Degrading Proteins, Making Medicines

Innovating Beyond New Heights | August 2026

Monte Rosa Therapeutics

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 and timeline of our preclinical and clinical programs, including: (i) the ongoing development of our VAV1-directed degrader MRT-6160 (DDY391), its planned multiple Phase 2 initiations 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 expectations regarding the GFORCE-1 and GFORCE-2 studies, Phase 1 data and Phase 2 initiation, planned Phase 2 studies in acute gout flares and hidradenitis suppurativa, 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-1β/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 interim results from our ongoing Phase 1/2 clinical study evaluating MRT-2359 in combination with enzalutamide in heavily pretreated patients with metastatic CRPC, the potential clinical activity and opportunity for MRT-2359 in prostate cancer, the activation of the MODeFIRe-1 Phase 2 study evaluating MRT-2359 in combination with a second-generation AR inhibitor in mCRPC patients with AR mutations, anticipated timing of first patient dosing, 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, an expected update on the MRT-2359 Phase 1/2 expansion arm by end of 2026; 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 programs initiating Phase 2 trials in 2026
- Multiple additional INDs for wholly owned pipeline anticipated over next 2 years
- Validation through multiple Pharma collaborations

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
- ~$350M in collaboration payments in last 3 years with potential for >$400M over the next 24 months

Most Disease-driving Biology Remains Inaccessible With Conventional Modalities

~15%
"druggable"

~85%

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 trial activated in participants with Sjögren's disease (to be conducted by Novartis); Monte Rosa expects its collaborator Novartis to initiate multiple Ph. 2 studies in immune-mediated diseases

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

MRT-8102 (NEK7)

- NEK7 enables NLRP3 inflammasome assembly, providing upstream IL-1/IL-18 and pyroptosis blockade beyond current biologics
- Interim Phase 1 data showed ~80–90% NEK7 degradation across doses with **deep biomarker suppression** in SAD, MAD and high-CRP cohorts consistent with **significant upstream pathway inhibition**
- Phase 2 studies planned in patients with elevated atherosclerotic risk and cardiometabolic syndrome (H2 2026 initiation), gout flares (Q4 2026 / Q1 2027) and hidradenitis suppurativa (H1 2027)

First-in-class NEK7 MGD for NLRP3 inflammasome-driven diseases (e.g. atherosclerosis, 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) initiating in 3Q 2026 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** *Licensed to Novartis**	MRT-6160 (DDY391)	Immune-mediated Diseases					Multiple Phase 2 initiations in 2026
	NEK7	MRT-8102	Atherosclerosis, Gout, Hidradenitis Suppurativa					Phase 1 data and Phase 2 initiation in H2 2026
		Next Generation	NLRP3/IL-1β-driven Inflammatory Diseases					IND submission in H2 2026
Oncology	**GSPT1**	MRT-2359	Castration-resistant Prostate Cancer					Ph 1/2 update by EOY; Phase 2 study ongoing
	CCNE1/ CDK2	Discovery	CCNE1 Amplified Tumors ER+ Breast Cancer					IND submission for CCNE1 MGD in 2027
Various	**Multiple Targets** *Includes those licensed/optioned to Roche and Novartis*	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.

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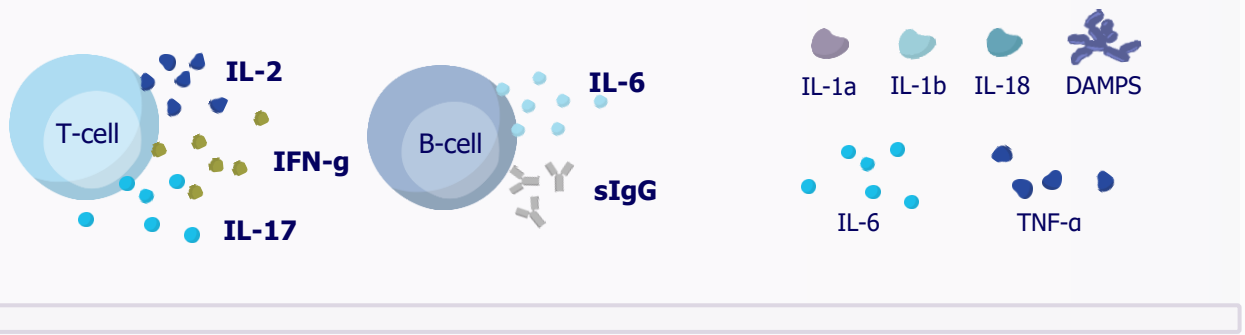
I&I Pipeline

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-1α/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

DAMPs = damage-associated molecular patterns

Monte Rosa Therapeutics

VAV1 Program (MRT-6160/DDY391)

Licensed to Novartis

MRT-6160 (DDY391) At a Glance

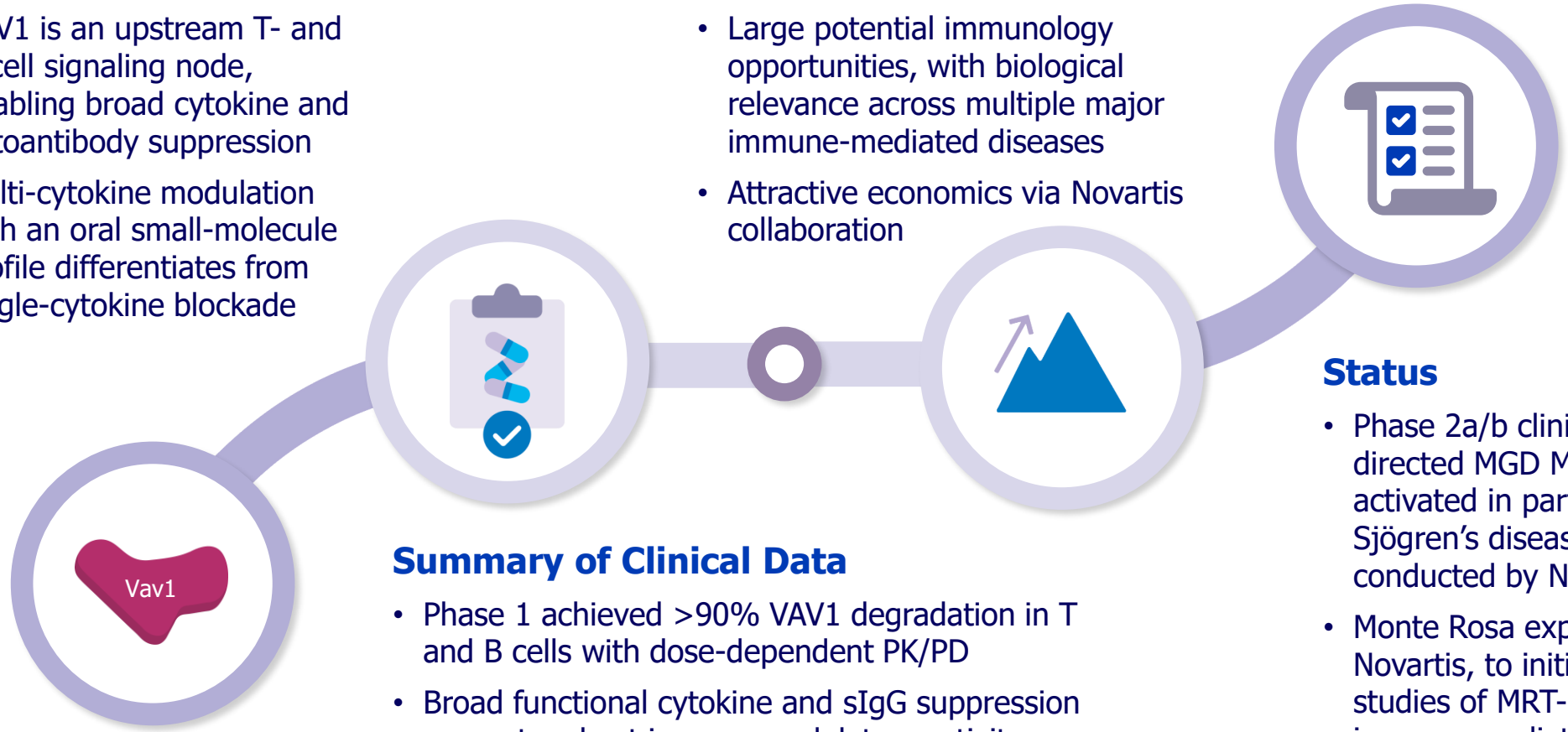
First-in-class VAV1 MGD for diverse T and B-cell driven diseases

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

- Phase 2a/b clinical trial for VAV1-directed MGD MRT-6160 (DDY391) activated in participants with Sjögren's disease; study to be conducted by Novartis**
- Monte Rosa expects its collaborator, Novartis, to initiate multiple Phase 2 studies of MRT-6160 (DDY391) in immune-mediated diseases in 2026

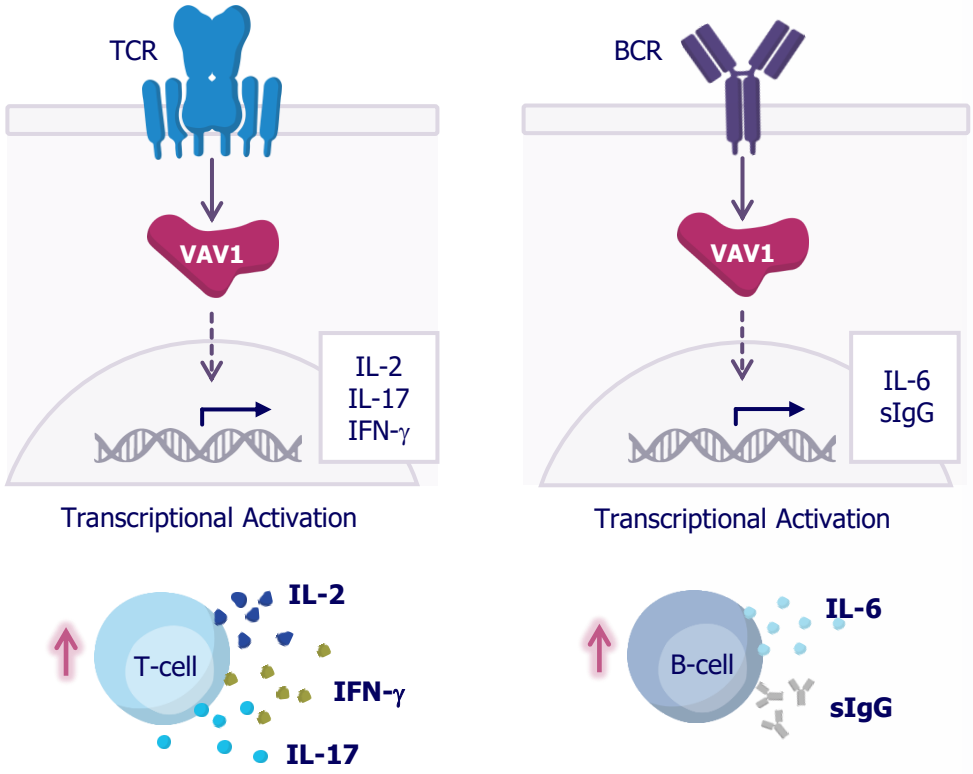
* NCT07737743.

Note: 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.

MRT-6160: Upstream Immune Modulation via Targeted VAV1 Degradation

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

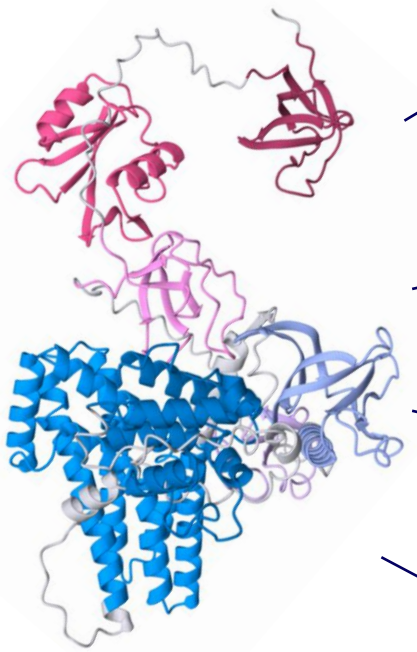
MRT-6160 Reduces Multiple Pathogenic Cytokines (IL-2, IL-6, IL-17) and Secreted Antibodies (sIgG)



- 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

ORENCIA® (abatacept)

RINVOQ® upadacitinib

B cell activation/Plasma cell differentiation (Antibody production)

Rituxan® Rituximab

VYVGART® Hytrulo

Th17 response

Cosentyx® (secukinumab)

omvoh™ (mirikizumab-mrkz) 300 mg/15 mL infusion | 100 mg/mL injection

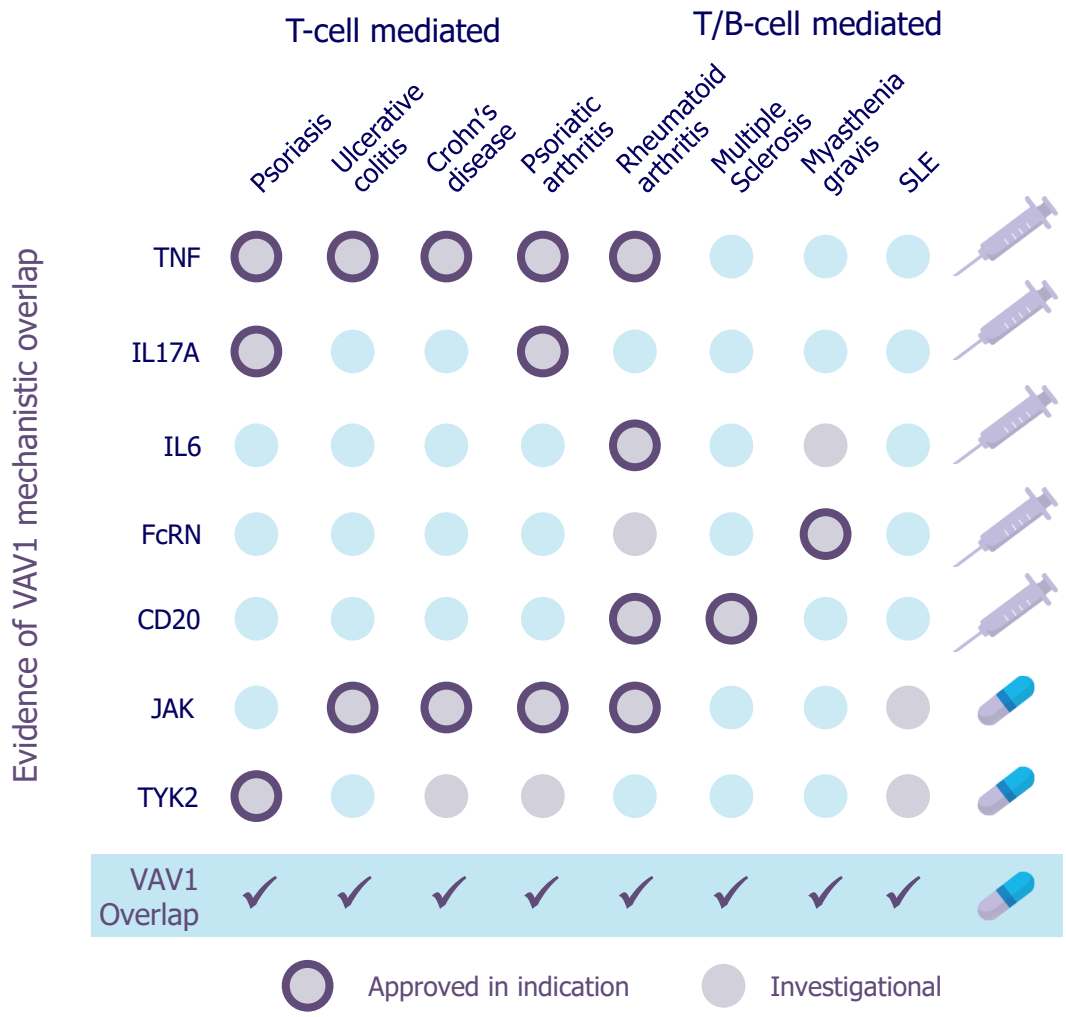
Pro-inflammatory cytokine production

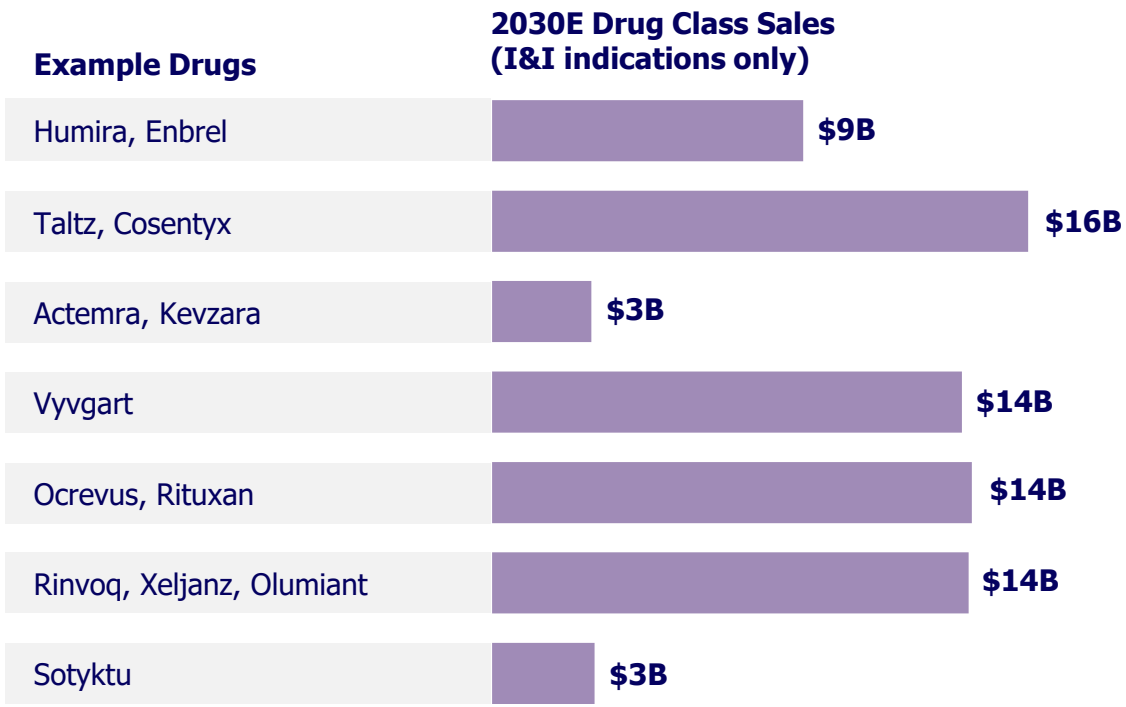
HUMIRA® adalimumab

ACTEMRA® tocilizumab

VAV1: Unique Mechanism with Broad Potential Applications

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

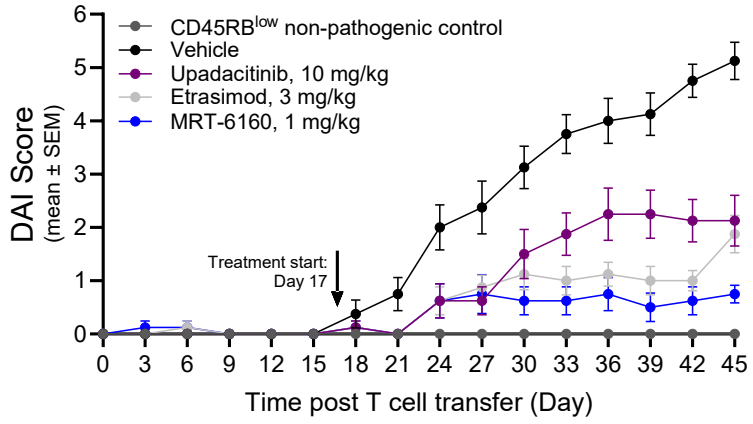




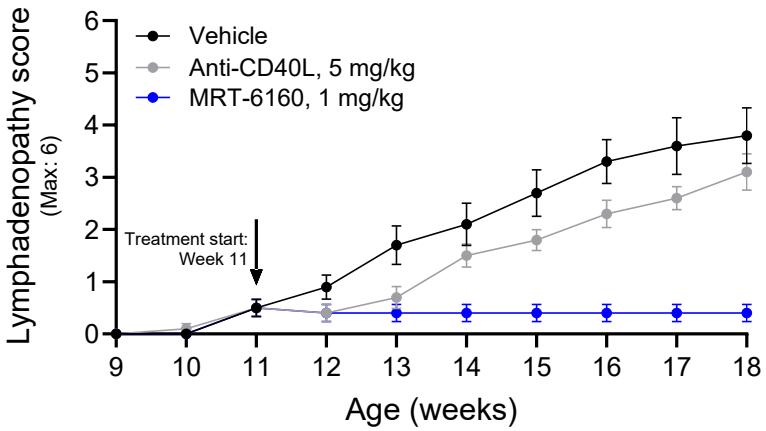
Note: Chart adapted from Hosack et al., Nat Rev Rheumatol 2023. Drug class sales from Evaluate Pharma. 2030E sales may include sales from anticipated future approvals.

Preclinical Data Support Broad Potential Application of MRT-6160

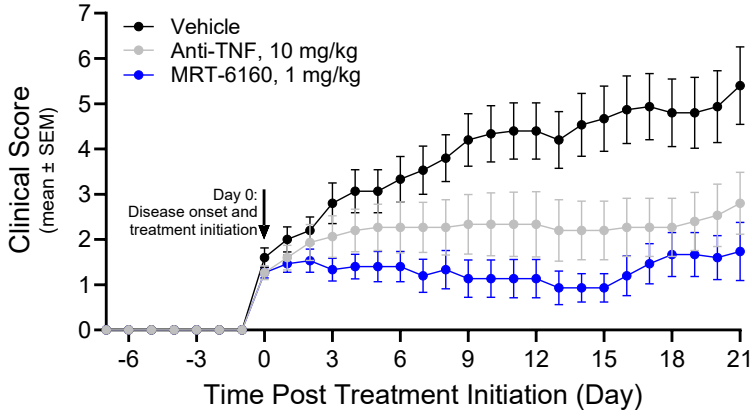
T-cell transfer-induced colitis model of inflammatory bowel disease



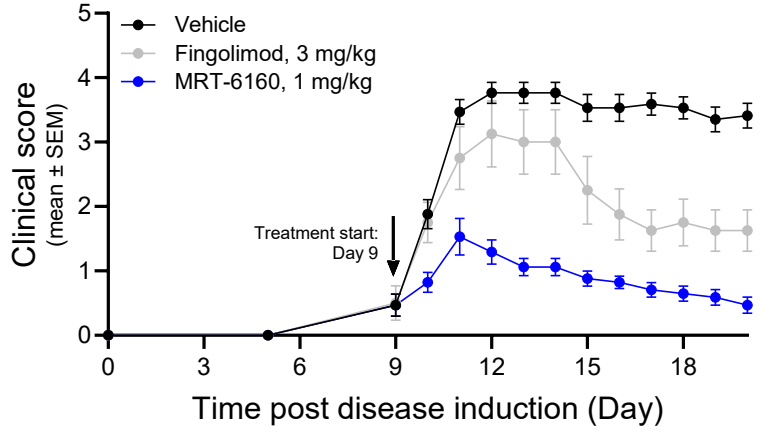
MRL-Fas^{lpr} spontaneous autoimmune disease model (e.g., SLE, Sjögren's)



Collagen-induced arthritis model of autoimmune arthritis



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



EAE = experimental autoimmune encephalomyelitis; SLE = systemic lupus erythematosus

Sources: DDW 2024 poster_T-cell transfer colitis; ACR 2025 poster_MRL-FASlpr; EULAR 2024 poster_CIA; FOCIS_2025 poster_EAE model

Summary of Phase 1 Data

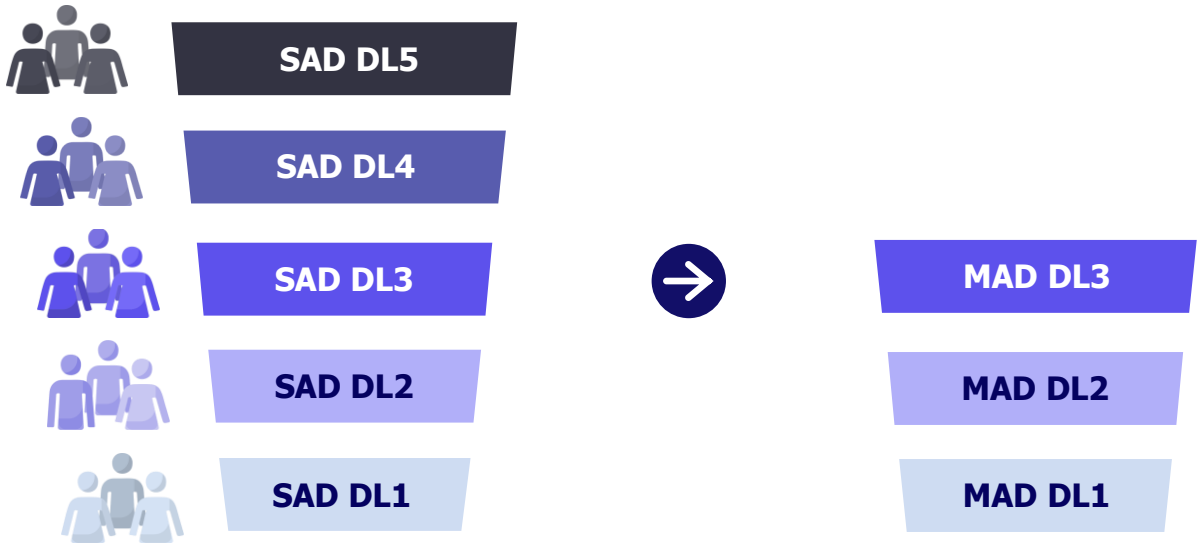
- Pharmacodynamic and functional *ex vivo* studies performed during Phase 1 suggest **significant effects on cytokine production** can be achieved **following** marked and sustained **degradation of VAV1** in humans
- Demonstrated levels of VAV1 degradation consistent with levels of degradation required 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

MAD cohorts
7 daily oral doses



Enrolled > 70 subjects

Study Endpoints

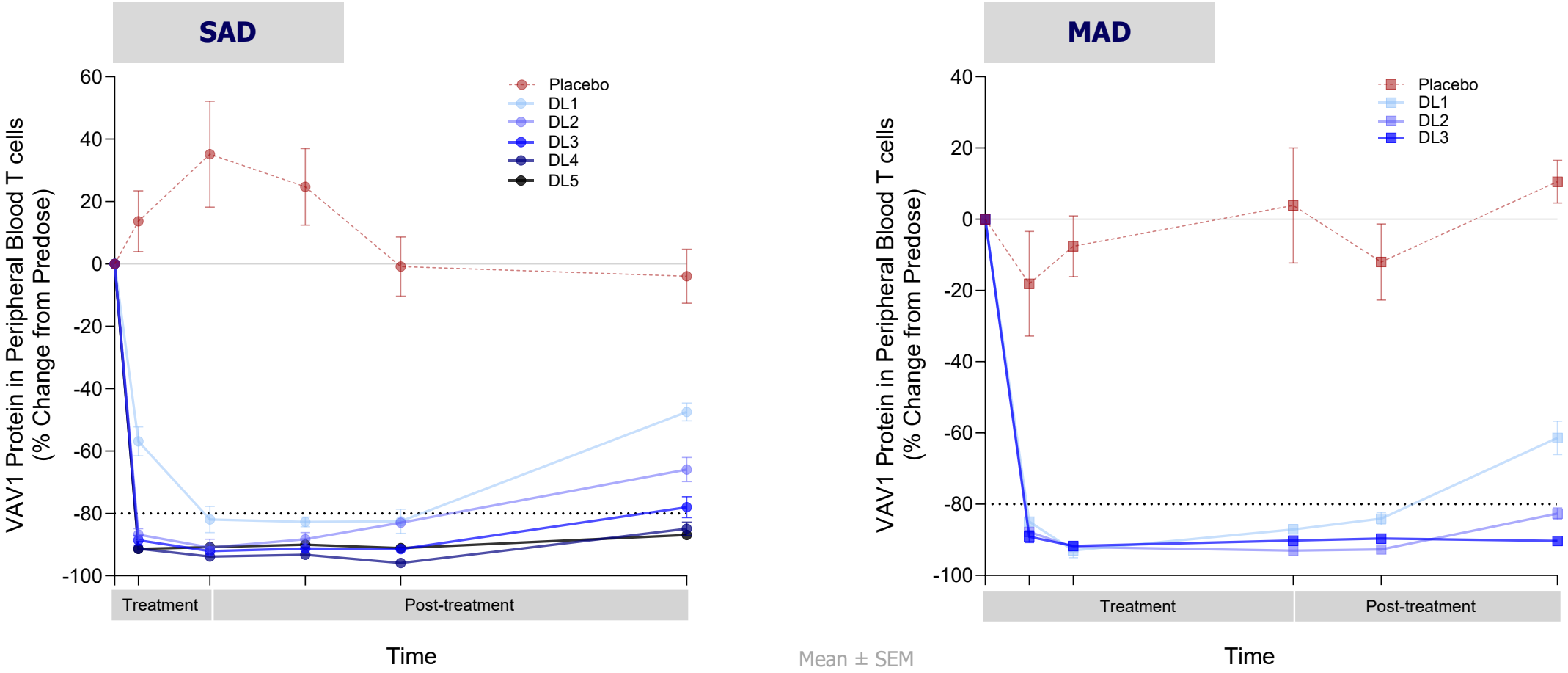
Primary

- Safety and tolerability

Secondary & exploratory

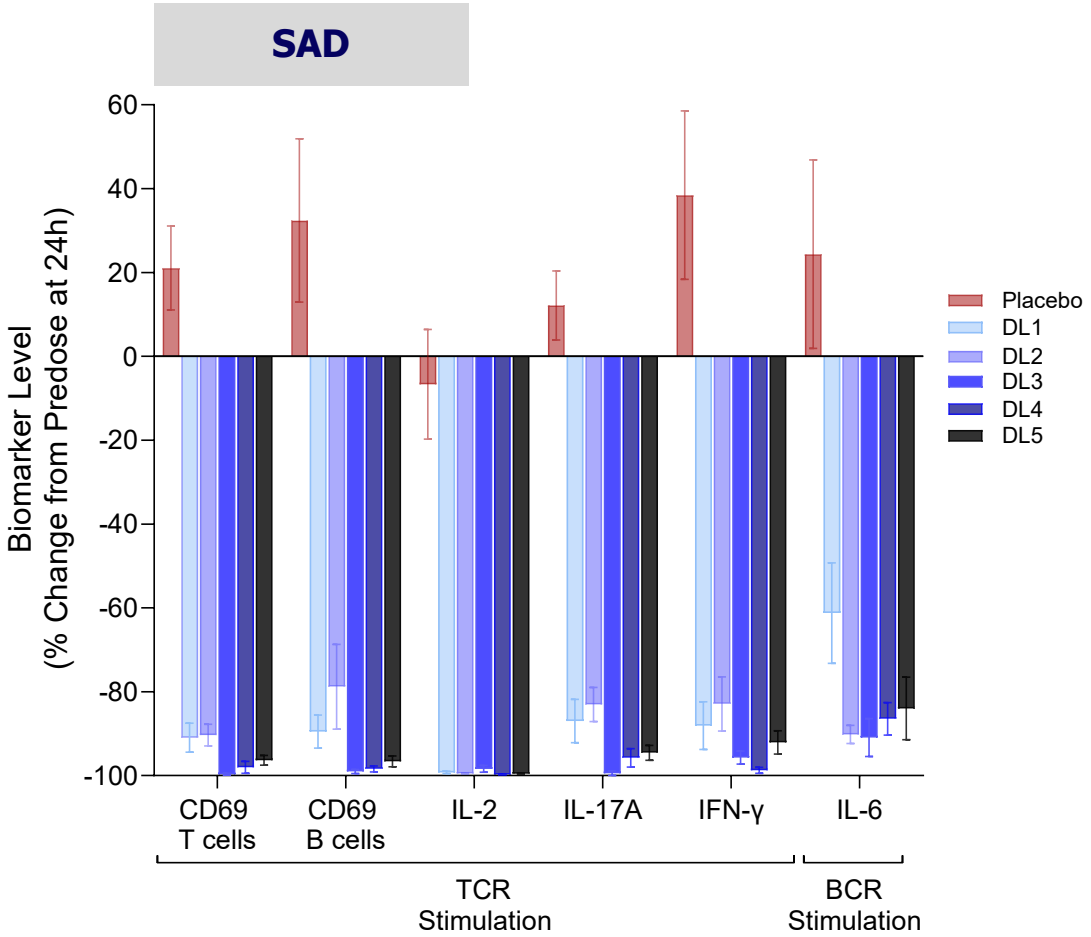
- Pharmacokinetics
- Pharmacodynamics
  - VAV1 degradation in T & B cells
  - Ex vivo response to TCR- and BCR-stimulation

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



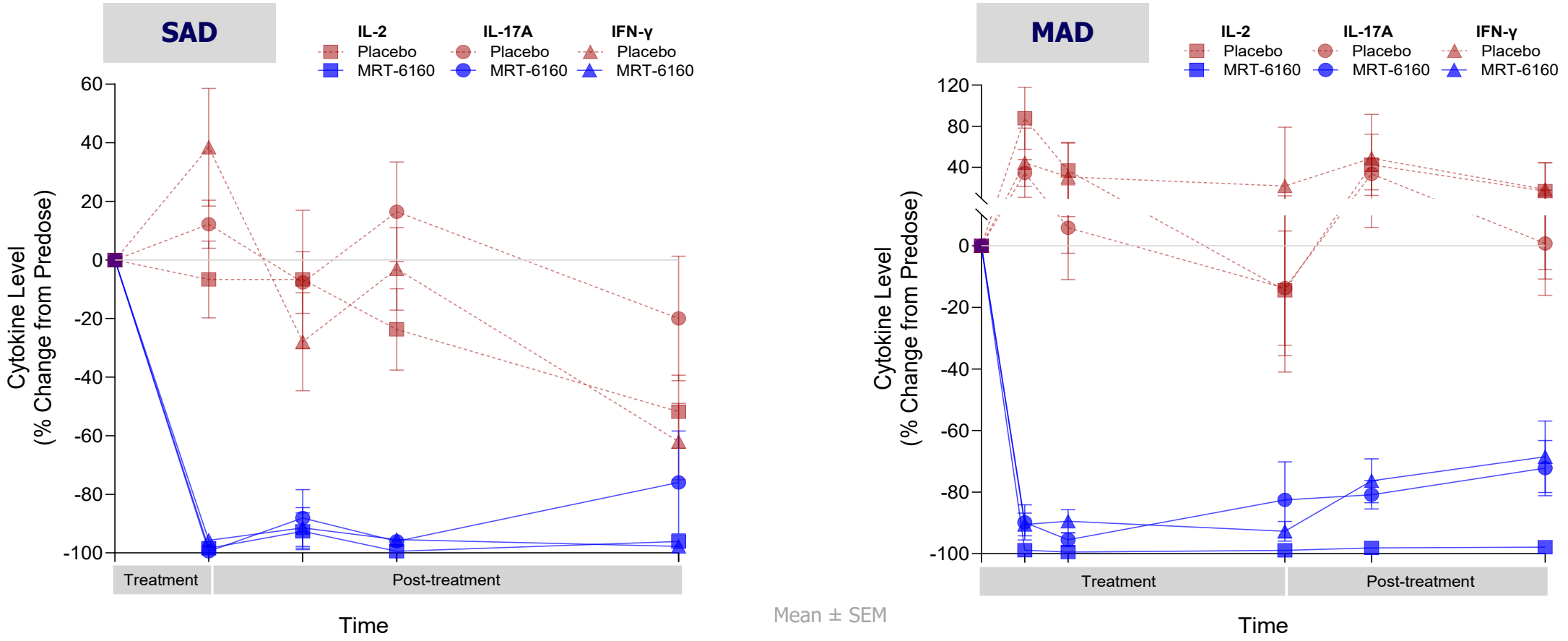
Mean ± SEM

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 ≥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)

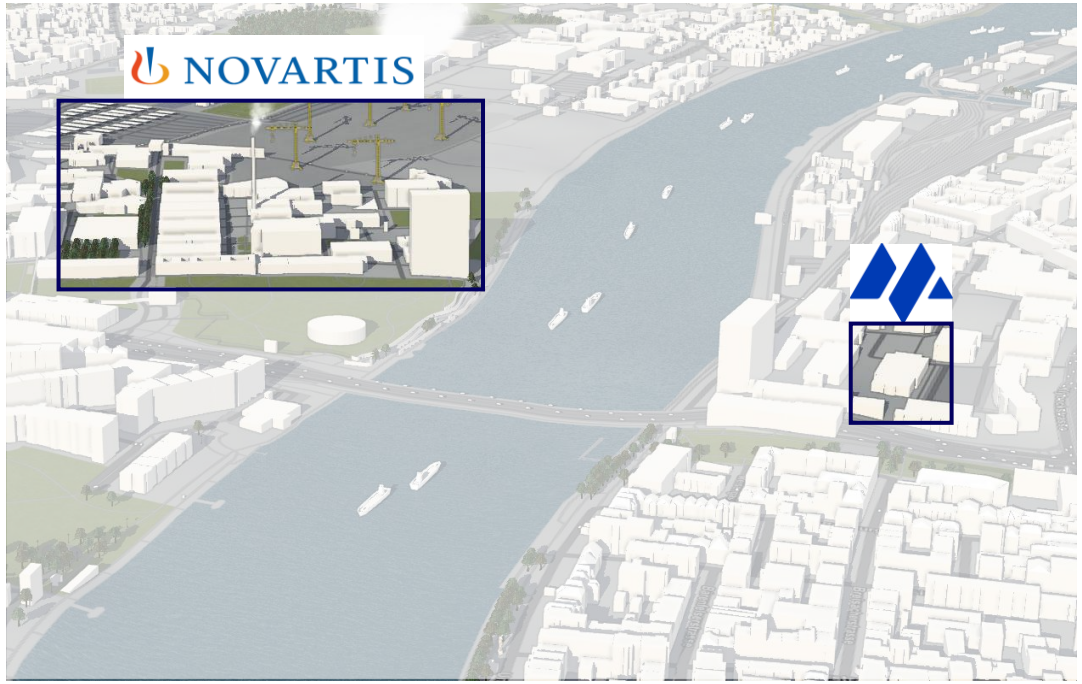
Safety Summary

- 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

NOVARTIS

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.

Monte Rosa Therapeutics

NEK7 Program (MRT-8102)

MRT-8102 At a Glance

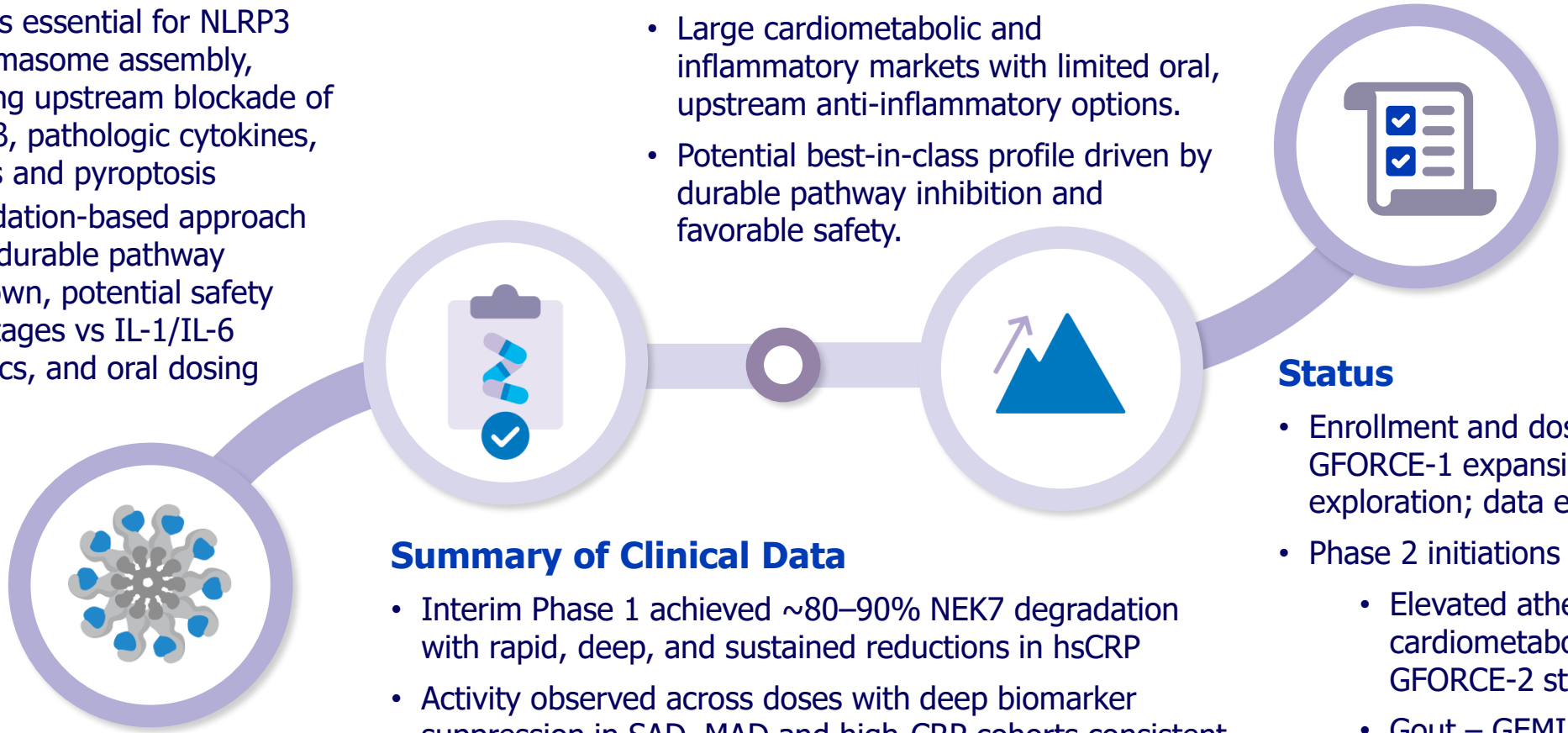
First-in-class NEK7 MGD for NLRP3 inflammasome driven diseases

NEK7 Rationale

- NEK7 is essential for NLRP3 inflammasome assembly, enabling upstream blockade of IL-1α/β, pathologic cytokines, DAMPs and pyroptosis
- Degradation-based approach offers durable pathway shutdown, potential safety advantages vs IL-1/IL-6 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 pathway inhibition and favorable safety.



Summary of Clinical Data

- Interim Phase 1 achieved ~80–90% NEK7 degradation with rapid, deep, and sustained reductions in hsCRP
- Activity observed across doses with deep biomarker suppression in SAD, MAD and high-CRP cohorts consistent with significant upstream pathway inhibition
- Favorable safety profile observed*

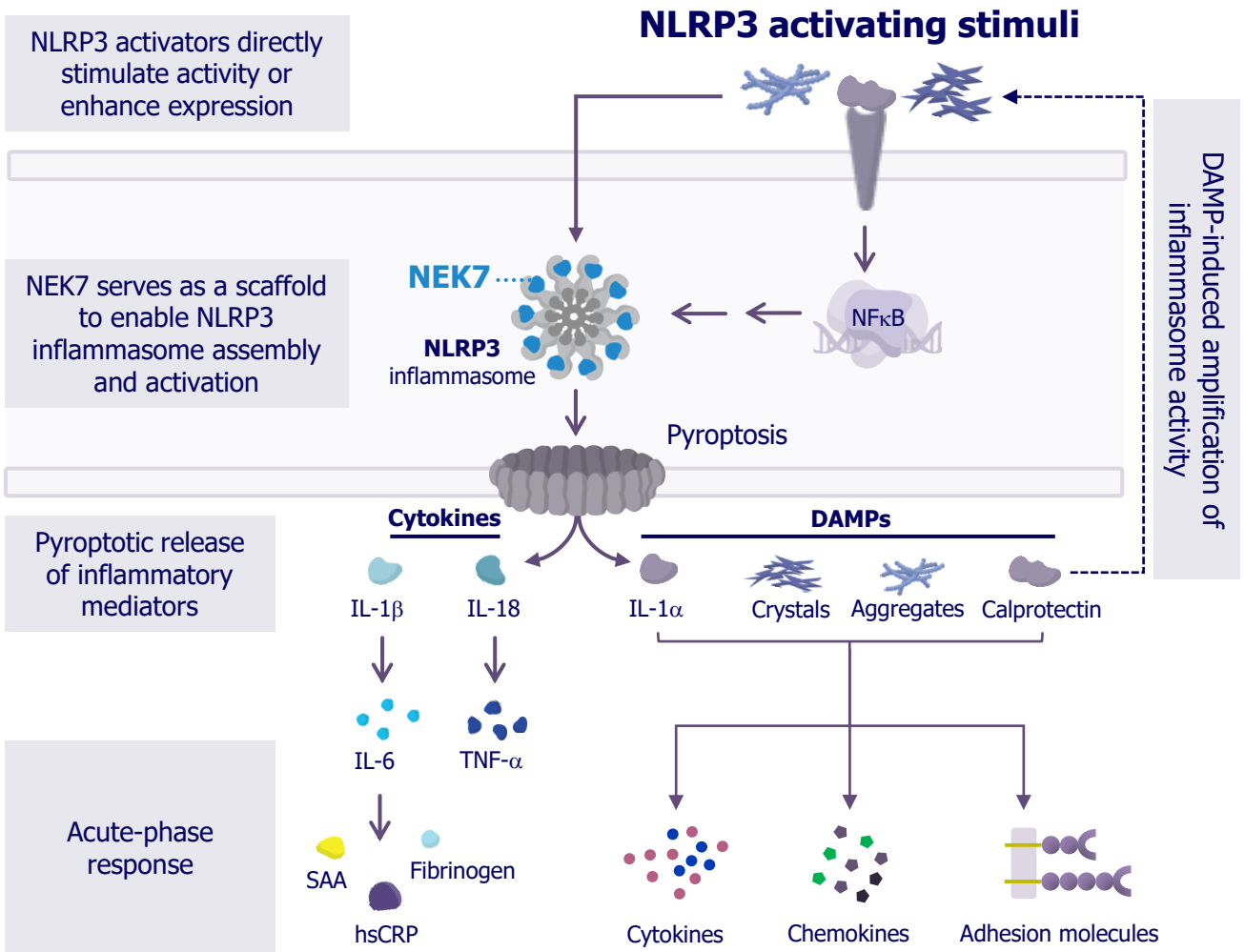
Status

- Enrollment and dosing complete for GFORCE-1 expansion with additional dose exploration; data expected in 2H 2026.
- Phase 2 initiations expected:
  - Elevated atherosclerotic risk and cardiometabolic syndrome – GFORCE-2 study (H2 2026)
  - Gout – GEMINI-1 study (Q4 2026 / Q1 2027)
  - Hidradenitis suppurativa – GALAXY-1 study (H1 2027)

* As of March 17, 2026 disclosure

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.

NEK7: A Compelling Upstream Target to Address NLRP3-Driven Inflammatory Diseases



- NEK7 enables NLRP3 inflammasome assembly in a kinase-independent manner
- NLRP3 inflammasome activation causes pyroptotic cell death, causing release of **IL-1α/β, IL-18, and DAMPs (e.g. calprotectin)**
  - IL-1β, IL-18 and DAMPs are highly inflammatory cytokines that fuel plaque inflammation while also stimulating the IL-6-CRP (acute phase response) axis
  - **DAMPs** further stimulate NLRP3 activity and concomitantly promote NLRP3-independent cytokine/chemokine production in neighboring cells in an IL-1/IL-6-independent manner
- **NEK7 degradation** has the potential to become an important treatment for **inflammation-driven diseases** by inhibiting all aspects of NLRP3 driven inflammation

DAMPs = damage-associated molecular patterns; hsCRP = C-reactive protein

MRT-8102 Has Potential to Serve Significant Market Opportunities Supported by Strong Biological Rationale

Atherosclerotic cardiovascular disease

- **~18.7M** U.S. patient population, with **35%** of patients having had a major ASCVD event (MI, stroke, PAD)
- **~50%** of at-risk patients show **arterial inflammation** through imaging
- **Inflammasome inhibition** provides a novel, upstream approach **that goes beyond downstream IL-6/CRP depletion** to address **residual CVD risk**

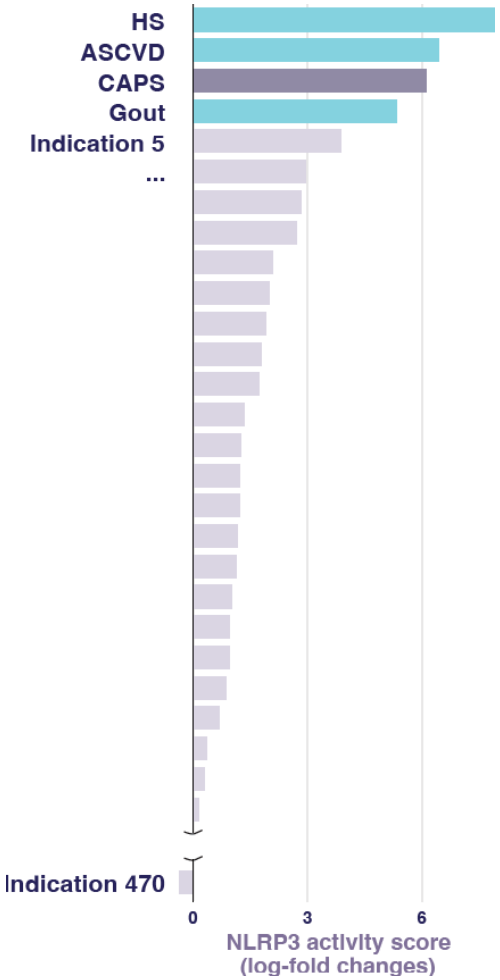
Gout

- **~10M** U.S. patient population, with **~30%** comorbid with stage 3-4 CKD
- Gout SOC therapies are **contraindicated** or **lack safety data** in CKD patients
- High unmet need among **chronic refractory** patients with **breakthrough flares**

Hidradenitis suppurativa

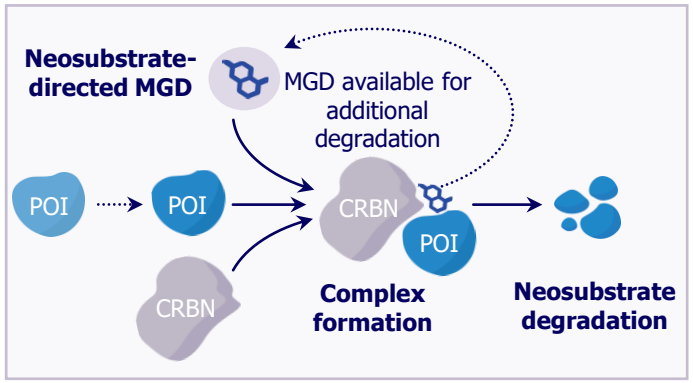
- **~400-450K** U.S. addressable population
- Significant unmet need with **~55%** patients poorly managed with SOC
- High NLRP3 pathway activity in both biologic-naïve HS patients and TNF non-responders

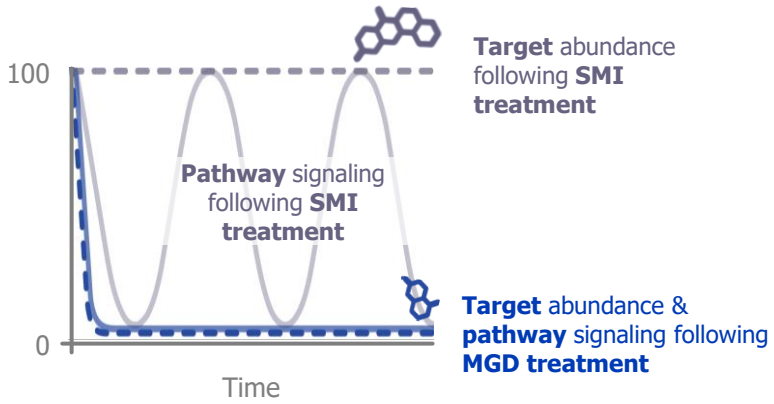
HS, ASCVD, & Gout are top NLRP3-activated indications across 400+ evaluated

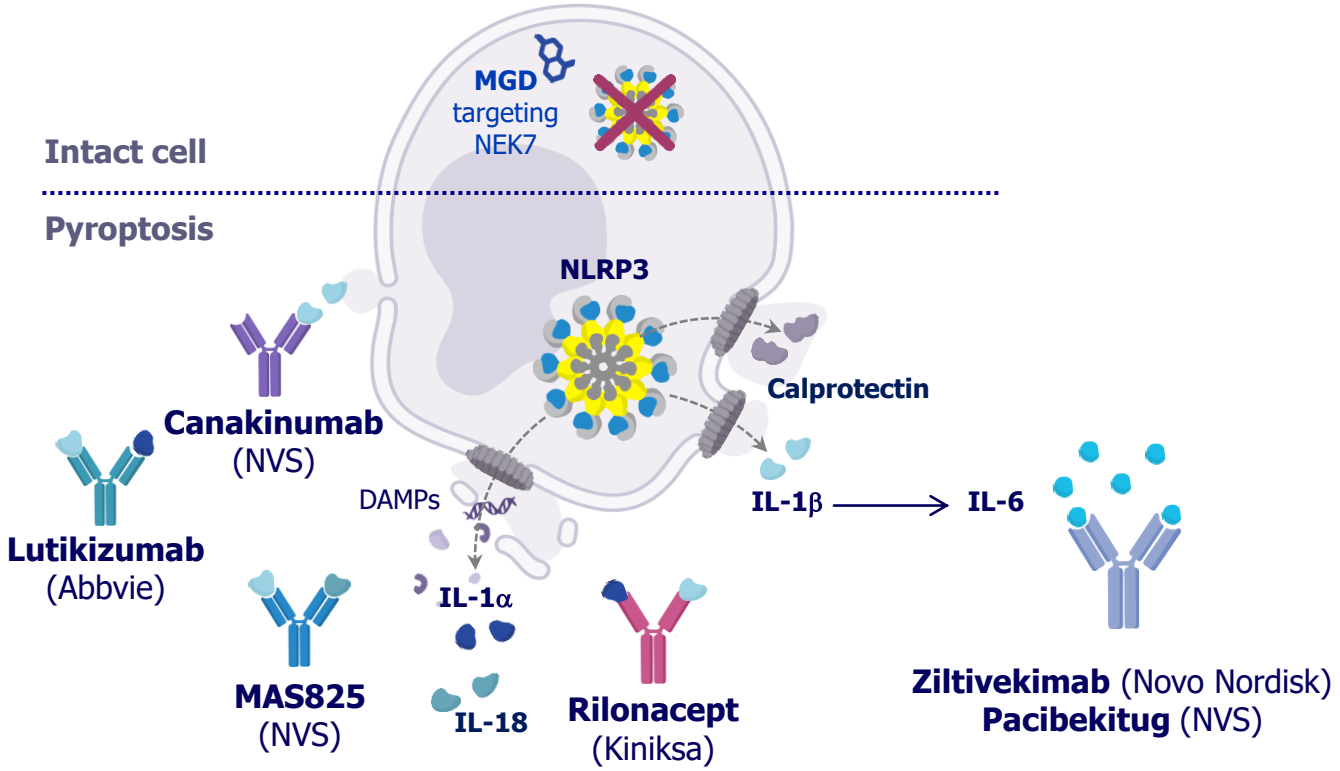


NLRP3 activity scores computed as the mean log fold-change (disease vs. control) from canonical inflammasome gene signatures across 900+ unique RNA-seq datasets (470 diseases, 513,390 patient profiles; oncology and rare diseases excluded).

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

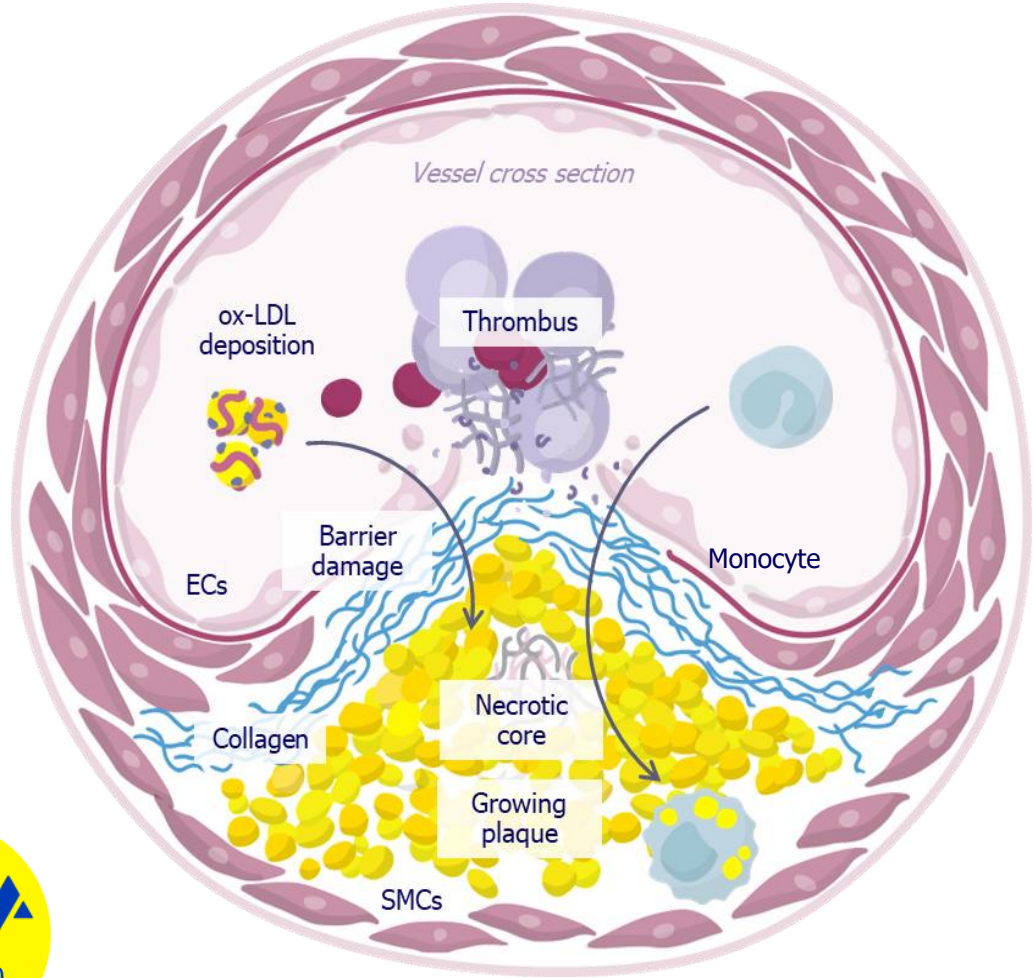
Due to inhibition of NLRP3 assembly, MRT-8102 **prevents pyroptotic cell death-mediated release of inflammatory cytokines and DAMPs** known to drive disease pathology.

Mono- and bispecific biologics fail to inhibit pyroptosis, leading to incomplete blockage of the pathological drivers of disease

DAMP = damage-associated molecular pattern

NLRP3-driven Atherosclerosis and Plaque Instability

The Role of the NLRP3/NEK7 Pathway in ASCVD and Plaque Inflammation



potentially best for therapeutic intervention

Lipid oxidation
Low density lipoprotein (LDL) particles become oxidized (oxLDL) in subendothelial compartment of blood vessels.

Formation of foam cells
Macrophages engulf oxLDLs to become foam cells. High intracellular cholesterol leads to formation of cholesterol crystals (CCs).

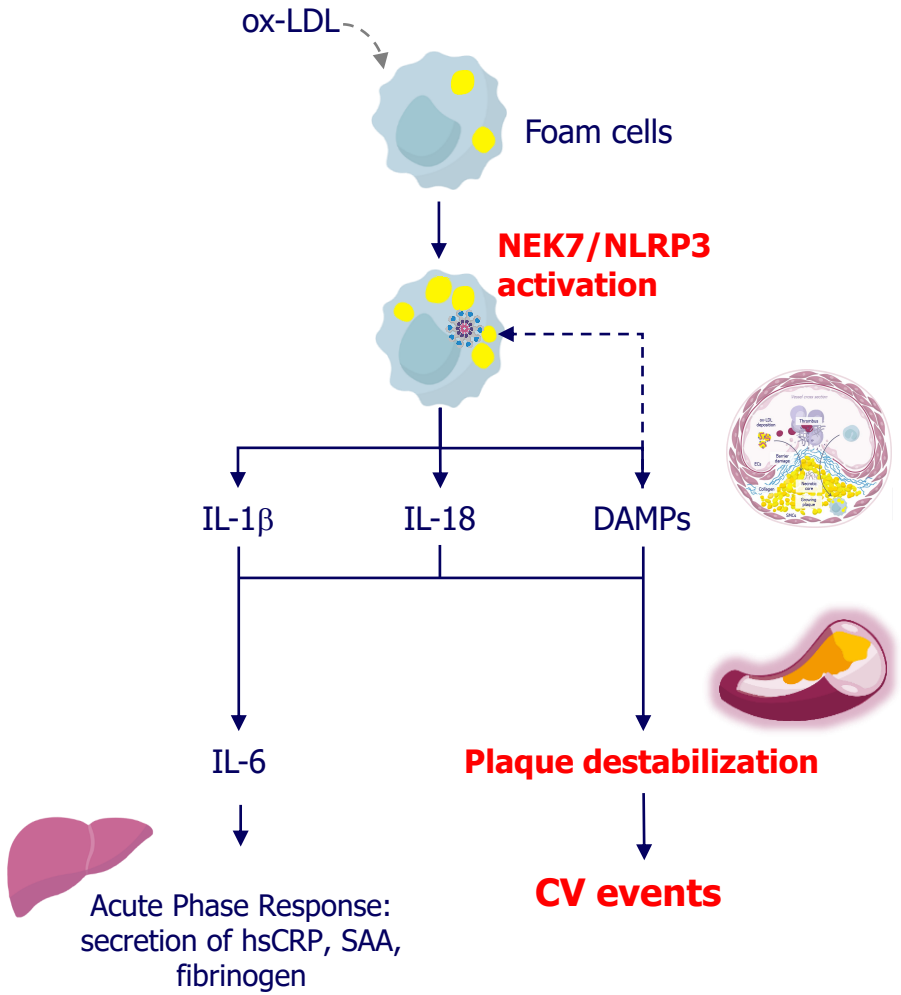
NEK7/NLRP3 activation
CC-mediated lysosomal damage triggers binding of NEK7 to NLRP3 leading to NLRP3 activation.

Local inflammation and plaque growth
NLRP3 triggers pyroptosis, releasing cellular debris, cholesterol, enzymes, IL-1β and other inflammatory factors that collectively destabilize plaques.

Systemic acute phase response
IL-1β induces IL-6; IL-6 boosts production of acute phase response proteins CRP, fibrinogen and SAA in liver.

NEK7 Degradation May Impact Multiple Drivers of Plaque Inflammation, Unlike IL-1β/IL-6 Biologics That Inhibit Single Downstream Nodes

NLRP3 activation in foam cells leads to release of a multitude of inflammatory factors



Upstream therapeutics have potential for broader pathway suppression

Lipid Lowering

Interventions lowering low density lipoprotein (LDL) have been shown to dampen inflammation and achieved significant hazard ratio improvement in outcomes trials, but with significant residual inflammatory risk

NEK7/NLRP3 inactivation

Inhibiting NEK7/NLRP3 inflammasome has the potential to dampen local, NLRP3-driven inflammation by preventing pyroptosis, inhibiting release of inflammatory cytokines/DAMPs, leading to plaque stabilization; colchicine has achieved PoC in two outcomes trials

Blockage of cytokine amplification loop

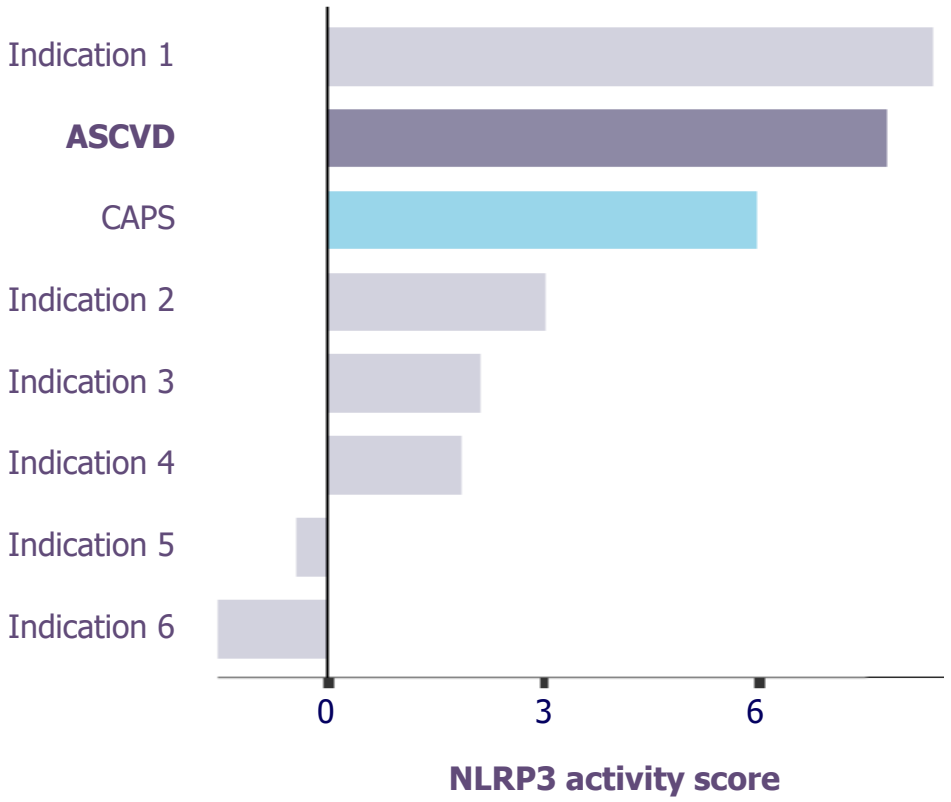
Targeting IL-1β led to positive long-term outcomes in CANTOS trial. Blockage of IL-1β may lead to reduction of local plaque inflammation by partially breaking the IL-1-driven self amplifying loop, but not directly affecting pyroptosis and release of cytokines/DAMPs

Blockage of IL6 and systemic acute phase response

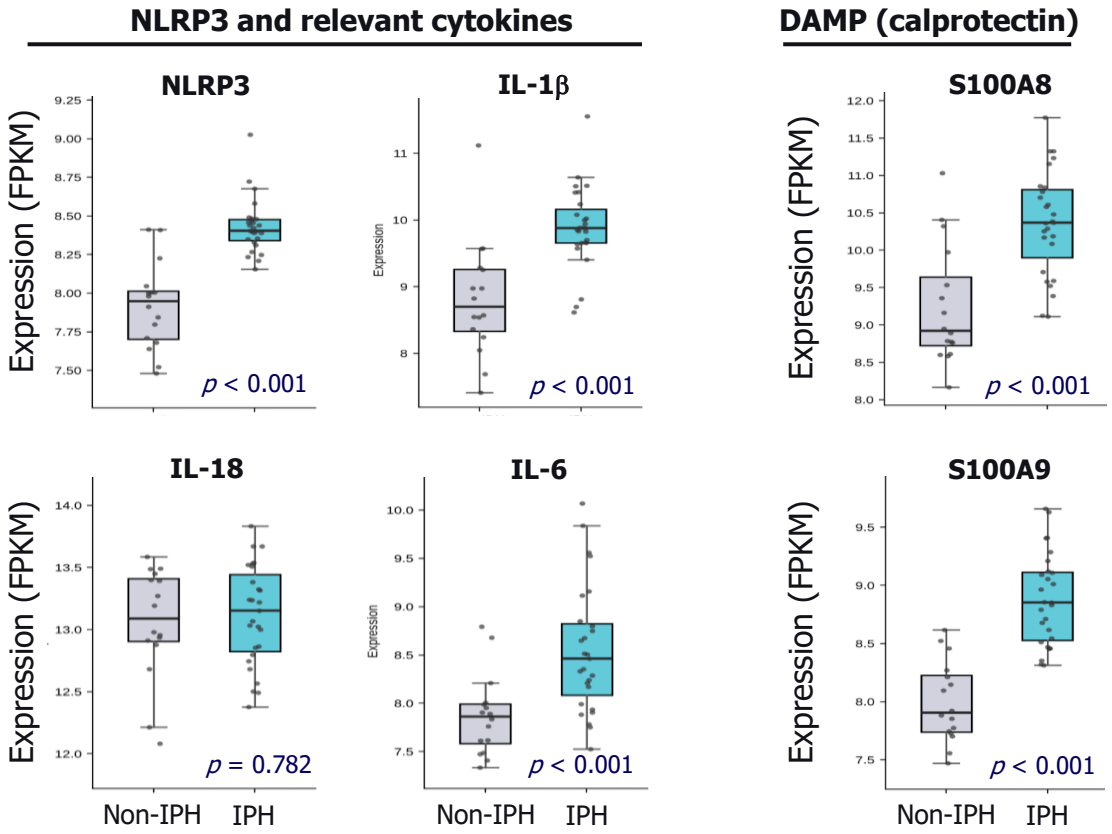
IL-6 boosts production of acute phase response proteins CRP, fibrinogen and SAA in liver, but its role in plaque stabilization has not been demonstrated

NLRP3 Activity and Multiple Downstream Inflammatory Factors Including DAMPs and Cytokines are Significantly Increased in Unstable Plaques

ASCVD ranks amongst top NLRP3 activated indications



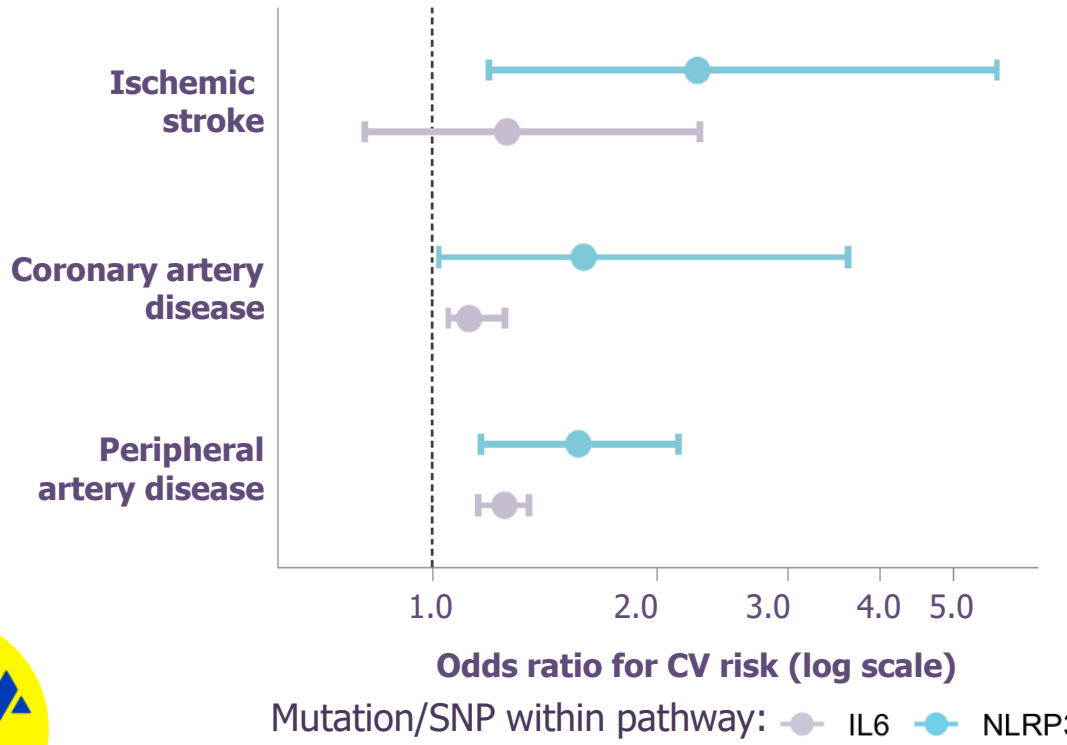
NLRP3, cytokines and DAMPs increased in expression in intraplaque hemorrhage (IPH) vs non-IPH samples



GSE163154: Jin H, Goossens P, Juhasz P, Eijgelaar W et al. Integrative multiomics analysis of human atherosclerosis reveals a serum response factor-driven network associated with intraplaque hemorrhage. Clin Transl Med 2021 Jun;11(6):e458. intraplaque hemorrhage is an instability marker of atherosclerotic plaques.

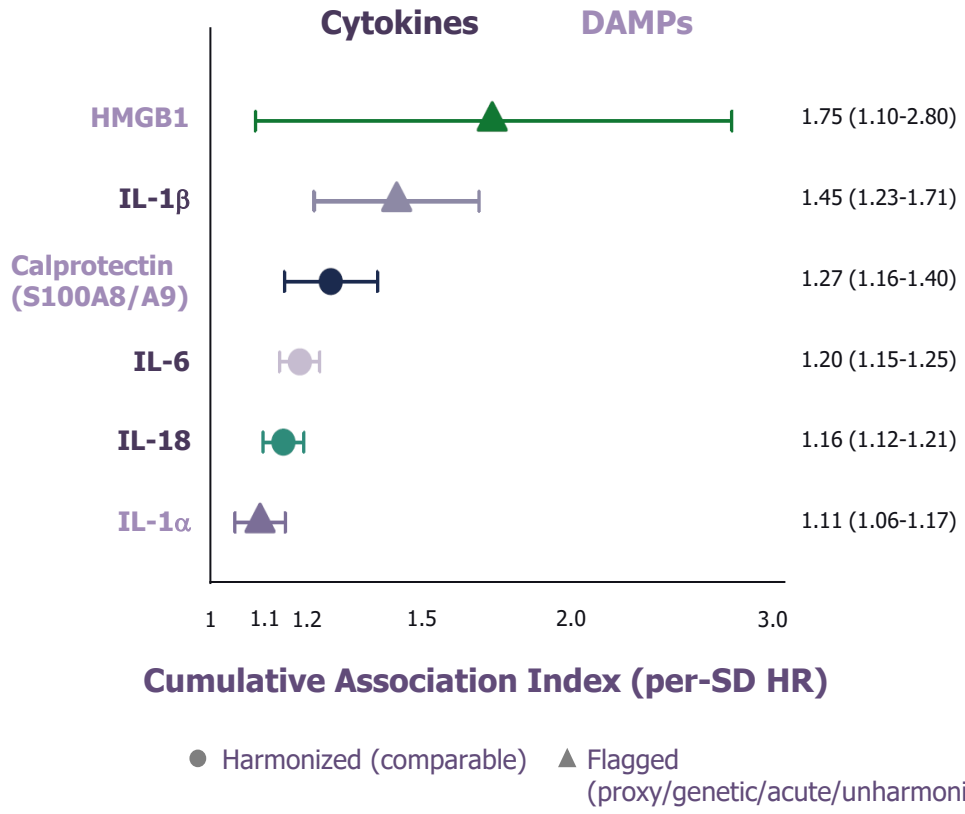
Causal Link Between NLRP3 and Cumulative Cardiovascular Risk is Well Established and Stronger than for IL-6 Alone

Human genetics* supports causal relationship between NLRP3 and ASCVD; weak relationship for IL-6



Point = unweighted mean of contributing study Ors; bar = envelope of contributing 95% CIs

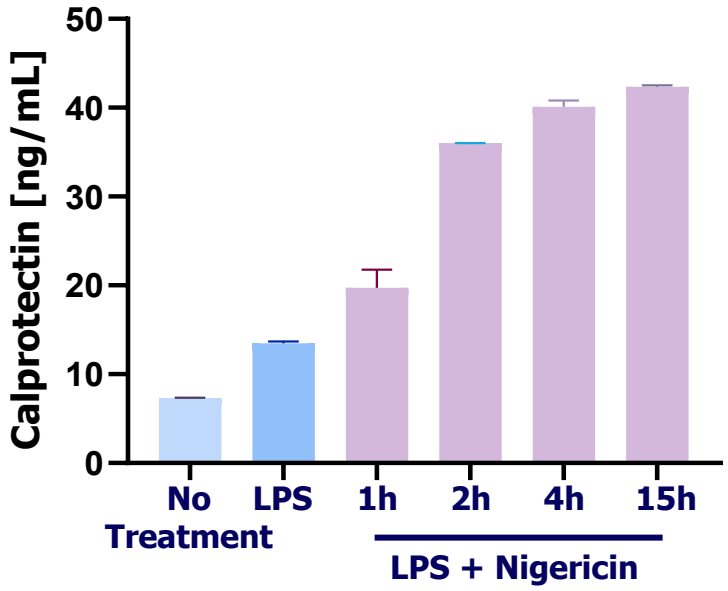
Cumulative CV risk associated with NLRP3-relevant cytokines and DAMPs



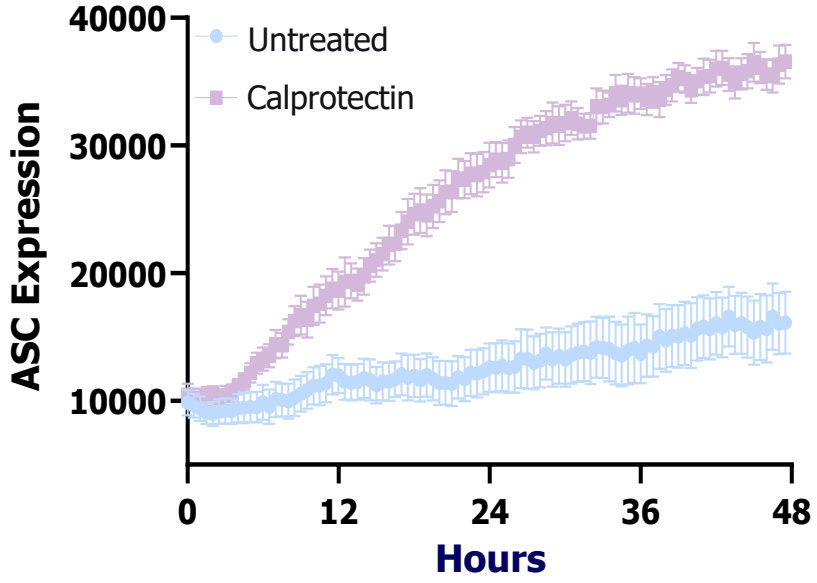
*Left figure: PMID: 33748830, 24026779, 21481392, 32811241, 31584380, 29957458, 39716574, 22421338, 24202303; right figure: PMID: 24026779, 24026779, 29957458, 32811241, 32811241, 32811241, 21481392, 12093765, 31584380, 22421338, 24202303, 24202303, 39716574, 39716574, 32861811, 32861811, 28845751, 29793629, 28845751, 33748830, 33748830, 22369934, 21435605. * Analysis based on Georgakis et al. Circ Genom Precis Med (2020); Zhu Z et al. Cell Mol Neurobiol (2016); Zhang K et al. Research Square (2021); Zhou D et al., BioMed Research International (2016). Odds ratios were directionally harmonized (OR = 1/OR) to display consistent benefit vs harm.*

Calprotectin is a Potent Driver of a Feed-Forward Loop that Further Enhances NEK7/NLRP3 Inflammasome Activity

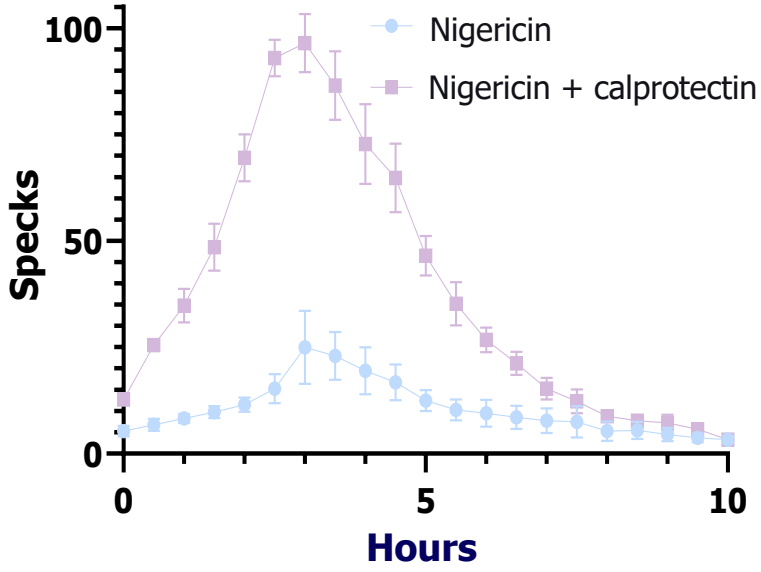
Activation of NLRP3 drives release of soluble calprotectin



Calprotectin enhances expression of inflammasome components*



Calprotectin promotes NLRP3 assembly**



Positive feedback loop between calprotectin release and NLRP3 signaling may amplify local inflammation***

Treatment of THP1 ASC reporter cell line with calprotectin; **Calprotectin pre-treatment followed by co-treatment with nigericin; * Croce et al., Circulation 2009*

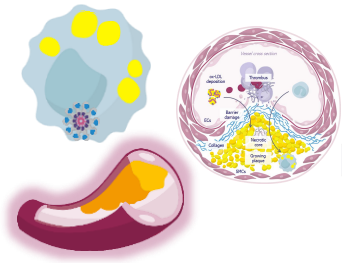
Upstream Targeting of NLRP3 Pathway Has Demonstrated MACE Benefit

Colchicine (NLRP3 modulation) showed MACE benefit of 23-31% across studies; CANTOS (IL-1b modulation) demonstrated 15% benefit

LoDoCo2

- 5,522 pts with **chronic CAD** randomized to **colchicine** or pbo
- Colchicine **reduced MACE by 31%**

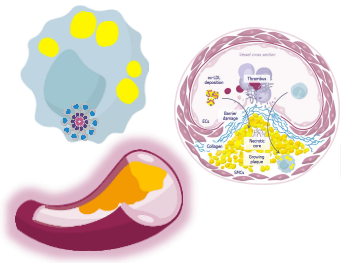
Plaque stabilization NLRP3 inactivation



COLCOT

- 4,745 pts **≤ 30 days post MI** randomized to **colchicine** or pbo
- Baseline median CRP 4.28 mg/L
- Colchicine **reduced MACE by 23%**

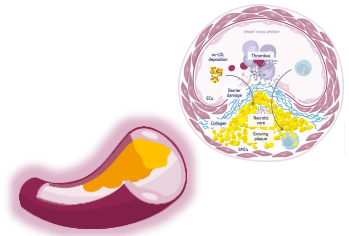
Plaque stabilization NLRP3 inactivation



CANTOS

- 10,061 pts **≥ 30 days post MI** randomized to **canakinumab** or pbo
- Baseline CRP≥2mg/L (median 4.1 to 4.2)
- Canakinumab **reduced MACE by 15%**

Reduction of plaque inflammation through IL1β inactivation



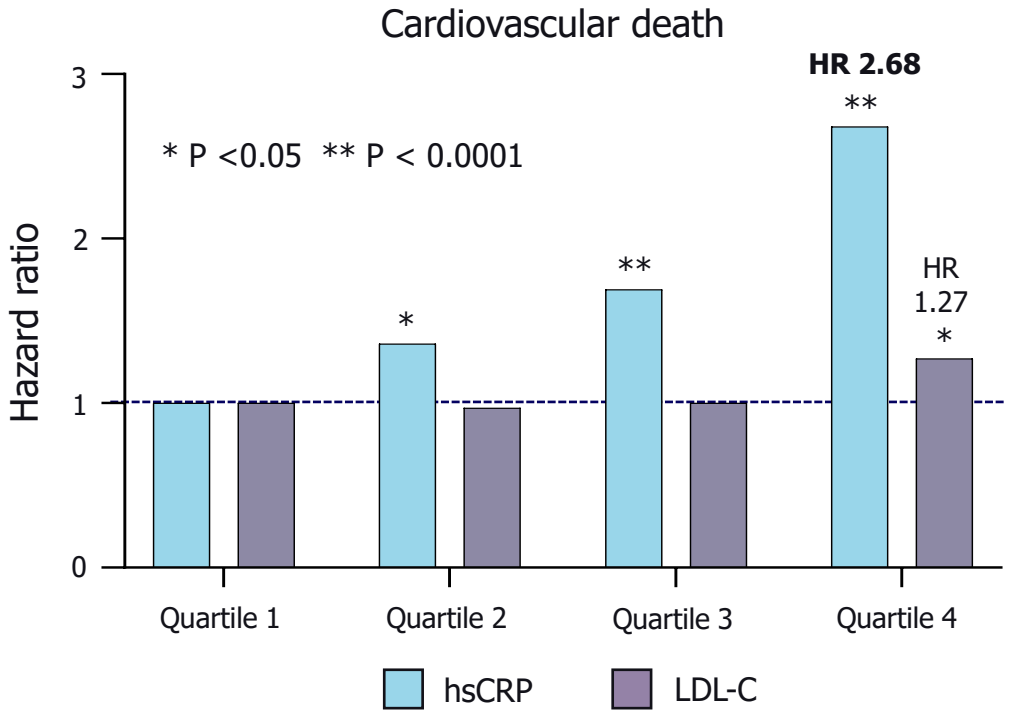
IL-6 modulation (ZEUS study) did not demonstrate MACE benefit

- 6,376 pts with **atherosclerosis and CKD** randomized to **ziltivekimab** or pbo
- Baseline CRP≥2mg/L (median 4.5)
- No effect on MACE

Inhibition of acute phase response mediated by IL6

Note: Lodoco2 MACE defined as CV death, MI, stroke, or revascularization; COLCOT MACE defined as CV death, resuscitated cardiac arrest, MI, stroke, or angina with revascularization; CANTOS and ZEUS MACE defined as CV death, MI, or stroke

CRP is a Validated Risk Factor For Future Cardiac Events and a Valuable PD Marker for Therapies Targeting NLRP3/IL-1 Axis



- **hsCRP unequivocally remains an important risk factor** for ASCVD
- hsCRP is **more predictive of cardiovascular-related deaths than LDL cholesterol** in patients on statins
- hsCRP is an important biomarker for anti-inflammatory drugs – any mechanism impacting plaque inflammation will have to lead to downregulation of hsCRP

However:

- While lowering of hsCRP can be a sign of eliminating plaque inflammation when targeting the NLRP3 pathway upstream, it can also simply be **an indicator of blocking acute phase response in the liver**
- **hsCRP is not a pathogenic protein,** so lowering it through direct (RNAi) or indirect mechanisms (IL-6 antibodies) might not block plaque inflammation

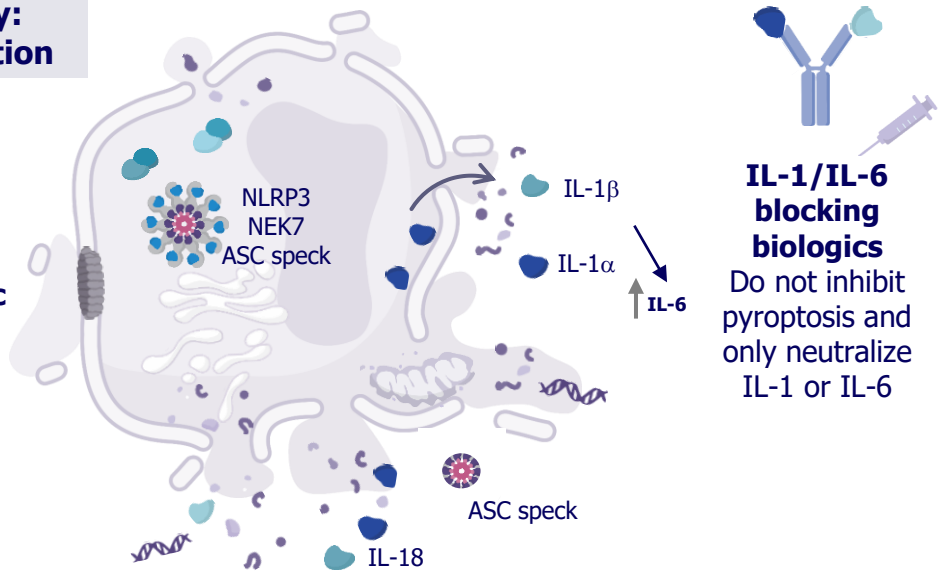
"The evidence linking chronic, low-grade inflammation to the initiation and progression of ASCVD is robust, and several **seminal randomized controlled clinical trials demonstrate that targeting inflammation reduces cardiovascular risk independent of lipid lowering**. We have thus entered an era when the evidence linking inflammation with ASCVD is no longer exploratory but is compelling and clinically actionable."
– American College of Cardiology, 2025

Ridker PM et al. NEJM (2017), Ridker PM, et al. Lancet (2023), Mensah GA, et al. J Am Coll Cardiol. (2025)

MRT-8102 Preclinical Profile

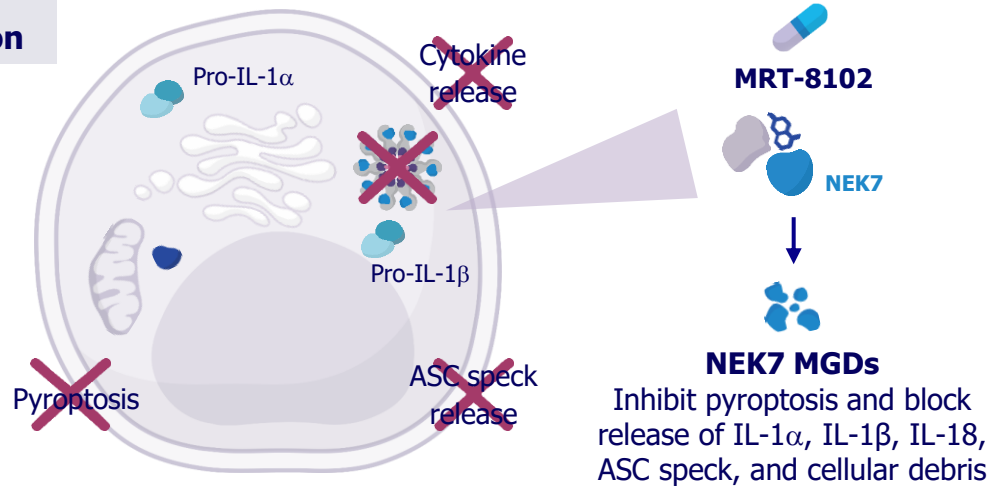
MRT-8102 Potently Inhibits Pyroptotic Cell Death, Unlike IL-1/IL-6 Biologics

IL-1/IL-6 Therapy: Reduced Inflammation

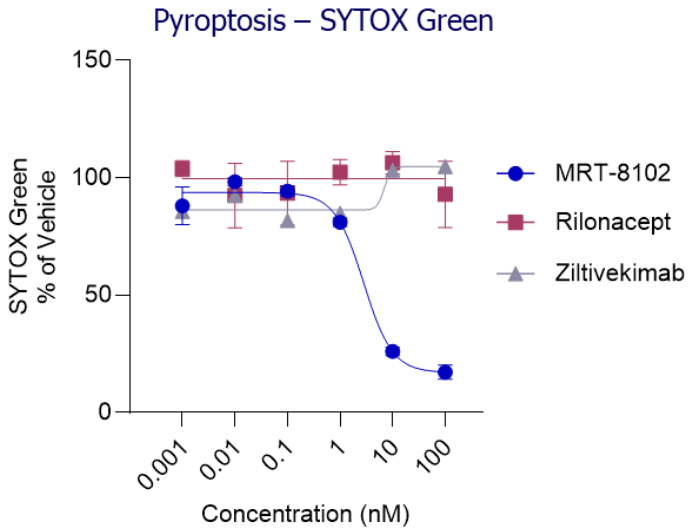


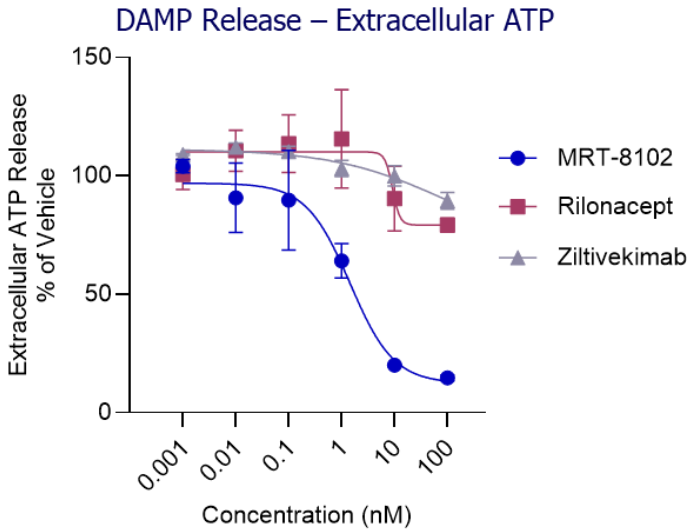
IL-1/IL-6 blocking biologics
Do not inhibit pyroptosis and only neutralize IL-1 or IL-6

NEK7 Therapy: Aborted Inflammation



NEK7 MGDs
Inhibit pyroptosis and block release of IL-1α, IL-1β, IL-18, ASC speck, and cellular debris

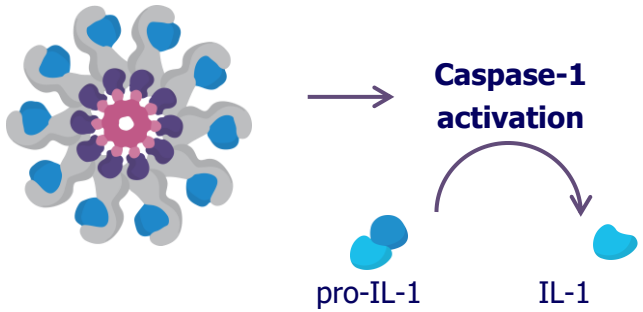




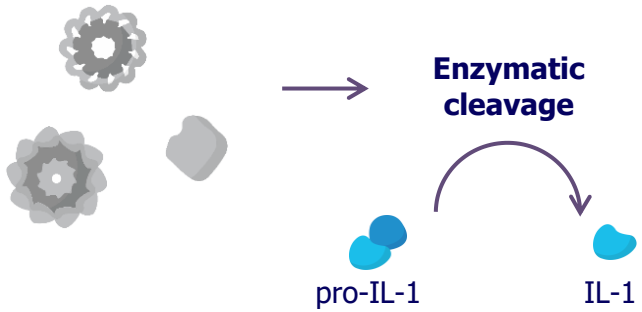
DAMP = damage-associated molecular pattern
LPS + Nigericin stimulation in hMDM (human monocyte-derived macrophages)

MRT-8102: Immune Profiling Predicts Lower Risk of Infection than anti-IL-1 Therapies

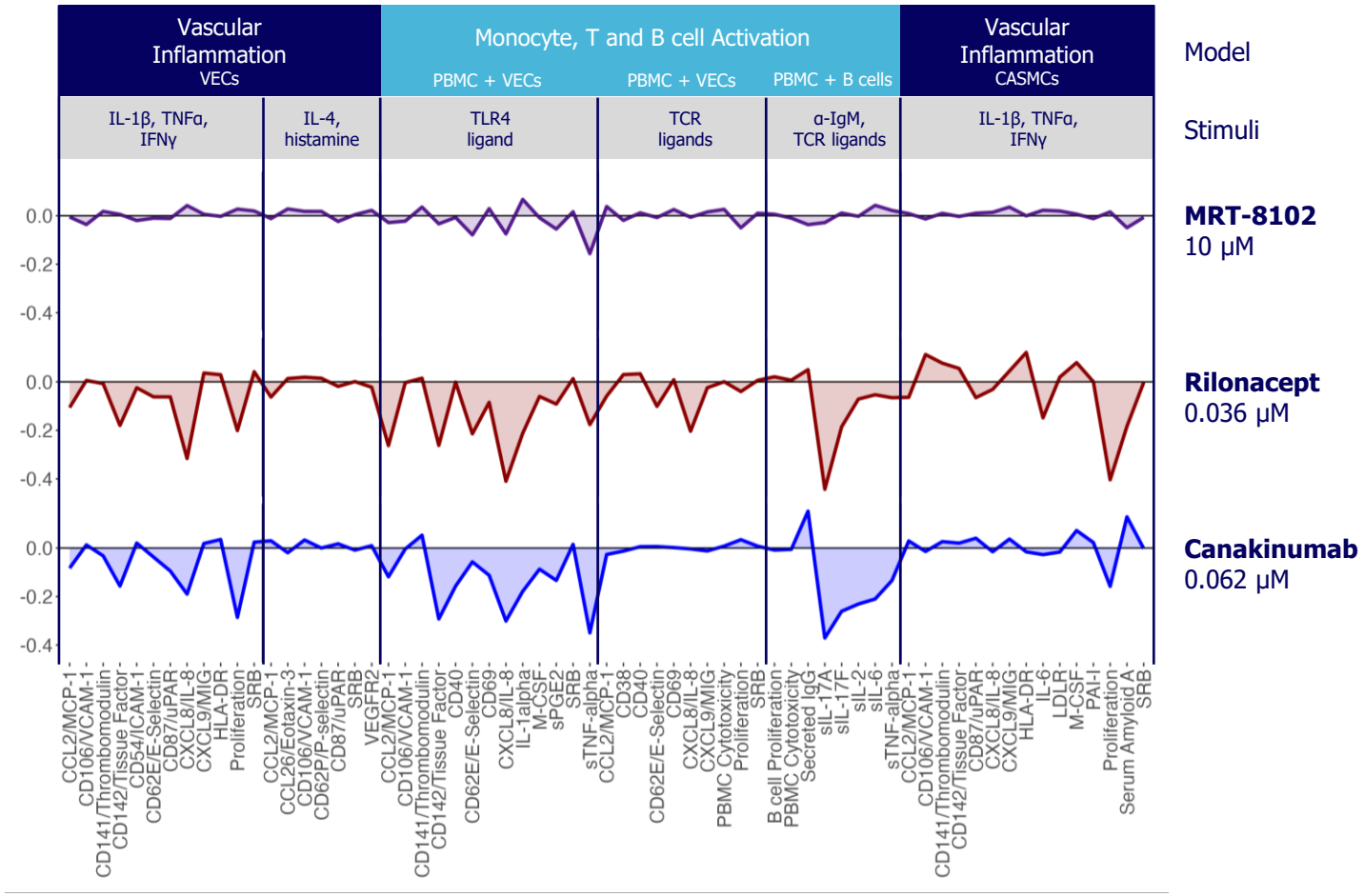
MRT-8102 targets only NLRP3/NEK7 inflammasome activation-mediated IL-1 release



Multiple enzymes and inflammasomes drive IL-1 release in NLRP3-independent manner



NLRP3-independent IL-1 inhibition is immunosuppressive across multiple stimuli

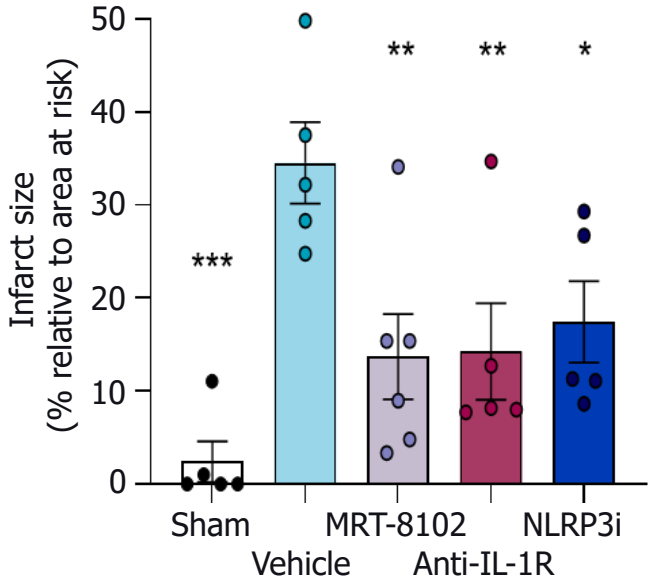


BioMAP® Diversity Plus Platform (Eurofins). Venular endothelial cells (VECs), peripheral blood mononuclear cells (PBMCs), coronary artery smooth muscle cells (CASMCs). Shark tooth plots show relative expression levels of indicated proteins in Drug treated vs. DMSO controls.

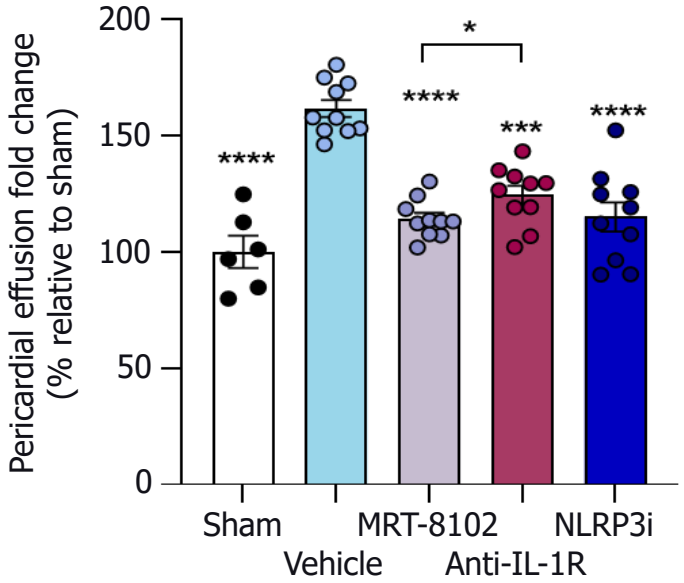
NEK7 Is Critical for a Broad Set of NLRP3-mediated Inflammatory Diseases In Preclinical Models

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

Prophylactic treatment in acute myocardial infarction (AMI) model

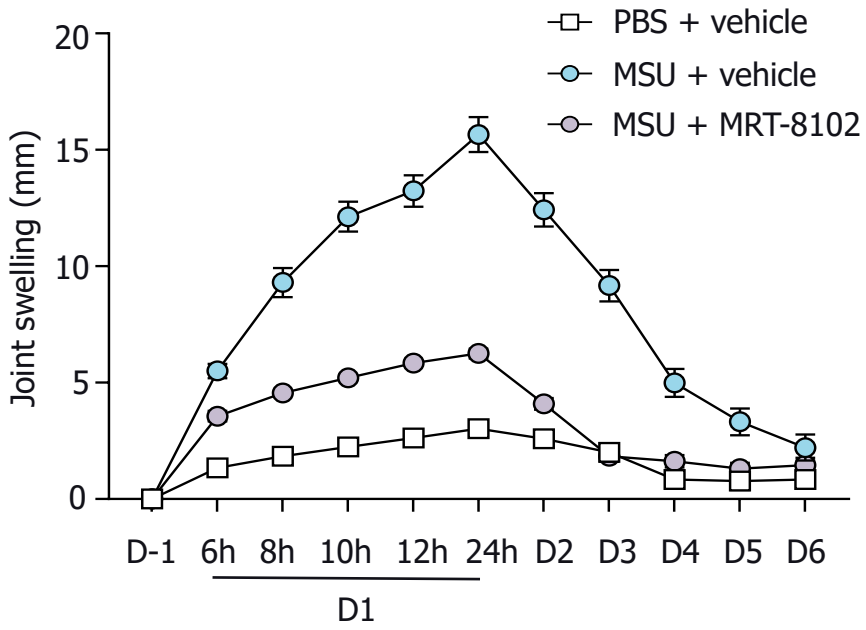


Prophylactic treatment in acute pericarditis model



Rabbit: MRT-8102 reduced MSU-induced gout flare

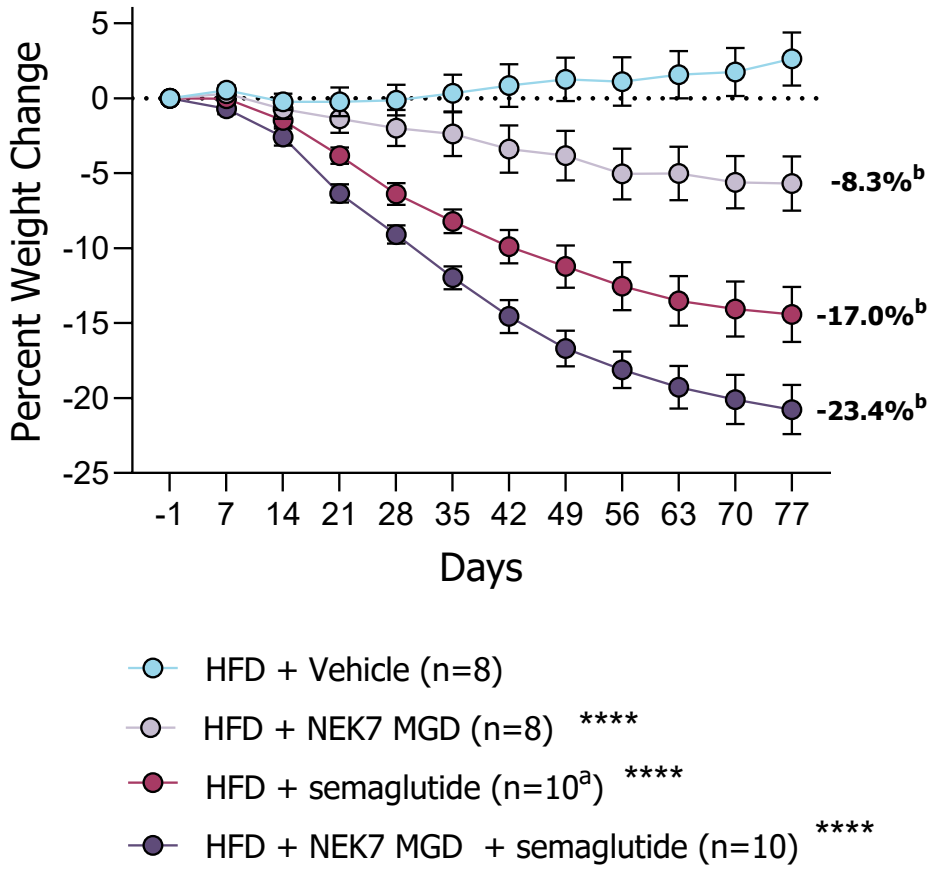
Prophylactic treatment in acute gout flare model



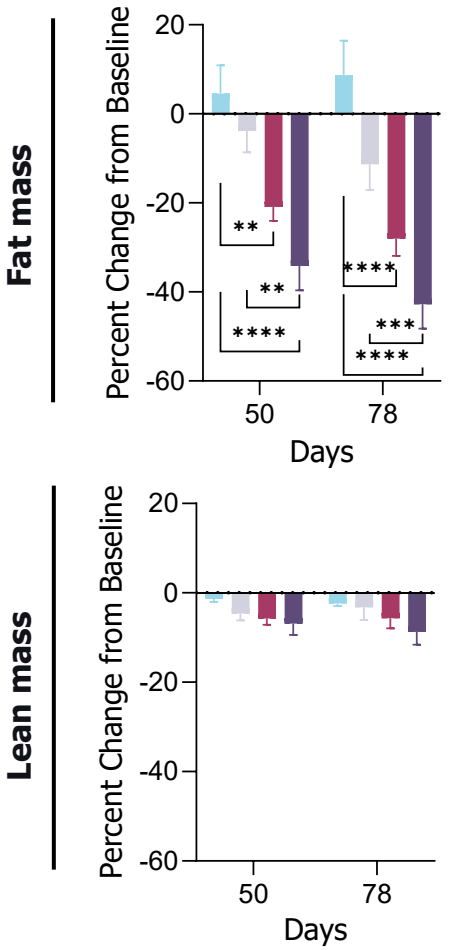
Mouse AMI (left): Coronary arterial ligation followed by reperfusion; CRBN^{I391V} mice; mouse pericarditis (middle): Zymosan injection to pericardium; CRBN^{I391V} mice; NLRP3i = MCC950; rabbit gout (right): Daily dosing from day -1; intra-articular injection of MSU on day 0; Statistics for MRT-8102- vs Vehicle-treated: Day 1, 6h - Day 4: *** p<0.001; Day 5: ** p<0.01; Day 6: * p<0.05

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

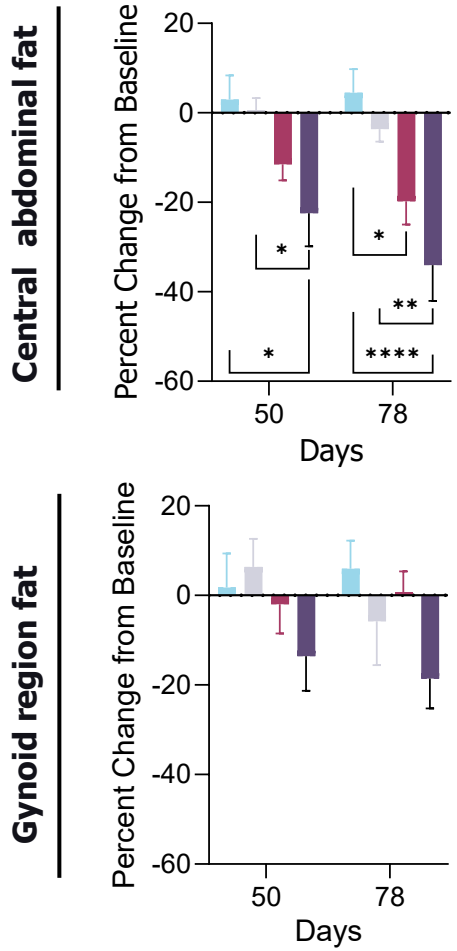
Cynomolgus monkey: NEK7 MGD promoted body weight loss alone and with semaglutide



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; [a]n=9 from Day 56 onwards; [b]Body weight decrease relative to vehicle. [c]DEXA (dual-energy X-ray absorptiometry) body composition analysis performed under anesthesia. 2-Way ANOVA with Šídák's multiple comparisons test. *P ≤ 0.05; **P ≤ 0.01; *** P ≤ 0.001; ****P ≤ 0.0001.

Favorable Preclinical Safety Profile with Wide Therapeutic Window

In a 3-month cyno toxicology study:

- No test article-related findings were observed
- NOAEL was determined as the highest dose tested, yielding a ~200-300-fold therapeutic index over the projected human efficacious dose
- No MRT-8102 related clinical signs were reported
- No changes in immunophenotyping were observed
- No gross or clinical pathology findings at any dose level tested were recorded

NOAEL = No Observed Adverse Effect Level

GFORCE-1 Study: Interim Results

Summary of Interim Results of Phase 1 Study

- MRT-8102, a NEK7-directed molecular glue degrader (MGD), induced rapid and compelling reduction in hsCRP across all doses tested in both healthy volunteers and high-CVD risk subjects (112 subjects in total)
- SAD (48 healthy volunteer subjects) and MAD (40 healthy volunteer subjects) cohorts completed with no adverse safety signals
    - MRT-8102 was dosed from 5 – 400mg (SAD: 40 – 400mg; MAD: 5 – 200mg) and data suggest maximum activity achieved from lowest dose level (5mg MAD)
    - ~80-90% NEK7 degradation noted in T cells at all dose levels tested
    - 78% reduction in hsCRP achieved in subjects with elevated baseline CRP levels after both single and multiple dose administration
    - Favorable AE profile with no adverse safety signal observed as of data cut off date of 12/23/25; safety profile further supported by 3 mos. results of ongoing cyno tox study showing NOAEL ~200-300-fold over projected human efficacious dose
- Part 3 (CRP PoC) of Phase 1 study exploring 40 mg MRT-8102 in high-risk CVD subjects (obesity/elevated CRP) is ongoing and 24 subjects have been evaluated up to end of week 4. Preliminary data for these subjects showed:
    - 85% sustained reduction of hsCRP through end of week 4
    - 94% subjects achieved reduction of hsCRP levels to <2 mg/L* after 4 weeks of dosing (baseline hsCRP level of 6.3 mg/L)
    - 31% reduction of fibrinogen after 4 weeks of dosing
    - No SAEs, no severe AEs as of data cut off date of 12/23/25, evaluation ongoing
- Study (now named GFORCE-1) will be expanded and additional dose levels will be explored to accelerate development in ASCVD; data expected in H2 2026
- Early hsCRP results continue to support MRT-8102 development across chronic inflammatory diseases such as ASCVD and MASH
    - hsCRP reduction data compares favorably to previously reported third party data on NLRP3 inhibitors in development and canakinumab (IL-1β antibody) and is on par with IL-6 biologics**

NOAEL, no observed adverse effect level
hsCRP, high-sensitivity C-reactive protein
*hsCRP levels of >2 mg/L are associated with elevated CVD risk
**Comparison not based on head-to-head studies

MRT-8102 Phase I Study – Dose Levels and Endpoints Reported in Interim Readout

Primary endpoint

- Safety and tolerability

Key secondary & exploratory endpoints

- PK (blood +/- CSF)
- NEK7 degradation
- Change in CRP level
- IL-6 (blood and CSF)
- Fibrinogen
- Ex-vivo: IL-1β

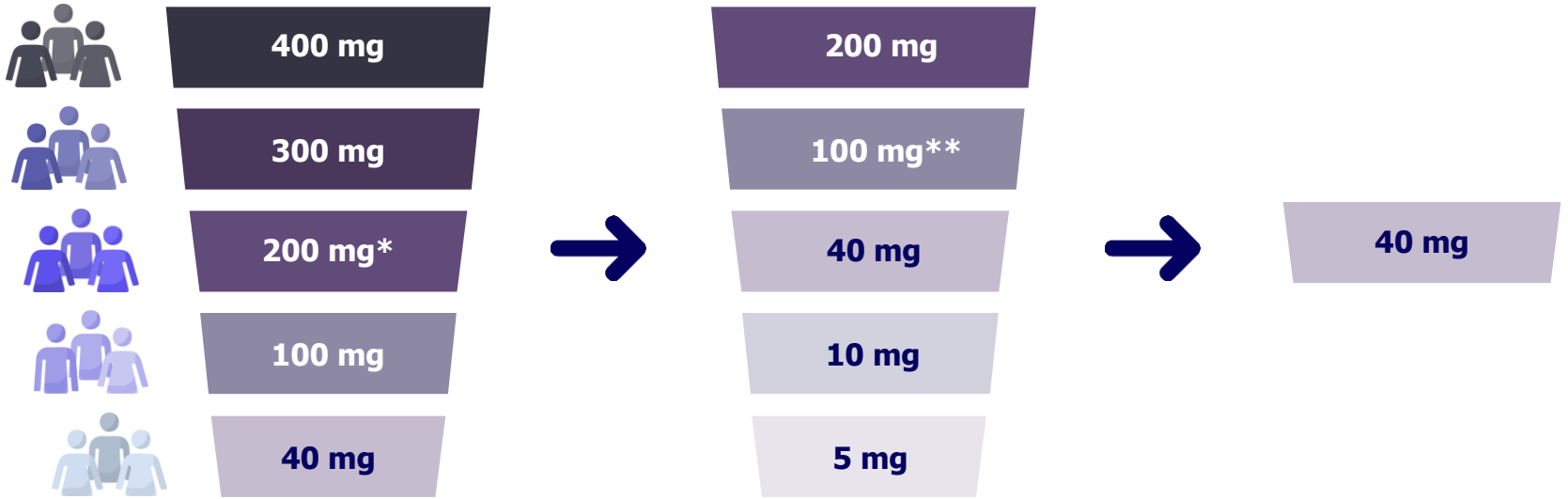
SAD cohorts (Part 1)
One oral dose
48 participants

MAD cohorts (Part 2)
7 daily oral doses
40 participants

CRP PoC in elevated CVD risk subjects (Part 3)
28 daily oral doses
~36 participants

All cohorts randomized, placebo controlled (6+2)

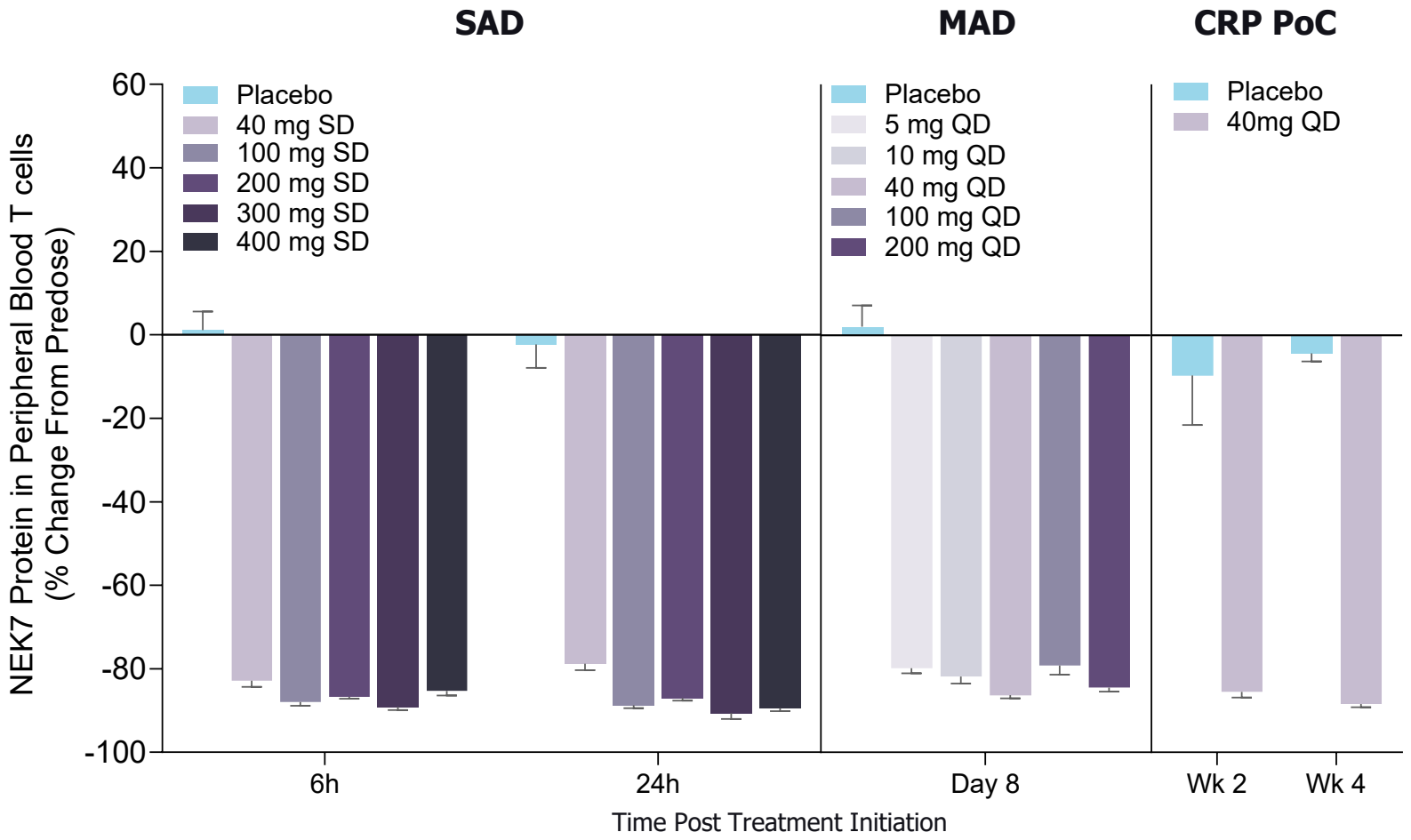
Cohort randomized 3:1 treatment vs placebo



Data cutoff December 23, 2025

* Additional subjects included in 200mg cohort due to sample processing issues; hence a total of 16 subjects have been enrolled in 200mg SAD dose level
**CSF collection

MRT-8102 Achieved 80 – 90% NEK7 Degradation in Peripheral Blood T Cells After Single and Multiple Dose Administration



Rapid and robust degradation of NEK7 noted in peripheral blood T cells **(~80 - 90%)** across all dose levels, consistent with preclinical findings

SAD – 48 subjects (placebo + MRT-8102); MAD - 40 subjects (placebo + MRT-8102); CRP PoC – 16 subjects (placebo + MRT-8102), data delivery pending for remaining 8 subjects.
Data are shown as Mean ± SEM. Day 8, week 2 and week 4 values shown are determined 24h post last dose.

SAD/MAD Data Demonstrated Favorable MRT-8102 Safety/Tolerability

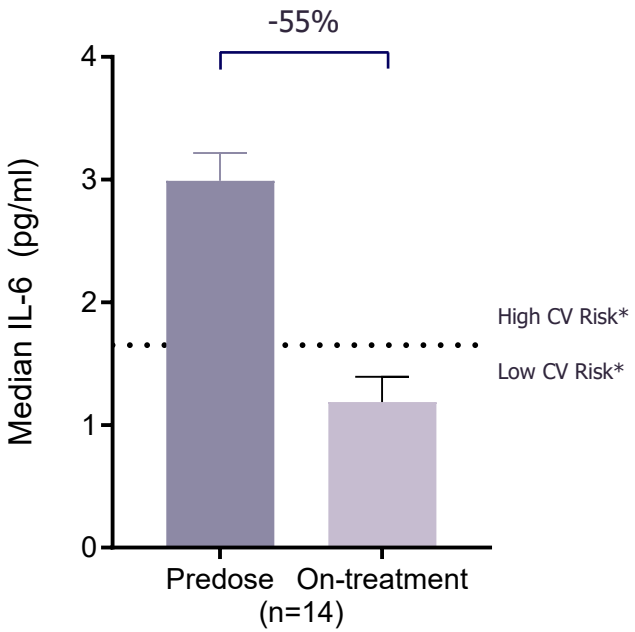
- Total of 88 participants treated in SAD/MAD cohorts (SAD, 48; MAD, 40)
- No SAEs reported and no treatment-emergent AEs > grade 2 in SAD/MAD
- MRT-8102 reported treatment-emergent AEs in 29% participants; placebo reported treatment-emergent AEs in 32% participants
    - Most frequent treatment-emergent AE was headache, reported in 9% of participants treated with MRT-8102 and 9% of participants treated with placebo

Data support broad therapeutic index for MRT-8102

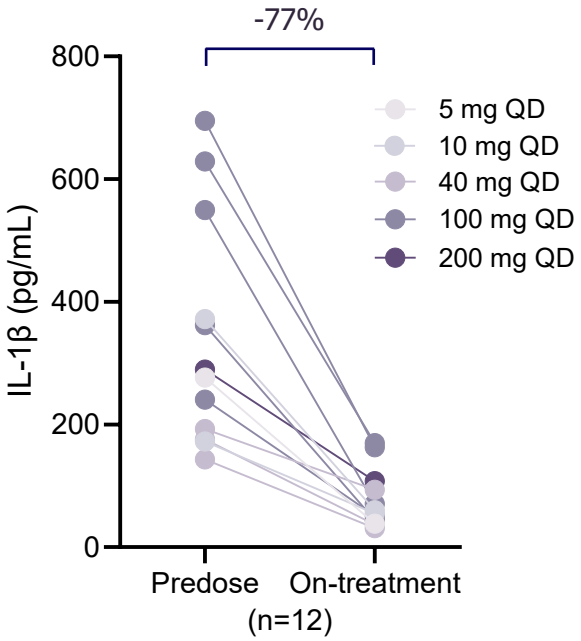
Note: One participant in Part 3, still blinded, was diagnosed with asymptomatic, acute infectious hepatitis A while on study (unknown if participant received MRT-8102 or placebo). Participant experienced a transient ALT elevation equivalent to a Gr 3 that improved while on treatment.

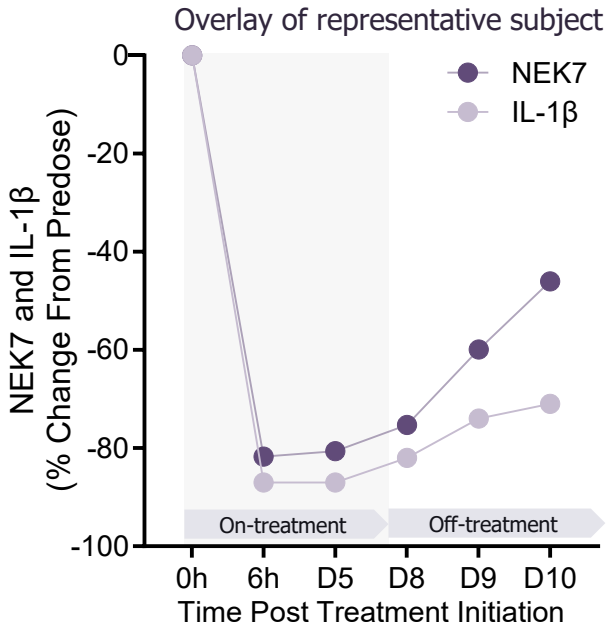
Multiple Daily Doses of MRT-8102 Led to Reductions of IL-6 and IL-1β

55% reduction of endogenous IL-6 plasma levels
Baseline CRP ≥1 mg/L



Rapid and sustained reduction of IL-1β after ex-vivo stimulation
Baseline CRP ≥1 mg/L





Significant reduction in median IL-6 levels to below CV risk threshold noted in subjects with elevated CRP

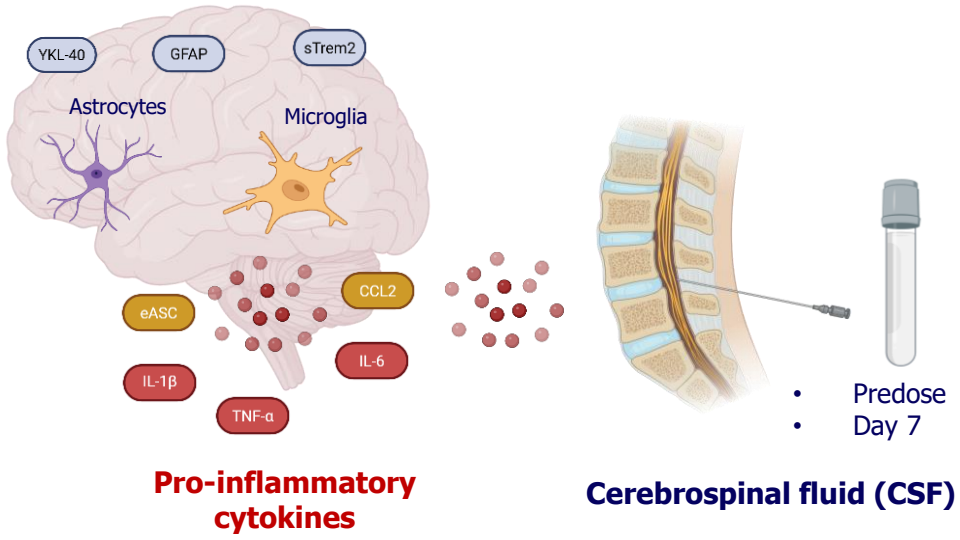
~80% inhibition in IL-1β secretion noted in subjects with elevated CRP at baseline at doses ranging from 5 – 200 mg

Suppression in IL-1β secretion correlates with NEK7 degradation across all time points

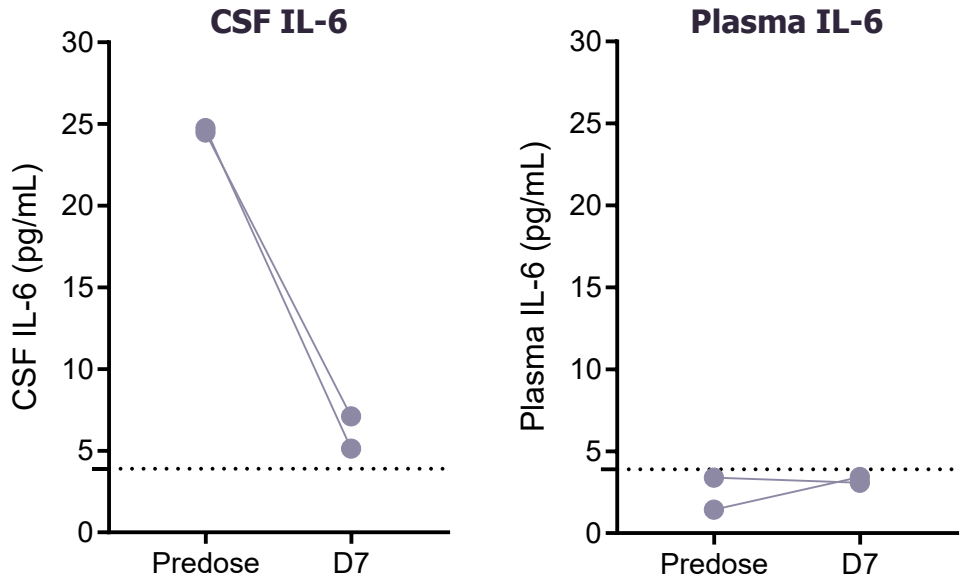
* Ridker PM et al. European Heart Journal (2018)

MRT-8102 Treatment Reduced IL-6 Levels in CSF Consistent with CNS Penetration

Cerebrospinal fluid (CSF) collection
(100 mg QD)



75% reduction of CSF IL-6
in 2 subjects with elevated levels at baseline



100 mg dose achieved levels of MRT-8102 in CSF consistent with pharmacologically active concentrations

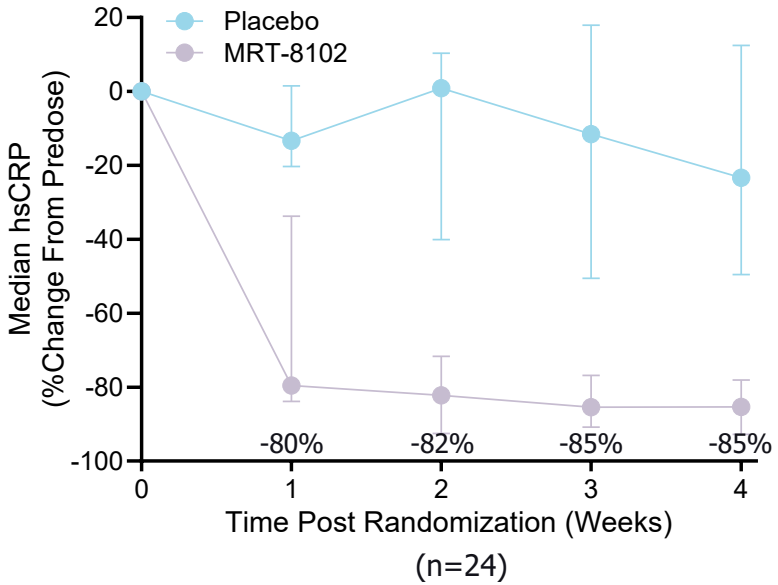
Significant decrease in CSF IL-6 noted in two subjects with elevated baseline levels following 7d administration

Plasma IL-6 levels at baseline for these two subjects were low suggesting CNS/CSF-specific effects

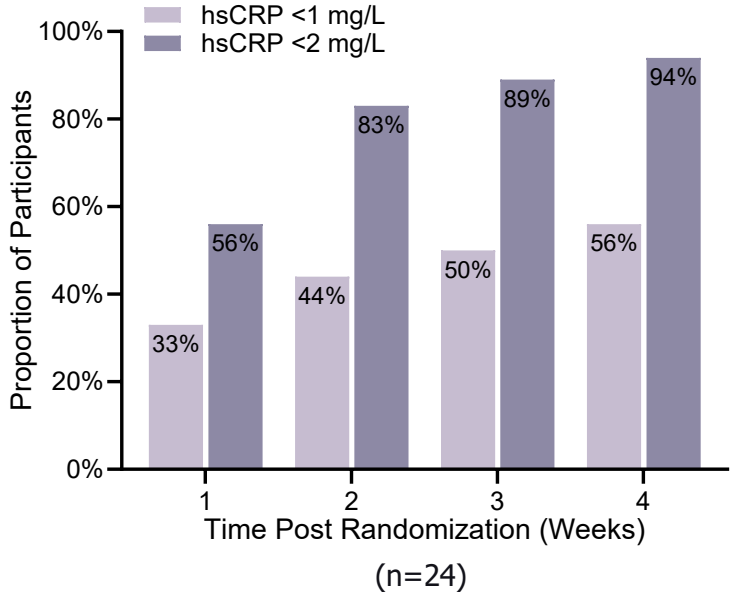
Dotted line indicates median established with CSF and plasma samples derived from healthy volunteers (n=20)

Interim Analysis of 40 mg Cohort Shows Rapid Reductions of hsCRP and Fibrinogen, Suggestive of Deep Upstream Pathway Block

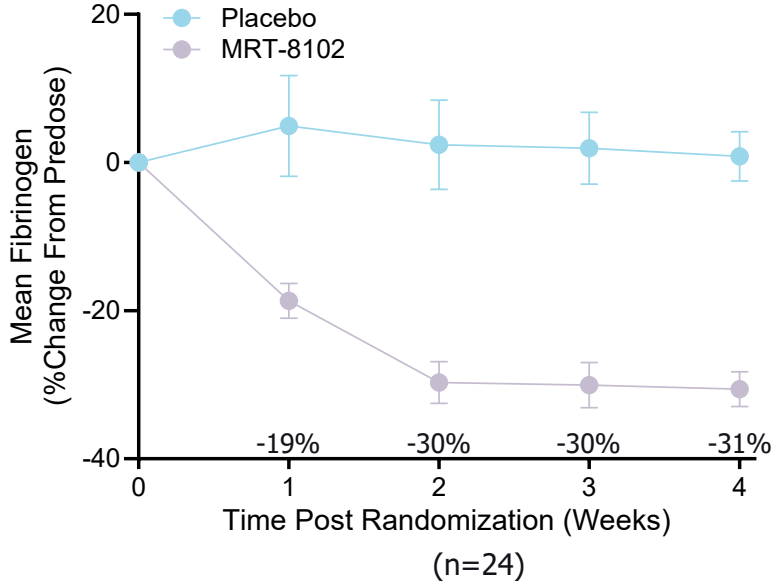
85% decrease of hsCRP after 4 weeks of dosing



94% of subjects show suppression of hsCRP to <2 mg/L*



Up to 31% reduction in fibrinogen after 4 weeks of treatment



85% reduction in CRP noted after 4 weeks of dosing that correlated well with sustained NEK7 degradation during the treatment period

94% of subjects show suppression of hsCRP to <2 mg/L after 4 weeks of dosing

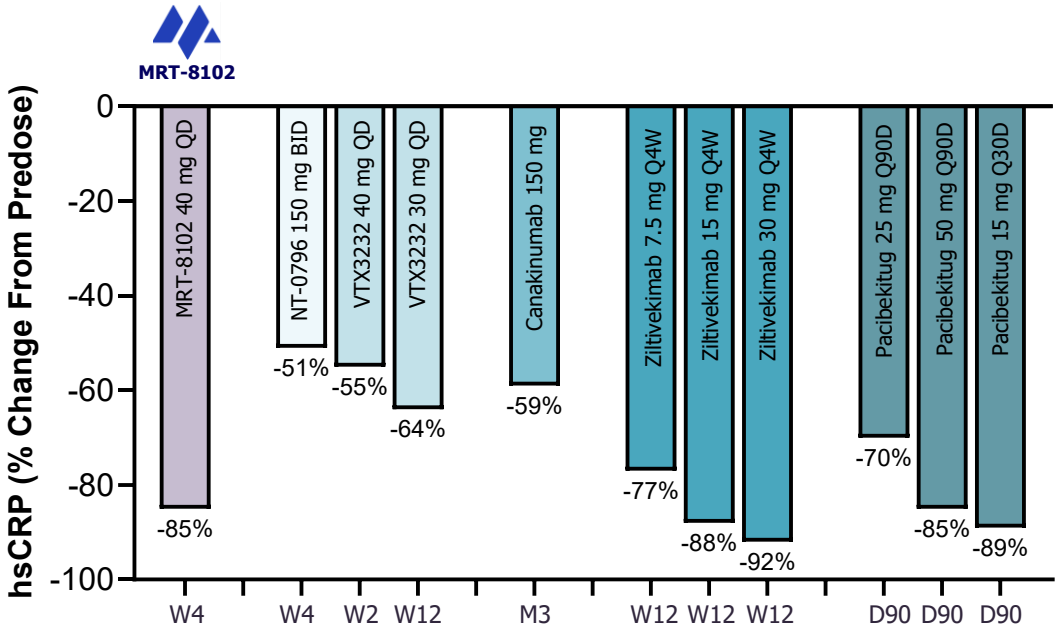
Up to **31%** reduction in fibrinogen, an independent atherosclerotic risk factor**, noted during treatment period

* Baseline median CRP: Placebo - 4.0 mg/L; MRT-8102 - 6.3 mg/L; Baseline mean Fibrinogen: Placebo - 394 mg/dL; MRT-8102 – 431 mg/dL

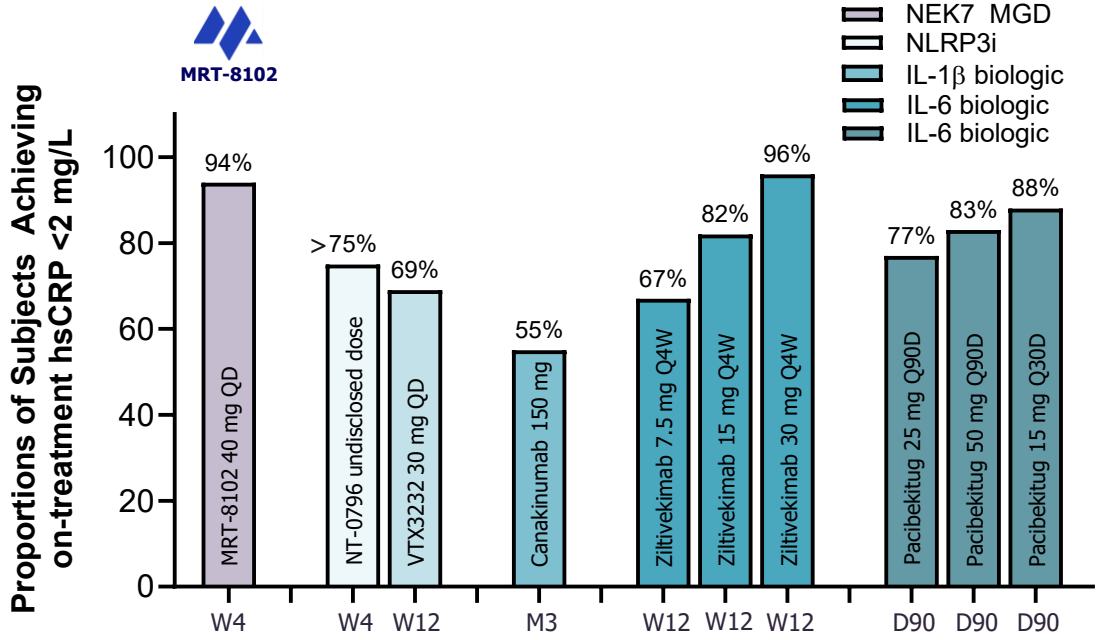
** Meade TW et al. Lancet (1986); Kannel WB et al. JAMA (1987); Fibrinogen Studies Collaboration, JAMA (2005)

MRT-8102 Induces Class-Leading Pathway Modulation

MRT-8102 suggested favorable reduction of hsCRP compared to other inflammasome and IL-6 targeted agents in development



MRT-8102 achieved favorable rates of hsCRP <2 mg/L compared to other inflammasome and IL-6 targeted agents



MRT-8102 data compares favorably to data reported for NLRP3 inhibitors and appears on par with data reported for IL-6 antibodies

MRT-8102 provides convenience of oral route of administration

MRT-8102 may also provide potential advantage of inhibiting pyroptotic cell death and hence have a superior effect on local inflammation and plaque stabilization in ASCVD

NT-0796 – Clarke N et al. Anti-Neuroinflammatory and Anti-Inflammatory Effects of the NLRP3 Inhibitor NT-0796 in Subjects with Parkinson's Disease. Movement Disorders 2025; Nodthera Press Release June 2024 for Obese Subjects with Cardiovascular risk; **VTX3232** – Ventyx Corporate Presentation August 2024 for HV and Ventyx Press Release October 2025 for Subjects with Obesity and Cardiovascular Risk Factor (CRP reduction from FAS, CRP <2 mg/L from MAS); **Canakinumab** - Ridker PM et al. Antiinflammatory Therapy with Canakinumab for Atherosclerotic Disease. NEJM 2017; Ridker PM et al. Relationship of C-reactive protein reduction to cardiovascular event reduction following treatment with canakinumab: a secondary analysis from the CANTOS randomized controlled trial. Lancet 2018; **Ziltivekimab** - Ridker PM et al. IL-6 inhibition with ziltivekimab in patients at high atherosclerotic risk (RESCUE): a double-blind, randomized, placebo-controlled, phase 2 trial. Lancet 2021; **Pacibekitug** - Tourmaline Bio Phase2 TranQuility Trial Topline Results May 2025. W –week; M –month; D –day.

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.

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

Study population

- Obesity (waist ≥ 40" for men or ≥ 35" for women and/or BMI ≥ 30)
- Elevated CRP ≥3 and <15 mg/L

Primary endpoint

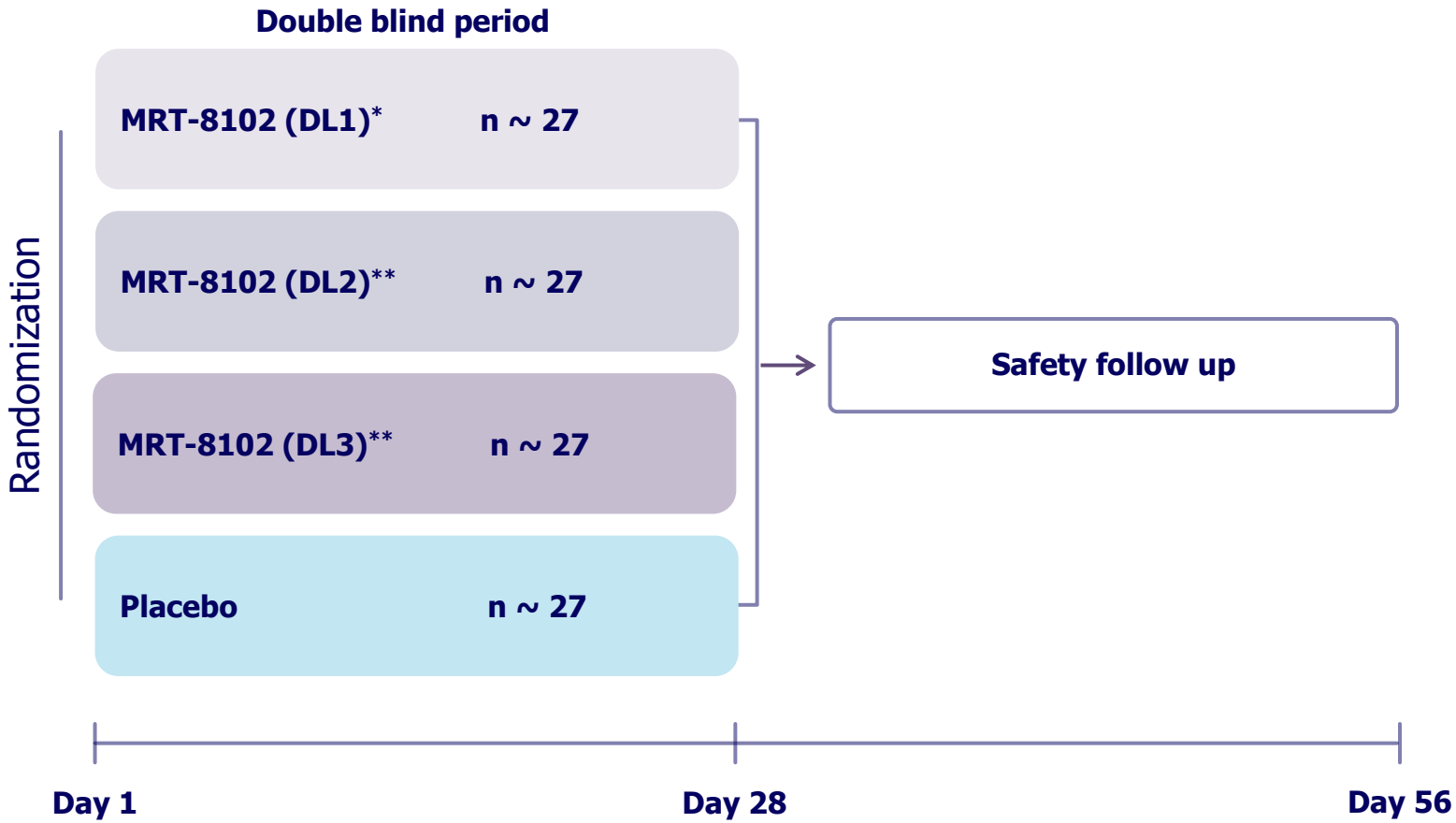
- Safety and tolerability of 28 days dosing

Secondary endpoints

- Change in CRP levels
- PK

Exploratory endpoints

- PD (NEK7, IL-6, IL-18, Fibrinogen, SAA)
- Body weight
- Other markers of CV risk



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

Expanded dose exploration to accelerate subsequent Phase 2 ASCVD study

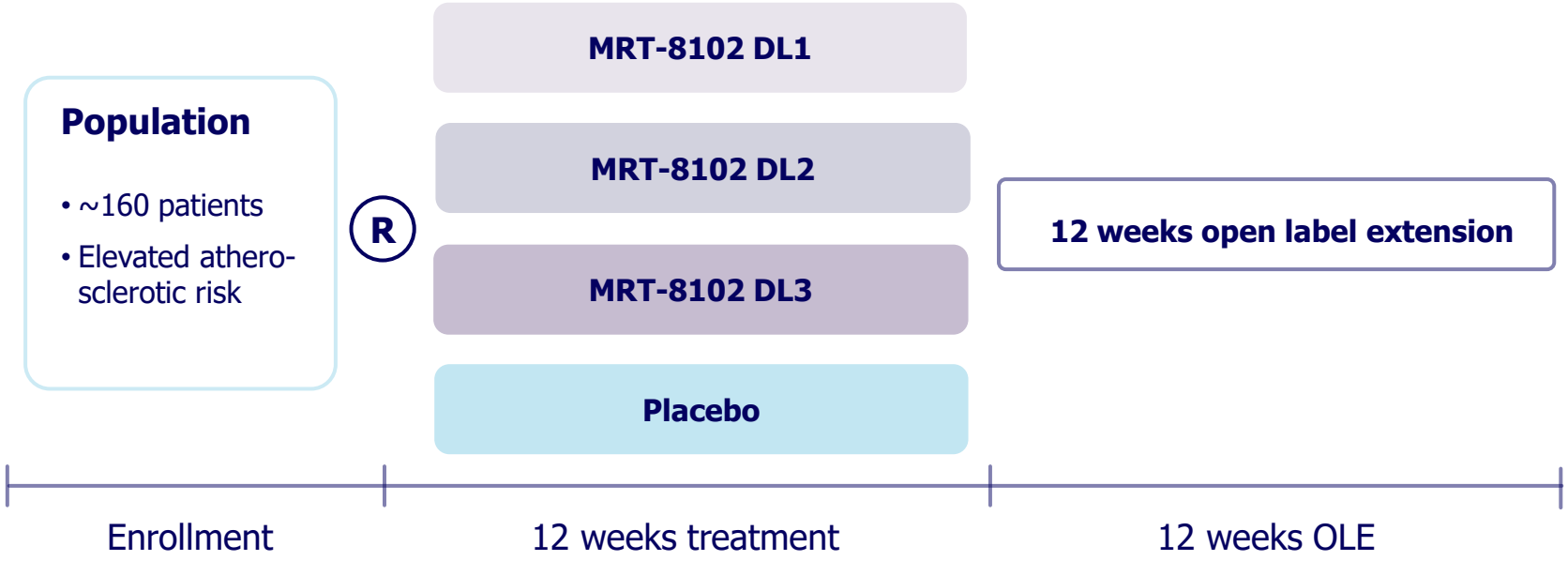
Data readout anticipated in H2 2026

GFORCE, Glue for CRP Elimination

* DL of 40 mg (n=27) with corresponding placebo (n=9) completed enrollment

** Two additional DLs with corresponding placebo added to the study

GFORCE-2: Phase 2b Study in Patients with Elevated Atherosclerotic Risk and Metabolic Syndrome



Study Goals

- Dose exploration
- Create long term PoC data on disease relevant biomarkers and ASCVD risk factors
- Establish 12 to 24-week safety data
- Generate exploratory data for MASH, obesity, anemia, etc.

Outcome measures and PoC expectation

- Change in critical biomarkers, including established ASCVD risk factors, from baseline through 12 weeks (and additional 12 weeks if enrolled in OLE)

Exploratory endpoints to inform additional Indications

- Liver fat and liver inflammation
- BMI, waist circumference, weight
- Anemia

Study initiation planned for H2 2026

Proposed trial design subject to review by FDA

ASCVD: Large Opportunity to Address Inflammation-Induced Atherosclerotic Risk With Safe, Oral Treatment

ASCVD Market Overview

18.7M
Patients in the U.S.

~35%
Patients have had ≥1 major ASCVD event*

~50%
At-risk patients show arterial inflammation through imaging**

Current Treatment Paradigm Focused on LDL-C Lowering

1L	Statins	±	Antiplatelet drug *(aspirin, prasugrel, ticagrelor)*			
2L	Statins	+	Ezetimibe, or bempedoic acid	±	Anti-platelet drug *(aspirin, prasugrel, ticagrelor)*	
3L	Statins	+	PCSK9 inhibitors	±	Anti-platelet drug *(aspirin, prasugrel, ticagrelor)*	

LDL-C lowering Anti-platelet

Additional interventions: lifestyle change, surgical procedures (angioplasty, endarterectomy, bypass, etc.)

MRT-8102 Opportunity

Potential to **address atherosclerotic risk induced by chronic inflammation**

- Even patients who achieve their LDL-C targets may still suffer from **up to 40% likelihood** in experiencing life-threatening cardiovascular events, demonstrating substantial residual risk not fully addressed by LDL-C lowering

Potential for **better safety / tolerability profile than biologics**

- Ability to provide robust inflammation control without broad immunosuppression and infection risk reported for IL-1 antibodies

Oral admin aligns with SOC therapies and facilitates potential combo approaches

* Major ASCVD events include myocardial infarction, ischemic stroke, or symptomatic peripheral artery disease; ** Arterial inflammation was detected using ^{18}F-FDG PET/MRI in middle-aged individuals with known atherosclerotic plaques

Source: Arnett et al. Circulation (2019); Pesce et al. Front Cardiovasc Med. (2025); Alanaeme et al. Am Heart J Plus (2022); Mazhar et al. Eur Heart J. (2024); Holtrop et al. Eur J Prev Cardiol. (2024); Carrero et al., J Am Heart Assoc. (2019); Hartley et al., eBioMedicine (2025), Fonarow et al. Clinical Cardiology (2021); Fernandez-Friera et al. JACC (2019)

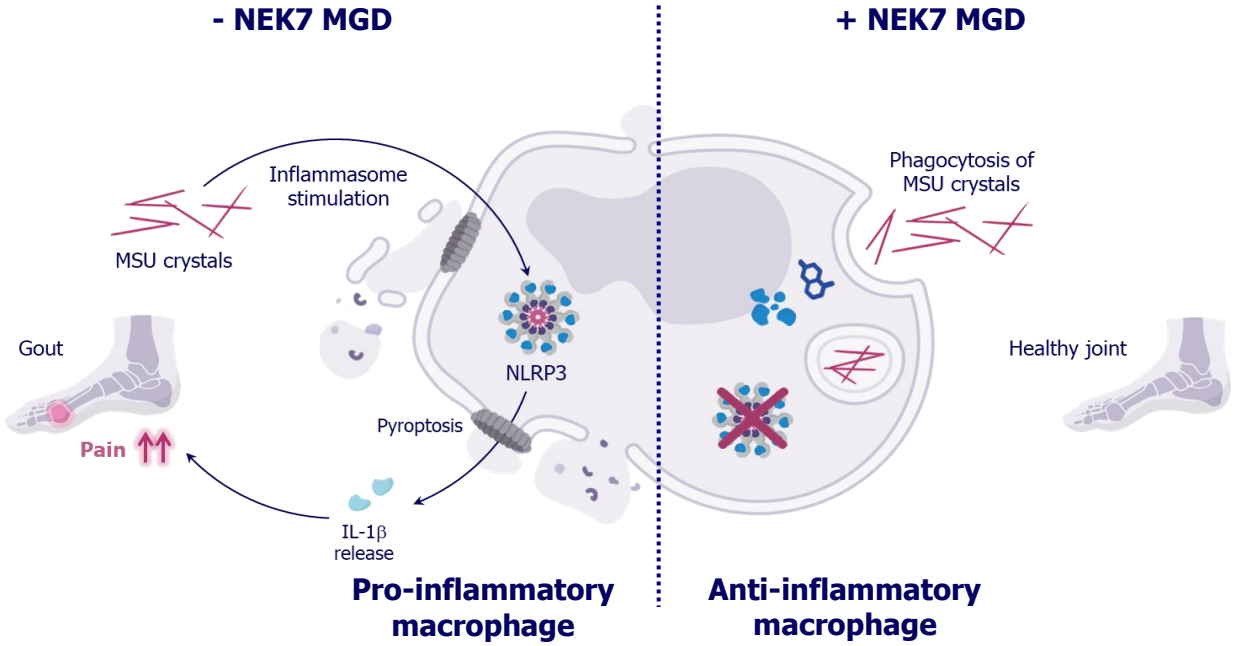
NLRP3-driven Inflammation in Gout Flares

MRT-8102 Has Potential to Resolve and Prevent Gout Flares

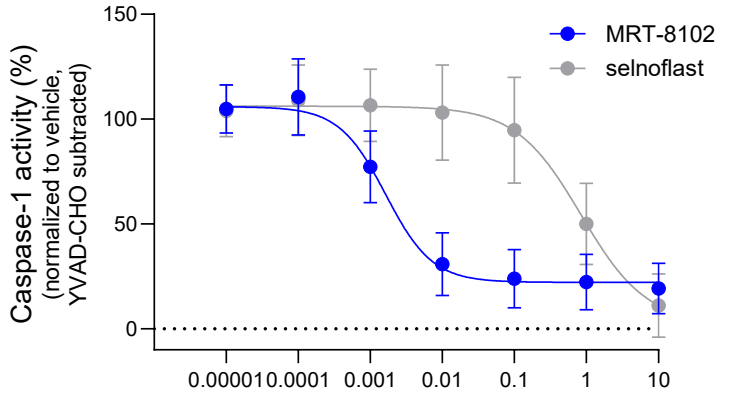
MSU-driven activation of NLRP3/NEK7 pathway

Resolution of inflammation and gout tophi via NEK7 MGD

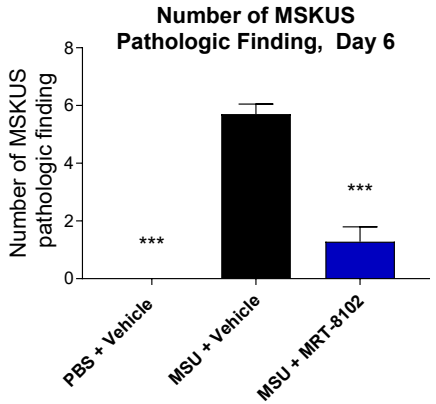
MRT-8102 reduces MSU-induced inflammasome activation and gout flare in a preclinical model

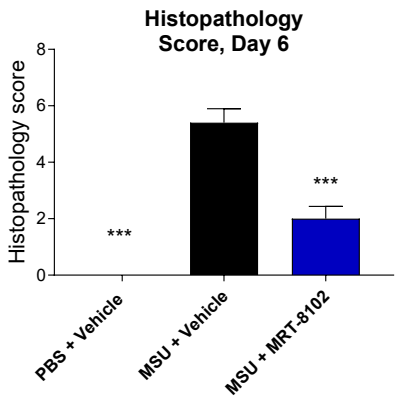


***In vitro* MSU stim**



***In vivo* rabbit gout**





Preclinical data supports 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

Gout: Large Market With High Unmet Need For New Prophylactic Therapies Underscored by Systemic Inflammation

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 SOCs 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 could result in **breakthrough flares**, a leading contributor to poor adherence to ULT (as low as 47%)

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**

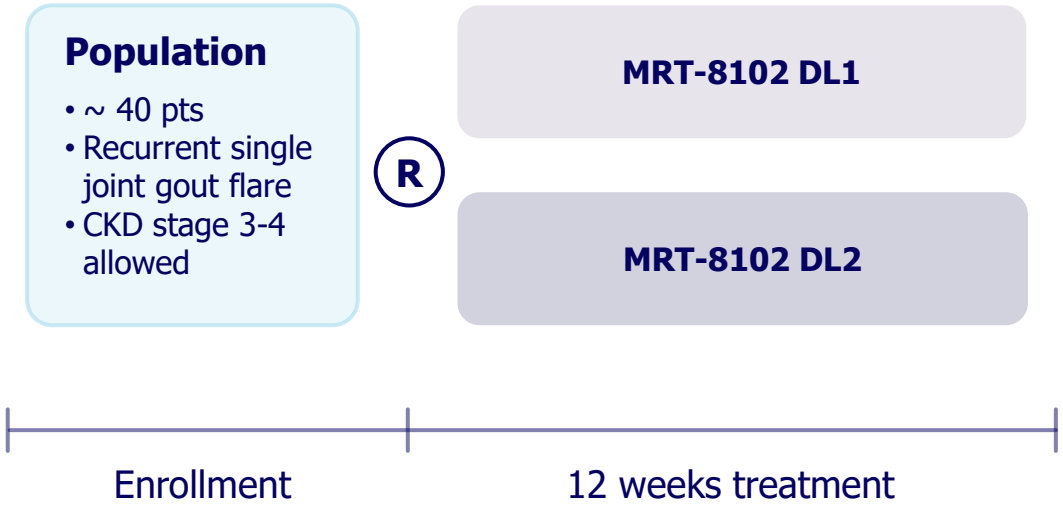
Expected to be safe for use in CKD-comorbid patients (no impact on kidney function)

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 Urate 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: Phase 2 Study in Gout Flare Prevention Following Acute Flare Management



Goals

- Dose exploration
- Safety and efficacy
- Establish PoC for flare prevention following acute flares

Outcome measures and PoC expectation

- Reduction in pain VAS by 72 hours
- Frequency of new flares

Study initiation planned for Q4 2026 / Q1 2027

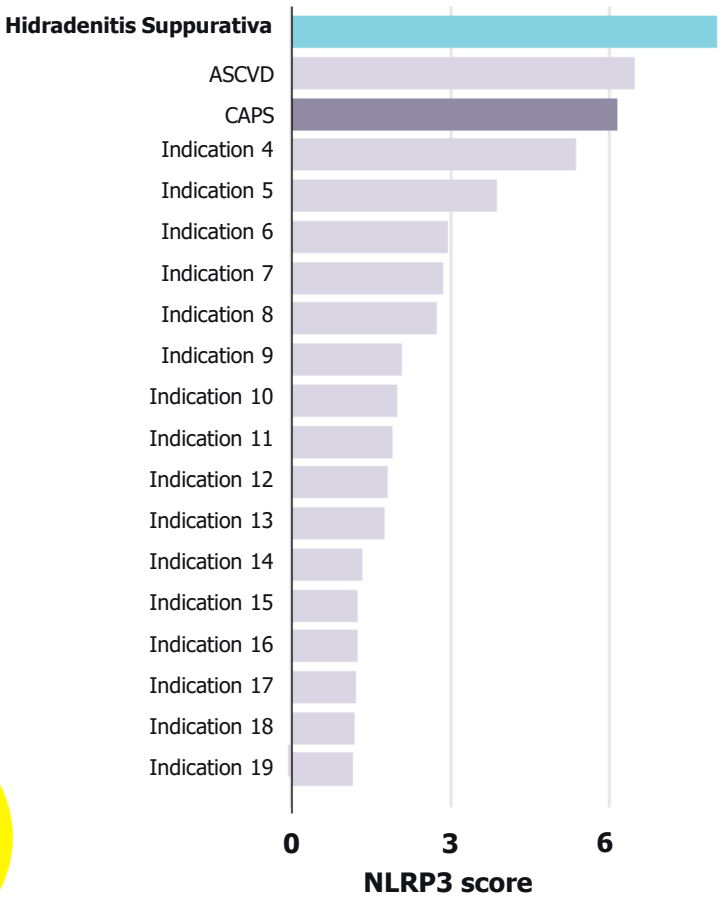
GEMINI: Glue **E**limination of **M**onosodium urate-**I**nduced **N**EK7 **I**nflammation

Proposed trial design subject to review by FDA

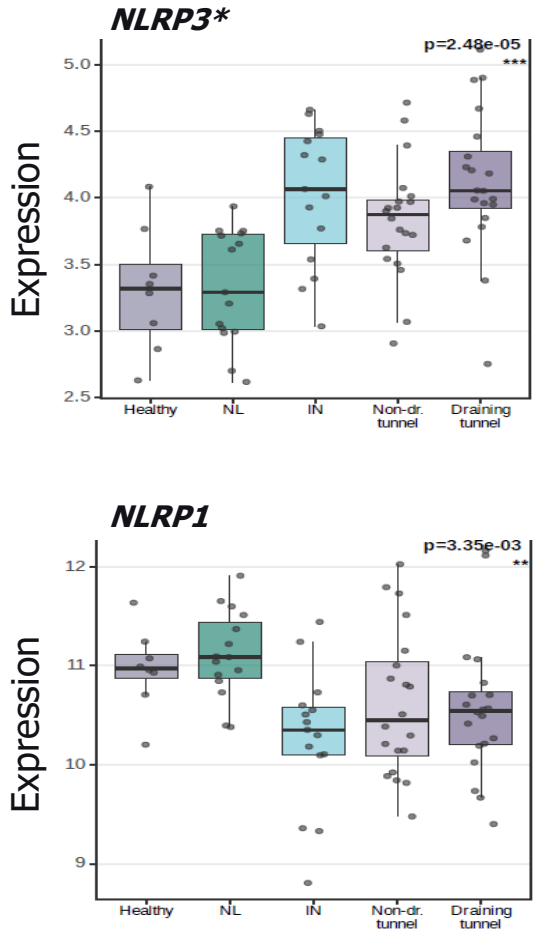
NLRP3-driven Inflammation in HS

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

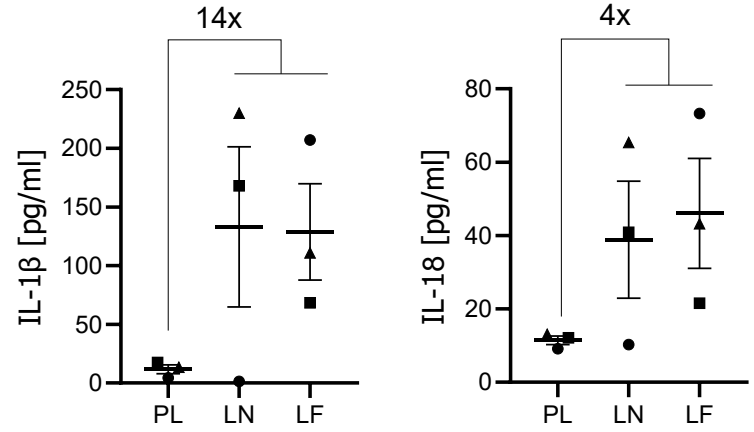
NLRP3 score highest in HS lesions



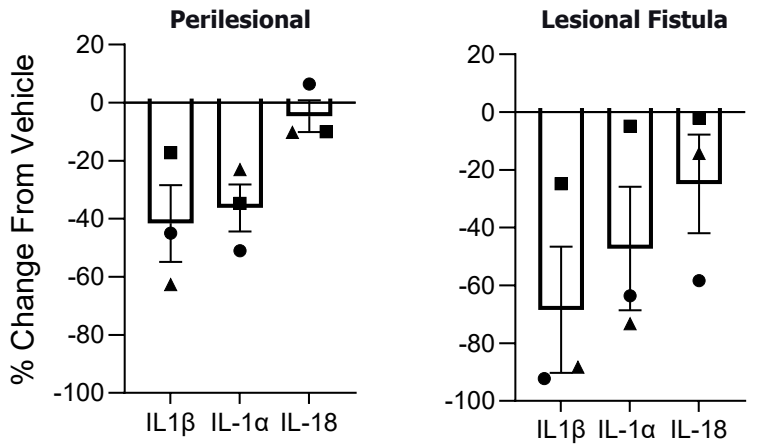
NLRP3:NLRP1 ratio increases during disease progression



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

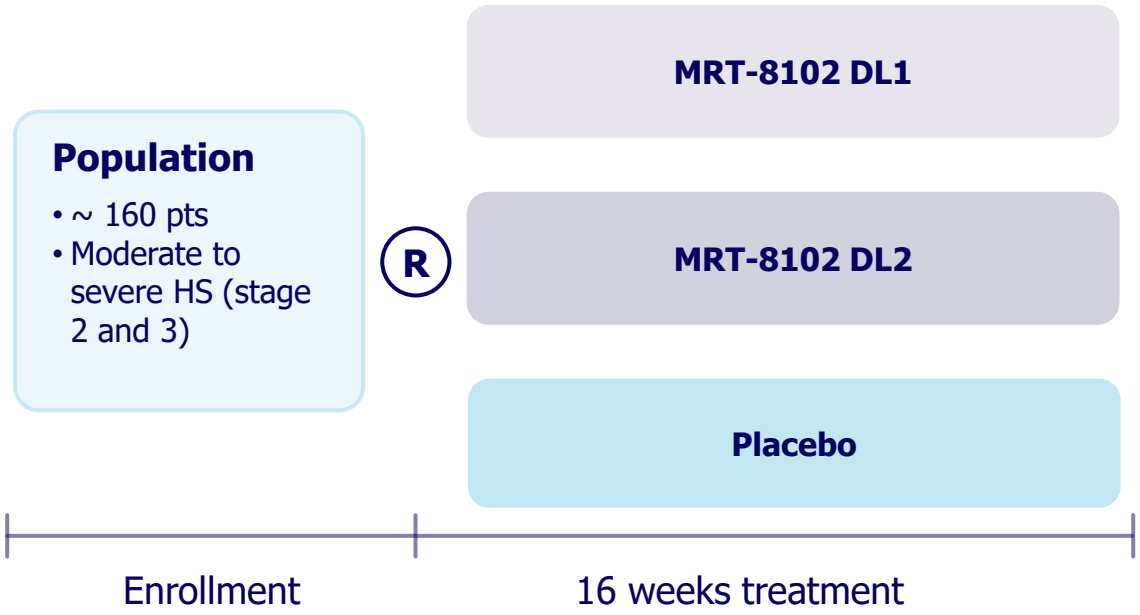
- Lutikizumab provides promising POC for the IL-1/inflammasome approach in HS

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

Oral regimen suitable for long-term maintenance treatment

Source: Jfri et al. JAMA Dermatology (2021); PharmaProjects; Piper Sandler (Apr 2026); HS Foundation; Cowen Therapeutics Outlook (Oct 2025); AlphaSense; TrialTrove; clinicaltrials.gov

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



Goals

- Dose exploration
- Safety and efficacy

Outcome measures and PoC expectation

- HiSCR75 after 16 weeks MRT-8102 relative to placebo

Study initiation planned for H1 2027

GALAXY: **G**lue-mediated **A**ttenuation of **L**esions, **A**bscesses, and e**X**acerbations in HS therap**Y**

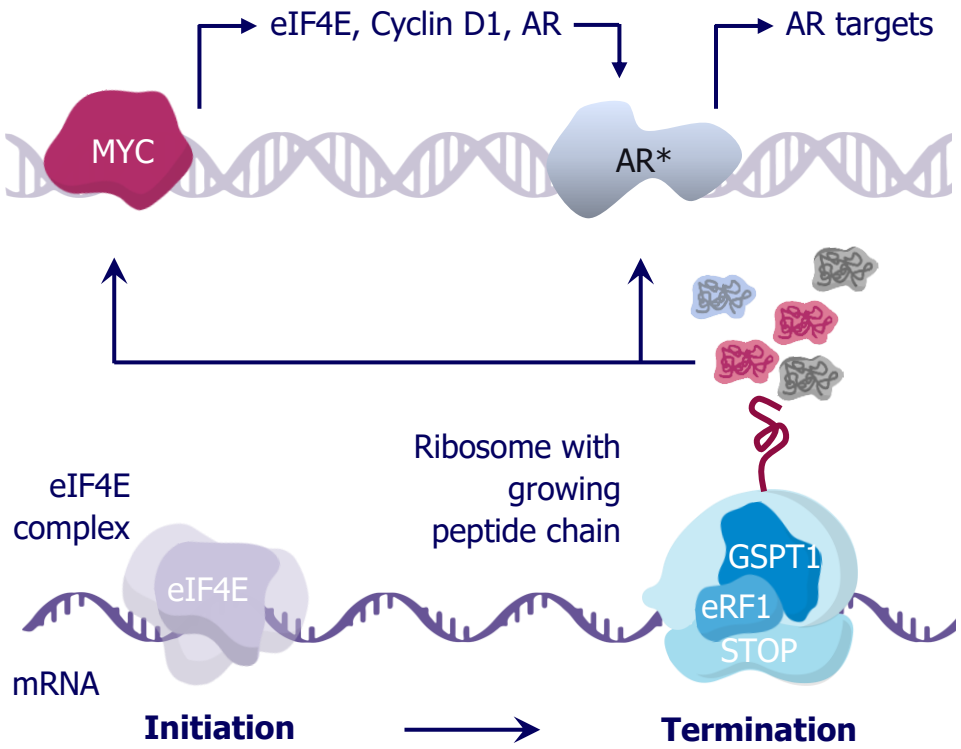
Proposed trial design subject to review by FDA

Monte Rosa Therapeutics

Oncology Pipeline

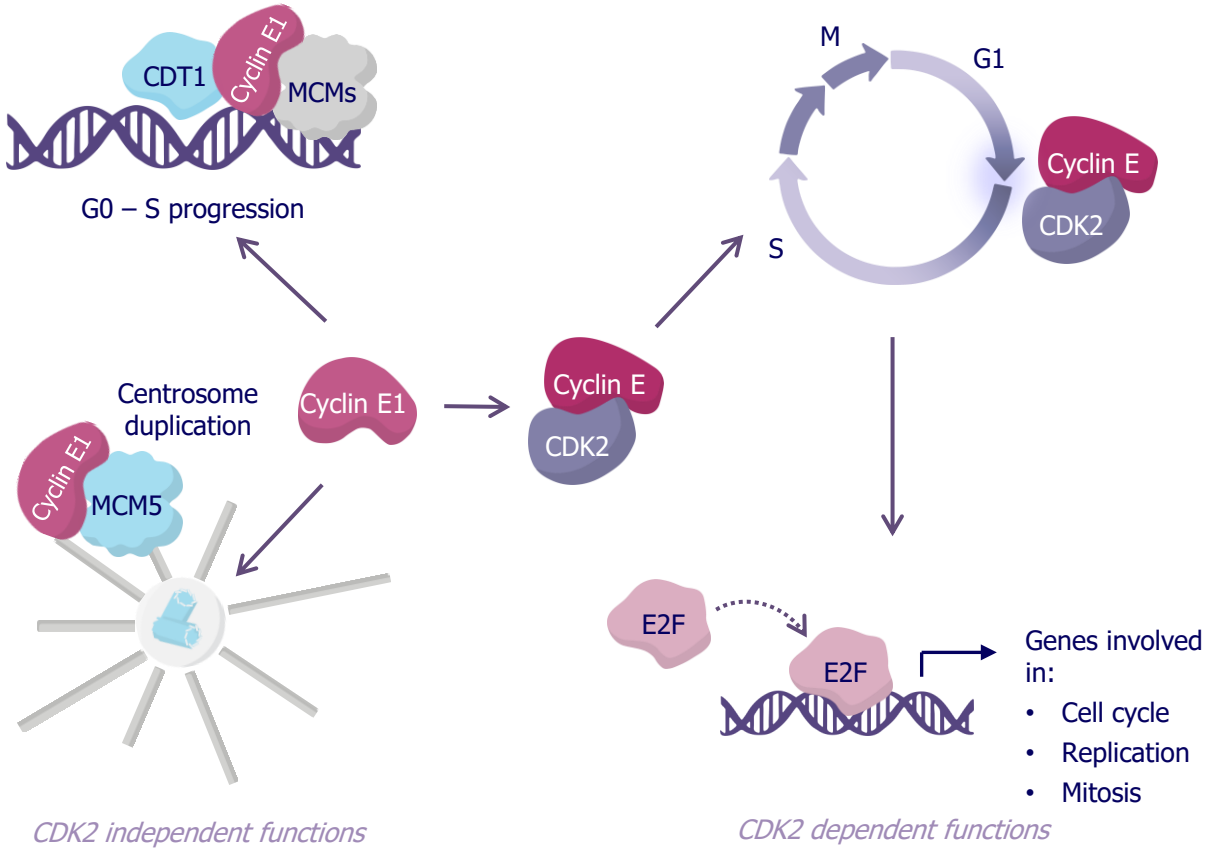
Degrading Undruggable and Difficult-to-Drug Oncology Targets

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

Monte Rosa Therapeutics

GSPT1 Program (MRT-2359)

MRT-2359 At a Glance

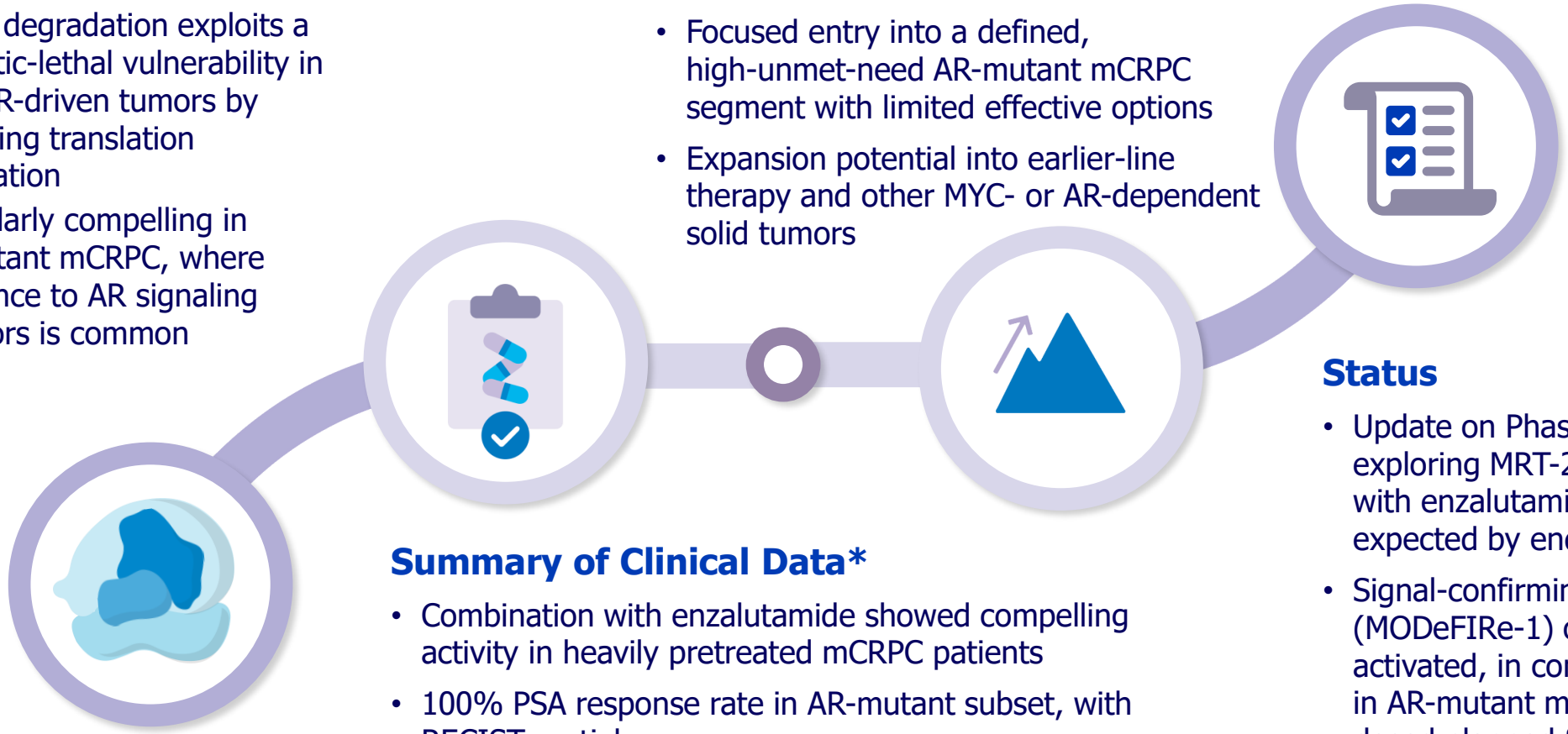
First-in-class oral GSPT1 MGD for AR-mutant metastatic castration-resistant prostate cancer (mCRPC)

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
- Signal-confirming Phase 2 study (MODeFIRe-1) of MRT-2359 activated, in combo with apalutamide in AR-mutant mCRPC; first patient dosed planned for Q3 2026
- 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

Note: * U.S. drug-treatable mCRPC patient population (2026) from Clarivate
Source: Clarivate; Antonarakis et al. JCO Precision Oncology (2024); Stewart et al. J Clin Oncol (2024); MRTx interviews

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

As disclosed Feb. 24, 2026; data cut-off January 30, 2026

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

Phase 2: Expansion Cohort

Combination of MRT-2359 with enzalutamide in heavily-pretreated metastatic castration resistant prostate cancer (CRPC)

As of January 30, 2026, enrolled 23 patients with heavily pretreated, RECIST measurable mCRPC

Well-tolerated dose level | 5/9 = 5 days on drug, 9 days off drug | 21/7 = 21 days on drug, 7 days off drug | RP2D = recommended Phase 2 dose

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 ≥20% Patients

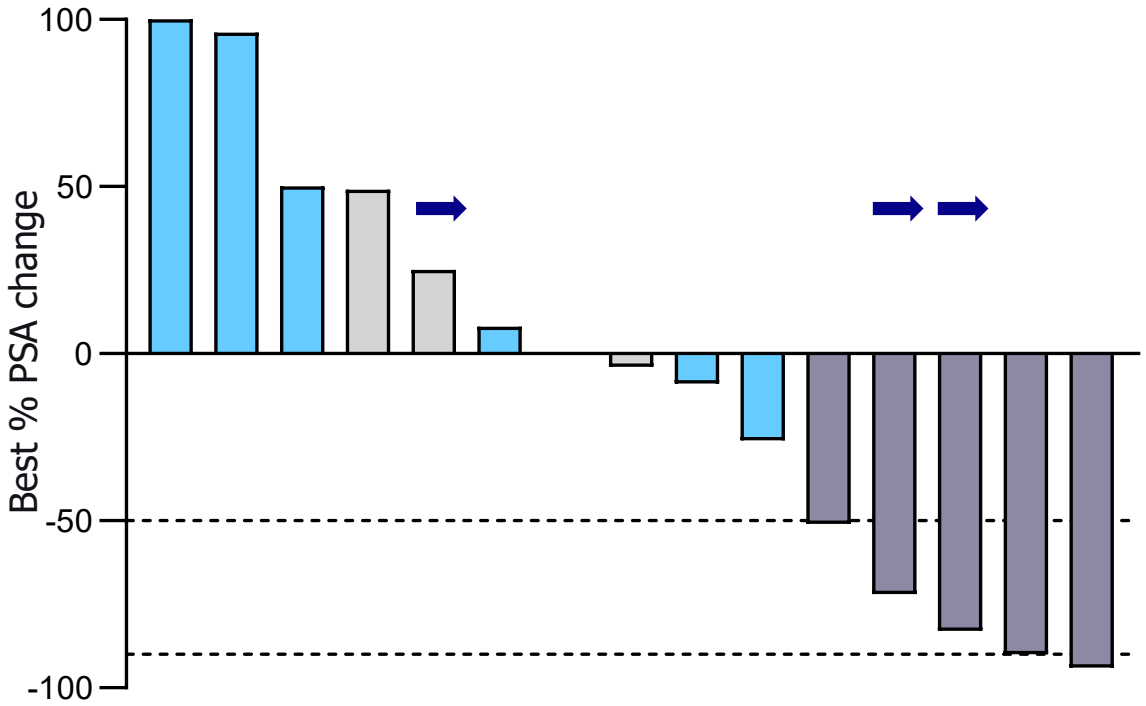
Dose Level	MRT-2359 0.5mg and Enzalutamide 160mg N=17				MRT-2359 0.75mg and Enzalutamide 160mg N=6				Total N=23
CTC AE V5 Grade	**G1 (%)**	**G2 (%)**	**G3 (%)**	**G4 (%)**	**G1 (%)**	**G2 (%)**	**G3 (%)**	**G4 (%)**	**All grades**
Fatigue	3 (18)	4 (24)	1 (6)	0	2 (33)	2 (33)	0	0	12 (52)
Diarrhea	5 (29)	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



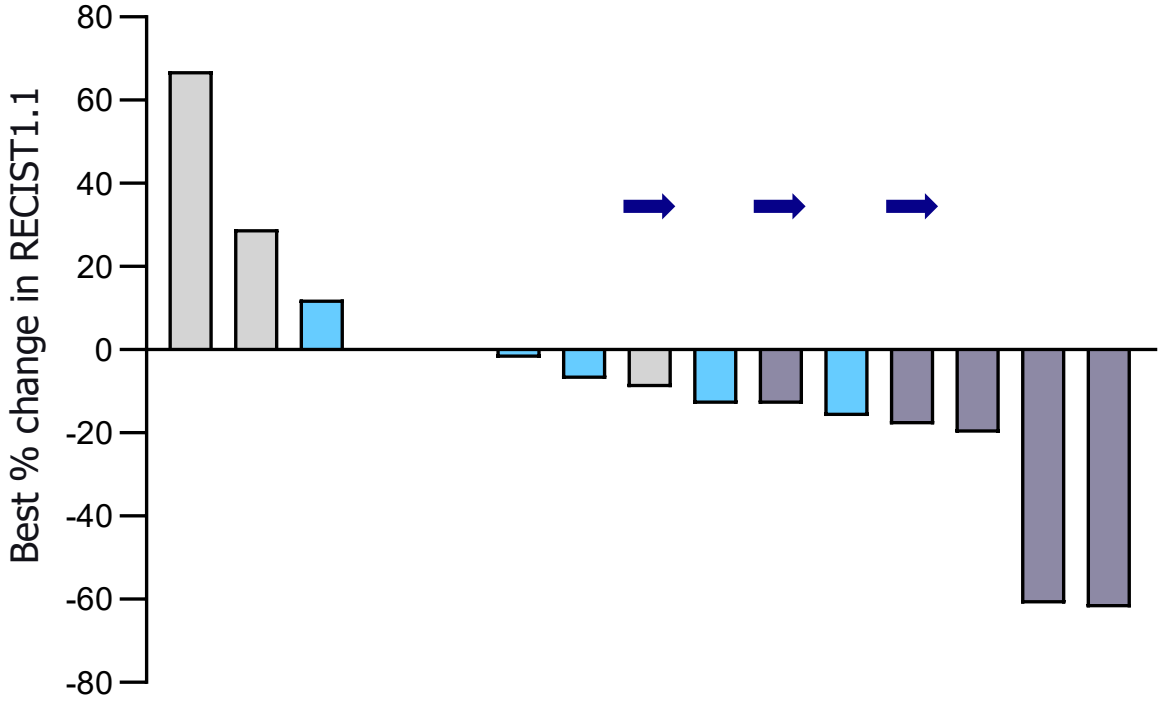
AR status	V7	V7	V7	WT	WT	V7	V7	WT	V7	V7	Mut	Mut	Mut	Mut	Mut
RECIST Response	PD	PD	SD	PD	SD	SD	SD	PD	SD	PD	SD	SD	SD	PR	PR
RECIST %	0	-13	0	+29	-9	+12	-2	+67	-16	-7	-20	-18	-13	-62	-61
Abiraterone	+	-	+	-	+	+	+	-	+	-	+	+	+	+	+
2nd gen ARi	+	+	+	+	-	+	+	+	+	+	+	-	+	-	+
Docetaxel	+	+	+	+	-	+	-	+	+	+	+	+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

Data cut-off January 30, 2026

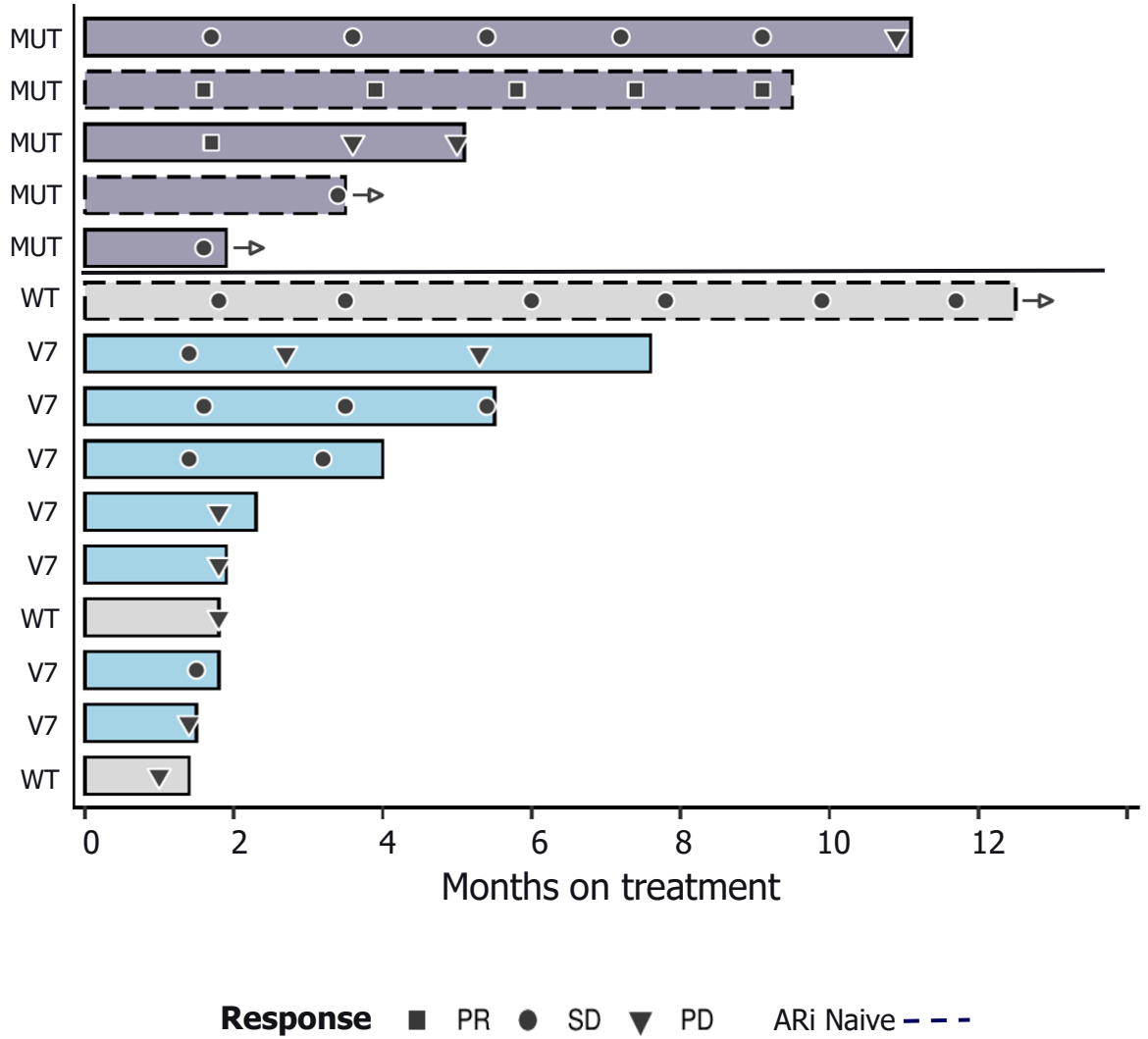
- MRT-2359 + enzalutamide achieved 100% PSA response rate; PSA response in 5 of 5 heavily pretreated patients with AR mutations
  - PSA50 (n=3)
  - PSA90 (n=2)
- PSA response rate in overall population suggests activity at least comparable to data shown in Phase 1 study of mevrometostat + enzalutamide

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



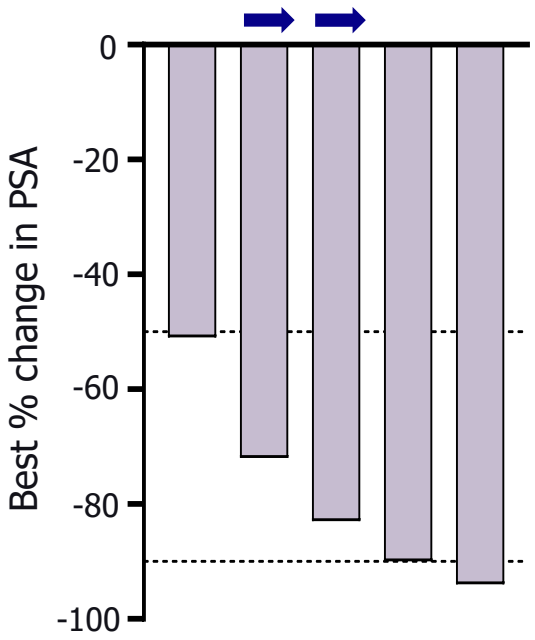
AR status	WT	WT	V7	V7	V7	V7	V7	WT	V7	Mut	V7	Mut	Mut	Mut	Mut
RECIST Response	PD	PD	SD	PD	SD	SD	PD	SD	PD	SD	SD	SD	SD	PR	PR
RECIST %	+67	+29	+12	0	0	-2	-7	-9	-13	-13	-16	-18	-20	-61	-62
Abiraterone	-	-	+	+	+	+	-	+	-	+	+	+	+	+	+
2nd gen ARi	+	+	+	+	+	+	+	-	+	+	+	-	+	+	-
Docetaxel	+	+	+	+	+	-	+	-	+	+	+	+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



Data cut-off January 30, 2026

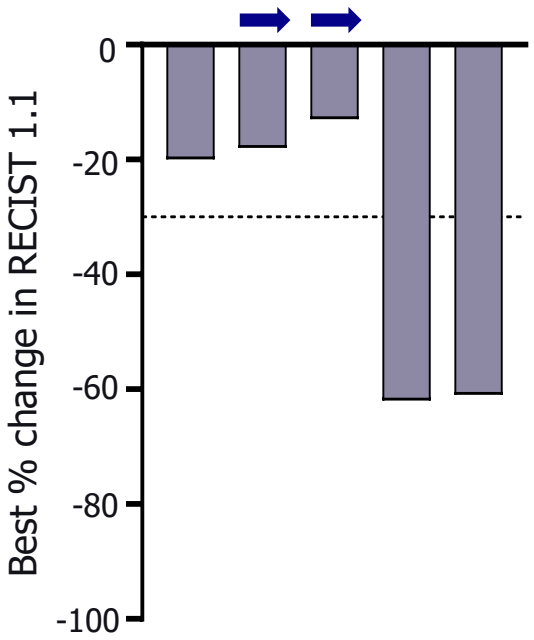
Compelling Activity in Heavily Pretreated Patients with AR Mutations

Best % change in PSA



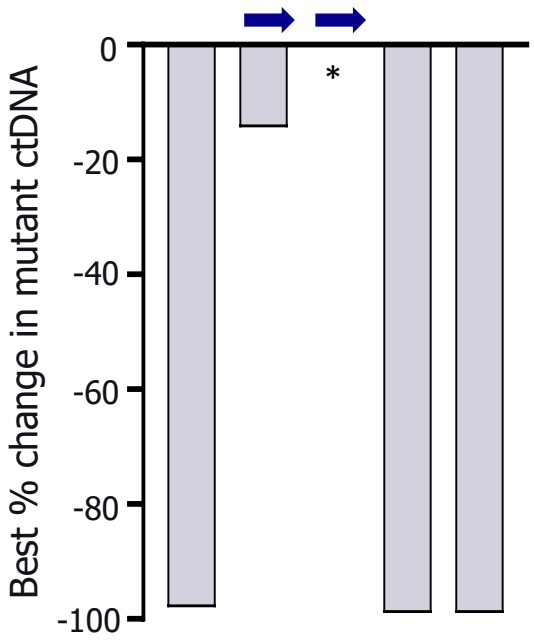
Response	SD	SD	SD	PR	PR
RECIST %	-20	-18	-13	-62	-61
Abiraterone	+	+	+	+	+
2nd gen ARi	+	-	+	-	+
Docetaxel	+	+	+	+	+
Pluvicto	-	+	+	+	+

Best % change in RECIST



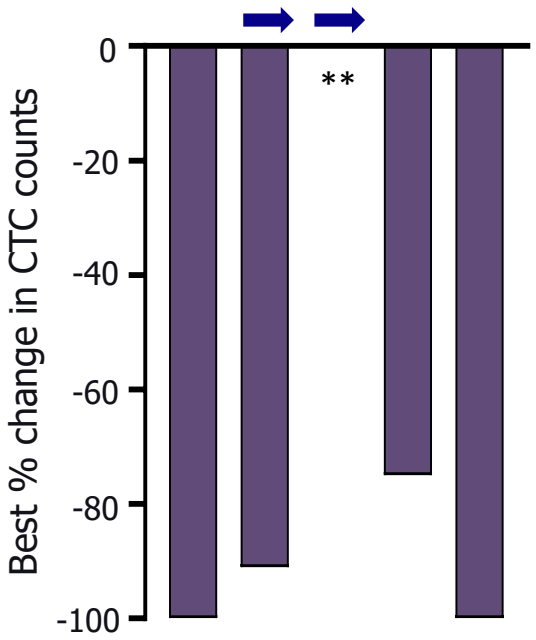
SD	SD	SD	PR	PR
-20	-18	-13	-62	-61
+	+	+	+	+
+	-	+	-	+
+	+	+	+	+
-	+	+	+	+

Best % change in ctDNA



SD	SD	SD	PR	PR
-20	-18	-13	-62	-61
+	+	+	+	+
+	-	+	-	+
+	+	+	+	+
-	+	+	+	+

Best % change in CTC counts



SD	SD	SD	PR	PR
-20	-18	-13	-62	-61
+	+	+	+	+
+	-	+	-	+
+	+	+	+	+
-	+	+	+	+

Data cut-off January 30, 2026

**QC failed; **Data pending*

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 activated; first patient dosed planned for Q3 2026

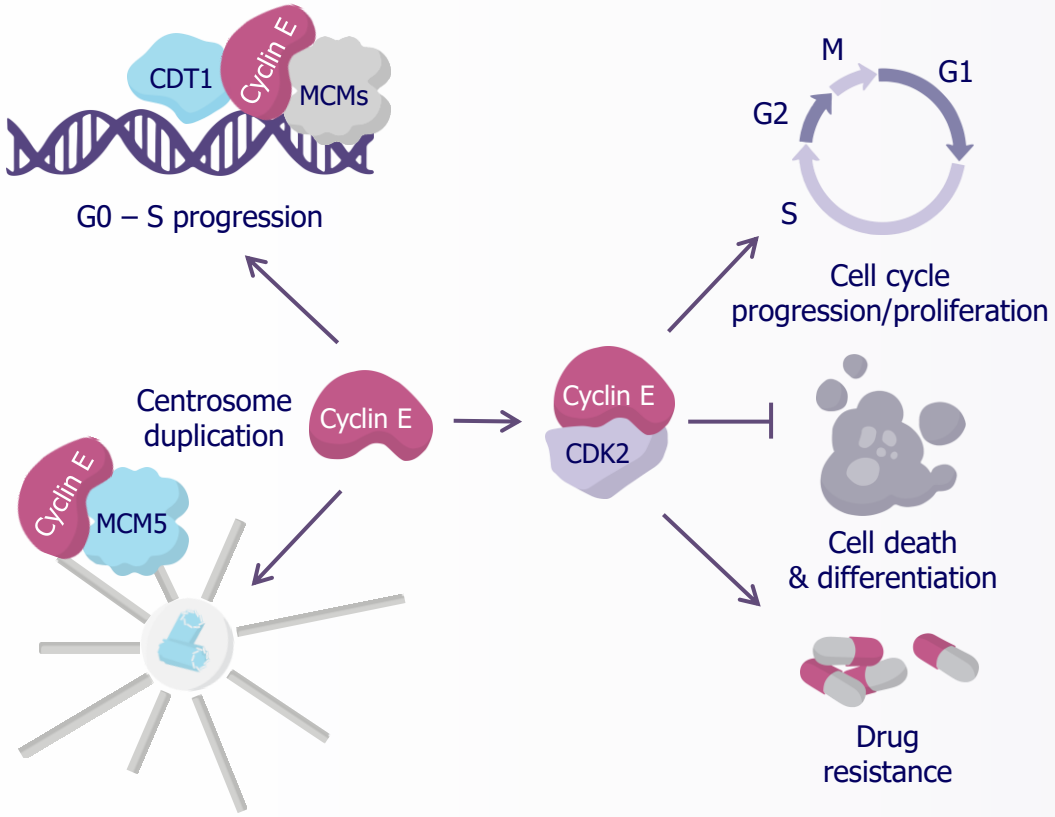
MODeFIRe: Molecular **De**grader **F**or **I**nhibitor **Re**sistance

Monte Rosa Therapeutics

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)

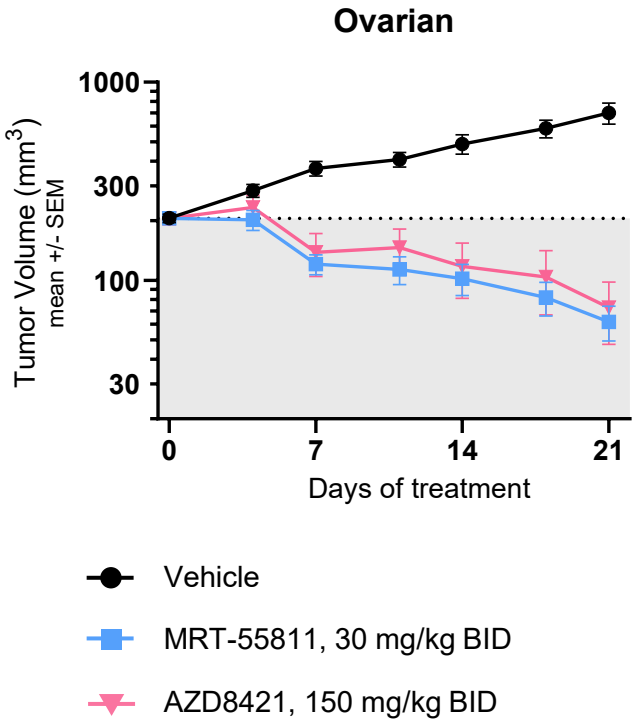
Clinical opportunity:

- 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

Source: Clarivate (2026 drug-treated advanced/metastatic patient incident population in G7 countries)

Potent and Highly Selective CCNE1-directed MGDs

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



21-day efficacy study in OVSAHO CDX

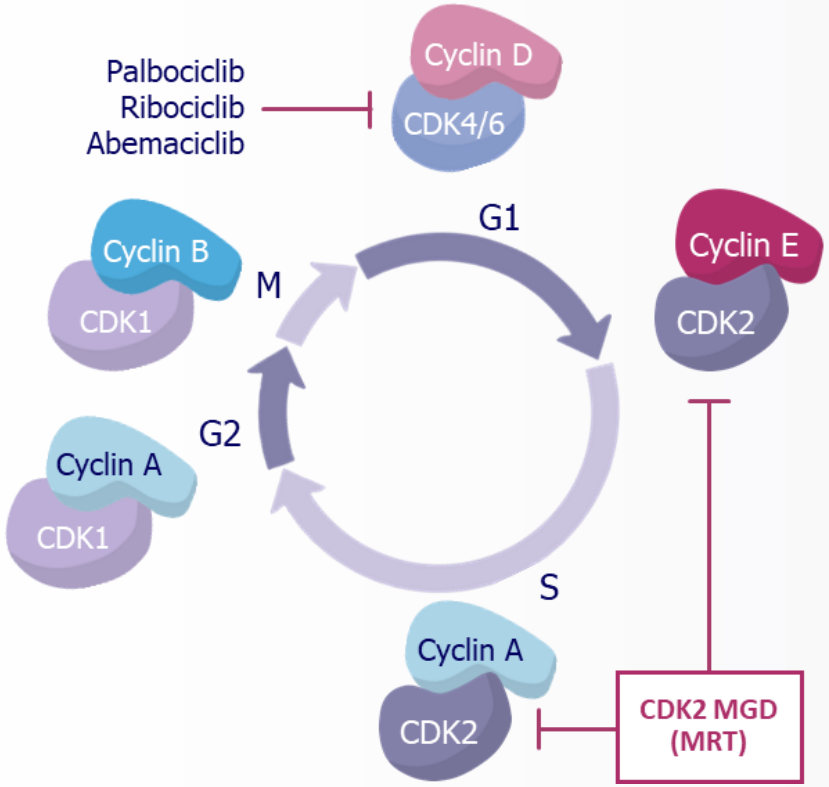
- MRT-55811 is a potent and highly selective CCNE1 molecular glue degrader that drives robust G1/S cell-cycle arrest in CCNE1-amplified cancer cells.
- CCNE1 degradation leads to downstream suppression of CDK2 activity and E2F pathway signaling, confirming on-mechanism cell-cycle inhibition
- MRT-55811 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

Monte Rosa Therapeutics

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

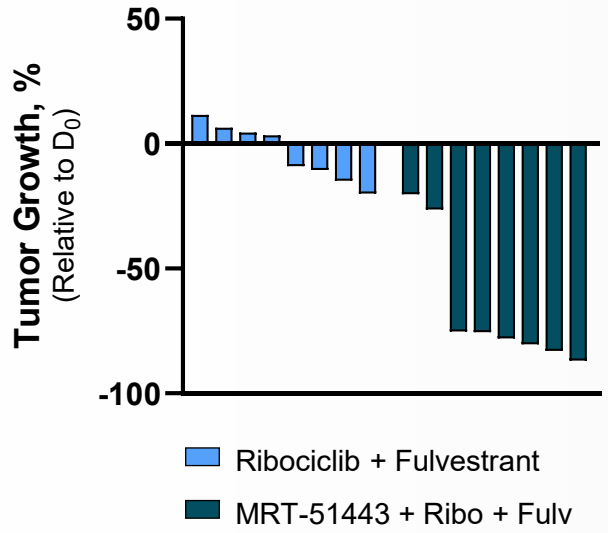
Clinical Opportunity:

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

Source: Clarivate (2026 drug-treated advanced/metastatic patient incident population in G7 countries)

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

Monte Rosa Therapeutics

Team

World-Class Leadership

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

Markus Warmuth, M.D.
Chief Executive Officer

H3 Biomedicine
Novartis

Sharon Townson, Ph.D.
Chief Scientific Officer

Kymera Therapeutics
Warp Drive Bio

John Castle, Ph.D.
Chief Data and Information Officer

agenus
BioNTech

Magnus Walter, DPhil
Chief Technology Officer

AbbVie
Lilly

Filip Janku, M.D., Ph.D.
Chief Medical Officer

The University of Texas MD Anderson Cancer Center

Phil Nickson, Ph.D., J.D.
Chief Business and Legal Officer

Momenta
FISH & RICHARDSON

Jennifer Champoux
Chief Operating Officer

H3 Biomedicine
Novartis

Andrew Funderburk
Chief Investor Relations and Strategy Officer

Kendall Investor Relations
Health Advances

Thank you

Monte Rosa Therapeutics