Intellia is Leading the Gene Editing Revolution

Corporate Overview

January 2024

MILTON
Living with ATTR amyloidosis with cardiomyopathy
Therapeutics’ Legal Disclaimer

This presentation contains "forward-looking statements" of Intellia Therapeutics, Inc. ("Intellia", "we" or "our") within the meaning of the Private Securities Litigation Reform Act of 1995. These forward-looking statements include, but are not limited to, express or implied statements about Intellia’s beliefs and expectations regarding: our ability to build a world-class gene editing toolbox to develop an unsuppressed gene editing pipeline; the safety, efficacy and advancement of our clinical programs for NTLA-2001 for the treatment of transthyretin ("ATTR") amyloidosis, NTLA-2002 for the treatment of hereditary angioedema ("HAE") and NTLA-3001 for the treatment of alpha-1 antitrypsin deficiency ("AATD")-associated lung disease pursuant to our clinical trial applications ("CTA") and investigational new drug ("IND") submissions, including the expected timing of data releases, regulatory filings, and the initiation and completion of clinical trials, including dosing the first patient in the pivotal Phase 3 MAGNITUDE trial for NTLA-2001 for ATTR-CM in Q1 2024, preparing for a Phase 3 study for the treatment of ATTR amyloidosis with polyneuropathy, presenting updated data from the ongoing Phase 1 study of NTLA-2001 in 2024, initiating the Phase 3 clinical trial for NTLA-2002 for HAE in 2024, presenting additional data from the Phase 1/2 study of NTLA-2002 in 2024, and dosing the first patient in the Phase 1 study of NTLA-3001 in 2024; the execution of its strategic priorities for 2024-2026, including the completion of patient enrollment for pivotal studies of NTLA-2001 and NTLA-2002, the planned BLA submission for NTLA-2002 for HAE in 2026, demonstrating human proof-of-concept for targeted in vivo gene insertion, initiating clinical development for its allogeneic ex vivo program, demonstrating preclinical proof-of-concept of editing in tissues outside the liver, and advancing DNA writing technology; the ability to generate data to initiate clinical trials and the timing of CTA and IND submissions; the advancement, expansion and acceleration of our CRISPR/Cas9 technology and related technologies, including DNA writing, base editing, manufacturing and delivery technologies, to advance and develop additional candidates and treatments; our ability to demonstrate our platform’s modularity and replicate or apply results achieved in preclinical studies, including those in its NTLA-2001, NTLA-2002 and NTLA-3001 programs, in any future studies, including human clinical trials; our ability to optimize the impact of our collaborations on our development programs, including, but not limited to, collaborations with Regeneron Pharmaceuticals, Inc. ("Regeneron"), including our co-development programs for ATTR amyloidosis, hemophilia A and hemophilia B, with AvenCell Therapeutics, Inc. ("AvenCell") for the development of universal CAR-T cell therapies, with SparingVision SAS ("SparingVision") for the development of ophthalmic therapies, with Kyverna Therapeutics, Inc. ("Kyverna") for the development of KYV-201, and with ONK Therapeutics Ltd. ("ONK") for the development of engineered NK cell therapies; the potential commercial opportunities, including value and market, for our product candidates, including the potential of NTLA-2001, NTLA-2002 and NTLA-3001 to be a single-dose treatment, the potential of NTLA-2001 to halt and reverse disease and result in lifelong, stable TTR reduction, the potential of NTLA-2002 to provide extensive and continuous reduction in kalikrein activity and eliminate significant treatment burden; and the potential of NTLA-3001 to achieve normal human levels of alpha-1 antitrypsin protein and halt progression of lung disease; our use of capital and other financial results; and our ability to fund operations into mid-2026.

Any forward-looking statements in this presentation are based on management’s current expectations and beliefs of future events, and are subject to a number of risks and uncertainties that could cause actual results to differ materially and adversely from those set forth in or implied by such forward-looking statements. These risks and uncertainties include, but are not limited to: risks related to our ability to protect and maintain our intellectual property position; risks related to valid third party intellectual property; risks related to our relationship with third parties, including our licensors and licensees; risks related to the ability of our licensors to protect and maintain their intellectual property position; uncertainties related to regulatory agencies’ evaluation of regulatory filings and other information related to our product candidates; uncertainties related to the authorization, initiation and conduct of studies and other development requirements for our product candidates, including uncertainties related to regulatory approvals to conduct clinical trials; risks related to the development and/or commercialization of any of Intellia’s or its collaborators’ product candidates, including that they may not be successfully developed and commercialized; risks related to the results of preclinical or clinical studies, including that they may not be positive or predictive of future results; risks related to the development of novel platform capabilities, including technologies related to editing in tissues outside the liver, base editing and DNA writing; risks related to Intellia’s reliance on collaborations, including that its collaborations with Regeneron, AvenCell, SparingVision, Kyverna, ONK or its other collaborations will not continue or will not be successful. For a discussion of these and other risks and uncertainties, and other important factors, any of which could cause Intellia’s actual results to differ from those contained in this presentation, we refer you to Intellia’s most recent Annual Report on Form 10-K and Quarterly Report on Form 10-Q as well as discussions of potential risks, uncertainties, and other important factors in Intellia’s other filings with the Securities and Exchange Commission. All information in this presentation is as of the date on its cover page, and Intellia undertakes no duty to update this information unless required by law.
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Intellia is Leading a New Era of Medicine

Turning Nobel-Prize-Winning Science into Medicine

• Poised to bring first-ever *in vivo* CRISPR therapy to market
• Initiated first-ever, pivotal Phase 3 program for an *in vivo* CRISPR therapy
• On track for second *in vivo* Phase 3 program in 2024

100+ patients dosed with Intellia’s investigational *in vivo* CRISPR-based therapies

Robust pipeline of *in vivo* and *ex vivo* programs

Comprehensive gene editing toolbox
Advancing a Full-Spectrum Genome Editing Company

CRISPR-Based Modular Platform

- EMPLOY NOVEL EDITING AND DELIVERY TOOLS

In Vivo
CRISPR *is* the therapy

- FIX THE TARGET GENE
- Genetic diseases

Ex Vivo
CRISPR *creates* the therapy

- REWIRE & REDIRECT CELLS
- Immuno-oncology
- Autoimmune diseases
Intellia is Developing Potentially Curative Gene Editing Treatments to Transform the Lives of Patients

**Full-Spectrum Strategy**
Pipeline of *in vivo* and *ex vivo* CRISPR-based therapies for life-threatening diseases with high unmet need

**Clinically Validated Modular Platform**
Modular technology enables a reproducible path to drug discovery and development

**Deploying Novel Tools**
Continued innovation across editing and delivery modalities for future therapeutic applications
Therapeutic Strategies to Treat Life-Threatening Diseases Have Advanced Over Time

INNOVATION TIMELINE

Small Molecule Drugs  Biologics  RNAi  Gene Therapy  Genome Editing

PROTEINS  RNA  DNA
CRISPR-Based Editing Technologies are a Promising New Therapeutic Modality

Potential of CRISPR-Based Editing Technologies

- Treat patients at the root cause of their disease
- Single dose treatment with potential lifelong benefit
- Reduce burden to the healthcare system over a patient’s lifetime
In Vivo Leader: First to Demonstrate Systemic CRISPR Gene Editing in Humans

CRISPR-Cas9 In Vivo Gene Editing for Transthyretin Amyloidosis

Julian D. Gillmore, M.D., Ph.D., Ed Gane, M.B., Ch.B., Jorg Taubel, M.D., Justin Kao, M.B., Ch.B., Marianna Fontana, M.D., Ph.D., Michael L. Maitland, M.D., Ph.D., Jessica Seitzer, B.S., Daniel O’Connell, Ph.D., Kathryn R. Walsh, Ph.D., Kristy Wood, Ph.D., Jonathan Phillips, Ph.D., Yuanxin Xu, M.D., Ph.D., Adam Amaral, B.A., Adam P. Boyd, Ph.D., Jeffrey E. Cehelsky, M.B.A., Mark D. McKee, M.D., Andrew Schiermeier, Ph.D., Olivier Harari, M.B., B.Chir., Ph.D., Andrew Murphy, Ph.D., Christos A. Kyrtos, Ph.D., Brian Zambrowicz, Ph.D., Randy Soltys, Ph.D., David E. Gutstein, M.D., John Leonard, M.D., Laura Sepp-Lorenzino, Ph.D., and David Lebwohl, M.D.
## 2023 Key Accomplishments

| NTLA-2001 ATTR & NTLA-2002 HAE | ✔ FDA clearance of IND for NTLA-2002 Phase 2 and NTLA-2001 Phase 3 studies  
| | ✔ Initiated the pivotal Phase 3 MAGNITUDE trial of NTLA-2001 for ATTR-CM  
| | ✔ Initiated and completed enrollment of the NTLA-2002 Phase 2 study  
| | ✔ Positive interim data updates from Phase 1 studies of NTLA-2001 and NTLA-2002  

| NTLA-3001 AATD | ✔ Submitted CTA for NTLA-3001 Phase 1 study for AATD-associated lung disease  

| Platform | ✔ Achieved key enabling research milestone for DNA writing technology  

**Ended 2023 with ~$1B in cash — expect to fund operations into mid-2026**
Intellia’s Strategic Priorities for 2024 – 2026

1. Execute pivotal trials for first two *in vivo* CRISPR-based therapies
   - Complete patient enrollment for pivotal studies of NTLA-2001 and NTLA-2002
   - Planned BLA submission for NTLA-2002 for HAE in 2026

2. Launch next wave of *in vivo* and *ex vivo* clinical programs
   - Demonstrate human proof-of-concept for targeted *in vivo* gene insertion
   - Initiate clinical development for first allogeneic *ex vivo* program

3. Deploy new gene editing and delivery modalities
   - Demonstrate preclinical proof-of-concept of editing in tissues outside the liver
   - Advance DNA writing technology
## Upcoming 2024 Key Clinical Program Milestones

<table>
<thead>
<tr>
<th>NTLA-2001</th>
<th>ATTR</th>
<th>Dose first patient in pivotal Phase 3 MAGNITUDE trial for ATTR-CM in Q1 2024</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Continue to open new sites and enroll patients</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prepare for the Phase 3 study for the treatment of ATTRv-PN</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Present updated data from the ongoing Phase 1 study in 2024</td>
</tr>
<tr>
<td>NTLA-2002</td>
<td>HAE</td>
<td>Initiate the Phase 3 study in 2H 2024, subject to regulatory feedback</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Present updated data from Phase 1 and new data from Phase 2 portion in 2024</td>
</tr>
<tr>
<td>NTLA-3001</td>
<td>AATD</td>
<td>Dose first patient in Phase 1 study of NTLA-3001 in 2024</td>
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# Broad Development Pipeline Fueled by Robust Research Engine

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<thead>
<tr>
<th>PROGRAM</th>
<th>APPROACH</th>
<th>Research and Preclinical</th>
<th>Early-Stage Clinical</th>
<th>Late-Stage Clinical</th>
<th>PARTNERS</th>
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<tr>
<td>NTLA-2001: Transthyretin Amyloidosis</td>
<td>Knockout</td>
<td></td>
<td></td>
<td></td>
<td><a href="#">Intellia Therapeutics</a> <a href="#">Regeneron</a></td>
</tr>
<tr>
<td>NTLA-2002: Hereditary Angioedema</td>
<td>Knockout</td>
<td></td>
<td></td>
<td></td>
<td><a href="#">Intellia Therapeutics</a></td>
</tr>
<tr>
<td>NTLA-3001: AATD-Lung Disease</td>
<td>Insertion</td>
<td></td>
<td></td>
<td></td>
<td><a href="#">Intellia Therapeutics</a></td>
</tr>
<tr>
<td>Hemophilia A / B</td>
<td>Insertion</td>
<td></td>
<td></td>
<td></td>
<td><a href="#">Intellia Therapeutics</a> <a href="#">Regeneron</a></td>
</tr>
<tr>
<td>Research Programs</td>
<td>Knockout, insertion or repair</td>
<td></td>
<td></td>
<td></td>
<td><a href="#">Intellia Therapeutics</a></td>
</tr>
<tr>
<td>Research Programs</td>
<td>Tissues outside the liver</td>
<td></td>
<td></td>
<td></td>
<td><a href="#">Intellia Therapeutics</a> <a href="#">Sparing Vision</a></td>
</tr>
<tr>
<td><strong>Ex Vivo: CRISPR creates the therapy</strong></td>
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<tr>
<td>Research Programs</td>
<td>Allogeneic and other</td>
<td></td>
<td></td>
<td></td>
<td><a href="#">Intellia Therapeutics</a> <a href="#">Vencell</a> <a href="#">kyvera</a> <a href="#">Onk</a></td>
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Lead refers to lead development and commercial party.
* Intellia is advancing both wholly owned and partnered programs.
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**In Vivo**

CRISPR is the therapy

**GENETIC DISEASES**

**Strategic Advantages:**

Potential curative therapy from a single dose

Systemic non-viral delivery of CRISPR/Cas9 provides transient expression and potential safety advantages

Potential for permanent gene knockout or gain of function by targeted insertion

Capable of delivering to multiple tissue types for various therapeutic applications
Modular Delivery Platform Enables Rapid and Reproducible Path to Clinical Development

Key Advantages of LNP Delivery

- Clinically-proven delivery to liver
- Large cargo capacity
- Transient expression
- Biodegradable
- Low immunogenicity
- Well-tolerated
- Redosing capability
- Scalable synthetic manufacturing
- Tunable to other tissues

LNP Delivery System:

- gRNA identifies genetic target
- Cas9 mRNA
- TTR gRNA
- KLKB1 gRNA
- Target-specific gRNA
NTLA-2001 for Transthyretin (ATTR) Amyloidosis

About ATTR Amyloidosis
- Caused by accumulation of misfolded TTR protein
- Primarily affects the nerves and/or the heart
- Chronic dosing is required with current treatment options

Our Approach
Knock out *TTR* gene with a single-dose CRISPR-based treatment
- Reduces wild-type and mutant TTR protein
- Aims to address polyneuropathy and cardiomyopathy

Key Advantages Includes Potential to:
- Halt and reverse disease with deep and consistent TTR reduction
- Be a single-dose treatment
- Expect lifelong, stable TTR reduction
## ATTR Amyloidosis: Large Commercial Opportunity with Significant Unmet Need

### NTLA-2001

Potential to be the best-in-class TTR reduction agent and only single-dose treatment

<table>
<thead>
<tr>
<th>Prevalence(^1,2)</th>
<th>50,000</th>
<th>(\sim)200-500K</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATTRv patients worldwide</td>
<td>ATTRwt patients worldwide</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Life Expectancy(^3)</th>
<th>2-7 years</th>
<th>10+ years</th>
</tr>
</thead>
<tbody>
<tr>
<td>after diagnosis for ATTR-CM patients</td>
<td>after diagnosis for ATTRv-PN patients</td>
<td></td>
</tr>
</tbody>
</table>

| Disease Burden\(^4\) | Patients experience **highly burdensome symptoms**, including heart failure, shortness of breath, muscle weakness and sensory deficits |

<table>
<thead>
<tr>
<th>Commercial Opportunity(^5,6)</th>
<th>$11B+</th>
<th>$450K+</th>
</tr>
</thead>
<tbody>
<tr>
<td>global market size expected by 2029</td>
<td>average annual cost of TTR reduction treatment in the U.S.</td>
<td></td>
</tr>
</tbody>
</table>

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2 Compiled from various sources.
4 Griffin et al. *JACC* 2021; Intellia Patient Survey 2022
5 GlobalData 2023
6 Redbook 2023
NTLA-2001 Phase 1 Study in ATTR Amyloidosis

Two-part, open-label, multi-center study in adults with hereditary ATTR amyloidosis with polyneuropathy (ATTRv-PN) or ATTR amyloidosis with cardiomyopathy (ATTR-CM)

**Intervention:** Single-dose CRISPR/Cas9-based gene editing therapy administered via an intravenous (IV) infusion

**PART I:** Single-Ascending Dose Escalation

- **ATTRv-PN patients** (n=36)
  - 0.1 mg/kg (n=3)
  - 0.3 mg/kg (n=3)
  - 0.7 mg/kg (n=3)
  - 1.0 mg/kg (n=6)

- **ATTR-CM patients** (n=36)
  - 0.7 mg/kg NYHA Class I/II (n=3)
  - 0.7 mg/kg NYHA Class III (n=6)
  - 1.0 mg/kg NYHA Class I/II (n=3)

**PART II:** Dose Expansion

- 55 mg (n=16)
- 80 mg (n=5)
- 55 mg NYHA Class I/II (n=12)
- 55 mg NYHA Class III (n=12)

**PRIMARY OBJECTIVES**
Evaluate safety, tolerability, PK and PD
- Measure serum TTR levels

**SECONDARY OBJECTIVES**
Evaluate efficacy on clinical measures of:
- Neurologic function in subjects with ATTRv-PN
- Cardiac disease in subjects with ATTR-CM

Clinicaltrials.gov ID: NCT04601051
### Most Frequent Treatment-Emergent Adverse Events

**TEAEs by Maximum Toxicity Grade and Preferred Term Reported in >5% of All ATTRv-PN and ATTR-CM Patients (N=65)**

<table>
<thead>
<tr>
<th>AE, Preferred Term, n (%)</th>
<th>Any Grade</th>
<th>Grade 1</th>
<th>Grade 2</th>
<th>Grade ≥3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infusion-related reaction</td>
<td>25 (38)</td>
<td>10 (15)</td>
<td>14 (22)</td>
<td>1 (2)</td>
</tr>
<tr>
<td>Headache</td>
<td>12 (18)</td>
<td>12 (18)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diarrhea</td>
<td>11 (17)</td>
<td>10 (15)</td>
<td>1 (2)</td>
<td></td>
</tr>
<tr>
<td>Back pain</td>
<td>7 (11)</td>
<td>7 (11)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COVID-19 infection</td>
<td>6 (9)</td>
<td>5 (8)</td>
<td>1 (2)</td>
<td></td>
</tr>
<tr>
<td>Cardiac failure</td>
<td>6 (9)</td>
<td>2 (3)</td>
<td>2 (3)</td>
<td>2 (3)</td>
</tr>
<tr>
<td>Upper respiratory tract infection</td>
<td>6 (9)</td>
<td>6 (9)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AST increased</td>
<td>5 (8)</td>
<td>3 (5)</td>
<td>1 (2)</td>
<td>1 (2)</td>
</tr>
<tr>
<td>Dizziness</td>
<td>5 (8)</td>
<td>5 (8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fatigue</td>
<td>5 (8)</td>
<td>5 (8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Muscle spasms</td>
<td>5 (8)</td>
<td>4 (6)</td>
<td>1 (2)</td>
<td></td>
</tr>
<tr>
<td>Vision blurred</td>
<td>5 (8)</td>
<td>5 (8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Atrial flutter</td>
<td>4 (6)</td>
<td>1 (2)</td>
<td></td>
<td>3 (5)</td>
</tr>
<tr>
<td>Constipation</td>
<td>4 (6)</td>
<td>2 (3)</td>
<td>2 (3)</td>
<td></td>
</tr>
<tr>
<td>Rash</td>
<td>4 (6)</td>
<td>4 (6)</td>
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</tbody>
</table>

- This includes all reported events, including those unrelated to NTLA-2001 (e.g., atrial flutter and cardiac failure hospitalizations)
- Infusion-related reactions were most common; nearly all were considered mild, and all resolved without sequelae, and all patients received the complete, planned dose
- Any liver enzyme elevations resolved spontaneously, were asymptomatic, and required no intervention (e.g., steroids) or hospitalization

*Data cutoff May 11, 2023.*

Patients reporting more than one AE related to NTLA-2001 are counted only once using the maximum toxicity grade. AEs coded to preferred term using Medical Dictionary for Regulatory Activities (MedDRA), version 23.0 for PN and version 24.0 for CM. Interim data presented are from the initial 65 of 72 patients dosed. Results from the final 7 patients enrolled after the data cutoff will be reported at a future date.
Regardless of Baseline TTR Levels, NTLA-2001 Led to Consistently Low and Sustained Absolute Serum TTR in All Patients

Data cutoff May 11, 2023.

Figure notes: Results for each dose level are shown out to the last time point with complete follow-up for the entire cohort. Interim data presented excludes the 0.1 mg/kg cohort from the dose-escalation of the polyneuropathy arm. The three patients in the 0.1 mg/kg cohort have been re-dosed at 55 mg and results will be shared in a future presentation. The 55 mg and 80 mg doses are the fixed doses corresponding to 0.7 mg/kg and 1.0 mg/kg, respectively.

Median (IQR) Serum TTR at Day 28 (n=62)

<table>
<thead>
<tr>
<th>Dose Level</th>
<th>Residual absolute TTR concentration at day 28</th>
<th>% Change from baseline in serum TTR at day 28</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.7 mg/kg (N=3)</td>
<td>17 µg/mL (11 to 24 µg/mL)</td>
<td>-91% (-88 to -94%)</td>
</tr>
<tr>
<td>0.3 mg/kg (N=3)</td>
<td></td>
<td></td>
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<tr>
<td>1.0 mg/kg (N=6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>55 mg (N=16)</td>
<td></td>
<td></td>
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<tr>
<td>80 mg (N=5)</td>
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</tbody>
</table>
A Phase 3, Randomized, Double-blind, Placebo-controlled Study to Evaluate NTLA-2001 in Patients with ATTR Amyloidosis with Cardiomyopathy (ATTR-CM)

**Randomization:**
2:1

**Primary Endpoint**
- Composite endpoint of CV-related mortality and CV-related events

**Key Secondary Endpoints**
- Serum TTR
- KCCQ-OS score

**Study Duration:**
- Dependent on occurrence of pre-specified number of CV events and a minimum of 18 months follow-up
- Majority of patients are expected to have ≥ 30 months of follow-up for the primary analysis

**Key Eligibility Criteria:**
- Adult patients with diagnosis of either hereditary or wild-type ATTR-CM
- NYHA Class I – III
- NT-proBNP baseline ≥ 1000 pg/mL

**Stratification:**
- NAC stage
- TTR genotype: wild-type vs. mutant
- Concomitant tafamidis use vs. no tafamidis

**NTLA-2001**
Single 55 mg IV infusion

**Placebo**
NTLA-2002 for Hereditary Angioedema (HAE)

About HAE

• Genetic disease characterized by recurring, severe and unpredictable swelling in various parts of the body

• Despite availability of existing therapies, significant unmet need persists

• Chronic dosing is required with current treatment options

Our Approach

Knock out KLKB1 gene with a single-dose CRISPR-based treatment

• Reduce kallikrein activity to prevent attacks

Key Advantages Includes Potential to:

• Be a single-dose treatment

• Provide extensive and continuous reduction in kallikrein activity
  – Intended to minimize the risk of breakthrough attacks

• Eliminate significant treatment burden
# HAE: Large Commercial Opportunity with Significant Unmet Need

<table>
<thead>
<tr>
<th><strong>NTLA-2002</strong></th>
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<tbody>
<tr>
<td>Potential to be the best-in-class HAE prophylaxis agent and only single-dose treatment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Prevalence</strong>(^1)</th>
<th>(~20,000) HAE patients worldwide</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnosis</strong>(^2)</td>
<td>20 years old</td>
</tr>
<tr>
<td></td>
<td>average age of diagnosis</td>
</tr>
<tr>
<td></td>
<td>Symptom onset typically occurs by 12 years old</td>
</tr>
<tr>
<td><strong>Disease Burden</strong>(^3)</td>
<td>50-60%</td>
</tr>
<tr>
<td></td>
<td>patients continue to have HAE attacks despite existing therapies</td>
</tr>
<tr>
<td></td>
<td>• Attacks can result in hospitalizations</td>
</tr>
<tr>
<td></td>
<td>• Patients subject to lifetime of attack risk and chronic treatment</td>
</tr>
<tr>
<td><strong>Commercial Opportunity</strong>(^4,5)</td>
<td>$6B+ global market size expected by 2029</td>
</tr>
<tr>
<td></td>
<td>$500K+ annual U.S. cost of leading prophylactic treatment</td>
</tr>
</tbody>
</table>

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2. Farkas et al. Allergy. 2017. 72;300-313
4. GlobalData 2023
5. Redbook 2023
NTLA-2002 Phase 1/2 Trial Design

International, multi-center study to assess safety, tolerability, PK, PD and effect of NTLA-2002 on attacks in adults with Type I or Type II HAE

**Total Enrollment:**
Up to 55 patients, age 18 and older

**Intervention:**
Single dose administered via an intravenous (IV) infusion

**Phase 1**
Open-Label, Single-Ascending Dose
- 75 mg (n=3)
- 50 mg (n=4)
- 25 mg (n=3)

**Phase 2**
Expansion study to confirm recommended dose
- 50 mg (n=10)
- 25 mg (n=10)
- Placebo arm (n=5)

**KEY ENDPOINTS**
- Evaluate safety and tolerability
- Change in plasma kallikrein protein and activity levels
- Change in attack rates (Phase 2)
NTLA-2002 Was Generally Well Tolerated Across All Dose Levels Evaluated

<table>
<thead>
<tr>
<th>Adverse events occurring in ≥ 2 patients</th>
<th>25 mg n = 3</th>
<th>50 mg n = 4</th>
<th>75 mg n = 3</th>
<th>All patients N = 10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Gr. 1</td>
<td>Gr. 2</td>
<td>Gr. 1</td>
<td>Gr. 2</td>
</tr>
<tr>
<td>Any TEAE (max grade)</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Infusion-related reaction</td>
<td>2</td>
<td>–</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Fatigue</td>
<td>1</td>
<td>–</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>COVID-19</td>
<td>3</td>
<td>–</td>
<td>1</td>
<td>–</td>
</tr>
<tr>
<td>Upper respiratory tract infection</td>
<td>1</td>
<td>–</td>
<td>1</td>
<td>–</td>
</tr>
<tr>
<td>Oropharyngeal pain</td>
<td>2</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Abdominal pain</td>
<td>1</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Headache</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Viral upper respiratory tract infection</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
</tbody>
</table>

No clinically significant laboratory findings observed
No treatment-emergent SAEs or ≥ Grade 3 TEAEs were observed
Median duration of follow-up for all patients was 9.0 months (range, 5.6-14.1 months)

Patients counted once per row with highest grade reported.
A Single Dose of NTLA-2002 Resulted in Dose-Dependent and Durable Reductions in Plasma Kallikrein Protein

Data cutoff February 17, 2023.
Data are mean values with standard deviation.
Mean percentage reduction callout on graph refers to last measurement as of the data cutoff date.

All doses achieved >60% mean kallikrein reduction
Across All Patients, a Single Dose of NTLA-2002 Led to a 95% Mean Reduction in Monthly HAE Attack Rate Through the Latest Follow-up

**ATTACK SEVERITY:** Mild | Moderate | Severe  
**PROPHYLAXIS WITHDRAWAL:**

![Diagram showing attack severity and prophylaxis withdrawal](image)

- **Historic monthly attack rate prior to screening (months):**
  - Pt. 1: 1.9
  - Pt. 2: 14.0
  - Pt. 3: 2.2

- **Administration of NTLA-2002:**
  - WK 16

- **Post-primary observation period (months):**
  - Pt. 1: 12.3
  - Pt. 2: 11.5
  - Pt. 3: 13.0

- **Attack severity:**
  - Mild
  - Moderate
  - Severe

- **Prophylaxis withdrawal:**
  - Berotralstat withdrawn at day 113
  - Danazol withdrawn at day 151
  - Berotralstat withdrawn at day 94
  - Stanozolol withdrawn at day 74
  - Danazol withdrawn at day 113
  - Danazol withdrawn at day 115

- **Dosage:***
  - 25 mg
  - 75 mg
  - 50 mg

- **Longest attack free duration post NTLA-2002 (months):**
  - Pt. 1: 7.5
  - Pt. 2: 10.1
  - Pt. 3: 8.9

- **Days:**
  - 0 to 448

**Note:**
- Berotralstat: 25 mg, 75 mg, 50 mg
- Danazol: 25 mg, 75 mg, 50 mg
- Stanozolol: 50 mg, 100 mg
- Danazol: 50 mg, 75 mg, 100 mg
- No concomitant prophylaxis
NTLA-3001 for Alpha-1 Antitrypsin Deficiency (AATD)-Associated Lung Disease

About AATD

- Genetic disorder leading to progressive lung and/or liver disease¹
- >60K AATD patients in the U.S.²*
- ~250K AATD patients globally³*

Our Approach

Targeted insertion of a functional SERPINA1 gene into the albumin locus
- Continuous expression of functional A1AT protein at normal levels

Key Advantages

- Designed to be a single-dose treatment
- Aims to achieve normal human levels of A1AT protein and halt progression of lung disease

¹ Remih et al. Curr Opin Pharmacol 2021; 59:149-156
² Brantly M. Clin Chem. 2006; 52:2180-2181
* In severe AATD patients defined as individuals with Pi*ZZ genotype.
Durable Production of Physiologic Levels of hA1AT Through One Year in NHP

Insertion Platform Enables Targeted, Stable Gene Insertion in the Albumin Locus

Precisely Create Insertion Site

Deliver Insertion Template

Gene of Interest

(LNP)

AAV

Gene of Interest

Promoter

Alb

Exon 1

Exon 2

Normal range: ~1000-2700 µg/mL, or 20-53 µM; Therapeutically relevant: 571 µg/mL, or 11 µM

Insertion Platform Enables Targeted, Stable Gene Insertion in the Albumin Locus

Human A1AT (hA1AT) Expression

Circulating hA1AT (µg/mL)

Time (weeks post insertion)

Buffer control (n=3)

Insertion (n=3)

Normal range

Therapeutically relevant

1 Stoller & Aboussouan. *The Lancet*, 2005
Normal range: ~1000-2700 µg/mL, or 20-53 µM; Therapeutically relevant: 571 µg/mL, or 11 µM
Significant Opportunities to Unlock Full Potential of *In Vivo* Platform

**CRITERIA USED TO SELECT POTENTIAL FUTURE CANDIDATES:**
- Unmet need
- Population size
- Technical feasibility

**Potential Liver Development Programs**

**RARE DISEASES**
- Blood disorders
- Lysosomal storage diseases
- Metabolic diseases

**PREVALENT DISEASES**
- Chronic viral diseases
- Dyslipidemia
- Hypertension
- NASH

**Unlocking Full Potential of Genome Editing**

**TARGET TISSUES**
- Bone marrow
- CNS/PNS
- Eye
- Heart
- Muscle

Expansion into tissue-specific diseases

---

* This is a selection of potential liver targets and does not represent all future opportunities.
** Individual targets could be developed by Intellia, Regeneron or through collaborations.
*** In collaboration with SparingVision
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2 In Vivo Portfolio
3 Ex Vivo Portfolio
4 Appendix
Ex Vivo

CRISPR creates the therapy

Strategic Advantages:

Utilizing proprietary CRISPR engineering platform to create differentiated cell therapies for IO and AI diseases

Targeting modalities, such as TCR, with broad potential in multiple indications

Focused on reproducing natural cell physiology for potential improvements to safety and efficacy in immuno-oncology
Proprietary Engineering Platform to Power Next-Generation Engineered Cell Therapies

LNP-BASED CELL ENGINEERING PLATFORM
Highly efficient sequential editing | Optimal cell performance | Scalable manufacturing process

ENABLES VERSATILE SOLUTIONS BY “MIXING AND MATCHING,” INCLUDING:

**Cell Type**
- HSCs, T cells
- NK cells, Macrophages

**Targeting Modality**
- TCRs
- CAR-Ts, Universal CARs

**Rewiring Instructions**
- Immune-enhancing edits
- Novel targets
### Differentiated Approach to Cell Therapy Genome Engineering

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<th>Gene Editing Approach</th>
<th>Delivery</th>
<th>Editing Mode</th>
<th>Knockout (KO)</th>
<th>Insertion</th>
<th>Key Questions From Preclinical Data</th>
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<td>Sequential</td>
<td>Cleavase or Base Editor</td>
<td>CRISPR insertion</td>
<td>Minimize random DSB?</td>
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<td>Other Approaches</td>
<td>Electroporation</td>
<td>Simultaneous</td>
<td>Simultaneous</td>
<td>Lenti/Retroviruses</td>
<td>Lenti/Retroviruses</td>
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</table>

**Key Questions**
- Minimize random DSB?
- Minimize random insertion?
- Minimize genotoxicity risk?

**Intellia Therapeutics**

LNP-based, sequential process + Precise CRISPR KOs & insertion(s) = Quality cell product

---

Slide based on preclinical data disclosed by Intellia. Intellia's cell product to be further explored in additional preclinical and clinical studies.
Sequential Editing with LNP Approach Minimizes Translocations While Retaining Robust Cell Viability and Expansion

ddPCR assay to detect TRAC-TRBC translocations

LNP Approach: Cell Expansion at D10

% TRAC-TRBC translocated cells
0.00 0.05 0.10 0.15 0.20 0.25
No Edit Electroporation Simultaneous LNP Sequential LNP

Fold Expansion
0 50 100 150
No Edit Simultaneous Sequential
Three Immune Concerns Must Be Addressed by Allogeneic Cell Therapies

1. **Graft-versus-host disease (GvHD)**
   T cell receptor (TCR) from allogeneic T cells recognizes and kills recipient (host) cells.

   *Largely solved with knockout (KO) of endogenous TCR*

2. **Rejection via host T cells**
   Human leukocyte antigen (HLA) molecules must match between donor and recipient to prevent rejection from:
   - Host CD8 (HLA class I) T cells
   - Host CD4 (HLA class II) T cells

3. **Rejection via host natural killer (NK) cells**
   NK cells will attack cells that lack HLA-I expression or have low HLA-I.

   *No validated solution yet*
Intellia’s Differentiated Allogeneic Approach Aims to Address All Three Immune Concerns

Key Potential Advantages

✓ Approach is applicable to CAR and TCR
✓ Solves for host NK and T cell rejection
✓ Avoids long-term immunosuppression

Intellia’s Editing Strategy

1a Knockout endogenous TCR
1b Insert target CAR or TCR
2a Knockout HLA Class II
2b Knockout HLA-A only
3 Partial HLA Class I match

Main Objective of Edit

Prevent Graft-versus-Host Disease (GvHD)
Direct T cell for tumor killing
Prevent CD4-mediated rejection
Prevent CD8-mediated rejection
Block NK cell activation and avoid NK-mediated rejection
Realizing the Promise of Gene Editing

At Intellia, we innovate every day to make CRISPR-based medicines a reality for patients.

This is just the beginning of the gene editing revolution.
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<td>Persistence of <em>In Vivo</em> Edits</td>
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<td><em>In Vivo</em> Editing of Hematopoietic Stem Cells</td>
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<td>Intellia’s Allogeneic Solution</td>
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<td>Platform: Identifying Potent and Highly Specific Guide RNAs</td>
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<td>Strategic Collaborations</td>
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Intellia’s Gene Editing Toolbox

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CRISPR/Cas9 and Derivative Gene Editing Technologies Can Be Used to Make Any Type of Edit

INTELLIA’S EDITING TOOLS

CRISPR/Cas9

DERIVATIVE TECHNOLOGIES

+ Base Editor

+ DNA Writer

+ Other Technologies

KNOCKOUT
Inactivation/deletion of disease-causing DNA sequence

INSERT
Insert new DNA sequence to manufacture therapeutic protein

REPAIR
Correction of “misspelled” disease-driving DNA sequence

INTELLIA SELECTS THE BEST TOOL FOR EACH THERAPEUTIC APPLICATION
A Tailored Approach to Maximize the Reach of Gene Editing Across Multiple Tissues

**INTELLIA’S DELIVERY TOOLS**

- **LNP:** Liver-targeted
- **LNP:** Bone marrow-targeted
- **AAV**
- **Other technologies**

**TARGET TISSUES**

- LNP: Liver-targeted
- Bone marrow-targeted
- Liver
- Bone Marrow
- AAV and other technologies: CNS/PNS, Eye, Muscle

*This is a representative list of target tissues and does not include all future opportunities.*
Persistence of *In Vivo* Edits

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Protein Reduction Remains Unchanged Following PHx Murine Model of Liver Regeneration

* Similar results obtained for control and LNP when sham surgery was performed.

Next generation sequencing (NGS) analysis to evaluate the frequency of insertion and deletion events (edits)
Gene Insertion Provides a Durability Advantage Over Conventional AAV Episomes in a PHx Murine Model of Rapid Liver Growth
In Vivo Editing of Hematopoietic Stem Cells

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Editing HSCs *In Vivo* Requires LNPs with Bone Marrow Tropism

LNPs designed, formulated and tested *in vivo* to identify compositions with enhanced delivery to bone marrow and HSCs.
Editing of Mouse Bone Marrow and HSCs is Durable Through At Least One Year

- Editing was similar across all time points assessed, in both whole bone marrow and HSCs populations
- Results highlight the potential for a single-course, long-lasting therapy

**Editing Over One Year Period**

```
<table>
<thead>
<tr>
<th>Weeks Post LNP Dose</th>
<th>Buffer</th>
<th>Whole bone marrow</th>
<th>Hematopoietic stem cells*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
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<td>24</td>
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<td>36</td>
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<tr>
<td>54</td>
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</tbody>
</table>
```

* Lin-Sca-1+c-Kit+CD34-Flk2- cell population
Editing of Mouse Bone Marrow and HSCs Increases with Multidosing

- Non-immunogenic LNP delivery platform may enable stepwise “treat-to-target” approach

* Blood. 2017;130(17):1946-1948
** Lin-Sca-1+c-KIt+CD34-Flk2- cell population

Level predicted to be curative for SCD*
Intellia’s Allogeneic Solution
# Immune Concerns Unaddressed by Current Allogeneic Solutions

## Intellia’s Approach

<table>
<thead>
<tr>
<th>Approach</th>
<th>Employ intense lymphodepletion regimen</th>
<th>Knockout (KO) HLA-I (B2M)</th>
<th>KO HLA-I &amp; express NK inhibitor (HLA-E)</th>
<th>Intellia’s Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoid rejection of cell therapy by host CD8 T cells</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Avoid rejection of cell therapy by host CD4 T cells</td>
<td>✔</td>
<td>✗</td>
<td>✗</td>
<td>✔</td>
</tr>
<tr>
<td>Avoid rejection of cell therapy by host NK cells</td>
<td>✔</td>
<td>✗</td>
<td>✗</td>
<td>✔</td>
</tr>
<tr>
<td>Avoid profound immunosuppression</td>
<td>✗</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
</tbody>
</table>

Slide based on preclinical data disclosed by Intellia. Intellia’s cell product to be further explored in additional preclinical and clinical studies.
Allo TCR-T Cells Resist NK Cell Killing for at Least 90 Days \textit{In Vivo}

Day -28

Mice engrafted with human NK cells or mock treated

Luciferase\textsuperscript{+} T cells

Days 0-90
IVIS imaging to detect Luciferase\textsuperscript{+} T cell signal

\textbf{B2M Knockout T cells}

>90% B2M KO T cells killed by NKs within 24h

\textbf{Allo TCR-T Cells}

Minimal Allo T cell rejection in the presence of NK cells
Platform: Identifying Potent and Highly Specific Guide RNAs
Comprehensive gRNA Specificity Assessment: An Off-Target Workflow

1: Discovery of Potential Off-Target Edits

- Computational prediction
- SITE-Seq Genomic DNA digest
- GUIDE-seq Cell-based DNA repair

Aggregate ALL potential off-target genomic loci

2: Cell-based Validation of True Off-Target Edits by Deep Sequencing

- Multiplex panel for NGS
- Targeted Amp-Seq NGS follow-up

Ex Vivo
- Cell drug product

In Vivo
- Edit cells *in vitro* using drug product formulation
- Therapeutically relevant human primary cell type(s) (multiple donors)
- Dose range to exceed projected therapeutic exposure (>10X)
Limited Overlap in Discovered Off-Target Loci by Three Leading Methods

1: Discovery of Potential Off-Target Edits

- Computational prediction
- SITE-Seq Genomic DNA digest
- GUIDE-seq Cell-based DNA repair

Aggregate ALL potential off-target genomic loci

658 non-overlapping potential off-target loci

SITE-Seq

431

GUIDE-Seq

174

Cas-OFFinder

178

37

14

Data above is a representative example
Off-Target Workflow In Practice: Representative Example

1: Discovery of Potential Off-Target Edits

- 658 non-overlapping potential off-target loci
  - SITE-Seq
  - GUIDE-Seq
  - Cas-OFFinder

2: Validation of Off-Target Edits in Cells

- Multiplex panel for NGS
- Targeted Amp-Seq NGS follow-up

In Vivo Programs

- Dose responses using drug product formulation
- Therapeutically relevant human primary cell type(s) (2 donors)
- Dose range to exceed projected therapeutic exposure (>10X)
- Validation: off-target indels detected in edited cells

Data above is a representative example
Validation of Off-Target Editing in Primary Human Hepatocytes at Supersaturating LNP CRISPR Concentrations to Maximize Sensitivity

658 potential off-target loci

7 validated off-target (OT) loci
2 in introns and 5 in intergenic regions

- SITE-Seq discovered 100%
- GUIDE-Seq and Cas-OFFinder discovered the same 3 out of 7 validated off-target loci 43%
- Eliminate gRNA with validated off-target indels in regions of the genome associated with cancer

Data above is a representative example
In Vitro: No Detectable Off-Target Editing with Pharmacologic Concentration of sgRNA
Strategic Collaborations

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Growing Intellia’s Impact on Patients Through Strategic Collaborations

- Genetic diseases
  - IO (Universal CAR-T)
- Autoimmune diseases
  - (CD19 CAR-T)
- Ophthalmology
  - IO (NK Cells)

Collaborations with:
- REGENERON
- kyverna.
- ONK THERAPEUTICS
Collaborations Helping to Accelerate the Development of CRISPR-Based Therapies

**REGENERON**

Collaboration Overview:

- Up to 15 *in vivo* targets with a mix of co-developed and licensed programs
  - Liver-centric product development
- ATTR (*in vivo* knockout): Intellia is lead party; Regeneron will share 25% of costs and profits
- Hemophilia A and B (*in vivo* insertion): Regeneron is lead party; Regeneron will share 65% of costs and profits
- *In vivo* targets exclusively developed by Regeneron:
  - Up to $320M in milestones per target
  - High single to low double-digit royalties
- Non-exclusive license to certain platform IP for up to 10 *ex vivo* CRISPR products in defined cell types
- New research collaboration as of September 2023 to develop treatments for neurological and muscular diseases

Click below to learn more about our other collaborations.
Abbreviations

AATD: alpha-antitrypsin deficiency
AAV: adeno-associated virus
AE: adverse event
AI: autoimmune disease
AST: aspartate transaminase
ATTR amyloidosis: transthyretin amyloidosis
ATTRv: hereditary ATTR amyloidosis
ATTRwt: wild-type ATTR amyloidosis
ATTR-CM: ATTR amyloidosis with cardiomyopathy
ATTRv-PN: hereditary ATTR amyloidosis with polyneuropathy
B2M: beta-2-microglobulin
BLA: biologics license application
CAR-T: chimeric antigen receptor T cells
CNS: central nervous system
CTA: clinical trial application
CV: cardiovascular
ddPCR: digital droplet polymerase chain reaction
DSB: double strand break
GvHD: graft-versus-host disease
EC90: concentration inducing 90% of maximal effect
Gr: Grade
gRNA: guide RNA
HAE: hereditary angioedema
Hem A/B: hemophilia A/B
HLA-I / II: human leukocyte antigen class I / II
HLA-E: human leukocyte antigen class E
HSC: hematopoietic stem cells
IND: investigational new drug
IO: immuno-oncology
IQR: interquartile range
KCCQ-OS: Kansas City Cardiomyopathy Questionnaire-Overall Summary
KLKB1: kallikrein B1
LNP: lipid nanoparticle
mRNA: messenger RNA
NAC: National Amyloidosis Centre
NASH: nonalcoholic steatohepatitis
NHP: non-human primate
NK: natural killer
NT-proBNP: N-terminal-pro-B-type natriuretic peptide
NYHA: New York Heart Association
PD: pharmacodynamics
PHx: partial hepatectomy
PK: pharmacokinetics
PNS: peripheral nervous system
SAE: serious adverse event
SCD: sickle cell disease
SD: standard deviation
sgRNA: single-guide RNA
TCR: T cell receptor
TEAE: treatment-emergent adverse event
TTR: transthyretin