FAETH THERAPEUTICS COMPANY OVERVIEW

Break through the PAM barrier.

Oral inhibition of the PI3K/AKT/mTOR pathway, one of the most frequently altered pathways in cancer.

NOVEMBER 2026

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Forward-Looking Statements

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PIKTOR (serabelisib and sapanisertib) is investigational; its safety and efficacy have not been established and it has not been approved by any regulatory authority. The PIK-201 results presented are preliminary and reflect the specified data cutoffs and analysis populations. Results may change with additional follow-up, response confirmation, data verification and analysis. Efficacy-evaluable analyses exclude certain treated patients, as described in this Presentation, and results may differ from analyses of all treated patients. PIK-201 is a single-arm study of PIKTOR in combination with paclitaxel and does not establish the contribution of individual components or comparative safety or efficacy. This Presentation includes information from third-party studies, publications and other sources and the Company's own estimates. The Company believes these sources are reliable but has not independently verified them. Data from different clinical trials are presented for context only: no head-to-head trials have been conducted, trials differ in design, populations and endpoints, cross-trial comparisons must be interpreted with caution, and no conclusions about comparative safety or efficacy should be drawn.

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Oral PAM[1] regimen, built for longer target coverage without class-defining toxicities

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PIKTOR

serabelisib (PI3Kα) + sapanisertib (mTORC1/2)

COMPLETE PAM BLOCKADE

Oral multi-node blockade that hits PAM at the **three nodes that we believe matter**.

PK EDGE (TOLERABILITY AND EFFICACY)

Intermittent dosing schedule that has been observed to flatten the peaks, providing **~2-3x more time above IC90** than other PAM inhibitors with a **low rate of stomatitis**

VALIDATED PATHWAY WITH LARGE MARKET OPPORTUNITIES

~$2.5B market opportunity in endometrial cancer[3]
~$10B market opportunity in 2L breast cancer[4]

CAPITALIZED THROUGH CATALYSTS

Expected to be fully funded through 2 major catalysts
- Phase 2 mature data disclosure
- Interim Phase 1b/2 breast data expected 2H 2027

Top-tier investors including Montanova, Avoro, Baker Brothers, Cormorant, Fairmount, RA Capital Management, and Vivo Capital[2]

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[1] PAM: PI3K/AKT/mTOR, a pathway that regulates cell metabolism, growth, and survival and is altered in up to half of solid tumors; [2] as of February 2026 private placement
[3] For Endometrial TAM estimates, refer to slide 11; [4] For 2L Breast TAM estimates, refer to slide 26.

Built on work by Dr. Lewis Cantley, discoverer of the PI3K pathway. Molecules designed by Kevan Shokat, one of the world's leading medicinal chemists



Lew Cantley, PhD

Dana Farber Cancer Institute, Harvard. Founder: Agios (NASDAQ), Petra, Volastra
Co-founder: Faeth (NASDAQ)



Kevan Shokat, PhD

Professor of Cellular & Molecular Pharmacology, UCSF; Professor of Chemistry, UC Berkeley; Howard Hughes Investigator

FAETH SCIENTIFIC CO-FOUNDERS

Sid Mukherjee, MD PhD

Asst. Prof., Columbia, Pulitzer Prize Winner, Time 100 Most Influential People

Oliver Maddocks, MPharm, PhD

CSO & Co-Founder, Honorary Professor of Cancer Biology & Metabolism, University of Glasgow

Karen Vousden, PhD

Group Leader, Crick Institute, Former Chief Scientist of CRUK, Director, Bristol Myers Squibb

Scott Lowe, PhD

Chair of Cancer Biology & Genetics at Memorial Sloan Kettering, Founder: ORIC (NASDAQ)

Greg Hannon, PhD

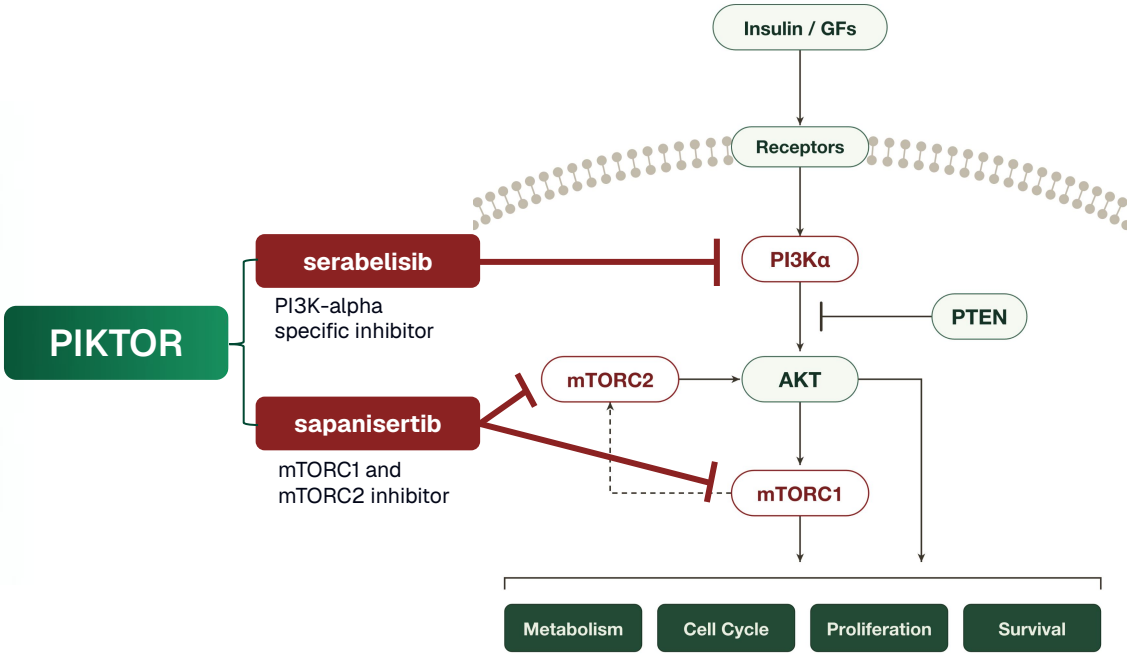
Former Director of CRUK Cambridge Institute

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PIKTOR: Designed for potent and selective multi-node PI3K/AKT/mTOR pathway inhibition

PIKTOR combines serabelisib (PI3K-alpha specific inhibitor) with sapanisertib (mTORC1 and mTORC2 inhibitor).

Targeting the PI3K/AKT/mTOR pathway to address one of the most-frequent genomic drivers in solid tumors[1].



© 2026 Faeth Therapeutics. [1] cBioPortal References: Cerami et al., Cancer Discov. 2012, and Gao et al., Sci. Signal, 2013

Multi-node synergy designed to allow each agent to run using multiple-fold lower doses than monotherapy RP2D

faeth PIKTOR

- Serabelisib
- Sapanisertib

	MONOTHERAPY RP2D	DOSE IN PIKTOR + PACLITAXEL[3]	REDUCTION
Serabelisib	900 mg QD×3dQW [1]	200 mg QD×3dQW	4.5× lower
Sapanisertib	9 mg QD×3dQW [2]	3 mg QD×3dQW	3× lower

Why the combination runs lower

- Vertical blockade — PI3Kα upstream + mTORC1/2 downstream — designed to hit the pathway at three nodes and close feedback escape routes[4]
- Deep inhibition at lower exposure of each agent designed to widen the therapeutic window — e.g., hyperglycemia rates less than half those reported in most single-node inhibitor trials[4]

Deep clinical experience underpins the dose: serabelisib and sapanisertib have been studied in ~1,000 patients across Takeda-era and subsequent trials, including ~150 patients treated with the PIKTOR combination (sapanisertib 2–8 mg / serabelisib 100–400 mg).[5]

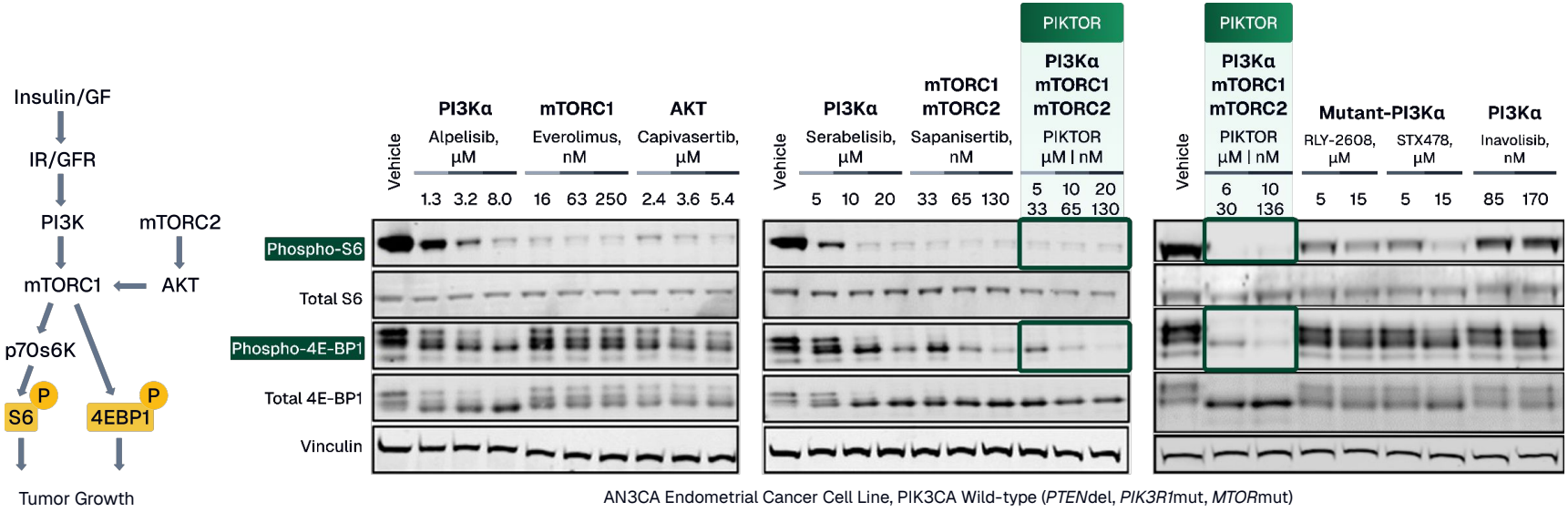
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[1]Juric et. al., Clin. Cancer Res. 23 (17) 2017. [2]Voss et. al., Br. J. Cancer 123 (11) 2020. [3]Starks et. al., Gyn. Onc. 166, 2022. [4]Tyrakis et. al., Br. J. Cancer 133, 2025. [5]Maddocks et al., STOP Cancer 2026; RP2D – Recommended Phase 2 Dose; QD×3dQW – once daily, 3 days per week; FIH – first-in-human.

Multi-node inhibition with PIKTOR achieved robust preclinical PI3K-pathway inhibition in cancer cell lines

PIKTOR reduced PI3K-pathway signaling in cancer cell lines **more than single-node inhibitors** at clinically relevant concentrations[1]

Preclinical data have been **recapitulated in human skin biopsy data** from clinical studies[2]



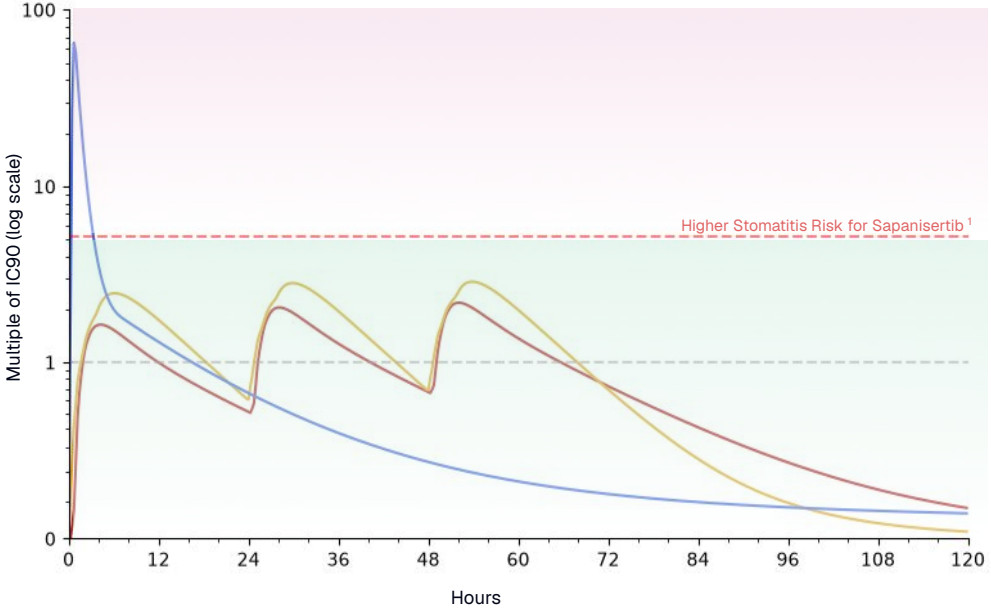
AN3CA Endometrial Cancer Cell Line, PIK3CA Wild-type (*PTEN*del, *PIK3R1*mut, *MTOR*mut)

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Western blot data shown is from AN3CA endometrial cancer cells (mutations in PTEN, PIK3R1, mTOR) and is replicated in multiple PI3K-mutated endometrial and breast-cancer cell lines [1].

[1] Tyrakis et. al., (2025) British Journal of Cancer, 133: 144-154; [2] *Exposure/Response Analysis of an Oral Multi-Node PI3K/AKT/mTOR Pathway Inhibitor Combination of Serabelisib and Sapanisertib. Maddocks et. al., STOP Cancer Conference, 2026*

Oral PIKTOR dosing is designed for sustained exposure with reduced Cmax-related toxicity risk



	Peak exposure (Cmax : IC90 ratio)	Time above IC90 / week	Plasma protein binding / free fraction	
			Bound	Free
Serabelisib	2.2	42 h	69%	31%
Sapanisertib	2.9	44 h	70%	30%
Gedatolisib	~65	15 h	98%	2%

The ratio of plasma drug concentration to cellular IC90 from 0 - 120 hours was calculated for serabelisib, sapanisertib, and gedatolisib. Sapanisertib (3 mg) with serabelisib (200mg), with food, QDx3dQW plasma drug concentration was obtained from Maddocks *et. al.,* 2026[1]. Gedatolisib (180 mg QW) drug concentration data was derived from Shapiro *et. al.,* 2015[2] by scaling 89 / 154 / 222 / 266 mg single dose data to 180 mg, assuming linearity. Mean gedatolisib plasma concentration at 180 mg was computed with a geometric mean per time-point across the scaled concentrations. The estimated time above IC90 was computed as the time a stepwise linear interpolation crossed the threshold. IC90 values for all drugs were calculated using IC50 values presented in Tyrakis *et. al.,* 2025[3]. The cellular IC50 values for all three drugs were derived from an average of six cell lines representing clinically relevant models i.e. HR+/HER2- breast cancer cell lines and endometrial cancer cell lines: MCF7, T47D, AN3CA, HEC1B, MFE-280, MFE-296. Dashed red line denotes the sapanisertib Cmax/IC90 ratio for the combined dose of sapanisertib and serabelisib (4 mg / 200 mg, QDx3dQW, fasted) resulting in Grade 3 stomatitis in a Phase 1b dose escalation study (NCT01899053, described in Maddocks *et. al.,* 2026[1]).

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[1] *Exposure/Response Analysis of an Oral Multi-Node PI3K/AKT/mTOR Pathway Inhibitor Combination of Serabelisib and Sapanisertib. Maddocks et. al., STOP Cancer Conference, 2026*
[2] *First-In-Human Study of PF-05212384 (PKI-587), a Small-Molecule, Intravenous, Dual Inhibitor of PI3K and mTOR In Patients With Advanced Cancer. Clin Cancer Res. 2015 April 15; 21(8): 1888–1895.doi:10.1158/1078-0432.CCR-14-1306.*
[3] *Multi-node inhibition targeting mTORC1, mTORC2 and PI3Kα potently inhibits the PI3K/AKT/mTOR pathway in endometrial and breast cancer models. British Journal of Cancer, 133: 144-154.https://doi.org/10.1038/s41416-025-03035-z*

PIKTOR: Designed to solve the challenges of drugging the PI3K pathway

	MULTI-NODE		SINGLE-NODE	
	faeth PIKTOR (Ph.2, Endometrial, Ph.1b Breast)	GEDATOLISIB Celcuity (Approved)	MUTANT-SPECIFIC Relay, Lilly, OnKure, Novartis (Investigational)	FDA-APPROVED Alpelisib, Everolimus, Capivasertib, Inavolisib
Mechanism of action Target profile	**PI3K-alpha mTORC1 mTORC2**	PI3K-alpha, PI3K-beta, PI3K-gamma, PI3K-delta, mTORC1 and mTORC2	Mutant PI3K-alpha	AKT or mTORC1 or PI3K-alpha
Multi-node inhibition	✓	✓	✗	✗
Potentially Immune Sparing (PI3K-alpha specific)	✓	✗	✓	✓
Broad pathway mutation coverage	✓	✓	✗	✗
Prevents wt-PI3K escape	✓	✓	✗	✓
Oral administration	✓	✗	✓	✓

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2L+ endometrial market, rising unmet need, one oral multi-nodal PAM-pathway option in development

Expanding market

Endometrial cancer is a growing market and now causes more U.S. deaths each year than ovarian cancer, the most of any gynecologic cancer[1]

High unmet need

With immunotherapy now standard in 1L, second-line options are limited: single-agent chemotherapy (paclitaxel) ~17% ORR, 3.8 mo PFS[2]. ADCs are moving into earlier lines, complicating TOPO1-ADC sequencing

Only oral multi-nodal PAM option[3]

PAM alterations occur in ~85% of all EC patients.[4] No PI3K inhibitor ever approved in EC[5]

ADC

6+ sponsors in Phase 2/3 trials[6]

AstraZeneca
Daiichi-Sankyo
MERCK
GSK
Genmab
GILEAD

PAM

1 enrolling oral multi-node program

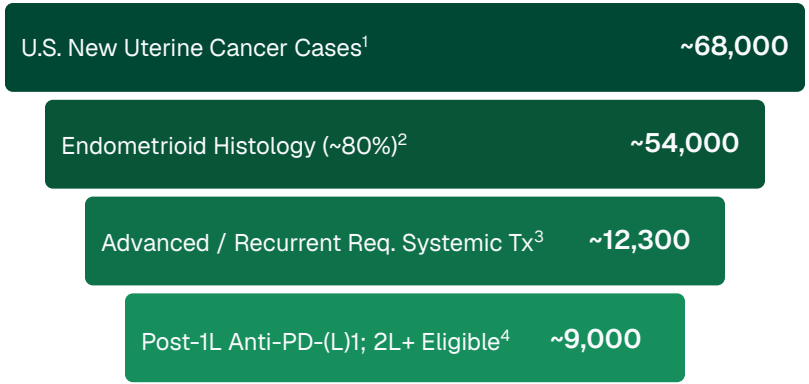
faeth
PIKTOR
Oral, intermittent dosing

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1. Uterine corpus cancer caused 13,342 recorded U.S. deaths in 2023, ranking fifth among cancer deaths in women; ovarian cancer ranked fifth in 2022 (Siegel RL, et al. CA Cancer J Clin. 2026;76(1):e70043, Table 12; Siegel RL, et al.CA Cancer J Clin. 2025;75(1):10-45, Table 11). Estimated 2026 deaths: 14,450 uterine corpus vs 12,450 ovarian (American Cancer Society. Cancer Facts & Figures 2026, Table 1). 2. TroFuse-005 control arm, patients assigned paclitaxel (n=119; Lorusso et al., Lancet 2026, supplement Table S15) 3. To our knowledge, based on a ClinicalTrials.gov search as of Nov. 2026. 4. Cancer Genome Atlas Research Network. Nature. 2013;497(7447):67-73; 5. FDA approvalsdatabase. 6. Lead sponsors of recruiting or active Phase 2/3 ADC trials in endometrial cancer, ClinicalTrials.gov, accessed 1 November 2026; Phase 3: AstraZeneca, Daiichi Sankyo, Genmab, Gilead, GSK, Merck. Logos illustrative.

Estimated PIKTOR addressable U.S. population (2L+)

U.S. Incident Therapeutic Build (Annual)



Potential FDA Label Population

Post-1L advanced/recurrent endometrioid EC

- Endometrioid histology
- Advanced or recurrent, not amenable to curative surgery/radiation
- Progressed on/after prior anti-PD-1/PD-L1-containing regimen and TOPO1-based ADC (if available)

~9,000
U.S. incident patients per year post-anti-PD-(L)1, endometrioid EC

~$2.5B
US TAM[5]

1. ACS 2026 / SEER 2025: ~68,000–69,000 new uterine corpus cases/yr. 2. Endometrioid histology ~80% (SEER-based series, 80–85%; Clarke, JCO 2019).
3. Advanced/recurrent requiring systemic Tx (~12,300/yr): de novo advanced ~9,700 (54K × 18% FIGO III/IV; SEER ~11% distant + ~half of 18% regional; conservatively 18%) + steady-state early-stage recurrence ~2,550/yr (44K early-stage entrants/yr × ~8% cumulative recurrence, 27% vaginal-only excluded (Åkesson, Gynecol Oncol 2023; all-stage endometrioid cohort); 73% require systemic Tx).
4. ~9,000 patients a year whose disease progresses after first-line platinum chemotherapy and an immune checkpoint inhibitor, whether or not they receive further treatment: ~12,300 advanced or recurrent × ~95% receiving 1L IO + chemo (company assumption; NCCN-preferred post NRG-GY018/RUBY) × ~77% progressing (company estimate). 5. U.S. total addressable market (TAM) = estimated U.S. patients per year × number of 28-day cycles × $30,000 per cycle (reported list price of gedatolisib (REVTORPYK); PIKTOR's pricehas not been set): ~9,000 patients × ~9.7 cycles (8.9 months, mean time on lenvatinib plus pembrolizumab, KEYNOTE-775; Makker, NEJM 2022; EMA Lenvima report, 2021), assuming all are treated.
Market size estimates reflect the stated assumptions on patient numbers, price and duration of therapy. They estimate the size of the treatment setting and are not forecasts of PIKTOR revenue or market share.

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GOG-3111/FTH-PIK-201 is a single-arm Phase 2 study of PIKTOR plus paclitaxel in pathway-altered endometrioid endometrial cancer

Eligibility Criteria

- Endometrioid endometrial cancer
- Second line or later
- Post immune checkpoint inhibitor and platinum
- Must have a PI3K/AKT/mTOR pathway mutation

Single arm

- **Sapanisertib** 3 mg
- **Serabelisib** 200 mg
- **Paclitaxel** 80 mg/m^2

Optional sub-study: diet to suppress glucose and insulin

Endpoints

Primary
ORR

Secondary
PFS, CBR, DOR, OS, safety/tolerability

Exploratory
PK, efficacy by specific mutations

NCT06463028

Study is being conducted in partnership with: GOG PARTNERS A GOG Foundation Program GOG-3111

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ORR: objective response rate. PFS: progression-free survival. CBR: clinical benefit rate. DOR: duration of response. OS: overall survival. PK: pharmacokinetics. Source: Faeth company materials, September 2026; ClinicalTrials.gov NCT06463028 GOG-3111.

Baseline demographics of PIK-201 reflect heavily pretreated and comorbid patient population

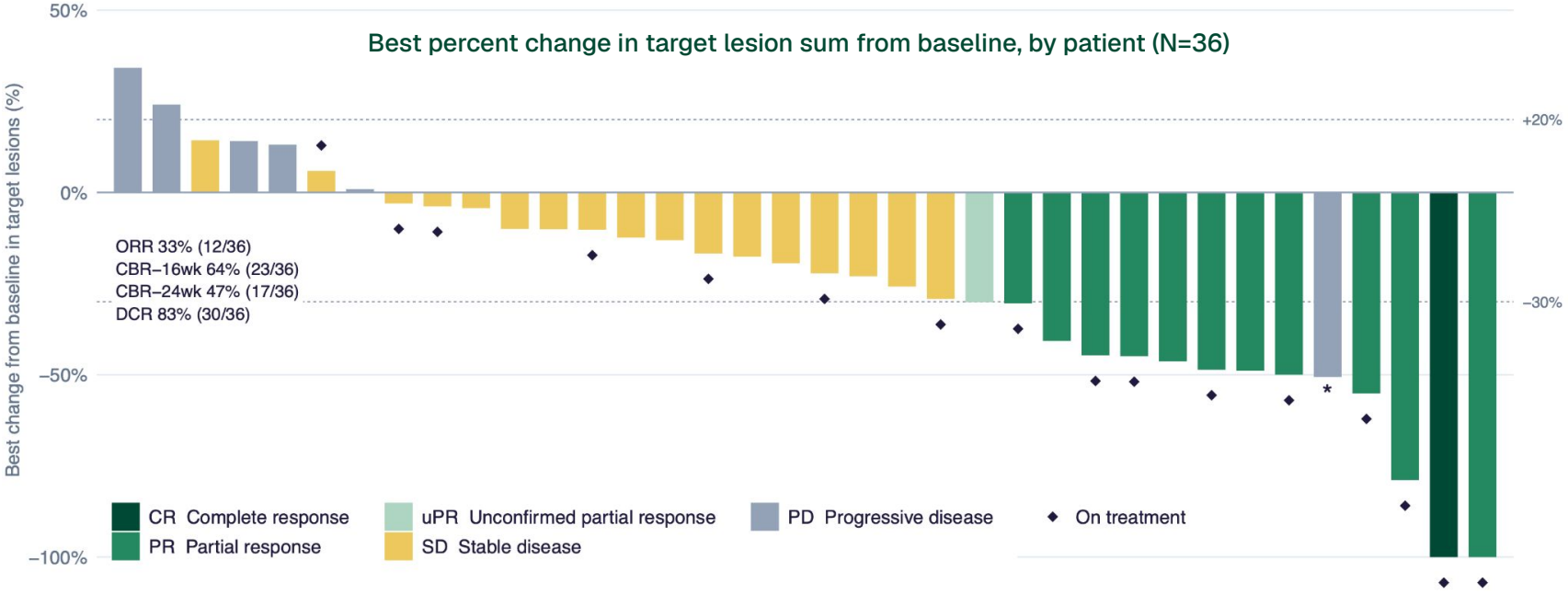
Characteristic	Overall (N=42)
Median age	64.5 years (range 34 to 86)
Sex	42 (100%) (F)
ECOG performance status	0 (55%), 1 (45%)
Race	34 (81%) White, 3 (7%) Black, 1 (2%) Asian, 4 (10%) multiracial / not reported
Median BMI (kg/m2)	29 (range 19 to 47)
Diabetes*	10 (24%)
Pre-diabetes**	10 (24%)

Characteristic	Overall (N=42)
Median Prior Lines of Therapy	2 (range 1-4)
1	9 (21%)
2	18 (43%)
3	10 (24%)
4	5 (12%)
Prior Taxane	42 (100%)
Prior IO	41 (98%)
Prior ADC	4 (10%)
Distant metastases	32 (76%)
including peritoneal spread	38 (90%)
Lung mets	15 (36%)
Liver mets	10 (24%)

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*Diabetes determination based on reported medical history, concomitant medication at baseline, and/or baseline HbA1c of 6.5% or higher. **Pre-diabetes determination based on baseline HbA1c of 5.6% to less than 6.5%. ECOG: Eastern Cooperative Oncology Group. BMI: body mass index. 10.23.26 data cut, enrollment and follow-up are ongoing.

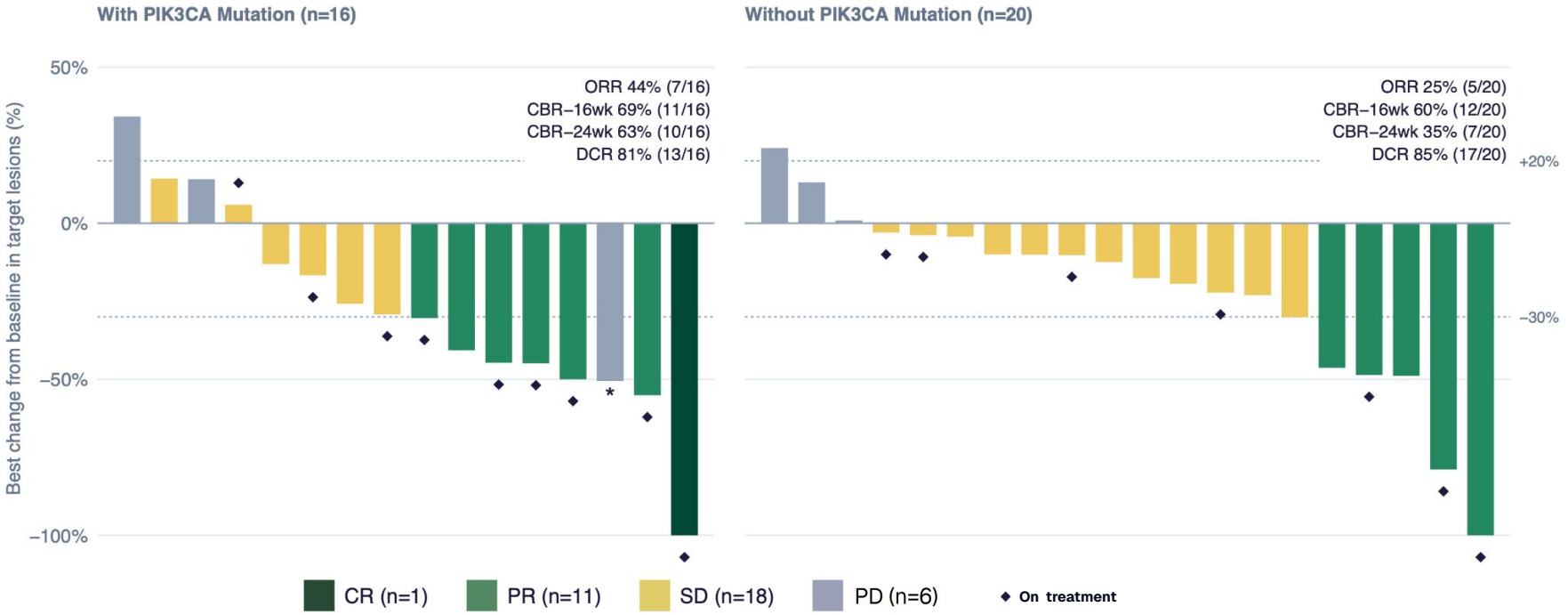
Ph2: PIKTOR + Paclitaxel achieved confirmed ORR of 33% (12/36) in efficacy-evaluable patients



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The data cut includes 42 treated patients, of whom 36 were efficacy-evaluable. The other six stopped study treatment before their first response scan: three because of rapid disease progression, and three for reasons otherthan a treatment-related adverse event. *Best overall response of PD due to a new lesion, despite a 50% reduction in target lesions. Objective responses among efficacy-evaluable patients.Bars show each patient's best change in target lesions, including post-treatment scans. CBR-16 (clinical benefit rate at 16 weeks): confirmed complete or partial response, or stable disease lasting at least 16 weeks from first dose. CBR-24: confirmed complete or partial response, or stable disease lasting at least 24 weeks from first dose. DCR: disease control rate, defined as patients who have SD, PR, or CR as a best response. 10.30.26 data cut, enrollment and follow-up are ongoing.

Ph2: PIKTOR + paclitaxel response by PIK3CA status

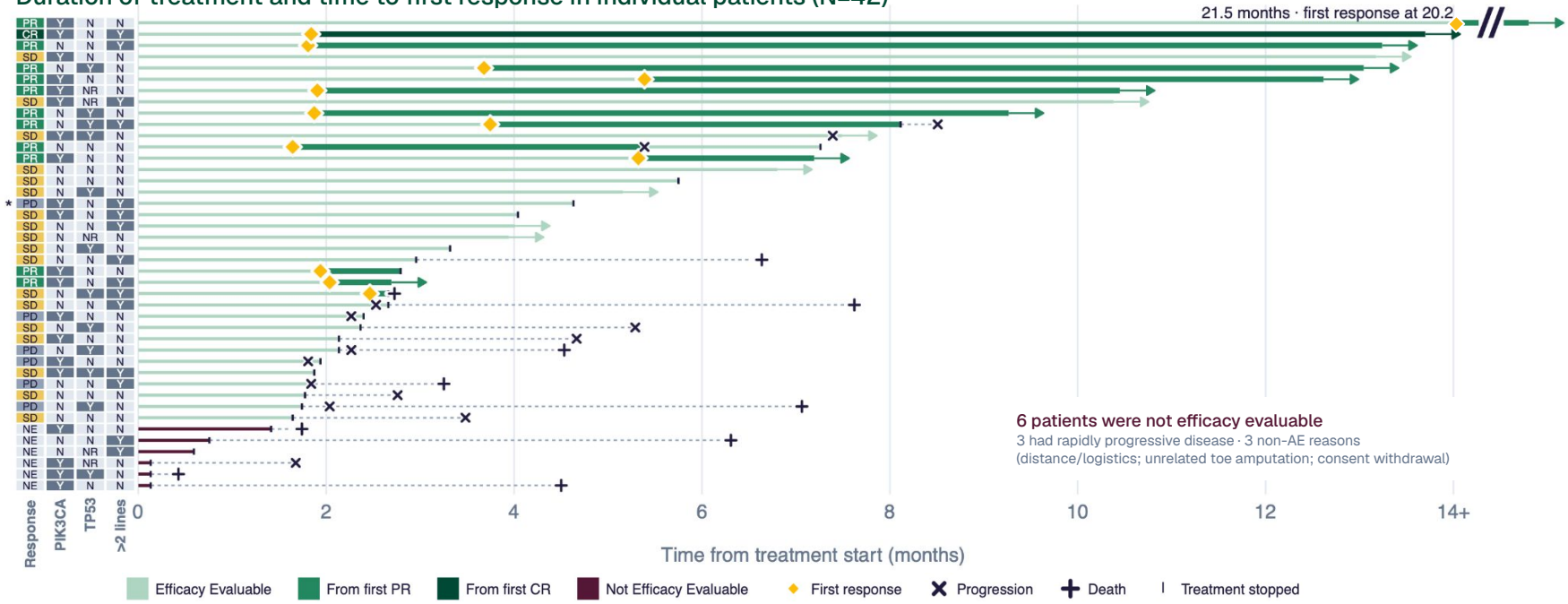


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*Best overall response of PD due to a new lesion, despite a 50% reduction in target lesions. 10.30.26 data cut, enrollment and follow-up are ongoing.

Ph2: PIKTOR + Paclitaxel showed potentially durable and clinically meaningful activity

Duration of treatment and time to first response in individual patients (N=42)

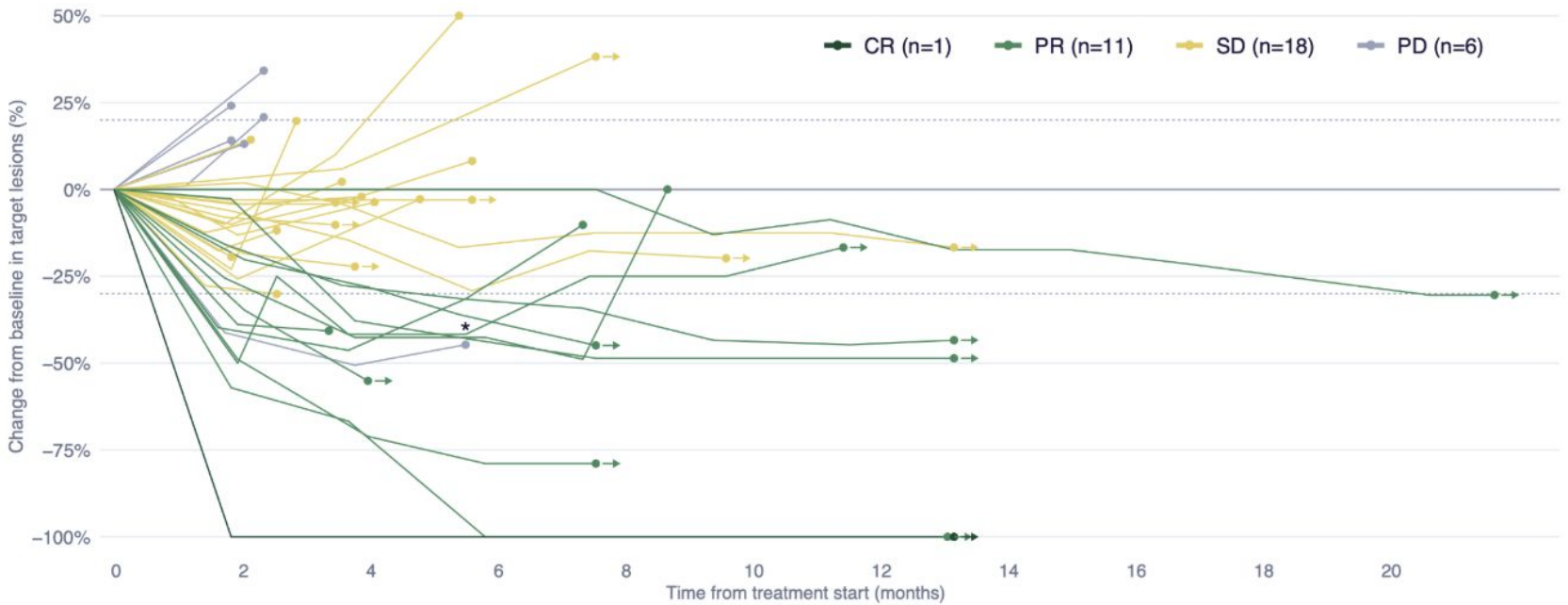


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As of the 10.30.26 data cut, enrollment and follow-up are ongoing. Green arrows denote a patient still on study treatment. Non-evaluable patients are denoted in purple. The data cut includes 42 treated patients, of whom 36 were efficacy-evaluable. The other six stopped study treatment before their first response scan: three because of rapid disease progression, and three for reasons other than a treatment-related adverse event. TP53 NR: not reported. *Best overall response of PD due to a new lesion, despite a 50% reduction in target lesions.

Ph2: Tumor shrinkage with PIKTOR + Paclitaxel

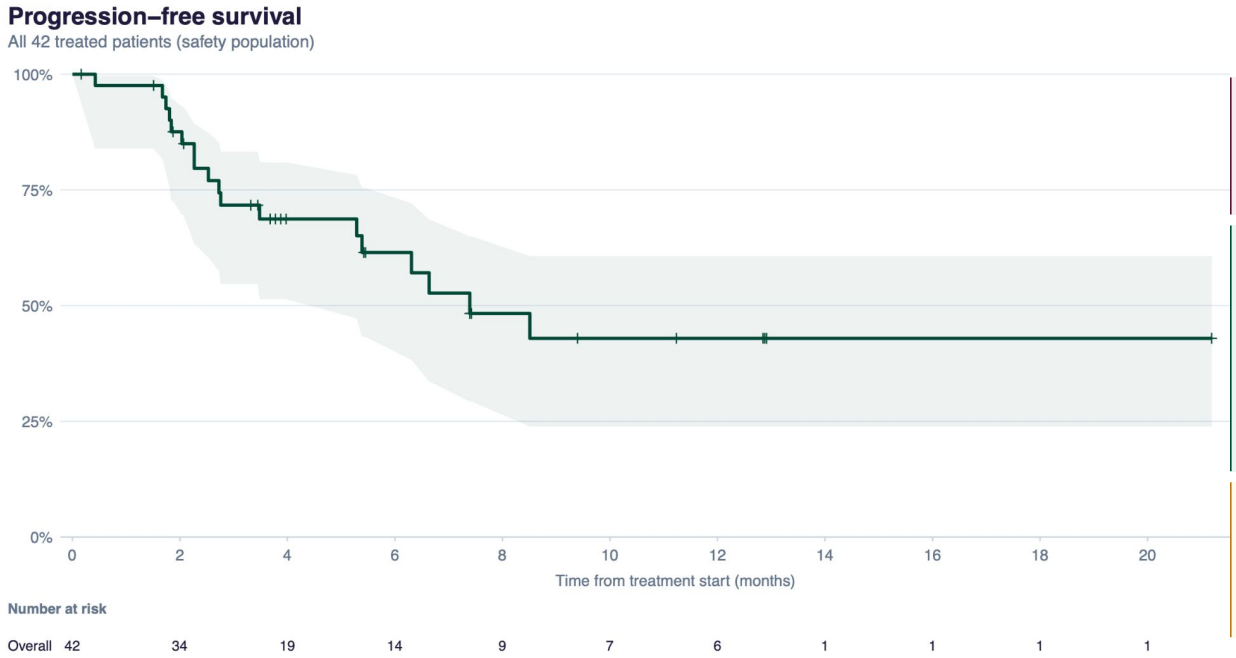
Change in target lesion size over time (N=36)



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Efficacy-evaluable population. 36 patients with post-baseline measurement. Colored by confirmed best overall response. Each line is one patient; values capped at +/-100%. Dashed lines mark the +20% (progression) and -30% (partial response) thresholds. 10.30.26 data cut, enrollment and follow-up are ongoing. *Best overall response of PD due to a new lesion, despite a 50% reduction in target lesions.

Ph2: Preliminary PFS of 7.4 mo and preliminary PFS6 of 62% in all 42 treated patients (safety population)



7.4 *Preliminary* median PFS (95% CI 5.3, NR)

8.5 *Preliminary* median PFS (95% CI 5.4, NR) in efficacy population

62% vs. **51%**

Preliminary progression-free survival at 6 months (95% CI 43, 75)

Sac-TMT PFS6[1]

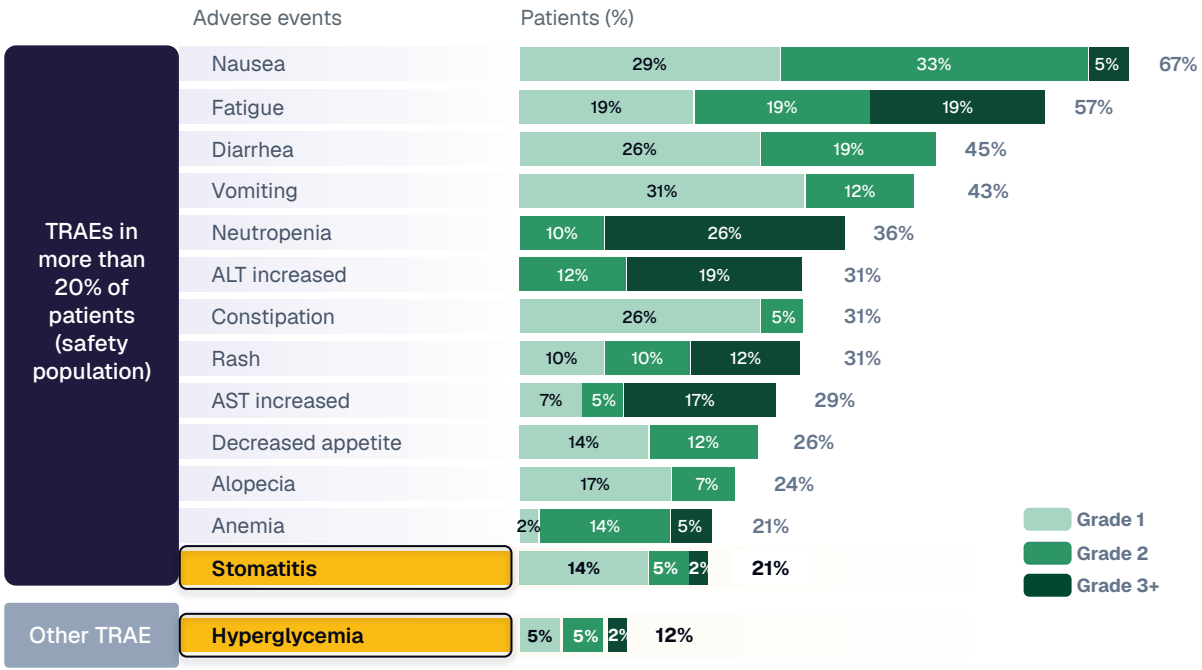
16 patients remain on treatment

16 of 42 patients remain on treatment at the data cut.

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All 42 treated patients (safety population), of whom 36 were in the efficacy population. The other six stopped study treatment before their first response scan: three because of rapid disease progression, and three for reasons other than a treatment-related adverse event. 10.30.26 data cut, enrollment and follow-up are ongoing. Tick marks indicate censored patients. 18 of 42 patients had a PFS event and 24 were censored: 15 on treatment without progression, 5 at the last scan before subsequent therapy, 4 off treatment without a PFS event. Numbers at risk shown under the x-axis. [1]Lorusso D, et al. Lancet 2026 (TroFuse-005), Figure 2A. NR: not reached. PFS: progression-free survival. PFS6: progression-free survival at 6 months. Cross-trial comparison; no head-to-head trials have been conducted.

Ph2: PIK-201 summary of treatment-related adverse events (TRAEs)



26% neutropenia, the most frequent grade 3 or higher TRAE

7%/7% **ALT** (Gr.1+2/Gr.3+)

2%/7% **AST** (Gr.1+2/Gr.3+)

elevations attributed to PIKTOR alone

2 of 42 patients discontinued due to TRAEs: headache, dizziness

No drug-related deaths

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Chart shows TRAEs in more than 20% of patients (N=42), related to any study drug (serabelisib, sapanisertib or paclitaxel); hyperglycemia shown as a select event. Overall, 27 of 42 patients (64%) had a grade 3 or higher TRAE. Grading by CTCAE V5.0. ALT: alanine aminotransferase. AST: aspartate aminotransferase. Neutropenia represents a grouped term (neutropenia and neutrophil count decreased); rash represents a grouped term (rash and rash maculo-papular). 10.23.26 data cut, enrollment and follow-up are ongoing.

Ph2: PIKTOR + Paclitaxel safety profile against relevant comparators

	*All grade % (G3+ %)**	**PIKTOR** with paclitaxel PIK-201 · n=42 *Treatment-related*	Endometrial		Breast Cancer		
			Len-Pembro KEYNOTE-775 · n=342 *US label*	**Sac-TMT** TroFuse-005 · n=384 *Treatment-related*	**Capivasertib** with fulvestrant CAPItello-291 · n=155 *US label*	**Zovegalisib** with fulvestrant ReDiscover · n=60[a] *Treatment-related*	**Gedatolisib** with fulvestrant VIKTORIA-1 · n=260[b] *US label*
PAM-related	Hyperglycemia	**12%** (2%)	NR[c]	**<10%**[d]	**19%** (2%)[e]	**43%** (8%)	**10%** (2%)[f]
	Rash	**31%** (12%)	**20%** (2%)	**<10%**[d]	**56%** (15%)[g]	**8%** (2%)	**35%** (6%)
	Stomatitis	**21%** (2%)[h]	**35%** (3%)	**55%** (10%)[h]	**25%** (2%)	**8%** (0%)	**63%** (16%)[h]
Other AEs	Nausea	**67%** (5%)	**49%** (3%)	**36%** (1%)	**35%** (1%)	**52%** (2%)	**47%** (2%)
	Vomiting	**43%** (0%)	**37%** (2%)	**18%** (1%)	**21%** (2%)	**23%** (0%)	**29%** (1%)
	Diarrhea	**45%** (0%)	**55%** (8%)	**17%** (2%)	**77%** (12%)	**57%** (3%)	**23%** (2%)
	ALT increased	**31%** (19%)	**55%** (9%)[i]	**<10%**[d]	**23%** (3%)[i]	**<15%**[d]	**30%** (2%)[i]
Discontinued for an AE (%)[j]		**5%**	**26%**	**3%**	**10%**	**7%**	**10%**

* Treatment-related: events investigators linked to treatment (for PIKTOR, any study drug, including paclitaxel). US label: events in the US prescribing information (PI), related or not.

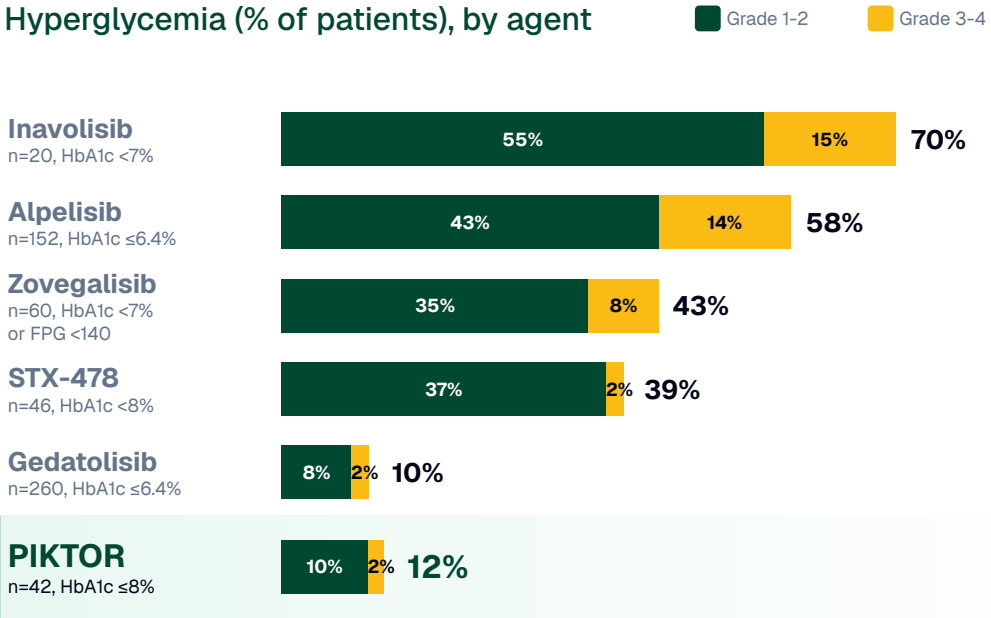
[a] 400 mg twice daily with food. [b] PIK3CA wild-type; label's two arms, with and without palbociclib, combined. [c] Label lists hyperglycemia only as a lab value. [d] Not listed; the source shows only events in at least 10% (TroFuse-005) or 15% (ReDiscover) of patients. [e] 2023 label; newer labels list it only as a lab value. [f] Treatment-related rate from Hurvitz, J Clin Oncol 2026, shown for comparability with PIKTOR (for hyperglycemia, the label lists it only as a lab value). [g] Label's combined row for skin reactions. [h] Steroid mouthwash to prevent stomatitis: recommended in TroFuse-005 (64% used one), required in VIKTORIA-1, not required in PIK-201. [i] Lab test results, which usually run higher than reported AEs. [j] Patients who stopped the drug because of an AE: treatment-related for PIKTOR, Sac-TMT and zovegalisib; related or not for the US label columns.

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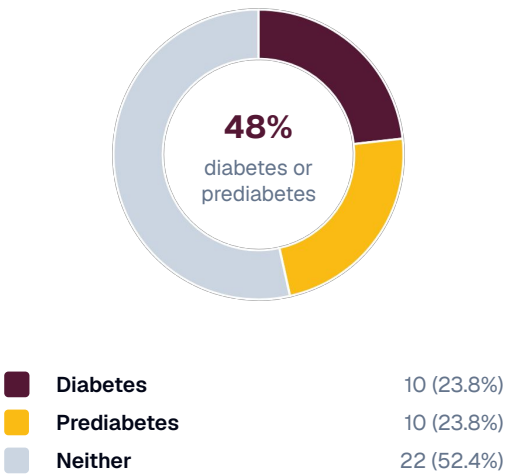
Sources: PIK-201, 10.23.26 data cut, enrollment and follow-up are ongoing. LENVIMA and KEYTRUDA PIs (rev. 10/2026); Lorusso et al., Lancet 2026 (TroFuse-005); TRUQAP PI (rev. 9/2026); Varkaris et al., ESMO TAT 2026 (ReDiscover, data as of 1/13/26); REVTORPYK PI (rev. 07/2026). Data are derived from different clinical trials at different points in time. No head-to-head trials of PIKTOR and any other drug have been conducted. As a result, cross-trial comparisons cannot be made.

Ph2: Hyperglycemia TRAEs occurred in 12% of patients despite 48% of patients having diabetes or prediabetes at baseline

Hyperglycemia (% of patients), by agent



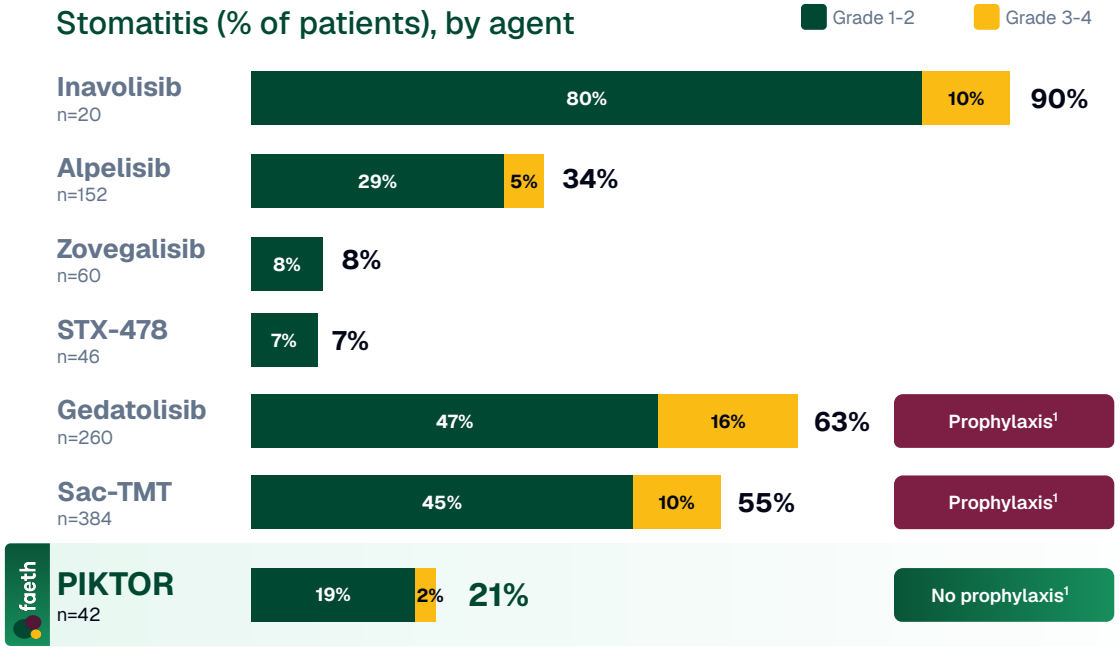
Baseline glycemic status, PIK-201 (N=42)



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Data are derived from different clinical trials at different points in time. No head-to-head trials of PIKTOR and any other drug have been conducted. As a result, cross-trial comparisons cannot be made. Treatment-related adverseevents, except STX-478 (all causes). HbA1c (hemoglobin A1c) under each drug is that trial's entry limit. PIKTOR: PIK-201, 10.23.26 data cut, enrollment and follow-up are ongoing. Inavolisib: GO39374, inavolisib + palbociclib + fulvestrant arm (Jhaveri, J Clin Oncol 2024). Alpelisib: VIKTORIA-1 Study 2 (Hurvitz, ASCO 2026). Zovegalisib: 400 mg fed cohort (Varkaris, ESMO TAT 2026). STX-478 (tersolisib): PIKALO-1, tersolisib + fulvestrant arm, n=46 (Jhaveri, ASCO 2026). Gedatolisib: VIKTORIA-1 Study 1, two arms pooled (Hurvitz, J Clin Oncol 2026). Diabetes: medical history, diabetes medication or baseline HbA1c ≥6.5%. Prediabetes: baseline HbA1c 5.6% to <6.5%. FPG: fasting plasma glucose. Percentages may not sum due to rounding.

Gr. 3 stomatitis TRAEs occurred in 2% of patients, despite no prophylaxis



Chemo alone (TroFuse-005 control arm):

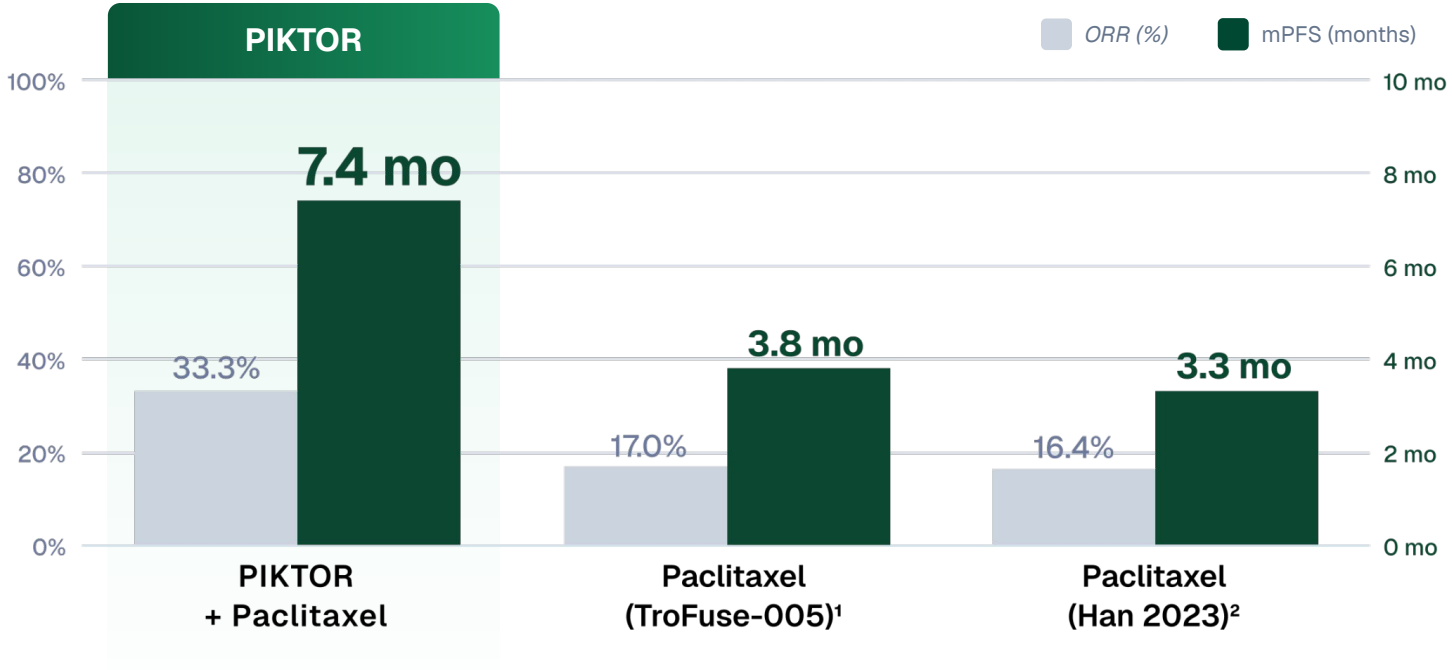
14% all grade

2% grade 3+

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Data are derived from different clinical trials at different points in time. No head-to-head trials of PIKTOR and any other drug have been conducted. As a result, cross-trial comparisons cannot be made. Treatment-related adverse events, except STX-478 (all causes). Stomatitis includesgrouped terms (e.g., mucosal inflammation, mouth ulceration) where so reported. Comparators are in HR+/HER2- advanced breast cancer except sac-TMT and its chemotherapy control arm (endometrial cancer). PIKTOR: PIK-201, 10.23.26 data cut. Inavolisib: GO39374, inavolisib + palbociclib +fulvestrant arm (Jhaveri, J Clin Oncol 2024). Alpelisib: VIKTORIA-1 Study 2, alpelisib + fulvestrant arm (Hurvitz, ASCO 2026). Zovegalisib: ReDiscover, 400 mg BID fed cohort (Varkaris, ESMO TAT 2026). STX-478 (tersolisib): PIKALO-1, tersolisib + fulvestrant arm, n=46 (Jhaveri, ASCO 2026). Gedatolisib: VIKTORIA-1 Study 1, two arms pooled (Hurvitz, J Clin Oncol 2026). Sac-TMT: TroFuse-005 (Lorusso, Lancet 2026). Percentages may not sum due to rounding. [1]Prophylaxis: required in VIKTORIA-1 (gedatolisib arms); in TroFuse-005, called for by the protocol from the start, with steroid mouthwash highly recommended and centrally supplied for routine use from a September 2024 amendment (64% of sac-TMT patients used one); not required in PIK-201.

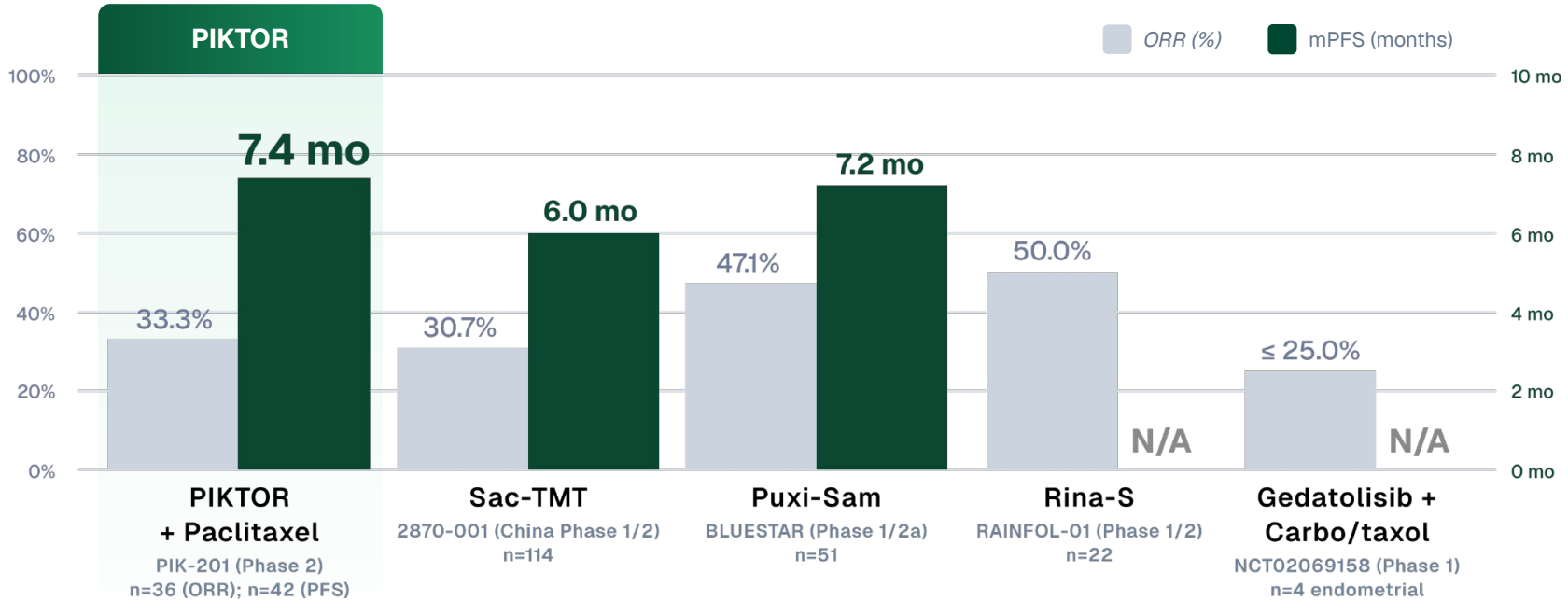
Preliminary ORR/PFS above salvage chemotherapy performance in a heavily pre-treated population



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Data are derived from different clinical trials at different points in time. No head-to-head trials of PIKTOR and any other drug have been conducted. As a result, cross-trial comparisons cannot be made. PIK-201 is a single-arm study, which is not directly comparable to PFS in randomized trials.PIKTOR values: Confirmed ORR 12 of 36 efficacy-evaluable patients, 33.3%, 10.30.26 data cut, estimated mPFS 7.4 mo, enrollment and follow-up are ongoing. [1]TroFuse-005 paclitaxel values are from Lorusso D, et al. Lancet 2026, Supplementary Appendix Table S15. They cover all patients assigned weekly paclitaxel as the physician's-choice control (n=119). This population includes all endometrial cancer histologies and is not limited to endometrioid. Patients were not randomized between paclitaxel and doxorubicin. Confirmed ORR is 17% (20/117; response-evaluable population). mPFS is 3.8 mo.[2]Han SN, et al. Gynecol Oncol 2023;178:110–118 (NCT02725268), weekly paclitaxel 80 mg/m² monotherapy arm, endometrioid histology only. Confirmed ORR is 16.4% (9/55; patients who received ≥1 dose; Table 3). mPFS is 3.3 mo (all randomized endometrioid patients, n=57). Not a pooled analysis.One axis scaled so that 100% = 10 months

Preliminary ORR/PFS in line with investigational ADC therapies and prior PAM + chemotherapy data



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Confirmed ORR. Estimated mPFS. PIKTOR: PIK-201 topline, data cut 10.30.26, enrollment and follow-up are ongoing. Sac-TMT: 4 mg/kg cohort, China Phase 1/2 study KL264-01 (Kelun-Biotech, CCHIO 2025; data cut 5.21.25). Puxi-Sam: 2.4 mg/kg, B7-H4-expressing endometrial cohort (ASCO2026). Rina-S: 100 mg/m² Q3W, cohort B2 (ASCO 2025); mPFS not reported (N/A). Gedatolisib: Colombo et al., Clin Cancer Res 2021;27(18):5012–19; Phase 1 gedatolisib + carboplatin AUC5 + paclitaxel 80 mg/m², endometrial subgroup (n=4); investigator-assessed best overall response per RECIST 1.1, unconfirmed; endometrial mPFS not reported (N/A). Data are derived from different clinical trials at different points in time. No head-to-head trials of PIKTOR and any other drug have been conducted. As a result, cross-trial comparisons cannot be made. One axis scaled so that 100% = 10months. ADC: antibody-drug conjugate.

Breast Cancer: Multi-node PAM blockade more than doubles addressable market relative to mutant-selective inhibitors

High unmet need

HR+/HER2- patients comprise ~70% of all metastatic breast cancer patients[1]

Most patients lack PI3K mutation

PIKTOR is designed to **work in all patients**; not just the ~40% that have an activating *PIK3CA* mutation.

Oral convenience

PIKTOR is taken with food on a 3 days on/4 days off schedule

PI3K MUT

~40% of HR+/HER2- breast cancer with activating *PIK3CA* mutation[2-5]

RELAY THERAPEUTICS

LOXO ONCOLOGY at Lilly

OnKure® THERAPEUTICS

+ multiple others

PI3K WT + PI3K MUT

100% of HR+/HER2- Breast Cancer

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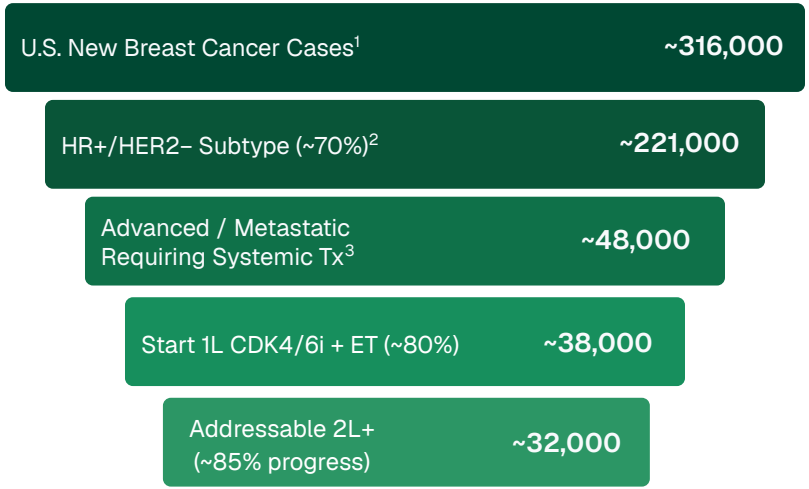
celcuity

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1. Howlader 2014; SEER subtype rates 91.3/130.8 per 100K) = ~221K/yr
2. Tao JJ, et al. *JCO Precis Oncol* 2025 · 3. Zhang Y, et al. *Cancer Cell* 2017;31:820–832.e3 · 4. *Breast Cancer Res Treat* 2025, PMID 40931235 · 5. Krishnamurthy N, et al. *Front Oncol* 2020;10:1475

HR+/HER2- breast cancer: Large unmet need

U.S. Incident Therapeutic Build (Annual)



~93,000
1L ETR and ETSadvanced/ metastatic patients (prevalence)

~$62B
1L U.S. TAM[4]

~32,000
2L post-CDK4/6i advanced/metastatic patients (incidence)

~$10B
2L U.S. TAM[5]

1. ACS Cancer Facts & Figures 2026 / SEER: ~316K new U.S. female breast cancer cases and ~42K breast cancer deaths per year.
2. HR+/HER2– ≈70% of cases (SEER 21, 2018–2022: 91.3 of 130.8 per 100K; Howlader 2014) = ~221K/yr.
3. Incidence: ~48K new HR+/HER2– advanced/metastatic patients/yr requiring systemic therapy = de novo stage IV ~13K (221K × ~6%; SEER; Malmgren 2018) + steady-state distant recurrence ~35K (~208K early-stage patients/yr × ~17% cumulative distant recurrence;company estimate informed by Pan, NEJM 2017). ~38K/yr start 1L CDK4/6i + ET (~80%; Parikh 2024; Flatiron).
4. 1L TAM: ~93K 1L patients (prevalence: endocrine-sensitive ~60K + endocrine-resistant ~33K; company estimates) × ~22 cycles (weighted average reflecting ~36-month and ~15-month durations of therapy in ETS and ETR) × $30K per 28-day cycle (REVTORPYK list price) = ~$62B. PIKTOR is not currently being studied in the first-line setting.
5. 2L TAM: ~32K patients/yr progressing on 1L CDK4/6i + ET (incidence; 38K × ~85% lifetime progression; PALOMA-2, MONALEESA-2) × ~10 cycles (~9 months; mean gedatolisib treatment duration 9.0–11.3 months, VIKTORIA-1; Celcuity 10-Q, Nov. 2026) × $30K per cycle =~$10B.

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PIKTOR's price has not been set. *Market size estimates reflect the stated assumptions on patient numbers, price and duration of therapy. They estimate the size of the treatment setting and are not forecasts of PIKTOR revenue or market share. Figures are presented as lower bounds.*

Serabelisib and Sapanisertib have each independently shown activity in HR+/HER2- breast cancer; Phase 1b/2 underway

		STUDY	DRUG / COMBINATION	ORR	DCR	mPFS	CR
HR+/HER2- (Phase 2)	**Sapanisertib**	Garcia-Saenz *et. al.*, 2022 [1]	Sapanisertib + Fulvestrant (n=47 arm B)	21.3%	75% PR+CR+SD	**7.2 m**	2/47
	Control Arm	Garcia-Saenz *et. al.*, 2022 [1]	Fulvestrant (n=46 arm A)	10.9%	61% PR+CR+SD	3.5 m	0/46
VIKTORIA-1 (Phase 3)	Gedatolisib	Hurvitz, S. *et. al.*, 2025 [2]	Gedatolisib + Fulvestrant (n=130)	28.3%	77% PR+CR+SD	**7.4 m**	NA

		STUDY	DRUG / COMBINATION	ORR	DCR	mPFS	CR
Breast Cancer Subjects from Phase 1	**Serabelisib**	Juric *et. al.*, 2017 [3]	Serabelisib (n=21)	14%	76% PR+CR+SD	NR	0/21
	Comparator Drug Data	Juric *et. al.*, 2018 [4]	Alpelisib (n=23)	4%	61% PR+CR+SD	NR	0/23

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The results are presented from different clinical trials at different points in time with differences in trial design. No head-to-head trials have been conducted among the results shown and cross-trial comparisons must be interpreted with caution. As a result, conclusive cross-trial comparisons cannot be made.

[1]Garcia-Saenz et. al., (2022) J. Clinical Cancer Research (2022) 28 (6): 1107–1116 [2]Hurvitz, S. et. al., (2025) ESMO Presentation [3]Juric et. al., (2017) Clin. Cancer Res. 23 (17) [4]Juric et. al., (2018) Journal of Clinical Oncology 36 (13),1291-1299

Breast: First patient dosed in Phase 1b trial in April 2026

Achieved in 2026	2027	2028
✓ Trial initiated; Ph1b dose escalation underway	○ Interim safety data from dose escalation	○ Expansion data
✓ First patient dosed Apr 2026	○ Interim efficacy data; expansion cohorts initiated	

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Breast: Ongoing Phase 1b/2 trial designed to rapidly identify recommended dose and initiate expansion cohorts

Cohort A
PIKTOR + Fulvestrant

- **A2: Sap 4 mg + Ser 200 mg**
- **A1:** Sap 2 mg + Ser 200 mg

A2 opens parallel with A1

Cohort B
PIKTOR + Fulvestrant + Palbociclib

- **B4 (optional):** Sap 4 mg + Ser 300 mg
- **B3:** Sap 4 mg + Ser 200 mg
- **B2:** Sap 3 mg + Ser 200 mg
- **B1:** Sap 2 mg + Ser 100 mg

Currently enrolling for Cohort B

Planned Cohort C
PIKTOR + Oral SERD ± Palbociclib

- **C3:** Sap 4 mg + Ser 200 mg (+ Oral SERD + Palbo)
- **C2:** Sap 2 mg + Ser 200 mg (+ Oral SERD + Palbo)
- **C1:** Sap 4 mg + Ser 200 mg (+ Oral SERD only)

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Key eligibility: HR+/HER2– breast cancer · ≥1 prior therapy
Treatment: Until disease progression, unacceptable toxicity, withdrawal of consent, or death

Two clinically de-risked indications outside of endometrial cancer and breast cancer add optionality to pipeline

Ovarian

Platinum-resistant ovarian cancer (PROC)

HR 0.66

PFS benefit in randomized Phase 2 DICE trial (90% CI: 0.45–0.96)

- Phase 2 complete (n=134): sapanisertib + paclitaxel vs. paclitaxel alone; late-breaking oral presentation at ESMO 2025
- Mean PFS 5.8 vs. 4.0 months with no meaningful added toxicity (Grade 3/4 AEs: 7.0% vs. 6.6%)
- Supported by ovarian responses in Phase 1b PIKTOR triplet (2 PRs, 4 SDs ≥6 months)

Supportive Ph2 data generated • TAM ~$2.5B

Lung

NFE2L2/KEAP1-mutated advanced NSCLC

25% ORR

Single-agent sapanisertib; mPFS 8.9 months (squamous NSCLC)

- Genotype-directed monotherapy activity — potentially the first genotype-directed therapy for squamous NSCLC
- FDA Fast Track designation granted based on these results
- PIKTOR adds PI3Kα blockade to the validated mTORC1/2 backbone — potential to deepen and extend responses

Phase 2 protocol in process • TAM ~$1.5B

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Krell J et al., ESMO 2025; Paik PK et al., J Thorac Oncol 2023;18(4):516–526; Starks DC et al., Gynecol Oncol 2022. TAM per internal company analysis. Abbreviations: PFS – progression-free survival; HR – hazard ratio; CI – confidence interval; ORR – overall response rate; AE – adverse event; IIT – investigator-initiated trial; TAM – total addressable market.

$174.8M[1] in cash expected to fund PIKTOR through anticipated readouts in endometrial cancer and breast cancer

PROGRAM	Achieved in 2026	2027
ENDOMETRIAL	✓ Received Fast Track Designation ✓ Topline data readout	• PIK-201 PFS update • Prepare for Ph3 trial
BREAST	✓ Trial initiated; Ph1b dose escalation underway (first patient dosed Apr 2026)	• Interim safety data from dose escalation • Interim efficacy data; expansion cohorts initiated
INDICATION EXPANSION (sapanisertib)		• Preclinical data on rare disease

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[1] $174.8M cash and cash equivalents as of September 30, 2026,
Abbreviations: EC - endometrial cancer, BC - breast cancer

Faeth team has deep drug development experience

Management team



Anand Parikh, JD
Chief Executive Officer



Oliver Maddocks, MPharm PhD
Chief Scientific Officer



Brian Stephenson, PhD, CFA
Chief Financial Officer



Debbie Chirnomas, MD MPH
Chief Medical Officer



Christopher Gerry, JD
General Counsel

Board



Anand Parikh, JD
Board Chair



Phil Donenberg
Board Member



Stephen Hahn, MD
Board Member



Saira Ramasastry
Board Member



Bob Holmen, JD
Board Member



Karen Vousden, PhD
Board Member



Adam Schayowitz, PhD, MBA
Board Member

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Appendix

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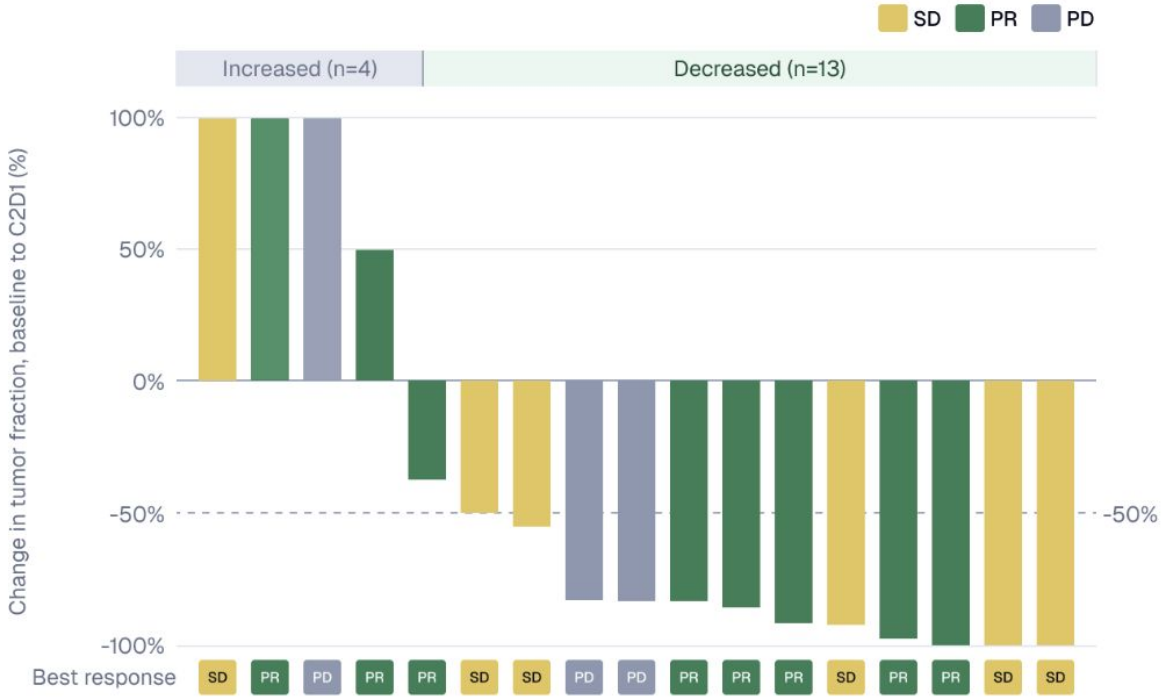
Exploratory analysis shows decrease in ctDNA tumor fraction after 1 treatment cycle in 13 of 17 efficacy-evaluable patients

13 of 17

patients' ctDNA tumor fraction decreased by cycle 2 day 1

12

decreased by ≥50%



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n=17 patients with paired baseline and C2D1 samples with ctDNA results reported at time of 10.30.26 data cut, enrollment and follow-up are ongoing. Increases above 100% are shown at 100% (actual +1,539%, +300% and +187%).

Robust IP portfolio and registration-ready CMC

Intellectual property

May 2037 — Composition of matter ISSUED
Issued COM patents for both APIs; serabelisib expiry includes PTA and expected 5 years of PTE

May 2039 — Combination MoT ISSUED
Issued patent covering PIKTOR + ISD method of treatment across a range of tumor types

~2048 — Pending Filings PENDING
Pending MoT filings (endometrial/breast; ovarian) plus novel formulation COM filing targeted 2027

CMC & supply

Mature DS/DP materials
Both drug substances highly stable; batches with 36–60 months of stability data and proven manufacturing history

Scale-up on track
DS/DP process optimization being completed; demo batches planned for 2026; registrational readiness on track

Supply secured
Ample DS/DP supply expected for ongoing and proposed Phase 1b / Phase 2 studies

Global exclusive licenses from Takeda for serabelisib and sapanisertib across all oncology indications

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Thank you

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