Bristol Myers Squibb®

ESMO 2024

Investor Presentation
September 2024

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ESMO 2024

Samit Hirawat

Executive VP
Chief Medical Officer
Head of Global Drug Development

BMS presents exciting data in oncology at ESMO 2024

Advancing IO development

Opdivo + Yervoy (CM-067 - Phase 3)

10-year data in metastatic melanoma

Subcutaneous Nivolumab (CM-67T - Phase 3)

15-month data supports improved patient & healthcare experience

Nivolumab + Relatlimab HD (RELA-104 - Phase 2)

Advancing into Phase 3 with LAG-3 in 1L NSCLC

Data across novel modalities

- AR LDD (Phase 1): Encouraging durability in post-ARPi mCRPC patients without prior chemotherapy
- EGFRxHER3 ADC (Phase 1): Promising GI/GU efficacy signal across multiple studies[1]
- Anti-Fucosyl GM1 (Phase 2): Novel mechanism may improve 1L ES-SCLC survival
- Krazati (Krystal 12 - Phase 3): Metastatic $KRAS^{G12C}$ NSCLC patients with brain metastasis data

1. Data presentations at ESMO 2024 conducted by Sichuan Biokin Pharmaceuticals Co., Ltd. and SystImmune, Inc.

Significant progress advancing our leadership in cancer drug development

We are extending in IO

- Entered Phase 3 with Nivolumab & Relatlimab HD in 1L NSCLC
- Filed Subcutaneous Nivolumab: U.S. FDA PDUFA date Dec 29th

Significantly expanding registrational pipeline

- 8 new trials across solid tumors spanning multiple novel modalities & platforms
- Biologics, Protein Degraders, ADCs, RPTs, & Targeted Therapies

Broadening into important solid tumors

Small cell lung, breast, & prostate cancers

Developing potential first-in-class and/or best-in-class medicines

ADC: Antibody Drug Conjugates; RPT: Radiopharmaceutical Therapies

Strong foundation in IO & broadening modalities beyond IO

IO & Biologics

OPDIVO (nivolumab) INJECTION FOR INTRAVENOUS USE 10 mg/mL

YERVOY (ipilimumab)

Opdualag (nivolumab and relatlimab-rmbw) Injection for intravenous use | 480 mg/160 mg

- **Nivolumab + Relatlimab HD**
- **Subcutaneous nivolumab[1]**
- **Anti-Fucosyl GM1**
- Anti-CCR8

Cell Therapy

Breyanzi (lisocabtagene maraleucel) SUSPENSION FOR IV INFUSION

Abecma (idecabtagene vicleucel) SUSPENSION FOR IV INFUSION

- GPRC5D CAR T
- BCMA x GPRC5D Dual Targeting CAR T*

Protein Degradation

- **AR LDD**
- Helios CELMoD*
- BCL6 LDD*
- HbF Activating CELMoD*
- CK1α Degrader
- iberdomide
- mezigdomide
- golcadomide

Radiopharmaceuticals

- **RYZ101**

Antibody Drug Conjugates

- **EGFRxHER3**
- CD33 GSPT1

Targeted Therapies

KRAZATI (adagrasib) 200 mg TABLETS

AUGTYRO (repotrectinib)

- **PRMT5i**

1. U.S. FDA PDUFA December 29th, 2024; application under review in EU; *Newer INDs in last 12 months

Not an exhaustive list of assets, programs, or indications

RELATIVITY-104: 1L NSCLC signal detecting Phase 2 study

Key Inclusion[1]:

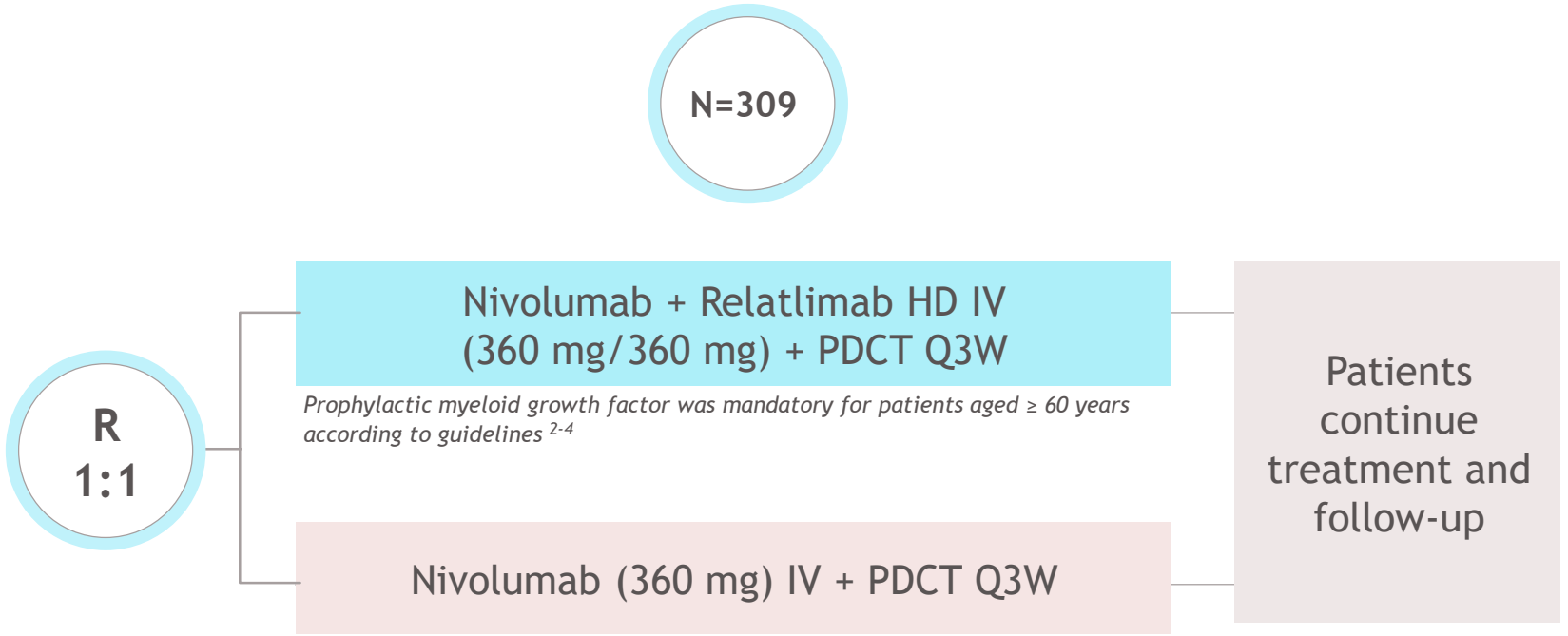
- 1L stage IV/recurrent NSCLC
- No prior systemic therapy for metastatic disease
- No EGFR, ALK, ROS-1 mutations
- ECOG PS 0–1

Primary Endpoint: ORR

Secondary Endpoints: Safety, DOR, ORR & PFS by PD-L1

Stratified by tumor

- PD-L1 (≥1% vs <1%)
- Histology (NSQ vs SQ)
- ECOG PS (0 vs 1)



Addressing two key questions: (1) Does LAG-3 add benefit to a PD-1/chemo combo & (2) in which patients?

1. NCT04623775; 2. During the first 4 cycles of treatment (PDCT period) for patients aged ≥ 60 years; or during the remaining PDCT treatment for patients aged < 60 years who had a grade ≥ 3 neutropenic AE;
3. Smith TJ et al. *J Clin Oncol* 2015;33:3199; 4. Klastersky J, et al. *Ann Oncol* 2016;27:v111

RELATIVITY-104: 1L NSCLC safety summary

	Part 2 Results			
	Nivo + Rela 360 mg + PDCT n=158		Nivo + PDCT n=149[a]	
Ongoing treatment,[b] n (%)	38 (24)		44 (30)	
Safety[c]	Any grade	Grade 3/4	Any grade	Grade 3/4
All-cause AEs, n (%)	158 (100)	112 (71)	148 (99)	104 (70)
TRAEs, n (%)	147 (93)	86 (54)	138 (93)	82 (55)
Serious TRAEs	37 (23)	33 (21)	36 (24)	32 (22)
TRAEs leading to discontinuation	21 (13)	12 (8)	21 (14)	13 (9)
TRAEs leading to death	6 (4)		5 (3)	

- Grade ≥3 treatment-related neutropenic AEs[d] occurred in 6.3% (NIVO + RELA 360 mg + PDCT) vs 13.5% (NIVO + PDCT)
- TRAEs leading to death:
  - NIVO + RELA 360 mg + PDCT: Neutropenic sepsis (n=2), febrile neutropenia (n=1), pneumonitis (n=2), pneumonia (n=1)
  - NIVO + PDCT: Febrile neutropenia, sepsis, septic shock, asthenia, lung disorder (n=1 each)
- Most common TRAEs (≥ 20%) with NIVO + RELA 360 mg + PDCT: anemia, nausea, neutropenia, thrombocytopenia, fatigue

[a]2 patients were randomized but not treated. [b]Median number of I-O doses received: 9 NIVO + RELA 360 mg + PDCT and 9 NIVO + PDCT (Part 2). [c]AEs were graded per CTCAE v5.0 and MedDRA v27.0. Includes events reported between the first dose and 30 days after the last dose of study treatment. [d]Includes neutropenia, febrile neutropenia, neutropenic sepsis, neutropenic infection, neutrophil count decreased, neutrophil percentage decreased, pancytopenia, sepsis, septic shock

RELATIVITY-104 demonstrates compelling LAG-3 benefit across patient subgroups in 1L NSCLC

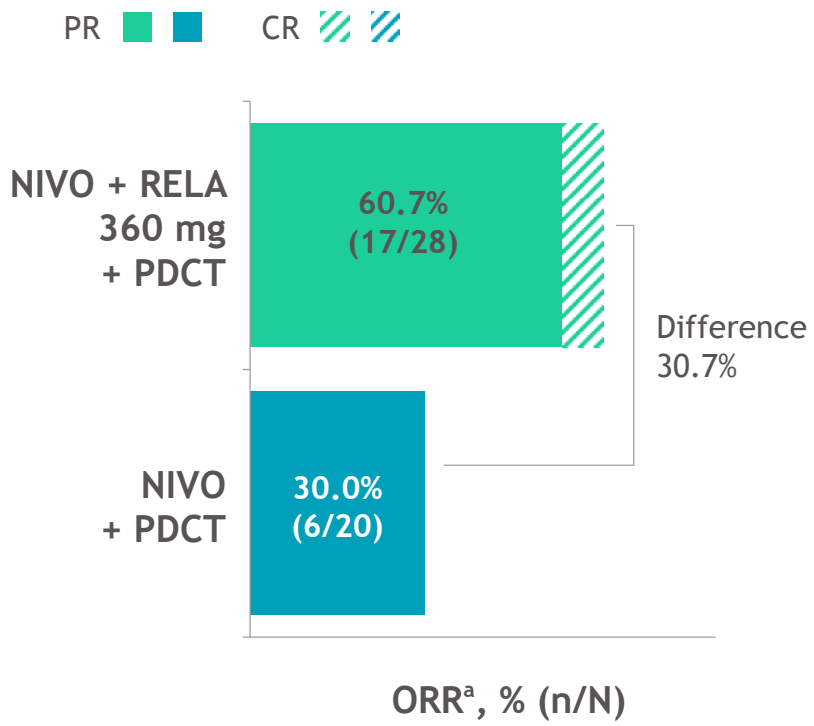
Subgroup, n[a,b]	RELA-104 Part 2 Results				
	mPFS, mo (90% CI)		PFS HR (90% CI)	ORR, % (90% CI)	
	Nivo + Rela 360 mg + PDCT	Nivo + PDCT		Nivo + Rela 360 mg + PDCT	Nivo + PDCT
PD-L1 expression[c]					
≥ 1% (n=79, 71)	**9.8 (5.9-13.8)**	**6.1 (4.2-7.0)**	**0.63 (0.45-0.88)**	**53.2 (43.3-62.8)**	**40.8 (31.0-51.3)**
< 1% (n=70, 67)	5.6 (5.3-7.0)	5.8 (5.4-7.0)	1.23 (0.89-1.70)	50.0 (39.6-60.4)	44.8 (34.4-55.5)
Histology					
NSQ (n=107, 104)	**8.3 (5.6-9.8)**	**6.1 (4.6-7.0)**	**0.86 (0.65-1.13)**	**46.7 (38.5-55.1)**	**38.5 (30.5-47.0)**
SQ (n=51, 47)	5.6 (5.3-8.2)	5.8 (5.4-7.1)	0.97 (0.66-1.43)	60.8 (48.3-72.3)	55.3 (42.3-67.8)

Median follow-up (range) for Part 2: 10.7 (0.0-18.7) months.

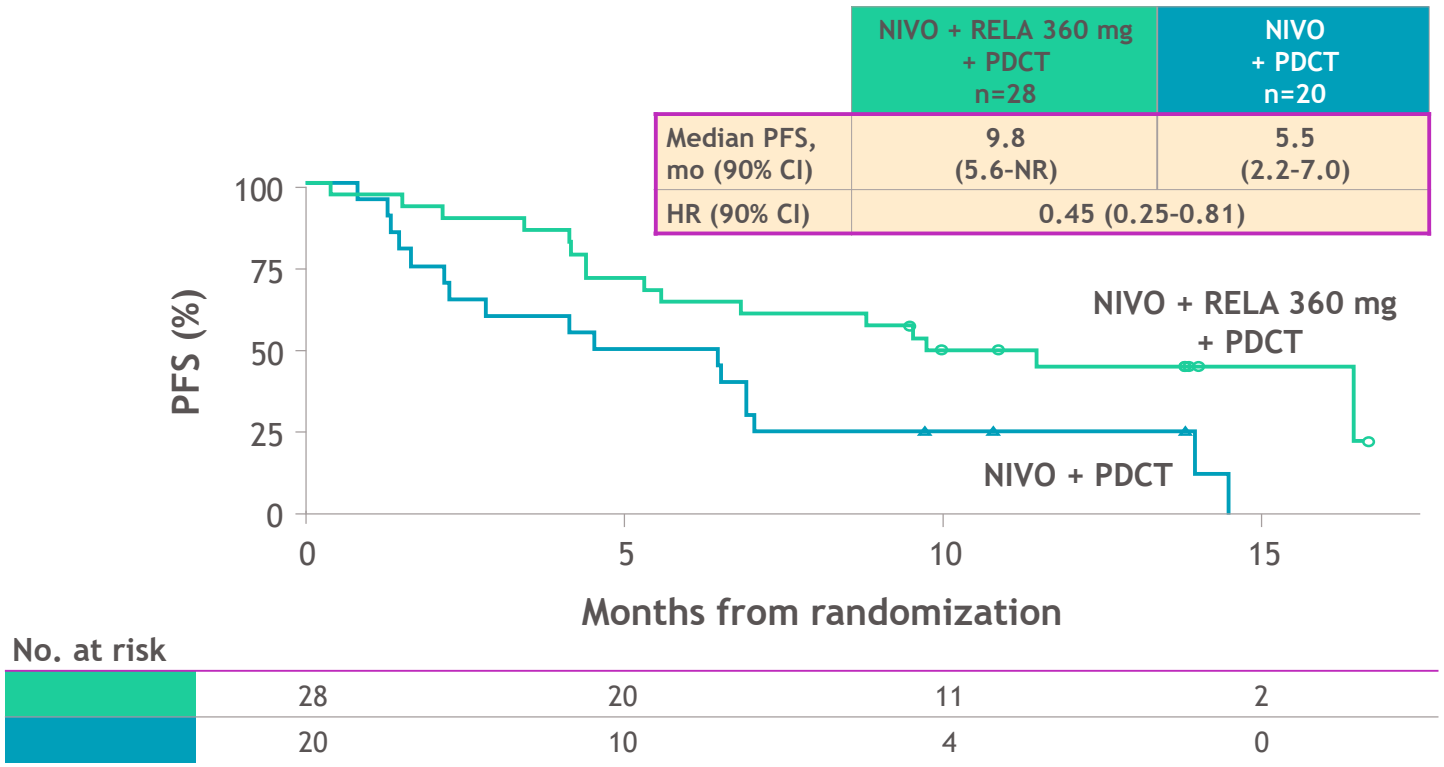
[a]ECOG PS was also a stratified patient subgroup that is not shown. [b]Number of patients in the NIVO + RELA 360 mg + PDCT and RELA + PDCT arms, respectively. [c]9 (NIVO + RELA 360 mg + PDCT) and 13 patients (NIVO + PDCT) were not evaluable.

RELATIVITY-104: LAG-3 enriches efficacy in PD-L1, 1-49% & NSQ in 1L NSCLC patients

Robust response rates



Improvement in PFS



Demonstrated improved benefit adding LAG-3 to PD-1 & PDCT

Median follow-up (range) for Part 2: 10.7 (0.0-18.6) months | [a]Part 1 RELA 360 mg dose in PD-L1 1-49% & NSQ (n = 13): mPFS 10.4 mo, ORR 46.2%; PDCT: platinum doublet chemotherapy

Phase 2 data in 1L NSCLC compared to historical control provides confidence in our Phase 3 strategy

PD-L1 (1-49%) & NSQ segment

	Nivo + Rela HD + Chemo RELA-104 Phase 2	Historical SOC reference Pembroluzimab + Chemotherapy KEYNOTE-189 Phase 3[1]	Velcheti RWD 2021[2]	Liu RWD 2022[3]	Waterhouse RWD 2024[4]
	N=28	N=128	N=77	N=104	n=2,058
ORR	61%	50%	55%	39%	NR
mPFS	9.8 mo.	9.4 mo.	5.9 mo.	5.7 mo.	5.9 mo.

1. M. Garassino et. al – 5-year outcomes from the Phase 3 KEYNOTE-189 study; 2. V. Velcheti et. al – Real-world outcomes of first line pembroluzimab plus chemotherapy 3. S. Liu et. al – Pembroluzimab-combination therapy: RW outcomes; 4. BMS internal analysis based on data analyzed from the Flatiron Database as referenced in the D. Waterhouse et. al NSCLC AACR 2024 poster

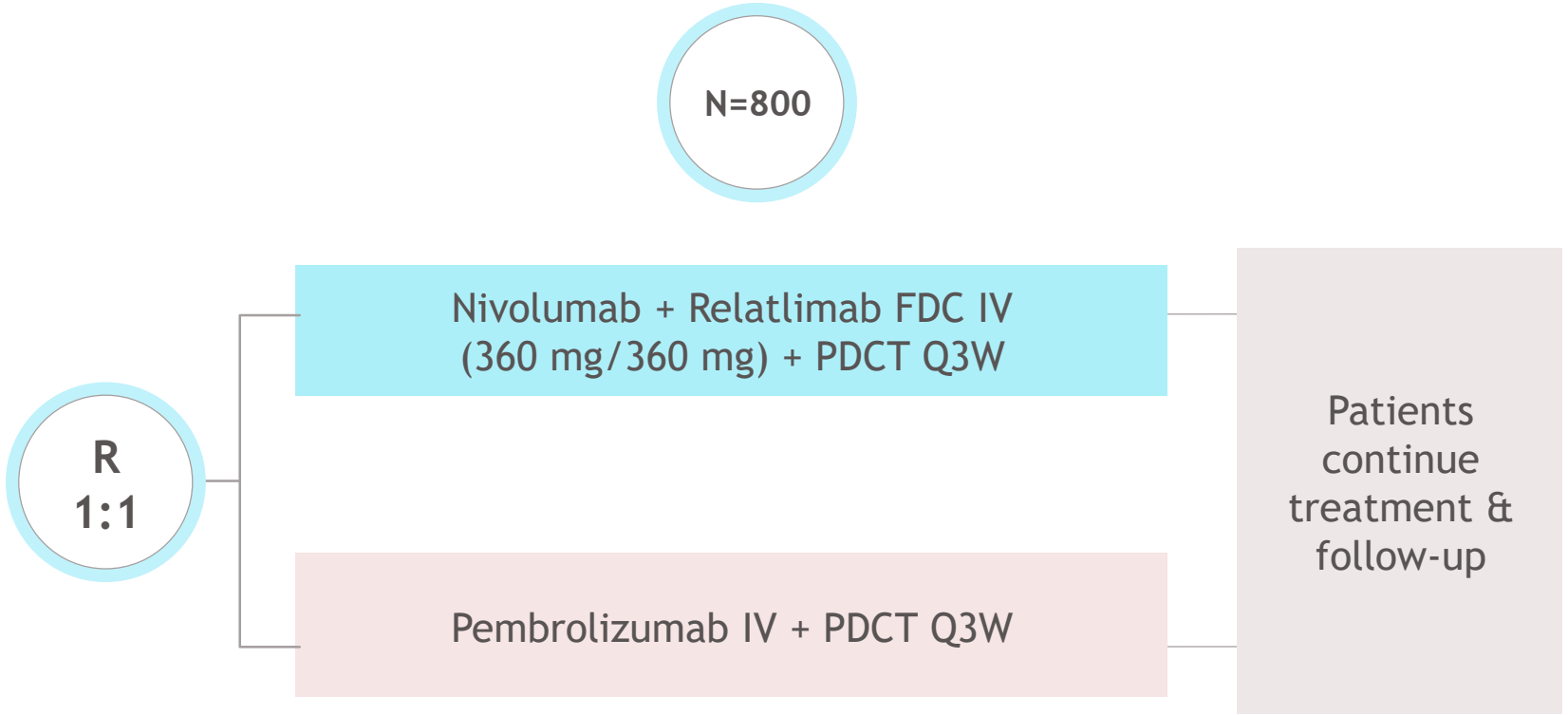
Nivolumab + Relatlimab HD: 1L NSCLC Phase 3 trial design

Key Inclusion[1]:

- Previously untreated, histologically confirmed stage IV or recurrent non-squamous NSCLC
- PD-L1 expression 1-49%
- No EGFR, ALK, ROS-1, BRAF, RET, NTRK mutations
- ECOG PS 0-1

Primary Endpoint: OS

Secondary Endpoints: PFS, ORR, DoR, Safety

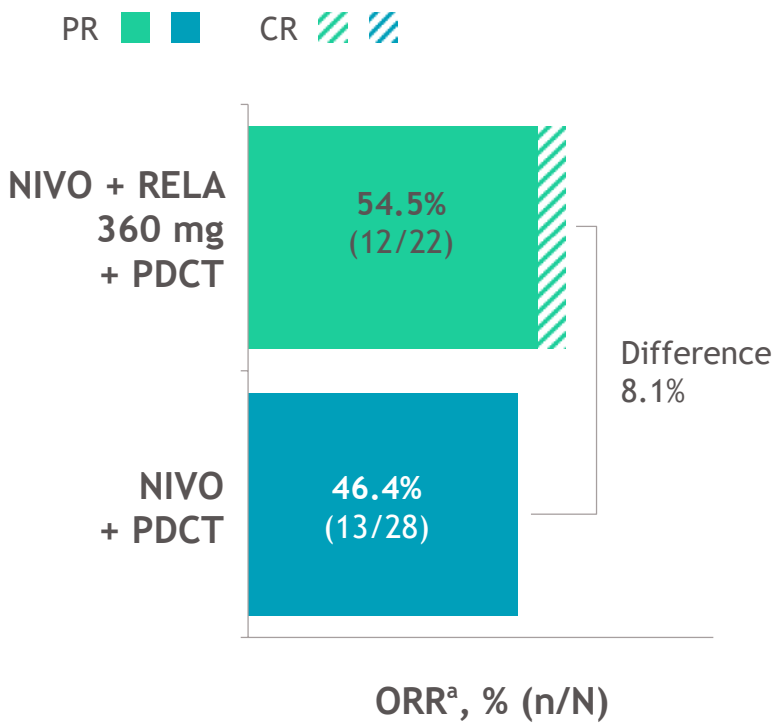


Phase 3 study initiating in PD-L1, 1-49% & NSQ histology

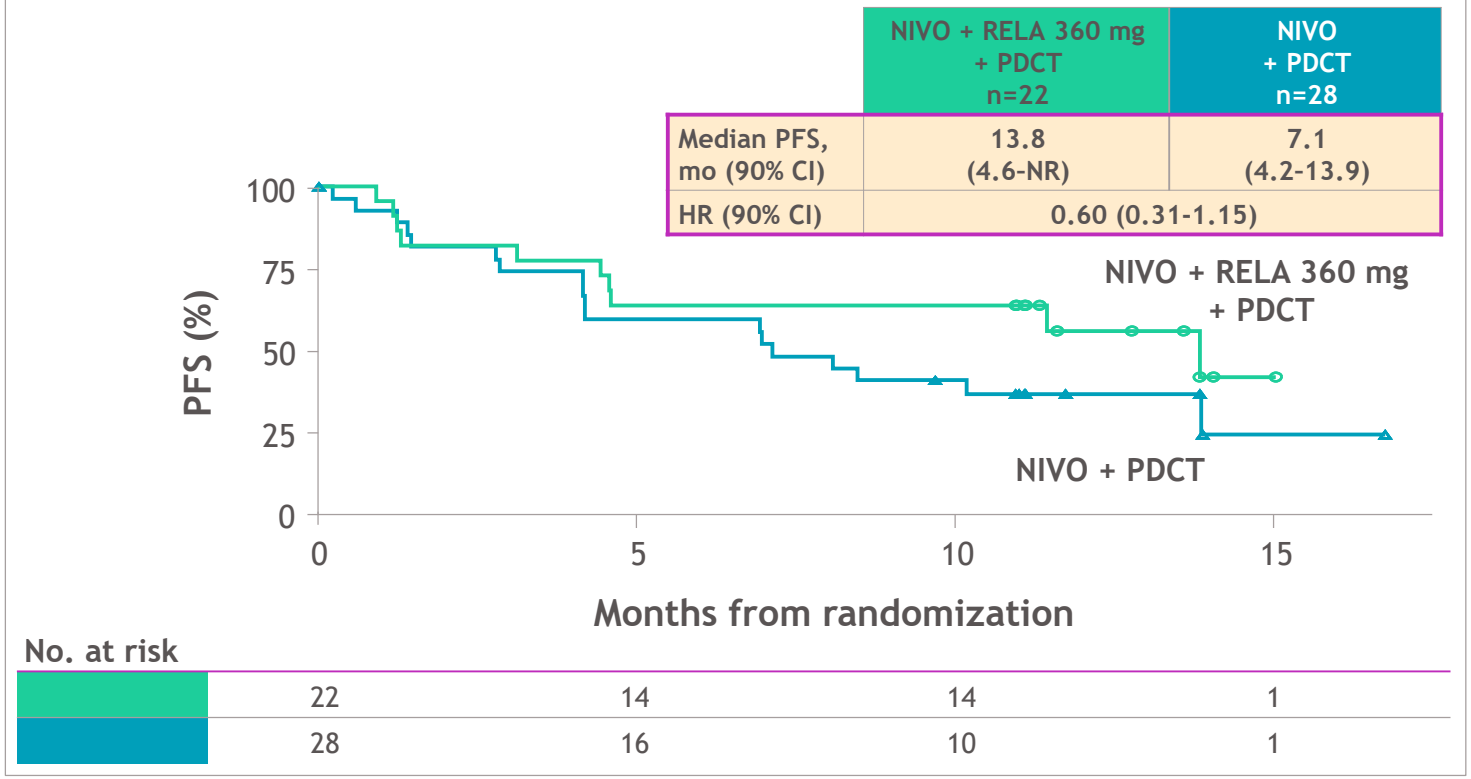
1. NCT06561386

Data supports extending 1L NSCLC development to PD-L1≥50% & NSQ patients

Promising efficacy



Solid PFS benefit observed



Median follow-up (range) for Part 2: 10.7 (0.0-18.6) months.
[a]Part 1 RELA 360 mg dose in PD-L1 ≥ 50% & NSQ (n = 9): mPFS not reached, ORR 55.6%; PDCT: platinum doublet chemotherapy

Nivolumab + Relatlimab HD Phase 3 programs advancing in 1L NSCLC

Demonstrated improved benefit adding LAG-3 to PD-1 & PDCT

Clinical data supports further Phase 3 investigation

Phase 3 trial initiating in PD-L1, 1-49% & NSQ patients

Developing Phase 3 trial in PD-L1 ≥50% & NSQ patients, potential to broaden addressable population in 1L NSCLC

Addressing significant unmet medical need in lung cancer

1L NSCLC[1]

Treated Population[2]: U.S.: ~105K & EU5: ~120K

Histology	NSQ	SQ
	75%	25%

PD-L1 Status[3]	<1%	1-49%	≥50%
	30-35%	40-45%	25-30%

AGA	EGFR	ALK	ROS1
	~13%	~5%	20-25%

OPDIVO (nivolumab) INJECTION FOR INTRAVENOUS USE 10 mg/mL

YERVOY (ipilimumab)

KRAZATI (adagrasib) 200 mg TABLETS

AUGTYRO™ (repotrectinib)

Nivolumab + Relatlimab HD

PRMT5i

EGFRxHER3

1L SCLC[1]

Treated Population: U.S.: ~26K & EU5: ~22K

Stages	ES-SCLC	LS-SCLC
	70%	30%

Anti-Fucosyl GM1

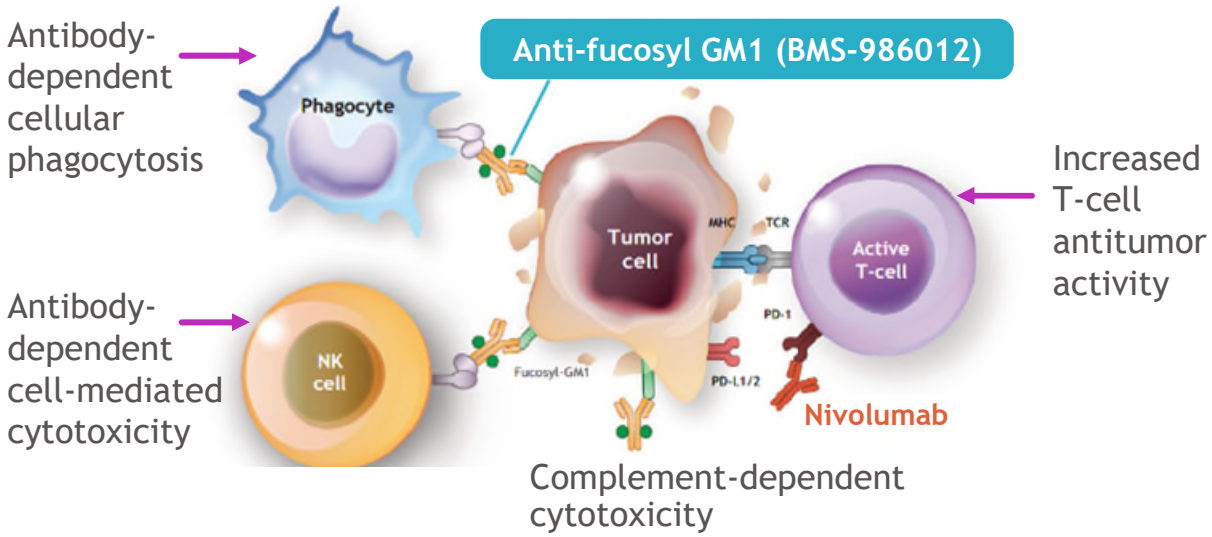
EGFRxHER3

RYZ101

Diversifying into novel treatment options for patient segments with high unmet needs

1. Decision Resource Group, BMS Internal Analysis 2. Includes EGFR/ALK; 3. Includes Unknown/Untested; AGA: Actionable Genomic Alterations NSQ: Non-Squamous; SQ: Squamous; ES-SCLC: Extensive Stage-Small Cell Lung Cancer; LS-SCLC: Limited-Stage Small Cell Lung Cancer; EU5 = UK, Spain, Germany, Italy, & France

Anti-Fucosyl GM1: Effective treatments needed in 1L ES-SCLC



Induces tumor cell death via immune mediated mechanisms

- SCLC is a life-threatening disease representing ~15% of all lung cancer cases, & has poor survival outcomes[1,2,3]
  - Extensive-stage: ~70% of SCLC cases
  - SOC in 1L ES-SCLC offers modest mOS of roughly one year
- Fucosyl-GM1 is highly expressed in ~50-90% of SCLC tumors[4] with limited normal tissue expression

Promising anti-tumor activity & durability observed in early trials[5]

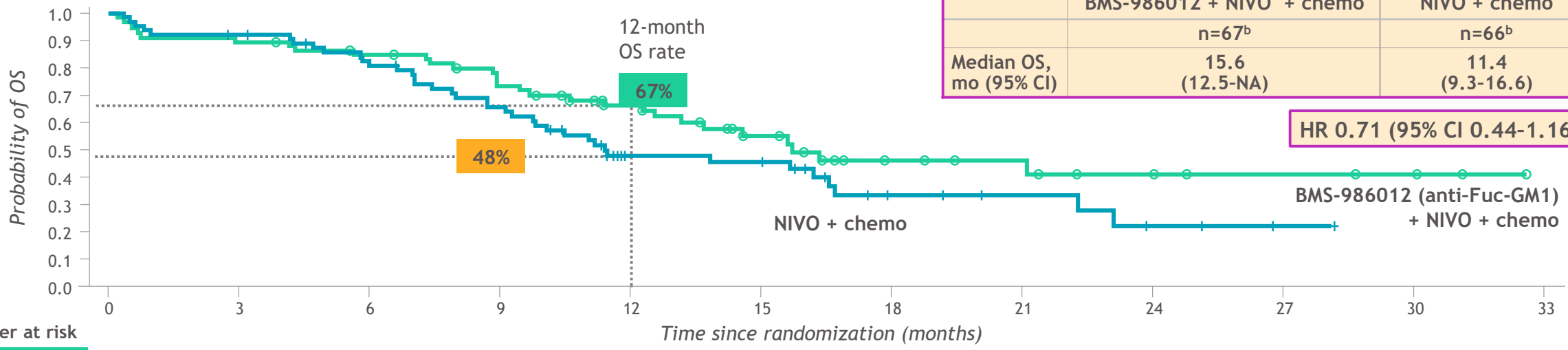
1. Rudin C, Brambilla E, Faivre-Finn C, et al. Small-cell lung cancer. Nat Rev Dis Primers 2021;7:3. 2. Horn L, Mansfield AS, Szczęsna A, et al. First-line atezolizumab plus chemotherapy in extensive-stage small-cell lung cancer. N Engl J Med 2018;379:2220-9. 3. Paz-Ares L, Dvorkin M, Chen Y, et al. Durvalumab plus platinum-etoposide versus platinum-etoposide in first-line treatment of extensive-stage small-cell lung cancer (CASPIAN): a randomised, controlled, open-label, phase 3 trial. Lancet 2019;394:1929-39. 4. Ponath P, Menezes D, Pan C, et al. A novel, fully human anti-fucosyl-GM1 antibody demonstrates potent in vitro and in vivo antitumor activity in preclinical models of small cell lung cancer. Clin Cancer Res. 2018;24:5178-89; 5. Chu Q, et al. JTO Clin Res Rep 2022;27;3:100400

Anti-Fucosyl GM1 combined with nivolumab & chemotherapy shows promising efficacy

At the February 2024 data cutoff (median follow-up of 17.2 mo)

Progression-free survival (Primary endpoint)[a]: Median PFS was 5.8 mo (95% CI, 5.0-7.9) with **BMS-986012 + NIVO + chemo** vs 5.1 mo (95% CI, 4.8-6.6) with **NIVO + chemo**; HR 0.81 (95% CI, 0.53-1.23, , *P* = 0.32)

OS (secondary endpoint)



	BMS-986012 + NIVO + chemo	NIVO + chemo
	n=67[b]	n=66[b]
Median OS, mo (95% CI)	15.6 (12.5-NA)	11.4 (9.3-16.6)

HR 0.71 (95% CI 0.44-1.16)

Number at risk

BMS-986012 + NIVO + chemo	67	59	54	45	33	20	11	9	5	4	3	0
NIVO + chemo	66	58	49	39	21	20	8	6	3	1	0	0

Planned Phase 3 vs. SOC trial to initiate early 2025

PFS and OS were estimated by Kaplan-Meier methods; HRs were calculated using stratified Cox proportional hazard models, and the P-value by a stratified log-rank test. Stratification was by ECOG PS and liver metastases. Symbols on Kaplan-Meier curves show censored patients. [a]n (%) of progression events or death were 41 (62) for BMS-986012 + NIVO + chemo, and 38 (58) for NIVO + chemo. [b]n (%) of events were 30 (45) for BMS-986012 + NIVO + chemo, and 38 (58) for NIVO + chemo.
BICR, blinded independent committee review; chemo, chemotherapy, carboplatin + etoposide; CI, confidence interval; DBL, database lock; ECOG PS, Eastern Cooperative Oncology Group performance status; ES, Extensive-Stage; Fuc-GM1, fucosyl-monosialoganglioside-1; HR, Hazard Ratio; mo, months; NIVO, Nivolumab; OS, Overall Survival; PFS, Progression-Free Survival; SCLC, Small Cell Lung Cancer.

Anti-Fucosyl GM1 combined with nivolumab & chemotherapy safety summary

	BMS986012 + Nivolumab + Chemotherapy (n=66)		Nivolumab + Chemotherapy (n=64)	
Patients, n (%)	**Grade 1/2**	**Grade 3/4**	**Grade 1/2**	**Grade 3/4**
Most Frequent TRAEs				
Pruritus	36 (55)	4 (6)	10 (16)	0
Neutropenia	5 (8)	18 (27)	2 (3)	18 (28)
Thrombocytopenia	18 (27)	2 (3)	12 (19)	8 (13)
Alopecia	18 (27)	0	17 (27)	0
Anemia	17 (26)	1 (2)	18 (28)	6 (9)
Nausea	13 (20)	1 (2)	17 (27)	0
Fatigue	13 (20)	0	6 (9)	0
Rash	10 (15)	1 (2)	5 (8)	0
Diarrhea	10 (15)	0	4 (6)	0
ALT increased	8 (12)	1 (2)	0	0

Patients, n (%)	**BMS986012 + Nivolumab + Chemotherapy**		**Nivolumab + Chemotherapy**	
Any AE	66 (100)	35 (53)	63 (98)	36 (56)
Any SAE	35 (53)	21 (32)	31 (49)	19 (30)
Any TRAE	61 (92)	33 (50)	60 (94)	29 (45)
AE leading to discontinuation	11 (17)	7 (11)	14 (22)	9 (14)
TRAE leading to discontinuation[a]	5 (8)	4 (6)	9 (14)	6 (9)
Treatment-related deaths (any study drug)[b]	2 (3)[c]		3 (5)[d]	

Pruritus events predominantly low-grade, and most resolved within 1-2 cycles (median duration[e] was 54 days with BMS-986012 + NIVO + chemo and 36 days with NIVO + chemo; select skin and hepatic AEs were predominantly low-grade

a. One TRAE leading to discontinuation was considered related to BMS-986012 grade 3 rash/grade 2 pruritus; b. No deaths related to study treatment were considered related to BMS-986012; c. Febrile neutropenia (n=1), multiorgan failure (n=1); d. Septic shock (n=1), pancytopenia (n=1), febrile neutropenia (n=1); e. Data on the resolution of pruritus are based on events reported at the 26th September 2023 DBL; the status of pruritis in 1 additional patient in the BMS-986012 + NIVO + chemo arm reported at the 26th February 2024 DBL is unknown; ALT, Alanine Aminotransferase; AE, Adverse Event; SAE, Serious Adverse Event; TRAE, Treatment-Related Adverse Event

Strong foundation in IO & broadening modalities beyond IO

IO & Biologics

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YERVOY (ipilimumab)

Opdualag (nivolumab and relatlimab-rmbw) Injection for intravenous use | 480 mg/160 mg

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Abecma (idecabtagene vicleucel) SUSPENSION FOR IV INFUSION

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- BCMA x GPRC5D Dual Targeting CAR T*

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1. U.S. FDA PDUFA December 29th, 2024; application under review in EU; *Newer INDs in last 12 months

Not an exhaustive list of assets, programs, or indications

AR LDD Case Study: MoA validated in metastatic castrate resistant prostate cancer

69-year-old male with mCRPC

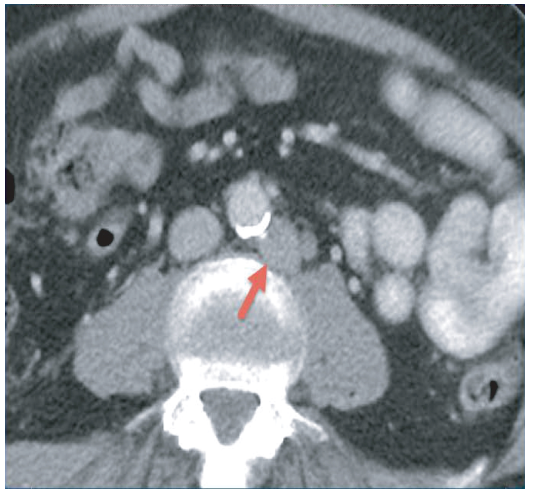
5 prior therapies including enzalutamide & talazoparib

Patient entered study with AR amplification & BRCA2 mutation

Treated with AR LDD; responded rapidly with PSA90* of ~97.5%

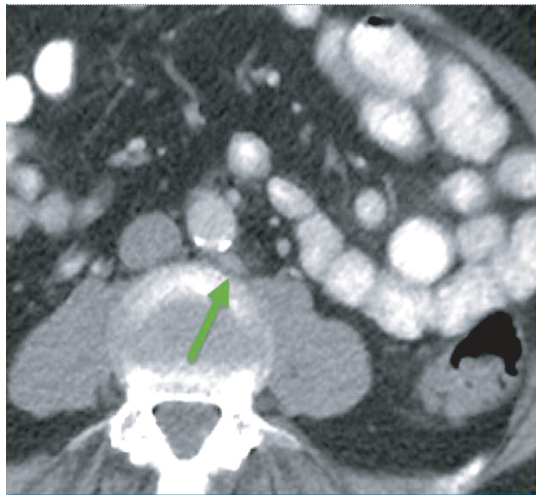
Target Lesion Reduction*[1]

Screening



AR protein expressed in tumor cells

On Treatment

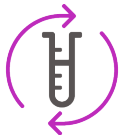


Radiographic Response

1. ASCO GU 2024: Rathkopf et. al, FIH study of BMS-986365; BMS Source: Patient case from BMS internal database; *Observed PSA decreases in this patient only serve to illustrate MoA and are not intended to represent expected outcomes; BRCA2, breast cancer gene 2; C5D1, cycle 5 day 1; MoA: Mechanism of Action

AR LDD: Dual AR degrader & antagonist showing clinical benefit in mCRPC patients

Clinical benefit observed in patients both with AR LBD WT and LBD mutant



Oral drug with ability to overcome resistance to ARPi (e.g., enzalutamide, abiraterone)

Endpoint	400 mg BID (n=20)	600 mg BID (n=20)	900 mg BID (n=20)
PSA30, % (n)	30% (6)	45% (9)	70% (14)
Median rPFS, mo. (95% CI)[1]	5.5 (2.7-NE)	5.5 (1.9-NE)	8.3 (3.8-NE)
Median rPFS in chemo-naïve patients: ~16.5 mo.; N=32			

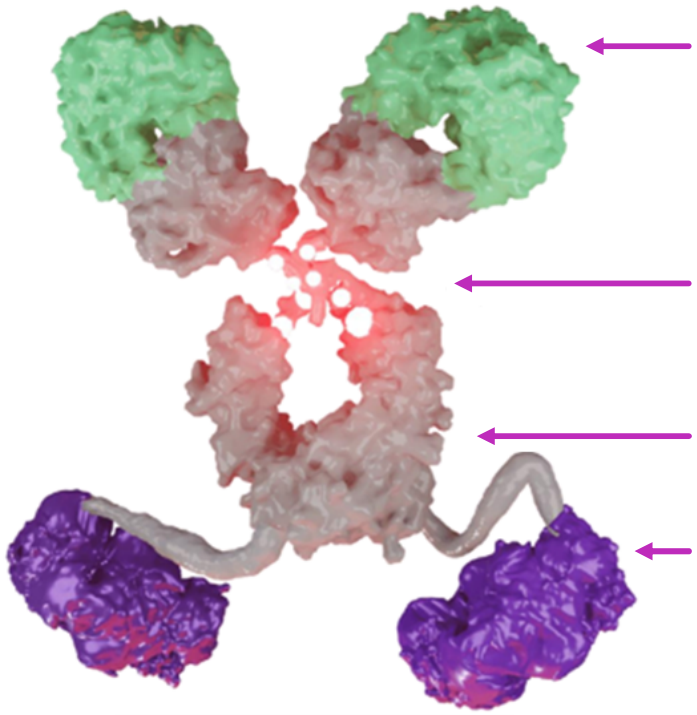
- Historical rPFS benchmark: ~6–9 mo. in post-ARPi, pre-chemo patients (e.g., 2nd ARPi, docetaxel)
- Tolerable with a manageable safety profile

Planned registrational trial to initiate in 2025

Updated Phase 1 data presentation at ESMO on Sept 16th during the GU Tumors, Prostate (1597 MO) mini-oral session

1. Pooled analysis of chemo-naïve and chemo-experienced patients; ARPi: Androgen Receptor Pathway Inhibitors; AR WT: Androgen Receptor Wild Type; AR LBD mutant: Androgen Receptor Ligand Binding Mutation

Potential first-in-class bispecific (EGFRxHER3) ADC targeting advanced solid tumors



αEGFR
Human EGFR
Affinity: High

DAR = 8
Cat B cleavable linker
Ed-04 (TOPI inhibitor)

Wt Fc IgG1

αHER3
Human HER3
Affinity: Low

- Compelling, single agent activity in Phase 1 data[1] in multiple solid tumors
  - NSCLC, breast cancers, bladder, & GI
- Potentially differentiated safety profile
  - Manageable myelosuppression & very low rates of ILD
- Potential for broad applicability in multiple tumor types
  - Global Phase 1 study ongoing & data expected in 2025[2]

1. Data presentations at ESMO 2024 conducted by Sichuan Biokin Pharmaceuticals Co., Ltd. and SystImmune, Inc. 2. NCT05983432 - Trial sponsored by SystImmune

EGFRxHER3 ADC: Early clinical data establishes proof of concept for future registrational opportunities

Single agent data in China-only studies

	ESMO 2023[2]	SABC 2023[3]		ESMO 2024[4]
	EGFRmut NSCLC	TNBC	HER2-/HR+	UC
N	40	35	38	12
Prior treatments[1]	2	3	4	1–2
cORR	52.5%	22.9%	18.4%	75%
DCR	87.5%	91.4%	94.7%	100%

GI/GU Phase 1 data at ESMO 2024

Breast cancer data update expected at a future medical congress

- Promising anti-tumor activity observed in refractory patients
- Manageable safety profile
  - Myelosuppression most common TRAE
  - Potential for lower ILD
- Exploring additional indications

Registrational trials planned in 2025

1. Represents median line of prior treatments; 2. Li-Zhang et. al.; 3. J-Wu et. al; 4. Ding Wei Ye et. al; cORR: confirmed Overall Response Rate; DCR: Disease Control Rate; TRAE: treatment-related adverse event

RayzeBio: Leading innovation in radiopharma therapies

Lead program
RYZ101

Robust
IND engine

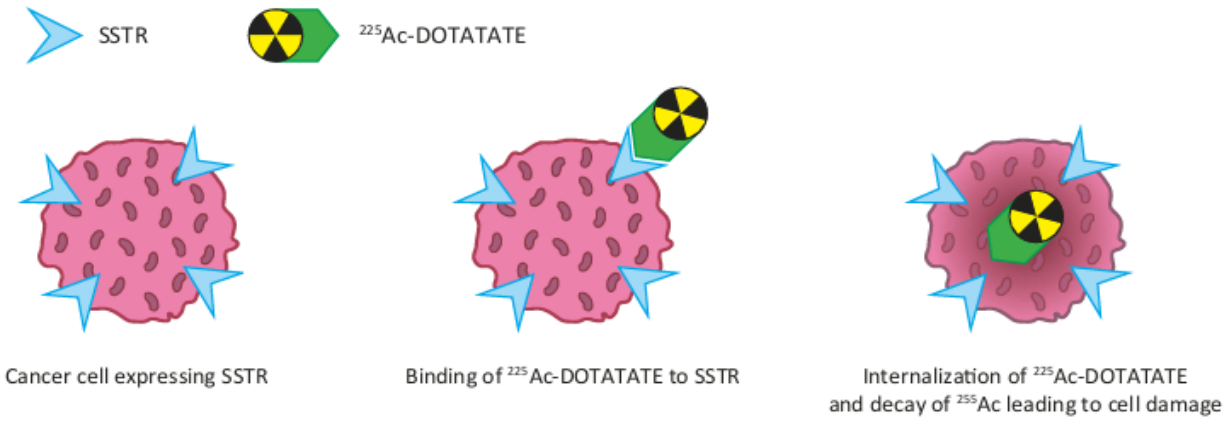
State-of-the-art
manufacturing facility

Actinium-based alpha emitter RPT:
Higher potency, potential for stronger efficacy & more targeted delivery

RYZ101: Lead asset & interim clinical data

RYZ101(^{225}AC-DOTATE)

- Targets SSTR2 expressed in multiple cancers
- 2030 U.S. target population[1]
  - GEP-NETs: ~5K patients (~90% SSTR2 expression)
  - SCLC: ~21K patients (~50% SSTR2 expression)
  - Breast cancer: ~25K (~30% SSTR2 expression)



Ph 1b/3 ACTION-1 (GEP-NETs)[2]

Summary of ORR (investigator-assessed) in the efficacy-evaluable population

Response, n (%)	Overall (N=17)
Objective response rate	7 (41.2)
CR	1 (5.9)
PR	6 (35.3)
Confirmed CR/PR	5 (29.4)
Treatment-related SAEs/AEs leading to drug discontinuation	0
Treatment-related Gr 3 or higher AEs[3]	5 (29.4)

Phase 3 data expected in 2026

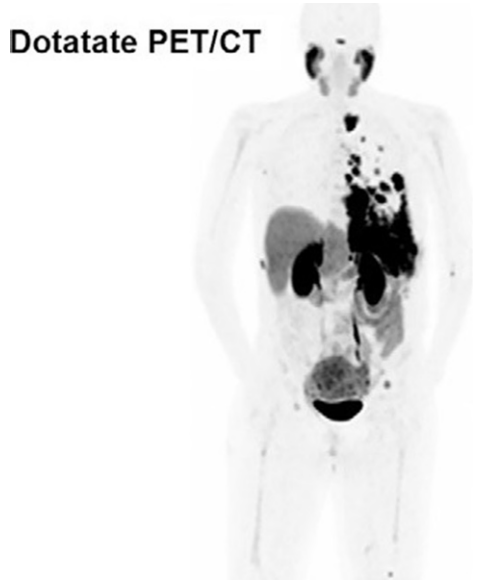
1. Represents 2030 U.S. incident population; RYZ101 GEP-NETS anticipated available population post-Lutathera disease progression. For SCLC, the 21K reflects the ES-SCLC population, which is ~70% of the SCLC population 2. ASCO 2024, Halperin et. al, data cutoff is as of December 14th, 2023; 3. The most common treatment-related Grade 3 or higher AEs were anemia (3 patients), lymphocyte count decreased (3 patients) and creatinine clearance decreased (2 patients)

RYZ101 case study: Near complete response observed in metastatic breast cancer

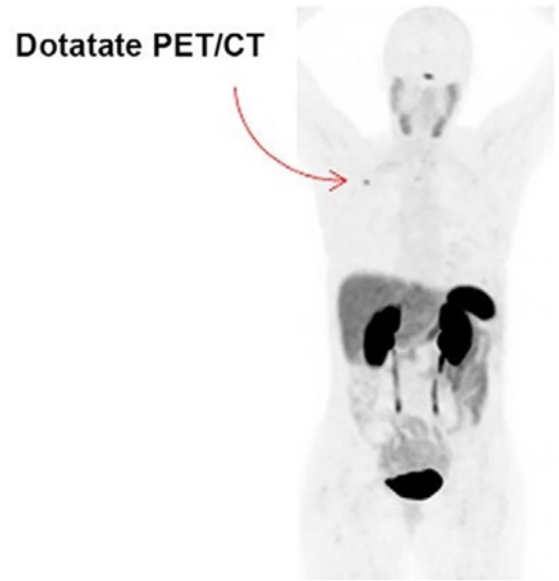
- 59-year-old female with ER+ breast cancer & severe dyspnea
- 11 prior therapies including ER antagonist, CDK4/6i, & multiple chemotherapies
- Patient entered study with strong positive SSTR2 expression
- 2 cycles of RYZ101: near complete response, dyspnea resolved

Study from dotatate imaging[1,2]

ER+ breast cancer patient



Baseline

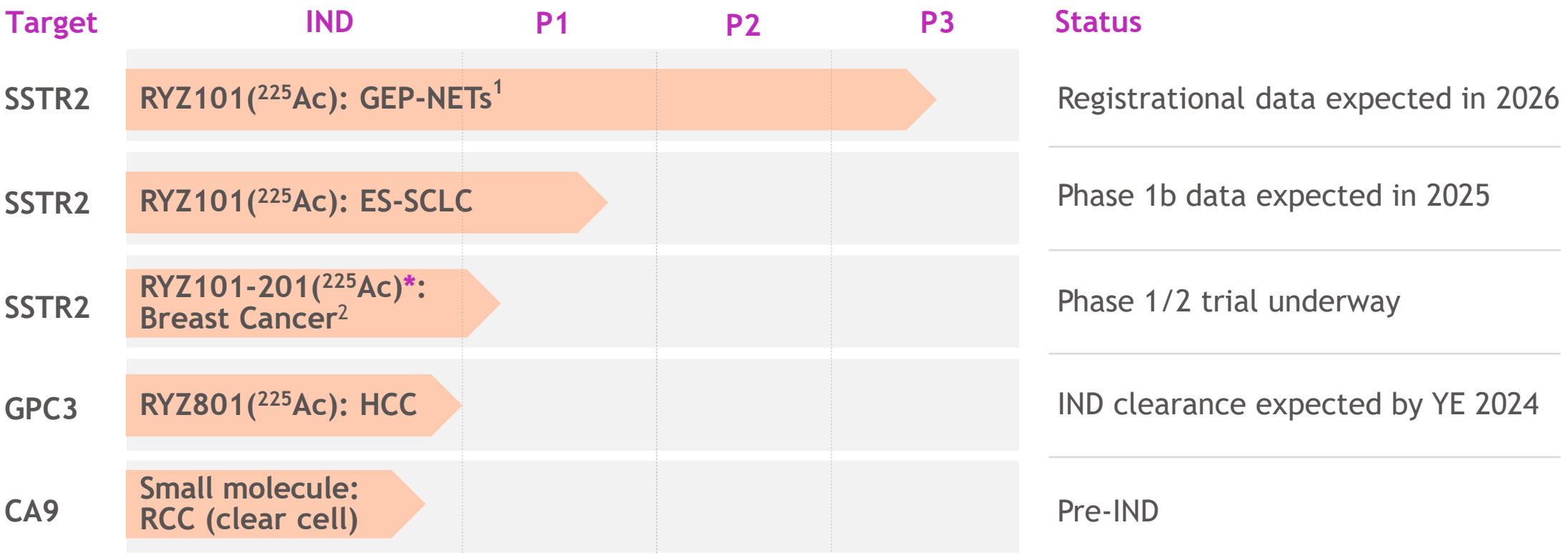


Two cycles of ^{225}Ac-Dotatate

1. Clinical trial will encompass ER+/HER- patients; Ulaner et al., *Radiology*, 2024. https://pubs.rsna.org/doi/abs/10.1148/radiol.233408?journalCode=radiology; NCT05880394; Images used with permission of Dr. Gary Ulaner, Molecular Imaging and Therapy, Hoag Family Cancer Institute

RayzeBio: Leading pipeline of RPT candidates

Clinical programs complemented by robust IND engine



*New study

Multiple potential first-in-class preclinical assets in development

1. GEP-NETs expressing SSTR2 who are refractory to LU-177SA treatment 2. HR+/HER2-

MTA-Cooperative PRMT5i: Potential transformative agent targeting ~10% of cancers

Unmet Need[1]

- *MTAP* deletion prevalent in several cancers (e.g., NSCLC, PDAC)
- Poor prognosis due to shorter OS in multiple tumor types[2]
- First generation, non-selective PRMT5 inhibitors observed heme-related toxicities

Clinical Development[1,3]

- Encouraging early data:
  - Efficacy signal across multiple tumors including NSCLC
  - Favorable safety profile (no dose-limiting heme toxicities observed)
- Updated Phase 1 data expected at medical congress in 2024

Rapidly advancing to next clinical stage in multiple solid tumors in 2025

1. AACR November 2023, Engstrom et. al, data cut-off June 13, 2023; 2. cBioPortal for Cancer Genomics. https://www.cbioportal.org/; 3. NCT05245500

8 new registrational trials added in oncology since last year

Registrational programs

Studies underway | Newly planned

KRAZATI (adagrasib) 200 mg TABLETS	RYZ101	KRAZATI (adagrasib) 200 mg TABLETS	Nivo + Rela HD	EGFRxHER3 ADC	Nivo + Rela HD	AR LDD	Anti-Fucosyl GM1
2L CRC	2L+ GEP-NETs	1L NSCLC PD-L1≥50%	1L NSCLC PD-L1 1-49% & NSQ	Solid tumors	1L NSCLC PD-L1≥50% & NSQ	mCRPC	1L ES-SCLC
2025-2026		*2027-2030 (Anticipated data readouts)*					

Data to establish PoC*

- Phase 1 - RYZ101 ES-SCLC (2024)
- Phase 1 – AR LDD mCRPC (2024)
- Phase 1 - EGFR x HER3 ADC in solid tumors (2025)[1]
- Phase 2 - Krazati 1L NSCLC (TPS <50%) (2025)

Key Phase 1 data*

- MTA-Cooperative PRMT5 inhibitor in solid tumors (2024)
- Anti-CCR8 in solid tumors (2025)
- RYZ101-201 ER+ Breast Cancer (2027)

1. Phase 1 global trial (U.S. & RoW); *Anticipated year of data readout

Significant progress advancing our leadership in cancer drug development

We are extending in IO

- Entered Phase 3 with Nivolumab & Relatlimab HD in 1L NSCLC
- Filed Subcutaneous Nivolumab: U.S. FDA PDUFA date Dec 29th

Significantly expanding registrational pipeline

- 8 new trials across solid tumors spanning multiple novel modalities & platforms
- Biologics, Protein Degraders, ADCs, RPTs, & Targeted Therapies

Broadening into important solid tumors

Small cell lung, breast, & prostate cancers

Developing potential first-in-class and/or best-in-class medicines

ADC: Antibody Drug Conjugates; RPT: Radiopharmaceutical Therapies

Bristol Myers Squibb®

Q&A

Samit Hirawat

Executive VP
Chief Medical Officer
Head of Global Drug Development