TERNS PHARMACEUTICALS

TERN-701 Phase 1 CARDINAL Study Initial Data from Dose Escalation

NASDAQ: TERN

December 3, 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 but not limited to statements regarding beneficial characteristics and potential therapeutic effects of our product candidates and compounds, projections of market potentials and industry trends, discussions of timelines and expectations related to our product candidates and clinical trials, including with respect to potential trial design, milestones and the availability of data, as well as information about the Company objectives or other prospects, and plans, 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 will occur at all. These risks are not exhaustive. 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. 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.

This presentation discusses product candidates that are investigational only and have not yet been approved for marketing by the U.S. Food and Drug Administration. No representation is made as to the safety or effectiveness of these product candidates for the use for which such product candidates are being studied. Data presented for our product candidates and other agents are not based on head-to-head trials and are based on publicly available data, which include cross-trial and/or cross-phase data and information.

Agenda and Participants

- **Opening Remarks** / Amy Burroughs, CEO
- **CARDINAL Interim Phase 1 Data** / Emil Kuriakose, CMO
- **Closing Remarks** / Amy Burroughs
- **Management Q&A** / Amy Burroughs, Emil Kuriakose, Mark Vignola, CFO

Chronic Myeloid Leukemia (CML) is a Chronic and Well-Established Indication, Yet an Unmet Need Still Exists

In 2024, CML therapies represented a ~$5B market opportunity

- ~10K new cases diagnosed in the United States, annually[1]
- U.S. prevalence is expected to triple by 2040[2]
- Majority of patients will take TKI therapy for life[3]

Approximately 40% switch therapy by five years due to intolerance and/or resistance[4]

- Chronic use of 1G, 2G active-site TKIs are associated with multiple AEs due to off target effects[4]
- First approved allosteric, asciminib, is superior to prior generation TKIs[5,6] and has opened up a new class
- There remains opportunity to continue to improve on efficacy, safety, tolerability and ease of use for these patients who are on lifelong therapy

1. American Cancer Society. (Jan 2024) Key Statistics for Chronic Myeloid Leukemia, (Aug 2024). 2. Jabbour E, Kantarjian H. Am J Hematol. (Sep 2022);97(9):1236-1256. 3. Bower H., et al. Journal of Clinical Oncology (Aug 2016);34(24):2851-7. 4. Novartis ASCO 2024 Investor Event. 5. Hughes TP et al. N Engl J Med. 2019;381(24):2315-2326. 6. Hochhaus A, et al. N Engl J Med. Published online 2024 May 31.
1G: first generation; 2G: second generation; AE: adverse events; TKI: tyrosine kinase inhibitors

Allosteric TKIs Represents the Next Generation of CML Medicines, with Superior Therapeutic Potential Over Active-Site TKIs

CML Drug Development by Decade

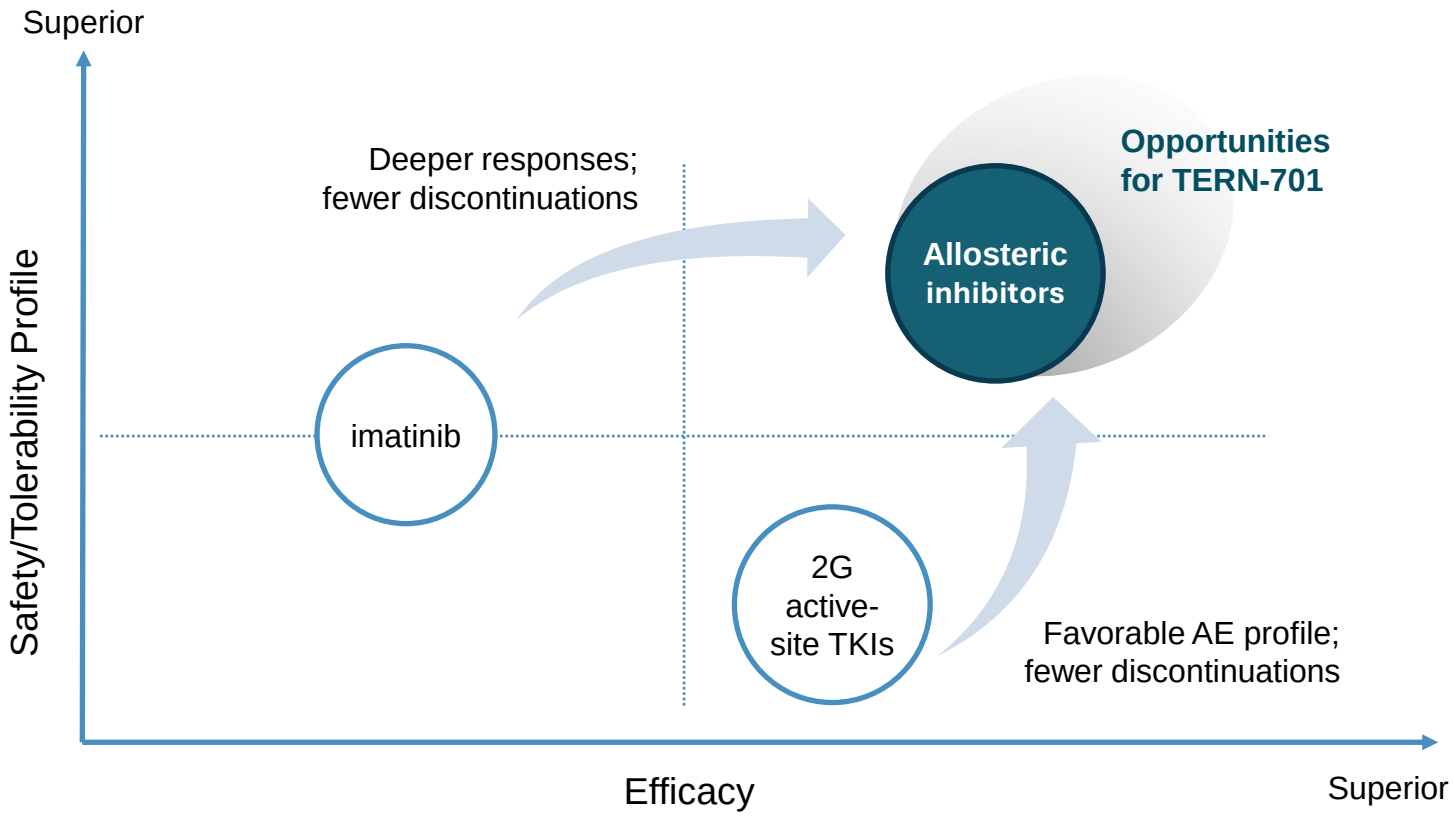
2000s Imatinib (1G active-site TKI) transforms CML from a fatal disease into a chronic, lifelong condition

2010s 2G active-site TKIs improve upon efficacy but with less favorable safety/tolerability

2020s Asciminib is the first approved allosteric BCR-ABL inhibitor, a novel, superior MoA for CML[2,3]

TERN-701 has the **potential to be the best-in-class** allosteric inhibitor

Opportunity for Next Generation, Allosteric BCR-ABL Inhibitors[1]



1. Per Novartis ASCO Investor Event | June 2, 2024. 2. Hughes TP et al. N Engl J Med. 2019;381(24):2315-2326. 3. Hochhaus A, et al. N Engl J Med. Published online 2024 May 31.
1G: 1st generation; 2G: 2nd generation; TKI: dasatinib, nilotinib, bosutinib; AE: adverse event; MoA: mechanism of action; TKI: tyrosine kinase inhibitor

TERN-701 has Early Signs of Differentiation from Asciminib and Opportunity to Achieve a Best-in-Class Profile

	TERN-701 Differentiation Matrix		
	Preclinical[1,2]	Early Clinical (Ph1)[3]	Late Clinical (Pivotal)[#]
Potency ≥ asciminib	✓	— N/A —	— N/A —
Once-daily (QD) dosing	✓	✓	✓
Lack of food effect	✓	✓	✓
Potential for improved efficacy & safety		**Early, encouraging data from** CARDINAL	✓
Potential for simplified label (QD across mutations, improved DDI)			✓

DDI: drug-drug interactions; N/A: not applicable; Ph: phase

1. Zhou et al. ASPET 2023. TERN-701 Preclinical Poster.pdf. 2. Data on File. 3. Anderson et al. SOHO 2024. TERN-701_FE_Poster.pdf

[#] Featured opportunities for TERN-701 are not based on late-stage clinical data and are potential differentiation points that Terns is exploring.

Note: No head-to-head study has been conducted with TERN-701 against asciminib or any other drug or product candidate. Differences exist in study designs and conditions, and caution should be exercised when comparing data across studies. Data and comparisons are shown for illustrative purposes only.

CARDINAL Interim Phase 1 Data

Emil Kuriakose, MD
CMO

TERN-701 Dose Escalation Interim Data Show Compelling Clinical Activity and Encouraging Safety

- **Early, promising safety and efficacy profile in a small number of difficult to treat patients (n=15)[1]**
  - **Compelling molecular responses** in heavily pre-treated patients with high baseline transcripts, and decreases in BCR::ABL1 in the majority of response evaluable patients
  - **Highly encouraging cumulative MMR rate of 50%[2]**
  - **No DLTs, AE-related treatment discontinuations, or dose reductions**
  - **Robust and continuous coverage** over target efficacious exposures at all dose levels
- As of today, 19 patients enrolled in the study with at least three patients enrolled in all escalation cohorts
- Plan to initiate dose expansion in 1H25

1. N=15 as of October 28, 2024 data cut-off
2. 5 of 10 non-T315i mutation patients with 3 or more months of treatment and/or MMR or better at baseline

AE: adverse event; DLT: dose limiting toxicities; MMR: major molecular response

CARDINAL is a Multicenter Global Phase 1 Study of TERN-701 in Patients with Relapsed/Refractory Chronic Phase CML

Dose escalation has enrolled rapidly and is near completion

CARDINAL

Study Population

Chronic phase **2L+** CML patients w/wo BCR::ABL1 mutations who have had:

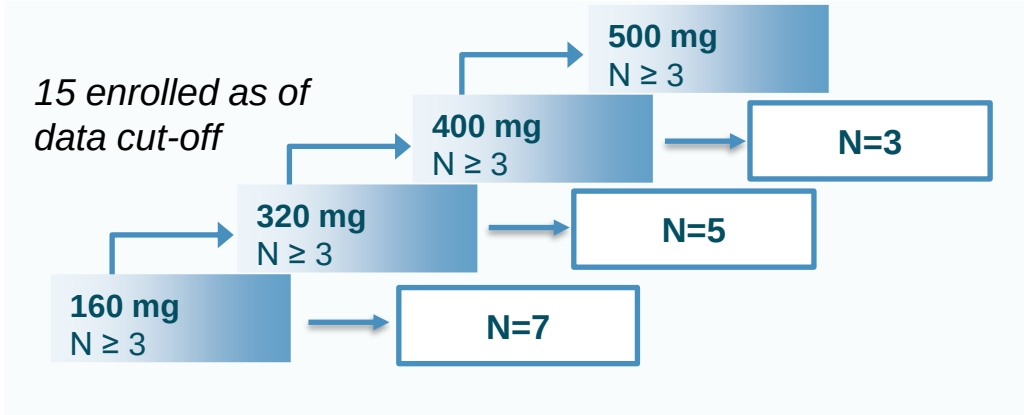
- Treatment failure / suboptimal response to ≥1 2G-TKI

OR

- Treatment failure / suboptimal response / intolerance to any ≥2 active-site TKIs
- Prior asciminib allowed

Part 1 Dose Escalation

TERN-701 Once-daily Monotherapy (N= up to 60)

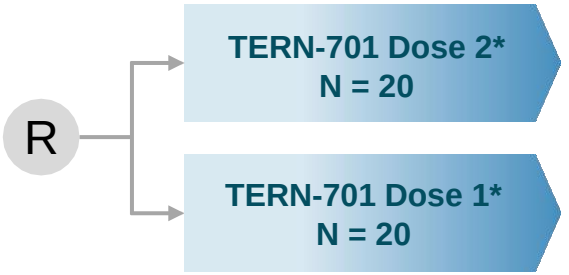


RDE Selection‡

Part 2 Dose Expansion

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

At least 2 dose levels will be selected



Endpoints For Part 1
- Primary: Safety/tolerability
- Secondary: PK, Efficacy

Endpoints For Part 2
- Primary: Efficacy
- Secondary: Safety/tolerability, PK

‡RDE: recommended dose for expansion will be selected following a Part 1 interim analysis
*Dose 1 expected to be ≥ 160mg. Dose 2 targeted be a dose level > 160 mg QD with sufficiently non-overlapping exposures and comparable safety to Dose 1
2G-TKI: dasatinib, nilotinib or bosutinib; PK: pharmacokinetics; TKI: tyrosine kinase inhibitor

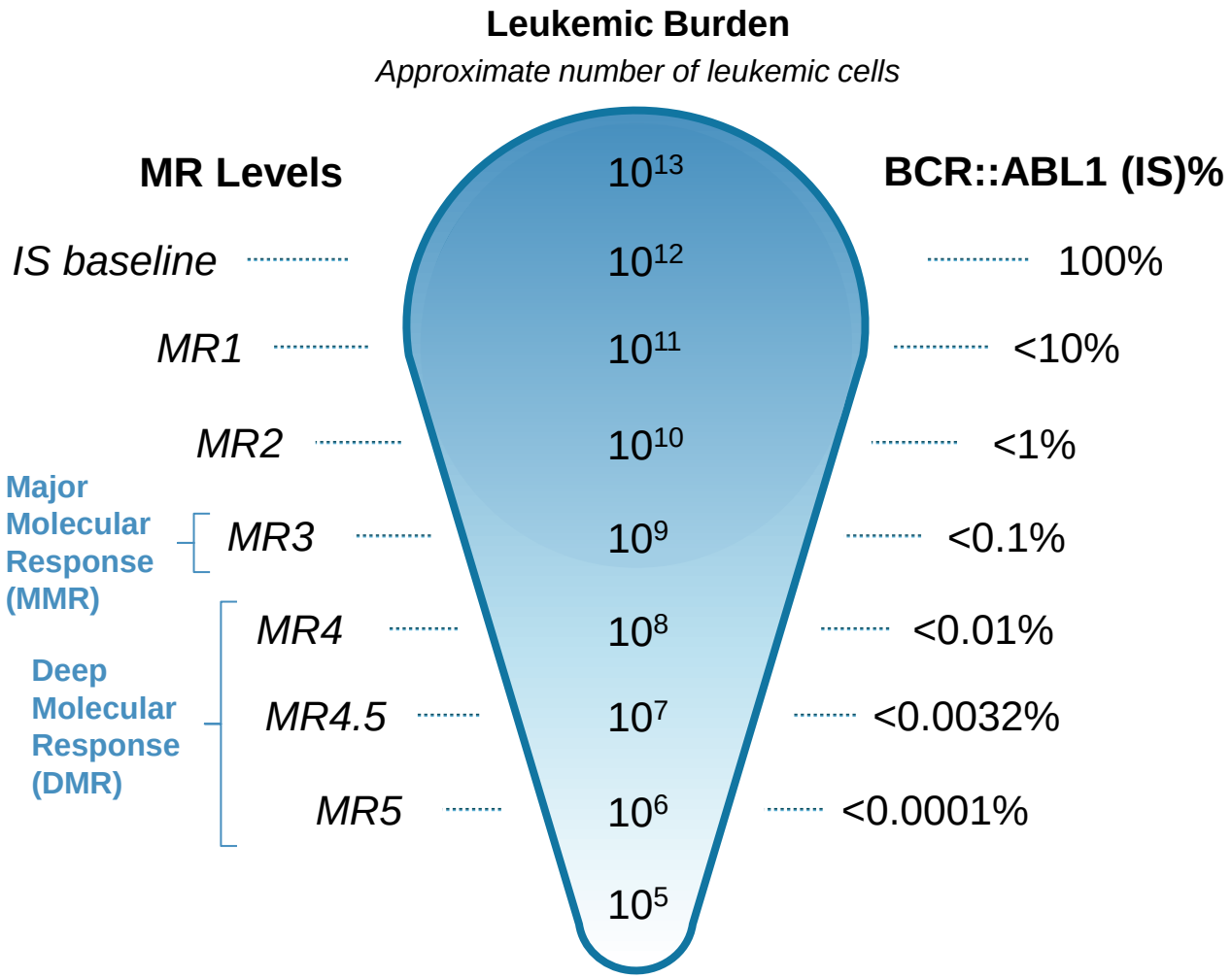
Efficacy and Safety Assessments in the CARDINAL Study

Efficacy Measures

- Molecular response assessed centrally evaluating change in BCR-ABL (IS) transcript levels from baseline
- Hematologic response in patients with hematologic relapse at baseline

Safety Assessments

- Dose limiting toxicities
- Treatment emergent hematologic and non-hematologic AEs
- Serious adverse events
- Dose discontinuations and reductions



1. Wang R et al. Medicine (Baltimore). 2019 Apr;98(15):e15222. 2. Saussele S et al. Leukemia. 2018 May;32(5):1222-1228. 3. Shah NP et al. Journal of the National Comprehensive Cancer Network 2024, 22(1), 43-69.
4. Talpaz M et al. Cancer. 2018 Apr 15;124(8):1660-1672. AEs: adverse events; IS: international standard; MR: molecular response

Enrolled Patients Have Heavily Pretreated Relapsed/Refractory CML with High Disease Burden

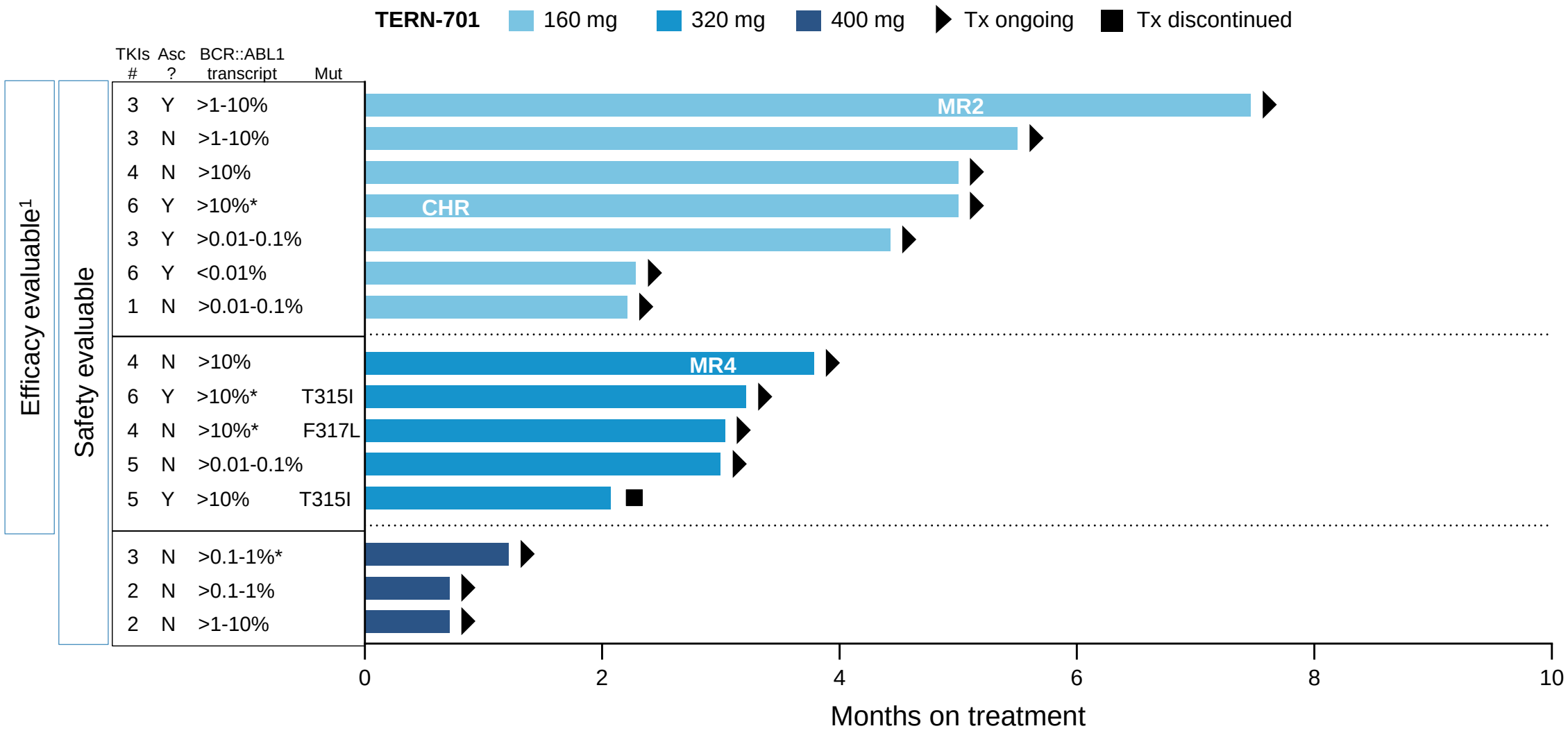
- High baseline disease burden
  - 60% with baseline BCR::ABL1 >1%
  - 73% without baseline MMR
  - 20% with BCR::ABL1 resistance mutation
- Heavily pre-treated population
  - Median 4 prior TKIs
  - 80% had ≥ 3 therapies
  - 47% had prior ponatinib
  - 40% had prior asciminib
- Of asciminib pre-treated patients
  - 1 treatment failure in a remote prior line
  - 5 had asciminib immediately before TERN-701
    - 1 treatment failure
    - 1 suboptimal response with intolerance*
    - 3 intolerant*

	Baseline Disease Status	CARDINAL (N=15)	
	Baseline BCR::ABL1		
No MMR	> 10%	40%	
No MMR	> 1% to 10%	20%	
No MMR	> 0.1% to 1%	13%	
≥ MMR	> 0.01% to 0.1%	20%	
≥ MMR	< 0.01%	7%	
	Median prior TKIs (range)	4 (1-6)	
	≥ 3 prior lines	80%	
	Prior ponatinib	47%	
	Prior asciminib	40%	
	BCR::ABL1 mutations	T315I	13%
		F317L	7%

* Reasons for asciminib intolerance: headache, skin rash & joint pain, hypertriglyceridemia & elevated liver function tests, edema and itching, ocular toxicity (right central retinal vein thrombosis)
MMR: major molecular response; TKI: tyrosine kinase inhibitor

Meaningful Activity in Refractory Patients with High BCR::ABL1

3-month median treatment duration; 14 of 15 patients remain on treatment



1. Defined as having a baseline BCR::ABL1 transcript and at least two post-baseline BCR-ABL transcript levels (centrally assessed)
* hematologic relapse
Asc?: prior asciminib; CHR: complete hematologic response; Mut: mutation; MR2: at least a 2-log reduction (i.e., BCR::ABL1^{IS} ≤ 1%); MR4: at least 4-log reduction (i.e., BCR::ABL1^{IS} ≤ 0.01%); Tx: treatment; TKI #: number of prior TKIs

Highly Encouraging Cumulative MMR Rate of 50% (5/10)

TERN-701 improved or maintained categorical response in all patients without T315I mutation

Categorical BCR::ABL1 (IS) response shift in non-T315Im patients with ≥ 3 months of treatment and/or ≥ MMR at baseline

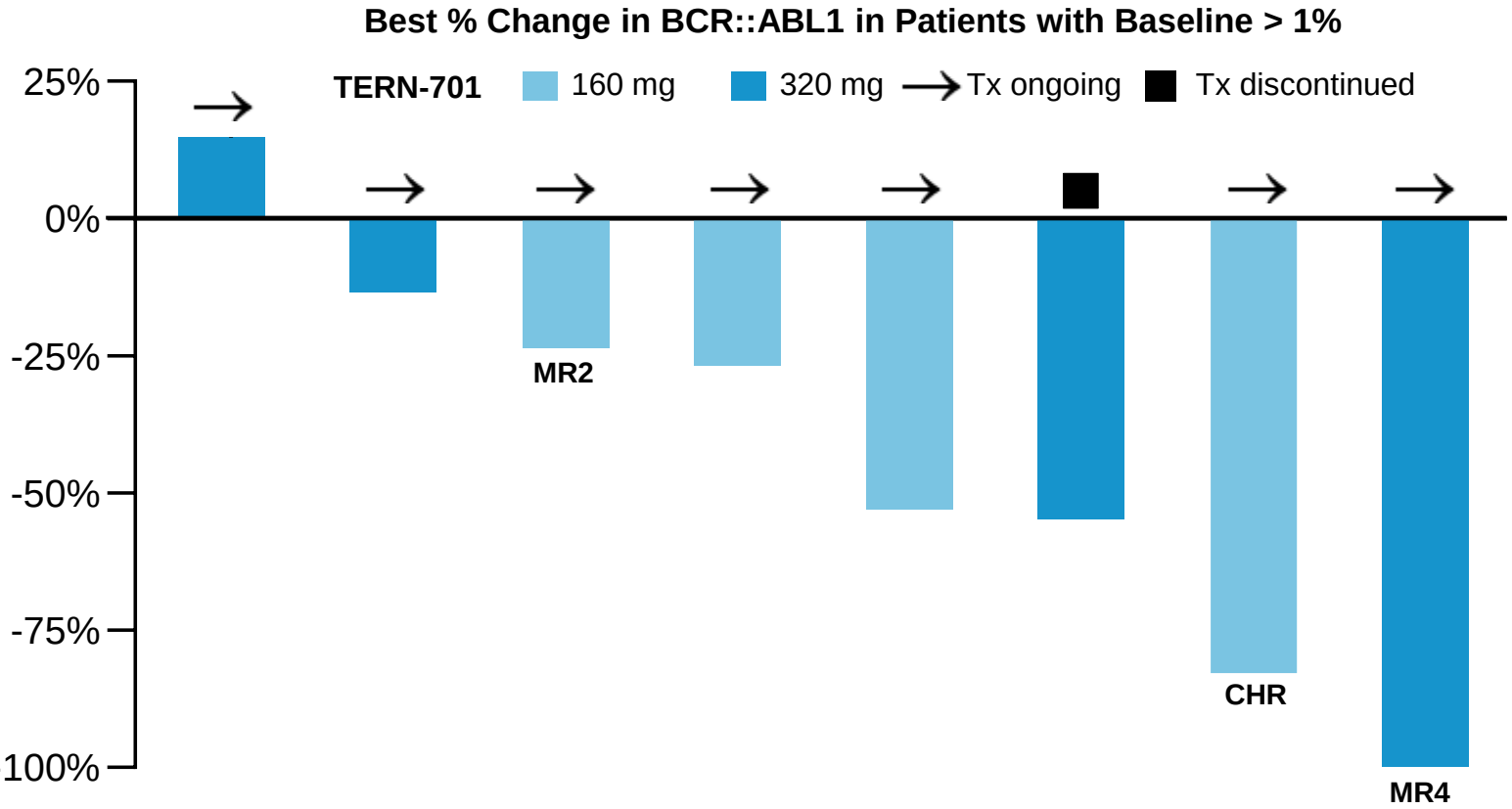
Post-treatment BCR::ABL1	Baseline BCR::ABL1						
	MR5 ≤0.001 (n=0)	**MR4.5** >0.001 to 0.0032 (n=0)	**MR4** >0.0032 to 0.01% (n=1)	**MR3 (MMR)** >0.01 to 0.1% (n=3)	**MR2** >0.1 to 1% (n=0)	**MR1** >1 to 10% (n=2)	>10% (n=4)
MR5 ≤0.001							
MR4.5 >0.001 to 0.0032							
MR4 >0.0032 to 0.01%			1				1
MR3 (MMR) >0.01 to 0.1%				3			
MR2 >0.1 to 1%						1	
MR1 >1 to 10%						1	
>10%							3

Table includes response evaluable patients without T315Im with ≥ 3 months of treatment with corresponding 3-month transcript level reported at visit cutoff, ≥ MMR at baseline, or treatment discontinuation at any time

Improvement in MR category | Stable | Lack of Efficacy | Molecular response shift

88% of Patients with Baseline Transcript > 1% Have Decreases in BCR::ABL1 Levels on Treatment

- 8 response evaluable patients had baseline transcript >1%
  - 6 had baseline transcript >10%
  - 4 had prior asciminib and 3G TKI*
- 88% (7/8) have decrease in BCR::ABL1 and continue treatment as of data cut-off
- One discontinuation due to loss of response after >50% decline in BCR::ABL1 in 6L patient with T315I mutation



Baseline transcript	> 10%#	> 10%#	>1-10%	> 10%#	> 1-10%	> 10%#	> 10%#	> 10%
Mutation	F317L	T315I				T315I		
# prior TKIs	4	6	3	4	3	5	6	4
Prior asciminib	N	Y	Y	N	N	Y	Y	N
Prior 3G TKI*	N	Y	Y	N	N	Y	Y	N

*3G TKI= ponatinib/olverembatinib/ELVN-001; # Baseline transcript >50%

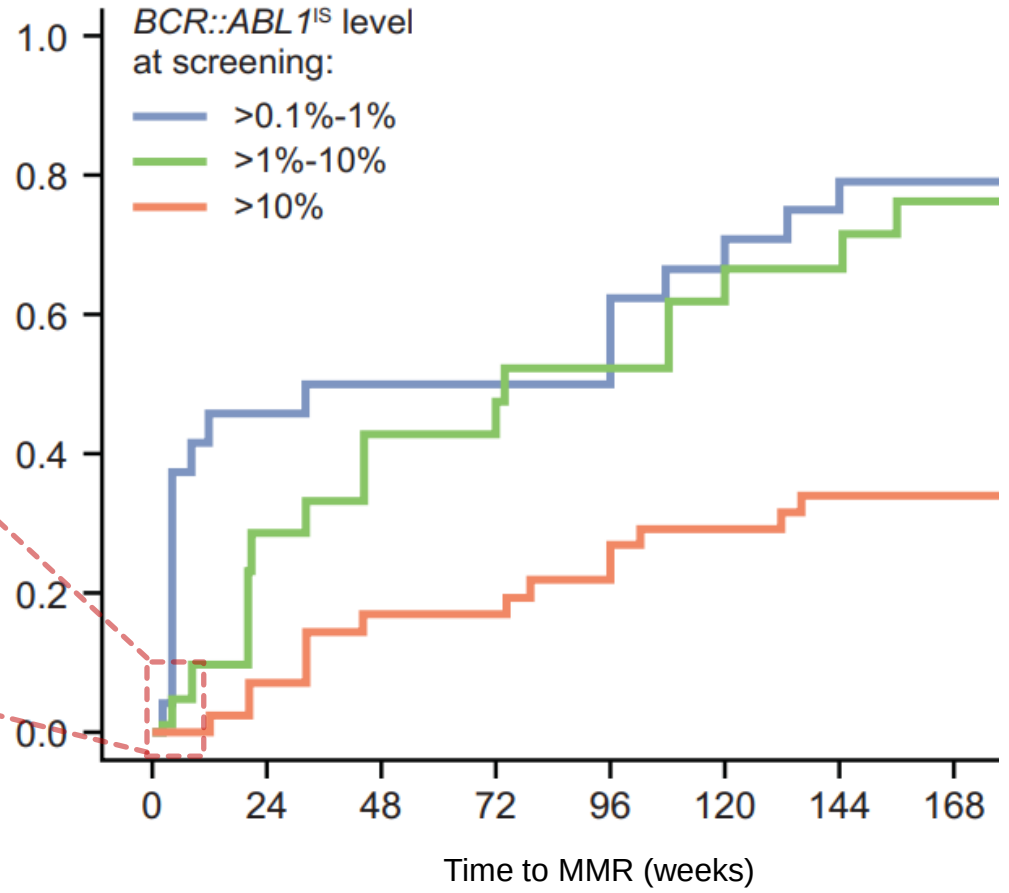
TERN-701 Early Molecular Response Data are Trending Favorably

Encouraging 3-month MMR in non-T315Im CML in a more refractory patient population than asciminib Ph1

- At 3 months, TERN-701 shows:
  - 1/4* with BCR::ABL1 >10% achieves DMR; 4/4 have decrease in transcript with treatment ongoing
  - 1/2 with BCR::ABL1 >1-10% achieves MR2 post-asciminib; 2/2 have decrease in transcript with treatment ongoing
- Asciminib showed <5% and <10% MMR at 3 months in patients without T315Im with BCR::ABL1 >10% and >1-10%, respectively

Baseline BCR::ABL1	Asciminib MMR at 3 months
>10% (N=41)	<5%
>1-10% (N=21)	<10%

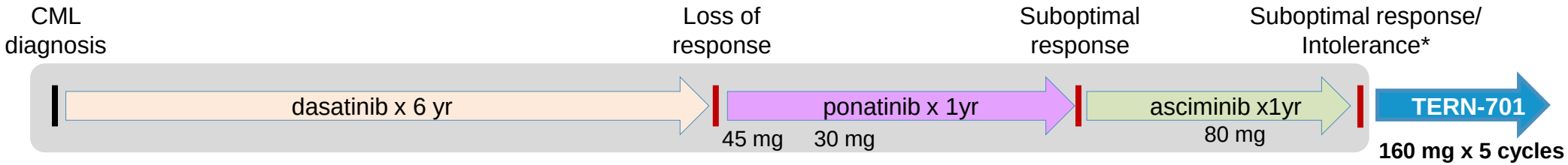
Incidence of MMR in non-T315I mutant CP CML in asciminib Phase 1



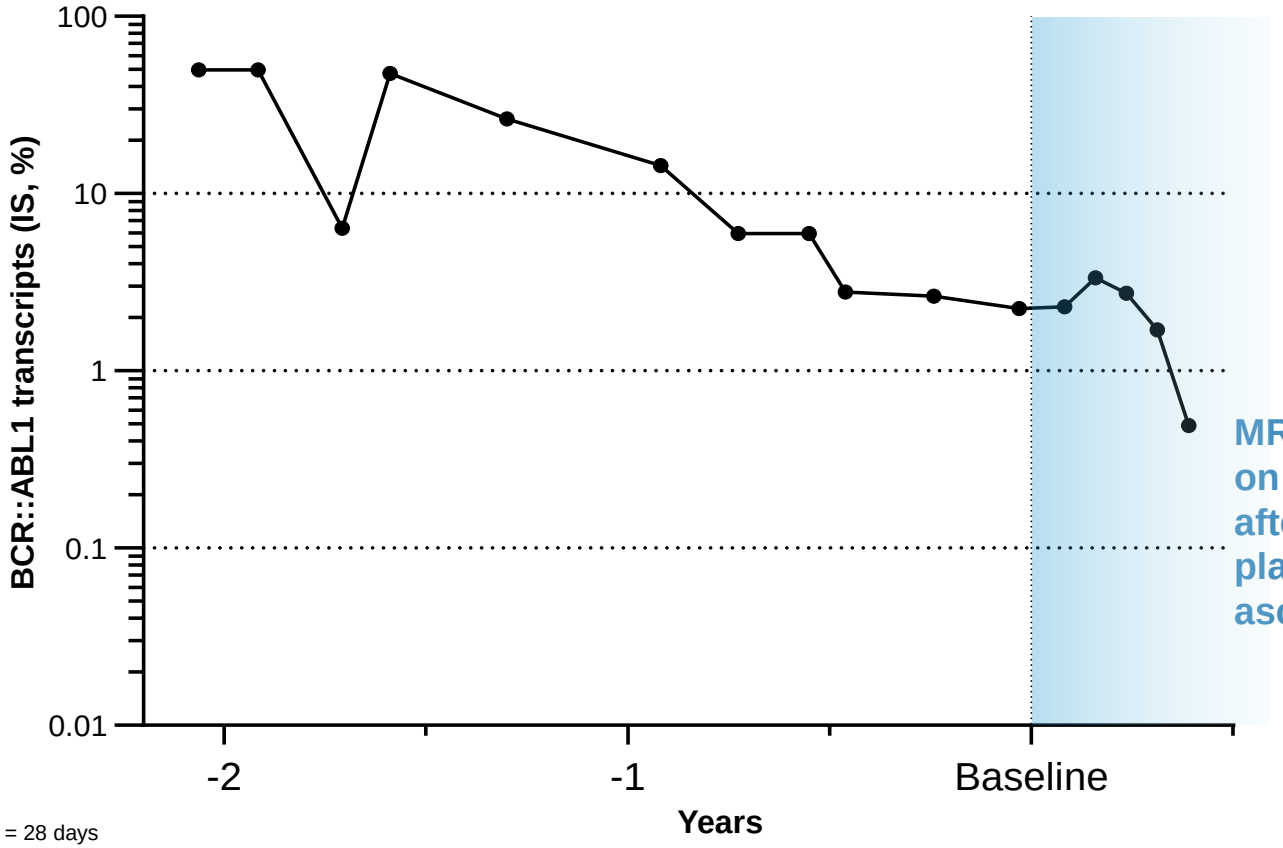
* 4 response-evaluable patients without T315I mutation and baseline transcript >10%
Note: No head-to-head study has been conducted with TERN-701 against asciminib or any other drug or product candidate. Differences exist in study designs and conditions, and caution should be exercised when comparing data across studies. Data and comparisons are shown for illustrative purposes only; CP: chronic phase; DMR: deep molecular response; MMR: major molecular response; MR2: at least a 2-log reduction (i.e., BCR::ABL1^{IS} ≤ 1%)
Mauro MJ, et al. Leukemia. 2023 May;37(5):1048-1059. Supplemental Material.

TERN-701 Deepens Response in Patient with Suboptimal Response to Asciminib

MR2 in 4L patient treated with 2G TKI, 3G TKI and asciminib with baseline BCR::ABL1 >1%



Patient Characteristics	
Age	35 years
Gender	Male
# of prior TKIs	3
BCR::ABL1 Mutations	None
Efficacy	MR1 to MR2

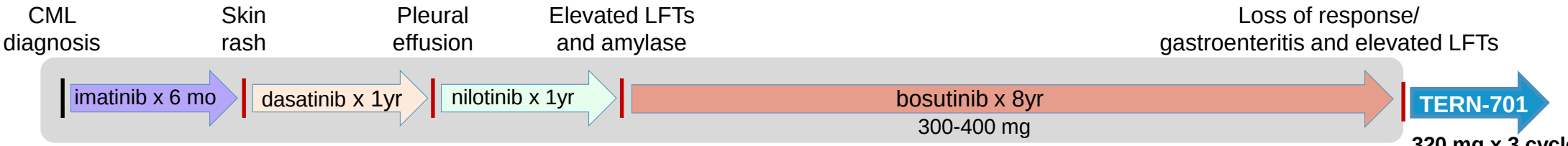


MR2 attained on TERN-701 after response plateau on asciminib

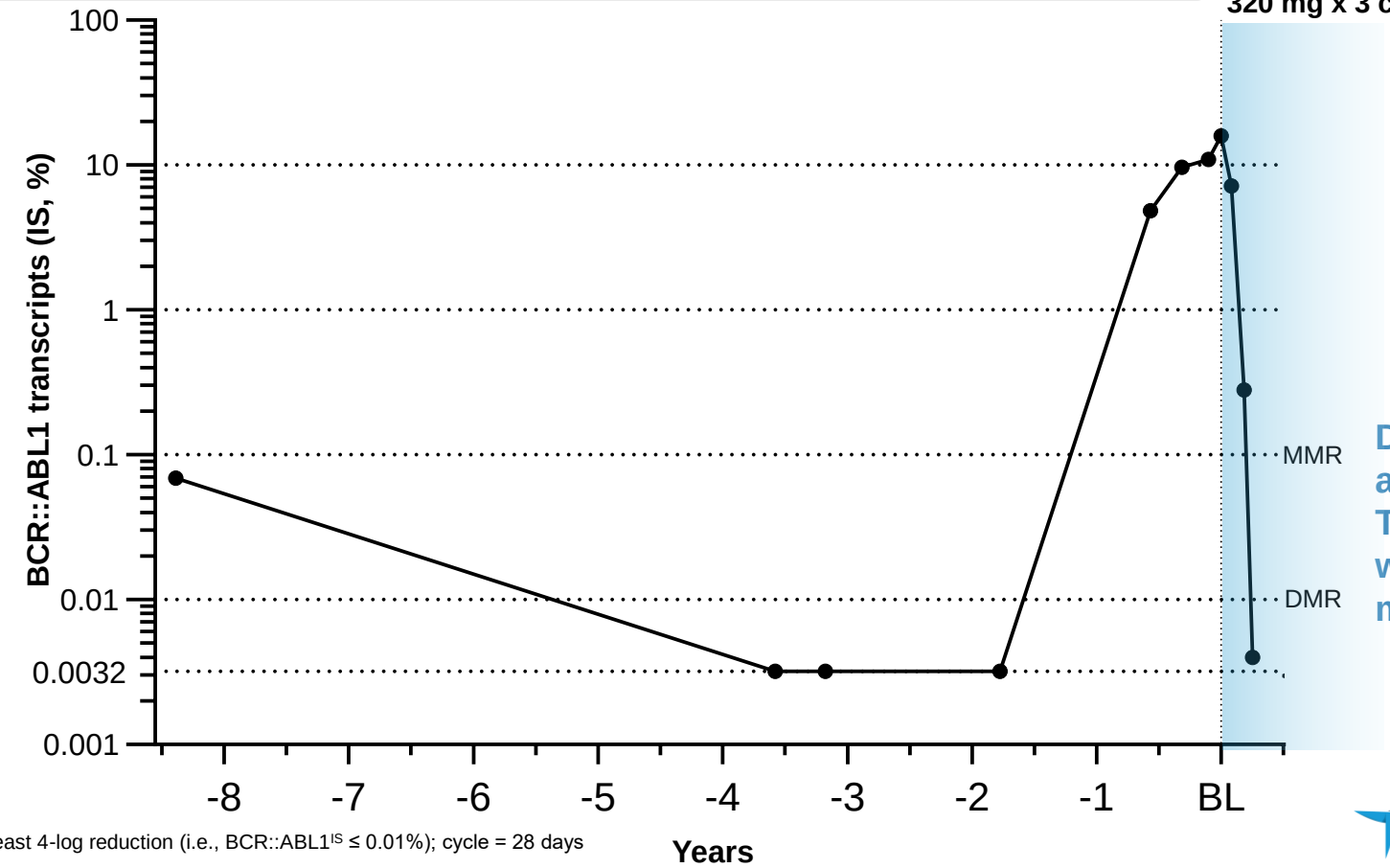
Hypertriglyceridemia/elevated liver function tests
MR1: at least 1-log reduction; MR2: at least a 2-log reduction (i.e., BCR::ABL1^{IS} ≤ 1%); cycle = 28 days

TERN-701 Achieves Rapid Deep Molecular Response in 5L Refractory Patient

MR4 in patient treated with imatinib and all 2G TKIs with loss of response to bosutinib and baseline transcript >10%



Patient Characteristics	
Age	52 years
Gender	Female
# of prior TKIs	4
BCR::ABL1 Mutations	None
Efficacy	>10% to MR4

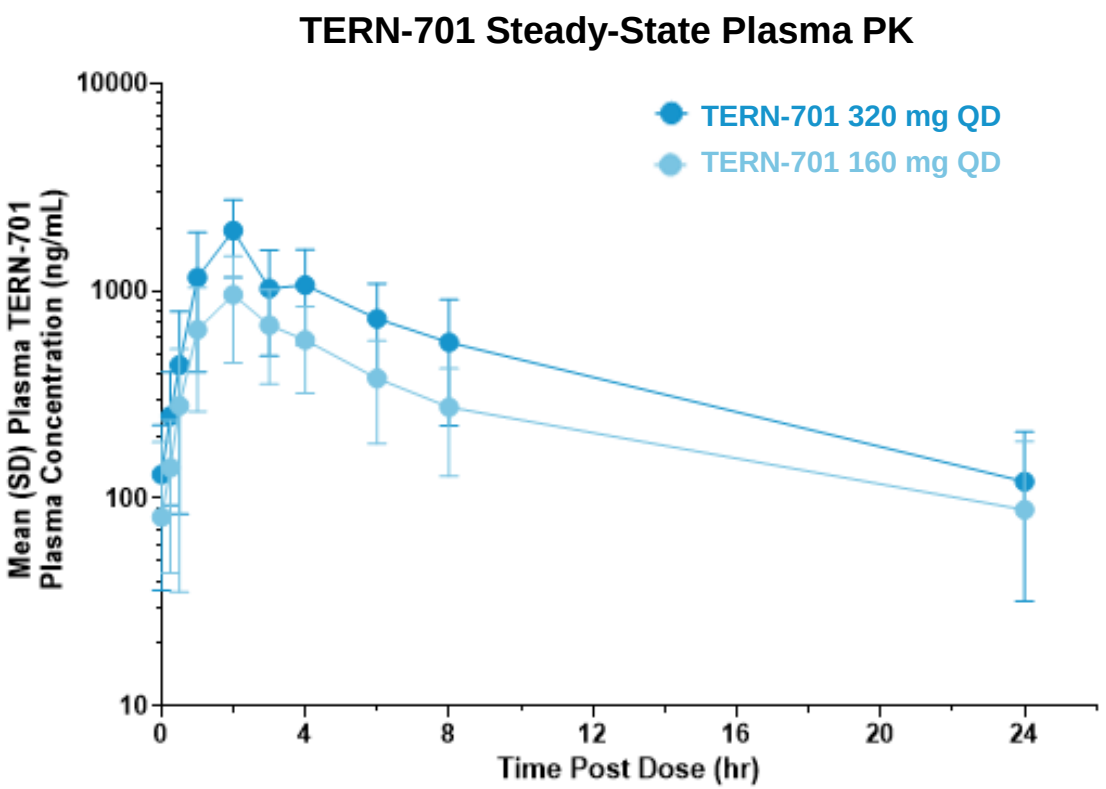


DMR achieved on TERN-701 within 3 months

BL: baseline; DMR: deep molecular response; LFTs: liver function tests; MR4: at least 4-log reduction (i.e., BCR::ABL1^{IS} ≤ 0.01%); cycle = 28 days

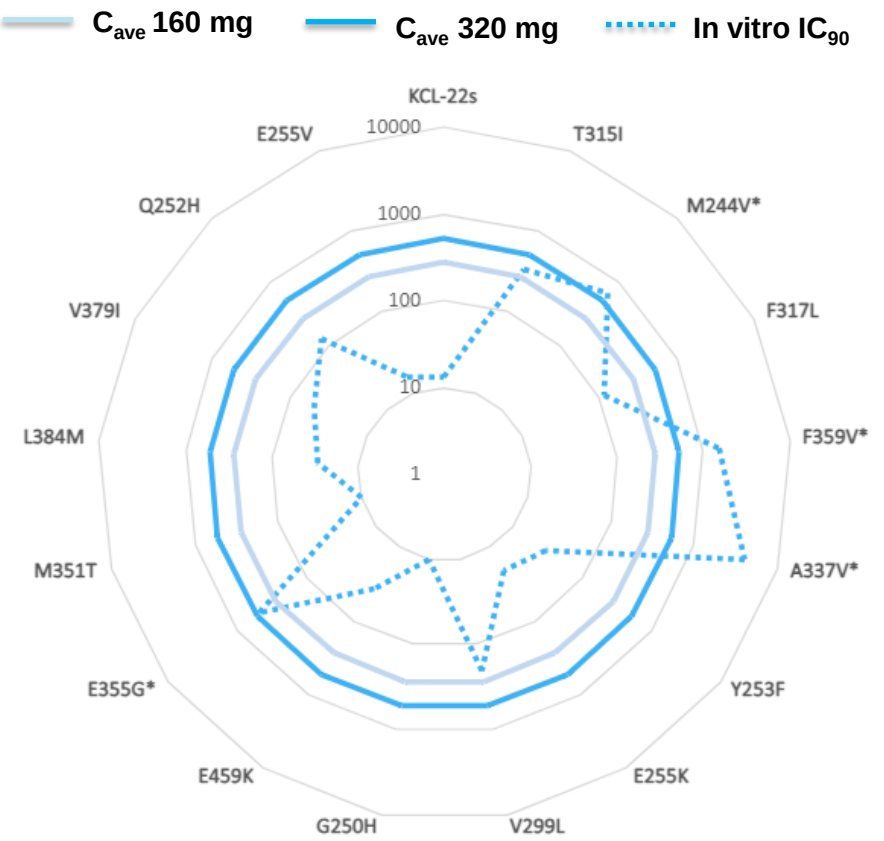
TERN-701 Achieves Robust Target Coverage Over Mutated and Non-Mutated BCR::ABL1 Variants with Once Daily Dosing

Linear PK with approximately dose proportional increases in exposure



Steady state PK for 400 mg not available as of data cut-off date
C_{ave} = $C_{average}$; PK: pharmacokinetics

Starting doses attain exposures exceeding in vitro IC_{90} for multiple BCR::ABL1 variants



In vitro IC_{90} values corrected for plasma protein binding
* denotes myristoyl mutations or mutations indicated in resistance to allosteric inhibition of BCR::ABL1

Emerging Safety Data for TERN-701 are Highly Encouraging

- ✓ No dose limiting toxicities (DLTs)
- ✓ No AE-related treatment discontinuations or dose reductions
- ✓ No ≥ Grade 3 treatment-related AEs
- ✓ No treatment-related SAEs
- ✓ No clinically meaningful changes in LFTs, amylase, or lipase
- ✓ No clinically meaningful changes in blood pressure, ECG, or other vitals

AEs: adverse events; ECG: electrocardiogram; LFTs: liver function tests; SAEs: serious adverse events

No Concerning Safety Signals for Hematologic Adverse Events

Majority of treatment-emergent hematologic adverse events are low grade

No hematologic DLTs or treatment related AEs > Grade 2

Hematologic Treatment-Emergent Adverse Events

Parameter SOC/PT n (%)	160 mg QD (N=7)		320 mg QD (N=5)		400 mg QD (N=3)		All patients (N=15)	
	All grade	≥ Grade 3	All grade	≥ Grade 3	All grade	≥ Grade 3	All grade	≥ Grade 3
Thrombocytopenia	2 (29%)	0	2 (40%)	0	0	0	4 (27%)	0
Anemia	1 (14%)	0	2 (40%)	1 (20%)*	0	0	3 (20%)	1 (7%)
Neutropenia	1 (14%)	0	3 (60%)	1 (20%)*	0	0	4 (27%)	1 (7%)
Thrombocytosis	0	0	2 (40%)	0	0	0	2 (13%)	0

* Neither grade ≥ 3 event was considered related to TERN-701

AEs: adverse events; DLT: dose limiting toxicities; G: grade; SOC: system organ class; PT: preferred term; QD: once-daily

No Concerning Safety Signals for Non-Hematologic Adverse Events

Majority of non-hematologic treatment-emergent adverse events are low grade

No non-hematologic DLTs or treatment related AEs > Grade 2

Non-Hematologic Treatment-Emergent Adverse Events in > 1 Patient

Parameter SOC/PT n (%)	160 mg QD (N=7)		320 mg QD (N=5)		400 mg QD (N=3)		All patients (N=15)	
	All Grade	≥ Grade 3	All Grade	≥ Grade 3	All Grade	≥ Grade 3	All Grade	≥ Grade 3
Nausea	1 (14%)	0	1 (20%)	0	1 (33%)	0	3 (20%)	0
Headache	3 (43%)	0	0	0	0	0	3 (20%)	0
Dizziness	1 (14%)	0	1 (20%)	0	0	0	2 (13%)	0
Fatigue	1 (14%)	0	1 (20%)	0	0	0	2 (13%)	0
Oedema peripheral	1 (14%)	0	1 (20%)	0	0	0	2 (13%)	0

AEs: adverse events; DLTs: dose limiting toxicities; PT: preferred term; QD: once-daily; SOC: system organ class

Incidence of Dose Limiting Toxicities (DLTs) for TERN-701 Trending Lower than Asciminib Phase 1

Both Phase 1 studies assessed DLTs during first 28 days of treatment

Asciminib Dose	Dose Limiting Toxicities
40 mg BID	Grade 3 lipase elevation (n=2)
80 mg BID	Grade 2 myalgia & arthralgia (n=1)
150 mg BID	Grade 3 acute coronary syndrome (n=1)
200 mg QD	Grade 3 clinical pancreatitis (n=1)
	Grade 3 lipase elevation (n=1)
	Grade 3 abdominal pain (n=1)
200 mg BID	Grade 3 bronchospasm (n=1)

TERN-701 Dose	Dose Limiting Toxicities
160 mg QD	No DLTs
320 mg QD	No DLTs
400 mg QD	No DLTs
500 mg QD	Undergoing evaluation

Hughes TP, et al. N Engl J Med 2019;381:2315-2326.
Note: No head-to-head study has been conducted with TERN-701 against asciminib. Differences exist in study designs and conditions, and caution should be exercised when comparing data across studies.

TERN-701 Emerging Data Support Potential Best-in-Class Profile

- Emerging data from the first 3 dose levels of TERN-701 Ph1 dose escalation (n=15) show[1]
  - **Clinically effective exposures** achieved at starting dose of 160 mg QD and above
  - **Compelling responses** in patients with high disease burden and poor response on prior 2G/3G TKIs and asciminib
  - **Well tolerated** with no DLTs, no dose reductions or AE-related discontinuations across all doses evaluated
- Deepening responses in patients with non-T315Im CML post-asciminib suggests **TERN-701 doses ≥ 160 mg may achieve more effective target coverage** compared to the approved asciminib dose
- On track to initiate dose expansion in 1H25, which will generate **more mature efficacy data including longer term MMR rates expected in 4Q25**

1. N=15 as of October 28, 2024 data cut-off

AE: adverse event; DLT: dose limiting toxicities

Acknowledgements

Terns would like to acknowledge and thank the trial participants, investigators and CARDINAL study team – thank you!

Closing Remarks

Amy Burroughs, CEO

Robust Clinical Data Generated Across Multiple Clinical Studies of TERN-701 Supports Efficient Full Development

CARDINAL dose expansion start in 1H25; additional efficacy data in 4Q25

1 Hansoh Phase (Ph) 1 3L+ CML

Informed Terns' Ph1 starting dose; provides additional clinical data in CML to support full development

2 Adult SAD HV Study

Showed consistent PK and lack of food effect

3 Terns Ph1 2L+ CML

CARDINAL

Early, encouraging safety and efficacy profile in difficult to treat patients

Next steps: dose expansion start in 1H25; **additional efficacy data in 4Q25**

Phase 3 Registrational Trial

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

Phase 3 Monotherapy
Frontline CML patients

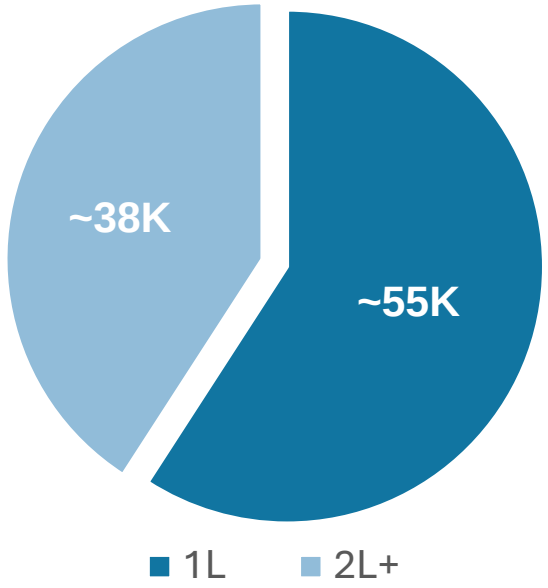
Phase 3 Monotherapy
2L+ CML patients

SAD: single ascending dose; HV: healthy volunteer; PK: pharmacokinetics

TERN-701 Has Broad Anticipated Opportunity Across 1L and 2L+

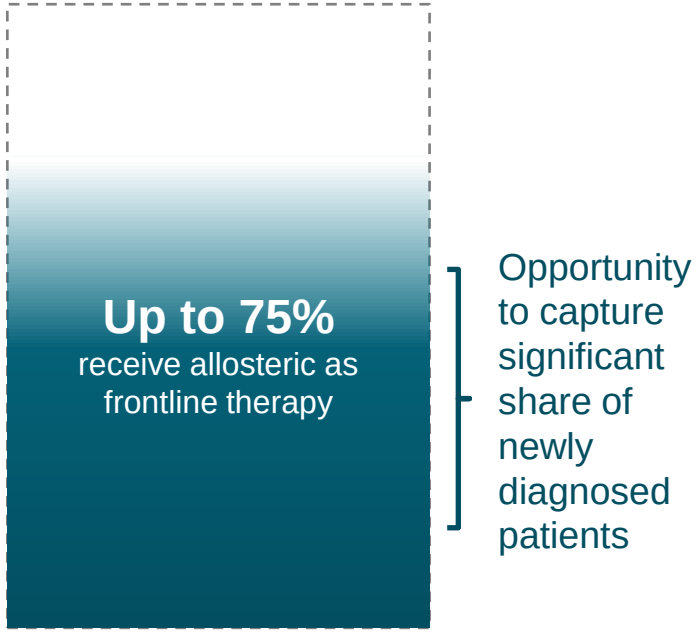
$5 billion current CML market opportunity poised for expansion with increasing addressable patient population

G7 Population with CML On Treatment[1]



1L Market Size
17K newly dx / year[1]

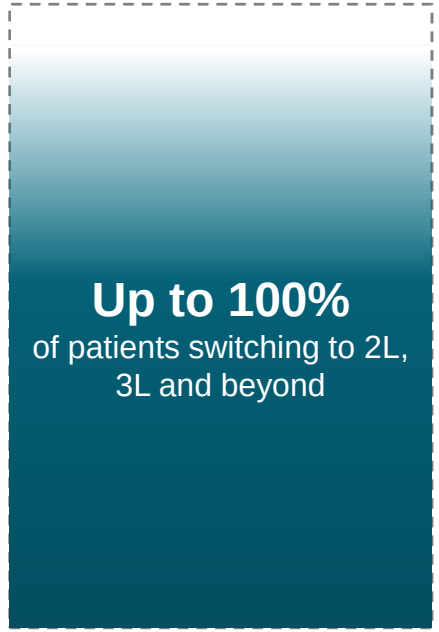
% of newly diagnosed patients addressable by TERN-701



Opportunity to capture significant share of newly diagnosed patients

2L+ Market Size
15K annual switches, ≥2L[2]

% of switching patients addressable by TERN-701



Opportunity to broadly address all lines of previously treated CML

Addressable market to expand as U.S. CML prevalence is expected to **triple by 2040**[3]

1. Novartis ASCO Investor Event | June 2, 2024; 2. Novartis R&D Investor Event | November 28, 2023; 3. Jabbour E, Kantarjian H. Am J Hematol. (Sep 2022);97(9):1236-1256
G7: Canada, France, Germany, Italy, Japan, the United Kingdom, and the United States; Dx: diagnosed

TERN-701 Has Early Signs of Differentiation from Asciminib and Opportunity to Achieve a Best-in-Class Profile

	TERN-701 Differentiation Matrix		
	Preclinical[1,2]	Early Clinical (Ph1)[3]	Late Clinical (Pivotal)[#]
Potency ≥ asciminib	✓	— N/A —	— N/A —
Once-daily (QD) dosing	✓	✓	✓
Lack of food effect	✓	✓	✓
Potential for improved efficacy & safety		**Early, encouraging data from** CARDINAL	✓
Potential for simplified label (QD across mutations, improved DDI)			✓

DDI: drug-drug interactions; N/A: not applicable; Ph: phase

1. Zhou et al. ASPET 2023. TERN-701 Preclinical Poster.pdf. 2. Data on File. 3. Anderson et al. SOHO 2024. TERN-701_FE_Poster.pdf

[#] Featured opportunities for TERN-701 are not based on late-stage clinical data and are potential differentiation points that Terns is exploring.

Note: No head-to-head study has been conducted with TERN-701 against asciminib or any other drug or product candidate. Differences exist in study designs and conditions, and caution should be exercised when comparing data across studies. Data and comparisons are shown for illustrative purposes only.

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 ongoing** Positive initial data in Dec '24; dose expansion start in 1H25; additional efficacy data in 4Q25
Metabolic						
TERN-601	Oral GLP-1R Agonist	Obesity	Phase 2 Ready			**Positive top-line Ph1 data (28-day PoC) Sept '24** Phase 2 initiation early 2Q25, initial 12-week data in 2H25
TERN-501 Combination	Oral 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	Oral 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

Management Q&A

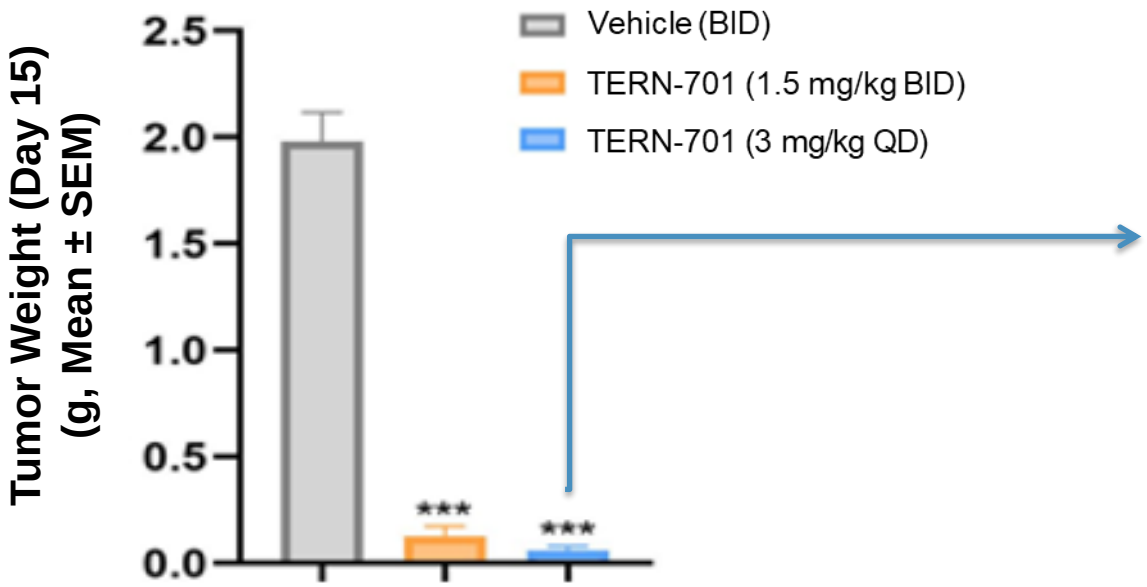
Amy Burroughs, CEO
Emil Kuriakose, CMO
Mark Vignola, CFO

Appendix

TERN-701 Showed Robust Tumor Growth Inhibition with High Tumor Drug Levels in CML Mouse Models

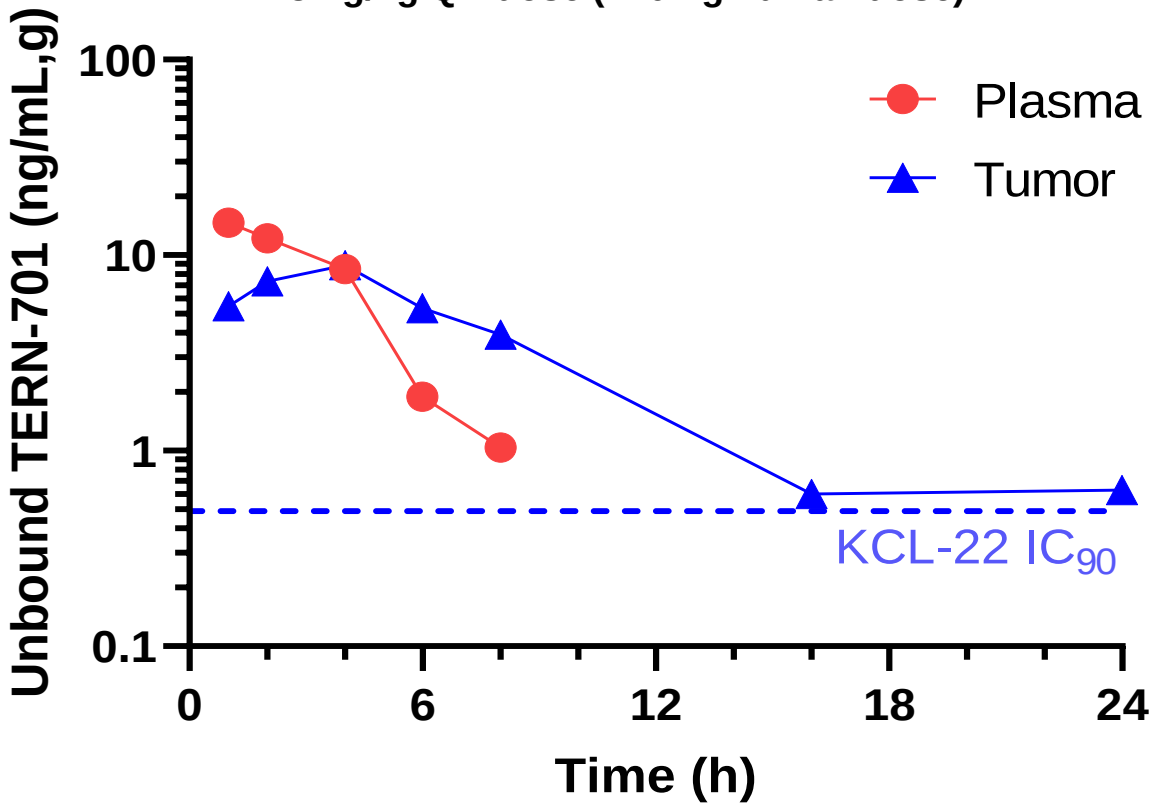
TERN-701 showed robust tumor growth inhibition in KCL-22 mouse xenograft at low doses

In vivo tumor growth inhibition in KCL-22 mouse xenograft



TERN-701 achieved robust and prolonged target coverage in leukemic cells in mouse model

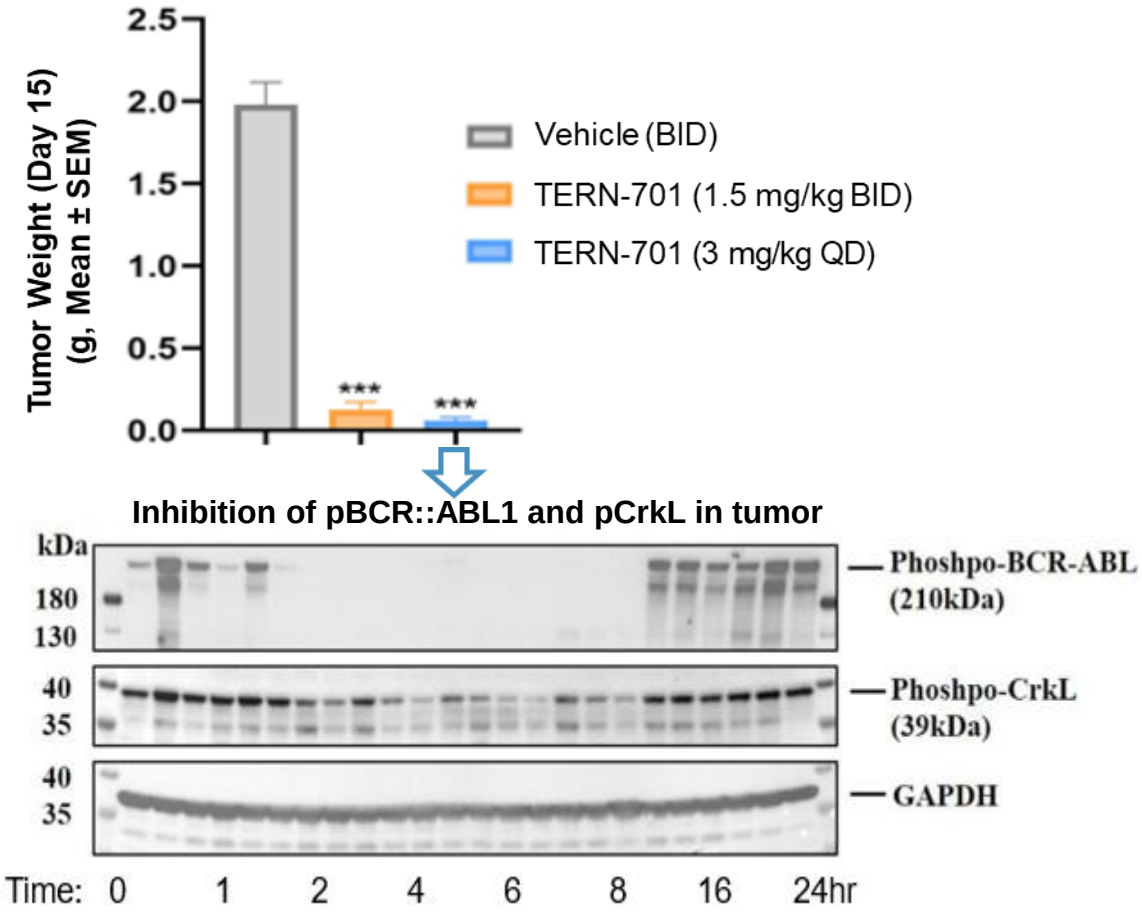
TERN-701 mouse plasma and tumor concentrations at 3mg/kg QD dose (~40mg human dose)



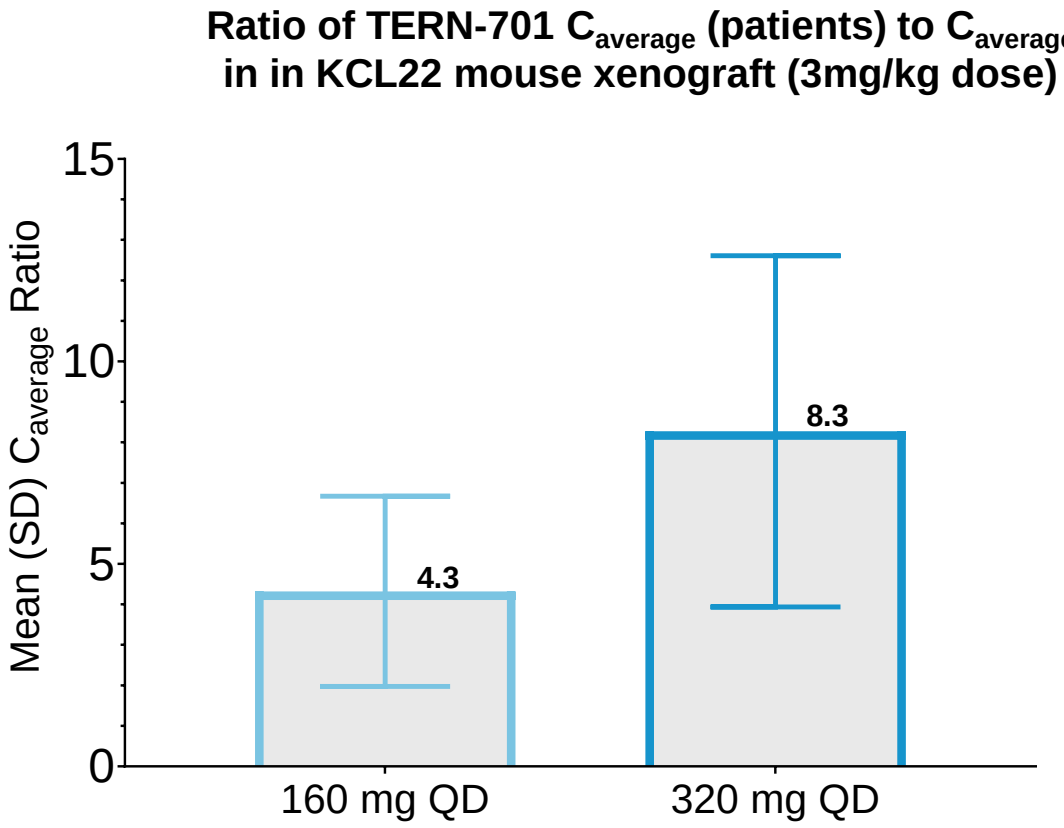
All error bars represent the SEM ***p<0.001.
BID: twice (two times) a day; PD: pharmacodynamic; QD; once-daily

TERN-701 Doses in CARDINAL Study are Associated with Potent Pharmacodynamic Inhibition of BCR::ABL1 Signaling

TERN-701 3mg/kg dose potently inhibits BCR::ABL1 signaling pathway in KCL-22 mouse xenograft



Clinical doses in CARDINAL achieve exposures with robust target coverage relative to 3mg/kg dose in mouse model



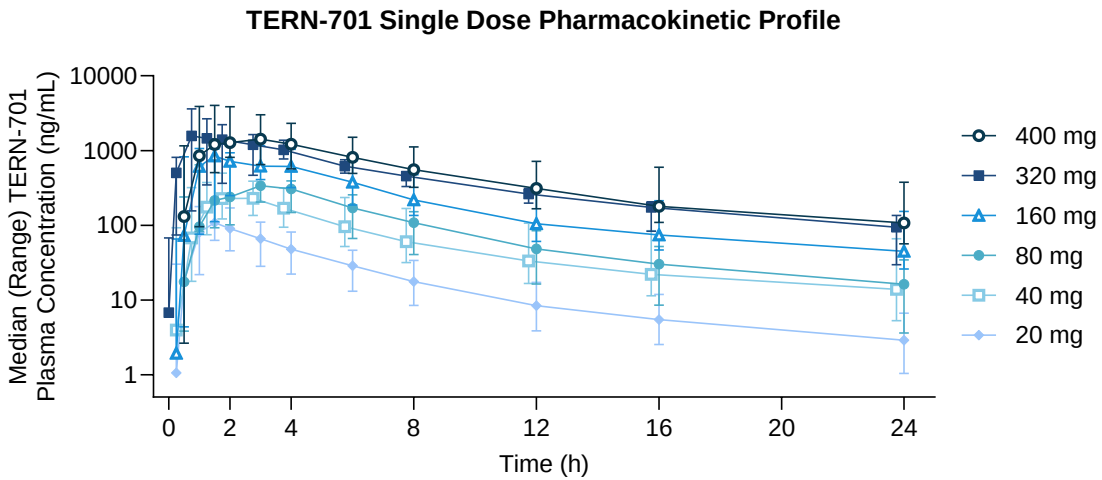
All error bars represent the SEM ***p<0.001.
BID: twice (two times) a day; PD: pharmacodynamic; QD; once-daily

TERN-701 PK Data from Adult Healthy Volunteer Study Supports Once-daily Dosing Without Regard to Food

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

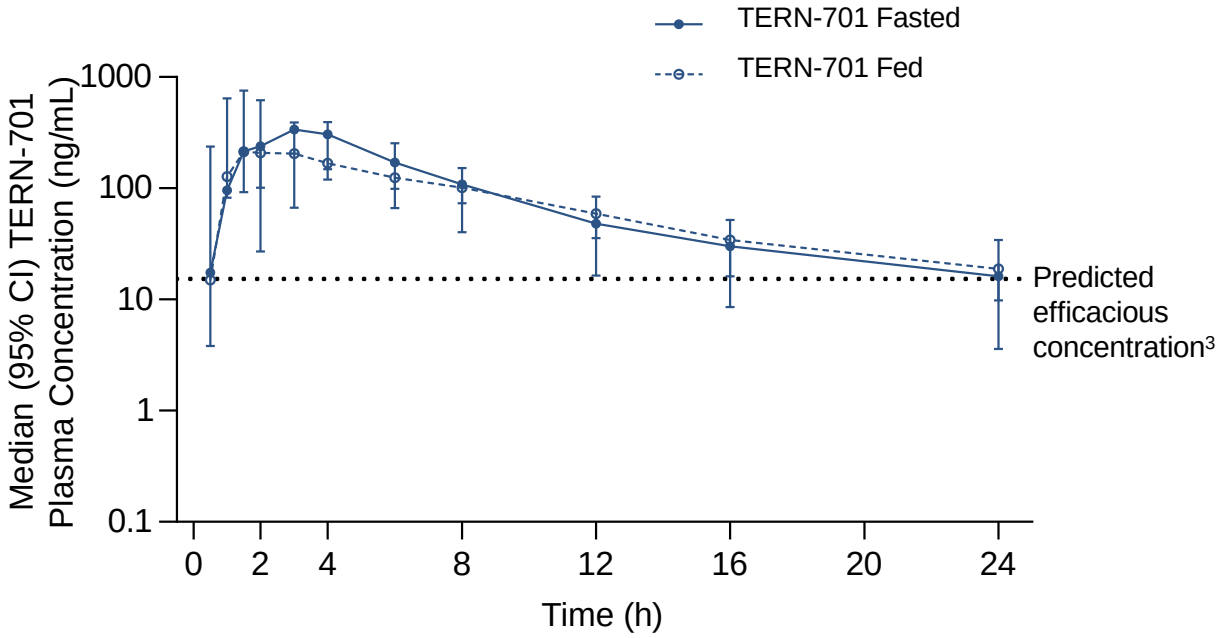
Favorable TERN-701 Pharmacokinetic Profile

- Linear PK with approximately **dose proportional increase in exposure from 40-400mg**[1]
- Median half-life of **8-14 hours supporting QD dosing**



No TERN-701 Food Effect

- **No clinically significant difference in TERN-701 exposure (AUC)** when dosed fasted or with a high-fat meal[2]



1. Across single dose TERN-701 range of 20 mg to 400 mg
2. TERN-701 80 mg dose; asciminib (40mg) change in exposure (ΔAUC_{inf}) from fed relative to fasted was (62%)
3. Effective plasma IC90 for the native BCR-ABL KCL-22 cell line