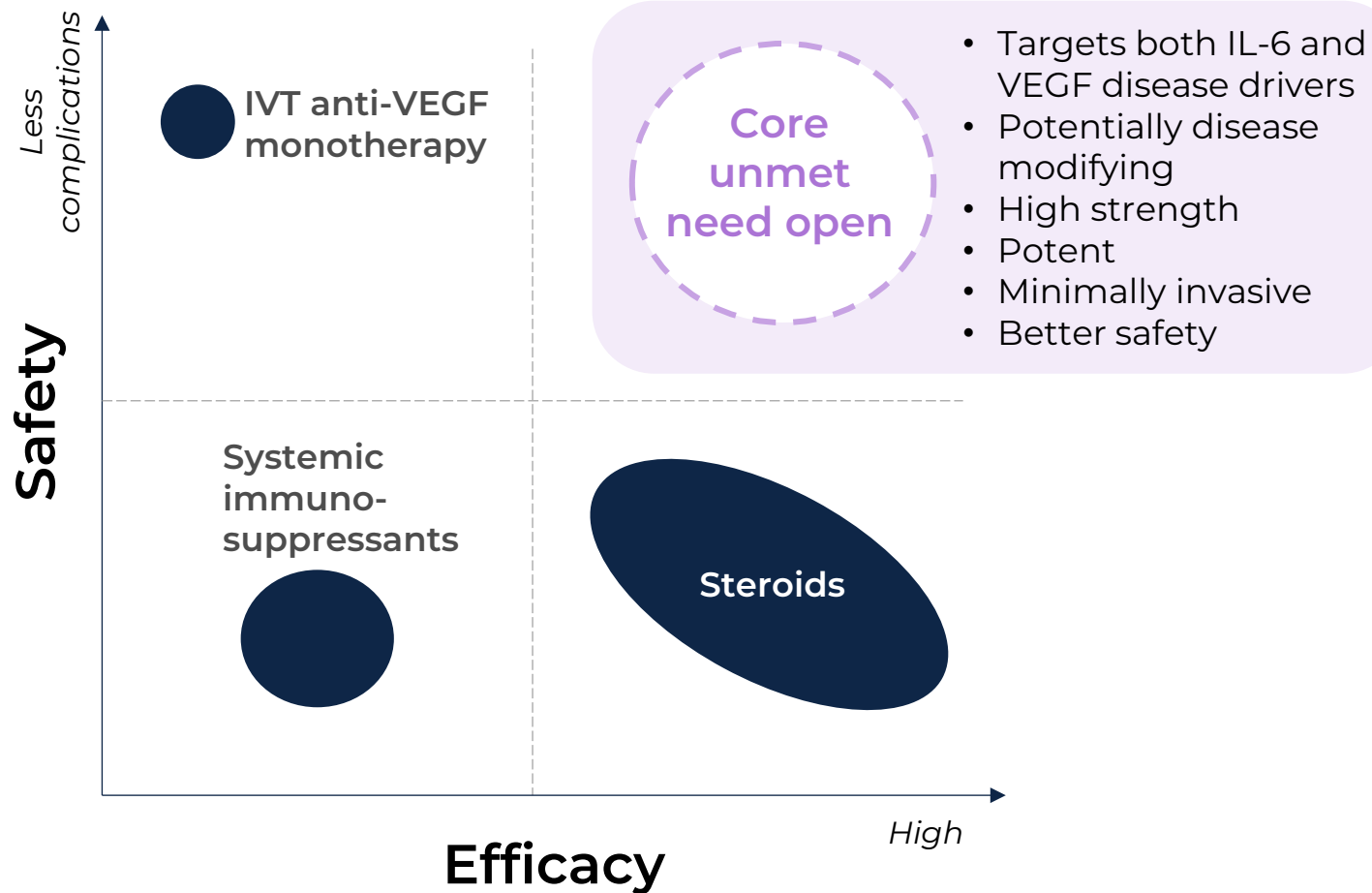
RPE cells: nuclei in blue, ZO1 (tight junction protein) in yellow. Red arrows indicate gaps in ZO-1 tight junction protein. Vascular cells: nuclei in purple, ZO1 (tight junction protein) in yellow, actin in green.

Bispecific KSI-101 restores barrier resistance from pre-existing insult greater than anti-IL-6 or anti-VEGF monotherapies alone



KSI-101 is poised to fulfill the core unmet need in MESI based on its potential to be a disease modifying, high-strength, locally administered and safe biologic

Illustrative

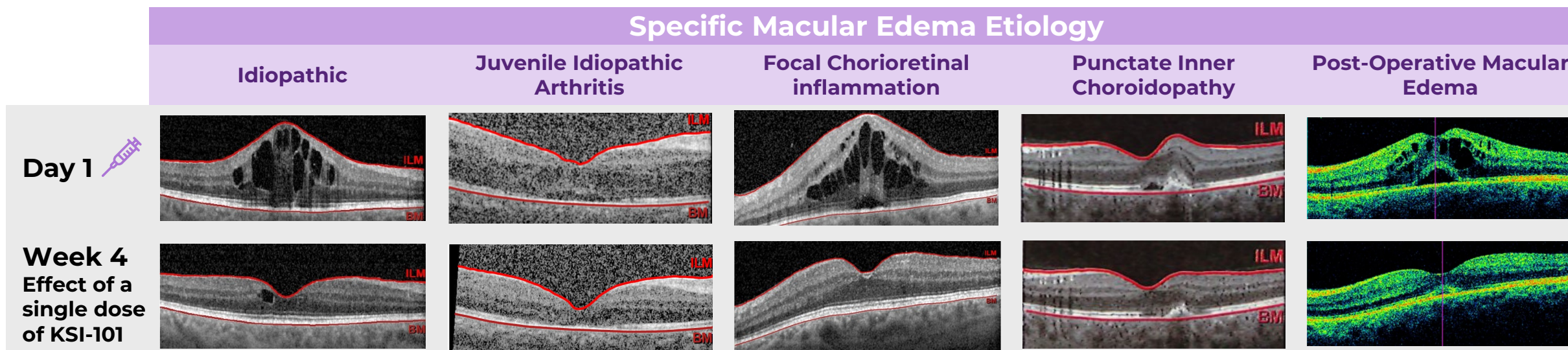
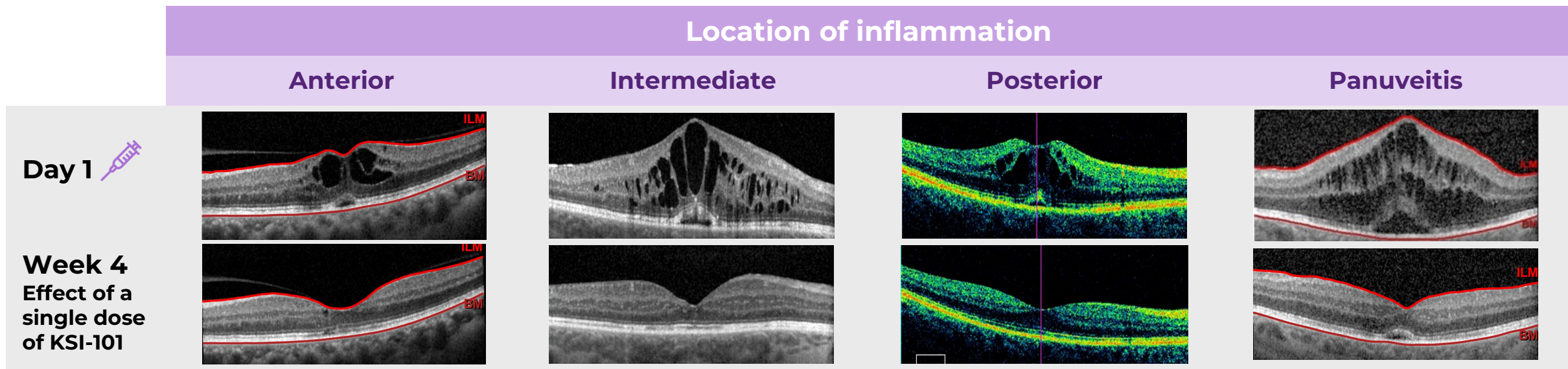


KSI-101 is designed to address the core unmet need

- **Dual anti-IL-6 and anti-VEGF inhibition**
- **Potential for disease modifying effect** based on its synergistic inhibition of IL-6 and VEGF, as demonstrated in preclinical models and clinical cases
- **High strength formulation** (100 mg/mL) and **high potency** provide the fire-power needed to treat “angry” inflammation and macular edema
- **Local (intravitreal) administration**
- **Safety profile in line with intravitreally administered biologics** (i.e., Eylea, Lucentis)

Unified treatment irrespective of presumed etiology

After a single dose of KSI-101, heterogenous MESI diseases show rapid and meaningful responses to the simultaneous IL-6 and VEGF inhibition, irrespective of the location of the inflammation or the specific macular edema diagnosis





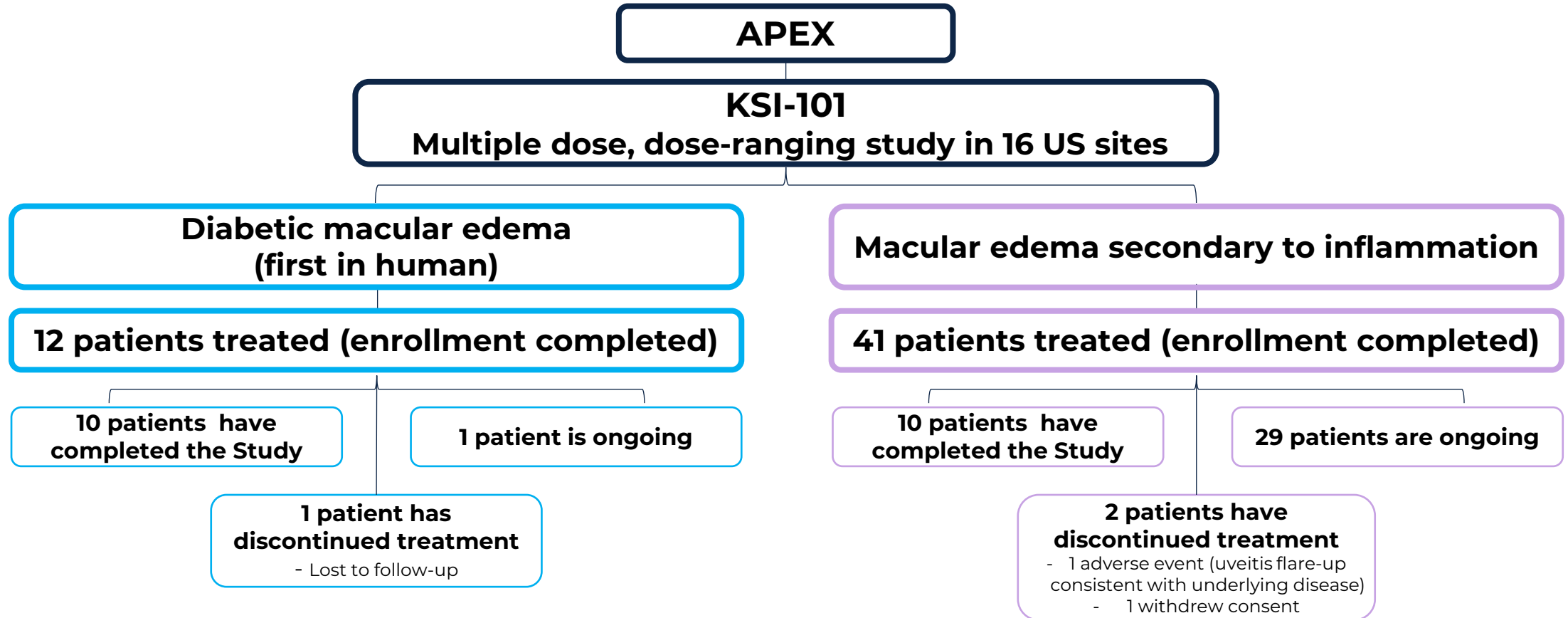
Sumit Sharma
MD

Phase 1b APEX Study

KSI-101 in DME and MESI

Phase 1b APEX study: KSI-101 in patients with diabetic macular edema (DME) and macular edema secondary to inflammation (MESI)

- APEX is an ongoing, open label, multicenter platform study on the safety, tolerability, bioactivity, and pharmacokinetics of multiple intravitreal therapies in retinal diseases



Preliminary data presented today

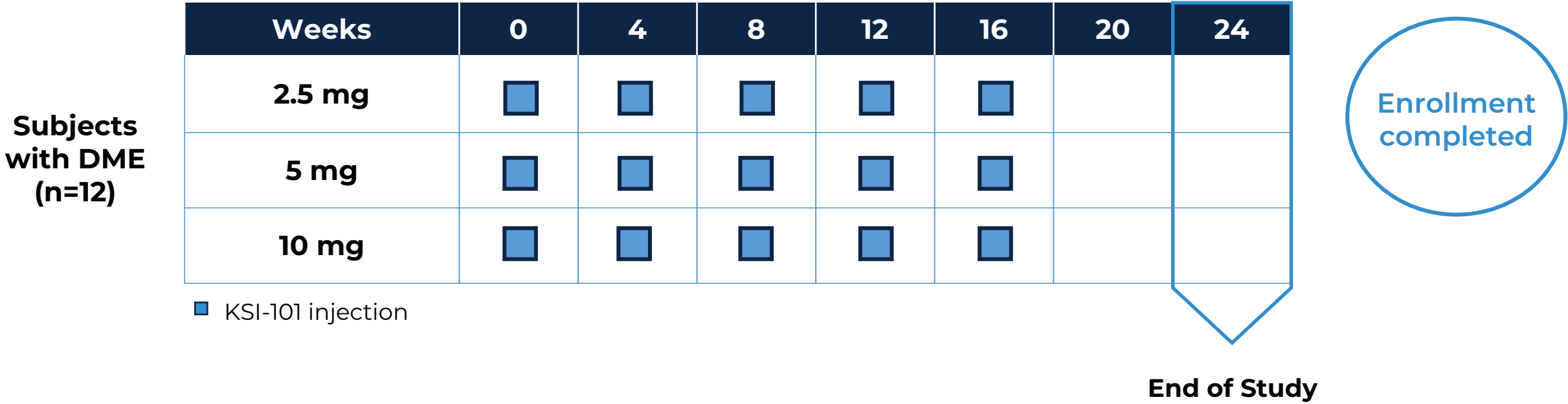


Sumit Sharma
MD

Diabetic Macular Edema

Phase 1b APEX KSI-101 in DME

Phase 1b APEX study: a first in human study of KSI-101 in patients with DME



Key inclusion criteria

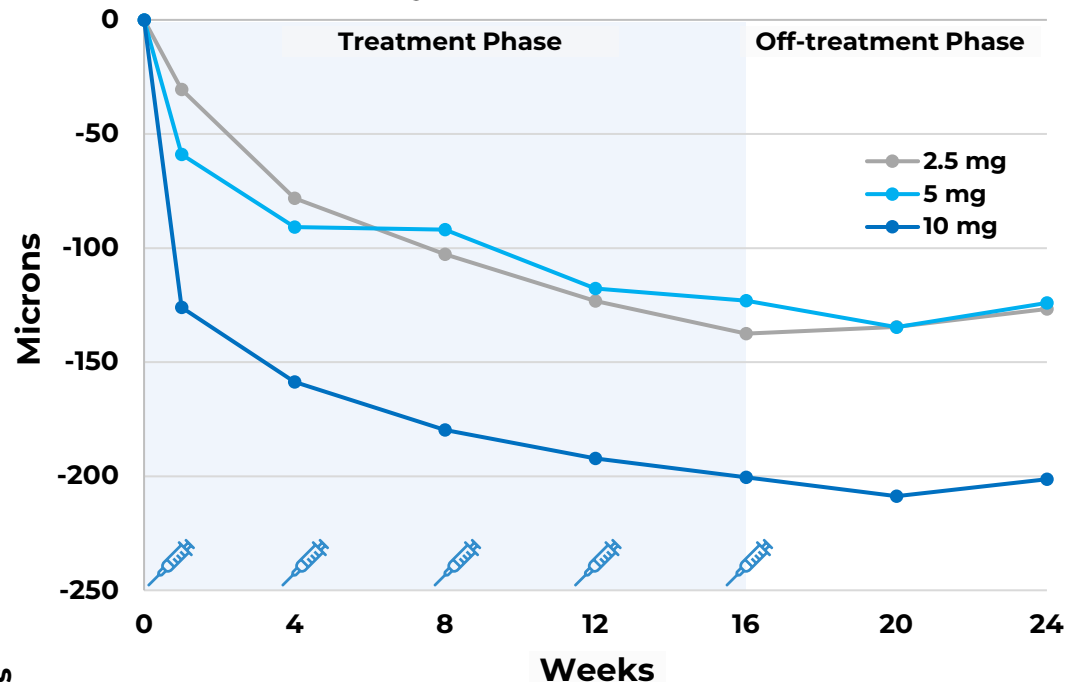
- Treatment-naive center-involving DME
- OCT CST of ≥ 400 and ≤ 650 microns
- BCVA score ≤ 75 and ≥ 25 (20/32 to 20/320 Snellen equivalent)

APEX KSI-101 in DME – Baseline Characteristics

	KSI-101 2.5 mg (n=4)	KSI-101 5 mg (n=4)	KSI-101 10 mg (n=4)	All KSI-101 (N=12)
Age, years , mean (SD)	54.5 (10.6)	68.3 (5.74)	56.5 (4.7)	59.8 (9.3)
Female , n (%)	0	0	2 (50)	2 (16.7)
Race, White , n (%)	4 (100)	4 (100)	4 (100)	12 (100)
DME disease duration, months , mean (SD)	1.8 (1.6)	13.0 (22.0)	4.1 (3.1)	6.3 (12.7)
BCVA, ETDRS Letters , mean (SD)	69.8 (3.3)	58.0 (13.9)	63.8 (9.9)	63.8 (10.4)
Snellen equivalent	~20/40	~20/63	~20/50	~20/50
OCT CST, μm , mean (SD)	442.0 (45.4)	483.0 (54.3)	485.8 (83.8)	470.3 (61.0)
Lens Status, pseudophakic , n (%)	1 (25)	1 (25)	1 (25)	3 (25)

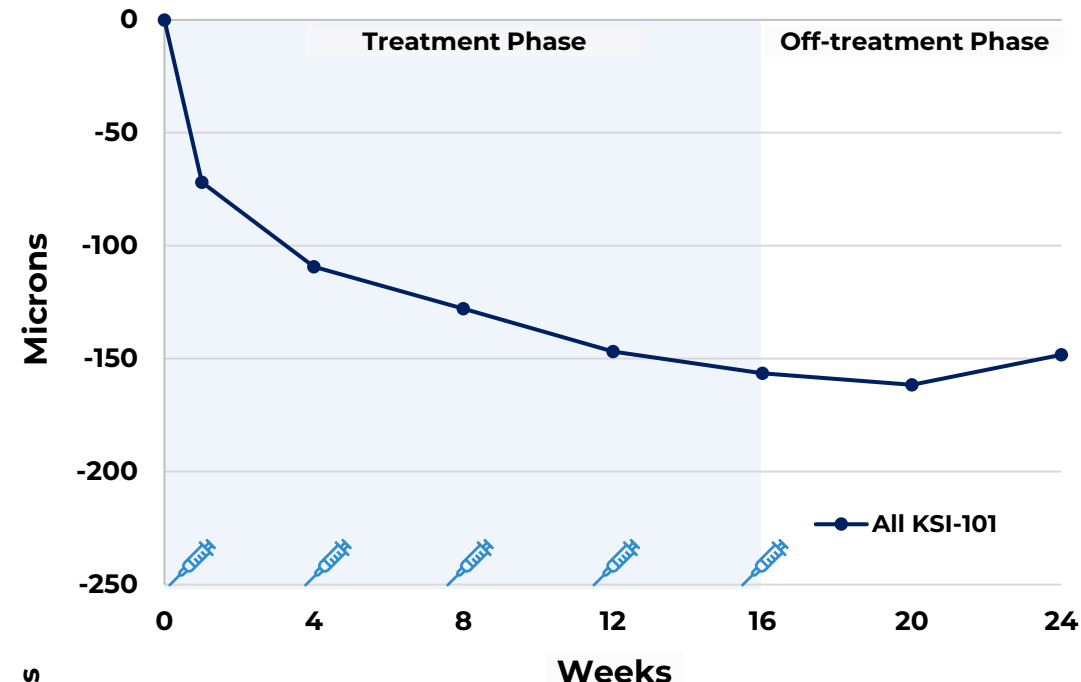
APEX KSI-101 in DME – Meaningful anatomical gains were achieved with all KSI-101 dose levels tested

Mean Change in OCT CST
by KSI-101 dose level



N values	0	4	8	12	16	20	24
2.5 mg	4	4	4	4	4	4	4
5 mg	4	4	3	3	3	3	3
10 mg	4	4	4	4	4	4	3

Mean Change in OCT CST
all KSI-101 dose levels combined

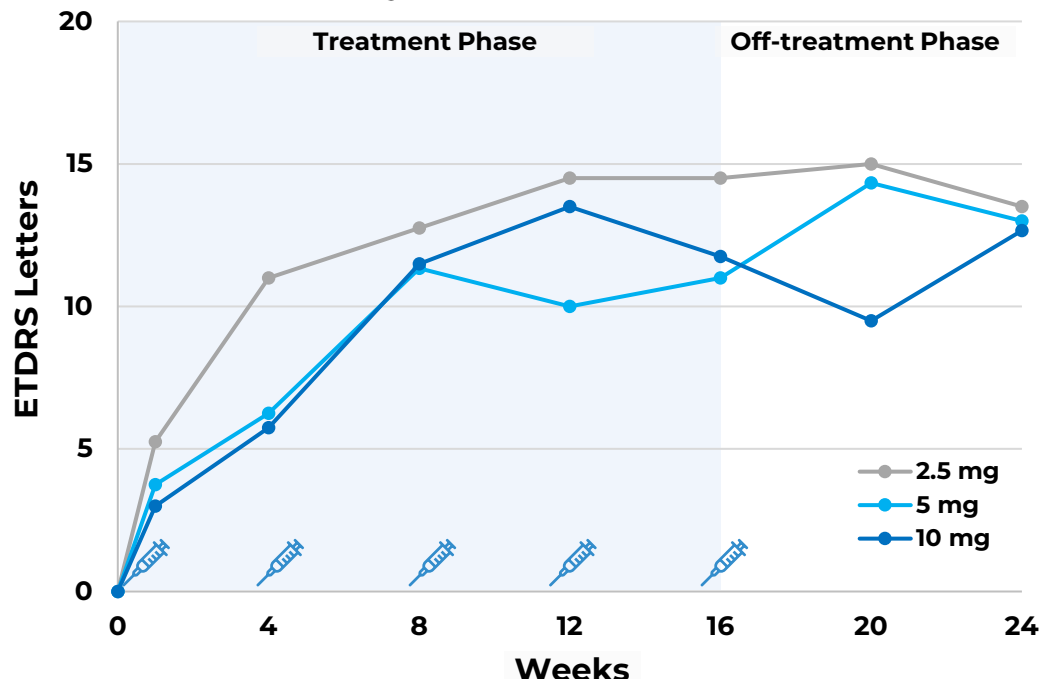


N values	0	4	8	12	16	20	24
All KSI-101	12	12	12	11	11	11	10

Bioactivity was observed in all dose levels, with an apparent additional benefit obtained with the highest KSI-101 dose level (10 mg)

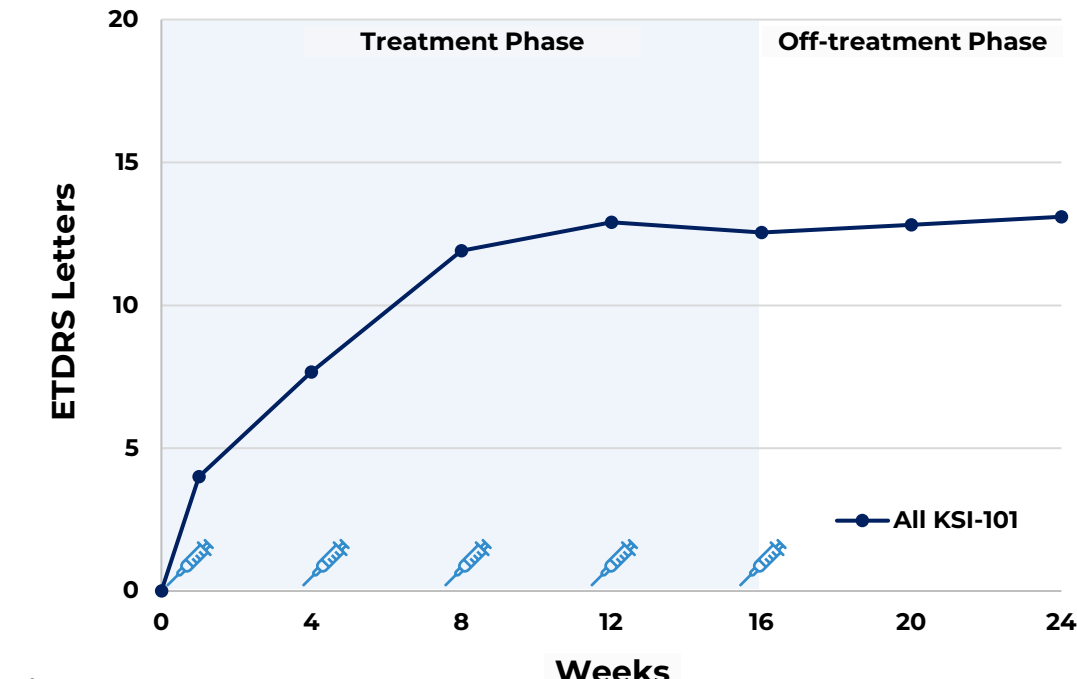
APEX KSI-101 in DME – Meaningful vision gains were achieved with all KSI-101 dose levels tested

Mean Change in BCVA by KSI-101 dose level



N values	2.5 mg	5 mg	10 mg
0	4	4	4
4	4	4	4
8	4	3	4
12	4	3	4
16	4	3	4
20	4	3	4
24	4	3	3

Mean Change in BCVA all KSI-101 dose levels combined



N values	All KSI-101
0	12
4	12
8	12
12	11
16	11
20	11
24	10

While the 10 mg dose level seems to have an anatomical advantage, meaningful visual gains and bioactivity were observed in all dose levels

APEX KSI-101 in DME – KSI-101 was well-tolerated

	KSI-101 2.5 mg (n=4)	KSI-101 5 mg (n=4)	KSI-101 10 mg (n=4)	All KSI-101 (N=12)
Summary of AEs in the Study eye, n (%)				
Subjects with ≥1 AEs	1 (25)	0	0	1 (8.3)
Treatment-related AEs	0	0	0	0
Serious AEs	0	0	0	0
Treatment-related serious AEs	0	0	0	0
Severe AEs	0	0	0	0
AEs leading to study discontinuation	0	0	0	0
AEs in the Study Eye, n (%)				
Intraocular inflammation	0	0	0	0
Occlusive retinal vasculitis	0	0	0	0
Cataract	0	0	0	0
Cataract traumatic*	1 (25.0)	0	0	1 (8.3)
Elevated IOP	0	0	0	0
Eye Pain	0	0	0	0



Sumit Sharma
MD

Macular Edema Secondary to Inflammation

Phase 1b APEX KSI-101 in MESI

Phase 1b APEX study: multiple dose study of KSI-101 in patients with MESI

Subjects with MESI (n=41)

Weeks	0	4	8	12	16	20	24
2.5 mg	■	■	■	■			
5 mg	■	■	■	■			
10 mg	■	■	■	■			

■ KSI-101 injection

Enrollment completed

End of Study

Key inclusion criteria

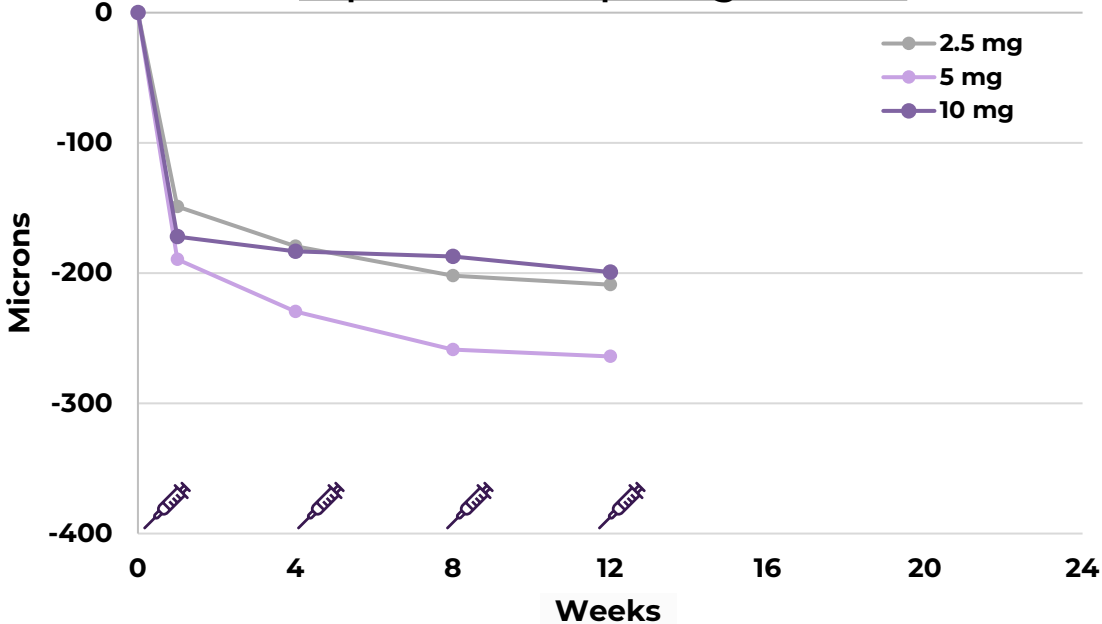
- Macular edema secondary to inflammation (MESI)
- Diagnosis of active or inactive non-infectious intraocular inflammation, acute or chronic.
- Active leakage as evidenced by fluorescein angiogram.
- OCT CST of ≥ 320 microns
- BCVA score ≤ 75 and ≥ 25 (20/32 to 20/320 Snellen equivalent)

APEX KSI-101 in MESI – Baseline Characteristics

	KSI-101 2.5 mg (n=13)	KSI-101 5 mg (n=14)	KSI-101 10 mg (n=14)	All KSI-101 (N=41)
Age, years , mean (SD)	74.2 (11.6)	67.4 (8.1)	67.5 (18.8)	69.6 (13.7)
Female , n (%)	8 (61.5)	7 (50.0)	8 (57.1)	23 (56.1)
Race, White , n (%)	11 (84.6)	11 (78.6)	14 (100)	36 (87.8)
MESI disease duration, months , mean (SD)	12.2 (20.1)	1.7 (1.2)	15.8 (37.2)	11.1 (26.5)
Inflammation anatomical location , n (%)				
Anterior	0	2 (14.3)	0	2 (4.9)
Intermediate	1 (7.7)	0	2 (14.3)	3 (7.3)
Posterior	10 (76.9)	6 (42.9)	10 (71.4)	26 (63.4)
Panuveitis	2 (15.4)	6 (42.9)	2 (14.3)	10 (24.4)
Patients with active inflammation , n (%)	3 (23.1)	10 (71.4)	5 (35.7)	18 (43.9)
Unilateral MESI , n (%)	9 (69.2)	6 (42.9)	5 (35.7)	20 (48.8)
BCVA, ETDRS Letters , mean (SD)	62.7 (7.4)	65.5 (7.8)	62.1 (8.4)	63.5 (7.8)
Snellen equivalent	~20/50	~20/50	~20/63	~20/50
OCT CST, μm , mean (SD)	461.7 (137.7)	487.0 (124.1)	528.6 (157.3)	493.2 (139.7)
Lens Status, pseudophakic , n (%)	9 (69.2)	13 (92.9)	11 (78.6)	33 (80.5)

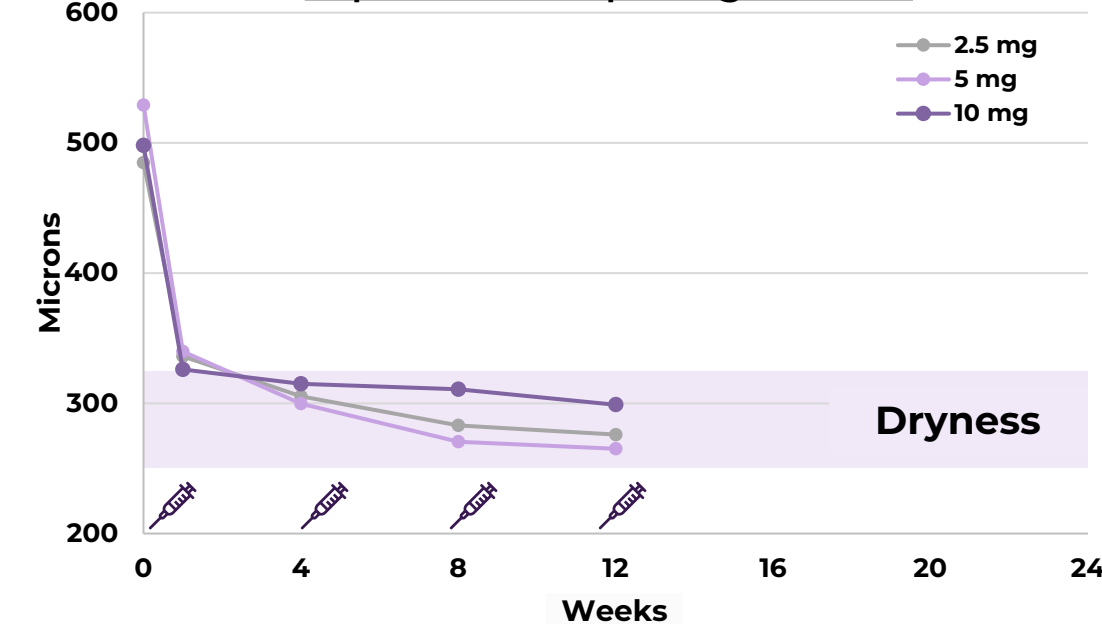
APEX KSI-101 in MESI – Meaningful anatomical gains are rapidly achieved, with all dose levels achieving dryness OCT CST levels as early as Week 4

Mean Change in OCT CST in patients completing Week 12



N values	2.5 mg	9	9	9	9	9
5 mg	8	8	8	8	8	8
10 mg	10	10	10	10	10	10

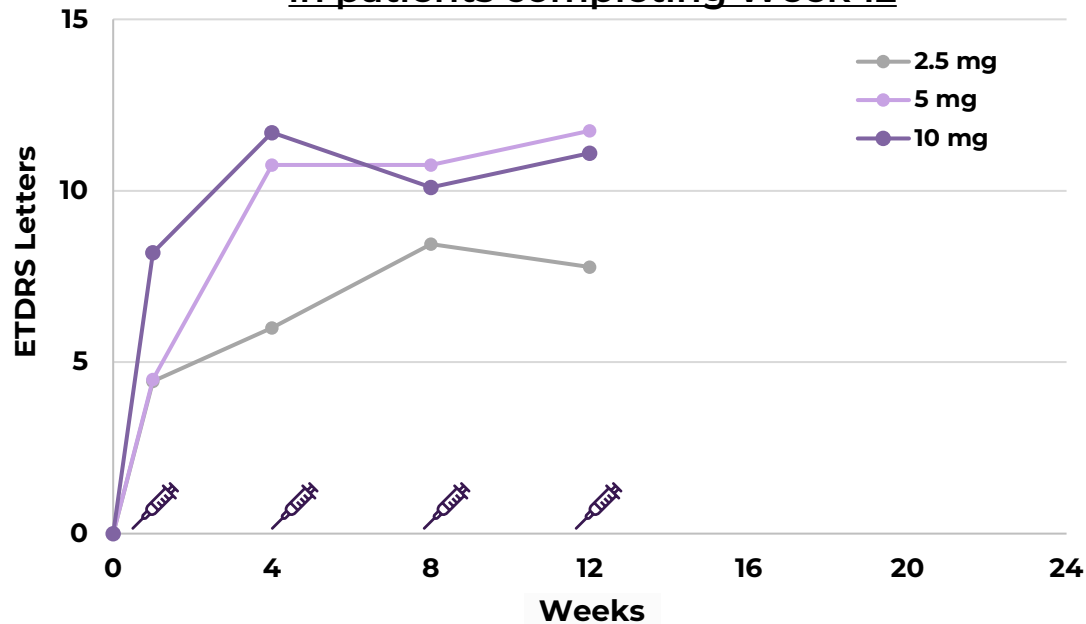
Observed OCT CST over time in patients completing Week 12



N values	2.5 mg	9	9	9	9	9
5 mg	8	8	8	8	8	8
10 mg	10	10	10	10	10	10

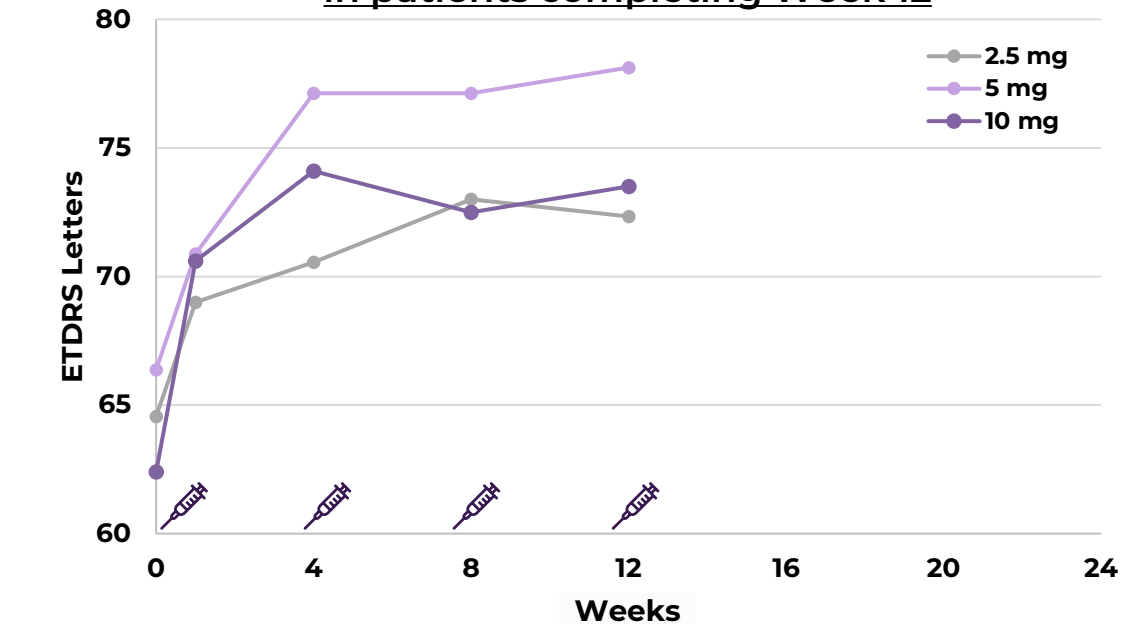
APEX KSI-101 in MESI – Meaningful visual acuity gains of more than two lines of vision have been achieved with the top two dose levels tested

Mean Change in BCVA
in patients completing Week 12



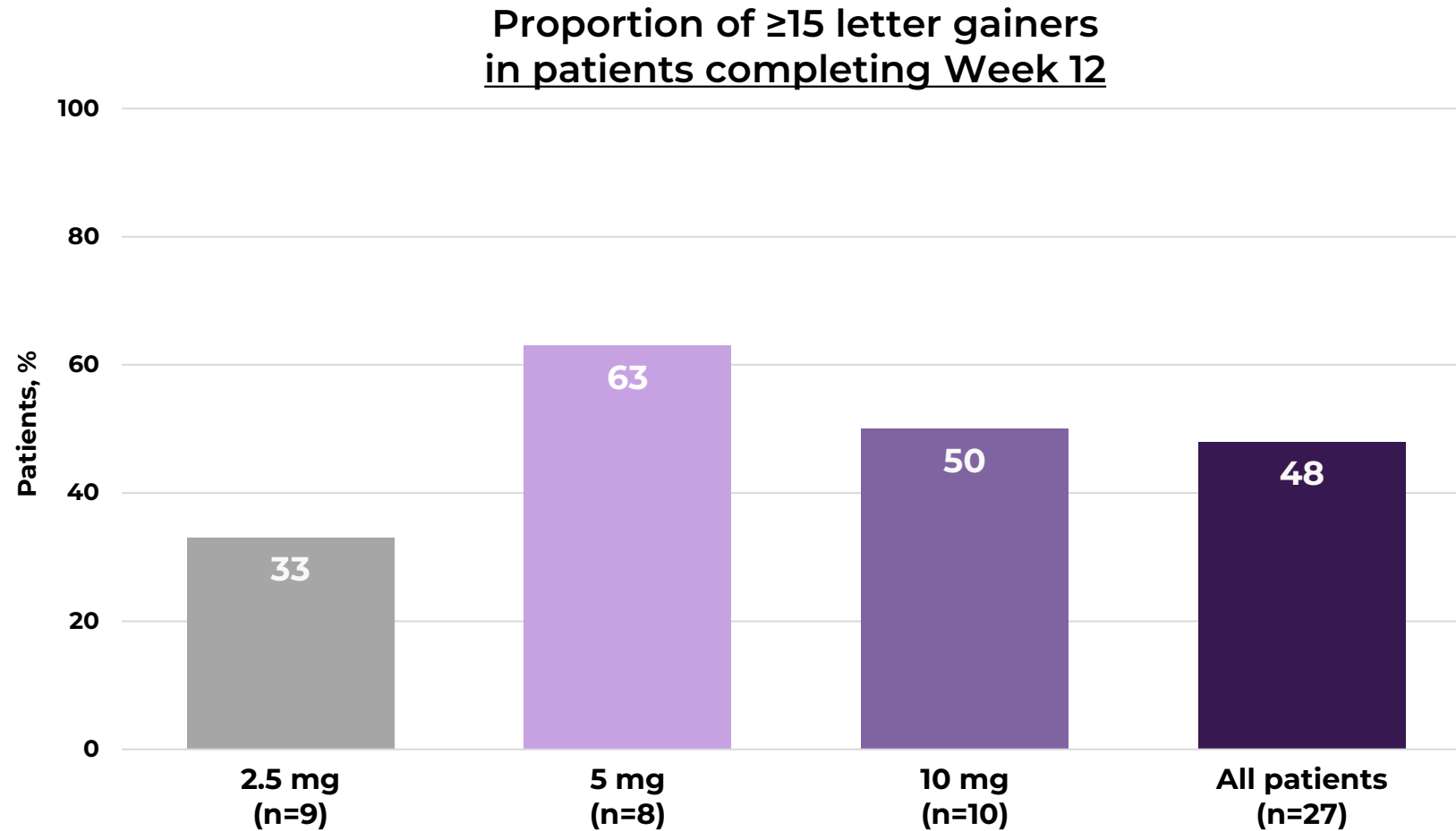
N values	2.5 mg	9	9	9	9	9
5 mg	8	8	8	8	8	8
10 mg	10	10	10	10	10	10

Observed BCVA over time
in patients completing Week 12



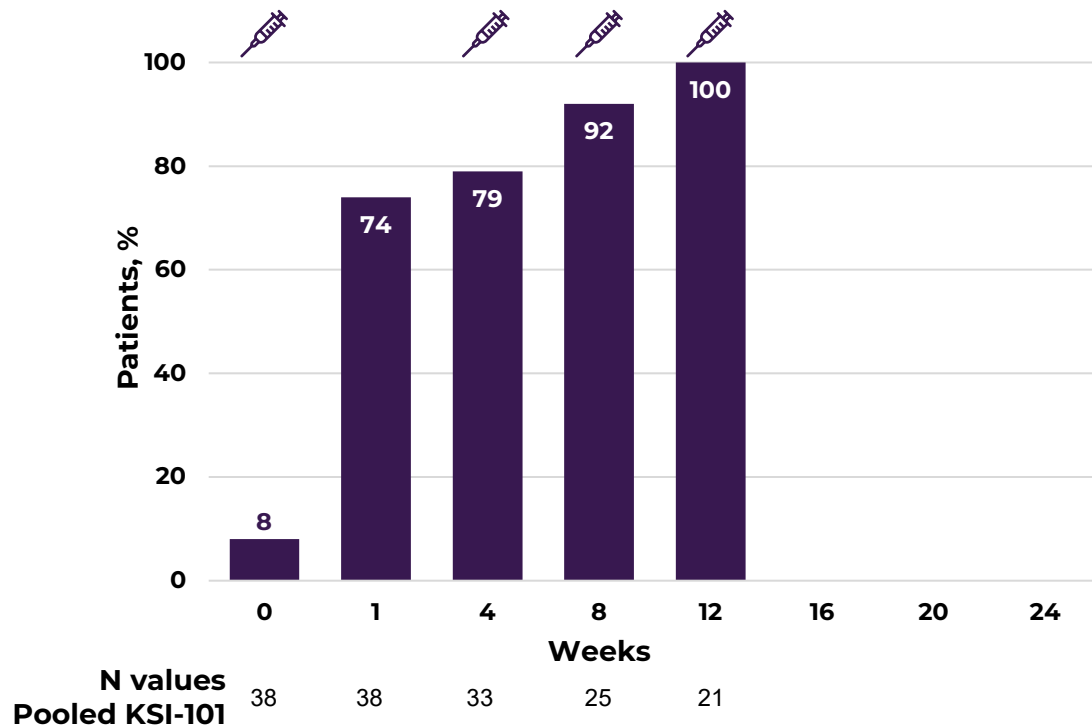
N values	2.5 mg	9	9	9	9	9
5 mg	8	8	8	8	8	8
10 mg	10	10	10	10	10	10

APEX KSI-101 in MESI – Half of patients have achieved a ≥ 15 letter gain, with an apparent additional benefit in the top two dose levels

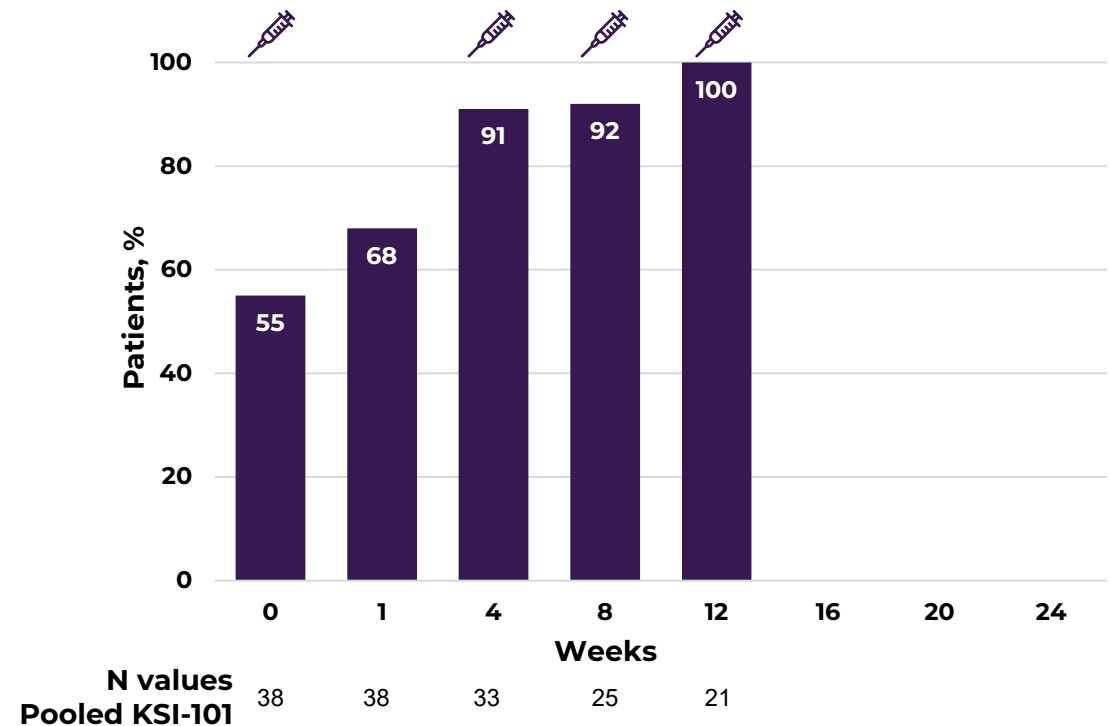


APEX KSI-101 in MESI – A single dose of KSI-101 results in the majority of patients achieving dryness. Over 90% of patients achieve dryness by Week 8

Proportion of patients achieving absence of IRF



Proportion of patients achieving absence of SRF



APEX KSI-101 in MESI – KSI-101 was well-tolerated

	KSI-101 2.5 mg (n=13)	KSI-101 5 mg (n=14)	KSI-101 10 mg (n=14)	All KSI-101 (N=41)
Summary of AEs in the Study eye, n (%)				
Subjects with ≥1 AEs	1 (7.7) ^a	2 (14.3)	2 (14.3)	5 (12.2)
Treatment-related AEs	1 (7.7) ^a	1 (7.1) ^b	0	2 (4.9)
Serious AEs	0	0	0	0
Treatment-related serious AEs	0	0	0	0
Severe AEs	0	0	0	0
AEs leading to study discontinuation	0	1 (7.1) ^b	0	1 (2.4)
Selected AEs in the Study Eye, n (%)				
Intraocular inflammation (recurrent uveitis flare-up)	1 (7.7) ^a	1 (7.1) ^b	0	2 (4.9)
Occlusive retinal vasculitis	0	0	0	0
Cataract	0	0	0	0
Elevated IOP	0	0	0	0
Eye Pain	1 (7.7) ^a	0	0	1 (2.4)
Vitreous hemorrhage	1 (7.7) ^a	0	0	1 (2.4)

Preliminary results. As the APEX study is ongoing, final results may be different due to additional data collection or data cleaning.

AE, Adverse event; IOP, intraocular pressure. Events are investigator reported. Adverse events are treatment-emergent events with start date ≥first study drug date and ≤last study drug date + 28 days.

^a Same patient. Vitreous hemorrhage secondary to aqueous humor sampling at the Day 1 visit (pre-dose). The patient had 3+ AC cells and flare and 2+ vitreous haze **prior** to the Day 1 KSI-101 dose. The patient has safely received all 4 doses of KSI-101 and is +24 letters in BCVA at their last visit and no intraocular inflammation

^b Same patient. Uveitis flare-up consistent with underlying disease



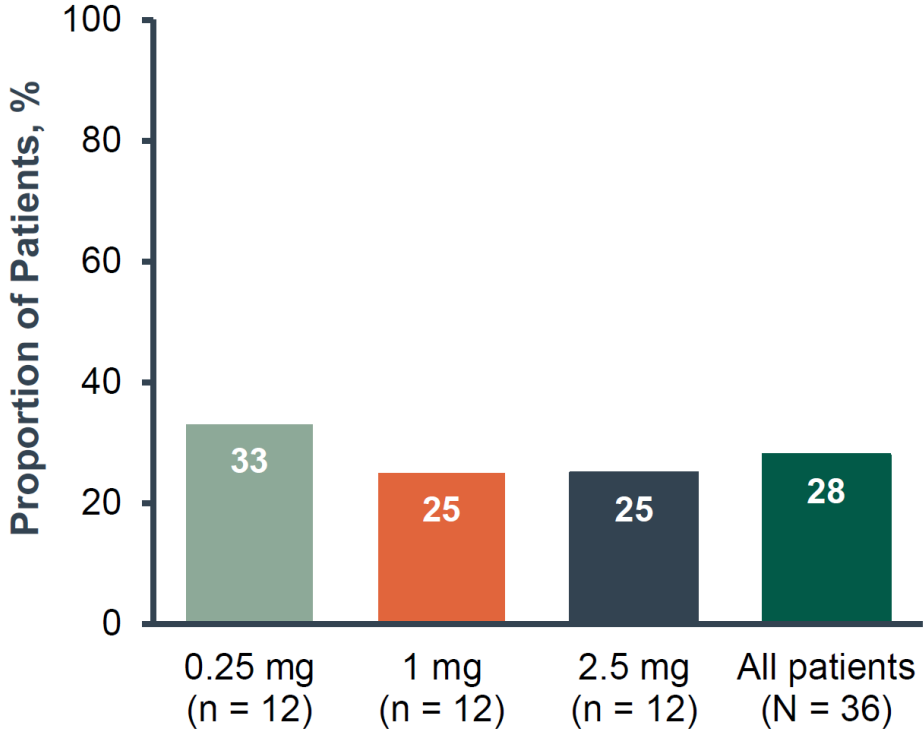
Sumit Sharma
MD

Macular Edema Secondary to Inflammation

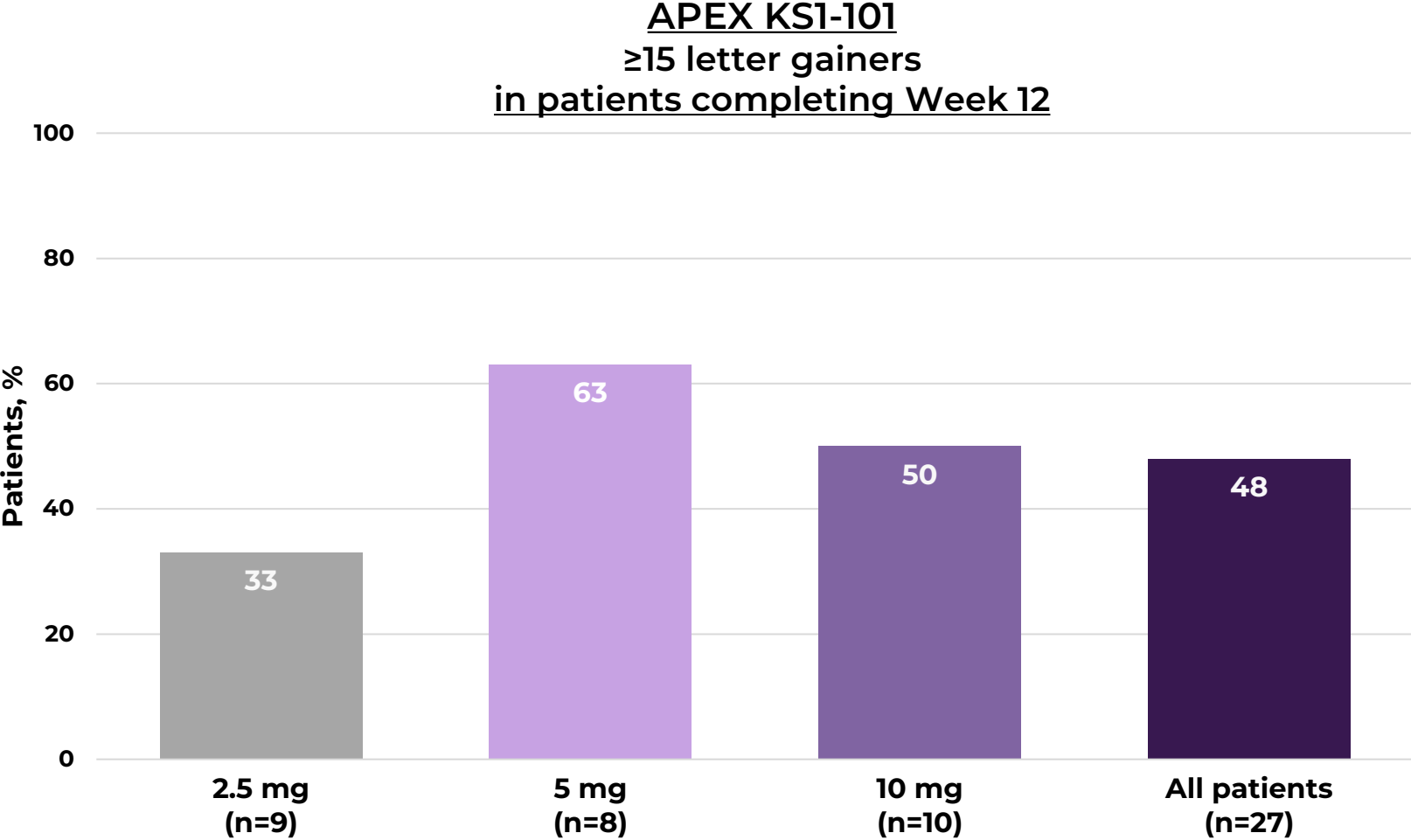
**How does KSI-101 fit into
the emerging treatment
landscape?**

DOVETAIL vamikibart – approximately a quarter of patients exhibit a ≥ 15 letter gain with anti-IL-6 monotherapy

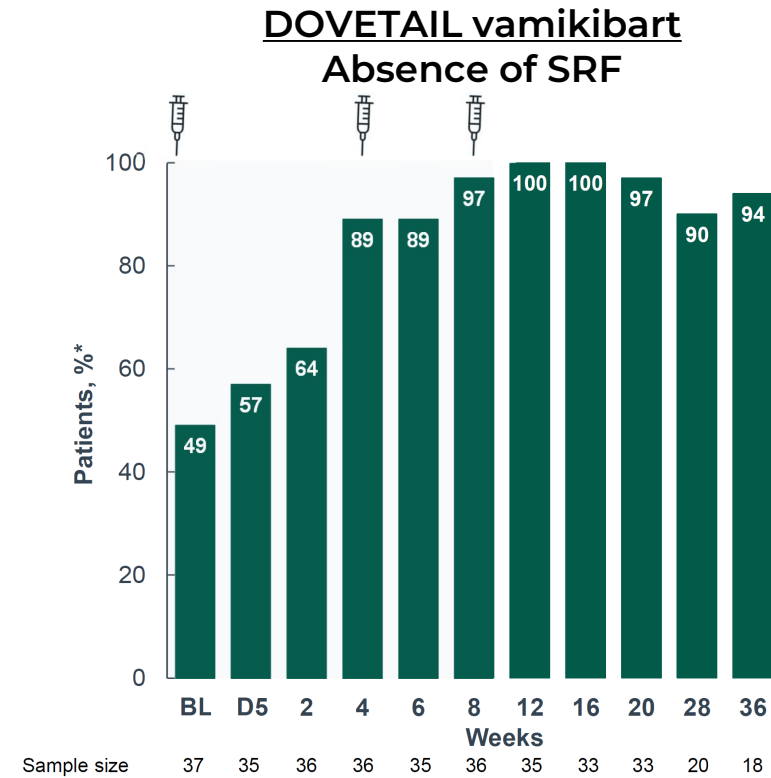
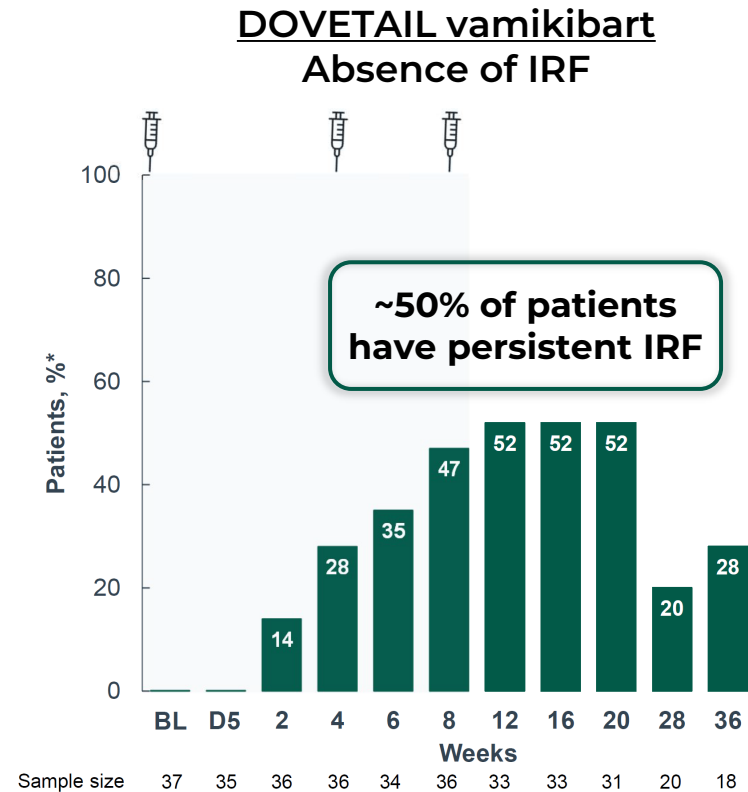
DOVETAIL vamikibart
 ≥ 15 letter gainers at Week 12



The dual IL-6 and VEGF inhibition of KSI-101 seems to confer additional visual benefits in patients with MESI, with ~half of patients achieving a ≥ 15 -letter improvement

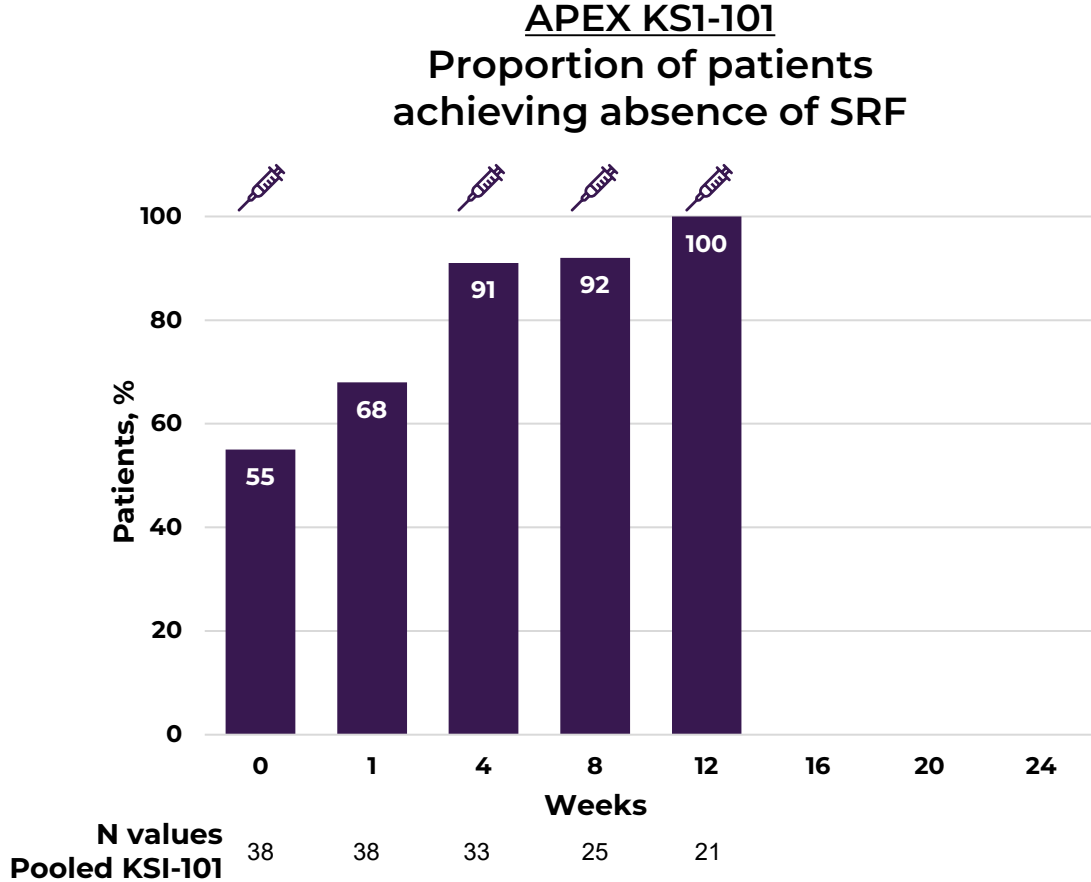
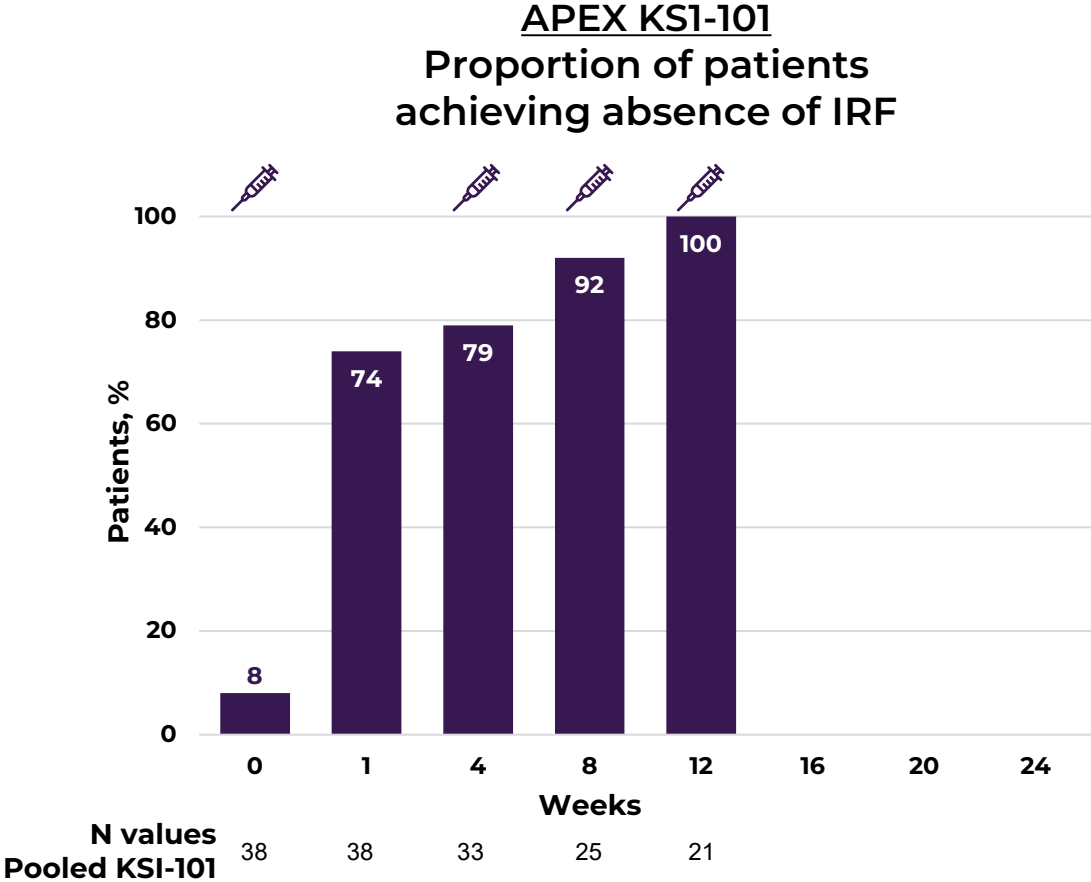


DOVETAIL vamikibart – while intravitreal IL-6 monotherapy is helpful, 50% of patients have persistent IRF



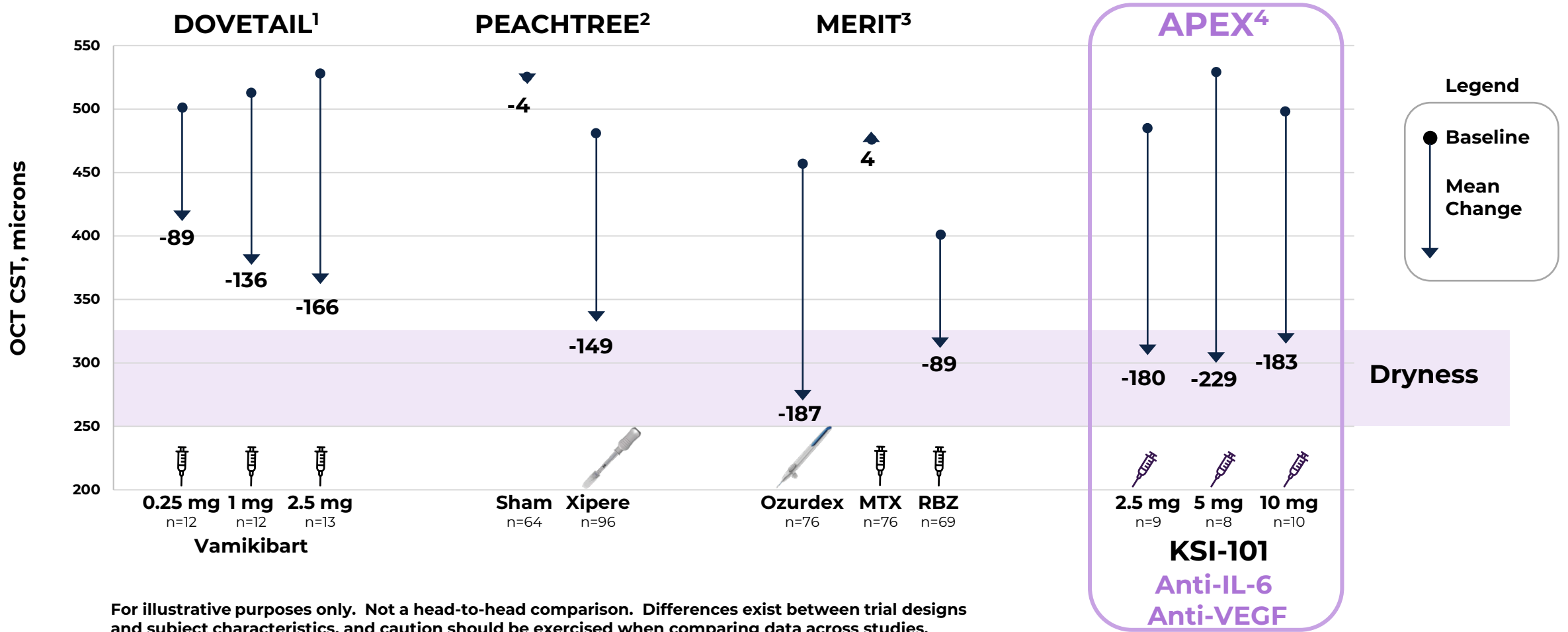
Persistent intraretinal fluid (IRF) is known to cause permanent negative effects on visual function

APEX KSI-101 in MESI – the dual IL-6 and VEGF inhibition of KSI-101 seems to provide faster and better disease control, with a clear effect seen as early as Week 1



KSI-101 rapidly dries the retina after a single injection

Mean Change in OCT CST and absolute CST achieved by Week 4

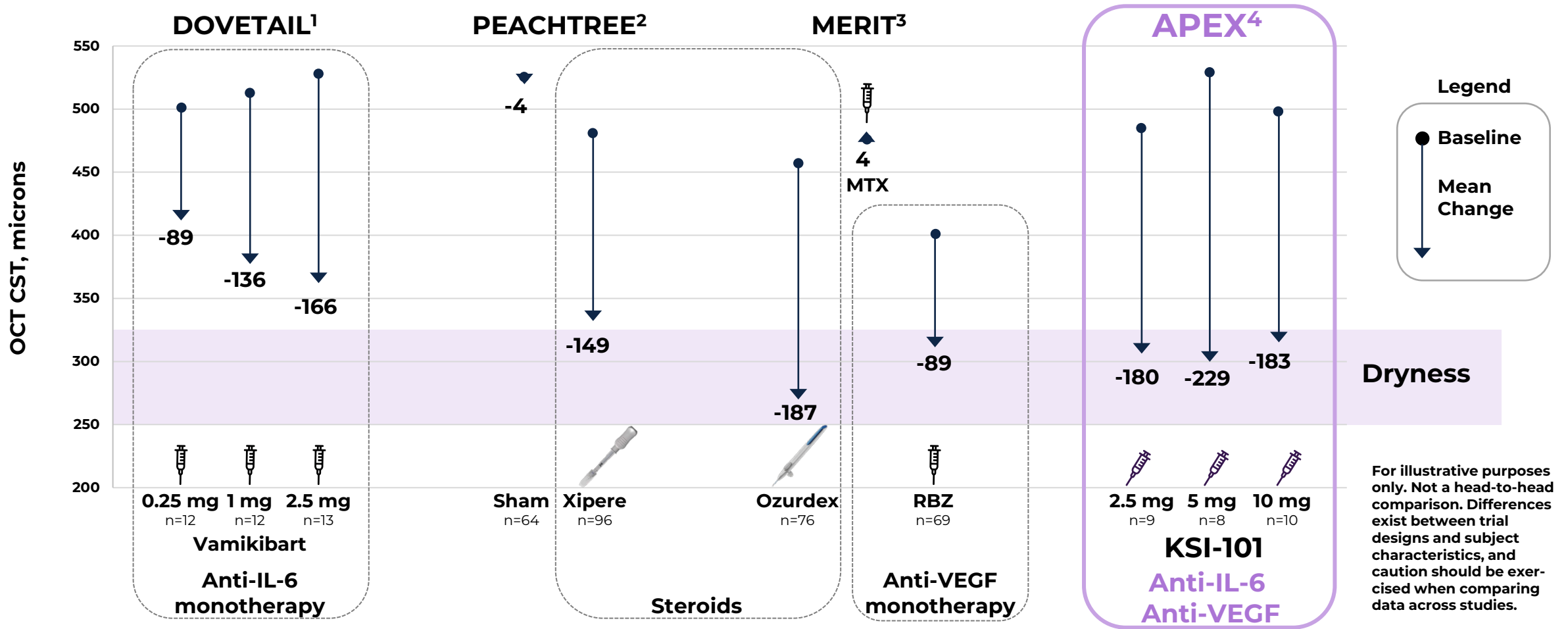


For illustrative purposes only. Not a head-to-head comparison. Differences exist between trial designs and subject characteristics, and caution should be exercised when comparing data across studies.

1. Sharma S, et al. A Novel Intravitreal Anti-IL-6 Monoclonal Antibody for Uveitic Macular Edema (UME): Preliminary Results From the Phase 1 DOVETAIL Study. Presented at the American Society of Retina Specialists, Seattle, WA, July 2023. Mean values adapted from CST graph on slide 10.
2. Yeh S, et al. Efficacy and Safety of Suprachoroidal CLS-TA for Macular Edema Secondary to Noninfectious Uveitis: Phase 3 Randomized Trial. Ophthalmology. 2020 Jul;127(7):948-955
3. Acharya NR, et al. The MERIT Trial Results. Ophthalmology. 2023 Sep;130(9):914-923. Mean values adapted from Figure S3 (supplemental).
4. Preliminary results. As the APEX study is ongoing, final results may be different due to additional data collection or data cleaning. Includes only patients in the per protocol set that completed the Week 12 visit by the cutoff date of 14-Jul-25 and meet all the eligibility criteria. Excludes one patient in the 10 mg dose with a significant epiretinal membrane at baseline (exclusion criterion)

Dual IL-6 and VEGF inhibition seems to provide a synergistic effect that results in additional anatomical benefits over either individual monotherapy

Mean Change in OCT CST and absolute CST achieved by Week 4



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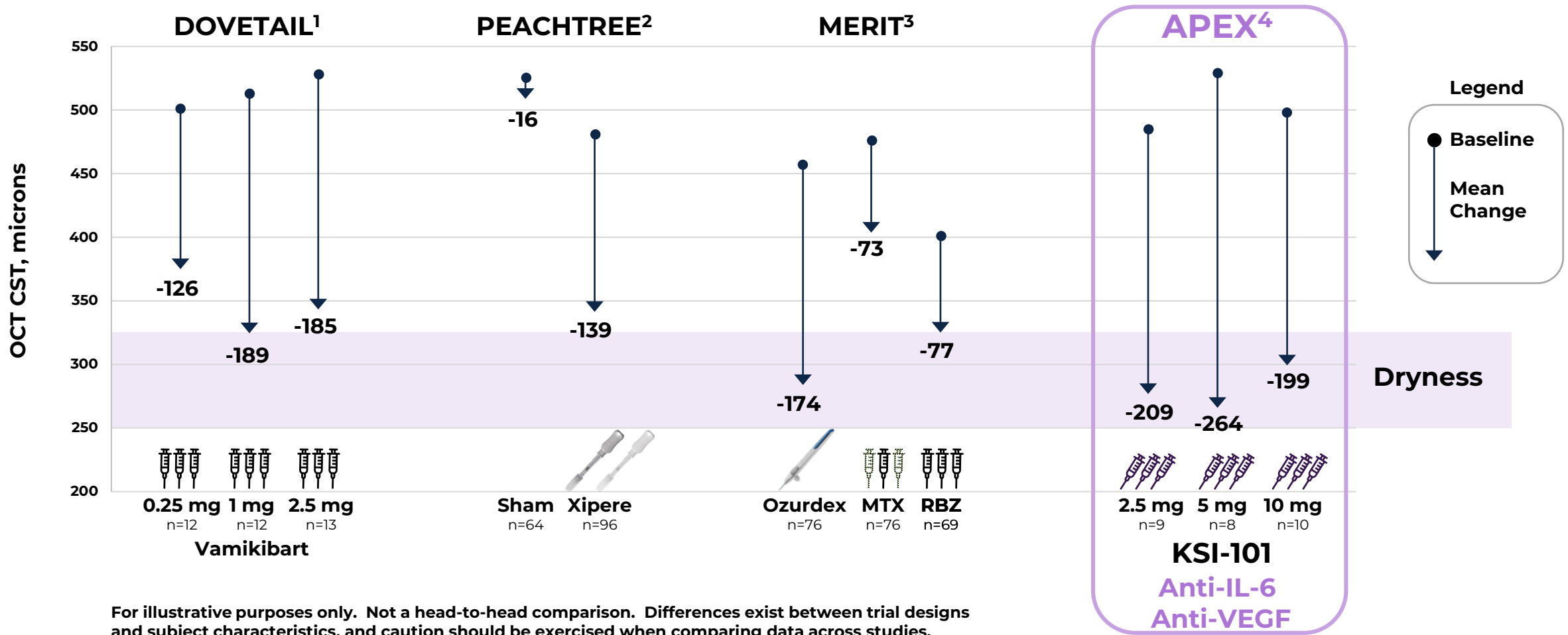
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KSI-101 provides continued disease control for MESI patients, as evaluated at Week 12 with the effect of 3 monthly doses

Mean Change in OCT CST and absolute CST achieved by Week 12

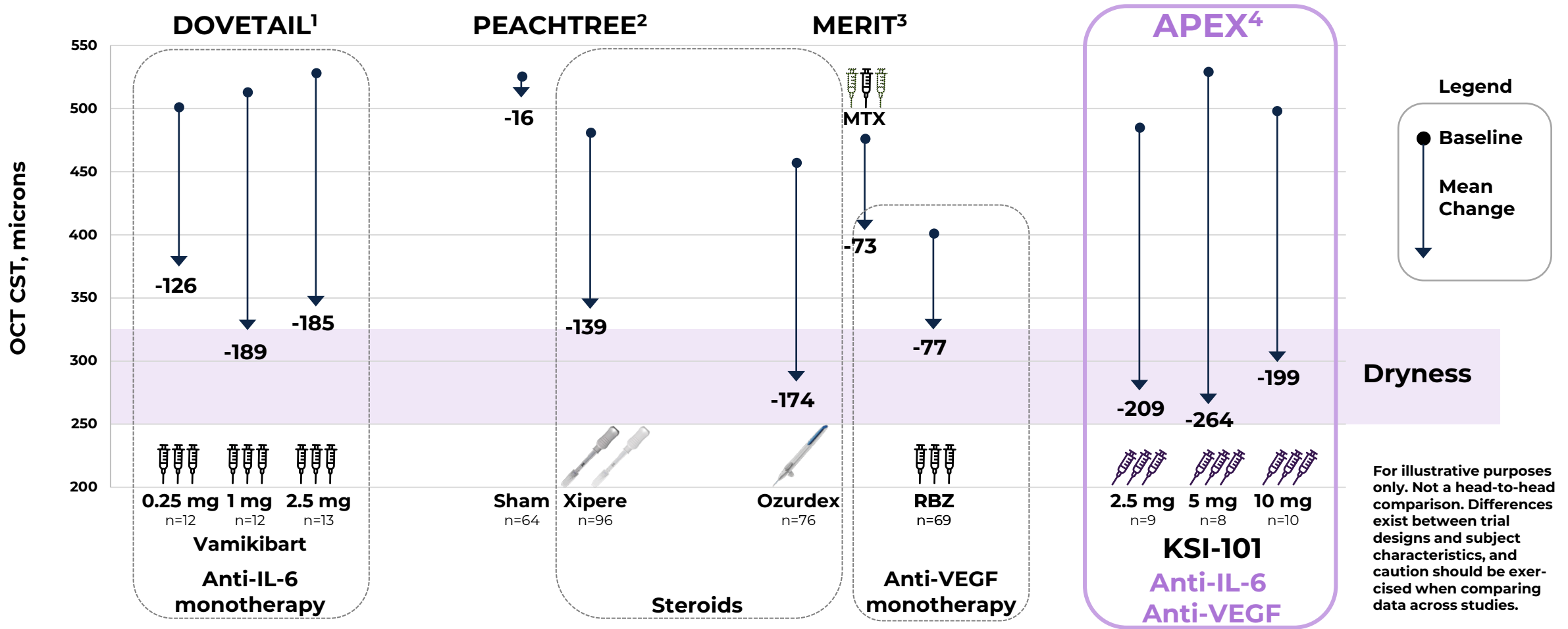


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Mean Change in OCT CST and absolute CST achieved by Week 12



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Sumit Sharma
MD

In Summary:

“Kodiak has designed a thoughtful bispecific trap-antibody-fusion protein. Early data from the Phase 1b APEX study are promising and show that –to date– the molecule appears safe and potent and to have a broad-spectrum activity in patients. I attribute this to the high strength and the dual anti-IL-6 and anti-VEGF mechanism. I see tremendous potential for KSI-101 to define a new treatment paradigm for patients with macular edema secondary to inflammation.

The objective now is to reproduce this data in a pivotal program, in similar populations as the APEX study, and for the molecule to take a next step towards the commercial marketplace and the many general ophthalmology, retina and uveitis practices in need!”



Charles Wykoff
MD, PhD

Macular Edema Secondary to Inflammation

PEAK and PINNACLE KSI-101 Pivotal Program

Phase 3 pivotal program in MESI – PEAK and PINNACLE Study Design

Weeks	Fixed monthly dosing						Individualized dosing						
	D1	4	8	12	16	20	24	28	32	36	40	44	48
KSI-101 5 mg (n~50)	■	■	■	■	■	■	◻	◻	◻	◻	◻	◻	
KSI-101 10 mg (n~50)	■	■	■	■	■	■	◻	◻	◻	◻	◻	◻	
Sham (n~50)	●	●	●	●	●	●	◐	◐	◐	◐	◐	◐	

- KSI-101 5 mg injection
- KSI-101 10 mg injection
- Sham injection
- ◻ Individualized treatment (PRN)
- ◐ Sham PRN

Primary endpoint

Key inclusion criteria

- Macular edema secondary to inflammation (MESI)
- Diagnosis of active or inactive non-infectious intraocular inflammation, acute or chronic.
- Active leakage as evidenced by fluorescein angiogram
- OCT CST of ≥ 320 microns
- BCVA score ≤ 78 and ≥ 25 (~20/25 to 20/320 Snellen)

Individualized treatment criteria (Week 24-44)

- Increase in OCT CST ≥ 50 μm compared to the lowest previous measurement, or
- OCT CST > 320 μm

PEAK and PINNACLE are actively enrolling

Phase 3 pivotal program in MESI – PEAK and PINNACLE Study Design

Weeks	Fixed monthly dosing						Individualized dosing						
	D1	4	8	12	16	20	24	28	32	36	40	44	48
KSI-101 5 mg (n~50)	■	■	■	■	■	■	◻	◻	◻	◻	◻	◻	
KSI-101 10 mg (n~50)	■	■	■	■	■	■	◻	◻	◻	◻	◻	◻	
Sham (n~50)	●	●	●	●	●	●	◐	◐	◐	◐	◐	◐	

- KSI-101 5 mg injection
- KSI-101 10 mg injection
- Sham injection
- ◻ Individualized treatment (PRN)
- ◐ Sham PRN

Primary endpoint

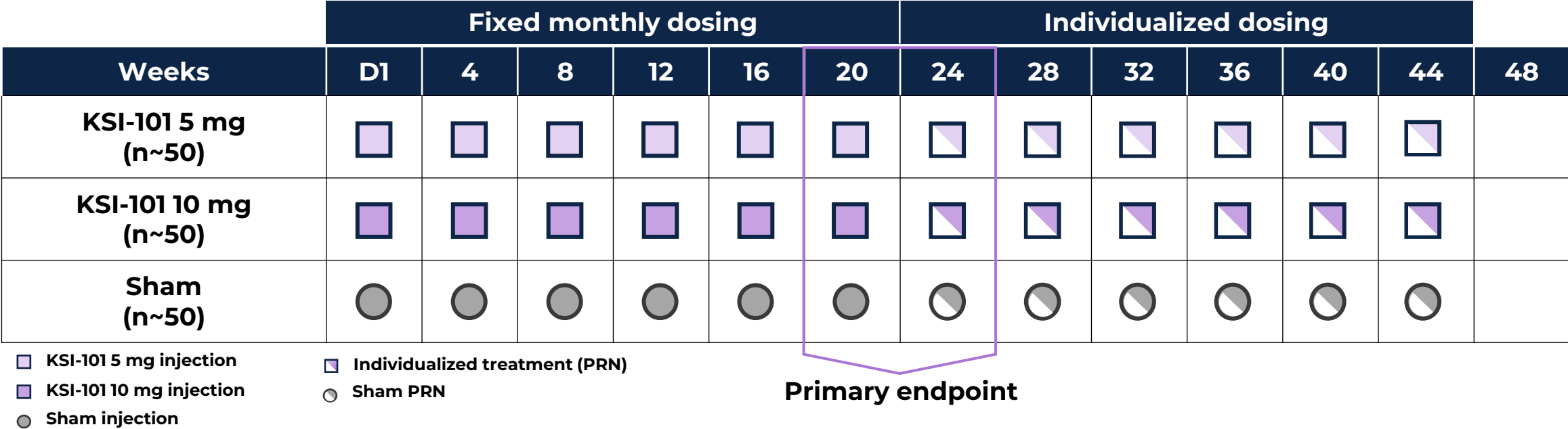
Rescue Treatment allowed from Week 4 to Week 44, when warranted

Rescue criteria

- BCVA decrease ≥ 15 letters *and* CST worsening by ≥ 100 μm from Day 1, due to MESI.
- Worsening of inflammation by ≥ 2 grade levels in anterior chamber cells and/or vitreous haze; or progression to grade 4.
- The intraocular inflammation complications in the Study Eye did not improve and require rescue treatment to prevent irreversible loss of vision per Investigator’s judgment.

PEAK and PINNACLE are actively enrolling

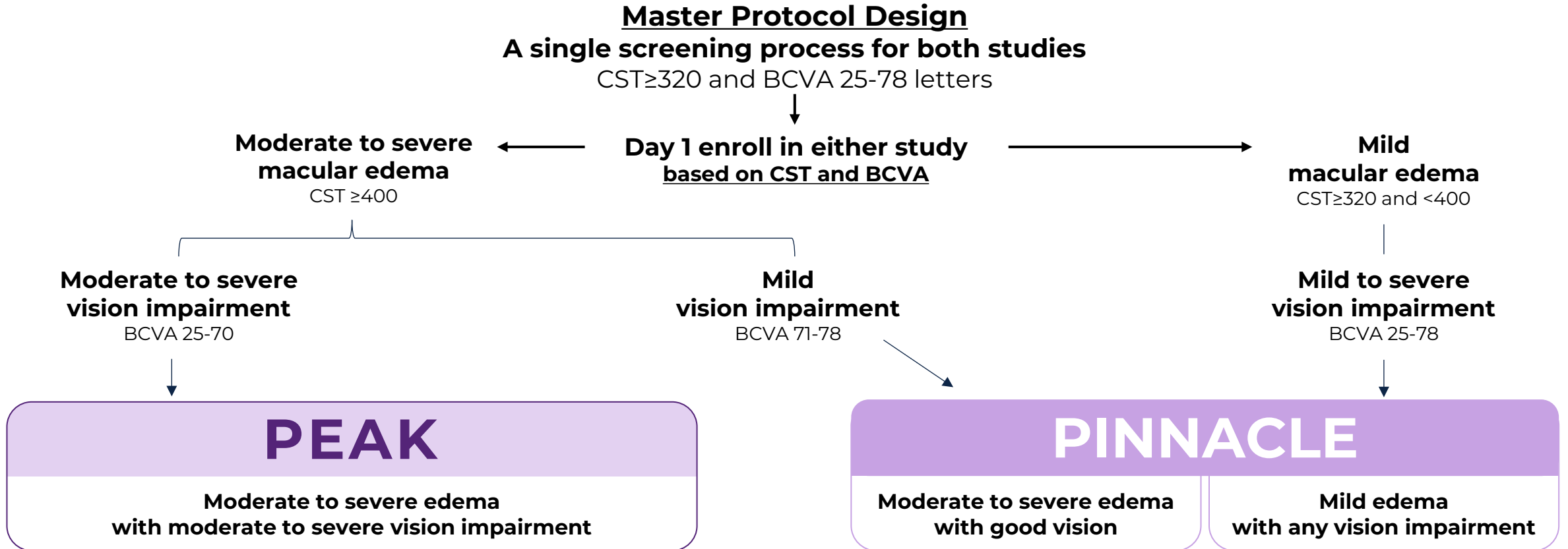
Phase 3 pivotal program in MESI – PEAK and PINNACLE Study Design



	PEAK	PINNACLE	
Primary endpoint	BCVA change from baseline to the average of Week 20 and 24		
Key secondary endpoints	Time to 15 letter gain	Time to 15 letter gain	Time to 15 letter loss

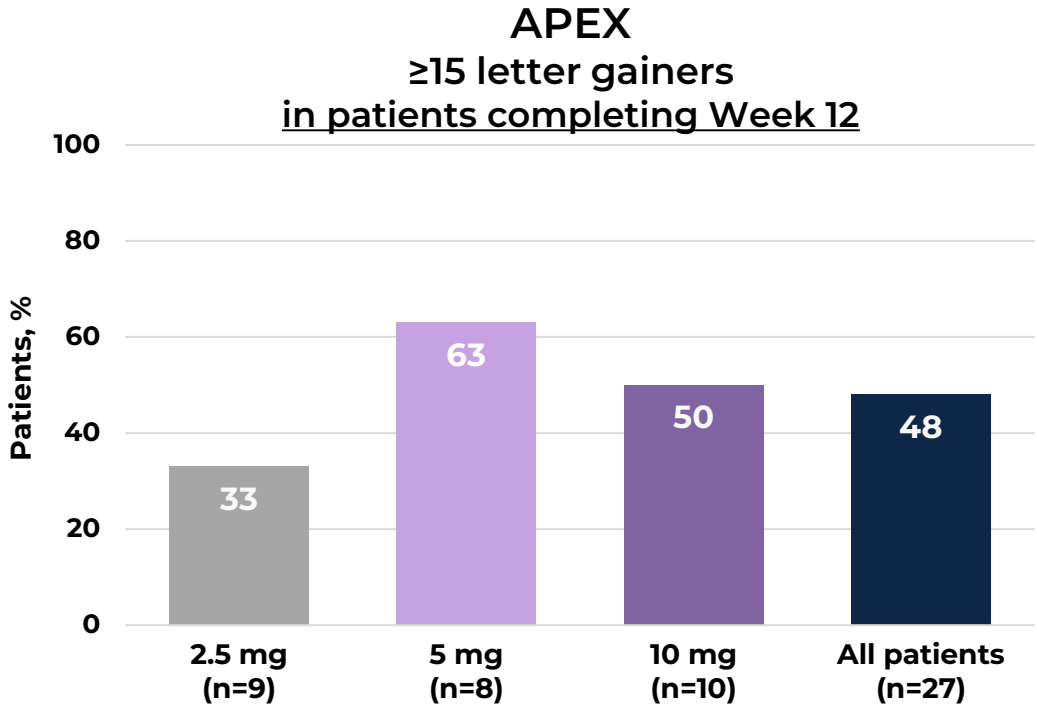
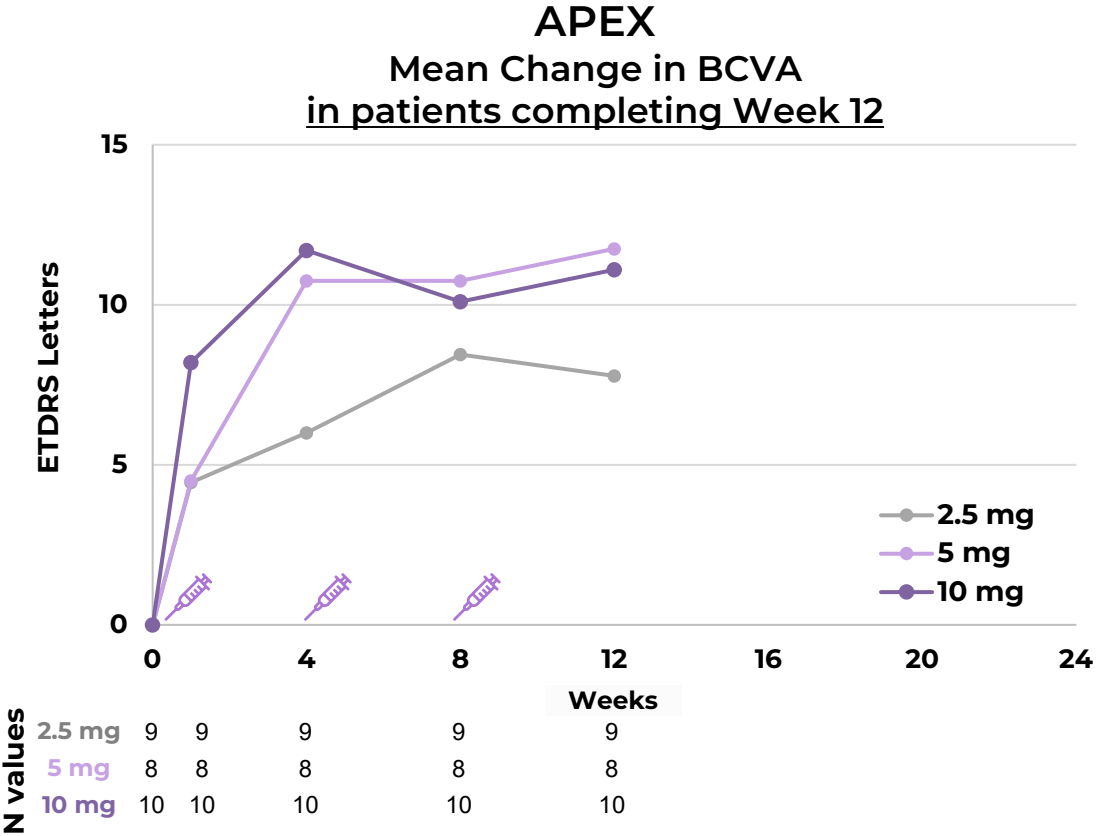
PEAK and PINNACLE are actively enrolling

PEAK and PINNACLE – Key question: are these identical studies?



Based on the MESI patient population studied in APEX, two distinct and complementary sub-populations will be studied in PEAK and PINNACLE, allowing both studies to run concurrently in all study sites and covering a wide spectrum of MESI patients

PEAK and PINNACLE – Key question: Why are the APEX top two dose levels selected?

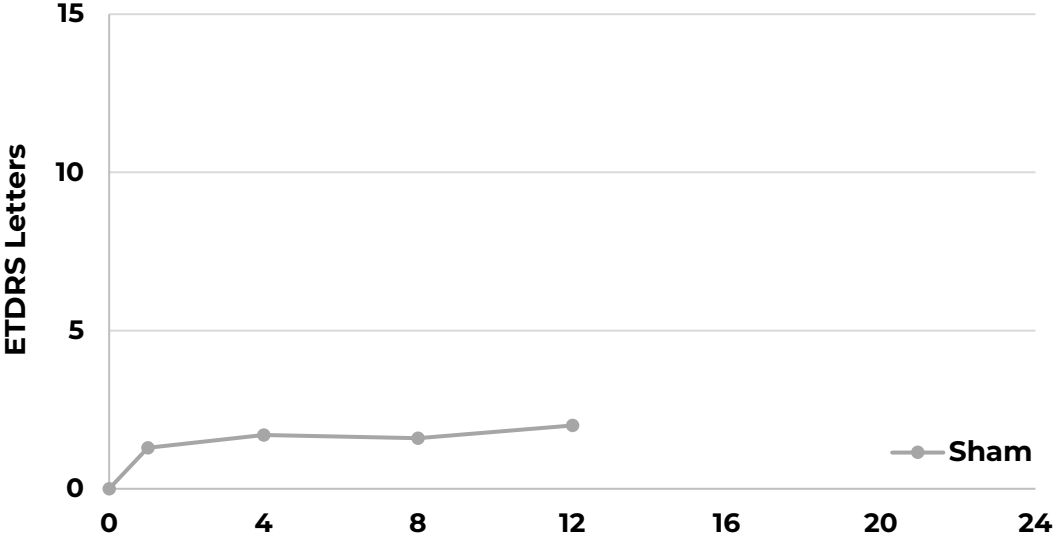


The KSI-101 5 mg and 10 gm dose levels were selected to advance into PEAK and PINNACLE, based on:

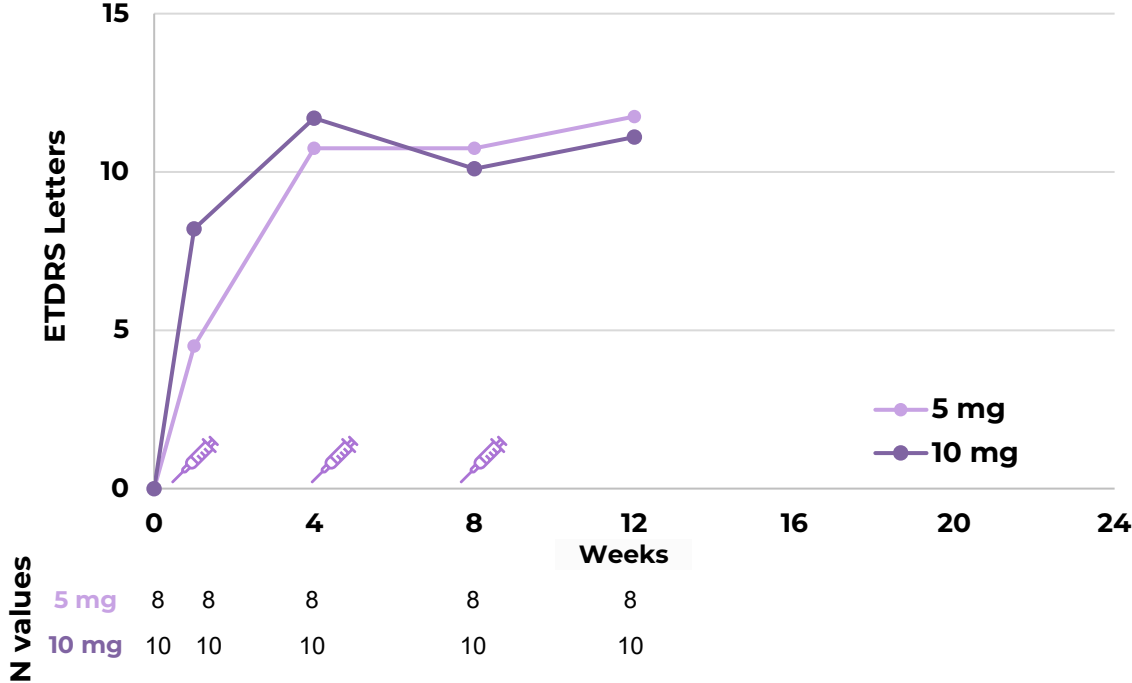
- Greater visual acuity gains achieved, particularly 15-letter gainers
- Similar safety profile across all dose levels

PEAK and PINNACLE – Key question: Why is mean change in BCVA the primary endpoint and not ≥ 15 letter gainers or losers?

PEACHTREE¹
 Mean Change in BCVA
in sham treated patients



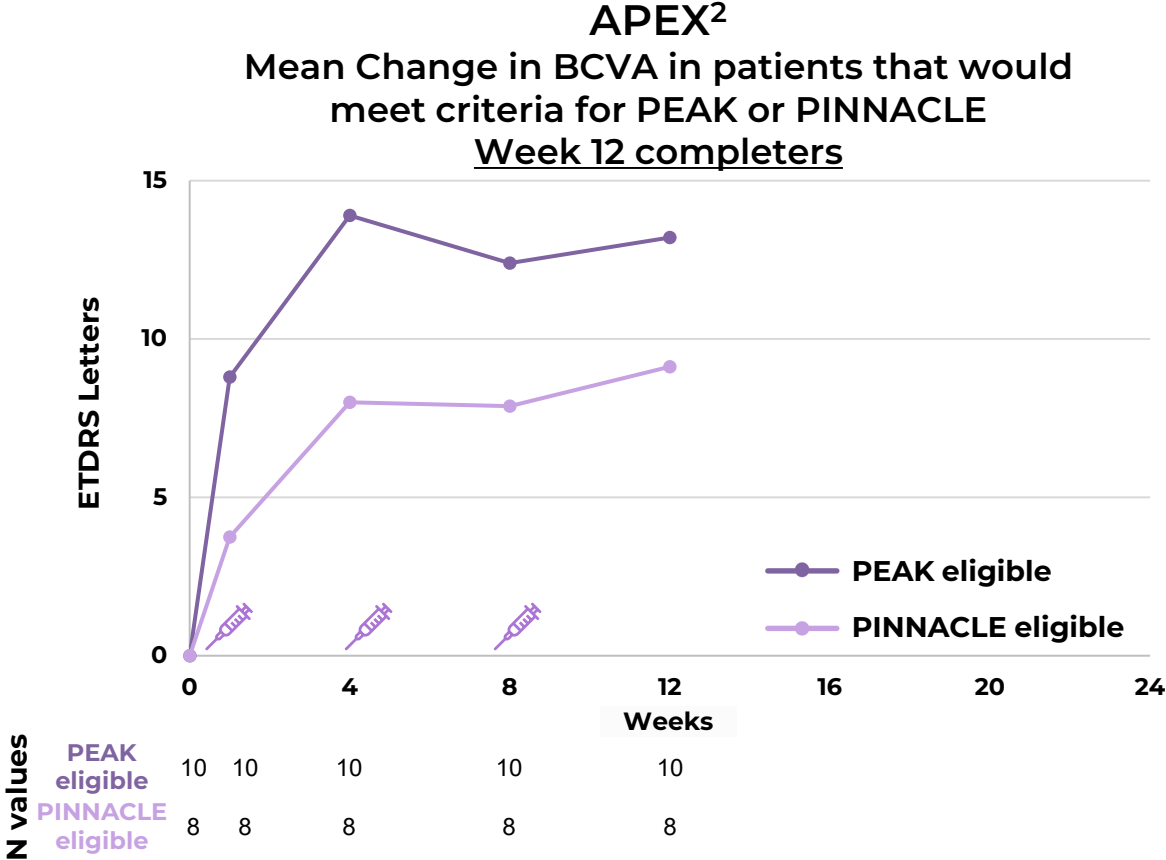
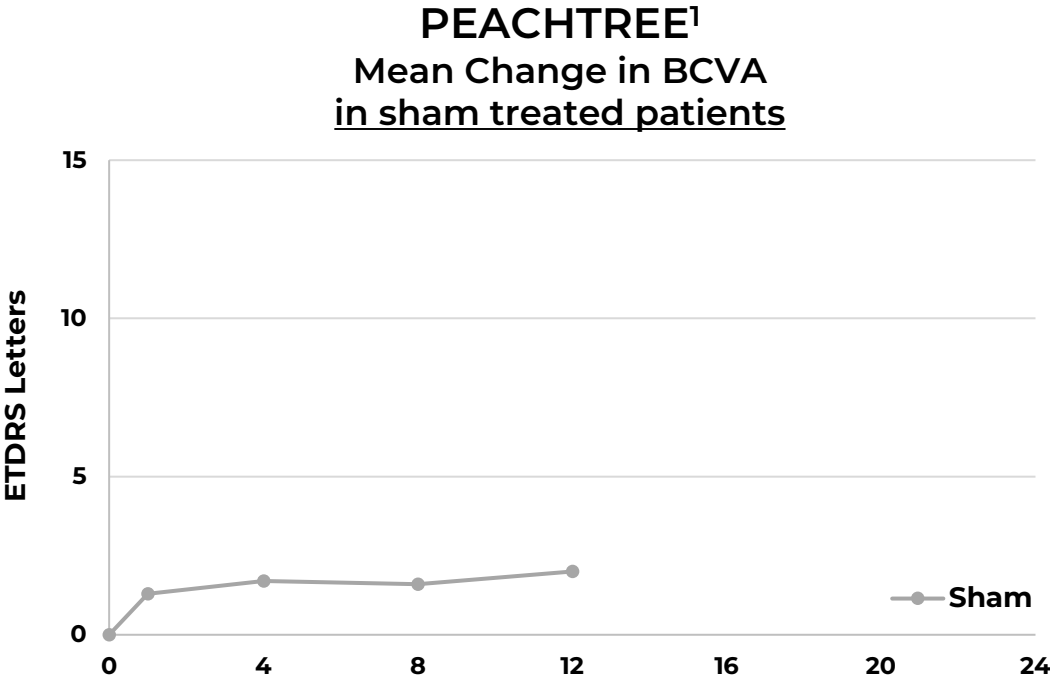
APEX²
 Mean Change in BCVA
in patients completing Week 12



Evaluating mean change in BCVA as the primary endpoint maximizes the potential for both studies to be positive

Cross-trial assessments should be interpreted with caution due to various limitations
 1. Yeh S, et al. Efficacy and Safety of Suprachoroidal CLS-TA for Macular Edema Secondary to Noninfectious Uveitis: Phase 3 Randomized Trial. Ophthalmology. 2020 Jul;127(7):948-955
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PEAK and PINNACLE – Key question: Why is mean change in BCVA the primary endpoint and not ≥ 15 letter gainers or losers?



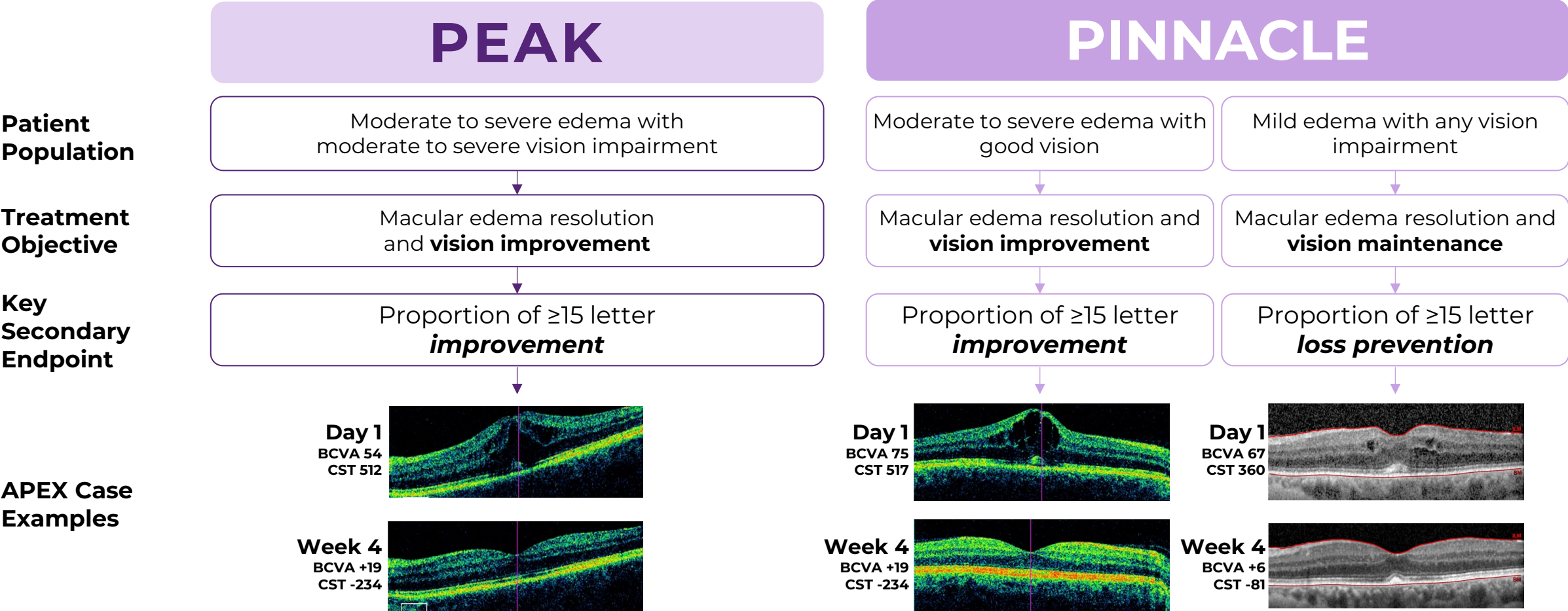
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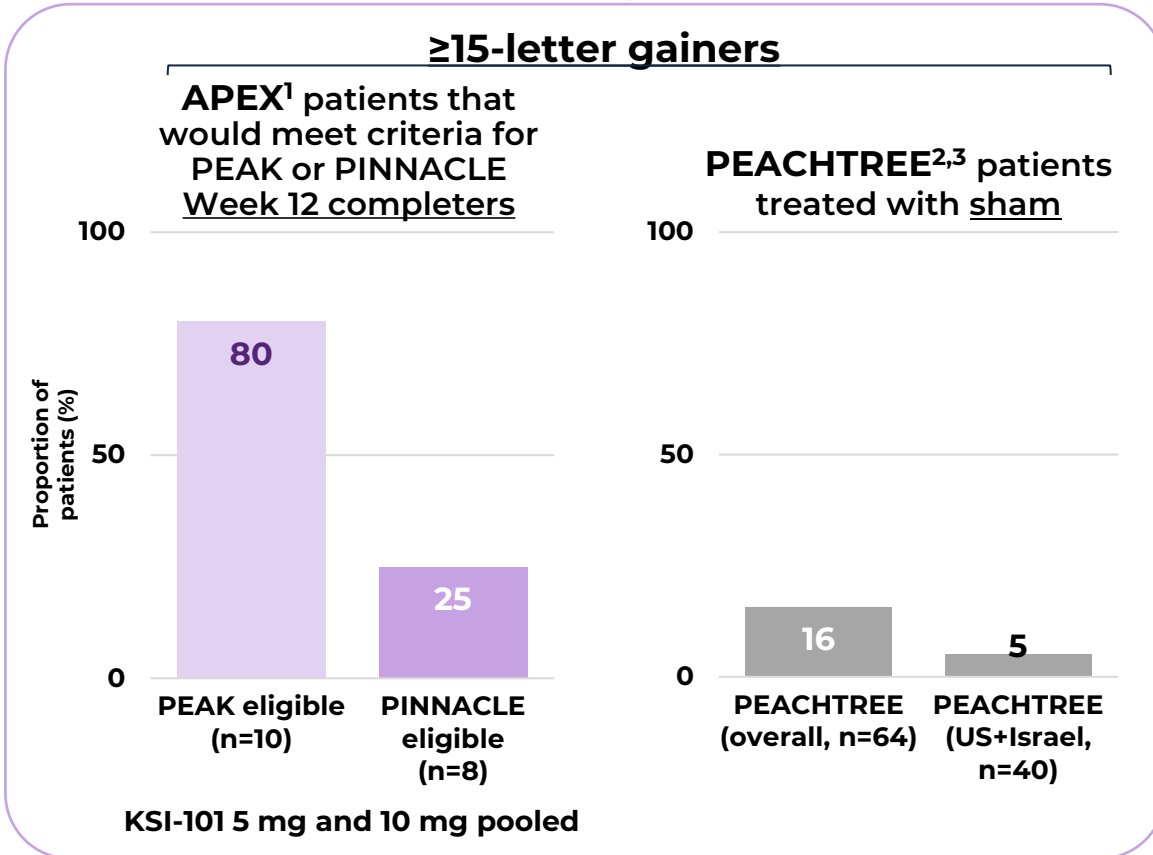
PEAK and PINNACLE – Key question: why are the key secondary endpoints different between PEAK and PINNACLE?



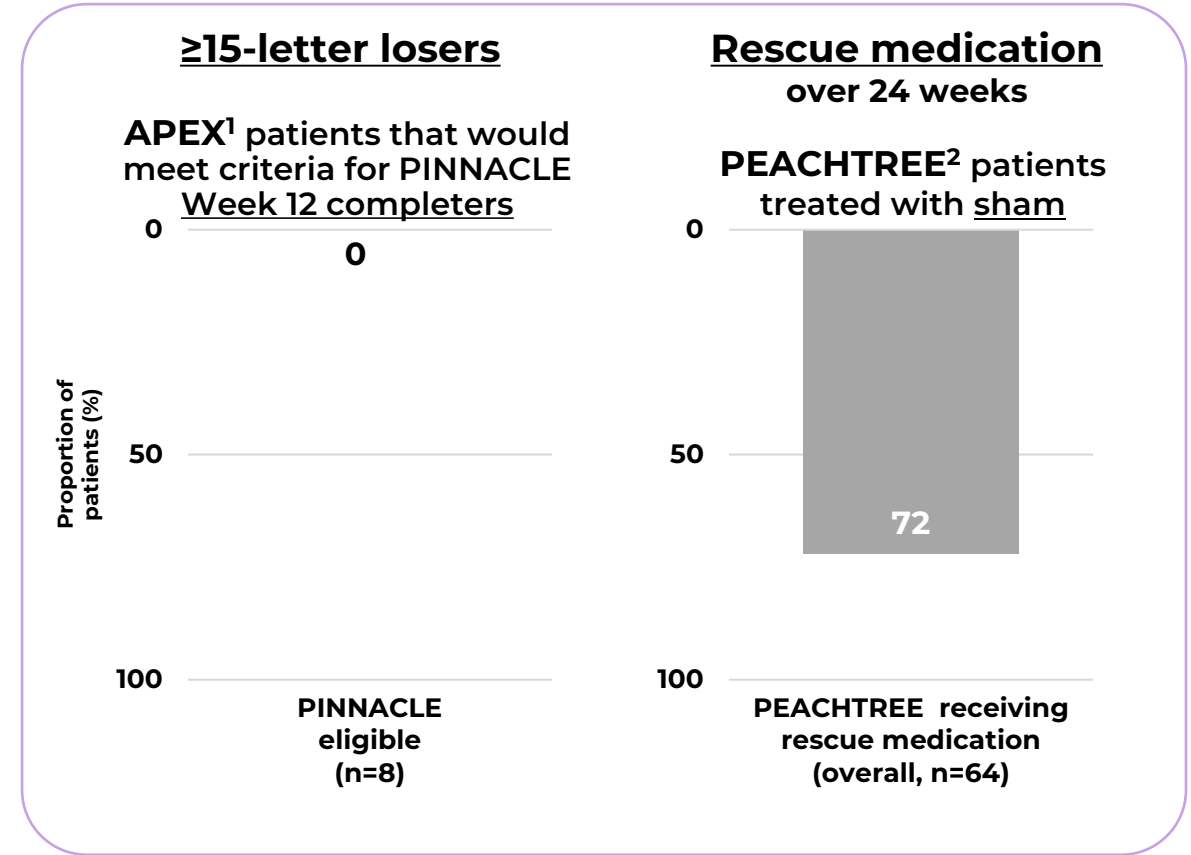
The Key Secondary Endpoints are tailored specifically to the patient population included in their respective study

PEAK and PINNACLE – Key question: how do the APEX data educate the probability of success of PEAK and PINNACLE?

Improving vision



Preventing vision loss



The APEX data provide confidence in the probability of success of PEAK and PINNACLE, based on the predicate study PEACHTREE

Cross-trial assessments should be interpreted with caution due to various limitations

1. Preliminary results. As the APEX study is ongoing, final results may be different due to additional data collection or data cleaning. Includes only patients in the per protocol set that meet all the inclusion and exclusion criteria. Excludes one patient in the 10 mg dose with a significant epiretinal membrane at baseline (exclusion criterion). Includes all data available by the 14-Jul-25 reporting date.

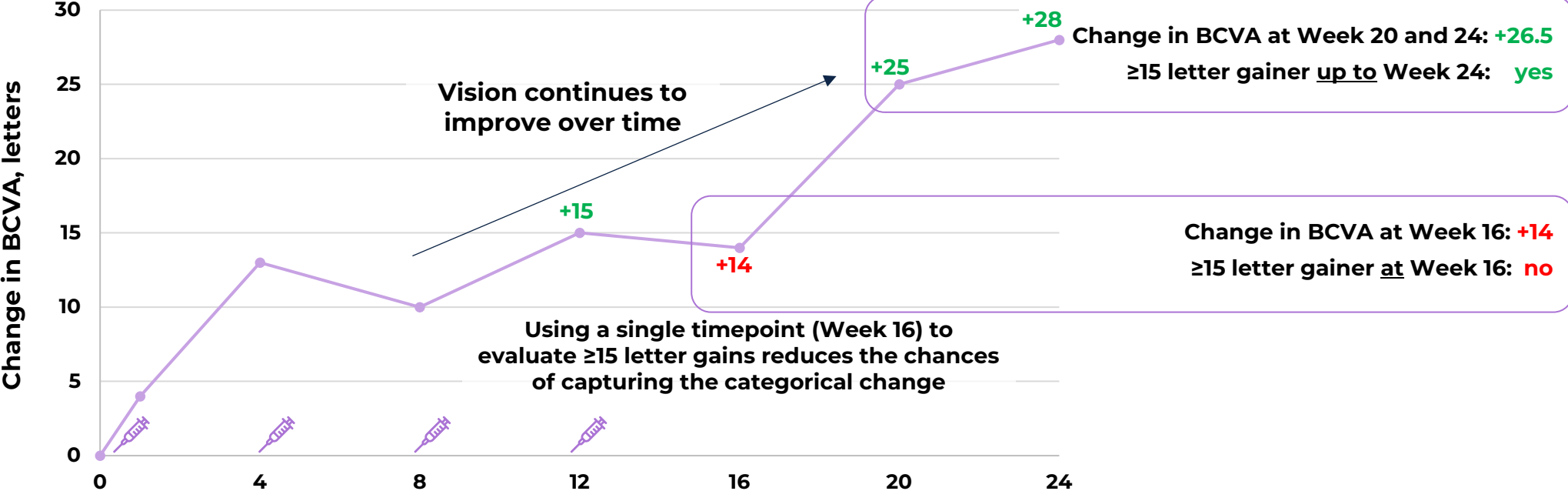
2. Yeh S, et al. Efficacy and Safety of Suprachoroidal CLS-TA for Macular Edema Secondary to Noninfectious Uveitis: Phase 3 Randomized Trial. Ophthalmology. 2020 Jul;127(7):948-955

3. Xipere FDA Center for Drug Evaluation and Research Biologics Licensing Application Statistical Review. Application number 211950Orig1s000

PEAK and PINNACLE – Key question: Why are the primary and key secondary endpoints evaluated up to Week 24 and not at Week 16?

APEX Case Example

Patient treated with KSI-101 5 mg

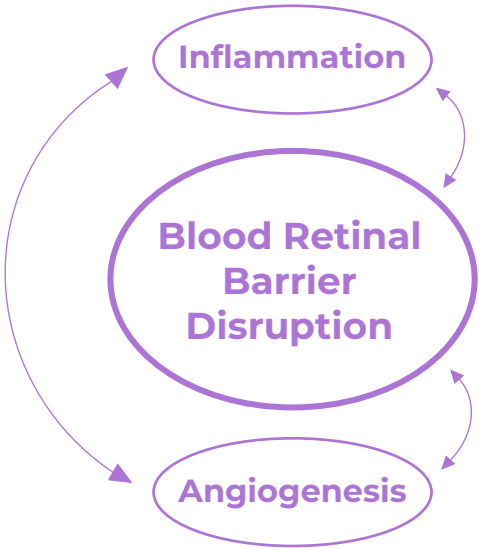


Optimizing the timing of the primary and key secondary endpoints from Week 16 to Week 24, maximizes the vision gains (mean change and categorical)

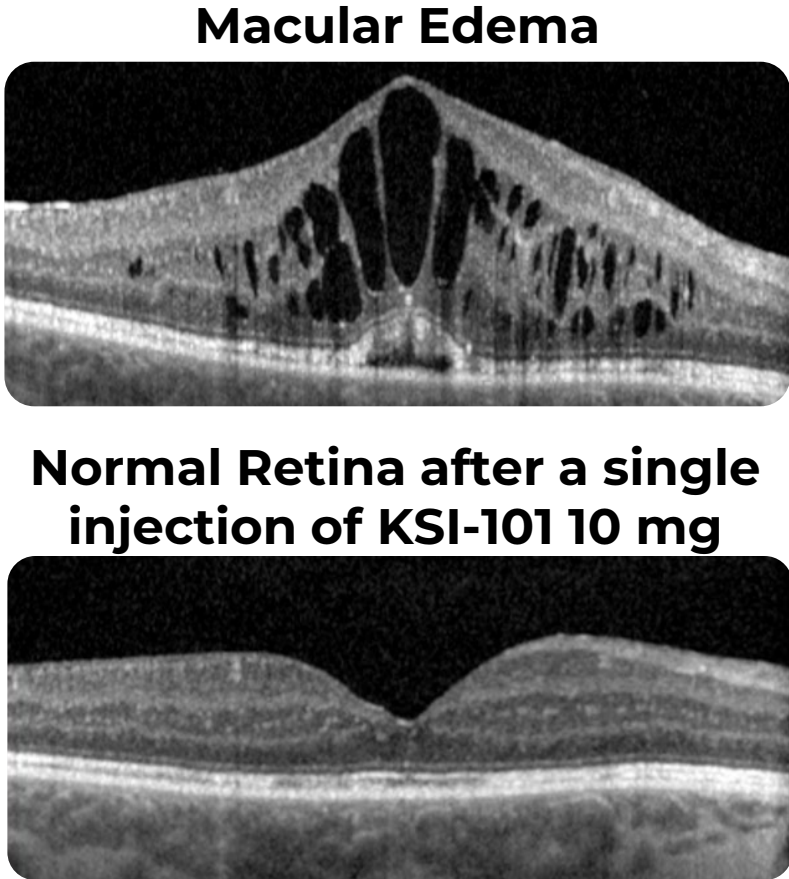
Evaluating the key secondary endpoints over time maximizes the chance of capturing the categorical change and thus, meeting the key secondary endpoint

MESI is a heterogeneous spectrum of diseases with a common clinical presentation and a common pathophysiology. KSI-101 has the potential to become the first line common therapy for MESI

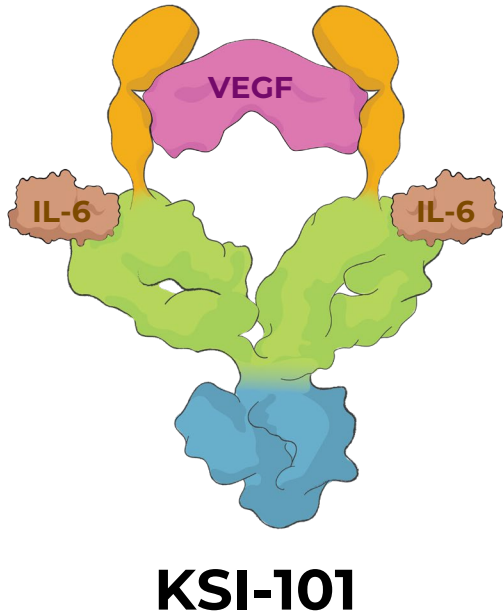
Common Pathophysiology



Common Clinical Presentation



Potential common therapy





Dolly S. Chang, MD, PhD
Chief Scientific Officer

A Patient's MESI Journey

Kodiak, Ophthalmologist and Glaucoma Surgeon



Dolly S. Chang, MD, PhD

Chief Scientific Officer, Kodiak Sciences Inc.

Ophthalmologist, Glaucoma Surgeon

Adjunct Clinical Assistant Professor of Ophthalmology, Stanford University

- At Kodiak, Dr. Chang oversees pipeline development and advances transformative therapies for retinal disease
- Prior to Kodiak, Dr. Chang was Group Medical Director at Genentech Research and Early Clinical Development (gRED), where she steered development programs through translational and clinical stages and championed new therapeutic areas including glaucoma neuroprotection
- Dr. Chang holds a position as Adjunct Clinical Assistant Professor at Stanford University's Byers Eye Institute, continuing her clinical practice in cataract and glaucoma surgeries

Patient journey #1: “a crazy amount of eye drops for macular edema and inflammation” – a physician's perspective as a patient



“I had macular edema that rose and fell with each flare, and I went through what felt like a million OCTs. The only treatment was Durezol eyedrops, which kept the inflammation in check, but it came at a cost—my eye pressure spiked, and I developed glaucoma.

In addition to Durezol, I was juggling three pressure-lowering drops, plus a non-steroidal and a dilating drop to prevent scarring. That became my routine that was exhausting to manage, even as a physician.

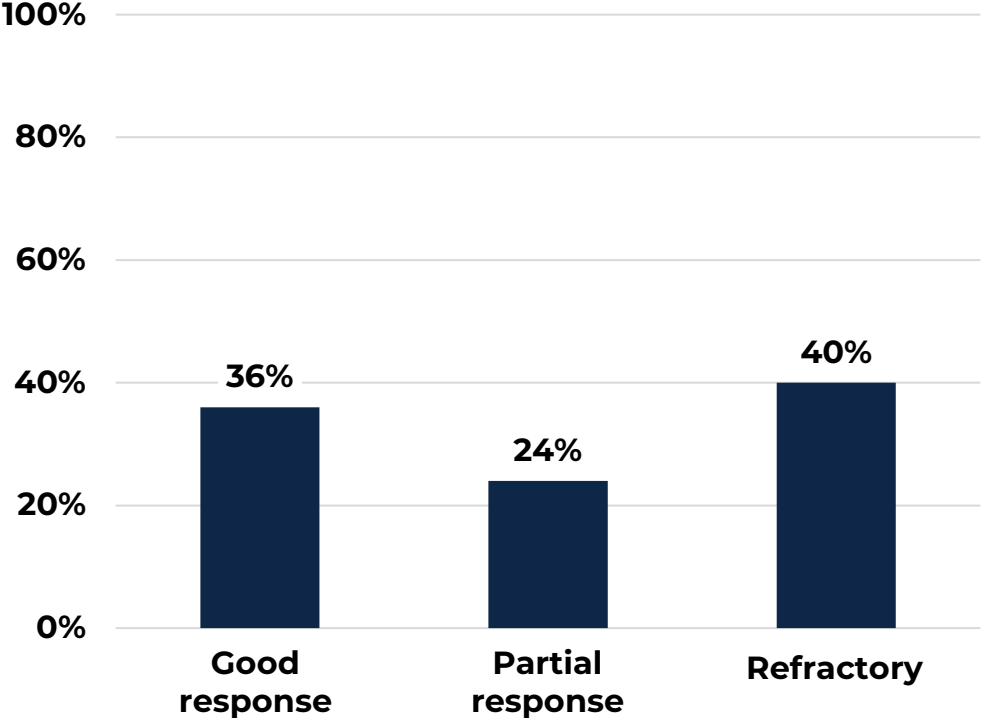
I was never treated with intravitreal steroids.”

Patient’s eyedrop schedule

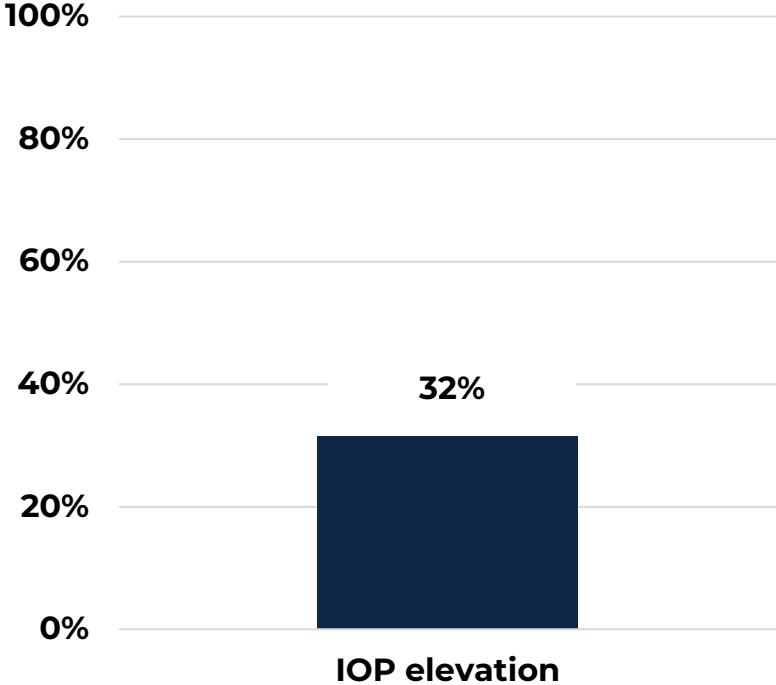
	Morning	Noon	Afternoon	Evening
Difluprednate	●			●
Ketorolac	●	●	●	●
Cyclopentolate	●		●	
Brimonidine	●	●	●	
Timolol	●		●	
Dorzolamide	●		●	

Limited resolution and IOP risk highlight limitations of steroid eyedrops in MESI

In 36% of patients, topical steroids (difluprednate, Durezol) controlled the disease. In 40% of patients, the disease was refractory to steroid drops



32% of patients on Durezol drops had an IOP response that is clinically concerning



Patient journey #2: 52-year-old healthy woman with bilateral blurry vision and floaters

No prior ocular history, only requires reading glasses

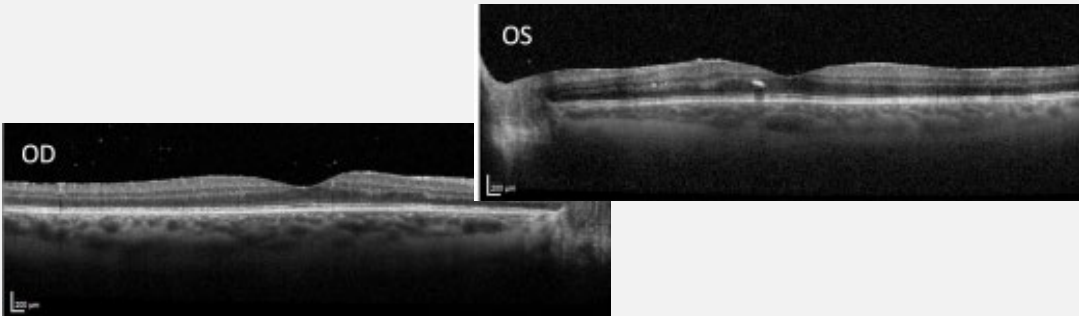


Eye examination:

- Vision OD 20/32 & OS 20/25, normal eye pressure
- Mild anterior segment inflammation, vitritis
- Scattered yellowish-white retinal lesions

Ocular imaging:

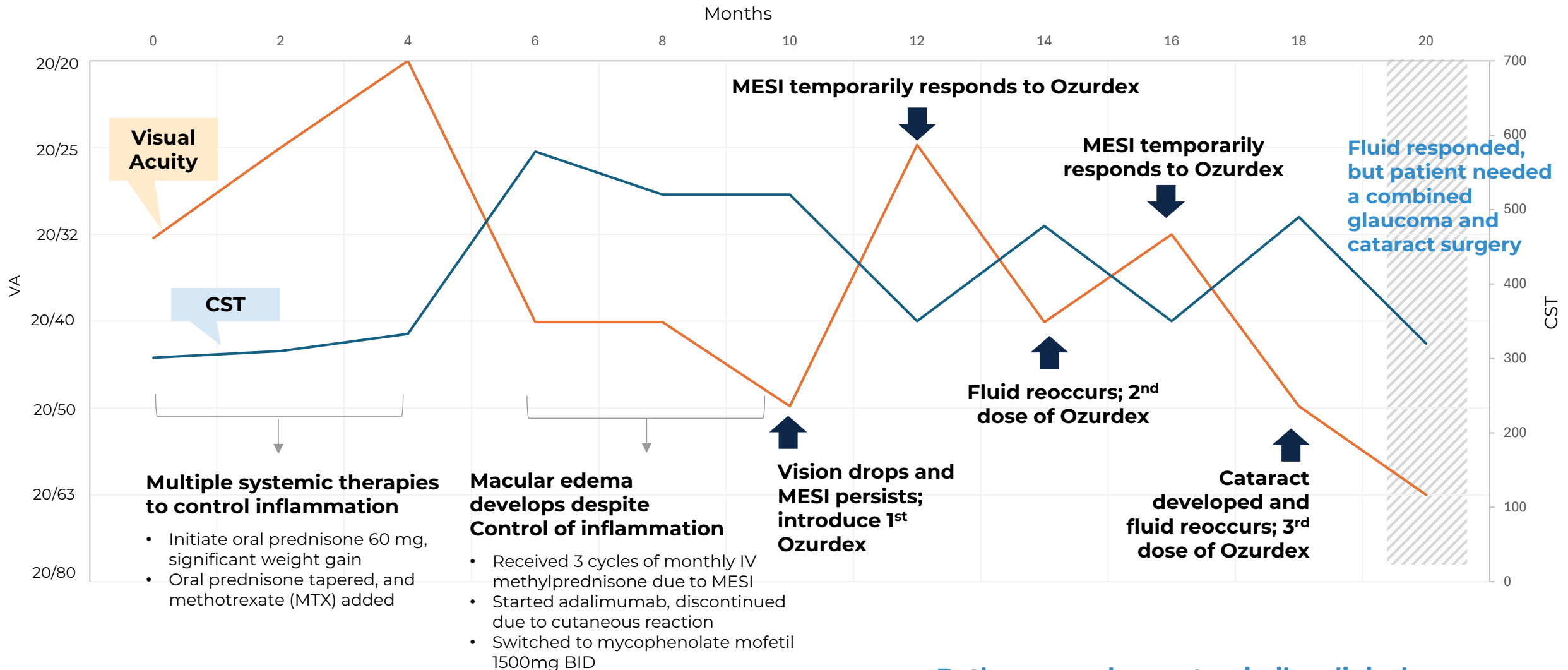
- OCT: no thickening at presentation
- Fluoresceine angiography: peripheral vasculitis



Physical exam	Differential Diagnosis
Rashes/lesions/ulcers	Behcet's, psoriasis, VKH, Lupus, herpes
Joints/arthritis/spine mobility	RA, ankylosing spondylitis, reactive arthritis
Lymphadenopathy	Sarcoidosis, infection, lymphoma
Neurological deficits/headache	MS, neurosarcoidosis, VKH, Behçet's, syphilis
Gastrointestinal system	IBD
Laboratory/Systemic Imaging	
CBC/DC	For all uveitis
ESR, CRP	For all uveitis
HLA-A29	Birdshot
ACE/Lysozyme	Sarcoidosis
Chest X-ray or CT	Sarcoidosis
RPR, VDRL, FTA-ABS	Syphilis
PPD	TB
QuantiFERON	TB
Chest X-ray	TB
Lyme antibodies	Lyme

This patient illustrates the diagnostic complexity of non-infectious uveitis—a broad work-up was negative except for HLA-A29+, which, with the presence of chorioretinal lesions, leading to a diagnosis of birdshot chorioretinopathy, a chronic, bilateral posterior uveitis

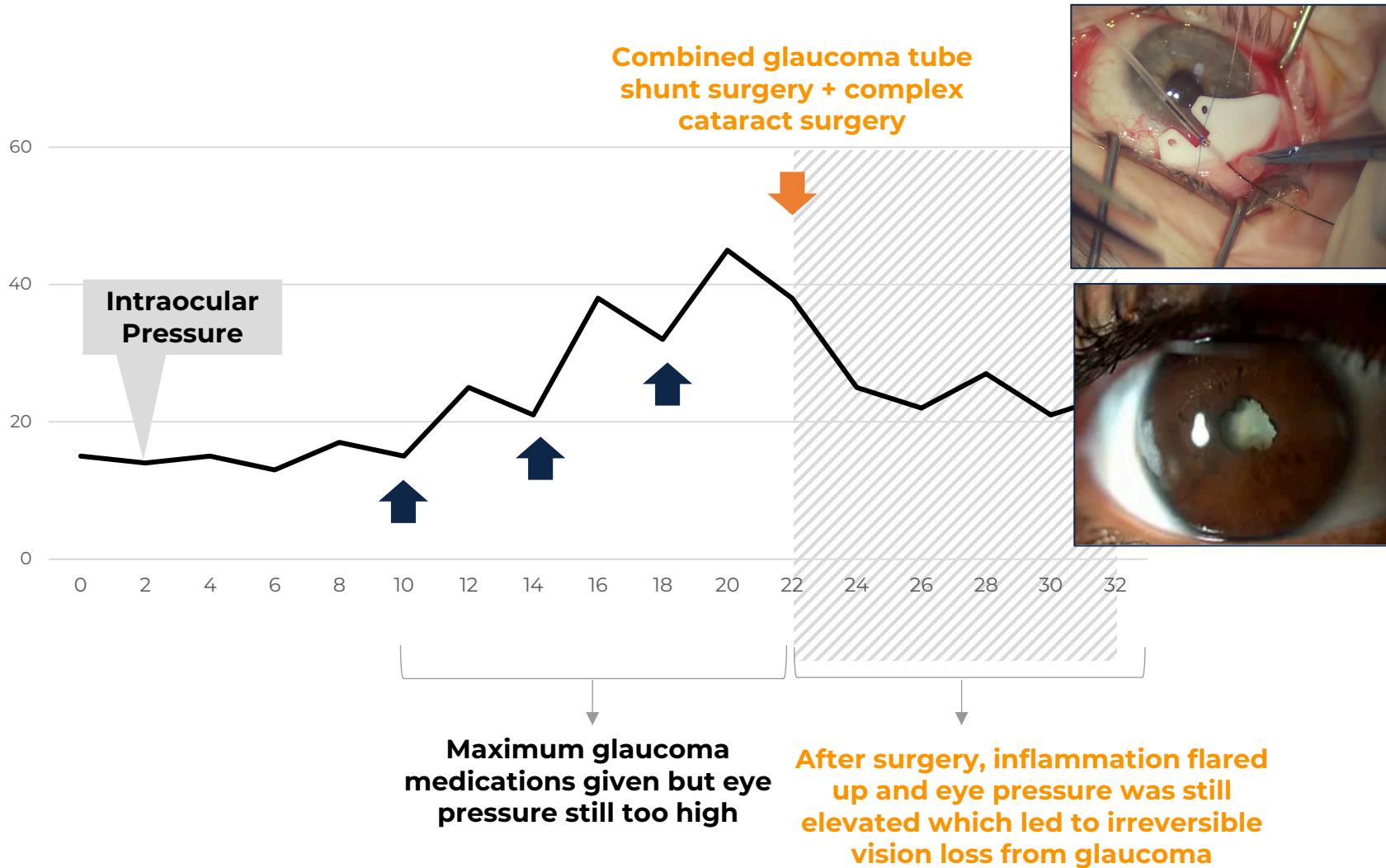
Treatment today is complex: MESI can persist and recur despite inflammation resolution and multiple therapies



This representative case is based on Dr. Quan Nguyen's clinical experience, literature, and reviewed by uveitis consultants. Int Med Case Rep J. 2025 Mar30;18:445-460. J Ophthalmic Inflamm Infect 2025 Mar 13;15(1):25; Clin Ophthalmol. 2013 Dec 18;8:73-81

Both eyes underwent a similar clinical course, only right eye is shown here

When steroids help and harm: the challenge of managing glaucoma in MESI patients requiring ocular steroids



The stronger the steroid, the stronger the side effects

For example, RETISERT® (fluocinolone acetonide intravitreal implant) label:

- **60% of patients will require chronic IOP lowering medications** to control intraocular pressure and **37% will require filtering procedures** to control intraocular pressure
- Within an average post-implantation period of approximately 2 years, **nearly all phakic eyes are expected to develop cataracts and require cataract surgery**

This representative case is based on Dr. Quan Nguyen's clinical experience, literature, and reviewed by uveitis consultants.

Toward unified MESI management: can KSI-101 deliver potency without the glaucoma and surgical burden of steroids?

Today

Complex Diagnosis

- Idiopathic
- Vogt-Koyanagi-Harada disease
- Behcet's disease
- HLA-B27 associated
- Juvenile idiopathic arthritis
- Multiple sclerosis
- Pars planitis
- Birdshot chorioretinopathy
- Multifocal choroiditis
- Sarcoidosis
- Refractory Irvine Gass syndrome

Complex Treatment Decisions

Considerations in Steroid Selection

- Glaucoma history, steroids intraocular pressure response
- Phakic versus pseudophakic
- Location of the primary inflammation
- Unilateral versus bilateral
- Prior response/fellow eye response
- Inflammation active versus inactive
- Chronicity of the MESI
- Vision
- Age

DUREZOL
(difluprednate ophthalmic emulsion) 0.05%

Ozurdex
(dexamethasone intravitreal implant) 0.7 mg

YUTIQ
(fluocinolone acetonide intravitreal implant) 0.18 mg

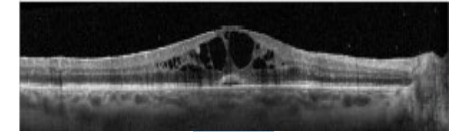
Petisart
(triamcinolone acetonide intravitreal implant) 0.59 mg

ILUVIEN
(fluocinolone acetonide intravitreal implant) 0.19mg

XIPERE
(triamcinolone acetonide injectable suspension) 40 mg/mL

Simplified Diagnosis and Treatment Journey

Diagnosis MESI with OCT



Treat with intravitreal biologic KSI-101

Patients are not undertreated due to side effects of steroid use

Patients can achieve disease remission and/or chronic disease control



Victor Perloth, MD
Chairman and CEO

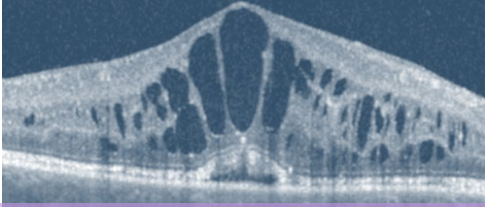
KSI-101 commercial opportunity

Problem Statement:

Ocular inflammation is the 4th leading cause of blindness among the working-age population in the developed world

MESI, a serious complication of ocular inflammation, is the primary contributor to vision loss and blindness in this group

A serious vision threatening disease



M

A **chronic** retinal condition that occurs when inflammation (past or present) disrupts the **blood-retinal barrier** triggering **edema**, and leading to **serious risk of vision loss**

MESI can be triggered by a variety of underlying **systemic and local autoimmune conditions** and represents a **prevalence of 450,000** patients in the US of which **~300,000 are trial-eligible**

>150,000 initial KSI-101 addressable MESI patients in the US

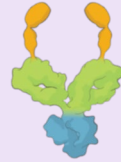


E

The **initial KSI-101 addressable population** is the **>150,000 MESI patients in the US** who are **contraindicated** for intraocular steroid injections, at risk of glaucoma or cataract development due to **chronic steroid treatment** or are **refractory from chronic steroid treatment**

Over time, avoiding the consequences of longer-term steroid use together with SOC matched efficacy can support a **first-line therapeutic of choice** profile for KSI-101

Differentiated potent high strength dual MOA

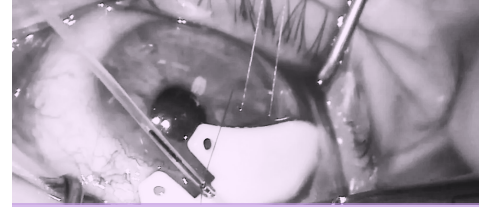


S

KSI-101 is in development for the treatment of MESI:

- Locally injected
- Potent
- High-dose
- First-in-class anti-IL6 and VEGF trap
- Bispecific protein

Potential for a simplified and safer MESI patient journey



I

Historically, physicians segment and treat patients based on presumed etiology, resulting a lengthy **trial and error patient journey**

KSI-101 offers the promise of **simplifying the MESI diagnostic and patient journey**, upgrading the **ophthalmologist** as the primary ocular caregiver, and improving patient outcome across etiologies

Excitement from physician interviews



Interviewed physicians are **impressed by the KSI-101 safety and efficacy product profile**,

noting that it **lacks the serious negative consequences** of chronic steroid use, including glaucoma and cataract,

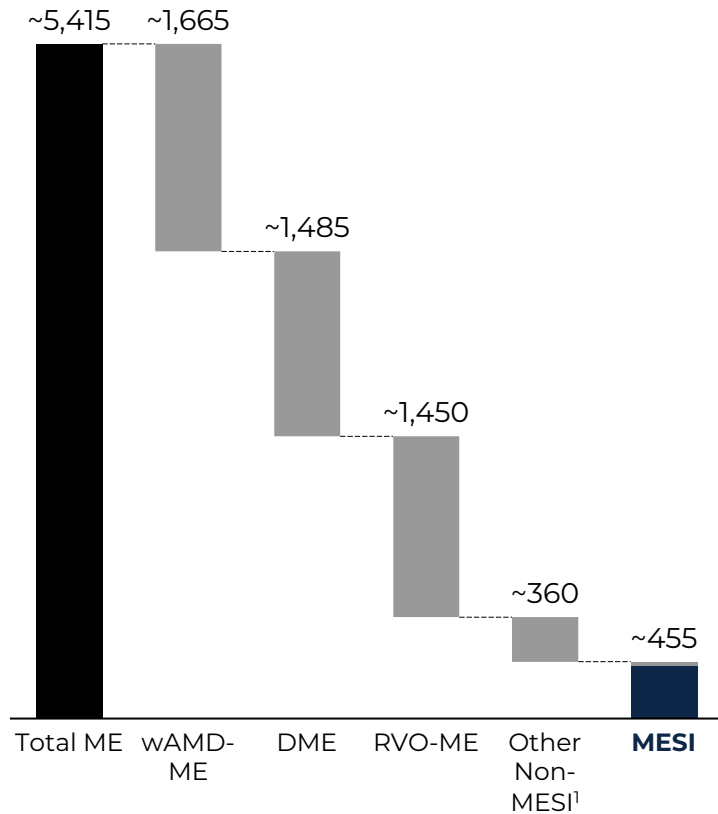
but has strong efficacy across etiologies **on par with current intraocular steroids**

MESI affects ~450,000 US patients (~300,000 trial eligible), estimated by two methodologies and often reported by etiology (defined autoimmune, idiopathic, procedural, infectious and other)

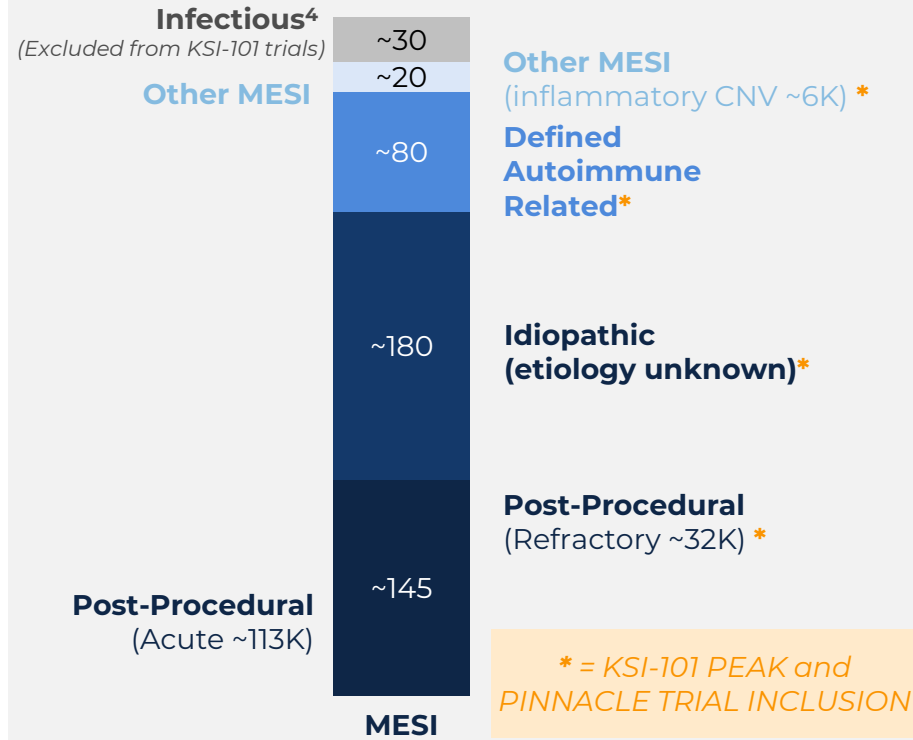
U.S. MESI EPIDEMIOLOGY

(2025) Thousands of patients

Method 1



Method 2



DEFINED AUTOIMMUNE ME³

HLA-B27	~20K
Ankylosing spondylitis	~15K
Multiple sclerosis	~10K
Idiopathic Multifocal Choroiditis	~7K
Sarcoidosis	~7K
Serpiginous choroidopathy	~6K
Vogt-Koyanagi-Harada	~4K

OTHER MESI

Scleritis	~10K
Inflammatory CNV	~6K

POST-PROCEDURAL ME²

Pars Plana Vitrectomy	~60K
Glaucoma surgery	~50K
Cataract surgery	~30K

~455K out of 5.4M ME patients in the U.S. may be classified under the “MESI” definition, ~298K meet KSI-101 trail inclusion

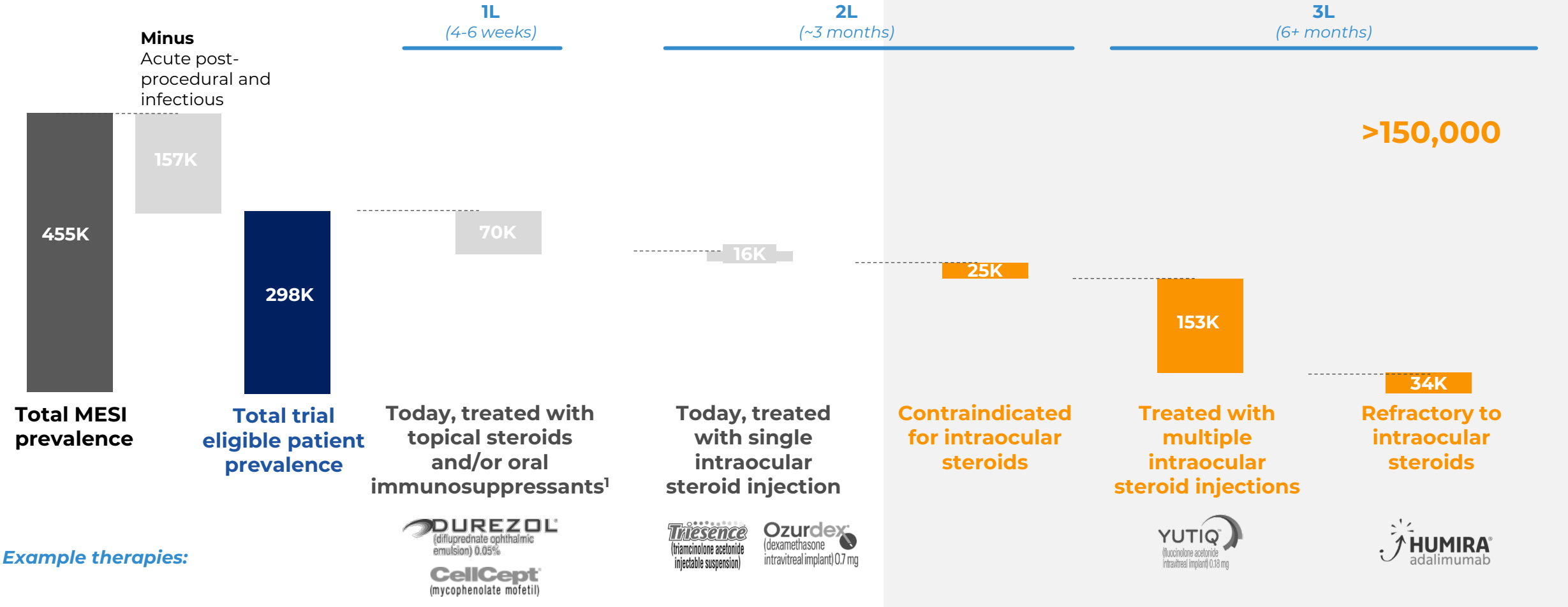
Note: ¹ Other Non-MESI includes epiretinal membrane ME and RP-associated ME; ² Non-exhaustive list, other types include laser photocoagulation, DMEK, DSEAK-ME, IOL replacement, scleral buckling, pneumatic retinopathy; ³ Non-exhaustive list, others include birdshot choroidopathy, multiple evanescent white dot syndrome, punctate inner choroidopathy, and more; ⁴ Non-exhaustive list, others include bartonella sp. Tuberculosis, endophthalmitis; DME = Diabetic Macular Edema; ERM = Epiretinal Membrane; HLA = Human Leukocyte Antigen, ME = Macular Edema; MESI = Macular Edema Secondary to Inflammation; RP = Retinitis Pigmentosa; RVO = Retinal Vein Occlusion; UME = Uveitic Macular Edema; wAMD = Wet Age-Related Degeneration

Source: See appendix

KSI-101 initial addressable population is greater than 150,000 MESI patients in the US

KSI-101 ADDRESSABLE POPULATION

of Patients



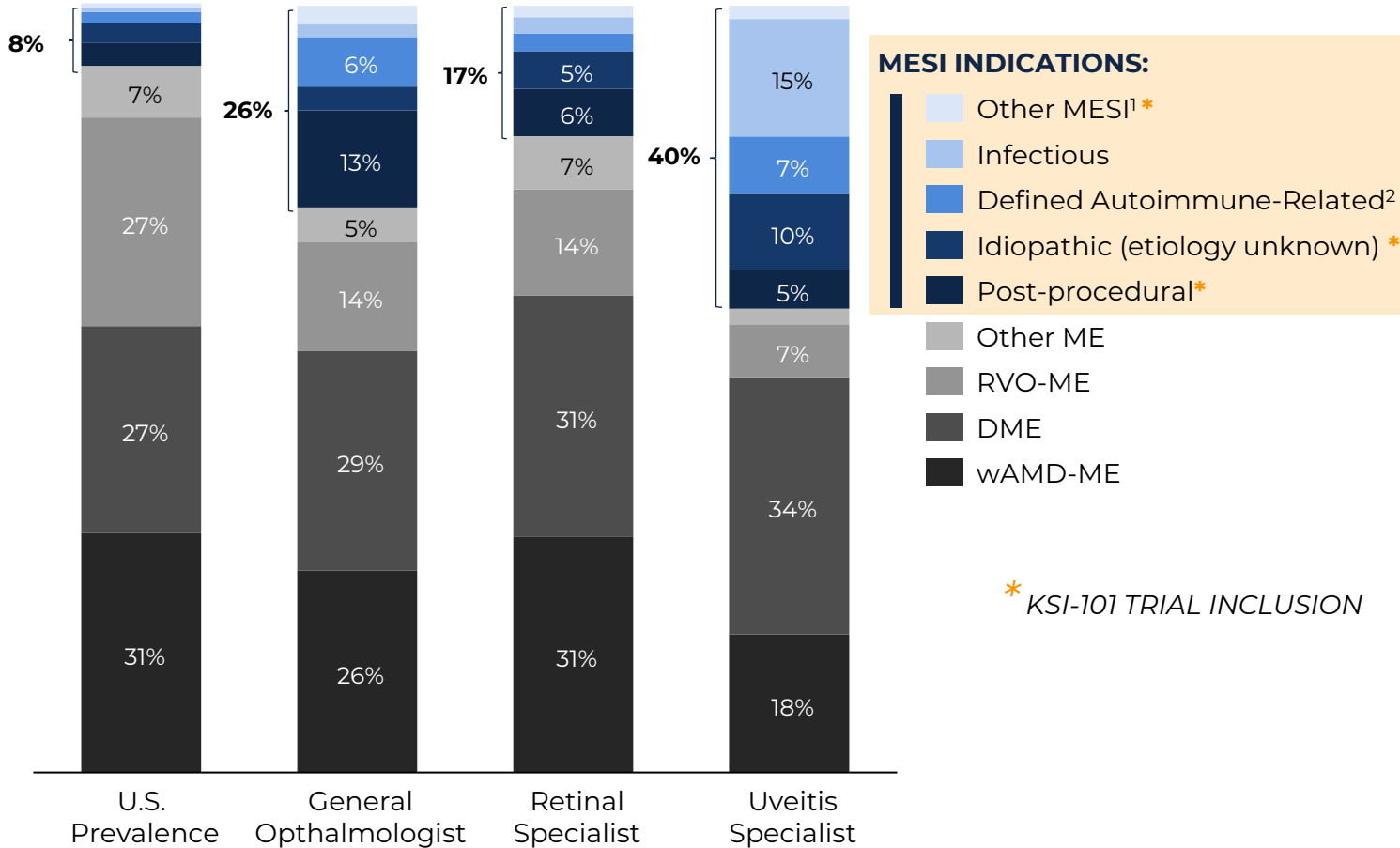
Note: ¹ First line includes eye drops or systemic immunosuppressants. Eyedrops prescribed by physicians includes steroidal and non-steroidal anti-inflammatory drops; IO = Intraocular; ME = Macular Edema; MESI = Macular Edema Secondary to Inflammation;
 Source: Bellocq et al., *BMJ* (2014); Birnbaum et al., *JAMA Ophthalmol.* (2011); Erden et al., *Ocular Immunol. Inflamm.* (2019); Kao et al., *A.A. Ophthalmol.* (2022); Expert Interviews (JUN 2025); MUST Research Group, *Ophthalmol.* (2019); Schallhorn et al., *Am. J. Ophthalmol.* (2018)

Most MESI patients are in the care of General Ophthalmologists and Retinal Specialists; complex cases are referred out to Uveitis Specialists

17% of retina specialists' current case load is MESI today

OPHTHALMOLOGY PRACTICE BREAKDOWN

% of ME patients by patient subtype across physician types

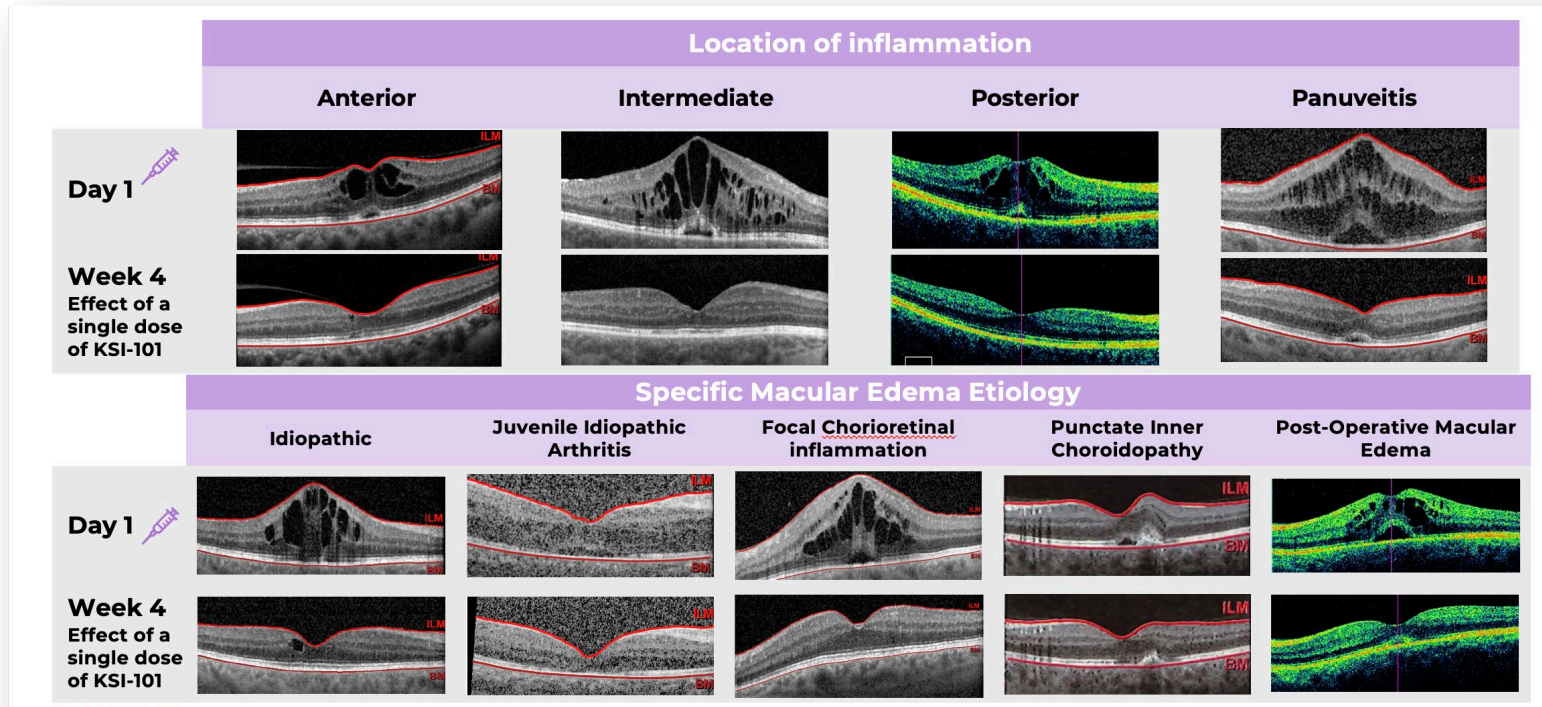


- **General ophthalmologists** act as the referral gatekeepers, being the most common physician subtype (~18K in the U.S.)
- **Retinal specialists** (~3K in the US) tend to treat a diverse set of macular edema patients (~17% of their current case load is MESI today)
- **Uveitis specialists** are rare (~200 in the U.S.) but are the most familiar with MESI subtypes as it makes up ~40% of their **practice**

Notes: ¹Other causes can include RP, scleritis, neoplasms, drug-induced, and trauma-induced; ²Non-exhaustive drivers include sarcoidosis, systemic lupus erythematosus, scleroderma, rheumatoid arthritis, Behcet's disease, Vogt-Koyanagi-Harada disease, and others; trauma-induced; DME = Diabetic Macular Edema, ERM = Epiretinal Membrane, ME = Macular Edema, MESI = Macular Edema Secondary to Inflammation, RP = Retinitis Pigmentosa, RVO = Retinal Vein Occlusion, wAMD = Wet Age-Related Degeneration

Source: Expert Interviews (JUN 25); Review of Optometry (2024); Ho and Avery, *Retina Today* (2025); Tsui et al., *J Acad Ophthalmol* (2022)

Physicians are impressed with both the **rapid response** by Week 4 and the **diversity of etiologies** responding to KSI-101



“... It’s **not much different than using anti-VEGF to treat DME, AMDs, and RVOs**. Those are very different diseases with very different pathophysiology but at the end of the day **the medicine is the same and it works well in all three diseases**. [...] I didn't see that before—but seeing these pictures and seeing the data that you showed me on the slide I don't see a reason not to...” – Retinal Specialist

Patients typically present with central vision loss or distortion, and ophthalmologists conduct routine workup and targeted tests

MESI DIFFERENTIAL DIAGNOSIS

PATIENT ARRIVES IN CLINIC



- Blurry vision
 - Metamorphopsia
 - Floaters
- May or may not come from referral upstream*

ROUTINE WORKUP



- Clinical history & symptoms
- Ocular exam¹
- OCT²
- Fluorescein angiography

TARGETED TESTS



- **Targeted lab tests** for infection (e.g., toxoplasmosis, syphilis, TB)
- **Systemic workup** for autoimmune markers (e.g., HLA-B27 typing, X-ray, MRI)

SYMPTOM CHARACTERIZATION

- **Is the vision loss central or peripheral?** Central vision loss may implicate pathology affecting the macula
- **Is vision loss unilateral or bilateral?** Unilateral may suggest an acute inflammatory or vascular event; bilateral may suggest systemic or chronic pathology
- **Where is the uveitis?** Anterior, intermediate, posterior, and panuveitis

ETIOLOGICAL CLARIFICATION

- **Is there an underlying systemic disease?** E.g., diabetes, autoimmune
- **Is there a known inflammatory condition?** E.g., uveitis, autoimmune, TB, syphilis, herpes
- **Has there been recent intraocular surgery?** E.g., cataract
- **Has the patient used medications known to induce macular edema?** E.g., prostaglandins, interferons

Note: ¹ Evaluate anterior chamber cells, vitreous haze, and other signs of intraocular inflammation; ² Identifies intraretinal cysts, subretinal fluid, and central sub-foveal thickness; HLA = Human Leukocyte Antigen, OCT = Optical Coherence Tomography, TB = Tuberculosis;
 Source: American Academy of Ophthalmology; Expert Interviews (JUN 2025)

MESI is diagnosed via dilated fundus exam & OCT, with subtypes often distinguished through clinical history and targeted lab testing

MESI DIAGNOSIS BY SUBTYPE OVERVIEW

MACULAR EDEMA SECONDARY TO INFLAMMATION

Idiopathic (etiology unknown)

Defined autoimmune-related

Post-procedural (refractory)

Infectious

INITIAL WORKUP

- **Clinical History & Symptoms:** Presents with blurred vision, central blind spots, or vitreous floaters
- **Ocular Examination:** Standard dilated fundus exam and slit-lamp biomicroscopy¹
- **OCT²:** Confirms presence, location, and severity of ME
- **Fluorescein Angiography:** Identifies inflammatory leakage pattern to aid in differential diagnosis

DIFFERENTIAL DIAGNOSIS

- **Diagnosis of exclusion**, where ME cannot be attributed to autoimmune, infectious, post-procedural, or other causes (e.g., medication- or trauma-induced)
- **History of systemic disease** and / or **symptoms** suggestive of autoimmune disease (e.g., joint pain, rashes)
- **Systemic workup** for autoimmune markers (e.g., HLA-B27 typing, X-ray, MRI) and **fluorescein angiography** for inflammatory leakage
- **Clinical presentation** indicative of infection (e.g., toxoplasmosis scar) with **unilateral** ME presentation
- **Targeted lab tests** for infection (e.g., toxoplasmosis, syphilis, TB)
- History of recent **cataract surgery** with symptoms presenting after an initial good post-op recovery followed by 4 – 6+ months of refractory response to topical steroid drops

Note: ¹ Used to evaluate anterior chamber cells, vitreous haze, and other signs of intraocular inflammation; ² Identifies intraretinal cysts, subretinal fluid, and central sub foveal thickness; HLA = Human Leukocyte Antigen, ME = Macular Edema; MESI = Macular Edema Secondary to Inflammation, OCT = Optical Coherence Tomography, TB = Tuberculosis
Source: American Academy of Ophthalmology; Expert Interviews (JUN 2025)

Physicians were open to using KSI-101 after eye drops and before steroid injections; Uveitis Specialists may use first-line in severe cases

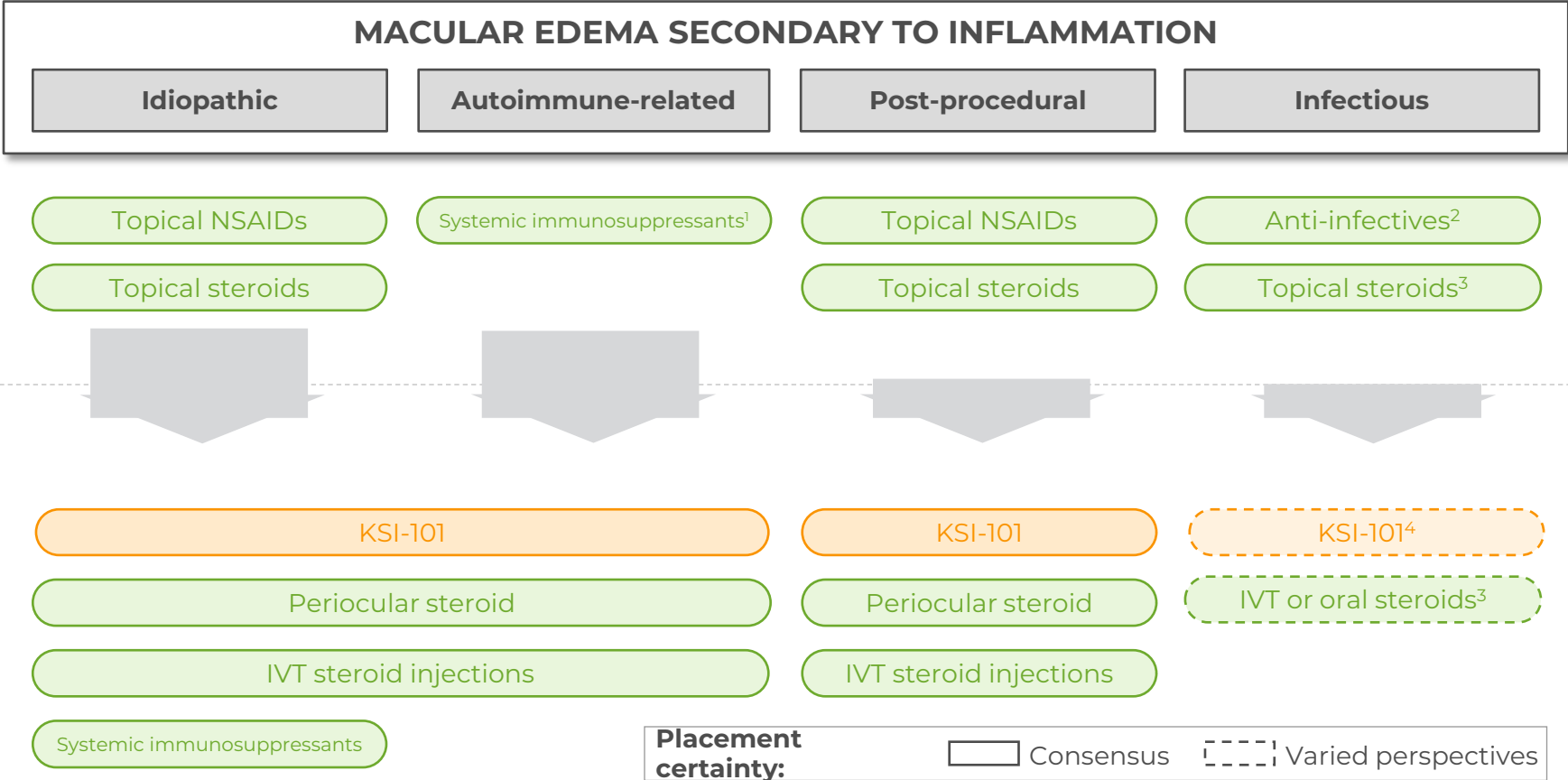
TREATMENT PARADIGM EVOLUTION

ILLUSTRATIVE

- KSI-101 is **generally considered early second line**, but **may be first-line** in patients with **more severe disease** or **contra-indications** to steroids

“... [I’d use Product X in] patients who fail my first line with topical therapy. I might **think of this as second line, maybe instead of going to a triamcinolone injection** or a dexamethasone implant ...”
 – Retina Specialist

“... If they are **younger, phakic, I will try [Product X] first ...**”
 – Retina Specialist



Note: ¹ Cases tend to be more severe and bilateral warranting systemic immunosuppressants (e.g., methotrexate, adalimumab, tocilizumab) and often prescribed in coordination with a rheumatologist; ² Majority of cases are resolved with anti-infective treatments; ³ Steroids cautiously introduced after infection control, some specialists may progress to IVT or oral steroids if inflammation persists, but do so cautiously; ⁴ KSI-101 placement in infectious ME is more variable, some physicians will use in place of steroids, others try to avoid ocular injections after recent infection, and others prefer drops / oral therapies that can be removed quickly in case infection re-emerges; IVT = Intravitreal Injections; ME = Macular Edema; NSAID = Non-Steroidal Anti-Inflammatory Drug;

Source: Expert Interviews (JUN 2025)



Victor Perloth, MD
Chairman and CEO

Summary

Kodiak Investor R&D Day July 2025 – Key Messages

Wholly Owned

KSI-101

- Strong 12-week data from Phase 1b APEX
- PEAK and PINNACLE – already enrolling
- Commercial opportunity of 150,000+ initial addressable patients with headroom

A potent reason to believe in Kodiak

Tarcocimab & KSI-501

- Science-based “heavyweights”?
- Tarcocimab: targeting BLA mid-2026 in wet AMD, RVO and diabetic retinopathy
- KSI-501: bispecific ABC[®] may be even better!



Pipeline, Digital Health, Manufacturing

- KSI-102, KSI-103: bispecifics for inflammation
- Duets for glaucoma and geographic atrophy
- VETi: AI headsets for commercial leadership
- URSUS: commercial manufacturing

Accelerating our technology and product leadership in retina



Q&A