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Investment Highlights

• Immuno-oncology company taking cancer care to the next level, bridging innate and adaptive immunity

• Lead program TTI-621 targets CD47, a 2\textsuperscript{nd} generation IO target that tumors use to evade the immune system

• Differentiated from competitors by superior monotherapy activity:
  • Potent format utilizing an active IgG1 Fc region
  • Single agent activity observed in multiple indications
  • Only CD47 agent resulting in monotherapy CRs
Trillium Pipeline

*Strong Clinical Focus on CD47 Blockade*

<table>
<thead>
<tr>
<th>Discovery</th>
<th>Preclinical</th>
<th>Phase 1a</th>
<th>Phase 1b/2</th>
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<tbody>
<tr>
<td>TTI-621 (SIRPα-IgG1 Fc) Intratumoral Administration</td>
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<tr>
<td>TTI-621 (SIRPα-IgG1 Fc) Intravenous Administration</td>
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<tr>
<td>TTI-622 (SIRPα-IgG4 Fc) Intravenous Administration</td>
<td></td>
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<tr>
<td>STING agonist</td>
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<tr>
<td>Undisclosed CD47 Program</td>
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Many Tumor Cells Use the CD47 “Do Not Eat” Signal to Inhibit Macrophage Phagocytosis

- CD47 delivers an inhibitory “do not eat” signal to macrophages through SIRPα
- Many hematologic and solid tumors express high levels of CD47
- High CD47 expression often correlates with aggressive disease and poor clinical outcomes
- Blocking CD47 has emerged as a promising strategy in immuno-oncology
TTI-621: A Dual Function SIRPαFc Decoy Receptor that Activates Innate and Adaptive Immunity

- Blocks the CD47 **DO NOT EAT** signal
- Delivers an **EAT** signal through FcγRs
- **Macrophage Phagocytosis**
- **Antigen Presentation & Adaptive Immunity**
The IgG1 Fc is a Distinguishing Feature of TTI-621

<table>
<thead>
<tr>
<th>CD47-Targeting Agent* (Company)</th>
<th>Isotype</th>
</tr>
</thead>
<tbody>
<tr>
<td>TTI-621 (Trillium)</td>
<td>IgG1</td>
</tr>
<tr>
<td>TG-1801 (TG Therapeutics)^</td>
<td>IgG1</td>
</tr>
<tr>
<td>TTI-622 (Trillium)</td>
<td>IgG4</td>
</tr>
<tr>
<td>Hu5F9 (Forty Seven)</td>
<td>IgG4</td>
</tr>
<tr>
<td>CC-90002 (Celgene)</td>
<td>IgG4</td>
</tr>
<tr>
<td>SRF231 (Surface Oncology)</td>
<td>IgG4</td>
</tr>
<tr>
<td>IBI188 (Innovent)</td>
<td>IgG4</td>
</tr>
<tr>
<td>AO-176 (Arch Oncology)</td>
<td>IgG2</td>
</tr>
<tr>
<td>ALX148 (ALX Oncology)</td>
<td>Inert IgG1</td>
</tr>
</tbody>
</table>

*Most clinical stage CD47 blockers employ weak effector Fc regions (IgG4, IgG2, inert IgG1)

*The only other IgG1 Fc is a bispecific restricted to B-cell malignancies

*TTI-621 is the only CD47 blocking agent that has demonstrated monotherapy CRs
The Fc Region is Critical When Blocking CD47

- IgG1 Fc region provides superior activation by engaging Fc receptors
- IgG1 format provides the highest likelihood of monotherapy activity
- Blockers with weaker Fc regions are adjuvants, limited to tumor types where a suitable anti-cancer antibody exists
- An IgG1 blocker requires low RBC binding to avoid hemolytic anemia, a distinguishing property of Trillium’s SIRPαFc format
TTI-621 Clinical Program

Intratumoral and Intravenous Administration with a Focus on T-Cell Lymphoma

Intratumoral Dosing (NCT02890368)
- Monotherapy: CTCL, Solid Tumors
- PD-1/PD-L1 Combination: CTCL, Solid Tumors
- IFNα Combination: CTCL

Intravenous Dosing (NCT02663518)
- Monotherapy: CTCL
- Monotherapy: PTCL
- PD-1 Combination: HL
- Rituximab Combination: B-NHL

Recruiting
- CTCL, Solid Tumors
- CTCL, Solid Tumors
- CTCL

Recruiting (1st Simon Stage)
- CTCL
- PTCL

Recruiting
- HL

Recruitment complete
- B-NHL
Intratumoral Administration of TTI-621

• Multicenter, open-label phase 1 study in patients with R/R mycosis fungoides (MF) or percutaneously accessible solid tumors (NCT02890368)

• Dosing progressed through three stages:
  • Single dose escalation (1, 3 or 10 mg)
  • Multiple injections (10 mg 3x/wk for 2 wk)
  • Induction (10 mg 3x/wk for 2 wk) followed by continuation therapy (10 mg/wk)

• 27 MF patients treated to date (Nov 2018)

• Local injections are very well tolerated (no ≥Grade 3 AEs, SAEs or DLTs)

• Clear signal of monotherapy activity in MF patients:
  • Rapid responses in injected and adjacent lesions
  • Emerging evidence for systemic responses
  • Anecdotal evidence for promising durability (>1 year) in one patient

85M with stage IIB MF with large cell transformation who failed 4 prior systemic therapies, PUVA and radiation received a single 10 mg injection of TTI-621 into the proximal lesion on the left foot

Querfeld et al. ASH 2017
Additional Examples of Rapid Tumor Regression in MF Patients Receiving TTI-621

A) 53M with stage IA MF who failed 5 prior systemic therapies received 10 mg induction and continuation therapy of TTI-621 into two lesions on the surface of the neck.

B) 72M with stage IIB MF with large cell transformation who failed prior topical therapy received a single 1 mg injection of TTI-621 into the lesion on the dorsal surface of the left foot; lesion has not returned after 52+ weeks.

C) CD4 staining of skin biopsies from patient in B).
CAILS Reductions in Injected Lesions Were Observed in the Majority of Patients

22 patients have available CAILS scores^  
- 20 (91%) with decreased CAILS  
- 9 (41%) with ≥50% reduction in CAILS  
- CAILS decreases:  
  - Occurred at all dose levels  
  - Following single and multiple injections  
  - In all stages IA to IVB  
  - In all lesion types

^Composite Assessment of Index Lesion Severity, a measure of local lesion responses
Systemic Effects Were Observed in One Patient Receiving Continuation Monotherapy

Injected Lesion – T01 (Left Calf)

Screening  Week 2  Week 7  Week 11

Distal Non-Injected Lesion – Abdomen

Screening  Week 2  Week 2  Week 9

Rapid resolution of lesions on abdomen (lower panel), left flank/back and arms (not shown) following TTI-621 injections of target lesions on left calf (upper panel), left ankle and right foot.

CAILS Scores: TTI-621 MWF x2 + Continuation Therapy
Two Distinct Opportunities for Intratumoral TTI-621 in CTCL

CTCL - 41,615 Patients (US)*

Early Stage (Stage IA-IIA)
- 71% of CTCL patients at diagnosis
- Indolent disease, but patients suffer intractable itching and skin infections
- Typically treated by dermatologists with skin-directed therapies
- Treatment goal is local disease control (CAILS endpoint)

Advanced Disease (Stage IIB-IVB)
- 29% of CTCL patients at diagnosis
- Can be aggressive, resulting in life-threatening disease
- Typically treated with systemic therapies by oncologists
- Treatment goal is global disease control (mSWAT endpoint)

For both populations, the value proposition for IT TTI-621 compared to current therapies:
new modality, good safety profile, rapid onset of action, potential for long durability

*SEER 2016
Expanding IT TTI-621 Beyond CTCL

• The safety and efficacy of IT TTI-621 in CTCL demonstrates proof-of-concept for local administration.

• We plan to explore larger market indications, particularly in the solid tumor space where IT administration is gaining popularity.

• Selection of additional indications will be based on:
  • Feasibility of local administration
  • CD47 expression
  • Macrophages in tumor microenvironment
  • Preclinical data

• Indications under consideration include bladder cancer, HPV+ head and neck cancer, cervical cancer.
Intravenous Administration of TTI-621

- Multicenter, open-label phase 1 study in patients with R/R hematologic malignancies (NCT02663518)

- Dose escalation performed in lymphoma patients; signal-seeking expansion in multiple hematologic cancers; trial now focused on T-cell malignancies (CTCL, PTCL)

- 179 patients treated to date (Dec 2018)

- Drug is well tolerated; conservative thrombocytopenia DLT definition limited exposure to 0.2 mg/kg, evolving data have enabled higher exposures

- **Monotherapy activity observed across multiple indications:**
  - MF (17% ORR), Sézary Syndrome (20% ORR), PTCL (18% ORR), DLBCL (25% ORR)
  - Only CD47-targeting agent to show monotherapy CRs
  - Efficacy seen despite suboptimal dosing
Evolution of the TTI-621 Intravenous Dose

*Deeper Understanding of Thrombocytopenia Has Enabled Dosing Beyond 0.2 mg/kg*

- **Dec 2016**: 0.2 mg/kg established as the MTD based on a very conservative DLT definition (any G4 thrombocytopenia regardless of duration)
- **Mar 2017**: Dose intensification from 0.2 to 0.5 mg/kg at Investigator’s discretion
  - Two transient G4 thrombocytopenias (lasting only 1 day) observed at 0.3 mg/kg wk1 dose
  - Attenuation of thrombocytopenia after wk1 led to discretionary dosing up to 0.5 mg/kg

- **Mar 2018**: Dose intensification from 0.2 to 0.5 mg/kg standardized over 5-8 wks
  - Dose intensification standardized across sites and compressed into shorter time period

- **Q1 2019**: Trial amended to dose beyond 0.5 mg/kg
  - Data demonstrate that thrombocytopenia at 0.5 mg/kg is similar to 0.2 mg/kg; dosing beyond 0.5 mg/kg to commence shortly
Intravenous TTI-621 is Well Tolerated

- Most frequent AEs were low-grade infusion reactions, clinically managed by pre-medication and close monitoring
- ≥ Grade 3 thrombocytopenia occurred in 18% patients
- Diverse patient population from the following expansion cohorts: AML, MDS, MPN, B-NHL, T-NHL, HL, MM, CLL, SCLC
IV TTI-621 Has Promising Single Agent Activity Even at Relatively Low Doses

<table>
<thead>
<tr>
<th>Indication</th>
<th>N</th>
<th>CR</th>
<th>PR</th>
<th>ORR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mycosis Fungoides</td>
<td>24</td>
<td>---</td>
<td>4 (17%)</td>
<td>17%</td>
</tr>
<tr>
<td>Sézary Syndrome</td>
<td>5</td>
<td>1 (20%)</td>
<td>---</td>
<td>20%</td>
</tr>
<tr>
<td>Peripheral T-cell Lymphoma</td>
<td>11</td>
<td>---</td>
<td>2 (18%)</td>
<td>18%</td>
</tr>
<tr>
<td>Diffuse Large B-cell Lymphoma</td>
<td>8</td>
<td>1 (13%)</td>
<td>1 (13%)</td>
<td>25%</td>
</tr>
<tr>
<td>Diffuse Large B-cell Lymphoma*</td>
<td>24</td>
<td>1 (4%)</td>
<td>5 (21%)</td>
<td>25%</td>
</tr>
</tbody>
</table>

*In combination with rituximab

Most responses were observed in patients receiving weekly doses of 0.2 mg/kg (monotherapy) or 0.1 mg/kg (combination)
**Even at Low Doses, TTI-621 is Emerging as the Superior Monotherapy CD47 Agent**

<table>
<thead>
<tr>
<th>CD47-Targeting Agent (Company)</th>
<th>Isotype</th>
<th>Monotherapy Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>TTI-621 (Trillium)</td>
<td>IgG1</td>
<td>17-25% ORR (B- and T cell lymphomas) at low IV doses</td>
</tr>
<tr>
<td>Hu5F9 (Forty Seven)</td>
<td>IgG4</td>
<td>5% ORR (solid tumors and lymphoma, N=44)*; Clinical program focused on combinations</td>
</tr>
<tr>
<td>ALX148 (ALX Oncology)</td>
<td>Inert IgG1</td>
<td>0% ORR (solid tumors, N=15)**</td>
</tr>
<tr>
<td>CC-90002 (Celgene)</td>
<td>IgG4</td>
<td>Monotherapy study terminated (AML/MDS)^</td>
</tr>
<tr>
<td>SRF231 (Surface Oncology)</td>
<td>IgG4</td>
<td>Expansion phase discontinued^^</td>
</tr>
</tbody>
</table>

* NCT02216409; Pts treated at ≥20 mg/kg (Sikic, JCO 2019)
^ NCT02641002
** NCT03013218; Pts treated at ≥10 mg/kg (Lakhani, ASCO 2018)
^^ NCT03512340; Surface Oncology strategic reset (Dec 2018)
The Rationale for Further IV Dose Escalation

• Current dosing regimen results in sub-saturating peripheral CD47 occupancy

• One Sézary patient achieved CR after 48 weeks of treatment; slow response to TTI-621 might be improved with higher dosing

• Rapid tumor responses observed after IT dosing suggest a benefit to achieving high concentrations
Expanding Our Immuno-Oncology Pipeline with a STING Agonist Program

- STING is involved in sensing cytosolic DNA and plays a key role in promoting tumor immunity
- STING agonists currently in clinical trials are based on high molecular weight cyclic dinucleotide (CDN) scaffolds that possess certain undesirable drug properties
- TTI-10001 is a novel, non-CDN, small molecule STING agonist that exhibits favorable potency, cell permeability, and tumor retention properties that could potentially overcome the limitations of CDNs
- Local injection of TTI-10001 induced complete regressions in both injected and distal tumors and protected mice from subsequent tumor challenge, demonstrating the induction of durable immunity (MC38 model)

Wang et al. AACR 2019
1. **Differentiated Approach to CD47 Blockade**:
   - Potent format using an active IgG1 Fc

2. **Superior Anti-tumor Activity**
   - Only CD47 blocker to result in monotherapy CRs

3. **De-Risked Programs**:
   - Monotherapy activity established
   - Target indications (CTCL, PTCL, DLBCL) identified

4. **Clear Paths Forward**:
   - IT administration in CTCL
   - New intratumoral indications
   - Intravenous dose intensification beyond 0.5 mg/kg