Revolution Medicines

On Target to Outsmart Cancer

November 2026

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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 fact are forward-looking statements. These include statements regarding our future results of operations, financial position and financial guidance, including expected operating and stock-based compensation expenses; funding, including our Royalty Pharma arrangement, our ability and decisions to draw additional tranches, and our obligations under that arrangement; business strategy, collaborations and licensing arrangements; the scope, progress, timing, results and costs of our research, clinical trials and data readouts; the potential benefits of RASONQUE® and our product candidates, including their potential to become a standard of care; market size and patient populations; the commercial launch and performance of RASONQUE, including revenue, adoption, reimbursement and access; the timing and likelihood of regulatory approvals, including in Europe and Japan; management's plans and objectives; and the impact of global events and macroeconomic conditions. 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 November 4, 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 November 4, 2026. Other than RASONQUE for its FDA-approved indication, our product candidates, and RASONQUE in other indications and combinations, 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 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.

Summaries of the RASONQUE (daraxonrasib) indication, dosage, warnings and precautions and adverse reactions included herein are not complete and do not include all of the information needed to use RASONQUE safely and effectively. Please see the Important Safety Information included in this presentation and the full Prescribing Information for RASONQUE at RASONQUE.com.

In the United States, RASONQUE is indicated for the treatment of adult patients with metastatic pancreatic adenocarcinoma who have received at least one prior systemic therapy or who are not candidates for multiagent systemic therapy. Outside the United States, daraxonrasib is investigational and has not been approved by any regulatory authority.

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Our Vision | Building a Global Targeted Medicines Franchise for Patients with RAS-Addicted Cancers



DISCOVER

Proprietary tri-complex platform underlies extensive and differentiated approach to sustained RAS(ON) innovation

DEVELOP

Deep late-stage clinical pipeline across tumor types and treatment settings

DELIVER

RASONQUE launched in the U.S.; preparing for potential commercial availability in Europe and Japan

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

Deep Pipeline of Clinically Validated RAS(ON) Inhibitors On Target to Transform Treatment for RAS-Addicted Cancers

Phase 3 Registrational Trials

	Molecule	Target	Trial	Treatment Setting	Regimen	Status
PDAC	RASONQUE	MULTI	RASolute 302	2L metastatic	Mono	Approved*
PDAC	RASONQUE	MULTI	RASolute 303	1L metastatic	Mono & Combo	Ongoing
PDAC	RASONQUE	MULTI	RASolute 304	Adjuvant in resectable	Mono	Ongoing
PDAC	Zoldonrasib	G12D	RASolute 305	1L metastatic	Combo	Ongoing
PDAC	RASONQUE + Zoldonrasib	G12D	RASolute 309	1L metastatic	Combo	Ongoing
NSCLC	RASONQUE	MULTI	RASolve 301	2L/3L metastatic	Mono	Ongoing
NSCLC	Zoldonrasib	G12D	RASolve 308	1L metastatic	Combo	Ongoing
NSCLC	Elironrasib	G12C	RASolve 307	1L metastatic	Combo	Ongoing
CRC	Zoldonrasib	G12D	RASonate 312[1]	1L metastatic	Combo	Initiating

Phase 1/2 Clinical Development

RASONQUE (daraxonrasib) is approved in the U.S. and is also being evaluated in other settings, where it remains investigational.
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, a mutant-targeted catalytic RAS(ON) inhibitor, is currently advancing through IND-enabling studies. For more information, visit ClinicalTrials.gov.

1L, first line; 2L, second line; 3L, third line; NSCLC, non-small cell lung cancer; PDAC, pancreatic adenocarcinoma
*RASONQUE is approved in the U.S. for adult patients with metastatic pancreatic adenocarcinoma who have received at least one prior systemic therapy or who are not candidates for multiagent systemic therapy.

(1) BeOne Medicines is funding and conducting the Phase 3 RASonate 312 trial as part of its collaboration with Revolution Medicines.

PDAC and Initial Commercial Performance

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PDAC

RASONQUE | Key Takeaways

Now Approved

RASONQUE™ (daraxonrasib) tablets 100 mg 150 mg

Unprecedented overall survival in registrational Phase 3 trial

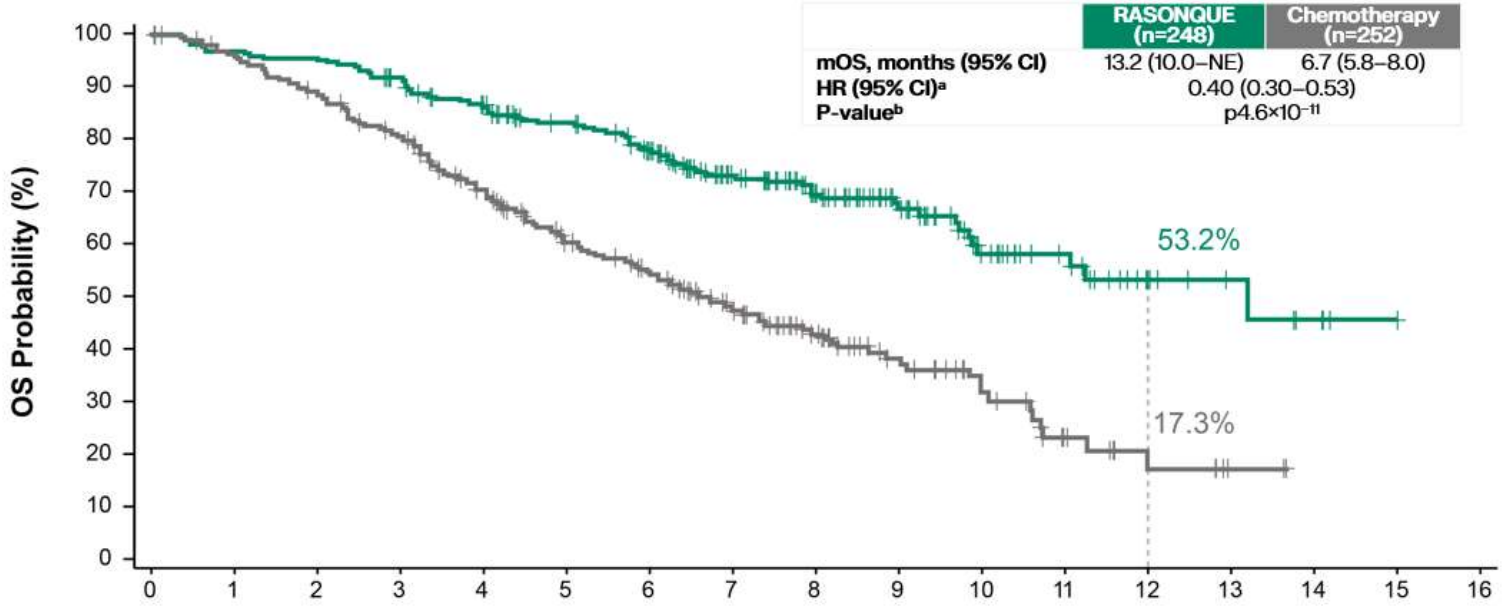
Poised to become new practice-changing standard of care in eligible patients with metastatic PDAC

Executing strong U.S. launch; EMA CHMP issued positive opinion

Foundation for RevMed's bold RAS(ON) inhibitor strategy

PDAC, pancreatic adenocarcinoma; OS. overall survival

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



Oral, once-daily RASONQUE demonstrated statistically significant and clinically meaningful improvements in overall survival, progression-free survival, and patient reported outcomes compared with SOC IV chemotherapy

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

60% reduction
in the risk of death
OS hazard ratio: 0.40

Near doubling median OS
to 13.2 months

Generally well tolerated[1]
Manageable safety profile

Presented at ASCO Annual meeting 2026. Data from O'Reilly EM, et al. N Engl J Med. 2026. DOI: 10.1056/NEJMoa2605555.
Progression-free survival was assessed by blinded independent central review (BICR). Data cutoff: 10 Feb 2026. Median (range) follow-up time was 8.5 (3.2–15.9) months; number of events: RASONQUE: 127 (51%); chemotherapy: 130 (52%). [a] HRs and 95% CIs were based on the stratified Cox model with Efron's method of tie handling. [b] P-values were calculated using the stratified log-rank test.
m, median; PFS, progression-free survival; OS, overall survival; SOC, standard of care. [1]Please see Full Prescribing Information at rasonque.com

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Launch is Focused on Three Strategic Priorities

RASONQUE™ (daraxonrasib) tablets 100 mg 150 mg

Enable

patients and HCPs to achieve optimal treatment experience

Establish

RASONQUE as the new standard of care for eligible patients with metastatic PDAC

Ensure

broad coverage and seamless patient access

HCP, healthcare professional; PDAC, pancreatic adenocarcinoma

RASONQUE U.S. Launch | Q3 Performance

Q3’26 net product revenue

$198M

Approximately five weeks of commercial availability following U.S. approval on August 26, 2026[1]

RASONQUE™ (daraxonrasib) tablets 100 mg 150 mg

>5,000 Unique patients treated in the U.S. with commercial product

>90% of U.S. PDAC covered lives with functional access[2]

Q3 revenue reflects a combination of:

EAP transitions, initial cohort of patients awaiting commercial availability, newly eligible patients, and initial specialty distribution stocking

EAP, expanded access program; PDAC, pancreatic adenocarcinoma

(1) Partial-quarter results do not establish normalized revenue

(2) Calculated as covered lives in U.S. health plans that have reimbursed at least one RASONQUE claim divided by covered lives across all U.S. plans included in the analysis. Formal coverage policies remain in development for most plans.

Organization in Place to Address All Key U.S. PDAC Stakeholders

U.S. PDAC Patients Treated by Site of Care

ACADEMIC HCPs

40% Scientific leadership, KOL activation & early adoption

COMMUNITY ONCOLOGY HCPs

60% Large treatment volume; focus on broad education & account reach

Key Access Stakeholders

PAYERS | IDNs | GPOs

Payers

Top 15 Payers ~80% of U.S. Covered Lives

Community & IDN/AMC

GPOs

Top 25 Stakeholders ~50% of Volume

Fit-for-purpose Field Teams in Place

Medical Affairs / MSLs

Academic HCPs / Opinion Leaders

Sales

Academic & Community HCPs

Fit-for-purpose Access Teams

National Account Teams

Primary: Payers, Integrated Delivery Networks & Group Purchasing Organizations

HCP: Healthcare Professionals; IDN: Integrated Delivery Networks; GPO: Group Purchasing Organizations; AMC: Academic Medical Center; MSL: Medical Science Liaison; KOL, key opinion leader; PDAC, pancreatic adenocarcinoma

Launching in the U.S. and Accelerating Global Launch Readiness

UNITED STATES	U.S. launch now underway
EUROPE	Positive CHMP opinion for daraxonrasib[1]
JAPAN	Launch readiness advancing
GLOBAL ACCESS	International opportunity prioritized in phases

GLOBAL NAMED PATIENT ACCESS[2]: Please visit revmed.com/pre-approval-access-to-investigational-medicines/

CHMP, Committee for Medicinal Products for Human Use

(1) A positive CHMP opinion does not constitute EU marketing authorization. Authorization remains subject to a decision by the European Commission.
(2) Ability to access the drug will vary from country to country depending on local and regional requirements for the supply of unapproved medicinal products.

PDAC | Our Broad Strategy Aimed at Changing Standard of Care Across Early- to Late-Stage Disease Settings

Approved in Metastatic PDAC

RASONQUE

First-Line Phase 3 Trials

RASolute 303 | RASolute 305 | RASolute 309

Adjuvant Phase 3 Trial

RASolute 304

Objectives:

- Establish RASONQUE as the new standard of care
  - First approved targeted medicine designed to broadly address metastatic PDAC by inhibiting RAS, its main driver
  - Foundation for commercial leadership in pancreatic cancer
- Expand across the treatment continuum
  - Four global Phase 3 registrational programs underway across first-line metastatic and adjuvant PDAC
  - Complementary monotherapy and combination strategies designed to address diverse patient needs

Strategy designed to transform treatment with a comprehensive franchise spanning every major stage of disease

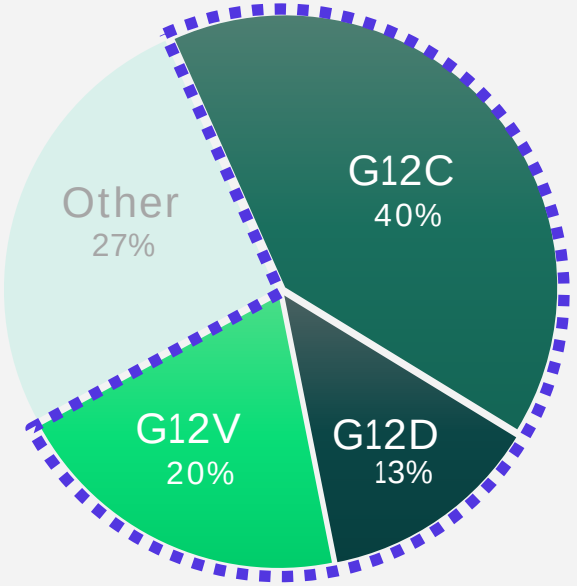
PDAC, pancreatic adenocarcinoma

NSCLC

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NSCLC | RAS(ON) Mutant-Selective Portfolio Designed for Treatment Landscape Segmented by Genetic Cause

Three RAS Variants Dominate RAS Mutant NSCLC[1]



Clinically Validated 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.

NSCLC | Layered Development Strategy Targeting RAS Tumor Drivers

RAS(ON) Multi-Selective Inhibition
for treatment across RAS mutations

RASONQUE
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	Zoldonrasib	RMC-5127
G12C	*G12D*	*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

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

NSCLC | Multi-Selective RAS(ON) Foundation in Previously Treated Disease, Complemented by Mutant-Selective Programs in First-Line

MULTI-SELECTIVE RAS(ON) INHIBITION
RASONQUE in previously treated NSCLC

MUTANT-SELECTIVE RAS(ON) INHIBITION
Elironrasib, zoldonrasib in 1L NSCLC

Regulatory and Guideline Updates

NCCN Guidelines® include daraxonrasib as Category 2A available targeted agent[1]

FDA BTD in previously treated metastatic KRAS non-G12C NSCLC

Registrational Development

Global Phase 3 RASolve 301 in previously treated RAS mutant NSCLC

First-Line Portfolio Expansion

RASolve 307 (elironrasib) and RASolve 308 (zoldonrasib) evaluate 1L combinations with pembrolizumab + chemotherapy

RASONQUE
Exploring novel combination approaches in 1L

RASONQUE is being advanced to establish the multi-selective foundation in previously treated NSCLC with mutant-selective programs potential to extend the portfolio into 1L disease

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(1) In metastatic NSCLC with KRAS G12, G13 or Q61 mutations. Daraxonrasib is investigational in NSCLC and has not been approved by the FDA for this use. NCCN recommendations do not change the FDA-approved indication.
NSCLC, non-small cell lung cancer; BTD, Breakthrough Therapy Designation; NCCN®, National Comprehensive Cancer Network®

CRC

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CRC | Advancing RASonate 312 and Broader Combination Strategies in Genetically Heterogeneous Disease

RASonate 312 | Global Phase 3 in 1L RAS G12D CRC

Zoldonrasib + cetuximab + FOLFOX/FOLFIRI

- Encouraging early clinical activity
- Phase 3 study in 1L CRC vs. standard of care

BeOne funding and conducting Phase 3 study utilizing its global development superhighway capabilities[1]

Broader Combination Development

Across mutant-selective and multi-selective programs:

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

Additional Clinical Evidence

Elironrasib + daraxonrasib doublet

- Encouraging antitumor activity in previously treated RAS G12C CRC

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CRC, colorectal cancer; SOC, standard of care.

(1) BeOne is funding and conducting RASonate 312 in lieu of upfront consideration under the previously announced collaboration, which includes regional rights in select Asian markets. Revolution Medicines retains development and commercial rights outside the licensed territory.

Discover

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Discover | Advancing the Next Wave of RAS(ON) Innovation



Highly productive discovery organization

Deep RAS biology expertise and drug discovery capabilities



Proprietary platform and differentiated expertise

Preclinical and translational insights advance differentiated RAS(ON) approaches



Continuing investment in potentially ground-breaking approaches

Exemplified by innovative new class of mutant-targeted catalytic RAS(ON) inhibitors, including RM-055

Financial Summary

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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

$3.7 billion
in cash and investments as of September 30, 2026[1]

+

$0.25 billion
first debt tranche proceeds received in October 2026

+

$1.0 billion
in additional committed capital[2]

Financial Guidance

$2.1 – $2.2 billion
2026 GAAP Operating Expenses[3]

(1) Cash and investments as of September 30, 2026; excludes $250 million received after quarter end under the first debt tranche of the Royalty Pharma funding arrangement.
(2) Up to $1.0 billion in additional committed capital remains available under the Royalty Pharma funding arrangement, subject to specified milestones and at the Company's election.
(3) 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 (RASONQUE in 2L)
✓	1H 2026	Initiate RASolute 305 (zoldonrasib + chemo combination in 1L)
✓	2H 2026	Initiate RASolute 309 (RASONQUE + zoldonrasib doublet in 1L)
✓	Aug 2026	FDA approval and U.S. launch of RASONQUE
	1H 2027	Complete enrollment in RASolute 303 (RASONQUE in 1L)
	TBD	Complete enrollment in RASolute 304 (RASONQUE in adjuvant)

Non-Small Cell Lung Cancer

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

Colorectal Cancer & RVMD-Led Collaborations

✓	Q1 2026	Initiate Phase 1 combination trial with PD-1/VEGF bi-specific
✓	Q4 2026	Initiate RASonate 312 (zoldonrasib combination in 1L)
	1H 2027	Update on combination CRC data

Early Development

Q4 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

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

Our Ambition | To Change the Trajectory of RAS-Driven Cancer

Our Commitment: To Patients

- Delivering our first approved medicine
- Advancing our innovative, differentiated portfolio of RAS(ON) inhibitors as a potential backbone for treating RAS-addicted cancers
- Working to reach more patients with RAS-addicted cancers



In the News

How an "Impossible" Idea Led to a Pancreatic Cancer Breakthrough

New York Times, May 2026

Finally, Real Progress Against Pancreatic Cancer

Bloomberg, April 2026

A pill that doubles survival: Revolution's FDA-approved drug gives pancreatic cancer patients a fighting chance

Economic Times, August 2026

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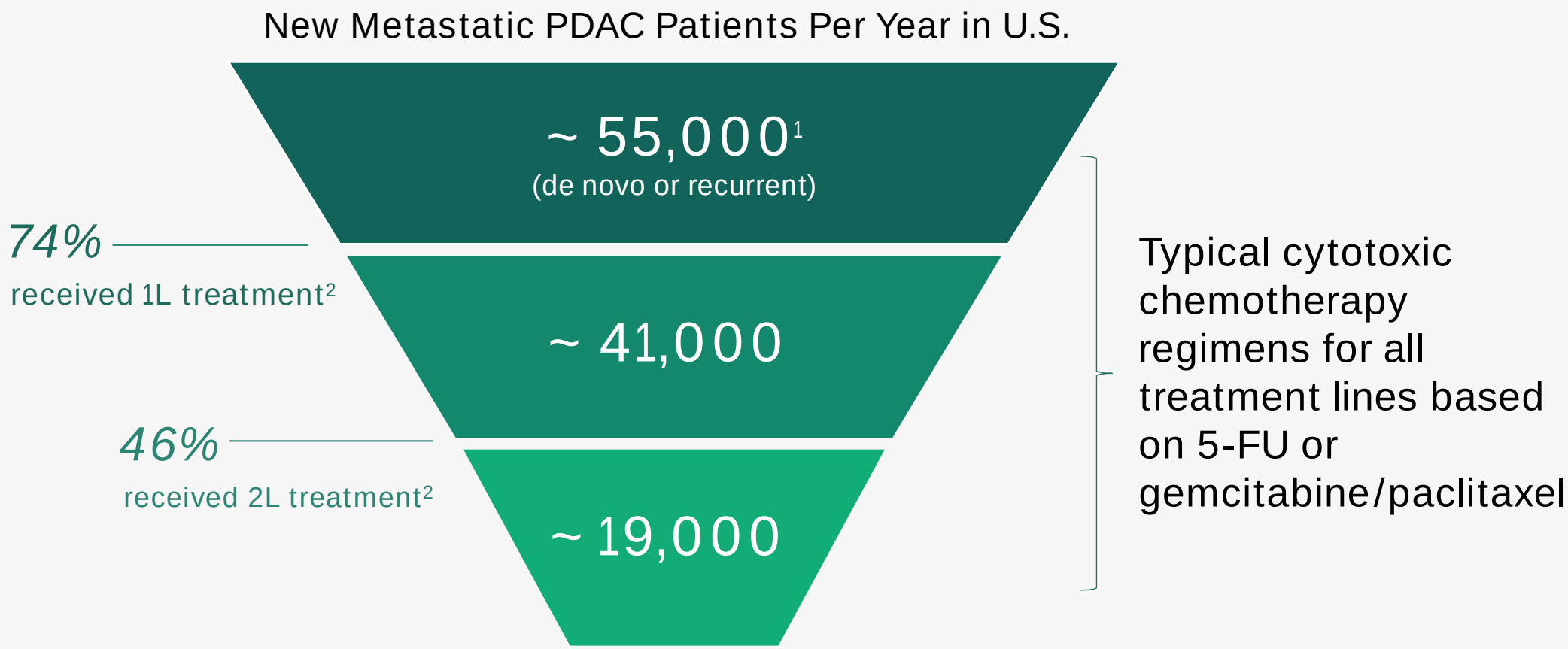
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Appendix

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

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Historical U.S. Metastatic Pancreatic Cancer Management



1L, first line; 2L, second line; 5-FU, 5-fluorouracil; PDAC, pancreatic adenocarcinoma.

References:
1. Oracle CancerMPact Patient Metrics, Stage IV newly incident + recurrent from earlier stages; accessed July 2026
2. King G, Ittershagen S, He L, Shen Y, Li F, Villacorta R. Treatment patterns in US patients receiving first-line and second-line therapy for metastatic pancreatic adenocarcinoma in the real world. Adv Ther. 2022;39(12):5433-5452. doi:10.1007/s12325-022-02317-9

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.

RASONQUE

RAS(ON) Multi-Selective Inhibitor

Active against:

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

FDA recognition:

- BTD: previously treated metastatic PDAC
- BTD: RASONQUE + GnP in 1L metastatic PDAC[1]
- BTD: previously treated non-G12C KRAS-mutant NSCLC
- Commissioner's National Priority Voucher
- Orphan Drug Designation for PDAC

U.S. FDA approved for:

- RASONQUE is approved in the U.S. for adult patients with metastatic pancreatic adenocarcinoma who have received at least one prior systemic therapy or are not candidates for multiagent systemic therapy.

NCCN Guidelines®:

- PDAC: Preferred, Category 1 subsequent therapy after prior systemic therapy; "Useful in Certain Circumstances" in 1L metastatic disease[2]
- NSCLC: Category 2A available targeted agent in metastatic KRAS G12-, G13- or Q61-mutant disease[3]

1. RASONQUE + GnP in 1L mPDAC and RASONQUE in NSCLC are investigational and not FDA approved.
2. NCCN recommendations do not change the FDA approved indication and vary by performance status. See NCCN Guidelines® for Pancreatic Adenocarcinoma, Version 4.2026 September 11, 2026. for complete recommendations.

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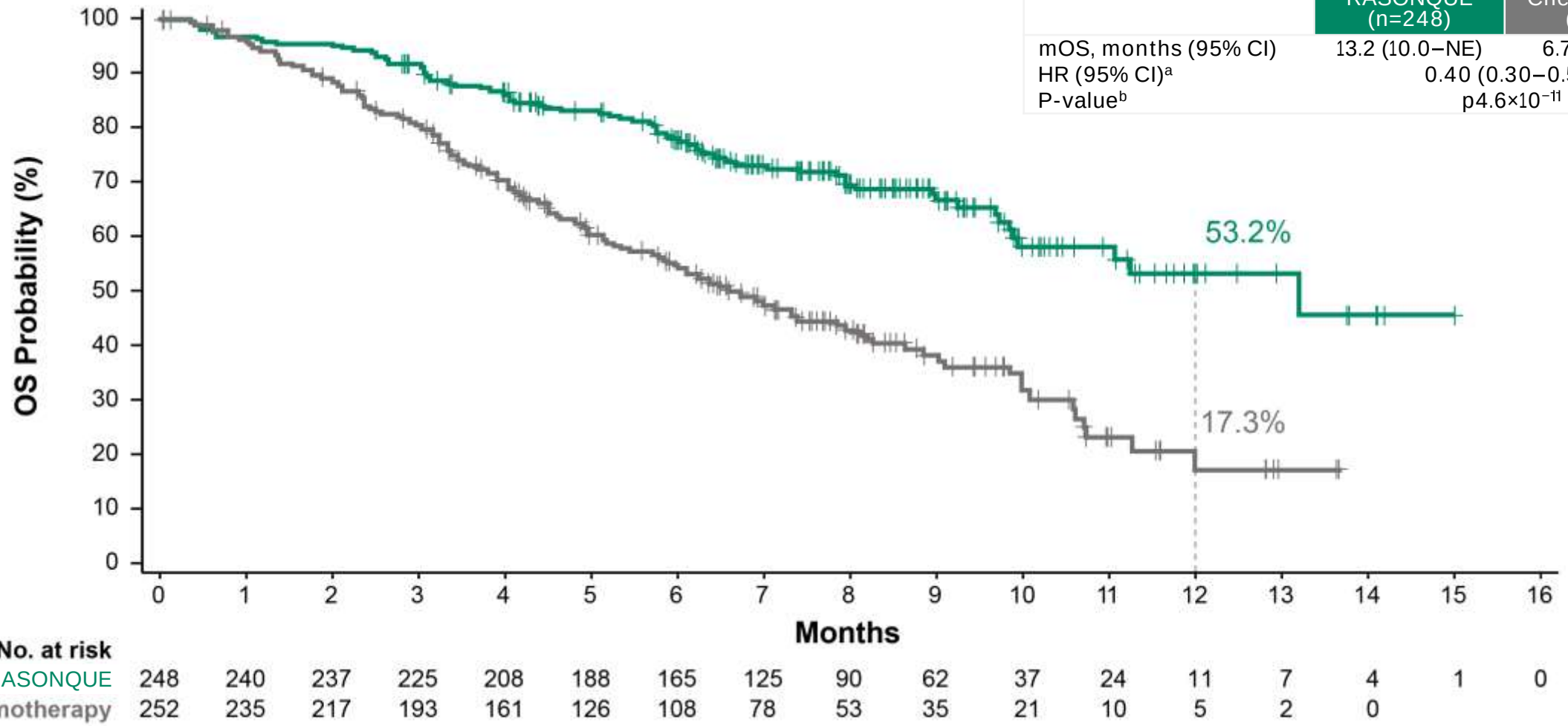
1L, first line; BTD, Breakthrough Therapy Designation; GnP, gemcitabine and nab-paclitaxel; PDAC, pancreatic adenocarcinoma; NCCN, National Comprehensive Cancer Network; NSCLC, non-small cell lung cancer; ODD, Orphan Drug Designation.

RASONQUE Clinical Data

Revolution Medicines

RASolute 302: Overall Survival in the Overall Study Population

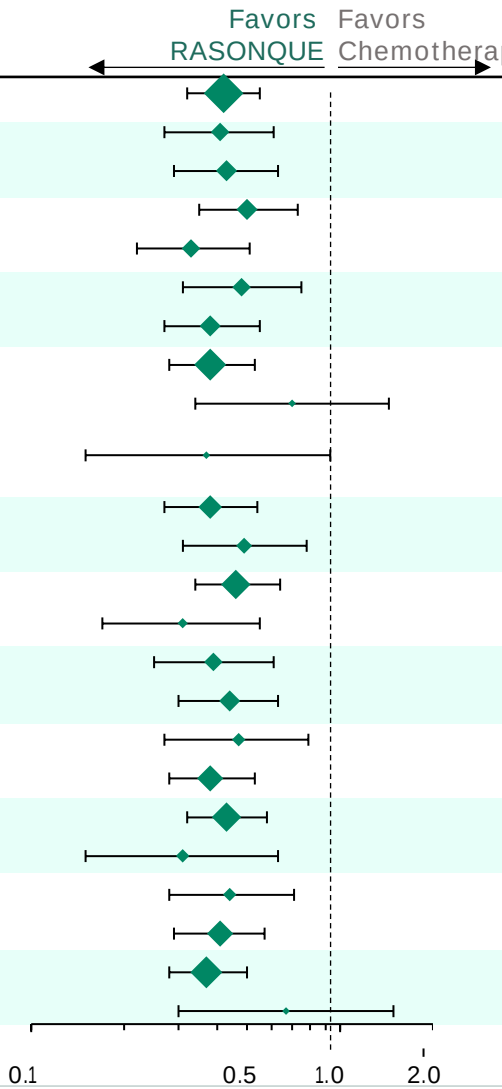
	RASONQUE (n=248)	Chemotherapy (n=252)
mOS, months (95% CI)	13.2 (10.0–NE)	6.7 (5.8–8.0)
HR (95% CI)[a]	0.40 (0.30–0.53)	
P-value[b]	p4.6×10^{-11}	



Presented at ASCO Annual meeting 2026. Data from 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: RASONQUE: 79 (32%); chemotherapy: 141 (56%).
[A] HRs and 95% CIs were based on the stratified Cox model with Efron's method of tie handling. [b] P-values were calculated using the stratified log-rank test.
m, median; NE, not estimable; OS, overall survival.

RASolute 302: Overall Survival Benefit Consistent Across All Subgroups

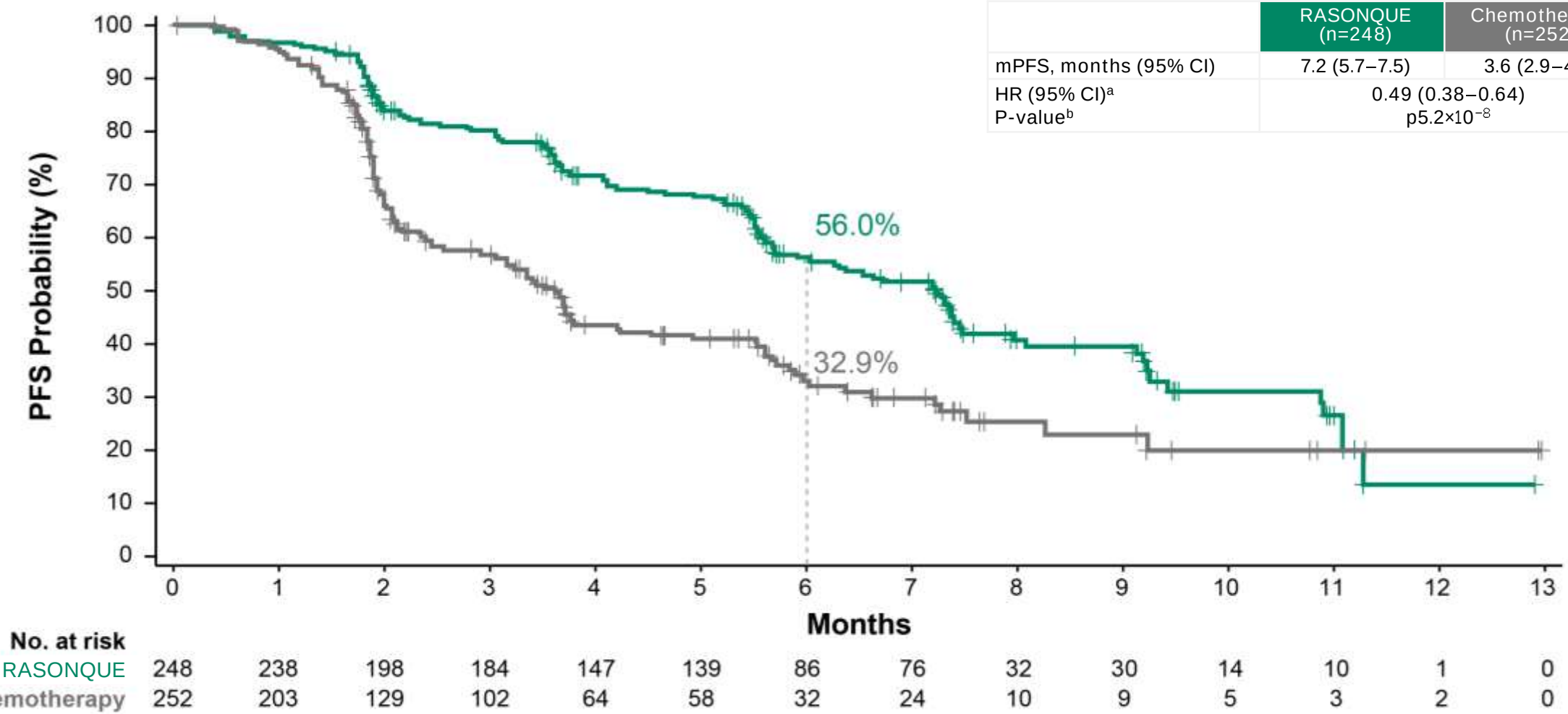
Population		Events/N RASONQUE	Events/N Chemotherapy	HR (95% CI)[a]
Overall		79/248	141/252	0.42 (0.32–0.55)
Age, years	<65	37/114	68/121	0.41 (0.27–0.61)
	≥65	42/134	73/131	0.43 (0.29–0.63)
Sex	Male	45/131	77/144	0.50 (0.35–0.73)
	Female	34/117	64/108	0.33 (0.22–0.51)
ECOG PS	0	33/129	51/118	0.48 (0.31–0.75)
	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)



Presented at ASCO Annual meeting 2026. Data from O'Reilly EM, et al. N Engl J Med. 2026. DOI: 10.1056/NEJMoa2605555.
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 RASONQUE 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.

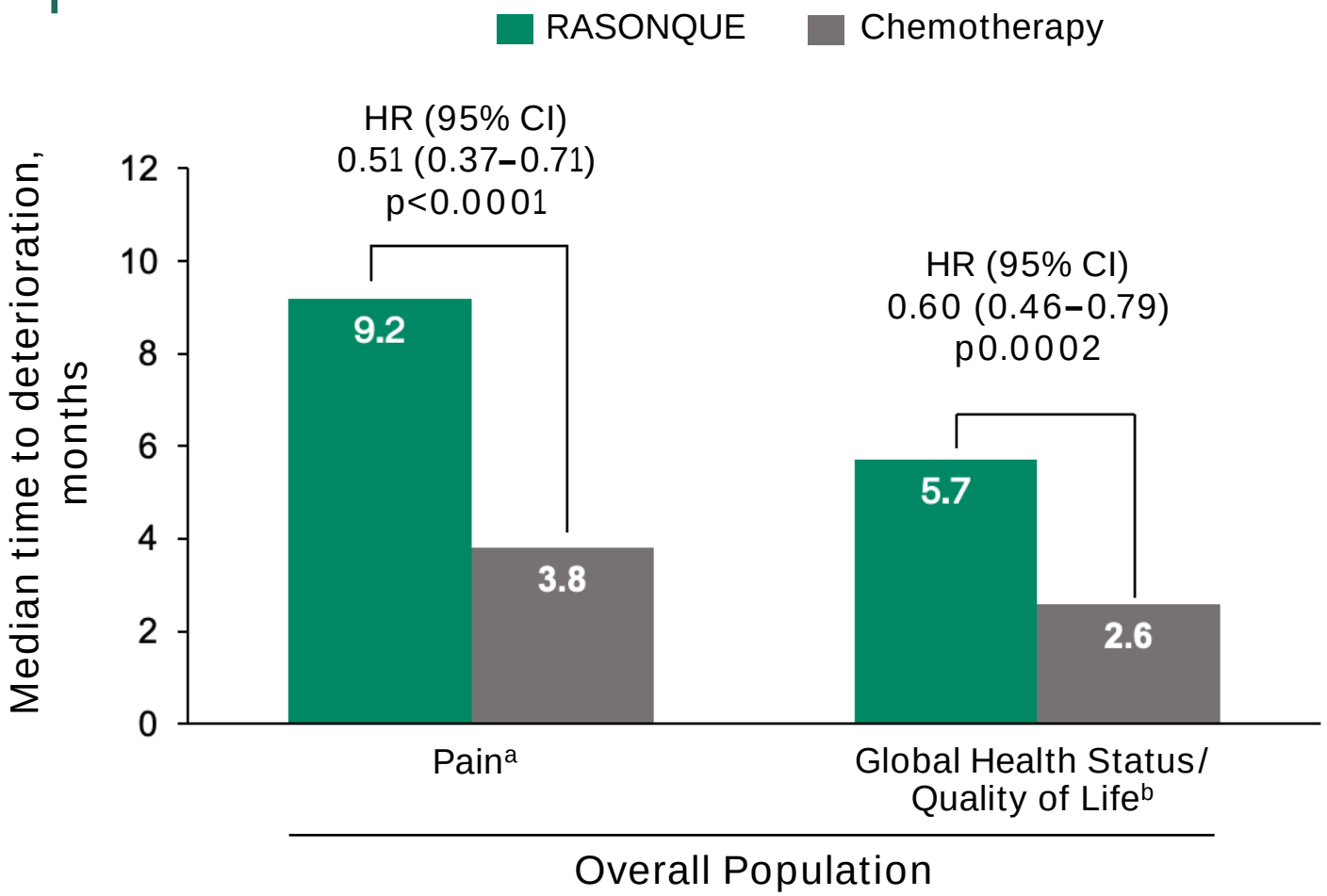
RASolute 302: Progression-Free Survival in the Overall Study Population

	RASONQUE (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]	p5.2×10^{-8}	



Presented at ASCO Annual meeting 2026. Data from O'Reilly EM, et al. N Engl J Med. 2026. DOI: 10.1056/NEJMoa2605555.
Progression-free survival was assessed by blinded independent central review (BICR). Data cutoff: 10 Feb 2026. Median (range) follow-up time was 8.5 (3.2–15.9) months; number of events: RASONQUE: 127 (51%); chemotherapy: 130 (52%). [a] HRs and 95% CIs were based on the stratified Cox model with Efron's method of tie handling. [b] P-values were calculated using the stratified log-rank test.
m, median; PFS, progression-free survival.

RASolute 302: Patient-Reported Outcomes in the Overall Study Population



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

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Presented at ASCO Annual meeting 2026. Data from O'Reilly EM, et al. N Engl J Med. 2026. DOI: 10.1056/NEJMoa2605555.
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. [a] Time 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. [b] Time 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.

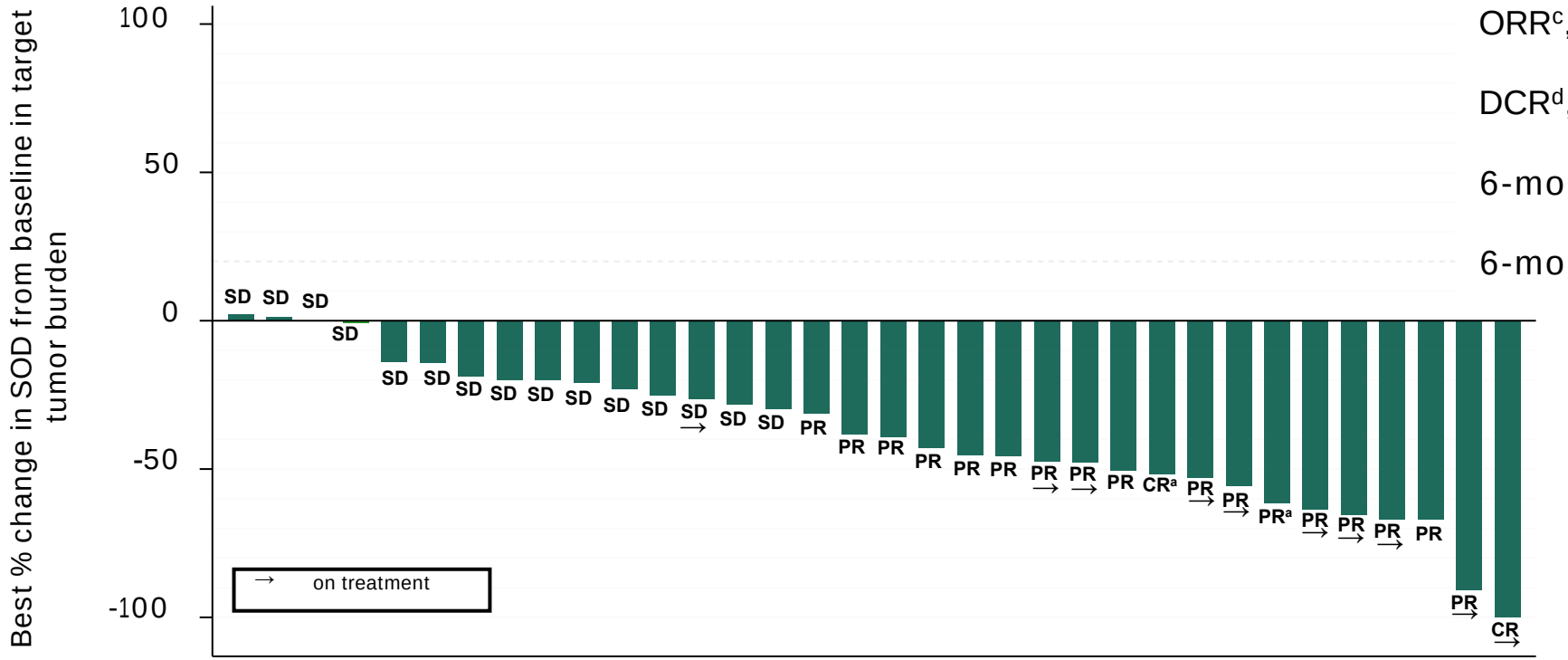
Safety Overview

	RASONQUE (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 (98)
TEAEs leading to dose interruption	167 (69)	135 (63)
TEAEs leading to dose reduction	90 (37)	126 (59)
TEAEs leading to discontinuation	7 (3)	31 (15)
Grade ≥3 TEAEs	149 (62)	149 (70)
Serious TEAEs	73 (30)	71 (33)
Grade 5 TEAEs	5 (2)	4 (2)

- Median dose intensity:
  - 93% with daraxonrasib
  - 65-95%[a] across chemotherapy regimens
- RASONQUE exposure
  - 52% of patients exposed to RASONQUE for 6 months or longer
  - 2% exposed for greater than 1 year
- Most common (≥5%) TEAEs leading to dose reduction:
  - RASONQUE: rash (18%), stomatitis (8%) and diarrhea (5%)

Source: RASONQUE U.S. Prescribing Information.
Data cutoff: 10 Feb 2026. TEAE, treatment-emergent adverse event.
[a] Medians across each component of the chemotherapy regimens.

1L PDAC: RASONQUE (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.

1L PDAC: RASONQUE (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.

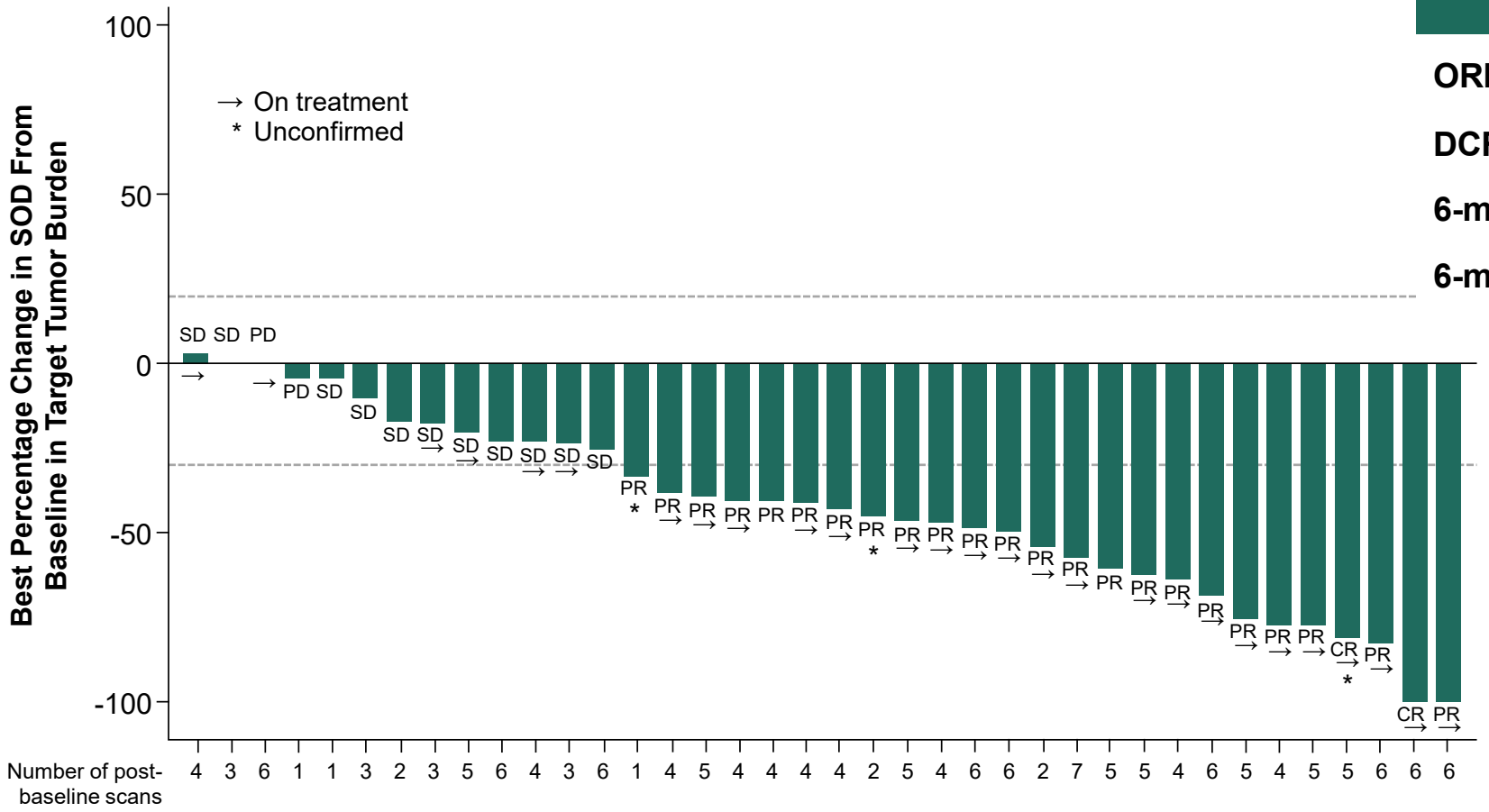
Data cutoff: Dec 1, 2025

1L PDAC: RASONQUE (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 RASONQUE, was identified on tumor assessment imaging; treatment was held, and given the ongoing nature of the finding, RASONQUE was discontinued.
1L, first line; PDAC, pancreatic adenocarcinoma; TRAE, treatment-related adverse event.

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

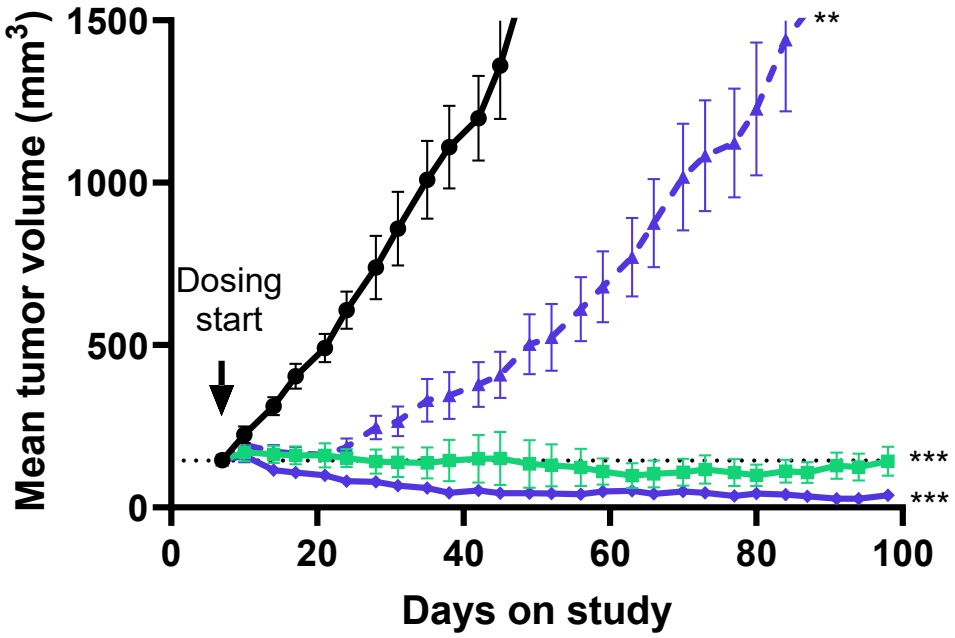
	All treated patients (n=40)	
	RASONQUE	GnP
Patients with dose modification due to TRAEs, n (%)	24 (60)	30 (75)
Dose interruption	24 (60)	21 (53)
Dose reduction	14 (35)	23 (58)
Patients with dose discontinuation due to TRAEs, n (%)	2 (5)[a]	6 (15)
Mean dose intensity, %	82	80
Median dose intensity, %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

Median (range) treatment duration is 8.2 (0.5-13.5) months.
[a]TRAEs that led to RASONQUE 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.

Data cutoff: Dec 1, 2025

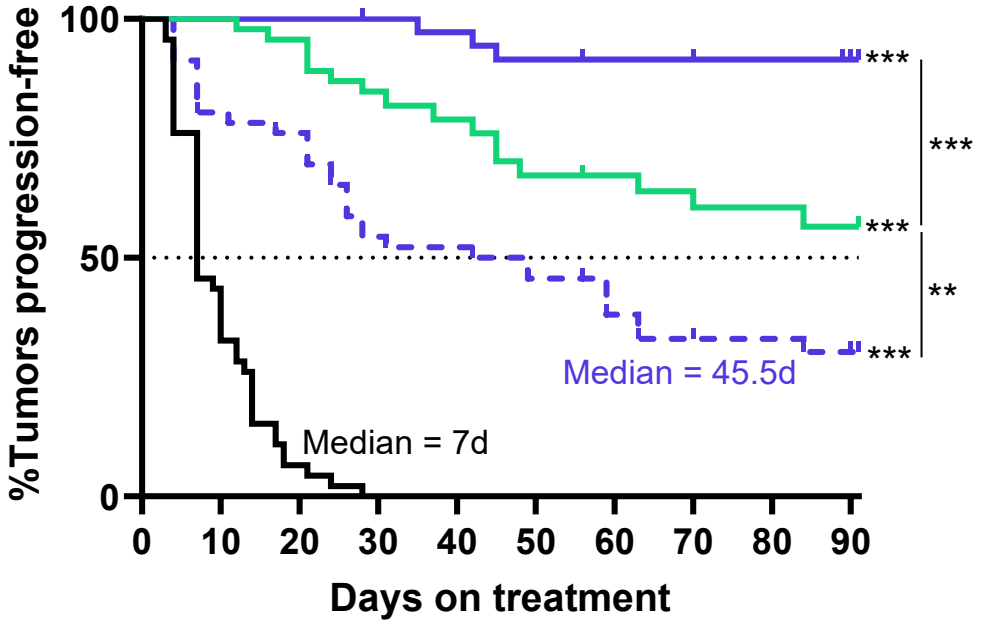
RASONQUE Combination with GnP Demonstrated Improved Depth and Durability of Responses in Preclinical Models of PDAC

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



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

10 PDAC Xenograft Models[1]



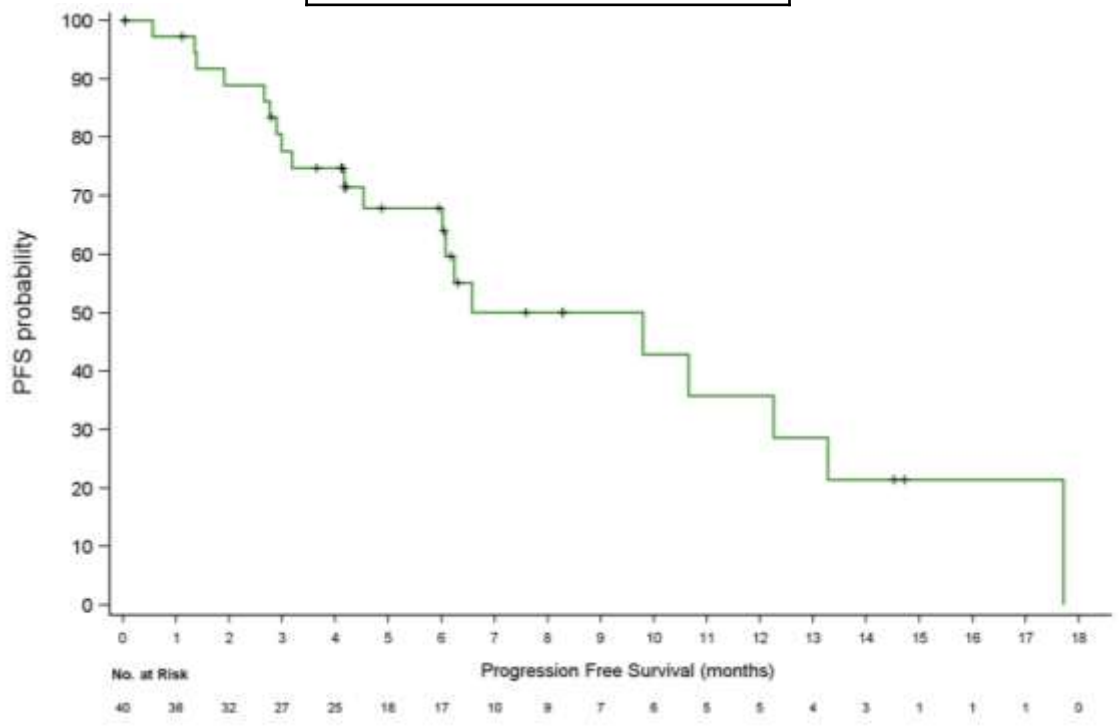
(1) 7 KRASG12X, 3 KRASWT PDAC xenograft models, n=46 per group
Progression defined as tumor doubling from baseline
** Adjusted p<0.01 *** Adjusted p<0.001 by Log-rank test

Control
GnP
RASONQUE 24 mg/kg po qd
RASONQUE + GnP

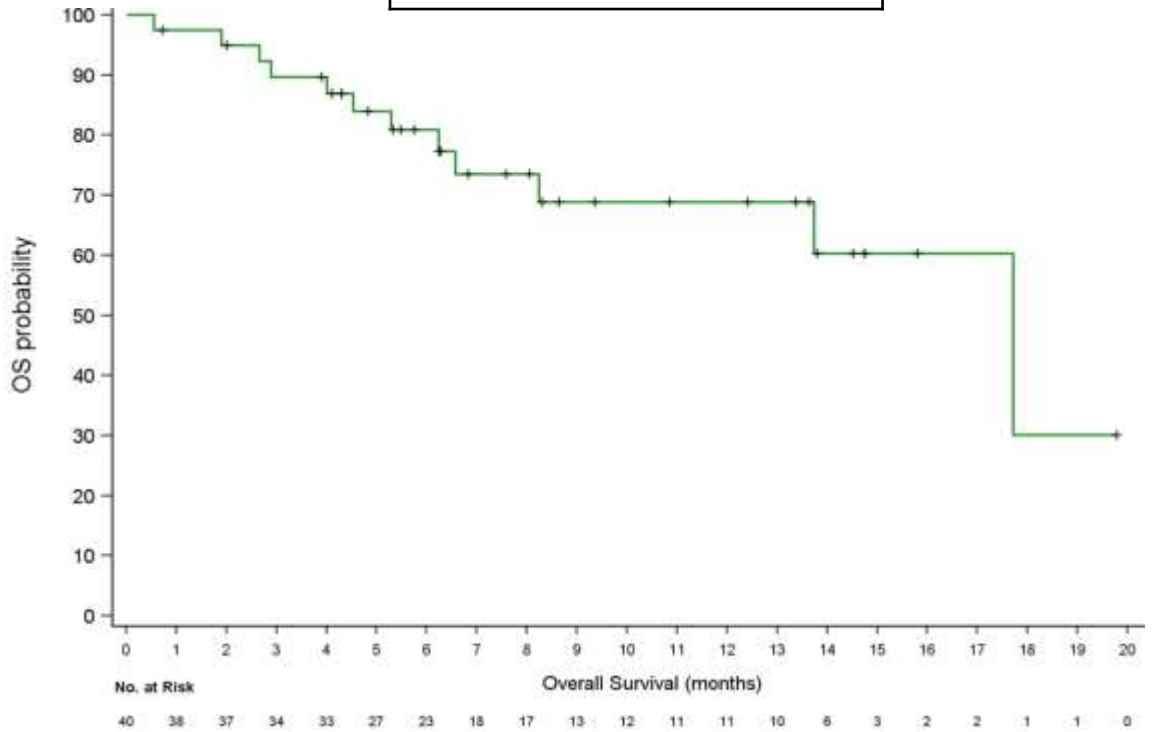
25 mg/kg translates to a clinical dose range of approximately 200-300 mg. Dose used in GnP arms translates to clinical dose of GnP, gemcitabine 50 mg/kg ip q3d + nab-paclitaxel 250 mg/kg iv qw;
PDAC, pancreatic adenocarcinoma.

2L/3L NSCLC: Encouraging Durability in Patients with RAS G12 Mutations Treated with RASONQUE 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 RASONQUE 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 RASONQUE. 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: RASONQUE 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: RASONQUE 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

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(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

RASONQUE 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

RASONQUE
300 mg PO QD
(N=230)

Investigator's Choice
SOC Chemotherapy(1)
(N=230)

Primary Endpoints
(RAS G12X)

- PFS, OS

Secondary Endpoints
(All Patients)

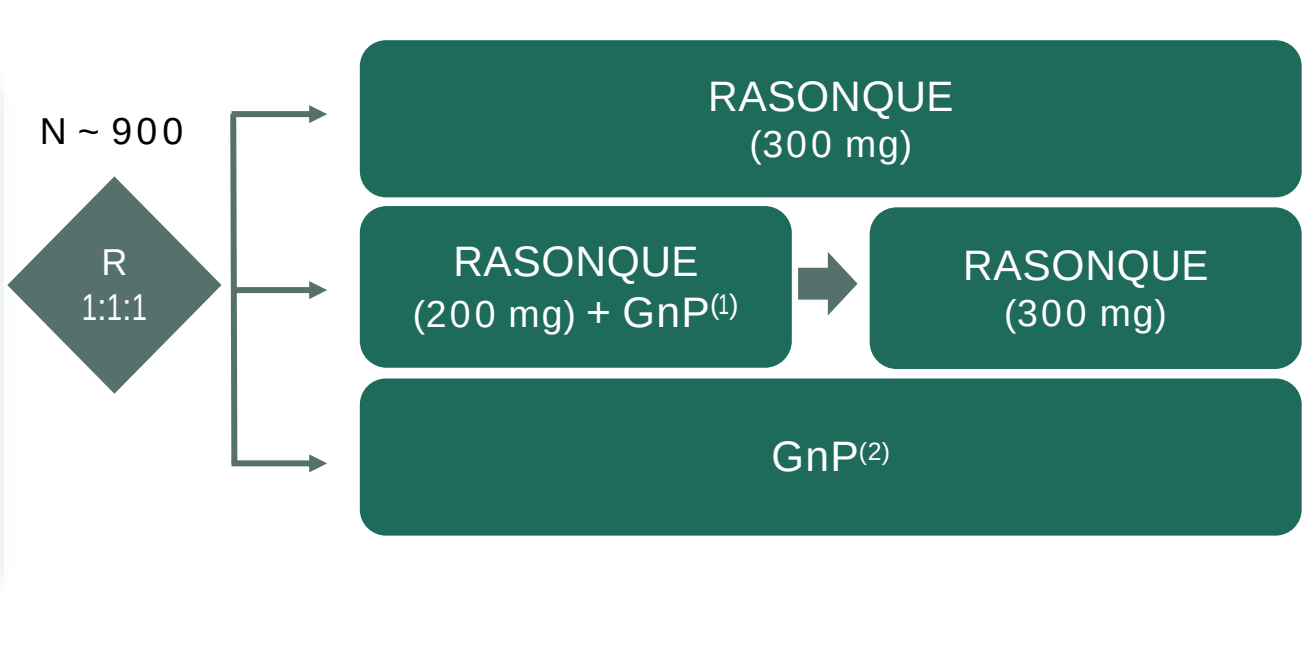
- PFS, OS
- ORR, DOR
- QoL

(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

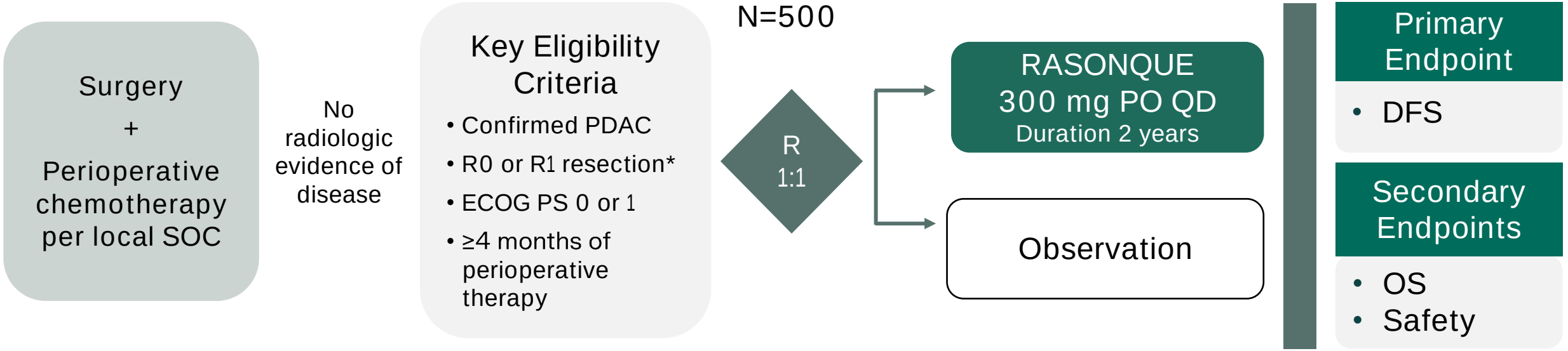
- PFS, OS

Secondary Endpoints

- ORR, DOR
- Safety

Treatment until disease progression or intolerance for all three arms. (1) RASONQUE (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 RASONQUE 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 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



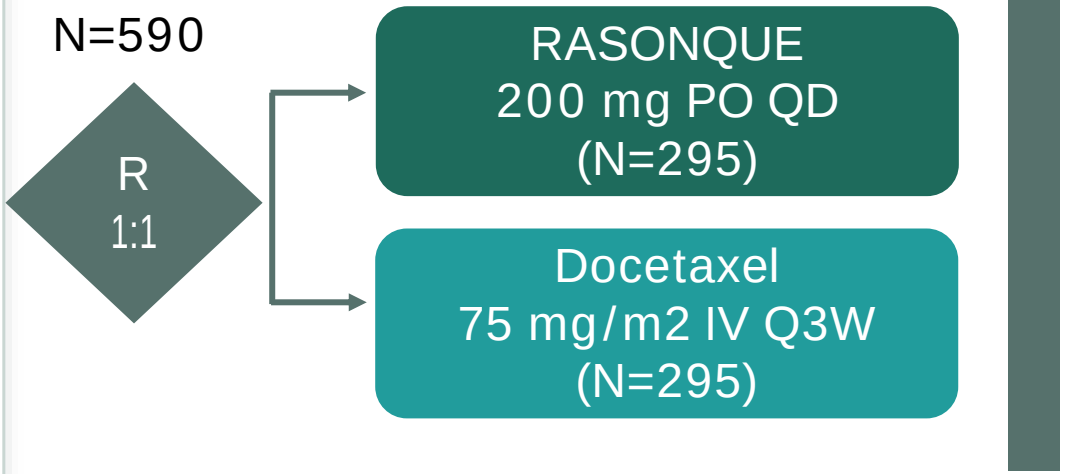
*R0 resection: No macroscopic residual tumor. No residual tumor at >1 mm of the surgical margins. R1 resection: No macroscopic residual tumor. Microscopic residual tumor at ≤1 mm of the surgical margins.
PDAC, pancreatic adenocarcinoma; SOC, standard of care; ECOG PS, Eastern Cooperative Oncology Group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

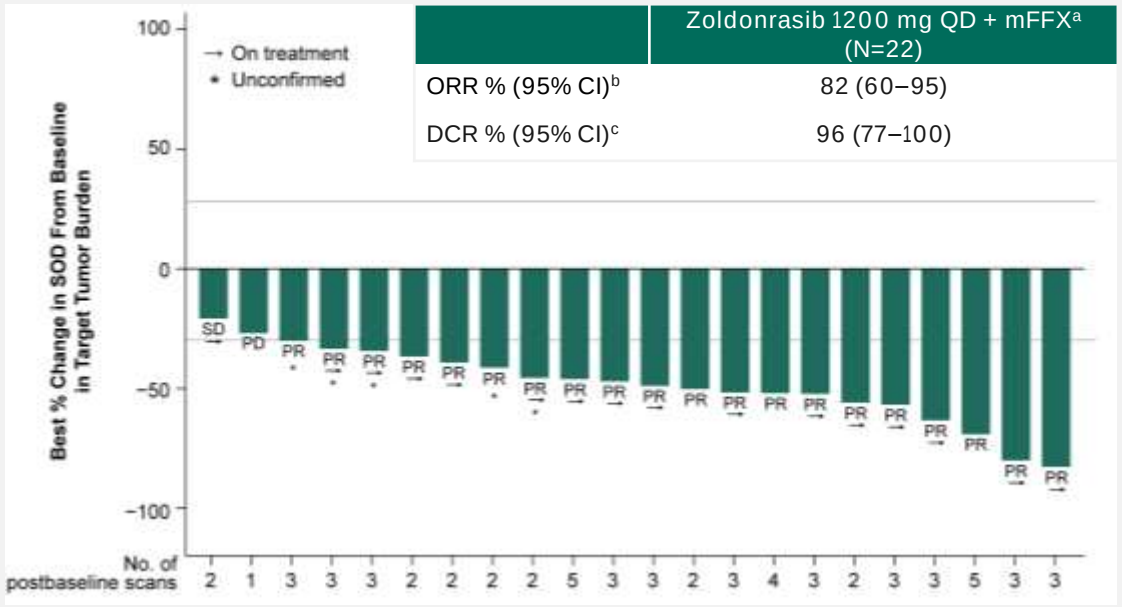
FDA granted:

- Breakthrough Therapy Designation: previously treated KRAS G12D mutated locally advanced or metastatic NSCLC
- Orphan Drug Designation for PDAC

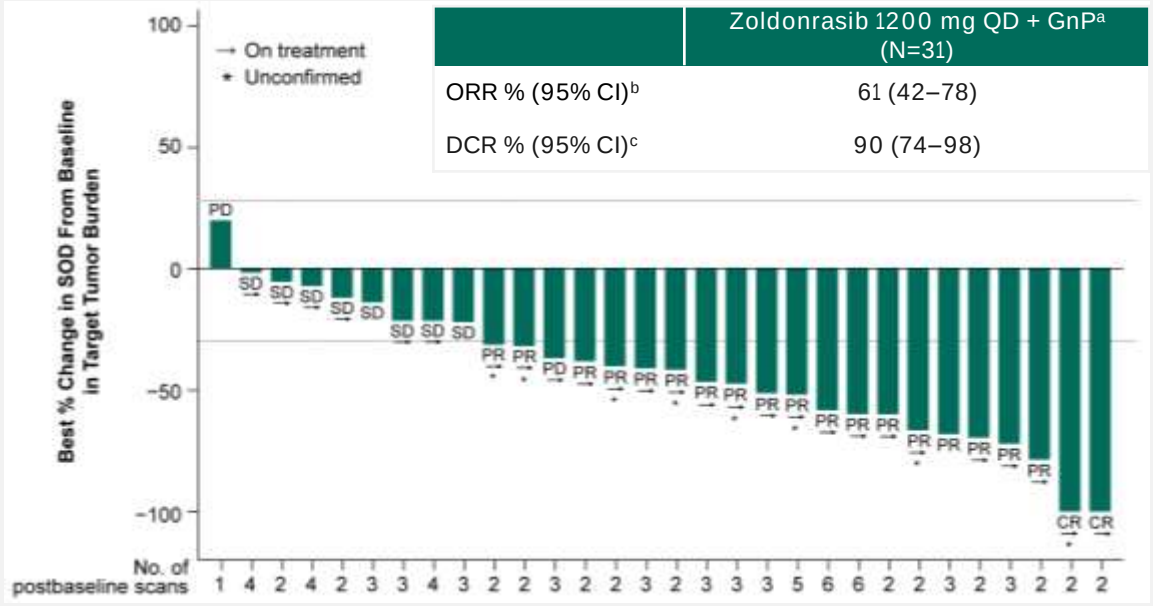
Zoldonrasib Clinical Data

Revolution Medicines

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)

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

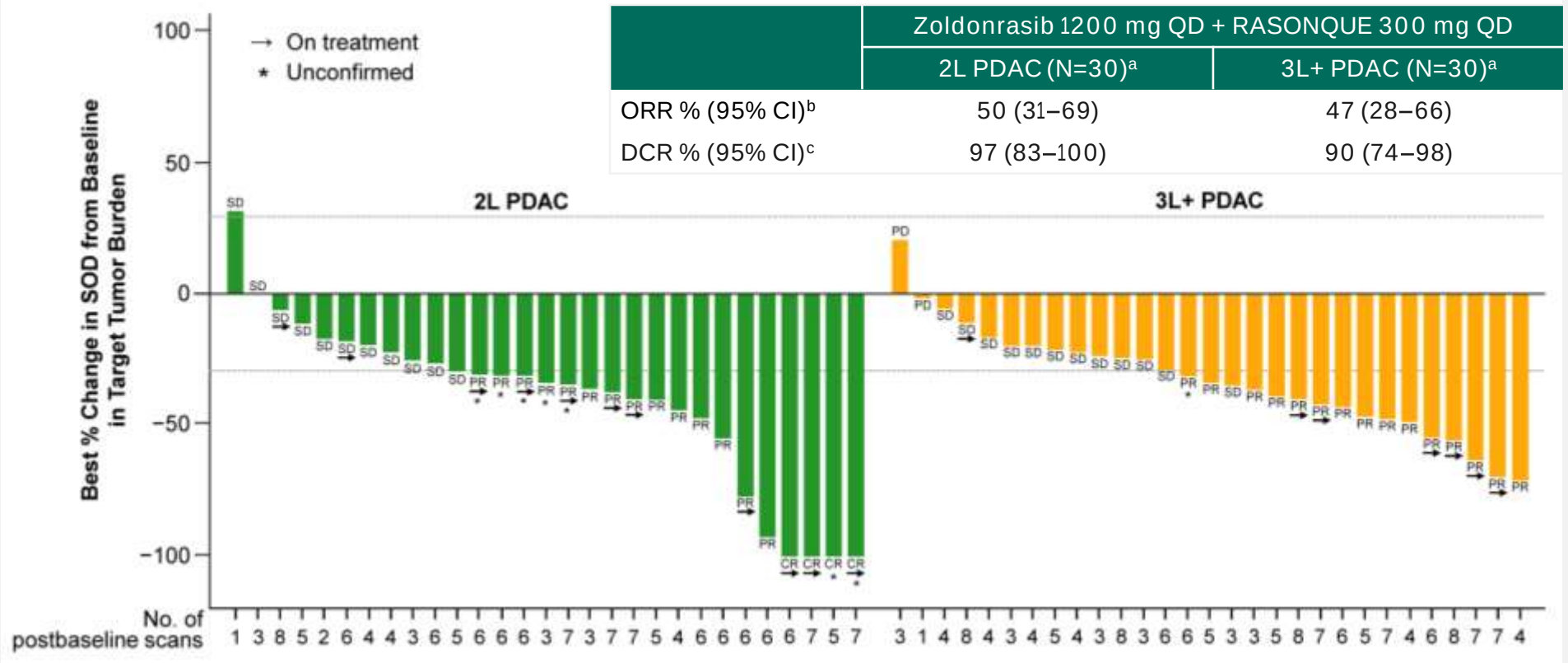
	Zoldonrasib 1200 mg QD + mFFX (N=41)	
	Any Grade	Grade ≥3
Any study drug-related AE, n (%)	40 (98)	25 (61)
TRAEs occurring in **≥20% of all patients, n (%)**		
Diarrhea	32 (78)	4 (10)
Nausea	25 (61)	1 (2)
Fatigue	21 (51)	2 (5)
Neutrophil count decreased	20 (49)	15 (37)
Vomiting	20 (49)	0
Platelet count 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 + RASONQUE Doublet Demonstrated Compelling Initial Antitumor Activity in Previously Treated RAS G12D PDAC



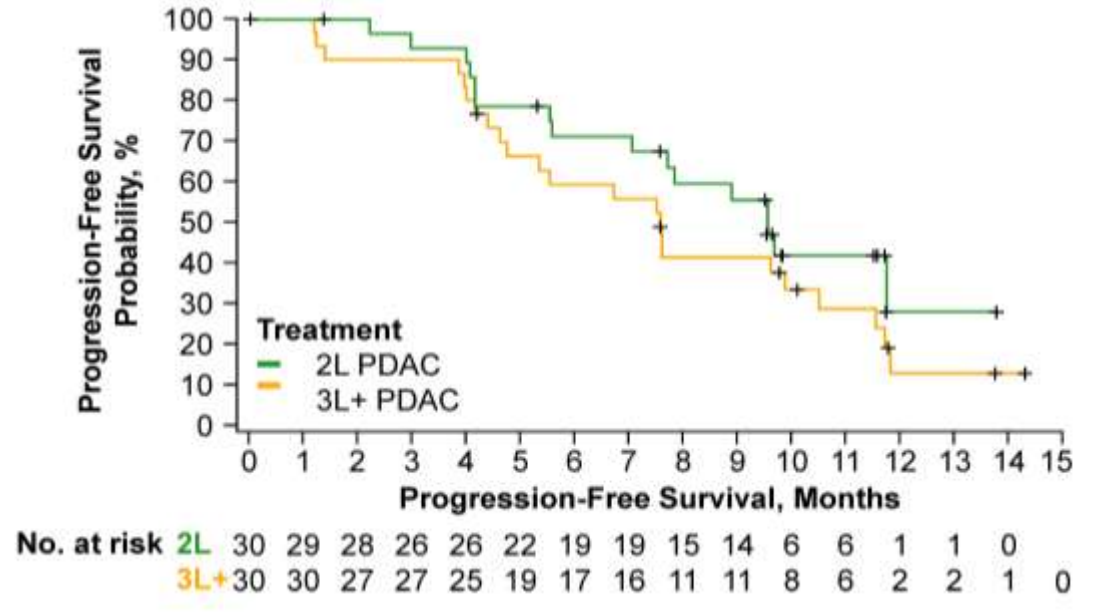
	Zoldonrasib 1200 mg QD + RASONQUE 300 mg QD	
	2L PDAC (N=30)[a]	3L+ PDAC (N=30)[a]
ORR % (95% CI)[b]	50 (31–69)	47 (28–66)
DCR % (95% CI)[c]	97 (83–100)	90 (74–98)

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 RASONQUE 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.

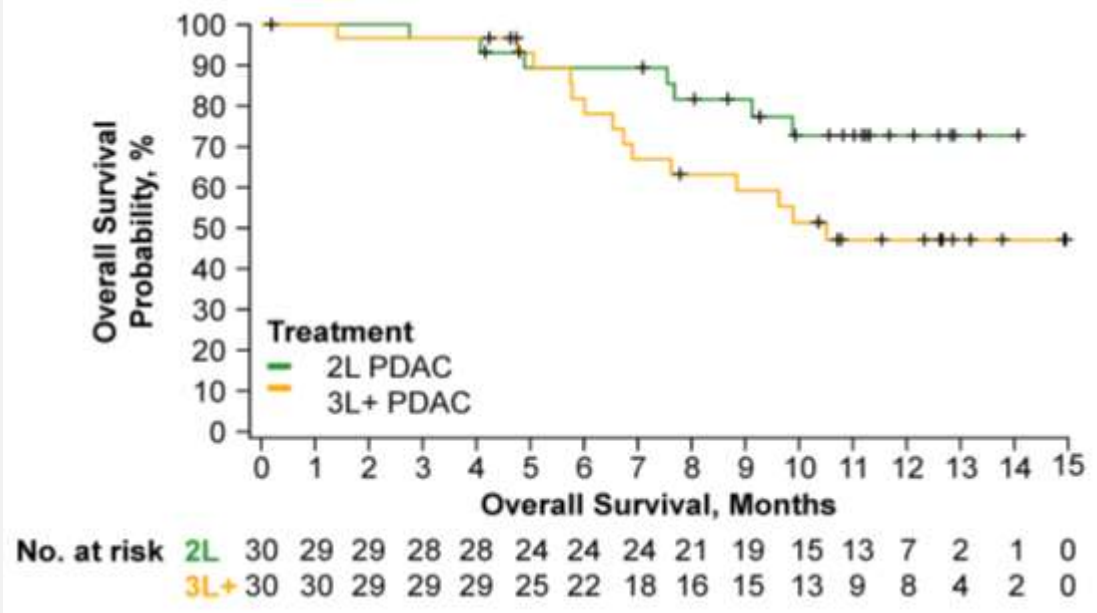
Data previously presented at ESMO GI (July 2026)

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

	Zoldonrasib 1200 mg QD + RASONQUE 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 + RASONQUE 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 + RASONQUE Doublet Demonstrated Manageable Safety and Tolerability Profile

	Zoldonrasib 1200 mg QD + RASONQUE 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 RASONQUE: 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 + RASONQUE 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)

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

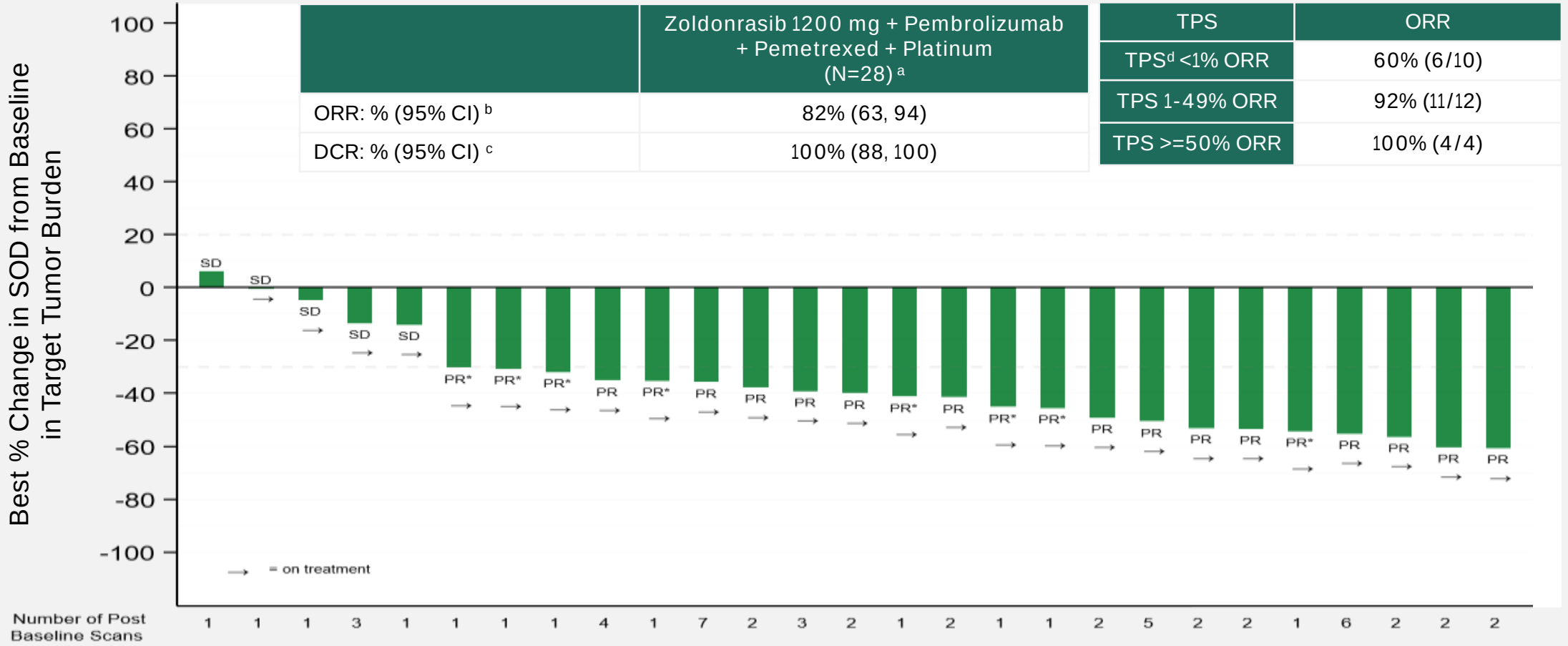
- TRAEs generally consistent with the established safety profile of SOC pembrolizumab and platinum doublet chemotherapy
- Minimal added toxicity and no Grade 5 TRAEs
- Favorable liver safety profile
- Supportive of continued combination development

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.

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%		

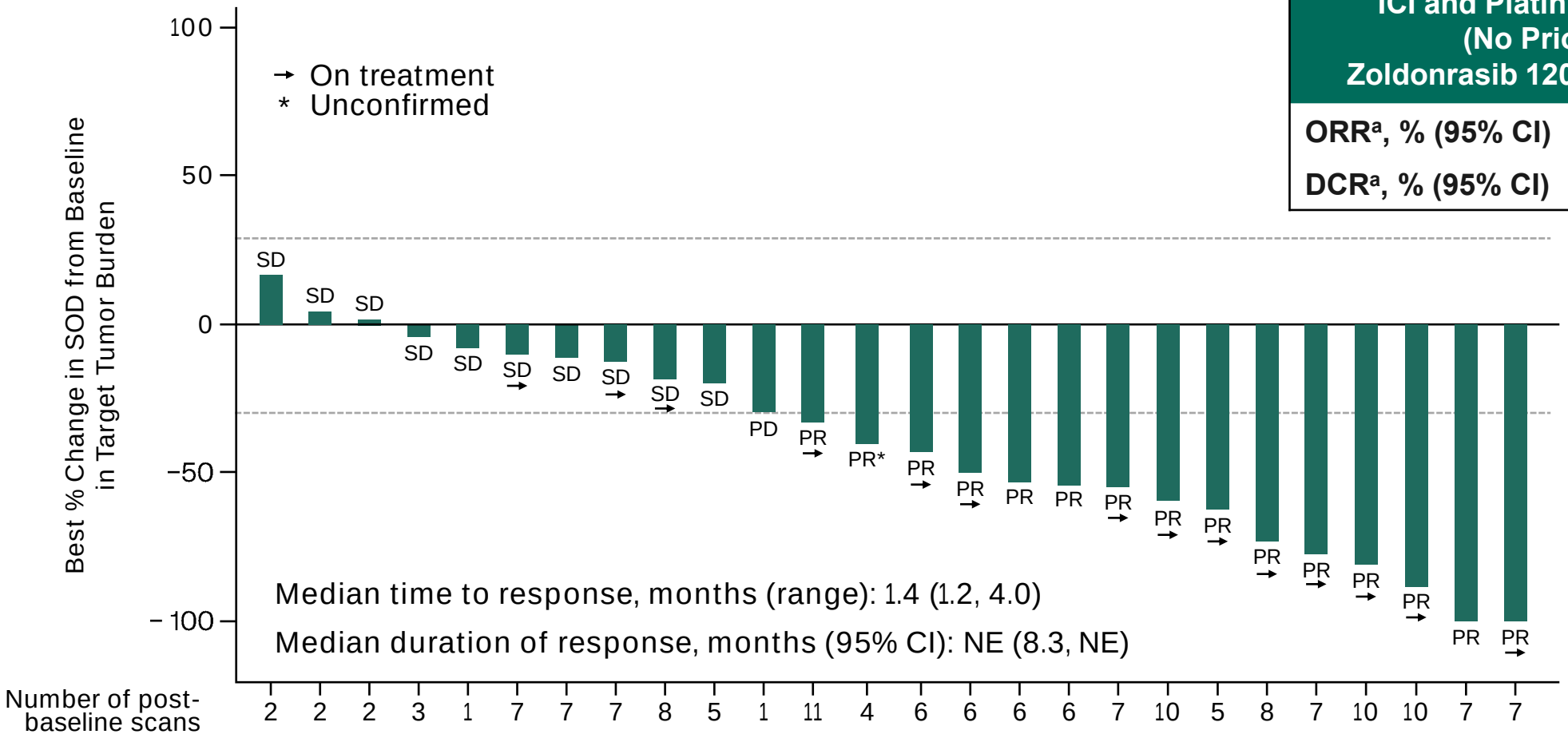
No treatment-related Grade 4 or 5 AEs or SAEs have been reported

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

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)

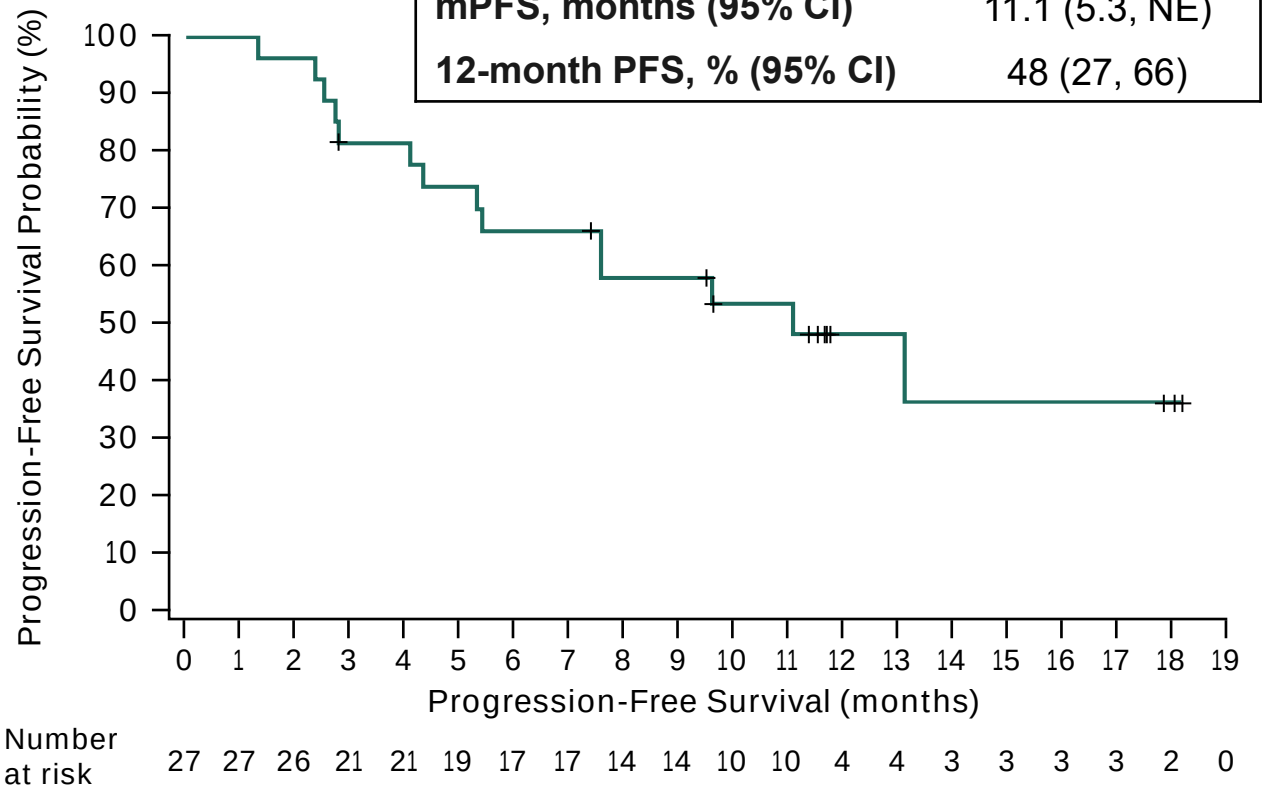


Median follow-up, months (range): 13.1 (9.1, 19.9).
[a]ORR (confirmed CR and PR) and DCR (CR+PR+SD) analyses included all NSCLC patients (with prior ICI and platinum chemotherapy treatment, but no docetaxel) who received first dose of zoldonrasib at least 14 weeks prior to data cutoff date. One patient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

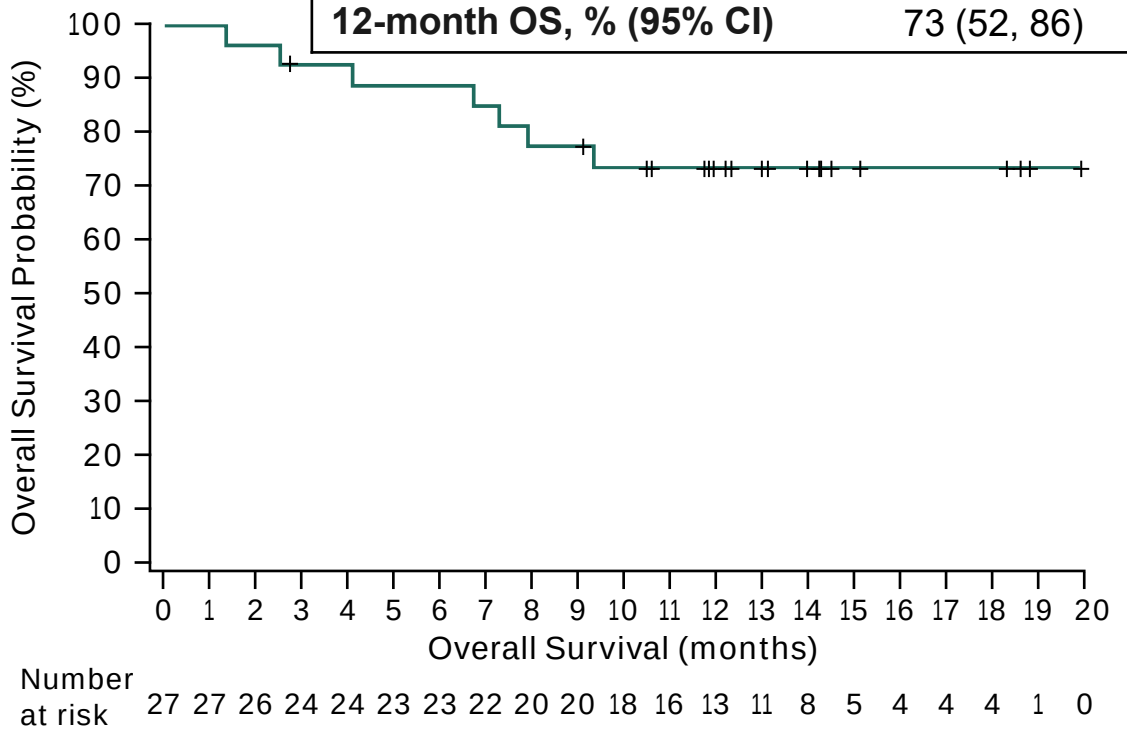
ICI and Platinum Chemo Treated (No Prior Docetaxel) Zoldonrasib 1200 mg PO QD (N = 27)

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) + RASONQUE (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 + 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

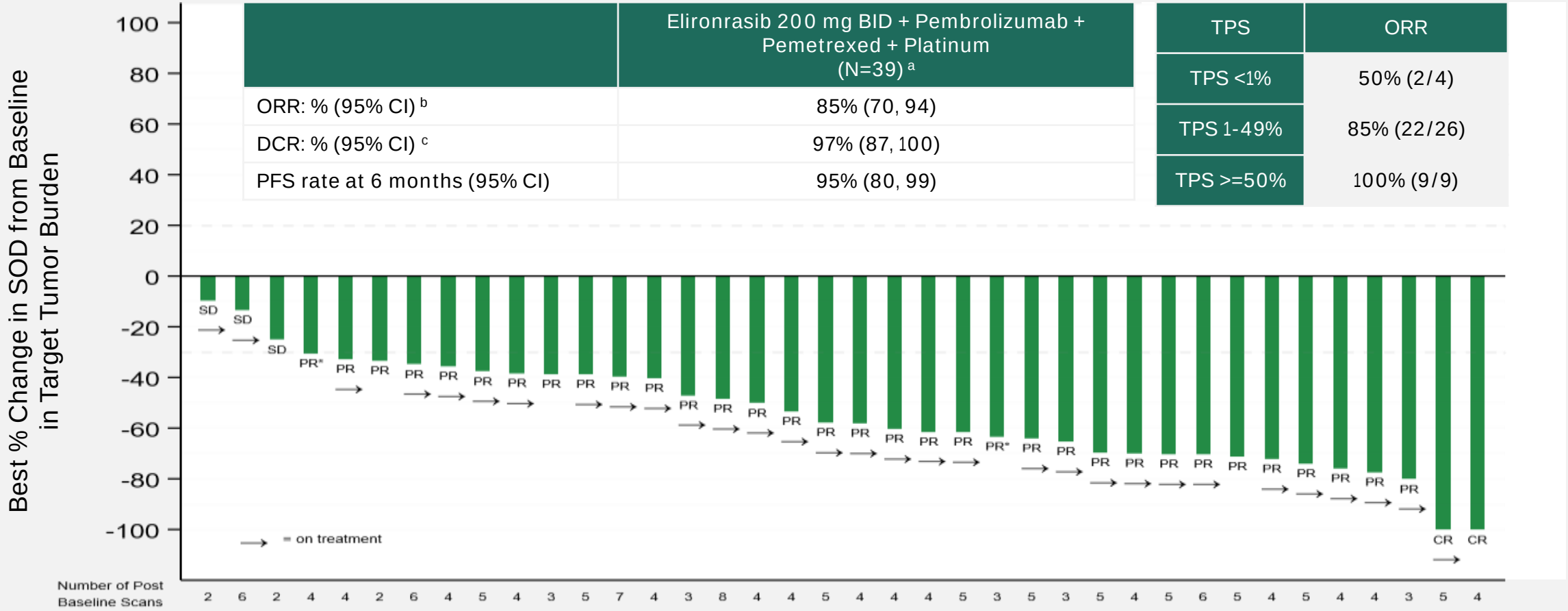
Revolution Medicines

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)

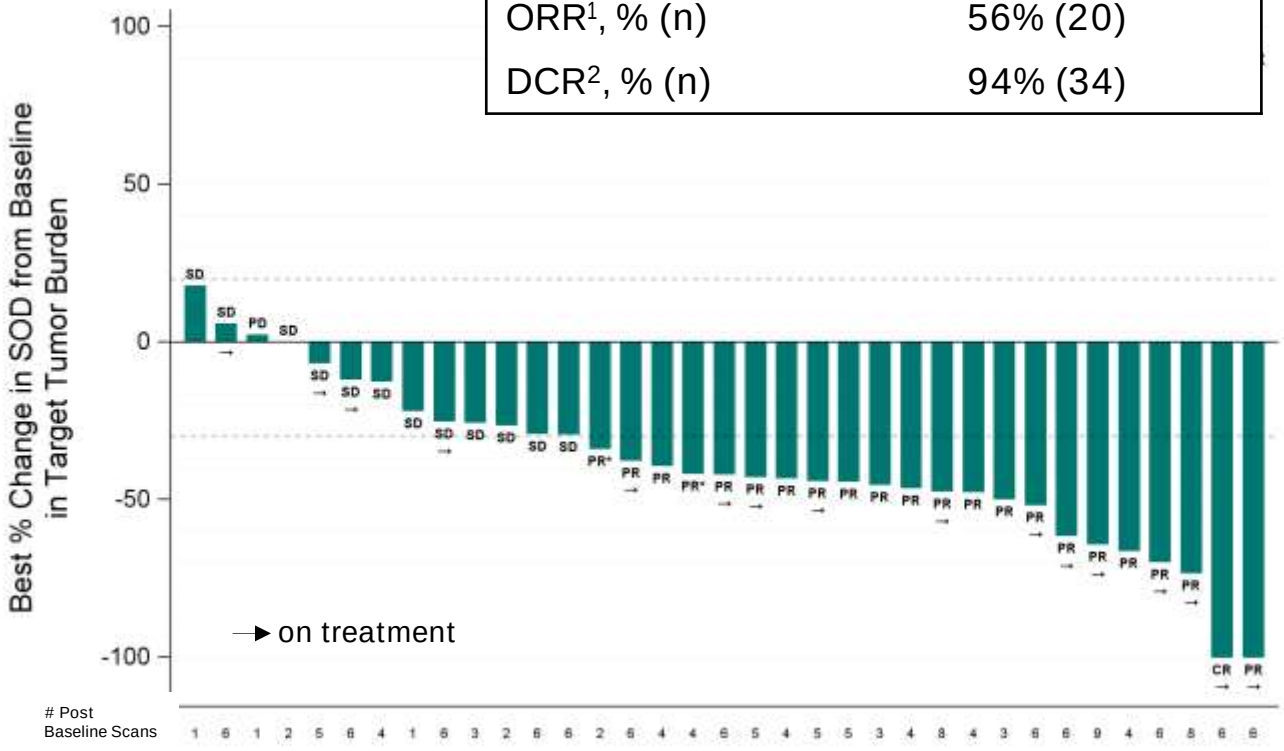


Data cutoff: 11 May 2026. Median follow-up, months (range): 8.7 (5.1, 14.8).

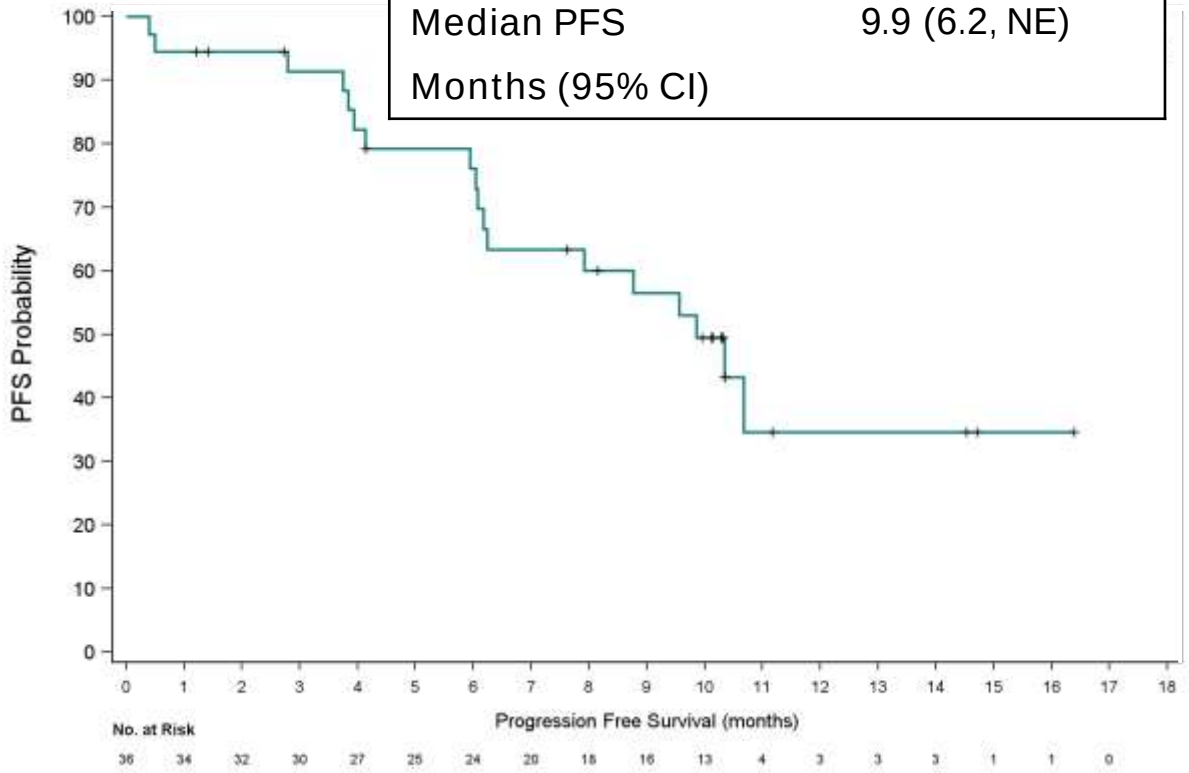
[a] All treated 1L NSCLC patients received a first dose of elironrasib 200 mg BID in combination with pembrolizumab 200 mg Q3W + pemetrexed + platinum at least 14 weeks prior to data cutoff date. [b] Objective response rate (ORR) (per RECIST v 1.1) includes complete responses (CR), partial responses 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.

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)



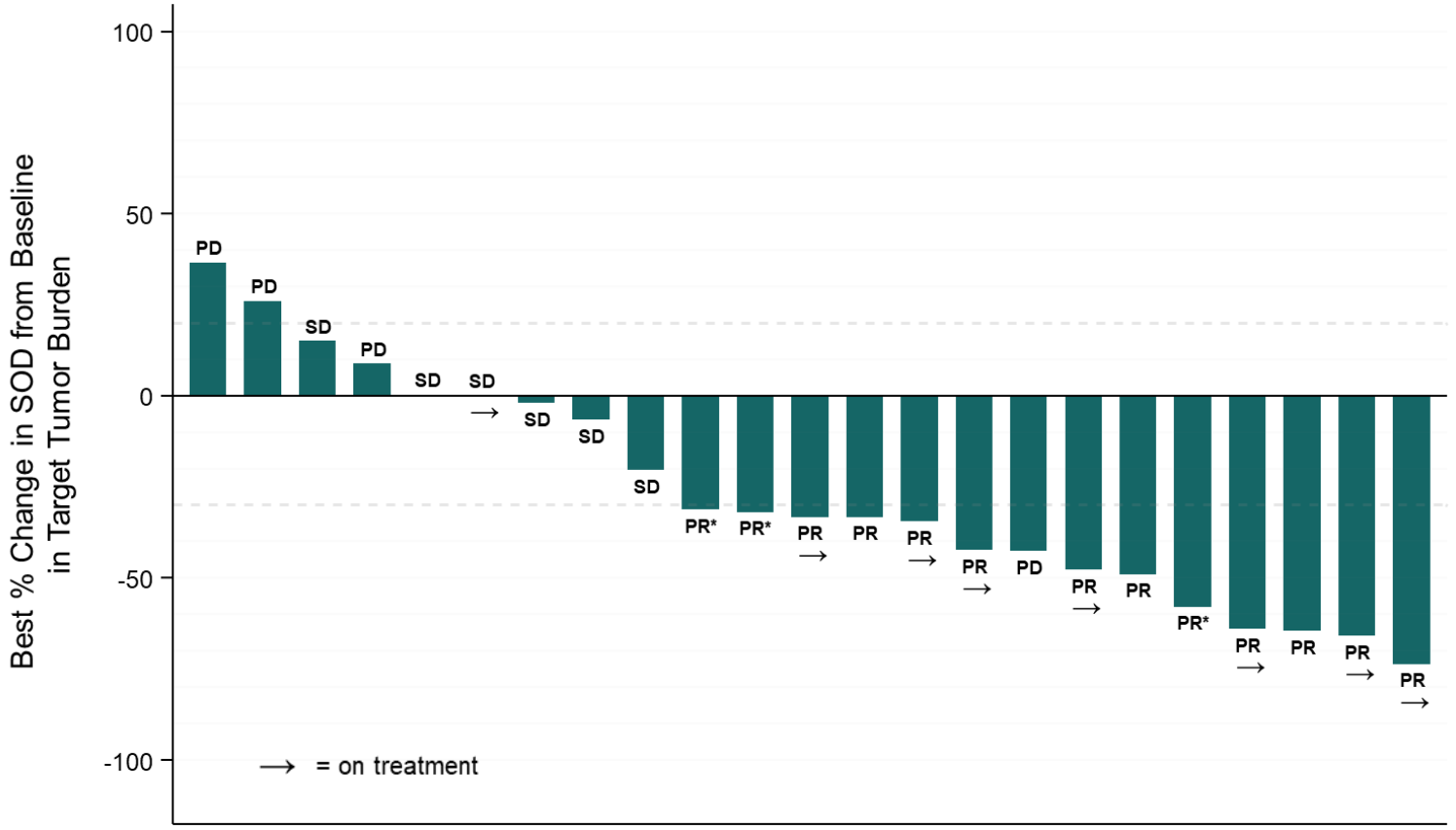
Elironrasib (200 mg BID) (N=36)	
Median PFS Months (95% CI)	9.9 (6.2, NE)



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.

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)

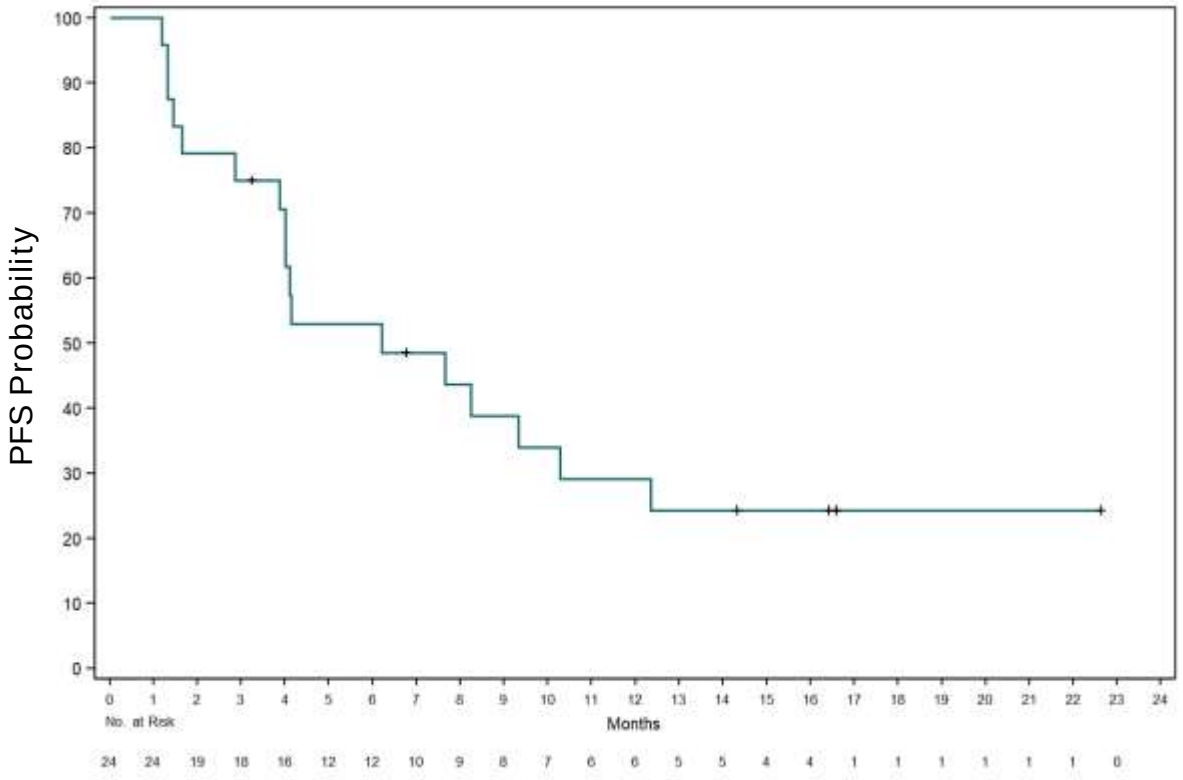
Median follow-up, months (range): 17.6 (10.3, 24.6) and 17.4 (14, 28.5). Median duration of response (95% confidence interval) is 11.2 mo (5.9-NE). (1) Objective response rate (ORR) (per RECIST v 1.1) includes complete (CR) and partial responses (PR) that were confirmed. (2) Disease control rate (DCR)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

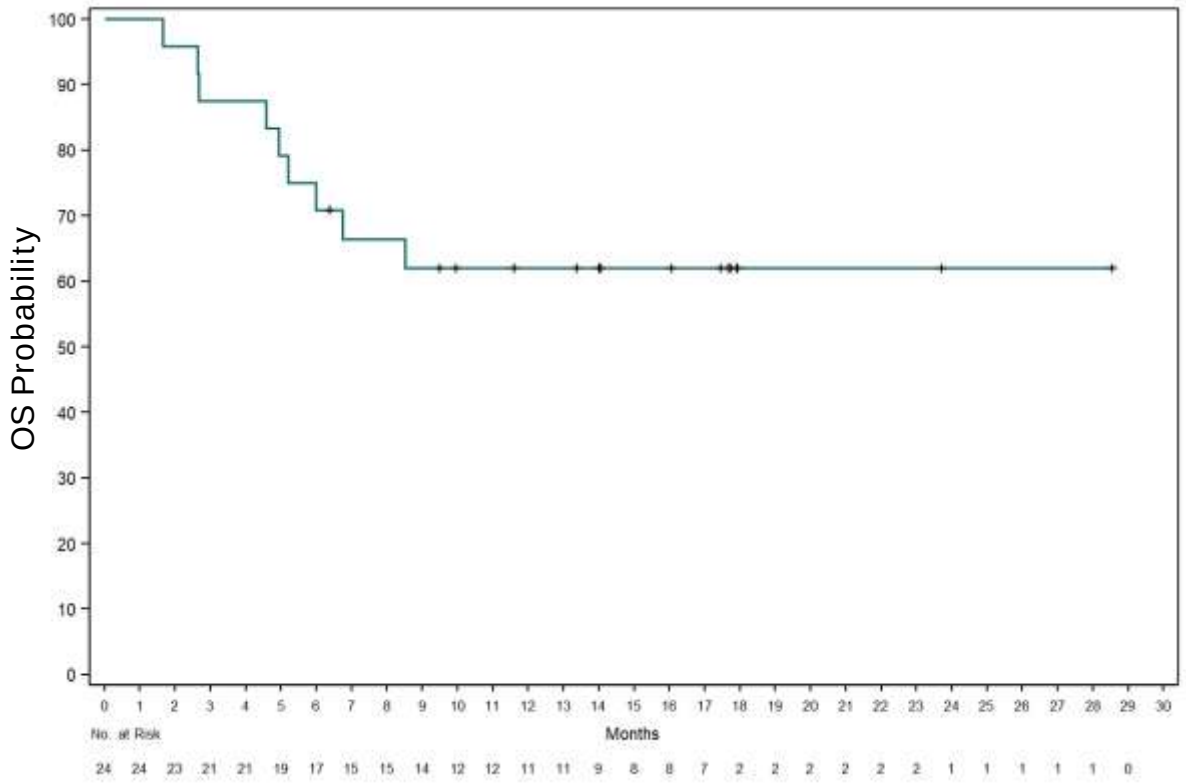
Data Cutoff: August 4, 2025

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

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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.

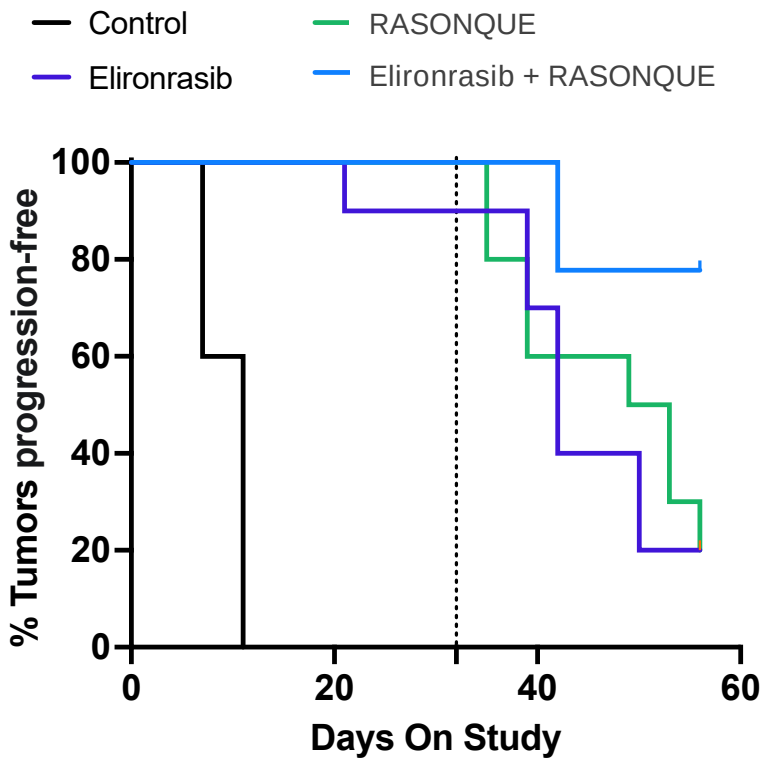
Data cutoff: Apr 7, 2025

Elironrasib + RASONQUE
RAS(ON) Inhibitor Doublet Background

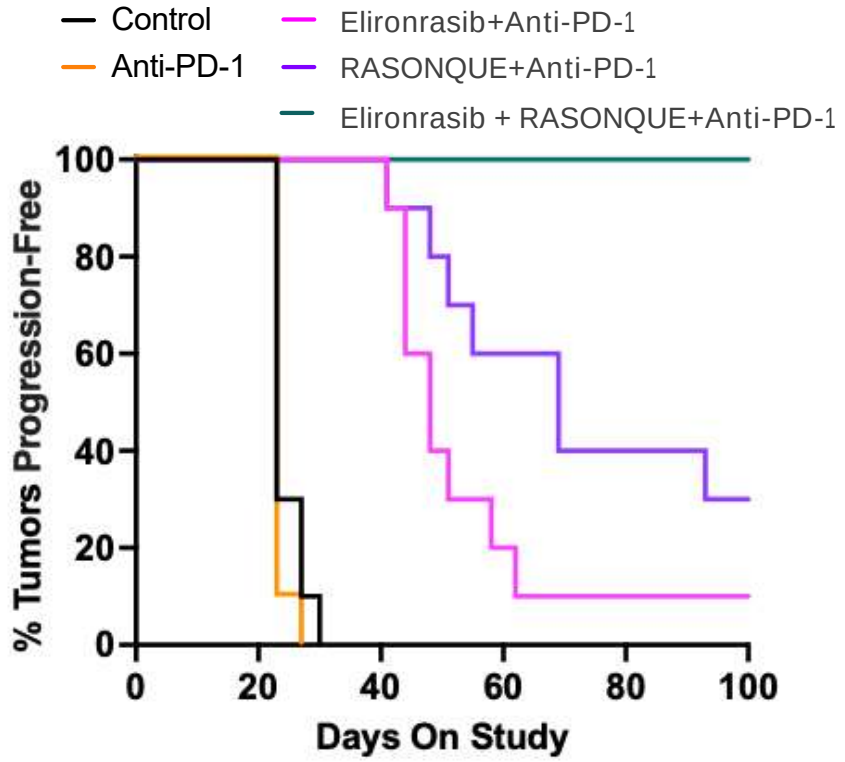
Revolution Medicines

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

Elironrasib and RASONQUE Show Combination Benefit in a NSCLC Model



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

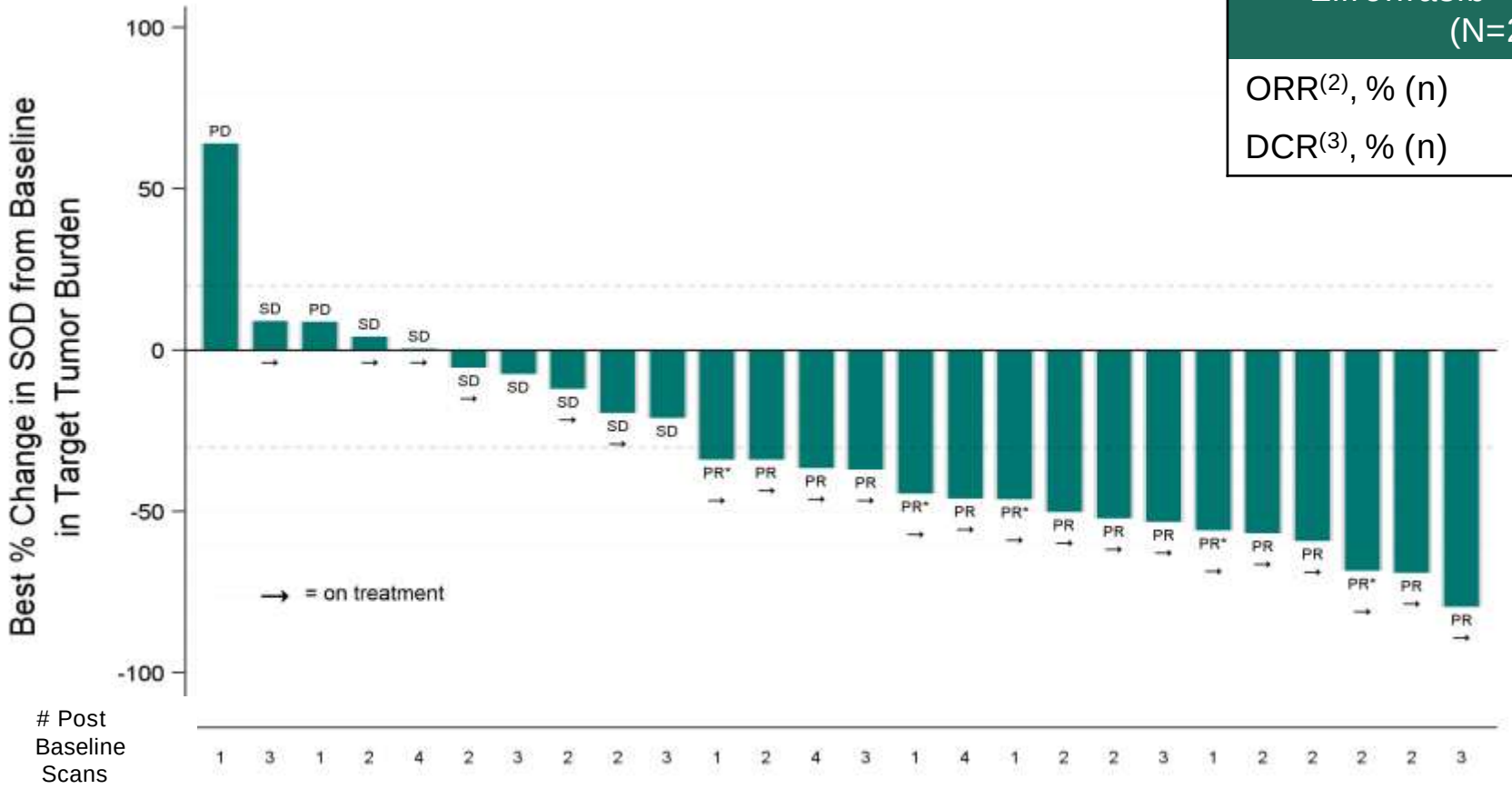


Left Chart: KPAR (NSCLC *KRAS G12C/G12C*), elironrasib (100 mg/kg, PO QD), RASONQUE (25 mg/kg PO QD)). Dashed line represents treatment stop. Days on study represent days on treatment.
Right Chart: e3LL (T cell excluded NSCLC, *KRAS G12C/G12C, NRAS*^{KO}), elironrasib (30 mg/kg, PO QD), RASONQUE (25 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 + RASONQUE: Doublet Shows Encouraging Antitumor Activity in Patients with 2L+ NSCLC Previously Treated with KRAS(OFF) G12C Inhibitor

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



The combination arm includes patients treated at elironrasib 200 mg BID + RASONQUE (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 + RASONQUE: Generally Well Tolerated in 2L+ NSCLC Patients Previously Treated with G12C(OFF) Inhibitor

	Elironrasib 200 mg BID + RASONQUE 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 RASONQUE	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 RASONQUE in RAS Mutant CRC or Elironrasib in CRC Previously Treated with KRAS G12C(OFF) Inhibitor

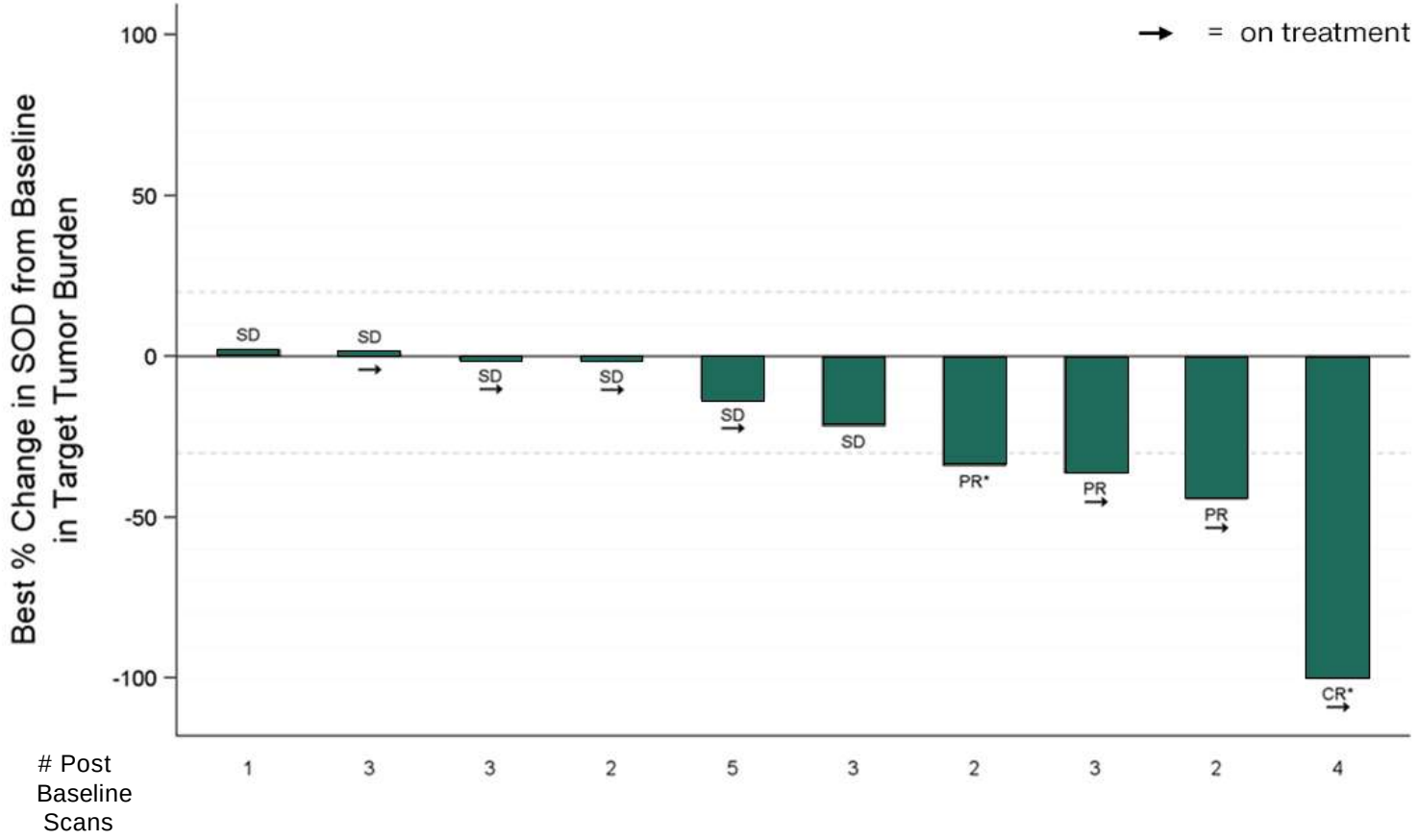
RAS Inhibitor	Population	ORR n/N (%)
RASONQUE in RAS Mutant CRC[1,3] 300 mg QD	RAS inhibitor naive	2/22 (9%)
Elironrasib in KRAS G12C Mutant CRC[2] 200 mg BID	Previously treated with a G12C(OFF) Inhibitor	0/6

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(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 RASONQUE 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
RASONQUE data cutoff: Sep 30, 2024

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



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

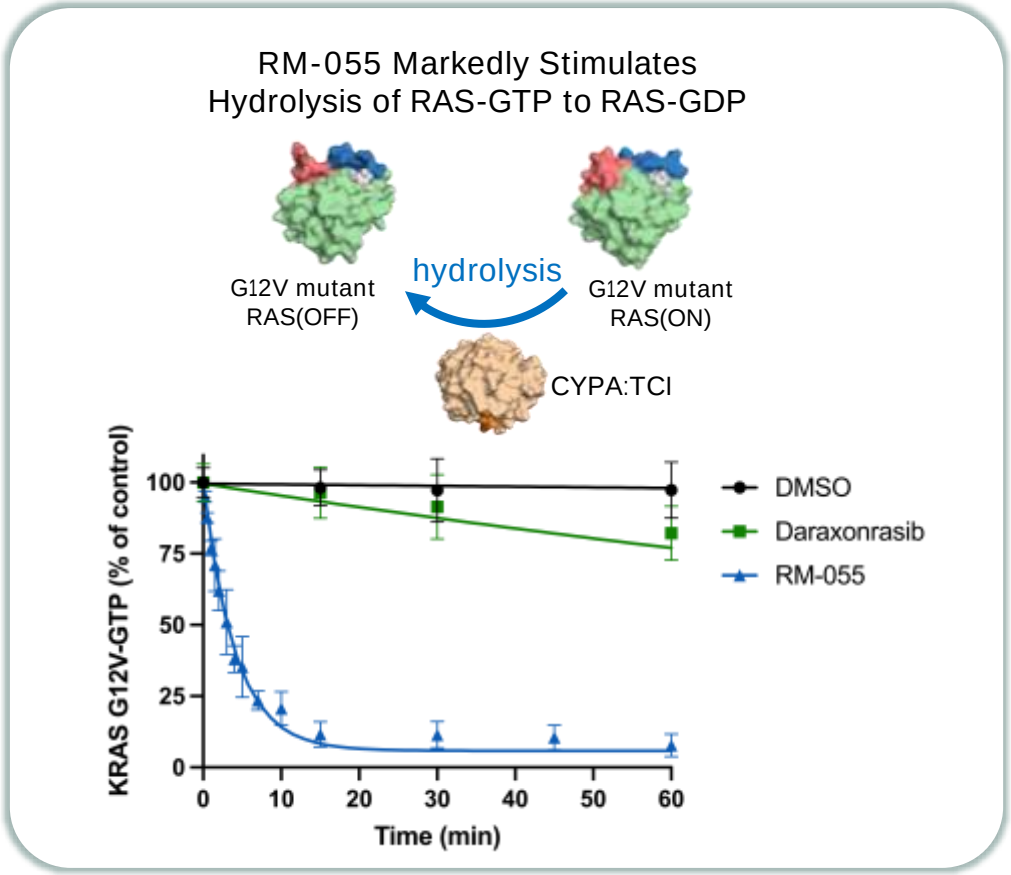
Analyses include all patients who received first dose of study drug(s) at least 8 weeks prior to data cutoff date (to allow 1 potential scan). (1) The combination arm includes patients treated at elironrasib 100 or 200 mg BID + RASONQUE (100-200 mg QD). (2) Objective response rate (ORR) (per RECIST v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

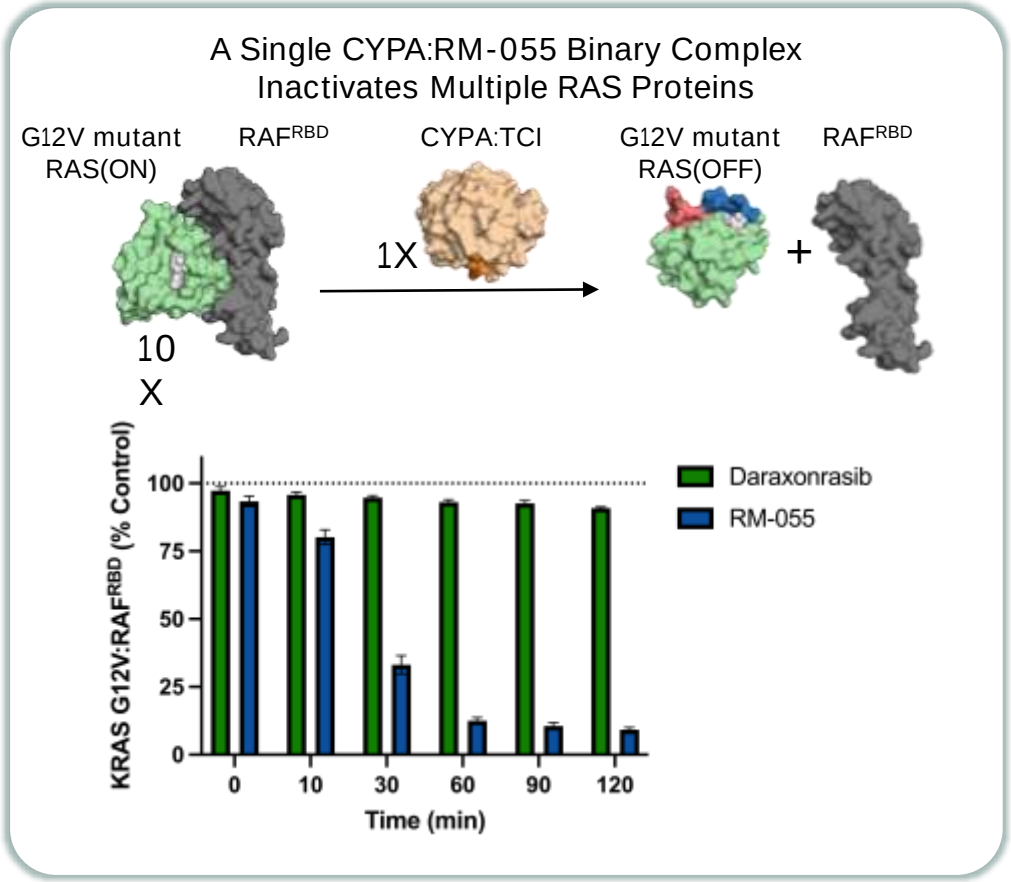
RM-055 Preclinical Data

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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

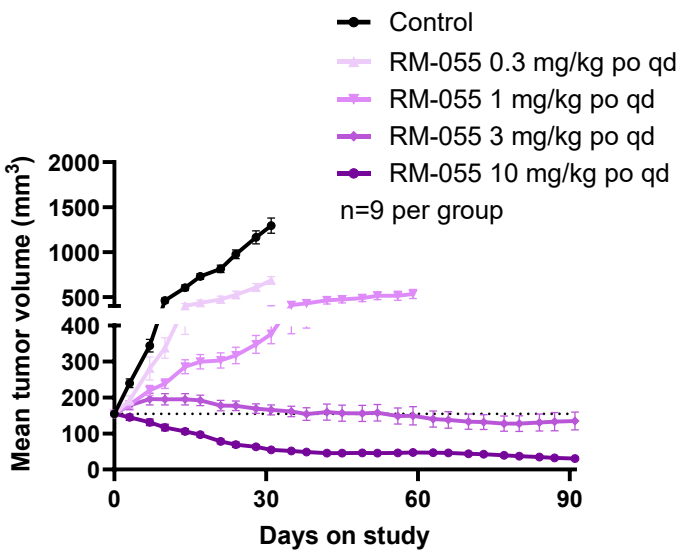


$KRAS^{G12V}$:RAF^{RBD} in ten-fold excess relative to CYPA:TCI binary complex

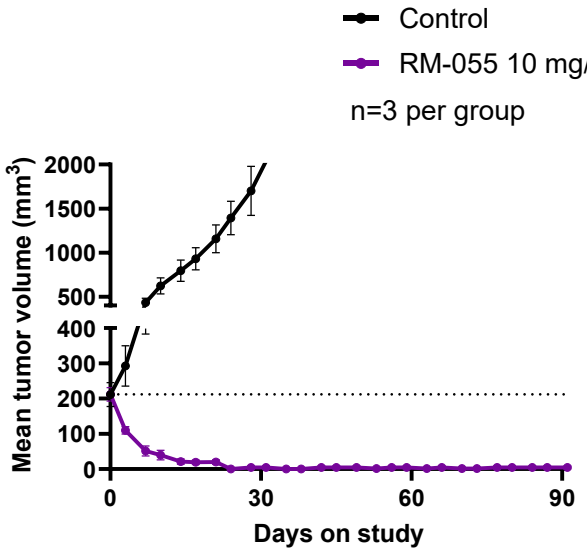
CYPA, cyclophilin A.

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

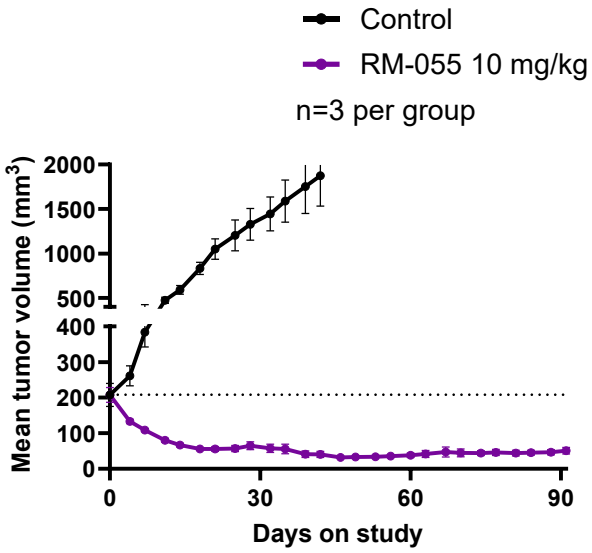
PDAC (KRAS G12D)[1]



NSCLC (KRAS G12C)[2]



CRC (KRAS G12V)[3]



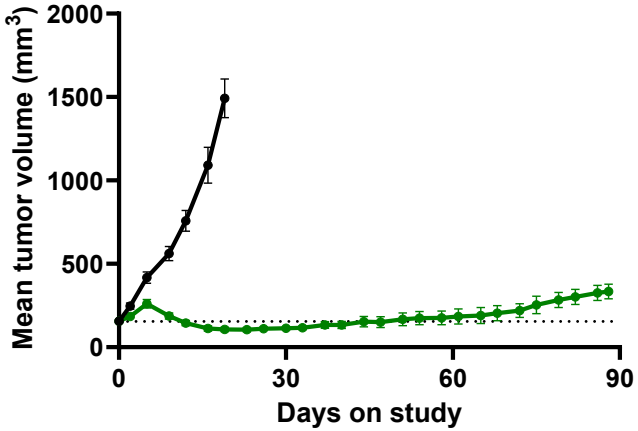
Models: [1]AsPC-1 (PDAC, KRAS$^{G12D/G12D}$); [2]LUN055 (NSCLC, KRAS$^{G12C\ Amp/WT}$); [3]CRC060 (CRC, KRAS^{G12V}).
All RM-055 treatment regimens were tolerated during treatment course based on body weight assessment.
PDAC, pancreatic adenocarcinoma; NSCLC, non-small cell lung cancer; CRC, colorectal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

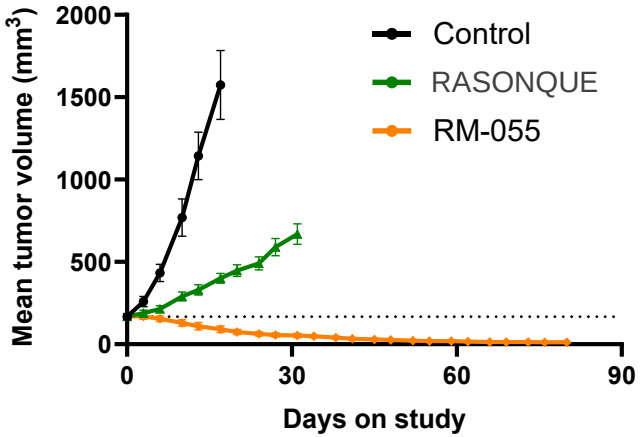
Innovative New Class of RAS(ON) Inhibitors Designed to Overcome RAS-Driven Drug Resistance and Extend Clinical Benefit

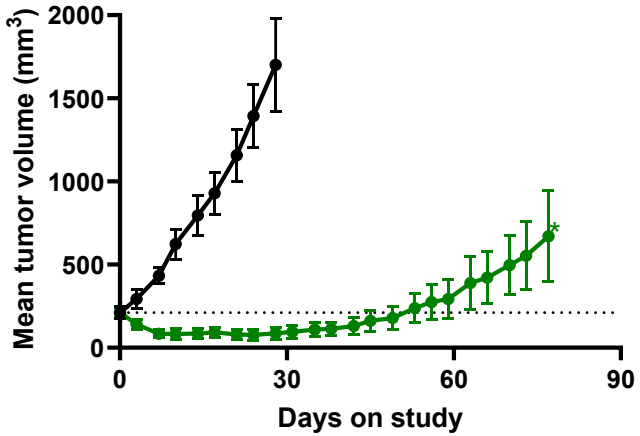
Standard Models → Resistant Models[3]

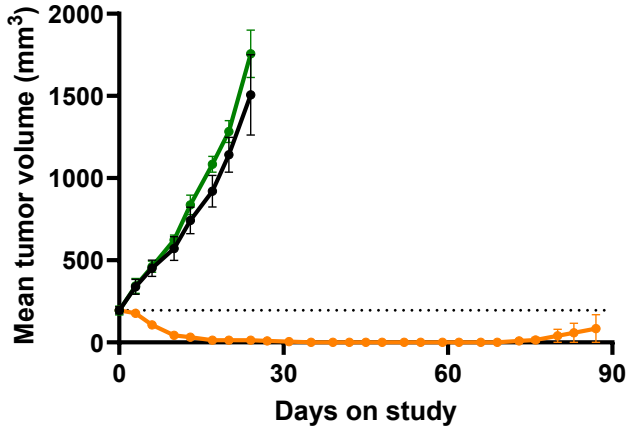
PDAC (KRAS G12D)[1]

NSCLC (KRAS G12C)[2]

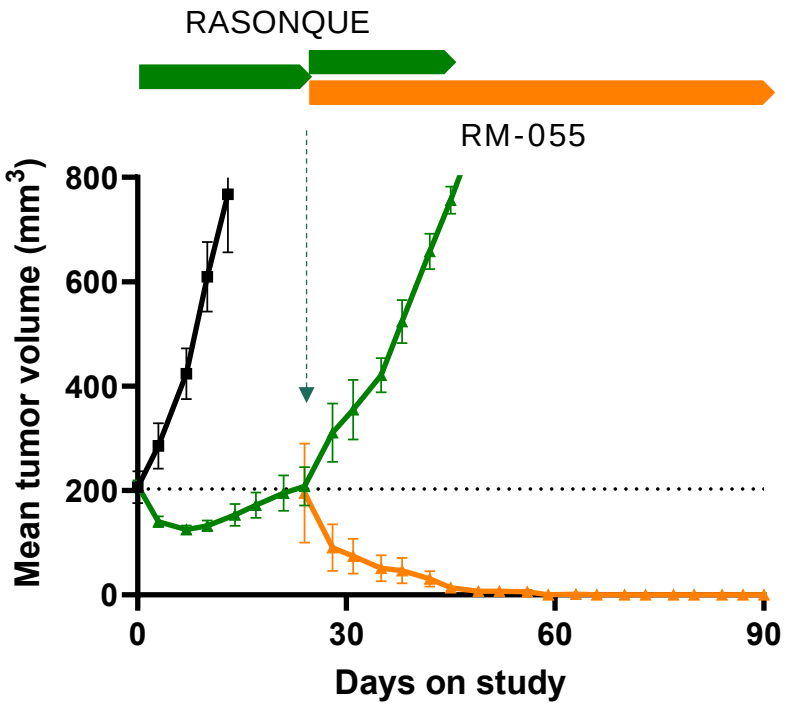








Post-Progression Treatment (NSCLC, KRAS G12C)[2]



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 RASONQUE inhibition is a function of reactivation of downstream RAS signaling. LUN055 (NSCLC, KRAS$^{G12C\ Amp/WT}$) with acquired resistance to RASONQUE n=3 per group. Resistance to RASONQUE inhibition is a function of increase in KRAS G12C copy number. RASONQUE 25 mg/kg po qd; RM-055 10 mg/kg po qd. PDAC, pancreatic adenocarcinoma; NSCLC, non-small cell lung cancer.

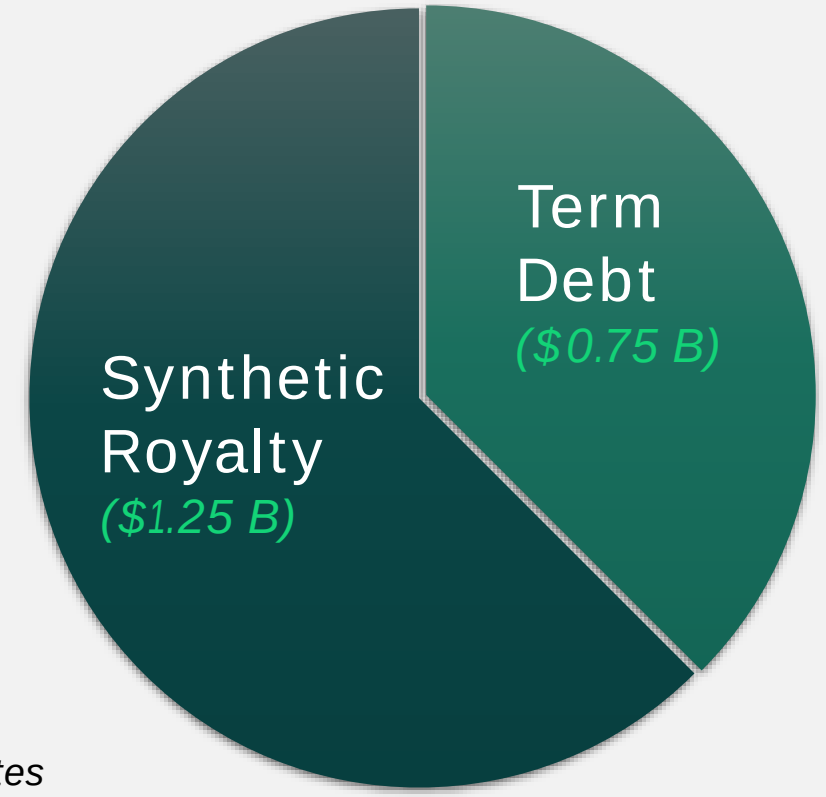
Royalty Pharma Partnership

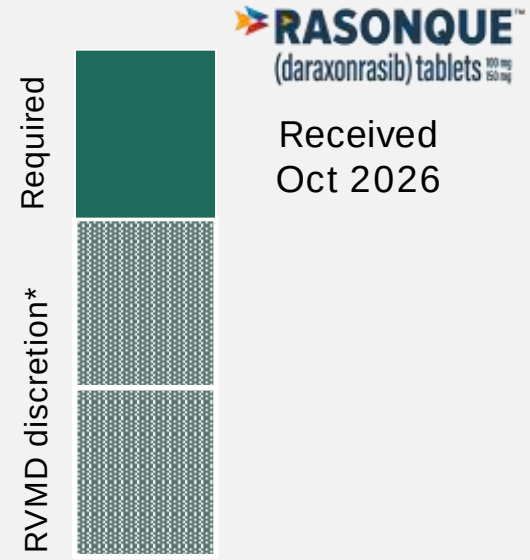
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Royalty Pharma Partnership Bolsters Strong Financial Position

Initial $2 Billion Commitment







5 Tranches

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

3 Tranches

Market-competitive interest rate linked to SOFR

* Future remaining tranches of $1.0 billion 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