Corporate Overview

January 2020
Forward-Looking Statements

This presentation contains forward-looking statements within the meaning of applicable securities laws. All statements contained herein that are not clearly historical in nature are forward-looking, and the words “anticipate”, “believe”, “expect”, “estimate”, “may”, “will”, “could”, “leading”, “intend”, “contemplate”, “shall”, “propose”, “plan” and similar expressions are generally intended to identify forward-looking statements. Forward-looking statements in this presentation include statements about, without limitation, the clinical plans and objectives for our TTI-621 and TTI-622 programs, our expectation about the timing of achieving certain milestones relating to our programs and our belief that our programs could achieve best-in-class status for CD47 blocking agents.

These forward-looking statements involve risks and uncertainties that may cause actual results, events or developments to be materially different from any future results, events or developments expressed or implied by such forward-looking statements. Such factors include, but are not limited to, Trillium’s ability to obtain financing to advance the products in its development portfolio; changing market conditions; the successful and timely completion of pre-clinical and clinical studies; the establishment of corporate alliances; the impact of competitive products and pricing; new product development risks; uncertainties related to the regulatory approval process or the ability to obtain drug product in sufficient quantity or at standards acceptable to health regulatory authorities to complete clinical trials or to meet commercial demand; and other risks detailed from time to time in Trillium’s ongoing quarterly and annual reporting.

A discussion of risks and uncertainties facing Trillium appears in Trillium’s Form 20-F for the year ended December 31, 2018 filed with the U.S. Securities Exchange Commission and available at www.sec.gov and www.sedar.com, each as updated by Trillium’s continuous disclosure filings, which are available at www.sedar.com and at www.sec.gov. Forward-looking statements are not guarantees of future performance and accordingly undue reliance should not be put on such statements due to the inherent uncertainty therein. Any forward-looking statements speaks only as of the date on which it is made and, except as may be required by applicable securities laws, the Company disclaims any intent or obligation, whether as a result of new information, future events or results or otherwise. All forward-looking statements herein are qualified in their entirety by this cautionary statement.
Company Highlights

- Clinical stage immuno-oncology company with focus on CD47
- Comprehensive clinical development program, with lead molecule that demonstrated monotherapy bioactivity in hematologic malignancies

- TTI-621 (SIRPα-IgG1 Fc): 200+ patients dosed; monotherapy activity in multiple indications at initial low doses; no red blood cell (RBC) binding; further dose escalation ongoing
- TTI-622 (SIRPα-IgG4 Fc): Strong safety profile with no RBC binding; initial dose escalation in progress

- CEO change end of September 2019
- Wide-ranging transformation program initiated
- Strategic re-prioritization completed
Transformation Program Under New CEO

Priorities and progress since September 2019

1. **Restructure** the footprint and cut cash burn
   - Reduced staff by 40%; strengthened clin. dev. team; reduced cash burn by ~40%
   - Completed (Oct 2019)

2. **Refocus** from intratumoral to IV program
   - Closed IT P1b study; IT program to be continued with non-dilutive funding
   - Completed (Nov 2019)

3. **Execute** 621 & 622 dose escalation studies
   - Reallocated resources to 621 & 622 IV studies
   - In progress

4. **Expand** from CTCL to larger indications
   - Initiate studies in AML/MDS, PTCL and other heme malignancy indications
   - In planning stages
Pipeline Overview

**Discovery**

**TTI-621**
(SIRPα-IgG1 Fc)

- Heme malignancies (activity observed in CTCL, PTCL, DLBCL)

**TTI-622**
(SIRPα-IgG4 Fc)

- Heme malignancies
- Dose escalation in progress

**Pre-clinical**

**CD47**

**Early stage development**

**STING**
(Agonist program)

- Ready for IND-enabling studies
- To be out-licensed

**Late stage development**

- PoC via IT administration and IV data at low initial doses
- 200+ patients dosed to date
- Dose escalation in progress

**TTI-621**
(SIRPα-IgG1 Fc)

- Heme malignancies (activity observed in CTCL, PTCL, DLBCL)

**TTI-622**
(SIRPα-IgG4 Fc)

- Heme malignancies
- Dose escalation in progress
Tumors Use CD47 “Do Not Eat” Signal to Evade Destruction by Innate Immune System

CD47 Pathway in Cancer

- Many hematologic and solid tumors express high levels of CD47
- High CD47 expression correlated with aggressive disease & poor outcomes
- CD47 delivers an inhibitory “do not eat” signal to macrophages through SIRPα

CD47 blockade emerging as a next-generation checkpoint inhibitor strategy in immuno-oncology
Trillium Molecules Are Differentiated From Other CD47 Agents on Several Dimensions

<table>
<thead>
<tr>
<th>Candidate</th>
<th>TTI-621</th>
<th>TTI-622</th>
<th>Magrolimab</th>
<th>ALX148</th>
<th>CC-90002</th>
<th>AO-176</th>
<th>TG-1801</th>
</tr>
</thead>
<tbody>
<tr>
<td>Molecule</td>
<td>WT SIRPαFc fusion protein</td>
<td>WT SIRPαFc fusion protein</td>
<td>CD47 mAb</td>
<td>High aff. SIRPαFc fusion protein</td>
<td>CD47 mAb</td>
<td>CD47 mAb</td>
<td>Bi-spec. Ab CD47/CD19</td>
</tr>
<tr>
<td>Fc isotype</td>
<td>IgG1</td>
<td>IgG4</td>
<td>IgG4</td>
<td>Inert IgG1</td>
<td>IgG4</td>
<td>IgG2</td>
<td>IgG1</td>
</tr>
<tr>
<td>RBC binding</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Minimal</td>
<td>No</td>
</tr>
<tr>
<td>Monotherapy CRs</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No data</td>
<td>No data</td>
</tr>
<tr>
<td>Development stage</td>
<td>P1b</td>
<td>P1a</td>
<td>P2</td>
<td>P1</td>
<td>P1</td>
<td>P1</td>
<td>P1</td>
</tr>
</tbody>
</table>

Sources: Company web sites, publications, presentations and filings; [www.clinicaltrials.gov](http://www.clinicaltrials.gov)

* Monotherapy trial (NCT02641002) discontinued (ASH 2019)

Other companies with clinical stage CD47-targeting agents: Seattle Genetics, Surface Oncology, I-Mab, Innovent Bio, Jiangsu Hengrui Medicine Co
• TTI-621 (SIRPα-IgG1Fc) CD47 program

• TTI-622 (SIRPα-IgG4Fc) CD47 program

• Corporate overview
TTI-621 Highlights

Differentiated and potentially best-in-class CD47 therapeutic

• Unique CD47 blocking agent that also delivers activating (FcR) signal
• Only CD47 agent to produce monotherapy CRs in patients
• No RBC binding, unlike other CD47 agents

Strong clinical PoC via intratumoral administration

• Established via P1b/2 study in CTCL
• Over 90% of patients show rapid lesion improvement, most within two weeks

Broad heme malignancy IV program now in dose optimization

• 200+ patients treated to date across range of heme malignancies
• Monotherapy responses observed in CTCL, PTCL, DLBCL at low doses
• Dose optimization in CTCL currently in progress

Abbreviations: CR – Complete Response; RBC – Red Blood Cell; CTCL – Cutaneous T-Cell Lymphoma; PTCL – Peripheral T-Cell Lymphoma; DLBCL – Diffuse Large B-Cell Lymphoma; IV - Intravenous
CD47 Blockade Alone Not Sufficient; 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 is a Dual Function SIRPαFc Decoy Receptor that Delivers “Do Not Eat” and “Eat” Signals

Blocks the CD47
DO NOT EAT signal

Delivers an EAT signal through FcγRs

Macrophage Phagocytosis

Antigen Presentation & Adaptive Immunity
Unlike Most Other CD47 Agents, TTI-621 Does Not Bind to Red Blood Cells (RBCs)

TTI-621 does not bind human RBCs1

TTI-621 does not agglutinate human RBCs

Benefits of RBC avoidance

- Enables use of an IgG1 Fc (provides an activating signal to enable monotherapy)
- Reduces risk of anemia in patients
- Lowsers amount of drug required by avoiding massive antigen sink
- Does not interfere with transfusion medicine testing

1Results confirmed by independent group (Piccione et al. Clin. Cancer Res. 2016)
TTI-621 Demonstrated Clinical PoC via *Intratumoral* Injection in CTCL

- **Phase 1 dose escalation & expansion study**
  - Data from 22 response-evaluable CTCL patients shown in this presentation
  - NCT02890368

- **Dosing regimens evaluated**
  - Single dose injections @ 1, 3 or 10 mg
  - Multiple injections @ 10 mg 3x/wk for 1-2 wks
  - Induction regimen (10 mg 3x/wk for 2 wks) followed by discreional continuation therapy of weekly injection of 10 mg

- **Local injections very well tolerated**
  - No ≥Grade 3 AEs, SAEs or DLTs

- **Clear signal of monotherapy activity with rapid onset**
  - Rapid responses in both injected and adjacent lesions
  - Initial evidence of systemic response in distal lesions
  - Anecdotal evidence of 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*
TTI-621 Intratumoral Injections in CTCL Induce Rapid Lesion Reductions

Querfeld et al. ASH 2018

CAILS* Scores in CTCL Patients (N=22)
- 20 (91%) with decreased CAILS
- 9 (41%) with ≥50% reduction in CAILS

CAILS Decline Profile
- Within 2 weeks in most patients (incl. after single injection)
- At all dose levels
- In all stages IA to IVB
- In all lesion types

*CAILS - Composite Assessment of Index Lesion Severity, a measure of local lesion responses
Patient example: CTCL Patient Receiving Single Agent Intratumoral TTI-621 Therapy

- 76-year old female with Stage IIB transformed MF, who had received prior bexarotene and methotrexate treatments, achieved CAILS-based CR on target lesions by Week 15 and overall PR with -85% change in mSWAT by Week 23

- Rapid resolution was observed of the injected lesion on the calf and of distal, non-injected lesions on abdomen, left flank/back and arms.
Intravenous TTI-621 Shows Monotherapy Activity at Low Doses in Heme Malignancies; Dose Escalation is Ongoing

• Phase 1, multicenter, open-label study in relapsed/refractory hematologic malignancies (NCT02663518)
  o Over 200 patients dosed to date (Dec 2019)

• Dosing evolution after determining transient nature of the on-target AE thrombocytopenia (TC)
  o Initial MTD determined as 0.2 mg/kg based on conservative DLT definition of TC (Grade 4 of any duration)
  o TC subsequently shown to be transient and not associated with bleeding, resulting in the revision of TC DLT definition (Grade 4 lasting 72+ hours) and dose re-escalation beyond initial MTD
  o Now escalating dose up to 1.4 mg/kg (as of Jan 2020, dosing at 1.0 mg/kg)

• Objective responses (incl. CRs) observed at initial low dose levels (up to 0.5 mg/kg) with monotherapy

<table>
<thead>
<tr>
<th>Indication</th>
<th>DLBCL</th>
<th>CTCL</th>
<th>PTCL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response evaluable N</td>
<td>7</td>
<td>42</td>
<td>22</td>
</tr>
<tr>
<td>Objective response rate</td>
<td>29%</td>
<td>19%</td>
<td>18%</td>
</tr>
</tbody>
</table>

  o Only CD47 agent to show CRs with monotherapy
IV TTI-621 Dose Escalation Study Overview

Dosing (mg/kg)
- Monotherapy Indications
  - Lymphoma
    - Completed (N=18)
      - Identified initial MTD (0.2 mg/kg)
  - Heme Malignancies
    - Completed (N=158)
      - Signal seeking across a range of indications
- Combination Indications
  - CTCL, PTCL
    - Completed (N=42)**
      - Further efficacy evaluation in TCLs

Status (N)
- Under initial DLT criteria
  - (Grade 4 Thrombocytopenia of any duration)
    - Part 1: Dose Escalation
      - 0.05, 0.1, 0.2, 0.3
    - Part 2: Initial Expansion
      - 0.2 up to 0.5 (mono)*
      - 0.1 up to 0.5 (combo)*
    - Part 3: Focused Expansion
      - 0.2 ramp-up to 0.5

Data for CTCL, PLCL & DLBCL on following pages

Under revised DLT criteria
- (Grade 4 TC lasting 72+ hours)
  - Part 4: Dose Optimization
    - 0.5, 0.7, 1.0, 1.4

- Ongoing
  - Re-assess MTD under amended protocol

*Most patients dosed at 0.2 mg/kg; some patients dose-intensified up to 0.5 mg/kg per investigator discretion
**Simon 2-stage design study; Stage 1 completed; Stage 2 on hold and replaced with Part 4 dose escalation

• 0.5 & 0.7 dose cohorts completed
• 1.0 cohort ongoing (as of Jan ’20)
Thrombocytopenia is *Transient* and Not Associated with Bleeding

**TTI-621 Induced Thrombocytopenia**

- On-target effect resulting from CD47 blockade and the TTI-621 IgG1 Fc
- Reversible within a week
- Pre-dose platelet levels remained relatively stable over the study
- Transient platelet decreases did not lead to increased risk of bleeding or impact drug delivery (*1/179 patients had dosing discontinued due to thrombocytopenia*)

*Shou, T Cell Lymphoma Forum 2019*
IV TTI-621 is Well Tolerated

- Diverse patient population: AML, MDS, MPN, B-NHL, T-NHL, HL, MM, CLL, SCLC (N=218)
- Dose range: 0.05-0.5 mg/kg; most dosing exposure at 0.2 mg/kg
- Most frequent AEs were low-grade infusion related reactions and thrombocytopenia
- ≥ Grade 3 thrombocytopenia occurred in 21% patients

<table>
<thead>
<tr>
<th>Related Adverse Events n (%)</th>
<th>Adverse Event Grades</th>
<th>Adverse Events by Grade</th>
<th>Total n=218</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Grade 1-2</td>
<td>Grade ≥3</td>
<td></td>
</tr>
<tr>
<td>Patients with Related TEAE</td>
<td>93 (43)</td>
<td>84 (39)</td>
<td>177 (81)</td>
</tr>
<tr>
<td>Infusion related reaction</td>
<td>84 (39)</td>
<td>5 (2)</td>
<td>89 (41)</td>
</tr>
<tr>
<td>≥ 15% Thrombocytopenia</td>
<td>16 (7)</td>
<td>46 (21)</td>
<td>62 (28)</td>
</tr>
<tr>
<td>Chills</td>
<td>22 (10)</td>
<td>22 (10)</td>
<td>44 (20)</td>
</tr>
<tr>
<td>Fatigue</td>
<td>33 (15)</td>
<td>0</td>
<td>33 (15)</td>
</tr>
<tr>
<td>Anaemia</td>
<td>11 (5)</td>
<td>18 (8)</td>
<td>29 (13)</td>
</tr>
<tr>
<td>Pyrexia</td>
<td>24 (11)</td>
<td>1 (0.5)</td>
<td>25 (11)</td>
</tr>
<tr>
<td>Nausea</td>
<td>22 (10)</td>
<td>0</td>
<td>22 (10)</td>
</tr>
<tr>
<td>Diarrhoea</td>
<td>19 (9)</td>
<td>1 (0.5)</td>
<td>20 (9)</td>
</tr>
<tr>
<td>Neutropenia</td>
<td>3 (1)</td>
<td>15 (7)</td>
<td>18 (8)</td>
</tr>
<tr>
<td>Headache</td>
<td>7 (3)</td>
<td>8 (4)</td>
<td>15 (7)</td>
</tr>
<tr>
<td>Vomiting</td>
<td>15 (7)</td>
<td>0</td>
<td>15 (7)</td>
</tr>
<tr>
<td>Hypotension</td>
<td>12 (6)</td>
<td>1 (0.5)</td>
<td>13 (6)</td>
</tr>
<tr>
<td>WBC decreased</td>
<td>1 (0.5)</td>
<td>7 (3)</td>
<td>8 (4)</td>
</tr>
<tr>
<td>Decreased appetite</td>
<td>2 (1)</td>
<td>5 (2)</td>
<td>7 (3)</td>
</tr>
</tbody>
</table>

Source: 01 October 2019 data cut
## 621-IV Monotherapy Effect Observed Across Lymphoma Indications at Initial Low Doses up to 0.5 mg/kg

*In Patients receiving weekly doses of up to 0.5 mg/kg*

<table>
<thead>
<tr>
<th>Indication</th>
<th>Therapy</th>
<th>evaluable N</th>
<th>CR</th>
<th>PR</th>
<th>ORR</th>
</tr>
</thead>
<tbody>
<tr>
<td>CTCL - Mycosis Fungoides</td>
<td>621 mono</td>
<td>26</td>
<td>--</td>
<td>6 (23%)</td>
<td>6 (23%)</td>
</tr>
<tr>
<td>CTCL - Sézary Syndrome</td>
<td>621 mono</td>
<td>16</td>
<td>1 (6%)</td>
<td>1 (6%)</td>
<td>2 (13%)</td>
</tr>
<tr>
<td>PTCL</td>
<td>621 mono</td>
<td>22</td>
<td>2 (9%)</td>
<td>2 (9%)</td>
<td>4 (18%)</td>
</tr>
<tr>
<td>DLBCL</td>
<td>621 mono</td>
<td>7</td>
<td>1 (14%)</td>
<td>1 (14%)</td>
<td>2 (29%)</td>
</tr>
<tr>
<td>DLBCL</td>
<td>621 + Rtx</td>
<td>25</td>
<td>1 (4%)</td>
<td>5 (20%)</td>
<td>6 (24%)</td>
</tr>
</tbody>
</table>

Data cut: 01 Oct 2019
CTCL data
621 IV Monotherapy with Dosing up to 0.5 mg/kg

Patient characteristics

<table>
<thead>
<tr>
<th></th>
<th>CTCL</th>
</tr>
</thead>
<tbody>
<tr>
<td>N (enrolled)</td>
<td>50</td>
</tr>
<tr>
<td>% stage III+ at diagnosis</td>
<td>52%</td>
</tr>
<tr>
<td># prior systemic Tx, median (min-max)</td>
<td>5 (1-26)</td>
</tr>
</tbody>
</table>

Response data

<table>
<thead>
<tr>
<th>Resp. eval. N</th>
<th>Response, n (%)</th>
<th>CR</th>
<th>PR</th>
<th>ORR</th>
</tr>
</thead>
<tbody>
<tr>
<td>MF</td>
<td>26</td>
<td>--</td>
<td>6 (23%)</td>
<td>6 (23%)</td>
</tr>
<tr>
<td>SS</td>
<td>16</td>
<td>1 (6%)</td>
<td>1 (6%)</td>
<td>2 (13%)</td>
</tr>
<tr>
<td>Total</td>
<td>42</td>
<td>1 (2%)</td>
<td>7 (17%)</td>
<td>8 (19%)</td>
</tr>
</tbody>
</table>

Patient-level data

Best mSWAT Response by Maximum Dose and Tumor Type: n=38

- Mycosis Fungoides: n=23
- Sézary Syndrome: n=15

Source: 01Oct2019 data cut

All subjects started at 0.2 mg/kg; 4 subjects are not included due to missing mSWAT scores (PD 3, PR 1); 2 Sézary Syndrome subjects had 0% change in mSWAT score.
## PTCL data

### 621 IV Monotherapy with Dosing up to 0.5 mg/kg

### Patient characteristics

<table>
<thead>
<tr>
<th></th>
<th>PTCL</th>
</tr>
</thead>
<tbody>
<tr>
<td>N (enrolled)</td>
<td>32</td>
</tr>
<tr>
<td>% stage III+ at diagnosis</td>
<td>78%</td>
</tr>
<tr>
<td># prior systemic Tx, median (min-max)</td>
<td>3 (1-7)</td>
</tr>
</tbody>
</table>

### Response data

<table>
<thead>
<tr>
<th>Resp. eval. N</th>
<th>Response, n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CR</td>
</tr>
<tr>
<td>22</td>
<td>2</td>
</tr>
</tbody>
</table>

*Response evaluable

All subjects received 0.2 mg/kg starting dose; 1 subject (PD) was not included due to missing Cheson response measurement.

Source: 01Oct2019 data cut

All subjects received 0.2 mg/kg starting dose; 1 subject (PD) was not included due to missing Cheson response measurement.
DLBCL data - 621 IV Monotherapy and Rituximab Combination with Dosing up to 0.5 mg/kg

Patient characteristics

<table>
<thead>
<tr>
<th></th>
<th>621</th>
<th>621+Rtx</th>
</tr>
</thead>
<tbody>
<tr>
<td>N (enrolled)</td>
<td>9</td>
<td>28</td>
</tr>
<tr>
<td>% stage III+ at diagnosis</td>
<td>78%</td>
<td>79%</td>
</tr>
<tr>
<td># prior systemic Tx, median (min-max)</td>
<td>3 (2-8)</td>
<td>4 (2-10)</td>
</tr>
</tbody>
</table>

Response data

<table>
<thead>
<tr>
<th></th>
<th>Resp. eval. N</th>
<th>Response, n (%)</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>CR</td>
<td>PR</td>
<td>ORR</td>
<td></td>
</tr>
<tr>
<td>621</td>
<td>7</td>
<td>1 (14%)</td>
<td>1 (14%)</td>
<td>2 (29%)</td>
<td></td>
</tr>
<tr>
<td>621+Rtx</td>
<td>25</td>
<td>1 (4%)</td>
<td>5 (20%)</td>
<td>6 (24%)</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>32</td>
<td>2 (6%)</td>
<td>6 (19%)</td>
<td>8 (25%)</td>
<td></td>
</tr>
</tbody>
</table>

Source: 01Oct2019 data cut

Starting doses for single agent TTI-621 ranged from 0.05 to 0.3 mg/kg and for rituximab combination 0.1 mg/kg
A 69 year old female with Stage IVA Sézary Syndrome, who has failed prior systemic Bexarotene and Romidepsin treatments, achieved an overall PR at week 16 with a 57% decrease in mSWAT.
Even at Low Doses, IV TTI-621 Is the Only CD47 Agent Observing Meaningful Single Agent Responses

<table>
<thead>
<tr>
<th>N</th>
<th>TTI-621 (Trillium)</th>
<th>Hu5F9 (Forty Seven)</th>
<th>ALX148 (ALX Oncology)</th>
<th>CC-90002 (Celgene)</th>
<th>SRF231 (Surface Oncology)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ORR with MonoTx agents</td>
<td>18-29% ORR in B- and T-cell lymphomas at up to 0.5 mg/kg*</td>
<td>5% ORR in solid tumors and lymphomas at ≥20 mg/kg¹</td>
<td>0% ORR in solid tumors at ≥10 mg/kg³</td>
<td>Monotherapy study in AML/MDS terminated due to lack of efficacy, doses up to 4 mg/kg⁴</td>
<td>Monotherapy expansion phase discontinued⁵</td>
</tr>
</tbody>
</table>

Key Points

- TTI-621 exhibits superior monotherapy activity vs. other CD47-targeting agents
- TTI-621 activity is seen at up to 100x lower doses
- Competing programs focused on combinations

1⁰NCT02216409; Sikic, JCO 2019  
2⁰NCT03248479; ASCO 2019  
3⁰NCT03013218; Lakhani, ASCO 2018  
4⁰NCT02641002; Zeidan, ASH 2019  
5⁰NCT03512340; Surface Oncology strategic reset (Dec 2018)
Near-term TTI-621 Clinical Development Plan: Move to Combo Therapies in Major Heme Malignancy Indications

**Initial dose finding and signal seeking**
- Completed
- Monotherapy
- In wide range of heme malignancies

**Dose escalation under revised DLT criteria**
- Ongoing, expect to identify MTD in 2020
  - Monotherapy
  - In CTCL

**Phase 1b/2 combo studies in larger indications**
- In planning stages, expect to initiate new studies in 2020
- Primarily in combinations with other agents
- Focus on larger heme malignancy indications (AML/MDS, PTCL, other)
- Potential monotherapy expansion cohort in CTCL
Contents

- TTI-621 (SIRPα-IgG1Fc) CD47 program
- TTI-622 (SIRPα-IgG4Fc) CD47 program
- Corporate overview
TTI-622: A Potential Best-in-Class IgG4 CD47 Blocker
Differentiated by Lack of RBC Binding

Advantages of TTI-622 vs CD47 mAbs that bind RBCs:
• Reduced risk of anemia
• Avoids massive antigen sink – lowers amount of drug required
• Non-interference with transfusion medicine testing
TTI-622 Clinical Study: Four Dose Level Cohorts Completed – No DLTs, SAEs or Grade 3+ Anemia & Thrombocytopenia Observed

- Phase 1, multicenter, open-label study in relapsed/refractory lymphoma or myeloma (NCT003530683)

- 3+3 dose monotherapy escalation in progress in lymphoma patients
  - Four dose level cohorts (0.02-2 mg/kg) now completed – no DLTs or SAEs observed; no drug-related ≥Grade 3 anemia and thrombocytopenia reported
  - Fifth cohort (4 mg/kg) currently enrolling
  - One partial response (PR) observed in a DLBCL patient (0.8 mg/kg cohort)

- TTI-622 to be developed in combination with other agents

- Expect to identify MTD or recommended Phase 2 dose in 2020
• TTI-621 (SIRPα-IgG1Fc) CD47 program

• TTI-622 (SIRPα-IgG4Fc) CD47 program

• Corporate overview
Highly Experienced Management Team and Directors

**Management Team**

- **Jan Skvarka, PhD**
  - Chief Executive Officer
- **Yaping Shou, MD PhD**
  - Chief Medical Officer
- **Bob Uger, PhD**
  - Chief Scientific Officer
- **James Parsons**
  - Chief Financial Officer
- **Penka Petrova, PhD**
  - Chief Development Officer
- **Kathleen Large**
  - SVP, Clinical Operations

**Board of Directors**

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Previous Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Robert Kirkman, MD</td>
<td>Executive Chair; Former CEO, Oncothyreon</td>
<td>Former CEO, Piramed</td>
</tr>
<tr>
<td>Jan Skvarka, PhD</td>
<td>CEO, Trillium</td>
<td></td>
</tr>
<tr>
<td>Calvin Stiller, OC, MD</td>
<td>Chair and Founder, OICR</td>
<td></td>
</tr>
<tr>
<td>Luke Beshar</td>
<td>Former CFO, NPS Pharma</td>
<td></td>
</tr>
<tr>
<td>Michael Moore, PhD DSc</td>
<td>Former CEO, Piramed</td>
<td></td>
</tr>
<tr>
<td>Thomas Reynolds, MD PhD</td>
<td>Former CMO, Seattle Genetics</td>
<td></td>
</tr>
<tr>
<td>Helen Tayton-Martin, PhD</td>
<td>CBO, Adaptimmune</td>
<td></td>
</tr>
<tr>
<td>Bob Uger, PhD</td>
<td>CSO, Trillium</td>
<td></td>
</tr>
</tbody>
</table>
## Comprehensive IP, Including Granted Composition of Matter Patents Expiring in Dec 2033+

### 1. Composition of Matter

<table>
<thead>
<tr>
<th></th>
<th>Granted in US, Europe, Japan, China, Australia; Expiring Dec 2033+ Pending in Canada</th>
</tr>
</thead>
<tbody>
<tr>
<td>• TTI-621</td>
<td></td>
</tr>
<tr>
<td>• TTI-622</td>
<td>Pending</td>
</tr>
</tbody>
</table>

### 2. Method of Use

<table>
<thead>
<tr>
<th></th>
<th>Use of SIRPαFc fusion proteins to treat hematologic cancers</th>
<th>US, Europe, China on appeal Granted in Japan, Canada, Australia</th>
</tr>
</thead>
</table>

### 3. Combinations

- Macrophage stimulation
- T cell checkpoint inhibitors
- HDAC inhibitors
- Proteasome inhibitors
- Radiation therapy
- anti-CD38 antibody
- anti-EGFR antibody
- Others (not disclosed)

### 4. Biomarkers

- Biomarkers for CD47 blockade

---

Pending
2020 – Key Milestones

- **TTI-621**
  - Expect to identify MTD or determine RP2D*
  - Provide study update no later than mid-2020
  - Initiate at least one study in larger heme malignancy indication

- **TTI-622**
  - Expect to identify MTD or determine RP2D
  - Provide study update no later than mid-2020

- **STING**
  - Out-license the program in 1H 2020

*MTD – Maximum Tolerated Dose; RP2D – Recommended Phase 2 Dose
Contact Information

Jan Skvarka, PhD
Chief Executive Officer
+1-857-412-7029 x221
jan@trilliumtherapeutics.com

James Parsons
Chief Financial Officer
+1-416-595-0627 x232
james@trilliumtherapeutics.com