Insmed Incorporated

Commercial Presentation

June 4, 2024

Forward Looking Statements

This presentation contains forward-looking statements that involve substantial risks and uncertainties. “Forward-looking statements,” as that term is defined in the Private Securities Litigation Reform Act of 1995, are statements that are not historical facts and involve a number of risks and uncertainties. Words herein such as “may,” “will,” “should,” “could,” “would,” “expects,” “plans,” “anticipates,” “believes,” “estimates,” “projects,” “predicts,” “intends,” “potential,” “continues,” and similar expressions (as well as other words or expressions referencing future events, conditions or circumstances) may identify forward-looking statements.

The forward-looking statements in this presentation are based upon the Company's current expectations and beliefs, and involve known and unknown risks, uncertainties and other factors, which may cause the Company's actual results, performance and achievements and the timing of certain events to differ materially from the results, performance, achievements or timings discussed, projected, anticipated or indicated in any forward-looking statements. Such risks, uncertainties and other factors include, among others, the following: the risk that the full data set from the ASPEN study or data generated in further clinical trials of brensocatib will not be consistent with the top-line results of the ASPEN study; failure to obtain, or delays in obtaining, regulatory approvals for brensocatib, TPIP or our other product candidates in the U.S., Europe or Japan or regulatory approvals for potential future brensocatib or TPIP indications; failure to successfully commercialize brensocatib, TPIP or our other product candidates, if approved by applicable regulatory authorities, in the U.S., Europe or Japan, or to maintain U.S., European or Japanese approval for brensocatib, TPIP or our other product candidates, if approved; uncertainties or changes in the degree of market acceptance of ARIKAYCE or, if approved, brensocatib or TPIP by physicians, patients, third-party payors and others in the healthcare community; failure to continue to successfully commercialize ARIKAYCE, our only approved product, in the U.S., Europe or Japan (amikacin liposome inhalation suspension, Liposomal 590 mg Nebuliser Dispersion, and amikacin sulfate inhalation drug product, respectively), or to maintain U.S., European or Japanese approval for ARIKAYCE; our inability to obtain full approval of ARIKAYCE from the FDA, including the risk that we will not successfully or in a timely manner validate a patient reported outcome (PRO) tool and complete the confirmatory post-marketing clinical trial required for full approval of ARIKAYCE, or our failure to obtain regulatory approval to expand ARIKAYCE’s indication to a broader patient population; failure to obtain, or delays in obtaining, regulatory approvals for ARIKAYCE outside the U.S., Europe or Japan, including separate regulatory approval for Lamira® in each market and for each usage; failure of third parties on which the Company is dependent, including Esteve Pharmaceuticals, S.A., Thermo Fisher Scientific, Inc. or the Company’s other third-party manufacturers, to manufacture sufficient quantities of ARIKAYCE, brensocatib, or TPIP for commercial or clinical needs, to conduct the Company's clinical trials, or to comply with the Company's agreements or laws and regulations that impact the Company's business or agreements with the Company; our inability to obtain and maintain adequate reimbursement from government or third-party payors for ARIKAYCE or, if approved, brensocatib or TPIP, or acceptable prices for ARIKAYCE or, if approved, brensocatib or TPIP; our inability to create or maintain an effective direct sales and marketing infrastructure or to partner with third parties that offer such an infrastructure for distribution of ARIKAYCE or, if approved, brensocatib or TPIP; risk that our competitors may obtain orphan drug exclusivity for a product that is essentially the same as a product we are developing for a particular indication; inaccuracies in our estimates of the size of the potential markets for ARIKAYCE, brensocatib, TPIP or our other product candidates, in our related estimates of peak sales potential, or in data we have used to identify physicians, expected rates of patient uptake, duration of expected treatment, or expected patient adherence or discontinuation rates; development of unexpected safety or efficacy concerns related to ARIKAYCE, brensocatib, TPIP or our other product candidates; restrictions or other obligations imposed on us by agreements related to brensocatib, including our license agreement with AstraZeneca AB, and failure to comply with our obligations under such agreements; failure to successfully conduct future clinical trials for ARIKAYCE, brensocatib, TPIP or our other product candidates, including due to the Company's potential inability to enroll or retain sufficient patients to conduct and complete the trials or generate data necessary for regulatory approvals, among other things; risks that the Company's clinical studies will be delayed, that serious side effects will be identified during drug development, or that any protocol amendments submitted will be rejected; risks that interim or partial data sets are not representative of a complete or larger data set or that blinded data will not be predictive of unblinded data; delays in the execution of plans to build out an additional third-party manufacturing facility approved by the appropriate regulatory authorities and unexpected expenses associated with those plans; the strength and enforceability of the Company’s intellectual property rights or the rights of third parties; the cost and potential reputational damage resulting from litigation to which the Company may become a party, including product liability claims; changes in laws and regulations applicable to our business, including any pricing reform and laws that impact our ability to utilize certain third parties in the research, development or manufacture of our product candidates, and failure to comply with such laws and regulations; inability to adapt to our highly competitive and changing environment; risk that we are unable to maintain our significant customers; our inability to attract and retain key personnel or to effectively manage our growth; risk that government healthcare reform materially increases our costs and damages our financial condition; risk that our operations are subject to a material disruption in the event of a cybersecurity attack or issue; business or economic disruptions due to catastrophes or other events, including natural disasters or public health crises; deterioration in general economic conditions in the U.S., Europe, Japan and globally, including the effect of prolonged periods of inflation, affecting us, our suppliers, third-party service providers and potential partners; and inability to repay the Company's existing indebtedness and uncertainties with respect to the Company's need and ability to access future capital.

The Company may not actually achieve the results, plans, intentions or expectations indicated by the Company's forward-looking statements because, by their nature, forward-looking statements involve risks and uncertainties because they relate to events and depend on circumstances that may or may not occur in the future. For additional information about the risks and uncertainties that may affect the Company's business, please see the factors discussed in Item 1A, "Risk Factors," in the Company's Annual Report on Form 10-K for the year ended December 31, 2023 and any subsequent Company filings with the Securities and Exchange Commission (SEC).

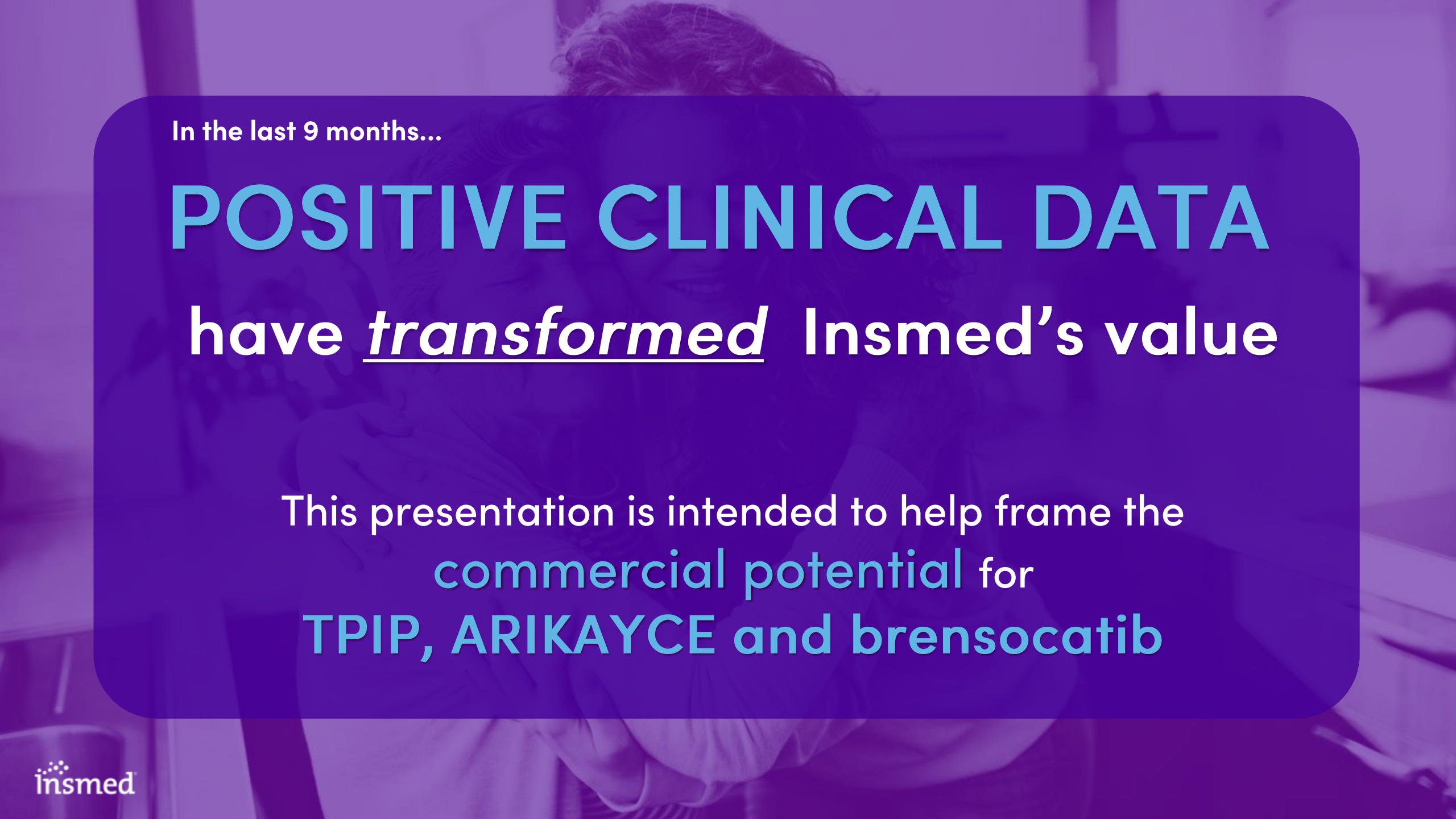
The Company cautions readers not to place undue reliance on any such forward-looking statements, which speak only as of the date of this presentation. The Company disclaims any obligation, except as specifically required by law and the rules of the SEC, to publicly update or revise any such statements to reflect any change in expectations or in events, conditions or circumstances on which any such statements may be based, or that may affect the likelihood that actual results will differ from those set forth in the forward-looking statements.

Additional Disclaimers

With respect to the blended and blinded data observed from the ongoing TPIP study in pulmonary arterial hypertension, the dose titration and efficacy analyses were based on data available as of April 1, 2024, and the safety analyses were based on data available as of January 25, 2024, respectively. These findings may not be representative of results after the study is completed and all data are collected and analyzed. As a result, later interim data readouts and final data from this study may be materially different than the observations described herein, including with respect to efficacy, safety and tolerability of TPIP.

Certain information contained in this presentation relates to or is based on studies, publications, surveys and other data obtained from third-party sources, as well as our own internal estimates and research. While we believe the information in these third-party sources to be reliable as of the date of this presentation, we have not independently verified any such information or the underlying assumptions relied on in such third-party sources. In addition, while we believe our internal research is reliable, such research has not been verified by any independent source.

Please be aware that brensocatib and TPIP are investigational products that have not been approved for sale or found safe or effective by the FDA or any regulatory authority. In addition, ARIKAYCE has not been approved for the treatment of all patients with MAC lung disease. This presentation is not promotion or advertisement of ARIKAYCE, brensocatib, or TPIP.



In the last 9 months...

POSITIVE CLINICAL DATA

have *transformed* Insmed's value

This presentation is intended to help frame the commercial potential for TPIP, ARIKAYCE and brensocatib

insmed

A portfolio of multi-indication programs each with blockbuster potential*

TPIP

- PH-ILD
- PAH

ARIKAYCE®

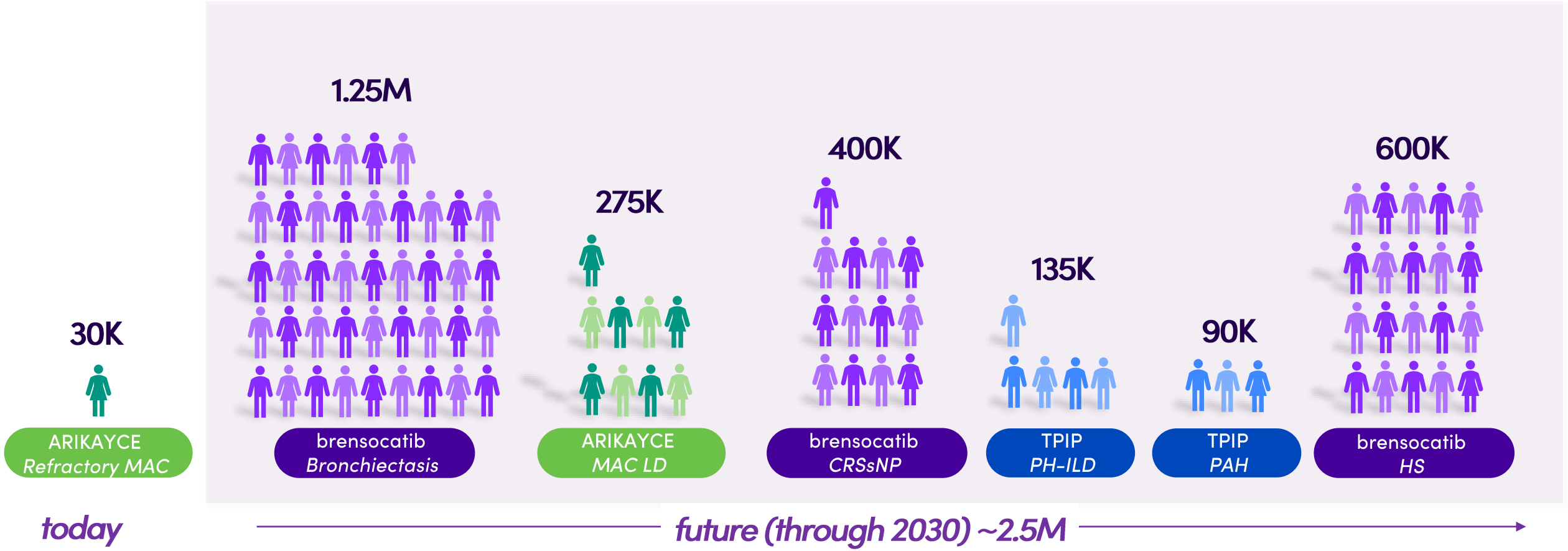
- Refractory MAC NTM**
- All MAC NTM

BRENSOCATIB

- Bronchiectasis
- CRSsNP
- HS

PH-ILD=Pulmonary hypertension due to interstitial lung disease; PAH=Pulmonary arterial hypertension
MAC=Mycobacterium avium complex; NTM=nontuberculous mycobacterial
Bronchiectasis refers to non-cystic fibrosis bronchiectasis; CRSsNP=Chronic rhinosinusitis sans nasal polyps; HS=Hidradenitis suppurativa
*If approved
**ARIKAYCE is currently approved for refractory MAC NTM

Potential addressable patients anticipated to grow substantially with a steady cadence of launches*



Bronchiectasis refers to non-cystic fibrosis bronchiectasis; MAC/MAC LD=mycobacterium avium complex lung disease; CRSsNP=chronic rhinosinusitis without nasal polyps, PH-ILD= pulmonary hypertension due to interstitial lung disease; PAH=pulmonary arterial hypertension; HS=hidradenitis suppurativa

*If approved

Note: Prevalence numbers depicted here are further detailed on slides 9, 10, 13, 17, 22, 24

Three therapies with positive clinical data in-hand have potential to be first- and/or best-in-disease*

TPIP

PH-ILD Phase 2

- Max. dose **well-tolerated**
- Nominally stat. sig. benefit on **clinical worsening**

PAH Phase 2**

- **PVR reduction** including placebo similar to treatment with other prostanoids

ARIKAYCE®

ARISE

- **Validated a PRO tool**
- **Nominally stat. sig. culture conversion** benefit at Month 7 compared to active control

BRENSOCATIB

ASPEN

- Potential for a **new standard of care in** bronchiectasis
- Unlocks **DPP1 mechanism** for neutrophil-mediated diseases

Peak sales potential

>$2bn | >$1bn | >$5bn

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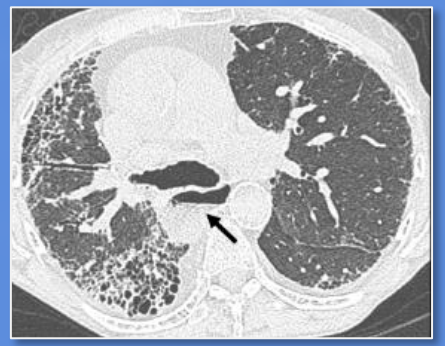
*"Best-in-disease/best-in-class" indicates a profile that could be considered more attractive than other treatment options for a particular disease. Head-to-head clinical trials are not anticipated.
**Based on blended and blinded data observed from the ongoing Phase 2 study of TPIP in PAH. Efficacy analyses were based on data available as of April 1, 2024
Bronchiectasis refers to non-cystic fibrosis bronchiectasis

TPIP

Pulmonary Hypertension due to Interstitial Lung Disease (PH-ILD)

A rapidly progressing disease associated with poor survival and decreased quality of life



Pulmonary Arterial Hypertension (PAH)

A devastating and debilitating disease that pervades all aspects of a patient's daily life

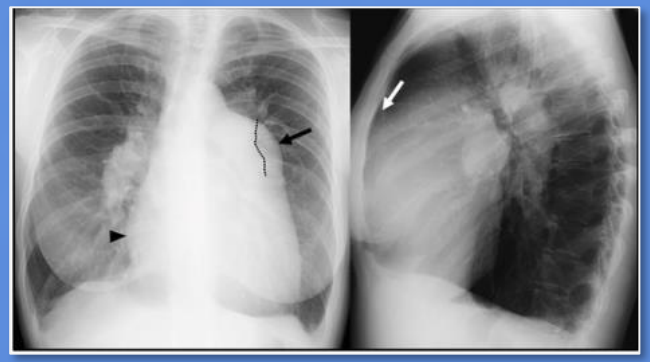


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Image Source: Valentini A, Franchi P, Cicchetti G, Messana G, Chiffi G, Strappa C, Calandriello L, del Ciello A, Farchione A, Preda L, et al. Pulmonary Hypertension in Chronic Lung Diseases: What Role Do Radiologists Play? *Diagnostics*. 2023; 13(9):1607. https://doi.org/10.3390/diagnostics13091607

TPIP has the potential to clearly differentiate from other treatments in PH-ILD and PAH

Convenience*
Once daily inhalation

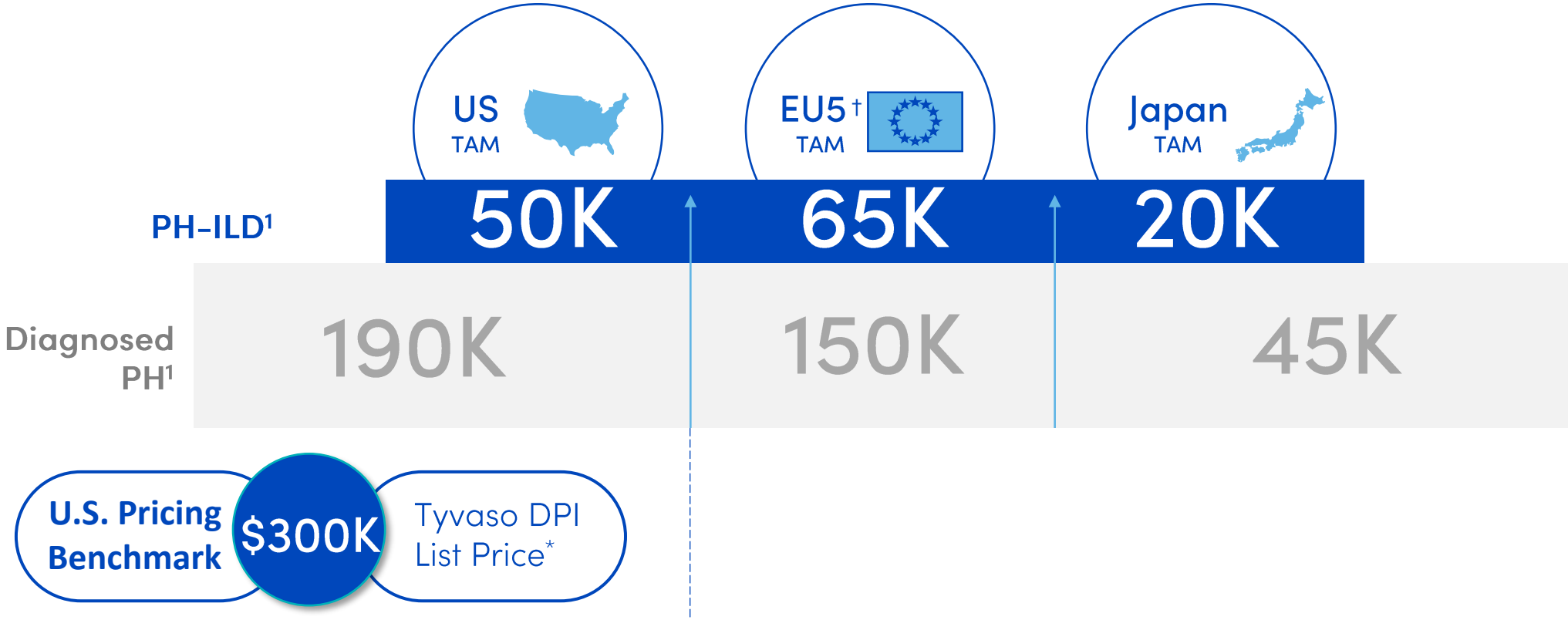
Safety**
Favorable safety profile

Higher Dosing
Tolerability may lead to improved outcomes

	TPIP	Remodulin®	Tyvaso®	Yutrepia®	Orenitram®	Uptravi®
Route of administration	Inhaled (dry powder)	IV or Subcutaneous	Inhaled (nebulized and dry powder)	Inhaled (dry powder)	Oral	Oral
Dosing frequency	Once daily	Continuous	4x per day	4x per day	2x or 3x per day	2x per day
Favorable tolerability for higher dose†	Yes**	Yes	No	Yes	No	No
Efficacy in PAH (WHO Group 1)	To be evaluated in Phase 2 and Phase 3	Yes	Yes	Yes	Yes	Yes
Efficacy in PH-ILD (WHO Group 3)	Pursuing in parallel to PAH	No data	Yes	Yes	No data	No data

*No head-to-head or convenience studies have been conducted or planned.
**Safety analysis based on topline safety and tolerability data from the Phase 2 PH-ILD study of TPIP disclosed on May 6, 2024
†Based on most recent publicly available data

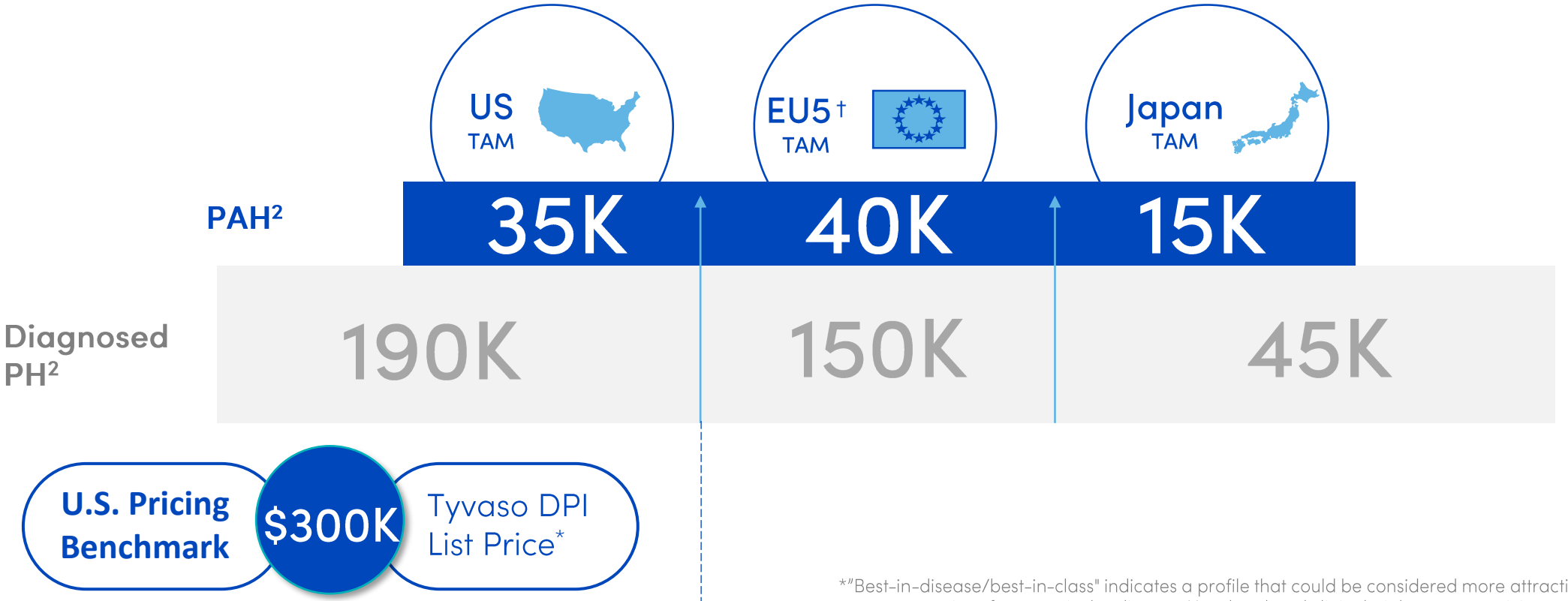
PH-ILD is a significant potential commercial opportunity, with ~135k patients



*Wholesale acquisition cost (WAC) as of March 12, 2024
For references, please refer to slides 29-32
TAM=Total Addressable Market

†EU5 comprised of France, Germany, Italy, Spain and the United Kingdom
Note: Diagnosed pulmonary hypertension (PH) consists of pulmonary arterial hypertension (PAH), pulmonary hypertension due to left heart diseases (PH-LHD), pulmonary hypertension due to interstitial lung disease (PH-ILD), chronic thromboembolic pulmonary hypertension (CTEPH), Idiopathic PH

TPIP represents potential best-in-class* prostanoid for ~90k patients with PAH



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Prostacyclins expected to remain cornerstone of PAH therapy; TPIP has potential to be prostacyclin of choice

Thoughts from Key Opinion Leaders in the PAH Space[3,4]

Phase 3 STELLAR trial suggests that sotatercept will be complementary with treprostinil products

Regardless of sotatercept's efficacy, the **prostacyclin pathway will remain important to PAH**

TPIP really sounds like something that could be **very** valuable to the patient

Note: Prostacyclins are part of the prostacyclin receptor agonist class

For references, please refer to slides 29-32

ARIKAYCE

Refractory Mycobacterium avium complex lung disease (rMAC LD)

Mycobacterium avium complex lung disease (MAC LD)

A rare and chronic disease that can cause irreversible lung damage

and is the most common form of NTM respiratory pathogen

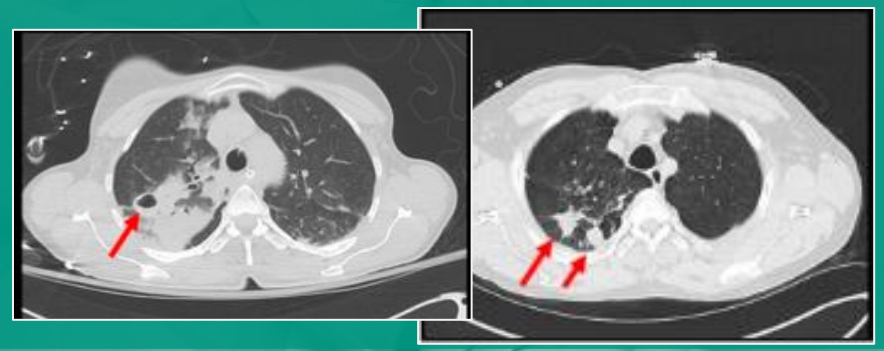

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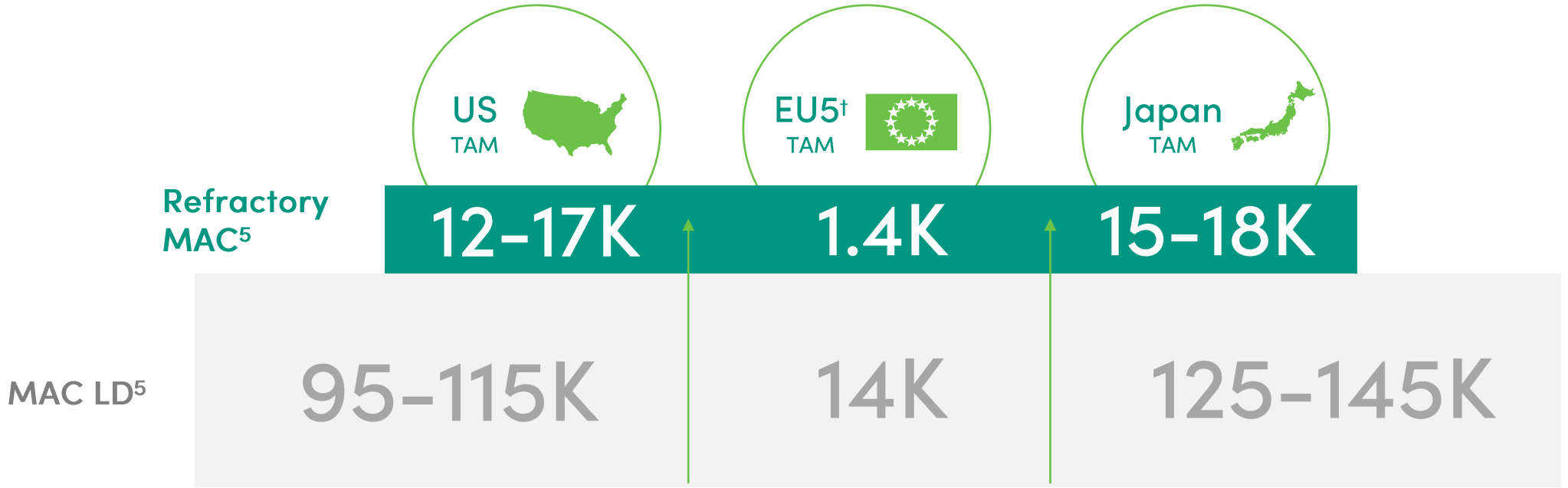
Image source: Hendrix C, McCrary M, Hou R, Abate G. Diagnosis and Management of Pulmonary NTM with a Focus on *Mycobacterium avium* Complex and *Mycobacterium abscessus*: Challenges and Prospects. *Microorganisms*. 2023; 11(1):47. https://doi.org/10.3390/microorganisms11010047

ARIKAYCE has the potential to be best in MAC LD treatment regimen to address ~275K patients



If approved, we anticipate marketing ARIKAYCE in MAC LD at same price and dosage as currently available ARIKAYCE

ARIKAYCE® (amikacin liposome inhalation suspension)

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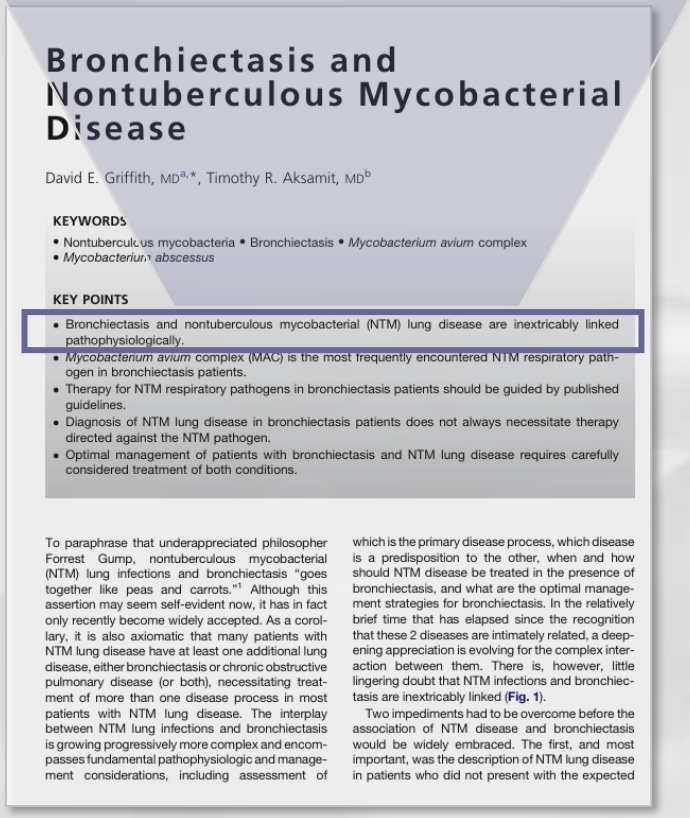
TAM=Total Addressable Market

For references, please refer to slides 29-32

†EU5 comprised of France, Germany, Italy, Spain and the United Kingdom

Bronchiectasis (BE) and nontuberculous mycobacterial (NTM) lung disease are **inextricably linked** pathophysiologically[6]



Bronchiectasis and Nontuberculous Mycobacterial Disease

David E. Griffith, MD[a,*], Timothy R. Aksamit, MD[b]

KEYWORDS

- Nontuberculous mycobacteria • Bronchiectasis • *Mycobacterium avium* complex
- *Mycobacterium abscessus*

KEY POINTS

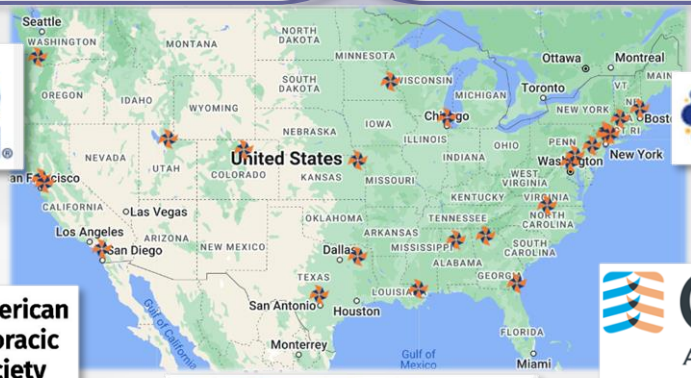
- Bronchiectasis and nontuberculous mycobacterial (NTM) lung disease are inextricably linked pathophysiologically.
- *Mycobacterium avium* complex (MAC) is the most frequently encountered NTM respiratory pathogen in bronchiectasis patients.
- Therapy for NTM respiratory pathogens in bronchiectasis patients should be guided by published guidelines.
- Diagnosis of NTM lung disease in bronchiectasis patients does not always necessitate therapy directed against the NTM pathogen.
- Optimal management of patients with bronchiectasis and NTM lung disease requires carefully considered treatment of both conditions.

To paraphrase that underappreciated philosopher Forrest Gump, nontuberculous mycobacterial (NTM) lung infections and bronchiectasis "goes together like peas and carrots."[1] Although this assertion may seem self-evident now, it has in fact only recently become widely accepted. As a corollary, it is also axiomatic that many patients with NTM lung disease have at least one additional lung disease, either bronchiectasis or chronic obstructive pulmonary disease (or both), necessitating treatment of more than one disease process in most patients with NTM lung disease. The interplay between NTM lung infections and bronchiectasis is growing progressively more complex and encompasses fundamental pathophysiologic and management considerations, including assessment of which is the primary disease process, which disease is a predisposition to the other, when and how should NTM disease be treated in the presence of bronchiectasis, and what are the optimal management strategies for bronchiectasis. In the relatively brief time that has elapsed since the recognition that these 2 diseases are intimately related, a deepening appreciation is evolving for the complex interaction between them. There is, however, little lingering doubt that NTM infections and bronchiectasis are inextricably linked (Fig. 1).

Two impediments had to be overcome before the association of NTM disease and bronchiectasis would be widely embraced. The first, and most important, was the description of NTM lung disease in patients who did not present with the expected

Physician and patient **overlap between NTM and BE** is high

Insmed has **strong relationships in this space,** spanning 6+ years



COPD FOUNDATION

IDWeek

ATS American Thoracic Society

CHEST AMERICAN COLLEGE of CHEST PHYSICIANS

NTMir Nontuberculous Mycobacteria NTM Info & Research, Inc.

For references, please refer to slides 29-32
Bronchiectasis refers to non-cystic fibrosis bronchiectasis

ARIKAYCE | brensocatib

In 2018, ARIKAYCE delivered a top 10 non-oncology rare disease launch...

...and we expect to deliver again

2018 → 2025

Focused engagement[7]

5K+

Healthcare Professional (HCP) targets

Increase in stakeholders[7]

5x

HCP targets

31x

Patient volume

Patient overlap[8]

44%

Of NTM patients also have bronchiectasis

In-house patient services

High touch patient services and specialty distribution

Consistency of field

94%

Current sales reps who have sold ARIKAYCE for more than 1 year

67%

Current field team that launched ARIKAYCE

Patient services heritage

One in-house patient support model with consistent specialty distribution model

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For references, please refer to slides 29-32

Bronchiectasis refers to non-cystic fibrosis bronchiectasis

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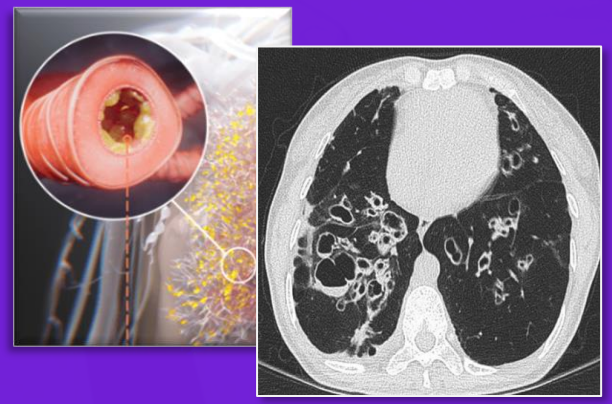
Bronchiectasis (BE)

A chronic, progressive inflammatory disease that causes permanent lung damage



Chronic Rhinosinusitis without Nasal Polyps (CRSsNP)

Hidradenitis Suppurativa (HS)

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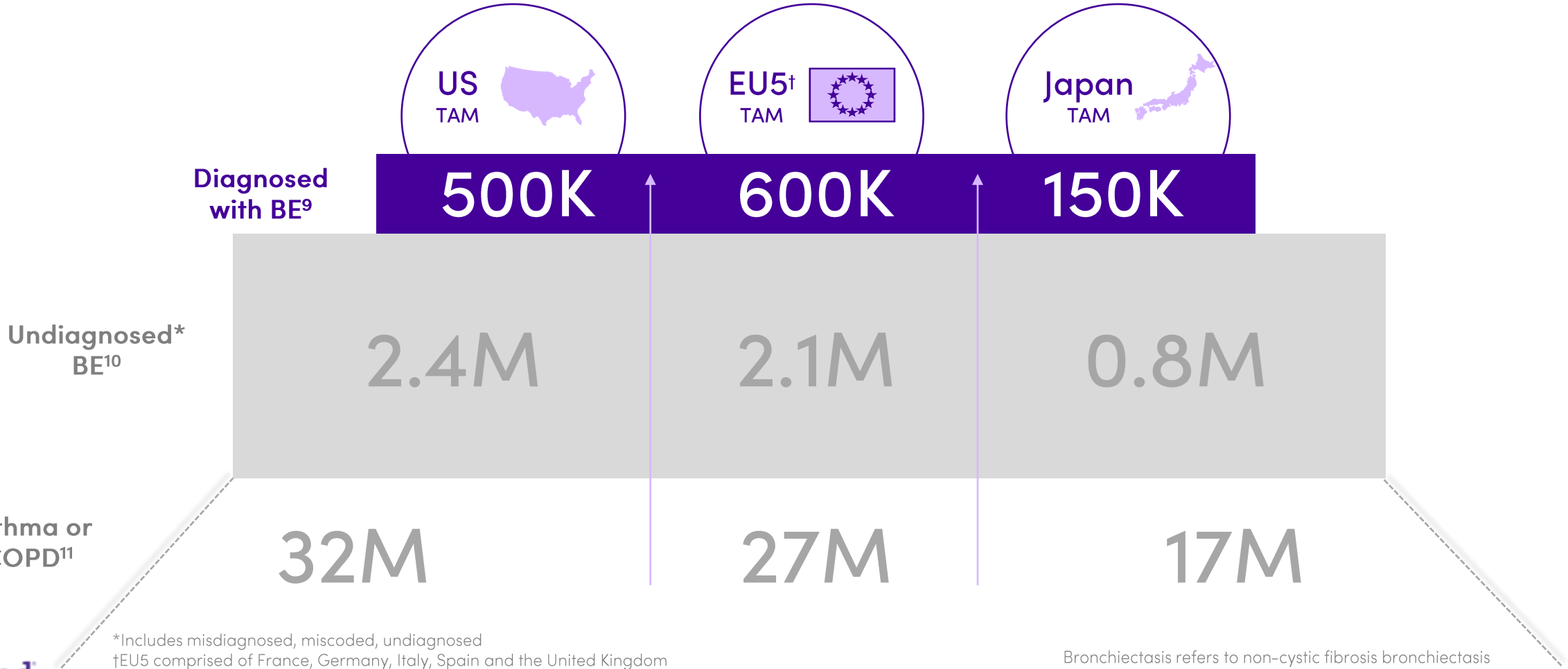
Bronchiectasis refers to non-cystic fibrosis bronchiectasis

Image Source: 1) Fraser CS, José RJ. Insights into Personalised Medicine in Bronchiectasis. *Journal of Personalized Medicine*. 2023; 13(1):133. https://doi.org/10.3390/jpm13010133. 2) Rethinkbronchiectasis.com

Bronchiectasis could represent a >1M patient indication at launch, *with significant growth potential*



*Includes misdiagnosed, miscoded, undiagnosed
†EU5 comprised of France, Germany, Italy, Spain and the United Kingdom
Note: COPD and asthma may be comorbid with bronchiectasis and not all patients with bronchiectasis have comorbid asthma or COPD

Bronchiectasis refers to non-cystic fibrosis bronchiectasis
TAM=Total Addressable Market
For references, please refer to slides 29-32

Other specialty pulmonary medications could be precedents for launch pricing

U.S. Launch List Price[12,13]	~$40k	$96k
Specialty pulmonary medications	Fasenra™ (benralizumab) Subcutaneous Injection 30 mg	OFEV® (nintedanib) capsules 150mg
Indication	Severe eosinophilic asthma	Idiopathic pulmonary fibrosis
Market Size[14,15]	~2.5M prevalent U.S. patients	130K prevalent U.S patients

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For references, please refer to slides 29-32

brensocatib - BE

Disease state education and field expansion well underway

Scientific Exchange

77

Publications of bronchiectasis and brensocatib*

36+

Global congresses, society, and patient advocacy meetings annually

Disease State

RETHINK BRONCHIECTASIS™ → *Launched May 2023*

Physician
Digital, congress & live events

Speak Up in BE → *Launched July 2023*

Patient
Digital and social campaign

→ *Launched Feb 2024*

Payer
Disease State & Burden

Field Expansion

2x

Field Medical & Market Access Teams**

120+

Field sales roles activated by ASPEN data †

*In the last 12 months
**As compared to May 2023
† Field sales roles posted post-ASPEN release

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Strong signals from stakeholders that uptake at launch could be rapid

U.S. Physicians

Intend to prescribe[16]

60%

See significantly high unmet need in bronchiectasis

80%

Likely to prescribe brensocatib

Patients

Motivated to act[17]

300K

Unique visits to disease state website*

26K

Highly engaged** visitors who have acted

Payers

Recognize disease burden[18]

Lives covered by engaged accounts:

>85%

Medicare lives†

>85%

Commercial lives †

*Since website launch in November 2023
**Highly engaged defined as those patients who have downloaded support tools or registered for CRM
†From February-May 2024; Commercial lives include VA, Tricare and DOD

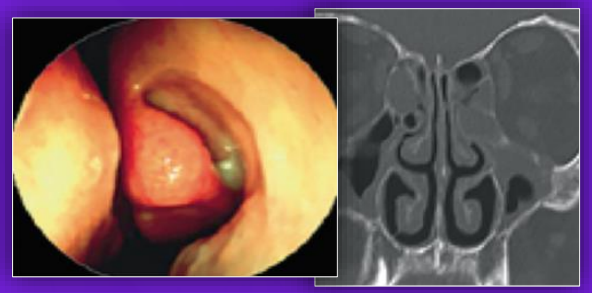
Bronchiectasis refers to non-cystic fibrosis bronchiectasis
For references, please refer to slides 29-32

BRENSOCATIB

Bronchiectasis (BE)

Chronic Rhinosinusitis without Nasal Polyps (CRSsNP)

A burdensome disease that significantly impairs quality of life



Hidradenitis Suppurativa (HS)

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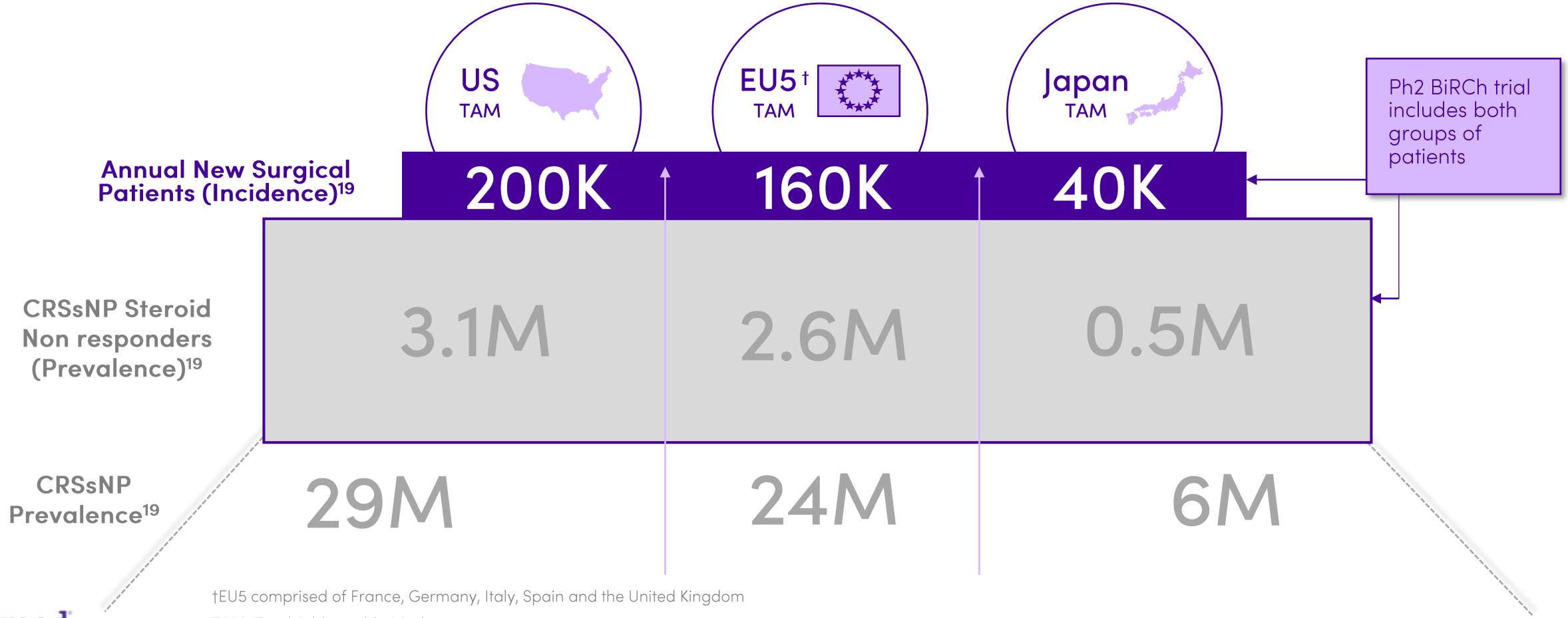
Image source: Yang Y, Zhang N, Crombruggen KV, Lan F, Hu G, Hong S, Bachert C. Differential Expression and Release of Activin A and Follistatin in Chronic Rhinosinusitis with and without Nasal Polyps. PLoS One. 2015 Jun 1;10(6):e0128564. doi: 10.1371/journal.pone.0128564. PMID: 26030615; PMCID: PMC4451080

CRSsNP is a significant symptomatic patient population, many of whom are progressing toward surgery



†EU5 comprised of France, Germany, Italy, Spain and the United Kingdom

TAM=Total Addressable Market

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BRENSOCATIB

Bronchiectasis (BE)

Chronic Rhinosinusitis without Nasal Polyps (CRSsNP)

Hidradenitis Suppurativa (HS)

A chronic, recurrent and debilitating inflammatory disease with significant treatment challenges

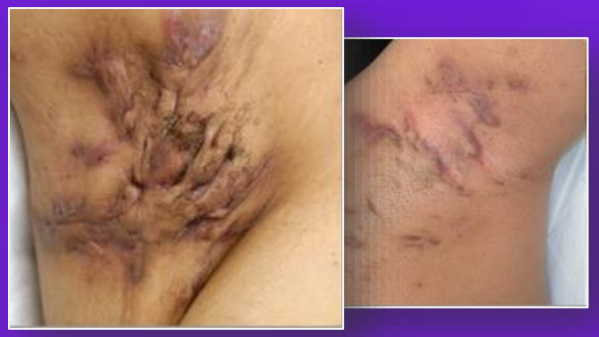

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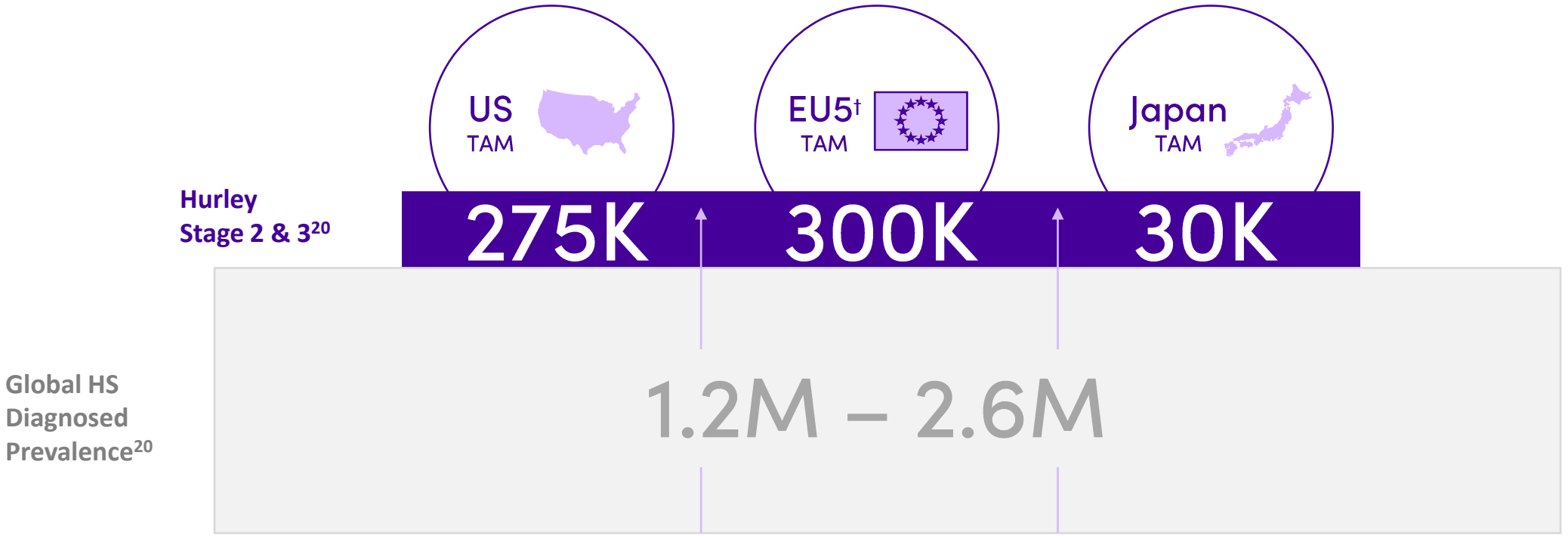
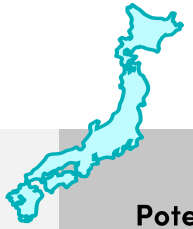
Image source: Z.N. Ovadja, M.M. Schuit, C.M.A.M. van der Horst, O. Lapid, Inter- and intrarater reliability of Hurley staging for hidradenitis suppurativa, *British Journal of Dermatology*, Volume 181, Issue 2, 1 August 2019, Pages 344–349, https://doi.org/10.1111/bjd.17588

Anticipated rapid initiation of Phase 2 HS trial by year-end with potential addressable market of >600K patients if successful



†EU5 comprised of France, Germany, Italy, Spain and the United Kingdom
TAM=Total Addressable Market
For references, please refer to slides 29-32

Strong, long-dated patent exclusivity



	Current Exclusivity	Potential Exclusivity	Current Exclusivity	Potential Exclusivity	Current Exclusivity	Potential Exclusivity
TPIP	2034	2041[d]	2034	2041[d]	2034	2041[d]
ARIKAYCE	2035	2041[a]	2035	2041[a]	2035	2041[a]
brensocatib	2035	2039[b]	2039	2040+[c]	2035	2040[c]

[a] Based on U.S. Patent Application No.18/024,040 and ex-U.S. counterpart applications issuing as patents. Additionally, given the complexity of drug product (liposomal inhalation with specific nebulizer), required bioequivalence testing could be difficult and lead to few generic entrants.
[b] Based on potential patent term extension (PTE) in the U.S. and US Application No. 16/975,292, which has been allowed, issuing in the U.S.
[c] Based on SPC and Japan PTE being capped at 5 years.
[d] Based on US Application No. 18/513,377 and ex-US counterparts issuing as a patent

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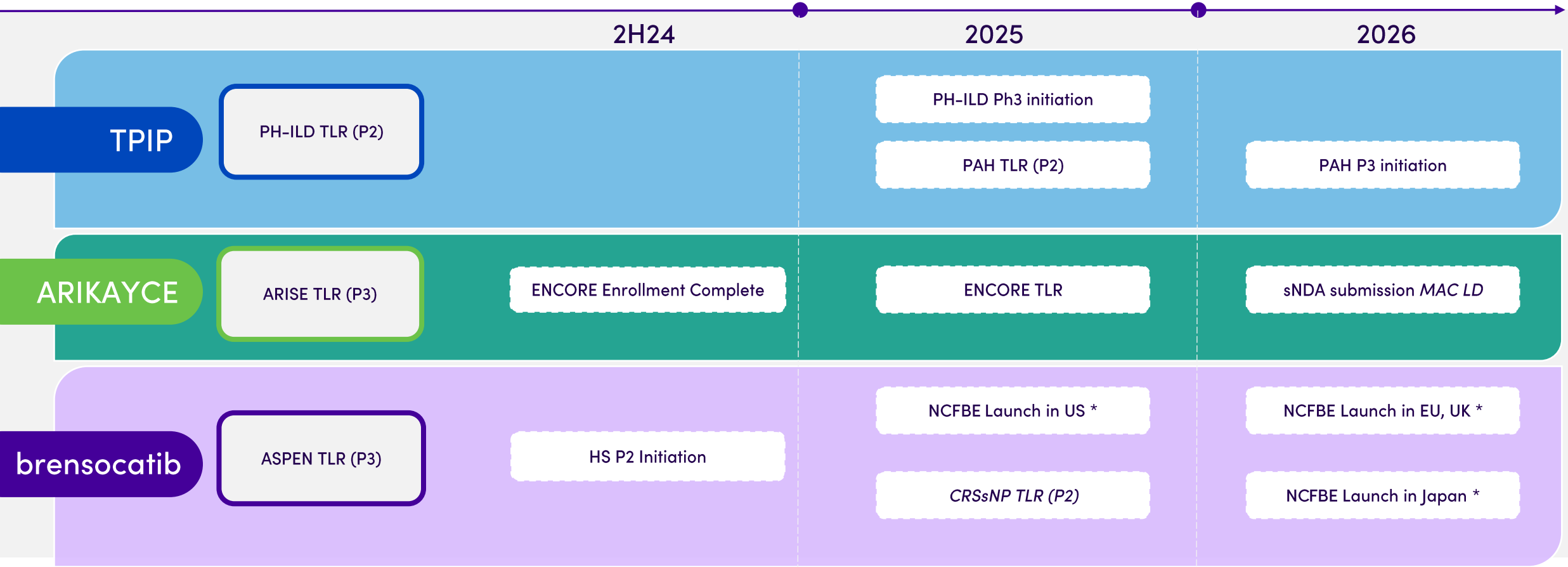
Expected pipeline catalysts provide additional opportunities for valuation inflection



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*Pending regulatory approval

TLR = Top Line Results

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