Revolution Medicines

On Target to Outsmart Cancer

May 2026

Legal Disclaimer

This presentation contains forward-looking statements within the meaning of the Private Securities Litigation Reform Act. All statements other than statements of historical facts contained in this presentation, including statements regarding our future results of operations and financial position, business strategy, product candidates, availability of funding, ability to manage existing collaborations and establish new strategic collaborations, licensing or other arrangements, the scope, progress, results and costs of developing our product candidates or any other future product candidates, conducting clinical trials, the potential market size and size of the potential patient populations for our product candidates, commercialization plans and capabilities, the timing and likelihood of success of obtaining product approvals, plans and objectives of management for future operations, future results of anticipated products and the impact of global events and other macroeconomic conditions on our business are forward-looking statements. These statements involve known and unknown risks, uncertainties and other important factors that may cause our actual results, performance or achievements to be materially different from any future results, performance or achievements expressed or implied by the forward-looking statements. Because forward-looking statements are inherently subject to risks and uncertainties, some of which cannot be predicted or quantified and some of which are beyond our control, you should not rely on these forward-looking statements as predictions of future events. The events and circumstances reflected in our forward-looking statements may not be achieved or occur and actual results could differ materially from those projected in the forward-looking statements. The information included in these materials is provided as of May 6, 2026, unless specified elsewhere herein, and is qualified as such. Except as required by applicable law, we undertake no obligation to update any forward-looking statements or other information contained herein, whether as a result of any new information, future events, changed circumstances or otherwise.

For a further description of the risks and uncertainties that could cause actual results to differ from those anticipated in these forward-looking statements, as well as risks relating to the business of Revolution Medicines in general, see Revolution Medicines' Quarterly Report on Form 10-Q filed with the Securities and Exchange Commission on May 6, 2026, and its future periodic reports to be filed with the Securities and Exchange Commission.

This presentation concerns product candidates that are under clinical investigation and which have not yet been approved for marketing by the U.S. Food and Drug Administration (FDA) or any other regulatory authority. These product candidates are currently limited by federal law to investigational use, and no representation is made as to their safety or effectiveness for the purposes for which they are being investigated.

This presentation includes certain information regarding publicly available results from clinical trials by third parties evaluating other product candidates. Such trials were not head-to-head trials with any of Revolution Medicines' product candidates and include differences in study protocols, patient populations and reporting standards, and caution should be exercised when comparing data across trials.

Growing Impact for Patients

Major milestone reached

- Unprecedented overall survival benefit demonstrated in RASolute 302, a randomized Phase 3 clinical trial of daraxonrasib (oral, once daily) in patients with previously treated metastatic pancreatic cancer

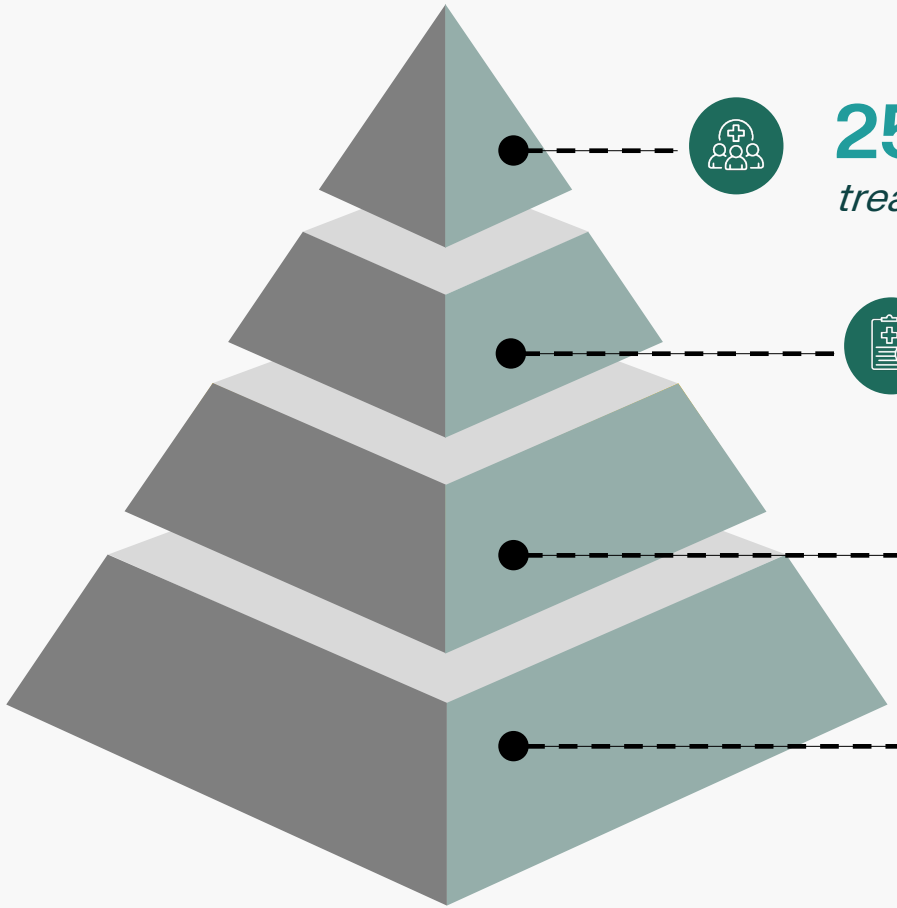
Expanding reach with daraxonrasib

- Preparation of NDA for FDA as first step in global registration
- Ongoing Phase 3 trials across treatment lines and tumor types

Robust pipeline momentum

- Expansive development programs with multiple pioneering investigational targeted medicines and rich discovery portfolio

Our Mission | Revolutionize Treatment Globally for Patients with RAS-Addicted Cancers through the Discovery, Development and Delivery of Innovative, Targeted Medicines



2500+ patients
treated with one or more of our RAS(ON) inhibitors

8 randomized Phase 3 registrational trials
- *active and planned for 2026*

+ extensive Phase 1/2 trials

4 clinical-stage investigational drugs
- *daraxonrasib | zoldonrasib | elironrasib | RMC-5127*

+ preclinical pipeline

3 common RAS-addicted cancers
pancreatic | non-small cell lung | colorectal

As of January 2026

Uniquely Positioned | Aiming to Change Global Standards of Care for Patients with Common RAS-Addicted Cancers

Pancreatic ductal adenocarcinoma

- >90% are RAS-driven(1)

Non-small cell lung cancer

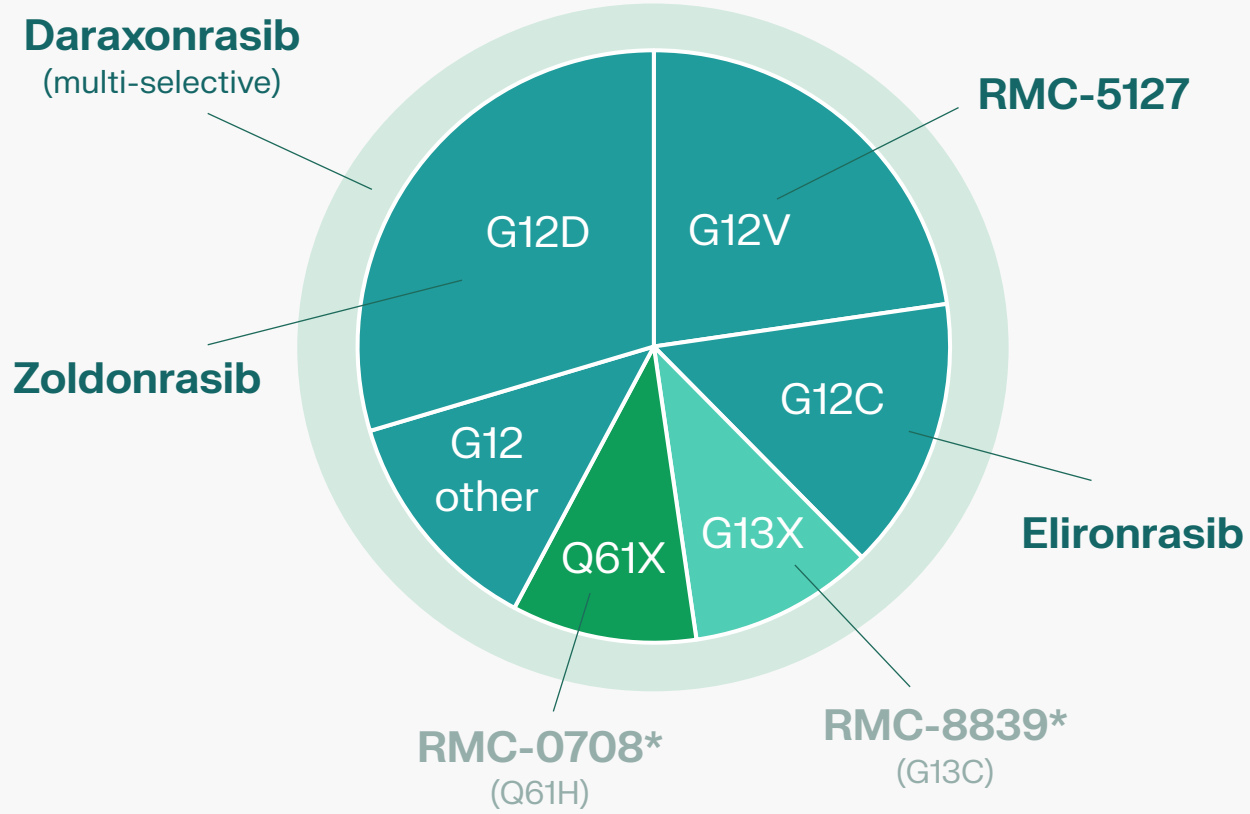
- ~30% are RAS-driven(1)
- RAS-targeted therapies exist for G12C only, no full approvals to-date

Colorectal cancer

- ~50% are RAS-driven(1)
- Challenging genetically heterogeneous disease with limited treatment options

Disease progression often associated with reactivation of RAS pathway signaling

Product Pipeline Targets RAS Variants Among RAS Mutant Solid Tumors



(1) Estimated using tumor mutation frequencies from FoundationCORE March 2022. * Preclinical assets.

Industry-Leading Capabilities | Advancing Targeted Treatment Regimens Based on RAS(ON) Inhibitors

- Proprietary tri-complex discovery platform targeting the oncogenic (or “ON”) state of RAS
- Robust clinical development programs and expertise to maximize impact for patients
- Expanding commercialization and operational capabilities to ensure delivery of successful launches and change global standards of care

Virtuous cycle of innovation driven by bench, bedside and commercial insights


Develop

Pipeline Led by Four Pioneering, Clinical-Stage, RAS(ON) Inhibitors

COMPOUND	FOCUS	STUDY DETAILS	EARLY CLIN. DEVELOPMENT	REGISTRATIONAL TRIAL
Daraxonrasib (MULTI)	PDAC	RASolute 302 — 2L metastatic		
		RASolute 303 — 1L metastatic		
		RASolute 304 — Adjuvant in resectable		
	NSCLC	RASolve 301 — 2L/3L metastatic		
		1L metastatic		*Planning ongoing*
	Solid tumors	+ SOC, RAS(ON) inhibitor doublets or other investigational agents		
Zoldonrasib (G12D)	PDAC	RASolute 305 — 1L metastatic		
		RASolute 309 — 1L metastatic		*Phase 3 initiation planned*
	NSCLC	RASolve 308 — 1L metastatic		*Initiation pending*
	Solid tumors	+ SOC, RAS(ON) inhibitor doublets or other investigational agents		
Elironrasib (G12C)	Solid tumors	Monotherapy		
		+ SOC, RAS(ON) inhibitor doublets or other investigational agents		
RMC-5127 (G12V)	Solid tumors	Monotherapy		

Additional clinical development opportunities include RAS(ON) mutant-selective inhibitors RMC-0708 (Q61H) and RMC-8839 (G13C) and additional novel targeted approaches for patients with RAS-addicted cancers.

Pancreatic Cancer | Registrational Trials to Maximize Potential Across Early- to Late-Stage Disease Settings

Clinical Evidence

Daraxonrasib | MULTI

- Unprecedented clinical profile across treatment lines, RAS mutations and regimens
  - **2L metastatic:** compelling monotherapy antitumor activity with manageable safety/tolerability profile; encouraging PFS and OS estimates relative to standard of care in 1L PDAC
  - **1L metastatic:** encouraging monotherapy and combination antitumor activity with manageable safety/tolerability profile

Zoldonrasib | G12D

- Encouraging antitumor activity with highly differentiated safety/tolerability
  - Clinical profile attractive for monotherapy and combination approaches

Registrational Trials

Daraxonrasib | MULTI

- **2L metastatic (RASolute 302):** daraxonrasib monotherapy vs. chemo ***Primary and key secondary endpoints met; study results are final***
- **1L metastatic (RASolute 303):** daraxonrasib monotherapy, or daraxonrasib + GnP vs GnP alone ***Ongoing***
- **Adjuvant (RASolute 304):** daraxonrasib vs. observation ***Ongoing***

Zoldonrasib | G12D

- **1L metastatic (RASolute 305):** zoldonrasib + chemo vs. chemo ***Initiated***
- **1L metastatic (RASolute 309):** zoldonrasib + daraxonrasib vs. chemo ***Start-up activities ongoing***

1L, first line; 2L, second line; PDAC, pancreatic ductal adenocarcinoma; PFS, progression-free survival; OS, overall survival; GnP, gemcitabine nab-paclitaxel.

Pancreatic Cancer | Registrational Trials Maximize Potential Across Early- to Late-Stage Disease Settings

Registrational Trials

Daraxonrasib | MULTI

- **2L metastatic (RASolute 302):** daraxonrasib monotherapy vs. chemo ***Primary and key secondary endpoints met; study results are final***
- **1L metastatic (RASolute 303):** daraxonrasib monotherapy, or daraxonrasib + GnP vs GnP alone ***Ongoing***
- **Adjuvant (RASolute 304):** daraxonrasib vs. observation ***Ongoing***

Zoldonrasib | G12D

- **1L metastatic (RASolute 305):** zoldonrasib + chemo vs. chemo ***Initiated***
- **1L metastatic (RASolute 309):** zoldonrasib + daraxonrasib vs. chemo ***Start-up activities ongoing***

Strategic Drivers

RASolute 302: Urgent need, fastest entry point into PDAC, opportunity to establish new SOC in 2L patients

RASolute 303: Opportunity to test two hypotheses and provides optionality, including chemo-free regimen in 1L; opportunity to establish new SOC in 1L patients

RASolute 304: Moving into early-stage disease, opportunity for all patients to have a RAS inhibitor option; potential to improve disease-free survival and establish new SOC

RASolute 305 and RASolute 309: Parallel development to test two hypotheses; pioneering RAS(ON) inhibitor doublet with compelling clinical and biologic rationale; zoldonrasib's differentiated safety/tolerability profile enables broad range of combinations

1L, first line; 2L, second line; GnP, gemcitabine nab-paclitaxel; PDAC, pancreatic ductal adenocarcinoma; SOC, standard of care.

2L Metastatic PDAC: Design of RASolute 302 Trial

Key Eligibility Criteria

- Confirmed PDAC
- 1 prior line of therapy in the metastatic setting
- ECOG PS 0-1

NCT06625320

N = 500

R
1:1

- Daraxonrasib 300 mg PO QD (N=230)
- Investigator's Choice SOC Chemotherapy[(1)] (N=230)

Primary Endpoints (RAS G12X)

- PFS, OS

Secondary Endpoints (All Patients)

- PFS, OS
- ORR, DOR
- QoL

(1) SOC chemotherapy options: Gemcitabine + nab-paclitaxel, modified FOLFIRINOX, NAL-IRI+5-FU+LV, or FOLFOX. 2L, second line. PDAC, pancreatic ductal adenocarcinoma; ECOG PS, Eastern Cooperative Oncology Group Performance Status; R, randomized; PO, oral administration; QD, once daily; SOC, standard of care; PFS, progression-free survival; OS, overall survival; ORR, objective response rate; DOR, duration of response; QoL, quality of life.

RASolute 302: Unprecedented Overall Survival Benefit in Patients with Previously Treated Metastatic Pancreatic Cancer

Oral, once-daily daraxonrasib demonstrated statistically significant and clinically meaningful improvements in PFS and OS compared with SOC IV chemotherapy

Daraxonrasib outcomes in the overall, intent-to-treat population:

60% reduction
in the risk of death

OS hazard ratio: **0.40**

Median OS
greater than one year

13.2 months vs. 6.7 months
with chemotherapy

Generally
well tolerated

Manageable safety profile;
no new safety signals

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(1) Intent-to-treat population includes patients with and without identified tumor RAS mutations. PFS, progression-free survival; OS, overall survival; SOC, standard of care.

1L PDAC: Compelling Clinical Activity, Including Initial Durability, in Daraxonrasib Monotherapy and Combination Reinforces Confidence in RASolute 303

	Daraxonrasib Monotherapy (n=38)[a]	Daraxonrasib + GnP (n=40)[b]
6-month PFS[c], % (95% CI)	71 (53, 83)	84 (68, 93)
6-month OS[c], % (95% CI)	83 (67, 92)	90 (76, 96)
ORR[d], % (95% CI)	47 (31, 64)	58 (41, 73)
DCR[e], % (95% CI)	92 (79, 98)	90 (76, 97)
	Median follow-up, months (range): 13 (9–16)	Median follow-up, months (range): 9.7 (5.7–13.8)

[a]Two patients who were included in the safety analysis were excluded from the efficacy analysis because they did not meet the definition of mPDAC: one patient had locally advanced disease and the other had a synchronous neuroendocrine tumor. [b]All treated patients received an initial dose of 200 mg QD of daraxonrasib and GnP every 2 weeks and had at least 18 weeks of follow up prior to data cutoff date. [c]Estimate based on Kaplan-Meier method. PFS and OS data remain immature. [d]Objective response rate (ORR) (per RECIST v 1.1) includes complete (CR) and partial responses that were confirmed (PR).[e]DCR includes CR, PR and SD.
GnP, gemcitabine nab-paclitaxel; CI, confidence interval; DCR, disease control rate; OS, overall survival; PFS, progression-free survival.

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Data cutoff: Dec 1, 2025

Non-Small Cell Lung Cancer | Broad Potential Across Lines of Therapy with Multi- and Mutant-Selective Approaches

Clinical Evidence

Daraxonrasib | MULTI

- Compelling monotherapy clinical results in previously treated patients, including ORR, PFS and OS
- Demonstrated combinability in 1L with pembrolizumab +/- chemotherapy with encouraging safety/tolerability and antitumor activity

Zoldonrasib | G12D

- Initial safety/tolerability and antitumor activity supports continued evaluation as monotherapy and combination

Elironrasib | G12C

- Differentiated clinical profile, including safety/tolerability and clinical activity observed in both G12C-naïve and G12C-previously treated patients

Registrational Trials

- **2L/3L metastatic (RASolve 301)**
  Ongoing
- **1L metastatic**
  Planning ongoing

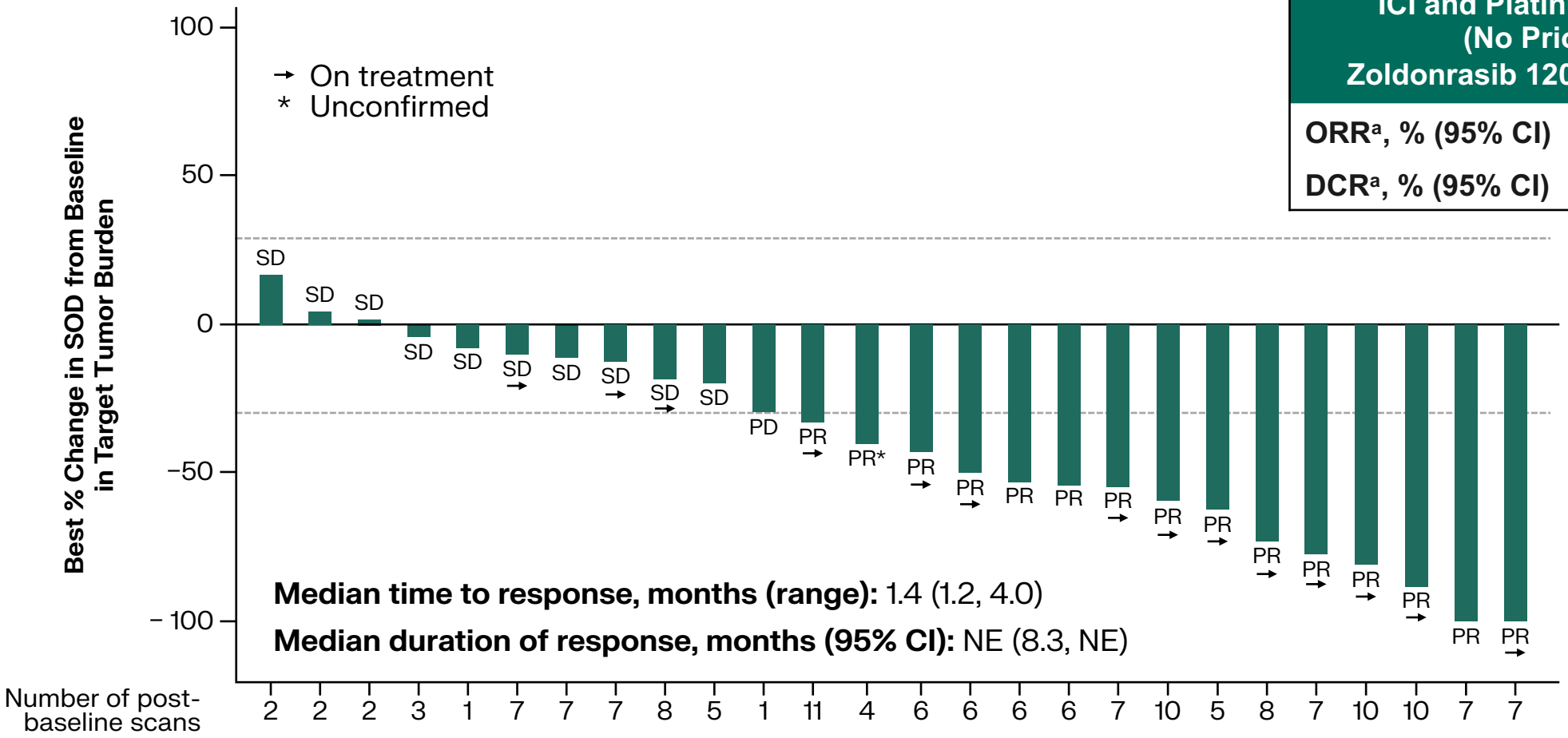
- **1L metastatic (RASolve 308)**
  Initiation pending

- Studying as monotherapy and in combinations informing potential registrational trials

ORR, objective response rate; PFS, progression-free survival; OS, overall survival; 1L, first line; 2L, second line; 3L, third line.

Promising Initial Activity of Zoldonrasib Monotherapy in Previously Treated Patients with KRAS G12D NSCLC

ICI and Platinum Chemo Treated (No Prior Docetaxel) Zoldonrasib 1200 mg PO QD (N = 27)	
ORR[a], % (95% CI)	52 (32, 71)
DCR[a], % (95% CI)	93 (76, 99)



Median follow-up, months (range): 13.1 (9.1, 19.9).

[a]ORR (confirmed CR and PR) and DCR (CR+PR+SD) analyses included all NSCLC patients (with prior ICI and platinum chemotherapy treatment, but no docetaxel) who received first dose of zoldonrasib at least 14 weeks prior to data cutoff date. One patient was included in the denominator of ORR but not displayed on the waterfall plot due to lack of adequate baseline/post-baseline assessments.

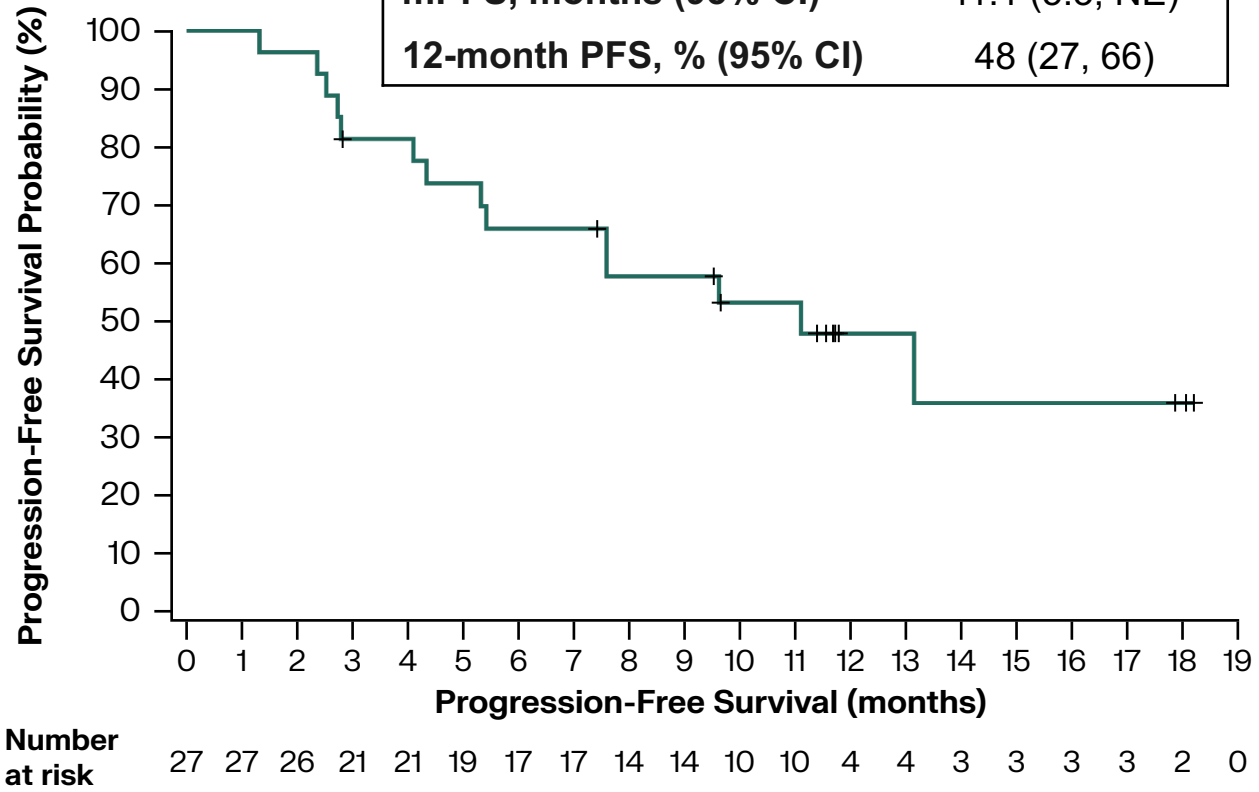
*One unconfirmed PR was excluded from the numerator of ORR because it will not confirm but was included in the denominator.

CI, confidence interval; CR, complete response; DCR, disease control rate; ICI, immune checkpoint inhibitor; KRAS, Kirsten rat sarcoma virus; NE, not estimable; NSCLC, non-small cell lung cancer; ORR, objective response rate; PD, progressive disease; PO, orally; PR, partial response; QD, once daily; SD, stable disease; SOD, sum of diameters.

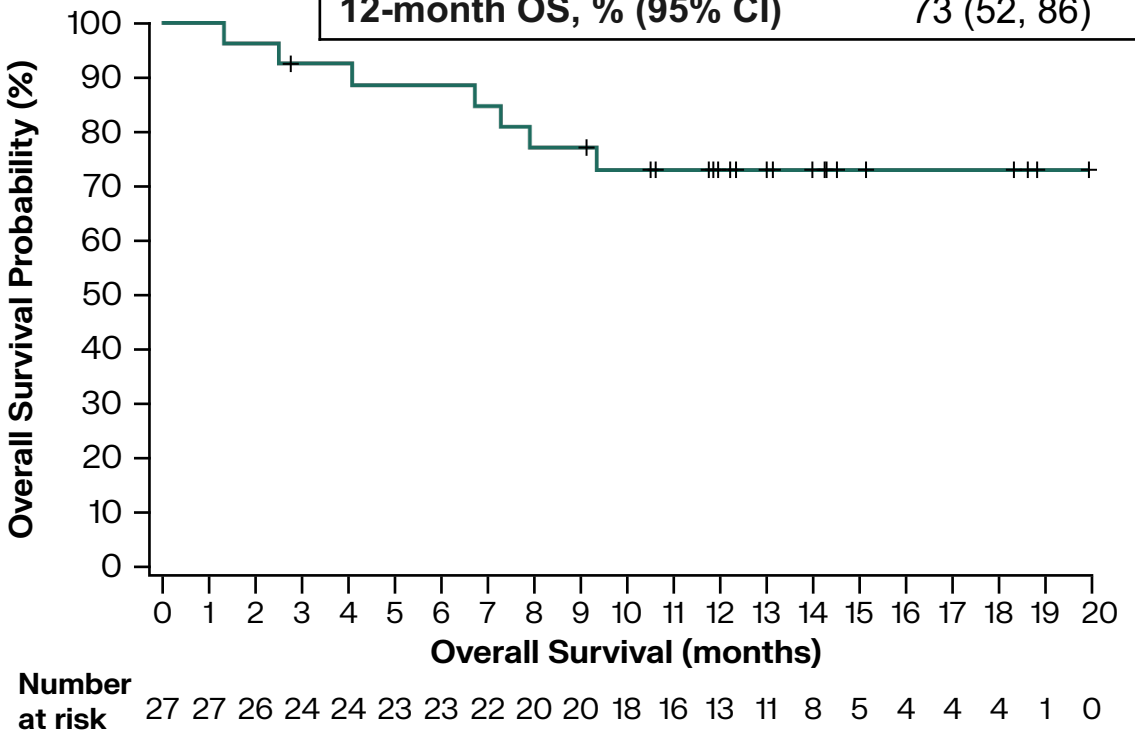
Data cutoff: Dec 1, 2025

Encouraging Initial Durability Data for Zoldonrasib Monotherapy in Previously Treated Patients with KRAS G12D NSCLC

ICI and Platinum Chemo Treated (No Prior Docetaxel) Zoldonrasib 1200 mg PO QD (N = 27)	
mPFS, months (95% CI)	11.1 (5.3, NE)
12-month PFS, % (95% CI)	48 (27, 66)



ICI and Platinum Chemo Treated (No Prior Docetaxel) Zoldonrasib 1200 mg PO QD (N = 27)	
mOS, months (95% CI)	NE (NE, NE)
12-month OS, % (95% CI)	73 (52, 86)



Median follow-up, months (range): 13.1 (9.1, 19.9).
CI, confidence interval; ICI, immune checkpoint inhibitor; KRAS, Kirsten rat sarcoma virus; m, median; NE, not estimable; NSCLC, non-small cell lung cancer; PFS, progression-free survival; OS, overall survival; PO, orally; QD, once daily.

Data cutoff: Dec 1, 2025

Colorectal Cancer | Exploring Combinations to Maximize Clinical Impact in Genetically Heterogeneous Disease

Clinical Evidence

Daraxonrasib | MULTI

- Evaluating daraxonrasib in combination with RAS(ON) mutant-selective inhibitors as part of RAS(ON) doublet combinations
  - Elironrasib plus daraxonrasib doublet has demonstrated encouraging antitumor activity in patients with late-line CRC

Zoldonrasib | G12D and Elironrasib | G12C

- Actively exploring range of clinical combinations

Enabling Registrational Trials

Evaluating multiple potential combinations to optimize potential clinical impact:

- RAS(ON) inhibitor doublets
- SOC chemotherapies
- EGFR antibodies
- Other novel approaches (bi-specifics, etc.)

CRC, colorectal cancer; SOC, standard of care.


Discover

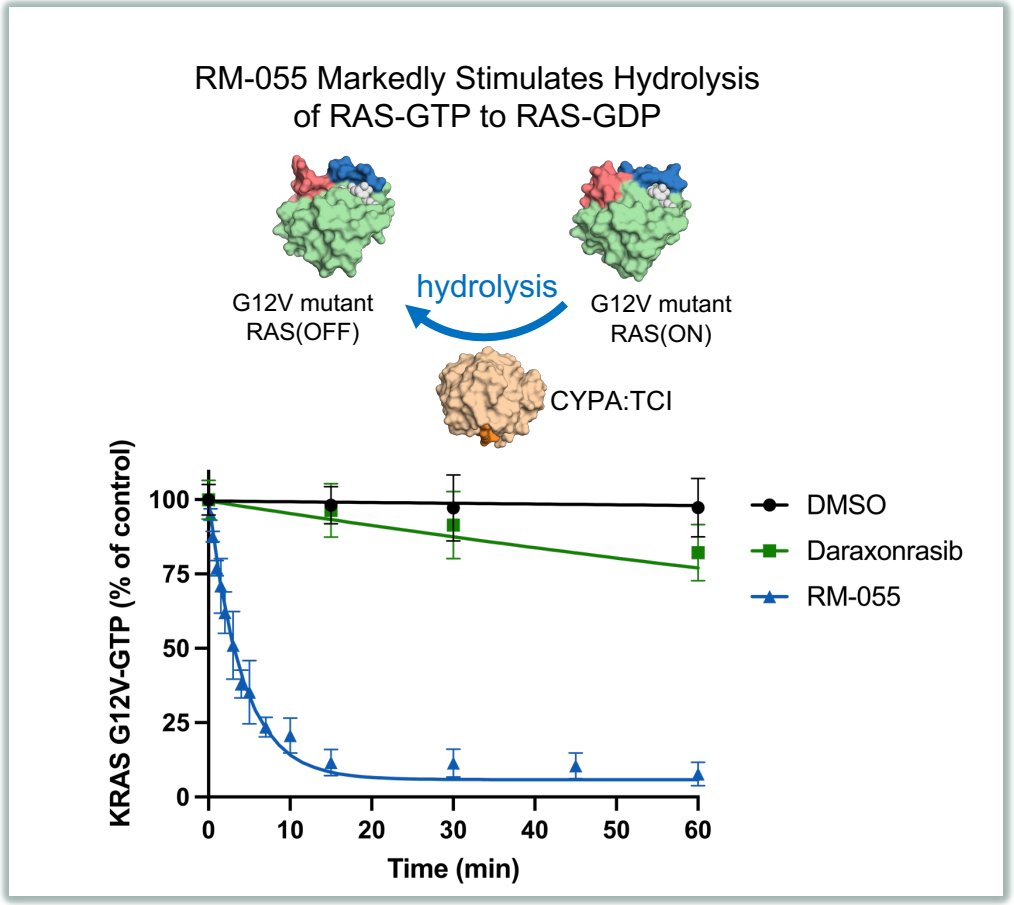
Discover | Continuous Innovation Through Unique Platform and Insights to Sustain Leadership Position and Impact

Highly productive, industry leading drug discovery capabilities

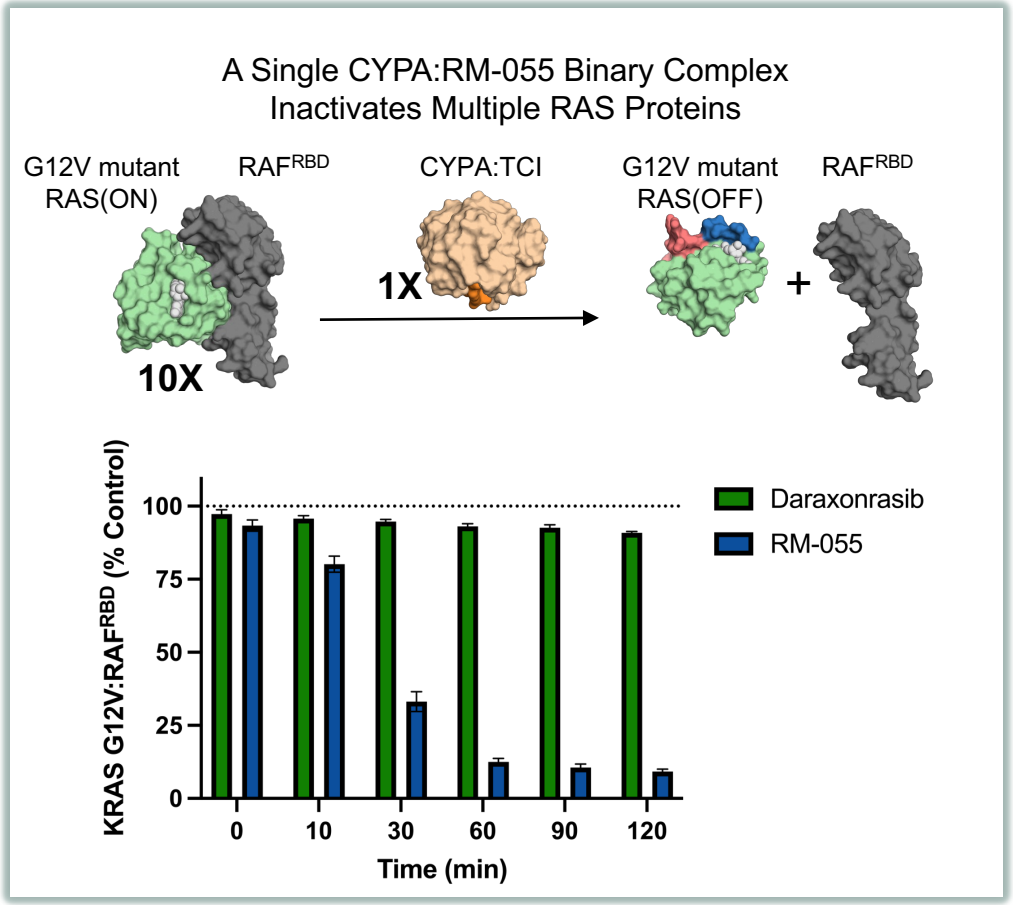
Singular focus on creating novel targeted therapies for patients with RAS-addicted cancers has created differentiated expertise and know-how

Continuing investment leveraging proprietary platform and clinical/translational insights from broad data sets to advance potentially ground-breaking approaches

RM-055, Exemplifying Innovative New Class of Mutant-Targeted Catalytic RAS(ON) Inhibitors, Designed to Mimic the Activity of Natural GAPs



CYPA:TCI binary complex in excess



$KRAS^{G12V}$:RAF^{RBD} in ten-fold excess relative to CYPA:TCI binary complex

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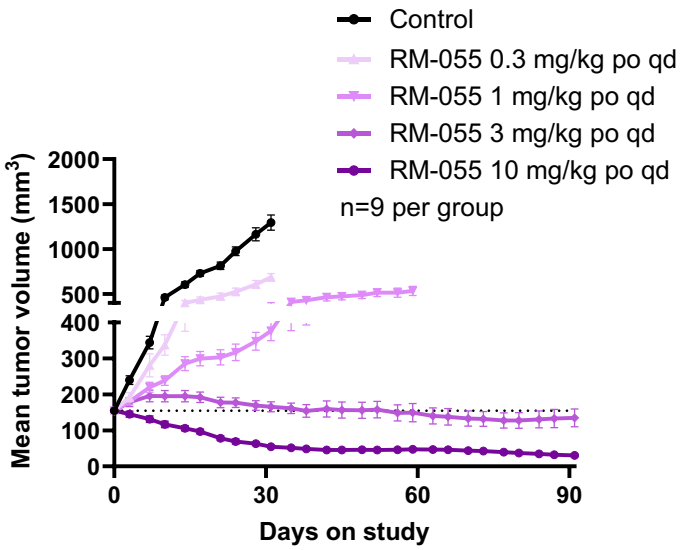
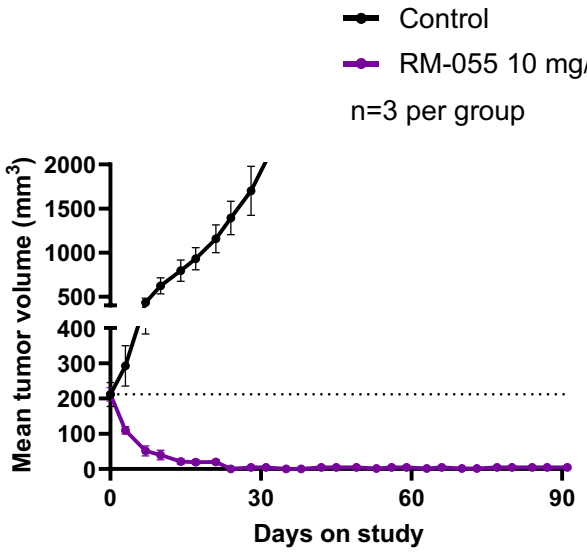
CYPA, cyclophilin A.

RM-055 Drives Deep and Durable Tumor Regressions in G12 Mutant KRAS Preclinical Models

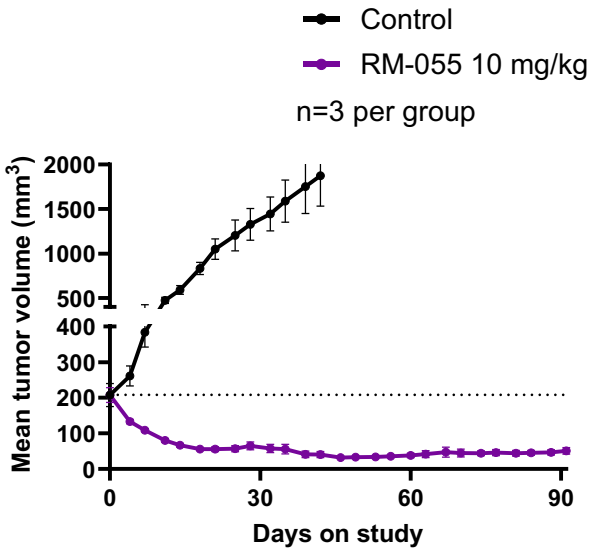
PDAC (KRAS G12D)[1]



NSCLC (KRAS G12C)[2]



CRC (KRAS G12V)[3]

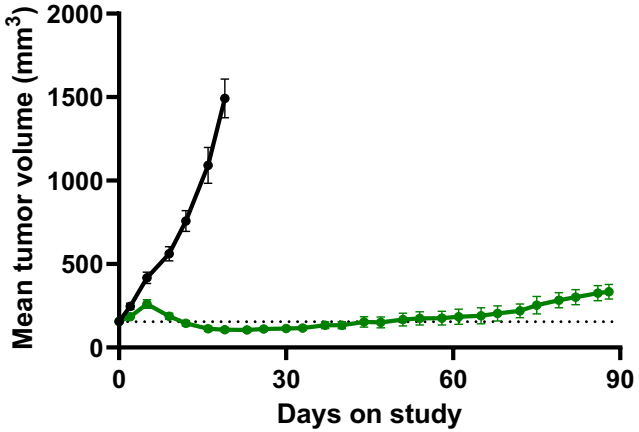


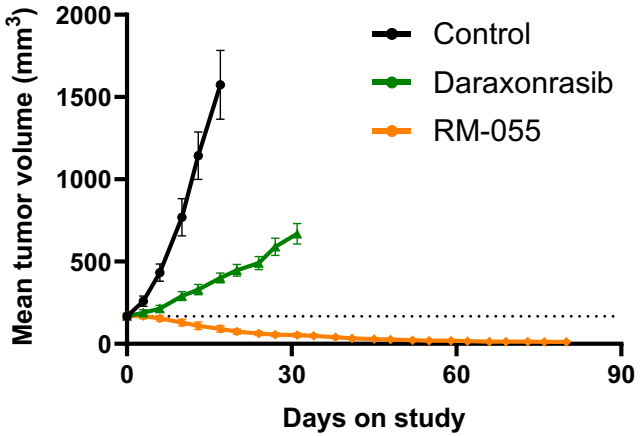
Models: [1]AsPC-1 (PDAC, KRAS$^{G12D/G12D}$); [2]LUN055 (NSCLC, KRAS$^{G12C\ Amp/WT}$); [3]CRC060 (CRC, KRAS^{G12V}).
All RM-055 treatment regimens were tolerated during treatment course based on body weight assessment.
PDAC, pancreatic ductal adenocarcinoma; NSCLC, non-small cell lung cancer; CRC, colorectal cancer.

Innovative New Class of RAS(ON) Inhibitors Designed to Overcome RAS-Driven Drug Resistance and Extend Clinical Benefit

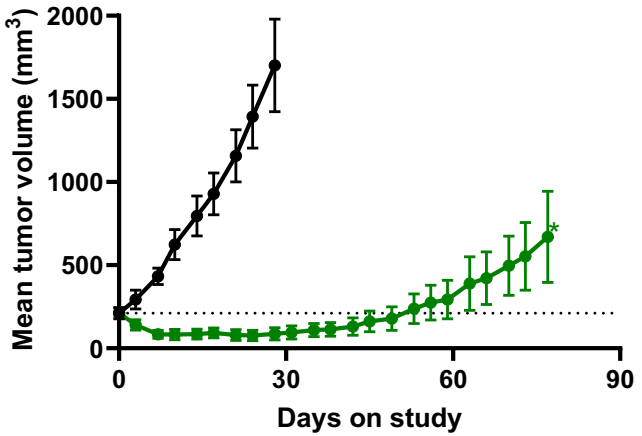
Standard Models → Resistant Models[3]

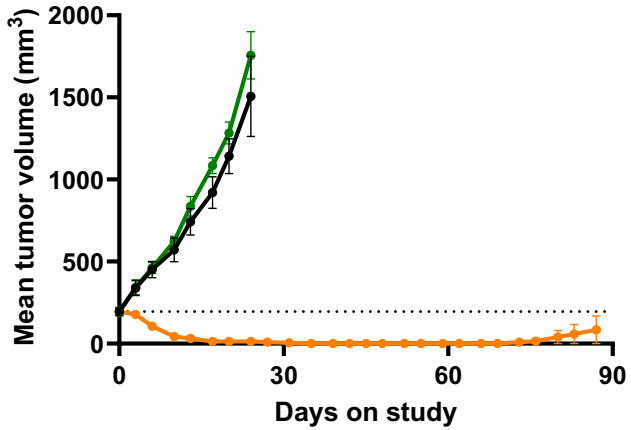
PDAC (KRAS G12D)[1]



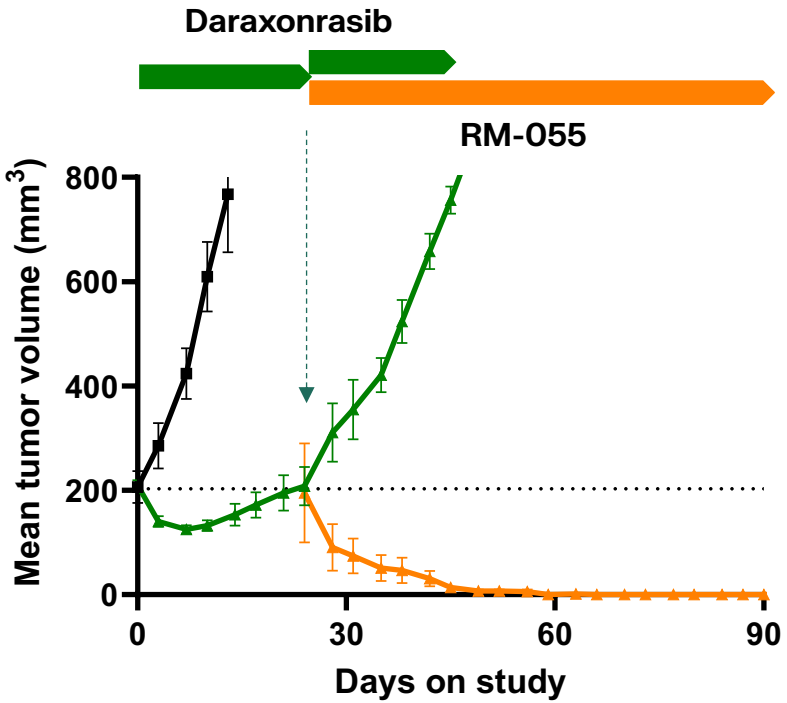


NSCLC (KRAS G12C)[2]





Post-Progression Treatment (NSCLC, KRAS G12C)[2]



Standard models: [1]HPAF-II (PDAC, KRAS$^{G12D\ Amp/WT}$) n=7 per group; [2]LUN055 (NSCLC, KRAS$^{G12C\ Amp/WT}$) n=2-3 per group. [3]Resistant models: HPAF-II (PDAC, KRAS$^{G12D\ Amp/WT}$) with acquired resistance to RMC-7977 (RAS(ON) multi-selective tool compound) n=9 per group. Reduced sensitivity to daraxonrasib inhibition is a function of reactivation of downstream RAS signaling. LUN055 (NSCLC, KRAS$^{G12C\ Amp/WT}$) with acquired resistance to daraxonrasib n=3 per group. Resistance to daraxonrasib inhibition is a function of increase in KRAS G12C copy number. Daraxonrasib 25 mg/kg po qd; RM-055 10 mg/kg po qd. PDAC, pancreatic ductal adenocarcinoma; NSCLC, non-small cell lung cancer.


Deliver

Deliver | Building State-of-the-Art Organization and Capabilities to Enable Successful Commercialization

- Scaling the commercialization organization in preparation for daraxonrasib launch readiness
- Core capabilities established in the US and building underway in priority international regions
- Experienced leadership team with a strong track record of success in broad range of oncology builds and launches
- Deep cross-functional talent across medical affairs, market access, marketing, sales and enabling functions

Creating Industry-Leading Global Targeted Medicines Franchise for Patients with RAS-Addicted Cancers

Strong financial position
enables broad execution
across compelling opportunities
to serve unmet needs

$1.9 billion
in cash and investments as of March 31, 2026

+

$2.4 billion
in net proceeds from April 2026 financing
+ receipt of 2nd royalty tranche from
Royalty Pharma in May 2026

+

$1.5 billion
in additional committed capital (1)

Financial Guidance

$1.7 – $1.8 billion
2026 GAAP Operating Expenses (2)

(1) $2.0 billion in total flexible committed capital from agreement with Royalty Pharma, of which $250 million was received as of March 31, 2026, and $250 million was received in May 2026. (2) includes $260 to $280 million in expected non-cash stock-based compensation expense.

Tracking Expected Impact

Pancreatic Cancer Program

- ✓ Readout for **RASolute 302** (daraxonrasib) 2L registrational trial
  1H 2026
- ✓ Update on daraxonrasib 1L mono + combination data
  1H 2026
- ✓ Initiate **RASolute 305** (zoldonrasib + chemo combination) 1L registrational trial
  1H 2026
- Initiate **RASolute 309** (daraxonrasib + zoldonrasib doublet) 1L registrational trial
  2H 2026

Non-Small Cell Lung Cancer Program

- Initiate **RASolve 308** (zoldonrasib combination) 1L registrational trial
  1H 2026
- Share plans to advance daraxonrasib combination in 1L
  2026
- Update on elironrasib registrational strategy
  2026
- Substantially complete enrollment in **RASolve 301** (daraxonrasib) 2L+ registrational trial
  2026

Colorectal Cancer & RVMD-Led Collaborations

- Update on combination CRC data
  2026
- ✓ Initiate Phase 1 combination trial with PD-1/VEGF bispecific
  Q1 2026

Early-Stage Programs

- Identify candidate RP2D for **RMC-5127**
  2H 2026
- Initiate Phase 1 trial with **innovative new class** of RAS(ON) inhibitors
  Q4 2026

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1H, first half; 1L, first line; CRC, colorectal cancer; RP2D, recommended Phase 2 dose.

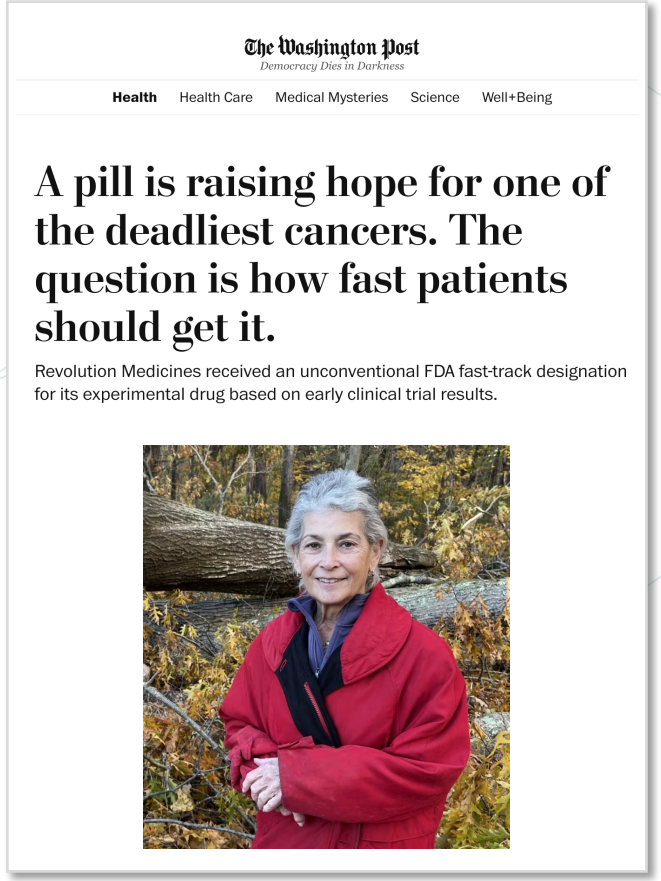
Our Why | Building on Strong Pillars for Growing Transformative Patient Impact

THE WALL STREET JOURNAL.

New Treatments Give Hope to Patients With One of the Deadliest Cancers

Half of all pancreatic-cancer patients live less than a year after diagnosis. But researchers say there is potential for change.

Published: February 28, 2025



The Washington Post
Democracy Dies in Darkness

Health Health Care Medical Mysteries Science Well+Being

A pill is raising hope for one of the deadliest cancers. The question is how fast patients should get it.

Revolution Medicines received an unconventional FDA fast-track designation for its experimental drug based on early clinical trial results.

Published: November 5, 2025

RAS-addicted cancers are among the **most common and difficult-to-treat** cancers in need of new targeted medicines

Extensive clinical evidence has shown that RAS(ON) inhibitors have the **potential to improve outcomes** and **change global standards of care** for patients living with such cancers

Compelling opportunities for further advancement through drug combinations and continuing **product innovation**

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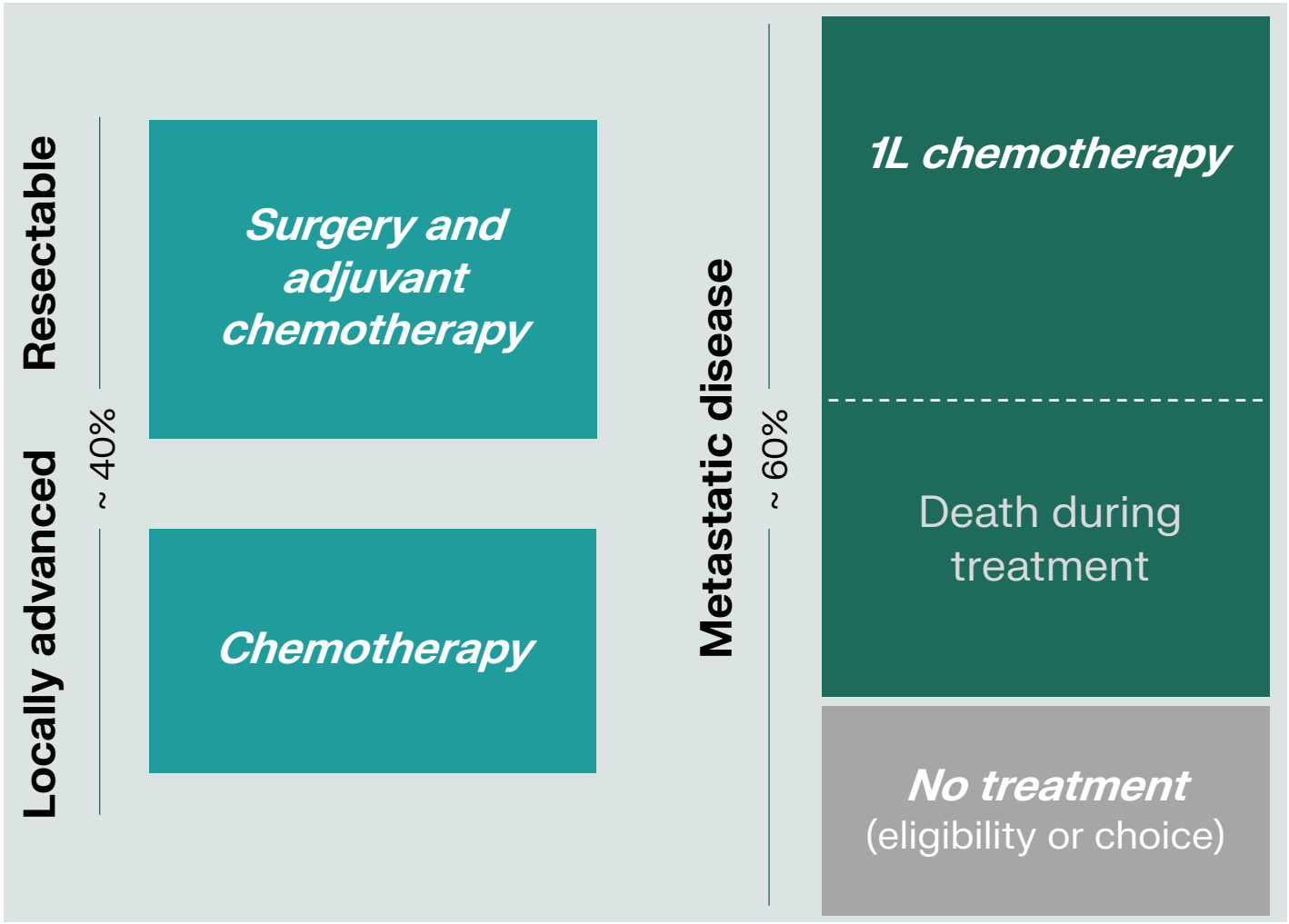
On Target to Outsmart Cancer®

Appendix

Reference Data Tables for Current Therapies Across PDAC, NSCLC and CRC

PDAC is an Aggressive Disease - Cytotoxic Chemotherapy is Global Standard of Care Across Lines of Therapy

56,000 new diagnoses annually (US)



Sources: https://pmc.ncbi.nlm.nih.gov/articles/PMC9618512/; mPDAC Treatment Rates Flatiron EMR Jan 1, 2014 – June 20, 2021, (N=11,410); CancerMPact® Patient Metrics, Oracle Life Sciences. Available from cancermpact.lsapps.oracle.com. Accessed 30 July 2025. PDAC, pancreatic ductal adenocarcinoma; 1L, first line; 2L, second

Adjuvant: High Unmet Need for Patients with Resectable PDAC

Resectable and borderline resectable disease accounts for **~15-25% of newly diagnosed patients with pancreatic cancer in the US.**[1,2]

While surgery with perioperative chemotherapy offers the possibility of a cure, ~80% advance to metastatic disease.[3]

5FU- and gemcitabine-based regimens are the most common perioperative treatments

Reported Efficacy

Study	Regimen	Treatment line	No. of patients	Median DFS (months)	3-year DFS (%)
PRODIGE 24[4]	**FOLFIRINOX**	Adjuvant	247	**21.6**	**39.7**
ESPAC-4[5]	**Gemcitabine + capecitabine**	Adjuvant	364	**13.9**	**20.9**

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(1) https://pmc.ncbi.nlm.nih.gov/articles/PMC9618512/. (2) mPDAC Treatment Rates Flatiron EMR Jan 1, 2014 – June 20, 2021, (N=11,410); CancerMPact® Patient Metrics, Oracle Life Sciences. Available from cancermpact.lsapps.oracle.com. (3) Cancers 2021, 13(18), 4724; https://doi.org/10.3390/cancers13184724. (4) PRODIGE 24, NEJM (2018) 379: 2395-2406. (5) ESPAC-4, Lancet (2017) 389: 1011-1024. PDAC, pancreatic ductal adenocarcinoma; DFS, disease-free survival. OS, overall survival.

1L PDAC: Significant Need for Improved Treatment(s)

Reported Efficacy and Safety

	Gemcitabine-based Gemcitabine/ nab-Paclitaxel	5FU-based mFOLFIRINOX or NALIRIFOX
Efficacy (1-7)		
ORR (%)*	23-43	32-42
DCR (%)	50-76	62-70
mPFS (mo)	5.5-7.1	6.4-8.0
mOS (mo)	8.5-11.7	11.1-11.7
Safety (4)		
G3+ TRAE Rate (%)	~70	~70
Dose Reduction due to TRAE (%)	~50	~50
Dose Discontinuation due to TRAE (%)	~25	~25

(1) PRODIGE4, NEJM (2011) 364: 1817-1825. (2) AVENGER 500, JCO (2024) 42:3692-3701. (3) NAPOLI-3, Lancet (2023) 402: 1272-1281. (4) MPACT, NEJM (2013) 369: 1691-1703. (5) HALO, JCO (2020) 38: 3185-3194. (6) RESOLVE, Ann Oncol (2021) 32: 600-608. (7) CanStem111P, eClinicalMedicine (2023) 58: 101897. * ORR range includes a mix of confirmed and unconfirmed responses.
PDAC, pancreatic ductal adenocarcinoma; ORR, objective response rate; DCR, disease control rate; mPFS, median progression-free survival; mOS, median overall survival; G3+, Grade 3 +; TRAE, treatment-related adverse event; 5-FU, 5-fluorouracil.

2L+ PDAC: Significant Need for Improved Treatment(s)

Reported Efficacy

Study	Regimen	Treatment line	No. of patients	ORR (%)	Median PFS (months)	Median OS (months)
NAPOLI 1[1]	**5-FU+LV+Nal-IRI**	2L+	117	8	**3.1**	**6.1**
SWOG S1513[2]	**FOLFIRI**	2L	58	10	**2.9**	**6.5**
SWOG S1115[3]	**FOLFOX**	2L	62	7	**2.0**	**6.7**
SEQUOIA[4]	**FOLFOX**	2L	284	6	**2.1**	**6.3**
QUILT-3.010[5]	**Gemcitabine + nab-paclitaxel**	2L	40	3	**2.7**	**6.6**
Trybeca-1[6]	**Gemcitabine + nab-paclitaxel**	2L	148	NA	**3.5**	**6.9**
GEMPAX[7]	**Gemcitabine + paclitaxel**	2L	140	17	**3.1**	**6.4**
Gupta et al.[8]	**5-FU+LV+Nal-IRI**	3L+	30	3	**1.9**	**5.0**
Enzler et al.[9]	**CBP501+cisplatin+nivolumab**	3L+	36	6	**1.9**	**5.1**

Reported Safety and Dose Modifications

- 5-FU/LV/Nal-IRI dose interruptions required in 62% of patients, dose reductions in 33%, and discontinuations in 11%[1]
- Gemcitabine + nab-paclitaxel dose modifications required in 63%[6]

(1) Onivyde USPI; (2) Chiorean EG, et al. Clin Cancer Res 2021:27:6314–33; (3) Chung V, et al. JAMA Oncol 2017;3:516–22; (4) Hecht JR, et al. J Clin Oncol 2021;39:1108–18; (5) Huffman BM, et al. JAMA Network Open 2023;6:e2249720. (6) Hammel P, et al. ASCO GI 2022; (7) Fouchardiere C, et al. J Clin Oncol 2024;42:1055-1066; (8) Gupta A, et al. Frontiers Oncol 2023: 13:1250136; (9) Enzler T, et al. Eur J Cancer 2024: 113950, means of median PFS and median OS from four experimental regimens provided

PDAC, pancreatic ductal adenocarcinoma; ORR, objective response rate; PFS, progression-free survival; OS, overall survival; NA, not available.

2L+ NSCLC: Significant Need for Improved Treatment(s)

Reported Efficacy

Study	Timing relative to CPI approval in 1L	Treatment arm	No. of patients	ORR (%)	Median PFS (months)	Median OS (months)
REVEL[1]	prior	Docetaxel, 2L+	625	14%	3.0	9.1
CheckMate 057[2]	prior	Docetaxel, 2L+	290	12%	4.2	9.4
OAK[3]	prior	Docetaxel, 2L+	425	13%	4.0	9.6
POPLAR[4]	prior	Docetaxel, 2L+	143	14.7%	3.0	9.7
CodeBreak 200[5]	after	Docetaxel, 2L+	174	13.2%	4.5	11.3
TROPION-Lung-01[6]	after	Docetaxel, 2L+	305	13%	3.7	11.8
KRYSTAL-12[7]	after	Docetaxel, 2L+	152	9.2%	3.8	NA
CodeBreak 200[5]	after	Sotorasib, 2L+	171	28%	5.6	10.6
KRYSTAL-12[7]	after	Adagrasib, 2L+	301	32%	5.5	NA

(1) Garon EB, et al. Lancet 2014;384:665-673. (2) Borghaei H, et al. N Engl J Med 2015; 373:1627-1639. (3) Rittmeyer A, et al. Lancet 2017;389:255-265. (4) Fehrenbacher L, et al. Lancet 2016;387:1837-1846. (5) de Langen AJ, et al. Lancet 2023;401:733-746. (6) Ahn MJ, J Clin Oncol. 2024 Sep 9:JCO2401544. doi: 10.1200/JCO-24-01544. (7) Mok TS, J Clin Oncol. 2024;42(17_suppl):LBA8509.
NSCLC, non-small cell lung cancer; CPI, check point inhibitor; 2L, second line; ORR, objective response rate; PFS, progression-free survival; OS, overall survival.

Later Line CRC: Significant Need for Improved Treatment(s)

Reported Efficacy

Study	Regimen	Treatment line	No. of patients	ORR (%)	DCR (%)	Median PFS (months)	Median OS (months)
RECOURSE[1]	**Trifluridine/tipiracil**	3L+	534	2%	44%	2.0 (1.9–2.1)	7.1 (6.5–7.8)
SUNLIGHT[2]	**Trifluridine/tipiracil + Bevacizumab**	3L	246	6%	77%	5.6 (4.5–5.9)	10.8 (9.4–11.8)
CORRECT[3]	**Regorafenib**	2L+	505	1%	41%	2.0 (1.9–2.3)	6.4 (5.8–7.3)

(1) Mayer R, et al. N Engl J Med 2015;372:1909-19; Lonsurf USPI. (2) Prager GW, et al. N Engl J Med 2023;388:1657-67; Lonsurf USPI. (3) Grothey A, et al. Lancet 2013;381:303–12; STIVARGA USPI.
CRC, colorectal cancer; ORR, objective response rate; DCR, disease control rate; PFS, progression-free survival; OS, overall survival; 3L, third line; 2L, second line.

Daraxonrasib

RAS(ON) Multi-Selective Inhibitor

Active against:

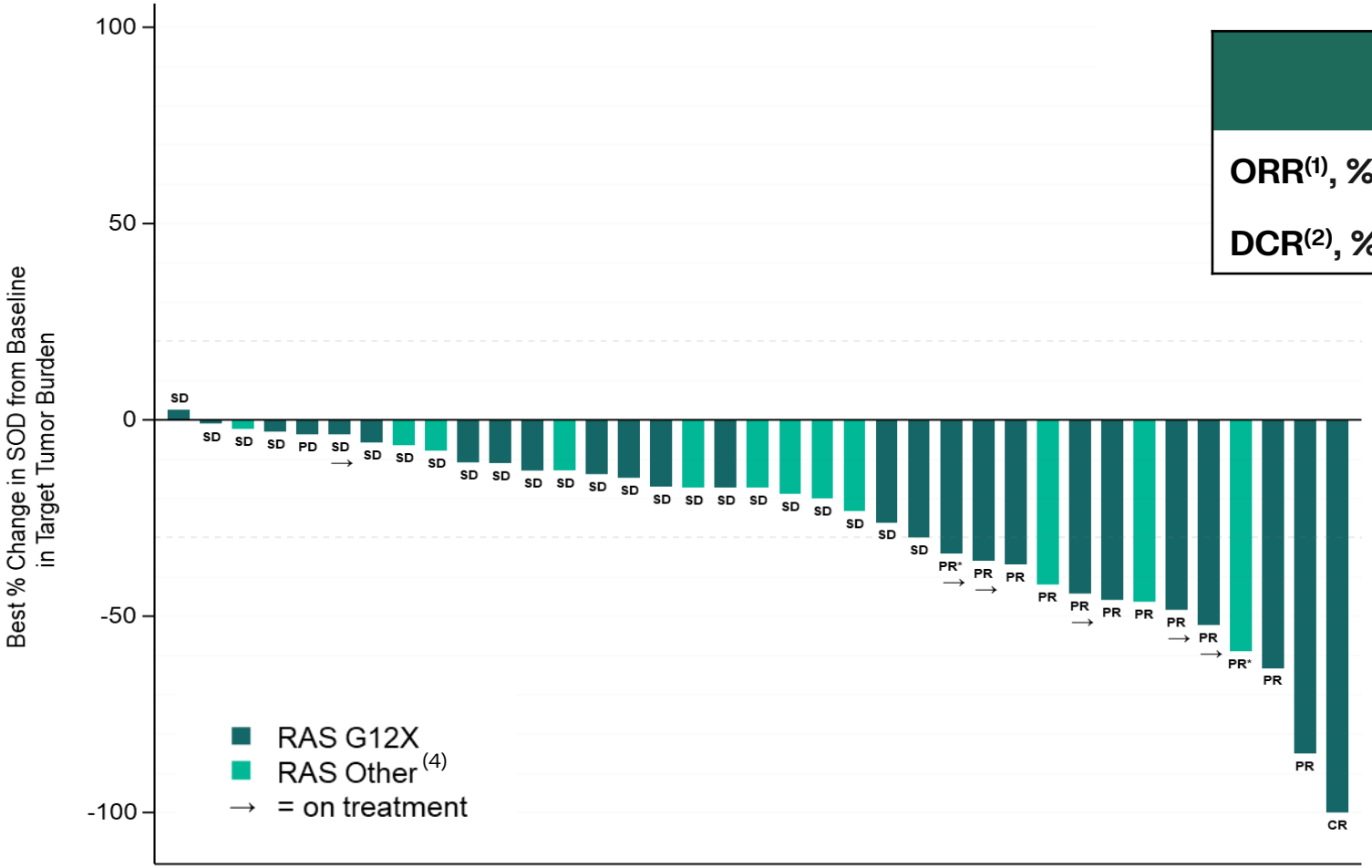
- Diverse RAS driver mutations
- Multiple drug resistance mechanisms, including secondary RAS mutations and wild-type RAS

FDA granted:

- Commissioner's National Priority Voucher
- Orphan Drug Designation
- Breakthrough Therapy Designation

Daraxonrasib Clinical Data

2L PDAC: Daraxonrasib (300 mg) Demonstrated Compelling Clinical Activity in Patients with RAS Mutations in Phase 1 Trial



	RAS G12X N=26	RAS Mutant(4) N=38(3)
ORR(1), % (n)	35% (9)	29% (11)
DCR(2), % (n)	92% (24)	95% (36)

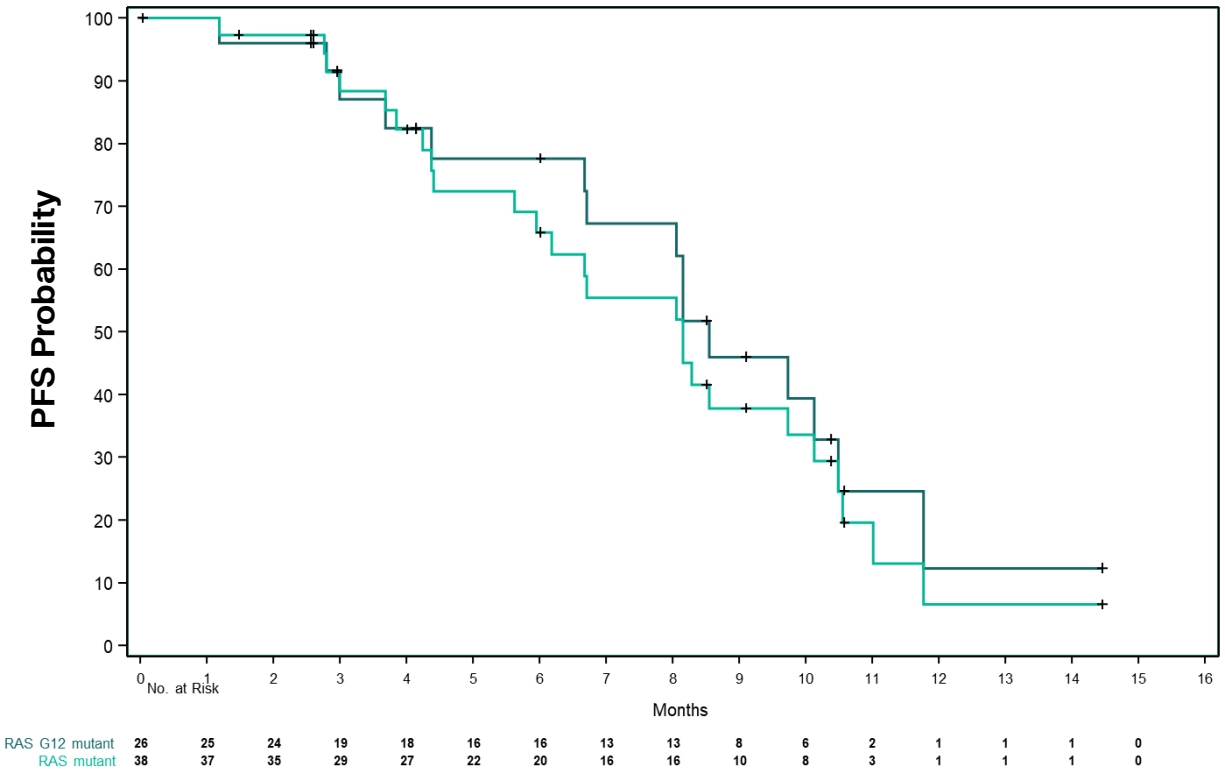
Median follow-up, months (range): 16.7 (10.3, 24.6) and 17.4 (10.3, 24.6) for RAS G12X and RAS Mutant, respectively. Median duration of response (95% confidence interval) is 8.2 months (3.8, NE) and 8.2 months (3.8, 8.8), respectively. (1) Objective response rate (ORR) (per RECIST v 1.1) includes complete (CR) and partial responses (PR) that were confirmed or still had the potential to confirm. (2) Disease control rate (DCR) includes CR, PR and stable disease (SD). (3) One patient included in the denominator for ORR and DCR calculations is not displayed on waterfall and treated as a non-responder for purposes of the ORR and DCR calculations due to lack of post-baseline target lesion assessment. (4) RAS Mutant or RAS Other defined as patients with G12X, G13X or Q61X PDAC.
2L, second line; PDAC, pancreatic ductal adenocarcinoma; PR*, unconfirmed partial response; RECIST, response evaluation criteria in solid tumors.

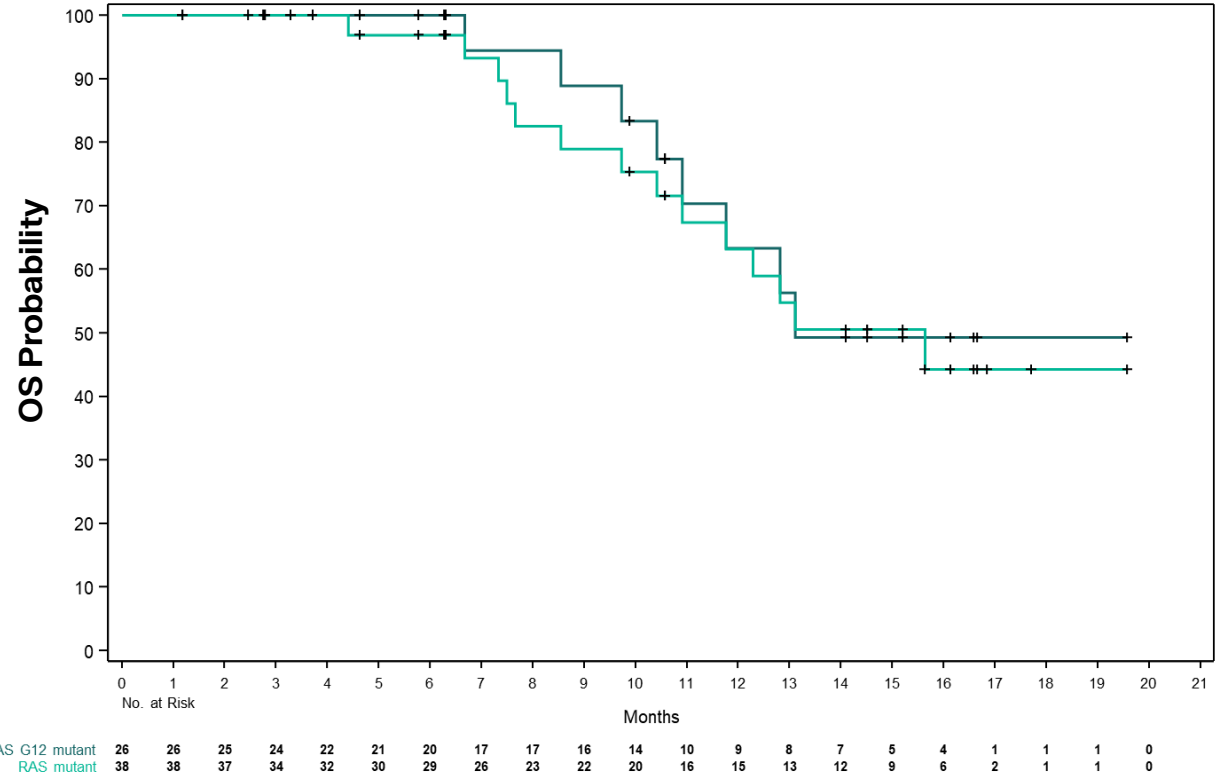
Data cutoff: June 30, 2025

2L PDAC: Daraxonrasib (300 mg) Demonstrated Encouraging Progression-Free Survival and Overall Survival in Phase 1 Trial

	Median PFS, Months (95% CI)
RAS G12X	8.5 (6.7, 10.5)
RAS Mutant	8.1 (5.9, 10.1)

	Median OS, Months (95% CI)
RAS G12X	13.1 (10.9, NE)
RAS Mutant	15.6 (10.9, NE)





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Median follow-up, months (range): 16.7 (10.3, 24.6) and 17.4 (10.3, 24.6) for RAS G12X and RAS Mutant, respectively. 2L, second line; PDAC, pancreatic ductal adenocarcinoma; PFS, progression-free survival; OS, overall survival; CI, confidence interval; NE, not estimable.

Data cutoff: June 30, 2025

2L+ PDAC: Daraxonrasib at 300 mg Daily Generally Well Tolerated in Phase 1 Trial

	N=83	
	Any Grade	**Grade ≥3**
Patients with Any TRAE, N (%)	80 (96%)	28 (34%)
TRAEs occurring in ≥15% of patients, N (%)		
Rash*	75 (90%)	6 (7%)
Stomatitis/mucositis*	45 (54%)	3 (4%)
Diarrhea	43 (52%)	3 (4%)
Nausea	32 (39%)	0
Vomiting	30 (36%)	0
Paronychia	15 (18%)	0
Fatigue	14 (17%)	1 (1%)
Other select TRAEs, N (%)		
Platelet count decreased	8 (10%)	3 (4%)
AST increased	8 (10%)	3 (4%)
Anemia	7 (8%)	6 (7%)
ALT increased	6 (7%)	2 (2%)
Neutrophil count decreased	5 (6%)	3 (4%)

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*Bundled term comprising multiple MedDRA preferred terms (PTs).
2L+. second line and beyond; PDAC, pancreatic ductal adenocarcinoma; TRAE, treatment-related adverse event; ALT, alanine transaminase.; AST, aspartate transaminase.

Data cutoff: June 30, 2025

2L+ PDAC: Acceptable Dose Modification and Dose Intensity Achieved in Patients Receiving Daraxonrasib at 300 mg Daily in Phase 1 Trial

	N=83
Patients with dose modification due to TRAEs, N (%)	40 (48%)
Dose interruption	36 (43%)
Dose reduction	25 (30%)
Patients with dose discontinuation due to TRAEs, N (%)	0
Mean dose intensity	86%

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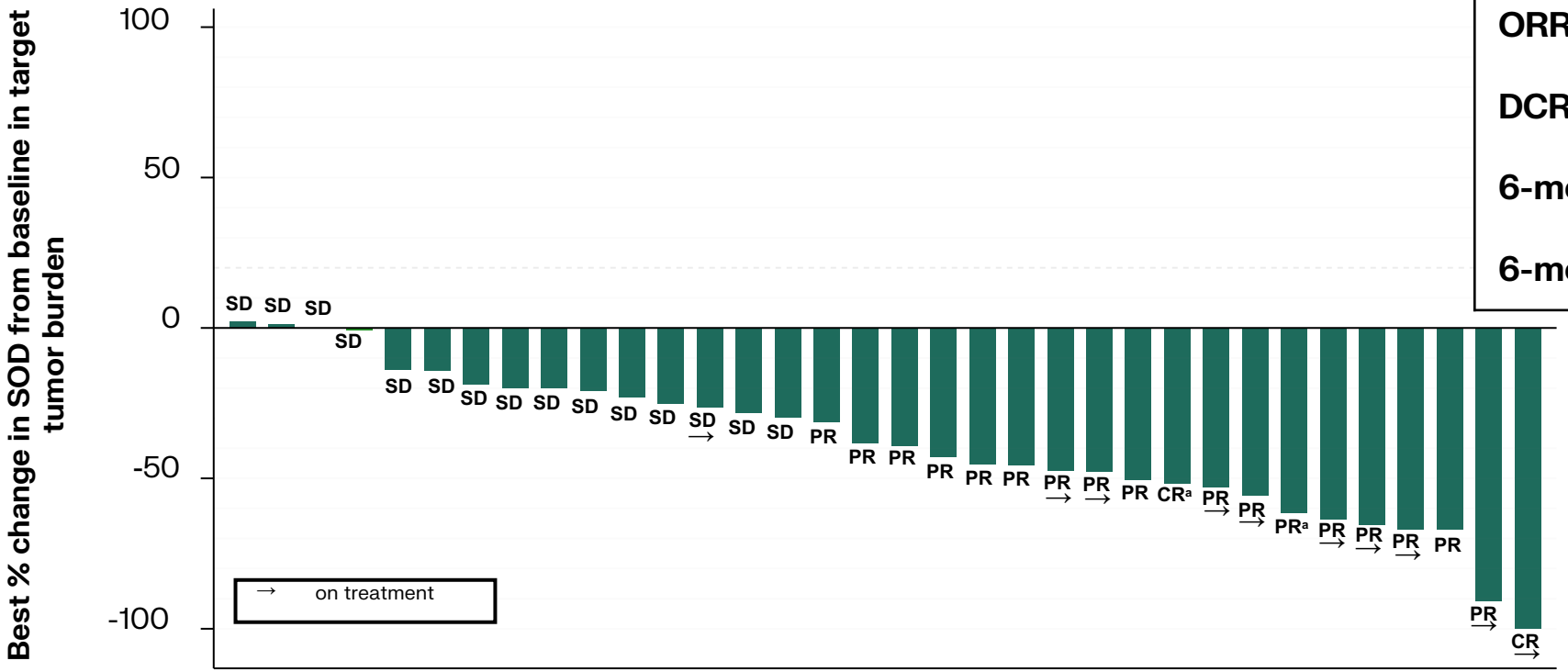
2L+, second line and beyond; PDAC, pancreatic ductal adenocarcinoma; TRAE, treatment-related adverse event.

Data cutoff: June 30, 2025

1L PDAC: Daraxonrasib (300 mg) Monotherapy Demonstrated Promising Initial Antitumor Activity in Patients with RAS Mutations



	All RAS (n=38)[b]
ORR[c], % (95% CI)	47 (31, 64)
DCR[d], % (95% CI)	92 (79, 98)
6-month PFS[e], % (95% CI)	71 (53, 83)
6-months OS[e], % (95% CI)	83 (67, 92)

Median follow-up, months (range): 13 (9–16)

[a]Unconfirmed responses. Unconfirmed CR was reclassified to unconfirmed PR due to data entry error. [b]Two patients who were included in the safety analysis were excluded from the efficacy analysis because they did not meet the definition of mPDAC: one patient had locally advanced disease and the other had a synchronous neuroendocrine tumor. [c]Includes confirmed CR and PR; four patients were included in the denominator of ORR but not displayed on the waterfall plot due to lack of adequate baseline/post-baseline tumor assessments. [d]DCR includes CR, PR and SD. [e]Estimate based on Kaplan-Meier method. PFS and OS data remain immature.

CI, confidence interval; CR, complete response; DCR, disease control rate; mPDAC, metastatic pancreatic adenocarcinoma; ORR, objective response rate; OS, overall survival; PFS, progression-free survival; PR, partial response; RAS, rat sarcoma; SD, stable disease; SOD, sum of diameters.

Data cutoff: Dec 1, 2025

1L PDAC: Daraxonrasib (300 mg) Monotherapy Generally Well Tolerated

n (%)	All RAS (n=40)	
	Any grade	Grade ≥3
Patients with any TRAE	38 (95)	15 (38)
Patients with serious TRAE	4 (10)	3 (8)
TRAEs occurring in ≥15% of patients		
Rash[a]	35 (88)	4 (10)
Diarrhea	25 (63)	4 (10)
Stomatitis	25 (63)	4 (10)
Nausea	21 (53)	1 (3)
Vomiting	20 (50)	2 (5)
Fatigue	14 (35)	1 (3)
Paronychia	8 (20)	0
Decreased appetite	7 (18)	0
Constipation	6 (15)	0

[a]Bundled term comprising multiple MedDRA preferred terms: dermatitis acneiform, dermatitis atopic, erythema, rash, rash maculo-papular, rash pustular.
Two treatment-naïve patients are included in this safety analysis but are excluded from the waterfall and ORR/DCR analysis because they do not meet the definition of 1L metastatic PDAC: one patient had locally advanced disease and the other had a synchronous neuroendocrine tumor. 1L, first line; PDAC, pancreatic ductal adenocarcinoma; TRAE, treatment-related adverse event.

Revolution Medicines

Data cutoff: Dec 1, 2025

1L PDAC: Daraxonrasib (300 mg) Monotherapy Demonstrated Acceptable Rate of Dose Modification and Favorable Dose Intensity

	All RAS (n=40)
Patients with dose modification due to TRAEs, n (%)	28 (70)
Dose interruption	24 (60)
Dose reduction	16 (40)
Patients with dose discontinuation due to TRAEs, n (%)	1 (3)[a]
Mean dose intensity, %	84
Median dose intensity, %	88

[a]An incidental Grade 1 bilateral renal artery dissection, assessed as possibly related to daraxonrasib, was identified on tumor assessment imaging; treatment was held, and given the ongoing nature of the finding, daraxonrasib was discontinued.
1L, first line; PDAC, pancreatic ductal adenocarcinoma; TRAE, treatment-related adverse event.

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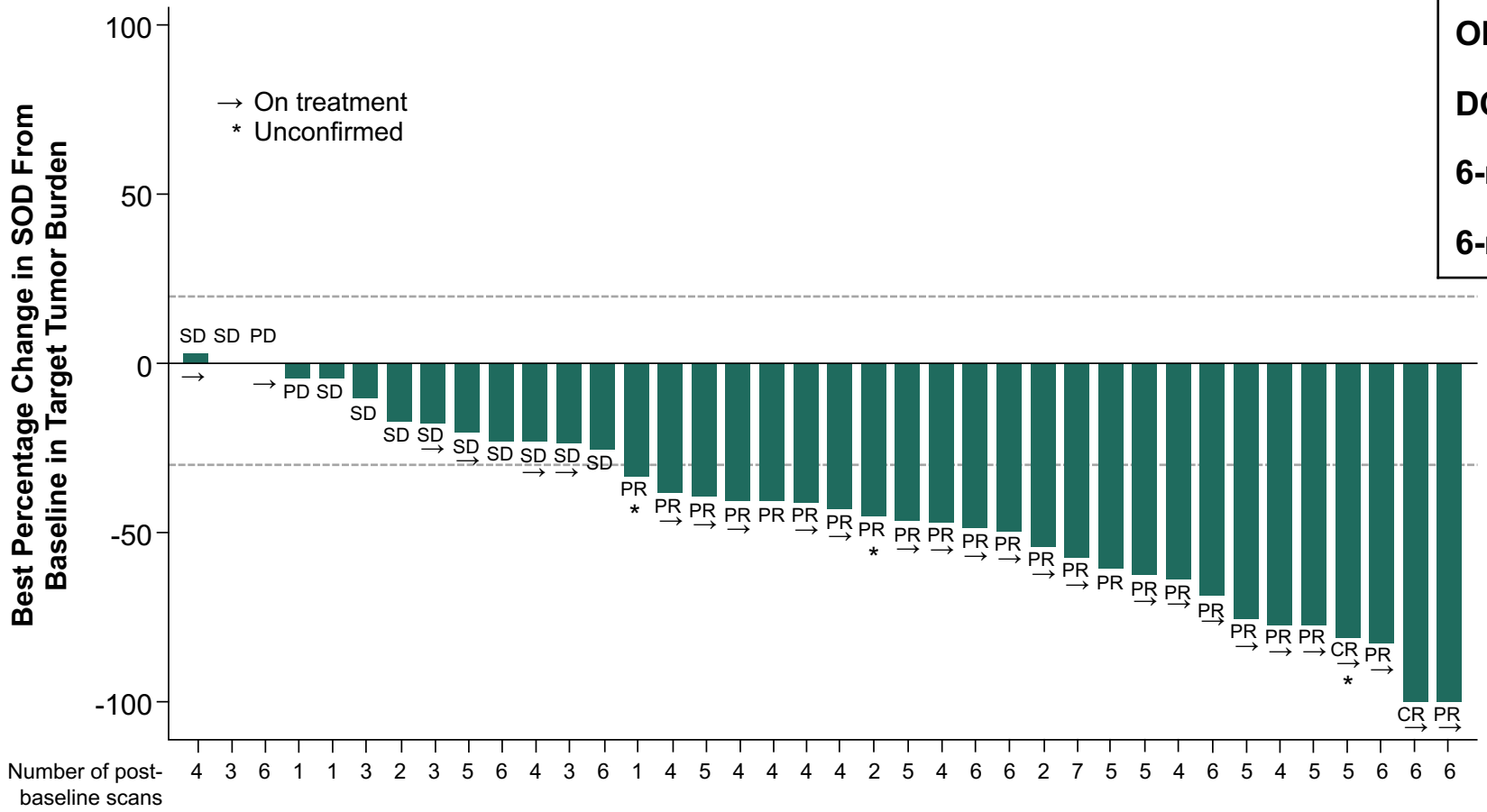
Data cutoff: Dec 1, 2025

1L PDAC: Daraxonrasib + GnP Demonstrated Encouraging Initial Antitumor Activity in Patients with RAS Mutations

	All treated (n=40)[a]
ORR[b], % (95% CI)	58 (41, 73)
DCR[c], % (95% CI)	90 (76, 97)
6-month PFS[d], % (95% CI)	84 (68, 93)
6-month OS[d], % (95% CI)	90 (76, 96)



Median follow-up, months (range): 9.7 (5.7–13.8). [a]All treated patients received an initial dose of 200 mg QD of daraxonrasib and GnP every 2 weeks and had at least 18 weeks of follow up prior to data cutoff date. [b]Objective response rate (ORR) (per RECIST v 1.1) includes complete (CR) and partial responses that were confirmed (PR). [c]Disease control rate (DCR) includes CR, PR and stable disease (SD). Two patients were included in the denominator of ORR but not displayed on the waterfall plot due to lack of adequate baseline/post-baseline assessments. [d]Estimate based on Kaplan-Meier method. PFS and OS data remain immature. 1L, first line; PDAC, pancreatic ductal adenocarcinoma; GnP, gemcitabine nab-paclitaxel; QD, once daily; Q2W, once every two weeks; PR*, unconfirmed partial response; RECIST, response evaluation criteria in solid tumors.

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Data cutoff: Dec 1, 2025

1L PDAC: Daraxonrasib + GnP Demonstrated Acceptable Safety/Tolerability

	All treated patients (n=40)	
	Any grade	**Grade ≥3**
TRAEs (any drug), n (%)	40 (100)	29 (73)
Serious TRAEs, n (%)	11 (28)	10 (25)
TRAEs occurring in ≥30% of patients, n (%)		
Rash[a]	36 (90)	6 (15)
Diarrhea	30 (75)	6 (15)
Fatigue	28 (70)	7 (18)
Nausea	27 (68)	2 (5)
Vomiting	22 (55)	0
Anemia	20 (50)	13 (33)
Stomatitis/mucositis[b]	18 (45)	4 (10)
Edema peripheral	17 (43)	0
Neutrophil count decreased	17 (43)	8 (20)
Peripheral neuropathy	15 (38)	0
Platelet count decreased	15 (38)	3 (8)
Alopecia	13 (33)	0
AST increased	12 (30)	1 (3)

Median (range) treatment duration is 8.2 (0.5-13.5) months. [a]Rash comprising multiple MedDRA preferred terms: catheter site rash, dermatitis, dermatitis acneiform, erythema, eyelid rash, rash, rash erythematous, rash macular, rash maculo-papular, and rash pustular. [b]Stomatitis/mucositis comprising multiple MedDRA preferred terms: mucosal inflammation and stomatitis.
1L, first line; PDAC, pancreatic ductal adenocarcinoma; GnP, gemcitabine nab-paclitaxel; TRAE, treatment-related adverse event; ALT, alanine transaminase; AST, aspartate transferase.

Data cutoff: Dec 1, 2025

1L PDAC: Daraxonrasib + GnP Demonstrated Acceptable Rate of Dose Modification and Favorable Dose Intensity for Daraxonrasib

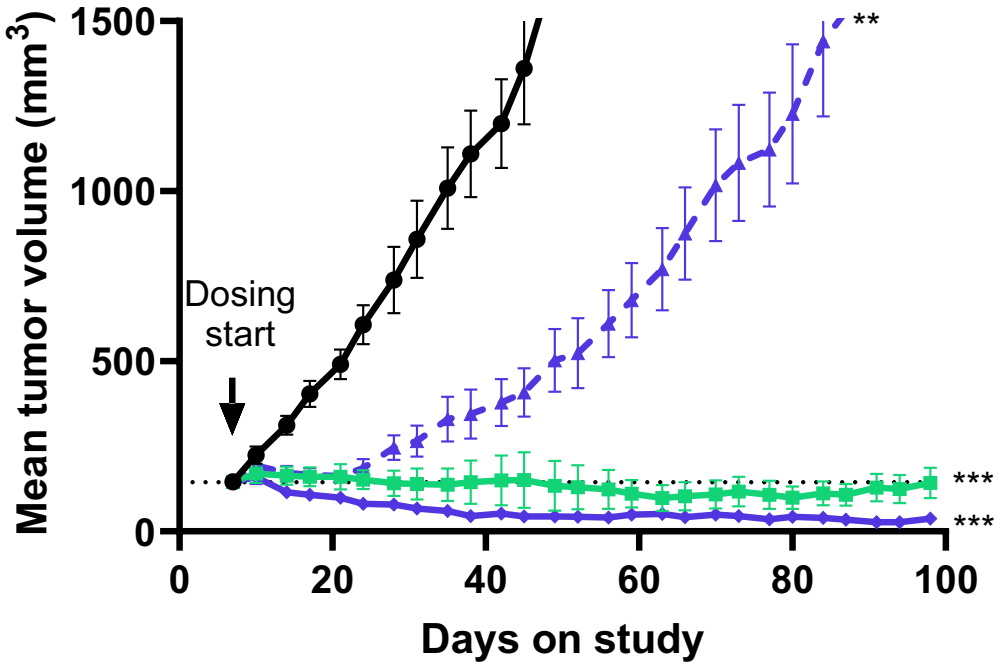
	All treated patients (n=40)	
	Daraxonrasib	**GnP**
Patients with dose modification due to TRAEs, n (%)	24 (60)	30 (75)
Dose interruption	24 (60)	21 (53)
Dose reduction	14 (35)	23 (58)
Patients with dose discontinuation due to TRAEs, n (%)	2 (5)[a]	6 (15)
Mean dose intensity, %	82	80
Median dose intensity, %	87	81

Median (range) treatment duration is 8.2 (0.5-13.5) months.
[a]TRAEs that led to daraxonrasib dose discontinuation included Grade 3 acute pancreatitis in one patient and Grade 3 nausea and Grade 2 vomiting in one patient.
1L, first line; PDAC, pancreatic ductal adenocarcinoma; GnP, gemcitabine nab-paclitaxel; TRAE, treatment-related adverse event.

Data cutoff: Dec 1, 2025

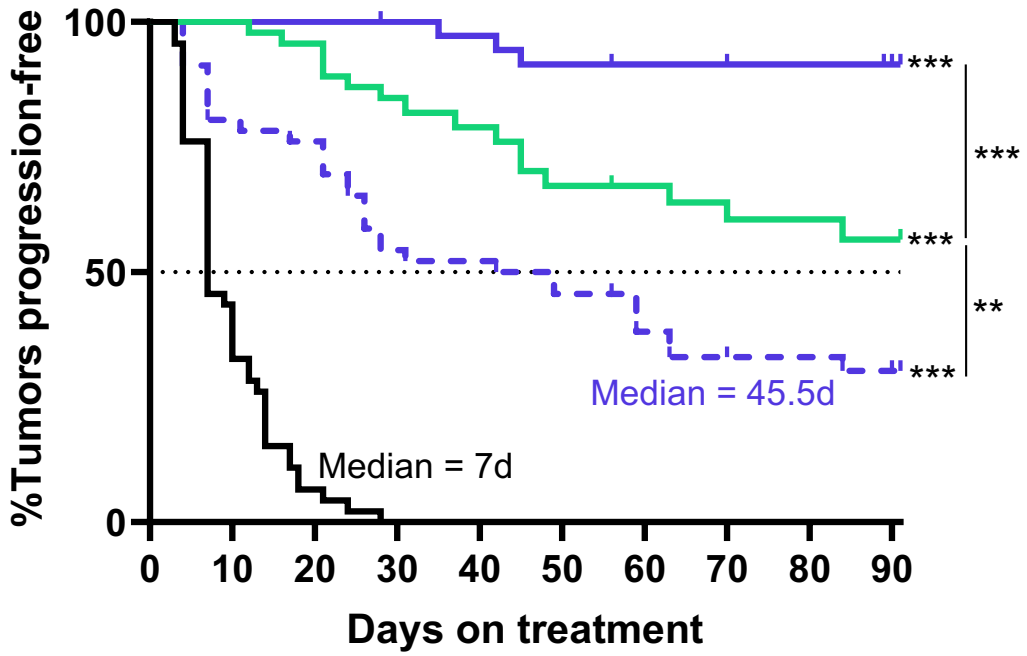
Daraxonrasib Combination with GnP Demonstrated Improved Depth and Durability of Responses in Preclinical Models of PDAC

Capan-1 (PDAC, *KRAS G12V / G12V*)



**p< 0.01
***p<0.001, 2-way repeated measures ANOVA

10 PDAC Xenograft Models[1]



(1) 7 KRASG12X, 3 KRASWT PDAC xenograft models, n=46 per group
Progression defined as tumor doubling from baseline
** Adjusted p<0.01 *** Adjusted p<0.001 by Log-rank test

Control
GnP
Daraxonrasib 25 mg/kg po qd
Daraxonrasib + GnP

25 mg/kg translates to a clinical dose range of approximately 200-300 mg. Dose used in GnP arms translates to clinical dose of GnP, gemcitabine 50 mg/kg ip q3d + nab-paclitaxel 250 mg/kg iv qw; PDAC, pancreatic ductal adenocarcinoma.

Highly Active Regimens of Daraxonrasib and GnP to be Deployed in Combination Arm of RASolute 303 Phase 3 1L PDAC Trial

Treatment	Target Ranges	RASolute 303 Combination Arm	Rationale for Selection
Daraxonrasib	**Dose:** 160–300 mg **Schedule:** QD	**Dose:** 200 mg **Schedule:** QD	• Highly active and generally well tolerated in 2L PDAC • Optimize risk/benefit in combination with GnP
GnP (Gemcitabine nab-Paclitaxel)	**Dose:** G – 1000 mg/m^2 nP – 125 mg/m^2 **Schedule (28-day):**[1, 2] Days 1, 15 or Days 1, 8, 15	**Dose:** G – 1000 mg/m^2 nP – 125 mg/m^2 **Schedule (28-day):** Days 1, 15	• Schedules commonly used with comparable outcomes • D1, 15 shows less severe bone marrow toxicity and neurotoxicity

Objectives for Combination Arm

Continuous suppression of RAS signaling | Additive antitumor mechanisms | Safety and tolerability

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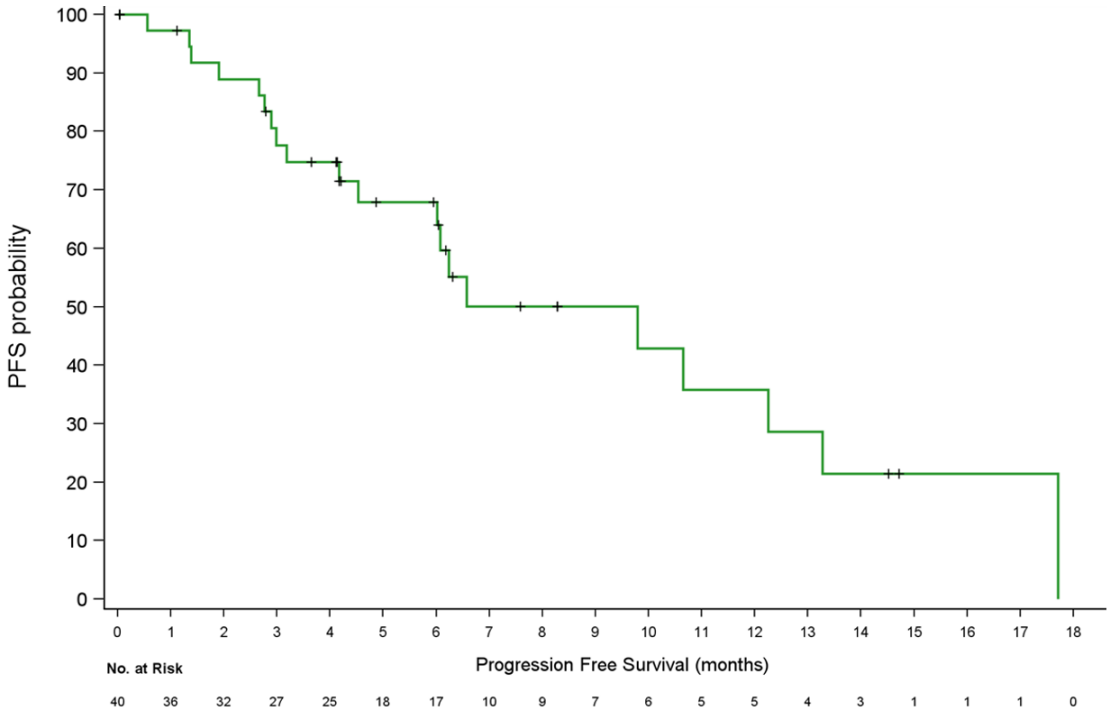
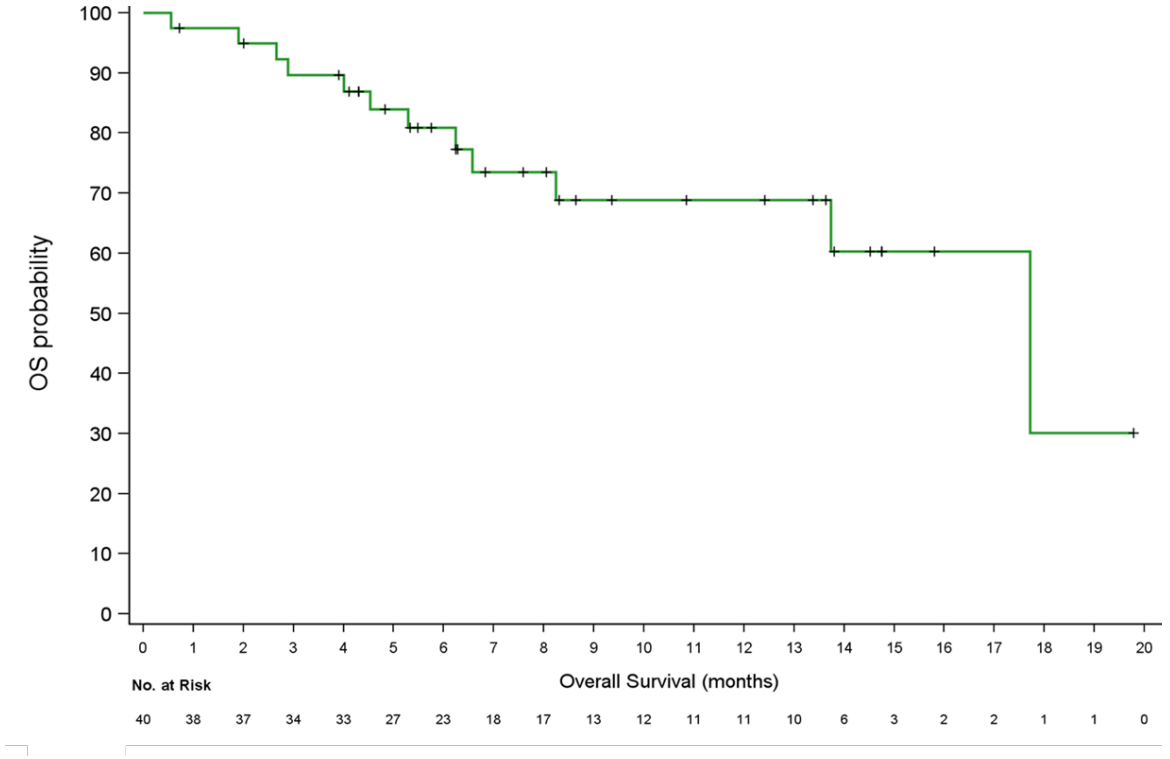
(1) J Gastrointest Oncol (2016) 7:469-478. (2) Ther Adv Med Oncol (2017) 9: 75-82. GnP, gemcitabine nab-paclitaxel; 1L, first line; PDAC, pancreatic ductal adenocarcinoma; QD, once daily; 2L second line.

2L/3L NSCLC: Encouraging Durability in Patients with RAS G12 Mutations Treated with Daraxonrasib at 120-220 mg Daily

Median PFS, Months (95% CI)
9.8 (6, 12.3)



Median OS, Months (95% CI)
17.7 (13.7, NE)



Median follow-up is 10.8 months. RMC-6236-001: 2L/3L patients with RAS G12X NSCLC treated with daraxonrasib at 120-220 mg daily. Population includes patients with RAS G12X mutant NSCLC who have received 1 or 2 prior lines of therapy which must include prior immunotherapy and platinum chemotherapy administered either concurrently or sequentially, and have not received docetaxel previously. Adjuvant therapy or multimodal therapy with curative intent is considered prior therapy if disease progression occurred or treatment completion was within 6 months of first dose of daraxonrasib. 2L, second line; 3L, third line; NSCLC, non-small cell lung cancer; PFS, progression-free survival; OS, overall survival; CI, confidence interval; NE, not estimable.

Data cutoff: Sep 30, 2024

2L/3L NSCLC: Daraxonrasib Generally Well Tolerated in Patients Treated at 120-220 mg Daily

	120-300 mg (N=124)		120-220 mg (N=73)		300 mg (N=51)	
	Any Grade	**Grade ≥3**	**Any Grade**	**Grade ≥3**	**Any Grade**	**Grade ≥3**
Any TRAE	121 (98%)	33 (27%)	71 (97%)	12 (16%)	50 (98%)	21 (41%)
TRAEs in ≥ 10% of patients, n (%)						
Rash[1]	110 (89%)	9 (7%)	66 (90%)	5 (7%)	44 (86%)	4 (8%)
Diarrhea	87 (70%)	10 (8%)	46 (63%)	1 (1%)	41 (80%)	9 (18%)
Nausea	68 (55%)	0 (0%)	36 (49%)	0 (0%)	32 (63%)	0 (0%)
Vomiting	55 (44%)	3 (2%)	29 (40%)	2 (3%)	26 (51%)	1 (2%)
Stomatitis	47 (38%)	3 (2%)	25 (34%)	0 (0%)	22 (43%)	3 (6%)
Paronychia	26 (21%)	0 (0%)	14 (19%)	0 (0%)	12 (24%)	0 (0%)
Fatigue	20 (16%)	0 (0%)	8 (11%)	0 (0%)	12 (24%)	0 (0%)
Dry skin	19 (15%)	0 (0%)	9 (12%)	0 (0%)	10 (20%)	0 (0%)
AST increased	17 (14%)	2 (2%)	11 (15%)	0 (0%)	6 (12%)	2 (4%)
ALT increased	15 (12%)	3 (2%)	10 (14%)	0 (0%)	5 (10%)	3 (6%)
Decreased appetite	14 (11%)	0 (0%)	4 (6%)	0 (0%)	10 (20%)	0 (0%)
Dysgeusia	12 (10%)	0 (0%)	3 (4%)	0 (0%)	9 (18%)	0 (0%)
Other select TRAEs, n (%)						
Anemia	9 (7%)	3 (2%)	4 (6%)	2 (3%)	5 (10%)	1 (2%)

- One Grade 4 pneumonitis (possibly related) observed at 300 mg dose level in patient with concomitant pneumocystis pneumonia
- No other Grade 4 TRAEs. No Grade 5 TRAEs

(1) Includes preferred terms of rash pustular, Rash papular, Rash maculopapular, Rash macular, Rash, Erythema, Dermatitis acneiform. Multiple types of rash may have occurred in the same patient.
TRAE, treatment-related adverse event; NSCLC, non-small cell lung cancer; ALT, alanine transaminase; AST, aspartate transferase.

Data cutoff: Sept 30, 2024

2L/3L NSCLC: Daraxonrasib Favorable Dose Intensity Maintained at 120-220 mg

	120-300 mg (N=124)	120-220 mg (N=73)	300 mg (N=51)
TRAEs leading to dose modification, n (%)	64 (52%)	30 (41%)	34 (67%)
Dose interruption	59 (48%)	25 (34%)	34 (67%)
Dose reduction	34 (27%)	15 (21%)	19 (37%)
TRAEs leading to dose discontinuation, n (%)	7 (6%)	3 (4%)	4 (8%)
TRAEs leading to dose reductions in ≥ 10% patients			
Diarrhea	12 (10%)	4 (6%)	8 (16%)
Rash[1]	13 (11%)	6 (8%)	7 (14%)
Mucositis/stomatitis	6 (5%)	1 (1%)	5 (10%)
Mean dose intensity[2]	86%	91%	78%

- For the 120-220 mg cohort, median treatment duration was 5.5 months
- Median cumulative duration of dose interruption was 8.5 days

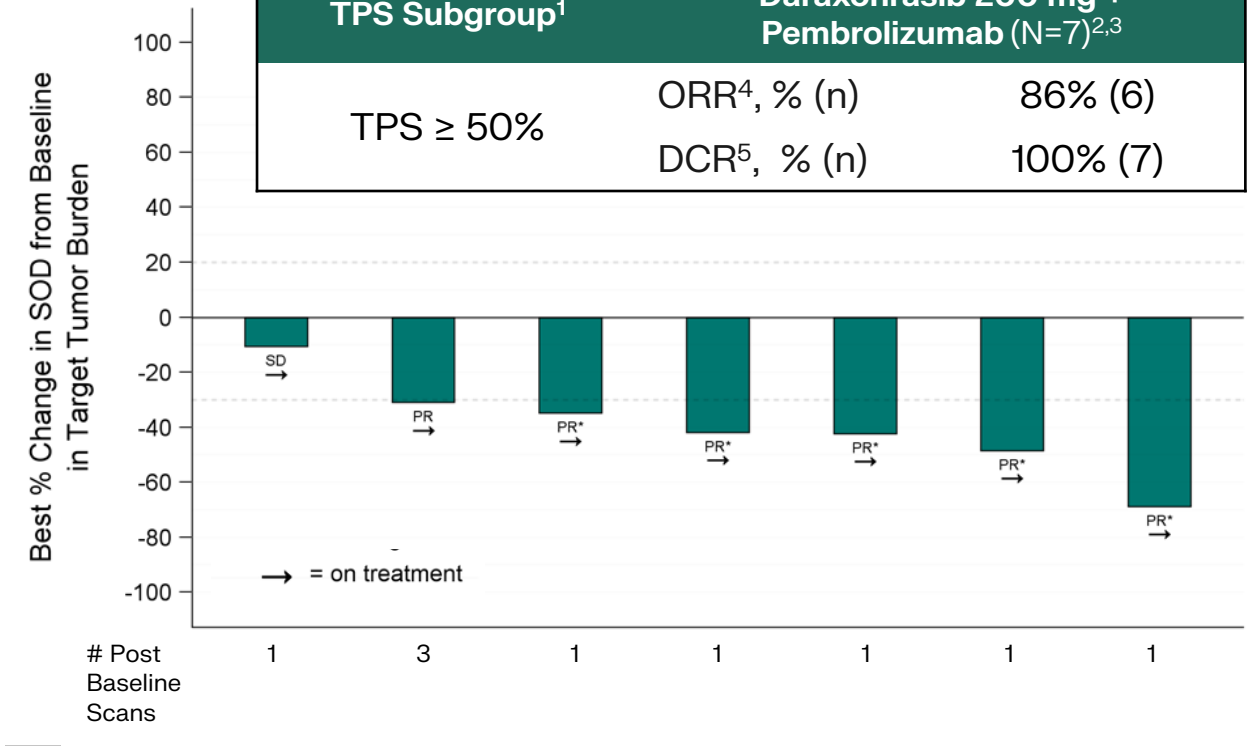
Revolution Medicines

(1) Includes preferred terms of Rash pustular, Rash maculopapular, Rash, Dermatitis acneiform. Multiple types of rash may have occurred in the same patient. (2) Mean dose intensity figures were updated on March 14, 2025 to correct for a programming error. Previously, the mean dose intensity was represented as 81% at the 120-300 mg dose range, 88% at the 120-220 mg dose range and 72% at the 300 mg dose. NSCLC, non-small cell lung cancer; TRAE, treatment-related adverse event.

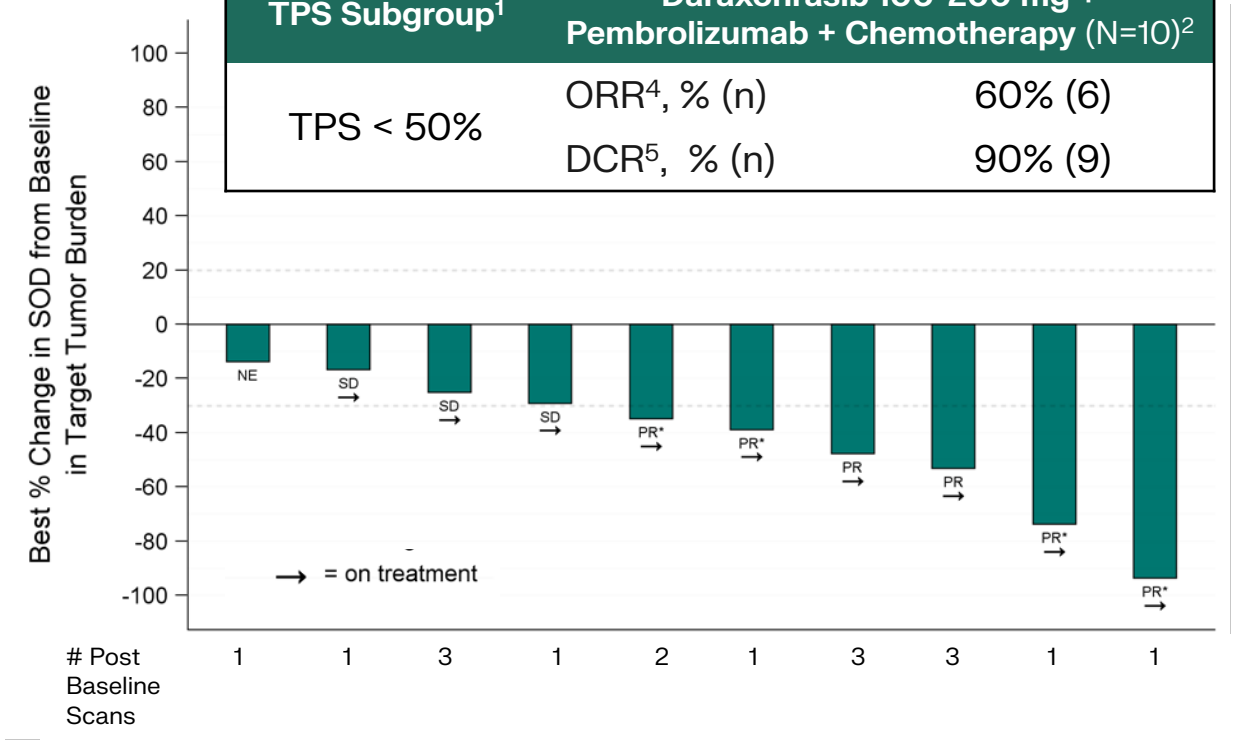
Data cutoff: Sept 30, 2024

1L NSCLC: Daraxonrasib + Pembrolizumab +/- Chemotherapy Demonstrated Encouraging Preliminary Antitumor Activity

TPS Subgroup[1]	Daraxonrasib 200 mg + Pembrolizumab (N=7)[2,3]	
TPS ≥ 50%	ORR[4], % (n)	86% (6)
	DCR[5], % (n)	100% (7)



TPS Subgroup[1]	Daraxonrasib 100-200 mg + Pembrolizumab + Chemotherapy (N=10)[2]	
TPS < 50%	ORR[4], % (n)	60% (6)
	DCR[5], % (n)	90% (9)



RAS mutations includes G12D, G12V, G12A, G12F, and Q61H. The patient described as not evaluable per RECIST v1.1 (NE) on the waterfall figure discontinued study after 1 cycle of treatment but achieved an unconfirmed stable disease. (1) Tumor proportion score (TPS) is based on local testing. (2) Includes efficacy evaluable patients defined as those who had one post-baseline scan or who died or had clinical progression prior to the first post-baseline response assessment. (3) Patients treated in the daraxonrasib + pembrolizumab in TPS ≥ 50% were not evaluated at the 100 mg dose. (4) Objective response rate (ORR) (per RECIST v 1.1) includes partial responses that were confirmed (PR) or still had the potential to confirm (PR*). (5) Disease control rate (DCR) includes complete responses (CR), PR and stable disease (SD). Chemotherapy = cisplatin/carboplatin plus pemetrexed. NSCLC, non-small cell lung cancer; SOD, sum of diameters; NE, not evaluable; RECIST; response evaluation criteria in solid tumors; 1L, first line.

Revolution Medicines

Data cutoff: Feb 10, 2025

1L NSCLC: Daraxonrasib + Pembrolizumab +/- Chemotherapy Generally Well Tolerated

	Daraxonrasib 200 mg + Pembrolizumab (N=10)		**Daraxonrasib (100-200 mg) + Pembrolizumab + Chemotherapy** (N=13)	
Median follow-up, months (range)	2.3 (0.9, 6.2)		2.6 (0.7, 5.6)	
Preferred Term	Any Grade	Grade ≥ 3	Any Grade	Grade ≥ 3
Any TRAE, ≥ 25% in any subset	9 (90%)	2 (20%)	12 (92%)	6 (46%)
Rash[1]	8 (80%)	0	5 (39%)	0
Nausea	5 (50%)	1 (10%)	6 (46%)	0
Diarrhea	6 (60%)	0	7 (54%)	1 (8%)
Vomiting	5 (50%)	0	4 (31%)	0
Stomatitis/mucositis[2]	3 (30%)	1 (10%)	6 (46%)	0
Fatigue	2 (20%)	0	5 (39%)	0
Neutrophil count decreased	0	0	6 (46%)	3 (23%)
Anemia	1 (10%)	0	5 (39%)	3 (23%)
Thrombocytopenia[3]	1 (10%)	0	6 (46%)	2 (15%)
Select TRAEs				
AST increased	1 (10%)	0	1 (8%)	0
ALT increased	1 (10%)	0	2 (15%)	0
Pneumonitis	1 (10%)	0	1 (8%)	0
Colitis	0	0	0	0

Revolution Medicines

(1) Includes dermatitis acneiform, rash, rash maculo-papular, rash erythematous, and rash pustular.(2) Includes mucosal inflammation and stomatitis. (3) Includes thrombocytopenia, platelet count decreased. Any treatment-related AE, including those considered related only to chemotherapy (cisplatin/carboplatin and pemetrexed) or pembrolizumab. 1L, first line; NSCLC, non-small cell lung cancer; TRAE, treatment-related adverse event; ALT, alanine transaminase; AST, aspartate transferase.

Data cutoff: Feb 10, 2025

1L NSCLC: Daraxonrasib + Pembrolizumab +/- Chemotherapy Combination Supports Favorable Dose Intensity

	Daraxonrasib 200 mg + Pembrolizumab (N=10)	**Daraxonrasib (100-200 mg) + Pembrolizumab + Chemotherapy** (N=13)
Daraxonrasib-related AEs:		
Leading to daraxonrasib dose reduction	1 (10%)	1 (8%)
Leading to daraxonrasib discontinuation	0[1]	1 (8%)
Pembrolizumab-related AEs:		
Leading to pembrolizumab discontinuation	0	1 (8%)
Chemotherapy-related AEs:		
Leading to chemotherapy dose reduction	-	5 (38%)
Leading to chemotherapy discontinuation	-	1 (8%)
Daraxonrasib mean relative dose intensity	93%	90%

(1) Data shown are investigator corrected from EDC.
Chemotherapy = carboplatin or cisplatin + pemetrexed; NSCLC, non-small cell lung cancer; 1L, first line; AE, adverse event.

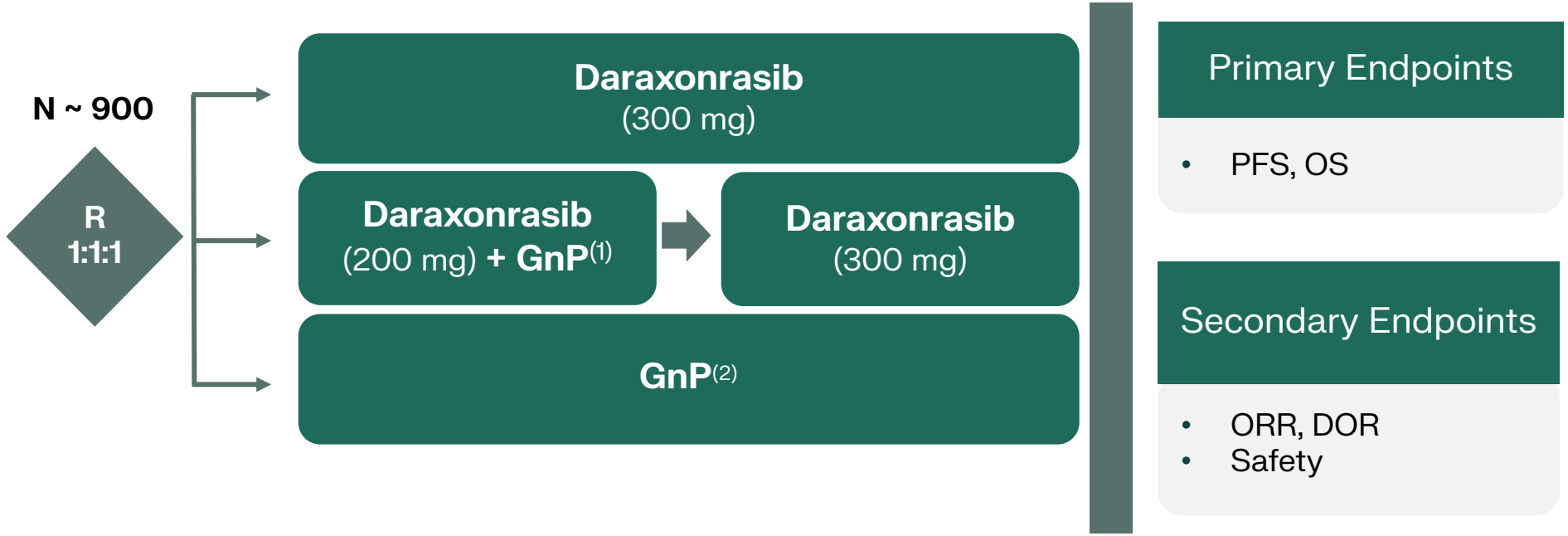
Data cutoff: Feb 10, 2025

Daraxonrasib Registrational Study Designs

1L Metastatic PDAC: Design of RASolute 303 Trial

Key Eligibility Criteria

- Confirmed metastatic PDAC, regardless of RAS status
- No prior systemic therapy for metastatic disease
- ECOG PS 0 or 1
- RAS mutation status (required for stratification)



Treatment until disease progression or intolerance for all three arms. (1) Daraxonrasib (200 mg) + GnP (1000 mg/m^2 and 125 mg/m^2) given on Days 1, 15 in a 28-day cycle for up to 6 months, followed by daraxonrasib monotherapy (300 mg). (2) GnP (1000 mg/m^2 and 125 mg/m^2) on Days 1, 8, and 15 in a 28-day cycle.
1L, first line; PDAC, pancreatic ductal adenocarcinoma; ECOG PS, Eastern Cooperative Oncology Group Performance Status; R, randomized; GnP, gemcitabine nab-paclitaxel; PFS, progression-free survival; OS, overall survival; ORR, objective response rate; DOR, duration of response.

Adjuvant Therapy in Resectable PDAC: Design of RASolute 304 Trial

Surgery

+

Perioperative chemotherapy per local SOC

No radiologic evidence of disease

Key Eligibility Criteria

- Confirmed PDAC
- R0 or R1 resection*
- ECOG PS 0 or 1
- ≥4 months of perioperative therapy

N=500

R
1:1

Daraxonrasib
300 mg PO QD
Duration 2 years

Observation

Primary Endpoint

- DFS

Secondary Endpoints

- OS
- Safety

*R0 resection: No macroscopic residual tumor. No residual tumor at >1 mm of the surgical margins. R1 resection: No macroscopic residual tumor. Microscopic residual tumor at ≤1 mm of the margins.

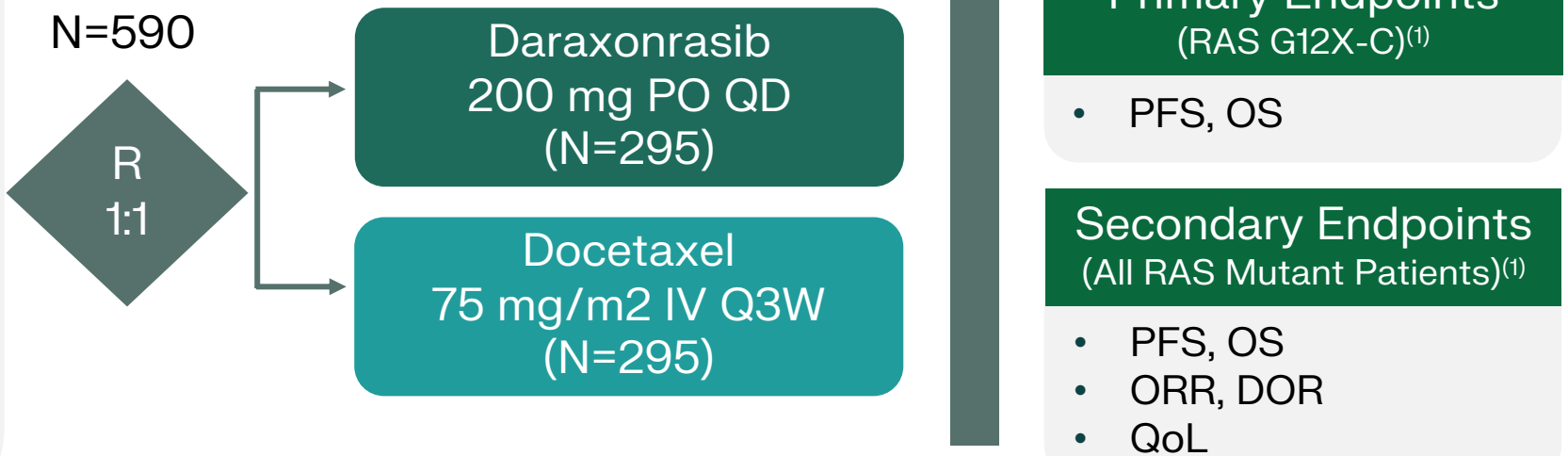
PDAC, pancreatic ductal adenocarcinoma; SOC, standard of care; ECOG PS, Eastern Cooperative Oncology Group Performance Status; R, randomized; PO, oral; QD, once daily; DFS, disease-free survival; OS, overall survival

Previously Treated NSCLC: Design of RASolve 301 Trial

Key Eligibility Criteria

- Locally advanced or metastatic NSCLC
- RAS genotypes: RAS G12X-C (core population), G12C, G13X or Q61X
- Prior therapies: 1 or 2 prior lines of therapy which must include immunotherapy and platinum chemotherapy administered concurrently or sequentially; no prior docetaxel or RAS inhibitor
- ECOG PS 0-1

NCT06881784



(1) Nested trial design to enable hierarchical evaluation of Core and Core + Expanded populations.
NSCLC, non-small cell lung cancer; ECOG PS, Eastern Cooperative Oncology Group Performance Status; R, randomized; PO, oral administration; QD, once daily; Q3W, once every three weeks; PFS, progression-free survival; OS, overall survival; ORR, objective response rate; DOR, duration of response; QoL, quality of life.

Elironrasib

RAS(ON) G12C-Selective Covalent Inhibitor

Active against

- Primary RAS G12C mutation
- Tumors in patients naïve to, or previously treated with, first-generation KRAS(OFF) inhibitors

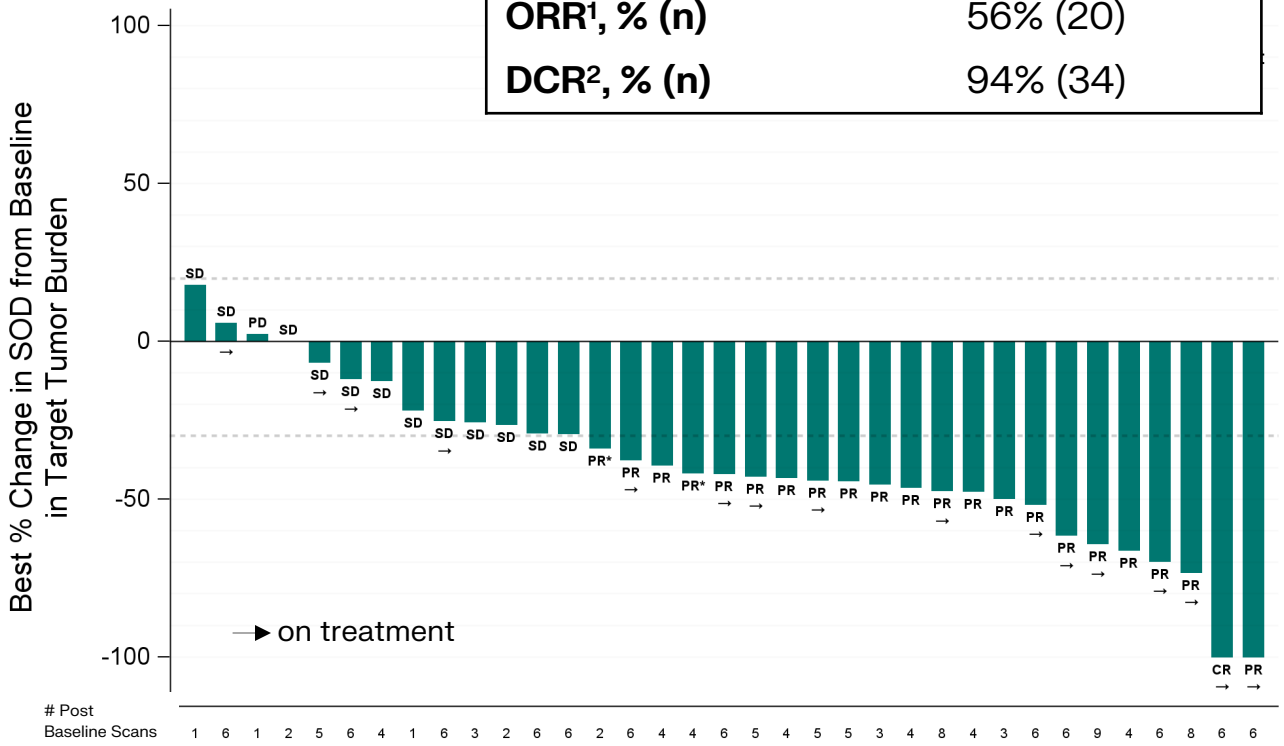
FDA granted:

- Breakthrough Therapy Designation

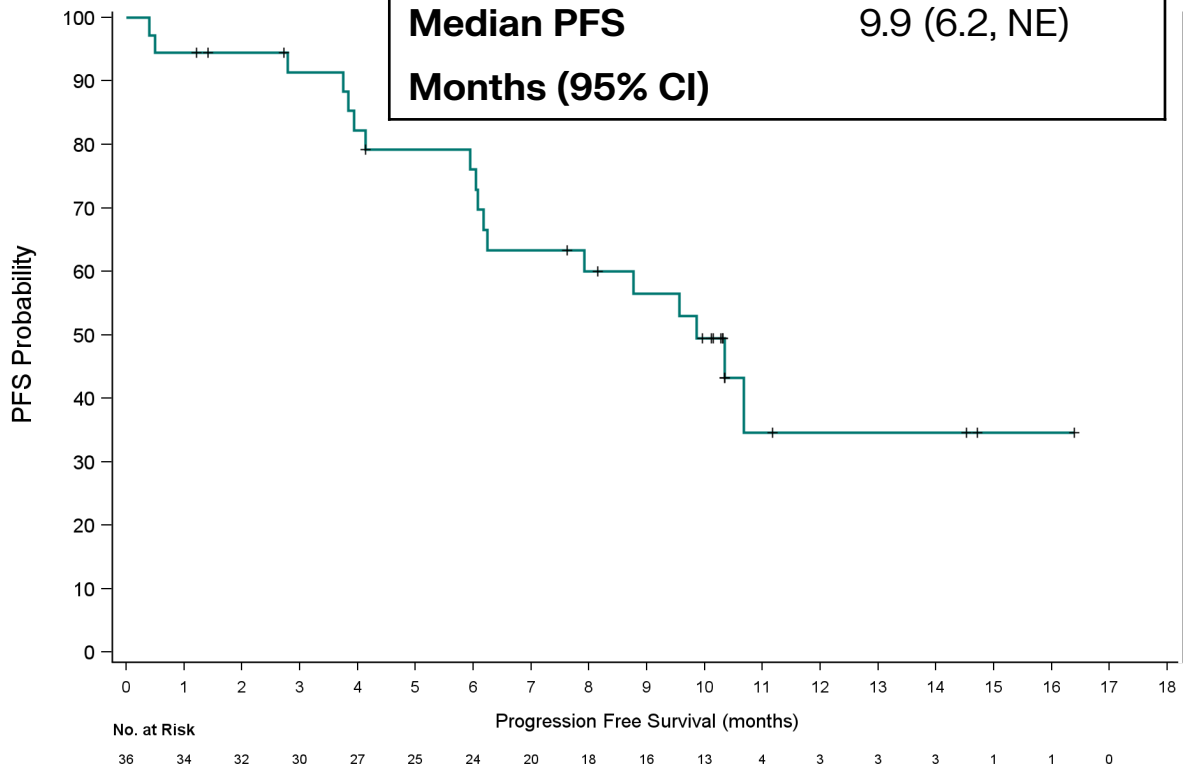
Elironrasib Clinical Data

Elironrasib Monotherapy: Encouraging Antitumor Activity and Durability in Patients with Previously Treated RAS G12C NSCLC

Elironrasib (200 mg BID) (N=36)	
ORR[1], % (n)	56% (20)
DCR[2], % (n)	94% (34)



Elironrasib (200 mg BID) (N=36)	
Median PFS Months (95% CI)	9.9 (6.2, NE)

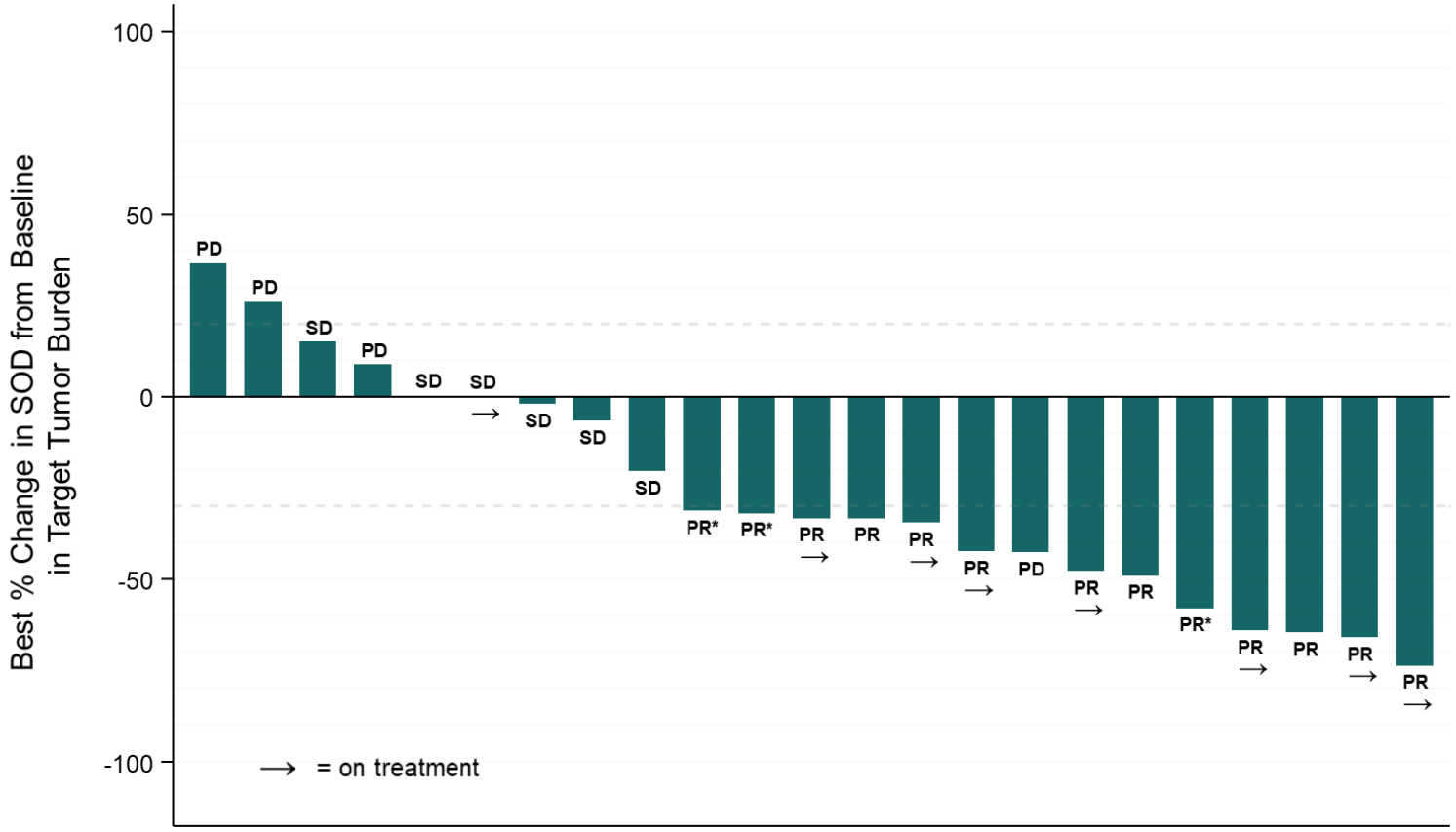


Data includes patients with previously treated NSCLC who have been treated with both immunotherapy and chemotherapy but have not received a G12C(OFF) inhibitor.
(1) Objective response rate (ORR) (per RECIST v 1.1) includes partial responses that were confirmed (PR) or still had the potential to confirm (PR*). (2) Disease control rate (DCR) includes CR, PR, and stable disease (SD). NSCLC, non-small cell lung cancer; BID, twice daily; PFS, progression-free survival; CI, confidence interval; NE, not evaluable; SOD, sum of diameters; RECIST; response evaluation criteria in solid tumors; PD, progressive disease.

Revolution Medicines

Data cutoff: Apr 7, 2025

Elironrasib Monotherapy: Encouraging Antitumor Activity in Patients with RAS G12C NSCLC Previously Treated with a G12C(OFF) Inhibitor



Elironrasib (200 mg BID) (N=24)	
ORR[1], % (n)	42% (10)
DCR[2], % (n)	79% (19)

Median follow-up, months (range): 17.6 (10.3, 24.6) and 17.4 (14, 28.5). Median duration of response (95% confidence interval) is 11.2 mo (5.9-NE). (1) Objective response rate (ORR) (per RECIST v 1.1) includes complete (CR) and partial responses (PR) that were confirmed. (2) Disease control rate (DCR) includes CR, PR and stable disease (SD). (3) One patient included in the denominator for ORR and DCR calculations is not displayed on waterfall and treated as a non-responder for purposes of the ORR and DCR calculations due to lack of post-baseline target lesion assessment.
NSCLC, non-small cell lung cancer; PR*, unconfirmed partial response; RECIST, response evaluation criteria in solid tumors; PD, progressive disease.

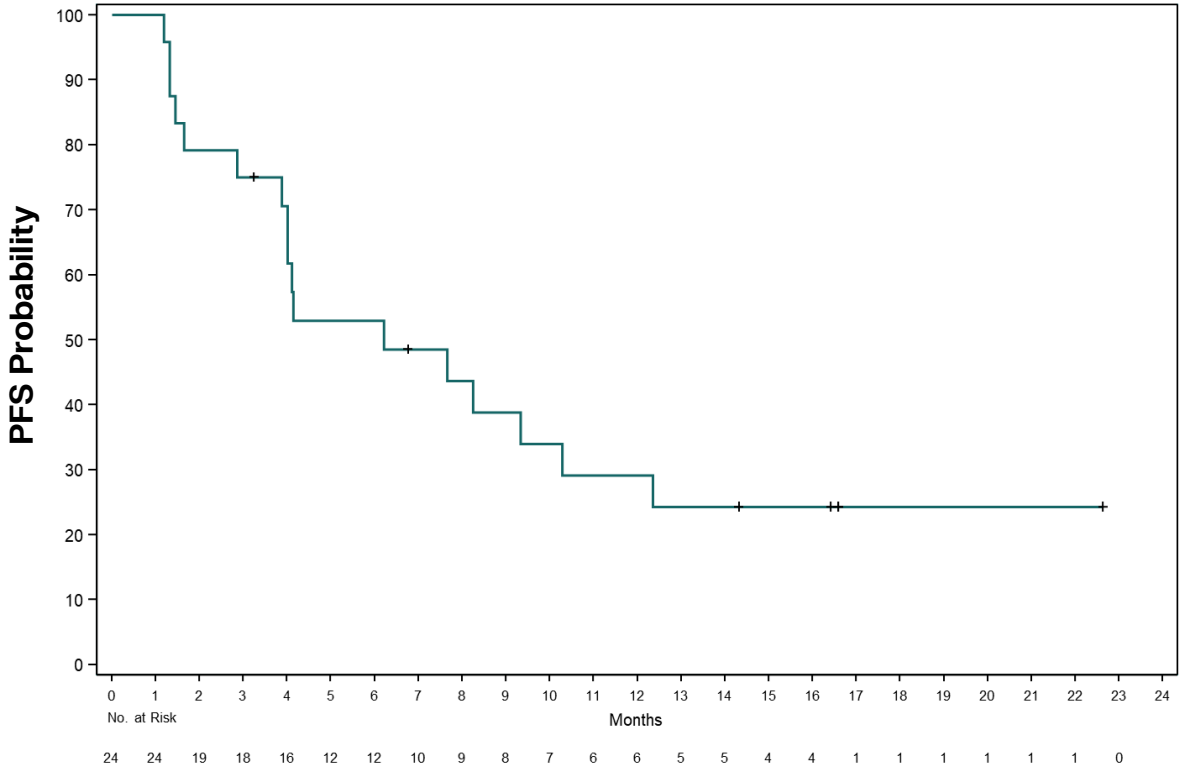
Revolution Medicines

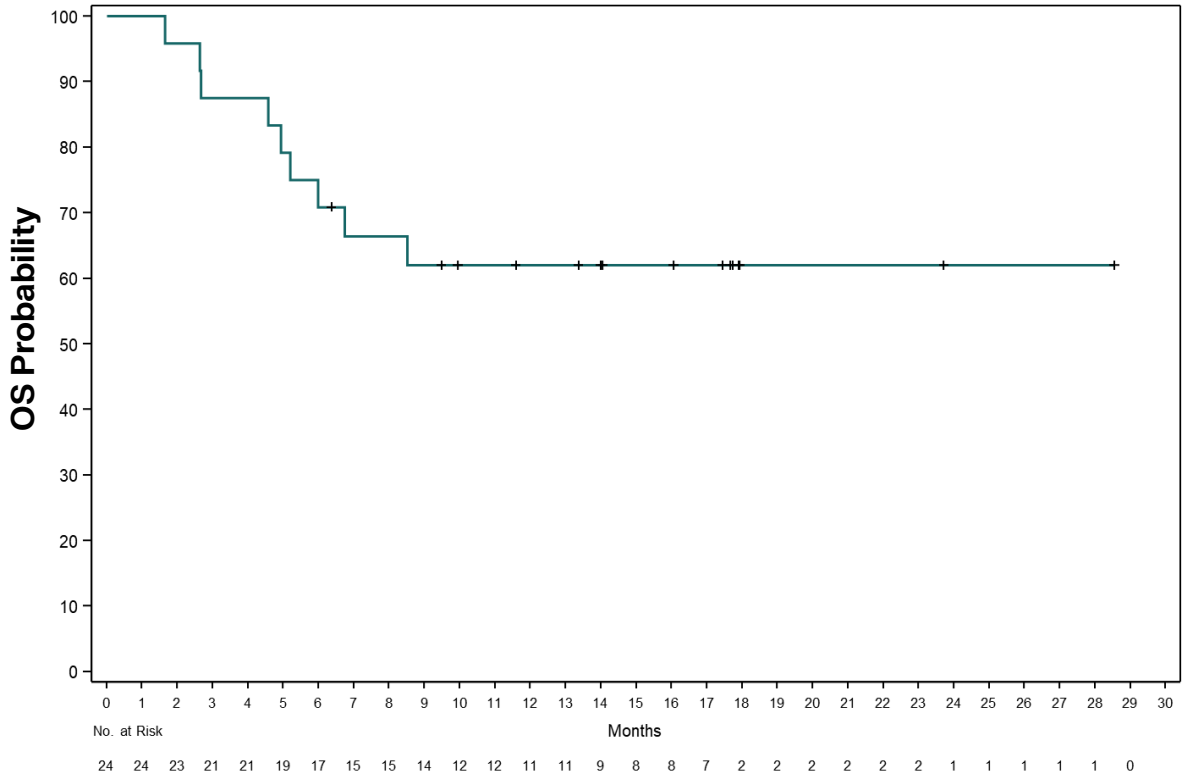
Data Cutoff: August 4, 2025

Elironrasib Monotherapy: Encouraging Durability in Patients with RAS G12C NSCLC Previously Treated with a G12C(OFF) Inhibitor

PFS, mo (CI)	6.2mo (4.0, 10.3)
6-mo PFS rate, % (CI)	53% (31-71)

Median OS, mo (CI)	NE (6.7, NE)
12-mo OS rate, % (CI)	62% (40-78)





Revolution Medicines

NSCLC, non-small cell lung cancer; mo, month; NE, not evaluable; OS, overall survival; PFS, progression free survival; CI, confidence interval: RECIST, response evaluation criteria in solid tumors.

Data Cutoff: August 4, 2025

Elironrasib Monotherapy: Generally Well Tolerated in Patients with Previously Treated RAS G12C NSCLC

	Elironrasib 200 mg BID (N=36)	
Maximum Severity of Treatment-Related AEs	**Any Grade**	**Grade ≥3**
Any TRAE	28 (78%)	7 (19%)
TRAEs in ≥ 15% of patients, n (%)		
Diarrhea	11 (31%)	2 (6%)
Nausea	8 (22%)	0
Electrocardiogram QT prolonged	8 (22%)	1 (3%)
Other select TRAEs, n (%)		
ALT increased	2 (6%)	1 (3%)
AST increased	3 (8%)	1 (3%)
TRAEs leading to dose modification, n (%)	10 (28%)	6 (17%)
Dose interruption	8 (22%)	5 (14%)
Dose reduction	7 (19%)	5 (14%)
TRAEs leading to treatment discontinuation, n (%)	1 (3%)	1 (3%)
Mean dose intensity	94%	

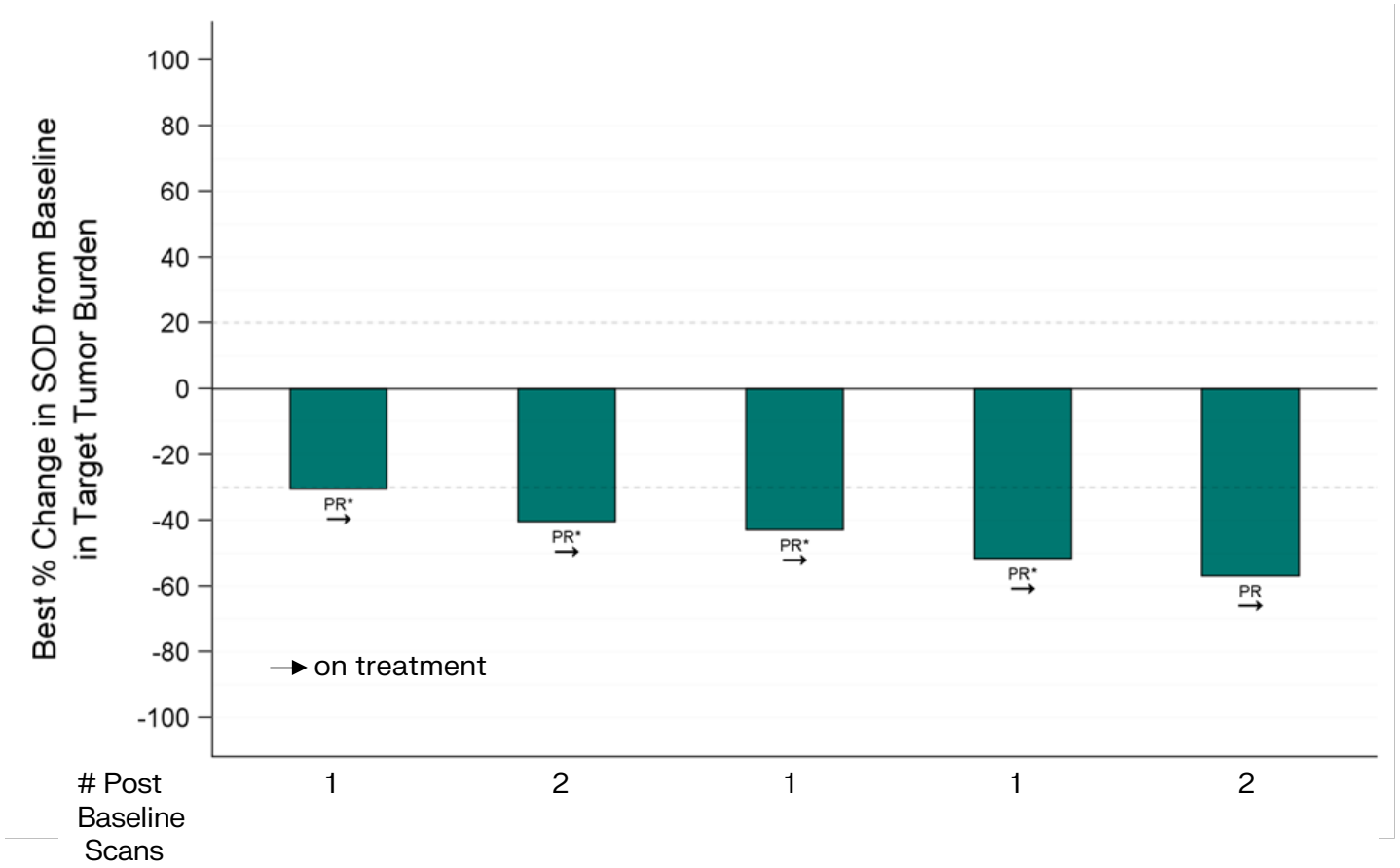
No treatment-related Grade 4 or 5 AEs or SAEs have been reported

Revolution Medicines

Included NSCLC patients who have previously been treated with both immunotherapy and chemotherapy but have not received a G12C(OFF) inhibitor. Median time on treatment was 9.0 months (range: 0.0–16.7) NSCLC, non-small cell lung cancer; BID, twice daily; AE, adverse event; ALT, alanine transaminase; AST, aspartate transferase; TRAE, treatment-related adverse event.

Data cutoff: Apr 7, 2025

Elironrasib + Pembrolizumab: Promising Preliminary Antitumor Activity in Patients with 1L RAS G12C NSCLC



Elironrasib 200 mg BID + Pembrolizumab in TPS[1] ≥ 50% (N=5)[2]	
ORR[3], % (n)	100% (5)
DCR[4], % (n)	100% (5)

(1) Tumor proportion score (TPS) is based on local testing. (2) Includes efficacy evaluable patients defined as those who had one post-baseline scan or who died or had clinical progression prior to the first post-baseline response assessment. (3) Objective response rate (ORR) (per RECIST v 1.1) includes partial responses that were confirmed (PR) or still had the potential to confirm (PR*). (4) Disease control rate (DCR) includes complete responses (CR), PR and stable disease (SD). NSCLC, non-small cell lung cancer; BID, twice daily; SOD, sum of diameters; 1L, first line.

Revolution Medicines

Data cutoff: Feb 10, 2025

Elironrasib + Pembrolizumab: Generally Well Tolerated with Favorable Dose Intensity in Patients with 1L RAS G12C NSCLC

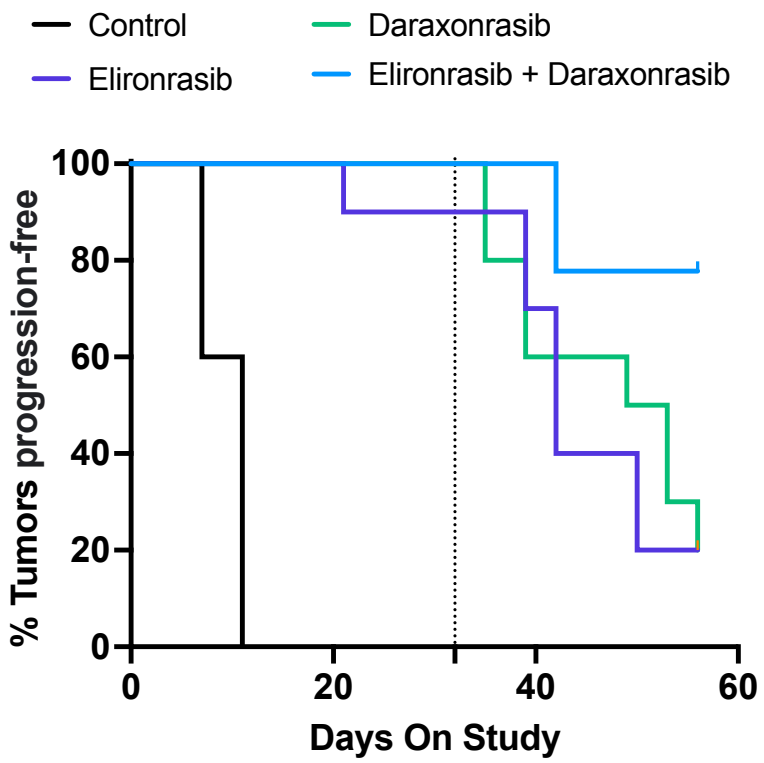
	Elironrasib 200 mg BID + Pembrolizumab (N=8)	
Median time on treatment, mo (range)	2.7 (0.7-3.2)	
	Any Grade	**Grade ≥3**
Any TRAE	6 (75%)	2 (25%)
TRAEs in ≥ 15% of patients, n (%)		
Nausea	2 (25%)	0
Diarrhea	2 (25%)	0
Electrocardiogram QT prolonged	2 (25%)	1 (13%)
Other select TRAEs, n (%)		
ALT elevated	2 (25%)[1]	0
AST elevated	1 (13%)[1]	1 (13%)[1]
TRAEs, n (%)		
Leading to elironrasib dose reduction	2 (25%)	
Leading to elironrasib dose discontinuation	0	
Leading to pembrolizumab dose discontinuation	1 (13%)	
Elironrasib mean dose intensity	85%	

(1) Increases in AST or ALT were reported to the sponsor under the term hepatic cytolysis.
1L, first line; NSCLC, non-small cell lung cancer; BID, twice daily; TRAE, treatment-related adverse event; ALT, alanine transaminase; AST, aspartate transferase.

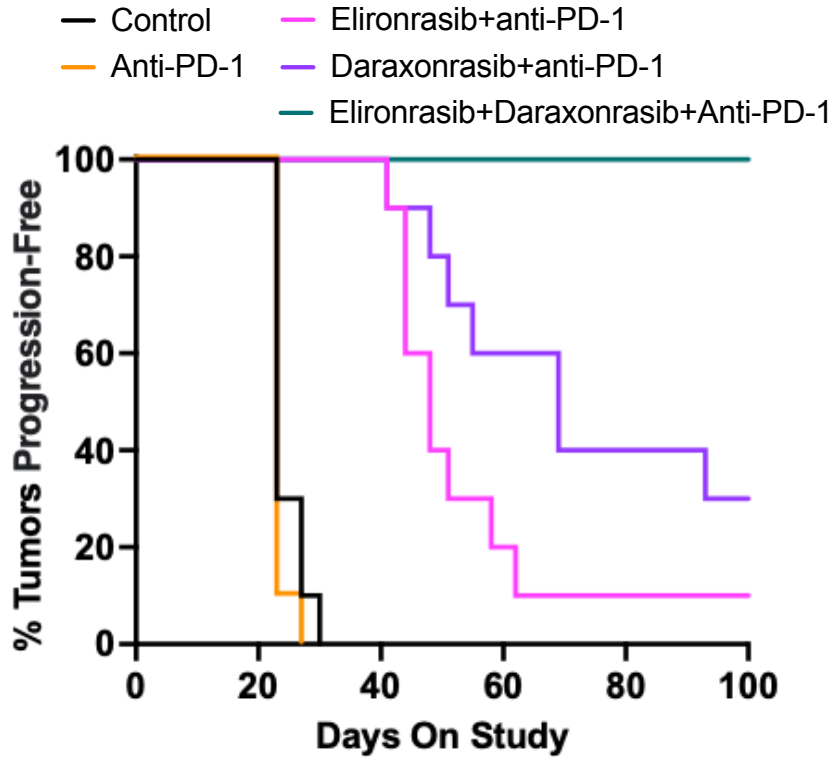
Elironrasib + Daraxonrasib
RAS(ON) Inhibitor Doublet Background

Elironrasib and Daraxonrasib Show Combination Benefit and Synergize with Anti-PD-1 in Preclinical NSCLC Models

Elironrasib and Daraxonrasib Show Combination Benefit in a NSCLC Model



RAS(ON) Inhibitor Doublet Sensitizes Immune-Refractory NSCLC to Anti-PD-1

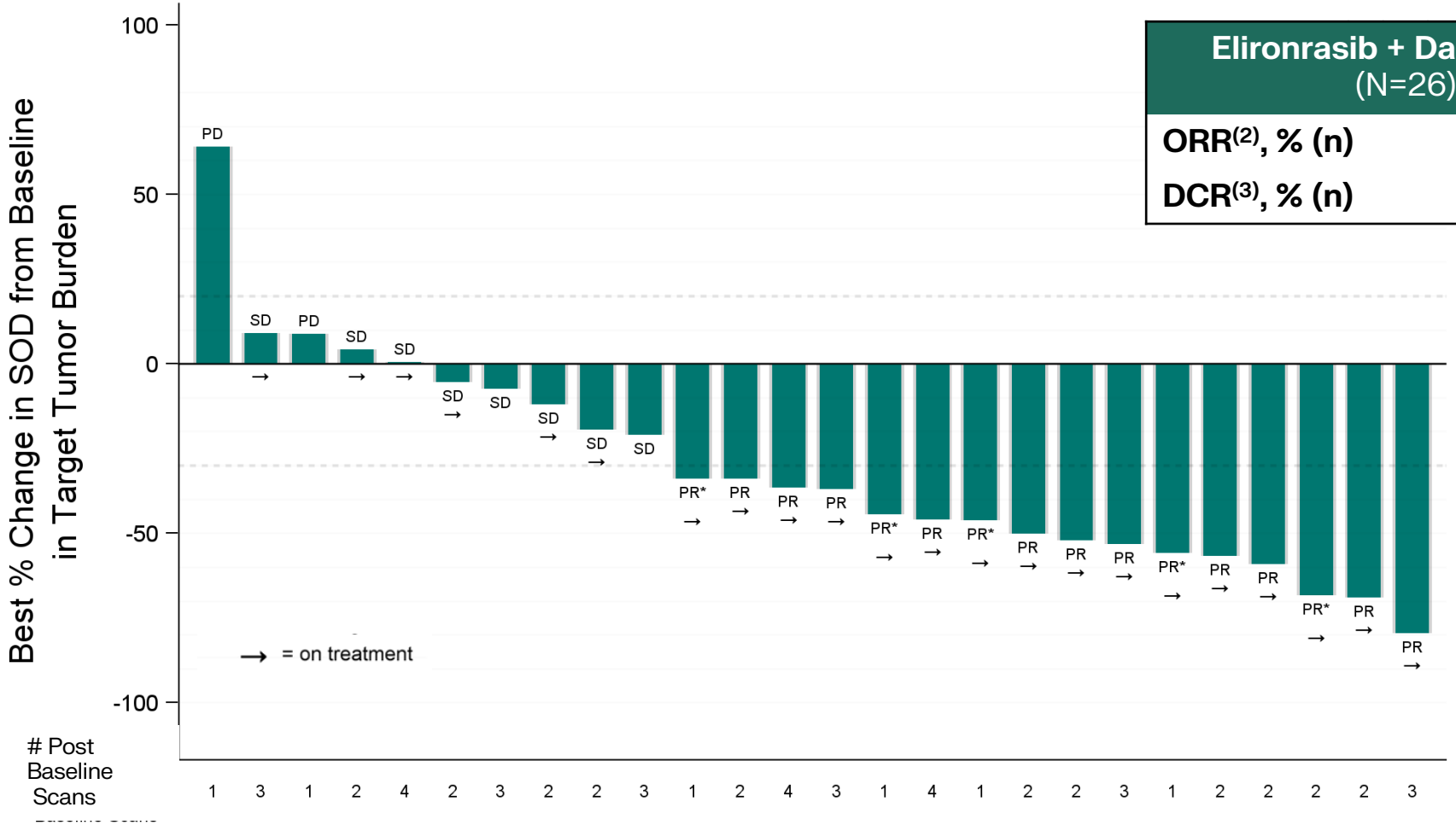


Revolution Medicines

Left Chart: KPAR (NSCLC *KRAS G12C/G12C*), elironrasib (100 mg/kg, PO QD), daraxonrasib (25 mg/kg PO QD)). Dashed line represents treatment stop. Days on study represent days on treatment. Right Chart: e3LL (T cell excluded NSCLC, *KRAS G12C/G12C, NRAS*^{KO}), elironrasib (30 mg/kg, PO QD), daraxonrasib (25 mg/kg PO QD)). Anti-PD-1 clone RMP1-14 CP151 (10 mg/kg IP BIW) in all graphs. Days on study represent days post tumor implant. NSCLC, non-small cell lung cancer; QD, once daily; BIW, twice-weekly.

Interim data: April 20, 2025

Elironrasib + Daraxonrasib: Doublet Shows Encouraging Antitumor Activity in Patients with 2L+ NSCLC Previously Treated with KRAS(OFF) G12C Inhibitor



Elironrasib + Daraxonrasib (N=26)[1]	
ORR[2], % (n)	62% (16)
DCR[3], % (n)	92% (24)

The combination arm includes patients treated at elironrasib 200 mg BID + daraxonrasib (100-200 mg QD).
(1) Includes efficacy evaluable patients defined as those who had one post-baseline scan or who died or had clinical progression prior to the first post-baseline response assessment. (2) Objective response rate (ORR) (per RECIST v 1.1) includes partial responses that were confirmed (PR) or still had the potential to confirm (PR*). Some patients may not appear in the waterfall due to either missing tumor assessment for 1 or more tumor lesions or discontinuing study drug prior to first tumor assessment. (3) Disease control rate (DCR) includes complete response (CR), partial response (PR) and stable disease (SD). NSCLC, non-small cell lung cancer; SOD, sum of diameters, PD, progressive disease; RECIST; response evaluation criteria in solid tumors; 2L, second line.

Revolution Medicines

Data cutoff: Feb 10, 2025

Elironrasib + Daraxonrasib: Generally Well Tolerated in 2L+ NSCLC Patients Previously Treated with G12C(OFF) Inhibitor

	Elironrasib 200 mg BID + Daraxonrasib 100-200 mg QD (N=33)	
Median time on treatment, mo (range)	3.61 (0.20-8.67)	
	Any Grade	**Grade ≥3**
Any TRAE	31 (94%)	15 (43%)
TRAEs in ≥ 20% of patients, n (%)		
Rash[1]	22 (67%)	4 (12%)
Diarrhea	19 (58%)	2 (6%)
Stomatitis/mucositis[2]	17 (52%)	3 (9%)
Nausea	15 (46%)	0
Vomiting	11 (33%)	0
Anemia	7 (21%)	0
Other select TRAEs, n (%)		
ALT increased	5 (15%)	0
AST increased	5 (15%)	0
Electrocardiogram QT prolonged	2 (6%)	1 (3%)
TRAEs leading to dose modification, n (%)	19 (58%)	12 (36%)
Dose interruption of any drug	17 (52%)	12 (36%)
Dose reduction of any drug	5 (15%)	0
Dose discontinuation of any drug	0	0
Mean dose intensity of elironrasib	95%	
Mean dose intensity of daraxonrasib	85%	

Included NSCLC patients who have previously been treated with immunotherapy, chemotherapy and a G12C(OFF) inhibitor.
(1) Includes preferred terms of rash pustular, rash papular, rash maculopapular, rash macular, rash, erythema, dermatitis acneiform, dermatitis bullous. Multiple types of rash may have occurred in the same patient. (2) Includes preferred terms of stomatitis and mucosal inflammation.
TRAE, treatment-related adverse event (to any drug); 2L+, second line and beyond; NSCLC, non-small cell lung cancer; ALT, alanine transaminase; AST, aspartate transferase.

Revolution Medicines

Data cutoff: Feb 10, 2025

Limited Monotherapy Activity of Either Daraxonrasib in RAS Mutant CRC or Elironrasib in CRC Previously Treated with KRAS G12C(OFF) Inhibitor

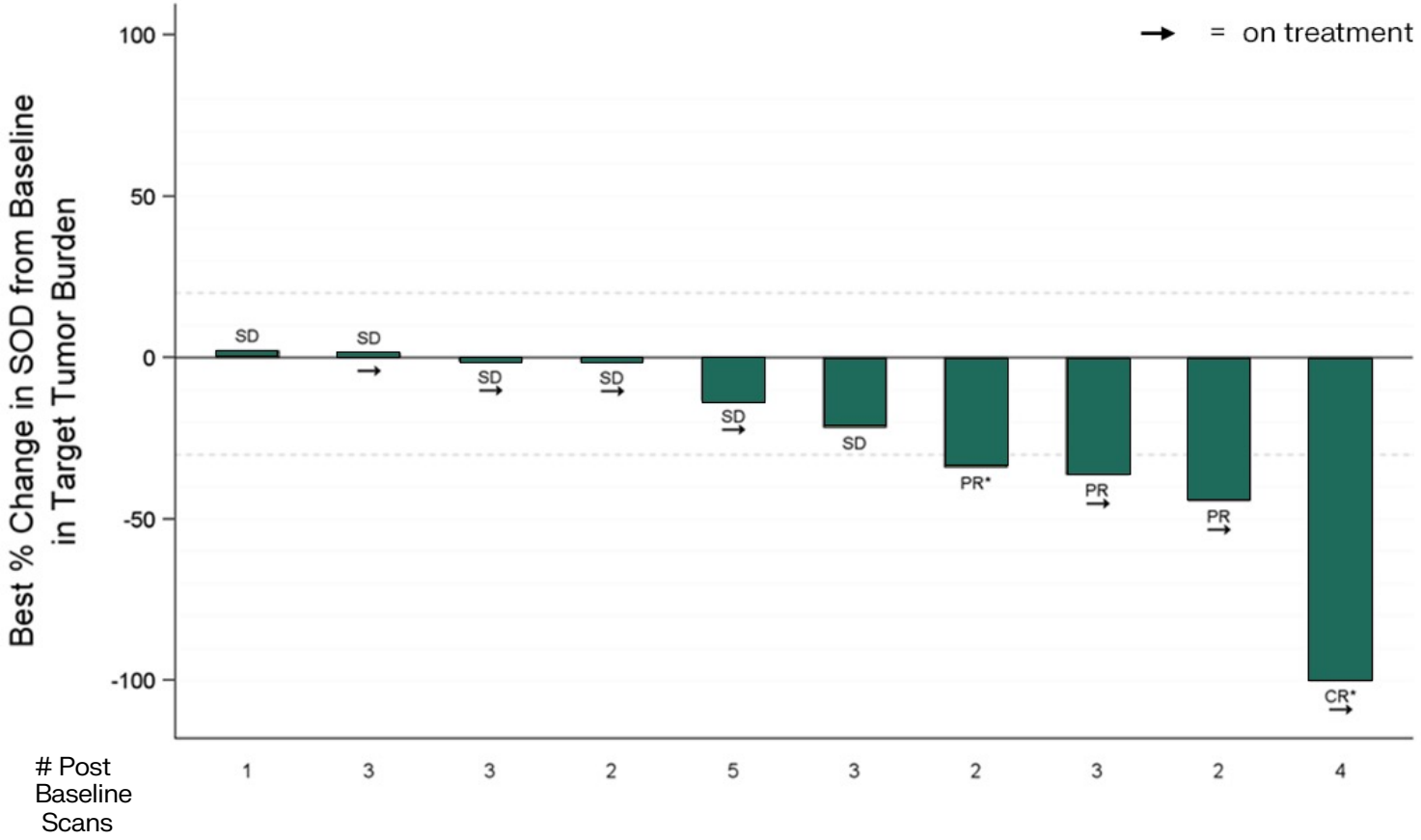
RAS Inhibitor	Population	ORR n/N (%)
Daraxonrasib in RAS Mutant CRC[1,3] 300 mg QD	RAS inhibitor naive	2/22 (9%)
Elironrasib in KRAS G12C Mutant CRC[2] 200 mg BID	Previously treated with a G12C(OFF) Inhibitor	0/6

Revolution Medicines

(1) KRAS G12X-C; all patients treated at 300 mg QD. (2) Elironrasib 200 mg BID (RP2D). (3) ORR (by RECISTv1.1) includes confirmed CRs/PRs. The analysis is based on patients who received first dose of daraxonrasib at least 14 weeks prior to data cutoff date (to allow 2 potential scans). CRC, colorectal cancer; ORR, objective response rate; QD, once daily; BID, twice daily; RECIST; response evaluation criteria in solid tumors.

Elironrasib data cutoff: Oct 28, 2024
Daraxonrasib data cutoff: Sep 30, 2024

Elironrasib + Daraxonrasib: Doublet Shows Encouraging Antitumor Activity in Patients with CRC Previously Treated with KRAS(OFF) G12C Inhibitor



Elironrasib + Daraxonrasib[1] (N=12)	
ORR[2], % (n)	25% (3)
DCR[3], % (n)	92% (11)

Analyses include all patients who received first dose of study drug(s) at least 8 weeks prior to data cutoff date (to allow 1 potential scan). (1) The combination arm includes patients treated at elironrasib 100 or 200 mg BID + daraxonrasib (100-200 mg QD). (2) Objective response rate (ORR) (per RECIST v 1.1) includes partial responses that were confirmed (PR) or still had the potential to confirm (PR*). Some patients do not appear in the waterfall due to either missing tumor assessment for 1 or more tumor lesions or discontinuing study drug prior to first tumor assessment. One patient with CR* has confirmed PR. (3) Disease control rate (DCR) includes complete response (CR), partial response (PR) and stable disease (SD).
CRC, colorectal cancer; SOD, sum of diameters; RECIST; response evaluation criteria in solid tumors.

Revolution Medicines

Data cutoff: Oct 28, 2024

Zoldonrasib

RAS(ON) G12D-Selective Covalent Inhibitor

Active against:

- Primary RAS G12D mutation
- Most common RAS driver in RAS-addicted solid tumors

FDA granted:

- Breakthrough Therapy Designation

Zoldonrasib Registrational Study Designs

1L Metastatic RAS G12D NSCLC: Design of RASolve 308 Trial

Key Eligibility Criteria

- Confirmed metastatic non-squamous NSCLC
- No prior systemic therapy for metastatic disease
- Documented RAS G12D mutation [1]
- ECOG PS 0–1

N = 430

R
1:1

Zoldonrasib (1200 mg) + KN-189 (N=215)

Placebo + KN-189 (N=215)

Primary Endpoints

- PFS (per BICR) [2]

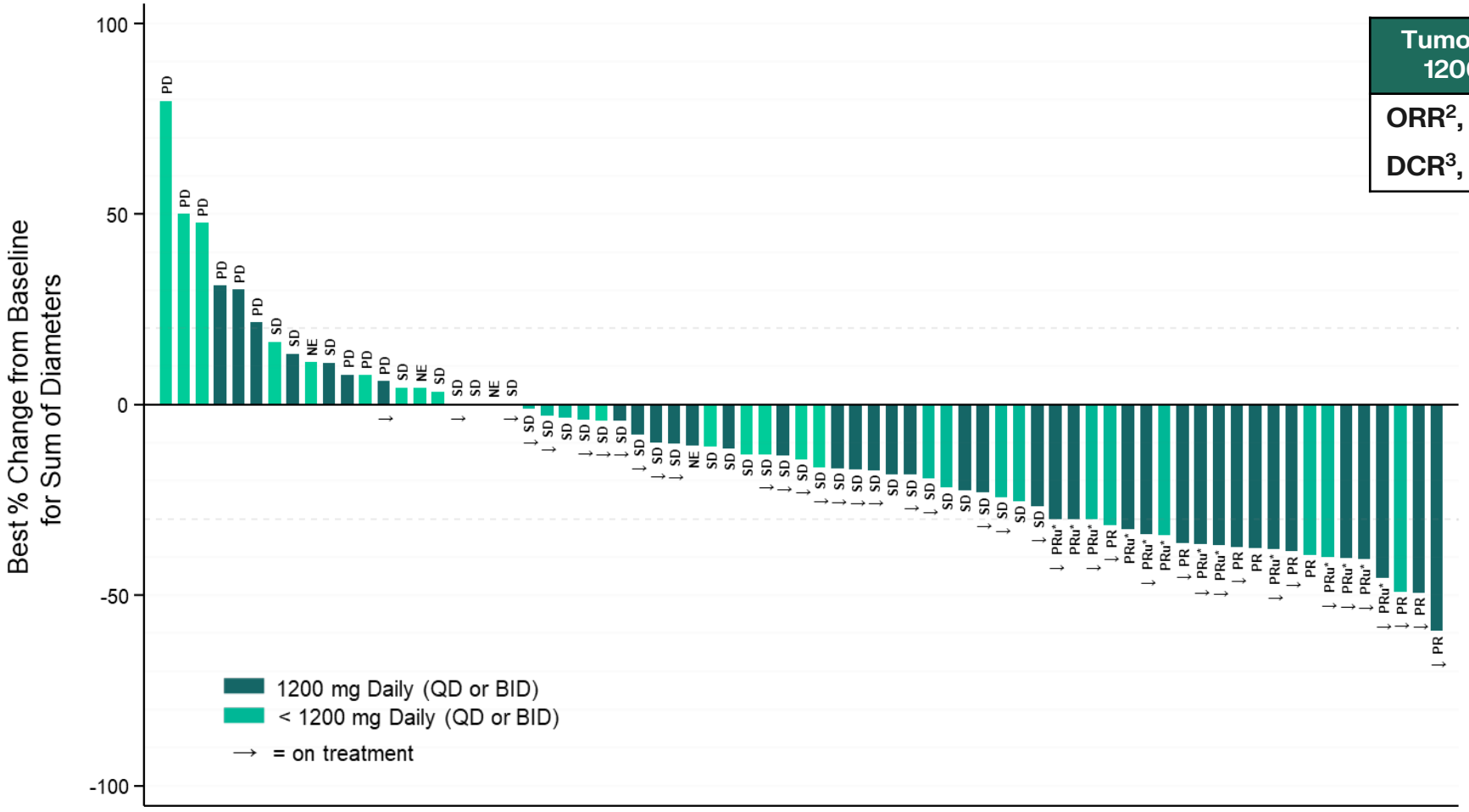
Secondary Endpoints

- OS
- ORR, DOR
- QoL
- Safety

[1] Previously identified by a local analytically validated molecular test on circulating tumor DNA or tumor tissue. [2] As assessed by BICR per RECIST v1.1.
Zoldonrasib or placebo given until PD; KN-189: pembrolizumab given up to 2 years or until PD and cis/carb given for 4 cycles (21-day cycle). No cross-over to zoldonrasib permitted per protocol; Treatment beyond progression permitted.
NSCLC, non-small cell lung cancer; ECOG PS, Eastern Cooperative Oncology Group Performance Status; R, randomized; KN-189, Keynote 189 is a combination treatment regimen of pembrolizumab with pemetrexed and platinum-based chemotherapy; PFS, progression-free survival; BICR, blinded independent central review; OS, overall survival; ORR, objective response rate; DOR, duration of response; QoL, quality of life.

Zoldonrasib Clinical Data

Encouraging Initial Activity of Zoldonrasib Monotherapy in Previously Treated Patients with KRAS G12D PDAC



Tumor Response for PDAC Patients Treated with 1200 mg Daily Dose (QD, N=20 or BID, N=20)[1]	
ORR[2], % (n)	30% (12)
DCR[3], % (n)	80% (32)

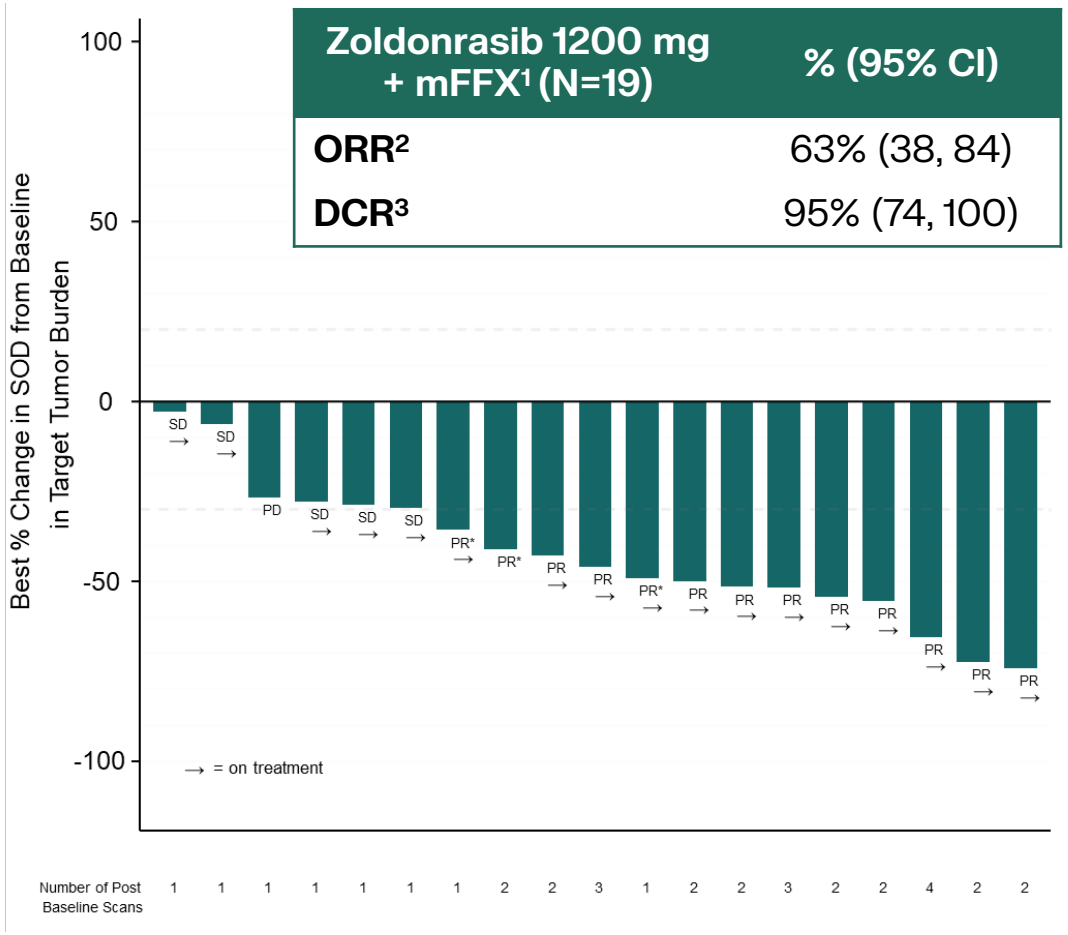
David S. Hong et al., Preliminary Safety, Pharmacokinetics, and Antitumor Activity of RMC-9805, an Oral, RAS(ON) G12D-Selective, Tri-Complex Inhibitor in Patients with KRAS G12D Pancreatic Ductal Adenocarcinoma (PDAC) from a Phase 1 Study in Advanced Solid Tumors, ENA 2024. (1) All treated patients with PDAC who received a first daily dose at least 14 weeks prior to data cutoff date (applies to waterfall plot and ORR table). (2) Objective response rate (ORR) (per RECIST v 1.1) includes partial responses that were confirmed (PR) or still had the potential to confirm (PR*). (3) Disease control rate (DCR) includes complete response (CR), PR and stable disease (SD). Some patients do not appear in the waterfall due to either missing tumor assessment for 1 or more tumor lesions or discontinuing study drug prior to first tumor assessment. PDAC, pancreatic ductal adenocarcinoma; QD, once daily; BID, twice daily; PD, progressive disease; NE, not evaluable; RECIST, response evaluation criteria in solid tumors

Revolution Medicines

Data cutoff: Sep 2, 2024

Advancing Zoldonrasib in 1L PDAC | Encouraging Initial Results in Combination with FOLFIRINOX

Zoldonrasib 1200 mg + mFFX[1] (N=19)	% (95% CI)
ORR[2]	63% (38, 84)
DCR[3]	95% (74, 100)



Safety/Tolerability Summary

- Initial safety and tolerability profile of the combination was largely consistent with the well-known profile of modified FOLFIRINOX alone
- High zoldonrasib dose intensity maintained with mFOLFIRINOX regimen

Median follow up: 3.9 months (range 2.7, 8.0). The waterfall plot includes all treated subjects who received first dose of zoldonrasib at least 10 weeks prior to data cutoff date (to allow 1 potential scan). [1] mFFX = oxaliplatin IV at 85 mg/m2, leucovorin IV at 400 mg/m2, irinotecan IV at 150 mg/m2, 5-fluorouracil IV at 2,400 mg/m2 (over 46-hour) given Q2W. [2] Objective response rate (ORR) (per RECIST v 1.1) includes partial responses that were confirmed (PR) or still had the potential to confirm (PR*). [3] Disease control rate (DCR) includes complete responses (CR), PR and stable disease (SD). PD, progressive disease.

Revolution Medicines

Data cutoff: December 1, 2025

Zoldonrasib Monotherapy: Generally Well Tolerated Across Indications

Patients Treated with 1200 mg QD Zoldonrasib (N=90)[1]				
Maximum Severity of Treatment-Related AEs	**Grade 1**	**Grade 2**	**Grade 3**	**Any Grade**
Any TRAE	49 (54%)	16 (18%)	2 (2%)	67 (74%)
TRAEs occurring in ≥10% of patients, n (%)				
Nausea	30 (33%)	5 (6%)	0	35 (39%)
Diarrhea	18 (20%)	3 (3%)	1 (1%)	22 (24%)
Vomiting	12 (13%)	4 (4%)	0	16 (18%)
Rash[2]	11 (12%)	0	0	11 (12%)
Other select TRAEs, n (%)				
AST increased	5 (6%)	2 (2%)	0	7 (8%)
ALT increased	4 (4%)	1 (1%)	1 (1%)	6 (7%)
Stomatitis/mucositis[3]	1 (1%)	0	0	1 (1%)
TRAEs leading to dose reduction, n (%)	2 (2%)	2 (2%)	0	4 (4%)
TRAEs leading to dose interruption, n (%)	3 (3%)	3 (3%)	2 (2%)	8 (9%)
TRAEs leading to treatment discontinuation, n (%)	1 (1%)	0	0	1 (1%)
Mean dose intensity		98%		

No treatment-related Grade 4 or 5 AEs or SAEs have been reported

Median time on treatment was 2.89 months (range: 0.03–9.66).
(1) Includes all tumor types (PDAC, NSCLC, CRC, and other types). (2) Includes preferred terms of Dermatitis acneiform, Rash, Rash maculo-papular. (3) Includes preferred terms of stomatitis and mucosal inflammation; AE, adverse event; ALT, alanine transaminase; AST, aspartate transferase; QD, once daily; TRAE, treatment-related adverse event.

Data cutoff: Dec 2, 2024

Zoldonrasib Monotherapy Generally Well Tolerated in Previously Treated Patients with KRAS G12D NSCLC

All Patients with NSCLC Treated with Zoldonrasib 1200 mg PO QD (N = 40)				
Maximum Severity of Treatment-Related AEs	**Grade 1**	**Grade 2**	**Grade 3[a]**	**Any Grade**
Any TRAE, n (%)	23 (58)	8 (20)	5 (13)	36 (90)
TRAEs occurring in ≥10% of all patients, n (%)				
Nausea	16 (40)	1 (3)	0	17 (43)
Vomiting	12 (30)	1 (3)	0	13 (33)
Diarrhea	11 (28)	0	1 (3)	12 (30)
Rash[b]	7 (18)	0	0	7 (18)
Decreased appetite	3 (8)	2 (5)	0	5 (13)
Anemia	2 (5)	1 (3)	1 (3)	4 (10)
Fatigue	4 (10)	0	0	4 (10)
AST increased	4 (10)	0	0	4 (10)

No treatment-related Grade 4 or 5 AEs or SAEs have been reported

Median time on zoldonrasib, months (range): 10.5 (1.3, 19.3).
[a]Grade 3 TRAEs include: 1 G3 diarrhea, 1 G3 anemia, 2 G3 blood creatine phosphokinase increased, 1 G3 facial paresis.
[b]Includes preferred terms of Dermatitis acneiform, Rash, Rash erythematous, Rash maculo-papular. AE, adverse event; AST, aspartate transferase; KRAS, Kirsten rat sarcoma virus; NSCLC, non-small cell lung cancer; PO, orally; QD, once daily; SAE, serious adverse event; TRAE, treatment-related adverse event.

Data cutoff: Dec 1, 2025

Zoldonrasib Monotherapy Led to Minimal Dose Modifications and Discontinuations with Favorable Dose Intensity Maintained

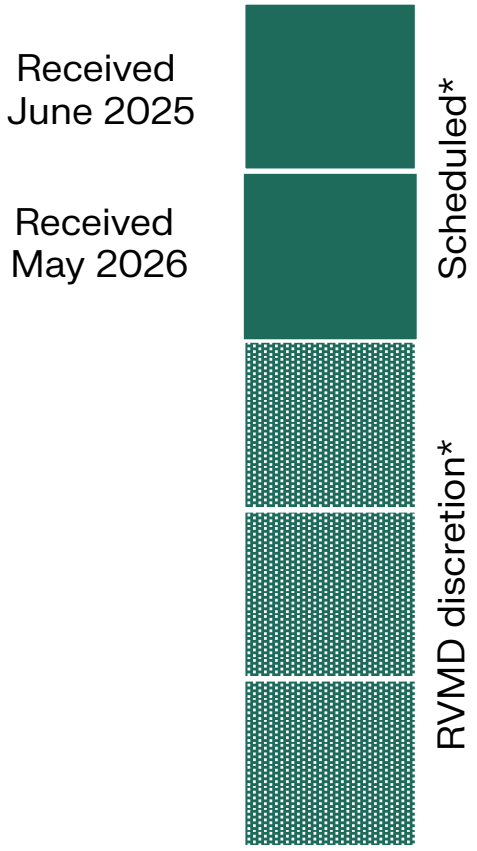
TRAEs Leading to Zoldonrasib Action Taken	All NSCLC Treated 1200 mg PO QD (N = 40)
Dose modification, n (%)	
Dose interruption	6 (15)
Dose reduction	1 (3)
Dose discontinuation, n (%)	2 (5)[a]
Zoldonrasib Relative Dose Intensity	
Mean/Median dose intensity (%)	94/97

[a]TRAE dose discontinuations include: 1 patient with G1 pneumonitis, 1 patient with G1 vomiting.
G1, Grade 1; NSCLC, non-small cell lung cancer; PO, orally; QD, once daily; TRAE, treatment-related adverse event.

Data cutoff: Dec 1, 2025

Royalty Pharma Partnership

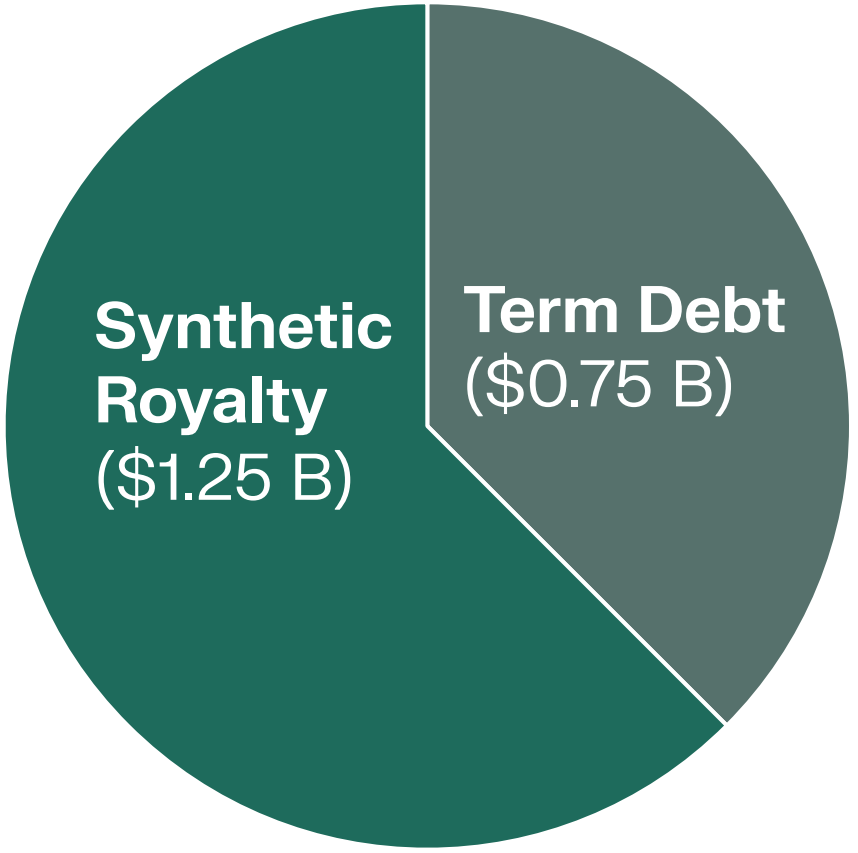
Royalty Pharma Partnership Bolsters Already Strong Financial Position by Providing $2 Billion in Flexible Committed Capital

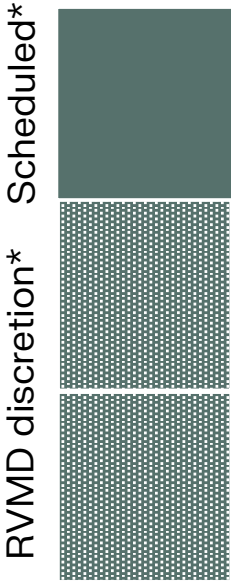


5 Tranches

Downward tiered, single-digit royalty rates on revenue, decreasing by tranche

$2 Billion Committed





RASolute302 approval

3 Tranches

Market-competitive interest rate linked to SOFR

Revolution Medicines

$250 million tranche
Up to $250 million tranche

* Future tranches can be drawn at RVMD's discretion subject to the satisfaction of the applicable development or commercial trigger.

$250 million tranche
Up to $250 million tranche