Revolution Medicines

On Target to Outsmart Cancer

August 2026

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This presentation includes certain information regarding publicly available results from clinical trials by third parties evaluating other products and 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.

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

DISCOVER

Continuous innovation through unique platform and insights to sustain leadership position and impact

DEVELOP

Broad clinical development across tumor types and treatment settings

DELIVER

Bringing transformative targeted medicines to patients through commercial excellence and global expansion

Insights from all three pillars drive a virtuous cycle that fuels **innovation** and **impact**

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

Pancreatic adenocarcinoma

- >90% are RAS-driven(1)

Non-small cell lung cancer

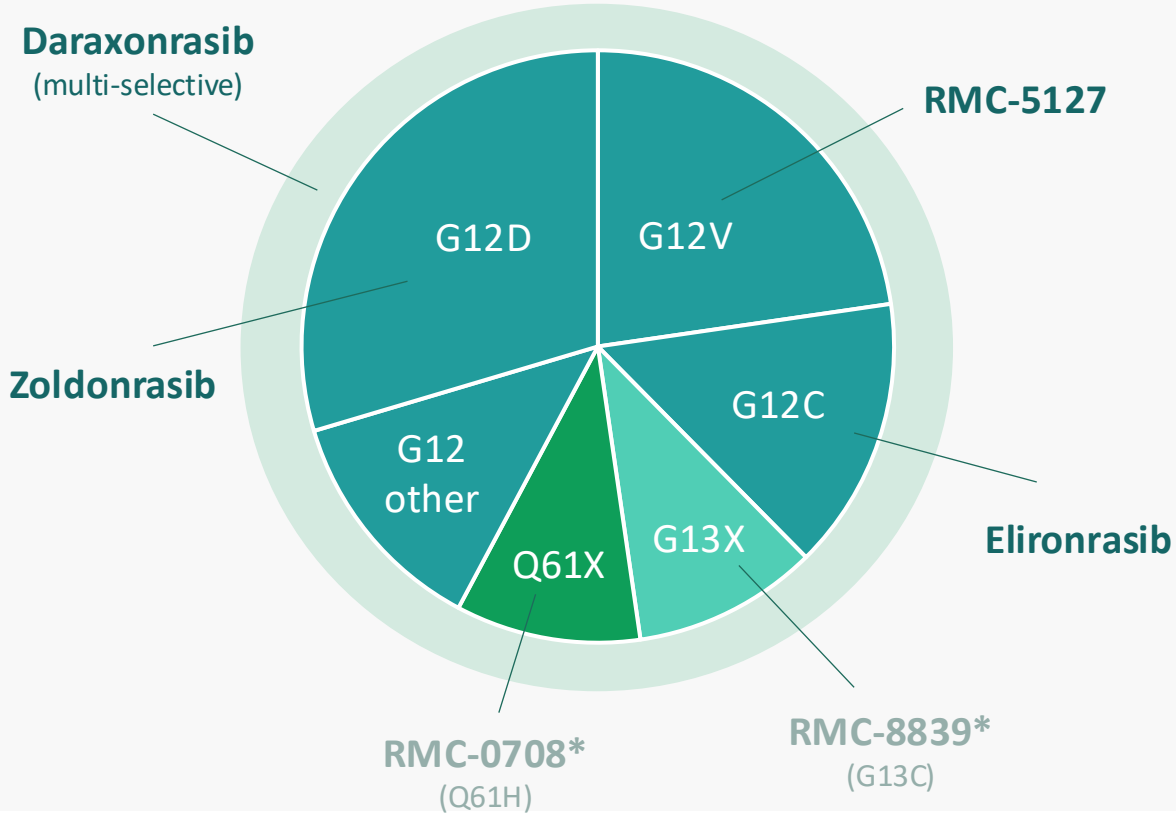
- ~30% are RAS-driven(1)
- RAS-targeted therapies exist for G12C only, no full approvals to-date

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.

2026: A Transformational Year Across Discovery, Development and Delivery

- **Discovery:** proprietary tri-complex platform underlies extensive portfolio of innovative, oral inhibitors targeting the oncogenic ("ON") state of RAS
- **Development:** deep late-stage pipeline of investigational medicines and robust global execution
- **Delivery:** U.S. NDA accepted for review by FDA and EMA phased review underway; U.S. commercial capabilities in place and launch ready


Develop

Advancing Broad and Differentiated Pipeline of RAS(ON) Inhibitors

Phase 3 Registrational Trials

	Molecule	Target	Trial	Treatment Setting	Regimen	Status
PDAC	Daraxonrasib	MULTI	RASolute 302	2L metastatic	Mono	Completed
PDAC	Daraxonrasib	MULTI	RASolute 303	1L metastatic	Mono & Combo	Ongoing
PDAC	Daraxonrasib	MULTI	RASolute 304	Adjuvant in resectable	Mono	Ongoing
PDAC	Zoldonrasib	G12D	RASolute 305	1L metastatic	Combo	Ongoing
PDAC	Zoldonrasib + Daraxonrasib	G12D	RASolute 309	1L metastatic	Combo	Initiated
NSCLC	Daraxonrasib	MULTI	RASolve 301	2L/3L metastatic	Mono	Ongoing
NSCLC	Zoldonrasib	G12D	RASolve 308	1L metastatic	Combo	Initiated
NSCLC	Elironrasib	G12C	RASolve 307	1L metastatic	Combo	Pending

Phase 1/2 Clinical Development

Daraxonrasib (MULTI), Zoldonrasib (G12D), Elironrasib (G12C), and RMC-5127 (G12V) are being evaluated in solid tumors across a range of monotherapy and combination treatment strategies. RM-055 is currently advancing through IND-enabling studies. For more information, visit ClinicalTrials.gov.

PDAC

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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

(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.

Pancreatic Cancer | Aim to Redefine Standard of Care Across Continuum of Disease

Previously Treated

First Line

Adjuvant

Excessive RAS(ON) signaling underlies all stages of PDAC

- Unprecedented Phase 3 results establish daraxonrasib as potential new standard of care
- Multiple registrational programs expanding across treatment settings
- Complementary RAS(ON) strategies designed to provide multiple treatment options for patients

Every patient journey is **unique** – our commitment is to develop multiple treatment options across PDAC continuum

PDAC, pancreatic adenocarcinoma.

Executing Rapidly Following Landmark RASolute 302 Results in Pancreatic Cancer – Daraxonrasib Enters **Delivery** Stage

Expanding Patient Access

- Robust Expanded Access Program active across the U.S.
- Daraxonrasib provided to physicians on behalf of >2,000 patients through academic and community sites in almost all 50 states

Advancing Toward Global Registration

- NDA accepted for review by U.S. FDA
- Phased review of MAA underway with EMA
- Accelerating engagement with global health authorities

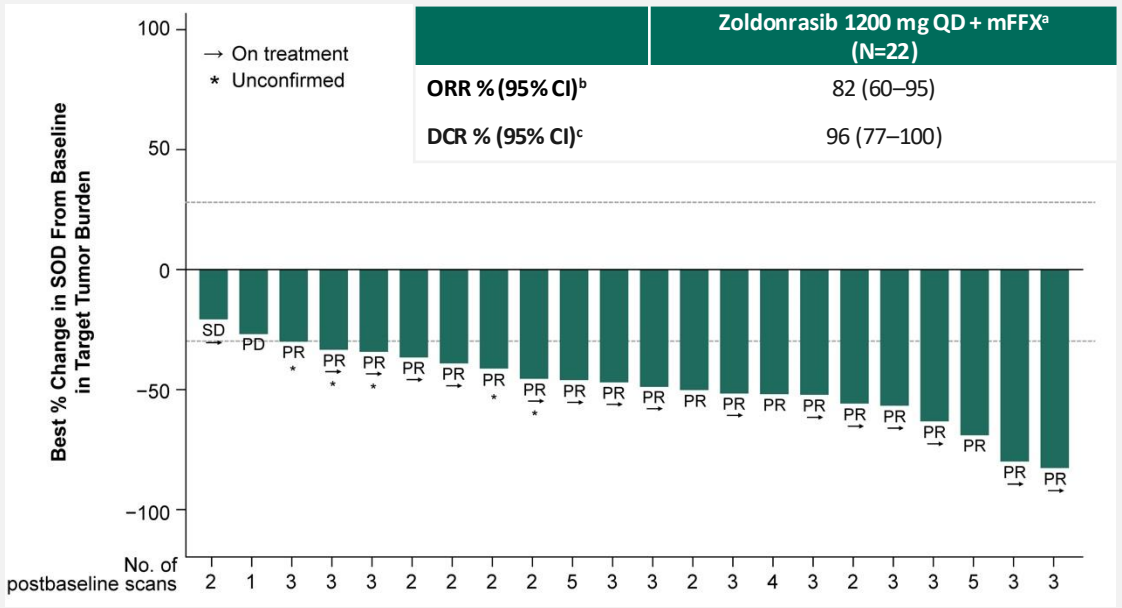
Achieving Launch Readiness

- U.S. organization launch ready and fully engaged in pre-commercial activities
- Medical affairs, market access, patient support capabilities and distribution channels in place
- Global launch readiness advancing at accelerating pace

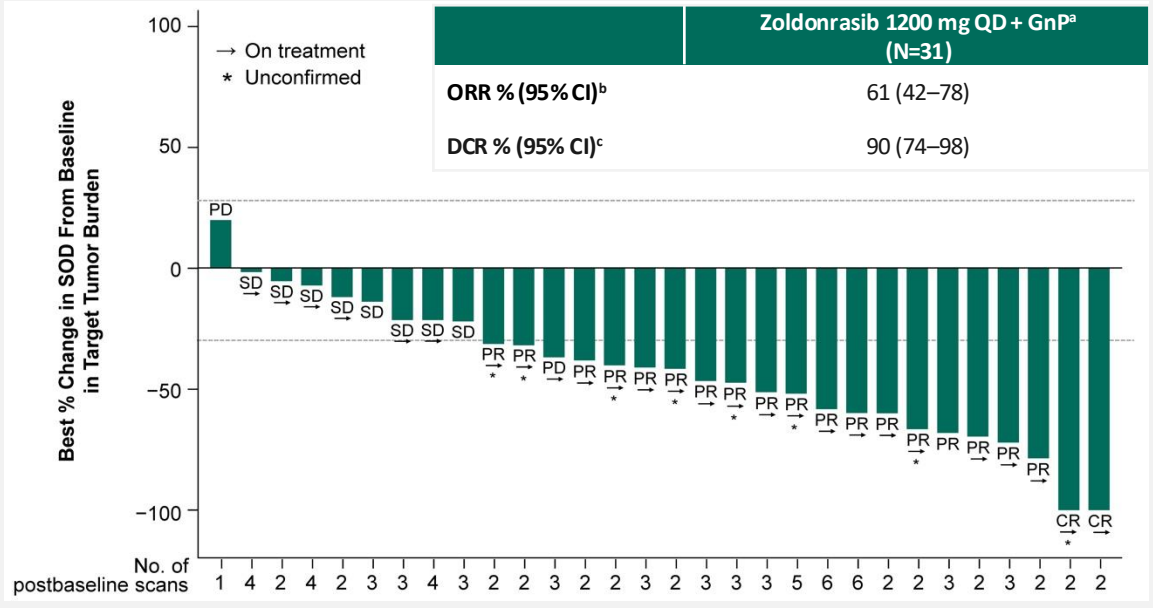
Driving Future Growth

- Multiple Phase 3 registrational trials advancing
- New pancreatic cancer combination data support expansion across treatment settings

Zoldonrasib + Chemotherapy Demonstrated Promising Initial Activity in First-Line RAS G12D PDAC



	Zoldonrasib 1200 mg QD + mFFX[a] (N=22)
ORR % (95% CI)[b]	82 (60–95)
DCR % (95% CI)[c]	96 (77–100)



	Zoldonrasib 1200 mg QD + GnP[a] (N=31)
ORR % (95% CI)[b]	61 (42–78)
DCR % (95% CI)[c]	90 (74–98)

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Data cutoff: 8 Feb 2026. Median follow-up, months (range) for zoldonrasib + mFFX: 6.1 (4.1–10.3); median follow-up, months (range) for zoldonrasib + GnP: 5.7 (4.1–11.9).
[a] Includes all patients with 1L PDAC who received their first dose of zoldonrasib in combination with chemotherapy at least 18 weeks prior to data cutoff. [b] Objective response rate (ORR) (per RECIST v 1.1) includes complete responses (CR), partial responses that were confirmed (PR) or still had the potential to confirm (PR*). [c] Disease control rate (DCR) includes CR, PR and stable disease (SD).
Patients who lack adequate baseline/post-baseline assessments are not displayed in the waterfall but included in the denominator for ORR.
mFFX, modified FOLFIRINOX; GnP, gemcitabine and nab-paclitaxel; 1L, first line; PD, progressive disease; PDAC, pancreatic adenocarcinoma; QD, once daily; RAS, rat sarcoma virus; SOD, sum of diameters.

Data previously presented at ESMO GI (July 2026)

Zoldonrasib + Chemotherapy Safety Profile Supports Development in First-Line Treatment for RAS G12D PDAC

	Zoldonrasib 1200 mg QD + mFFX (N=41)	
	Any Grade	**Grade ≥3**
Any study drug-related AE, n (%)	40 (98)	25 (61)
TRAEs occurring in ≥20% of all patients, n (%)		
Diarrhea	32 (78)	4 (10)
Nausea	25 (61)	1 (2)
Fatigue	21 (51)	2 (5)
Neutrophil count decreased	20 (49)	15 (37)
Vomiting	20 (49)	0
Platelet count decreased	18 (44)	3 (7)
Peripheral sensory neuropathy	15 (37)	1 (2)
Anemia	11 (27)	5 (12)
Paresthesia	11 (27)	0

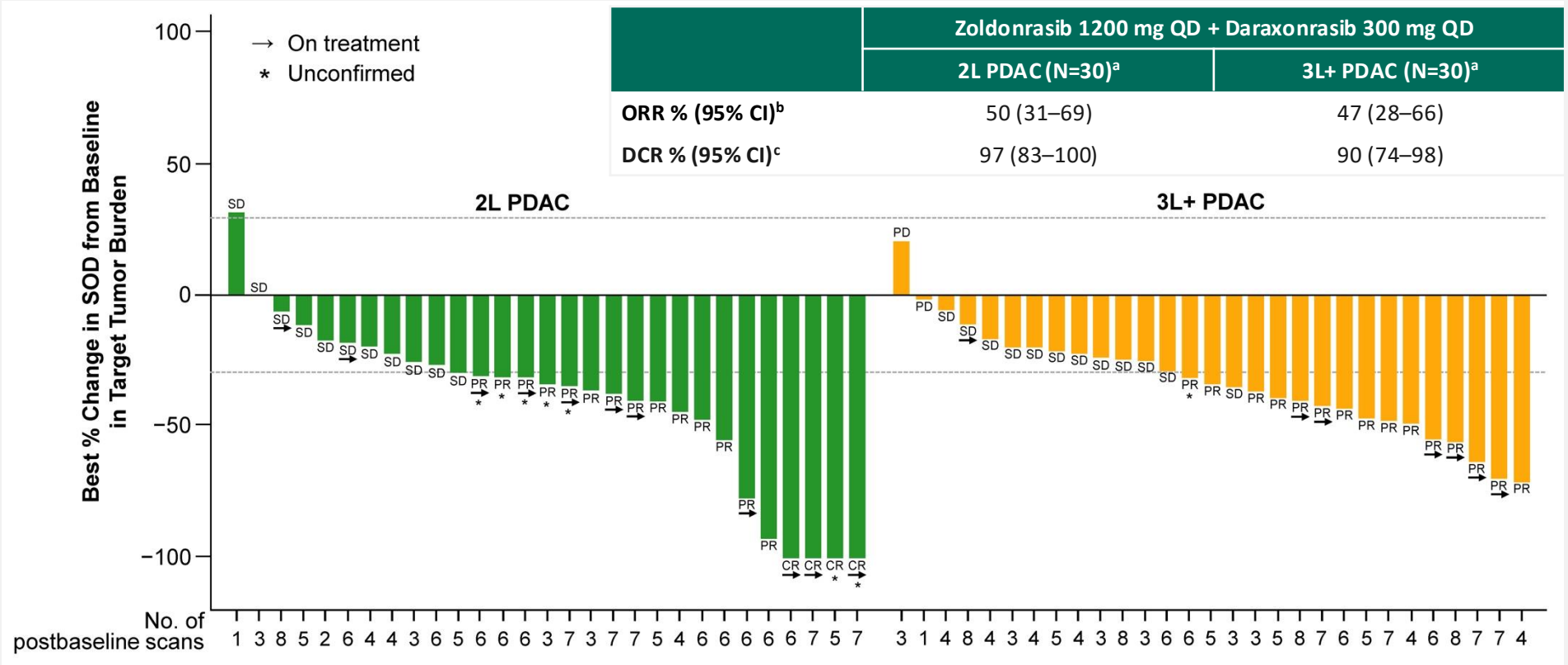
	Zoldonrasib 1200 mg QD + GnP (N=40)	
	Any Grade	**Grade ≥3**
Any study drug-related AE, n (%)	40 (100)	32 (80)
TRAEs occurring in ≥20% of all patients, n (%)		
Fatigue	32 (80)	10 (25)
Nausea	28 (70)	1 (3)
Neutrophil count decrease	22 (55)	14 (35)
Anemia	19 (48)	11 (28)
Rash[a]	17 (43)	0
Diarrhea	17 (43)	0
Peripheral sensory neuropathy	17 (43)	1 (3)
Alopecia	15 (38)	0
Vomiting	15 (38)	1 (3)
Decreased appetite	12 (30)	1 (3)
Platelet count decreased	10 (25)	4 (10)
Aspartate aminotransferase increased	9 (23)	1 (3)
Edema	9 (23)	1 (3)
White blood cell count decreased	8 (20)	4 (10)

Data cutoff: 8 Feb 2026. Median treatment duration, months (range) for zoldonrasib in combination with mFFX: 3.9 (0.2–10.3); median treatment duration, months (range) for zoldonrasib in combination with GnP: 4.7 (0.5–11.9). [a] Rash consists of dermatitis acneiform, rash, rash macular, and rash maculopapular.
1L, first line; GnP, gemcitabine; mFFX, modified FOLFIRINOX; PDAC, pancreatic adenocarcinoma; QD, once daily; RAS, rat sarcoma virus; TRAE, treatment-related adverse event.

Data previously presented at ESMO GI (July 2026)

Zoldonrasib + Daraxonrasib Doublet Demonstrated Compelling Initial Antitumor Activity in Previously Treated RAS G12D PDAC

	Zoldonrasib 1200 mg QD + Daraxonrasib 300 mg QD	
	2L PDAC (N=30)[a]	3L+ PDAC (N=30)[a]
ORR % (95% CI)[b]	50 (31–69)	47 (28–66)
DCR % (95% CI)[c]	97 (83–100)	90 (74–98)



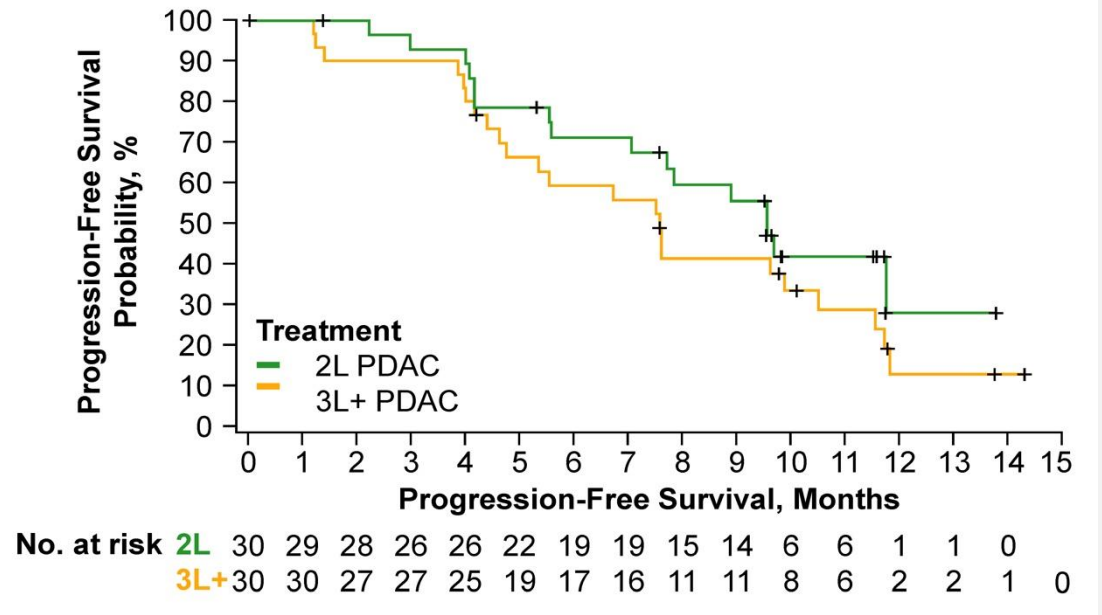
Data cutoff: 9 Feb 2026. Median follow-up, months (range) for 2L PDAC: 12.0 (9.9–14.1); Median follow-up, months (range) for 3L+ PDAC: 12.6 (10.7–14.9).

[a] Includes all patients with PDAC who received their first dose of zoldonrasib in combination with daraxonrasib at least 14 weeks prior to data cutoff. One patient with unconfirmed (PR*) in 2L will never confirm due to PD but remains on treatment. [b] Objective response rate (ORR) (per RECIST v 1.1) includes complete responses (CR), partial responses that were confirmed (PR) or still had the potential to confirm (PR*). [c] Disease control rate (DCR) includes CR, PR and stable disease (SD). Patients who lack adequate baseline/post-baseline assessments are not displayed in the waterfall but included in the denominator for ORR. 2L, second line; 3L+, third line and beyond; PD, progressive disease; PDAC, pancreatic adenocarcinoma; QD, once daily; SOD, sum of diameters.

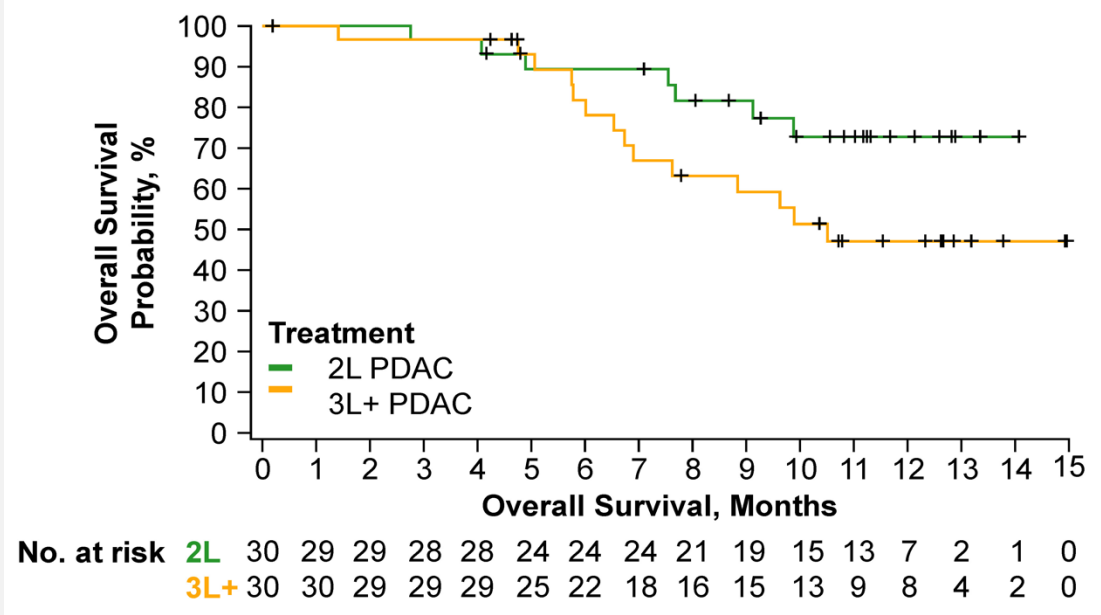
Data previously presented at ESMO GI (July 2026)

Zoldonrasib + Daraxonrasib Doublet Demonstrated Compelling Preliminary Durability in Previously Treated RAS G12D PDAC

	Zoldonrasib 1200 mg QD + Daraxonrasib 300 mg QD	
	2L PDAC (N=30)	3L+ PDAC (N=30)
mPFS (95% CI), months	9.6 (7.1–NE)	7.6 (4.6–10.5)
6-month PFS (95% CI), %	71 (50–84)	59 (39–74)



	Zoldonrasib 1200 mg QD + Daraxonrasib 300 mg QD	
	2L PDAC (N=30)	3L+ PDAC (N=30)
mOS (95% CI), months	NE (NE–NE)	10.5 (6.7–NE)
6-month OS (95% CI), %	89 (71–97)	82 (62–92)



Data cutoff: 9 Feb 2026. Median follow-up, months (range) for 2L PDAC: 12.0 (9.9–14.1); median follow-up, months (range) for 3L+ PDAC: 12.6 (10.7–14.9).
2L, second line; 3L+, third line and beyond; KRAS; m, median; NE, not estimable; OS, overall survival; PDAC, pancreatic adenocarcinoma; PFS, progression-free survival; QD, once daily.

Data previously presented at ESMO GI (July 2026)

Zoldonrasib + Daraxonrasib Doublet Demonstrated Manageable Safety and Tolerability Profile

	Zoldonrasib 1200 mg QD + Daraxonrasib 300 mg QD All 2L+ PDAC Treated (N=60)	
	Any Grade	**Grade ≥3**
Any study drug-related AE, n (%)	58 (97)	21 (35)[a]
TRAEs occurring in ≥10% of all patients, n (%)		
Rash[b]	54 (90)	7 (12)
Diarrhea	38 (63)	3 (5)
Nausea	34 (57)	1 (2)
Stomatitis/mucositis[c]	32 (53)	4 (7)
Fatigue	17 (28)	2 (3)
Vomiting	17 (28)	1 (2)
Anemia	12 (20)	6 (10)
Aspartate aminotransferase increased	7 (12)	0
Decreased appetite	7 (12)	0
Thrombocytopenia	7 (12)	0
Alanine aminotransferase increased	6 (10)	0
Edema peripheral	6 (10)	0

Data cutoff: 9 Feb 2026. Median treatment duration, months (range) for zoldonrasib: 7.9 (0.1–14.9); median treatment duration, months (range) for daraxonrasib: 7.5 (0.1–14.9) months.
[a] No Grade 4 TRAEs were reported; one Grade 5 TRAE of intestinal perforation was reported in a patient treated with zoldonrasib 1200 mg QD + daraxonrasib 300 mg QD. [b] Rash includes preferred terms of dermatitis acneiform, rash, rash maculo-papular, and rash pruritic. [c] Stomatitis/mucositis includes preferred terms of stomatitis, mucosal inflammation, and aphthous ulcer.
2L+, second line and beyond; AE, adverse event; PDAC, pancreatic adenocarcinoma; QD, once daily; TRAE, treatment-related adverse event.

Data previously presented at ESMO GI (July 2026)

NSCLC

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Non-Small Cell Lung Cancer | Layered Development Strategy Targeting RAS Tumor Drivers

RAS(ON) Multi-Selective Inhibition

for treatment across RAS mutations

Daraxonrasib
G12, G13, Q61

RASolve 301 to establish treatment foundation in previously treated NSCLC

Exploring innovative combinations in 1L to expand potential impact

RAS(ON) Mutant-Selective Inhibition

for treatment by individual RAS tumor mutation

Elironrasib
G12C

Zoldonrasib
G12D

RMC-5127
G12V

Compelling profiles for combination with SOC

Initial mutant-selective inhibitor strategy in 1L NSCLC

- NSCLC treatment defined by classes of oncogenic drivers; increasingly by specific tumor mutations
- ~30% of NSCLC carries a RAS mutation[1]
- Portfolio offers opportunity to address majority of patients with RAS mutant disease

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(1) estimated using tumor mutation frequencies from FoundationCORE March 2022.
NSCLC, non-small cell lung cancer; 1L, first line; SOC, standard of care

Daraxonrasib | Establishing the Foundation in Previously Treated RAS Mutant NSCLC

Recognition of Clinical Potential

FDA Breakthrough Therapy Designation in previously treated metastatic KRAS mutant (non-G12C) NSCLC

Registrational Development

Global Phase 3 registrational trial (RASolve 301) in previously treated RAS mutant NSCLC progressing well

Future Opportunities

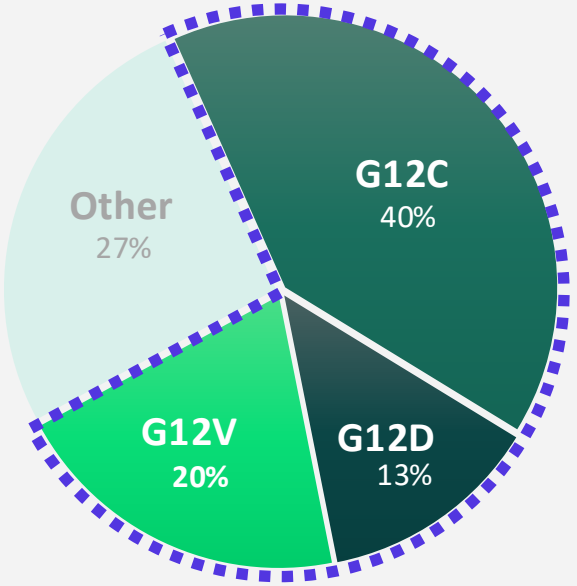
Broad clinical development ongoing, including exploring novel combination strategies to further improve outcomes

Daraxonrasib is being advanced in NSCLC through strategy spanning ongoing registrational development in previously treated disease and exploration of innovative combination approaches

NSCLC, non-small cell lung cancer.

Non-Small Cell Lung Cancer | RAS(ON) Mutant-Selective Portfolio Designed for Treatment Landscape Segmented by Genetic Cause

Three RAS Variants Dominate RAS Mutant NSCLC[1]



Promising Clinical Portfolio of RAS(ON) Mutant-Selective Inhibitors

- Clinical-stage mutant-selective inhibitors address >70% of RAS mutant NSCLC
- Highly encouraging monotherapy efficacy and safety profiles for elironrasib (G12C) and zoldonrasib (G12D)
- Promising initial results from mutant-selective inhibitors plus 1L standard of care inform registrational strategy

Uniquely positioned to address majority of patients with RAS mutant NSCLC

(1) 30% of patients with NSCLC harbor a RAS mutation (estimated using tumor mutation frequencies from FoundationCORE March 2022); percentages within chart represent distribution of RAS mutation subtypes among patients with RAS mutant NSCLC. NSCLC, non-small cell lung cancer; 1L, first line.

Zoldonrasib + Pembrolizumab + Chemotherapy: Baseline Patient Characteristics

	Zoldonrasib 1200 mg QD + Pembrolizumab + Pemetrexed + Platinum (N=38)
Median age, years (range)	64 (28, 84)
Sex - Male, n (%)	20 (53%)
ECOG PS 1, n (%)	17 (45%)
Current/Past Smoker, n (%)	28 (74%)
Metastatic at initial diagnosis [stage IV], n (%)	31 (82%)
Brain metastasis, n (%)	5 (13%)
Liver metastasis, n (%)	5 (13%)
PD-L1 expression (based on local testing)	
TPS < 1%	15 (39%)
TPS 1–49%	15 (39%)
TPS ≥ 50%	6 (16%)
Missing	2 (5%)

Data cutoff: 11 May 2026.

Zoldonrasib + Pembrolizumab + Chemotherapy: Manageable Safety Profile with Minimal Added Toxicity

	Zoldonrasib 1200 mg + Pembrolizumab + Pemetrexed + Platinum (N=38)	
	Any Grade	**Grade >= 3**
Any TRAE, n (%)	34 (89%)	9 (24%)
TRAEs in ≥20% of patients, n (%)		
Nausea	19 (50%)	1 (3%)
Anaemia	14 (37%)	4 (11%)
Diarrhoea	13 (34%)	0
Vomiting	11 (29%)	1 (3%)
Fatigue	9 (24%)	0
ALT increased [a]	9 (24%)	3 (8%)
AST increased [a]	8 (21%)	1 (3%)
Asthenia	8 (21%)	2 (5%)
Constipation	8 (21%)	0

- TRAEs generally consistent with the established safety profile of SOC pembrolizumab and platinum doublet chemotherapy
- Minimal added toxicity and no Grade 5 TRAEs
- Favorable liver safety profile
- Supportive of continued combination development

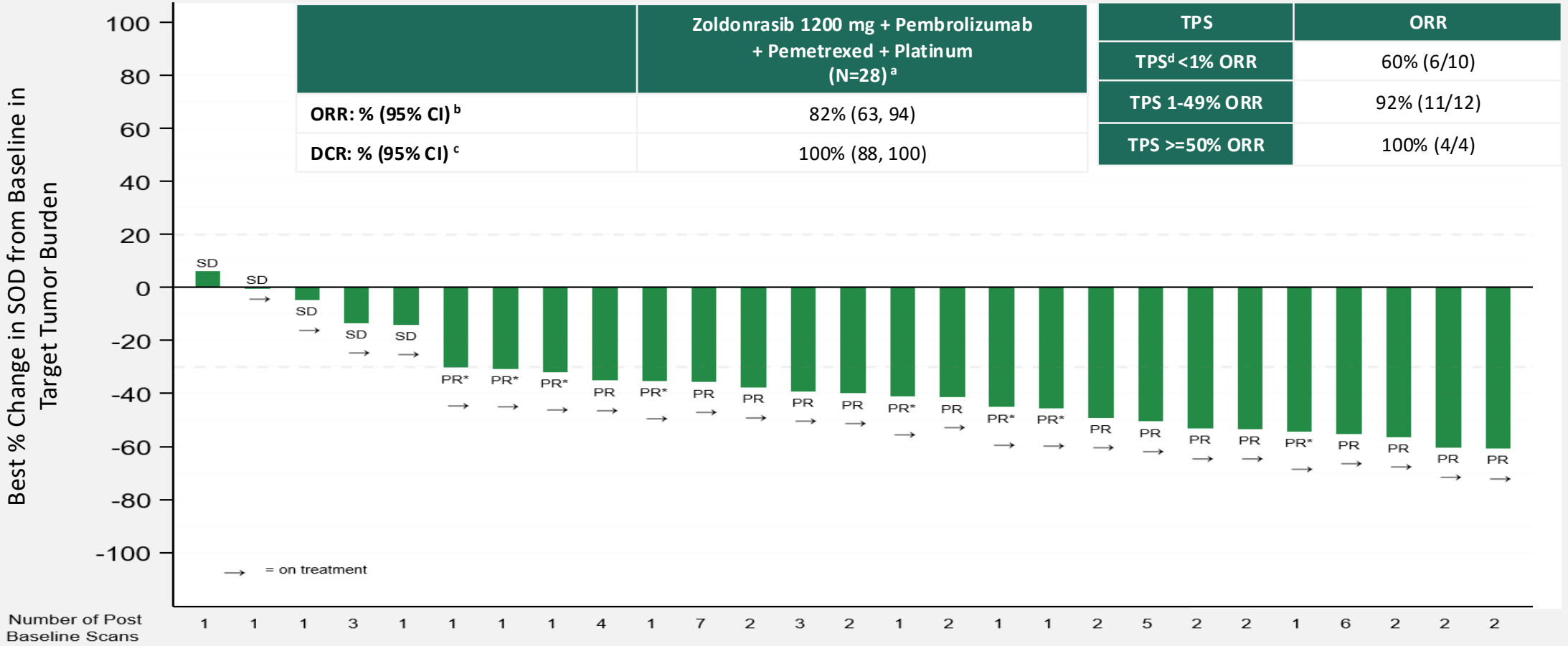
Data cutoff: 11 May 2026. Median treatment duration, months (range) for zoldonrasib: 2.5 (0.2–11.1).

[a] Grade 3 ALT/AST elevations occurred in 3 patients (4 events: 3 ALT, 1 AST); elevation in all 3 patients resolved following dose interruption and/or modification, with no recurrent Grade 3 ALT.

Zoldonrasib + Pembrolizumab + Chemotherapy: Encouraging Antitumor Activity

	Zoldonrasib 1200 mg + Pembrolizumab + Pemetrexed + Platinum (N=28) [a]
ORR: % (95% CI) [b]	82% (63, 94)
DCR: % (95% CI) [c]	100% (88, 100)

TPS	ORR
TPS[d] <1% ORR	60% (6/10)
TPS 1-49% ORR	92% (11/12)
TPS >=50% ORR	100% (4/4)



Data cutoff: 11 May 2026. Median follow-up, months (range): 3.4 (2.0, 11.1). [a] All treated 1L NSCLC patients received a first dose of zoldonrasib 1200 mg QD in combination with pembrolizumab 200 mg Q3W + pemetrexed + platinum at least 8 weeks prior to data cutoff date. [b] Objective response rate (ORR) (per RECIST v 1.1) includes complete responses (CR), partial responses that were confirmed (PR)or still had the potential to confirm (PR*). [c] Disease control rate (DCR) includes CR, PR and stable disease (SD). [d] Two patients are missing TPS (Tumor Proportion Score) assessment.
Patients who lack adequate baseline/post-baseline assessments are not displayed in the waterfall but included in the denominator for ORR.
1L, first line; PD, progressive disease; SOD, sum of diameters; QD, once daily.

Elironrasib + Pembrolizumab + Chemotherapy: Baseline Patient Characteristics

	Elironrasib 200 mg BID + Pembrolizumab + Pemetrexed + Platinum (N=39)
Median age, years (range)	66 (40, 84)
Sex - Male, n (%)	16 (41%)
ECOG PS 1, n (%)	19 (49%)
Current/Past Smoker, n (%)	38 (97%)
Metastatic at initial diagnosis [stage IV], n (%)	31 (79%)
Brain metastasis, n (%)	6 (15%)
Liver metastasis, n (%)	3 (8%)
PD-L1 expression (based on local testing)	
TPS < 1%	4 (10%)
TPS 1–49%	26 (67%)
TPS ≥ 50%	9 (23%)

Data cutoff: 11 May 2026.

Elironrasib + Pembrolizumab + Chemotherapy
Manageable Safety Profile with Minimal Added Toxicity

	Elironrasib 200 mg BID + Pembrolizumab + Pemetrexed + Platinum (N=39)	
	Any Grade	**Grade ≥3**
Any TRAE	**38 (97%)**	**20 (51%)**
TRAEs in ≥20% of patients, n (%)		
Nausea	29 (74%)	3 (8%)
Anemia	22 (56%)	7 (18%)
ALT increased [a]	18 (46%)	3 (8%) [b]
AST increased [a]	16 (41%)	2 (5%) [b]
Fatigue	16 (41%)	1 (3%)
Diarrhea	16 (41%)	4 (10%)
Asthenia	14 (36%)	3 (8%)
Vomiting	13 (33%)	2 (5%)
Neutropenia	11 (28%)	5 (13%)
Decreased appetite	11 (28%)	1 (3%)
Constipation	9 (23%)	1 (3%)
Dysgeusia	9 (23%)	0

- TRAEs generally consistent with the established safety profile of SOC pembrolizumab and platinum doublet chemotherapy
- Minimal added toxicity and no Grade 5 TRAEs
- Favorable liver safety profile
- Supportive of continued combination development

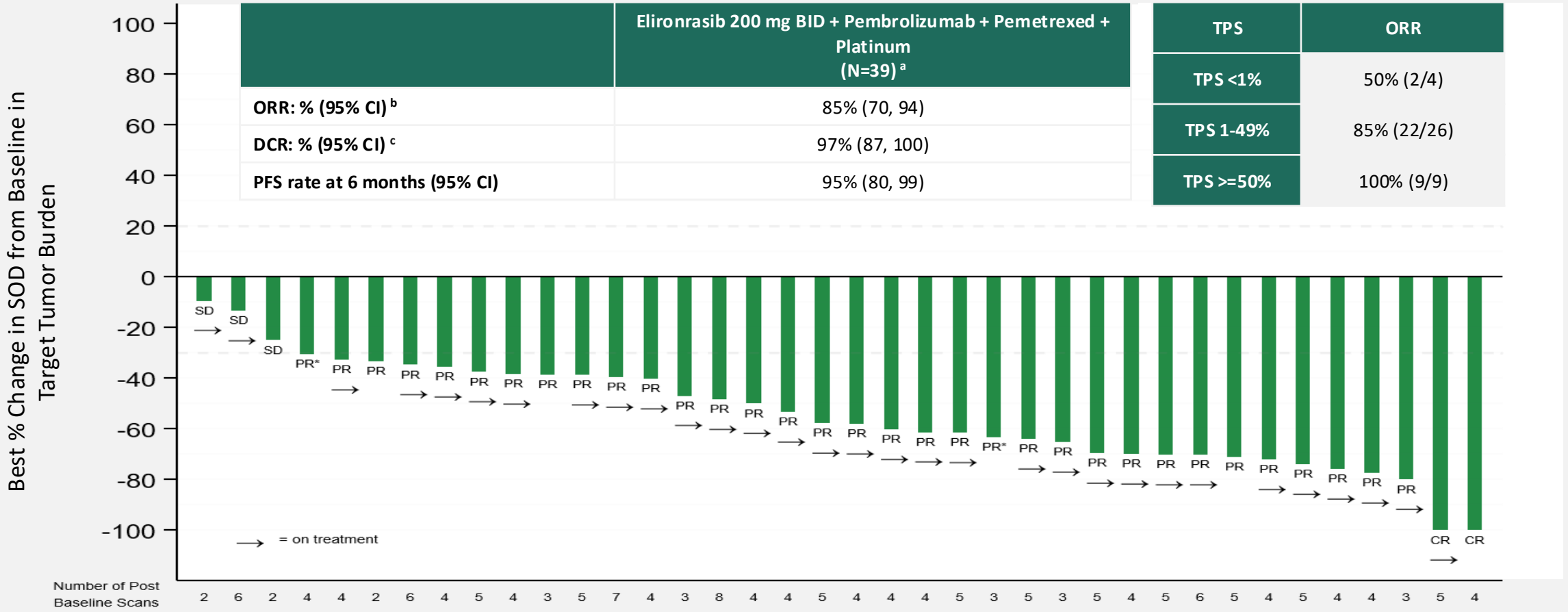
Data cutoff: 11 May 2026. Median treatment duration, months (range) for elironrasib: 7.8 (1–14.8).

[a] Grade 3 ALT/AST elevations occurred in 4 patients; all events resolved; treatment was interrupted and/or dose modified in each of these four patients, and only 1 received systemic corticosteroids for the elevations.

Elironrasib + Pembrolizumab + Chemotherapy: Encouraging Antitumor Activity

	Elironrasib 200 mg BID + Pembrolizumab + Pemetrexed + Platinum (N=39) [a]
ORR: % (95% CI) [b]	85% (70, 94)
DCR: % (95% CI) [c]	97% (87, 100)
PFS rate at 6 months (95% CI)	95% (80, 99)

TPS	ORR
TPS <1%	50% (2/4)
TPS 1-49%	85% (22/26)
TPS >=50%	100% (9/9)



Data cutoff: 11 May 2026. Median follow-up, months (range): 8.7 (5.1, 14.8).

[a] All treated 1L NSCLC patients received a first dose of elironrasib 200 mg BID in combination with pembrolizumab 200 mg Q3W + pemetrexed + platinum at least 14 weeks prior to data cutoff date. [b] Objective response rate (ORR) (per RECIST v 1.1) includes complete responses (CR), partial responses that were confirmed (PR) [c] Disease control rate (DCR) includes CR, PR and stable disease (SD). Patients who lack adequate baseline/post-baseline assessments are not displayed in the waterfall but included in the denominator for ORR. TPS, Tumor Proportion Score; 1L, first line; PD, progressive disease; SOD, sum of diameters; BID, twice daily; PR*, unconfirmed partial response.

CRC

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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.

Revolution Medicines

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


Deliver

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

- Launch-ready U.S. commercial capabilities positioned for daraxonrasib in PDAC
- Patient services program, commercial supply, and distribution network are ready
- Experienced leadership team with a strong track record of success in broad range of oncology builds and launches
- Global launch capabilities and readiness advancing at accelerating pace

Well positioned to execute a strong launch and deliver daraxonrasib to patients quickly and broadly, pending regulatory approvals

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PDAC, pancreatic adenocarcinoma.

Financial Summary

Revolution Medicines

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

$3.9 billion

in cash and investments as of June 30, 2026

+

$1.5 billion

in additional committed capital[1]

Financial Guidance

$2.1 – $2.2 billion

2026 GAAP Operating Expenses[2]

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(1) $2.0 billion in total flexible committed capital from agreement with Royalty Pharma, of which $500 million was received as of June 30, 2026. (2) includes $270 to $290 million in expected non-cash stock-based compensation expense.

Corporate Updates

Tracking Expected Impact

Pancreatic Cancer

✓	**1H 2026**	Readout for **RASolute 302** (daraxonrasib in 2L)
✓	**1H 2026**	Initiate **RASolute 305** (zoldonrasib + chemo combination in 1L)
✓	**2H 2026**	Initiate **RASolute 309** (daraxonrasib + zoldonrasib doublet in 1L)
	TBD	FDA approval and US launch of daraxonrasib
	TBD	Complete enrollment in **RASolute 303** and **RASolute 304** (daraxonrasib in 1L and adjuvant)

Non-Small Cell Lung Cancer

✓	**1H 2026**	Initiate **RASolve 308** (zoldonrasib combination in 1L)
	Q4 2026	Initiate **RASolve 307** (elironrasib combination in 1L)
	2026	Complete enrollment in **RASolve 301** (daraxonrasib in 2L+)
	2027	Initial readout for **RASolve 301** (daraxonrasib in 2L+)

Colorectal Cancer & RVMD-Led Collaborations

✓	**Q1 2026**	Initiate Phase 1 combination trial with PD-1/VEGF bispecific
	Q4 2026	Update on combination CRC data

Early Development

2H 2026	Identify candidate RP2D for **RMC-5127**
Q4 2026	Initiate Phase 1 trial with **innovative new class** of RAS(ON) inhibitors
2027	Initial clinical data for **RMC-5127**

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

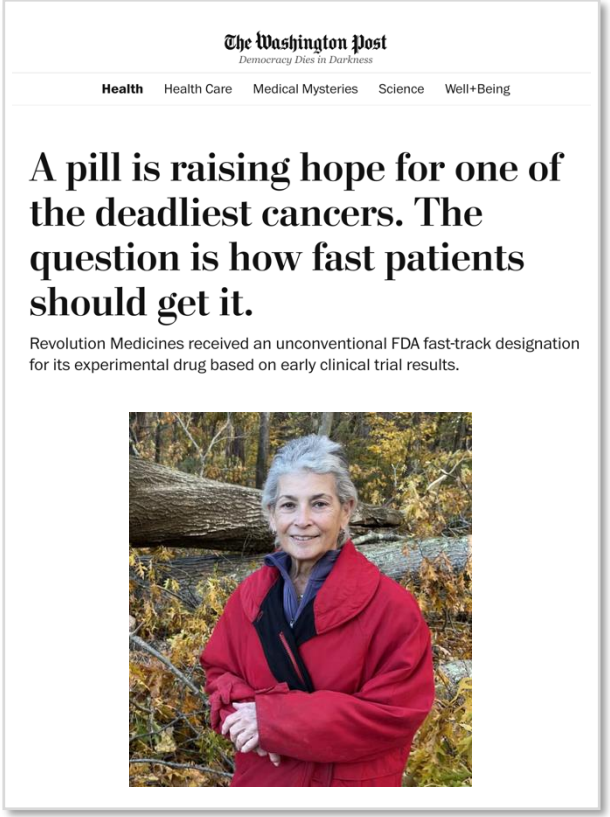
Our Why | Building on Strong Pillars for Growing Transformative Patient Impact


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

Our Mission

Our mission is to revolutionize treatment globally for patients with RAS-addicted cancers through the **discovery**, **development** and **delivery** of innovative, targeted medicines.

Confidential

Revolution Medicines

On Target to Outsmart Cancer®

Appendix

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

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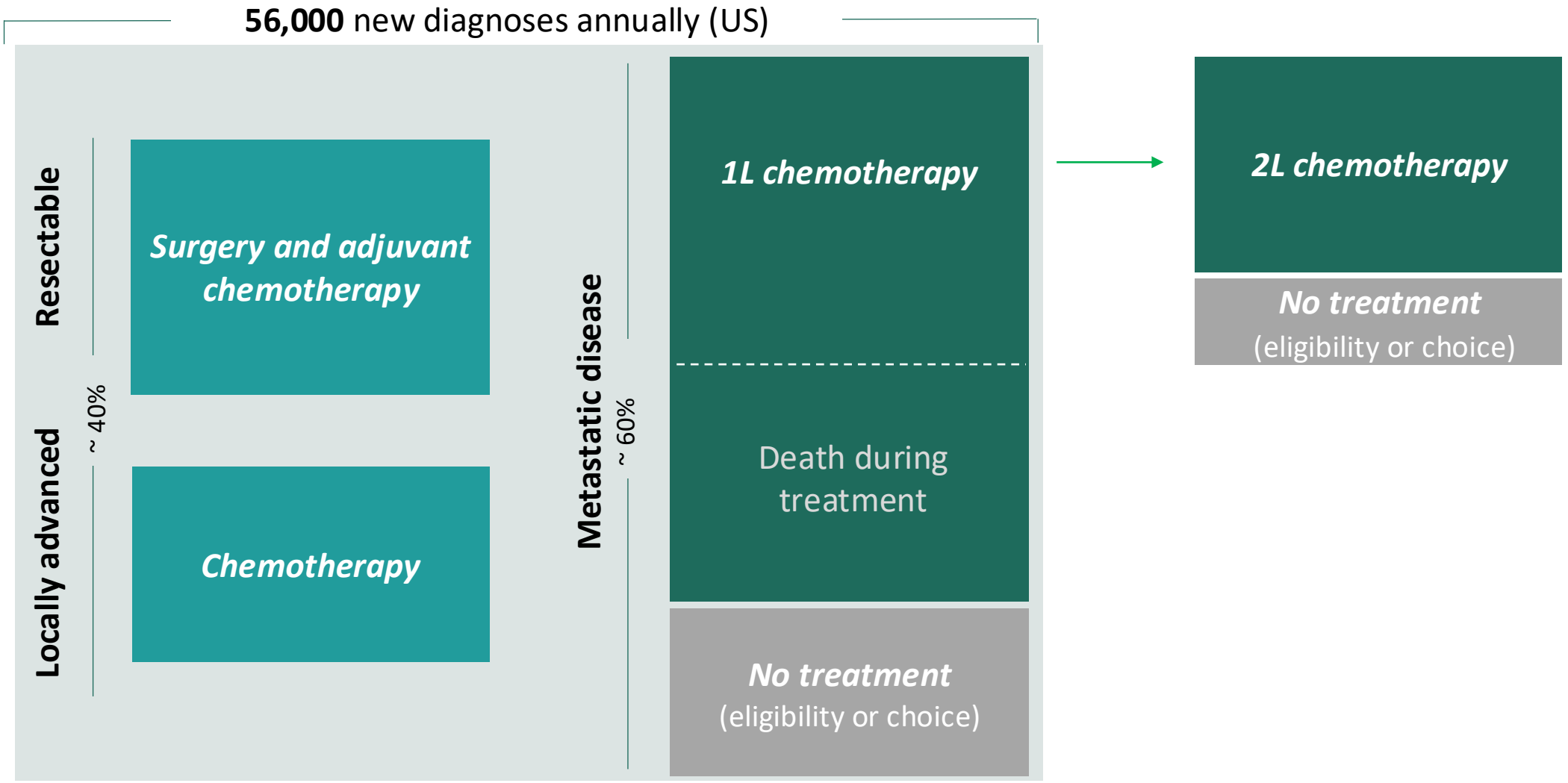
PDAC is an Aggressive Disease - Cytotoxic Chemotherapy is Global Standard of Care Across Lines of Therapy



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 adenocarcinoma; 1L, first line; 2L, second line.

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**

(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 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 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]

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(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 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

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Daraxonrasib Clinical Data

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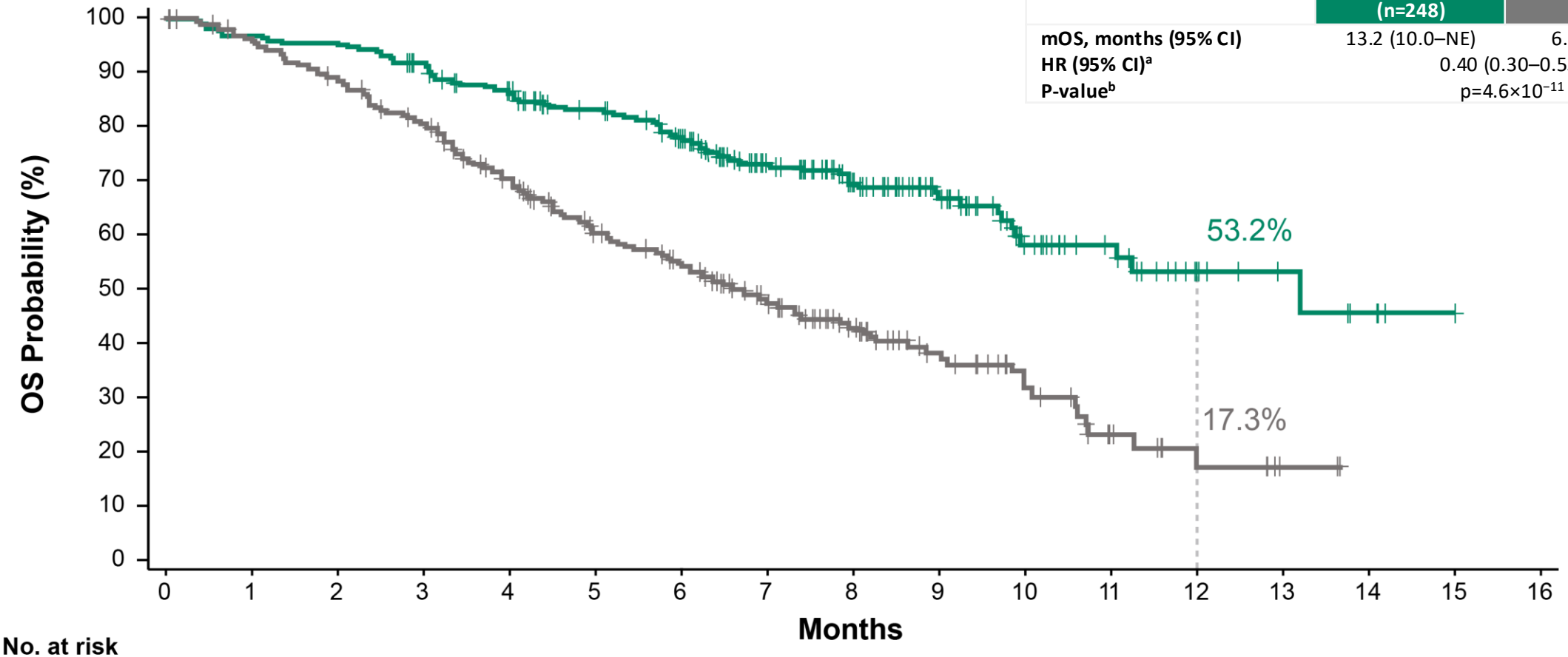
RASolute 302: Overall Survival in the Overall Study Population

	Daraxonrasib (n=248)	Chemotherapy (n=252)
mOS, months (95% CI)	13.2 (10.0–NE)	6.7 (5.8–8.0)
HR (95% CI)[a]	0.40 (0.30–0.53)	
P-value[b]	$p=4.6\times10^{-11}$	



No. at risk																	
Daraxonrasib	248	240	237	225	208	188	165	125	90	62	37	24	11	7	4	1	0
Chemotherapy	252	235	217	193	161	126	108	78	53	35	21	10	5	2	0		

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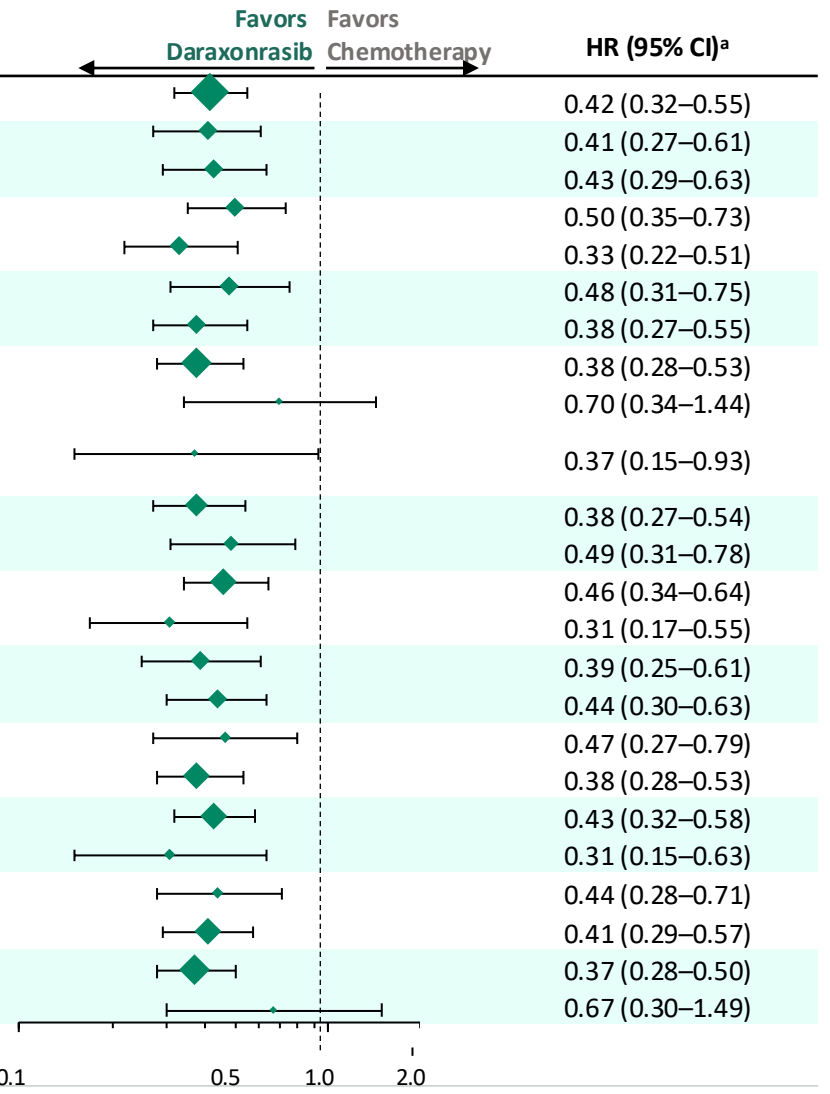
Data previously presented at the © 2026 ASCO, Inc. Reused with permission. All rights reserved and published in: O'Reilly EM, et al. N Engl J Med. 2026. DOI: 10.1056/NEJMoa2605555.
Data cutoff: 10 Feb 2026. Median (range) follow-up time was 8.5 (3.2–15.9) months; number of events: daraxonrasib: 79 (32%); chemotherapy: 141 (56%).
aHRs and 95% CIs were based on the stratified Cox model with Efron's method of tie handling. bP-values were calculated using the stratified log-rank test.
m, median; NE, not estimable; OS, overall survival.

RASolute 302: Overall Survival Benefit Consistent Across Subgroups

Population		Events/N Daraxonrasib	Events/N Chemotherapy	HR (95% CI)[a]
Overall		79/248	141/252	0.42 (0.32–0.55)
Age, years	<65	37/114	68/121	0.41 (0.27–0.61)
	≥65	42/134	73/131	0.43 (0.29–0.63)
Sex	Male	45/131	77/144	0.50 (0.35–0.73)
	Female	34/117	64/108	0.33 (0.22–0.51)
ECOG PS	0	33/129	51/118	0.48 (0.31–0.75)
	1[b]	46/119	90/134	0.38 (0.27–0.55)
Tumor RAS mutational status	RAS G12D/V	59/197	110/197	0.38 (0.28–0.53)
	Other RAS G12	13/31	17/34	0.70 (0.34–1.44)
	RAS G13 or Q61, or no RAS mutation identified	7/20	14/21	0.37 (0.15–0.93)
Metastatic disease at diagnosis	Yes	51/154	94/154	0.38 (0.27–0.54)
	No	28/94	47/98	0.49 (0.31–0.78)
Prior 5-FU-based regimen	Yes	62/181	103/186	0.46 (0.34–0.64)
	No	17/67	38/66	0.31 (0.17–0.55)
Prior gemcitabine-based regimen	Yes	31/110	61/114	0.39 (0.25–0.61)
	No	48/138	80/138	0.44 (0.30–0.63)
Prior pancreatectomy	Yes	21/83	40/92	0.47 (0.27–0.79)
	No	58/165	101/160	0.38 (0.28–0.53)
Liver metastases at baseline	Yes	68/174	113/176	0.43 (0.32–0.58)
	No	11/74	28/76	0.31 (0.15–0.63)
Peritoneal metastases at baseline	Yes	28/76	48/83	0.44 (0.28–0.71)
	No	51/172	93/169	0.41 (0.29–0.57)
CA19-9 level at baseline	≥40 U/mL	70/211	121/195	0.37 (0.28–0.50)
	<40 U/mL	9/36	19/56	0.67 (0.30–1.49)



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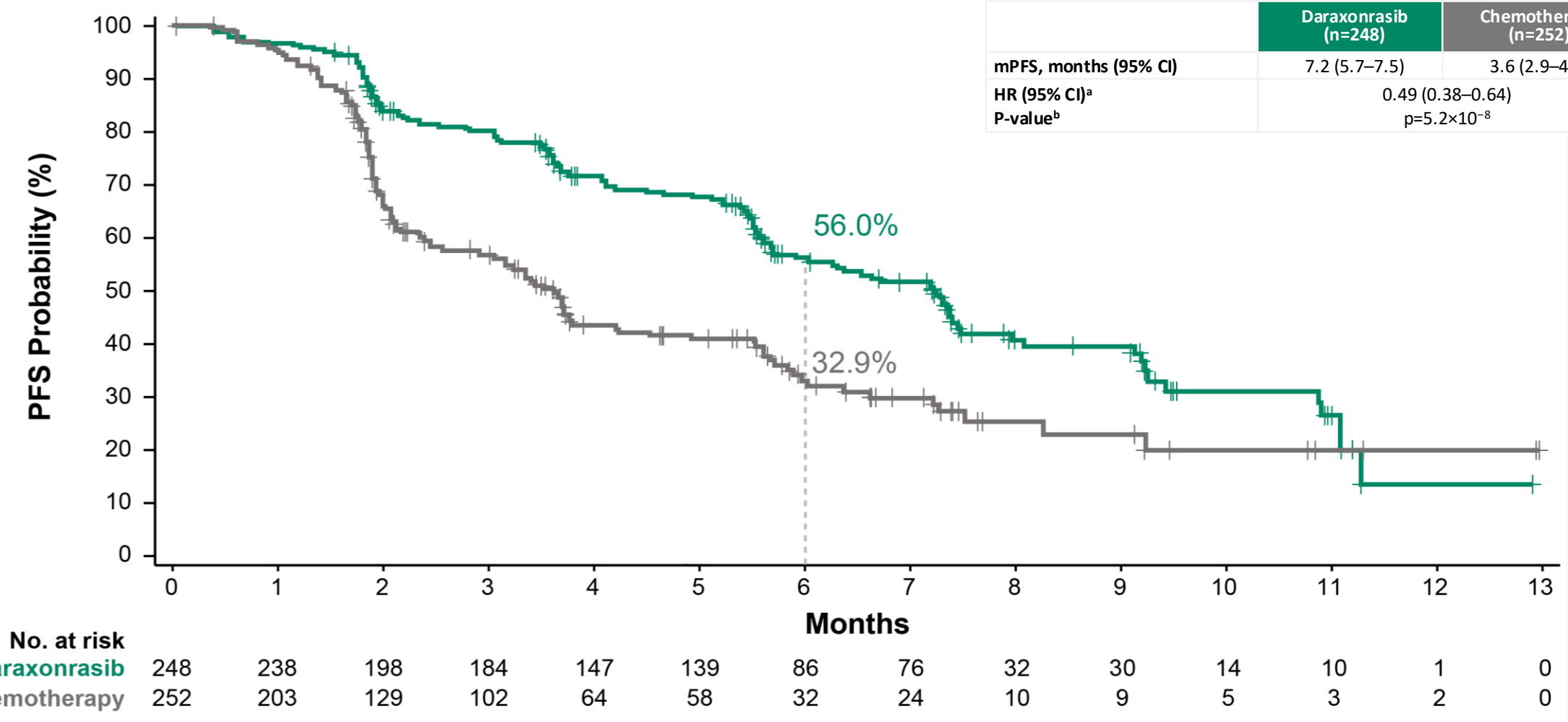
Data cutoff: 10 Feb 2026. 5-FU, 5-fluorouracil; ECOG, Eastern Cooperative Oncology Group; PS, performance status.
aThe size of diamonds is relative to the size of the population in each subgroup. HRs and 95% CIs were based on the unstratified Cox model with Efron's method of tie handling. bThree patients (including 2 patients randomized to the daraxonrasib arm and 1 patient randomized to the chemotherapy arm) had ECOG PS >1 at baseline. These patients were not dosed due to no longer meeting trial eligibility criteria.

RASolute 302: Progression-Free Survival in the Overall Study Population (by BICR)

	Daraxonrasib (n=248)	Chemotherapy (n=252)
mPFS, months (95% CI)	7.2 (5.7–7.5)	3.6 (2.9–4.2)
HR (95% CI)[a]	0.49 (0.38–0.64)	
P-value[b]	$p=5.2\times10^{-8}$	



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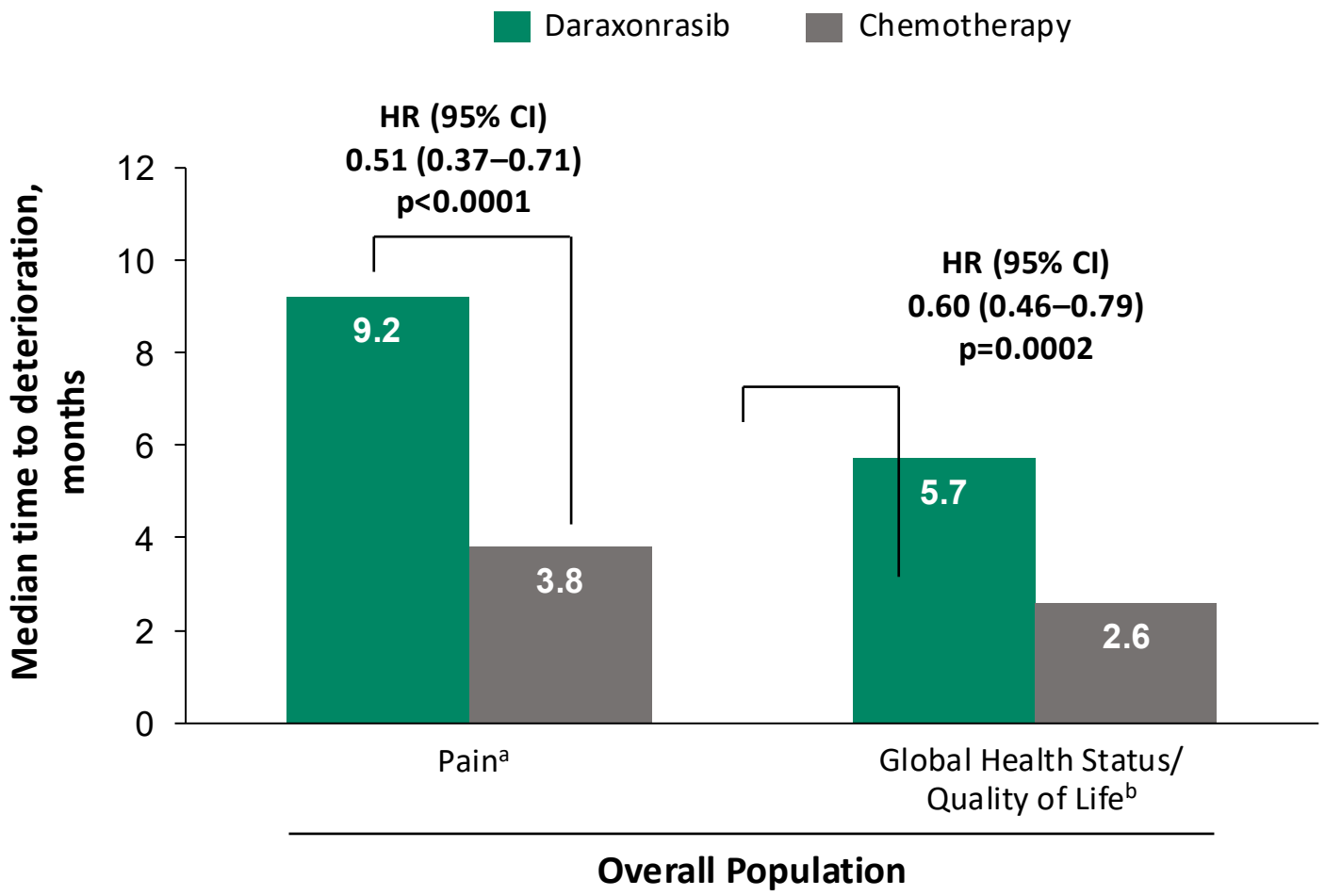
Data cutoff: 10 Feb 2026. Median (range) follow-up time was 8.5 (3.2–15.9) months; number of events: daraxonrasib: 127 (51%); chemotherapy: 130 (52%).
aHRs and 95% CIs were based on the stratified Cox model with Efron's method of tie handling. bP-values were calculated using the stratified log-rank test.
BICR, blinded independent central review; m, median; PFS, progression-free survival.

RASolute 302: Patient-Reported Outcomes (Overall Population)



- EORTC QLQ-PAN26 and EORTC QLQ-C30 questionnaires were administered on day 1 of each cycle and at end of treatment visit
- Daraxonrasib significantly delayed time to deterioration in both symptom of pain and global health status/quality of life compared with chemotherapy

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Data cutoff: 10 Feb 2026. EORTC QLQ-C30, European Organisation for the Research and Treatment of Cancer Quality of Life Questionnaire; EORTC QLQ-PAN26, European Organisation for the Research and Treatment of Cancer Quality of Life Questionnaire – Pancreatic Cancer Module. aTime to deterioration in clinically relevant symptom of pain was defined as the time from randomization to an increase of at least 10 points from baseline in pain, or death, whichever occurs first, in the EORTC QLQ-PAN26 pain scale. bTime to deterioration in global health status/quality of life was defined as the time from randomization to a decrease of at least 10 points from baseline in global health status/quality of life, or death, whichever occurs first, in EORTC QLQ-C30.

RASolute 302: Safety Overview

	Daraxonrasib (n=241)	Chemotherapy (n=214)
Median time on treatment, months (range)	6.2 (0.03-14.1)	1.5-3.2[a] (0.03-12.9)
Any TEAEs, n (%)	241 (100)	209 (97.7)
Any TRAEs, n (%)	236 (97.9)	200 (93.5)
TRAEs leading to dose interruption	135 (56.0)	118 (55.1)
TRAEs leading to dose reduction	87 (36.1)	123 (57.5)
TRAEs leading to discontinuation	3 (1.2)[b]	24 (11.2)
Grade ≥3 TRAEs	105 (43.6)	123 (57.5)
Serious TRAEs	26 (10.8)	40 (18.7)
Grade 5 TRAEs	1 (0.4)[c]	0

- Median dose intensity:
  - 93% with daraxonrasib
  - 65-95%[a] across chemotherapy regimens
- Most common (≥5%) TRAEs leading to dose reduction:
  - Daraxonrasib: rash (17%) and stomatitis (7%)
  - Chemotherapy: neutropenia (17%), thrombocytopenia (14%), fatigue (13%), diarrhea (10%), and peripheral neuropathy (8%)
- TRAEs leading to treatment discontinuation:
  - 1% with daraxonrasib
  - 11% with chemotherapy

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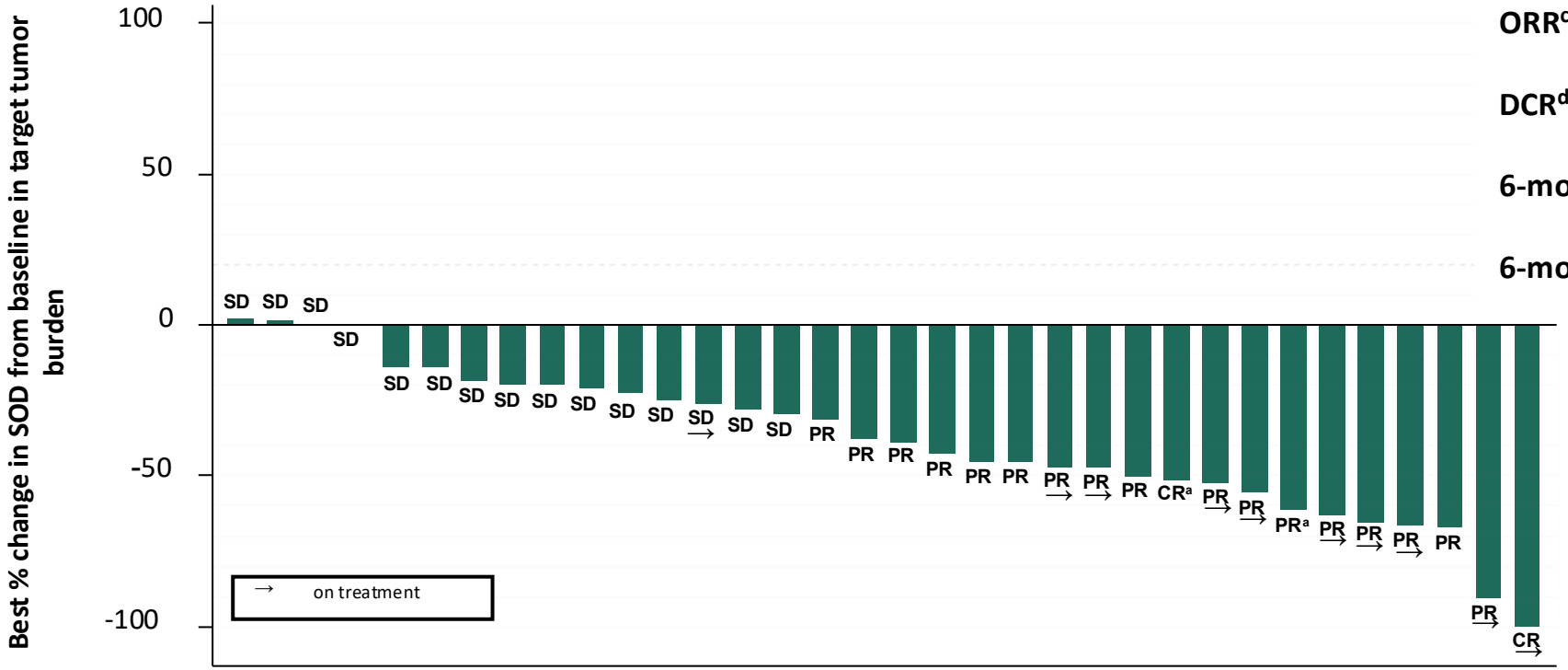
Data cutoff: 10 Feb 2026. ALT, alanine aminotransferase; AST, aspartate aminotransferase; TEAE, treatment-emergent adverse event; TRAE, treatment-related adverse event.
aMedians across each component of the chemotherapy regimens. bTwo patients with grade 3 maculo-papular rash, and 1 patient with grade 3 ALT increased and grade 4 AST increased. cOne patient in the daraxonrasib arm died from treatment-related pneumonitis.

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

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[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 adenocarcinoma; TRAE, treatment-related adverse event.

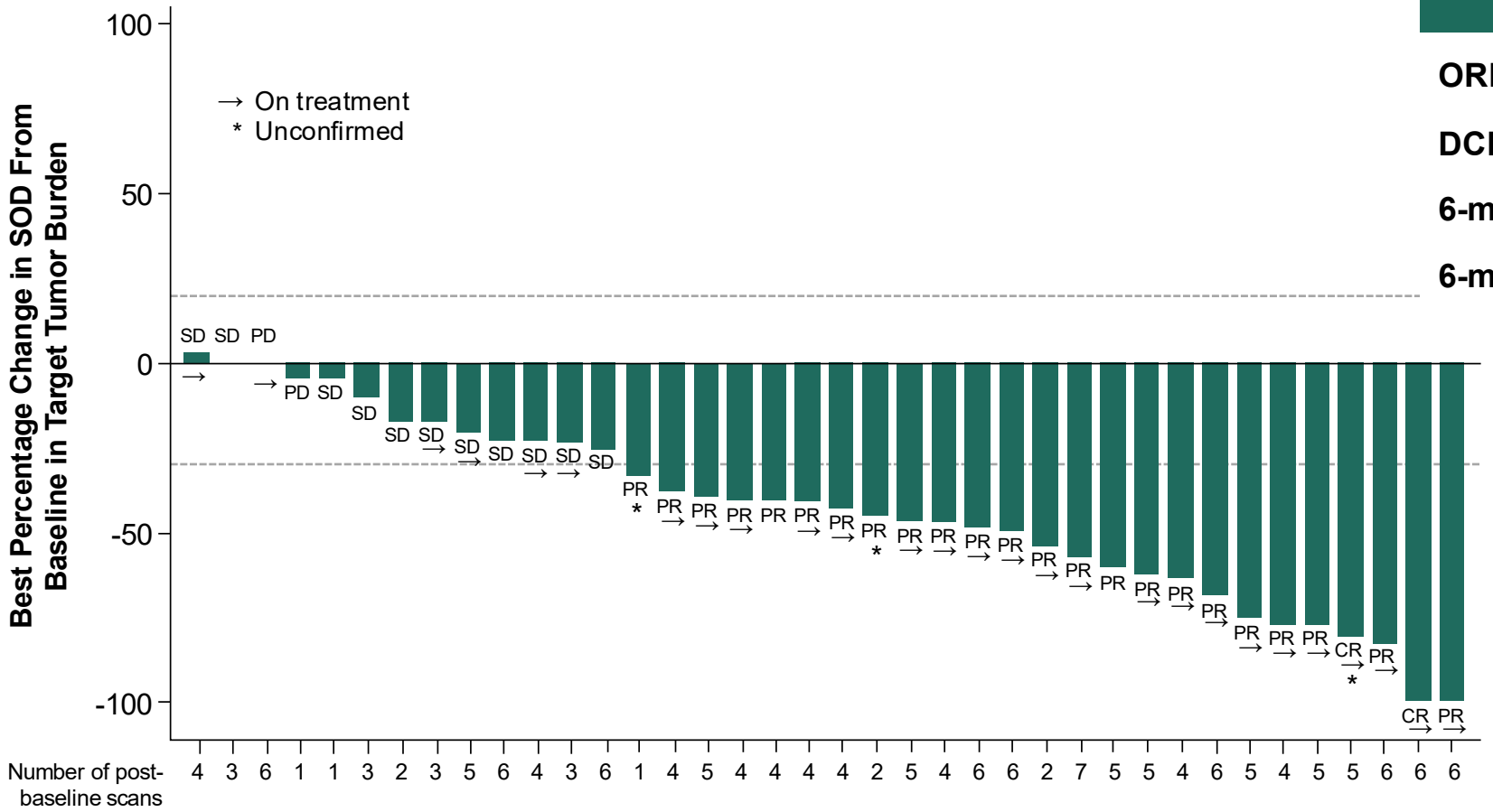
Data cutoff: Dec 1, 2025

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 adenocarcinoma; TRAE, treatment-related adverse event.

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 adenocarcinoma; GnP, gemcitabine nab-paclitaxel; QD, once daily; Q2W, once every two weeks; PR*, unconfirmed partial response; RECIST, response evaluation criteria in solid tumors.

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 adenocarcinoma; GnP, gemcitabine nab-paclitaxel; TRAE, treatment-related adverse event; ALT, alanine transaminase; AST, aspartate transferase.

Data cutoff: Dec 1, 2025

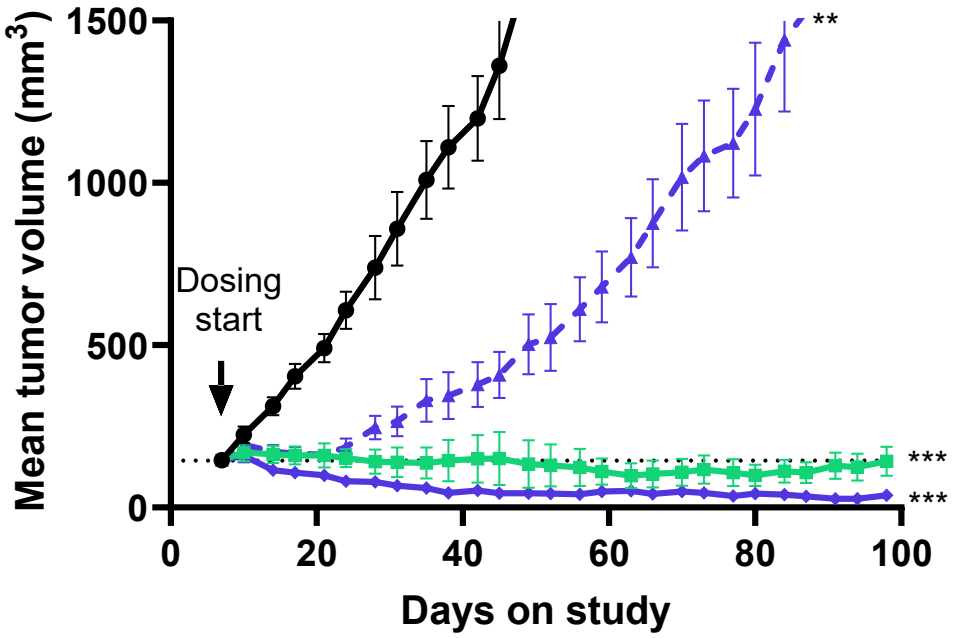
1L PDAC: Daraxonrasib + GnP Demonstrated Acceptable Rate of Dose Modification and Favorable Dose Intensity for Daraxonrasib

	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 adenocarcinoma; GnP, gemcitabine nab-paclitaxel; TRAE, treatment-related adverse event.

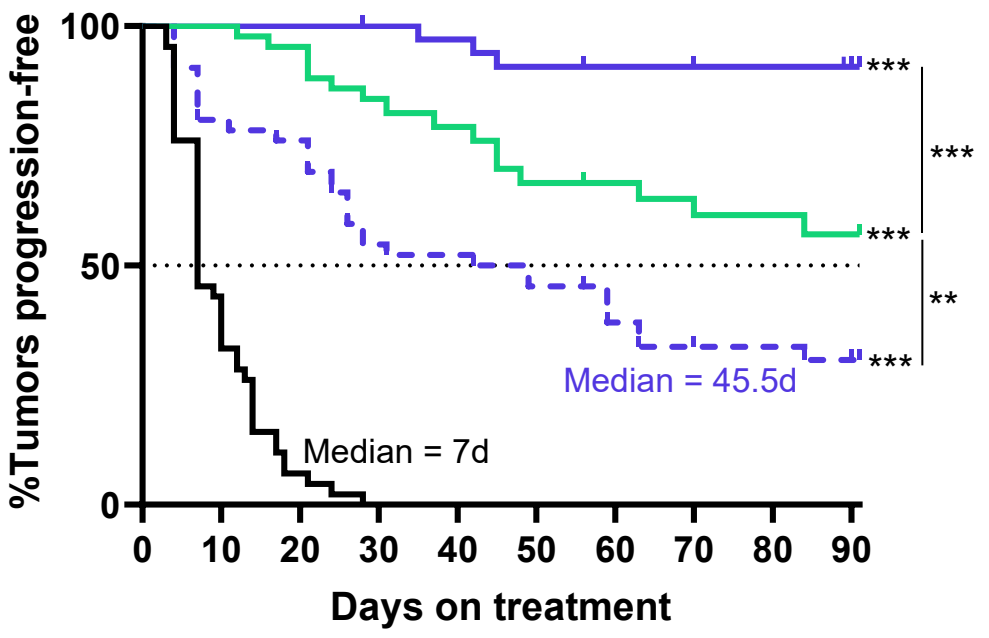
Daraxonrasib Combination with GnP Demonstrated Improved Depth and Durability of Responses in Preclinical Models of PDAC

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 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

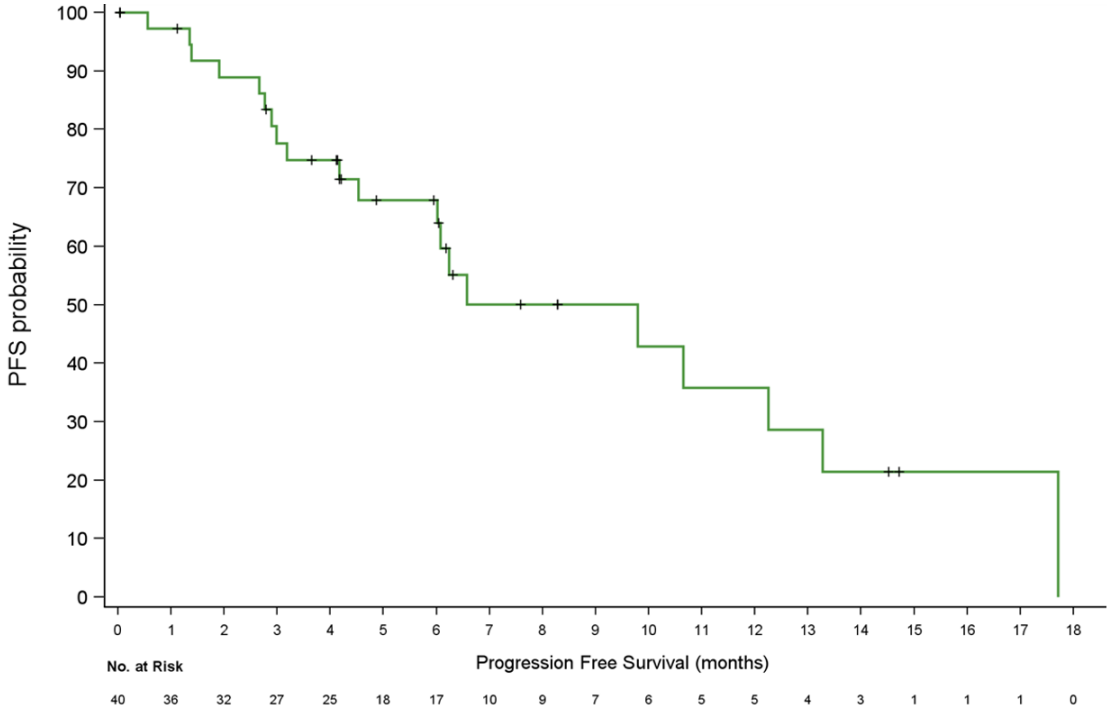
Objectives for Combination Arm

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

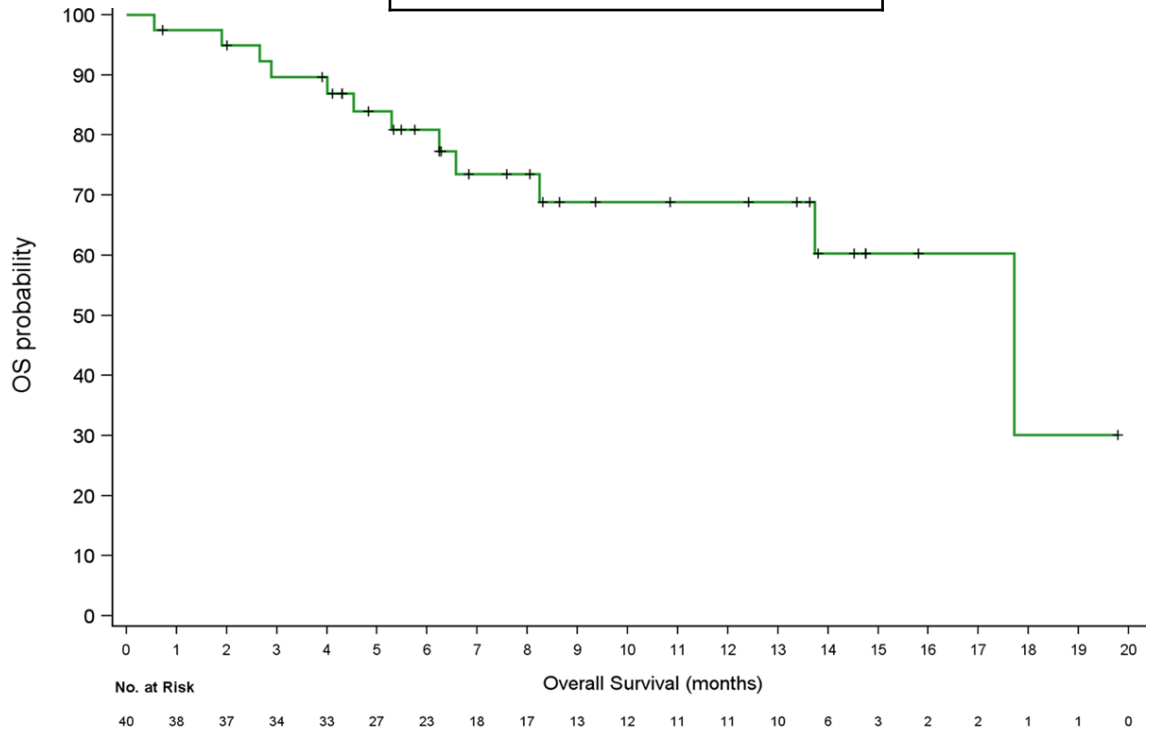
(1) J Gastrointest Oncol (2016) 7:469-478. (2) Ther Adv Med Oncol (2017) 9: 75-82. GnP, gemcitabine nab-paclitaxel; 1L, first line; PDAC, pancreatic adenocarcinoma; QD, once daily; 2L second line.

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

(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.

Daraxonrasib Registrational Study Designs

Revolution Medicines

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)

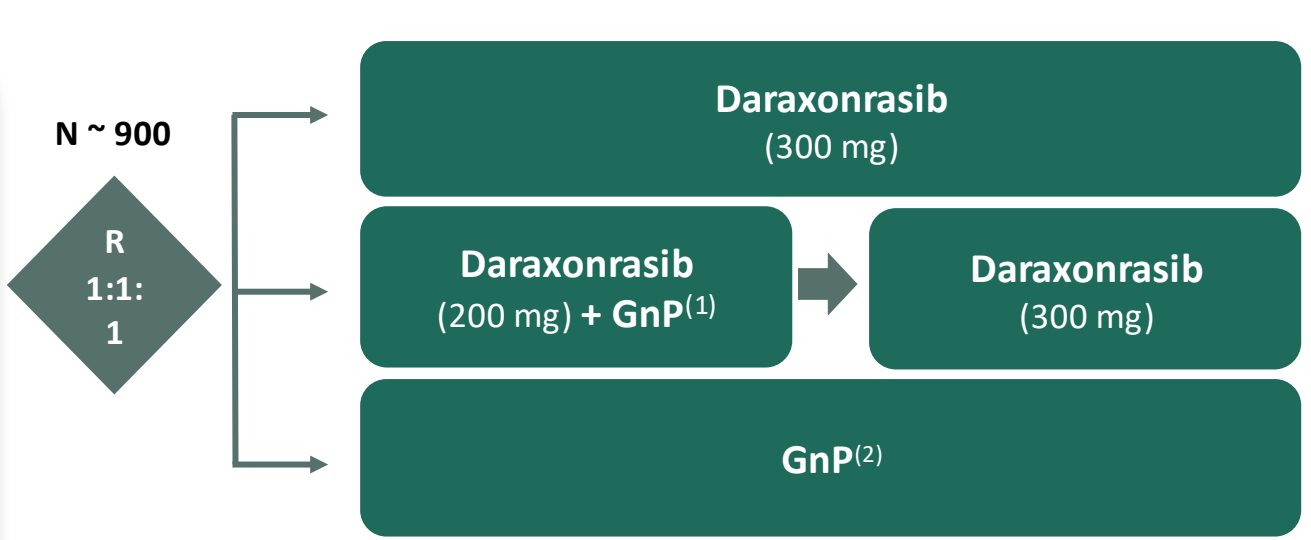
- PFS, OS
- ORR, DOR
- QoL

(1) SOC chemotherapy options: Gemcitabine + nab-paclitaxel, modified FOLFIRINOX, NAL-IRI+5-FU+LV, or FOLFOX. 2L, second line. PDAC, pancreatic 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.

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)



Primary Endpoints

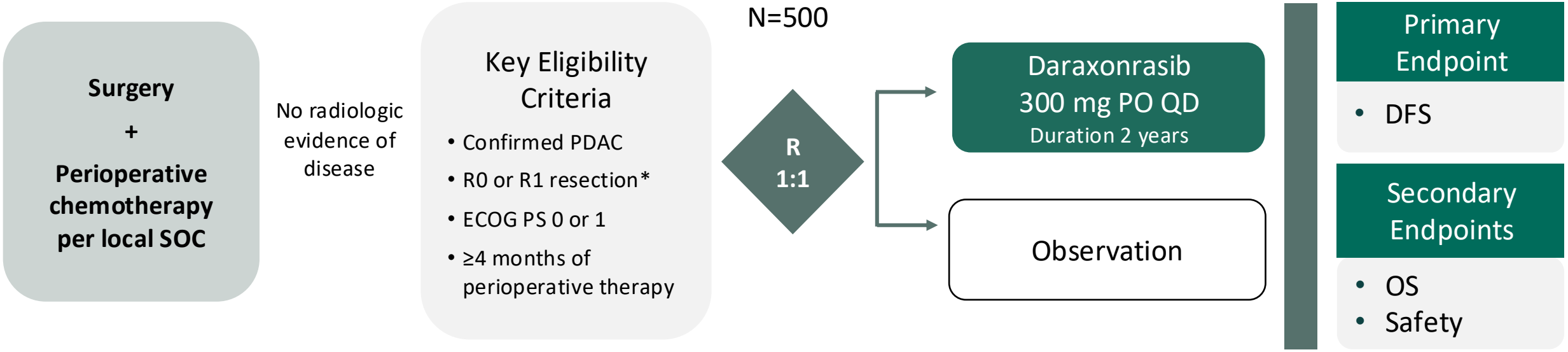
- PFS, OS

Secondary Endpoints

- ORR, DOR
- Safety

Treatment until disease progression or intolerance for all three arms. (1) Daraxonrasib (200 mg) + GnP (1000 mg/m² and 125 mg/m²) 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/m² and 125 mg/m²) on Days 1, 8, and 15 in a 28-day cycle.
1L, first line; PDAC, pancreatic 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



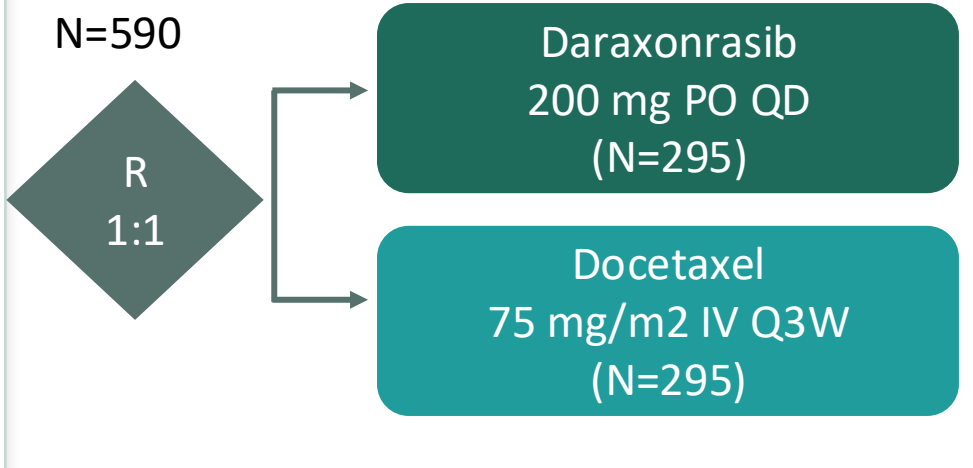
*R0 resection: No macroscopic residual tumor. No residual tumor at >1 mm of the surgical margins. R1 resection: No macroscopic residual tumor. Microscopic residual tumor at ≤1 mm of the surgical margins.
PDAC, pancreatic adenocarcinoma; SOC, standard of care; ECOG PS, Eastern Cooperative Oncology Group 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



Primary Endpoints
(RAS G12X-C)(1)

- PFS, OS

Secondary Endpoints
(All RAS Mutant Patients)(1)

- PFS, OS
- ORR, DOR
- QoL

(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.

Zoldonrasib

RAS(ON) G12D-Selective Covalent Inhibitor

Active against:

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

FDA granted:

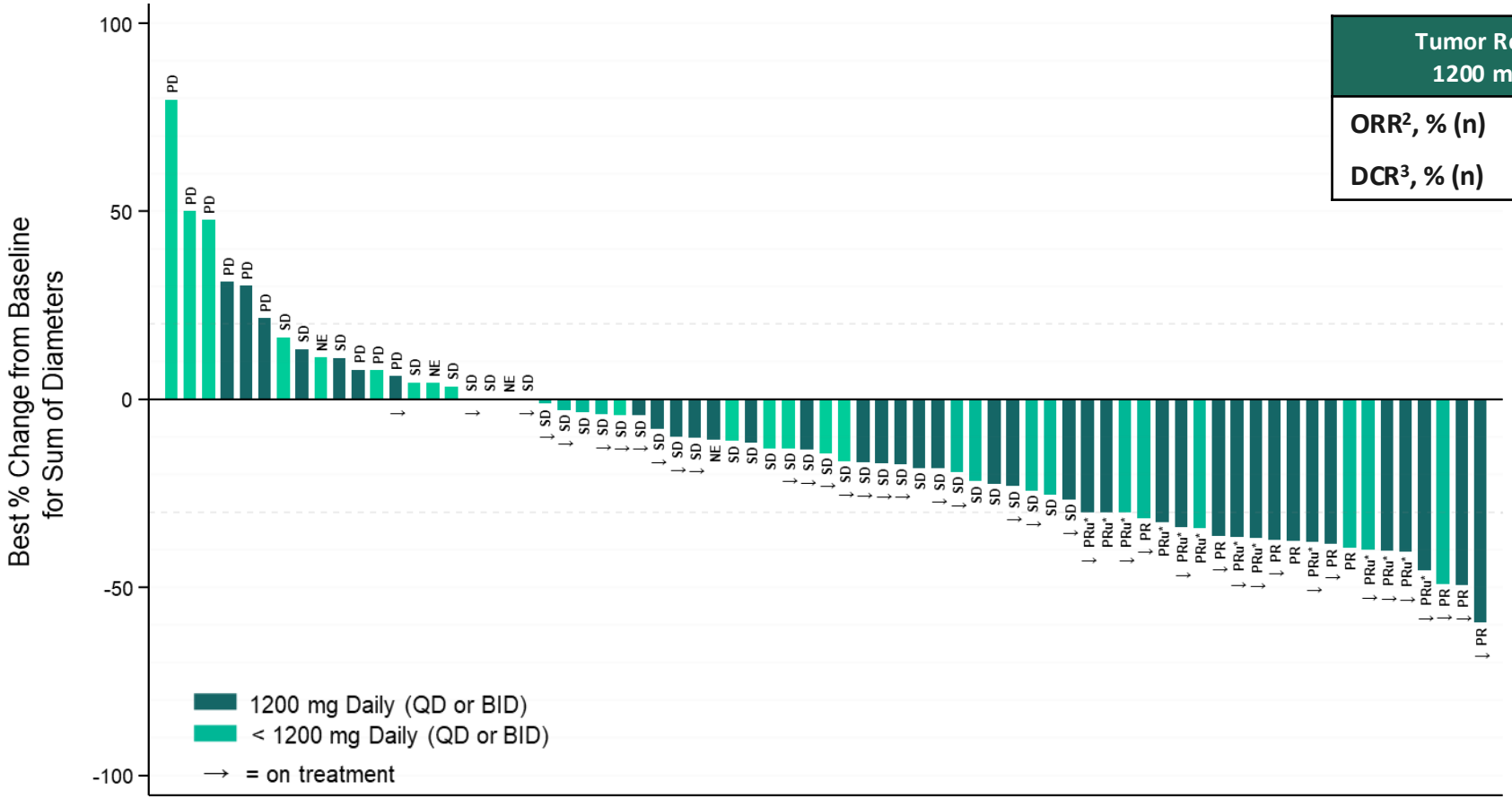
- Breakthrough Therapy Designation

Revolution Medicines

Zoldonrasib Clinical Data

Revolution Medicines

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 adenocarcinoma; QD, once daily; BID, twice daily; PD, progressive disease; NE, not evaluable; RECIST, response evaluation criteria in solid tumors.

Data cutoff: Sep 2, 2024

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%		

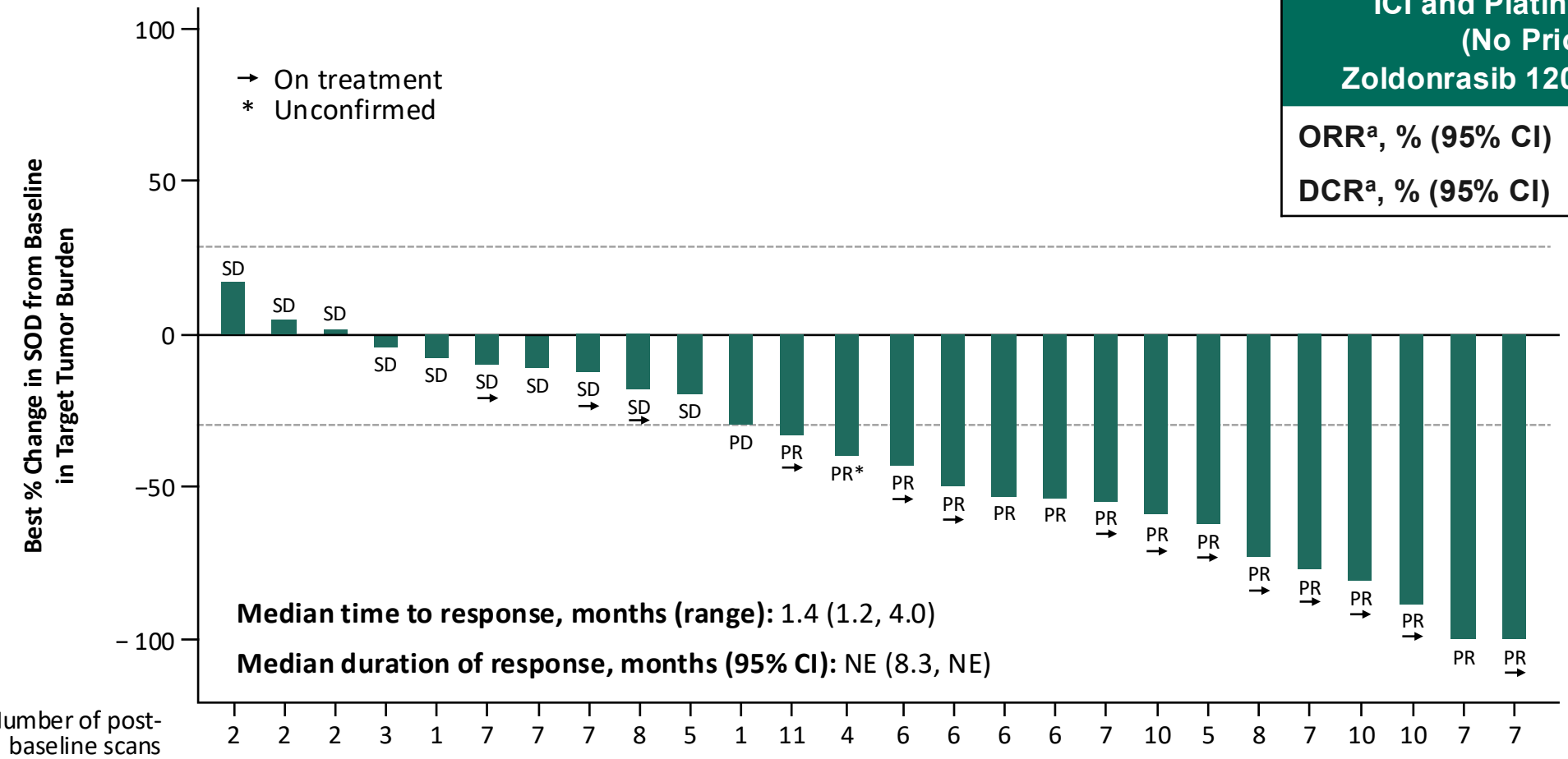
No treatment-related Grade 4 or 5 AEs or SAEs have been reported

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 maculopapular. (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

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)



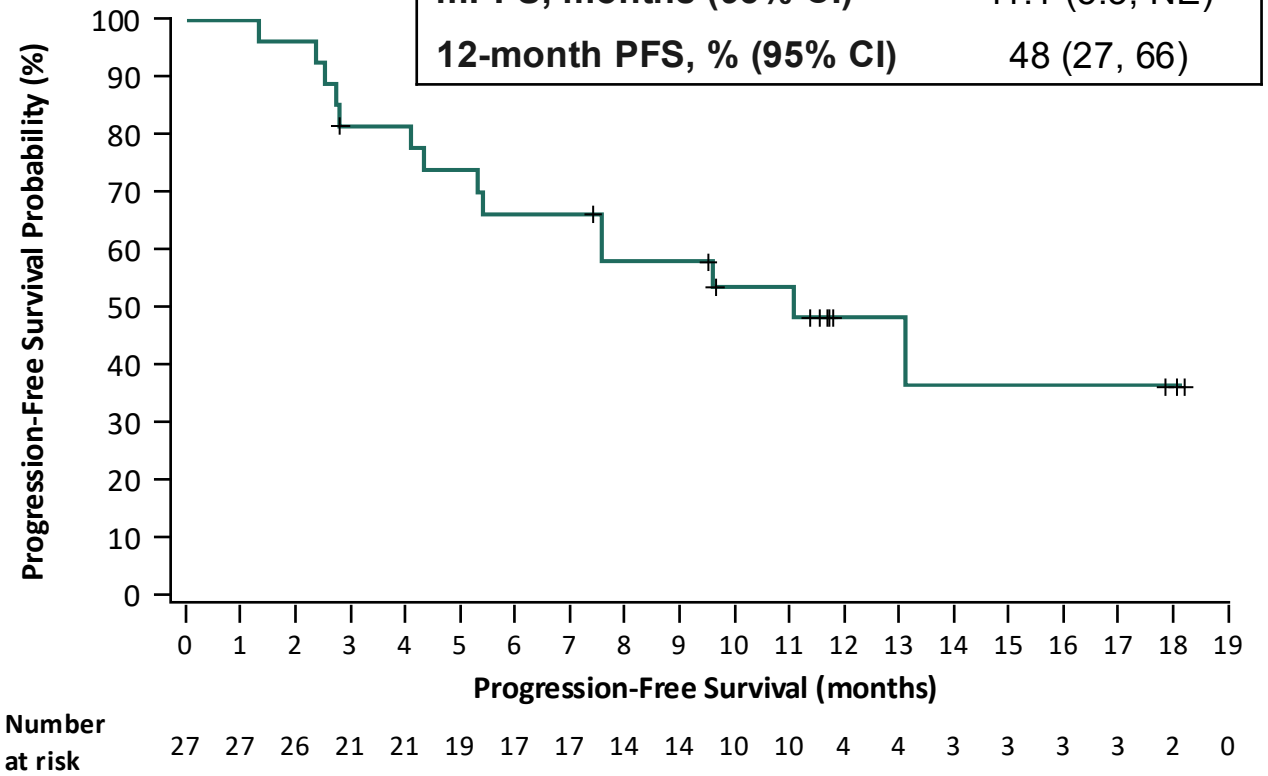
Median follow-up, months (range): 13.1 (9.1, 19.9).
[a]ORR (confirmed CR and PR) and DCR (CR+PR+SD) analyses included all NSCLC patients (with prior ICI and platinum chemotherapy treatment, but no docetaxel) who received first dose of zoldonrasib at least 14 weeks prior to data cutoff date. One patient 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

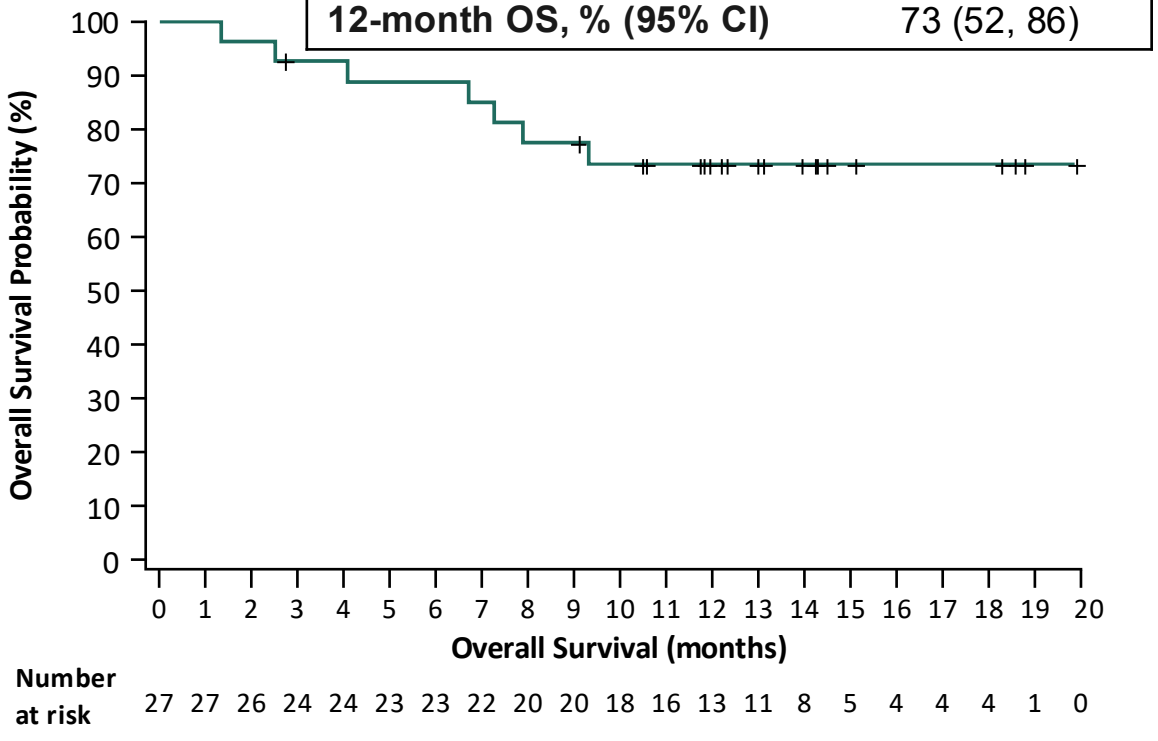
ICI and Platinum Chemo Treated (No Prior Docetaxel) Zoldonrasib 1200 mg PO QD (N = 27)

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

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.

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

Zoldonrasib Registrational Study Designs

Revolution Medicines

1L Metastatic RAS G12D PDAC: Design of RASolute 305 Trial

Key Eligibility Criteria

- Confirmed metastatic pancreatic adenocarcinoma
- No prior systemic therapy for metastatic disease
- Documented KRAS G12D mutation
- ECOG PS 0–1

NCT07621718

N = 670

R
1:1

- Zoldonrasib (1200 mg QD) + mFOLFIRINOX or Gemcitabine/Nab-paclitaxel (n=335)
- Placebo + mFOLFIRINOX or Gemcitabine/Nab-paclitaxel (n=335)

Primary Endpoints

- PFS, OS

Secondary Endpoints

- ORR, DOR
- Safety
- PROs

1L, first-line; PDAC, pancreatic adenocarcinoma; ECOG PS, Eastern Cooperative Oncology Group performance status; KRAS, Kirsten rat sarcoma virus; QD, once daily; R, randomized.

1L Metastatic RAS G12D PDAC: Design of RASolute 309 Trial

Key Eligibility Criteria

- Confirmed metastatic pancreatic adenocarcinoma
- No prior systemic therapy for metastatic disease
- Documented KRAS G12D mutation
- ECOG PS 0–1

N = 400

R
1:1

- Zoldonrasib (1200 mg QD) + Daraxonrasib (300 mg QD) (n=200)
- Gemcitabine/Nab-paclitaxel (n=200)

Primary Endpoints

- PFS, OS

Secondary Endpoints

- ORR, DOR
- Safety
- PROs

1L, first line; PDAC, pancreatic adenocarcinoma; ECOG PS, Eastern Cooperative Oncology Group performance status; KRAS, Kirsten rat sarcoma virus; QD, once daily; R, randomized.

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.

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

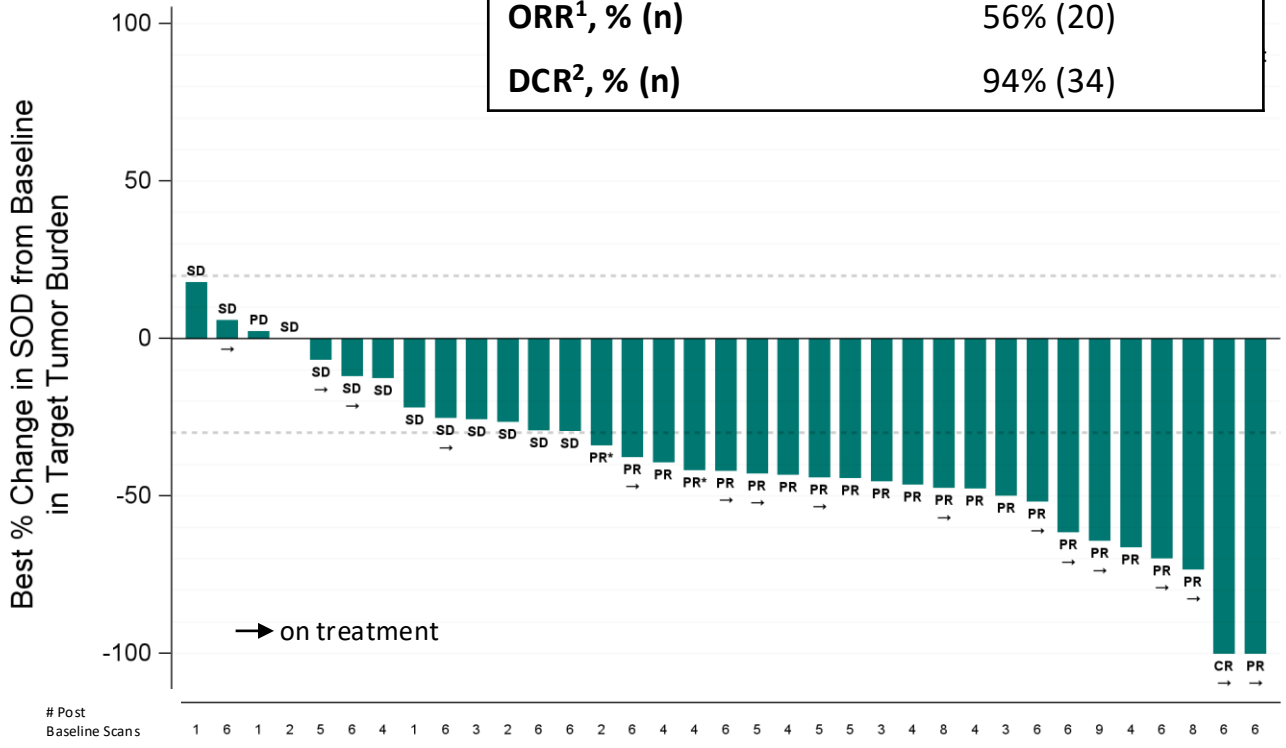
Revolution Medicines

Elironrasib Clinical Data

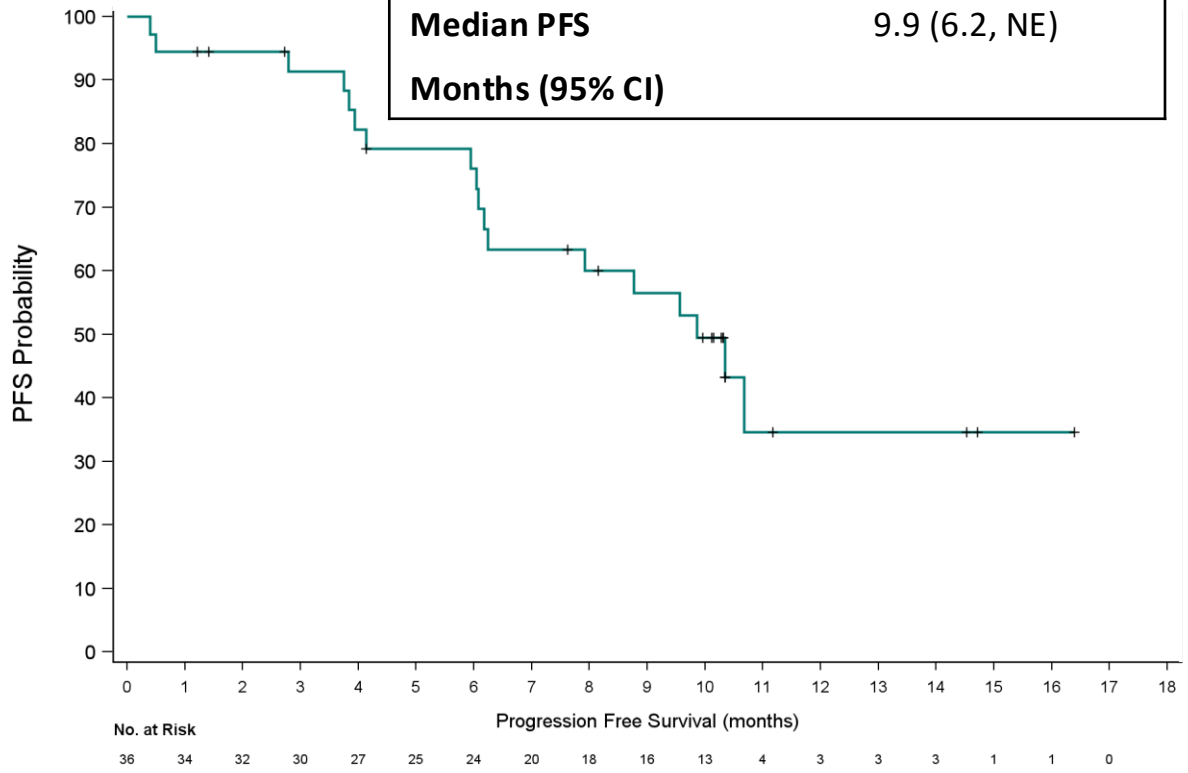
Revolution Medicines

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)



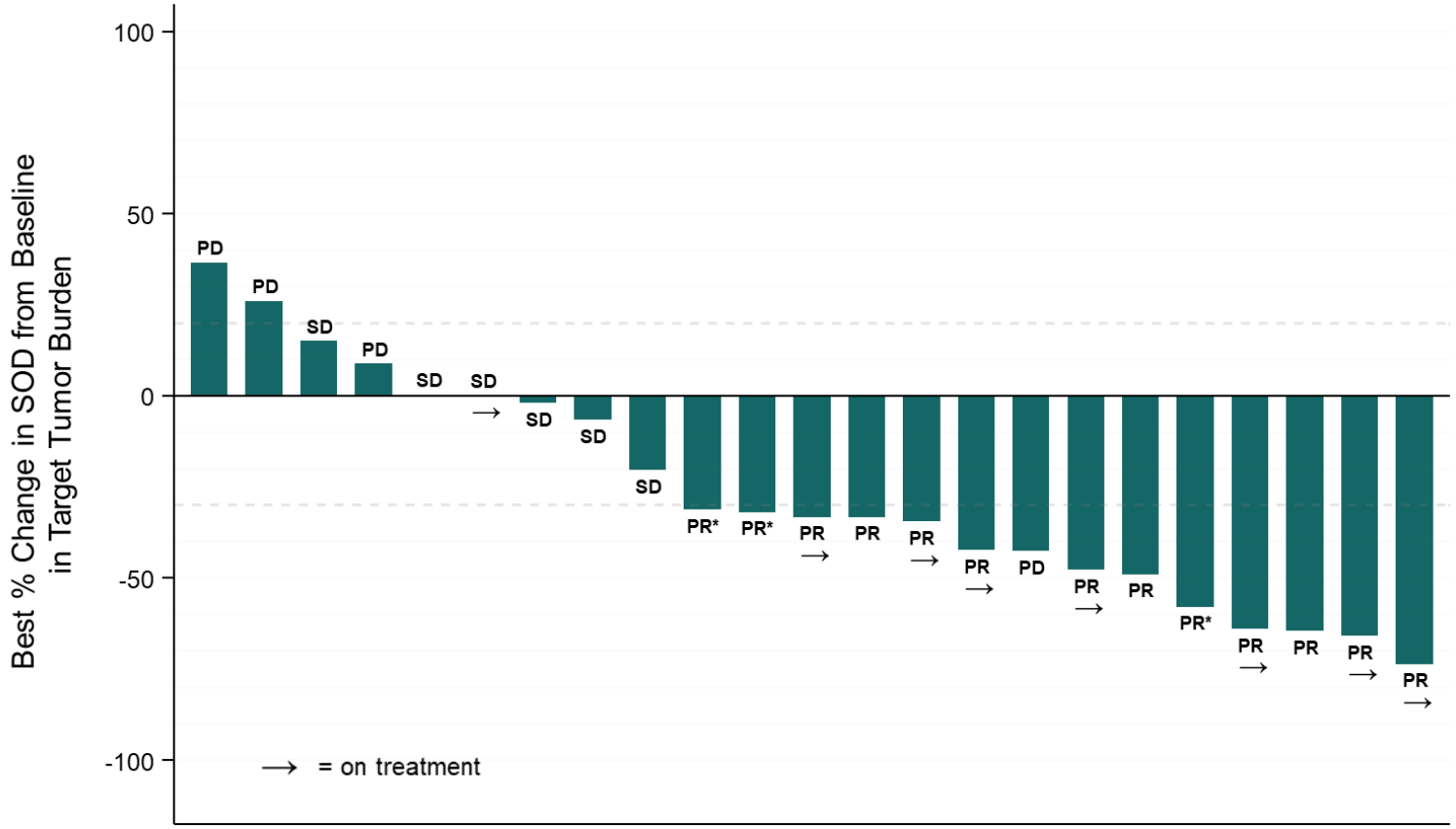
Elironrasib (200 mg BID) (N=36)	
Median PFS Months (95% CI)	9.9 (6.2, NE)



Data includes patients with previously treated NSCLC who have been treated with both immunotherapy and chemotherapy but have not received aG12C(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.

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)

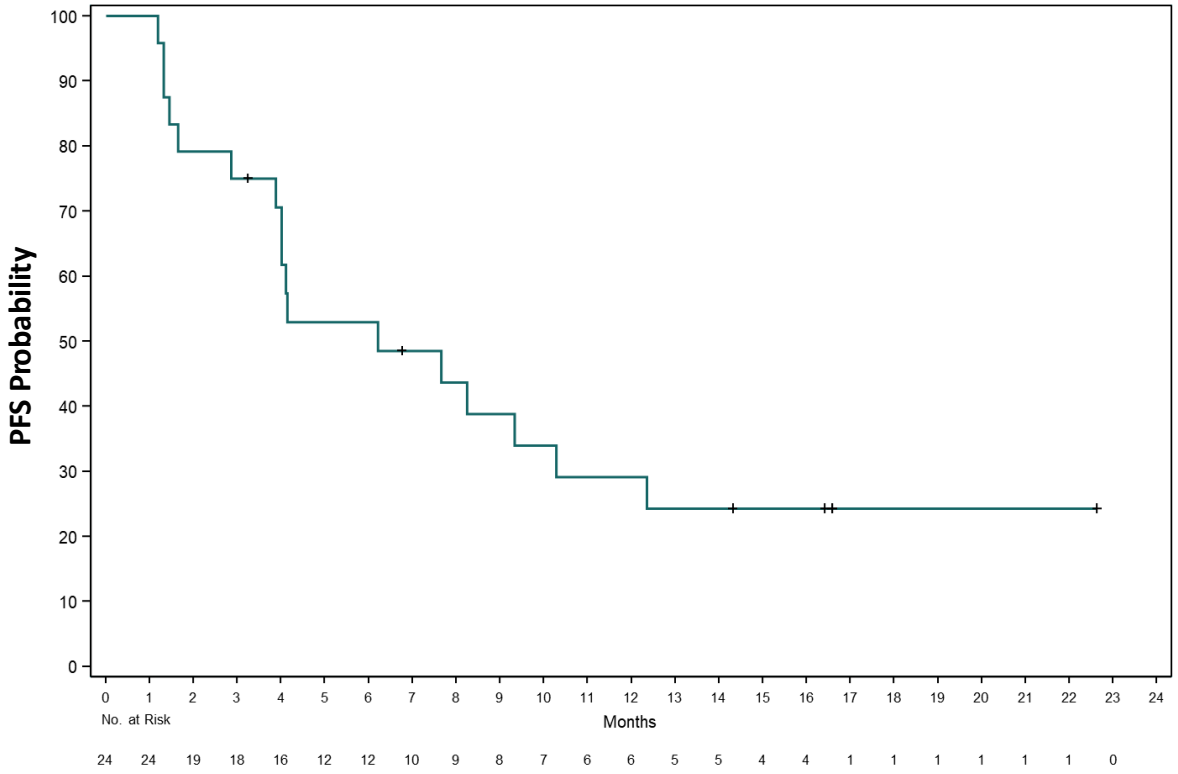
Median follow-up, months (range): 17.6 (10.3, 24.6) and 17.4 (14, 28.5). Median duration of response (95% confidence interval) is 11.2 mo (5.9-NE). (1) Objective response rate (ORR) (per RECIST v 1.1) includes complete (CR) and partial responses (PR) that were confirmed. (2) Disease control rate (DCR) 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.

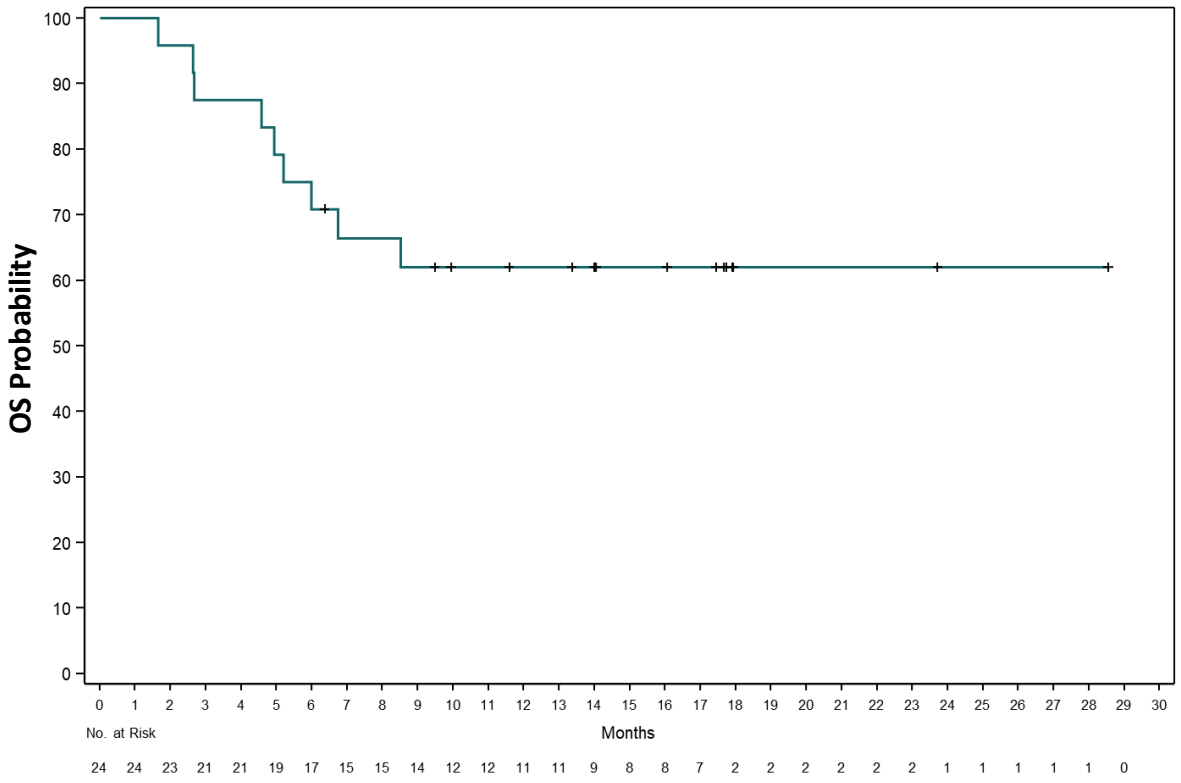
Data Cutoff: August 4, 2025

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)





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.

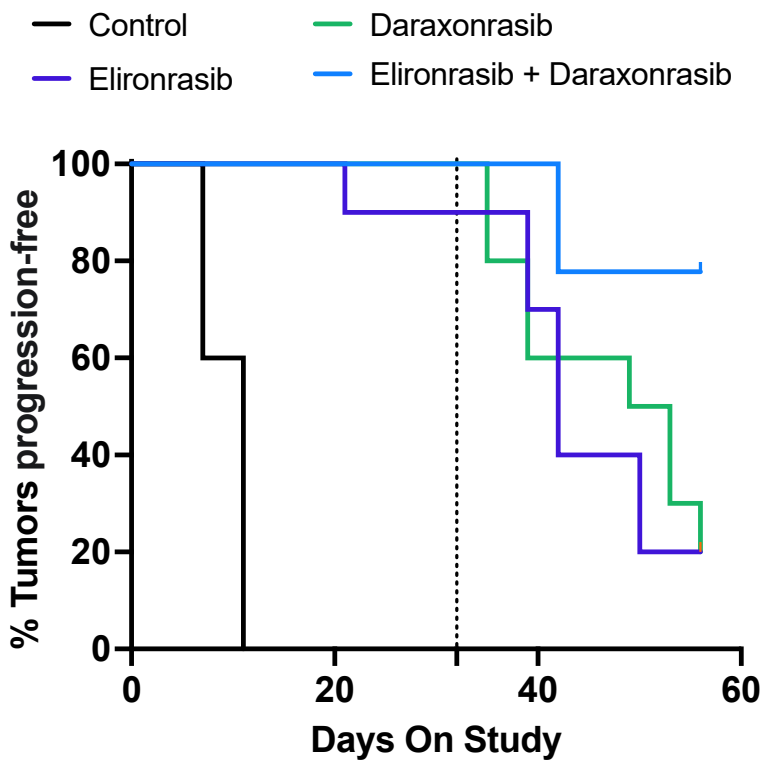
Data cutoff: Apr 7, 2025

Elironrasib + Daraxonrasib
RAS(ON) Inhibitor Doublet Background

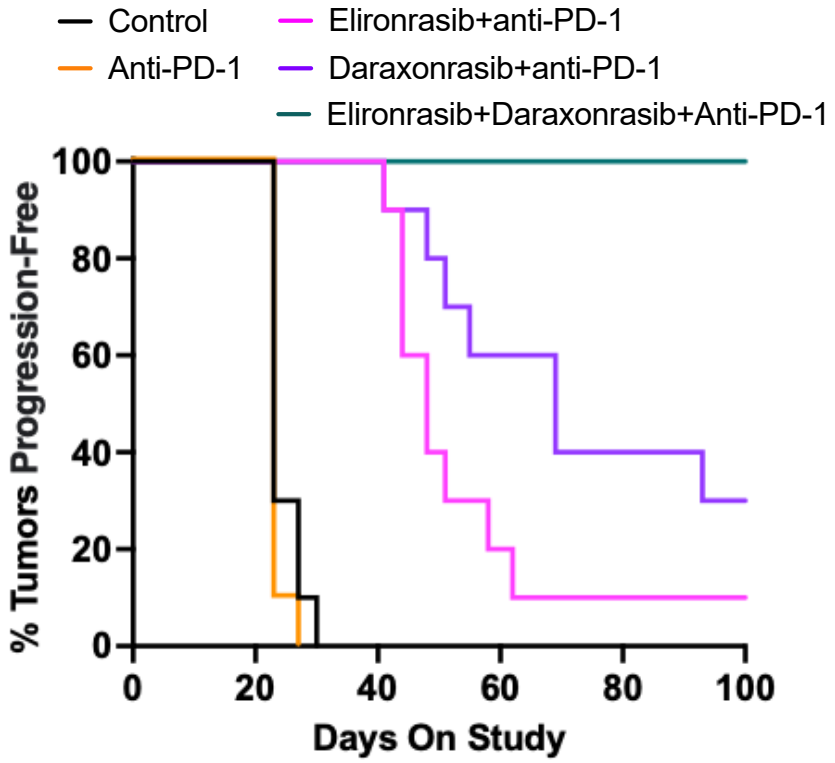
Revolution Medicines

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

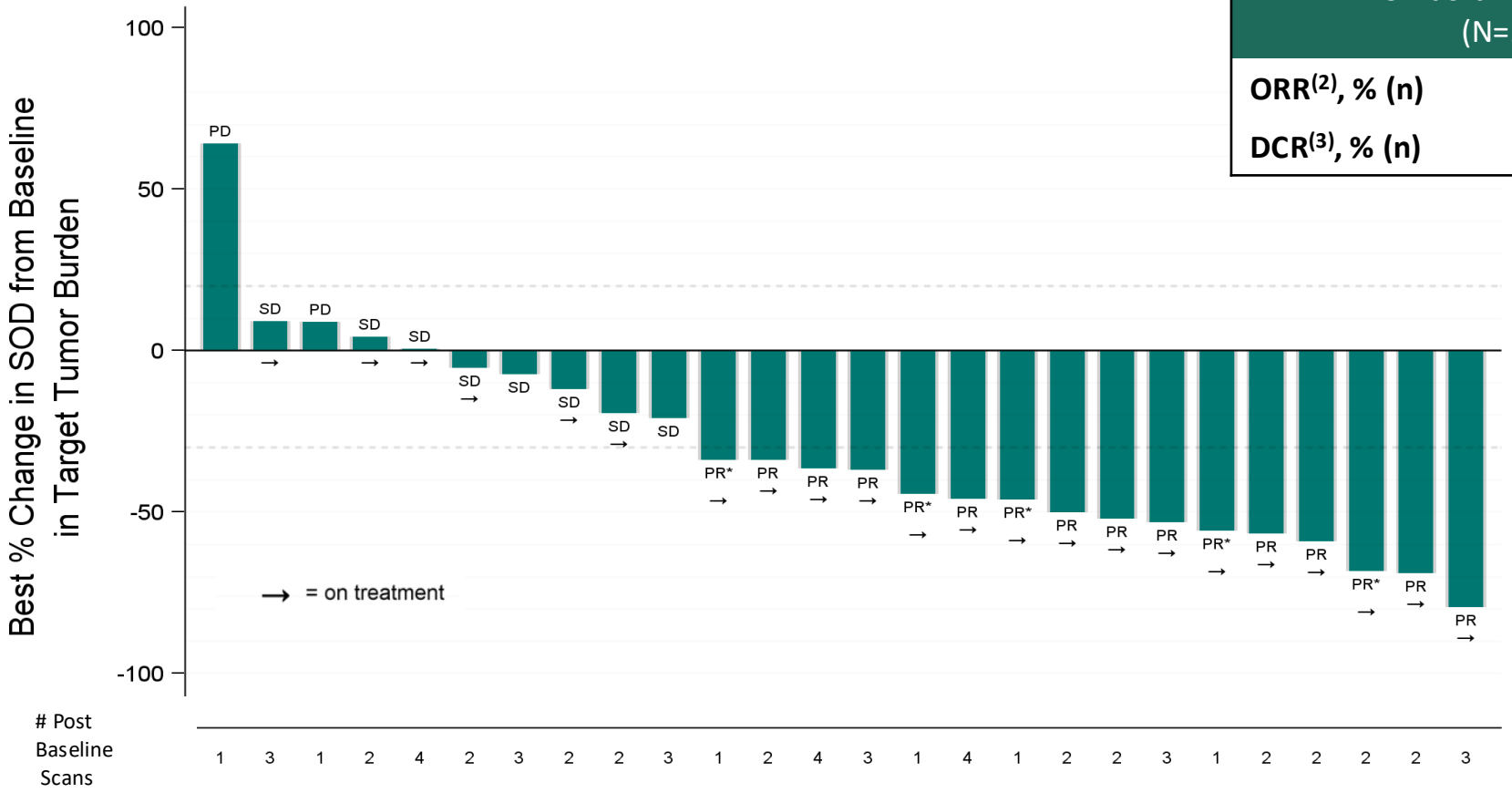


Left Chart: KPAR (NSCLC *KRAS G12C/G12C*), elironrasib (100 mg/kg, PO QD), daraxonrasib (25 mg/kg PO QD)). Dashed line represents treatment stop. Days on study represent days on treatment. Right Chart: e3LL (T cell excluded NSCLC, *KRAS G12C/G12C, NRAS*^{KO}), elironrasib (30 mg/kg, PO QD), daraxonrasib (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.

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.

Data cutoff: Feb 10, 2025

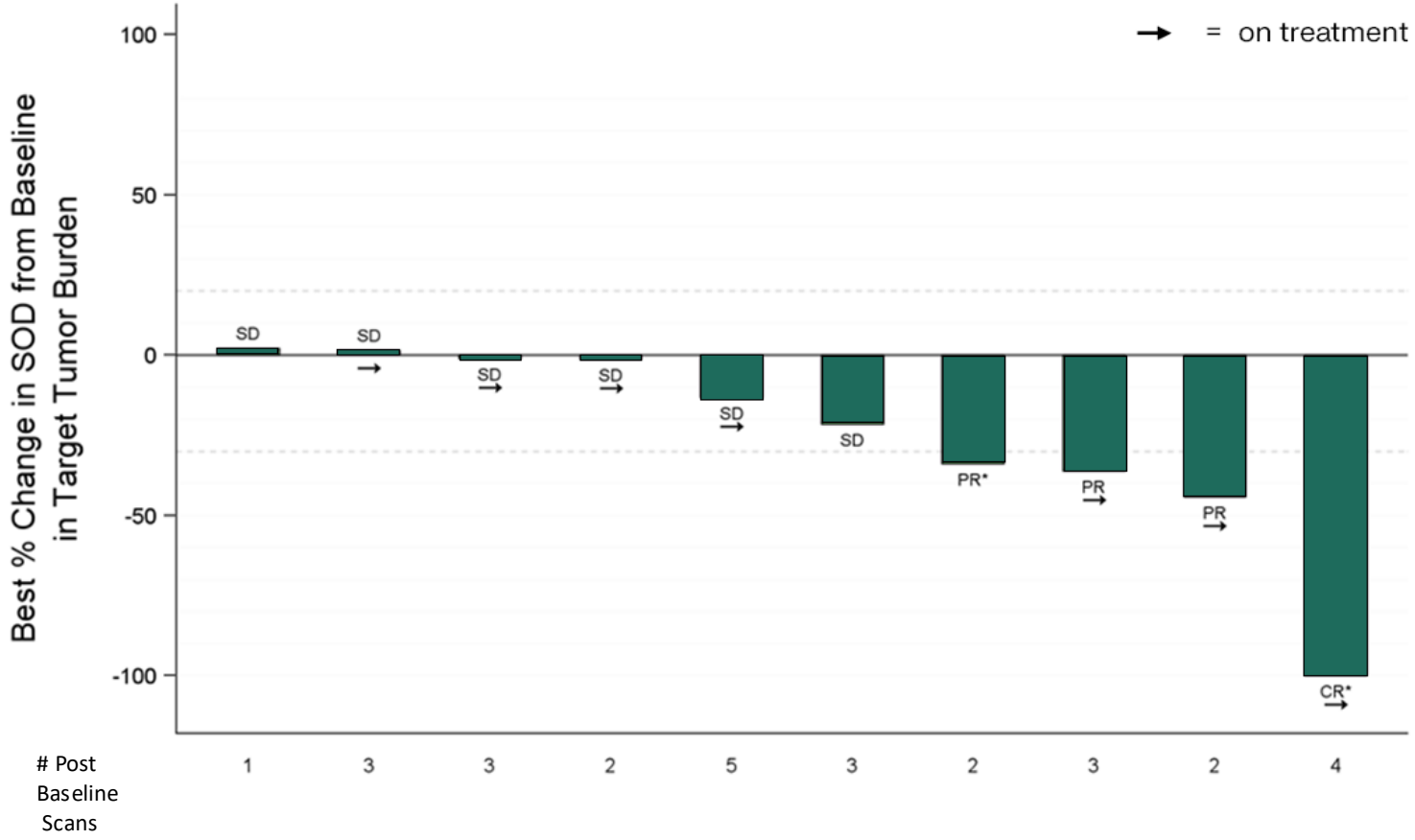
Limited Monotherapy Activity of Either Daraxonrasib in RAS Mutant CRC or Elironrasib in CRC Previously Treated with KRAS G12C(OFF) Inhibitor

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

(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)

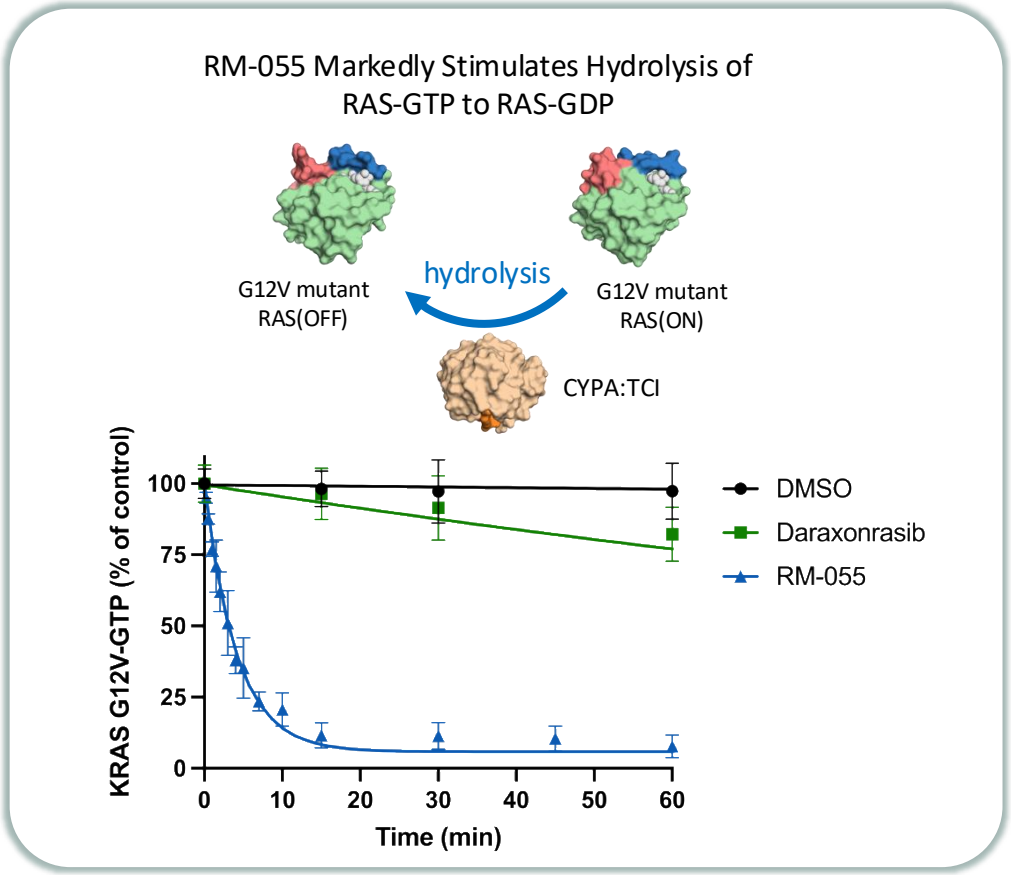
Analyses include all patients who received first dose of study drug(s) at least 8 weeks prior to data cutoff date (to allow 1 potential scan). (1) The combination arm includes patients treated at elironrasib 100 or 200 mg BID + daraxonrasib (100-200 mg QD). (2) Objective response rate (ORR) (per RECIST 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.

Data cutoff: Oct 28, 2024

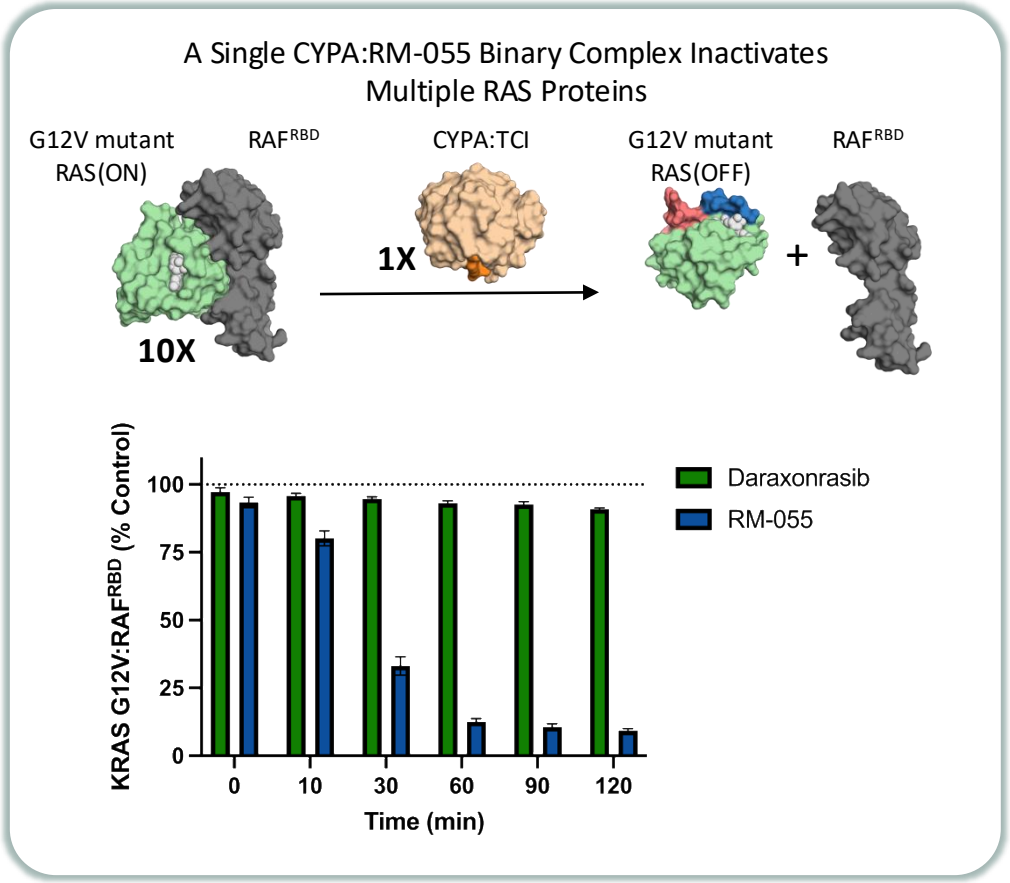
RM-055 Preclinical Data

Revolution Medicines

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

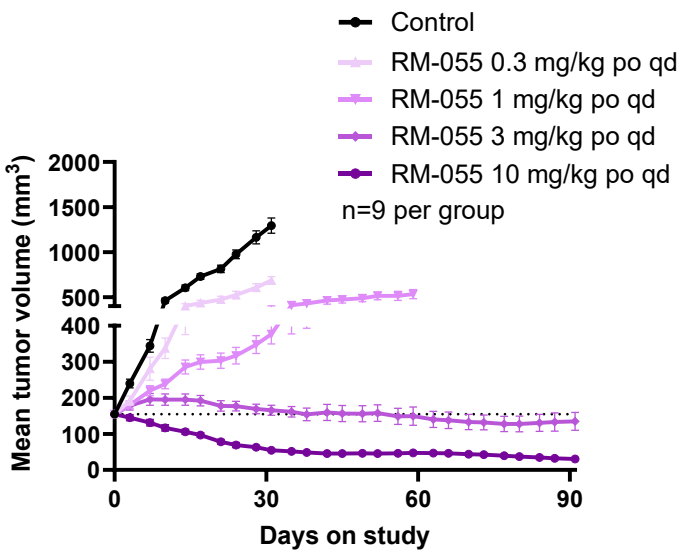


$KRAS^{G12V}$:RAF^{RBD} in ten-fold excess relative to CYPA:TCI binary complex

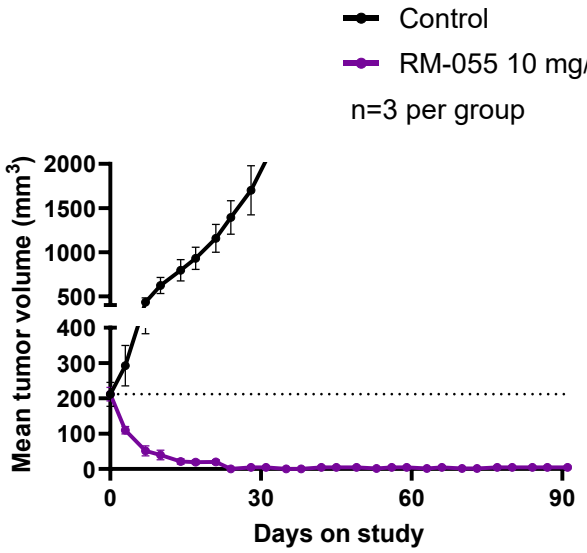
CYPA, cyclophilin A.

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

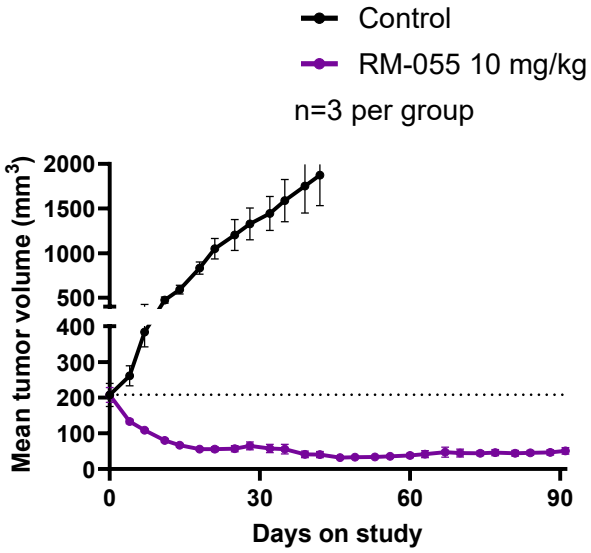
PDAC (KRAS G12D)[1]



NSCLC (KRAS G12C)[2]



CRC (KRAS G12V)[3]

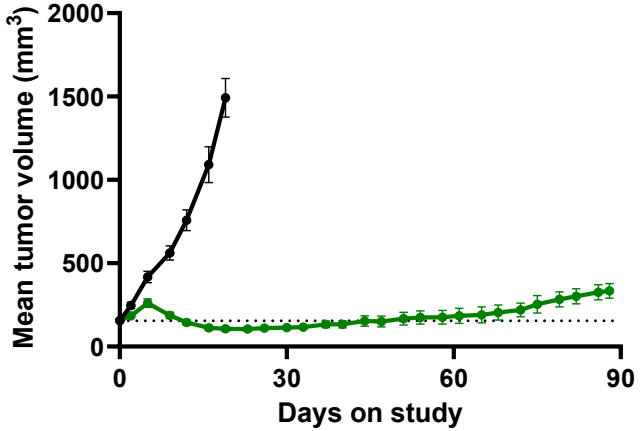


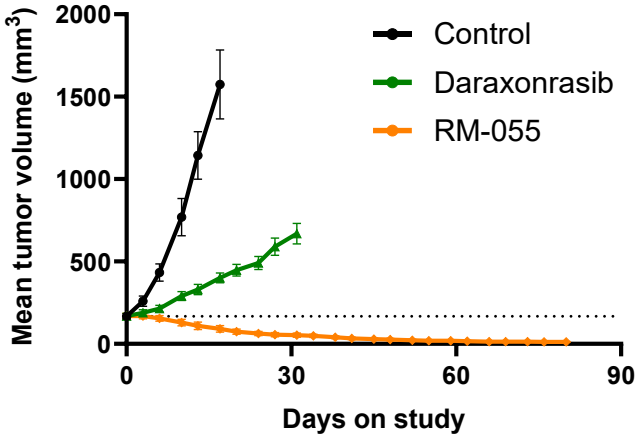
Models: [1]AsPC-1 (PDAC, KRAS$^{G12D/G12D}$); [2]LUN055 (NSCLC, KRAS$^{G12C\ Amp/WT}$); [3]CRC060 (CRC, KRAS^{G12V}).
All RM-055 treatment regimens were tolerated during treatment course based on body weight assessment.
PDAC, pancreatic adenocarcinoma; NSCLC, non-small cell lung cancer; CRC, colorectal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

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

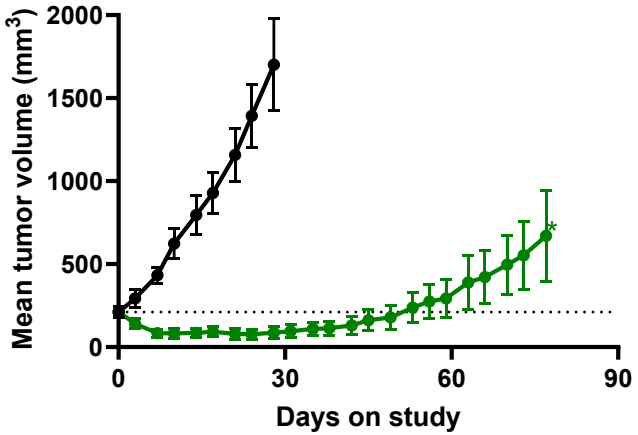
Standard Models → **Resistant Models**[3]

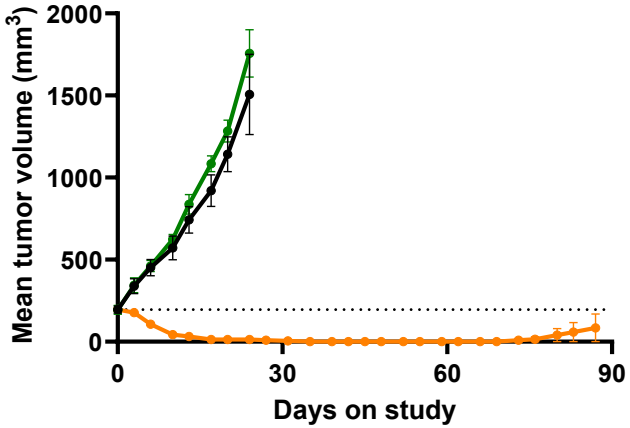
PDAC (KRAS G12D)[1]





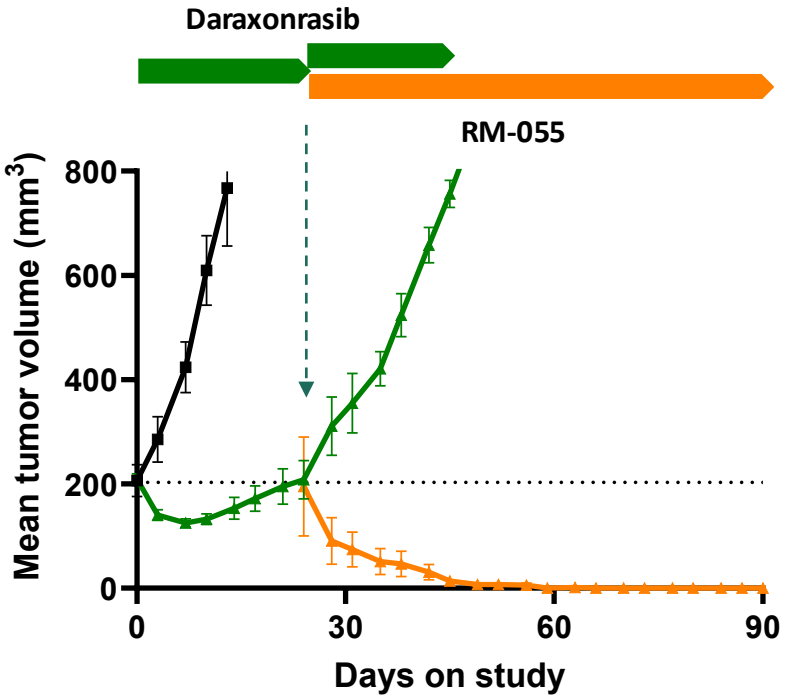
NSCLC (KRAS G12C)[2]





Post-Progression Treatment

(NSCLC, KRAS G12C)[2]



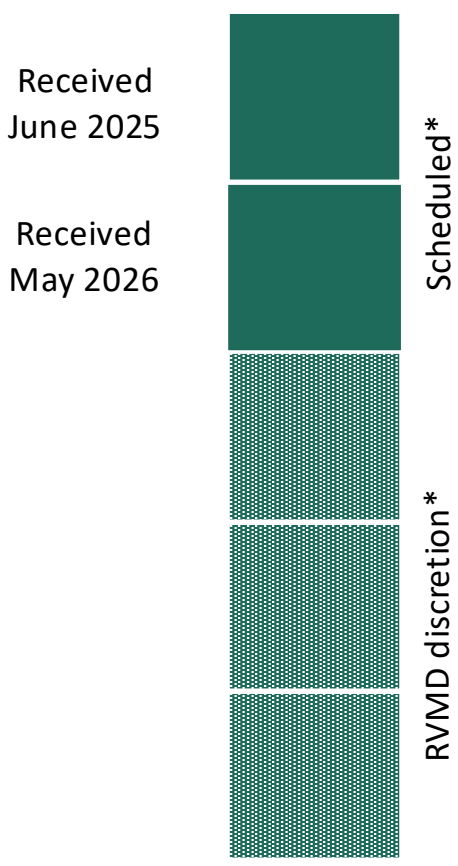
Standard models: [1]HPAF-II (PDAC, KRAS$^{G12D\ Amp/WT}$) n=7 per group; [2]LUN055 (NSCLC, KRAS$^{G12C\ Amp/WT}$) n=2-3 per group. [3]Resistant models: HPAF-II (PDAC, KRAS$^{G12D\ Amp/WT}$) with acquired resistance to RMC-7977 (RAS(ON) multi-selective tool compound) n=9 per group. Reduced sensitivity 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 adenocarcinoma; NSCLC, non-small cell lung cancer.

Royalty Pharma Partnership

Revolution Medicines

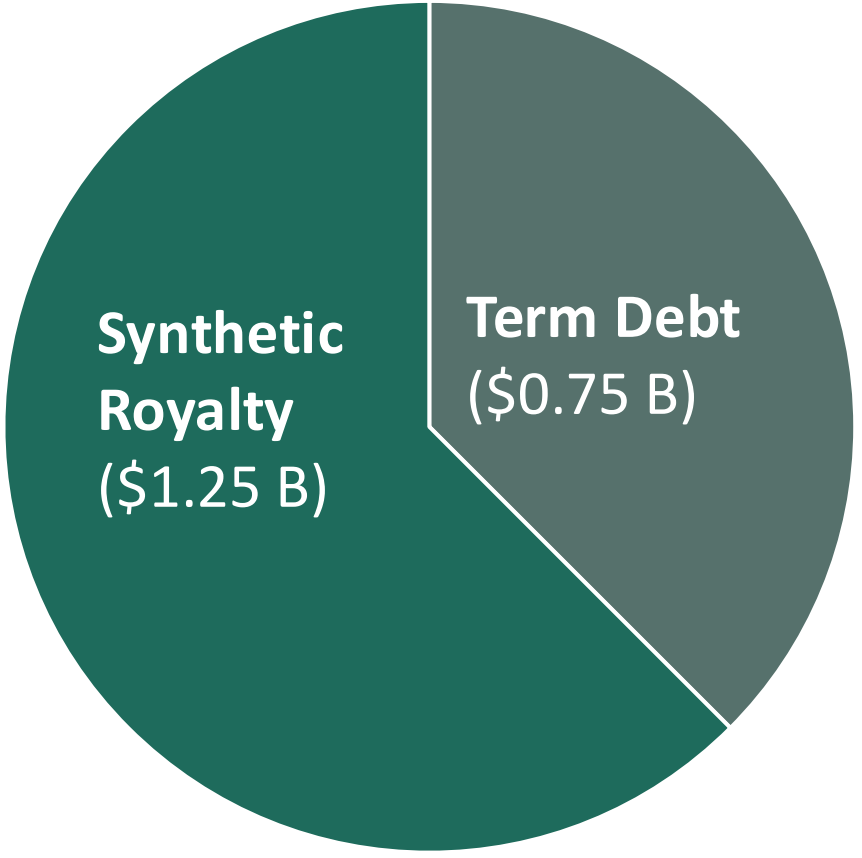
Royalty Pharma Partnership Bolsters Already Strong Financial Position by Providing $2 Billion in Flexible Committed Capital

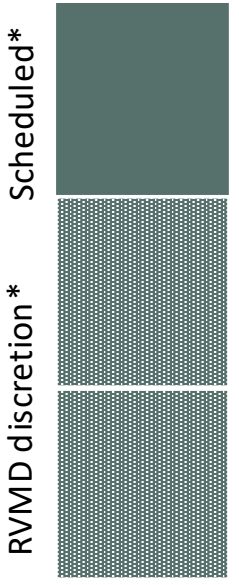
$2 Billion Committed



5 Tranches

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





RASolute302 approval

3 Tranches

Market-competitive interest rate linked to SOFR

$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