Corporate Presentation

H.C. Wainwright & Co.
21st Annual Global Investment Conference
September 8-10, 2019 – New York

NASDAQ/TSX: TRIL
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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 2nd 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></th>
<th>Discovery</th>
<th>Preclinical</th>
<th>Phase 1a</th>
<th>Phase 1b/2</th>
</tr>
</thead>
<tbody>
<tr>
<td>TTI-621 (SIRPα-IgG1 Fc)</td>
<td>Intratumoral Administration</td>
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<td>Intravenous Administration</td>
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<tr>
<td>TTI-622 (SIRPα-IgG4 Fc)</td>
<td>Intravenous Administration</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>
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<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>
<tr>
<td>SGN-CD47M (Seattle Genetics)</td>
<td>Unknown</td>
</tr>
<tr>
<td>TJC4 (I-Mab)</td>
<td>Unknown</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

*Clinical stage compounds
^CD19/CD7 bispecific
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 better suited to combination therapy with agents that deliver an “eat” signal.
- 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
  - CTCL
- Monotherapy
  - PTCL
- PD-1 Combination
  - HL
- Rituximab Combination
  - B-NHL

*Recruiting*
*Recruiting*
*Recruiting*
*Recruiting*
*Recruitment Complete (1st Simon Stage)*
*Recruiting (1st Simon Stage)*
*Recruiting*
*Recruitment complete*

*Dose optimization (> 0.5 mg/kg)*
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

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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).

Querfeld et al. ASH 2017
Querfeld et al. ASH 2018
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

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

- T01 L. Calf
- T02 L. Ankle
- T03 R. Foot
- L01 L. Calf
- L02 R. Knee
- L05 R. Thigh

Querfeld et al. ASH 2018

Data Cut-off: November 5, 2018
Two Distinct Opportunities for Intratumoral TTI-621 in CTCL

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

CTCL - 41,615 Patients (US)*

*SEER 2016
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 a 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

Mar 2018
Dose intensification from 0.2 to 0.5 mg/kg standardized over 5-8 wks

Q1 2019
Trial amended to dose beyond 0.5 mg/kg

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

Dose intensification standardized across sites and compressed into shorter time period

Data demonstrate that thrombocytopenia at 0.5 mg/kg is similar to 0.2 mg/kg; dosing beyond 0.5 mg/kg in progress
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

<table>
<thead>
<tr>
<th>Related Adverse Events</th>
<th>Adverse Event Grades</th>
<th>Cohort(s): All</th>
<th>Total n=179</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Gr 1-2</td>
<td>Grade 3 ≥3</td>
<td></td>
</tr>
<tr>
<td>Infusion Related Reaction</td>
<td>69 (39)</td>
<td>3 (2)</td>
<td>72 (40)</td>
</tr>
<tr>
<td>≥ 15%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thrombocytopenia</td>
<td>11 (6)</td>
<td>33 (18)</td>
<td>44 (25)</td>
</tr>
<tr>
<td>Chills</td>
<td>34 (19)</td>
<td>34 (19)</td>
<td></td>
</tr>
<tr>
<td>Fatigue</td>
<td>27 (15)</td>
<td>27 (15)</td>
<td></td>
</tr>
<tr>
<td>≥ 5%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anaemia</td>
<td>8 (4)</td>
<td>12 (7)</td>
<td>20 (11)</td>
</tr>
<tr>
<td>Pyrexia</td>
<td>18 (10)</td>
<td>18 (10)</td>
<td></td>
</tr>
<tr>
<td>Diarrhoea</td>
<td>16 (9)</td>
<td>1 (1)</td>
<td>17 (9)</td>
</tr>
<tr>
<td>Vomiting</td>
<td>14 (8)</td>
<td>1 (1)</td>
<td>15 (8)</td>
</tr>
<tr>
<td>Neutropenia</td>
<td>13 (7)</td>
<td>13 (7)</td>
<td></td>
</tr>
<tr>
<td>Headache</td>
<td>13 (7)</td>
<td>13 (7)</td>
<td></td>
</tr>
<tr>
<td>Hypotension</td>
<td>7 (4)</td>
<td>2 (1)</td>
<td>9 (5)</td>
</tr>
</tbody>
</table>

Source: 28 Nov 2018 DDLs
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)

Shou, T Cell Lymphoma Forum 2019
Uger, Discovery on Target 2018
Even at Low Doses, TTI-621 is Emerging as the Superior Monotherapy CD47 Agent

<table>
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<th>CD47-Targeting Agent (Company)</th>
<th>Isotype</th>
<th>Monotherapy Experience</th>
</tr>
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<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)(^1); 10% ORR (AML/MDS, N=10)(^2); Clinical program focused on combinations</td>
</tr>
<tr>
<td>ALX148 (ALX Oncology)</td>
<td>Inert IgG1</td>
<td>0% ORR (solid tumors, N=15)(^3)</td>
</tr>
<tr>
<td>CC-90002 (Celgene)</td>
<td>IgG4</td>
<td>Monotherapy study terminated (AML/MDS)(^4)</td>
</tr>
<tr>
<td>SRF231 (Surface Oncology)</td>
<td>IgG4</td>
<td>Expansion phase discontinued(^5)</td>
</tr>
</tbody>
</table>

\(^1\)NCT02216409; Pts treated at ≥20 mg/kg (Sikic, JCO 2019)  
\(^2\)NCT03248479; ASCO 2019  
\(^3\)NCT03013218; Pts treated at ≥10 mg/kg (Lakhani, ASCO 2018)  
\(^4\)NCT02641002  
\(^5\)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
Trillium Key Messages

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
   • Intravenous dose intensification beyond 0.5 mg/kg