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Company Overview

NASDAQ: TERN

MARCH 2026

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, planned research and development activities, future results from clinical and preclinical testing, the clinical utility and therapeutic and market potential of the Company’s product candidates, 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,” “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, 2024, and subsequent Quarterly Reports on Form 10-Q. 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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We're Reimagining Known Biology to Deliver High Impact Medicines

TERN-701 has Potential to be the Best-in-Disease Therapy for CML

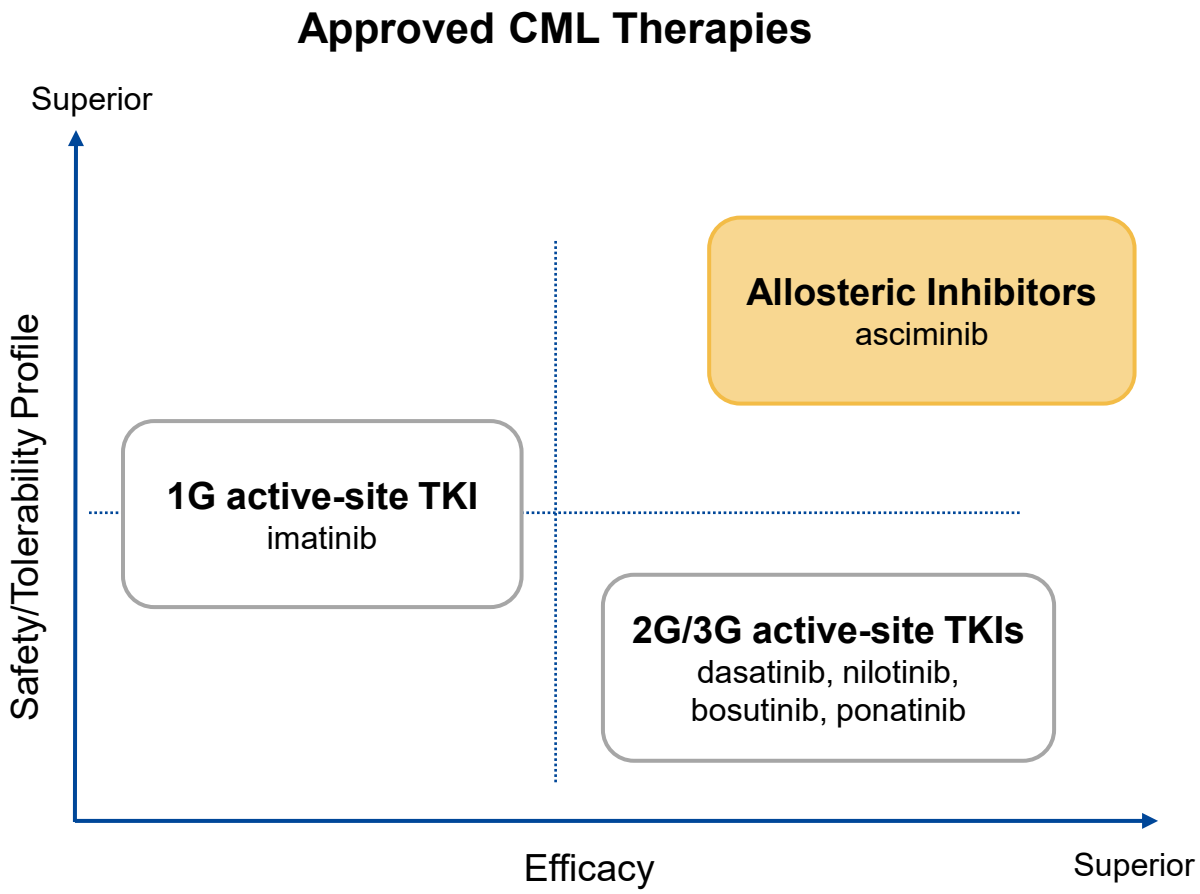
TERN-701 | A highly-selective, next generation, oral allosteric BCR-ABL inhibitor for CML

- Potential **best-in-disease** treatment in a $5B+ CML market
- Unprecedented efficacy: **75% MMR achievement** by 24 weeks[1]
- **Encouraging safety and tolerability** profile at all doses evaluated
- **Multiple important milestones** planned in 2026: pivotal dose selection and EOP2 regulatory interaction (mid-26), updated and expanded CARDINAL data (2H26) and 2L+ pivotal trial initiation (late ’26/early ’27)

Balance Sheet: Cash of ~$1.0B and ~115M shares outstanding[2], provides runway into 2031 including potential first approval & commercial launch of TERN-701

CML: chronic myeloid leukemia; RP2D: recommended Phase 2 doses
1. At expansion dose range in a refractory Phase 1 population
2. Year-end 2025 unaudited cash, cash equivalents and marketable securities; shares include common stock and prefunded warrants

Allosteric Inhibitors are a Superior Class to Active-site TKIs, Leading to Rapid Uptake Across All Lines of Treatment



22% **Asciminib NBRx share of front-line**

52% **Asciminib NBRx share in 2L** *(53% in 3L+)*

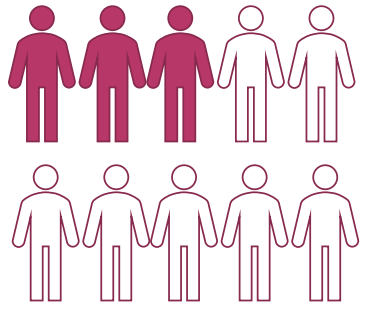
$4B+ **Asciminib anticipated peak sales**

Sources: Novartis ASCO Investor Event | June 2, 2024; Novartis Q3 2025 Results Presentation | October 28, 2025; Meet Novartis Management | November 20, 2025
NBRx: New to brand Rx

However, Asciminib Leaves Opportunities for Improvement Across Efficacy, Safety, and Convenience

Asciminib Patients Who *Fail to Reach Efficacy* threshold ( )

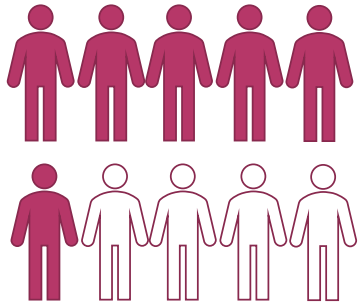
1L



- 32% -

do not reach **MMR** at 48 weeks[1]

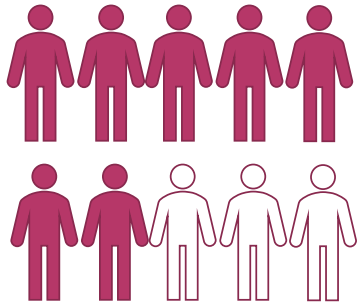
2L



- 57% -

do not reach **MMR** at 24 weeks[2]

3L+



- 75% -

do not reach **MMR** at 24 weeks[3]

Adverse Event Profile of Asciminib[4]

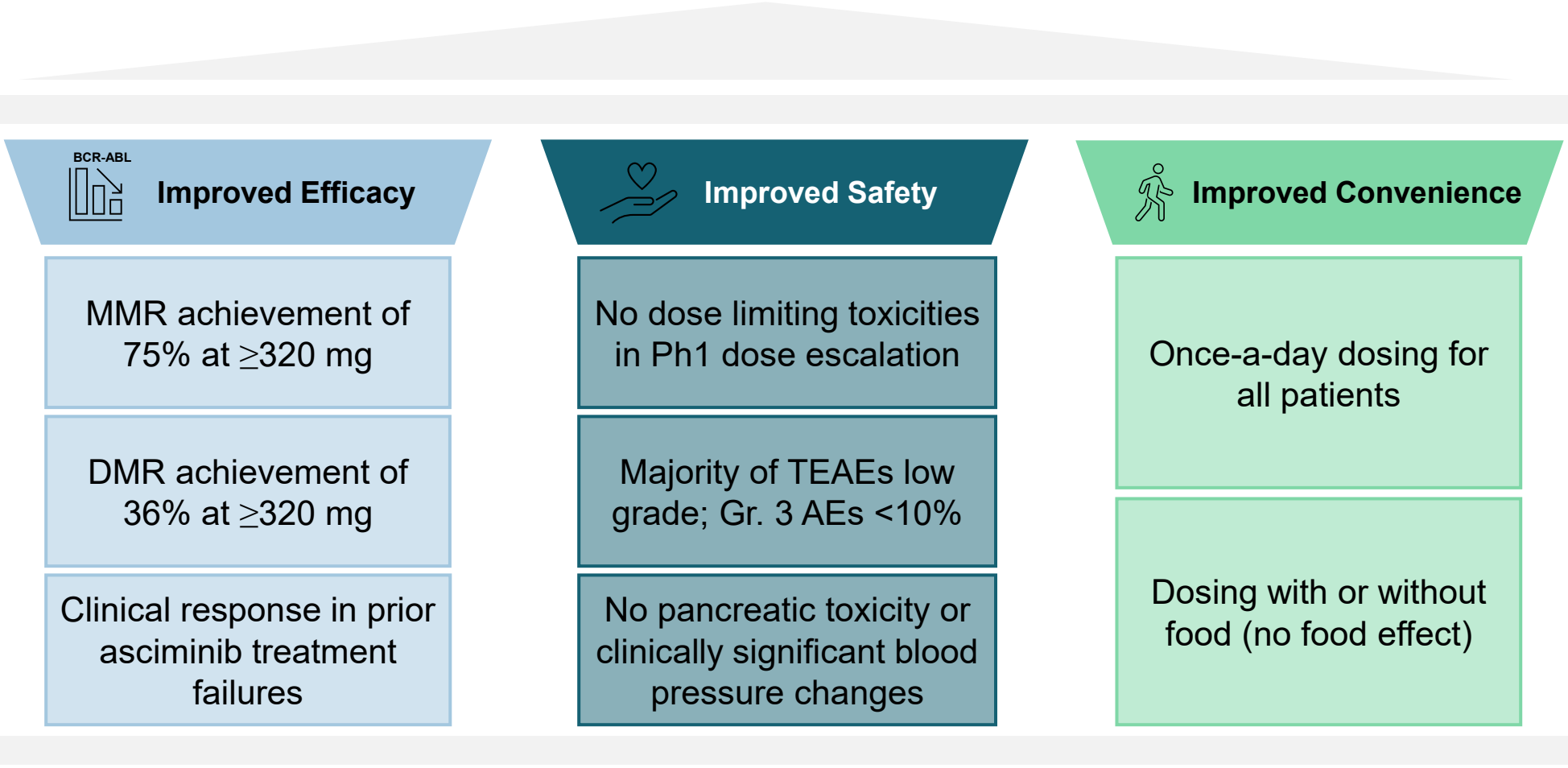
Pancreatic Toxicity	20%
Hypertension	18%

Patient Adherence[4]

Can’t be taken with food

1. Hochhaus A, et al. *N Engl J Med* 2024;391:885-898. 2. Atallah E. et al. 66th ASH Annual Meeting, December 7-10th, 2024 Abstract # 479. 3. Rea D et al. *Blood* 2021; 138 (21): 2031–2041.
4. SCEMBLIX® (asciminib). Prescribing information, November 2025. Accessed December 2025.

We are Building a Strong Foundation for TERN-701 to be the Best-In-Disease Therapy for CML



Data cut-off 13Sep2025
Note: MMR/DMR achievement rates in Phase 1 study, based on 24-week time point
MMR: major molecular response; DMR: deep molecular response; TEAE: treatment emergent adverse events; AE: adverse events; BP: blood pressure

TERN-701 Demonstrates Strong Potential for Best-in-Disease Efficacy

24Wk molecular responses in non-T315I CML	TERN-701 Ph1 CARDINAL All doses	TERN-701 Ph1 CARDINAL ≥320 mg QD	Asciminib Ph1 'X2101 All doses	Asciminib Ph3 ASCEMBL* 40 mg BID
MMR Achievement Rate	**64%** (18/28)	**75%** (18/24)	24% (19/80)	25.5% (40/157)
DMR Achievement Rate	**29%** (10/34)	**36%** (10/28)	14% (15/105)	10.8% (ND)

*ASCEMBL Ph3 dosed at RP2D (40mg BID)
24Wk= 24 week; DMR= deep molecular response. Included patients achieving MR4, BCR::ABL1IS ≤0.01%; MR4.5, BCR::ABL1IS ≤0.0032%; and MR5, BCR::ABL1IS ≤0.001
ND= Numerator and denominator not disclosed
Hughes TP, et al. *N Engl J Med* 2019;381:2315-2326. Mauro M. et al. *Leukemia* 2023; 37:1048–1059. Rea D et al. *Blood* 2021; 138 (21): 2031–2041. Data cut-off 13Sep2025
No head-to-head clinical studies have been conducted comparing TERN-701 with marketed or investigational drugs. Differences exist in study designs and conditions, and caution should be exercised when comparing data across studies.

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CARDINAL December 2025
Data Update

TERN-701 Demonstrates Potential for Best-in-Disease Efficacy and Safety in the Phase 1 CARDINAL Study

CARDINAL

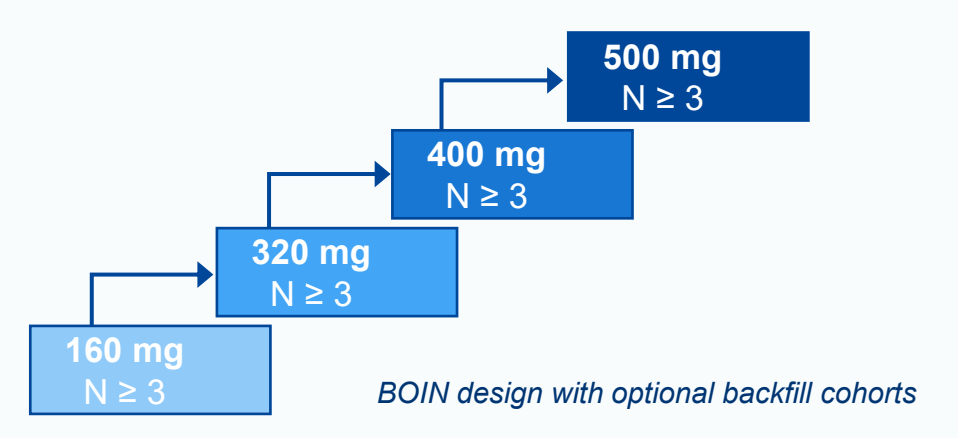
- **Enrolled predominantly 3L+ refractory CML population** (N=63 as of 13 Sept 2025 data cut-off)
  - 38% prior asciminib treated, of which 75% discontinued asciminib due to lack of efficacy
- **Unprecedented 24-week MMR achievement** in non-T315Im CP-CML (N=38 efficacy evaluable)
  - 64% at all doses; 75% at doses ≥320 mg QD
  - 43% in prior asciminib; 50% in prior asciminib, ponatinib and/or investigational TKI
- **Observed favorable safety and tolerability profile**
  - No DLTs observed; MTD not identified
  - Majority of TEAEs low grade; Gr. 3 AEs <10%
  - No pancreatic toxicity, no clinically significant changes in blood pressure
- **Accelerated study enrollment** (enrolled N=85+ as of Dec 2025)

MMR: major molecular response; CP-CML: chronic phase-chronic myeloid leukemia; QD: once-daily; TKI: tyrosine kinase inhibitor; DLT: dose limiting toxicities; MTD: maximum tolerated dose: TEAE: treatment emergent adverse events; AE: adverse events; Data cut-off 13Sep2025

Phase 1/2 CARDINAL Trial Design in CP-CML as of December 2025

Part 1 Dose Escalation

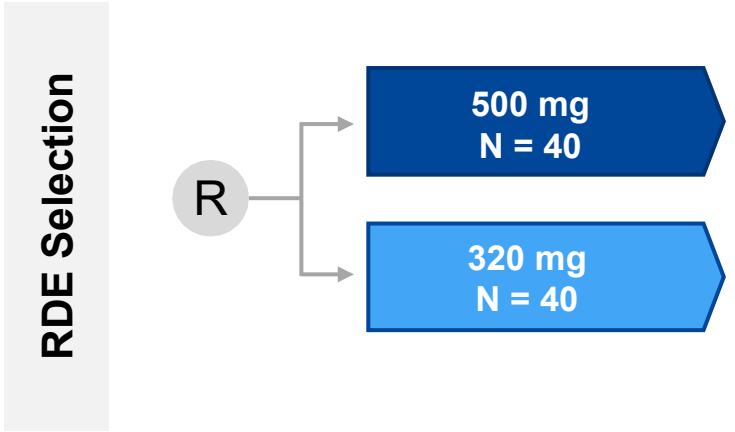
TERN-701 QD (N= up to 80)



- Received ≥ 2 TKIs OR had treatment failure/suboptimal response to frontline 2G TKI
- Prior asciminib/ponatinib failure/intolerance allowed; myristate pocket resistance mutations excluded
- T315I and non-T315I mutations allowed

Part 2 Dose Expansion

TERN-701 QD (N≈80)



- Treatment failure or suboptimal response to ≥ 1 prior TKI
- Prior asciminib/ponatinib treatment failure/intolerance allowed; myristate pocket resistance mutations excluded
- Only non-T315I mutations allowed

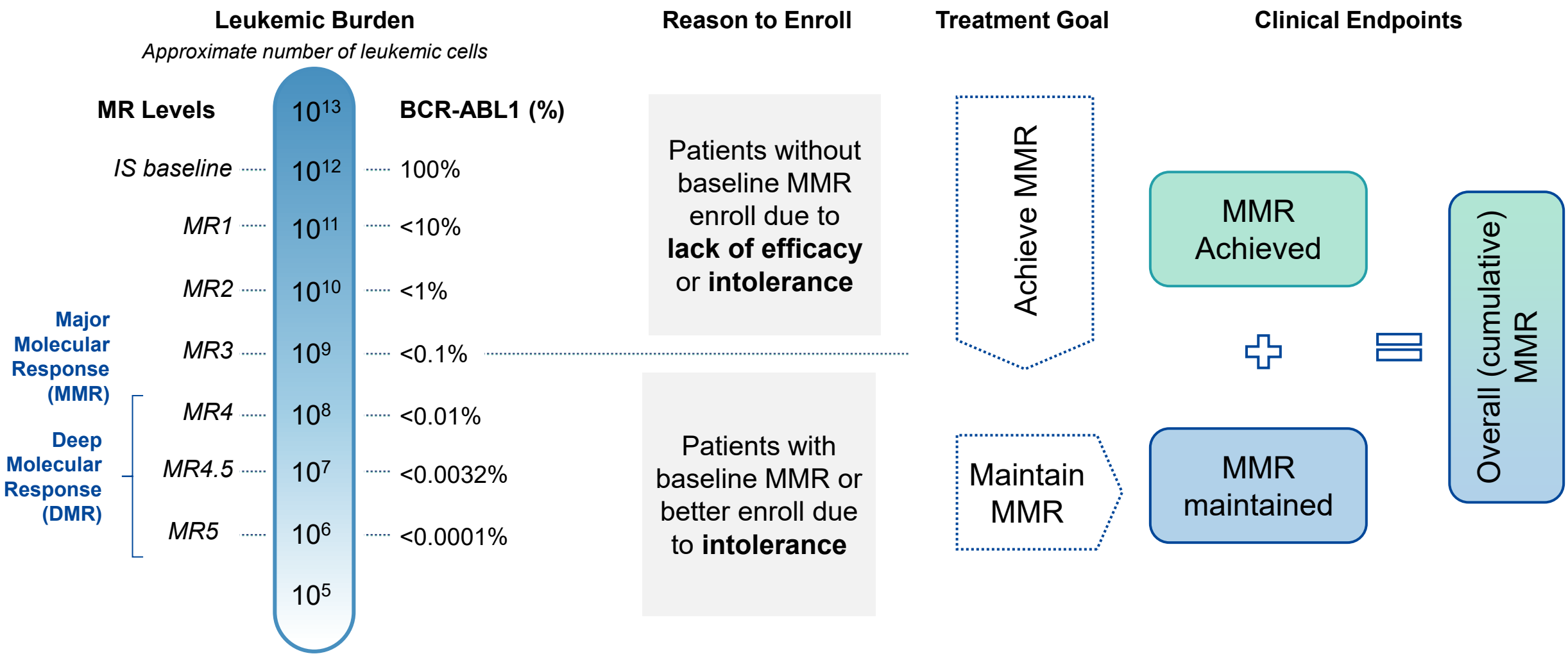
Primary Endpoints: Safety and tolerability (including dose-limiting toxicities)

Secondary Endpoints: Efficacy (molecular responses) and pharmacokinetics

CP-CML: chronic phase-chronic myeloid leukemia

Phase 1 CML Studies Enroll Patients With or Without Baseline MMR

MMR achievement is the regulatory endpoint in pivotal studies which only enroll patients without baseline MMR



IS: international standard; MR: molecular response

Wang R et al. *Medicine* (Baltimore). 2019 Apr;98(15):e15222; Saussele S et al. *Leukemia*. 2018 May;32(5):1222-1228; Shah NP et al. *Journal of the National Comprehensive Cancer Network* 2024, 22(1), 43-69; Talpaz M et al. Cancer. 2018 Apr 15;124(8):1660-1672. Pamuk et al. *Clin Cancer Res*. 2024 Oct 1;30(19):4266-4271.

Patients are Heavily Pretreated with High Disease Burden

	All Patients (N=63)	
Age, median (range), years	57 (29–86)	
Baseline *BCR::ABL1*^{IS}, n (%)		
>10%	28 (44%)	
>1% to 10%	8 (13%)	
>0.1% to 1%	16 (25%)	
≤0.1%	11 (18%)	
Discontinuation to last TKI, n (%)*		
Lack of efficacy (per ELN 2020 criteria)	40 (64%)	
Lack of tolerability	18 (29%)	
Median number of prior unique TKIs (range)	3 (1–6)	
≥3 prior, n (%)	38 (60%)	
Prior asciminib	24 (38%)	Lack of efficacy: 18 (75%) Lack of tolerability: 6 (25%)
Prior ponatinib	14 (22%)	Lack of efficacy: 11 (79%) Lack of tolerability: 3 (21%)
BCR::ABL1 mutations, n (%)	T315I / F317L / E255K	6 (10%) / 2 (3%) / 1 (2%)

*Five patients discontinued last TKI for other reasons
Data cut-off 13Sep2025

87% of Patients Remain on Treatment with a Median Treatment Duration of 6 Months

Patients, n (%)	All Patients (N=63)
Median duration of treatment, months (range)	6.1 (0.2–19)
Treatment ongoing	55 (87%)
Discontinued from treatment	8 (13%)
Treatment failure	4
Adverse events*	1
Physician decision	1
Other (withdrew consent / lost to follow-up)	2

*Grade 2 diarrhea, fatigue and joint pain. This patient had similar AEs with prior dasatinib and asciminib
Data cut-off 13Sep2025

TERN-701 Continues to Exhibit an Encouraging Overall Safety / Tolerability Profile

Patient Incidence, n (%)	All Patients (N=63)
Treatment-Emergent Adverse Events (TEAEs)	
Dose Limiting Toxicities	0 (0%)
AEs Leading to Treatment Discontinuation	1 (2%)
Overall, Any Grade	51 (81%)
Overall, Grade 3 or Higher	20 (32%)

- No DLTs in dose escalation and MTD was not reached

DLT= dose limiting toxicities; MTD= maximum tolerated dose; AE= adverse events
Data cut-off 13Sep2025

Low Rates of Treatment Emergent Cytopenias Were Observed

Hematologic Treatment-Emergent Adverse Events (TEAEs) in ≥ 10%

	160 mg QD n=10		320 mg QD n=21		400 mg QD n=13		500 mg QD n=19		All patients (N=63)	
Preferred Term, n (%)	**All Gr.**	**≥ Gr. 3**	**All Gr.**	**≥ Gr. 3**	**All Gr.**	**≥ Gr. 3**	**All Gr.**	**≥ Gr. 3**	**All Gr.**	**≥ Gr. 3**
Thrombocytopenia[1]	2 (20%)	0	5 (24%)	3 (14%)	2 (15%)	2 (15%)	1 (5%)	0	10 (16%)	5 (8%)
Neutropenia[2]	1 (10%)	0	4 (19%)	2 (10%)	2 (15%)	2 (15%)	1 (5%)	1 (5%)	8 (13%)	5 (8%)
Anemia[3]	1 (10%)	0	2 (10%)	1 (5%)	1 (8%)	0	2 (11%)	0	6 (10%)	1 (2%)

QD: once-daily
1. Thrombocytopenia includes platelet count decreased and thrombocytopenia; 2. Neutropenia includes neutrophil count decreased and neutropenia; 3. Leukopenia includes white blood cell count decreased and leukopenia
Data cut-off 13Sep2025

Majority of Non-Hematologic AEs were Grade 2 or Less

- No clinical pancreatitis or symptomatic lipase elevations of any grade
- No clinically significant changes in blood pressure

Treatment-Emergent Adverse Events (TEAEs) in ≥ 10%

	160 mg QD n=10		320 mg QD n=21		400 mg QD n=13		500 mg QD n=19		All patients (N=63)	
Preferred Term, n (%)	**All Gr.**	**≥ Gr. 3**	**All Gr.**	**≥ Gr. 3**	**All Gr.**	**≥ Gr. 3**	**All Gr.**	**≥ Gr. 3**	**All Gr.**	**≥ Gr. 3**
Diarrhoea	1 (10%)	0	5 (24%)	0	3 (23%)	0	4 (21%)	0	13 (21%)	0
Headache	3 (30%)	0	6 (29%)	0	2 (15%)	0	1 (5%)	0	12 (19%)	0
Nausea	4 (40%)	0	4 (19%)	0	2 (15%)	0	2 (11%)	0	12 (19%)	0
Fatigue	1 (10%)	0	4 (19%)	0	2 (15%)	1 (8%)	2 (11%)	0	9 (14%)	1 (2%)
Abdominal pain	3 (30%)	1 (10%)	2 (10%)	0	1 (8%)	0	2 (11%)	0	8 (13%)	1 (2%)
Myalgia	0	0	4 (19%)	0	3 (23%)	0	1 (5%)	0	8 (13%)	0
Back pain	1 (10%)	0	2 (10%)	0	1 (8%)	0	3 (16%)	0	7 (11%)	0
Rashes	2 (20%)	0	1 (5%)	1 (5%)	2 (15%)	0	2 (11%)	0	7 (11%)	1 (2%)
ALT increased	1 (10%)	0	2 (10%)	0	0	0	3 (16%)	0	6 (10%)	0
Dizziness	1 (10%)	0	4 (19%)	0	1 (8%)	0	0	0	6 (10%)	0

AEs: adverse events; ALT: alanine aminotransferase; QD: once-daily
Data cut-off 13Sep2025

Grade 3 or Higher TEAEs Were All Less than 10%

Grade ≥ 3 Adverse Events Regardless of Treatment Relationship (>1 Patient)

Preferred Term, n (%)	160 mg QD n=10	320 mg QD n=21	400 mg QD n=13	500 mg QD n=19	All patients (N=63)
Thrombocytopenia[1]	0	3 (14%)	2 (15%)	0	5 (8%)
Neutropenia[2]	0	2 (10%)	2 (15%)	1 (5%)	5 (8%)
Leukopenia[3]	0	1 (5%)	1 (8%)	0	2 (3%)

- Low rate of ≥G3 TEAEs (all <10%)
- One patient with G3 peripheral ischemia (foot) unrelated to treatment
  - Patient had 5-year history of peripheral vascular disease with chronic ponatinib treatment
  - AE occurred ~2 months after ponatinib discontinuation

TEAEs: treatment emergent adverse events; QD: once-daily
1. Thrombocytopenia includes platelet count decreased and thrombocytopenia; 2. Neutropenia includes neutrophil count decreased and neutropenia; 3. Leukopenia includes white blood cell count decreased and leukopenia
A patient with multiple severity grades for an AE was only counted under the maximum grade.
Data cut-off 13Sep2025

CARDINAL Uses the Same MMR Efficacy Evaluability Criteria by 24 Weeks as the Asciminib Phase 1 Study

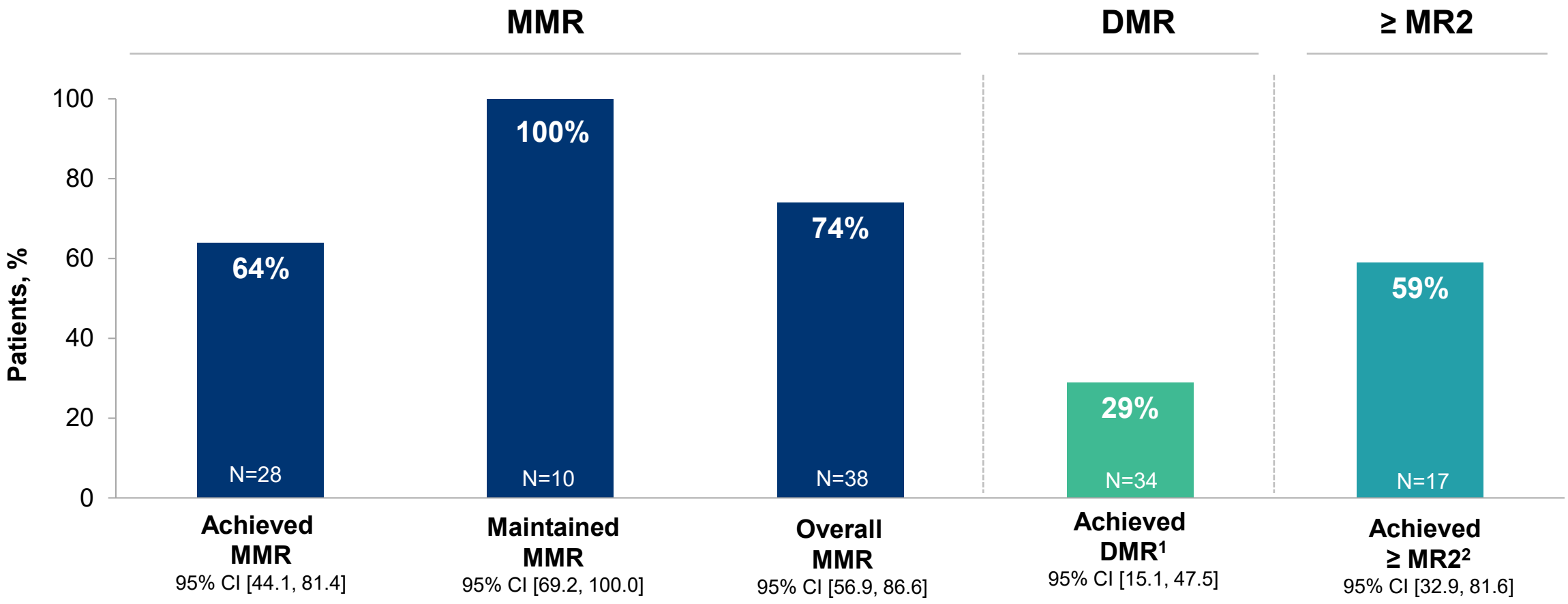
- Efficacy evaluable cohort includes patients **without T315I or atypical transcripts**
- As of 13 September 2025, **38 patients were evaluable for MMR by 24 weeks,** assessed centrally

Efficacy Evaluable Criteria

- Received TERN-701 for at least 24 weeks, OR
- **Achieved** MMR or better prior to 24 weeks (if no MMR at baseline), OR
- **Maintained** MMR or better for ≥24 weeks (if in MMR at baseline), OR
- Discontinued treatment for any reason prior to 24 weeks

Source: Hughes TP, et al. Supplementary appendix. *N Engl J Med* 2019;381:2315-26.
Data cut-off 13Sep2025

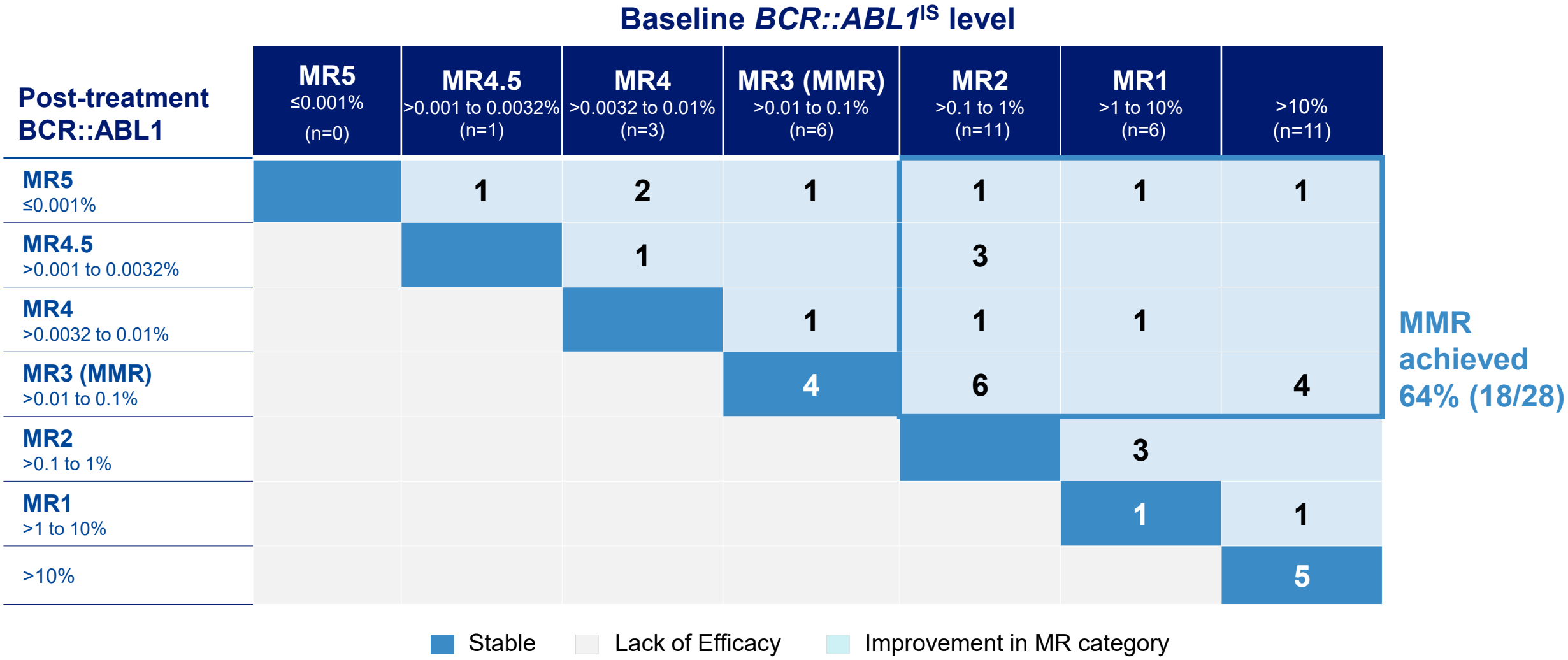
TERN-701 Shows Unprecedented Rates of Molecular Response



1. Included patients with baseline BCR::ABLIS >0.01% achieving MR4, BCR::ABL1IS ≤0.01%; MR4.5, BCR::ABL1IS ≤0.0032%; and MR5, BCR::ABL1IS ≤0.001
2. Included patients with BCR:ABL1IS >1% at baseline

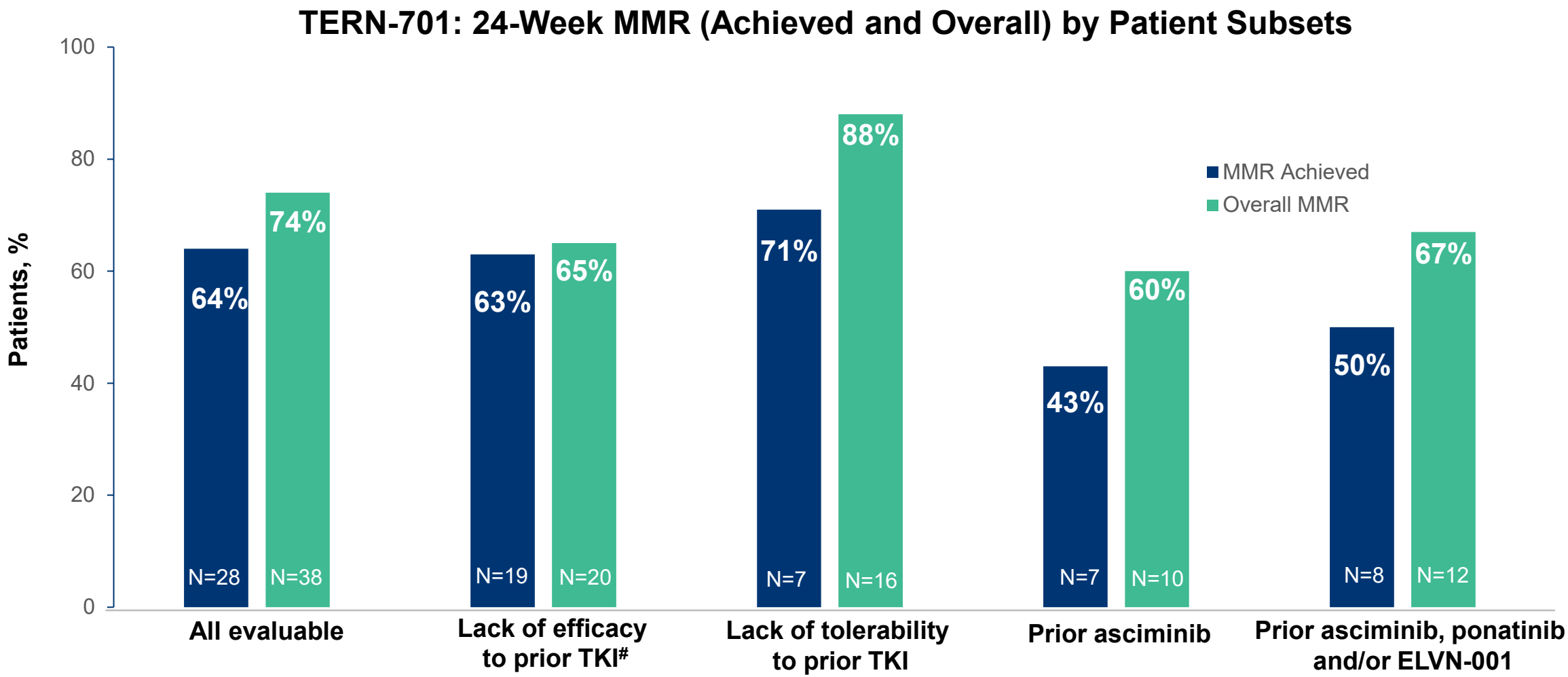
Data cut-off 13Sep2025

MMR and DMR Seen Across Full Spectrum of Baseline Transcripts



MR: molecular response; MMR: major molecular response; DMR: deep molecular response
Data cut-off 13Sep2025

Strong MMR Rates in Difficult to Treat Subgroups Supports Best-in-Disease Efficacy Potential

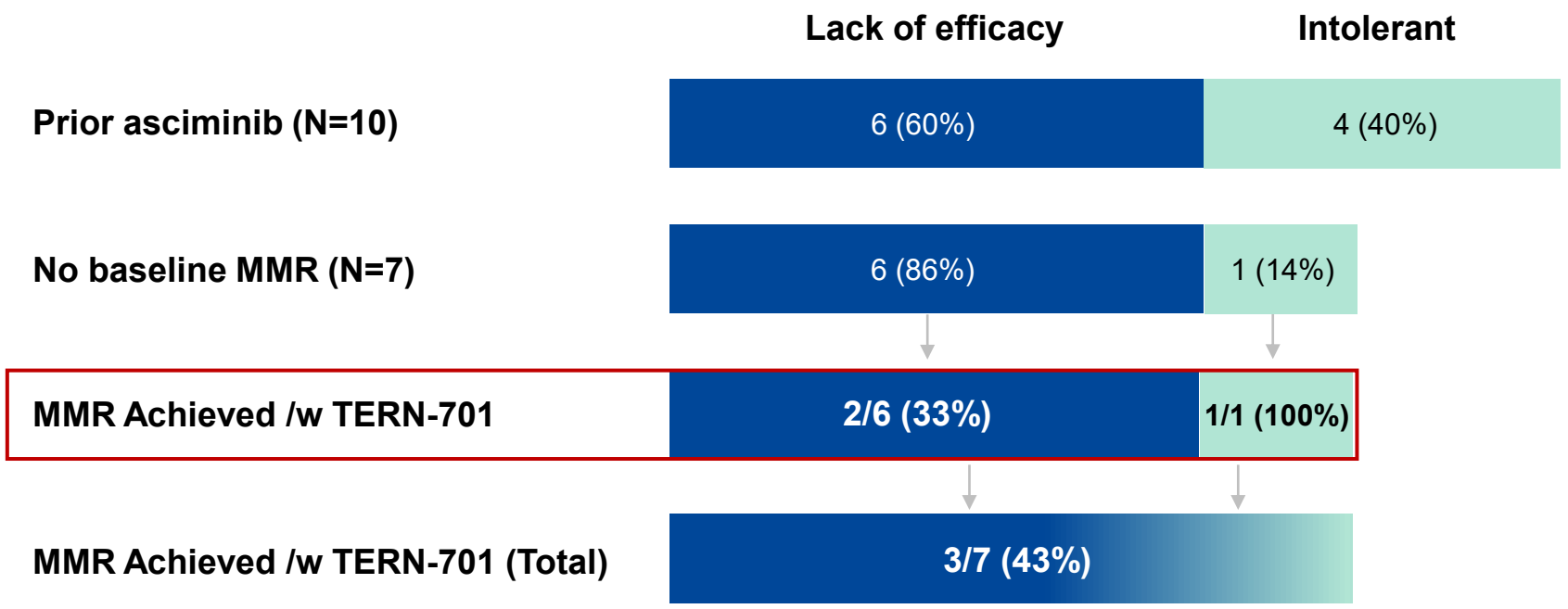


#per ELN 2020 criteria
Data cut-off 13Sep2025

Encouraging Rates of MMR Achievement in Patients with Prior Lack of Efficacy and/or Intolerance to Asciminib

Subgroup Analysis: Prior Asciminib Treated Patients

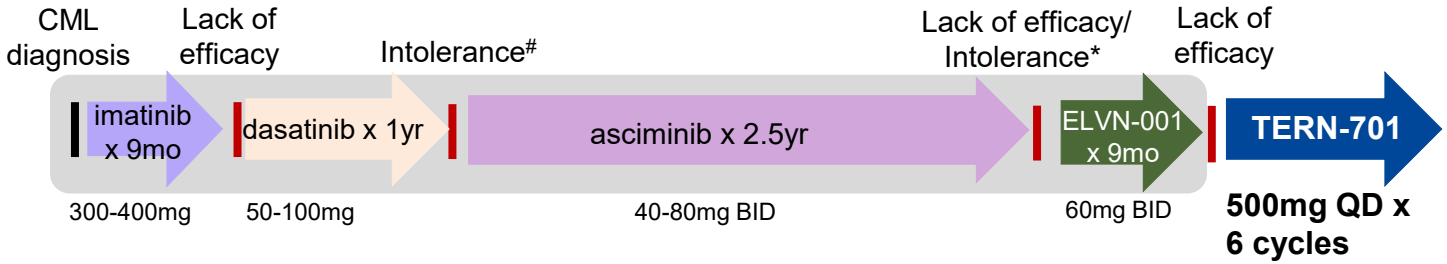
- 10 MMR-evaluable patients were prior asciminib treated
- 5/10 patients also had prior ponatinib and/or ELVN-001 (see appx. for detail)
- 7/10 patients, including all MMR achievers, remain on treatment as of the data cut-off

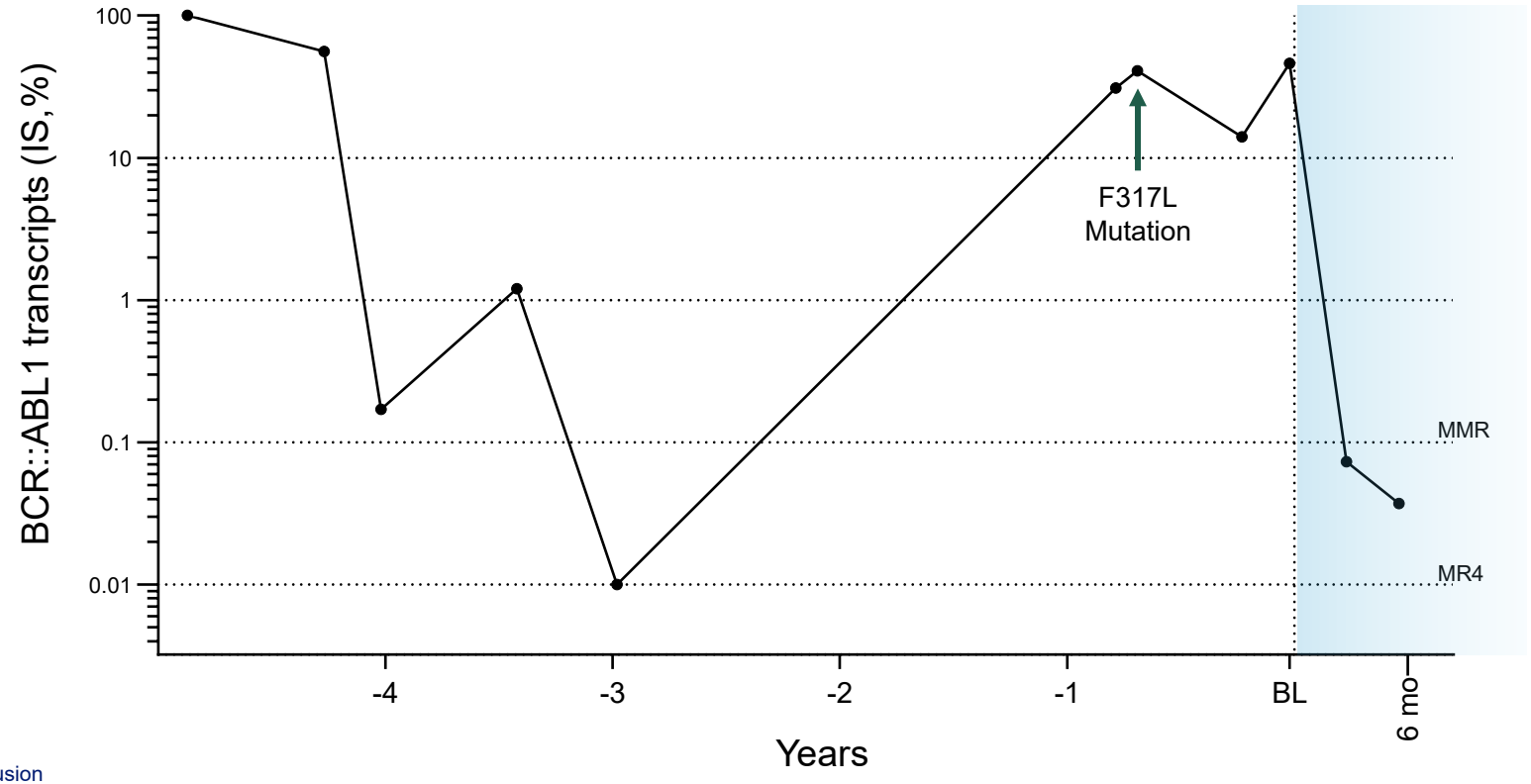


Data cut-off 13Sep2025

Rapid MMR in Highly Refractory, Elderly Patient with Mutated CML and Lack of Efficacy with Prior Asciminib and ELVN-001

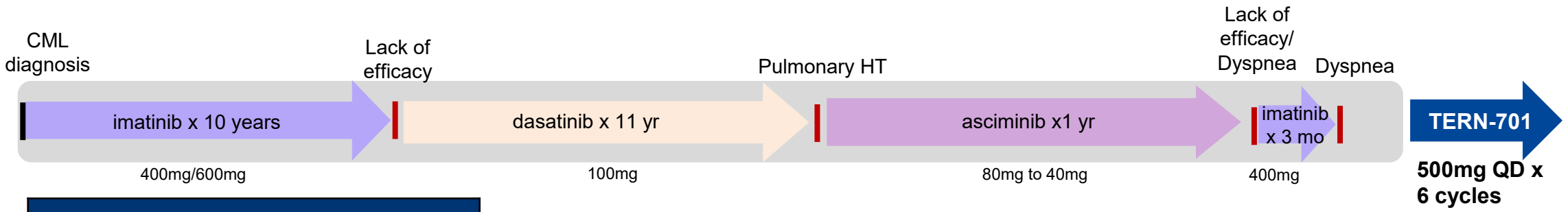
Baseline Patient Characteristics	
Age	80
Sex	Male
# of prior TKIs	4
BCR::ABL1 Mutations	F317L (100%#)
Efficacy	>10% to MMR



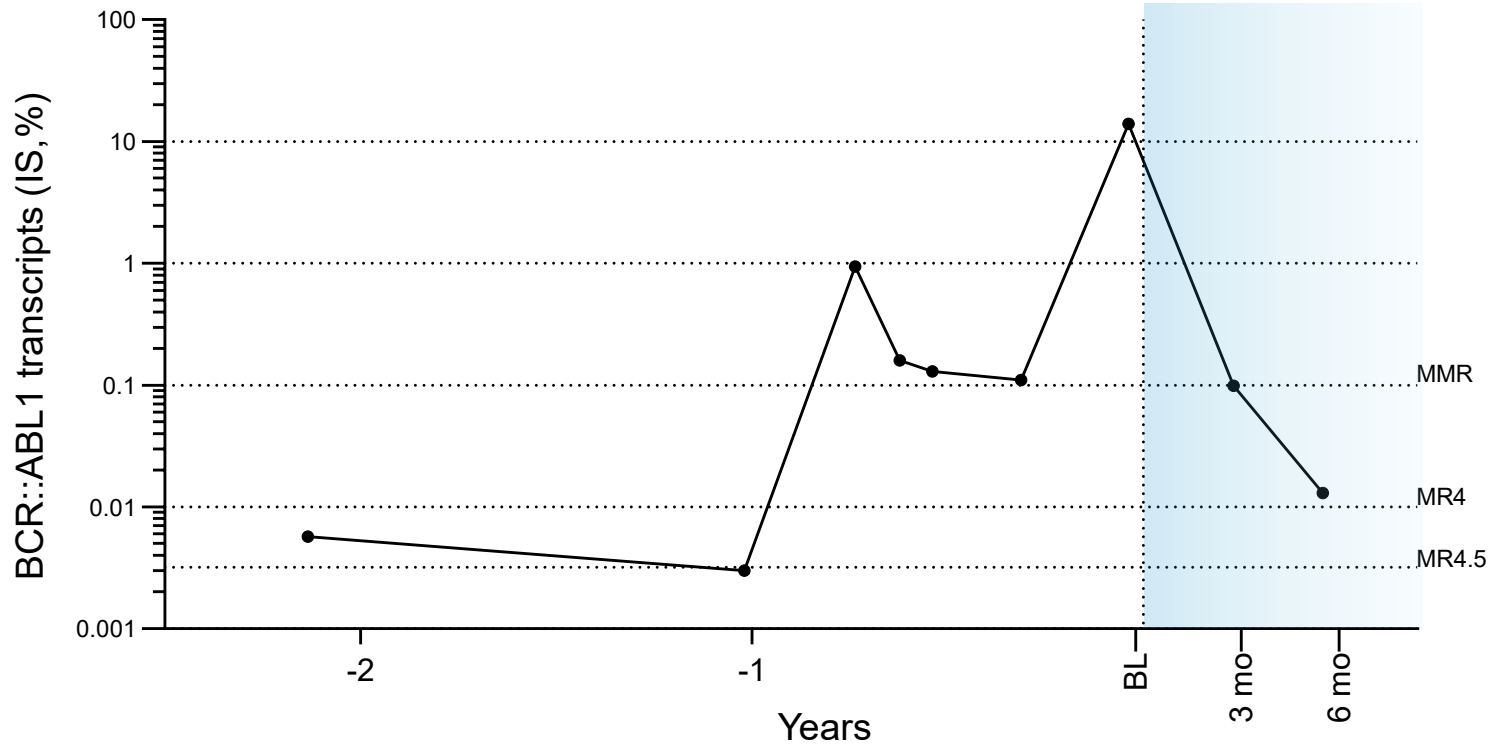


#ratio of mutant:natïve BCR::ABL1 on central assessment; *lipase elevation; #pleural effusion
BL: baseline; MMR: major molecular response; MR: molecular response; MR4: BCR::ABL1IS ≤ 0.01%; cycle = 28 days
Data cut-off 13Sep2025

Another Rapid MMR Achievement in Young Patient with Lack of Efficacy on Prior Asciminib



Baseline Patient Characteristics	
Age	44 years
Sex	Male
# of prior TKIs	3
BCR::ABL1 Mutations	None
Efficacy	>10% to MMR



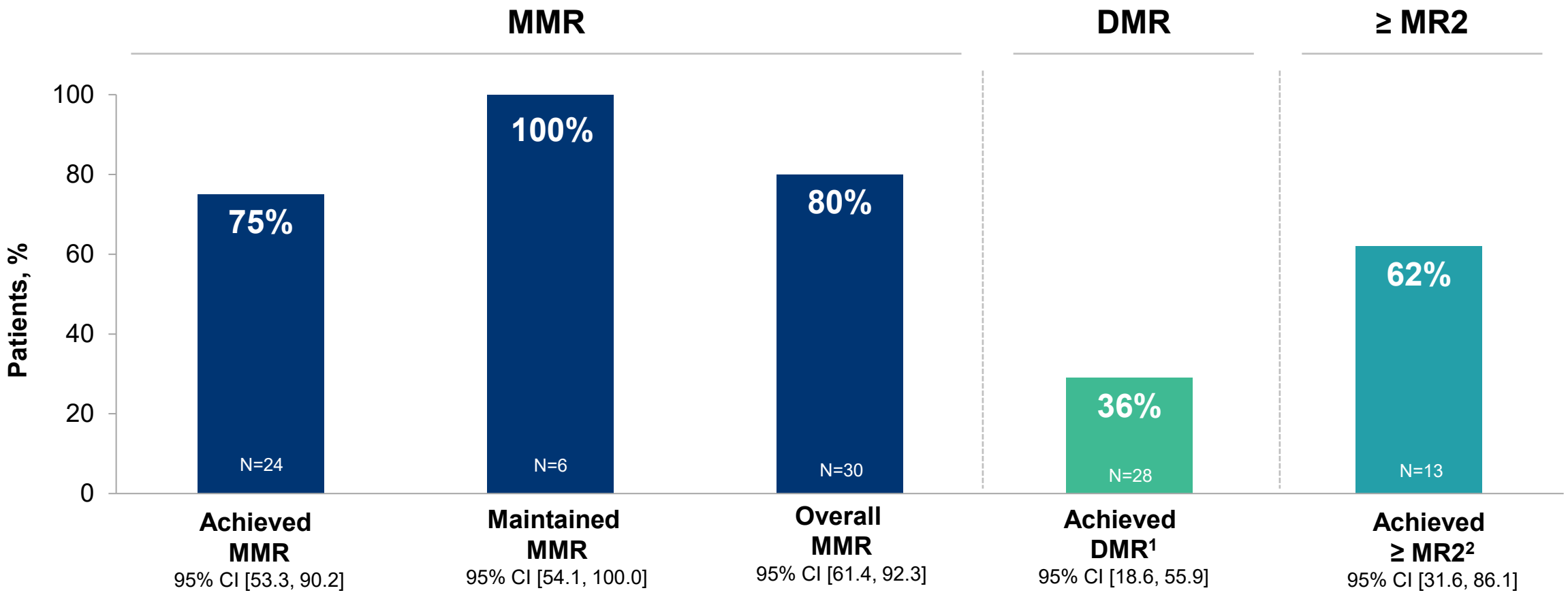
BL: baseline; MMR: major molecular response; MR: molecular response; MR4:.BCR::ABL1^{IS} ≤ 0.01%; MR4.5: BCR::ABL1^{IS} ≤ 0.032%, cycle = 28 days
Data cut-off 13Sep2025

Patients Treated at Doses ≥320 mg Have Similar Baseline Characteristics to Full Study Population

	Pts at Doses ≥320 mg (N=53)	Pts at All Doses (N=63)
Age, median (range), years	57 (30–82)	57 (29–86)
Baseline *BCR::ABL1*^{IS}, n (%)		
>10%	25 (47%)	28 (44%)
>1% to 10%	5 (9%)	8 (13%)
>0.1% to 1%	16 (30%)	16 (25%)
≤0.1%	7 (13%)	11 (18%)
Discontinuation to last TKI, n (%)*		
Lack of efficacy (per ELN 2020 criteria)	36 (68%)	40 (64%)
Lack of tolerability	12 (23%)	18 (29%)
Median # of prior unique TKIs (range)	3 (1–6)	3 (1–6)
≥3 prior lines, n (%)	32 (60%)	38 (60%)
Prior ponatinib	11 (21%)	14 (22%)
Prior asciminib	20 (38%)	24 (38%)
BCR::ABL1 mutations, n (%) T315I / F317L / E255K	5 (9%) / 2 (4%) / 1 (2%)	6 (10%) / 2 (3%) / 1 (2%)

*Five patients discontinued last TKI for other reasons
Data cut-off 13Sep2025

TERN-701 Shows Unprecedented Rates of 24-Week Molecular Response at Doses ≥320 mg



1. Included patients with baseline BCR::ABLIS >0.01% achieving MR4, BCR::ABL1IS ≤0.01%; MR4.5, BCR::ABL1IS ≤0.0032%; and MR5, BCR::ABL1IS ≤0.001
2. Included patients with BCR:ABL1 IS >1% at baseline
Data cut-off 13Sep2025; RP2D: recommended Phase 2 doses

TERN-701 Shows 75% MMR Achievement at Doses ≥320 mg

MMR Achieved by 24 weeks	Overall MMR by 24 weeks	DMR Achieved by 24 weeks
75% (18/24)	80% (24/30)	36% (10/28)

Baseline BCR::ABL1

Post-treatment BCR::ABL1	MR5 ≤0.001% (n=0)	MR4.5 >0.001 to 0.0032% (n=1)	MR4 >0.0032 to 0.01% (n=1)	MR3 (MMR) >0.01 to 0.1% (n=4)	MR2 >0.1 to 1% (n=11)	MR1 >1 to 10% (n=4)	>10% (n=9)
MR5 ≤0.001%		1	1	1	1	1	1
MR4.5 >0.001 to 0.0032%					3		
MR4 >0.0032 to 0.01%				1	1	1	
MR3 (MMR) >0.01 to 0.1%				2	6		4
MR2 >0.1 to 1%						1	
MR1 >1 to 10%						1	1
>10%							3

DMR achieved 36% (10/28)

MMR achieved 75% (18/24)

MMR: major molecular response; DMR: deep molecular response
Data cut-off 13Sep2025

CARDINAL Enrolls a More Refractory Patient Population Than Asciminib Phase 1 and 3 Studies

2014 — **Ph1 study of asciminib**

2017 — **Asciminib Ph3 study**

2021 — SCEMBLIX® (asciminib) 20 mg, 40 mg tablets approved in 3L+ CP-CML[3]

2024 — CARDINAL

Enrolled population

- No prior asciminib[1,2]
- Imatinib / 2GTKI / ponatinib failure / intolerant[1,2]
- Predominantly 3L+ patients[1,2]

Enrolled population

- Asciminib failure / intolerant[4,5]
- Imatinib / 2GTKI / ponatinib failure / intolerant[4,5]
- Predominantly 3L+ patients[4,5]

1. Hughes TP, et al. *N Engl J Med* 2019;381:2315-2326. 2. Rea D et al. *Blood* 2021; 138 (21): 2031–2041. 3. Pamuk et al. *Clin Cancer Res.* 2024 Oct 1;30(19):4266-4271.
4. ClinicalTrials.gov identifier: NCT06163430. 5. Jabbour E., et al. 67th ASH Annual Meeting and Exposition; December 6-9, 2025; Orlando, FL Abstract #901.

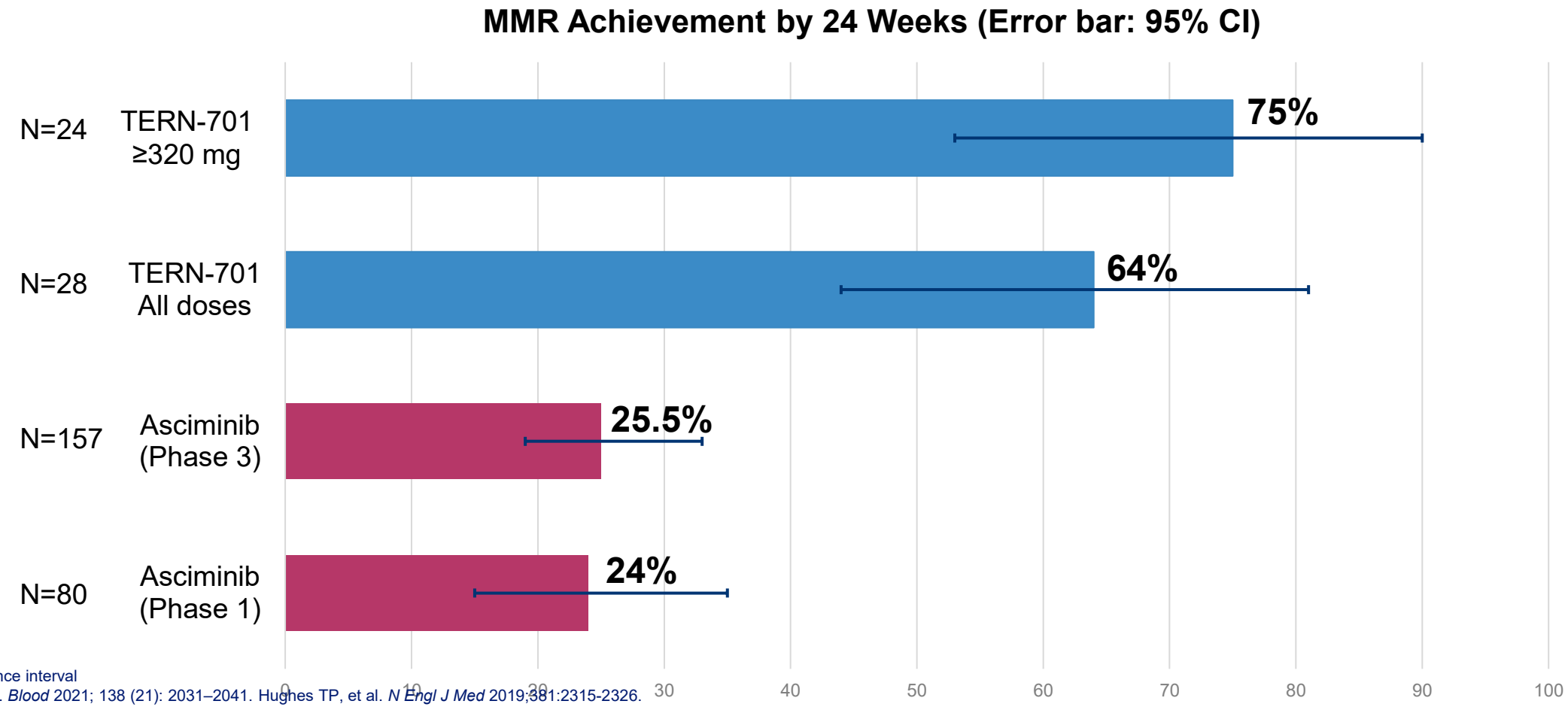
TERN-701 Efficacy Shows Best-in-Disease Potential Across Multiple Measures of Molecular Response

24Wk molecular responses in non-T315I CML	TERN-701 Ph1 CARDINAL All doses	TERN-701 Ph1 CARDINAL ≥320 mg QD	Asciminib Ph1 'X2101 All doses	Asciminib Ph3 ASCEMBL* 40 mg BID
MMR Achievement Rate	**64%** (18/28)	**75%** (18/24)	24% (19/80)	25.5% (40/157)
DMR Achievement Rate	**29%** (10/34)	**36%** (10/28)	14% (15/105)	10.8% (ND)
MR2 Achievement Rate	**59%** (10/17)	**62%** (8/13)	48% (30/62)	40.8% (ND)

*ASCEMBL Ph3 dosed at RP2D (40mg BID)
DMR= deep molecular response. Included patients achieving MR4, BCR::ABL1IS ≤0.01%; MR4.5, BCR::ABL1IS ≤0.0032%; and MR5, BCR::ABL1IS ≤0.001
MR2= BCR::ABL1IS ≤1%; included patients with BCR:ABL1IS >1% at baseline
ND= Numerator and denominator not disclosed
Hughes TP, et al. *N Engl J Med* 2019;381:2315-2326. Mauro M. et al. *Leukemia* 2023; 37:1048–1059. Rea D et al. *Blood* 2021; 138 (21): 2031–2041. Hochhaus A et al. European Hematology Association Congress. June 12-15, 2025; Milan, Italy. Abstract: S165.
Data cut-off 13Sept2025
No head-to-head clinical studies have been conducted comparing TERN-701 with marketed or investigational drugs. Differences exist in study designs and conditions, and caution should be exercised when comparing data across studies.

TERN-701's MMR Achievement (All Doses) Exceeds Asciminib's with Clearly Separated Confidence Intervals

Lower bound of 95% CI for TERN-701's 24-week MMR rate exceeds MMR rate for asciminib



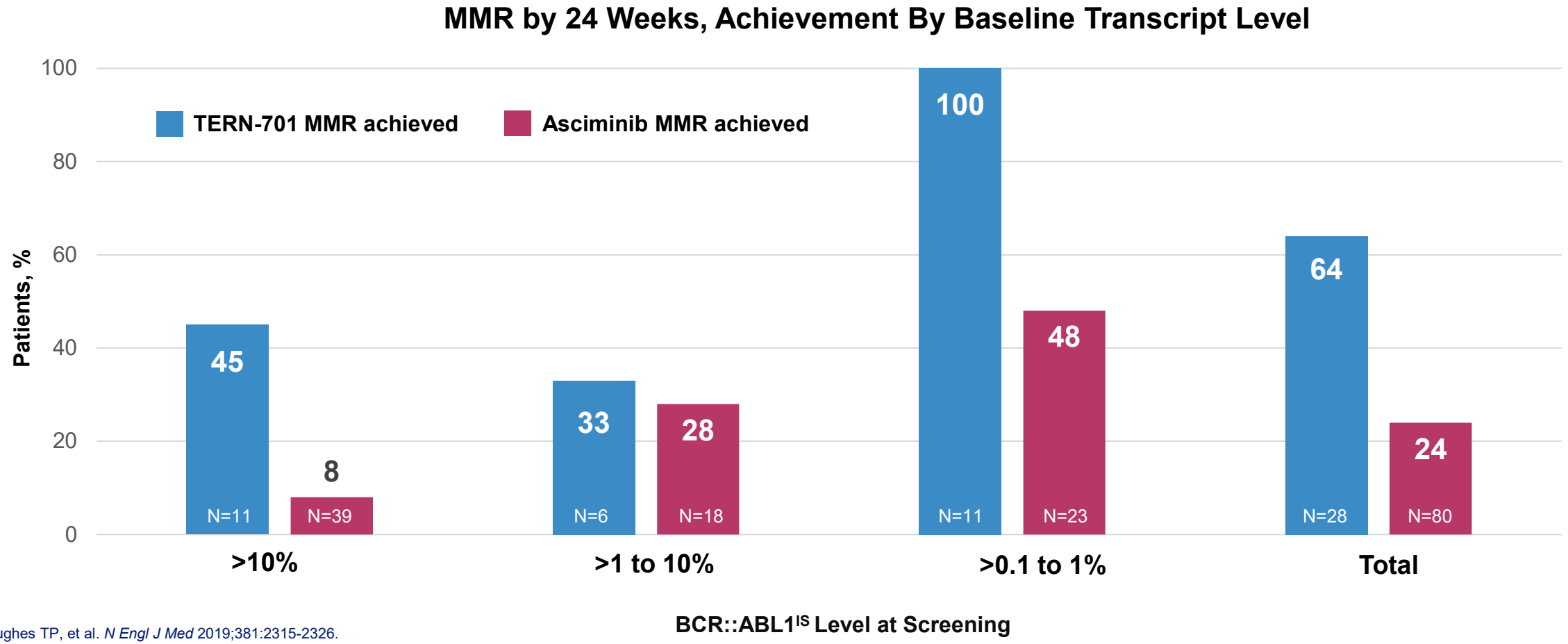
CI: confidence interval

Rea D et al. *Blood* 2021; 138 (21): 2031–2041. Hughes TP, et al. *N Engl J Med* 2019;381:2315-2326.

Data cut-off 13Sep2025

Note: No head-to-head clinical studies have been conducted comparing TERN-701 with marketed or investigational drugs. Differences exist in study designs and conditions, and caution should be exercised when comparing data across studies

TERN-701 MMR Achievement (All Doses) By 24 Weeks Trending Higher Than Asciminib Across All Baseline Transcript Categories

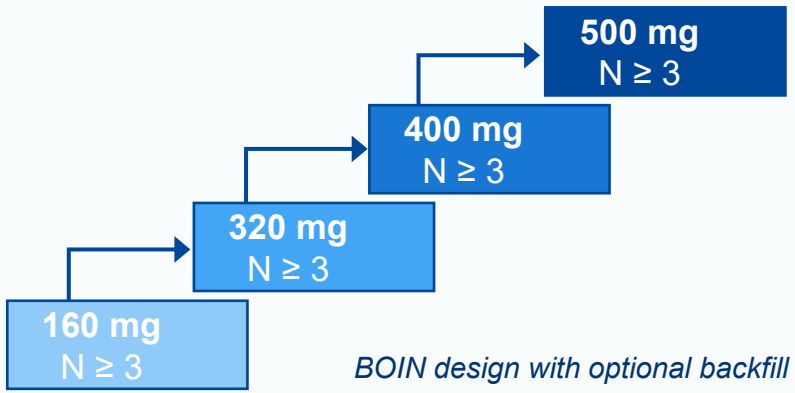


Hughes TP, et al. *N Engl J Med* 2019;381:2315-2326.
Data cut-off 13Sep2025
Note: No head-to-head clinical studies have been conducted comparing TERN-701 with marketed or investigational drugs. Differences exist in study designs and conditions, and caution should be exercised when comparing data across studies

As of January 2026, CARDINAL Trial Includes New Mutation Cohort

Part 1 Dose Escalation

TERN-701 QD (N= up to 80)

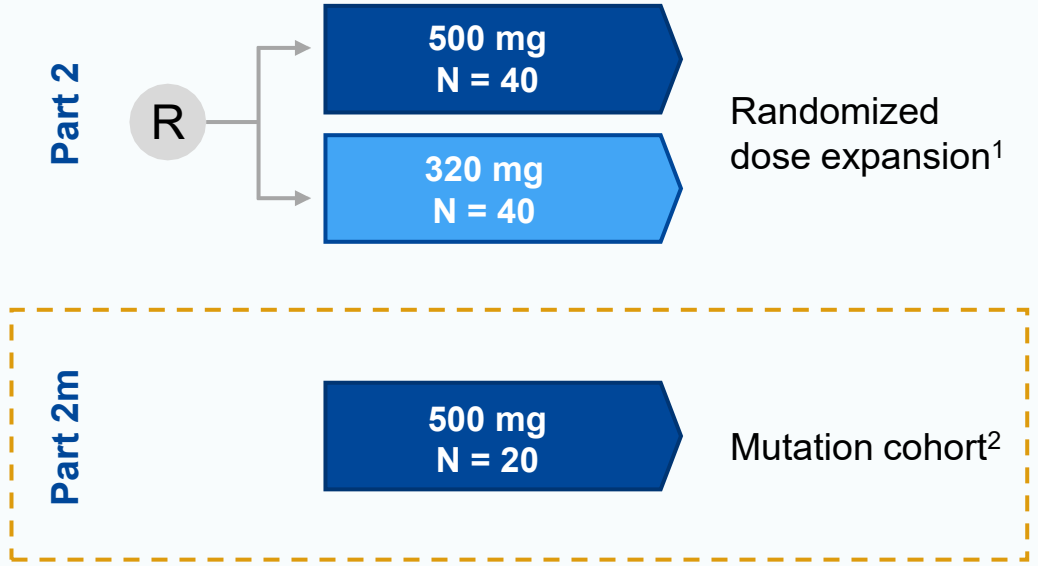


BOIN design with optional backfill cohorts

RDE Selection

Part 2 Dose Expansion

TERN-701 QD (N≈100)



Primary Endpoints: Safety and tolerability (including dose-limiting toxicities)

Secondary Endpoints: Efficacy (molecular responses) and pharmacokinetics

CML: chronic myeloid leukemia

1. Excluded mutations: T315I, M244V, E355G, A337V, P465S, V468F, I502L, G463D, G463S, C46W and mutation(s) in the SH2/SH3 contact sites or C lobe
2. Included mutations: T315I, M244V, H396R, E355G, F359I/C/V and I502L. Other mutations not listed but present in the P-loop, active site, A-loop and C-helix can be considered for inclusion on a case-by-case basis

TERN-701 Data Provides Strong Momentum Towards Pivotal Trials

24-week MMR has strong readthrough from Ph.1 to Ph.3 trials in relapsed/refractory CML[1]

CARDINAL
TERN-701 Phase 1/2
2L+ CML patients

Phase 3 2L+ CML Study
Planned initiation late 2026 / early 2027

★ *Potential initial approval*

Anticipated 2L+ trial design:
- TERN-701 vs dealer's choice 2G TKI (dasatinib, nilotinib, bosutinib)
- Primary endpoint of MMR achievement at 24 weeks
- Non-T315Im population

Pivotal trials expected to run in parallel

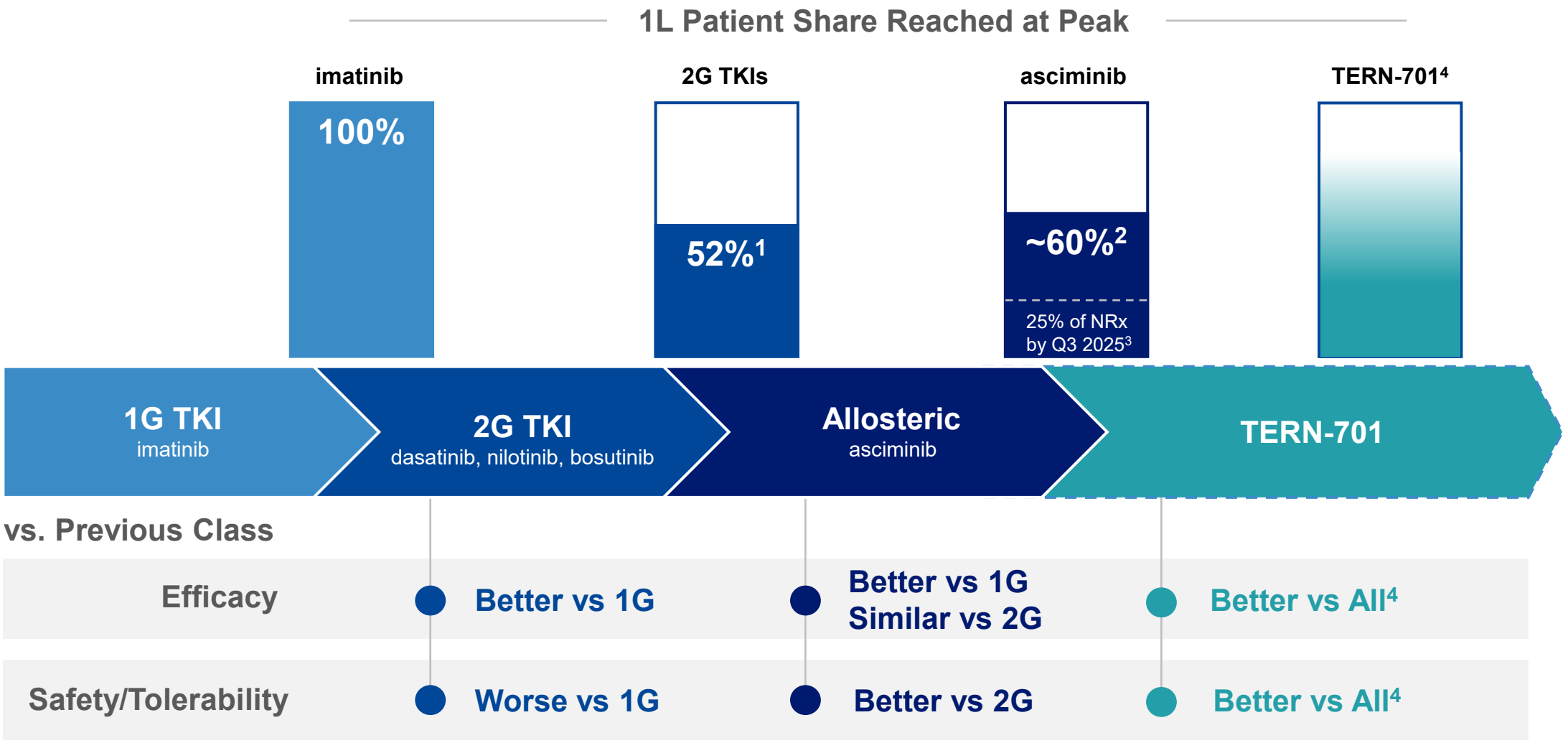
Phase 3 Frontline CML Study
Planned initiation within 6-12 mos of 2L+ start

★ *Potential second approval*

Potential 1L trial design:
- TERN-701 vs dealer's choice TKI (w/wo asciminib control)
- Primary endpoint of MMR achievement at 48 weeks
- Non-T315Im population

1. Hughes TP, et al. *N Engl J Med* 2019;381:2315-2326. Mauro M et al. *Leukemia* 2023; 37:1048-1059. Rea D et al. *Blood* 2021; 138 (21): 2031–2041

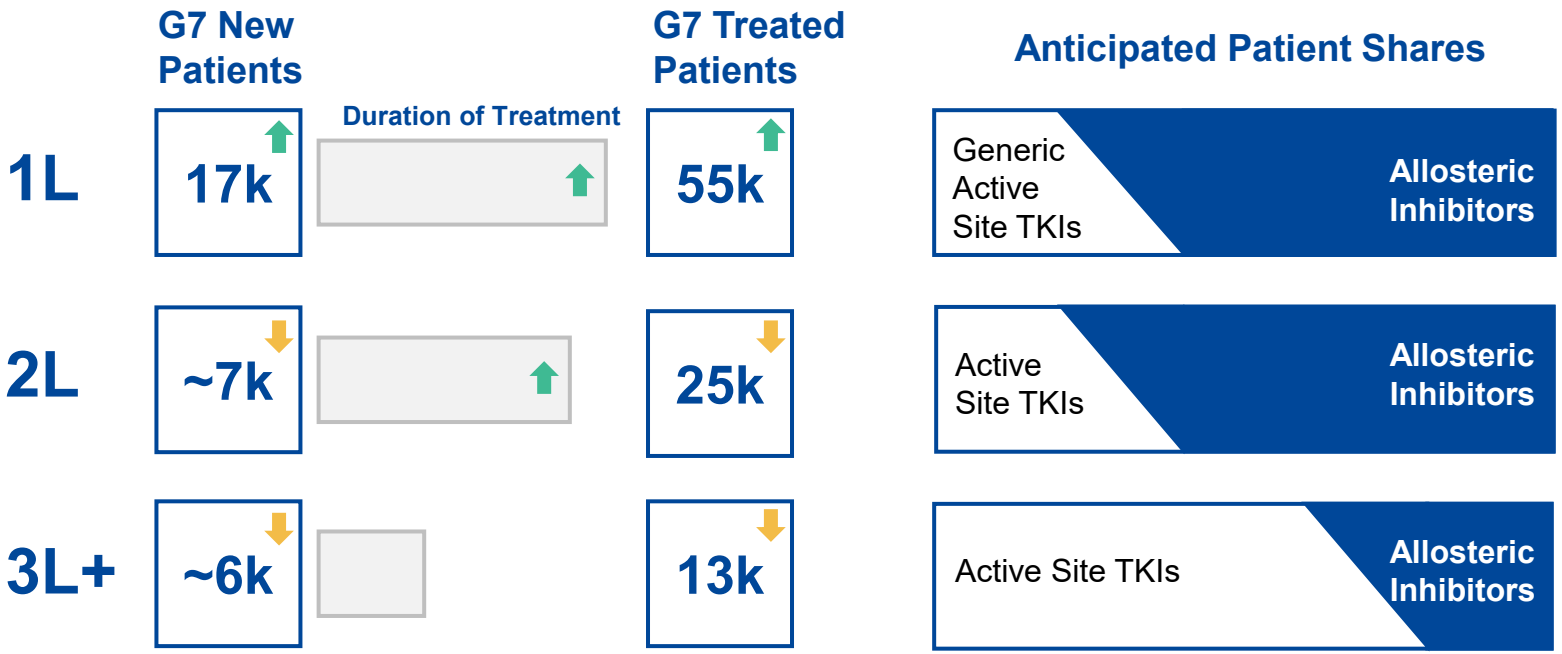
Appetite for CML Innovation Remains Strong: New & Improved Entrants Capture Majority 1L Share Even as Standard Therapies Become Generic



1. Novartis ASCO Investor Event, June, 2024; 2. Projected peak share based on ClearView Market Sizing 2025; 3. Novartis Q3 2025 Quarterly Earnings; 4. Aspirational profile based on TERN-701 data presented at ASH 2025

TERN-701 Well-Positioned In Early Lines If Approved

Majority of market opportunity expected in the 1L and 2L settings



TERN-701 Opportunity

HIGH: Best-In-Disease Profile to Capture New Patients

HIGH: Switch from Both Asciminib and Active Site TKIs

LOW: Anticipated High Early-Line Use

Anticipated Trends

- ↑ Increasing CML Incidence (New Patients) due to Aging Population
- ↑ Increasing 1L/2L Duration of Treatment due to Higher Allosteric Use
- ↓ Decreasing 2L/3L+ New Starts - Patients Stay Longer on Allosteric Inhibitors

Sources: SEER Data, 2024; Novartis ASCO Investor Event, June,2024; Kantar Health, CML prevalence in G7, 2024 and CML incidence in G7 patients in 2024; CancerMPact® Treatment Architecture 2025; ClearView Opportunity Analysis, July 2025

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Conclusions

Significant Clinical Progress Enables Development Plan For All Lines of Treatment

- Reaffirmed unprecedented efficacy from abstract of **64% MMR achieved** by 24 weeks
- **75% MMR achieved and 36% DMR** by 24 weeks at doses of ≥ 320mg
- Continued **favorable safety and tolerability profile** with majority of TEAEs low grade
- **Enrollment accelerating** in Q4 with n=85+ in trial as of December 8, 2025

Data cut-off 25Sep2025

TERN-701 has Multiple Significant Catalysts Upcoming in 2026

TERN-701
(Allosteric BCR-ABL inhibitor)

Pivotal Dose Selection
(mid-26)

EOP2 Regulatory Interaction
(mid-26)

CARDINAL **2H26 Data Update**
(by 2H26)

2L+ Pivotal Trial Initiation
(late 2026 / early 2027)

Note: Relative position of expected milestones on illustration does not denote or imply chronological order.
EOP2: End of Phase 2

Strong Financial Position Supports Upcoming Milestones

Cash*

~$1.0B

Runway into

2031

includes first potential approval and launch of TERN-701

Shares*

~115M

* Year-end 2025 unaudited cash, cash equivalents and marketable securities; shares include common stock and prefunded warrants

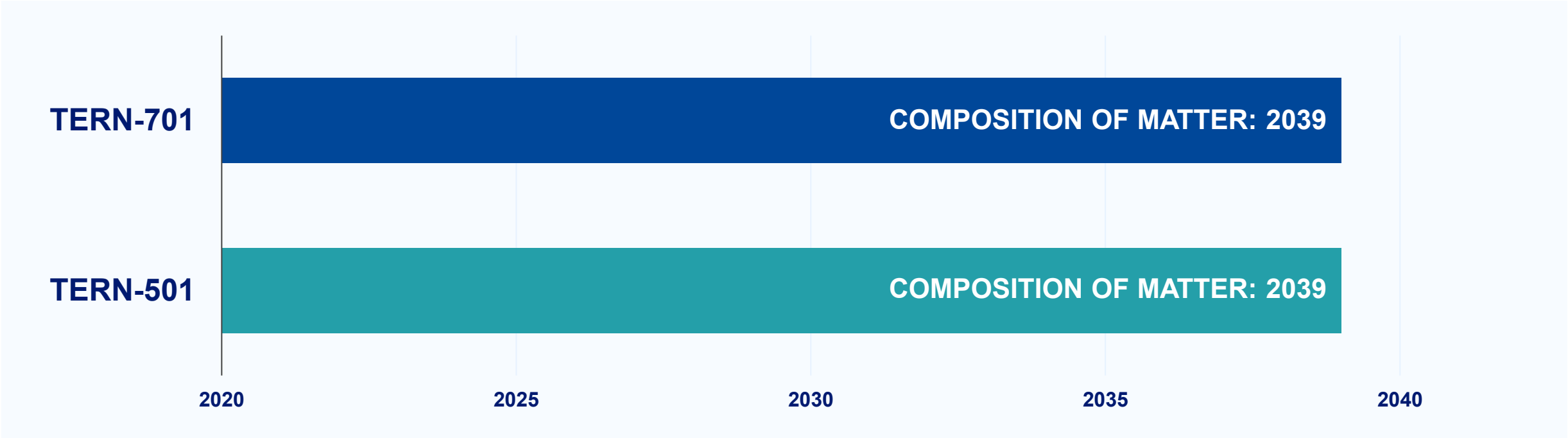
Multiple Wholly-owned Opportunities Targeting Serious Diseases

PROGRAM	MECHANISM	INDICATION	DISCOVERY	PRECLINICAL	PHASE 1 / PHASE 2	PHASE 3
Oncology						
TERN-701[1]	Allosteric BCR-ABL Inhibitor	CML	Phase 1/2 CARDINAL			
Discovery	Undisclosed	Undisclosed	Discovery			
Metabolic – **available for partnering**						
TERN-501	THR-β agonist for use alone or in combination with other metabolic therapies for MASH/NASH/obesity (Phase 2 ready)					
TERN-801	GIPR antagonist development candidate for obesity					

1. Terns licensed to Hansoh development and commercialization rights for TERN-701 in mainland China, Taiwan, Hong Kong and Macau
2. CML: chronic myeloid leukemia, THR-β: thyroid hormone receptor beta, MASH: metabolic dysfunction-associated steatohepatitis, NASH: non-alcoholic steatohepatitis; GIPR: glucose-dependent insulinotropic polypeptide receptor

Intellectual Property Position

- Patent exclusivity could be extended for a period of up to 5 years through patent term extension
- Issued patents and pending applications cover polymorphs, methods of treatment/dosing, and combination treatment approaches



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

Mission. Vision. Identity.

mission

To advance transformative medicines that address serious diseases.

vision

To pioneer significant innovations across the lifecycle of drug development.

our name tells our story

Terns are remarkable birds whose instincts mirror our approach to medicine. Like these extraordinary navigators, we at Terns are:

dynamic and agile

We approach complex science with focused innovation and elegant solutions

instinctively adaptive

We pivot quickly when needed without losing our rigor and focus

natural pathfinders

We chart clear courses from validated science to meaningful therapeutic advances

built for the journey

We pursue breakthrough treatments with the endurance to overcome almost any obstacle

steadfast in purpose

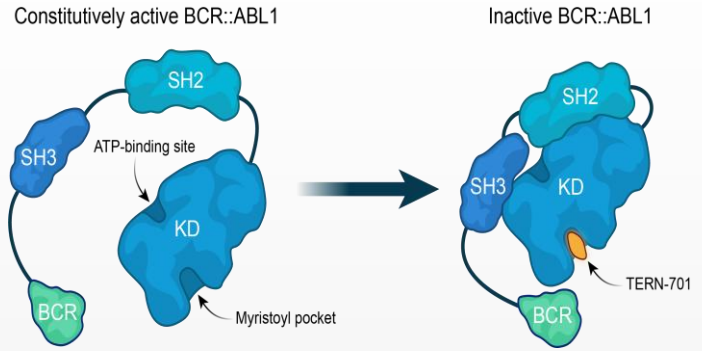
We maintain an unwavering commitment to people living with serious diseases

terns

Appendix

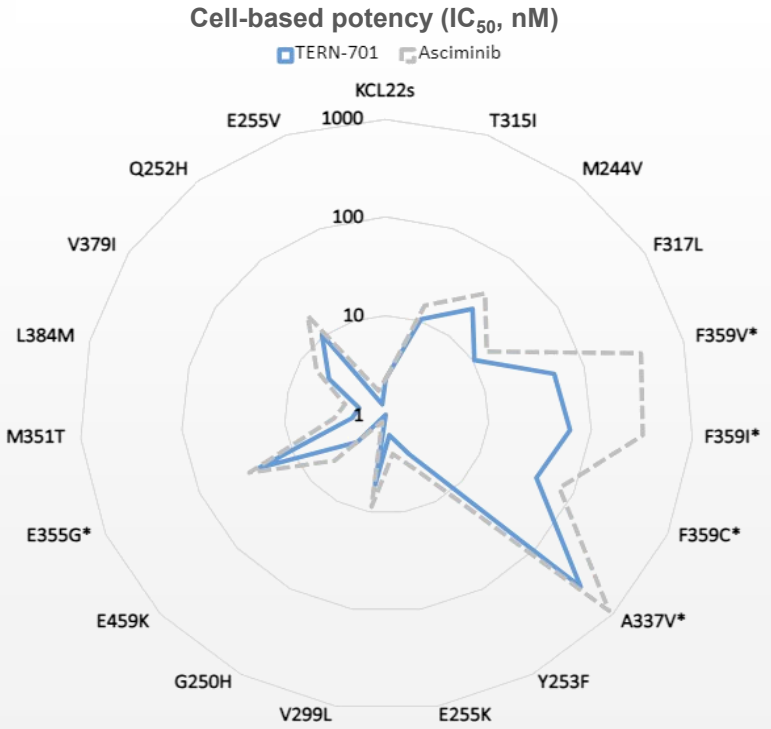
Differentiated TERN-701 Properties Provide Rationale for Potential Best-in-Disease Efficacy in CML

1. **Highly selective, novel** binding site on BCR::ABL1

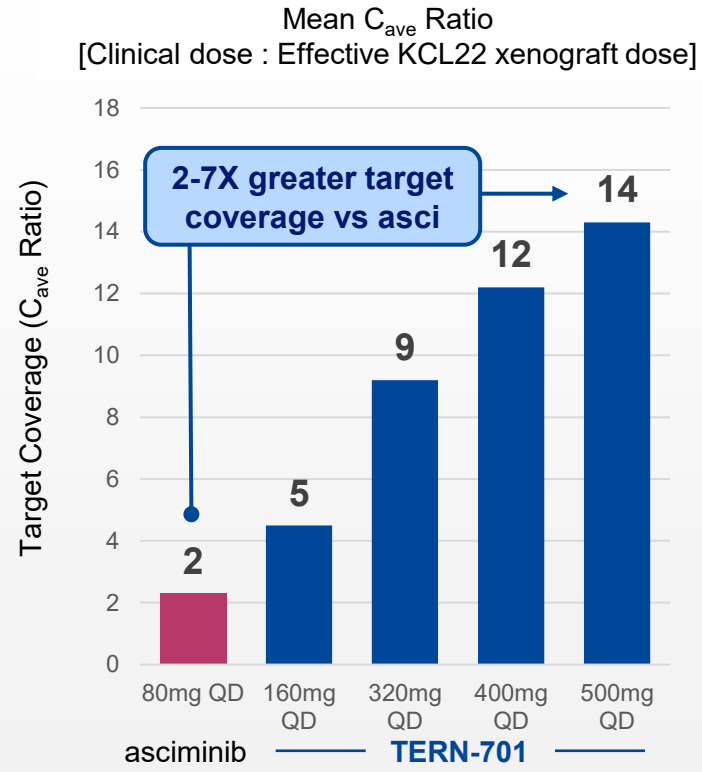


Allosteric TKIs have **>1,000X selectivity** for BCR::ABL over wild-type kinases compared to active-site TKIs (greater selectivity → improved safety profile)

2. **More potent** than asciminib vs native & mutant BCR::ABL1 *in vitro*



3. **Greater target coverage** than approved dose of asciminib

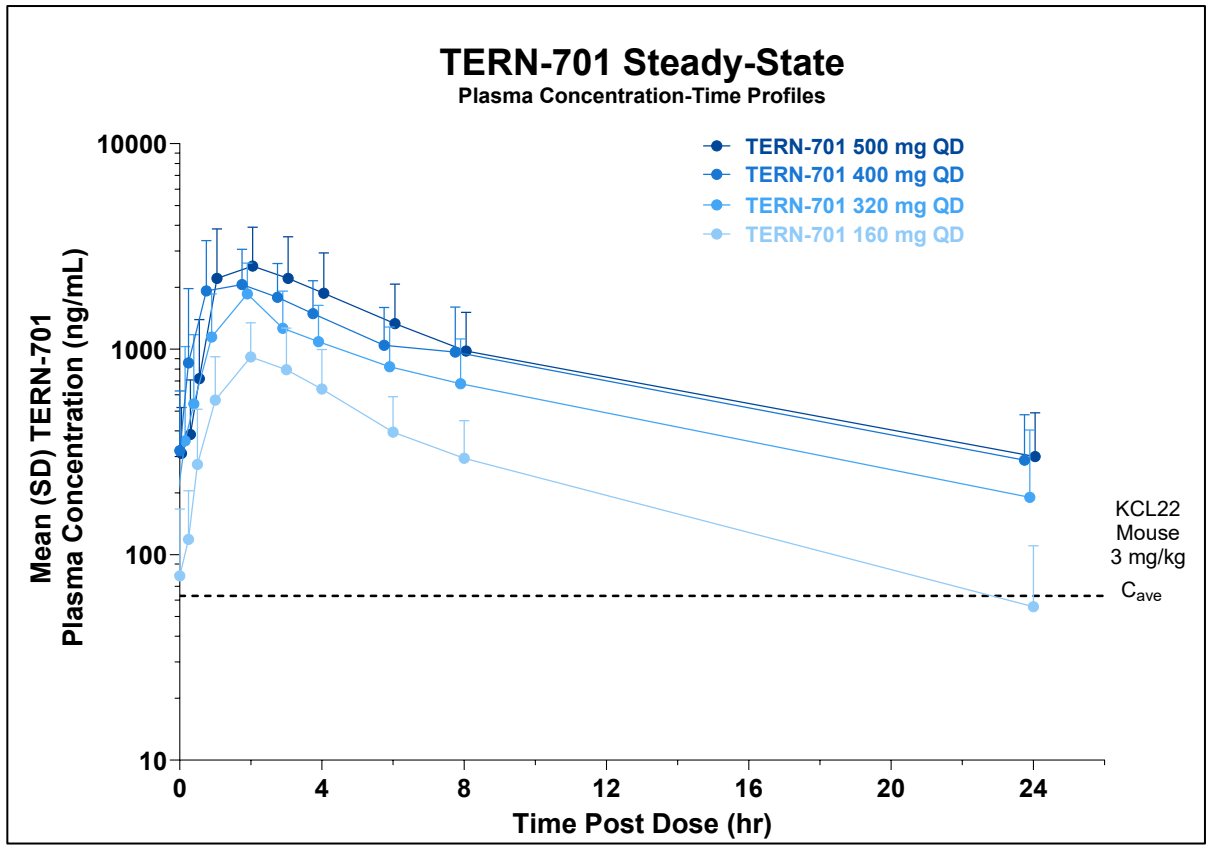


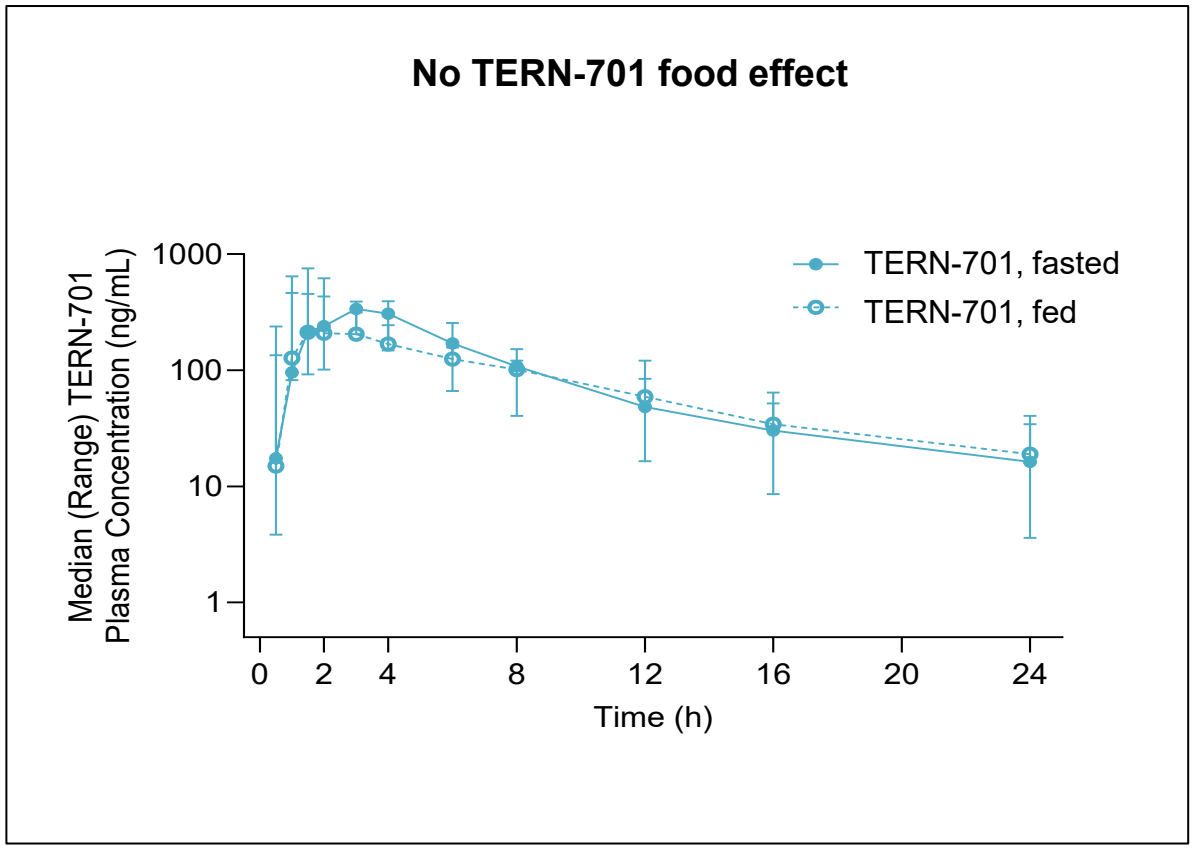
* Denotes myristoyl mutations or mutations indicated in resistance to allosteric inhibition of BCR::ABL1

TERN-701 Phase 1: Pharmacokinetic Profile

- Linear PK with approximately **dose proportional increase in exposure** from 160-500 mg

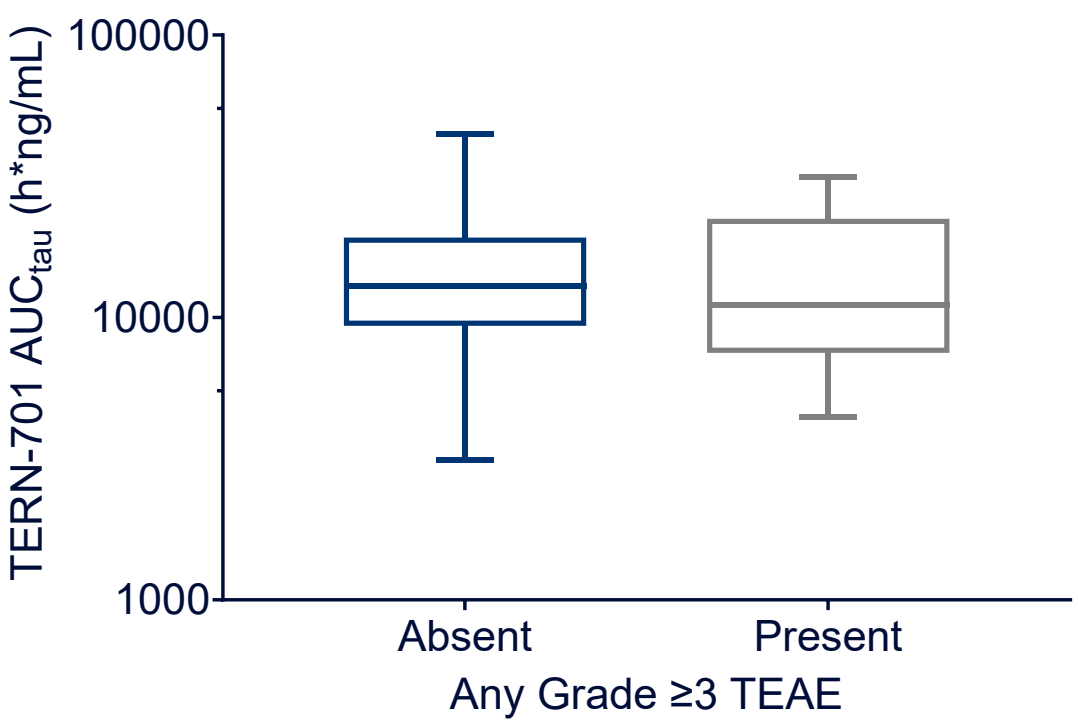
- No **clinically significant difference** in exposure (AUC) when dosed fasted or with a high-fat meal

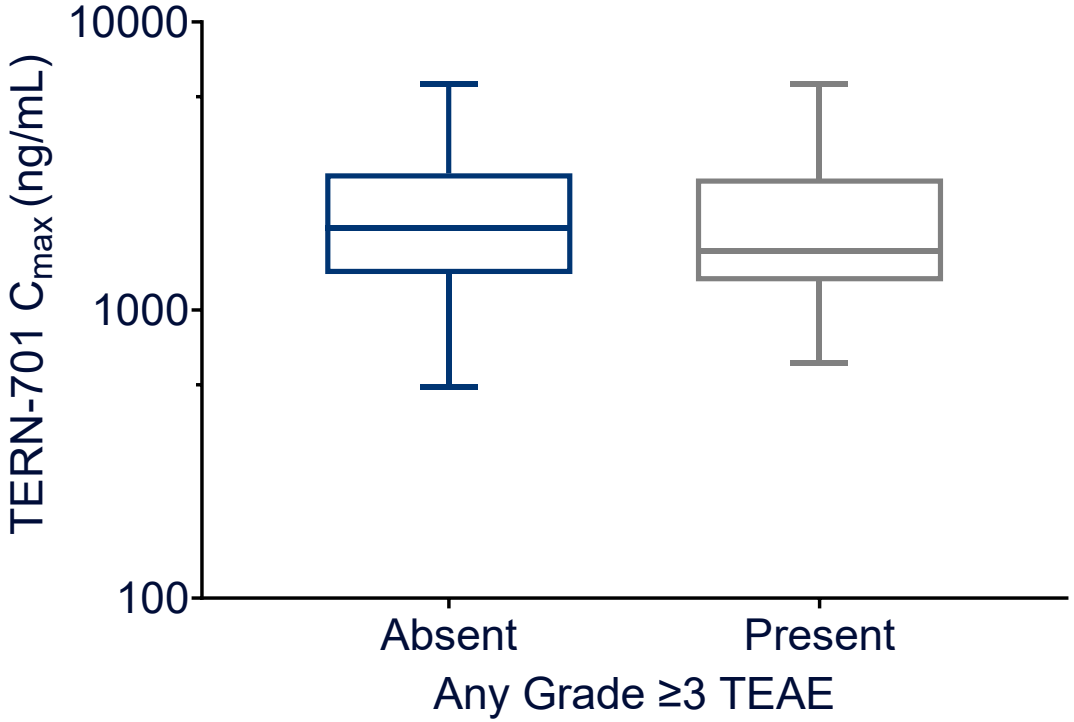




Exposure-Safety Analysis Shows No Relation Between TERN-701 Exposure and Grade 3 or Higher TEAEs

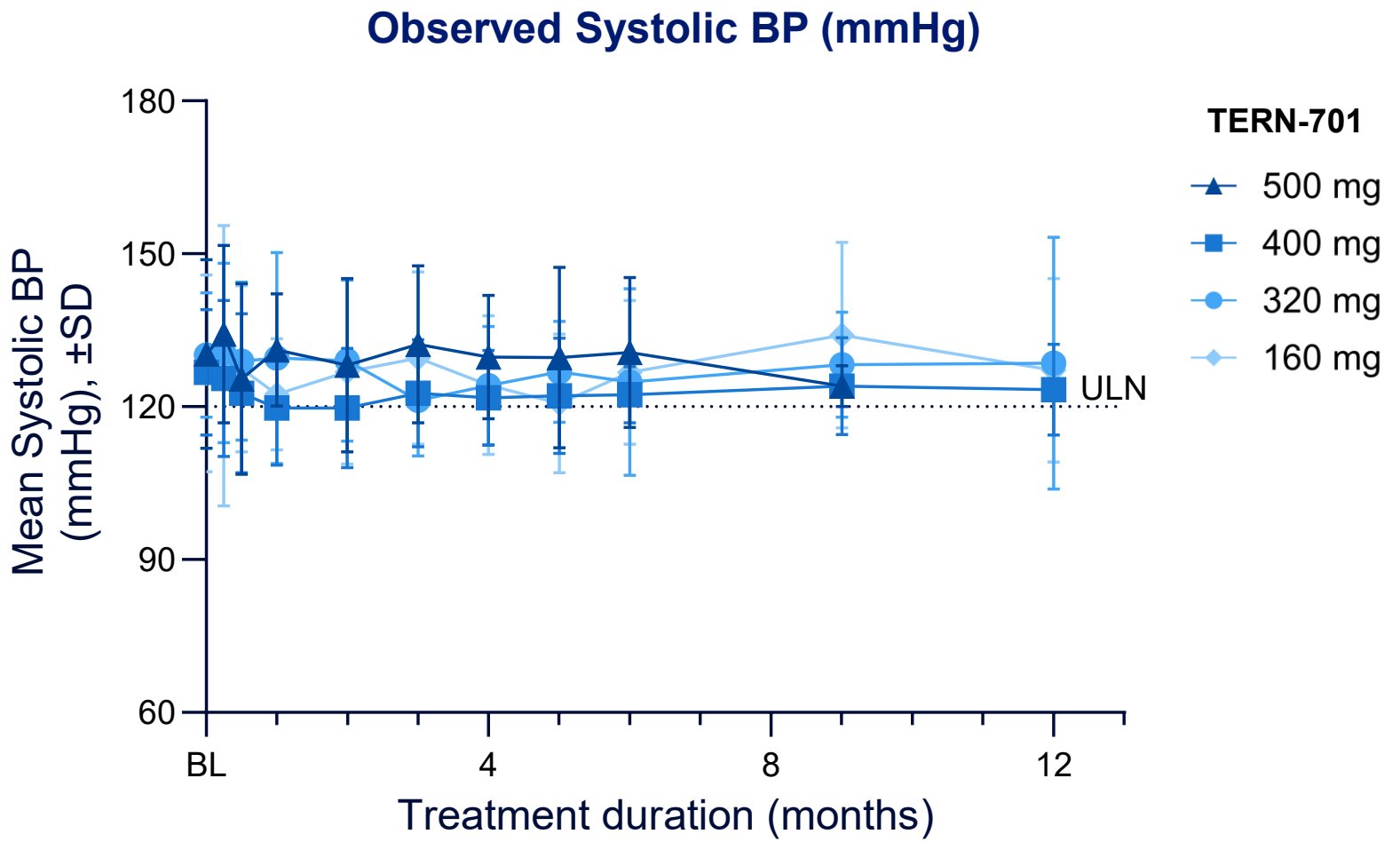
- **No difference in TERN-701 exposure** in patients who had Grade ≥3 TEAE compared to those who did not





Safety data cut-off 13Sept2025. Steady-state PK collected on Cycle 1 Day 15. Analysis includes all patients who received at least 1 dose with available steady state PK data

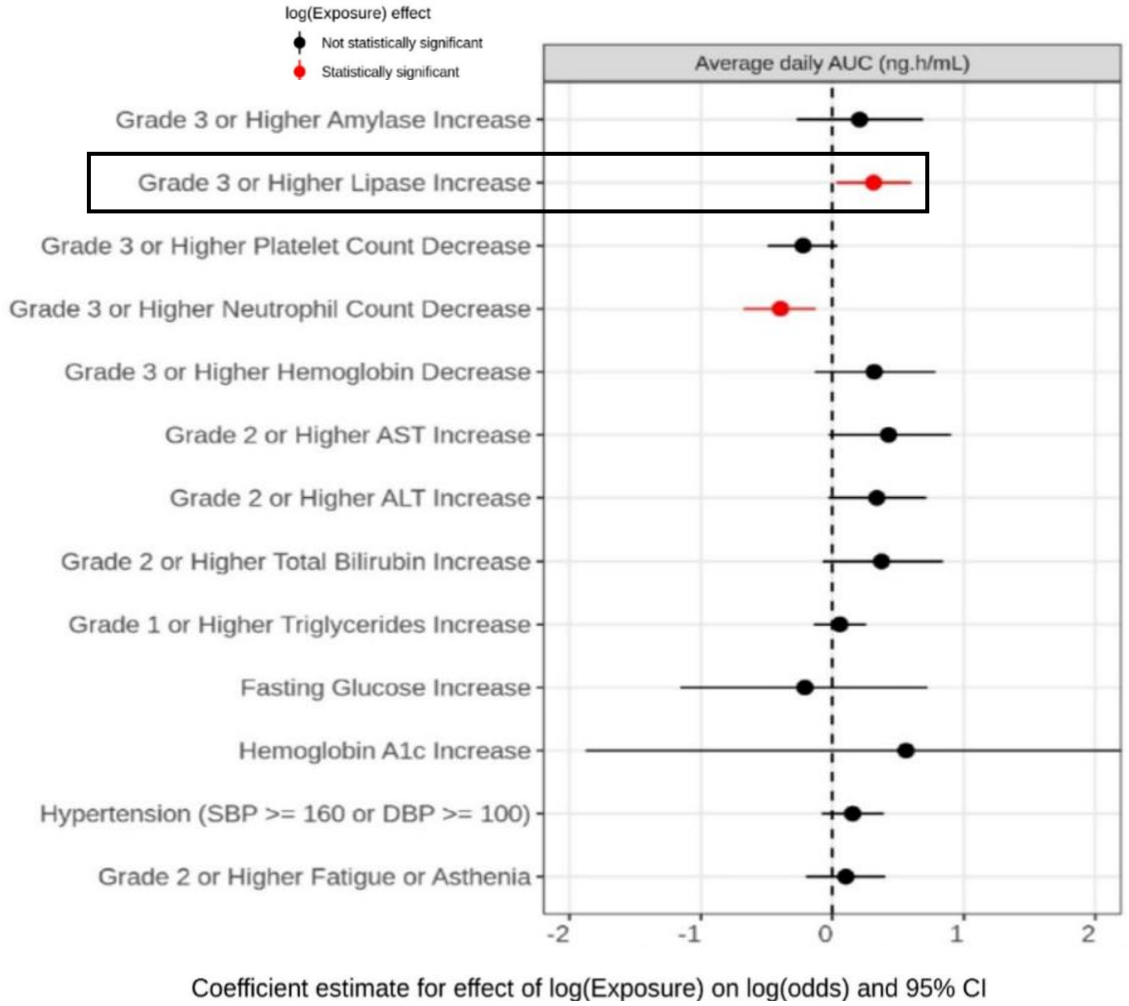
No Dose-related Elevations in Systolic Blood Pressure



Safety data cut-off 13Sept2025; Analysis includes all patients who received at least 1 dose of TERN-701.

No Correlation Between TERN-701 Exposure and Changes in Lipase

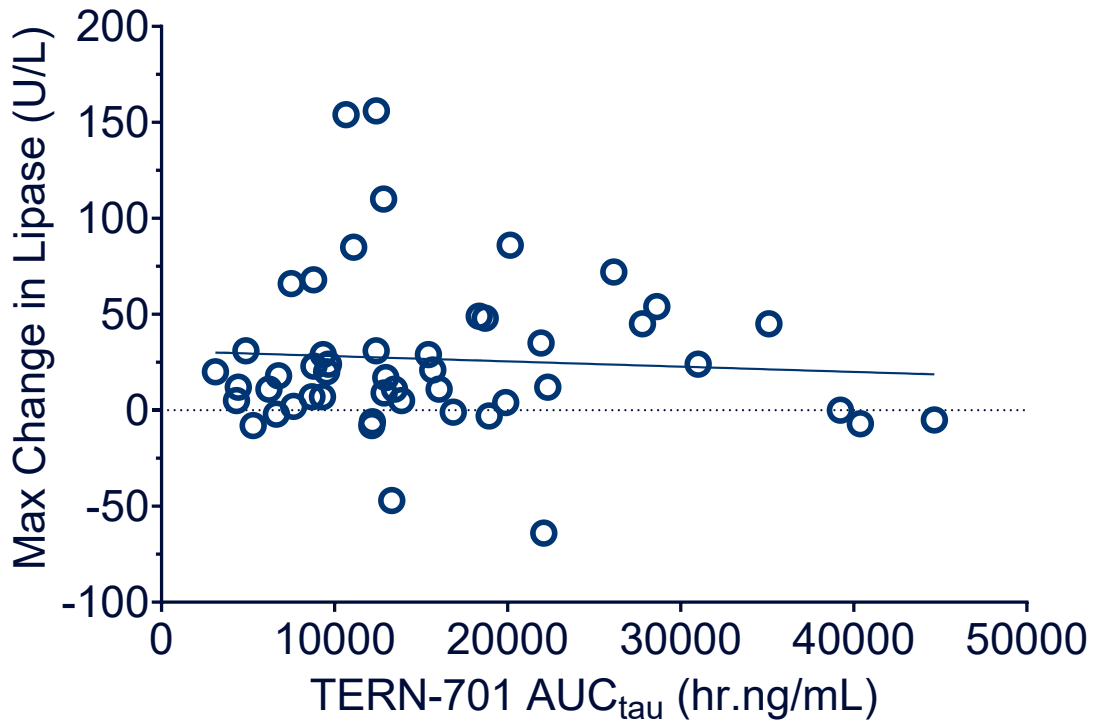
- Asciminib has **significantly increased risk of ≥Gr. 3 lipase elevation** with increasing exposure



Source: Sy et al 2025

- **No correlation** between TERN-701 exposure and changes in lipase

All lipase elevations were asymptomatic, transient, and resolved without dose modification

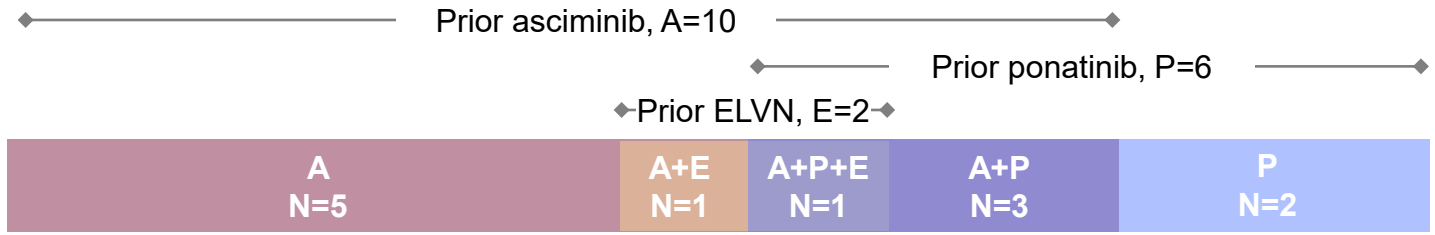


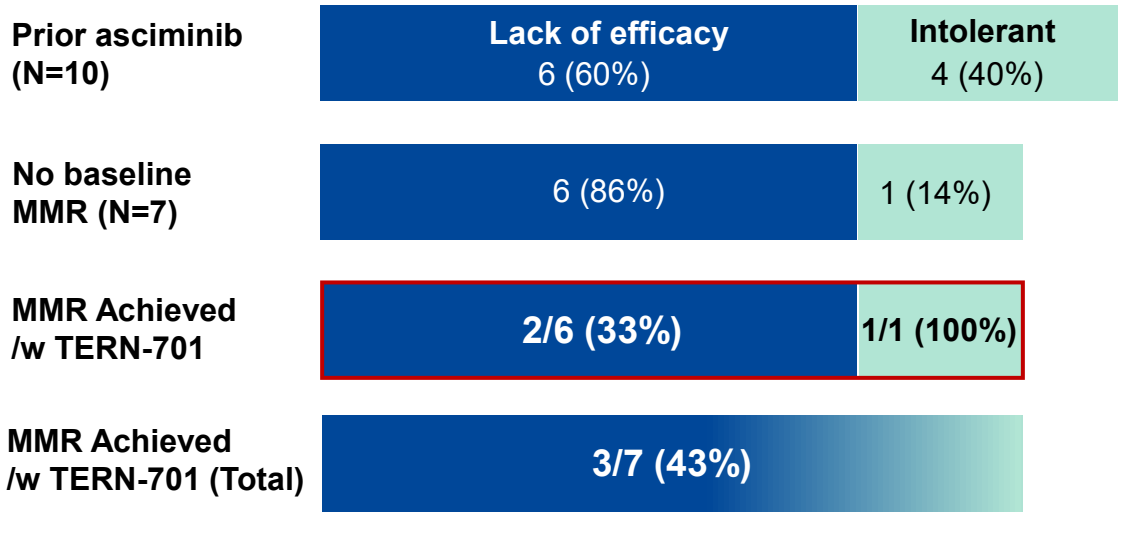
Steady-state PK collected on Cycle 1 Day 15. Analysis includes all patients with available PK data who received at least 1 dose of TERN-701 as of 13Sept2025 data-cut. R^2 values for all linear regression analyses are <0.1 indicating no correlation.

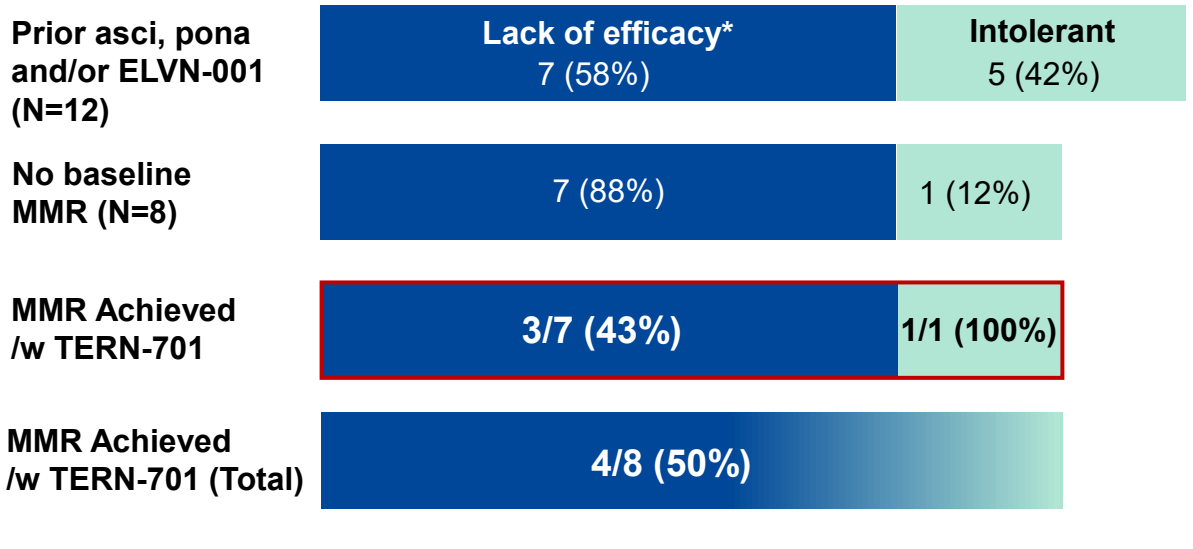
Encouraging Rates of MMR Achievement in Patients with Prior Lack of Efficacy and/or Intolerance to Asciminib, Ponatinib and/or ELVN-001

75% (9/12) in this difficult to treat subgroup remain on treatment as of the data cut-off

MMR evaluable pts with prior asciminib, ponatinib and/or ELVN-001 (N=12) breakdown →







Data cut-off 13Sep2025

* Lack of efficacy to ≥1 of the TKIs

64% MMR Achievement Maintained in Expanded ASH Dataset with Additional Efficacy Evaluable Patients

- Six additional 24-week MMR evaluable pts between data-cuts (3 with baseline >10%, 3 with baseline MR2)
- 4/6 achieved MMR or better within 24 weeks
- Several additional patients have improvement in response category across range of baseline transcripts

ASH Abstract (30Jun data-cut): 64% MMR (14/22)

Baseline *BCR::ABL1*^{IS} level

Post-treatment BCR::ABL1	MR5 (n=0)	MR4.5 (n=1)	MR4 (n=3)	MR3 (MMR) (n=6)	MR2 (n=8)	MR1 (n=6)	>10% (n=8)
MR5		1	2	1		1	1
MR4.5			1		1		
MR4					2	1	
MR3 (MMR)				5	5		3
MR2						2	
MR1							2
>10%							4

ASH Data (13Sept data-cut): 64% MMR (18/28)

Baseline *BCR::ABL1*^{IS} level

MR5 (n=0)	MR4.5 (n=1)	MR4 (n=3)	MR3 (MMR) (n=6)	MR2 (n=11)	MR1 (n=6)	>10% (n=11)
	1	2	1	1	1	1
		1		3		
			1	1	1	
			4	6		4
					3	
					1	1
						5

Stable | Lack of Efficacy | Improvement in MR category

Tables includes response evaluable non-T315Im patients that have ≥1 baseline assessment with at least 6 months of treatment at visit cutoff, achievement of MMR or better prior to 6 months or treatment discontinuation prior to 6 months for any reason