MindMed

Corporate Presentation

November 2024

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There are numerous risks and uncertainties that could cause actual results, plans and objectives to differ materially from those expressed in forward-looking statements, including history of negative cash flows, limited operating history, incurrence of future losses, availability of additional capital, compliance with laws and regulations, difficulty associated with research and development, risks associated with clinical trials or studies, heightened regulatory scrutiny, early stage product development, clinical trial risks, regulatory approval processes, novelty of the psychedelic inspired medicines industry, as well as those risk factors described in the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2023 under headings such as “Special Note Regarding Forward-Looking Statements,” and “Risk Factors” and “Management's Discussion and Analysis of Financial Condition and Results of Operations” and other filings and furnishings made by the Company with the securities regulatory authorities in all provinces and territories of Canada which are available under the Company's profile on SEDAR+ at www.sedarplus.ca and with the U.S. Securities and Exchange Commission on EDGAR at www.sec.gov.

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Cautionary Note Regarding Regulatory Matters

The United States federal government regulates drugs through the Controlled Substances Act. MM120 is a proprietary, pharmaceutically optimized form of lysergide D-tartrate and MM402, or R(-)-MDMA, is our proprietary form of the R-enantiomer of MDMA (3,4-methylenedioxymethamphetamine). Lysergide and MDMA are Schedule I substances under the Controlled Substances Act. While the Company is focused on programs using psychedelic or hallucinogenic compounds and non-hallucinogenic derivatives of these compounds, including in its MM120, MM402 and other product candidates, the Company does not have any direct or indirect involvement with the illegal selling, production or distribution of any substances in the jurisdictions in which it operates. The Company is a neuro-pharmaceutical drug development company and does not deal with psychedelic or hallucinogenic substances except within laboratory and clinical trial settings conducted within approved regulatory frameworks. The Company's products will not be commercialized prior to applicable regulatory approval, which will only be granted if clinical evidence of safety and efficacy for the intended uses is successfully developed.

Market and Industry Data

This Presentation includes market and industry data that has been obtained from third party sources, including industry publications. MindMed believes that the industry data is accurate and that the estimates and assumptions are reasonable, but there is no assurance as to the accuracy or completeness of this data. Third party sources generally state that the information contained therein has been obtained from sources believed to be reliable, but there is no assurance as to the accuracy or completeness of included information. Although the data is believed to be reliable, MindMed has not independently verified any of the data from third party sources referred to in this Presentation or ascertained the underlying economic assumptions relied upon by such sources. References in this Presentation to research reports or to articles and publications should be not construed as depicting the complete findings of the entire referenced report or article. MindMed does not make any representation as to the accuracy of such information.

We Aim To Be A Global Leader In Brain Health

MindMed

Pipeline
Diversified pipeline of clinical programs targeting significant unmet medical needs

Management
Expertise in drug development and commercialization

Research
Leveraging decades of preclinical and clinical research with promising results in Phase 2b

Expected Runway
Expected cash runway through key clinical readouts and into 2027[1]

Market Protection Strategies
IP and R&D strategies intended to maximize market exclusivity and protection

1. The company's cash and cash equivalents of $295.3 million as of September 30, 2024, expected to fund operations into 2027 based on our current operating plan.

Experienced Leadership with a Proven Track Record

Robert Barrow
Chief Executive Officer and Board Director

Dan Karlin, MD, MA
Chief Medical Officer

Miri Halperin Wernli, PhD
Executive President

Stephanie Fagan, MS
Chief Corporate Affairs Officer

Carrie Liao, CPA
Chief Accounting Officer

Francois Lilienthal, MD, MBA
Chief Commercial Officer

Gregg Pratt, PhD
Chief Regulatory and Quality Assurance Officer

Mark Sullivan, JD
Chief Legal Officer and Corporate Secretary

Strong Experience in Brain Health Innovation[1]

Latuda® (lurasidone HCl) tablets

Trintellix® vortioxetine 5mg·10mg·20mg tablets

PERSERIS® (risperidone) for extended-release injectable suspension 90 mg · 120 mg

Fintepla® (fenfluramine) 2.2 mg/mL oral solution

Stalevo® (carbidopa, levodopa and entacapone) tablets

Lamictal® lamotrigine tablets

Rozerem® ramelteon 8-mg tablets

Selincro® nalmefene

Suboxone® Sublingual Film (buprenorphine and naloxone) C-III 2 mg/0.5 mg • 4 mg/1 mg • 8 mg/2 mg • 12 mg/3 mg

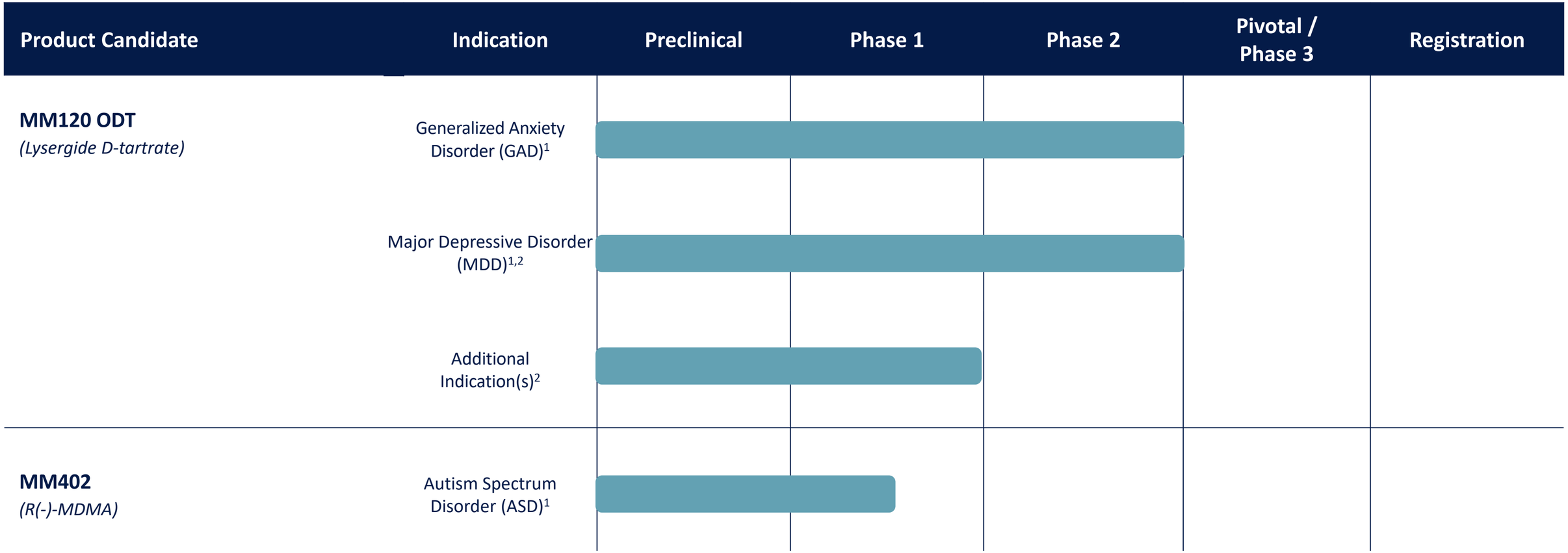
Sublocade® (buprenorphine extended-release) injection for subcutaneous use C-III 100mg·300mg

COBENFY™ (xanomeline and trospium chloride) capsules 50mg/20mg, 100mg/20mg, 125mg/30mg

Bristol Myers Squibb™ · Johnson & Johnson · Shire · Wyeth · Roche · KARUNA THERAPEUTICS

ACADIA · AstraZeneca · NOVARTIS · MERCK · Pfizer · Lundbeck

MindMed Research & Development Pipeline



1. Full trial details and clinicaltrials.gov links available at mindmed.co/clinical-digital-trials/
2. Studies in exploration and/or planning stage.

LSD: lysergide; R(-)-MDMA: rectus-3,4-methylenedioxymethamphetamine

Next Steps and Anticipated Milestones for R&D Pipeline

2H2024	1H2025	2H2025	1H2026	2H2026
Voyage MM120-300 for GAD Phase 3 initiation			**Voyage** MM120-300 for GAD Phase 3 Readout	
	Panorama MM120-301 for GAD Phase 3 initiation			**Panorama** MM120-301 for GAD Phase 3 Readout
	Emerge MM120-310 for MDD Phase 3 Initiation			**Emerge** MM120-310 for MDD Phase 3 Readout

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MM120 ODT

Lysergide D-tartrate

Program Overview

Key Highlights of MM120 Program

Positive 12-Week Durability in Phase 2b Trial of GAD[1]

- Primary and secondary endpoints met with statistical significance
- 7.7-point improvement over placebo (*d*=0.81; p=0.003)
- 48% clinical remission rate at Week 12

Breakthrough Therapy Designation for GAD[2]

- Recognizes preliminary evidence of substantial improvement over SOC
- FDA organizational commitment and efficient development support

Enhanced Product Profile of MM120 ODTs

- Results from PK bridging study demonstrate differentiated profile
- Rapid absorption, better bioavailability & greater therapeutic AUC

Market Protection Strategies and IP Portfolio

- IP-driven R&D strategies to maximize market protection potential
- Advancing IP portfolio with recent and near-term potential grants

1. Source: Study MMED008 internal study documents and calculations.
2. Source: https://www.fda.gov/patients/fast-track-breakthrough-therapy-accelerated-approval-priority-review/breakthrough-therapy

AUC: area under the curve; ODT: orally disintegrating tablet; PK: pharmacokinetic; SOC: standard of care

MM120: Potential to Address Large Unmet Needs in Major Brain Health Disorders

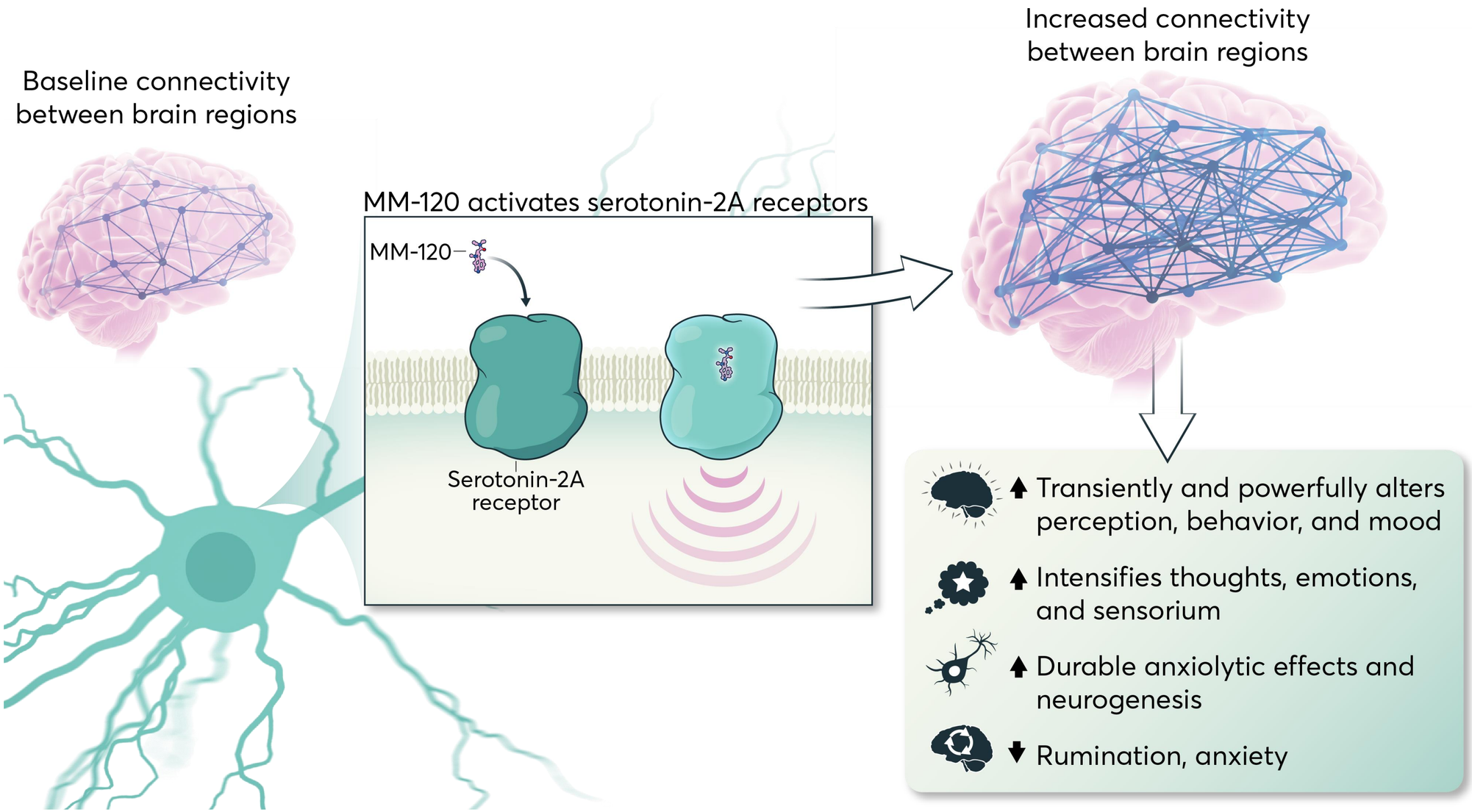
Potential Best-in-Class Therapy with Novel MOA

	Generalized Anxiety Disorder (GAD)	Major Depressive Disorder (MDD)
Preliminary Clinical Evidence	**Effect size (d=0.8)** more than double SOC[1] **48% remission** 12 weeks after single dose[1]	**Rapid (1 day) & durable (12-week, 18.7 point) effect** on depression in GAD[1] trial **An extensive body of historical evidence**
Large Market Opportunities	**20 million US adults** with GAD[2] **13 million** treated for GAD each year[2]	**31 million US adults** with MDD[2] **18 million** treated for MDD each year[2]
Significant Need for New Treatments	**SRIs[3]:** 50% failure rate with frequent undesirable AEs **Benzodiazepines:** dependence & tolerance; appropriate for short-term use	**SRIs[4]:** 31% resistant to 1st and 2nd line treatments **3rd line treatments:** intensive, time-consuming and poor tolerability

1. Based on results from Phase 2b Study MMED008. Comparisons to standard of care / other drug classes based on historical comparison not head-to-head comparison trial.
2. Mental and Substance Use Disorders Prevalence Study (MDPSU): Findings Report 2023.
3. Garakani A, et al., (2020) Pharmacotherapy of Anxiety Disorders: Current and Emerging Treatment Options. Front. Psychiatry 11:595584. doi: 10.3389/fpsyt.2020.595584
4. Zhdanava M, Pilon D, Ghelerter I, et al. The Prevalence and National Burden of Treatment-Resistant Depression and Major Depressive Disorder in the United States. J Clin Psychiatry. 2021;82(2):20m13699. Published 2021 Mar 16.

GAD: generalized anxiety disorder; MDD: major depressive disorder; MDE: major depressive episode; MOA: mechanism of action; US: United States

Clinical Rationale and Mechanism of Action



MM120 ODT Program Overview

Aligned clinical trial designs across indications maximize operational efficiencies

Generalized Anxiety Disorder (GAD)

Voyage

MM120-300

N=200[1,2]
(1:1 randomization)

MM120 ODT vs. Placebo

- **Part A:** 12-week DB, RCT
- **Part B:** 40-week Extension with OL Treatment

Initiation: 2H2024[3]

Panorama

MM120-301

N=240[1,2]
(5:2:5 randomization)

MM120 ODT vs. Placebo (including 50 µg control)

- **Part A:** 12-week DB, RCT
- **Part B:** 40-week Extension with OL Treatment

Initiation: 1H2025[3]

Major Depressive Disorder (MDD)

Emerge

MM120-310

N=140[2]
(1:1 randomization)

MM120 ODT vs. Placebo

- **Part A:** 12-week DB, RCT
- **Part B:** 40-week Extension with OL Treatment

Initiation: 1H2025[3]

Name TBA

MM120-311

Design TBA

1. Studies will employ an adaptive design with interim blinded sample size re-estimation based on nuisance parameters (e.g. patient retention rate, variability of primary outcome measure) which allows for an increase of sample size up to 50% to maintain statistical power.
2. Clinical study designs subject to ongoing regulatory discussion and review, including of Phase 3 clinical trial protocols.
3. Expected first patient dosing

DB: double blind; ODT: orally disintegrating tablet; OL: open-label; RCT: randomized controlled trial

Strategies to Address Key Drug Class Methodological Considerations

Expectancy Bias & Functional Unblinding

- Blinded centralized raters for primary outcome measure
- Dose-response in Phase 2 across ‘functionally active’ doses
- Complementary studies with multiple ‘functionally masking’ arms
- Pre- and post-dose expectancy questionnaire (participants)
- Post-dose blinding questionnaire (participants and raters)
- Drug effect isolated from psychotherapeutic intervention

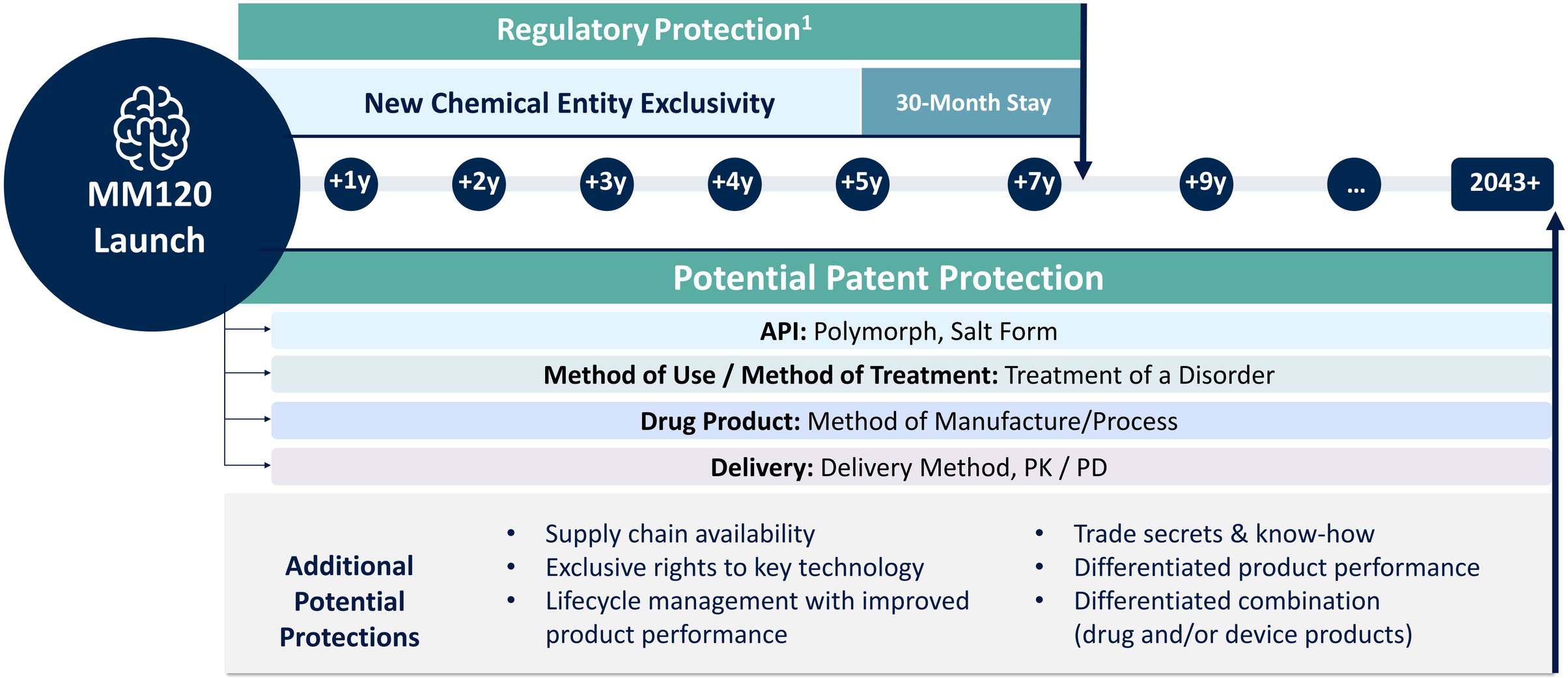
Cardiovascular Safety

- Collection of ECGs in Phase 3 Clinical Trials
- Dedicated TQT study in parallel with Phase 3

Adverse Event Collection

- Collection of all AEs, including “positive” and MOA-related
- Frequent assessment to define time course for resolution of drug effects

MM120 | Multiple Layers of Intellectual Property and Protection



1. Section 505 of the Federal Food, Drug and Cosmetic Act, 21 U.S.C. § 355.
PK: pharmacokinetic; PD: pharmacodynamic

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MM120 ODT
Lysergide D-tartrate

Phase 3 Program in GAD

MM120 for GAD | Phase 3 Program Overview

Phase 3 Program

Two Phase 3 pivotal clinical trials in GAD[1]

- 12-week randomized, placebo-controlled primary efficacy study design
- 40-week extension phase to characterize safety and define retreatment parameters

Consistent Protocol Design & Conduct

Key design elements largely consistent between Phase 2b and Phase 3 studies

- Hamilton Anxiety Scale (HAM-A) primary outcome measure
  - Primary endpoint: change from baseline to Week 12[2]
- Limited changes to key inclusion/exclusion criteria
  - No planned change in dosing session monitoring protocol
- Duration of treatment session monitoring reduced[3]

Program Alignment

Alignment with FDA on program design reached at EOP2 meeting

- Study designs believed to be consistent with FDA guidance
- Program initiation expected in 2H2024

1. Clinical study designs subject to ongoing regulatory discussion and review, including of Phase 3 clinical trial protocols
2. Primary endpoint in Phase 2b study was change from baseline to Week 4
3. Phase 2b study required 12-hour minimum duration of treatment session monitoring

EOP2: end of Phase 2; GAD: generalized anxiety disorder

Phase 2 Results in GAD Demonstrated 12-Week Durability with Effect Size Over Double the Standard of Care[1,3]

Comparative Effect Sizes in GAD

Key Highlights of Phase 2b 12 Week Results

- Maximum **effect size *d*=0.81 more than double** the standard of care[2,3]
- **Rapid and durable clinical response** after single administration[3]
- Clinical activity with **no psychotherapeutic intervention** beyond study drug

1. Source: Study MMED008 internal study documents and calculations. Comparisons to standard of care/other drug classes based on historical comparison not head-to-head comparison trial.
2. HAM-A scores based on ANCOVA LS Mean. in Study MMED008. Effect size based on post hoc calculation using LS Mean change between group and pooled standard deviation of week 12 HAM-A scores between groups.
3. Based on 100 µg dose group.
4. Source: RB Hidalgo, J Psychopharmacol. 2007 Nov;21(8):864-72.

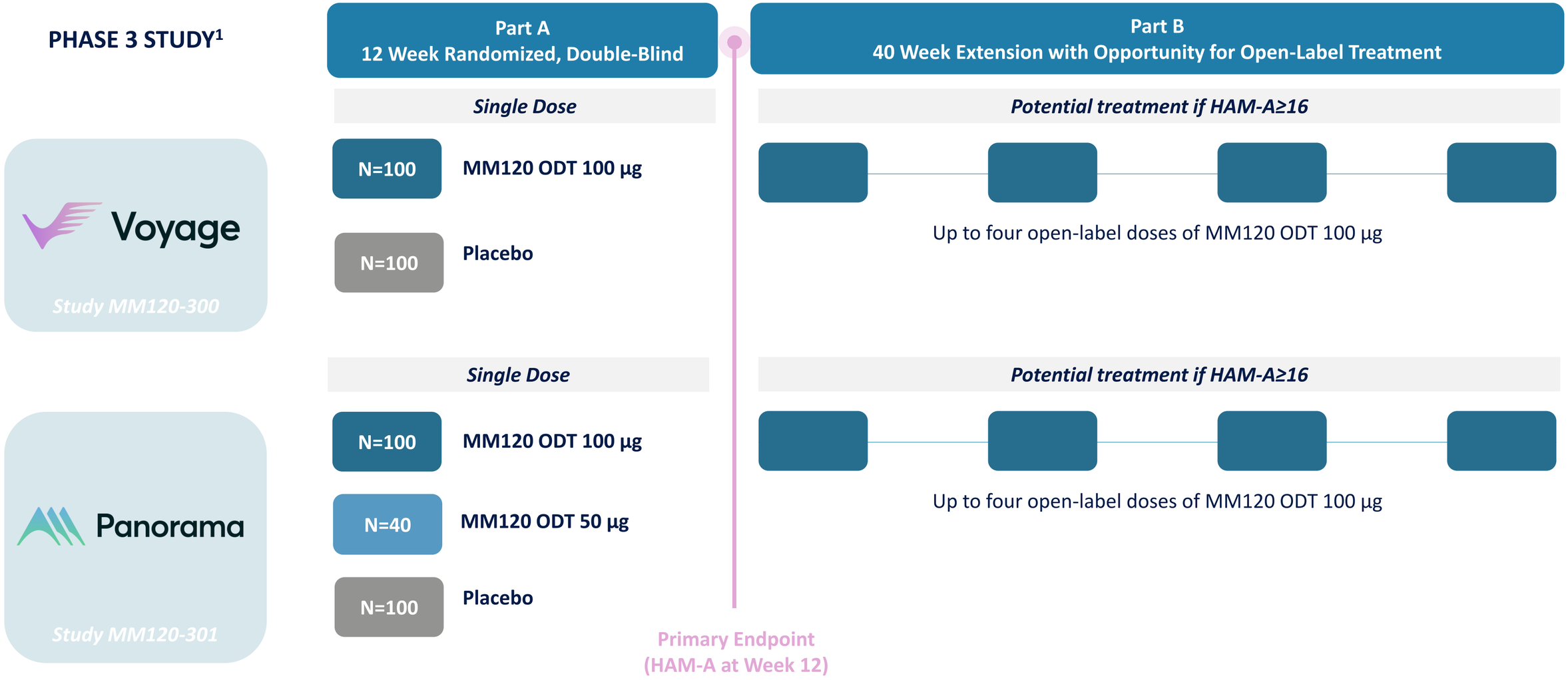
Phase 2 Results in GAD Delivered on Target Product Profile after Single Dose and Support Phase 3 Advancement[1,2]

Fast Acting	1.8-point reduction in CGI-S within 24 hours ($p<0.0001$)
Durable Activity	21.9-point improvement in HAM-A at Week 12 ($p=0.003$) represents further improvement from Week 4
Response / Remission	48% of participants in remission at Week 12[3]
Limited Side Effect Burden	Favorable tolerability profile with most AEs limited to dosing day
Scalability, Access & Value	Results achieved with no additional therapy

1. Source: Study MMED008 internal study documents and calculations. 100 µg dose group.
2. Represents all analyzed secondary endpoints in week 12 topline analysis, including HAM-A, CGI-S and MADRS.
3. p-values not calculated for remission rates between groups.

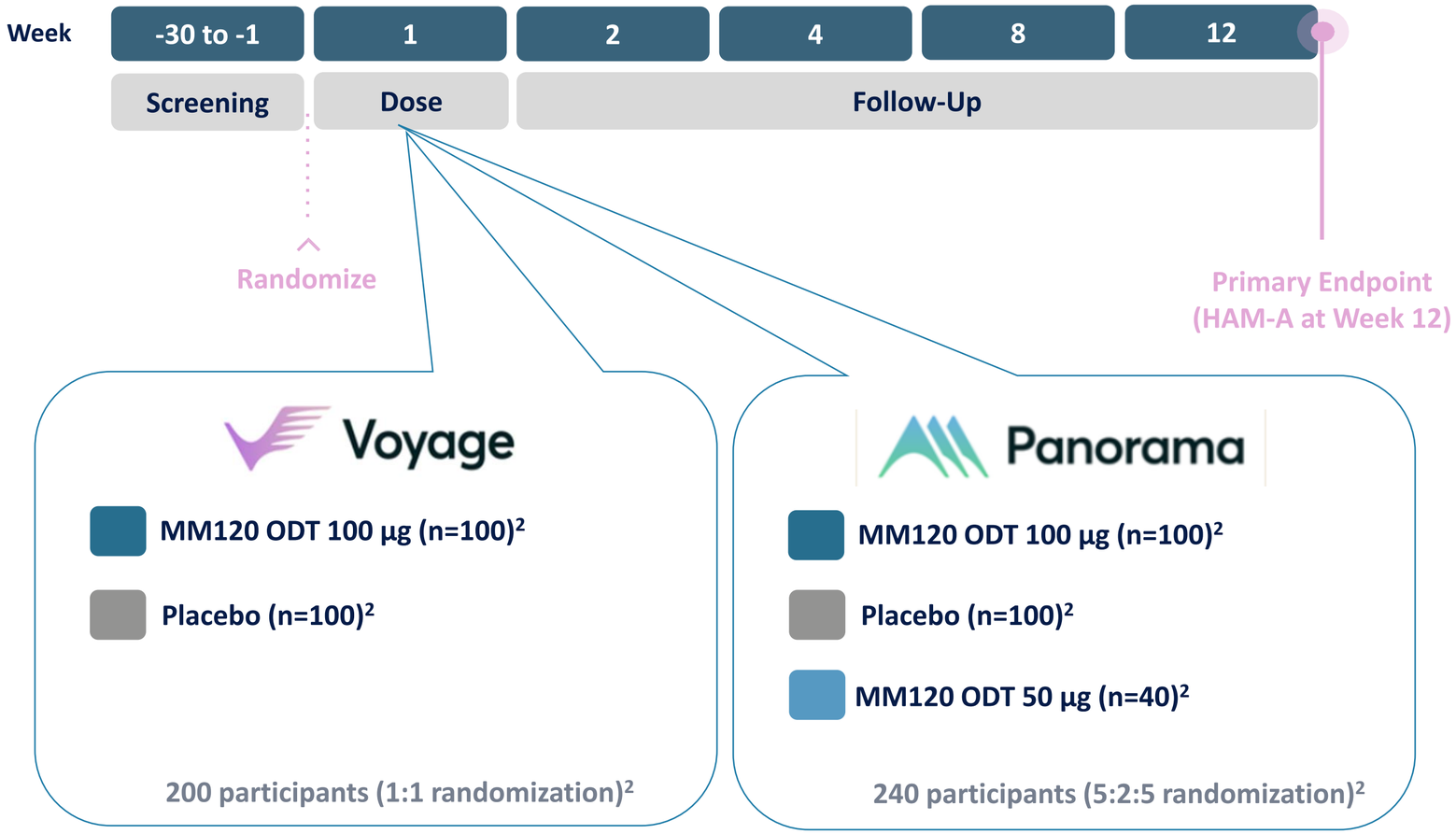
CGI-S: Clinical Global Impressions – Severity; HAM-A: Hamilton Anxiety Scale.

MM120 for GAD | Phase 3 Study Designs



1. Studies will employ an adaptive design with interim blinded sample size re-estimation based on nuisance parameters (e.g. patient retention rate, variability of primary outcome measure) to maintain statistical power. Clinical study designs subject to ongoing regulatory discussion and review, including of Phase 3 clinical trial protocols.

Phase 3 GAD Part A Schematics: Two Pivotal Studies with Complementary Designs[1]



STUDY MM120-300 & MM120-301 | Part A

A Phase 3 Study of a Single Dose of MM120 for Generalized Anxiety Disorder

SELECT ENTRY CRITERIA

- Men and Women
- Ages 18-74
- Diagnosis of GAD
- HAM-A ≥ 20

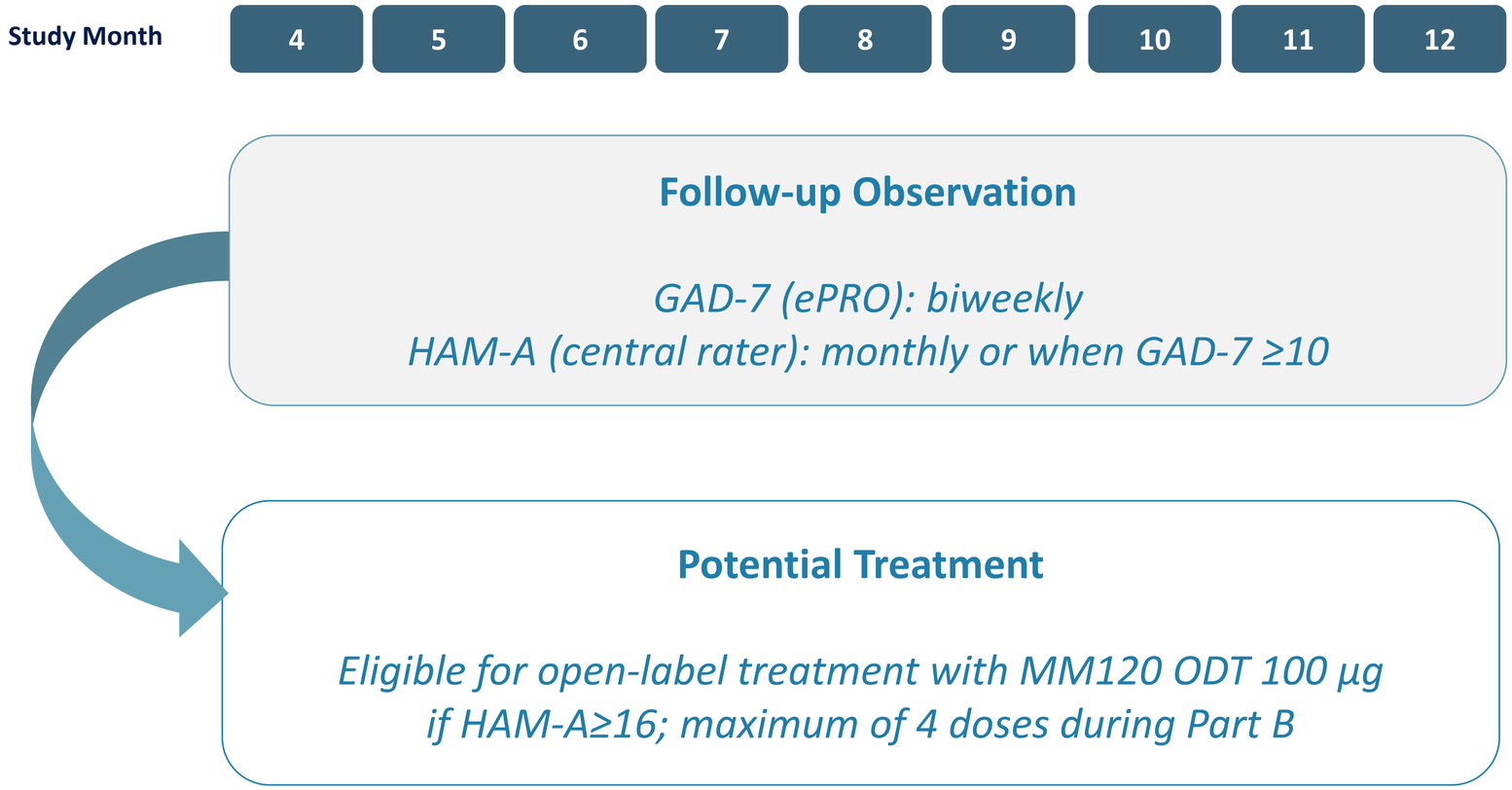
KEY SECONDARY ENDPOINTS

- HAM-A at Week 1
- CGI-S at Day 2
- Time to retreatment / inefficacy

1. Source: Study MM120-300 and Study MM120-301 internal study documents.
2. Study will employ an adaptive design with interim blinded sample size re-estimation based on nuisance parameters (e.g. patient retention rate, variability of primary outcome measure) allowing for up to 50% more subjects in each arm to maintain statistical power. Clinical study designs subject to ongoing regulatory discussion and review, including of Phase 3 clinical trial protocols.

µg: microgram; CGI-S: Clinical Global Impressions - Severity; GAD: generalized anxiety disorder; HAM-A: Hamilton Anxiety Rating Scale; ODT: orally disintegrating tablet

Phase 3 GAD Part B Schematics: Extension Phase



MM120-300 & -301 | Part B

Part B Outcomes:

- Safety of repeated treatment
- Time to retreatment / inefficacy
- Average treatments/year
- Response to retreatment

1. Source: Study MM120-300 and MM120-301 study documents.

µg: microgram; ePRO: electronic patient reported outcome; HAM-A: Hamilton Anxiety Rating Scale

Phase 3 GAD Part A Trials: Primary & Key Secondary Endpoints[1]

Voyage Panorama

Primary

Change in HAM-A from Baseline to Week 12
MM120 ODT 100 µg vs. placebo

Key Secondaries

Change in HAM-A from Baseline to Week 1
MM120 ODT 100 µg vs. placebo

Change in CGI-S from Baseline to Day 2
MM120 ODT 100 µg vs. placebo

Time to Retreatment / Inefficacy
MM120 ODT 100 µg vs. placebo

Phase 2b HAM-A Results at Week 12[2]

-21.9 points from Baseline
-7.7 points vs. placebo (p=0.003)

Phase 3 studies have 90% power to detect a 5.0-point difference vs. placebo[3]

1. Clinical study designs subject to ongoing regulatory discussion and review, including of Phase 3 clinical trial protocols.
2. 100 µg dose group.
3. Based on assumption of n=85 evaluable subjects per arm; standard deviation of 10 and resulting effect size of d=0.5. Studies will employ an adaptive design with interim blinded sample size re-estimation based on nuisance parameters (e.g. patient retention rate, variability of primary outcome measure) allowing for up to 50% more subjects in each arm to maintain statistical power.

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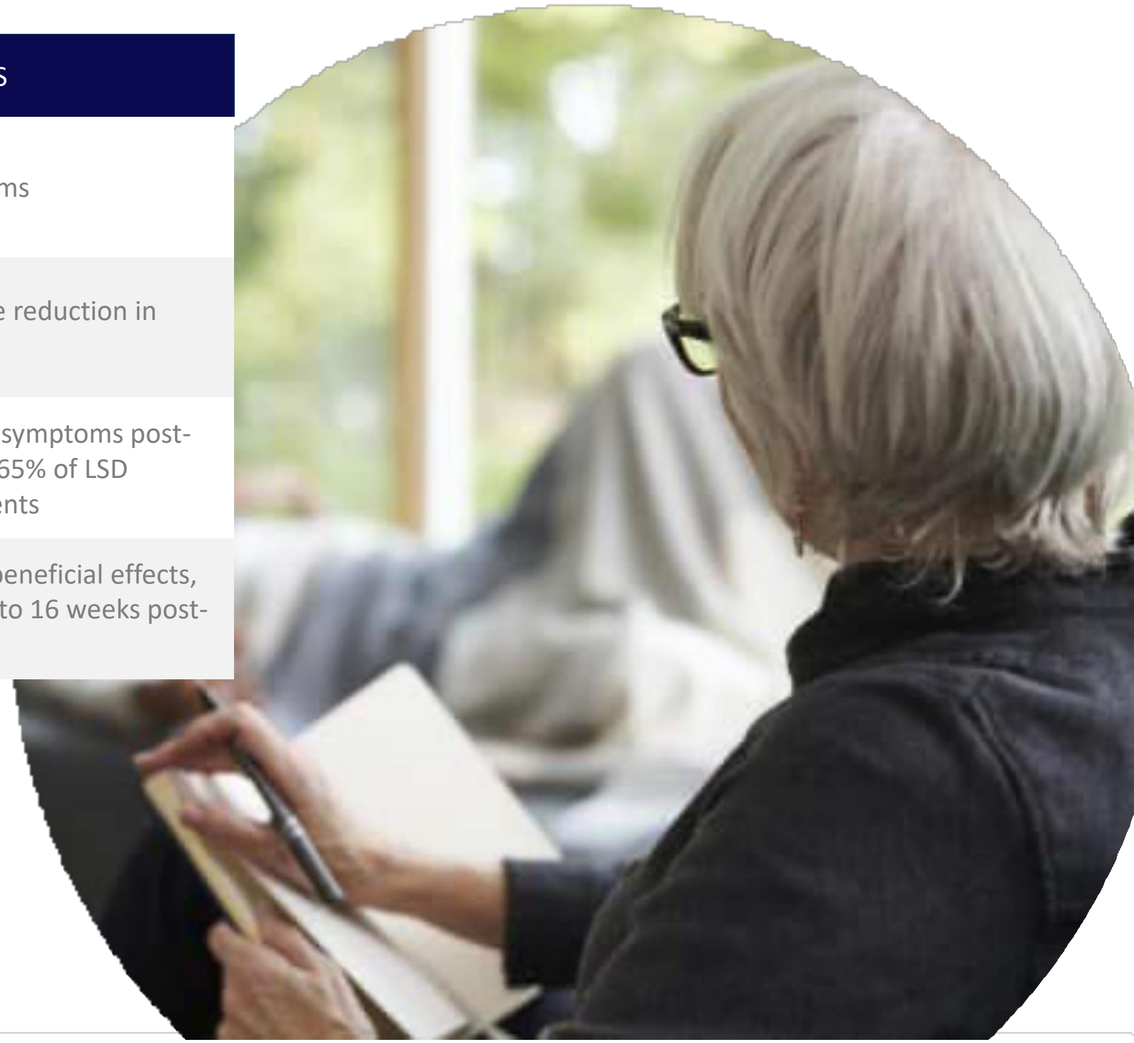
MM120 ODT
Lysergide D-tartrate

Phase 3 Program in MDD

Decades of Clinical Research Supports LSD's Unique Potential

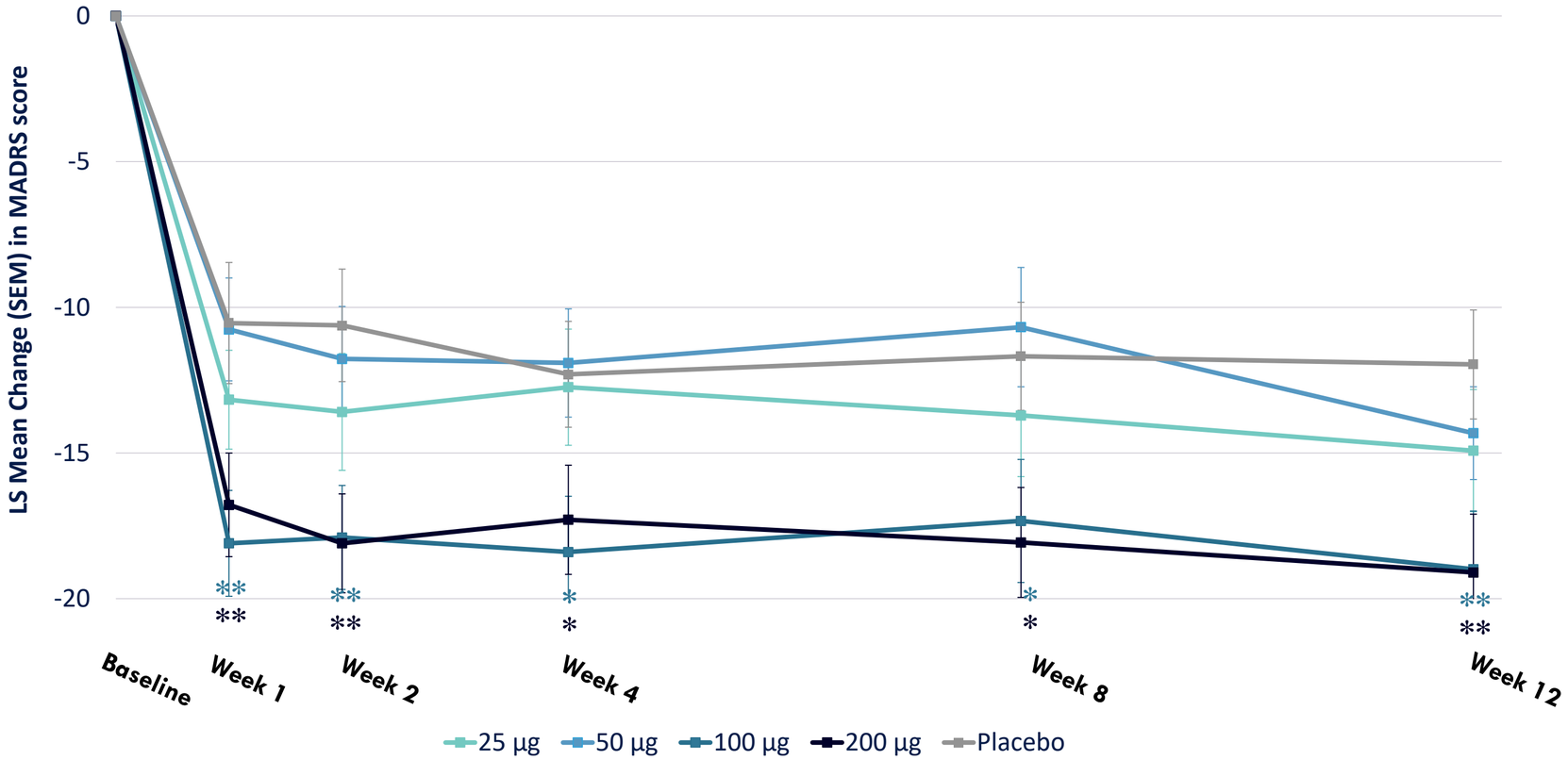
STUDIES	INDICATION(S)	SAMPLE SIZE	KEY FINDINGS
21 STUDIES PRIOR TO 1974	Anxiety, depression & neurotic illnesses	512 patients	Up to 95% reduction in symptoms
GASSER 2014	Anxiety in terminal illness	12 patients	Effect size of d=1.1 with durable reduction in anxiety at 1 year
HOLZE 2023	Anxiety	42 patients	Rapid and durable reduction in symptoms post-treatment. Clinical response in 65% of LSD patients vs. 9% of placebo patients
MULLER 2023	Major Depressive Disorder	61 patients	Significant, rapid, durable and beneficial effects, with benefit maintained for up to 16 weeks post-treatment (p=0.008)



1. Rucker JJ, Jelen LA, Flynn S, Frowde KD, Young AH. Psychedelics in the treatment of unipolar mood disorders: a systematic review. J Psychopharmacol. 2016;30(12):1220-1229.
2. Gasser P, Holstein D, Michel Y, Doblin R, Yazar-Klosinski B, Passie T, Brenneisen R. Safety and efficacy of lysergic acid diethylamide-assisted psychotherapy for anxiety associated with life-threatening diseases. J Nerv Ment Dis. 2014 Jul;202(7):513-20.
3. Holze F, Gasser P, Müller F, Dolder PC, Liechti ME. Lysergic Acid Diethylamide-Assisted Therapy in Patients With Anxiety With and Without a Life-Threatening Illness: A Randomized, Double-Blind, Placebo-Controlled Phase II Study. Biol Psychiatry. 2023 Feb 1;93(3):215-223.
4. Muller F. 2023, April 18. A Study on the Efficacy and Safety of LSD in Depressive Disorders [Conference presentation]. Basel, Switzerland. NCT03866252.

MM120 Antidepressant Potential Demonstrated in GAD Patients with Comorbid Depression (MADRS) [1,2]

MADRS Change from Baseline[3]



Change from Baseline[2,3]

- Week 4: -18.1 points
- Week 12: -18.7 points

Improvement over Placebo[2,3]

- Week 4: -5.7 points, p<0.05
- Week 12: -6.4 points, p<0.01

*p<0.05
**p≤0.01

1. Source: MindMed internal study documents and calculations. Full analysis set population.
2. Based on 100 µg dose group.
3. Significance achieved despite study not being powered for these pairwise comparisons. Based on observed MADRS score at each timepoint.

µg: microgram; MADRS: Montgomery-Åsberg Depression Rating Scale

MM120 for MDD | Phase 3 Study Design[1]

PHASE 3 STUDY[1]

Emerge

MM120-310

Part A
12 Week Randomized, Double-Blind

Single Dose

N=70 **MM120 ODT 100 µg**

N=70 **Placebo**

Primary Endpoint
(MADRS at Week 6)

Part B
40 Week Extension with Opportunity for Open-Label Treatment

Potential treatment if MADRS≥20

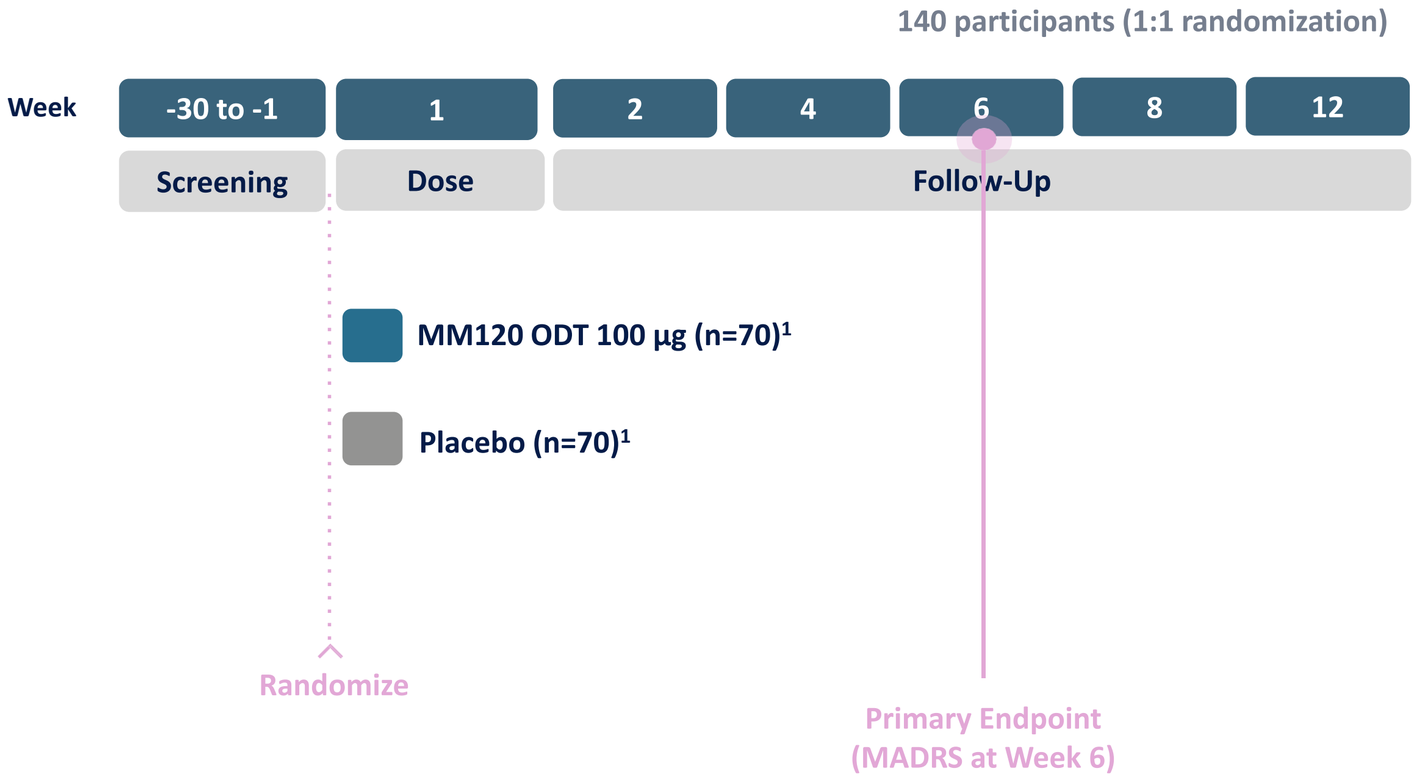
Up to four open-label doses of MM120 ODT 100 µg

MM120-311

[Design TBA]

1. Clinical study designs subject to ongoing regulatory discussion and review, including of Phase 3 clinical trial protocols.

Phase 3 MDD Trial Schematic: Emerge Study[1]



MM120-310 | Part A

A Phase 3 Study of a Single Dose of MM120 for Major Depressive Disorder

KEY ENTRY CRITERIA

- Men and Women
- Ages 18-74
- Diagnosis of MDD
- MADRS ≥ 26

SECONDARY ENDPOINTS[2]

- MADRS at Week 12
- MADRS at Week 1
- CGI-S at Day 2
- Time to retreatment / inefficacy

1. Source: Study MM120-310 study documents. Clinical study designs subject to ongoing regulatory discussion and review, including of Phase 3 clinical trial protocols.
2. Select secondary endpoints.

µg: microgram; CGI-S: Clinical Global Impressions – Severity; MADRS: Montgomery-Asberg Depression Rating Scale

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MM120 ODT
Lysergide D-tartrate

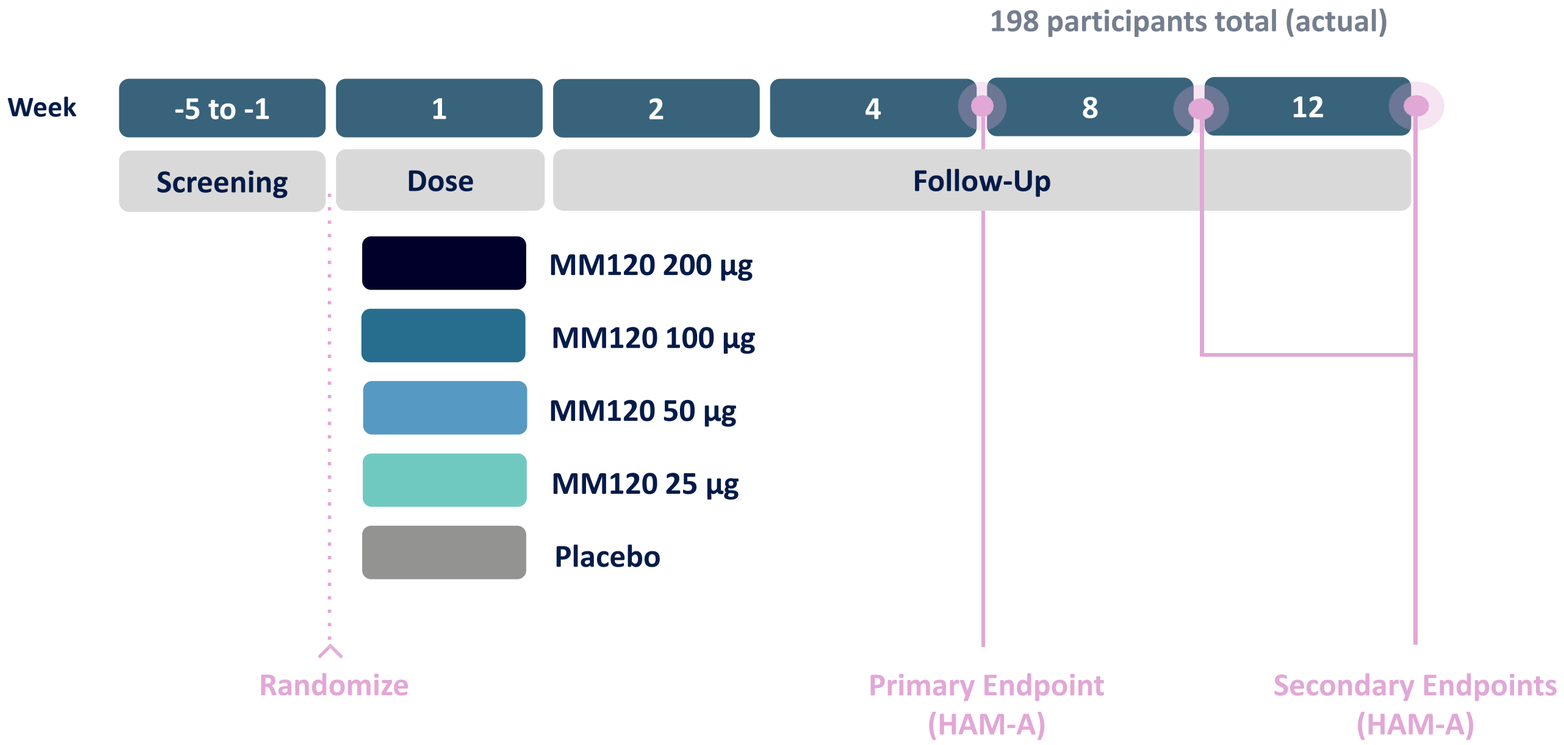
Phase 2b Results in GAD

Phase 2b Trial of MM120 Utilized Standard GAD Design and Endpoints and was Aligned with FDA Draft Guidance for Drug Class[1]

- **Standard GAD study design with endpoints that have supported registration for approved drugs**
- **Randomized, double-blind, placebo-controlled, 12-week trial**
  - Single administration of MM120 or placebo
  - No psychotherapeutic intervention
  - Trial design closely aligned with subsequently issued FDA 2023 Draft Guidance[2]
  - Patients washed out of anxiety pharmacotherapy prior to randomization
- **Enrolled 198 patients with GAD**
- **Five-arm dose optimization design with 1:1:1:1:1 randomization**
- **Primary endpoint: change in Hamilton Anxiety Scale (HAM-A) at week 4**
  - Assessed by central rater blinded to treatment assignment and visit number

1. Source: Study MMED008 internal study documents and calculations.
2. FDA 2023 Draft Guidance: Psychedelic Drugs: Considerations for Clinical Investigations.

Phase 2b Trial Schematic[1]



Study MMED008 | MM120 for GAD

A Phase 2b Dose Optimization Study of a Single Dose of MM120 in Generalized Anxiety Disorder

KEY ENTRY CRITERIA

- Men and Women
- Ages 18-74
- Diagnosis of GAD
- HAM-A ≥ 20

ADDITIONAL ENDPOINTS

- MADRS
- CGI-S / I
- PGI-S / C
- SDS
- EQ-5D-5L
- PSQI
- ASEX

1. Source: Study MMED008 internal study documents.

µg: microgram; HAM-A: Hamilton Anxiety Rating Scale; MADRS: Montgomery-Asberg Depression Rating Scale; CGI-S: Clinical Global Impressions - Severity; PGI-S: Patient Global Impression - Severity; SDS: Sheehan Disability Scale; EQ-5D-5L: EuroQol-5 Dimension; PSQI: Pittsburgh Sleep Quality Index; ASEX: Arizona Sexual Experiences Scale

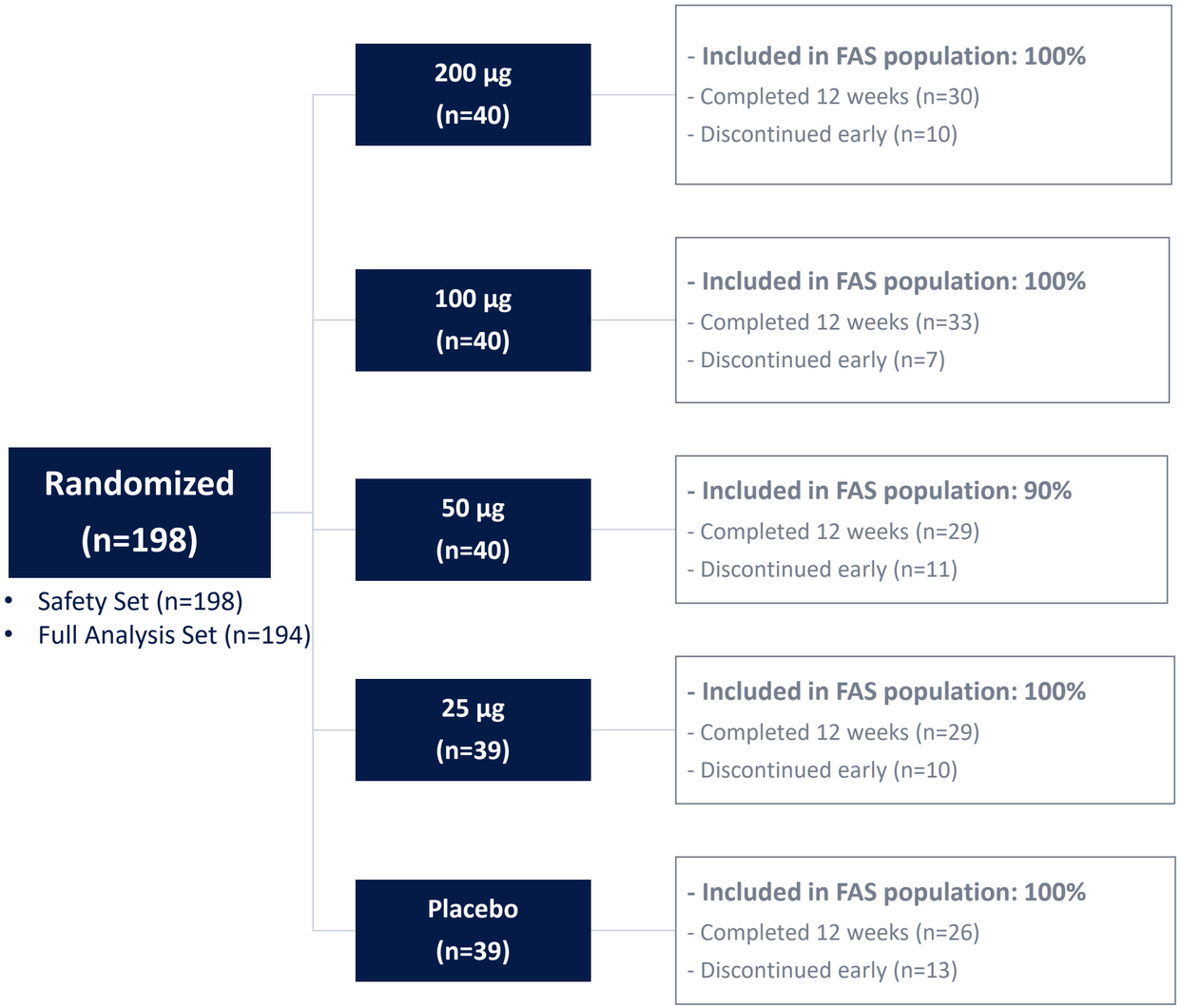
Treatment Paradigm: Standalone Drug Effects with No Psychotherapeutic Intervention[1]

- Dosing session monitors (DSMs) in the room provide no psychotherapeutic intervention
- Delivery protocol consistent with 2023 FDA Draft Guidance[2]
- No significant changes planned to treatment session delivery between Phase 2 and Phase 3

	Pre-treatment	During treatment	Post-treatment
Patient Journey in MMED008	✓ Comprehensive informed consent process ✓ Eligibility evaluation	✓ Continuous monitoring by DSMs ✓ Music, eye shades, reading, writing ✓ Concludes when discharge criteria met	✓ Follow-up visits for assessment only
Not Part of Patient Journey in MMED008	x No “preparation” x Pre-treatment activities consisted of a comprehensive informed consent process	x No “assisted therapy” x No psychotherapy and no therapeutic intervention beyond study drug	x No “integration” x No ongoing therapeutic engagement as part of clinical trial activities

1. Source: Study MMED008 internal study documents.
2. FDA 2023 Draft Guidance: Psychedelic Drugs: Considerations for Clinical Investigations.

Participant Disposition Aligned with Historical Expectations[1]



79% 12-week completion rate

in high dose groups[2] despite need for follow-up visits with no additional treatment

74% 12-week completion rate

of all randomized participants which is consistent with other studies in drug class

1. Source: Study MMED008 internal study documents and calculations. Safety population.
2. High dose groups include 100 and 200 µg dose groups.

FAS: Full Analysis Set

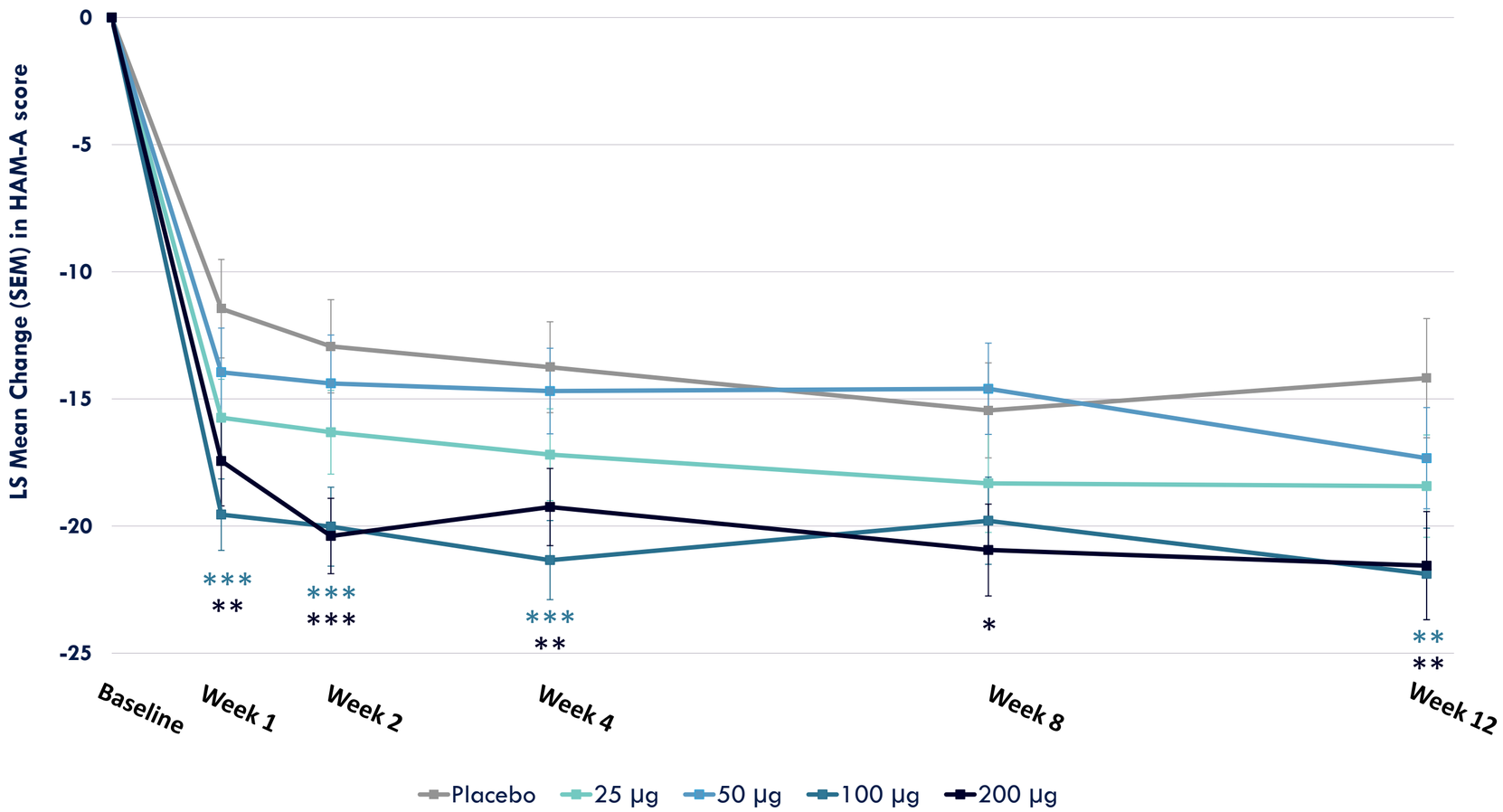
Participant Demographics and Baseline Characteristics Generally Balanced Across Groups[1]

Demographic (n=194)	MM120				Placebo
	25 µg (n=39)	50 µg (n=36)	100 µg (n=40)	200 µg (n=40)	(n=39)
Mean age (years)	38.0	45.3	42.7	42.1	38.7
Sex, female (%)	51.3%	55.6%	40.0%	70.0%	66.7%
Race (% white)	84.6%	80.6%	90.0%	82.5%	76.9%
Baseline HAM-A score	30.2	30.3	29.3	31.0	30.3
Baseline CGI-S score	4.9	4.9	4.8	5.1	4.9

1. Source: Study MMED008 internal study documents and calculations. Full analysis set population.

Statistically and Clinically Significant Reductions in HAM-A Score Continued at Week 12[1,2]

HAM-A Change from Baseline



Change from Baseline[2]

- Week 4: -21.3 points
- Week 12: -21.9 points

Improvement over Placebo[2]

- Week 4: -7.6 pts, p=0.0004
- Week 12: -7.7 pts, p=0.003

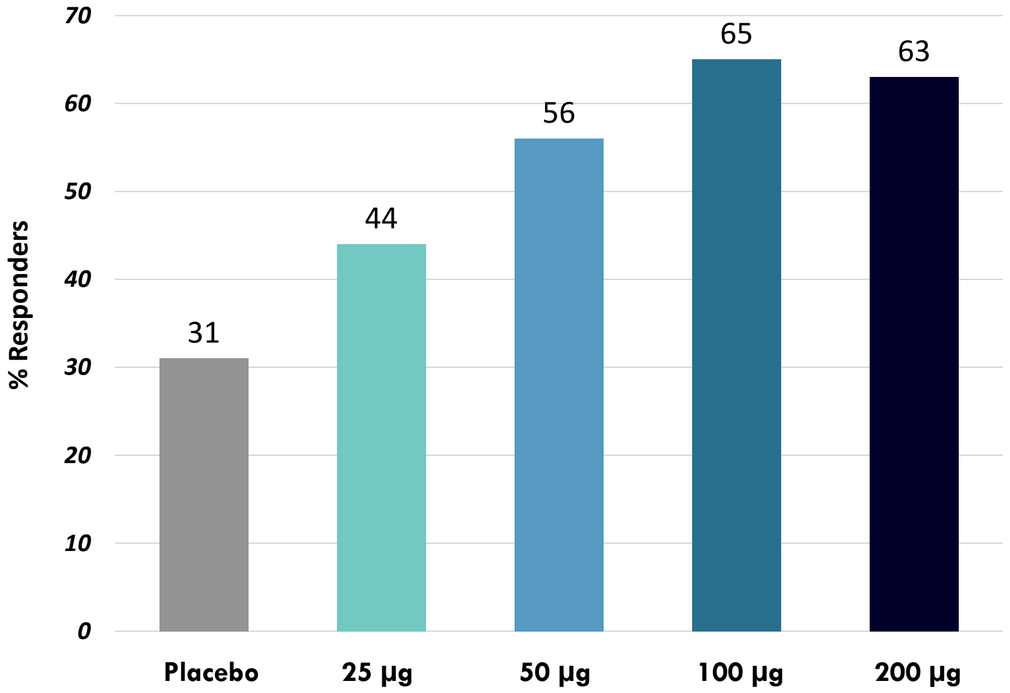
*p<0.05
**p≤0.01
***p≤0.001

1. Source: Study MMED008 internal study documents and calculations. Full analysis set population.
2. Based on 100 µg dose group.

µg: microgram; HAM-A: Hamilton Anxiety Rating Scale; NOTE: Significance achieved despite study not being powered for these pairwise comparisons.

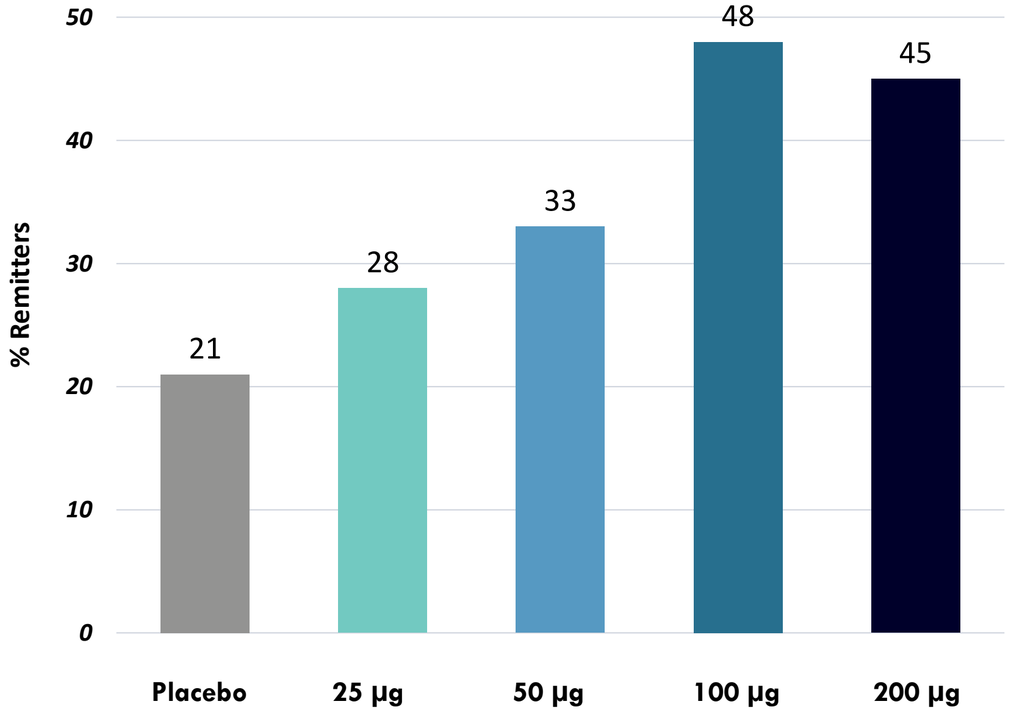
Continued Response and Remission through Week 12 with 65% Clinical Responder Rate and 48% Clinical Remission Rate[1]

HAM-A Response Rate at Week 12[2]



p-values not calculated

HAM-A Remission Rate at Week 12[2]

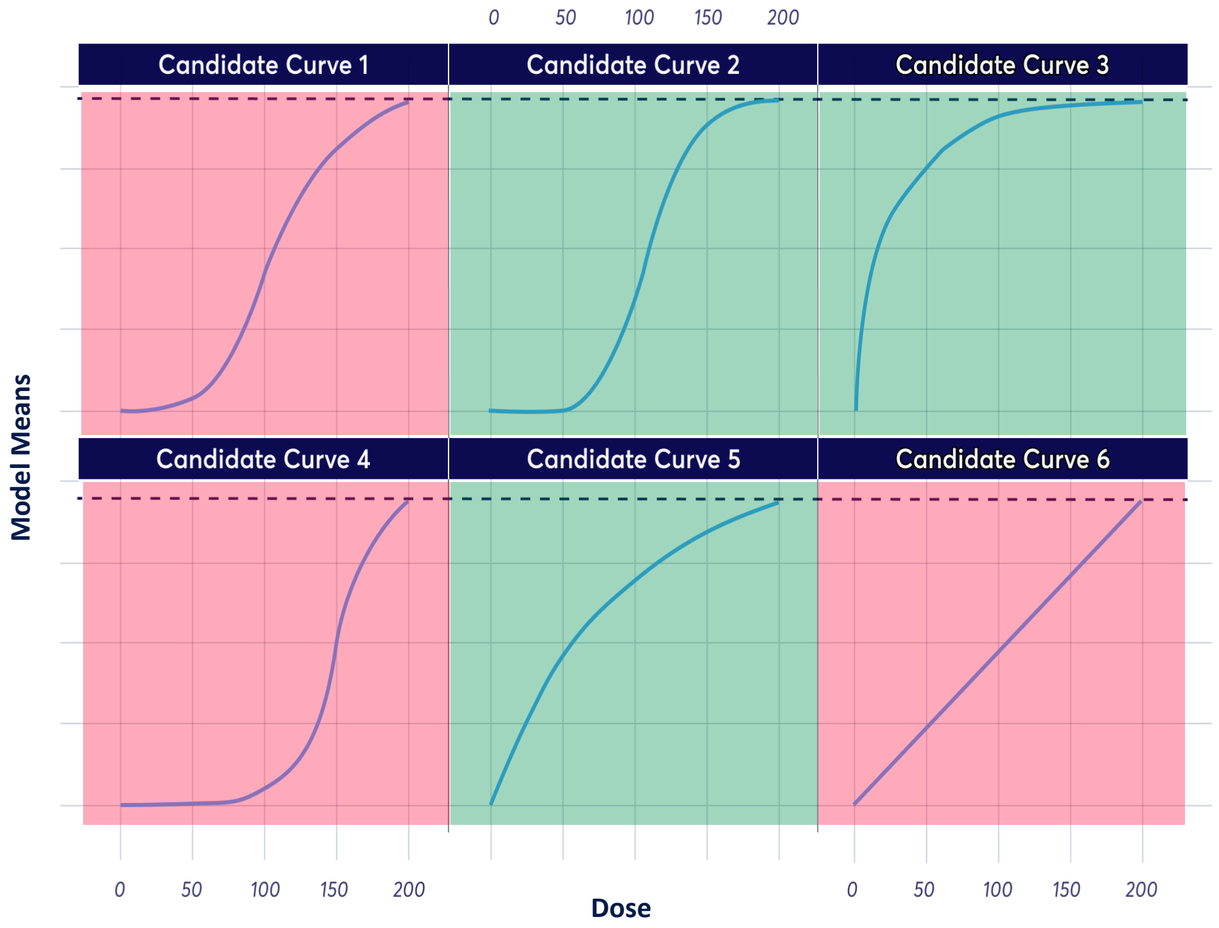


p-values not calculated

1. Source: Study MMED008 internal study documents and calculations. Full analysis set population.
2. Response is defined as a 50% or greater improvement on HAM-A score; Remission is defined as a HAM-A score of ≤ 7.

µg: microgram; HAM-A: Hamilton Anxiety Rating Scale

Primary & Key Secondary Analysis (MCP-Mod) Support Dose Response Relationship for MM120 in GAD[1]



Key Takeaways from MCP-Mod Analysis[2]

- Statistically significant dose response relationship with multiple model fits
- Supports dose selection of 100 µg for subsequent studies in GAD
- Pre-specified model estimates and observed responses drive dose selection for Phase 3 studies

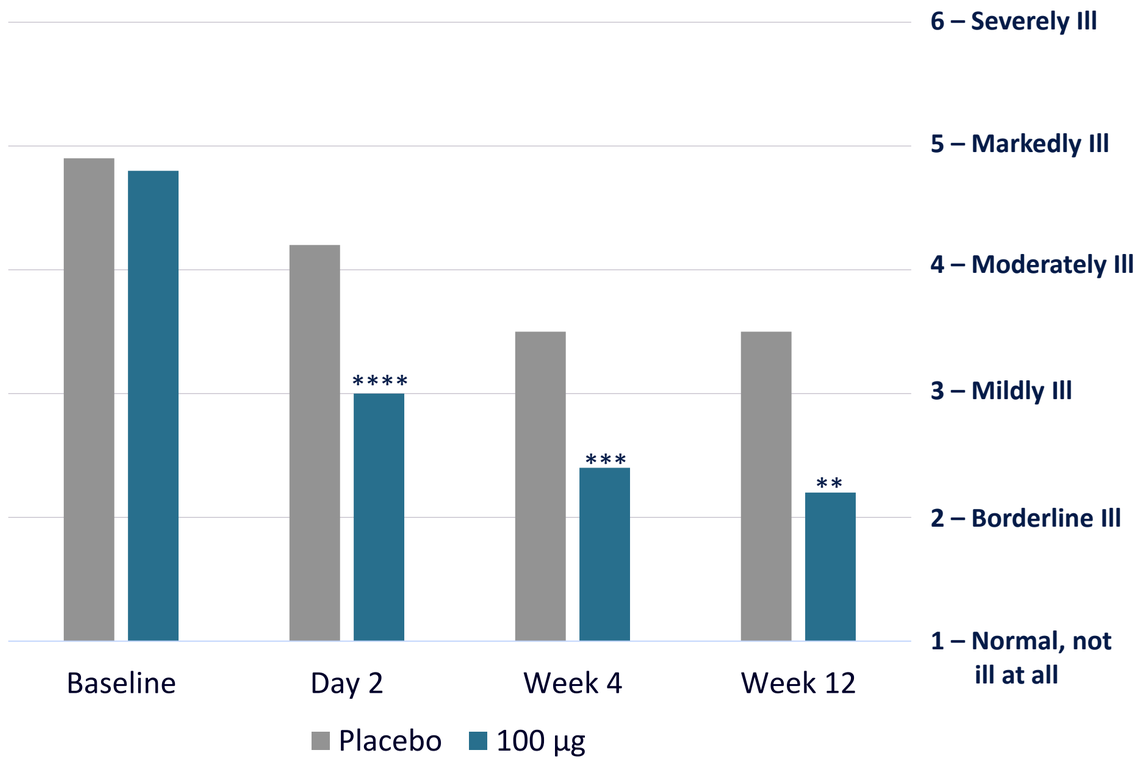
1. Source: Study MMED008 internal study documents and calculations. Full analysis set population.
2. Source: Novartis. "The MCP-Mod methodology – A statistical methodology for dose-response.

Rapid and Sustained Improvements in Clinical Global Impressions – Severity (CGI-S) Starting on Day 2 and Continuing through Week 12[1]

CGI-S Improvement in 100 µg Group

- Statistically and clinically significant improvement by Day 2 and maintained through Week 12
- Greater than 2-unit improvement in CGI-S score through Week 12
- Participants on average only borderline-to-mildly ill at Week 12

CGI-S Scores at Week 12[2]



*p<0.05
**p≤0.01
***p≤0.001
****p≤0.0001

1. Source: Study MMED008 internal study documents and calculations. Full analysis set population.
2. Significance achieved despite study not being powered for these pairwise comparisons.

µg: microgram; CGI-S: Clinical Global Impressions - Severity

MM120 was Well-tolerated with Mostly Transient, Mild-to-Moderate Adverse Events Consistent with Drug Class Expectations[1]

Favorable tolerability profile

- Virtually all (99%) adverse events (AEs) were mild-to-moderate in severity
- Minimal (2.5%) treatment emergent AEs (TEAEs) led to study withdrawal
- No drug-related serious adverse events (SAEs)[2]

No SAEs related to study drug

- Only SAE was in 50 µg dose group and deemed unrelated
- AE profile consistent with historical studies and drug class

No suicidal behavior or suicidality signal[3]

- No suicidal or self-injurious behavior
- ≤ 2 participant per arm reported suicidal ideation during the study
- No indication of increased suicidality or suicide-related risk

1. Source: Study MMED008 internal study documents and calculations. Safety population.
2. One serious adverse event (SAE) was observed in the 50 µg dose group: panic attack on study day 98 that was deemed not related to treatment.
3. Suicidality assessment based on reported adverse events.

Most Common (≥10%) TEAEs in High-Dose Groups Demonstrate Favorable Tolerability Profile[1,2]

Preferred Term Subjects (%) with AE	MM120								Placebo (n=39)	
	25 µg (n=39)		50 µg (n=40)		100 µg (n=40)		200 µg (n=40)			
	DD	AFT	DD	AFT	DD	AFT	DD	AFT	DD	AFT
Illusion	12 (31)	1 (2.6)	18 (45)	1 (2.5)	24 (60)	1 (2.5)	30 (75)	–	3 (7.7)	–
Nausea	3 (7.7)	–	11 (28)	–	16 (40)	1 (2.5)	24 (60)	2 (5.0)	1 (2.6)	2 (5.1)
Headache	4 (10)	2 (5.1)	9 (23)	2 (5.0)	10 (25)	4 (10)	10 (25)	1 (2.5)	8 (21)	1 (2.6)
Hallucination, visual	6 (15)	1 (2.6)	9 (23)	–	9 (23)	–	6 (15)	–	1 (2.6)	–
Euphoric mood	2 (5.1)	–	5 (13)	–	11 (28)	–	6 (15)	–	1 (2.6)	–
Anxiety	1 (2.6)	3 (7.7)	3 (7.5)	3 (7.5)	4 (10)	–	5 (13)	1 (2.5)	–	2 (5.1)
Mydriasis	1 (2.6)	–	7 (18)	–	8 (20)	–	4 (10)	–	1 (2.6)	–
Hyperhidrosis	1 (2.6)	–	4 (10)	–	9 (23)	–	5 (13)	–	–	–
Paraesthesia	2 (5.1)	–	2 (5.0)	–	2 (5.0)	–	8 (20)	–	2 (5.1)	1 (2.6)
Blood pressure increased	3 (7.7)	–	5 (13)	–	4 (10)	–	4 (10)	–	–	–
Dizziness	3 (7.7)	–	2 (5.0)	–	3 (7.5)	–	5 (13)	–	1 (2.6)	–
Tremor	–	–	3 (7.5)	–	2 (5.0)	1 (2.5)	8 (20)	–	–	–
Thinking abnormal	1 (2.6)	–	2 (5.0)	–	4 (10)	1 (2.5)	5 (13)	–	–	–
Pseudohallucination	–	–	3 (7.5)	–	3 (7.5)	–	4 (10)	–	–	–
Feeling abnormal	1 (2.6)	–	2 (5.0)	–	–	–	–	4 (10)	1 (2.6)	1 (2.6)
COVID-19	–	1 (2.6)	–	2 (5.0)	–	1 (2.5)	–	4 (10)	–	–

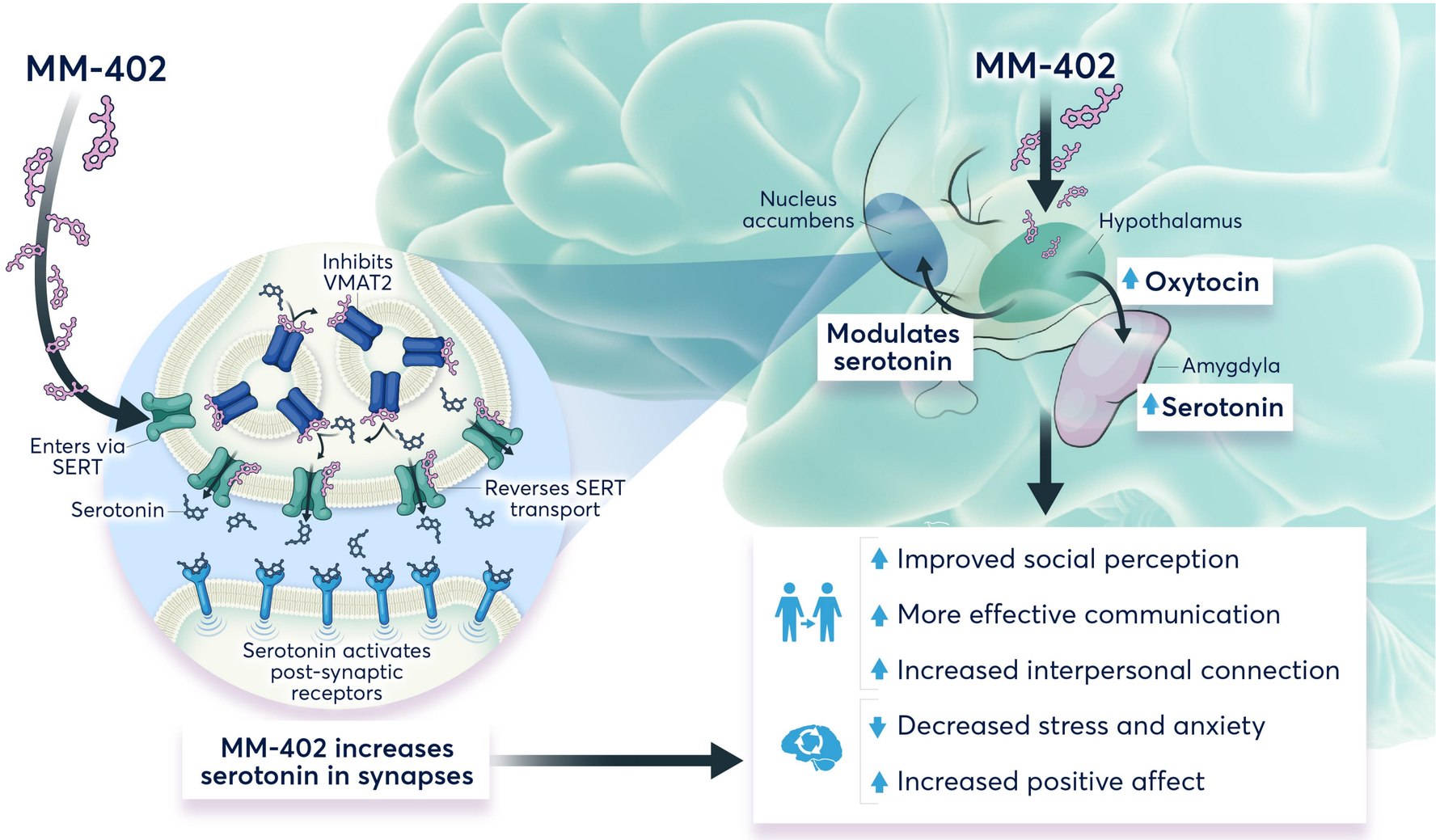
1. Source: Study MMED008 internal study documents and calculations. Safety population.
2. High dose groups include 100 and 200 µg dose groups.

AFT: After Dosing Day; DD: Dosing Day; TEAE: Treatment-emergent adverse event.

MindMed

MM402
R(-)-MDMA

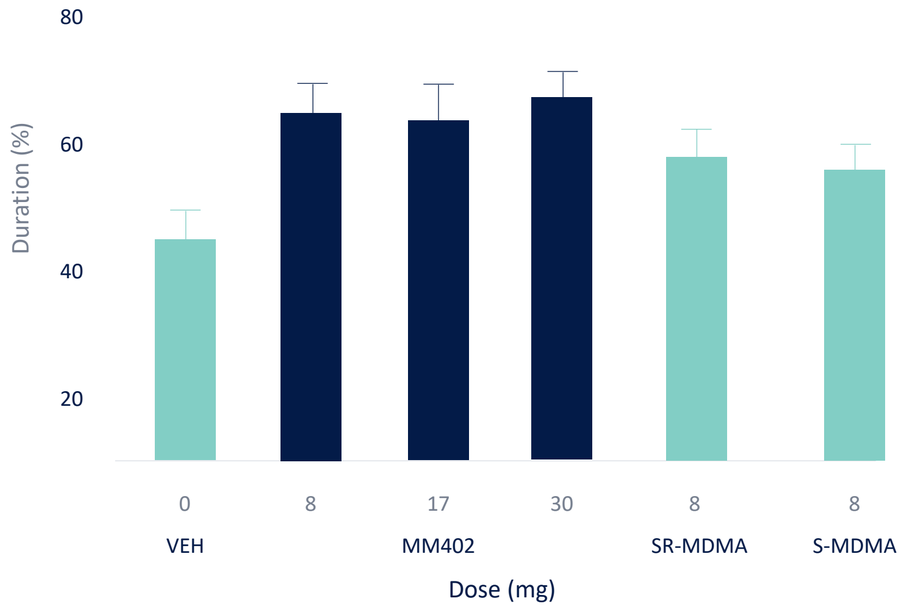
Differentiated Mechanism of Action Targets Key Pathways



Addressing the Urgent Need For Novel ASD Therapies

- MM402 is the serotonergic enantiomer of MDMA
- Potential first-in-class therapy for core symptoms of ASD
- Intend to develop for daily, at-home use

Increased duration of interaction in the three-chamber social interaction test[1]



Enhanced pro-social effects with potentially **reduced side effects** compared to MDMA

less stimulant activity

increased social interaction[2]

increasing feelings of connectedness

reduced dopamine-related adverse effects[2]

1. "MM402 demonstrates better efficacy than S(+)-3,4-MDMA or (±)-3,4-MDMA in Fmr1 knockout mice, an animal model of autism spectrum disorder". Presented at ECNP 2023. Data from "stranger" portion of "Duration in the arena" data.
2. Pitts EG, Curry DW, Hampshire KN et al. 2018; Psychopharmacology; 235(2):377-392.

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