Investor Webcast

December 8, 2025

Real Challenges. Real Solutions.

Precision therapies for genetically defined diseases

Forward Looking Statements and Risk Factors

This presentation and the accompanying oral commentary contain forward-looking statements that involve risks, uncertainties and assumptions. If the risks or uncertainties ever materialize or the assumptions prove incorrect, our results may differ materially from those expressed or implied by such forward looking statements. All statements other than statements of historical fact could be deemed forward-looking, including, but not limited to, any statements of the plans, strategies, and objectives of management for future operations, including our clinical development, regulatory and commercialization plans and timelines; any projections of financial information; any statement about historical results that may suggest trends for our business; any statement of expectation or belief regarding future events; potential markets or market size, technology developments, our clinical and research pipelines, clinical and pre-clinical data or the implications thereof, enforceability of our intellectual property rights, competitive strengths or our position within the industry; any statements regarding the anticipated benefits of our collaborations or other strategic transactions; and any statements of assumptions underlying any of the items mentioned.

These statements are based on estimates and information available to us at the time of this presentation and are not guarantees of future performance. Actual results could differ materially from our current expectations as a result of many risks and uncertainties, including but not limited to, risks associated with: the potential impacts of raising additional capital, including dilution to our existing stockholders, restrictions our operations or requirements that we relinquish rights to our technologies or product candidates; the success, cost, and timing of our product development activities and clinical trials; the timing of our planned regulatory submissions to the FDA for our product candidate bezuclastinib and feedback from the FDA as to our plans; our ability to obtain and maintain regulatory approval for our bezuclastinib product candidate and any other product candidates we may develop, and any related restrictions, limitations, and/or warnings in the label of an approved product candidate; the potential for our identified research priorities to advance our bezuclastinib product candidate; the ability to license additional intellectual property relating to our product candidates from third-parties and to comply with our existing license agreements and collaboration agreements; the ability and willingness of our third-party research institution collaborators to continue research and development activities relating to our product candidates; our ability to commercialize our products in light of the intellectual property rights of others; our ability to obtain funding for our operations, including funding necessary to complete further development and commercialization of our product candidates; the; the commercialization of our product candidates, if approved; our plans to research, develop, and commercialize our product candidates; our ability to attract collaborators with development, regulatory, and commercialization expertise; our expectations regarding our ability to obtain and maintain intellectual property protection for our product candidates; among others. For a further description of the risks and uncertainties that could cause actual results to differ from those expressed in these forward-looking statements, as well as risks relating to our business in general, see our periodic filings filed from time to time with the Securities and Exchange Commission. Unless as required by law, we assume no obligation and do not intend to update these forward-looking statements or to conform these statements to actual results or to changes in our expectations.

All of Cogent Biosciences, Inc. (“Cogent”) product candidates are investigational product candidates and their safety and efficacy have not yet been established. Cogent has not obtained marketing approval for any product, and there is no certainty that any marketing approvals will be obtained or as to the timelines on which they will be obtained.

Agenda and Speakers

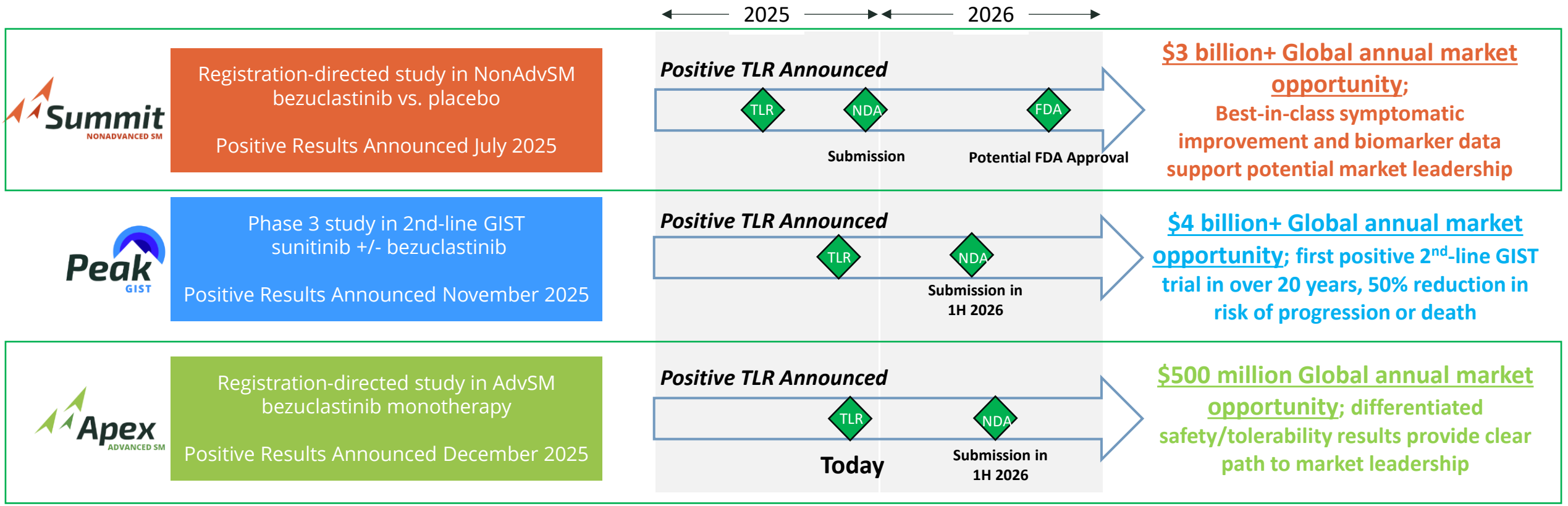
Andrew Robbins
President and
Chief Executive Officer

Lindsay A.M. Rein, MD
Associate Professor of Medicine in the Division of Hematologic Malignancies and Cellular Therapy, Duke University

Jessica Sachs, M.D.
Chief Medical Officer

• Introduction and Corporate Overview	Andrew Robbins
• NonAdvSM Disease Overview • Full SUMMIT Results	Dr. Lindsay Rein
• SUMMIT Pathobiology Data • SUMMIT 48 Week Preview • APEX TLR	Andrew Robbins
• Q&A	All

Bezuclastinib Emerging as Potential Best-in-Class KIT Inhibitor Across Indications



Aggregate global annual sales opportunity >$7.5 billion with limited competition;
IP protection anticipated through 2043 based on strength of COM,
PTE pending formulation patent application

cogent BIOSCIENCES

TLR: Top-line results including primary endpoint; COM: Composition of Matter; PTE: Patent term extension

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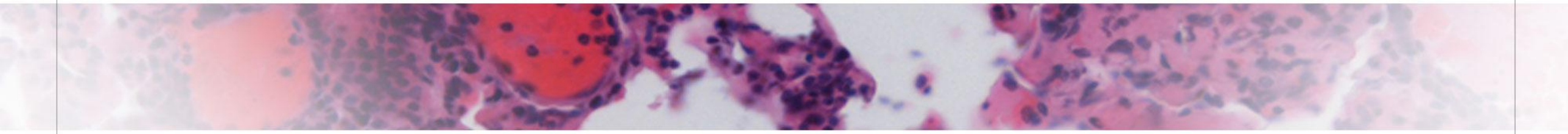
SUMMIT Trial
Bezuclastinib in NonAdvSM
ASH 2025 Full Results

Real Challenges. Real Solutions.

Precision therapies for genetically defined diseases

Full Results Expected to be Presented at an Upcoming Medical Meeting

American Society of Hematology
Helping hematologists conquer blood diseases worldwide



Efficacy and Safety Results From the Pivotal Summit Trial: Bezuclastinib in Adults with Non-Advanced Systemic Mastocytosis

Lindsay Rein[1], Nathan A. Boggs[2], Prithviraj Bose[3], Brian D. Modena[4], Vito Sabato[5], Karin Hartmann[6], Cem Akin[7], Tracy I. George[8], Cecilia Arana Yi[9], Hanneke Oude Elberink[10], Deepti H. Radia[11], Andreas Reiter[12], Miguel Piris-Villaespesa[13], Ingunn Dybedal[14], Jens Panse[15-16], Stephen T. Oh[17], Pankit Vachhani[18], Anthony M. Hunter[19], Mariana Castells[20], Cristina Bulai Livideanu[21], Paul van Daele[20], Arnold Kirshenbaum[23], Ivan Alvarez-Twose[24], Jennifer E. Vaughn[25], Minakshi Taparia[26], Sonia Cerquozzi[27], Andrzej Mital[28], Marek Hus[29], Alessandra Romano[30], John M Fahrenholz[31], Frederick Lansigan[32], Cristina Papayannidis[33], Helena Pomares-Marin[34], Michela Rondoni[35], Celalettin Ustun[36], Richard Herrscher[37], Michael Manning[38], Stephane Barete[39], Mar Guilarte[40], Candido Rivera[41], Jonathan A. Bernstein[42], Peter Vadas[43], Chiara Elena[44], Derek McCulloch[45], Nina Orfali[46], Clodagh Keohane[47], Francesco Mannelli[48], Philippe Schafhausen[49], Amanda Pilla[50], Jenna Zhang[50], Lei Sun[50], Nisha Shah[50], Hina Jolin[50], Rachael Easton[50], Jessica Sachs[50], Frank Siebenhaar[51], Daniel J. DeAngelo[52]

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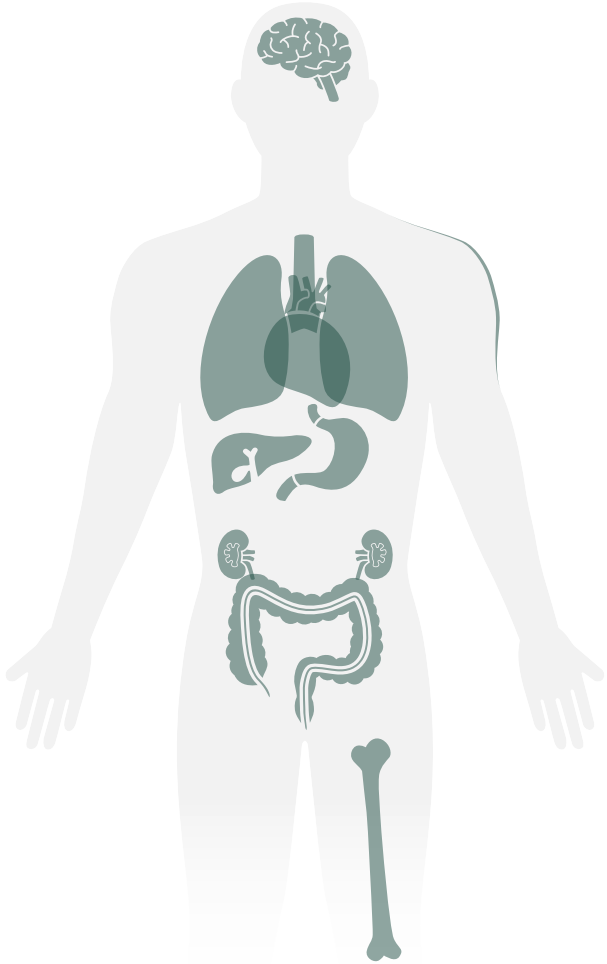
Bezuclastinib (CGT9486) is an oral, potent, and selective type 1 TKI with activity against *KIT* p.D816V, the activating mutation in most patients with systemic mastocytosis[1-5]

- Non-advanced SM (NonAdvSM), including indolent SM, smoldering SM, and bone marrow mastocytosis subtypes, is the most prevalent form of SM[3,6,7]
- NonAdvSM can be associated with debilitating symptoms, including life-threatening anaphylaxis, which can significantly impair quality of life[5,8,9]
- Bezuclastinib is highly active against *KIT* p.D816V, has minimal brain penetration and spares closely related kinases, which may minimize off-target toxicities, such as bleeding, cognitive impairment, edema, and pleural effusion[1,2,10]



Symptoms of NonAdvSM

Neurocognitive
Difficulty concentrating, difficulty remembering, brain fog, cognitive dysfunction, anxiety, depression

Fatigue
Tiredness

Cardiovascular
Hypotension, tachycardia, palpitations, chest tightness

Skin
Itching, flushing, skin redness, spots

Gastrointestinal
Nausea, abdominal pain, diarrhea, vomiting, bloating, GERD

Pain
Headache, bone pain, joint pain

GERD, gastroesophageal reflux disease; SM, systemic mastocytosis; TKI, tyrosine kinase inhibitor.

1. DeAngelo DJ, et al. *Hemasphere.* 2022; 6(suppl). **2.** Guarnieri A, et al. Poster presented at: AACR Annual Meeting; April 8-13, 2022; Orleans, LA. **3.** Ungerstedt J, et al. *Cancers.* 2022;14(16):3942. doi:10.3390/cancers14163942 **4.** Li JY, et al. *Cancers (Basel).* 2023.15(23). **5.** Tse KY, et al. *J Allergy Clin Immunol Glob.* 2024.3(4):100316. **6.** Scherber RM and Borate U. *Br J Haematol.* 2018;180:11-23. **7.** Gilreath JA, et al. *Clin Pharmacol.* 2019;11:77-92. **8.** Pardanani A. *Am J Hematol.* 2021;96(4):508-25. **9.** Piris-Villaespesa M and Alvarez-Twose I. *Front Pharmacol.* 2020;11(443): doi: 10.3389/fphar.2020.00443. **10.** Das A, et al. *Crit Rev Oncol Hematol.* 2021;157:103186.

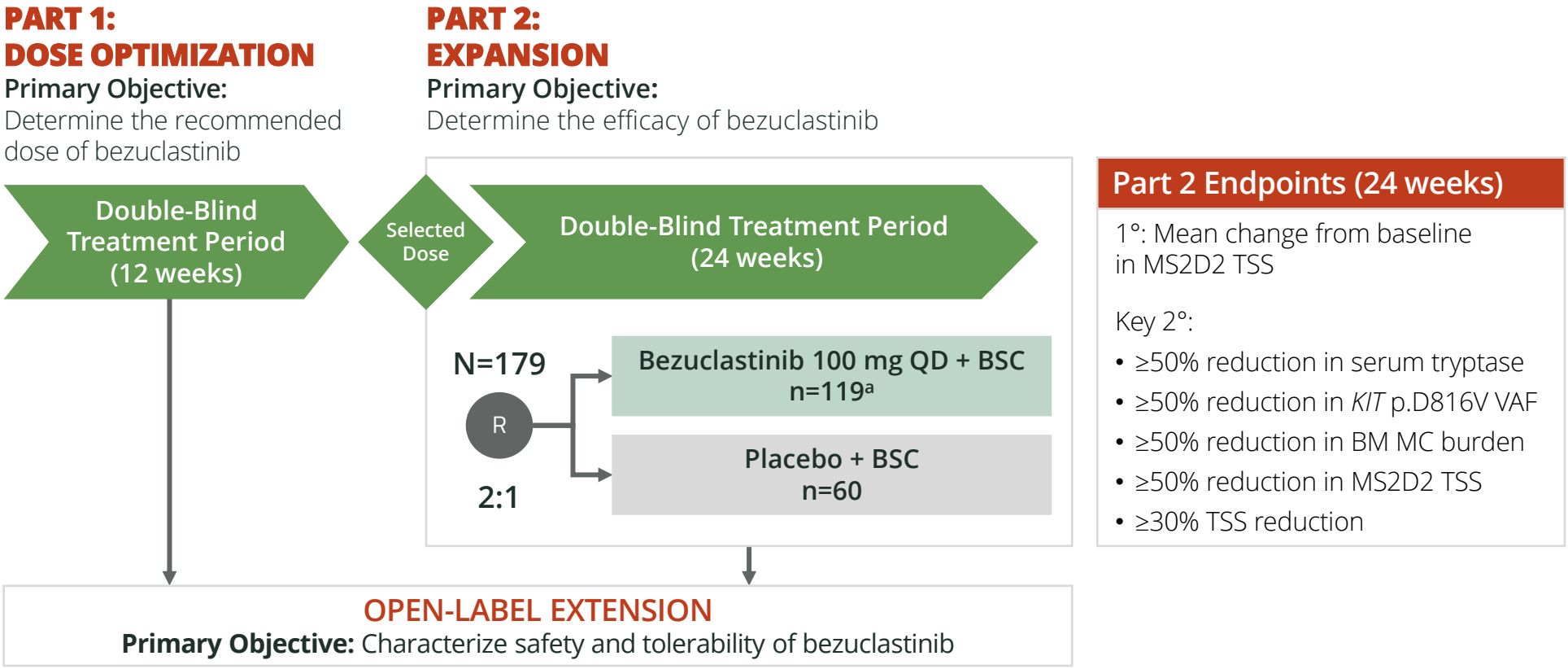
Summit (NCT05186753): Pivotal phase 2 multicenter, randomized, double-blind, placebo-controlled study evaluating bezuclastinib in NonAdvSM

Eligibility

ISM, BMM, or SSM based on WHO 2022 classification

Inadequate symptom control (moderate to severe symptoms) despite ≥2 anti-mediator therapies

BSC medications include H1RA, H2RA, cromolyn, LTRAs, corticosteroids, omalizumab, and PPIs



Part 2 Endpoints (24 weeks)

1°: Mean change from baseline in MS2D2 TSS

Key 2°:

- ≥50% reduction in serum tryptase
- ≥50% reduction in *KIT* p.D816V VAF
- ≥50% reduction in BM MC burden
- ≥50% reduction in MS2D2 TSS
- ≥30% TSS reduction

The Summit open-label extension assessing long term efficacy and safety of bezuclastinib in patients with NonAdvSM is ongoing

[a]One patient withdrew consent and did not receive treatment.

BM, bone marrow; BMM, bone marrow mastocytosis; BSC, best supportive care; H1RA, histamine receptor type 1 antagonist; HR2A, H2RA, histamine receptor type 2 antagonist; ISM, indolent SM; LTRA, leukotriene receptor antagonists; MC, mast cell; MS2D2, mastocytosis symptom severity daily diary; NonAdvSM, non-advanced systemic mastocytosis; PPI, proton pump inhibitors; QD, once daily; R, randomized; SSM, smoldering SM; TSS, total symptom score; VAF, variant allele frequency; WHO, World Health Organization.

Patient demographics and characteristics were representative of a broad NonAdvSM population

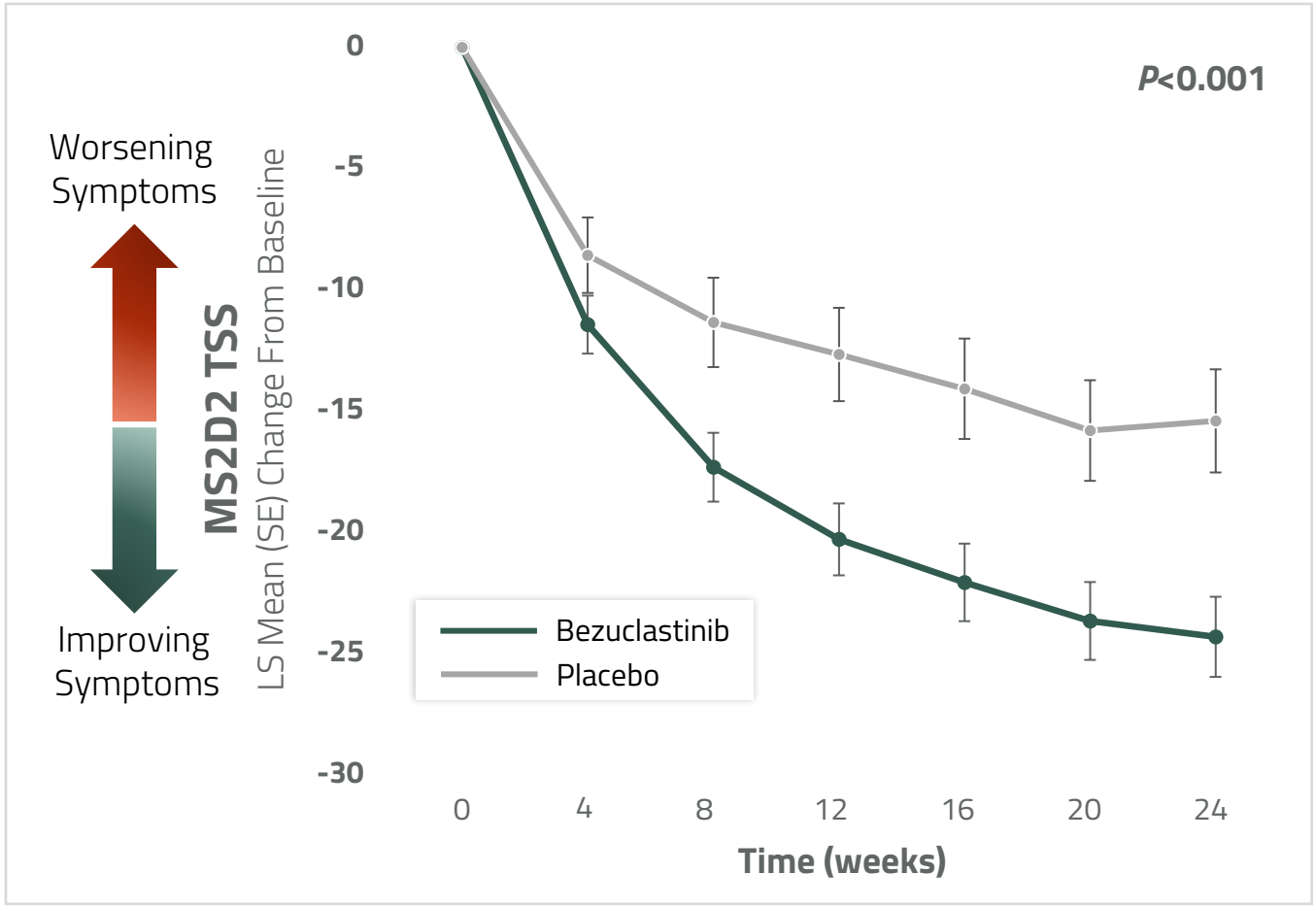
Baseline Characteristics	Bezuclastinib 100 mg QD (N=119)	Placebo (N=60)
Female, n (%)	**74 (62.2)**	**44 (73.3)**
Median age in years, (range)	**51 (24–73)**	**52 (23–78)**
NonAdv subtype, n (%)		
Indolent SM	**97 (81.5)**	**50 (83.3)**
Smoldering SM	**8 (6.7)**	**4 (6.7)**
BM mastocytosis	**14 (11.8)**	**6 (10.0)**
Region, n (%)		
North America	**53 (44.5)**	**28 (46.7)**
Europe	**64 (53.8)**	**30 (50.0)**
Asia-Pacific	**2 (1.7)**	**2 (3.3)**
SM therapy		
Prior KIT inhibitor[a], n (%)	**17 (14.3)**	**5 (8.3)**
Best supportive care medications, median (range)	**3 (0–6)**	**3 (1–7)**

Disease Severity	Bezuclastinib 100 mg QD (N=119)	Placebo (N=60)
Mean MS2D2 TSS, (range)	**57.1 (18–105.2)**	**52.6 (12.8–91.3)**
***KIT* p.D816V[b] in whole blood, detected, n (%)**	**91 (76.5)**	**48 (80.0)**
Median *KIT* p.D816V VAF[b], % (range)	**0.22 (0[c]–32.28)**	**0.30 (0[c]–33.59)**
Median bone marrow MC burden, % (range)	**10 (1–75)**	**10 (1–75)**
Median serum tryptase, ng/mL (range)	**39.9 (6.3–448.0)**	**41.2 (7.1–692.0)**
Serum tryptase <20 ng/mL, n (%)	**22 (18.2)**	**10 (16.7)**
Most severe MS2D2 TSS symptoms at baseline in >10% of patients, n (%)		
Tiredness	**54 (45.4)**	**24 (40.0)**
Spots	**39 (32.8)**	**21 (35.0)**
Bone pain	**16 (13.4)**	**9 (15.0)**

[a]KIT inhibitors included: avapritinib, imatinib, midostaurin, dasatinib, masitinib. [b]Limit of detection equals 0.03%. [c]Undetected.
BM, bone marrow; MC, mast cell; MS2D2, mastocytosis symptom severity daily diary; NonAdvSM, nonadvanced SM; QD, once daily; SM, systemic mastocytosis; TSS, total symptom score; VAF, variant allele frequency.

Data cutoff: May 22, 2025.

Primary endpoint was achieved through rapid, durable, statistically significant, and clinically meaningful symptom improvement



Mean Change in TSS at Week 24 [95% CI]		
Bezuclastinib	**Placebo**	***P* Value**
-24.32 (-27.56, -21.08)	**-15.41** (-19.58, -11.24)	**<0.001**
-8.91 (-13.56, -4.26)		

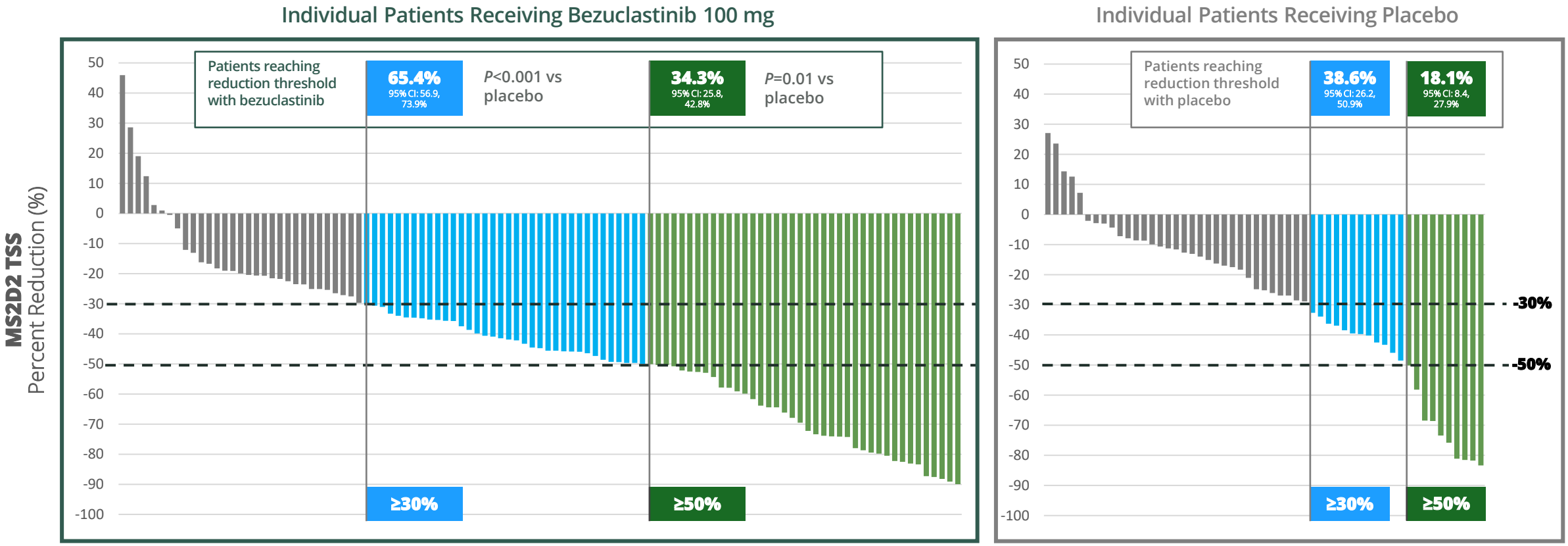
- Significant improvement observed as early as 6 weeks

CI, confidence interval; LS, least squares; MS2D2, mastocytosis symptom severity daily diary; SE, standard error; TSS, total symptom score.

Data cutoff: May 22, 2025.

Bezuclastinib achieves robust symptom reduction

A significantly greater proportion of patients treated with bezuclastinib achieved ≥30%[a] and ≥50% reductions in MS2D2 TSS compared with placebo



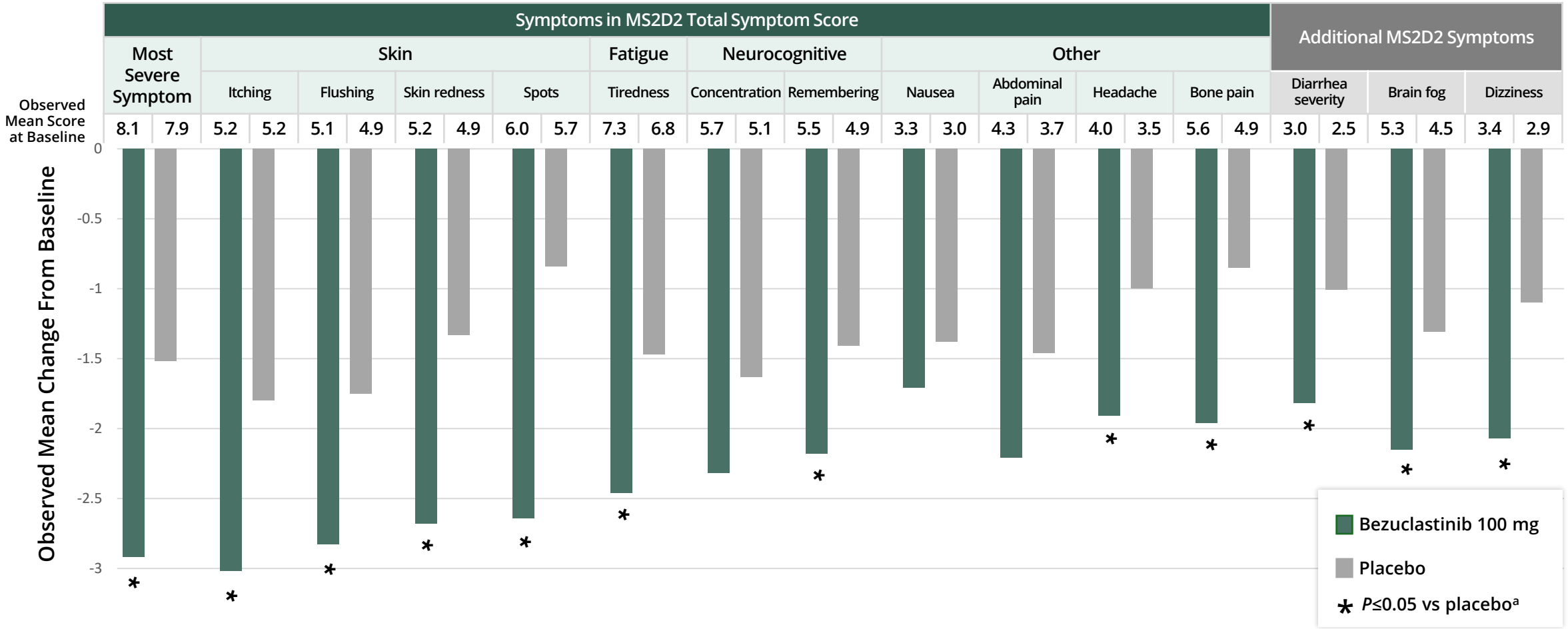
- In patients receiving bezuclastinib with detectable *KIT* p.D816V mutation in blood, 71.2% and 42.6% of patients had reductions of ≥30% and ≥50%, respectively

[a]Symptom reductions of ≥30% represent clinically meaningful change as determined by anchor-based analyses.

MS2D2, mastocytosis symptom severity daily diary; TSS, total symptom score.

Data cutoff: May 22, 2025.

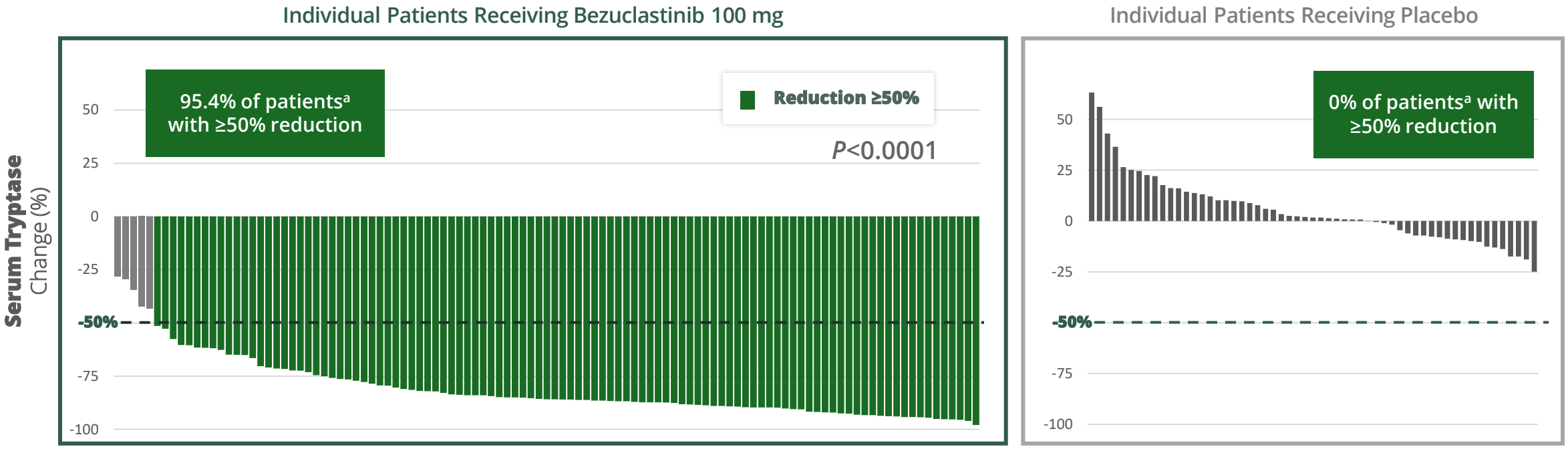
Bezuclastinib delivers clinically meaningful symptom relief across all symptoms measured in patients with NonAdvSM at 24 weeks



[a]Unadjusted *P* values based on ANCOVA model adjusted for TSS baseline and tryptase level, no multiplicity adjustment.
MS2D2, mastocytosis symptom severity daily diary; TSS, total symptom score.

Data cutoff: May 22, 2025.

Bezuclastinib significantly reduced serum tryptase, a core indicator of mast cell burden

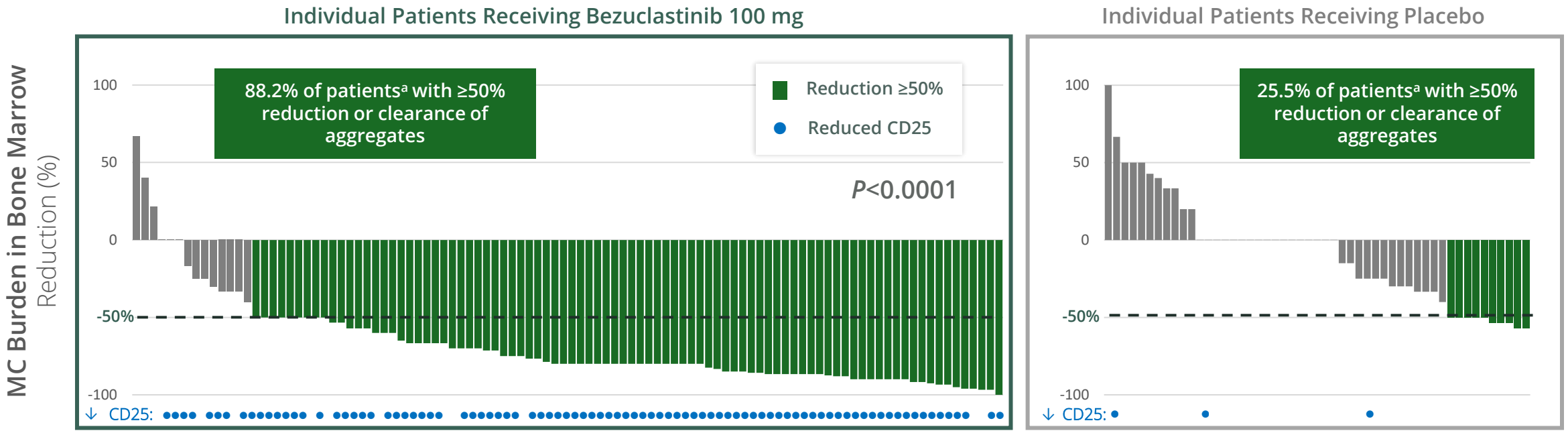


		Bezuclastinib	Placebo
Median serum tryptase at 24 weeks, ng/mL (range)		**6.1** (2.1-97.7)	**42.5** (6.4-298.0)
Patients reaching ≥50% reduction in serum tryptase at 24 weeks, % (n/N)	ITT population[b]	**87.4** (104/119)	**0** (0/60)
	Patients with data at 24 weeks	**95.4** (104/109)	**0** (0/57)
Patients achieving threshold[c], % (n/N)	<20ng/mL	**83.1** (74/89)	**0** (0/47)
	<11.4ng/mL	**77.9** (81/104)	**0** (0/55)

[a]Patients with data at 24 weeks. [b]ITT population: patients missing data at baseline and/or week 24 are treated as nonresponders for this analysis.
[c]Of patients with baseline serum tryptase above threshold.
ITT, intention to treat.

Data cutoff: May 22, 2025.

Bezuclastinib significantly reduced bone marrow mast cell burden and abnormal mast cell phenotype

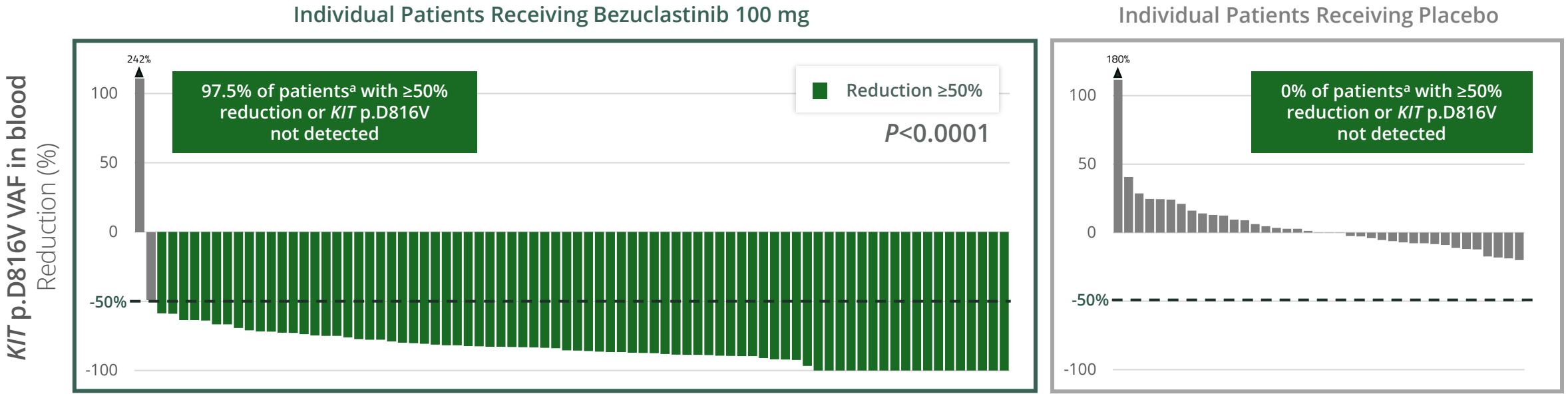


		Bezuclastinib	Placebo
Median mast cell burden at 24 weeks (range)		**3.0** (0-50)	**10.0** (1-75)
Patients reaching ≥50% reduction in mast cell burden or clearance of aggregates at 24 weeks, % (n/N)	ITT population[b]	**75.6** (90/119)	**21.7** (13/60)
	Patients with data at 24 weeks	**88.2** (90/102)	**25.5** (13/51)

[a]Patients with data at 24 weeks. [b]ITT population: patients missing data at baseline and/or week 24 are treated as nonresponders for this analysis.
ITT, intention to treat.

Data cutoff: May 22, 2025.

Bezuclastinib significantly reduced *KIT* p.D816V variant allele frequency, a molecular driver of disease



		Bezuclastinib	Placebo
KIT p.D816V VAF in blood at 24 weeks, %	Median (range)	**0.05** (0-3.5)	**0.33** (0-32.8)
Patients reaching ≥50% reduction in *KIT* p.D816V VAF in blood[b] or undetectable mutation at 24 weeks, % (n/N)	ITT population[c]	**85.7%** (78/91)	**0%** (0/48)
Patients achieving milestone, % (n/N)	50% reduction or *KIT* p.D816V not detected	**97.5%** (78/80)	**0%** (0/39)
	KIT p.D816V not detected	**22.5%** (18/80)	**0%** (0/39)

[a]Patients with data at 24 weeks. [b]Limit of detection equals 0.03%. [c]ITT population: patients missing data at baseline and/or week 24 are treated as nonresponders for this analysis.
ITT, intention to treat; VAF, variant allele frequency.

Data cutoff: May 22, 2025.

Smoldering SM and prior avapritinib subgroups demonstrate meaningful improvements in symptoms and objective measures of disease

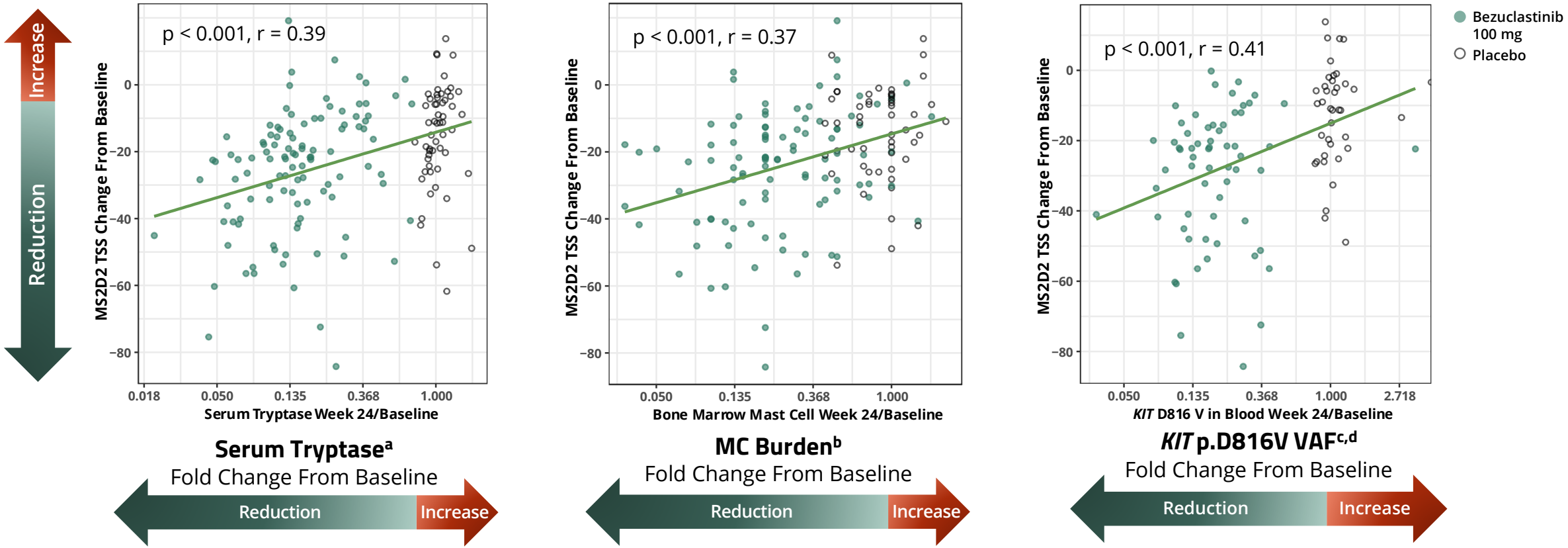
	Patients Receiving Bezuclastinib		
	Overall population (N=119)	**Smoldering SM** (N=8)	**With prior avapritinib exposure** (N=11)
Symptom severity at 24 weeks, change from baseline LS mean (95% CI)			
MS2D2 total symptom score	**-24.3** (-27.6, -21.1)	**-35.6** (-48.1, -23.1)	**-21.6** (-32.6, -10.6)
Markers of mast cell burden at 24 weeks with ≥50% reduction from baseline or reaching other threshold, % (n/N)			
***KIT* p.D816V in whole blood[a]**	**85.7** (78/91)	**100** (8/8)	**83** (5/6)
Bone marrow mast cell burden[b]	**75.6** (90/119)	**75** (6/8)	**63.6** (7/11)
Serum tryptase	**87.4** (104/119)	**100** (8/8)	**82** (9/11)

[a]For *KIT* p.D816V in whole blood, patients could reach ≥50% reduction from baseline or undetectable; limit of detection equals 0.03%.
[b]For bone marrow mast cell burden, patients could reach ≥50% reduction from baseline or clearance of aggregates.
CI, confidence interval; LS, least squares; MS2D2, mastocytosis symptom severity daily diary; SM, systemic mastocytosis.

Data cutoff: May 22, 2025.

The magnitude of symptom improvement correlates with the degree of mast cell burden improvement

- Greater reduction in serum tryptase, bone marrow MCs, and *KIT* p.D816V VAF was significantly correlated with greater reduction in symptom severity, as assessed with the MS2D2 TSS



[a]Bezuclastinib (n=107) and placebo (n=56). [b]Bezuclastinib (n=99) and placebo (n=51). [c]Bezuclastinib (n=62) and placebo (n=38). [d]Limit of detection equals 0.03%.
MC, mast cell; MS2D2, mastocytosis symptom severity daily diary; TSS, total symptom score; VAF, variant allele frequency.

Data cutoff: May 22, 2025.

Bezuclastinib demonstrated a favorable and manageable safety profile

	Bezuclastinib 100 mg QD (N=118)	Placebo (N=60)
TEAEs, n (%)	116 (98.3)	53 (88.3)
Serious TEAEs, n (%)	5 (4.2)	3 (5.0)
Reductions due to drug-related TEAEs, n (%)	13 (11.0)	0
DCs due to drug-related TEAEs, n (%)	7 (5.9)[b]	0
TEAEs ≥10% that occurred in greater frequency in bezuclastinib arm , n (%)		
Hair color changes	82 (69.5)	3 (5.0)
Altered taste[a]	28 (23.7)	0
Nausea	26 (22.0)	8 (13.3)
ALT/AST increased[a]	26 (22.0)	4 (6.6)
Headache	21 (17.8)	7 (11.7)
Alopecia	14 (11.9)	2 (3.3)
ALP increased	12 (10.2)	2 (3.3)

- The majority of TEAEs were of low grade (70% grade 1) and reversible
- Variety of AEs occurred more often in the placebo group (vs the bezuclastinib group): dizziness (10% vs 12%), fatigue (7% vs 12%), arthralgia (6% vs 15%), diarrhea (13% vs 18%)
- Low rate of cognitive impairment AEs reported in bezuclastinib group compared to placebo, including disturbance in attention (0% vs 5%) and memory impairment (1% vs 7%)
- The only hepatic events reported were lab abnormalities
  - The transaminase elevation AEs reported were transient and there were no significant changes in liver function as measured by coagulation parameters (INR, PT, PTT) or bilirubin
  - 5.9% of patients experienced ≥grade 3 transaminase elevation AEs and no patient required hospitalization
- All treatment-related DCs were due to transaminase elevations and all events fully resolved

Adverse events per CTCAE v5.0.

[a]Includes pooled terms. [b]One additional patient discontinued after the data cutoff.

AE, adverse event; ALP, alkaline phosphatase; ALT, alanine aminotransferase; AST, aspartate aminotransferase; DC, discontinuation; INR, international normalized ratio; PT, prothrombin time; PTT, partial thromboplastin time; QD, once daily; TEAE, treatment-emergent adverse event.

Data cutoff: May 22, 2025.

Bezuclastinib represents a promising new treatment with evidence of disease modification in patients with NonAdvSM

- Patients receiving bezuclastinib achieved clinically meaningful symptom improvement, with a mean TSS reduction of -24.32 at Week 24 vs -15.41 for placebo alongside improvements across all 14 patient-reported symptoms
- Significant reductions in objective disease markers:
  - Serum tryptase: ↓ ≥50% in 95.4% of patients
  - Bone marrow mast cell burden: ↓ ≥50% in 88.2%
  - *KIT* p.D816V variant allele frequency: ↓ ≥50% in 97.5%
- First demonstration of significant correlation between reduction in objective measures of disease and improvement in symptom severity, consistent with the pathogenetic link between the neoplastic mast cell and clinical symptomatology
- Bezuclastinib was well tolerated, with most TEAEs being low grade and reversible
- NDA submission for a broad NonAdvSM population is expected by end of 2025 with Breakthrough Therapy Designation recently granted by the FDA for patients with NonAdvSM previously treated with avapritinib and with smoldering SM

FDA, US Food and Drug Administration; NDA, new drug application; NonAdvSM, non-advanced SM; SM, systemic mastocytosis; TEAE, treatment-emergent adverse event; TSS, total symptom score.

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SUMMIT Trial Pathobiology and 48 Week Follow-Up

Real Challenges. Real Solutions.

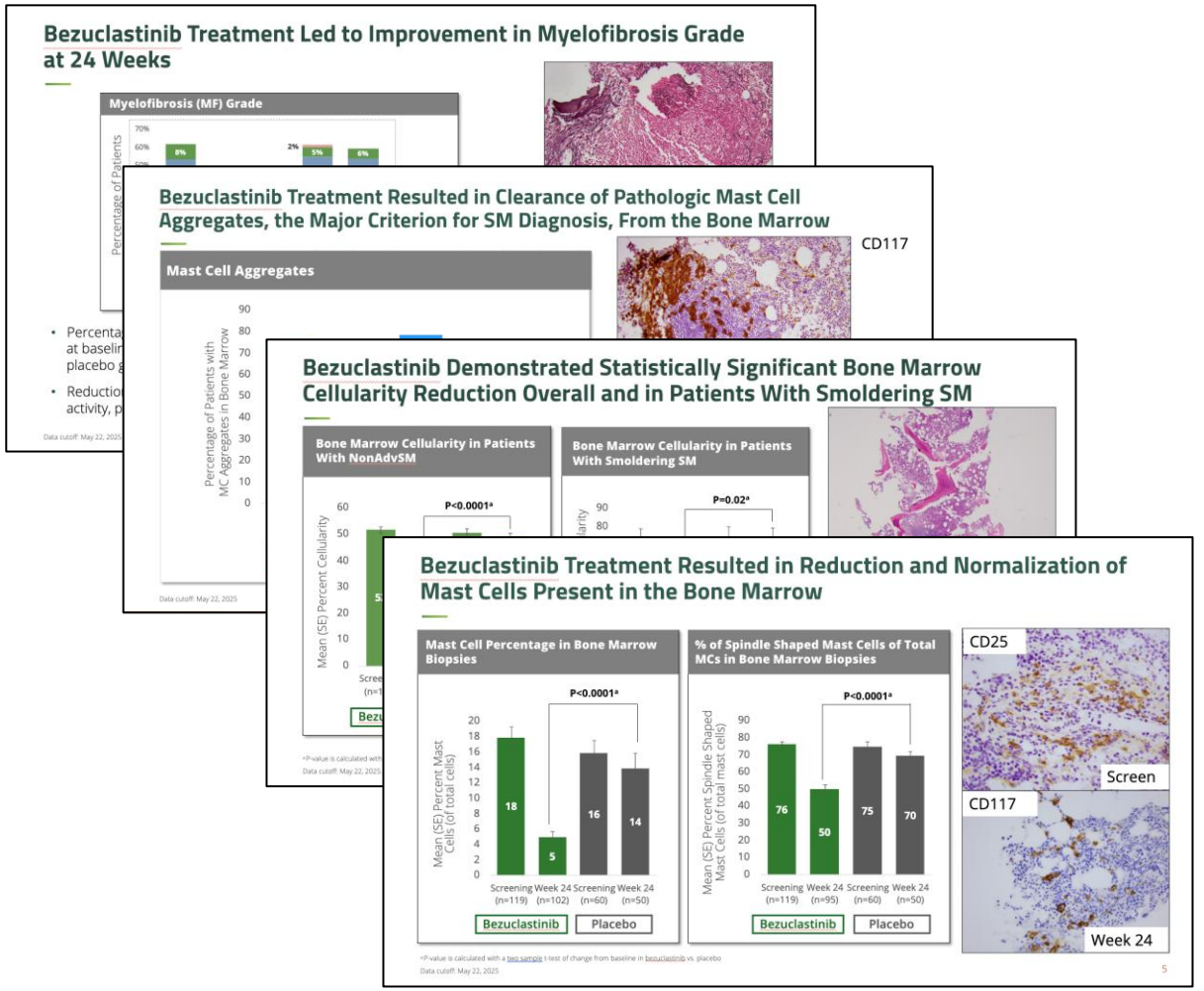
Precision therapies for genetically defined diseases

Bezuclastinib Treatment Demonstrates Reversal of Key Bone Marrow Pathology in Non Advanced Systemic Mastocytosis Patients

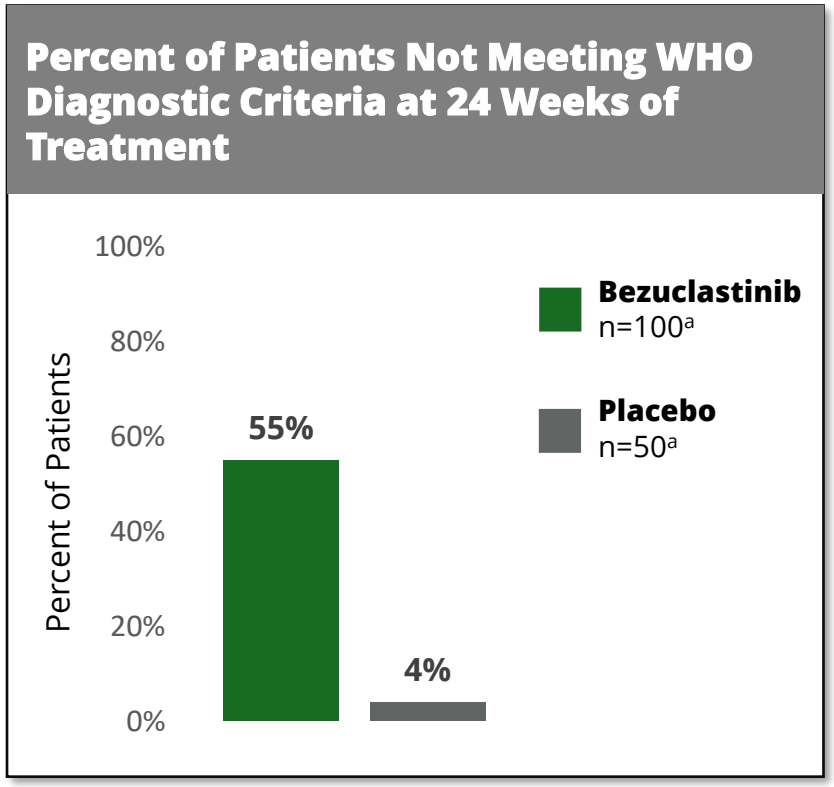
Monday, Dec 8th 5:00 pm: ASH Oral Presentation

Presenter: Dr. Tracy George, MD, President and Chief Scientific Officer at ARUP Laboratories; Professor, University of Utah
Location: - West Hall D2

- SUMMIT data demonstrate that bezuclastinib:
  - Dramatically reduces dense mast cell aggregates
  - Decreases quantity of mast cells in bone marrow, including those with atypical morphology
  - Normalizes mast cell phenotype with clear impact on CD25 and CD30 expression
- Importantly: the effects of bezuclastinib treatment seen in bone marrow correspond to pathologic response and resolution of the criteria used to diagnosis NonAdvSM



55% of Patients Receiving Bezuclastinib No Longer Meet WHO Diagnostic Criteria and 91% Achieve Pure Pathologic Response



Percent of Patients with Exploratory Pure Pathologic Response[1] (PPR) at 24 Weeks of Treatment

Evaluable Population[b]	Bezuclastinib N=57	Placebo N=31
Overall Response Rate Either Complete or Partial Remission	**91%** (52)	**0%** (0)
• **Complete Remission (CR)** Clearance of aggregates, serum tryptase ≤20 ng/mL, and full or partial hematologic recovery	**67%** (38)	**0%** (0)
• **Partial Remission (PR)** 50% reduction in MC burden and serum tryptase	**25%** (14)	**0%** (0)
Stable Disease (SD) Not meeting criteria for PR or CR	**9%** (5)	**100%** (31)

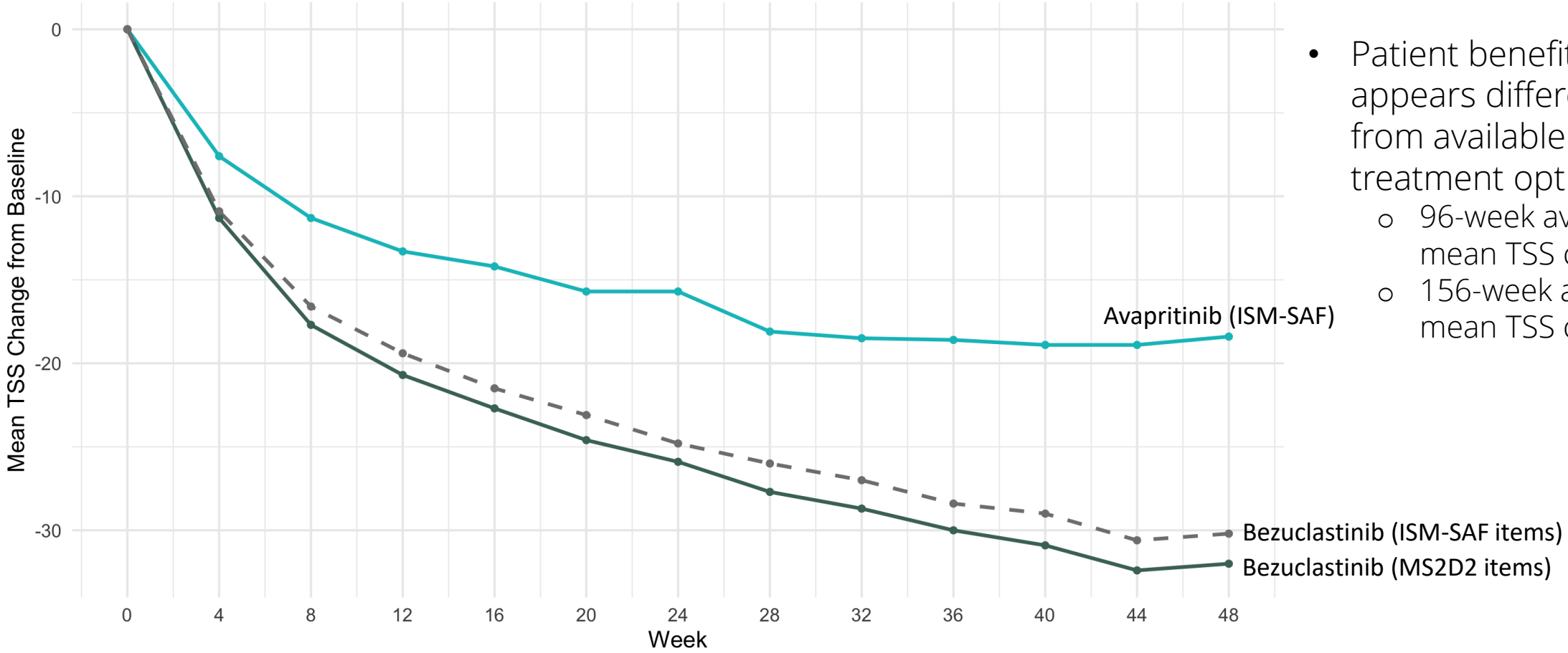
- Exploratory analyses of WHO Diagnostic and Pure Pathologic Response Criteria at 24 weeks indicate evidence of disease modification

[a]Patients missing data required for SM diagnosis at 24 weeks were excluded. [b]Evaluable patients are defined as those with bone marrow MC aggregates, a positive KIT blood result, and serum tryptase >20ng/mL at baseline and non-missing evaluable response at Cycle 7

1. Shomali et al. *Int J Mol Sci*. 2021; 22(6).

Data cutoff: May 22, 2025.

48 Week Preview: Bezuclastinib Effect on Symptoms Shows Deep and Sustained Improvement

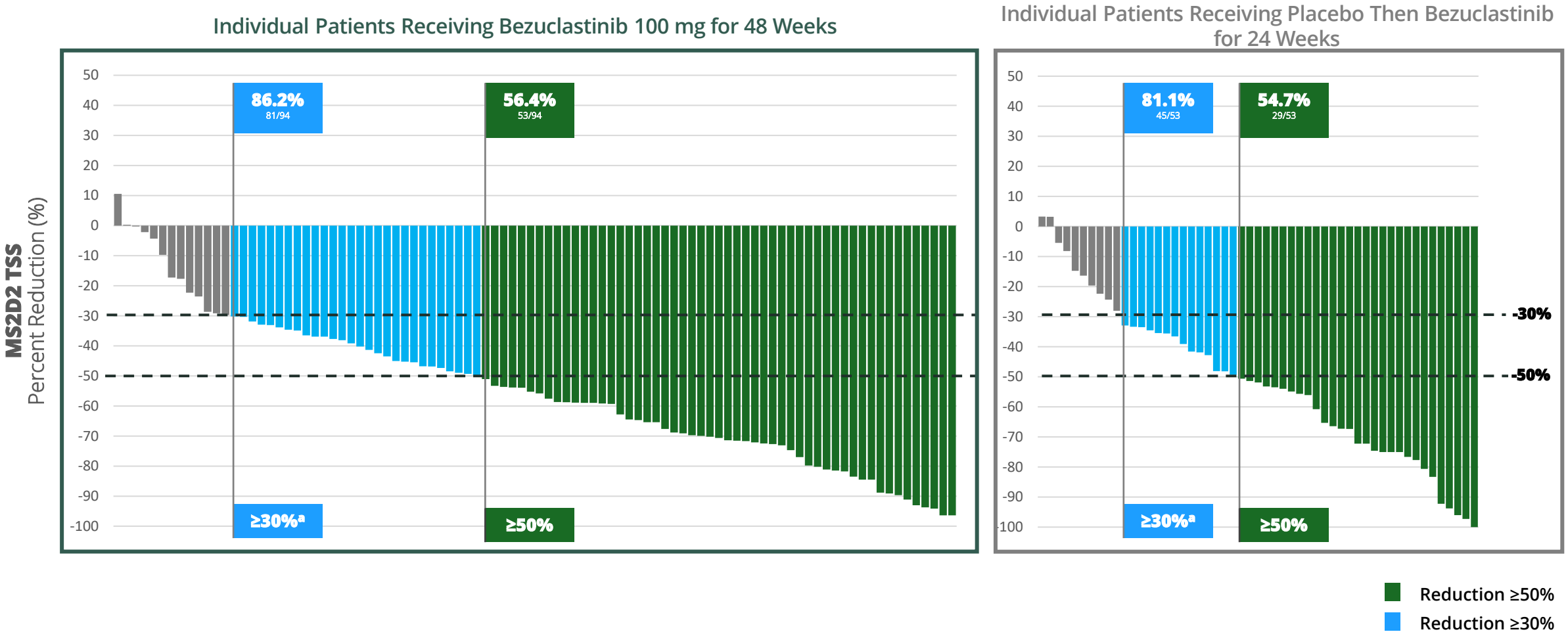


- Patient benefit appears differentiated from available ISM treatment options
  - 96-week avapritinib mean TSS change: -17.5*
  - 156-week avapritinib mean TSS change: -19.4*

Avapritinib data through week 48 from Giannetti et al (AAAAI, 2024).
* Tashi et al (ASH, 2025)

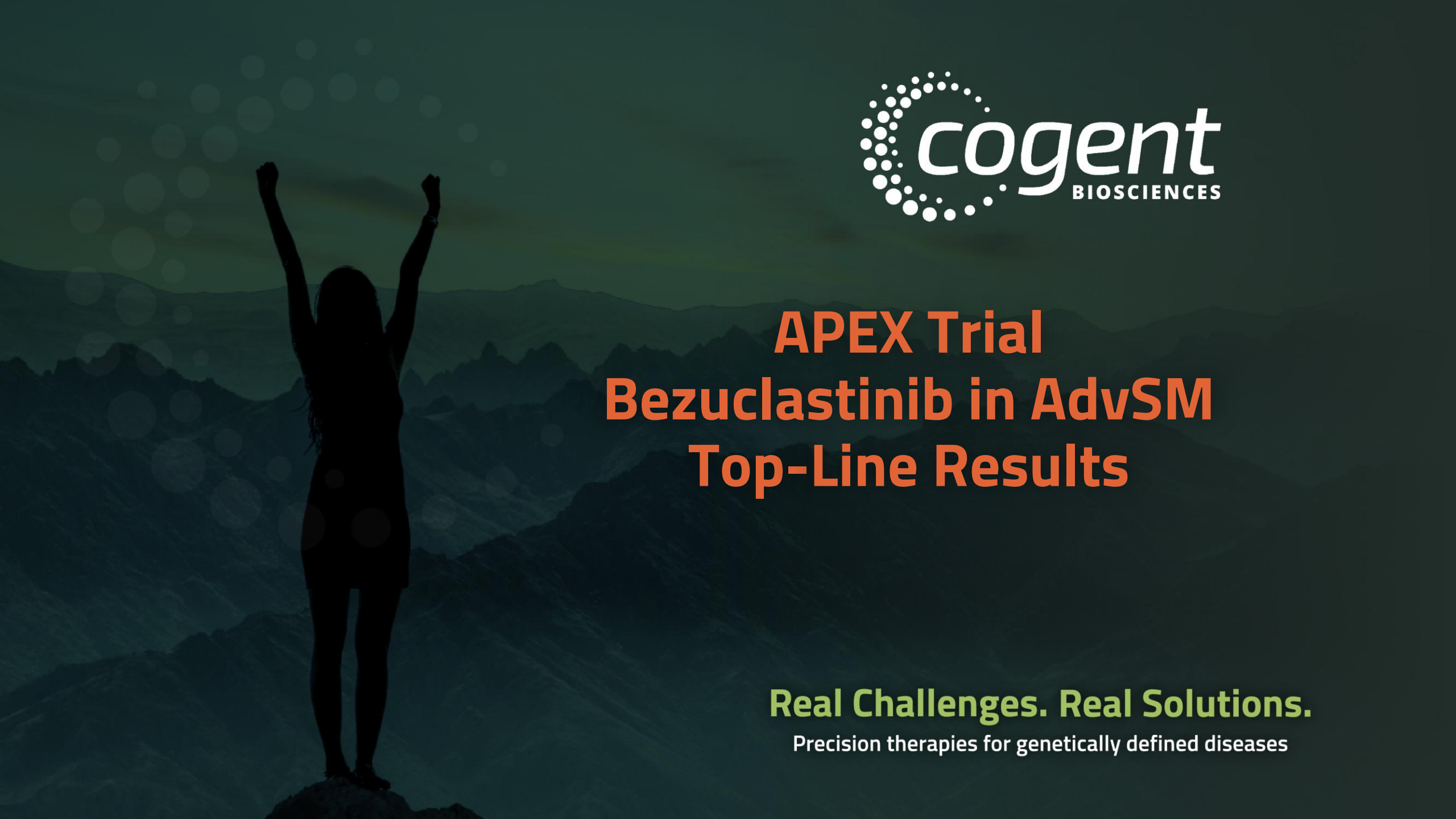
Data cutoff: November 17, 2025.

48 Week Preview: 86% of Patients Achieve Clinically Meaningful Symptom Improvement



[a]Symptom reductions of ≥30% represent clinically meaningful change as determined by anchor-based analyses.

Data cutoff: November 17, 2025

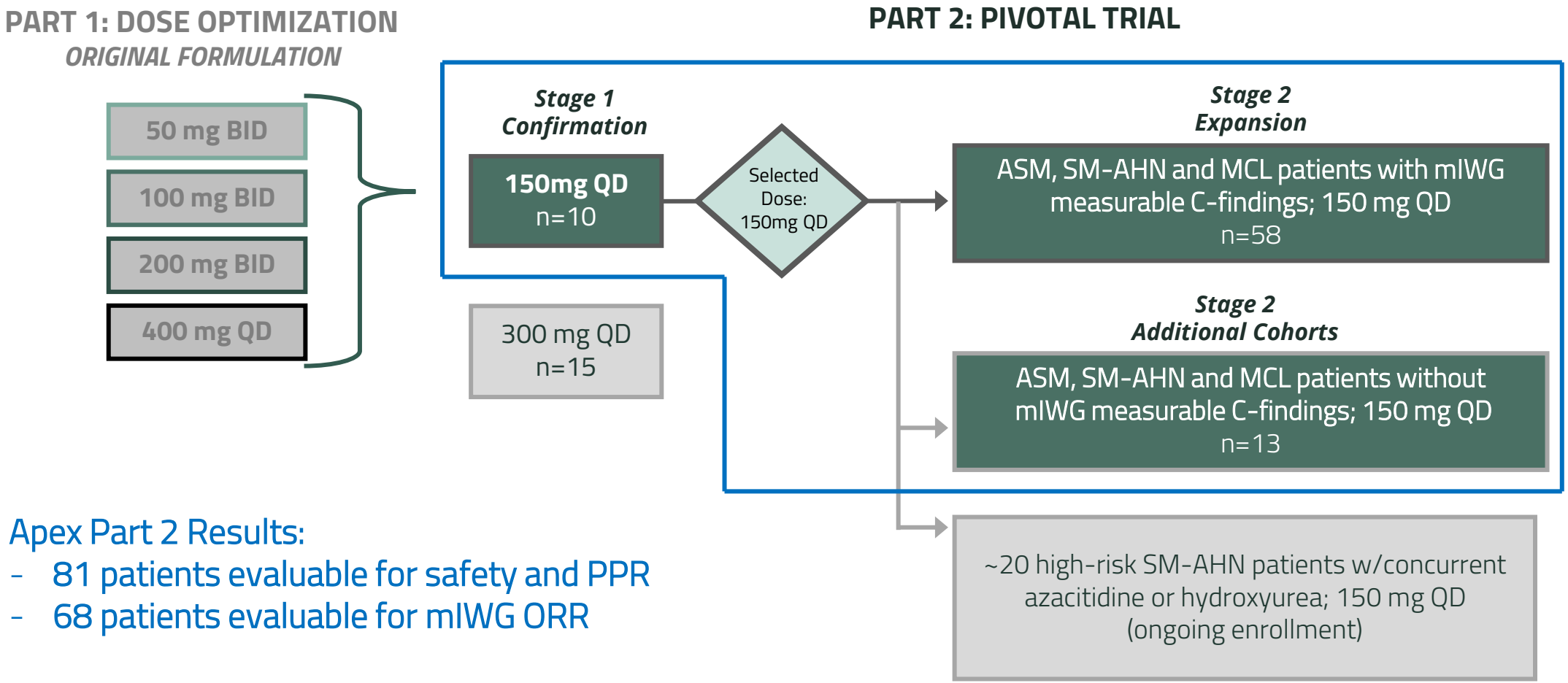


APEX Trial
Bezuclastinib in AdvSM
Top-Line Results

Real Challenges. Real Solutions.

Precision therapies for genetically defined diseases

APEX Part 2: Phase 2 Registration-Directed, Open-Label Clinical Study of Bezuclastinib in Patients with Advanced Systemic Mastocytosis



Apex Part 2 Results:

- 81 patients evaluable for safety and PPR
- 68 patients evaluable for mIWG ORR

APEX Part 2: Patients Demographics and Baseline Characteristics

Primary Endpoint: ORR (CR/CRh + PR + CI) per modified IWG-MRT-ECNM response criteria as assessed by CRRC
Key Secondary Endpoint: ORR (CR/CRh + PR) per PPR

Patient Demographics	Part 2 150mg QD
# Patients	81
Female, n (%)	23 (28.4)
Median Age in years, (range)	70 (43, 87)
ECOG PS at screening, n (%)	
0	24 (29.6)
1	37 (45.7)
≥2	20 (24.7)
Clinical Characteristics	
AdvSM Subtype per Central Eligibility Review, n (%)	
ASM	11 (13.6)
SM-AHN	57 (70.4)
MCL and MCL-AHN	13 (16.0)
SRSF2/ASXL1/RUNX1 Mutation in PB	48 (59.3)

SM Therapy	Part 2 150mg QD
Prior AdvSM or AHN Therapy	36 (44.4)
Prior TKI Inhibitor, n (%)	28 (34.6)
Prior Avapritinib, n (%)	6 (7.4)
Prior Midostaurin, n (%)	24 (29.6)
Baseline Mast Cell Burden	
Median KIT D816V in Whole Blood, % (range) BLD, n (%)	6.7 (0.0 - 91.4) 8 (9.9)
Median BM MC Burden, % (range)	35 (3, 95)
Median Serum Tryptase at baseline, ng/mL (range) % Tryptase < 20	191 (23, 1987) 0
mIWG-MRT-ECNM Evaluable Population	
Patients evaluable per mIWG-MRT-ECNM by EC, n (%)	68 (84.0)

AdvSM, advanced systemic mastocytosis; ASM, aggressive SM; CRRC, Central Response Review Committee; SM-AHN, SM with associated hematologic neoplasm; MCL, mast cell leukemia; MCL-AHN, mast cell leukemia with associated hematologic neoplasm; MC, mast cell; PB, Peripheral Blood; PPR, Pure Pathologic Response Criteria; VAF, variant allele frequency

Data cut-off as of 19Sep25

APEX Part 2: Patients Receiving 150mg Bezuclastinib Achieved Positive Results on Primary (mIWG) and Key Secondary (PPR) Endpoints

	Best ORR per mIWG, n (%) N=68	Best PPR, n (%) N=81
Overall Response Rate		
CR+CRh+PR+CI	39 (57.4)	-
CR+CRh+PR	33 (48.5)	65 (80.2)
Best Overall Response		
Complete Response (CR+CRh)	9 (13.2)	46 (56.8)
Molecular CR/CRh	-	18 (22.2)
Partial Response (PR)	24 (35.3)	19 (23.5)
Clinical Improvement (CI)	6 (8.8)	-
Stable Disease (SD)	25 (36.8)	15 (18.5)
Progressive Disease (PD)	2 (2.9)	0
Not Evaluable (NE)	2 (2.9)	1 (1.2)

Median Duration of Treatment: 9.4 months

At time of data cut-off, multiple ongoing patients had unconfirmed responses

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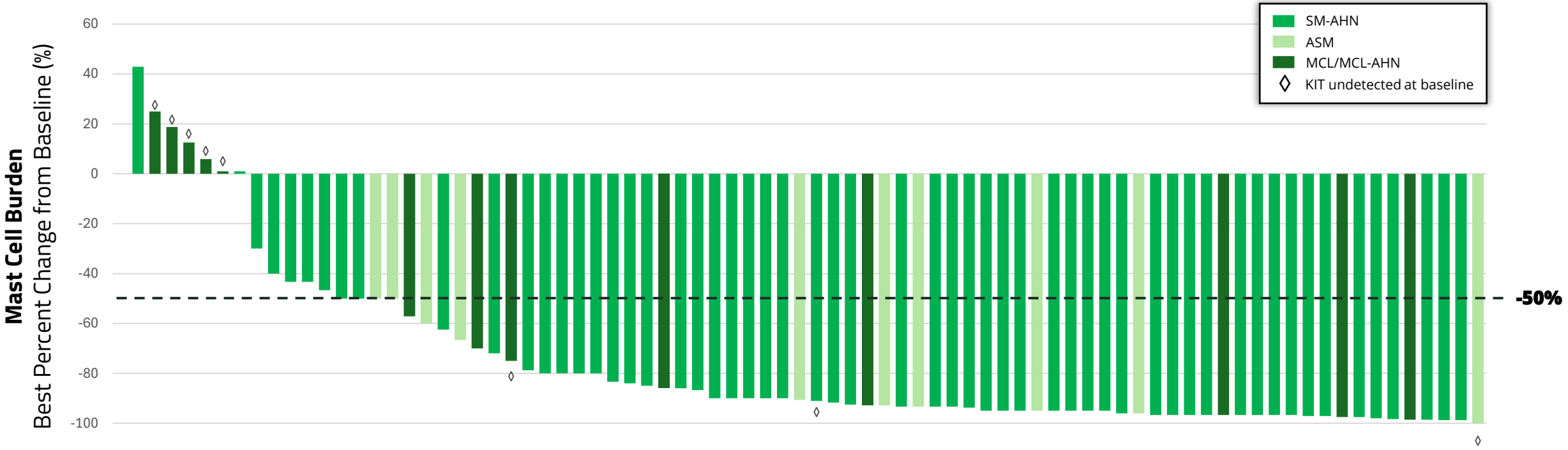
Data cut-off as of 19Sep25

APEX Part 2: Bezuclastinib Significantly Reduced Objective Measures of Disease Burden Including Mast Cells, Serum Tryptase, and KIT D816V VAF



	Serum Tryptase N=80[a]	MC Burden N=80[a]	KIT D816V VAF N=43[b]
Best percent change from baseline, mean	-83.4%	-75.5%	-77.3%
Patients reaching ≥50% reduction from baseline or defined threshold[c]	**89%**	**89%**	**91%**

[a]Includes patients who had at least one post baseline assessment.
[b]Includes patients who had detectable VAF at baseline and one post baseline assessment.
[c]Threshold: for mast cell burden is clearance of MC aggregates and for KIT D816V VAF is reaching undetectable level of KIT (limit of detection is 0.03%).

Data cut-off as of 19Sep25

APEX Part 2: Bezuclastinib was Well Tolerated with a Favorable Safety Profile

	150mg QD Bezuclastinib N=81	
TRAEs, n (%)	75 (92.6)	
Drug-related SAEs, n (%)	5 (6.2)	
Reductions due to TRAEs, n (%)	12 (14.8)	
DCs due to TRAEs, n (%)	0	
TRAEs in ≥ 10% of patients; Preferred term, n(%)		
	Any grade	**Grade ≥ 3**
Hematological events, n (%)		
Neutropenia*	24 (29.6)	19 (23.5)
Thrombocytopenia*	20 (24.7)	11 (13.6)
Anemia	13 (16.0)	8 (9.9)
Non- Hematological events, n (%)		
Hair color changes	25 (30.9)	0
Altered taste*	23 (28.4)	0
ALT/AST increased*	17 (21.0)	1 (1.2)
Blood ALP increased	11 (13.6)	4 (4.9)
Diarrhea	12 (14.8)	0
Nausea	12 (14.8)	1 (1.2)
Alopecia	9 (11.1)	0
Peripheral edema	9 (11.1)	0

*Pooled terms

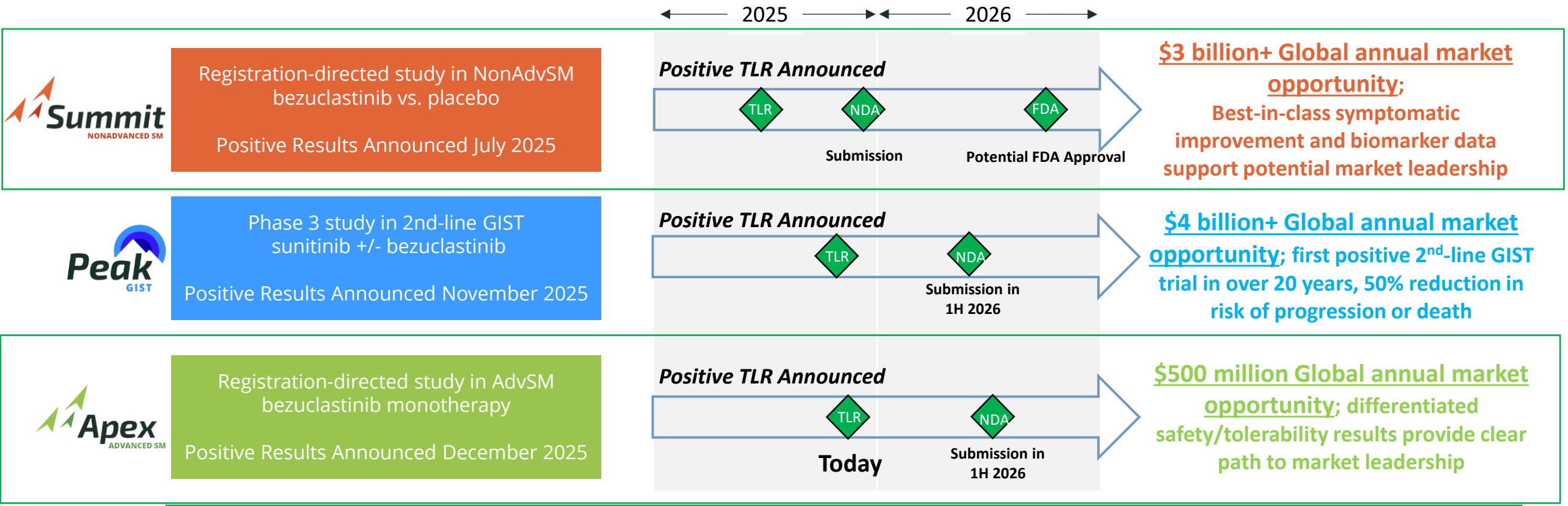
Data cut-off as of 19Sep25

- Hematological events were reversible and manageable
- Treatment related hepatic events were transient and manageable lab abnormalities
- Dose reductions were primarily due to hematological events; no other adverse event led to dose reduction in more than one patient
- No discontinuations due to treatment-related AEs
- No treatment-related deaths were reported

Bezuclastinib Represents a Promising New Treatment Option for ASM Patients

- Patients receiving bezuclastinib achieved high rates of response:
  - 57% ORR (CR+CRh+PR+CI) per mIWG-MRT-ECNM
  - 80% ORR (CR+CRh+PR) per PPR
- Significant reductions in objective disease markers underscore potent target engagement and impact on KIT-driven disease pathology:
  - Serum tryptase: ↓ ≥50% in 89% of patients
  - Bone marrow mast cell burden: ↓ ≥50% in 89%
  - *KIT* p.D816V variant allele frequency: ↓ ≥50% in 91%
- Bezuclastinib was well-tolerated, with infrequent need for dose reduction and no patients requiring discontinuation for treated related adverse events
  - Only 1 patient experienced Gr 3 AST/ALT, and remains on study following dose reduction
  - Encouraging safety profile potentially allows for concomitant treatment in patients who require other cytoreductive therapies for AHN or post-transplant
- NDA submission for AdvSM population is expected in 1H 2026

Bezuclastinib Emerging as Potential Best-in-Class KIT Inhibitor Across Indications



Aggregate global annual sales opportunity >$7.5 billion with limited competition;
IP Protection anticipated through 2043 based on strength of COM,
PTE pending formulation patent application

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TLR: Top-line results including primary endpoint; COM: Composition of Matter; PTE: Patent term extension


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Q&A
Real Challenges. Real Solutions.
Precision therapies for genetically defined diseases