UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, D.C. 20549

FORM 8-K

CURRENT REPORT
Pursuant to Section 13 or 15(d)
of the Securities Exchange Act of 1934

Date of Report (Date of earliest event reported): June 17, 2025

Biomea Fusion, Inc.
(Exact name of Registrant as Specified in Its Charter)

Delaware	001-40335	82-2520134
(State or Other Jurisdiction of Incorporation)	(Commission File Number)	(IRS Employer Identification No.)

Biomea Fusion, Inc.
900 Middlefield Road, 4th Floor
Redwood City, California 94063
(Address of principal executive offices, including zip code)

(650) 980-9099
(Telephone number, including area code, of agent for service)

N/A
(Former name or former address, if changed since last report.)

Check the appropriate box below if the Form 8-K filing is intended to simultaneously satisfy the filing obligation of the registrant under any of the following provisions:

☐ Written communications pursuant to Rule 425 under the Securities Act (17 CFR 230.425)

☐ Soliciting material pursuant to Rule 14a-12 under the Exchange Act (17 CFR 240.14a-12)

☐ Pre-commencement communications pursuant to Rule 14d-2(b) under the Exchange Act (17 CFR 240.14d-2(b))

☐ Pre-commencement communications pursuant to Rule 13e-4(c) under the Exchange Act (17 CFR 240.13e-4(c))

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Trading Symbol(s)	Name of each exchange on which registered
Common Stock	BMEA	The Nasdaq Global Market

Indicate by check mark whether the registrant is an emerging growth company as defined in Rule 405 of the Securities Act of 1933 (§ 230.405 of this chapter) or Rule 12b-2 of the Securities Exchange Act of 1934 (§ 240.12b-2 of this chapter).

Emerging growth company ☒

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Item 7.01 Regulation FD Disclosure

On June 17, 2025, Biomea Fusion, Inc. (the "Company") posted to the "Investors & Media" section of the Company's website at *www.biomeafusion.com* an updated corporate presentation (the "Corporate Presentation"). A copy of the Corporate Presentation is furnished herewith as Exhibit 99.1 to this Current Report on Form 8-K.

The information contained in Item 7.01 of this Current Report on Form 8-K, including Exhibit 99.1 attached hereto, is being furnished and shall not be deemed to be "filed" for the purposes of Section 18 of the Securities Exchange Act of 1934 (the "Exchange Act"), or otherwise subject to the liabilities of that section and shall not be incorporated by reference in any filing under the Securities Act of 1933 or the Exchange Act, except as shall be expressly set forth by specific reference in such filing.

Item 8.01 Other Events

On June 17, 2025, the Company reported new preclinical findings from a 28-day weight loss study in obese non-human primates evaluating BMF-650, the Company's investigational, next-generation oral small molecule Glucagon-like peptide-1 receptor agonist ("GLP-1 RA") candidate.

The weight reduction study was conducted in 15 obese cynomolgus monkeys. The study demonstrated a clear, dose-dependent reduction in daily food intake and pronounced and continuous weight loss over a four-week treatment period. BMF-650 was administered orally once daily at 10 mg/kg and 30 mg/kg and resulted in body weight decreasing progressively, with the respective dose groups achieving a 12% and 15% average weight reduction from baseline over 4 weeks. These effects compared favorably to published preclinical data of another leading oral GLP-1 RA candidate in development.

Study Design and Key Preclinical Findings

- The study used 15 obese cynomolgus monkeys, randomized into three groups receiving vehicle, BMF-650 at 10 mg/kg, or 30 mg/kg daily for 28 days.
- Daily food intake was reduced to an average of 35g/day (10 mg/kg) and 16g/day (30 mg/kg) versus 109 g/day for the vehicle control group.
- BMF-650 induced rapid and durable weight loss as observed during the study, with reductions of 12% (10 mg/kg) and 15% (30 mg/kg) from baseline at Day 28.

BMF-650 Preclinical Highlights

- Similar to the broader orforglipron chemotype class, designed to improve PK properties, to enhance oral bioavailability, achieve less variability and a higher plasma protein binding for a cleaner safety and tolerability profile.
- Goal to achieve a more patient-friendly titration profile than current GLP-1 RAs.
- Demonstrated robust glycemic control and appetite suppression in multiple preclinical models resulting in pronounced and dose-dependent weight reduction.
- Generally well tolerated without safety concerns outside of the observed class effects.

Next Steps

- Investigational New Drug ("IND") submission on track for the second half of 2025.
- A full set of preclinical data for BMF-650 is planned for submission and presentation at an upcoming medical conference.

Item 9.01 Financial Statements and Exhibits

(d) Exhibits

99.1	Corporate Presentation, dated June 17, 2025
104	Cover Page Interactive Data File (embedded within the Inline XBRL Document).

Forward-Looking Statements

Statements in this Current Report on Form 8-K (this "Current Report") may include statements which are not historical facts and are considered forward-looking statements within the meaning of Section 27A of the Securities Act of 1933, as amended (the "Securities Act"), and Section 21E of the Securities Exchange Act of 1934, as amended (the "Exchange Act"). These statements may be identified by words such as "aims," "anticipates," "believes," "could," "estimates," "expects," "forecasts," "goal," "intends," "may," "plans," "possible," "potential," "seeks," "will," and variations of these words or similar expressions that are intended to identify forward-looking statements. Any such statements in this Current Report that are not statements of historical fact, including statements regarding the clinical and therapeutic potential of the Company's product candidates and development programs, including BMF-650, the potential of BMF-650 as a treatment for type 2 diabetes and obesity, the Company's research, development, partnership and regulatory plans, the mechanism of action of the Company's product candidate and development programs; the progress and initiation of the Company's ongoing and upcoming clinical trials, including the Company's planned IND submission for BMF-650, the anticipated initiation of, and availability of data from the Company's clinical trials; the Company's planned interactions with regulators and the timing of such events may be deemed to be forward-looking statements. The Company intends these forward-looking statements to be covered by the safe harbor provisions for forward-looking statements contained in Section 27A of the Securities Act and Section 21E of the Exchange Act and are making this statement for purposes of complying with those safe harbor provisions. Any forward-looking statements in this Current Report are based on the Company's current expectations, estimates and projections only as of the date hereof and are subject to a number of risks and uncertainties that could cause actual results to differ materially and adversely from those set forth in or implied by such forward-looking statements, including the risk that results of preclinical studies may not be predictive of future preclinical results or clinical results in connection with planned clinical trials and the risk that the Company may encounter delays in preclinical or clinical development, interactions with regulatory authorities related to clinical development, and in the initiation, conduct and completion of the Company's planned clinical trials and other research and development activities. These risks concerning the Company's business and operations are described in additional detail in its periodic filings with the U.S. Securities and Exchange Commission ("SEC"), including its most recent periodic report filed with the SEC and subsequent filings thereafter. The Company explicitly disclaims any obligation to update any forward-looking statements except to the extent required by law.

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

Biomea Fusion, Inc.

Date: June 17, 2025

By: /s/ Michael J.M. Hitchcock

Interim Chief Executive Officer, Director
(Principal Executive Officer)

Exhibit 99.1


biomea
FUSION
Corporate Update
June 2025
biomea
FUSION
biomea
FUSION

Legal Disclaimer & Forward-Looking Statement

Certain statements in this presentation and the accompanying oral commentary are forward-looking statements. These statements relate to future events or the future business and financial performance of Biomea Fusion, Inc. (the "Company") and involve known and unknown risks, uncertainties and other factors that may cause the actual results, levels of activity, performance or achievements of the Company or its industry to be materially different from those expressed or implied by any forward-looking statements. In some cases, forward-looking statements can be identified by terminology such as "may," "will," "could," "would," "should," "expect," "plan," "anticipate," "intend," "believe," "estimate," "predict," "potential" or other comparable terminology. All statements other than statements of historical fact could be deemed forward-looking, including any projections of financial information or profitability, the initiation, timing and results of pending or future preclinical studies and clinical trials, the actual or potential actions of the Food and Drug Administration (FDA), the status and timing of ongoing research, development and corporate partnering activities, any statements about historical results that may suggest trends for the Company's business; any statements of the plans, strategies, and objectives of management for future operations and any statements of expectation or belief regarding future events, potential markets or market size, or technology developments. The Company has based these forward-looking statements on its current expectations, assumptions, estimates and projections. While the Company believes these expectations, assumptions, estimates and projections are reasonable, such forward-looking statements are only predictions and involve known and unknown risks and uncertainties, many of which are beyond the Company's control. For a discussion of these and other risks and uncertainties, and other important factors, any of which could cause our actual results to differ from those contained in the forward-looking statements, see the section entitled "Risk Factors" in our most recent annual report on Form 10-K and quarterly report on Form 10-Q filed with the Securities and Exchange Commission (the SEC), as well as discussions of potential risks, uncertainties, and other important factors in our other subsequent filings with the SEC. The forward-looking statements in this presentation are made only as of the date hereof. Except as required by law, the Company assumes no obligation and does not intend to update these forward-looking statements or to conform these statements to actual results or to changes in the Company's expectations. This presentation also contains estimates and other statistical data made by independent parties and by us relating to market size and growth and other data about our industry. This data involves a number of assumptions and limitations, and you are cautioned not to give undue weight to such estimates. In addition, projections, assumptions, and estimates of our future performance and the future performance of the markets in which we operate are necessarily subject to a high degree of uncertainty and risk. Certain information contained in this presentation relates to or is based on studies, publications, surveys and other data obtained from third-party sources and the Company's own internal estimates and research. While the Company believes these third-party sources to be reliable as of the date of this presentation, it has not independently verified, and makes no representation as to the adequacy, fairness, accuracy or completeness of, any information obtained from third-party sources. In addition, all of the market data included in this presentation involves a number of assumptions and limitations, and there can be no guarantee as to the accuracy or reliability of such assumptions. Finally, while we believe our own internal research is reliable, such research has not been verified by any independent source.

This presentation shall not constitute an offer to sell or the solicitation of an offer to buy these securities, nor shall there be any sale of these securities in any state or jurisdiction in which such offer, solicitation, or sale would be unlawful prior to registration or qualification under the securities laws of any such state or jurisdiction.

Biomea Fusion: Oral Small Molecules For Diabetes and Obesity

- Potentially transformative disease-modifying activity in type 2 diabetes (T2D): Targets a root cause by restoring functional beta cells to enable endogenous insulin production – A result not achieved by currently available therapies
- Icovamenib is a menin inhibitor showing an emerging competitive clinical profile, demonstrating significant and durable HbA1c reductions, up to ~1.5% sustained well beyond end of treatment
- Oral, short-course therapy designed for durability and boost adherence and persistence, addressing a key barrier in chronic T2D management
- Addresses a critical unmet need in insulin-deficient T2D, the most vulnerable patient group at highest risk of macrovascular (CV) complications, rapid treatment failure, and fastest progression to insulin dependence
- Synergistic with GLP-1 therapies, expanding reach across broader T2D populations, and demonstrating additional benefits in weight loss, glucose control and muscle mass preservation in preclinical combination studies
- Efficient and cost-effective clinical pathway, with potential for a shorter Phase III program due to short term treatment - based on initial regulatory feedback
- Advancing BMF-650, a next-generation oral GLP-1 RA with best-in-class potential, into clinical development later this year

Biomea Fusion: A Diabetes and Obesity Medicines Company

"We believe we may have a method to reverse diabetes, to reset the body, so diabetes patients no longer require ongoing medication."

	Study	Indications	Anticipated Milestones for 2H 2025
ICOVAMENIB Menin Program (Potential First-In-Class)	COVALENT-111 Phase II	Type 2 Diabetes	52 Week Follow-up Data (26 Week Follow-up Data announced 12/24)
	COVALENT-112 Phase II	Type 1 Diabetes	52 Week Follow-up Data from those patients that completed original 12 weeks of dosing
	COVALENT- 211 Phase IIb	Type 2 Diabetes Severe Insulin Deficient Diabetes	FDA Type C Meeting Update Planned Initiation of Phase IIb in Severe Insulin Deficient Patients (discuss Phase III Pgm requirements)
	COVALENT- 212 Phase II	Type 2 Diabetes Combination with GLP-1 based therapies	Planned Initiation of Phase II in Patients uncontrolled on GLP-1 based therapies
BMF-650 Oral GLP-1RA	IND-Enabling Studies	Diabetes/Obesity	Weight Reduction in Obese Monkeys Preclinical Update – 2Q 2025 Planned Initiation of Phase I Study in Obese Healthy Volunteers 2H 2025

Biomea Fusion Pipeline Summary: Two High-Value Programs Targeting Unmet Needs in Diabetes & Obesity

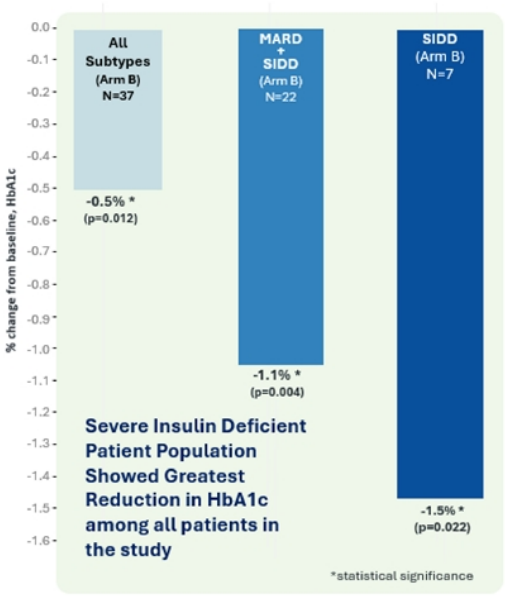
	ICOVAMENIB	BMF-650
Mechanism of Action	Novel Menin Inhibition *Enhanced insulin production driven by a restored and functionally improved pool of pancreatic beta cells*	Oral GLP-1 RA *Demonstrated in preclinical studies, appetite suppression comparable to orforglipron with potential improved tolerability*
Route of Administration	Oral	Oral
Program Highlights	Greatest HbA1c reductions were observed in insulin-deficient diabetes patients among all patients in the study (a population with poor glycemic control and limited treatment options) Durable HbA1c improvement sustained through week 26, over 3 months after last dose (follow-up through week 52 is ongoing) In combination with GLP-1 RA, icovamenib enhanced insulin secretion, drove quality weight loss, and preserved muscle mass	Built on similar scaffold as orforglipron Drive for Best-in-Class Status with optimized exposure profile Improved PK properties (greater bioavailability, less variability, and well sustained exposure during dosing intervals) Increased AUC to drive greater weight loss and tolerability (higher plasma protein binding for better tolerability) Superior glucose regulation and robust weight loss efficacy in non-human primates
Market Opportunity	**Over 7M[1] Addressable U.S. Target Patients and over 11M[2] in the EU** **$6B current US gross revenue potential** (10% uptake x $10k in target T2D patients[3])	Current estimates for U.S. obesity drug market is **approximately $50B[3] annual US gross revenue potential by 2030**
Anticipated Milestone	52 Week Data Read Out expected in 2H 2025 Phase IIb study proposal expected to be shared with FDA in 2H 2025	Weight Reduction in Obese Monkeys Preclinical Update – Expected 2Q 2025 IND submission targeted for 2H 2025

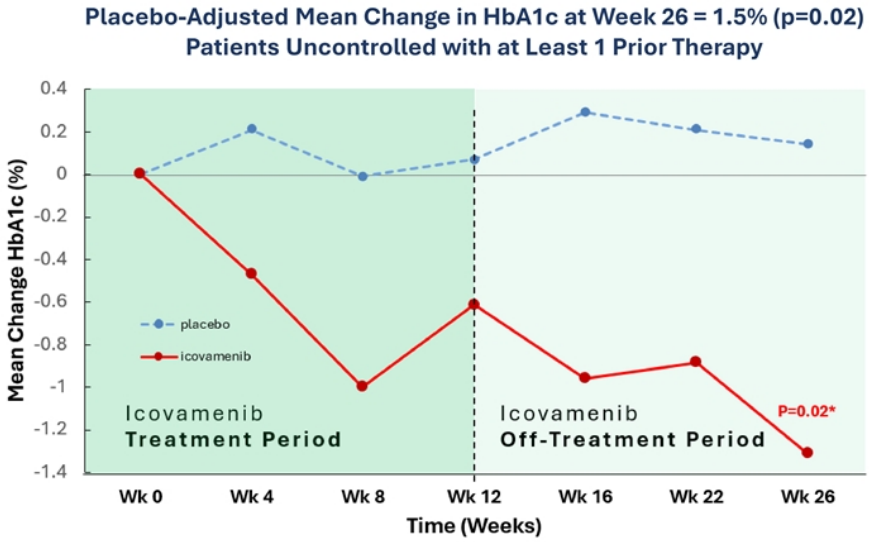
1. Zohu Lancet 2024; 404: 2077–93
2. IDF www.diabetesatlas.org
3. Horizon Grand View Research and Morgan Stanely research estimates

Biomea Pipeline: Advancing Potential First-in-Class and Best-in-Class Approaches for Diabetes and Obesity

Program/ Asset	Route of Admin	Pre-Clinical	Phase I	Phase II	Phase III	Global Rights	Next Milestone in 2H 2025
Icovamenib **Potential First-in-Class** *Oral Menin Inhibitor Monotherapy with combo potential*	**Oral**	**Type 2 Diabetes**					
		COVALENT-111 – T2D ongoing				biomea FUSION	**52 Week Follow up data expected 2H 2025**
		Type 2 Diabetes - Severe Insulin Deficiency					
		COVALENT-211 – T2D planned				biomea FUSION	**Commencement of Phase IIb study expected in 2H 2025**
		Type 2 Diabetes – Combo Study with GLP-1 - RA					
		COVALENT-212 – T2D planned				biomea FUSION	**Commencement of Phase IIa study expected in 2H 2025**
BMF-650 **Potential Best-in-Class** *Oral GLP-1 RA Monotherapy*	**Oral**	**Obesity/ Type 2 Diabetes**					
		IND Enabling Studies				biomea FUSION	**IND clearance expected in 2H 2025** **Commencement of Phase I in 2H 2025**

Short Course of Icovamenib Demonstrated Clinically Significant Impact on HbA1c Reductions in a Severe Insulin-Deficient Population





Oral Icovamenib Regimen Ends at 12 Weeks, HbA1c Continues to Decrease: 52-week Data Expected 2H 25

High Unmet Need in Patients with Severe Insulin-Deficient Type 2 Diabetes

$6B + Estimated U.S. Revenue Potential (based on 10% penetration at 10K/yearly)

150M

Severe Insulin-Deficient T2D worldwide cases

2022 Global Estimates[1]

7M

Severe Insulin-Deficient T2D US cases

2025 U.S. Estimates[2]

60+

approved T2D therapies, all chronic agents and none **address a root cause of the disease**

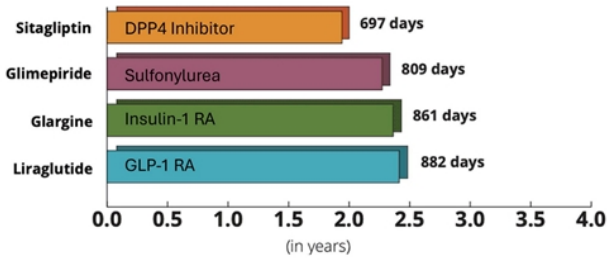
18-44%
Depending on ethnicity

of all T2D patients are severely insulin-deficient, this group has the highest failure rates among all T2D subgroups[3]

1. Zohu Lancet 2024; 404: 2077–93 (adjusted by company to account for Severe Insulin-deficient patients). 2. IDF www.diabetesatlas.org. 3. Fendo2022 doi: 10.3389/fendo.2022.927661 https://doi.org/10.1371/journal.pone.0304036.

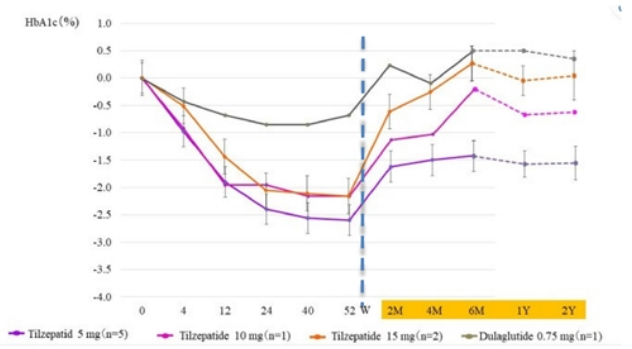
Current Chronic Diabetes Treatments: Despite Initial Effectiveness, There is No Lasting Impact

Mean Time to Loss of Glucose Control (HbA1c>7%)



Nathan, et al. N Engl J Med 2022;387:1063-107

Impact of tirzepatide on HbA1c: Sustained Reduction During Treatment, Rebound After Discontinuation



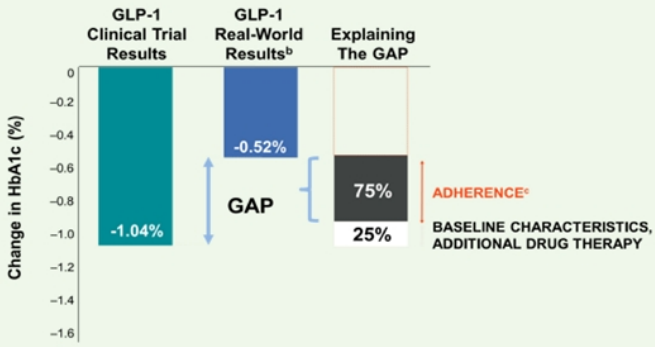
Kubota M, et al. Cureus. 2023 Oct 4;15(10)

Despite a multitude of standard-of-care therapies, 50% of people with diabetes continue to have uncontrolled glucose levels. There is a need for novel, durable solutions to improve long-term outcomes.

Challenges with Current Standard of Care: Many Patients Fail to Achieve Glycemic Control or Stay on Therapy

Discontinuation rates of T2D Therapies[1-2]

Poor Adherence is a Key Driver of the Efficacy Gap Between Clinical Trial Results and Real-World Results[3]



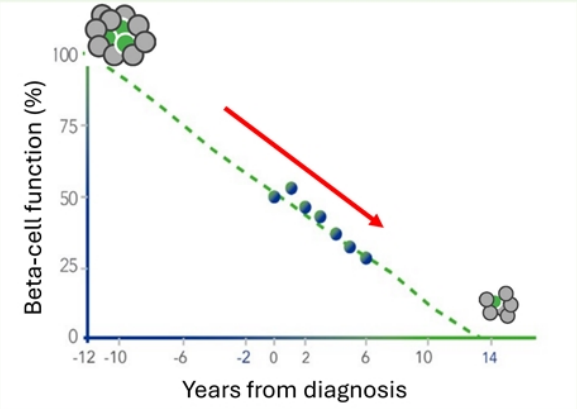
1. Khan, et al. JAMA 2024 doi:10.1001/jama.2024.22284.
2. Alkabbani W, et al. Diabetes Obes Metab. 2023;25:3490-3500
3. Edelman S. Diabetes Care 2017;40(11):1425–1432

[b]Optum/Humedica SmartFile database (2007–2014) was used [GLP-1 RA (221 patients); DPP-4i (652 patients)]. Change in HbA1c measured from drug initiation to 365±90 days later.
[c]Medical adherence classified as poorly adherent if percentage of days covered (PDC) <80%.

Today's T2D Agents are not Addressing a Root Cause of Diabetes: The Progressive Decline in Beta-Cell Mass and Function

Loss of Beta-Cell Function

A Root Cause of Diabetes Leading to Insulin Deficiency

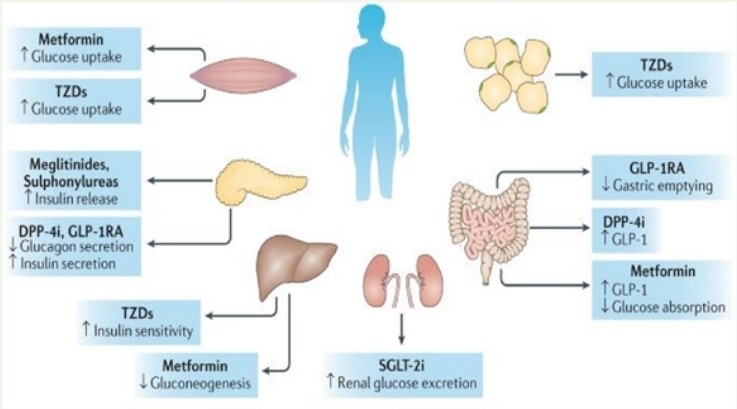


Adapted from DeFronzo RA. *Diabetes.* 2009;58:773-795.

Currently Approved Therapies

Target the Symptoms of T2D, Not a Root Cause

HYPERGLYCEMIA



Nat Rev Endocrinol. 2016;12:337–346

Type 2 Diabetes (T2D) is a Heterogeneous Disease – Two Core Drivers

Analysis from two independent 4,000 patient studies, (ADOPT and RECORD)

INSULIN-DEFICIENT DIABETES

Severe insulin-deficient diabetes (SIDD)

Initial target group for icovamenib

18%

Median HOMA-B	49%
Median HbA1c	8.3%
Median BMI	29 kg/m^2

Mild age-related diabetes (MARD)

39%

Median HOMA-B	64%
Median HbA1c	7.0%
Median BMI	29 kg/m^2

INSULIN RESISTANT DIABETES

Mild obesity-related diabetes (MOD)

22%

Median HOMA-B	74%
Median HbA1c	7.2%
Median BMI	36 kg/m^2

Severe insulin resistant diabetes (SIRD)

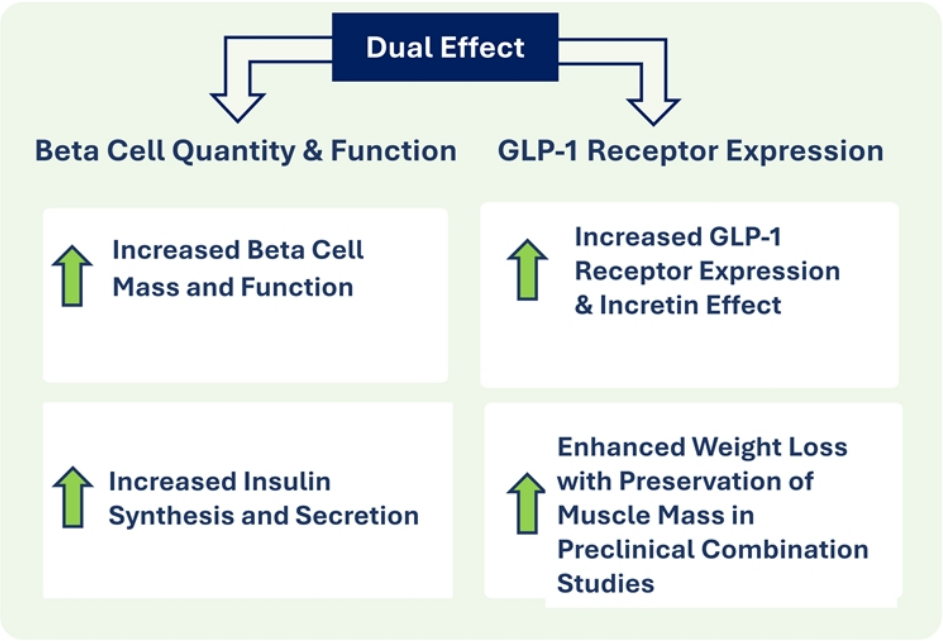
15%

Median HOMA-B	101%
Median HbA1c	7.0%
Median BMI	34 kg/m^2

Ahlqvist et al. Lancet Diabetes Endocrinol 2018; 6: 361–69

Icovamenib: Potential First-in-Class Disease Modifying Candidate for Diabetes

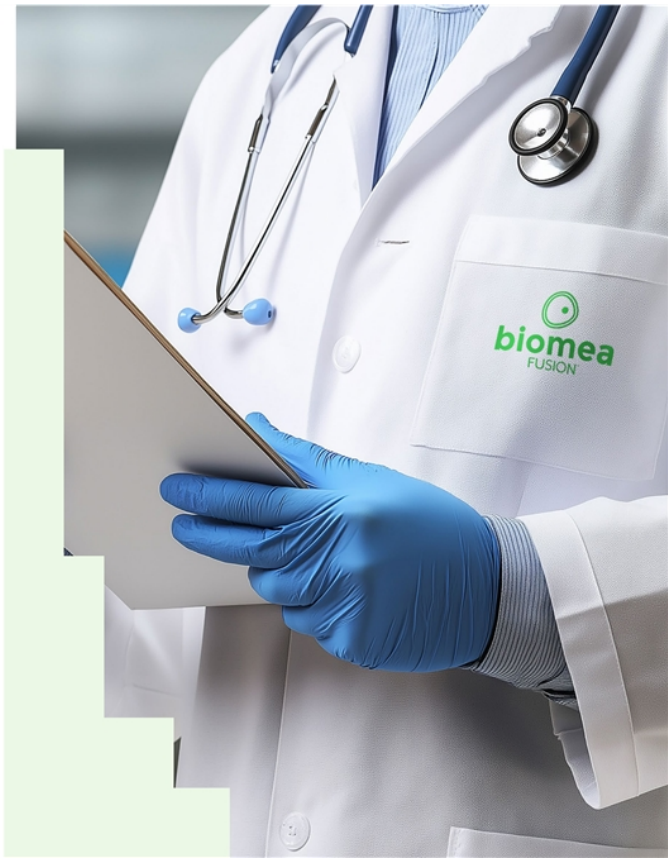
Mechanism of Action: Selective & Partial Menin Inhibition



Icovamenib Differentiating Features

- ✓ Oral – Convenient, once-daily oral therapy
- ✓ Non-Chronic – Limited duration dosing with sustained effect
- ✓ Well Tolerated – Favorable safety profile observed to date
- ✓ MOA complementary to other agents used

biomea FUSION™



COVALENT-111

Phase 2a Double-Blinded, Randomized Placebo Controlled Study in Type 2 Diabetes

Topline Results at 26 Weeks

Trial Design

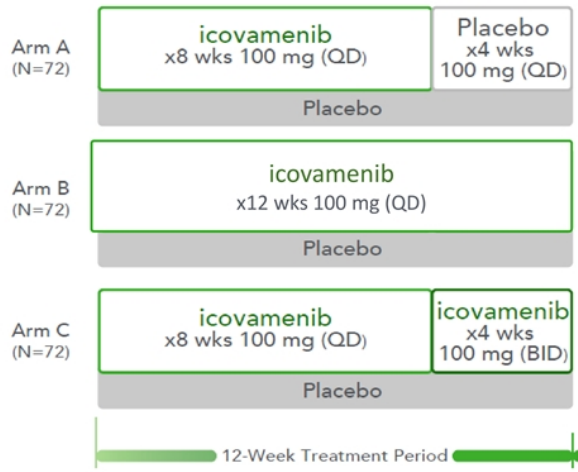
Phase 2a Randomized, Double-Blind, Placebo-controlled Study in Participants with T2D

N=216 Planned Participants

3:1

Eligibility Criteria

- Adults (18-65 years) with T2D (<7 years)
- HbA1c 7.0-10.5%
- BMI 25-40 kg/m2
- Treated with up to 3 antidiabetic agents (excluding insulin and SFUs)
- N=72 participants per arm (3:1 ratio, icovamenib: PBO)



Primary Endpoints:

- Change of HbA_{1c} from baseline at Week 26
- Safety and tolerability at Week 52

Secondary Endpoint:

- Proportion of subjects achieving an HbA_{1c} < 7% at Week 26
- Measure of glycemic control (plasma glucose, c-peptide and insulin) at Week 26
- The β-cell function (HOMA-β and HOMA-IR) at Week 26

Baseline Demographics and Characteristics

Per Protocol Population on 1 or more antihyperglycemic agents at baseline (N=165)

Parameter Mean (SD) or %	Arm A Icovamenib (8 weeks of dosing 100mg QD) (N=45)	Arm B Icovamenib (12 weeks of dosing 100 mg QD) (N=37)	Arm C Icovamenib (8 weeks of 100 mg QD + 4 weeks of 100 BID) (N=33)	Combined Arms icovamenib (N=115)	Combined Arms Placebo (N=50)
Age (yr)	55 (7)	56 (6)	51 (10)	54 (8)	55 (7)
Duration of T2D Diagnosis (yr)	4.3 (1.8)	4.7 (1.8)	4.2 (2.2)	4.4 (1.9)	4.3 (2.0)
Sex (% Female)	31	54	36	40	42
HbA1c (%)	8.3 (1.1)	8.3 (1.0)	8.0 (0.8)	8.2 (1.0)	8.3 (1.0)
Fasting C-peptide (ng/mL)	3.4 (1.2)	3.9 (1.7)	3.7 (1.8)	3.7 (1.5)	3.5 (1.4)
BMI (kg/m^2)	30.9 (4.7)	32.6 (4.5)	32.4 (4.9)	31.9 (4.7)	32.6 (4.1)
BMI <30 kg/m^2 (%)	49	24	30	36	26
BMI ≥30 kg/m^2 (%)	51	73	70	63	74

Demographics and baseline characteristics were well matched between icovamenib- and placebo-treated participants

Antihyperglycemic Agents at Baseline

Per Protocol Population on 1 or more antihyperglycemic agents at baseline (N=165)

Parameter	Arm A Icovamenib (8 weeks of dosing 100mg QD) (N=45)	Arm B Icovamenib (12 weeks of dosing 100 mg QD) (N=37)	Arm C Icovamenib (8 weeks of 100 mg QD + 4 weeks of 100 BID) (N=33)	Combined Arms icovamenib (N=115)	Combined Arms Placebo (N=50)
Number of T2D Medications, n (%)					
0	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
1	39 (87)	23 (62)	23 (70)	85 (74)	41 (82)
2	4 (9)	11 (30)	7 (21)	22 (19)	7 (14)
3	2 (4)	3 (8)	3 (9)	8 (7)	2 (4)
Metformin Monotherapy, n (%)	36 (80)	18 (49)	22 (67)	76 (66)	38 (76)
SGLT2i, n (%)	6 (13)	13 (35)	8 (24)	27 (23)	8 (16)
DPP4i, n (%)	3 (7)	5 (14)	3 (9)	11 (10)	2 (4)
GLP-1 based agent, n (%)	3 (7)	3 (8)	5 (15)	11 (10)	4 (8)

Most participants treated with metformin monotherapy with approximately 20% treated with SGLT2i, 10% with DPP4i, and 10% with GLP-based medicines

T2D Subtype at Baseline

Per Protocol Population on 1 or more antihyperglycemic agents at baseline (N=165)

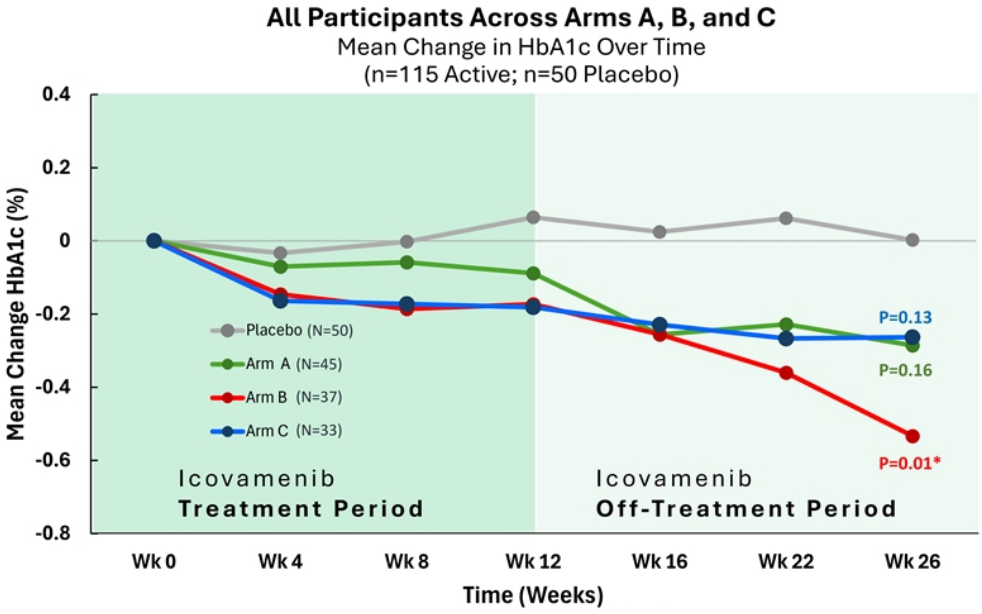
Parameter	Arm A Icovamenib (8 weeks of dosing 100mg QD) (N=45)	Arm B Icovamenib (12 weeks of dosing 100 mg) QD (N=37)	Arm C Icovamenib (8 weeks of 100 mg QD + 4 weeks of 100 BID) (N=33)	Combined Arms icovamenib (N=115)	Combined Arms Placebo (N=50)
SIDD, n (%)	12 (27)	7 (19)	4 (12)	23 (20)	11 (22)
MARD, n (%)	11 (24)	6 (16)	5 (15)	22 (19)	8 (16)
MOD, n (%)	20 (44)	21 (57)	23 (70)	64 (56)	27 (54)
SIRD, n (%)	2 (4)	3 (8)	1 (3)	6 (5)	4 (8)

SIDD = Severe Insulin-Deficient Diabetes
MARD = Mild Age-Related Diabetes
MOD = Mild Obesity-Related Diabetes
SIRD = Severe Insulin-Resistant Diabetes

Despite all participants being overweight or obese, approximately 40% were in the insulin-deficient subgroups (SIDD and MARD)

Change in HbA1c from Baseline at Week 26 by Study Arm

Per Protocol Population taking 1 or more antihyperglycemic medications at baseline, by study arm (A, B, C, and Placebo)



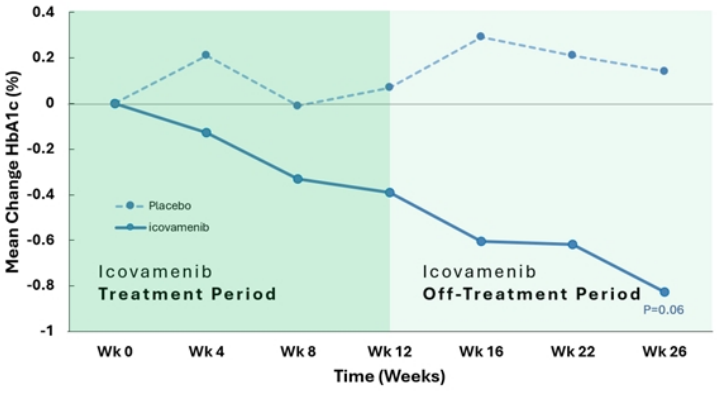
Change in HbA1c from Baseline at Week 26, SIDD Participants

Per Protocol Population taking 1 or more antihyperglycemic medications at baseline (study arms combined and placebo)

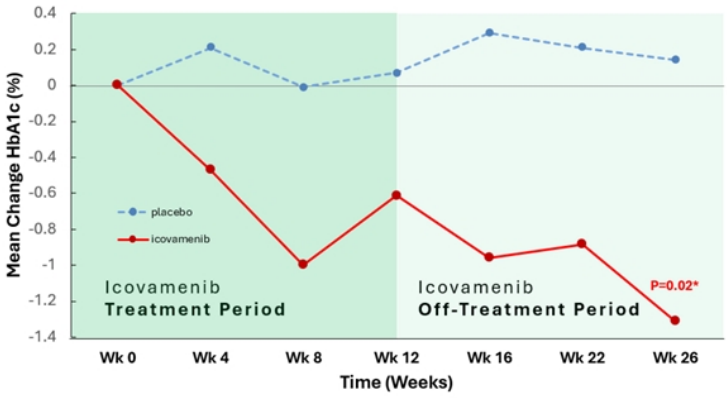
Participants with Pre-specified Severe Insulin-Deficient Diabetes

Mean Change in HbA1c Over Time

Arm A, B, and C (n=23 Active; n=11 Placebo)



Arm B (n=7 Active; n=11 Placebo)



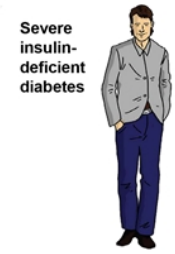
Arm A: 8 weeks of dosing 100mg QD;
Arm B: 12 weeks of dosing 100 mg QD;
Arm C: 8 weeks of 100 mg QD + 4 weeks of 100 BID

Despite Short Course Oral Dosing, Icovamenib Performed in Line with GLP-1 RA Therapies on HbA1c Reduction within Severe Insulin-Deficient Subgroup

Currently Approved Type 2 Diabetes Agents w/Chronic Dosing

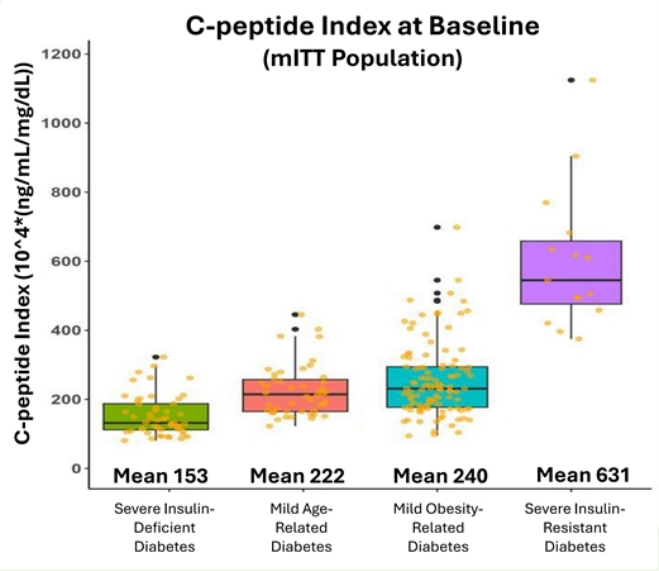
Therapy	Dosing Regimen	Administration Route	Observation Period	Mean HbA1c Reduction (placebo adj. %)
ICOVAMENIB (Menin Inhibitor)	**12 Weeks**	**Oral**	**Week 26**	**-1.5% (100mg)**
Ozempic (GLP 1 Agonist)	Chronic Dosing	Injectable	Week 30	-1.2 (0.5mg) -1.5 (1mg)
Mounjaro (GLP-1/GIP Agonist)	Chronic Dosing	Injectable	Week 40	-1.7 (5mg) -1.6 (15mg)
Jardiance (SGLT2 Inhibitor)	Chronic Dosing	Oral	Week 24	-0.7 (10mg) -0.9 (25mg)
Januvia (DPP4 Inhibitor)	Chronic Dosing	Oral	Week 24	-0.8 (100mg)

Ozempic FDA Label; Mounjaro FDA Label; Jardiance FDA Label; Januvia Label



Disclaimer: The data presented above are based on cross-study comparisons and are not based on any head-to-head clinical trials. Cross-study comparisons are inherently limited and may suggest misleading similarities and differences. The values shown in the cross-study comparisons are directional and may not be directly comparable.

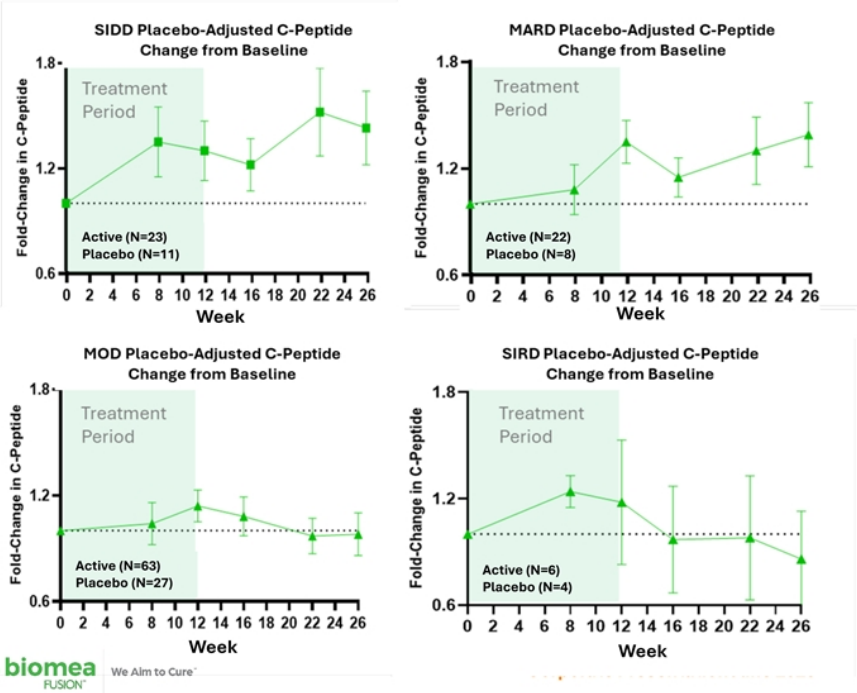
Pre-specified Patients with Severe Insulin-Deficient Diabetes had the Lowest Baseline Insulin, as Measured by the C-peptide Index during a 2-hour OGTT



- **The C-peptide Index is a well-validated measure of beta-cell function (C-peptide per unit of glucose as measured during OGTT, a standardized test). By comparing the levels of C-peptide to glucose, healthcare providers can evaluate how effectively the pancreas is producing insulin in response to blood glucose levels.**
- *The lowest insulin production occurred in participants with Severe Insulin-Deficient Diabetes*
- *By contrast, the highest insulin production occurred in participants with Severe Insulin-Resistant Diabetes*

COVALENT-111 Expansion Cohort

Icovamenib Increased Insulin Secretion (measured by C-peptide) in Insulin-Deficient, but Not in Insulin-Resistant T2D



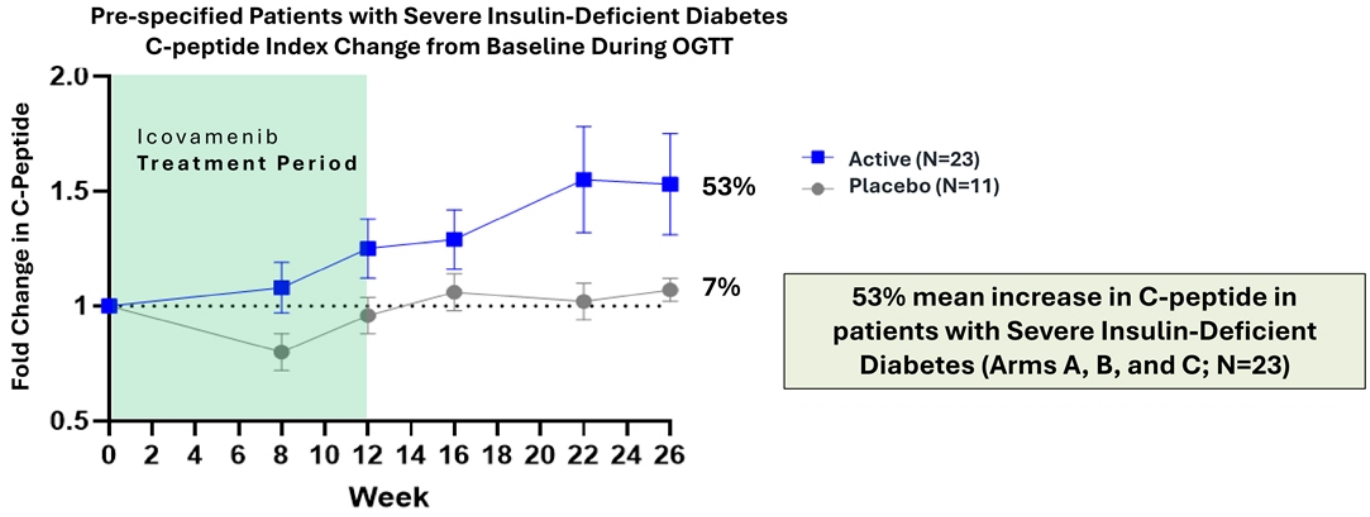
Insulin-Deficient participants demonstrated an **increase** in C-peptide over time

Insulin-Resistant participants did **not** demonstrate an **increase** in C-peptide over time

SIDD, Severe Insulin-Deficient Diabetes
MARD, Mild Age-Related Diabetes
MOD, Mild Obesity-Related Diabetes
SIRD, Severe Insulin-Resistant Diabetes

Icovamenib Increased Insulin Secretion as Measured by C-peptide

At Week 26, there was a 53% increase in insulin secretion, with more than half of the increase occurring after icovamenib treatment ended

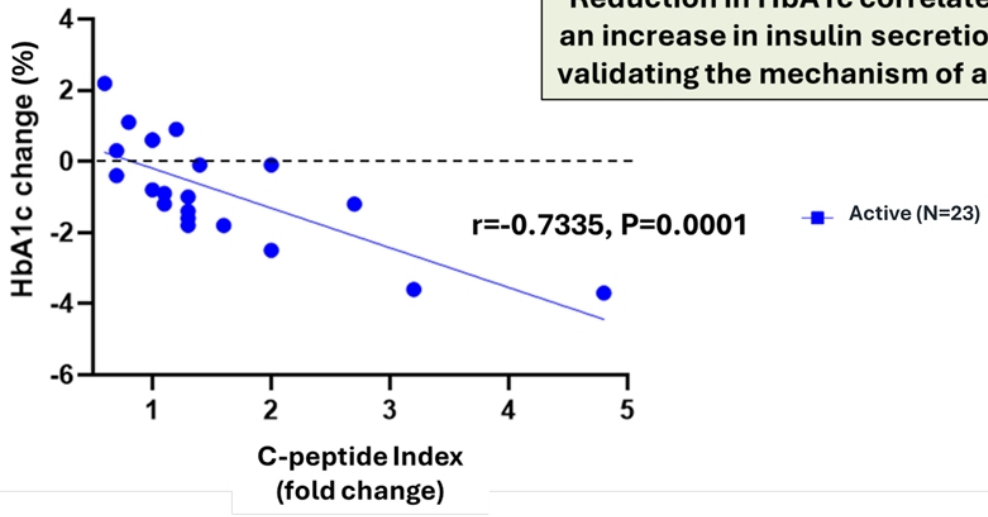


53% mean increase in C-peptide in patients with Severe Insulin-Deficient Diabetes (Arms A, B, and C; N=23)

Change from Baseline at Week 26 in C-peptide Index Versus HbA1c

Pre-specified Severe Insulin-Deficient Diabetes Participants (Arms A, B, and C) n=23

Reduction in HbA1c correlated significantly with an increase in insulin secretion (C-peptide Index), validating the mechanism of action of icovamenib



C-peptide Index (CPI) = 10^4 x Mean AUC C-peptide/Mean AUC glucose

Overview of Treatment Emergent Adverse Events Through 26 Weeks

(Safety Population, N=267)

Parameter	Arm A icovamenib (N=67)	Arm B icovamenib (N=66)	Arm C icovamenib (N=67)	Combined Arms icovamenib (N=200)	Combined Arms placebo (N=67)
Patients with ≥1 TEAE	18 (27)	20 (30)	14 (21)	52 (26)	19 (28)
SAEs*	1 (1)	0 (0)	1 (1)	2 (1)	1 (1)
Treatment Discontinuation due to TEAE	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
Study Discontinuation due to TEAE	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
Deaths	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)

Data are n (%)
TEAE, Treatment Emergent Adverse event
SAE, Serious adverse event
*Arm A had an SAE of atrial fibrillation. Unrelated to study treatment and occurred during the treatment period. Subject required hospitalization and was discharged in 3 days. Subject continued in the study.
*Arm C had an SAE of COVID-19. Unrelated to study treatment and occurred during the treatment period. Subject required hospitalization and was discharged in 3 days. Subject continued in the study.
*Placebo Arm had an SAE of nephrolithiasis. Unrelated to study treatment and occurred during the treatment period. Subject required hospitalization and was discharged in 3 days. Subject continued in the study.

Treatment Emergent Adverse Events (TEAEs) Occurring in ≥5% in any Study Arm and TEAEs reported for ALT and/or AST Elevations

(Safety Population, N=267)

Parameter	Arm A icovamenib (N=67)	Arm B icovamenib (N=66)	Arm C icovamenib (N=67)	Combined Arms icovamenib (N=200)	Combined Arms placebo (N=67)
Diarrhea	4 (6)	2 (3)	1 (1)	7 (4)	0 (0)
Nausea	2 (3)	3 (5)	2 (3)	7 (4)	1 (1)
Hyperglycemia	1 (1)	4 (6)	1 (1)	6 (3)	3 (4)
Headache	0 (0)	3 (5)	1 (1)	4 (2)	3 (4)
ALT increase	2 (3)	0 (0)	2 (3)	4 (2)	0 (0)
AST increase	2 (3)	0 (0)	1 (1)	3 (2)	0 (0)

Data are n (%) of TEAE with ≥5% frequency in any arm and ALT or AST increase irrespective of incidence; Safety population
TEAE, treatment-emergent adverse event; ALT, alanine aminotransferase; AST, aspartate aminotransferase
Diarrhea: In the icovamenib arms, all 7 events were Grade 1.
Nausea: In the icovamenib arms, 6 of 7 events were Grade 1 and 1 event was Grade 2 (Arm B). In the placebo arm, the 1 event was Grade 1.
Hyperglycemia: In the icovamenib arms, 5 of 6 events were Grade 2 and 1 event was Grade 1 (Arm C). In the placebo arm, all 3 events were Grade 2.
Headache: In the icovamenib arms, 3 of the 4 events were Grade 1 and 1 event was Grade 2 (Arm B). In the placebo arm, 2 of the 3 events were Grade 1 and 1 event was Grade 2.
ALT increase: In the icovamenib arms, 3 of the 4 events were Grade 1 and 1 event was Grade 2 (Arm A).
AST increase: In the icovamenib arms, all 3 events were Grade 1.

Subjects with TEAE of Hypoglycemia

(Safety Population, N=267)

	Arm A icovamenib (N=67)	Arm B icovamenib (N=66)	Arm C icovamenib (N=67)	Combined Arms icovamenib (N=200)	Combined Arms placebo (N=67)
Level 1, N (%)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
Level 2, N (%)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
Level 3, N (%)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)

Level 1 (mild hypoglycemia) <70 and ≥55 mg/dL
Level 2 (moderate hypoglycemia) <55 mg/dL regardless of presence of symptoms
Level 3 (Severe) hypoglycemia characterized by altered mental and/or physical status requiring assistance

Summary and Conclusions

Simple, easy and only short term	▪ 12-week oral dosing led to 1.5% placebo-adjusted HbA1c reduction at Week 26 (p=0.02) in patients with severe insulin-deficient diabetes
Addresses the most critical patient population	▪ Improvements in glycemic control were most significant in participants with severe insulin-deficient diabetes, who have the highest unmet need in diabetes, highest comorbidities, and failure rate, and required insulin earlier than other subgroups[1-2]
Clinically meaningful, durable and sustained results at Week 26 (1)	▪ Pre-specified severe insulin-deficient diabetes in Arm B (100 mg QD X 12 weeks) showed a statistically significant placebo-adjusted mean reduction in HbA1c of 1.5% at Week 26 (p=0.02)
Validation of MoA Menin inhibition	▪ With menin inhibition a change in HbA1c was achieved that was highly correlated with a change in stimulated C-peptide (r=-0.7335 and P=0.0001)
Potential for long-term beta-cell restoration	▪ Insulin-deficient patients who received icovamenib demonstrated a persistent increase in C-peptide levels beyond the active treatment period, over 3 months after the final dose of icovamenib
Well-tolerated, mirroring placebo	▪ No clinically significant elevations in aminotransferases and no treatment emergent hypoglycemia
Complementary to commonly used therapies	▪ And competitively differentiated as a precision approach for type 2 diabetes

1. Ahlqvist, et al. The Lancet Diabetes & Endocrinology (2018) 6(5), 361–369
2. Sanz-Pastor, et al Front. Endocrinol., 13 March 2024

Key Opinion Leader FIRST RESPONSES

"Icovamenib's recent data has shown an impressive restoration of beta cell function as demonstrated by significant elevations in C-peptide even after the treatment period ended. This data validates the mechanism of action of this menin inhibitor as a disease modifying agent and helps address the poor adherence and persistence commonly seen in type 2 diabetes. "
Steve Edelman, M.D., Endocrinologist, Professor of Medicine UCSD / VA San Diego

"The icovamenib data looks exciting. After 26 weeks there have been statistically significant and clinically relevant reductions in HbA1c and excellent tolerability in a prespecified insulin-deficient type 2 diabetes cohort. The data presented today help to confirm icovamenib's mechanism of action. A robust increase in insulin secretion, as measured by C-peptide, was demonstrated 3 months after the icovamenib dosing period and this improvement appears to be continuing. We have not previously seen data like this with any antihyperglycemic agent. As more trials are conducted, I believe that inhibition of menin may lead to benefits across all subtypes of diabetes. I applaud Biomea for developing a potential new treatment option that may be disease modifying for patients with diabetes."
Ralph DeFronzo, M. D., Endocrinologist, Professor of Medicine UTHSCSA

"Great foray into precision medicine. We need to be addressing patients in a much more individualized manner. By addressing insulin-deficient diabetes patients with icovamenib, we have seen post treatment that the beta cell pool is being restored and producing a higher level of insulin, as measured by C-peptide. This indicates a fundamental and potentially lasting impact on the disease and validates the mechanism of action of menin inhibition."
Melanie Davies, M.D., Diabetologist, Professor of Diabetes Medicine at the University of Leicester

Key Opinion Leader FIRST RESPONSES

"Icovamenib is a very interesting molecule that acts quite differently than anything I have seen before. We are observing glucose controlled and beta cell-specific proliferation and an increase in stimulated C-peptide secretion leading to patient benefits that continued after the icovamenib dosage ended. I am very excited to further explore the many opportunities that the covalent inhibition of menin will provide to patients."
Rohit Kulkarni, M.D., Ph.D., Professor of Medicine at Harvard Medical School

"***The C-peptide data which was presented during ATTD is a meaningful update, as we now have insight into why insulin-deficient patients may respond better to icovamenib treatment. The potential to restore endogenous insulin production capacity is an exciting development in the treatment of type 2 diabetes."***
Jeremy Pettus, M.D., Endocrinologist, Professor of Medicine UCSD

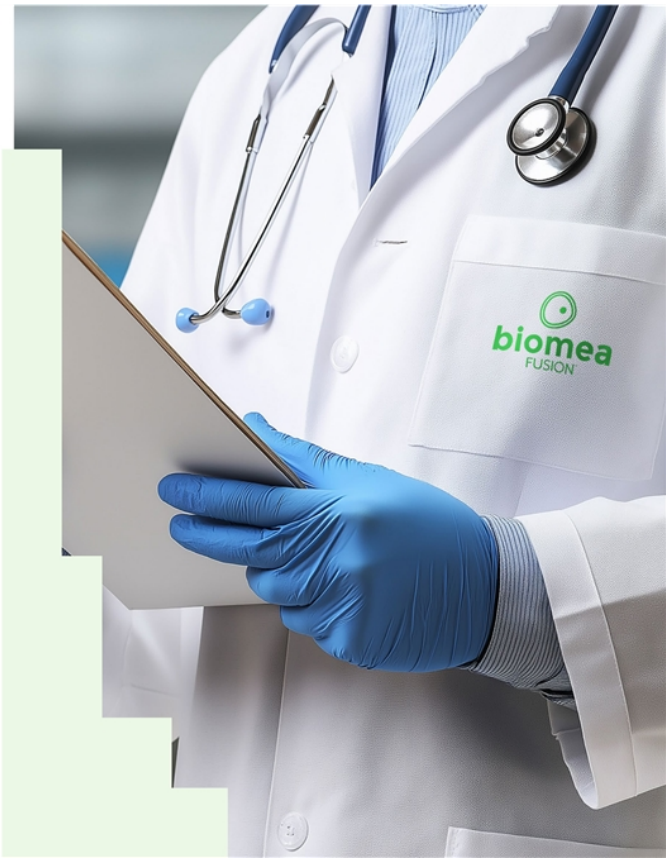
"We do not have an agent today that addresses one of the root cause of diabetes - beta cell dysfunction - icovamenib would be the first. Patients are achieving lasting benefits without continuous chronic dosing, suggesting that icovamenib may be disease modifying. I am very impressed."
Alice Cheng, M.D., Endocrinologist, Associate Professor of Medicine University of Toronto

"The Icovamenib data are quite interesting because of the continued effects despite having stopped it for 14 weeks. Usually, one would expect to see the HbA1c levels climb towards baseline when the medication is stopped, but with Icovamenib, the HbA1c levels decreased, which is quite intriguing and unprecedented."
Julio Rosenstock, MD., Director Velocity Clinical Research at Medical City Dallas and Clinical Professor of Medicine, Univ. of Texas Southwestern Medical Center

biomea FUSION™

Icovamenib

In Combination with GLP-1 Based Therapies
in Preclinical / Clinical Experiments



Menin suppresses GLP-1 receptor signaling*

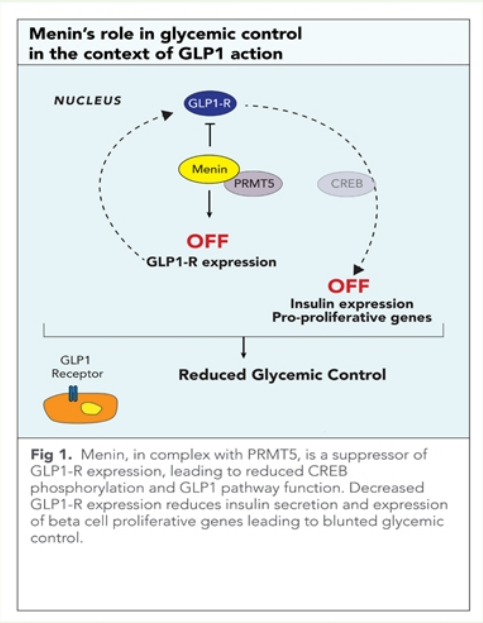


Fig 1. Menin, in complex with PRMT5, is a suppressor of GLP1-R expression, leading to reduced CREB phosphorylation and GLP1 pathway function. Decreased GLP1-R expression reduces insulin secretion and expression of beta cell proliferative genes leading to blunted glycemic control.

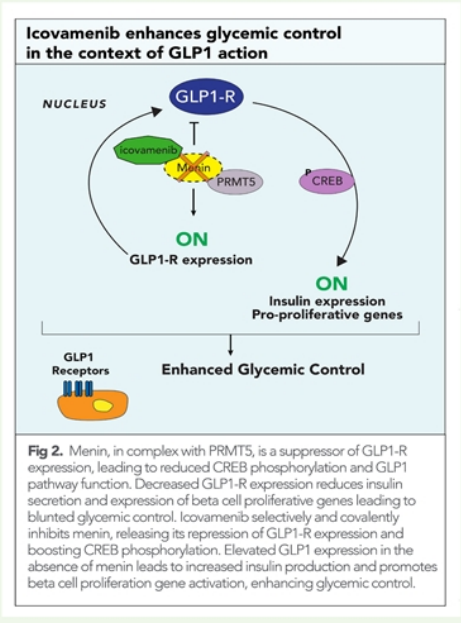


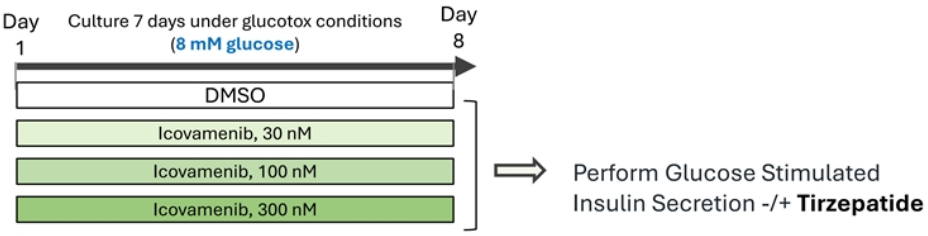
Fig 2. Menin, in complex with PRMT5, is a suppressor of GLP1-R expression, leading to reduced CREB phosphorylation and GLP1 pathway function. Decreased GLP1-R expression reduces insulin secretion and expression of beta cell proliferative genes leading to blunted glycemic control. Icovamenib selectively and covalently inhibits menin, releasing its repression of GLP1-R expression and boosting CREB phosphorylation. Elevated GLP1 expression in the absence of menin leads to increased insulin production and promotes beta cell proliferation gene activation, enhancing glycemic control.

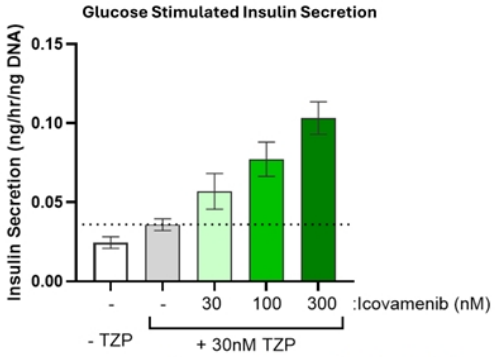
*AJP-Endocrinol Metab • doi:10.1152/ajpendo.00241.2016 • www.ajpendo.org; J. Cell Biol. 2019 Vol. 218 No. 3 855–870; The FASEB Journal. 2025;39:e70370.

Combination Treatment: Icovamenib enhanced responsiveness of islets to GLP-1/GIP dual receptor agonist Tirzepatide

Cadaver derived human islets

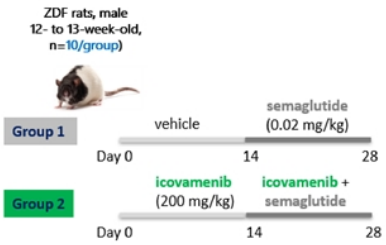
Non-diabetic donor:
38-year old white male, BMI: 29.2, HbA1C 5.2%

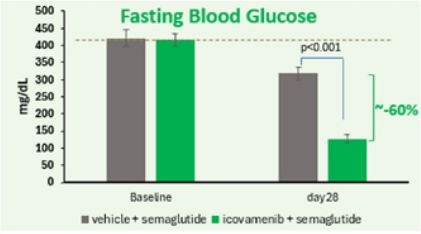




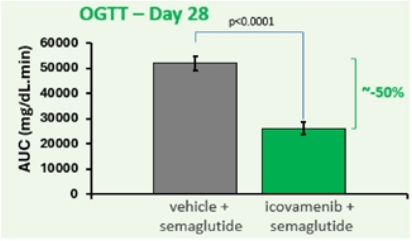
Glucose Stimulated Insulin Secretions increased by 58 to 186% with combination of icovamenib + tirzepatide vs tirzepatide alone

Combination treatment of icovamenib and low-dose semaglutide reduces body weight and boosts lean mass fraction relative to baseline

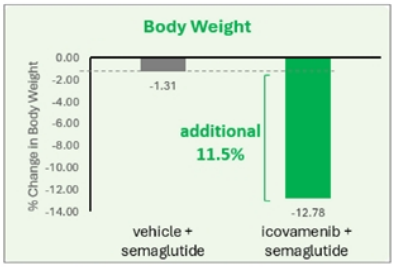




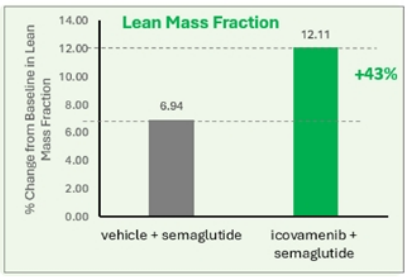
Fasting blood glucose reduced to normal range in combination group



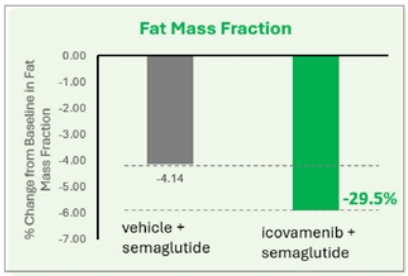
Significant reduction in combination group vs. semaglutide



Greater body weight loss in combination group vs. low dose semaglutide at Day 25



Higher gain in lean mass fraction vs. baseline in combination group compared to low dose semaglutide at Day 25

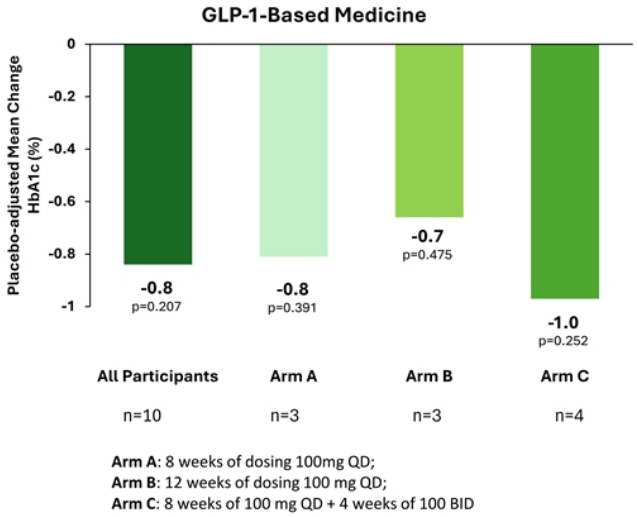


Greater reduction in fat mass fraction vs. baseline in combination group
compared to low dose semaglutide at Day 25

Change in HbA1c from Baseline to Week 26 in Patients Taking GLP1-RA of Clinical Study COVALENT-111 (n=10)

Icovamenib displayed **clinically meaningful 0.8% reduction in HbA1c** in participants **uncontrolled** on GLP-1-based therapies at Baseline

- 0.8% reduction in HbA1c with icovamenib as add-on to "failing" GLP-1 RA-based therapy
- 5/5 pts on 0.25mg to 1mg semaglutide lost additional weight when initiating icovamenib
- Up to 14% of additional weight loss observed at Week 26
- COV-111 did not have protocol-mandated dietary requirements/restrictions



Arm A: 8 weeks of dosing 100mg QD;
Arm B: 12 weeks of dosing 100 mg QD;
Arm C: 8 weeks of 100 mg QD + 4 weeks of 100 BID

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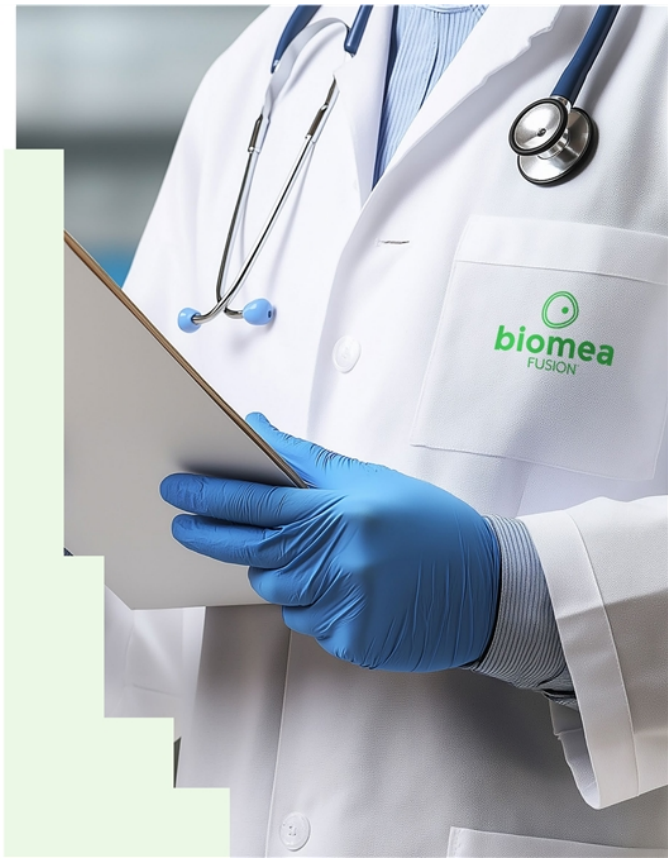


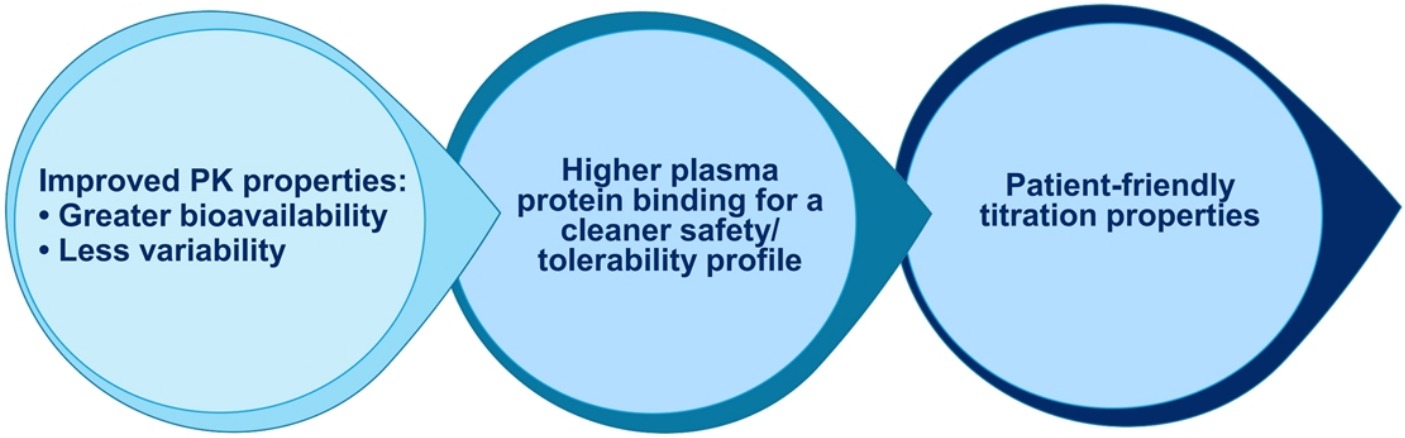
BMF-650

Next-Generation, Oral Small Molecule GLP-1 Receptor Agonist

Overview of Pre-Clinical Findings
Status: IND enabling Studies
First Patient Enrollment: Expected H2 2025

Achieving a Greater Therapeutic Window with BMF-650
A Next-Generation Oral GLP-1 Receptor Agonist

Better properties exhibited by BMF-650 in preclinical studies than Orforglipron



"Why a greater therapeutic window"?

- Only 3 of 10 patients in the real-world setting are staying on a GLP-1 based therapy

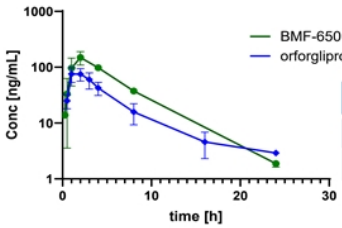
BMF-650 Showed Favorable In Vitro On-Target Activity and Off-Target Selectivity

Compound	GLP-1 human EC_{50}		β-arrestin1 EC_{50}	β-arrestin2 EC_{50}
	25 °C	37 °C		
BMF-650	8.6 nM	2.6 nM	> 10 μM	> 10 μM
orforglipron	2.6 nM	0.1 nM	> 10 μM	> 10 μM

- Good potency on-target to achieve more efficient drug titration
- No off-target concerns from counter-screening assays

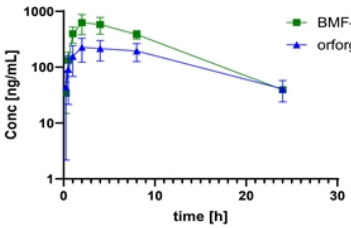
Pharmacokinetics of BMF-650 Showed Very Good Preclinical Bioavailability with Low Inter-Individual Variability

Cynomolgus monkey PO PK



Compound	cyno PO	$T_{1/2}$ (h)	%F
BMF-650	**0.36 mg/kg**	**3.66**	**54.0**
orforglipron	**0.36 mg/kg**	**3.70**	**29.4**

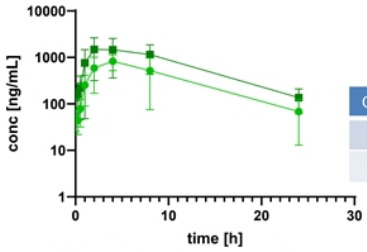
Sprague-Dawley rat PO PK



Compound	rat PO	$T_{1/2}$ (h)	%F
BMF-650	**5 mg/kg**	**5.14**	**32.6**
orforglipron	**5 mg/kg**	**7.44**	**11.2**

BMF-650 showed 2 to 3-fold greater oral bioavailability in comparison to orfoglipron

Cynomolgus monkey PK day 6 BMF-650



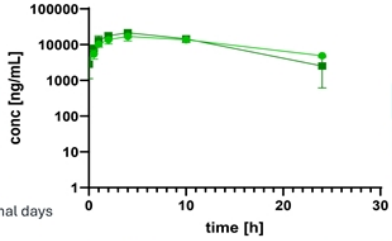
Compound	cyno PO	Day	AUC**
BMF-650	**3 mg/kg**	**6***	**9,353**
BMF-650	**6 mg/kg**	**6#**	**19,918**

* d6 of 6 days of daily PO dosing; d6# after 6 additional days of PO dosing at indicated dose level. ** hr*ng/mL

Dose Proportionate Exposure

PO =per oral

Sprague-Dawley rat PK days 1, 7 BMF-650



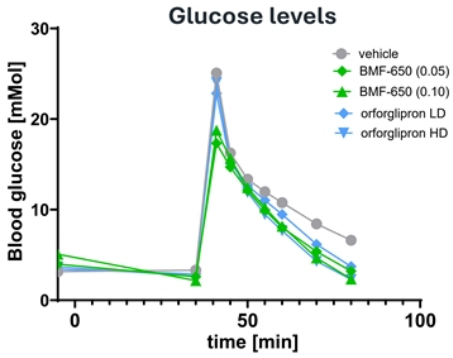
Compound	rat PO	day	AUC*
BMF-650	**70 mg/kg**	**1**	**269,100**
BMF-650	**70 mg/kg**	**7**	**289,370**

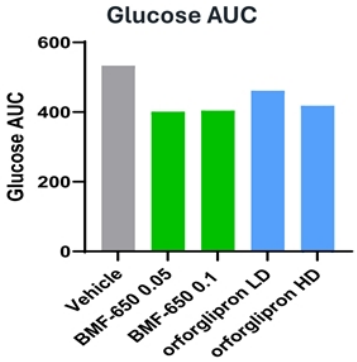
Continuous Exposure after multiple days

Projected Human Dose for BMF-650 is Similar Among the Oral Agents
All titration doses shown target obesity indications

	Orforglipron (Eli Lilly)	BMF-650 (Biomea)	GSBR-1290 (Structure Therapeutics)	CT-996 (Roche/Carmot)
Doses tested in cynomolgus monkeys to address food intake	0.05 to 1 mg/kg	2 to 30 mg/kg	2 to 10 mg/kg	3 to 30 mg/kg
Clinical titration target	36 mg	150 mg (projected)	120 mg	120 mg

BMF-650 Potentiated Blood Glucose Reduction in Cynomolgus Monkeys





	Vehicle	BMF-650 0.05mg/kg	BMF-650 0.1mg/kg	orforglipron Low dose (lit)*	orforglipron high dose (lit)*
AUC Mean (N=4)	533	401	404	461	418
Glucose lowering	0	-25%	-24%	-14%	-22%

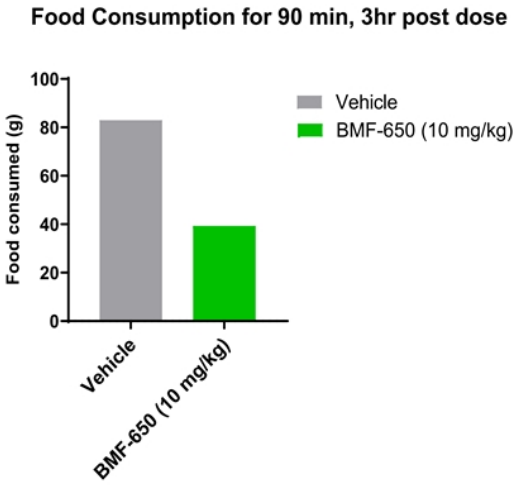
*PNAS November 24, 2020. vol. 117 no. 47 29959-29967

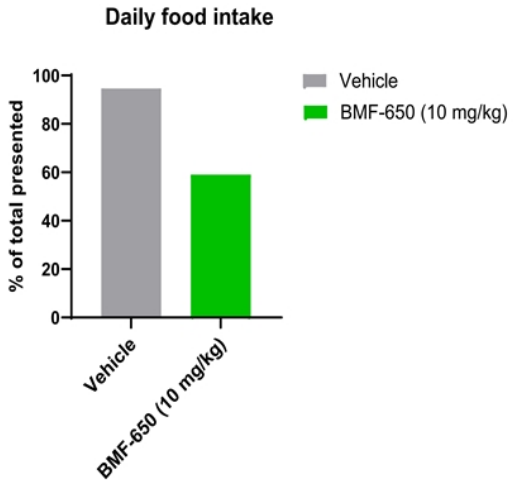
High and low dosing levels for orforglipron based on publications: 0.0018 and 0.0054 mg/kg

Very good glucose control observed with small molecule GLP-1 R agonists (BMF-650)

BMF-650 demonstrated good appetite suppression in cynomolgus monkeys

Averages of First 90-Minute Window and Across All Six Days of the Experiment



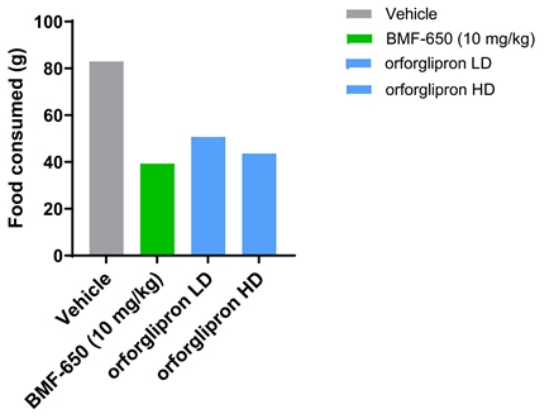


- Food consumption tested daily in cynomolgus monkeys (n=4)
- BMF-650 demonstrated good appetite suppression over the 6-day treatment period

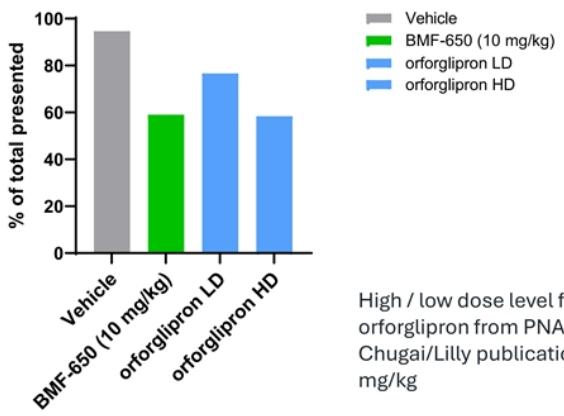
BMF-650 demonstrated meaningful appetite suppression in cynomolgus monkeys

Averages of First 90-Minute Window and Across All Six Days of the Experiment in Comparison to Orfoglipron

Food Consumption for 90 min, 3hr post dose



Daily food intake



High / low dose level for orforglipron from PNAS Nov 2020 Chugai/Lilly publication: 0.1 / 0.05 mg/kg

- Food consumption tested daily in cynomolgus monkeys (n=4)
- BMF-650 demonstrated meaningful appetite suppression over the 6-day treatment period

Key Evaluation of Preclinical Activity:
Set up of Weight Loss Study in Obese Cynomolgus Monkeys

- 15 Obese cynomolgus monkeys were selected for the study and followed for 14 days prior to study start
- Monkeys were distributed among 3 groups of 5 individuals at day -2

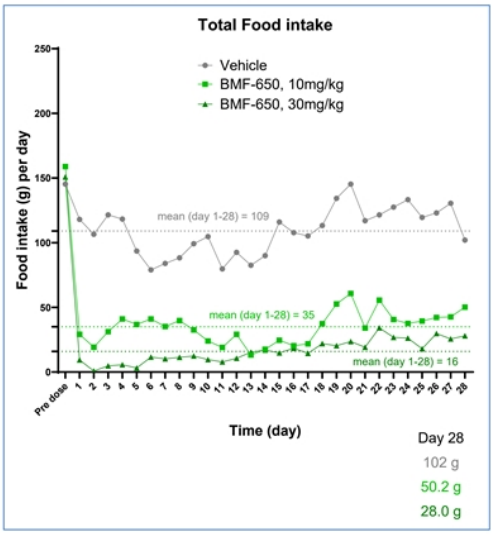
	Group 1	Group 2	Group 3
Weight average [kg]	12.0	12.2	12.0
Daily food intake average [g]	154	156	147

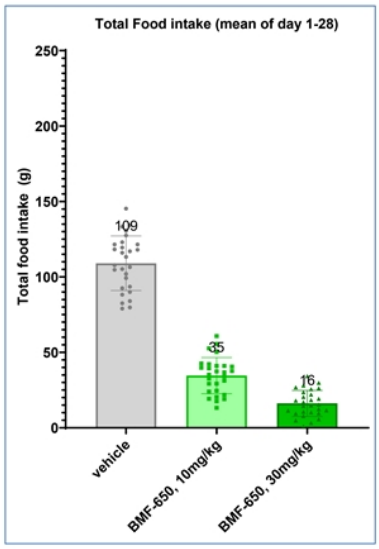
- Monkeys were dosed QD with BMF-650: 10 or 30 mg/kg, or vehicle as a solution via oral gavage for 28 days.
- Food rations were presented as breakfast, fruit snack, and dinner. Consumption was tracked.
- Body weight was recorded daily.
- Physical observations were recorded daily.
- Lab values were measured on days -5, 13, 20, and 29 per protocol.

Pre-study period 14 days	28 days of BMF-650 daily dosing

Study designed to capture detailed daily food consumption and weight changes

Weight Loss Study in Obese Cynomolgus Monkeys: Food Intake Assessment

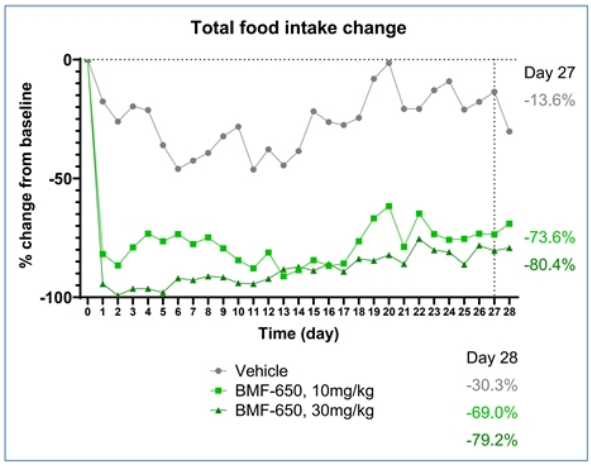




Bar = 28-day average
Dot = 1 (of 28) day average

Meaningful and dose dependent food intake reduction for the duration of the study

Weight Loss Study in Obese Cynomolgus Monkeys: Food Intake Assessment



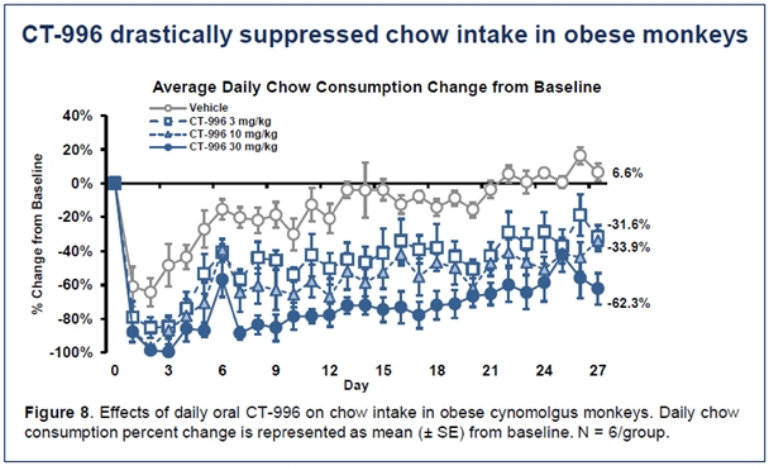


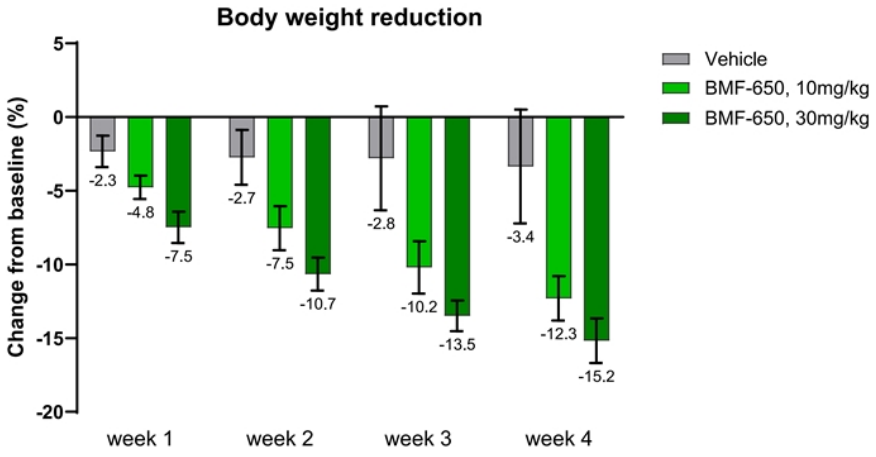
Figure 8. Effects of daily oral CT-996 on chow intake in obese cynomolgus monkeys. Daily chow consumption percent change is represented as mean (± SE) from baseline. N = 6/group.

Literature data; Carmot Therapeutics (now part of the Roche group), ADA 2024.

Cross-study comparison with CT-996 (Roche/Carmot) while not head-to-head appears favorable for BMF-650

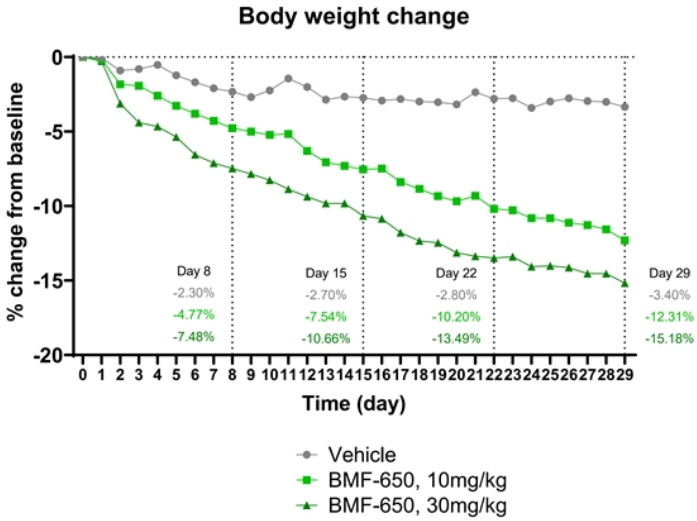
No head-to-head studies of BMF-650 and CT-996 have been conducted. Comparing results from different preclinical studies may be unreliable due to differences in study designs, study endpoints, and other parameters.

Weight Loss Study in Obese Cynomolgus Monkeys: Body Weight Reduction



Meaningful, dose dependent, and continuous body weight reduction observed

Weight Loss Study in Obese Cynomolgus Monkeys: Body Weight Reduction



CT-996 progressively lowered body weight in obese monkeys

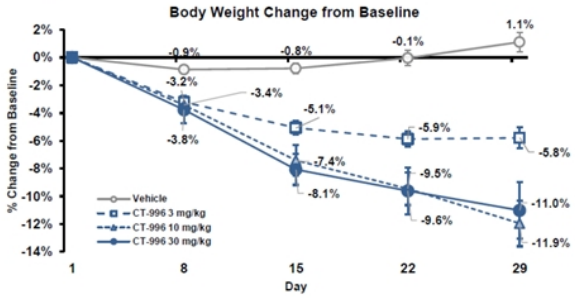


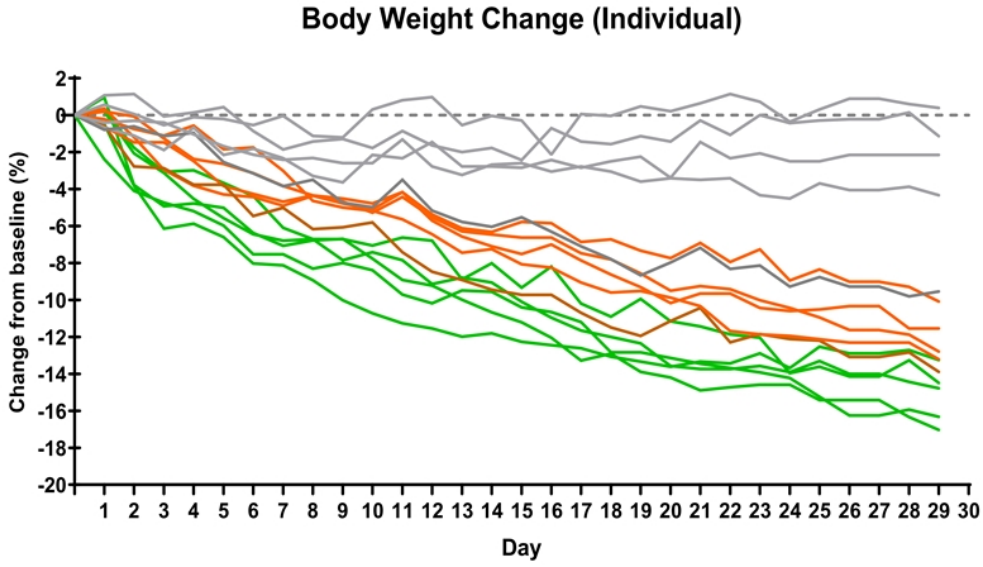
Figure 6. Effects of CT-996 on body weight in obese cynomolgus monkeys following once-daily oral administration. Weekly body weight percent change is represented as mean (± SE) from baseline. N = 6/group.

Literature data; Carmot Therapeutics (now part of the Roche group), ADA 2024.

Weight loss in cross-study comparison with CT-996 (Roche/Carmot) while not head-to-head appears favorable

No head-to-head studies of BMF-650 and CT-996 have been conducted. Comparing results from different preclinical studies may be unreliable due to differences in study designs, study endpoints, and other parameters.

Oral BMF-650 Promotes Body Weight Reduction in Obese Cynomolgus Monkeys



Mean reduction in BW (Day 29)

Vehicle	-3.4%
BMF-650 10mg/kg	-12.3%
BMF-650 30mg/kg	-15.2%

(5 animals per dose group)

BMF-650 - Preclinical Observation of Adverse Events

Low number of adverse events and decreasing frequency over time

- BMF-650 generally well tolerated
- No elevations of AST & ALT
- 420 dosing occurrences (280 active / 140 placebo)
- Total events of emesis in the active group 18 (6.4%)
- Most of the events occurred in the first week and particularly in the first two days
- Study was run without a titration scheme, once daily dosing over 28 days
- 8 / 18 occurred in one monkey (#3) at the 10 mg/kg dose (LD)

	Emesis*	Emesis Contribution from Monkey #3
Week 1	16%**	6%
Week 2	4.2%	3%
Week 3	4.2%	3%
Week 4	1.4%	-

* Events per 70 weekly dosing occurrences

**8% (1/2) on Days 1 & 2 of Week 1

BMF-650 Demonstrated a Preclinical Profile Supporting Advancement

IND Submission Expected 2H 2025

- BMF-650 is similar to the broader orforglipron chemotype
- Superior oral bioavailability vs. orforglipron (across species)
- Intrinsic potency
- Robust glucose lowering and appetite suppression in primate models
- Projected clinical dose aligned with other leading oral GLP-1 agents
- Generally well tolerated without safety concerns to date

NEXT STEPS

Weight Reduction in Obese Monkeys Preclinical Update ✓
IND Filing – Expected in 2H 25
Initiation of Phase I in Obese, Healthy Volunteers – planned for 2H 2025

Biomea Fusion: Oral Small Molecules For Diabetes and Obesity

- Potentially transformative disease-modifying activity in type 2 diabetes (T2D): Targets a root cause by restoring functional beta cells to enable endogenous insulin production – A result not achieved by currently available therapies
- Icovamenib is a menin inhibitor showing an emerging competitive clinical profile, demonstrating significant and durable HbA1c reductions, up to ~1.5% sustained well beyond end of treatment
- Oral, short-course therapy designed for durability and boost adherence and persistence, addressing a key barrier in chronic T2D management
- Addresses a critical unmet need in insulin-deficient T2D, the most vulnerable patient group at highest risk of macrovascular (CV) complications, rapid treatment failure, and fastest progression to insulin dependence
- Synergistic with GLP-1 therapies, expanding reach across broader T2D populations, and demonstrating additional benefits in weight loss, glucose control and muscle mass preservation in preclinical combination studies
- Efficient and cost-effective clinical pathway, with potential for a shorter Phase III program due to short term treatment - based on initial regulatory feedback
- Advancing BMF-650, a next-generation oral GLP-1 RA with best-in-class potential, into clinical development later this year

Company Financials (NASDAQ: BMEA)

For the three months ended March 31, 2025

	Three Months Ended March 31, 2025 (unaudited)
Operating expenses:	
R&D	$ 22,897
G&A	6,815
Total Operating Expenses	29,712
Loss from operations	(29,712)
Interest and other income, net	450
Net loss	$ (29,262)
Other comprehensive loss:	
Changes in unrealized gain on short term investments, net	—
Comprehensive loss	$ (29,262)
Net loss per common share, basic and diluted	$ (0.80)
Weighted-average number of shares of common stock used to compute basic and diluted net loss per common share	36,627,148

1Q 25 Operating Expenses minus Stock Based Comp	**$29.3 M**
Cash, Cash Equivalents, and Restricted Cash as of March 31, 2025	**$36.2 M**

Biomea Fusion: A Diabetes and Obesity Medicines Company

"We believe we may have a method to reverse diabetes, to reset the body, so diabetes patients no longer require ongoing medication."

	Study	Indications	Anticipated Milestones for 2H 2025
ICOVAMENIB Menin Program (Potential First-In-Class)	COVALENT-111 Phase II	Type 2 Diabetes	52 Week Follow-up Data (26 Week Follow-up Data announced 12/24)
	COVALENT-112 Phase II	Type 1 Diabetes	52 Week Follow-up Data from those patients that completed original 12 weeks of dosing
	COVALENT- 211 Phase IIb	Type 2 Diabetes Severe Insulin Deficient Diabetes	FDA Type C Meeting Update Planned Initiation of Phase IIb in Severe Insulin Deficient Patients (discuss Phase III Pgm requirements)
	COVALENT- 212 Phase II	Type 2 Diabetes Combination with GLP-1 based therapies	Planned Initiation of Phase II in Patients uncontrolled on GLP-1 based therapies
BMF-650 Oral GLP-1RA	IND-Enabling Studies	Diabetes/Obesity	Weight Reduction in Obese Monkeys Preclinical Update – 2Q 2025 Planned Initiation of Phase I Study in Obese Healthy Volunteers 2H 2025

Thank you

biomea FUSION We Aim to Cure™