RELAY®
THERAPEUTICS

Corporate Presentation

November 2026

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Zovegalisib – Potential To Address 3 Large Commercial Opportunities

	2L Breast Cancer	1L Breast Cancer	Vascular Anomalies
Estimated US TAM	$2-3B	$7-8B	$6-8B

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Note: TAM calculated based on market benchmarks and internal analysis

2L Breast Cancer – Ph1/2 Data at Ph3 Dose Showed Clinically Meaningful PFS

2L Breast Cancer

$2-3B
Estimated US TAM

ReDiscover-2 STUDY

Ph3 regimens

Zovegalisib shows favorable efficacy in 2L+ patients

Ph3 regimens			
Zovegalisib + Fulv 400mg BID (Phase 3 Dose)	2L & 3L+	11.1mo mPFS 11.2mo in Kinase | 11.0mo in Non-Kinase	ORR: 43%
Capivasertib + Fulv (4 days on, 3 off)	Post-CDK4/6	5.5mo mPFS	ORR: 26%

Full enrollment estimated mid-2027

Sources: ReDiscover Ph1/2 preliminary data as of 1/13/2026; Capi + fulv Ph3 data from CAPItello-291, Turner N Engl J Med 2023; 388:2058-2070. Note: These data are derived from different clinical trials at different points in time, with differences in molecule composition, trial design and patient populations. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted.

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1L Breast Cancer – Establishing Zovega + Atirmo + AI Combinability for 1L Use

1L Breast Cancer

$7-8B

Estimated US TAM

	Doublet		Triplet
	Standard of Care CDK4/6 + ET		**Zovega + Atirmo + ET**
Study Population	**1L** Patients	vs.	**Median 3L** Patients
Efficacy	**53-55%** ORR	vs.	✓ **44%** ORR
Tolerability	**50-90%** Gr3+ AE	vs.	✓ **40%** Gr3+ AE

Phase 3 trial in 1L Breast Cancer estimated to initiate in early 2027

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Vascular Anomalies – Zovega's Promising Initial Efficacy Data & Tolerability Profile

Vascular Anomalies

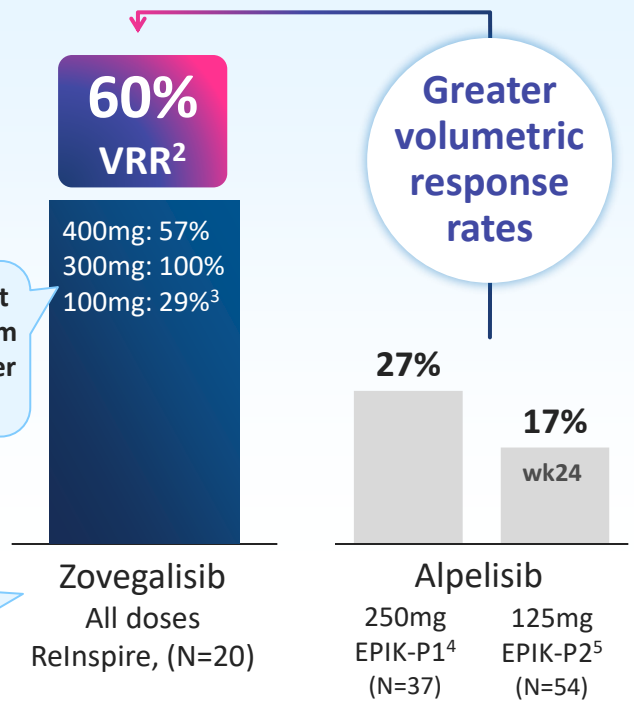
$6-8B

Estimated US TAM[1]

89% of patients with investigator-reported clinical improvement (IGIC at week 12)

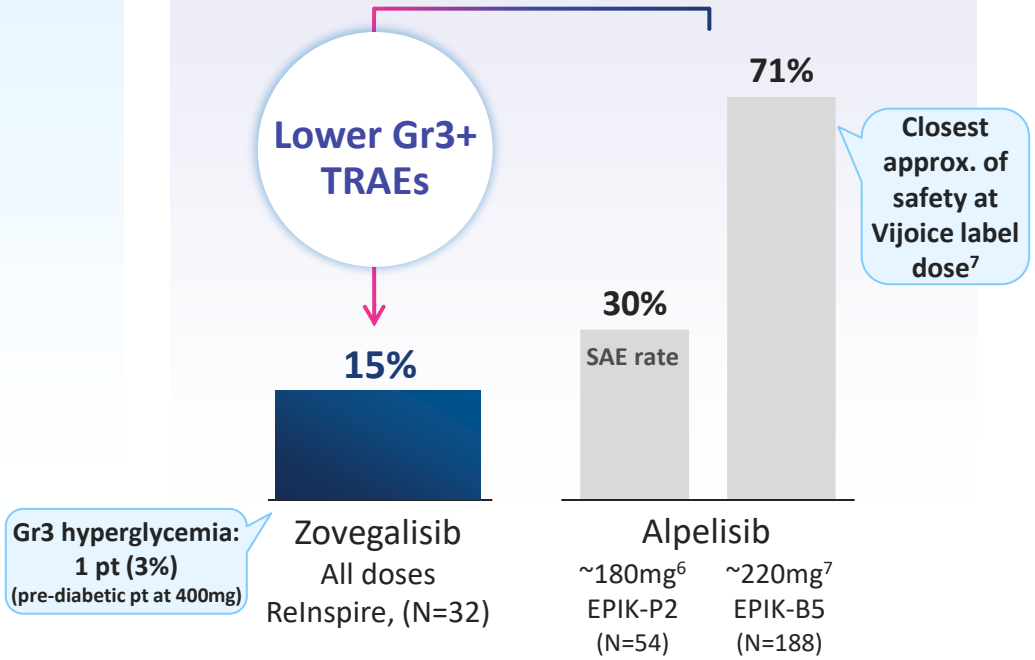
Initial Efficacy Data

Volumetric Response Rate (VRR)



Initial Tolerability Data

Gr3+ AEs



Data and regulatory update to be presented at ASH 2026 in December

1. TAM calculated based on market benchmarks and internal analysis; 2. Includes both confirmed and unconfirmed responses. 3. After the data cut-off date, one 100mg BID patient that did not have a volumetric response as of the data cut-off date has converted to an unconfirmed response, resulting in a 100mg BID volumetric response rate of 43% (3/7), a volumetric response rate of 69% (9/13) for patients treated at 300mg BID or 100mg BID, and a volumetric response rate of 65% (13/20) across doses. None of the other response-evaluable patients' response statuses have changed since the data cut-off date; 4. EPIK-P1 as cited in Vijoice FDA label, label dose is 250mg QD; 5. EPIK-P2: Canaud 2024 Blood 144:5512 and results from clintrials.gov listing, 125mg QD was starting dose; 6. 180mg dose approximated from rates of dose escalation after week 26 listed on clintrials.gov listing; 7. EPIK-B5: SABCS 2025 #RF7-02, 220mg dose approximated from dose modification data; Gr3 TRAEs = Grade 3+ Treatment-Related Adverse Events, IGIC = Investigator Global Impression of Change scale, SD = Stable Disease, uVR = unconfirmed volumetric response. Note: These data are derived from different clinical trials at different points in time, with differences in molecule composition, trial design and patient populations. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted.

ReInspire median follow-up: 14 weeks

ReInspire preliminary data as of 04/15/2026

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Relay Tx – Clear Path to Addressing Large Commercial Opportunities

Zovegalisib granted BTD

	Zovegalisib Program Interim data shared in 2026 → key value drivers	Clinical Benchmark Hurdle[1]	Anticipated Next Steps
2L Breast Cancer ~$2-3B TAM[2]	**11.1mo mPFS at pivotal dose** **for Zovega + fulv doublet** → Rapid execution of ongoing 2L pivotal trial	Capi+fulv in 2L: **5.5mo mPFS**	**Complete enrollment of Phase 3 estimated mid-2027**
1L Breast Cancer ~$7-8B TAM	**44% ORR in median 3L patients** **for Zovega + Atirmo + fulv triplet** → Aim to initiate 1L pivotal trial in early 2027	CDK+ET in 2L+ **14-32% ORR**	**Regulatory update on 1L Ph3 trial design by YE2026;** **Phase 1/2 data in 2027**
Vascular Anomalies ~$6-8B TAM	**60% VRR across all doses[4]** → Continue enrollment of adults + pediatrics; establish potential regulatory path	Alpelisib & KP-001 **11-16% VRR[3]** *at week 12 & 16*	**Data and regulatory update at ASH 2026**

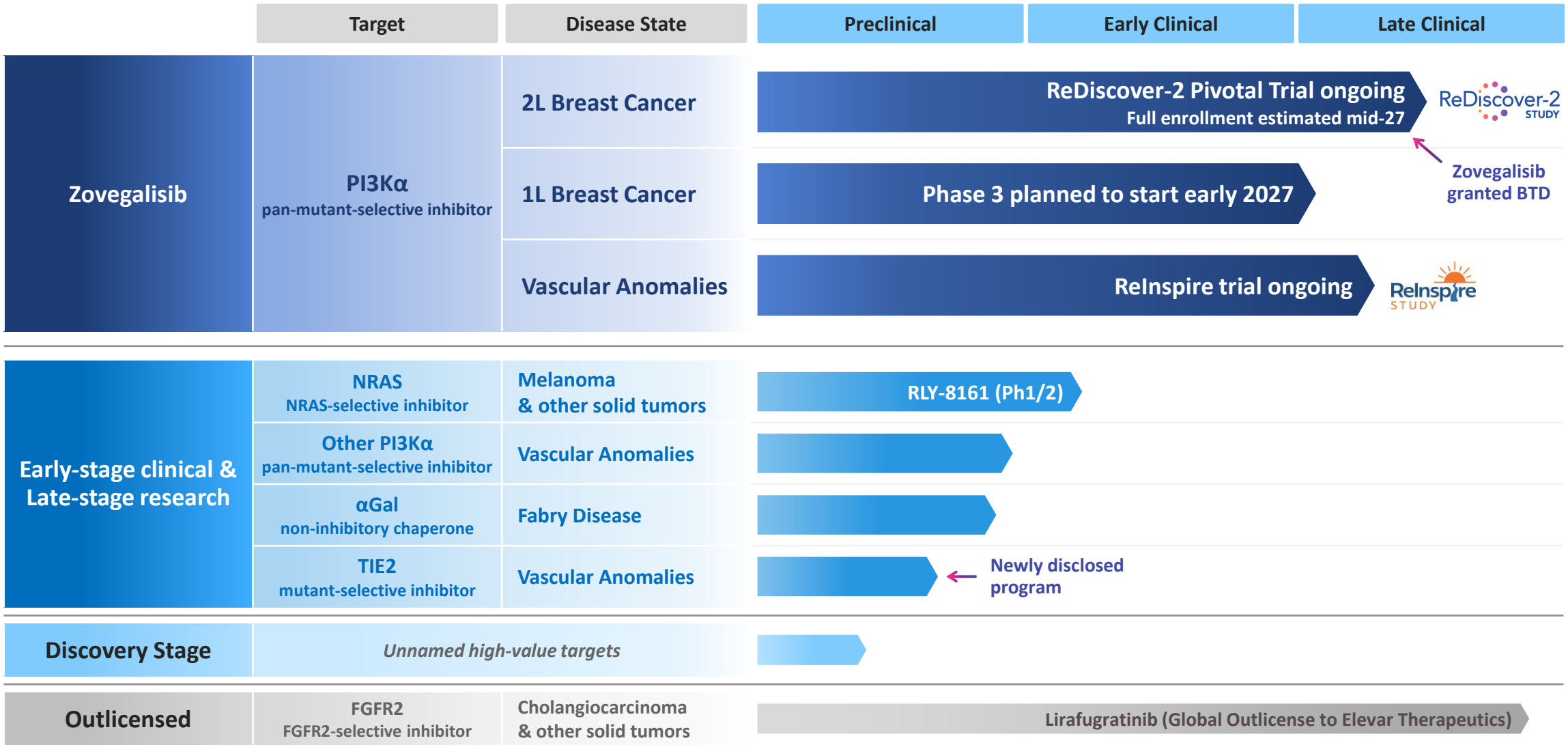
~$849M Cash as of end 3Q 2026

1. Clinical benchmark references: 2L breast cancer: capivasertib + fulvestrant (CDK4/6-experienced patient sub-population of CAPItello-291, Turner N Engl J Med 2023; 388:2058-2070) ; 1L breast cancer: CDK+ET in 2L+ (PACE Ph2: SABCS 2022 #GS3-06; postMONARCH Ph3: ASCO 2024 #1001; MAINTAIN Ph2: ASCO 2022 #LBA1004); atirmociclib Ph1: Pfizer R&D Oncology Day Feb 2024; vascular anomalies: alpelisib (EPIK-P2, Canaud 2024 Blood 144:5512) and KP-001 (Ozeki 2025, Orphanet Journal of Rare Diseases 20:64); 2. TAM calculated based on market benchmarks and internal analysis; 3. these benchmarks represent the earliest volumetric response evaluation timepoint; 4. Includes both confirmed and unconfirmed responses. After the data cut-off date, one 100mg BID patient that did not have a volumetric response as of the data cut-off date has converted to an unconfirmed response, resulting in a 100mg BID volumetric response rate of 43% (3/7), a volumetric response rate of 69% (9/13) for patients treated at 300mg BID or 100mg BID, and a volumetric response rate of 65% (13/20) across doses. None of the other response-evaluable patients' response statuses have changed since the data cut-off date. VRR = Volumetric Response Rate. Note: These data are derived from different clinical trials at different points in time, with differences in molecule composition, trial design and patient populations. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted.

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ReDiscover preliminary data: doublet as of 01/13/2026, triplet as of 04/13/2026; ReInspire preliminary data as of 04/15/2026

Relay Tx – Broad Precision Medicine Pipeline



αGal, galactose-alpha-1,3-galactose; BTD, FDA Breakthrough Therapy Designation; FGFR2, fibroblast growth factor receptor 2; NRAS, neuroblastoma RAS viral oncogene homolog; PI3Kα, phosphoinositide 3-kinase alpha; TIE2, Angiopoietin-1 receptor

FDA Approved Sept 2026

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Zovegalisib – Potential To Address 3 Large Commercial Opportunities

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2L Breast Cancer

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Ph3 regimens

Zovegalisib + Fulv
400mg BID
(Phase 3 Dose)

Capivasertib + Fulv
(4 days on, 3 off)

Zovegalisib shows favorable efficacy in 2L+ patients

2L & 3L+	11.1mo mPFS 11.2mo in Kinase | 11.0mo in Non-Kinase	ORR: 43%
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Sources: ReDiscover Ph1/2 preliminary data as of 1/13/2026; Capi + fulv Ph3 data from CAPItello-291, Turner N Engl J Med 2023; 388:2058-2070. Note: These data are derived from different clinical trials at different points in time, with differences in molecule composition, trial design and patient populations. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted.

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Zovegalisib – ReDiscover Trial Baseline Demographics

ReDiscover Clinical Trial 400mg BID Fed Data

	Zovegalisib + Fulvestrant	
	600 mg BID Fasted (N=64)	400mg BID Fed (N=60)
Age, Median (Range), Years	59.0 (34, 80)	60.0 (32, 78)
ECOG, 0 / 1, n (%)	38 (59.4) / 26 (40.6)	33 (55.0) / 27 (45.0)
Local PIK3CA Baseline Results		
Kinase Mutation, n (%)	31 (48.4)	33 (55.0)
Non-Kinase Mutations, n (%)	33 (51.6)	27 (45.0)
BMI ≥30 or HbA1c ≥5.7%, n (%)	22 (34.4)	29 (48.3)
Pre-diabetic[1] n (%)	22 (34.4)	26 (43.3)
Patients with Visceral Metastases, n (%)[2]	39 (60.9)	43 (71.7)
Measurable Disease, n (%)	42 (65.6)	37 (61.7)
Prior Lines of Therapy in Advanced Setting		
1, n (%)	35 (54.7)	36 (60.0)
2+, n (%)	29 (45.3)	22 (36.7)
Prior Therapies in Advanced Setting		
CDK4/6, n (%)[4]	64 (100.0)	59 (98.3)
Fulvestrant or Novel SERD, n (%)	33 (51.6)	26 (43.3)
Chemo / ADC, n (%)	17 (26.6)	11 (18.3)
ESR1 Mutation (Central Read)[4], n (%)	18 (28.6)	23 (40.4)

← Phase 3 dose

← 400mg BID fed cohort has higher rate of pre-diabetes and visceral disease

1. Baseline HbA1c ≥5.7, glucose ≥100, or medical history of pre-diabetes mellitus; 2. Visceral metastatic sites include brain, lung, liver, pleural, peritoneal involvement; 3. 5 (3@600 and 2@400) patients received prior CDK4/6 in the adjuvant setting which is allowed per protocol; 1 subject @400 received "other CDK4 inhibitor"; 4. Percentage was based on pts with evaluable ctDNA data at baseline; ECOG = Eastern Cooperative Oncology Group performance status.

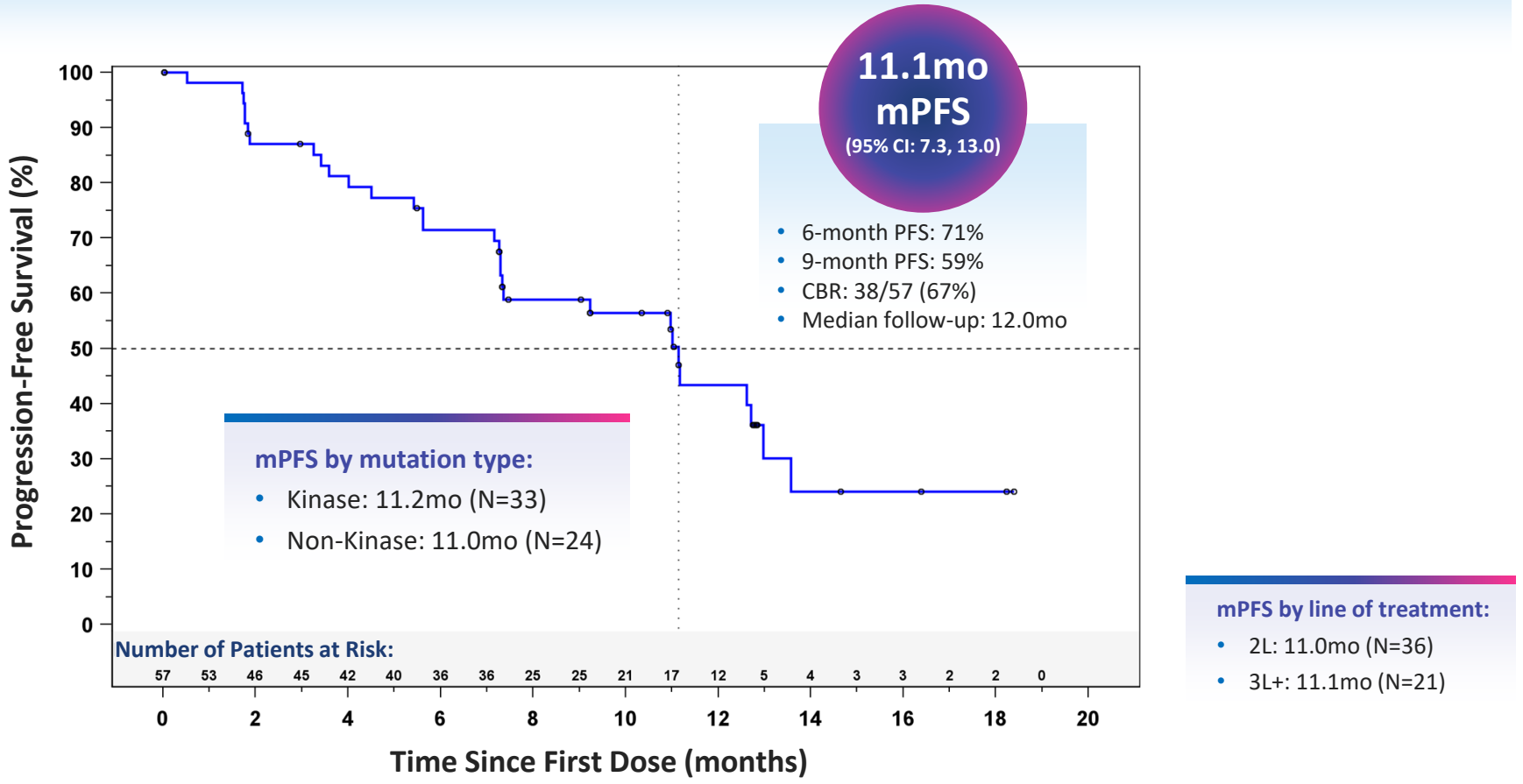
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Zovegalisib – Efficacy: Median PFS 11.1 Months

ReDiscover Clinical Trial 400mg BID Fed Data

Zovegalisib 400mg BID Fed + Fulvestrant

(N=57)



mPFS by line of treatment:

- 2L: 11.0mo (N=36)
- 3L+: 11.1mo (N=21)

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Note: Follow-up estimated based on reversed KM. PFS estimates based on KM methods.

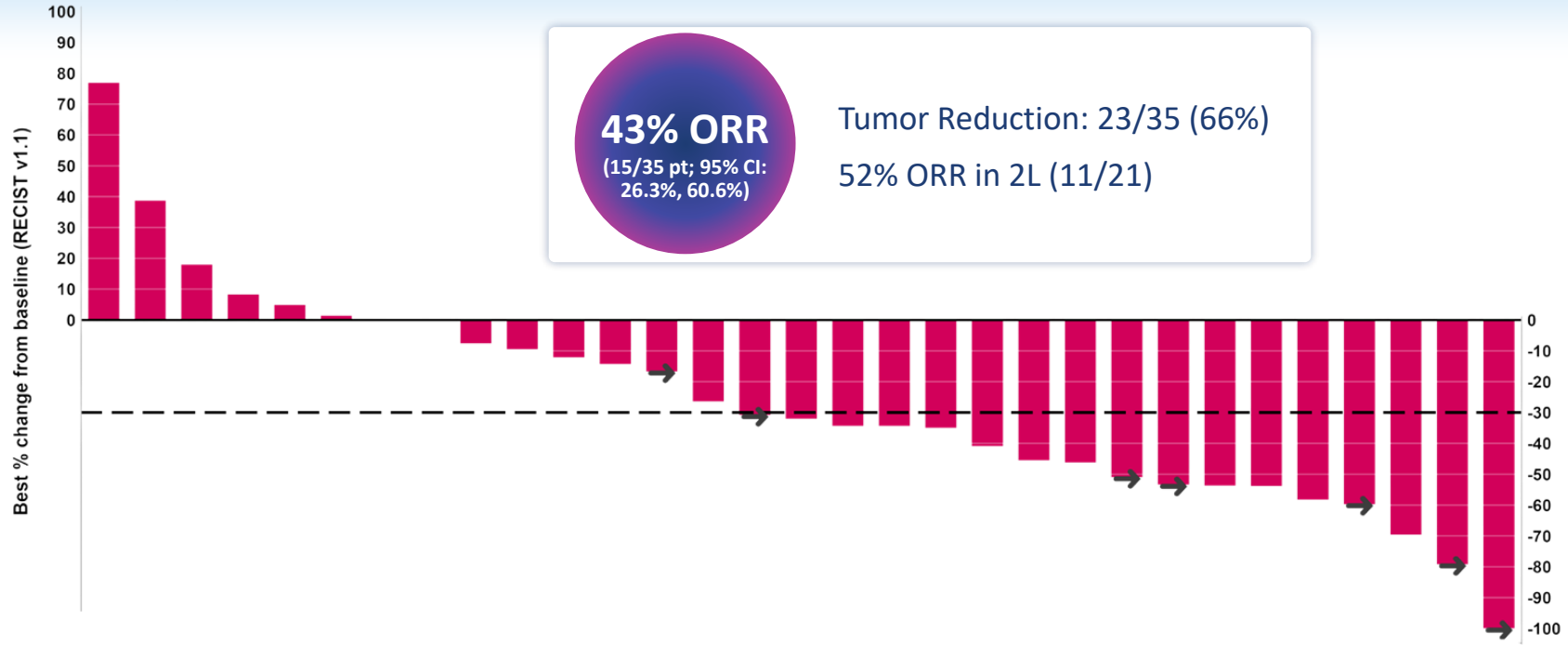
ReDiscover preliminary data as of 01/13/2026

Zovegalisib – Efficacy: Confirmed ORR 43%

ReDiscover Clinical Trial 400mg BID Fed Data

Zovegalisib 400mg BID Fed + Fulvestrant

Measurable Disease (N=35)[1]



Prior Serd	Y	Y			Y	Y		Y				Y	Y		Y	Y			Y	Y					Y	Y		Y	Y	Y	
≥2 prior lines	Y	Y		Y		Y		Y				Y	Y		Y				Y	Y					Y					Y	
PIK3CA mut	K	NK	NK	K	NK	NK	NK	NK	NK	NK	K	K	K	NK	K	K	K	NK	K	NK	K	K	K	K	NK	K	K	K	K	K	K
ESR1	Y	N	N	Y	Y	Y	N	Y	N	N	Y	Y	Y	Y	N	N	Y	N	Y	Y	N	N	N	N	N	Y	N	N	Y	N	N
BOR	PD	PD	PD	PD	SD	SD	SD	SD	SD	SD	SD	SD	SD	PD	PR	SD	PR	PR	SD	PR	PR	PR	PR	PR	PR	PR	PR	PR	PR	PR	PR

BOR = Best Overall Response:

- PR Partial Response
- SD Stable Disease
- PD Progressive Disease

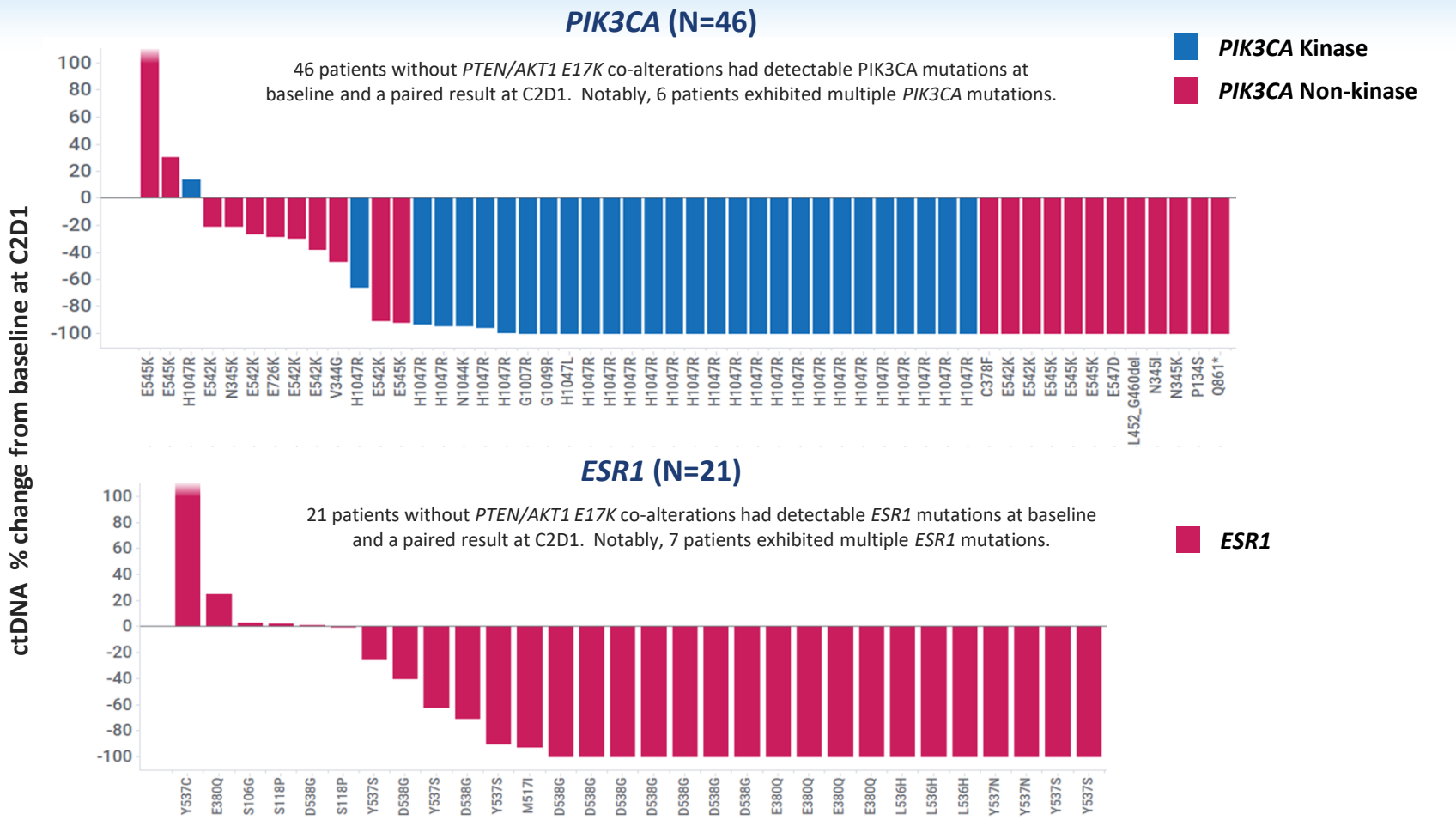
[1] Excludes patients with PTEN or AKT1 E17K co-mutation at baseline. [2] Includes 4 pts discontinued treatment prior to 1st post-baseline scan: 1 with scan performed at other site, it was assessed as PD, but no image was available, 1 withdrew consent, 1 AE (creatinine increased) and 1 Clinical PD; PIK3CA mutation: "K" = Kinase domain mutation, "NK" = Non-Kinase domain mutation

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Zovegalisib – Efficacy: ctDNA Clearance

ReDiscover Clinical Trial 400mg BID Fed Data

Zovegalisib 400mg BID Fed + Fulvestrant



- **94%** of patients had decline in of clearance in *PIK3CA* ctDNA by C2D1
- **81%** of patients had decline in or clearance in *ESR1* ctDNA by C2D1

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1. N=36 patients without PTEN/AKT co-alterations who have detectable PIK3CA at baseline and a paired C1D1-C2D1 ctDNA result are presented

ReDiscover preliminary data as of 01/13/2026

PI3Kα Inhibitors – Efficacy Profiles

ReDiscover Clinical Trial 400mg BID Fed Data

Doublet Combination Regimens

	Alpelisib + fulv Approved 2019	Capivasertib + fulv Phase 3 comparator	Zovegalisib + fulv (Phase 3 Dose: 400mg BID Fed)
Data source	EPIK-B5[1] (N=188)	CAPItello-291[2] (N=355)	**ReDiscover** **(N=57)**
% ≥2 prior LoT	84%	23%	**37%**
% prior SERD[3]	NR	0%	**43%**
mPFS	**7.4mo**	**5.5mo[4]**	**11.1mo** **Kinase** 11.2mo **Non-kinase** 11.0mo
CBR	NR	56%	**67%**
ORR	23%	26%[5]	**43%**

Phase 3 trial regimens

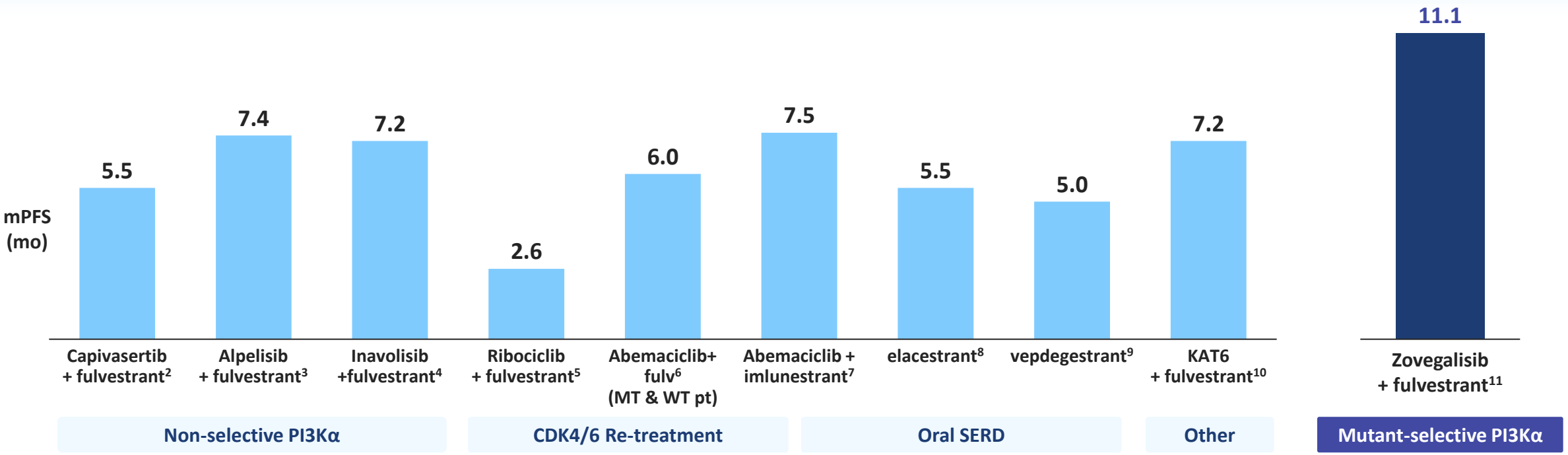
Capi ORR & CBR include 30% of pts who are CDK4/6-naïve

1. EPIK-B5, SABCS 2025 #RF7-02; 2. Turner N Engl J Med 2023; 388:2058-2070 (n=355), and FDA prescribing information; 3. Prior SERD includes fulvestrant and next-generation SERDs; 4. 5.5mo mPFS reported in CDK4/6-experienced patient sub-population of CAPItello-291. Note: These data are derived from different clinical trials at different points in time, with differences in molecule composition, trial design and patient populations. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted.

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Limited Duration of Benefit Following CDK4/6 Inhibitor Regardless of MoA

mPFS in CDK4/6-Experienced, *PIK3CA*mut Patient Population[1]



Current therapies only provide ~5-7.5mo mPFS for CDK4/6-experienced, *PIK3CA*mut patient population

1. Includes ET monotherapy and doublet combinations. Not shown is palbociclib + gedatolisib + fulvestrant triplet combination Ph1 data: mPFS 14.6mo, n=11 at intermittent dosing schedule (source: CELC corporate presentation, Layman R. Lancet Oncol. 2024;25:474-8); 2.CAPItello-291: Turner N Engl J Med 2023; 388:2058-2070 (n=355); 3. EPIK-B5, SABCS 2025 #RF7-02; 4. Inavolisib Ph1b: SABCS 2021 #P5-17-05 (n=60); 5. MAINTAIN: Kalinsky J Clin Oncol 2023; 41(24):4004-4013; 6. postMONARCH: Kalinsky J Clin Oncol 2024; 43:1101-1112; 7. EMBER-3 PI3K-path mutated subgroup analysis: Saura, ESMO Breast 2025; 8. EMERALD subgroup analysis: Bardia Clin Cancer Res 2024;30(10):4299-4309; 9. VERITAC-2: Campone NEJM 2025; 10. Mukohara Nature Medicine 2024;30:2242-2250; 11. ReDiscover preliminary data as of 01/13/26.
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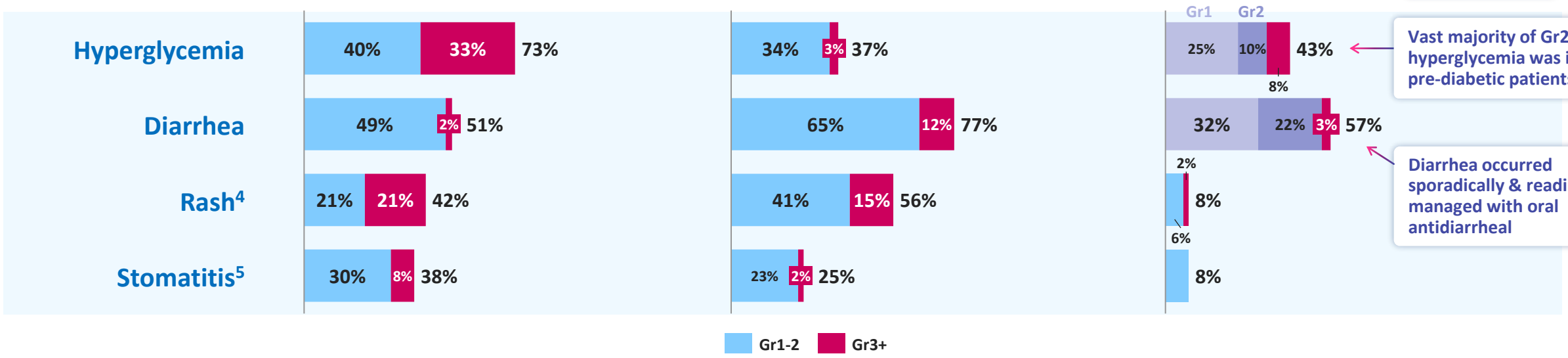
PI3Kα Inhibitors – Tolerability Profiles

ReDiscover Clinical Trial 400mg BID Fed Data

Doublet Combination Regimens

	Alpelisib + fulv Approved 2019	Capivasertib + fulv Phase 3 comparator	Zovegalisib + fulv (Phase 3 Dose: 400mg BID Fed)
Data benchmark	EPIK-B5[1] (N=188)	CAPItello-291[2] (N=355)	**ReDiscover** **(N=60)**
HbA1c enrollment criteria	Undisclosed	<8%[3]	**<7%**

53% of patients pre-diabetic at baseline[6]



Vast majority of Gr2/3 hyperglycemia was in pre-diabetic patients

Diarrhea occurred sporadically & readily managed with oral antidiarrheal

1. EPIK-B5, SABCS 2025 #RF7-02; 2. FDA Prescribing Information; 3. per CAPItello-291 enrollment criteria; 4. Rash for alpelisib references the cumulative sum of rates of rash and rash maculo-papular from the EPIK-B5 study, and may include overlap. Rash for capivasertib references Cutaneous Adverse Reactions grouped term includes a number of preferred terms listed in FDA Prescribing Information; 5. Stomatitis for alpelisib references the cumulative sum of rates of stomatitis and mucosal inflammation from the EPIK-B5 study, and may include overlap; 6. Pre-diabetic: baseline HbA1c ≥5.7 to <6.5, glucose ≥100, or medical history of pre-diabetes mellitus.

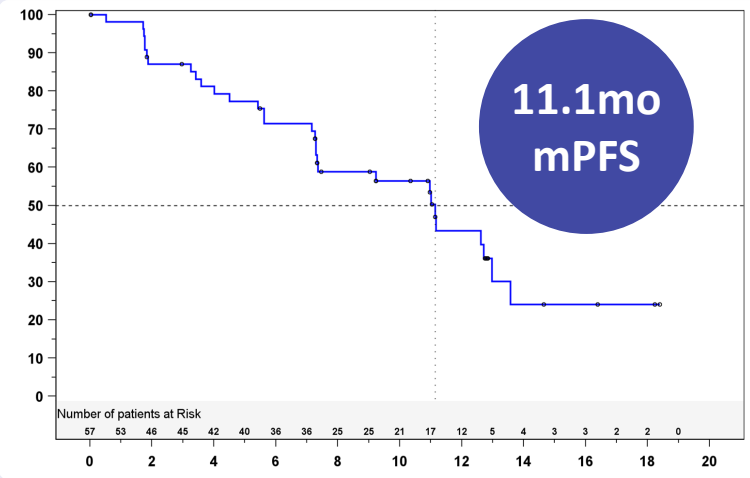
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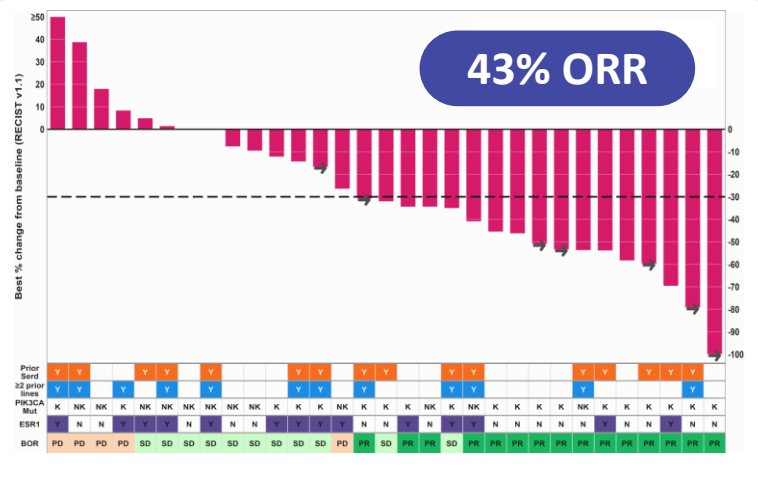
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Zovegalisib – Consistent Activity Between 400mg & 600mg Doses

400mg BID Fed + Fulv[2]

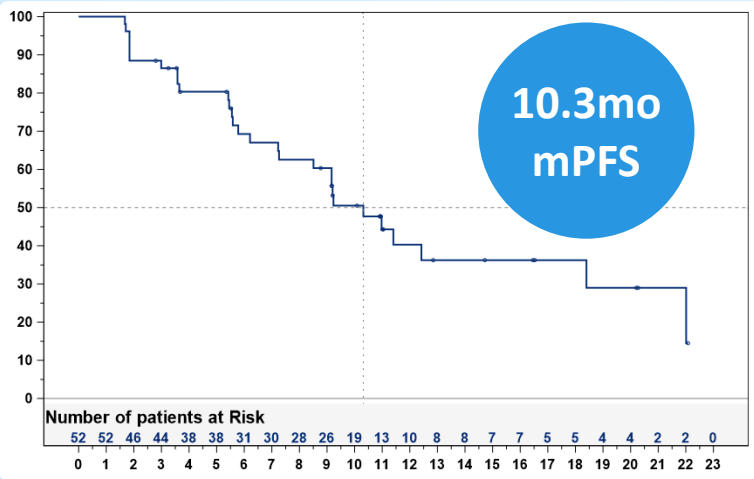
Median follow-up: 12.0mo

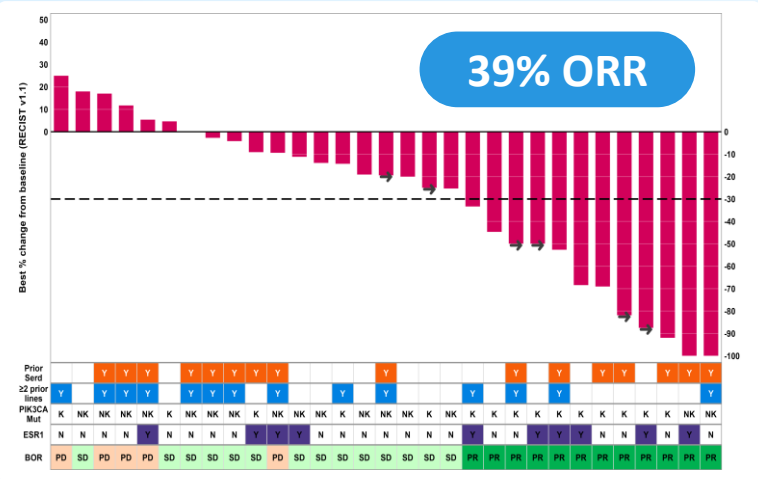




600mg BID Fasted + Fulv[1]

Median follow-up: 12.5mo





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1. ReDiscover preliminary data as of 03/26/2025; 2. ReDiscover preliminary data as of 01/13/2026

Zovegalisib – TRAEs

		400mg BID Fed (N=60)			
		All Gr	Gr1	Gr2	Gr3
TRAE ≥15%[1]	Diarrhea	57%	32%	22%	3%
	Fatigue	52%	20%	27%	5%
	Nausea	52%	28%	22%	2%
	Blood creatinine increase	47%	25%	20%	2%
	Hyperglycemia	43%	25%	10%	8%
	Dysgeusia	37%	28%	8%	-
	Headache	28%	17%	12%	-
	Hypokalemia	25%	12%	3%	10%
	Decreased appetite	23%	22%	2%	-
	Vomiting	23%	17%	7%	-
	Anemia	20%	10%	7%	3%
Other select TRAE[1]	Rash	8%	3%	3%	2%
	Stomatitis	8%	7%	2%	-

← Diarrhea occurred intermittently & readily managed with oral antidiarrheal

← Most hyperglycemia observed was Grade 1 (no intervention required)

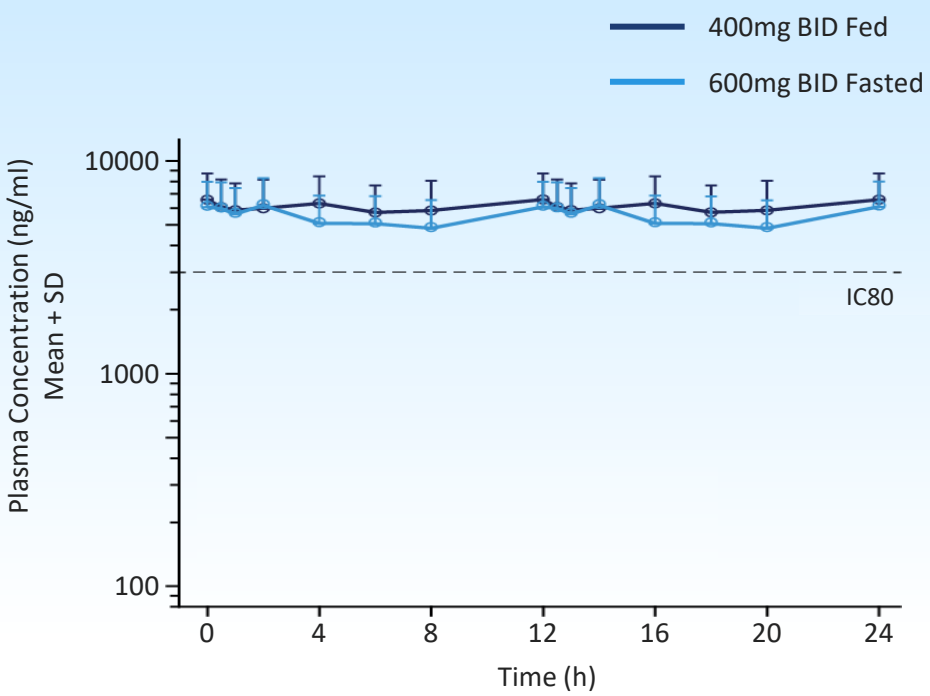
- Vast majority of Gr2/3 hyperglycemia observed in pre-DM patients

TRAEs includes MedDRA v28.0 Preferred Terms (PT): Fatigue: Fatigue, Asthenia; Creatinine Increased: Blood creatinine increased, hypercreatininaemia; Hyperglycemia: Hyperglycemia, Blood Glucose Increased; Hypokalemia: Hypokalemia and blood potassium decreased; Rash: Rash, Rash Macular, Rash Maculo-Papular. Note: 4 dose discontinuations due to:(1) Chronic kidney disease, Gr2; (1) Creatinine increase, Gr2; (1) neutropenia, Gr3; (1) Severe cutaneous adverse reaction dress syndrome, Gr3.

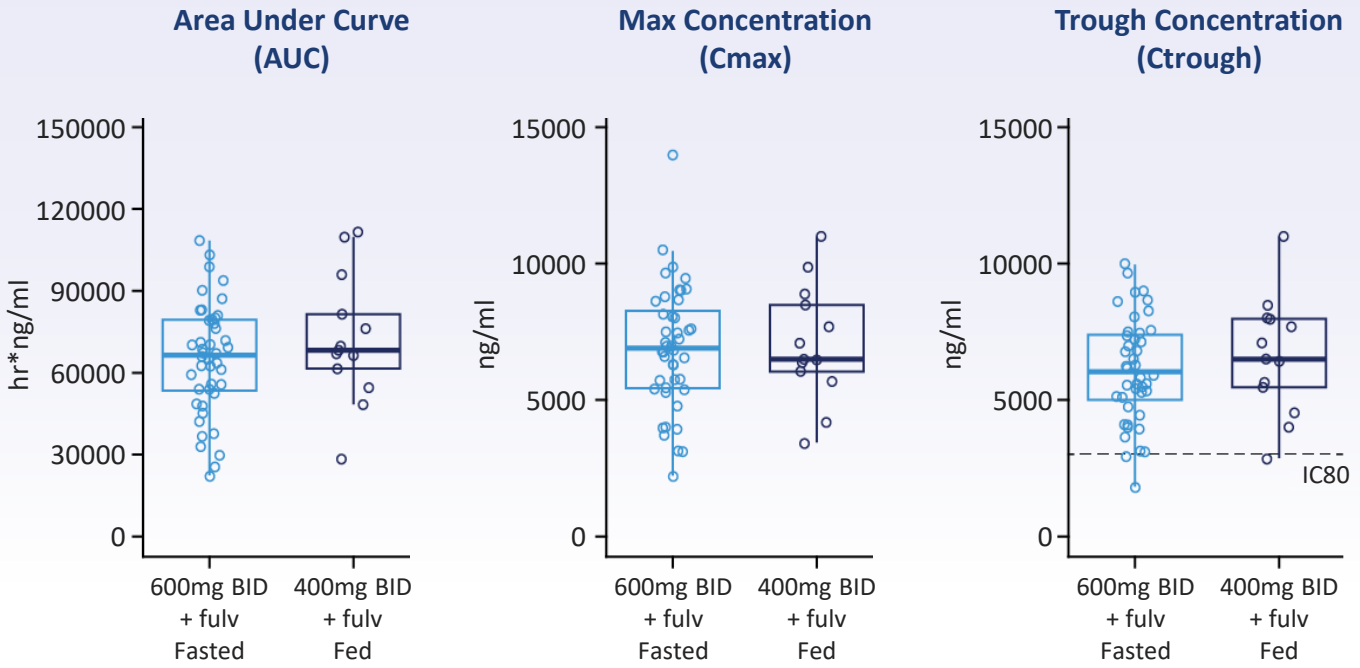
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Zovegalisib – PK Profile for 400mg BID Fed Dose

Mean Concentration vs Time at Cycle 1 Day 15



Steady State Pharmacokinetics Measures at Cycle 1 Day 15



Average zovega concentration approaches IC90 in majority of patients, covers IC80 at trough for nearly all patients

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ReDiscover preliminary data as of 10/28/2025

Zovegalisib – Phase 3 ReDiscover-2 Trial

ReDiscover-2 STUDY

Initiated mid-2025, enrolling globally

Key eligibility criteria:

- HR+/HER2- advanced Breast Cancer
- Any *PIK3CA* mutation with no known PTEN or AKT mutation
- HbA1c <7% and fasting plasma glucose <140 mg/dL at baseline
- 1 prior CDK4/6 inhibitor in either metastatic or adjuvant1 setting
- Up to 1 prior chemotherapy[2] (no prior ADC)
- 1 or 2 prior endocrine therapies
- 6 months or longer duration of therapy on frontline ET regimen

Zovegalisib granted BTD in 2L breast cancer setting

R 1:1

N=540

Zovegalisib (400 mg BID Fed) + fulvestrant

Capivasertib (400 mg BID 4 days on, 3 days off) + fulvestrant

Stratification:
PIK3CA mutation type, visceral disease, geography

Primary endpoints (hierarchical):

- PFS (kinase)
- PFS (overall)

Key secondary endpoints:

- OS
- ORR
- DoR
- CBR
- QoL

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1. Disease progression during or within 1 year of completing adjuvant therapy; 2. Applies to chemotherapy administered in the advanced setting.

Zovegalisib – Potential To Address 3 Large Commercial Opportunities

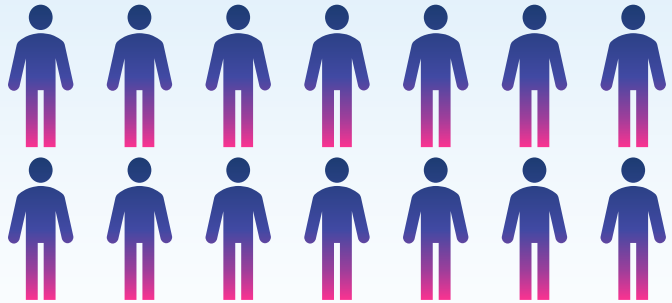
	2L Breast Cancer	1L Breast Cancer	Vascular Anomalies
Estimated US TAM	$2-3B	**$7-8B**	$6-8B

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Note: TAM calculated based on market benchmarks and internal analysis

1L Breast Cancer – Large Commercial Market

~35,000 Patients
1L Breast Cancer
(PIK3CA mutated)



Patients in G7 markets[1]

Large Existing CDK4/6 Market in 1L+

IBRANCE® palbociclib 125 mg capsules	Verzenio® abemaciclib	KISQALI® ribociclib 200 mg tablets
~$3B	~$3B	~$4B

Estimated global sales in metastatic setting[2]

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1. Decision Resources Group market forecast G7 drug treated HR+/HER2- patients totals ~84,000 in 2026, assume 40% PIK3CA-mut (March 2026) ; 2. Global sales estimations for 2026 Evaluate Pharma, March 2026.

PIK3CA Mutant Inhibition Provides Clear Benefit in 1L Breast Cancer

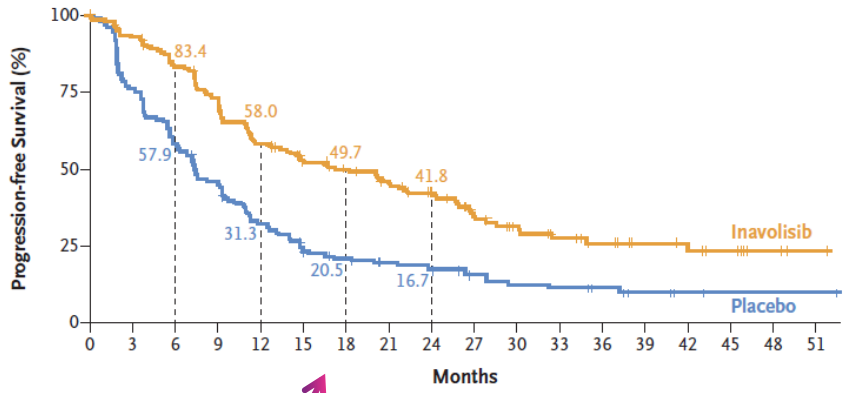
Non-selective PI3Kα inhibitor has shown PFS & OS benefit in 1L

INAVO120[1]: 1L Endocrine Resistant

Inavolisib + palbo + fulv

vs.

placebo + palbo + fulv



PFS HR: 0.42
(17.2mo vs. 7.3mo)

OS HR: 0.67
(34.0mo vs. 27.0mo)

However, toxicity is limiting; inavolisib not broadly used in 1L

91% Gr3+ AE rate[1]

"Dear Dr." letter for ketoacidosis[2]

<$150M annual sales in 2025[3]
despite proven OS benefit

Opportunity to improve outcomes for PIK3CAmut patients in 1L

Sources: 1. INAVO120: Jhaveri 2025, N Engl J Med 2025;393:151-161; 2. Genentech Important Drug Warning, March 2025; 3. Company financial results

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Zovegalisib – Establishing 1L Triplet Combinability in Median 3L Patients

Ideal 1L Profile of Zovegalisib Triplet

Zovega + CDKi + ET

Superior efficacy

Comparable tolerability

Supportive data from median 3L patients:

Triplet similar ORR in median 3L vs. CDK4/6+ET doublet ORR in 1L

Triplet toxicity profile appropriate for long-term 1L use

Current ongoing zovegalisib triplet dose finding in 2L+ patients

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1L Breast Cancer – Demonstrating Zovega + Atirmo + AI Combinability

	Doublet		Triplet
	Standard of Care CDK4/6 + ET		Zovega + Atirmo + ET
Study Population	1L Patients	vs.	Median 3L Patients
Efficacy	53-55% ORR	vs.	✓ 44% ORR
Tolerability	50-90% Gr3+ AE	vs.	✓ 40% Gr3+ AE

Zovega + Atirmo + ET selected as go-forward 1L regimen;
Trial intended to initiate in early 2027

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Zovegalisib – Laying the Foundation for Potential Next-Gen 1L Combos

Ph1 arms for triplet combinations (in 2L+ patients)

Zovegalisib	+	Atirmociclib (CDK4-selective)	+	fulvestrant
Zovegalisib	+	Ribociclib (CDK4/6i)	+	fulvestrant
Zovegalisib	+	Palbociclib (CDK4/6i)	+	fulvestrant

Zovega + Atirmo + ET
Selected as preferred go-forward regimen for 1L Phase 3 trial

Recent topline readout for FourLight-1 trial[1]:

- Atirmo + fulv in 2L patients
- 0.6 Hazard Ratio
- Only 6% discontinued due TEAE

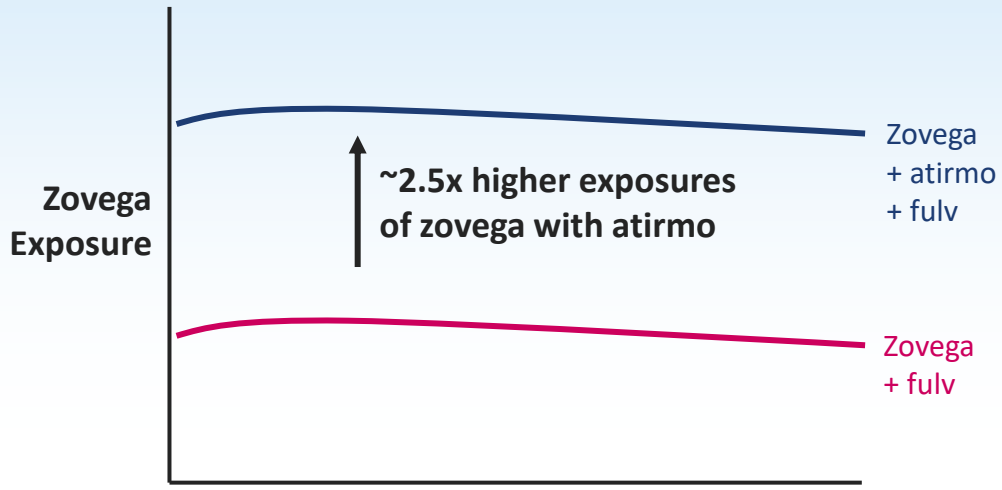
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1. FourLight-1 evaluates atirmociclib + fulvestrant vs. fulvestrant or everolimus + exemestane

Zovegalisib Triplet – Dose Escalation

Positive Drug Interaction Observed

Zovega exposures ~2.5x higher in atirmo triplet combo than in fulvestrant doublet at same dose



Atirmociclib exposures are not impacted by zovega

Dose Escalation

Phase 3 dose, pending regulatory feedback

- **200mg BID Zovega**
- **150mg BID Zovega**
- **100mg BID Zovega**

+ atirmo (100-300mg) + fulvestrant

The following data is for 62 patients dosed with zovega + atirmo triplet (median follow-up 7.4mo)

excludes 200mg BID zovega + 300mg BID atirmo dose which is deprioritized for further development (N=7)

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Zovegalisib + Atirmociclib Triplet – Demographics

	Zovegalisib + Atirmociclib + Fulvestrant (n=62)
Age, Median (Range), Years	61.5 (33, 79)
ECOG, 0 / 1, n (%)	45 (72.6) / 17 (27.4)
Local PIK3CA Baseline Results	
Kinase Mutation, n (%)	33 (53.2)
Non-Kinase Mutations, n (%)	29 (46.8)
Pre-diabetic[1] n (%)	29 (46.8)
Measurable Disease, n (%)	38 (61.3)
Patients with Visceral Metastases, n (%)[2]	39 (62.9)
Prior Lines of Therapy in Advanced Setting, n (%)	2
0	2 (3.2)
1	28 (45.2)
2	19 (30.6)
3+	13 (21.0)
Prior Therapies in Advanced Setting	
CDK4/6, n (%)[3]	59 (95.2)
Fulvestrant or Novel SERD, n (%)	36 (58.1)
Chemo / ADC, n (%)	18 (29.0)
PI3Ki / AKTi, n (%)	10 (16.1)
ESR1 Mutation[4], n (%)	22/53 (41.5)

← **Nearly half of patients are pre-diabetic**

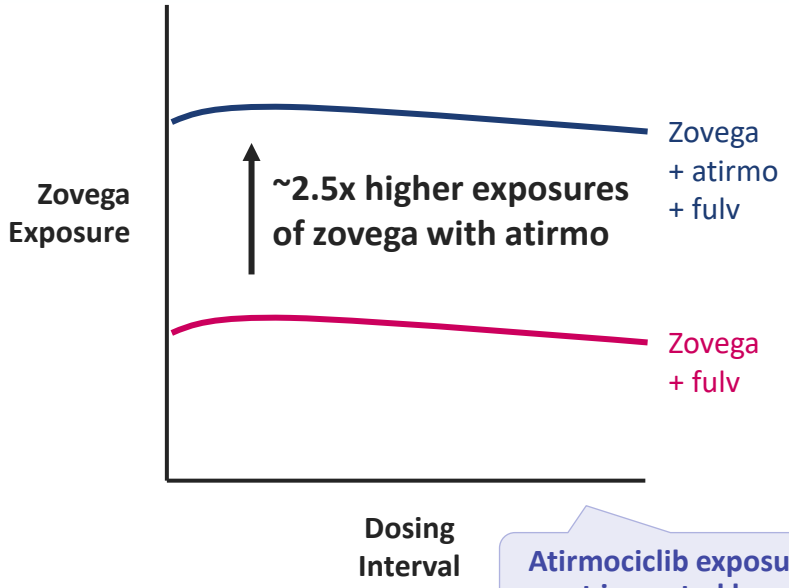
← **Median 3L with 21% of patients 4L+**
(zovega doublet data is median 2L)

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1. Baseline HbA1c ≥5.7, glucose ≥100, or medical history of pre-diabetes mellitus; 2. Visceral metastatic sites include brain, lung, liver, pleural, peritoneal involvement; 3. 3 patients received prior CDK4/6 in the adjuvant setting which is allowed per protocol; 4. Percentage was based on pts with evaluable ctDNA data at baseline. ECOG = Eastern Cooperative Oncology Group performance status

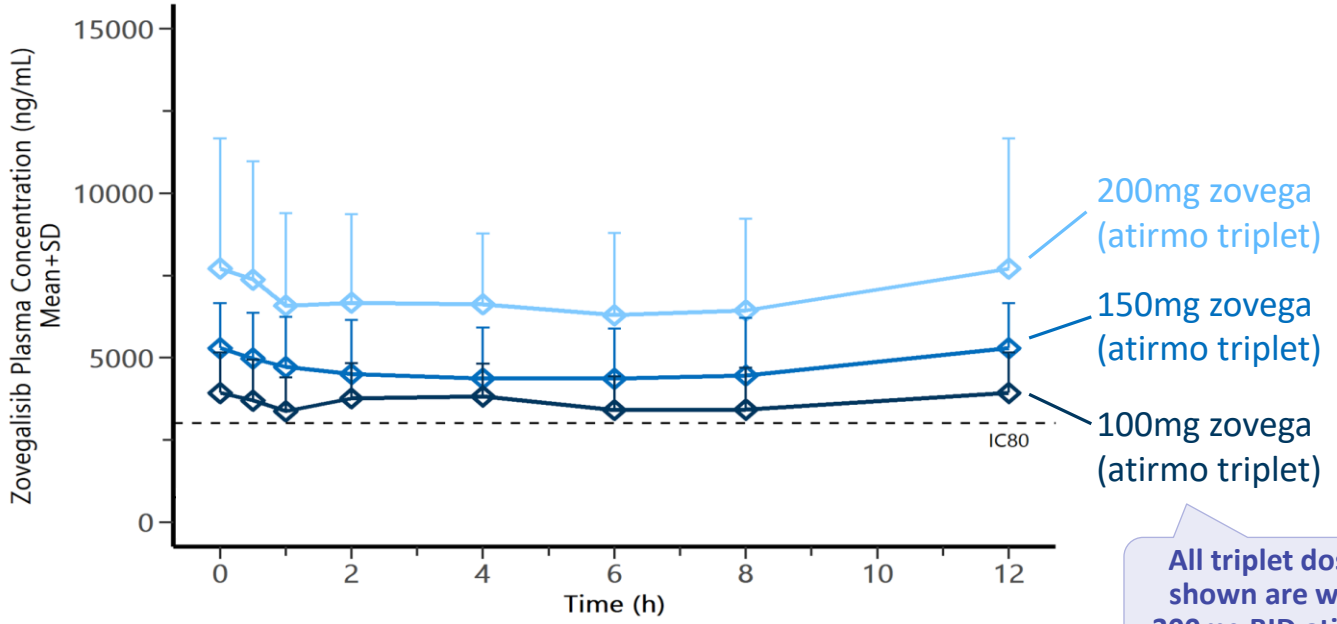
Zovegalisib PK Profiles with Atirmociclib + Fulvestrant

Drug interaction observed



Atirmociclib exposures are not impacted by zovega

Dose proportional exposures of zovegalisib above IC80

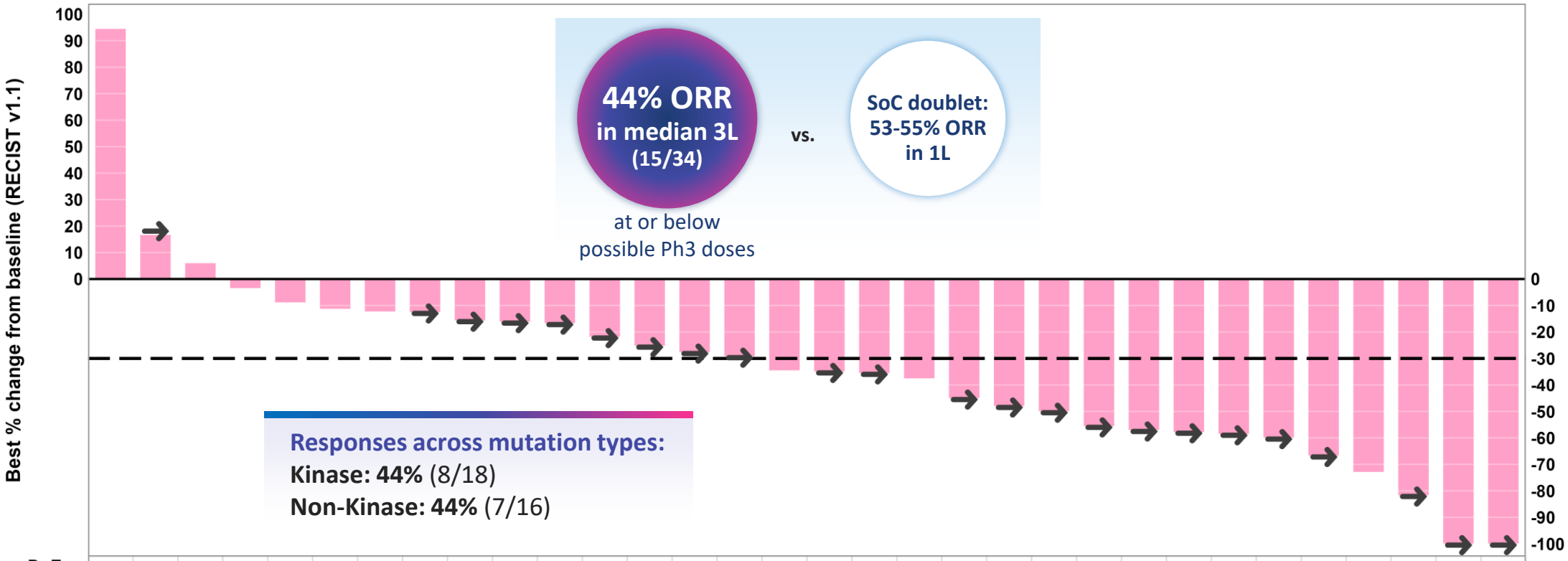


All zovega doses above IC80

All triplet doses shown are with 300mg BID atirmo

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Zovegalisib + Atirmociclib Triplet – Efficacy in Median 3L Patients



DoE (weeks)	10	12	27	18	16	16	32	41	32	20	20	8	40	14	28	16	36	40	10	40	48	49	64	14	42	48	40	8	33	40	29	40
Prior Serd	Y	Y	Y	Y	Y		Y			Y	Y	Y	Y	Y	Y	Y	Y		Y		Y								Y		Y	Y
≥2 prior lines		Y	Y	Y	Y		Y				Y				Y	Y	Y		Y		Y					Y			Y		Y	Y
PIK3CA Mut	NK	NK	NK	K	K	K	K	K	NK	K	NK	K	K	K	K	NK	NK	NK	NK	K	NK	K	K	K	NK	NK	K	K	K	NK	K	NK
Prior PI3K AKT			Y	Y											Y		Y												Y		Y	
BOR	PD	SD	SD	SD	SD	SD	SD	SD	SD	SD	SD	SD	SD	SD	SD	SD	PR	PR	SD	PR	PR	PR	PR	uPR	PR	PR	PR	uPR	PR	PR	uCR	PR

Median 3L patients

21% of patients saw prior PI3K pathway inhibitors

2 patients (1 was pre-treated with PI3K pathway inhibitors) who discontinued prior to first post-baseline scan were included in the denominator, which are not shown;
ORR includes 2 unconfirmed PR

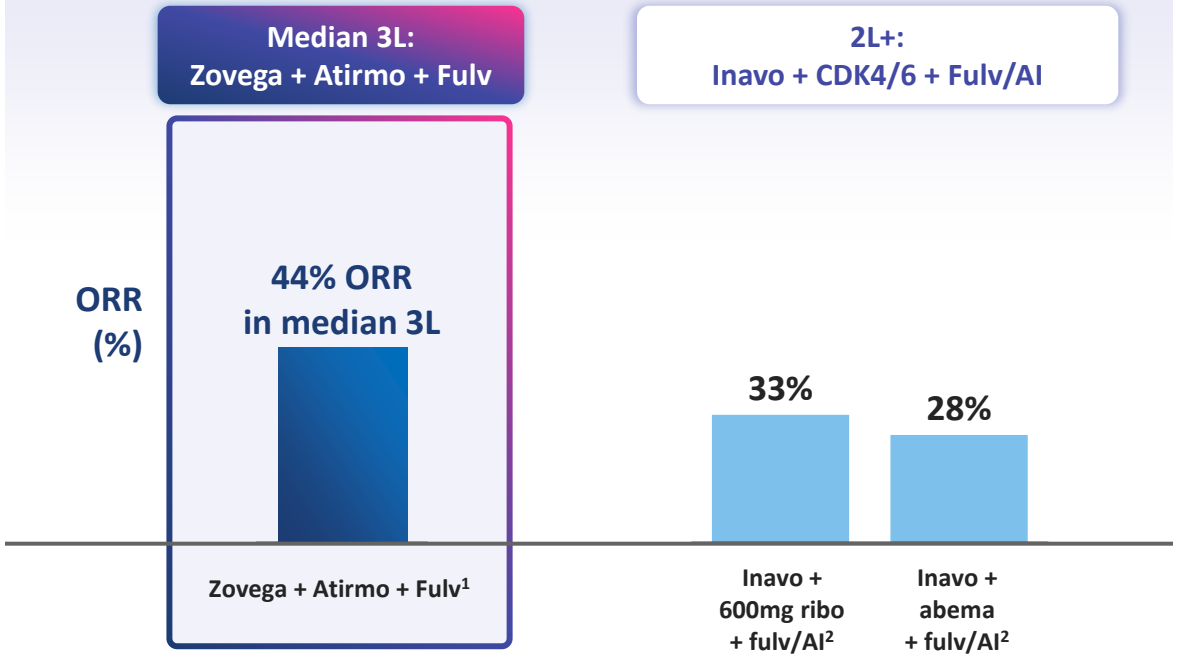
uCR was a confirmed PR

ReDiscover preliminary data as of 04/13/2026

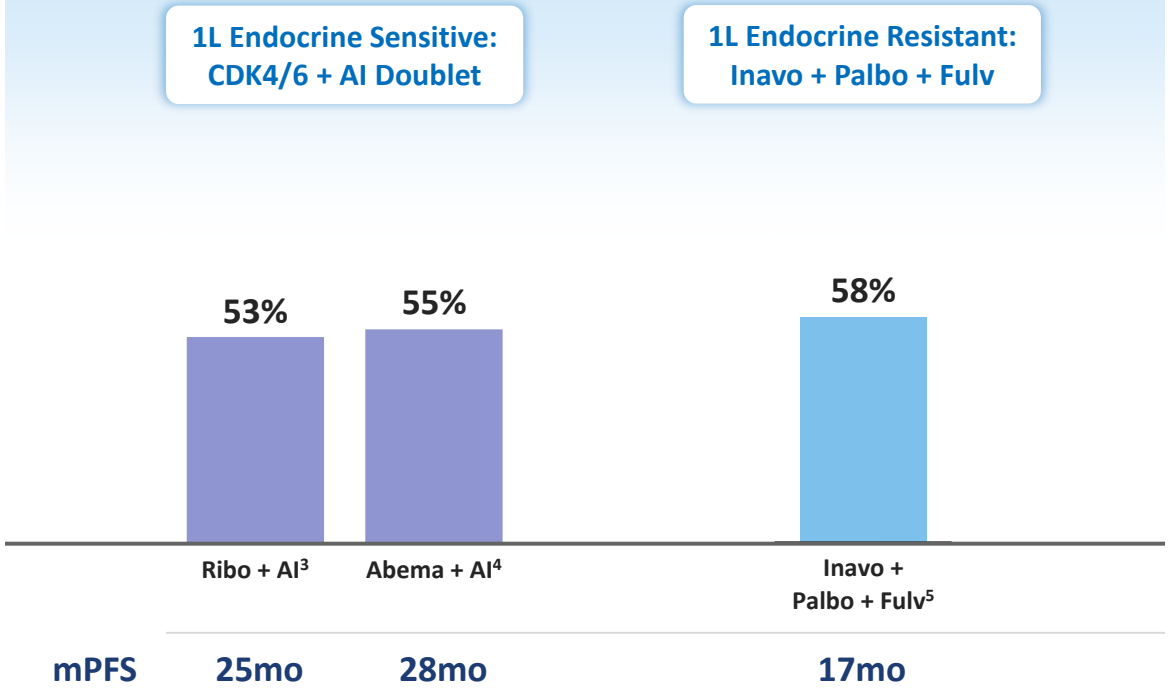
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Zovega Triplet Efficacy Compared Favorably to CDK Regimens in 1L and 2L+

Triplet in 2L+



Approved Regimens in 1L



Zovega + atirmo triplet ORR in median 3L was similar to rates of 1L SoC

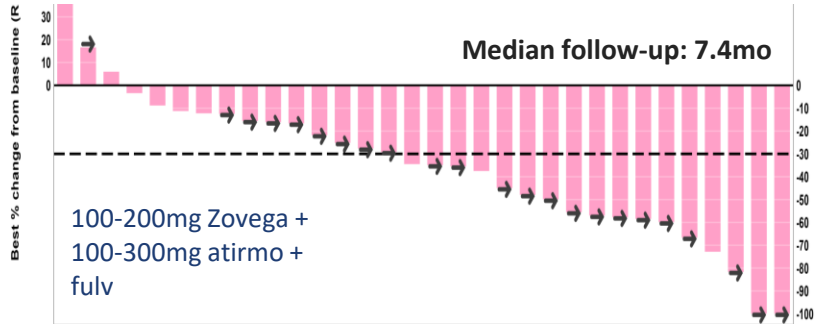
1. ReDiscover preliminary data as of 04/06/2026; 2. MORPHEUS trial SABCS 2025, PD10-08; 3. KISQALI package insert, Novartis Pharmaceuticals; 2017, and Annals of Oncology 29: 1541–1547 (2018); 4. VERZENIO package insert, Eli Lilly and Company (2017); 5. ITOVEBI package insert, Genentech USA, Inc., A Member of the Roche Group (2024). Note: These data are derived from different clinical trials at different points in time, with differences in molecule composition, trial design and patient populations. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted.

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Triplet Efficacy – Zovegalisib + Atirmo vs. Tersolisib + Ribo/Palbo

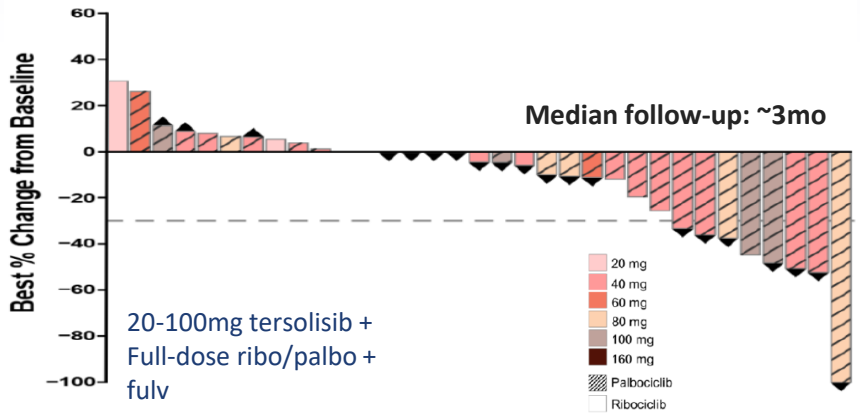
Zovega + Atirmo + Fulv Triplet[1]

44% ORR



Tersolisib + Ribo/Palbo Triplet (SABCS 2025[2])

24% ORR



Zovega + atirmo triplet shows higher ORR and greater lesion reduction than tersolisib + ribo/palbo triplet

1. ReDiscover preliminary data as of 04/13/2026; 2. SABCS 2025 (Jhaveri, PS1-08-24).
Note: These data are derived from different clinical trials at different points in time, with differences in molecule composition, trial design and patient populations. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted.

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Zovegalisib – TRAEs ≥15%

Median 3L →

TRAE ≥15%	Zovegalisib + Atirmociclib + fulvestrant (N=62)			
	All Gr	Gr1	Gr2	Gr3+
Diarrhea	58%	34%	18%	7%
Neutropenia[1,2]	48%	5%	18%	26%
Fatigue[2]	42%	26%	13%	3%
Rash[2]	34%	19%	8%	7%
Nausea	26%	23%	2%	2%
Alopecia	24%	21%	3%	-
Hyperglycemia[2]	23%	18%	5%	-
White Blood Cell Count Decrease	18%	5%	7%	7%
Dry Skin	16%	15%	2%	-
Hypokalemia[1,2]	15%	8%	5%	2%

← 40% Gr3+ TRAEs

← Diarrhea occurred intermittently & was readily managed with oral antidiarrheal

Low rates of dose modification and discontinuation

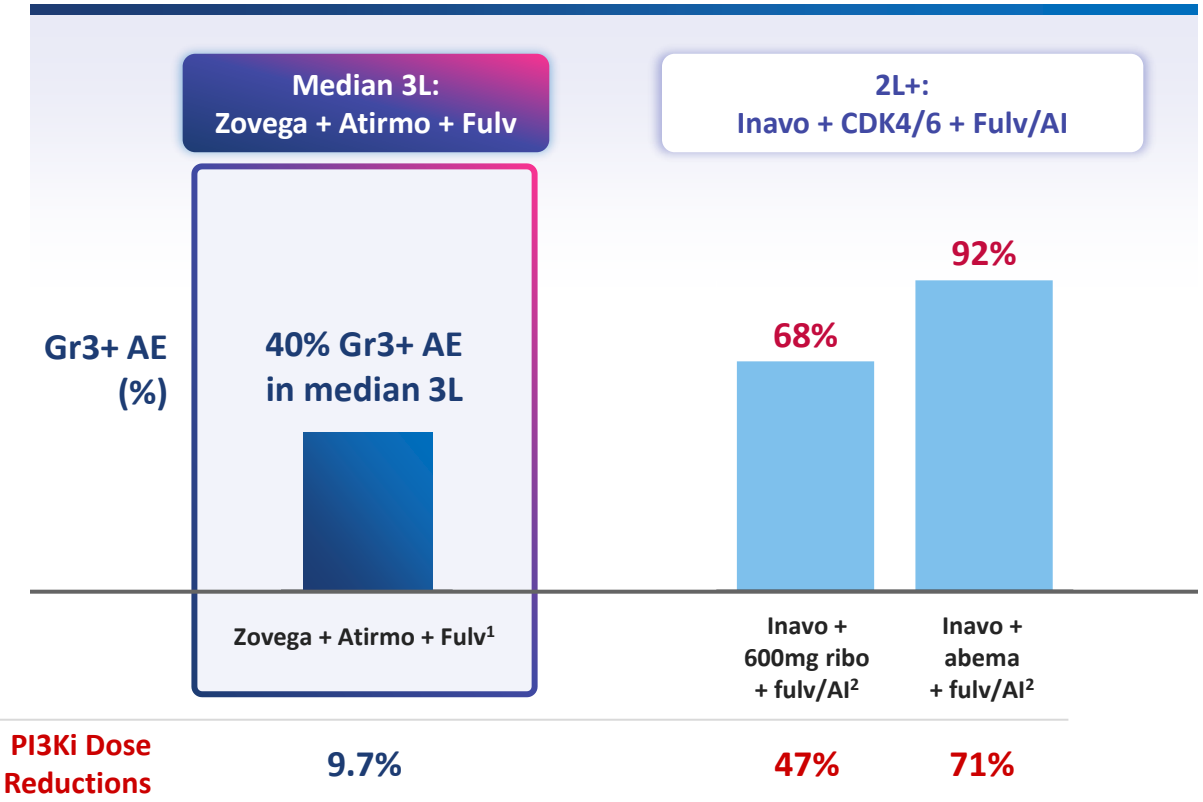
- Dose reduction of zovega due to TRAE: 6 patients (9.7%)
- Dose discontinuation of zovega due to TRAE: 2 patients (3.2%)

Note: 1: 1 patient with Gr4 neutropenia; 1 pt with G4 hypokalemia
2: Hyperglycemia includes Preferred Terms (PT): Hyperglycemia and Blood Glucose Increased; Neutropenia includes Neutropenia and Neutrophil Count Decreased; Fatigue includes the PTs: Fatigue, and Asthenia; Hypokalemia includes the PTs: Hypokalemia and Blood Potassium Decreased; Rash includes the PTs: Rash, Rash Macular, Rash Maculo-Papular.

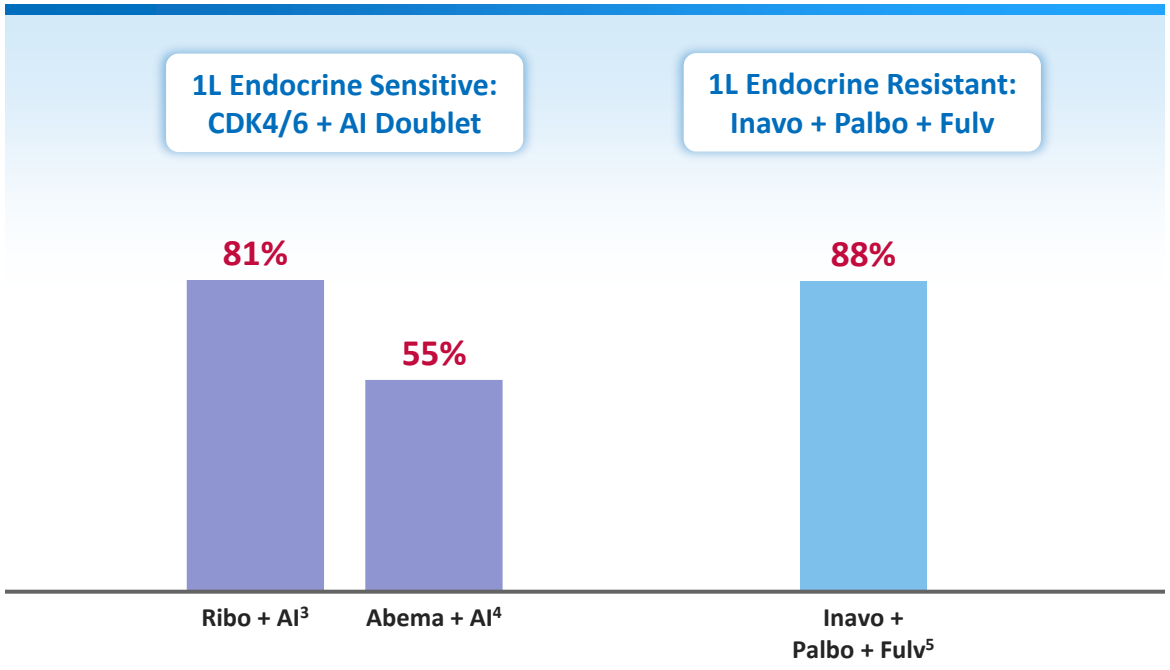
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Zovega Triplet Safety Compared Favorably to CDK Regimens in 1L and 2L+

Triplet in 2L+



Approved Regimens in 1L

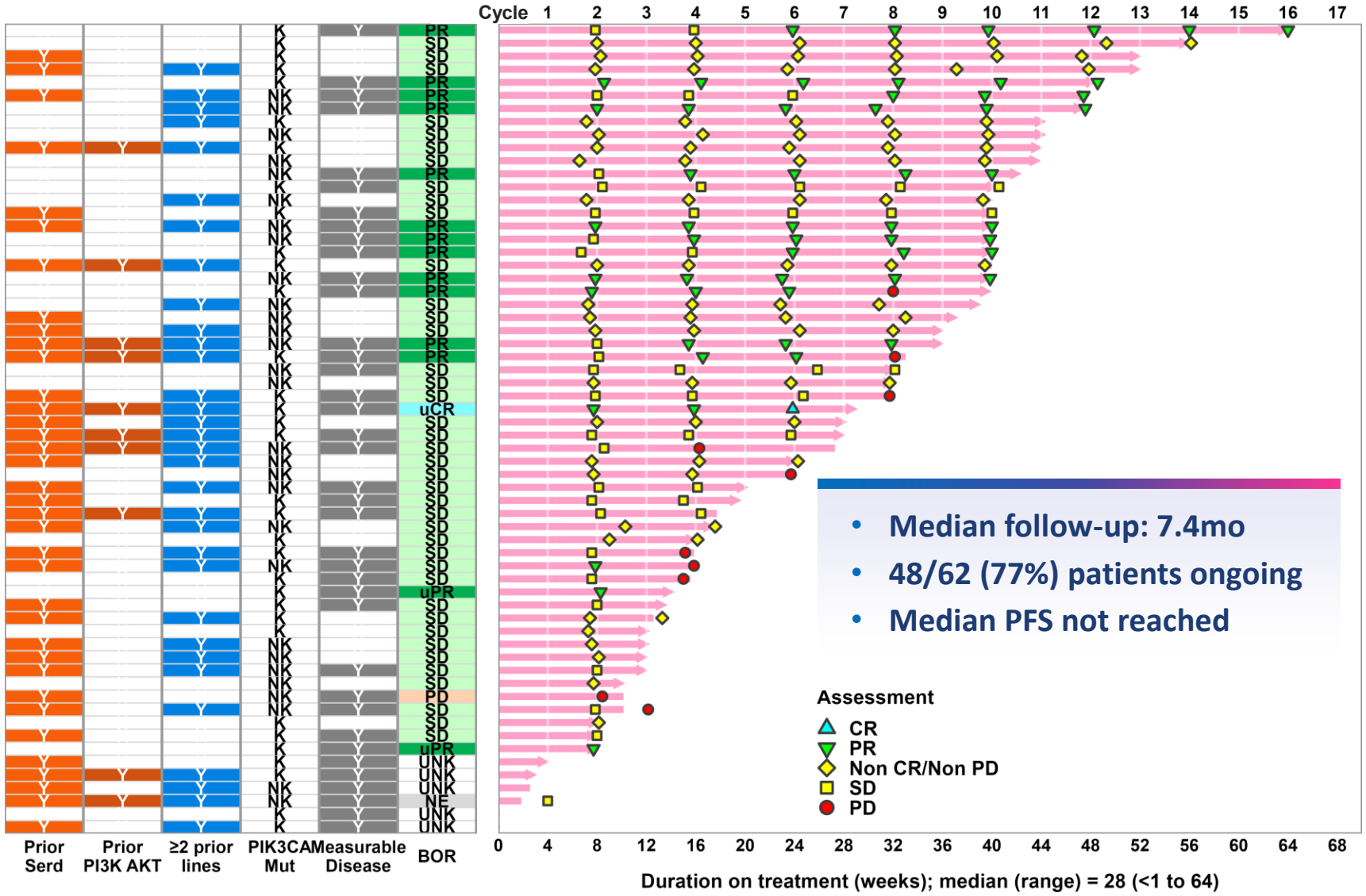


Zovega + atirmo triplet AE rate is lower than that of 1L SoC

1. ReDiscover preliminary data as of 04/13/2026; 2. MORPHEUS trial SABCS 2025, PD10-08; 3. MONALEESA-2, Hortobagyi, GN et al, N Engl J Med 2016;375:1738-48; 4. MONARCH-3, Goetz MP et al, J Clin Oncol 35, 3638-3646(2017); 5. INAVO120, Turner et al, N Engl J Med 2024;391:1584-1596.
Note: These data are derived from different clinical trials at different points in time, with differences in molecule composition, trial design and patient populations. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted.

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Zovegalisib + Atirmociclib Triplet – Swimlane



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Preliminary 1L Metastatic HR+/HER2- Breast Cancer Trial Schema

Preliminary Trial Design
(subject to regulatory feedback)

Key eligibility criteria:

- HR+, HER2- advanced / met BC
- PIK3CA mutation
- No prior line of tx in adv/met setting
- Endocrine sensitive

R 1:1

- Zovegalisib + Atirmociclib + AI
- CDK4/6 (investigator's choice) + AI

Key endpoints:

- mPFS (primary)
- OS (key secondary)

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Zovegalisib – Multiple Future Potential Development Options

PIK3CA-mutated Breast Cancer

	Opportunity Size: 1L PIK3CAm	Adjuvant	1L	2L+
HR+/HER2-	~35k patients	Zovega + ET (+/- CDK)	Zovega + CDK + ET	ReDiscover-2 STUDY Zovega + fulv
			Zovega + ET[1] (select populations)	Zovega + Oral SERD
HER2+	~10k patients	Zovega + HER2-targeted +/- ET		
TNBC	~5k patients	Zovega + chemo/IO		

Patients in G7 markets[2]

1. Patients who had early disease relapse on adjuvant CDK4/6 are eligible for ongoing ReDiscover-2 trial; 2. Decision Resources Group market forecast G7 drug treated HR+/HER2- patients totals ~84,000 in 2026, assume 40% PIK3CA-mut (March 2026)

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Clinical Trial Supply Agreement with Pfizer and Next Steps



- Relay to sponsor, fully operationalize, and fund 1L Phase 3 trial
- Relay retains full global rights for zovegalisib
- Pfizer supplies atirmociclib for experimental arm & palbociclib for control arm

Plan for regulatory interaction in 2026
Aim to initiate Phase 3 trial in 1L Breast Cancer in early 2027

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Zovegalisib – Potential To Address 3 Large Commercial Opportunities

	2L Breast Cancer	1L Breast Cancer	Vascular Anomalies
Estimated US TAM	$2-3B	$7-8B	**$6-8B**

Note: TAM calculated based on market benchmarks and internal analysis

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Vascular Anomalies – Zovega's Promising Initial Efficacy Data & Tolerability Profile

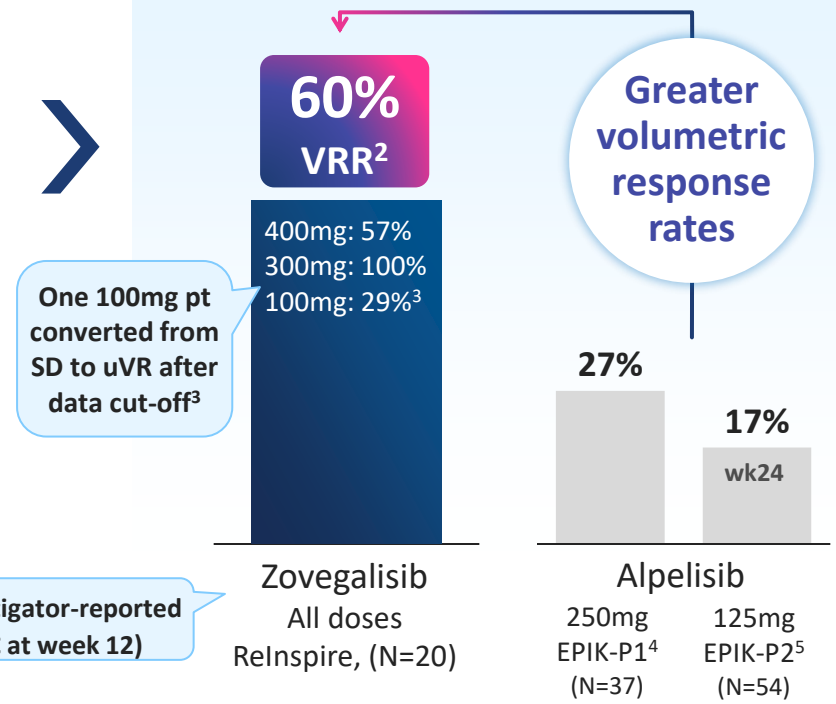
Vascular Anomalies

$6-8B

Estimated US TAM[1]

Initial Efficacy Data

Volumetric Response Rate (VRR)

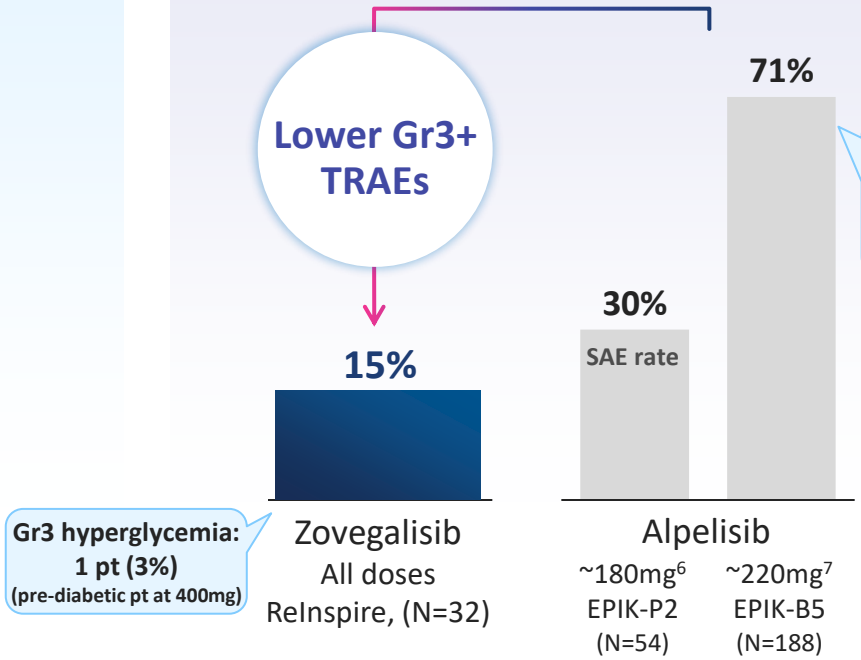


One 100mg pt converted from SD to uVR after data cut-off[3]

89% of patients with investigator-reported clinical improvement (IGIC at week 12)

Initial Tolerability Data

Gr3+ AEs



Gr3 hyperglycemia: 1 pt (3%) (pre-diabetic pt at 400mg)

Data and regulatory update to be presented at ASH 2026 in December

1. TAM calculated based on market benchmarks and internal analysis; 2. Includes both confirmed and unconfirmed responses. 3. After the data cut-off date, one 100mg BID patient that did not have a volumetric response as of the data cut-off date has converted to an unconfirmed response, resulting in a 100mg BID volumetric response rate of 43% (3/7), a volumetric response rate of 69% (9/13) for patients treated at 300mg BID or 100mg BID, and a volumetric response rate of 65% (13/20) across doses. None of the other response-evaluable patients' response statuses have changed since the data cut-off date; 4. EPIK-P1 as cited in Vijoice FDA label, label dose is 250mg QD; 5. EPIK-P2: Canaud 2024 Blood 144:5512 and results from clintrials.gov listing, 125mg QD was starting dose; 6. 180mg dose approximated from rates of dose escalation after week 26 listed on clintrials.gov listing; 7. EPIK-B5: SABCS 2025 #RF7-02, 220mg dose approximated from dose modification data; Gr3 TRAEs = Grade 3+ Treatment-Related Adverse Events, IGIC = Investigator Global Impression of Change scale, SD = Stable Disease, uVR = unconfirmed volumetric response. Note: These data are derived from different clinical trials at different points in time, with differences in molecule composition, trial design and patient populations. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted.

ReInspire median follow-up: 14 weeks

ReInspire preliminary data as of 04/15/2026

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Vascular Anomalies Overview

~170k US patients with PIK3CA-driven Vascular Anomalies

Somatic PIK3CA mutation → **drives malformed vasculature** → **leading to vascular anomalies**





Current treatment options are limited

Local Treatments: temporary, only treat symptoms → **Systemic Treatments: non-selective, limited toxicity/efficacy** → **Large unmet medical need**

Zovegalisib is uniquely positioned to address driver of disease

First mutant-selective PI3Kα inhibitor

Initial clinical data showing:

- Selectivity
- Tolerability
- Efficacy

Potential for chronic systemic treatment option

Sources: ISSVA classification, NORD, Mayo Clinic, Novartis, Penington et al 2023, Gallagher et al 2022, Luks et al 2015, Limaye et al 2015, Peyre et al 2021, Hong et al 2021, and company primary market research

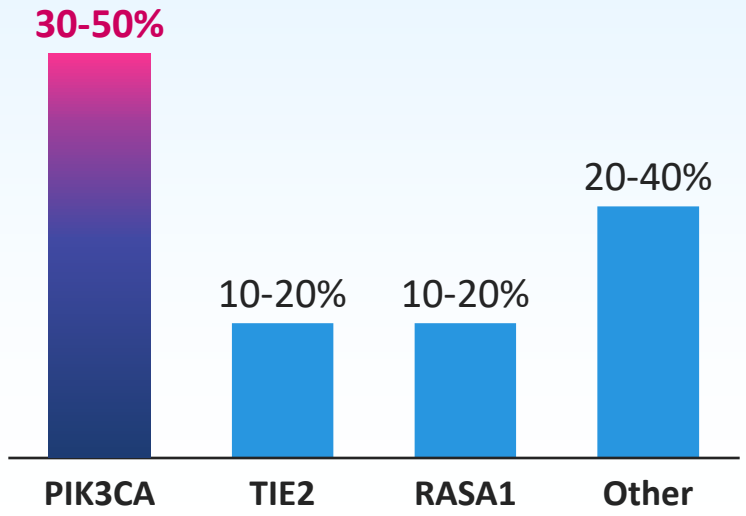
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Vascular Anomalies – Disparate Disorders Driven by Common Somatic Mutations

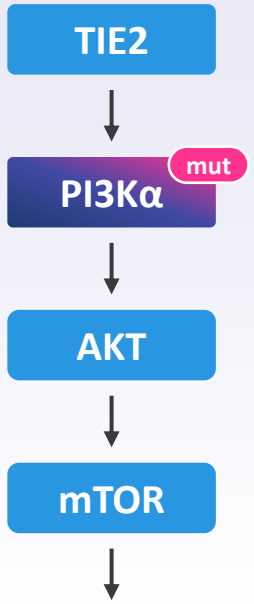
PIK3CA mutations are among the most common driver of Vascular Anomalies[1]

Mutation Frequency by Gene[2]

Unlike cancer, these are often single-driver events occurring in an otherwise quiet genome with intact cell regulation



Somatic mutations to the PI3K pathway drive abnormal development in Vascular Anomalies



Abnormal proliferation, growth, differentiation, angiogenesis

- Cell/tissue overgrowth
- Disorganized vasculature
- Weak vessel walls

Vascular Anomalies

Other tissue types may also be implicated in overgrowth

Mutant PI3Kα is a validated driver of the majority of vascular anomalies

1. For vascular anomalies that may require chronic systemic treatment; 2. Stor et al. 2023

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Vascular Anomalies – Patient Referral Pathway

	Local Providers	Vascular Anomaly Centers of Excellence
DETAILS	**Generalized set of healthcare providers:** • Primary care • Dermatologist • ENT • surgeon	**Coordinated care from vascular anomaly experts:** • Genetic testing, multidisciplinary care team, clinical trial & reimbursement support, etc. • Often associated with children's hospitals in US/Europe
PRESENTATION	**Often present early (birth to 2 years old)** HCP involved depends on primary symptoms	**Usually referral from local providers**
DIAGNOSIS	**Symptoms not usually diagnosed** as part of broader condition	**Experts will diagnose VAs clinically** (+/- genetic testing)
TREATMENT	**Symptomatic treatment,** watch-and-wait approach	**Multidisciplinary treatment approach:** Surgeon, interventional radiologist, dermatologist, hematologist-oncologist

Referral may take years:

- range of symptoms
- rarity of conditions
- misdiagnosis

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Vascular Anomalies – Current Treatment Paradigm

Disease severity	Mild	Moderate	Severe
Current Treatment Paradigm	Watch & wait; Supportive treatment	Local intervention when necessary/possible	Attempt systemic therapy (limited duration)

Available Tx Options	• Compression garments
	• Anticoagulants
	• Pain medication
		• Surgery
		• Laser therapy
		• Sclerotherapy (TARA-002)
		• Topical (QTORIN®)
			• Non-selective targeting:
			  • Alpelisib
			  • Sirolimus
			  • Serabelisib (KP-001)

Limitations	⊖ Temporary; insufficient for majority of patients	⊖ Invasive, painful, likely to recur; Limited to cutaneous or well-defined lesions	⊖ Incomplete responses, side effects & toxicities limit widespread use

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Vascular Anomalies – Potential Future Treatment Paradigm

Disease severity	Mild	Moderate	Severe
Future Treatment Paradigm	Watch & wait; Supportive treatment	**Evaluate chronic systemic therapy** +/- complementary interventions when feasible/beneficial	
Potential Available Tx Options	• Compression garments • Anticoagulants • Pain medication	**Mutant-selective targeting: zovegalisib** +/- complementary local tx: • Surgery, laser therapy • Sclerotherapy (TARA-002) • Topical (QTORIN®)	

Potential benefits of zovegalisib:
Earlier use, better targeting of disease driver, chronic treatment

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Vascular Anomalies – Patient Numbers

Key Vascular Anomalies (VAs) Subtypes



PIK3CA-Related Overgrowth Spectrum (PROS)	Lymphatic Malformations (LM)	Venous Malformations (VeM)	
~5-10k PIK3CA US patients	**~60-65k PIK3CA** US patients	**~20-25k PIK3CA** US patients	**~50-60k TIE2** US patients
	10-30% seek systemic tx		**~5-10%** seek systemic tx

Initial clinical focus: ~25k PIK3CAm + ~2-4k TIE2m US patients seeking systemic therapy

Sources: ISSVA classification, NORD, Mayo Clinic, Novartis, Penington et al 2023, Gallagher et al 2022, Luks et al 2015, Limaye et al 2015, Peyre et al 2021, Hong et al 2021, and company primary market research

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Vascular Anomalies – Phenotype & Symptoms

Variety of Observed Symptoms are Part of Subtypes of the Same Disease

Symptoms



Cosmetic abnormalities



Pain



Reduced mobility



Bleeding



Clotting (risk of stroke)



Reduced blood perfusion



Infection



Vascular invasion of organ tissue

Symptoms occur with a range of severity

PIK3CA-driven Vascular Anomalies

PROS
(PIK3CA-Related Overgrowth Spectrum)

PIK3CA-driven Lymphatic Malformations
(LM)

PIK3CA-driven Venous Malformations
(VeM)

PIK3CA-driven Cerebral Cavernous Malformations
(CCM)

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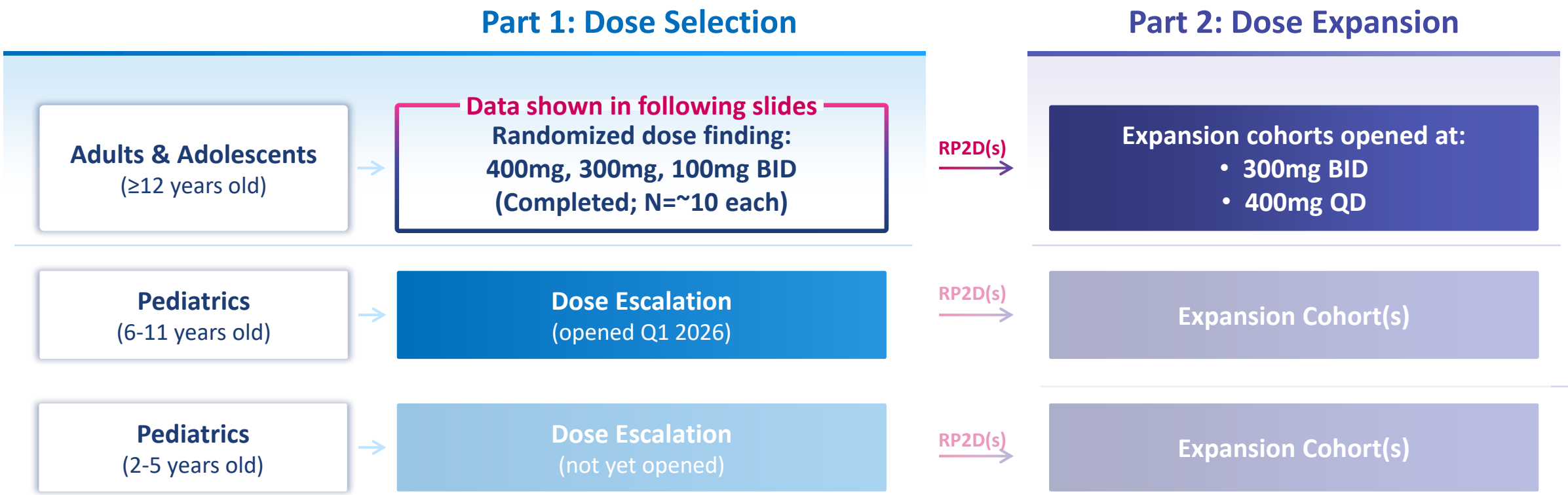
Vascular Anomalies – Systemic Therapy Options

	1st Generation Non-selective PI3K pathway inhibition	2nd Generation Non-selective PI3Kα inhibition		3rd Generation Mutant-selective PI3Kα inhibition
	Sirolimus ***(mTORi)***	**Serebelisib** ***(KP-001)***	**Alpelisib**	**Zovegalisib**
1st Patent Filing	**1994**[1]	**2007**	**2008**	**2019**
Clinical Dev't in VAs	**2010s:** Early use in VAs **2016:** Ph3 VASE trial starts	**2021:** 1st VAs trial in Japan **2026:** Ph3 trial in US	**2020:** EPIK-P1 for AA	**2024:** ReInspire
Approvals	**1999:** Renal transplant *later LAM ('15), angiofibroma ('22)*	**FIH 2013** for solid tumors (not approved)	**2019:** Breast cancer **2023:** AA in PROS	n/a
	mTOR inhibition leads to immunosuppression: infection risk	**Target coverage limited by WT PI3Kα toxicity: Diarrhea/GI tox, hyperglycemia, rash, hair loss, decreased growth velocity**		**Greater target coverage allowing for lower toxicity from WT PI3Kα and other off-target inhibition**

1. First patents for oncology

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Zovegalisib – Study Design: RelnspIre



Enrollment open in adults & adolescents in part 2 and pediatrics (6-11 y/o) in part 1

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Zovegalisib – RelnspireTrial Demographics

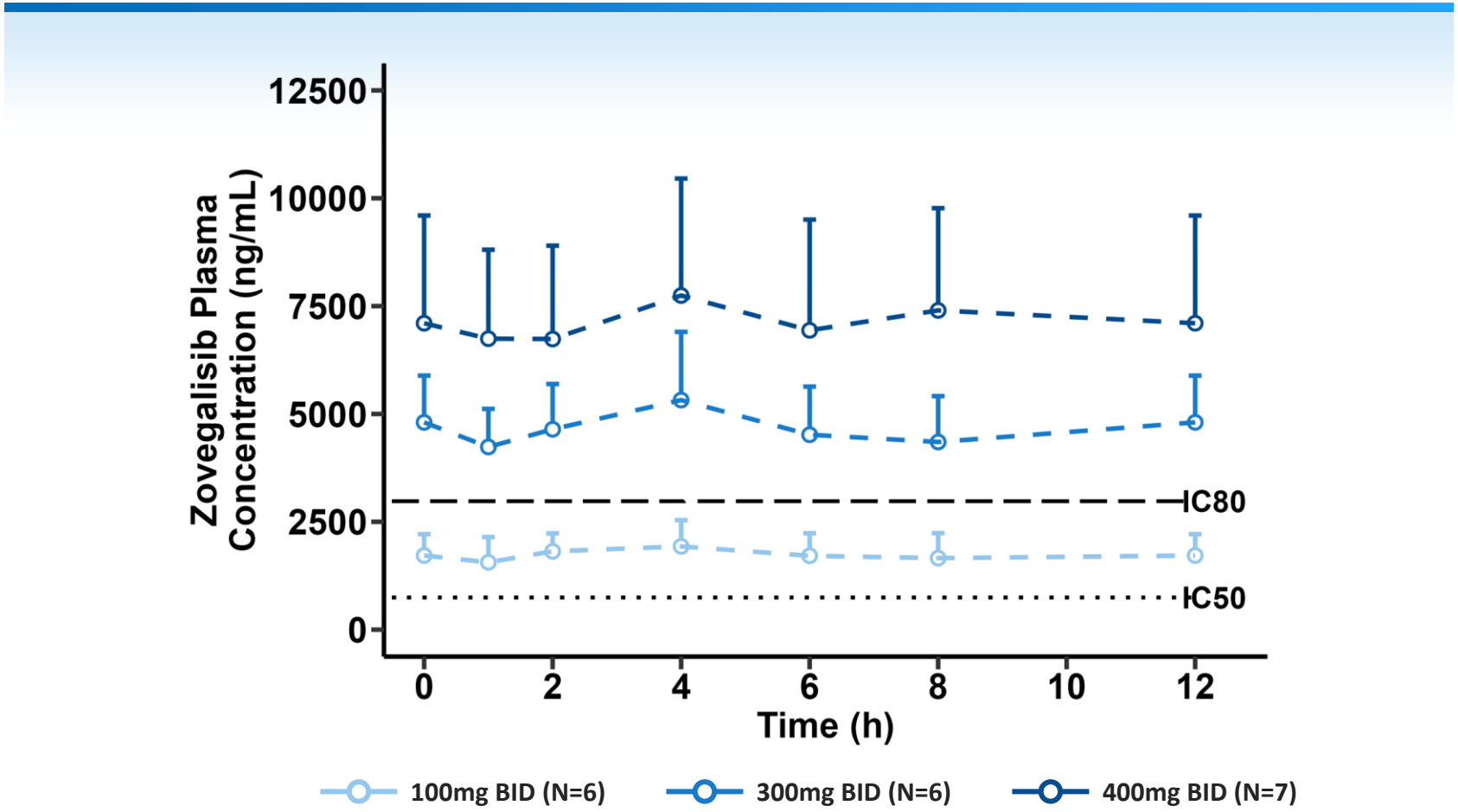
	Total (N=32)	100mg BID (N=11)	300mg BID (N=11)	400mg BID (N=10)
Age (years), median (range)	**24.5 (12, 63)**	31 (13, 50)	24 (13, 54)	19.5 (12, 63)
12-17 / ≥18, n (%)	**10 (31) / 22 (69)**	4 (36) / 7 (64)	2 (18) / 9 (82)	4 (40) / 6 (60)
Sex, M/F, n (%)	**14 (44) / 18 (56)**	6 (55) / 5 (45)	5 (45) / 6 (55)	3 (30) / 7 (70)
Disease Classification, n (%)				
PROS	**22 (69)**	8 (73)	6 (54)	8 (80)
CLOVES	**5 (16)**	1 (9)	3 (27)	1 (10)
KTS	**10 (31)**	4 (36)	2 (18)	4 (40)
Other	**7 (22)**	3 (27)	1 (9)	3 (30)
LM	**8 (25)**	3 (27)	4 (36)	1 (10)
VeM	**2 (6)**	0	1 (9)	1 (10)
Performance Status at Baseline, 50-70/ ≥80[1], n (%)	**5 (16) / 27 (84)**	2 (18) / 9 (82)	1 (9) / 10 (91)	2 (20) / 8 (80)
Pre-diabetic[2], n (%)	**8 (25)**	1 (9)	6 (55)	1 (10)
Local PIK3CA Status at Baseline, n (%)				
Kinase mutation	**10 (31)**	4 (36)	4 (36)	2 (20)
Non-Kinase mutation	**16 (50)**	4 (36)	6 (55)	6 (60)
No mutation documented	**6 (19)**	3 (27)	1 (9)	2 (20)
Prior disease-related systemic treatment, median	**1**	1	2	1
None, n (%)	**9 (28)**	3 (27)	3 (27)	3 (30)
Prior alpelisib / sirolimus, n (%)	**23 (72)**	8 (73)	8 (73)	7 (70)
Prior disease-related surgery, n (%)	**19 (59)**	5 (45)	6 (55)	8 (80)
Prior catheter-based procedures, n (%)	**18 (56)**	6 (55)	8 (73)	4 (40)

1. Lansky performance status for patients <16 years old or Karnofsky performance status for patients ≥16 years old; 2. Baseline HbA1c ≥5.7, glucose ≥100, or medical history of pre-diabetes mellitus

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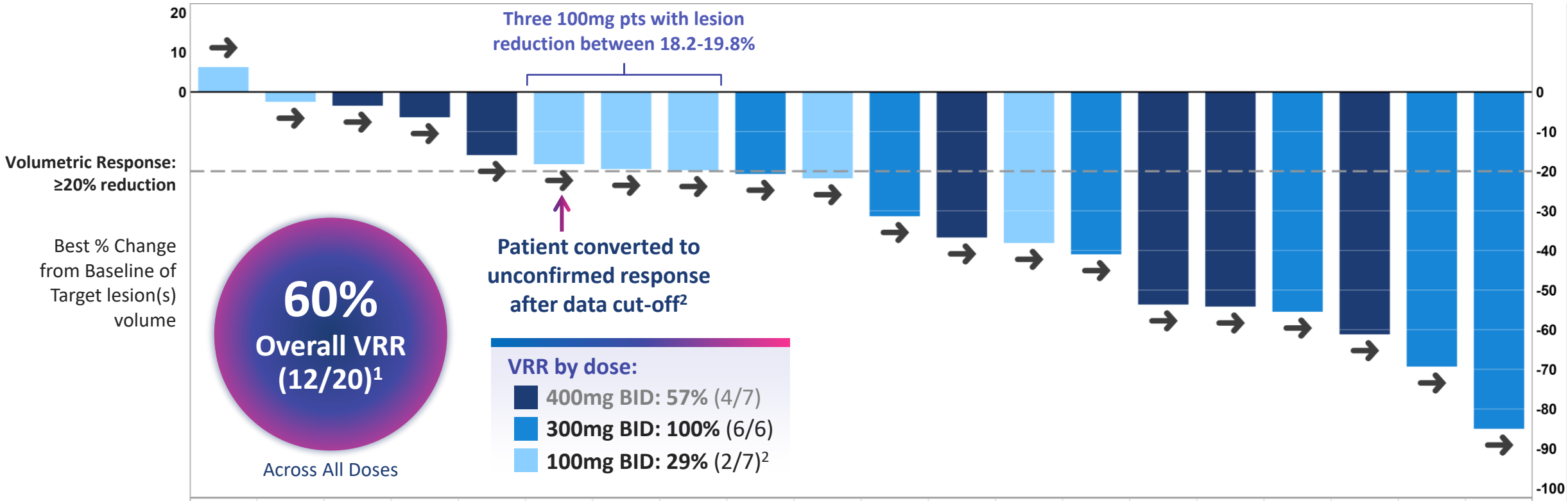
Zovegalisib – All Initial Doses Resulted in Exposures Projected to be Active

C1D15 Mean Concentration-Time Profiles By Dose



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Zovegalisib – 60% Volumetric Response Rate by BICR Across All Doses



Subtype	LM	PROS	VeM	PROS	PROS	PROS	PROS	PROS	PROS	PROS	LM	PROS	PROS	PROS	PROS	PROS	PROS	PROS	LM	LM
PROS subtype		KTS		FAO	KTS	FAO	FAVA	KTS	CLOVES	CLOVES		KTS	KTS	KTS	CLOVES	FAVA	CLOVES	KTS		
PIK3CA mutation	NK	NK	NK	NK	Unk	K	Unk	NK	NK	K	NK	Unk	K	NK	K	NK	NK	NK	K	Unk
Prior alp/siro	S	A + S	S	—	A + S	—	A + S	—	S	A	A + S	—	—	—	A + S	A + S	A + S	S	—	S
BL volume (L)	0.4	5.4	0.5	0.9	1.2	0.4	0.8	18.0	3.4	0.9	0.2	2.7	0.4	1.0	1.2	0.1	0.2	0.3	0.1	0.1
% Change from Baseline W12	6.3	-2.5	-3.5	-6.4	-15.9	-18.2	-1.4	-12.7	-20.7	-21.8	-31.4	-36.7	-38.1	-41.0	-53.7	-44.1	-49.0	-50.7	-69.3	-70.9
W24		3.5					-19.5	-19.8								-54.2	-55.5	-54.4		-75.6
W36		8.9																-61.2		-85.0
BOR	SD	SD	SD	SD	SD	SD	SD	SD	uVR	uVR	uVR	uVR	uVR	uVR	uVR	cVR	cVR	cVR	uVR	cVR

1. Includes both confirmed and unconfirmed responses. 2. After the data cut-off date, one 100mg BID patient that did not have a volumetric response as of the data cut-off date has converted to an unconfirmed response, resulting in a 100mg BID volumetric response rate of 43% (3/7), a volumetric response rate of 69% (9/13) for patients treated at 300mg BID or 100mg BID, and a volumetric response rate of 65% (13/20) across doses. None of the other response-evaluable patients' response statuses have changed since the data cut-off date. Volumetric Response (VR) = 20% or greater reduction in target lesion volume by blinded independent central review (BICR); cVR = Confirmed Volumetric Response (VR with 2nd scan to confirm response), uVR = Unconfirmed Volumetric Response (VR without confirmatory scan), SD = Stable Disease

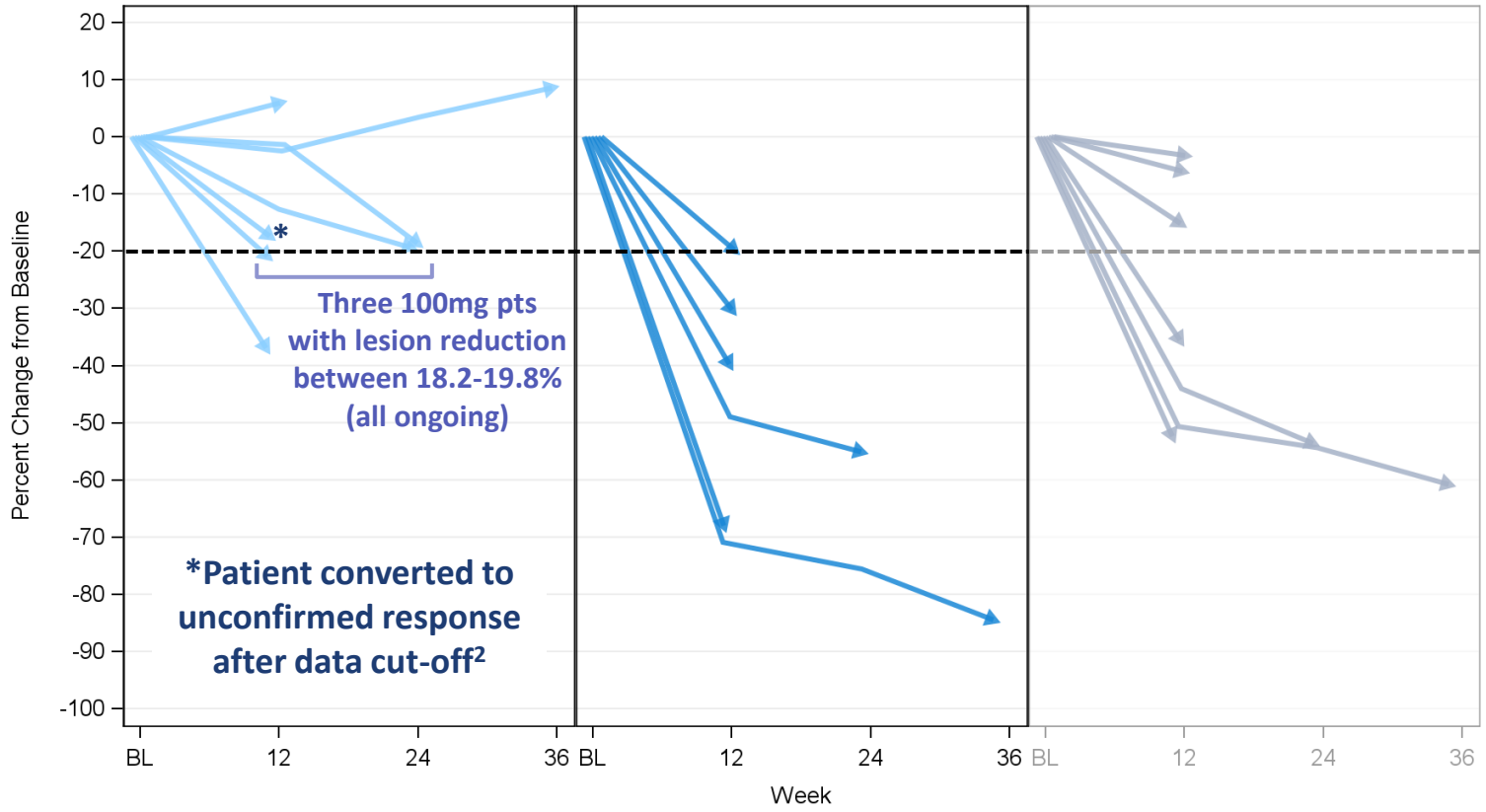
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Zovegalisib – Volumetric Response Over Time (BICR)

100mg VRR: 29% (2/7)[1]

300mg VRR: 100% (6/6)

400mg VRR: 57% (4/7)



60%
Overall VRR (12/20)[1]

All patients ongoing

Reductions generally deepened over time at all doses

1. Includes both confirmed and unconfirmed responses. 2. After the data cut-off date, one 100mg BID patient that did not have a volumetric response as of the data cut-off date has converted to an unconfirmed response, resulting in a 100mg BID volumetric response rate of 43% (3/7), a volumetric response rate of 69% (9/13) for patients treated at 300mg BID or 100mg BID, and a volumetric response rate of 65% (13/20) across doses. None of the other response-evaluable patients' response statuses have changed since the data cut-off date.

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Zovegalisib – Initial Efficacy Data Supports Clear Symptomatic Benefit

Investigator-Reported (IGIC)

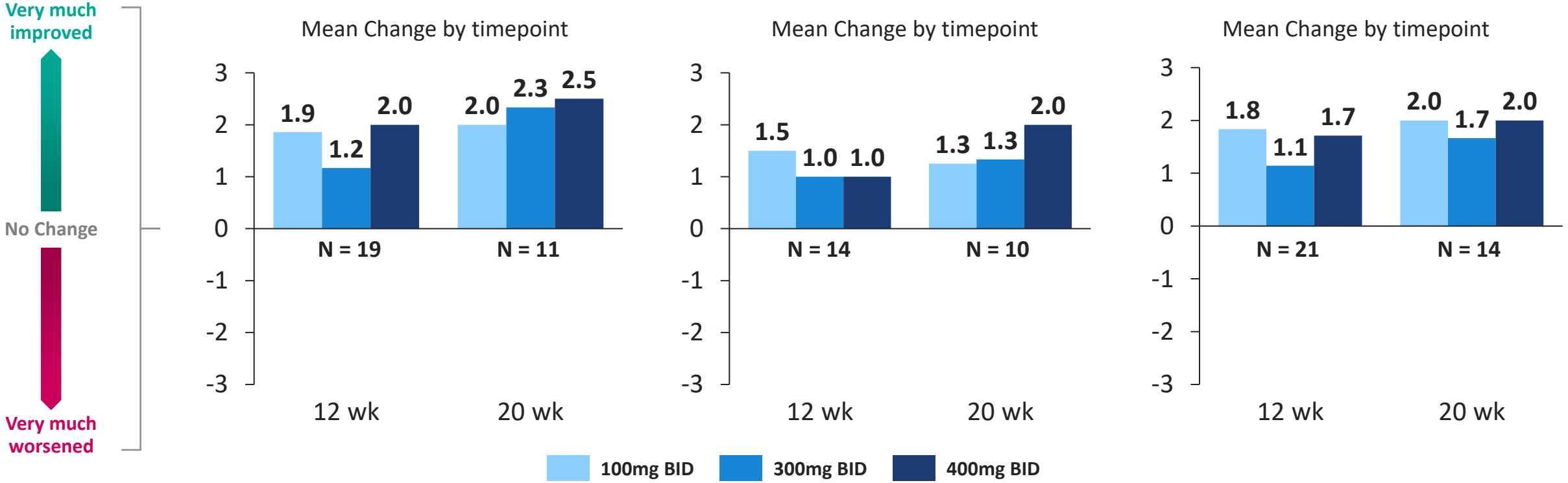
89%
of patients improved by week 12

Patient-Reported (PGIC)

79%
of patients improve by week 12

Pain (IADRSS)

71%
of pain symptoms improved by week 12



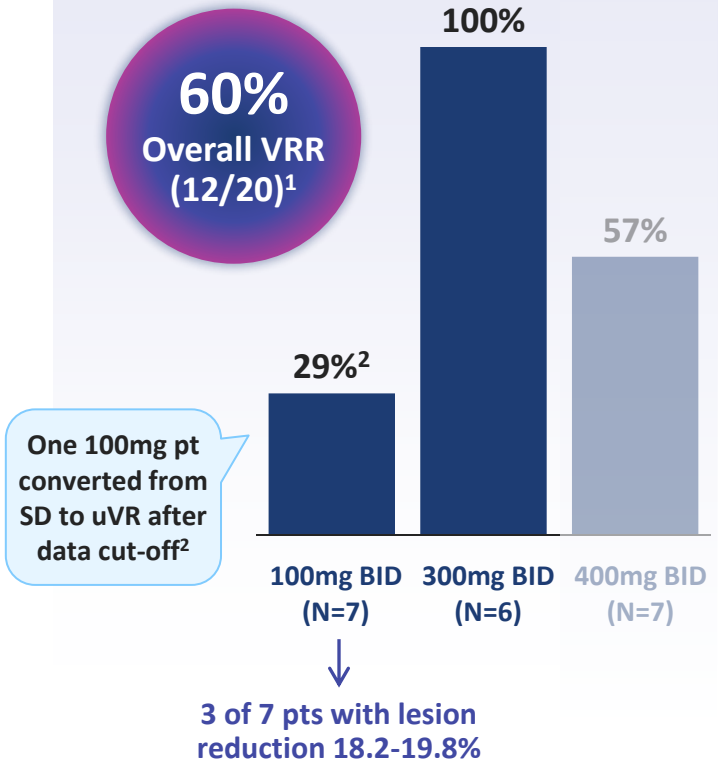
IGIC = Investigator Global Impression of Change, PGIC = Patient Global Impression of Change, IADRSS = Investigator Assessment of Disease-Related Signs and Symptoms.
Note: N for IGIC and PGIC is number of patients; N for IADRSS pain is number of most bothersome pain symptoms, where some patients may have more than one pain symptom.
Scale: +3 very much improved, +2 minimally improved, +1 minimally improved, 0 no change, -1 minimally worse, -2 much worse, -3 very much worse

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Zovegalisib – Initial Efficacy Data Summary

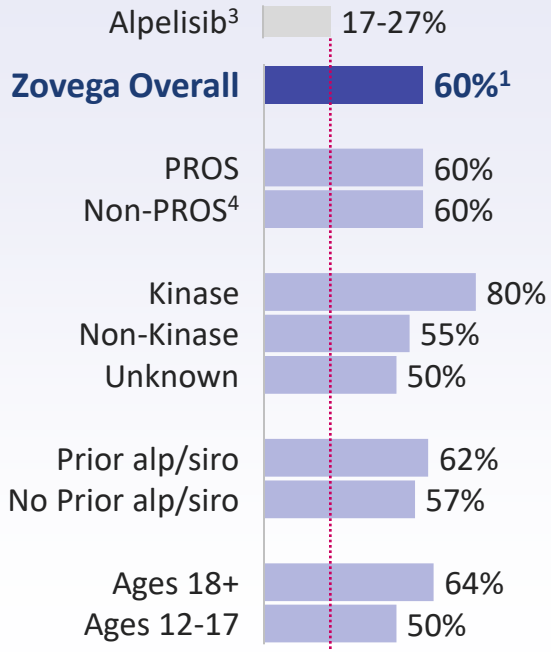
Meaningful Efficacy Data

Volumetric Response Rate (VRR)



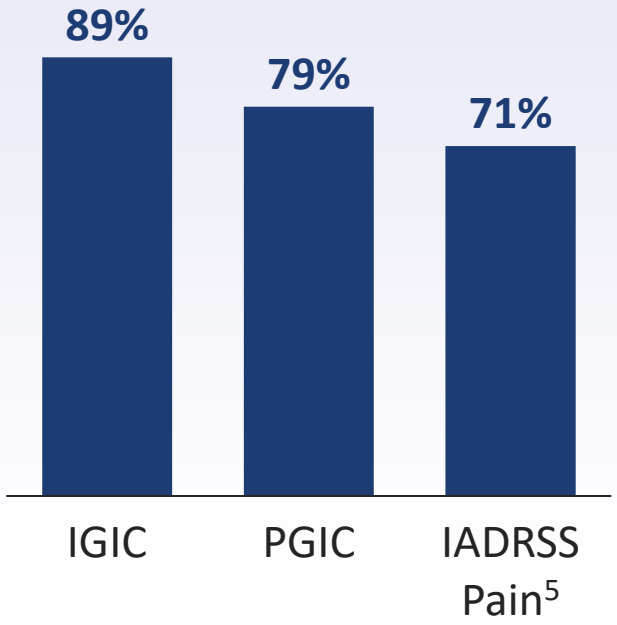
Consistent Across Subgroups

Subgroup VRR[1]



Broad Symptomatic Benefit

% of Patients with Improvement at Week 12



1. Includes both confirmed and unconfirmed responses. 2. After the data cut-off date, one 100mg BID patient that did not have a volumetric response as of the data cut-off date has converted to an unconfirmed response, resulting in a 100mg BID volumetric response rate of 43% (3/7), a volumetric response rate of 69% (9/13) for patients treated at 300mg BID or 100mg BID, and a volumetric response rate of 65% (13/20) across doses. None of the other response-evaluable patients' response statuses have changed since the data cut-off date; 3. EPIK-P1: Vijoice FDA label and EPIK-P2: Canaud 2024 Blood 144:5512; 4. Non-PROS = LM and VeM; 5. IADRSS rate shown is percentage of pain symptoms improved; Alp = alpelisib, Siro = sirolimus; IGIC = Investigator Global Impression of Change, PGIC = Patient Global Impression of Change, IADRSS = Investigator Assessment of Disease-Related Signs and Symptoms, SD = Stable Disease, uVR = unconfirmed volumetric response. Note: These data are derived from different clinical trials at different points in time, with differences in molecule composition, trial design and patient populations. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted.

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Zovegalisib – Treatment-Related Adverse Events ≥15% of Patients

No discontinuations due to adverse events

		100mg BID (N=11)				300mg BID (N=11)				100mg+300mg BID (N=22)				400mg BID (N=10)			
		All Gr	Gr1	Gr2	Gr3+	All Gr	Gr1	Gr2	Gr3+	All Gr	Gr1	Gr2	Gr3+	All Gr	Gr1	Gr2	Gr3+
	Any TRAE	82%	36%	45%	-	91%	55%	18%	18%	86%	45%	32%	9%	90%	20%	50%	20%
TRAE ≥15%	Headache	18%	18%	-	-	73%	73%	-	-	45%	45%	-	-	50%	30%	20%	-
TRAE ≥15%	Fatigue	18%	9%	9%	-	55%	36%	18%	-	36%	23%	14%	-	20%	10%	10%	-
TRAE ≥15%	Nausea	27%	18%	9%	-	45%	36%	9%	-	36%	27%	9%	-	70%	40%	30%	-
TRAE ≥15%	Diarrhea	27%	27%	-	-	18%	18%	-	-	23%	23%	-	-	10%	-	10%	-
TRAE ≥15%	Hyperglycemia	-	-	-	-	45%	18%	27%	-	23%	9%	14%	-	40%	20%	10%	10%
TRAE ≥15%	Decreased appetite	18%	9%	9%	-	18%	9%	9%	-	18%	9%	9%	-	20%	10%	10%	-
Other select TRAE	Rash	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Other select TRAE	Stomatitis	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Median Relative Dose Intensity	100%				99%				99%				77%			
	Dose Reduction due to TRAE, n (%)	1 (9%)[2]				4 (36%)				5 (23%)				7 (70%)			

Majority of hyperglycemia observed in patients prediabetic at baseline[1]

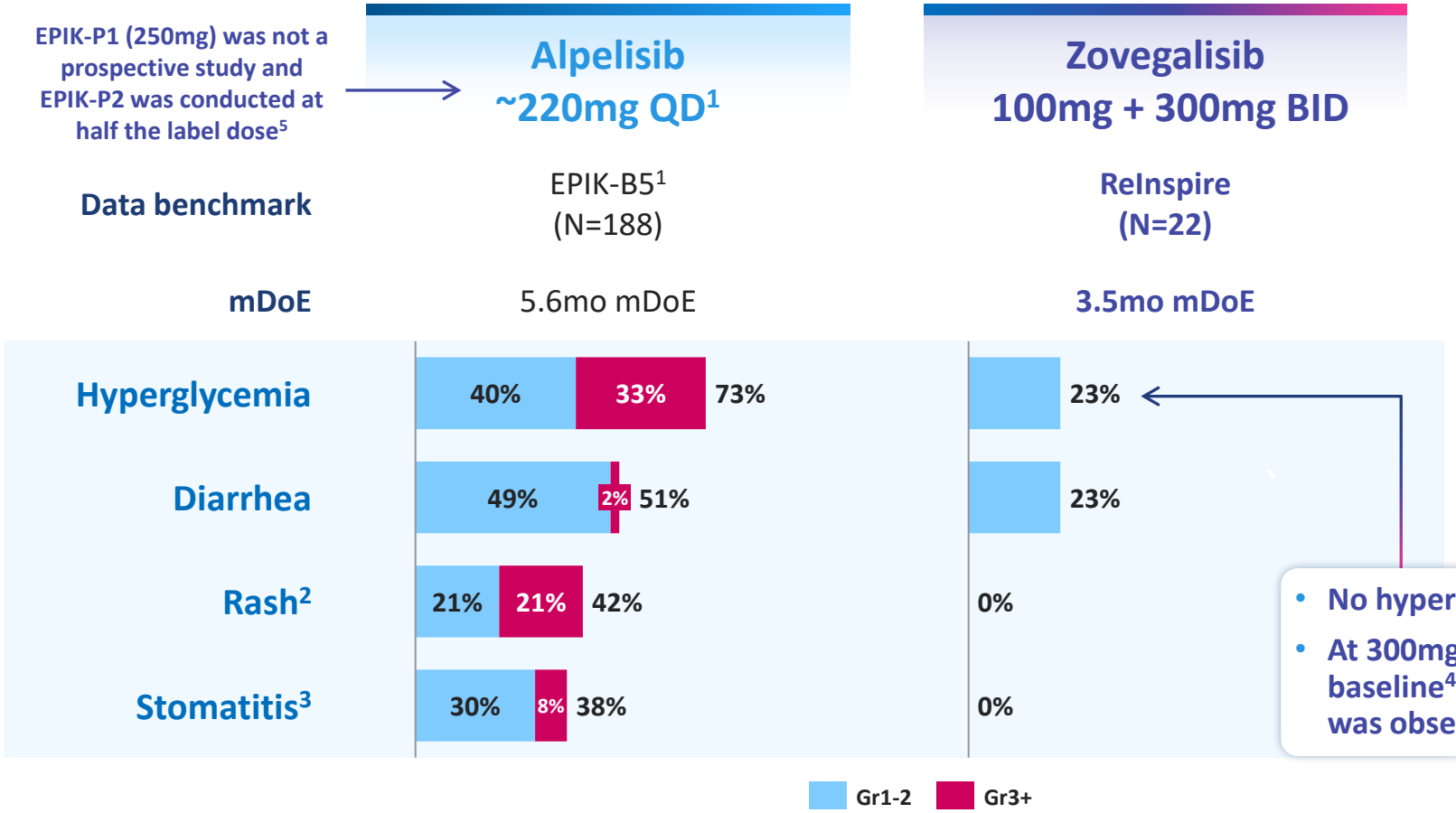
No Grade 3 hyperglycemia

1. Baseline HbA1c ≥5.7, glucose ≥100, or medical history of pre-diabetes mellitus; 2. Patient later increased back up to original dose of 100mg BID

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PI3Kα Inhibitors – Tolerability Profile Across Known Key Pathway AEs

EPIK-P1 (250mg) was not a prospective study and EPIK-P2 was conducted at half the label dose[5]



At 100mg and 300mg BID:

- No rash or stomatitis of any grade
- No Gr3 hyperglycemia or diarrhea
- No discontinuations
- Median dose intensity >99%

- **No hyperglycemia at 100mg**
- **At 300mg, 55% of patients were pre-diabetic at baseline[4], and the majority of hyperglycemia was observed in these patients**

1. EPIK-B5, SABCS 2025 #RF7-02, 220mg dose approximated from dose modification data; 2. Rash for alpelisib references the cumulative sum of rates of rash and rash maculo-papular from the EPIK-B5 study, and may include overlap; 3. Stomatitis for alpelisib references the cumulative sum of rates of stomatitis and mucosal inflammation from the EPIK-B5 study, and may include overlap; 4. Pre-diabetic: baseline HbA1c ≥5.7 to <6.5, glucose ≥100, or medical history of pre-diabetes mellitus; 5. EPIK-P1 is a retrospective study, label dose is 250mg QD, and EPIK-P2: Canaud 2024 Blood 144:5512, 125mg QD was starting dose. Note: These data are derived from different clinical trials at different points in time, with differences in molecule composition, trial design and patient populations. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted.

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Alpelisib EPIK-P2 Results – Safety Data in Adults

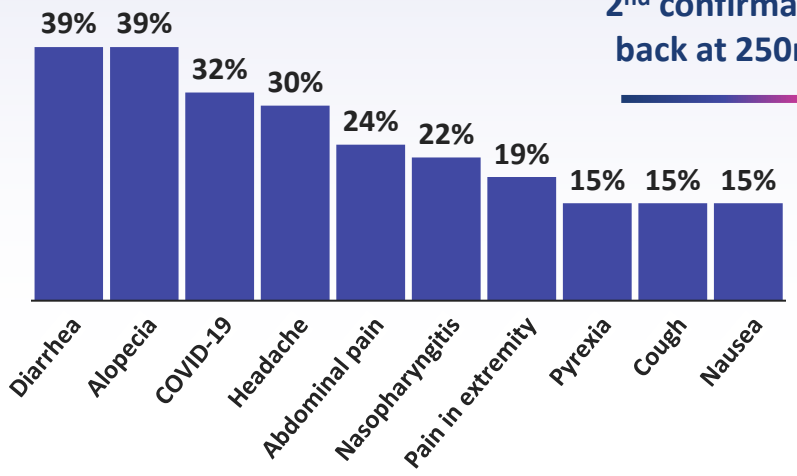
EPIK-P2[1] Up to Week 48

17% ORR

~180mg avg dose[3]

30% SAEs

66% of pts escalated dose up from 125mg after Week 28



2nd confirmatory trial back at 250mg dose

EPIK-P4[1] initiated 2025

250mg starting dose

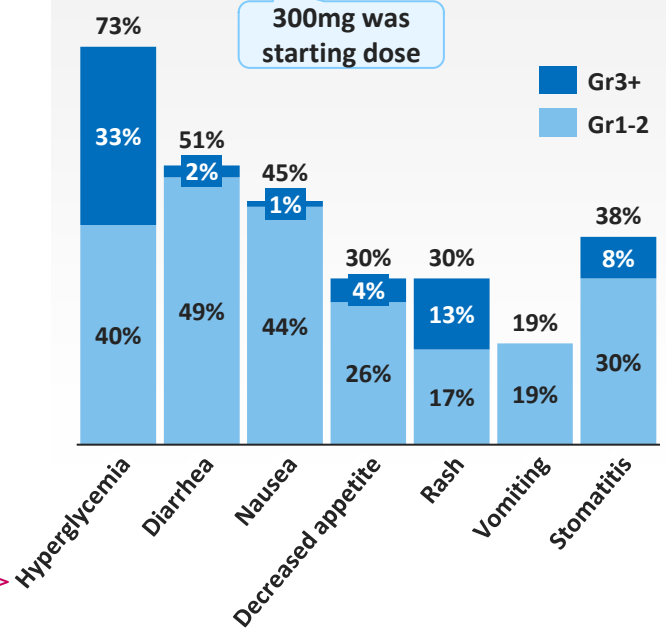
Trial ongoing

EPIK-B5[2] (breast cancer)

~220mg avg dose[4]

71% Gr3+ AEs

300mg was starting dose

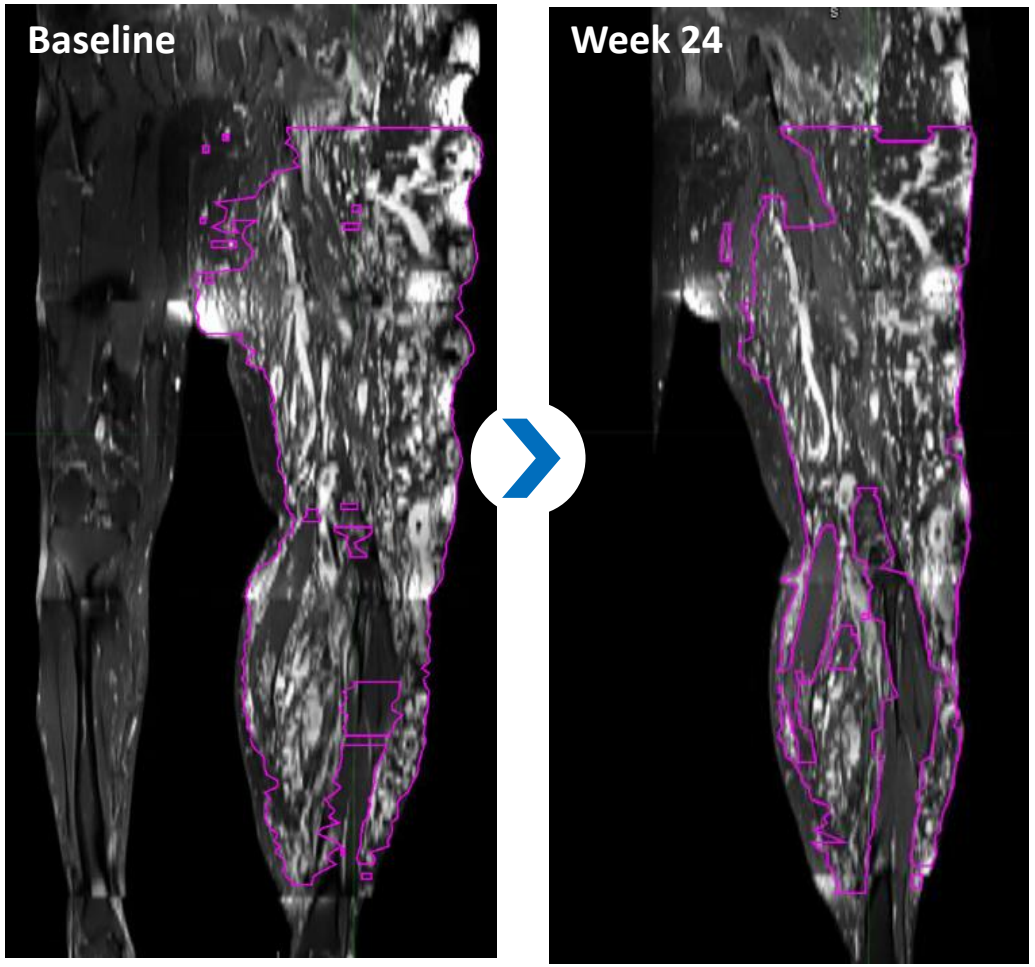


EPIK-P1 (per FDA Label[5]): "Increased Glucose" Lab Abnormality: 11% Grade 3, 56% all grade

1. Canaud 2024 Blood 144:5512 and results from clintrials.gov listing; 2. SABCS 2025 #RF7-02 3. approximated from data on clintrials.gov listing. 4. approximated from dose modification data from SABCS 2025 #RF7-02; 5. VIJOICE™ prescribing information

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Patient Vignette – Adult Patient with PROS Achieved Meaningful Clinical and Radiographical Improvement with Zovega 100mg BID



18 liter lesion at baseline

3.6 liter reduction (-19.8%) at 24wk

44-year-old male with KTS (PROS)

- PIK3CA mutation: Q546K
- Prior sclerotherapy x3, no prior systemic tx
- Minimal mobility at baseline
- **Dosed with 100mg zovegalisib**

19.8% volumetric reduction at week 24

(13% reduction seen at week 12)

- **3.6 liter lesion reduction**
- Deepening reduction at each scan

Dramatic and rapid clinical improvement

"Much Improved" IGIC overall status

Investigator Global Impression of Change

Note: Symptom improvement shown here is for Week 24

Tolerable profile allowing for prolonged dosing

- No dose modifications
- Patient remains on therapy at 100mg BID

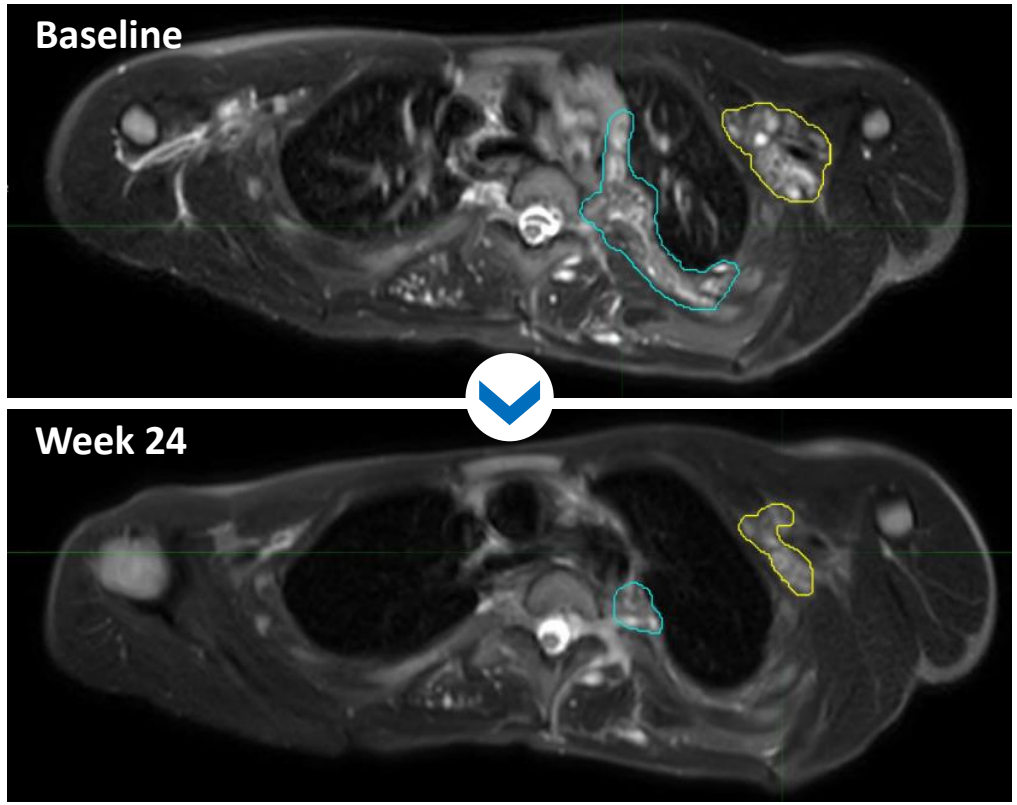
"The participant used to not be able to walk further than front door to car. Within 2 weeks, he walked around the block."

- ReInspire Investigator

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The information presented on the slide may not be representative of all patient experiences

Patient Vignette – Previously Systemically Treated Pediatric Patient with PROS Achieved Meaningful Radiographic & Clinical Improvement with Zovega 300mg BID



12-year-old male with CLOVES (PROS)

- PIK3CA mutation: E542K
- Prior surgery x6, laser therapy x12, sirolimus (no response) and alpelisib
- Painful chest lesion, with lymphatic leakage
- **Dosed with 300mg zovegalisib**

55% volumetric reduction at week 24

(49% reduction seen at week 12)

- Deepening reduction at each scan

Dramatic and rapid clinical improvement

"Much Improved" IGIC overall status

Investigator Global Impression of Change

Note: Symptom improvement shown here is for Week 24

Tolerable profile allowing for prolonged dosing

- No dose modifications
- Patient remains on therapy at 300mg BID

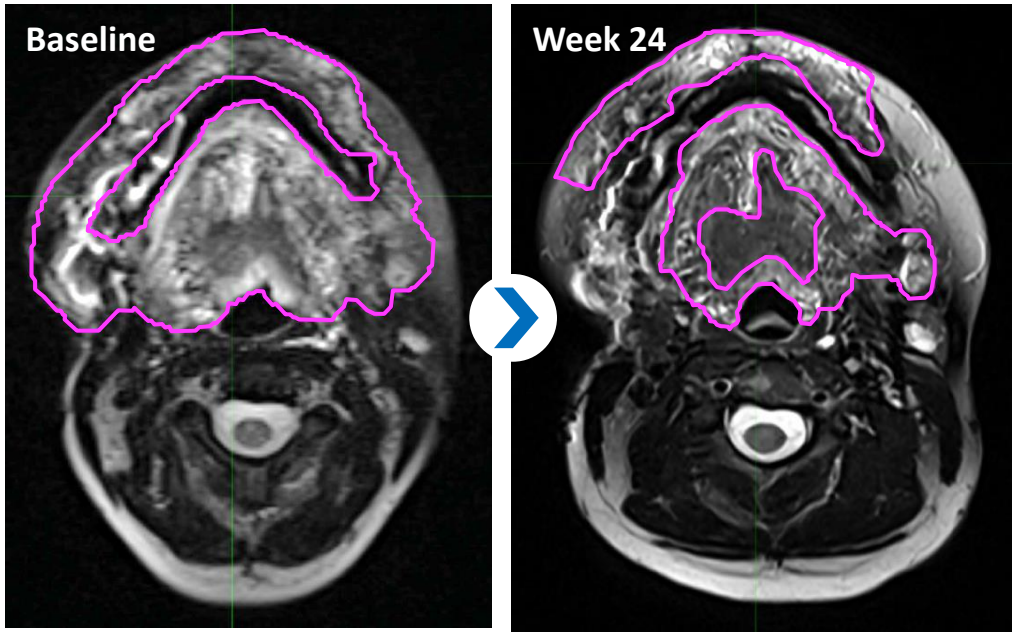
"After initiation of zovegalisib, the patient has experienced a marked reduction in overgrowth size, improved clothing fit, and decreased sensitivity of affected areas. Episodes of drainage and cellulitis have resolved, and previously painful stimuli such as ECG sticker placement are now well tolerated."

- ReInspire Investigator

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The information presented on the slide may not be representative of all patient experiences

Patient Vignette – Adult patient with Facial LM Experienced Meaningful Improvement in Pain and Radiographic Response with Zovega 300 mg BID



"She had a meaningful decrease in pain and fullness"

- ReInspire Investigator

42-year-old female with facial LM

- PIK3CA mutation: E545K
- Prior sclerotherapy x3, embolization x2, surgery x4, sirolimus (no response, dc for AEs) & alpelisib (improvement, but dc for AEs)
- **Dosed with 300mg zovegalisib**

53% volumetric reduction at week 24*

(31% reduction seen at week 12)

- Deepening reduction at each scan

Dramatic and rapid clinical improvement

"Much Improved" IGIC overall status

Investigator Global Impression of Change

Most bothersome symptoms:

(Investigator Assessment of Disease-Related Signs and Symptoms)

- Ear pain → Much improved
- Oral pain → Minimally improved
- Jaw pain → No change

Tolerable profile allowing for prolonged dosing

- No dose modifications
- Patient remains on therapy at 300mg BID

Note: Symptom improvement shown here is for Week 24

ReInspire preliminary data as of 04/15/2026

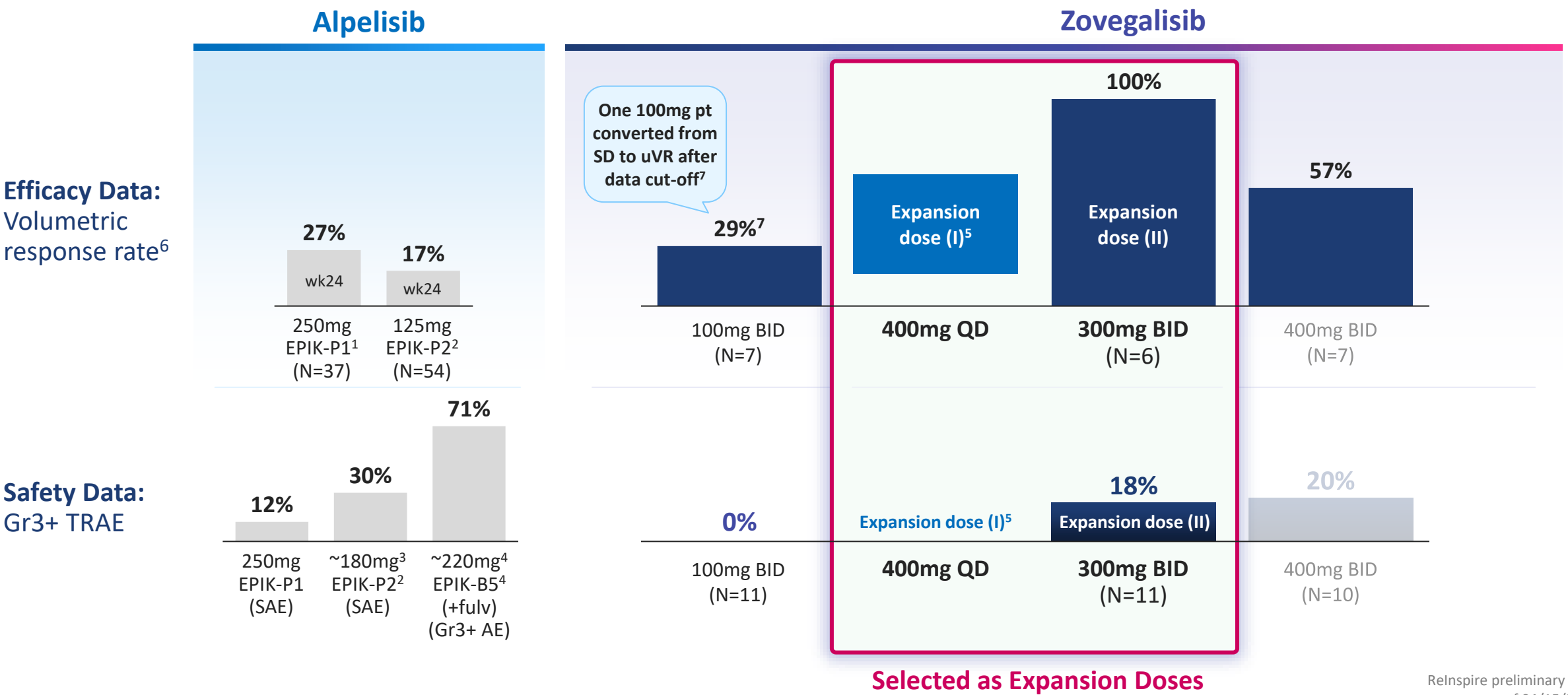
*Week 24 scan provided after data cutoff

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The information presented on the slide may not be representative of all patient experiences

Zovegalisib - Clear Path to Finding Dose to Evaluate Potential for Differentiated Profile

RELAY THERAPEUTICS



ReInspire preliminary data as of 04/15/2026

1. EPIK-P1: FDA review document; 2. EPIK-P2: Canaud 2024 Blood 144:5512 and results from clintrials.gov listing, 125mg QD was starting dose; 3. 180mg dose approximated from rates of dose escalation after week 26 listed on clintrials.gov listing; 4. EPIK-B5: SABCS 2025 #RF7-02, 220mg dose approximated from dose modification data; 5. 400mg QD expansion cohort yet to be initiated; 6. ReInspire VRR Includes both confirmed and unconfirmed responses. 7. After the data cut-off date, one 100mg BID patient that did not have a volumetric response as of the data cut-off date has converted to an unconfirmed response, resulting in a 100mg BID volumetric response rate of 43% (3/7), a volumetric response rate of 69% (9/13) for patients treated at 300mg BID or 100mg BID, and a volumetric response rate of 65% (13/20) across doses. None of the other response-evaluable patients' response statuses have changed since the data cut-off date. SD = Stable Disease, uVR = unconfirmed volumetric response. Note: These data are derived from different clinical trials at different points in time, with differences in molecule composition, trial design and patient populations. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted.

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Potential for Accelerated Approval Pathway*

RELAY THERAPEUTICS

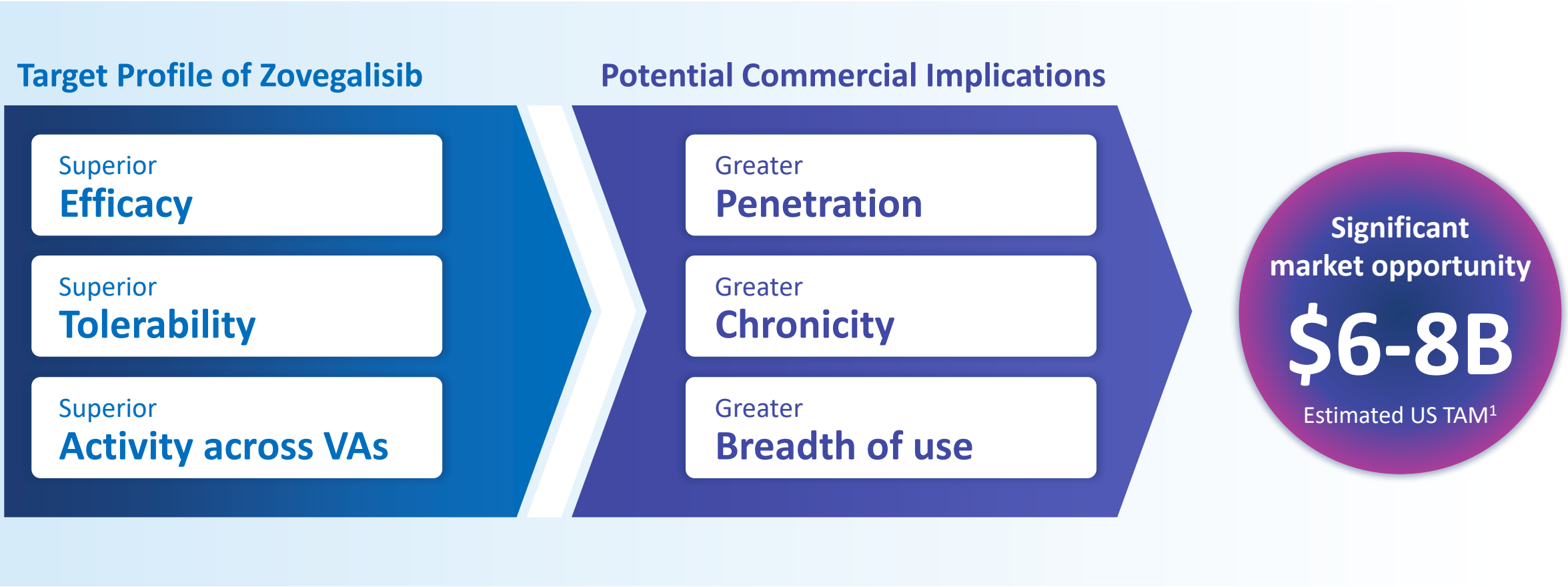
Basket of:
- PROS
- LMs
- VeMs

	Dose Selection	Dose Expansion	Confirmatory
Adults & Adolescents (≥12 years old)	Dose Randomization: 400mg BID; 300mg BID; 100mg BID	300mg BID; 400mg QD	Potential Accelerated Approval dataset → Add'l pt at RP3D
Pediatrics (6-11 years old)	Dose Escalation	Expansion	
Pediatrics (2-5 years old)	Potential Dose Escalation Start		

*Illustrative and subject to discussion with the U.S. Food and Drug Administration

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Vascular Anomalies – Mutant-Selective Approach Has Potential to Unlock Significant Market



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1. TAM calculated based on market benchmarks and internal analysis

VAs – Development of Mutant-Selective Vascular Anomalies Franchise

	PI3Kα	Newly disclosed program: TIE2
Primary VA subtypes implicated	PROS, LMs, VeMs	Driving mutation in 50-60% of Venous Malformations
US patients (seeking systemic tx)	25k	~2-4k
US Total Addressable Market	$6-8B	~$1B

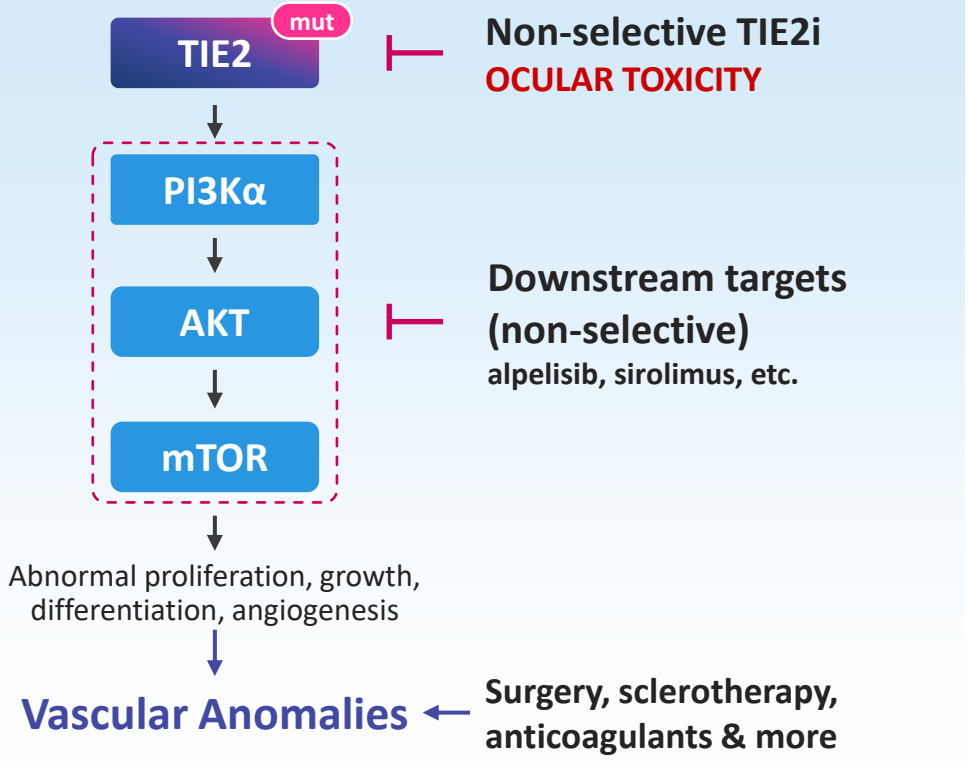
Note: TAM calculated based on market benchmarks and internal analysis

Sources: ISSVA classification, NORD, Mayo Clinic, Novartis, Penington et al 2023, Gallagher et al 2022, Luks et al 2015, Limaye et al 2015, Peyre et al 2021, Hong et al 2021, and company primary market research

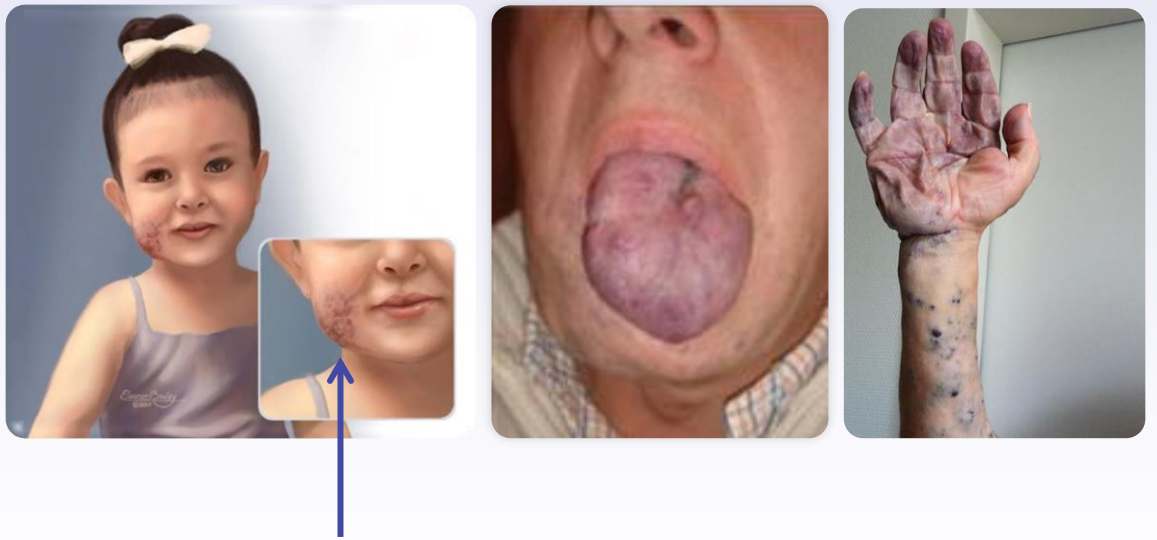
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TIE2 – Leading Driver of Venous Malformations with No Selective Tx Options

TIE2 is another common driver of vascular anomalies, namely venous malformations



Venous Malformations symptoms are caused by fluid buildup from poorly formed vasculature



Enlarged veins create soft blue patches; pain and swelling are common

~50-60k patients in US with TIE2-driven Venous Malformations

Sources: : ISSVA classification, NORD, Mayo Clinic, Novartis, Penington et al 2023, Gallagher et al 2022, Luks et al 2015, Limaye et al 2015, Peyre et al 2021, Hong et al 2021, and company primary market research
Photo sources: Johns Hopkins All Children's Hospital, Vascular Anomalies Clinic; Limaye et al Nature Genetics 2008; Wohlgemuth, Compva clinical presentation venous malformation

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TIE2 – Complementary to Zovegalisib in PIK3CA-Driven VAs

Key Vascular Anomalies (VAs) Subtypes



	PIK3CA-Related Overgrowth Spectrum (PROS)	Lymphatic Malformations (LM)	Venous Malformations (VeM)	
	~5-10k PIK3CA US patients	~60-65k PIK3CA US patients	~20-25k PIK3CA US patients	~50-60k TIE2 US patients
		10-30% seek systemic tx		~5-10% seek systemic tx

Initial clinical focus: ~25k PIK3CAm + ~2-4k TIE2m US patients seeking systemic therapy

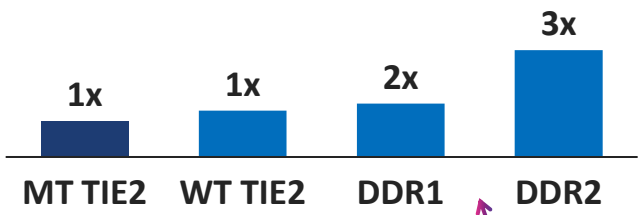
Sources: ISSVA classification, NORD, Mayo Clinic, Novartis, Penington et al 2023, Gallagher et al 2022, Luks et al 2015, Limaye et al 2015, Peyre et al 2021, Hong et al 2021, and company primary market research

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TIE2 – Wild-type Signaling Required in Mice and Humans

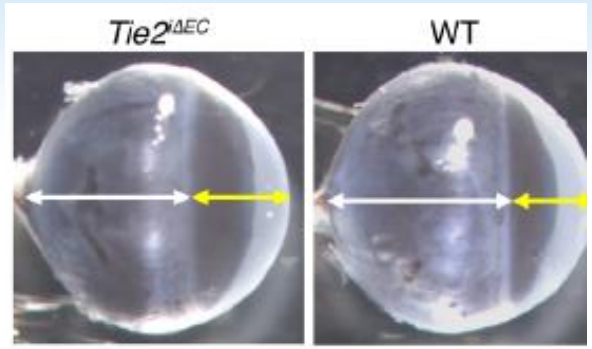
Currently available targeted approaches lack selectivity

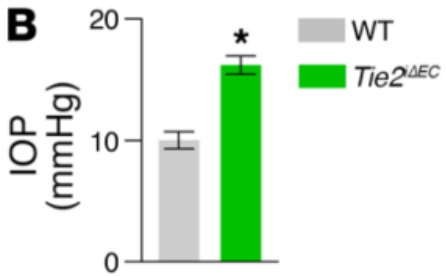
Rebastinib



Off-target DDR1/2 inhibition associated with skeletal toxicity

Loss of TIE2 signaling induces intraocular pressure & glaucoma in mice





IOP = intraocular pressure

Rebastinib shown to drive increased IOP

Loss of TIE2 signaling associated with visual impairments & AEs in humans

TIE2 loss-of-function mutations implicated in Primary Congenital Glaucoma in humans

IOP and ocular AEs seen in rebastinib clinical studies

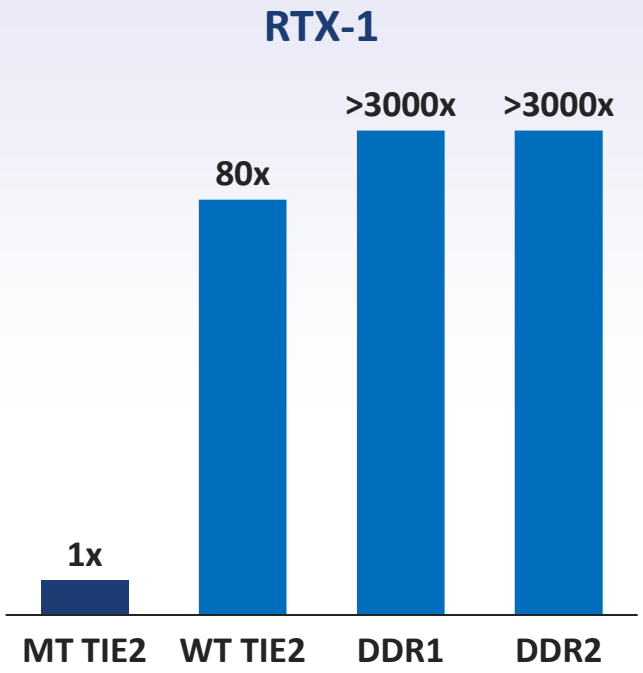
Unmet need for mutant-selective TIE2 inhibitor

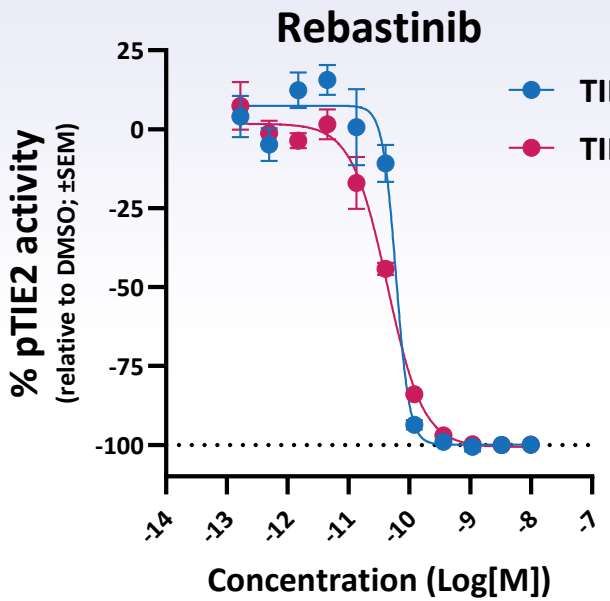
Cellular selectivity and potency using in-house assays; Sources: Kim 2027, JCI; Souma 2016, JCI; Cortes 2017, Haematologica

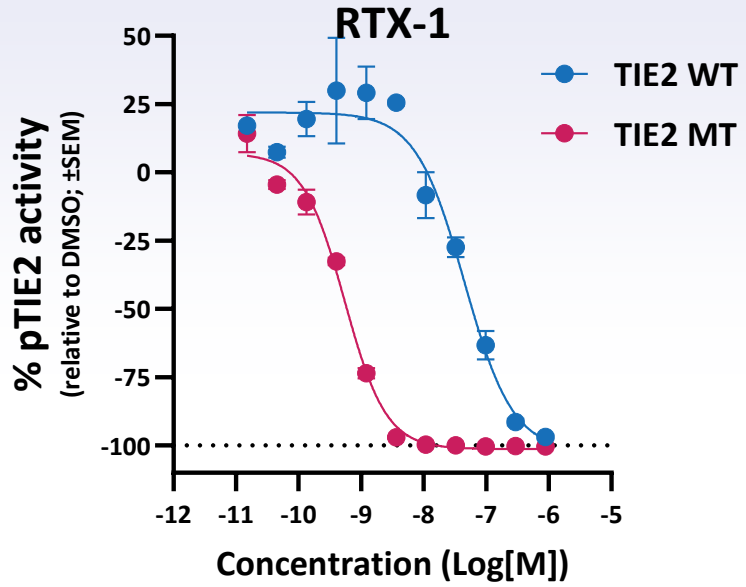
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Relay Tx Lead Compound is Highly Potent and Mutant-Selective

RTX-1 is kinase- and TIE2 mutant-selective







Relay Tx compounds achieve selectivity for mutant TIE2 over wild-type & other off-targets

Cellular selectivity and potency using in-house assays

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NRAS – Large Validated Market With Significant Unmet Need

	Solid Tumors
	NRAS-Driven Solid Tumors
Novel Approach	RLY-8161 (1st NRAS-selective inhibitor)
Genetically Defined	NRAS mutations
Clinically Validated	Non-selective RAF/MEK/Pan-RAS
Unmet Medical Need	• Lack of selectivity • Challenging AE profile • Limited efficacy
Commercially Attractive	~29,000 patients[1]



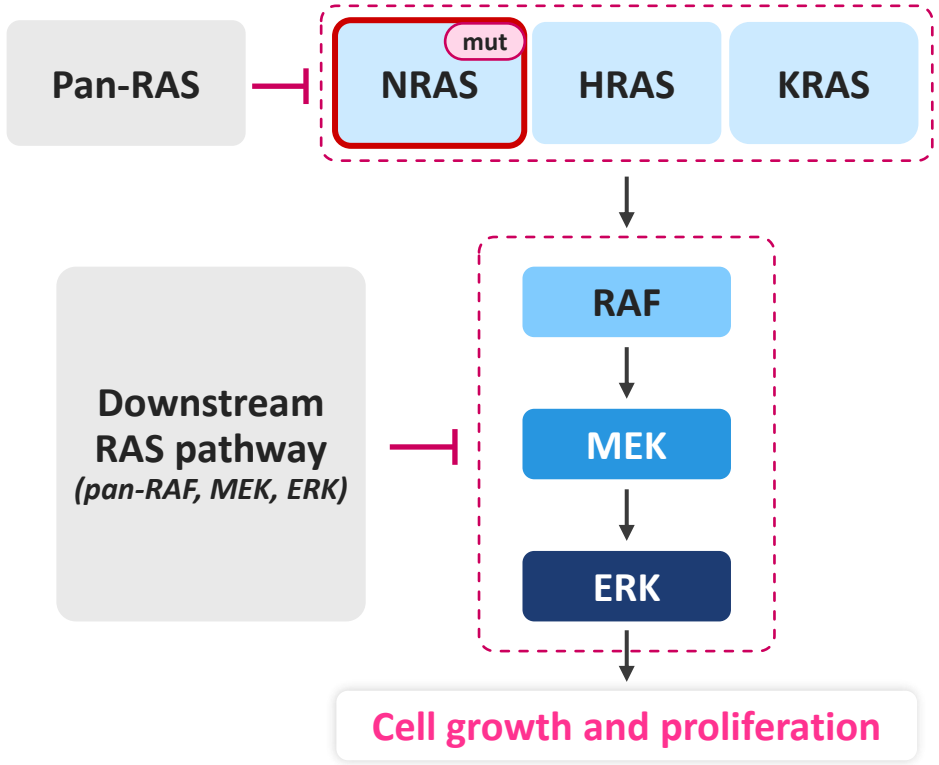
Initiated Phase 1/2 trial in NRAS-mutant melanoma & other solid tumors

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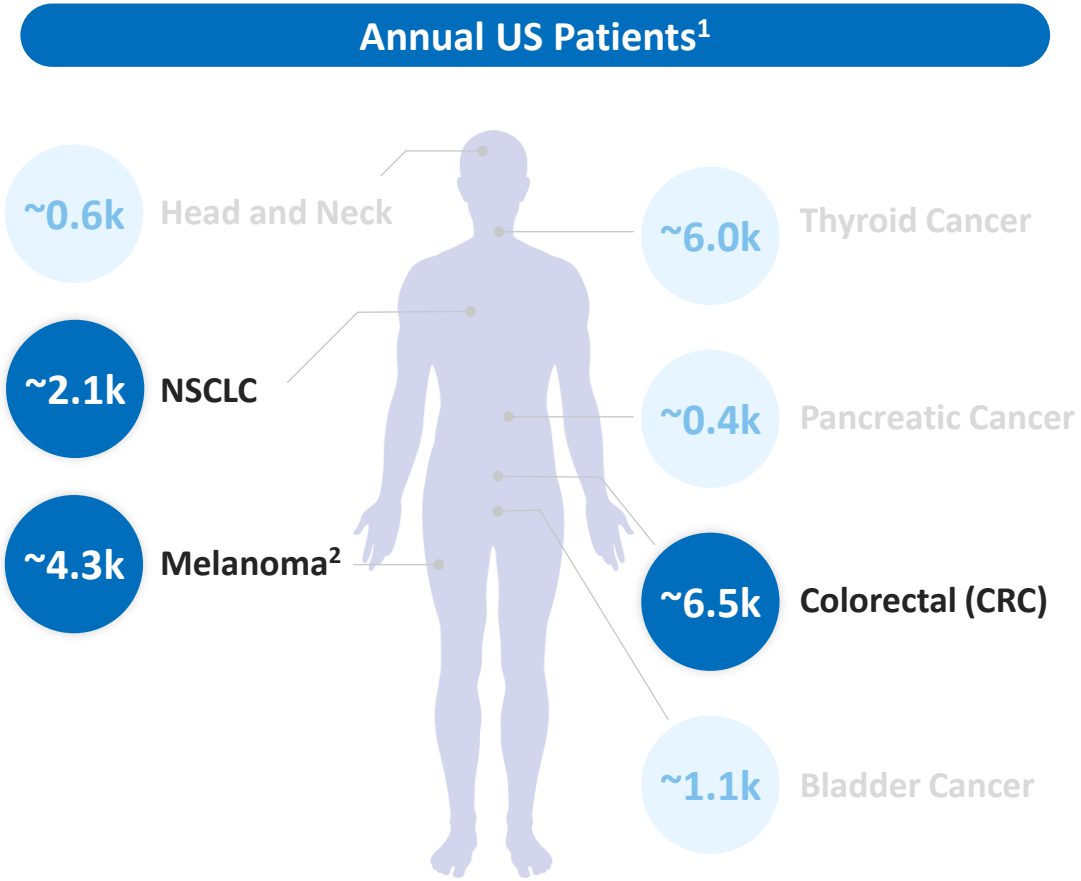
1. Newly diagnosed (incident) solid tumors with an NRAS mutation, excluding stage 0-II newly diagnosed melanoma patients (SEER, 3rd party source for alteration rate, Jan 2026)

NRAS – Large Validated Market With Significant Unmet Need

NRAS mutations are a key driver of solid tumors, though no NRAS-selective agent exists



NRAS mutations observed in broad range of tumor types

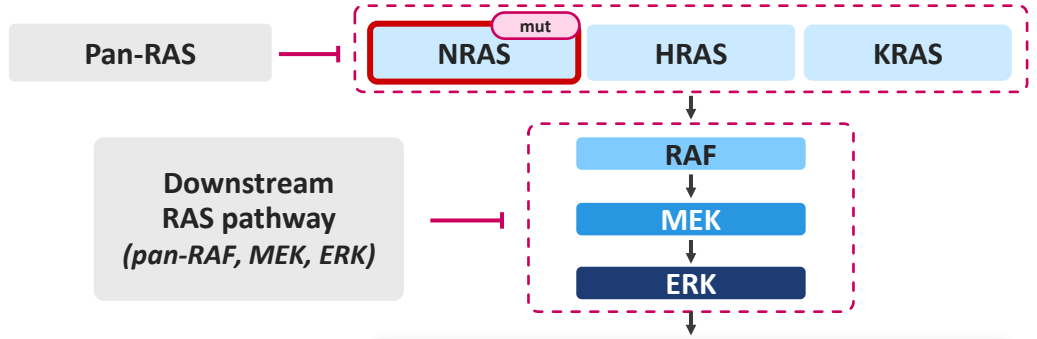


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1. Newly diagnosed (incident) patients with an NRAS mutation for each tumor type (SEER, 3rd party source for alteration rate, Jan 2026); 2. Melanoma includes incident stage III and IV patients only (excludes stage 0-II patients)

Limited Therapeutic Window of Current Agents – Pan-RAF/RAS & MEK Inhibitors

Non-Selective Agents in Development



Scholl et al. 2007; Drosten et al. 2014; Esteban et al. 2001

Limited Tolerability

	Rash	Liver Toxicity
MEK + RAFi	25 – 80%	Inc. ALT: <10 – 22% Inc. AST: <10 – 20%
Pan-RAS *(PDAC)*	91%	Inc. ALT: 7% Inc. AST: 5%

KRAS KO is embryonic lethal in mice, whereas NRAS KO is tolerated

Limited Target Inhibition

	Dose Modifications
MEK + RAFi	62 – 100%
Pan-RAS *(PDAC)*	42%

Limited Efficacy

Regimen (2L *NRAS*mut melanoma)	ORR	PFS (mo)
Naporafenib (RAFi) + trametinib (MEKi)	13 – 47%	4.2 – 5.5
Exarafenib (RAFi) + binimetinib (MEKi)	33%	--

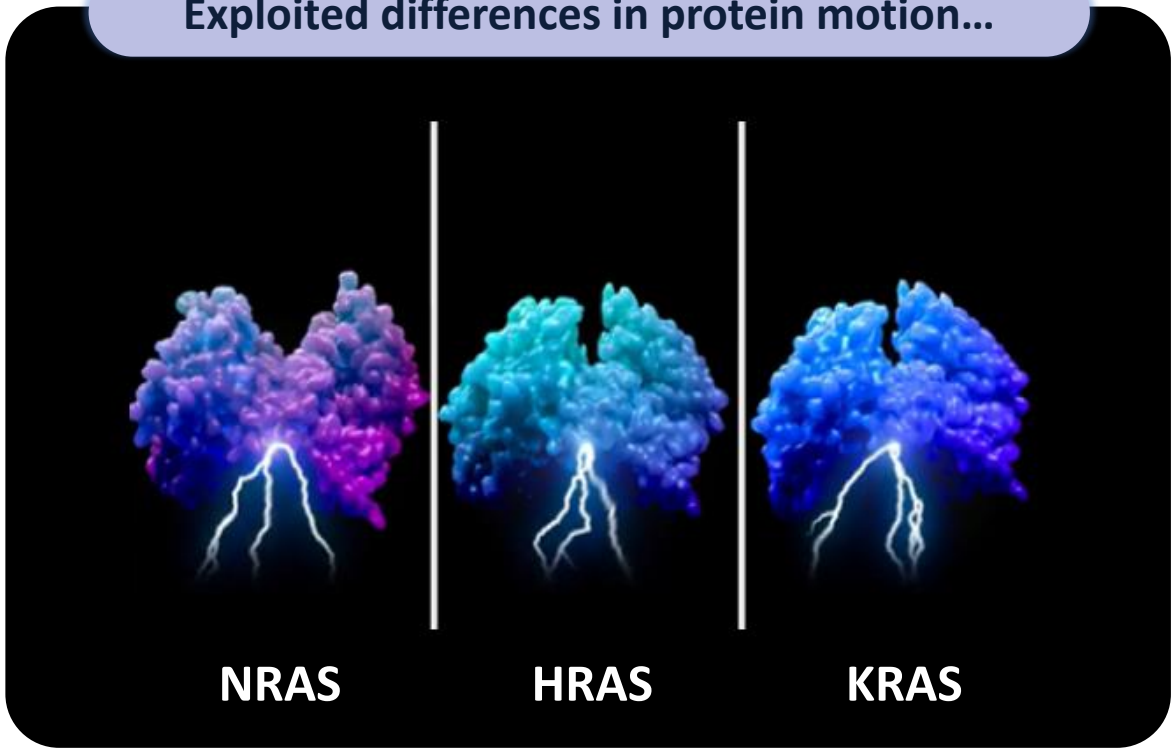
Belvarafenib (RAFi) + cobimetinib (MEKi) had shown 39% ORR (n=13), but belvarafenib development discontinued

Sources: ESMO 2024 #613MO (exarafenib + binimetinib - efficacy evaluable n=33 and 35% of total n=52 received prior MAPKi), ASCO 2021 #3007 (Belvarafenib + cobimetinib, n=32 all, 13 for efficacy), de Braud 2023 J Clin Oncol 41:2651 (naporafenib + trametinib, n=30 expansion arm), ASCO 2023 #9510 (tunlametinib, n=95), ESMO 2023 652O (RMC-6236, n=111 pts at ≥80mg); Scholl et al. 2007; Drosten et al. 2014; Esteban et al. 2001; Revolution Medicines Corporate Presentation 12/02/2024.

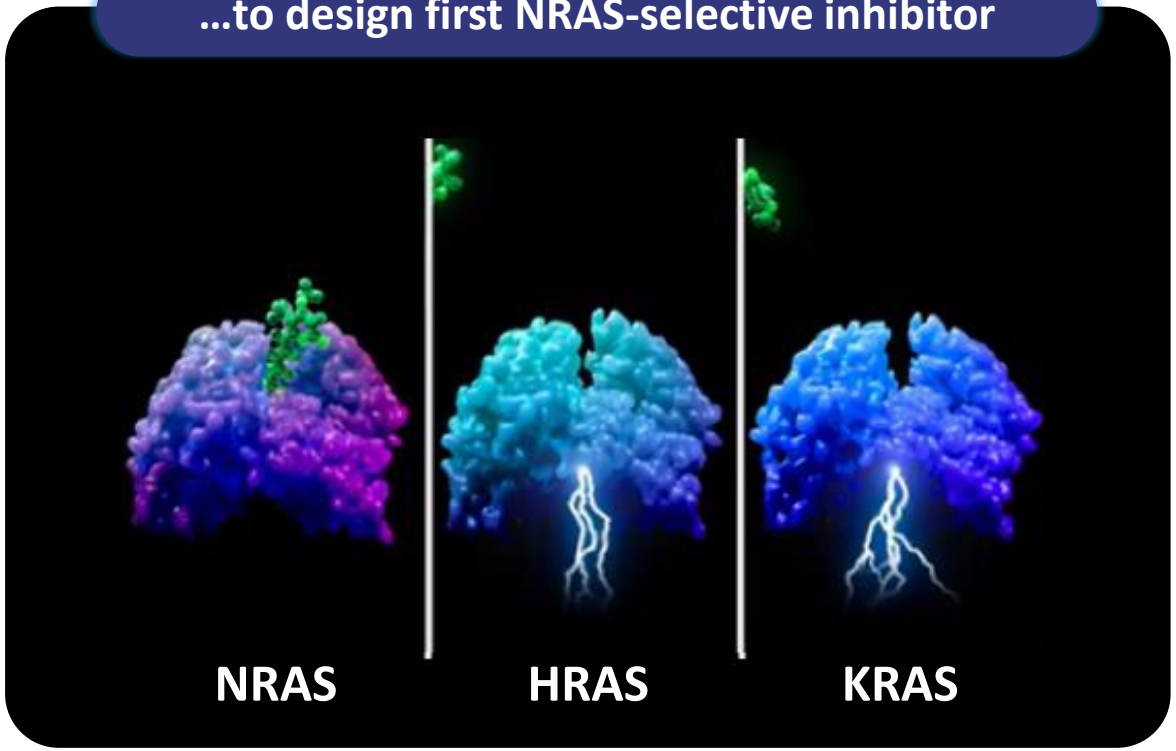
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NRAS – Dynamo® Platform Discovered a Novel Allosteric Pocket

Exploited differences in protein motion…



…to design first NRAS-selective inhibitor



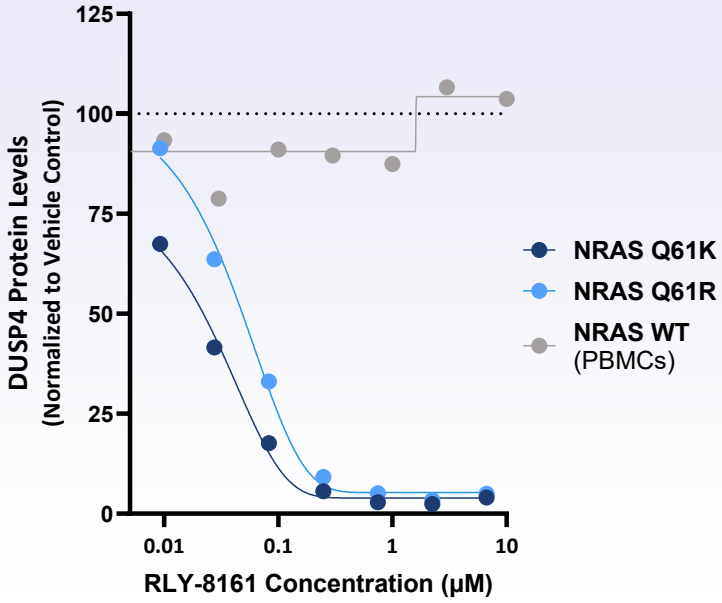
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NRAS Inhibitors Are Potent, Selective & Active Across NRAS Mutations

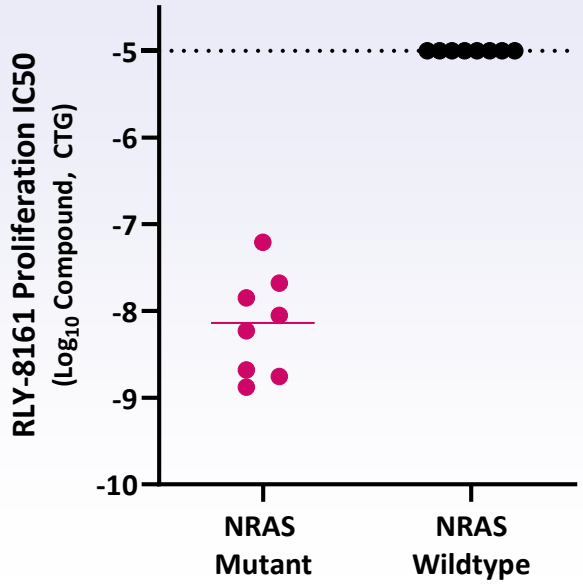
Relay Tx compounds bind to the ON-state with selectivity for NRAS[1]

RLY-8161	Binding Affinity (nM)
NRAS Q61R (ON)	22
NRAS Q61K (ON)	30
NRAS Q61L (ON)	38
NRAS G13D (ON)	38
NRAS G12D (ON)	38
NRAS WT (ON)	107
HRAS Q61K (ON)	No binding observed
KRAS Q61K (ON)	
KRAS WT (ON)	

…inhibit pathway signaling only in NRAS mutant cells[2]



…inhibiting proliferation of only NRAS mutant cells[3]



NRAS$^{G12C, G13R, Q61R, Q61K, Q61L}$

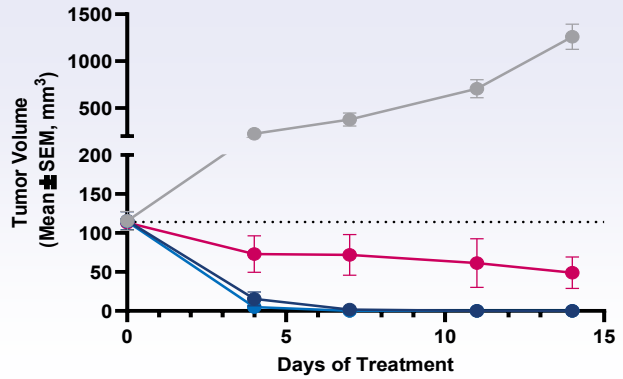
- KRAS$^{WT, Q61K, G12S}$
- HRAS$^{WT, G13D, Q61L}$

1. Based on SPR analysis of purified protein. 2. Based on DUSP4 assay of SK-MEL-2, SK-MEL-30, and PBMC cell lines evaluated at 24hr timepoint. 3. Based on cell proliferation panel (16 cell lines) evaluated at 3-5d timepoint depending on cell line; note that no effect on viability was observed at -5 log_{10} compound concentration.

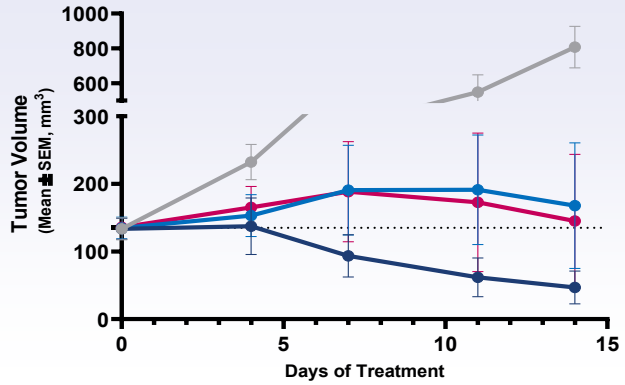
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Deep Regressions in PDXs Across Histologies & NRAS Genotypes

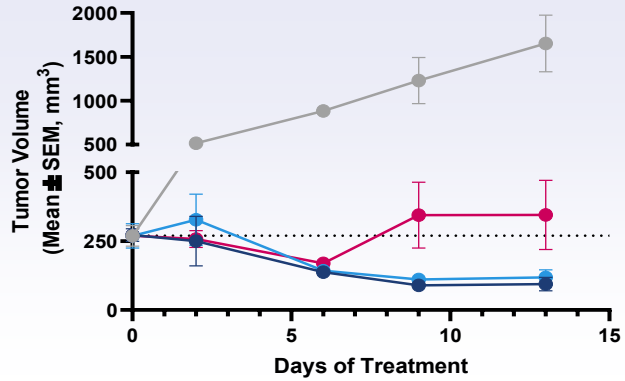
ME12175 Melanoma ($NRAS^{Q61R/R}$)



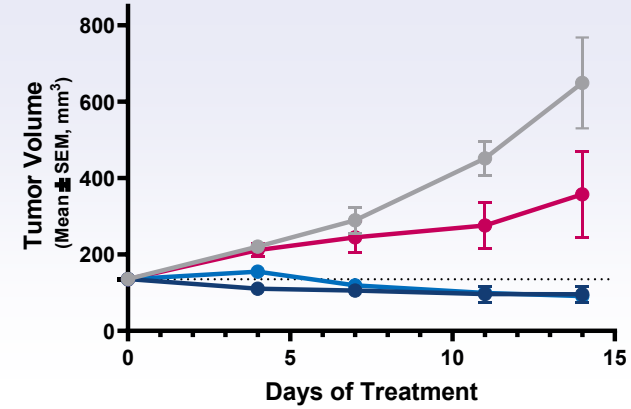
LU5153 NSCLC ($NRAS^{Q61K/K}$ $TP53^{R273L}$)



CTG-1282 Endometrial ($NRAS^{Q61K/WT}$)



CR14818 CRC ($NRAS^{Q61K/K}$, $TP53^{T253P}$, $APC^{R216Ter}$)



- Vehicle
- RLY-8161 20 mg/kg QD
- RLY-8161 25 mg/kg QD
- RLY-8161 100 mg/kg QD
- Binimetinib+ Exarafenib 3+10 mg/kg BID

Relay Tx compounds well tolerated in exploratory animal toxicology studies at exposures >10X above the predicted efficacious exposure level

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Exposure margin based on toxicology studies in dogs and rats

Fabry Disease – Large Validated Market With Significant Unmet Need

Genetic Disease

Fabry Disease

Novel Approach	**1st non-inhibitory, allosteric αGal chaperone**
Genetically Defined	***GLA* mutations**
Clinically Validated	**Galafold® (migalastat) approved in Fabry Disease**
Unmet Medical Need	**Limited αGal activation & limited mutational coverage**
Commercially Attractive	**~10,000 US patients[1]** ***(chronic treatment)***



Advance to IND-ready

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1. Prevalence of Fabry patients (National Fabry Disease Foundation, Jan 2026)

Fabry Disease – Large Validated Market With Significant Unmet Need

Fabry disease is a lysosomal storage disorder affecting ~10,000 patients in US[1]

Over 1,000 different *GLA* gene mutations

Reduces αGal protein levels

Leads to accumulation of toxic Gb3 substrate

Broad clinical manifestations; Life threatening cardiac & renal disfunction



Current therapies have established a market but have key limitations

Approved Therapies

Enzyme Replacement Therapy (ERT, intravenous)

~$1.7B peak sales[2]

(~$1.7B in 2026)

Inhibitory Chaperone Therapy (migalastat)

40% of pts

~$850M peak sales[3]

(~$570M in 2026)

>$3B total market forecasted[4] for Fabry tx despite limitations

Limitations of Approved Therapies

1. Burdensome biweekly IV delivery
2. Poor biodistribution, short half-life
3. Infusion reactions / neutralizing Ab
4. Symptom return between infusions

Studies show worsening post ERT-to-migalastat switch

1. Limited αGal activation
2. Limited mutational coverage
3. Not combined with ERT

Need for a non-inhibitory αGal chaperone

1. Prevalence of Fabry patients (National Fabry Disease Foundation, Jan 2026); 2. Combination of Fabrazyme® (~$1,250M) and Replagal® (~$550M) 2032 forecasted WW sales per EvaluatePharma, Sept 2026; 3. Galafold® 2032 forecasted WW sales per EvaluatePharma, Sept 2026; 4. 2023 forecast of all ERT, inhibitory chaperone, and gene tx per EvaluatePharma Sept 2025

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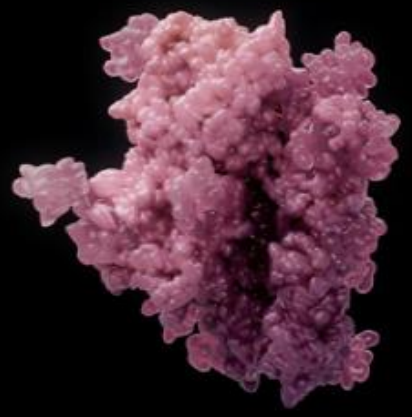
Fabry Disease – Dynamo® Discovered a Novel Allosteric Pocket

αGal

Normal



Mutant

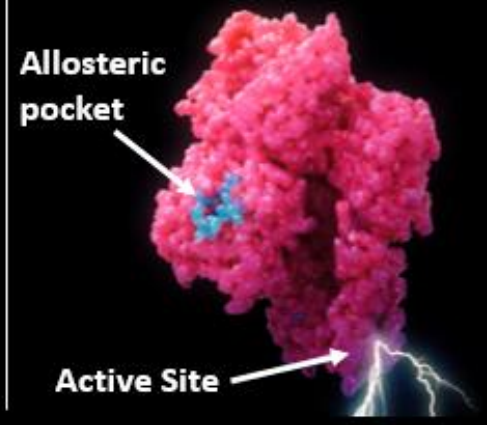


Inhibitory vs Non-Inhibitory Chaperone

Inhibitory



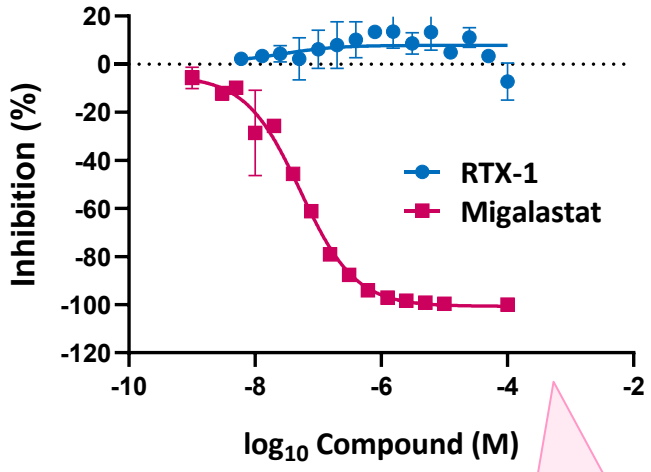
Non-Inhibitory



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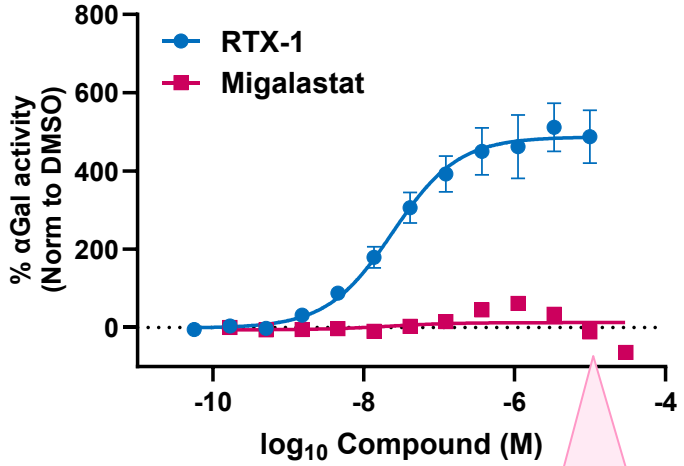
Relay Tx Compounds are Non-Inhibitory and More Potently Activate αGal in Cells

Migalastat inhibits αGal function while Relay compounds do not



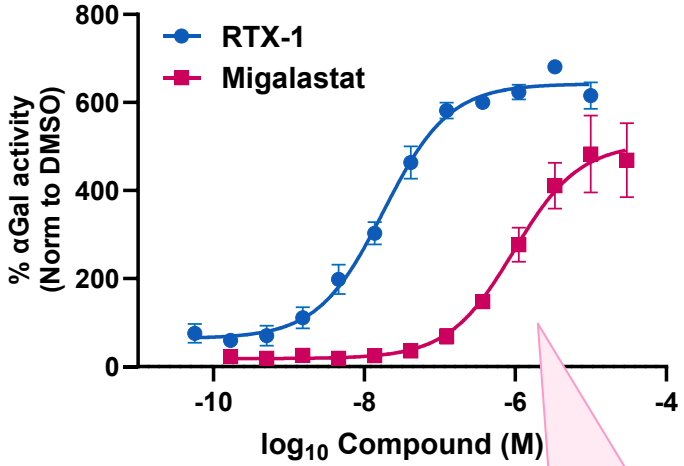
Significant protein inhibition observed with migalastat in biochemical assay, but not with Relay Tx compound

RTX-1 can activate αGal in cells without a compound washout



Migalastat is inhibitory, preventing activation of aGal

RTX-1 still shows superior activation vs migalastat post-washout

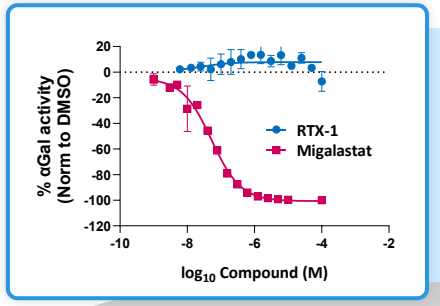


Activity following 2 hr washout; migalastat must be washed out to show activity

Note: Biochemical assay run with WT αGal; 1 hr incubation at room temperature

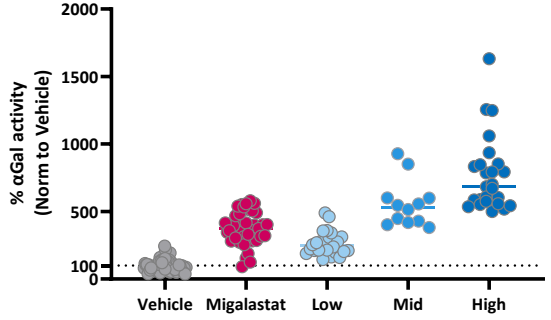
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Fabry Disease – Potential Benefits of Non-Inhibitory Chaperone Approach

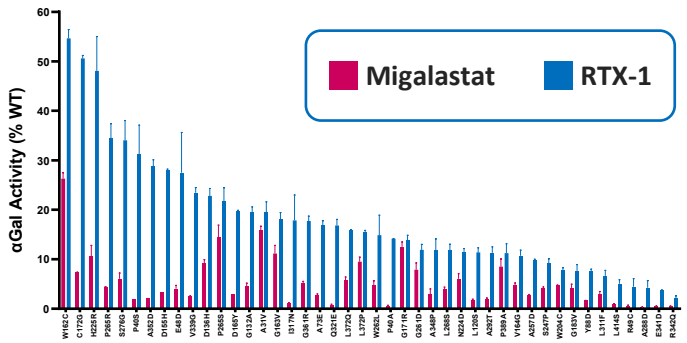


Relay Tx Solution:
Non-Inhibitory Chaperone to Stabilize Protein and Increase Activity

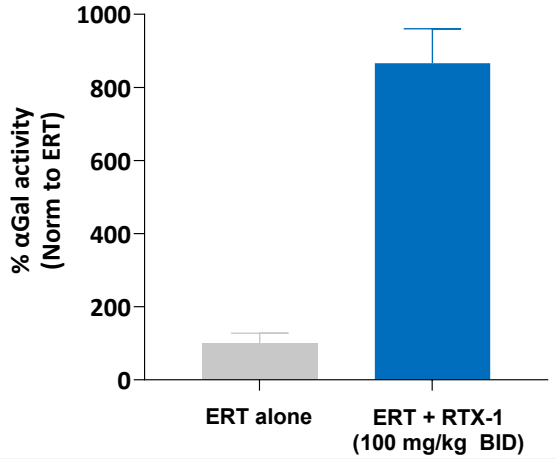
1 Superior αGal activation[1]



2 Broad mutational coverage[2]



3 Combinable with ERT[3]



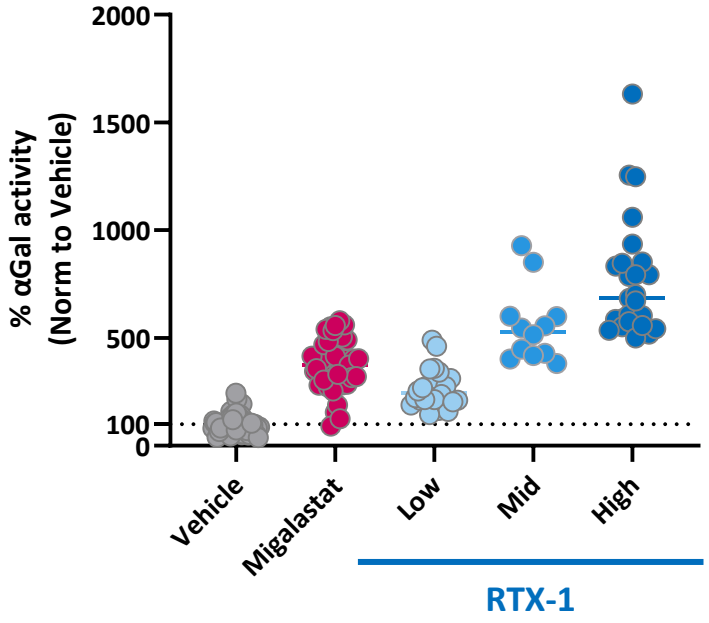
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Notes: 1. R301Q mut αGal (2hr post compound washout, expressed in *GLA* KO HEK293 cells); 2. In vitro αGal activity assay (4MU) across multiple GLA mutations expressed in HEK293 GLA KO cells (assessed at 1uM); 3. *GLA* KO mouse model, activity assessed following single dose of ERT and 14-day treatment with RTX-1

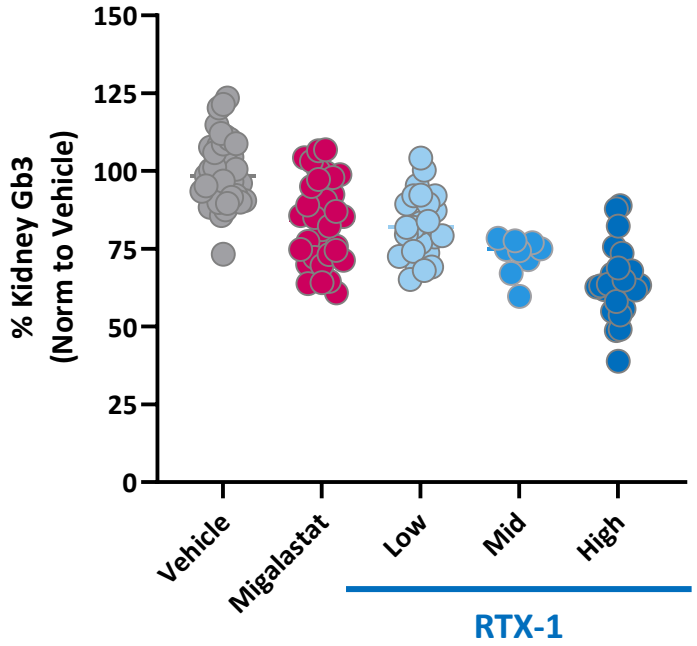
RTX-1 Leads to Higher Levels of *in Vivo* αGal Activity and Substrate Clearance

R301Q Mutant Mouse Model (Amenable Mutation)

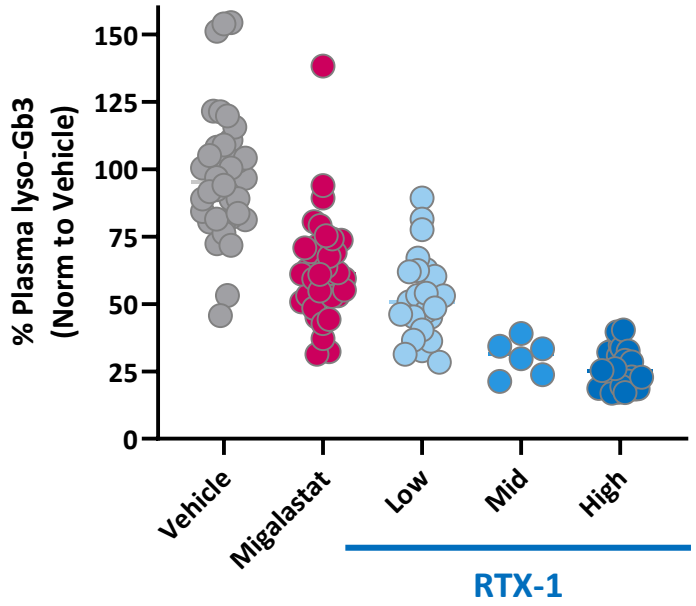
Kidney αGal activity



Kidney Gb3



Plasma lyso-Gb3



Migalastat = 30 mg/kg QOD

Estimated clinically relevant dose

RTX-1 Low / Mid / High = 30, 60, 100 mg/kg BID

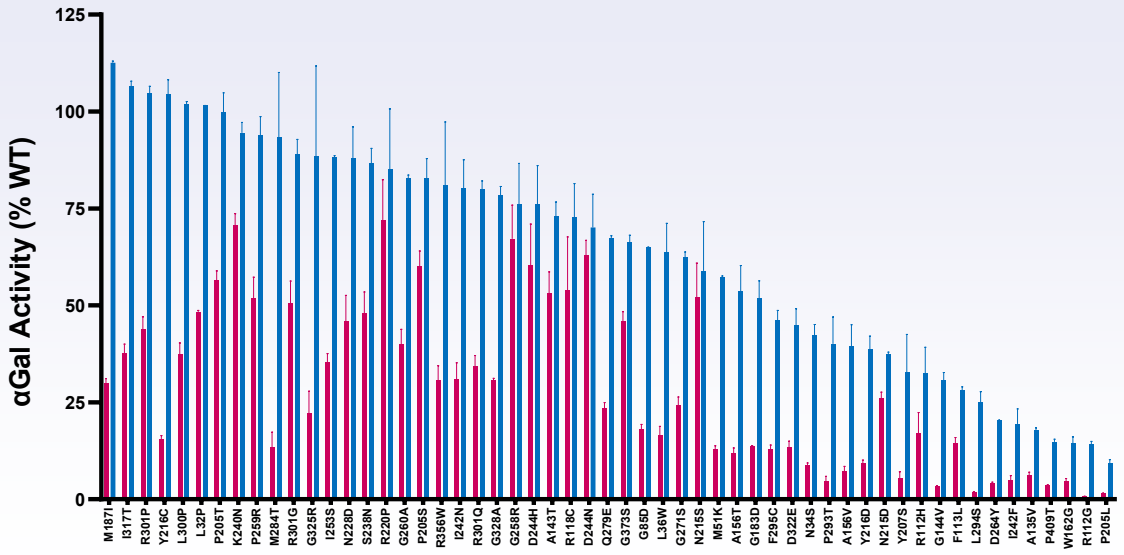
Approximates exposures for range of achievable human dose predictions

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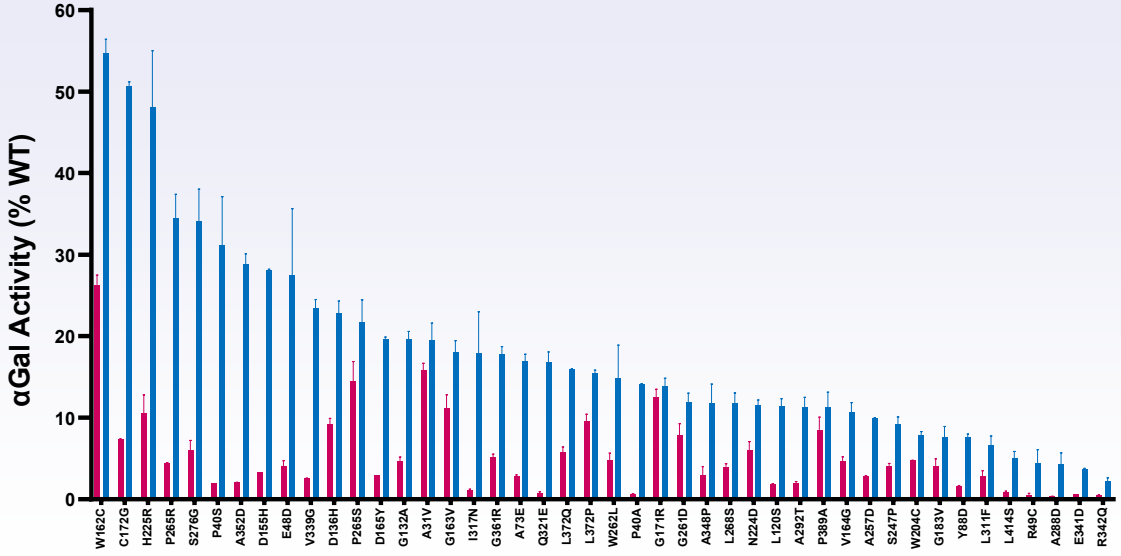
Activity and Gb3 levels measured at 28 days in humanized *GLA* R301Q mutant mouse model; data are from five independent studies

Relay Tx Chaperone Outperforms Migalastat Across a Panel of ~100 Mutations

Amenable Mutations



Non-Amenable Mutations



Migalastat RTX-1

Amenability per migalastat label

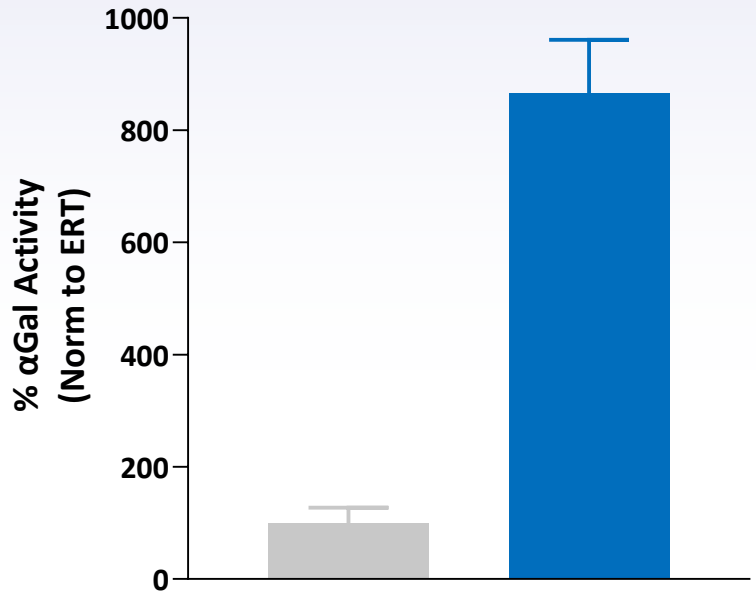
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Note: In vitro αGal activity assay (4MU) across multiple *GLA* mutations expressed in HEK293 *GLA* KO cells; αGal activity evaluated at 1µM of migalastat and 290 nM RTX-1

Relay Tx Non-Inhibitory Chaperones Combinable with ERT

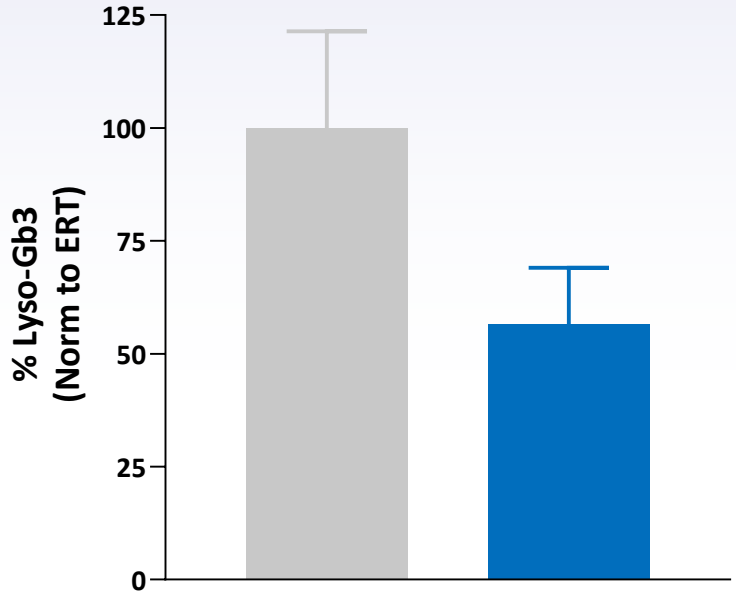
In vivo αGal activity

Activity in kidney following single dose of ERT and 14-day treatment with RTX-1 (*GLA* KO mouse model)



In vivo lyso-Gb3 reduction

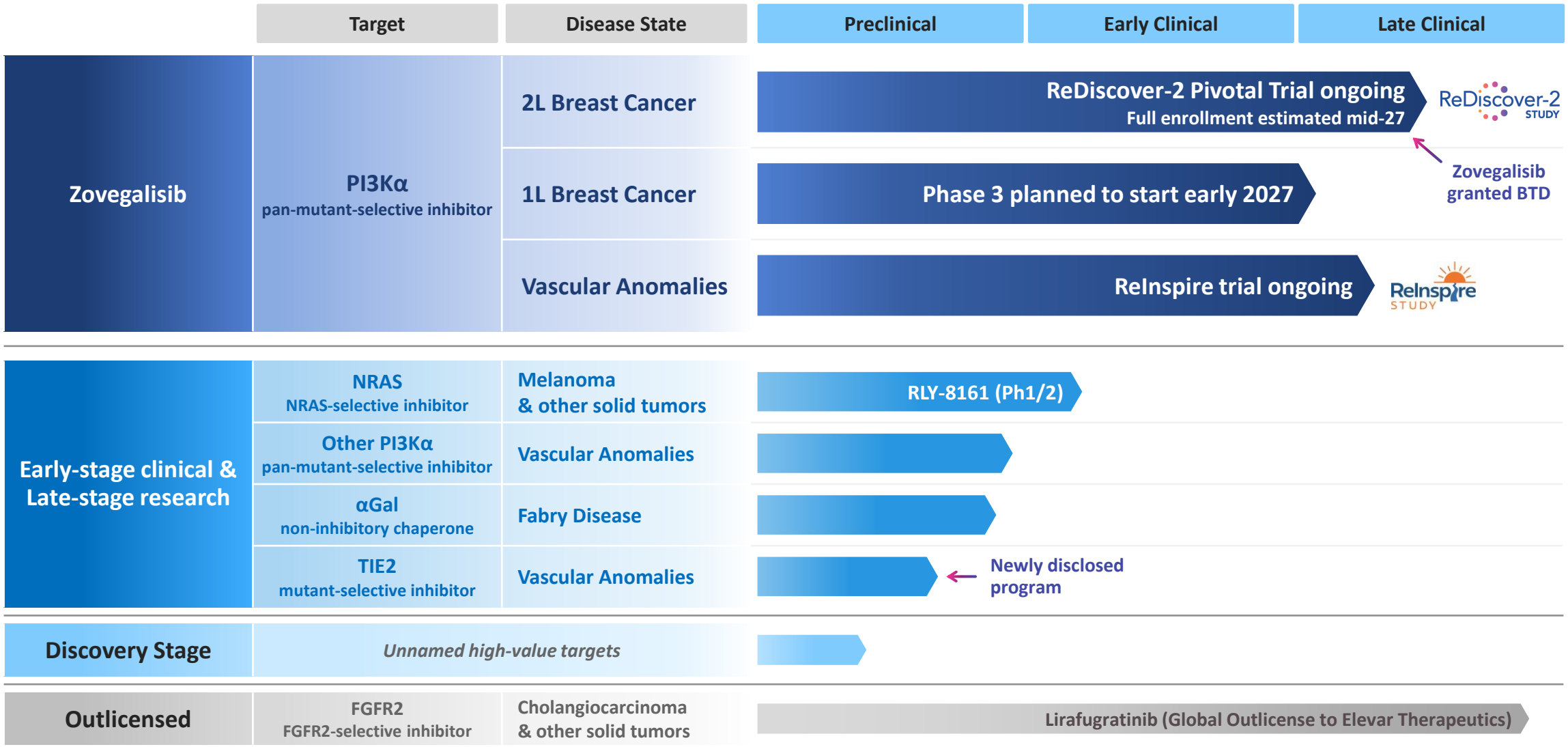
Plasma lyso-Gb3 levels following single dose of ERT and 14-day treatment with RTX-1 (*GLA* KO mouse model)



ERT alone ERT + RTX-1 (100 mg/kg BID)

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Relay Tx – Broad Precision Medicine Pipeline



αGal, galactose-alpha-1,3-galactose; BTD, FDA Breakthrough Therapy Designation; FGFR2, fibroblast growth factor receptor 2; NRAS, neuroblastoma RAS viral oncogene homolog; PI3Kα, phosphoinositide 3-kinase alpha; TIE2, Angiopoietin-1 receptor

FDA Approved Sept 2026

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Zovegalisib – Potential To Address 3 Large Commercial Opportunities

	2L Breast Cancer	1L Breast Cancer	Vascular Anomalies
Estimated US TAM	$2-3B	$7-8B	$6-8B

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Note: TAM calculated based on market benchmarks and internal analysis

Relay Tx – Clear Path to Addressing Large Commercial Opportunities

Zovegalisib granted BTD

	Zovegalisib Program Interim data shared in 2026 → key value drivers	Clinical Benchmark Hurdle[1]	Anticipated Next Steps
2L Breast Cancer ~$2-3B TAM[2]	**11.1mo mPFS at pivotal dose** **for Zovega + fulv doublet** → Rapid execution of ongoing 2L pivotal trial	Capi+fulv in 2L: **5.5mo mPFS**	**Complete enrollment of Phase 3 estimated mid-2027**
1L Breast Cancer ~$7-8B TAM	**44% ORR in median 3L patients** **for Zovega + Atirmo + fulv triplet** → Aim to initiate 1L pivotal trial in early 2027	CDK+ET in 2L+ **14-32% ORR**	**Regulatory update on 1L Ph3 trial design by YE2026;** **Phase 1/2 data in 2027**
Vascular Anomalies ~$6-8B TAM	**60% VRR across all doses[4]** → Continue enrollment of adults + pediatrics; establish potential regulatory path	Alpelisib & KP-001 **11-16% VRR[3]** *at week 12 & 16*	**Data and regulatory update at ASH 2026**

~$849M Cash as of end 3Q 2026

1. Clinical benchmark references: 2L breast cancer: capivasertib + fulvestrant (CDK4/6-experienced patient sub-population of CAPItello-291, Turner N Engl J Med 2023; 388:2058-2070) ; 1L breast cancer: CDK+ET in 2L+ (PACE Ph2: SABCS 2022 #GS3-06; postMONARCH Ph3: ASCO 2024 #1001; MAINTAIN Ph2: ASCO 2022 #LBA1004); atirmociclib Ph1: Pfizer R&D Oncology Day Feb 2024; vascular anomalies: alpelisib (EPIK-P2, Canaud 2024 Blood 144:5512) and KP-001 (Ozeki 2025, Orphanet Journal of Rare Diseases 20:64); 2. TAM calculated based on market benchmarks and internal analysis; 3. these benchmarks represent the earliest volumetric response evaluation timepoint; 4. Includes both confirmed and unconfirmed responses. After the data cut-off date, one 100mg BID patient that did not have a volumetric response as of the data cut-off date has converted to an unconfirmed response, resulting in a 100mg BID volumetric response rate of 43% (3/7), a volumetric response rate of 69% (9/13) for patients treated at 300mg BID or 100mg BID, and a volumetric response rate of 65% (13/20) across doses. None of the other response-evaluable patients' response statuses have changed since the data cut-off date. VRR = Volumetric Response Rate. Note: These data are derived from different clinical trials at different points in time, with differences in molecule composition, trial design and patient populations. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted.

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ReDiscover preliminary data: doublet as of 01/13/2026, triplet as of 04/13/2026; ReInspire preliminary data as of 04/15/2026

