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# Company Overview

NASDAQ: TERN

**September 2024**

# Forward-Looking Statements and Disclaimers

This presentation contains forward-looking statements about Terns Pharmaceuticals, Inc. (the “Company,” “we,” “us,” or “our”) and its industry that involve substantial risks and uncertainties. All statements other than statements of historical facts contained in this presentation, including statements regarding the Company’s strategy, future financial condition, future operations, projected costs, prospects, plans, objectives of management and expected market growth, are forward-looking statements. In some cases, you can identify forward-looking statements by terminology such as “aim,” “anticipate,” “assume,” “believe,” “contemplate,” “continue,” “could,” “design,” “due,” “estimate,” “expect,” “goal,” “intend,” “may,” “objective,” “plan,” “positioned,” “potential,” “predict,” “seek,” “should,” “target,” “will,” “would” and other similar expressions that are predictions of or indicate future events and future trends, or the negative of these terms or other comparable terminology. The Company has based these forward-looking statements largely on its current expectations, estimates, forecasts and projections about future events and financial trends that it believes may affect its financial condition, results of operations, business strategy and financial needs. In light of the significant uncertainties in these forward-looking statements, you should not rely upon forward-looking statements as predictions of future events. Although the Company believes that it has a reasonable basis for each forward-looking statement contained in this presentation, it cannot guarantee that the future results, levels of activity, performance or events and circumstances reflected in the forward-looking statements will be achieved or occur at all. For a detailed discussion of the risk factors that could affect our actual results, please refer to the risk factors identified in our Securities and Exchange Commission ("SEC") reports, including but not limited to our Annual Report on Form 10-K for the year ended December 31, 2023. These risks are not exhaustive. New risk factors emerge from time to time and it is not possible for our management to predict all risk factors, nor can we assess the impact of all factors on our business or the extent to which any factor, or combination of factors, may cause actual results to differ materially from those contained in, or implied by, any forward-looking statements. Except as required by law, we undertake no obligation to update publicly any forward-looking statements for any reason after the date of this presentation.

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Developing small molecule medicines, with clinically validated mechanisms of action, to address oncology and metabolic diseases with large unmet medical need

# Terns Investment Highlights and Strategic Approach

## Each of Terns' molecules meet the following strategic criteria:

- ✓ Oral, small molecule compounds
- ✓ Clinically validated mechanisms with higher PTS
- ✓ Indications with high unmet needs

### *Oncology*

De-risked and accelerated development pathways

Optionality for in-house full development

Complementary with other assets

### *Metabolic*

Large markets with multiple ways to win (e.g., combinations)

Opportunity to create significant value before seeking partnership

### Strong Balance Sheet

Cash of $387M[1] expected to provide runway into 2028

1. As of June 30, 2024, adjusted for net proceeds from the September 2024 offering; includes marketable securities

PTS: probability of technical success

# Terns Pipeline: Broad Rights to Multiple Wholly-owned Opportunities Targeting Serious Diseases

| PROGRAM | MECHANISM | INDICATION | PRECLINICAL | EARLY-STAGE CLINICAL DEVELOPMENT | LATE-STAGE CLINICAL DEVELOPMENT | STATUS / NEXT MILESTONE |
|---|---|---|---|---|---|---|
| ***Oncology*** | | | | | | |
| TERN-701 | Allosteric BCR-ABL Inhibitor | CML | Phase 1 CARDINAL | | *Anticipated registrational trial following Ph 1 trial* | **Ph1 CARDINAL trial initiated** Interim data from initial cohorts in Dec '24 |
| ***Metabolic*** | | | | | | |
| TERN-601 | Oral GLP-1R Agonist | Obesity | Phase 2 Ready | | | **Positive top-line Ph1 data (28-day PoC) Sept '24** Phase 2 initiation 2025 |
| TERN-501 Combination | THR-β Agonist + Metabolic Agent | Obesity | Phase 2 Ready | | | **Positive Ph2a NASH data** Preclinical data in combo with GLP-1 (enhanced and higher quality weight) |
| TERN-800 Series | GIPR Modulators | Obesity | GIPR Antagonist Lead Opt. | | | **GIPR antagonist lead optimization underway** |

CML: chronic myeloid leukemia, GIPR: glucose-dependent insulinotropic polypeptide receptor, GLP-1R: glucagon-like peptide-1 receptor, NASH: non-alcoholic steatohepatitis, opt: optimization, PoC: proof of concept, THR-β: thyroid hormone receptor beta

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# TERN-701

## Allosteric BCR-ABL TKI for Chronic Myeloid Leukemia

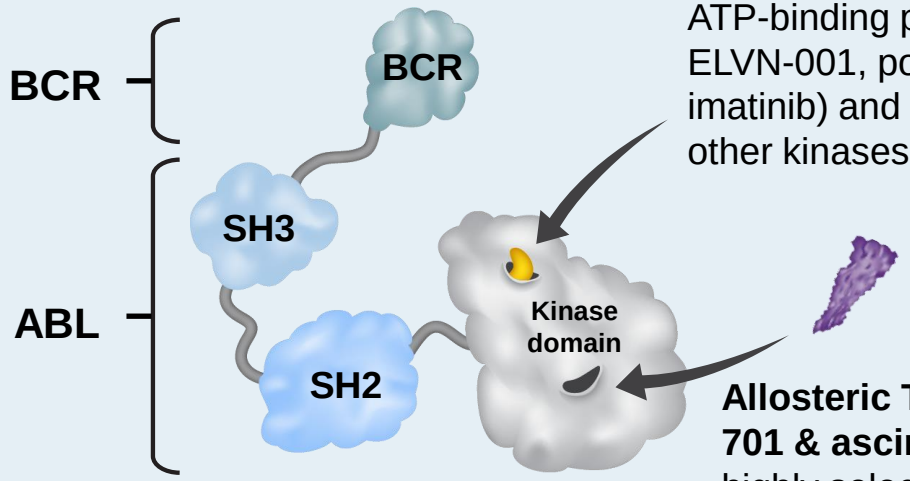
- Allosteric TKIs have significant efficacy improvement over active-site TKIs
- CML is a $5B orphan indication with need for multiple agents and limited allosteric competition
- TERN-701 Phase 1 trial (CARDINAL) progressing; interim data in Dec 2024

# Allosteric TKI: an Improved Approach for CML Treatment



*TERN-701 is an internally-developed allosteric TKI with an expected profile ≥ asciminib*

**Active BCR-ABL1 ➔ Cell proliferation / reduced apoptosis**




**Active-site TKIs** bind to ATP-binding pocket (e.g., ELVN-001, ponatinib, imatinib) and can inhibit other kinases

**Allosteric TKIs (TERN-701 & asciminib)** are highly selective for BCR-ABL, binding specifically to the myristoyl pocket

**Inactive BCR-ABL1 ➔ Cell death**

- CML is a **chronic, orphan indication** with a **sizeable market (>$5B)** and a need for **multiple agents,** driven by lifelong treatment and frequent switching
- **Allosteric** TKIs have shown ~2x efficacy improvement over older standard-of-care active-site TKIs and are better tolerated, with a relative lack of competition in the class
- **Blockbuster expectations** for 1st approved allosteric TKI, asciminib: label in 3L CML expected to expand into 1L
- TERN-701 is the **only other allosteric** in development with the potential to differentiate from asciminib in **efficacy and ease of use** (e.g., food effect)
- **Phase 1 CARDINAL trial progressing** with site activations globally and study-eligible subjects being identified by investigators

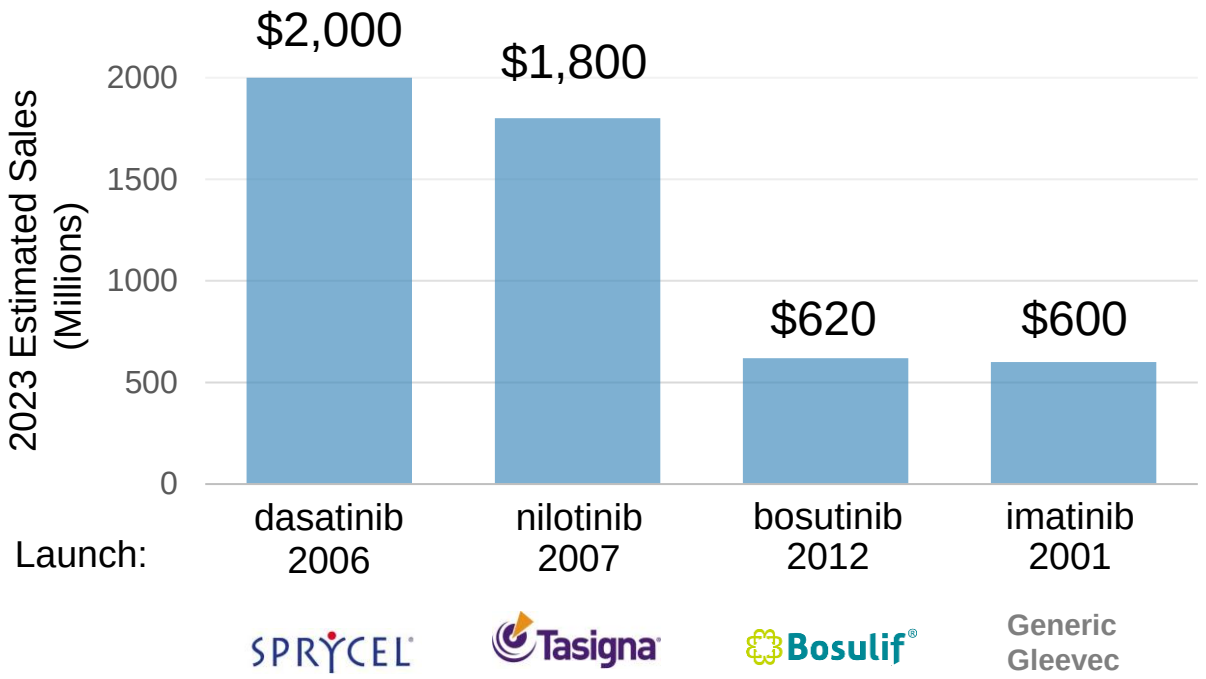
Note: 1L: 1st line; 3L: 3rd line; TKI: tyrosine kinase inhibitor
Source: Réa et al Blood 2021, NVS 2Q 2022 Earnings, Factset estimates

# CML is a Sizeable Market With Need for Multiple Agents

CML is a chronic, orphan indication with:

- ~9,280 new cases being diagnosed in the U.S. in 2024[1]
- U.S. CML **prevalence today is ~110K and is expected to triple** by 2040, driven by improved survival[2,3]
- Patients responding to treatment have a **life expectancy almost the same as the general population** and live decades with their disease requiring life-long treatment[4]

## Current Standard of Care Active-Site TKIs represent a **~$5B Market**[5]




1. Cancer.org Key Statistics for Chronic Myeloid Leukemia, 2. Huang et al Cancer 2020; 3. Jabbour, Kantarjian, AJH 2020; 4. Bower et al., Journal of Clinical Oncology 2016; 5. Factset estimates (Note: 2023E ponatinib sales of ~$160M)

# Frequent Switching Occurs Between TKIs, Most Commonly Due to Intolerance

- **~40%** of people started on a TKI switch to an alternative TKI[1]

- Reasons to switch may include[2]:
  - side effects / intolerance
  - co-morbidity
  - inadequate response
  - drug-drug interaction

- Physicians are seeking additional novel therapies that are **safe**, **efficacious** and **well-tolerated**

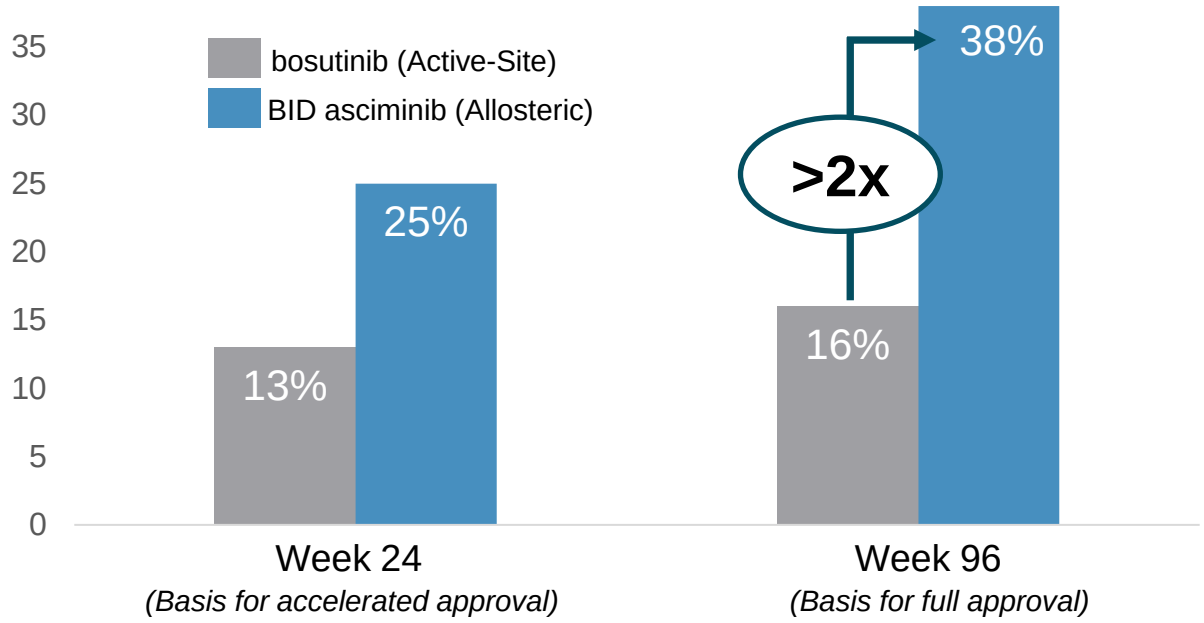
1. Schiffer Blood 2021; Cortes 2023; 2. Hochhaus et al, Leukemia 2020

# The Only Approved Allosteric TKI for CML has Shown a Benefit Over 2nd Gen Active-site TKIs, Leading to Blockbuster Expectations



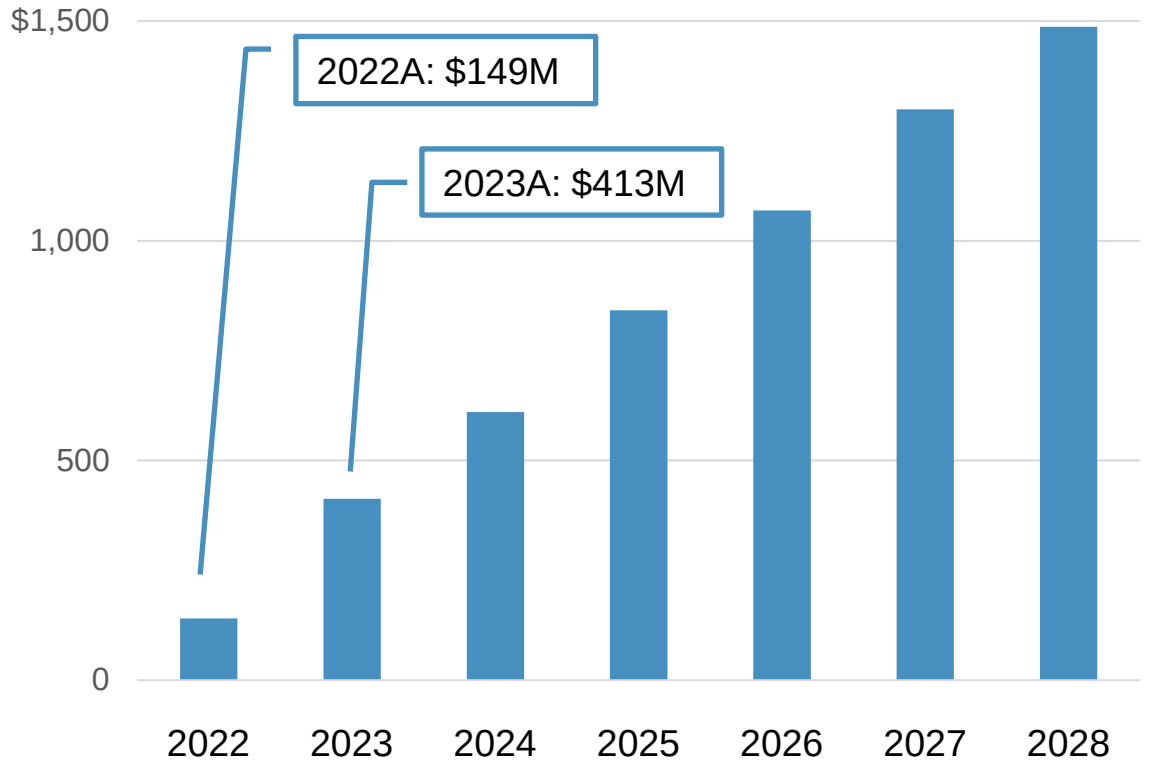
- Asciminib showed **>2x improvement in MMR** in 3L patients over 96 weeks[1] in Phase 3
- Asciminib also had a **~3x lower discontinuation rate** than bosutinib over 96 weeks[2]

*% of Patients Achieving MMR*




- Analysts expect asciminib to rapidly approach **blockbuster sales**

*Consensus Sales Estimates ($mm)[3]*



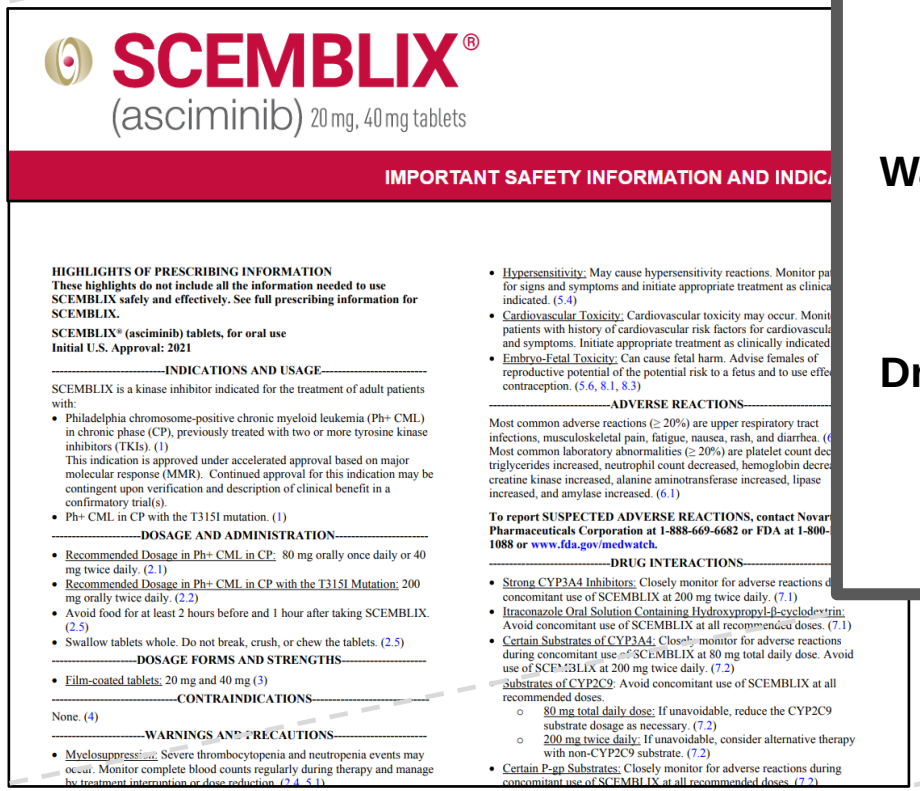

Note: 3L: 3rd line; BID: twice-daily; MMR: major molecular response; Scemblix has 3L+ U.S. market share of NBRx 43%, TRx 22% as of 4Q23 (NVS 4Q23 Earnings)

1. Scemblix Prescribing Information 2. (8% asciminib vs 26% bosutinib) 3. Estimates from EvaluatePharma; may include sales beyond 3L setting

# Asciminib (Scemblix) Has Multiple Limitations that Represent Opportunities for TERN-701



*TERN-701 has the potential to be a differentiated BCR-ABL inhibitor with advantages over asciminib, including more convenient dosing to improve treatment options and quality of life for people living with CML*



SCEMBLIX®
(asciminib) 20 mg, 40 mg tablets

IMPORTANT SAFETY INFORMATION AND INDIC

**HIGHLIGHTS OF PRESCRIBING INFORMATION**
**These highlights do not include all the information needed to use SCEMBLIX safely and effectively. See full prescribing information for SCEMBLIX.**

**SCEMBLIX® (asciminib) tablets, for oral use**
**Initial U.S. Approval: 2021**

**----------INDICATIONS AND USAGE----------**

SCEMBLIX is a kinase inhibitor indicated for the treatment of adult patients with:

- Philadelphia chromosome-positive chronic myeloid leukemia (Ph+ CML) in chronic phase (CP), previously treated with two or more tyrosine kinase inhibitors (TKIs). (1)
  This indication is approved under accelerated approval based on major molecular response (MMR). Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial(s).
- Ph+ CML in CP with the T315I mutation. (1)

**----------DOSAGE AND ADMINISTRATION----------**

- Recommended Dosage in Ph+ CML in CP: 80 mg orally once daily or 40 mg twice daily. (2.1)
- Recommended Dosage in Ph+ CML in CP with the T315I Mutation: 200 mg orally twice daily. (2.2)
- Avoid food for at least 2 hours before and 1 hour after taking SCEMBLIX. (2.5)
- Swallow tablets whole. Do not break, crush, or chew the tablets. (2.5)

**----------DOSAGE FORMS AND STRENGTHS----------**

- Film-coated tablets: 20 mg and 40 mg (3)

**----------CONTRAINDICATIONS----------**

None. (4)

**----------WARNINGS AND PRECAUTIONS----------**

- Myelosuppression: Severe thrombocytopenia and neutropenia events may occur. Monitor complete blood counts regularly during therapy and manage by treatment interruption or dose reduction. (2.4, 5.1)
- Hypersensitivity: May cause hypersensitivity reactions. Monitor pa for signs and symptoms and initiate appropriate treatment as clinica indicated. (5.4)
- Cardiovascular Toxicity: Cardiovascular toxicity may occur. Monit patients with history of cardiovascular risk factors for cardiovascula and symptoms. Initiate appropriate treatment as clinically indicated
- Embryo-Fetal Toxicity: Can cause fetal harm. Advise females of reproductive potential of the potential risk to a fetus and to use effe contraception. (5.6, 8.1, 8.3)

**----------ADVERSE REACTIONS----------**

Most common adverse reactions (≥ 20%) are upper respiratory tract infections, musculoskeletal pain, fatigue, nausea, rash, and diarrhea. ( Most common laboratory abnormalities (≥ 20%) are platelet count dec triglycerides increased, neutrophil count decreased, hemoglobin decre creatine kinase increased, alanine aminotransferase increased, lipase increased, and amylase increased. (6.1)

**To report SUSPECTED ADVERSE REACTIONS, contact Novar Pharmaceuticals Corporation at 1-888-669-6682 or FDA at 1-800-1088 or www.fda.gov/medwatch.**

**----------DRUG INTERACTIONS----------**

- Strong CYP3A4 Inhibitors: Closely monitor for adverse reactions d concomitant use of SCEMBLIX at 200 mg twice daily. (7.1)
- Itraconazole Oral Solution Containing Hydroxypropyl-β-cyclodextrin: Avoid concomitant use of SCEMBLIX at all recommended doses. (7.1)
- Certain Substrates of CYP3A4: Closely monitor for adverse reactions during concomitant use of SCEMBLIX at 80 mg total daily dose. Avoid use of SCEMBLIX at 200 mg twice daily. (7.2)
- Substrates of CYP2C9: Avoid concomitant use of SCEMBLIX at all recommended doses.
  - 80 mg total daily dose: If unavoidable, reduce the CYP2C9 substrate dosage as necessary. (7.2)
  - 200 mg twice daily: If unavoidable, consider alternative therapy with non-CYP2C9 substrate. (7.2)
- Certain P-gp Substrates: Closely monitor for adverse reactions during concomitant use of SCEMBLIX at all recommended doses. (7.2)

## Dosage and Administration:

- Multiple doses for different BCR-ABL variants
- Requires BID dosing in many clinical settings
- 3-hour fasting requirement (2-hours before, 1-hour after)

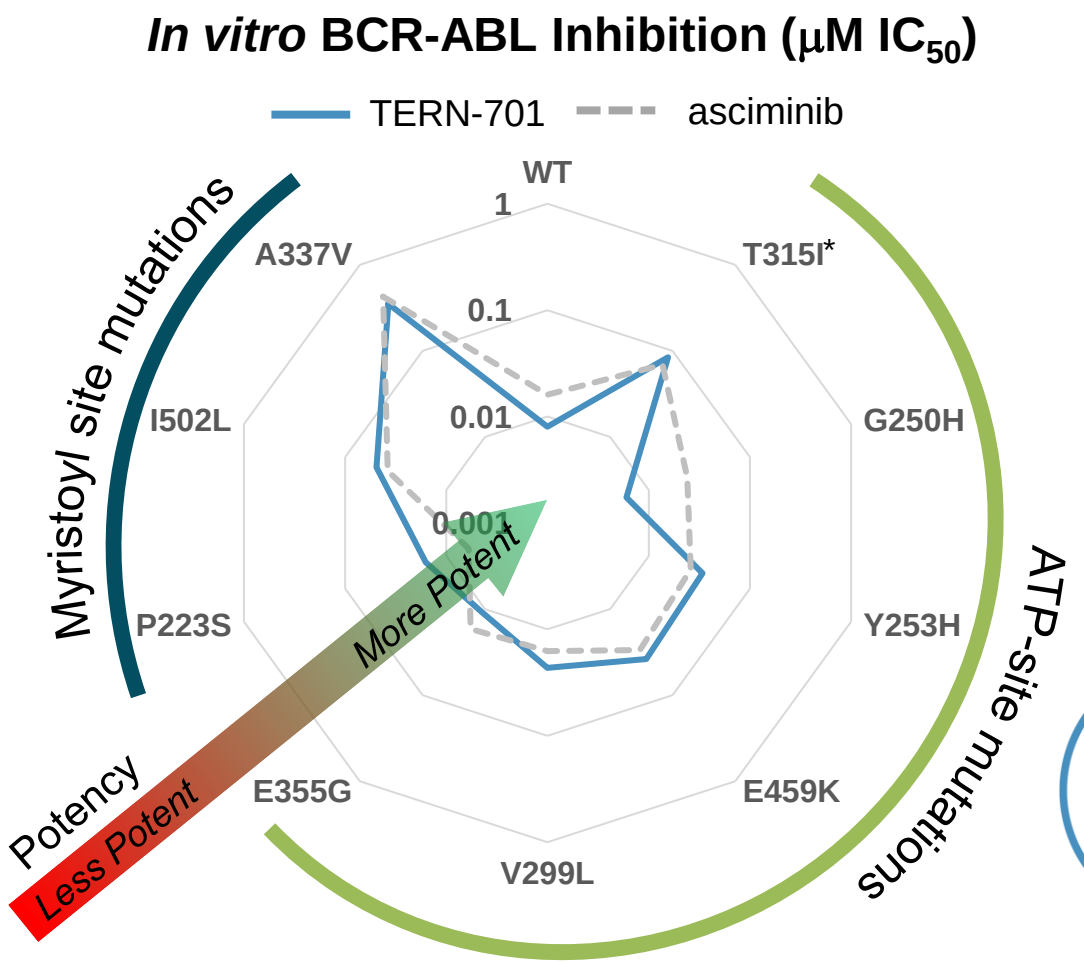
## Warnings and Precautions:

- Pancreatic toxicity
- Cardiovascular toxicity

## Drug Interactions:

- CYP3A4 inhibitors/substrates
- CYP2C9 substrates
- P-gp substrates

# TERN-701 Potency Suggests Anti-Tumor Activity Comparable to asciminib; With Opportunities to Differentiate




In non-clinical assays, **TERN-701 demonstrated a similar profile to asciminib** including high potency against:

- wild type BCR-ABL, and
- most-common mutations occurring in patients treated with active-site TKIs

**TERN-701** could have optimized dosing & easier use vs asciminib

Note: WT (wild-type) and BCR-ABL mutations were evaluated in an ABL auto-phosphorylation assay
* T315i mutation was evaluated in a cell proliferation assay

# TERN-701 PK Supports Once-daily Dosing Without Regard to Food

*Dosing with or without food is a key differentiator within the allosteric BCR-ABL class*

## Favorable TERN-701 Pharmacokinetic Profile

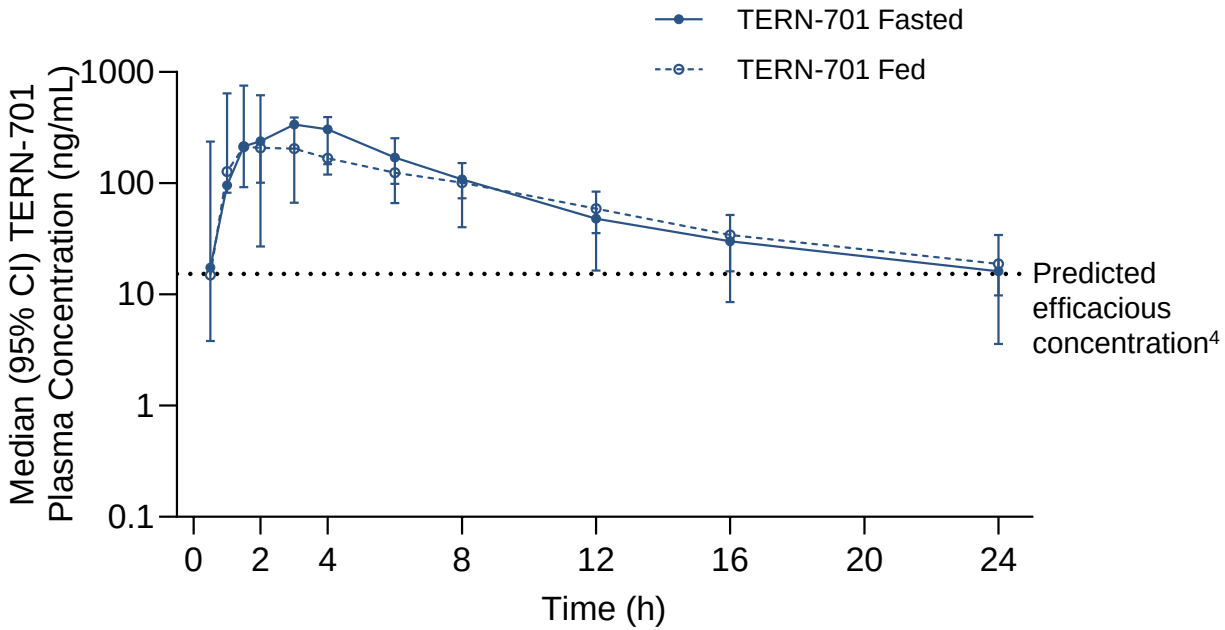
- Linear PK with approximately **dose proportional increase in exposure**[1]
- Median half-life of **8-12 hours supporting QD dosing**

## Consistent PK Across Populations

- PK profile of TERN-701 in Western healthy volunteers were **generally consistent** with that observed in the Phase 1 clinical study in CML patients in China[2]

## No TERN-701 Food Effect

- **No clinically significant difference in TERN-701 exposure (AUC)** when dosed fasted or with a high-fat meal[3]




1. Across single dose TERN-701 range of 20 mg to 160 mg
2. Phase 1 study evaluating same doses led by Hansoh, Terns' corporate partner in China
3. TERN-701 80 mg dose; asciminib (40mg) change in exposure ($\Delta AUC_{inf}$) from fed relative to fasted was (62%)
4. Effective plasma IC90 for the native BCR-ABL KCL-22 cell line

# Phase 1 CARDINAL Trial Design, Interim Data Expected Dec '24



*Starting dose appears safe and clinically active based on emerging early clinical data from partner's ongoing Phase 1 trial in China*

## TERN-701

### CARDINAL Trial Design

*Population*

- CP **2L and 3L** CML patients
- Treatment failure / suboptimal response to at least **one prior 2nd gen active-site TKI**† (i.e., 2L)
- Intolerance on current TKI (including asciminib)

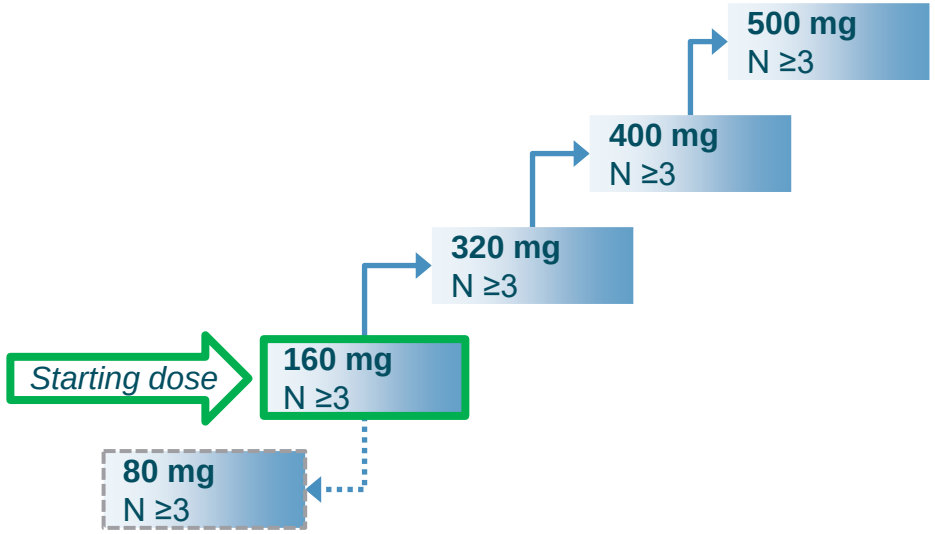
*Endpoints For Part 1*

- Primary: Safety and tolerability
- Secondary: PK, efficacy (BCR-ABL transcript level Δ)

## Part 1 Dose Escalation

**TERN-701 Once-daily Monotherapy (N≈24-36)**

*BOIN design with optional backfill cohorts*

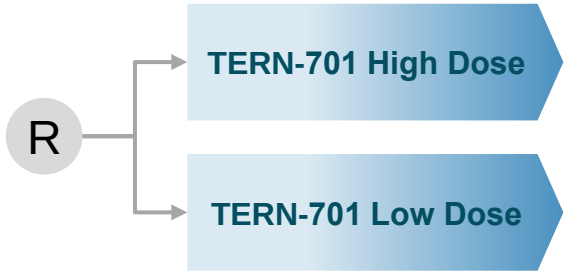



RDE Selection*

## Part 2 Dose Expansion

**TERN-701 Once-daily Monotherapy (N≈40)**

*At least 2 dose levels will be selected*




*Endpoints For Part 2*

- Primary: Efficacy (hematologic, molecular responses)
- Secondary: Safety, tolerability, PK

Patients may continue therapy beyond primary endpoint measures, through the end of study

Note: Terns starting dose represents 4X that of the 40mg starting dose in the China Phase 1 trial of TERN-701
† 2nd gen active-site TKI = dasatinib, nilotinib, or bosutinib
*RDE = recommended doses for expansion; will be selected following a Part 1 interim analysis; CP: Chronic phase, BOIN: Bayesian optimal interval

# Next Steps for TERN-701 in CML

*Anticipated pivotal trial following Phase 1 CARDINAL trial*

**1H24**

**Phase 1 Global**
**~1-2 yrs***


- CARDINAL trial is progressing
- Interim data from initial cohorts expected in Dec 2024

**Phase 3 Registrational Trial**
**2-3 years***

**Evaluating multiple options for pivotal trial(s)** including frontline patients and second line:

**Phase 3 Monotherapy**
*Frontline CML patients*

**Phase 3 Monotherapy**
*2L+ CML patients*

*Trial durations estimated based on enrollment projections from asciminib development program
Note: TERN-701 trial-in-progress poster (ASCO 2023) and non-clinical xenograft activity poster (ASPET 2023, SOHO 2023 and John Goldman 2023) available on Terns' scientific publication website

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## Our Approach for Metabolic

Focused on the discovery and development of oral, small-molecule candidates within established MoAs for building future, *best-in-class oral combination therapies* for the treatment of obesity

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# TERN-601

## Oral GLP-1 Agonist with Differentiated Profile for Obesity

- Statistically significant and dose-dependent weight loss over 28 days with QD dosing
- Well-tolerated with unremarkable safety findings despite rapid titration to target doses
- Potential to be a leading GLP-1R agonist with promising efficacy, tolerability & manufacturing scalability

# Positive Phase 1 Results Demonstrate TERN-601 is Well Positioned for Phase 2 and Long-Term Differentiation

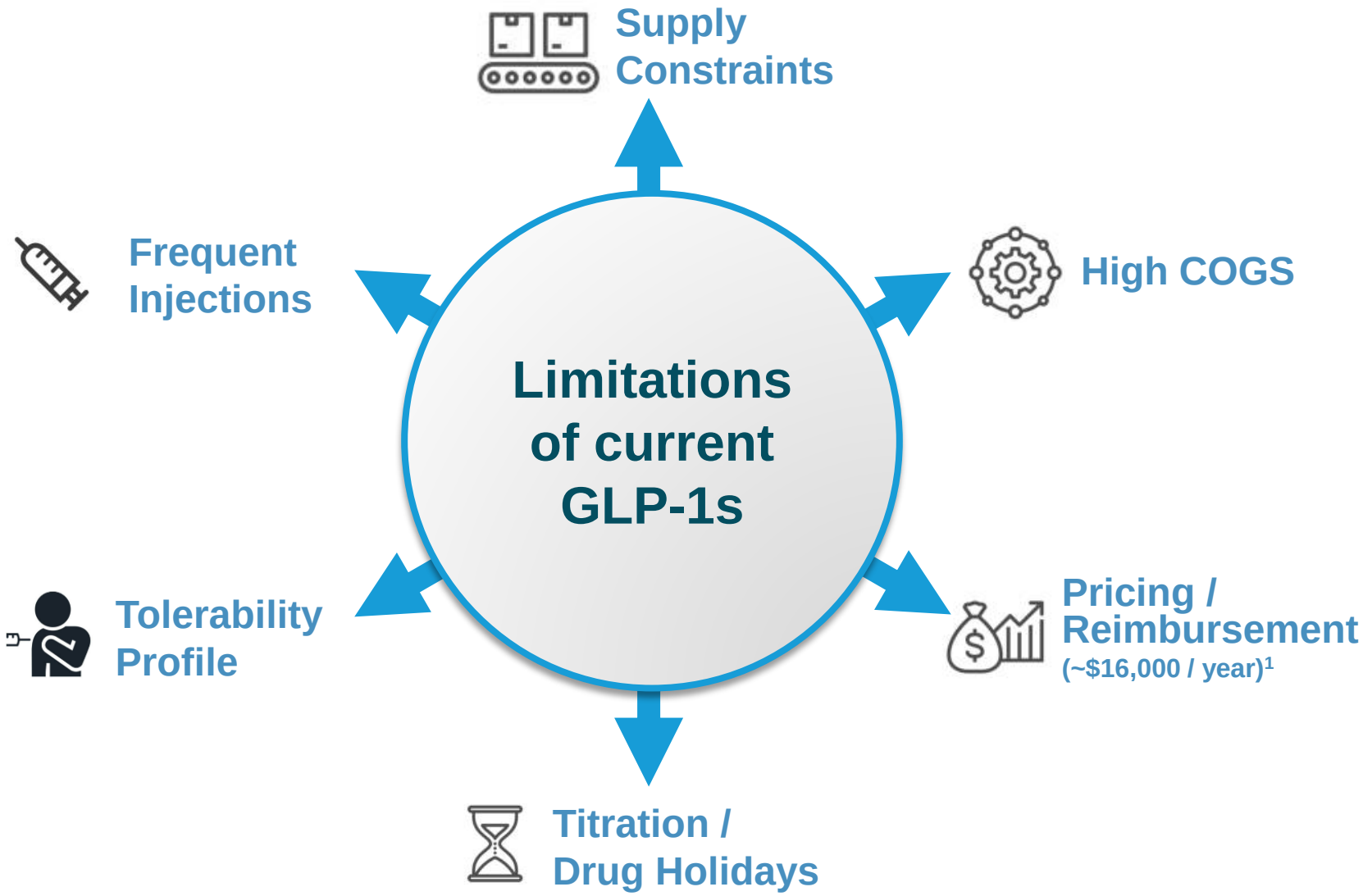


- **Statistically significant** and **dose-dependent** weight loss over 28 days with QD dosing
- **Well tolerated** with unremarkable safety findings despite **rapid titration to target doses**
- **Distinct drug properties** enabled sustained target coverage and a flat PK curve, and may lead to a differentiated clinical profile in subsequent studies
- Potential to be a leading GLP-1R agonist with promising **efficacy, tolerability and manufacturing scalability**
- **Plan to initiate Phase 2** trial in 2025

GLP-1R: glucagon-like peptide-1 receptor, PK: pharmacokinetic, QD: once-daily

# Oral, Small-Molecule GLP-1s May Address Limitations of Current Injectable GLP-1s






1. Novocare: Wegovy has a list price of $1,349 / package * 12 pkgs/year

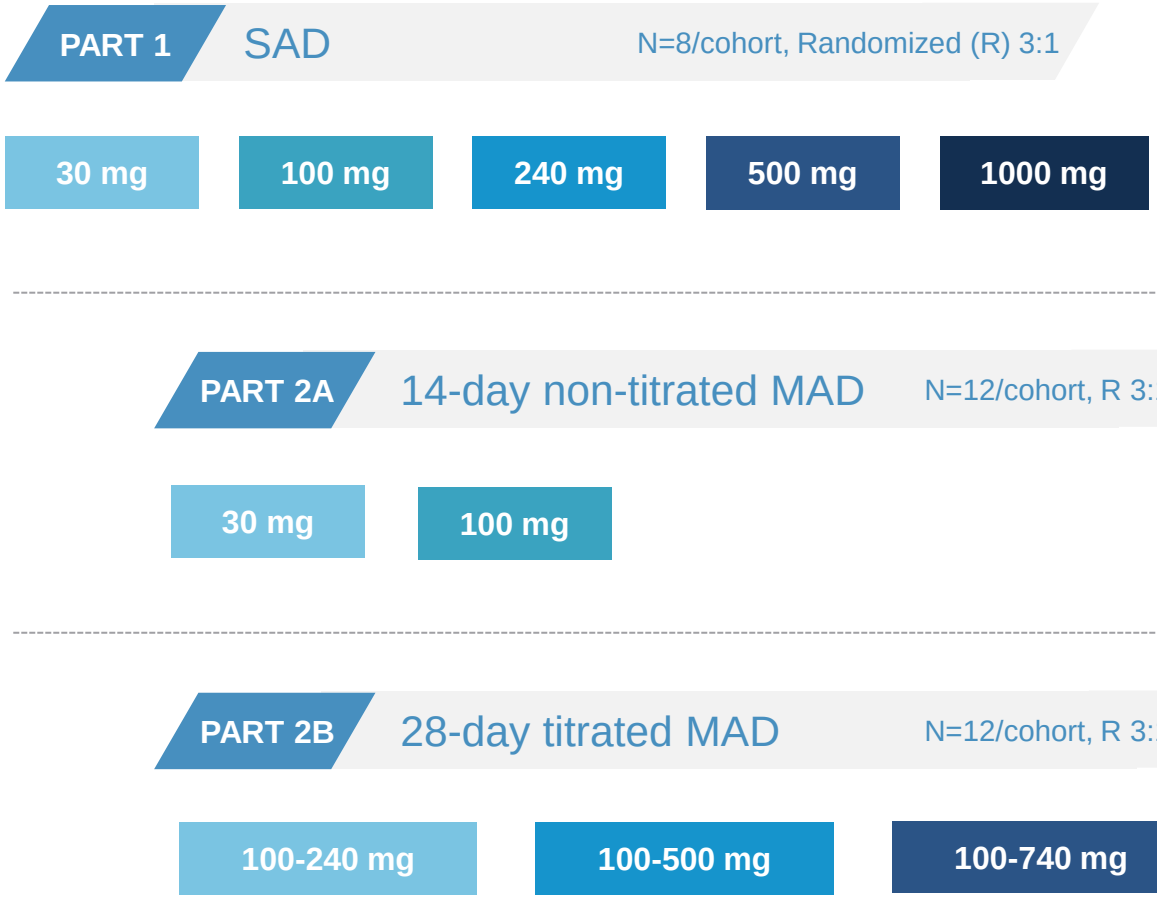
# TERN-601 First-In-Human Study Leveraged an Efficient Design to Explore a Wide Dose Range

## Phase 1 Trial Design

*Population*
- Healthy adults with obesity or overweight
- Non-diabetic
- BMI ≥ 27 to < 40 kg/m$^2$ (Part 2)

*Endpoints*
- Primary: safety and tolerability
- Secondary / exploratory: PK, change in body weight over 28 days, etc.

*Location*
- U.S. inpatient Phase 1 center



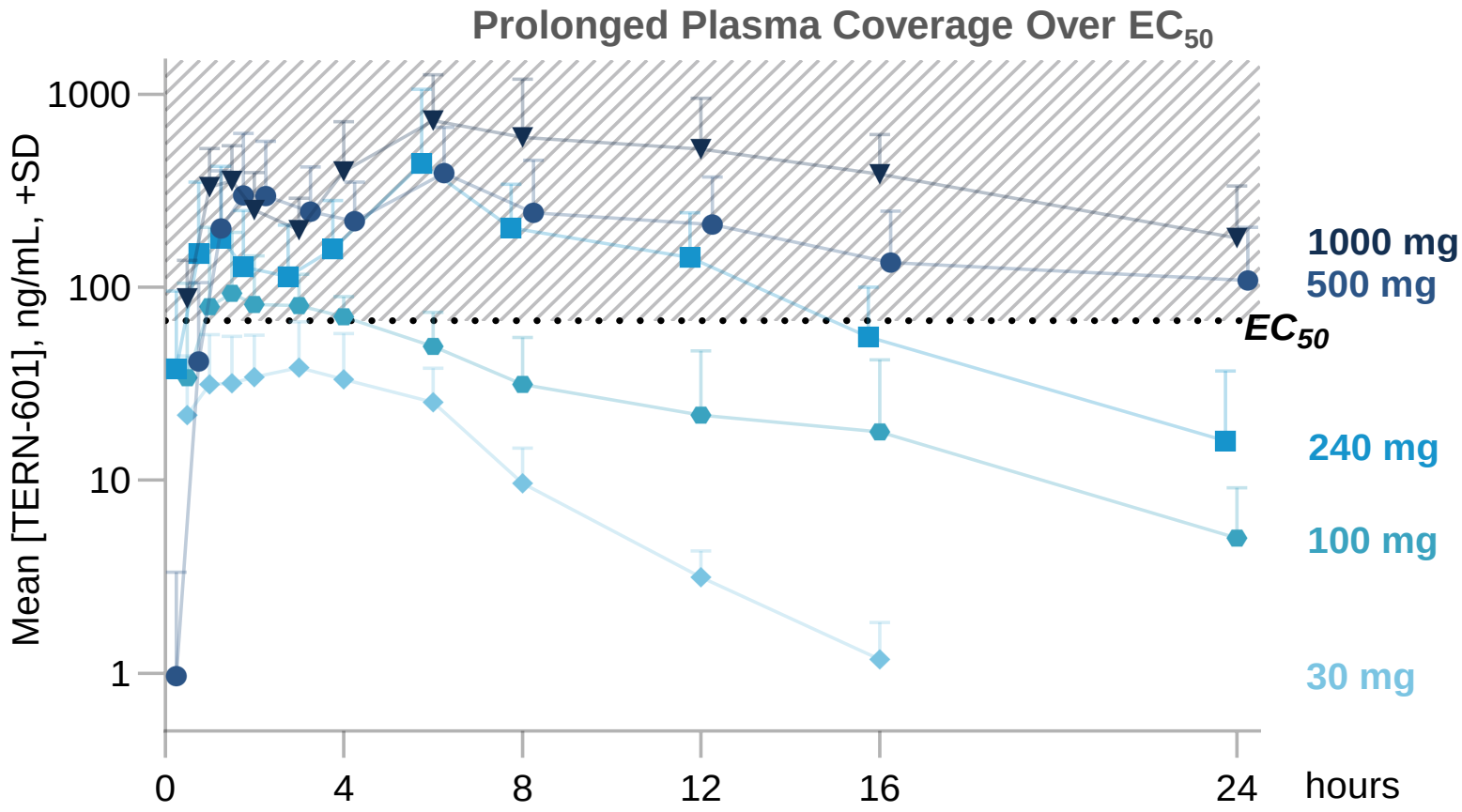

## Study objectives

- Use PK data to identify once-daily target doses for 28-day titration
- Use safety/tolerability and PD data to identify optimal starting dose for 28-day titration
- Assess safety / tolerability of fast titration to target doses and weight loss over 28 days

BMI: body mass index, MAD: multiple ascending dose, PD: pharmacodynamic, PK: pharmacokinetic, SAD: single ascending dose

# Prolonged Absorption of TERN-601 at Target Doses Drove Sustained Target Coverage with Once-Daily Dosing

- Prolonged absorption at ≥240 mg led to sustained 16-24 hour target coverage in plasma despite ~4-6 hour elimination half-life
- SAD PK identified 240 mg and above as potentially efficacious target doses for 28-day MAD cohorts




Note: Dotted line represents estimated protein-binding adjusted $EC_{50}$ (concentration at which 50% of maximal activity is observed) in CHO-K1 cells (subclone of the Chinese hamster ovary cell line) expressing hGLP-1R (humanized GLP1 receptor)
MAD: multiple ascending dose, PK: pharmacokinetic, SAD: single ascending dose, SD: standard deviation

# Baseline Characteristics Well-Balanced Across 28-Day MAD Cohorts



*BMI consistent across groups (~30 kg/m$^2$), with predominantly male participants (≥70%)*

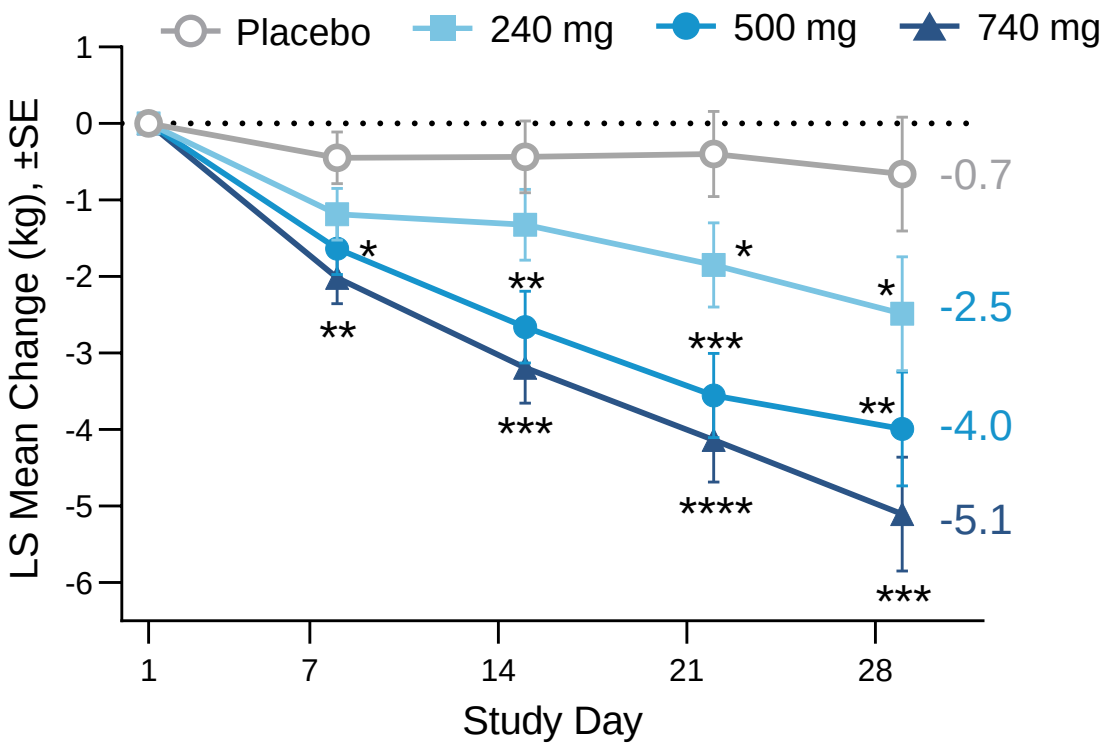
| Mean (SD)<br>Median | Placebo pooled (N=9) | 240 mg (N=10) | 500 mg (N=9) | 740 mg (N=9) |
|---|---|---|---|---|
| **Age, year** | 41.4 (9.2)<br>40 | 44.7 (10.7)<br>49.5 | 46.7 (12.7)<br>45 | 46.7 (12.1)<br>50 |
| **Male, n (%)** | 7 (78%) | 7 (70%) | 8 (89%) | 7 (78%) |
| **Weight, kg** | 90.9 (7.8)<br>91.8 | 93.4 (14.2)<br>92.6 | 95.0 (10.6)<br>93.8 | 93.3 (13.7)<br>93.1 |
| **BMI, kg/m$^2$** | 29.7 (1.6)<br>28.8 | 30.6 (2.8)<br>30.3 | 31.2 (2.1)<br>30.4 | 30.1 (2.2)<br>29.4 |
| **HbA1c, %** | 5.6 (0.2)<br>5.5 | 5.5 (0.3)<br>5.7 | 5.6 (0.3)<br>5.6 | 5.5 (0.2)<br>5.5 |

BMI: body mass index, HbA1c: hemoglobin A1c, MAD: multiple ascending dose, N: number of participants in analysis set, SD: standard deviation

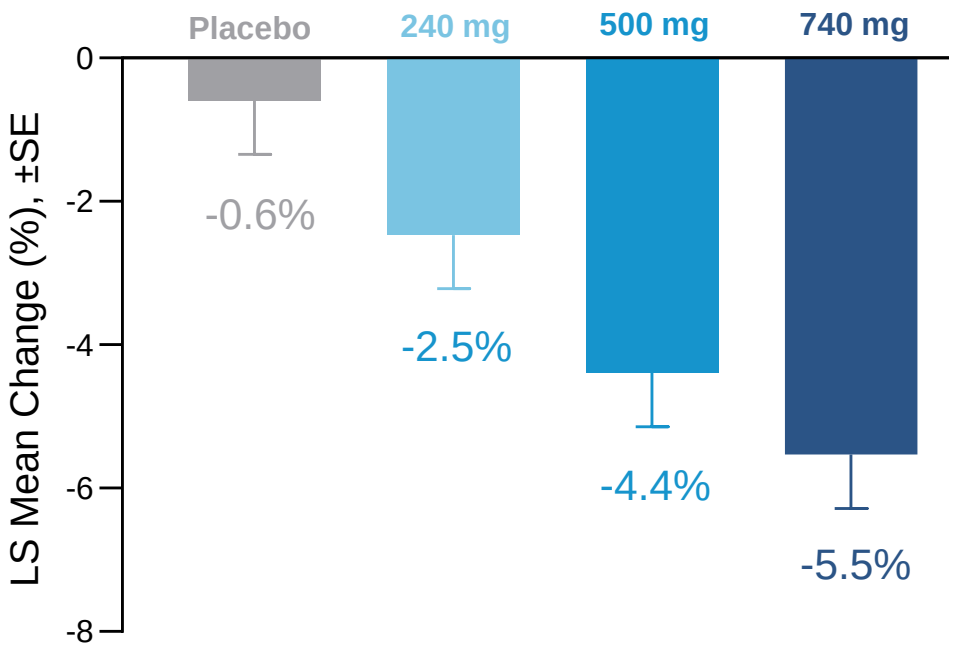
# TERN-601 Showed Dose-Dependent 28-Day Mean Weight Loss Up to 5.5%



## Mean Body Weight Change from Baseline (kg)




## Mean Body Weight Change from Baseline (%)

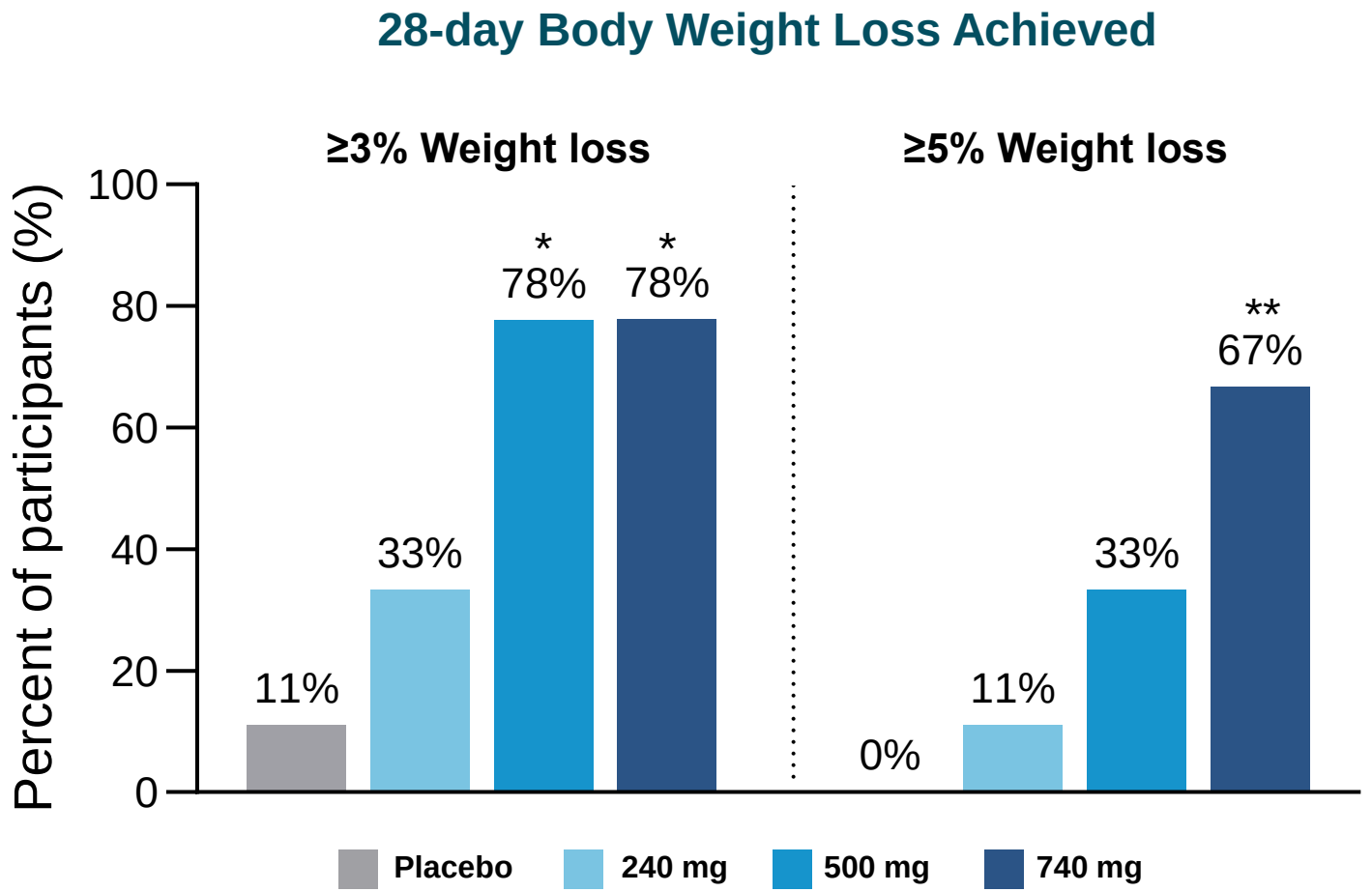



| | | | | |
|---|---|---|---|---|
| N | 9 | 9 | 9 | 9 |
| PBO-adjusted | - | -1.9% | -3.8% | -4.9% |
| P-value | - | <0.1 | <0.01 | <0.0001 |

*p-value <0.1; **p-value <0.01; ***p-value <0.001, ****p <0.0001
LS: Least Squares, N: number of participants in analysis set, PBO: placebo, SE: standard error
Note: 1 participant (240mg) discontinued study early due to unrelated Grade 1 AE (menstrual bleeding determined to be unrelated to study drug); participant was replaced

# Clear Dose Response With 67% of Participants Losing ≥ 5% Baseline Body Weight at Top Dose



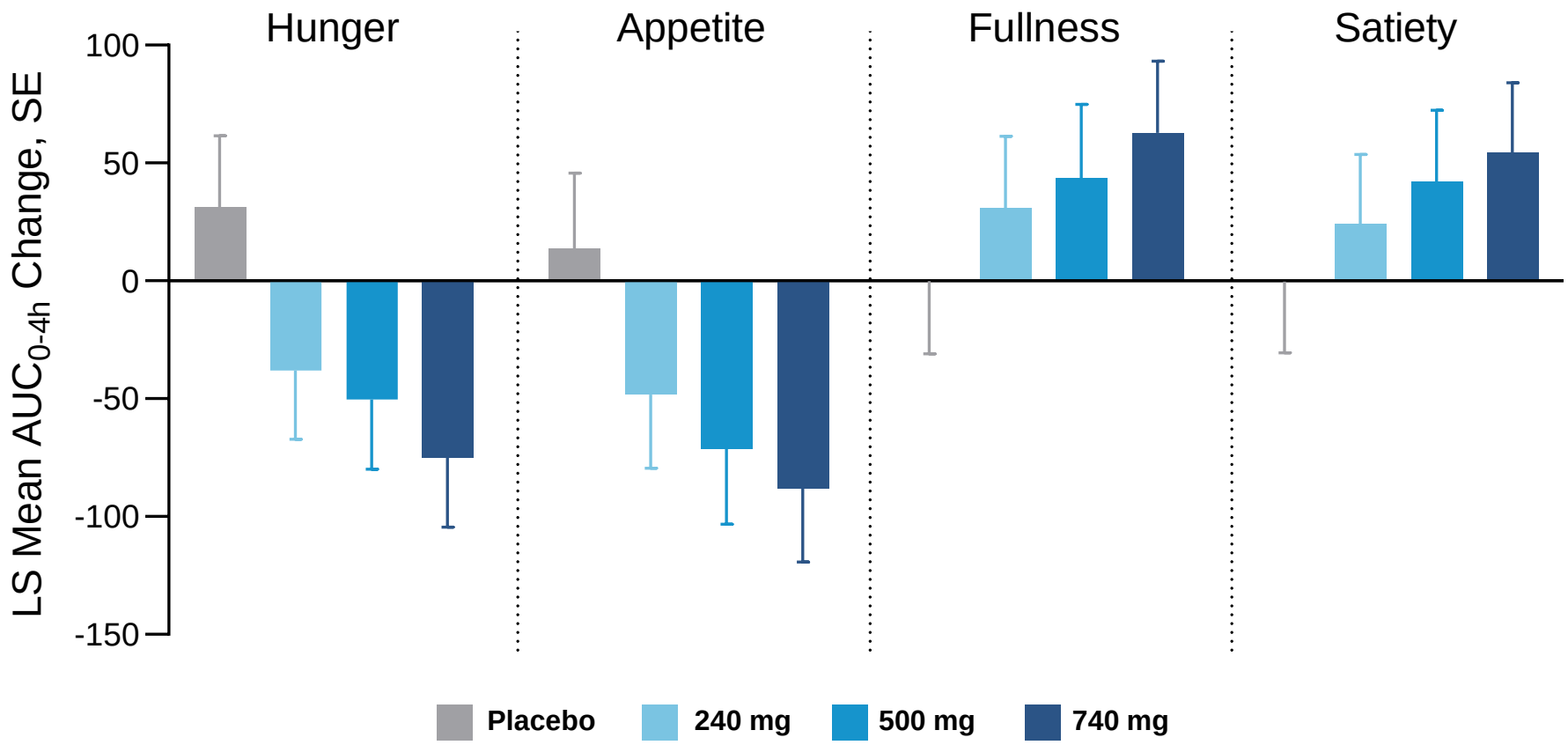



*p-value <0.1; **p-value <0.01, relative to placebo

# Meaningful Changes in Hunger/Satiety Scores Seen at All Doses with Clear Dose Relationship



## Day 27 Change from Baseline – Participant Appetite Questionnaire




Data based on patient-reported appetite and satiety scores measured using the visual analog scale (0-100 mm)
$AUC_{0\text{-}4hr}$ = area under the curve from timepoint 0 to 4 hr (hr.mm), LS: least squares, SE: standard error

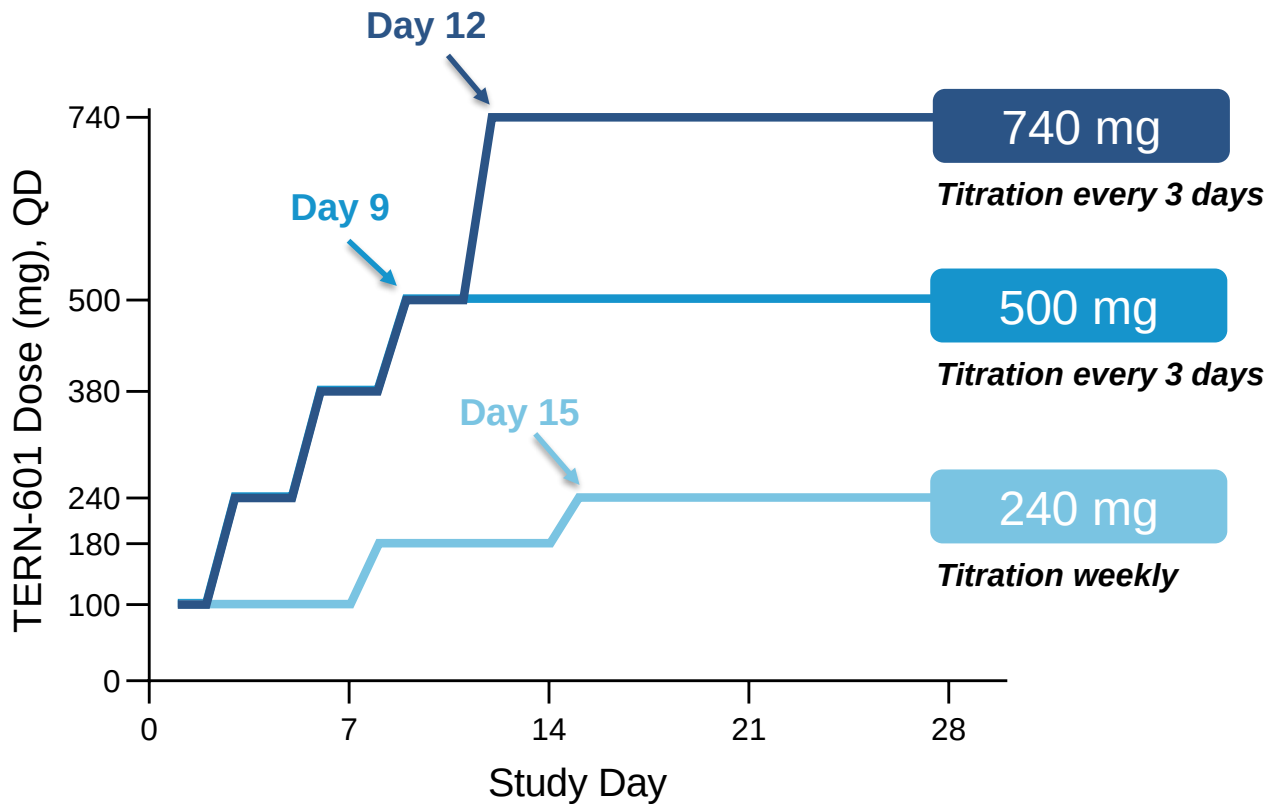
# 28-Day MAD Design Assessed Tolerability of Fast Titration to Target Doses



*Well tolerated despite fast titration suggests potential for improved tolerability in subsequent studies with slower titration*

- Safety / tolerability data from completed cohorts guided titration speed and target dose for subsequent cohorts
- Primary measures of tolerability guiding escalation / titration decisions were:
  - Dose interruptions / reductions / discontinuations
  - Severity of GI AEs

**All Cohorts Completed Titration Within the First 2 Weeks**




GI AEs: gastrointestinal adverse events, MAD: multiple ascending dose, QD: once-daily

# TERN-601 Was Well Tolerated With Unremarkable Safety Findings Despite Rapid Titration to Target Doses

- No drug-related discontinuations, interruptions or dose reductions
  - No dose related adverse events
  - Adverse events were generally mild and evenly distributed across arms, including placebo
  - No drug-related serious adverse events

- Favorable safety profile with no severe or serious AEs
  - >95% of treatment emergent adverse events were mild (Grade 1)

- No clinically meaningful changes in liver enzymes
  - Liver enzymes remained < 1.5X ULN while on treatment at all doses

- Majority of GI-related AEs mild in severity despite fast titration
  - GI AEs consistent with class increased with faster titration to target doses, as expected, and were not dose limiting

# Compelling 28-Day Data Amongst Oral GLP-1RA Peers



| | TERN-601 | danuglipron | GSBR-1290 | orforglipron | RGT-075 | CT-996 |
|---|---|---|---|---|---|---|
| ≥3% Placebo-Adjusted Weight Loss | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| No Dose Interruptions or Reductions Due to AEs | ✓ | ✗ | ✓ | ? | ✗ | ✗ |
| No Drug-Related AE Discontinuations | ✓ | ✗ | ✓ | ✗ | ✗ | ✓ |
| No Severe TEAEs | ✓ | ✗ | ✓ | ✓ | ✓ | ✓ |
| Rapid Dose Titration (>50% of Days at Highest Dose) | ✓ | ✓ | ✗ | ✗ | ✗ | ✗ |

Note: Assessments based on entirety of Phase 1 28-day datasets of peer compounds (any/all doses/cohorts); no head-to-head study has been conducted with TERN-601 against the other drug product candidates. Differences exist in study designs and conditions, and caution should be exercised when comparing data across studies. Data are shown for illustrative purposes only.
Sources: danuglipron: Saxena A, et al. *Nature Medicine*. 2021;27:1079-87; GSBR-1290: Structure Therapeutics Corporate Presentation; GSBR-1290 Phase 1b MAD Results. 2023 September 29; orforglipron: Pratt E, et al. *Diabetes Obes Metab*. 2023;25:2642-49; RGT-075: Priner M. et al. *Diabetes* 2022;71(Supplement_1):94-LB; CT-996: Presented at the 60th European Association for the Study of Diabetes Annual Meeting. Safety, Pharmacokinetics and Pharmacodynamics of CT-996, an Oral Small-Molecule, Signal-Biased GLP-1 Receptor Agonist Over 4 Weeks in Adults with Obesity. 11 September 2024.

AE: adverse event, GLP-1R agonist: glucagon-like peptide-1 receptor agonist, TEAE: treatment emergent adverse event

# Distinct Drug Properties May Confer Advantages For an Orally-Dosed GLP-1R Agonist

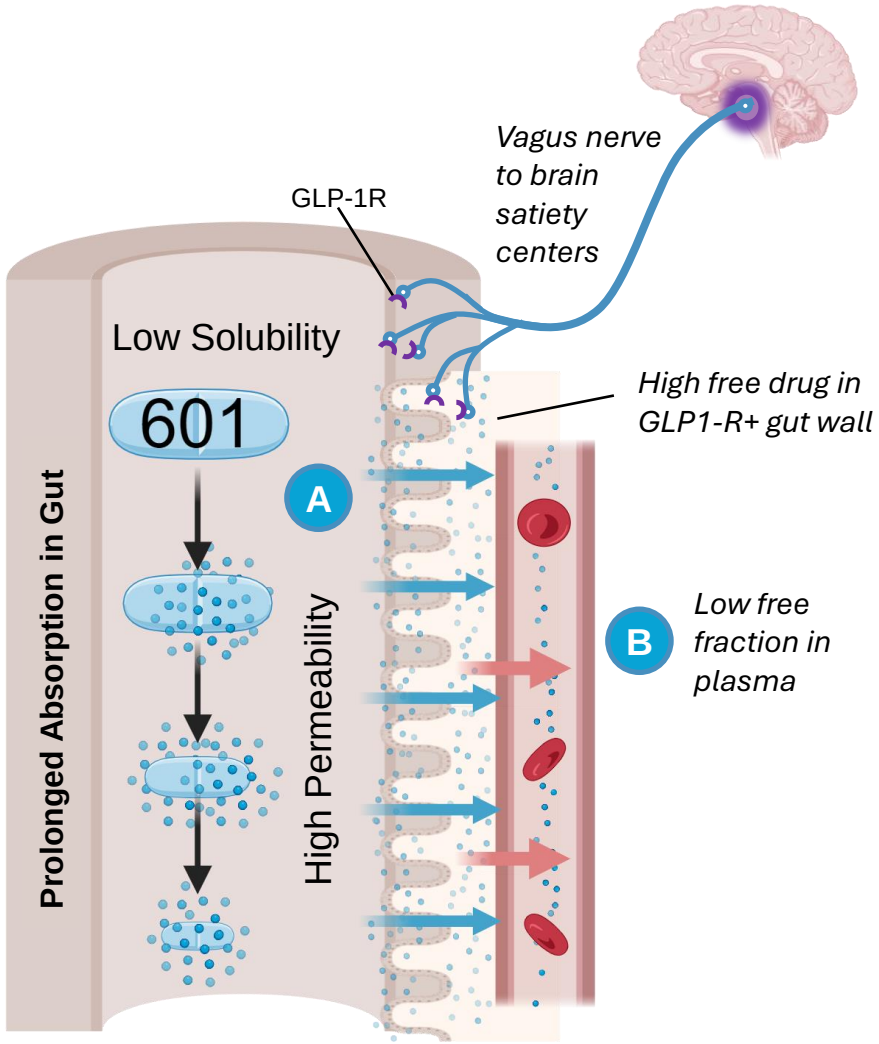


| | TERN-601 Property | Advantage |
|---|---|---|
| Drug Product | Tablet | Convenient once-daily oral dosing |
| Solubility | Low | Prolonged absorption and flat PK curve |
| Gut Permeability | High | |
| Gut wall: Plasma Concentration Ratio | High | High levels of GLP-1R activation in gut |
| Plasma Protein Binding | High | Allows high doses with good tolerability |

GLP-1R: glucagon-like peptide-1 receptor; PK: pharmacokinetic

# Distinct Properties Enable Tolerable Target Doses that Achieve Robust GLP-1R Activation and Flat PK Curve

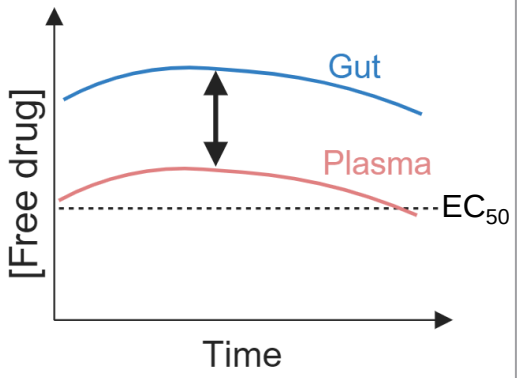





**A**

Low solubility & high permeability results in:

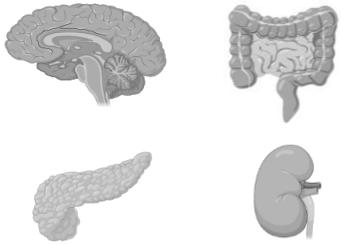
- **Prolonged absorption** and **flat PK curve** allowing **QD dosing**
- **High drug levels in gut wall** that strongly activate GLP-1R in gut triggering satiety centers in brain




**B**

Low free fraction may allow:

- **Tolerable higher doses** that drive both **gut and systemic GLP-1R** activation



GLP-1R: glucagon-like peptide-1 receptor, PK: pharmacokinetic, QD: once-daily
$EC_{50}$: concentration at which 50% of maximal activity is observed

# TERN-601 Well Positioned for Subsequent Studies: Plan to Initiate Phase 2 in 2025

| Clinical Data To Date: | | Potential Impact on Future Development: |
|---|---|---|
| ✓ Thorough exploration of dose range | → | **No new dose range exploration anticipated** |
| ✓ Well tolerated despite fast titration scheme | → | **Improved tolerability with slower titration** |
| ✓ Flat PK with sustained target coverage | → | **Compelling weight loss over longer durations** |
| ✓ Robust PD effects at all dose levels | → | **Optionality to pursue high/low doses for various patient segments** |

PD: pharmacodynamic, PK: pharmacokinetic

# Next Steps for TERN-601 in Obesity

*Evaluating paths to run a comprehensive, efficient and expedient trial in Phase 2*

- ✓ **Positive Phase 1**
- ✓ **Operational and CMC Readiness**

## Next Steps to Finalize Phase 2 Plans

- Gather additional feedback from scientific advisors based on the Phase 1 data
- Design Phase 2 to be informative and support an expeditious path to the pivotal trial
- Solicit regulatory feedback on development plan
- Plan to initiate Phase 2 in 2025

# TERN-800 Series

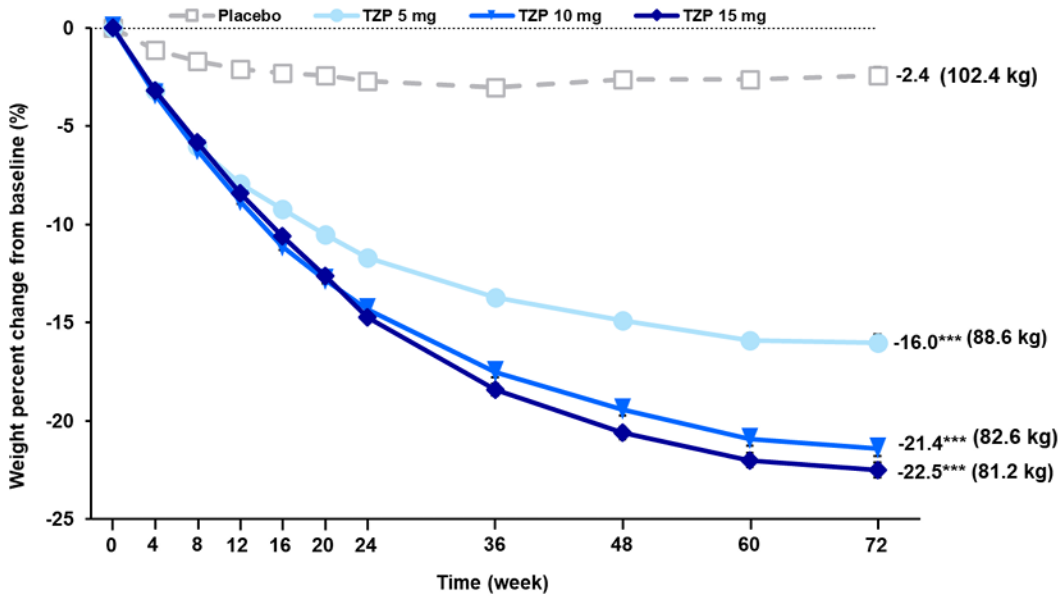
- Prioritizing efforts on nominating a GIPR antagonist development candidate
- Candidate nomination activities ongoing
- Focused on potential first-in-class GIPR modulators

# GIPR Modulators Have Shown High Potential in Weight Loss (~15% - ~20%)

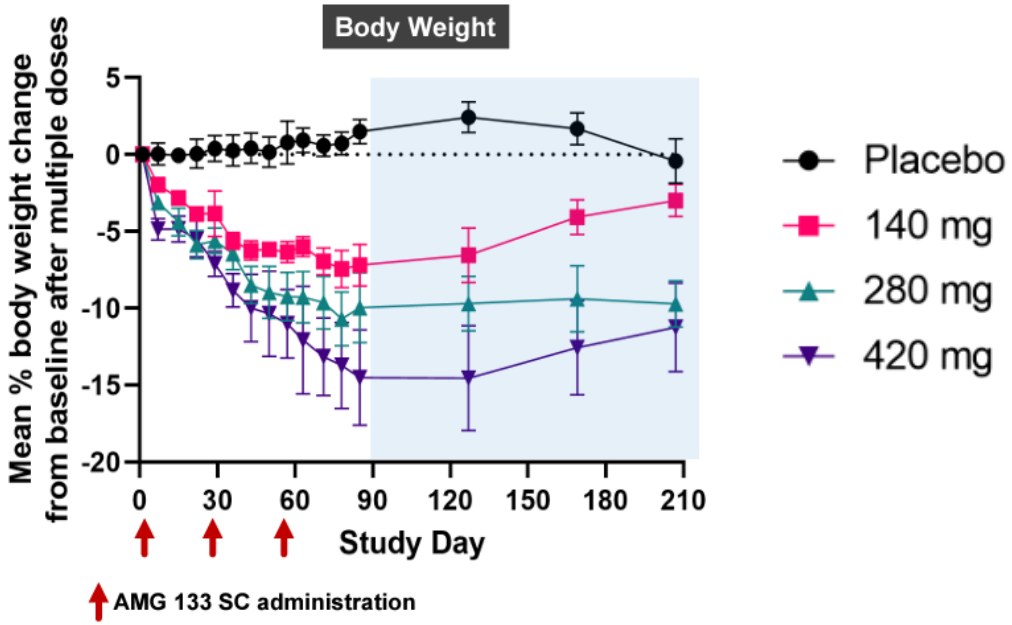


*Terns' GIPR discovery efforts are ongoing; prioritizing GIPR antagonist for candidate nomination*

**tirzepatide**, a GLP-1 / GIPR *agonist*, showed ~20% mean weight loss over 72 weeks:




**AMG-133**, a GLP-1 agonist / GIPR *antagonist*, also showed significant weight loss up to 150 days:




Source: Campbell Mol Metab. 2021 Apr; 46: 101139; AMGN data disclosure; LLY data disclosure

# TERN-800 Series is Underway: Prioritizing Efforts Towards Nominating a GIPR Antagonist Candidate

## GIPR Antagonist in Lead Optimization

- Prioritizing efforts on nominating a GIPR antagonist development candidate based on in house discoveries and growing scientific rationale supporting GLP-1 agonist & GIPR antagonist combos for obesity


## GIPR Modulator Discovery Efforts Ongoing

- Combining internal chemistry expertise with external synthesis teams to develop initial set of ‘800 series compounds based on improving known scaffolds
- Focused on modulators that can be combined with GLP-1s

TERNS PHARMACEUTICALS

# TERN-501

## Highly-Selective THR-β Agonist

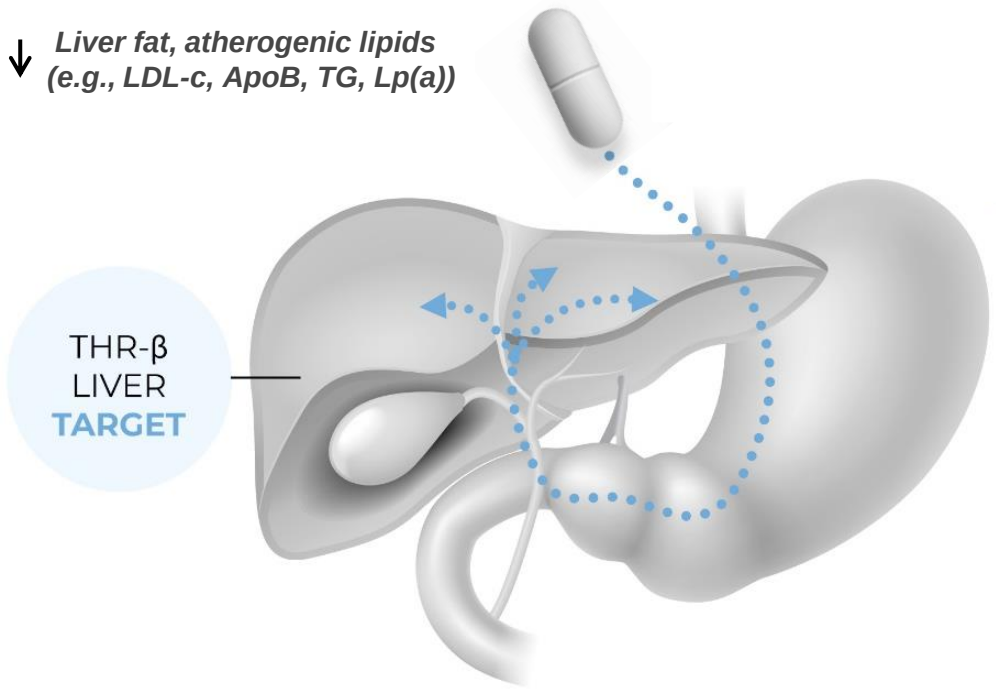
- Potential best-in-class THR-β agonist on efficacy and tolerability based on Phase 2 clinical data
- Emerging superior profile for combinations with GLP-1s to enhance weight loss and metabolic health
- Evaluating opportunities to further develop TERN-501 as a partner therapy for cardiometabolic disease

# TERN-501: A Differentiated THR-β Agonist

## THR-β regulates key aspects of energy metabolism (e.g., fatty acid & lipid synthesis, liver fat removal through fatty acid oxidation)

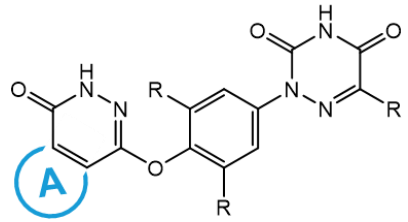
↑ *Sex hormone binding globulin*

↓ *Liver fat, atherogenic lipids (e.g., LDL-c, ApoB, TG, Lp(a))*




## Other THR-β agonists face limitations with off-target effects, unpredictable PK, or need for CYP metabolism

- TERN-501 was screened for **a differentiated, potentially best-in-class profile**:




TERN-501

  - High β/α selectivity → low dose, broad therapeutic window, low CV side effects and improved efficacy
  - Better gastrointestinal profile vs peer molecules → improved tolerability
  - Predictable PK, once-daily dosing with low drug-drug interaction potential → attractive partner for combinations

- **Positive top-line DUET results** announced August 2023: compelling profile of **efficacy, tolerability & combinability** vs peers

Source: Sinha et al. Thyroid (2019); TERN-501 EASL 2020 Poster

# TERN-501 Has Best-in-Class Potential



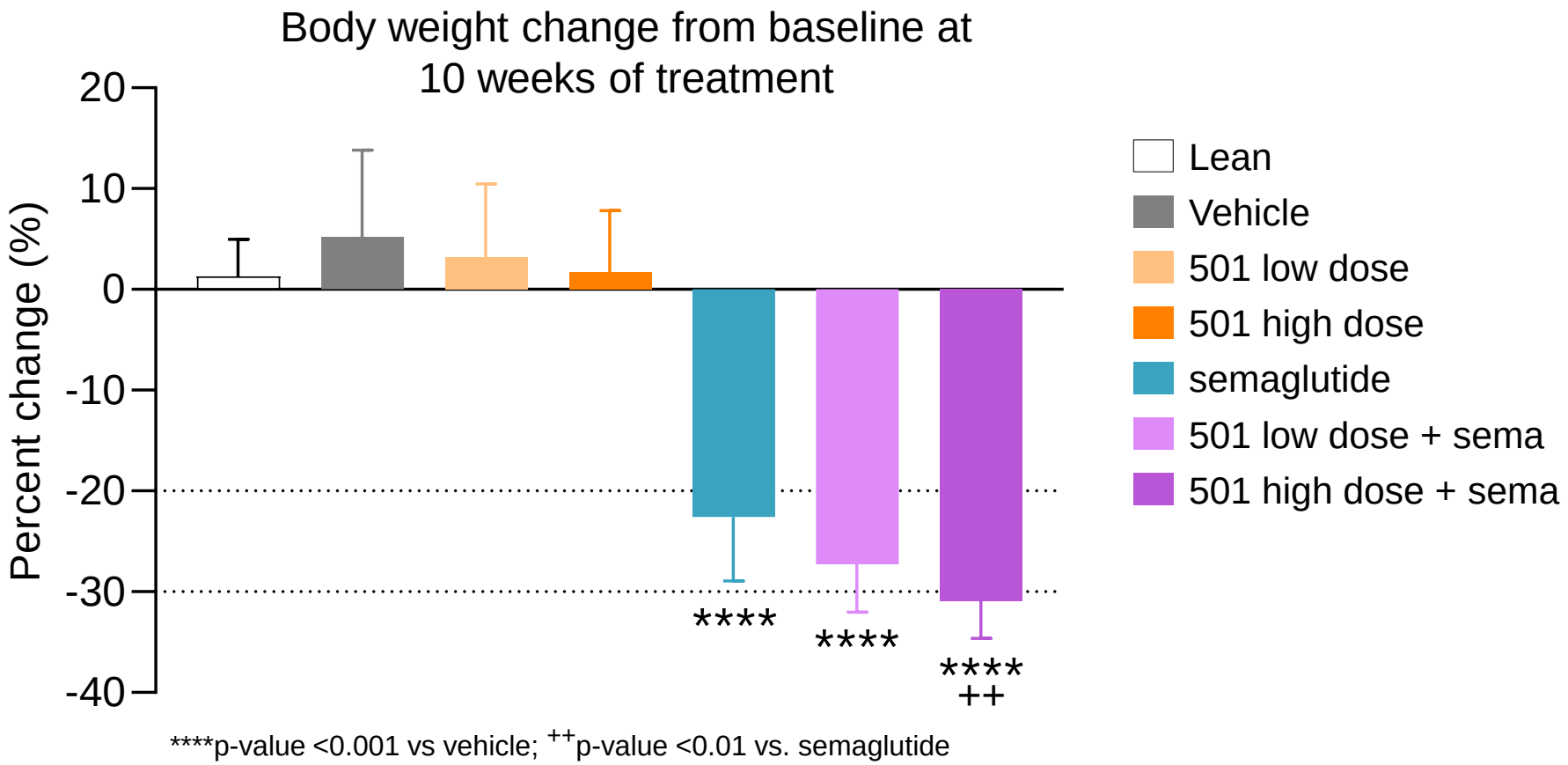
| Comparison of THR-βs | TERN-501 | Resmetirom | VK2089 | ALG-055009 | ASC41 |
|---|---|---|---|---|---|
| **Class Leading Liver Fat Reductions** | ✓ | - | ✓- | ? | - |
| Once-Daily Dosing | ✓ | ✓ | ? | ✓ | ✓ |
| Safe/Efficacious @ Low Dose | ✓ | - | ? | - | - |
| High THR-β / α Selectivity | ✓ | ✓ | - | ✓ | - |
| Combinability (Linear, Non-variable PK) | ✓ | - | - | ✓ | - |
| Not Metabolized by CyP | ✓ | - | - | ✓ | - |
| Lack of Cardiovascular AEs | ✓ | ✓ | - | ✓ | ✓ |
| Lack of Central Thyroid Effects | ✓ | ✓ | - | - | - |
| Lack of GI Adverse Events | ✓ | - | ✓ | - | ✓ |
| **Total Score** | **9** | 4 | 2 | 5 | 3 |

Scoring based on publicly available data; comparisons were not done on a head-to-head basis and includes cross-trial and/or cross-phase comparisons; AEs refer to treatment-related AEs; references available upon request.

# Non-clinical Data Suggests TERN-501 May Augment Weight Loss Effects of GLP-1R Agonist

*Preliminary data in diet-induced obese (DIO) NASH mice*[1]

- Semaglutide induces significant body weight loss after 10-weeks of treatment
- TERN-501 **significantly enhances** body weight loss effects of semaglutide




****p-value <0.001 vs vehicle; $^{++}$p-value <0.01 vs. semaglutide

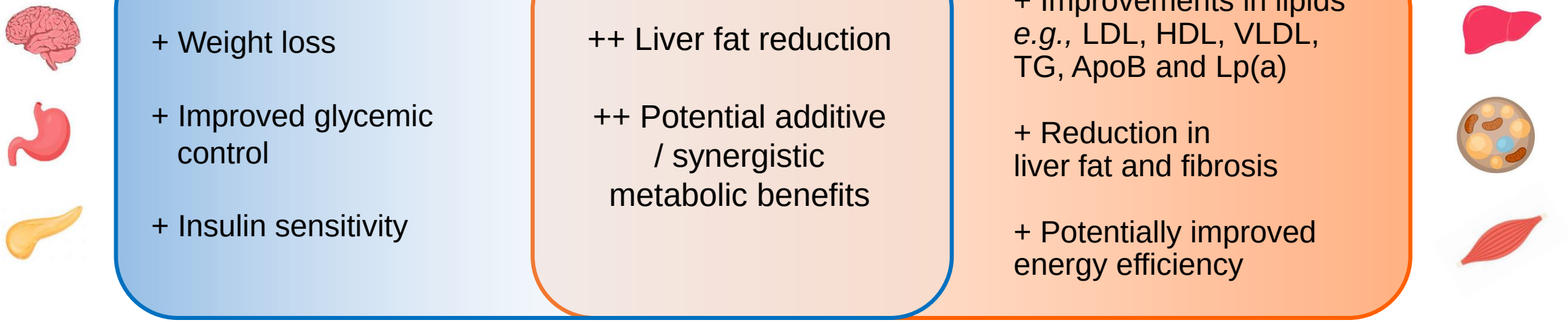
1. Body weight change after 10-weeks of treatment; mice on Gubra amylin high fat, cholesterol, and fructose diet for >35-weeks prior to study start

Note: TERN-501 dosed orally, once-daily; semaglutide dosed subcutaneously, once-daily. The same doses of TERN-501 and semaglutide monotherapy arms were used in combination arms

# Combination of GLP-1 and THR-β Has the Potential to Improve Multiple Metabolic Disorders

*Potential beneficial effects of simultaneously targeting multiple pathways involved in weight control and metabolism*

- Terns is uniquely positioned to develop an oral GLP-1 + THR-β combination



# Conclusions

- Strong Balance Sheet
- Multiple upcoming milestones

# Strong Financial Position Supports Upcoming Milestones


* As of June 30, 2024, adjusted for net proceeds from the September 2024 offering; shares include common stock and prefunded warrants

# Key Completed and Upcoming Milestones

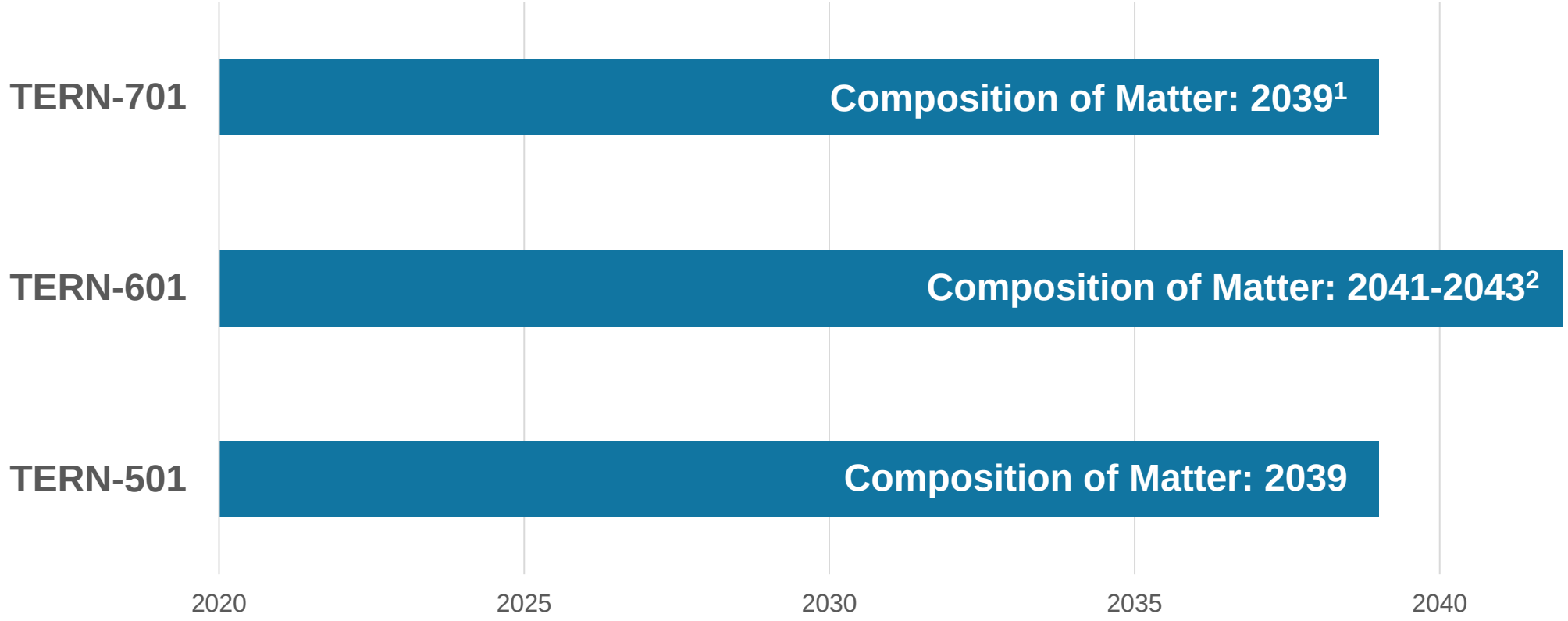
*Multiple clinical milestones expected across Terns' pipeline*

| | 1H 2023 | 2H 2023 | 1H 2024 | 2H 2024 |
|---|---|---|---|---|
| **TERN-701 (Allosteric BCR-ABL)** | | ✓ U.S. Ph 1 Trial initiated (Dec 2023) | | CARDINAL **Interim data from initial Phase 1 cohorts** (Dec 24) |
| **TERN-601 (GLP-1 Agonist)** | | ✓ Phase 1 trial initiated (Nov 2023) | | ✓ **Phase 1 top-line data** (Sept 24) |
| **TERN-501 (THR-β Agonist)** | | ✓ DUET MASH Phase 2a combo trial top-line data (Aug 2023) | | |

Note: Check mark (✓) denotes completed milestones, all other milestones are anticipated future milestones. Relative position of completed or expected milestones on illustration does not denote or imply chronological order

# Terns: Robust Intellectual Property

- Patent exclusivity could be extended for a period of up to 5 years through patent term extension
- Issued patents and pending applications cover polymorphs, drug product formulations and combo approaches




All figures above denote US timelines only, similar coverage periods assumed for other territories.

1. As a designated orphan drug, TERN-701 may be entitled an additional 30 month stay
2. We own multiple composition of matter patent application families directed to our GLP-1R agonist compounds, including TERN-601, for which claims have not yet been granted. Any patents that may issue from applications in these families are generally projected to expire in 2041-2043, not including any patent term adjustments and/or patent term extensions that may be available.

# Mission. Vision. Core Values.

## MISSION

To advance transformative medicines that address serious diseases

## VISION

To pioneer significant innovations across the lifecycle of drug development

TRUST
EVOLVE
RESPECT
NURTURE
SOAR

**Trust**: empowered and accountable to do the right thing

**Evolve**: learning and growing from our successes, failures and changes in the environment

**Respect**: celebrating the diversity of our backgrounds, opinions and experiences

**Nurture**: fostering internal and external relationships

**Soar**: aiming high and being your best

# Appendix

# CARDINAL Design Features Multiple Differentiation Opportunities for TERN-701 in the CML Landscape

*Improved ability to dose optimize TERN-701*

- Starting dose that appears safe and clinically active
- Opportunity to efficiently develop TERN-701 as a dose-optimized allosteric inhibitor for CML

*Inclusion of 2L chronic phase CML patients*

- Better positions Terns to move directly to a 2L (or earlier line) pivotal study
- No allosteric inhibitor currently approved for 2L CML patients

*Allosteric MoA excitement*

- High interest given limited allosteric inhibitor treatment options
- Reduced competition for trial enrollment

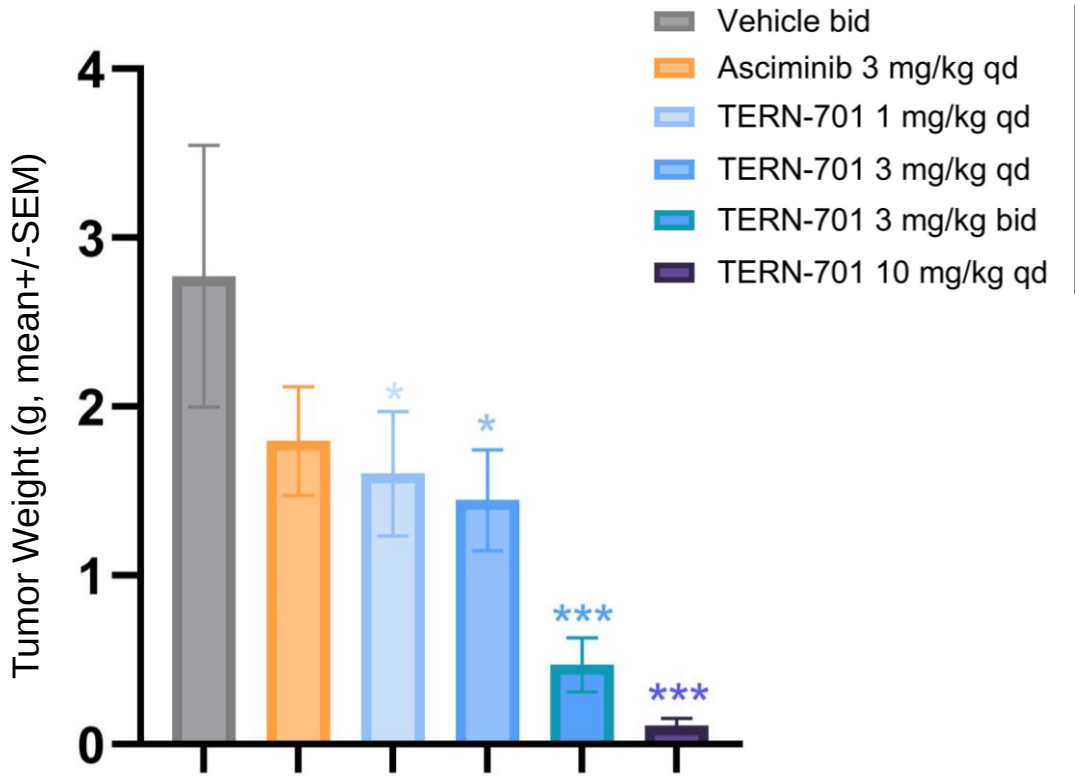
**Opportunities for TERN-701 to be uniquely positioned → Initial data expected in Dec 2024**

Note: 2L: 2nd line, MoA: mechanism of action

# TERN-701 Showed a Greater Anti-Tumor Effect vs. asciminib in Non-clinical Models of CML

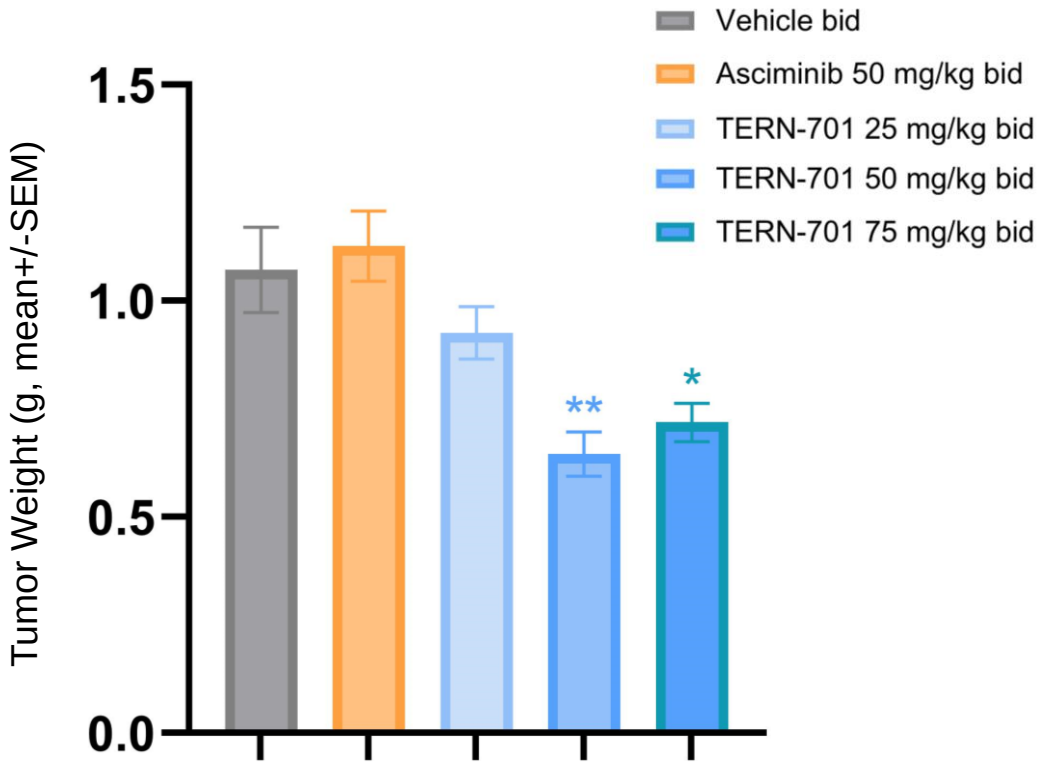
## K562 Xenograft

*(Day 14)*




## Ba/F3 BCR-ABL1-T315I Allograft

*(Day 15)*



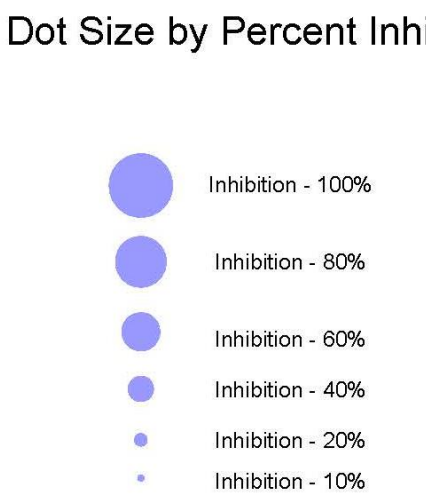

Source: ASPET TERN-701 poster

Note: NOD-SCID (K562) and BALB/c nude mice (Ba/F3T315I) were implanted with CML cells, randomized, and administered the indicated TKIs once tumor volumes reached a mean size of 110 mm. Mean tumor weights for each of the treatment groups at the conclusion of the study. All error bars represent the SEM. *p<0.05, **p<0.01, ***p<0.001.
asciminib was utilized as the free base, TERN-701 was formulated as an optimized salt form

# TERN-701 Also Demonstrated High Selectivity on a Broad Kinase Panel, Suggesting Reduced Potential for Off-Target Activity

**TERN-701** was assessed at 1 µM against a panel of 375 kinases

No kinase, including wild-type ABL1, was observed to be inhibited by >50% → reduced potential for TERN-701 off-target activity

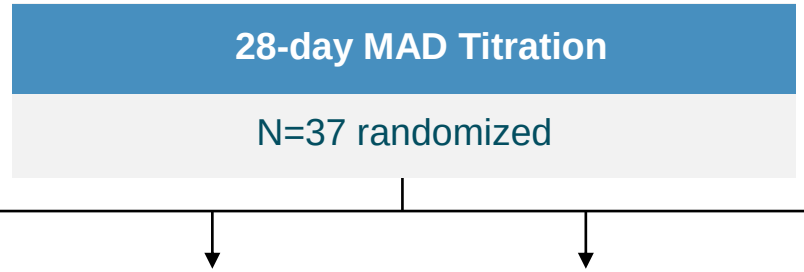




Source: ASPET TERN-701 poster

# No Drug-Related Discontinuations, Interruptions or Dose Reductions






| | Placebo pooled (N=9) | 240 mg (N=10) | 500 mg (N=9) | 740 mg (N=9) |
|---|---|---|---|---|
| **Completed Treatment** | 9 (100%) | 9 (90%)* | 9 (100%) | 9 (100%) |
| **Discontinued Study Drug Due to Related-AE** | 0 | 0 | 0 | 0 |
| **Dose Interruption Due to AE** | 0 | 0 | 0 | 0 |
| **Dose Reduction Due to AE** | 0 | 0 | 0 | 0 |

* 1 participant discontinued study early due to unrelated Grade 1 AE (menstrual bleeding determined to be unrelated to study drug); participant was replaced
AE: adverse event, MAD: multiple ascending dose, N: number of participants in analysis set

# Favorable Safety Profile with No Severe or Serious AEs



*>95% of treatment emergent adverse events were mild (Grade 1)*

## Treatment Emergent AEs by Maximum Severity

| Event, N (%) | Placebo pooled (N=9) | 240 mg (N=10) | 500 mg (N=9) | 740 mg (N=9) |
|---|---|---|---|---|
| Grade 1 (Mild) | 5 (55.6%) | 5 (50%) | 9 (100%) | 3 (33.3%) |
| Grade 2 (Moderate) | 0 | 1 (10%) | 0 | 6 (66.7%) |
| Grade ≥3 (Severe) | 0 | 0 | 0 | 0 |
| Serious Adverse Events | 0 | 0 | 0 | 0 |

- Majority of AEs were consistent with known effects of GLP-1R agonist class (e.g. gastrointestinal)
- No clinically meaningful changes in ECGs, heart rate or blood pressure

AE: adverse event, ECG: electrocardiogram, N: number of participants in analysis set, GLP-1R agonist: glucagon-like peptide-1 receptor agonist

# No Clinically Meaningful Changes in Liver Enzymes



*Liver enzymes remained ≤ 1.5X ULN while on treatment at all doses*

| Mean (SD) Change from Baseline to Day 29 | Placebo pooled (N=9) | 240 mg (N=10) | 500 mg (N=9) | 740 mg (N=9) |
|---|---|---|---|---|
| **ALT (U/L)** | -3.4 (7.6) | -4.0 (6.4) | -9.0 (6.4) | -9.0 (9.7) |
| **AST (U/L)** | -2.4 (4.6) | -1.3 (3.3) | -7.0 (4.6) | -5.1 (8.7) |
| **Bilirubin (mg/dL)** | 0.01 (0.11) | 0.15 (0.14) | 0.09 (0.35) | 0.18 (0.47) |

ULN: upper limit of normal; ALT: alanine transaminase; AST: aspartate transaminase; N: number of participants in analysis set; SD: standard deviation

# Majority of GI-Related AEs Mild in Severity Despite Fast Titration



*GI AEs consistent with class increased with faster titration to target doses, as expected, and were not dose limiting*

## Treatment Emergent GI AEs by Maximum Severity

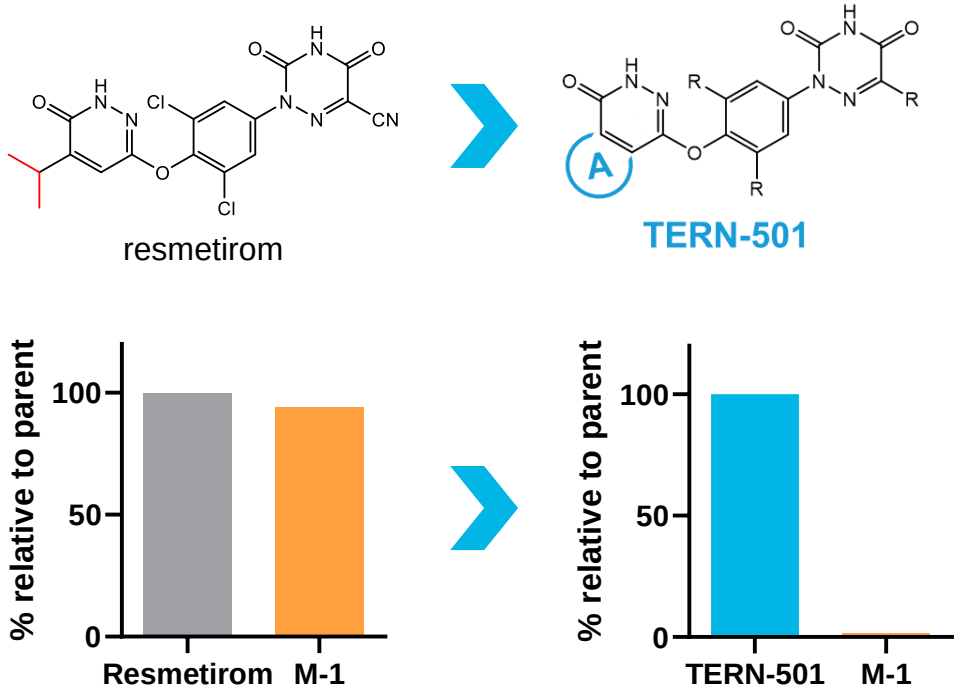
| Event, N (%) | Placebo pooled (N=9) | 240 mg (N=10) | 500 mg (N=9) | 740 mg (N=9) |
|---|---|---|---|---|
| **Nausea** | | | | |
| Grade 1 (Mild) | 2 (22.2%) | 0 | 7 (77.8%) | 2 (22.2%) |
| Grade 2 (Moderate) | 0 | 0 | 0 | 6 (66.7%) |
| **Vomiting** | | | | |
| Grade 1 (Mild) | 0 | 0 | 4 (44.4%) | 6 (66.7%) |
| Grade 2 (Moderate) | 0 | 0 | 0 | 1 (11.1%) |
| **Diarrhea** | | | | |
| Grade 1 (Mild) | 0 | 0 | 2 (22.2%) | 2 (22.2%) |
| Grade 2 (Moderate) | 0 | 0 | 0 | 0 |
| **Constipation** | | | | |
| Grade 1 (Mild) | 0 | 1 (10.0%) | 0 | 5 (55.6%) |
| Grade 2 (Moderate) | 0 | 1 (10.0%) | 0 | 0 |

AE: adverse event, GI: gastrointestinal, N: number of participants in analysis set, GLP-1R agonist: glucagon-like peptide-1 receptor agonist

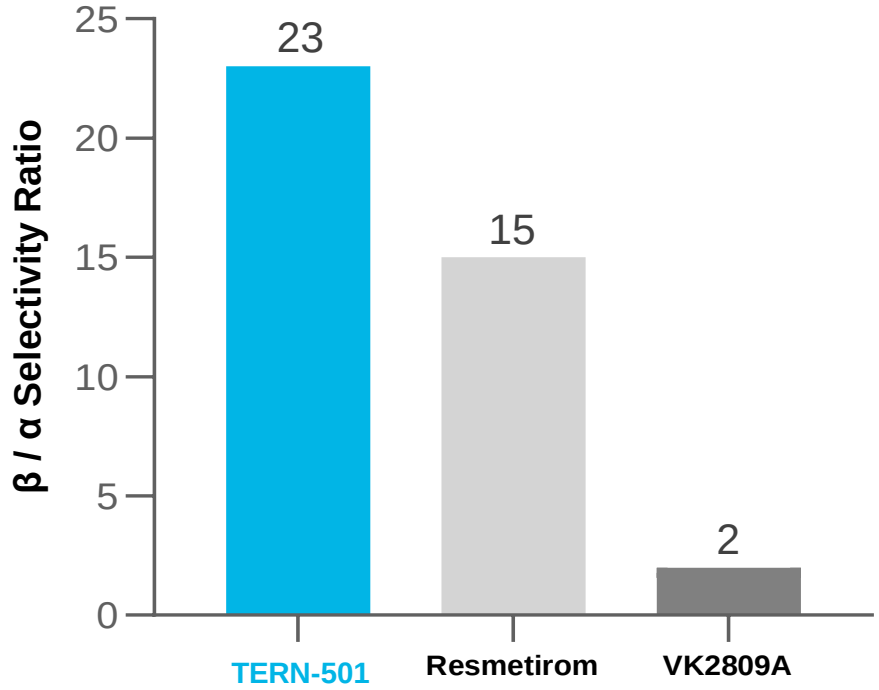
# TERN-501 Improved PK & THR-β Selectivity

*Differentiated and excellent candidate for co-formulation*

## TERN-501: Improved Pharmacokinetics




## TERN-501: Improved THR-β ratio

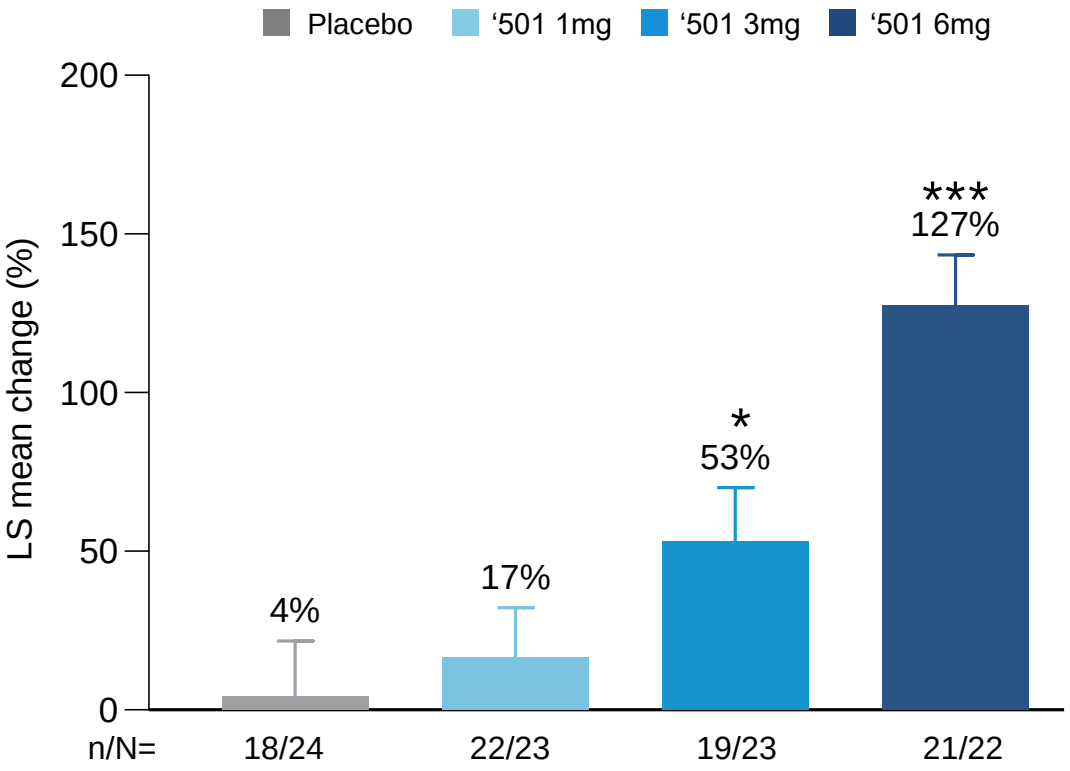



Source: (Left) TERN-501 metabolite data in hepatocytes from pre-clinical Terns ADME study, resmetirom metabolite data in human (80mg/day) from US provisional 62/516,594
(Right) using methods described in J. Med. Chem. 2014, 57, 3912−3923

# TERN-501 Demonstrated Compelling SHBG Increases and Liver Fat Reduction with Convenient Once-Daily Dose

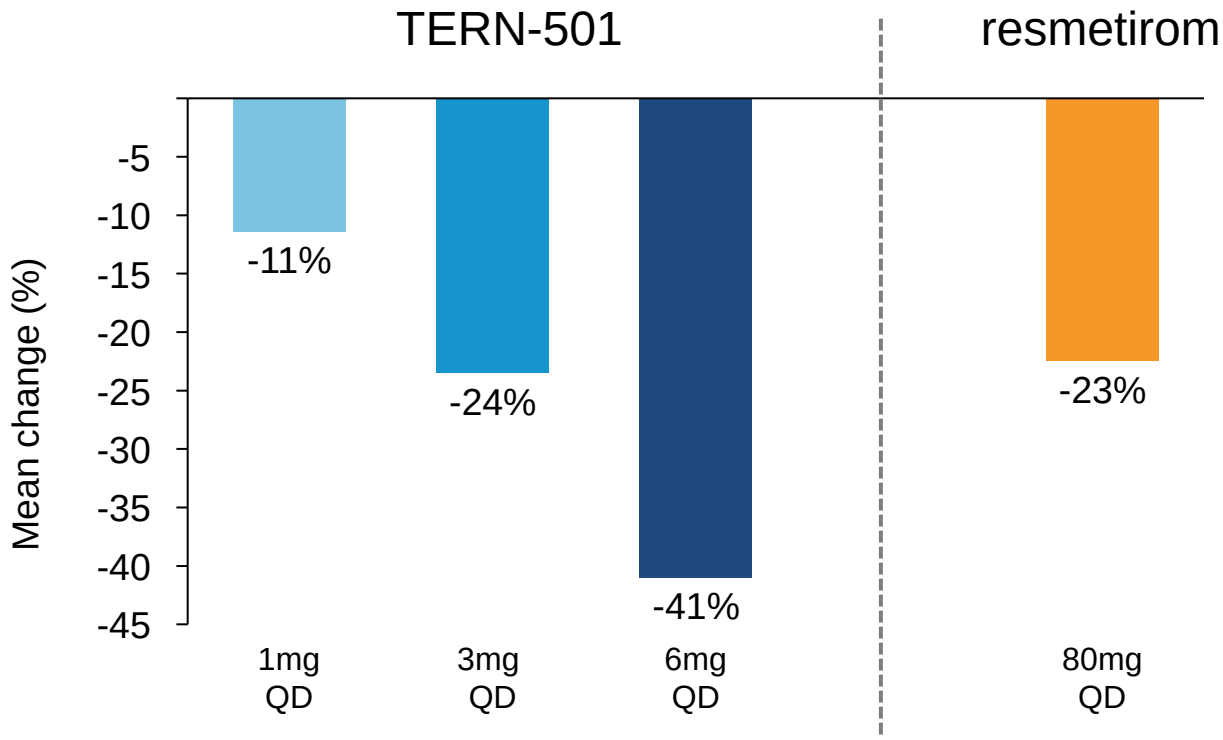
DUET

## TERN-501 Relative Change in SHBG (Week 12)




*p-value <0.05; **p-value <0.01; ***p-value <0.001 for monotherapy vs. placebo
n=number of patients with data available; N=number of patients in analysis set
SHBG: sex hormone binding globulin

## Placebo Adjusted Mean Relative Change in Liver Fat from Baseline (MRI-PDFF at Week 12)†




† The Phase 2 clinical trial evaluating resmetirom was conducted by another party in a similar patient population with different protocols at different sites and at different times from the DUET trial. Results do not reflect a head-to-head trial and are shown for illustrative purposes only.
Source: MDGL: Harrison et al. Lancet (2019), Table 2, placebo response -10.4%
Baseline liver fat % (n): TERN-501: 1mg QD 17% (n=23), 3mg QD 20% (n=23), 6mg QD 17% (n=22); resmetirom: 80mg QD 20% (n=84)

# Drug-related AEs of Interest for TERN-501 Were Balanced Among Treatment Arms

DUET

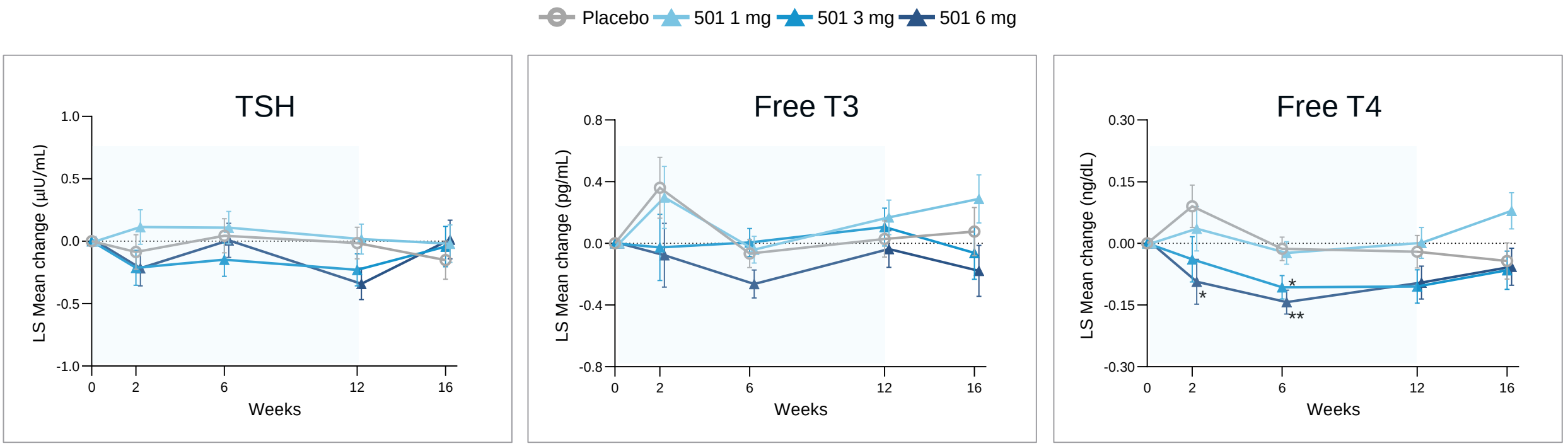
*No differences seen between TERN-501 and placebo; no drug-related CV events observed*

| *Participants, n* | Placebo (N=24) | TERN-501 1mg (N=23) | TERN-501 3mg (N=23) | TERN-501 6mg (N=22) |
|---|---|---|---|---|
| **Gastrointestinal disorders** | **2** | **1** | **3** | **2** |
| *Diarrhea* | *1* | *1* | *2* | *1* |
| *Nausea* | *0* | *0* | *1* | *0* |
| *Abdominal distension* | *0* | *0* | *0* | *0* |
| *Abdominal pain (upper)* | *0* | *0* | *0* | *0* |
| *Constipation* | *0* | *0* | *0* | *1* |
| *Dyspepsia* | *0* | *0* | *0* | *0* |
| *Frequent bowel movements* | *1* | *0* | *0* | *0* |
| *Vomiting* | *1* | *0* | *0* | *0* |
| **Cardiac disorders** | **0** | **0** | **0** | **0** |
| **Pruritus** | **2** | **0** | **1** | **2** |

Drug-related: deemed by study investigator as related or possibly related to study drug.

# No Signs of Central Thyroid Axis Modulation Observed

DUET




- Mean changes in thyroid axis hormones (TSH, free T3, and free T4) at Week 12 were similar to placebo and remained within normal limits in all TERN-501 containing arms (monotherapy and combination [not shown])
  - No difference from placebo in TSH and free T3 at any time point
  - Initial transient decreases in free T4 up to Week 6 in TERN-501 3 mg and 6 mg arms, as observed with other THR-β agonists; no difference from placebo at Week 12

*p-value <0.05; **p-value <0.01 for monotherapy vs. placebo
The blue shaded area indicates treatment period
T3, triiodothyronine; T4, thyroxine; TSH, thyroid stimulating hormone
Taub et al. *Atherosclerosis*. 2013 Oct;230(2):373-80. Harrison et al. *Lancet*. 2019 Nov 30;394(10213):2012-2024. Lian et al. *Meeting of the American College of Cardiology*. 2016. Charfi et al. *Hepatology* 2022 Oct; 76:S638