biomea FUSION™

Corporate Presentation

43rd Annual J.P. Morgan Healthcare Conference - January 15, 2025

biomea FUSION

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Biomea Fusion: A Diabetes and Obesity Medicines Company

	Study	Indications	Anticipated Milestones for 2025
Icovamenib (BMF-219) Menin Program (Potential First-In-Class)	COVALENT-111 Phase 2	Type 2 Diabetes	2H 2025: 52 Week Data
	COVALENT-112 Phase 2	Type 1 Diabetes	2H 2025: Open Label Data
	COVALENT- 311 Phase 2/3	Type 2 Diabetes Severe Insulin Deficient Diabetes	1H 2025 Meet with FDA to Discuss Phase II/III (Adaptive Design) and Advance to Late-stage Development
	COVALENT-211 Phase 2	Type 2 Diabetes GLP-1RA combination	1H 2025 Meet with FDA to Discuss Phase II and Initiate Combination Study
BMF-650 GLP-1R Agonist (Potential Best-In-Class)	IND-Enabling Studies	Diabetes/Obesity	2H 2025 IND Cleared and First Participant Dosed
BMF-500 FLT-3 Program	COVALENT-103 Phase 1	AML/ALL (Acute Leukemia)	Dose Escalation Completion – Partnering Strategy

A Long History of Developing Multi-Billion Dollar Drugs - Together

Thomas Butler
Chairman & CEO

biomea FUSION
Co-Founder

The FUSION™ SYSTEM
icovamenib*
Co-Inventor

imbruvica® (ibrutinib)
560, 420, 280, 140 mg tablets | 140, 70 mg capsules

Veklury® remdesivir 100 MG FOR INJECTION
Co-Inventor

Ramses Erdtmann
President & COO

biomea FUSION
Co-Founder

imbruvica® (ibrutinib)
560, 420, 280, 140 mg tablets | 140, 70 mg capsules

Juan Frías, M.D.
Chief Medical Officer

once weekly mounjaro® (tirzepatide) injection 0.5 mL
2.5 mg | 5 mg | 7.5 mg | 10 mg | 12.5 mg | 15 mg

farxiga® (dapagliflozin) 5mg & 10mg tablets

Jardiance® (empagliflozin) tablets 10 mg/25 mg

OZEMPIC® semaglutide injection 0.5mg, 1mg

ONCE-WEEKLY wegovy® semaglutide injection 2.4 mg

once weekly trulicity® (dulaglutide) injection 0.5 mL
0.75 mg | 1.5 mg | 3.0 mg | 4.5 mg

Invokana® (canagliflozin) tablets

Byetta® (exenatide) injection

Januvia® sitagliptin

Naomi Cretcher
Chief of People

imbruvica® (ibrutinib)
560, 420, 280, 140 mg tablets | 140, 70 mg capsules

Heow Tan
Chief Technical & Quality Officer

ZADAXIN

imbruvica® (ibrutinib)
560, 420, 280, 140 mg tablets | 140, 70 mg capsules

Xtampza® ER (oxycodone) EXTENDED-RELEASE CAPSULES (II)

PLENAXIS®

HylatopicPlus Cream

Franco Valle
Chief Financial Officer

imbruvica® (ibrutinib)
560, 420, 280, 140 mg tablets | 140, 70 mg capsules

AMTAGVI™ (lifileucel) Suspension for IV infusion

Attruby™ (acoramidis) 356 mg tablet

Icovamenib & BMF-650 (Oral Small Molecule GLP-1 RA) to Become Cornerstones of Our Metabolic Franchise

Our Strategic Focus

- Biomea to prioritize the development of icovamenib to address critical needs in the metabolic disease space
- Previously announced COV-111 positive topline data and in-vivo GLP-1 RA combination data supports focus
- Icovamenib development in type 2 diabetes to focus on patients with severe insulin deficiency and on patients treated with GLP-1 RA therapies

Anticipated Key Milestones for 2025

1H: 2025

- Meet with the FDA to discuss icovamenib clinical development plan

2H:2025

- COV-111 52-Week Data
- COV-112 Open Label Data
- IND filing for BMF-650
- Advance icovamenib in late-stage development for type 2 diabetes
- Initiate Phase I for BMF-650

Icovamenib Value Proposition

Key Benefits of Icovamenib

- First-in-class therapy with a novel mechanism of action
- Unique treatment effect: Durable treatment impact on beta cell function and incretin effect
- Oral, once-daily, 12-week treatment
- Has enhanced endogenous insulin production
- Has improved beta cell function*
- Has promoted body weight loss *
- Has increased proportion of lean mass / preserve lean mass*

Development Rationale

- People with the lowest insulin production demonstrate the highest all-cause mortality, and the highest treatment failure
- Icovamenib has demonstrated superior treatment efficacy in this patient population
- Has promoted weight loss and increases muscle mass pct when combined with a GLP-1 RA therapy*
- Supports GLP-1 RA combination, GLP-1 RA mono as maintenance post combination
- Supports Novel-Novel combo with oral small molecule GLP-1 RA

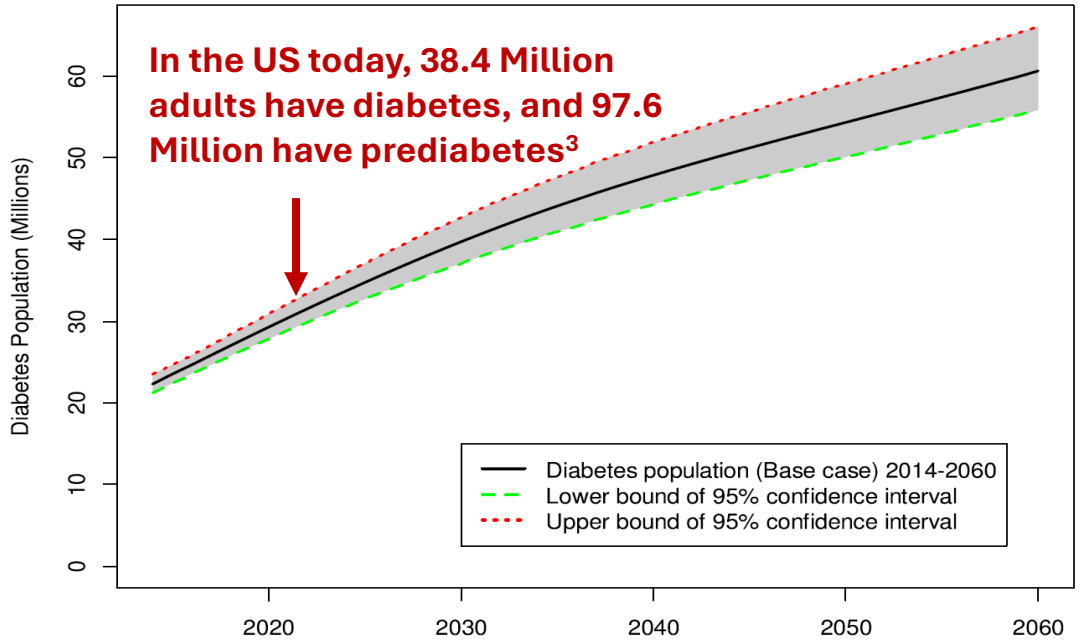
*in preclinical studies

1 in 3 Americans will Develop Diabetes During Their Lifetime - CDC

In the U.S. **80% of people with diabetes will die from diabetes.**[1] Premature mortality caused by diabetes results in an estimated **12-14 years of life lost**.[2]

Diabetes creates one of the largest economic burdens on the U.S. health care system. **$1 out of every $4 in U.S. health care** costs is being spent on caring for people with diabetes.

There are over 60+ approved type 2 diabetes therapies but **none of them address the root cause of the disease.**

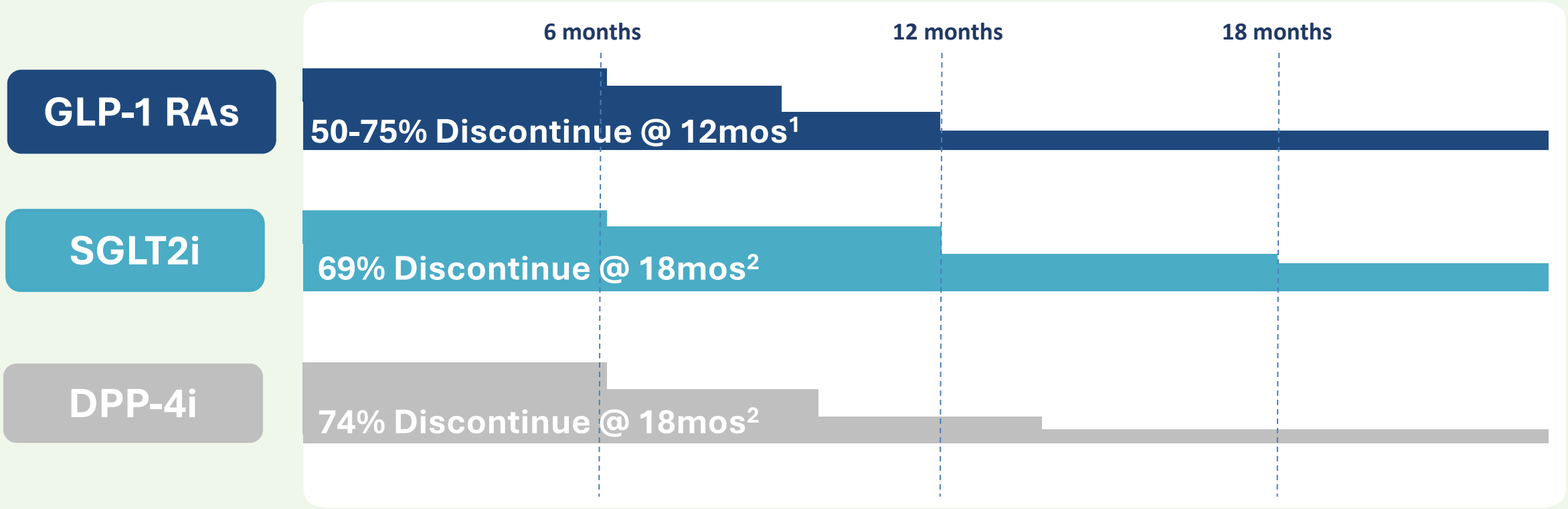


Over 800 million adults globally are living with diabetes[4]

Today diabetes remains poorly controlled in approximately 50% of patients treated with standard of care agents[4]

1. Tabish Int J Health Sci. 2007 Jul;1(2):V–VIII.
2. National library of Medicine 1(2); 2007 Jul PMC3068646
3. CDC National Diabetes Statistics Report accessed January 2025
4. Zohu Lancet 2024; 404: 2077–93

Challenges with Current Standard of Care



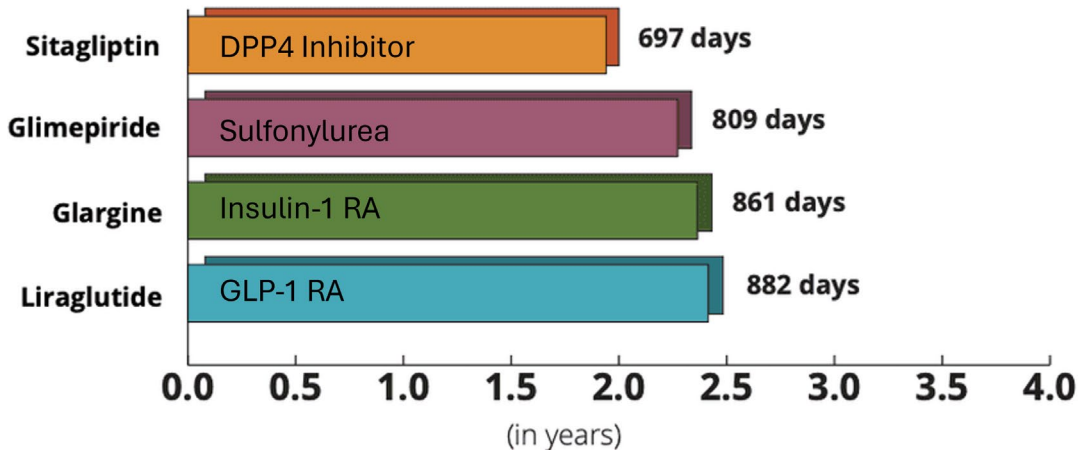
Reasons for Discontinuations

• Side Effects • Glycemic Control Not Met • Injection Aversion • Cost and Affordability

1. Khan, et al. JAMA 2024 doi:10.1001/jama.2024.22284.
2. Alkabbani W, et al. Diabetes Obes Metab. 2023;25:3490-3500

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

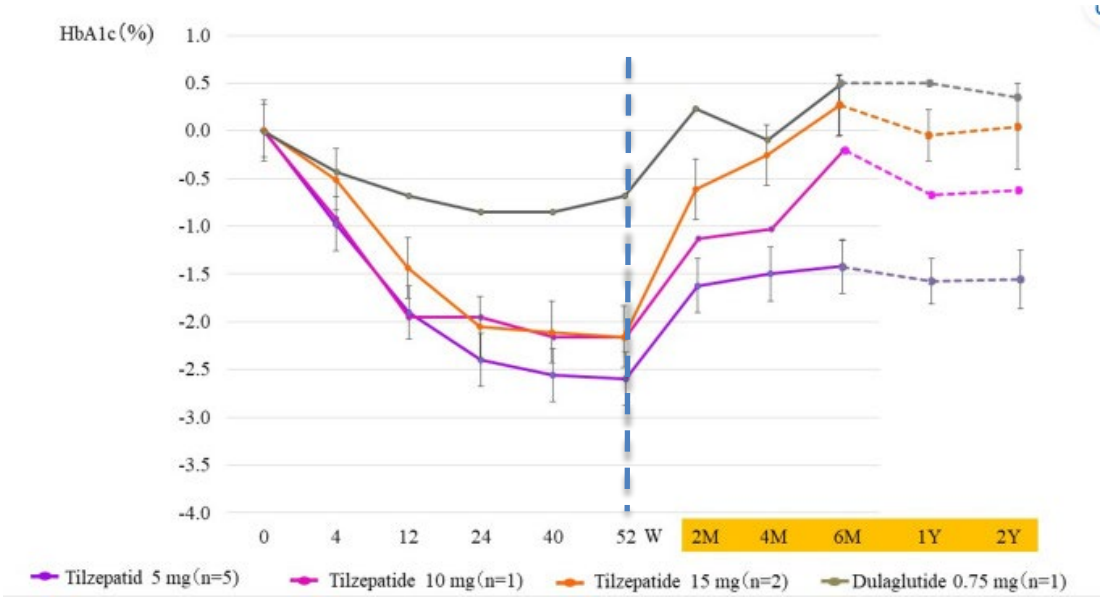
Mean time to Loss of Glucose Control (A1c>7%)



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

- Average time to loss of glucose control ranges from less than 2 years to just over 2.4 years
- Highlights the progressive nature of diabetes and the inability of current therapies to provide lasting glycemic control

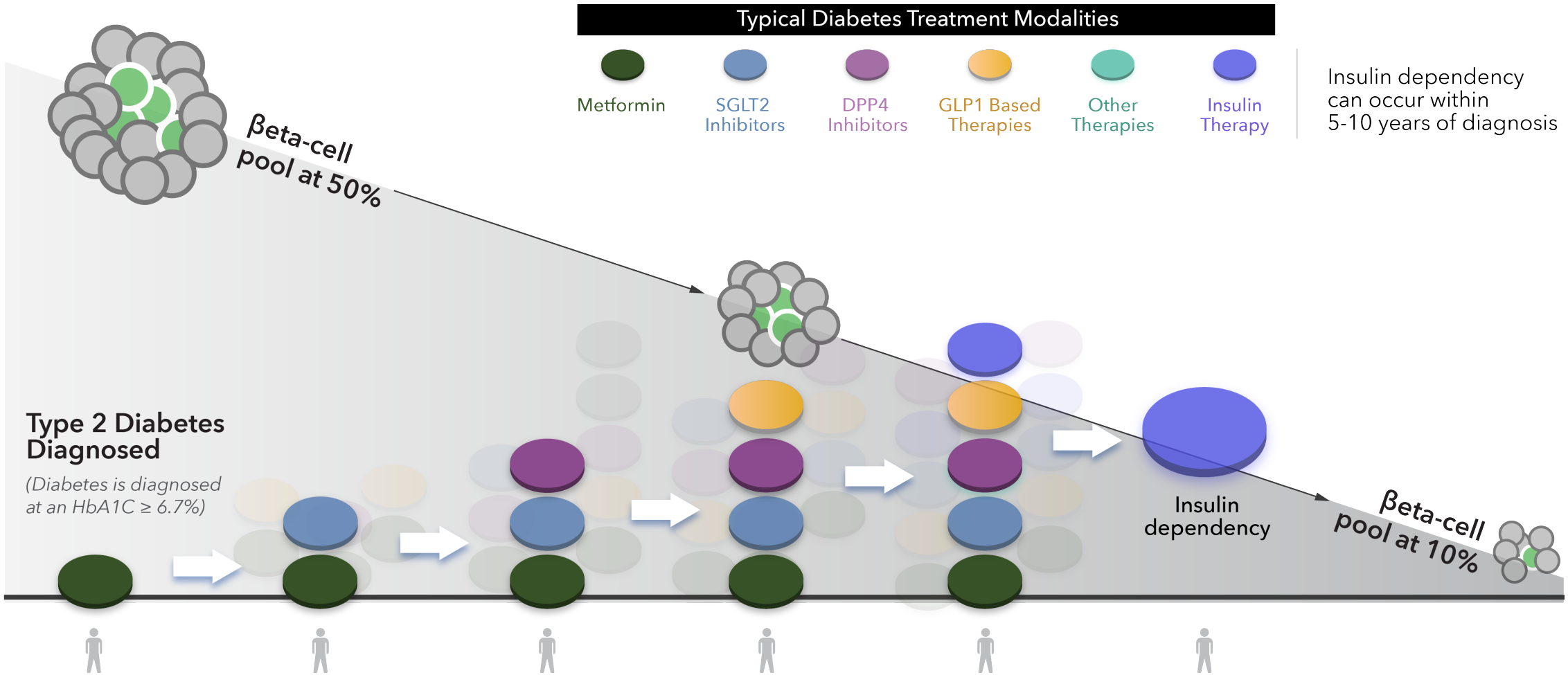
Impact of tirzepatide on HbA1c: Sustained Reduction During Treatment, Rebound After Discontinuation



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

- HbA1c levels rebound during the 52-week off-treatment phase, approaching baseline levels
- Continuous therapy is necessary to sustain glycemic control with current treatments
- There is a need for novel, durable solutions to improve long-term outcomes for diabetes patients

Type 2 Diabetes Today - Chronic and Stacked Treatments to Overcome B-cell Loss



Adapted from IQVIA disease analyser Nov 2022; *UCSF FAQ; Diabetes.org Fast Facts*

Current Treatment Landscape in Type 2 Diabetes

- Adults with type 2 diabetes see multiple agents over time
- Agents are prescribed to drive patients to glycemic target
- Agents are prescribed for extra-glycemic benefit
- Higher the baseline HbA1c, higher # of agents are needed

- Current type 2 diabetes agents yield poor compliance
- Oral is the preferred route versus injectable
- Difficult to continue "medication for life"
- Poor tolerability at the most effective dose levels

Adults with Type 2 Diabetes Cycle Through Many Therapies to Tackle Their Disease

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)

low BMI, severe beta-cell dysfunction, low insulin resistance, and high HbA1c, often with early onset and a high risk of complications.

18%

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

Mild age-related diabetes (MARD)

older age at onset, normal to slightly elevated BMI, mild beta-cell dysfunction, low insulin resistance, and slow disease progression

39%

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

INSULIN RESISTANT DIABETES

Mild obesity-related diabetes (MOD)

high BMI, insulin resistance, preserved beta-cell function, and a strong link to obesity with moderate HbA1c levels.

22%

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

Severe insulin resistant diabetes (SIRD)

high BMI, severe insulin resistance, normal or elevated insulin production, and a high risk of cardiovascular disease and metabolic complications.

15%

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

Adjusted from: https://www.thelancet.com/journals/landia/article/PIIS2213-8587(18)30051-2/abstract
"Novel subgroups of adult-onset diabetes and their association with outcomes: a data-driven cluster analysis of six variables"

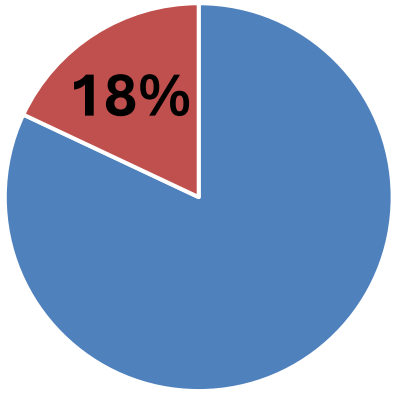
Ahlqvist et al. Diabetes 2020;69:2086–2093 | https://doi.org/10.2337/dbi20-0001

What is a SIDD patient?

- SIDD Patients have the lowest insulin production out of all adults with type 2 diabetes
- They represent the highest unmet medical need, displaying the highest all-cause mortality and worst CV outcomes
- They have the highest treatment failure rate among adults with type 2 diabetes
- They represent approximately 18% of the type 2 diabetes patient population (approx. 14M U.S./EU and 50 Million in Asia)
- They typically present with a BMI less than 32 kg/m^2 and a baseline HbA1c of at least 8.5%

Reduce the proportion of adults with diabetes who have an A1c value above 9 percent — D-03 - Healthy People 2030 | odphp.health.gov

Severe insulin-deficient diabetes (SIDD)



Low Insulin Resistance
Low Insulin Production
Lower BMI

Icovamenib: First-in-Class Product Candidate for the Treatment of Diabetes

Mechanism of Action: Selective & Partial Menin Inhibition

Dual Effect

Beta Cell Quantity & Function

- **Increased beta cell mass and function**
- **Increased Insulin Synthesis and Secretion**

GLP-1 Expression

- **Increased GLP-1 Receptor Expression & Incretin Effect**
- **Enhanced Weight Loss with Preservation of Muscle Mass***

*in preclinical studies

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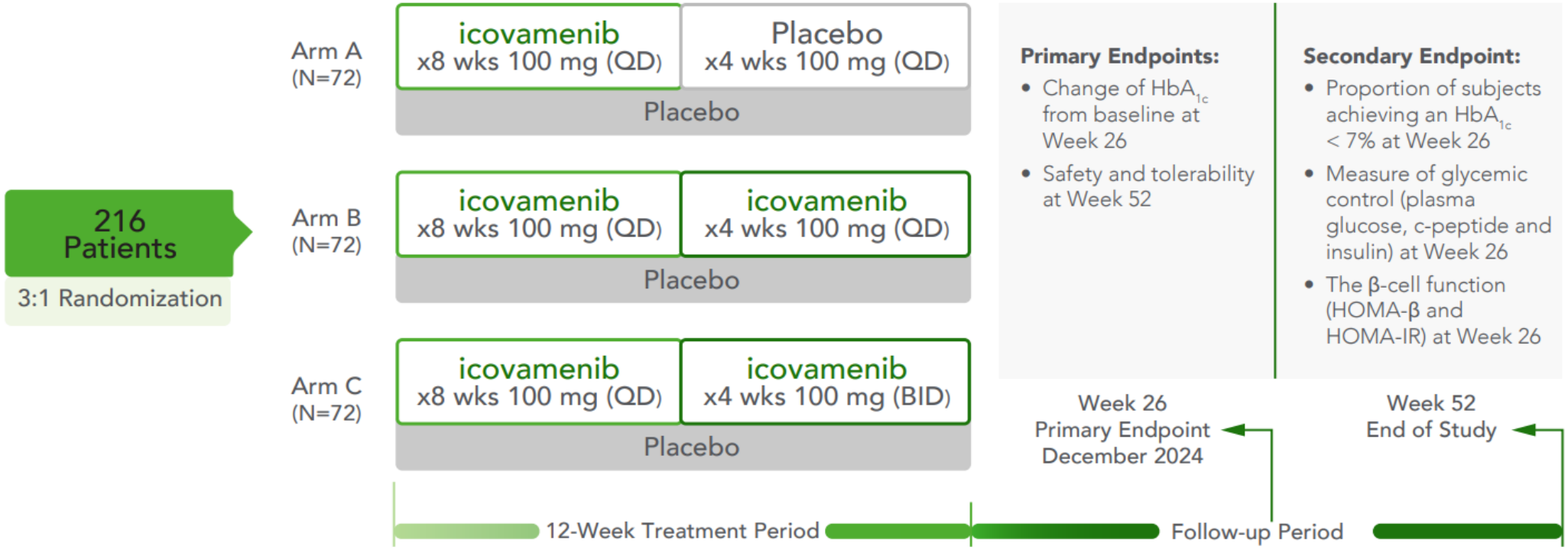
COVALENT-111

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

Phase 2a Double-Blinded, Randomized Placebo Controlled Study in Type 2 Diabetes (T2D)

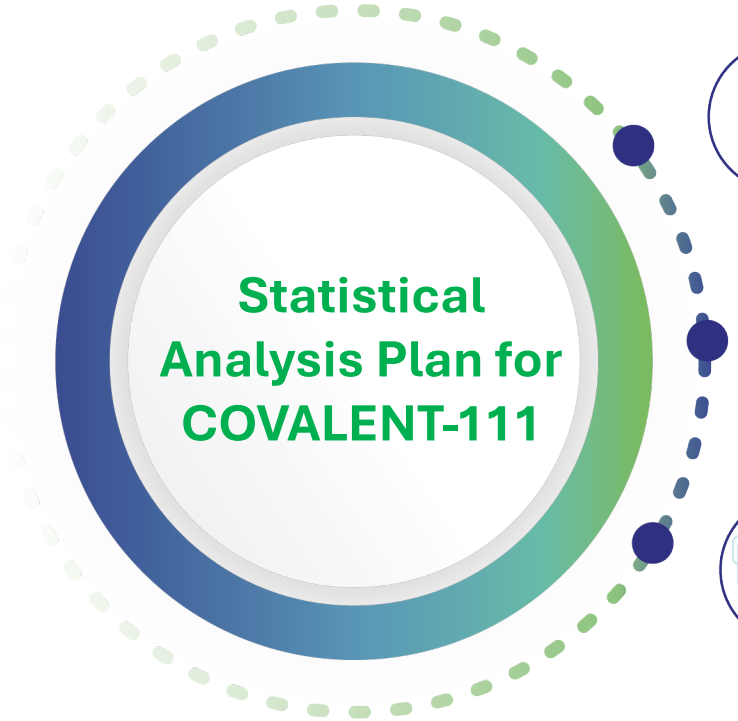
An ongoing dose-finding study evaluating the addition of icovamenib in T2D patients with uncontrolled glycemia on standard of care

Patients receive icovamenib for a fixed treatment period, up to 12 weeks
Durability of treatment effect is measured at Week 26 and Week 52



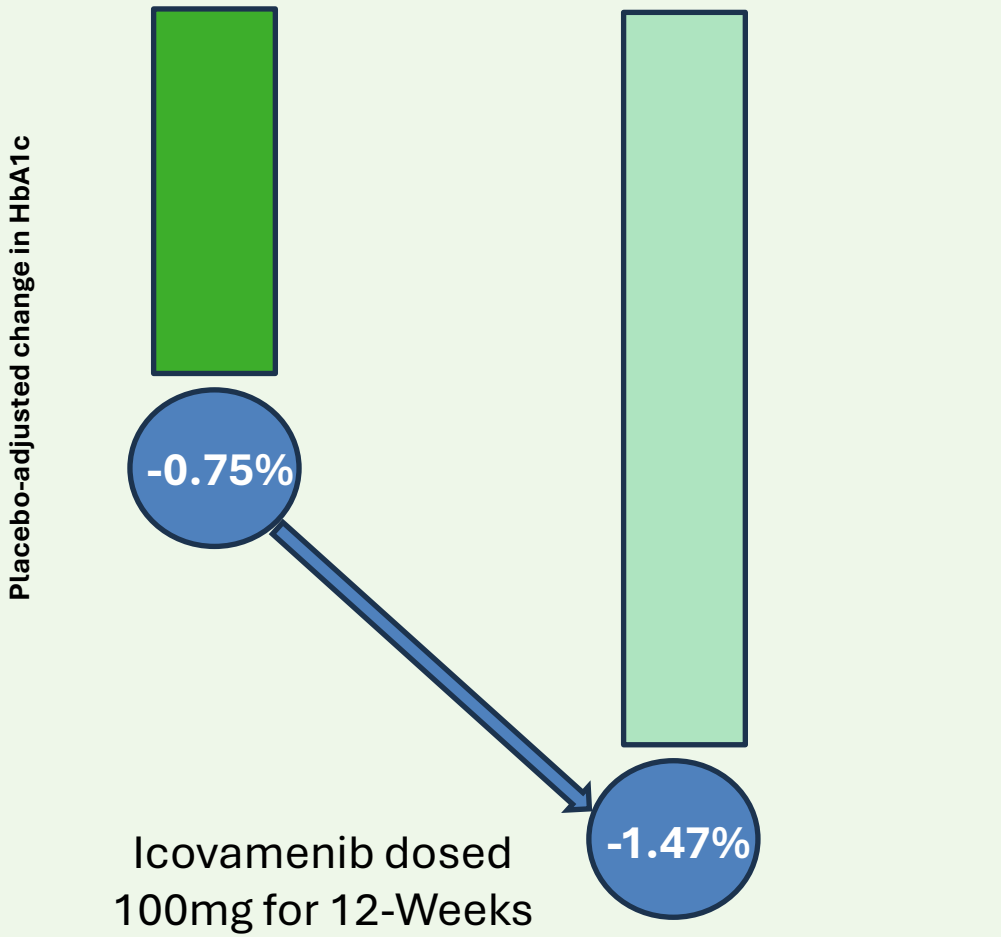
Phase 2a Double-Blinded, Randomized Placebo Controlled Study in Type 2 Diabetes

A dose-finding study in T2D patients on standard of care with uncontrolled glycemia



- Prespecified subgroup analysis to include review of HbA1c reduction within each subgroup (SIDD, MARD, MOD, and SIRD)
- Subgroup analysis based on algorithm established per Ahlqvist E, et al. Lancet Diabetes Endocrinol. 2018;6:361-369
- Arm A, B, C primary analysis of HbA1c reduction

Icovamenib Displayed a 100% Response Rate and 1.5% Reduction in HbA1c at Week 26 in Patients Uncontrolled on Standard of Care



0 – 12 weeks

Icovamenib Treatment Period

12 – 26 weeks

Icovamenib Off-Treatment Period

Response Rate of SIDD Patients in COVALENT 111: 100%
(All severe insulin deficient diabetes patients treated with 100mg of icovamenib for 12 weeks responded with a HbA1c reduction)

Severe insulin-deficient diabetes (SIDD)

Low Insulin Resistance
Low Insulin Production
Lower BMI

Icovamenib Dosed at 100mg for 12 Weeks Demonstrated Statistically Significant Reductions in HbA1c Across All Patient Segments

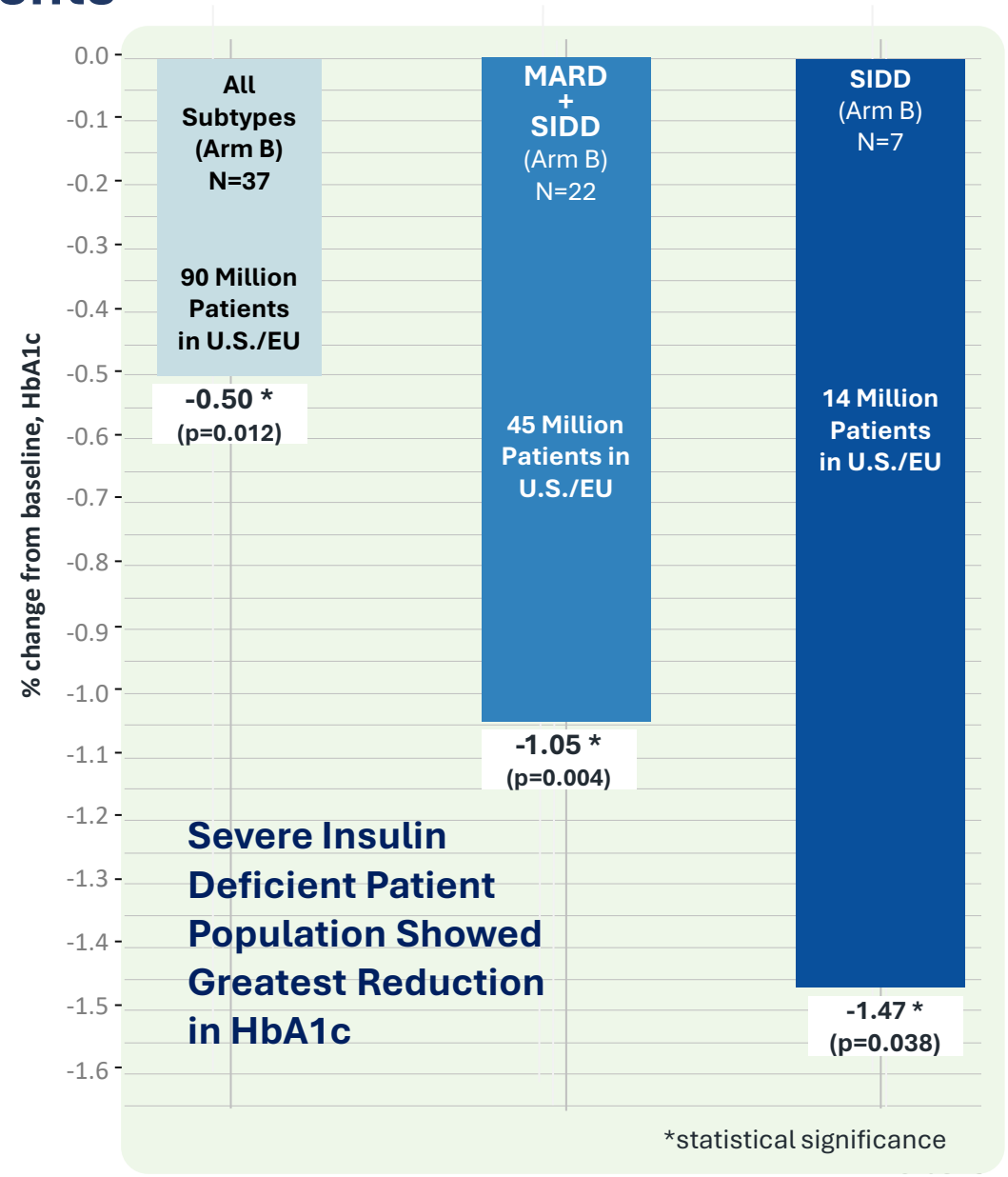
Placebo-Adjusted Mean Change in HbA1c at Week 26
Patients Uncontrolled with at Least 1 Prior Therapy

The SIDD Patient population is approximately 14 Million in the U.S./EU and 50 Million in Asia

Arm B: 12 weeks of dosing 100 mg QD

MARD/SIDD: Mild Age-Related and Severe Insulin-Deficient Diabetes (insulin deficient)

Severe insulin-deficient diabetes (SIDD)

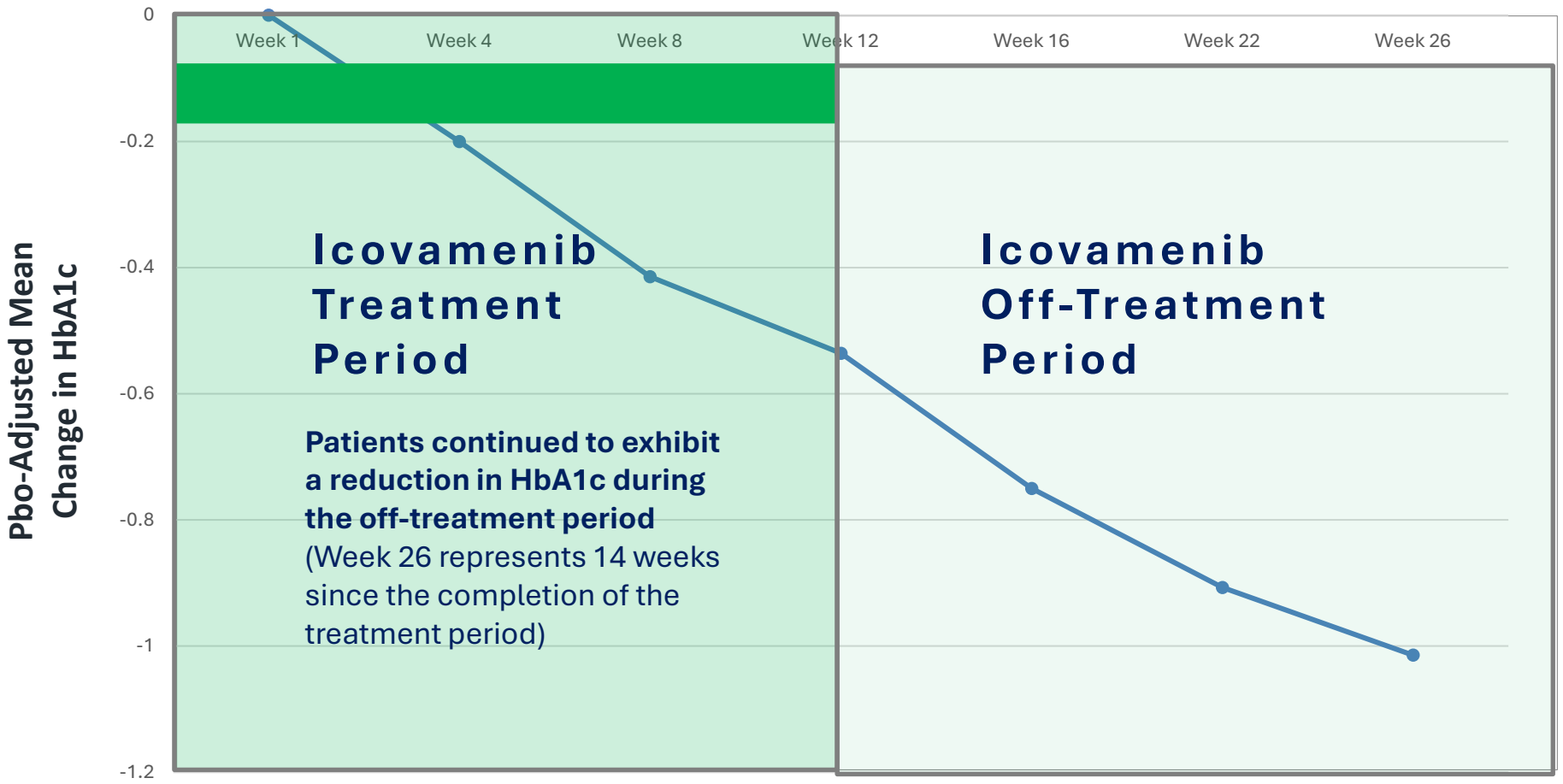


Ahlqvist et al. Diabetes 2020;69:2086–2093 | https://doi.org/10.2337/dbi20-0001

biomea FUSION™ We Aim to Cure™

HbA1c Reduction Has Continued Over Time – Outside the Treatment Period

Severe Insulin Deficient Diabetes (SIDD) Patients Mean Change in HbA1c – All Arms



Severe insulin-deficient diabetes (SIDD)

Low Insulin Resistance
Low Insulin Production
Lower BMI

Summary Table of Efficacy Analysis

Targeted Patients – Severe Insulin Deficient Patients (SIDD)

		Number of Patients	Reduction in HbA1C	P Value	
ARM B & C	All patients 12 weeks dosing	69	-0.42%	0.015	*
ARM B & C	SIDD/MARD (12 weeks)	22	-0.84%	0.008	*
ARM B & C	SIDD (12 weeks)	11	-1.17%	0.038	*

		Number of Patients	Reduction in HbA1C	P Value	
ARM B	All patients 12 weeks dosing	37	-0.50%	0.012	*
ARM B	SIDD/MARD (12 weeks)	13	-1.05%	0.004	*
ARM B	SIDD (12 weeks)	7	-1.47%	0.022	*

* Statistically Significant

icovamenib has the potential to be the only disease modifying agent in diabetes

Arm B: 12 weeks of dosing at 100 mg QD
Arm C: 8 weeks of 100 mg QD + 4 weeks of 100 BID
MARD/SIDD: insulin deficient diabetes patients

Arm C: 2/4 SIDD pts completed full 12 weeks

Arm B: 6/7 SIDD pts completed full 12 weeks

Prespecified SIDD Subgroup Performed In-line with GLP-1 RA Based Therapies

Currently Approved Type 2 Diabetes Agents w/Chronic Dosing				
Drug (Mechanism of Action)	**Dosing Frequency**	**Medication 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)
Summary		-	-	**0.7% ~ 1.7%**

Note: data shown are not from head-to-head studies and no head-to-head studies have been conducted

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

Severe insulin-deficient diabetes (SIDD)

Baseline HbA1c and BMI Can Enrich for the Desired Phenotype

BMI and baseline HbA1c inclusion criteria can enrich for SIDD to over 90%

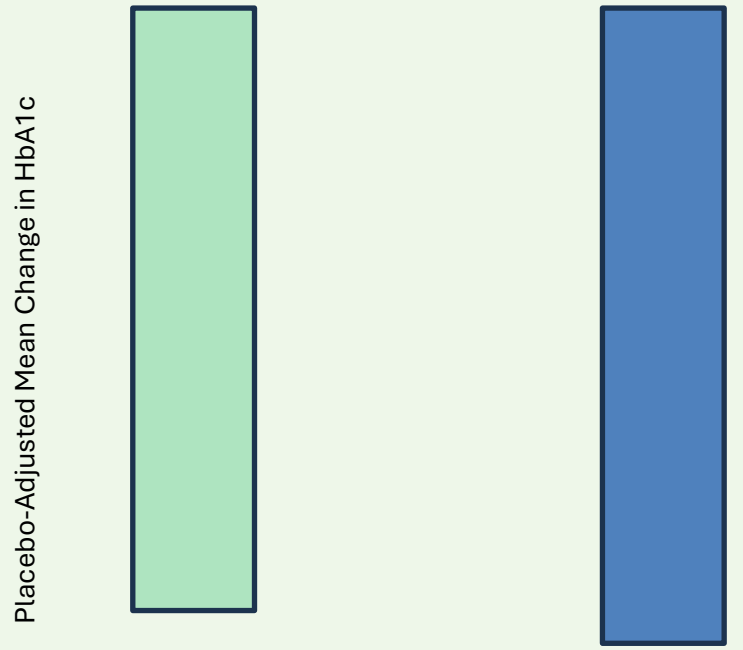
Baseline HbA1c 8.5 of higher

BMI <32

Severe insulin-deficient diabetes (SIDD)

Low Insulin Resistance
Low Insulin Production
Lower BMI

COVALENT-111 Week 26 (12 Weeks at 100mg)



-1.47%

SIDDs per Alquist Algorithm

-1.54%

All patients with HbA1c ≥ 8.5 & BMI <32

Adapted from Ahlqvist et al. Diabetes 2020;69:2086–2093 | https://doi.org/10.2337/dbi20-0001

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icovamenib

in combination with GLP-1 based therapies

Menin Suppresses GLP-1 Receptor Transcript Levels

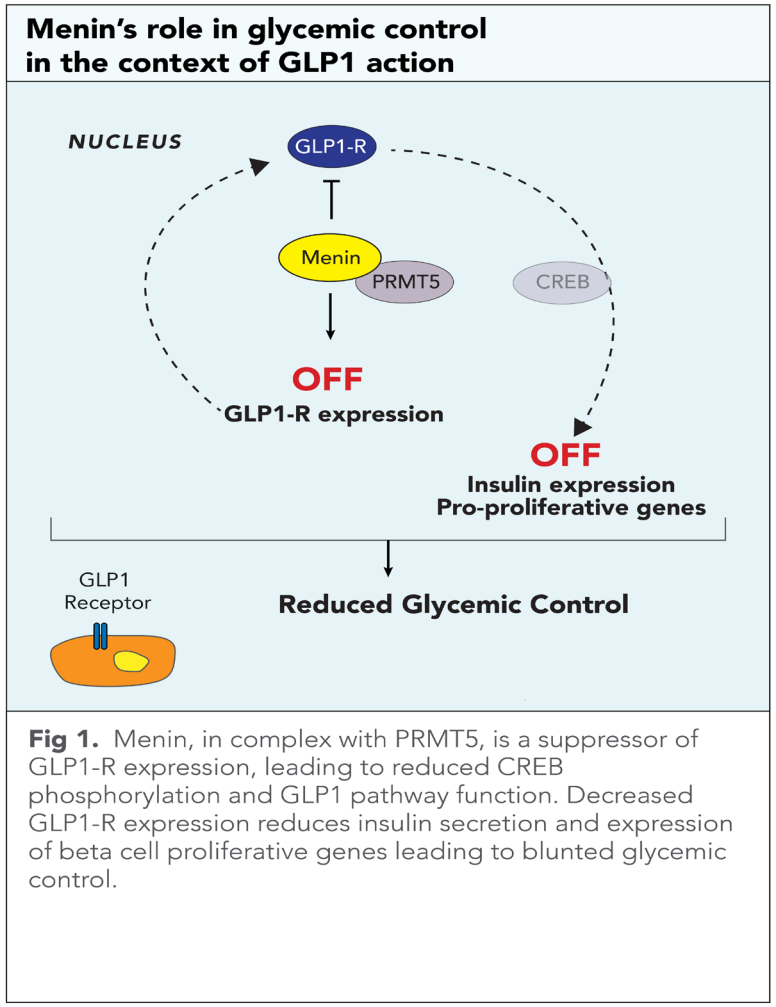


Fig 1. Menin, in complex with PRMT5, is a suppressor of GLP1-R expression, leading to reduced CREB phosphorylation and GLP1 pathway function. Decreased GLP1-R expression reduces insulin secretion and expression of beta cell proliferative genes leading to blunted glycemic control.

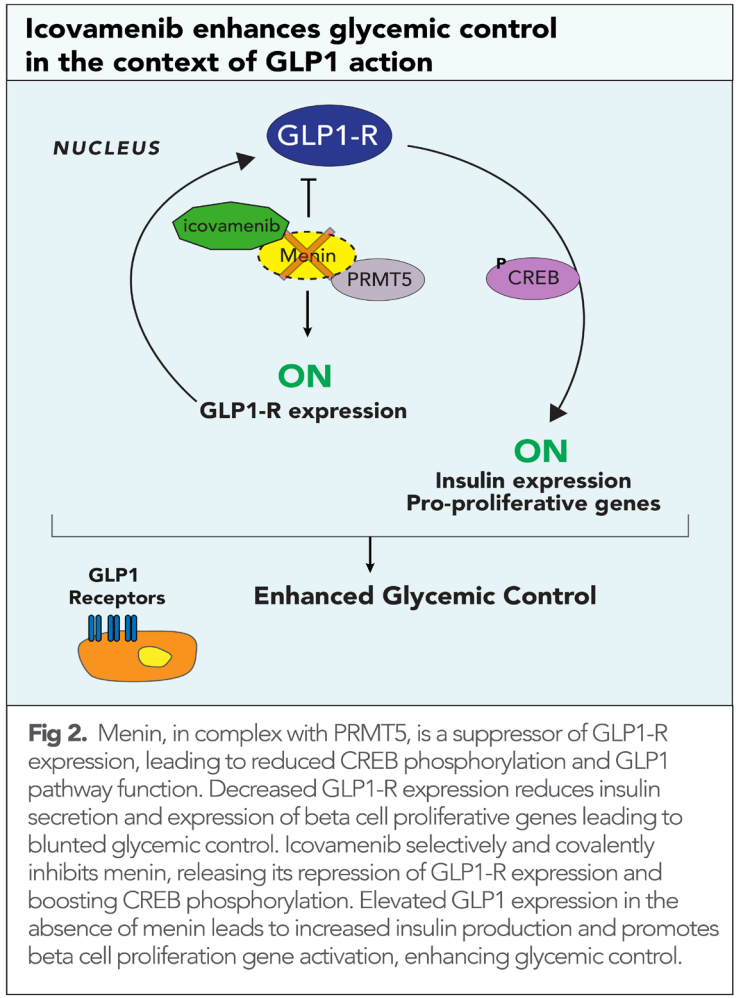
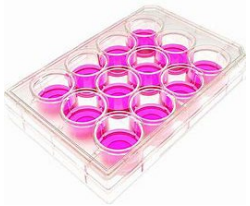


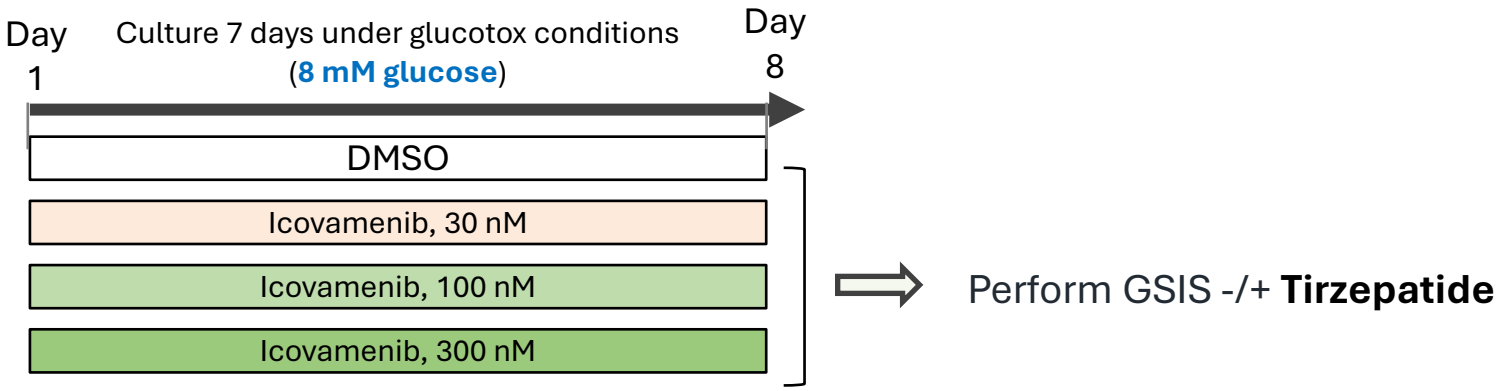
Fig 2. Menin, in complex with PRMT5, is a suppressor of GLP1-R expression, leading to reduced CREB phosphorylation and GLP1 pathway function. Decreased GLP1-R expression reduces insulin secretion and expression of beta cell proliferative genes leading to blunted glycemic control. Icovamenib selectively 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.

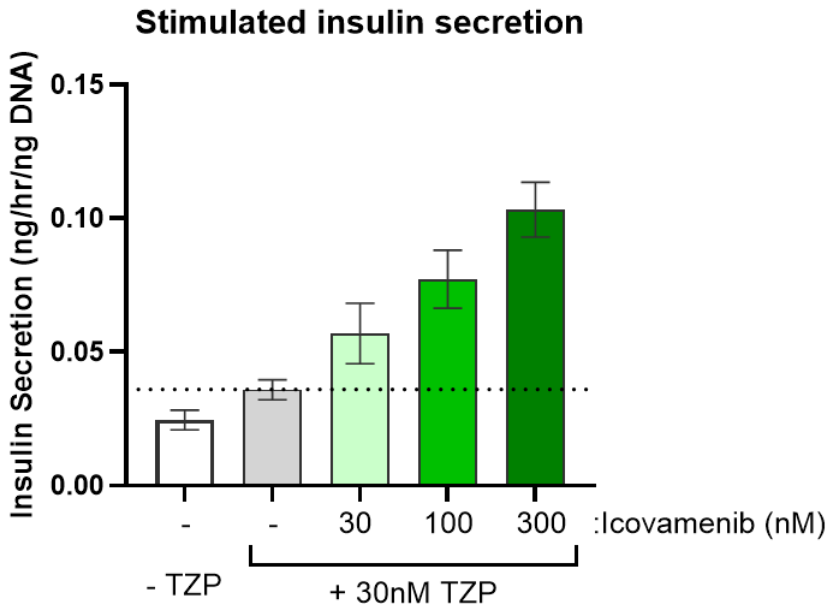
Combination Treatment: Icovamenib Enhanced Responsiveness of Islets to GLP-1/GIP Dual Receptor Agonist - Tirzepatide

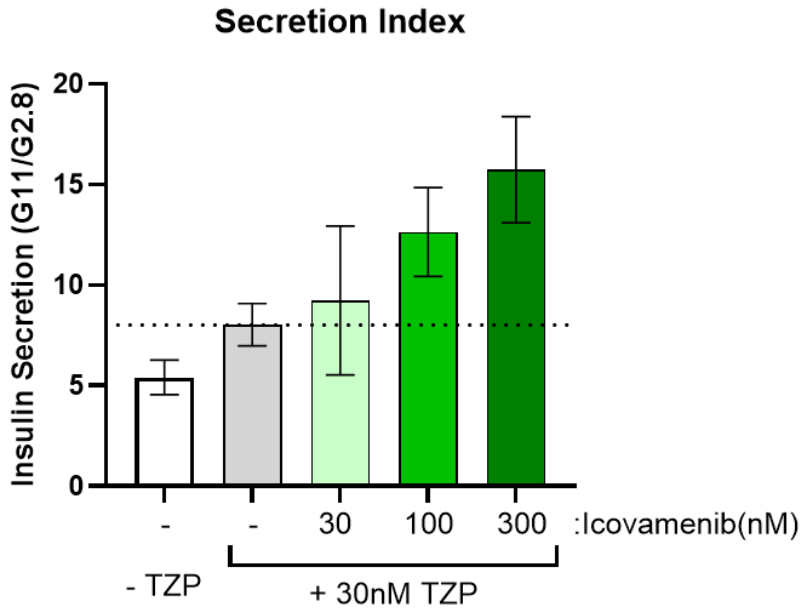
Cadaver derived human islets



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

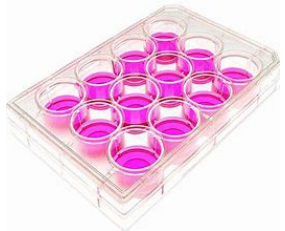




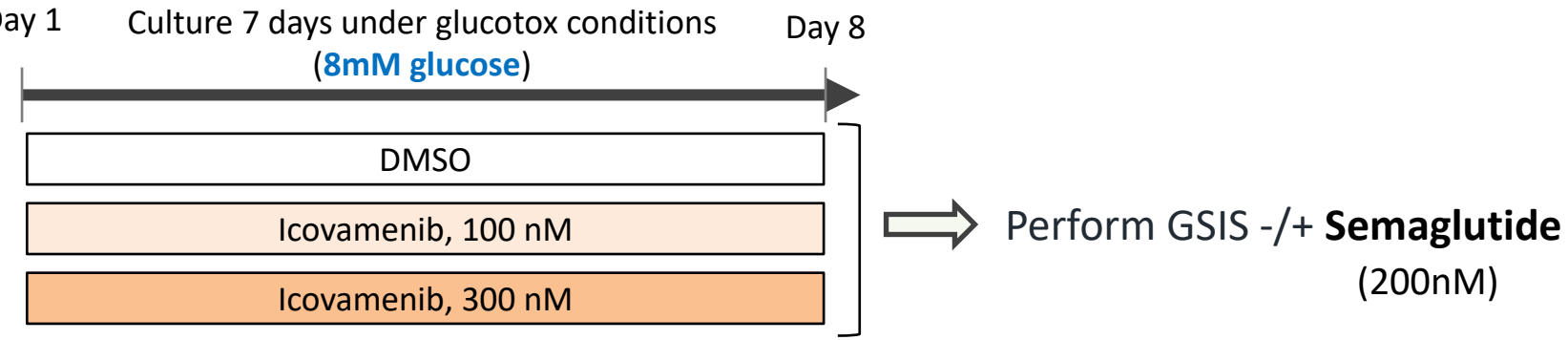


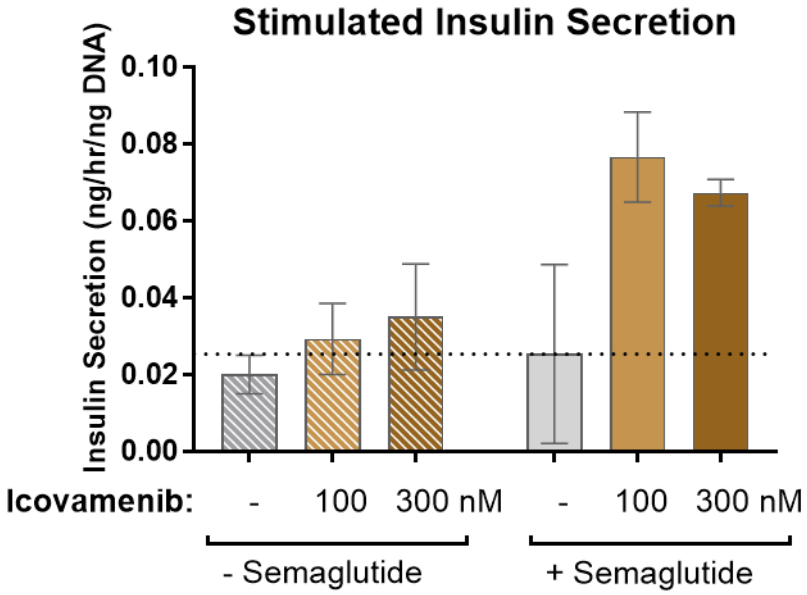
Combination Treatment: Icovamenib Enhanced Responsiveness of Islets to GLP-1 Receptor Agonist - Semaglutide

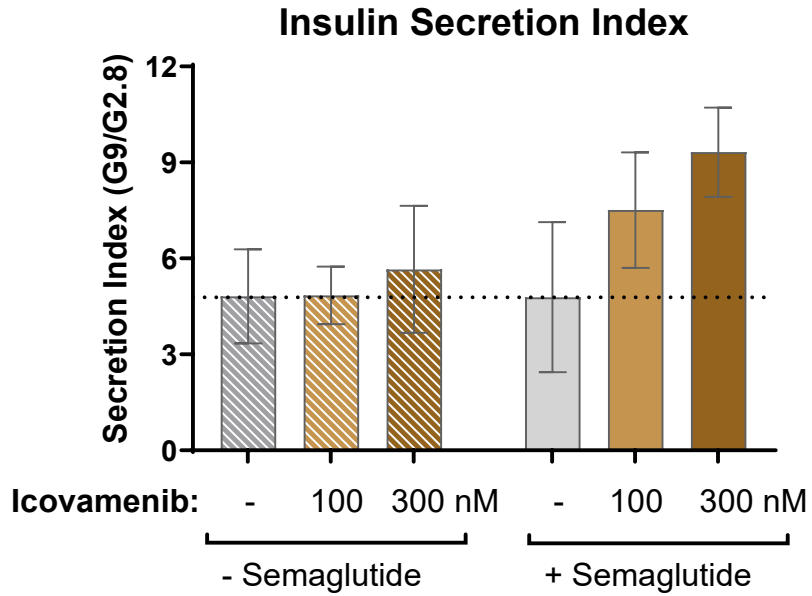
Cadaver derived human islets



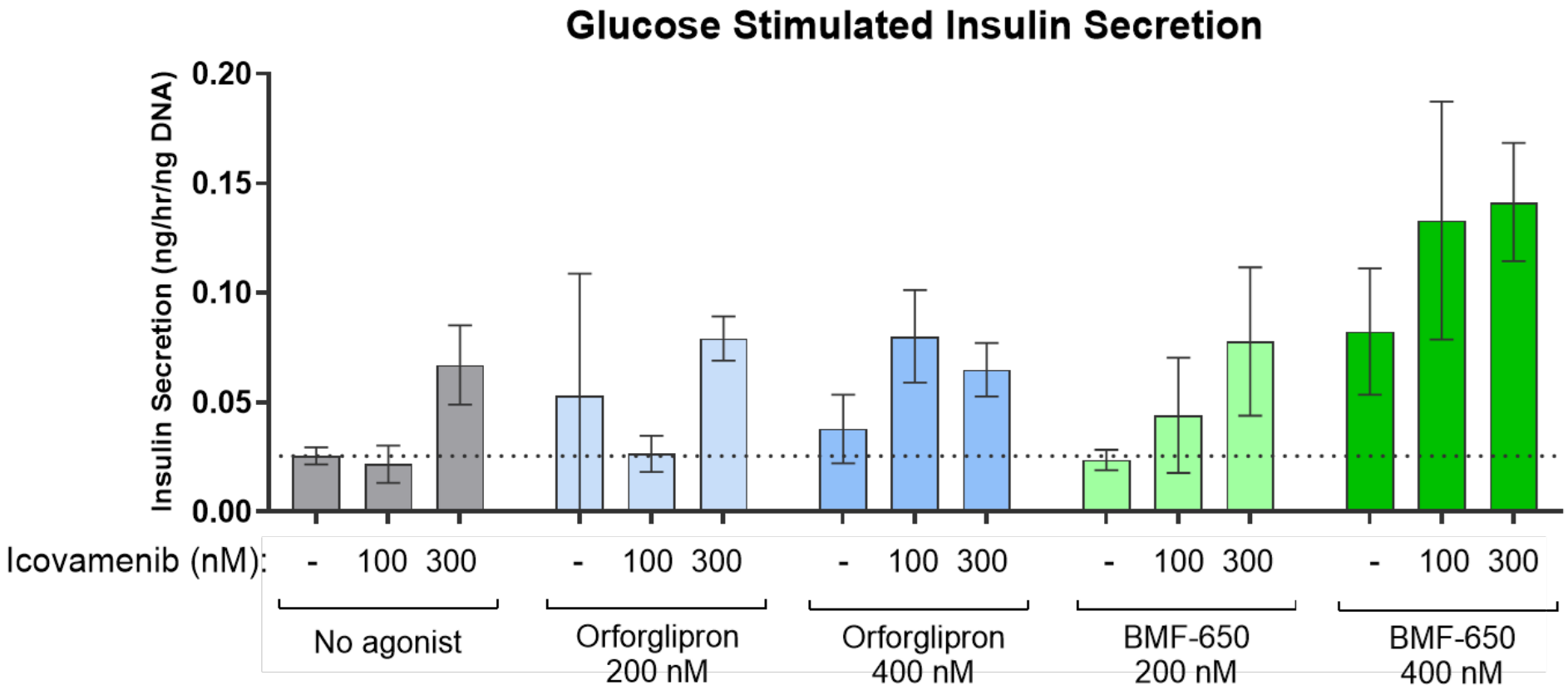
Non-diabetic donor:
41-year-old Hispanic male, BMI 27.8, HbA1c 5.3%





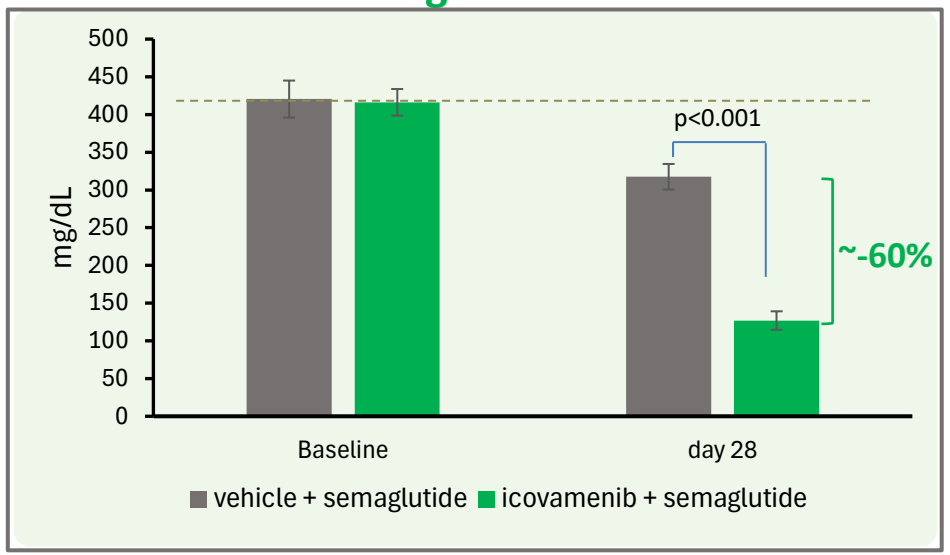


Combination Treatment: Icovamenib Enhanced Responsiveness of Islets to the Small Molecule GLP-1 Receptor Agonists - Orforglipron and BMF-650



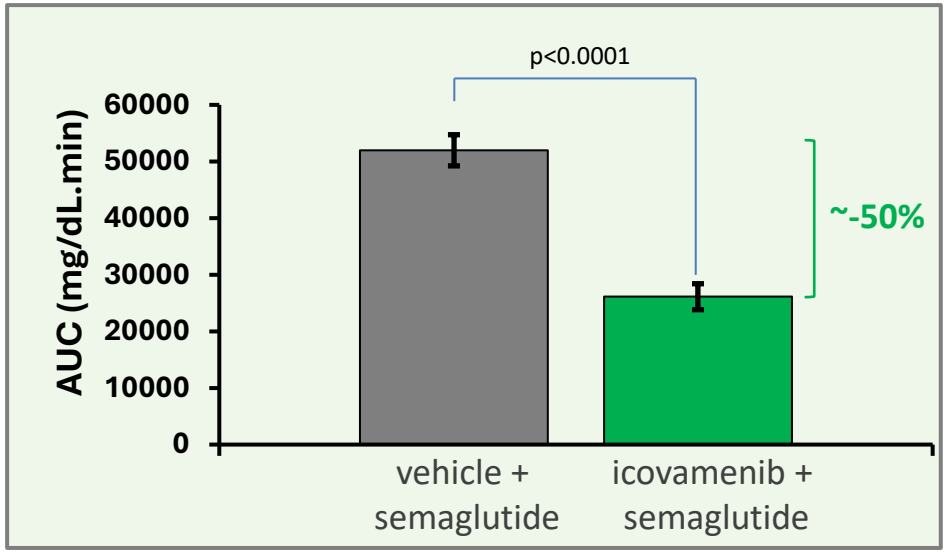
Combination Treatment of Icovamenib and Low Dose Semaglutide Extends Marked Glycemic Control in Diabetic Animals

Fasting Blood Glucose



Fasting blood glucose reduced to normal range in combination group

OGTT – Day 28



Significant reduction in combination group vs. semaglutide

ZDF rats, male
12- to 13-week-old,
n=10/group)

Group 1

vehicle → semaglutide (0.02 mg/kg)

Day 0 — 14 — 28

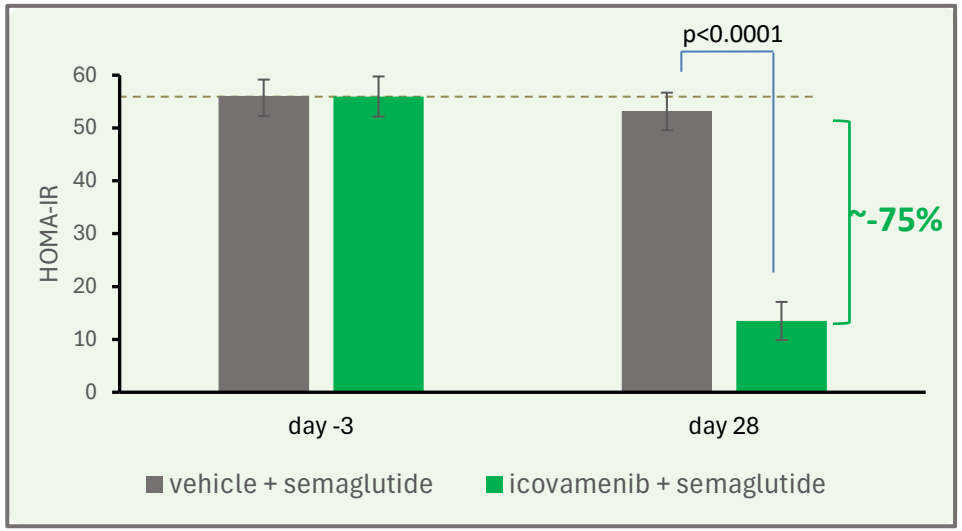
Group 2

icovamenib (200 mg/kg) → icovamenib + semaglutide

Day 0 — 14 — 28

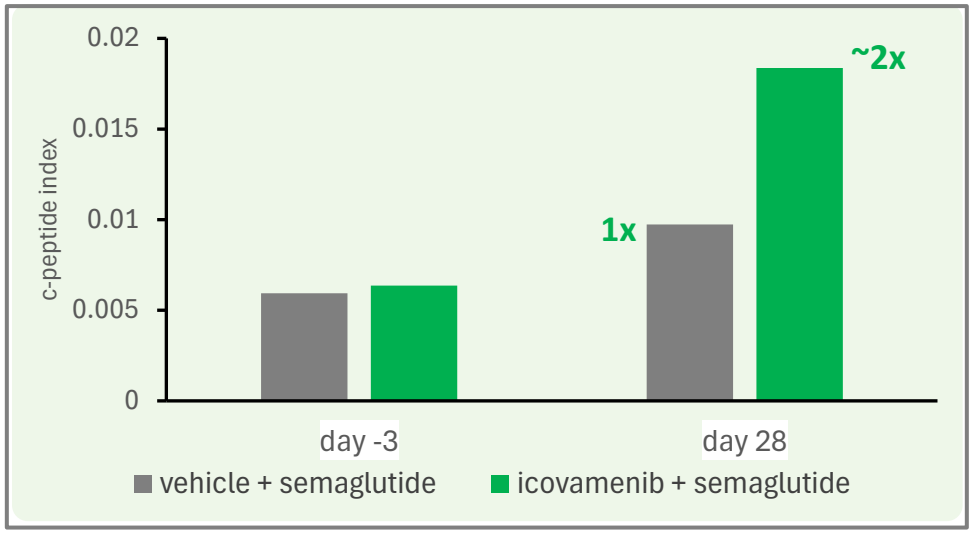
Combination Treatment of Icovamenib and Low Dose Semaglutide Significantly Reduced Insulin Resistance and Elevates C-peptide Index

HOMA-IR



Significant reduction in combination group vs. semaglutide

C-peptide Index



C-peptide index is doubled in combination group vs. semaglutide

ZDF rats, male
12- to 13-week-old,
n=10/group)

Group 1

vehicle → semaglutide (0.02 mg/kg)

Day 0 — 14 — 28

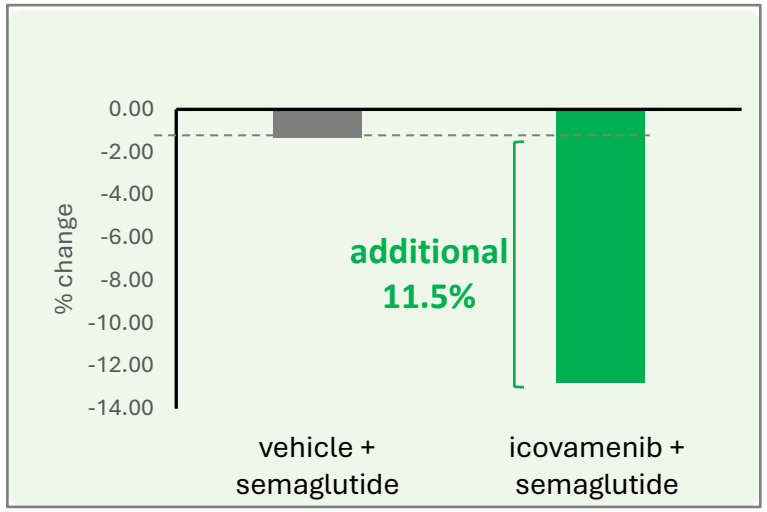
Group 2

icovamenib (200 mg/kg) → icovamenib + semaglutide

Day 0 — 14 — 28

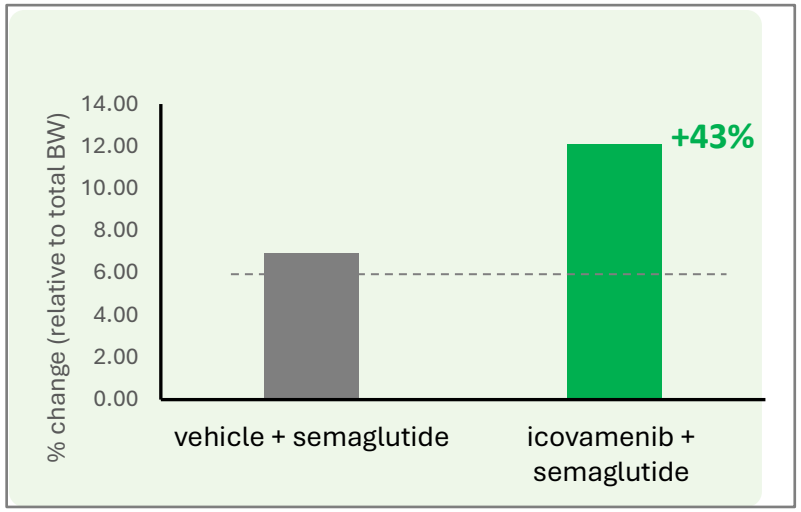
Combination Treatment of Icovamenib and Low Dose Semaglutide Reduces Body Weight and Boosts Lean Mass

Body Weight



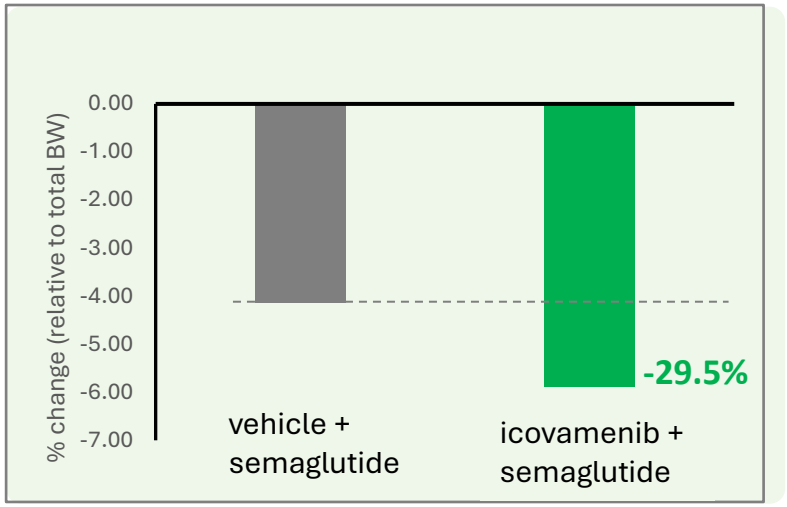
Greater body weight loss in combination group vs. low dose semaglutide at Day 25

Lean Mass Composition



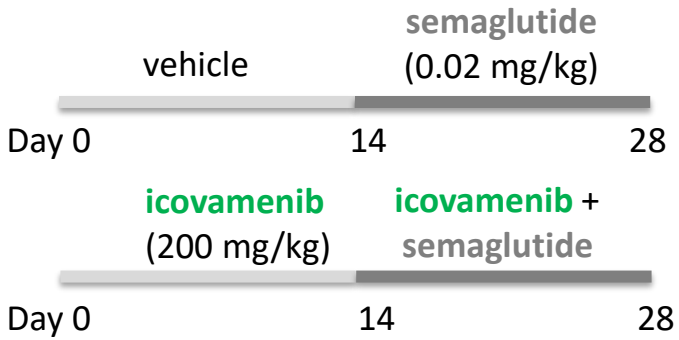
Higher gain in lean mass in combination group vs. low dose semaglutide at Day 25

Fat Mass Composition



Greater reduction in fat mass in combination group vs. low dose semaglutide at Day 25

ZDF rats, male
12- to 13-week-old,
n=10/group)

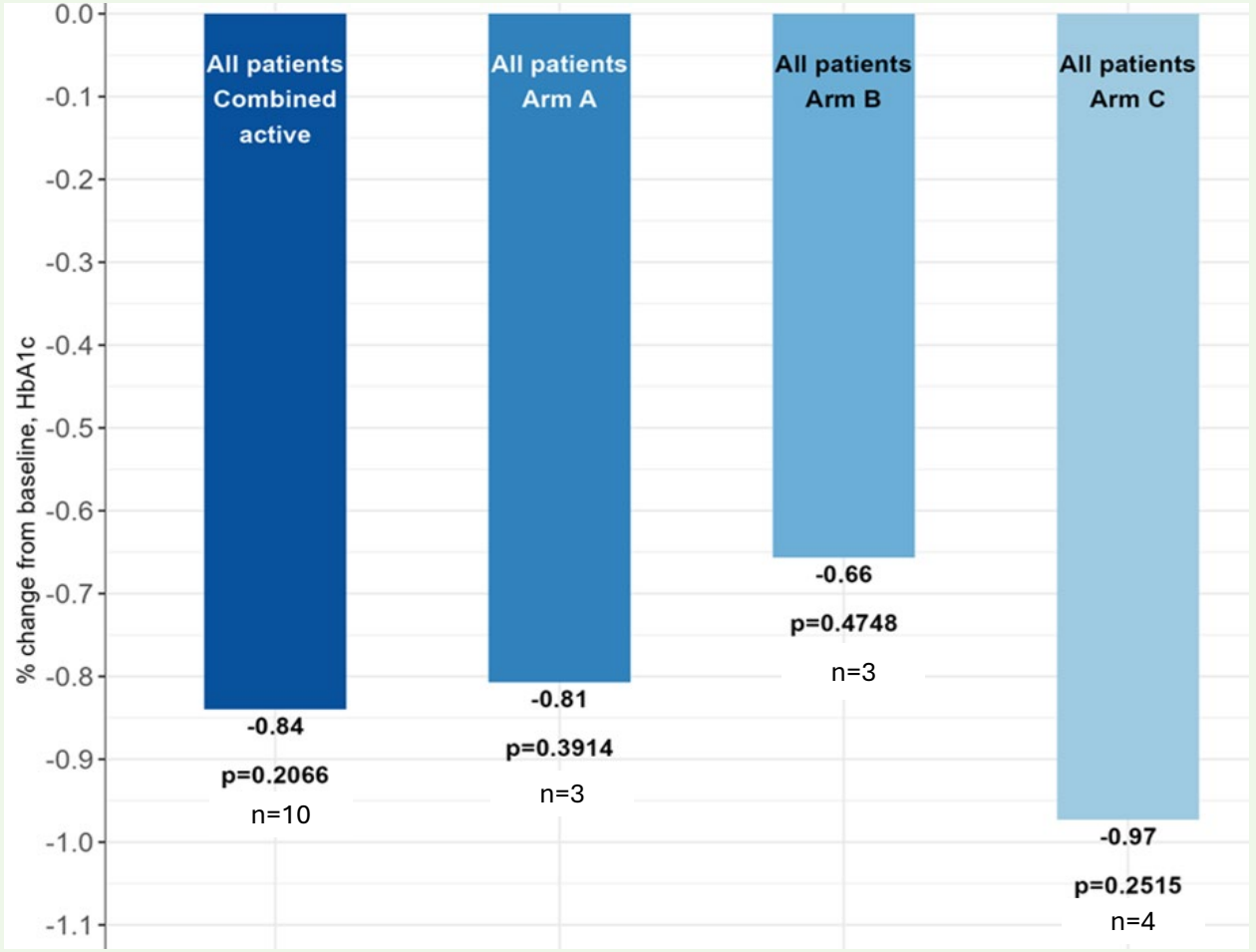


Icovamenib Drove Additional HbA1c Reduction in Patients on a GLP-1 RA Based Therapy

Icovamenib displays **clinically meaningful 1.0% reduction in HbA1c** in patients currently **uncontrolled** on GLP-1 RA based therapies

- 5/5 pts on 0.25mg to 1mg Ozempic lost additional weight when initiating icovamenib
- Up to 14% of additional weight loss observed at Week 26
- ~1.0% reduction in HbA1c of add-on therapy
- COV-111 did not have meal requirements during study

Placebo-Adjusted Mean Change in HbA1c at Week 26
Uncontrolled with GLP-1 Agonist-Based Therapy



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

Overview of Adverse Events Through 26 Weeks (mITT Population, N=225)

Parameter	Arm A icovamenib (N=59)	Arm B icovamenib (N=54)	Arm C icovamenib (N=55)	Combined Arms icovamenib (N=168)	Combined Arms placebo (N=57)
Patients with ≥1 TEAE	18 (31)	19 (35)	13 (24)	50 (30)	18 (32)
SAEs	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
Treatment Discontinuation due to AE	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
Study Discontinuation due to AE	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

Safety and Tolerability (mITT Population, N=225)

Parameter	Arm A icovamenib (N=59)	Arm B icovamenib (N=54)	Arm C icovamenib (N=55)	Combined Arms icovamenib (N=168)	Combined Arms placebo (N=57)
Diarrhea	4 (7)	2 (4)	1 (2)	7 (4)	0 (0)
Nausea	2 (3)	3 (6)	2 (4)	7 (4)	1 (2)
Hyperglycemia	1 (2)	4 (7)	1 (2)	6 (4)	3 (5)
Headache	0	3 (6)	1 (2)	4 (2)	3 (5)
ALT increase	2 (3)	0	2 (4)	4 (2)	0
AST increase	2 (3)	0	1 (2)	3 (2)	0

Data are n (%) of TEAE with ≥5% frequency in any arm and ALT or AST increase irrespective of incidence; mITT population (safety analysis set)
TEAE, treatment-emergent adverse event; ALT, alanine aminotransferase; AST, aspartate aminotransferase

Diarrhea: In icovamenib arms, all 7 events were Grade 1.

Nausea: In icovamenib arms, 6 of 7 events were Grade 1 and 1 event was Grade 2 (Arm B). In placebo arm, the 1 event was Grade 1.

Hyperglycemia: In icovamenib and placebo arms, all events were Grade 2.

Headache: In icovamenib arms, 3 of the 4 events were Grade 1 and 1 event was Grade 2 (Arm B). In the placebo arm, 3 of the 4 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.

Icovamenib: Late-Stage Clinical Development in Type 2 Diabetes

Development of icovamenib to focus on two key patient segments
- Severe Insulin Deficient Diabetes Patients
- All Patients in Combination with a GLP-1 RA

1. <u>Severely Insulin Deficient Diabetes (SIDD) Subjects</u>

We aim to improve glycemic control in the patient population with the highest unmet medical need in type 2 diabetes

2. <u>GLP-1 Combination</u>

We aim to maximize the incretin effect while preserving lean mass and increasing body weight loss

A. Subjects initiating a GLP-1 RA based therapy
B. Subject uncontrolled on a GLP-1 RA based therapy

Biomea Fusion: A Diabetes and Obesity Medicines Company

	Study	Indications	Anticipated Milestones for 2025
Icovamenib (BMF-219) Menin Program (Potential First-In-Class)	COVALENT-111 Phase 2	Type 2 Diabetes	2H 2025: 52 Week Data
	COVALENT-112 Phase 2	Type 1 Diabetes	2H 2025: Open Label Data
	COVALENT- 311 Phase 2/3	Type 2 Diabetes Severe Insulin Deficient Diabetes	1H 2025 Meet with FDA to Discuss Phase II/III (Adaptive Design) and Advance to Late-stage Development
	COVALENT-211 Phase 2	Type 2 Diabetes GLP-1RA combination	1H 2025 Meet with FDA to Discuss Phase II and Initiate Combination Study
BMF-650 GLP-1R Agonist (Potential Best-In-Class)	IND-Enabling Studies	Diabetes/Obesity	2H 2025 IND Cleared and First Participant Dosed
BMF-500 FLT-3 Program	COVALENT-103 Phase 1	AML/ALL (Acute Leukemia)	Dose Escalation Completion – Partnering Strategy

JP MORGAN 2025 Summary

Advancing a First-in-Class, Precision-Based Treatment for Diabetes

- Icovamenib is an oral, once daily, simple, 12-week treatment for diabetes
- Icovamenib displayed comparable efficacy to a GLP-1 RA chronic therapy in the target patient population at Week 26, with just 12 weeks of treatment
- Icovamenib displayed in the pre-specified severe insulin deficient diabetes (SIDD) patients a placebo-adjusted mean reduction in HbA1c 1.5%
- The SIDD patient population represents the highest unmet medical need and approx 18% of the diabetes population
- Icovamenib was well tolerated with no study drug discontinuations due to TEAEs
- Icovamenib added on top of an existing GLP-1 RA therapy demonstrated a clinically meaningful 1% reduction in HbA1c in study participants with uncontrolled diabetes
- BMF-650 a next generation oral GLP-1 RA to treat diabetes and obesity is on schedule, advancing towards the clinic with IND filing in 2H 2025.

Company Financials (NASDAQ: BMEA)

As of September 30, 2024

	Three Months Ended September 30, 2024
Operating expenses:	
R&D	$ 27,244
G&A	6,795
Total Operating Expenses	34,039
Loss from operations	(34,039)
Interest and other income, net	1,252
Net loss	$ (32,787)
Other comprehensive loss:	
Changes in unrealized gain on short term investments, net	—
Comprehensive loss	$ (32,787)
Net loss per common share, basic and diluted	$ (0.91)
Weighted-average number of common shares used to compute basic and diluted net loss per common share	36,220,736

Q3 Operating Expenses minus Stock Based Comp	**$29.3 M**
Cash, Cash Equivalents, Investments, and Restricted Cash as of 30 September 2024	**$88.3 M**


Thank you
biomea
FUSION
We Aim to Cure™