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Investor webcast: PROPEL 2 data update and ACCEL program initiation

June 4th 2024

Forward-looking statements

This presentation contains forward-looking statements. Statements made or presented may include statements that are not historical facts and are considered forward-looking within the meaning of Section 27A of the Securities Act of 1933, as amended (the Securities Act), and Section 21E of the Securities Exchange Act of 1934, as amended (the Exchange Act), which are usually identified by the use of words such as “anticipates,” “believes,” “estimates,” “expects,” “intends,” “may,” “plans,” “projects,” “seeks,” “should,” “will,” and variations of such words or similar expressions or the negative of these terms. We intend these forward-looking statements to be covered by the safe harbor provisions for forward-looking statements contained in Section 27A of the Securities Act and Section 21E of the Exchange Act. These forward-looking statements, including statements relating to the clinical, therapeutic and market potential of our programs and product candidates, including our clinical development program for infigratinib in achondroplasia, the timing and success of our clinical development programs, the progress of our ongoing and planned clinical trials of infigratinib in achondroplasia and in hypochondroplasia, including enrollment timelines for PROPEL3, our Phase 3 trial for infigratinib in achondroplasia and our ACCEL clinical program in hypochondroplasia, our planned interactions with regulatory authorities, the availability of data from our clinical trials of infigratinib, and the timing of these events, reflect our current views about our plans, intentions, expectations and strategies, which are based on the information currently available to us and on assumptions we have made. Although we believe that our plans, intentions, expectations and strategies as reflected in or suggested by those forward-looking statements are reasonable, we can give no assurance that the plans, intentions, expectations or strategies will be attained or achieved. Furthermore, actual results may differ materially from those described in the forward-looking statements and will be affected by a number of risks, uncertainties and assumptions, including, but not limited to, initial and ongoing data from our clinical trials not being indicative of final data, the design and success of ongoing and planned clinical trials, difficulties with enrollment in our clinical trials, adverse events that may be encountered in our clinical trials, the FDA or other regulatory agencies not agreeing with our regulatory approval strategies, components of our filings, such as clinical trial designs, conduct and methodologies, or the sufficiency of data submitted, potential adverse impacts such as delays in regulatory review, manufacturing and supply chain interruptions, adverse effects on healthcare systems and disruption of the global economy, the impacts of current macroeconomic and geopolitical events, including hostilities in Ukraine, increasing rates of inflation and rising interest rates, on our overall business operations and expectations, as well as those risks set forth in the Risk Factors section of our Annual Report on Form 10-K for the year ended December 31, 2023 and our other filings with the U.S. Securities and Exchange Commission. Moreover, we operate in a very competitive and rapidly changing environment in which new risks emerge from time to time. These forward-looking statements are based upon the current expectations and beliefs of our management as of the date of this presentation and are subject to certain risks and uncertainties that could cause actual results to differ materially from those described in the forward-looking statements. Except as required by applicable law, we assume no obligation to update publicly any forward-looking statements, whether as a result of new information, future events or otherwise. No representation is made as to the safety or effectiveness of the product candidates for the therapeutic use for which such product candidates are being studied. In addition, certain information to be communicated in this presentation involves a number of assumptions and limitations, and there can be no guarantee as to the accuracy or reliability of such assumptions. Such research has not been verified by any independent source. The Company makes no representation or warranty, express or implied, as to the accuracy or completeness of the information communicated in this presentation or as to the existence, substance or materiality of any information omitted from this presentation. The Company disclaims any and all liability for any loss or damage (whether foreseeable or not) suffered or incurred by any person or entity as a result of anything contained or omitted from this presentation and such liability is expressly disclaimed.

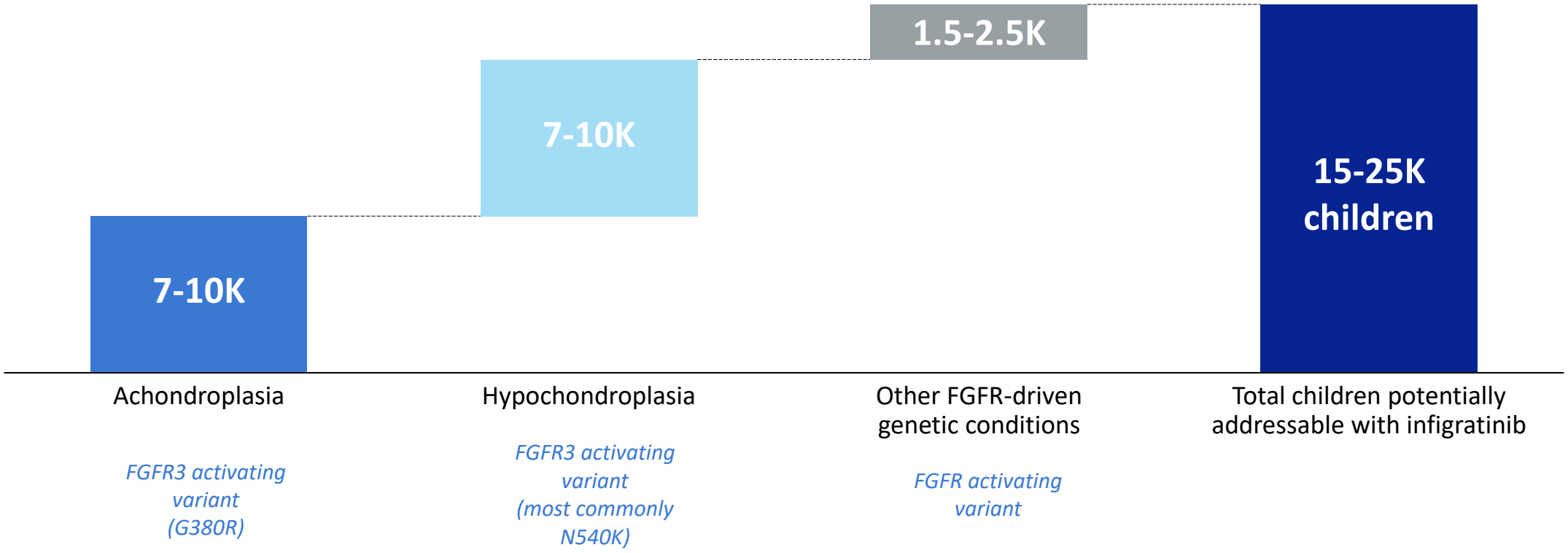
To the children, families, advocates, and physicians who have been a part of this program:

Thank you

Developing new treatment options relies entirely on your guidance, dedication, and effort

Achondroplasia, hypochondroplasia, and related FGFR-driven genetic conditions represent a large unmet medical need

Children eligible for FGFR inhibitor treatment in the US and Europe



BridgeBio is committed to developing a treatment option for children with FGFR-driven conditions

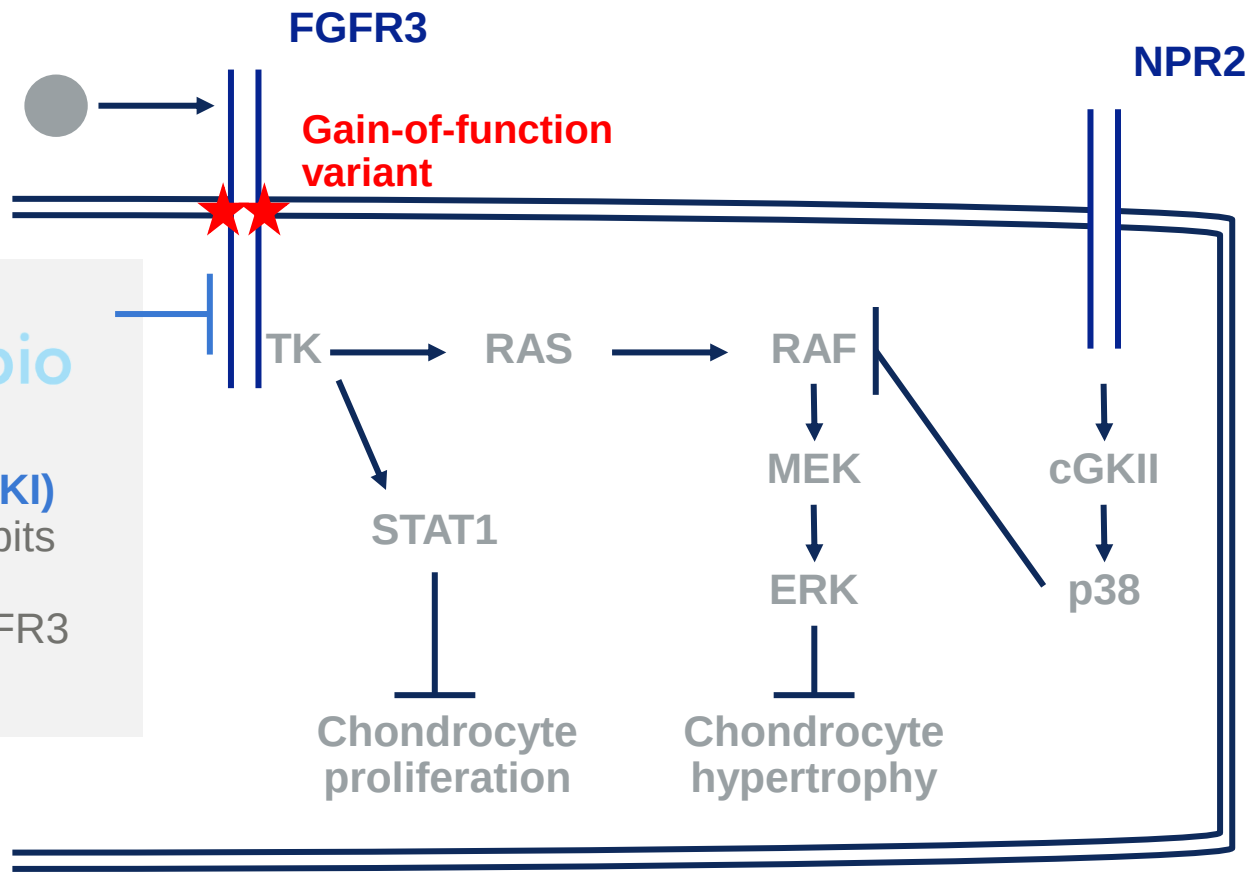
Source: CDC birth estimates; EU Eurostats birth estimates; Foreman et al 2020 Am J Med Genet; Bober et al 2020 Gene Reviews; Wenger et al 2020 Gene Reviews; Al-Namman et al 2019 J Oral Biol Craniofac Res

We are developing infigratinib as a treatment option based on three key principles

Objectives		Design principles
✓ **Maximize efficacy** For all the manifestations of ACH—not just height– which matter for families and physicians	→	**Target the condition directly at the source (FGFR3)**
✓ **Demonstrate safety** Avoiding hypotension & injection site reactions with no hyperphosphatemia, ocular effects or VEGFR3 or JAK2 off-target effects	→	**Use low doses to ensure safety**
✓ **Avoid injections** For children and families, to reduce burden and pain of treatment	→	**Provide an oral treatment option**

Infigratinib is the only treatment option in the clinic that could incorporate all of these features

Infigratinib addresses the first design principle by directly targeting the underlying cause of achondroplasia and hypochondroplasia: FGFR3 overactivity



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Infigratinib (FGFR1-3 TKI)
Directly inhibits the gain-of-function FGFR3 receptor

- Infigratinib targets achondroplasia and hypochondroplasia **directly at the source**: FGFR3 overactivity
- Infigratinib **inhibits both downstream pathways** responsible for the clinical phenotype associated with achondroplasia
- Thus infigratinib's mechanism of action provides an **advantageous approach to treatment of achondroplasia**

SOURCE: Ornitz DM et al. Developmental Dynamic 2017; Richette Joint Bone Spine 2007; Unger Curr Osteoporos Rep 2017, Hoover-Fong Am J Gen Med 2017

Agenda

Cohort 5 in ACH: Data Update
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[1]Insert source / footnote

Cohort 5 (0.25 mg/kg) of the PROPEL2 Trial: Infigratinib continues to be well-tolerated, with no related AEs

- **In Cohort 5 (the highest dose escalation level of 0.25 mg/kg):**
  - No serious adverse events (SAEs), no AEs that required treatment discontinuation
  - Most TEAEs were grade 1 in severity and **none of the TEAEs** were assessed as related to study drug
  - **0 subjects with grade 3 TEAEs**
  - **0 ocular adverse events**
  - **0 hyperphosphatemia events**
  - No accelerated progression of the bone age
- Safety profile for cohorts 1-4 has continued with no new hyperphosphatemia events, ocular events, or SAEs

Infigratinib in PROPEL 2 cohort 5 is well-tolerated with no safety signals identified through month 18

Source: Data on file

Reported AEs across all cohorts are common in the pediatric population, especially in children with achondroplasia

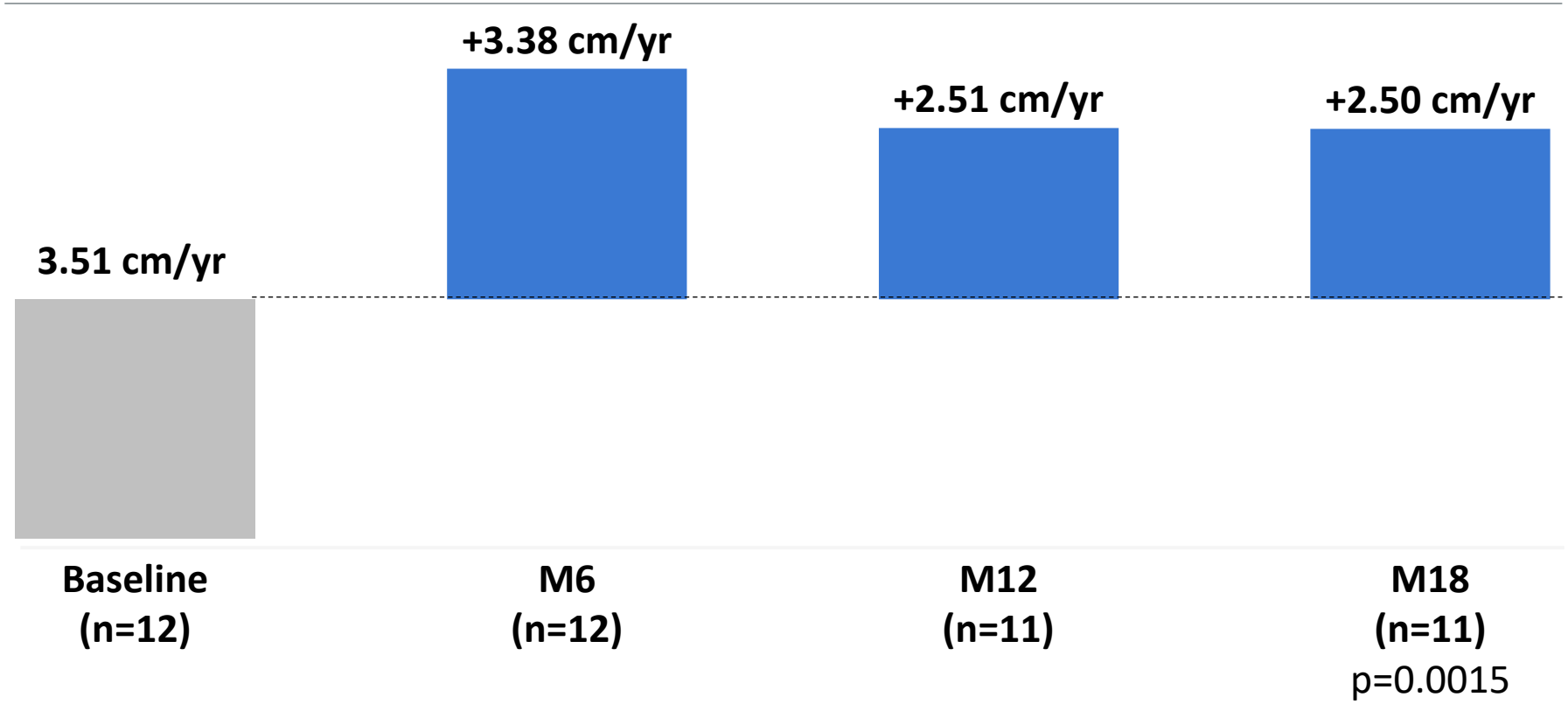
AEs occurring in ≥10% of study participants	Total (%) N = 72
Nasopharyngitis	29 (40.3%)
COVID-19	24 (33.3%)
Headache	24 (33.3%)
Vomiting	22 (30.6%)
Pain in extremity	20 (27.8%)
Ear infection	19 (26.4%)
Pyrexia	18 (25.0%)
Abdominal pain	11 (15.3%)
Cough	11 (15.3%)
Diarrhea	11 (15.3%)
Rhinitis	11 (15.3%)
Viral infection	11 (15.3%)
Upper respiratory tract infection	10 (13.9%)
Abdominal pain upper	8 (11.1%)
Ear pain	8 (11.1%)
Nausea	8 (11.1%)
Oropharyngeal pain	8 (11.1%)
Otitis media	8 (11.1%)

Infigratinib continues to demonstrate a well-tolerated safety profile

Source: Data on file

Cohort 5: The best-in-class change from baseline in AHV at M6 is sustained at M12 and M18

Mean change from baseline in annualized height velocity (AHV)



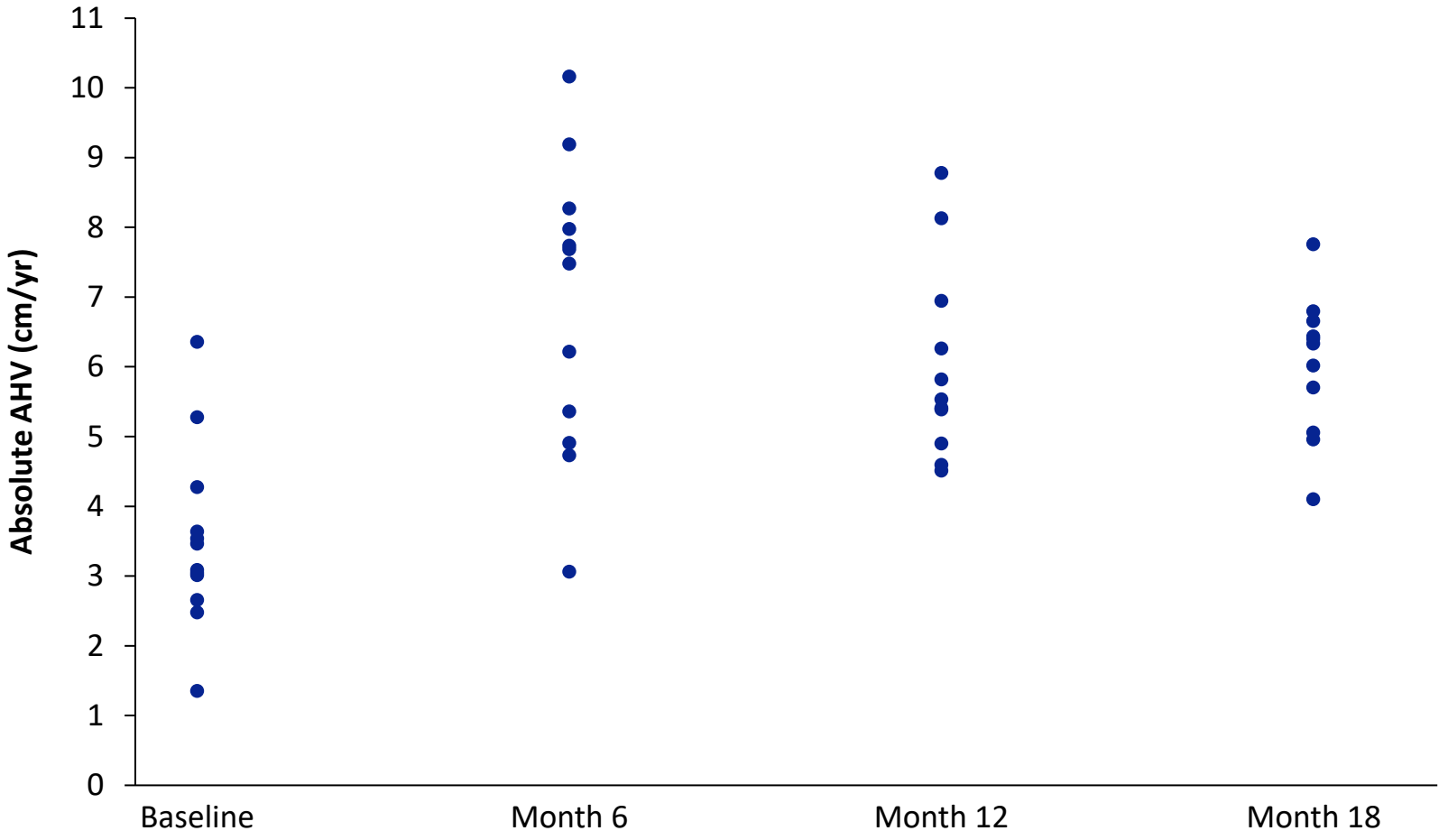
Baseline demographics	
Female:Male ratio	**7:5**
Mean age at screening (yr)	**7.24**
<5	8%
5 - <8	58%
8 - <11	25%
>=11	8%
Baseline AHV (cm/yr) Mean (SD)	**3.51 (1.3)**

At each timepoint, infigratinib change from baseline AHV is higher than that reported by any other treatment option

Source: Data on file. NOTE: 1 child dropped out before month 12 assessments as study site closed due to PI departure. This child was a responder at month 6.

The response to infigratinib was broad, with 10 out of 11 kids having an increase from baseline in AHV at M18 compared to baseline

Absolute AHV individual values, cm/yr



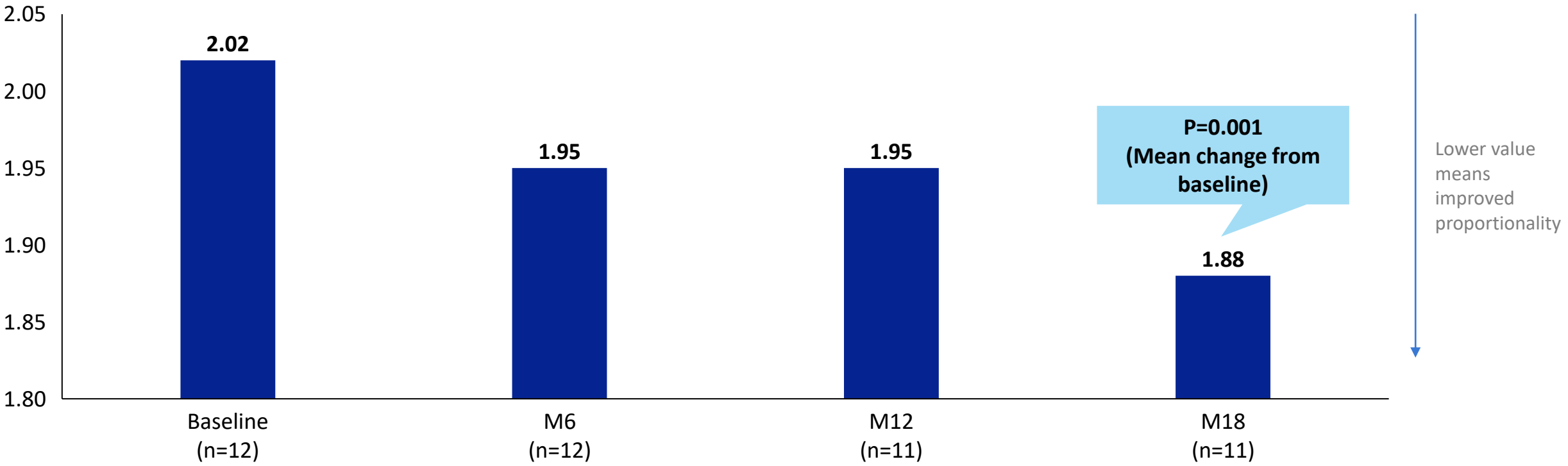
<u>91%</u> of participants had an increase in AHV from Baseline to M18

<u>73%</u> of participants had an increase of greater than 25% in AHV from Baseline to M18

Source: Data on file

Infigratinib shows a persistent decrease in upper/lower body segment ratio at the cohort 5 dose

Upper body to lower body segment ratio



Statistically significant proportionality improvements after only 18 months demonstrates strong potential for a meaningful effect on body proportionality

Source: Data on file. NOTE: 1 child dropped out before month 12 assessments as study site closed due to PI departure. This child was a responder at month 6.

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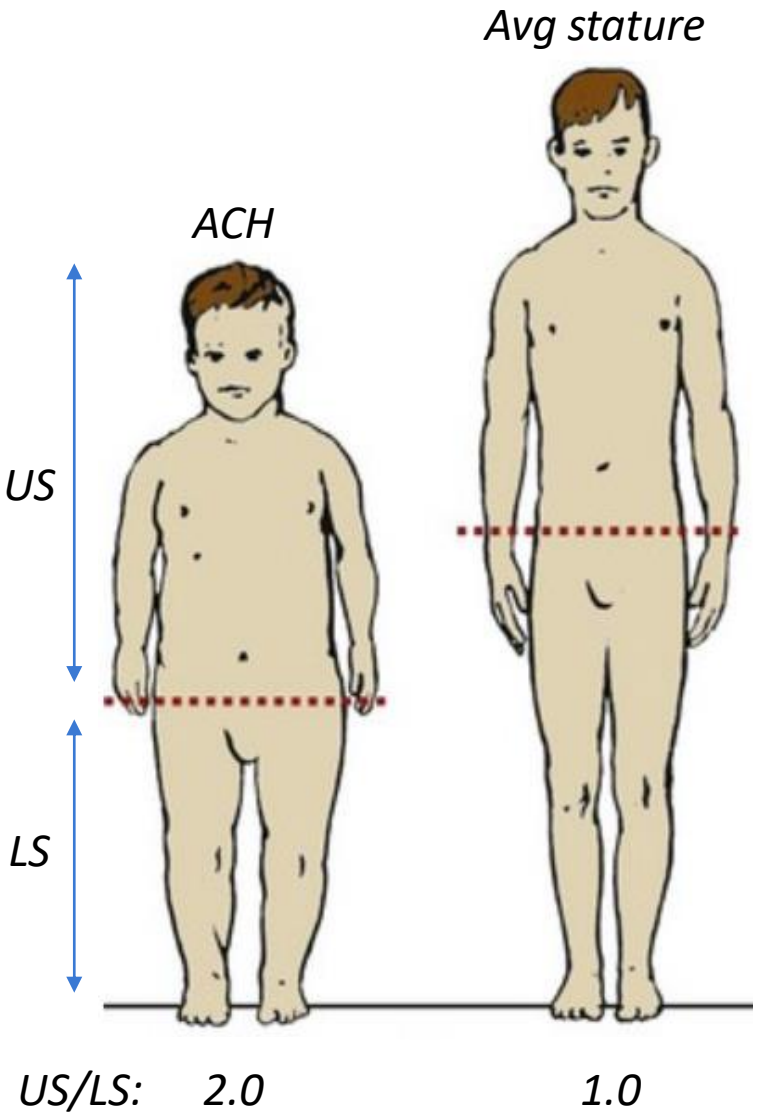
Proportionality links changes in linear growth to potential benefits beyond height



- Achondroplasia is a **disproportionate** skeletal dysplasia (upper body segment to lower body segment ratio of ~2.0 versus ~1.0 in average statured children)
- Disproportionality is associated with delayed motor milestones, balance and impaired functionality in children with achondroplasia
- The cumulative improvements in proportionality seen with infigratinib are encouraging with the **potential to enhance functionality, activities of daily living and quality of life**

Proportionality is a critical endpoint in achondroplasia

SOURCE: Image adapted from Themes, U. (2016, July 3). Heritable diseases of connective tissue. Musculoskeletal; US: Upper body segment; LS: Lower body segment

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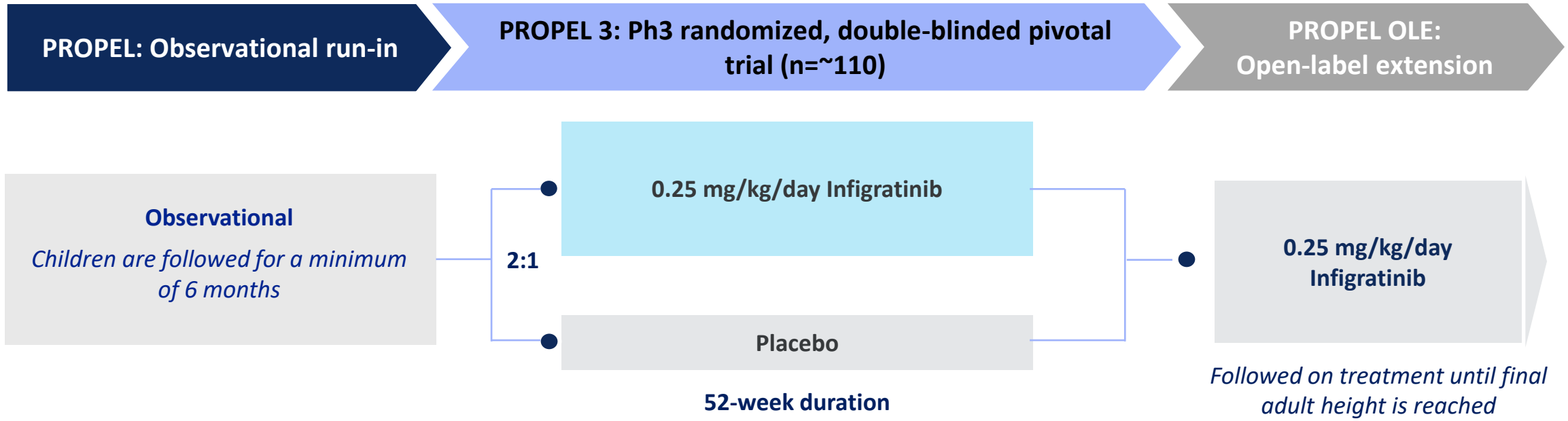
PROPEL 3, the phase 3 trial of infigratinib for achondroplasia, is underway with last participant in expected by end of 2024



Key inclusion criteria

- Children 3 – <18 years old with open growth plates

Primary endpoint:

Change from baseline in annualized height velocity at week 52

Key secondary endpoints:

Change from baseline in height z-score

Change from baseline in upper body:lower body segment ratio

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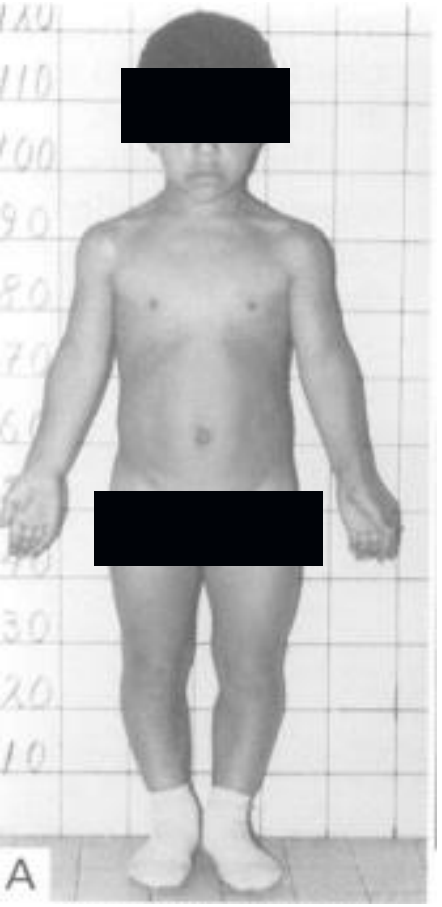
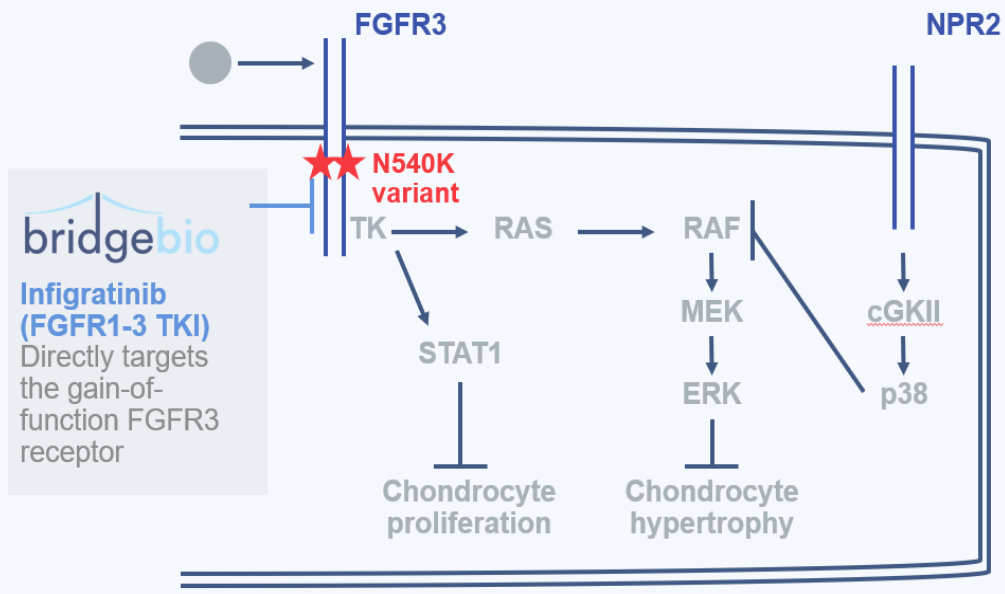
Hypochondroplasia is a FGFR3-related skeletal dysplasia with a need for treatment options



- Autosomal dominant condition
- Similar incidence to achondroplasia
- Greater genetic heterogeneity in *FGFR3* pathogenic variants (e.g. N540K in addition to others)
- Clinical features:
  - Moderate disproportionate short stature
  - Head circumference larger than average
  - Tibia bowing
- Medical complications are milder and less frequent than in achondroplasia
  - Motor milestones less delayed
  - Reports of epilepsy, temporal lobe abnormalities & other cognitive functions[2,3]

Infigratinib directly targets FGFR3 signaling



Infigratinib directly targets the underlying cause of hypochondroplasia, FGFR3 overactivity

1. Rousseau et al. J Med Genet. 1996;33(9):749-752; 2. Linnankivi et al (2012). Am J Med Genet. 158A:3119–3125; 3. Philpott et al (2013). Pediatr Radiol (2013). 43:1190–1195

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Similar to the PROPEL program in ACH, the ACCEL clinical program consists of an observational run-in and an interventional study with long-term follow-up

ACCEL

Observational Run-in

Children and adolescents (2.5 to <17 years) with hypochondroplasia (HCH)

Primary objective: Establish baseline height velocity

Primary endpoints: Annualized height velocity (AHV)

ACCEL 2/3

Phase 2/3 Open-Label Phase followed by a Double-Blinded, Randomized, Placebo-Controlled Study

Ph2: Open-Label Phase

Children (5 – 11 years with growth potential) with HCH who completed ≥6 months in ACCEL

Primary objectives: Obtain preliminary efficacy, safety and tolerability of infigratinib in HCH

Primary endpoints: Change from baseline in HV and safety endpoints

Pivotal Ph3: Double-Blind, Randomized, Placebo-Controlled Phase

Children and adolescents (3 – <18 years with growth potential) with HCH who completed ≥6 months in ACCEL

Primary objectives: Evaluate safety and efficacy of infigratinib in HCH

Primary endpoints: Change from baseline in AHV vs. placebo at 52 wks

ACCEL OLE

Open-Label Extension (planned)

Eligible children and adolescents who completed either portion will be offered treatment with infigratinib until final height/near final height

Primary objectives: Evaluate long term safety, tolerability and efficacy of infigratinib in HCH

The ACCEL trials will also evaluate changes in growth, body proportions and HCH-related complications

Clinicaltrials.gov listing: NCT06410976 (ACCEL)

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Conclusions

- **Best-in-class efficacy and well-tolerated safety profile** of infigratinib in achondroplasia are sustained through 18 months in the current data, now with a **statistically-significant improvement in proportionality**
- **PROPEL 3 pivotal study** of infigratinib in achondroplasia is enrolling quickly, on track for **last participant in by end of 2024**
- Expansion of **infigratinib in hypochondroplasia is now initiated**, with the ACCEL clinical trial open and **first participant consented**
- BridgeBio is committed to **exploring infigratinib's scientific potential** and is evaluating **additional FGFR-driven genetic conditions** including Crouzon, Apert, & Muenke syndromes

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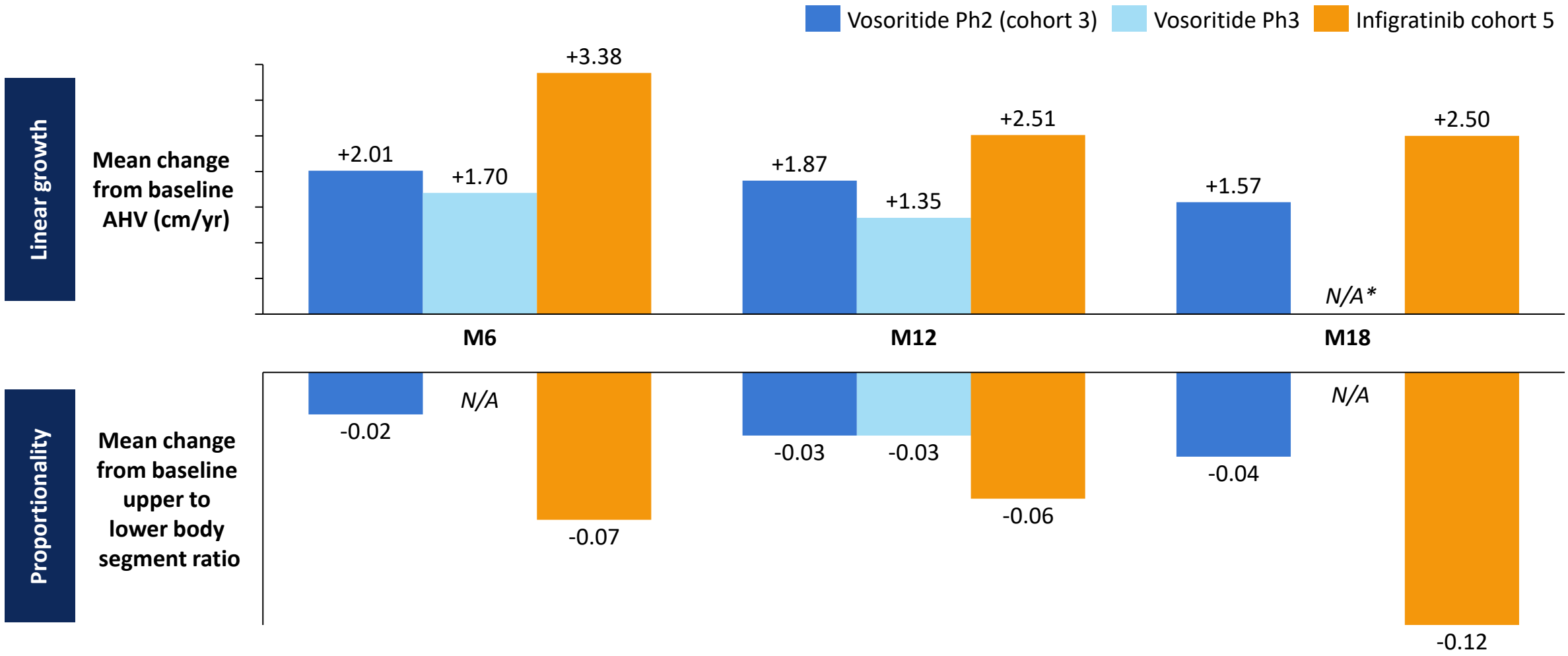
Thank you

In both CFBL AHV and proportionality, current infigratinib data is best-in-class across several timepoints



Source: Infigratinib data on file; Vosoritide phase 2 data from Savarirayan et al NEJM 2019; Vosoritide phase 3 data from vosoritide FDA integrated review
*Available published M18 AHV data from vosorotide's Ph. 3 (Savarirayan et al Nature Genet Med 2021) only calculates AHV from trailing 6 months instead of full M0-M18 duration