Corporate Overview
October 8, 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 severity, duration and spread of the COVID-19 outbreak, as well as the direct and indirect impacts that the pandemic may have on our operations; 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 40-F for the year ended December 31, 2019 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

• **Leading next generation immuno-oncology player**, with focus on CD47 target, an innate immune system checkpoint

• **Two highly differentiated CD47 assets, with best-in-class monotherapy activity** demonstrated across multiple heme malignancy indications and lack of RBC* binding

• **Broad transformation program** under new leadership, including strategy reset with focus on large heme malignancies and solid tumors

• **Strong healthcare focused investor base**, incl. strategic investment from Pfizer; approximately $290M in cash

*RBC – Red Blood Cell
Transformation Program Under New CEO
Priorities and progress since September 2019

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

2. **Revise strategy & portfolio priorities**
   Discontinued lead intratumoral (IT) program in CTCL; refocused on IV programs in large heme malignancy indications and exploratory IT effort in solid tumors
   - Completed (Nov-Dec 2019)

3. **Secure funding**
   Raised ~$300M from top healthcare investors and Pfizer
   - Completed (Jan & Sep 2020)

4. **Ensure execution of ongoing clinical studies**
   Reallocated resources to existing 621 & 622 dose escalation studies
   - In progress

5. **Strengthen the organization and key capabilities**
   Rotated two board members; forming SAB & KOL panels; scaling up the org.
   - In progress
Progress Over Past Three Months

Announced:

**TTI-622**
SIRPα-IgG4 Fc

- Completed safety evaluation of 8 mg/kg cohort; now escalating to 12 mg/kg
- No significant safety signals observed
- 6/18 (33%) objective responses at doses 0.8-8.0 mg/kg, incl. 3/6 (50%) at 8.0 mg/kg
  - 1 CR + 5 PRs; in highly R/R patients (3-9 prior systemic therapies); all responses observed at first response assessment at 8 wks; across multiple lymphoma indications; monotherapy
- Dose dependent increases in serum exposure support dose escalation beyond 8 mg/kg

**TTI-621**
SIRPα-IgG1 Fc

- Completed safety evaluation of 1.4 mg/kg cohort; now escalating to 2.0 mg/kg*
- No significant safety signals observed*
- 1 PR + 1 skin CR out of 6 CTCL patients at 1.0 mg/kg observed; dose dependent improvement in skin disease score (mSWAT); monotherapy
- Dose dependent increases in serum exposure support dose escalation beyond 1.4 mg/kg

*Previously reported on July 30, 2020
Progress Over Past Three Months (continued)

**Announced:**

- **Sep 8**
  - **Pfizer Investment**
  - $25M equity investment in common stock
  - Dr. Jeff Settleman, Pfizer Oncology CSO, to join Trillium SAB (currently being formed)
  - Trillium retains all product rights

- **Sep 10**
  - **Fundraising**
  - Raised $150M in a public follow-on offering
  - Approximately $290M in cash and cash equivalents as of September 10

- **Sep 18**
  - **Governance**
  - Mike Kamarck, PhD, biologics manufacturing industry veteran, joins Board of Directors
    - Currently Chief Technology, Officer, Vir Biotechnology
    - SVP Global Vaccines and Biologics Manufacturing & President Merck BioVentures, Merck
    - President, Technical Operations and Product Supply, Wyeth

- **Oct 5**
  - **Intellectual Property**
  - Allowance received for the use of SIRPaFc to treat hematologic and solid tumors (method of use patent)
  - Allowance received for a TTI-622 composition of matter patent

*Previously reported on July 30, 2020*
## Pipeline Overview

<table>
<thead>
<tr>
<th>Target</th>
<th>Candidate</th>
<th>Indication</th>
<th>Discovery</th>
<th>Preclinical</th>
<th>Early Stage Development</th>
<th>Late Stage Development</th>
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<tbody>
<tr>
<td>CD47 – INNATE IMMUNE CHECKPOINT</td>
<td>TTI-621</td>
<td>Heme malignancies</td>
<td>DISCOVERY</td>
<td>PRECLINICAL</td>
<td>EARLY STAGE DEVELOPMENT</td>
<td>LATE STAGE DEVELOPMENT</td>
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<td>TTI-621</td>
<td>Solid Tumors</td>
<td>DISCOVERY</td>
<td>PRECLINICAL</td>
<td>EARLY STAGE DEVELOPMENT</td>
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<td>Heme malignancies</td>
<td>DISCOVERY</td>
<td>PRECLINICAL</td>
<td>EARLY STAGE DEVELOPMENT</td>
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<td>TTI-622</td>
<td>Solid Tumors</td>
<td>DISCOVERY</td>
<td>PRECLINICAL</td>
<td>EARLY STAGE DEVELOPMENT</td>
<td>LATE STAGE DEVELOPMENT</td>
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</table>
Upcoming Milestones

• Provide data updates for TTI-621 & 622 at ASH 2020

• Expect to identify MTD/RP2D* for TTI-621 & 622 in 4Q20-1H21, subject to potential Covid-19 related delays & nature of dose selection uncertainties

• Initiate new clinical studies in 2021, with the following priorities:
  o Heme malignancies: P1b/2 studies in AML/MDS, multiple myeloma, PTCL, DLBCL
  o Solid tumors: P1 signal seeking study/ies

*MTD – Maximum Tolerated Dose; RP2D – Recommended Phase 2 Dose
• CD47 landscape and Trillium differentiation

• TTI-621 (SIRPα-IgG1Fc) CD47 program

• TTI-622 (SIRPα-IgG4Fc) CD47 program

• IP and team
Tumors Use CD47 “Don’t Eat Me” Signal to Evade Destruction by Innate Immune System

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

CD47 blockade emerging as a next-generation checkpoint inhibitor strategy in immuno-oncology
Macrophage Activation Requires CD47 Blockade and Delivery of an Eat Signal

- CD47 blockade alone is not sufficient to trigger macrophage anti-tumor activity
- Macrophages must also receive an “eat” (pro-phagocytic) signal
- IgG1 Fc delivers a strong “eat” signal, IgG4 Fc a moderate signal
TTI-621 and TTI-622: Two Novel CD47 Blocking Agents that Deliver Different “Eat” Signals

**Shared Properties**
- Do not bind RBCs
- Monotherapy activity demonstrated in lymphoma patients
- Half the size of an antibody

**TTI-621** (SIRPα-IgG1 Fc)
- **SIRPα domain:** Blocks CD47 DON’T EAT ME signal
- **IgG1 Fc:** Delivers strong EAT signal

**TTI-622** (SIRPα-IgG4 Fc)
- **IgG4 Fc:** Delivers moderate EAT signal
Trillium Molecules Are Differentiated by 1) Monotherapy Activity; 2) Lack of RBC Binding; 3) Lower Molecular Weight

<table>
<thead>
<tr>
<th>Candidate</th>
<th>TTI-621</th>
<th>TTI-622</th>
<th>Magrolimab</th>
<th>ALX148</th>
<th>Lemzoparlimab</th>
<th>AO-176</th>
<th>TG-1801</th>
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<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>
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<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>
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<td>Mol. weight (approx.)</td>
<td>75 kD</td>
<td>75 kD</td>
<td>150 kD</td>
<td>75 kD</td>
<td>150 kD</td>
<td>150 kD</td>
<td>150 kD</td>
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<tr>
<td>RBC binding</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Minimal</td>
<td>Minimal</td>
<td>No</td>
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<tr>
<td>Monotherapy / incl. CR</td>
<td>Yes / Yes</td>
<td>Yes / Yes</td>
<td>Yes / No</td>
<td>No / No</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
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<td>Development stage</td>
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<td>P3</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

- Other companies with clinical stage CD47-targeting agents: ImmuneOncia, Innovent, Jiangsu Hengrui, Kahr Medical, Shattuck Labs, Zai Lab
- Companies with discontinued CD47 programs: Celgene, Seattle Genetics, Surface Onc.
Unlike Most Other CD47 Agents, TTI-621 & 622 Do Not Bind to Red Blood Cells (RBCs)

TTI-621 and TTI-622 do not bind human RBCs¹

Benefits of RBC avoidance

- Reduces risk of anemia in patients
- Lowers 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)

Even at Low Doses, TTI-621 & 622 Are Showing Best-in-Class Single Agent Response Rates in the CD47 Field

<table>
<thead>
<tr>
<th>Agent</th>
<th>Indication</th>
<th>ORR at doses</th>
<th>Notes</th>
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</thead>
<tbody>
<tr>
<td>TTI-621</td>
<td>Lymphomas</td>
<td>18-29%</td>
<td>*Further dose escalation ongoing (now dosing at 2.0 mg/kg)</td>
</tr>
<tr>
<td>(Trillium)</td>
<td>up to 0.5 mg/kg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TTI-622</td>
<td>Lymphomas</td>
<td>33%</td>
<td>*Further dose escalation ongoing (now dosing at 12.0 mg/kg)</td>
</tr>
<tr>
<td>(Trillium)</td>
<td>0.8-8.0 mg/kg*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Magrolimab</td>
<td>Lymphomas</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>(Gilead)</td>
<td>up to 30 mg/kg</td>
<td></td>
<td>*Further dose escalation ongoing (now dosing at 2.0 mg/kg)</td>
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<tr>
<td>ALX148</td>
<td>AML/ MDS</td>
<td>0%</td>
<td>ORR in solid tumors at ≥10 mg/kg³</td>
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<tr>
<td>(ALX Oncology)</td>
<td></td>
<td></td>
<td>MonoTx study in AML/MDS terminated due to lack of efficacy, doses up to 4 mg/kg⁴</td>
</tr>
<tr>
<td>CC-90002</td>
<td>solid tumors</td>
<td>5% Nov. 18</td>
<td></td>
</tr>
<tr>
<td>(Celgene)</td>
<td>AML/MDS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SRF231</td>
<td>Monotherapy</td>
<td>0%</td>
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<tr>
<td>(Surface Onc.)</td>
<td></td>
<td></td>
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1NCT02216409; Sikic, JCO 2019
2NCT03013218; Lakhani, ASCO 2018
3NCT03512340; Surface Oncology strategic reset (Dec 2018)
4NCT02641002; Zeidan, ASH 2019
5NCT03248479; ASCO 2019

ORR with Monotherapy by Agent & Indication(s)
• CD47 landscape and Trillium differentiation

• TTI-621 (SIRPα-IgG1Fc) CD47 program

• TTI-622 (SIRPα-IgG4Fc) CD47 program

• IP and team
• Clinical **proof-of concept of bioactivity** established by intratumoral dosing in CTCL patients

• Intravenous TTI-621 is being **evaluated in a four-part phase 1 study** in patients with **relapsed/refractory hematologic malignancies** (NCT02663518)
  - Part 1: Dose escalation identified initial MTD (0.2 mg/kg) based on conservative thrombocytopenia DLT definition (Grade 4 of any duration)
  - Parts 2-3: Expansion with further dosing up to 0.5 mg/kg
  - Part 4 (ongoing): Dose optimization beyond 0.5 mg/kg based on revised thrombocytopenia DLT definition (Grade 4 >72 hrs) in cutaneous T-cell lymphoma (CTCL)

• TTI-621 **well tolerated**; most common AEs are IRRs and transient thrombocytopenia

• **Single agent activity** observed across different lymphoma indications (DLBCL, PTCL, CTCL)

• Currently dosing at 2 mg/kg - 10x the initial MTD
**Intratumoral** TTI-621 Injections in CTCL Induce Rapid Lesion Reductions and Provide Initial PoC of Bioactivity

- **Phase 1 dose escalation & expansion study**
  - R/R CTCL; N=22 response-evaluable patients
  - 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) + continuation Tx of weekly 10 mg injections

- **Patient example**

  85M with stage IIB MF with large cell transformation who failed 4 prior systemic therapies, PUVA & radiation; received a **single 10 mg injection** of TTI-621

  **CTCL: Overall CAILs Score Decrease**

  *Injections across 2 or 3 lesions; all other patients received injection(s) in a single lesion
  † received TTI-621 + IFNo2a maintenance

  *CAILS - Composite Assessment of Index Lesion Severity, a measure of local lesion responses

  Querfeld et al. ASH 2017
**Intravenous** TTI-621 Dose Escalation Study Overview

**Dosing (mg/kg)**
- Monotherapy
  - Lymphoma: 0.05, 0.1, 0.2, 0.3
- Combination
  - Heme Malignancies: 0.2 up to 0.5 (mono)*
  - Lymphoma: 0.2 ramp-up to 0.5

**Monotherapy Indications**
- Lymphoma
- CD20+ NHL (rituximab)

**Combination Indications**
- Lymphoma: 0.1 up to 0.5 (combo)*
- Heme Malignancies: 0.2 up to 0.5 (mono)*

**Status (N)**
- Part 1: Dose Escalation
  - Completed (N=18) Identified initial MTD (0.2 mg/kg)
- Part 2: Initial Expansion
  - Completed (N=158) Signal seeking across a range of indications
- Part 3: Focused Expansion
  - Completed (N=42)** Further efficacy evaluation in TCLs
- Part 4: Dose Optimization
  - Ongoing Re-assess MTD under amended protocol

**Under initial DLT criteria** (Grade 4 Thrombocytopenia of any duration)
- Part 1: Dose Escalation
- Part 2: Initial Expansion
- Part 3: Focused Expansion

**Under revised DLT criteria** (Grade 4 TC lasting 72+ hours)
- Part 4: Dose Optimization

*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

Data for CTCL, PTCL & DLBCL on following pages

- 0.5-1.4 mg/kg cohorts completed
- Dosing at 2.0 mg/kg ongoing (Sep ‘20)
Thrombocytopenia is *Transient* and Not Associated with Bleeding (*Parts 1-3 & Part 4 data*)

**TTI-621 Induced Thrombocytopenia**

- On-target effect resulting from CD47 blockade and TTI-621 IgG1 Fc
- Reversible within a week; recovery pattern consistent between Parts 1-3 and Part 4
- No apparent dose dependency in platelet decreases with doses from 0.2 – 1.4 mg/kg
- No increased risk of bleeding or impact on drug delivery
- Only 1/214 (Parts 1-3) and 0/15 (Part 4) patients had dosing discontinued due to thrombocytopenia

Data cutoff: 22 Jun 2020
TTI-621 is Well Tolerated

(Parts 1-3 vs Part 4 data)

- **Parts 1-3:**
  - Multiple heme indications: AML, MDS, MPN, B-NHL, T-NHL, HL, MM, CLL (N=214)
  - Dose range: 0.05-0.5 mg/kg; most patients dosed at 0.2 mg/kg

- **Part 4:**
  - Single indication: CTCL patients (N=15)
  - Dose range: 0.5, 0.7, 1.0 and 1.4 mg/kg

- **Most frequent AEs in Part 4:**
  - IRR (Gr≥3, 13%), managed by prolonged infusion time and steroid pre-medication at initial infusions only; 1 Gr3 IRR DLT at 1.0 mg/kg
  - Thrombocytopenia (Gr≥3, 13%) – no DLTs observed

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### Related Adverse Events

<table>
<thead>
<tr>
<th>Related Adverse Events</th>
<th>Parts 1-3 n=214</th>
<th>Part 4 n=15</th>
<th>Total N=229</th>
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<tbody>
<tr>
<td>Grade</td>
<td>1-2</td>
<td>3-4</td>
<td>1-2</td>
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<tr>
<td>IRR (Infusion Related Reaction)</td>
<td>90 (42)</td>
<td>3 (1)</td>
<td>8 (53)</td>
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<td>≤30% Thrombocytopenia</td>
<td>24 (11)</td>
<td>41 (19)</td>
<td>1 (7)</td>
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<tr>
<td>≥20% Chills</td>
<td>47 (22)</td>
<td>2 (13)</td>
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<tr>
<td>≤20% Fatigue</td>
<td>33 (15)</td>
<td>2 (1)</td>
<td>1 (7)</td>
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<tr>
<td>Anaemia</td>
<td>14 (7)</td>
<td>16 (7)</td>
<td></td>
</tr>
<tr>
<td>Pyrexia</td>
<td>25 (12)</td>
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<td>1 (7)</td>
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<tr>
<td>Nausea</td>
<td>23 (11)</td>
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<td>2 (13)</td>
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<tr>
<td>≤10% Diarrhoea</td>
<td>19 (9)</td>
<td>1 (0.5)</td>
<td>2 (13)</td>
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<tr>
<td>Neutropenia</td>
<td>5 (2)</td>
<td>14 (7)</td>
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<tr>
<td>Headache</td>
<td>16 (7)</td>
<td></td>
<td>1 (7)</td>
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<tr>
<td>Vomiting</td>
<td>14 (7)</td>
<td>1 (0.5)</td>
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<td>Hypotension</td>
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<td>Decreased Appetite</td>
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<td>Creatinine increased</td>
<td>8 (4)</td>
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<td>Leukopenia</td>
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<td>Dizziness</td>
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<td>Dyspnoea</td>
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<td>1 (7)</td>
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<tr>
<td>AST increased</td>
<td>5 (2)</td>
<td>1 (0.5)</td>
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As of 10 July 2020
### Monotherapy Activity Demonstrated Across Indications; Preliminary Data Suggest Dose-Dependent Improvement in Skin Disease Scores (mSWAT)

<table>
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<tr>
<th>Indication</th>
<th>Dose (mg/kg)</th>
<th>N*</th>
<th>Response assessment</th>
<th>Notes</th>
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<td></td>
<td></td>
<td></td>
<td>CR</td>
<td>PR</td>
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<tr>
<td>DLBCL</td>
<td>Up to 0.5</td>
<td>7</td>
<td>1 (14%)</td>
<td>1 (14%)</td>
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<tr>
<td>PTCL</td>
<td>Up to 0.5</td>
<td>22</td>
<td>2 (9%)</td>
<td>2 (9%)</td>
</tr>
<tr>
<td>CTCL</td>
<td>Up to 0.5</td>
<td>45</td>
<td>1 (2%)</td>
<td>7 (16%)</td>
</tr>
<tr>
<td></td>
<td>0.7</td>
<td>3</td>
<td>0 (0%)</td>
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<tr>
<td></td>
<td>1.0</td>
<td>6</td>
<td>0 (0%)</td>
<td>1 (17%)</td>
</tr>
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</table>

Note: 1.4 mg/kg cohort response assessment data not yet available
*Response evaluable patients; **Overall assessment SD; # For patients treated at 0.5 mg/kg in Part 4 (N=3)

- First CD47 blocking agent to demonstrate monotherapy CRs
- Clinical activity seen in heavily pretreated patients (systemic therapies: median 3, range 1-12)
- Activity seen across multiple lymphoma indications
- Dose-dependent improvement in skin disease scores (mSWAT) observed in Part 4
Emerging TTI-621 Profile

- **Monotherapy activity** => (i) de-risk program; (ii) stronger foundation for combination therapies, including with PD-1

- **Well tolerated** => no anemia (no RBC binding); transient thrombocytopenia, IRRs

- **Potential solid tumor advantage** ... half molecular weight of mAbs

- **Very low dose** ... today 2 mg/kg vs. other CD47 blockers up to 30 mg/kg
• CD47 landscape and Trillium differentiation

• TTI-621 (SIRPα-IgG1Fc) CD47 program

• TTI-622 (SIRPα-IgG4Fc) CD47 program

• IP and team
TTI-622 Highlights

- **26 patients dosed** in ongoing dose escalation study in **R/R lymphomas** with **doses up to 8.0 mg/kg**
- **No significant safety signals** observed at doses up to 8 mg/kg
  - One DLT of Gr 4 thrombocytopenia at 8 mg/kg in 6 evaluable patients; no clinical sequelae
- Observed **6/18 (33%) objective responses** at doses 0.8-8 mg/kg (Cohorts 3-6), **including 3/6 (50%) at 8 mg/kg**
  - 1 CR + 5 PRs
  - In highly R/R patients, with 3 to 9 prior systemic therapies
  - Across dose levels: 1/4 (25%) responders at each of 0.8, 2.0 and 4.0 mg/kg doses, and 3/6 (50%) responders at 8 mg/kg
  - Across multiple indications: DLBCL, CTCL with LCT, PTCL and FL*
  - All responses observed at **first response assessment** at 8 weeks
- **Dose dependent increases in serum exposure** support dose escalation beyond 8 mg/kg
- **Now dosing at 12 mg/kg**

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*Abbreviations: DLBCL – Diffuse Large B Cell Lymphoma; PTCL – Peripheral T Cell Lymphoma; CTCL w/ LCT – Cutaneous T Cell Lymphoma with Large Cell Transformation; FL – Follicular Lymphoma*
TTI-622-01 Study Overview

- NCT03530683
- TTI-622 monotherapy
- Weekly infusions
- Treat to progression
- Advanced R/R all-comer lymphomas
- Response assessment per Lugano criteria
- 3+3 escalation schema
No Significant Safety Signals Observed

Adverse Events (AEs) in ≥2 Patients By Grade (Cohorts 1-6)

- Overall low incidence of AEs; related Gr≥3 AEs limited to hematologic AEs occurring in 4/26 patients
- In Cohort 6 (8 mg/kg, N=6):
  - DLT: Gr 4 thrombocytopenia with prophylactic platelet transfusion in 1 patient (patient resumed study at 4mg/kg)
  - Gr3 neutropenia/Gr3 anemia in 1 patient who received 2 doses of TTI-622 and disease progressed shortly after; causality confounded
- The DLT event (Gr4 thrombocytopenia) is the only related SAE reported to date

<table>
<thead>
<tr>
<th>Adverse Events</th>
<th>Related</th>
<th>All</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>n (%)</td>
<td>Gr 1-2</td>
<td>Gr 3-4</td>
<td></td>
</tr>
<tr>
<td>Thrombocytopenia</td>
<td>3 (12)</td>
<td>1 (4)</td>
<td>7 (27)</td>
</tr>
<tr>
<td>Constipation</td>
<td>6 (23)</td>
<td>6 (23)</td>
<td></td>
</tr>
<tr>
<td>Nausea</td>
<td>6 (23)</td>
<td>6 (23)</td>
<td></td>
</tr>
<tr>
<td>Fatigue</td>
<td>3 (12)</td>
<td>4 (15)</td>
<td></td>
</tr>
<tr>
<td>Pain</td>
<td>3 (12)</td>
<td>1 (4)</td>
<td>4 (15)</td>
</tr>
<tr>
<td>Abdominal pain</td>
<td>2 (8)</td>
<td>3 (12)</td>
<td>5 (19)</td>
</tr>
<tr>
<td>Back pain</td>
<td>1 (4)</td>
<td>3 (12)</td>
<td>4 (15)</td>
</tr>
<tr>
<td>Diarrhoea</td>
<td>3 (12)</td>
<td>3 (12)</td>
<td>6 (23)</td>
</tr>
<tr>
<td>Fall</td>
<td>3 (12)</td>
<td>3 (12)</td>
<td>6 (23)</td>
</tr>
<tr>
<td>Insomnia</td>
<td>3 (12)</td>
<td>3 (12)</td>
<td>6 (23)</td>
</tr>
<tr>
<td>Leukocytosis</td>
<td>1 (4)</td>
<td>3 (12)</td>
<td>4 (15)</td>
</tr>
<tr>
<td>Neutropenia</td>
<td>3 (12)</td>
<td>3 (12)</td>
<td>6 (23)</td>
</tr>
<tr>
<td>Pruritus</td>
<td>2 (8)</td>
<td>3 (12)</td>
<td>5 (19)</td>
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<tr>
<td>Pyrexia</td>
<td>1 (4)</td>
<td>3 (12)</td>
<td>4 (15)</td>
</tr>
<tr>
<td>ALP increased</td>
<td>2 (8)</td>
<td>2 (8)</td>
<td>4 (15)</td>
</tr>
<tr>
<td>ALT increased</td>
<td>1 (4)</td>
<td>1 (4)</td>
<td>2 (8)</td>
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<tr>
<td>Anaemia</td>
<td>1 (4)</td>
<td>1 (4)</td>
<td>2 (8)</td>
</tr>
<tr>
<td>AST Increased</td>
<td>1 (4)</td>
<td>1 (4)</td>
<td>2 (8)</td>
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<tr>
<td>Cellulitis</td>
<td>2 (8)</td>
<td>2 (8)</td>
<td>4 (15)</td>
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<tr>
<td>Creatinine increased</td>
<td>2 (8)</td>
<td>2 (8)</td>
<td>4 (15)</td>
</tr>
<tr>
<td>Decreased appetite</td>
<td>1 (4)</td>
<td>2 (8)</td>
<td>3 (12)</td>
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<tr>
<td>Dyspnoea</td>
<td>1 (4)</td>
<td>1 (4)</td>
<td>2 (8)</td>
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<tr>
<td>Dysuria</td>
<td>2 (8)</td>
<td>2 (8)</td>
<td>4 (15)</td>
</tr>
<tr>
<td>Headache</td>
<td>1 (4)</td>
<td>2 (8)</td>
<td>2 (8)</td>
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<tr>
<td>Hypotension</td>
<td>2 (8)</td>
<td>1 (4)</td>
<td>3 (12)</td>
</tr>
<tr>
<td>Night sweats</td>
<td>2 (8)</td>
<td>2 (8)</td>
<td>4 (15)</td>
</tr>
<tr>
<td>Peripheral swelling</td>
<td>2 (8)</td>
<td>2 (8)</td>
<td>4 (15)</td>
</tr>
<tr>
<td>Rash</td>
<td>1 (4)</td>
<td>2 (8)</td>
<td>3 (12)</td>
</tr>
</tbody>
</table>

As of August 14, 2020

Additional related adverse events occurring in 1 patient each included infusion related reaction and LDH increased, both Gr 1-2 intensity

Platelet levels, by patient

Cohort 4  Cohort 5  Cohort 6
Substantial Monotherapy Activity Demonstrated Across Dose Levels and Indications

<table>
<thead>
<tr>
<th>Cohort &amp; dose</th>
<th>ORR</th>
<th>Responder characteristics</th>
<th>Indication</th>
<th>Prior lines of therapy</th>
<th>Best response</th>
<th>First response</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.8 mg/kg</td>
<td>1/4 (25%)</td>
<td>DLBCL</td>
<td>4</td>
<td>CR</td>
<td>PR wk 8</td>
<td>CR wk 36</td>
</tr>
<tr>
<td>2.0 mg/kg</td>
<td>1/4 (25%)</td>
<td>PTCL</td>
<td>7</td>
<td>PR</td>
<td>Wk 8</td>
<td></td>
</tr>
<tr>
<td>4.0 mg/kg</td>
<td>1/4 (25%)</td>
<td>DLBCL</td>
<td>5</td>
<td>PR</td>
<td>Wk 8</td>
<td></td>
</tr>
<tr>
<td>8.0 mg/kg</td>
<td>3/6* (50%)</td>
<td>CTCL w/ LCT</td>
<td>4</td>
<td>PR</td>
<td>Wk 8</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>FL</td>
<td>3</td>
<td>PR</td>
<td>Wk 8</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CTCL w/ LCT</td>
<td>9</td>
<td>PR</td>
<td>Wk 8</td>
<td></td>
</tr>
</tbody>
</table>

- **33% (6/18) ORR** at combined doses of 0.8 to 8.0 mg/kg, and 50% (3/6) at 8.0 mg/kg
- **Heavily pretreated patients** with 3-9 prior lines of therapy in responders
- **Broad therapeutic window** - responses at 0.8 to 8 mg/kg
- **Across multiple lymphoma indications**
- **Fast onset of action** – all responses observed at first assessment at wk 8
- **Response durability being evaluated**

*Cohort 6 enrolled 7 patients, of which 6 were DLT evaluable – as of Sep 8, only 6 patients had response assessment
Abbreviations: DLBCL – Diffuse Large B Cell Lymphoma; PTCL – Peripheral T Cell Lymphoma; CTCL w/ LCT – Cutaneous T Cell Lymphoma with Large Cell Transformation; FL – Follicular Lymphoma
Responder example: CR in DLBCL Patient Post 4 Prior Therapies

- **78 y/o male with non-GCB DLBCL**
- **Prior lines of therapy:**
  1. R-EPOCH/R-CEOP,
  2. PI3Kd inhibitor,
  3. Syk inhibitor,
  4. IRAK4 inhibitor
- **Dose 0.8 mg/kg**
- **Achieved PR Weeks 8, 16, 24 and CR Weeks 36, 48**
- **Treatment ongoing for 16 mths**
Dose Dependent Increases in TTI-622 Serum Exposure Support Continued Dose Escalation Beyond 8 mg/kg

- Dose dependent increase in TTI-622 serum exposure
  - Following a single IV infusion (figure below)
  - Following weekly dosing (data not shown)
  - No plateau in dose-exposure relationship up to 8 mg/kg

Mean TTI-622 Serum Concentration Profiles
Week 1 - Single Infusion

- Dose dependent increase in serum trough levels
- Steady state TTI-622 serum exposures likely not reached until week 5+
- Implied effective half-life minimally 3 days and as long as 6-7 days

Summary based on available preliminary data as of August 4th, 2020
Emerging TTI-622 Profile

• **Monotherapy activity** => (i) de-risk program; (ii) stronger foundation for combination therapies, including with PD-1

• **Strong safety profile** ... no RBC binding => no anemia

• **Potential solid tumor advantage** ... half molecular weight of mAbs

• **Low dose** ... today at 12 mg/kg vs. other CD47 blockers up to 30
• CD47 landscape and Trillium differentiation

• TTI-621 (SIRPα-IgG1Fc) CD47 program

• TTI-622 (SIRPα-IgG4Fc) CD47 program

• IP and team
Comprehensive IP, Including Granted Composition of Matter Patents Expiring in 2037-38 (incl. PTE)

### Composition of Matter

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong></td>
<td><strong>2</strong></td>
</tr>
<tr>
<td><strong>1.</strong> TTI-621</td>
<td><strong>2.</strong> Method of Use</td>
</tr>
<tr>
<td>Granted in US, EU, Japan, China, AUS, HK Expiring Dec. 2033 plus ~4 yrs PTE Pending in Canada</td>
<td><strong>SIRPαFc fusion proteins to treat heme and solid tumors</strong></td>
</tr>
<tr>
<td>TTI-622</td>
<td>Granted in JAP, CAN, AUS</td>
</tr>
<tr>
<td>Allowed in US, granted in Japan Pending in others above</td>
<td>Allowed in US</td>
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<tr>
<td>Pending in Canada</td>
<td>On appeal in EU</td>
</tr>
<tr>
<td><strong>3.</strong> Combinations</td>
<td><strong>4.</strong> Biomarkers</td>
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<tr>
<td><strong>4.</strong> Additional applications pending in US, Europe and others</td>
<td><strong>Biomarkers for CD47 blockade</strong></td>
</tr>
<tr>
<td><strong>5.</strong> Macrophage stimulation</td>
<td>Pending</td>
</tr>
<tr>
<td><strong>6.</strong> T cell checkpoint inhibitors</td>
<td><strong>7.</strong> HDAC inhibitors</td>
</tr>
<tr>
<td><strong>8.</strong> Proteasome inhibitors</td>
<td><strong>Pending</strong></td>
</tr>
<tr>
<td><strong>9.</strong> Radiation therapy</td>
<td><strong>10.</strong> anti-CD38 antibody</td>
</tr>
<tr>
<td><strong>11.</strong> anti-EGFR antibody</td>
<td><strong>12.</strong> Others (not disclosed)</td>
</tr>
<tr>
<td><strong>13.</strong> allowed in US</td>
<td><strong>14.</strong> Additional applications pending in US, Europe and others</td>
</tr>
</tbody>
</table>

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1. TRILLIUM THERAPEUTICS INC.
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 Ops

Board of Directors

<table>
<thead>
<tr>
<th>Robert Kirkman, MD</th>
<th>Board Chair; Former CEO, Oncothyreon</th>
<th>Thomas Reynolds, MD PhD</th>
<th>Former CMO, Seattle Genetics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan Skvarka, PhD</td>
<td>CEO, Trillium</td>
<td>Helen Tayton-Martin, PhD</td>
<td>CBO, Adaptimmune</td>
</tr>
<tr>
<td>Luke Beshar</td>
<td>Former CFO, NPS Pharma</td>
<td>Paul Walker</td>
<td>Partner, NEA</td>
</tr>
<tr>
<td>Mike Kamarck, PhD</td>
<td>CTO Vir; frm exec roles at Merck, Wyeth</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Company Highlights

• **Leading next generation immuno-oncology player**, with focus on CD47 target, an innate immune system checkpoint

• **Two highly differentiated CD47 assets, with best-in-class monotherapy activity** demonstrated across multiple heme malignancy indications and lack of RBC\* binding

• **Broad transformation program** under new leadership, including strategy reset with focus on large heme malignancies and solid tumors

• **Strong healthcare focused investor base**, incl. strategic investment from Pfizer; approximately $290M in cash

* RBC – Red Blood Cell
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