Biomea Fusion Corporate Presentation

At-a-Glance

biomea FUSION™

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Transforming diabetes and obesity

Biomea Fusion founded in 2017 (public in 2021; NASDAQ: BMEA)
Clinical-stage company advancing two differentiated metabolic investigative programs

Icovamenib (target: menin reduction)

- **Diabetes**
- **Oral**
- **Small molecule**

COVALENT-211 & 212 (Phase 2)

Type 2 Diabetes
Failing standard of care
(i.e. Insulin-deficient & GLP-1 inadequately controlled)

BMF-650 (target: GLP-1 RA)

- **Weight loss**
- **Oral**
- **Small molecule**

GLP-131 (Phase 1)

Overweight & Obesity
(BMI ≥30kg/m2)

ICOVAMENIB

Potential first-in-class menin inhibitor aimed to restore functional beta-cells

Aims to serve a significant unmet need for millions of diabetes patients failing on standard of care

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Icovamenib is developed to:

+ Employ and enhance body's natural response to hyperglycemia as evidenced in pregnancy
+ Conditionally drive beta-cell proliferation and activity only in presence of high glucose levels
+ Enhance GLP-1 efficacy by upregulating GLP-1 receptors on the beta-cell surface
+ Target beta-cell restoration and potentially delay or prevent onset of end-stage disease

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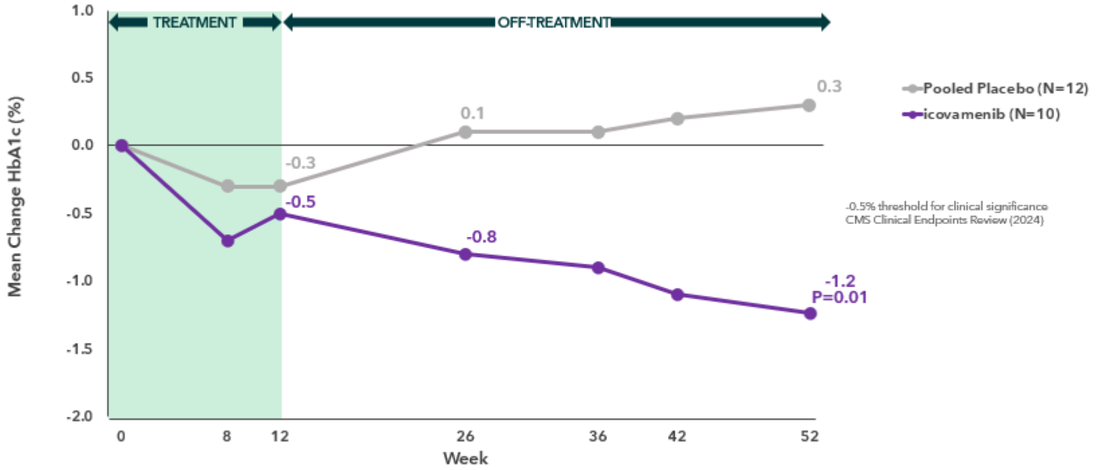
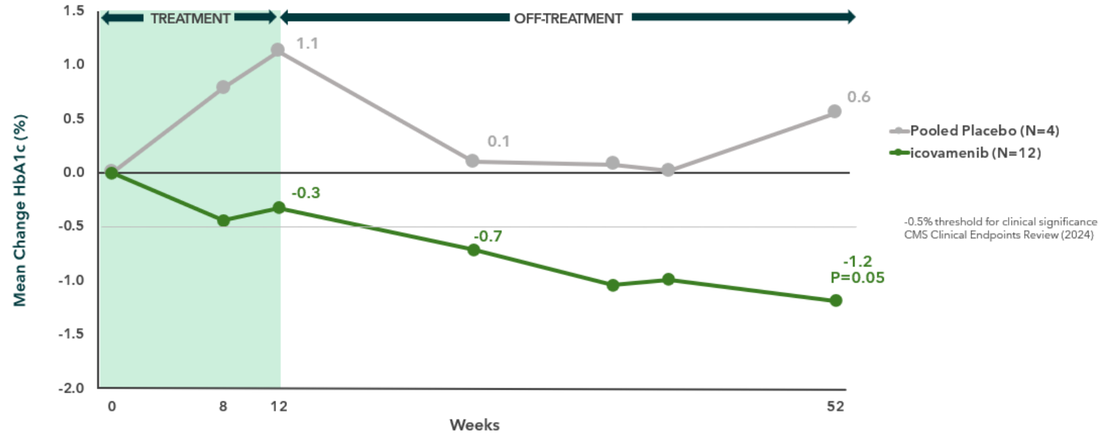
Severe insulin-deficient diabetes patients after 12-weeks of dosing



GLP-1 RA uncontrolled diabetes patients after 12 weeks of dosing



Post-hoc analysis of patients on GLP-1 based therapy not achieving stable HbA1c <7% at enrollment (9 months after last dose)

Early signs of clinical activity with 12 weeks of dosing in diabetes patients failing standard of care therapies

BMF-650

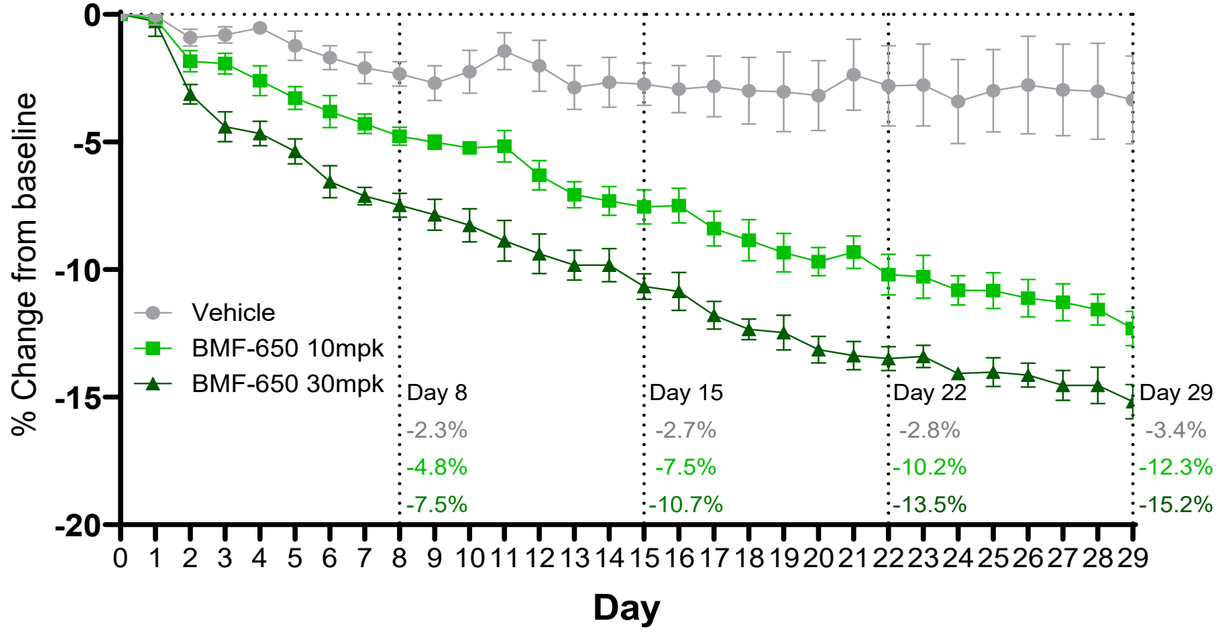
Oral GLP-1 RA developed for improved patient friendly tolerability

Aims to serve a significant unmet need with millions of obese Americans dropping off the available GLP-1 RAs agents within the first year[1]

BMF-650 is developed to:

- \+ Built on the orforglipron scaffold with key structural improvements
- \+ Greater oral exposure and bioavailability with lower variability observed in preclinical models
- \+ Higher plasma protein binding supporting better tolerability
- \+ Potential for simplified dose escalation schedule with generally well-tolerated safety profile

~15% Body Weight Reduction in 28-day Obese Monkey Study



1. Prime Therapeutics & Magellan Rx Management, 2023 real-world claims analysis.

ICOVAMENIB

Potential first-in-class oral menin inhibitor for diabetes

Preclinical and first clinical results

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Diabetes patients are poorly controlled with 1:3 US diabetes patients estimated to require insulin as a last resort

Icovamenib targets menin to allow for beta-cell restoration which may delay or prevent onset of end-stage disease

80%

of people with diabetes will die from the disease[1]

The end-stage in the evolution of diabetes is insulin-dependence, which drives complications such as kidney disease, nerve damage, vision loss, and cardiovascular issues.

12-14 years

of life lost from diabetes[2]

Diabetes today remains poorly controlled in 50% of patients treated with standard of care agents[3] The burden to the healthcare system is immense. There is no current therapy except for insulin replacement

60+

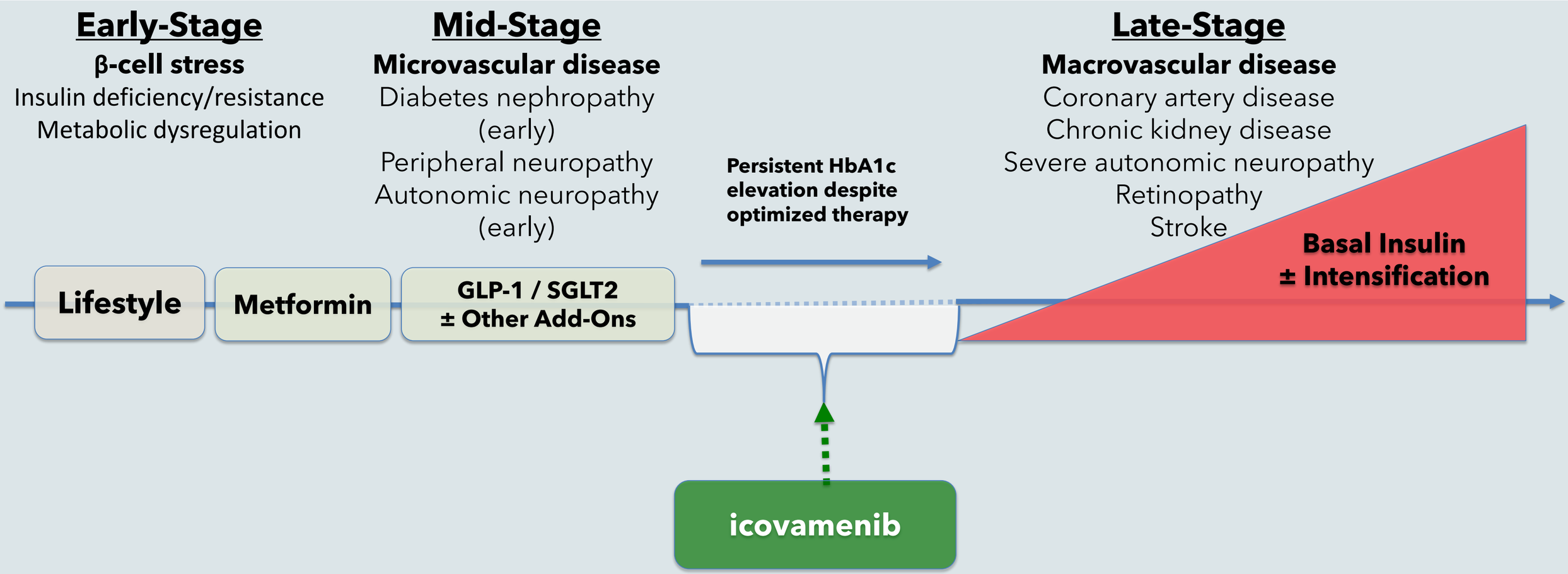
Approved therapies are not adequately resolving the growing problem of type 2 diabetes.

No current therapy restores beta-cell function

1.Tabish Int J Health Sci. 2007 Jul;1(2):V–VIII.
2.National library of Medicine 1(2); 2007 Jul PMC3068646
3.Zohu Lancet 2024; 404:2077–93

4. CDC, Natl. Diabetes Stat. Rep., 2022
5. ADA, Standards of Care in Diabetes, Diabetes Care, 2024
6. Li J Diabetes Complications 2012;26(1):17-22

Icovamenib aims to delay need for insulin therapy
and reduce complications and disease burden



In the U.S., more than half of patients with diabetes remain above HbA1c targets ≥7%[1]
Depending on the GLP-1 RA agent, 15-45% do not achieve HbA1c < 7% in clinical trials[2]

1.NHANES analyses of glycemic control among U.S. adults with diabetes (JAMA; Diabetes Care); 2.SUSTAIN, AWARD, and SURPASS clinical trial programs for GLP-1 receptor agonists

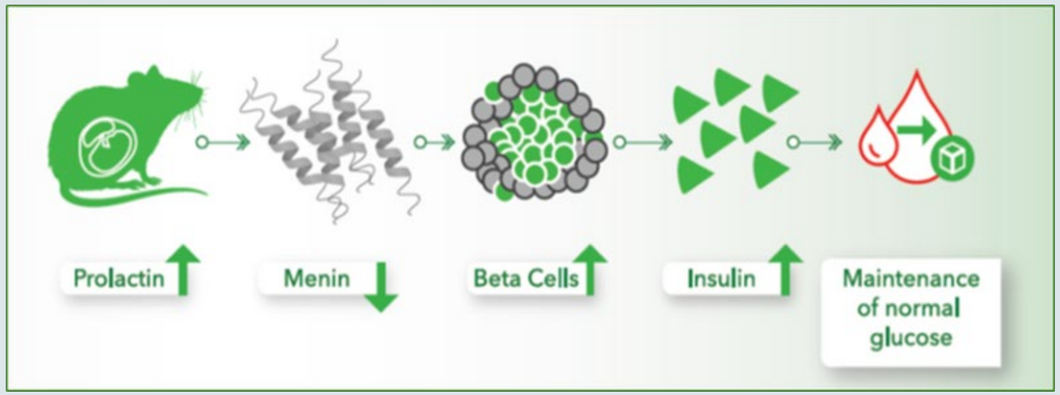
Physiologic suppression of menin can expand beta cell mass

- Physiologic states such as pregnancy and lactation suppress menin, enabling beta-cell expansion and increased insulin output

- Preclinical and human data consistently link reduced menin signaling to improved beta-cell mass and function.

First in a 2005 paper in Proceedings of the National Academy of Sciences (PNAS) by Satyajit K. Karnik et al. titled “Menin regulates pancreatic islet growth by promoting histone methylation and expression of genes encoding p27^Kip1 and p18^INK4c”

- Icovamenib has been shown to directly inhibit menin, aiming to pharmacologically replicate a naturally occurring, validated biologic process



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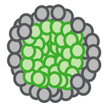
Icovamenib's mechanism of action

Icovamenib promotes selective and partial reduction in menin levels

Lowering menin levels releases the break on beta cell proliferation and GLP-1 and GLP-1 receptor expression

Induction of beta cell proliferation



Pancreatic islet

Increased expression of
- **GLP-1**
- **GLP-1 receptor**

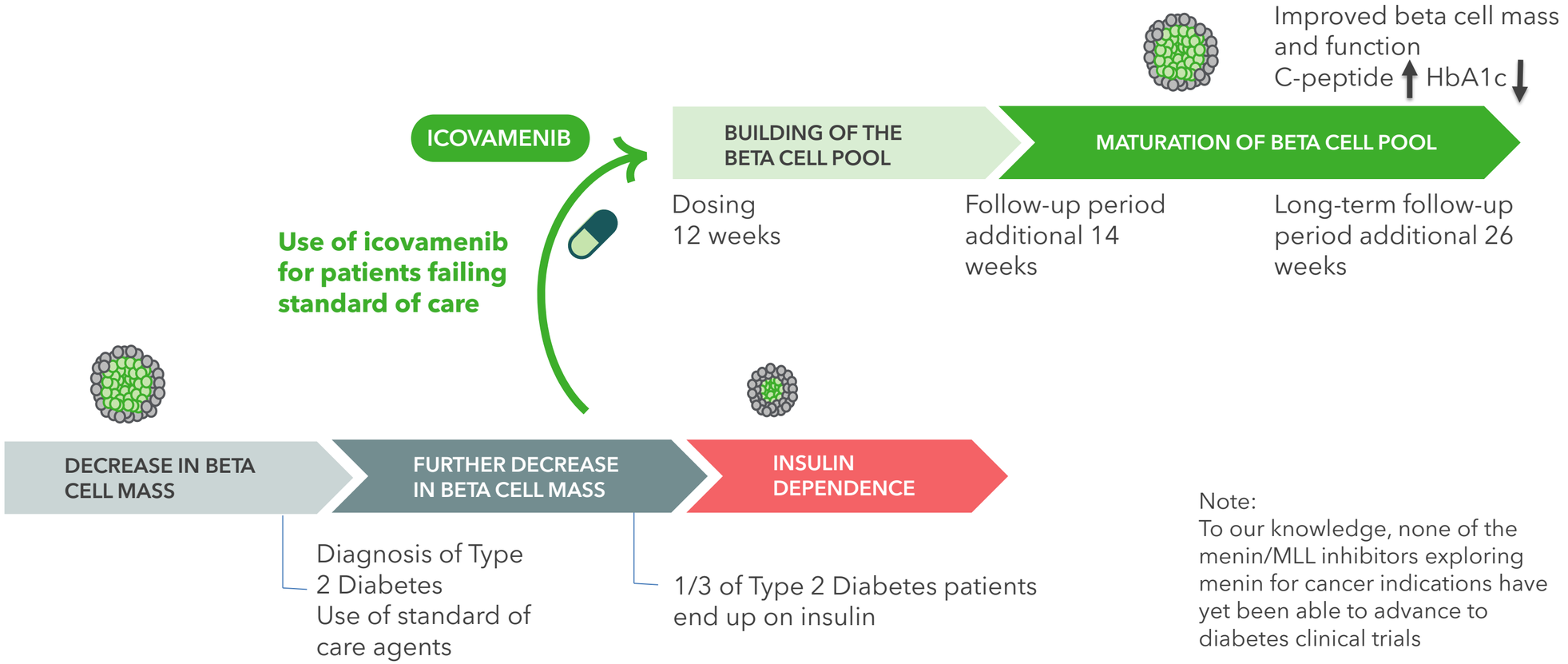
IMPROVED BETA CELL MASS & FUNCTION

- ↑ Increase in insulin/C-peptide
- ↓ Decrease in blood glucose (HbA1c)

IMPROVED INCRETIN EFFECTS

- ↑ Synergistic with GLP-1 based therapies
- ↑ Improved beta cell function
- ↓ Decrease in blood glucose (HbA1c)
- ↓ Potential for weight loss
- ↑ Potential for lean mass/muscle preservation

Icovamenib increased beta cell quantity, function & GLP-1 receptor expression following a short treatment period

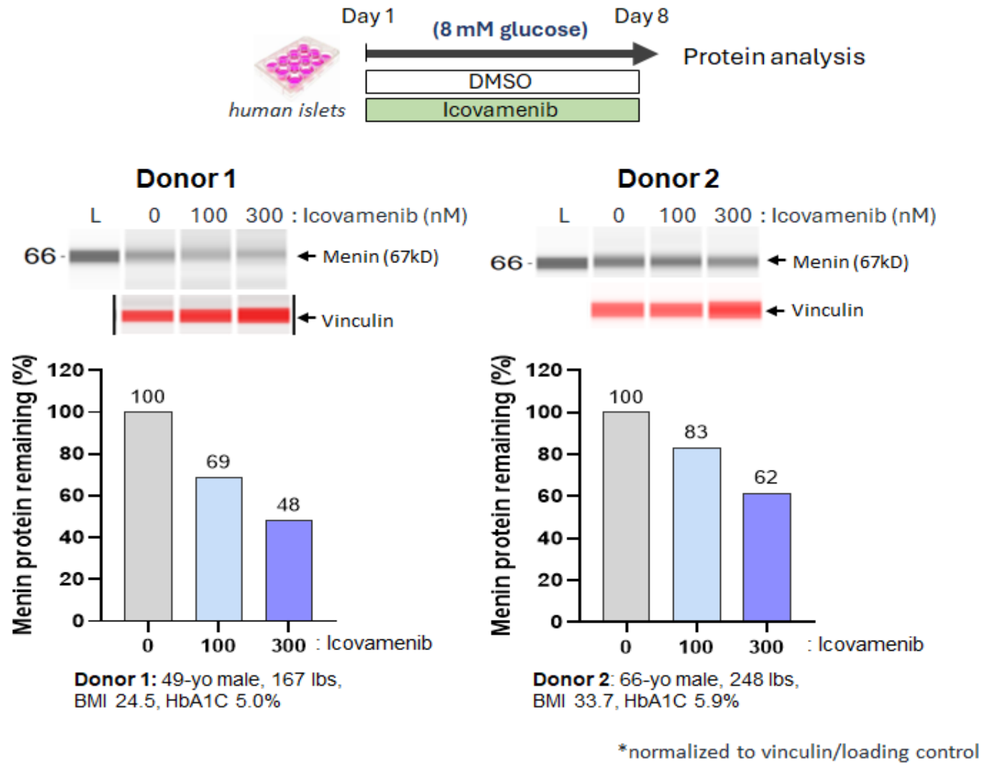


Note:
To our knowledge, none of the menin/MLL inhibitors exploring menin for cancer indications have yet been able to advance to diabetes clinical trials

ICOVAMENIB | PRECLINICAL

Icovamenib downregulated menin protein levels & promoted beta cell proliferation in ex vivo human islet cultures

MENIN LEVELS DOWNREGULATED

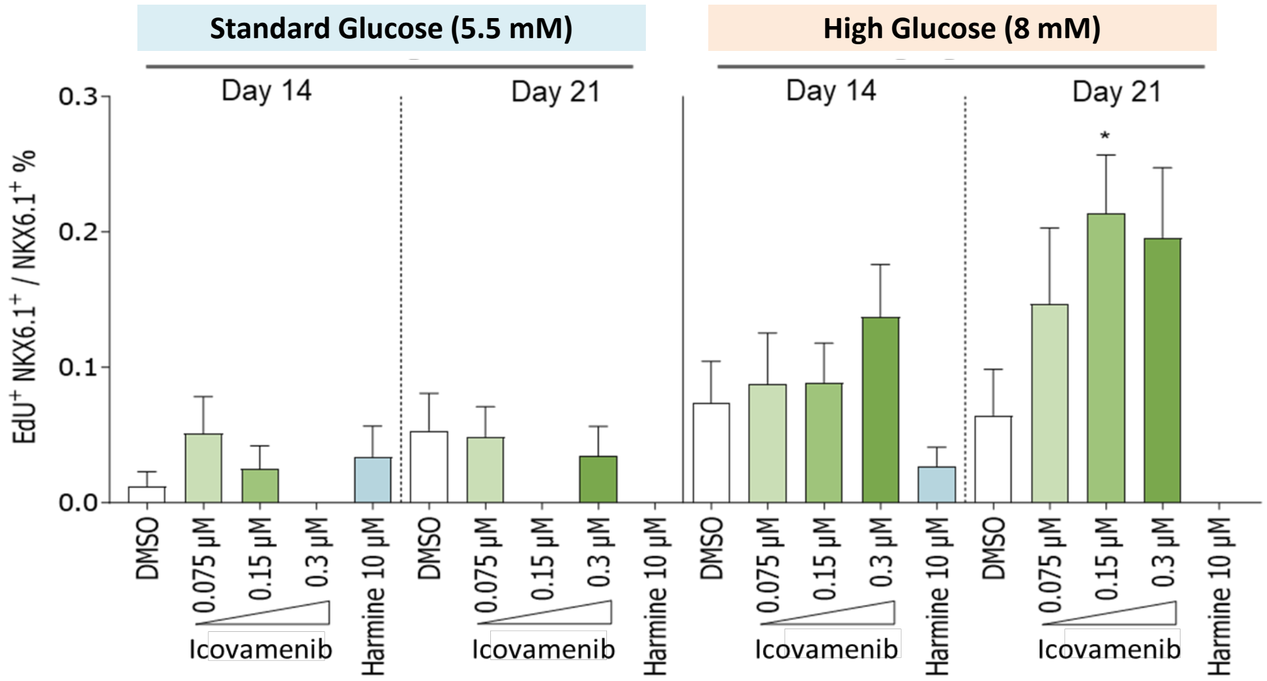


Donor 1: 49-yo male, 167 lbs, BMI 24.5, HbA1C 5.0%

Donor 2: 66-yo male, 248 lbs, BMI 33.7, HbA1C 5.9%

*normalized to vinculin/loading control

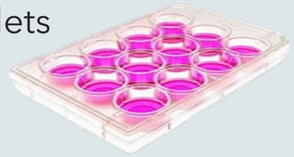
ICOVAMENIB CONDITIONALLY PROMOTED BETA CELL PROLIFERATION ONLY UNDER HYPERGLYCEMIC CONDITIONS

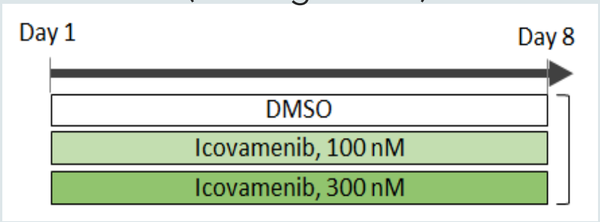


Icovamenib also enhanced GLP-1 receptor & insulin expression in combination with semaglutide

Culture 7 days under glucotox conditions (8mM glucose)

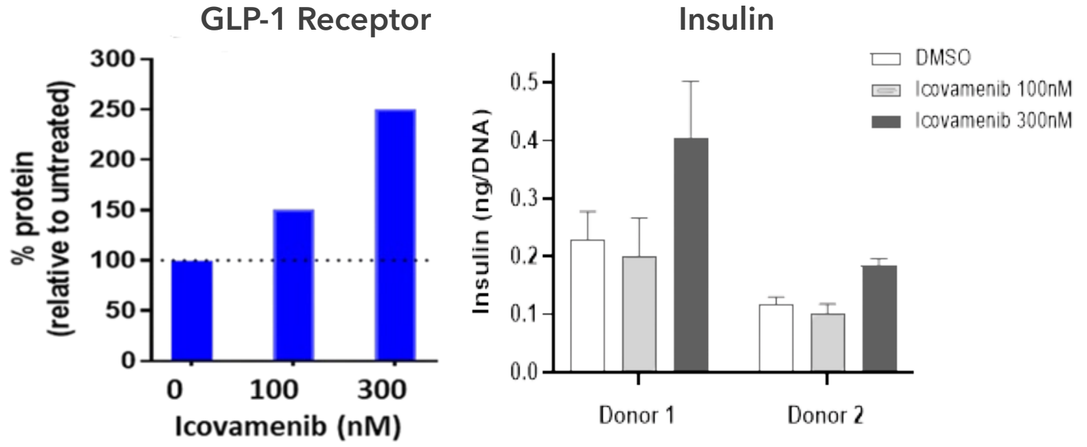
Cadaver derived human islets



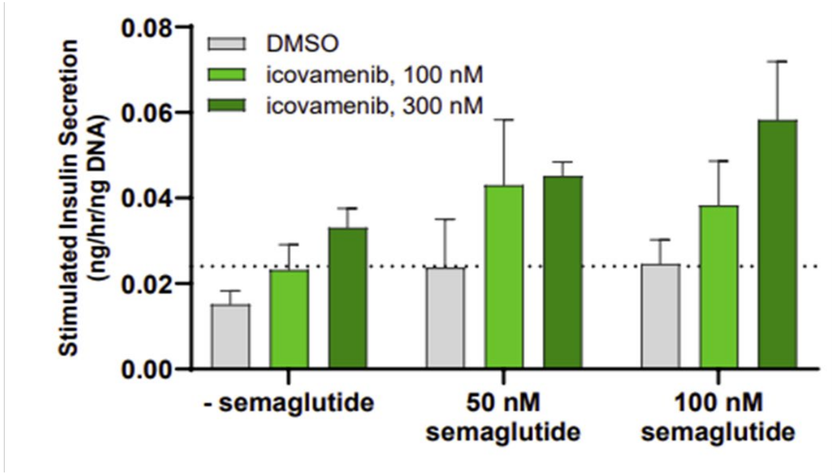


- Gene expression & Protein analysis
- Glucose Stimulated Insulin Secretion -/+ Semaglutide (200nM)

ICOVAMENIB INCREASED GLP-1 RECEPTOR AND INSULIN EXPRESSION

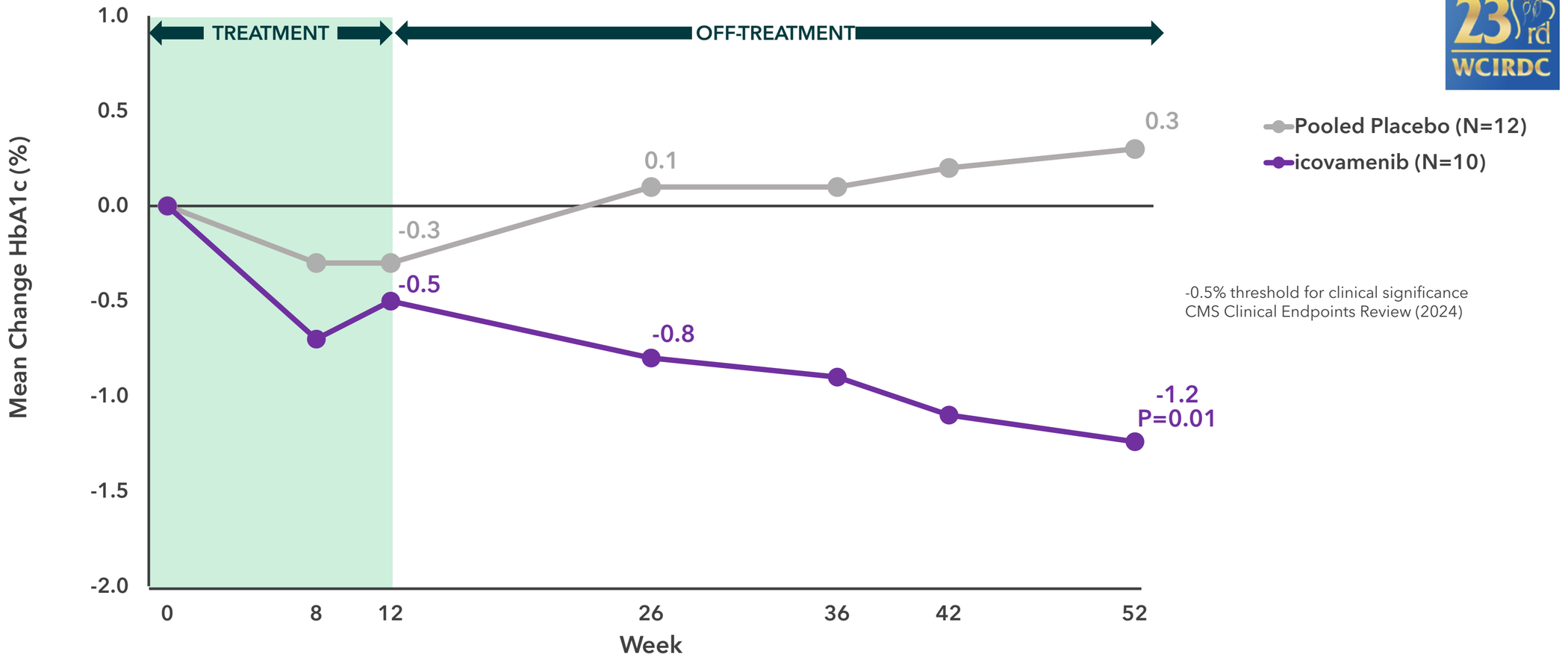


ICOVAMENIB IN COMBINATION WITH SEMAGLUTIDE INCREASED GLUCOSE-STIMULATED INSULIN SECRETION



ICOVAMENIB

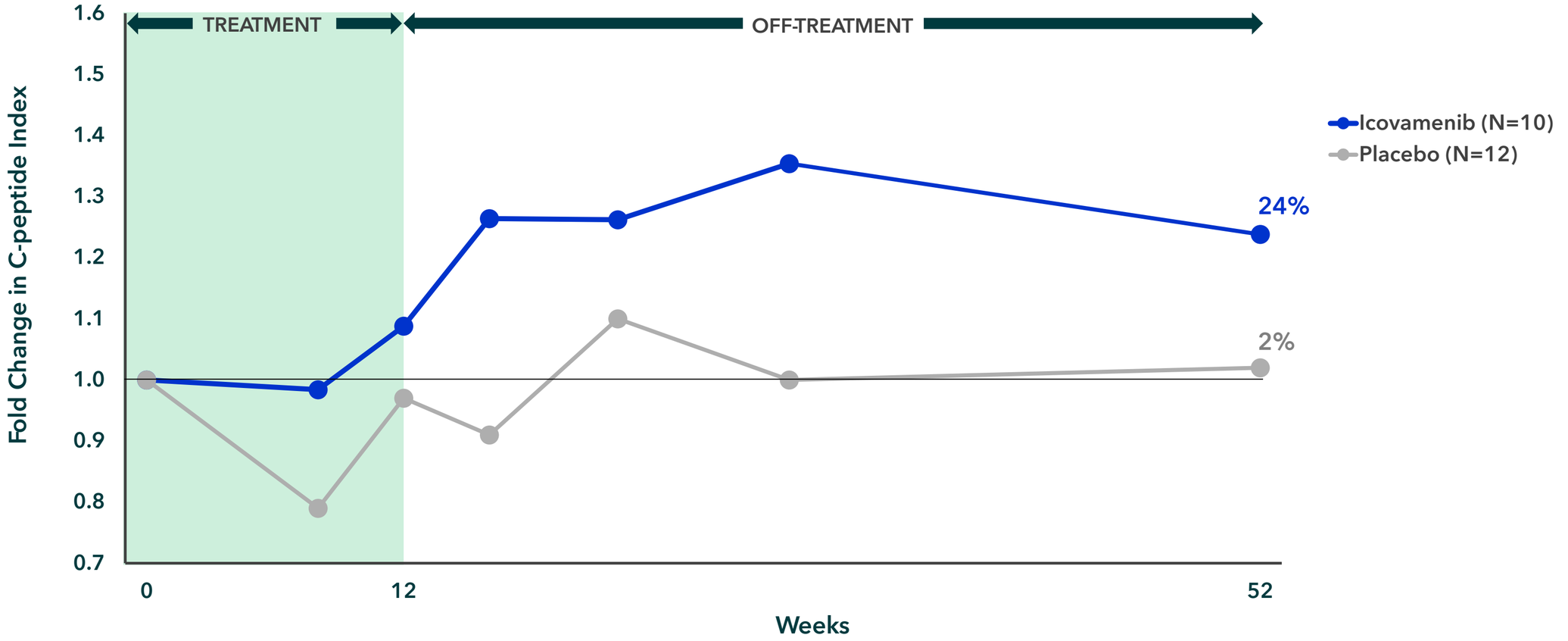
12 weeks of dosing (arms B&C) delivered lasting benefit through 52 weeks for severe insulin-deficient diabetes patients



Arm A was excluded from this analysis because it included only 8 weeks of dosing which the company is not planning to pursue.

ICOVAMENIB

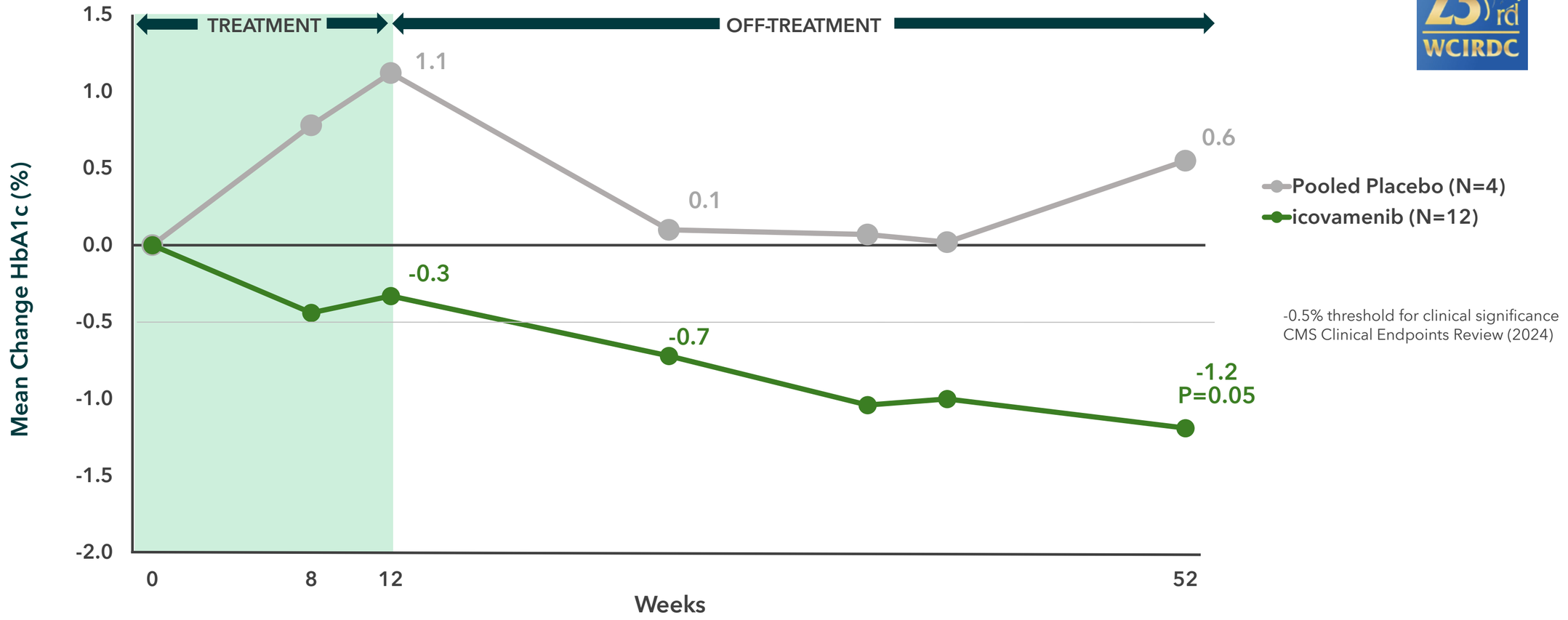
Icovamenib increased insulin secretion as measured by C-peptide index in severe insulin-deficient patients (arms B&C)



Data censored at onset of rescue medication, defined as any modification in antihyperglycemic therapy

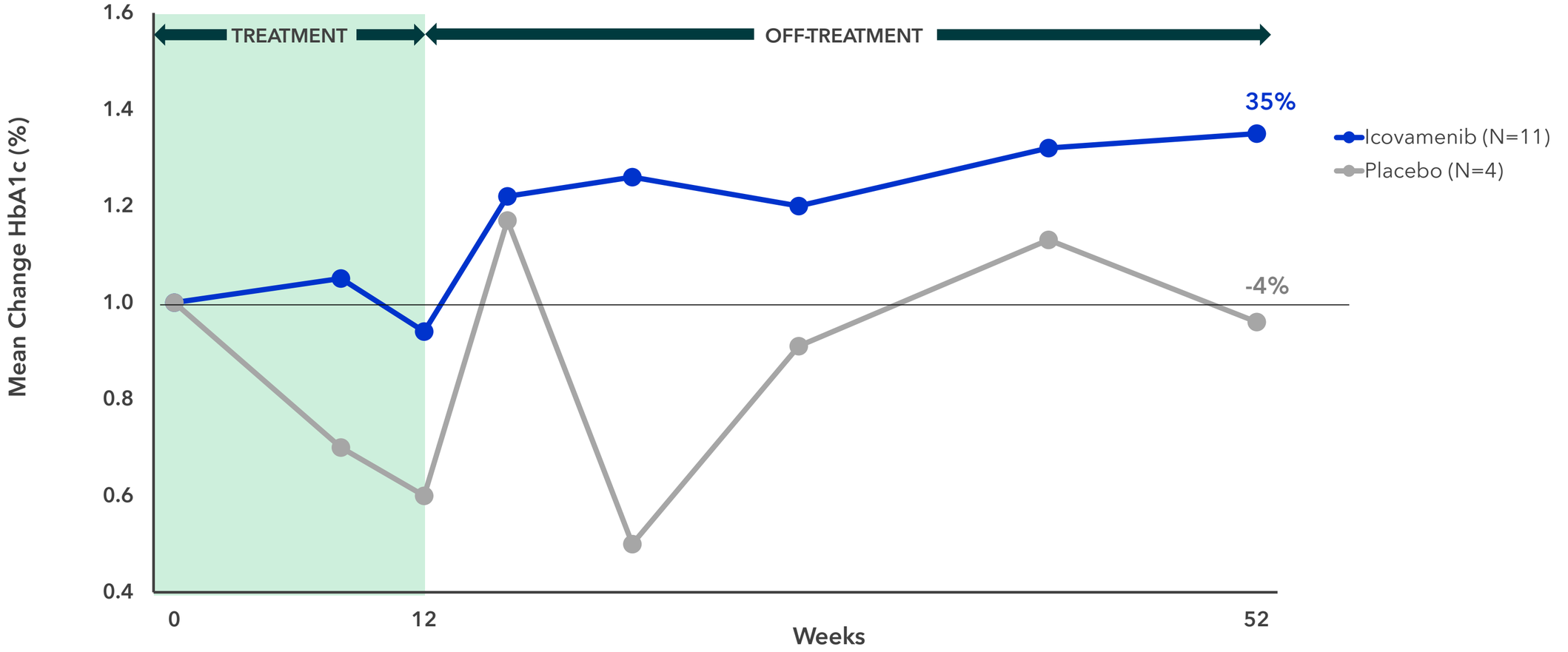
ICOVAMENIB

Patients on a GLP-1 based therapy at enrollment showed durable & clinically meaningful response in reduction of blood sugar (HbA1c)



ICOVAMENIB

Icovamenib increased insulin secretion as measured by C-peptide index in GLP-1 RA treated patients – 9 months post last dose



Data censored at onset of rescue medication, defined as any modification in antihyperglycemic therapy

ICOVAMENIB | COVALENT-111

Favorable 52-week safety profile

Parameter	Arm A icovamenib (N=67)	Arm B icovamenib (N=67)	Arm C icovamenib (N=67)	Combined Arms icovamenib (N=201)	Combined Arms placebo (N=66)
Patients with ≥1 TEAE, N (%)	19 (28)	22 (33)	14 (21)	55 (27)	18 (27)
Treatment-Related SAEs, N (%)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
SAEs*, N (%)	1 (1)	0 (0)	1 (1)	2 (1)	1 (1)
Treatment Discontinuation due to TEAE, N (%)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
Study Discontinuation due to TEAE, N (%)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
ALT increase, N (%)	3 (4)	0	2 (3)	5 (3)	0
AST increase, N (%)	3 (4)	0	1 (1)	4 (2)	0
Resolution of ALT/AST w/o treatment interruption (%)	100	100	100	100	N/A
Deaths, N (%)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)

Data are n (%) TEAE = Treatment Emergent Adverse event. SAE = Serious Adverse Event. Data are n (%) of TEAE with ≥5% frequency in any arm. ALT (alanine aminotransferase) or AST (aspartate aminotransferase) increase irrespective of incidence %.

*Arm A had an SAE of atrial fibrillation, unrelated to study treatment and occurred during the treatment period.

*Arm C had an SAE of COVID-19. Unrelated to study treatment and occurred during the treatment period.

*Placebo Arm had an SAE of nephrolithiasis. Unrelated to study treatment and occurred during the treatment period.

ALT increase: In the icovamenib arms, 4 of the 5 events were Grade 1 and 1 event was Grade 2.

AST increase: In the icovamenib arms, all 4 events were Grade 1.

All incidences of ALT and AST elevations resolved without interruption.

Note:
In AML studies icovamenib demonstrated a well-tolerated safety profile across all dose levels, with up to 500 mg QD / 325 mg BID, and dose durations extending over 1 year

Short treatment with icovamenib delivered HbA1c reductions comparable to chronic injectable & oral standards of care

Comparing icovamenib to currently approved type 2 diabetes agents with chronic dosing

THERAPY	DOSING REGIMEN	ADMINISTRATION ROUTE	OBSERVATION PERIOD	MEAN HbA1c REDUCTION (PLACEBO ADJ. %)
Ozempic (GLP-1 Agonist)	**Chronic dosing**	Injectable	Week 52 (SUSTAIN 8)	-1.5 (1mg)
Mounjaro (GLP-1/GIP Agonist)	**Chronic dosing**	Injectable	Week 40 (SURPASS 1)	-1.9 (5mg) -2.1 (15 mg)
Jardiance (SGLT2 Inhibitor)	**Chronic dosing**	Oral	Week 52 (Extension study)	-0.6 (10mg) -0.6 (25mg)
Januvia (DPP4 Inhibitor)	**Chronic dosing**	Oral	Week 52 (Sitagliptin)	-0.5 (100mg)
Icovamenib (menin inhibitor)	**12 weeks dosing**	**Oral**	**Week 52 (COVALENT-111)**	**-1.5% to -1.8%* (100 mg)**

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

*Icovamenib data are from a Phase II study in selected populations: insulin deficient diabetes patients and GLP-1 inadequate responders.

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.

Optimal dose, dose-duration, target population identified for phase IIb program

ICOVAMENIB

Phase IIa key derisking-insights:

- ✓ Optimal dose selected, 100 mg
- ✓ Food Effect Study confirmed optimal PK exposure of icovamenib within 30 minutes after a meal
- ✓ 12-week treatment observed to drive durable and lasting effects, no chronic treatment required
- ✓ Strong clinical activity in insulin-deficient and GLP-1 inadequate responder populations
- ✓ Treatment-emergent AEs comparable to placebo

Direct application in Phase II Studies

COVALENT-211

Phase II trial in type 2 insulin deficient diabetes patients failing standard of care

- Adult participants with T2D who were treated with 1-3 antidiabetic medications
- HbA1c 7.5%-10.5% and BMI ≤ 32 kg/m^2
- Background therapy maintained unless rescue required

COVALENT-212

Phase II trial in type 2 diabetes patients failing standard of care while on a GLP-1 RA

- Adult participants with T2D who are not achieving glycemic targets despite GLP-1-based therapy
- HbA1c ≥7.5% and ≤9.5% and BMI 25 to 40 kg/m^2
- Background therapy maintained unless rescue required

BMF-650

An investigational next-generation oral GLP-1 receptor agonist for obesity

Preclinical results and clinical overview

biomea FUSION™

Obesity remains inadequately controlled despite GLP-1 therapies, with millions discontinuing or failing treatment

Obesity is a chronic, progressive disease associated with cardiometabolic complications and increased mortality

42%

Of U.S. adults have obesity[1]

Obesity is a chronic disease characterized by excess adiposity and metabolic dysfunction. It is strongly associated with type 2 diabetes, cardiovascular disease, fatty liver disease, and certain cancers.

50-70%

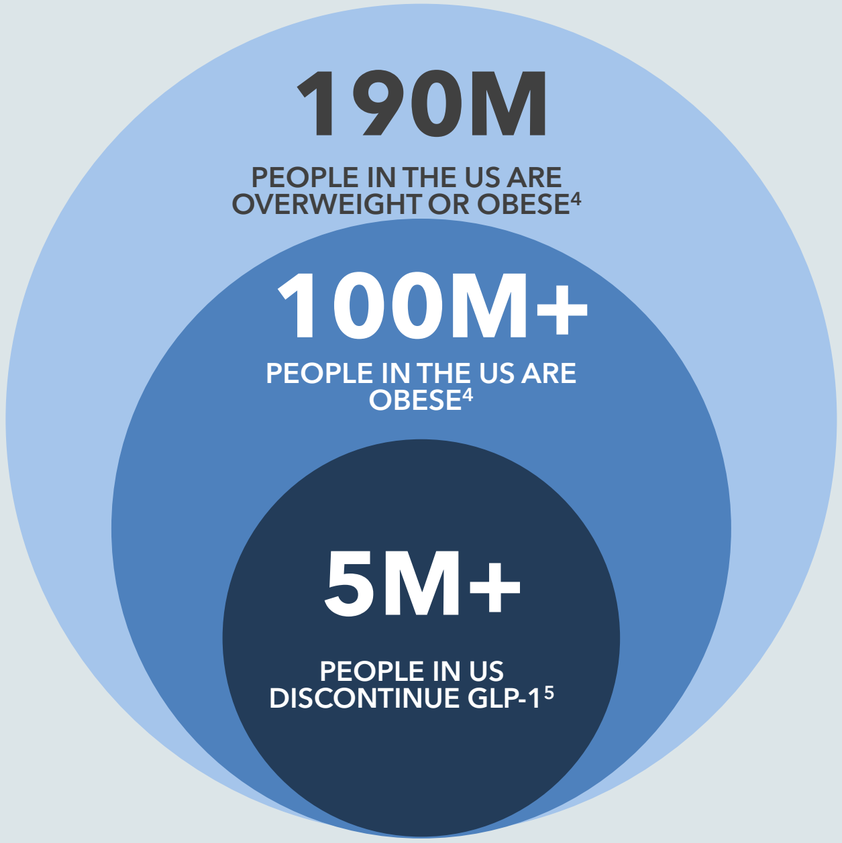
Of patients discontinue GLP-1 therapy within 12 months[2]

Real-world data show high discontinuation rates due to GI side effects, cost, access barriers, and tolerability challenges. Weight regain is common after discontinuation.

>60%

of adults with obesity have at least one obesity-related comorbidity[3]

Despite lifestyle interventions and approved pharmacotherapies, many patients discontinue treatment or fail to achieve sustained weight loss. Long-term disease modification remains an unmet need.



1. CDC Adult Obesity Facts, 2023
2. Real-world GLP-1 discontinuation analyses (claims database studies 2023–2024)
3. STEP and SURMOUNT program responder analyses
4. CDC National Health and Nutrition Examination Survey
5. IQVIA prescription data

BMF-650

Developed to deliver strong efficacy with improved oral tolerability

An Investigational Next-Generation Oral GLP-1 Receptor Agonist

Proposed differentiated properties of BMF-650

Improved PK Profile

Greater oral exposure with lower variability observed in preclinical studies

Generally Favorable Safety Profile

Better tolerability associated with higher plasma protein binding in preclinical models

Patient Friendly Design

Oral delivery with the potential for simplified dose escalation

Greater therapeutic window matters

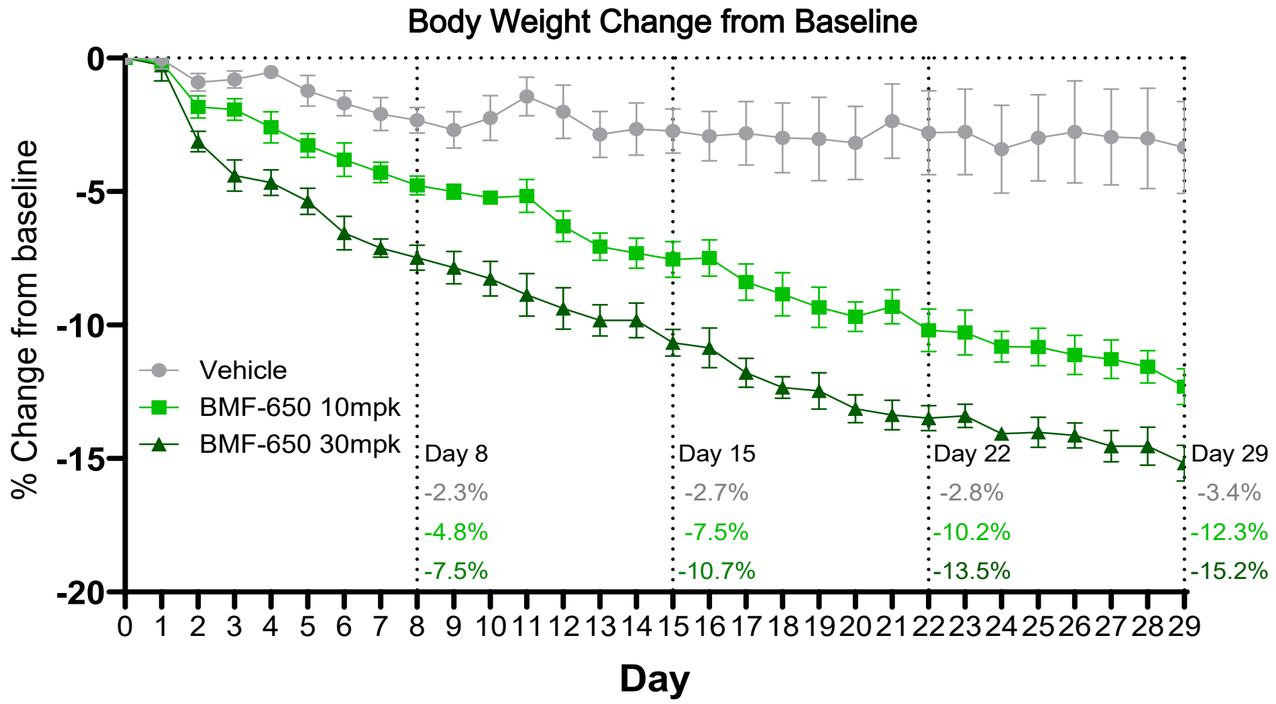
- Only 3 of 10 patients remain on GLP-1 therapy at one year due to tolerability, GI effects and complexity of use.
- An oral agent with improved tolerability could potentially expand the long-term use.

1. Khan, et al. JAMA 2024 doi:10.1001/jama.2024.22284.

BMF-650 demonstrated robust, dose dependent weight loss in obese monkeys

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

BMF-650 up to ~15% body weight reduction after 28-days



CT-996 body weight change

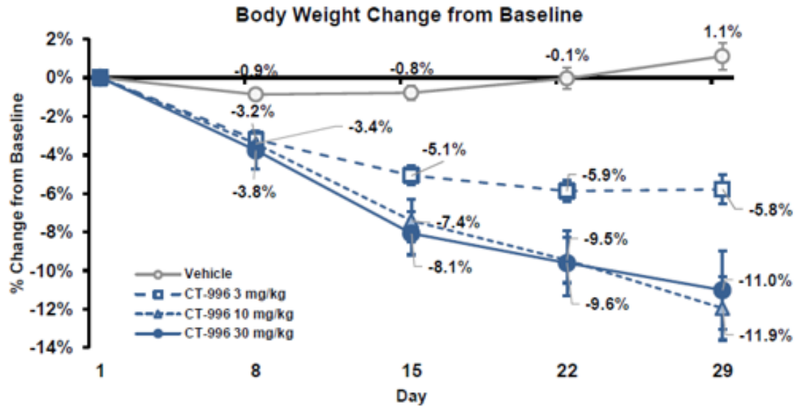


Figure 6. Effects of CT-996 on body weight in obese cynomolgus monkeys following once-daily oral administration. Weekly body weight percent change is represented as mean (± SE) from baseline. N = 6/group.

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

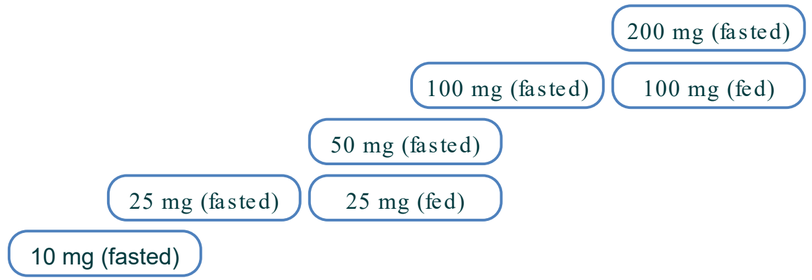
Disclaimer: No head-to-head studies of BMF-650 and CT-996 have been conducted. Comparing results from different preclinical studies may be unreliable due to differences in study designs, study endpoints, and other parameters.

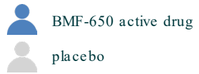
BMF-650 | GLP-131

A Randomized, Double -blind, Placebo -controlled, FIH Study of an Oral Non -peptide GLP -1 Receptor Agonist

Part 1 is a single ascending dose (SAD) study and Part 2 is a multiple ascending dose (MAD) study.

	Single Ascending Dose (SAD)	Multiple Ascending Dose (MAD)
Objectives	Safety and tolerability, PK, and food effect	Safety and tolerability, and efficacy (weight-loss)
Eligibility	Healthy overweight or obese patients (BMI 25.0–40.0 kg/m²)	Healthy overweight or obese patients (BMI 30.0–45.0 kg/m²)
Design	N=40 5 cohorts x 	N=40 4 cohorts x 





COHORT	7 DAYS → 7 DAYS → 7 DAYS → 21 DAYS
4	75 mg → 200 mg → 400 mg → 400 mg
3	75 mg → 150 mg → 300 mg → 300 mg
2	50 mg → 100 mg → 200 mg → 200 mg
1	10 mg → 25 mg → 50 mg → 100 mg

Body weight at Baseline versus Day 28 and Day 42 on treatment

Biomea pipeline

Biomea Fusion retains full worldwide rights across all programs and is currently funded through major catalysts into 1Q 2027

PROGRAM	INDICATION	PHASE I	PHASE II	PHASE III	UPCOMING MILESTONES
ICOVAMENIB Potential first-in-class oral menin inhibitor	**Type 1 diabetes** Patients - All comers *(>2M US Patients)* [1]	**COVALENT-112** (study completed)			52-week follow-up data of those patients who completed dosing expected **2Q 2026**
	Type 2 diabetes Patients with insulin deficiency *(~7M US Patients)* [2]	**COVALENT-211** (study initiated)			Phase II 26-week data (primary endpoint) anticipated **4Q 2026**
	Type 2 diabetes Patients not controlled on GLP-1 based therapies *(>3M US Patients)* [3,4]	**COVALENT-212** (study initiated)			Phase II 26-week data (primary endpoint) anticipated **4Q 2026**
BMF-650 Potential best-in-class oral GLP-1 RA	**Obesity** *(>100M US Patients)* [5]	**GLP-131** (study enrolling)			Phase I 28-day weight reduction data expected **2Q 2026**

1.National Diabetes Statistics Report, Accessed January 28, 2026
2. International Diabetes Federation. IDF Diabetes Atlas www.diabetesatlas.org (Based on company calculations)
3.NCHS Data Brief dated August 2025. Accessed January 28, 2026 (Based on company calculations)
4.Chitnis AS. Clinical effectiveness of liraglutide across body mass index in patients with type 2 diabetes in the United States: a retrospective cohort study. Adv Ther. 2014 Sep;31(9):986-99 (Based on company calculations)
5.National Center for Health Statistics August 2023. Accessed January 28, 2026

THANK YOU

(NASDAQ: BMEA)

For questions or inquiries, please reach out to Meichiel Weiss at ir@biomeafusion.com

www.biomeafusion.com

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