Relieve pain.
Restore health.

Corporate Presentation | September 2026

LATIGO BIO

Disclaimer

This presentation contains forward-looking statements that involve risks and uncertainties that could cause actual results to be materially different from historical results or from any future results expressed or implied by such forward-looking statements regarding Latigo Biotherapeutics, Inc. (the "Company"). All statements other than statements of historical facts contained in this presentation, including statements regarding the Company's strategy, future financial condition and future operations, the Company's expected cash runway, the Company's expectations with regard to its research and development programs, the design and results of current or planned clinical trials and preclinical studies, including the timing and availability of data from such studies and trials, the Company's expectations regarding the potential benefits, activity, effectiveness and safety of its product candidates vis-à-vis other approved pain medications, the Company's preclinical, clinical and regulatory development plans, including the timing and likelihood of regulatory filings and approvals for the Company's product candidates, whether the Company's abdominoplasty trial may serve as one of the two pivotal adequate well-controlled trials required to support approval of onzotrigine (LTG-001) for the treatment of moderate to severe acute pain, including postoperative pain, the Company's ability to commercialize its product candidates, the potential expected revenue that suzetrigine could generate on an annualized basis and whether that could be indicative of the potential revenue onzotrigine could generate, if approved, the potential market size and size of the potential patient populations for current and any future product candidates and the potential benefits of collaborations, prospects, plans and objectives of management are forward-looking statements.

In some cases, you can identify forward-looking statements by terminology such as "aim," "anticipate," "assume," "believe," "contemplate," "continue," "could," "design," "due," "estimate," "expect," "goal," "intend," "may," "objective," "plan," "positioned," "potential," "predict," "seek," "should," "target," "will," "would" and other similar expressions that are predictions of or indicate future events and future trends, or the negative of these terms or other comparable terminology. The Company has based these forward-looking statements largely on the Company's current expectations and projections about future events and financial trends that the Company believes may affect its financial condition, results of operations, business strategy and financial needs. These statements are inherently uncertain and investors are cautioned not to unduly rely upon these statements. Although the Company believes that it has a reasonable basis for these forward-looking statements, these forward-looking statements are subject to a number of known and unknown risks, uncertainties and assumptions and the Company cannot guarantee that the future results, levels of activity, performance or events and circumstances reflected in the forward-looking statements will be achieved or occur at all. The actual results may differ materially from those expressed or implied by these forward-looking statements. Factors that may cause actual results to differ materially include the risk that results from earlier studies or clinical trials may not be indicative of results from subsequent studies or clinical trials, interim results of a clinical trial are not necessarily indicative of final results and one or more of the clinical outcomes may materially change following more comprehensive reviews of the data, the risk that the Company may not obtain approval to market its product candidates or that such approval may be delayed, the risk that the Company's product candidates, if approved, will not be able to generate revenue or revenue consistent with market expectations or revenue achieved or expected to be achieved by competitor drugs, including suzetrigine, risks regarding the projected market size for the Company's product candidates, uncertainties associated with performing clinical trials, regulatory filings and applications, risks associated with reliance on third parties to successfully conduct clinical trials, the risks associated with reliance on outside financing to meet capital requirements, and other risks associated with the process of discovering, developing and commercializing drugs that are safe and effective for use in humans to treat pain, and in the endeavor of building a business around such drugs. For a further list and description of the risks and uncertainties that the Company faces, please refer to the Company's most recent periodic and other filings with the Securities and Exchange Commission, which are available at www.sec.gov.

Except as required by law, the Company undertakes no obligation to publicly update any forward-looking statements, whether as a result of new information, future events or otherwise. This presentation discusses product candidates that are undergoing clinical trials and which have not yet been approved for marketing by the U.S. Food and Drug Administration. No representation is made as to the safety or effectiveness of these product candidates for the use for which such product candidates are being studied.

Caution should be exercised when interpreting results from separate trials involving separate product candidates. Differences exist between clinical trial design, patient populations and the product candidates themselves, which limit the conclusions that can be drawn from comparisons across different trials. This presentation includes certain market, industry and competitive data from the Company's own estimates and research, as well as from publicly available information, reports of governmental agencies and industry and academic publications, research and surveys and market data analysis conducted by third parties commissioned by the Company.

This presentation contains references to the Company's trademarks and to trademarks belonging to other entities. Solely for convenience, trademarks and trade names referred to in this presentation, including logos, artwork and other visual displays, may appear without the ® or ™ symbols, but such references are not intended to indicate, in any way, that their respective owners will not assert, to the fullest extent under applicable law, their rights thereto. The Company does not intend its use or display of other companies' trade names or trademarks to imply a relationship with, or endorsement or sponsorship of the Company by, any other companies.

Reimagining Pain Management Away From Opioids: Building The Innovative Pain Company

Targeting pain, one of the largest areas of unmet need, where innovation has been limited

Late clinical stage portfolio of differentiated $Na_v1.8$ inhibitors across acute (Onzotrigine[1]) and chronic pain (LTG-321)

Opportunity to expand to complementary mechanism of actions additive to $Na_v1.8$

Deep capabilities across R&D to pioneer innovation in pain

Well capitalized with ~$397MM raised in upsized IPO and expected cash runway into 2029

Multiple clinical milestones expected in 2H 2027

[1] Previously referred to as LTG-001

Experienced Leadership Team with Deep Expertise in Pain

Nima Farzan
CEO

- 3X CEO, IPO and ~$700m capital raised as CEO
- Private & public company exits

KINNATE BIOPHARMA PaxVax NOVARTIS

Neil Singla
CMO

- Founder/CEO of preeminent pain CRO/site network
- Along with team, conducted >250 pain studies over 20+ years

Lotus CLINICAL RESEARCH® LLC Analgesic CRO & Research Site

Bryan Moyer
SVP, Discovery

- 20+ years of pain and CNS research
- Discovered multiple compounds in clinic

AMGEN

Neha Krishnamohan
CFO / CBO

- 3X CFO, 15+ years of experience in healthcare & finance
- Executed $100B+ financing and M&A transactions

artiva KINNATE BIOPHARMA Goldman Sachs

Naomi Lowy
SVP, Global Regulatory Affairs

- 18+ years in FDA & regulatory advisory
- Former deputy director pain division of FDA (DAAP)[1]
- Co-authored recent FDA acute/chronic pain guidances

FDA Hyman, Phelps & McNamara PC

[1] DAAP: Division of Anesthesia, Addiction Medicine, and Pain Medicine

Latigo Built for the Emerging Inflection Point in Pain Innovation

Committed to Building a Best-in-Class, Multi-modal, Pain Focused Company

- $Na_v1.8$ Pioneering Innovation in Pain
- New Emerging Pain Targets

LATIGO BIO

- Scarcity of Pain Pipelines
- Differentiated Pain Capabilities at Latigo

Pain represents a significant market with substantial unmet need

Pain Remains a Debilitating Condition, Despite 250M Pain Prescription Medications Every Year in the US

Pain represents one of the largest and most pervasive therapeutic markets in the US

Musculoskeletal Pain
Damage to Tissue

Acute Post-Surgical

Acute Non-Surgical

Chronic Musculoskeletal

~20M Moderate-to-Severe Osteoarthritis Pain Patients[1]
~20M Chronic Lower Back Pain Patients[2]

Neuropathic Pain
Misfiring of Neurons

Chronic Neuropathic

~10M Neuropathic Patients (e.g., DPN, LSR)[3]

~80M
Americans require acute pain prescription annually[4]

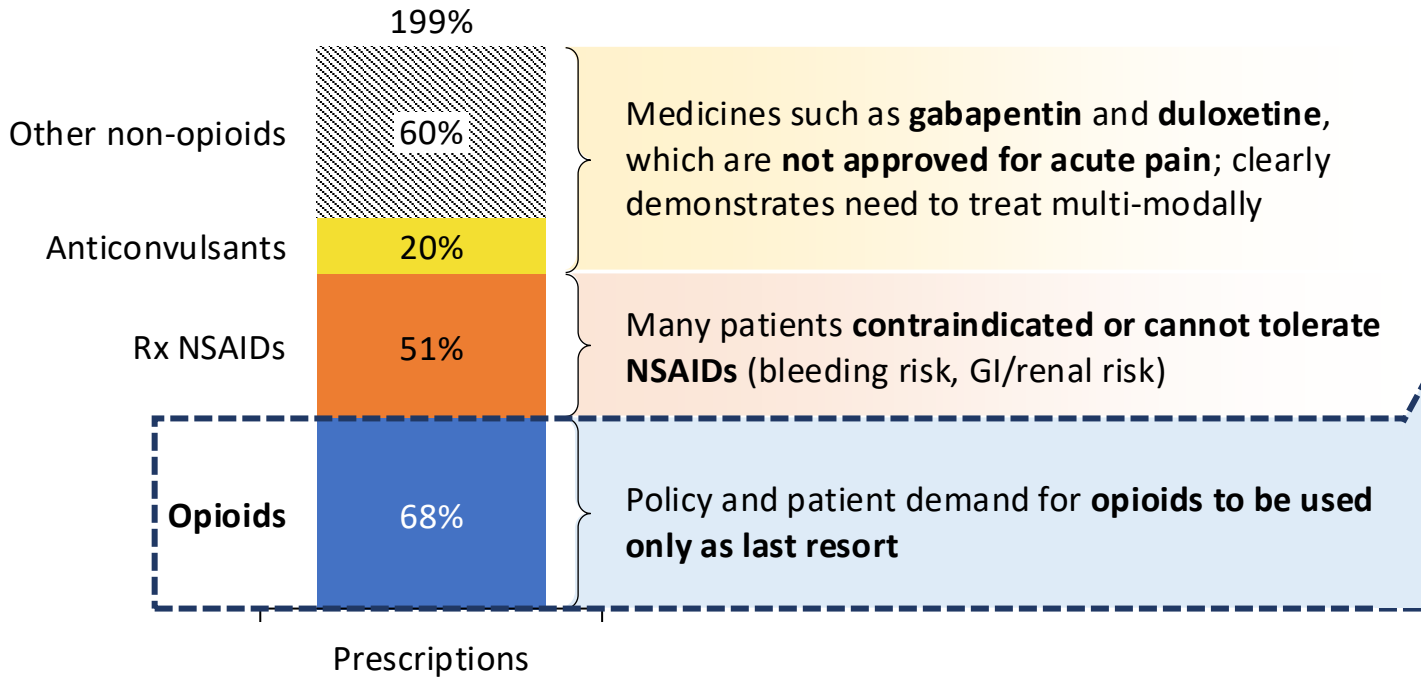
~60M
Americans suffered from chronic pain[5]

[1] 2020 CDC data and Schepman et al., JHEOR. 2022;9(1):58-67; [2] Feldman and Nahin, The Journal of Pain, 2022; 23, 2144-2154; [3] Lopez et al., Pain Reports. 2026 Jan; 11; [4] AARP 2025 [5] Zajacova et al., Pain. 2026 Jan 1;167(1):142-149.
Note: DPN: Diabetic Peripheral Neuropathy; LSR: Lumbosacral Radiculopathy

Substantial Unmet Need in Pain Demonstrated by Significant Off-Label Use and Continued Reliance on Opioids, Despite Clear Risks

Average Acute Pain Patient Receives ~2 Pain Management Prescriptions[1]

Percent of patients receiving each type of prescription pain medicine per episode (sums to more than 100% due to multi-modal treatment)



Opioid Challenges

- **Addiction Risk:** ~11% of patients persistently use opioids after minor surgical procedures[2]
- **Dispersion Risk:**
  - Unused opioids can be dispersed into community
  - ~67-92% of patients have excess opioids after surgery[3]
- **Side Effects:** Constipation, nausea, sedation etc.

Note: Other includes $Na_V1.8$ blockers, neuropathic adjuvants (e.g., Gabapentin, Duloxetine), muscle relaxants, topical / local anesthetics; steroid injections and any combination therapy with Opioid / NSAIDs

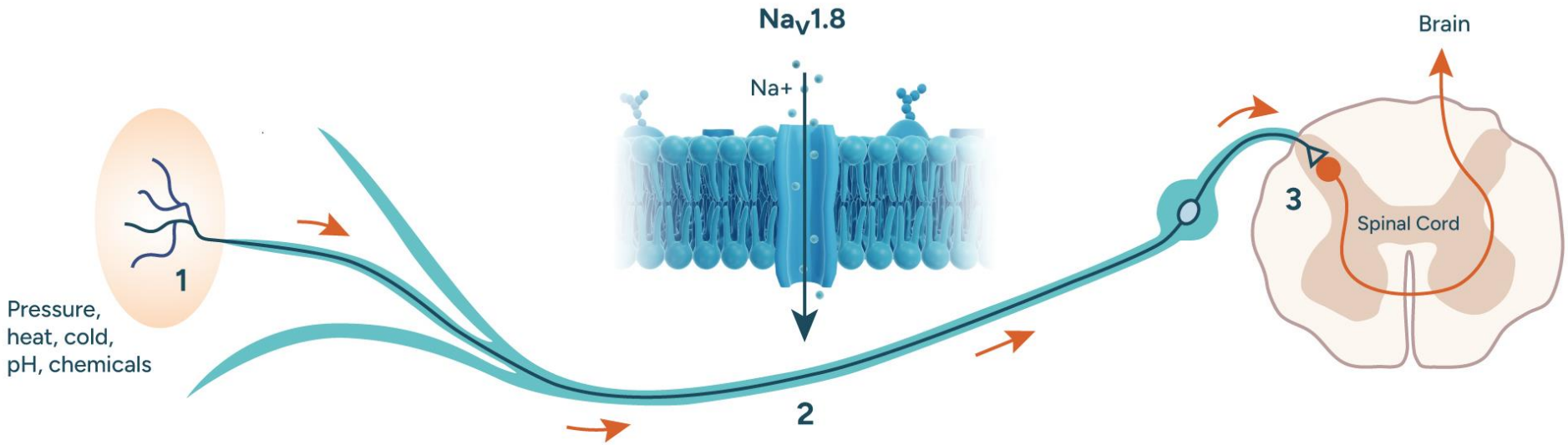
[1]2025 Komodo claims data analysis. [2] Lawal OD, et al. JAMA Netw Open. 2020;3(6):e207367; [3] Bicket MC, et al. JAMA Surg. 2017;152(11):1066-1071

$Na_V1.8$ Transmits Pain Signals Independent of Source, Peripherally Blocking Pain Sensation

Transduction of pain signal

***Transmission** of pain signal*

Perception of pain signal



$Na_V1.8$ transmits diverse pain signals

Modified from Waxman and Zamponi Nat Neurosci 17(2): 153-63, 2014 and Chung et al Nat Rev Disease Primers 8:45, 2022

Latigo Pipeline of Pain Therapies, Focused on $Na_v1.8$

Molecule	Discovery	Preclinical	Phase 1	Phase 2	Phase 3	Recent Progress / Anticipated Milestones
Onzotrigine (LTG-001) Acute Pain	**Demonstrated highest analgesic effect seen in abdominoplasty trial*; results published in NEJM[1]**					**Abdominoplasty Trial Completed[2]** **Phase 3 Bunionectomy & Safety Trial Initiation 2H 2026; Topline Results 2H 2027**
LTG-321 Chronic Pain	**Potential First-in-Class in OA**					**Phase 2 Initiated; Topline Results 2H 2027**
Onzotrigine IV Acute Pain	**Designed to allow IV to oral therapy transition**					**Bioavailability Study Completed**
LTG-418	**Potential for improved potency, novel formulations**					**Drug Candidate Selected**

Undisclosed targets in discovery for chronic pain

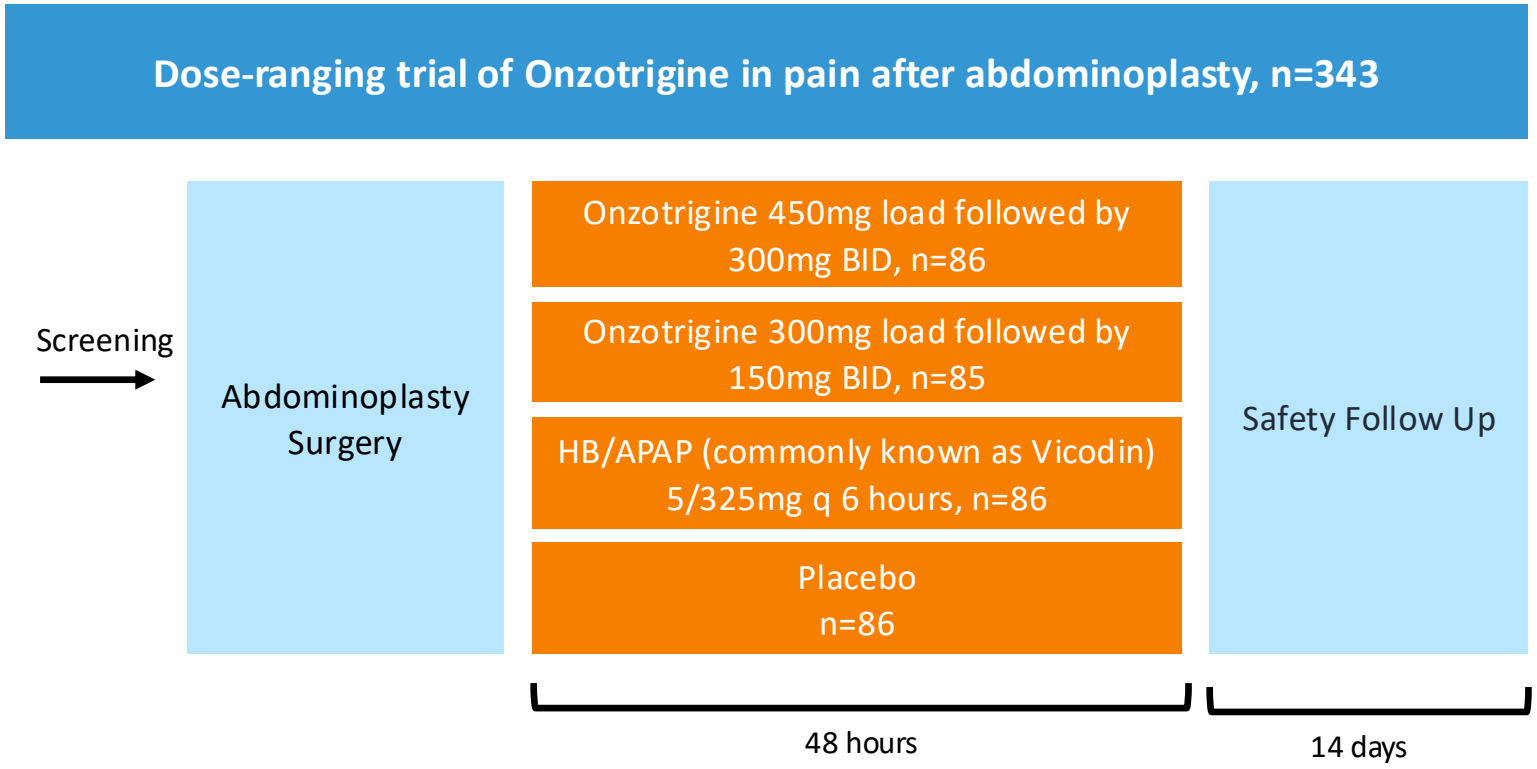
*Based on management's assessment of currently available information.

[1] The *New England Journal of Medicine*

[2] Based on our discussions with the FDA, this trial may serve as one of the two pivotal adequate well-controlled trials required to support approval of onzotrigine for the treatment of moderate to severe acute pain, including postoperative pain.

Abdominoplasty Trial Exploring Onzotrigine – One of Two Pivotal Adequate Well-Controlled Trials to Support Acute Pain Approval[1]

Onzotrigine
Acute Pain



Enrollment initiated – July 2025
Enrollment completed – December 2025

Primary Endpoint

- Summed Pain Intensity Difference (SPID) from 0-48 hours, high dose onzotrigine vs. placebo

Design (matched to suzetrigine for benchmarking)

- Same active opioid comparator as used with suzetrigine Phase 3
- Same time-to-onset measures used in suzetrigine Phase 3
- Added opioid rescue medication (oxycodone 5mg) to enable opioid-sparing endpoints vs. ibuprofen 400mg for suzetrigine

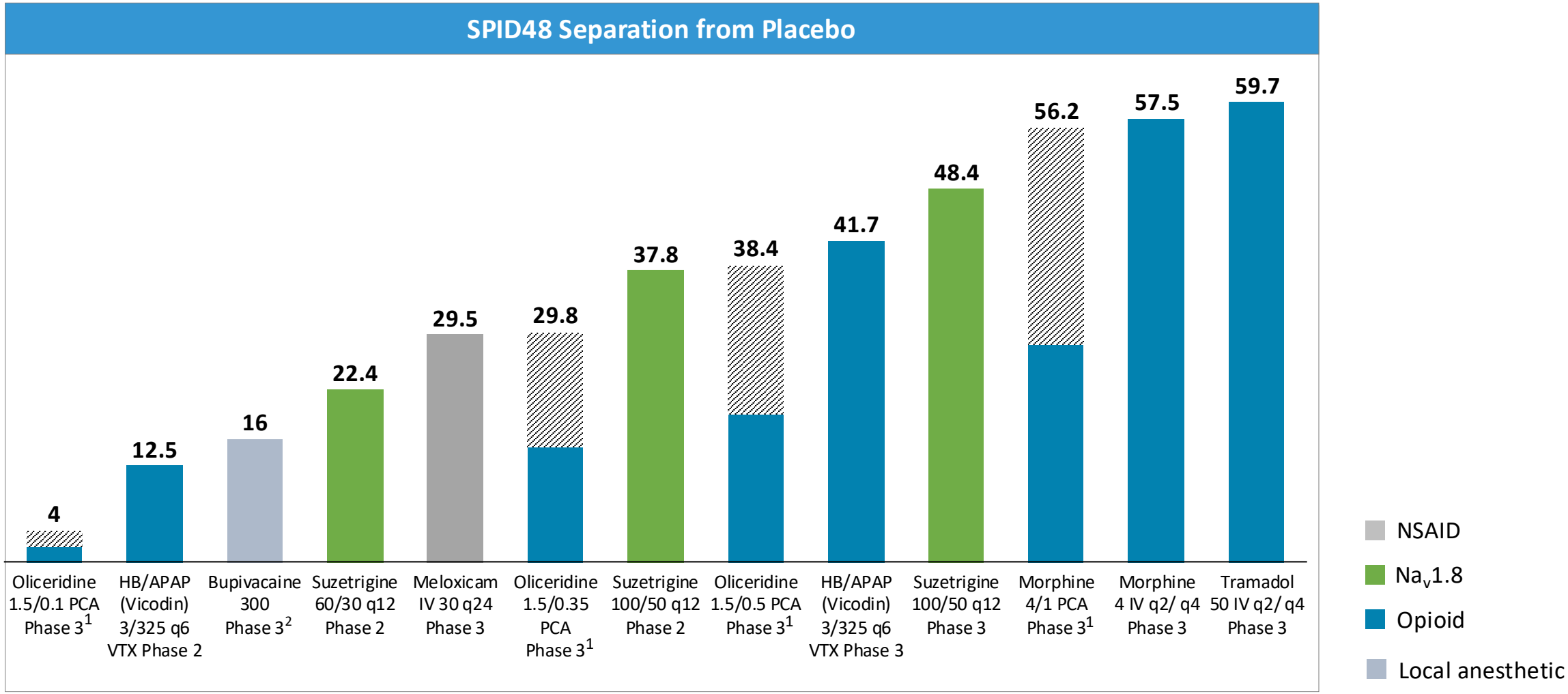
Disposition and Demographics

- 4 sites in the US
- 334 (97%) of subjects completed study treatment
- 328 (96%) of subjects completed study
- Average age 41 years, 68% of patients were white
- Baseline NPRS: 7.4

[1]Based on our discussions with the FDA, this trial may serve as one of the two pivotal adequate well-controlled trials required to support approval of onzotrigine for the treatment of moderate to severe acute pain, including postoperative pain.

Analgesic Effect Seen in Separate Previously Reported Abdominoplasty Trials (6 Trials, 13 Dose Arms)

Onzotrigine
Acute Pain



Note: All dosing in mg unless otherwise noted; [1]Estimated by doubling of SPID24 data for oliceridine dose arms and morphine 4mg IV bolus + 1mg IV PCA from oliceridine label [2]bupivacaine hydrochloride implant· Reflects AUC48
Note: These data are derived from different clinical trials at different points in time, with differences in trial design and patient populations. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted.

Onzotrigine High Dose: 50% Greater Analgesic Effects than Vicodin Comparator; 2x Faster than Third-Party Phase 3 Trial of Suzetrigine

Onzotrigine
Acute Pain

Onzotrigine Observed Differentiation

~30% *greater analgesic effect vs. suzetrigine[1]*

~50% *greater analgesic effect vs. Vicodin*

2.3x *faster pain relief*

Opioid Sparing

	Onzotrigine abdominoplasty High Dose[1]	Suzetrigine Phase 3 abdominoplasty[2]
Analgesic Effect: SPID48 placebo subtracted		
Study Drug	**62**	*48*
HB/APAP (Vicodin)	**41**	*42*
Onset: Time to Meaningful Pain Relief	**52 minutes**	119 minutes
Opioid Sparing: Participants Not Requiring Opioid Rescue	**52%**	Not studied

19% didn't use rescue (ibuprofen)

[1] Onzotrigine High Dose: 450mg loading dose followed by 300mg BID

[2] Suzetrigine phase 3 abdominoplasty trial. These data are derived from different clinical trials at different points in time, with differences in trial design and patient populations. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted.

Abdominoplasty Trial Results Published in NEJM on July 30th 2026[1]

Onzotrigine
Acute Pain

Only the second original research publication in NEJM reporting clinical results for a novel drug for acute pain in the last 15 years

ORIGINAL ARTICLE

Phase 2b Trial of a $Na_v1.8$ Inhibitor for Acute Pain

Neil Singla, M.D.,[1] Nathaniel P. Katz, M.D.,[2,3] Ben Vaughn, M.S.,[1] Timothy Rogier,[1] Todd Bertoch, M.D.,[4] Harold Minkowitz, M.D.,[5,6] and Mallory Loflin, Ph.D.[1]

ABSTRACT

Includes comparative data of the analgesic effects observed with onzotrigine (LTG-001) relative to other agents, including IV opioids in abdominoplasty

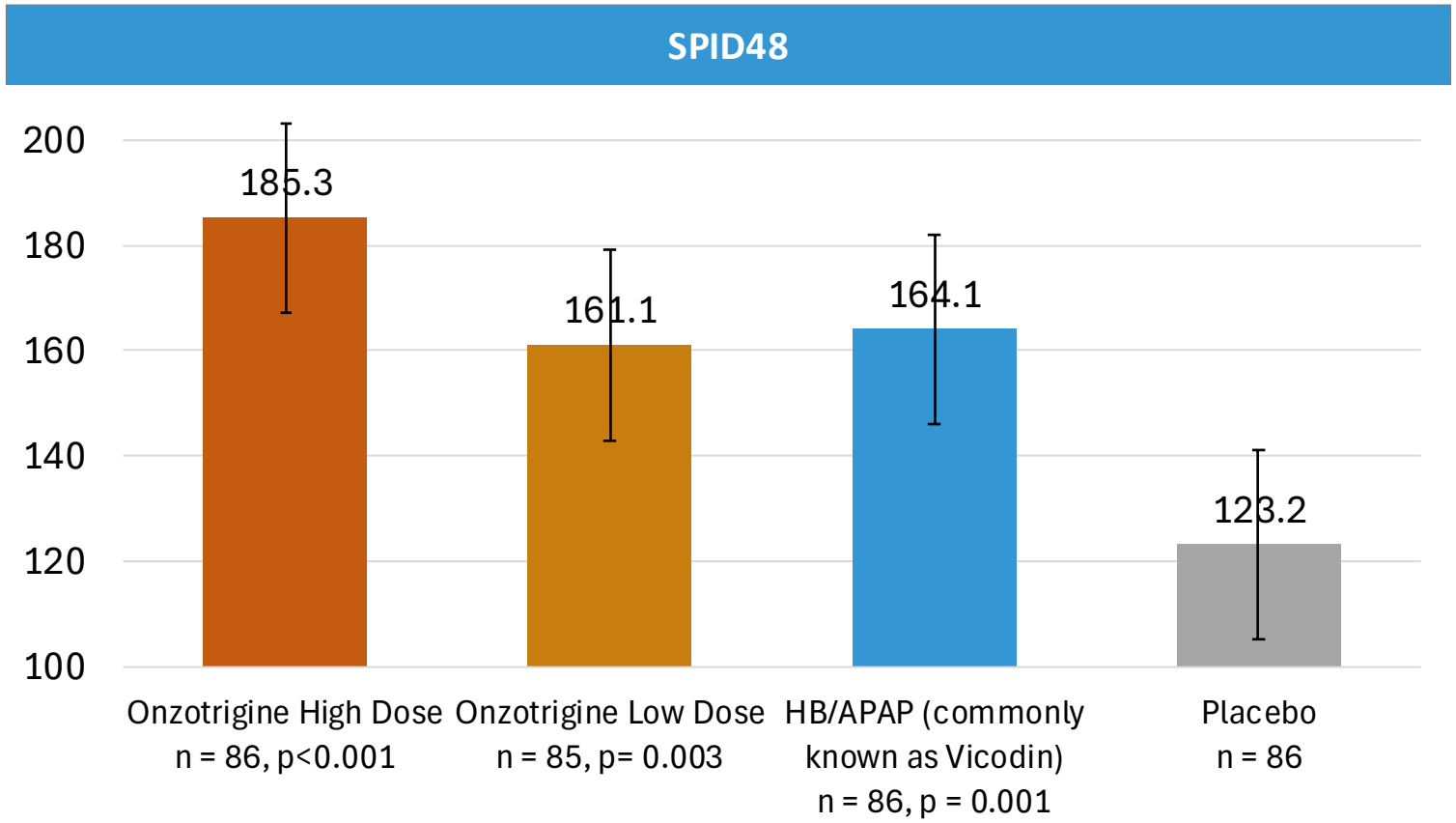
DISCUSSION

For contextualization of the results, the magnitude of the effect[24] was compared with the published results from other placebo-controlled trials that were conducted under a sponsor-initiated investigational new drug application and had the SPID48 as an outcome in patients undergoing abdominoplasty.[13,25,26] In a comparison of the least-squares mean difference in the SPID48 from placebo across these trials, the value for high-dose LTG-001 (62.1) was similar to those for opioids that were administered intravenously (57.5 and 59.7),[18,25] and the value for low-dose LTG-001 (37.8) was similar to those for the approved $Na_v1.8$ inhibitor suzetrigine (48.4) and for oral hydrocodone bitartrate–acetaminophen (40.9 and 41.7) and higher than the value for meloxicam (an NSAID) administered intravenously (29.5) (Fig.

[1] NEJM: New England Journal of Medicine; N Engl J Med 2026;395:454-64.

Onzotrigine Demonstrated Significantly More Pain Reduction than Placebo (Primary Endpoint of SPID48)

Onzotrigine
Acute Pain



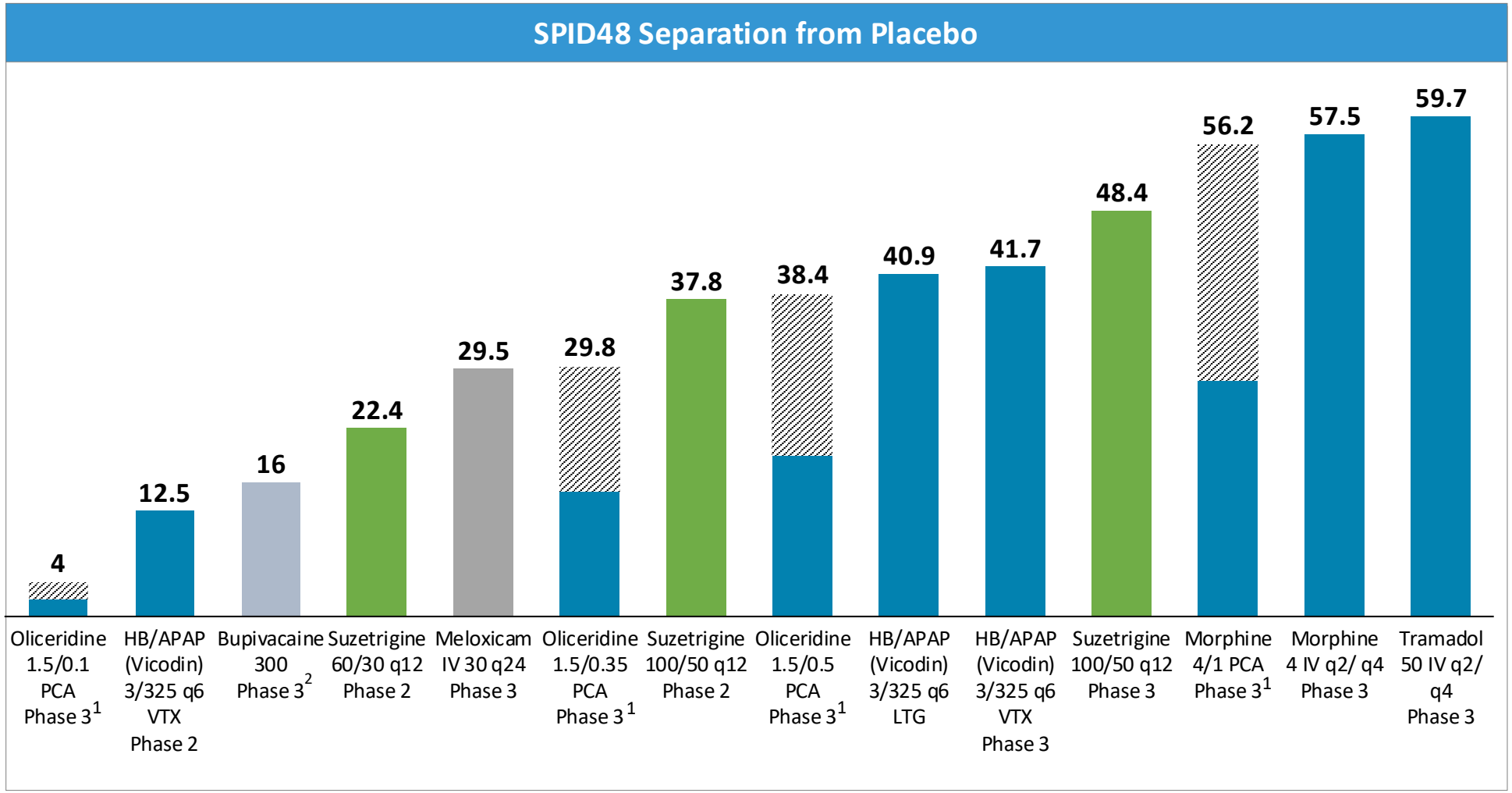
SPID48 placebo subtracted	62.1	37.8	40.9

- All active arms showed statistically significant separation from placebo (p = <0.001-0.003)
- Onzotrigine high dose Standardized Effect Size (SES) of 0.74 compared to 0.53 for suzetrigine[1] (onzotrigine 40% higher)

[1]These data are derived from different clinical trials at different points in time, with differences in trial design and patient populations. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted.

Onzotrigine had the Highest Analgesic Effect Seen Relative to Dose Arms in Separate Previously Reported Abdominoplasty Trials (7 Trials, 14 Dose Arms)

Onzotrigine
Acute Pain



- Opioid-level analgesia – Onzotrigine high dose: highest placebo separation over 48 hours
- Surpassed two historical studies using 4mg IV morphine
- Surpassed Vicodin comparator by 50%
- More than doubled NSAID
- Average placebo response: 123[3]

NSAID
$Na_v1.8$
Opioid
Local anesthetic

Note: All dosing in mg unless otherwise noted; [1]Estimated by doubling of SPID24 data for oliceridine dose arms and morphine 4mg IV bolus + 1mg IV PCA from oliceridine label [2] bupivacaine hydrochloride implant· Reflects AUC48 [3]The average pain reduction seen from the placebo arms from previously reported abdominoplasty trials that were conducted over 48 hours excluding onzotrigine.
Note: These data are derived from different clinical trials at different points in time, with differences in trial design and patient populations. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted.

Onset Matters for Acute Pain and Onzotrigine's Abdominoplasty Trial Data Suggest Rapid Onset for $Na_v1.8$

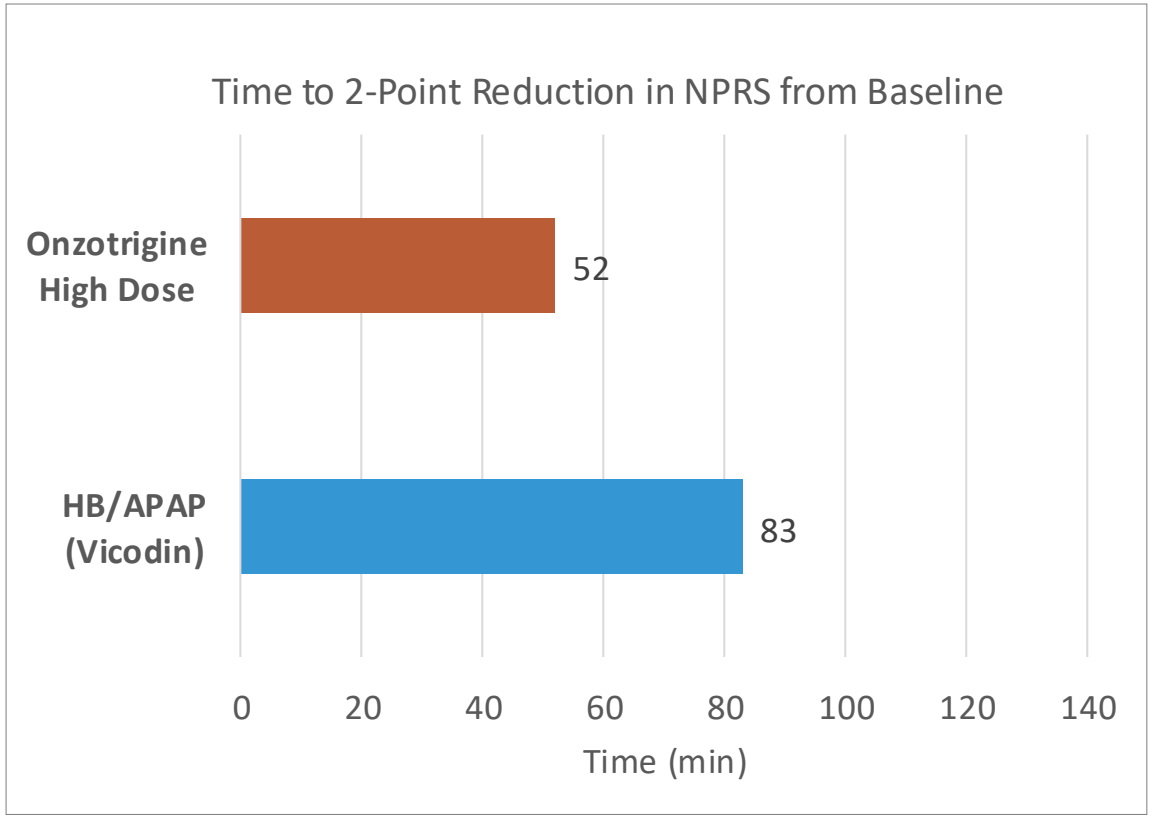
Why Onset Matters for Acute Pain

- Patients want immediate pain relief
- Clinicians and regulators worry about "drug stacking" – where patients take extra doses or other MoAs if they don't feel early relief

Onset of Pain Relief Across Acute Pain Labels

Acute Pain Medicine (oral)	Onset in Label
Dsuvia (sufentanil)	54 min
Celebrex (celecoxib)	60 min
Ultracet (tramadol/APAP)	<1 hour
Zipsor (diclofenac)	<1 hour
Journavx (suzetrigine)	2-4 hours

Onset of Pain Relief in Onzotrigine Abdominoplasty Trial



Note: These data are derived from different clinical trials at different points in time, with differences in trial design and patient populations. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted.

Onzotrigine Met Opioid-Free Endpoint FDA Has Used for Opioid Sparing Labels in Third-Party Drugs

Onzotrigine
Acute Pain

% of Opioid-Free Patients		P-value v. placebo
Onzotrigine High Dose	**52.3**	<0.001
Onzotrigine Low Dose	**49.4**	<0.001
Placebo	**22.1**	

There are only three therapies (infiltration analgesics) which include opioid free claims in their labels

Exparel (Bupivacaine Nerve Block or Instillation)	
Hemorrhoidectomy (72 hours)	
Active	**28%**
Placebo	**10%**
Shoulder Surgery (48 hours)	
Active	**13%**
Placebo	**1%**

Xaracoll (Bupivacaine Implant)	
Inguinal Hernia Repair 1 (72 hours)	
Active	**36%**
Placebo	**22%**
Inguinal Hernia Repair 2 (72 hours)	
Active	**28%**
Placebo	**12%**

Zynrelef (Bupivacaine + Meloxicam Instillation)	
Bunionectomy (72 hours)	
Active	**29%**
Placebo	**2%**
Inguinal Hernia (72 hours)	
Active	**51%**
Placebo	**22%**

Onzotrigine Was Generally Well Tolerated With Overall AE Levels Below Placebo

- AEs were mostly mild to moderate
- Overall AEs lower in active than in placebo
- No individual AE was meaningfully more common in any active arm than in placebo, except pyrexia and presyncope, which were mild to moderate
  - Pyrexia: 5 of the 6 cases in the high dose arm were deemed unrelated to treatment
  - Presyncope: All cases were deemed unrelated to treatment
- Serious AEs for onzotrigine deemed unrelated to treatment

	High Dose	Low Dose	HB/APAP (commonly k/a Vicodin)	Placebo
Participants with any TEAEs, n (%)	43 (50.0)	53 (62.4)	54 (62.8)	56 (65.1)
Participants with any severe TEAE (Grade 3+), n (%)	3 (3.5)	3 (3.5)	6 (7.0)	3 (3.5)
Participants with serious AEs, n (%)	1 (1.2)	1 (1.2)	1 (1.2)	1 (1.2)
Participants with AEs leading to treatment discontinuation, n (%)	0	0	4 (4.7)	0
AEs reported in ≥3%* and at greater rate than placebo, n (%)				
Pyrexia	6 (7.0)	2 (2.4)	1 (1.2)	2 (2.3)
Presyncope	5 (5.8)	0	1 (1.2)	1 (1.2)

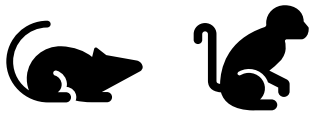
AE: adverse event; TEAE: treatment-emergent adverse event
*Note. 3% threshold represents occurrence in >2 patients

Higher Level of $Na_V1.8$ Target Inhibition in Nerve Supports Onzotrigine's Clinical Results

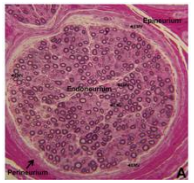
Onzotrigine
Acute Pain

Latigo Differentiated Capability to Look at Target Inhibition at Site of Action

1) Systemic Dosing of $Na_V1.8$ Inhibitors



2) Dissection of Sciatic Nerve at Various Times



3) Quantitate Drug in Nerve by Mass Spec

Onzotrigine Engaged More $Na_V1.8$ Channels at the Site of Action vs. Suzetrigine

	Onzotrigine Target Dose: 450 / 300 mg BID	Suzetrigine Target Dose: 100/50 mg BID
Drug at Nerve (Site of Action)	1790 nM	18 nM[1]
Free Fraction	21.6%	1%
In Vitro Potency Human DRG Neurons	104 nM	0.68 nM / 2.52 nM[2]
Potency Shift w/assay to Mimic Nerve Environment^	2.7x	9.3x / 5.5x[2]
Potency at Site of Action	281	10.2[3]
Predicted Target Inhibition % (Range for 2x Variation in Potency or Free Fraction)	**86% (76-93)**	**64% (47-78)[1]**

Note: These data are derived from different preclinical studies at different points in time, with differences in design. As a result, cross-study comparisons cannot be made, and no head to head preclinical studies were performed.
^Electrophysiology assay to determine compound potency conducted with 2% albumin to mimic protein level in endoneurial fluid surrounding axons expressing $Na_V1.8$ channels in vivo; Synthesized version of suzetrigine used;
[1] Incorporates parent & active metabolite. Drug at nerve reflects sum of parent & active metabolite; [2] Parent and active metabolite respectively; [3] average potency shift of parent & metabolite

Planned Designs for Onzotrigine Phase 3 Bunionectomy and Open-Label Safety Trials

Onzotrigine
Acute Pain

	Phase 3 Trial for Onzotrigine in Moderate to Severe Acute Pain after Bunionectomy	Phase 3 Onzotrigine Safety Trial
Onzotrigine Regimen	Onzotrigine 450mg load, then 300mg BID (both trials)	
Study Population	Bunionectomy surgery (n = ~400)	Surgical & non-surgical (n = ~400)
Design	1:1 randomization, onzotrigine vs. placebo, double-blind, placebo-controlled, parallel group study	Open-label, onzotrigine as part of multi-modal regimen
Rescue	Oxycodone (same as prior abdominoplasty)	N/A
Primary Endpoint	SPID48: onzotrigine vs. placebo	Safety-related findings
Key Secondary Endpoints	Onset of action, opioid-sparing effect	% Opioid free, Patient & Clinician Global Assessment
Duration	48h treatment period	Up to 30 days treatment period

Initiation Planned for 2H 2026

Data Generated for Onzotrigine to Date Support Differentiated Target Product Profile to Approved Na_v 1.8 Inhibitor Suzetrigine

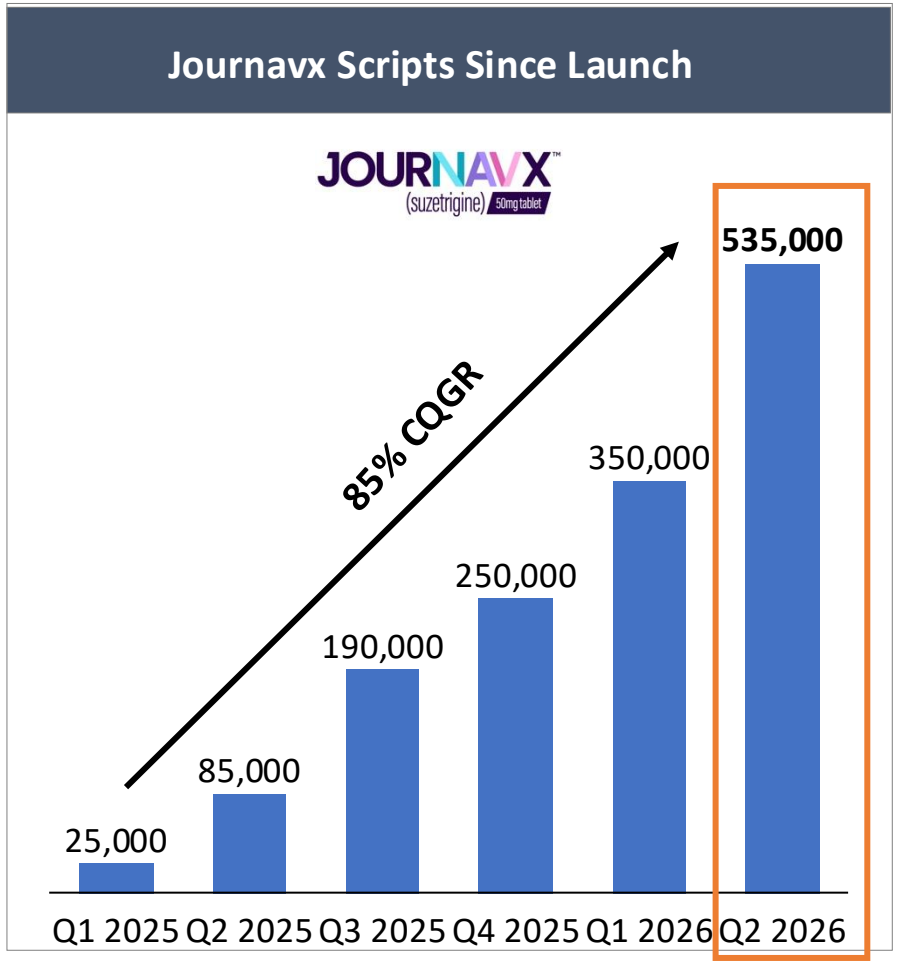
	Suzetrigine's Approved Label	Onzotrigine Target Product Profile
Indication	**Broad acute pain**	**Broad acute pain**
Magnitude of Pain Relief	SPID48 Δ vs. placebo = **48** (Abdominoplasty)	SPID48 Δ vs. placebo = **62** (Abdominoplasty)
Onset of Action	**119 mins** (Abdominoplasty)	**52 mins** (Abdominoplasty)
Opioid Sparing	-	**Potential for Opioid-free** claim with 52% Opioid-free data in Abdominoplasty
Safety Profile	No SAEs Pruritus, muscle spasms, CPK elevation, rash	**Comparable** or lower AE incidence vs. suzetrigine (Abdominoplasty)
Duration of use	No duration restriction Drug not studied for **>14 days**	No duration restriction Drug not studied for **>30 days***
Contraindications	• Avoid use with strong and moderate CYP3A inducers • Contraindicated with strong CYP3A4 inhibitors Dose reduction with moderate • Additional contraceptive measures	None based on data generated to date

**possible based on planned safety study design*

Note: These data are derived from different clinical trials at different points in time, with differences in trial design and patient populations. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted.

Strong Early Launch Momentum with Rapid Patient Demand for Journavx

Onzotrigine
Acute Pain



Clear Patient Demand for Journavx with Accelerating Growth

- Recent quarter scripts of 535K nearly matched all script volume from first year of launch
- Q2 '26 volume equates to ~>$600MM[1] in gross revenue on a run rate

Market access has been improving

- 260M lives covered, formally contracted with all 3 national PBMs
- 22 state Medicaid programs provide coverage
- 3 of 4 Medicare Part D plans recently covered
- Recently eligible for separate, non-DRG payment for Medicare outpatient procedures (NOPAIN Act)

High GTN limiting initial revenues due to Patient Support Program (PSP)

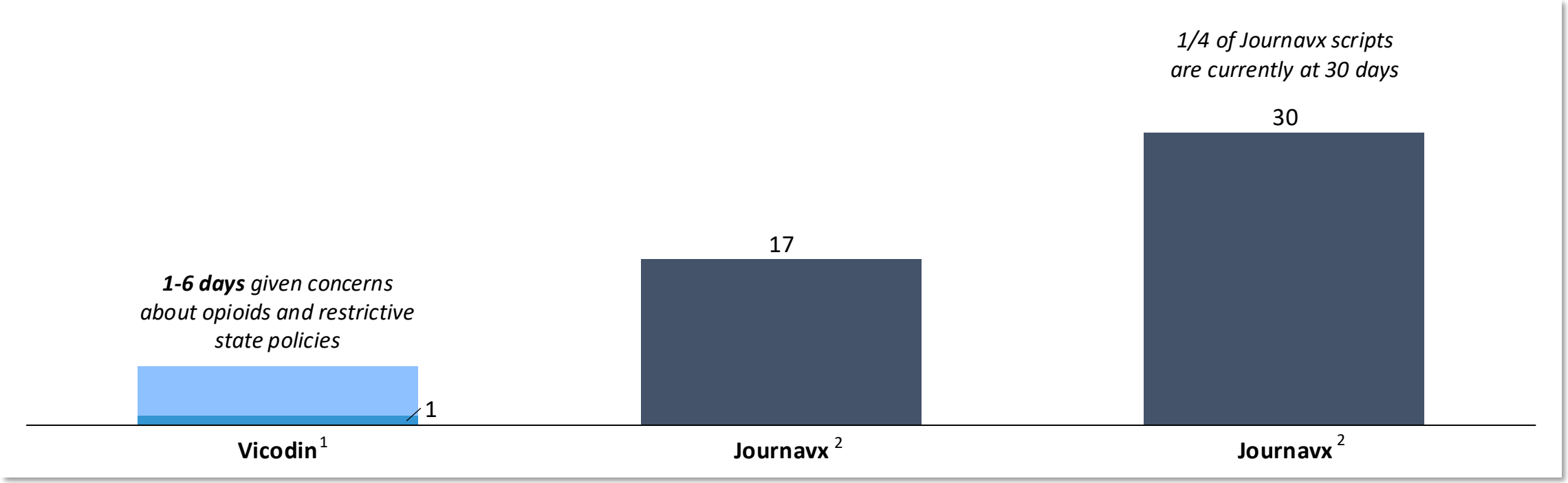
- $79M revenue in 1H 2026 vs. $60M for full year 2025
  - 71% QoQ sequential growth
- PSP should be discontinued by 2027 as access improves
- Vertex guiding to >3x prescription and revenue growth in 2026 vs. 2025 and GTN normalizing in the 1H2027

Source: Vertex Pharmaceuticals Q4 2024, Q3 & Q4 2025, Q1 & Q2 2026 earnings presentations and earnings call transcript. 2026 JPM press release.
Assumes 535,000 scripts per quarter, average prescription length of 10 days at $31 / day

Journavx's Retail Scripts Are at an Average of 17 Days with 1/4 at 30 Days

Onzotrigine
Acute Pain

Retail Days of Therapy (Average Treatment Duration in Days)



Average script length longest amongst anesthesiologists/pain specialists & rheumatologists –specialties typically managing chronic pain

[1] Vicodin prescription days: Tran et al., J Manag Care Spec Pharm. 2017 May;23(5):532-539; [2] IQVIA Claims data of retail scripts from February 2025 to January 2026. Reflects volume weighted average.

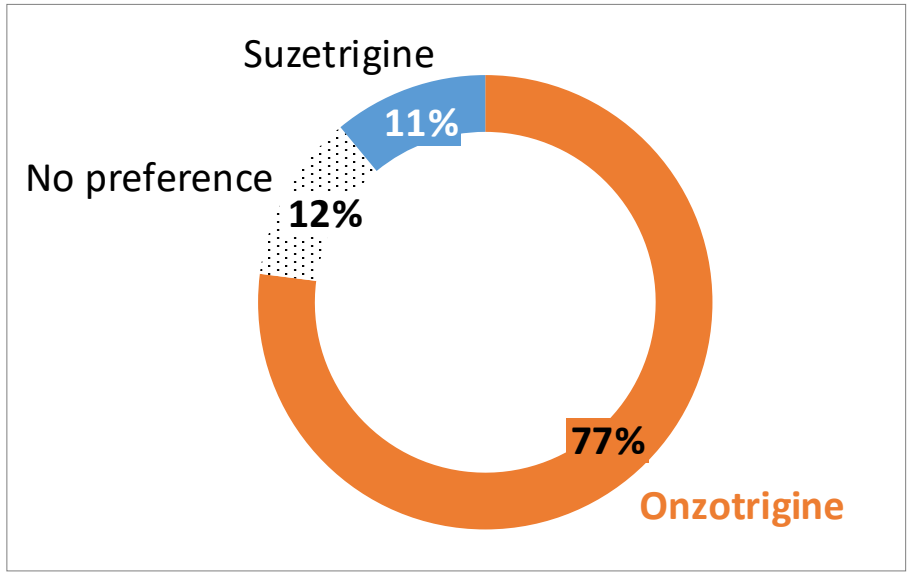
Market Research Shows Substantial Majority of HCPs Prefer Onzotrigine Target Product Profile (TPP) – Driven By Onset

Blinded Target Product Profiles Tested

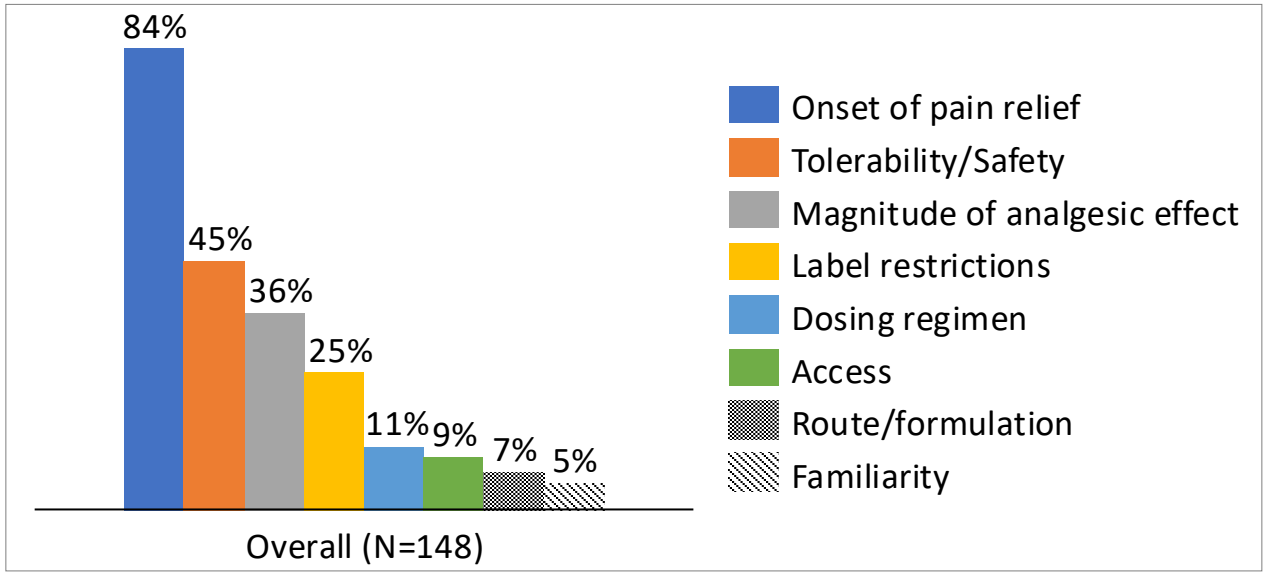
		Suzetrigine *(on market)*	Onzotrigine TPP *(estimated profile prior to abdominoplasty trial results)*
Analgesic Effect	**SPID48** vs. PBO	**29-48**	**36-57**
	Onset	**2-4 hours**	**1 hour**

Actual results in abdominoplasty were ***better*** than what we tested

Product Preference



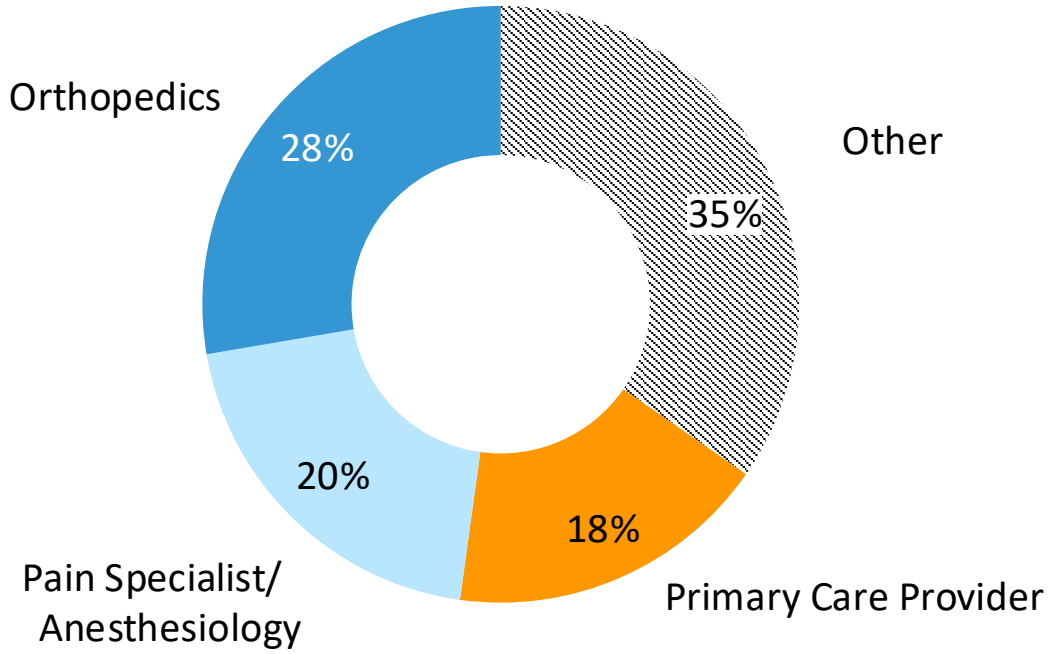
Factors Driving Preference for Onzotrigine



Q15.Based on the profiles provided, which product would you be more likely to prescribe overall?
Q16.What are the most important factors influencing your preference between Product A and Product B? (Select all that apply) | HCPs that stated preference for Product B. N=148
Source: Market survey conducted by Latigo in 2025

Orthopedics and Pain Specialists Drive Primary Retail Script Volume for Journavx

Share of Rx by Specialty[1] (% of Total Prescriptions)

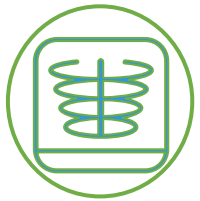
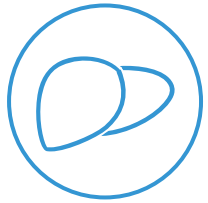


Significant primary care volume indicates <u>organic growth</u> driven by unmet need, outside of Vertex Pharmaceutical's promotional focus on institutional accounts

Note: excludes RN/NP/PA. Other includes physical therapy, plastic surgery, podiatry, neurology, general surgery, dentist, etc. [1] IQVIA Claims data of retail scripts from February 2025 to January 2026. Reflects volume weighted average.

Orthopedic Surgeons & Pain Specialists Are Key Call Points (And Largest Volume of Journavx Scripts Today Along with PCPs)

Onzotrigine
Acute Pain

	Post-Surgical Acute Pain					Non-Surgical Acute Pain		
	 ORTHOPEDIC SURGERY	 PLASTIC SURGERY	 GENERAL SURGERY	 ENT	 OBGYN	 EMERGENCY MEDICINE	 PRIMARY CARE	 PAIN SPECIALISTS
PHYSICIANS[1]	~20k	~7.5k	~26.5k	~10k	~44k	~50k	~124k	~7k
PROCEDURE VOLUME *2025*[2]	9M	2M*	6M	3M	7M	~40M[3] *ED + urgent care visits for pain*		11M[4] *Acute flares of chronic pain*

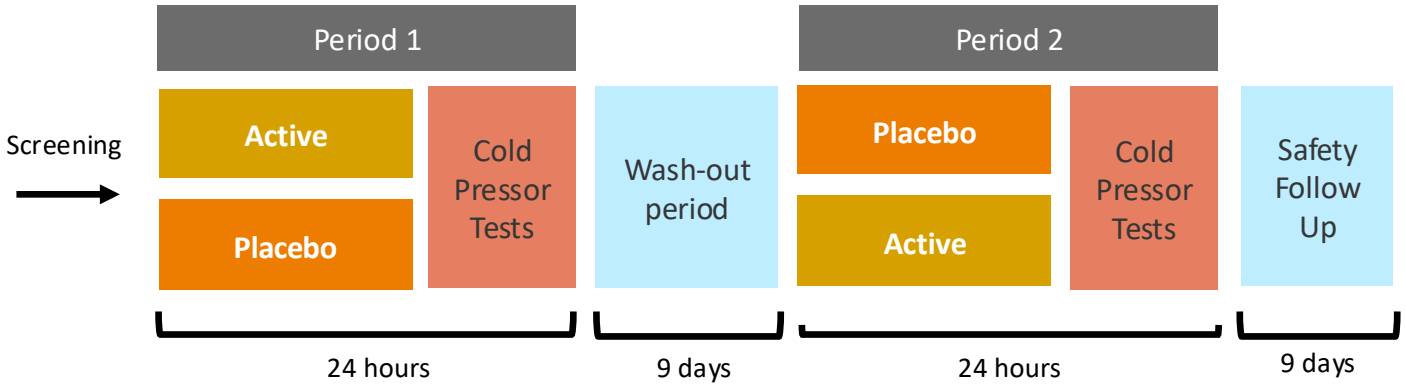
~70% of surgeries are performed as outpatient procedures, requiring reliance on pain management outside the hospital[5]

Often managing acute flares of chronic pain (esp. Pain Specialist use)

[1]AMA physician workforce database. [2] Life science intelligence 2024; [3] CDC 2022 and FAIR Health White Paper, 2025; [4] Todd et al., West J Emerg Med. 2010 Dec;11(5):408-15.; [5] Ambulatory Surgery Center Association, 2023. *Excludes "skin lesion procedures" which require minimal post-procedure pain management

Latigo Data Support Cold Pressor Test (CPT) as a Reliable Pharmacodynamic Biomarker for Drug Development Decision Making

Randomized, Double-blind, Placebo-controlled, Cross-Over Study Cold-Pressor Test



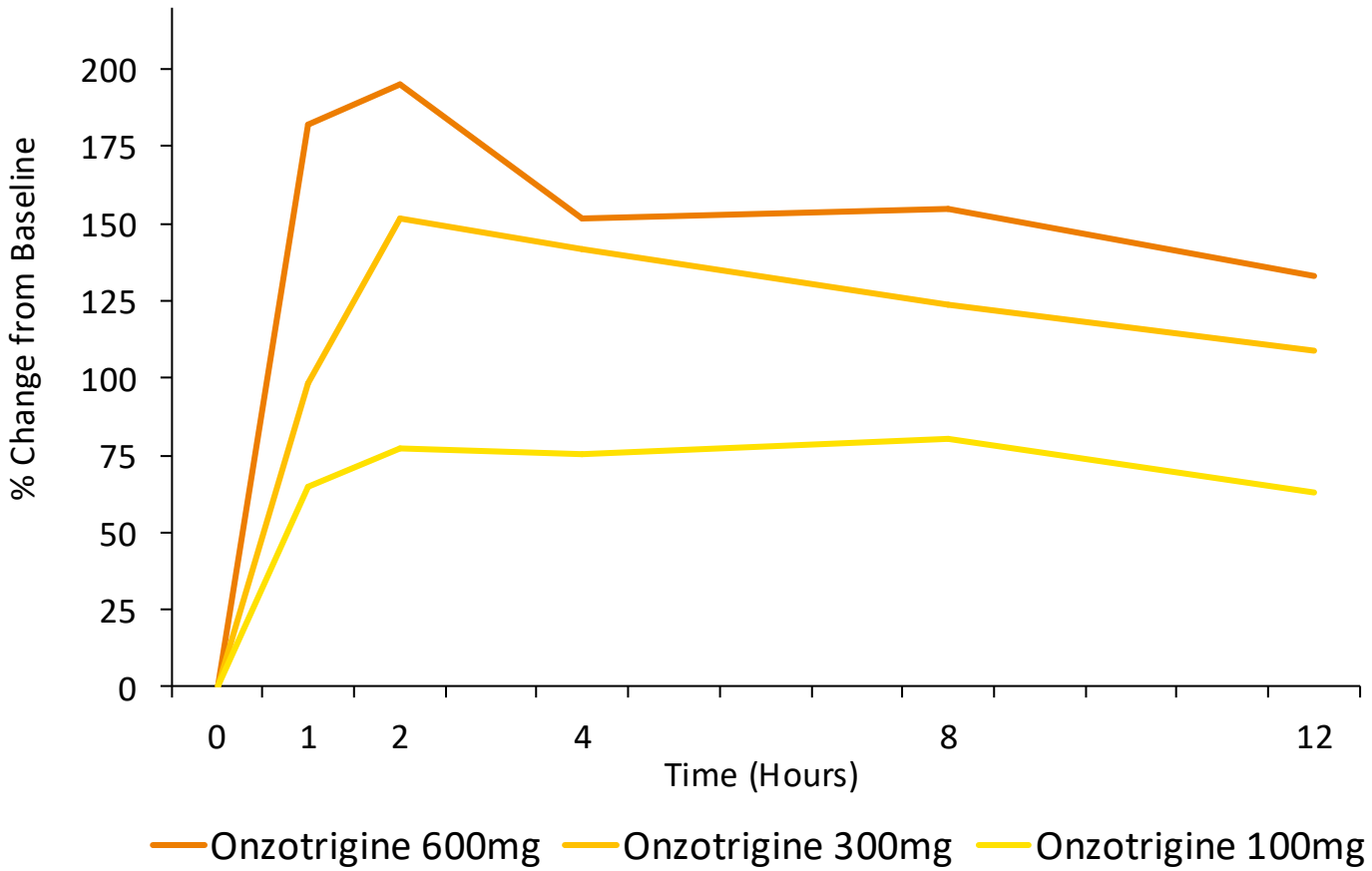
N=20

Study has been run with onzotrigine (100mg, 300mg, 600mg), LTG-305 (480mg 1 - and 5- day dosing), LTG-321 (90mg, 270mg), and suzetrigine (100mg)

Cold Pressor Test

CPT Has Predicted Analgesic Effects in a Later-Stage Clinical Trial

Cold Pressor Mean PTT % Change from Baseline, Placebo-Subtracted



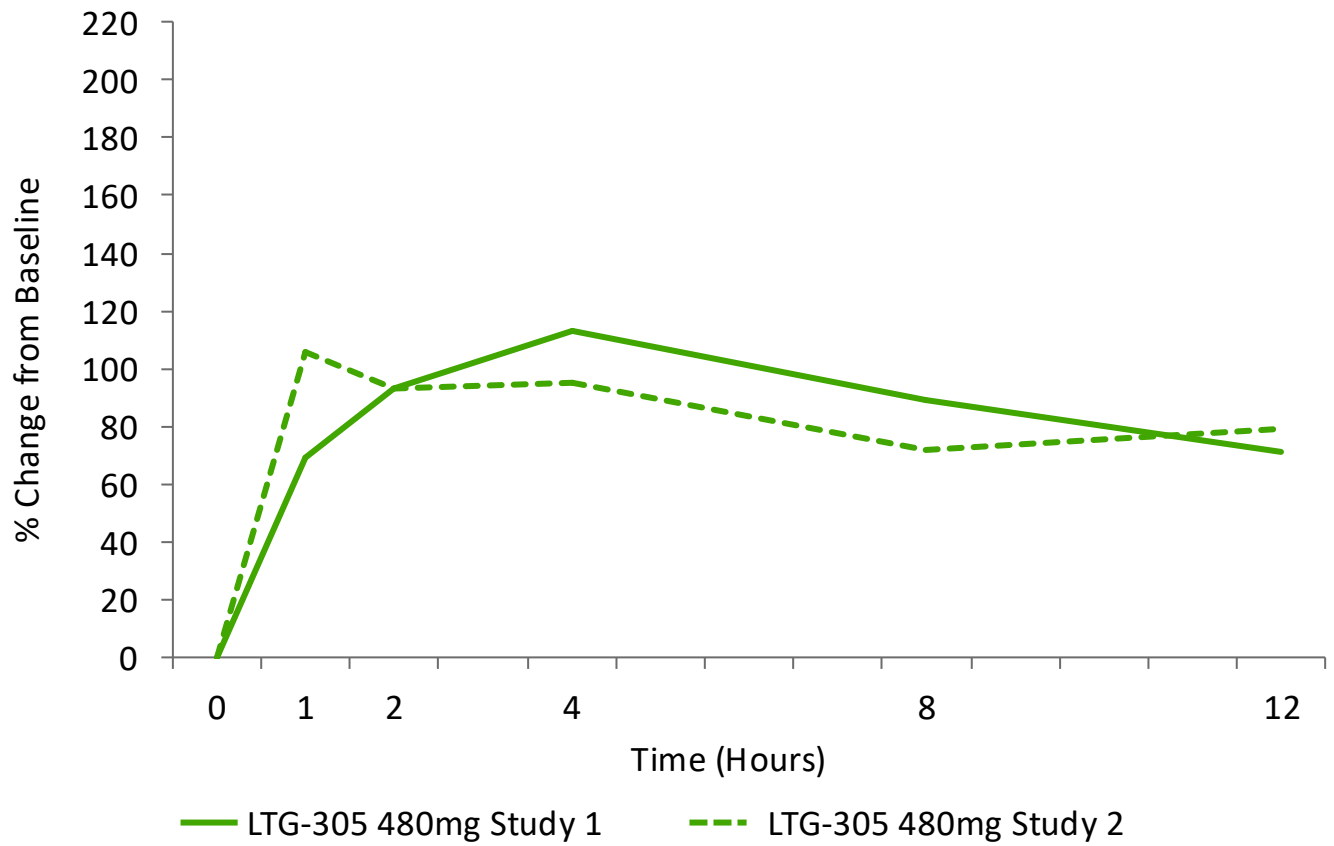
PTT: Pain tolerance threshold

CPT as an Archetypal Translational Model

- **Dose Ranging:** The two drugs we tested with multiple doses onzotrigine (shown on left) and LTG-321 both showed dose ranging with separation across each dose level

CPT Has Predicted Analgesic Effects in a Later-Stage Clinical Trial (Cont.'d)

Mean PTT % Change from Baseline, Placebo-Subtracted



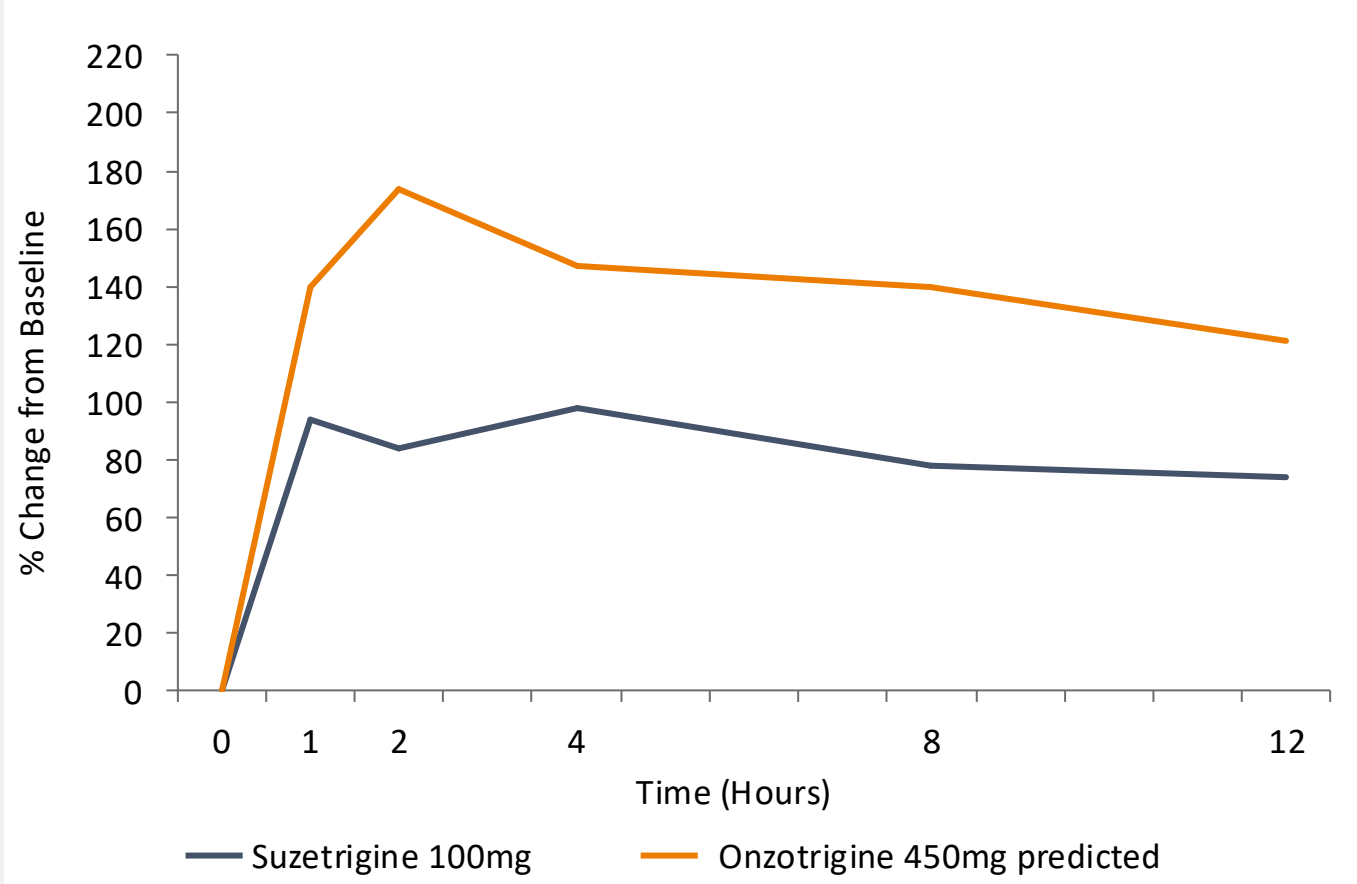
CPT as an Archetypal Translational Model

- **Repeatable:** We repeated the CPT with LTG-305 and got nearly consistent results

PTT: Pain tolerance threshold

CPT Has Predicted Analgesic Effects in a Later-Stage Clinical Trial (Cont.'d)

Mean PTT % Change from Baseline, Placebo-Subtracted

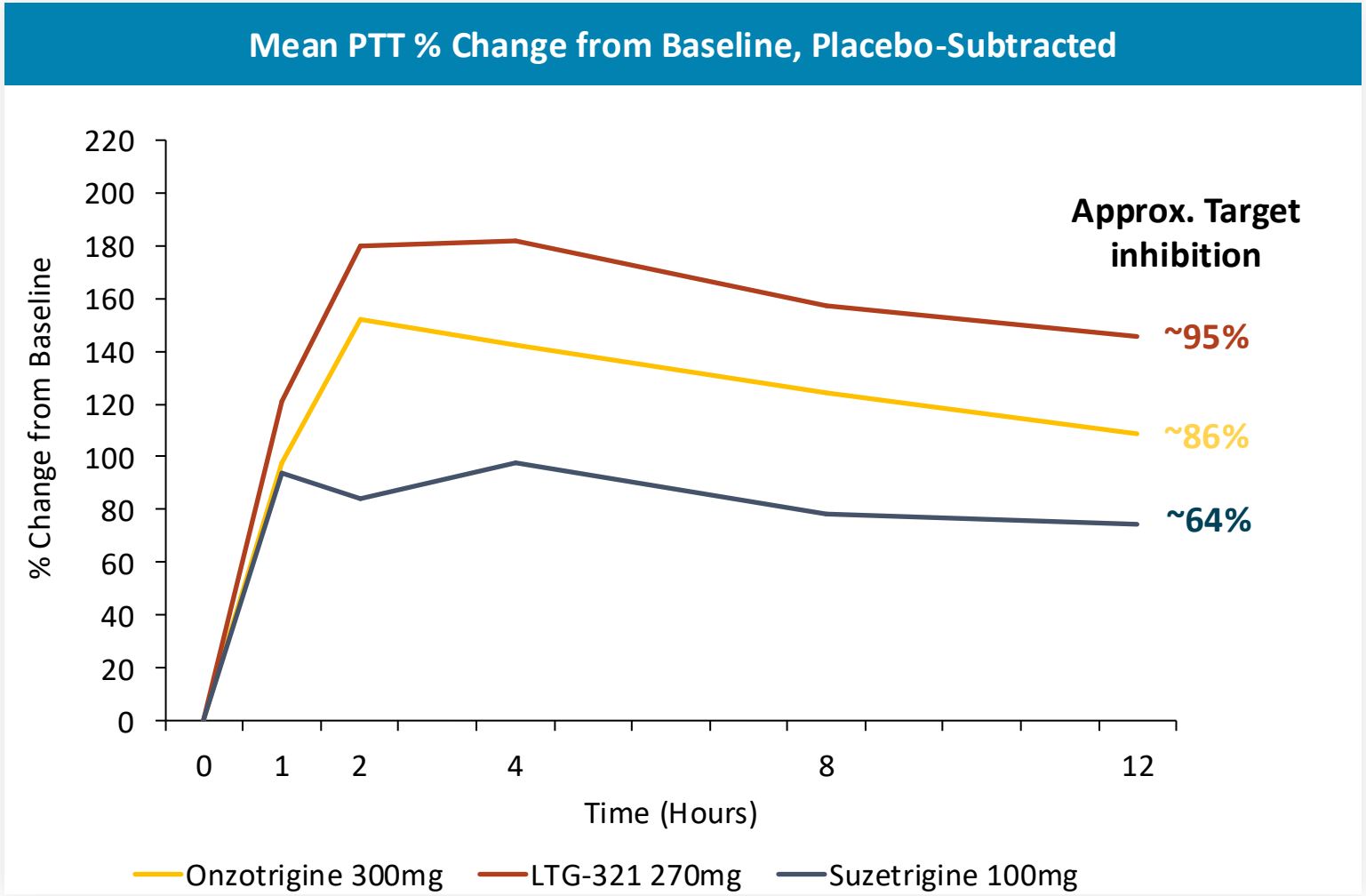


CPT as an Archetypal Translational Model

- **Predictive**: CPT predicted analgesic effect for a single dose in abdominoplasty
  - CPT data – Ran 100mg commercially-available suzetrigine in same CPT trial (450mg of onzotrigine (predicted) demonstrated ~70% higher AUC than 100mg of suzetrigine)
  - SPID12 of abdominoplasty (measuring impact of only the first dose) – 450mg of onzotrigine was 80% higher than 100mg of suzetrigine

Note: These data are derived from different clinical trials at different points in time, with differences in patient populations. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted.

LTG-321: Highest Known CPT Data for Any $Na_v1.8$



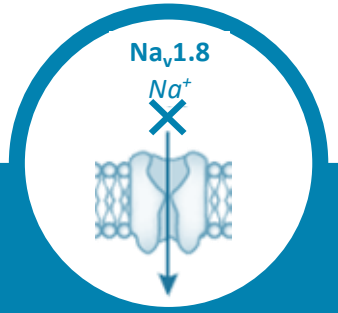
Results

LTG-321 analgesic effect at 270 mg dose, surpassed onzotrigine 300 mg by 26%[1]

Note: These data are derived from different clinical trials at different points in time, with differences in trial design and patient populations. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted.

[1] Reflects total aggregate effect or AUC over 12 hours

Why Proof of Concept in Osteoarthritis (OA) for Chronic Pain?



Preclinical Evidence of Potential Mechanism of Action in Musculoskeletal Pain

Mechanism of Action Validated in OA

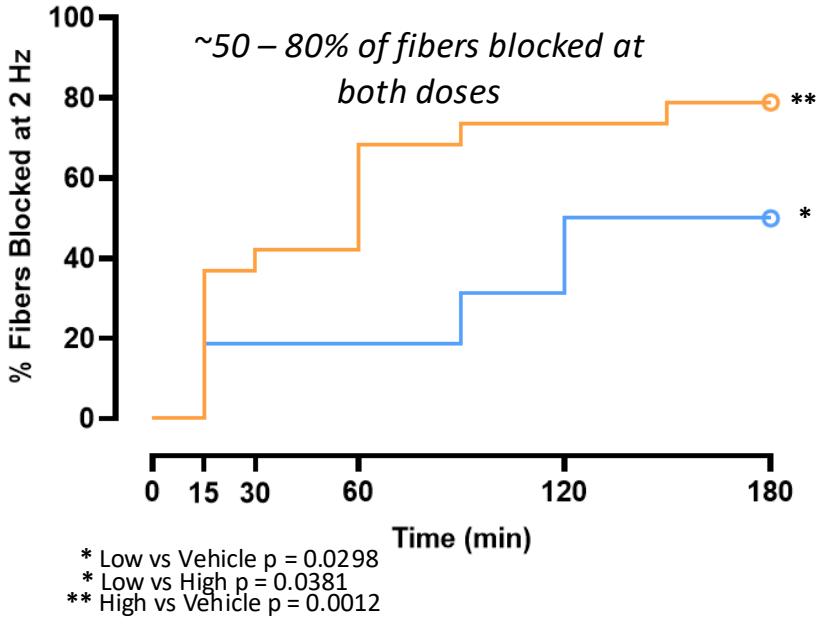
Most Reliable Chronic Pain Model

Latigo's Expertise

Lower Na_v 1.8 Target Inhibition Needed for Action Potential (AP) Block in Preclinical Musculoskeletal Pain Models

LTG-321
Chronic Pain

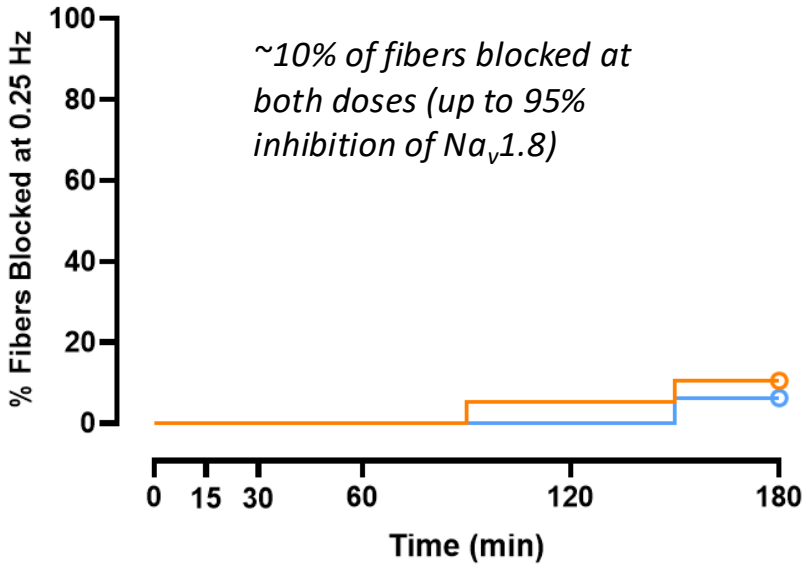
High Frequency – 2 Hz



* Low vs Vehicle p = 0.0298
* Low vs High p = 0.0381
** High vs Vehicle p = 0.0012

Firing Frequency Mimicking **Musculoskeletal Pain**

Low Frequency – 0.2 Hz



Firing Frequency Mimicking **Neuropathic Pain**

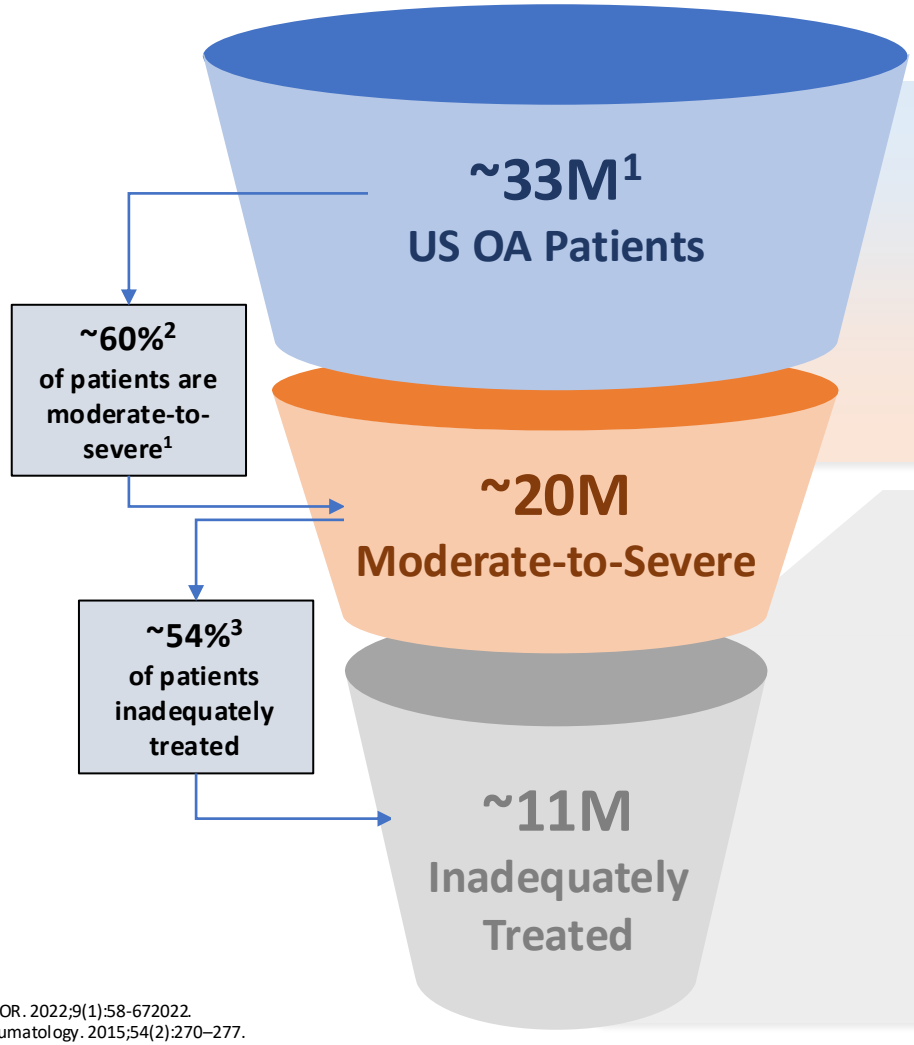
Onzotrigine (70-80% Na_V1.8 Inhibition, n=16 fibers)
2.8 mg/kg bolus + 0.67 mg/kg/hr infusion i.v.
Onzotrigine (90-95% Na_V1.8 Inhibition, n=19 fibers)
8.4 mg/kg bolus + 2 mg/kg/hr infusion i.v.

Target Inhibition Achieved with Na_v 1.8 Alone Informs Musculoskeletal Pain as Initial Prioritization for Chronic Pain Development

>99% inhibition of Na_v 1.8 required to meaningfully reduce low frequency AP firing in neuropathic pain model vs. **>70% inhibition** to reduce higher frequency AP firing musculoskeletal pain model

Limited Treatment Options for Patients with Osteoarthritis Pain Today, Driving Patients Towards Chronic Opioid Use Despite Risks

LTG-321
Chronic Pain



No effective disease-modifying medications

Pain management:
- **1L: Acetaminophen**
- **2L: NSAIDs**

No good pharmacological 3L treatments for chronic pain patients[4]
- 53% on opioids despite risk of dependence, tolerability
- 34% on anticonvulsants or on antidepressants
- ***Risks associated with opioids and tolerability concerns with NSAIDs are exacerbated by chronic use***

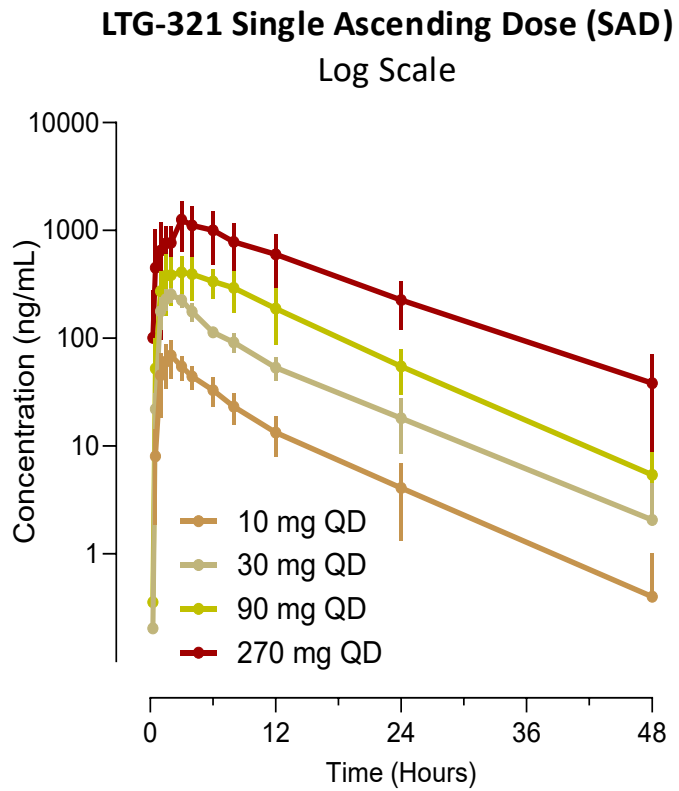
Ultimately seek single-joint relief through surgery
- ~1.3M annual knee and hip replacement surgeries[5]

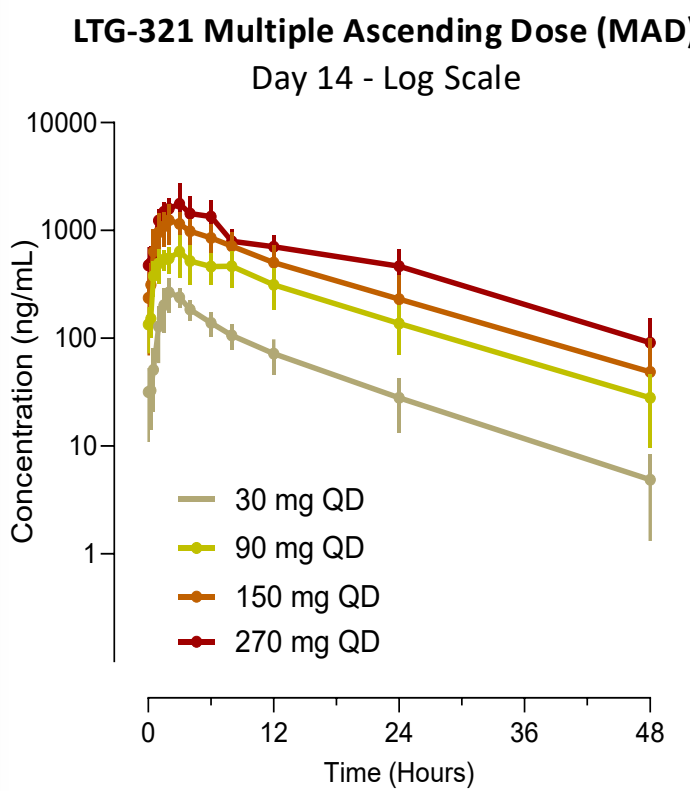
[1]2020 CDC data
[2] Schepman et al., JHEOR. 2022;9(1):58-672022.
[3] Conaghan et al., Rheumatology. 2015;54(2):270–277.
[4] 2025 Komodo claims data analysis
[5] American College of Rheumatology, March 2025

LTG-321: Dose Proportional Exposure Across All Doses in Phase 1 SAD / MAD

LTG-321
Chronic Pain

Dose-proportional Exposure Observed Across All Doses Tested in Phase 1 SAD / MAD Trial[1]





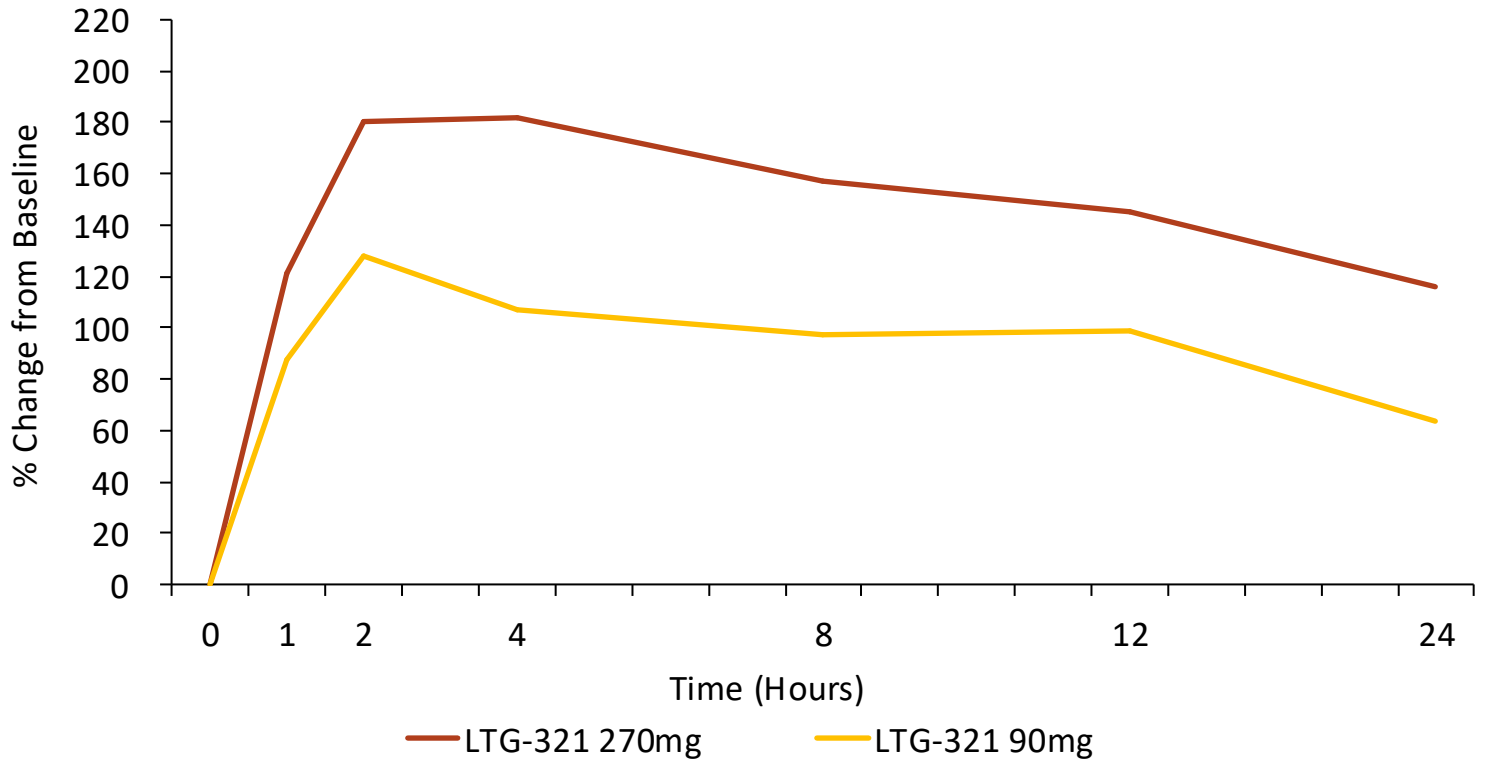
Results

- Phase 1 SAD/MAD[1]: LTG-321 well tolerated in healthy participants across cohorts
- Explored in SAD cohorts 10mg up to 270mg
- MAD cohorts explored 30mg up to 270mg once daily for 14 days
- Dose proportional exposure observed across all doses tested in participants across all cohorts
- ~33x 28-day NHP tox safety margin at 150mg QD dose

[1] As of May 2026 data cut off
Note: SAD: Single ascending dose; MAD: Multiple ascending dose; PK: Pharmacokinetic

LTG-321: Highest Known CPT data for Any $Na_v1.8$

Cold Pressor Mean PTT % Change from Baseline, Placebo-Subtracted



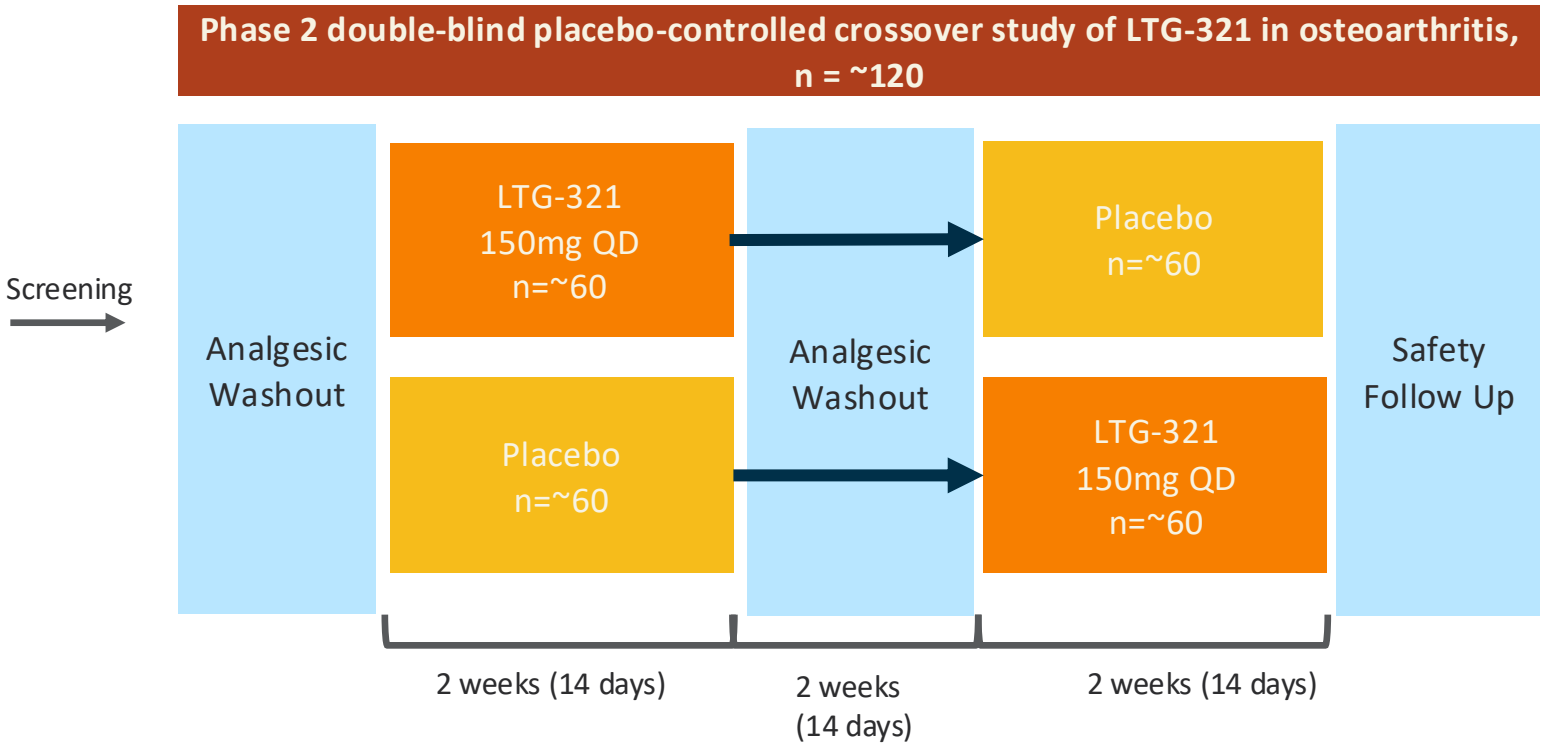
Results / Phase 2 Trial Dose Selection

- Both doses tested showed continued activity out to 24 hours
- LTG-321 analgesic effect at 270 mg dose, surpassed onzotrigine 300 mg by 26%[1]
- 150 mg repeat dosing exposure was comparable to 270 mg single dose
- Will target **150mg QD for Phase 2 OA trial**

LTG-321 Dose / Cohort	Cmax (ng/mL)	AUC_{0-24} (h*ng/mL)
270 mg CPT	1050	12400
150 mg MAD Day 14	1330	14100

As of May 2026 data cut off
[1]Reflects total aggregate effect or AUC over 12 hours

LTG-321 Chronic: Initiated Phase 2 Within-Subject Crossover Trial in Osteoarthritis (OA) of the Knee

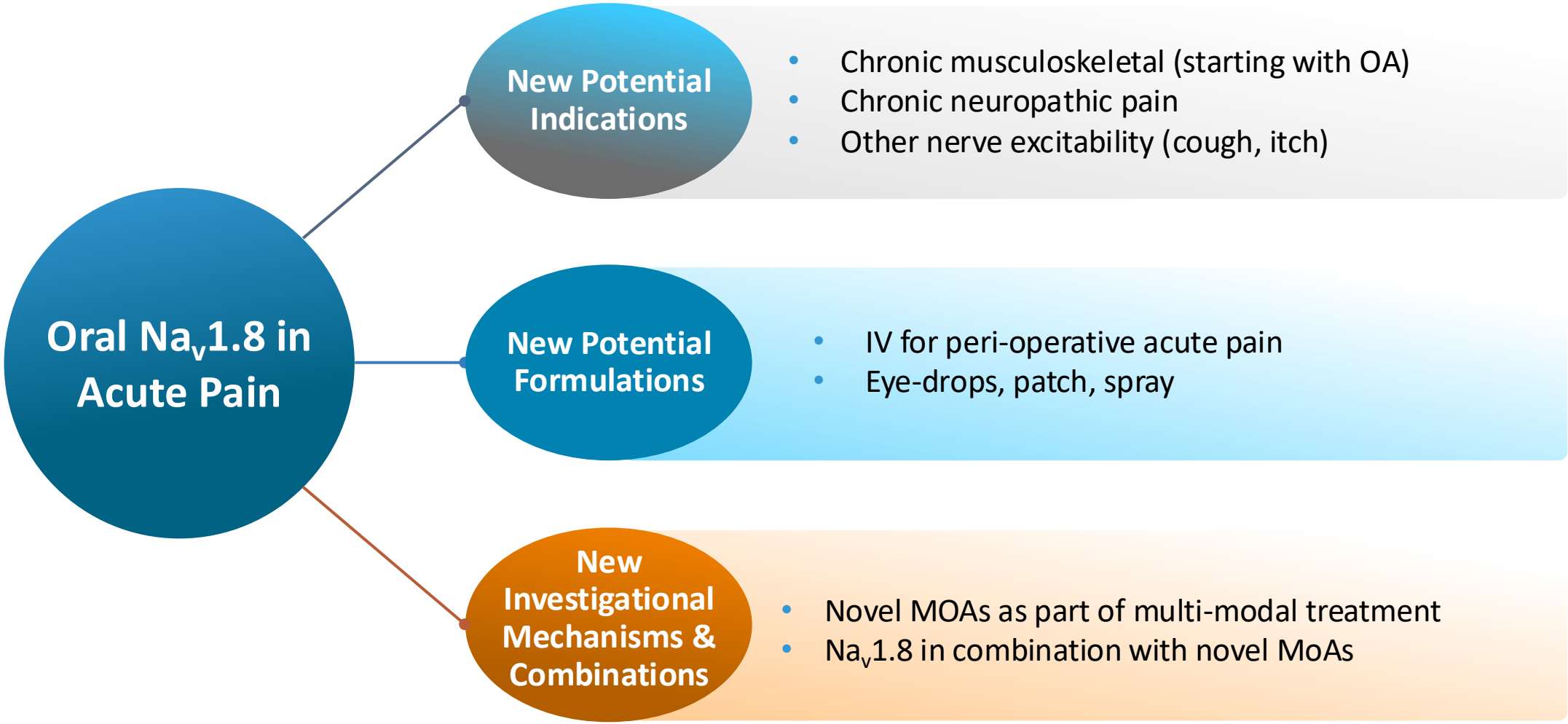


Design
- Crossover design intended to reduce variability

Primary Endpoint
- Change in WOMAC pain subscale from Baseline to 2 Weeks, LTG-321 vs. placebo

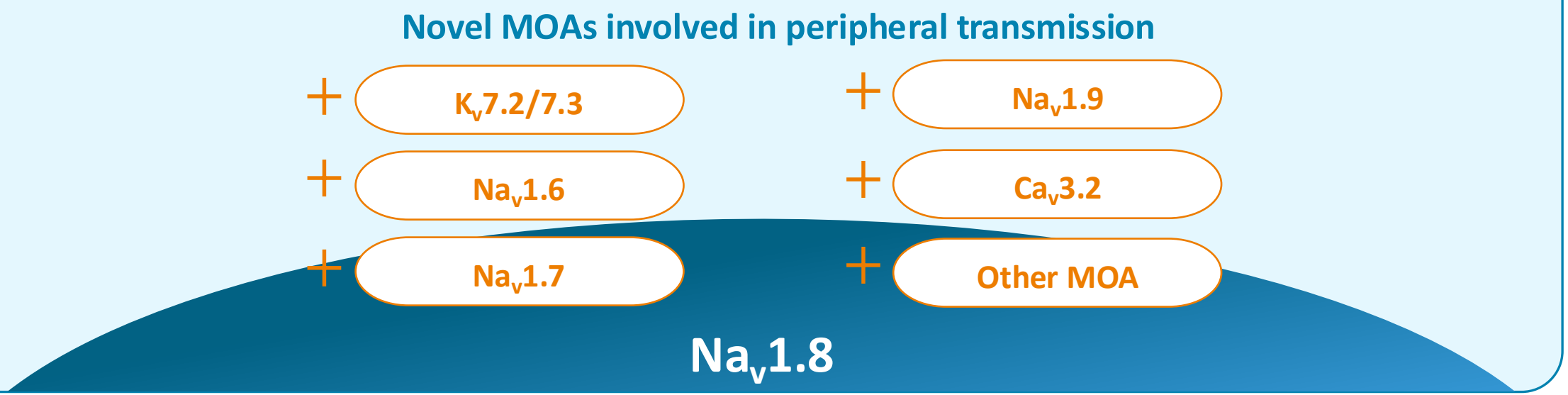
Rescue
- Acetaminophen (500mg every 4 to 6 hours up to max 3,000mg per day)

Oral $Na_v1.8$ in Acute Pain is the First Step in Life Cycle Management to Expand Portfolio



$Na_v1.8$ is Potentially the Ideal Foundational Therapy Target for a Multi-modal Pain Franchise

- Well tolerated for broad patient population based on suzetrigine approved label and data from clinical trials of other $Na_v1.8$ product candidates
- Can potentially be used in combination with other mechanisms

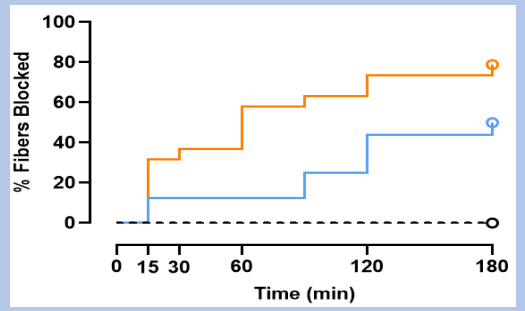


Execution of Best-in-Class $Na_V1.8$ Multi-Modal Pain Strategy – Latigo's Differentiation

Differentiated Pain Capabilities at Latigo

Pain Biology Expertise

- Internal e-phys models to validate targets and assess compounds
- Microneurography *in vivo* model – models drug activity without relying on behavior



in vivo & *ex vivo* E-phys

Clinical Translation

- Rapid, inexpensive proof of concept and early dose-finding in healthy volunteers with induced pain studies
- Accurate and has predicted analgesic effect in a late-stage trial

Cold Pressor Test

Clinical Execution

- Team has run over 250 pain studies
- Conducted full dose range finding abdominoplasty trial that read out in 6 months with potential best-in-class execution metrics

Abdominoplasty Trial

Anticipated Milestones for Onzotrigine and LTG-321

Onzotrigine (Acute Pain)

2H2026: Initiate Phase 3 Bunionectomy & Safety Trials

2H2027: Phase 3 Bunionectomy & Safety Trials Topline Results

LTG-321 (Chronic Pain)

2H2027: Phase 2 OA Proof of Concept Topline Results

Thank You

LATIGO BIO

Latigo Biotherapeutics
1300 Rancho Conejo Blvd, Suite 305
Thousand Oaks, CA 91320

info@latigobio.com