

Degrading Proteins, Making Medicines

Innovating Beyond New Heights | October 2026



Forward-Looking Statements

This communication includes express and implied "forward-looking statements," including forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995. Forward-looking statements include all statements that are not historical facts and, in some cases, can be identified by terms such as "may," "might," "will," "could," "would," "should," "expect," "intend," "plan," "objective," "anticipate," "believe," "estimate," "predict," "potential," "continue," "ongoing," or the negative of these terms, or other comparable terminology intended to identify statements about the future. Forward-looking statements contained herein include, but are not limited to, statements about: our ability to grow our product pipeline and to successfully complete research, development and commercialization of our drug candidates in current or future indications, including the timing and results of clinical trials; our progress in developing only-in-class and first-in-class molecular glue degrader ("MGD") therapeutics; the Company's QuEEN discovery engine, including its breadth, versatility and broad potential applications, and the Company's ability to create long-term value through focused pipeline execution and strategic collaborations, to expand the targetable protein space for MGD drug discovery, and to rationally design MGDs with unprecedented selectivity; the growing recognition of MGDs as a distinct and potentially transformative therapeutic modality and our ability to leverage unique insights into protein degradation to expand beyond current modalities, statements around potential multi-billion-dollar market opportunities and the potential for our product candidates to be only-in-class therapies, market size and patient population estimates, commercial opportunity projections, 2030 estimated drug class sales projections (including projections incorporating assumptions about anticipated future product approvals), and third-party market data on which such estimates are based, statements about the advancement, timing, design and results of our preclinical and clinical programs, including: (i) the ongoing development of our VAV1-directed degrader MRT-6160 (DDY391), its ongoing and planned Phase 2 studies in collaboration with Novartis, and its potential broad application across immune-mediated diseases; (ii) the ongoing development of our NEK7-directed MGD MRT-8102, including results from the GFORCE-1 study, expectations regarding the GFORCE-2 study and other planned clinical studies in coronary artery disease, gout and hidradenitis suppurativa, and the interpretation and potential significance of clinical, safety, pharmacodynamic and biomarker data, the potential application of MRT-8102 in additional inflammatory and metabolic indications, our belief that the data support a broad therapeutic index for MRT-8102, the potential for a favorable safety profile, its potential to provide upstream pathway inhibition, stabilize plaques, prevent thrombosis and address residual cardiovascular risk in ASCVD, the potential for upstream targeting of the NLRP3/NEK7 pathway to provide advantages over downstream IL-1 β /IL-6 biologics, the potential to avoid on-off pharmacodynamics and off-target toxicities of NLRP3 inhibitors, the potential for MRT-8102 treatment to lead to resolution of tophi through enhanced phagocytic potential of macrophages without activation of NLRP3 and flares, its potential for flare management and long-term prophylaxis, and its potential clinical activity in biologic-naïve and refractory patients; (iii) the ongoing development of a second-generation NEK7-directed MGD optimized for CNS penetration and expected IND submission timing; (iv) the ongoing Phase 1/2 clinical study evaluating MRT-2359 in combination with enzalutamide in heavily pretreated patients with metastatic CRPC, the interpretation and potential significance of results from that study, the potential clinical activity and opportunity for MRT-2359 in prostate cancer, the ongoing MoDeFIRE-1 Phase 2 study evaluating MRT-2359 in combination with a second-generation AR inhibitor in mCRPC patients with AR mutations, the potential to expand to other AR-driven populations, including patients without prior second-generation AR inhibitors, and potential expansion into earlier-line settings and combination regimens, anticipated clinical data updates from the MRT-2359 program; and (v) our discovery programs, including CCNE1/CDK2, the potential clinical significance of preclinical data including xenograft tumor regression and combination therapy data, anticipated IND submissions, plans to announce additional targets, the anticipated timing and significance of scientific presentations and clinical data readouts, the expected potential clinical benefit of any of our candidates and advancement and application of our platform; our ability to capitalize on research and translational insights, including the potential translational significance of preclinical data from NEK7-directed programs; our ability to optimize collaborations with industry partners; obligations under our collaboration agreements, including expectations regarding future milestone and other payments, actions taken by our collaborators, and the future development and commercialization of various products, regulatory filings for our development programs, including the planned timing of such regulatory filings, such as IND applications, and potential review by regulatory authorities, our use of capital, expenses and other financial results in the future, availability of funding for existing programs, ability to fund operations into 2029, and cash runway positioning statements regarding the expected clinical benefit, efficacy, safety, tolerability, selectivity, differentiation, competitive positioning or other comparative performance of our product candidates relative to existing or investigational therapies, including statements based on cross-trial analyses, and our expectations of success for our programs, strength of collaboration relationships and the strength of our financial position, among others. By their nature, these statements are subject to numerous risks and uncertainties, including those risks and uncertainties set forth in our most recent Annual Report on Form 10-K for the year ended December 31, 2025 filed with the U.S. Securities and Exchange Commission on March 17, 2026, most recent Quarterly Reports on Form 10-Q and any subsequent filings, that could cause actual results, performance or achievement to differ materially and adversely from those anticipated or implied in the statements, as well as the risk that outcomes of preclinical studies may not be predictive of clinical trial results and the risk that initial or interim results from a clinical trial may not be predictive of the final results of the trial or the results of future trials, and, with respect to comparisons between our product candidates and other therapies discussed in these materials, the risk that such comparisons are based on post-hoc analyses of publicly available information from different clinical trials conducted by different parties with different study designs and patient populations and that no head-to-head clinical trials have been conducted. You should not rely upon forward-looking statements as predictions of future events. Although our management believes that the expectations reflected in our statements are reasonable, we cannot guarantee that the future results, performance, or events and circumstances described in the forward-looking statements will be achieved or occur. Recipients are cautioned not to place undue reliance on these forward-looking statements, which speak only as of the date such statements are made and should not be construed as statements of fact. We undertake no obligation to publicly update any forward-looking statements, whether as a result of new information, any future presentations, or otherwise, except as required by applicable law. Certain information contained in these materials and any statements made orally during any presentation of these materials that relate to the materials or are based on studies, publications, surveys and other data obtained from third-party sources and our own internal estimates and research. While we believe these third-party studies, publications, surveys and other data to be reliable as of the date of these materials, we have not independently verified, and make no representations as to the adequacy, fairness, accuracy or completeness of, any information obtained from third-party sources. In addition, no independent source has evaluated the reasonableness or accuracy of our internal estimates or research and no reliance should be made on any information or statements made in these materials relating to or based on such internal estimates and research. 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Monte Rosa Therapeutics – A Leader in Targeted Protein Degradation

Delivering Value

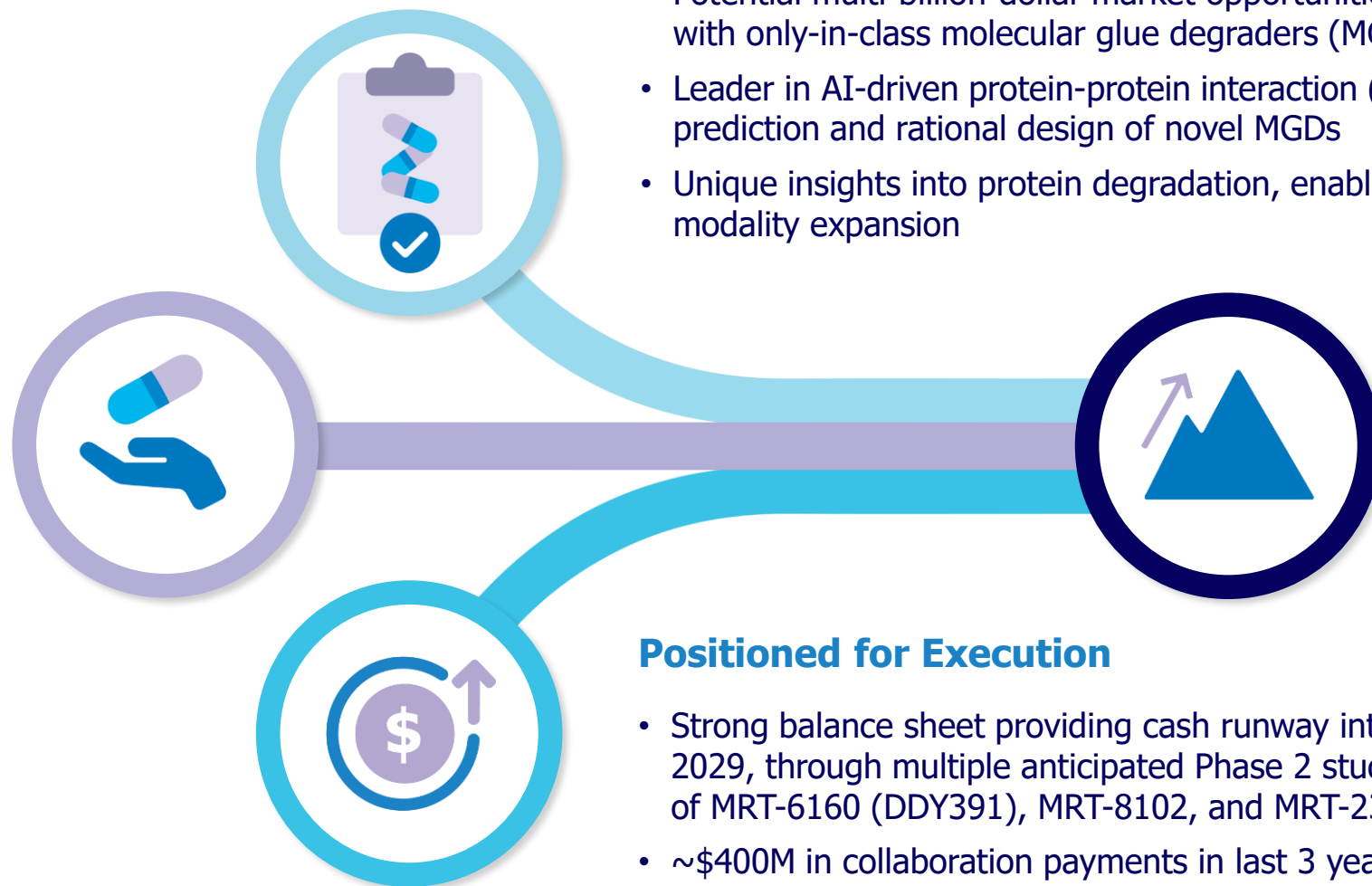
- Uniquely differentiated pipeline with 3 clinical programs, addressing highly validated yet undruggable targets in indications with high unmet medical need
- Three Phase 2 initiations expected in 2026
- Multiple additional INDs for wholly owned pipeline anticipated over next 2 years
- Productive ongoing collaborations with industry-leading pharma partners

Building the Future

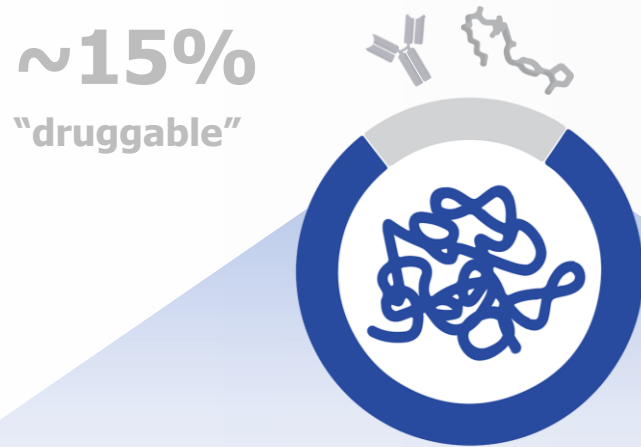
- Potential multi-billion-dollar market opportunities with only-in-class molecular glue degraders (MGDs)
- Leader in AI-driven protein-protein interaction (PPI) prediction and rational design of novel MGDs
- Unique insights into protein degradation, enabling modality expansion

Positioned for Execution

- Strong balance sheet providing cash runway into 2029, through multiple anticipated Phase 2 studies of MRT-6160 (DDY391), MRT-8102, and MRT-2359
- ~\$400M in collaboration payments in last 3 years with potential for >\$350M over the next 24 months



Most Disease-driving Biology Remains Inaccessible With Conventional Modalities

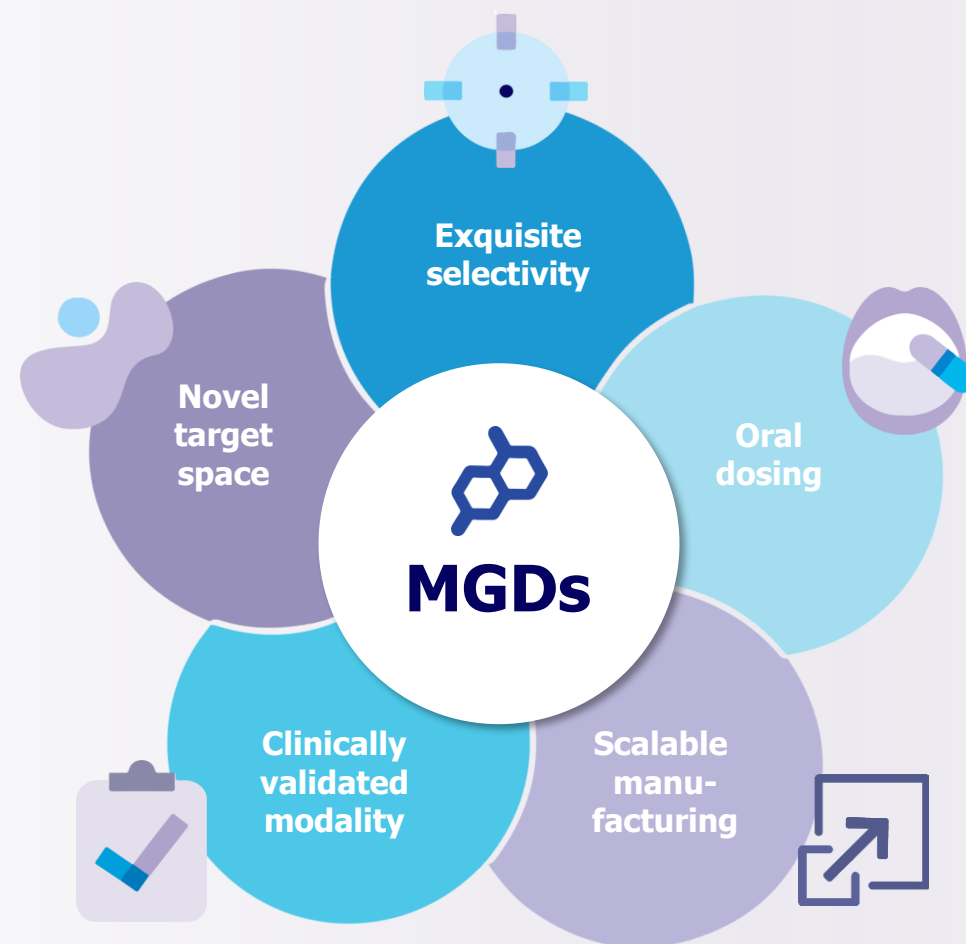


of the human proteome is considered
"undruggable" by conventional
small-molecule or antibody approaches

- **Many disease-driving proteins are not addressable with existing therapeutic modalities**, including small-molecule inhibitors, antibodies, and even other targeted protein degraders, because they lack enzymatic activity or suitable binding pockets.
- **Partial inhibition is often insufficient for validated oncogenic and immunologic targets**, leading to suboptimal efficacy, resistance, and dose-limiting toxicity. Most current drugs modulate protein function rather than eliminating the disease-causing protein.
- As a result, **a significant portion of validated disease biology remains beyond the reach of approved or investigational medicines.**

Monte Rosa MGDs: Opportunity for Paradigm-Changing Medicines

- **MGDs are small molecules that remove the entire disease-causing protein** rather than partially suppressing its activity, eliminating both enzymatic and non-enzymatic functions
- **Protein elimination enables catalytic and durable pharmacology**, as a single MGD molecule can trigger thousands of repeated degradation events rather than requiring continuous target occupancy
- **MGD approach unlocks targets that are inaccessible to inhibitors or antibodies**, including intracellular proteins lacking well-defined binding pockets or enzymatic activity
- By degrading key signaling nodes, **MGDs can deliver more precise pathway-level modulation** with the potential for improved efficacy and selectivity versus traditional modalities
- AI/ML-powered **QuEEN™ product engine has delivered highly potent, exquisitely selective “only-in-class” MGDs**



Next-Gen MGD-Based Therapeutics Delivering Meaningful Clinical Results

MRT-6160/ DDY391 (VAV1)*

- VAV1 is an upstream T- and B-cell signaling node, enabling broad cytokine and autoantibody suppression with a single oral agent
- Phase 1 demonstrated **>90% VAV1 degradation** with **robust cytokine and CD69 suppression** and a favorable safety profile
- Phase 2a/b clinical trials (conducted by Novartis) activated in Sjögren's disease and psoriatic arthritis; Monte Rosa expects its collaborator Novartis to initiate additional Ph. 2 studies

**First-in-class VAV1 MGD
for diverse immune-
mediated diseases (e.g.
Sjögren's disease,
psoriatic arthritis, others)**

MRT-8102 (NEK7)

- NEK7 enables NLRP3 inflammasome assembly, providing upstream DAMPs/IL-1/IL-18 and pyroptosis blockade beyond current biologics
- GFORCE-1 study showed MRT-8102 normalized multiple ASCVD pathogenic drivers of local plaque inflammation, thrombosis, and systemic inflammation
- Phase 2 studies planned in patients with gout flares (Q4 2026 / Q1 2027), coronary artery disease (H1 2027 initiation), and hidradenitis suppurativa (H1 2027)

**First-in-class NEK7 MGD
for NLRP3 inflammasome-
driven diseases (e.g. CAD,
gout, HS)**

MRT-2359 (GSPT1)

- GSPT1 degradation exploits a translation-termination vulnerability in MYC- and AR-driven tumors, particularly AR-mutant mCRPC
- Combination with AR inhibitor delivered compelling activity in heavily pretreated mCRPC, including **100% PSA response rate and RECIST PRs in AR-mutant patients**
- Signal-confirming Phase 2 (MODeFIRE-1) ongoing in AR-mutant mCRPC with a second-generation AR inhibitor

**First-in-class oral GSPT1
MGD for AR mutant
metastatic CRPC**

* Novartis has exclusive worldwide rights to develop, manufacture and commercialize MRT-6160 (DDY391) and other VAV1 MGDs. Monte Rosa is eligible for up to \$2.1B in development, regulatory, and sales milestones, beginning upon initiation of Phase 2 studies, and is also eligible for 30% US P&L share and ex-US tiered royalties.

Monte Rosa Pipeline and Upcoming Milestones

	Target	Compound	Indication(s)	Preclinical	Phase 1	Phase 2	Phase 3	Next Anticipated Milestone
Immunology & Inflammation	VAV1 <i>Licensed to Novartis*</i>	MRT-6160 (DDY391)	Sjögren's disease					Additional Ph 2 initiations
			Psoriatic arthritis					
	NEK7	MRT-8102	Coronary artery disease, gout, hidradenitis suppurativa					Multiple Ph 2 initiations in 2026-27; Gout data update in H2 2027
		Next Generation	NEK7/NLRP3-driven Diseases					IND submission in 2026
Oncology	GSPT1	MRT-2359	Castration-resistant Prostate Cancer					Ph 1/2 update in 2026; Ph 2 update in 2027
	CCNE1/CDK2	Discovery	CCNE1 Amplified Tumors ER+ Breast Cancer					IND submissions in 2027
Various	Multiple Targets <i>Includes those licensed/optioned to Roche and Novartis</i>	Discovery	I&I, Oncology, Genetic and Neurological Diseases					Announce additional targets

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Notes: IND = investigational new drug. ER = estrogen receptor. I&I = immunology and inflammation.

Creating Value through Strategic Collaborations

	NOVARTIS		Roche
Scope	Global license for VAV1 molecular glue degraders, including MRT-6160 (DDY391) (Oct. 2024)	Collaboration for degraders to treat immune-mediated diseases (Sep. 2025)	Strategic collaboration to develop MGDs for cancer and neurological diseases (Oct. 2023)
Financial Terms	• \$150M upfront payment • Eligible for up to \$2.1B in development, regulatory, and sales milestones, starting at Phase 2 • Novartis fully funds Phase 2 • Eligible for 30% US P&L share and ex-US tiered royalties	• \$120M upfront payment plus option maintenance payments • Eligible for option exercise payments and development, regulatory, and sales milestones, and tiered royalties on global net sales • Up to \$5.7B total deal value	• \$50M upfront payment • Eligible for >\$2B preclinical, clinical, commercial and sales milestone payments and tiered royalties
Strategic Goal	Accelerate and broaden scope of clinical development of MRT-6160 (DDY391) while retaining substantial value for Monte Rosa	Expedite additional I&I programs leveraging Monte Rosa QuEEN™ platform and Novartis capabilities in immune-mediated diseases	Expand platform to develop MGDs against previously undruggable targets in cancer and neurological diseases

Notes: Under the terms of the Oct. 2024 Novartis agreement, Monte Rosa has a global exclusive development and commercialization license agreement with Novartis to advance VAV1-directed MGDs, including MRT-6160 (DDY391). Novartis is responsible for conducting and funding Phase 2 studies. Monte Rosa will co-fund any Phase 3 clinical development and will share 30% of any profits and losses associated with the manufacturing and commercialization of MRT-6160 (DDY391) in the U.S., and is also eligible for tiered royalties on ex-U.S. net sales. Under the terms of the Sep. 2025 Novartis agreement, Monte Rosa granted Novartis an exclusive license to an undisclosed target and the exclusive option to obtain licenses to two programs from Monte Rosa’s preclinical immunology portfolio. Under the terms of the Roche agreement, Monte Rosa Therapeutics will lead discovery and preclinical activities against multiple select cancer and neurological disease targets to a defined point. Roche gains the right to exclusively pursue further preclinical and clinical development of the compounds.

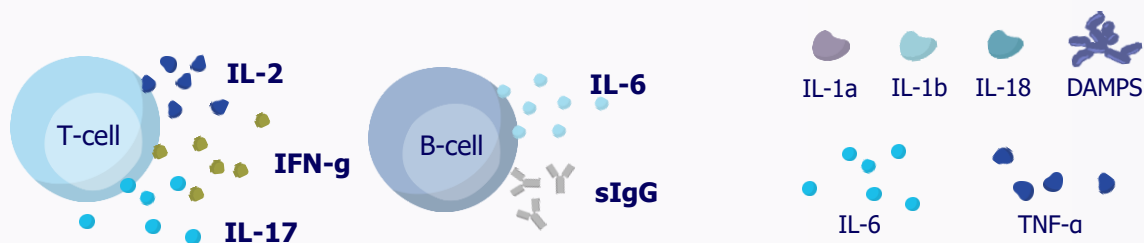


I&I Pipeline

Beyond Biologics-in-a-Pill: Potential for Next-Generation I&I Drugs

Degrading previously undruggable signaling nodes to modulate multiple cytokines

	VAV1 (Adaptive Immunity) MRT-6160 (DDY391)	NEK7 (Innate Immunity) MRT-8102
Primary Cell Types	T cells, B cells	Myeloid cells
Core Biology	Antigen-driven activation	Inflammasome assembly
Key Cytokines/ Immune Mediators	IL-2, IL-17, IFN- γ , IL-6, sIgG	IL-1 α/β , IL-18, DAMPs, IL-6, TNF- α
Therapeutic Impact	Targeted immune modulation	Control of inflammasome-driven inflammation



- **Most current biologics inhibit single downstream cytokines**, often leaving parallel immune pathways active and limiting depth and durability of response
- **VAV1 and NEK7 sit at upstream control points in adaptive** (T- and B-cell) and innate (myeloid / inflammasome) immunity, respectively
- **Degrading these nodes suppresses entire cytokine programs**, not just individual mediators, across both arms of the immune system
- Upstream, multi-arm immune control **supports broader efficacy potential while using oral administration**, creating substantial differentiation versus injectable, single-target biologics therapies



VAV1 Program (MRT-6160/DDY391)

Licensed to Novartis

MRT-6160 (DDY391) At a Glance

First-in-class VAV1 MGD for diverse T and B-cell driven diseases

VAV1 Rationale

- VAV1 is an upstream T- and B-cell signaling node, enabling broad cytokine and autoantibody suppression
- Multi-cytokine modulation with an oral small-molecule profile differentiates from single-cytokine blockade

Opportunity

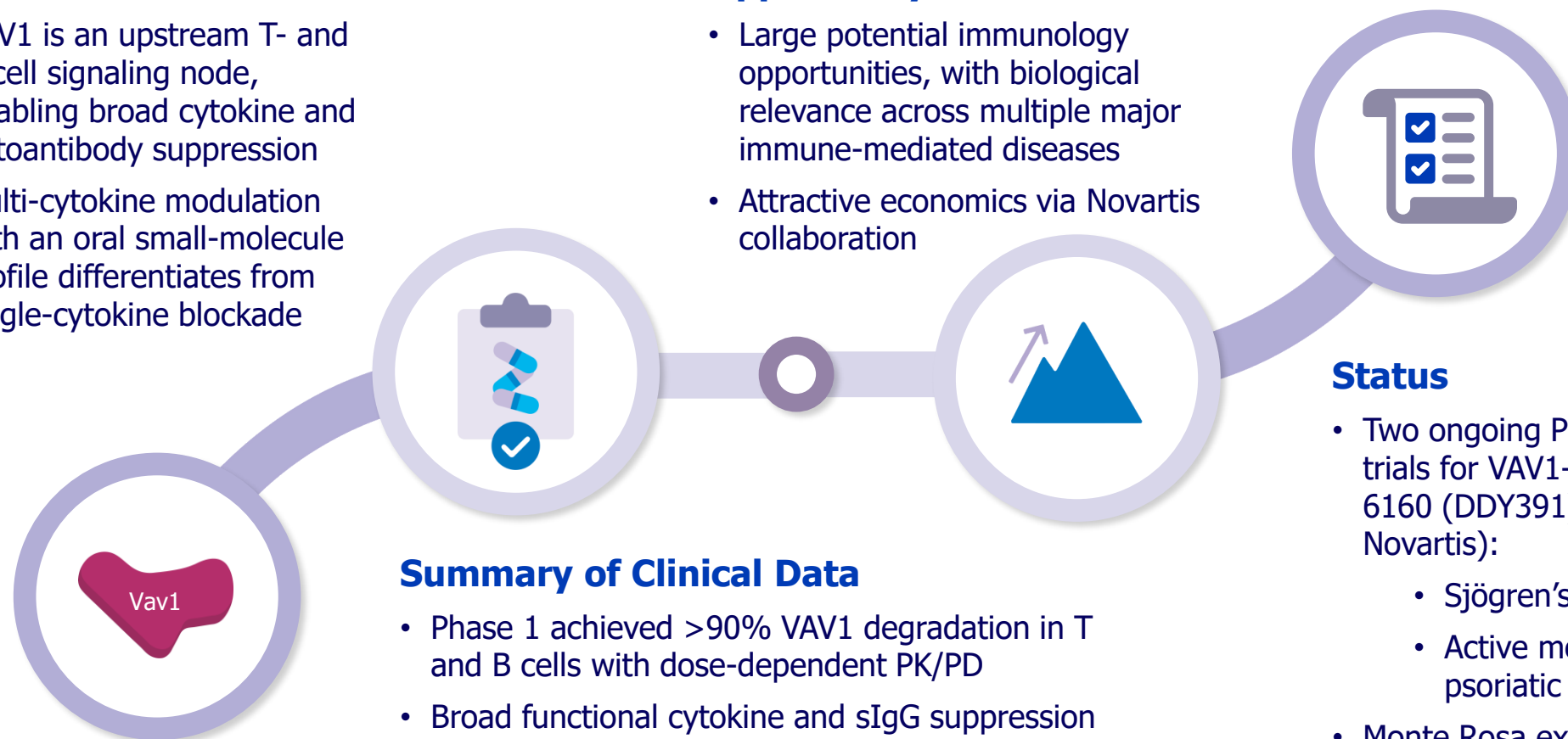
- Large potential immunology opportunities, with biological relevance across multiple major immune-mediated diseases
- Attractive economics via Novartis collaboration

Summary of Clinical Data

- Phase 1 achieved >90% VAV1 degradation in T and B cells with dose-dependent PK/PD
- Broad functional cytokine and sIgG suppression supports robust immunomodulatory activity
- Favorable safety profile with no SAEs observed in Phase 1 study supports chronic use

Status

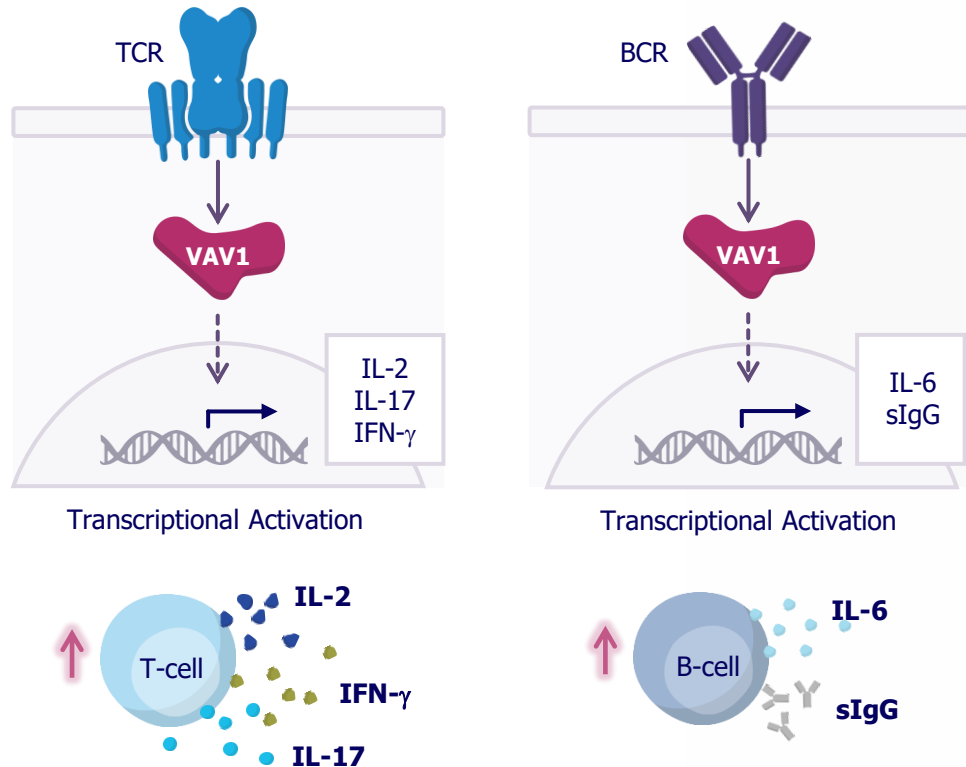
- Two ongoing Phase 2a/b clinical trials for VAV1-directed MGD MRT-6160 (DDY391) (conducted by Novartis):
 - Sjögren's disease (SjD)*
 - Active moderate to severe psoriatic arthritis (PsA)**
- Monte Rosa expects its collaborator, Novartis, to initiate additional Phase 2 studies of MRT-6160 (DDY391) in immune-mediated diseases



MRT-6160: Upstream Immune Modulation via Targeted VAV1 Degradation

Oral MGD delivering coordinated suppression of pathogenic T- and B-cell signaling

MRT-6160 Reduces Multiple Pathogenic Cytokines (IL-2, IL-6, IL-17) and Secreted Antibodies (sIgG)

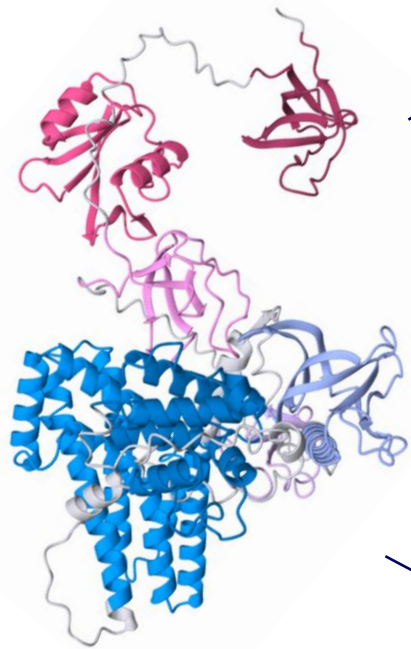


- MRT-6160 is an oral molecular glue degrader that **selectively induces degradation of the VAV1 protein**
- Loss of VAV1 **disrupts T-cell and B-cell receptor signaling**, suppressing pathogenic activation and effector function
- VAV1 degradation **reduces multiple inflammatory cytokines and autoantibody production** rather than targeting a single mediator
- By acting on an upstream signaling node, MRT-6160 delivers **coordinated modulation of adaptive immune responses** through **clinically validated pathways**

VAV1: Upstream Targeting Node Controlling Clinically Validated Pathways

VAV1 signaling is associated with several T and B cell immunologic outcomes

Clinically validated pathway in autoimmune/inflammatory disease



VAV1

T cell activation

B cell activation/Plasma cell differentiation
(Antibody production)

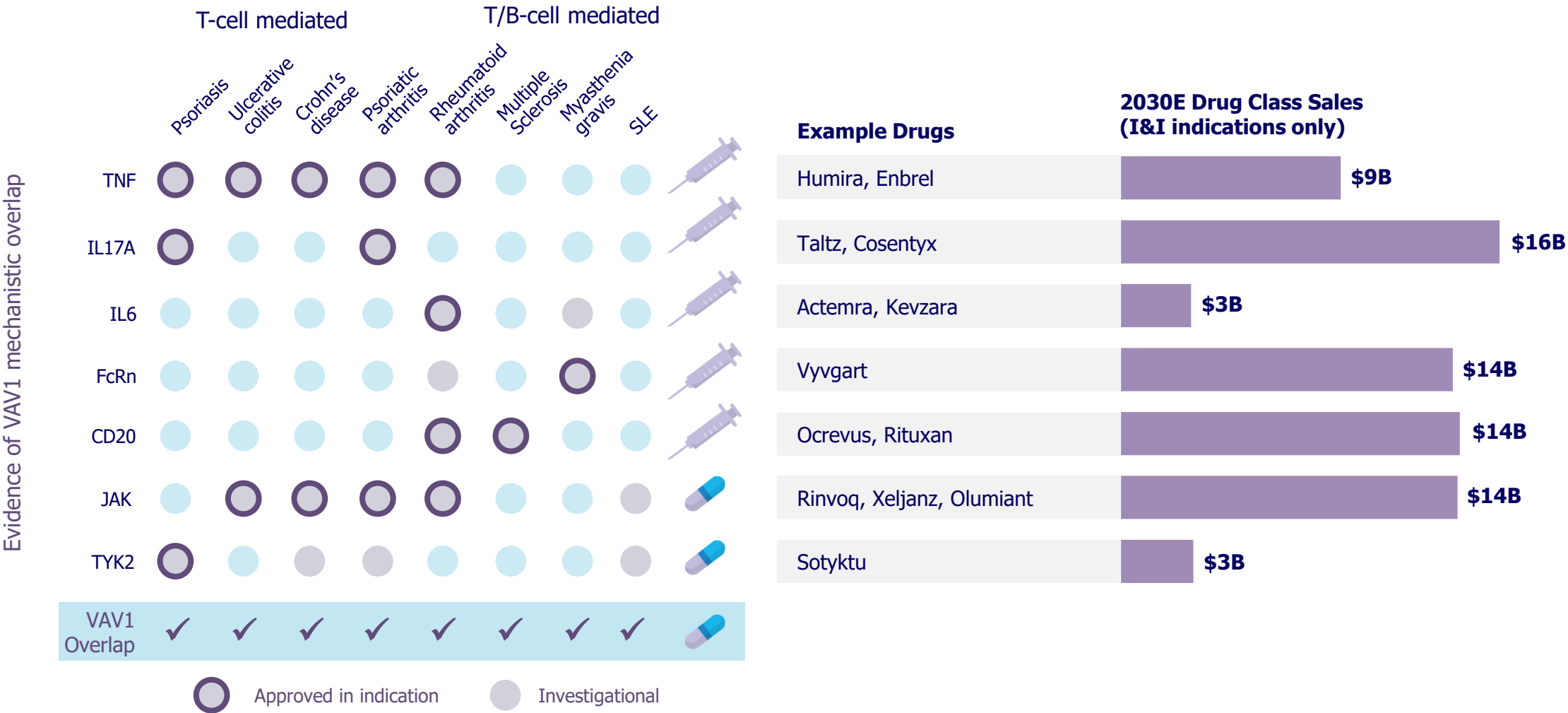
Th17 response

Pro-inflammatory cytokine production



VAV1: Unique Mechanism with Broad Potential Applications

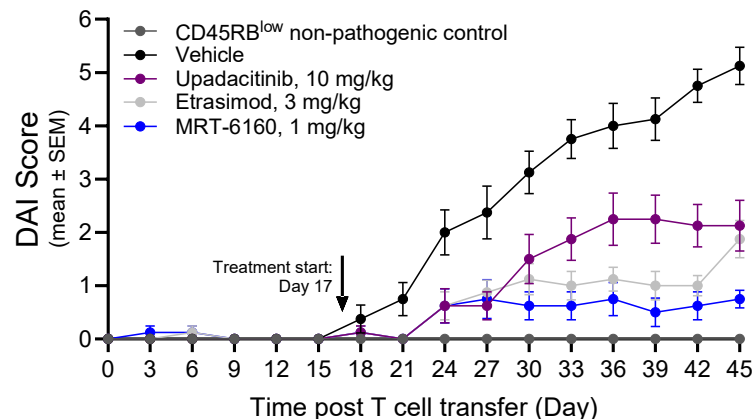
Potential to address multiple autoimmune diseases with a safe, oral therapy



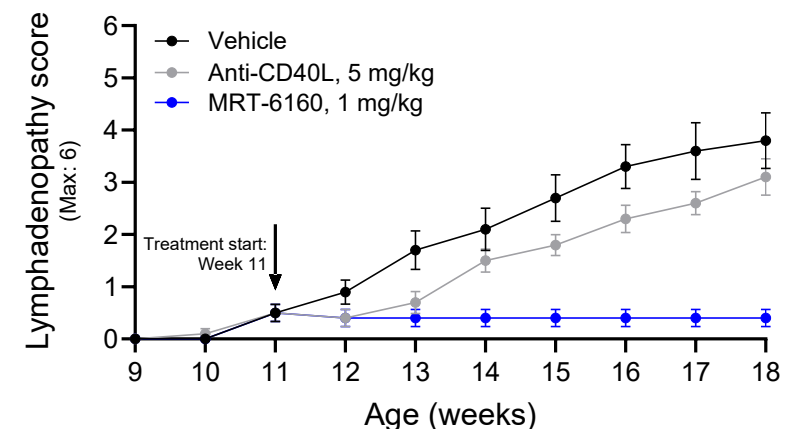
Note: Chart adapted from Hosack et al., Nat Rev Rheumatol 2023. Drug class sales from Evaluate Pharma. 2030E sales may include sales from anticipated future approvals.

Preclinical Data Support Broad Potential Application of MRT-6160

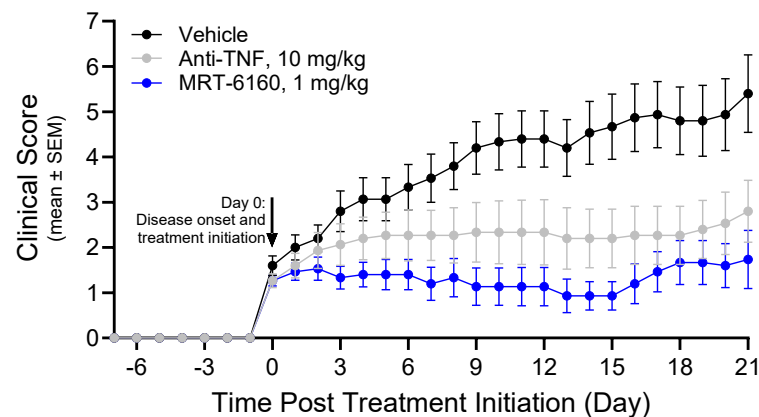
T-cell transfer-induced colitis model of inflammatory bowel disease



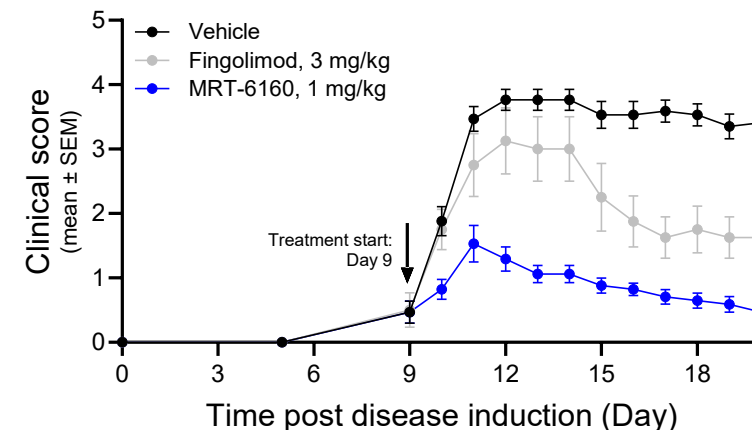
MRL-Fas^{lpr} spontaneous autoimmune disease model (e.g., SLE, Sjögren's)



Collagen-induced arthritis model of autoimmune arthritis



EAE model of neuroinflammatory disease (e.g., multiple sclerosis)



Summary of Phase 1 Data

- Pharmacodynamic and functional *ex vivo* studies performed during Phase 1 suggest **significant effects on cytokine production** can be achieved **following** marked and sustained **degradation of VAV1** in humans
- Demonstrated levels of VAV1 degradation consistent with levels of degradation required to induce efficacy in preclinical models
- Functional impact on cytokine production consistent with levels predicted to be required to achieve efficacy in humans (based on benchmark clinical data)
- **Highly favorable safety profile** in humans
- Presented Phase 1 data as well as chronic toxicology package support **broad potential applications in multiple immune-mediated diseases**

MRT-6160 Phase 1 Healthy Volunteers Study: Design and Objectives

All cohorts randomized & placebo controlled

SAD cohorts

One oral dose



SAD DL5



SAD DL4



SAD DL3



SAD DL2



SAD DL1



MAD cohorts

7 daily oral doses

MAD DL3

MAD DL2

MAD DL1

Study Endpoints

Primary

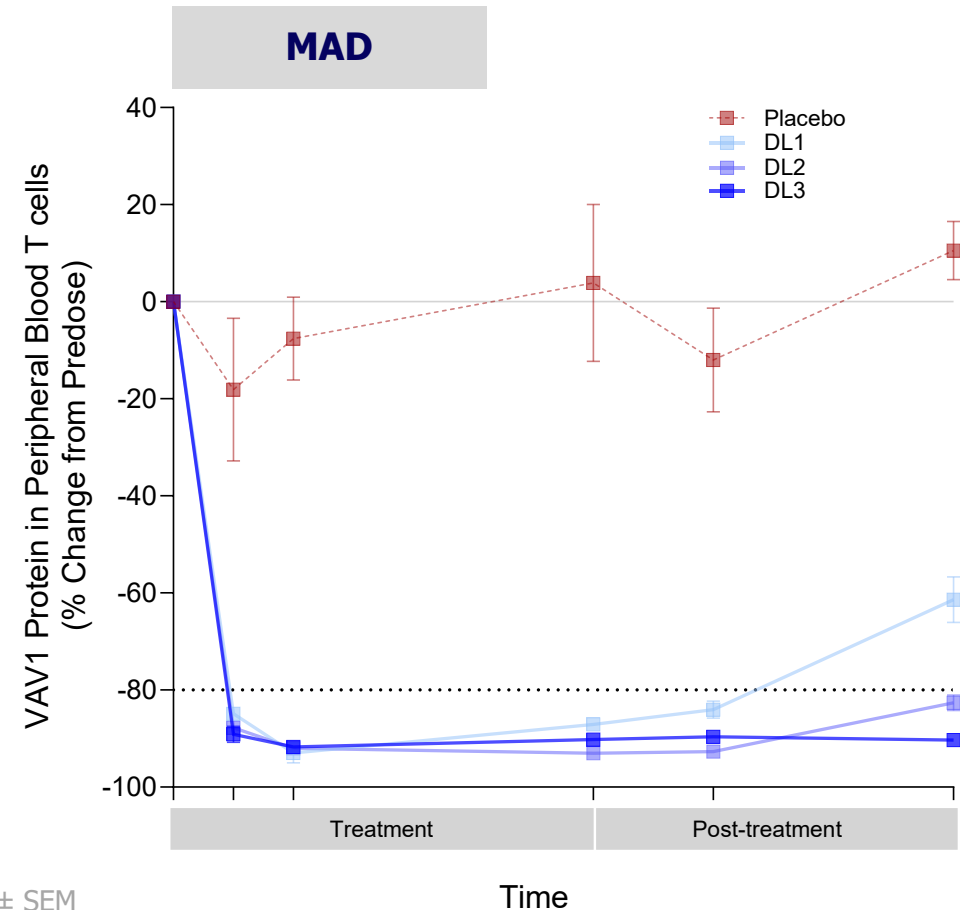
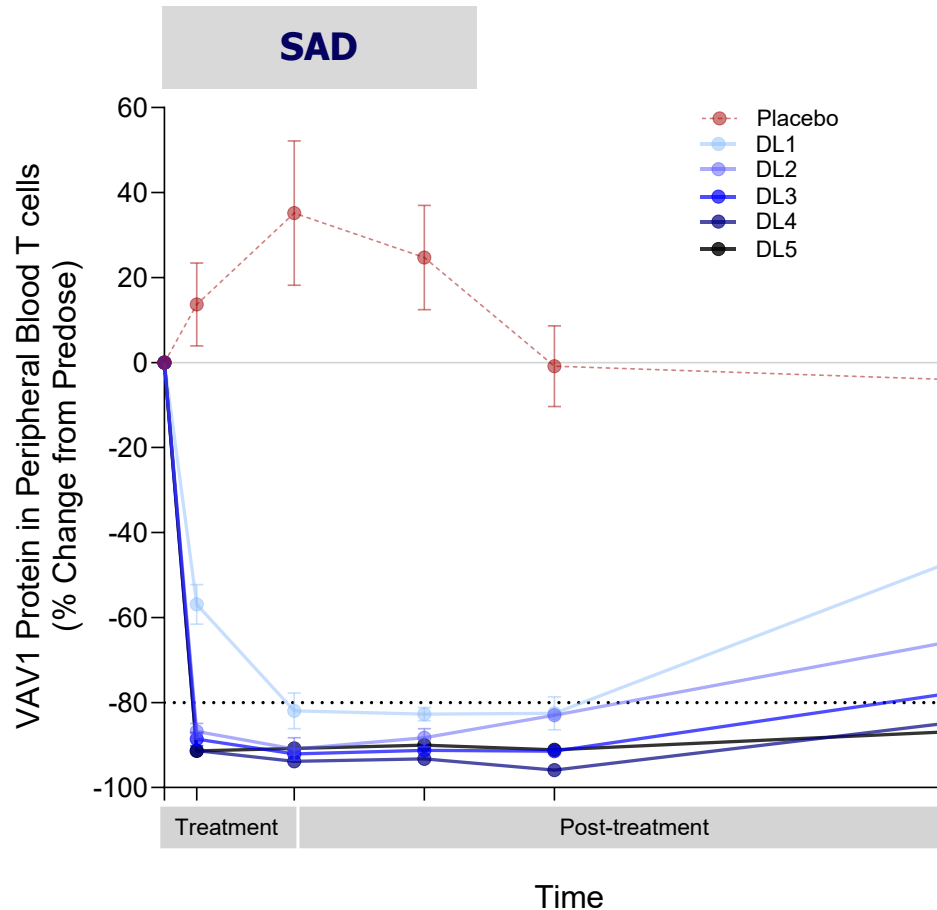
- Safety and tolerability

Secondary & exploratory

- Pharmacokinetics
- Pharmacodynamics
 - VAV1 degradation in T & B cells
 - Ex vivo response to TCR- and BCR-stimulation

Enrolled > 70 subjects

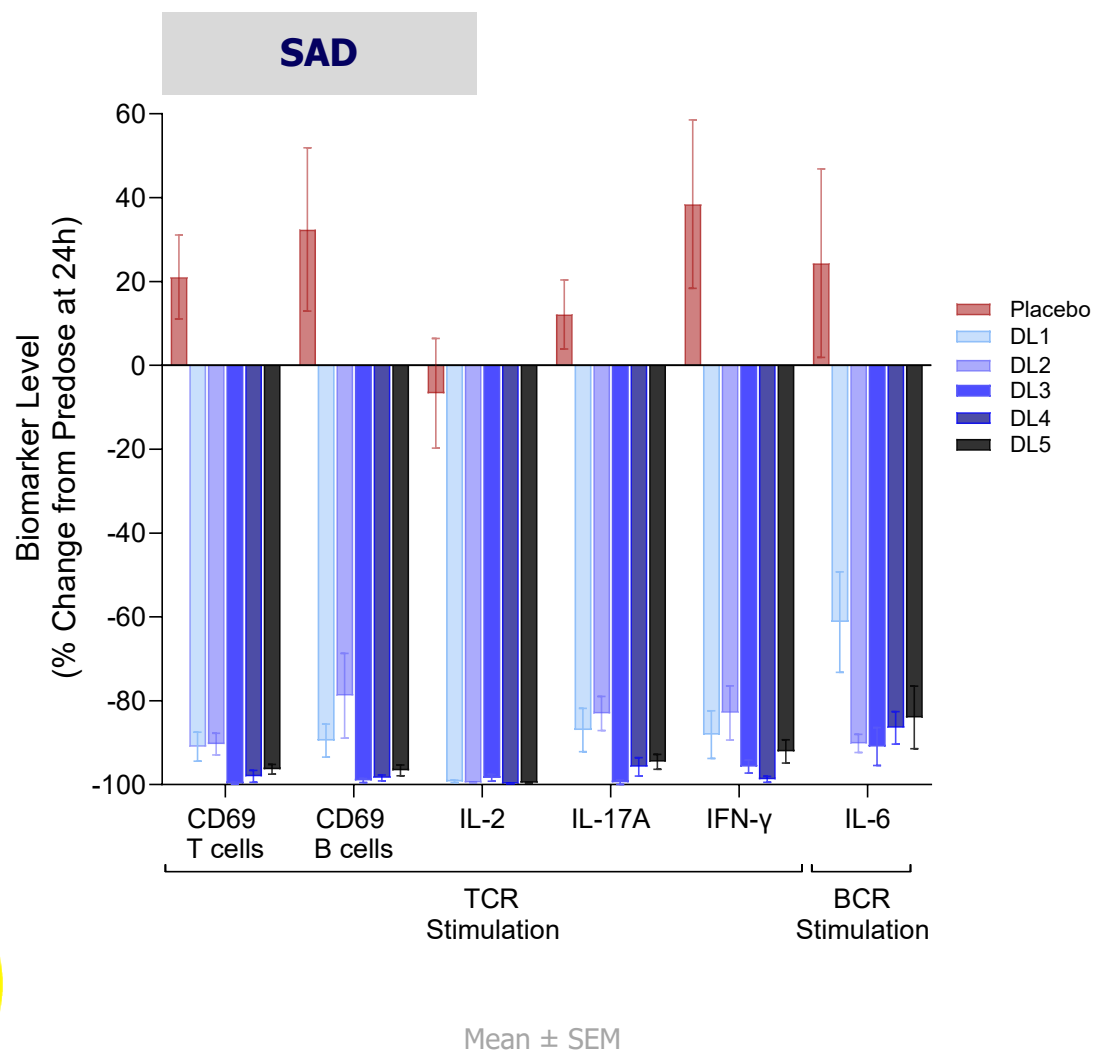
MRT-6160 Achieved Dose-Dependent VAV1 Degradation >90% in Peripheral Blood T Cells After Single and Multiple Dose Administration



- Dose-dependent, marked degradation of VAV1 in peripheral blood T cells (> 90%; except DL1)
- Similar results observed in peripheral blood B cells
- VAV1 protein reduction is sustained, with dose-dependent recovery post treatment



VAV1 Degradation by MRT-6160 Resulted in Significant Functional Inhibition of T and B Cells following a Single Dose Administration

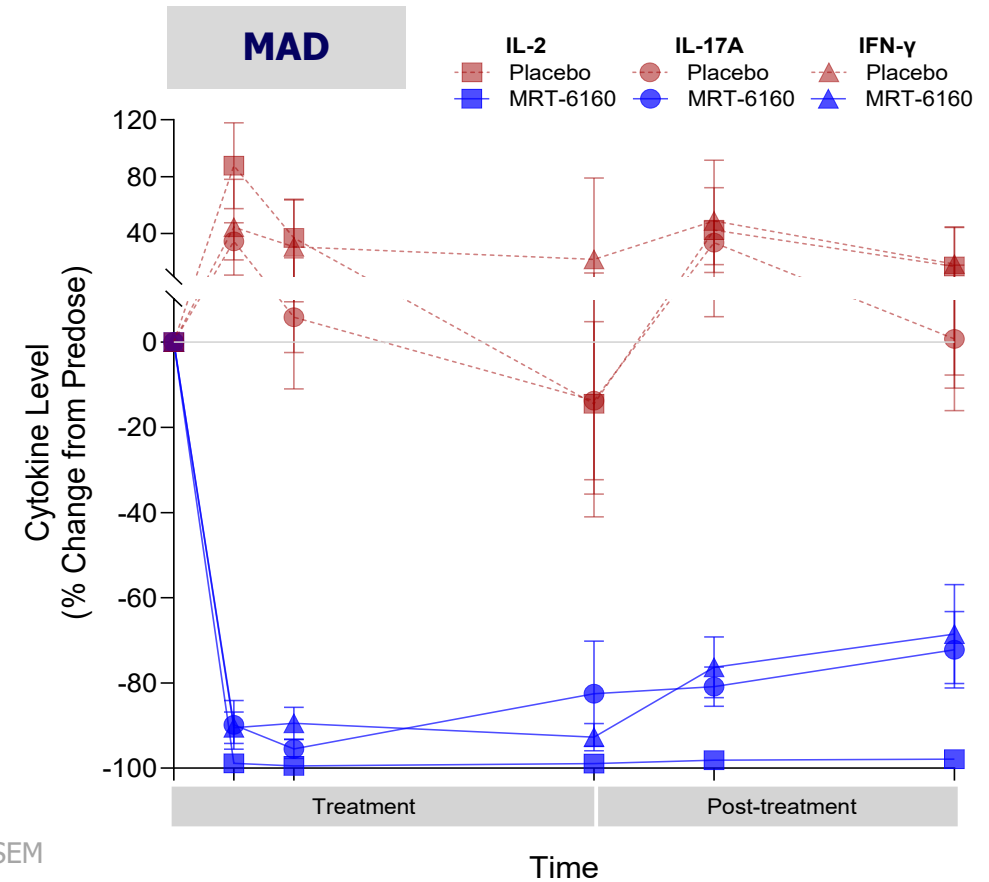
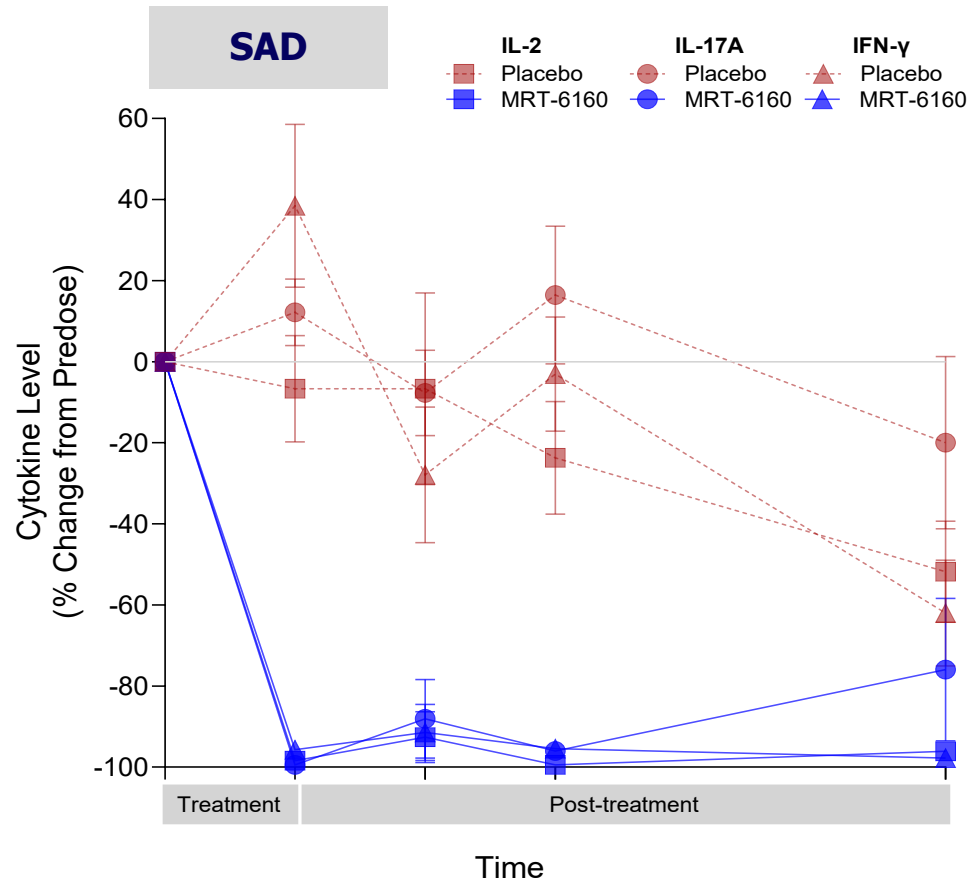


MRT-6160 treatment:

- Significantly attenuated CD69 upregulation on T and B cells following TCR stimulation, reflecting functional inhibition
- Significantly (up to 99%) inhibited IL-2, IFN-γ and IL-17A secretion from whole blood derived T cells following ex vivo TCR stimulation
- Attenuated IL-6 production by 60-90% across dose levels following B-cell stimulation

Pharmacodynamic studies suggest robust functional effects on cytokine production can be achieved with $\geq 80\%$ degradation of VAV1

MRT-6160 Resulted in Sustained Suppression of TCR-mediated Cytokine Production following Single or Multiple Dose Administration



- Significant and sustained suppression of IL-2, IL-17A and IFN- γ secretion from whole blood following ex vivo stimulation of TCR (data for selected SAD and MAD dose shown as example)

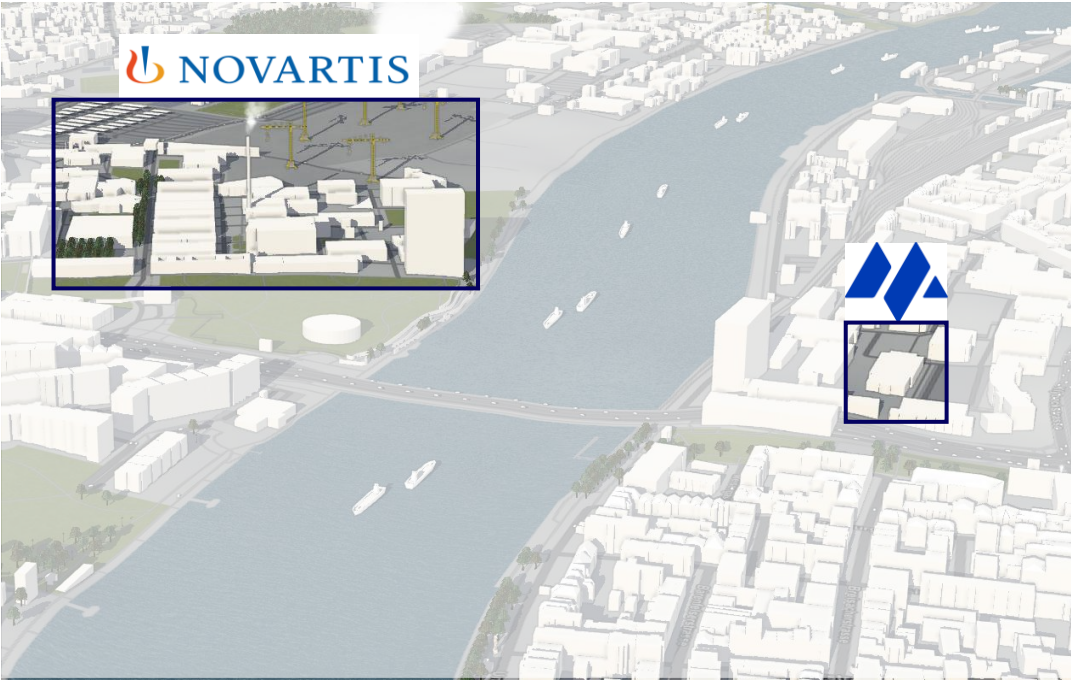
Safety Summary

- MRT-6160 was well tolerated with no serious adverse events (SAE)
- Observed treatment-emergent adverse events (TEAE) were mild (82%) or moderate (18%) and self-limiting
- Overall TEAE frequency was similar between MRT-6160 and placebo
- TEAE observed in 2 or more subjects treated with MRT-6160:
 - SAD: pain from vessel puncture (2)
 - MAD: cough (2), diarrhea (3), feeling hot (4), headache (5), nasal congestion (2), oropharyngeal pain (3) and pyrexia (2)

Strategic Agreement to Accelerate and Broaden MRT-6160 (DDY391) Development



Scope	Global license agreement with Novartis to advance VAV1-directed molecular glue degraders including MRT-6160 (DDY391), in development for immune-mediated conditions (announced Oct. 2024)
Financial Terms	• \$150M upfront payment • Eligible for up to \$2.1B in development, regulatory, and sales milestones, beginning upon initiation of Phase 2 studies • NVS fully funds Phase 2 studies • Eligible for 30% US P&L share and ex-US tiered royalties
Strategic Goal	Accelerate and broaden scope of clinical development of MRT-6160 (DDY391) while retaining substantial value for Monte Rosa

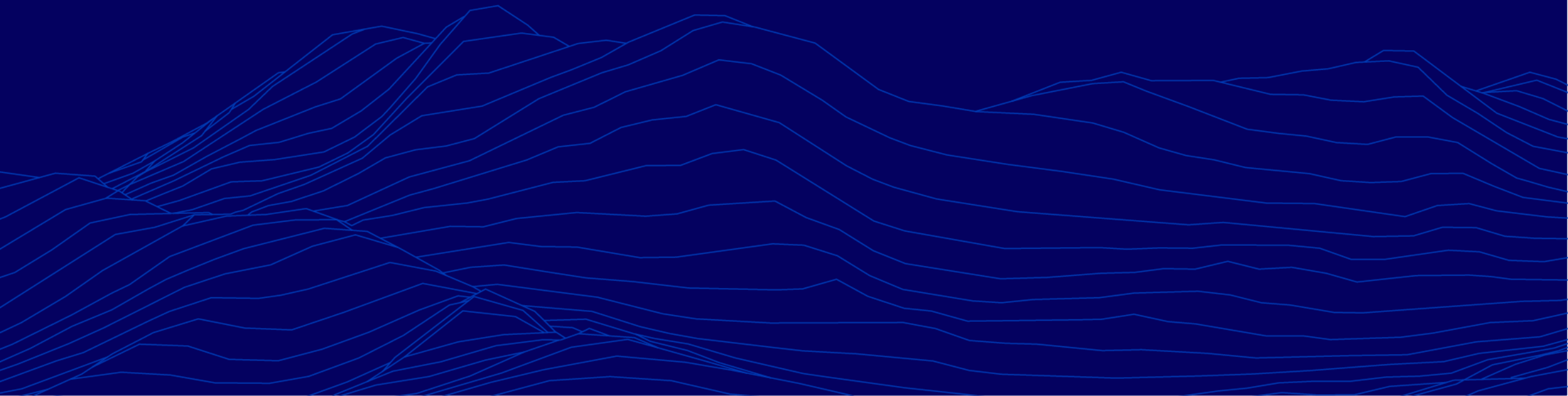


Basel

Notes: Monte Rosa has a global exclusive development and commercialization license agreement with Novartis to advance VAV1-directed MGDs, including MRT-6160 (DDY391). Novartis is responsible for conducting and funding Phase 2 studies. Monte Rosa will co-fund any Phase 3 clinical development and will share 30% of any profits and losses associated with the manufacturing and commercialization of MRT-6160 (DDY391) in the U.S., and is also eligible for tiered royalties on ex-U.S. net sales.



NEK7 Program (MRT-8102)



MRT-8102 At a Glance

First-in-class NEK7 MGD for NLRP3 inflammasome driven diseases

NEK7 Rationale

- NEK7 is essential for NLRP3 inflammasome assembly, enabling upstream blockade of IL-1 α / β , pathologic cytokines, DAMPs and pyroptosis
- NEK7 degradation approach offers durable pathway shutdown, potential safety/efficacy advantages vs biologics, and oral dosing

Opportunity

- Large cardiometabolic and inflammatory markets with limited oral, upstream anti-inflammatory options
- Potential best-in-class profile driven by durable upstream pathway inhibition and favorable safety profile

Summary of Clinical Data

- GFORCE-1 study showed normalization of local and systemic pathogenic drivers of ASCVD in subjects with elevated CVD risk, including drivers of local plaque progression, thrombosis, and systemic inflammation
- Data demonstrated favorable safety and tolerability profile for MRT-8102 over 4 weeks dosing + 4 weeks follow-up, with no SAEs; TEAE rates comparable to pbo; no evidence of increased infection risk*

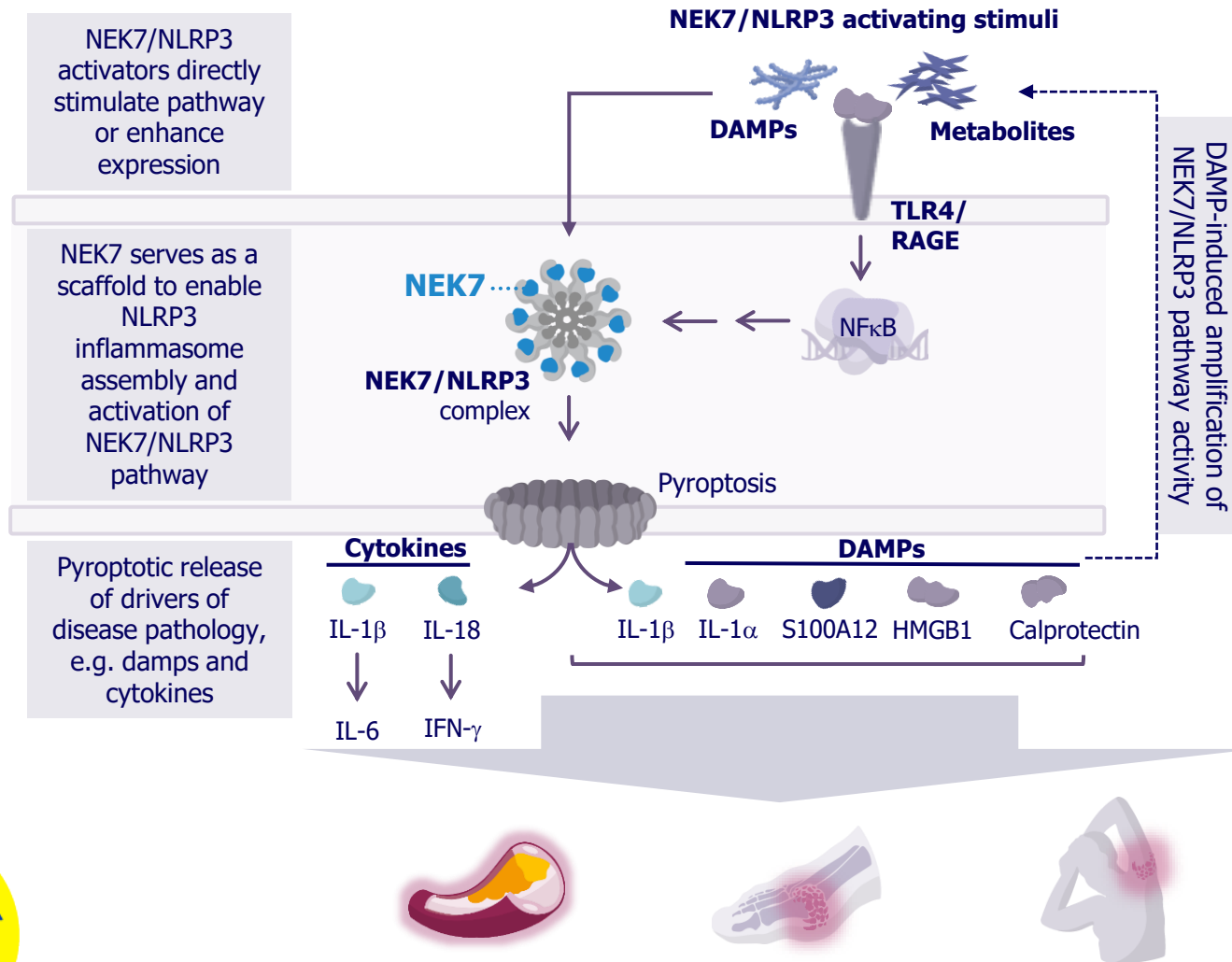
Status

- GFORCE-1 study in subjects with elevated CVD risk completed
- Phase 2 initiations expected:
 - Gout – GEMINI-1 study (Q4 2026 / Q1 2027)
 - Coronary artery disease – GFORCE-2 study (H1 2027)
 - Hidradenitis suppurativa – GALAXY-1 study (H1 2027)

Note: Comparisons between MRT-8102 and other therapies represented herein are based on post-hoc analyses comparing MRT-8102 clinical information with publicly available information for other therapies. Any comparisons use information from different clinical trials, conducted by different parties, at different points in time, with differences in trial designs and patient populations. No head-to-head clinical trials have been conducted, cross-trial comparisons should not be made, and this information is provided only for illustrative purposes.

* As of Oct. 1, 2026 disclosure

NEK7 Enables Pathogenic NLRP3 Activation to Drive Disease Biology

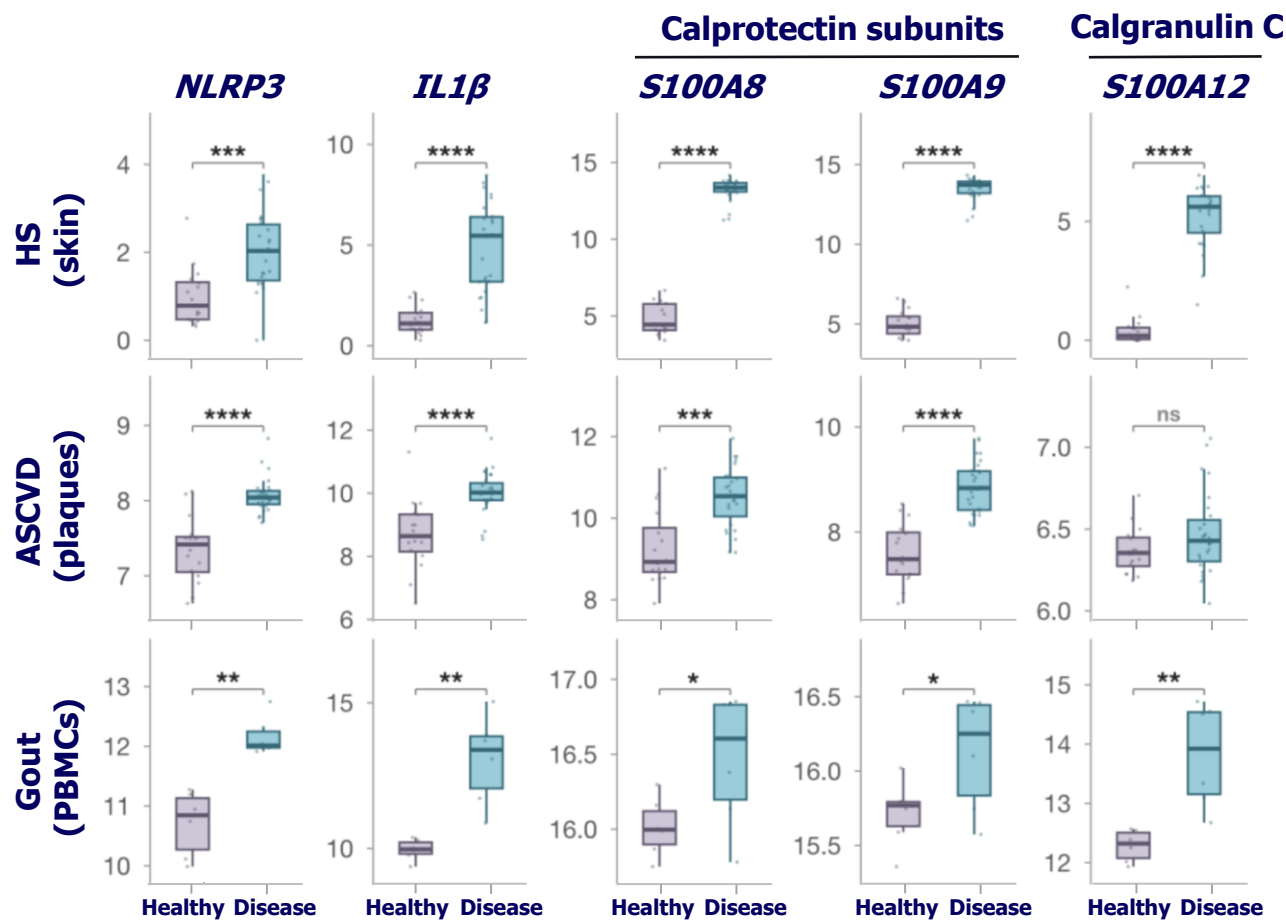
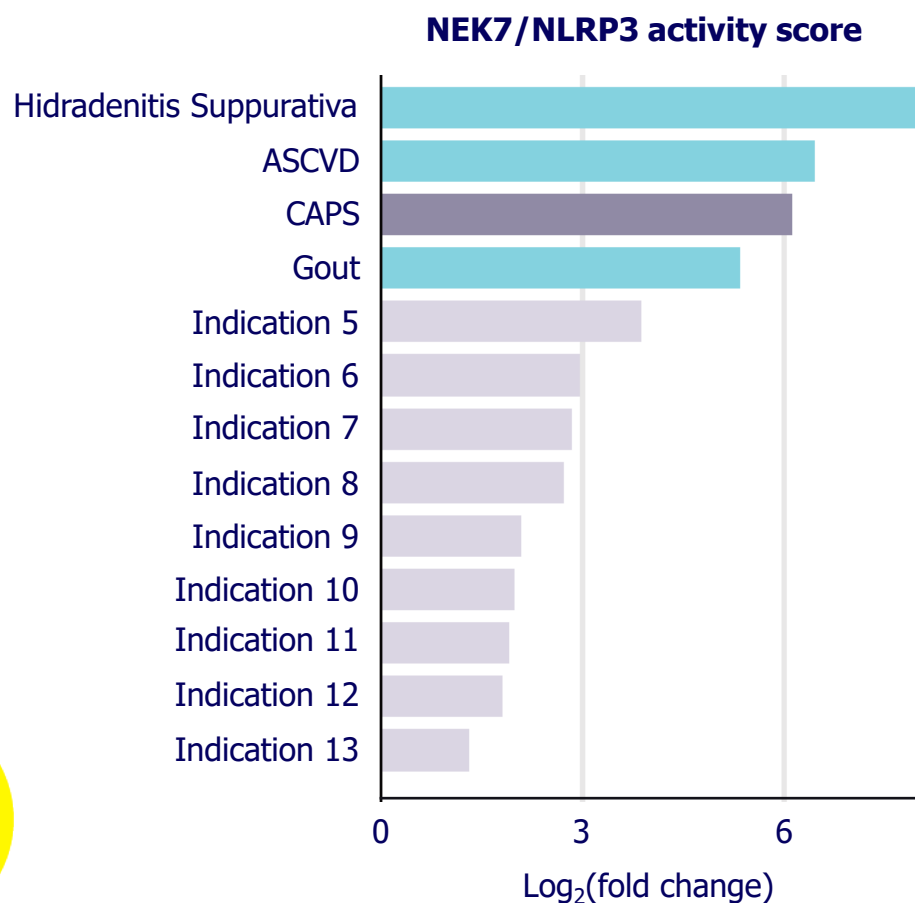


- Multiple metabolic and genetic factors can promote NEK7-mediated NLRP3 inflammasome complex assembly in a kinase-independent manner
- NEK7/NLRP3 pathway activation causes pyroptotic cell death, leading to release of **IL-1α/β, IL-18, and DAMPs (e.g., HMGB1, Calprotectin, S100A12)**
 - IL-1β and IL-18 are highly inflammatory cytokines
 - **DAMPs** further stimulate NEK7/NLRP3 activity and concomitantly promote NLRP3-independent cytokine/chemokine production in neighboring cells
 - DAMPs and IL-1β are responsible for the majority of local pathogenesis and tissue changes characteristic of ASCVD, gout, hidradenitis suppurativa (HS) and other indications
- **Interference with pathway at most upstream point, through NEK7 degradation, has potential to achieve most meaningful efficacy across NEK7/NLRP3 driven indications**, including ASCVD, gout and HS

Members of the NEK7/NLRP3 Downstream Signaling Cascade are Elevated Across Multiple Indications with High Unmet Need

ASCVD, HS and gout have highest pathological NEK7/NLRP3 activity scores

Upregulation of pathogenic cascade downstream of pyroptosis is conserved across the top NEK7/NLRP3-active indications



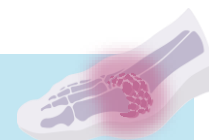
Large Market Opportunities Supported by Strong Biological Rationale

Coronary artery disease



- **Central role of NEK7/NLRP3 in plaque biology** and atherogenic progression
- **~14M** U.S. patient population, with **45-50%** of patients having experienced at least one prior MI
- **>30%** of CAD patients suffer from **residual inflammatory risk** despite optimized lipid-lowering therapy
- **NEK7 degradation and NEK7/NLRP3 pathway inhibition** provide a novel, upstream approach **that goes beyond downstream single-cytokine depletion** to address residual CVD risk

Gout



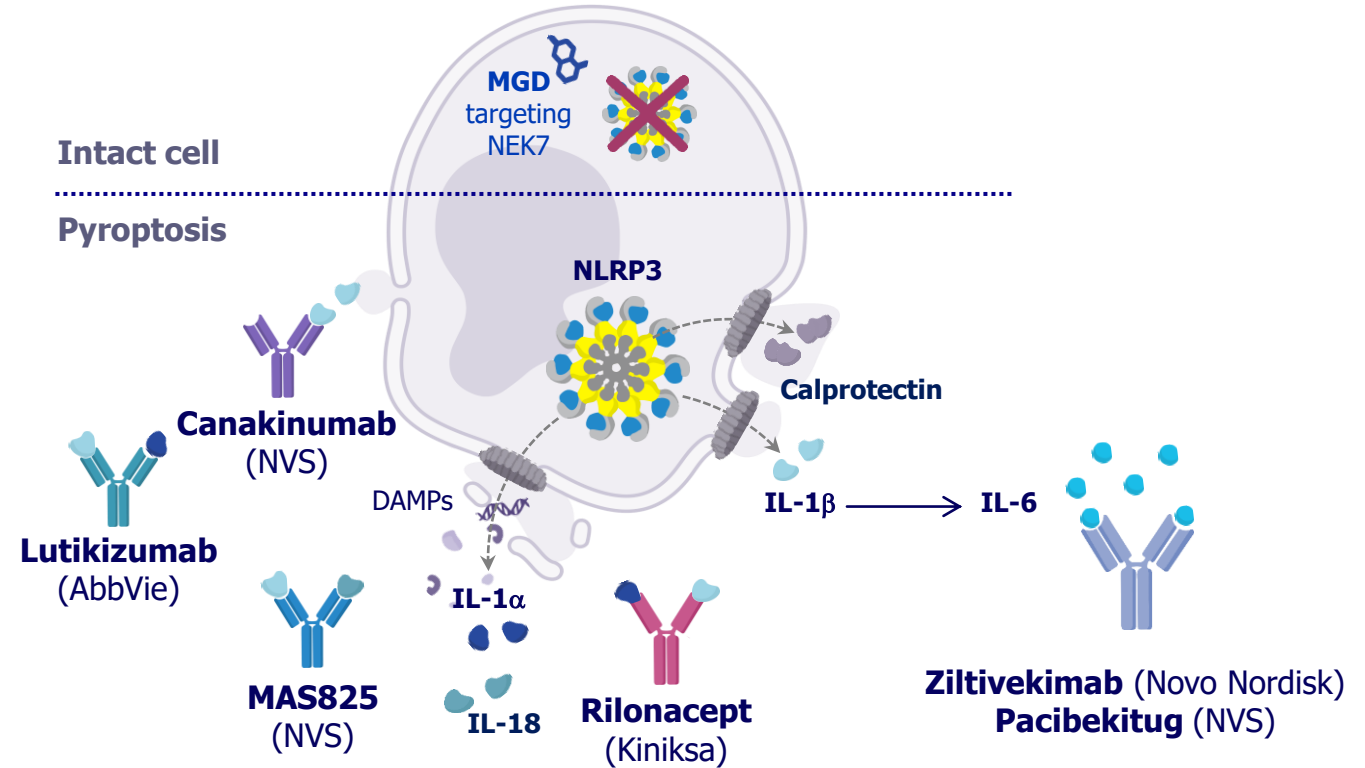
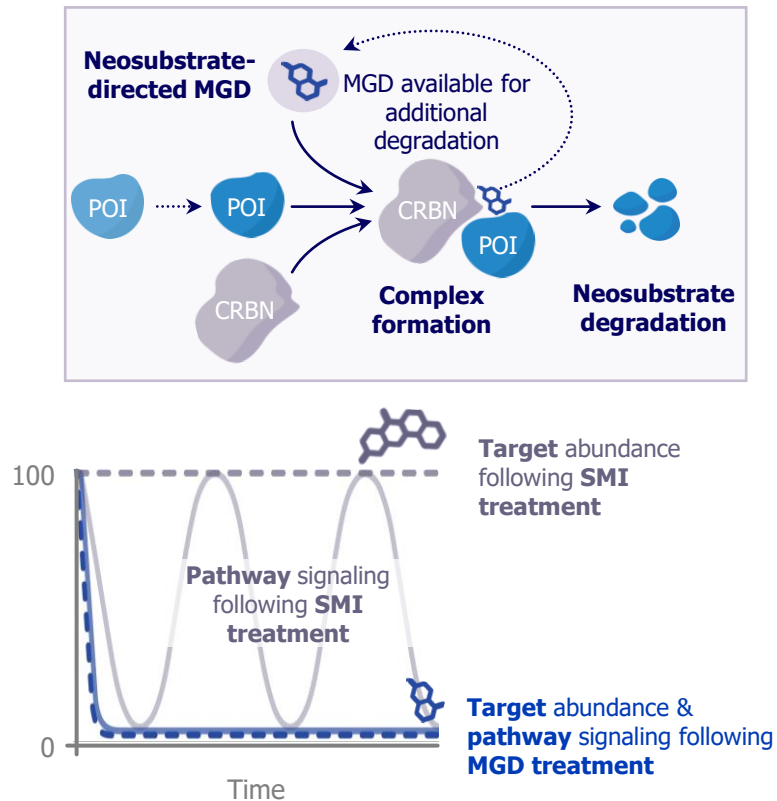
- **Canonical NEK7/NLRP3-pathway disease:** MSU crystals trigger NEK7-mediated NLRP3 assembly, driving IL-1 β release and flare pathology
- **~10M** U.S. patient population, with **~30%** comorbid with renal disease
- SOC treatment often insufficient in preventing gout flares, resulting in **breakthrough flares**, a leading contributor to poor adherence
- High unmet need for long-term flare prophylaxis: **>55%** of gout-treating physicians surveyed are **not satisfied with current prophylaxis options (>65% for CKD co-morbid patients)**

Hidradenitis suppurativa



- **Highest NEK7/NLRP3-pathway activity score** of any indication studied, with consistent upregulation of NLRP3, IL-1 β , and DAMPs in lesional tissue
- **~400-450K** U.S. addressable population
- Significant unmet need with **~55%** patients poorly managed with SOC
- IL-1 antibodies **provide promising POC** for the NEK7/NLRP3 pathway
- Opportunity to target inflammasome assembly, **upstream of IL-1 and DAMP-driven pathogenesis in HS lesions**, unlike single-mediator TNF/IL-17 biologics

NEK7-directed MGD MRT-8102 is Highly Differentiated Over Other NLRP3/IL-1/IL-6 Pathway Modalities



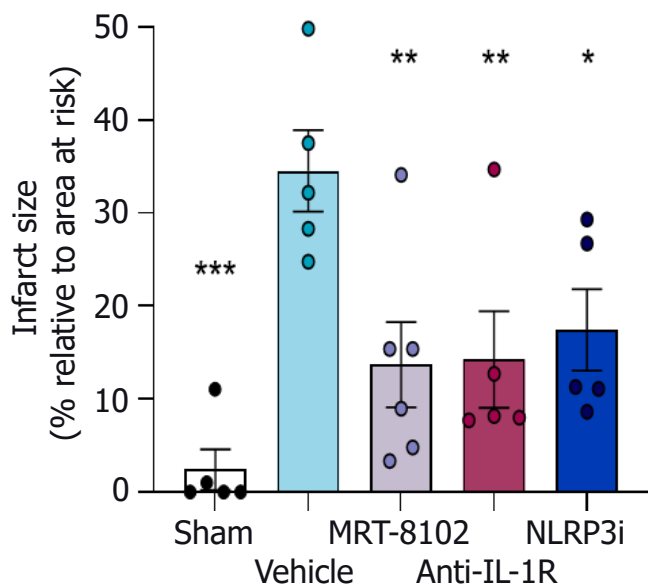
In contrast to small molecule inhibitors (SMIs), MRT-8102 induces **catalytic NEK7 degradation**, long-lasting inflammasome disassembly and inactivation, and sustained inhibition of cytokine release

Due to inhibition of NLRP3 assembly, MRT-8102 **prevents pyroptotic cell death-mediated release of inflammatory cytokines and DAMPs** known to drive disease pathology. Mono- and bispecific biologics fail to inhibit pyroptosis, leading to incomplete blockage of the pathological drivers of disease

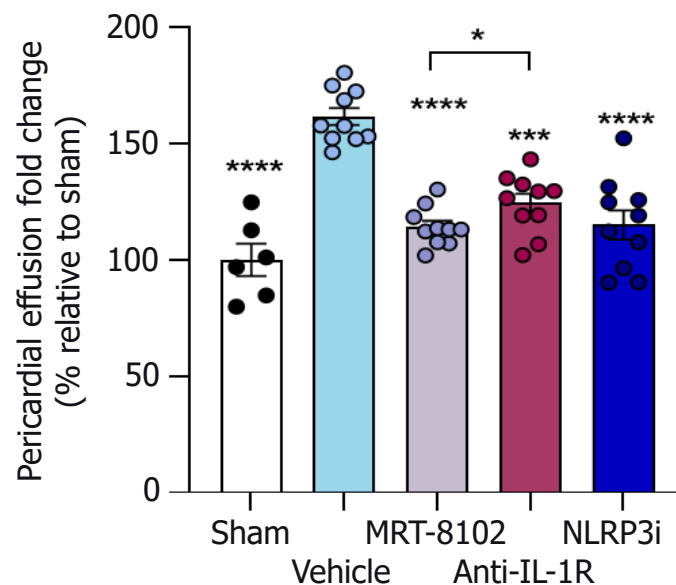
NEK7 Is Critical for a Broad Set of NLRP3-mediated Inflammatory Diseases In Preclinical Models

Mouse: MRT-8102 reduced heart damage in two cardiovascular disease models

Prophylactic treatment in acute myocardial infarction (AMI) model

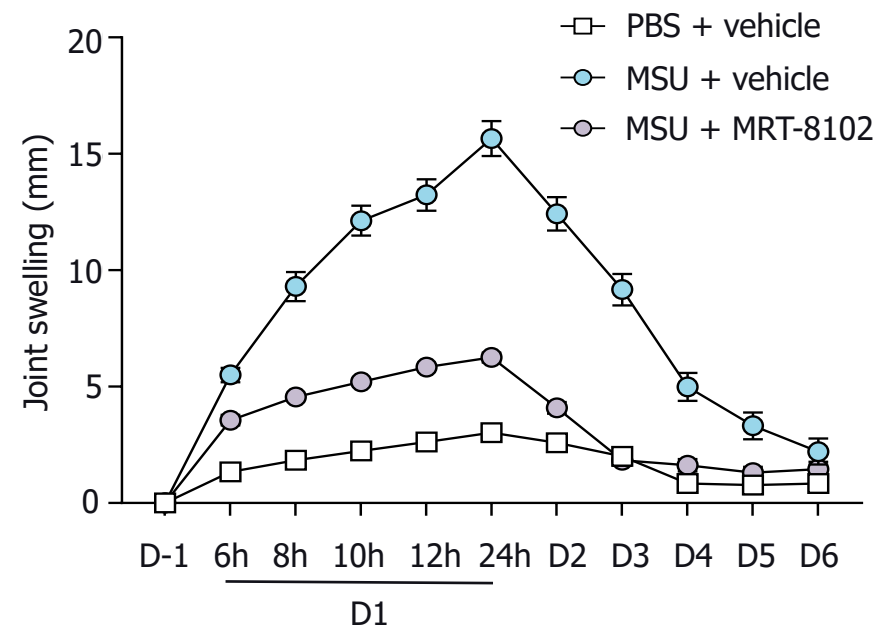


Prophylactic treatment in acute pericarditis model



Rabbit: MRT-8102 reduced MSU-induced gout flare

Prophylactic treatment in acute gout flare model

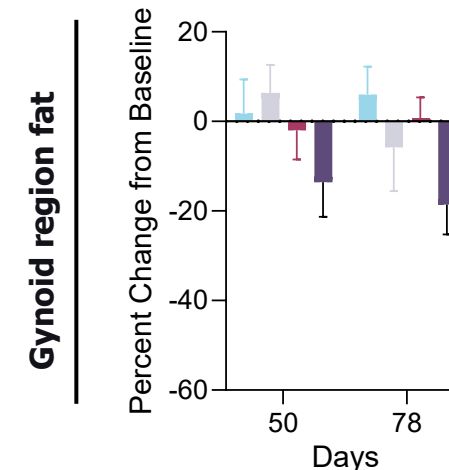
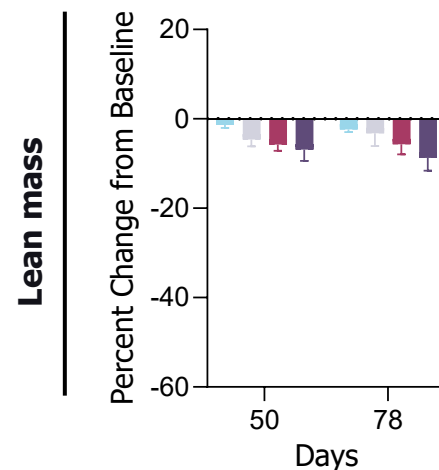
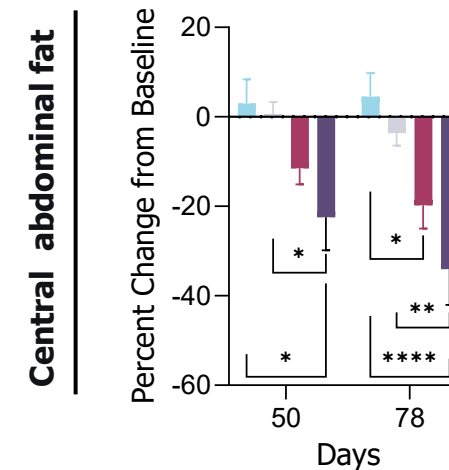
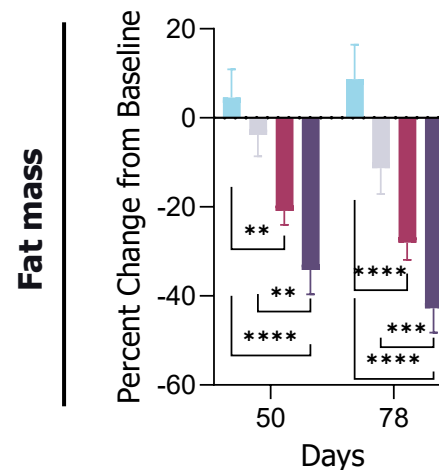
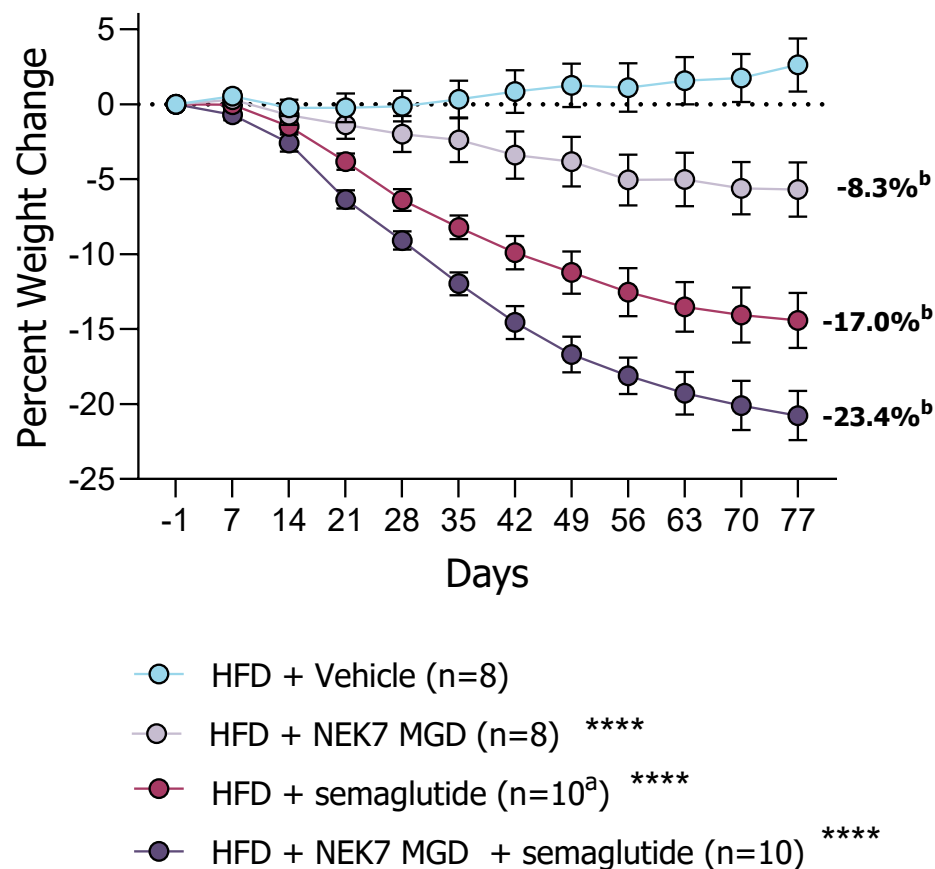


NEK7 MGD, Alone or in Combo with Semaglutide, Drove Preferential Abdominal Fat Loss While Sparing Lean Mass in a Cyno Obesity Model

Cynomolgus monkey: NEK7 MGD promoted body weight loss alone and with semaglutide

Preferential decrease of fat mass over lean mass^c

Percent fat (relative to whole body)^c

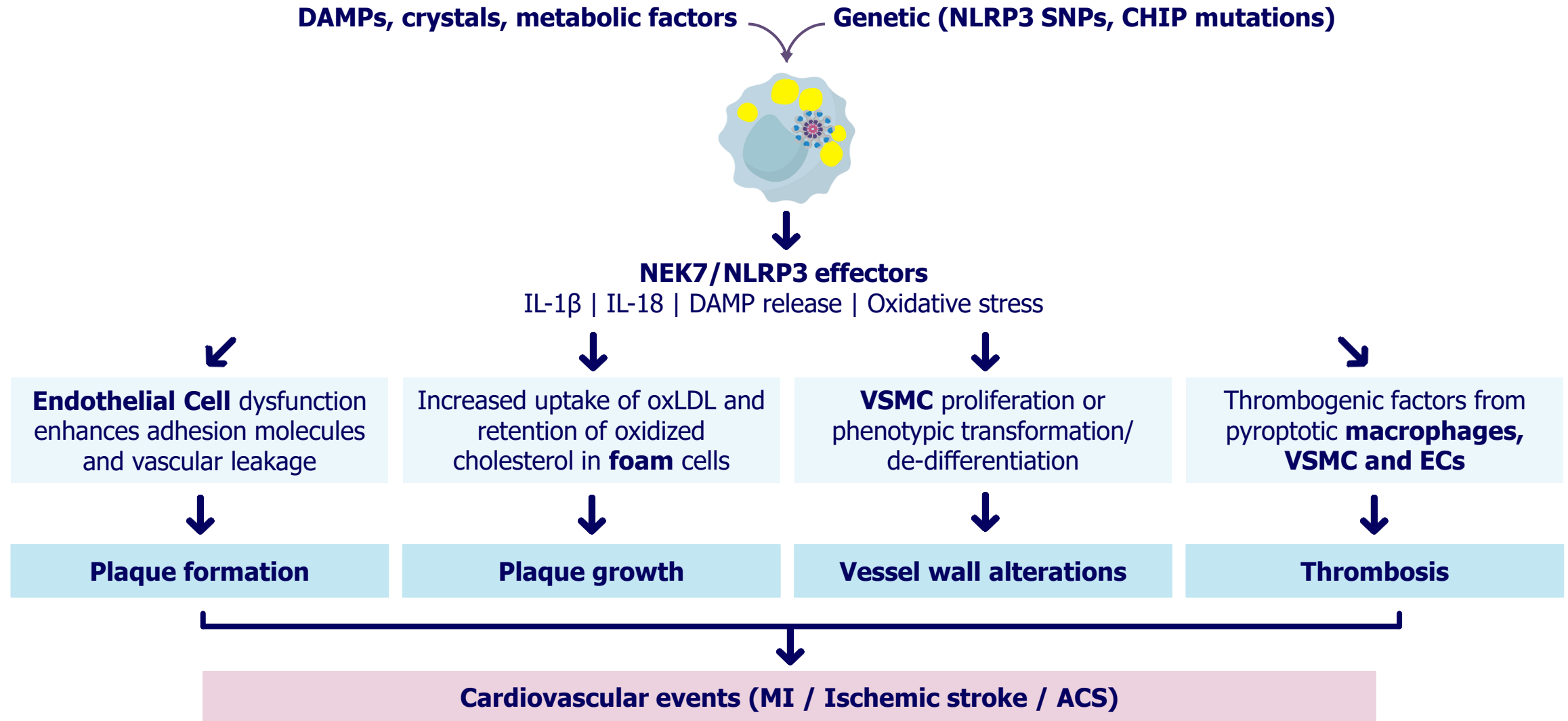


Study subjects selected from colony of HFD (high fat diet)-fed animals and randomized before enrollment; ^an=9 from Day 56 onwards; ^bBody weight decrease relative to vehicle. ^cDEXA (dual-energy X-ray absorptiometry) body composition analysis performed under anesthesia. 2-Way ANOVA with Šidák's multiple comparisons test. *P ≤ 0.05; **P ≤ 0.01; ***P ≤ 0.001; ****P ≤ 0.0001.

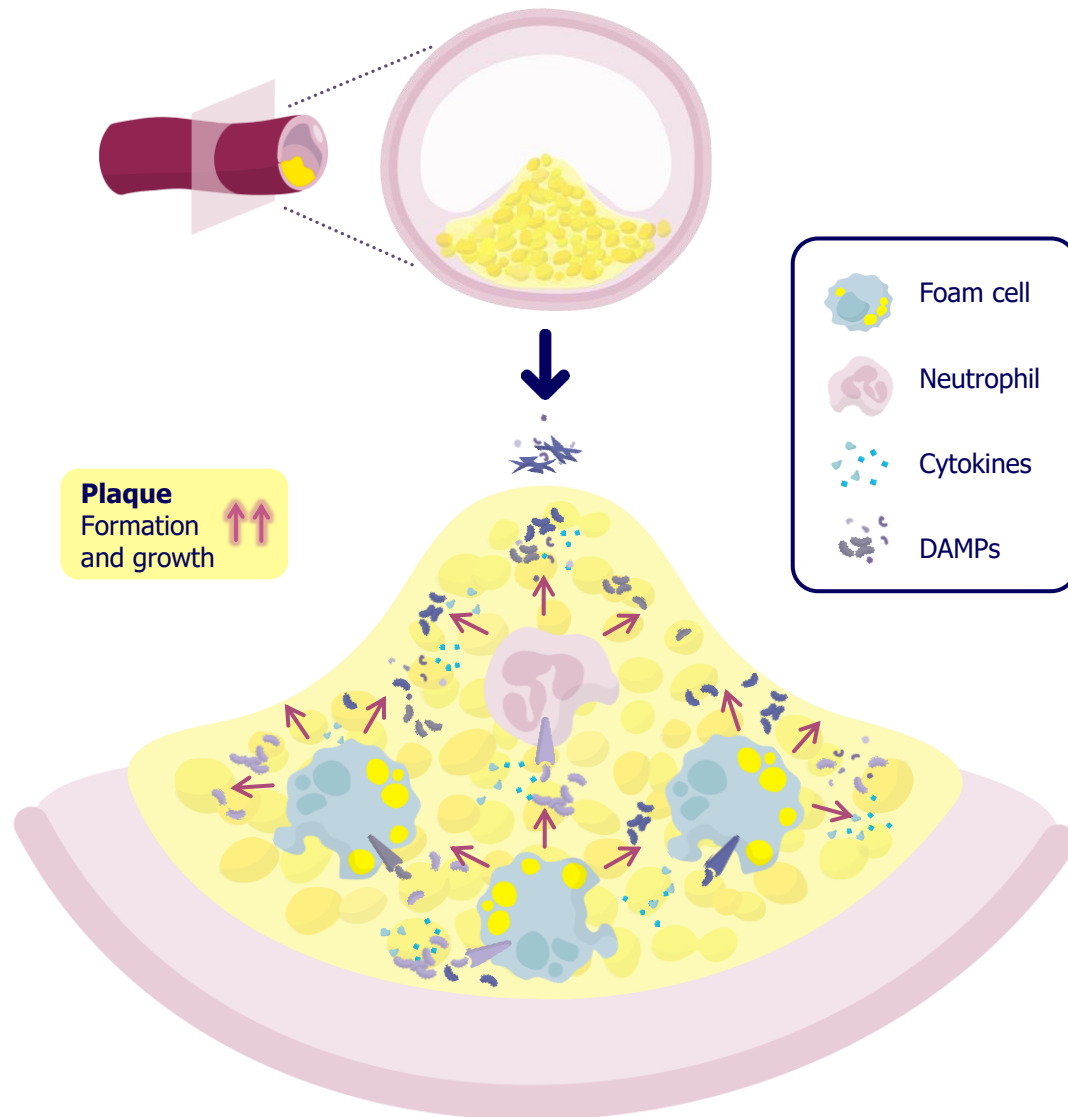


The Role of the NEK7/NLRP3 Pathway in ASCVD

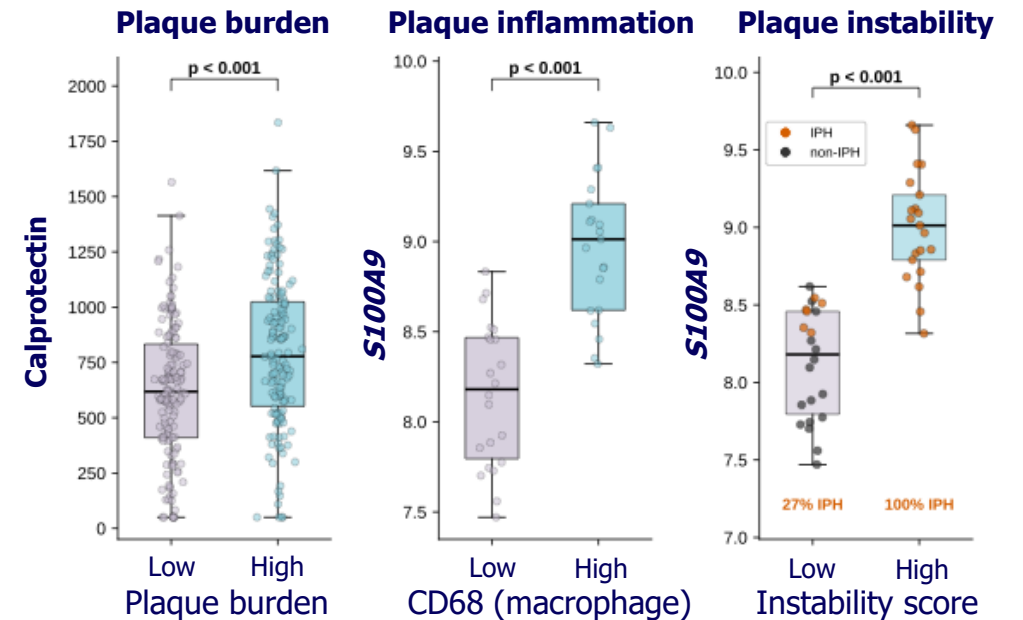
The Multifaceted Pathogenic Role of the NEK7/NLRP3 Pathway in Plaque Biology and Atherogenic Progression



DAMPs, Including Calprotectin, Potently Activate NEK7/NLRP3 in Neighboring Cells to Amplify Plaque Burden and Instability



Calprotectin levels correlate with plaque burden, inflammation and instability

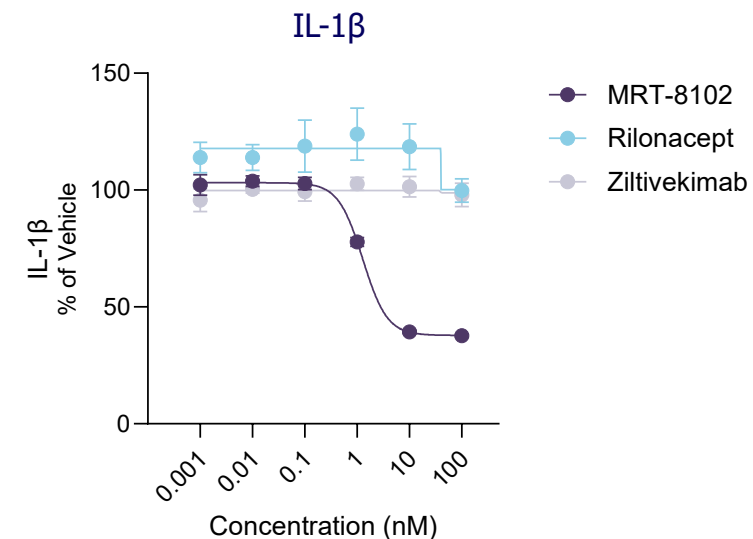
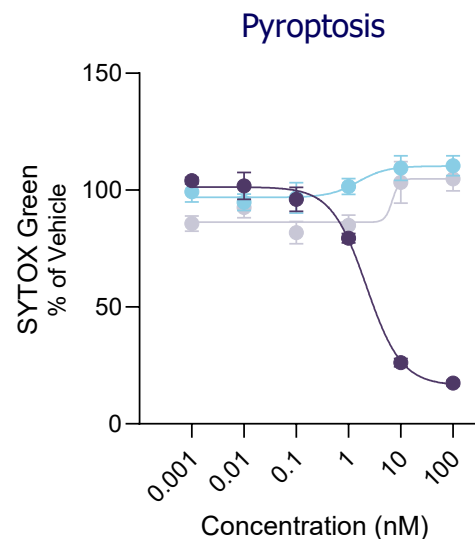
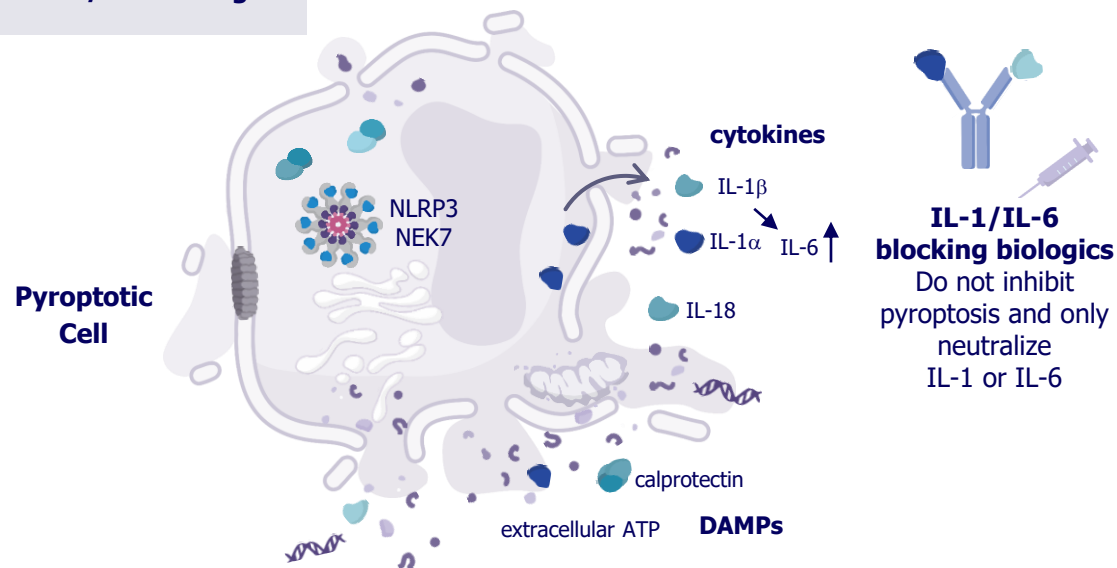


Circulating calprotectin levels significantly associate with increased plaque burden, enhanced plaque inflammation, and plaque instability

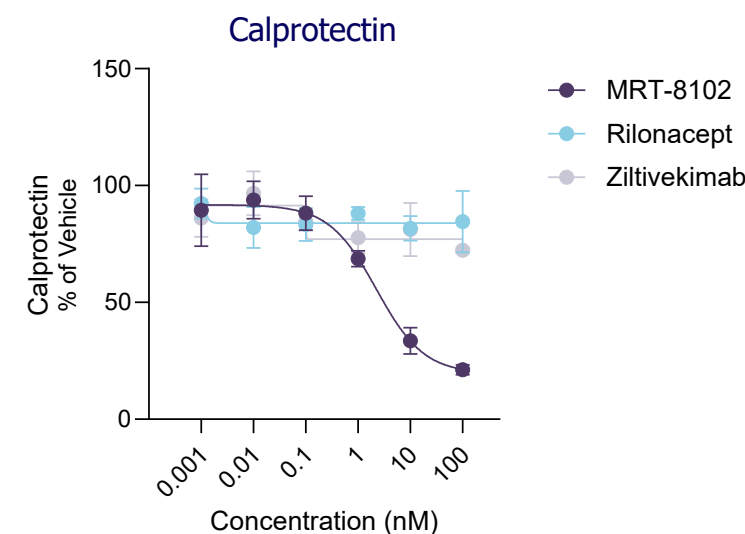
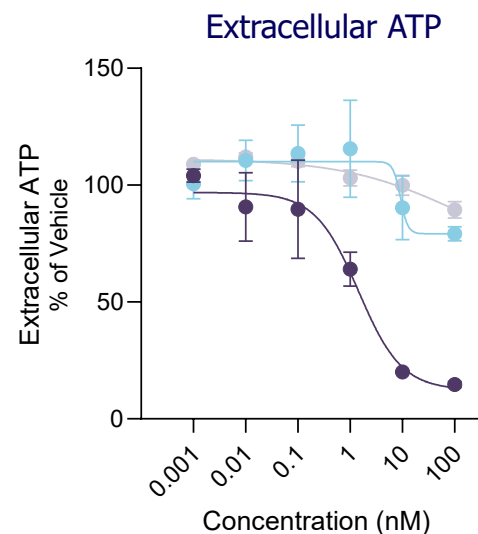
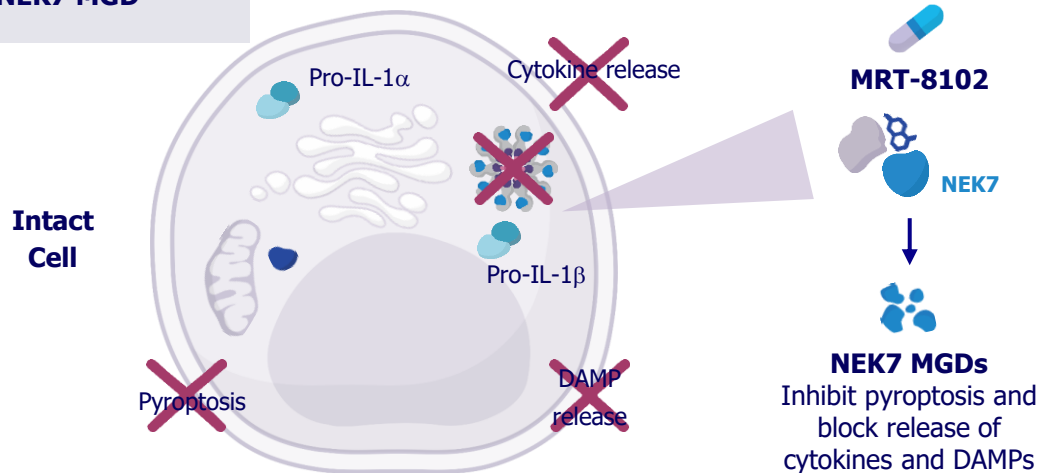
Croce et al., Circulation, 2009. Data from Peng et al., Cardiovasc Diabetol, 2011, Cheng et al., Front Med, 2022, Cotoi et al. 2014, Demir et al., Medicina, 2026, and GSE163154. Simulated data (n = 300) calibrated to the meta-analytic pooled $r = 0.290$ (REML, 5 estimates, N = 1,133), median-split into burden groups, and compared by Mann-Whitney U test.

MRT-8102 Potently Inhibits Pyroptosis and Release of DAMPs and IL-1 β

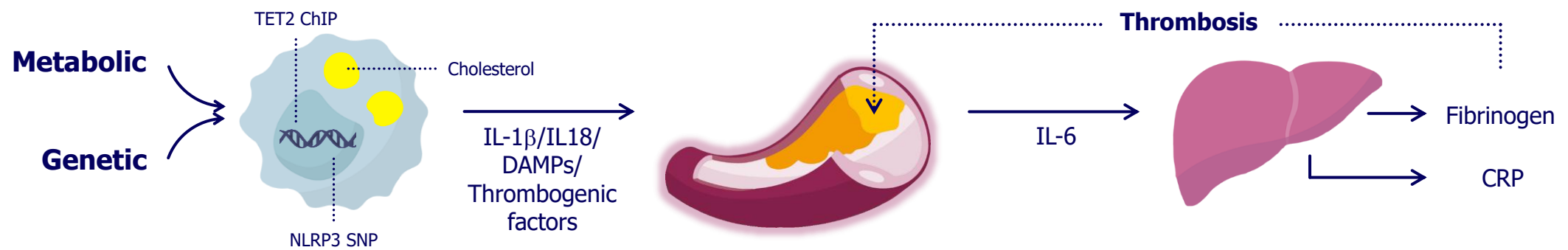
Anti-IL-1/IL-6 biologics



NEK7 MGD



Clinical Experience Supports Upstream Targeting of NEK7/NLRP3 Pathway as a Superior Approach to Impact MACE



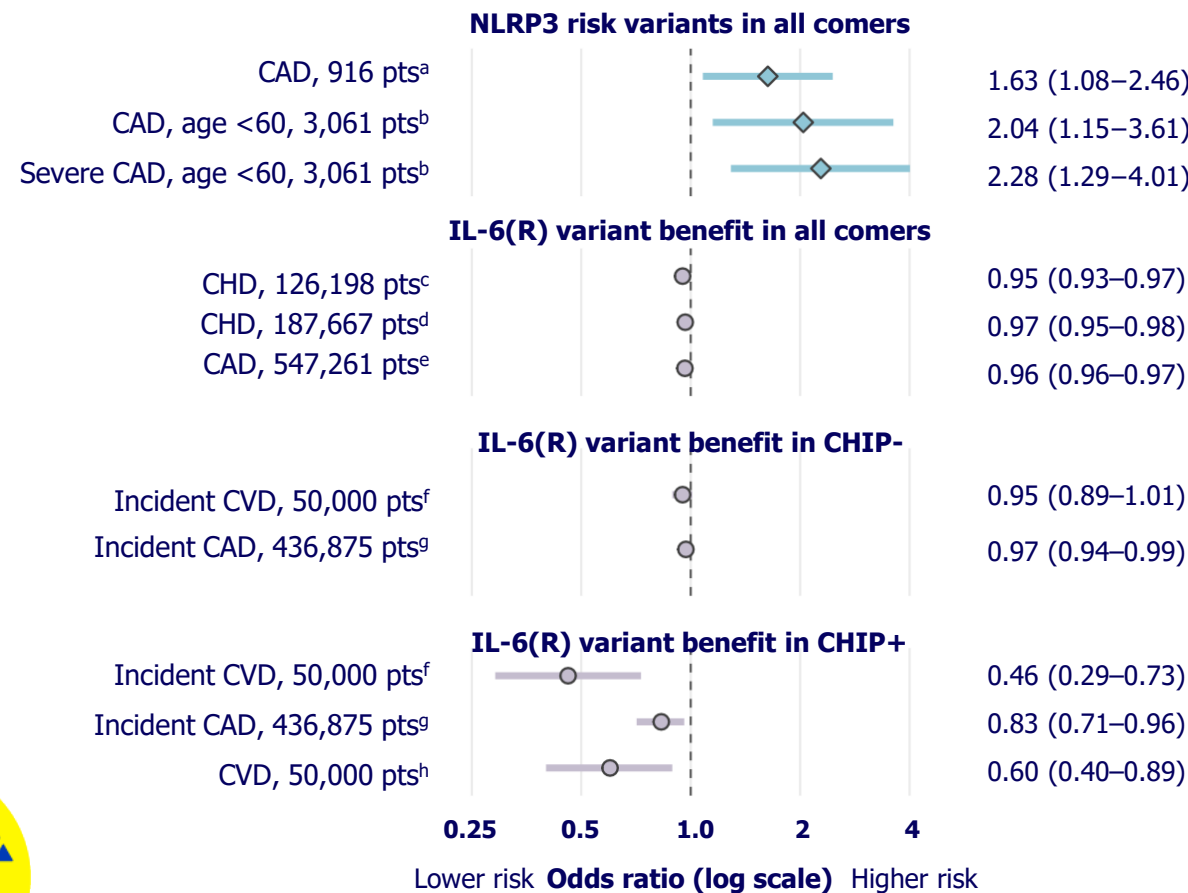
LoDoCo2	COLCOT	CANTOS	ZEUS
NEK7/NLRP3 pathway modulation		IL-1β neutralization	IL-6 neutralization
5,522 pts with chronic CAD (>6 months post MI) randomized to colchicine or pbo - Baseline median CRP unknown - Colchicine reduced MACE by 31%; no risk of infection, significant GI AEs	4,745 pts $\leq$ 30 days post-MI randomized to colchicine or pbo - Baseline median CRP 4.28 mg/L - Colchicine reduced MACE by 23%; no risk of infection, significant GI AEs	10,061 pts $\geq$ 30 days post MI randomized to canakinumab (anti-IL-1β) or pbo - Mean time since MI 4.57 years - Baseline CRP$\geq$2mg/L (median 4.1 to 4.2) - Canakinumab reduced MACE by 15%; risk of infection increased	6,376 pts with ASCVD and moderate-severe CKD randomized to ziltivekimab (anti-IL-6) or pbo - Baseline CRP$\geq$2mg/L (median 4.5) No significant effect on MACE; risk of infection increased

Clinical efficacy achieved

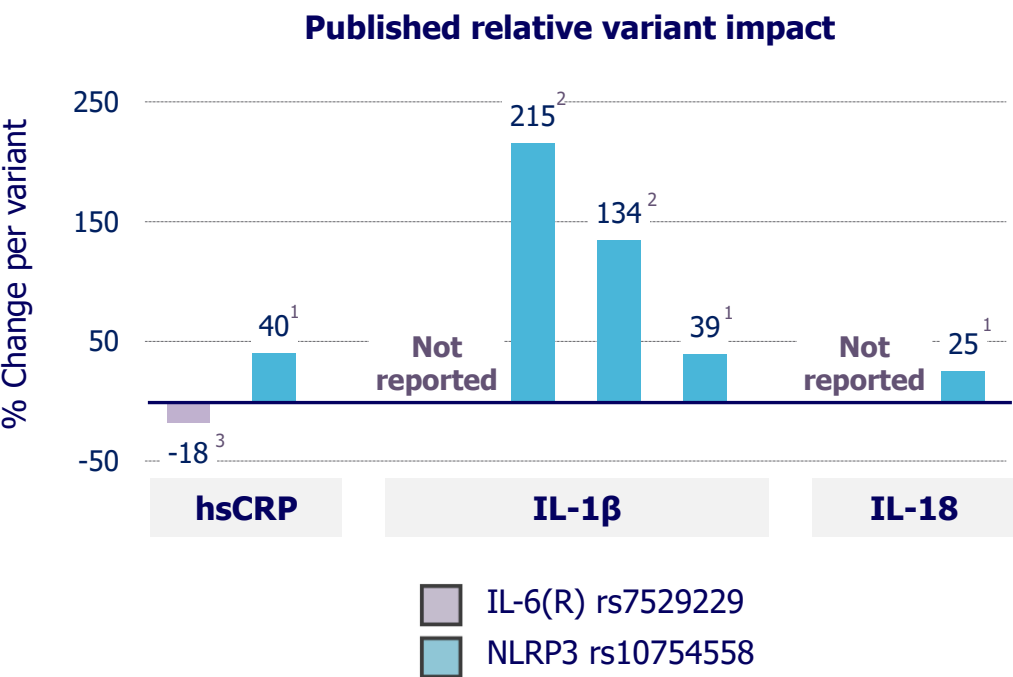
Results are from separate clinical trials with different agents, populations and study designs and should not be interpreted as head-to-head comparisons

NLRP3 Activating Variants Increase Signaling and Cardiovascular Risk

**NLRP3 variant associated with strong risk of CVD;
IL-6(R) benefit restricted to CHIP+ subgroup**



**NLRP3 risk variant shows larger effect on inflammatory
cytokines and CRP compared to IL-6(R) variant**



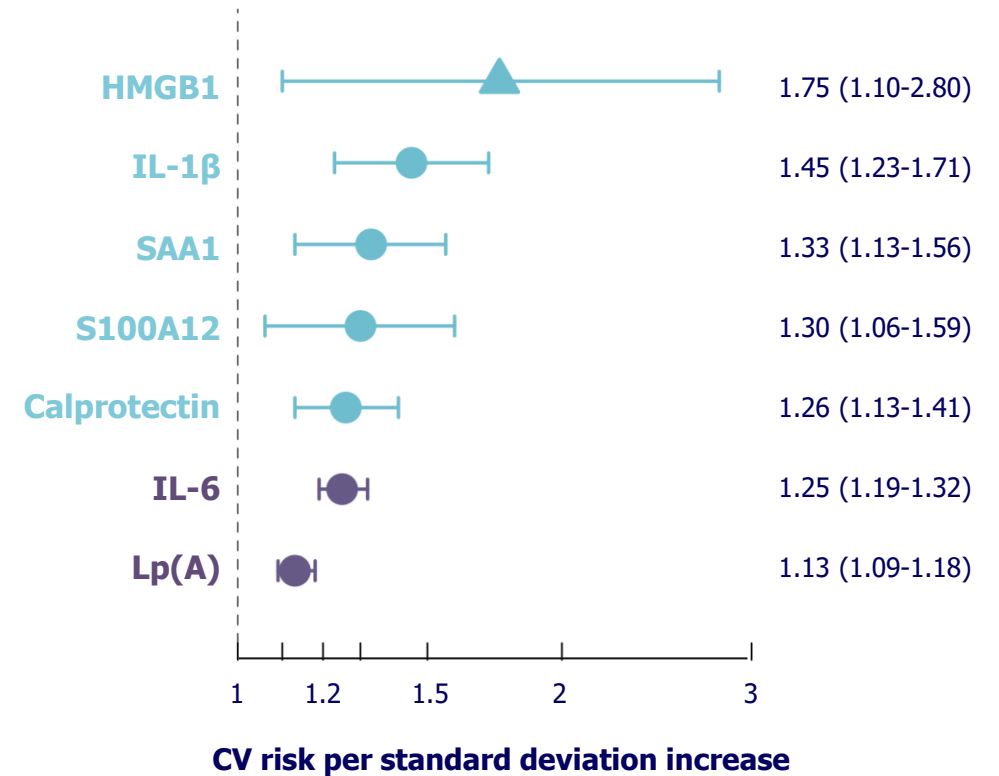
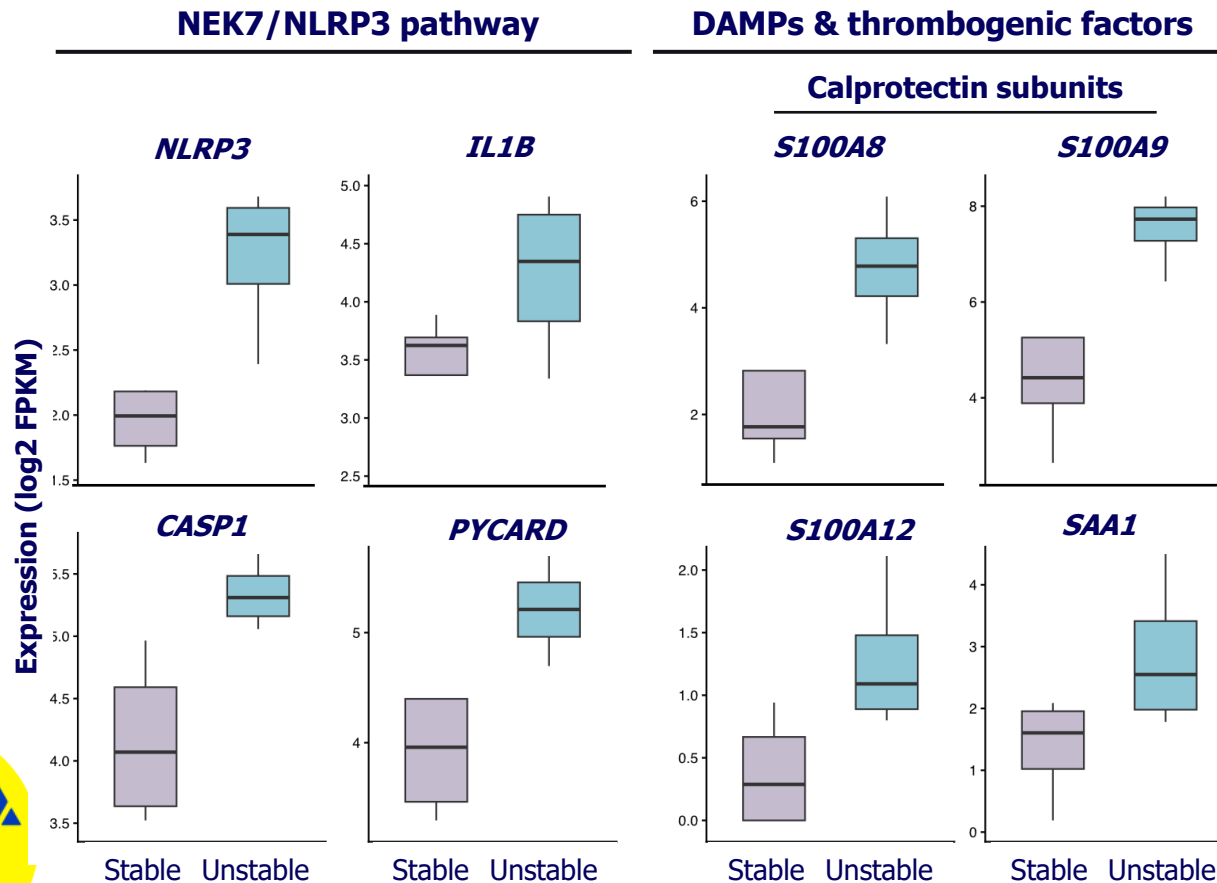
Left: ^aZhou et al. (2016); ^bSchunk et al. (2021); ^cSwerdlow et al. (2012); ^dSarwar et al. (2012); ^eRosa et al. (2019); ^fBick et al. (2019); ^gVlasschaert et al. (2023); ^hKessler et al. (2022); Right: ¹Wu et al. (2022); ²Zhou et al. (2016); ³Tchuisseu-Kwangoua et al. (2025). % differences: NLRP3 rs10754558 = (GG – CC)/CC; IL-6(R) rs7529229 (proxy rs2228145) = (CC – AA)/AA



Mediators of NLRP3 Pathway Driven Atherosclerosis/-thrombosis are Established Cumulative Cardiovascular Risk Factors

NLRP3, relevant cytokines, and DAMP levels are significantly increased in unstable plaques

Cumulative CV risk associated with NEK7/NLRP3-relevant cytokines, lipids, and DAMPs



● Harmonized per-SD HR ▲ Non-harmonized (per-doubling, acute STEMI)

RNA-seq of stable and unstable section of human atherosclerotic plaques GEO GSE120521

Data from PMIDs 24026779, 29957458, 21435605, 25341801, 39322770, 28845751, 28428221, 39178030, 30006491, 19622820, 23034020



GFORCE-1 Clinical Study Results

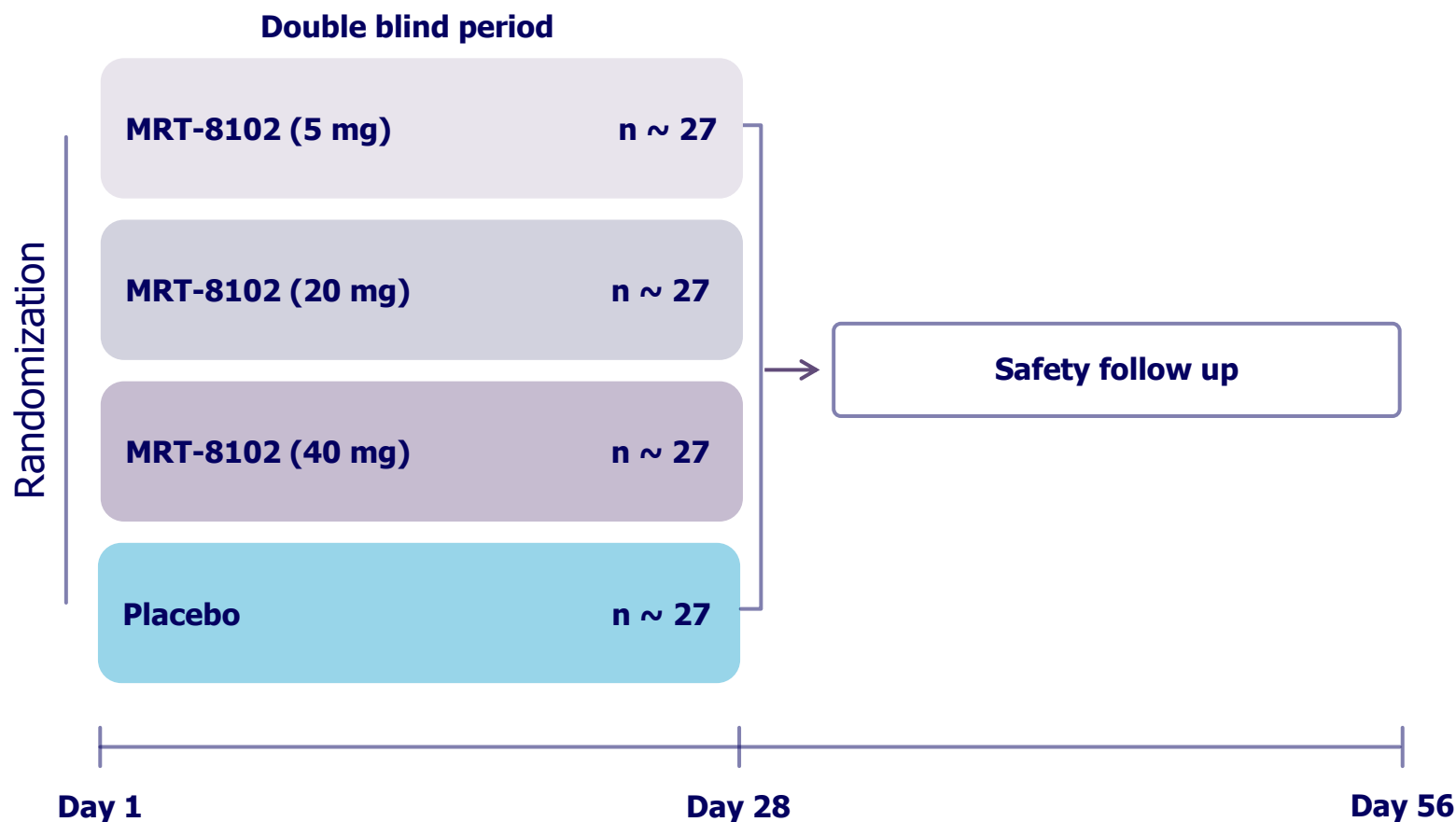
As disclosed on October 1, 2026

GFORCE-1: A Phase 1 Study of MRT-8102 in Subjects with Elevated CVD Risk

MRT-8102, a selective first-in-class NEK7 MGD, demonstrated a favorable safety and tolerability profile, sustained NEK7 degradation, and broad normalization of elevated pathogenic drivers of ASCVD

- **Study design:** 108 subjects with elevated CVD risk; 8-week study, randomized to MRT-8102 at 5, 20, and 40 mg QD, or placebo for 4 weeks dosing
- **Target engagement:** Robust, sustained, and equal NEK7 degradation across all three dose levels
- **Safety:** No SAEs; TEAE rate similar to placebo (33% vs. 30%); no increased infection risk
- **Activity on plaque and vessel wall biology and thrombogenic factors demonstrated, supporting broad potential for MRT-8102 to impact ASCVD:**
 - Pathogenic drivers of ASCVD, including IL-1 β , HMGB1, Calprotectin, S100A12, SAA, and Fibrinogen reduced to healthy-volunteer levels at all doses
- **Opportunity for precision medicine approach:** NLRP3 risk-allele carriers show higher baseline levels for DAMPs, suggestive of elevated pathway activity and potential for faster and more severe atherosclerotic remodeling, and identifying a genetically enrichable population for potential future development

GFORCE-1 Study: Dose Exploration of MRT-8102 in Subjects with Elevated CVD Risk



Study population

- Obesity, elevated CRP ≥ 3 and < 15 mg/L

Primary endpoint

- Safety and tolerability of 28 days dosing with 28 days follow up

Secondary endpoints

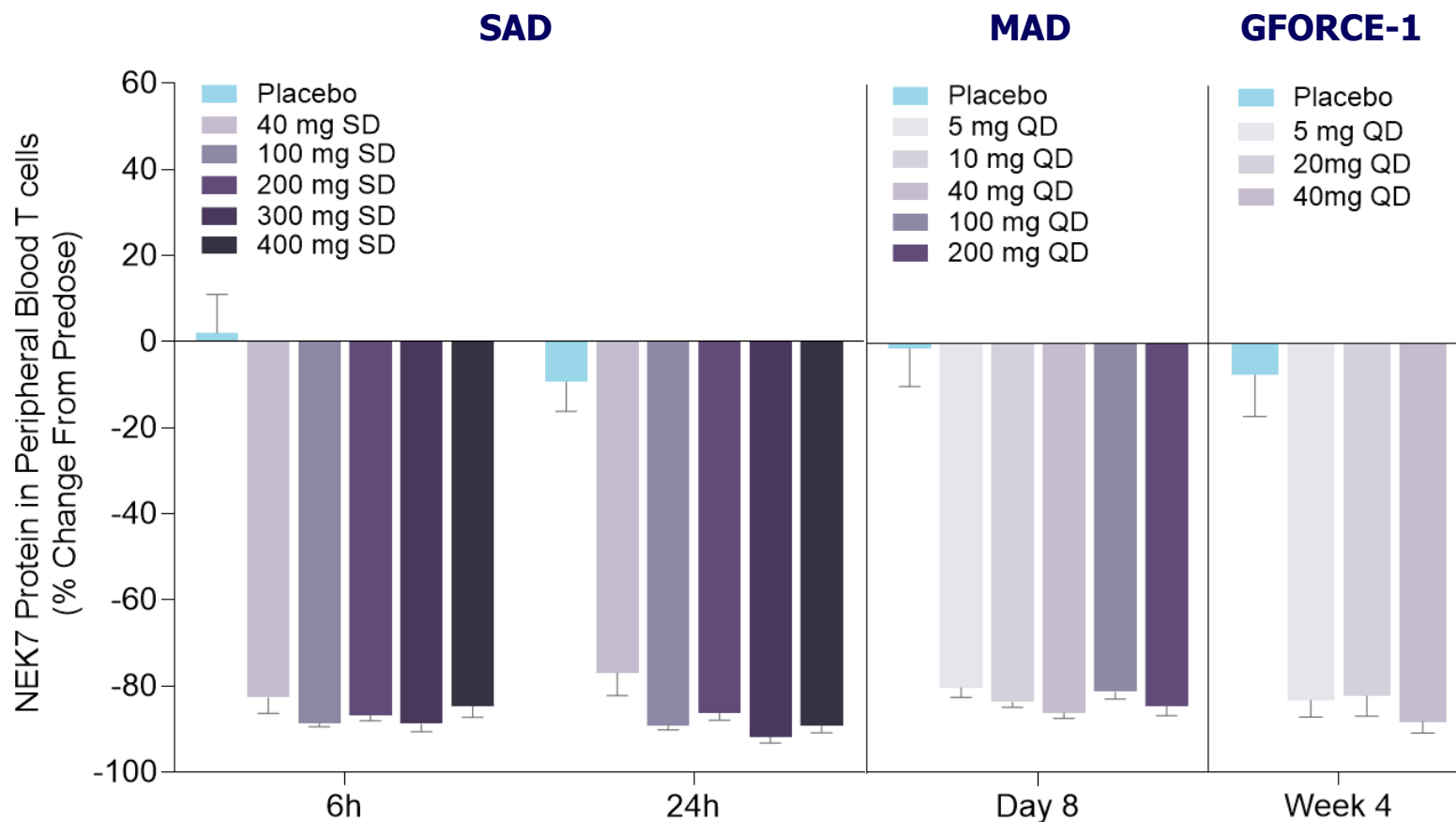
- Change in CRP levels
- PK

Additional exploratory PD endpoints

- NEK7 (target engagement)
- DAMPs and cytokines to inform ASCVD pathogenic drivers + systemic inflammation
- Thrombogenic factors
- Lipids, lipoproteins, and other markers of CV risk (Lp(a), LDL-C)

CRP endpoint: absolute reduction and reduction to < 2 mg/L
CRP measurements: pre-dose, D1, D7, D14, D21, D28, D35

MRT-8102 Achieved Robust and Sustained NEK7 Degradation



Robust and sustained degradation of NEK7 noted in peripheral blood T cells (~80 - 90%) across all dose levels at week 4, consistent with preclinical findings

GFORCE-1: Summary of Unblinded Safety Data

- Safety data were collected over 8 weeks for 108 participants (MRT-8102, n=81; placebo, n=27)
- No SAEs were reported
- Frequency of treatment-emergent AEs (TEAEs) was similar between MRT-8102 (33% participants) and placebo (30% participants)
- Most (86%) of MRT-8102 TEAEs were grade 1*
- The most frequent TEAEs were
 - Headaches in 4% of participants on MRT-8102 and 11% of participants on placebo
 - Arthralgia in 5% of participants on MRT-8102 and 4% of participants on placebo
- There were no serious infections; frequency of minor infections was similar in participants on MRT-8102 (7% participants) and placebo (7% participants)

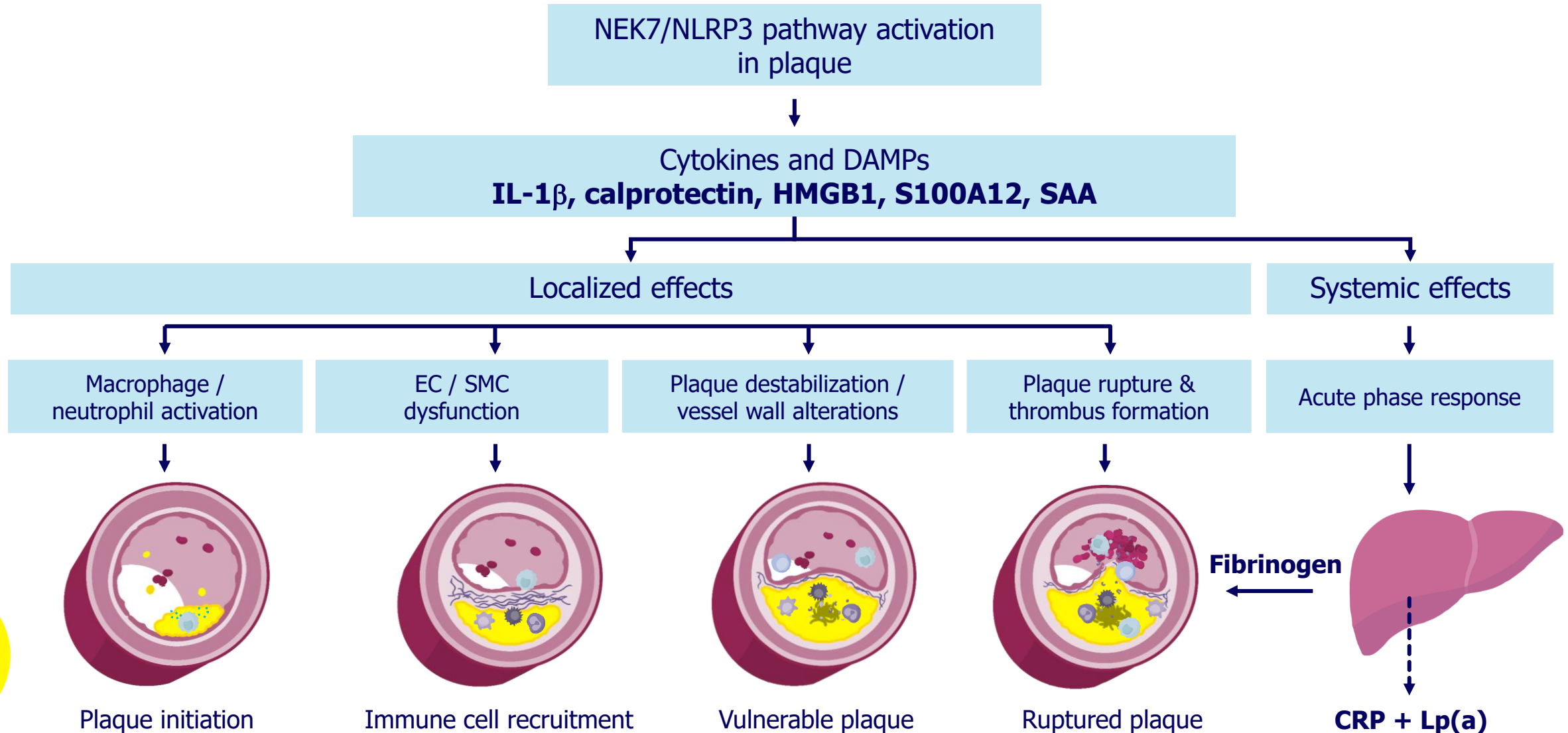
** There was one episode of grade 3 elevation of liver enzymes in a patient with incidental finding of asymptomatic hepatitis A, and one episode of grade 3 shoulder pain in a patient with accidental shoulder dislocation*

GFORCE-1 Population: Probing ASCVD Pathogenic Drivers in CVD Risk Subjects

GFORCE-1 enrolled a population at risk of CVD and a biomarker profile that is informative of established ASCVD

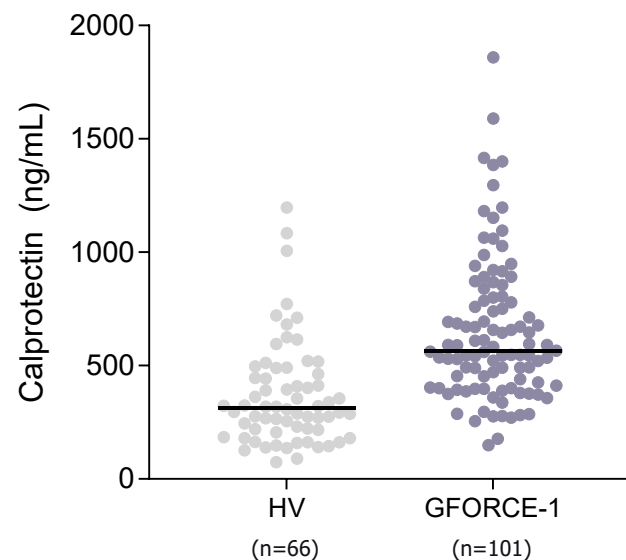
- **Population:** Obese subjects at elevated CVD risk, reflecting a population with a high ratio of silent atherosclerosis; established ASCVD diagnosis not required
 - Based on REACT study, prevalence of silent atherosclerosis in general population ages 40-49 estimated to be up to 70%¹, presumably further enriched in GFORCE-1 by focus on obese subjects with high CRP².
- **Translational relevance:** Baseline levels of key local ASCVD drivers and systemic biomarkers were elevated and closely tracked patterns reported in diagnosed ASCVD patients; degree of elevation for some markers may not equal that in established ASCVD patients
- **Reference arm:** A separate healthy-volunteer cohort from the SAD/MAD arm of the trial (not risk-enriched) provided a real-world normal-range comparator for all analyses of key molecular drivers of ASCVD and systemic biomarkers
- **Genetic stratification:** NLRP3 SNP genotyping in a subset of participants enabled correlation of baseline elevation of key ASCVD drivers with validated NLRP3 risk alleles: risk-allele carriers show higher levels of key ASCVD pathogenic drivers

Key ASCVD Pathogenic Drivers and Markers of Systemic Inflammation Assessed in GFORCE-1

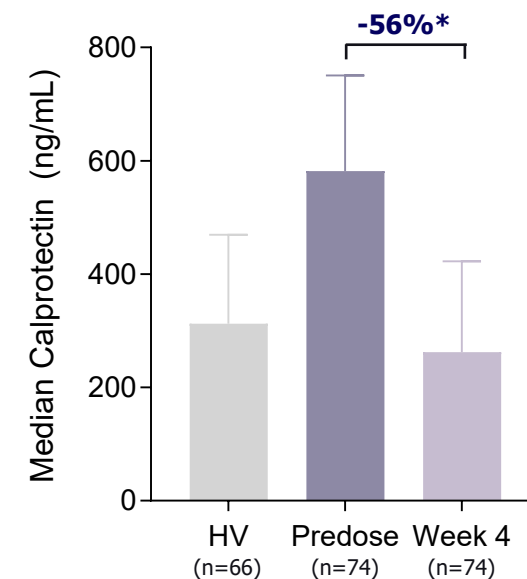
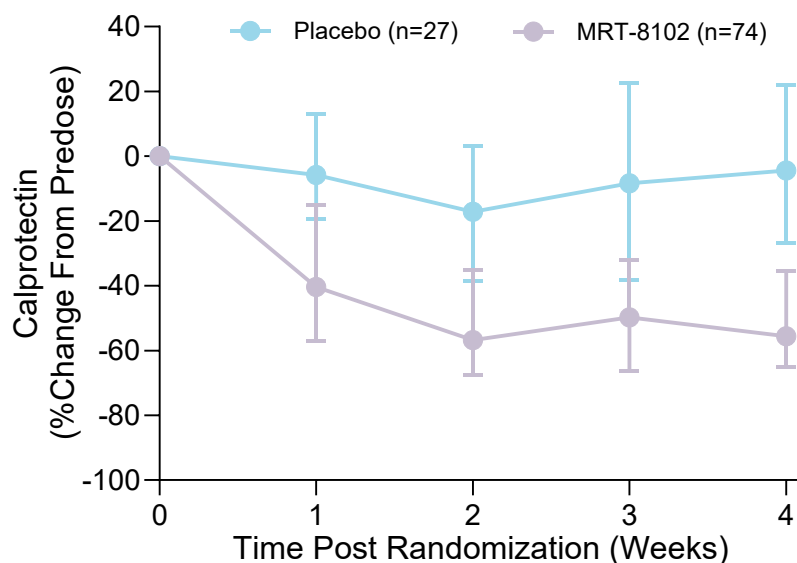


MRT-8102 Reduced Plasma Calprotectin to Healthy Volunteer Levels

Calprotectin is elevated in subjects with elevated CVD risk



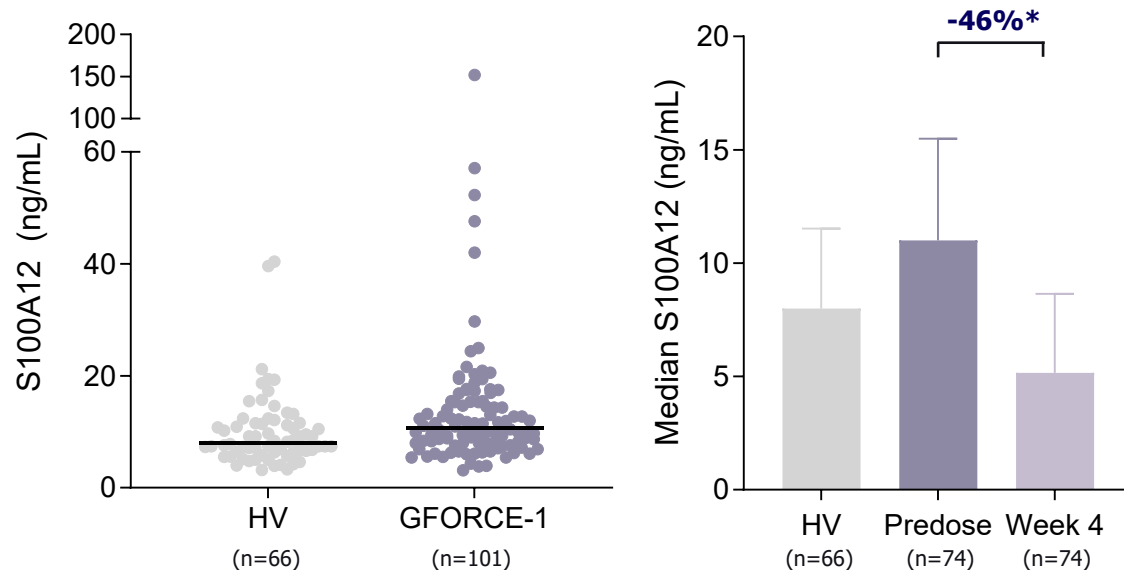
Treatment reduced Calprotectin to levels associated with low risk of future CV events (week 4)



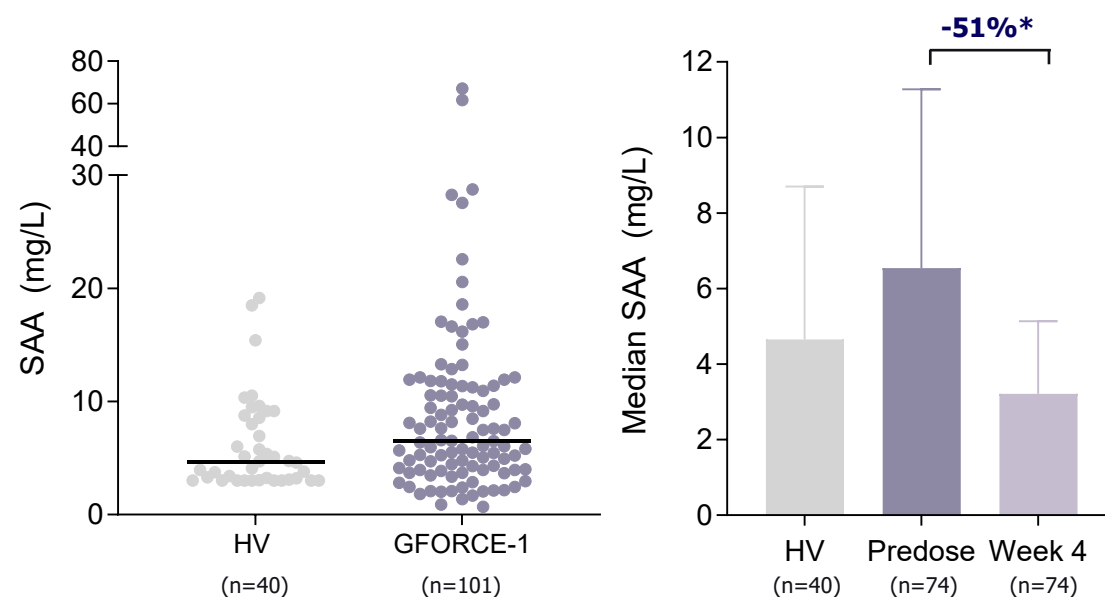
Median reduction of **56%** in plasma calprotectin to levels comparable to those observed in healthy volunteers after 4 weeks of dosing

MRT-8102 Reduced Plasma S100A12 and Serum SAA to Healthy Volunteer Levels

MRT-8102 reduces S100A12 to levels in HVs



MRT-8102 reduces SAA to levels in HVs

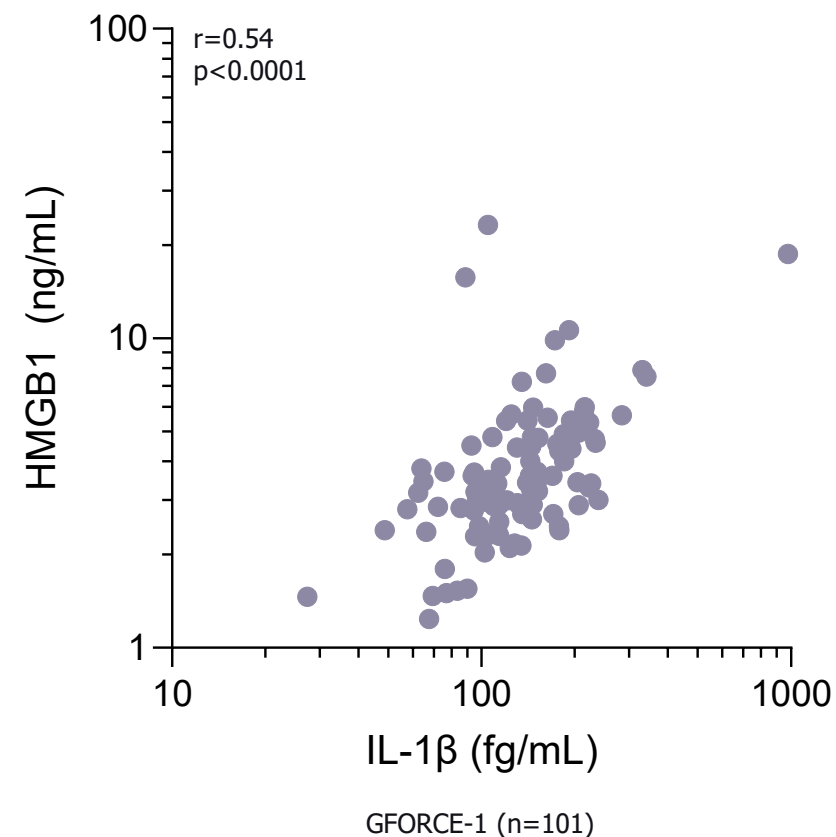
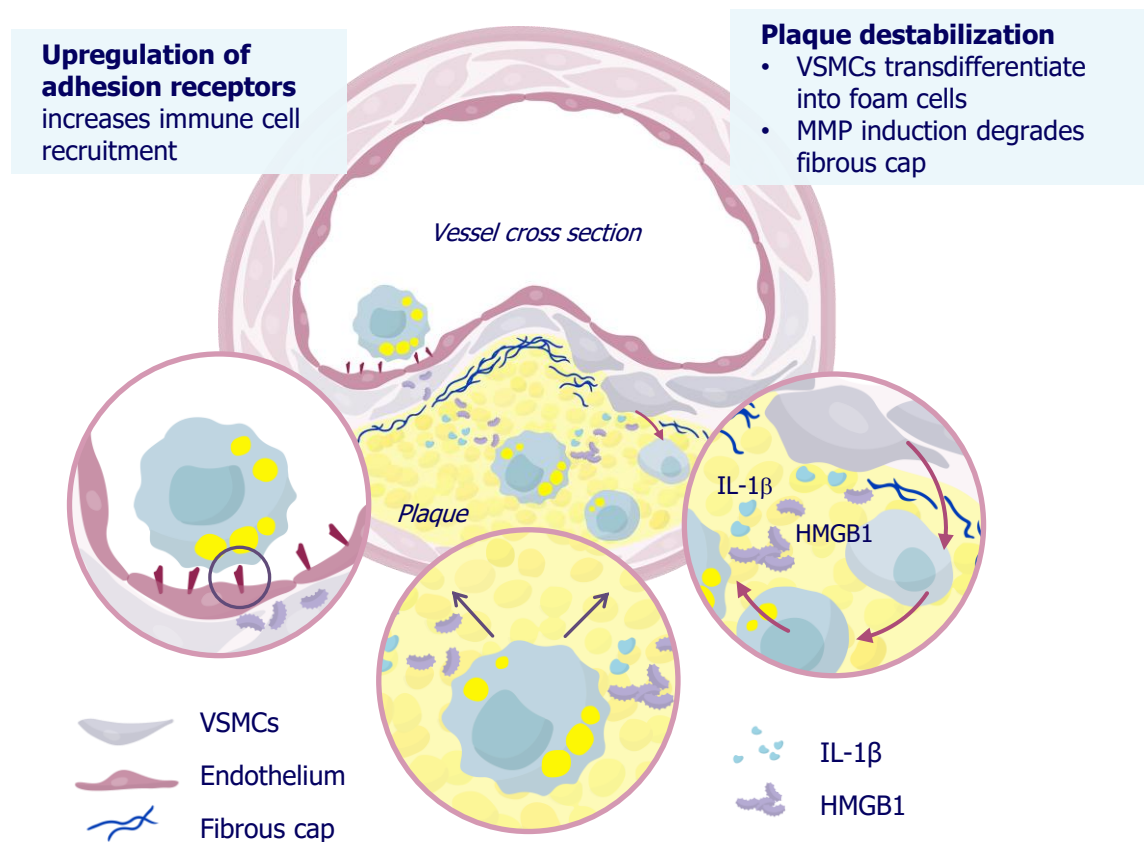


Median reduction of **46%** and **51%** in plasma S100A12 and serum SAA, respectively, to levels comparable to those observed in healthy volunteers after 4 weeks of dosing

Pathological Crosstalk between HMGB1 and IL-1 β Downstream of NEK7/NLRP3 Reinforces Plaque Progression and Instability in ASCVD

Biological crosstalk between HMGB1 and IL-1 β influences multiple aspects of vessel and plaque biology

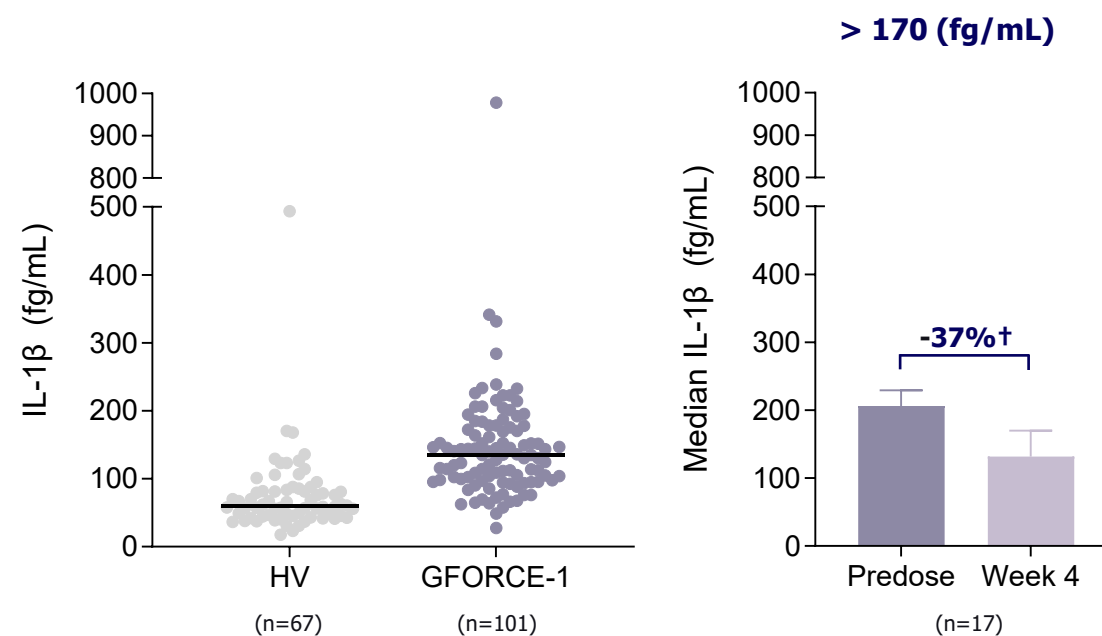
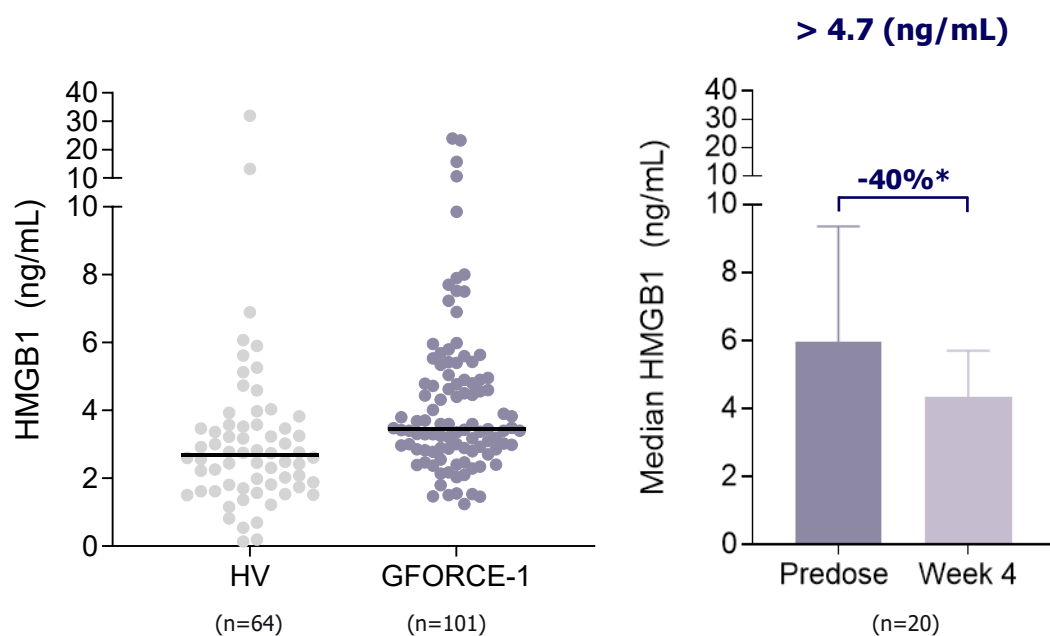
HMGB1 and IL-1 β baseline levels strongly correlate, reinforcing biological proximity



MRT-8102 Treatment Reduced HMGB1 and IL-1 β Levels

MRT-8102 treatment resulted in meaningful HMGB1 reduction in subjects with higher baseline levels

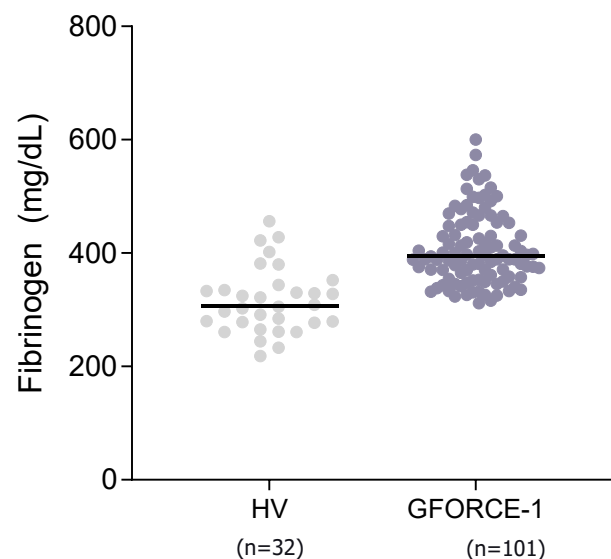
MRT-8102 treatment resulted in meaningful IL-1 β reduction in subjects with higher baseline levels



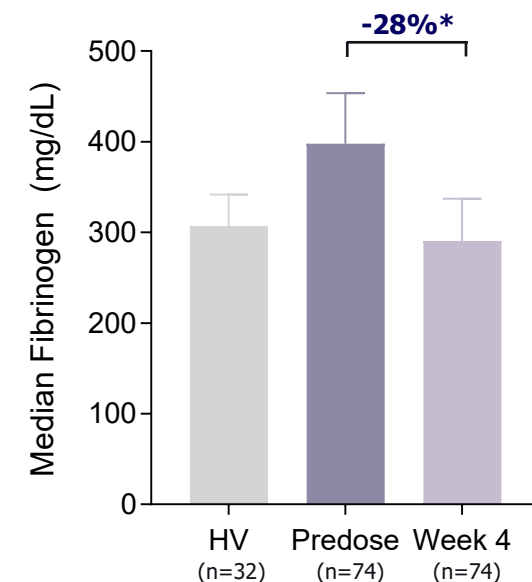
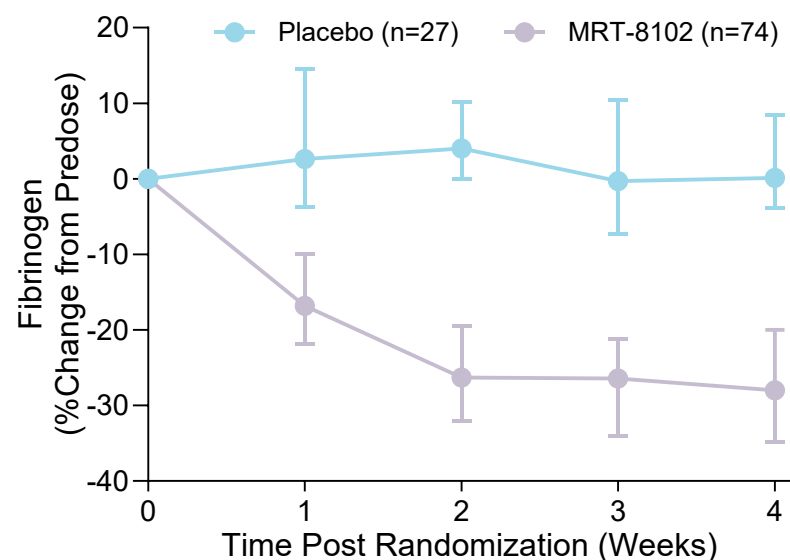
- HMGB1 and IL-1 β were elevated in GFORCE-1 population versus healthy volunteers (baseline)
- Treatment led to a median reduction of **40%** and **37%** in HMGB1 and IL-1 β levels, respectively, in subjects with elevated baseline levels; no statistically significant decrease in placebo

MRT-8102 Treatment Led to Reductions in Fibrinogen

Fibrinogen baseline is elevated in GFORCE-1 population



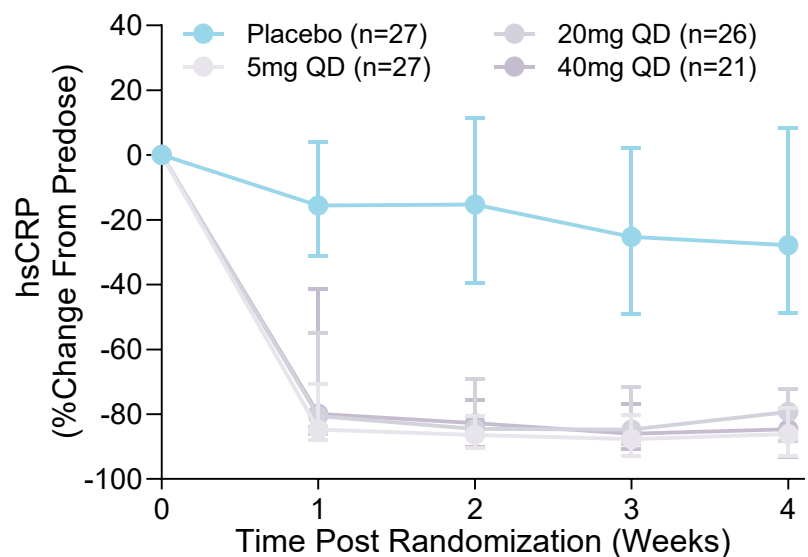
Treatment significantly reduced fibrinogen to normal physiological levels



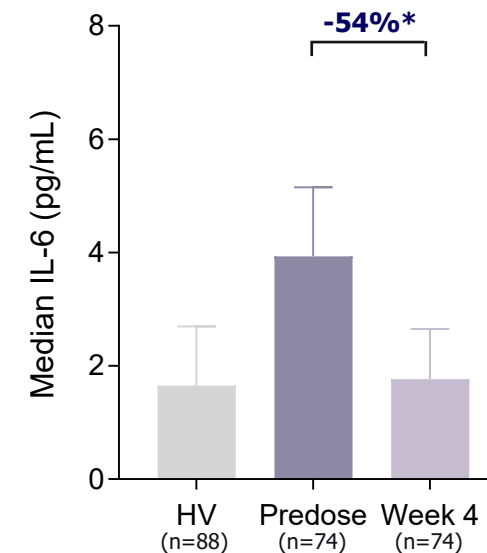
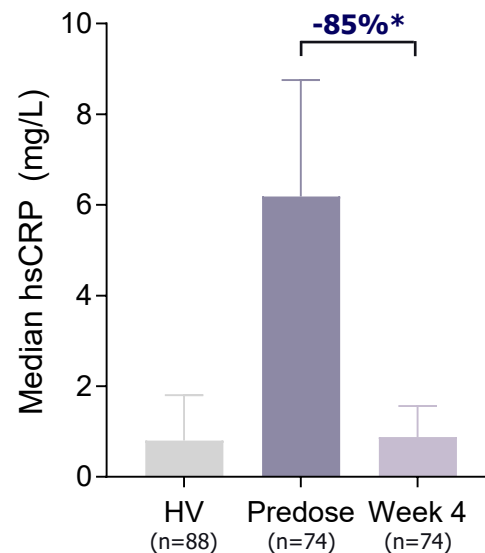
Median reduction of **28%** in fibrinogen to levels comparable to those observed in healthy volunteers after 4 weeks of dosing

MRT-8102 Induced Rapid and Sustained Reductions in hsCRP and IL-6 Levels

**Robust decrease of hsCRP
after 4 weeks of dosing**



**hsCRP and IL-6 reduced to levels associated
with low risk of future CV events**



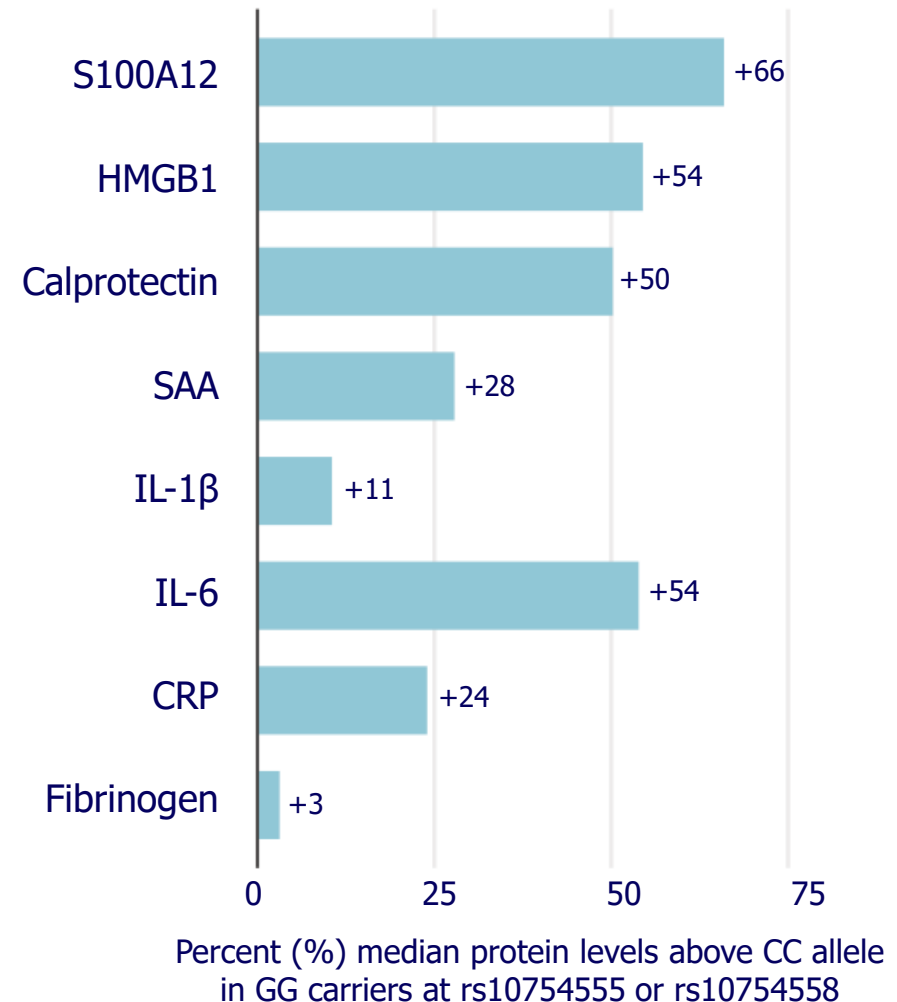
- Median reduction of **85%** in serum hsCRP to levels detected in healthy volunteers; **86%** of subjects showed suppression of hsCRP to <2 mg/L
- Median reduction of **54%** in plasma IL-6 to levels associated with low risk of future CV events

Data are medians (IQR); * $p < 0.0001$ compared to predose; p -value from Wilcoxon test; HV: SAD and MAD part
% Change from predose in hsCRP at week 4 per cohort: 5mg QD -86%, 20mg QD -79%; 40mg QD -85%

NLRP3 Risk Alleles Correlate to Baseline Increase of ASCVD Drivers

- Two high-priority NLRP3 risk SNPs, rs10754555 and rs10754558, have been linked to increased NLRP3 pathway activation and cardiovascular risk.
- In line with published data, **nearly 1 in 3 subjects (29%) carry a highest-risk genotype** (GG at either locus); over half of subjects (57%) carry moderate NLRP3 genetic risk.
- Significant increases in baseline levels of ASCVD drivers were identified, in particular for DAMPs and cytokines, in carriers of NLRP3 risk (GG) alleles, **suggesting elevated pathway activity and potential for faster and more severe atherosclerotic and thrombotic remodeling.**

Elevated levels in NLRP3 risk allele carriers





MRT-8102 for Coronary Artery Disease

CAD: Large Opportunity to Address Atherosclerotic Risk with a Safe, Oral Treatment Targeting NEK7

CAD Market Overview



~14M

Adults suffer from CAD in the U.S.

45-50%

Patients have experienced at least 1 prior MI

High Unmet Medical Need in CAD

>30%

CAD patients suffer from residual inflammatory risk despite optimized lipid-lowering therapy

~1 in 7

CAD patients experience a subsequent MACE event within 5 years despite achieving target LDL-C level

~30-fold

Greater risk of cardiac mortality in patients* with high coronary plaque inflammation (determined by FAI score)

MRT-8102 Opportunity

Potential to **complement existing lipid and metabolic therapies**

- ▶ Targeting NEK7/NLRP3 pathway could provide **broader suppression of atherogenic and thrombotic pathways**
- ▶ **Oral administration** aligns with SOC and facilitates potential combo approaches

Potential for **differentiated efficacy and safety profile vs. IL-1 and IL-6 antibodies**

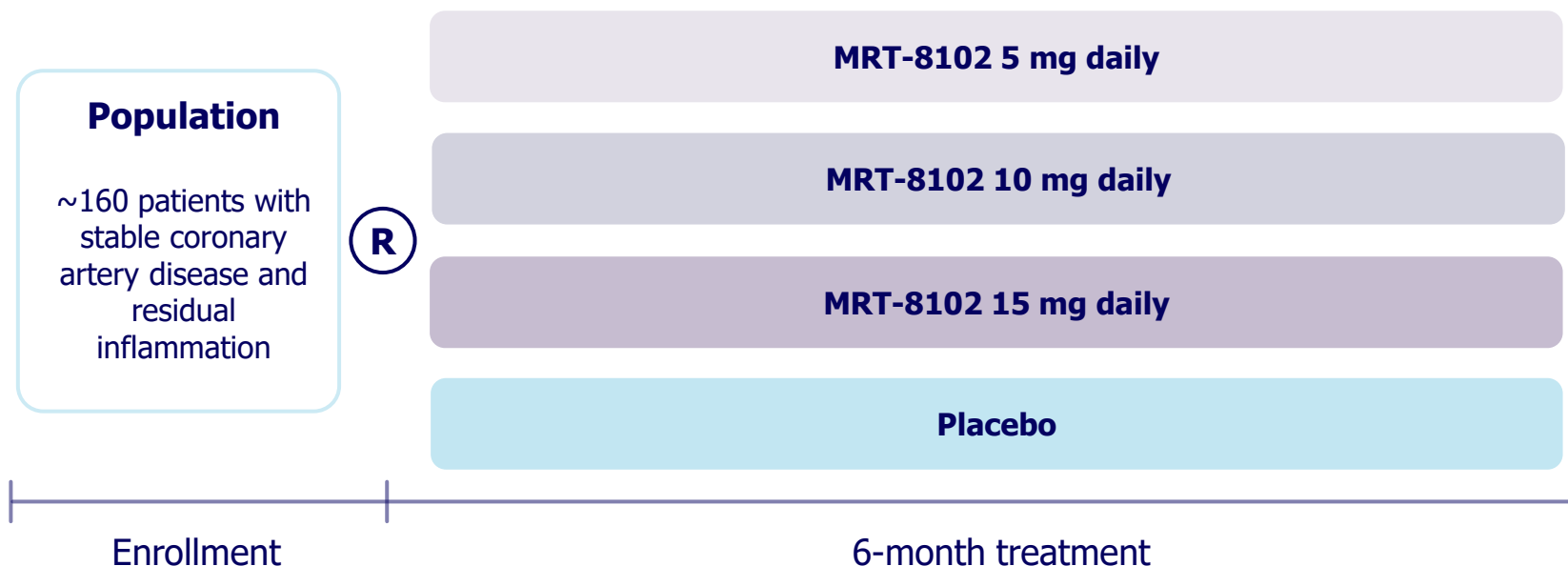
- ▶ Upstream mechanism addresses high-risk plaque biology **beyond** suppression of individual cytokines
- ▶ Ability to provide robust inflammation control **without increased infection risk**

*Risk of cardiac mortality captures all patients, with and without CAD, from ORFAN study undergoing diagnostic coronary CTA

Sources: Su et al. Journal of Vascular Surgery (2024); Alanaeme et al. Am Heart J Plus (2022); Martin et al. Circulation (2025); Chan et al. Lancet (2024); Hassan et al. Front Cardiovasc Med. (2026); Kim et al. Korean Circ J. (2026); Watanabe et al. J Am Heart Assoc. (2026); Virani et al. Circulation (2021); Tsao et al. Circulation (2023); Budoff et al. Eur Heart J. (2023); Peikert et al. Clin Res Cardiol. (2020); Wong et al. J Clin Lipidol. (2019); Sanchez-Bacaicoa et al. Eur J Clin Invest. (2021); Schwartz et al. J Am Coll Cardiol. (2021); O'Donoghue et al. Circulation (2022)



GFORCE-2: A Phase 2b Study in Patients with Coronary Artery Disease



Outcome measures

- Change in levels of key pathogenic ASCVD drivers including atherogenic, thrombogenic mediators and lipids
- Change in **local** cardiac imaging, from baseline to 6 months

Exploratory endpoints

- Cardiac imaging
- Establish pharmacogenomic evidence base
- Liver fat/liver inflammation
- Anemia

Study initiation planned for H1 2027



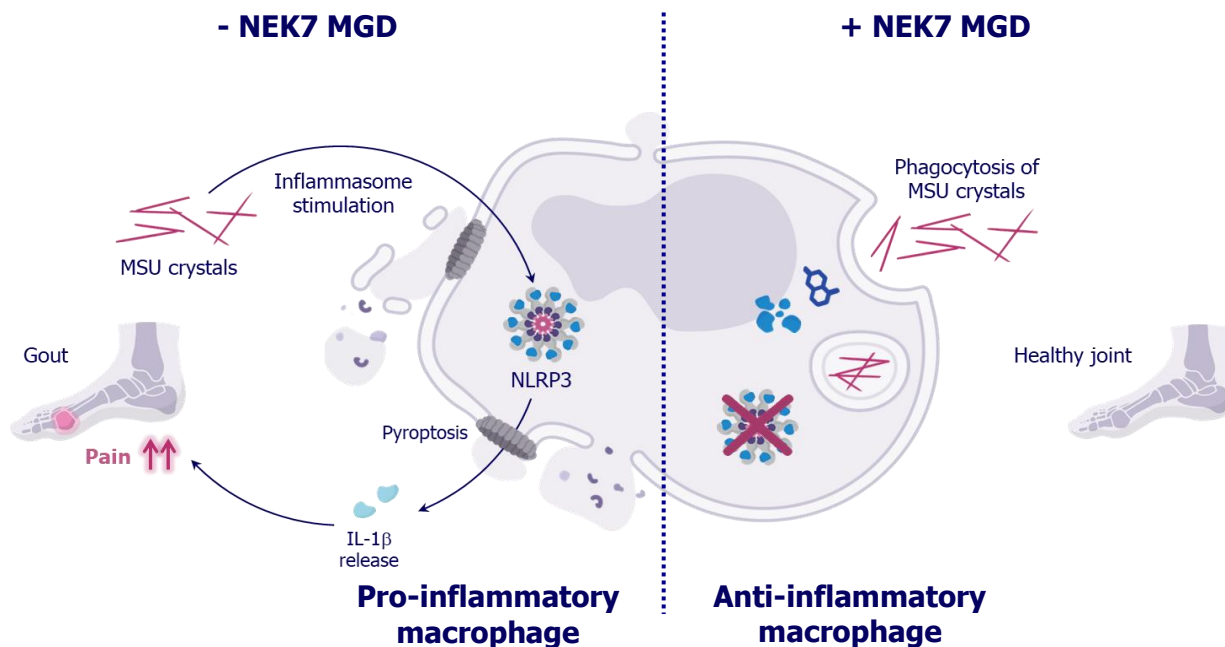
MRT-8102 for Treatment and Prevention of Gout Flares

MRT-8102 Has Potential to Resolve and Prevent Gout Flares

MSU-driven activation of NLRP3/NEK7 pathway

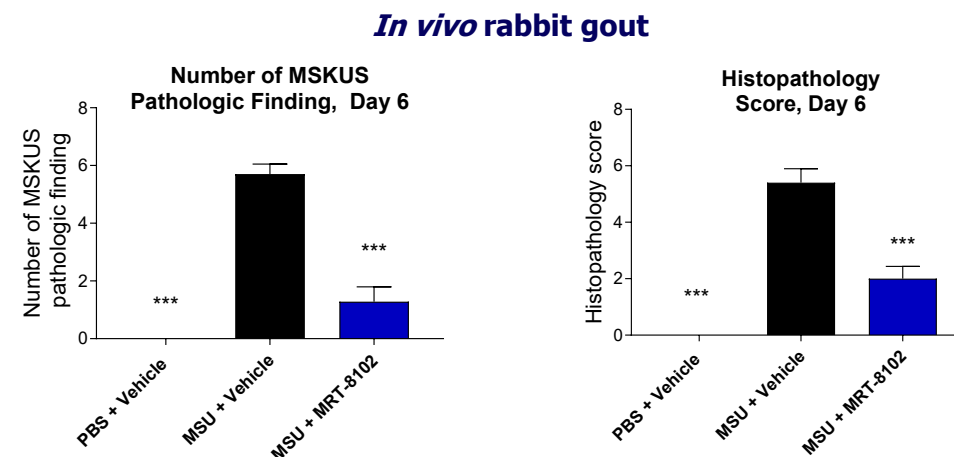
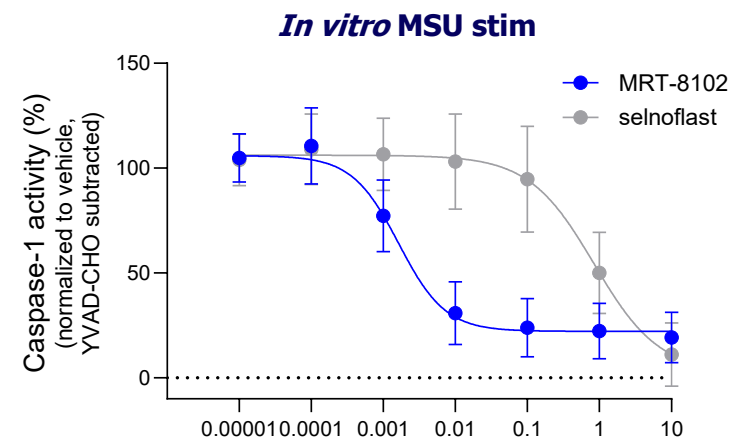
Resolution of inflammation and gout tophi via NEK7 MGD

MRT-8102 reduces MSU-induced inflammasome activation and gout flare in a preclinical model



Preclinical data support that MRT-8102 treatment has potential to reduce tophi through enhanced phagocytic potential of macrophages without activation of NLRP3 and flares.

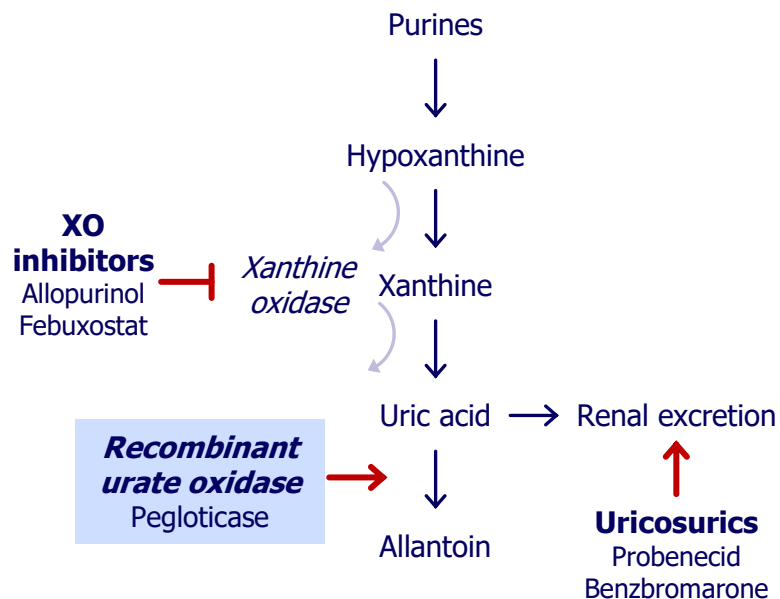
70% of patients experience flares within three months of Krystexxa treatment likely due to dissolution of tophi and resulting MSU-induced NLRP3 activation.



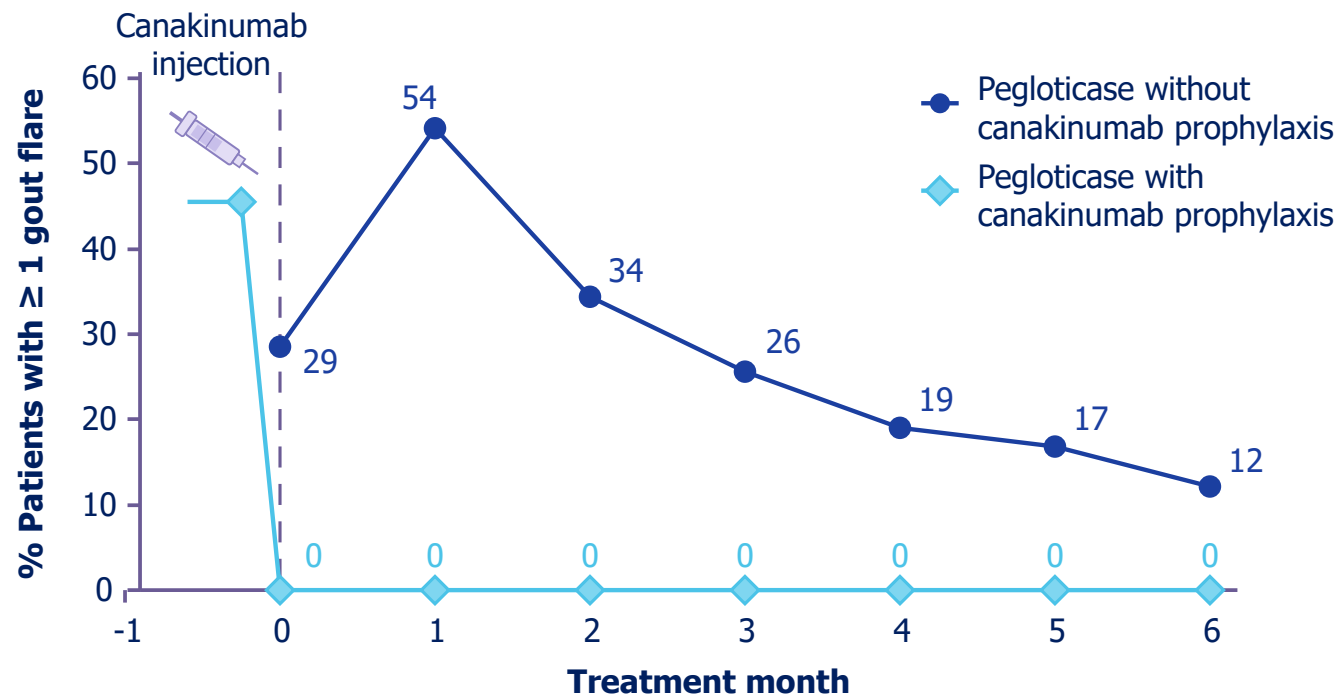
Top: Human monocyte-derived macrophages LPS + MSU stimulation. Pretreatment with molecular glue degrader (MGD) or NLRP3 inhibitor (selnoflast)
 Bottom: Daily dosing from day -1, 50 mg/kg; intra-articular injection of MSU on day 0; MSKUS = musculoskeletal ultrasound
 *** denotes $p < 0.0005$ compared to MSU + vehicle condition

Short-term Increase in Gout Flares Following ULT Treatment is Largely Driven by the NEK7/NLRP3-IL-1 β Axis

Urate lowering therapies can trigger a short-term increase in gout flares



Prophylaxis with canakinumab treatment prevents the short-term increase in gout flares following Pegloticase treatment



Rapid uric acid reduction can increase the likelihood of crystal mobilization and activate the NEK7/NLRP3 cascade, leading to a short-term induction of gout flares. Pathway modulation can prevent flares.

Gout: Large Market With High Unmet Need For New Prophylactic Therapies

Gout Market Overview



~10M

Gout patients in the U.S.;
present in ~15% of high-risk
cardiovascular patients

~30%

Gout patients comorbid
with stage 3-4 CKD

30-40%

Gout patients primarily
managed by specialists*

Significant unmet medical need in gout

>55%

Gout-treating physicians surveyed are **not satisfied**
with current prophylaxis options

>65%

Gout-treating physicians **not satisfied**
with prophylaxis treatment for gout patients comorbid
with CKD

1L SOC are either **contraindicated or lacking long-term safety data for CKD**, requiring dose titration and close monitoring

Low dose SOC treatment or fixed-dose strategies are often **insufficient** in preventing gout flares and result in **breakthrough flares**, a leading contributor to poor adherence to ULT (as low as 47%)

IL-1 inhibitors efficacious for flare treatment but are **cost/access-limited**, not indicated for flare prophylaxis due to safety concerns



MRT-8102 Opportunity

Strong efficacy potential for flare
management and long-term prophylaxis

Favorable safety / tolerability profile,
providing sufficient inflammation reduction
without high infection risk or GI side effects

Expected to be safe for use in CKD-comorbid patients (no impact on kidney function)

Convenient **oral** regimen allowing for
improved compliance

Note: * Includes rheumatologists and nephrologists

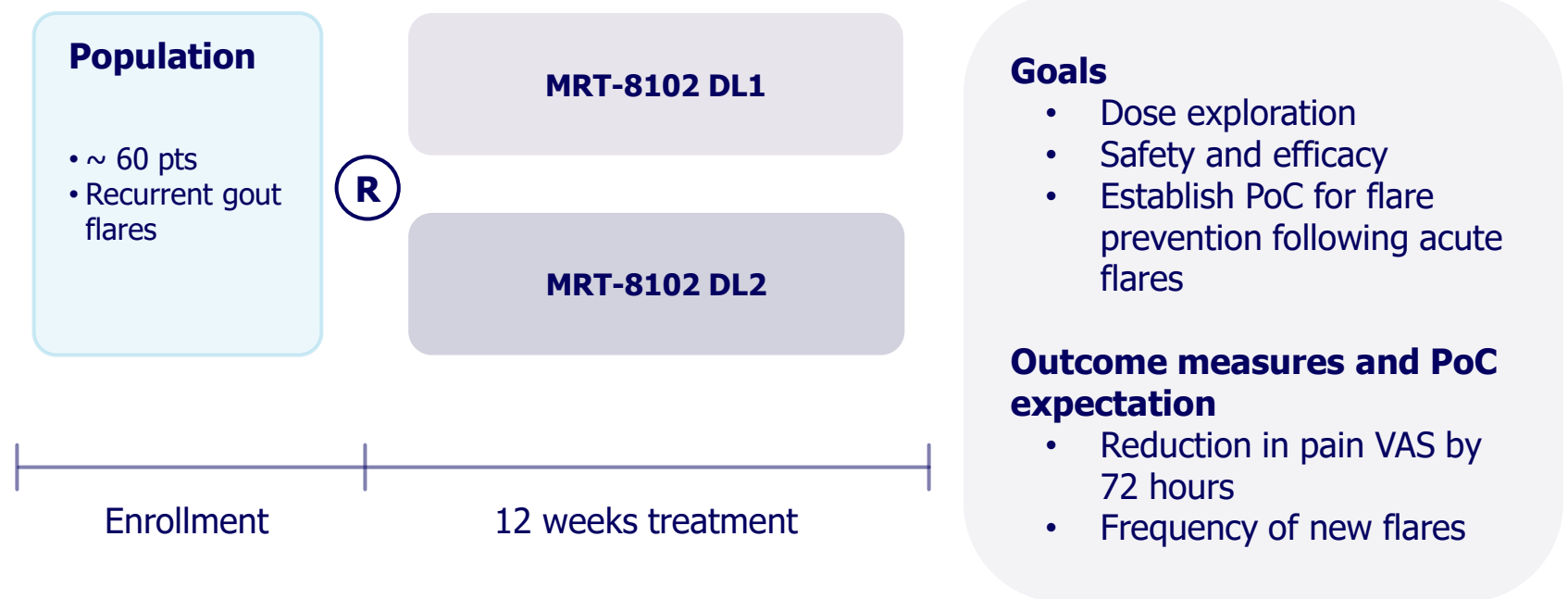
Source: Zhu et al. Am J Med. (2012); Mohammed et al. PLoS One (2019); Stern et al. Gout Urates Cryst. Depos. Dis. (2024); Schlesinger and Lipsky. Seminars in Arthritis and Rheumatism (2020); Yin et al. BMJ Open (2018); FitzGerald et al. Arthritis Care Res (2020); Maher et al. Arthritis Care Res (2020); Monte Rosa survey of gout-treating physicians (Nov 2025) and interviews

GEMINI-1 A Phase 2 Study in Gout Flare Prevention Following Acute Flare Management

WHY MRT-8102 FOR GOUT

- Gout is a canonical NEK7/NLRP3 pathway disease: MSU crystals trigger NEK7-mediated NLRP3 complex assembly, driving release of IL-1 β and DAMPs, and inducing flare pathology
- GFORCE-1 showed durable suppression of relevant NEK7/NLRP3 disease drivers, acting directly on gout's core mechanism; 40–60% of gout patients also carry elevated CV risk

GEMINI-1 STUDY



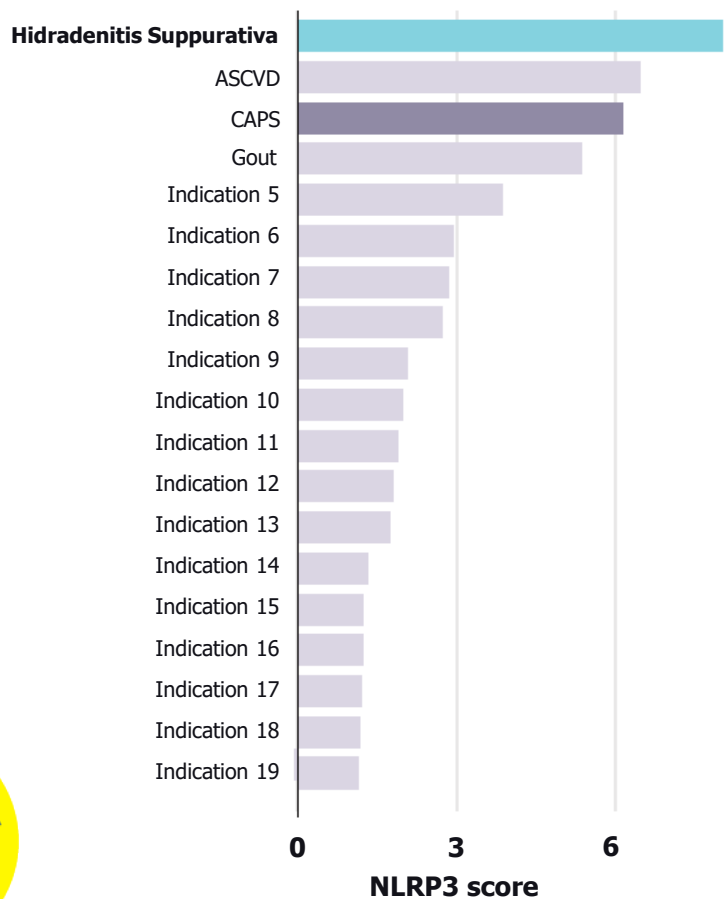
Study initiation planned for Q4 2026 / Q1 2027; data update expected in H2 2027



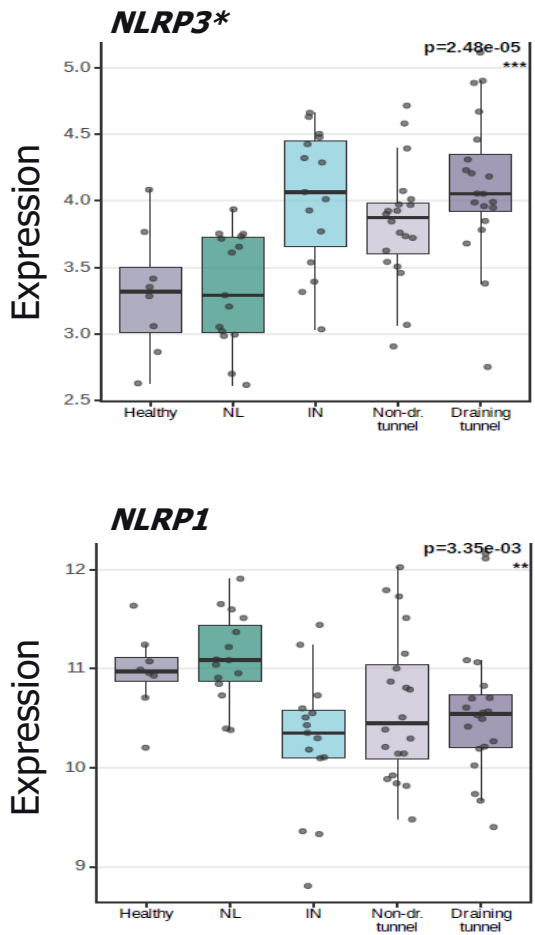
MRT-8102 for Hidradenitis Suppurativa

MRT-8102 Significantly Suppresses NLRP3 Activity in Ex Vivo HS Lesions

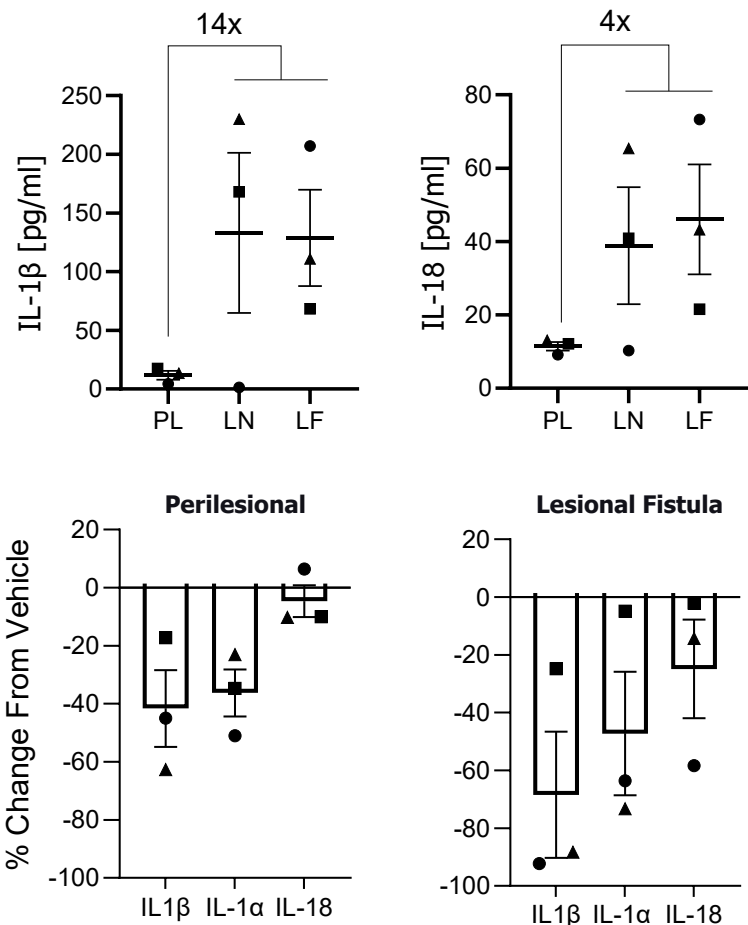
NLRP3 score highest in HS lesions



NLRP3:NLRP1 ratio increases during disease progression



MRT-8102 suppresses NLRP3 activity in human HS lesions



NLRP3 activity correlates with disease severity

MRT-8102 robustly reduces NLRP3 activity

NL = non-lesional; IN = inflammatory nodules; PL = perilesional; LN = lesional nodules; LF = lesional fistulas.

NLRP3 activity scores computed as the mean log fold-change (disease vs. control) from canonical inflammasome gene signatures across 900+ unique RNA-seq datasets (470 diseases, 513,390 patient profiles; oncology and rare diseases excluded). HS skin explants were cultured for 24h in presence of vehicle or MRT-8102 10nM. Supernatants were analyzed with immunoassay. Three independent donors are shown.

HS: Significant Unmet Need for New Oral Therapies

HS Market Overview



2-3M

Hidradenitis suppurativa patients in the U.S.

400-450K

Moderate-to-severe patients eligible for advanced therapies

Large unmet medical need in HS

55%

Of HS patients are not well-managed with SOC, even with anti-TNF and anti-IL-17 biologic approvals

<25%

Of moderate-to-severe HS patients are treated with a biologic

Promising IL-1 / inflammasome approach

Lutikizumab and abdakibart Phase 2 studies demonstrated the role of IL-1/NLRP3 inflammasome in HS pathophysiology, suggesting **the next important MOA** in the HS treatment paradigm



MRT-8102 Opportunity

Potential for **robust clinical activity** in both biologic-naïve and refractory patients

- ▶ Lutikizumab provides promising POC for the IL-1/inflammasome approach in HS

Potential differentiation in **safety / tolerability** measures, including expected low risk of infection and neutropenia events

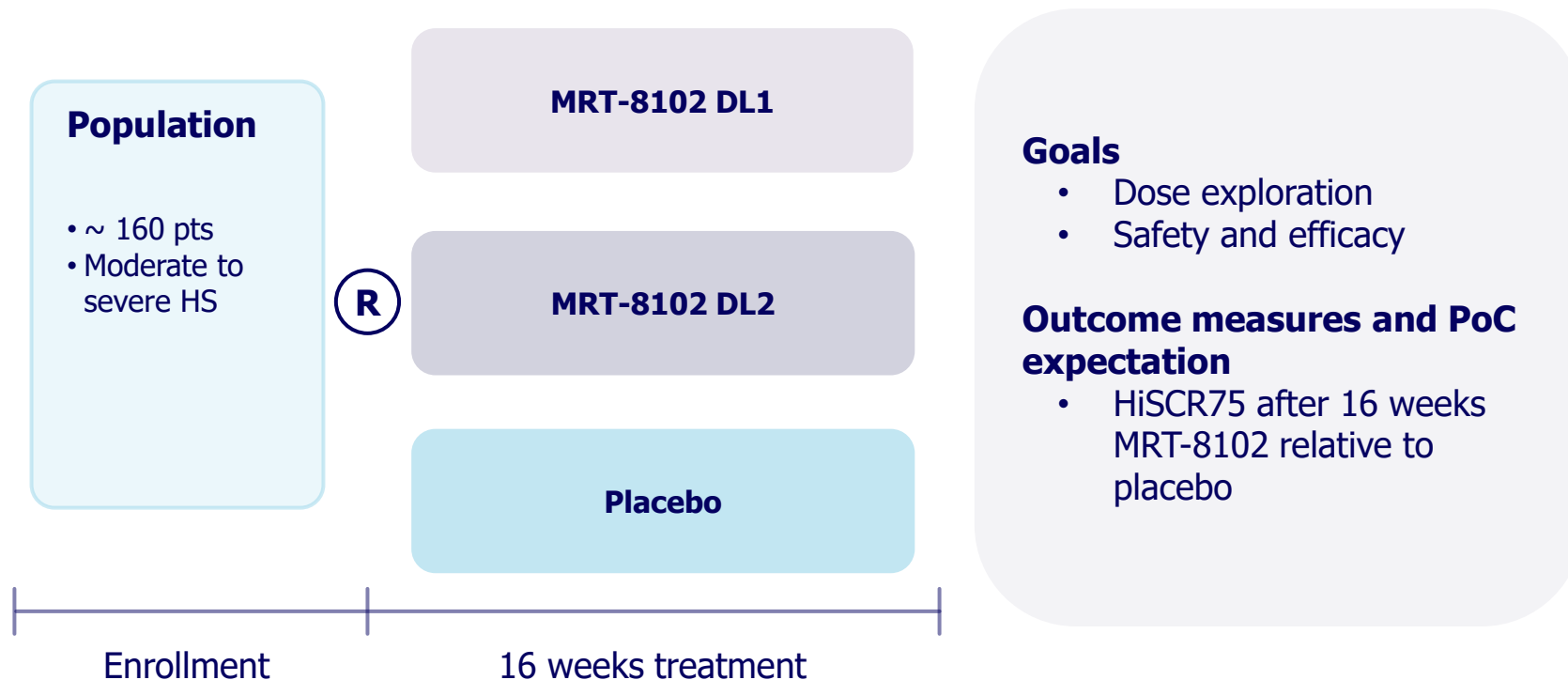
Oral regimen suitable for long-term maintenance treatment

GALAXY-1 A Phase 2 Randomized Study in Moderate to Severe Hidradenitis Suppurativa

WHY MRT-8102 FOR HS

- HS ranks highest in NEK7/NLRP3 pathway score of any indication we studied, with consistent upregulation of NLRP3, IL-1 β , and DAMPs in lesional tissue
- NEK7 degradation acts upstream of both the IL-1 and DAMP-driven pathology in HS lesions, unlike single-mediator TNF/IL-17 biologics
- IL-1 antibodies provide promising POC for the NEK7/NLRP3 pathway approach in HS

GALAXY-1 STUDY



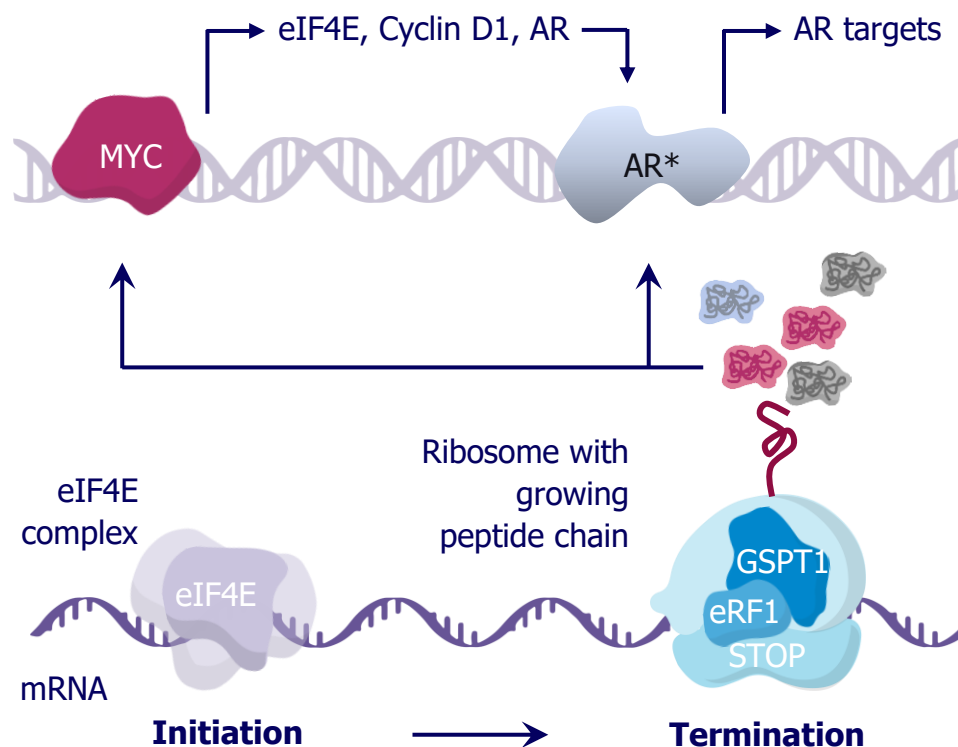
Study initiation planned for H1 2027



Oncology Pipeline

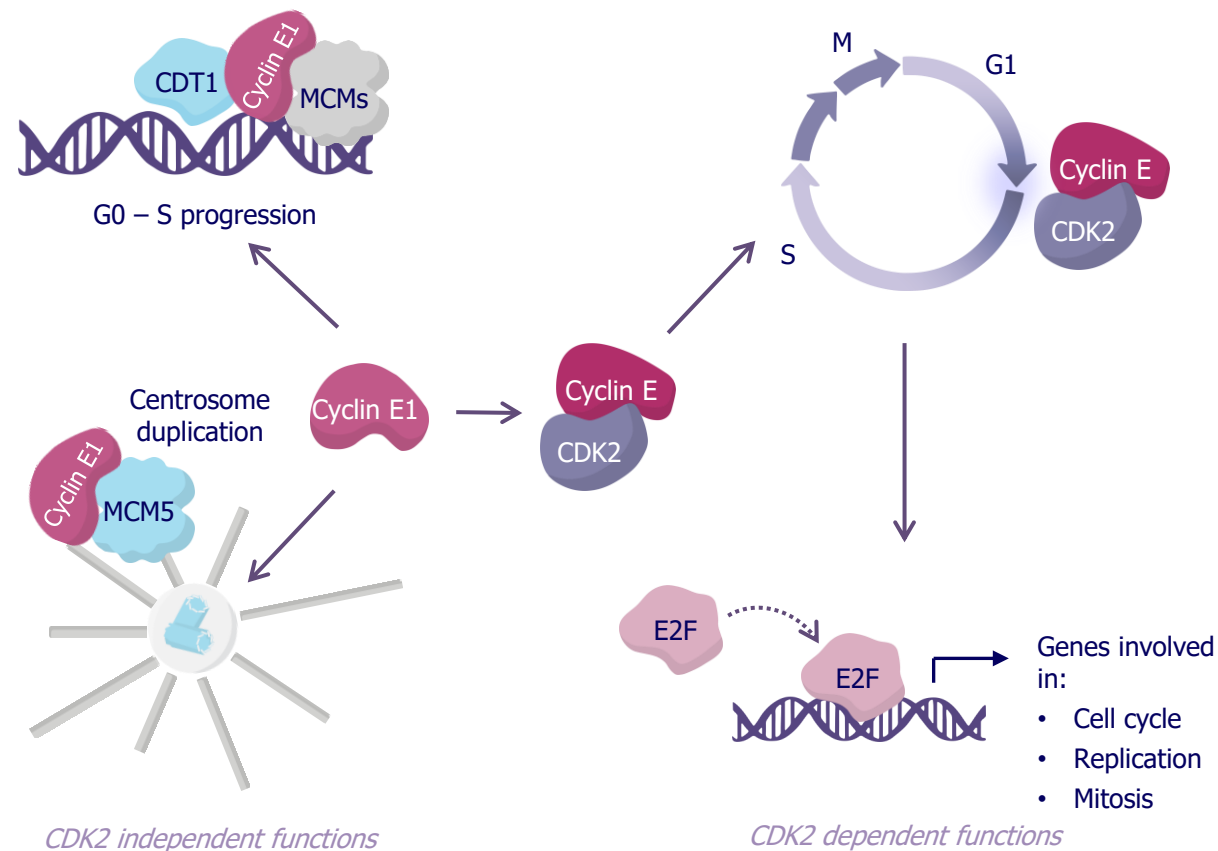
Degrading Undruggable and Difficult-to-Drug Oncology Targets

Therapy-resistant mCRPC is characterized by increased MYC, E2F, AR and other oncogenic pathway activity



MRT-2359 + AR inhibitor suppressed multiple oncogenes including AR, MYC and Cyclin D1

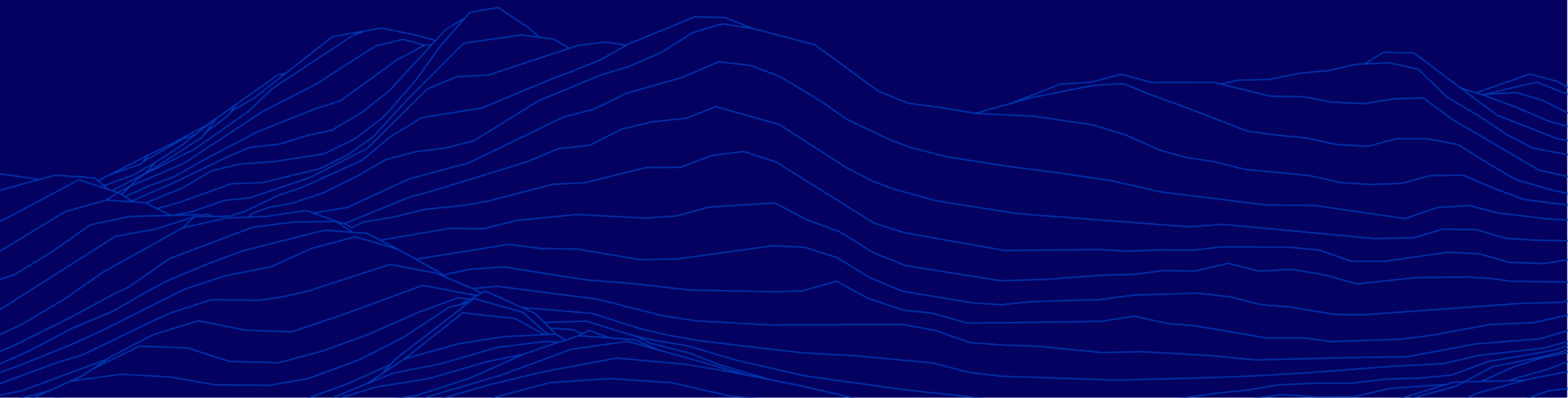
CCNE1 and CDK2 are highly validated targets for solid tumors that drive multiple hallmark cancer mechanisms



CCNE1 and CDK2 are highly validated oncogenes in a variety of solid tumors, including breast, ovarian and endometrial cancer



GSPT1 Program (MRT-2359)



MRT-2359 At a Glance

First-in-class oral GSPT1 MGD for AR-mutant metastatic castration-resistant prostate cancer (mCRPC)

GSPT1 Rationale

- GSPT1 degradation exploits a synthetic-lethal vulnerability in MYC/AR-driven tumors by disrupting translation termination
- Particularly compelling in AR-mutant mCRPC, where resistance to AR signaling inhibitors is common

Opportunity

- Focused entry into a defined, high-unmet-need AR-mutant mCRPC segment with limited effective options
- Expansion potential into earlier-line therapy and other MYC- or AR-dependent solid tumors

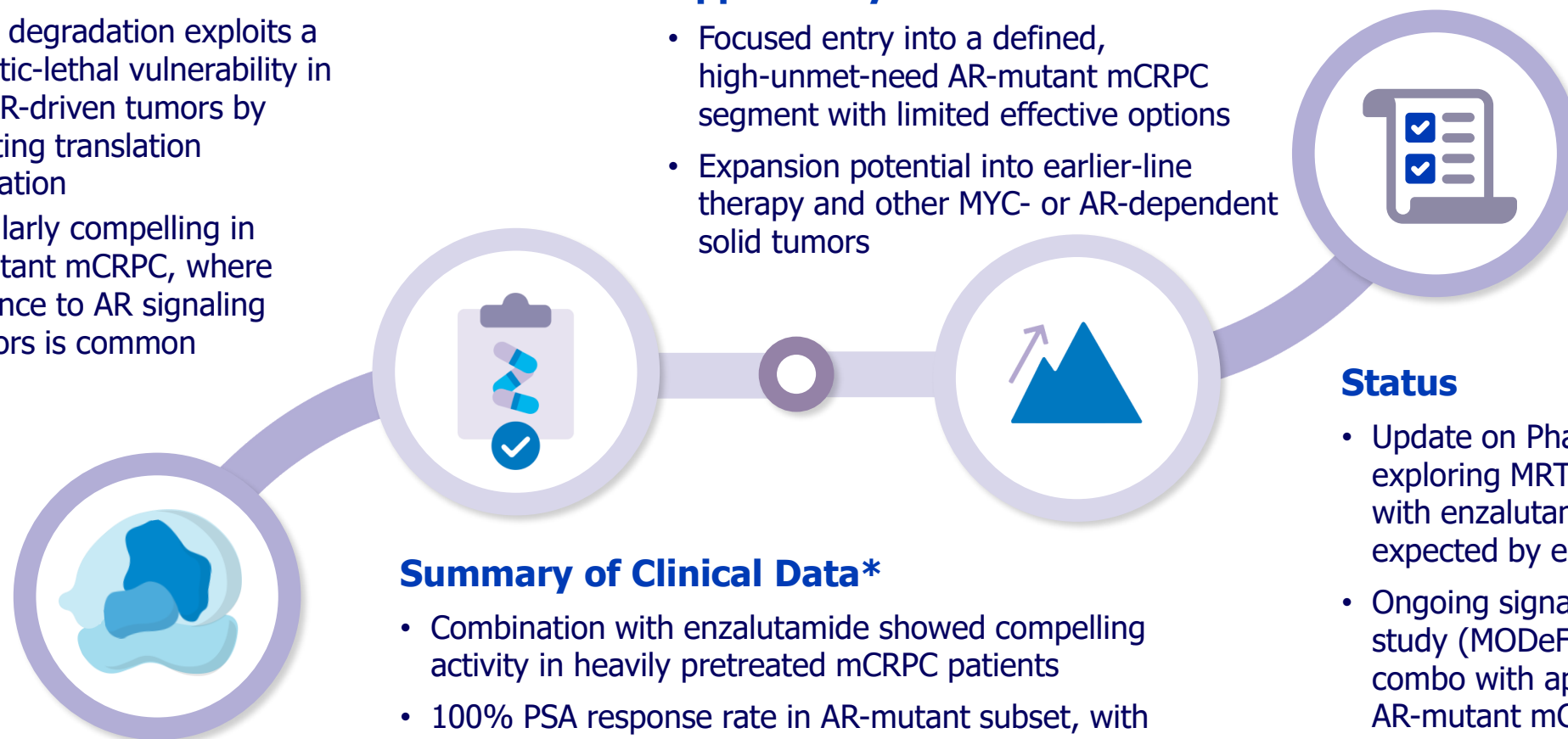
Summary of Clinical Data*

- Combination with enzalutamide showed compelling activity in heavily pretreated mCRPC patients
- 100% PSA response rate in AR-mutant subset, with RECIST partial responses
- Signals of durability and manageable safety profile support advancement into Phase 2 study

Status

- Update on Phase 1/2 expansion arm exploring MRT-2359 in combination with enzalutamide in advanced CRPC expected by end of year
- Ongoing signal-confirming Phase 2 study (MODeFIRE-1) of MRT-2359 in combo with apalutamide in AR-mutant mCRPC; data update expected in 2027
- Potential expansion into earlier-line and additional AR-driven populations pending Phase 2 readout

* As of data cut-off of January 30, 2026, as disclosed Feb. 24, 2026



Potential to Address Key Unmet Need for mCRPC Patients With AR Mutations

mCRPC Market Overview



~60K

mCRPC annual incident population in the U.S.*

~20-30%

Patients carrying AR mutations post-ARPI treatment

Unmet Need of mCRPC AR-mutant Population

Poor prognosis, easy to identify patient population

- AR mutations in mCRPC patients have been reported to have **significantly shorter overall survival**
- AR mutations easily identified with **existing blood-based diagnostic tests**

Limited treatment options

- Currently, there is **no approved targeted therapy** for AR LBD-mutated patients
- Given AR LBD mutations are associated with **resistance** to 2nd generation ARPIs, therapy options for these patients are often limited to **chemo and radioligand therapies**

Need for therapy with minimal QoL impact

- Patients with AR LBD mutations often suffer from **significant side effects and poor quality of life** when taking chemo or radioligand therapies
- There is a strong desire among oncologists to have a **new non-chemo, non-radioligand treatment option** for AR LBD-mutated patients

MRT-2359 Opportunity in AR Mutant mCRPC

Potential for **high rates of durable responses** in AR-mutant patient population with high unmet need

Maintain patients on **all-oral regimen** well-suited for use in community urologist/ oncologist setting

Well-tolerated with minimal additive toxicity to standard-of-care AR inhibitors

Potential for indication expansion into earlier line in combination with 2nd generation AR inhibitors or radioligand therapy

Clinical Data Summary

- MRT-2359 in combination with enzalutamide achieved compelling clinical activity in a subset of heavily pre-treated metastatic castration resistant prostate cancer (mCRPC) patients with androgen receptor (AR) mutations.
- Of the 5 patients with AR mutations:
 - 5 patients showed a PSA response, including 2 patients with PSA90 and 3 patients with PSA50 responses
 - 2 patients showed RECIST partial responses (1 confirmed, 1 unconfirmed)
 - 3 patients had stable disease (all with reduction in size of target lesions), leading to a 100% disease control rate in the AR mutant population
 - 2 patients remained on therapy for 10 cycles or longer and 2 patients remained on drug as of data cut off on January 30, 2026
- 5 additional patients without AR mutations had stable disease per RECIST, several of which associated with tumor size reductions of target lesions, resulting in an overall disease control rate (DCR) of 67% in a total of 15 evaluable patients
- Combination of MRT-2359 and enzalutamide was well tolerated with mild or moderate, manageable fatigue and GI adverse events (AEs) being the most frequent toxicities
- Data support potential of combination of MRT-2359 with 2nd generation androgen receptor inhibitors for mCRPC patients with AR mutations (up to 30% of 2nd line+ mCRPC), with additional potential in earlier line settings or in combination with other agents



MRT-2359 Phase 1/2 Clinical Study Design

Phase 1: Dose Escalation

Monotherapy of MRT-2359 in lung cancer, high-grade neuroendocrine tumors and solid tumors with N-/L-MYC amplification



Patient Demographics, Clinical Characteristics and Prior Therapies: MRT-2359 Compared to Mevrometostat Phase I Trial

Patient Characteristics	MRT-2359 + Enzalutamide Total (N=23)	Mevrometostat + Enzalutamide Phase I total (N=47) ¹
Age, median (range), years	71 (54-83)	70 (53 – 87)
Race, N (%)		
White	14 (61)	40 (85)
Black	7 (30)	4 (9)
Asian	0 (0)	2 (4)
Other	2 (9)	1 (2)
ECOG performance status, N (%)		
0-2	23 (100)	47 (100)
Histology subtype, N (%)		
Adenocarcinoma	20 (87)	47 (100)
Adenocarcinoma with neuroendocrine differentiation ²	3 (13)	ND ³
Lesions at baseline, n (%)		
RECIST measurable disease	23 (100)	16 (34)
Soft tissue only	1 (5)	10 (21)
Liver metastases	6 (27)	ND ³
Number of prior lines of therapy, median (range)	5 (1-18)	ND ³
Prior abiraterone, second gen ARI naive N (%)	5 (22)	20 (43)
Prior second gen ARI +/- abiraterone N (%)	18 (78)	27 (57)
Prior docetaxel and/or cabazitaxel N (%)	19 (83)	23 (49)
Prior Pluvicto N (%)	13 (57)	ND ³
Baseline PSA, ng/mL, median (range)	19.66 (0.66 – 4989)	49.9 (0-9,650)

Data cut-off January 30, 2026

Notes: ¹ Mevrometostat + enzalutamide data from Schweizer et al. ASCO (2024). ² Identified by RNAseq analysis of study tumor biopsies collected before dosing. ³ ND, not disclosed.

Comparisons between MRT-2359 and other therapies represented herein are based on post-hoc analyses comparing MRT-2359 clinical information with publicly available information for other therapies. Any comparisons use information from different clinical trials, conducted by different parties, at different points in time, with differences in trial designs and patient populations. No head-to-head clinical trials have been conducted, cross-trial comparisons should not be made, and this information is provided only for illustrative purposes.

Combination of MRT-2359 and Enzalutamide was Well Tolerated and May be Favorable over EZH2 Inhibitors

Treatment-Related AEs Occurring in $\geq 20\%$ Patients

Dose Level	MRT-2359 0.5mg and Enzalutamide 160mg N=17				MRT-2359 0.75mg and Enzalutamide 160mg N=6				Total N=23
CTC AE V5 Grade	G1 (%)	G2 (%)	G3 (%)	G4 (%)	G1 (%)	G2 (%)	G3 (%)	G4 (%)	All grades
Fatigue	3 (18)	4 (24)	1 (6)	0	2 (33)	2 (33)	0	0	12 (52)
Diarrhea	5 (29)	1 (6)	1 (6)	0	4 (67)	0	0	0	11 (48)
Nausea	1 (6)	3 (18)	1 (6)	0	1 (17)	2 (33)	0	0	8 (35)
Decreased appetite	1 (6)	2 (12)	0	0	2 (33)	1 (17)	1 (17)	0	7 (30)
Vomiting	1 (6)	2 (12)	0	0	1 (17)	3 (50)	0	0	7 (30)
Anemia	3 (18)	1 (6)	0	0	0	0	2 (33)	0	6 (26)
Arthralgia	3 (18)	1 (6)	0	0	1 (17)	1 (17)	0	0	6 (26)
Lymphopenia	1 (6)	0	3 (18)	0	0	0	1 (17)	0	5 (22)
Muscular Weakness	2 (12)	2 (12)	0	0	0	0	1 (17)	0	5 (22)
Neutropenia	2 (12)	0	1 (6)	0	0	0	2 (33)	0	5 (22)

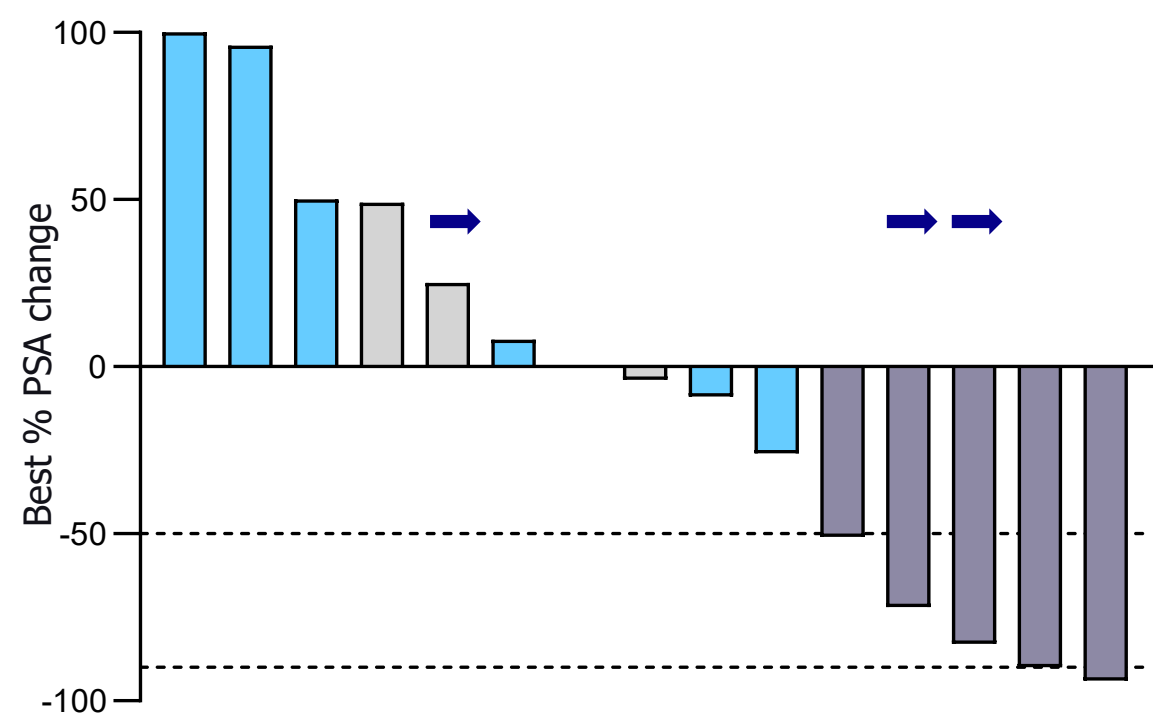
- Combination of MRT-2359 and enzalutamide was well tolerated
- Most frequent AEs were fatigue, diarrhea, and nausea which were classified as mild or moderate and were manageable and not therapy limiting

Data cut-off January 30, 2026

Note: Comparisons between MRT-2359 and other therapies represented herein are based on post-hoc analyses comparing MRT-2359 clinical information with publicly available information for other therapies. Any comparisons use information from different clinical trials, conducted by different parties, at different points in time, with differences in trial designs and patient populations. No head-to-head clinical trials have been conducted, cross-trial comparisons should not be made, and this information is provided only for illustrative purposes.



MRT-2359 and Enzalutamide Achieved High PSA Response Rate in AR Mutant mCRPC

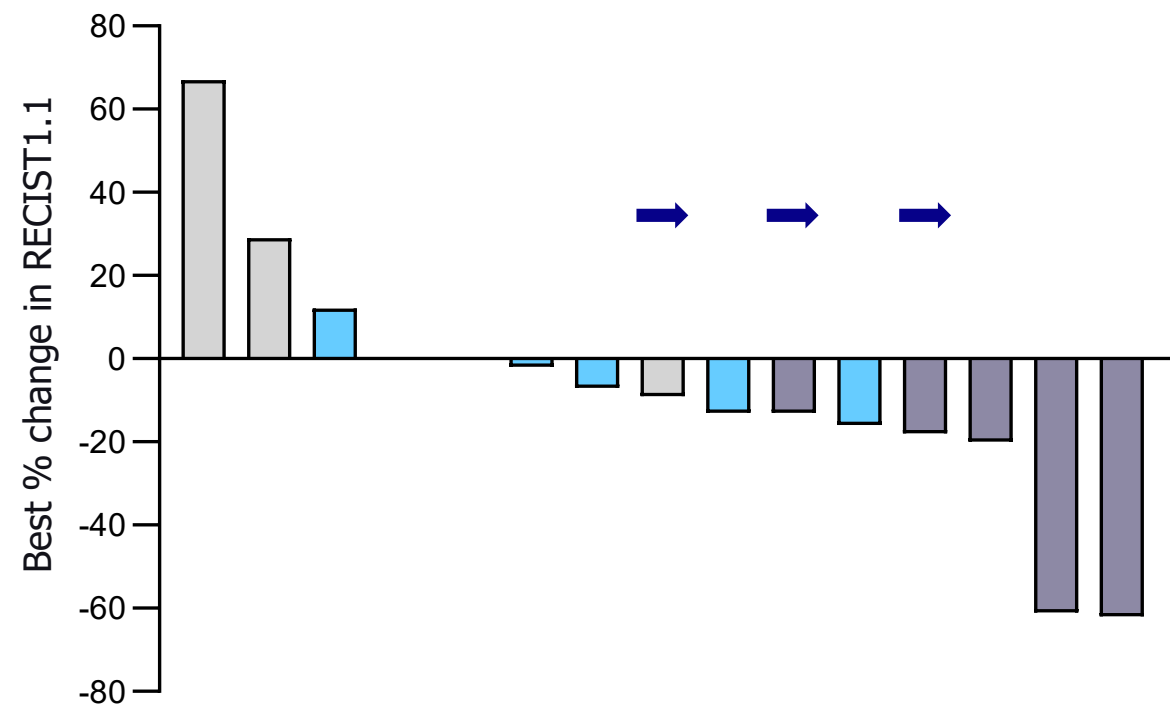


- MRT-2359 + enzalutamide achieved 100% PSA response rate; PSA response in 5 of 5 heavily pretreated patients with AR mutations
 - PSA50 (n=3)
 - PSA90 (n=2)
- PSA response rate in overall population suggests activity at least comparable to data shown in Phase 1 study of mevrrometostat + enzalutamide

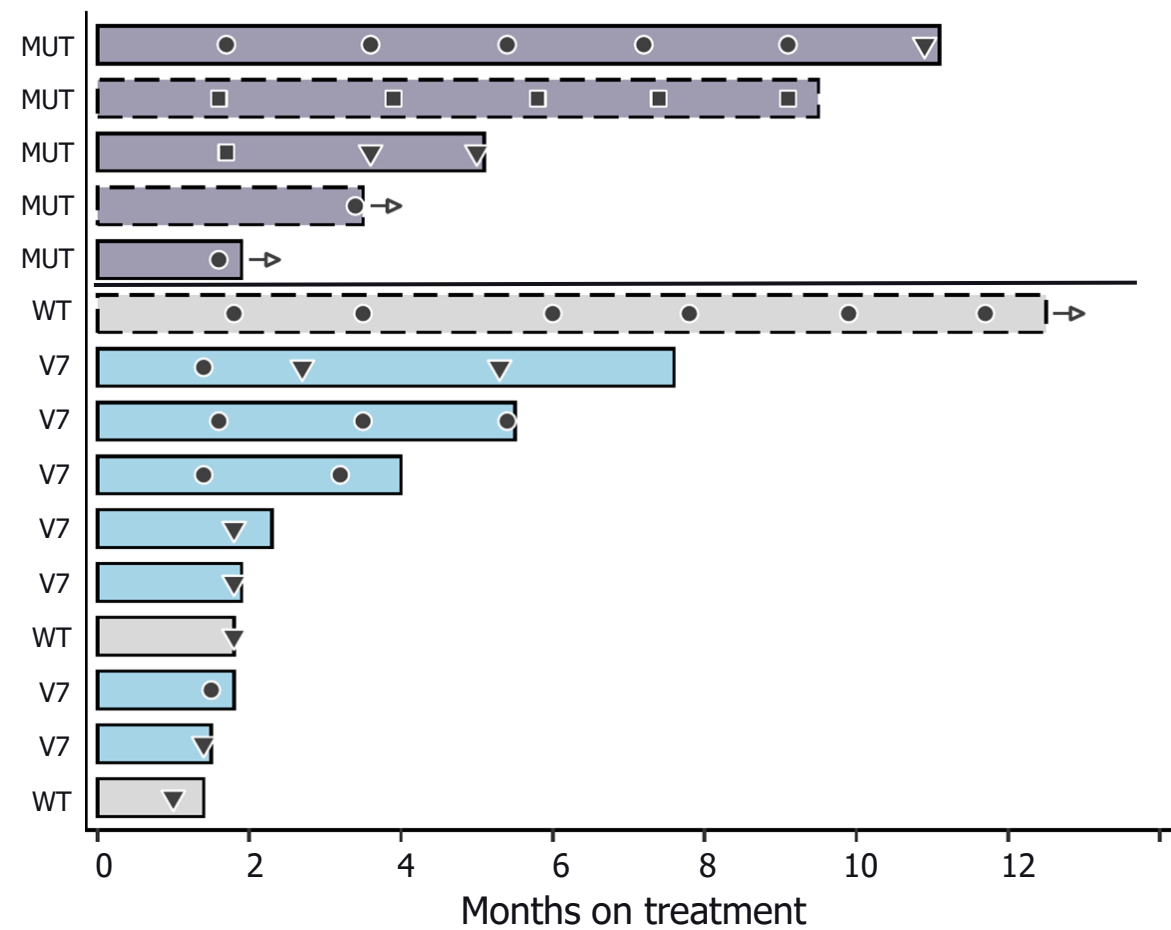
AR status	V7	V7	V7	WT	WT	V7	V7	WT	V7	V7	Mut	Mut	Mut	Mut	Mut
RECIST Response	PD	PD	SD	PD	SD	SD	SD	PD	SD	PD	SD	SD	SD	PR	PR
RECIST %	0	-13	0	+29	-9	+12	-2	+67	-16	-7	-20	-18	-13	-62	-61
Abiraterone	+	-	+	-	+	+	+	-	+	-	+	+	+	+	+
2 nd gen ARi	+	+	+	+	-	+	+	+	+	+	+	-	+	-	+
Docetaxel	+	+	+	+	-	+	-	+	+	+	+	+	+	+	+
Pluvicto	+	+	-	+	-	+	-	+	+	-	-	+	+	+	+
Dose (mg)	0.75	0.75	0.5	0.5	0.5	0.75	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5

Note: Comparisons between MRT-2359 and other therapies represented herein are based on post-hoc analyses comparing MRT-2359 clinical information with publicly available information for other therapies. Any comparisons use information from different clinical trials, conducted by different parties, at different points in time, with differences in trial designs and patient populations. No head-to-head clinical trials have been conducted, cross-trial comparisons should not be made, and this information is provided only for illustrative purposes.

MRT-2359 plus Enzalutamide Achieved Tumor Regressions in AR Mutant mCRPC



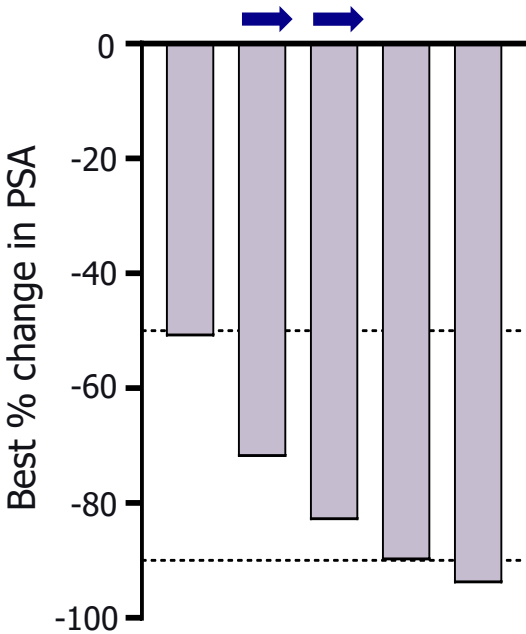
AR status	WT	WT	V7	V7	V7	V7	V7	WT	V7	Mut	V7	Mut	Mut	Mut	Mut
RECIST Response	PD	PD	SD	PD	SD	SD	PD	SD	PD	SD	SD	SD	SD	PR	PR
RECIST %	+67	+29	+12	0	0	-2	-7	-9	-13	-13	-16	-18	-20	-61	-62
Abiraterone	-	-	+	+	+	+	-	+	-	+	+	+	+	+	+
2 nd gen ARi	+	+	+	+	+	+	+	-	+	+	+	-	+	+	-
Docetaxel	+	+	+	+	+	-	+	-	+	+	+	+	+	+	+
Pluvicto	+	+	+	+	-	-	-	-	+	+	+	+	-	+	+
Dose (mg)	0.5	0.5	0.75	0.75	0.5	0.5	0.5	0.5	0.75	0.5	0.5	0.5	0.5	0.5	0.5



Response ■ PR ● SD ▼ PD ARI Naive - - -

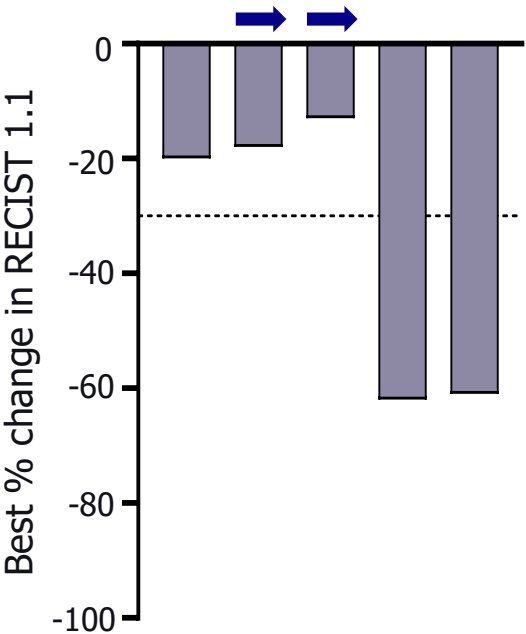
Compelling Activity in Heavily Pretreated Patients with AR Mutations

Best % change in PSA



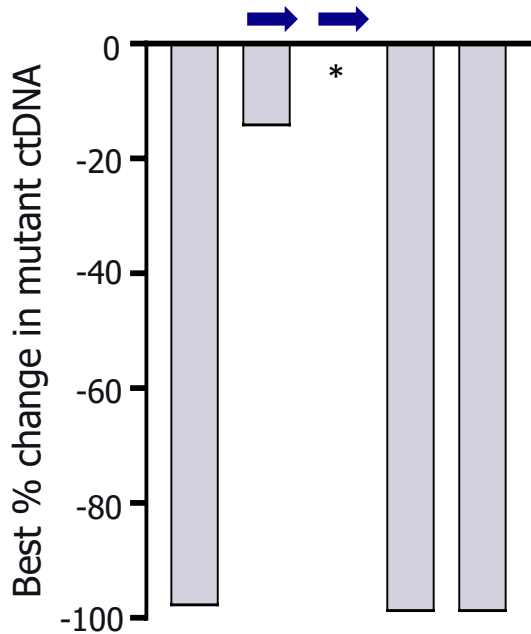
Response	SD	SD	SD	PR	PR
RECIST %	-20	-18	-13	-62	-61
Abiraterone	+	+	+	+	+
2 nd gen ARi	+	-	+	-	+
Docetaxel	+	+	+	+	+
Pluvicto	-	+	+	+	+

Best % change in RECIST



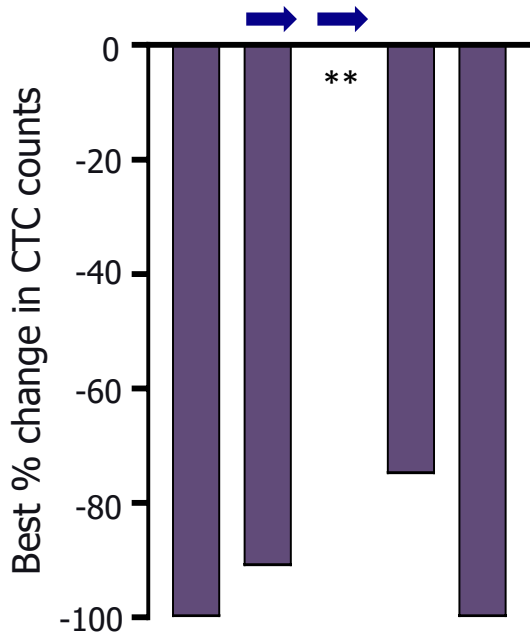
Response	SD	SD	SD	PR	PR
RECIST %	-20	-18	-13	-62	-61
Abiraterone	+	+	+	+	+
2 nd gen ARi	+	-	+	-	+
Docetaxel	+	+	+	+	+
Pluvicto	-	+	+	+	+

Best % change in ctDNA



Response	SD	SD	SD	PR	PR
RECIST %	-20	-18	-13	-62	-61
Abiraterone	+	+	+	+	+
2 nd gen ARi	+	-	+	-	+
Docetaxel	+	+	+	+	+
Pluvicto	-	+	+	+	+

Best % change in CTC counts



Response	SD	SD	SD	PR	PR
RECIST %	-20	-18	-13	-62	-61
Abiraterone	+	+	+	+	+
2 nd gen ARi	+	-	+	-	+
Docetaxel	+	+	+	+	+
Pluvicto	-	+	+	+	+



MODeFIRE-1 MRT-2359 Phase 2 Study in CRPC (up to 25 pts)



Study Population

Simon's 2-Stage Design
(up to 25 pts)
mCRPC with AR mutations
PSA +/- RECIST measurable,
ARPI and chemo pretreated



Treatment

MRT-2359 0.5mg (21/7) +
2nd gen AR inhibitor apalutamide

28-day cycles

- Enrollment completion ~12 months after initiation
- Endpoints include PSA response, RECIST, DoR, rPFS, and safety

Potential to expand to other AR-driven populations, including patients without prior 2nd generation AR inhibitors, as well as into combinations with RL therapies independent of AR status

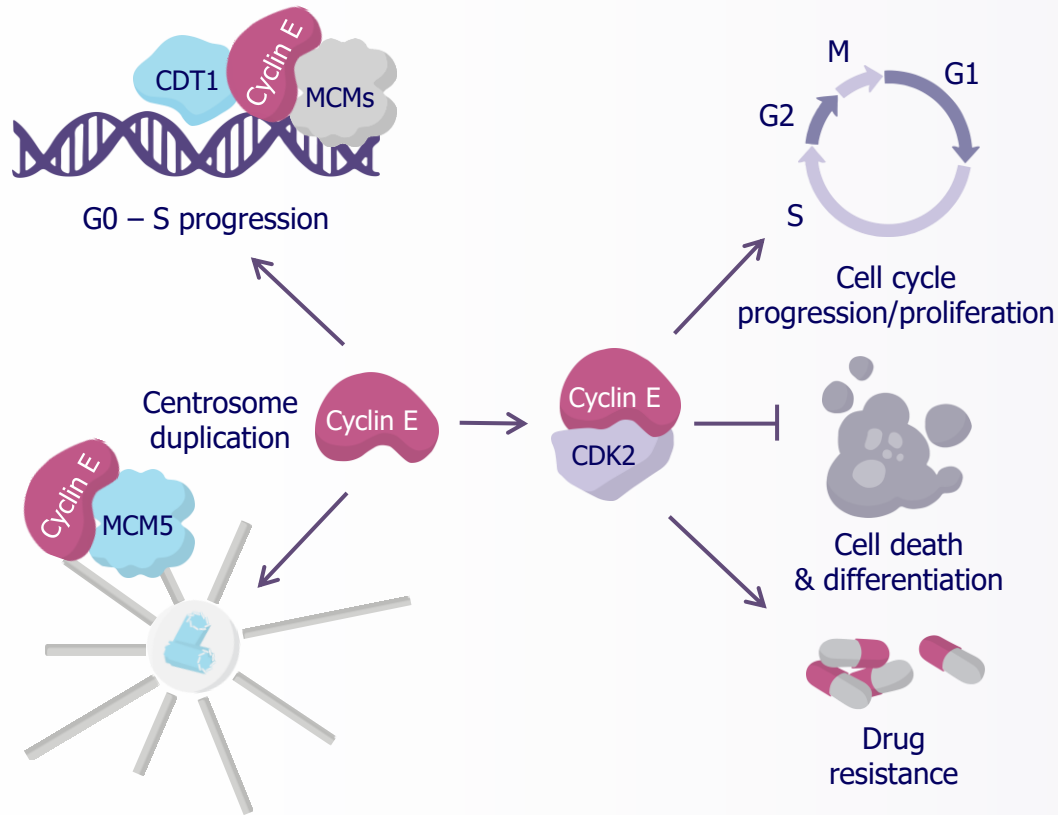
Study ongoing; clinical data update expected in 2027



CCNE1 Program

CCNE1 (Cyclin E1) is a Target for Solid Tumors with Deregulated Cyclin E1

Cyclin E drives multiple hallmark cancer mechanisms



Therapeutic hypothesis:

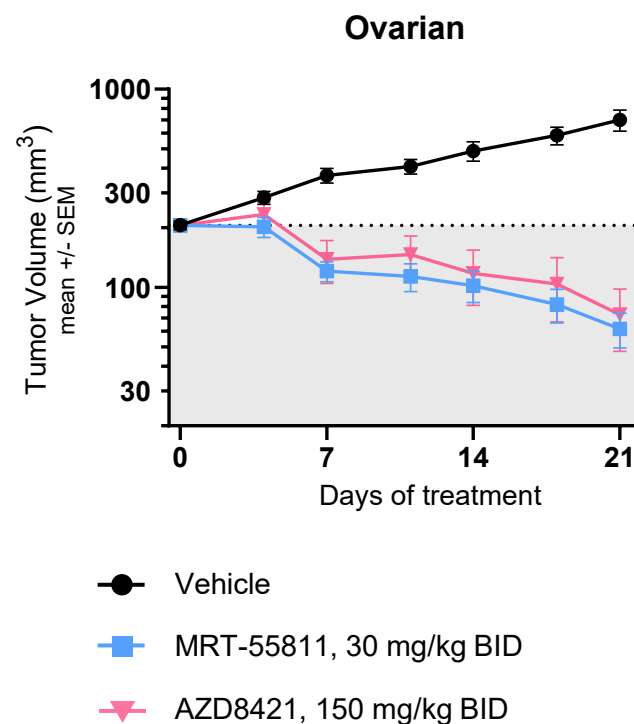
- CCNE1 (Cyclin E1) is a well-recognized human oncogene that drives multiple hallmarks of cancer, and has been considered undruggable
- Selective degradation of cyclin E1 can target tumors with deregulated cyclin E1 (amplification or overexpression)

Clinical opportunity:

- First-in-class Cyclin E1 degraders for Cyclin E1 amplified cancers
 - Ovarian (~20% of ~80K patients), endometrial (~10% of ~50K patients), gastroesophageal cancer (~10% of ~200K patients), breast cancer and others

Potent and Highly Selective CCNE1-directed MGDs

MRT-55811 induced tumor regression in *CCNE1* amplified ovarian model



21-day efficacy study in OVSAHO CDX

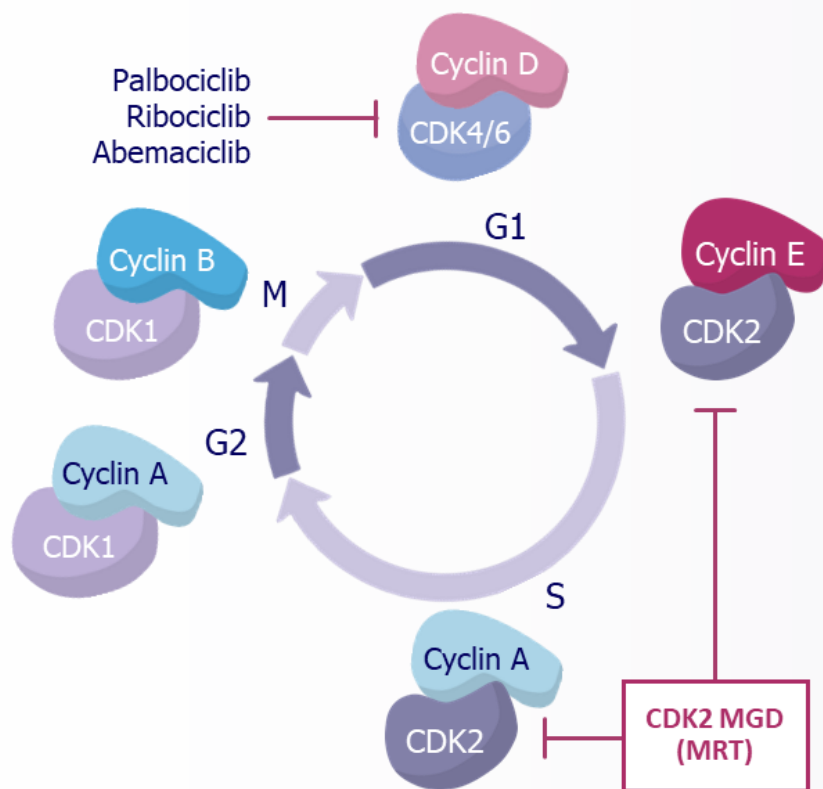
- MRT-55811 is a potent and highly selective CCNE1 molecular glue degrader that drives robust G1/S cell-cycle arrest in CCNE1-amplified cancer cells.
- CCNE1 degradation leads to downstream suppression of CDK2 activity and E2F pathway signaling, confirming on-mechanism cell-cycle inhibition
- MRT-55811 induces co-degradation and ubiquitination of the CCNE1–CDK2 holoenzyme, supporting a catalytic and durable mechanism of action
- The CCNE1 MGD shows superior selectivity and potency in high-CCNE1 tumors versus CDK2 and CDK4/6 inhibitors, particularly in ovarian, endometrial, gastric, and breast cancer models
- Treatment with MRT-55811 resulted in tumor regression across multiple CCNE1-amplified xenograft models, including gastric, ovarian, and breast cancers



CDK2 Program

CDK2 is a Key Driver of Cell Cycle Progression in Cancer

CDK2: a key cell cycle regulator



Therapeutic hypothesis:

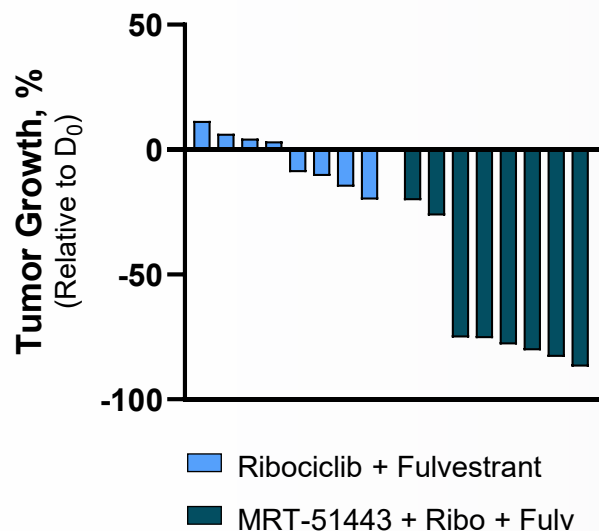
- CDK2 is a key driver of cancers with cyclin dependent kinase pathway alterations
- MGDs will achieve greater selectivity against other CDKs and kinases in general, as well as more sustained pathway inhibition compared to inhibitors

Clinical Opportunity:

- ER-positive breast cancer pre- and post-treatment with CDK4/6 inhibitors (~600K patients)

Differentiated CDK2 Selectivity Supports Combination Strategies

**MRT-51443 triple combination
substantially reduced tumor growth
vs. ribo + fulv in MCF7 model**

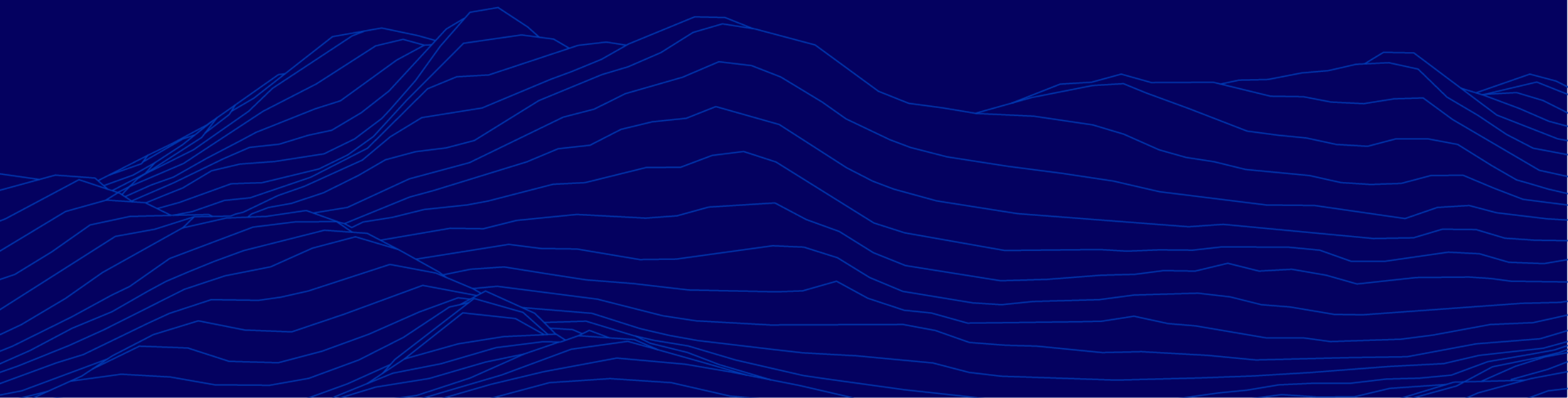


28-day efficacy; MRT-51443 30 mpk PO BID,
ribociclib 75 mpk PO QD, fulvestrant 5
mg/mouse s.c. QW

- MRT-51443 selectively degrades CDK2, leading to G1 arrest and inhibition of proliferation in CDK2-dependent cancer cells
- CDK2 degradation results in reduced expression of E2F target genes, confirming effective pathway shutdown at the transcriptional level
- Compared with clinical CDK2 inhibitors, MRT-51443 demonstrates superior selectivity with minimal off-target kinase activity, leading to less CDK2-independent growth inhibition and lack of impact on hematologic colony formation assays.
- Combination of a CDK2 MGD with CDK4/6 inhibition delays resistance onset in ER-positive breast cancer models in vitro
- Triple combination of MRT-51443 with ribociclib and fulvestrant drives robust tumor regression and meaningfully outperforms CDK4/6 inhibitor plus fulvestrant alone in ER-positive breast cancer xenografts



Team



World-Class Leadership

Deep expertise in molecular glue discovery, drug development and precision medicine



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Thank you

