MANAGEMENT CALL TO DISCUSS INTERIM PHOENIX DATA

Forward-Looking Statements

This presentation contains certain “forward-looking” statements that are made pursuant to the safe harbor provisions of the Private Securities Litigation Reform Act of 1995. All statements, other than statements of historical or present facts, are forward-looking statements, including statements regarding our future financial condition, business strategy, and plans and objectives of management for future operations. In some cases, you can identify forward-looking statements by terminology such as “believe,” “will,” “may,” “estimate,” “continue,” “aim,” “assume,” “anticipate,” “contemplate,” “model,” “intend,” “target,” “project,” “should,” “plan,” “expect,” “predict,” “could,” “possible,” “seek,” “goal”, “potential,” “hypothesize,” “likely” or the negative of these terms or other similar terms or expressions that concern our expectations, strategy, plans, or intentions. These statements are based on our intentions, beliefs, projections, outlook, analyses, or current expectations using currently available information, are not guarantees of future performance, and involve certain risks and uncertainties. Although we believe that the expectations reflected in these forward-looking statements are reasonable, we cannot assure you that our expectations will prove to be correct. Therefore, actual outcomes and results could materially differ from what is expressed, implied, or forecast in these statements. Any differences could be caused by a number of factors including but not limited to: the success, cost, and timing of our product development activities and clinical trials; our ability to advance our NRF2 activators and other technologies; our ability to obtain and maintain regulatory approval of our product candidates, and limitations and warnings in the label of an approved product candidate; our ability to obtain funding for our operations, including funding necessary to complete further development and commercialization of our product candidates; our plans to research, develop, and commercialize our product candidates; the commercialization of our product candidates, if approved; the rate and degree of market acceptance of our product candidates; the size and growth potential of the markets for our product candidates, and our ability to identify target patient populations and serve those markets, especially for diseases with small patient populations; the success of competing therapies that are or may become available; our expectations regarding our ability to obtain and maintain intellectual property protection for our product candidates; the ability to license additional intellectual property relating to our product candidates and to comply with our existing license agreements; our ability to contract with third-party suppliers and manufacturers and their ability to perform adequately; our ability to attract collaborators with development, regulatory, and commercialization expertise; our ability to attract and retain key scientific or management personnel; our ability to grow our organization and increase the size of our facilities to meet our anticipated growth; the accuracy of our estimates regarding expenses, future revenue, capital requirements, and needs for additional financing; and regulatory developments in the United States and foreign countries.

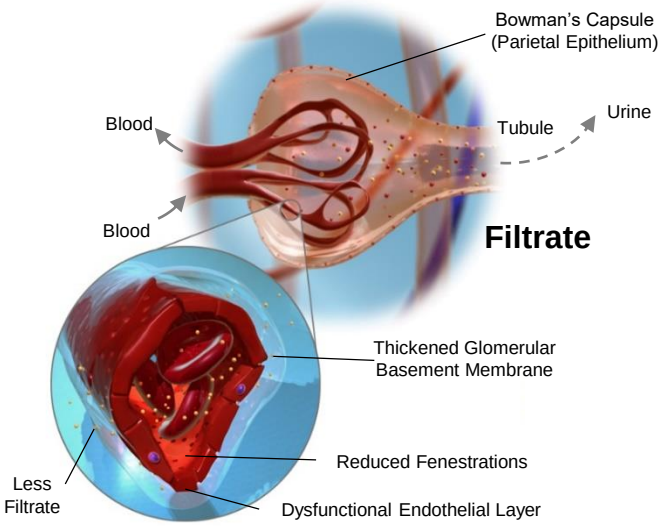
Additional factors that could cause actual results to differ materially from our expectations can be found in our Securities and Exchange Commission filings. Moreover, we operate in a very competitive and rapidly changing environment. New risk factors emerge from time to time, and it is not possible for our management to predict all risk factors, nor can we assess the effects of all factors on our business or the extent to which any factor, or combination of factors, may cause actual results to differ materially from those contained in, or implied by, any forward-looking statements. All forward-looking statements included in this presentation are expressly qualified in their entirety by these cautionary statements. The forward-looking statements speak only as of the date made and, other than as required by law, we undertake no obligation to publicly update or revise any forward-looking statements, whether as a result of new information, future events, or otherwise.

Bardoxolone Consistently Improved Kidney Function Through Unique MOA

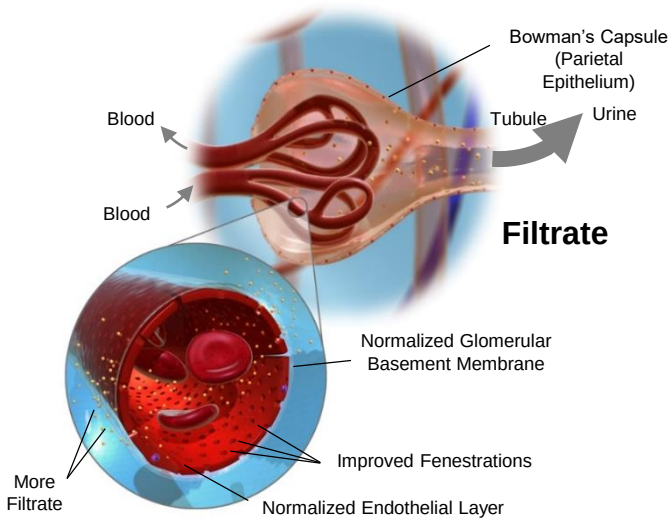
In 11 clinical trials, bardoxolone increased estimated GFR (eGFR) compared to placebo

- Bardoxolone increases GFR by reducing inflammatory signaling and restoring glomerular function as demonstrated in animal models
- eGFR increases verified as true improvement by “gold standard” inulin clearance method
- Kidney function improvements have been durable for up to two years and are partially retained following drug withdrawal
- Bardoxolone reduced the risk of kidney failure in diabetic CKD

Inflamed



Bardoxolone

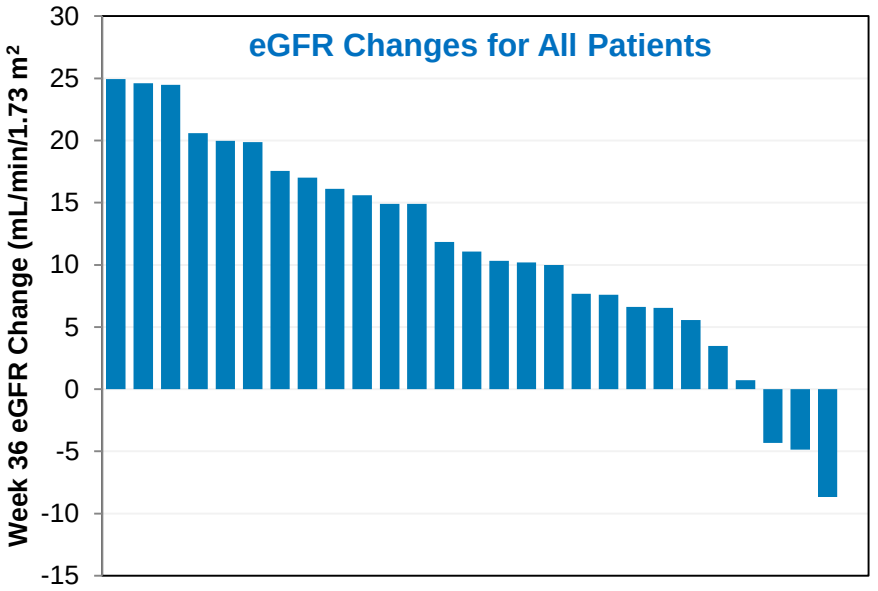


REATA PHARMACEUTICALS

CARDINAL Phase 2 Results Through Week 36

- Large, significant increases in eGFR observed through Week 36
- High patient retention rate with 90% of patients on study after 9 months
- No discontinuations due to bardoxolone-related adverse events
- Patients followed for 2 years, retained benefit analysis at week 52 will occur in 3Q18

Change From Baseline in eGFR		
	Week 12	**Week 36**
N	30	27
Mean ± SE	13.4 ± 1.4	11.3 ± 1.6
95% CI	(10.5, 16.3)	(7.9, 14.6)
p-value	<0.000000001	<0.000001



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CARDINAL
FOR PATIENTS WITH ALPORT SYNDROME

Bardoxolone Previously Improved Kidney Function in Three Forms of CKD

Diabetic CKD *Hyperglycemia*

Alport Syndrome *Glomerular Defects*

PAH *Cardio-renal Syndrome*

ADPKD *Cyst Formation*

IgAN *Activated IgA*

FSGS *Podocytopathies*

Inflammation and Fibrosis

↓

Loss of Kidney Function (eGFR)

↓

ESRD Dialysis Transplant

	Disease	Baseline eGFR	Interim eGFR Increase	Time point	Long-term eGFR Increase	Time point
BEAM	T2D CKD	32	12	Week 12	11	1 year
CARDINAL	Alport	54	13	Week 12	11	9 months
LARIAT	PAH	77	11	Week 16	11	2 years

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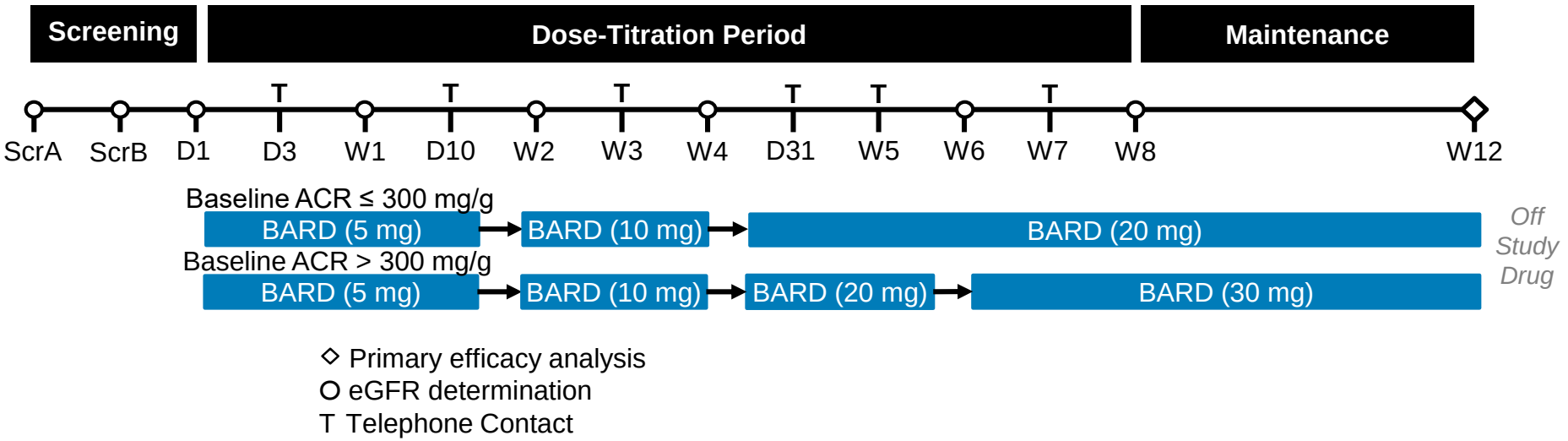
PHOENIX Study Design Overview

Design	Open-label, multi-center Phase 2 Study	
Enrollment size	Approximately 100 patients; 25-30 patients in each of 4 cohorts	
Treatment	Titration from 5 mg up to 20 mg or 30 mg daily for 12 weeks	
Key Eligibility Criteria	Inclusion	Exclusion
	• Age ≥ 18 – 65 years old • ADPKD: PKD1 mutation by genetic testing • IgAN: biopsy confirmation • Baseline eGFR: 30 to 90 mL/min/1.73 m^2	• Significant cardiovascular history • BNP > 200 ng/mL
Endpoints	• eGFR change at week 12 • Safety	



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PHOENIX Baseline Characteristics

Characteristic	ADPKD (N=31)	IgAN (N=26)
Age, years (mean, SD)	47.4 ± 9.5	48.5 ± 9.5
Female (n,%)	21 (68%)	11 (42%)
White/Caucasian (n,%)	25 (81%)	22 (85%)
Baseline eGFR, mL/min/1.73 m^2 (mean, SD)	47.7 ± 13.6	46.2 ± 12.6
Baseline ACR, mg/g (geometric mean)	44.3	104.0
Receiving ACEi or ARB (n,%)	25 (81%)	25 (96%)

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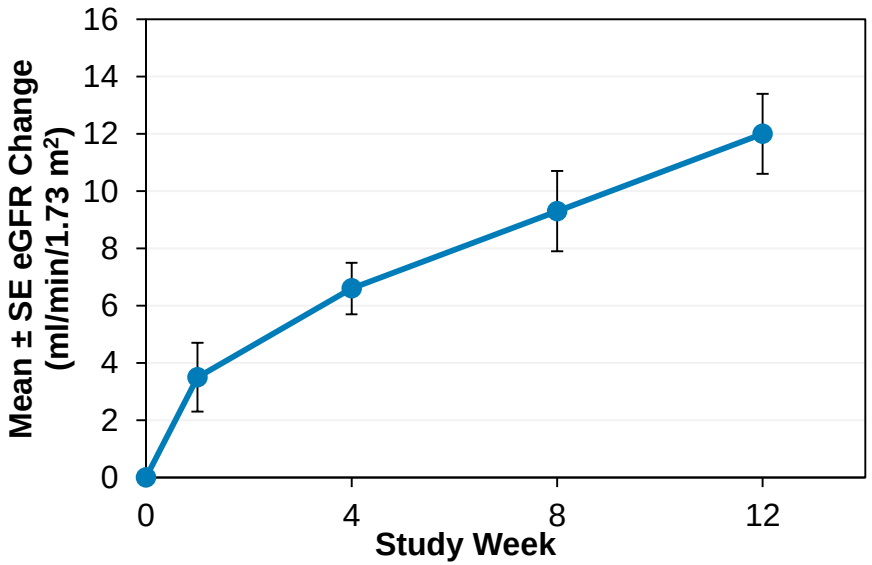
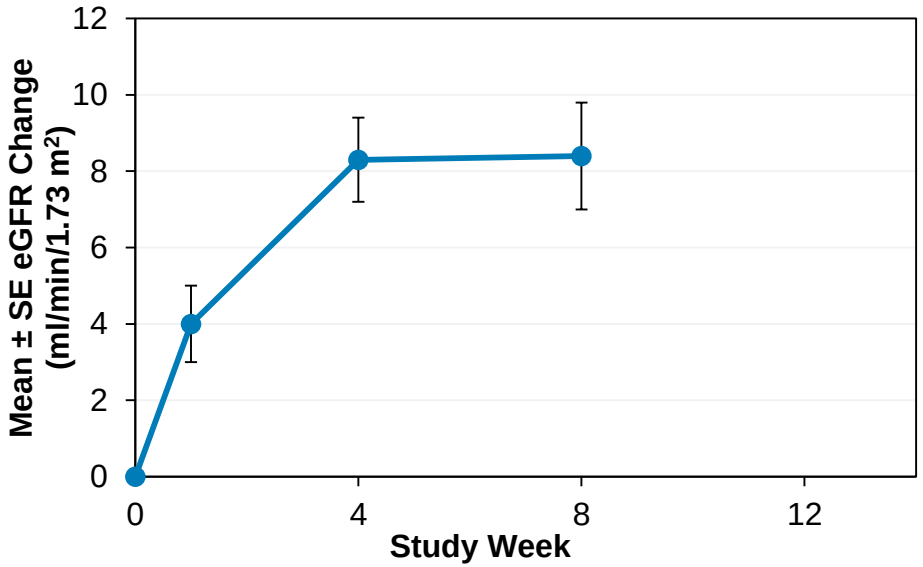
Bard Significantly Improved eGFR in ADPKD Patients



	BL eGFR	Change from Baseline in eGFR			
		WK1	WK4	WK8	WK12
N	31	31	31	15	8
Mean ± SE	47.7 ± 2.4	3.5 ± 1.2	6.6 ± 0.9	9.3 ± 1.4	12.0 ± 1.4
95% CI		(1.2 , 5.9)	(4.8, 8.5)	(6.5, 12.1)	(9.2, 14.9)
p-value	-	p=0.005	p<0.0001	p<0.0001	p<0.0001

REATA PHARMACEUTICALS

Bard Significantly Improved eGFR in IgAN Patients



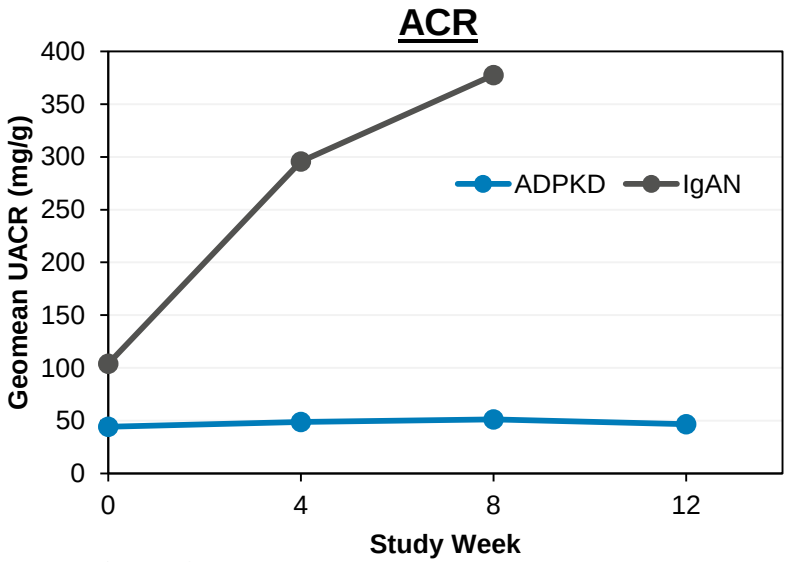
	BL eGFR	Change from Baseline in eGFR		
		WK1	WK4	WK8
N	26	24	16	9
Mean ± SE	46.2 ± 2.5	4.0 ± 1.0	8.3 ± 1.1	8.4 ± 1.4
95% CI		(2.0 , 5.9)	(6.1, 10.6)	(5.7, 11.1)
p-value	-	p=0.0001	p<0.0001	p<0.0001

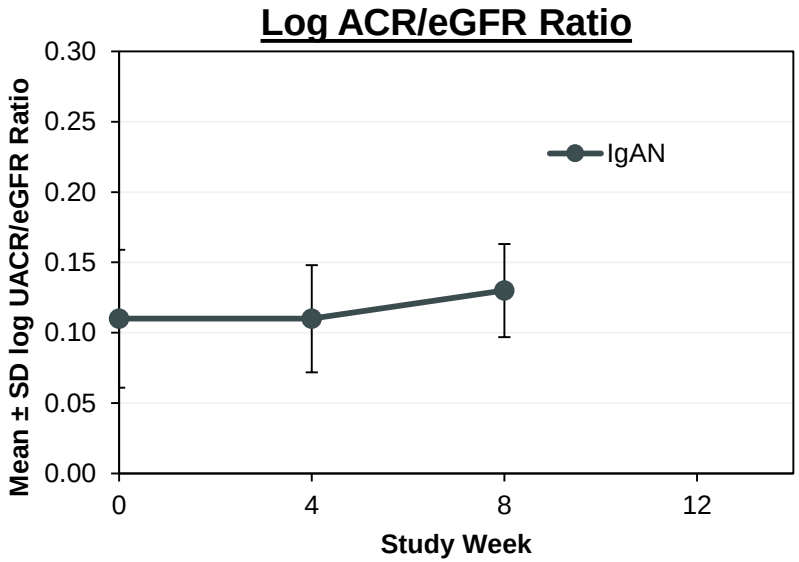
Data not shown beyond Week 8 since <25% of final data are available

REATA PHARMACEUTICALS

Summary of Albuminuria Data

- Urinary albumin excretion, measured as ACR, unchanged in ADPKD cohort because PKD patients have an intact filtration barrier
  - Patients had normal to near-normal levels of albuminuria at baseline and after treatment
  - Increases in eGFR not expected to increase ACR because healthy filtration barrier blocks it
- Upon study entry, ACR is abnormally high in IgA nephropathy cohort because protein filtration is impaired due to the disease process
  - Patients had elevated albuminuria at baseline and after treatment
  - Increases in GFR increase flow of protein through the impaired filtration barrier
  - Log ACR/eGFR ratio is unchanged from baseline, demonstrating that increases in eGFR observed in the IgA nephropathy cohort are accounted for by increases in GFR

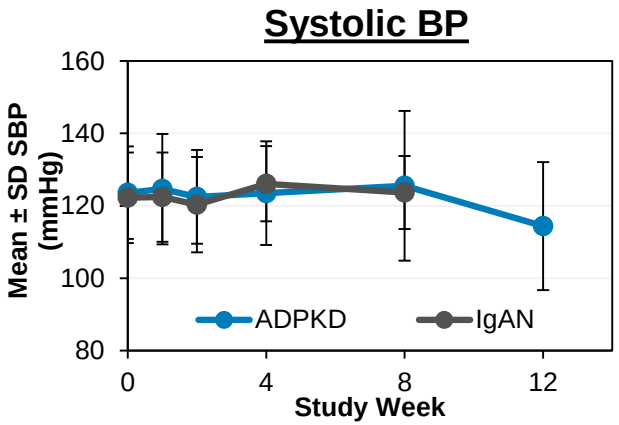


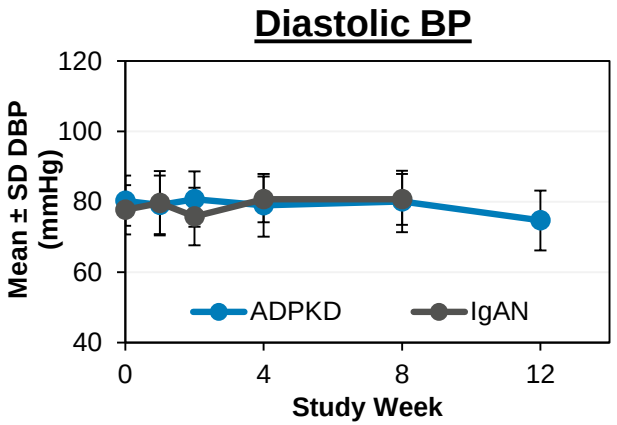


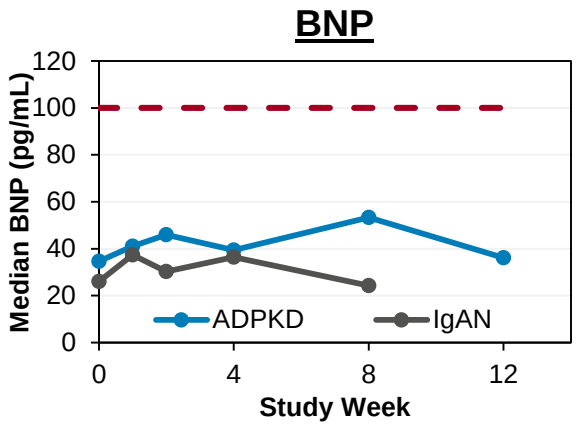
REATA PHARMACEUTICALS

Summary Blood Pressure and BNP

- Blood pressure and BNP stable and within normal limits upon study entry
- No significant changes from baseline during treatment
- No evidence of overt fluid retention







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Summary of Safety

- No treatment-related serious adverse events to date
- AEs to date have been mild to moderate in intensity
- Most commonly reported AE is muscle spasms, which is associated with reductions in CK

Preferred Term	ADPKD (N=31)
Muscle spasms	12 (39%)
Upper respiratory tract infection	3 (10%)

*AEs reported in >2 patients

Preferred Term	IgAN (N=26)
Muscle spasms	3 (12%)
Headache	3 (12%)

*AEs reported in >2 patients

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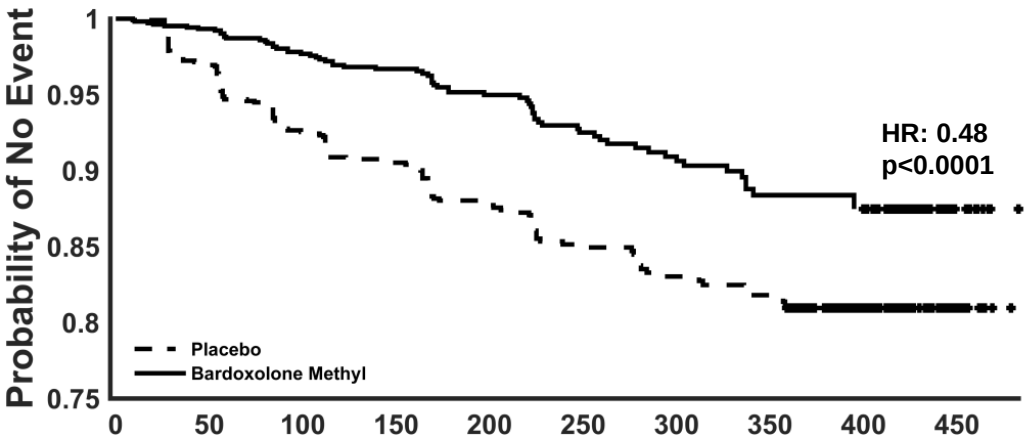
Increases in eGFR Translated to Reduced Risk of Kidney Failure Outcomes in BEACON

- Post-hoc analyses from the BEACON study in T2D CKD showed bardoxolone methyl significantly reduced likelihood of kidney failure outcomes
- Composite of adjudicated ESRD, 30% decline, or eGFR < 15: HR=0.48, p<0.001
- Selected as a Top 10 Abstract at ERA-EDTA and presented by Christoph Wanner, one of the top European and global KOLs

ESRD, ≥ 30% Decline or eGFR < 15 mL/min/1.73 m^2



Number of Patients										
PBO	1097	1041	850	734	570	429	317	216	92	13
BARD	1088	991	823	687	538	390	304	185	91	11

Future Development and Commercialization

Large unmet medical need exists in ADPKD and IgA nephropathy

- In the U.S., ADPKD is the leading inheritable cause of CKD and the 4th leading cause of ESRD
  - U.S. prevalence of ADPKD is approximately 400,000 people; 116,000 patients are diagnosed
  - 50% of patients progress to ESRD; ADPKD is responsible for 5% of all ESRD
- IgA nephropathy is the most prevalent primary chronic glomerular disease worldwide
  - U.S. prevalence of IgA nephropathy is approximately 120,000 people
  - 50% of patients progress to ESRD; Leading cause of ESRD in young Caucasian adults

Bardoxolone may substantially impact the cost burden of ADPKD and IgAN

- Bardoxolone significantly reduced the likelihood of kidney failure outcomes in BEACON
- The average per-patient cost burden for ADPKD at ESRD is 3x the cost burden at stage 3
- U.S. Medicare spending alone totaled $64B for CKD and $34B for ESRD in 2015

Significant upcoming news flow for bardoxolone in CKD

- Full week 12 data for ADPKD, IgAN and T1D CKD in 3Q18
- 52-week retained benefit data from Phase 2 of CARDINAL in 3Q18
- KHK commences pivotal T2D CKD trial in Japan in 2018
- Full week 12 data for FSGS in 1H19
- Pivotal CARDINAL data in 2H19

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Q&A