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STOP NEUROINFLAMMATION. START LIVING.

Unlocking a new era of care for neuroinflammatory diseases.

Investor Call

November 3, 2026
Nasdaq: ANNX



Forward-Looking Statements

This presentation contains “forward-looking” statements about Annexon, Inc. and our industry that involve substantial risks and uncertainties. All statements other than statements of historical facts, including statements regarding our clinical and preclinical programs, timing and commencement of future nonclinical studies and clinical trials and research and development programs, timing of clinical results, anticipated timing of submission of a Biologics Licensing Application, strategic plans for our business and product candidates, including additional indications which we may pursue, our financial position, runway and anticipated milestones, 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,” “focus,” “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.

Forward-looking statements are not guarantees of future performance and are subject to risks and uncertainties that could cause actual results and events to differ materially from those anticipated, including, but not limited to, risks and uncertainties related to: our history of net operating losses; our ability to obtain necessary capital to fund our clinical programs; the early stages of clinical development of our product candidates; the effects of COVID-19 or other public health crises on our clinical programs and business operations; our ability to obtain regulatory approval of and successfully commercialize our product candidates; any undesirable side effects or other properties of our product candidates; our reliance on third-party suppliers and manufacturers; the outcomes of any future collaboration agreements; and our ability to adequately maintain intellectual property rights for our product candidates. These and other risks are described in greater detail under the section titled “Risk Factors” contained in our Annual Report on Form 10-K filed with the Securities Exchange Commission (SEC) on August 12, 2026 and our other filings with the SEC from time to time. All forward-looking statements in this presentation speak only as of the date of this presentation. Except as required by law, we undertake no obligation to publicly update any forward-looking statements, whether as a result of new information, future events or otherwise .

This presentation concerns drug candidates that are under clinical investigation, and which have not yet been approved for marketing by the U.S. Food and Drug Administration (FDA). These are currently limited by federal law to investigational use, and no representation is made as to their safety or effectiveness for the purposes for which they are being investigated.

This presentation also contains estimates and other statistical data made by independent parties and by us relating to market size and growth and other data about our industry. This data involves a number of assumptions and limitations, and you are cautioned not to give undue weight to such estimates or statistical data. Neither we nor any other person makes any representation as to the accuracy or completeness of such data or undertakes any obligation to update such data after the date of this presentation.

Introduction



Doug Love
President & CEO



Roger Goldberg, MD, MBA
Retina and Vitreous Diseases · Bay Area Retina Associates



W Lloyd Clark, MD
SVP of Ophthalmology



Ted Yednock, PhD
Chief Innovation Officer

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Agenda

TIME (ET)	TOPIC	PRESENTER
11:00-11:05am	**Introduction & Overview**	**Douglas Love, Esq** President & CEO
11:05-11:15am	**Clinical Insights in Dry AMD with Geographic Atrophy**	**Roger Goldberg, MD** Retina and Vitreous Diseases · Bay Area Retina Associates
11:15-11:35am	**Vonaprument Vision Protection in P2 Trial and P3 Clinical Program**	**Lloyd Clark, MD** SVP, Ophthalmology Strategy & Innovation
11:35-11:45am	**Summary & Takeaways**	**Douglas Love, Esq** President & CEO
11:45am-12:15pm	**Q&A**	**Presenters and Ted Yednock, PhD** Chief Innovation Officer

OUR FOCUS:

Protecting function for patients with devastating neuroinflammatory diseases

The future of medicine isn't simply extending life. It's ...

Protecting the ability to live life.

Annexon is pioneering a new class of targeted therapies designed to stop inflammation at its source in the body, brain, and eye before damage becomes irreversible.

Potential Groundbreaking Lead Therapies for Patients in Large Underserved Global Markets



Tanruprubart for GBS

First potential targeted rapid-acting therapy

- Comprehensive EU MAA filed
- Positive FORWARD study data to support planned US BLA



Vonaprument for GA

First potential vision-preserving treatment

- 1st significant vision-sparing data in Phase 2 evaluating vision
- 1st Phase 3 trial evaluating vision - Mo 15 primary outcome Q4 2026

Pipeline expansion opportunities including 1st oral inhibitor of classical complement in the clinic (ANX1502), and 1st demonstration of inhibition of C1q inflammation in CNS for an array of diseases (e.g., HD, TBI)

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Takeaways for Today

ARCHER II

Highlighting Key Aspects of ARCHER II Phase 3 Trial

1. What vision protection means to patients and physicians
2. Designed to replicate vision protection in targeted patient population
3. Larger, longer, well-powered pivotal trial with multiple ways to win
4. On track for 15-month primary analysis in Q4 2026

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Vision is what Matters to Patients and Physicians in GA



Roger Goldberg, MD, MBA

Geographic Atrophy Remains a Significant Unmet Need

No approved treatments demonstrating vision preservation

GA IS A LEADING CAUSE OF BLINDNESS IN THE ELDERLY

GA severely limits independence and greatly impacts quality of life

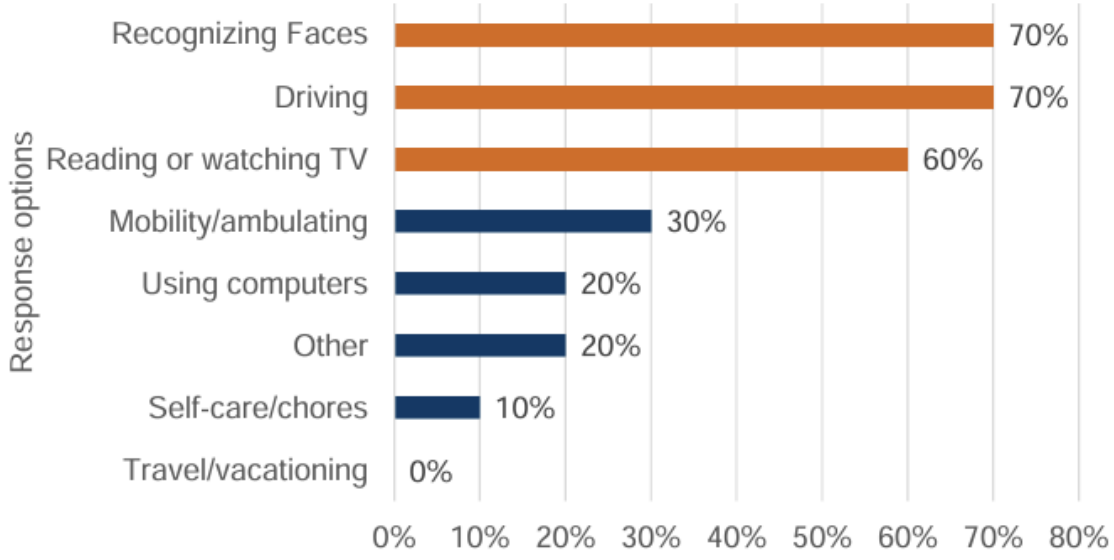
- Avg. Age of GA Patient: **79 years**
- Incidence projected to increase due to aging population



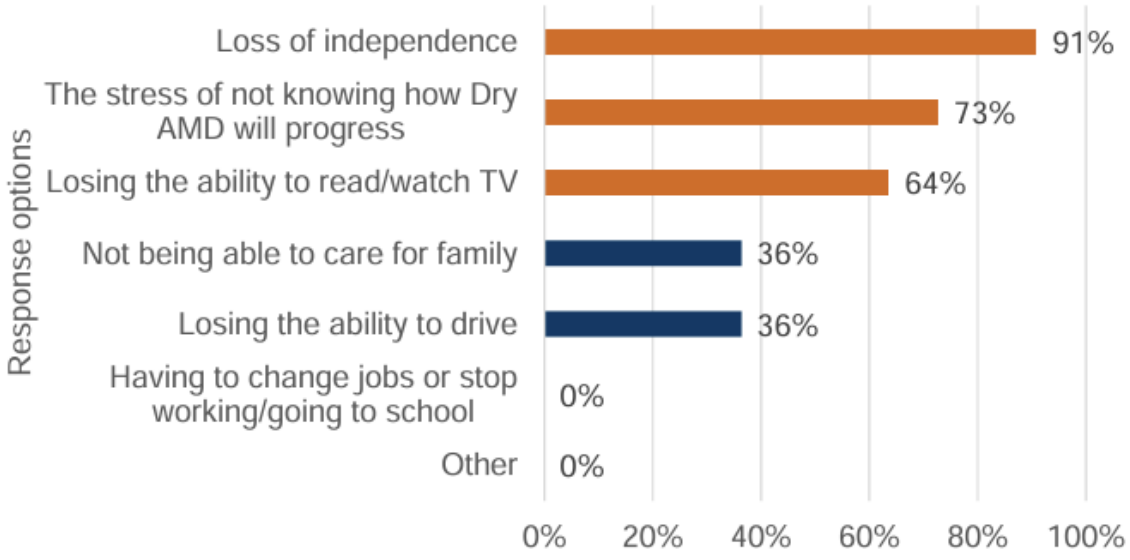
Vision Loss from GA Meaningfully Impacts Patients' Daily Lives

Recent survey results in patients with GA and their caregivers

ACTIVITIES GA PATIENTS ARE NOT ABLE TO DO, OR STRUGGLE WITH



WHAT WORRIES GA PATIENTS MOST ABOUT THEIR CONDITION IN THE FUTURE

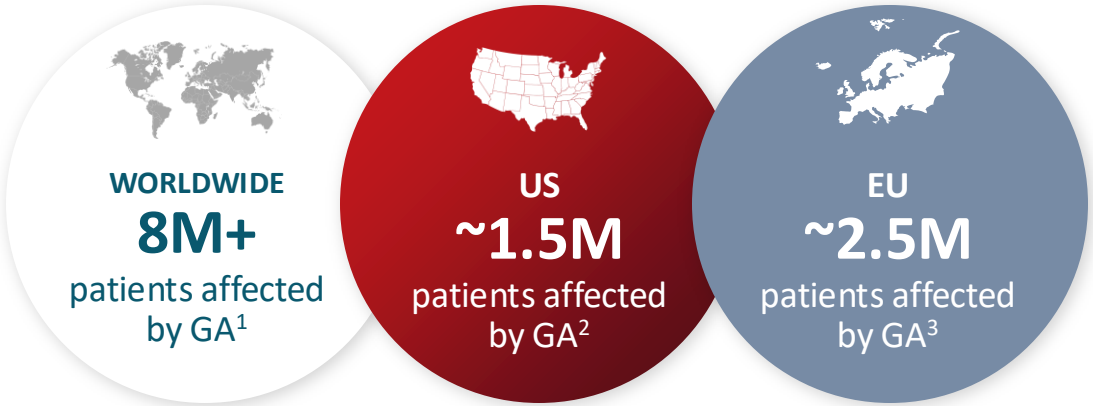


From the Voice of the Patient Report; Dry Age-Related Macular Degeneration (AMD) Externally-Led Patient Focused Drug Development Meeting (EL-PFDD) Meeting; Report date: May 17, 2024

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GA is a Significant and Rapidly Growing Unmet Need Worldwide

GA WORLDWIDE PREVALENCE IMPACTS MILLIONS



1 in 100

Americans over age 50 have Advanced AMD

INCIDENCE PROJECTED TO INCREASE WITH AGING POPULATION

[1]Keenan et al, Ophthalmology. 2018 Jul 27;125(12):1913–1928; [2]Tufail A, et al. Presented at the 15th EURETINA Congress, Nice, France, September 17-20, 2015. Accessed November 21, 2019; [3]Based on Colijin JM, *et al.*, 2016; Wong WL, *et al.*, 2014; Rudnicka AR, *et al.*, 2014; Korb CA, *et al.*, 2014; Piermarocchi S, *et al.*, 2011; Fernandez-Arias C, *et al.*, 2011; Augood CA, *et al.*, 2006; [4]Rudnicka AR et al., Ophthalmology. 2012;119(3):571-80. doi:10.1016/j.ophtha.2011.09.027

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ARCHER II Phase 3 Endpoint – BCVA 15 Letter Loss – is the Gold Standard Visual Acuity Endpoint in Retina Space

PRODUCT	FUNCTIONAL PRIMARY ENDPOINT
Wet AMD	
Lucentis	Proportion losing <15 letters BCVA
Eylea	Mean BCVA change
Vabysmo	Mean BCVA change
DME	
Lucentis	BCVA ≥15 letter
Eylea	Mean BCVA change
Vabysmo	Mean BCVA change
GA	
Syfovre	N/A
Izervay	N/A

BCVA 15 Letter Loss

- Represents 3 lines of letter loss
  - Loss of independence (e.g., inability to read, drive)
  - Impact on independent living

Clinically relevant, stable endpoint when confirmed at two consecutive visits

Vonaprument Represents Potential Paradigm Shift for GA Patients

Vision protection is what matters to patients, physicians and payers.

CURRENT PARADIGM

Lesion Growth Slowing Medicines

(no vision protection)

SYFOVRE (pegcetacoplan injection)

izervay (avacincaptad pegol intravitreal solution)

→

<10%

of US patients being treated today[1]

1 Derived from current publicly stated data that 10-15-% of US patients already diagnosed with GA have received treatment. But only about half (800,000 of 1.5m) of patients who are thought to have GA are actually diagnosed. Using 1.5m as a denominator, less than 10% have received treatment.

Vonaprument

Establishing a new standard of care

Enhanced benefit-risk enables full activation of global market opportunity

HIGHLY DIFFERENTIATED PRODUCT PROFILE

25 microliter dose Fab antibody

Non-pegylated, low viscosity

Well-tolerated

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Unprecedented ARCHER Phase 2 Visual Acuity Outcomes

Lloyd Clark, MD



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Vonaprument Overview
Only GA Program to Demonstrate Significant Vision Protection



Mechanistic Rationale for Functional Protection



Protected Key Retinal Structure Required For Central Vision



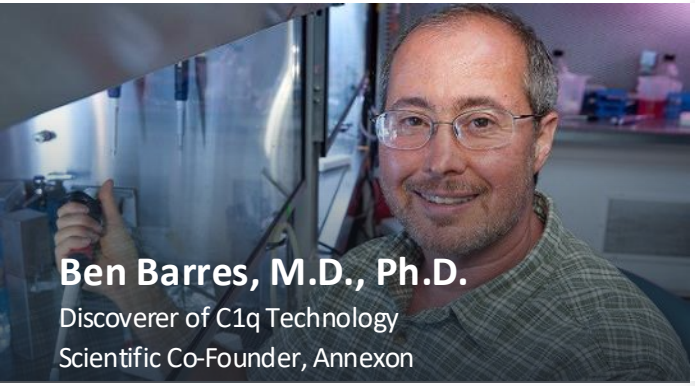
Protected BCVA Gold Standard Ophthalmology Outcome

Anti-C1q stops inflammation & damage on vision-required photoreceptors

Preserved functional photoreceptors followed by RPEs

Dose dependent protection across multiple measures

Anti-C1q is a Well-Researched & Differentiated Approach to Treating Neurodegeneration (protect synaptic / neuronal function)



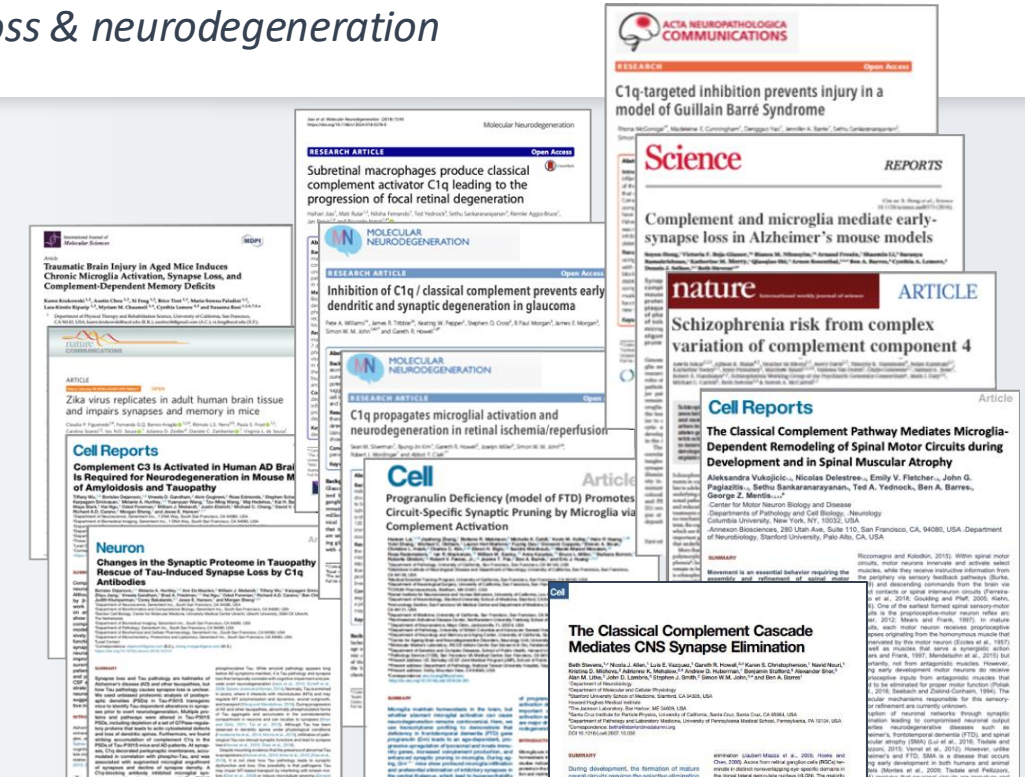
Ben Barres, M.D., Ph.D.
Discoverer of C1q Technology
Scientific Co-Founder, Annexon

C1q PLAYS KEY ROLE in NEURODEGENERATION PROCESS

- *Normal role for synapse elimination in development*
- *Pathogenic role in neurodegenerative diseases*
- *Anti-C1q protects against synapse loss & neurodegeneration*

Anti-C1q Protective in Neurodegenerative Diseases, Including:

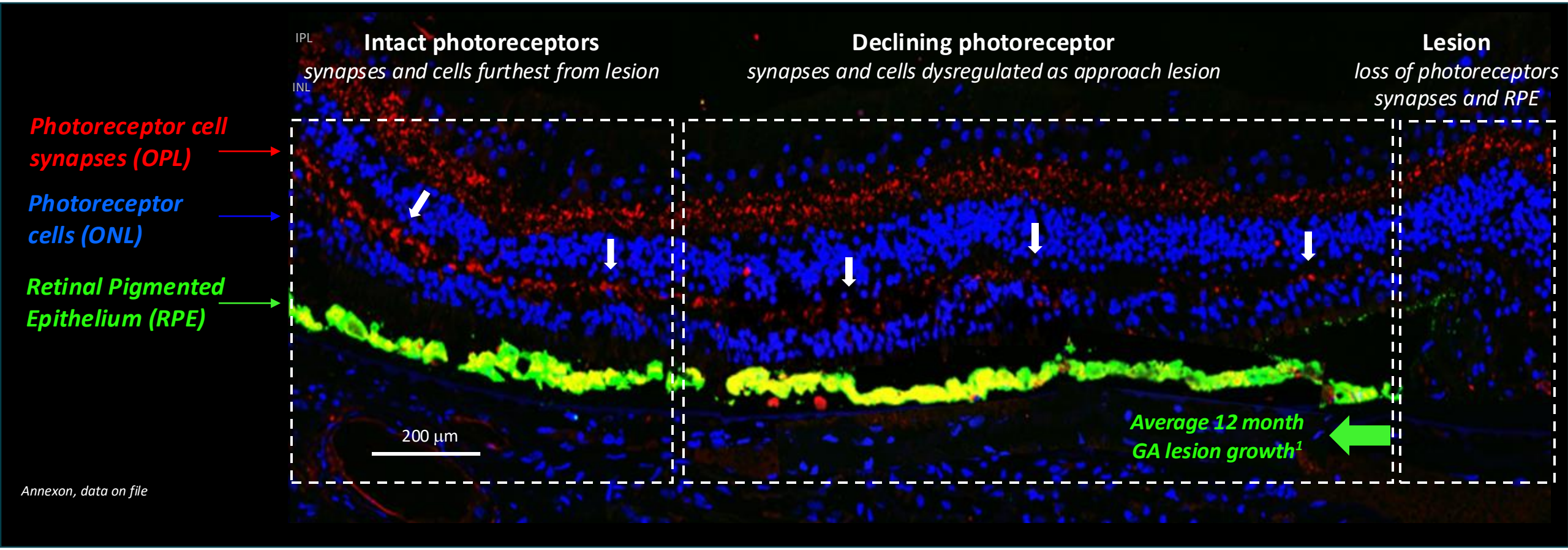
- Dry AMD (photoreceptor damage)
- Glaucoma
- Retinal ischemia
- Multiple Sclerosis/ Optic Neuritis
- Huntington's disease
- Guillain-Barré syndrome
- Alzheimer's disease
- Traumatic brain injury



[1]Stevens, et al., 2007 DOI 10.1016/j.cell.2007.10.036; Schafer et al., 2012 DOI 10.1016/j.neuron.2012.03.026; Hong, et al., 2016 doi: 10.1126/science.aad8373; Lui et al., 2016 doi.org/10.1016/j.cell.2016.04.001; [2]Davies et al., 1987 *J Neurological Sci* **78**:151; Terry, et al., 1991 *Ann Neurol* **30**:572; [3]Yoshiyama et al., 2007 DOI 10.1016/j.neuron.2007.01.010

In GA Photoreceptors and Synapses are Lost Before RPE Loss

Photoreceptors responsible for visual acuity. Photoreceptor loss = vision loss



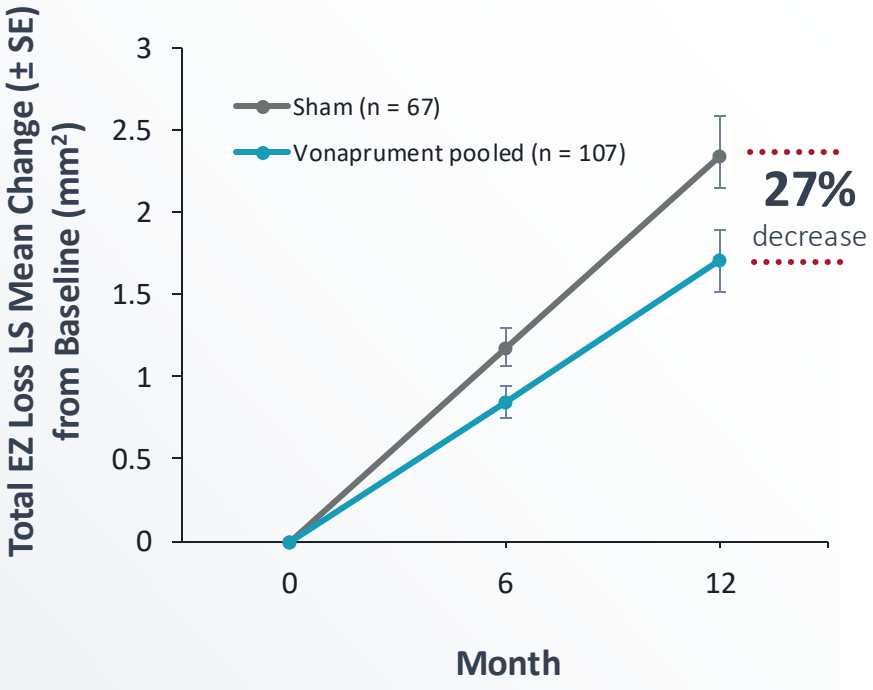
Photoreceptor Health	Functional retina	Reduced function	Lost function

[1]Selkoe, 2002 doi: 10.1126/science.1074069; Burger, et al., doi.org/10.1016/j.ydbio.2021.04.001; [2]Bird et al., 2014 *JAMA Ophthalmol* doi:10.1001/jamaophthalmol.2013.5799; Li, et al., 2018 *Retina* 38:1937; Pfau, et al., 2020 10.1001/jamaophthalmol.2020.2914; Sarks, et al., 1988 *Eye* 2:552; [3]Heier, et al., 2020 Ophthalmology Retina **4**:673; [4]Shen, et al., 2020 *Ophthalmol Retina* **4**:899

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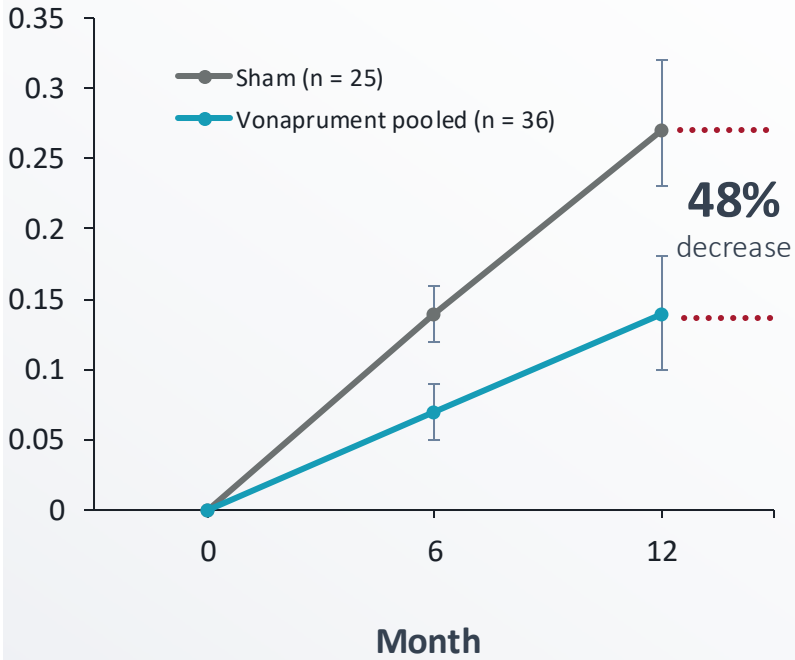
ARCHER Phase 2: Greater Protection Against EZ Loss in Central Retina Necessary for Visual Acuity

PAN-MACULA



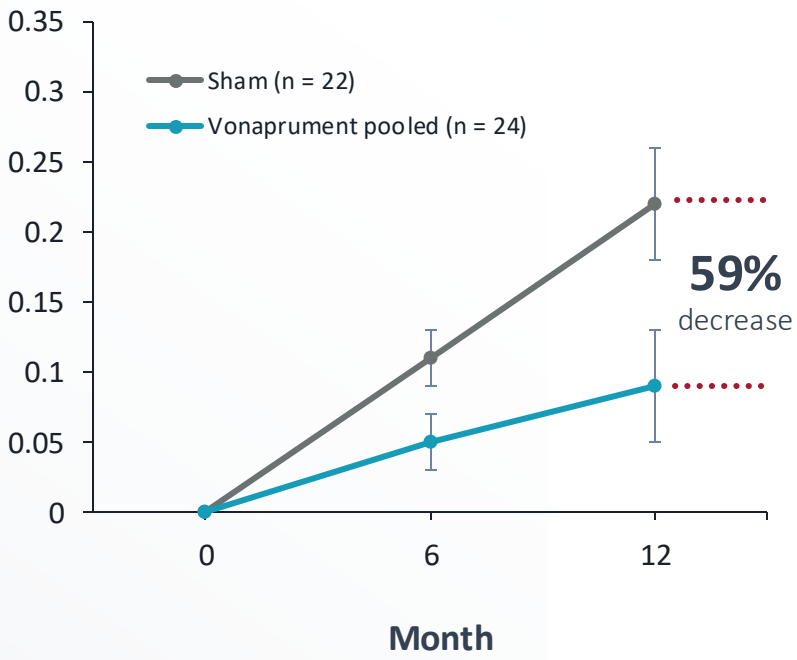
Nominal p-value^ Vonaprument Pooled vs Sham 0.0457

CENTRAL 2.0 MM



Vonaprument Pooled vs Sham 0.0218

CENTRAL 1.5 MM



Vonaprument Pooled vs Sham 0.0319

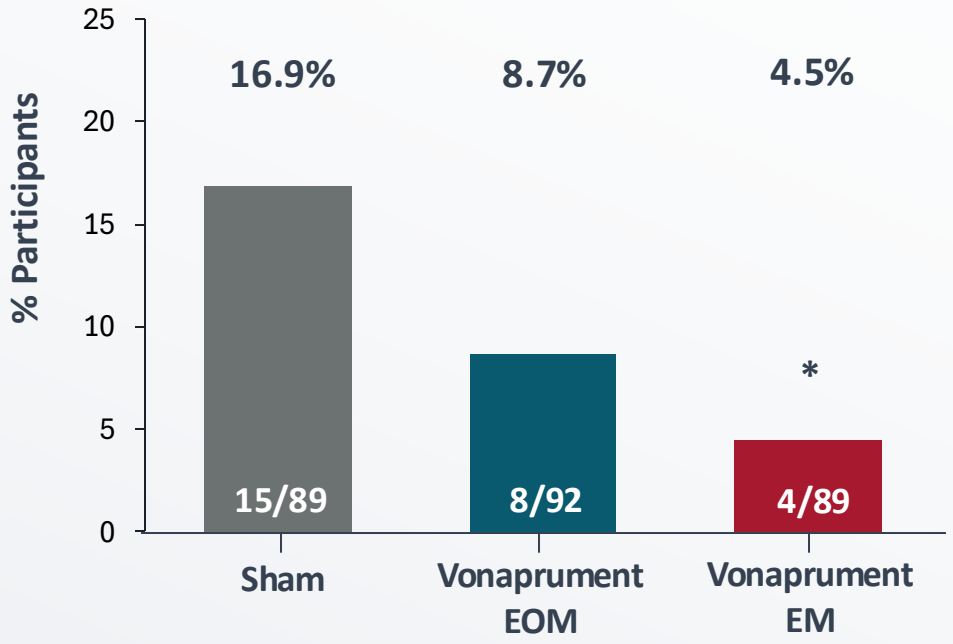
^Nominal p-values from a linear mixed model for repeated measures model (slope) analysis;
Heidelberg Spectralis OCT population with baseline OCT data, excludes patients with >98% atrophy/attenuation at baseline

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ARCHER Phase 2: Dose-Dependent Vision Protection at Month 12 and Over Time

PARTICIPANTS WITH CONFIRMED BCVA ≥15-LETTER LOSS THROUGH MONTH 12#

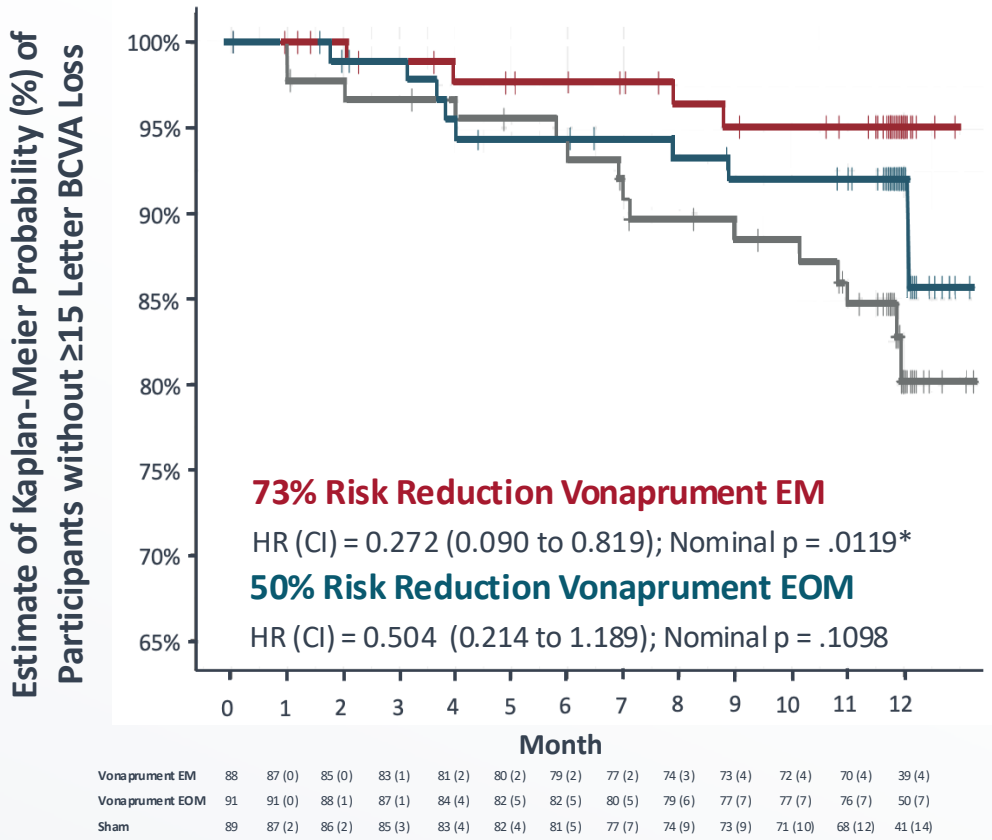
Month 12 event confirmed at month 15



	Sham	Vonaprument EOM	Vonaprument EM
Nominal p-value vs sham^	---	.0994	.0076

#Confirmed BCVA 15-LL at two consecutive visits including month 12 supported by ensuing (off-treatment) visit; visits were monthly through Month 12 and then at Months 15 and 18
^Nominal p-value from a Chi-square test in ITT population: *Nominal p < .05

PROBABILITY OF CONFIRMED BCVA ≥15-LETTER LOSS THROUGH MONTH 12#



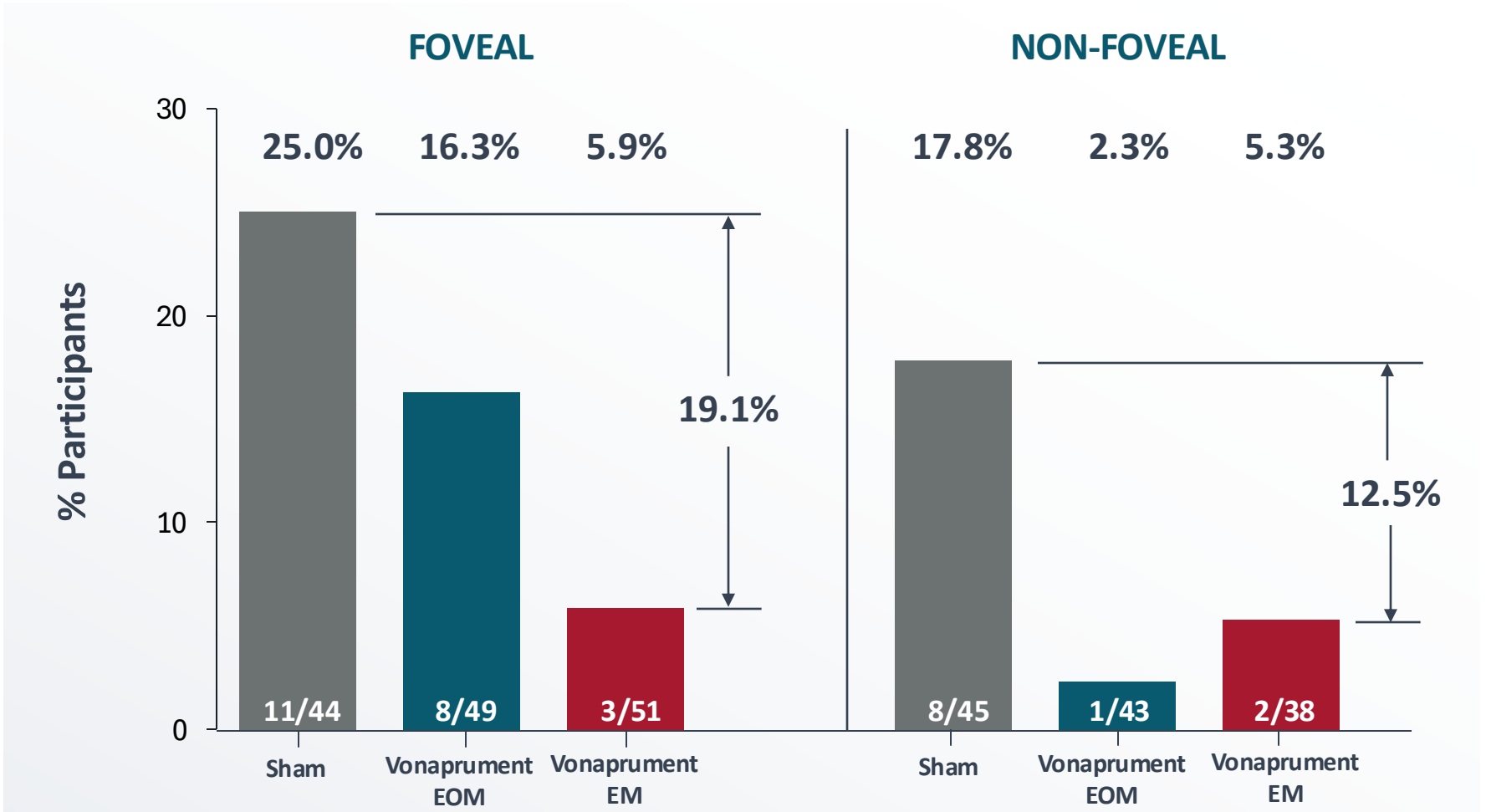
Vonaprument EM	88	87 (0)	85 (0)	83 (1)	81 (2)	80 (2)	79 (2)	77 (2)	74 (3)	73 (4)	72 (4)	70 (4)	39 (4)
Vonaprument EOM	91	91 (0)	88 (1)	87 (1)	84 (4)	82 (5)	82 (5)	80 (5)	79 (6)	77 (7)	77 (7)	76 (7)	50 (7)
Sham	89	87 (2)	86 (2)	85 (3)	83 (4)	82 (4)	81 (5)	77 (7)	74 (9)	73 (9)	71 (10)	68 (12)	41 (14)

#Confirmed BCVA 15-LL at two consecutive visits including month 12 supported by ensuing (off-treatment) visit
HR, hazard ratio; Nominal log-rank test (versus sham) p-values are presented; *Nominal p < 0.05

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ARCHER Phase 2: Demonstrated Dose-Dependent Vision Protection in Participants with Foveal and Non-Foveal Lesions

Vonaprument treatment effect across the disease spectrum



Review of Subgroup based on Structural Characteristics

Participants with confirmed BCVA ≥15-letter loss through month 12#

Nominal summary p-value vs. sham^	
ANX007 EM	0.0019
ANX007 EOM	0.0254

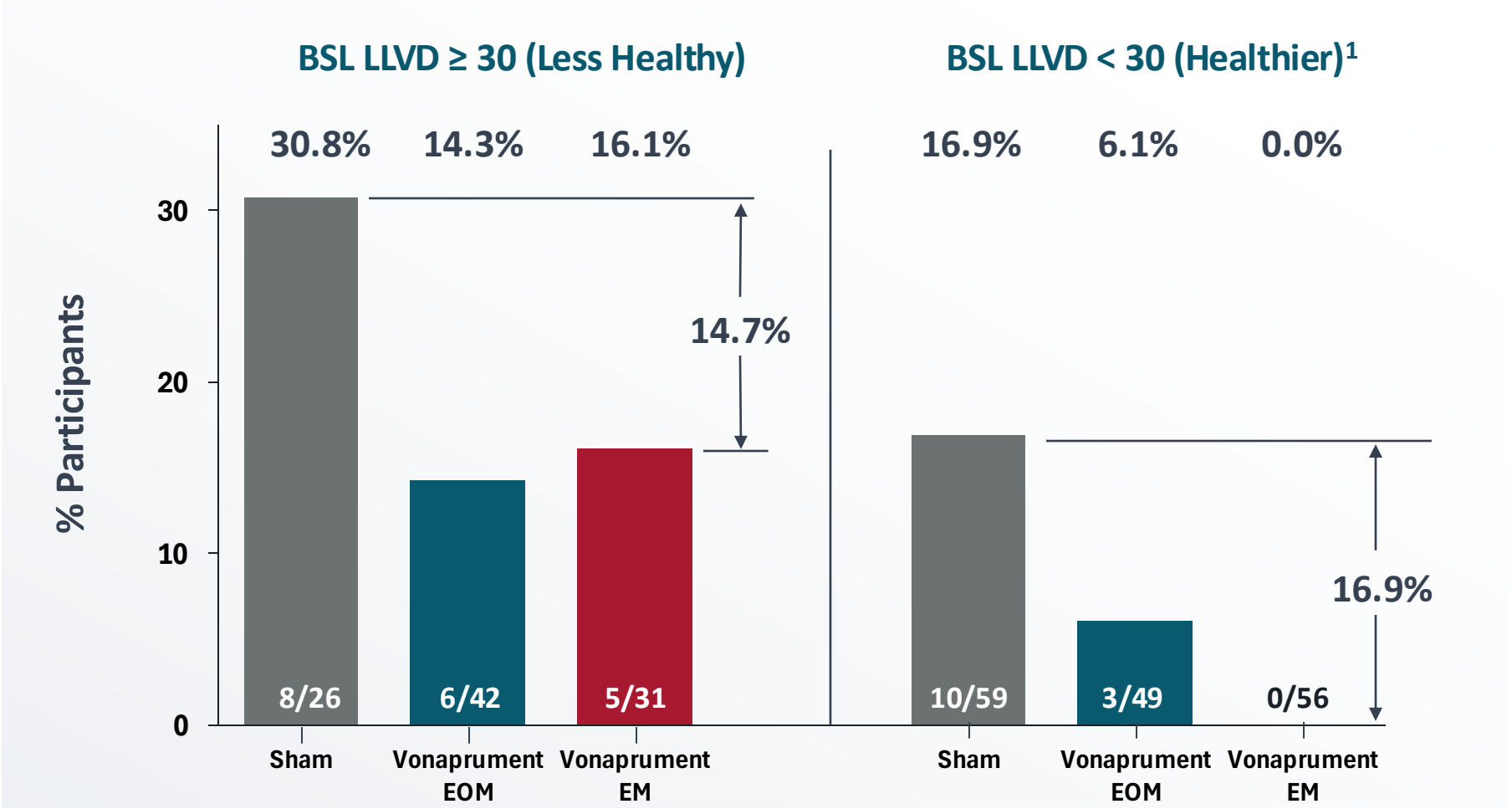
#Confirmed for two consecutive visits at any time through month 12 or at last study visit
^Nominal p-value from a Cochran Mantel-Haenszel test (General Association) in ITT population
Final data

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ARCHER Phase 2: Demonstrated Dose-Dependent Vision Protection in Both Healthier and Less Healthy Eyes

Broad treatment effect across severity of photoreceptor dysfunction



Review of Subgroup based on Visual Acuity Measures

Participants with confirmed BCVA ≥15-letter loss through month 12[#]

Nominal summary p-value vs. sham^	
ANX007 EM	0.0016
ANX007 EOM	0.0183

[1]LLVD <30 at baseline were designated as eyes with less advanced disease, based on mean baseline values in lampalizumab Phase 3 studies. Holz FG, et al. Efficacy and Safety of Lampalizumab for Geographic Atrophy Due to Age-Related Macular Degeneration: Chroma and Spectri Phase 3 Randomized Clinical Trials. JAMA Ophthalmol. 2018;136(6):666–677.

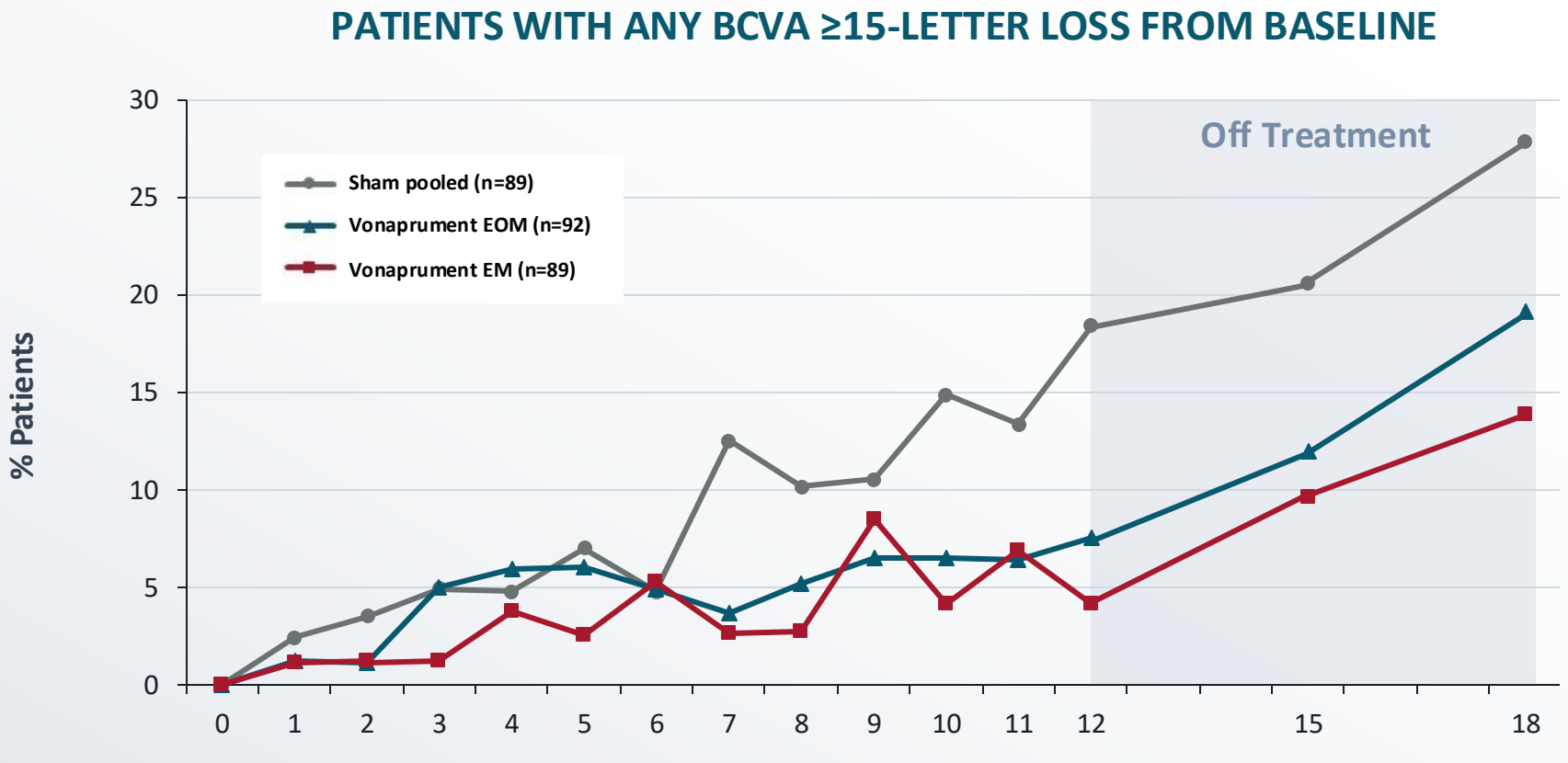
[#]Confirmed for two consecutive visits at any time through month 12 or at last study visit

^Nominal p-value from a Cochran Mantel-Haenszel test (General Association) in ITT population

Final data

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ARCHER Phase 2: Demonstrated Dose-dependent, Disease-modifying Effect of Vonaprument



Demonstration of treatment effect and disease-modifying mechanism of action

Total Subjects

	Month 12	Month 15	Month 18
Sham	76	73	72
EOM	80	75	73
EM	72	73	72

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Strategically Designed ARCHER II Phase 3 Trial

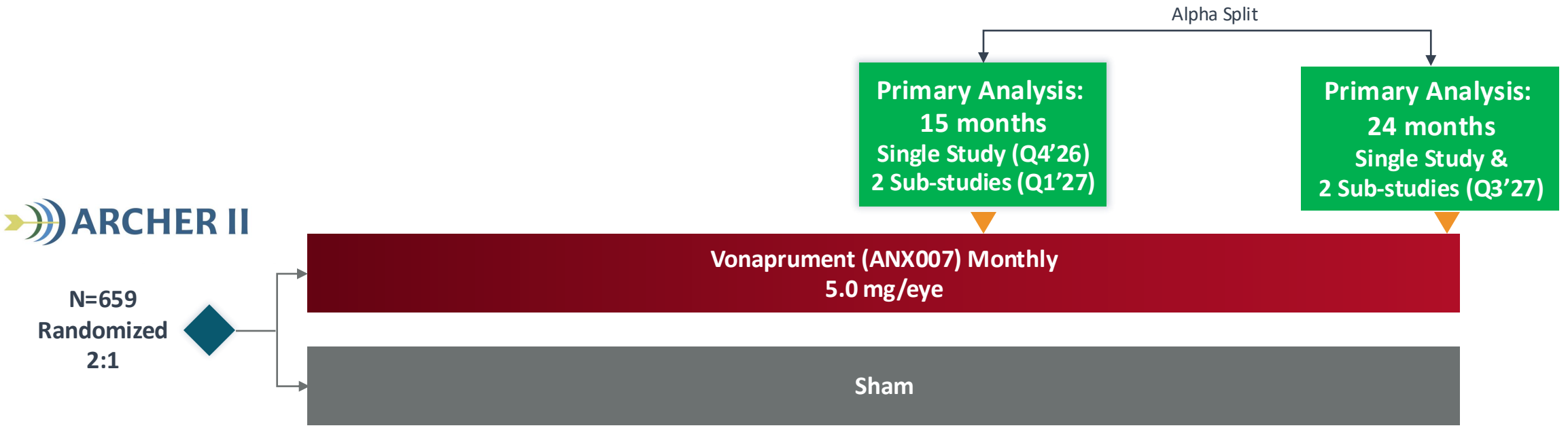


Lloyd Clark, MD

ARCHER II Phase 3: Designed and Executed for Success

KEY ATTRIBUTES	DESIGNED TO INCREASE PROBABILITY OF SUCCESS
Larger, Longer Study	• Over-enrolled (n=659), powered to ≥90% • Higher patient retention increased power to ≥90%
Dual Endpoint Strategy to Show Vision Outcomes	• Powered to show positive treatment effect at Month 15 or Month 24 • Alpha allocated between Month 15 (majority) and Month 24 for efficacy in label
Global Regulatory Strategy	• Two pre-defined, well-powered sub-studies for US filing • PRIME designation and Product Development Coordinator for EU filing
Controlled for Disease Heterogeneity	• Enrolled patients at risk for vision loss but with enough vision to protect • Consistent treatment effect across broad spectrum of disease • Longer timepoints for more vision loss events and widening treatment delta

ARCHER II Phase 3: Designed and Powered to Confirm Vision Protection



Sites: North America, Europe, AUS, NZ

GLOBAL REGISTRATION PATH

EMA Prime and FDA Fast Track designations

Single protocol for EU filing

Single protocol analyzed as 2 sub-studies for US filing (powered at sub-study level)

DUAL PRIMARY ENDPOINTS

Landmark analysis of proportion of patients with confirmed BCVA ≥15-Letter Loss at Month 15 or Month 24

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ARCHER II Baseline Characteristics Well-Positioned to Successfully Replicate Phase 2 Vision Protection Outcomes

BASELINE VISUAL ACUITY MEASURES	ARCHER P2 (N = 270)	ARCHER II P3 (N = 659)
Mean BCVA (SD)	58.4 (16.2)	65.8 (10.5)
Baseline BCVA <45 Letters	23.3%	0.0%*
Mean LLVA (SD)	33.0 (16.9)	38.3 (17.2)
Mean LLVD (SD)	25.7 (16.9)	27.6 (15.6)
LLVD < 30 Letters	62.4%	60.7%

STRUCTURAL CHARACTERISTICS	ARCHER P2	ARCHER II P3
GA Lesion Size (mm^2), mean (SD)	7.36 (4.01)	7.23 (3.49)
GA Lesion Location (% Subfoveal)	51.9%	54.8%
Total EZ Loss, mm^2 (% of Total Area Lost)	12.7 (35.3%)	12.3 (34.3%)

Excluded subjects VA<20/100, no vision loss events

No 15-LL events (0/56) in P2 monthly arm

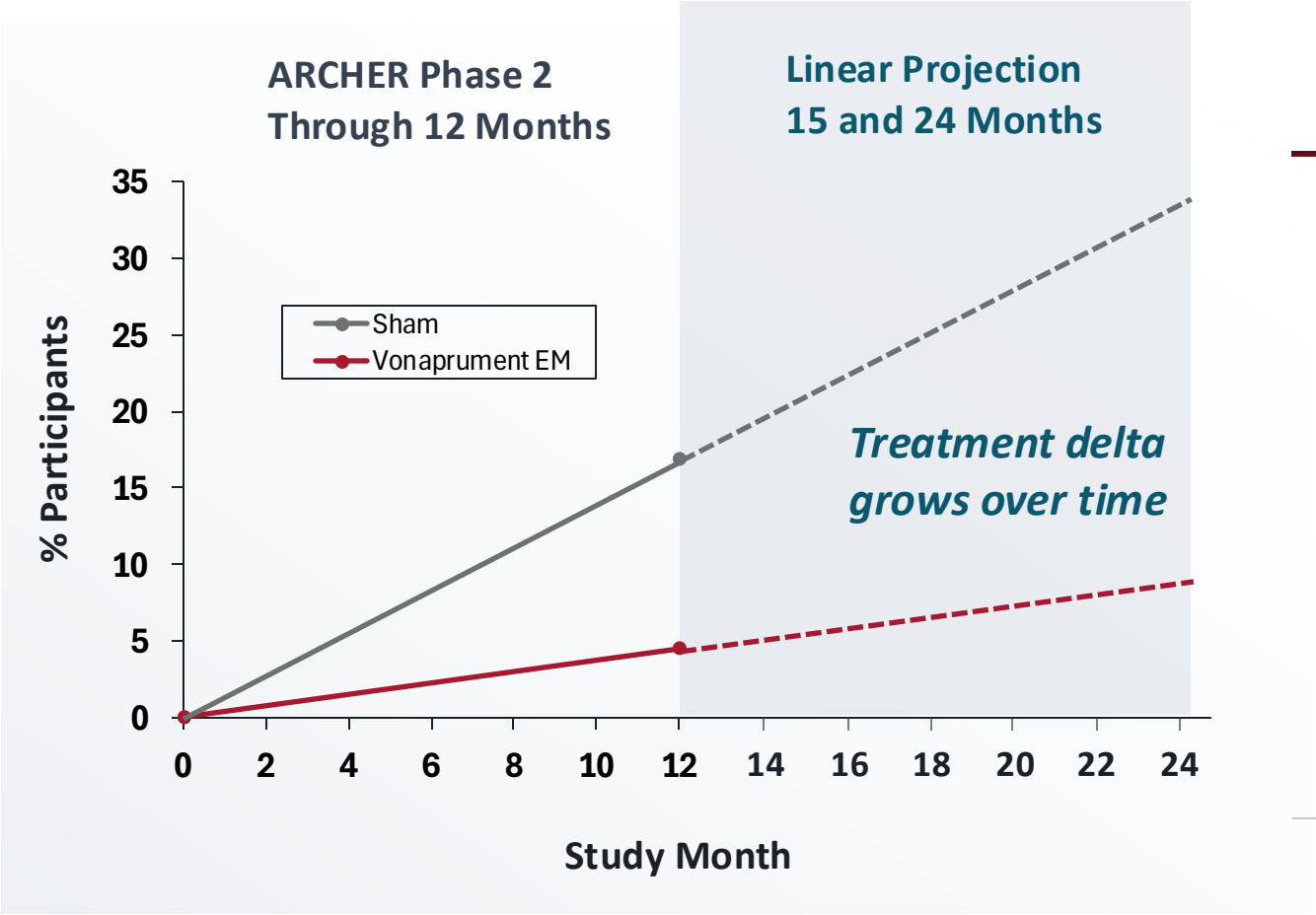
20% treatment delta in P2 ARCHER

*Individuals with baseline BCVA <45 letters not enrolled in ARCHER II due to very low incidence of BCVA 15-letter loss in ARCHER

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Illustration of Event Based Analysis Which Gets Stronger Over Time

Why we like month 15 as our base case and month 24 with growing treatment delta



ARCHER II Key Features for Success

- ✓ **Larger** sample size (N=659; n~330/substudy)
- ✓ Prior GA trials[1] informed masked event rate projections, which have held during study
- ✓ Linear progression of vision loss events in GA
- ✓ **Longer** timepoints to accumulate more sham events
- ✓ Result: Both 15 & 24 month primary endpoints **de-risked with trial design and execution**

[1]Sunness et al (1999) Ophthalmology; Schmitz-Valckenberg (2016) Ophthalmologica; Anegondi at al (2025) Ophthalmology

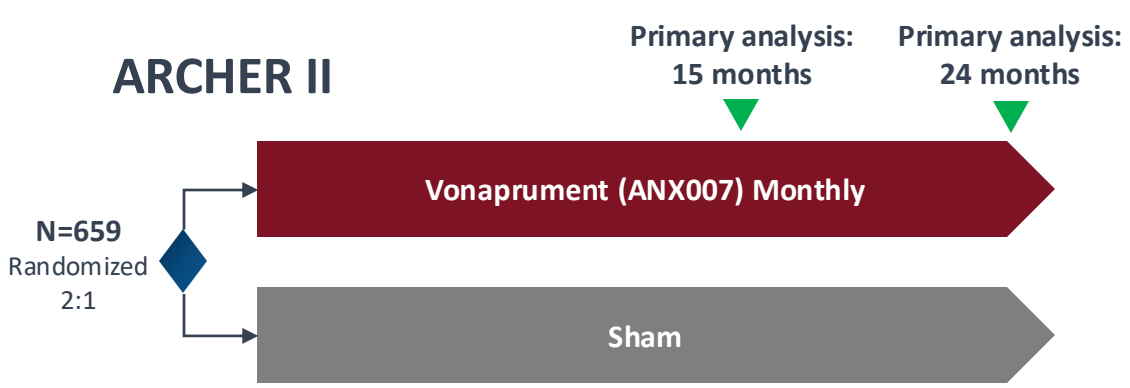
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ARCHER II: One Protocol Supporting Both EMA and FDA Filings

Phase 3 powered at Sub-study level

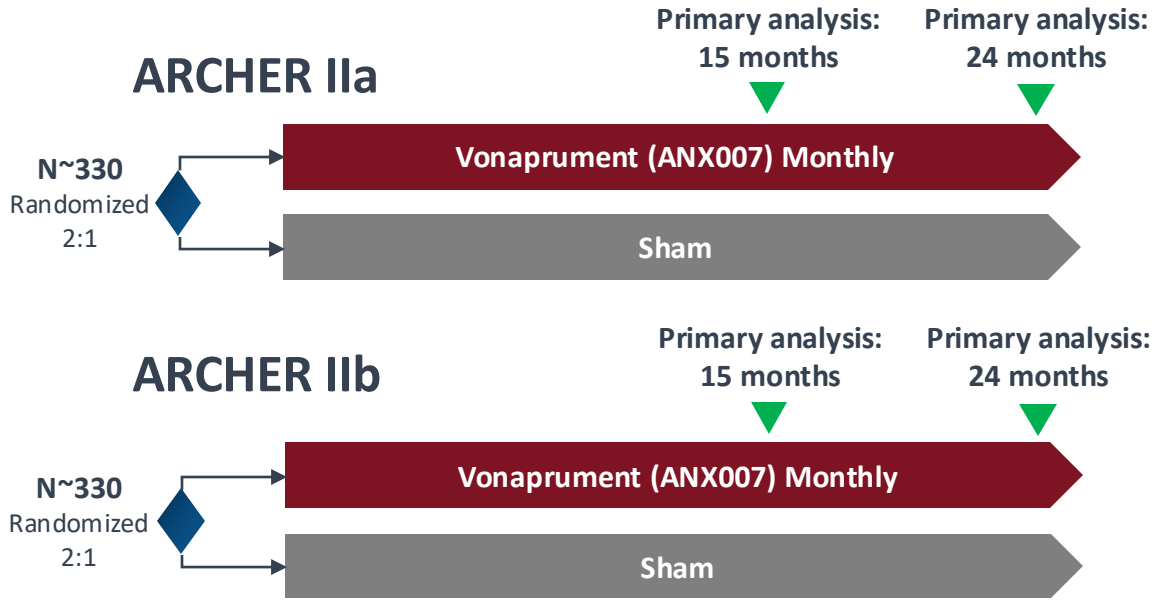
EMA

Single Study



FDA

2 Sub-studies



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ARCHER II Phase 3: Potential Outcomes Scenarios & Expected Timing

	Q4'26	Q1'27	Q3'27
SINGLE STUDY & SUBSTUDIES HIT 15 Mos Primary Analysis	**PR: SINGLE STUDY HITS** Primary Endpoint for EU at 15 mos (no p value)	**PR 1: TWO SUBSTUDIES HIT** Primary Endpoint for US at 15 mos (no p value) **PR 2: TOPLINE 15 MO DATA for Single Study & Substudies**	**PR: TOPLINE 24 MO DATA for Single Study & Substudies**
SINGLE STUDY HITS 15 Mos Primary Analysis **SUBSTUDIES CONTINUE** to 24 Mos	**PR: SINGLE STUDY HITS** Primary Endpoint for EU at 15 mos (no p value)	**PR: TWO SUBSTUDIES CONTINUE** to 24 mos	**PR: TOPLINE 24 MO DATA for Single Study & Substudies**
SINGLE STUDY CONTINUES to 24 Mos	**PR: SINGLE STUDY CONTINUES** to 24 mos		**PR: TOPLINE 24 MO DATA for Single Study & Substudies**

**Futility – assessed by Data Monitoring Committee*

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Summary of Vonaprument Program



Douglas Love, Esq

First in Class Vision Protection as New Standard of Care in GA

WORLDWIDE

8M+

patients affected by GA[1]





EU

~2.5M

patients affected by GA[3]



US

~1.5M

patients affected by GA[2]

Less than

10%

of US patients receive treatment[4]

Lack of clear functional benefit of current GA therapies
Vonaprument poised to capture and drive immense GA market

[1]Keenan et al, Ophthalmology. 2018 Jul 27;125(12):1913–1928; [2]Tufail A, et al. Presented at the 15th EURETINA Congress, Nice, France, September 17-20, 2015. Accessed November 21, 2019; [3]Based on Colijin JM, *et al.*, 2016; Wong WL, *et al.*, 2014; Rudnicka AR, *et al.*, 2014; Korb CA, *et al.*, 2014; Piermarocchi S, *et al.*, 2011; Fernandez-Arias C, *et al.*, 2011; Augood CA, *et al.*, 2006; [4]Rudnicka AR et al., Ophthalmology. 2012;119(3):571-80. doi:10.1016/j.ophtha.2011.09.027 4 Derived from current publicly stated data that 10-15-% of US patients already diagnosed with GA have received treatment. But only about half (800,000 of 1.5m) of patients who are thought to have GA are actually diagnosed. Using 1.5m as a denominator, less than 10% have received treatment.

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Vonaprument GA Program Designed & Executed for Success

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8M+ patients with global unmet need