REFINITIV STREETEVENTS

EDITED TRANSCRIPT

BIOMEA FUSION INC TO ANNOUNCE OUR LEAD CLINICAL CANDIDATE

EVENT DATE/TIME: October 30, 2024 / 8:30PM UTC

CORPORATE PARTICIPANTS

- **Rainer Erdtmann** *Biomea Fusion Inc - President, Co-Founder, Chief Operating Officer, Director*
- **Thomas Butler** *Biomea Fusion Inc - Chairman of the Board, Chief Executive Officer, Co-Founder*
- **Juan Fras** *Biomea Fusion Inc - Chief Medical Officer*
- **Mini Balakrishnan** *Biomea Fusion Inc - Executive Director - Biology*
- **Thorsten Kirschberg** *Biomea Fusion Inc - Executive Vice President - Chemistry*

CONFERENCE CALL PARTICIPANTS

- **Operator**
- **Yigal Nochomovitz** *Citi - Analyst*
- **Jason Kolbert** *EF Hutton - Analyst*
- **Joe Pantginis** *H. C Wainwright & Co., LLC. - Analyst*
- **George Farmer** *Scotiabank - Analyst*
- **Tony Butler** *Rodman & Renshaw - Analyst*
- **Billal Jahangiri** *Truist Securities - Analyst*
- **Matthew Biegler** *Oppenheimer & Co., Inc. - Analyst*
- **Eric Joseph** *JPMorgan - Analyst*
- **Peter Lawson** *Barclays Estimates - Analyst*

PRESENTATION

Operator

Good day and welcome to the Biomea announces lead clinical GLP-1 RA candidate, BMF-650, and pre-clinical combination data conference call. (Operator Instructions)

I would now like to turn the call over to Mr. Ramses Erdtmann. You may begin.

Rainer Erdtmann *Biomea Fusion Inc - President, Co-Founder, Chief Operating Officer, Director*

Thank you, operator. Good afternoon, everyone, and thank you for dialing into this exciting update call. Some quick introductions. My name is Ramses Erdtmann; I'm the COO, President, and Co-Founder of Biomea.

With me on the call today from our team and available to answer questions are our CEO, Chairman, and Co-Founder of Biomea, Thomas Butler; as well as our CMO, Dr. Juan Pablo Frias; and two key members of our research team, our Executive Director of Biology, Mini Balakrishnan; and our Executive Vice President of Chemistry, Thorsten Kirschberg.

I would also like to welcome Dr Rohit Kulkarni, a physician, scientist, and diabetes researcher, serving as Professor of Medicine at Harvard Medical School and Co-Head of the section on Islet and Regenerative Biology at the Joslin Diabetes Center. He will be available to answer questions during the Q&A section of this call.

Before we start, let me remind you that this non-confidential presentation contains forward-looking statements about the business prospects of Biomea Fusion, including expectations regarding Biomea Fusion's clinical trials and pre-clinical study results in potential future product candidates in different areas of therapeutic research and development.

Results may differ materially from those expressed or implied in this presentation, depending on the progress of Biomea Fusion's pre-clinical and clinical development activities, actions of regulatory authorities, availability of capital future actions in the pharmaceutical market, and developments by competitors and those factors detailed in Biomea Fusion's filings with the SEC such as 10-Q, 10-K, and 8-K reports.

All forward-looking statements made during this presentation are based on the beliefs of Biomea Fusion as of this date only, and future events or simply the passage of time may cause these beliefs to change. Please be aware that you should not place undue reliance on the forward-looking statements made today.

I will now turn the call over to our, CEO Thomas Butler.

Thomas Butler *Biomea Fusion Inc - Chairman of the Board, Chief Executive Officer, Co-Founder*

Thank you, Ramses. Today, we will cover two recent key milestones we have achieved here at Biomea. As we further interrogated the menin pathway, we learned that the protein menin, in complex with the protein PRMT5, is a suppressor of GLP-1 receptor expression, leading to reduced GLP-1 receptor pathway function.

Such decreased GLP-1 receptor expression reduces insulin secretion and expression of beta cell-proliferative genes which are mediated by the GLP-1 pathway. Overall, menin reduces glycemic control. We have now looked into this relationship to try to understand what happens to GLP-1 receptor expression if we inhibit menin and its function.

We have done multiple pre-clinical experiments using human islet and observed that our product candidate, icovamenib, which you all remember as BMF-219, when used in combination with the GLP-1-based therapy, leads to enhanced insulin secretion.

We believe that menin inhibition leads to elevated GLP-1 receptor expression, which then leads to increased insulin production, enhancing glycemic control. This is a remarkable finding that a covalent menin inhibitor seems to improve the impact of a GLP-1-based therapy.

During this call, we will present our findings which have influenced the design of our planned Phase II study COVALENT-112, which we intend to initiate in 2025. In this trial, we want to use icovamenib in combination with the GLP-1-based therapy to determine if we can improve glycemic efficacy with this combination and if there is persistence in this effect when a GLP-1 based therapy is discontinued.

Incretins have become the foundation of obesity treatment, and we believe icovamenib in combination with a GLP-1-based therapy has the potential to become the backbone of the treatment of both diabetes and obesity. A few more words on icovamenib and the upcoming type 2 diabetes study read out of COVALENT-111, which is planned for later this quarter.

This study aims to identify the go-forward dose for late-stage development as well as identify biomarkers for those patients that are the best responders to icovamenib alone. Essentially, the study serves as a compass for the design of our next set of studies.

As you may recall, in this study, we included type 2 diabetes patients with a BMI of 25 up to a BMI of 40 who have had an onset of diabetes any time within the last seven years and who are failing their current treatments, which could have been up to three anti-diabetic medications including GLP-1 based therapies.

This study readout will serve two-fold, to understand the impact of dosing the broader patient population with 8 weeks and 12 weeks of treatment, as well as to determine icovamenib's impact on insulin-deficient and insulin-resistant patients. Our goal is to select the optimal dose and the optimal patient set to advance the late-stage clinical development following the readout.

Inhibiting menin in patients with diabetes is a brand new and still investigative treatment modality, and we are learning quite quickly how to best apply menin inhibition to the type 2 diabetes population. We have observed in the dose escalation studies for the responders and how to qualify them with typical biomarkers.

We are now exploring how these early findings will translate to a larger study population of quite heterogeneous patients. We prespecified in our statistical analysis plan biomarkers that will help confirm the optimal patient set. This will help us define a steady population we can discuss with the FDA during our End of Phase II meeting in 2025.

It will be a very exciting readout. Stay tuned. We're expecting it in December. We have also achieved another key milestone with our research team as we have now advanced our next-generation, oral, small-molecule, GLP-1 receptor agonist, BMF-650, into IND-enabling studies.

This is the third program which we had discussed to start the 2024 year and plan to reveal in the second half. Adding our own GLP-1 receptor agonist development candidate to the armament of Biomea's investigational therapies could allow us to address an even larger patient population, in particular, those patients who may require and benefit most from a GLP-1-based therapy versus just icovamenib alone.

Ideally, BMF-650 can help drive down weight as well as insulin resistance in diabetes patients and support long-term glycemic control once the beta cell pool has been improved from icovamenib treatment. With BMF-650, it is our goal to bridge the gap towards the efficacy of peptides and to improve the persistent dilemma of the GLP-1-based therapy class.

We wanted to develop a next-generation, oral GLP-1 receptor agonist for diabetes patients and, of course, also for those who battle with obesity. The next generation concept is aimed at driving further advancement in the safety to efficacy profile of an oral, small-molecule, GLP-1 receptor agonist.

I would like to turn the call over now to our CMO, Dr. Juan Pablo Frias. He has served as principal investigator on over 100 Phase III studies and participated in the clinical development of more than 20 approved diabetic agents, including the development of the two GLP-1-based therapies which make up more than 90% of this market, semaglutide and tirzepatide.

Here, Dr. Frias was a key investigator of the two dominant Phase III study programs, the SUSTAIN and the SURPASS programs. Both have led to multiple approvals and publications in the Lancet, New England Journal of Medicine, and others. We are very fortunate to have him lead our clinical development efforts. Juan Pablo?

Juan Fras *Biomea Fusion Inc - Chief Medical Officer*

Thank you, Tom. Let me start by acknowledging the current state of the situation in diabetes. Today, we have over 60 FDA-approved therapies to address the disease. And yes, we've come a long way, yet we have, by no means, conquered diabetes.

In fact, data from the CDC indicate that approximately half of patients still fail to achieve the generally accepted hemoglobin A1C target of less than 7%. And unfortunately, this has not changed significantly over the past 20 years.

Today, 80% of people living with diabetes will die from their disease, and premature mortality caused by diabetes results in an estimated 12 to 14 years of reduced life expectancy. Diabetes remains one of the largest economic burdens on the US healthcare system and is the seventh leading cause of death in this country.

Additionally, we have an ever-increasing obesity crisis, with at least one in five US adults living with obesity and over 1 billion people worldwide suffering from the consequences of the complications of this disease. These are both significant health crises that must be addressed.

When I started my career in medicine some 30-plus years ago, we had very few treatment options for diabetes and none for obesity. At the time, we used sulfonylureas, which worked by stimulating the already failing pancreatic beta cells to secrete more insulin.

In 1995, we started using metformin, which became more widely used over time and works in large part by decreasing hepatic glucose production and improving insulin sensitivity. Of course, we used and are still using insulin, which to this day is the only therapeutic option other than pramlintide for persons with type 1 diabetes and is also commonly used in persons with type 2 diabetes who do not respond adequately to existing first-, second-, or third-line therapies.

That was our basic armamentarium for a long time. These medications laid the foundation for the more advanced treatments available today known as GLP-1-based therapies, including GLP-1 receptor agonist and dual GIP and GLP-1 receptor agonist, as well as the SGLT2 inhibitors.

The first GLP-1 receptor agonist for the treatment of type 2 diabetes was approved in 2005 and needed to be administered by subcutaneous injection twice daily. This was followed in 2010 by liraglutide with the convenience of once-daily administration. And then in 2017, FDA approved semaglutide, which is administered once weekly and witha significant improvement to what we had

used until then.

The latest advancement came with tirzepatide in 2022, which is a dual GIP and GLP-1 receptor agonist and is also administered via subcutaneous injection once weekly. One of the first drugs approved by FDA for the treatment of obesity in the US was orlistat, which received approval in 1999.

A few drugs were approved after that, but most prominently, liraglutide in 2014, which was the first GLP-1 receptor agonist addressing the obesity epidemic. This was followed by semaglutide in 2021 and tirzepatide in late 2023.

The reduction in frequency of administration has become a key improvement over the years for the management of diabetes, in addition to improved effectiveness and extra glycemic benefits of GLP-1-based therapies such as cardiovascular risk reduction and weight loss. Today, the route of administration remains a hurdle for the adoption of these agents, as some studies suggest the patients' interest can drop by half because they are not willing to administer routine injections and would prefer an oral agent.

So far, only one oral GLP-1 receptor agonist has been approved, semaglutide. We've come a long way in the management of type 2 diabetes and other cardiometabolic diseases. The GLP-1-based therapies are at the forefront of these therapeutic advances. Multiple challenges, however, remain.

Let's review the criteria for what the next generation of GLP-1-based therapies should ideally fulfill to move this field forward. I believe there should be oral agents, which have the potency to achieve similar glucose-lowering efficacy as injectables. Based on publicly disclosed data to date, oral GLP-1-based therapies in development do not appear to meet this efficacy requirement.

A disruptive next-generation GLP-1 receptor agonist should also address the side effect profile of current agents as many patients discontinued treatment due to gastrointestinal and other side effects. The use of GLP-1-based therapies is often limited by these factors.

As seen in real-world studies, persistence with GLP-1-based therapy can drop to as low as 27% after one year. There is also a need for a better price point for payers and for patients. Additionally, we need to ease the current supply shortage, which is impacting this entire class by creating scalable manufacturing.

In short, oral dosing, improved glycemic efficacy, a more acceptable tolerability profile, enhanced quality of weight loss, and availability of drug supply are key criteria for the next generation of GLP-1-based therapies. These were also the criteria we used in the development of BMF-650.

We believe our new development candidate, a next-generation, oral, small molecule, GLP-1 receptor agonist, BMF-650, has the potential to address many of these issues that I've described. BMF-650 is an oral GLP-1 receptor agonist that has been designed to be equally effective as the current class of injectables while further limiting the known side effect profile. The Biomea research team will provide an overview of BMF-650 following my prepared remarks.

I would now like to also add a bit more color to what Tom addressed at the onset of our call, our plan to evaluate icovamenib in combination with a GLP-1-based agent. Given the complementary mechanisms of action of icovamenib, increased beta cell mass and function, and GLP-1-based therapies increased nutrient-stimulated insulin secretion and enhanced peripheral insulin sensitivity, we believe that administering these agents as part of a combination regimen has the potential to provide a synergistic response and improved efficacy.

We believe icovamenib may increase beta cell mass, which may enhance nutrient-stimulated insulin secretion resulting from a GLP-1-based therapy and that the improved insulin sensitivity resulting from a GLP-1 receptor-based therapy may increase the effectiveness of the improved beta cell mass resulting from icovamenib.

Additionally, we believe that this may overcome an important issue with the GLP-1-based therapies. The increase in beta cell mass from icovamenib may allow lower doses of GLP-1-based therapies to achieve glycemic targets, potentially reducing side effects and improving tolerability of these agents.

We also believe that given the generally poor persistence with GLP-1-based therapies, the use of icovamenib early in the course of therapy may increase the probability of a durable glycemic response should the GLP-1-based agent be discontinued.

Lastly, both agents, icovamenib and GLP-1-based therapies, have mechanisms of action that are also complementary to metformin and SGLT2 inhibitors, two very commonly used agents in type 2 diabetes. I have not covered the potential of this combination in obesity, but this is something we plan to provide updates on in future presentations.

I will now turn the call over to Mini, our Head of Biology, to provide additional background information on our GLP-1 receptor agonist program. Mini?

Mini Balakrishnan *Biomea Fusion Inc - Executive Director - Biology*

Thank you, Juan. My name is Mini Balakrishnan; I'm Executive Director and Head of Biology and been with Biomea for three years. I also lead the Islet Biology Group here at Biomea.

The core purpose of our team is to conduct experiments and to understand biological processes and mechanisms, which enable us not only to design but also test new drugs that address specific physiological conditions. Let me start by describing some of the tools we use and the experiments we conduct to ensure we are on the right path.

When measuring functional activity, in vitro models are typically used to surrogate biological environments to the human body. We test our molecules first in different animal species, for example, rodents or monkeys; and we also use human islets to address questions of translational nature.

For our human islet studies, we use living donor tissues from recently deceased individuals. Gathering detailed information in this way allows us to probe into the potential mechanisms and how it may work in vivo in humans. The ex vivo cultured human islets offer a physiologically relevant system to test activity, for example, of the GLP-1-based therapies.

Insulin secretion is increasingly studied in our field with such isolated human islets. At Biomea, we also use human islets to help assess the human pancreatic response to our therapies. We presented some of our islet experiments during the Annual World Congress Meeting in Los Angeles last year. You can find these data presented on our website. Please turn your attention to Slide 5.

Here, we display the ability of icovamenib to induce beta cell proliferation when human donor islets were cultured under hyperglycemic conditions. On the X-axis, we showed DMSO, which is a vehicle control and then icovamenib at various concentrations.

The duration of treatment was one week, two weeks and three weeks. We included harmine as a positive control as it has been found to significantly increase the proliferation of human beta cells. However, it's also known that harmine is non-selective, inducing proliferation of both beta and alpha cells.

We believe that the results we are displaying are quite provocative. Covalent menin inhibitor, icovamenib, induced dose-dependent and selective proliferation of islet beta cells with continued exposure under hypoglycemic conditions.

We've since repeated the study using islet preparations from multiple human donors and confirmed that the exposure to icovamenib in a hypoglycemic environment, beta cells re-enter the cell cycle and do proliferate. And we're very excited about these early findings.

Intact, human islets are difficult to obtain and also require special handling to culture and perform ex-vivo studies. Slide 6 is a brief glimpse into one of the key tools we use, confocal laser scanning microscopy, which allows us to look inside an intact whole human islet and quantify the effects of our compounds on physiological events in specific cell subsets.

For example, by precisely identifying and counting every proliferating cell in the 3D islet, we found that icovamenib increased the number of proliferating beta cells. We use this powerful approach to also visualize compound-induced effects on specific target proteins of interest within the islet cells.

Let us now turn to our GLP-1 receptor agonist program. Slide 8 shows some of the scientific background Tom highlighted in his introduction that is very relevant here.

Menin and the protein arginine methyltransferase 5 or PRMT5 suppresses GLP-1 receptor transcript levels. This was first researched by the lab of Professor Hua from UPenn in 2017. Menin seems to suppress the GLP-1 receptor pathway function and ultimately reduce insulin secretion.

On the right side of slide 8, you can see the postulated effect of icovamenib. The selective covalent inhibition of menin would release this repression of the GLP-1 receptor expression, thus leading to elevated GLP-1 receptor expression and increased insulin production, enhancing glycemic control.

If you'd like to learn more about the scientific and academic publications on menin, the GLP-1 relationship, and specific related topics, please check out our website where we have a very detailed literature and publication section. Let's review our islet

experiments and see if this postulated effect holds true in the human islet environment. Please turn to slide 9.

Here, we evaluated islet function after culturing them under hypoglycemic conditions with and without icovamenib treatment. We then use these islets to test for insulin secretion potentiated by tirzepatide, a GLP-1 and GIP dual receptor agonist.

We tested the hypothesis: if menin were inhibited, would tirzepatide show improved results? As seen in both graphs, the results reveal a dose-dependent effect of icovamenib. As we increase the concentration of icovamenib during the pretreatment period, we see enhanced insulin secretion mediated by tirzepatide.

In this experiment, icovamenib more than doubled the insulin secretion. We have also done a similar study with semaglutide. Please turn to slide 10 for those results. Here again, we observed similar effects.

On the right side, we are showing the secretion index, which helps us understand how well the pancreas is functioning in response to high glucose levels. A higher ratio indicates a stronger insulin response to the glucose stimulation.

Here again, we observed that exposure of the islets to our menin inhibitor induced a dose-dependent enhancement in insulin secretion, potentiated by the GLP-1 receptor agonist, semaglutide. Also seen here, icovamenib pretreatment more than doubled the insulin secretion versus semaglutide alone. The magnitude of such observed responses can vary obviously depending on the donor islet tissue used.

I would like to share one more slide testing this combination. Let's turn to slide 11. Here, the islets were exposed to icovamenib at two concentrations or DMSO, which is the vehicle, and then tested for response to orforglipron. Again, you can see that exposure of the islets to our menin inhibitor, icovamenib, improved insulin secretion potentiated by GLP-1 receptor agonist, almost doubling the response depending on the dose.

We've also added here on the far right, two dose levels of our own small molecule GLP-1 receptor agonist, BMF-650. We have tested it in this model either alone or in combination with icovamenib at a low and a high dose. We could not have asked for better results in this experiment, and it's exciting to see how the science can translate to potential benefits.

On slide 12, we would like to provide our context and outlook on the data we presented. We believe combining icovamenib with a GLP-1-based therapy has the potential to be treatment paradigm shifting and offer additional options to current successful treatment regimens for diabetes.

Potential benefits offered by the combination therapy include lower dosing requirements for current GLP-1-based therapies; improved tolerability, adherence, and therapeutic window; improved initial responsiveness; and ultimately, greater patient persistence and treatment results. We strongly believe in the benefits of combining icovamenib with the GLP-1-based therapy and have designed a new Phase II trial, COVALENT-211, to test these preclinical results.

I would now like to turn the call over to our Head of Chemistry. Thorsten?

Thorsten Kirschberg *Biomea Fusion Inc - Executive Vice President - Chemistry*

Thank you, Mini. My name is Thorsten Kirschberg; I'm the Executive Vice President of Chemistry here at Biomea. I joined the company more than four years ago, and I have been instrumental in the design of the compounds we are currently pursuing clinically and preclinically at Biomea.

The slide Mini just showed is a great segue to my presentation, introducing Biomea's next-generation GLP-1 receptor agonist development candidate, BMF-650. We started the research effort for a next-generation GLP-1 receptor agonist last year with our core team here at Biomea, consisting of senior synthetic chemists, which are experts in their field, many of whom I and Tom have worked with in the past.

We also utilized our internally designed Biomea Fusion System, which provides deep insight into target structure and greatly expedites the scaffold creation and molecule optimization process. Without the support of the Fusion system, we would have not gotten to a prospective IND candidate in such a short time.

On slide 14, we outlined the attributes we focused on to arrive at an optimized candidate. We targeted the reduction of PK variability and the increase in oral bioavailability. We also wanted to achieve elevated plasma protein binding.

We believe that enhanced properties in these areas will bring about easier up-titration to the target dose, fewer incidence of nausea and GI-related effects, leading to better adherence and, overall, a greater therapeutic window. Did we achieve this? I believe we did.

Let's take a deeper dive into the properties of this next-generation, oral, small-molecule GLP-1 receptor agonist, including studies evaluating BMF-650 and orforglipron from Eli Lilly, the current frontrunner of the oral GLP-1 receptor agonists. Please turn to slide 15.

Here, we look at the human GLP-1 receptor EC50 values and the EC50 values for beta arrestin recruitment. Overall, the results were similar to those of orforglipron. We see good potency, while the greater than 10 micromolar EC50 value for beta arrestin activation indicates the desirable biased agonism and suggests the potential for a favorable safety profile. We conducted further efficacy assessments in human donor islet experiments.

Turning now to slide 16. Here, we tested the insulin secretion impact of BMF-650 versus orforglipron and observed that our next-generation GLP-1 receptor agonist, BMF-650, potentiated the glucose-stimulated insulin secretion of healthy donor islets.

With respect to the in vivo behavior of BMF-650, pharmacokinetic studies were performed. Slide 17 depicts PK curves and tabulates the selected PK parameters of BMF-650 in cynomolgus monkeys and Sprague Dawley rats. In these studies, we observed a higher bioavailability than orforglipron and a smoother PK curve in general, with less inter-animal variability. We believe this may support successful up-titration in patients and may translate to a favorable tolerability profile.

Now let us look at Slide 18. Here, we present a short summary of lead molecules in the oral GLP-1 receptor agonist space and their clinical titration targets. The table also summarizes oral dose levels used in preclinical cynomolgus monkey studies.

Titration targets for the human dose cluster around the 100-milligram level, yet doses studied in monkeys varied much more widely. These differences are likely due to the physiochemical properties of the compounds and their species-related effects.

With the next slides, slides 19 to 24, we are presenting our experiments to assess in vivo efficacy with cynomolgus monkeys. These studies use the same design that Lilly published in The Proceedings of the National Academy of Science paper from November 2020, describing preclinical findings with their oral GLP-1 receptor agonist or orforglipron.

Primary outcome criteria for GLP-1 receptor agonists are glucose-stimulated insulin secretion, blood glucose reduction, and appetite suppression, the latter being measured by a detailed review of the daily food intake. Slides 19 and 22 describe the experiments with cynomolgus monkeys. Key design features are highlighted for transparency.

The group size in these experiments was n equals to four, and these studies were done in a crossover design. Every compound was tested in the same four monkeys after a washout period in both the intravenous and oral studies, respectively.

Please turn to slide 20, where we are showing the glucose-stimulated insulin secretion in cynomolgus monkeys at dose levels which we believe can be considered relevant to human studies. Relying on the published work, we are comparing BMF-650 with the indicated high and low dose for orforglipron in cynomolgus monkeys.

One can see that orforglipron is very potent, yet its insulin area under the curve was lower than that of BMF-650. Both compounds demonstrated pronounced improvements in insulin secretion in these cynomolgus monkeys.

On slide 21, we are showing the corresponding glucose control of each of the two compounds in this experiment. Here as well, BMF -650 improved the glucose reduction relative to vehicle and also relative to orforglipron at the two dose levels published in 2020 by Eli Lilly.

Our last experiment is described on Slide 22, where we measure appetite suppression in the cynomolgus monkeys after daily oral compound administration. In this separate cohort of cynomolgus monkeys, we recorded how the animals responded to the presentation of food, both during peak systemic compound levels and also for the whole day over a six-day period.

As expected, in these experiments, we observed a marked appetite suppression with BMF-650 as shown on slide 23. Here, we compare the appetite suppression of the cohort of monkeys over the six-day dosing interval, average for the 90-minute windows, and for the full day. Bars represent the average of all 4 monkeys over the 6 days.

BMF-650 performed very well under these conditions with very good daily appetite suppression characteristics. These data support the potential we have with BMF-650 as an oral agent addressing obesity, a field we have not previously included within our pipeline assets.

I am particularly proud of the outcome shown on slide 24. On this slide, you can see that the magnitude of the effect compares well to what was seen for orforglipron when dosed at both dose levels published in the 2020 literature disclosure. Good appetite suppression is observed for both compounds. We are starting our GLP tox work early next year and are planning to file the IND in 2025, as you can see on slide 25.

This ends my prepared remarks. I will now turn the call over to the operator to open up the call for questions and answers.

QUESTIONS AND ANSWERS

Operator

Thank you. We will now begin the question-and-answer session. (Operator Instructions) Yigal Nochomovitz, Citigroup.

Yigal Nochomovitz *Citi - Analyst*

Hi. Great. Thank you so much for taking all the questions. And obviously, you shared a lot of new data here, a lot to absorb. I guess the first question is, based on what appears to be very similar biochemical parameters for 650 and orforglipron, is the argument here essentially on improved bioavailability that's driving the potential differentiation? Or is there anything else that we need to be aware of? That's the first question.

Thomas Butler *Biomea Fusion Inc - Chairman of the Board, Chief Executive Officer, Co-Founder*

Yeah. Great question, Yigal. This is Tom. I'll pass it on to Thorsten to address. But overall, we were looking for a compound that we think can support a greater therapeutic window. And our vision is -- for the GLP-1 space is that we think oral small molecule is the future.

And we see that orfo is clearly in the lead in terms of efficacy to safety profile. And we think that this space can handle more than one really strong oral small molecule. And so that's the first component.

And then the second component you can see is, obviously, from all the islet work and islet research that we've built in-house at our innovation center here in San Carlos, you can see that even just the intrinsic potency of BMF-650 is performing quite well in our islet experiments, showing a nice increase in insulin secretion capacity.

And Thorsten, do you want to add anything.

Thorsten Kirschberg *Biomea Fusion Inc - Executive Vice President - Chemistry*

Thank you, Tom, and thank you for the opportunity to add a little. Tom has really addressed very key aspects here already. So the higher oral viability is a key feature. We certainly do see less variability in the PK from the oral administration.

I think this is a very important added feature to this compound. And we also wanted higher plasma protein binding. This is a feature that worked very well for semaglutide. And I do think it also has a place in the small molecule oral GLP-1 receptor agonist space.

Yigal Nochomovitz *Citi - Analyst*

Okay, thank you. And then another question. So I don't think I saw -- are you going to do NHP studies with 650 and icovamenib as well? Is that in process? Or can you explain that part?

Thomas Butler *Biomea Fusion Inc - Chairman of the Board, Chief Executive Officer, Co-Founder*

Sure, yeah. So we have a number of experiments that we're designing where we would use icovamenib in combination with the GLP -1-based therapy, and that would include BMF-650. So more to come.

Yigal Nochomovitz *Citi - Analyst*

Okay. And then for 211, you're going to -- have you decided which GLP-1 you're going to go for? I mean, I was looking at the experiments that you showed nicely. I guess it's different donor islets. So it's -- I guess it's not entirely clear which is the better choice, the tirzepatide or the other one. Have you made a determination yet as to which one you're going to use or could it be both?

Juan Fras *Biomea Fusion Inc - Chief Medical Officer*

Hi. Yeah, this is Juan. We have not finalized that yet. So we're continuing to assess, and we think it will likely be semaglutide or tirzepatide. More to come on that, I would say.

Yigal Nochomovitz *Citi - Analyst*

Last quick one. Just is 650 also a covalent mechanism or it's different?

Thorsten Kirschberg *Biomea Fusion Inc - Executive Vice President - Chemistry*

So thank you. I got the mic. It's Thorsten again. No, it is not.

Juan Fras *Biomea Fusion Inc - Chief Medical Officer*

You would have liked to --

Thorsten Kirschberg *Biomea Fusion Inc - Executive Vice President - Chemistry*

Yes, it is true. I would have liked to, but the opportunities were just not there. We looked, but it is a non-covalent.

Yigal Nochomovitz *Citi - Analyst*

Got it. Okay, great. Thanks so much.

Operator

Jason Kolbert, EF Hutton.

Jason Kolbert *EF Hutton - Analyst*

Thanks. It's a pleasure to follow up on some of Dr. Nochomovitz's questions. I guess I'd like to understand what the implications are for 219 and the COVALENT-111 and 112 trials, given this news. Does that influence your judgment on where you go once the data is announced at the end of the year on those studies?

Thomas Butler *Biomea Fusion Inc - Chairman of the Board, Chief Executive Officer, Co-Founder*

This will only build upon COVALENT-111 and 112. And I think where we see icovamenib's pure play is in this beta cell deficient group, which makes up about 50% of type 2 diabetes. In the insulin-resistant group, the other 50%, we think that this combination of icovamenib and a GLP-1-based therapy could be very exciting.

Jason Kolbert *EF Hutton - Analyst*

Are any of the patients in those trials on GLP inhibitors so that you can kind of glean some data on what the interaction looks like between 219 and GLP?

Thomas Butler *Biomea Fusion Inc - Chairman of the Board, Chief Executive Officer, Co-Founder*

Yeah, absolutely. So we're excited for this expansion readout come December because we do indeed have patients who are on Ozempic or Mounjaro. The numbers are small, but we do have them.

And I think there, we will see the impact of 8 and 12 weeks of icovamenib for these patients. But keep in mind that COVALENT-211 that we mentioned as a combination, these are for patients who have yet seen a GLP-1-based therapy.

For COVALENT-111 expansion phase, keep in mind that these are patients who are already on a GLP-1 and they're not meeting their glycemic target. I don't know if you want to add anything, Juan?

Juan Fras *Biomea Fusion Inc - Chief Medical Officer*

No, nothing to add. I would say, though, it doesn't play in the current 112 study in people with type 1 diabetes, but we certainly would see a place potentially for BMF-650 in patients with type 1 diabetes as well in combination with icovamenib. So you mentioned type 1 diabetes, and I think there could be a role there also.

Jason Kolbert *EF Hutton - Analyst*

Terrific. Thank you so much. Appreciate the questions.

Operator

Joe Pantginis, H.C. Wainwright.

Joe Pantginis *H. C Wainwright & Co., LLC. - Analyst*

Hey, everybody. Good morning. Thanks for taking my questions and nice initial profiles here. So thanks for sharing the data.

With regard to the potential for icovamenib and combinations with GLP, looking towards the, I guess, combo setting approved, where would you say the border is with regard to GLP-1 discontinuation? Do you have to see a particular weight loss?

Other products that are in development are saying, oh, maybe if we can get rid of GLP-1, we'll look for maintenance therapy. How do you define the cutoffs or the product profile here?

Thomas Butler *Biomea Fusion Inc - Chairman of the Board, Chief Executive Officer, Co-Founder*

Do you mind repeating the last sentence, Joe? You just broke up a little bit for us. I want to make sure we answered the question appropriately.

Joe Pantginis *H. C Wainwright & Co., LLC. - Analyst*

Yeah. So like what do you look at potential cutoffs with regard to weight loss, say, discontinue the GLP-1?And would icovamenib be chronic? Or is it similar to current diabetes profile where you would look to discontinue that as well once a certain beta cell mass is rejuvenated, if you will?

Thomas Butler *Biomea Fusion Inc - Chairman of the Board, Chief Executive Officer, Co-Founder*

Great question. Do you want to talk about that?

Juan Fras *Biomea Fusion Inc - Chief Medical Officer*

Yeah, no. This is Juan. No, I think we still envision with the combination that icovamenib would be finite therapy. So let's say, 12 weeks, we build the beta cell pool up. The patient is on the GLP-1 receptor agonist.

Now from a glucose perspective, you may be able to have a patient on a lower dose of the GLP-1 receptor agonist based therapy and get similar glycemic control. But we'll see whether that holds true for overweight and obesity as well.

But I would envision that those patients would continue their GLP-1 receptor agonist or their dual agonist oftentimes for the extra glycemic effects, but again, may be able to get away with a lower dose. And if they did discontinue, and we'll see this in clinical trials later on, whether we'd be able to have a better maintenance of glycemic control off the GLP-1 receptor agonist.

So I think we'll need to see over time. But what we envision with the combination would still be sort of finite therapy with the Icovamenib.

Joe Pantginis *H. C Wainwright & Co., LLC. - Analyst*

Thanks for those details. And then if I could ask, with regard to the upcoming update in December, I guess my question is pretty forward-looking here. With regard to biomarkers, (inaudible) you look to studies or pivotal studies (inaudible) are going to look at cell masses.

And I guess, (inaudible) towards designing a pivotal study, how you might look to or want to include the definition of pre-existing beta cell masses, what those cutoffs might be, and how important that would be in designing a study?

Thomas Butler *Biomea Fusion Inc - Chairman of the Board, Chief Executive Officer, Co-Founder*

Sorry. You're breaking up a little bit, Joe, but I think I got the gist of your question. And please correct if I didn't. But the way we look at it is in a simplistic manner, meaning we really look at it where you can define the patient populations into two main subcategories of the beta cell deficient and the insulin resistant.

You can further break those down into four phenotypes that are described into the literature. So in our top line readout, we will look at both ways, right? We will look at the individual phenotypes. We'll also look at really pragmatic cutoffs such as BMI, right?

So BMI of 30 has been done really globally to segregate those who are beta cell deficient insulin resistant. We will do similar cuts as well as BMI of 27.

Joe Pantginis *H. C Wainwright & Co., LLC. - Analyst*

Okay. Appreciate the comments.

Operator

George Farmer, Scotiabank.

George Farmer *Scotiabank - Analyst*

Hi, good afternoon. Thanks for taking my question. This is a great body of data to see. I was wondering if you could comment on the theoretical risk of hypoglycemia with the combination. It looks like there's certainly some synergy going on. And then at least with monotherapy 650, did you see any hypoglycemia in the NHPs?

Thomas Butler *Biomea Fusion Inc - Chairman of the Board, Chief Executive Officer, Co-Founder*

Yeah, great question. So no, we don't see a hypoglycemia risk. Obviously, we need to get into the clinic to see what's the safety of the combination as well as the efficacy.

But again, each agent independently do not have hypoglycemic risk. So theoretically, the combination should also not have hypoglycemic risk. But if you want to add any more?

Juan Fras *Biomea Fusion Inc - Chief Medical Officer*

No, I would agree. Again, we don't see -- based on the mechanism of action and the glucose dependence of both mechanisms, I wouldn't anticipate seeing clinically significant hypoglycemia. So again, we'll need to see in trials, but there's nothing that makes us think that this would be an issue.

George Farmer *Scotiabank - Analyst*

Okay. And then one more, if I may. In your earlier experience with icovamenib, did you see any evidence of weight loss in the patients that were treated?

Thomas Butler *Biomea Fusion Inc - Chairman of the Board, Chief Executive Officer, Co-Founder*

Yeah. So a small N, but we did. And I think for us, we need to see what weight loss we would expect in combination with the GLP-1, and that's additional work that we need to do. But the science is there, right? If you have proper menin inhibition, you increase GLP-1 expression. And that GLP-1 expression is not restricted to the pancreas only.

George Farmer *Scotiabank - Analyst*

Okay, great. Thanks very much.

Operator

Tony Butler, Rodman & Renshaw.

Tony Butler *Rodman & Renshaw - Analyst*

Thank very much. Appreciate the call. Good afternoon. My question is around, again, the GI side effects.

If it's known that situations where you can actually increase the overall availability of drugs in the body, at least of a GLP-1 agonist such that you extend agonism, you may be able to drop some of the GI effects, I guess. But I'm still trying to understand what if it does give you some level of faith that when you put this into human, the GI side effects will actually be minimal?

And was it truly related to the oral Lilly drug or I mean, the relationship, if you will, or something that just gives you that feeling that the GI side effects could be less aggressive than what's been seen?

Thomas Butler *Biomea Fusion Inc - Chairman of the Board, Chief Executive Officer, Co-Founder*

Yeah. I'll pass it on to Juan. But what I would say is we see the GI effects being caused by two main categories. One is you have a relatively steep titration, and so you're constantly trying to titrate patients up to higher and higher exposure in order to get the body weight loss or the reduction in A1C that are highlighted in publications.

And a lot of times, as you're doing the titration, you can't get to those higher dose levels. And so our working hypothesis is if we can increase the number of GLP-1 receptor expression across the target organs, then you drop the dose required to reach that maximum efficacy, you have a much smoother titration. I don't know, Juan, you want to add.

Juan Fras *Biomea Fusion Inc - Chief Medical Officer*

Yeah, I think potentially, sourcing this would be in your court as well that the pharmacokinetics may play towards less side effects as well as the flatter profile over time. I mean, so maybe a little bit of both. But certainly, over time, we'll need to work out what the initiation and the subsequent escalation of the regimen looks like to minimize, but there is a potential that it could be lower. But again, we'll need to see.

Tony Butler *Rodman & Renshaw - Analyst*

Appreciate it. Thanks, Tom. Thank you, Juan.

Operator

Joe Catanzaro, Piper Sandler.

Unidentified_1

This is Michael on for Joe. Thank you for taking our questions. We're wondering how you're thinking about potential dosing strategies when combining 219 with 650? Are you imagining treating both agents concurrently for a fixed period or treating with 219 for a fixed period and then maintenance therapy with 650? And one more, does 650 come from a novel chemical series or is it structurally similar to other oral non-peptide GLP-1 receptor agonists? Thank you.

Thomas Butler *Biomea Fusion Inc - Chairman of the Board, Chief Executive Officer, Co-Founder*

Great question. So BMF-650 scaffold comes from the Chugai scaffold, so similar backbone, I should say. And then I'll pass on to Juan in terms of the 211 design, but we're really thinking about having icovamenib dosed at the same time as the GLP as well as getting the first pretreatment of icovamenib for the first 12 weeks and then you go through the titration of the GLP-1 receptor agonist.

Juan Fras *Biomea Fusion Inc - Chief Medical Officer*

Yeah, this is Juan. I completely agree. So for someone who is not currently on a GLP-1 receptor agonist or dual agonist, the plan will be, in this study anyway, and what I would envision clinically later will be to initiate these together.

So with semaglutide, for example, titrating to the 2-milligram dose over 12 weeks, and you would use that time to get through the icovamenib dosing, the 12 weeks of dosing. But there will be other clinical situations where we described previously for COVALENT-111 patients who are already on GLP-1 receptor agonist, for example, that they would remain on their GLP-1 receptor agonist and they would go through the dosing period of icovamenib. But for the 211 study, the plan will be to initiate them simultaneously.

Unidentified_1

Okay, great. Thank you.

Operator

Billal Jahangiri, Trust Securities.

Billal Jahangiri *Truist Securities - Analyst*

Hi. This is Bilal on for Kripa. Great data. I guess I was wondering, who are these patients that are not meeting their glycemic target in 111? And I guess, what are those characteristics? Is it higher baseline, BMI, or adherence issues?

Are they not able to reach the effective dose that you mentioned? And then you also mentioned there was a small N there. And I was wondering what the reason behind that is. And is that representative of the real-world population? Is that percentage of patients that you have, those that don't get the desired effects on GLPs?

Juan Fras *Biomea Fusion Inc - Chief Medical Officer*

Yeah, this is Juan. So when we say they're not well controlled, this is a baseline by definition. These are patients that have a baseline at screening, have a hemoglobin A1C over 7%. And in COVALENT-111, the way it's set up is that at least 75% of the patients have to be on either diet and exercise alone, so lifestyle alone with or without metformin.

So most of those patients are metformin monotherapy. And then the remaining patients, up to 25% of patients, can be on up to three agents, excluding insulin and insulin secretagogue. So some of those patients are on GLP-1 receptor agonists or dual agonists, SGLT2 inhibitors, DPP4 inhibitors, and metformin.

So by definition, they're not well controlled. We have not unblinded that trial yet. So we don't have any results at this point.

So that's why there are relatively few patients or participants that are on GLP-1 receptor agonists because, again, by definition, we want at least 75% to be metformin monotherapy. So only metformin or diet and exercise alone, and then the remaining up to 25% may be on a GLP-1 receptor agonist or dual agonist. So the numbers are relatively small there.

Thorsten Kirschberg *Biomea Fusion Inc - Executive Vice President - Chemistry*

Can I add one word? You mentioned -- in the study, we have enrolled over 200 patients, and that's going to be the readout. And the patient population that we define goes from a BMI of 25 to a BMI of 40. If you think of a BMI of 40, that patient is really heavy, meaning that patient has other issues besides not only the diabetes, he's obese.

And so we still tested them because we wanted to understand what does icovamenib do in all patients. But what Tom had mentioned earlier, where we see the pure play is in those that are more insulin depleted. And if you go into the literature and you look it up on our website, you can see that obese patients oftentimes have an over proliferation of beta cells because they're trying to fend off the insulin resistance in their system.

So we will show you everything. But the readout, and that's why right now, what we're thinking is we probably will get all sorts of patients from both sides of the fence. And since it's about 50-50 in the population, we should have a similar amount of patients on this readout matching both types. Does that make sense?

Billal Jahangiri *Truist Securities - Analyst*

Yeah, it does. Thank you so much. And I guess, are we really seeing translational data on the GLP receptor kinetics or some way to show that it's upregulating after Icovamenib?

Thomas Butler *Biomea Fusion Inc - Chairman of the Board, Chief Executive Officer, Co-Founder*

Yeah, Mini?

Mini Balakrishnan *Biomea Fusion Inc - Executive Director - Biology*

This is Mini Balakrishnan from Biology. Yes, we are doing those translational studies, and at least our preliminary data seems to trend that way. So very excited to see that.

Billal Jahangiri *Truist Securities - Analyst*

Great. I'm looking forward to seeing that. Thank you so much.

Operator

Matthew Biegler, Oppenheimer.

Matthew Biegler *Oppenheimer & Co., Inc. - Analyst*

Hi, everyone. Thanks for the update. I wanted to ask about biomarkers in COVALENT-211 that you're planning on looking at, maybe things that can show some early synergy between ICO and GLP-1, specifically beta cell functional capacity, cell mass, insulin release dynamics. Do you think anything there that we should be aware of that maybe can provide some early proof of concept? Thanks.

Juan Fras *Biomea Fusion Inc - Chief Medical Officer*

Yeah. I mean we will do, whether it's an OGTT or a meal tolerance test. We'll be looking at beta cell function, and they're really looking at C-peptide secretion, stimulated C-peptide. We will -- beyond that, really, nothing more sophisticated in this particular study. I mean we certainly may do more smaller, more mechanistic studies, potentially, again, look at an IVGTT, those sorts of things. But it really is more around looking at beta cell function with this combination.

Thomas Butler *Biomea Fusion Inc - Chairman of the Board, Chief Executive Officer, Co-Founder*

Yeah. And I'll just add, keep in mind that the icovamenib is on board as we're titrating up the GLP-1 receptor agonist. So we will be able to see kind of in real time how many patients need to continue to titrate in order to get improved glycemic control versus those who will be able to stay at the lower dose levels and achieve their glycemic target.

Matthew Biegler *Oppenheimer & Co., Inc. - Analyst*

That makes sense. Looking forward to it. Thanks.

Operator

Eric Joseph, JPMorgan.

Eric Joseph *JPMorgan - Analyst*

Thanks for taking my question. Just as a point of clarification, just when it comes to the icovamenib plus GLP-1 combo strategy. What in vivo modeling have you done so far? And can you talk about sort of the additive impact you're seeing on glucose control, insulin sensitivity, other models beyond sort of the cell data that you're presenting today?

Thomas Butler *Biomea Fusion Inc - Chairman of the Board, Chief Executive Officer, Co-Founder*

Great question, Eric. This is Tom. Yeah, so all that work is ongoing, and we are planning, obviously, to share that in upcoming academic conferences to show actually the in vivo impact as well. So we're excited to get this together along with some of the preliminary work that Mini has shared about the mRNA of GLP-1. So lots more to share and see what potential benefits can come out of this combination.

Eric Joseph *JPMorgan - Analyst*

Got it. And then if I'm just looking at slide 11, comparing 650 with Orfo, you actually have this on its own without icovamenib, this induction of insulin secretion on its own. So I guess what do you think mechanistically is sort of driving that? I think you're also seeing that in the monkey studies as well.

Do you necessarily need a combination with icovamenib to kind of get this induced beta cell stimulation? Could 650 kind of get you all the way there on its own?

Thomas Butler *Biomea Fusion Inc - Chairman of the Board, Chief Executive Officer, Co-Founder*

Yeah. I think that's an astute observation. Obviously, 650 is doing a really nice job, but we do see the benefit of adding icovamenib to the agent. So if you look at page 11 as an example, so leveraging 100 nanomolar of icovamenib with 400 nanomolar 650 is now reaching some of those levels that you would see with a peptide-based therapy.

And so what our aim is really to achieve is what novel-novel oral combinations, we can get what the peptides are achieving from an efficacy perspective. And if you can lower the amount of the GLP-1 from a contribution perspective, we can really start to enable a very strong efficacy to safety profile for patients.

Eric Joseph *JPMorgan - Analyst*

Thanks for taking my questions.

Operator

Peter Lawson, Barclays.

Peter Lawson *Barclays Estimates - Analyst*

Great. Thanks so much. Just as we think about cash burn, and there's a lot of exciting avenues you can explore here, I wonder if you could talk through how you're thinking about resource allocation, diabetes over oncology and your GLP-1 over menin inhibitor in diabetes. Just kind of how you're thinking of with resource allocation for those kind of four quadrants.

Thomas Butler *Biomea Fusion Inc - Chairman of the Board, Chief Executive Officer, Co-Founder*

Yeah. Great question, Peter. And we feel very fortunate to have so many exciting agents in-house to develop. And so we want to be mindful of our in-house resources, both from an employee base, but also from a capital base. And so we will look to balance using capital investments, but as well as partnerships to pursue these various programs.

And we'll be in a very strong position to end the year where we will get multiple data cards not only for the metabolic space with our compounds, but also in the oncology space. And I think there, we'll be able to then look at how corporate development can really lean in and help provide additional support.

Peter Lawson *Barclays Estimates - Analyst*

Got you. And then on the route forward and plans for publishing and presenting the data, just your thoughts around presenting this and over the next 6 to 12 months, the data flow we should be thinking about?

Thomas Butler *Biomea Fusion Inc - Chairman of the Board, Chief Executive Officer, Co-Founder*

Yeah. So obviously, in December, we have big data flow. We're very excited about COVALENT-111 reading out and showing what icovamenib can do after 8 and 12 weeks of treatment in this patient population. And it's a big number, right, 267 patients enrolled?

So we're excited to get all this data that's coming out from the broader patient population, but also into those 2 key segments that I mentioned earlier in the call. Obviously, we're also very excited about getting this initial proof of concept in type 1 diabetes, looking at patients who have been diagnosed within three years as well as between 3 and 15.

And then, of course, as we complete escalation in the oncology side, we will get to see what does the efficacy and safety look like of icovamenib and of BMF-500 in the various indications that we're pursuing. So there's going to be a lot of data coming in Q4.

There'll be additional data in Q1. And we have a nice publication strategy that the team is working on so that we'll have our presentations at ATTD Asia coming up in November, showing you long-term benefit from icovamenib in beta cell deficient patients as well as World Congress and ATTD in Amsterdam in March. So lots to come.

Peter Lawson *Barclays Estimates - Analyst*

Great. And then just finally on the data, the appetite suppression you showed in monkeys, what does it look like for different doses for 650. And I guess, when do we see longer-term follow-up that is both around sustained appetite suppression and also safety, which is a key aspect here?

Thomas Butler *Biomea Fusion Inc - Chairman of the Board, Chief Executive Officer, Co-Founder*

Yeah. So as Thorsten mentioned, the GLP work is ongoing and the formal tox support IND-enabling studies will kick off early next year and will put us in position for IND filing. And then from an in vivo efficacy profile perspective, that also will be ongoing in parallel, and we'll look to share more data in 2025.

Peter Lawson *Barclays Estimates - Analyst*

Perfect. Thanks so much.

Operator

There are no further questions. I would now like to turn the call over to Mr. Thomas Butler, Biomea's CEO, for closing remarks. You may begin.

Thomas Butler *Biomea Fusion Inc - Chairman of the Board, Chief Executive Officer, Co-Founder*

Thank you, operator, and thank you all very much for dialing into this exciting call. It's really a pleasure to have Thorsten and Mini here and to announce this third program with BMF-650. We're very excited for COVALENT-111 and 112 readouts here in December, and we look forward to providing those updates very soon.

Thank you again for participating. Talk to you soon.

Operator

That concludes today's conference call. Thank you all for joining. You may now disconnect.

DISCLAIMER

The London Stock Exchange Group and its affiliates (collectively, "LSEG") reserves the right to make changes to documents, content, or other information on this web site without obligation to notify any person of such changes. No content may be modified, reverse engineered, reproduced or distributed in any form by any means, or stored in a database or retrieval system, without the prior written permission of LSEG. The content shall not be used for any unlawful or unauthorized purposes. LSEG does not guarantee the accuracy, completeness, timeliness or availability of the content. LSEG is not responsible for any errors or omissions, regardless of the cause, for the results obtained from the use of the content. In no event shall LSEG be liable to any party for any direct, indirect, incidental, exemplary, compensatory, punitive, special or consequential damages, costs, expenses, legal fees, or losses (including, without limitation, lost income or lost profits and opportunity costs or losses caused by negligence) in connection with any use of the content even if advised of the possibility of such damages.

In the conference calls upon which Summaries are based, companies may make projections or other forward-looking statements regarding a variety of items. Such forward-looking statements are based upon current expectations and involve risks and uncertainties. Actual results may differ materially from those stated in any forward-looking statement based on a number of important factors and risks, which are more specifically identified in the companies' most recent SEC filings. Although the companies may indicate and believe that the assumptions underlying the forward-looking statements are reasonable, any of the assumptions could prove inaccurate or incorrect and, therefore, there can be no assurance that the results contemplated in the forward-looking statements will be realized.

LSEG assumes no obligation to update the content following publication in any form or format. The content should not be relied on and is not a substitute for the skill, judgment and experience of the user, its management, employees, advisors and/or clients when making investment and other business decisions. LSEG does not act as a fiduciary or an investment advisor except where registered as such.

THE INFORMATION CONTAINED IN TRANSCRIPT SUMMARIES REFLECTS LSEG'S SUBJECTIVE CONDENSED PARAPHRASE OF THE APPLICABLE COMPANY'S CONFERENCE CALL AND THERE MAY BE MATERIAL ERRORS, OMISSIONS, OR INACCURACIES IN THE REPORTING OF THE SUBSTANCE OF THE CONFERENCE CALLS. IN NO WAY DOES LSEG OR THE APPLICABLE COMPANY ASSUME ANY RESPONSIBILITY FOR ANY INVESTMENT OR OTHER DECISIONS MADE BASED UPON THE INFORMATION PROVIDED ON THIS WEB SITE OR IN ANY SUMMARY. USERS ARE ADVISED TO REVIEW THE APPLICABLE COMPANY'S CONFERENCE CALL ITSELF AND THE APPLICABLE COMPANY'S SEC FILINGS BEFORE MAKING ANY INVESTMENT OR OTHER DECISIONS.