ProKidney

Developing Solutions for Dialysis Prevention

Virtual KOL Event and Recap of RMCL-002 Final Data

May 28, 2024

Forward-looking Statements

This presentation includes “forward-looking statements” within the meaning of the “safe harbor” provisions of the Private Securities Litigation Reform Act of 1995. ProKidney’s actual results may differ from its expectations, estimates and projections and consequently, you should not rely on these forward-looking statements as predictions of future events. Words such as “expect,” “estimate,” “project,” “budget,” “forecast,” “anticipate,” “intend,” “plan,” “may,” “will,” “could,” “should,” “believes,” “predicts,” “potential,” “continue,” and similar expressions (or the negative versions of such words or expressions) are intended to identify such forward-looking statements. These forward-looking statements include, without limitation, the Company’s expectations with respect to financial results, future performance, development and commercialization of products, if approved, the potential benefits and impact of the Company’s products, if approved, potential regulatory approvals, and the size and potential growth of current or future markets for the Company’s products, if approved. Most of these factors are outside of the Company’s control and are difficult to predict. Factors that may cause such differences include, but are not limited to: the inability to maintain the listing of the Company’s Class A ordinary shares on the Nasdaq; the inability to implement business plans, forecasts, and other expectations or identify and realize additional opportunities, which may be affected by, among other things, competition and the ability of the Company to grow and manage growth profitably and retain its key employees; the risk of downturns and a changing regulatory landscape in the highly competitive biotechnology industry; the inability of the Company to raise financing in the future; the inability of the Company to obtain and maintain regulatory clearance or approval for its products, and any related restrictions and limitations of any cleared or approved product; the inability of the Company to identify, in-license or acquire additional technology; the inability of Company to compete with other companies currently marketing or engaged in the biologics market and in the area of treatment of kidney diseases; the size and growth potential of the markets for the Company’s products, if approved, and its ability to serve those markets, either alone or in partnership with others; the Company’s estimates regarding expenses, future revenue, capital requirements and needs for additional financing; the Company’s financial performance; the Company’s intellectual property rights; uncertainties inherent in cell therapy research and development, including the actual time it takes to initiate and complete clinical studies and the timing and content of decisions made by regulatory authorities; the impact of COVID-19 or geo-political conflict such as the war in Ukraine on the Company’s business; and other risks and uncertainties indicated from time to time in the Company’s filings with the Securities and Exchange Commission. The Company cautions readers that the foregoing list of factors is not exclusive and cautions readers not to place undue reliance upon any forward-looking statements, which speak only as of the date made. The Company does not undertake or accept any obligation or undertaking to release publicly any updates or revisions to any forward-looking statements to reflect any change in its expectations or any change in events, conditions or circumstances on which any such statement is based.

Agenda

Opening Remarks	**Bruce Culleton, MD** CEO, ProKidney
2024 Treatment Landscape for Patients with DKD	**Steven G. Coca, DO, MS** Professor of Medicine (Nephrology) at the Icahn School of Medicine at Mount Sinai
Treating CKD: Current and Future Trends	**Arnold L. Silva, MD, PhD** Director of Clinical Research at Boise Kidney and Hypertension and CaRe Research Network
RMCL-002 Final Data	**Bruce Culleton, MD** CEO, ProKidney
Q&A	

KOL Biographies

Steven G. Coca, DO, MS is a Professor of Medicine at the Icahn School of Medicine at Mount Sinai, the Associate Chair for Clinical and Translational Research for the Department of Internal Medicine, and the Director of Clinical Research for the Division of Nephrology. Dr. Coca's research focuses on the utility of blood and urine biomarkers for risk stratification of patients with acute kidney injury and chronic kidney disease. He has been a part of several large NIH funded consortia on biomarkers in kidney disease, including TRIBE-AKI, ASSESS-AKI, CKD Biocon, and the KPMP (Kidney Precision Medicine Project). He has over 300 publications, and has received several awards, including the Distinguished Researcher Award from the American Society of Nephrology in 2021. His work on prognostic biomarkers and risk models has led to the development of KidneyIntelX, a new bioprognostic test for patients with type 2 diabetes and CKD, that was recently approved by the FDA and is commercially in use in clinical practice at several large healthcare systems.

Arnold L. Silva, MD, PhD is the director of the Home Hemodialysis and Peritoneal Dialysis programs at Boise Kidney & Hypertension Institute. Dr. Silva received his bachelor's and master's degrees in Biology from California State University in Fresno, CA. He received his PhD from the University of Arizona in Tucson, studying the physiology of membrane transport and cell volume regulation. He received his MD from the University of Arizona, followed with residency training in internal medicine and nephrology fellowship at the University of Arizona affiliated hospitals. Dr. Silva has been appointed Clinical Assistant Professor of Medicine at the University of Arizona, and has taught in many areas of biology, biochemistry, and physiology for California State University and University of California. Dr. Silva has been very active as an independent investigator in the basic sciences and clinical research throughout his career, and currently acts as a Principal Investigator on projects for Boise Kidney.

ProKidney

Disrupting the CKD Treatment Landscape

Renal Autologous Cell Therapy:

Rilparencel (REACT®) proprietary autologous cellular therapy being evaluated to **preserve kidney function** in moderate to severe chronic kidney disease caused by diabetes

An Introduction to ProKidney

Goal

Preserve kidney function in advanced CKD patients

Preserve kidney function in patients with moderate to severe chronic kidney disease caused by diabetes who are faced with limited options for care beyond transplantation or dialysis

Rilparencel

A proprietary autologous cellular therapy with RMAT designation

Currently in pivotal Phase 3 clinical development with REGEN-006 (PROACT1) and REGEN-016 (PROACT2)

Supported by three Phase 2 clinical trials in advanced CKD patient populations

Leadership

Leadership Team with Clinical Development & Regulatory Experience

Together the team brings over 150 years cumulative experience in the discovery, development, manufacturing and commercialization of biotechnology, pharmaceutical, and device products

Milestones

Meaningful Near-Term Milestones

Phase 2 REGEN-007 interim results in mid-2024

Resume manufacturing and PROACT 1 Phase 3 trial, commence PROACT 2 Phase 3 trial in mid-2024

CKD = chronic kidney disease RMAT = regenerative medicine advanced therapy

What is Rilparencel and Why is it Relevant?

Unmet Needs

Over **35 million U.S. adults** have chronic kidney disease (CKD)[1]

More than **135,000 of these CKD patients progress to dialysis** every year[1]

Total annual costs to Medicare for patients with CKD (including ESRD) exceed $138B[2]

Our Goals

Preserve kidney function

Reduce or potentially eliminate time spent on dialysis

Return autonomy to patients and their families

Our Product

Rilparencel is a **proprietary** cell therapy using the patient's own kidney cells

Early clinical data demonstrate a potential to **preserve** kidney function

May provide greater benefit to **higher-risk** CKD patients

Our Plan

Phase 3 clinical program **PROACT 1 and PROACT 2 are focused** on patients with Stage 3b / 4 CKD caused by type 2 diabetes

Potential label expansion to re-dose rilparencel for **long-term dialysis prevention**

1. CDC Fact Sheet. https://www.cdc.gov/kidneydisease/publications-resources/ckd-national-facts.html
2. USRDS 2023 Annual Report

Agenda

Opening Remarks	**Bruce Culleton, MD** CEO, ProKidney
2024 Treatment Landscape for Patients with DKD	**Steven G. Coca, DO, MS** Professor of Medicine (Nephrology) at the Icahn School of Medicine at Mount Sinai
Treating CKD: Current and Future Trends	**Arnold L. Silva, MD, PhD** Director of Clinical Research at Boise Kidney and Hypertension and CaRe Research Network
RMCL-002 Final Data	**Bruce Culleton, MD** CEO, ProKidney
Q&A	

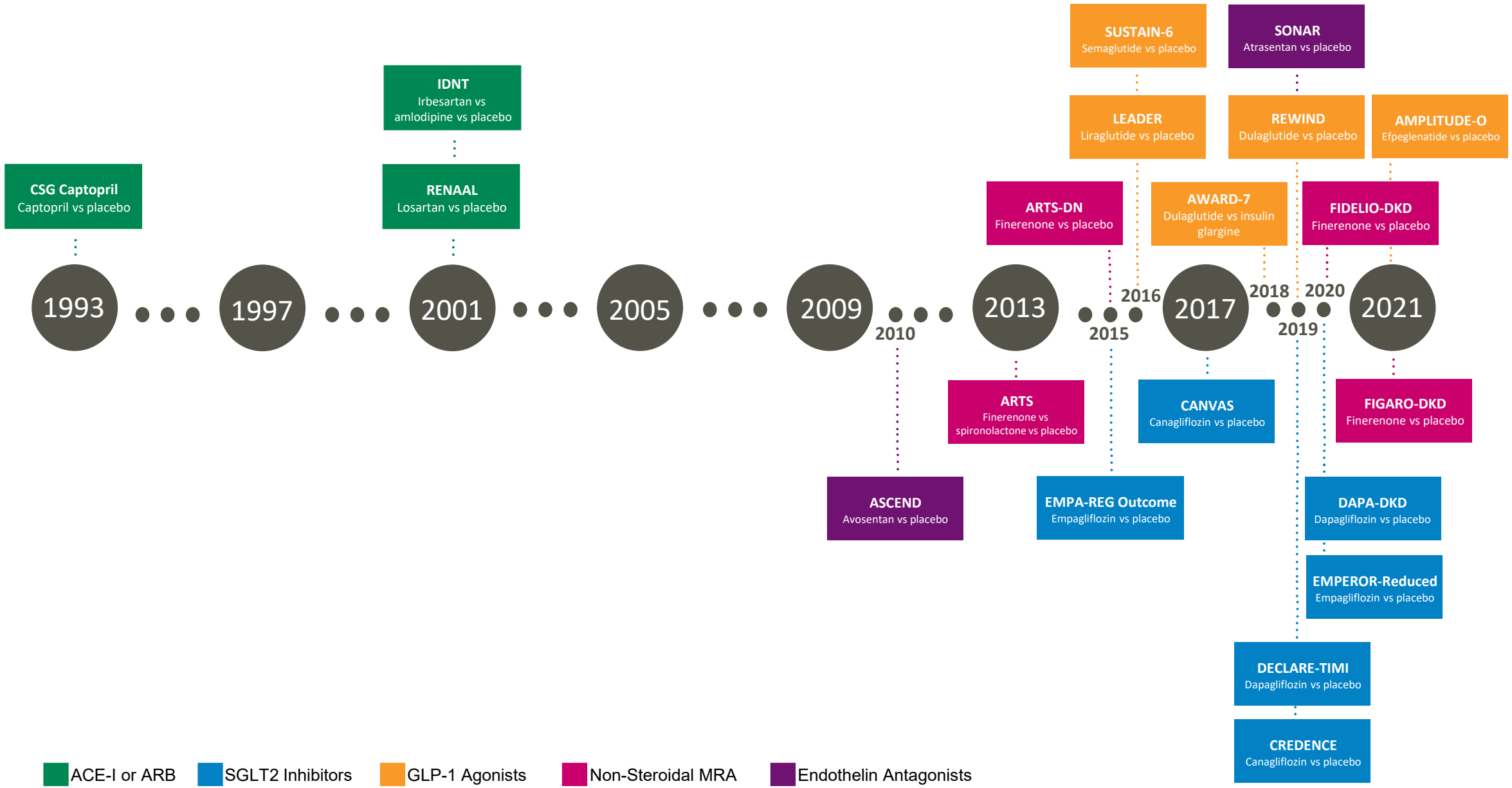
2024 Treatment Landscape for Patients with Diabetic Kidney Disease

Steven Coca, DO, MS

Professor of Medicine (Nephrology)

Icahn School of Medicine at Mount Sinai, NY, NY

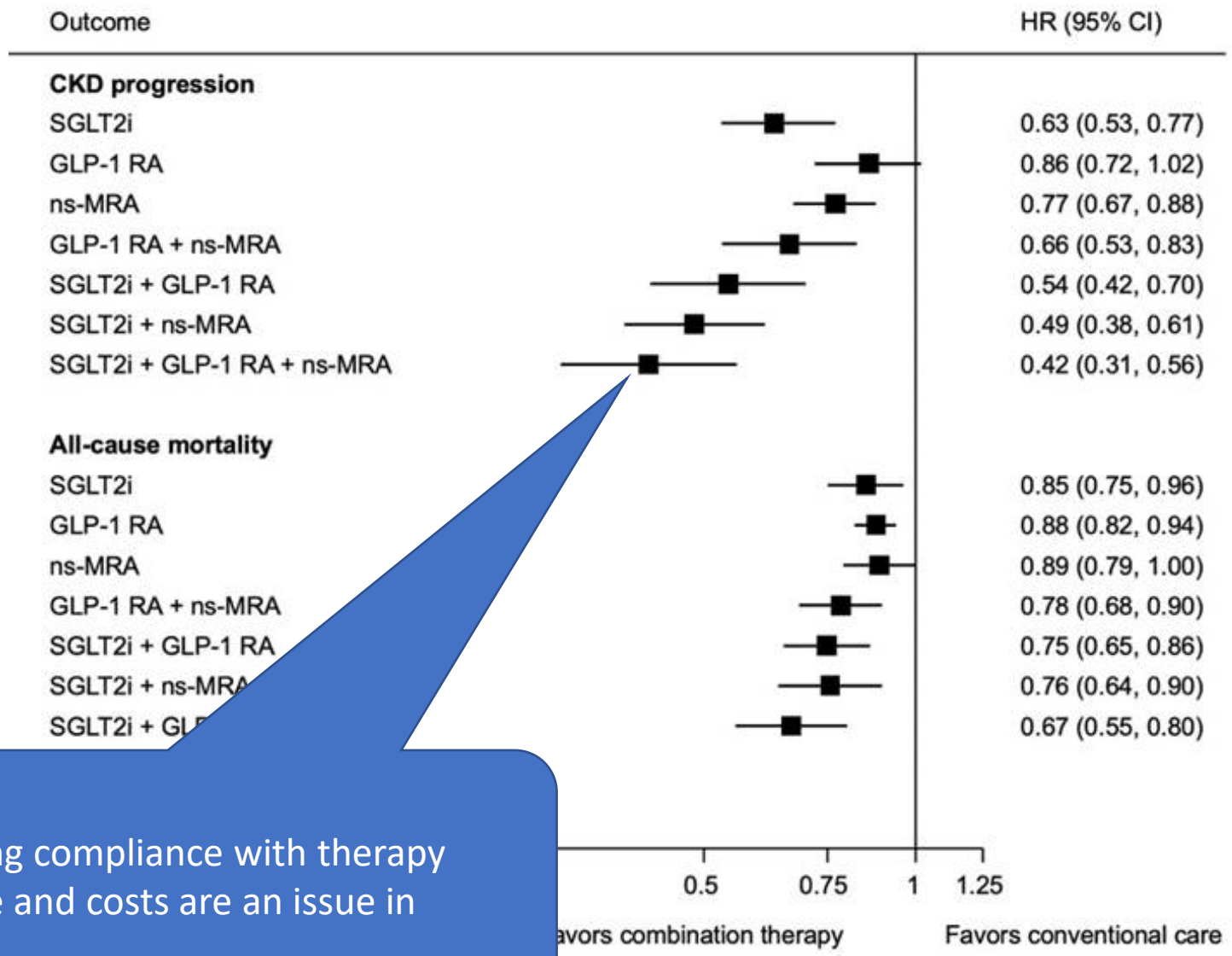
Timeline of Landmark Trials in Diabetic Kidney Disease



Multiple Pillars of DKD Therapy in 2024

Mosenzon O, et al. Adv Chronic Kidney Dis 2021;28:347-360

Estimated Lifetime Benefits of Combination Therapy with SGLT2i, GLP1 RAs, and ns-MRA in DKD



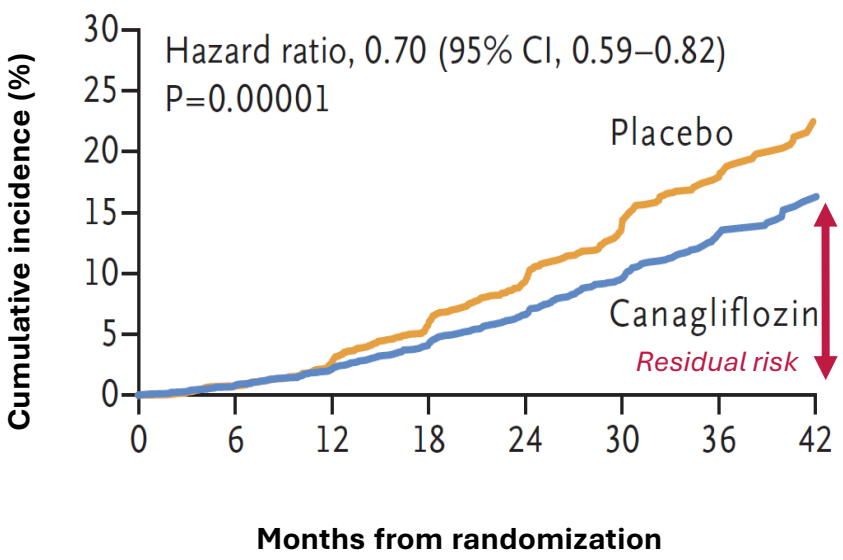
-Best case scenario
-Assumes high lifelong compliance with therapy
-Long-term tolerance and costs are an issue in practice

Neuen BL, et al Circulation 2024 (online ahead of print)

High Residual risk of CKD progression Despite Effectiveness of SGLT2i in Providing a Decrease in Risk Compared to Standard of Care

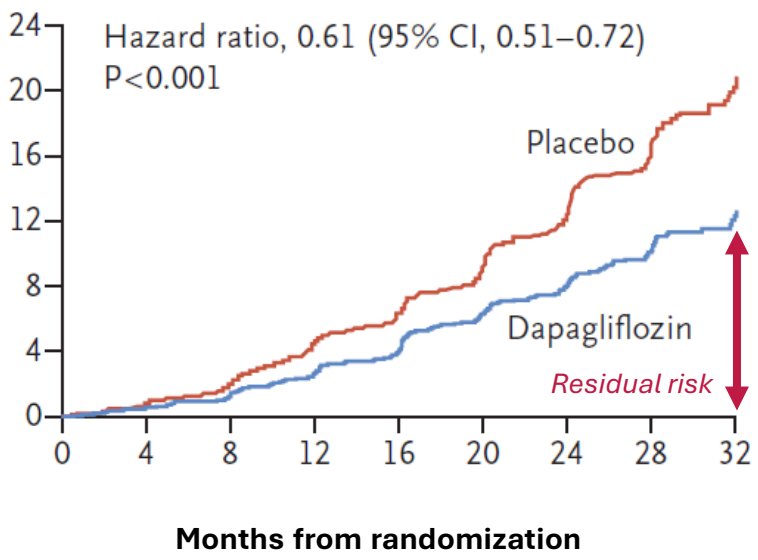
CREDENCE[1]

Primary outcome: Composite of ESRD, doubling of serum creatinine, or death for renal or CV disease



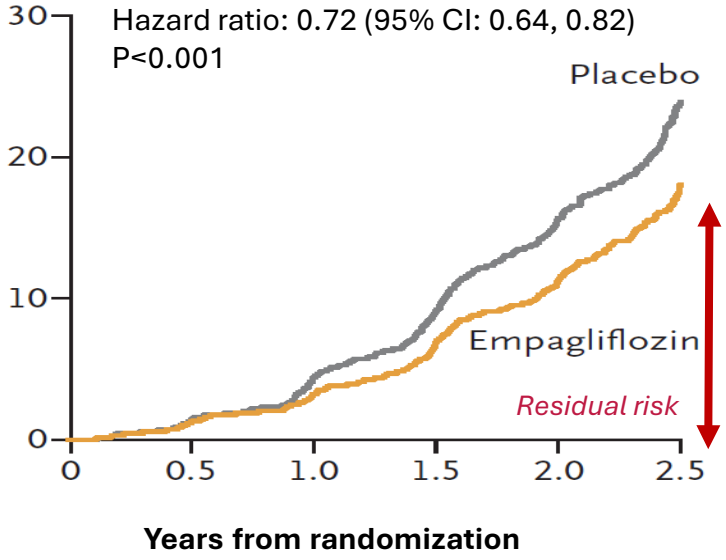
DAPA-CKD[2]

Primary outcome: ≥50% eGFR decline, ESRD, or death from renal or CV causes



EMPA-KIDNEY[3]

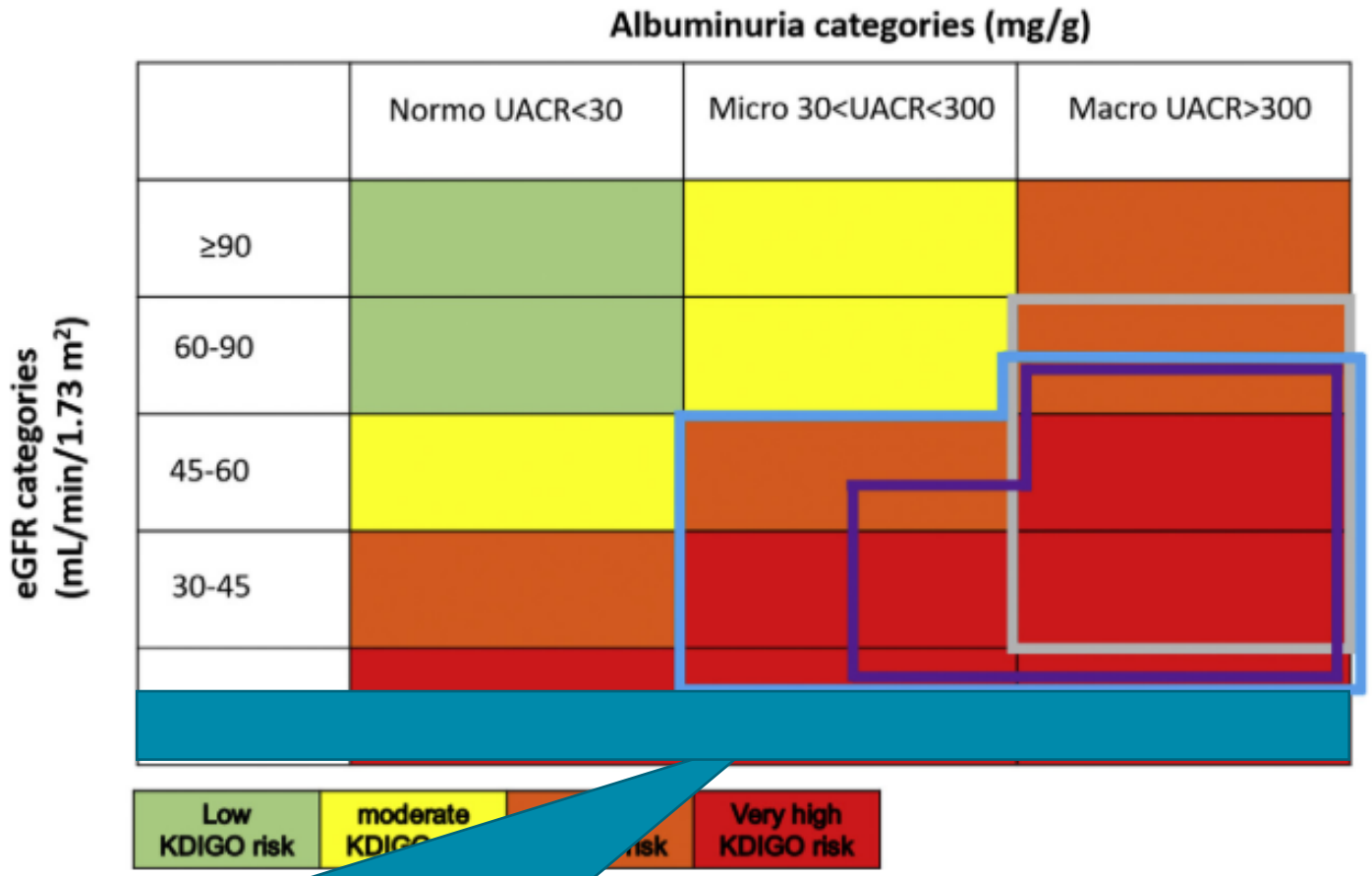
Primary outcome: Composite of ESRD, sustained decline in eGFR to <10 mL/min/1.73 m^2 or ≥40%, or death from renal causes



CI, confidence interval; CKD, chronic kidney disease; CV, cardiovascular; eGFR, estimated glomerular filtration rate; ESRD, end-stage renal disease; HR, hazard ratio

1. Perkovic V, et al. *N Engl J Med* 2019;380:*2295-2306*; 2. Heerspink HJL, et al. *N Engl J Med* 2020;383:1436-1446; 3. The EMPA-KIDNEY Collaborative Group. *N Engl J Med* 2023;388:117-127

SGLT2i, GLP1-RA, and Finerenone Trials Enrolled Higher Risk Patients off the KDIGO Heatmap and Down to eGFR ≈25 ml/min/1.73m²



CREDENCE
canagliflozin vs placebo
$HR_{[95\% CI]}$ =0.70 [0.59-0.82]

FIDELIO-DKD
finerenone vs placebo
$HR_{[95\%CI]}$ =0.82 [0.73-0.93]

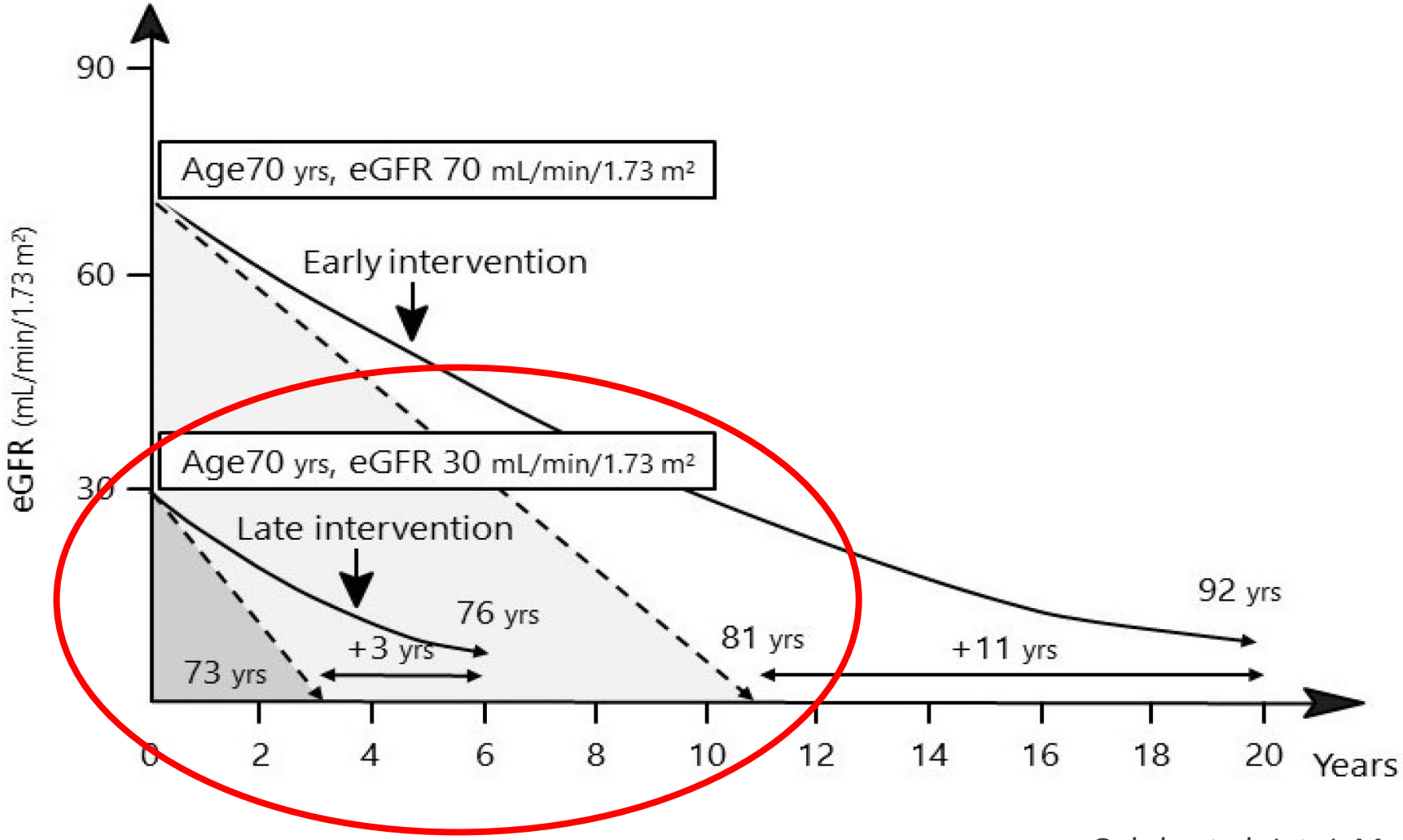
FLOW
semaglutide vs placebo
ongoing

HR 0.76

Most of CKD G4 excluded from the major DKD trials

Mosenzon O, et al. Adv Chronic Kidney Dis 2021;28:347-360

While early intervention can delay ESKD for many years, late interventions (more common) only allows for a small to moderate delay in ESKD



Gohda et al. *Int. J. Mol. Sci.* **2022**, *23*(22), 13749

Conclusions

- Tremendous progress and treatment options in DKD over the last 5-7 years
- We can now SLOW the progression to ESKD
- We cannot completely stop progression
- There is still substantial residual risk of progression
  - Inability to treat all higher risk DKD with triple/quadruple therapies
  - Even on therapies, progression still occurs
  - Minimal data on efficacy in advanced DKD
- **There is a need for more treatment options for advanced stages of DKD to prevent progression to ESKD**

Agenda

Opening Remarks	**Bruce Culleton, MD** CEO, ProKidney
2024 Treatment Landscape for Patients with DKD	**Steven G. Coca, DO, MS** Professor of Medicine (Nephrology) at the Icahn School of Medicine at Mount Sinai
Treating CKD: Current and Future Trends	**Arnold L. Silva, MD, PhD** Director of Clinical Research at Boise Kidney and Hypertension and CaRe Research Network
RMCL-002 Final Data	**Bruce Culleton, MD** CEO, ProKidney
Q&A	

Treating CKD: Current and Future Trends

Arnold L. Silva MD, PhD
Director of Clinical Research
Boise Kidney and Hypertension
CaRe Research Network

The Burden of CKD

- Affects over 40 million Americans
- Similar numbers in Europe
- CKD linked to CVD and Metabolic Disease
- ~90% of patients with CKD remain undiagnosed

CKD is a Progressive Disease

- Declining eGFR is associated with increased CVD risk
- Those who reach ESKD have high mortality
- Survival not improved in ESKD population over last 2 decades despite high investment in research
- Cost: ESKD patients are ~1% of the total Medicare population but consume ~7% of the Medicare budget

CKD: New Therapies

- SGLT2 agents and MRAs
- Both shown to reduced proteinuria
- Both attenuate eGFR decline
- BUT patients still progress with eGFR loss > 2 mL/min/1.73 m^2 per year
- Goal is to reduce eGFR decline to < 1 mL/min/1.73 m^2 per year to preserve renal function

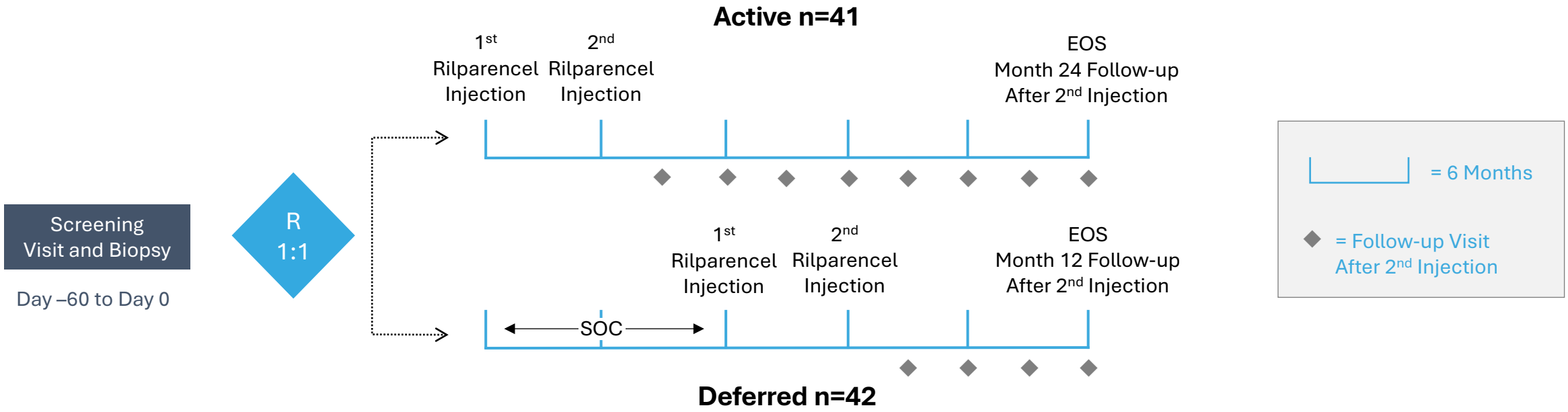
Cell Therapy: REACT® (rilparencel)

- Autologous/Homologous Approach
- Safety profile established in > 100 patients
- No demonstrated immunogenic or tumorgenicity
- Phase 2 data demonstrates reduction in eGFR decline to < 1 mL/min/1.73 m^2 per year

Agenda

Opening Remarks	**Bruce Culleton, MD** CEO, ProKidney
2024 Treatment Landscape for Patients with DKD	**Steven G. Coca, DO, MS** Professor of Medicine (Nephrology) at the Icahn School of Medicine at Mount Sinai
Treating CKD: Current and Future Trends	**Arnold L. Silva, MD, PhD** Director of Clinical Research at Boise Kidney and Hypertension and CaRe Research Network
RMCL-002 Final Data	**Bruce Culleton, MD** CEO, ProKidney
Q&A	

RMCL-002: Trial Design



Key Entry Criteria

Type 2 Diabetes Mellitus (DKD)

Male or female 30-80 years of age

eGFR ≥20 and ≤50 mL/min/1.73m^2

Not on kidney dialysis, HbA1c <10%

Study Endpoints

Rilparencel and procedure related adverse events

Change in kidney function (assessed by eGFR)

Study Timeframe

First patient injected in 2017

RMAT granted for Phase 3 program in January 2022

RMAT = Regenerative Therapy Advanced Medicine; SOC = Standard of Care

RMCL-002: Study Objectives and Endpoints

Study Objectives

- To assess the safety and efficacy of up to two rilparencel injections given 6 months apart and delivered into the biopsied kidney using a percutaneous approach

Study Endpoints

- Procedural and investigational product-related adverse events
- Change in kidney function as measured by serial measurements of estimated glomerular filtration rate (eGFR)

RMCL-002 Baseline Subject Characteristics are Balanced and Represent a High-Risk CKD Population

	ACTIVE ARM (n=41)	DEFERRED ARM (n=42)
Age, years *(mean +/- SD)*	66.1 +/- 9.9	64.6 +/- 8.9
Female : Male, %	29% : 71%	36% : 64%
Hispanic or Latino, %	17%	10%
Race, %		
Black or African American	2.5%	14%
White	95%	74%
Other	2.5%	12%
Blood pressure, mm HG	133 / 72	135 / 73
eGFR, ml/min/1.73m^2 *(mean +/- SD)*	33.9 +/- 8.6	31.7 +/- 7.4
Stage 3A CKD, n (%)	5 (12%)	3 (7%)
Stage 3B CKD, n (%)	21 (51%)	18 (43%)
Stage 4 CKD, n (%)	15 (37%)	21 (50%)
UACR mg/g *(median +/- interquartile range)*	740 (68, 1597)	598 (58, 1985)
Geometric Mean of UACR mg/g	389	330
HbA1c, % *(mean +/- SD)*	7.2 +/- 1.0	7.1 +/- 1.0

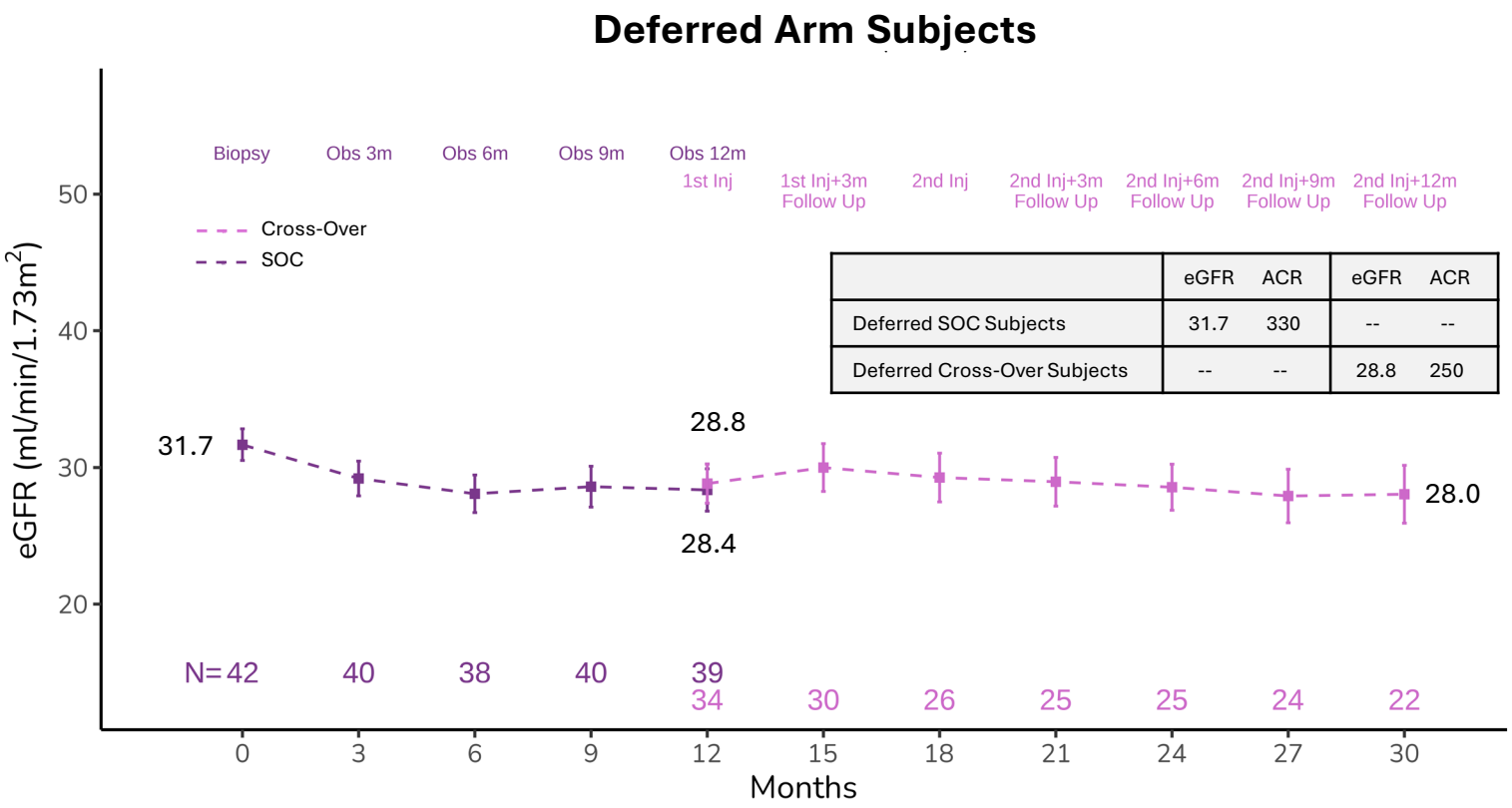
No Rilparencel-related SAEs Identified in RMCL-002

ADVERSE EVENT	BIOPSY # of events (n=83)*	RILPARENCEL INJECTION # of events (n=132)*
Hematoma (including Page Kidney during biopsy)	2	2
Pain	0	2
Acute Kidney Injury	1	1
CKD progression (eGFR progression)	0	1
Pyrexia	0	1
Anemia	0	1
Pneumonia	0	1
Creatinine increase	0	1

Other events with possible-relatedness include kidney fibrosis and indeterminate renal vessel occlusion or vasospasm

Data as of April 26, 2024; SAE = serious adverse events

Deferred to Cross-Over Subjects Showed Preservation of eGFR after Rilparencel Injection



	eGFR	ACR	eGFR	ACR
Deferred SOC Subjects	31.7	330	--	--
Deferred Cross-Over Subjects	--	--	28.8	250

Average eGFR of the Deferred cohort was 31.7 at baseline vs 28.4 at 12 months

[absolute difference of -3.3 ml/min/1.73m² over 12 months]

Average eGFR at 1st injection after cross-over was 28.8 vs 28.0 at 18 months

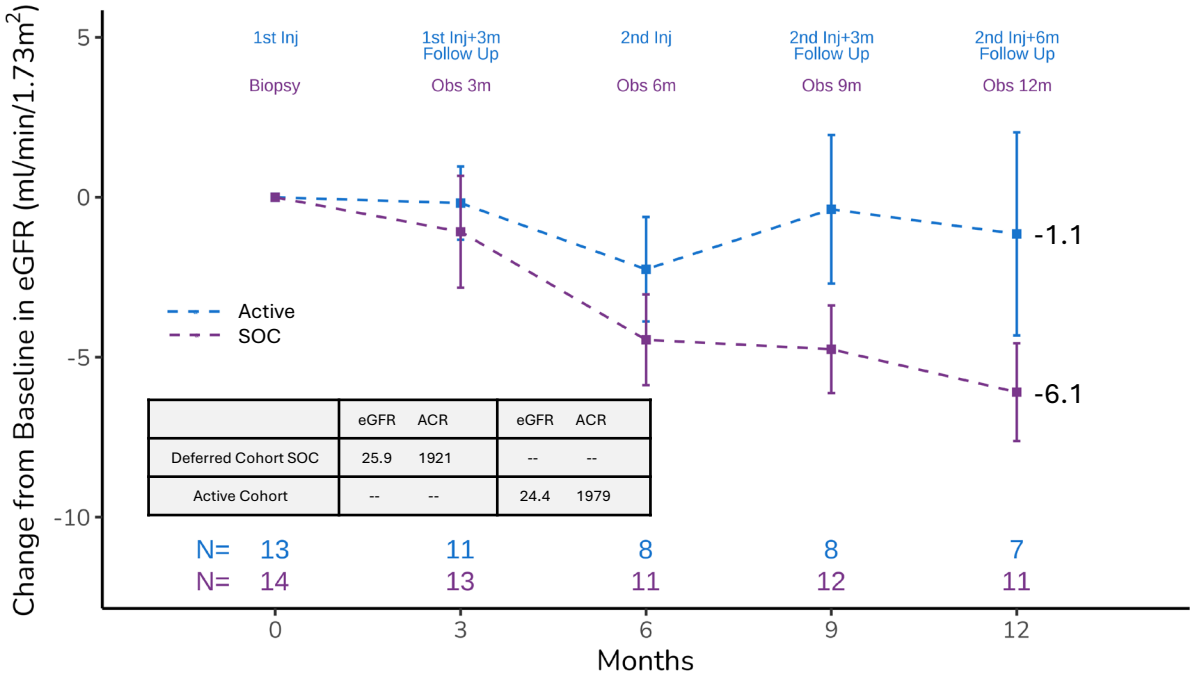
[absolute difference of -0.8 ml/min/1.73m² over 18 months]

Data points are mean +/- SEM ; Data as of April 26, 2024

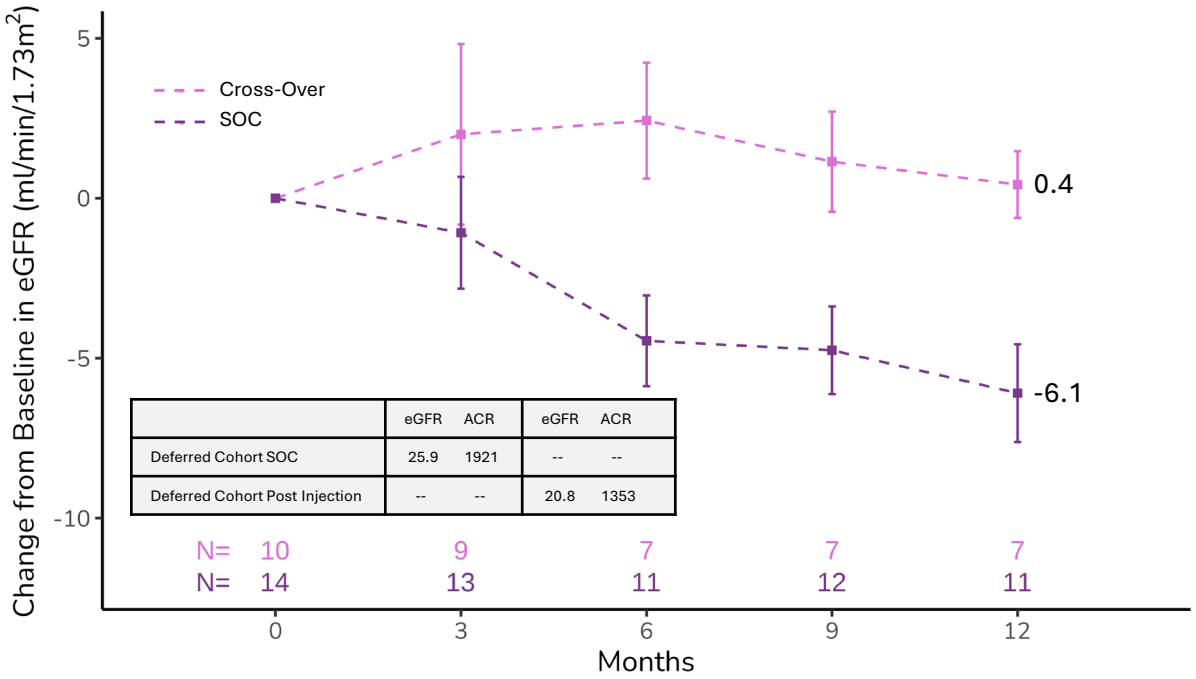
Subgroup Analysis of Diabetic Subjects with CKD Stage 4 and Class A3 Albuminuria*

Stabilization of Kidney Function in Active and Deferred Arm Subjects at 12 Months vs SOC

UACR Severe & CKD4 Subgroups in Active vs Deferred Arm



UACR Severe & CKD4 Subgroups in Deferred Arm



***Patients with Stage 4 CKD & Class A3 (Severe Albuminuria, >300 mg/g) are one of the fastest progressing CKD patient populations[1]**

Data points are mean +/- SEM ; Data as of April 26, 2024; 1. Oshima M, et al. Trajectories of kidney function in diabetes: a clinicopathological update. Nat Rev Nephrol. 2021;17(11):740-750. doi:10.1038/s41581-021-00462-y

PROKIDNEY

RMCL-002 Final Data Takeaways

Key Findings

- Showed potential to **preserve kidney function** for up to 30 months in several patient groups
- Benefit to kidney function was most notable in subjects who had the **highest risk of kidney failure** (Stage 4 CKD with high UACR[1])
- Injections were **well tolerated** with a consistent safety profile comparable to kidney biopsy

Key Actions

We have **enriched** our Phase 3 PROACT 1 Study to include more subjects with the **highest risk of kidney failure**

PROACT 1 **amendment completed and submitted to the FDA** in late March

1. UACR = urine albumin-to-creatinine ratio (a measure of albuminuria)

Overview of the Rilparencel Clinical Program

	PRECLINICAL	IND	PHASE 1	PHASE 2	PHASE 3	STATUS
Pivotal Trial Program						
Diabetes Type II – Prevent/Delay ESRD in Stage 3/4 CKD (20-35 ml/min/1.73m^2, n=685)			006/PROACT 1			Ongoing
Diabetes Type II – Prevent/Delay ESRD in Stage 3/4 CKD (20-44 ml/min/1.73m^2, n=600)			016/PROACT 2			Enrollment Mid-2024
Long term follow-up study for patients previously treated with rilparencel			008			Ongoing
Supportive Trials						
Diabetes Type II – Prevent/Delay ESRD in Stage 3/4 CKD (20-50 ml/min/1.73m^2, n=83 randomized)			002			Final Data Presented
Diabetes Type I & II – Prevent/Delay ESRD in Stage 3/4 CKD (20-50 ml/min/1.73m^2, n=53 randomized)			007			Fully Enrolled
Completed Trials						
Diabetes Type II – Delay ESRD in Stage 4/5 CKD (14-20 ml/min/1.73m^2, n=10)			003			Trial Completed
Congenital Anomalies – Prevent/Delay ESRD (14-50 ml/min/1.73m^2, n=5)			004			Trial Completed

Frozen product | Unilateral injections | Bilateral injections | ESRD = End-Stage Renal Disease

As of May 2024

Q&A

ProKidney