ENGINEERING MEDICINES
TO IMPROVE PATIENT CARE

Elegrobart REVEAL-1 Topline Results

March 30, 2026

Cautionary note regarding forward-looking statements

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This presentation and the related teleconference contain forward-looking statements. These statements may be identified by the use of words such as, but not limited to, “anticipate,” “believe,” “continue,” “could,” “estimate,” “expect,” “intend,” “may,” “might,” “on track,” “plan,” “potential,” “predict,” “project,” “design,” “should,” “target,” “will,” or “would” or other similar terms or expressions that concern our expectations, plans and intentions. Forward-looking statements are neither historical facts nor assurances of future performance. Instead, they are based on our current beliefs, expectations, and assumptions. Forward-looking statements include, without limitation, statements regarding: preclinical development, clinical development, and anticipated commercialization of Viridian’s product candidates; anticipated data results and timing of their disclosure, including elegrobart topline data from the REVEAL-2 trial; Viridian’s expectations regarding the anticipated timing or likelihood of regulatory submissions and approvals, including the anticipated approval of the BLA for veligrotug and the anticipated submission of a BLA for elegrobart; elegrobart’s potential to be the first subcutaneous autoinjector for the treatment of TED; that the veligrotug commercial infrastructure will support a potential elegrobart launch, if approved; Viridian’s product candidates potentially being best-in-class; Viridian's product candidates potentially being treatments of choice in TED; and that Viridian’s cash, potential near-term milestones from its 2025 royalty agreement and anticipated commercial revenues, if veligrotug and elegrobart are approved, will be sufficient to fund its business plans through profitability.

New risks and uncertainties may emerge from time to time, and it is not possible to predict all risks and uncertainties. No representations or warranties (expressed or implied) are made about the accuracy of any such forward-looking statements. Such forward-looking statements are subject to a number of material risks and uncertainties including but not limited to: potential utility, efficacy, potency, safety, clinical benefits, clinical response, and convenience of Viridian’s product candidates; that results or data from completed or ongoing clinical trials may not be representative of the results of ongoing or future clinical trials; that the results of ongoing or future clinical trials may not support submission for regulatory approvals; the timing, progress and plans for our ongoing or future research, preclinical, and clinical development programs; changes to trial protocols for ongoing or new clinical trials; expectations and changes regarding the timing for regulatory filings; expectations and changes regarding the timing for enrollment and data; uncertainty and potential delays related to clinical drug development; the duration and impact of regulatory delays in our clinical programs, including as a result of a prolonged government shutdown; the timing of and our ability to obtain and maintain regulatory approvals for our therapeutic candidates; manufacturing risks; competition from other therapies or products; estimates of market size; other matters that could affect the sufficiency of existing cash, cash equivalents, and short-term investments to fund operations; our financial position; our future operating results and financial performance; Viridian’s intellectual property position; that our product candidates may not be commercially successful, if approved; and other risks described from time to time in the “Risk Factors” section of our filings with the Securities and Exchange Commission (SEC), including those described in our most recent Annual Report on Form 10-K or Quarterly Report on Form 10-Q, as applicable, and supplemented from time to time by our Current Reports on Form 8-K. Any forward-looking statement speaks only as of the date on which it was made. Neither the company, nor its affiliates, advisors, or representatives, undertake any obligation to publicly update or revise any forward-looking statement, whether as a result of new information, future events or otherwise, except as required by law. These forward-looking statements should not be relied upon as representing the company’s views as of any date subsequent to the date hereof.

Agenda

Introduction

Steve Mahoney
President & Chief Executive Officer

REVEAL-1 Phase 3 Topline Results

Radhika Tripuraneni, MD
Chief Medical Officer

Closing Remarks

Steve Mahoney
President & Chief Executive Officer

Analyst Q&A

Steve Mahoney, President & Chief Executive Officer

Radhika Tripuraneni, MD, Chief Medical Officer

Shan Wu, Ph.D., Chief Business Officer

Tony Casciano, Chief Commercial Officer

Viridian is developing an IGF-1R antibody franchise with the potential to transform the treatment of patients with TED

Topline data today

Steroids/Surgery

Teprotumumab

First approved **targeted therapy** for TED

8 IV infusions

Veligrotug

Next-gen anti-IGF-1R with potential to become **IV treatment of choice** in TED

5 IV infusions

Elegrobart

Potential to be the **first subcutaneous autoinjector** in TED

Q4W or Q8W self-administered autoinjector

Today — **PDUFA Target June 30, 2026** — **Planned Q1 2027 BLA**

Veligrotug and elegrobart are investigational products that have not been approved by any regulatory authority; the safety and efficacy have not been established.

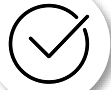
BLA = Biologics License Application, IGF-1R = insulin-like growth factor-1 receptor, IV = intravenous, Q4W = every 4 weeks, Q8W = every 8 weeks, SC = subcutaneous, TED = thyroid eye disease.

REVEAL-1 in active TED patients met primary endpoint and elegrobart was generally well tolerated

(Active TED)

Achieved **the primary endpoint** with high statistical significance **($p < 0.0001$);** 54% of Q4W patients achieved a proptosis response versus 18% placebo at week 24

Achieved **clinically meaningful outcomes** on multiple **secondary endpoints: 63% PRR in the Q8W arm** versus 18% placebo, **51% diplopia complete resolution** in the Q4W arm versus 16% placebo, all at week 24



Rapid onset of treatment effect in as few as 4 weeks

Generally well tolerated in both dose groups, with **low rate of hearing impairment AEs** through week 24

Elegrobart has the potential to be the **first subcutaneous autoinjector in TED** that allows patients to self-administer at home, with potentially **as few as 3 doses**

Source: Viridian REVEAL-1 week 24 topline data on file (interim topline database lock).
AE = adverse event, IGF-1R = insulin-like growth factor-1 receptor, PRR = proptosis responder rate, Q4W = every 4 weeks, Q8W = every 8 weeks, TED = thyroid eye disease.

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REVEAL-1 is a phase 3 randomized, controlled, double-masked trial of elegrobart in active TED

Treatment Phase

(20 weeks treatment with primary endpoint at 24 weeks)

Treatment Arms *(1:1:1)*

D1[1] *W4* *W8* *W12* *W16* *W20* *W24*

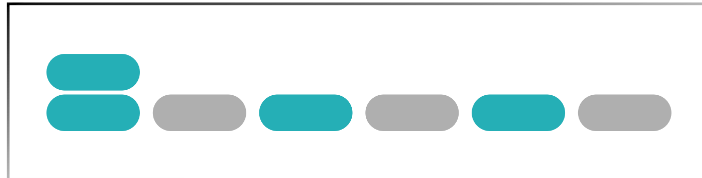
Follow-up through W52

Key Inclusion Criteria

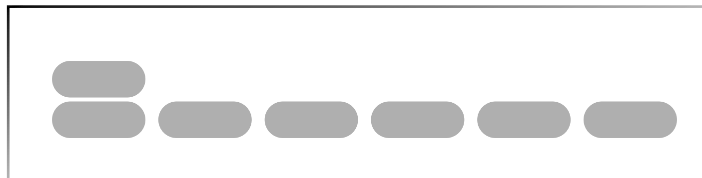
- CAS ≥3
- Onset of TED symptoms within 15 months
- Proptosis of ≥3 mm

Elegrobart Q4W[1]

Elegrobart Q8W[1, 2]



Placebo



Key: *Elegrobart 300 mg* *Placebo*

Primary Endpoint Analysis

Primary efficacy endpoint:
Proptosis responder rate (PRR) in Q4W arm

Key secondary endpoints:

- Proptosis mean change from baseline
- Clinical Activity Score (CAS) reduction to 0 or 1
- Diplopia responder rate
- Diplopia complete resolution
- Q8W endpoints

Additional efficacy & safety follow-up at:

- *Week 36*
- *Week 52*

[1] 600 mg loading dose given as two 300 mg injections; [2] Placebo injections administered at alternating study visits to maintain study masking across arms.
D = day, mm = millimeter, Q4W = every 4 weeks, Q8W = every 8 weeks, TED = thyroid eye disease, W = week.

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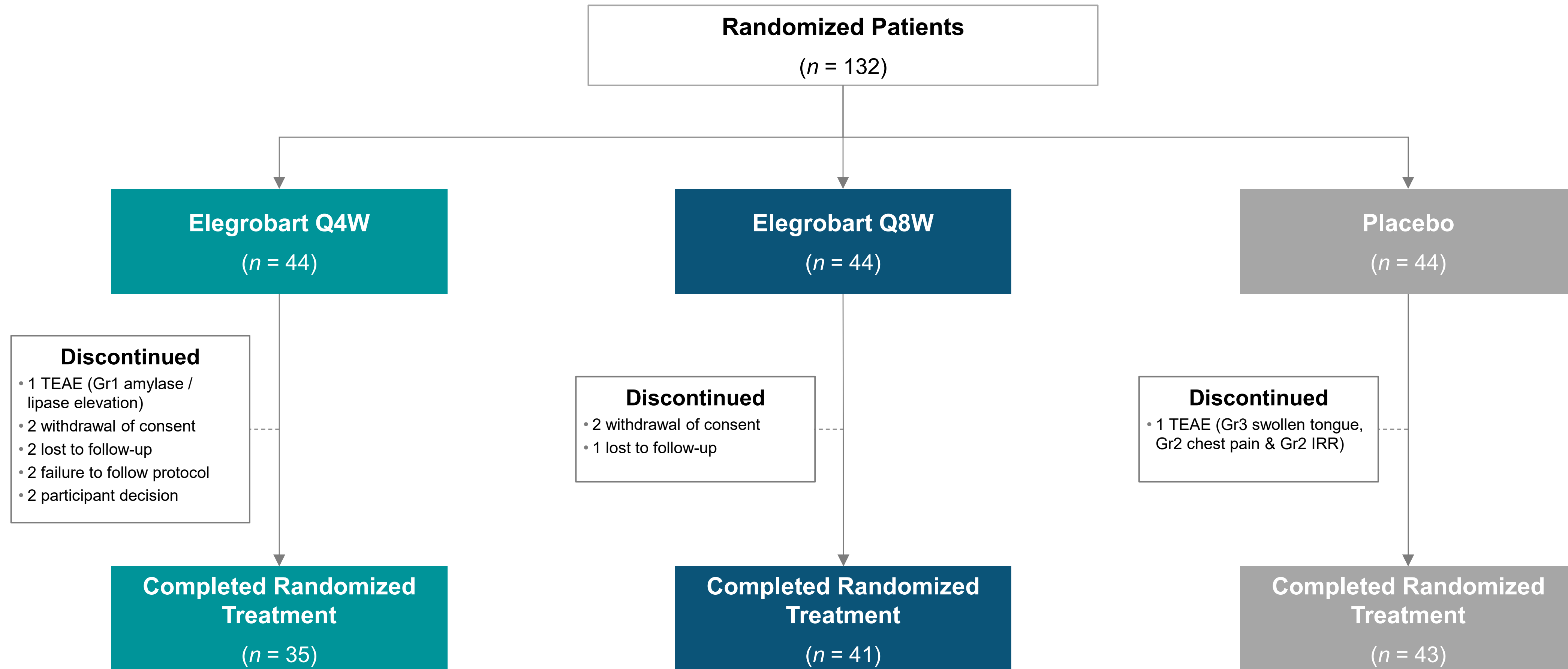
REVEAL-1 is the largest pivotal clinical trial conducted in active TED to date



Source: Viridian REVEAL-1 week 24 topline data on file (interim topline database lock).
Q4W = every 4 weeks, Q8W = every 8 weeks. Gr = grade, TEAE = treatment-emergent adverse event, IRR = infusion related reaction.

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REVEAL-1 baseline characteristics were well-balanced between arms

		Elegrobart Q4W (*n* = 44)	Elegrobart Q8W (*n* = 44)	Placebo (*n* = 44)
Participant Demographics	Age in years, mean (SD)	52.6 (12.1)	48.1 (12.4)	48.5 (12.9)
	Female sex, n (%)	35 (80%)	34 (77%)	35 (80%)
	White race, n (%)	36 (82%)	36 (82%)	35 (80%)
Disease Characteristics	Months since TED onset, mean (SD)	6.6 (4.4)	7.7 (4.3)	8.3 (5.2)
	Baseline proptosis by exophthalmometry (mm), mean (SD)	22.3 (2.6)	22.7 (3.3)	21.8 (2.5)
	Baseline CAS, mean (SD)	4.3 (1.0)	4.2 (1.0)	4.0 (0.9)
	Participants with diplopia, n (%)	28 (64%)	27 (61%)	31 (70%)
	Diplopia (Gorman Score), mean (SD)[1]	1.8 (0.8)	1.8 (0.8)	1.8 (0.7)

Source: Viridian REVEAL-1 week 24 topline data on file (interim topline database lock).
Note: all proptosis & CAS reported values and endpoints in the data analysis are based on study eye (defined as eye with greater proptosis at baseline).
[1] Of patients with diplopia at baseline.
CAS = clinical activity score, mm = millimeter, SD = standard deviation, TED = thyroid eye disease.

REVEAL-1 achieved high statistical significance on primary endpoint at 24 weeks

			Elegrobart (n = 44 per arm)	Placebo (n = 44)	p-value
Primary Endpoint	Q4W	**FDA:** Proptosis responder rate (exophthalmometry)[1]	54%	18%	$p < 0.0001$*
		EMA: Overall responder rate (ORR)[2]	51%	16%	$p = 0.0001$*
Key Secondary Endpoints	Q4W	Proptosis mean change from baseline (exophthalmometry)	-2.33 mm	-0.81 mm	$p < 0.0001$*
		Clinical activity score (CAS) reduction to 0 or 1	57%	50%	$p = 0.24$
		Diplopia responder rate[3]	71%	32%	$p = 0.0009$
		Diplopia complete resolution[4]	51%	16%	$p = 0.0013$
	Q8W	Proptosis responder rate (exophthalmometry)[1]	63%	18%	$p < 0.0001$
		EMA: Overall responder rate (ORR)[2]	58%	16%	$p < 0.0001$
		Proptosis mean change from baseline (exophthalmometry)	-2.50 mm	-0.81 mm	$p < 0.0001$
		Clinical activity score (CAS) reduction to 0 or 1	69%	50%	$p = 0.03$
		Diplopia responder rate[3]	54%	32%	$p = 0.05$
		Diplopia complete resolution[4]	28%	16%	$p = 0.14$
Other Secondary Endpoints	Q4W	Proptosis responder rate[1] (MRI)	50%	2%	$p < 0.0001$
		Proptosis mean change from baseline (MRI)	-2.04 mm	-0.22 mm	$p < 0.0001$
	Q8W	Proptosis responder rate[1] (MRI)	36%	2%	$p < 0.0001$
		Proptosis mean change from baseline (MRI)	-1.99 mm	-0.22 mm	$p < 0.0001$

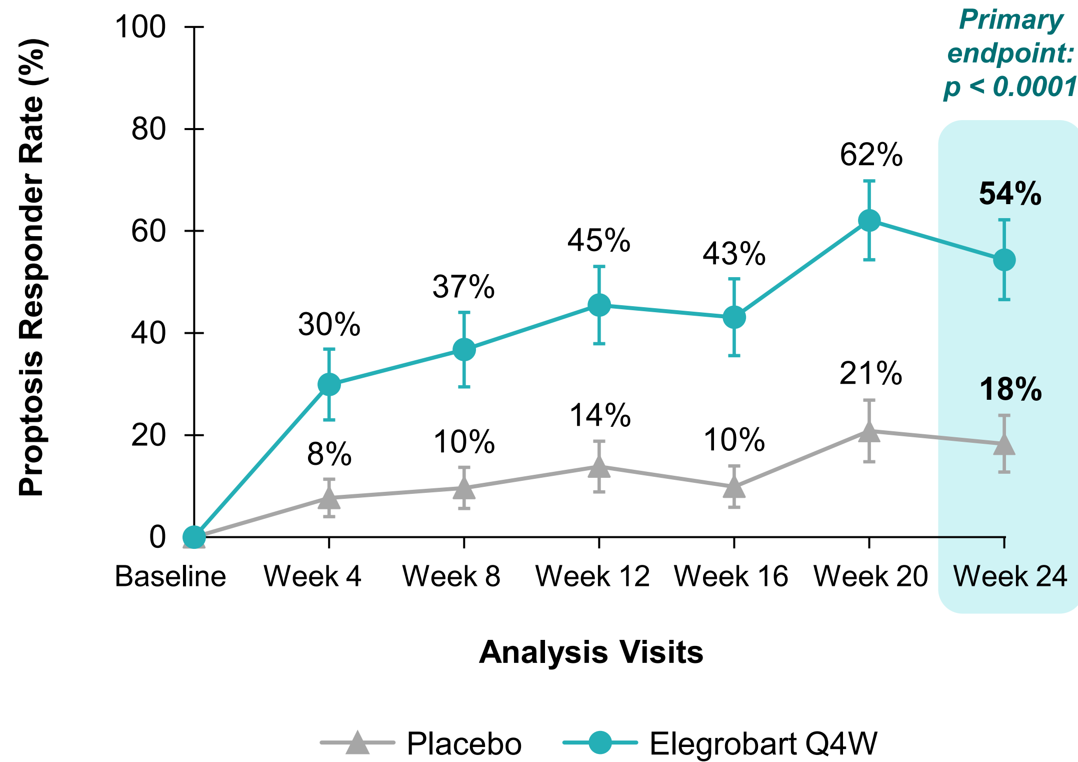
Source: Viridian REVEAL-1 week 24 topline data on file (interim topline database lock).

* Statistically significant. Key secondary endpoints below Q4W "CAS Reduction to 0 or 1" in the prespecified testing hierarchy and other secondary endpoints are nominally significant if below the statistically significant threshold of 0.025.

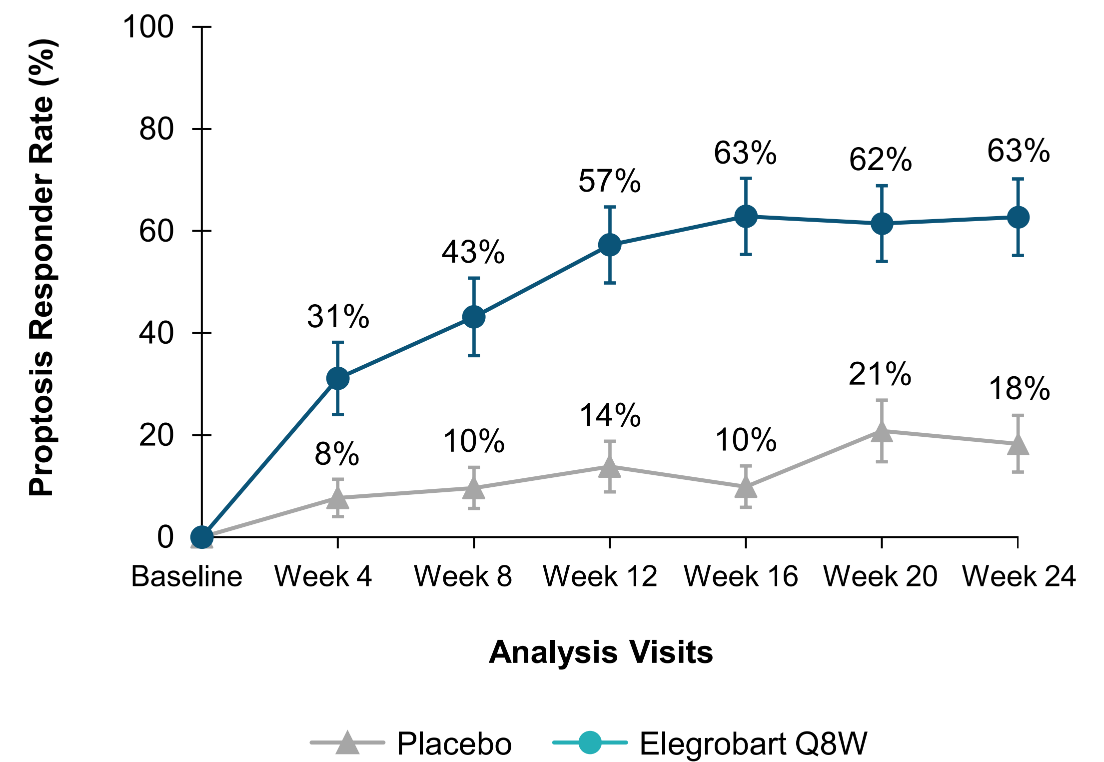
[1] Participants with ≥2 mm reduction in proptosis from baseline in study eye, without deterioration in fellow eye (≥2 mm increase), [2] Participants with both proptosis and CAS response; CAS response defined as ≥2-point reduction in CAS from baseline in study eye, without deterioration in fellow eye (≥2-point increase), [3] Participants with reduction of ≥1 on Gorman Score at week 24, among patients with diplopia at baseline, [4] Participants with baseline diplopia (Gorman Score >0) and a score of 0 at week 24. CAS = clinical activity score, mm = millimeter, MRI = magnetic resonance imaging, Q4W = every 4 weeks, Q8W = every 8 weeks.

Significant proptosis responder rate as early as 4 weeks after just one dose and across all time points in both arms

Proptosis Responder Rate – Q4W



Proptosis Responder Rate – Q8W



Rapid onset of treatment effect: proptosis response in patients receiving elegrobart was observed as early as week 4, after just one dose

Source: Viridian REVEAL-1 week 24 topline data on file (interim topline database lock).
Primary endpoint was statistically significant. PRR at time points prior to week 24 were prespecified exploratory endpoints. Results at all time points and across both treatment arms prior to week 24 were nominally significant ($p < 0.025$).
PRR = proptosis responder rate, Q4W = every 4 weeks, Q8W = every 8 weeks.

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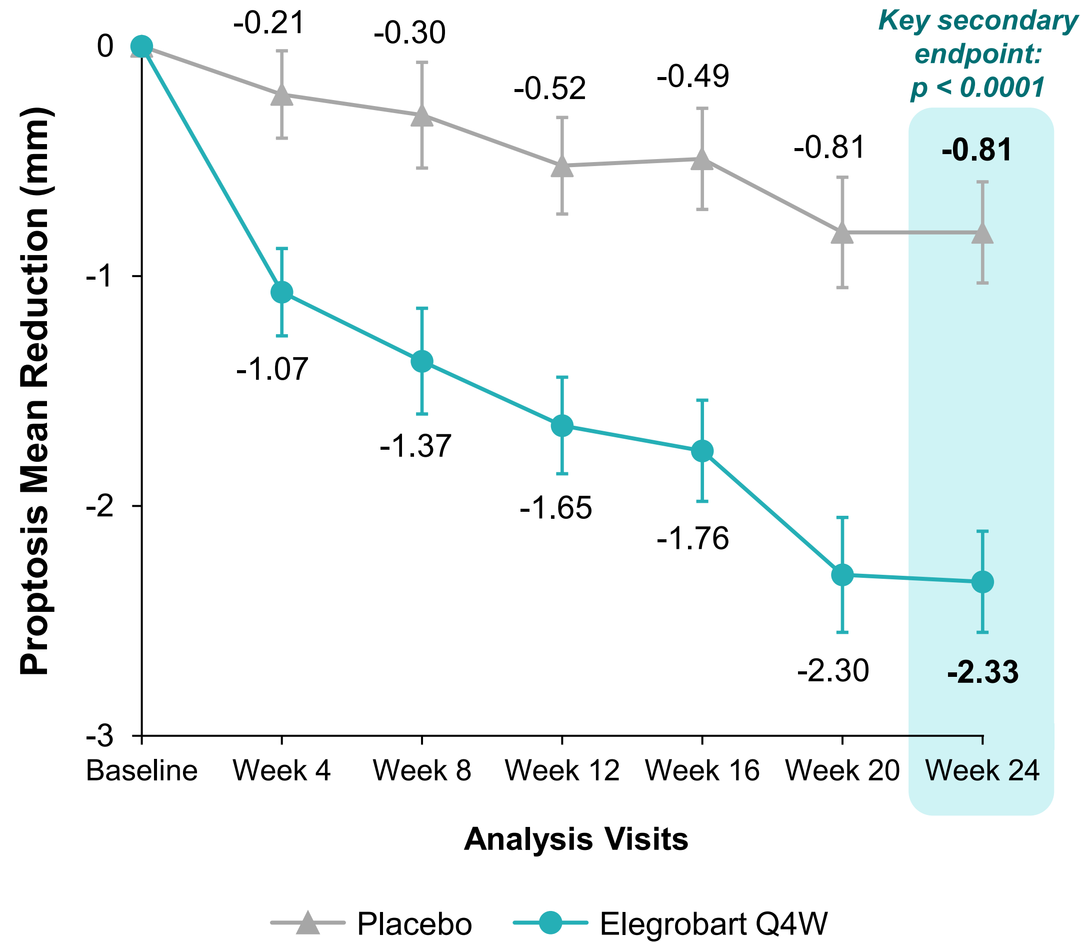
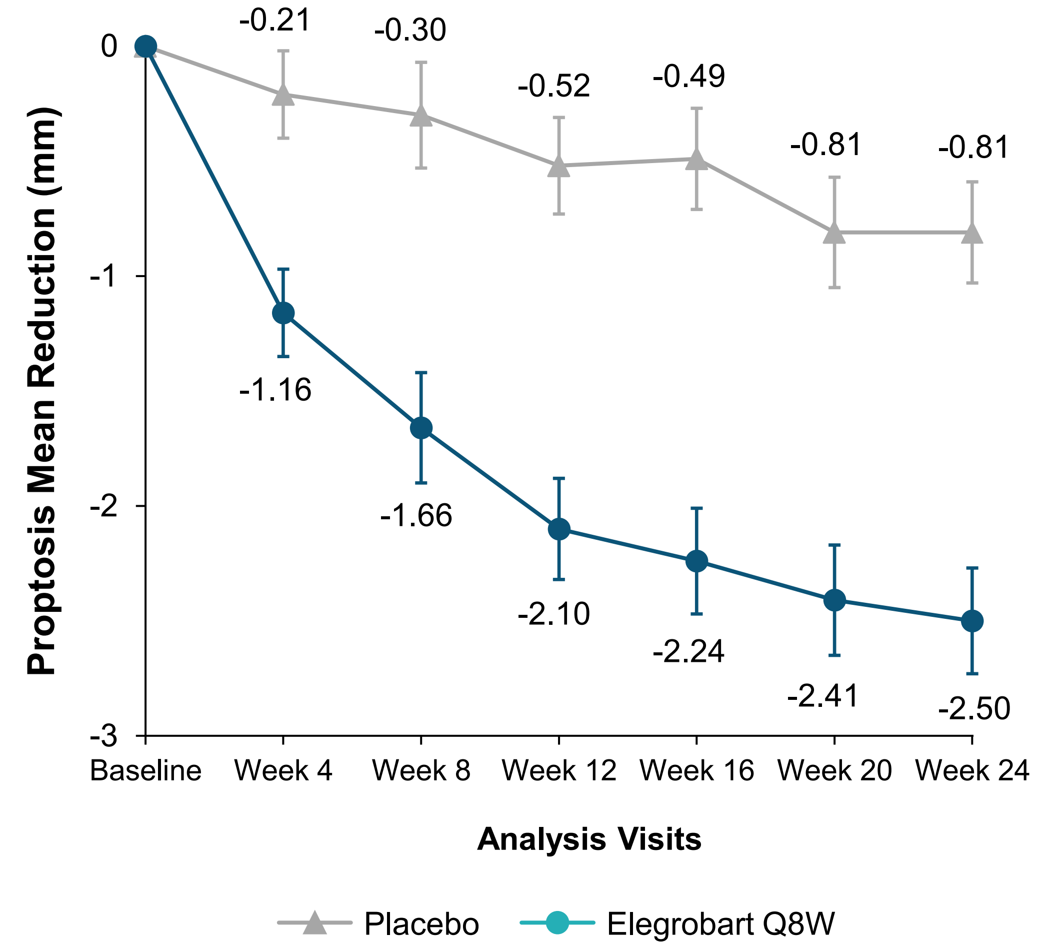
Significant proptosis mean change from baseline at all time points across both treatment arms, including at week 4





Source: Viridian REVEAL-1 week 24 topline data on file (interim topline database lock).
The key secondary endpoint of mean change from baseline at week 24 for Q4W arm was statistically significant. Proptosis mean change from baseline at time points prior to week 24 were prespecified exploratory endpoints. Results at all time points and across both treatment arms prior to week 24 were nominally significant ($p < 0.025$).
mm = millimeter, Q4W = every 4 weeks, Q8W = every 8 weeks.

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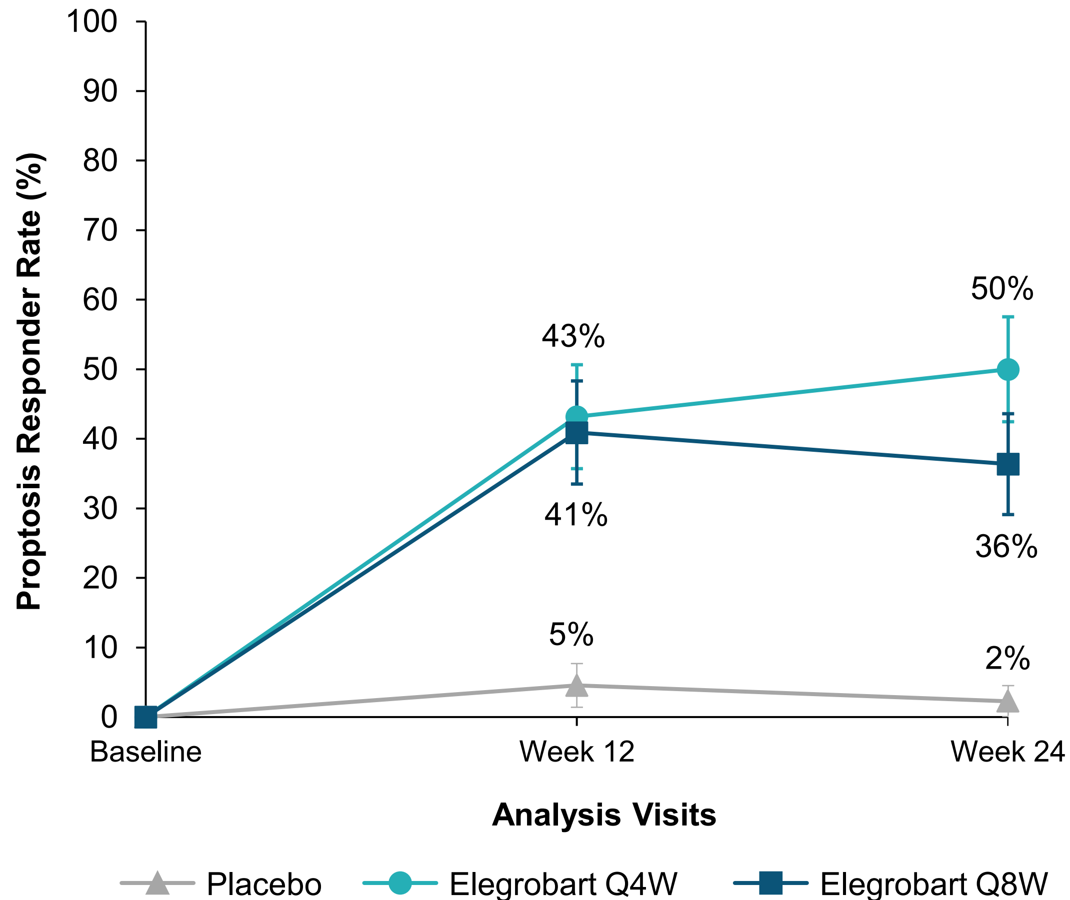
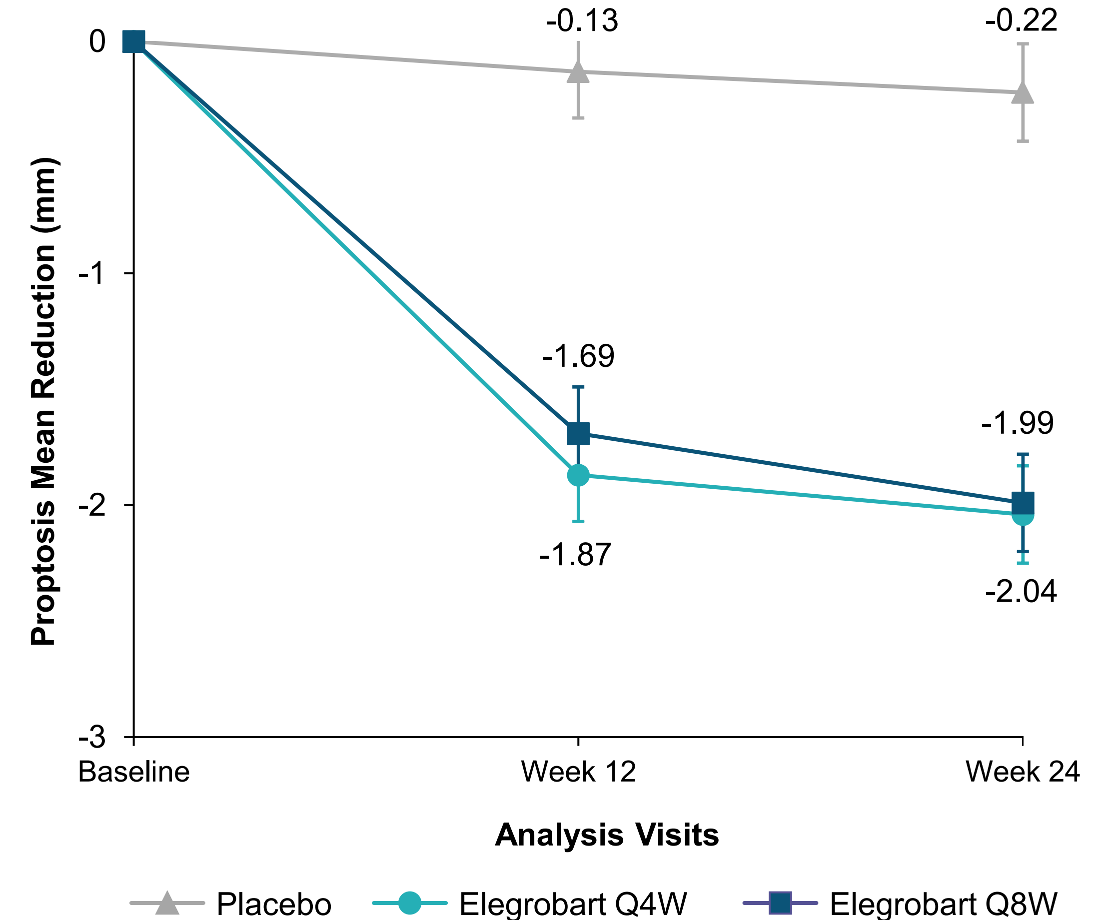
Proptosis endpoints as measured by MRI were consistent with exophthalmometer, and significant at all time points

Proptosis Responder Rate (MRI)



Proptosis Mean Change from Baseline (MRI)



Source: Viridian REVEAL-1 week 24 topline data on file (interim topline database lock).
PRR and proptosis mean change from baseline at all time points prior to week 24 were prespecified exploratory endpoints. Results at all time points and across both treatment arms were nominally significant ($p < 0.025$). MRI assessment was only conducted at baseline, week 12, and week 24.
mm = millimeter, Q4W = every 4 weeks, Q8W = every 8 weeks.

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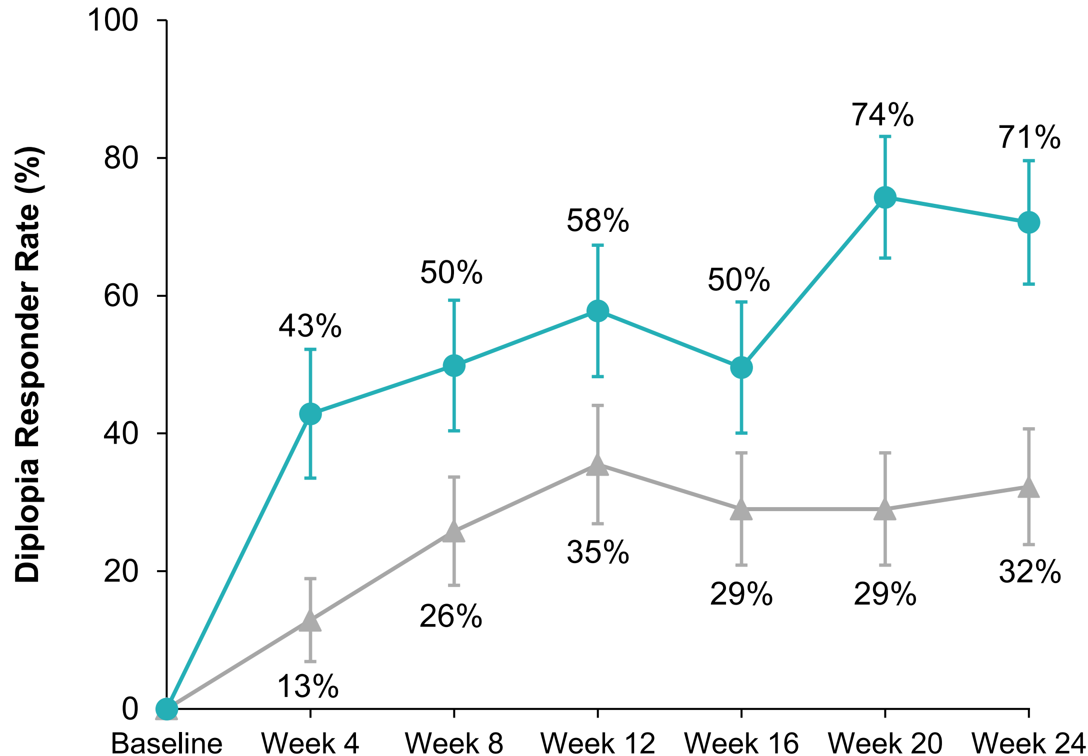
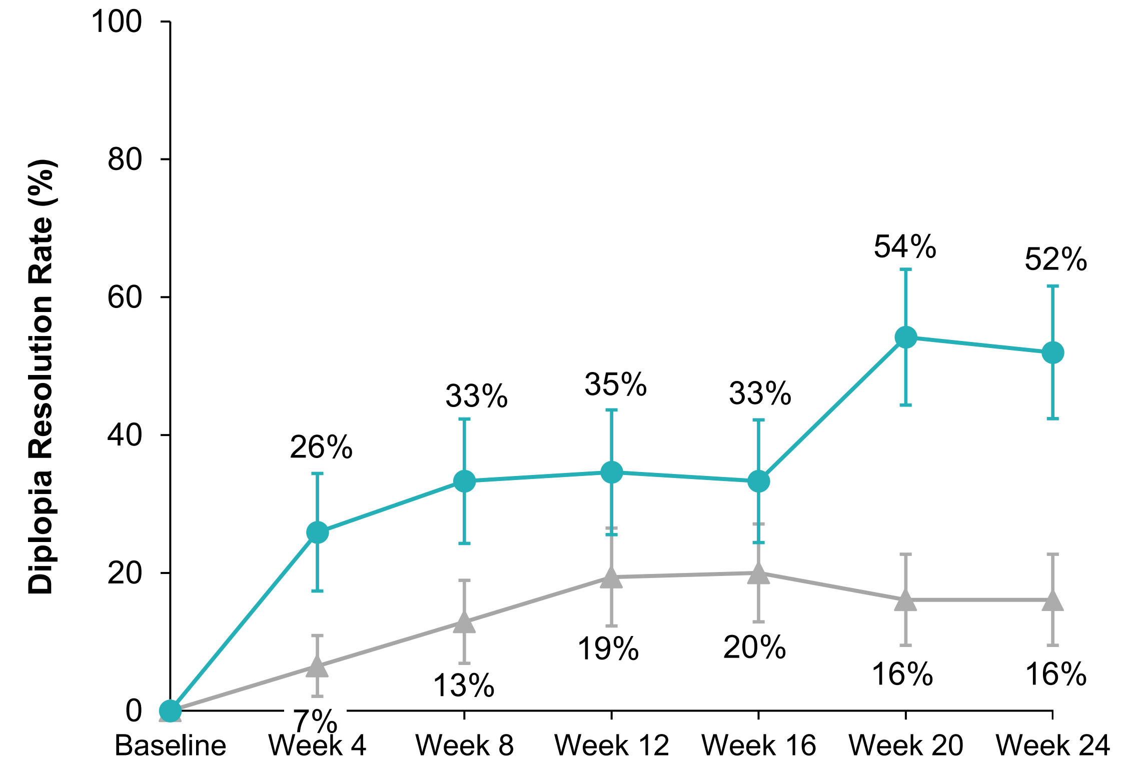
Diplopia responder rate and complete resolution for patients receiving elegrobart Q4W improved throughout treatment period





Note: diplopia time course data not shown for Q8W treatment arm given week 24 endpoints did not meet nominal significance threshold

Source: Viridian REVEAL-1 week 24 topline data on file (interim topline database lock).
Diplopia responder rate and diplopia complete resolution at time points prior to week 24 were prespecified exploratory endpoints.
Q4W = every 4 weeks, Q8W = every 8 weeks.

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Elegrobart was generally well tolerated through week 24

	Elegrobart Q4W N=44 *n* (%)	Elegrobart Q8W N=44 *n* (%)	Placebo N=44 *n* (%)
Participants with any treatment-emergent adverse event (TEAE)	40 (91%)	31 (70%)	24 (55%)
Participants with any serious AE (SAE)	2 (5%)[1]	2 (5%)[2]	0
Participants with any **treatment-related** TEAE	32 (73%)	22 (50%)	12 (27%)
Participants with any **treatment-related** SAE	1 (2%)[1]	0	0

- **Vast majority of TEAEs in both treatment arms were mild**
- **Only 2 treatment discontinuations due to TEAEs**
  - 1 in placebo arm (related TEAE)[3]
  - 1 in elegrobart Q4W arm (unrelated TEAE)[4]

Source: Viridian REVEAL-1 week 24 topline data on file (interim topline database lock).
[1] 2 participants with 3 Gr3 SAEs: dehydration due to norovirus (unrelated), headache with left-ear tinnitus (related); [2] 2 participants with 4 Gr3 SAEs: three abscesses (unrelated), pulmonary embolism (unrelated); [3] Related TEAE discontinuation in placebo arm was due to Gr3 swollen tongue, Gr2 chest pain, & Gr2 IRR; [4] Unrelated TEAE discontinuation in Q4W arm was due to Gr1 amylase increase & Gr1 lipase increase.
AE = adverse event, MedDRA= medical dictionary for regulatory activities, SAE = serious adverse event, TEAE = treatment-emergent adverse event, Gr = grade, IRR = infusion related reaction.

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AE categories for elegrobart in REVEAL-1 were consistent with those generally expected from the anti-IGF-1R class

AEs occurring at ≥10% frequency in any arm	**Elegrobart Q4W** N=44 *n* (%)	**Elegrobart Q8W** N=44 *n* (%)	**Placebo** N=44 *n* (%)
Muscle spasms	18 (41%)	16 (36%)	3 (7%)
Injection site reactions (ISR)[1,2]	15 (34%)	9 (21%)	7 (16%)
Headache	7 (16%)	3 (7%)	3 (7%)
Ear discomfort	7 (16%)	3 (7%)	1 (2%)
Alopecia	7 (16%)	3 (7%)	1 (2%)
Diarrhea	6 (14%)	4 (9%)	2 (5%)
Hearing impairment[1,3]	6 (14%)	2 (5%)	1 (2%)
Hyperglycemia[1]	5 (11%)	5 (11%)	1 (2%)
Injection related reactions (IRR)[1]	5 (11%)	2 (5%)	2 (5%)
Menstrual disorders[1,4]	5 / 17 (29%)	6 / 23 (26%)	1 / 20 (5%)

Source: Viridian REVEAL-1 week 24 topline data on file (interim topline database lock).
[1] Includes multiple terms aggregated using standard sets of MedDRA terms; [2] All ISRs were Grade 1 except for one Grade 2 in Q8W arm (erythema), and majority of ISRs were erythema; [3] All hearing impairment events in the treatment arms were tinnitus with no reductions in hearing. There was one hypoacusis event in placebo arm; [4] Reported as percentage of menstruating women.
AE = adverse event, MedDRA = medical dictionary for regulatory activities.

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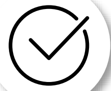
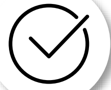
REVEAL-1 in active TED patients met primary endpoint and elegrobart was generally well tolerated

(Active TED)

Achieved **the primary endpoint** with high statistical significance **(p < 0.0001);** 54% of Q4W patients achieved a proptosis response versus 18% placebo at week 24



Achieved **clinically meaningful outcomes** on multiple **secondary endpoints: 63% PRR in the Q8W arm** versus 18% placebo, **51% diplopia complete resolution** in the Q4W arm versus 16% placebo, all at week 24



Rapid onset of treatment effect in as few as 4 weeks

Generally well tolerated in both dose groups, with **low rate of hearing impairment AEs** through week 24

Elegrobart has the potential to be the **first subcutaneous autoinjector in TED** that allows patients to self-administer at home, with potentially **as few as 3 doses**

Source: Viridian REVEAL-1 week 24 topline data on file (interim topline database lock).
AE = adverse event, IGF-1R = insulin-like growth factor-1 receptor, PRR = proptosis responder rate, Q4W = every 4 weeks, Q8W = every 8 weeks, TED = thyroid eye disease.

REVEAL-2 in chronic TED, the second pivotal phase 3 study for elegrobart, is on track for topline data readout in Q2 2026

CHRONIC TED

Key Inclusion Criteria

- Proptosis of ≥3 mm
- Any CAS (0–7)
- Onset of TED symptoms >15 months

Trial Design

- N = 195 (actual enrollment: 204 patients)
- 24-week primary endpoint, 52-week total follow-up
- Double-masked, parallel-group, placebo-controlled

Patients without response at 24 weeks may receive open-label elegrobart

CAS = clinical activity score, mm = millimeter, TED = thyroid eye disease.

Veligrotug: Approaching full launch-readiness in preparation for June 30 PDUFA target action date under Priority Review

Veligrotug is well positioned to become the IV treatment-of-choice for TED patients[1,2]

Diplopia Resolution & Response: Significant impact on diplopia in chronic TED

Rapid Onset: Significant proptosis response demonstrated in as few as 3 weeks

Generally Well Tolerated: Low rate of hearing impairment AEs

Reduced Treatment Burden: ~70% shorter infusion time and shorter course of therapy[3]

Veligrotug received Breakthrough Therapy Designation (BTD) and Priority Review from FDA

Launch preparations well underway with experienced team in place

Medical Affairs

Full team engaging in scientific exchange

Field Sales

Wave one hires in market engaging with HCPs

Patient Services

Actively engaging offices and infusion centers in introductory conversations

Market Access

Payer engagements ongoing with positive feedback on veli value

Viridian go-to-market approach is grounded in comprehensive understand of the TED market

Veligrotug and elegrobart are investigational products that have not been approved by any regulatory authority; the safety and efficacy have not been established.

Sources: [1] Viridian THRIVE data on file, [2] Viridian THRIVE-2 data on file, [3] Compared with current available anti-IGF-1R treatment option.
AE = adverse event, BLA = Biologic License Application, FDA = U.S. Food and Drug Administration, HCP = Health Care Professional, IV = intravenous, TED = thyroid eye disease.

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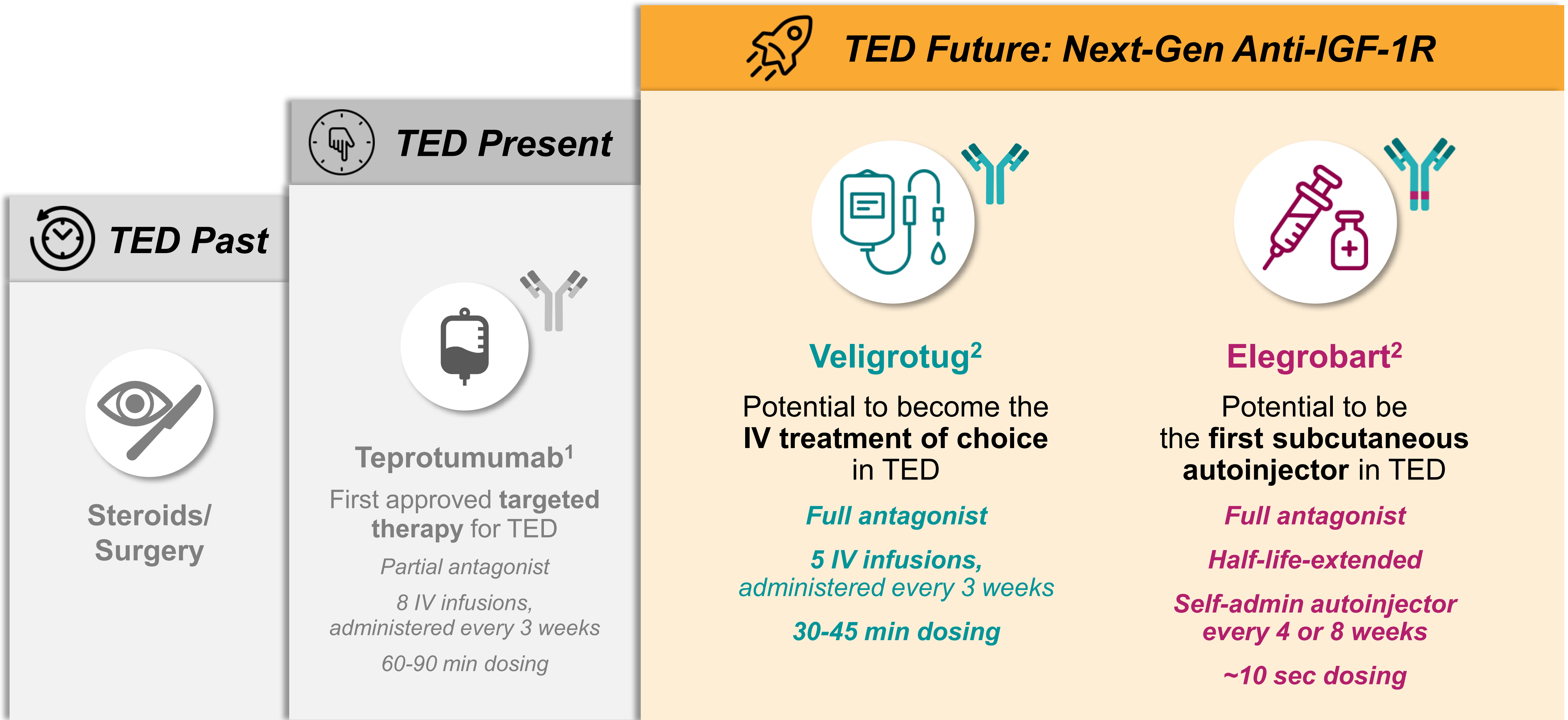
Viridian has the potential to provide multiple differentiated treatment solutions for TED patients in one portfolio



Veligrotug and elegrobart are investigational products that have not been approved by any regulatory authority. The safety and efficacy have not been established.

[1] Teprotumumab Prescribing Information, [2] Planned product profile, including planned clinical dosing regimen. Veligrotug and elegrobart are investigational products that have not been approved by any regulatory authority. The safety and efficacy have not been established. IGF-1R = insulin-like growth factor-1 receptor, IV = intravenous, TED = thyroid eye disease.

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Thank you to the TED community: patients, advocates, investigators, research staff, and partners who made this trial a success