Risk Factors Comparison 2024-02-22 to 2023-02-23 Form: 10-K

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~~Below is a summary of the principal factors that make an investment in our common stock speculative or risky. This summary does not address all of the risks that we face. Additional discussion of the risks summarized in this risk factor summary, and other risks that we face, can be found below under the heading " Risk Factors " and should be carefully considered, together with other information in this Annual Report on Form 10- K and our other filings with the U. S. Securities and Exchange Commission, or the SEC, before making investment decisions regarding our common stock. • Certain of our product candidates are in preclinical or clinical development, which is a lengthy and expensive process with uncertain outcomes and the potential for substantial delays. We may not receive regulatory approval to market any of these product candidates in any jurisdictions, which would materially and adversely affect our business, prospects, operating results and financial condition. • Our clinical trials may fail to demonstrate substantial evidence of the safety and efficacy of product candidates that we may identify and pursue for their intended uses, which would prevent, delay or limit the scope of regulatory approval and commercialization. • Drug development is a highly uncertain undertaking and involves a substantial degree of risk. We have incurred significant losses since our inception and anticipate that we will continue to incur significant losses for the foreseeable future. We have not generated significant product revenue since inception, which, together with our limited operating history, may make it difficult for you to assess our future viability. • We may encounter substantial delays in clinical trials for a variety of reasons, including difficulties in patient enrollment, and we may not be able to conduct or complete clinical trials on the expected timelines, if at all. • Results of earlier studies or clinical trials may not be predictive of future clinical trial results, and initial studies or clinical trials may not establish an adequate safety or efficacy profile for our product candidates to justify proceeding to advanced clinical trials or an application for regulatory approval. • Use of our product candidates could be associated with side effects, adverse events or other properties or safety risks, which could delay or halt their clinical development, prevent their regulatory approval, cause us to abandon a product candidate, limit their commercial potential, if approved, or result in other significant negative consequences to our business, prospects, operating results and financial condition. • Certain of our product candidates are under development for the treatment of patient populations with significant comorbidities that may result in deaths or serious adverse or unacceptable side effects and require us to abandon or limit our clinical development activities. • Interim, " top- line, " and preliminary data from our clinical trials that we announce or publish from time to time may not be predictive of future clinical trial results and may change as more data become available, as additional analyses are conducted, or as audit and verification procedures are performed on such preliminary data. • Our conduct of clinical trials for product candidates and our plans to commercialize certain product candidates outside the United States could expose us to additional risks and uncertainties, including with respect to our ability to obtain regulatory approvals or comply with applicable laws and regulations outside the United States. • Even though we may apply for orphan drug designation for our product candidates, we may not be able to obtain orphan drug marketing exclusivity. • Even if we obtain regulatory approval for any of our current product candidates, we will be subject to ongoing regulatory obligations and continued regulatory review, which may result in significant expense to maintain compliance with such obligations or as a result of any penalties to which we may become subject for any failure to comply with such obligations. • Certain of our product candidates, including our protein therapeutic and gene therapy product candidates, are novel, complex and difficult to manufacture. We could experience manufacturing problems that delay our development or commercialization activities or otherwise harm our business. • Certain of our product candidates are based on a novel adeno- associated virus, or AAV, gene therapy technology with which there is limited clinical or regulatory experience to date, which makes it difficult to predict the time and cost of product candidate development and subsequently obtaining regulatory approval. • We face significant competition from other biotechnology and pharmaceutical companies, and our operating results will suffer if we fail to compete effectively. • Our future success depends on our ability to retain key employees, directors, consultants and advisors and to attract, retain and motivate qualified personnel. • We will need substantial additional financing to develop and, if approved, commercialize our product candidates and implement our operating plans. If we fail to obtain additional financing, when needed on acceptable terms, or at all, we may be forced to delay, reduce or terminate our research and development programs, future commercialization efforts or other operations. • We rely and will continue to rely on third parties to conduct our clinical trials and some aspects of our research and preclinical testing, and for the manufacture of our product candidates for preclinical studies and clinical trials and, if approved, any products that we determine to commercialize. If these third parties do not successfully carry out their contractual duties or meet expected deadlines, we may not be able to obtain regulatory approval of or commercialize our product candidates. • Our rights to develop and commercialize our product candidates are subject in part to the terms and conditions of licenses granted to us by others, and the patent protection, prosecution and enforcement for some of our product candidates may be dependent on our licensors, the loss of which could result in the loss of intellectual property and other protection, and would harm our business. • If we are unable to obtain and maintain sufficient intellectual property protection for our product candidates, including acoramidis, low- dose infigratinib, BBP- 418, BBP- 631 encaleret, and our KRAS inhibitor portfolio, or if the scope of the intellectual property protection obtained is not sufficiently broad, our competitors could develop and commercialize products or product candidates similar or identical to ours, and our ability to successfully commercialize our potential product candidates may be impaired. • If any of our current product candidates receive marketing approval, they may fail to achieve the degree of market acceptance by physicians, patients, healthcare payors, and others in the medical community necessary for commercial success. • Because we have multiple programs and product candidates in our development pipeline and are pursuing a variety of target indications and~~

treatment modalities, we may expend our limited resources to pursue a particular product candidate and fail to capitalize on development opportunities or product candidates that may be more profitable or for which there is a greater likelihood of success. • We have incurred a significant amount of debt and may in the future incur additional indebtedness. Servicing our debt requires a significant amount of cash, and we may not have sufficient cash flow from our business to pay our substantial debt. • The ongoing COVID- 19 pandemic, including newly discovered variants, could adversely impact our business, including our clinical trials and preclinical studies. • Unfavorable global economic conditions, including market volatility, inflationary pressures, acts of war and civil and political unrest, could have a negative impact on our stock price, increase our operating expenses and impair our ability to raise additional capital on acceptable terms, or at all. PART I ITEM 1. BUSINESS Overview BridgeBio Pharma, Inc. is a commercial- stage biopharmaceutical company founded to discover, create, test and deliver transformative medicines to treat patients who suffer from genetic diseases and cancers with clear genetic drivers. BridgeBio' s pipeline of development programs ranges from early science to advanced clinical trials. BridgeBio was founded in 2015 and its team of experienced drug discoverers, developers and innovators are committed to applying advances in genetic medicine to help patients as quickly as possible. Since inception, BridgeBio has created 15 Investigational New Drug applications, or INDs, and had two products approved by the U. S. Food and Drug Administration. We work across over 20 disease states at various stages of development. Several of our programs target indications that we believe present the potential for our product candidates, if approved, to target portions of market opportunities of at least $ 1. 0 billion in annual sales. We focus on genetic diseases because they exist at the intersection of high unmet patient need and tractable biology. Our approach is to translate research pioneered at academic laboratories and leading medical institutions into products that we hope will ultimately reach patients. We are able to realize this opportunity through a confluence of scientific advances, including: (i) identification of the genetic underpinnings of disease as more cost- efficient genome and exome sequencing becomes available; (ii) progress in molecular biology; and (iii) the development and maturation of longitudinal data and retrospective studies that enable the linkage of genes to diseases. We believe that this early- stage innovation represents one of the greatest practical sources for new drug creation. We believe we have developed a world- class product platform that supports the continued growth of our Company and the advancement of our pipeline. Our Pipeline Our pipeline could deliver up to eight potential Phase 3 readouts over the next five years, of which we expect acoramidis, low- dose infigratinib, encaleret, BBP- 418 and BBP- 631 to be in markets of one billion dollars or more. The following table summarizes our development programs, their estimated patient populations, their therapeutic modalities and their development status: Of our investigational programs, we believe the following have the greatest potential to drive significant near- term value for our Company due to a combination of factors, including their stage of development, potential availability of expedited development pathways, degree of unmet medical need and potential market size in the applicable target indication: • Acoramidis (also known as AG10), a small molecule stabilizer of transthyretin, or TTR, that is in an ongoing Phase 3 clinical trial for the treatment of TTR amyloid cardiomyopathy, or ATTR- CM. • Low- dose infigratinib, a small molecule selective FGFR1- 3 inhibitor that is in an ongoing Phase 2 clinical trial for the treatment of children with achondroplasia. • Encaleret, a small molecule antagonist of the calcium sensing receptor, or CaSR, that is in ongoing Phase 2b and Phase 3 pivotal clinical trials for Autosomal Dominant Hypocalcemia Type 1, or ADH1. • BBP- 418, an orally administered substrate replacement product candidate that has delivered positive interim data from an ongoing Phase 2 clinical trial for the treatment of Limb- Girdle Muscular Dystrophy type 2I, or LGMD2I, with a Phase 3 clinical trial planned to start in 2023. • BBP- 631, an AAV5 gene transfer product candidate that is in an ongoing Phase 1 / 2 clinical trial for the treatment of congenital adrenal hyperplasia, or CAH, driven by 21- hydroxylase deficiency, or 21OHD. • KRAS inhibitor portfolio for the treatment of KRAS- driven cancers, including: • BBO- 8520, a next- generation KRAS G12C dual GTP / GDP inhibitor, which has shown greater potency in preclinical KRAS models than first- generation KRAS G12C GDP- only inhibitors and which we plan to enter into the clinic in 2023; • a novel PI3Kα: RAS breaker molecule, which we intend to move into IND- enabling studies in 2023; and • a preclinical pan- KRAS inhibitor program in lead optimization. Acoramidis (Eidos): TTR Amyloidosis Summary We are developing acoramidis, also known as AG10, an oral small molecule TTR stabilizer, for the treatment of TTR amyloidosis, or ATTR. A Phase 3 clinical trial in 632 patients with ATTR cardiomyopathy, or ATTR- CM, known as the ATTRibute- CM study, is currently ongoing. We anticipate reporting top- line 30- month outcomes data from Part B of the ATTRibute- CM study in mid- 2023. We continue to believe acoramidis has the potential to demonstrate benefit on the 30- month hierarchical composite primary endpoint, which includes all- cause mortality and cardiovascular- related hospitalizations. On December 27, 2021, we reported that ATTRibute- CM did not meet its Part A primary endpoint of change for baseline in six- minute walk distance at Month 12. We observed improvements in acoramidis- treated participants relative to placebo- treated participants at Month 12 on key secondary and exploratory endpoints including on N- terminal pro BNP, or NT- proBNP, a cardiac biomarker, and serum TTR concentration, a measure of TTR stabilization and the Kansas City Cardiomyopathy Questionnaire Overall Score, or KCCQ- OS, a quality- of- life measurement. Market Opportunity We believe that the total market for ATTR therapeutic interventions will continue to grow for the foreseeable future as the population of diagnosed patients increases as a result of heightened disease awareness and the increased adoption of non- invasive diagnostic techniques. The number of estimated diagnosed ATTR- CM patients in the United States has grown from fewer than 5, 000 in 2019 to more than 30, 000 in 2021. As such, if acoramidis is approved, we believe that there could be a significant population of newly diagnosed patients who have not previously been treated with a disease- modifying therapy and could be treated with acoramidis. If approved, we believe that acoramidis could have meaningful commercial potential. Further, we believe that acoramidis, if approved, has the potential to be a best- in- class stabilizer for the treatment of ATTR. Disease Overview ATTR is a disease caused by destabilization of TTR tetramers resulting in progressive amyloid deposition. TTR is a protein that occurs naturally in the form of a tetramer, consisting of four identical subunits, or monomers, and performs multiple physiologic roles, including the transport of essential hormones and vitamins. In ATTR, TTR tetramers become destabilized due to a mutation in the TTR gene or as part of the natural aging process. Destabilized TTR dissociates into monomers, self- aggregates, and

assembles into fibrils that are deposited, predominantly in the heart and nervous system, driving disease pathophysiology. Cardiomyopathic ATTR is commonly categorized by its genotypic cause with wild- type ATTR cardiomyopathy, or ATTRwt- CM, which results from an age- related process, and variant ATTR cardiomyopathy, or ATTRv- CM. Both forms of the disease are progressive and fatal. ATTRwt- CM and ATTRv- CM patients generally present with symptoms later in life (older than 50) and have median life expectancies of two to five years from diagnosis if untreated. Progression of both forms of the disease can cause significant disability, impact productivity and quality of life, and create a significant economic burden due to the costs associated with patient need for supportive care. As the disease progresses, ATTRwt- CM and ATTRv- CM patients may experience recurrent hospitalizations and repeated interventions. The worldwide estimated prevalence of ATTRwt- CM and ATTRv- CM is greater than 400, 000 and 40, 000, respectively. We believe that cardiomyopathic ATTR is significantly underdiagnosed today. For example, recent literature has suggested that between 10 % to 13 % of patients diagnosed with heart failure with preserved ejection fraction may have undiagnosed ATTR- CM. The heart failure with preserved ejection fraction segment represents approximately half of the 6. 0 million to 7. 0 million estimated people with heart failure in the United States. With the increasing availability of disease- modifying therapeutics, disease awareness is heightened. We believe the population of diagnosed ATTR- CM patients is also growing rapidly due to the shift to an accurate and reliable non- invasive diagnostic imaging technique. Historically, a heart biopsy was required to make a diagnosis of ATTR- CM. Recently, however, it has been shown that scintigraphy with technetium- labelled radiotracers paired with single- photon emission computerized tomography, or SPECT, CT imaging is a highly accurate, non- invasive, and cost- effective method for ATTR- CM diagnosis. We believe that both increased disease awareness and availability of this non- invasive diagnostic imaging technique are allowing for earlier diagnosis of ATTR- CM patients and the identification of previously misdiagnosed patients. Design Criteria Acoramidis is a clinical- stage, orally administered, small molecule TTR stabilizer being developed to treat ATTR at its source. We designed acoramidis to meet two primary criteria – to preserve circulating native TTR and to reduce amyloid deposition by minimizing toxic TTR monomer formation. TTR is a protein which has been highly conserved throughout evolution, and which is abundant in the plasma with relatively rapid turnover requiring sustained metabolic energy expenditure. Thus, we seek to achieve maximal stabilization of the TTR tetramer rather than elimination. Acoramidis has been shown in preclinical studies and clinical trials to prevent the dissociation of tetrameric TTR into monomers, and in preclinical studies, to reduce the rate of amyloid fibril formation. In addition, it has been shown to lead to increased circulating levels of tetrameric TTR. Acoramidis has been designed to bind TTR in a way that causes TTR' s conformational structure to mimic that of the well- characterized T119M variant, a naturally occurring rescue mutation that super stabilizes the TTR tetramer. The T119M variant has been observed to prevent the dissociation of TTR tetramers into monomers; T119M tetramers dissociate 40- fold more slowly than wild- type tetramers in biochemical assays. Known as a trans- allelic trans- suppressor, individuals who coinherit the T119M rescue mutation along with a TTR- destabilizing mutation are protected against the development of ATTR. In third- party clinical trials of tafamidis, another orally administered, small molecule TTR stabilizer, interventional approaches that increased TTR stabilization led to improved outcomes in this disease, as measured by all- cause mortality and cardiovascular- related hospitalizations, and were correlated with increases in serum TTR. Further, based on genetic data, there is a correlation between the level of TTR stabilization, serum TTR levels and disease severity. As a result, we believe that serum TTR is a predictive biomarker for disease prognosis and that there may be a relationship between more effective TTR stabilization, serum TTR levels and improved clinical outcomes. Based on results from comparative nonclinical studies, we believe that acoramidis has the potential to stabilize TTR to a greater extent than other TTR stabilizers. Clinical Data Phase 2 Data In November 2018, we announced Phase 2 data for acoramidis in symptomatic patients with ATTR- CM. The randomized, placebo- controlled, dose- ranging clinical trial included 49 patients with symptomatic ATTR- CM, of which 14 had ATTR- CM. Eligible patients were randomized in a 1: 1: 1 ratio to placebo or 400 milligrams or mg, or 800 mg of acoramidis twice daily over 28 days. Overall, acoramidis was well- tolerated in symptomatic ATTR- CM subjects with no safety signals of potential clinical concern attributed to study drug. Acoramidis significantly raised serum TTR concentrations ($p < 0. 0001$) by 50 % and 36 % in subjects administered 800 mg twice daily and 400 twice daily, respectively, at day 28. Normalized serum TTR levels were observed in all actively treated subjects at day 28. In November 2019, we announced data from our Phase 2 open- label extension, or OLE, suggesting long- term tolerability of acoramidis and stabilization of ATTR- CM disease measures. Acoramidis was well- tolerated in the OLE and no safety signals of potential clinical concern were attributed to study drug. The rate of all- cause mortality (including either death or cardiac transplantation, 8. 5 %) and cardiovascular- related hospitalizations (proportion experiencing at least one event, 25. 5 %) observed in an exploratory analysis of OLE participants following a median of 15 months since Phase 2 initiation were lower than those observed at 15 months in placebo- treated patients in the ATTR- ACT study (all- cause mortality including death or cardiac transplantation, 15. 3 %; cardiovascular- related hospitalizations, 41. 8 %). In April 2022, we presented updated results from our Phase 2 OLE, demonstrating continued long- term tolerability of acoramidis and stabilization of ATTR- CM disease measures. With a median of 38 months of continuous treatment, acoramidis was generally well- tolerated in the OLE and no safety signals of potential clinical concern were attributed to study drug. Phase 3 Data In February 2019, we initiated ATTRibute- CM, a global Phase 3 randomized, placebo- controlled clinical trial of acoramidis in ATTR- CM. ATTRibute- CM enrolled 632 subjects with symptomatic ATTR- CM, associated with either wild- type or variant TTR and New York Heart Association, or NYHA, Class I- III symptoms. Subjects were randomized 2: 1 between treatment (acoramidis 800 mg) and placebo twice daily in a two- part trial. In Part A, change in 6MWD at 12 months was compared between treatment and placebo groups as a potential registrational endpoint. In Part B, the hierarchical composite primary endpoint including all- cause mortality and cardiovascular hospitalizations will be compared between treatment and control groups at 30 months. Secondary endpoints include quality of life as assessed by the KCCQ- OS, safety parameters, serum TTR levels, a measure of TTR stabilization, and NT- proBNP levels, a cardiac biomarker. In Part B, concomitant use of tafamidis is allowed. A schematic of the trial is shown below: On December 27, 2021, we reported topline data from Part A of

the ATTRibute- CM trial which did not meet its primary endpoint of change from baseline in 6MWD (p = 0. 76). Mean observed 6MWD decline for the acoramidis and placebo arms were 9 meters and 7 meters, respectively. Decline observed in both arms of ATTRibute- CM was similar to expected functional decline in healthy elderly adults at 12 months. We observed improvements in acoramidis- treated participants relative to placebo- treated participants at Month 12 on secondary and exploratory endpoints including NT- proBNP, serum TTR concentration and KCCQ- OS. Acoramidis was generally well-tolerated with no safety signals of clinical concern identified. To protect the integrity of Part B, as sponsor, our access to unblinded adverse event data for Part A excludes adverse events leading to a cardiovascular hospitalization (as determined by investigators) excepting events with the outcome of death. Adverse events, or AEs, occurred in 85. 3 % of placebo- treated participants and 91. 9 % of acoramidis- treated participants. In both the placebo and active treatment groups, most of the AEs were mild to moderate in severity. Serious adverse events, or SAEs, occurred in 23. 2 % of placebo- treated participants and 20. 2 % of acoramidis- treated participants. AEs leading to death occurred in 6. 2 % of placebo- treated participants and 4. 5 % of acoramidis- treated participants. We continue to believe acoramidis has the potential to demonstrate benefit on the 30- month hierarchical composite primary endpoint, which includes all- cause mortality and cardiovascular- related hospitalizations. We anticipate reporting top- line 30- month results from Part B of the ATTRibute- CM trial in mid- 2023. Competition If acoramidis is approved as a treatment for ATTR- CM, we expect to face competition from Vyndaqel / Vyndamax (tafamidis meglumine / tafamidis), which is approved in certain territories, including the United States, the European Union, and Japan as a treatment for ATTR- CM. Additionally, there are a number of RNAi, antisense oligonucleotide, antibody, and gene editing product candidates that are currently in development as potential treatments for ATTR- CM. Low- dose Infigratinib: Achondroplasia We are developing low- dose infigratinib, an oral FGFR1- 3 selective tyrosine kinase inhibitor, or TKI, as a treatment option for children with achondroplasia. We are currently enrolling patients in PROPEL, a prospective observational study in children with achondroplasia and PROPEL 2, a Phase 2 dose- escalation and expansion study of low- dose infigratinib in children with achondroplasia. In July 2022, we reported initial data showing an increase from baseline in annualized growth velocity of 1. 52 cm per year in children with achondroplasia ages 5 or older in PROPEL2' s fourth dose escalation cohort (0. 125 mg / kg once a day). We have enrolled a fifth dose (0. 25 mg / kg once a day) escalation cohort and anticipate sharing preliminary early results in the first quarter of 2023. We believe that achondroplasia and other FGFR- driven skeletal dysplasias represent a potentially over five billion dollar total global market opportunity. The achondroplasia market alone has grown steadily since the end of 2021, driven by a newly available therapy driving children to seek treatment, as well as growing awareness of the new treatment among pediatric endocrinologists. We believe that low- dose infigratinib, if approved, would have meaningful commercial potential to demonstrate best- in- class efficacy as well as a differentiated oral route of administration preferred by many patients. Condition Overview Achondroplasia is the most frequent cause of disproportionate short stature, and mutations in the FGFR3 gene have been shown to be the molecular source of the condition. Achondroplasia has a prevalence of greater than 55, 000 in the United States and European Union, and an estimated worldwide incidence of one in 10, 000 to 30, 000 live births. The condition leads to a disproportionate short stature with anomalies in bone development and potential for foramen magnum stenosis, spinal stenosis, cardiovascular complications and obesity. The average height is approximately 4' 4 " for a male and 4' 1 " for a female with achondroplasia. Lifespan and intelligence are most often normal. Achondroplasia is an autosomal dominant condition caused by a gain- of- function point mutation in the FGFR3 gene. Approximately 97 % of cases are due to G380R substitution and 80 % of cases are the result of de novo mutations. FGFR3 is expressed in osteoblasts and chondrocytes where it plays a critical role in regulating bone growth through the MAPK pathway, which drives hypertrophic differentiation, and through the STAT1 pathway, which drives chondrocyte proliferation. Apart from growth hormones, which are approved in Japan, there is only one medicine approved for marketing by the FDA, European Medicines Agency, or the EMA, and the Pharmaceuticals and Medical Devices Agency, or PMDA, for the treatment of achondroplasia: Voxzogo (vosoritide), a C- type natriuretic peptide, or CNP, analog which activates the MAPK pathway but not the STAT1 pathway. We are developing low- dose infigratinib based upon two key design principles — we seek to target achondroplasia at its source (FGFR3 gain- of- function mutations) in order to maximize clinical activity against all manifestations of the condition, not just height; and we seek to provide a tolerable oral treatment option in order to provide a reduced burden of treatment versus injection for children and their families. We believe low- dose infigratinib is the only investigational therapy in development that incorporates both of these design principles. Low- dose infigratinib is designed to directly target FGFR3 gain- of- function mutations which are the drivers behind the pathophysiology of achondroplasia. As an FGFR1- 3 inhibitor, we believe that low- dose infigratinib has the potential to decrease pathologic signaling downstream of FGFR3 and treat achondroplasia at its source. Unlike potentially competitive CNP mimetic approaches, which only inhibit MAPK signaling, our approach is aimed at also inhibiting STAT1 signaling. Low- dose infigratinib is also designed for an oral route of administration. Blinded market research indicates that oral administration is the preferred route of administration amongst healthcare providers who treat children with achondroplasia. In the four dosing cohorts completed in our Phase 2 dose escalation trial as well as in the fifth dosing cohort as of February 9, 2023, low- dose infigratinib has been generally well-tolerated with no serious adverse events reported. As of February 9, 2023, there have been no discontinuations due to adverse events, no dose- dependent phosphate elevation, and no ocular adverse events. Preclinical Data Low- dose infigratinib has been studied preclinically in a mouse model of achondroplasia that recapitulates anomalies of the growth plates, vertebrae, and intervertebral discs. Investigators observed that low- dose infigratinib rescued ex vivo bone growth of mutant mouse embryo femurs after six days of treatment. Further, 15 days of treatment showed in vivo bone growth, which mimics human achondroplasia in many respects. Effects on both appendicular and axial skeletal parameters were observed in this study. Below are figures demonstrating the extent of femur growth and intervertebral disc width rescue in wild- type, untreated model, and low- dose infigratinib treated (2 mg / kg) model mice: In vivo bone growth was further demonstrated at lower doses (0. 2 mg / kg and 0. 5 mg / kg) by the same laboratory. Together, preclinical studies at all doses have demonstrated meaningful increases in

skeletal growth parameters between treated and untreated mutant mice, as follows: Increase in length compared to non- treated mouse (%) Notably, treatment with low- dose infigratinib did not modify the expression of FGFR1 in the hypertrophic zone of the growth plate. The effects seen were mainly due to FGFR3 inhibition, with no other gross side effects being observed in these preclinical studies. Furthermore, survival was improved after 15 days in low- dose infigratinib treated mice, regardless of dose, as compared to untreated mice. Clinical Development Plan We are currently enrolling patients in PROPEL, a prospective observational study in children with achondroplasia. The study will establish annualized growth velocity, or AGV, for each child for a minimum period of six months. PROPEL is designed to provide baseline measurements for children that we anticipate enrolling in either PROPEL 2, an ongoing Phase 2 study of low- dose infigratinib, or in an anticipated Phase 3 trial to follow. PROPEL 2 is designed as an open- label, dose- escalation and expansion trial in children with achondroplasia prior to growth plate closure. The primary objective of this study is to assess safety and tolerability in children with achondroplasia. Secondary objectives will include PK analyses, change in growth velocity, and assessment of quality of life. In July 2022, we reported initial data showing an increase from baseline in annualized growth velocity of 1. 52 cm per year in children with achondroplasia ages 5 or older in PROPEL2' s fourth dose escalation cohort. We have enrolled a fifth dose escalation cohort and anticipate sharing preliminary early results in the first quarter of 2023. We anticipate initiating a Phase 3 pivotal trial for low- dose infigratinib in achondroplasia in 2023, following feedback from the FDA. Key Competitors Low- dose infigratinib is the only oral direct FGFR1- 3 inhibitor that has been publicly disclosed in development for the treatment of achondroplasia. There are three other identified companies developing compounds for the treatment of achondroplasia using alternative mechanistic approaches: Ascendis Pharma A / S (TransCon CNP), Sanofi S. A. (SAR442501), and Ribomic (RBM- 007). In addition, BioMarin Pharmaceutical Inc. has developed Voxzogo (vosoritide), a CNP analog, for the treatment of achondroplasia. Encaleret: Autosomal Dominant Hypocalcemia Type 1 and Hypoparathyroidism Encaleret is an oral small molecule antagonist of the calcium sensing receptor, or CaSR, that we are developing for the treatment of Autosomal Dominant Hypocalcemia Type 1, or ADH1. We are currently studying encaleret in ongoing Phase 2b and Phase 3 clinical trials as a potential treatment for patients with ADH1. We reported results from the Phase 2b study in 2022. In 13 participants in the Phase 2b trial, treatment with encaleret resulted in rapid and sustained restoration of normal mineral homeostasis, with mean values of blood calcium, urinary calcium, and blood parathyroid hormone, or PTH within the normal range by day 5 of therapy and sustained at 24 weeks, and was well- tolerated without any reported serious adverse events. Encaleret has been granted orphan drug and fast track designations by the FDA for the treatment of autosomal dominant hypocalcemia. Encaleret has also been granted orphan designation by the European Commission as a treatment for hypoparathyroidism, inclusive of ADH1. We believe that ADH1 is a market with significant commercial potential. ADH1 is caused by gain- of- function variants of the CASR gene, and independent studies of general population genetic datasets estimate that there are 25, 000 carriers of ADH1- causative variants in the EU and US. If approved, encaleret could be the first target- directed therapy indicated for ADH1. Encaleret is an investigational, orally administered, small molecule antagonist of the CaSR. It has been studied in more than 1, 200 human subjects in its prior development and was observed to increase serum calcium in a dose- dependent manner. The rationale for developing encaleret as a potential treatment for patients with ADH1 is based on both non- clinical and clinical evidence. Antagonists of the CaSR have been shown in vitro to shift the aberrant CaSR " set- point " back towards a normal IC50 for calcium and in vivo to increase PTH secretion, elevate blood calcium concentrations, and reduce urinary calcium excretion. By selectively antagonizing the CaSR, encaleret may restore normal CaSR function in individuals with ADH1 and may address symptoms associated with hypocalcemia and hypercalciuria On June 13, 2022, we reported positive data from our Phase 2b clinical trial of encaleret in patients with ADH1. Thirteen adults with ADH1 caused by nine unique CASR variants participated in the three- period, Phase 2b, open- label, dose- ranging clinical trial. Oral calcium and activated vitamin D supplements were discontinued prior to encaleret initiation. Periods 1 and 2 each evaluated encaleret over the course of five inpatient days and Period 3 included a 24- week outpatient evaluation. Based on 24- week outpatient data, we observed: • Mean values of blood calcium, urinary calcium, and blood parathyroid hormone, key biochemical parameters of mineral homeostasis, were normalized by Period 2, Day 5 and were sustained through Period 3, Week 24 of the trial. • At Week 24 of encaleret treatment, 92 % (12 / 13) of participants had achieved normal trough blood calcium levels in the absence of extra- dietary calcium supplements and active vitamin D, and 77 % (10 / 13) of participants had normal urinary calcium excretion. • Encaleret was well- tolerated with no serious adverse events reported; there were no treatment discontinuations or study withdrawals. The participants who completed Period 3 of the study were eligible to continue in an open- label extension of up to 25 months. We also announced the initiation of our Phase 3 registrational trial of encaleret in ADH1 in 2022. We believe encaleret is the only molecule that has been publicly disclosed to be in development specifically for the treatment of ADH1. There are other identified companies developing compounds for the treatment of hypoparathyroidism using recombinant parathyroid hormone analogs or PTH receptor agonists: Ascendis Pharma A / S (TransCon PTH), Amolyt Pharma (AZP- 3601), EnteraBio Ltd. (EB612), and Extend Biosciences Inc. (EXT607). BBP- 418: Limb Girdle Muscular Dystrophy Type 2I BBP- 418 is an investigational, orally administered, small molecule substrate replacement therapy that we are developing for the treatment of LGMD2I, also known as LGMDR9. We are currently studying BBP- 418 in an ongoing open- label dose- ascending Phase 2 clinical trial in patients with LGMD2I. We reported top- line data in October 2022. We anticipate initiating a global Phase 3 clinical trial in 2023. LGMD2I is an inherited neuromuscular disorder characterized by lower- limb weakness and loss of ambulation, and possible pulmonary and cardiac dysfunction. BBP- 418 has a potentially- addressable population of 7, 000, including both LGMD2I and other potentially- addressable dystroglycanopathies, in the United States and Europe. Currently, there is no disease- modifying treatment available. Standard of care is supportive care to alleviate end organ dysfunction. The rationale for developing BBP- 418 as a potential treatment for LGMD2I is based on our understanding of the disease mechanism. In healthy tissue, properly functioning Fukutin- Related Protein, or FKRP, glycosylates alpha- dystroglycan, or αDG. This glycosylation helps to stabilize muscle cells by binding extracellular ligands. In LGMD2I, mutated FKRP does not function properly and results in

dysfunctional, hypo- glycosylated αDG in muscle cells, limiting αDG' s ability to function as a " shock absorber " for muscle fibers and increasing cellular susceptibility to damage. BBP- 418 is designed to target the disease mechanism of LGMD2I by supplying supra- physiological levels of BBP- 418 upstream to drive residual activity of the mutant FKRP enzyme and potentially increase αDG glycosylation levels. On October 14, 2022, we shared positive interim data from the ongoing Phase 2 clinical trial of BBP- 418 in patients with LGMD2I at the 27th International Hybrid Annual Congress of the World Muscle Society. The open- label, dose- ascending Phase 2 trial enrolled 14 participants, including both ambulatory and non- ambulatory patients with LGMD2I, across three cohorts. As of August 16, 2022, based on the data after 12 months of treatment, we observed: • Increased glycosylation αDG in all dose cohorts, with an average increase in αDG ratio of 0. 21 at day 90. • Greater than 75 % reduction in creatine kinase, a key marker of muscle breakdown, sustained over 12 months. • Improvements from baseline in the north star assessment for dysferlinopathy (0. 95) and 10- meter walk test (10MWT) velocity (0. 09 m / s) at 12 months. • No treatment- related serious adverse events or dose limiting toxicities reported with 12 months of treatment. Our Phase 2 clinical trial investigating BBP- 418 in LGMD2I is ongoing. Following the release of top- line data from our Phase 2 trial, we have engaged with regulatory authorities to align on a Phase 3 trial design and intend to initiate a Phase 3 clinical trial in 2023. We believe BBP- 418 is the only clinical- stage oral therapy disclosed to be in clinical development for potentially disease- modifying treatment of LGMD2I. There are no other oral therapies publicly known to be in development. There are two other identified companies developing gene therapies for the treatment of LGMD2I: Asklepios Biopharmaceutical, Inc. (LION- 101) and Atamayo Therapeutics (ATA- 001- FKRP / ATA- 100). BBP- 631: Congenital Adrenal Hyperplasia We are developing BBP- 631, a AAV gene transfer product candidate, for the treatment of CAH, caused by 21OHD. BBP- 631 was granted fast track designation from the FDA for the treatment of congenital adrenal hyperplasia 21- hydroxylase deficiency in 2021. As of February 22, 2023, four patients have been treated at the first two dose levels (1. 5e13 vg / kg and 3e13 vg / kg). We plan to provide an update from patients treated at the third dose level (6e13 vg / kg) by the end of 2023. We believe that CAH due to 21- hydroxylase, or 21OH, deficiency has one of the five largest patient populations that may be amenable to gene therapy, and is therefore a significant commercial opportunity. Over 75, 000 people are estimated to be in the addressable CAH population across the US and EU; furthermore, the unmet need is significant given the side effects associated with the present standard of care treatments. CAH is a debilitating and life- threatening disease with no available cure, despite newborn screening for the disease being conducted in every U. S. state. The disease is defined by an inability to produce cortisol and aldosterone, and an excess production of testosterone. Lack of cortisol disrupts glucose metabolism and the body' s normal response to stress, leading to potentially fatal adrenal crises, while lack of aldosterone disrupts sodium retention, resulting in low blood pressure, arrhythmia and dehydration. Additionally, excess testosterone causes virilization in females, often leading to ambiguous genitalia and masculinizing features at birth. Hormonal changes during puberty compound the CAH deficiencies. Females often suffer from limited fertility and require intensive treatment before, during and after pregnancy, and up to 40 % of adult males will have adrenal rest tumors that can lead to gonadal dysfunction and infertility, occasionally requiring surgery. Over 90 % of CAH cases are caused by 21OHD, a genetic defect in the CYP21A2 gene coding for the enzyme 21OH. Mutations resulting in loss of enzymatic activity of 21OH prevent conversion of progesterone into 11- deoxycorticosterone and 17- hydroxyprogesterone (17OHP) into 11- deoxycortisol, which are the precursors to aldosterone and cortisol, respectively. CAH patients with 21OHD can be divided into two categories depending on the type of genetic mutation: classic and non- classic. We are primarily focused on treating classic patients, who have the more severe phenotype and that can be categorized into simple virilizing (approximately 25 % of patients) and salt- wasting (approximately 75 %) by the severity of aldosterone deficiency and level of residual 21OH enzyme activity. Patients with the salt- wasting form of disease have residual enzyme activity of 0 % to 1 % of normal and patients with the simple virilizing phenotype have 1 % to 10 % enzyme activity. All patients with the classic form require treatment at birth, as cortisol deficiency can lead to adrenal crisis as early as one to four weeks of life and can quickly lead to death. The salt- wasting form has an incidence of one in 20, 000 births, while the simple virilizing form has an incidence of one in 60, 000 births. Together, these translate to an estimated 600 classic patients born in the United States and Europe per year. We estimate there are more than 75, 000 patients in the United States and Europe in the total addressable patient population. Current standard of care treatments do not cure patients, but replace missing glucocorticoids, such as cortisol, and mineralocorticoids, such as aldosterone, as well as reduce excessive androgen secretion. Although glucocorticoids are the mainstay of CAH therapy, individuals respond in varying ways, and chronic use of glucocorticoids in children and adults requires careful management because of the well- known side effects of these drugs, such as Cushingoid features, metabolic disease, obesity, hypertension, growth retardation, glucose intolerance, electrolyte disturbance, bone demineralization / increased risk of fracture and delayed puberty. Clinical management of classic CAH is often a very difficult balance between hyperandrogenism and hypercortisolism. BBP- 631 is an intravenously administered AAV5 gene transfer product candidate designed for the treatment of CAH due to 21OHD by replacing the 21OH enzyme in the adrenal cortex. Replacement of enzyme function has the potential to normalize flux through the pathway, simultaneously addressing the lack of cortisol and aldosterone, as well as the excess of testosterone and other androgens. Genotype- phenotype correlation studies in CAH suggest that non- classic patients, who are often asymptomatic and do not require treatment, have enzyme activity that is as little as 10 % to 20 % of normal individuals. We believe that an AAV gene therapy may be able to restore this level of enzymatic activity in CAH patients with both simple virilizing and salt- wasting forms of disease, providing substantial clinical impact and potentially eliminating the need for treatment with exogenous steroids. BBP- 631 was granted both FDA and EMA orphan drug designation in 2018 for the treatment of CAH caused by 21OHD. Initial preclinical activity was explored in a Cyp21 knockout mouse model using AAVrh10. An intravenous, or IV, injection of vector genomes was observed to improve multiple disease- related factors over a 15- week duration window, including an increase in body weight, a decrease in urinary progesterone (the main substrate of 21OH), and an increase in renin expression (signaling an increased capacity for salt retention). A study in non- human primates, or NHP, comparing evaluated AAV serotypes 1, 5 and 6 identified AAV5 as the

optimum serotype. We observed significant transfection in the adrenals where 21OH is synthesized. Additionally, AAV5 has relatively low seroprevalence in the human population, which may limit potential immunogenicity issues. We have completed two sets of NHP studies designed to evaluate durability of expression, dosing / transgene expression relationships and preliminary safety. In the first set of experiments, which evaluated a lower dose of 3x1012 vector genomes per kilogram, we observed sustained increases in Cyp21 mRNA levels up to six months out. We did not observe rapid decreases in vector genome counts and mRNA levels due to adrenal cell turnover between 1. 5 and six months, providing preliminary support for sustained transgene expression. In a second set of experiments, a total of 20 NHPs were treated with BBP- 631 at one of three IV doses. Vector copy number and transgene mRNA expression in the adrenal glands were analyzed at four and 12 weeks post- dosing in the low- and medium- dose arms, and at 12 and 24 weeks post- dosing in the high- dose arm. No dose- related AEs were observed at any of the doses tested at any time point. Overall, treatment with BBP- 631 resulted in high vector copy number, or VCN, and mRNA expression in the adrenal gland, suggesting strong tropism and uptake of BBP- 631 for the adrenal gland. In the high- dose arm, VCNs were maintained between 12 and 24 weeks. Furthermore, mRNA levels increased between 4 and 12 weeks for the medium dose arm and were consistent between 12 and 24 weeks for the high dose arm. Researchers also saw dose- dependent increases in both VCNs and mRNA levels across the three doses tested. There are two alternative therapeutic classes being investigated for treatment of CAH. The first are corticotropin- releasing factor type 1, or CRF1, receptor antagonists. CRF1 receptor antagonists regulate the release of adrenocorticotropic hormone, or ACTH, from the pituitary gland, which stimulates androgen and cortisol synthesis in the adrenal gland. In healthy individuals, endogenous cortisol provides negative feedback to the release of ACTH, which keeps androgen synthesis well- regulated. Because this negative feedback is severely impaired in CAH patients, supraphysiologic doses of exogenous steroids are required to normalize androgen synthesis in these patients. While CRF1 receptor antagonists may regulate androgen synthesis, they do not address the lack of cortisol or aldosterone production in these patients. Therefore, steroid supplementation is still required with CRF1 receptor antagonists. Two CRF receptor antagonists, Crinecerfont (under development by Neurocrine Biosciences, Inc.) and Tildacerfont (under development by Spruce Biosciences, Inc.), are currently in Phase 3 and Phase 2b clinical trials, respectively. The second alternative therapeutic class is ACTH receptor antagonists. Inhibition of this pathway, which is downstream of the CRF1 pathway, also results in inhibition of androgen and cortisol synthesis in the adrenal gland. However, like CRF1 receptor antagonists, ACTH inhibitors do not address the lack of cortisol or aldosterone production in these patients. CRN04904, an oral ACTH antagonist, is currently in Phase 1 clinical development by Crinetics Pharmaceuticals, Inc. While these alternative therapeutic mechanisms attempt to address meaningful aspects of the disease by potentially reducing the need for exogenous steroids, neither is able to address the disease at its source by targeting the complete set of features that define the disease. In particular, these mechanisms cannot obviate the need to administer steroids because they do not address the body' s inability to synthesize cortisol and aldosterone. In contrast, we believe enzymatic replacement by gene therapy has the potential to simultaneously address all facets of the disease by restoring proper flux through the hormonal pathways, reducing androgen production by providing alternative pathways for the precursor molecules to be converted into cortisol or aldosterone. KRAS- Driven Cancers Our KRAS inhibitor portfolio is focused on approaches to inhibit oncogenic RAS signaling through novel selective mechanisms for the treatment of KRAS- driven cancers. It is comprised of three main efforts: • KRAS G12C dual inhibitor • BBO- 8520 is the first- known, investigational small molecule to directly bind and inhibit KRAS G12C in both its active (guanosine triphosphate, or GTP, bound) and inactive (guanosine diphosphate, or GDP, bound) conformations. In binding the active state, BBO- 8520 is designed to disrupt effector protein binding and downstream oncogenic signaling. As of the date of this Annual Report on Form 10- K, we are not aware of a clinical- stage KRAS G12C inhibitor that directly binds the switch II pocket and inhibits the active and oncogenic GTP- bound form of the protein. In addition to its novel dual reactivity, BBO- 8520 is designed to have a significantly higher potency than first- generation KRAS G12C GDP- only inhibitors. We have shown this molecule to be active in vitro against several resistant mutants that have evolved in response to GDP- inhibitor treatment. In vivo, BBO- 8520 showed differentiated activity in some PDX models and led to tumor regression. We believe this could lead to differentiated activity in cancer patients with KRAS G12C driven cancer. We plan to enter the clinic with BB- 8520 dual inhibitor in 2023. • PI3Kα: RAS breaker • We are also pursuing PI3Kα: RAS breakers, investigational small molecules that are designed to block RAS driven PI3Kα activation. Currently, the only approved PI3Kα inhibitor blocks both aberrant and normal kinase activity from the protein, which results in hyperglycemia and insulin- driven resistance. Through novel protein- protein interaction inhibition, breaker molecules have the potential to deliver tumor selectivity that spares normal glucose metabolism by interfering with oncogenic signaling. In addition to treating patients currently served by PI3Kα inhibitors, we expect this novel approach to potentially have broad utility for many other patients with oncogene- driven tumors (including HER2 / HER3 dependency, RAS mutant tumors, PI3Kα mutant tumors, and tumors driven by RTK activation of RAS signaling) as both a monotherapy and in combination with other agents. We anticipate development candidate selection will take place in 2023 with IND filing in 2024. • Pan- KRAS inhibitor • Our pan- KRAS program is designed to target multiple KRAS mutants, including KRAS G12D and KRASG12V, which are present in a large percentage of colorectal, pancreatic and non- small cell lung cancer tumors. We have achieved in vivo target engagement and have identified lead candidates with promising oral bioavailability. Development candidate selection is planned for 2023. KRAS is a member of the RAS family of oncogenes, which also includes HRAS and NRAS, and together comprises some of the most well- known monogenic drivers of cancer. Mutations in NRAS are frequently found in leukemia and melanoma, while HRAS is frequently mutated in bladder, thyroid, and head and neck squamous cell carcinoma. KRAS mutations are a frequent driver of a number of the largest cancer indications with high unmet medical need, including 30 % of non- small cell lung cancers, 98 % of pancreatic adenocarcinomas and 45 % of colorectal adenocarcinomas. The most common KRAS mutations involve a change from glycine at position 12 in the protein to aspartic acid (G12D, 36 % of all KRAS mutations), valine (G12V, 24 %), and cysteine (G12C, 15 %), but also include mutations at glycine 13 and glutamine 61. In aggregate, over 500, 000 patients in the United States and Europe are

diagnosed with KRAS- driven cancers, annually. BBP- 398: Targeting Multiple Oncology Indications BBP- 398 is a small molecule inhibitor of SHP2 being developed as a potential treatment of cancers driven by hyperactive receptor tyrosine kinase, or RTK, or MAPK signaling. We entered into a co- development agreement with Bristol- Myers- Squibb or BMS, in July 2021 for the development of BBP- 398 in combination with nivolumab, a PD- 1 inhibitor, and we entered into an exclusive license agreement with BMS in May 2022 under which Navire granted BMS exclusive rights to develop and commercialize BBP- 398 in all indications worldwide, except for the People' s Republic of China, Macau, Hong Kong, Taiwan, Singapore and South Korea (Asia Region). We are currently enrolling patients in three separate Phase 1 trials (NAV- 1001, NAV- 1003, and NAV- 1004), which we are responsible for completing per the terms of the license agreement with BMS and the clinical trial collaboration and supply agreement with Amgen Inc., entered into in January 2022, regarding the conduct of combination trials with Amgen' s KRAS G12C inhibitor (sotarasib). NAV- 1001 is an ongoing monotherapy dose escalation and expansion clinical trial in patients with RAS and RTK mutations. In 2022, we initiated NAV- 1003 and NAV- 1004, combination trials with BBP- 398 and KRAS G12C inhibitor (sotorasib; Amgen) and PD- 1 (nivolumab; BMS) inhibitors, respectively. Additionally, LianBio is now enrolling patients in a Phase 1 monotherapy dose escalation trial in the Asian Region per our Exclusive License Agreement that we entered into in August 2020. A Phase 1 clinical trial studying BBP- 398 and an EGFR inhibitor (osimertinib) will be run in China by LianBio, and is expected to initiate in 2023. BBP- 671: PKAN and Organic Acidemias BBP- 671 is an oral, small molecule, allosteric activator of pantothenate kinases that we are developing for the treatment of Pantothenate Kinase Associated Neurodegeneration, or PKAN, and Organic Acidemias, or OAs. BBP- 671 is currently in Phase 1 development. The healthy volunteer portion of the Phase 1 clinical trial has been completed, demonstrating initial safety and tolerability, target engagement, and suitable PK for BBP- 671. The OA cohort of the Phase 1 clinical trial is now enrolling. BBP- 671 has received orphan drug designation as a treatment of propionic acidemia, or PA, and as a treatment of PKAN in the United States and the European Union. BBP- 671 was also designated as a drug for a rare pediatric disease for treatment of both PKAN and PA. PKAN is a rare genetic disorder with progressive neurodegeneration. Early onset patients typically demonstrate motor deficits with possible visual problems from retinal degeneration within six years of age. Later onset disease is heterogeneous, with psychiatric symptoms and progressive parkinsonism developing in late childhood to adulthood. The prevalence of PKAN is approximately one in 1, 000, 000, with between 800 to 850 patients in the United States and the European Union. There are currently no approved treatments for PKAN. OAs are caused by mutations in enzymes that disrupt amino acid metabolism leading to acute decompensations requiring hospitalization, as well as long- term complications involving multiple organ systems, such as the heart, pancreas, kidney, liver and brain. The incidence of OAs is approximately five in 100, 000 births. The standard of care includes dietary restriction and supplementation, but unmet need remains high due to metabolic decompensations and long- term complications. BBP- 812: Canavan Disease BBP- 812 is an AAV gene therapy product candidate that we are developing for the treatment of Canavan Disease. BBP- 812 was granted fast track designation from the FDA for the treatment of Canavan Disease in 2021 and our Phase 1 / 2 clinical trial of BBP- 812 for the treatment of Canavan disease is ongoing. We presented preliminary biomarker data from three patients at our low dose (1. 32e13 vg / kg) on October 13, 2022, and expect to dose the first patient at our high dose (3e14 vg / kg) by the end of 2023. Canavan Disease is a fatal, progressive neurodegenerative disorder that begins in infancy. The disease is a leukodystrophy, caused by degradation of white matter in the brain. Patients typically miss developmental milestones, have a rapidly increasing head circumference, progressive lack of motor control, and often do not live past their mid- teens. The incidence of Canavan Disease is approximately one in 100, 000 births worldwide. No treatments are approved for Canavan Disease; care is focused on symptom management. Additional Program- Related Information Manufacturing We do not own or operate, and currently have no plans to establish, any manufacturing facilities. We currently depend on third- party contract manufacturing organizations, or CMOs, for all of our requirements of raw materials, drug substance and drug product for our preclinical research and our ongoing clinical trials of our product candidates. Aside from a manufacturing agreement that we entered into in December 2019 through one of our subsidiaries, that was terminated by mutual agreement in May 2022, we have not entered into long- term agreements with our current CMOs. We intend to continue to rely on CMOs for later- stage development and commercialization of our product candidates, including any additional product candidates that we may identify. Although we rely on CMOs, we have personnel and third- party consultants with extensive manufacturing experience to oversee the relationships with our contract manufacturers. Several of our development candidates have or are in the near term expected to have redundant and overlapping drug substance and drug product supply chains. Sales and Marketing We intend to build a commercial infrastructure in the United States and selected other territories to support the commercialization of our current product candidates when we believe a regulatory approval in a particular territory is likely. Because most of our target indications are rare diseases with a concentrated prescribing audience and a small number of key opinion leaders who influence the treatments prescribed for the relevant patient population, we currently believe that we can effectively address each market using our own targeted, specialty sales and marketing organization supported by internal sales personnel, an internal marketing group and distribution support. To date, we have received regulatory approval for two products that we previously developed, TRUSELTIQ (infigratinib) for the treatment of patients with previously- treated locally advanced or metastatic cholangiocarcinoma, or CCA harboring an FGFR2 fusion or rearrangement, and NULIBRY (fosdenopterin) for injection as the first therapy to reduce the risk of mortality in patients with MoCD Type A. Sentynl Therapeutics, Inc., or Sentynl, acquired global rights to NULIBRY in the first quarter of 2022 and is now responsible for the ongoing development and commercialization of NULIBRY in the United States and developing, manufacturing and commercializing fosdenopterin globally. Following FDA approval of TRUSELTIQ (infigratinib) in May 2021, we were the principal selling party of this product in the United States. Commencing in January 2022, we sold the remaining transitional supply of TRUSELTIQ to Helsinn Healthcare S. A. and Helsinn Therapeutics (U. S.), Inc., or collectively, Helsinn, and Helsinn became the principal selling party. Helsinn announced that it will stop supplying TRUSELTIQ by March 31, 2023. In December 2022, we entered into a mutual termination agreement with Helsinn concerning,

among other things, steps to wind down the commercialization of infigratinib in oncology indications. (See Note 11 to our consolidated financial statements.) We evaluate our commercialization strategy as we advance each product candidate through clinical development and to regulatory approval. In any core markets outside of the United States that we may identify, where appropriate, we may utilize strategic partners, distributors or contract sales forces to expand the commercial availability of our product candidates, if approved. We currently do not expect that we will require large pharmaceutical partners for the commercialization of any of our product candidates, if approved, although we may consider partnering in certain territories or indications or for other strategic purposes. Programs Prioritized for Partnership In January 2022, we committed to a restructuring initiative that included, among other components, the reprioritization of our development programs. As part of this restructuring initiative, we plan to advance several programs only through potentially new partnerships. Some of these investigational programs are identified below. • BBP- 711, an oral, small molecule inhibitor of glycolate oxidase, for treatment of primary hyperoxaluria and patients who experience recurrent kidney stones; • BBP- 589 / PTR- 01, an IV- administered recombinant collagen type VII, or rC7, protein replacement therapy candidate, for the treatment of recessive dystrophic epidermolysis bullosa; • BBP- 681, a transdermal P13K inhibitor, for treatment of cutaneous venous and lymphatic malformations; • BBP- 561, a topical KLK5 / 7 inhibitor, for treatment of Netherton Syndrome; • BBP- 472, a series of small molecule P13KB inhibitors, for treatment of children with autism spectrum disorders characterized by loss of the PTEN protein; and • BBP- 818, a preclinical AAV gene therapy product candidate, for treatment of classic galactosemia. In addition, we have a preclinical discovery program (BBP- 954) for irreversible inhibitors of glutathione peroxidase 4, or GPX4, for the treatment of solid and hematological cancers. In December 2022, our co- development partner, Helsinn, terminated our partnership for this discovery program. Intellectual Property We strive to protect the proprietary technology that we believe is important to our business through a variety of methods, including seeking and maintaining patents and patent applications intended to cover our product candidates and compositions, their methods of use and processes for their manufacture, our platform technologies and any other aspects of inventions that are commercially important to the development of our business. We seek to obtain domestic and international patent protection and, in addition to filing and prosecuting patent applications in the United States, we may file counterpart patent applications in additional countries where we believe such foreign filing is likely to be beneficial, including Australia, Canada, Europe, China, Japan, and Mexico. We have entered into various license agreements to obtain the rights to use certain patents for the development and commercialization of our product candidates. See " Our Material Agreements. " We also rely on trade secrets to protect aspects of our business that are not amenable to, or that we do not consider appropriate for, patent protection. Our success will depend on our ability to obtain and maintain patent and other proprietary rights protecting our commercially important technology, inventions and know- how related to our business, defend and enforce our current and future issued patents, if any, preserve the confidentiality of our trade secrets and operate without infringing the valid and enforceable patents and proprietary rights of third parties. We continually assess and refine our intellectual property strategy in order to best fortify our position, and file additional patent applications when our intellectual property strategy warrants such filings. We also rely on know- how, continuing technological innovation, and potential in- licensing opportunities to develop and maintain our intellectual property portfolio. We seek to obtain domestic and international patent protection, and endeavor to promptly file patent applications for new commercially valuable inventions. The patent positions of biopharmaceutical companies like us are generally uncertain and involve complex legal, scientific, and factual questions. In addition, the coverage claimed in a patent application can be significantly reduced before the patent is issued, and patent scope can be reinterpreted by the courts after issuance. Moreover, many jurisdictions permit third parties to challenge issued patents in administrative proceedings, which may result in further narrowing or even cancellation of patent claims. We cannot predict whether the patent applications we are currently pursuing will issue as patents in any particular jurisdiction or whether the claims of any patents, if issued, will provide sufficient protection from competitors. Because patent applications in the United States and certain other jurisdictions are maintained in secrecy for 18 months or potentially even longer, and since publication of discoveries in the scientific or patent literature often lags behind actual discoveries, we cannot be certain of the priority of inventions covered by pending patent applications. Moreover, we may have to participate in interference proceedings or derivation proceedings declared by the United States Patent and Trademark Office, or USPTO, to determine priority of invention. As of February 13, 2023, our intellectual property portfolio is composed of 135 issued patents and 81 patent applications that we license from academic and research institutions and other third parties, and 33 issued patents and 374 pending patent applications that we own or co- own, including through our subsidiaries. These patents and patent applications generally provide us with the rights to develop our product candidates in the United States and worldwide. Our intellectual property portfolios for each of the programs that we consider to be our core value drivers are further described below. For our subsidiary, QED Therapeutics, Inc., we license rights from Novartis to two issued U. S. patents, and related pending and issued foreign patents and patent applications in Australia, Canada, China, Europe, Japan and Mexico, as well as in other countries in Asia and in South America, that are directed to compositions of matter of infigratinib. The foreign patents and patent applications, if issued, are expected to expire between 2025 and 2030. The issued U. S. patents are expected to expire between 2028 and 2029, which takes into account patent term adjustments granted by the USPTO as well as a terminal disclaimer of one issued patent to another U. S. patent. Upon the initial approval of infigratinib, QED applied for 1, 516 days of patent term extension, or PTE, for the U. S. patent covering the infigratinib compound; assuming grant of the PTE application, the term of this patent may be extended from August 25, 2029, to October 19, 2033. We also license rights from Novartis to two issued U. S. patents, one pending U. S. patent application, and related pending and issued foreign patents and patent applications in Australia, Canada, China, Europe, Japan and Mexico, as well as in other countries in Asia and in South America, that are directed to pharmaceutical formulations containing infigratinib. The issued patents and patent applications, if issued, are expected to expire in 2034. In addition, we license rights from Novartis to one issued U. S. patent, one pending U. S. patent application, and related pending and issued foreign patents and patent applications in Australia, Canada, China, Europe, Japan and Mexico, as well as in other countries in

Asia, that are directed to methods of treating hypophosphatemic disorders. The issued patents and patent applications, if issued, are expected to expire in 2033. We also license rights from Inserm Transfert ESA and Assistance Publique- Hôpitaux de Paris to two issued U. S. patents and one pending U. S. patent application, and one granted patent in Europe, that are directed to methods of treating skeletal dysplasias, achondroplasia using infigratinib. The issued U. S. patents, granted patent in Europe, and the pending patent application, if issued, are expected to expire in 2032. In addition, QED Therapeutics, Inc. owns three pending U. S. patent applications, one pending Patent Cooperation Treaty, or PCT, patent application, and related pending foreign patent applications in Australia, Canada, China, Europe, Japan and Mexico, as well as in other countries in Asia, that are directed to methods of treating various cancers or skeletal disorders using infigratinib. If any patents issue from these patent applications, such patents would be expected to expire between 2040 and 2043. For our subsidiary Eidos Therapeutics, Inc., we license rights from the Board of Trustees of the Leland Stanford Junior University, or Stanford, to ten issued U. S. patents, two pending U. S. patent applications, one issued European patent, and one issued Japanese patent with claims directed to composition of matter and methods of use relating to acoramidis. These patents are expected to expire in 2031 or 2033. In addition, we own four issued U. S. patents, three pending U. S. patent applications, and 51 related foreign patent applications pending in various jurisdictions, including Australia, Canada, Europe, China, Japan, and Mexico, with claims directed to salt and solid forms, methods of manufacturing, dosing methods, and formulations relating to acoramidis. The issued U. S. patents are expected to expire in 2038 or 2039. The pending U. S. and foreign patent applications, if issued, are also expected to expire in 2038 or 2039. For our subsidiary Adrenas Therapeutics, Inc., we own one pending U. S. patent application, one pending PCT patent application, and six related foreign patent applications pending in various jurisdictions including Canada, China, Europe, Japan, and Korea with claims directed to recombinant AAV vectors relating to BBP- 631 and dosing of the same. These patent applications, if issued, are expected to expire in 2039 or 2042. Our subsidiary TheRas, Inc. co- owns with Leidos Biomedical Research, Inc., or Leidos, and Lawrence Livermore National Security, LLC, or Livermore, six pending U. S. patent applications, four pending PCT applications, and eight pending foreign applications with claims directed to modulators of K- RAS, which include claims to the modulators as composition of matter and their use in therapy, including the treatment of cancer. Any patents issuing from these applications are expected to expire between 2042 and 2044. In addition, TheRas co- owns with Leidos and Livermore one pending U. S. patent application, one pending PCT application, and two pending foreign applications with claims directed to compounds that may disrupt interactions between PI3Kα and small GTPases, which include claims to the compounds as composition of matter and their use in therapy, including the treatment of cancer. Any patents issuing from these applications are expected to expire in 2043. License Agreement with Alexion In September 2019, through our subsidiary Eidos Therapeutics, Inc., or Eidos, we entered into a license agreement, or the Alexion License Agreement, with Alexion Pharma International Operations Unlimited Company, a subsidiary of Alexion Pharmaceuticals, Inc., or together, Alexion, to develop and commercialize acoramidis in Japan. Additionally, in September 2019, Eidos entered into a stock purchase agreement with Alexion, pursuant to which Eidos sold to Alexion 556, 173 shares of its common stock for aggregate cash proceeds of $ 25. 0 million. Under the terms of the Alexion License Agreement, Eidos granted Alexion an exclusive license to certain of our intellectual property rights to develop, manufacture and commercialize acoramidis in Japan. In consideration for the license grant, Eidos received an upfront payment of $ 25. 0 million, with the potential for an additional one- time payment of $ 30. 0 million subject to the achievement of a regulatory milestone. In addition, Eidos is entitled to receive royalties in the low double-digits on net sales by Alexion of acoramidis in Japan. The royalty rate is subject to reduction if Alexion is required to obtain intellectual property rights from third parties to develop, manufacture or commercialize acoramidis in Japan, or upon the introduction of generic competition into the market. License Agreement with the Board of Trustees of the Leland Stanford Junior University In April 2016, through Eidos, we entered into an exclusive license agreement with Stanford for rights relating to novel transthyretin aggregation inhibitors. Under our agreement, Stanford has granted us an exclusive worldwide license to make, use and sell products that are covered by the licensed patent rights. This license grant expires when the last licensed patent expires. The patent rights exclusively licensed to us under the license are described in more detail above under the heading " Intellectual property — Eidos Therapeutics, Inc. " Stanford retains the right, on behalf of itself and all other non-profit academic research institutions, to practice under the patent rights for any non- profit purpose, including sponsored research and collaborations. We may grant sublicenses to third parties so long as we are actively pursuing the development or commercialization of products covered by the patent rights. We may also be required to sublicense our rights under the agreement at Stanford' s request under certain conditions, including if we are unwilling or unable to serve a potential market or territory and there is a third party willing to be a sublicensee in such market or territory. We are obligated to pay to Stanford a yearly license maintenance fee during the term of the agreement, but we may offset the maintenance fee against earned royalty payments due on net sales occurring in that year. Stanford is entitled to receive a royalty as a percentage of net sales of licensed products, in the low single digits. We have agreed to pay Stanford a percentage of non- royalty revenue we receive from our sublicensees, with the amount owed decreasing annually for three years based on when we enter into the applicable sublicense agreement. In addition, we are obligated to pay Stanford up to approximately $ 1. 0 million upon the achievement of specific intellectual property, clinical and regulatory milestone events. In the event of a change of control transaction with respect to Eidos, we are obligated to pay Stanford a change of control fee of $ 250, 000 in connection with the assignment of the license agreement to the acquirer of Eidos. Under the license agreement with Stanford, we are obligated to use commercially reasonable efforts to develop, manufacture, and commercialize at least one licensed product; to develop markets for such licensed products; and to meet certain development milestones as agreed upon between us and Stanford. Subject to the expiration of the license grant described above, the agreement does not have a specified term. We may terminate the agreement by providing prior written notice to Stanford, and Stanford has the right to terminate the agreement if we fail to achieve certain milestones or make payments under the agreement, or are not actively pursuing development of a licensed product, or if we otherwise materially breach the agreement and fail to cure such breach within a specified grace period. Infigratinib: License Agreement with

Novartis International Pharmaceutical Ltd. In January 2018, through our subsidiary QED Therapeuties, Inc., or QED, we entered into a license agreement with Novartis International Pharmaceutical Ltd., or Novartis, for certain intellectual property rights, including patents and know- how, related to infigratinib for the treatment of patients with FGFR- driven diseases, including CCA, UC and achondroplasia. We refer to this agreement as the Novartis License. Pursuant to the Novartis License, we obtained a license to research, develop, make, have made, use, import, offer for sale, sell, have sold and otherwise commercialize infigratinib, as well as therapeutic products incorporating infigratinib that would, but for the license grant, infringe Novartis' license patent rights, or that were developed using or that incorporate or embody Novartis' licensed know- how, in all fields of use worldwide. The license grant to us includes the right to sublicense through multiple tiers. We also have certain rights to intellectual property licensed to Novartis' affiliate under a materials transfer agreement with a third party. The Novartis License is subject to Novartis' existing obligations to supply a third party with infigratinib to support the third party' s clinical trials, and we have an ongoing obligation to inform Novartis of our or our sublicensees' intent to seek regulatory approval for and commercialize infigratinib for various indications, with potential reversionary rights to Novartis in the event of a subsequent decision not to seek regulatory approval and commercialization, or a determination by Novartis that we have failed to sufficiently pursue regulatory approval and commercialization, for Novartis to grant such third party limited rights to develop and commercialize infigratinib. Under the terms of the Novartis License, we made a one- time payment of $ 15. 0 million to Novartis and agreed to issue shares of Series A preferred stock of QED valued at approximately $ 1. 7 million in the aggregate to Novartis. In addition, we are obligated to make contingent milestone payments totaling $ 60. 0 million upon achievement of certain regulatory milestones. We are also obligated to make contingent milestone payments totaling $ 35. 0 million upon achievement of certain sales milestones for therapeutic products incorporating infigratinib. QED also agreed to pay Novartis tiered low double- digit royalties on net sales of therapeutic products incorporating infigratinib. Following the FDA' s approval of TRUSELTIQ in May 2021, we paid a one- time regulatory milestone payment to Novartis of $ 20. 0 million. Under the Novartis License, we are required to use commercially reasonable efforts to develop infigratinib, and to obtain regulatory approval for and commercialize infigratinib in the United States and the European Union. We may terminate the Novartis License in its entirety or on a product- by- product or country- by- country basis at any time with 60 days' prior written notice to Novartis. Novartis may terminate if QED ceases to function as a going concern, is the subject of certain bankruptcy or similar proceedings, or otherwise winds down or discontinues its business. Either party may terminate for material breach that is not cured by the other party within a specified time period of receiving notice of such material breach. Otherwise, the Novartis License terminates on a product- by- product and country- by- country basis on the latest of the expiration of licensed patent rights, the expiration of regulatory exclusivity, or the tenth anniversary of the first commercial sale in such country. Fosdenopterin: Asset Purchase Agreement with Alexion Pharma Holding Unlimited Company In June 2018, through our subsidiary Origin Biosciences, Inc., we entered into an asset purchase agreement with Alexion Pharma Holding Unlimited Company, or Alexion Pharma, pursuant to which we acquired Alexion' s right, title and interest in certain assets relating to fosdenopterin, including patents and other intellectual property rights. In the event that a priority review voucher is granted to us by the FDA, we have agreed to pay Alexion Pharma a percentage in the mid- teens of any proceeds received by us from our sale of the PRV to a third party. If we do not sell the PRV to a third party within 180 days after our receipt of the PRV, we are obligated to pay Alexion Pharma $ 18. 8 million, which amount is creditable against any amounts otherwise due to Alexion Pharma in accordance with the preceding sentence upon any future sale by us of the PRV. We are obligated to make contingent milestone payments totaling $ 3. 0 million upon achievement of certain development milestones and $ 17. 0 million upon achievement of certain sales milestones for products containing the fosdenopterin molecule. We also agreed to pay Alexion Pharma tiered royalties ranging from the low- to mid- teens on net sales of products containing the fosdenopterin molecule. In 2021, we paid Alexion a $ 2. 0 million regulatory milestone upon the FDA' s approval of NULIBRY, a $ 1. 0 million sales- based milestone payment, and $ 15. 0 million as a result of the sale of the PRV to Eidos. We are obligated to use commercially reasonable efforts to obtain a PRV, achieve specified milestone events and commercialize at least one product containing the fosdenopterin molecule after receipt of regulatory approval. BBP- 398: License Development and Commercialization Agreement with Bristol- Myers Squibb Company On May 12, 2022, BridgeBio and our subsidiary, Navire Pharma, Inc., or Navire, entered into an exclusive license development and commercialization agreement with Bristol- Myers Squibb Company, or BMS, pursuant to which Navire granted BMS exclusive rights to develop and commercialize Navire' s product candidate, BBP- 398, in all indications worldwide, except for the People' s Republic of China, Macau, Hong Kong, Taiwan, Thailand, Singapore, and South Korea, or collectively, the Asia Region. We refer to this agreement as the Navire- BMS License Agreement. Under the terms of the Navire- BMS License Agreement, Navire was entitled to receive a non- refundable, upfront payment of $ 90. 0 million, which Navire collected in full in June 2022. Additionally, Navire is eligible to receive additional payments totaling up to approximately $ 815. 0 million in the aggregate, subject to the achievement of development, regulatory and commercial milestones, as well as tiered royalties in the low- to- mid teens as a percentage of adjusted net sales by BMS of the licensed products sold worldwide, outside of the Asia Region. Navire will retain the option to acquire higher royalties in the United States in connection with funding a portion of development costs upon the initiation of registrational studies. Based on the terms of the Navire- BMS License Agreement, Navire will continue to lead its ongoing Phase 1 monotherapy and combination therapy trials and BMS will lead and fund all other development and commercialization activities. Government Regulation Government authorities in the United States at the federal, state and local level and in other countries regulate, among other things, the research, development, manufacture, testing, quality control, approval, labeling, packaging, storage, record- keeping, promotion, advertising, distribution, post- approval monitoring and reporting, marketing and export and import of drug and biological products, including gene therapies, as well as diagnostics, and any future product candidates. Generally, before a new drug, biologic or diagnostic can be marketed, considerable data demonstrating its quality, safety and efficacy must be obtained, organized into a format specific for each regulatory authority, submitted for review and approved, authorized, or

cleared by the applicable regulatory authority. U. S. Government Regulation of Drug and Biological Products In the United States, the FDA regulates drugs under the Federal Food, Drug and Cosmetic Act, or FDCA, and its implementing regulations and biologics under the FDCA and the Public Health Service Act, or PHSA, and their implementing regulations. Both drugs and biologics also are subject to other federal, state and local statutes and regulations, such as those related to competition. The process of obtaining regulatory approvals and the subsequent compliance with appropriate federal, state, and local statutes and regulations requires the expenditure of substantial time and financial resources. Failure to comply with the applicable U. S. requirements at any time during the product development process, approval process or following approval may subject an applicant to administrative actions or judicial sanctions. These actions and sanctions could include, among other actions, the FDA' s refusal to approve pending applications, withdrawal of an approval, license revocation, a clinical hold, untitled or warning letters, voluntary or mandatory product recalls or market withdrawals, product seizures, total or partial suspension of production or distribution, injunctions, fines, refusals of government contracts, restitution, disgorgement and civil or criminal fines or penalties. Any agency or judicial enforcement action could have a material adverse effect on our business, the market acceptance of our product candidates, if approved, and our reputation. Our product candidates must be approved by the FDA through either a New Drug Application, or NDA or a Biologics License Application, or BLA, process before they may be legally marketed in the United States. The process generally involves the following: • completion of extensive preclinical studies in accordance with applicable regulations, including studies conducted in accordance with Good Laboratory Practices, or GLP, requirements; • submission to the FDA of an IND, which must become effective before human clinical trials may begin; • approval by an Institutional Review Board, or IRB, or independent ethics committee at each clinical trial site before each human trial may be initiated; • performance of adequate and well- controlled human clinical trials in accordance with applicable IND regulations, Good Clinical Practices, or GCP, requirements and other clinical trial- related regulations to establish the safety and efficacy of the investigational product for each proposed indication; • submission to the FDA of an NDA or BLA; • a determination by the FDA within 60 days of its receipt of an NDA or BLA to accept the filing for review; • satisfactory completion of one or more FDA pre- approval inspections of the manufacturing facility or facilities where the drug or biologic will be produced to assess compliance with Current Good Manufacturing Practices, or cGMP, requirements to assure that the facilities, methods and controls are adequate to preserve the drug or biologic' s identity, strength, quality and purity; • potential FDA audit of the clinical trial sites that generated the data in support of the NDA or BLA; • payment of user fees for FDA review of the NDA or BLA; and • FDA review and approval of the NDA or BLA, including consideration of the views of any FDA advisory committee, prior to any commercial marketing or sale of the drug or biologic in the United States. The preclinical and clinical testing and approval process requires substantial time, effort and financial resources, and the regulatory scheme for drugs and biologics is evolving and subject to change at any time. We cannot be certain that any approvals for our product candidates will be granted on a timely basis, or at all. Preclinical Studies Before testing any drug, biological or gene therapy candidate in humans, the product candidate must undergo rigorous preclinical testing. Preclinical studies include laboratory evaluation of product chemistry and formulation, as well as in vitro and animal studies to assess safety and in some cases to establish a rationale for therapeutic use. The conduct of preclinical studies is subject to federal and state regulations and requirements, including GLP regulations for safety / toxicology studies. An IND sponsor must submit the results of the preclinical tests, together with manufacturing information, analytical data, any available clinical data or literature and plans for clinical trials, among other things, to the FDA as part of an IND. An IND is a request for authorization from the FDA to administer an investigational product to humans, and must become effective before human clinical trials may begin. Some long- term preclinical testing, such as animal tests of reproductive AEs and carcinogenicity, may continue after the IND is submitted. An IND automatically becomes effective 30 days after receipt by the FDA, unless before that time, the FDA raises concerns or questions related to one or more proposed clinical trials and places the trial on clinical hold. In such a case, the IND sponsor and the FDA must resolve any outstanding concerns before the clinical trial can begin. As a result, submission of an IND may not result in the FDA allowing clinical trials to commence. Additionally, the review of information in an IND submission may prompt FDA to, among other things, scrutinize existing INDs or any marketed products and could generate requests for information or clinical holds on other product candidates or programs. Clinical Trials The clinical stage of development involves the administration of the investigational product to healthy volunteers or patients under the supervision of qualified investigators, generally physicians not employed by or under the trial sponsor' s control, in accordance with GCP requirements, which include the requirement that all research subjects provide their informed consent for their participation in any clinical trial. Clinical trials are conducted under protocols detailing, among other things, the objectives of the clinical trial, dosing procedures, subject selection and exclusion criteria and the parameters to be used to monitor subject safety and assess efficacy. Each protocol, and any subsequent amendments to the protocol, must be submitted to the FDA as part of the IND. Furthermore, each clinical trial must be reviewed and approved by an IRB for each institution at which the clinical trial will be conducted to ensure that the risks to individuals participating in the clinical trials are minimized and are reasonable in relation to anticipated benefits. The IRB also approves the informed consent form that must be provided to each clinical trial subject or his or her legal representative, and must monitor the clinical trial until completed. There also are requirements governing the reporting of ongoing clinical trials and completed clinical trial results to public registries. Information about certain clinical trials, including clinical trial results, must be submitted within specific timeframes for publication on the www. clinicaltrials. gov website. In addition to the submission of an IND to the FDA before initiation of a clinical trial in the United States, certain human clinical trials involving recombinant or synthetic nucleic acid molecules are subject to oversight by institutional biosafety committees, or IBC' s, as set forth in the NIH Guidelines for Research Involving Recombinant or Synthetic Nucleic Acid Molecules, or NIH Guidelines. Under the NIH Guidelines, recombinant and synthetic nucleic acids are defined as (i) molecules that are constructed by joining nucleic acid molecules and that can replicate in a living cell (i. e., recombinant nucleic acids); (ii nucleic acid molecules that are chemically or by other means synthesized or amplified, including those that are chemically or otherwise

modified but can base pair with naturally occurring nucleic acid molecules (i. e., synthetic nucleic acids); or (iii) molecules that result from the replication of those described in (i) or (ii). Specifically, under the NIH Guidelines, supervision of human gene transfer trials includes evaluation and assessment by an IBC, a local institutional committee that reviews and oversees research utilizing recombinant or synthetic nucleic acid molecules at that institution. The IBC assesses the safety of the research and identifies any potential risk to public health or the environment, and such review may result in some delay before initiation of a clinical trial. While the NIH Guidelines are not mandatory unless the research in question being conducted at or sponsored by institutions receiving NIH funding of recombinant or synthetic nucleic acid molecule research, many companies and other institutions not otherwise subject to the NIH Guidelines voluntarily follow them. A sponsor who wishes to conduct a clinical trial outside of the United States may, but need not, obtain FDA authorization to conduct the clinical trial under an IND. If a foreign clinical trial is not conducted under an IND, the sponsor may submit data from the clinical trial to the FDA in support of an NDA or BLA. The FDA will accept a well- designed and well- conducted foreign clinical study not conducted under an IND if the study was conducted in accordance with GCP requirements, and the FDA is able to validate the data through an onsite inspection if deemed necessary. Clinical trials generally are conducted in three sequential phases, known as Phase 1, Phase 2 and Phase 3, and may overlap. • Phase 1 clinical trials generally involve a small number of healthy volunteers or disease- affected patients who are initially exposed to a single dose and then multiple doses of the product candidate. The primary purpose of these clinical trials is to assess the metabolism, pharmacologic action, side effect tolerability and safety of the product candidate. • Phase 2 clinical trials involve studies in disease- affected patients to evaluate proof of concept and / or determine the dose required to produce the desired benefits. At the same time, safety and further PK and PD information is collected, possible adverse effects and safety risks are identified, and a preliminary evaluation of efficacy is conducted. • Phase 3 clinical trials generally involve a large number of patients at multiple sites and are designed to provide the data necessary to demonstrate the effectiveness of the product for its intended use, its safety in use and to establish the overall benefit / risk relationship of the product and provide an adequate basis for product labeling. Post- approval trials, sometimes referred to as Phase 4 clinical trials, may be conducted after initial marketing approval. These trials are used to gain additional experience from the treatment of patients in the intended therapeutic indication and are commonly intended to generate additional safety data regarding use of the product in a clinical setting. In certain instances, the FDA may mandate the performance of Phase 4 clinical trials as a condition of approval of an NDA or BLA. Progress reports detailing the results of the clinical trials, among other information, must be submitted at least annually to the FDA and written IND safety reports must be submitted to the FDA and the investigators 15 days after the trial sponsor determines the information qualifies for reporting for serious and unexpected suspected AEs, findings from other studies or animal or in vitro testing that suggest a significant risk for human subjects and any clinically important increase in the rate of a serious suspected adverse reaction over that listed in the protocol or investigator brochure. The sponsor must also notify the FDA of any unexpected fatal or life- threatening suspected adverse reaction as soon as possible but in no case later than seven calendar days after the sponsor' s initial receipt of the information. Phase 1, Phase 2, Phase 3 and other types of clinical trials may not be completed successfully within any specified period, if at all. The FDA or the sponsor may suspend or terminate a clinical trial at any time on various grounds, including a finding that the research subjects or patients are being exposed to an unacceptable health risk. Similarly, an IRB can suspend or terminate approval of a clinical trial at its institution if the clinical trial is not being conducted in accordance with the IRB' s requirements or if the drug or biologic has been associated with unexpected serious harm to patients. Additionally, some clinical trials are overseen by an independent group of qualified experts organized by the clinical trial sponsor, known as a data safety monitoring board or committee. This group provides authorization for whether a trial may move forward at designated check points based on access to certain data from the trial. Concurrent with clinical trials, companies usually complete additional animal studies and also must develop additional information about the chemistry and physical characteristics of the drug or biologic as well as finalize a process for manufacturing the product in commercial quantities in accordance with cGMP requirements. The manufacturing process must be capable of consistently producing quality batches of the product and, among other things, companies must develop methods for testing the identity, strength, quality and purity of the final product. Additionally, appropriate packaging must be selected and tested, and stability studies must be conducted to demonstrate that the product candidates do not undergo unacceptable deterioration over their shelf life. FDA Review Process Following completion of the clinical trials, data are analyzed to assess whether the investigational product is safe and effective for the proposed indicated use or uses. The results of preclinical studies and clinical trials are then submitted to the FDA as part of an NDA or BLA, along with proposed labeling, chemistry and manufacturing information to ensure product quality and other relevant data. The NDA or BLA is a request for approval to market the drug or biologic for one or more specified indications and must contain proof of safety and efficacy for a drug or safety, purity and potency for a biologic. The application may include both negative and ambiguous results of preclinical studies and clinical trials, as well as positive findings. Data may come from company- sponsored clinical trials intended to test the safety and efficacy of a product' s use or from a number of alternative sources, including studies initiated by investigators. To support marketing approval, the data submitted must be sufficient in quality and quantity to establish the safety and efficacy of the investigational product to the satisfaction of FDA. FDA approval of an NDA or BLA must be obtained before a drug or biologic may be marketed in the United States. Under the Prescription Drug User Fee Act, or PDUFA, as amended, each NDA or BLA must be accompanied by a user fee. FDA adjusts the PDUFA user fees on an annual basis. Fee waivers or reductions are available in certain circumstances, including a waiver of the application fee for the first application filed by a small business. Additionally, no user fees are assessed on NDAs or BLAs for products designated as orphan drugs, unless the product also includes a non- orphan indication. The FDA reviews all submitted NDAs and BLAs before it accepts them for filing, and may request additional information rather than accepting the NDA or BLA for filing. The FDA must make a decision on accepting an NDA or BLA for filing within 60 days of receipt, and such decision could include a refusal to file by the FDA. Once the submission is accepted for filing, the FDA begins an in- depth review of the NDA or BLA.

Under the goals and policies agreed to by the FDA under PDUFA, the FDA targets ten months, from the filing date, in which to complete its initial review of a new molecular entity NDA or original BLA and respond to the applicant, and six months from the filing date of a new molecular entity NDA or original BLA designated for priority review. The FDA does not always meet its PDUFA goal dates for standard and priority NDAs or BLAs, and the review process is often extended by FDA requests for additional information or clarification. The FDA has developed the Oncology Center of Excellence Real- Time Oncology Review, or RTOR, pilot program to facilitate a more efficient review process for certain oncology product candidates. Although this program allows FDA to begin reviewing clinical data prior to submission of a complete NDA or BLA, the program is not intended to change the PDUFA review timelines. Before approving an NDA or BLA, the FDA will conduct a pre- approval inspection of the manufacturing facilities for the new product to determine whether they comply with cGMP requirements. The FDA will not approve the product unless it determines that the manufacturing processes and facilities are in compliance with cGMP requirements and adequate to assure consistent production of the product within required specifications. The FDA also may audit data from clinical trials to ensure compliance with GCP requirements. Additionally, the FDA may refer applications for novel products or products which present difficult questions of safety or efficacy to an advisory committee, typically a panel that includes clinicians and other experts, for review, evaluation and a recommendation as to whether the application should be approved and under what conditions, if any. The FDA is not bound by recommendations of an advisory committee, but it considers such recommendations when making decisions on approval. The FDA likely will reanalyze the clinical trial data, which could result in extensive discussions between the FDA and the applicant during the review process. After the FDA evaluates an NDA or BLA, it will issue an approval letter or a Complete Response Letter. An approval letter authorizes commercial marketing of the drug or biologic with specific prescribing information for specific indications. A Complete Response Letter indicates that the review cycle of the application is complete, and the application will not be approved in its present form. A Complete Response Letter usually describes all of the specific deficiencies in the NDA or BLA identified by the FDA. The Complete Response Letter may require the applicant to obtain additional clinical data, including the potential requirement to conduct additional pivotal Phase 3 clinical trial (s) and / or to complete other significant and time- consuming requirements related to clinical trials, or to conduct additional preclinical studies or manufacturing activities. If a Complete Response Letter is issued, the applicant may either resubmit the NDA or BLA, addressing all of the deficiencies identified in the letter, or withdraw the application or request an opportunity for a hearing. Even if such data and information are submitted, the FDA may decide that the NDA or BLA does not satisfy the criteria for approval. Data obtained from clinical trials are not always conclusive and the FDA may interpret data differently than we interpret the same data. Orphan Drug Designation and Exclusivity Under the Orphan Drug Act, the FDA may grant orphan drug designation to a drug or biological product intended to treat a rare disease or condition, which is generally a disease or condition that affects fewer than 200, 000 individuals in the United States, or 200, 000 or more individuals in the United States and for which there is no reasonable expectation that the cost of developing and making the product available in the United States for this type of disease or condition will be recovered from sales of the product. Orphan drug designation must be requested before submitting an NDA or BLA. After the FDA grants orphan drug designation, the identity of the therapeutic agent and its potential orphan use are disclosed publicly by the FDA. Orphan drug designation does not convey any advantage in or shorten the duration of the regulatory review and approval process. If a product that has orphan drug designation subsequently receives the first FDA approval for the disease or condition for which it has such designation, the product is entitled to orphan drug exclusivity, which means that the FDA may not approve any other applications to market the same drug for the same indication for seven years from the date of such approval, except in limited circumstances, such as a showing of clinical superiority to the product with orphan exclusivity by means of greater effectiveness, greater safety or providing a major contribution to patient care or in instances of drug supply issues. Competitors, however, may receive approval of either a different product for the same indication or the same product for a different indication but that could be used off- label in the orphan indication. Orphan drug exclusivity also could block the approval of our products for seven years if a competitor obtains approval before we do for the same product, as defined by the FDA, for the same indication we are seeking approval, or if our product is determined to be contained within the scope of the competitor' s product for the same indication or disease. If we pursue marketing approval for an indication broader than the orphan drug designation we have received, we may not be entitled to orphan drug exclusivity. Orphan drug status in the European Union has similar, but not identical, requirements and benefits. Rare Pediatric Disease Designation and Priority Review Vouchers Under the FDCA, as amended, the FDA incentivizes the development of drugs and biologics that meet the definition of a " rare pediatric disease, " defined to mean a serious or life- threatening disease in which the serious of life- threatening manifestations primarily affect individuals aged from birth to 18 years and the disease affects fewer than 200, 000 individuals in the United States or affects more than 200, 000 in the United States and for which there is no reasonable expectation that the cost of developing and making in the United States a drug for such disease or condition will be received from sales in the United States of such drug. The sponsor of a product candidate for a rare pediatric disease may be eligible for a voucher that can be used to obtain a priority review for a subsequent human drug or biologic application after the date of approval of the rare pediatric disease drug product, referred to as a priority review voucher, or PRV. A sponsor may request rare pediatric disease designation from the FDA prior to the submission of its NDA or BLA. A rare pediatric disease designation does not guarantee that a sponsor will receive a PRV upon approval of its NDA or BLA. Moreover, a sponsor who chooses not to submit a rare pediatric disease designation request may nonetheless receive a PRV upon approval of their marketing application if they request such a voucher in their original marketing application and meet all of the eligibility criteria. If a PRV is received, it may be sold or transferred an unlimited number of times. Congress has extended the PRV program through September 30, 2024, with the potential for PRVs to be granted through September 30, 2026. Expedited Development and Review Programs A sponsor may seek to develop and obtain approval of its product candidates under programs designed to accelerate the development, FDA review and approval of new drugs and biologics that meet certain criteria. For example, the FDA has a fast track program that is intended to expedite

or facilitate the process for reviewing new drugs and biologics that are intended to treat a serious or life threatening disease or condition and demonstrate the potential to address unmet medical needs for the condition. Fast track designation applies to both the product and the specific indication for which it is being studied. For a fast track- designated product, the FDA may consider sections of the NDA or BLA for review on a rolling basis before the complete application is submitted, if the sponsor provides a schedule for the submission of the sections of the application, the FDA agrees to accept sections of the application and determines that the schedule is acceptable, and the sponsor pays any required user fees upon submission of the first section of the application. The sponsor can request the FDA to designate the product for fast track status any time before receiving NDA or BLA approval, but ideally no later than the pre- NDA or pre- BLA meeting. A product submitted to the FDA for marketing, including under a fast track program, may be eligible for other types of FDA programs intended to expedite development or review, such as priority review and accelerated approval. Priority review means that, for a new molecular entity or original BLA, the FDA sets a target date for FDA action on the marketing application at six months after accepting the application for filing as opposed to ten months. A product is eligible for priority review if it is designed to treat a serious or life- threatening disease condition and, if approved, would provide a significant improvement in safety and effectiveness compared to available therapies. The FDA will attempt to direct additional resources to the evaluation of an application for a new drug or biologic designated for priority review in an effort to facilitate the review. If criteria are not met for priority review, the application for a new molecular entity or original BLA is subject to the standard FDA review period of ten months after FDA accepts the application for filing. Priority review designation does not change the scientific / medical standard for approval or the quality of evidence necessary to support approval. Under the Food and Drug Omnibus Reform Act of 2022, or FDORA, a platform technology incorporated within or utilized by a drug or biologic is eligible for designation as a designated platform technology if (1) the platform technology is incorporated in, or utilized by, a drug approved under an NDA or BLA; (2) preliminary evidence submitted by the sponsor of the approved or licensed drug, or a sponsor that has been granted a right of reference to data submitted in the application for such drug, demonstrates that the platform technology has the potential to be incorporated in, or utilized by, more than one drug without an adverse effect on quality, manufacturing, or safety; and (3) data or information submitted by the applicable person indicates that incorporation or utilization of the platform technology has a reasonable likelihood to bring significant efficiencies to the drug development or manufacturing process and to the review process. A sponsor may request the FDA to designate a platform technology as a designated platform technology concurrently with, or at any time after, submission of an IND application for a drug that incorporates or utilizes the platform technology that is the subject of the request. If so designated, the FDA may expedite the development and review of any subsequent original NDA or BLA for a drug that uses or incorporates the platform technology. Designated platform technology status does not ensure that a drug will be developed more quickly or receive a faster FDA review process or ultimate FDA approval. In addition, the FDA may revoke a designation if the FDA determines that a designated platform technology no longer meets the criteria for such designation. A product may also be eligible for accelerated approval if it is designed to treat a serious or life- threatening disease or condition and generally provides a meaningful advantage over available therapies upon a determination that the product has an effect on either a surrogate or intermediate clinical endpoint that is reasonably likely to predict clinical benefit or on a clinical endpoint that can be measured earlier than irreversible morbidity or mortality, or IMM, that is reasonably likely to predict an effect on IMM or other clinical benefit, taking into account the severity, rarity, or prevalence of the disease or condition and the availability or lack of alternative treatments. As a condition of approval, the FDA may require that a sponsor of a drug or biologic receiving accelerated approval perform adequate and well- controlled post- marketing confirmatory clinical trials with due diligence and, under FDORA, the FDA is permitted to require, as appropriate, that such confirmatory studies be underway prior to approval or within a specified time period after accelerated approval is granted. In addition, the FDA currently requires, unless otherwise informed by the agency, pre- approval of promotional materials, which could adversely impact the timing of the commercial launch of the product. Under FDORA, the FDA has increased authority for expedited procedures to withdraw approval of a drug or indication approved under accelerated approval if, for example, the confirmatory trial fails to verify the predicted clinical benefit of the product. Additionally, a drug or biologic may be eligible for designation as a breakthrough therapy if the product is intended, alone or in combination with one or more other drugs or biologics, to treat a serious or life-threatening condition and preliminary clinical evidence indicates that the product may demonstrate substantial improvement over currently approved therapies on one or more clinically significant endpoints, such as substantial treatment effects observed early in clinical development. If the FDA designates a breakthrough therapy, it may take actions appropriate to expedite the development and review of the application, which may include holding meetings with the sponsor and the review team throughout the development of the therapy; providing timely advice to, and interactive communication with, the sponsor regarding the development of the drug to ensure that the development program to gather the nonclinical and clinical data necessary for approval is as efficient as practicable; involving senior managers and experienced review staff, as appropriate, in a collaborative, cross- disciplinary review; assigning a cross- disciplinary project lead for the FDA review team to facilitate an efficient review of the development program and to serve as a scientific liaison between the review team and the sponsor; and considering alternative clinical trial designs when scientifically appropriate, which may result in smaller trials or more efficient trials that require less time to complete and may minimize the number of patients exposed to a potentially less efficacious treatment. Breakthrough therapy designation comes with all of the benefits of fast track designation, which means that the sponsor may file sections of the BLA for review on a rolling basis if certain conditions are satisfied, including an agreement with the FDA on the proposed schedule for submission of portions of the application and the payment of applicable user fees before the FDA may initiate a review. As part of the 21st Century Cures Act, Congress amended the FDCA to facilitate an efficient development program for, and expedite review of regenerative medicine advanced therapies, or RMATs, which include cell and gene therapies, therapeutic tissue engineering products, human cell and tissue products, and combination products using any such therapies or products. RMATs do not include those human cells, tissues, and cellular and tissue based products

regulated solely under section 361 of the PHSA and 21 CFR Part 1271. This program is intended to facilitate efficient development and expedite review of regenerative medicine therapies, which are intended to treat, modify, reverse, or cure a serious or life- threatening disease or condition and qualify for RMAT designation. A sponsor may request that the FDA designate a product candidate as a RMAT concurrently with or at any time after submission of an IND. The FDA has 60 calendar days to determine whether the product candidate meets the criteria, including whether there is preliminary clinical evidence indicating that the product candidate has the potential to address unmet medical needs for a serious or life- threatening disease or condition. A BLA for a product candidate that has received RMAT designation may be eligible for priority review or accelerated approval through use of surrogate or intermediate endpoints reasonably likely to predict long- term clinical benefit, or reliance upon data obtained from a meaningful number of sites. Benefits of RMAT designation also include early interactions with FDA to discuss any potential surrogate or intermediate endpoint to be used to support accelerated approval. A product candidate with RMAT designation that is granted accelerated approval and is subject to post- approval requirements may fulfill such requirements through the submission of clinical evidence from clinical studies, patient registries, or other sources of real world evidence, such as electronic health records; the collection of larger confirmatory data sets; or post- approval monitoring of all patients treated with such therapy prior to its approval. The FDA has also announced the availability of the RTOR pilot program for oncology product candidates that are likely to demonstrate substantial improvements over available therapy, which may include drugs previously granted breakthrough therapy designation for the same or other indications and candidates meeting other criteria for other expedited programs, such as fast track and priority review. Submissions for RTOR consideration should also have straightforward study designs and endpoints that can be easily interpreted (such as overall survival or progression free survival). Acceptance into the RTOR program does not guarantee or influence approvability of the application, which is subject to the usual benefit- risk evaluation by FDA reviewers, but the program allows FDA to review data earlier, before an applicant formally submits a complete application. The RTOR program does not affect FDA' s PDUFA timelines. Even if a product qualifies for one or more of these programs, the FDA may later decide that the product no longer meets the conditions for qualification or the time period for FDA review or approval may not be shortened. Furthermore, fast track designation, priority review, accelerated approval, breakthrough therapy and RMAT designation do not change the standards for approval. Pediatric Information and Pediatric Exclusivity Under the Pediatric Research Equity Act, or PREA, certain NDAs and BLAs and certain supplements to an NDA or BLA must contain data to assess the safety and efficacy of the drug for the claimed indications in all relevant pediatric subpopulations and to support dosing and administration for each pediatric subpopulation for which the product is safe and effective. The FDA may grant deferrals for submission of pediatric data or full or partial waivers. The Food and Drug Administration Safety and Innovation Act, or FDASIA, amended the FDCA to require that a sponsor who is planning to submit a marketing application for a drug that includes a new active ingredient, new indication, new dosage form, new dosing regimen or new route of administration submit an initial Pediatric Study Plan, or PSP, within 60 days of an end- of- Phase 2 meeting or, if there is no such meeting, as early as practicable before the initiation of the Phase 3 or Phase 2 / 3 study. The initial PSP must include an outline of the pediatric study or studies that the sponsor plans to conduct, including study objectives and design, age groups, relevant endpoints and statistical approach, or a justification for not including such detailed information, and any request for a deferral of pediatric assessments or a full or partial waiver of the requirement to provide data from pediatric studies along with supporting information. The FDA and the sponsor must reach an agreement on the PSP. A sponsor can submit amendments to an agreed- upon initial PSP at any time if changes to the pediatric plan need to be considered based on data collected from preclinical studies, early phase clinical trials and / or other clinical development programs. A drug or biologic product can also obtain pediatric market exclusivity in the United States. Pediatric exclusivity, if granted, adds six months to existing exclusivity periods and patent terms. This six- month exclusivity, which runs from the end of other exclusivity protection or patent term, may be granted based on the voluntary completion of a pediatric study in accordance with an FDA- issued " Written Request " for such a study. Post- Marketing Requirements Following approval of a new product, the manufacturer and the approved product are subject to continuing regulation by the FDA, including, among other things, monitoring and record- keeping activities, reporting of adverse experiences to applicable regulatory authorities, complying with promotion and advertising requirements, which include, among other things, standards for direct- to- consumer advertising, requirements for promotional activities on the internet, restrictions on promoting products for unapproved uses or in patient populations that are not described in the product' s approved label (known as " off- label use ") and limitations on industry- sponsored scientific and educational activities. Although physicians may prescribe legally available products for off- label uses, manufacturers may not market or promote such off- label uses. The FDA does not regulate the behavior of physicians in their choice of treatment, but the FDA regulations do impose stringent restrictions on manufacturers' communications regarding off- label uses. The FDA and other agencies actively enforce the laws and regulations prohibiting the promotion of off- label uses, and a company that is found to have improperly promoted off- label uses may be subject to significant liability, including investigation by federal and state authorities. Prescription drug promotional materials must be submitted to the FDA in conjunction with their first use or first publication, and may be required to be reviewed in advance in certain circumstances such as for products that receive accelerated approval. Further, if there are any modifications to the drug or biologic, including changes in indications, labeling or manufacturing processes or facilities, the applicant may be required to submit and obtain FDA approval of a new NDA / BLA or NDA / BLA supplement, which may require the development of additional data or preclinical studies and clinical trials. Such regulatory reviews can result in denial or modification of the planned changes, or requirements to conduct additional tests or evaluations that can substantially delay or increase the cost of the planned changes. The FDA may also place other conditions on approvals including the requirement for a REMS, to assure the safe use of the product. If the FDA concludes a REMS is needed, the sponsor of the NDA or BLA must submit a proposed REMS. The FDA will not approve the NDA or BLA without an approved REMS, if required. A REMS could include medication guides, physician communication plans or elements to assure safe use, such as restricted distribution methods, patient registries and

other risk minimization tools. Any of these limitations on approval or marketing could restrict the commercial promotion, distribution, prescription or dispensing of products. Product approvals may be withdrawn for non- compliance with regulatory requirements, if problems occur following initial marketing or if the FDA determines that the product is no longer safe or effective. FDA regulations require that products be manufactured in specific approved facilities and in accordance with cGMP regulations. We rely, and expect to continue to rely, on third parties for the production of clinical and commercial quantities of any approved products in accordance with cGMP regulations. NDA and BLA holders using contract manufacturers, laboratories or packagers are responsible for the selection and monitoring of qualified firms, and, in certain circumstances, qualified suppliers to these firms. These manufacturers must comply with cGMP regulations that require, among other things, quality control and quality assurance, the maintenance of records and documentation and the obligation to investigate and correct any deviations from cGMP. Manufacturers and other entities involved in the manufacture and distribution of approved drugs or biologics are required to register their establishments with the FDA and certain state agencies, and are subject to periodic unannounced inspections by the FDA and certain state agencies for compliance with cGMP requirements and other laws. Accordingly, manufacturers must continue to expend time, money and effort in the area of production and quality control to maintain cGMP compliance. The discovery of violative conditions, including failure to conform to cGMP regulations, could result in enforcement actions, and the discovery of problems with a product after approval may result in restrictions on a product, manufacturer or holder of an approved NDA or BLA, including recall or withdrawal of the product from the market. Any distribution of prescription drugs and biologics and pharmaceutical samples must comply with the U. S. Prescription Drug Marketing Act, or PDMA, and the PHSA. In addition, the Drug Supply Chain Security Act, or DSCSA, was enacted in 2013 with the aim of building an electronic system to identify and trace certain prescription drugs and biologics distributed in the United States. The DSCSA mandates phased- in and resource- intensive obligations for pharmaceutical manufacturers, wholesale distributors, and dispensers over a 10- year period that is expected to culminate in November 2023. The law' s requirements include the quarantine and prompt investigation of a suspect product, to determine if it is illegitimate, notifying trading partners and the FDA of any illegitimate product, and compliance with product tracking and tracing requirements. Once an approval is granted, the FDA may issue enforcement letters or withdraw the approval of the product if compliance with regulatory requirements and standards is not maintained or if problems occur after the drug or biologic reaches the market. Corrective action could delay drug or biologic distribution and require significant time and financial expenditures. Later discovery of previously unknown problems with a drug or biologic, including AEs of unanticipated severity or frequency, or with manufacturing processes, or failure to comply with regulatory requirements, may require revisions to the approved labeling to add new safety information, including the addition of new warning and contraindications; imposition of post- market studies or clinical trials to assess new safety risks; or imposition of distribution or other restrictions under a REMS program. Other potential consequences include, among other things: • mandated corrective advertising or communications with doctors; • restrictions on the marketing or manufacturing of the drug or biologic, suspension of the approval, complete withdrawal of the drug from the market or product recalls; • fines, warning letters or holds on post- approval clinical trials; • refusal of the FDA to approve applications or supplements to approved applications, or suspension or revocation of drug or biologic approvals; • drug or biologic seizure or detention, or refusal to permit the import or export of drugs; or • injunctions or the imposition of civil or criminal penalties. Regulation of Companion Diagnostics We believe that the success of certain of our product candidates may depend, in part, on the development and commercialization of a companion diagnostic. Companion diagnostics identify patients who are most likely to benefit from a particular therapeutic product; identify patients likely to be at increased risk for serious side effects as a result of treatment with a particular therapeutic product; or monitor response to treatment with a particular therapeutic product for the purpose of adjusting treatment to achieve improved safety or effectiveness. Companion diagnostics are regulated as medical devices by the FDA. In the United States, the FDCA and its implementing regulations, and other federal and state statutes and regulations govern, among other things, medical device design and development, preclinical and clinical testing, premarket clearance or approval, registration and listing, manufacturing, labeling, storage, advertising and promotion, sales and distribution, export and import, and post- market surveillance. Unless an exemption or FDA exercise of enforcement discretion applies, diagnostic tests generally require marketing clearance or approval from the FDA prior to commercialization. The two primary types of FDA marketing authorization applicable to a medical device are premarket notification, also called 510 (k) clearance, and approval of a premarket, or PMA approval. To obtain 510 (k) clearance for a medical device, or for certain modifications to devices that have received 510 (k) clearance, a manufacturer must submit a premarket notification demonstrating that the proposed device is substantially equivalent to a previously cleared 510 (k) device or to a preamendment device that was in commercial distribution before May 28, 1976, or a predicate device, for which the FDA has not yet called for the submission of a PMA. In making a determination that the device is substantially equivalent to a predicate device, the FDA compares the proposed device to the predicate device or predicate devices and assesses whether the subject device is comparable to the predicate device or predicate devices with respect to intended use, technology, design and other features which could affect safety and effectiveness. If the FDA determines that the subject device is substantially equivalent to the predicate device or predicate devices, the subject device may be cleared for marketing. The 510 (k) premarket notification pathway generally takes from three to twelve months from the date the application is completed, but can take significantly longer. PMA applications must be supported by valid scientific evidence, which typically requires extensive data, including technical, preclinical, clinical and manufacturing data, to demonstrate to the FDA' s satisfaction the safety and effectiveness of the device. For diagnostic tests, a PMA application typically includes data regarding analytical and clinical validation studies. As part of its review of the PMA, the FDA will conduct a pre- approval inspection of the manufacturing facility or facilities to ensure compliance with the Quality System Regulation, or QSR, which requires manufacturers to follow design, testing, control, documentation and other quality assurance procedures. The FDA' s review of an initial PMA application is required by statute to take between six to ten months, although the process typically takes longer, and may require several

years to complete. If the FDA evaluations of both the PMA application and the manufacturing facilities are favorable, the FDA will either issue an approval letter or an approvable letter, which usually contains a number of conditions that must be met in order to secure the final approval of the PMA. If the FDA' s evaluation of the PMA or manufacturing facilities is not favorable, the FDA will deny the approval of the PMA or issue a not approvable letter. A not approvable letter will outline the deficiencies in the application and, where practical, will identify what is necessary to make the PMA approvable. Once granted, PMA approval may be withdrawn by the FDA if compliance with post- approval requirements, conditions of approval or other regulatory standards is not maintained or problems are identified following initial marketing. On July 31, 2014, the FDA issued a final guidance document addressing the development and approval process for " In Vitro Companion Diagnostic Devices. " According to the guidance document, for novel therapeutic products that depend on the use of a diagnostic test and where the diagnostic device could be essential for the safe and effective use of the corresponding therapeutic product, the premarket application for the companion diagnostic device should be developed and approved or cleared contemporaneously with the therapeutic, although the FDA recognizes that there may be cases when contemporaneous development may not be possible. However, in cases where a drug cannot be used safely or effectively without the companion diagnostic, the FDA' s guidance indicates it will generally not approve the drug without the approval or clearance of the diagnostic device. The FDA also issued a draft guidance in July 2016 setting forth the principles for co- development of an in vitro companion diagnostic device with a therapeutic product. The draft guidance describes principles to guide the development and contemporaneous marketing authorization for the therapeutic product and its corresponding in vitro companion diagnostic. Once cleared or approved, the companion diagnostic device must adhere to post- marketing requirements including the requirements of FDA' s quality system regulation, adverse event reporting, recalls and corrections along with product marketing requirements and limitations. Like drug and biologic makers, companion diagnostic makers are subject to unannounced FDA inspections at any time during which the FDA will conduct an audit of the product (s) and the Company' s facilities for compliance with its authorities. Biosimilars and Exclusivity Certain of our product candidates are regulated as biologics. An abbreviated approval pathway for biological products shown to be similar to, or interchangeable with, an FDA- licensed reference biological product was created by the Biologics Price Competition and Innovation Act of 2009, or BPCI Act, as part of the ACA. This amendment to the PHSA, in part, attempts to minimize duplicative testing. Biosimilarity, which requires that the biological product be highly similar to the reference product notwithstanding minor differences in clinically inactive components and that there be no clinically meaningful differences between the product and the reference product in terms of safety, purity and potency, can be shown through analytical studies, animal studies and a clinical trial or trials. Interchangeability requires that a biological product be biosimilar to the reference product and that the product can be expected to produce the same clinical results as the reference product in any given patient and, for products administered multiple times to an individual, that the product and the reference product may be alternated or switched after one has been previously administered without increasing safety risks or risks of diminished efficacy relative to exclusive use of the reference biological product without such alternation or switch. Complexities associated with the larger, and often more complex, structure of biological products as compared to small molecule drugs, as well as the processes by which such products are manufactured, pose significant hurdles to implementation that are still being worked out by the FDA. A reference biological product is granted four and twelve- year exclusivity periods from the time of first licensure of the product. The FDA will not accept an application for a biosimilar or interchangeable product based on the reference biological product until four years after the date of first licensure of the reference product, and the FDA will not approve an application for a biosimilar or interchangeable product based on the reference biological product until twelve years after the date of first licensure of the reference product. " First licensure " typically means the initial date the particular product at issue was licensed in the United States. Date of first licensure does not include the date of licensure of (and a new period of exclusivity is not available for) a biological product if the licensure is for a supplement for the biological product or for a subsequent application by the same sponsor or manufacturer of the biological product (or licensor, predecessor in interest, or other related entity) for a change (not including a modification to the structure of the biological product) that results in a new indication, route of administration, dosing schedule, dosage form, delivery system, delivery device or strength, or for a modification to the structure of the biological product that does not result in a change in safety, purity, or potency. Therefore, one must determine whether a new product includes a modification to the structure of a previously licensed product that results in a change in safety, purity, or potency to assess whether the licensure of the new product is a first licensure that triggers its own period of exclusivity. Whether a subsequent application, if approved, warrants exclusivity as the " first licensure " of a biological product is determined on a case- by- case basis with data submitted by the sponsor. Other Regulatory Matters Manufacturing, sales, promotion and other activities following product approval are also subject to regulation by numerous regulatory authorities in the United States in addition to the FDA, including the Centers for Medicare and Medicaid Services, or CMS, including the Office of Inspector General and Office for Civil Rights, other divisions of the Department of HHS, the Department of Justice, the Drug Enforcement Administration, the Consumer Product Safety Commission, the Federal Trade Commission, the Occupational Safety & Health Administration, the Environmental Protection Agency and state and local governments. Healthcare providers, physicians, and third party payors will play a primary role in the recommendation and prescription of any products for which we obtain marketing approval. Our current and future arrangements with healthcare providers and physicians and any future arrangements with third party payers, may expose us to broadly applicable fraud and abuse and other healthcare laws and regulations that may constrain the business or financial arrangements and relationships through which we market, sell and distribute any drugs for which we obtain marketing approval. In the United States, these laws include: the federal Anti- Kickback Statute, the False Claims Act, and the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Anti- Kickback Statute makes it illegal for any person, including a prescription drug manufacturer (or a party acting on its behalf), to knowingly and willfully solicit, receive, offer or pay any remuneration, directly or indirectly, in cash or in kind, that is intended to induce or reward referrals, including the purchase, recommendation, order or prescription of a particular drug, for

which payment may be made under a federal healthcare program, such as Medicare or Medicaid. Violations of this law are punishable by imprisonment, criminal fines, administrative civil money penalties and exclusion from participation in federal healthcare programs. In addition, a person or entity does not need to have actual knowledge of the statute or specific intent to violate it. Moreover, the ACA provides that the government may assert that a claim including items or services resulting from a violation of the federal Anti- Kickback Statute constitutes a false or fraudulent claim for purposes of the federal civil False Claims Act or federal civil money penalties. Although we would not submit claims directly to payors, drug manufacturers can be held liable under federal civil and criminal false claims laws and civil monetary penalty laws, such as the federal civil False Claims Act, which imposes criminal and civil penalties, including through civil whistleblower or qui tam actions, against individuals or entities (including manufacturers) for, among other things, knowingly presenting, or causing to be presented to federal programs (including Medicare and Medicaid) claims for items or services, including drugs, that are false or fraudulent, claims for items or services not provided as claimed, or claims for medically unnecessary items or services. Penalties for a False Claims Act violation include three times the actual damages sustained by the government, plus mandatory civil penalties for each separate false claim, the potential for exclusion from participation in federal healthcare programs and, although the federal False Claims Act is a civil statute, conduct that results in a False Claims Act violation may also implicate various federal criminal statutes. The government may deem manufacturers to have " caused " the submission of false or fraudulent claims by, for example, providing inaccurate billing or coding information to customers or promoting a product off- label. Claims which include items or services resulting from a violation of the federal Anti- Kickback Statute are false or fraudulent claims for purposes of the False Claims Act. Our future marketing and activities relating to the reporting of wholesaler or estimated retail prices for our products, if approved, the reporting of prices used to calculate Medicaid rebate information and other information affecting federal, state and third- party reimbursement for our products, if approved, and the sale and marketing of our product candidates, are subject to scrutiny under this law. HIPAA created federal criminal statutes that prohibit among other things, knowingly and willfully executing, or attempting to execute, a scheme to defraud or to obtain, by means of false or fraudulent pretenses, representations or promises, any money or property owned by, or under the control or custody of, any healthcare benefit program, including private third party payors, knowingly and willfully embezzling or stealing from a healthcare benefit program, willfully obstructing a criminal investigation of a healthcare offense, and knowingly and willfully falsifying, concealing or covering up by trick, scheme or device, a material fact or making any materially false, fictitious or fraudulent statement in connection with the delivery of or payment for healthcare benefits, items or services. Like the federal Anti- Kickback Statute a person or entity does not need to have actual knowledge of the statute or specific intent to violate it in order to have committed a violation. The civil monetary penalties statute imposes penalties against any person or entity that, among other things, is determined to have presented or caused to be presented a claim to a federal health program that the person knows or should know is for an item or service that was not provided as claimed or is false or fraudulent. We may be subject to data privacy and security regulations by both the federal government and the states in which we conduct our business. HIPAA, as amended by the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH), and their implementing regulations, including the Final Omnibus Rule published in January 2013, which imposes requirements on certain covered healthcare providers, health plans, and healthcare clearinghouses, as well as their respective business associates, independent contractors, or agents of health covered entities, that perform services for them that involve the creation, maintenance, receipt, use, or disclosure of, individually identifiable health information relating to the privacy, security, and transmission of individual identifiable health information. Among other things, HITECH makes HIPAA' s security standards directly applicable to business associates, defined as independent contractors or agents of covered entities, which include certain health care providers, health plans, and healthcare clearinghouses, that create, receive or obtain protected health information in connection with providing a service for or on behalf of a covered entity. HITECH also created new tiers of civil monetary penalties, amended HIPAA to make civil and criminal penalties directly applicable to business associates, and gave state attorneys general new authority to file civil actions for damages or injunctions in federal courts to enforce the federal HIPAA laws and seek attorneys' fees and costs associated with pursuing federal civil actions. In addition, there may be additional federal, state, and non- U. S. laws which govern the privacy and security of health and other personal information in certain circumstances, many of which differ from each other in significant ways and may not have the same effect, thus complicating compliance efforts. Failure to comply with these laws, where applicable, can result in the imposition of significant civil and criminal penalties. In addition, many states in which we operate have laws that protect the privacy and security of sensitive and personal information. Certain state laws may be more stringent or broader in scope, or offer greater individual rights, with respect to sensitive and personal information than federal, international, or other state laws, and such laws may differ from each other, which may complicate compliance efforts. Where state laws are more protective than HIPAA, we must comply with the state laws we are subject to, in addition to HIPAA. In certain cases, it may be necessary to modify our planned operations and procedures to comply with these more stringent state laws. Further, in some cases where we process sensitive and personal information of individuals from numerous states, we may find it necessary to comply with the most stringent state laws applicable to any of the information. California recently enacted the California Consumer Privacy Act, or CCPA, which creates new individual privacy rights for California consumers (as defined in the law) and places increased privacy and security obligations on entities handling personal data of consumers or households. The CCPA will require covered companies to provide certain disclosures to consumers about its data collection, use and sharing practices, and to provide affected California residents with ways to opt- out of certain sales or transfers of personal information. The CCPA went into effect on January 1, 2020, and the California State Attorney General submitted final regulations for review on June 2, 2020, which were finalized and are now effective. The California State Attorney General has commenced enforcement actions against violators as of July 1, 2020. Further, a new California privacy law, the California Privacy Rights Act, or CPRA, was passed by California voters on November 3, 2020. The CPRA will create additional obligations with respect to processing and storing personal information

effective January 1, 2023 (with certain provisions having retroactive effect to January 1, 2022). We will continue to monitor developments related to the CPRA and anticipate additional costs and expenses associated with CPRA compliance. Other U. S. states also are considering omnibus privacy legislation and industry organizations regularly adopt and advocate for new standards in these areas. While the CCPA and CPRA contain an exception for certain activities involving PHI under HIPAA, we cannot yet determine the impact the CCPA, CPRA or other such future laws, regulations and standards may have on our business. Additionally, some observers have noted that the CCPA and CPRA could mark the beginning of a trend toward more stringent privacy legislation in the U. S., which could increase our potential liability and adversely affect our business. Already, in the United States, we have witnessed significant developments at the state level. For example, on March 2, 2021, Virginia enacted the Consumer Data Protection Act, or the CDPA and, on July 8, 2021, Colorado' s governor signed the Colorado Privacy Act, or CPA, into law. The CDPA and the CPA both became effective January 1, 2023. While the CDPA and CPA incorporate many similar concepts of the CCPA and CPRA, there are also several key differences in the scope, application, and enforcement of the law that will change the operational practices of regulated businesses. Moreover, on March 24, 2022, Utah' s governor signed the Utah Consumer Privacy Act, or UCPA, into law. The UCPA will take effect on December 31, 2023. Also, in May 2022, Connecticut Governor Ned Lamont signed the Connecticut Data Privacy Act, or CTDPA, into law. The UCPA and CTDPA draw heavily upon their predecessors in Virginia and Colorado. With the CTDPA, Connecticut became the fifth state to enact a comprehensive privacy law. A number of other states have proposed new privacy laws, some of which are similar to the above discussed recently passed laws. Such proposed legislation, if enacted, may add additional complexity, variation in requirements, restrictions and potential legal risk, require additional investment of resources in compliance programs, impact strategies and the availability of previously useful data and could result in increased compliance costs and / or changes in business practices and policies. The existence of comprehensive privacy laws in different states in the country would make our compliance obligations more complex and costly and may increase the likelihood that we may be subject to enforcement actions or otherwise incur liability for noncompliance. Additionally, the federal Physician Payments Sunshine Act, or the Sunshine Act, within the ACA, and its implementing regulations, require that certain manufacturers of drugs, devices, biological and medical supplies for which payment is available under Medicare, Medicaid or the Children' s Health Insurance Program (with certain exceptions) report annually to CMS information related to certain payments or other transfers of value made or distributed to physicians and teaching hospitals, or to entities or individuals at the request of, or designated on behalf of, physicians, certain other healthcare professionals, and teaching hospitals and to report annually certain ownership and investment interests held by physicians, certain other healthcare professionals, and their immediate family members. Effective January 1, 2022, these reporting obligations extend to include transfers of value made to certain non- physician providers such as physician assistants and nurse practitioners. In addition, many states also govern the reporting of payments or other transfers of value, many of which differ from each other in significant ways, are often not pre- empted, and may have a more prohibitive effect than the Sunshine Act, thus further complicating compliance efforts. Similar federal, state and foreign fraud and abuse laws and regulations, such as state anti- kickback and false claims laws, may apply to sales or marketing arrangements and claims involving healthcare items or services. Such laws are generally broad and are enforced by various state agencies and private actions. Many U. S. states have adopted laws similar to the federal Anti- Kickback Statute and False Claims Act, and may apply to our business practices, including, but not limited to, research, distribution, sales or marketing arrangements and claims involving healthcare items or services reimbursed by non- governmental payors, including private insurers. In addition, some states have passed laws that require us to comply with the April 2003 Office of Inspector General Compliance Program Guidance for Pharmaceutical Manufacturers and / or the Pharmaceutical Research and Manufacturers of America' s Code on Interactions with Healthcare Professionals. Additionally, we are subject to state and foreign equivalents of each of the healthcare laws and regulations described above, some of which may be broader in scope and may apply regardless of payor, in addition to items and services reimbursed under Medicaid and other state programs. Some state laws require pharmaceutical companies to comply with the pharmaceutical industry' s voluntary compliance guidelines and the relevant federal government compliance guidance, and require drug manufacturers to report information related to payments and other transfers of value to physicians and other healthcare providers or marketing expenditures. Several states also impose other marketing restrictions or require pharmaceutical companies to make marketing or price disclosures to the state and require the registration of pharmaceutical sales representatives. State and foreign laws, including, for example, the European Union General Data Protection Regulation, which became effective May 2018 also govern the privacy and security of health information in some circumstances, many of which differ from each other in significant ways and often are not preempted by HIPAA, thus complicating compliance efforts. There are ambiguities as to what is required to comply with these state requirements and if we fail to comply with an applicable state law requirement we could be subject to penalties. Finally, there are state and foreign laws governing the privacy and security of health information, many of which differ from each other in significant ways and often are not preempted by HIPAA, thus complicating compliance efforts. In order to distribute products commercially, we must comply with state laws that require the registration of manufacturers and wholesale distributors of drug and biological products in a state, including, in certain states, manufacturers and distributors who ship products into the state even if such manufacturers or distributors have no place of business within the state. Several states have enacted legislation requiring pharmaceutical and biotechnology companies to establish marketing compliance programs, file periodic reports with the state, make periodic public disclosures on sales, marketing, pricing, clinical trials and other activities, and / or register their sales representatives, as well as to prohibit pharmacies and other healthcare entities from providing certain physician prescribing data to pharmaceutical and biotechnology companies for use in sales and marketing, and to prohibit certain other sales and marketing practices. We must also comply with federal government price reporting laws, which require us to calculate and report complex pricing metrics in an accurate and timely manner to government programs. All of our activities are potentially subject to federal and state consumer protection and unfair competition laws. The scope and enforcement of each of these laws is uncertain and subject to rapid change in the current

environment of healthcare reform, especially in light of the lack of applicable precedent and regulations. Federal and state enforcement bodies have recently increased their scrutiny of interactions between healthcare companies and healthcare providers, which has led to a number of investigations, prosecutions, convictions and settlements in the healthcare industry. It is possible that governmental authorities will conclude that our business practices may not comply with current or future statutes, regulations or case law involving applicable fraud and abuse or other healthcare laws and regulations. If our operations are found to be in violation of any of these laws or any other governmental regulations that may apply to us, we may be subject to significant civil, criminal and administrative penalties, damages, fines, disgorgement, contractual damages, reputational harm, diminished profits and future earnings, individual imprisonment, exclusion of drugs from government funded healthcare programs, such as Medicare and Medicaid, and the curtailment or restructuring of our operations, any of which could adversely affect our ability to operate our business and our financial results. Further, defending against any such actions can be costly and time consuming, and may require significant financial and personnel resources. Therefore, even if we are successful in defending against any such actions that may be brought against us, our business may be impaired. If any of the physicians or other healthcare providers or entities with whom we expect to do business is found to be not in compliance with applicable laws, they may be subject to criminal, civil or administrative sanctions, including exclusions from government funded healthcare programs. Ensuring business arrangements comply with applicable healthcare laws, as well as responding to possible investigations by government authorities, can be time- and resource- consuming and can divert a Company' s attention from the business. In the U. S., to help patients afford our approved product, we may utilize programs to assist them, including patient assistance programs and co- pay coupon programs for eligible patients. PAPs are regulated by and subject to guidance from CMS OIG. In addition, at least one insurer has directed its network pharmacies to no longer accept co- pay coupons for certain specialty drugs the insurer identified. Our co- pay coupon programs could become the target of similar insurer actions. In addition, in November 2013, the CMS issued guidance to the issuers of qualified health plans sold through the ACA' s marketplaces encouraging such plans to reject patient cost- sharing support from third parties and indicating that the CMS intends to monitor the provision of such support and may take regulatory action to limit it in the future. The CMS subsequently issued a rule requiring individual market qualified health plans to accept third- party premium and cost- sharing payments from certain government- related entities. In September 2014, the OIG of the HHS issued a Special Advisory Bulletin warning manufacturers that they may be subject to sanctions under the federal anti- kickback statute and / or civil monetary penalty laws if they do not take appropriate steps to exclude Part D beneficiaries from using co- pay coupons. Accordingly, companies exclude these Part D beneficiaries from using co- pay coupons. Current and Future Legislation In the United States and some foreign jurisdictions, there have been, and likely will continue to be, a number of legislative and regulatory changes and proposed changes regarding the healthcare system directed at broadening the availability of healthcare, improving the quality of healthcare, and containing or lowering the cost of healthcare. For example, in March 2010, the ACA was enacted in the United States. The ACA includes measures that have significantly changed, and are expected to continue to significantly change, the way healthcare is financed by both governmental and private insurers. Among the provisions of the ACA of greatest importance to the pharmaceutical industry are that the ACA: • made several changes to the Medicaid Drug Rebate Program, including increasing pharmaceutical manufacturers' rebate liability by raising the minimum basic Medicaid rebate on most branded prescription drugs to 23. 1 % of average manufacturer price, or AMP, and adding a new rebate calculation for " line extensions " (i. e., new formulations, such as extended release formulations) of solid oral dosage forms of branded products, as well as potentially impacting their rebate liability by modifying the statutory definition of AMP. • imposed a requirement on manufacturers of branded drugs to provide a 70 % (increased pursuant to the Bipartisan Budget Act of 2018, effective as of 2019) point- of- sale discount off the negotiated price of branded drugs dispensed to Medicare Part D beneficiaries in the coverage gap (i. e., " donut hole ") as a condition for a manufacturer' s outpatient drugs being covered under Medicare Part D. • extended a manufacturer' s Medicaid rebate liability to covered drugs dispensed to individuals who are enrolled in Medicaid managed care organizations. • expanded the entities eligible for discounts under the 340B Drug Discount Program. • established a new methodology by which rebates owed by manufacturers under the Medicaid Drug Rebate Program are calculated for drugs that are inhaled, infused, instilled, implanted, or injected. • imposed an annual, nondeductible fee on any entity that manufactures or imports certain branded prescription drugs, apportioned among these entities according to their market share in certain government healthcare programs. • established a new Patient- Centered Outcomes Research Institute to oversee, identify priorities in, and conduct comparative clinical effectiveness research, along with funding for such research. The research conducted by the Patient- Centered Outcomes Research Institute may affect the market for certain pharmaceutical products. The ACA established the Center for Medicare and Medicaid Innovation within CMS to test innovative payment and service delivery models to lower Medicare and Medicaid spending, potentially including prescription drug spending. Since its enactment, there have been numerous judicial, administrative, executive, and legislative challenges to certain aspects of the ACA. On June 17, 2021, the U. S. Supreme Court dismissed the most recent judicial challenge to the ACA brought by several states without specifically ruling on the constitutionality of the ACA. Prior to the Supreme Court' s decision, President Biden issued an executive order to initiate a special enrollment period from February 15, 2021 through August 15, 2021 for purposes of obtaining health insurance coverage through the ACA marketplace. The executive order also instructed certain governmental agencies to review and reconsider their existing policies and rules that limit access to healthcare, including among others, reexamining Medicaid demonstration projects and waiver programs that include work requirements, and policies that create unnecessary barriers to obtaining access to health insurance coverage through Medicaid or the ACA. It is unclear how other healthcare reform measures of the Biden administration or other efforts, if any, to challenge, repeal or replace the ACA will impact our business. Prior to the Biden administration, on October 13, 2017, former President Trump signed an Executive Order which terminated the cost sharing subsidies that reimburse insurers under the ACA. The former Trump administration concluded that cost- sharing reduction, or CSR, payments to insurance companies required under the ACA have not received

necessary appropriations from Congress and announced that it will discontinue these payments immediately until those appropriations are made. Several state Attorneys General filed suit to stop the administration from terminating the subsidies, but their request for a restraining order was denied by a federal judge in California on October 25, 2017. On August 14, 2020, the U. S. Court of Appeals for the Federal Circuit ruled in two separate cases that the federal government is liable for the full amount of unpaid CSRs for the years preceding and including 2017. For CSR claims made by health insurance companies for years 2018 and later, further litigation will be required to determine the amounts due, if any. Further, on June 14, 2018, the U. S. Court of Appeals for the Federal Circuit ruled that the federal government was not required to pay more than $ 12 billion in ACA risk corridor payments to third- party payors who argued the payments were owed to them. On April 27, 2020, the United States Supreme Court reversed the U. S. Court of Appeals for the Federal Circuit' s decision and remanded the case to the U. S. Court of Federal Claims, concluding the government has an obligation to pay these risk corridor payments under the relevant formula. It is unclear what impact these rulings will have on our business. In addition, CMS published a final rule that would give states greater flexibility as of 2020 in setting benchmarks for insurers in the individual and small group marketplaces, which may have the effect of relaxing the essential health benefits required under the ACA for plans sold through such marketplaces. In addition, other legislative and regulatory changes have also been proposed and adopted in the United States since the ACA was enacted: • On August 2, 2011, the U. S. Budget Control Act of 2011, among other things, included aggregate reductions of Medicare payments to providers of 2 % per fiscal year. These reductions went into effect on April 1, 2013 and, due to subsequent legislative amendments to the statute, will remain in effect through 2030. Pursuant to the Coronavirus Aid, Relief, and Economic Security Act, also known as the CARES Act, as well as subsequent legislation, this 2 % reduction was suspended from May 1, 2020 through March 31, 2022 due to the COVID- 19 pandemic. Following the suspension, a 1 % payment reduction began April 1, 2022, lasting through June 30, 2022. The 2 % payment reduction resumed on July 1, 2022. • On January 2, 2013, the U. S. American Taxpayer Relief Act of 2012 was signed into law, which, among other things, further reduced Medicare payments to several types of providers. • On April 13, 2017, CMS published a final rule that gives states greater flexibility in setting benchmarks for insurers in the individual and small group marketplaces, which may have the effect of relaxing the essential health benefits required under the ACA for plans sold through such marketplaces. • On May 30, 2018, the Right to Try Act, was signed into law. The law, among other things, provides a federal framework for certain patients to access certain investigational new drug products that have completed a Phase 1 clinical trial and that are undergoing investigation for FDA approval. Under certain circumstances, eligible patients can seek treatment without enrolling in clinical trials and without obtaining FDA permission under the FDA expanded access program. There is no obligation for a pharmaceutical manufacturer to make its drug products available to eligible patients as a result of the Right to Try Act. • On May 23, 2019, CMS published a final rule to allow Medicare Advantage Plans the option of using step therapy for Part B drugs beginning January 1, 2020. • On December 20, 2019, former President Trump signed into law the Further Consolidated Appropriations Act (H. R. 1865), which repealed the Cadillac tax, the health insurance provider tax, and the medical device excise tax. It is impossible to determine whether similar taxes could be instated in the future. • On March 11, 2021, President Biden signed the American Rescue Plan Act of 2021 into law, which eliminates the statutory Medicaid drug rebate cap, currently set at 100 % of a drug' s average manufacturer price, for single source and innovator multiple source drugs, beginning January 1, 2024. • In August 2022, the Inflation Reduction Act of 2022, or IRA was signed into law. The IRA includes several provisions that will impact our business to varying degrees, including provisions that reduce the out- of- pocket cap for Medicare Part D beneficiaries to $ 2, 000 starting in 2025; impose new manufacturer financial liability on certain drugs in Medicare Part D, allow the U. S. government to negotiate Medicare Part B and Part D price caps for certain high- cost drugs and biologics without generic or biosimilar competition, require companies to pay rebates to Medicare for certain drug prices that increase faster than inflation, and delay the rebate rule that would limit the fees that pharmacy benefit managers can charge. Further under the IRA, orphan drugs are exempted from the Medicare drug price negotiation program, but only if they have one rare disease designation and for which the only approved indication is for that disease or condition. If a product receives multiple rare disease designations or has multiple approved indications, it will not qualify for the orphan drug exemption. In addition, there have been several changes to the 340B drug pricing program, which imposes ceilings on prices that drug manufacturers can charge for medications sold to certain health care facilities. On December 27, 2018, the District Court for the District of Columbia invalidated a reimbursement formula change under the 340B drug pricing program, and CMS subsequently altered the FYs 2019 and 2018 reimbursement formula on specified covered outpatient drugs, or SCODs. The court ruled this change was not an " adjustment " which was within the Secretary' s discretion to make but was instead a fundamental change in the reimbursement calculation. However, most recently, on July 31, 2020, the U. S. Court of Appeals for the District of Columbia Circuit overturned the district court' s decision and found that the changes were within the Secretary' s authority. On September 14, 2020, the plaintiffs- appellees filed a Petition for Rehearing En Banc (i. e., before the full court), but was denied on October 16, 2020. Plaintiffs- appellees filed a petition for a writ of certiorari at the Supreme Court on February 10, 2021. On Friday July 2, 2021, the Supreme Court granted the petition. It is unclear how these developments could affect covered hospitals who might purchase our future products and affect the rates we may charge such facilities for our approved products in the future, if any. On June 15, 2022, the Supreme Court unanimously reversed the Court of Appeals' decision, holding that HHS' s 2018 and 2019 reimbursement rates for 340B hospitals were contrary to the statute and unlawful. We continue to review developments impacting the 340B program. Additionally, there has been increasing legislative and enforcement interest in the United States with respect to drug pricing practices. Specifically, there has been heightened governmental scrutiny over the manner in which manufacturers set prices for their marketed products, which has resulted in several U. S. Congressional inquiries and proposed and enacted federal and state legislation designed to, among other things, bring more transparency to drug pricing, reduce the cost of prescription drugs under Medicare, and review the relationship between pricing and manufacturer patient programs. At a federal level, President Biden signed an Executive Order on July 9, 2021 affirming the

administration' s policy to (i) support legislative reforms that would lower the prices of prescription drug and biologics, including by allowing Medicare to negotiate drug prices, by imposing inflation caps, and, by supporting the development and market entry of lower- cost generic drugs and biosimilars; and (ii) support the enactment of a public health insurance option. Among other things, the Executive Order also directs HHS to provide a report on actions to combat excessive pricing of prescription drugs, enhance the domestic drug supply chain, reduce the price that the Federal government pays for drugs, and address price gouging in the industry; and directs the FDA to work with states and Indian Tribes that propose to develop section 804 Importation Programs in accordance with the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, and the FDA' s implementing regulations. FDA released such implementing regulations on September 24, 2020, which went into effect on November 30, 2020, providing guidance for states to build and submit importation plans for drugs from Canada. On September 25, 2020, CMS stated drugs imported by states under this rule will not be eligible for federal rebates under Section 1927 of the Social Security Act and manufacturers would not report these drugs for " best price " or Average Manufacturer Price purposes. Since these drugs are not considered covered outpatient drugs, CMS further stated it will not publish a National Average Drug Acquisition Cost for these drugs. If implemented, importation of drugs from Canada may materially and adversely affect the price we receive for any of our product candidates. Further, on November 20, 2020 CMS issued an Interim Final Rule implementing the Most Favored Nation, or MFN, Model under which Medicare Part B reimbursement rates would have been be calculated for certain drugs and biologicals based on the lowest price drug manufacturers receive in Organization for Economic Cooperation and Development countries with a similar gross domestic product per capita. However, on December 29, 2021 rescinded the Most Favored Nations rule. Additionally, on December 2, 2020, HHS published a regulation removing safe harbor protection for price reductions from pharmaceutical manufacturers to plan sponsors under Part D, either directly or through pharmacy benefit managers, unless the price reduction is required by law. The rule also creates a new safe harbor for price reductions reflected at the point- of- sale, as well as a safe harbor for certain fixed fee arrangements between pharmacy benefit managers and manufacturers. Pursuant to court order, the removal and addition of the aforementioned safe harbors were delayed and recent legislation imposed a moratorium on implementation of the rule until January 1, 2026. This deadline was delayed to January 1, 2027 by the Bipartisan Safer Communities Act. The Inflation Reduction Act of 2022 further delayed implementation of this rule to January 1, 2032. Further, on December 31, 2020, CMS published a new rule, effective January 1, 2023, requiring manufacturers to ensure the full value of co- pay assistance is passed on to the patient or these dollars will count toward the Average Manufacturer Price and Best Price calculation of the drug. On May 21, 2021, PhRMA sued the HHS in the U. S. District Court for the District of Columbia, to stop the implementation of the rule claiming that the rule contradicts federal law surrounding Medicaid rebates. On May 17, 2022, the U. S. District Court for the District of Columbia granted PhRMA' s motion for summary judgement invalidating the Medicaid Accumulator Rule. We cannot predict how the implementation of and any further changes to this rule will affect our business. Although a number of these and other proposed measures may require authorization through additional legislation to become effective, and the Biden administration may reverse or otherwise change these measures, both the Biden administration and Congress have indicated that they will continue to seek new legislative measures to control drug costs. We expect that additional U. S. federal healthcare reform measures will be adopted in the future, any of which could limit the amounts that the U. S. Federal Government will pay for healthcare drugs and services, which could result in reduced demand for our drug candidates or additional pricing pressures. Individual states in the United States have also become increasingly active in passing legislation and implementing regulations designed to control pharmaceutical and biological product pricing, including price or patient reimbursement constraints, discounts, restrictions on certain drug access and marketing cost disclosure and transparency measures, and designed to encourage importation from other countries and bulk purchasing. Legally mandated price controls on payment amounts by third- party payors or other restrictions could harm our business, financial condition, results of operations and prospects. In addition, regional healthcare authorities and individual hospitals are increasingly using bidding procedures to determine what pharmaceutical products and which suppliers will be included in their prescription drug and other healthcare programs. This could reduce the ultimate demand for our drugs or put pressure on our drug pricing, which could negatively affect our business, financial condition, results of operations and prospects. We cannot predict what healthcare reform initiatives may be adopted in the future. Further federal, state and foreign legislative and regulatory developments are likely, and we expect ongoing initiatives to increase pressure on drug pricing. Such reforms could have an adverse effect on anticipated revenues from product candidates and may affect our overall financial condition and ability to develop product candidates. Packaging and Distribution in the United States If our products, once approved, are made available to authorized users of the Federal Supply Schedule of the General Services Administration, additional laws and requirements apply. Products must meet applicable child- resistant packaging requirements under the U. S. Poison Prevention Packaging Act. Manufacturing, sales, promotion and other activities also are potentially subject to federal and state consumer protection and unfair competition laws. The distribution of pharmaceutical products is subject to additional requirements and regulations, including extensive record- keeping, licensing, storage and security requirements intended to prevent the unauthorized sale of pharmaceutical products. The failure to comply with any of these laws or regulatory requirements subjects firms to possible legal or regulatory action. Depending on the circumstances, failure to meet applicable regulatory requirements can result in criminal prosecution, fines or other penalties, injunctions, exclusion from federal healthcare programs, requests for recall, seizure of products, total or partial suspension of production, denial or withdrawal of product approvals, or refusal to allow a firm to enter into supply contracts, including government contracts. Any action against us for violation of these laws, even if we successfully defend against it, could cause us to incur significant legal expenses and divert our management' s attention from the operation of our business. Prohibitions or restrictions on sales or withdrawal of future products marketed by us could materially affect our business in an adverse way. Changes in regulations, statutes or the interpretation of existing regulations could impact our business in the future by requiring, for example: (i) changes to our manufacturing arrangements; (ii) additions or modifications to product labeling; (iii) the recall or

discontinuation of our potential products; or (iv) additional record- keeping requirements. If any such changes were to be imposed, they could adversely affect the operation of our business. Other U. S. Environmental, Health and Safety Laws and Regulations We may be subject to numerous environmental, health and safety laws and regulations, including those governing laboratory procedures and the handling, use, storage, treatment and disposal of hazardous materials and wastes. From time to time and in the future, our operations may involve the use of hazardous and flammable materials, including chemicals and biological materials, and may also produce hazardous waste products. Even if we contract with third parties for the disposal of these materials and waste products, we cannot completely eliminate the risk of contamination or injury resulting from these materials. In the event of contamination or injury resulting from the use or disposal of our hazardous materials, we could be held liable for any resulting damages, and any liability could exceed our resources. We also could incur significant costs associated with civil or criminal fines and penalties for failure to comply with such laws and regulations. We maintain workers' compensation insurance to cover us for costs and expenses we may incur due to injuries to our employees, but this insurance may not provide adequate coverage against potential liabilities. However, we do not maintain insurance for environmental liability or toxic tort claims that may be asserted against us. In addition, we may incur substantial costs in order to comply with current or future environmental, health and safety laws and regulations. Current or future environmental laws and regulations may impair our research, development or production efforts. In addition, failure to comply with these laws and regulations may result in substantial fines, penalties or other sanctions. U. S. Patent Term Extension and Marketing Exclusivity Depending upon the timing, duration and specifics of FDA approval of a drug or biologic, some U. S. patents may be eligible for limited patent term extension under the Drug Price Competition and Patent Term Restoration Act of 1984, commonly referred to as the Hatch- Waxman Act. The Hatch- Waxman Act permits extension of a patent term of up to five years beyond the normal expiration date of the patent as compensation for patent term lost during the FDA regulatory review process. Patent term extension, however, cannot extend the remaining term of a patent beyond a total of 14 years from the product' s approval date and only those claims covering such approved drug product, a method for using it or a method for manufacturing it may be extended. Only one patent applicable to an approved drug is eligible for the extension and the application for the extension must be submitted prior to the expiration of the patent. The USPTO, in consultation with the FDA, reviews and approves the application for any patent term extension. An NDA or BLA applicant may apply for extension of patent term for its currently owned or licensed patents to add patent life beyond its current expiration date, depending on the expected length of the clinical trials and other factors involved in the filing of the relevant NDA or BLA. Marketing exclusivity provisions under the FDCA also can delay the submission or the approval of certain applications. The FDCA provides a five- year period of non- patent marketing exclusivity within the United States to the first applicant to gain approval of an NDA for a new chemical entity. A drug is a new chemical entity if the FDA has not previously approved any other new drug containing the same active moiety, which is the molecule or ion responsible for the action of the drug substance. During the exclusivity period, the FDA may not accept for review an ANDA, or a 505 (b) (2) NDA submitted by another Company for another version of such drug where the applicant does not own or have a legal right of reference to all the data required for approval. However, an application may be submitted after four years if it contains a certification of patent invalidity or non- infringement. The FDCA also provides three years of marketing exclusivity for an NDA, 505 (b) (2) NDA or supplement to an existing NDA if new clinical investigations, other than bioavailability studies, that were conducted or sponsored by the applicant are deemed by the FDA to be essential to the approval of the application, for example, new indications, dosages or strengths of an existing drug. This three- year exclusivity covers only the conditions of use associated with the new clinical investigations and does not prohibit the FDA from approving ANDAs for drugs containing the original active agent. Five- year and three- year exclusivity will not delay the submission or approval of a full NDA. However, an applicant submitting a full NDA would be required to conduct or obtain a right of reference to all of the preclinical studies and adequate and well- controlled clinical trials necessary to demonstrate safety and effectiveness. European Union Drug Development In the European Union or EU, our future products also may be subject to extensive regulatory requirements. As in the United States, medicinal products can be marketed only if a marketing authorization from the competent regulatory agencies has been obtained. Similar to the United States, the various phases of preclinical and clinical research in the European Union are subject to significant regulatory controls. In April 2014, the EU adopted the new Clinical Trials Regulation (EU) No 536 / 2014, or EU Clinical Trials Regulation, which replaced the Clinical Trials Directive 2001 / 20 / EC, or Directive, on January 31, 2022. The transitory provisions of the new EU Clinical Trials Regulation provided that, by January 31, 2025, all ongoing clinical trials must have transitioned to the new EU Clinical Trials Regulation. The new EU Clinical Trials Regulation overhauled the previous system of approvals for clinical trials in the EU. Specifically, the new EU Clinical Trials Regulation, which is directly applicable in all Member States (meaning no national implementing legislation in each EU Member State is required), aims at simplifying and streamlining the approval of clinical trials in the EU. For instance, it provides for a streamlined application procedure via a single entry point (through the Clinical Trials Information Systems) and strictly defined deadlines for the assessment of clinical trial applications. European Union Drug Review and Approval In the EU, medicinal products can only be commercialized after obtaining a marketing authorization, or MA. There are two types of marketing authorizations. • The centralized MA is issued by the European Commission through the centralized procedure, based on the opinion of the Committee for Medicinal Products for Human Use, or CHMP, of the EMA, and is valid throughout the entire territory of the EU, and in the additional Member States of the European Economic Area (Iceland, Liechtenstein and Norway). The centralized procedure is mandatory for certain types of products, including medicines produced by biotechnological processes, products designated as orphan medicinal products, advanced- therapy medicinal products (gene- therapy, somatic cell- therapy or tissue- engineered medicines) and medicinal products containing a new active substance indicated for the treatment of HIV, AIDS, cancer, neurodegenerative disorders, diabetes, auto- immune and other immune dysfunctions and viral diseases. The centralized procedure is optional for products containing a new active substance not yet authorized in the EU, or for products that constitute a significant therapeutic, scientific or technical innovation or which are in the interest of public health in the EU. • Under the

centralized procedure, the EMA' s Committee for Medicinal Products for Human use, or CHMP, is responsible for conducting the initial assessment of a product and for several post- authorization and maintenance activities, such as the assessment of modifications or extensions to an existing MA. Under the centralized procedure in the EU, the maximum timeframe for the evaluation of a marketing authorization application, or MAA, by the EMA is 210 days, excluding clock stops, when additional written or oral information is to be provided by the applicant in response to questions asked by the CHMP. Clock stops may extend the timeframe of evaluation of an MAA considerably beyond 210 days. Where the CHMP gives a positive opinion, it provides the opinion together with supporting documentation to the European Commission, who makes the final decision to grant an MA, which is issued within 67 days of receipt of the EMA' s recommendation. Accelerated assessment might be granted by the CHMP in exceptional cases, when a medicinal product is expected to be of major public health interest, particularly from the point of view of therapeutic innovation. If the CHMP accepts such request, the time limit of 210 days will be reduced to 150 days, excluding clock stops, but it is possible that the CHMP may revert to the standard time limit for the centralized procedure if it determines that the application is no longer appropriate to conduct an accelerated assessment. • National MAs, which are issued by the competent authorities of the Member States of the EU and only cover their respective territory, are available for products not falling within the mandatory scope of the centralized procedure. Where a product has already been authorized for marketing in a Member State of the EU, this national MA can be recognized in another Member State through the mutual recognition procedure. If the product has not received a national MA in any Member State at the time of application, it can be approved simultaneously in various Member States through the decentralized procedure. Under the decentralized procedure an identical dossier is submitted to the competent authorities of each of the Member States in which the MA is sought, one of which is selected by the applicant as the Reference Member State, or RMS. The competent authority of the RMS prepares a draft assessment report, a draft summary of the product characteristics, or SmPC, and a draft of the labeling and package leaflet, which are sent to the other Member States (referred to as the Concerned Member States) for their approval. If the Concerned Member States raise no objections, based on a potential serious risk to public health, to the assessment, SmPC, labeling, or packaging proposed by the RMS, the product is subsequently granted a national MA in all the Member States (i. e., in the RMS and the Concerned Member States). Under the above described procedures, before granting the MA, the EMA or the competent authorities of the Member States of the EU make an assessment of the risk- benefit balance of the product on the basis of scientific criteria concerning its quality, safety and efficacy. Now that the United Kingdom (which comprises Great Britain and Northern Ireland) has left the European Union, Great Britain is no longer covered by centralized MAs (under the Northern Ireland Protocol, centralized MAs continue to be recognized in Northern Ireland). All medicinal products with a current centralized MA were automatically converted to Great Britain MAs on January, 1 2021. For a period of three years from January 1, 2021, the Medicines and Healthcare products Regulatory Agency, or MHRA, the UK medicines regulator, may rely on a decision taken by the European Commission on the approval of a new MA in the centralized procedure, in order to more quickly grant a new Great Britain MA. A separate application will, however, still be required. On January 24, 2023, the MHRA announced that a new international recognition framework will be put in place from January 1, 2024, which will have regard to decisions on the approval of MAs made by the European Medicines Agency and certain other regulators. The MHRA also has the power to have regard to MAs approved in EU Member States through decentralized or mutual recognition procedures with a view to more quickly granting an MA in the United Kingdom or Great Britain. European Union New Chemical Entity Exclusivity In the EU, innovative medicinal products approved on the basis of a complete and independent data package qualify for eight years of data exclusivity upon marketing authorization and an additional two years of market exclusivity. The data exclusivity, if granted, prevents generic or biosimilar applicants from referencing the innovator' s preclinical and clinical trial data contained in the dossier of the reference product when applying for a generic or biosimilar MA in the EU, during a period of eight years from the date on which the reference product was first authorized in the EU. During the additional two- year period of market exclusivity, a generic or biosimilar MAA can be submitted, and the innovator' s data may be referenced, but no generic or biosimilar product can be placed on the EU market until the expiration of the market exclusivity. The overall ten- year period will be extended to a maximum of 11 years if, during the first eight years of those ten years, the marketing authorization holder obtains an authorization for one or more new therapeutic indications which, during the scientific evaluation prior to their authorization, are determined to bring a significant clinical benefit in comparison with currently approved therapies. There is no guarantee that a product will be considered by the EMA to be an innovative medicinal product, and products may not qualify for data exclusivity. Even if a product is considered to be an innovative medicinal product so that the innovator gains the prescribed period of data exclusivity, however, another Company could nevertheless also market another version of the product if such Company obtained an MA based on an MAA with a complete and independent data package of pharmaceutical tests, preclinical tests and clinical trials. European Union Orphan Designation and Exclusivity In the EU, the EMA' s Committee for Orphan Medicinal Products grants an orphan designation in respect of a product if its sponsor can establish that: (1) the product is intended for the diagnosis, prevention or treatment of a life- threatening or chronically debilitating condition; (2) either (i) such condition affects no more than five in 10, 000 persons in the EU when the application is made, or (ii) it is unlikely that the product, without the benefits derived from orphan status, would generate sufficient return in the EU to justify the necessary investment in its development; and (3) there must be no satisfactory method of diagnosis, prevention or treatment of such condition authorized for marketing in the EU, or, if such a method exists, the product would be of significant benefit to those affected by that condition. In the EU, orphan designation entitles a party to financial incentives such as reduction of fees or fee waivers and ten years of market exclusivity is granted following grant of a marketing authorization. During this market exclusivity period, neither the EMA nor the European Commission nor any of the competent authorities in the EU Members States can accept an application or grant a marketing authorization for a " similar medicinal product. " A " similar medicinal product " is defined as a medicinal product containing a similar active substance or substances as contained in an authorized orphan medicinal product, and which is intended for the same therapeutic indication. This period

may be reduced to six years if the orphan designation criteria are no longer met, including where it is shown that the product is sufficiently profitable not to justify maintenance of market exclusivity. Market exclusivity may also be revoked in very select cases, such as if (i) it is established that a similar medicinal product is safer, more effective or otherwise clinically superior to the authorized product; (ii) the marketing authorization holder consents to such revocation; or (iii) the marketing authorization holder cannot supply enough orphan medicinal product. Orphan designation must be requested before submitting an application for marketing approval. Orphan designation does not convey any advantage in, or shorten the duration of, the regulatory review and approval process. Since January 1, 2021, a separate process for orphan designation has applied in Great Britain. There is now no pre- marketing authorization orphan designation (as there is in the EU) in Great Britain and the application for orphan designation will be reviewed by the MHRA at the time of an MAA for a UK or Great Britain MA. The criteria for orphan designation are the same as in the EU, save that they apply to Great Britain only (e. g., there must be no satisfactory method of diagnosis, prevention or treatment of the condition concerned in Great Britain, as opposed to the EU). European Pediatric Investigation Plan In the EU, MAAs for new medicinal products have to include the results of studies conducted in the pediatric population, in compliance with a pediatric investigation plan, or PIP, agreed with the EMA' s Pediatric Committee, or PDCO, unless the EMA has granted a product- specific waiver, a class waiver, or a deferral for one or more of the measures included in the PIP. This requirement also applies when a Company wants to add a new indication, pharmaceutical form or route of administration for a medicine that is already authorized. The PIP sets out the timing and measures proposed to generate data to support a pediatric indication of the drug for which marketing authorization is being sought. The PDCO can grant a deferral of the obligation to implement some or all of the measures of the PIP until there are sufficient data to demonstrate the efficacy and safety of the product in adults. Further, the obligation to provide pediatric clinical trial data can be waived by the PDCO when this data is not needed or appropriate because the product is likely to be ineffective or unsafe in children, the disease or condition for which the product is intended occurs only in adult populations, or when the product does not represent a significant therapeutic benefit over existing treatments for pediatric patients. If an MA is obtained and trial results are included in the product information, even when negative, the product is eligible for six- months' supplementary protection certificate extension. In the case of orphan medicinal products, a two- year extension of the orphan market exclusivity may be available. This pediatric reward is subject to specific conditions and is not automatically available when data in compliance with the PIP are developed and submitted. Regulatory Requirements After a Marketing Authorization has been Obtained If authorization for a medicinal product in the EU is obtained, the holder of the MA is required to comply with a range of requirements applicable to the manufacturing, marketing, promotion, and sale of medicinal products. These include: • Compliance with the EU' s stringent pharmacovigilance or safety reporting rules must be ensured. These rules can impose post- authorization studies and additional monitoring obligations. • The manufacturing of authorized medicinal products, for which a separate manufacturer' s license is mandatory, must also be conducted in strict compliance with the applicable EU laws, regulations and guidance, including Directive 2001 / 83 / EC, Directive 2003 / 94 / EC, Regulation (EC) No 726 / 2004 and the European Commission Guidelines for Good Manufacturing Practice. These requirements include compliance with EU cGMP standards when manufacturing medicinal products and active pharmaceutical ingredients, including the manufacture of active pharmaceutical ingredients outside of the EU with the intention to import the active pharmaceutical ingredients into the EU. • Much like the Anti- Kickback Statue prohibition in the United States, the provision of benefits or advantages to physicians to induce or encourage the prescription, recommendation, endorsement, purchase, supply, order or use of medicinal products is also prohibited in the European Union. The provision of benefits or advantages to induce or reward improper performance generally is governed by the national anti- bribery laws of the European Union Member States, and the Bribery Act 2010 in the UK. Infringement of these laws could result in substantial fines and imprisonment. EU Directive 2001 / 83 / EC, which is the EU Directive governing medicinal products for human use, further provides that, where medicinal products are being promoted to persons qualified to prescribe or supply them, no gifts, pecuniary advantages or benefits in kind may be supplied, offered or promised to such persons unless they are inexpensive and relevant to the practice of medicine or pharmacy. This provision has been transposed into the Human Medicines Regulations 2012 and so remains applicable in the UK despite its departure from the EU. Payments made to physicians in certain EU Member States must be publicly disclosed. Moreover, agreements with physicians often must be the subject of prior notification and approval by the physician' s employer, his or her competent professional organization and / or the regulatory authorities of the individual EU Member States. These requirements are provided in the national laws, industry codes or professional codes of conduct, applicable in the EU Member States. Failure to comply with these requirements could result in reputational risk, public reprimands, administrative penalties, fines or imprisonment. The aforementioned EU rules are generally applicable in the European Economic Area, or EEA, which consists of the EU Member States, plus Norway, Liechtenstein, and Iceland. Brexit and the Regulatory Framework in the United Kingdom The UK formally left the EU on January 31, 2020, and the EU and the UK have concluded a trade and cooperation agreement, or TCA, which was provisionally applicable since January 1, 2021 and has been formally applicable since May 1, 2021. The TCA includes specific provisions concerning pharmaceuticals, which include the mutual recognition of GMP, inspections of manufacturing facilities for medicinal products and GMP documents issued, but does not foresee wholesale mutual recognition of UK and EU pharmaceutical regulations. At present, Great Britain has implemented EU legislation on the marketing, promotion and sale of medicinal products through the Human Medicines Regulations 2012 (as amended) (under the Northern Ireland Protocol, the EU regulatory framework will continue to apply in Northern Ireland). Except in respect of the new EU Clinical Trials Regulation, the regulatory regime in Great Britain therefore in many ways aligns with current EU medicines regulations, however it is possible that these regimes will diverge more significantly in the future now that Great Britain' s regulatory system is independent from the EU and the TCA does not provide for mutual recognition of UK and EU pharmaceutical legislation. European Data Collection The collection and use of personal health data in the EEA is governed by the General Data Protection Regulation, or GDPR or EU GDPR, which became effective May 25, 2018. The GDPR applies to any Company established in

the EEA and to companies established outside the EEA that process personal data in connection with the offering of goods or services to data subjects in the EEA or the monitoring of the behavior of data subjects in the EEA. The GDPR enhances data protection obligations for data controllers of personal data, including stringent requirements relating to the consent of data subjects, expanded disclosures about how personal data is used, requirements to conduct privacy impact assessments for " high risk " processing, limitations on retention of personal data, mandatory data breach notification and " privacy by design " requirements, and creates direct obligations on service providers acting as data processors. The GDPR also imposes strict rules on the transfer of personal data outside of the EEA to countries that do not ensure an adequate level of protection, like the United States. Failure to comply with the requirements of the GDPR and the related national data protection laws of the EEA Member States may result in fines up to € 20 million or 4 % of a company' s global annual revenues for the preceding financial year, whichever is higher. Moreover, the GDPR grants data subjects the right to claim material and non- material damages resulting from infringement of the GDPR. Given the breadth and depth of changes in data protection obligations, maintaining compliance with the GDPR, will require significant time, resources and expense, and we may be required to put in place additional mechanisms ensuring compliance with the new data protection rules. This may be onerous and adversely affect our business, financial condition, results of operations and prospects. In addition, further to the United Kingdom' s exit from the European Union on January 31, 2020, the GDPR ceased to apply in the United Kingdom at the end of the transition period on December 31, 2020. However, as of January 1, 2021, the United Kingdom' s European Union (Withdrawal) Act 2018 incorporated the GDPR (as it existed on December 31, 2020 but subject to certain UK specific amendments) into UK law, referred to as the UK GDPR. The UK GDPR and the UK Data Protection Act 2018 set out the United Kingdom' s data protection regime, which is independent from but aligned to the European Union' s data protection regime. The UK Government has announced plans to reform its data protection legal framework in the Data Reform Bill, but those have been put on hold. Non- compliance with the UK GDPR may result in monetary penalties of up to £ 17. 5 million or 4 % of worldwide revenue, whichever is higher. The UK GDPR includes restrictions on cross- border data transfers. Adequate safeguards must be implemented to enable the transfer of personal data outside of the EU or the U. K., in particular to the U. S., in compliance with EU and UK data protection laws. On June 4, 2021, the European Commission, or EC, issued new forms of standard contractual clauses for data transfers from controllers or processors in the EEA (or otherwise subject to the EU' s GDPR) to controllers or processors established outside the EEA (and not subject to the EU GDPR). The new standard contractual clauses replace the standard contractual clauses that were adopted previously under the Data Protection Directive. The UK is not subject to the EC' s new standard contractual clauses but has published its own version of standard clauses, referred to as " International Data Transfer Agreement " which entered into force on March 21, 2022 and enables transfers originating from the UK. Transfers made pursuant to these new mechanisms need to be assessed on a case- by- case basis to ensure the law in the recipient country provides " essentially equivalent " protections to safeguard the transferred personal data as the EEA, and businesses are required to adopt supplementary measures if such standard is not met. We will be required to implement these new safeguards when conducting restricted data transfers under the UK GDPR and doing so will require significant effort and cost. Although the UK is regarded as a third country under the European Union' s GDPR, the European Commission has now issued a decision recognizing the UK as providing adequate protection under the EU GDPR and, therefore, transfers of personal data originating in the EU to the UK remain unrestricted. Like the EU GDPR, the UK GDPR restricts personal data transfers outside the United Kingdom to countries not regarded by the United Kingdom as providing adequate protection. The UK government has confirmed that personal data transfers from the United Kingdom to the EEA remain free flowing. Rest of the World Regulation For other countries outside of the European Union and the United States, such as countries in Eastern Europe, Latin America or Asia, the requirements governing the conduct of clinical trials, product licensing, pricing and reimbursement vary from country to country. Additionally, the clinical trials must be conducted in accordance with GCP requirements and the applicable regulatory requirements and the ethical principles that have their origin in the Declaration of Helsinki. If we fail to comply with applicable foreign regulatory requirements, we may be subject to, among other things, fines, suspension or withdrawal of regulatory approvals, product recalls, seizure of products, operating restrictions and criminal prosecution. Additional Laws and Regulations Governing International Operations If we further expand our operations outside of the United States, we must dedicate additional resources to comply with numerous laws and regulations in each jurisdiction in which we plan to operate. The Foreign Corrupt Practices Act, or FCPA, prohibits any U. S. individual or business from paying, offering, authorizing payment or offering of anything of value, directly or indirectly, to any foreign official, political party or candidate for the purpose of influencing any act or decision of the foreign entity in order to assist the individual or business in obtaining or retaining business. The FCPA also obligates companies whose securities are listed in the United States to comply with certain accounting provisions requiring the company to maintain books and records that accurately and fairly reflect all transactions of the corporation, including international subsidiaries, and to devise and maintain an adequate system of internal accounting controls for international operations. Compliance with the FCPA is expensive and difficult, particularly in countries in which corruption is a recognized problem. In addition, the FCPA presents particular challenges in the pharmaceutical industry, because, in many countries, hospitals are operated by the government, and doctors and other hospital employees are considered foreign officials. Certain payments to hospitals in connection with clinical trials and other work have been deemed to be improper payments to government officials and have led to FCPA enforcement actions. Various laws, regulations and executive orders also restrict the use and dissemination outside of the United States, or the sharing with certain non- U. S. nationals, of information classified for national security purposes, as well as certain products and technical data relating to those products. If we expand our presence outside of the United States, it will require us to dedicate additional resources to comply with these laws, and these laws may preclude us from developing, manufacturing, or selling certain product candidates outside of the United States, which could limit our growth potential and increase our development costs. The failure to comply with laws governing international business practices may result in substantial civil and criminal penalties and suspension or debarment

from government contracting. The U. S. Securities and Exchange Commission, or the SEC, also may suspend or bar issuers from trading securities on U. S. exchanges for violations of the FCPA' s accounting provisions. Coverage and Reimbursement Successful commercialization of new drug products depends in part on the extent to which reimbursement for those drug products will be available from government health administration authorities, private health insurers, and other organizations. In the United States and markets in other countries, patients generally rely on third- party payors to reimburse all or part of the costs associated with their treatment. Adequate coverage and reimbursement from governmental healthcare programs, such as Medicare and Medicaid, and commercial payors is critical to new product acceptance. Our ability to successfully commercialize our product candidates will depend in part on the extent to which coverage and adequate reimbursement for these products and related treatments will be available from government health administration authorities, private health insurers and other organizations. Even if coverage is provided, the approved reimbursement amount may not be high enough to allow us to establish or maintain pricing sufficient to realize a sufficient return on our investment. Government authorities and third- party payors, such as private health insurers and health maintenance organizations, decide which medications they will pay for and establish reimbursement levels. Government authorities and third- party payors, such as private health insurers and health maintenance organizations, decide which drug products they will pay for and establish reimbursement levels. The availability and extent of reimbursement by governmental and private payors is essential for most patients to be able to afford a drug product. Sales of drug products depend substantially, both domestically and abroad, on the extent to which the costs of drugs products are paid for by health maintenance, managed care, pharmacy benefit and similar healthcare management organizations, or reimbursed by government health administration authorities, private health coverage insurers and other third- party payors. A primary trend in the U. S. healthcare industry and elsewhere is cost containment. Government authorities and third- party payors have attempted to control costs by limiting coverage and the amount of reimbursement for particular drug products. In many countries, the prices of drug products are subject to varying price control mechanisms as part of national health systems. In general, the prices of drug products under such systems are substantially lower than in the United States. Other countries allow companies to fix their own prices for drug products, but monitor and control company profits. Accordingly, in markets outside the United States, the reimbursement for drug products may be reduced compared with the United States. There is also significant uncertainty related to the insurance coverage and reimbursement of newly approved products and coverage may be more limited than the purposes for which the medicine is approved by the FDA or comparable foreign regulatory authorities. In the United States, the principal decisions about reimbursement for new drug products are typically made by CMS, an agency within the HHS. CMS decides whether and to what extent a new drug product will be covered and reimbursed under Medicare, and private payors tend to follow CMS to a substantial degree. However, no uniform policy of coverage and reimbursement for drug products exists among third- party payors and coverage and reimbursement levels for drug products can differ significantly from payor to payor. Factors payors consider in determining reimbursement are based on whether the product is: • a covered benefit under its health plan; • safe, effective and medically necessary; • appropriate for the specific patient; • cost- effective; and • neither experimental nor investigational. Third- party payors may limit coverage to specific products on an approved list or formulary, which might not include all of the FDA- approved products for a particular indication. Also, third- party payors may refuse to include a particular branded drug on their formularies or otherwise restrict patient access to a branded drug when a less costly generic equivalent or another alternative is available. Net prices for drugs may be reduced by mandatory discounts or rebates required by government healthcare programs or private payors and by any future relaxation of laws that presently restrict imports of drugs from countries where they may be sold at lower prices than in the United States. Third- party payors are increasingly challenging the prices charged for medical products and services, examining the medical necessity, and reviewing the cost- effectiveness of medical products and services and imposing controls to manage costs. We cannot be sure that reimbursement will be available for any product candidate that we commercialize and, if reimbursement is available, the level of reimbursement. In addition, many pharmaceutical manufacturers must calculate and report certain price reporting metrics to the government, such as average sales price, or ASP, and best price. Penalties may apply in some cases when such metrics are not submitted accurately and timely. Further, these prices for drugs may be reduced by mandatory discounts or rebates required by government healthcare programs. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, or the MMA, established the Medicare Part D program to provide a voluntary prescription drug benefit to Medicare beneficiaries. Under Part D, Medicare beneficiaries may enroll in prescription drug plans offered by private entities that provide coverage of outpatient prescription drugs. Unlike Medicare Parts A and B, Part D coverage is not standardized. Part D prescription drug plan sponsors are not required to pay for all covered Part D drugs, and each drug plan can develop its own drug formulary that identifies which drugs it will cover and at what tier or level. While all Medicare drug plans must give at least a standard level of coverage set by Medicare, Part D prescription drug plan sponsors are not required to pay for all covered Part D drugs, and each drug plan can develop its own drug formulary that identifies which drugs it will cover and at what tier or level. However, Part D prescription drug formularies must include drugs within each therapeutic category and class of covered Part D drugs, though not necessarily all the drugs in each category or class. Any formulary used by a Part D prescription drug plan must be developed and reviewed by a pharmacy and therapeutic committee. Government payment for some of the costs of prescription drugs may increase demand for drugs for which we obtain marketing approval. Any negotiated prices for any of our future products covered by a Part D prescription drug plan will likely be lower than the prices we might otherwise obtain. Moreover, while the MMA applies only to drug benefits for Medicare beneficiaries, private payors often follow Medicare coverage policy and payment limitations in setting their own payment rates. Any reduction in payment that results from the MMA may result in a similar reduction in payments from non- governmental payors. For a drug product to receive federal reimbursement under the Medicaid or Medicare Part B programs or to be sold directly to U. S. government agencies, the manufacturer must extend discounts to entities eligible to participate in the 340B drug pricing program. The required 340B discount on a given product is calculated based on the average manufacturer price, or AMP, and Medicaid rebate amounts reported by the manufacturer. As of

2010, the ACA expanded the types of entities eligible to receive discounted 340B pricing, although under the current state of the law these newly eligible entities (with the exception of children' s hospitals) will not be eligible to receive discounted 340B pricing on orphan drugs. As 340B drug pricing is determined based on AMP and Medicaid rebate data, the revisions to the Medicaid rebate formula and AMP definition described above could cause the required 340B discount to increase. The American Recovery and Reinvestment Act of 2009 provides funding for the federal government to compare the effectiveness of different treatments for the same illness. The plan for the research was published in 2012 by the Department of HHS, the Agency for Healthcare Research and Quality and the National Institutes for Health, and periodic reports on the status of the research and related expenditures are made to Congress. Although the results of the comparative effectiveness studies are not intended to mandate coverage policies for public or private payors, it is not clear what effect, if any, the research will have on the sales of our drug candidates, if any such drug or the condition that they are intended to treat are the subject of a trial. It is also possible that comparative effectiveness research demonstrating benefits in a competitor' s drug could adversely affect the sales of our drug candidate. If third- party payors do not consider our drugs to be cost- effective compared to other available therapies, they may not cover our drugs after approval as a benefit under their plans or, if they do, the level of payment may not be sufficient to allow us to sell our drugs on a profitable basis. These laws, and future state and federal healthcare reform measures may be adopted in the future, any of which may result in additional reductions in Medicare and other healthcare funding and otherwise affect the prices we may obtain for any product candidates for which we may obtain regulatory approval or the frequency with which any such product candidate is prescribed or used. Outside of the United States, the pricing of pharmaceutical products and medical devices is subject to governmental control in many countries. For example, in the European Union, pricing and reimbursement schemes vary widely from country to country. Some Member States provide that products may be marketed only after the proposed pricing has been approved. Some Member States may require the completion of additional studies that compare the cost effectiveness of a particular therapy to currently available therapies or so- called health technology assessments, in order to obtain reimbursement or pricing approval. A Member State may approve a specific price for the medicinal product or it may instead adopt a system of direct or indirect controls on the profitability of the company placing the medicinal product on the market. Member States may allow companies to fix their own prices for products, but monitor and control product volumes and issue guidance to physicians to limit prescriptions. Efforts to control prices and utilization of pharmaceutical products and medical devices will likely continue as countries attempt to manage healthcare expenditures. There can be no assurance that any country that has price controls or reimbursement limitations for pharmaceutical products will allow favorable reimbursement and pricing arrangements for any of our product candidates. Historically, products launched in the European Union do not follow price structures of the U. S. and generally prices tend to be significantly lower. Human Capital Management Our human capital philosophy relies on attracting and retaining team members who consistently demonstrate top performance. Our culture and our approach to talent reinforces this philosophy, including recruiting, professional development, performance management and total rewards. We have provided below additional details on some of our core human resources processes. As of December 31, 2022, we had 392 full- time employees and four part- time employees. Of these, 297 focus on driving forward research and development programs, either directly or through our affiliates, and 99 work across our affiliates to provide strategic business development, finance and executive leadership expertise, as well as general and administrative services generally across our affiliates. We have never had a work stoppage, and none of our employees is represented by a labor organization or under any collective- bargaining arrangements. We consider our employee relations to be good. Recruiting In 2020, we established a talent acquisition capability to support our affiliates in hiring the right talent at the right time. Our team of experienced talent acquisition professionals works closely with hiring managers to understand the required skills and capabilities for an open role, and then supports the interview process and evaluation of candidates. We strive to hire top talent, and therefore need a high- quality recruiting process and candidate experience. We endeavor to fill every role with the most qualified candidate possible, which sometimes requires partnership with an external recruitment agency. We are consistently looking at new opportunities and avenues to recruit talented individuals to work at BridgeBio. The talent acquisition team' s focus in 2023 is to meet the hiring needs across BridgeBio and our affiliates. We recognize that our current and potential future team members have options for employment opportunities, including with other biotech and pharma companies, research and academic institutions, government entities, and consulting and investment firms. To attract and retain top performing team members, we focus on creating an environment that allows for autonomy, professional growth and impact while also offering a competitive total rewards package. Professional Development and Performance Management We invest in the professional development of our team members through regular feedback and guidance, as well as targeted learning and development opportunities to meet demonstrated needs. We established a set of five core attributes that we expect every BridgeBio team member to demonstrate while performing in their roles: Patient Champion, Entrepreneurial Operator, Truth Seeker, Inspires Excellence and High- Quality Executor. BridgeBio conducts semi- annual performance review processes for all team members to evaluate performance and provide feedback against these attributes. The feedback focuses on strengths and opportunities for improvement to enable the professional development of all team members. At the end of the year, the performance review includes self, peer, and manager feedback and also includes a formal rating and informs compensation decisions, including performance bonus, salary adjustments and promotions. Core Values and Ethics Millions worldwide are afflicted with genetic diseases, but small patient populations and industry reluctance to conduct early- stage development means that for many, treatments have not been forthcoming. We are committed to bridging this gap: between business case and scientific possibility, between patient and hope. This starts with our first core value: to put patients first. We also strive to think independently. Our goal is to not simply accept the ideas and opinions of others as fact, but instead to ask " why? " and " why not? " We endeavor to bring a rigorous, first- principles mindset to each problem that we take on. We encourage all of our team members to speak up when they have an idea or feedback to share, taking pride in a culture that is radically transparent when it comes to debating ideas. A commitment to independent thinking requires us to consider the ideas

of others and to adopt them if they prove best. We strive to maintain a culture where any idea is worthy of both consideration and testing. We know that every minute counts. Our decentralized model strives to deliver treatments from discovery to patients as fast as humanly possible by utilizing focused teams of experts for each asset. Big decisions can be taken by people best- equipped to understand them, without wasting time on unnecessary cycles. And we let Science speak. Our model was designed to promote the rational assessment of our programs. Decisions about a program' s fate are driven by its performance against a set of objective criteria, giving each potential medicine' s scientific merits the last word. All employees are responsible for upholding these values and the BridgeBio Code of Business Conduct and Ethics, which forms the foundation of our policies and practices. Total Rewards To attract and retain top talent, we offer a competitive total rewards package. We peg total direct compensation at the upper end of market. We link a portion of every employee' s compensation to performance through a performance bonus program. To create a sense of ownership and align employee incentives with our long- term success, we offer eligible employees equity ownership in the company through stock option or restricted stock unit grants and our employee stock purchase plan. We also designed a program to incentivize affiliate- level employees to achieve specific milestones at core value- inflection points, such as IND or NDA approval. We focus our benefits offering on areas critical to keeping our employees and their immediate families healthy and productive. We offer physical and mental health benefits to all employees who work at least 30 hours per week, on average. We have a flexible paid time off policy to empower team members to take the time they need, when they need it. Diversity, Equity and Inclusion We believe that a diverse, equitable and inclusive culture is critical to BridgeBio' s success. We are proud to promote unique voices within and outside our organization, and are eager to learn from others' experiences, as we know that a diverse and inclusive workforce is a business imperative and key to our long- term success. In 2022, our Diversity, Equity & Inclusion, or DE & I, Executive & Steering Committees continued their impactful work in carrying out the DE & I vision for BridgeBio. The DE & I sub- committees also designed and implemented point solutions to address issues that were surfaced through related focus groups and surveys. Among the many DE & I events the Committees organized and held throughout the year, we hosted a DE & I Lunch & Learn series that focused on the prominent issues impacting underrepresented minorities in healthcare clinical trials and how we, as a company, can do our part to help address these disparities. Employee Resource Groups (ERGs) continued to be a foundational element to our DE & I efforts. The Women at Bridge ERG continued to have an impact across the Company in 2022. We built upon our speaker series and featured talks from influential women in the sciences, including members of our Board of Directors. Our mentorship program continued to drive impact as well. The success of Women at Bridge inspired a second employee resource group to emerge, Asians @ Bridge, in the third quarter of 2021. Asians @ Bridge held a series of cultural, educational and community events in 2022 that received exceptional feedback from participants and attendees. We also kicked off the planning for an employee resource group supporting the LGBTQ community, called Pride @ Bridge, which was launched in January 2023. Response to COVID- 19 With the continuation of the COVID- 19 global pandemic, we continue to take extra precautions to reduce the risk of virus exposure for all employees, and to place our employees' health and safety front and center. Our response to the pandemic in 2022 revolved around three major components: (1) adequate safety protocols; (2) testing requirements; and (3) vaccination requirements. • Safety protocols: Building off the strong framework we laid in 2020, we continued to tune our protocols in accordance with federal, including Center for Disease Control and Prevention, state, and local guidelines. Our Covid Task Force, formed in 2020, met and continues to meet regularly to ensure we are staying on top of the rapidly changing situation across all of our facilities, and communicating these changes to our employees in a timely manner. • Testing: We continue to offer testing options for all BridgeBio employees who are on- site. In addition, in advance of any larger scale events, we worked to ensure that all attendees attested to having obtained a negative test prior to attendance. • Vaccines: We made the decision in 2021 to mandate vaccines for all of our employees in the wake of President Biden' s and the Occupational Safety and Health Administration' s mandate. We created a vaccine exemption request review committee and implemented a formal process for evaluating those with either a medical or a sincerely held religious belief exemption request. Corporate and Other Information We were incorporated as a Delaware corporation in 2019 under the name BridgeBio Pharma, Inc. Our principal executive offices are located at 3160 Porter Drive, Suite 250, Palo Alto, CA 94304. Our telephone number is (650) 391- 9740. Our web page address is https: / / bridgebio. com. Our investor relations website is located at https: / / investor. bridgebio. com. We make available free of charge on our investor relations website under " SEC Filings " our Annual Reports on Form 10 - K, Quarterly Reports on Form 10 - Q, Current Reports on Form 8 - K, including exhibits, our directors' and officers' Section 16 Reports and any amendments to those reports after filing or furnishing such materials to the SEC. References to our website address do not constitute incorporation by reference of the information contained on the website, and the information contained on the website is not part of this document or any other document that we file with or furnish to the SEC. ITEM 1A. RISK FACTORS Our business involves significant risks, some of which are described below. You should carefully consider the risks and uncertainties described below, together with all of the other information contained in this Annual Report on Form 10- K, including " Management' s Discussion and Analysis of Financial Condition and Results of Operations " and the consolidated financial statements and the related notes. If any of the following risks actually occur, it could harm our business, prospects, operating results and financial condition and future prospects. In such event, the market price of our common stock could decline, and you could lose all or part of your investment. Additional risks and uncertainties not presently known to us or that we currently deem immaterial may also impair our business operations. This Annual Report on Form 10- K also contains forward- looking statements that involve risks and uncertainties. Our actual results could differ materially from those anticipated in the forward- looking statements as a result of factors that are described below and elsewhere in this Annual Report. Risks Related to Our Financial Position and Growth Strategy Drug development is a highly uncertain undertaking and involves a substantial degree of risk. We have incurred significant losses since our inception and anticipate that we will continue to incur significant losses for the foreseeable future. We have not generated significant revenue since inception, which, together with our limited operating history, may make it difficult for you to assess our future viability. Pharmaceutical and biopharmaceutical product development

is a highly speculative undertaking and involves a substantial degree of risk. We are a newly commercial- stage biopharmaceutical company with a limited operating history upon which you can evaluate our business and prospects. Our subsidiaries, on whose success we largely rely, are primarily early- stage biopharmaceutical companies. To date, we have focused principally on identifying, acquiring or in- licensing and developing our product candidates at the subsidiary level, almost all of which are in discovery, lead optimization, preclinical or clinical development. Our pipeline of product candidates will require substantial additional development time, including extensive clinical research, and resources before we would be able to apply for or receive additional regulatory approvals and begin generating revenue from sales of those product candidates, if approved. We are not profitable and have incurred losses in each year since our inception in April 2015. Our net losses for the years ended December 31, **2023,** 2022 ~~,~~ **and** 2021 ~~and 2020~~ were $ **653. 3 million, $** 484. 7 million ~~,~~ **and** $ 586. 5 million ~~and $ 505. 5 million~~ , respectively. As of December 31, ~~2022~~ **2023** , we had an accumulated deficit of $ ~~1~~ **2** . ~~9~~ **6** billion. We had two products approved for commercial sale, NULIBRY and ~~TRUSELTIQ~~ **TRUSELTIQTM** , but did not generate any significant revenues from product sales, and have financed operations solely through the sale of equity securities, debt financings and sale of certain assets. Sentynl purchased the global rights to NULIBRY in March 2022 and Helsinn, who is the principal selling party of ~~TRUSELTIQ~~ **TRUSELTIQTM** , ~~will discontinue~~ **discontinued** selling ~~TRUSELTIQ~~ **TRUSELTIQTM** ~~by~~ **in** March 31, 2023. We continue to incur significant research and development, or R & D, and other expenses related to ongoing operations and expect to incur losses for the foreseeable future. In addition ~~, as a result of the ongoing COVID- 19 pandemic~~ , we believe that potential delays in our ongoing and planned clinical trials and adjustments to certain of our study procedures **for various reasons** ~~with respect to our ongoing clinical trials~~ , such as ~~enabling alternate~~ **challenges in enrollment, additional requirements imposed by regulatory authorities or investigative** ~~site~~ **sites** , **or supply chain issues** ~~telehealth and home visits and at- home drug delivery~~ , could increase our expenditures or draw out our expenditures over a longer period of time than originally estimated. Additionally, changes to our selection of contract research organizations, or CROs, for non- clinical laboratory activities and engagement with ~~contract manufacturing organizations, or~~ CMOs, to mitigate any potential ~~near- term~~ impacts to our supply chain may increase our expenditures relative to initial expectations. We anticipate these losses will increase substantially in future periods. Because of the numerous risks and uncertainties associated with drug development and commercialization, we are unable to predict the timing or amount of our expenses, or when we will be able to generate any meaningful revenue or achieve or maintain profitability, if ever. In addition, our expenses could increase beyond our current expectations if we are required by the ~~U. S. Food and Drug Administration, or~~ FDA, or comparable foreign regulatory authorities, to conduct nonclinical or preclinical studies or clinical trials in addition to those that we currently anticipate or to otherwise provide data beyond that which we currently believe is necessary to support an application for marketing approval or to continue clinical development, or if there are any delays in any of our or our future collaborators' clinical trials or the development of our product candidates, that we may identify. We anticipate incurring significant costs associated with commercializing any future product candidates, if approved, and ongoing compliance efforts. We may never be able to successfully commercialize a marketable drug or achieve profitability. Revenue from the sale of any product will be dependent, in part, upon the size of the markets in the territories for which we have or may gain regulatory approval, the accepted price for the product, the ability to obtain reimbursement at any price and whether we own the commercial rights for that territory. Our growth strategy depends on our ability to generate revenue. Even if we achieve profitability in the future, we may not be able to sustain profitability in subsequent periods. Our failure to achieve sustained profitability would depress ~~the value of~~ our ~~Company~~ **stock price** and could impair our ability to raise capital, expand our business, diversify our research and development pipeline, market our product candidates, if approved, that we may identify and pursue, or continue our operations. Our prior losses, combined with expected future losses, have had and will continue to have an adverse effect on our stockholders' deficit and working capital. If we obtain a controlling interest in additional companies in the future, it could adversely affect our operating results and the value of our common stock, thereby disrupting our business. As part of our strategy, we expect to form and invest in additional wholly- owned subsidiaries and variable interest entities, or VIEs. Investments in our existing and any future subsidiaries involve numerous risks, including, but not necessarily limited to: • risk of conducting research and development activities in new therapeutic areas or treatment modalities in which we have little to no experience; • diversion of financial and managerial resources from existing operations; • our ability to negotiate a proposed acquisition, in- license or investment in a timely manner or at a price or on terms and conditions favorable to us; • our ability to combine and integrate a potential acquisition into our existing business to fully realize the benefits of such acquisition; • the impact of regulatory reviews on a proposed acquisition, in- license or investment; and • the outcome of any legal proceedings that may be instituted with respect to a potential acquisition, in- license or investment. If we fail to properly evaluate potential acquisitions, in- licenses, investments or other transactions associated with the creation of new research and development programs or the maintenance of existing ones, we might not achieve the anticipated benefits of any such transaction, we might incur costs in excess of what we anticipate, and management resources and attention might be diverted from other necessary or valuable activities. For instance, in January 2021, we completed our acquisition of all of the outstanding shares of common stock of Eidos that were not previously owned by us or our subsidiaries, to which we refer as the Eidos Merger. In connection with the Eidos Merger and our integration of Eidos' historical operations into our business, the attention of certain members of each company' s management and each company' s resources were diverted from day- to- day business operations. Additionally, the interests of our stockholders were diluted as a result of our issuance of shares of our common stock to Eidos' stockholders and our assumption of certain equity awards of Eidos in connection with the transaction. We may engage in similar discussions in the future with respect to other potential transactions that may divert our time and resources from our ongoing operations. In addition, from time to time we have pursued, and may in the future pursue, research and development programs through our wholly- owned subsidiaries and VIEs that we may ultimately determine not to advance, based on our ongoing assessment of the likelihood of success relative to the costs and risks associated with the program. Risks Related to the Development of Our

Product Candidates We may encounter substantial delays in clinical trials, or may not be able to conduct or complete clinical trials on the expected timelines, if at all. Clinical testing is expensive, time consuming and subject to uncertainty. We cannot guarantee that any of our ongoing and planned clinical trials will be conducted as planned or completed on schedule, if at all. Moreover, even if these trials are initiated or conducted on a timely basis, issues may arise that could result in the suspension or termination of such clinical trials. A failure of one or more clinical trials can occur at any stage of testing, and our ongoing and future clinical trials may not be successful. Events that may prevent successful or timely initiation or completion of clinical trials include: • inability to generate sufficient preclinical, toxicology or other in vivo or in vitro data to support the initiation or continuation of clinical trials; • delays in confirming target engagement, patient selection or other relevant biomarkers to be utilized in preclinical and clinical product candidate development; • delays in reaching a consensus with regulatory agencies as to the design or implementation of our clinical trials; • delays in reaching agreement on acceptable terms with prospective CROs and clinical trial sites, the terms of which can be subject to extensive negotiation and may vary significantly among different CROs and clinical trial sites; • delays in identifying, recruiting and training suitable clinical investigators; • delays in obtaining required Institutional Review Board, or IRB, approval at each clinical trial site; • imposition of a temporary or permanent clinical hold by regulatory agencies for a number of reasons, including after review of an Investigational New Drug application, or IND, or IND amendment, clinical trial application, or CTA, or CTA amendment, or equivalent application or amendment; or as a result of a new safety finding that presents unreasonable risk to clinical trial participants or a negative finding from an inspection of our clinical trial operations or study sites; • developments in trials for other product candidates with the same targets or related modalities as our product candidates conducted by third parties that raise regulatory or safety concerns about risk to patients of the treatment, or if the FDA or other governmental authority finds that the investigational protocol or plan is clearly deficient to meet its stated objectives; • difficulties in securing access to materials for the comparator arm of certain of our clinical trials; • delays in identifying, recruiting and enrolling suitable patients to participate in clinical trials, and delays caused by patients withdrawing from clinical trials or failing to return for post- treatment follow- up; • difficulty collaborating with patient groups and investigators; • failure by CROs, other third parties or us to adhere to clinical trial requirements; • failure to perform in accordance with the FDA' s or any other regulatory authority' s current good clinical practices, or GCP, requirements, or regulatory guidelines in other countries; • occurrence of adverse events, or AEs, associated with the product candidate that are viewed to outweigh its potential benefits; • changes in regulatory requirements and guidance that require amending or submitting new clinical protocols; • changes in the standard of care on which a clinical development plan was based, which may require new or additional trials; • the cost of clinical trials of any product candidates that we may identify and pursue being greater than we anticipate; • clinical trials of any product candidates that we may identify and pursue producing negative or inconclusive results or failing to meet a specified endpoint, which may result in our deciding, or regulators requiring us, to conduct additional clinical trials or to abandon product development programs; • delays in clinical trial enrollment or clinical trial initiation resulting from **any global health emergency, such as** the ~~ongoing~~ COVID- 19 pandemic ~~, including the emergence of new variants, or any future pandemics~~ ; • transfer of manufacturing processes to larger- scale facilities operated by a CMO, or by us, and delays or failure by our CMOs or us to make any necessary changes to such manufacturing process; and • delays in manufacturing, testing, releasing, validating or importing / exporting sufficient stable quantities of product candidates that we may identify for use in clinical trials, or the inability to do any of the foregoing. Any inability to successfully initiate **, conduct** or complete clinical trials could result in additional costs to us or impair our ability to generate revenue. In addition, if we make manufacturing or formulation changes to our product candidates, we may be required to or we may elect to conduct additional nonclinical studies or clinical trials to bridge data obtained from our modified product candidates to data obtained from nonclinical and clinical research conducted using earlier versions of these product candidates. Clinical trial delays could also shorten any periods during which our product candidates have patent protection and may allow our competitors to bring products to market before we do, which could impair our ability to successfully commercialize product candidates and may harm our business and results of operations. We could also encounter delays if an ongoing or planned clinical trial is suspended or terminated by us, by the data safety monitoring board, or DSMB, including for our ongoing Phase 3 clinical trial of ~~acoramidis~~ **low- dose infigratinib** , **our** ongoing Phase 2 and planned Phase 3 clinical trials of ~~low~~ **BBP** - **418** ~~dose infigratinib~~ , **and** our ongoing ~~Phase 2 and planned~~ Phase 3 clinical ~~trials of BBP- 418, our ongoing Phase 1 / 2 clinical~~ trial ~~of BBP- 631 and our ongoing Phase 2b and Phase 3 clinical trials~~ of encaleret, or by the FDA or other regulatory authority, or if the IRBs of the institutions in which such trials are being conducted suspend or terminate the participation of their clinical investigators and sites subject to their review. Such authorities may suspend or terminate a clinical trial due to a number of factors, including failure to conduct the clinical trial in accordance with regulatory requirements or our clinical protocols, inspection of the clinical trial operations or trial site by the FDA or other regulatory authorities resulting in the imposition of a clinical hold, unforeseen safety issues or adverse side effects, failure to demonstrate a benefit from using a product candidate, changes in governmental regulations or administrative actions or lack of adequate funding to continue the clinical trial. For instance, although acoramidis failed to meet its primary endpoint at Month 12 in the ATTRibute- CM Study, the ATTRibute- CM independent data monitoring committee recommended continuing the study through the Month 30 endpoint based on unblinded data reviews **and achieved positive results at the Month 30 endpoint** . We have in the past received, and may receive in the future, partial or full clinical hold notices from the FDA or other regulatory authorities, which have required, and may in the future require, us to conduct additional studies, generate additional data, amend our clinical trial protocols and / or delay or halt the initiation or continuation of our clinical trials. We may be required or may voluntarily determine to place one or more of our product candidates on clinical hold in the future for various reasons, which could delay or otherwise impair our clinical development efforts and ability to obtain regulatory approval for any such product candidate. Additionally, the FDA may determine, upon review of an IND submission, that we have not provided sufficient information needed to assess the risks to subjects of the proposed studies, or that our IND submission is otherwise insufficient to support initiation of a clinical trial. There is no

guarantee that the FDA will agree that our responses are sufficient, and we may be required to conduct additional preclinical studies or manufacturing steps before the FDA allows our proposed clinical trials to proceed. Moreover, principal investigators for our clinical trials may serve as scientific advisors or consultants to us from time to time and receive compensation in connection with such services. Under certain circumstances, we may be required to report some of these relationships to the FDA or comparable foreign regulatory authorities. The FDA or comparable foreign regulatory authority may conclude that a financial relationship between us and a principal investigator has created a conflict of interest or otherwise affected interpretation of the study. The FDA or comparable foreign regulatory authority may therefore question the integrity of the data generated at the applicable clinical trial site and the utility of the clinical trial itself may be jeopardized. This could result in a delay in approval, or rejection, of our marketing applications by the FDA or comparable foreign regulatory authority, as the case may be, and may ultimately lead to the denial of marketing approval of one or more of our product candidates. Delays in the initiation, conduct or completion of any clinical trial of our product candidates will increase our costs, slow down the product candidate development and approval process and delay or potentially jeopardize our ability to commence product sales and generate revenue from such product candidates, if approved. In addition, many of the factors that cause, or lead to, a delay in the commencement or completion of clinical trials may also ultimately lead to the denial of regulatory approval of our product candidates. In the event we identify any additional product candidates to pursue, we cannot be sure that submission of an IND or a CTA will result in the FDA or comparable foreign regulatory authority allowing clinical trials to begin in a timely manner, if at all. Any of these events could have a material adverse effect on our business, prospects, financial condition and results of operations **. Results of earlier studies or clinical trials may not be predictive of future clinical trial results, and initial studies or clinical trials may not establish an adequate safety or efficacy profile for our product candidates to justify proceeding to advanced clinical trials or an application for regulatory approval** . The results of nonclinical and preclinical studies and clinical trials may not be predictive of the results of later- stage clinical trials, and interim results of a clinical trial do not necessarily predict final results. In addition, for certain of our product candidates that we acquired, we did not undertake the preclinical studies and clinical trials ourselves. The results of preclinical studies and clinical trials in one set of patients or disease indications, or from preclinical studies or clinical trials that we did not lead, may not be predictive of those obtained in another. In some instances, there can be significant variability in safety or efficacy results between different clinical trials of the same product candidate due to numerous factors, including changes in trial procedures set forth in protocols, differences in the size and type of the patient populations, changes in and adherence to the dosing regimen and other clinical trial protocols and the rate of dropout among clinical trial participants. In addition, preclinical and clinical data are often susceptible to various interpretations and analyses, and many companies that have believed their product candidates performed satisfactorily in preclinical studies and clinical trials have nonetheless failed to obtain marketing approval. Product candidates in later stages of clinical trials may fail to show the desired safety and efficacy profile despite having progressed through nonclinical studies and initial clinical trials. For instance, acoramidis failed to meet its primary endpoint at Month 12 in the ATTRibute- CM Study as mean observed six- minute walk distance, or 6MWD, decline for the acoramidis and placebo arms were 9 meters and 7 meters, respectively, both of which declines are similar to healthy elderly adults and less than prior untreated ATTR- CM cohorts; however, **acoramidis met** the **primary endpoint at** ~~ATTRibute- CM independent data monitoring committee has recommended that the study continue through the~~ Month 30 endpoint ~~based on unblinded data reviews~~ **(a hierarchical analysis inclusive of all- cause mortality and frequency of cardiovascular- related hospitalizations)** . A number of companies in the pharmaceutical and biopharmaceutical industry have suffered significant setbacks in advanced clinical trials due to lack of efficacy or adverse safety profiles, ~~notwithstanding~~ **despite** promising results in earlier studies, and we cannot be certain that we will not face similar setbacks. Even if early- stage clinical trials are successful, we may need to conduct additional clinical trials of our product candidates in additional patient populations or under different treatment conditions before we are able to seek approvals from the FDA and regulatory authorities outside the United States to market and sell these product candidates. Our failure to obtain marketing approval for our product candidates for commercially viable indications, or at all, would substantially harm our business, prospects, financial condition and results of operations. Additionally, some clinical trials of our product candidates performed to date were designed as open- label studies and were conducted at a limited number of clinical sites on a limited number of patients. An " open- label " clinical trial is one where both the patient and investigator know whether the patient is receiving the investigational product candidate or either an existing approved drug or placebo. Most typically, open- label clinical trials test only the investigational product candidate and sometimes may do so at different dose levels. Open- label clinical trials are subject to various limitations that may exaggerate any therapeutic effect as patients in open- label clinical trials are aware when they are receiving treatment. Open- label clinical trials may be subject to a " patient bias " where patients perceive their symptoms to have improved merely due to their awareness of receiving an experimental treatment. Moreover, patients selected for early clinical trials often include the most severe sufferers and their symptoms may have been bound to improve notwithstanding the new treatment. In addition, open- label clinical trials may be subject to an " investigator bias " where those assessing and reviewing the physiological outcomes of the clinical trials are aware of which patients have received treatment and may interpret the information of the treated group more favorably given this knowledge. Given that our Phase 2 ~~clinical trial of acoramidis included an open- label clinical trial extension and our Phase 2~~ dose- escalation and expansion study of low- dose infigratinib in children with achondroplasia, or PROPEL 2, ~~is~~ **was** designed as an open- label trial, the results from ~~these~~ **this** clinical ~~trials~~ **trial** may not be predictive of future clinical trial results with ~~these~~ **this** or other product candidates for which we include an open- label clinical trial when studied in a controlled environment with a placebo or active control. We may encounter difficulties enrolling patients in clinical trials, and clinical development activities could thereby be delayed or otherwise adversely affected. The timely completion of clinical trials in accordance with their protocols depends, among other things, on our ability to enroll a sufficient number of patients who remain in the trial until its conclusion. The indications for which we plan to evaluate our current product candidates **each** represent a rare disease or condition with

limited patient populations from which to draw participants in clinical trials. Due to our focus on the development of product candidates for the treatment of Mendelian diseases and genetically driven cancers, many of which are rare conditions, we may not be able to identify and enroll a sufficient number of patients, or those with required or desired characteristics and criteria, in a timely manner. We may experience difficulties in patient enrollment in our clinical trials for a variety of reasons, including: • the size and nature of a patient population; • the patient eligibility criteria defined in the applicable clinical trial protocols, which may limit the patient populations eligible for clinical trials to a greater extent than competing clinical trials for the same indication; • the size of the study population required for analysis of the trial' s primary endpoints; • the severity of the disease under investigation; • the proximity of patients to a trial site; • the design of the trial; • the ability to recruit clinical trial investigators with the appropriate competencies and experience; • the approval or concurrent enrollment of clinical trials involving competing product candidates currently under development for Mendelian diseases or genetically driven cancers, or competing clinical trials for similar therapies or targeting patient populations meeting our patient eligibility criteria; • clinicians' and patients' perceptions as to the potential advantages and side effects of the product candidate being studied in relation to other available therapies and product candidates; • the ability to obtain and maintain patient consents; and • the risk that patients enrolled in clinical trials will not complete such trials for any reason ~~, including due to the ongoing COVID- 19 pandemic~~ . If we have difficulty enrolling sufficient numbers of patients to conduct clinical trials as planned, we may need to delay or terminate ongoing or planned clinical trials, either of which would have an adverse effect on our business. Use of our product candidates could be associated with side effects, adverse events or other properties or safety risks, which could delay or halt their clinical development, prevent their regulatory approval, cause us to suspend or discontinue clinical trials, abandon a product or product candidate, limit the commercial potential of a product candidate, if approved, or result in other significant negative consequences that could ~~severely~~ harm our business, prospects, operating results and financial condition. As is the case with pharmaceuticals generally, it is likely that there may be side effects and adverse events, or AEs, associated with use of our product candidates. Results of our clinical trials could reveal a high and unacceptable severity and prevalence of side effects or unexpected characteristics. Undesirable side effects caused by our product candidates could cause us or regulatory authorities to interrupt, delay or halt clinical trials, and could result in a more restrictive label or the delay or denial of regulatory approval by the FDA or comparable foreign regulatory authorities. The drug- related side effects of our product candidates could affect patient recruitment or the ability of enrolled patients to complete the trial or result in potential product liability claims. Any of these occurrences may harm our business, financial condition and prospects significantly. Moreover, if our product candidates are associated with undesirable side effects in preclinical studies or clinical trials or have characteristics that are unexpected, we may elect to abandon their development or limit their development to more narrow uses or subpopulations in which the undesirable side effects or other characteristics are less prevalent, less severe or more acceptable from a risk- benefit perspective, which may limit the commercial expectations for the product candidate if approved. We may also be required to modify or terminate our study plans based on findings in our preclinical studies or clinical trials. ~~For instance, in our Phase 2 clinical trial of infigratinib for the treatment of FGFR- driven cancers, the most commonly reported treatment emergent AE of any grade was hyperphosphatemia, which is an electrolyte disorder in which there is an elevated level of phosphate in the blood. These and other~~ AEs that we may observe in our ongoing and future preclinical studies and clinical trials of our product candidates could require us to delay, modify or abandon our development plans for the affected product candidate or other product candidates that share properties of the affected product candidate. Many product candidates that initially show promise in early- stage testing may later be found to cause side effects that prevent further development. As we work to advance existing product candidates and to identify new product candidates, we cannot be certain that later testing or trials of product candidates that initially showed promise in early testing will not be found to cause similar or different unacceptable side effects that prevent their further development. It is possible that as we test our product candidates in larger, longer and more extensive clinical trials, or as the use of our product candidates, if they receive regulatory approval, becomes more widespread, illnesses, injuries, discomforts and other AEs that were observed in earlier trials, as well as conditions that did not occur or went undetected in previous trials, will be reported by subjects. If such side effects become known later in development or upon approval, such findings may harm our business, financial condition and prospects significantly. Additionally, adverse developments in clinical trials of pharmaceutical and biopharmaceutical products conducted by others may cause the FDA or other regulatory oversight bodies to suspend or terminate our clinical trials, to change the requirements for approval of any of our product candidates. In addition to side effects caused by a product candidate, the administration process or related procedures also can cause adverse side effects. If any such AEs occur, our clinical trials of a product candidate could be suspended or terminated. If we are unable to demonstrate that any AEs were caused by the administration process or related procedures, the FDA, the European Commission, the EMA, or other regulatory authorities could order us to cease further development of, or deny approval of, a product candidate for any or all targeted indications. Even if we can demonstrate that all future ~~serious adverse events, or~~ SAEs ~~,~~ are not product- related, such occurrences could affect patient recruitment, or the ability of enrolled patients to complete the trial. Moreover, if we elect, or are required, to not initiate, delay, suspend or terminate any future clinical trial of any of our product candidates, the commercial prospects of such product candidates may be harmed and our ability to generate product revenues from any of these product candidates may be delayed or eliminated. Any of these occurrences may harm our ability to develop other product candidates, and may harm our business, financial condition and prospects significantly. Additionally, if any of our product candidates receives marketing approval, the FDA could impose a boxed warning in the labeling of our product and could require us to adopt a risk evaluation and mitigation strategy, or REMS, and could apply elements to assure safe use to ensure that the benefits of the product outweigh its risks, which may include, among other things, a Medication Guide outlining the risks of the product for distribution to patients and a communication plan to health care practitioners. Furthermore, if we or others later identify undesirable side effects caused by our product candidates once approved, several potentially significant negative consequences could result, including: • regulatory authorities may suspend or withdraw

approvals of such product or product candidate; • regulatory authorities may require additional warnings or statements on the label; • regulatory authorities may refuse to approve label expansion for additional indications of such product or product candidate; • we may be required by the FDA to implement a REMS; • we may be required to change the way a product or product candidate is distributed, administered or conduct additional clinical trials; • we may be subject to regulatory investigations and enforcement actions; • we may decide to remove such product or product candidate from the marketplace; • we could be sued and held liable for harm caused to patients; and • our reputation may suffer. Any of these occurrences could prevent us from achieving or maintaining market acceptance of the particular product or product candidate, if approved, and may harm our business, financial condition and prospects significantly. **Certain of our product candidates are under development for the treatment of patient populations with significant comorbidities that may result in deaths or serious adverse or unacceptable side effects and require us to abandon or limit our clinical development activities.** Patients in certain of our ongoing and planned clinical trials of product candidates in genetically driven cancers ~~, including clinical trials of infigratinib of FGFR- driven cancers and our Phase 1 monotherapy dose escalation and expansion clinical trial of BBP- 398 in patients with RAS and RTK mutations~~ , as well as patients who may undergo treatment with other product candidates that we may develop, may also receive chemotherapy, radiation, and / or other high dose or myeloablative treatments in the course of treatment of their disease, and may therefore experience side effects or AEs, including death, that are unrelated to our product candidates. While these side effects or AEs may be unrelated to our product candidates, they may still affect the success of our clinical trials. The inclusion of critically ill patients in our clinical trials may also result in deaths or other adverse medical events due to underlying disease or to other therapies or medications that such patients may receive. Any of these events could prevent us from advancing our product candidates through clinical development, and from obtaining regulatory approval, and would impair our ability to commercialize our product candidates. Any inability to advance our product candidates through clinical development may harm our business, financial condition, results of operations and prospects. Interim, " top- line, " and preliminary data from our clinical trials that we announce or publish from time to time may change as more patient data become available or as additional analyses are conducted, and as the data are subject to audit and verification procedures that could result in material changes in the final data. From time to time, we may publish interim, " top- line " or preliminary data from our clinical trials. Interim data from clinical trials that we may complete are subject to the risk that one or more of the clinical outcomes may materially change as patient enrollment continues and more patient data become available. Preliminary or " top- line " data also remain subject to audit and verification procedures that may result in the final data being materially different from the preliminary data we previously published. As a result, interim and preliminary data should be viewed with caution until the final data are available. Material adverse changes between preliminary, " top- line " or interim data and final data could significantly harm our business, financial condition, results of operations and prospects. Risks Related to Regulatory Review and Approval of our Product Candidates Our product candidates are in preclinical or clinical development, which is a lengthy and expensive process with uncertain outcomes and the potential for substantial delays. We cannot give any assurance that any of our product candidates will receive regulatory approval, which is necessary before they can be commercialized. Before obtaining marketing approval from regulatory authorities for the sale of our product candidates, we must conduct extensive clinical trials to demonstrate the safety and efficacy of the product candidates in humans. To date, we have focused substantially all of our efforts and financial resources on identifying, acquiring, and developing our product candidates, including conducting lead optimization, nonclinical studies, preclinical studies and clinical trials, and providing general and administrative support for these operations. We cannot be certain that any clinical trials will be conducted as planned or completed on schedule, if at all. Our inability to successfully complete preclinical and clinical development could result in additional costs to us and negatively impact our ability to generate revenue. Our future success is dependent on our ability to successfully develop, obtain regulatory approval for, and then successfully commercialize product candidates. While we previously had two products approved for sale, we have not generated significant revenue from sales of drugs, and we may never be able to successfully commercialize a marketable drug. All of our product candidates require additional development; management of preclinical, clinical and manufacturing activities; and regulatory approval. In addition, we will need to obtain adequate manufacturing supply; complete the build- out of a commercial organization; commence product candidate- specific marketing efforts; and obtain reimbursement before we generate any significant revenue from commercial product sales from such product candidates, if ever. Many of our product candidates are in early- stage research or translational phases of development, and the risk of failure for these programs is high. We cannot be certain that our product candidates will be successful in clinical trials or receive regulatory approval. Further, our product candidates may not receive regulatory approval even if they are successful in clinical trials. If we do not receive regulatory approvals for our product candidates, we and our subsidiaries may not be able to continue operations, which may result in us winding down and dissolving the subsidiary, selling or out- licensing the technology or pursuing an alternative strategy. If we are unable to obtain regulatory approval in one or more jurisdictions for any product candidates that we may identify and develop, our business will be substantially harmed. We cannot commercialize a product until the appropriate regulatory authorities have reviewed and approved the product candidate. Approval by the FDA and comparable foreign regulatory authorities is lengthy and unpredictable, and depends upon numerous factors, including substantial discretion of the regulatory authorities. Approval policies, regulations or the type and amount of nonclinical or clinical data necessary to gain approval may change during the course of a product candidate' s development and may vary among jurisdictions, which may cause delays in the approval or the decision not to approve an application. **It** ~~While we previously obtained regulatory approvals from the FDA, European Medicines Agency, or EMA, and State of Israel Ministry of Health, for NULIBRY (fosdenopterin) to reduce the risk of mortality in patients with molybdenum cofactor deficiency, or MoCD, Type A, and from the FDA and Health Canada for TRUSELTIQ (infigratinib) for the treatment of adults with previously- treated, unresectable locally- advanced or metastatic cholangiocarcinoma with a FGFR2 fusion or other rearrangement, it~~ is possible that our current product candidates and any other product candidates which we may seek to develop in the future will not ever obtain regulatory approval. We

cannot be certain that any of our product candidates will receive regulatory approval or that if approved, any of our product candidates, will be successfully commercialized. Obtaining marketing approval is an extensive, lengthy, expensive and inherently uncertain process, and regulatory authorities may delay, limit or deny approval of our product candidates for many reasons, including, but not limited to: • the inability to demonstrate to the satisfaction of the FDA or comparable foreign regulatory authorities that the applicable product candidate is safe and effective as a treatment for our targeted indications; • the FDA or comparable foreign regulatory authorities may disagree with the design, endpoints or implementation of our clinical trials; • the population studied in the clinical program may not be sufficiently broad or representative to assure safety or efficacy in the full population for which we seek approval; • the FDA or comparable foreign regulatory authorities may require additional preclinical studies or clinical trials beyond those that we currently anticipate; • the FDA or comparable foreign regulatory authorities may disagree with our interpretation of data from nonclinical studies or clinical trials; • the data collected from clinical trials of product candidates that we may identify and pursue may not be sufficient to support the submission of a new drug application, or NDA, biologics license application, or BLA, or other submission for regulatory approval in the United States or elsewhere; • we may be unable to demonstrate to the FDA or comparable foreign regulatory authorities that a product candidate' s risk- benefit ratio for its proposed indication is acceptable; • the FDA or comparable foreign regulatory authorities may identify deficiencies in the manufacturing processes, test procedures and specifications, or facilities of third- party manufacturers with which we contract for clinical and commercial supplies; and • the approval policies or regulations of the FDA or comparable foreign regulatory authorities may change in a manner that renders the clinical trial design or data insufficient for approval. In addition, even if an NDA, BLA, or other submission for regulatory approval, is filed and accepted for review, the FDA or comparable regulatory authorities may delay their review or approval process or may decline to grant regulatory approval for a variety of reasons. **For example, on December 5, 2023 we submitted an application for approval with the FDA for acoramidis but cannot predict when, or if, we will receive a decision on approval from the FDA.** The lengthy approval process, as well as the unpredictability of the results of clinical trials and evolving regulatory requirements, may result in our failure to obtain regulatory approval to market product candidates that we may pursue in the United States or elsewhere, which would significantly harm our business, prospects, financial condition and results of operations **. Our clinical trials may fail to demonstrate substantial evidence of the safety and efficacy of product candidates that we may identify and pursue for their intended uses, which would prevent, delay or limit the scope of regulatory approval and commercialization** . Before obtaining regulatory approvals for the commercial sale of our product candidates, we must demonstrate through lengthy, complex and expensive nonclinical studies, preclinical studies and clinical trials that the applicable product candidate is both safe and effective for use in each target indication, and in the case of our product candidates regulated as biological products, that the product candidate is safe, pure, and potent for use in its targeted indication. Each product candidate must demonstrate an adequate risk versus benefit profile in its intended patient population and for its intended use. Clinical testing is expensive and can take many years to complete, and its outcome is inherently uncertain. Failure can occur at any time during the clinical development process. Most product candidates that begin clinical trials are never approved by regulatory authorities for commercialization. We have limited experience in designing clinical trials and may be unable to design and execute a clinical trial to support future marketing approvals. We cannot be certain that our current clinical trials or any other future clinical trials will be successful. Additionally, any safety concerns observed in any one of our clinical trials in our targeted indications could limit the prospects for regulatory approval of our product candidates in those and other indications, which could have a material adverse effect on our business, financial condition and results of operations. In addition, even if such clinical trials are successfully completed, we cannot guarantee that the FDA or comparable foreign regulatory authorities will interpret the results as we do, and more trials could be required before we submit our product candidates for approval. Success in clinical trials in a particular indication does not ensure that a product candidate will be successful in other indications. Similarly, approval of a product candidate in a particular indication does not ensure that that the product candidate will be successful in other indications. Moreover, results acceptable to support approval in one jurisdiction may be deemed inadequate by another regulatory authority to support regulatory approval in that other jurisdiction. To the extent that the results of the trials are not satisfactory to the FDA or comparable foreign regulatory authorities for support of a marketing application, we may be required to expend significant resources, which may not be available to us, to conduct additional trials in support of potential approval of our product candidates. Even if regulatory approval is secured for a product candidate, the terms of such approval may limit the scope and use of the specific product candidate, which may also limit its commercial potential. We conduct clinical trials for product candidates outside the United States, and the FDA and comparable foreign regulatory authorities may not accept data from such trials. We currently conduct clinical trials outside the United States, including in Europe. For instance, our Phase 3 clinical trials of acoramidis ~~include~~ **included** patients outside of the United States. The acceptance by the FDA or comparable foreign regulatory authority of study data from clinical trials conducted outside the United States or another jurisdiction may be subject to certain conditions or may not be accepted at all. In cases where data from foreign clinical trials are intended to serve as the basis for marketing approval in the United States, the FDA will generally not approve the application on the basis of foreign data alone unless (i) the data are applicable to the U. S. population and U. S. medical practice; (ii) the trials were performed by clinical investigators of recognized competence and pursuant to GCP regulations; and (iii) the data may be considered valid without the need for an on- site inspection by the FDA or, if the FDA considers such as inspection to be necessary, the FDA is able to validate the data through an on- site inspection or other appropriate means. Additionally, the FDA' s clinical trial requirements, including sufficient size of patient populations and statistical powering, must be met. Many foreign regulatory authorities have similar approval requirements. In addition, such foreign trials would be subject to the applicable local laws of the foreign jurisdictions where the trials are conducted. There can be no assurance that the FDA or any comparable foreign regulatory authority will accept data from trials conducted outside of the United States or the applicable jurisdiction, including from our **previous** ~~ongoing and planned~~ Phase 3 clinical trials of

acoramidis, for which we have enrolled cohorts outside the United States. If the FDA or any comparable foreign regulatory authority does not accept such data, it would result in the need for additional trials, which would be costly and time- consuming and delay aspects of our business plan, and which may result in product candidates that we may develop not receiving approval or clearance for commercialization in the applicable jurisdiction. Even if we obtain FDA approval for **any of** our current product candidates in the United States, we may never obtain approval to commercialize any of these product candidates outside of the United States, which would limit our ability to realize their full market potential. In order to market any products outside of the United States, we must establish and comply with numerous and varying regulatory requirements of other countries regarding safety and effectiveness. Clinical trials conducted in one country may not be accepted by regulatory authorities in other countries, and regulatory approval in one country does not mean that regulatory approval will be obtained in any other country. Approval processes vary among countries and can involve additional product testing and validation and additional or different administrative review periods from those in the United States, including additional preclinical studies or clinical trials, as clinical trials conducted in one jurisdiction may not be accepted by regulatory authorities in other jurisdictions. In many jurisdictions outside the United States, a product candidate must be approved for reimbursement before it can be approved for sale in that jurisdiction. In some cases, the price that we intend to charge for our products, once approved is also subject to approval. Seeking foreign regulatory approval could result in difficulties and costs and require additional nonclinical studies or clinical trials which could be costly and time- consuming. Regulatory requirements can vary widely from country to country and could delay or prevent the introduction of our product candidates in those countries. The foreign regulatory approval process may include all of the risks associated with obtaining FDA approval. While we previously had two products approved for sale in the United States, we do not have any product candidates approved for sale in international markets, and we ~~do not~~ have **only limited** experience in obtaining regulatory approval in international markets. If we fail to comply with regulatory requirements in international markets or to obtain and maintain required approvals, or if regulatory approval in international markets is delayed, our target market will be reduced and our ability to realize the full market potential of any approved products will be harmed. Even though we may apply for orphan drug designation for our product candidates, we may not be able to obtain such designations or maintain the benefits associated with orphan drug status, including orphan drug marketing exclusivity. Our business strategy focuses on the development of product candidates for the treatment of genetic diseases, which may be eligible for FDA or EMA orphan drug designation. Regulatory authorities in some jurisdictions, including the United States and European Union, may designate drugs or biologics for relatively small patient populations as orphan drugs. ~~Under the Orphan Drug Act, the FDA may designate a drug as an orphan drug if it is intended to treat a rare disease or condition, which is generally defined as a patient population of fewer than 200, 000 individuals annually in the United States, or a patient population of 200, 000 or more in the United States where there is no reasonable expectation that the cost of developing the drug will be recovered from sales in the United States. In order to obtain orphan drug designation, the request must be made before submitting an NDA or BLA. In the United States, orphan drug designation entitles a party to financial incentives such as opportunities for grant funding towards clinical trial costs, tax advantages, and user- fee waivers.~~ After the FDA grants orphan drug designation, the generic identity of the drug and its potential orphan use are disclosed publicly by the FDA. Orphan drug designation does not convey any advantage in, or shorten the duration of, the regulatory review and approval process ~~If a product that has orphan drug designation subsequently receives the first FDA approval of that particular product for the disease for which it has such designation, the product is entitled to orphan product exclusivity, which means that the FDA may not approve any other applications, including an NDA or BLA, to market the same drug or biologic for the same indication for seven years, except in limited circumstances such as a showing of clinical superiority to the product with orphan drug exclusivity or if the FDA finds that the holder of the orphan drug exclusivity has not shown that it can assure the availability of sufficient quantities of the orphan drug to meet the needs of patients with the disease or condition for which the drug was designated~~ . ~~As a result, even~~ **Even** if one of our product candidates receives orphan exclusivity, the FDA can still approve other drugs or biologics for use in treating the same indication or disease or the same biologic for a different indication or disease during the exclusivity period. Furthermore, the FDA can waive orphan exclusivity if we are unable to manufacture sufficient supply of our product or orphan drug exclusivity can be overcome if a subsequent applicant demonstrates clinical superiority over our product. ~~In~~ **See** the ~~European Union~~ **section titled** ~~, the Committee for~~ **" Business — Government Regulation —** Orphan **Drug** ~~Medicinal Products of the EMA grants an orphan designation~~ **Designation** ~~in respect of a product if its sponsor can establish that (1) the product is intended for the diagnosis, prevention or treatment of a life- threatening or chronically debilitating condition, (2) either (i) such condition affects not more than five in 10, 000 persons in the European Union when the application is made, or (ii) it is unlikely that the product, without the benefits derived from orphan status, would generate sufficient return in the European Union to justify the necessary investment in its development;~~ and **Exclusivity** ~~(3) there must be no satisfactory method of diagnosis, prevention, or treatment of such condition authorized for marketing in the European Union, or, if such method exists, the product would be of significant benefit to those affected by that condition~~ . **"** We have obtained from the FDA orphan drug designations, including for: acoramidis for the treatment of transthyretin amyloidosis; low- dose infigratinib for the treatment of achondroplasia; encaleret for the treatment of autosomal dominant hypocalcemia (including ADH type 1 and ADH type 2); BBP- ~~631 for the treatment of CAH caused by 21OHD; BBP-~~ 812 for the treatment of Canavan Disease; and BBP- 671 for the treatment of PKAN and PA. We have obtained from the EMA and European Commission, orphan drug designation for: acoramidis for the treatment of ATTR amyloidosis; low- dose infigratinib for the treatment of achondroplasia ~~; BBP- 631 for the treatment of CAH caused by 21 OHD~~ ; BBP- 418 for the treatment of limb- girdle muscular dystrophy; BBP- 812 for the treatment of Canavan Disease; BBP- 671 for the treatment of PKAN and PA; and encaleret as a treatment for hypoparathyroidism (inclusive of ADH1). We may seek orphan drug designation for other product candidates. Even if we obtain orphan drug designation, exclusive marketing rights in the United States may be limited if we seek approval for an indication broader than the orphan designated indication and may be lost if the FDA later determines that the request for designation was

materially defective, if we are unable to assure sufficient quantities of the product to meet the needs of patients with the rare disease or condition, or if a subsequent applicant demonstrates clinical superiority over our products. In addition, although we may seek orphan drug designation for other product candidates, we may never receive such designations. Any failure to obtain, maintain or otherwise recognize the benefits of orphan drug designation for our product candidates could have a material adverse effect on our prospects. On August 3, 2017, Congress passed the FDA Reauthorization Act of 2017, or FDARA. FDARA, among other things, codified the FDA' s pre- existing regulatory interpretation to require that a sponsor demonstrate the clinical superiority of an orphan drug that is otherwise the same as a previously approved drug for the same rare disease in order to receive orphan drug exclusivity. The legislation reverses prior precedent holding that the Orphan Drug Act unambiguously requires that the FDA recognize the orphan exclusivity period regardless of a showing of clinical superiority. Moreover, in the Consolidated Appropriations Act of 2021, Congress did not further change this interpretation when it clarified that the interpretation codified in FDARA would apply in cases where FDA issued an orphan designation before the enactment of FDARA but where product approval came after the enactment of FDARA. The FDA may further reevaluate the Orphan Drug Act and its regulations and policies. We do not know if, when, or how the FDA may change the orphan drug regulations and policies in the future, and it is uncertain how any changes might affect our business. Depending on what changes the FDA may make to its orphan drug regulations and policies, our business could be adversely impacted. The FDA has granted rare pediatric disease designation to BBP- 671 for the treatment of PKAN and PA, low- dose infigratinib for the treatment of achondroplasia, and BBP- 812 for the treatment of Canavan Disease. However, a marketing application for BBP- 671 **or any other product candidate** , if approved, may not meet the eligibility criteria for a priority review voucher. The FDA has granted rare pediatric disease designation to BBP- 671 for the treatment of PKAN and PA, low- dose infigratinib for the treatment of achondroplasia, and BBP- 812 for the treatment of Canavan Disease. Designation of a drug as a drug for a rare pediatric disease does not guarantee that an NDA for such drug will meet the eligibility criteria for a rare pediatric disease priority review voucher at the time the application is approved. Under the Federal Food, Drugs, and Cosmetic Act, or FDCA, we will need to request a rare pediatric disease priority review voucher in our original NDA for BBP- 671. The FDA may determine that an NDA for any of BBP- 671, low- dose infigratinib, or BBP- 812, if approved, does not meet the eligibility criteria for a priority review voucher, including for the following reasons: • achondroplasia, Canavan Disease, PKAN or PA no longer meets the definition of a rare pediatric disease; • the NDA contains an active ingredient (including any ester or salt of the active ingredient) that has been previously approved in an NDA; • the NDA is not deemed eligible for priority review; • the NDA does not rely on clinical data derived from studies examining a pediatric population and dosages of the drug intended for that population (that is, if the NDA does not contain sufficient clinical data to allow for adequate labeling for use by the full range of affected pediatric patients); or • the NDA is approved for a different adult indication than the rare pediatric disease for which BBP- 671, low- dose infigratinib, or BBP- 812 is designated (for example, if BBP- 671 ~~,~~ is approved for an indication based on specific genetic alterations that would be inclusive of, but not limited to, BBP- 671). The authority for the FDA to award rare pediatric disease priority review vouchers for drugs and biologics that receive rare pediatric disease designation on or prior to September 30, 2024 is currently limited to those candidates that receive rare pediatric disease designation on or prior to September 30, 2024, and the FDA may only award rare pediatric disease priority review vouchers through September 30, 2026. However, it is possible the FDA' s authority to award rare pediatric disease priority review vouchers will be further extended by Congress. Absent any such extension, if an NDA for BBP- 671, low- dose infigratinib or BBP- 812 is not approved prior to September 30, 2026 for any reason, regardless of whether it meets the criteria for a rare pediatric disease priority review voucher, it will not be eligible for a priority review voucher. Accelerated approval by the FDA, even if granted for any of our product candidates, may not lead to a faster development or regulatory review or approval process and it does not increase the likelihood that our product candidates will receive marketing approval. We may seek approval of our product candidates using the FDA' s accelerated approval pathway. We may seek approval of additional product candidates, where applicable, under the FDA' s accelerated approval pathway. This pathway may not lead to a faster development, regulatory review or approval process and does not increase the likelihood that our product candidates will receive marketing approval. A product may be eligible for accelerated approval if it treats a serious or life- threatening condition, generally provides a meaningful advantage over available therapies, and demonstrates an effect on a surrogate endpoint that is reasonably likely to predict clinical benefit. As a condition of approval, the FDA may require that a sponsor of a product receiving accelerated approval perform adequate and well- controlled post- marketing confirmatory clinical trials. These confirmatory trials must be completed with due diligence. Under the Food and Drug Omnibus Reform Act of 2022, or FDORA, the FDA is permitted to require, as appropriate, that a post- approval confirmatory trial or trials be underway prior to approval or within a specified time period after the date accelerated approval was granted. FDORA also requires sponsors to send updates to the FDA every 180 days on the status of such studies, including progress toward enrollment targets, and the FDA must promptly post this information publicly. Furthermore, under FDORA, the FDA is empowered to take action, such as issuing fines, against companies that fail to conduct with due diligence any post- approval confirmatory trial or submit timely reports to the agency on their progress. In addition, for products under consideration for accelerated approval, the FDA currently requires, unless otherwise requested by the agency, pre- approval of promotional materials ~~intended for~~ **prior to** dissemination or publication ~~within 120 days of marketing approval be submitted to the agency for review during the review period~~ , which could adversely impact the timing of the commercial launch of the product. Thus, even if we seek to utilize the accelerated approval pathway, we may not be able to obtain accelerated approval and, even if we do, we may not experience a faster development, regulatory review or approval process for that product. In addition, receiving accelerated approval does not assure that the product' s accelerated approval will eventually be converted to a traditional approval. We may not elect or be able to take advantage of any expedited development or regulatory review and approval processes available to product candidates granted breakthrough therapy, fast track or regenerative medicine advanced therapy designation by the FDA. We intend to evaluate and continue ongoing discussions with the FDA on regulatory strategies that

could enable us to take advantage of expedited development pathways for certain of our product candidates, although we cannot be certain that our product candidates will qualify for any expedited development pathways or that regulatory authorities will grant, or allow us to maintain, the relevant qualifying designations. Potential expedited development pathways that we could pursue include breakthrough therapy, fast track designation and / or regenerative medicine advanced therapy, or RMAT. Breakthrough therapy designation is intended to expedite the development and review of product candidates that are designed to treat serious or life- threatening diseases when " preliminary clinical evidence indicates that the drug may demonstrate substantial improvement over existing therapies on one or more clinically significant endpoints, such as substantial treatment effects observed early in clinical development. " The designation of a product candidate as a breakthrough therapy provides potential benefits that include more frequent meetings with the FDA to discuss the development plan for the product candidate and ensure collection of appropriate data needed to support approval; more frequent written correspondence from the FDA about matters such as the design of the proposed clinical trials and use of biomarkers; intensive guidance on an efficient drug development program, beginning as early as Phase 1; organizational commitment involving senior managers; and eligibility for rolling review and priority review. Fast track designation is designed for product candidates intended for the treatment of a serious or life- threatening disease or condition, where nonclinical or clinical data demonstrate the potential to address an unmet medical need for this disease or condition. We may **also** seek RMAT designation for one or more of our product candidates. **See** ~~In 2017,~~ the ~~FDA established the~~ **section titled, " Business — Government Regulation — Expedited Development and Review Programs " for additional information regarding** RMAT designation ~~as part of its implementation of the 21st Century Cures Act to expedite review of any drug that meets the following criteria: it qualifies as a RMAT, which is defined as a cell therapy, therapeutic tissue engineering product, human cell and tissue product, or any combination product using such therapies or products, with limited exceptions; it is intended to treat, modify, reverse, or cure a serious or life- threatening disease or condition; and preliminary clinical evidence indicates that the drug has the potential to address unmet medical needs for such a disease or condition. Like breakthrough therapy designation, RMAT designation provides potential benefits that include more frequent meetings with the FDA to discuss the development plan for the product candidate, and eligibility for rolling review and priority review. Products granted RMAT designation may also be eligible for accelerated approval on the basis of a surrogate or intermediate endpoint reasonably likely to predict long- term clinical benefit, or reliance upon data obtained from a meaningful number of sites, including through expansion to additional sites. RMAT- designated products that receive accelerated approval may, as appropriate, fulfill their post- approval requirements through the submission of clinical evidence, clinical trials, patient registries, or other sources of real world evidence, such as electronic health records; through the collection of larger confirmatory data sets; or via post- approval monitoring of all patients treated with such therapy prior to approval of the therapy~~ . Although some of our product candidates, including the following, were granted fast track designation by the FDA, we may elect not to pursue any of breakthrough therapy, fast track or RMAT designations for our other product candidates, and the FDA has broad discretion whether or not to grant these designations: • BBP- 418 for the treatment of LGMD2I, • encaleret for the treatment of ADH1, ~~• BBP- 631 for the treatment of CA,~~ and • BBP- 812 for the treatment of Canavan Disease. Even if we believe a particular product candidate is eligible for breakthrough therapy, fast track designation or RMAT, there can be no assurance that the FDA would decide to grant it. Breakthrough therapy designation, fast track and RMAT designation do not change the standards for product approval, and there is no assurance that such designation or eligibility will result in expedited review or approval or that the approved indication will not be narrower than the indication covered by the breakthrough therapy, fast track or RMAT designation. Thus, even if we do receive breakthrough therapy, fast track or RMAT designation, we may not experience a faster development process, review or approval compared to conventional FDA procedures. The FDA may withdraw breakthrough therapy, fast track or RMAT designation if it believes that the product no longer meets the qualifying criteria. Our business may be harmed if we are unable to avail ourselves of these or any other expedited development and regulatory pathways. Additionally, certain oncology product candidates may be eligible for review under the Real- Time Oncology Review, or RTOR ~~, pilot program~~ , which is an initiative of the FDA' s Oncology Center of Excellence designed to expedite the delivery of safe and effective cancer treatments to patients. Although this program allows the FDA to review data earlier, before an applicant formally submits a complete application, acceptance into the RTOR pilot does not guarantee or influence approvability of the application, which is subject to the usual benefit- risk evaluation by FDA reviewers, and it does not affect the FDA' s ~~PDUFA~~ **Prescription Drug User Fee Act** timelines **. Although early approvals have occurred with applications selected for RTOR, this may not be the case for our application even if it is selected for RTOR. If at any time the FDA determines our participation in RTOR, if selected, is no longer appropriate, the FDA may rescind our acceptance and instruct us to follow routine submission procedures for marketing approval** . We may seek designation for our platform technology as a designated platform technology, but we might not receive such designation, and even if we do, such designation may not lead to a faster development or regulatory review or approval process. We may seek designation for our platform technology as a designated platform technology ~~. Under FDORA, a platform technology incorporated within or utilized by a drug or biologic is eligible for designation as a designated platform technology if (1) the platform technology is incorporated in, or utilized by, a drug approved under an NDA or BLA; (2) preliminary evidence submitted by the sponsor of the approved or licensed drug, or a sponsor that has been granted a right of reference to data submitted in the application for such drug, demonstrates that the platform technology has the potential to be incorporated in, or utilized by, more than one drug without an adverse effect on quality, manufacturing, or safety; and (3) data or information submitted by the applicable person indicates that incorporation or utilization of the platform technology has a reasonable likelihood to bring significant efficiencies to the drug development or manufacturing process and to the review process~~ . A sponsor may request the FDA to designate a platform technology as a designated platform technology concurrently with, or at any time after, submission of an IND application for a drug that incorporates or utilizes the platform technology that is the subject of the request. If so designated, the FDA may expedite the development and review of any subsequent original NDA or

BLA for a drug that uses or incorporates the platform technology. Even if we believe our platform technology meets the criteria for such designation, the FDA may disagree and instead determine not to grant such designation. In addition, the receipt of such designation for a platform technology does not ensure that a drug will be developed more quickly or receive a faster FDA review process or ultimate FDA approval. Moreover, the FDA may revoke a designation if the FDA determines that a designated platform technology no longer meets the criteria for such designation. **See the section titled, " Business — Government Regulation — Expedited Development and Review Programs. "** If we are unable to successfully validate, develop and obtain regulatory approval for companion diagnostic tests for our drug candidates that require or would commercially benefit from such tests, or experience significant delays in doing so, we may not realize the full commercial potential of these product candidates. In connection with the clinical development of our product candidates for certain indications, we may work with collaborators to develop or obtain access to in vitro companion diagnostic tests to identify patient subsets within a disease category who may derive selective and meaningful benefit from our drug candidates ~~. For example, we developed a companion diagnostic for infigratinib in patients with CCA in collaboration with Foundation Medicine, or FMI, which received FDA approval at the same time as TRUSELTIQ~~ . Such companion diagnostics would be used during our clinical trials as well as in connection with the commercialization of our product candidates. To be successful, we or our collaborators will need to address a number of scientific, technical, regulatory and logistical challenges. The FDA and comparable foreign regulatory authorities regulate in vitro companion diagnostics as medical devices and, under that regulatory framework, will likely require the conduct of clinical trials to demonstrate the safety and effectiveness of any diagnostics we may develop, which we expect will require separate regulatory clearance or approval prior to commercialization. We may rely on third parties for the design, development and manufacture of companion diagnostic tests for our therapeutic product candidates that may require such tests. If we enter into such collaborative agreements, we will be dependent on the sustained cooperation and effort of our future collaborators in developing and obtaining approval for these companion diagnostics. It may be necessary to resolve issues such as selectivity / specificity, analytical validation, reproducibility, or clinical validation of companion diagnostics during the development and regulatory approval processes. Moreover, even if data from preclinical studies and early clinical trials appear to support development of a companion diagnostic for a product candidate, data generated in later clinical trials may fail to support the analytical and clinical validation of the companion diagnostic. We and our future collaborators may encounter difficulties in developing, obtaining regulatory approval for, manufacturing and commercializing companion diagnostics similar to those we face with respect to our therapeutic candidates and therapeutics themselves, including issues with achieving regulatory clearance or approval, production of sufficient quantities at commercial scale and with appropriate quality standards, and in gaining market acceptance. If we are unable to successfully develop companion diagnostics for these therapeutic product candidates, or experience delays in doing so, the development of these therapeutic product candidates may be adversely affected, these therapeutic product candidates may not obtain marketing approval, and we may not realize the full commercial potential of any of these therapeutics that have or may obtain marketing approval. As a result, our business, results of operations and financial condition could be materially harmed. In addition, a diagnostic company with whom we contract may decide to discontinue selling or manufacturing the companion diagnostic test that we anticipate using in connection with development and commercialization of our product candidates or our relationship with such diagnostic company may otherwise terminate. We may not be able to enter into arrangements with another diagnostic company to obtain supplies of an alternative diagnostic test for use in connection with the development and commercialization of our product candidates or do so on commercially reasonable terms, which could adversely affect and / or delay the development or commercialization of our therapeutic candidates. If approved, our investigational products regulated as biologics may face competition from biosimilars approved through an abbreviated regulatory pathway. The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, or collectively the ACA, includes a subtitle called the Biologics Price Competition and Innovation Act of 2009, or BPCIA, which created an abbreviated approval pathway for biological products that are biosimilar to or interchangeable with an FDA- licensed reference biological product. Under the BPCIA, an application for a biosimilar product may not be submitted to the FDA until four years following the date that the reference product was first licensed by the FDA. In addition, the approval of a biosimilar product may not be made effective by the FDA until 12 years from the date on which the reference product was first licensed. During this 12- year period of exclusivity, another company may still market a competing version of the reference product if the FDA approves a BLA for the competing product containing the sponsor' s own preclinical data and data from adequate and well- controlled clinical trials to demonstrate the safety, purity, and potency of the other company' s product. The law is complex and is still being interpreted and implemented by the FDA. As a result, its ultimate impact, implementation, and meaning are subject to uncertainty. We believe that any of our product candidates approved as a biological product under a BLA should qualify for the 12- year period of exclusivity. However, there is a risk that this exclusivity could be shortened due to congressional action or otherwise, or that the FDA will not consider our investigational medicines to be reference products for competing products, potentially creating the opportunity for generic competition sooner than anticipated. Other aspects of the BPCIA, some of which may impact the BPCIA exclusivity provisions, have also been the subject of recent litigation. Moreover, the extent to which a biosimilar, once licensed, will be substituted for any one of our reference products in a way that is similar to traditional generic substitution for non- biological products is not yet clear, and will depend on a number of marketplace and regulatory factors that are still developing. If competitors are able to obtain marketing approval for biosimilars referencing any of our product candidates, our products may become subject to competition from such biosimilars, which would impair our ability to successfully commercialize and generate revenues from sales of such products. Our product candidates, if approved, will be ~~,~~ subject to ongoing regulatory obligations and continued regulatory review, which may result in significant additional expense and we may be subject to penalties if we fail to comply with regulatory requirements or experience unanticipated problems with our product candidates. Our product candidates, if approved, will be ~~,~~ subject to ongoing regulatory requirements and review by the FDA and other applicable regulatory

authorities for manufacturing, labeling, packaging, storage, advertising, promotion, sampling, record- keeping, conduct of post-marketing studies, and submission of safety, efficacy, and other post- market information, including both federal and state requirements in the United States and requirements of comparable foreign regulatory authorities. Manufacturers and manufacturers' facilities are required to comply with extensive requirements imposed by the FDA and comparable foreign regulatory authorities, including ensuring that quality control and manufacturing procedures conform to current good manufacturing practices, or cGMP, regulations. As such, we and our CMOs will be subject to continual review and inspections to assess compliance with cGMP and adherence to commitments made in any NDA, BLA or marketing authorization application, or MAA. Accordingly, we and others with whom we work must continue to expend time, money, and effort in all areas of regulatory compliance, including manufacturing, production and quality control. Furthermore, under the Drug Supply Chain Security Act, for certain commercial prescription drug products, manufacturers and other parties involved in the supply chain must also meet chain of distribution requirements and build electronic, interoperable systems for product tracking and tracing and for notifying the FDA of counterfeit, diverted, stolen, and intentionally adulterated products or other products that are otherwise unfit for distribution in the U. S. In addition, the distribution of prescription pharmaceutical products, including samples, is subject to the Prescription Drug Marketing Act, or PDMA, which regulates the distribution of drugs and drug samples at the federal level, and sets minimum standards for the registration and regulation of drug distributors by the states. Both the PDMA and state laws limit the distribution of prescription pharmaceutical product samples and impose requirements to ensure accountability in distribution. Prescription drug products must also meet applicable child- resistant packaging requirements under the U. S. Poison Prevention Packaging Act. If we are not able to comply with post- approval regulatory requirements, we could have the marketing approvals for any approved products withdrawn by regulatory authorities and our ability to market such products could be limited, which could adversely affect our ability to achieve or sustain profitability and we could be subject to substantial penalties. As a result, the cost of compliance with post- approval regulations may have a negative effect on our operating results and financial condition. Any regulatory approvals that we may receive for our product candidates, are or will be subject to limitations on the approved indicated uses for which the product may be marketed and promoted or to the conditions of approval, or contain requirements for potentially costly post- marketing testing, including Phase 4 clinical trials and surveillance to monitor the safety and efficacy of the product. We will be required to report certain adverse reactions and production problems, if any, to the FDA and comparable foreign regulatory authorities. Any new legislation addressing drug safety issues could result in delays in product development or commercialization, or increased costs to assure compliance. Additionally, under FDORA, sponsors of approved drugs and biologics must provide six months' notice to the FDA of any changes in marketing status, such as the withdrawal of a drug, and failure to do so could result in the FDA placing the product on a list of discontinued products, which would revoke the product' s ability to be marketed. The FDA and other agencies, including the Department of Justice, closely regulate and monitor the post- approval marketing, labeling, advertising and promotion of products to ensure that they are manufactured, marketed and distributed only for the approved indications and in accordance with the provisions of the approved label. We are required to comply with requirements concerning advertising and promotion for products that may be approved. Promotional communications with respect to prescription drugs are subject to a variety of legal and regulatory restrictions and must be consistent with the information in the product' s approved label. As such, we may not promote those products for indications or uses for which they do not have approval. The holder of an approved NDA, BLA or MAA must submit new or supplemental applications and obtain approval for certain changes to the approved product, product labeling, or manufacturing process. We could also be asked to conduct post- marketing clinical trials to verify the safety and efficacy of our products, if approved in general or in specific patient subsets. If original marketing approval was obtained via the accelerated approval pathway, we could be required to conduct a successful post- marketing clinical trial to confirm clinical benefit for those products. If a regulatory agency discovers previously unknown problems with a product, such as AEs of unanticipated severity or frequency, or problems with the facility where the product is manufactured, or disagrees with the promotion, marketing or labeling of a product, such regulatory agency may impose restrictions on that product or us, including requiring withdrawal of the product from the market. If we fail to comply with applicable regulatory requirements, a regulatory agency or enforcement authority may, among other things: • issue warning or untitled letters that would result in adverse publicity; • impose civil or criminal penalties; • suspend or withdraw regulatory approvals; • suspend any of our ongoing clinical trials; • refuse to approve pending applications or supplements to approved applications submitted by us; • impose restrictions on our operations, including closing our CMOs' facilities; • impose restrictions on the labeling of products; • impose restrictions on product distribution or use, such as a REMS; • seize or detain products; or • require a product recall. Any government investigation of alleged violations of law could require us to expend significant time and resources in response, and could generate negative publicity. Any failure to comply with ongoing regulatory requirements may significantly and adversely affect our ability to commercialize and generate revenue from our products. If regulatory sanctions are applied or if regulatory approval is withdrawn, ~~the value of our Company and~~ our operating results will be adversely affected **and our stock price may decline** . The FDA' s and other regulatory authorities' policies may change, and additional government regulations may be enacted that could prevent, limit or delay regulatory approval of our product candidates or suspend, withdraw or modify regulatory approval of our products. The FDA and other regulatory agencies actively enforce the laws and regulations prohibiting the promotion of off- label uses. If any of our current product candidates are approved and we are found to have improperly promoted off- label uses of our products, we may become subject to significant liability. The FDA and other regulatory agencies strictly regulate the promotional claims that may be made about prescription products. In particular, while the FDA permits the dissemination of truthful and non- misleading information about an approved product, a sponsor may not promote a product for uses that are not approved by the FDA or such other regulatory agencies as reflected in the product' s approved labeling. If we are found to have promoted such off- label uses, we may become subject to significant liability. The federal government has levied large civil and criminal fines against companies for alleged improper promotion of off- label use

and has enjoined several companies from engaging in off- label promotion. The FDA has also requested that companies enter into consent decrees, corporate integrity agreements or permanent injunctions under which specified promotional conduct must be changed or curtailed. If we cannot successfully manage the promotion of our product candidates, if approved, we could become subject to significant liability, which would materially adversely affect our business and financial condition. Notwithstanding regulations related to product promotion, the FDA and other regulatory authorities allow companies to engage in truthful, non- misleading, and non- promotional scientific exchange concerning their products. We intend to engage in medical education activities and communicate with healthcare providers in compliance with all applicable laws and regulatory guidance. Risks Related to the Novel Nature of our Product Candidates Certain of our product candidates, including our protein therapeutic and gene therapy product candidates, are novel, complex and difficult to manufacture. We could experience manufacturing problems that result in delays in our development or commercialization programs or otherwise harm our business. The manufacturing processes our CMOs use to produce our product candidates, including our protein therapeutic and gene therapy product candidates, are complex, novel and have not been validated for commercial use. Several factors have caused and may cause future production interruptions, including restrictions on certain manufacturing operations and shortages in on- site personnel at our CMOs' manufacturing facilities ~~as a result of governmental " stay at home " orders~~ **, equipment malfunctions, facility contamination, raw material shortages or contamination, natural disasters, disruption** in ~~response~~ **utility services, human error or disruptions in the operations of our suppliers, including historical disruptions related** to the COVID- 19 pandemic, **which could reoccur** ~~equipment malfunctions, facility contamination, raw material shortages or contamination, natural disasters, disruption~~ in **connection with any future global pandemic** ~~utility services, human error or disruptions in the operations of our~~ - **or** ~~suppliers~~ **health emergency** . Several of our small molecule product candidates are particularly complex and difficult to manufacture, in some cases due to the number of steps required, the process complexity and the toxicity of end or intermediate- stage products. Our protein therapeutic and gene therapy product candidates require processing steps that are more complex than those required for most small molecule drugs. Moreover, unlike small molecules, the physical and chemical properties of certain of our biologic product candidates generally cannot be fully characterized. As a result, assays of the finished product may not be sufficient to ensure that the product is consistent from lot- to- lot or will perform in the intended manner. Accordingly, our CMOs must employ multiple steps to control the manufacturing process to assure that the process is reproducible and the product candidate is made strictly and consistently in compliance with the process. Problems with the manufacturing process, even minor deviations from the normal process, could result in product defects or manufacturing failures that result in lot failures, product recalls, product liability claims or insufficient inventory to conduct clinical trials or supply commercial markets. We may encounter problems achieving adequate quantities and quality of clinical- grade materials that meet the FDA, the EMA or other applicable standards or specifications with consistent and acceptable production yields and costs. In addition, the FDA, the EMA and other foreign regulatory authorities may require us to submit samples of any lot of any approved product together with the protocols showing the results of applicable tests at any time. Under some circumstances, the FDA, the EMA or other foreign regulatory authorities may require that we not distribute a lot until the agency authorizes its release. Slight deviations in the manufacturing process, including those affecting quality attributes and stability, may result in unacceptable changes in the product that could result in lot failures or product recalls. Lot failures or product recalls could cause us to delay product launches or clinical trials, which could be costly to us and otherwise harm our business, financial condition, results of operations and prospects. Our CMOs also may encounter problems hiring and retaining the experienced scientific, quality assurance, quality- control and manufacturing personnel needed to operate our manufacturing processes, which could result in delays in production or difficulties in maintaining compliance with applicable regulatory requirements. Any problems in our CMOs' manufacturing process or facilities could result in delays in planned clinical trials and increased costs, and could make us a less attractive collaborator for potential partners, including larger biotechnology companies and academic research institutions, which could limit access to additional attractive development programs. Problems in our manufacturing process could also restrict our ability to meet potential future market demand for any products that may be approved **. Certain of our product candidates are based on a novel adeno- associated virus, or AAV, gene therapy technology with which there is limited clinical or regulatory experience to date, which makes it difficult to predict the time and cost of product candidate development and subsequently obtaining regulatory approval** . Certain of our product candidates are based on gene therapy technology and our future success depends on the successful development of this novel therapeutic approach. We cannot assure you that any development problems we or other gene therapy companies experience in the future related to gene therapy technology will not cause significant delays or unanticipated costs in the development of our product candidates, or that such development problems can be solved. In addition, the clinical study requirements of the FDA, the EMA and other regulatory agencies and the criteria these regulators use to determine the safety and efficacy of a product candidate vary substantially according to the type, complexity, novelty and intended use and market of the potential products. The regulatory approval process for novel product candidates such as ours can be more expensive and take longer than for other, better known or extensively studied therapeutic modalities. Further, as we are developing novel treatments for diseases in which there is limited clinical experience with new endpoints and methodologies, there is heightened risk that the FDA, the EMA or comparable foreign regulatory bodies may not consider the clinical trial endpoints to provide clinically meaningful results, and the resulting clinical data and results may be more difficult to analyze. To date, few gene therapy products have been approved by the FDA or comparable foreign regulatory authorities, which makes it difficult to determine how long it will take or how much it will cost to obtain regulatory approvals for our product candidates in the United States, the European Union or other jurisdictions. Further, approvals by one regulatory agency may not be indicative of what other regulatory agencies may require for approval. Regulatory requirements governing the development of gene therapy products have changed frequently and may continue to change in the future. In 2016, the FDA established the Office of Tissues and Advanced Therapies, or OTAT, within its Center for Biologics Evaluation and Research, or CBER, to consolidate the

review of gene therapy and related products, and to advise CBER on its review. In September 2022, the FDA announced retitling of OTAT to the Office of Therapeutic Products, or OTP, and elevation of OTP to a " Super Office " to meet its growing cell and gene therapy workload. In addition, under guidelines issued by the National Institutes of Health, or NIH, gene therapy clinical trials are also subject to review and oversight by an institutional biosafety committee, or IBC, a local institutional committee that reviews and oversees research utilizing recombinant or synthetic nucleic acid molecules at that institution. Before a clinical trial can begin at any institution, that institution' s institutional review board, or IRB, and its IBC assesses the safety of the research and identifies any potential risk to public health or the environment. While the NIH guidelines are not mandatory unless the research in question is being conducted at or sponsored by institutions receiving NIH funding of recombinant or synthetic nucleic acid molecule research, many companies and other institutions not otherwise subject to the NIH Guidelines voluntarily follow them. Moreover, serious adverse events or developments in clinical trials of gene therapy product candidates conducted by others may cause the FDA or other regulatory bodies to initiate a clinical hold on our clinical trials or otherwise change the requirements for approval of any of our product candidates. Although the FDA decides whether individual cell and gene therapy protocols may proceed, the review process and determinations of other reviewing bodies can impede or delay the initiation of a clinical trial, even if the FDA has reviewed the trial and approved its initiation. Similarly, the EMA governs the approval of gene therapies in the European Union and may issue new guidelines concerning the development and marketing authorization for gene therapy products and require that we comply with these new guidelines. These regulatory review committees and advisory groups and the new guidelines they promulgate may lengthen the regulatory review process, require us to perform additional studies or trials, increase our development costs, lead to changes in regulatory positions and interpretations, delay or prevent approval and commercialization of our product candidates or lead to significant post- approval limitations or restrictions. As we advance our product candidates, we will be required to consult with these regulatory and advisory groups and comply with applicable guidelines. If we fail to do so, we may be required to delay or discontinue development of such product candidates. These additional processes may result in a review and approval process that is longer than we otherwise would have expected. Delays as a result of an increased or lengthier regulatory approval process or further restrictions on the development of our product candidates can be costly and could negatively impact our ability to complete clinical trials and commercialize our current and future product candidates, if approved, in a timely manner, if at all. Our product candidates based on gene therapy technology may cause undesirable and unforeseen side effects or be perceived by the public as unsafe, which could delay or prevent their advancement into clinical trials or regulatory approval, the imposition of a clinical hold, limit the commercial potential or result in significant negative consequences. Public attitudes may be influenced by claims that gene therapy as a novel technology is unsafe, unethical, or immoral, and, consequently, our product candidates may not gain the acceptance of the public or the medical community. Adverse public attitudes may adversely impact our ability to enroll clinical trials. In addition, the FDA has imposed an increased number of clinical holds on gene therapy candidates in recent years. Moreover, our success will depend upon physicians prescribing, and their patients being willing to receive, treatments that involve the use of product candidates we may develop in lieu of, or in addition to, existing treatments with which they are already familiar and for which greater clinical data may be available. For example, there have been several significant adverse side effects in prior clinical trials of gene therapy product candidates, including reported cases of leukemia and death seen in other trials using other vectors. While new AAV vectors have been developed to reduce these side effects, gene therapy is still a relatively new approach to disease treatment and additional adverse side effects could develop. There also is the potential risk of delayed AEs following exposure to gene therapy products due to persistent biologic activity of the genetic material or other components of products used to carry the genetic material. Possible adverse side effects that could occur with treatment with gene therapy products include an immunologic reaction early after administration which could be detrimental to the patient' s health or substantially limit the effectiveness and durability of the treatment. For example, an increasingly anticipated side effect of AAV gene therapy is the development of a T- cell immunological response, most often seen affecting the liver. Any actual or perceived negative effects of our AAV gene therapy product candidates or those under development by third parties could impair our ability to continue the development of these product candidates and have an adverse effect on our prospects. Risks Related to Our Reliance on Third Parties We expect to rely on third parties to conduct our clinical trials and some aspects of our research and preclinical testing, and those third parties may not perform satisfactorily, including failing to meet deadlines for the completion of such trials, research or testing. We currently rely and expect to continue to rely on third parties, such as CROs, clinical data management organizations, medical institutions and clinical investigators, to conduct some aspects of research and preclinical testing and clinical trials. Any of these third parties may terminate their engagements with us or be unable to fulfill their contractual obligations. If any of our relationships with these third parties terminate, we may not be able to enter into arrangements with alternative third parties on commercially reasonable terms, or at all. If we need to enter into alternative arrangements, it will delay our product development activities. Our reliance on these third parties for research and development activities reduces control over these activities but does not relieve us of our responsibilities. For example, we remain responsible for ensuring that each of our respective clinical trials is conducted in accordance with the general investigational plan and protocols for the trial and applicable legal, regulatory, and scientific standards, and our reliance on third parties does not relieve us of our regulatory responsibilities. In addition, the FDA and comparable foreign regulatory authorities require compliance with GCPs for conducting, recording and reporting the results of clinical trials to assure that data and reported results are credible, reproducible and accurate and that the rights, integrity and confidentiality of trial participants are protected. Regulatory authorities enforce these GCPs through periodic inspections of trial sponsors, principal investigators and trial sites. If we or any of these third parties fail to comply with applicable GCP regulations, some or all of the clinical data generated in our clinical trials may be deemed unreliable and the FDA or comparable foreign regulatory authorities may require us to perform additional nonclinical or clinical trials or to enroll additional patients before approving our marketing applications. We cannot be certain that, upon inspection, such regulatory authorities will determine that any of our clinical trials complies

with the GCP regulations. For any violations of laws and regulations during the conduct of clinical trials, we could be subject to untitled and warning letters or enforcement action that may include civil penalties up to and including criminal prosecution. We also are required to register ongoing clinical trials and post the results of completed clinical trials on a government- sponsored database within certain timeframes. Failure to do so can result in fines, adverse publicity, and civil and criminal sanctions. If these third parties do not successfully carry out their contractual duties, meet expected deadlines or conduct clinical trials in accordance with regulatory requirements or our stated protocols, we will not be able to obtain, or may be delayed in obtaining, marketing approvals for any product candidates we may develop and will not be able to, or may be delayed in our efforts to, successfully commercialize our medicines. Our failure or the failure of these third parties to comply applicable regulatory requirements or our stated protocols could also subject us to enforcement action. We also expect to rely on other third parties to store and distribute drug supplies for our clinical trials. Any performance failure on the part of our distributors could delay clinical development or marketing approval of any product candidates we may develop or commercialization of our medicines, producing additional losses and depriving us of potential product revenue. We rely entirely on third parties for the manufacturing of our current product candidates or other product candidates that we may develop for preclinical studies and clinical trials. Our business could be harmed if those third parties fail to provide us with sufficient quantities of drug product, or fail to do so at acceptable quality levels or prices. We do not currently have, nor do we plan to acquire, the infrastructure or capability internally to manufacture drug supplies for our ongoing clinical trials or any future clinical trials that we may conduct, and we lack the resources to manufacture our product candidates, if approved, on a commercial scale. We rely, and expect to continue to rely, on third- party manufacturers to produce our current product candidates or other product candidates that we may identify for clinical trials, as well as for commercial manufacture of any product candidates that may receive marketing approval. Although we generally do not begin a clinical trial unless we believe we have a sufficient supply of a product candidate to complete the trial, any significant delay or discontinuity in the supply of a product candidate, or the raw material components thereof, for an ongoing clinical trial due to the need to replace a third- party manufacturer could considerably delay the clinical development and potential regulatory approval of our product candidates, which could harm our business and results of operations. We also expect to rely primarily on third parties for the manufacturing of commercial supply of our product candidates, if approved. We may be unable to identify and appropriately qualify third- party manufacturers or establish agreements with third- party manufacturers or do so on acceptable terms. Even if we are able to establish agreements with third-party manufacturers, reliance on third- party manufacturers entails additional risks, including: • reliance on the third party for sourcing of raw materials, components, and such other goods as may be required for execution of its manufacturing processes and the oversight by the third party of its suppliers; • reliance on the third party for regulatory compliance and quality assurance for the manufacturing activities each performs; • the possible breach of the manufacturing agreement by the third party; • the possible misappropriation of proprietary information, including trade secrets and know- how; and • the possible termination or non- renewal of the agreement by the third party at a time that is costly or inconvenient for us. Furthermore, all of our CMOs are engaged with other companies to supply and / or manufacture materials or products for such companies, which exposes our manufacturers to regulatory risks for the production of such materials and products. The facilities used by our contract manufacturers to manufacture our product candidates are subject to review by the FDA pursuant to inspections that will be conducted after we submit an NDA or BLA to the FDA. We do not control the manufacturing process of, and are completely dependent on, our contract manufacturing partners for compliance with the regulatory requirements, known as cGMP, requirements for manufacture of drug and biologic products. If our contract manufacturers cannot successfully manufacture material that conforms to our specifications and the strict regulatory requirements of the FDA or others, we will not be able to secure or maintain regulatory approval for our product candidates manufactured at these manufacturing facilities. In addition, we have no control over the ability of our contract manufacturers to maintain adequate quality control, quality assurance and qualified personnel. If the FDA or a comparable foreign regulatory agency does not approve these facilities for the manufacture of our product candidates or if any agency withdraws its approval in the future, we may need to find alternative manufacturing facilities, which would negatively impact the ability to develop, obtain regulatory approval for or market, if approved, our product candidates. On March 27, 2020, **in response to the COVID- 19 pandemic, former** President Trump signed into law the CARES Act ~~in response to the COVID- 19 pandemic. Throughout the COVID- 19 pandemic~~ , **which** ~~there has been public concern over the availability and accessibility of critical medical products, and the CARES Act enhances~~ **enhanced the** FDA' s ~~existing~~ authority with respect to drug shortage measures. Under the CARES Act, we must have in place a risk management plan that identifies and evaluates the risks to the supply of approved drugs for certain serious diseases or conditions for each establishment where the drug or active pharmaceutical ingredient is manufactured. The risk management plan will be subject to FDA review during an inspection. If we experience shortages in the supply of our product candidates that receive marketing approval, our results could be materially impacted. Our product candidates may compete with other product candidates and marketed drugs for access to manufacturing facilities. **In** ~~For example, since the beginning of the COVID- 19 pandemic, several vaccines for COVID- 19 have received Emergency Use Authorization by the FDA and a number of those later received marketing approval. Additional~~ -- **addition** ~~vaccines may be authorized or approved in the future. The resultant demand for vaccines and potential for manufacturing facilities and materials to be commandeered under the Defense Production Act of 1950~~ , **any** ~~or equivalent foreign legislation, may make it more difficult to obtain materials or manufacturing slots for the products needed for our clinical trials, which could lead to delays in these trials or issues with commercial supply. Any~~ performance failure on the part of our existing or future manufacturers could delay clinical development, marketing approval or commercialization. Our current and anticipated future dependence upon others for the manufacturing of our product candidates may adversely affect our future profit margins and our ability to commercialize any product candidates that receive marketing approval on a timely and competitive basis. The drug substance and drug product for certain of our product candidates are currently acquired from single- source suppliers. The loss of these suppliers, or their failure to supply us with the drug substance

or drug product, could materially and adversely affect our business. The drug substance and drug product for certain of our product candidates are manufactured by single- source suppliers or CMOs under development and manufacturing contracts and services and quality agreements and purchase orders. We do not currently have any other suppliers for the drug substance or drug product of these product candidates and, although we believe that there are alternate sources of supply that could satisfy our clinical and commercial requirements, we cannot assure you that identifying alternate sources and establishing relationships with such sources would not result in significant delay in the development of our product candidates. Our dependence on single-source suppliers exposes us to certain risks, including the following: • our suppliers may cease or reduce production or deliveries, raise prices or renegotiate terms; • delays caused by supply issues may harm our reputation; and • our ability to progress our business could be materially and adversely impacted if our single- source suppliers upon which we rely were to experience a significant business challenges, disruption or failures due to issues such as financial difficulties or bankruptcy, issues relating regulatory or quality compliance issues, or other legal or reputational issues. Additionally, we may not be able to enter into supply arrangements with alternative suppliers on commercially reasonable terms, or at all. A delay in the development of our product candidates or having to enter into a new agreement with a different third party on less favorable terms than we have with our current suppliers could have a material adverse impact upon on our business. If the contract manufacturing facilities on which we rely do not continue to meet regulatory requirements or are unable to meet our supply demands, our business will be harmed. All entities involved in the preparation of product candidates for clinical trials or commercial sale, including our existing CMOs for all of our product candidates, are subject to extensive regulation. Components of a finished therapeutic product approved for commercial sale or used in late- stage clinical trials must be manufactured in accordance with cGMP, or similar regulatory requirements outside the United States. These regulations govern manufacturing processes and procedures, including recordkeeping, and the implementation and operation of quality systems to control and assure the quality of investigational products and products approved for sale. Poor control of production processes can lead to the introduction of contaminants or to inadvertent changes in the properties or stability of our product candidates. Our failure, or the failure of third- party manufacturers, to comply with applicable regulations could result in sanctions being imposed on us, including clinical holds, fines, injunctions, civil penalties, delays, suspension or withdrawal of approvals, license revocation, suspension of production, seizures or recalls of product candidates or marketed drugs, operating restrictions and criminal prosecutions, any of which could significantly and adversely affect clinical or commercial supplies of our product candidates. We or our CMOs must supply all necessary documentation in support of an NDA, BLA or MAA on a timely basis, and must adhere to regulations enforced by the FDA and other regulatory agencies through their facilities inspection program. Some of our CMOs have never produced a commercially approved pharmaceutical product and therefore have not obtained the requisite regulatory authority approvals to do so. The facilities and quality systems of some or all of our third- party contractors must pass a pre- approval inspection for compliance with the applicable regulations as a condition of regulatory approval of our product candidates or any of our other potential products. In addition, the regulatory authorities may, at any time, audit or inspect a manufacturing facility involved with the preparation of our product candidates or our other potential products or the associated quality systems for compliance with the regulations applicable to the activities being conducted. Although we oversee the CMOs, we cannot control the manufacturing process of, and are completely dependent on, our CMO partners for compliance with the regulatory requirements. If these facilities do not pass a pre- approval plant inspection, regulatory approval of the applicable product candidates may not be granted or may be substantially delayed until any violations are corrected to the satisfaction of the regulatory authority, if ever. The regulatory authorities also may, at any time following approval of a product for sale, audit the manufacturing facilities of our third- party contractors. If any such inspection or audit identifies a failure to comply with applicable regulations or if a violation of our product specifications or applicable regulations occurs independent of such an inspection or audit, we or the relevant regulatory authority may require remedial measures that may be costly and / or time consuming for us or a third party to implement, and that may include the temporary or permanent suspension of a clinical trial or commercial sales or the temporary or permanent closure of a facility. Any such remedial measures imposed upon us or third parties with whom we contract could materially harm our business. Additionally, if supply from one approved manufacturer is interrupted, an alternative manufacturer would need to be qualified through an NDA, BLA supplement or MAA variation, or equivalent foreign regulatory filing, which could result in further delay. The regulatory agencies may also require additional studies if a new manufacturer is relied upon for commercial production. In some cases, the technical skills required to manufacture our product candidates may be unique or proprietary to the original CMO and we may have difficulty, or there may be contractual restrictions prohibiting us from, transferring such skills to a back- up or alternate supplier, or we may be unable to transfer such skills at all. In addition, if we are required to change CMOs for any reason, we will be required to verify that the new CMO maintains facilities and procedures that comply with quality standards and with all applicable regulations. We will also need to verify, such as through a manufacturing comparability study, that any new manufacturing process will produce our product or product candidate according to the specifications previously submitted to or approved by the FDA or another regulatory authority. The delays associated with the verification of a new CMO could negatively affect our ability to develop product candidates or once approved, to commercialize those product candidates in a timely manner or within budget. In addition, changes in manufacturers often involve changes in manufacturing procedures and processes, which could require that we conduct bridging studies between our prior clinical supply used in our clinical trials and that of any new manufacturer. We may be unsuccessful in demonstrating the comparability of clinical supplies, which could require the conduct of additional clinical trials. Accordingly, switching manufacturers may involve substantial costs and is likely to result in a delay in our desired clinical and commercial timelines. These factors could cause us to incur higher costs and could cause the delay or termination of clinical trials, regulatory submissions, required approvals, or commercialization of our product candidates. Furthermore, if our suppliers fail to meet contractual requirements and we are unable to secure one or more replacement suppliers capable of production at a substantially equivalent cost, our clinical trials may be delayed or we could lose potential revenue. Collaborative

relationships with third parties could cause us to expend significant resources and incur substantial business risk with no assurance of financial return. We anticipate relying upon strategic collaborations for marketing and commercializing our existing product candidates. For example, Eidos is party to a license agreement with Alexion Pharma International Operations Unlimited Company, or Alexion, pursuant to which we depend on Alexion for the clinical development and commercialization of acoramidis in Japan, and QED ~~has~~ **was** previously ~~entered into~~ **party to** a license and collaboration agreement with Helsinn Healthcare S. A. and Helsinn Therapeutics (U. S.), Inc., to which we refer collectively as Helsinn, pursuant to which QED granted to Helsinn exclusive licenses to develop, manufacture and commercialize QED' s product candidate, infigratinib, in **selected** ~~oncology and all other~~ indications ~~except achondroplasia or any other skeletal dysplasias, worldwide (except for the People' s Republic of China, Hong Kong~~ and **geographic territories. The collaboration** ~~Macau for which regions QED has entered into a partnership~~ with ~~LianBio). We subsequently received a notice of termination of the collaboration from~~ Helsinn, **was terminated effective in March** ~~citing commercial considerations. In December 2022~~ **2023 pursuant to** ~~, we signed~~ a mutual termination agreement. In addition, we may rely even more on strategic collaborations for R & D of other product candidates, and we may sell or license other product offerings through strategic partnerships with pharmaceutical and biotechnology companies. If we enter into R & D collaborations during the early phases of product development, success will in part depend on the performance of research collaborators. We will not directly control the amount or timing of resources devoted by research collaborators to activities related to product candidates. Research collaborators may not commit sufficient resources to our R & D programs. If any research collaborator fails to commit sufficient resources, the preclinical or clinical development programs related to the collaboration could be delayed or terminated. Also, collaborators may pursue existing or other development- stage products or alternative technologies in preference to those being developed in collaboration with us. Finally, if we fail to make required milestone or royalty payments to collaborators or to observe other obligations in agreements with them, the collaborators may have the right to terminate or stop performance of those agreements. Establishing strategic collaborations is difficult and time- consuming. Our discussions with potential collaborators may not lead to the establishment of collaborations on favorable terms, if at all. Potential collaborators may reject collaborations based upon their assessment of our financial, regulatory or intellectual property position. In addition, there have been a significant number of recent business combinations among large pharmaceutical companies that have resulted in a reduced number of potential future collaborators. Even if we successfully establish collaborations, these relationships may never result in the successful development or commercialization of product candidates or the generation of sales revenue. To the extent that we enter into collaborative arrangements, the related product revenues are likely to be lower than if we directly marketed and sold such products. Such collaborators may also consider alternative product candidates or technologies for similar indications that may be available to collaborate on and whether such a collaboration could be more attractive than the one with us for any future product candidate. Management of our relationships with collaborators will require: • significant time and effort from our management team; • coordination of our marketing and R & D programs with the marketing and R & D priorities of our collaborators; and • effective allocation of our resources to multiple projects. If we are unable to establish or maintain such strategic collaborations on terms favorable to us in the future, our R & D efforts and potential to generate revenue may be limited. We are parties to and may seek to enter into additional collaborations, licenses and other similar arrangements, and may not be successful in maintaining existing arrangements or entering into new ones, and even if we are, we may not realize the benefits of such relationships. The success of our collaboration arrangements will depend heavily on the efforts and activities of our collaborators. Collaborations are subject to numerous risks, which may include risks that: • collaborators may have significant discretion in determining the efforts and resources that they will apply to collaborations; • collaborators may not pursue development and commercialization of our product candidates or may elect not to continue or renew development or commercialization programs based on clinical trial results, changes in their strategic focus due to their acquisition of competitive products or their internal development of competitive products, availability of funding or other external factors, such as a business combination that diverts resources or creates competing priorities; • collaborators may delay clinical trials, provide insufficient funding for a development program, stop a clinical trial, abandon a product candidate, repeat or conduct new clinical trials or require a new formulation of a product candidate for clinical testing; • collaborators could independently develop, or develop with third parties, products that compete directly or indirectly with our products or product candidates; • a collaborator with marketing, manufacturing and distribution rights to one or more products may not commit sufficient resources to or otherwise not perform satisfactorily in carrying out these activities; • we could grant exclusive rights to our collaborators that would prevent us from collaborating with others; • collaborators may not properly maintain or defend our intellectual property rights or may use our intellectual property or proprietary information in a way that gives rise to actual or threatened litigation that could jeopardize or invalidate our intellectual property or proprietary information or expose us to potential liability; • disputes may arise between us and a collaborator that cause the delay or termination of the research, development or commercialization of our current or future product candidates or that results in costly litigation or arbitration that diverts management attention and resources; • collaborations may be terminated, which may result in a need for additional capital to pursue further development or commercialization of the applicable current or future products or product candidates; • collaborators may own or co- own intellectual property covering products that result from our collaboration with them, and in such cases, we would not have the exclusive right to develop or commercialize such intellectual property; • disputes may arise with respect to the ownership of any intellectual property developed pursuant to our collaborations; and • a collaborator' s sales and marketing activities or other operations may not be in compliance with applicable laws resulting in civil or criminal proceedings. Additionally, we may seek to enter into additional collaborations, joint ventures, licenses and other similar arrangements for the development or commercialization of our product candidates, due to capital costs required to develop or commercialize the product candidate or manufacturing constraints. We may not be successful in our efforts to establish such collaborations for our product candidates because our research and development pipeline may be insufficient, our product candidates may be deemed to be at too early of

a stage of development for collaborative effort or third parties may not view our product candidates as having the requisite potential to demonstrate safety and efficacy or significant commercial opportunity. In addition, we face significant competition in seeking appropriate strategic partners, and the negotiation process can be time consuming and complex. Further, any future collaboration agreements may restrict us from entering into additional agreements with potential collaborators. We cannot be certain that, following a strategic transaction or license, we will achieve an economic benefit that justifies such transaction. Even if we are successful in our efforts to establish such collaborations, the terms that we agree upon may not be favorable to us, and we may not be able to maintain such collaborations if, for example, development or approval of a product candidate is delayed, the safety of a product candidate is questioned or **actual or projected** sales of an approved product candidate are unsatisfactory. For example, **our license and collaboration agreement with** ~~on August 23, 2022, we received written notice from~~ Helsinn ~~Group, or~~ **for** ~~Helsinn, of its intent to terminate~~ the ~~Amended~~ **development** and **commercialization of** ~~Restated License and Collaboration Agreement (" Amended~~ QED ~~- Helsinn License~~ **' s product candidate, infigratinib, in selected indications** and ~~Collaboration Agreement ")~~ **geographic territories was terminated** for convenience ~~, pursuant to its terms~~ **by Helsinn effective in March 2023** , citing commercial considerations ~~, and in December 2022 we entered into a mutual termination agreement with Helsinn~~ . In addition, any potential future collaborations may be terminable by our strategic partners, and we may not be able to adequately protect our rights under these agreements. Furthermore, strategic partners may negotiate for certain rights to control decisions regarding the development and commercialization of our product candidates, if approved, and may not conduct those activities in the same manner as we do. Any termination of collaborations we enter into in the future, or any delay in entering into collaborations related to our product candidates, could delay the development and commercialization of our product candidates and reduce their competitiveness if they reach the market, which could have a material adverse effect on our business, financial condition and results of operations. Risks Related to Our Intellectual Property If we are unable to obtain and maintain sufficient intellectual property protection for our product candidates, including acoramidis, low- dose infigratinib, BBP- 418, **and** ~~BBP- 631,~~ encaleret ~~and any KRAS inhibitor candidates~~ , or if the scope of the intellectual property protection obtained is not sufficiently broad, our competitors could develop and commercialize products or product candidates similar or identical to ours, and our ability to successfully commercialize our product candidates may be impaired. As is the case with other pharmaceutical and biopharmaceutical companies, our success depends in large part on our ability to obtain and maintain protection of the intellectual property we may own solely and jointly with others, particularly patents, in the United States and other countries with respect to our product candidates and technology. We seek to protect our proprietary position by filing patent applications in the United States and abroad related to our product candidates. Obtaining and enforcing pharmaceutical and biopharmaceutical patents is costly, time consuming and complex, and we may not be able to file and prosecute all necessary or desirable patent applications, or maintain, enforce and license any patents that may issue from such patent applications, at a reasonable cost or in a timely manner. It is also possible that we will fail to identify patentable aspects of our research and development output before it is too late to obtain patent protection. We may not have the right to control the preparation, filing and prosecution of patent applications, or to maintain the rights to patents licensed to third parties. Therefore, these patents and applications may not be prosecuted and enforced in a manner consistent with the best interests of our business. The patent position of biotechnology and pharmaceutical companies generally is highly uncertain, involves complex legal, technological and factual questions and has in recent years been the subject of much litigation. In addition, the laws of foreign countries may not protect our rights to the same extent as the laws of the United States, or vice versa. Further, we may not be aware of all third- party intellectual property rights potentially relating to our product candidates. Publications of discoveries in the scientific literature often lag behind the actual discoveries, and patent applications in the United States and other jurisdictions are typically not published until 18 months after filing or, in some cases, not at all. Therefore, we cannot know with certainty whether we were the first to make the inventions claimed in our patents or pending patent applications, or that we were the first to file for patent protection of such inventions. Furthermore, the scope of a patent claim is determined by an interpretation of the law, the written disclosure in a patent and the patent' s prosecution history and can involve other factors such as expert opinion. Our analysis of these issues, including interpreting the relevance or the scope of claims in a patent or a pending application, determining applicability of such claims to our proprietary technologies, product candidates, predicting whether a third party' s pending patent application will issue with claims of relevant scope, and determining the expiration date of any patent in the United States or abroad that we consider relevant may be incorrect, which may negatively impact our ability to develop and market our product candidates. We do not always conduct independent reviews of pending patent applications of and patents issued to third parties. As a result, the issuance, scope, validity, enforceability and commercial value of our patent rights are highly uncertain. Our pending and future patent applications may not result in patents being issued that protect our product candidates, in whole or in part, or which effectively prevent others from commercializing competitive products. Even if our patent applications issue as patents, they may not issue in a form that will provide us with any meaningful protection, prevent competitors from competing with us or otherwise provide us with any competitive advantage. Our competitors may be able to circumvent our patents by developing similar or alternative product candidates in a non- infringing manner. Our ability to enforce patent rights also depends on our ability to detect infringement. It may be difficult to detect infringers who do not advertise the components or methods that are used in connection with their products and services. Moreover, it may be difficult or impossible to obtain evidence of infringement in a competitor' s or potential competitor' s product or service. We may not prevail in any lawsuits that we initiate and the damages or other remedies awarded if we were to prevail may not be commercially meaningful. If we initiate lawsuits to protect or enforce our patents, or litigate against third- party claims, such proceedings would be expensive and would divert the attention of our management and technical personnel. Such proceedings could also provoke third parties to assert claims against us, including that some or all of the claims in one or more of our patents are invalid or otherwise unenforceable. Moreover, we may be subject to a third- party preissuance submission of prior art to the United States Patent and Trademark Office, or the USPTO, or become involved in opposition, derivation, reexamination, inter

partes review, post- grant review or interference proceedings challenging our patent rights or the patent rights of others. An adverse determination in any such submission, proceeding or litigation could reduce the scope of, or invalidate, our patent rights, allow third parties to commercialize our product candidates and compete directly with us, without payment to us, or result in our inability to manufacture or commercialize drugs without infringing third- party patent rights. In addition, if the breadth or strength of protection provided by our patents and patent applications is threatened, regardless of the outcome, it could dissuade companies from collaborating with us to license, develop or commercialize current or future product candidates. In addition, the issuance of a patent is not conclusive as to its inventorship, scope, validity or enforceability, and our patents may be challenged in the courts or patent offices in the United States and abroad. Such challenges may result in loss of exclusivity or freedom to operate or in patent claims being narrowed, invalidated or held unenforceable, in whole or in part, which could limit our ability to stop others from using or commercializing similar or identical product candidates to ours, or limit the duration of the patent protection of our product candidates. Given the amount of time required for the development, testing and regulatory review of new product candidates, patents protecting such product candidates might expire before or shortly after such product candidates are commercialized. As a result, our patent portfolio may not provide us with sufficient rights to exclude others from commercializing drugs similar or identical to ours. Furthermore, our intellectual property rights may be subject to a reservation of rights by one or more third parties. For example, the research resulting in certain of our patent rights and technology was funded in part by the U. S. government. As a result, the government has certain rights, including march- in rights, to such patent rights and technology. When new technologies are developed with government funding, the government generally obtains certain rights in any resulting patents, including a non- exclusive license authorizing the government to use the invention or to have others use the invention on its behalf. These rights may permit the government to disclose our information to third parties and to exercise march- in rights to use or allow third parties to use our technology **under certain circumstances** . ~~The~~ **For example, the** government ~~can~~ **may** exercise its march- in rights if it determines that action is necessary because we fail to achieve practical application of the government- funded technology, because action is necessary to alleviate health or safety needs, to meet requirements of federal regulations, or to give preference to U. S. industry. In addition, our rights in such inventions may be subject to certain requirements to manufacture products embodying such inventions in the United States. Any exercise by the government of such rights or by any third party of its reserved rights could harm our competitive position, business, financial condition, results of operations, and prospects. Our rights to develop and commercialize our product candidates are subject in part to the terms and conditions of licenses granted to us by others, and the patent protection, prosecution and enforcement for some of our product candidates may be dependent on our licensors. We currently are reliant upon licenses of certain intellectual property rights and proprietary technology from third parties that are important or necessary to the development of our proprietary technology, including technology related to product candidates. These licenses, and other licenses we may enter into in the future, may not provide adequate rights to use such intellectual property rights and proprietary technology in all relevant fields of use or in all territories in which we may wish to develop or commercialize technology, and product candidates in the future. Licenses to additional third- party proprietary technology or intellectual property rights that may be required for our development programs may not be available in the future or may not be available on commercially reasonable terms. In that event, we may be required to expend significant time and resources to redesign our proprietary technology or product candidates or to develop or license replacement technology, which may not be feasible on a technical or commercial basis. If we are unable to do so, we may not be able to develop and commercialize technology, and product candidates in fields of use and territories for which we are not granted rights pursuant to such licenses, which could harm our competitive position, business, financial condition, results of operations and prospects significantly. In some circumstances, we may not have the right to control the preparation, filing, prosecution and enforcement of patent applications, or to maintain the patents, covering technology that we license from third parties. In addition, some of our agreements with our licensors require us to obtain consent from the licensor before we can enforce patent rights, and our licensor may withhold such consent or may not provide it on a timely basis. Therefore, we cannot be certain that our licensors or collaborators will prosecute, maintain, enforce and defend such intellectual property rights in a manner consistent with the best interests of our business, including by taking reasonable measures to protect the confidentiality of know- how and trade secrets, or by paying all applicable prosecution and maintenance fees related to intellectual property registrations for any of our product candidates. We also cannot be certain that our licensors have drafted or prosecuted the patents and patent applications licensed to us in compliance with applicable laws and regulations, which may affect the validity and enforceability of such patents or any patents that may issue from such applications. This could cause us to lose rights in any applicable intellectual property that we in- license, and as a result our ability to develop and commercialize product candidates may be adversely affected and we may be unable to prevent competitors from making, using and selling competing products. In addition, our licensors may own or control intellectual property that has not been licensed to us and, as a result, we may be subject to claims, regardless of their merit, that we are infringing or otherwise violating the licensor' s rights. In addition, while we cannot currently determine the amount of the royalty obligations we would be required to pay on sales of future products, if any, the amounts may be significant. The amount of our future royalty obligations will depend on the technology and intellectual property we use in our product candidates that we successfully develop and commercialize. ~~Therefore, even though we have previously developed and commercialized two approved products, we did not generate significant revenues from sales of those products, and may be unable to achieve or maintain profitability with any future product candidates that we may commercialize.~~ In addition, we may seek to obtain additional licenses from our licensors and, in connection with obtaining such licenses, we may agree to amend our existing licenses in a manner that may be more favorable to the licensors, including by agreeing to terms that could enable third parties (potentially including our competitors) to receive licenses to a portion of the intellectual property rights that are subject to our existing licenses. Any of these events could have a material adverse effect on our competitive position, business, financial condition, results of operations, and prospects **.** If we fail to comply with our obligations in the agreements under which we

license intellectual property rights from third parties, or these agreements are terminated or we otherwise experience disruptions to our business relationships with our licensors, we could lose intellectual property rights that are important to our business. We are party to various agreements that we depend on to operate our business, and our rights to use currently licensed intellectual property, or intellectual property to be licensed in the future, are or will be subject to the continuation of and our compliance with the terms of these agreements. For example, we are a party to an exclusive license agreement with the Board of Trustees of the Leland Stanford Junior University, or Stanford, and may need to obtain additional licenses from others to advance our research and development activities to allow the commercialization of acoramidis or any other product candidates we may identify and pursue. Our license agreement with Stanford imposes, and we expect that future license agreements will impose, various development, diligence, commercialization, and other obligations on us. In particular, under our license agreement with Stanford, we are required to use commercially reasonable efforts to engage in various development and commercialization activities with respect to licensed products, and must satisfy specified milestone and royalty payment obligations. We are also a party to a license agreement with Novartis International Pharmaceutical Ltd. for infigratinib under which we are required to use commercially reasonable efforts to develop infigratinib, and to obtain regulatory approval for and commercialize at least one therapeutic product incorporating infigratinib in the United States and the European Union. ~~We obtained regulatory approval for TRUSELTIQ in the United States in May 2021.~~ In spite of our efforts, our licensors might conclude that we have materially breached our obligations under such license agreements and might therefore terminate the license agreements, thereby removing or limiting our ability to develop and commercialize products and technology covered by these license agreements. For example, if our license agreement with Stanford is terminated, competitors or other third parties would have the freedom to seek regulatory approval of, and to market, products identical to acoramidis and we may be required to cease our development and commercialization of acoramidis. Any of the foregoing could have a material adverse effect on our competitive position, business, financial condition, results of operations and prospects. Moreover, disputes may arise regarding intellectual property subject to a licensing agreement, including: • the scope of rights granted under the license agreement and other interpretation- related issues; • the extent to which our product candidates, technology and processes infringe on intellectual property of the licensor that is not subject to the licensing agreement; • the sublicensing of patent and other rights under our collaborative development relationships; • our diligence obligations under the license agreement and what activities satisfy those diligence obligations; • the inventorship and ownership of inventions and know- how resulting from the joint creation or use of intellectual property by our licensors and us and our partners; and • the priority of invention of patented technology. In addition, certain provisions in our license agreements may be susceptible to multiple interpretations. The resolution of any contract interpretation disagreement that may arise could narrow what we believe to be the scope of our rights to the relevant intellectual property or technology, or increase what we believe to be our financial or other obligations under the agreement, either of which could have a material adverse effect on our business, financial condition, results of operations and prospects. Moreover, if disputes over intellectual property that we have licensed prevent or impair our ability to maintain our current licensing arrangements on commercially acceptable terms, we may be unable to successfully develop and commercialize the affected product candidates, which could have a material adverse effect on our competitive position, business, financial condition, results of operations and prospects. Third- party claims of intellectual property infringement may prevent or delay our development and commercialization efforts. Our commercial success depends in part on our avoiding infringement of the patents and proprietary rights of third parties. However, our research, development and commercialization activities may be subject to claims that we infringe or otherwise violate patents or other intellectual property rights owned or controlled by third parties. There is a substantial amount of litigation, both within and outside the United States, involving patent and other intellectual property rights in the biotechnology and pharmaceutical industries, including patent infringement lawsuits in the courts, and interferences, oppositions ~~and ,~~ inter partes ~~reexamination~~ **review, and other** proceedings before the USPTO, and corresponding foreign patent offices. Numerous U. S. and foreign issued patents and pending patent applications, which are owned by third parties, exist in the fields in which we are pursuing development candidates. As the biotechnology and pharmaceutical industries expand and more patents are issued, the risk increases that acoramidis, low- dose infigratinib, BBP- 418, ~~BBP- 631,~~ encaleret ~~, any KRAS inhibitor candidates~~ or other product candidates that we may identify may be subject to claims of infringement of the patent rights of third parties. Other third parties may assert that we are employing their proprietary technology without authorization. There may be other third- party patents or patent applications with claims to materials, formulations, methods of manufacture or methods for treatment related to the use or manufacture of our product candidates. Because patent applications can take many years to issue, there may be currently pending patent applications which may later result in issued patents that our product candidates may infringe. In addition, third parties may obtain patents in the future and claim that use of our technologies infringes upon these patents. If any third- party patents were held by a court of competent jurisdiction to cover the manufacturing process of our product candidates, any molecules formed during the manufacturing process or any final product itself, the holders of any such patents may be able to block our ability to commercialize such product or product candidate unless we obtained a license under the applicable patents, or until such patents expire. Similarly, if any third- party patents were held by a court of competent jurisdiction to cover aspects of our formulations, processes for manufacture or methods of use, including combination therapy, the holders of any such patents may be able to block our ability to develop and commercialize the applicable product or product candidate unless we obtained a license or until such patent expires. In either case, such a license may not be available on commercially reasonable terms or at all, or it may be non- exclusive, which could result in our competitors gaining access to the same intellectual property rights. Parties making claims against us may obtain injunctive or other equitable relief, which could effectively block our ability to further develop and commercialize our product candidates. Defense of these claims, regardless of their merit, would involve substantial litigation expense and would be a substantial diversion of employee resources from our business. In the event of a successful claim of infringement against us, we may have to pay substantial damages, including treble damages and attorneys' fees for willful infringement, pay royalties, redesign our

infringing products or obtain one or more licenses from third parties, which may be impossible or require substantial time and monetary expenditure. Parties making claims against us may be able to sustain the costs of complex patent litigation more effectively than we can because they have substantially greater resources. Furthermore, because of the substantial amount of discovery required in connection with intellectual property litigation or administrative proceedings, there is a risk that some of our confidential information could be compromised by disclosure. In addition, any uncertainties resulting from the initiation and continuation of any litigation could have material adverse effect on ability to raise additional funds or otherwise have a material adverse effect on our business, results of operations, financial condition and prospects. Patent terms may be inadequate to protect our competitive position on product candidates for an adequate amount of time. Patents have a limited lifespan. In the United States, if all maintenance fees are timely paid, the natural expiration of a patent is generally 20 years from its earliest U. S. non- provisional or international patent application filing date. Various extensions may be available, but the life of a patent, and the protection it affords, is limited. Even if patents covering our product candidates are obtained, once the patent life has expired, we may be open to competition from competitive products, including generics or biosimilars. Given the amount of time required for the development, testing and regulatory review of products or new product candidates, patents protecting such products or candidates might expire before or shortly after such products or candidates are commercialized. As a result, our owned and licensed patent portfolio may not provide us with sufficient rights to exclude others from commercializing products similar or identical to ours. If we are not able to obtain, or in applicable cases maintain, patent term extension or non- patent exclusivity in the United States under the Hatch- Waxman Act and in foreign countries under similar legislation, thereby potentially extending the marketing exclusivity term of our product candidates, our business may be materially harmed. Depending upon the timing, duration and specifics of FDA marketing approval of our product candidates, one of the U. S. patents covering each of such products or product candidates or the use thereof may be eligible for up to five years of patent term extension under the Hatch- Waxman Act. The Hatch- Waxman Act allows a maximum of one patent to be extended per FDA approved product as compensation for the patent term lost during the FDA regulatory review process. A patent term extension cannot extend the remaining term of a patent beyond a total of 14 years from the date of product approval and only those claims covering such approved drug product, a method for using it or a method for manufacturing it may be extended. Patent term extension also may be available in certain foreign countries upon regulatory approval of our product candidates. Nevertheless, we may not be granted patent term extension either in the United States or in any foreign country because of, for example, failing to exercise due diligence during the testing phase or regulatory review process, failing to apply within applicable deadlines, failing to apply prior to expiration of relevant patents or otherwise failing to satisfy applicable requirements. Moreover, the term of extension, as well as the scope of patent protection during any such extension, afforded by the governmental authority could be less than we request. If we are unable to obtain patent term extension, or the term of any such extension is less than we request, the period during which we will have the right to exclusively market any products that may be approved, may be shortened and our competitors may obtain approval of competing products following our patent expiration sooner, and our revenue could be reduced, possibly materially. It is possible that we will not obtain patent term extension under the Hatch- Waxman Act for a U. S. patent covering a product candidate even where that patent is eligible for patent term extension, or if we obtain such an extension, it may be for a shorter period than we had sought. Further, for certain of our licensed patents, we do not have the right to control prosecution, including filing with the USPTO, an application for patent term extension under the Hatch- Waxman Act. Thus, if one of our licensed patents is eligible for patent term extension under the Hatch- Waxman Act, we may not be able to control whether an application to obtain a patent term extension is filed, or an extension obtained, from the USPTO. Also, there are detailed rules and requirements regarding the patents that may be submitted to the FDA for listing in the Approved Drug Products with Therapeutic Equivalence Evaluations, or the Orange Book. We may be unable to obtain patents covering our product candidates that contain one or more claims that satisfy the requirements for listing in the Orange Book. Even if we submit a patent for listing in the Orange Book, the FDA may decline to list the patent, or a manufacturer of generic drugs may challenge the listing. If one of our current product candidates is approved and a patent covering that product candidate is not listed in the Orange Book, a manufacturer of generic drugs would not have to provide advance notice to us of any abbreviated new drug application, or ANDA, filed with the FDA to obtain permission to sell a generic version of such product. Depending upon the timing and specifics of marketing approval of our products, the FDA and other applicable regulatory authorities may grant certain non- patent exclusivities. Although we intend to seek new chemical entity exclusivity, and potentially other exclusivities, for product candidates we are developing, we may not be successful in doing so. Moreover, these non- patent exclusivities, if granted, are limited and other companies may be able to submit marketing applications and receive approval earlier than we anticipate. If we are unable to protect the confidentiality of our trade secrets, the value of our technology could be materially adversely affected and our business would be harmed. We seek to protect our confidential proprietary information, in part, by confidentiality agreements and invention assignment agreements with our employees, consultants, scientific advisors, contractors and collaborators. These agreements are designed to protect our proprietary information. However, we cannot be certain that such agreements have been entered into with all relevant parties, and we cannot be certain that our trade secrets and other confidential proprietary information will not be disclosed or that competitors will not otherwise gain access to our trade secrets or independently develop substantially equivalent information and techniques. For example, any of these parties may breach the agreements and disclose proprietary information, including trade secrets, and we may not be able to obtain adequate remedies for such breaches. We also seek to preserve the integrity and confidentiality of our confidential proprietary information by maintaining physical security of our premises and physical and electronic security of our information technology systems, but it is possible that these security measures could be breached. If any of our confidential proprietary information were to be lawfully obtained or independently developed by a competitor, we would have no right to prevent such competitor from using that technology or information to compete with us, which could harm our competitive position. Unauthorized parties may also attempt to copy or reverse engineer certain aspects of our product

candidates that we consider proprietary. We may not be able to obtain adequate remedies in the event of such unauthorized use. Enforcing a claim that a party illegally disclosed or misappropriated a trade secret can be difficult, expensive and time-consuming, and the outcome is unpredictable. In addition, some courts inside and outside the United States are less willing or unwilling to protect trade secrets. Trade secrets will also over time be disseminated within the industry through independent development, the publication of journal articles and the movement of personnel skilled in the art from company to company or academic to industry scientific positions. Though our agreements with third parties typically restrict the ability of our advisors, employees, collaborators, licensors, suppliers, third- party contractors and consultants to publish data potentially relating to our trade secrets, our agreements may contain certain limited publication rights. In addition, if any of our trade secrets were to be lawfully obtained or independently developed by a competitor, we would have no right to prevent such competitor from using that technology or information to compete with us, which could harm our competitive position. Despite employing the contractual and other security precautions described above, the need to share trade secrets increases the risk that such trade secrets become known by our competitors, are inadvertently incorporated into the technology of others, or are disclosed or used in violation of these agreements. If any of these events occurs or if we otherwise lose protection for our trade secrets, the value of this information may be greatly reduced and our competitive position, business, financial condition, results of operations, and prospects would be harmed. If our trademarks and trade names are not adequately protected, then we may not be able to build name recognition in our markets of interest and our business may be adversely affected. Our registered or unregistered trademarks or trade names, may be challenged, infringed, circumvented or declared generic or determined to be infringing on other marks. We may not be able to protect our rights to these trademarks and trade names, which we need to build name recognition among potential collaborators or customers in our markets of interest. At times, competitors may adopt trade names or trademarks similar to ours, thereby impeding our ability to build brand identity and possibly leading to market confusion. In addition, there could be potential trade name or trademark infringement claims brought by owners of other trademarks or trademarks that incorporate variations of our registered or unregistered trademarks or trade names. Over the long term, if we are unable to establish name recognition based on our trademarks and trade names, then we may not be able to compete effectively and our business may be adversely affected. We may license our trademarks and trade names to third parties, such as distributors. Though these license agreements may provide guidelines for how our trademarks and trade names may be used, a breach of these agreements or misuse of our trademarks and tradenames by our licensees may jeopardize our rights in or diminish the goodwill associated with our trademarks and trade names. Our efforts to enforce or protect our proprietary rights related to trademarks, trade names, trade secrets, domain names, copyrights or other intellectual property may be ineffective and could result in substantial costs and diversion of resources and could adversely affect our competitive position, business, financial condition, results of operations and prospects. We may become involved in lawsuits to protect or enforce our patents or other intellectual property, which could be expensive, time consuming and unsuccessful. Competitors may infringe our patents or other intellectual property. If we were to initiate legal proceedings against a third party to enforce a patent covering one or more of our product candidates, the defendant could counterclaim that the patent covering our product candidate is invalid and / or unenforceable. In patent litigation in the United States, defendant counterclaims alleging invalidity and / or unenforceability are commonplace. Grounds for a validity challenge could be an alleged failure to meet any of several statutory requirements, including novelty, nonobviousness, written description or enablement. Grounds for an unenforceability assertion could be an allegation that someone connected with prosecution of the patent withheld relevant information from the USPTO, or made a misleading statement, during prosecution. The outcome following legal assertions of invalidity and unenforceability is unpredictable. Interference or derivation proceedings provoked by third parties or brought by us or declared by the USPTO may be necessary to determine the priority of inventions with respect to our patents or patent applications. An unfavorable outcome could require us to cease using the related technology or to attempt to license rights to it from the prevailing party. Our business could be harmed if the prevailing party does not offer us a license on commercially reasonable terms or at all, or if a non-exclusive license is offered and our competitors gain access to the same technology. Our defense of litigation or interference or derivation proceedings may fail and, even if successful, may result in substantial costs and distract our management and other employees. In addition, the uncertainties associated with litigation could have a material adverse effect on our ability to raise the funds necessary to continue clinical trials, continue research programs, license necessary technology from third parties, enter into development partnerships that would help us bring product candidates to market. Furthermore, because of the substantial amount of discovery required in connection with intellectual property litigation, there is a risk that some of our confidential information could be compromised by disclosure during this type of litigation. There could also be public announcements of the results of hearings, motions, or other interim proceedings or developments. If securities analysts or investors perceive these results to be negative, it could have a material adverse effect on the price of our common stock. We may be subject to claims challenging the inventorship of our patents and other intellectual property. Our agreements with employees and our personnel policies provide that any inventions conceived by an individual in the course of rendering services to us shall be our exclusive property. Although our policy is to have all such individuals enter into these agreements, we may not obtain these agreements in all circumstances, and individuals with whom we have these agreements may not comply with their terms. The assignment of intellectual property may not be automatic upon the creation of an invention and despite such agreement, such inventions may become assigned to third parties. In the event of unauthorized use or disclosure of our trade secrets or proprietary information, these agreements, even if obtained, may not provide meaningful protection, particularly for our trade secrets or other confidential information. We or our licensors may be subject to claims that former employees, collaborators or other third parties have an interest in our owned or in- licensed patents, trade secrets, or other intellectual property as an inventor or co-inventor. For example, we or our licensors may have inventorship disputes arise from conflicting obligations of employees, consultants or others who are involved in developing our product candidates. Litigation may be necessary to defend against these and other claims challenging inventorship or our or our licensors' ownership of our owned or in- licensed patents, trade

secrets or other intellectual property. If we or our licensors fail in defending any such claims, in addition to paying monetary damages, we may lose valuable intellectual property rights, such as exclusive ownership of, or right to use, intellectual property that is important to our product candidates. Even if we are successful in defending against such claims, litigation could result in substantial costs and be a distraction to management and other employees. Issued patents covering our product candidates could be found invalid or unenforceable if challenged in court. If we or one of our licensing partners initiated legal proceedings against a third party to enforce a patent covering one or more of our product candidates, the defendant could counterclaim that the patent covering the relevant product candidate is invalid and / or unenforceable. In patent litigation in the United States, defendant counterclaims alleging invalidity and / or unenforceability are commonplace. Grounds for a validity challenge could be an alleged failure to meet any of several statutory requirements, including novelty, nonobviousness, written description or enablement. Grounds for an unenforceability assertion could be an allegation that someone connected with prosecution of the patent withheld relevant information from the USPTO, or made a misleading statement, during prosecution. Third parties may also raise similar claims before administrative bodies in the United States or abroad, even outside the context of litigation. Such mechanisms include re- examination, post grant review, and equivalent proceedings in foreign jurisdictions (e. g., opposition proceedings). Such proceedings could result in revocation or amendment to our patents in such a way that they no longer cover our products or product candidates. The outcome following legal assertions of invalidity and unenforceability is unpredictable. With respect to the validity question, for example, we cannot be certain that there is no invalidating prior art, of which we and the patent examiner were unaware during prosecution. If a defendant were to prevail on a legal assertion of invalidity and / or unenforceability, we would lose at least part, and perhaps all, of the patent protection on our product candidates. Such a loss of patent protection would have a material adverse impact on our business. We may be subject to claims that our employees, consultants or independent contractors have wrongfully used or disclosed confidential information of third parties or that our employees have wrongfully used or disclosed alleged trade secrets of their former employers. As is common in the biotechnology and pharmaceutical industry, we employ individuals who were previously employed at universities or other biotechnology or pharmaceutical companies, including our competitors or potential competitors. Although we try to ensure that our employees, consultants and independent contractors do not use the proprietary information or know- how of others in their work for us, we may be subject to claims that we or our employees, consultants or independent contractors have inadvertently or otherwise used or disclosed intellectual property, including trade secrets or other proprietary information, of any of our employee' s former employer or other third parties. Litigation may be necessary to defend against these claims. If we fail in defending any such claims, in addition to paying monetary damages, we may lose valuable intellectual property rights or personnel, which could adversely impact our business. Even if we are successful in defending against such claims, litigation could result in substantial costs and be a distraction to management and other employees. Obtaining and maintaining our patent protection depends on compliance with various procedural, document submission, fee payment and other requirements imposed by governmental patent agencies, and our patent protection could be reduced or eliminated for non- compliance with these requirements. Periodic maintenance fees, renewal fees, annuity fees and various other governmental fees on patents and / or applications will be due to be paid to the USPTO and various governmental patent agencies outside of the United States in several stages over the lifetime of the patents and / or applications. We have systems in place to remind us to pay these fees, and we employ an outside ~~firm~~ **entity** and rely on outside counsel to pay these fees due to non- U. S. patent agencies. However, we cannot guarantee that our licensors have similar systems and procedures in place to pay such fees. The USPTO and various non- U. S. governmental patent agencies require compliance with a number of procedural, documentary, fee payment and other similar provisions during the patent application process. We employ reputable law firms and other professionals to help us comply, and in many cases, an inadvertent lapse can be cured by payment of a late fee or by other means in accordance with the applicable rules. However, there are situations in which non- compliance can result in abandonment or lapse of the patent or patent application, resulting in partial or complete loss of patent rights in the relevant jurisdiction. In such an event, our competitors might be able to enter the market and this circumstance would have a material adverse effect on our business. We may not be able to protect our intellectual property rights throughout the world. Filing, prosecuting and defending patents on our product candidates in all countries throughout the world would be prohibitively expensive, and our intellectual property rights in some countries outside the United States can be less extensive than those in the United States. In addition, the laws of some foreign countries do not protect intellectual property rights to the same extent as federal and state laws in the United States. Consequently, we may not be able to prevent third parties from practicing our inventions in all countries outside the United States, or from selling or importing products made using our inventions in and into the United States or other jurisdictions. Competitors may use our technologies in jurisdictions where we have not obtained patent protection to develop their own products and may also export infringing products to territories where we have patent protection, but enforcement is not as strong as that in the United States. These products may compete with our products, and our patents or other intellectual property rights may not be effective or sufficient to prevent them from competing. Many companies have encountered significant problems in protecting and defending intellectual property rights in foreign jurisdictions. The legal systems of certain countries, particularly certain developing countries, do not favor the enforcement of patents, trade secrets, and other intellectual property protection, particularly those relating to biotechnology and pharmaceutical products, which could make it difficult for us to stop the infringement of our patents or marketing of competing products in violation of our proprietary rights generally. Proceedings to enforce our patent rights in foreign jurisdictions, whether or not successful, could result in substantial costs and divert our efforts and attention from other aspects of our business, could put our patents at risk of being invalidated or interpreted narrowly and our patent applications at risk of not issuing and could provoke third parties to assert claims against us. We may not prevail in any lawsuits that we initiate and the damages or other remedies awarded, if any, may not be commercially meaningful. Accordingly, our efforts to enforce our intellectual property rights around the world may be inadequate to obtain a significant commercial advantage from the intellectual property that we develop or license. Changes in U. S. patent law could diminish the

value of patents in general, thereby impairing our ability to protect our products. Changes in either the patent laws or interpretation of the patent laws in the United States could increase the uncertainties and costs surrounding the prosecution of patent applications and the enforcement or defense of issued patents. Assuming that other requirements for patentability are met, prior to March 2013, in the United States, the first to invent the claimed invention was entitled to a patent, while outside the United States, the first to file a patent application was entitled to the patent. After March 2013, under the Leahy- Smith America Invents Act, or the America Invents Act, enacted in September 2011, the United States transitioned to a first inventor to file system in which, assuming that other requirements for patentability are met, the first inventor to file a patent application will be entitled to the patent on an invention regardless of whether a third party was the first to invent the claimed invention. A third party that files a patent application in the USPTO after March 2013, but before us could therefore be awarded a patent covering an invention of ours even if we had made the invention before it was made by such third party. This will require us to be cognizant of the time from invention to filing of a patent application. Since patent applications in the United States and most other countries are confidential for a period of time after filing or until issuance, we cannot be certain that we or our licensors were the first to either (i) file any patent application related to our product candidates or (ii) invent any of the inventions claimed in our or our licensor' s patents or patent applications. The America Invents Act also includes a number of significant changes that affect the way patent applications are prosecuted and also may affect patent litigation. These include allowing third party submission of prior art to the USPTO during patent prosecution and additional procedures to attack the validity of a patent by USPTO administered post- grant proceedings, including post- grant review, inter partes review, and derivation proceedings. Because of a lower evidentiary standard in USPTO proceedings compared to the evidentiary standard in United States federal courts necessary to invalidate a patent claim, a third party could potentially provide evidence in a USPTO proceeding sufficient for the USPTO to hold a claim invalid even though the same evidence would be insufficient to invalidate the claim if first presented in a federal district court action. Accordingly, a third party may attempt to use the USPTO procedures to invalidate our patent claims that would not have been invalidated if first challenged by the third party as a defendant in a federal district court action. Therefore, the America Invents Act and its implementation could increase the uncertainties and costs surrounding the prosecution of our owned or in- licensed patent applications and the enforcement or defense of our owned or in- licensed issued patents, all of which ~~could have a material adverse effect on our competitive position, business, financial condition, results of operations, and prospects.~~ In addition, the patent positions of companies in the development and commercialization of pharmaceuticals are particularly uncertain. Recent U. S. Supreme Court rulings have narrowed the scope of patent protection available in certain circumstances and weakened the rights of patent owners in certain situations. This combination of events has created uncertainty with respect to the validity and enforceability of patents, once obtained. Depending on future actions by the U. S. Congress, the federal courts, and the USPTO, the laws and regulations governing patents could change in unpredictable ways that could have a material adverse effect on our existing patent portfolio and our ability to protect and enforce our intellectual property rights in the future. Risks Related to Commercialization Our product candidates, if approved, may fail to achieve the degree of market acceptance by physicians, patients, healthcare payors, and others in the medical community necessary for commercial success. The commercial success of our product candidates, if approved, will depend upon their degree of market acceptance by physicians, patients, third- party payors, and others in the medical community. Our product candidates, if approved, may nonetheless fail to gain sufficient market acceptance by physicians, patients, healthcare payors, and others in the medical community. The degree of market acceptance of our product candidates we may develop, if approved for commercial sale, will depend on a number of factors, including: • the efficacy and safety of such product candidates as demonstrated in pivotal clinical trials and published in peer- reviewed journals; • the potential and perceived advantages compared to alternative treatments, including any similar generic treatments; • the ability to offer these products for sale at competitive prices; • the ability to offer appropriate patient access programs, such as co- pay assistance; • convenience and ease of dosing and administration compared to alternative treatments; • the clinical indications for which the product candidate is approved by the FDA or comparable regulatory authorities; • product labeling or product insert requirements of the FDA or other comparable foreign regulatory authorities, including any limitations, contraindications or warnings contained in a product' s approved labeling; • restrictions on how the product is distributed; • the timing of market introduction of competitive products; • publicity concerning these products or competing products and treatments; • the strength of marketing and distribution support; • favorable third- party coverage and sufficient reimbursement or other assistance for patients who are uninsured or underinsured; and • the prevalence and severity of any side effects or AEs. Sales of medical products also depend on the willingness of physicians to prescribe the treatment, which is likely to be based on a determination by these physicians that the products are safe, therapeutically effective and cost effective. In addition, the inclusion or exclusion of products from treatment guidelines established by various physician groups and the viewpoints of influential physicians can affect the willingness of other physicians to prescribe the treatment. We cannot predict whether physicians, physicians' organizations, hospitals, other healthcare providers, government agencies or private insurers will determine that our products are safe, therapeutically effective and cost effective as compared with competing treatments. If any product candidates we develop do not achieve an adequate level of acceptance, we may not generate significant product revenue, and we may not become profitable. If we are unable to establish sales and marketing capabilities or enter into agreements with third parties to sell and market any product candidates we may develop, we may not be successful in commercializing those product candidates if and when they are approved. To achieve commercial success for any approved product for which we retain sales and marketing responsibilities, we must continue to develop a sales and marketing organization or outsource these functions to third parties. In the future, we may choose to grow our focused sales, marketing, and commercial support infrastructure to market and sell our product candidates, if and when they are approved. We may also elect to enter into collaborations or strategic partnerships with third parties to engage in commercialization activities with respect to selected product candidates, indications or geographic territories, including territories outside the United States, as we did with Helsinn in the case of ~~TRUSELTIQ~~ **TRUSELTIQTM** once it was

approved, although there is no guarantee we will be able to enter into similar arrangements in the future even if the intent is to do so. There are risks involved with both establishing our own commercial capabilities and entering into arrangements with third parties to perform these services. For example, recruiting and training a sales force or reimbursement specialists is expensive and time consuming and could delay any product launch. If the commercial launch of a product candidate for which we recruit a sales force and establish marketing and other commercialization capabilities is delayed or does not occur for any reason, we would have prematurely or unnecessarily incurred these commercialization expenses. This may be costly, and our investment would be lost if we cannot retain or reposition commercialization personnel. Factors that may inhibit our efforts to commercialize any approved product on our own include: • the inability to recruit and retain adequate numbers of effective sales, marketing, reimbursement, customer service, medical affairs, and other support personnel; • the inability of sales personnel to obtain access to physicians or persuade adequate numbers of physicians to prescribe any future approved products; • the inability of reimbursement professionals to negotiate arrangements for formulary access, reimbursement, and other acceptance by payors; • the inability to price products at a sufficient price point to ensure an adequate and attractive level of profitability; • manufacturing disruptions that delay or prevent the launch of any approved products; • the lack of complementary products to be offered by sales personnel, which may put us at a competitive disadvantage relative to companies with more extensive product lines; and • unforeseen costs and expenses associated with creating an independent commercialization organization. If we enter into arrangements with third parties to perform sales, marketing, commercial support, and distribution services, our product revenue or the profitability of product revenue may be lower than if we were to market and sell any products we may develop internally. In addition, we may not be successful in entering into arrangements with third parties to commercialize, if approved, our product candidates or may be unable to do so on terms that are favorable to us or them. We may have little control over such third parties, and any of them may fail to devote the necessary resources and attention to sell and market our products effectively or may expose us to legal and regulatory risk by not adhering to regulatory requirements and restrictions governing the sale and promotion of prescription drug products, including those restricting off-label promotion. If we do not continue to build on our commercialization capabilities successfully, either on our own or in collaboration with third parties, we will not be successful in commercializing our product candidates, if approved. The insurance coverage and reimbursement status of newly- approved products is uncertain. Our product candidates may become subject to unfavorable pricing regulations, third- party coverage and reimbursement practices, or healthcare reform initiatives, which would harm our business. Failure to obtain or maintain adequate coverage and reimbursement for new or current products could limit our ability to market those products and decrease our ability to generate revenue. The regulations that govern marketing approvals, pricing, coverage, and reimbursement for new drugs vary widely from country to country. In the United States, recently enacted legislation may significantly change the approval requirements in ways that could involve additional costs and cause delays in obtaining approvals. Some countries require approval of the sale price of a drug before it can be marketed. In many countries, the pricing review period begins after marketing or product licensing approval is granted. In some foreign markets, prescription pharmaceutical pricing remains subject to continuing governmental control even after initial approval is granted. As a result, we might obtain marketing approval for a product in a particular country, but then be subject to price regulations that delay our commercial launch of the product, possibly for lengthy time periods, and negatively impact the revenue we are able to generate from the sale of the product in that country. Adverse pricing limitations may hinder our ability to recoup our investment in one or more product candidates even if those product candidates may obtain marketing approval. See the section ~~entitled~~ -- **titled** , " Business — Government Regulation — Coverage and Reimbursement. " Our ability to successfully commercialize our product candidates also will depend in part on the extent to which coverage and adequate reimbursement for these products and related treatments will be available from government health administration authorities, private health insurers, and other organizations. Government authorities and third- party payors, such as private health insurers and health maintenance organizations, decide which medications they will pay for and establish reimbursement levels. The availability of coverage and extent of reimbursement by governmental and private payors is essential for most patients to be able to afford treatments such as gene therapy products. Sales of these product candidates or other product candidates, if approved, that we may identify will depend substantially, both domestically and abroad, on the extent to which the costs of our product candidates will be paid by health maintenance, managed care, pharmacy benefit and similar healthcare management organizations, or reimbursed by government health administration authorities, private health coverage insurers and other third-party payors. If coverage and adequate reimbursement is not available, or is available only to limited levels, we may not be able to successfully commercialize our product candidates. Even if coverage is provided, the approved reimbursement amount may not be high enough to allow us to establish or maintain pricing sufficient to realize a sufficient return on our investment. Additionally, we may develop companion diagnostic tests for use with our product candidates. We, or our collaborators, may be required to obtain coverage and reimbursement for these tests separate and apart from the coverage and reimbursement we seek for our product candidates, once approved. Even if we obtain regulatory approval or clearance for such companion diagnostics, there is significant uncertainty regarding our ability to obtain coverage and adequate reimbursement for the same reasons applicable to our product candidates. Medicare reimbursement methodologies, whether under Part A, Part B, or clinical laboratory fee schedule may be amended from time to time, and we cannot predict what effect any change to these methodologies would have on any product or product candidate or companion diagnostic for which we receive approval. Our inability to promptly obtain coverage and adequate reimbursement from both third- party payors for the companion diagnostic tests that we develop and for which we obtain regulatory approval could have a material and adverse effect on our business, financial condition, results of operations and prospects. If we fail to comply with healthcare laws, we could face substantial penalties and our business, operations and financial conditions could be adversely affected. Healthcare providers, physicians and third- party payors in the United States and elsewhere play a primary role in the recommendation and prescription of pharmaceutical products. Arrangements with third- party payors and customers can expose pharmaceutical manufacturers to

broadly applicable fraud and abuse and other healthcare laws and regulations, which may constrain the business or financial arrangements and relationships through which such companies sell, market and distribute pharmaceutical products. In particular, the promotion, sales and marketing of healthcare items and services, as well as certain business arrangements in the healthcare industry, are subject to extensive laws designed to prevent fraud, kickbacks, self- dealing and other abusive practices. These laws and regulations may restrict or prohibit a wide range of ownership, pricing, discounting, marketing and promotion, structuring and commission (s), certain customer incentive programs and other business arrangements generally. Activities subject to these laws also involve the improper use of information obtained in the course of patient recruitment for clinical trials. See the section ~~entitled~~ -- **titled** , " Business — Government Regulation — Other Regulatory Matters. " Because of the breadth of these laws and the narrowness of the statutory exceptions and regulatory safe harbors available, it is possible that some of our business activities, including compensation of physicians with stock or stock options, could, despite efforts to comply, be subject to challenge under one or more of such laws. Additionally, the FDA or foreign regulators may not agree that we have mitigated any risk of bias in our clinical trials due to payments or equity interests provided to investigators or institutions which could limit a regulator' s acceptance of those clinical trial data in support of a marketing application. Moreover, efforts to ensure that our business arrangements will comply with applicable healthcare laws may involve substantial costs. It is possible that governmental and enforcement authorities will conclude that our business practices may not comply with current or future statutes, regulations or case law interpreting applicable fraud and abuse or other healthcare laws and regulations. If any such actions are instituted against us, and we are not successful in defending ourselves or asserting our rights, those actions could have a significant impact on our business, including the imposition of significant civil, criminal and administrative penalties, damages, disgorgement, monetary fines, exclusion from participation in Medicare, Medicaid and other federal healthcare programs, integrity and oversight agreements to resolve allegations of non- compliance, contractual damages, reputational harm, diminished profits and future earnings, and curtailment or restructuring of our operations, any of which could adversely affect our ability to operate our business and our results of operations. In addition, the approval and commercialization of any of our product candidates outside the United States will also likely subject us to foreign equivalents of the healthcare laws mentioned above, among other foreign laws. Third party patient assistance programs that receive financial support from companies have become the subject of enhanced government and regulatory scrutiny. Government enforcement agencies have shown increased interest in pharmaceutical companies ~~'~~ **'** product and patient assistance programs, including reimbursement support services, and a number of investigations into these programs have resulted in significant civil and criminal settlements. The U. S. government has established guidelines that suggest that it is lawful for pharmaceutical manufacturers to make donations to charitable organizations who provide co- pay assistance to Medicare patients, provided that such organizations, among other things, are bona fide charities, are entirely independent of and not controlled by the manufacturer, provide aid to applicants on a first- come basis according to consistent financial criteria and do not link aid to use of a donor ~~'~~ **'** s product. However, donations to patient assistance programs have received some negative publicity and have been the subject of multiple government enforcement actions, related to allegations regarding their use to promote branded pharmaceutical products over other less costly alternatives. Specifically, in recent years, there have been multiple settlements resulting out of government claims challenging the legality of their patient assistance programs under a variety of federal and state laws. It is possible that we may make grants to independent charitable foundations that help financially needy patients with their premium, co- pay, and co- insurance obligations. If we choose to do so, and if we or our vendors or donation recipients are deemed to fail to comply with relevant laws, regulations or evolving government guidance in the operation of these programs, we could be subject to damages, fines, penalties, or other criminal, civil, or administrative sanctions or enforcement actions. We cannot ensure that our compliance controls, policies, and procedures will be sufficient to protect against acts of our employees, business partners, or vendors that may violate the laws or regulations of the jurisdictions in which we operate. Regardless of whether we have complied with the law, a government investigation could impact our business practices, harm our reputation, divert the attention of management, increase our expenses, and reduce the availability of foundation support for our patients who need assistance. Further, it is possible that changes in insurer policies regarding co- pay coupons and / or the introduction and enactment of new legislation or regulatory action could restrict or otherwise negatively affect these patient support programs, which could result in fewer patients using affected products, and therefore could have a material adverse effect on our sales, business, and financial condition. Although a number of these and other proposed measures may require authorization through additional legislation to become effective, and the current U. S. presidential administration may reverse or otherwise change these measures, both the current U. S. presidential administration and Congress have indicated that they will continue to seek new legislative measures to control drug costs. We cannot predict how the implementation of and any further changes to this rule will affect our business. Failure to comply with health and data protection laws and regulations could lead to government enforcement actions (which could include civil or criminal penalties), private litigation and / or adverse publicity, and could negatively affect our operating results and business. We and any potential collaborators may be subject to federal, state, and foreign data protection laws and regulations (i. e., laws and regulations that address privacy and data security). In the United States, numerous federal and state laws and regulations, including federal health information privacy laws, state data breach notification laws, state health information privacy laws, and federal and state consumer protection laws (e. g., Section 5 of the Federal Trade Commission Act), that govern the collection, use, disclosure and protection of health- related and other personal information could apply to our operations or the operations of our collaborators. In addition, we may obtain health information from third parties (including research institutions from which we obtain clinical trial data) that are subject to privacy and security requirements under HIPAA, as amended by the Health Information Technology for Economic and Clinical Health Act of 2009, or HITECH. Depending on the facts and circumstances, we could be subject to civil, criminal, and administrative penalties if we knowingly obtain, use, or disclose individually identifiable health information maintained by a HIPAA- covered entity in a manner that is not authorized or permitted by HIPAA. ~~California recently enacted~~ **In addition, as discussed further in the section titled, " Business — Government**

Regulation — ~~the~~ Other Regulatory Matters ~~California Consumer Privacy Act~~ **, " a number of U. S. states have passed** or **are considering comprehensive** ~~CCPA, which creates new individual~~ privacy ~~rights for California consumers (as defined in the law~~ **laws** ~~) and places increased privacy and security obligations on entities handling personal data of consumers or households. Further, a new privacy law, the California Privacy Rights Act, or CPRA, was passed by California voters on November 3, 2020. The CPRA will create additional obligations relating to personal information effective January 1, 2023 (with certain provisions having retroactive effect to January 1, 2022). While the legislation and proposed regulations include the CCPA and CPRA contain an exception for activities~~ that **may** ~~are subject to HIPAA, we cannot yet determine the~~ impact ~~the CCPA, CPRA or other such future laws, regulations and standards may have on~~ our business. The uncertainty surrounding the implementation of **recent** ~~the CCPA, CPRA~~ and ~~other similar~~ **emerging state privacy** laws, regulations and standards that may be adopted in other jurisdictions exemplifies the vulnerability of our business to the evolving regulatory environment related to personal data and protected health information. Compliance with U. S. and international data protection laws and regulations could require us to take on more onerous obligations in our contracts, restrict our ability to collect, use and disclose data, or in some cases, impact our ability to operate in certain jurisdictions. Failure to comply with these laws and regulations could result in government enforcement actions (which could include civil, criminal and administrative penalties), private litigation, and / or adverse publicity and could negatively affect our operating results and business. Moreover, clinical trial subjects, employees and other individuals about whom we or our potential collaborators obtain personal information, as well as the providers who share this information with us, may limit our ability to collect, use and disclose the information. Claims that we have violated individuals' privacy rights, failed to comply with data protection laws, or breached our contractual obligations, even if we are not found liable, could be expensive and time- consuming to defend and could result in adverse publicity that could harm our business. ~~Additionally, some observers have noted~~ **Artificial intelligence presents risks and challenges** that **can impact our business including by posing security risks to our confidential information, proprietary information, and personal data. Issues in** the ~~CCPA~~ **development and use of artificial intelligence, combined with** ~~and~~ **an** ~~CPRA~~ **uncertain regulatory environment, may result in reputational harm, liability, or other adverse consequences to our business operations. As with many technological innovations, artificial intelligence presents risks and challenges that** could ~~mark~~ **impact our business. We may adopt and integrate generative artificial intelligence tools into our systems for specific use cases reviewed by legal and information security. Our vendors may incorporate generative artificial intelligence tools into** ~~the~~ **their** ~~beginning~~ **offerings without disclosing this use to us, and the providers** of ~~a trend toward more stringent~~ **these generative artificial intelligence tools may not meet existing or rapidly evolving regulatory or industry standards with respect to** privacy ~~legislation in the U. S., which could increase our potential liability~~ and ~~adversely affect our business. Already, in the United States, we have witnessed significant developments at the state level. For example, on March 2, 2021, Virginia enacted the CDPA and, on July 8, 2021, Colorado' s governor signed the CPA, into law. The CDPA and the CPA both became effective January 1, 2023. While the CDPA and CPA incorporate many similar concepts of the CCPA and CPRA, there are also several key differences in the scope, application, and enforcement of the law that will change the operational practices of regulated businesses. The new laws will, among other things, impact how regulated businesses collect and process personal sensitive data, conduct~~ data protection ~~assessments, transfer personal data~~ **and may inhibit our or our vendors' ability** to **maintain** ~~affiliates, and~~ **an** ~~respond to consumer~~ **adequate level of service and experience. If we, our vendors, or our third-party partners experience an actual or perceived breach or privacy or security incident because of the use of generative artificial intelligence, we may lose valuable intellectual property** rights ~~requests The uncertainty surrounding the implementation of recent~~ and **confidential information and our** ~~emerging state privacy laws, regulations~~ **reputation** and ~~standards that may~~ **the public perception of the effectiveness of our security measures could** be ~~adopted in~~ **harmed. Further, bad actors around** ~~other~~ **the world** ~~jurisdictions exemplifies the vulnerability of our business to the evolving regulatory environment related to personal data and protected health information. Compliance with U. S. and international data protection laws and regulations could require us to take on more onerous obligations in our contracts, restrict our ability to collect,~~ use ~~and disclose data~~ **increasingly sophisticated methods** , ~~or in some cases, impact our ability to operate in certain jurisdictions. Failure to comply with these laws and regulations could result in government enforcement actions (which could include~~ **including** ~~civil, criminal and administrative penalties), private litigation, and / or adverse publicity and could negatively affect our operating results and business. Moreover, clinical trial subjects, employees and other~~ **the** ~~individuals about whom we or our potential collaborators obtain~~ **use of artificial intelligence, to engage in illegal activities involving the theft and misuse of** personal information, **confidential** ~~as well as the providers who share this~~ information ~~with us~~ , ~~may limit our ability to collect, use~~ and ~~disclose~~ **intellectual property. Any of** ~~the~~ **these outcomes could damage our reputation, result in the loss of valuable property and** information ~~. Claims that we have violated individuals' privacy rights~~ , ~~failed to comply with data protection laws, or breached our contractual obligations, even if we are not found liable, could be expensive~~ and ~~time-consuming to defend and could result in adverse~~ **adversely impact** ~~publicity that could harm~~ our business. European data collection is governed by restrictive regulations governing the use, processing and cross- border transfer of personal information. **Where** ~~In the event~~ we ~~decide to~~ conduct ~~additional~~ clinical trials **and** ~~or continue to~~ enroll subjects in our ~~ongoing or future~~ clinical trials in the European ~~Union or in~~ **Economic Area (** the **" EEA ") or in the United Kingdom (the "** UK **")** , we **are** ~~may be~~ subject to **European data protection regulations which include** additional privacy restrictions. The collection and use of **data (including** personal health data **)** in the ~~European Union is~~ **EEA and UK are** governed by the provisions of the **EU GDPR and** UK GDPR **(together " GDPR " and each as defined in the section titled, " Business — Government Regulation — European Data Collection ")** . The GDPR imposes several **stringent requirements on companies that process personal data, including** requirements relating to the **processing of health and other sensitive data, obtaining** consent of ~~the individuals~~ **data subjects** to whom the personal data relates, ~~the~~ **providing detailed** information ~~provided~~ to **data subjects about how** ~~the~~ **their** ~~individuals~~ **personal data is used** , notification of data **breaches** ~~processing obligations~~ to

the competent national data protection authorities and **implementing safeguards to protect** the security and confidentiality of ~~the~~ personal data. The ~~UK~~ GDPR also imposes strict rules on the transfer of personal data out of the ~~European~~ **EEA and UK to** ~~Union~~ ~~-~~ **non** ~~to~~ ~~-~~ **adequate territories such as** the United States **; any inability to transfer personal data from the EEA and UK to the United States in compliance with data protection laws may impede our ability to conduct trials and may adversely affect our business and financial position** . Failure to comply with the requirements of the ~~UK~~ GDPR, and the related national data protection laws of the ~~European Union~~ **UK and EEA** Member States may result in **significant** fines ~~and~~ **,** other administrative penalties **and private rights of action from data subjects and consumer associations. Compliance with the GDPR and any other data privacy and data security laws and regulations is a rigorous and time- intensive process and requires significant resources and an ongoing review of our technologies, systems and practices, as well as those of any third- party collaborators, service providers, contractors or consultants that process or transfer personal data** . The **GDPR and other changes in laws or regulations associated with the enhanced protection of certain types of sensitive data, such as healthcare data or other personal information from our clinical trials, could require us to change our business practices and put in place additional compliance mechanisms, may interrupt or delay our development, regulatory and commercialization activities and increase our cost of doing business, and could lead to government enforcement actions, private litigation and significant fines and penalties against us and could have a material adverse effect on our business, financial condition or results of operations. Although the EU GDPR and the** UK GDPR **currently impose substantially similar obligations, it is possible that over time the UK GDPR could become less aligned with the EU GDPR, particularly with the introduction of the new Data Reform Bill into the UK legislative process. In addition, EEA Member States have adopted national laws to supplement the EU GDPR, which may partially deviate from the EU GDPR, and the competent authorities in the EEA Member States may interpret EU GDPR obligations slightly differently from country to country, such that we do not expect to operate in a uniform legal landscape in the EEA and UK with respect to data protection** regulations ~~may impose~~ **. The potential of the respective provisions and enforcement of the EU GDPR and UK GDPR further diverging in the future creates** additional ~~responsibility~~ **regulatory challenges** and ~~liability in~~ **uncertainties for us. The lack of clarity on future UK laws and** ~~relation~~ **regulations and their interaction with EU laws and regulations could add legal risk, uncertainty, complexity and compliance cost** to **the handling of European** personal data ~~that we process~~ and **our privacy and data security** ~~we may be required to put in place additional mechanisms ensuring~~ compliance ~~with these~~ **, and could require us to** ~~and~~ **amend** ~~/ or~~ **our processes** ~~new data protection rules. This may be onerous~~ and ~~adversely affect our business, financial condition, prospects~~ **procedures to implement different compliance measures for the UK** and **the EEA** ~~results of operations~~ . Healthcare legislative measures aimed at reducing healthcare costs may have a material adverse effect on our business and results of operations. The United States and many foreign jurisdictions have enacted or proposed legislative and regulatory changes affecting the healthcare system that could prevent or delay marketing approval of our product candidates or any future product candidates, restrict or regulate post- approval activities and affect our ability to profitably sell any product for which we obtain marketing approval. Changes in regulations, statutes or the interpretation of existing regulations could impact our business in the future by requiring, for example: (i) changes to our manufacturing arrangements; (ii) additions or modifications to product labeling; (iii) the recall or discontinuation of any products; or (iv) additional record- keeping requirements. If any such changes were to be imposed, they could adversely affect the operation of our business. See the section ~~entitled~~ ~~-~~ **titled** , " Business — Government Regulation — Current and Future Legislation. " In addition, the Creating and Restoring Equal Access to Equivalent Samples Act, or CREATES Act, was enacted in 2019 requiring sponsors of approved NDAs and BLAs to provide sufficient quantities of product samples on commercially reasonable, market- based terms to entities developing generic drugs and biosimilar biological products. The law establishes a private right of action allowing developers to sue application holders that refuse to sell them product samples needed to support their applications. If we are required to provide product samples or allocate additional resources to responding to such requests or any legal challenges under this law, our business could be adversely impacted. There have been, and likely will continue to be, legislative and regulatory proposals at the foreign, federal and state levels directed at containing or lowering the cost of healthcare. The implementation of cost containment measures or other healthcare reforms may prevent us from being able to generate revenue, attain profitability, or commercialize our product candidates, if approved. Such reforms could have an adverse effect on anticipated revenue from product candidates that we may successfully develop and for which we may obtain regulatory approval and may affect our overall financial condition and ability to develop product candidates. We cannot predict the initiatives that may be adopted in the future. The continuing efforts of the government, insurance companies, managed care organizations and other payors of healthcare services to contain or reduce costs of healthcare and / or impose price controls may adversely affect **:** • the demand for our product candidates, if approved; • our ability to receive or set a price that we believe is fair for our future products; • our ability to generate revenue and achieve or maintain profitability; • the amount of taxes that we are required to pay; and • the availability of capital. We expect that the ACA, as well as other healthcare reform measures that may be adopted in the future, may result in additional reductions in Medicare and other healthcare funding, more rigorous coverage criteria, lower reimbursement, and new payment methodologies. This could lower the price that we receive for any approved product. Any denial in coverage or reduction in reimbursement from Medicare or other government- funded programs may result in a similar denial or reduction in payments from private payors, which may prevent us from being able to generate sufficient revenue, attain profitability or commercialize our product candidates, if approved **. If we fail to comply with our reporting and payment obligations under the Medicaid Drug Rebate program or other governmental pricing programs, we could be subject to additional reimbursement requirements, penalties, sanctions and fines, which could have a material adverse effect on our business, financial condition, results of operations and growth prospects. We participate in the Medicaid Drug Rebate program, the 340B drug pricing program, and the VA' s FSS pricing program. Under the Medicaid Drug Rebate program, we are required to pay a rebate to each state Medicaid program for our covered outpatient drugs that are**

dispensed to Medicaid beneficiaries and paid for by a state Medicaid program as a condition of having federal funds being made available to the states for our drugs under Medicaid and Medicare Part B. Those rebates are based on pricing data reported by us on a monthly and quarterly basis to CMS, the federal agency that administers the Medicaid Drug Rebate program. These data include the average manufacturer price and, in the case of innovator products, the best price for each drug which, in general, represents the lowest price available from the manufacturer to any entity in the U. S. in any pricing structure, calculated to include all sales and associated rebates, discounts and other price concessions. Our failure to comply with these price reporting and rebate payment obligations could negatively impact our financial results. The ACA made significant changes to the Medicaid Drug Rebate program. CMS issued a final regulation, which became effective on April 1, 2016, to implement the changes to the Medicaid Drug Rebate program under the ACA. The issuance of the final regulation has increased and will continue to increase our costs and the complexity of compliance, has been and will continue to be time- consuming to implement, and could have a material adverse effect on our results of operations, particularly if CMS challenges the approach we take in our implementation of the final regulation. Federal law requires that any company that participates in the Medicaid Drug Rebate program also participate in the Public Health Service' s 340B drug pricing program in order for federal funds to be available for the manufacturer' s drugs under Medicaid and Medicare Part B. The 340B program requires participating manufacturers to agree to charge statutorily defined covered entities no more than the 340B " ceiling price " for the manufacturer' s covered outpatient drugs. These 340B covered entities include a variety of community health clinics and other entities that receive health services grants from the Public Health Service, as well as hospitals that serve a disproportionate share of low- income patients. The 340B ceiling price is calculated using a statutory formula based on the average manufacturer price and Medicaid rebate amount for the covered outpatient drug as calculated under the Medicaid Drug Rebate program, and in general, products subject to Medicaid price reporting and rebate liability are also subject to the 340B ceiling price calculation and discount requirement. Any additional future changes to the definition of average manufacturer price and the Medicaid rebate amount under the ACA, other legislation, or in regulation could affect our 340B ceiling price calculations and negatively impact our results of operations. The Health Resources and Services Administration, or HRSA, which administers the 340B program, issued a final regulation regarding the calculation of the 340B ceiling price and the imposition of civil monetary penalties on manufacturers that knowingly and intentionally overcharge covered entities, which became effective on January 1, 2019. We also are required to report our 340B ceiling prices to HRSA on a quarterly basis. Implementation of the civil monetary penalties regulation and the issuance of any other final regulations and guidance could affect our obligations under the 340B program in ways we cannot anticipate. In addition, legislation may be introduced that, if passed, would further expand the 340B program to additional covered entities or would require participating manufacturers to agree to provide 340B discounted pricing on drugs used in the inpatient setting. Pricing and rebate calculations vary across products and programs, are complex, and are often subject to interpretation by us, governmental or regulatory agencies and the courts. In the case of our Medicaid pricing data, if we become aware that our reporting for a prior quarter was incorrect, or has changed as a result of recalculation of the pricing data, we are obligated to resubmit the corrected data for up to three years after those data originally were due. Such restatements and recalculations increase our costs for complying with the laws and regulations governing the Medicaid Drug Rebate program and could result in an overage or underage in our rebate liability for past quarters. Price recalculations also may affect the ceiling price at which we are required to offer our products under the 340B program or could require us to issue refunds to 340B covered entities. Significant civil monetary penalties can be applied if we are found to have knowingly submitted any false pricing information to CMS, or if we fail to submit the required price data on a timely basis. Such conduct also could be grounds for CMS to terminate our Medicaid drug rebate agreement, in which case federal payments may not be available under Medicaid or Medicare Part B for our covered outpatient drugs. Significant civil monetary penalties also can be applied if we are found to have knowingly and intentionally charged 340B covered entities more than the statutorily mandated ceiling price. We cannot assure you that our submissions will not be found by CMS or HRSA to be incomplete or incorrect. In order to be eligible to have our products paid for with federal funds under the Medicaid and Medicare Part B programs and purchased by certain federal agencies and grantees, as noted above, we participate in the VA' s FSS pricing program. As part of this program, we are obligated to make our products available for procurement on an FSS contract under which we must comply with standard government terms and conditions and charge a price that is no higher than the statutory Federal Ceiling Price, or FCP, to four federal agencies (the VA, U. S. Department of Defense, or DOD, Public Health Service, and the U. S. Coast Guard). The FCP is based on the Non- Federal Average Manufacturer Price, or Non- FAMP, which we calculate and report to the VA on a quarterly and annual basis. Pursuant to applicable law, knowing provision of false information in connection with a Non- FAMP filing can subject a manufacturer to significant penalties for each item of false information. These obligations also contain extensive disclosure and certification requirements. We also participate in the Tricare Retail Pharmacy program, under which we pay quarterly rebates on utilization of innovator products that are dispensed through the Tricare Retail Pharmacy network to Tricare beneficiaries. The rebates are calculated as the difference between the annual Non- FAMP and FCP. We are required to list our covered products on a Tricare Agreement in order for these products to be eligible for DOD formulary inclusion. If we overcharge the government in connection with our FSS contract or Tricare Agreement, whether due to a misstated FCP or otherwise, we are required to refund the difference to the government. Failure to make necessary disclosures and / or to identify contract overcharges can result in allegations against us under the FCA and other laws and regulations. Unexpected refunds to the government, and responding to a government investigation or enforcement action, would be expensive and time- consuming, and could have a material adverse effect on our business,

financial condition, results of operations and growth prospects . Recent federal legislation and actions by state and local governments may permit reimportation of drugs from foreign countries into the United States, including foreign countries where the drugs are sold at lower prices than in the United States, which could materially adversely affect our operating results. We may face competition in the United States for our product candidates if approved, from therapies sourced from foreign countries that have placed price controls on pharmaceutical products. In the United States, the Medicare Modernization Act contains provisions that may change U. S. importation laws and expand pharmacists' and wholesalers' ability to import cheaper versions of an approved drug and competing products from Canada, where there are government price controls. ~~These~~ -- **The** ~~changes to U. S. importation laws will not take effect unless and until the Secretary of the HHS certifies that the changes will pose no additional risk to the public' s health and safety and will result in a significant reduction in the cost of products to consumers. Further, the MMA provides that these changes to U. S. importation laws will not take effect unless and until the Secretary of HHS certifies that the changes will pose no additional risk to the public' s health and safety and will result in a significant reduction in the cost of products to consumers. On September 23, 2020, the Secretary of HHS made such certification to Congress, and on October 1, 2020, the FDA published a final rule that allows for the importation of certain prescription drugs from Canada. Under the final rule, States and Indian Tribes, and in certain future circumstances pharmacists and wholesalers, may submit importation program proposals to the FDA for review and authorization. Since the issuance of the final rule, on November 23, 2020, several industry groups filed federal lawsuits in the U. S. District Court for the District of Columbia, requesting injunctive relief to prevent implementation of the rule. Further, authorities in Canada have passed rules designed to safeguard the Canadian drug supply from shortages. On September 25, 2020, CMS stated drugs imported by States under this rule will not be eligible for federal rebates under Section 1927 of the Social Security Act and manufacturers would not report these drugs for " best price " or Average Manufacturer Price purposes. Since these drugs are not considered covered outpatient drugs, CMS further stated it will not publish a National Average Drug Acquisition Cost for these drugs. Separately, the~~ FDA also issued a final guidance document outlining a pathway for manufacturers to obtain an additional National Drug Code, or NDC, for an FDA- approved drug that was originally intended to be marketed in a foreign country and that was authorized for sale in that foreign country. **See the section titled, " Business — Government Regulation — Current and Future Legislation " for more information regarding legislative and regulatory changes and proposed changes regarding the healthcare system directed at broadening the availability of healthcare, improving the quality of healthcare, and containing or lowering the cost of healthcare.** If **certain of these changes are** implemented, importation of drugs from Canada may materially and adversely affect the price we receive for any of our product candidates. The regulatory and market implications of the final rule and guidance are unknown at this time. Proponents of drug reimportation may attempt to pass legislation that would directly allow reimportation under certain circumstances. Legislation or regulations allowing the reimportation of drugs, if enacted, could decrease the price we receive for any products that we may develop and adversely affect our future revenues and prospects for profitability. We will continue to monitor developments and their potential effect on our business. We face significant competition in an environment of rapid technological and scientific change, and there is a possibility that our competitors may achieve regulatory approval before us or develop therapies that are safer, more advanced or more effective than ours, which may negatively impact our ability to successfully market or commercialize any product candidates we may develop and ultimately harm our financial condition. The development and commercialization of new drug products is highly competitive. We may face competition with respect to any product candidates that we seek to develop or commercialize in the future from major pharmaceutical companies, specialty pharmaceutical companies, and biotechnology companies worldwide. Potential competitors also include academic institutions, government agencies, and other public and private research organizations that conduct research, seek patent protection, and establish collaborative arrangements for research, development, manufacturing, and commercialization. There are a number of large pharmaceutical and biotechnology companies that are currently pursuing the development and commercialization of products for the treatment of the indications that our core value drivers are pursuing ~~, including, but not limited to: tafamidis, a TTR tetramer stabilizer (presently marketed by Pfizer Inc. as Vyndamax and Vyndaqel), a competitor to acoramidis; vosoritide, a CNP analog (presently marketed by BioMarin Pharmaceutical Inc. as Voxzogo), a potential competitor to low- dose infigratinib as a treatment for achondroplasia; erinecerfont, a CRF1 receptor antagonist, a competitor to BBP- 631; Natpara, a parathyroid hormone, a competitor to encaleret~ . If any ~~of these or other competitors, including~~ competitors for our ~~other~~ product candidates ~~,~~ receive FDA approval before we do, our product candidates would not be the first treatment on the market, and our market share may be limited. In addition to competition from other companies targeting our target indications, any products we may develop may also face competition from other types of therapies. Many of our current or potential competitors, either alone or with their strategic partners, have significantly greater financial resources and expertise in research and development, manufacturing, preclinical testing, conducting clinical trials, obtaining regulatory approvals, and marketing approved products than we do. Mergers and acquisitions in the pharmaceutical and biotechnology industries may result in even more resources being concentrated among a smaller number of our competitors. Smaller or early- stage companies may also prove to be significant competitors, particularly through collaborative arrangements with large and established companies. These competitors also compete with us in recruiting and retaining qualified scientific and management personnel and establishing clinical trial sites and patient registration for clinical trials, as well as in acquiring technologies complementary to, or necessary for, our programs. Our commercial opportunity could be reduced or eliminated if our competitors develop and commercialize products that are safer, more effective, have fewer or less severe side effects, are more convenient, or are less expensive than any products that we may develop. Furthermore, currently approved products could be discovered to have application for treatment of our targeted disease indications or similar indications, which could give such products significant regulatory and market timing advantages over our product candidates. Our competitors also may obtain FDA or other regulatory approval for their products more rapidly than we may obtain approval for ours and may obtain orphan product exclusivity from the FDA for indications that we are targeting,

which could result in our competitors establishing a strong market position before we are able to enter the market. Additionally, products or technologies developed by our competitors may render our product candidates uneconomical or obsolete and we may not be successful in marketing those product candidates, once approved, against competitors. In addition, we could face litigation or other proceedings with respect to the scope, ownership, validity and / or enforceability of our patents relating to our competitors' products and our competitors may allege that our products infringe, misappropriate or otherwise violate their intellectual property. The availability of our competitors' products could limit the demand, and the price we are able to charge, for any products that we may develop and commercialize. See **the section titled,** " Risks Related to Our Intellectual Property. " If the market opportunities for our product candidates are smaller than we believe they are, our revenue may be adversely affected, and our business may suffer. Our ability to successfully identify patients and acquire a significant market share will be necessary for us to achieve profitability and growth. We focus research and product development on treatments for Mendelian diseases and genetically driven cancers, many of which are rare or orphan indications. Our projections of both the number of individuals who are affected by our target disease indications and have the potential to benefit from treatment with our product candidates, are based on our beliefs and estimates. These estimates have been derived from a variety of sources, including the scientific literature, and may prove to be incorrect. Further, new studies may change the estimated incidence or prevalence of these diseases. The number of patients may turn out to be lower than expected. The effort to identify patients with diseases we seek to treat is in early stages, and we cannot accurately predict the number of patients for whom treatment might be possible. Additionally, the potentially addressable patient population for our product candidates may be limited or may not be amenable to treatment with our products or product candidates, and new patients may become increasingly difficult to identify or gain access to, which would adversely affect our results of operations and our business. Further, even if we obtain significant market share for our product candidates under development in our key value driver programs, because the potential target populations are small, we may never achieve profitability despite obtaining such significant market share. In addition, market share could be limited by the availability of other treatments ~~including Vyndamax (tafamidis) and Vyndaqel (tafamidis meglumine), for which Pfizer Inc. has been approved for the treatment of ATTR- CM the United States and Japan (Vyndaqel only)~~ . As a result, even if approved, acoramidis will not be the first treatment on the market for ATTR- CM, and its market share and potential to generate revenues may be limited. Risks Related to Our Business and Industry **Adverse developments affecting the financial services industry, such as actual events or concerns involving liquidity, defaults, or non- performance by financial institutions or transactional counterparties, could adversely affect our current and projected business operations, financial condition and results of operations. Actual events involving limited liquidity, defaults, non- performance or other adverse developments that affect financial institutions, transactional counterparties or other companies in the financial services industry or the financial services industry generally, or concerns or rumors about any events of these kinds or other similar risks, have in the past and may in the future lead to market- wide liquidity problems. For example, on March 10, 2023, Silicon Valley Bank, or SVB, was closed by the California Department of Financial Protection and Innovation, which appointed the Federal Deposit Insurance Corporation, or FDIC, as receiver. Similarly, on March 12, 2023, Signature Bank and Silvergate Capital Corp. were each swept into receivership and thereafter, First Republic Bank on May 1, 2023. In these cases, borrowers under credit agreements, letters of credit and certain other financial instruments with SVB, Signature Bank or any other financial institution that is placed into receivership by the FDIC may be unable to access undrawn amounts thereunder. If any of our lenders or counterparties to any such instruments were to be placed into receivership, we may be unable to access such funds, which could result in liquidity constraints or failures. In addition, if any of our collaboration partners, suppliers or other parties with whom we conduct business are unable to access funds pursuant to such instruments or lending arrangements with such a financial institution, such parties' ability to pay their obligations to us or to enter into new commercial arrangements requiring additional payments to us could be adversely affected. In this regard, counterparties to SVB credit agreements and arrangements, and third parties such as beneficiaries of letters of credit (among others), may experience direct impacts from the closure of SVB, or the sale of its assets, and uncertainty remains over liquidity concerns in the broader financial services industry. Similar impacts have occurred in the past, such as during the 2008- 2010 financial crisis. Inflation and rapid increases in interest rates have led to a decline in the trading value of previously issued government securities with interest rates below current market interest rates. Although the U. S. Department of Treasury, FDIC and Federal Reserve Board have announced a program to provide up to $ 25 billion of loans to financial institutions secured by certain of such government securities held by financial institutions to mitigate the risk of potential losses on the sale of such instruments, widespread demands for customer withdrawals or other liquidity needs of financial institutions for immediate liquidity may exceed the capacity of such program. Additionally, there is no guarantee that the U. S. Department of Treasury, FDIC and Federal Reserve Board will provide access to uninsured funds in the future in the event of the closure of other banks or financial institutions, or that they would do so in a timely fashion. Although we assess our banking and other business relationships as we believe necessary or appropriate, our access to funding sources and other credit arrangements in amounts adequate to finance or capitalize our current and projected future business operations could be significantly impaired by factors that affect us, the financial institutions with which we have credit agreements or arrangements directly, or the financial services industry or economy in general. These factors could include, among others, events such as liquidity constraints or failures, the ability to perform obligations under various types of financial, credit or liquidity agreements or arrangements, disruptions or instability in the financial services industry or financial markets, or concerns or negative expectations about the prospects for companies in the financial services industry or the supervision thereof. These factors could involve financial institutions or financial services industry companies with which we have financial or business relationships, but could also include factors involving financial markets or the financial services industry generally. The results of events or concerns that involve one or more of these factors could include a variety of**

material and adverse impacts on our current and projected business operations and our financial condition and results of operations. These could include, but may not be limited to, the following: • Delayed access to deposits or other financial assets or the uninsured loss of deposits or other financial assets; • Delayed or lost access to, or reductions in borrowings available under revolving existing credit facilities or other working capital sources and / or delays, inability or reductions in our ability to refund, roll over or extend the maturity of, or enter into new credit facilities or other working capital resources; • Potential or actual breach of contractual obligations that require us to maintain letters of credit or other credit support arrangements; • Potential or actual breach of financial covenants in our credit agreements or credit arrangements; • Potential or actual cross- defaults in other credit agreements, credit arrangements or operating or financing agreements; or • Termination of cash management arrangements and / or delays in accessing or actual loss of funds subject to cash management arrangements. In addition, investor concerns regarding the U. S. or international financial systems could result in less favorable commercial financing terms, including higher interest rates or costs and tighter financial and operating covenants, or systemic limitations on access to credit and liquidity sources, thereby making it more difficult for us to acquire financing on acceptable terms or at all. Any decline in available funding or access to our cash and liquidity resources could, among other risks, adversely impact our ability to meet our operating expenses, financial obligations or fulfill our other obligations, result in breaches of our financial and / or contractual obligations or result in violations of federal or state wage and hour laws. Any of these impacts, or any other impacts resulting from the factors described above or other related or similar factors not described above, could have material adverse impacts on our liquidity and our current and / or projected business operations and financial condition and results of operations. In addition, any further deterioration in the macroeconomic economy or financial services industry could lead to losses or defaults by our collaboration partners, suppliers or other parties with whom we do business, which in turn, could have a material adverse effect on our current and / or projected business operations and results of operations and financial condition. Any bankruptcy or insolvency of a collaboration partner, supplier or other party with whom we do business, or the failure of any such party to make payments when due, or any breach or default by any such party, or the loss of any significant business relationships, could result in material losses to us and may have a material adverse impact on our business. Our corporate restructuring ~~initiative~~ **initiatives** ~~and the~~ **, including any** associated workforce ~~reduction~~ **reductions or reorganizations,** ~~announced in January 2022~~ may not result in the full anticipated savings and may disrupt operations. In January 2022, we committed to a restructuring initiative designed to drive operational changes in our business processes, efficiencies, and cost savings to advance our corporate strategy and development programs. The restructuring initiative included, among other components, consolidation and rationalization of our facilities, reprioritization of development programs and the reduction in our workforce. We may not fully realize the anticipated benefits, savings and improvements in our cost structure from **this restructuring initiative** ~~our~~ **or other** restructuring efforts **that we may undertake in the future,** due to unforeseen difficulties, delays or unexpected costs and the expenses of restructuring may be greater than anticipated. If we are unable to realize anticipated cost savings from ~~the~~ **our** restructuring **initiatives** , our operating results and financial condition may be adversely affected. Furthermore, our reprioritization of development programs may be disruptive to our operations. For example, our workforce reductions could yield unanticipated consequences, such as turnover beyond planned reductions or increased difficulties in **conducting** our day- to- day operations. Our workforce reductions could also harm our ability to attract and retain qualified personnel who are critical to our business **and make it difficult for us to pursue, or prevent us from pursuing, new opportunities and initiatives due to insufficient personnel, or require us to incur additional and unanticipated costs to hire new personnel to pursue such opportunities or initiatives** . Any failure to attract or retain qualified personnel could prevent us from successfully executing key ~~technical~~ **business** initiatives **and** ~~. The COVID- 19 pandemic could~~ adversely impact our business, ~~results of operations and~~ financial condition ~~. The ongoing COVID- 19 pandemic has dramatically impacted the global health and economic environment~~ , ~~including millions of confirmed cases~~ and **results** ~~deaths, business slowdowns or shutdowns, labor shortages, supply chain challenges, changes in government requirements, regulatory challenges, inflationary pressures and market volatility. Although we have, to date, managed to continue most~~ of ~~our~~ operations **. Our** ~~, we cannot predict the~~ future **success depends** ~~course of events nor can we assure that this global pandemic, including its economic impact, will not have a material adverse impact~~ on our ~~business, results of operations and financial condition. The extent to which COVID- 19 may impact us will depend on a variety of factors and future developments, which are highly uncertain and cannot be predicted with confidence, including the duration, scope and severity of the pandemic, the duration and extent of travel restrictions and social distancing in the United States and other countries, business closures or other business disruptions, including supply chain disruptions and labor shortages, and the effectiveness of actions taken in the United States and other countries to contain and treat COVID- 19, including global vaccination efforts. Public health actions undertaken globally in response to the COVID- 19 pandemic, including quarantines, stay- at- home, executive and similar government orders and the prioritization of healthcare resources, have adversely impacted and could continue to adversely impact our business, results of operations and financial condition. As a result of these public health actions, we have experienced and continue to experience, and may in the future experience, disruptions that severely impact our business, clinical trials and preclinical studies, and operations, including: • delays or difficulties in enrolling patients in our clinical trials; • delays or difficulties in clinical site initiation, including difficulties in recruiting clinical site investigators and clinical site staff; • increased rates of patients withdrawing from our clinical trials following enrollment as a result of contracting COVID- 19, being forced to quarantine or not accepting home health visits; and • diversion of healthcare resources away from the conduct of clinical trials, including the diversion of hospitals serving as our clinical trial sites and hospital staff supporting the conduct of our clinical trials. As a result of the ongoing COVID- 19 pandemic, our business, results of operations and preclinical and clinical development processes have been and may continue to be negatively impacted, including in connection with the~~ ability ~~of regulators~~ to ~~continue ensuring the timely review and approval of applications. During the COVID- 19 public~~

~~health emergency, a number of companies announced receipt of complete response letters due to the FDA' s inability to complete required inspections for their applications. Our ability to conduct our business in the manner and on the timelines presently planned could have a material adverse impact on our business, results of operations and financial condition. To the extent the ongoing COVID- 19 pandemic adversely affects our business and financial results, it may also have the effect of heightening many of the other risks described in this " Risk Factors " section, such as those relating to our clinical development operations, the supply chain for our ongoing and planned clinical trials and commercial sales, the availability of governmental and regulatory authorities to conduct inspections of our clinical trial sites, review materials submitted by us in support of our applications for regulatory approval and grant approval for our product candidates, and our ability to raise additional capital to support our operations and to service our indebtedness. In addition, any recurrence or subsequent " wave " of COVID- 19 cases, including those caused by new variants, could cause other widespread or more severe impacts depending on where infection rates are highest. While certain~~ **retain key employees** ~~vaccines and treatments for COVID- 19 have been authorized for use~~, **directors** ~~some in emergency cases~~, **consultants and advisors and to attract, retain and motivate qualified personnel** ~~there can be no assurance that such measures will halt or slow the progression of COVID- 19 in a timely manner or at all~~. We are highly dependent on the management, research and development, clinical, financial and business development expertise of our executive officers, our directors, our Management Committee as well as the other members of our scientific and clinical teams. If we were to lose Dr. **Neil** Kumar **, our founder and Chief Executive Officer,** or any of our other executives or key personnel, we may not be able to find appropriate replacements on a timely basis. In addition, because certain of our employees provide a centralized source of support across multiple subsidiaries, the loss of any of these employees could negatively affect the operations of the affected subsidiaries, and our financial condition and results of operations could be materially adversely affected. Furthermore, each of our executive officers may terminate their employment with us at any time. We do not maintain " key person " insurance for any of our executives or employees. Recruiting and retaining qualified ~~scientific and clinical~~ personnel **will be critical to** ~~and, if we progress the development of~~ our ~~drug pipeline toward scaling~~ **success as we continue to scale** up **our organization** for commercialization ~~, sales and marketing personnel, will also be critical to our success~~. The loss of the services of our executive officers or other key employees could impede the achievement of research, development and commercialization objectives and seriously harm our ability to successfully implement our business strategy. Furthermore, replacing executive officers and key employees may be difficult and may take an extended period of time because of the limited number of individuals in our industry with the breadth of skills and experience required to successfully develop, gain regulatory approval for and commercialize our product candidates. Competition to hire qualified personnel in our industry is intense, and we may be unable to hire, train, retain or motivate these key personnel on acceptable terms given the competition among numerous pharmaceutical and biotechnology companies for similar personnel. Furthermore, to the extent we hire personnel from competitors, we may be subject to allegations that they have been improperly solicited or that they have divulged proprietary or other confidential information, or that their former employers own their research output. We also experience competition for the hiring of scientific and clinical personnel from universities and research institutions. In addition, we rely on consultants and advisors, including scientific and clinical advisors, to assist us in formulating our research and development and commercialization strategy. Our consultants and advisors may be employed by employers other than us and may have commitments under consulting or advisory contracts with other entities that may limit their availability to us. If we are unable to continue to attract and retain high quality personnel, our ability to pursue our growth strategy will be limited. Our reliance on a central team consisting of a limited number of employees who provide various administrative, research and development and other services across our organization, and on dedicated teams at the subsidiary level presents operational challenges that may adversely affect our business. As of December 31, ~~2022~~ **2023** , we had ~~392~~ **556** employees. While we believe ~~this~~ **our** structure enables us to reduce certain infrastructure costs, the small size of our central team **, consisting of employees engaged in providing administrative, research and development and other services across our entire organization,** may cause us to be unable to devote adequate personnel, time and resources to support the operations of all of our subsidiaries, including their research and development activities, employee recruiting and retention efforts and the management **of** financial and accounting and reporting matters. From time to time, members of our central team may not have access to adequate information regarding aspects of the business and operations of our subsidiaries to sufficiently manage these affairs. Additionally, because our dedicated subsidiary- level employees and management are primarily incentivized at the subsidiary level, these employees and management team members may not be sufficiently incentivized to maximize the overall value of our entire organization. If our central team fails to provide adequate administrative, research and development or other services across our entire organization, or our subsidiary- level employees and management do not perform in a manner that aligns with the interests of our entire organization, our business, financial condition and results of operations could be harmed. Changes in funding for, or disruptions to the operations of, the FDA, the SEC and other government agencies could hinder their ability to hire and retain key leadership and other personnel, prevent new products and services from being developed or commercialized in a timely manner or otherwise prevent those agencies from performing normal functions on which the operation of our business may rely, which could negatively impact our business. Inadequate funding for the FDA, the SEC and other government agencies, including from government shut downs, or other disruptions to these agencies' operations, could hinder their ability to hire and retain key leadership and other personnel, prevent new products and services from being developed or commercialized in a timely manner or otherwise prevent those agencies from performing normal business functions on which the operation of our business may rely, which could negatively impact our business. The ability of the FDA to review and approve new products or take action with respect to other regulatory matters can be affected by a variety of factors, including government budget and funding levels, ability to hire and retain key personnel and accept payment of user fees, the availability of personnel and other resources ~~in light of governmental " stay- at- home " orders in response to the COVID- 19 pandemic~~ , and statutory, regulatory and policy changes. Average review times at the agency have fluctuated in recent years as a result. In addition, government funding of the SEC and

other government agencies on which our operations may rely, including those that fund research and development activities is subject to the political process, which is inherently fluid and unpredictable. Disruptions at the FDA and other agencies may also slow the time necessary for new drugs to be reviewed and / or approved, or for other actions to be taken, by relevant government agencies, which would adversely affect our business. For example, over the last several years, including for 35 days beginning on December 22, 2018, the U. S. government has shut down several times and certain regulatory agencies, such as the FDA and the SEC, have had to furlough critical FDA, SEC and other government employees and stop critical activities. ~~Since March 2020, when foreign and domestic inspections of facilities were largely placed on hold, the FDA has been working to resume pre- pandemic levels of inspection activities, including routine surveillance, bioresearch monitoring and pre- approval inspections. Should the FDA determine that an inspection is necessary for approval of a marketing application and an inspection cannot be completed during the review cycle due to restrictions on travel, and the FDA does not determine a remote interactive evaluation to be adequate, the FDA has stated that it generally intends to issue, depending on the circumstances, a complete response letter or defer action on the application until an inspection can be completed. Regulatory authorities outside the United States may adopt similar restrictions or other policy measures in response to the COVID- 19 pandemic and may experience delays in their regulatory activities.~~ If a prolonged government shutdown or disruption to the operations of the FDA **or other regulatory authorities** occurs, it could significantly impact the ability of the FDA **or such other regulatory authorities** to timely review and process our regulatory submissions, which could have a material adverse effect on our business. Similarly, a prolonged government shutdown or disruption to the operations of the USPTO could prevent the timely review of our patent applications, which could delay the issuance of any U. S. patents to which we might otherwise be entitled. Future government shutdowns and similar events could impact our ability to access the public markets and obtain necessary capital in order to properly capitalize and continue our operations. We will need to expand our organization and we may experience difficulties in managing this growth, which could disrupt our operations. As of December 31, ~~2022~~ **2023** , we had ~~392~~ **550** full **- time employees and six part** - time employees across all of our companies. As we mature, we expect to expand our full- time employee base and to hire more consultants and contractors. Our management may need to divert a disproportionate amount of its attention away from our day- to- day activities and devote a substantial amount of time toward managing these growth activities. We may not be able to effectively manage the expansion of our operations, which may result in weaknesses in our infrastructure, operational mistakes, loss of business opportunities, loss of employees and reduced productivity among remaining employees. Our expected growth could require significant capital expenditures and may divert financial resources from other projects, such as the commercialization of our product candidates, if approved and development of additional product candidates. If our management is unable to effectively manage our growth, our expenses may increase more than expected, our ability to generate and / or grow revenues could be reduced, and we may not be able to implement our business strategy. Our future financial performance and our ability to commercialize product candidates if approved, and compete effectively will depend, in part, on our ability to effectively manage any future growth. Because we have multiple programs and product candidates in our development pipeline and are pursuing a variety of target indications and treatment modalities, we may expend our limited resources to pursue a particular product candidate and fail to capitalize on development opportunities or product candidates that may be more profitable or for which there is a greater likelihood of success. We focus on the development of product candidates to address Mendelian diseases and genetically driven cancers, regardless of the treatment modality or the particular target indication within this space. Because we have limited financial and personnel resources, we may forego or delay pursuit of opportunities with potential target indications or product candidates that later prove to have greater commercial potential than our current and planned development programs and product candidates. Our resource allocation decisions may cause us to fail to capitalize on viable commercial products or profitable market opportunities. Our spending on current and future research and development programs and other future product candidates for specific indications may not yield any commercially viable future product candidates. If we do not accurately evaluate the commercial potential or target market for a particular product candidate, we may be required to relinquish valuable rights to that product candidate through collaboration, licensing or other royalty arrangements in cases in which it would have been more advantageous for us to retain sole development and commercialization rights to such future product candidates. Additionally, we may pursue additional in- licenses or acquisitions of development- stage assets or programs, which entails additional risk to us. Identifying, selecting and acquiring promising product candidates requires substantial technical, financial and human resources expertise. Efforts to do so may not result in the actual acquisition or license of a successful product candidate, potentially resulting in a diversion of our management' s time and the expenditure of our resources with no resulting benefit. For example, if we are unable to identify programs that ultimately result in approved products, we may spend material amounts of our capital and other resources evaluating, acquiring and developing products that ultimately do not provide a return on our investment. Product liability lawsuits against us could cause us to incur substantial liabilities and could limit commercialization of any product candidates that we may develop. We face an inherent risk of product liability exposure related to the testing of product candidates in human clinical trials in the commercial sales of approved medicines. If we cannot successfully defend ourselves against claims that our product candidates or medicines caused injuries, we could incur substantial liabilities. Regardless of merit or eventual outcome, liability claims may result in: • decreased demand for any product candidates or medicines; • injury to our reputation and significant negative media attention; • withdrawal of clinical trial participants; • significant costs to defend the related litigation; • substantial monetary awards to trial participants or patients; • loss of revenue; and • the inability to successfully commercialize our product candidates or medicines. Although we maintain product liability insurance, including coverage for clinical trials that we sponsor and for our commercial product sales, it may not be adequate to cover all liabilities that we may incur. We anticipate that we will need to increase our insurance coverage as we commence additional clinical trials and as we commercialize product candidates that may be approved. The market for insurance coverage is increasingly expensive, and the costs of insurance coverage will increase as our clinical programs and commercialization efforts increase in size. We may not be able to maintain insurance coverage at a

reasonable cost or in an amount adequate to satisfy any liability that may arise. Our employees, independent contractors, consultants, commercial partners and vendors may engage in misconduct or other improper activities, including noncompliance with regulatory standards and requirements. We are exposed to the risk of fraud, misconduct or other illegal activity by our employees, independent contractors, consultants, commercial partners and vendors. Misconduct by these parties could include intentional, reckless and negligent conduct that fails to: comply with the laws of the FDA and comparable foreign regulatory authorities; provide true, complete and accurate information to the FDA and comparable foreign regulatory authorities; comply with manufacturing standards we have established; comply with healthcare fraud and abuse laws in the United States and similar foreign fraudulent misconduct laws; or report financial information or data accurately or to disclose unauthorized activities. If we obtain FDA approval of our product candidates and begin commercializing those products in the United States, we believe that our potential exposure under such laws will increase significantly, and our costs associated with compliance with such laws are also likely to increase. In particular, research, sales, marketing, education and other business arrangements in the healthcare industry are subject to extensive laws designed to prevent fraud, kickbacks, self- dealing and other abusive practices. These laws and regulations may restrict or prohibit a wide range of pricing, discounting, educating, marketing and promotion, sales and commission, certain customer incentive programs and other business arrangements generally. Activities subject to these laws also involve the improper use of information obtained in the course of patient recruitment for clinical trials, which could result in regulatory sanctions and cause serious harm to our reputation. We have adopted a code of business conduct and ethics applicable to our employees and directors, but it is not always possible to identify and deter misconduct by employees and third parties, and the precautions we take to detect and prevent this activity may not be effective in controlling unknown or unmanaged risks or losses or in protecting us from governmental investigations or other actions or lawsuits stemming from a failure to be in compliance with such laws. If any such actions are instituted against us, and we are not successful in defending ourselves or asserting our rights, those actions could have a significant impact on our business, including the imposition of significant fines or other sanctions. Our international operations may expose us to business, regulatory, political, operational, financial **, tax** , pricing and reimbursement and economic risks associated with doing business outside of the United States. We are conducting clinical trials internationally through a global CRO, and our business strategy incorporates potential international expansion to target patient populations outside the United States. If we receive regulatory approval for and commercialize any of our product candidates in patient populations outside the United States, we may hire sales representatives and conduct physician and patient association outreach activities outside of the United States. Doing business internationally involves a number of risks, including, but not limited to: • multiple, conflicting, and changing laws and regulations such as privacy regulations, tax laws, export and import restrictions, employment laws, regulatory requirements, and other governmental approvals, permits, and licenses; • failure by us to obtain and maintain regulatory approvals for the use of our products in various countries; • additional potentially relevant third- party patent rights; • complexities and difficulties in obtaining protection and enforcing our intellectual property; • difficulties in staffing and managing foreign operations; • complexities associated with managing multiple payor reimbursement regimes, government payors, or patient self- pay systems; • limits in our ability to penetrate international markets; • financial risks, such as longer payment cycles, difficulty collecting accounts receivable, the impact of local and regional financial crises on demand and payment for our products, and exposure to foreign currency exchange rate fluctuations; • natural disasters, political and economic instability, including wars, terrorism, and political unrest, ~~outbreak of disease~~ **global or widespread health emergencies** (such as the COVID- 19 pandemic), boycotts, curtailment of trade, and other business restrictions; • certain expenses including, among others, expenses for travel, translation, and insurance; and • regulatory and compliance risks that relate to maintaining accurate information and control over sales and activities that may fall within the purview of the U. S. Foreign Corrupt Practices Act, its books and records provisions, or its anti- bribery provisions. Any of these factors could significantly harm our potential international expansion and operations and, consequently, our results of operations. If we fail to maintain an effective system of disclosure controls and internal control over financial reporting, our ability to produce timely and accurate financial statements or comply with applicable regulations could be impaired, which could negatively affect the price of our common stock. As a public company, we are required to maintain internal control over financial reporting and to report any material weaknesses in such internal controls. The Sarbanes- Oxley Act of 2002, or the Sarbanes- Oxley Act, requires that we evaluate and determine the effectiveness of our internal control over financial reporting and, pursuant to Section 404 (b) of the Sarbanes Oxley Act, or Section 404 ~~, beginning with our second annual report following our IPO~~ , provide a management report on internal control over financial reporting. In addition, we are required to include an attestation report on internal control over financial reporting issued by our independent registered public accounting firm. Any failure to develop or maintain effective controls, or any difficulties encountered in their implementation or improvement, could harm our results of operations, cause us to fail to meet our reporting obligations, result in a restatement of our financial statements for prior periods, or adversely affect the results of management evaluations and independent registered public accounting firm audits of our internal control over financial reporting that we will eventually be required to include in our periodic reports that will be filed with the SEC. ~~In addition, to the extent we acquire or establish additional consolidated subsidiaries and VIEs, the financial statements of such entities may not be initially prepared by us, and we will not have direct control over their financial statement preparation. As a result, we will, for our financial reporting, depend on what these entities report to us, which could result in our adding monitoring and audit processes, and increase the difficulty of implementing and maintaining adequate controls over our financial processes and reporting in the future, which could lead to delays in our external reporting. In particular, this may occur where we are establishing such entities with partners that do not have sophisticated financial accounting processes in place, or where we are entering into new relationships at a rapid pace, straining our integration capacity. We have in the past identified material weaknesses in our internal control over financial reporting. Although these material weaknesses were remediated, we could identify additional material weaknesses in the future, and a combination of significant deficiencies could result in a material weakness. If we identify any such additional material weaknesses or are~~

~~required to restate previously issued financial statements for any additional periods, our reputation could be impaired which could cause a loss of investor confidence and adversely materially affect our business, operating results and financial condition. Additionally, if we do not receive the information from the consolidated subsidiaries or controlled VIEs on a timely basis, it could cause delays in our external reporting. Ineffective disclosure controls and procedures and internal controls over financial reporting could also cause investors to lose confidence in our reported financial and other information, which would likely have a negative effect on the trading price of our common stock. Historically, we have relied upon and expect to continue to rely upon third- party contracted service providers to assist with our financial reporting. The process of designing, implementing and maintaining the internal control over financial reporting required to comply with the Sarbanes- Oxley Act is time consuming, costly, and complicated.~~ If we are unable to assert that our internal control over financial reporting is effective or ~~when required in the future,~~ if our independent registered public accounting firm issues an adverse opinion on the effectiveness of our internal control over financial reporting, investors may lose confidence in the accuracy and completeness of our financial reports, the market price of our common stock could be adversely affected and we could become subject to investigations or sanctions by the stock exchange on which our securities are listed, the SEC, or other regulatory authorities, which could require additional financial and management resources. We do not expect that our disclosure controls or our internal control over financial reporting will prevent all errors and all fraud. A control system, no matter how well designed and operated, can provide only reasonable, not absolute, assurance that the objectives of the control system are met. Further, the design of a control system must reflect the fact that there are resource constraints, and the benefits of controls must be considered relative to their costs. Because of the inherent limitations in all control systems, no evaluation of controls can provide absolute assurance that all control issues and instances of fraud, if any, have been detected. These inherent limitations include the realities that judgments in decision-making can be faulty, and that breakdowns can occur because of a simple error or mistake. Additionally, controls can be circumvented by the individual acts of some persons, by collusion of two or more people or by management override of the controls. The design of any system of controls is also based in part upon certain assumptions about the likelihood of future events, and there can be no assurance that any design will succeed in achieving its stated goals under all potential future conditions; over time, controls may become inadequate because of changes in conditions, or the degree of compliance with policies or procedures may deteriorate. Because of the inherent limitations in a cost- effective control system, misstatements due to error or fraud may occur and may not be detected. Risks Related to Our Indebtedness **We have incurred a significant amount of debt and may in the future incur additional indebtedness. Servicing our debt requires a significant amount of cash, and we may not have sufficient cash flow from our business to pay our substantial debt.** As of December 31, ~~2022~~ **2023** , we and our subsidiaries had total consolidated indebtedness of $ 1. 7 billion, including $ 550. 0 million of indebtedness outstanding under our unsecured 2. 50 % Convertible Senior Notes due 2027, or the 2027 Notes, $ 747. 5 million of indebtedness outstanding under our 2. 25 % Convertible Senior Notes due 2029, or the 2029 Notes, and $ ~~445~~ **455** . ~~2~~ **4** million of indebtedness under our loan agreement by and among U. S. Bank National Association, certain lenders, ~~BridgeBio~~ **we** as borrower, and certain **of our** subsidiaries ~~of BridgeBio~~ as guarantors, or **the Loan Agreement. On January 17, 2024, we incurred $ 450. 0 million of gross initial principal indebtedness under our financing agreement by and among Blue Owl Capital Corporation as administrative agent, certain lenders, we as borrower, and certain of our subsidiaries as guarantors, which together with a first amendment dated February 12, 2024 are referred to as the Financing Agreement, and fully repaid the indebtedness outstanding under** the Loan Agreement. Subject to the limitations in the terms of our existing and future indebtedness, we and our subsidiaries may incur additional indebtedness, secure existing or future indebtedness, or refinance our indebtedness. We may be required to use a substantial portion of our cash ~~flows from operations~~ to pay interest and principal on our indebtedness. Our ability to make scheduled payments of the principal of, to pay interest on or to refinance our indebtedness, depends on our future performance and our ability to generate sufficient cash flow from our operations, which are subject to economic, financial, competitive and other factors beyond our control. Such payments will reduce the funds available to us for working capital, capital expenditures, and other corporate purposes and limit our ability to obtain additional financing for working capital, capital expenditures, expansion plans, and other investments, which may in turn limit our ability to implement our business strategy, heighten our vulnerability to downturns in our business, the industry, or in the general economy, limit our flexibility in planning for, or reacting to, changes in our business and the industry, and prevent us from taking advantage of business opportunities as they arise. Additionally, if we are unable to generate sufficient cash flow to service our indebtedness and fund our operations, we may be required to adopt one or more alternatives, such as selling assets, restructuring debt or obtaining additional equity capital on terms that may be onerous or highly dilutive. We may not be able to engage in any of these activities or engage in these activities on desirable terms, which could result in a default on our debt obligations. We have incurred indebtedness under our convertible senior notes and are party to a **financing** ~~loan and security~~ agreement that contain operating and financial covenants that may restrict our business and financing activities. In March 2020, we issued the 2027 Notes, pursuant to which we pay interest semiannually in arrears at a rate of 2. 50 % per year. The 2027 Notes will mature on March 15, 2027 unless earlier converted or repurchased, at which time we will settle any conversions of the 2027 Notes in cash, shares of our common stock or a combination thereof, at our election. In January and February 2021, we issued the 2029 Notes, pursuant to which we pay interest semiannually in arrears at a rate of 2. 25 % per year. The 2029 Notes will mature on February 1, 2029 unless earlier converted or repurchased, at which time we will settle any conversions of the 2029 Notes in cash, shares of our common stock or a combination thereof, at our election. Under certain circumstances, the holders of the 2027 Notes and the 2029 Notes, or collectively, the Notes, may require us to repay all or a portion of the principal and interest outstanding under the Notes in cash prior to their respective maturity dates, which could have an adverse effect on our financial results. In ~~November~~ **January** ~~2021~~ **2024** , we entered into the ~~Loan~~ **Financing** Agreement, pursuant to which ~~we were~~ **the lenders thereunder agreed to** ~~extended~~ -- **extend** ~~term loans~~ **a senior secured credit facility to us** in an aggregate principal amount of up to $ 750. 0 million, comprised of (i) ~~a tranche 1 advance~~ **an initial term loan** of $ 450. 0 million, or the

~~Tranche 1 Advance~~ **Initial Term Loan** , and (ii) ~~a tranche 2 advance~~ **subject to the satisfaction** of **certain terms and conditions set forth in the Financing Agreement, one or more incremental term loans in an aggregate principal amount not to exceed** $ 300. 0 million **. The Initial** ~~, or the Tranche 2 Advance, or collectively, the~~ Term Loan ~~Advances. The Tranche 1 Advance~~ was funded on ~~November~~ **January** 17, ~~2021~~ **2024** . ~~In May~~ **We are required to make principal payments of $ 22. 5 million on the outstanding balance of the term loans commencing on June 30,** ~~2022~~ **2027** ~~, we amended~~ **in quarterly installments in amounts and subject to conditions as set forth in** the ~~Loan~~ **Financing** Agreement **, including variable interest rates and additional quarterly installments of $ 10. 0 million if our market capitalization is at any time after January 17, 2024 less than $ 1. 5 billion. The stated maturity date of the term loans is January 17, 2029, with** ~~to~~ **two springing earlier maturity dates at 91 days prior to the stated maturity dates of the 2027 Notes and the 2029 Notes, respectively, in each case to the extent there is an aggregate outstanding amount of such notes of more than $ 50 million on such dates. The Financing Agreement restricts our ability** , among other things **and subject** ~~, reduce the Tranche 2 Advance~~ to **certain limited exceptions** ~~$ 100. 0 million. In November 2022, we further amended the Loan Agreement to, among other things, terminate the ability for us to draw down the Tranche 2 Advance. The term loans mature on November 16, 2026. The Loan Agreement may restrict our ability, among other things~~ , to: • sell, transfer or otherwise dispose of any of our business or property ~~, subject to limited exceptions~~ ; • make material changes to our business; • enter into transactions resulting in significant changes to the voting control of our stock; • make certain changes to our organizational structure; • consolidate or merge with other entities or acquire other entities; • incur additional indebtedness or create encumbrances on our assets; • pay dividends, or make distributions on **or** ~~and, in certain cases,~~ repurchase our stock; • enter into transactions with our affiliates; • ~~repay~~ **make payments in respect of** subordinated indebtedness **or royalty monetization transactions** ; or • make certain investments. In addition, we are required **to maintain,** under the ~~Loan~~ **Financing** Agreement **, a minimum unrestricted cash balance of $ 70, 000, 000 at all times and** to comply with various operating covenants and default clauses that may restrict our ability to finance our operations, engage in business activities or expand or fully pursue our business strategies. **As security for the obligations under the Financing Agreement, we and our subsidiaries that are party to the Financing Agreement as guarantors are required to grant to the administrative agent, for the benefit of the lenders and secured parties, a continuing first priority security interest in substantially all of our assets and the assets of our subsidiaries that are party to the Financing Agreement as guarantors (including all equity interests owned or hereafter acquired by us or such subsidiaries), subject to certain exceptions.** A breach of any of these covenants or clauses could result in a default under the ~~Loan~~ **Financing** Agreement, which could cause all of the outstanding indebtedness under the facility to become immediately due and payable ~~. Under the Loan Agreement, we also have~~ **and cause us to incur additional fees related to** an ~~obligation to pledge~~ **early repayment,** ~~our~~ - **or** ~~equity interests in our subsidiaries. In addition, certain of our non- operating subsidiaries, which are subsidiaries other than those predominantly involved in advancing our development programs, are also obligated to enter into a joinder agreement, whereby they are also required to comply with the terms of the Loan Agreement. Any breach by us, or any event of default under, our Loan Agreement could~~ result in a material adverse effect on our business, financial condition and operating results. The conditional conversion feature of the Notes, if triggered, may adversely affect our financial condition and operating results. In the event the conditional conversion feature of the Notes is triggered, holders of the Notes will be entitled to convert the notes at any time during specified periods at their option. If one or more holders elect to convert their Notes, unless we elect to satisfy our conversion obligation by delivering solely shares of our common stock (other than paying cash in lieu of delivering any fractional share), we would be required to settle a portion or all of our conversion obligation through the payment of cash, which could adversely affect our liquidity. In addition, even if holders do not elect to convert their Notes, we could be required under applicable accounting rules to reclassify all or a portion of the outstanding principal of the ~~notes~~ **Notes** as a current rather than long- term liability, which would result in a material reduction of our net working capital. Risks Related to Our Need for Additional Capital We ~~will~~ **may** require substantial additional funding to achieve our business goals. If we are unable to obtain this funding when needed and on acceptable terms, we could be forced to delay, limit or terminate our product development and commercialization efforts. Developing and commercializing biopharmaceutical products is expensive and time- consuming, and we **may** ~~expect to~~ require substantial additional capital to conduct research, preclinical testing and human studies, may establish pilot scale and commercial scale manufacturing processes and facilities, and establish and develop quality control, regulatory, marketing, sales and administrative capabilities to support our existing programs and pursue potential additional programs. We are also responsible for the payments to third parties of expenses that may include milestone payments, license maintenance fees and royalties, including in the case of certain of our agreements with academic institutions or other companies from whom intellectual property rights underlying their respective programs have been in- licensed or acquired. Because the outcome of any preclinical or clinical development and regulatory approval process is highly uncertain, we cannot reasonably estimate the actual amounts necessary to successfully complete the development, regulatory approval process and commercialization of any future product candidates we may identify. As of December 31, ~~2022~~ **2023** , we had working capital of $ ~~427~~ **333** . ~~4~~ **7** million, of which cash, cash equivalents ~~and marketable securities~~ amounted to $ ~~428~~ **375** . ~~3~~ **9** million, restricted cash amounted to $ ~~37~~ **16** . ~~9~~ **7** million, and investment in equity securities amounted to $ ~~43~~ **58** . ~~7~~ **9** million. We expect that our cash and cash equivalents ~~, marketable securities~~ , restricted cash and investment in equity securities will be sufficient to fund our operations through at least the next 12 months from the date of this report. However, our operating plan may change as a result of many factors currently unknown to us, including ~~the effects of the COVID- 19 pandemic on~~ **our need for, and ability to raise, capital to support** our research ~~and~~ **,** development and commercialization ~~activities~~ **plans** , and we may need to seek additional funds sooner than planned, through public or private equity or debt financings or other sources, such as **royalty financings,** strategic collaborations or license and development agreements. Any additional fundraising efforts for us may divert our management from their day- to- day activities, which may adversely affect our ability to develop and commercialize product candidates that we may identify and pursue. Moreover, such

financing may result in dilution to stockholders, imposition of debt covenants and repayment obligations, or other restrictions that may affect our business. In addition, we may seek additional capital due to favorable market conditions or strategic considerations even if we believe we have sufficient funds for our current or future operating plans. Our future funding requirements will depend on many factors, including, but not limited to: • the time and cost necessary to **establish internal commercialization capabilities or enter into collaborations with third parties for the commercialization of acoramidis or any other product candidate, if approved; • our ability to satisfy the conditions required by the funding of the Investment Amount (as defined below) under the Funding Agreement; • the time and cost necessary to** complete ongoing and planned clinical trials, including our ongoing Phase 3 clinical ~~trial of acoramidis, our ongoing Phase 2 and planned Phase 3 clinical~~ trials of low- dose infigratinib, ~~our ongoing Phase 2 clinical trial of BBP- 631~~ and our ongoing Phase 3 clinical trial of encaleret; • the time and cost necessary to pursue regulatory approvals for our product candidates, and the costs of post- marketing studies that could be required by regulatory authorities; • the progress, timing, scope and costs of our nonclinical studies, preclinical studies, clinical trials and other related activities, including the ability to enroll patients in a timely manner, for the ongoing and planned clinical trials set forth above, and potential future clinical trials; • the costs of obtaining adequate clinical and commercial supplies of raw materials and drug products for our product candidates, including gene therapies such as BBP- ~~631, and BBP-~~ 812 and any other product candidates we may identify and develop; • our ability to successfully identify and negotiate acceptable terms for third- party supply and contract manufacturing agreements with CMOs; • our ability to successfully commercialize any product candidates that may be approved; • the manufacturing, selling and marketing costs associated with any product candidates that may be approved, including the cost and timing of expanding our internal sales and marketing capabilities or entering into strategic collaborations with third parties to leverage or access these capabilities; • the amount and timing of sales and other revenues from any approved products, including the sales price and the availability of adequate third- party reimbursement; • the cash requirements of any future acquisitions or discovery of product candidates; • the time and cost necessary to respond to technological and market developments; • the costs of acquiring, licensing or investing in intellectual property rights, products, product candidates and businesses; • our ability to continue to discover and develop additional product candidates, and the time and costs associated with identifying additional product candidates; • our ability to attract, hire and retain qualified personnel; and • the costs of maintaining, expanding and protecting our intellectual property portfolio. Additional funds may not be available when we need them, on terms that are acceptable, or at all. If adequate funds are not available to us on a timely basis, we may be required to delay, limit or terminate one or more research or development programs or the commercialization of any product candidates or be unable to expand operations or otherwise capitalize on business opportunities, as desired, which could materially affect our business, prospects, financial condition and results of operations. **The sale or issuance of our securities, including the sale or issuance of common stock to, or through, Goldman Sachs & Co. LLC, or Goldman Sachs, and SVB Securities LLC, or SVB, pursuant to our Equity Distribution Agreement, dated May 4, 2023, or the ATM Agreement, may cause significant dilution and the sale of such securities, or the perception that such sales may occur, could cause the price of our common stock to fall. In May 2023, we entered into the ATM Agreement with Goldman Sachs and SVB, pursuant to which we may offer and sell our common stock, having aggregate sales proceeds of up to $ 450. 0 million, to or through Goldman Sachs and SVB, from time to time, in an " at- the- market " offering program. In connection with the ATM Agreement, we filed a registration statement on Form S- 3 / ASR (File No. 333- 271650) pursuant to which we may issue the shares of common stock subject to the ATM Agreement, and, so long as we qualify as a " well- known seasoned issuer " as defined in Rule 405 of the Securities Act of 1933, as amended, or the Securities Act, an unlimited amount of shares of our common stock, preferred stock, debt securities, warrants and / or units. Sales to, or through, Goldman Sachs and SVB by us under the ATM Agreement or otherwise pursuant to the registration statement could result in substantial dilution to the interests of other holders of our common stock. Additionally, the sale of a substantial number of shares of our common stock or other securities, or the anticipation of such sales, could make it more difficult for us to sell equity or equity- related securities in the future at a time and at a price that we might otherwise wish to effect sales. The Funding Agreement contains certain conditions to the Purchasers' funding obligations and various covenants and restrictions on our operations that, if violated, may adversely affect our financial condition and operating results. An increase of the royalty rate on the net sales of acoramidis under the Funding Agreement could harm our financial condition and operating results. In January 2024, we and our subsidiaries Eidos Therapeutics, Inc., BridgeBio Europe B. V. and BridgeBio International GmbH (together, the " Seller Parties ") entered into a Funding Agreement (the " Funding Agreement ") with LSI Financing 1 Designated Activity Company and CPPIB Credit Europe S. à r. l. (together, the " Purchasers "), and Alter Domus (US) LLC, as the collateral agent, to help support a future commercial launch of acoramidis. Under the Funding Agreement, the Purchasers' obligation to pay us $ 500. 0 million (in the aggregate, net of certain transaction expenses) (the " Investment Amount ") is conditioned upon the first FDA approval of acoramidis, subject to certain conditions relating to the FDA approval and other customary conditions. We cannot guarantee that we will obtain FDA approval of acoramidis or that the FDA approval will satisfy all applicable conditions under the Funding Agreement. Other conditions may be beyond our control or dependent on factors that we cannot predict. If we fail to satisfy all the conditions for the Purchasers' funding obligations under the Funding Agreement (and the Purchasers refuse to waive unsatisfied conditions), the Purchasers will not be required to fulfill their obligation to pay us the Investment Amount, and we may be unable to find alternative sources of funding on acceptable terms, or at all. If we lack sufficient funds, our ability to successfully commercialize acoramidis may be materially adversely affected. Under the Funding Agreement, the Seller Parties are required to comply with various covenants, including using commercially reasonable efforts to obtain regulatory approval for and commercialize acoramidis, providing the Purchasers with certain clinical, commercial, regulatory and intellectual property updates and certain financial statements, and providing notices upon the occurrence of certain events, each as agreed under the**

Funding Agreement. Compliance with these covenants may limit our flexibility in operating our business and our ability to take actions that might otherwise be advantageous to us and our stockholders. Pursuant to the Funding Agreement, the Seller Parties have granted to the collateral agent, for the benefit of the Purchasers, a security interest in specific assets related to acoramidis. If the Seller Parties are unable to comply with applicable obligations, the Purchasers may be entitled to take possession of such assets, which could have a material adverse effect on our business, financial condition and results of operations. Under the Funding Agreement, following the Purchasers' payment of the Investment Amount to us, the Purchasers will have the right to receive payments (the " Royalty Interest Payments ") equal to 5 % of the global net sales of acoramidis (" Net Sales "). However, under certain conditions, including conditions relating to sales performance of acoramidis by or on behalf of us, the rate of the Royalty Interest Payments may adjust to a maximum rate of 10 % in 2027. Such increase (s) could result in additional payments by us to the Purchasers and materially harm our liquidity and profitability or otherwise affect our financial condition and operating results. Raising additional capital may cause dilution to our existing stockholders, restrict our operations or require us to relinquish rights to current product candidates or to any future product candidates on unfavorable terms. We may seek additional capital through any number of available sources, including, but not limited to, public and private equity offerings, debt **financings, royalty** financings, strategic partnerships and alliances and licensing arrangements. We, and indirectly, our stockholders, will bear the cost of issuing and servicing any such securities and of entering into and maintaining any such strategic partnerships or other arrangements. Because any decision by us to issue debt or equity securities in the future will depend on market conditions and other factors beyond our control, we cannot predict or estimate the amount, timing or nature of any future financing transactions. To the extent that we raise additional capital through the sale of additional equity or debt securities, your ownership interest will be diluted, and the terms may include liquidation or other preferences that adversely affect your rights as a stockholder. The incurrence of additional indebtedness would result in increased fixed payment obligations and could involve additional restrictive covenants, such as limitations on our ability to incur additional debt, limitations on our ability to acquire, sell or license intellectual property rights and other operating restrictions that could adversely impact our ability to conduct our business. Additionally, any future collaborations we enter into with third parties may provide capital in the near term, but limit our potential cash flow and revenue in the future. If we raise additional funds through strategic partnerships and alliances and licensing arrangements with third parties, we may have to relinquish valuable rights to our technologies or product candidates, or grant licenses or other rights on unfavorable terms. In addition, if one of our subsidiaries raises funds through the issuance of equity securities to third parties, our stockholders' deficit interests in such subsidiary could be substantially diminished. If one of our subsidiaries raises additional funds through collaboration and licensing arrangements, it may be necessary to relinquish some rights to our **intellectual property rights,** technologies or ~~our~~ product candidates **,** or grant licenses on terms that are not favorable to us. If we engage in other acquisitions or strategic partnerships, this may increase our capital requirements, dilute our stockholders, cause us to incur debt or assume contingent liabilities, and subject us to other risks. We may engage in various acquisitions and strategic partnerships in the future, including licensing or acquiring complementary products, intellectual property rights, technologies, or businesses. Any acquisition or strategic partnership may entail numerous risks, including: • increased operating expenses and cash requirements; • the assumption of indebtedness or contingent liabilities; • the issuance of our equity securities which would result in dilution to our stockholders; • assimilation of operations, intellectual property, product candidates of an acquired company, including difficulties associated with integrating new personnel; • the diversion of our management' s attention from our existing product programs and initiatives in pursuing such an acquisition or strategic partnership; • difficulties in retaining key employees and personnel and uncertainties in our ability to maintain key business relationships; • risks and uncertainties associated with the other party to such a transaction, including the prospects of that party and their existing products or product candidates and regulatory approvals; and • our inability to generate revenue from acquired intellectual property, technology and / or products sufficient to meet our objectives or even to offset the associated transaction and maintenance costs. In addition, if we undertake such a transaction, we may issue dilutive securities, assume or incur debt obligations, incur large one- time expenses and acquire intangible assets that could result in significant future amortization expense, any of which could have a material adverse effect on our business, prospects, financial condition and results of operations. For example, the Eidos Merger resulted in a reduction of our cash and dilutive issuances of our equity securities to the former Eidos stockholders. Any similar transactions in the future that require us to provide cash or stock consideration could harm our financial condition and negatively impact our existing stockholders. Recent volatility in capital markets and lower market prices for our securities may affect our ability to access new capital through sales of shares of our common stock or issuance of indebtedness, which may harm our liquidity **, increase our cost of capital** , limit our ability to grow our business, pursue acquisitions or improve our operating infrastructure and restrict our ability to compete in our markets. Our operations consume substantial amounts of cash, and we intend to continue to make significant investments to support our business growth, respond to business challenges or opportunities, develop new product candidates, retain or expand our current levels of personnel, improve our existing product candidates, enhance our operating infrastructure, and potentially acquire complementary businesses and technologies. Our future capital requirements may be significantly different from our current estimates and will depend on many factors, including the need to: • finance unanticipated working capital requirements; • continue the research and development of our existing product candidates and develop or enhance our technological infrastructure; • pursue acquisitions, in- licenses or other strategic relationships; and • respond to competitive pressures. Accordingly, we may need to pursue **additional** equity, debt or other financings to meet our capital needs. With uncertainty in the capital markets and other factors, such financing may not be available on terms favorable to us or at all. If we raise additional funds through further issuances of equity or convertible debt securities, our existing stockholders could suffer significant dilution, and any new equity securities we issue could have rights, preferences, and privileges superior to those of holders of our common stock. In addition, any **additional** debt financing secured by us may **also** subject us to **increased** fixed payment obligations and covenants limiting

or restricting our ability to take specific actions such as capital- raising activities, incurring additional debt, making capital expenditures or declaring dividends, and could involve additional restrictive covenants relating to our capital- raising activities and other financial and operational matters, which may make it more difficult for us to obtain additional capital and to pursue business opportunities, including potential acquisitions. If we raise additional capital through marketing and distribution arrangements or other collaborations, **other royalty financings,** or strategic alliances or licensing arrangements with third parties, we may have to relinquish certain valuable rights to our product candidates, technologies, future revenue streams or research programs or grant licenses on terms that may not be favorable to us. ~~Furthermore~~ **To meet our liquidity needs** , **we have previously relied, in part, on borrowed funds, and may do so again in the future.** ~~recent~~ **Recent and continued** increases in interest rates could affect our ability to obtain working capital through borrowings such as bank credit lines and public or private sales of debt securities, which may result in lower liquidity, reduced working capital and other adverse impacts on our business. If we are unable to obtain adequate financing or financing on terms satisfactory to us, we could face significant limitations on our ability to invest in our operations and otherwise suffer harm to our business. Risks Related to Our Common Stock The market price of our common stock has been and may be highly volatile, and purchasers of our common stock could incur substantial losses. The market price of our common stock has been and is likely to continue to be volatile. Our stock price has been and may be subject to wide fluctuations in response to a variety of factors, including the following: • adverse results or delays in our preclinical studies or clinical trials; • reports of AEs or other negative results in clinical trials of third parties' product candidates that target our product candidates' target indications; • inability for us to obtain additional funding, or to service our existing debt obligations, on reasonable terms or at all; • any delay in filing an IND, BLA or NDA for our product candidates and any adverse development or perceived adverse development with respect to the FDA' s review of that IND, BLA or NDA; • failure to develop successfully and commercialize our product candidates; • the termination of, or any other failure to develop successfully and commercialize our product candidates; • announcements we make regarding our current product candidates, acquisition of potential new product candidates and companies and / or in- licensing; • the termination of, or any other failure to maintain our existing license arrangements or enter into new licensing and collaboration agreements; • failure by us or our licensors to prosecute, maintain or enforce our intellectual property rights; • changes in laws or regulations applicable to future products; • inability to obtain adequate clinical or commercial supply for our product candidates or the inability to do so at acceptable prices; • adverse regulatory decisions, including failure to reach agreement with applicable regulatory authorities on the design or scope of our planned clinical trials; • failure to obtain and maintain regulatory exclusivity for our product candidates; • regulatory approval or commercialization of new products or other methods of treating our target disease indications by our competitors; • failure to meet or exceed financial projections we may provide to the public or to the investment community; • the perception of the pharmaceutical industry by the public, legislatures, regulators and the investment community; • announcements of significant acquisitions, strategic partnerships, joint ventures or capital commitments by us, our strategic collaboration partners or our competitors; • disputes or other developments relating to proprietary rights, including patents, litigation matters and our ability to obtain patent protection for our technologies; • additions or departures of our key scientific or management personnel; • significant lawsuits, including patent or stockholder litigation, against us; • changes in the market valuations of similar companies; • sales or potential sales of substantial amounts of our common stock; • trading volume of our common stock; • acts of war or periods of widespread civil unrest, including the increasingly volatile global economic conditions resulting from the conflicts in Ukraine **and in Israel and the Gaza Strip** ; • general economic and market conditions, including inflationary pressures and stock market volatility; and • continued increases in interest rates that increase the cost of **our existing indebtedness** any potential new indebtedness. In addition, companies trading in the stock market in general, and **The Nasdaq Global Market, or** Nasdaq, in particular, have experienced extreme price and volume fluctuations that have often been unrelated or disproportionate to the operating performance of these companies. Broad market and industry factors, including the effects of the **ongoing conflicts in Ukraine and in Israel and the Gaza Strip, widespread inflationary pressures and interest rate increases, any global health emergency such as the** COVID- 19 pandemic, and ~~the ongoing conflict in Ukraine, and~~ global economic conditions on the global economy, may negatively affect the market price of our common stock, regardless of our actual operating performance. We have in the past been, and could be subject to securities class action litigation and other types of stockholder litigation. The stock market in general, and ~~The~~ Nasdaq ~~Global Market~~ and biotechnology companies in particular, have experienced extreme price and volume fluctuations that have often been unrelated or disproportionate to the operating performance of these companies. In the past, **we have been subject to stockholder litigation related to the Eidos Merger, and** securities class action litigation has often been instituted against companies following periods of volatility in the market price of a company' s securities. We could also be subject to other types of litigation, which may involve claims of breach of fiduciary duties by our directors or officers for misuse / mismanagement of company assets / resources or conflicts of interest. Any such litigation, if instituted, could result in substantial costs and a diversion of management' s attention and resources, which would harm our business, operating results, or financial condition. Additionally, the dramatic increase in the cost of directors' and officers' liability insurance may cause us to opt for lower overall policy limits or to forgo insurance that we may otherwise rely on to cover significant defense costs, settlements, and damages awarded to plaintiffs. Future sales and issuances of our common stock or rights to purchase common stock, including pursuant to our equity incentive plans, would result in additional dilution of the percentage ownership of our stockholders and could cause our stock price to fall. We will need additional capital in the future to continue our planned operations. To the extent we raise additional capital by issuing equity securities, our stockholders may experience substantial dilution. We may sell common stock, convertible securities or other equity securities in one or more transactions at prices and in a manner we determine from time to time. If we sell common stock, convertible securities or other equity securities in more than one transaction, investors may be materially diluted by subsequent sales. These sales may also result in material dilution to our existing stockholders, and new investors could gain rights superior to our existing stockholders. Pursuant to our 2021 Amended and Restated Stock Option and

Incentive Plan, or the A & R 2021 Plan, we are authorized to grant stock options and other stock- based awards to our employees, directors and consultants. In addition, pursuant to our **Amended and Restated** 2019 Inducement Equity Plan, we are authorized to grant stock options and other stock- based awards to prospective officers and employees who are not currently employed by us or one of our subsidiaries. If our board of directors, ~~or the Board of Directors,~~ elects in the future to increase the number of shares available for future grant and, in the case of the A & R 2021 Plan, if our stockholders approve of any such further increase, our stockholders may experience additional dilution, and our stock price may fall. Any sales of a significant portion of our total outstanding shares **, including shares of common stock underlying resale registration statements filed on behalf of certain of our stockholders,** into the market could cause the market price of our common stock to decline significantly. Sales of a substantial number of shares of our common stock in the public market could occur at any time. These sales or the perception in the market that the holders of a large number of shares of common stock intend to sell shares, could reduce the market price of our common stock. Shares of unvested restricted stock and common stock issued and outstanding as of ~~the~~ **our corporate reorganization in connection with our initial public offering in** 2019 ~~Reorganization~~ will become available for sale immediately upon the vesting of such shares. Shares issued upon the exercise of stock options **or the vesting of restricted stock units** outstanding under our equity incentive plans or pursuant to future awards granted under those plans will become available for sale in the public market to the extent permitted by the provisions of applicable vesting schedules, any applicable market standoff ~~agreement~~ **agreements** , and Rule 144 and Rule 701 under ~~the Securities Act of 1933, as amended, or~~ the Securities Act. Certain holders of our common stock have rights, subject to conditions, to require us to file registration statements covering their shares or to include their shares in registration statements that we may file for ourselves or other stockholders. **Sales of** ~~In July 2020, we filed~~ a **substantial number of shares of our common stock underlying the resale** registration ~~statement~~ **statements** on Form S- **3 /** ~~3ASR~~ **ASR filed on July 26, 2023 and November 2, 2023 in the public market by the selling stockholders named in these registration statements, or the perception** that **these sales might occur** ~~became effective automatically upon filing. Pursuant to this registration statement~~ , **could depress the market price of our** ~~we were authorized to issue up to $ 350. 0 million in~~ common stock ~~in~~ **and could impair our ability to raise capital through the sale of additional equity securities or other securities convertible into or exchangeable for equity securities, regardless of whether there is any relationship between such** sales ~~deemed to be an~~ **and** ~~" at~~ the **performance** ~~market offering " as defined by the Securities Act and, so long as we qualify as a " well- known seasoned issuer " as defined in Rule 405~~ of ~~the Securities Act, an unlimited amount of shares of our common stock, preferred stock, debt securities, warrants and / or~~ **our business** ~~units. In July 2020, we filed a registration statement on Form S- 3ASR, or the Selling Stockholder Form S- 3, relating to the offer and resale from time to time by certain of our stockholders, of up to an aggregate of 65, 121, 374 shares of our common stock. In February 2021, one of our stockholders completed a sale of 3, 450, 000 shares of our common stock in an underwritten public offering pursuant to the Selling Stockholder Form S- 3~~ . We may also file registration statements in the future that register a substantial number of shares of our common stock where if any additional shares are sold pursuant to these registration statements, or if it is perceived that they will be sold, in the public market, the market price of our common stock could decline. We have also filed registration statements on Form S- 8 registering the issuance of shares of common stock issued or reserved for future issuance under our equity compensation and equity inducement plans. Shares registered under these registration statements on Form S- 8 can be freely sold in the public market upon issuance and once vested, subject to volume limitations applicable to affiliates. In addition, certain of our executive officers, employees and affiliates have established or may in the future establish programmed selling plans under Rule 10b5- 1 of the Securities Exchange Act of 1934, as amended, for the purpose of effecting sales of our common stock. If any of these additional shares are sold, or if it is perceived that they will be sold, in the public market, the market price of our common stock could decline. If securities analysts do not publish research or reports about our business or if they publish negative evaluations of our stock, the price of our stock could decline. The trading market for our common stock relies in part on the research and reports that industry or financial analysts publish about us or our business. If one or more of the analysts covering our business downgrade their evaluations of our stock, the price of our stock could decline. If one or more of these analysts cease to cover our stock, we could lose visibility in the market for our stock, which in turn could cause our stock price to decline. Our principal stockholders and certain members of our management own a significant percentage of our stock and will be able to exert significant control over matters subject to stockholder approval. Based upon our common stock outstanding as of December 31, ~~2022~~ **2023** , our beneficial stockholders, directors, and executive officers beneficially own ~~58~~ **56** . ~~4~~ **1** % of our outstanding common stock. These stockholders will have the ability to influence us through their ownership positions. These stockholders may be able to determine all matters requiring stockholder approval. For example, these stockholders, acting together, may be able to control elections of directors, amendments of our organizational documents, or approval of any merger, sale of assets, or other major corporate transaction. In turn, this may have an adverse effect on the market price of our common stock. This may prevent or discourage unsolicited acquisition proposals or offers for our common stock that you may believe are in your best interest as one of our stockholders. In certain circumstances, these stockholders' interests as stockholders may differ or even conflict with the interests of our **other** stockholders. Provisions in our amended and restated certificate of incorporation and amended and restated bylaws, as well as provisions of Delaware law, could make it more difficult for a third party to acquire us or increase the cost of acquiring us, even if doing so would benefit our stockholders or remove our current management. Our amended and restated certificate of incorporation and amended and restated bylaws and Delaware law contain provisions that may have the effect of delaying or preventing a change in control of us or changes in our management. Our amended and restated certificate of incorporation and amended and restated bylaws include provisions that: • authorize " blank check " preferred stock, which could be issued by our Board of Directors without stockholder approval and may contain voting, liquidation, dividend and other rights superior to our common stock; • create a classified Board of Directors whose members serve staggered three- year terms; • specify that special meetings of our stockholders can be called only by our Board of Directors or stockholders holding at least 25 % of our outstanding voting stock;

• prohibit stockholder action by written consent; • establish an advance notice procedure for stockholder approvals to be brought before an annual meeting of our stockholders, including proposed nominations of persons for election to our Board of Directors; • provide that vacancies on our Board of Directors may be filled only by a majority of directors then in office, even if less than a quorum, or by the holders of a majority of the outstanding shares of capital stock then entitled to vote at an election of directors; • specify that no stockholder is permitted to cumulate votes at any election of directors; • expressly authorize our Board of Directors to modify, alter or repeal our amended and restated bylaws; and • require supermajority votes of the holders of our common stock to amend specified provisions of our amended and restated certificate of incorporation and amended and restated bylaws. These provisions, alone or together, could delay or prevent hostile takeovers and changes in control or changes in our management. In addition, because we are incorporated in Delaware, we are governed by the provisions of Section 203 of the Delaware General Corporation Law, which limits the ability of stockholders owning in excess of 15 % of our outstanding voting stock to merge or combine with us. Any provision of our amended and restated certificate of incorporation or amended and restated bylaws or Delaware law that has the effect of delaying or deterring a change in control could limit the opportunity for our stockholders to receive a premium for their shares of our common stock, and could also affect the price that some investors are willing to pay for our common stock. Our amended and restated bylaws designate specific courts as the exclusive forum for certain litigation that may be initiated by our stockholders, which could limit our stockholders' ability to obtain a favorable judicial forum for disputes with us. Pursuant to our amended and restated bylaws, unless we consent in writing to the selection of an alternative forum, the Court of Chancery of the State of Delaware will be the sole and exclusive forum for any state law claim for (i) any derivative action or proceeding brought on our behalf; (ii) any action asserting a claim of breach of or based on a fiduciary duty owed by any of our current or former directors, officers or employees to us or our stockholders; (iii) any action asserting a claim against us arising pursuant to any provision of the Delaware General Corporation Law or our amended and restated certificate of incorporation or amended and restated bylaws; (iv) any action to interpret, apply, enforce or determine the validity of our amended and restated certificate of incorporation or amended and restated bylaws; or (v) any action asserting a claim governed by the internal affairs doctrine of the State of Delaware. Our amended and restated bylaws further provide that, unless we consent in writing to the selection of an alternative forum, the federal district courts of the United States will be the sole and exclusive forum for resolving any complaint asserting a cause of action arising under the Securities Act. The forum selection clauses in our amended and restated bylaws may limit our stockholders' ability to obtain a favorable judicial forum for disputes with us. Our operating results may fluctuate significantly, which makes our future operating results difficult to predict and could cause our operating results to fall below expectations or our guidance. Our quarterly and annual operating results may fluctuate significantly in the future, which makes it difficult for us to predict our future operating results. Our operating results may fluctuate due to a variety of factors, many of which are outside of our control and may be difficult to predict, including but not limited to the following: • the timing, results and cost of, and level of investment in, our clinical development activities for our current product candidates and any other product candidates we may identify and pursue, which may change from time to time; • the cost of manufacturing our current product candidates and the related materials or other product candidates that we may identify, which may vary depending on the quantity of production and the terms of agreements with manufacturers; • our ability to conduct our ongoing and planned clinical trials in accordance with our current plans and to obtain regulatory approval for our current product candidates or other product candidates that we may identify, and the timing and scope of any such approvals we may receive; • the timing and success or failure of clinical trials for competing product candidates, or any other change in the competitive landscape of our industry, including consolidation among our competitors or partners; • expenditures that we or will or may incur to acquire or develop additional product candidates and technologies; • the level of demand for our current product candidates or other product candidates that we may identify, should they receive approval, which may vary significantly; • future accounting pronouncements or changes in our accounting policies; • **future tax regulation changes that impact effective tax rates; • the success of our restructuring initiatives; •** the risk / benefit profile, cost and reimbursement policies with respect to our current product candidates or other product candidates that we may identify, if approved, and existing and potential future drugs that compete with our product candidates; • **changes in** ~~the success of our restructuring initiative; and • the changing and volatile U. S., European and~~ global economic ~~environments~~ **and market conditions** , including **inflationary pressures, interest rate increases, supply chain shortages and stock market** volatility ~~associated with the~~ **; and • acts of war, armed conflicts and political or civil unrest, including volatile** global ~~COVID- 19 pandemic~~ **economic conditions resulting from the conflict in Ukraine and the Israel / Hamas conflict** . The cumulative effects of these factors could result in large fluctuations and unpredictability in our quarterly and annual operating results. As a result, comparing our operating results on a period- to- period basis may not be meaningful. This variability and unpredictability could also result in our failing to meet the expectations of industry or financial analysts or investors for any period. If our operating results fall below the expectations of analysts or investors or below any forecasts we may provide to the market, or if the forecasts we provide to the market are below the expectations of analysts or investors, the price of our common stock could decline substantially. Our future ability to utilize our net operating loss carryforwards and certain other tax attributes may be limited. We have incurred substantial losses during our history and we do not expect to become profitable in the near future and we may never achieve profitability. To the extent that we continue to generate taxable losses, unused losses will carry forward indefinitely if not utilized, subject to expiration of such carryforwards in the case of federal net operating loss carryforwards generated prior to 2018. In addition, under Sections 382 and 383 of the Internal Revenue Code of 1986, as amended, or the Code, and corresponding provisions of state law, if a corporation undergoes an " ownership change, " generally defined as a greater than 50 percentage point change (by value) in its equity ownership over a three- year period, the corporation' s ability to use its pre- change net operating loss carryforwards, or NOLs, and other pre- change tax attributes to offset its post- change income or taxes may be limited. Our existing net operating losses or credits may be subject to limitations arising from previous ownership changes and if we undergo future ownership changes, many of which may be outside of our control, our ability to

utilize our net operating losses or credits could be further limited by Sections 382 and 383 of the Code. Accordingly, we may not be able to utilize a material portion of our net operating losses or credits. In addition, the amount of post- 2017 NOLs that we are permitted to deduct in taxable years beginning after December 31, ~~2022~~ **2023** is limited to 80 % of our taxable income in such year. Changes in tax ~~law~~ **laws or regulations** may adversely affect ~~us or~~ **our financial condition** ~~our investors. The rules dealing with U. S. federal, state~~ and **results of operations** ~~local income taxation are constantly under review by persons involved in the legislative process and by the Internal Revenue Service and the U. S. Treasury Department~~ . Changes ~~to~~ **in** tax laws ~~(which~~ **or regulations, or** changes ~~may have retroactive application)~~ **in interpretations of existing tax laws and regulations,** could adversely affect ~~us or~~ **our** ~~holders~~ **financial condition and results** of ~~our common stock~~ **operations, possibly with retroactive effect** . For example, ~~under Section 174 of~~ the **Biden administration** ~~Code, in taxable years beginning after December 31, 2021, expenses that are incurred for research~~ and ~~development in the~~ **members of Congress have proposed, and future** U. S. ~~will be capitalized and amortized~~ **presidential administrations may propose, various U. S. federal tax law changes** , which **, if enacted,** may have an adverse effect on our ~~cash flow~~ **business operations and financial performance** . ~~In recent years~~ **Outside of the U. S.** , ~~many such~~ **various governments and organizations are increasingly focused on tax reform and other legislative or regulatory action to increase tax revenue, including the base erosion and profit shifting, or BEPS, project that is being led by the Organization for Economic Co- operation and Development, or OECD, and other initiatives led by the OECD or the European Commission. With our international operations and potential expansion, these types of** changes ~~have been made, and changes are likely~~ to ~~continue to occur in~~ the **taxation of** ~~future. It cannot be predicted whether, when, in what form or~~ **our activities** ~~with what effective dates tax laws, regulations and rulings may be enacted, promulgated or issued, which~~ could ~~result in an~~ increase ~~in our~~ **the amount of taxes imposed on** ~~or~~ **our business, and** ~~our shareholders' tax liability or require changes in the manner in which we operate in order to minimize or mitigate any adverse~~ **adversely** ~~effects~~ **affect our financial condition and results** of **operations** ~~changes in tax law~~ . We have never and do not currently intend to pay dividends on our common stock, and, consequently, our stockholders' ability to achieve a return on their investment will depend on appreciation in the price of our common stock. We have never paid cash dividends on any of our capital stock and do not currently intend to pay any cash dividends on our common stock for the foreseeable future. In addition, pursuant to the ~~Loan~~ **Financing** Agreement, we are not permitted to declare or pay any cash dividends or make cash distributions on any class of our capital stock or any other equity interest, except in limited circumstances. We currently intend to invest our future earnings, if any, to fund our growth. Therefore, you are not likely to receive any dividends on your common stock for the foreseeable future. Since we do not intend to pay dividends, your ability to receive a return on your investment will depend on any future appreciation in the market value of our common stock. There is no guarantee that our common stock will appreciate or even maintain the price at which our holders have purchased it. We have incurred and will continue to incur significant costs as a result of operating as a public company, and our management is required to devote substantial time to new compliance initiatives. **As a public company, we incur significant legal, tax, accounting and other expenses which are greater than those for private companies.** We are subject to ~~financial reporting and other requirements for which our accounting and other management systems and resources may not be adequately prepared. As a public company, we incur significant legal, accounting and other expenses that we did not incur as a private company. We are subject to~~ the reporting requirements of the Exchange Act, ~~which~~ **the Sarbanes- Oxley Act, the Dodd- Frank Act, the listing requirements of the Nasdaq and other applicable securities laws and regulations. For example, the Exchange Act** requires, among other things, that we file with the SEC, annual, quarterly and current reports with respect to our business and financial condition and that of our consolidated subsidiaries. **These reporting** ~~In addition, the Sarbanes- Oxley Act, as well as rules subsequently adopted by the SEC and Nasdaq to implement provisions of the Sarbanes- Oxley Act, impose significant~~ requirements ~~on~~ **also continue to change, which has created uncertainty for** public companies **like us** , ~~including requirements to file annual, quarterly,~~ and ~~event driven reports with respect to our business~~ **accommodating the evolving standards may require additional legal** and financial ~~condition, and requirements for the establishment and maintenance of effective disclosure and financial controls and changes in corporate governance practices. Pursuant to Section 404, we are required to furnish a report by our management on our internal control over financial reporting, including an attestation report on internal control over financial reporting issued by our independent registered public accounting firm. Our compliance with Section 404, including the auditor attestation requirement, necessitates that we incur substantial accounting expense and expend significant management efforts. We will continue to dedicate internal resources, potentially engage outside consultants, and adopt a detailed work plan to assess and document the adequacy of internal control over financial reporting, continue steps to improve control processes as appropriate, validate through testing that controls are functioning as documented, and implement a continuous reporting and improvement process for internal control over financial reporting. Despite our efforts, there is a risk that neither we nor our independent registered public accounting firm will be able to conclude within the prescribed timeframe that our internal control over financial reporting is effective as required by Section 404. This could result in an adverse reaction in the financial markets due to a loss of confidence in the reliability of our financial statements. Further, in July 2010, the Dodd- Frank Wall Street Reform and Consumer Protection Act, or the Dodd- Frank Act, was enacted. There are significant corporate governance and executive compensation- related provisions in the Dodd- Frank Act that require the SEC to adopt additional rules and regulations in these areas such as " say on pay " and proxy access. Stockholder activism, the current political environment and the current high level of government intervention and regulatory reform may lead to substantial new regulations and disclosure obligations, which may lead to additional~~ compliance costs ~~and impact the manner in which we operate our business in ways we cannot currently anticipate~~ . Additionally, there continues to be public interest and increased legislative pressure related to environmental, social and governance, or ESG, activities of public companies. We risk negative stockholder reaction, including from proxy advisory services, as well as damage to our brand and reputation, if we do not act responsibly in a number of key areas, including diversity and inclusion, environmental stewardship, support for local communities, corporate governance and

transparency and considering ESG and human capital factors in our operations. There is a growing number of states requiring organizations to report their board composition as well or mandating gender diversity and representation from underrepresented communities, including New York and California. ~~We expect the rules and regulations applicable to us as a public company to substantially increase our legal and financial compliance costs and to make some activities more time- consuming and costly.~~ If these requirements divert the attention of our management and personnel from other business concerns, they could have a material adverse effect on our business, financial condition and results of operations. The ~~increased~~ **compliance** costs ~~will~~ **also** decrease our net income or increase our net loss, and may require us to reduce costs in other areas of our business, including our subsidiaries. For example, our status as a public Company makes it more difficult and more expensive for us to obtain director and officer liability insurance and we may be required to ~~incur~~ **continue incurring** substantial costs to maintain the level of coverage that we believe is appropriate for a public Company. We cannot predict or estimate the amount or timing of additional costs we may incur to comply with ongoing requirements or respond to any changes of these requirements. The impact of these requirements could also make it more difficult for us to attract and retain qualified persons to serve on our Board of Directors, our board committees or as executive officers. Our business could be negatively impacted by corporate citizenship and environmental, social and corporate governance, or ESG, matters and / or our reporting of such matters. There is an increasing focus from certain investors, consumers, and other stakeholders concerning corporate citizenship and sustainability matters. We could be perceived as not acting responsibly in connection with these matters. Our business could be negatively impacted by such matters. Any such matters, or related corporate citizenship and sustainability matters, could have a material adverse effect on our business. ~~Risks Following the Eidos Merger We may be subject to litigation in connection with the Eidos Merger. Lawsuits have been filed against us, certain of our subsidiaries, Eidos and Eidos' directors in connection with the Eidos Merger. Moreover, additional lawsuits may be filed against us, Eidos, our subsidiaries or our respective directors or executive officers in connection with the Eidos Merger and the related transactions, and while it is not possible to accurately predict future litigation and its impact, it is possible that such suits could result in substantial costs to BridgeBio and Eidos. The defense or settlement of any legal proceedings or future litigation could be time- consuming and expensive, divert the attention of BridgeBio management and / or Eidos management away from their regular business, and, if any one of these legal proceedings or any future litigation is adversely resolved against either BridgeBio or Eidos, could have a material adverse effect on their respective financial condition, results of operations or liquidity.~~ General Risk Factors If we fail to comply with environmental, health and safety laws and regulations, we could become subject to fines or penalties or incur costs that could harm our business. We are subject to numerous environmental, health and safety laws and regulations, including those governing laboratory procedures and the handling, use, storage, treatment and disposal of hazardous materials and wastes. Our operations involve the use of hazardous and flammable materials, including chemicals and biological materials. Our operations also produce hazardous waste products. We generally contract with third parties for the disposal of these materials and wastes. We cannot eliminate the risk of contamination or injury from these materials. In the event of contamination or injury resulting from our use of hazardous materials, we could be held liable for any resulting damages, and any liability could exceed our resources. We also could incur significant costs associated with civil or criminal fines and penalties for failure to comply with such laws and regulations. Although we maintain workers' compensation insurance to cover us for costs and expenses that we may incur due to injuries to our employees resulting from the use of hazardous materials, this insurance may not provide adequate coverage against potential liabilities. We do not maintain insurance for environmental liability or toxic tort claims that may be asserted against us in connection with our storage or disposal of biological, hazardous or radioactive materials. In addition, we may incur substantial costs in order to comply with current or future environmental, health and safety laws and regulations. These current or future laws and regulations may impair our research, development or production efforts. Our failure to comply with these laws and regulations also may result in substantial fines, penalties or other sanctions. Unfavorable global economic conditions could adversely affect our business, financial condition or results of operations. Our ability to invest in and expand our business and meet our financial obligations, to attract and retain third- party contractors and collaboration partners and to raise additional capital depends on our operating and financial performance, which, in turn, is subject to numerous factors, including the prevailing economic and political conditions and financial, business and other factors beyond our control, such as the rate of unemployment, the number of uninsured persons in the United States, political influences and inflationary pressures. For example, an overall decrease in or loss of insurance coverage among individuals in the United States due to high levels of unemployment ~~(particularly as a result of the COVID- 19 pandemic)~~ , underemployment or the repeal of certain provisions of the ACA, may decrease the demand for healthcare services and pharmaceuticals. Additionally, the availability of healthcare services and resources ~~is currently~~ **can be** constrained due to **a public health emergency, such as during** the COVID- 19 pandemic. If fewer patients are seeking medical care because they do not have insurance coverage or are unable to obtain medical care for their conditions due to resource constraints on the healthcare system, we may experience difficulties in any eventual commercialization of our product candidates and our business, results of operations, financial condition and cash flows could be adversely affected. In addition, our results of operations could be adversely affected by general conditions in the global economy and in the global financial markets upon which pharmaceutical and biopharmaceutical companies such as us are dependent for sources of capital. In the past, global financial crises have caused extreme volatility and disruptions in the capital and credit markets. A severe or prolonged economic downturn ~~, including as a result of the COVID- 19 pandemic,~~ could result in a variety of risks to our business, including a reduced ability to raise additional capital when needed on acceptable terms, if at all, and weakened demand for our product candidates. A weak or declining economy could also strain our suppliers, possibly resulting in supply disruption. Any of the foregoing could harm our business **,** and we cannot anticipate all of the ways in which **a public health emergency, such as** the COVID- 19 pandemic, **or similar outbreaks, the** current economic climate **,** and financial market conditions could adversely impact our business. ~~The global economic conditions created by~~ **Further, military conflicts or wars (such as Russia' s invasion of Ukraine or** the **armed** conflict ~~between Russia and Ukraine could adversely~~

~~affect our business, financial condition, stock price and results of operations. In February 2022, Russia commenced a military invasion of Ukraine, and sustained conflict and disruption~~ in **Israel** ~~the region is likely. Although the conflict has had little direct impact on our business to date, the uncertainty~~ and ~~ripple effects created by this conflict may have unknown indirect impacts. As a result of the invasion, the U. S. and certain other~~ -- **the Gaza Strip) can** ~~countries have imposed sanctions on Russia and could impose further sanctions that could~~ damage or disrupt international commerce and the global economy. It is not possible to predict the broader or longer- term consequences of ~~this~~ **such** ~~conflict~~ **conflicts** , or the sanctions imposed to date, which could include further sanctions **and counter- sanctions** , embargoes, regional instability, retaliatory cyber- attacks, geopolitical shifts and adverse effects on macroeconomic conditions, security conditions, currency exchange rates and financial markets. The potential effects of ~~the~~ **such** ~~conflict~~ **conflicts** include but are not limited to changes in laws and regulations affecting our business, fluctuations in foreign currency markets, potential supply chain disruptions **, inflationary pressures** , and increased market volatility and uncertainty that could have an adverse impact on macroeconomic factors that affect our business **, financial condition, stock price** and **results of** operations. Our internal computer systems, or those used by our third- party ~~research institution~~ collaborators, ~~CROs or other~~ contractors or consultants, may fail or suffer security breaches, which could result in a material disruption of our ~~product~~ development programs **and business operations** . Despite the implementation of security measures, our internal computer systems and those of our ~~current and future~~ CROs **, CMOs, third- party logistics providers, third- party collaboration and commercialization partners,** and other contractors and consultants may be vulnerable to damage from computer viruses, unauthorized access, natural disasters, terrorism, cybersecurity threats, war, and telecommunication and electrical failures. Although to our knowledge we have not experienced any such material system failure or security breach to date, if such an event were to occur and cause interruptions in our operations, it could result in a material disruption of development programs and business operations. For example, the loss of clinical trial data from completed, ongoing or future clinical trials **or commercialization information** could result in delays in our regulatory approval **or commercialization** efforts and significantly increase our costs to recover or reproduce the data. Likewise, we rely on third parties for research and development, the manufacture and supply of drug product and drug substance and to conduct clinical trials and commercialization activities. We depend on these third parties to implement adequate controls and safeguards to protect against and report cyber incidents. If they fail to do so, we may suffer financial and other harm, including to our information, operations, performance, and reputation. To the extent that any disruption or security breach were to result in a loss of, or damage to, our data or systems, or inappropriate disclosure of confidential or proprietary information, we could incur liability and the further development and commercialization of our product candidates could be delayed. We also rely on third- party service providers for aspects of our internal control over financial reporting, and such service providers may experience a material system failure or fail to carry out their obligations in other respects, which may impact our ability to produce accurate and timely financial statements, thus harming our operating results, our ability to operate our business, and our investors' view of us. ~~Cyber~~ **Cybersecurity** threats, both on premises and in the cloud, are evolving and include, but are not limited to: malicious software, destructive malware, ransomware, attempts to gain unauthorized access to systems or data, disruption to operations, critical systems or denial of service attacks; unauthorized release of confidential, personal or otherwise protected information; corruption of data, networks or systems; harm to individuals; and loss of assets. In addition, we could be impacted by ~~cyber~~ **cybersecurity** threats or other disruptions or vulnerabilities found in products or services we use that are provided to us by third- parties. The techniques used by criminal elements to attack computer systems are sophisticated, change frequently and may originate from less regulated and remote areas of the world. As a result, we may not be able to address these techniques proactively or implement adequate preventative measures. These events, if not prevented or effectively mitigated, could damage our reputation, require remedial actions and lead to loss of business, regulatory actions, potential liability and other financial losses. Certain data breaches must also be reported to affected individuals and various government and / or regulatory agencies, and in some cases to the media, under provisions of HIPAA, as amended by HITECH, other U. S. federal and state law, and requirements of non- U. S. jurisdictions, including the EU GDPR and relevant member state law in the EU and other foreign laws, and financial penalties may also apply. Our insurance policies may not be adequate to compensate us for the potential losses arising from breaches, failures or disruptions of our infrastructure, catastrophic events and disasters or otherwise. In addition, such insurance may not be available to us in the future on economically reasonable terms, or at all. Further, our insurance may not cover all claims made against us and defending a suit, regardless of its merit, could be costly and divert management' s attention. We or the third parties upon whom we depend may be adversely affected by climate change, earthquakes, outbreak of disease, or other natural disasters and our business continuity and disaster recovery plans may not adequately protect us from a serious disaster. Climate change, earthquakes, outbreak of disease, or other natural disasters, including extreme weather events and changing weather patterns such as storms, flooding, droughts, fires and temperature changes, which have become more common, could severely disrupt our operations, and have a material adverse effect on our business, results of operations, financial condition and prospects. If a natural disaster, extreme weather risk, power outage, cybersecurity attack or other event occurred that prevented us from using all or a significant portion of our headquarters, that damaged critical infrastructure, such as the manufacturing facilities of our third- party CMOs, or that otherwise disrupted operations, it may be difficult or, in certain cases, impossible for us to continue our business for a substantial period of time. For example, we may experience delays in the supply of drug product for our clinical trials as a result of disruptions to the operations of the manufacturing facilities of some of our third- party CMOs ~~due to the global COVID- 19 pandemic. Any continued or subsequent measures taken by governmental authorities or business to contain the spread of COVID- 19, or the perception that such measures may be required in the future should another outbreak occur, could adversely affect our business, financial condition or results of operations by limiting our CMOs' ability to manufacture product, forcing closure of facilities that we rely upon or increasing the costs associated with obtaining clinical or commercial supplies of our product candidates. The extent to which the COVID- 19 pandemic impacts our results will depend on future developments, which are highly~~

~~uncertain and cannot be accurately predicted, including new information which may emerge concerning the severity of and duration of COVID- 19 pandemic and the actions to contain the pandemic or treat its impact, among others~~ . The disaster recovery and business continuity plans we have in place currently are limited and are unlikely to prove adequate in the event of a serious disaster or similar event. In addition, cybersecurity liability insurance is difficult to obtain and may not cover any damages we would sustain based on any breach of our computer security protocols or other cybersecurity attack. We may incur substantial expenses as a result of the limited nature of our disaster recovery and business continuity plans, which, particularly when taken together with our lack of earthquake insurance, could have a material adverse effect on our business. Climate change or legal, regulatory or market measures to address climate change may negatively affect our business and results of operations. Climate change resulting from increased concentrations of carbon dioxide and other greenhouse gases in the atmosphere could present risks to our operations, including an adverse impact on global temperatures, weather patterns and the frequency and severity of extreme weather and natural disasters. Natural disasters and extreme weather conditions, such as a hurricane, tornado, earthquake, wildfire or flooding, may pose physical risks to our facilities and disrupt the operation of our supply chain. The impacts of the changing climate on water resources may result in water scarcity, limiting our ability to access sufficient high- quality water in certain locations, which may increase operational costs. Concern over climate change may also result in new or additional legal or regulatory requirements designed to reduce greenhouse gas emissions and / or mitigate the effects of climate change on the environment. If such laws or regulations are more stringent than current legal or regulatory obligations, we may experience disruption in, or an increase in the costs associated with sourcing, manufacturing and distribution of our product candidates, which may adversely affect our business, results of operations or financial condition. Further, the impacts of climate change have an influence on customer preferences, and failure to provide climate- friendly products could potentially result in loss of market share. The increasing use of social media platforms presents new risks and challenges. Social media is increasingly being used to communicate about our research, product candidates, investigational medicines, and the diseases our product candidates and investigational medicines are being developed to treat. Social media practices in the biopharmaceutical industry continue to evolve and regulations relating to such use are not always clear. This evolution creates uncertainty and risk of noncompliance with regulations applicable to our business, resulting in potential regulatory actions against us. For example, patients may use social media channels to comment on their experience in an ongoing blinded clinical study or to report an alleged adverse event. When such disclosures occur, there is a risk that we fail to monitor and comply with applicable adverse event reporting obligations or we may not be able to defend our business or the public' s legitimate interests in the face of the political and market pressures generated by social media due to restrictions on what we may say about our development candidates, investigational medicines and approved products. There is also a risk of inappropriate disclosure of sensitive information or negative or inaccurate posts or comments about us on any social networking website. If any of these events were to occur or we otherwise fail to comply with applicable regulations, we could incur liability, face regulatory actions, or incur other harm to our business. Our business operations may subject us to disputes, claims and lawsuits, which may be costly and time- consuming and could materially and adversely impact our financial position and results of operations. From time to time, we may become involved in disputes, claims and lawsuits relating to our business operations. For example, we may, from time to time, face or initiate claims related to intellectual property matters, employment matters, or commercial disputes. Any dispute, claim or lawsuit may divert management' s attention away from our business, we may incur significant expenses in addressing or defending any dispute, claim or lawsuit, and we may be required to pay damage awards or settlements or become subject to equitable remedies that could adversely affect our operations and financial results. Litigation related to these disputes may be costly and time- consuming and could materially and adversely impact our financial position and results of operations if resolved against us. In addition, the uncertainty associated with litigation could lead to increased volatility in our stock price.