CORPORATE PRESENTATION

Leading the Next Era of Precision Medicine

August 12, 2026

FORWARD-LOOKING STATEMENTS

This presentation contains forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995. The words "believe," "may," "should," "will," "estimate," "plan," "continue," "anticipate," "intend," "expect," "potential," "vision" and similar expressions (including the negative thereof) are intended to identify forward-looking statements. Such statements include, but are not limited to, statements regarding the future operations, financial results and financial condition of Kura Oncology, Inc. ("Kura," "Kura Oncology," "we," "us" or "our"); Kura's value proposition; our research, preclinical and clinical development activities; plans, enrollment, development strategy and projected timelines for ziftomenib, darlifarnib, KO-7246 and other preclinical assets; the expected timing and presentation or publication of clinical and preclinical data; plans to initiate and report data from additional darlifarnib combination studies; expectations regarding the therapeutic, market and commercial potential of KOMZIFTI® and our product candidates, including the potential for ziftomenib to serve as a broadly combinable backbone across AML and for darlifarnib to serve as a combination platform across RCC and RAS-driven solid tumors; expectations regarding the launch, adoption, new patient starts, prescriptions, revenue growth and potential market leadership of KOMZIFTI; expectations regarding regulatory approvals and development in additional indications; anticipated cash runway and collaboration payments; and expectations regarding our collaboration with Kyowa Kirin. Because such statements are subject to risks and uncertainties, actual results may differ materially from those expressed or implied by such forward-looking statements. Factors that contribute to the uncertain nature of the forward-looking statements include: the risk that we may not achieve the value proposition we currently anticipate; risks associated with market competition, market acceptance and commercialization of KOMZIFTI; risks associated with the conduct of preclinical studies and clinical trials; the risk that we may not obtain access to compounds we seek to evaluate in combination with our product candidates; the potential for the U.S. Food and Drug Administration ("FDA") to disagree with our interpretation of clinical trial data, to require additional clinical trials or to require modifications to ongoing clinical trials; potential delays in the commencement, enrollment, completion or analysis of clinical testing, reporting of data or initiation of planned studies; significant issues regarding clinical trial design or execution that could result in increased costs and delays or limit our ability to obtain regulatory approval; the risk that our product candidates or additional indications may not receive regulatory approval; the potential for KOMZIFTI or our product candidates to have unexpected adverse side effects; risks that early clinical results, including preliminary response and durability data, may not be confirmed in larger or later-stage trials; the risk that the anticipated market opportunity for our product candidates may differ from our current expectations; the risk that we may not be able to obtain additional financing; and the risk that our collaboration with Kyowa Kirin may not be successful. Additional risks and uncertainties may emerge from time to time, and it is not possible for Kura's management to predict all risk factors and uncertainties.

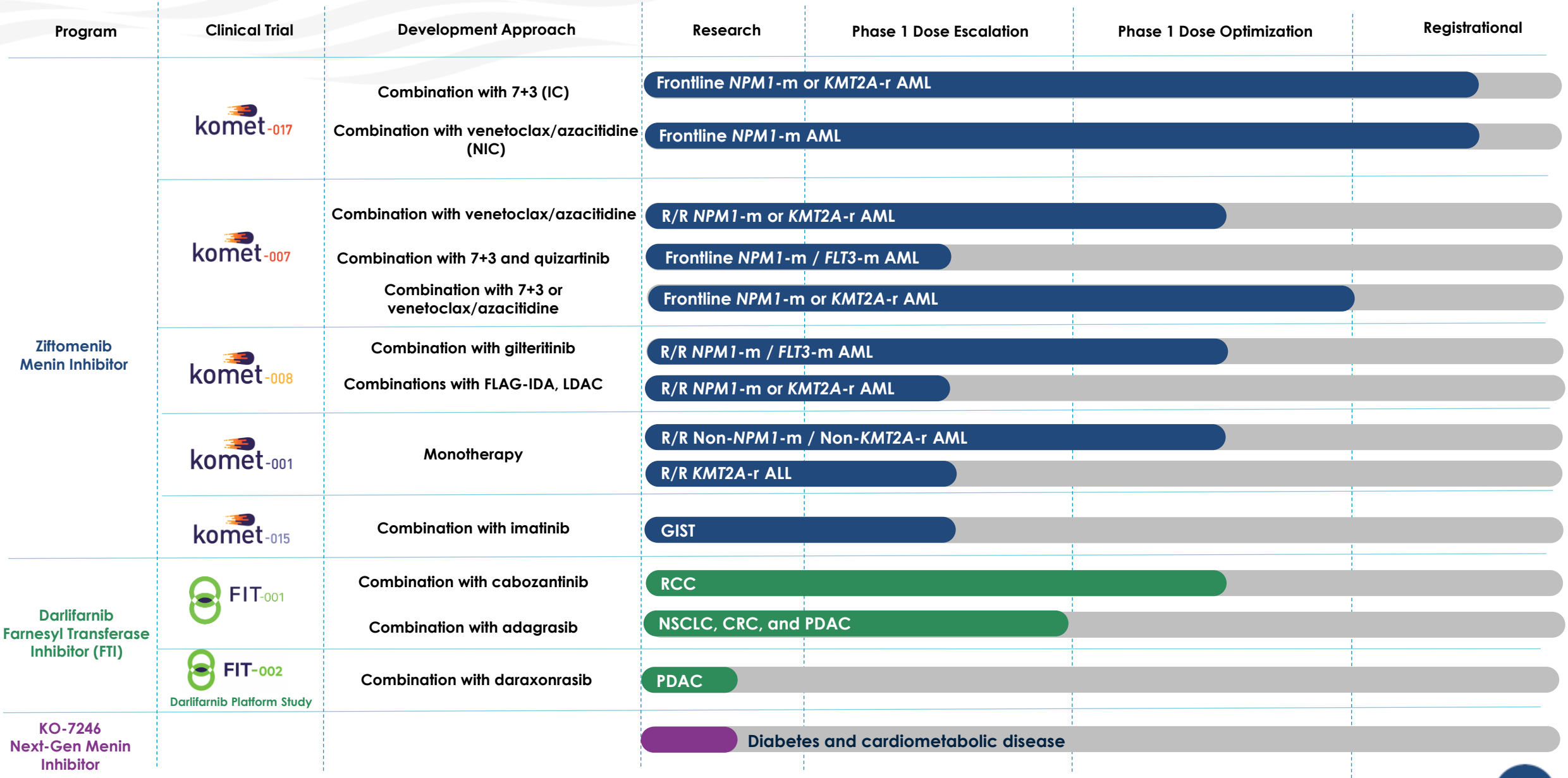
All forward-looking statements contained in this presentation speak only as of the date on which they were made. Other risks and uncertainties affecting us are described more fully in our filings with the Securities and Exchange Commission ("SEC"). We undertake no obligation to update such statements to reflect events that occur or circumstances that exist after the date on which they were made.

This presentation may also contain statistical, preclinical and clinical data obtained from and prepared by third parties. The recipient is cautioned not to give undue weight to such disclosures. Neither Kura nor any other person makes any representation as to the accuracy or completeness of such data or undertakes any obligation to update such data after the date of this presentation.

KURA ONCOLOGY HAS A COMPELLING VALUE PROPOSITION IN 2026

- KOMZIFTI® (ziftomenib) approved for adult patients with relapsed/refractory *NPM1*-mutated AML
- Robust new patient starts and early launch momentum
- Advancing ziftomenib to address up to 50% of AML patients
- Multiple 2026 readouts expected to support ziftomenib as a broadly combinable AML backbone
- Proof-of-concept data position darlifarnib as a foundational backbone therapy in RCC and RAS-driven solid tumors
- Strong Financial Position: $519.0 million in cash and investments as of 6/30/26, plus $180 million in anticipated payments

ADVANCING TWO CORE STRATEGIC PIPELINE ASSETS



The investigational agents and investigational uses of marketed products identified above have not been approved by the U.S. Food and Drug Administration (FDA). Safety and efficacy have not been established.
Progress bars indicate the stage of development based on ongoing or completed activities. A partial bar indicates a phase in progress; a full bar indicates completion of a phase. Bars do not represent scale, duration, or likelihood of success.

2026: BUILDING A FOUNDATION FOR CONTINUED LONG-TERM GROWTH

2026 PRIORITIES

- Execute KOMZIFTI launch to establish market leadership in R/R *NPM1*-m AML
- Drive comprehensive data generation strategy in combination and 1L AML Ph 3 study execution
- Confirm POC of darlifarnib combinations in RCC, CRC, PDAC, NSCLC, and other solid tumors
- Advance additional preclinical assets to expand portfolio

2030+ VISION

- **Establish KOMZIFTI as standard of care in menin-driven AML**
- **Achieve multiple product approvals in major disease areas**
- **Expand commercial franchise beyond AML**
  - ***Darlifarnib in RCC, PDAC, NET, and RAS- and PI3K-driven solid tumors***
  - ***Ziftomenib + imatinib in GIST***
- **Realize multi-billion-dollar revenue potential; retain key strategic rights**

STRATEGIC COLLABORATION WITH KYOWA KIRIN POSITIONS KURA TO UNLOCK THE FULL VALUE OF ZIFTOMENIB AND PIPELINE

- Kura retains **leadership and key strategic rights** to ziftomenib in the U.S. to preserve strategic flexibility
- 50/50 U.S. co-development/co-promote with Kura booking 100% U.S. sales and leading commercial strategy and global development
- Enables **broad development and commercialization**, including 1L fit/unfit, combos with targeted therapies, and maintenance setting

KURA ONCOLOGY | Kyowa KIRIN

FINANCIAL HIGHLIGHTS AND OUTLOOK

Well-capitalized to support KOMZIFTI commercial launch and pipeline advancement

- $9.1 million of KOMZIFTI net product revenue in 2Q 2026, up 57% over 1Q 2026
- $519.0 million in cash, cash equivalents and short-term investments as of June 30, 2026
- Cash, cash equivalents and short-term investments as of June 30, 2026, together with anticipated collaboration payments under the agreement with Kyowa Kirin, are expected to fund the ziftomenib AML program through the topline results from the first pivotal Phase 3 KOMET-017 frontline trial, anticipated in 2028

FDA APPROVED

komzifti™
ziftomenib
200 mg capsules

Please see additional Important Safety Information and full Prescribing Information, including Boxed Warning.

komzifti™
(ziftomenib)
200 mg capsules

2Q 2026: KOMZIFTI ACHIEVES MAJORITY SHARE OF NEW PATIENT STARTS IN SECOND FULL QUARTER OF LAUNCH

Majority share in menin inhibitor class

~115
new patient starts
+35% vs 1Q 2026

250+
total prescriptions
+59% vs 1Q 2026

$9.1 M net product revenue
+57% vs 1Q 2026

First and only once-daily targeted therapy for adults with R/R *NPM1*-m AML

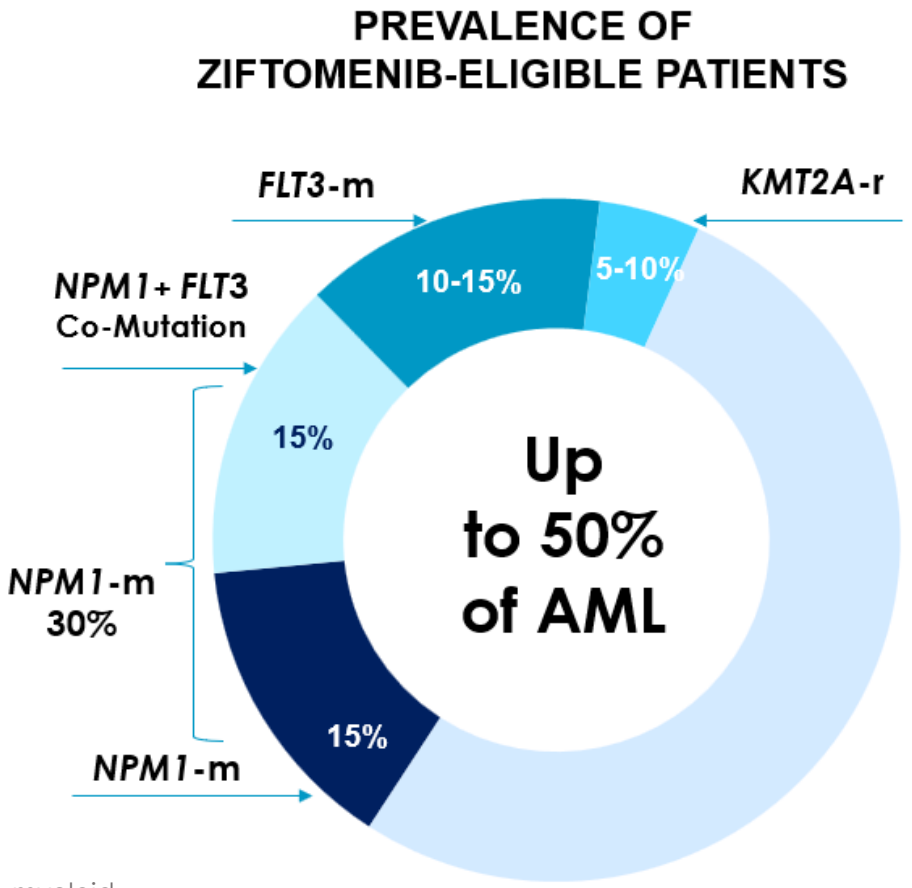
Please see additional Important Safety Information and full Prescribing Information, including Boxed Warning.

UP TO 50% OF AML PATIENTS MAY BENEFIT FROM MENIN INHIBITOR THERAPY

22,010 new cases of AML diagnosed in the U.S. each year[1]

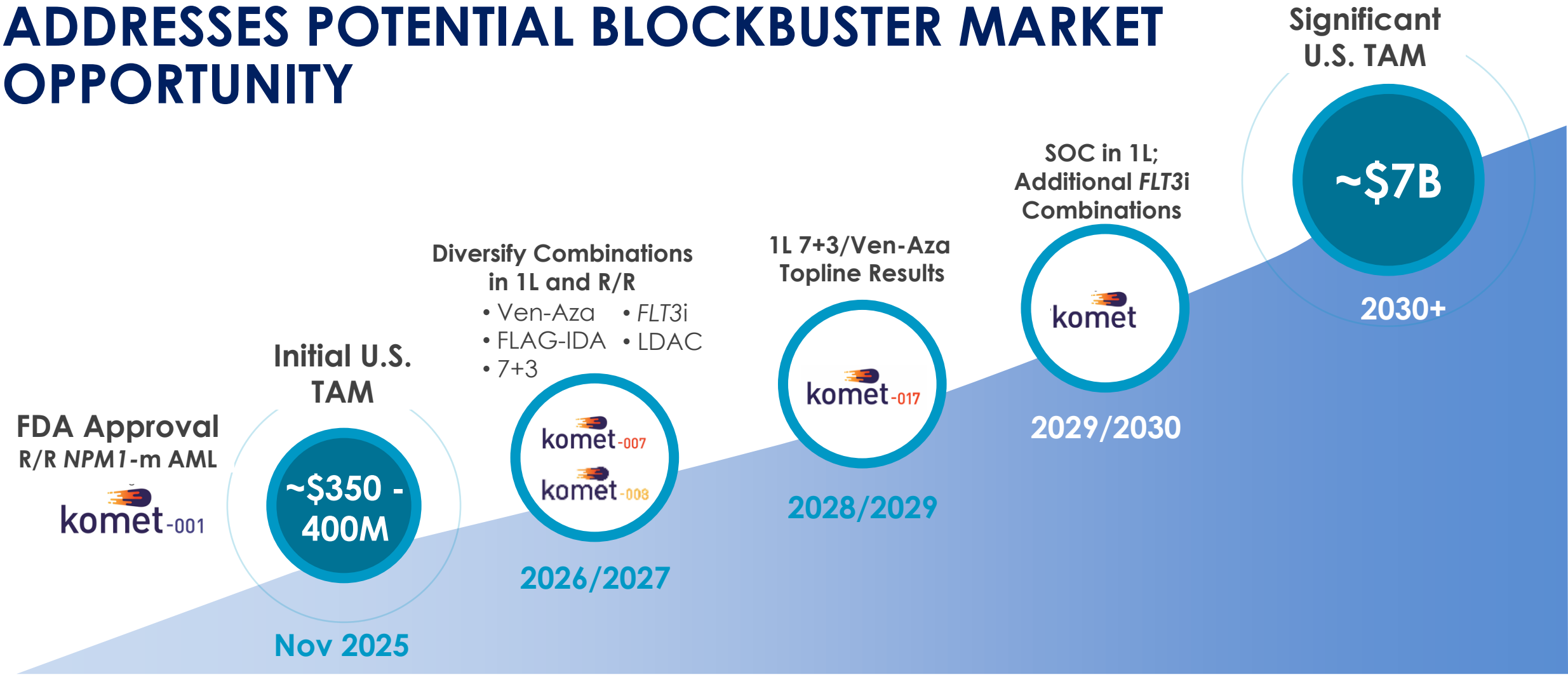
AML is characterized by significant genetic heterogeneity due to driver mutations, including *NPM1*-m, *FLT3*-m, *IDH1/2*-m and *KMT2A*-r[2,3]

NPM1 mutations are observed in 30% to 35% of cases and are an important upstream driver mutation that uses the menin pathway[4,5]



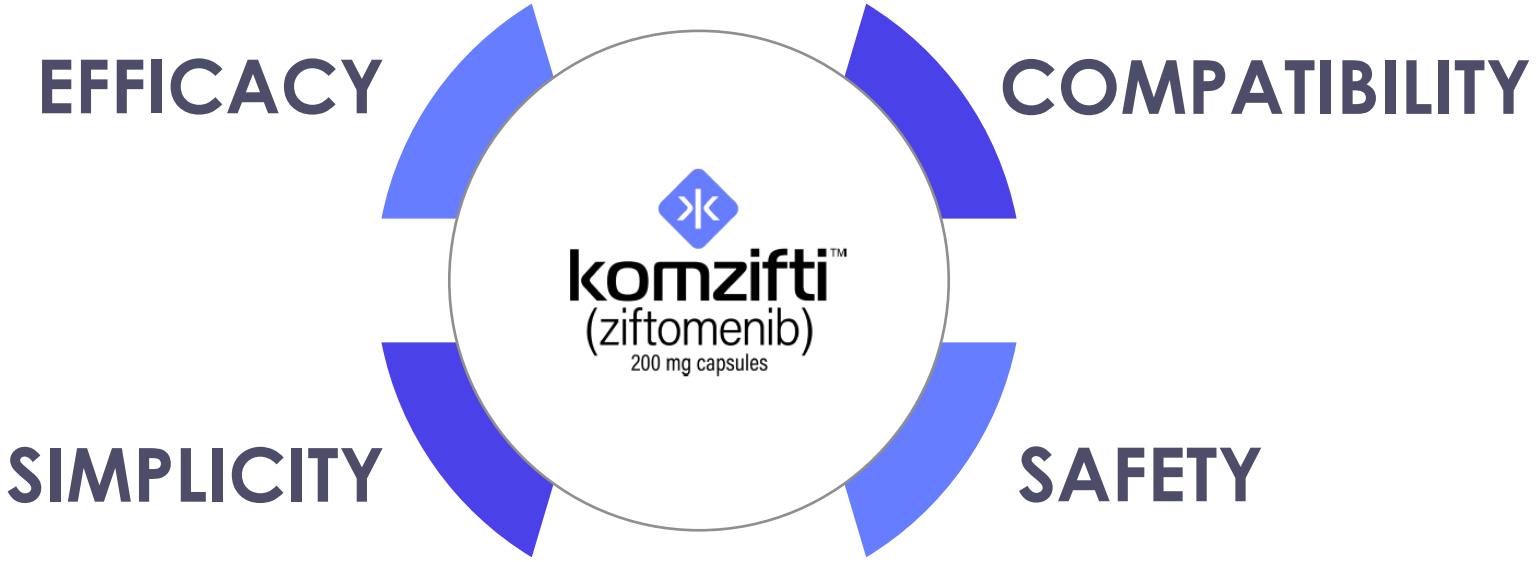
1. American Cancer Society. Updated December 27, 2025. https://www.cancer.org/cancer/types/acute-myeloid-leukemia/about/key-statistics.html. 2. Papaemmanuil *et al. N. Engl. J. Med.* 2016; 374(23):2209-2221; doi:10.1056/NEJMoa1516192. 3. The Cancer Genome Atlas Research Network. *N. Engl. J. Med.* 2013; 368(22):2059-2074; doi:10.1056/NEJMoa1301689. 4. Burrows *et al.* Poster presented at: AACR-NCI-EORTC International Conference on Molecular Targets and Cancer Therapeutics: Discovery, Biology, and Clinical Applications; October 26-30, 2017; Philadelphia, PA. 5. Falini and Dillon. *Blood Cancer Discov.* 2024; 5(1):8-20.

COMPREHENSIVE DEVELOPMENT STRATEGY ADDRESSES POTENTIAL BLOCKBUSTER MARKET OPPORTUNITY



KOMZIFTI'S DIFFERENTIATED PROFILE

KOMZIFTI is indicated for the treatment of adult patients with relapsed or refractory acute myeloid leukemia (AML) with a susceptible nucleophosmin 1 (*NPM1*) mutation who have no satisfactory alternative treatment options.



Please see additional Important Safety Information and full Prescribing Information, including Boxed Warning.

INVESTIGATING ZIFTOMENIB ACROSS THE AML CONTINUUM

RELAPSED / REFRACTORY

IC or NIC Therapy or Tolerable Therapy

Transplant/ No Transplant

Targeted Therapy in *FLT3*-m, *IDH1*/2-m and/or *NPM1*-m

Non-Intensive Therapy/ Palliative Care

komet ACUTE LEUKEMIAS

KOMET-001
NPM1-m AML
KMT2A-r ALL
Non-*NPM1*-m / Non-*KMT2A*-r AML

KOMET-007
Zifto + Ven/Aza
Zifto + Ven Only

KOMET-008
Zifto + FLAG-IDA
Zifto + LDAC
Zifto + gilt

1L TREATABLE

IC or NIC Therapy

Transplant/ No Transplant

Post-Transplant/ Consolidation Maintenance

komet ACUTE LEUKEMIAS

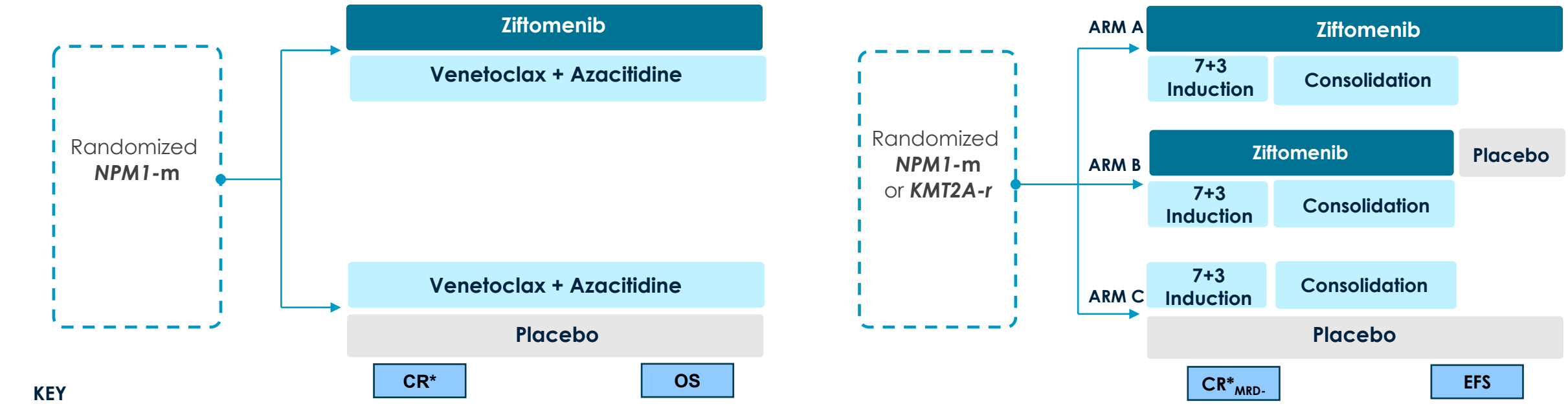
KOMET-007
Zifto + Ven/Aza
Zifto + 7+3
Zifto + 7+3 + quiz

KOMET-017-IC
Zifto + 7+3
Placebo + 7+3

KOMET-017-NIC
Zifto + Ven/Aza
Placebo + Ven/Aza

Investigator/Company-Sponsored Studies Across Adult and Pediatric Hematologic Malignancies

KOMET-017 PROVIDES TREATMENT OPTIONS TO BROAD FRONTLINE AML PATIENT POOL



* Dual primary endpoint with potential for U.S. accelerated approval.

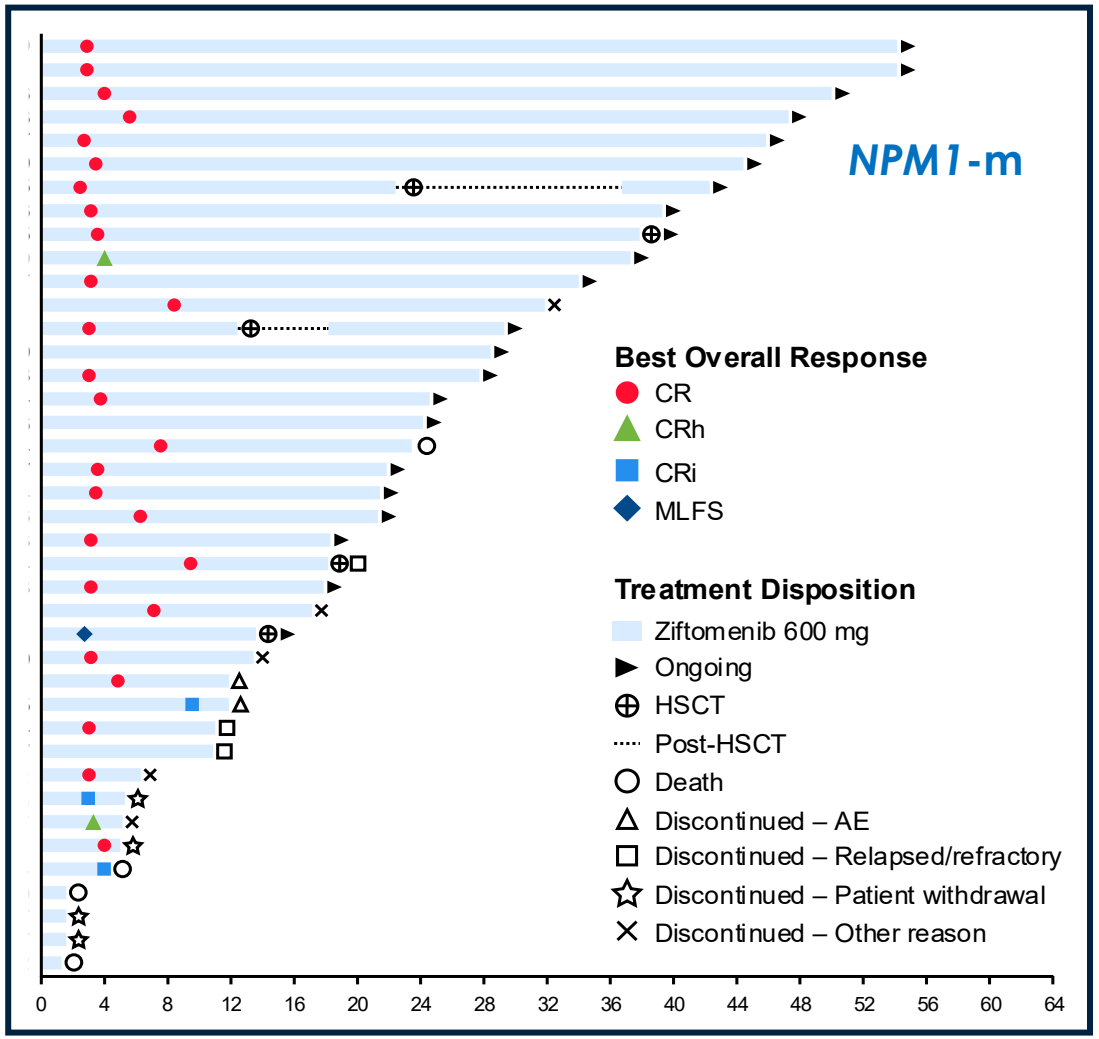
Ziftomenib in Combination with Venetoclax and Azacitidine in Newly Diagnosed *NPM1*-m Acute Myeloid Leukemia: Phase 1b Results from KOMET-007

Gail J. Roboz, MD[1], Eunice S. Wang, MD[2], Amir T. Fathi, MD[3], Harry Erba, MD, PhD[4], Keith W. Pratz, MD[5], Guru Subramanian Guru Murthy, MD, MS[6], Leonard C. Alsfeld, MD[7], James S. Blachly, MD[8], Kiran Naqvi, MD[9], Ghayas C. Issa, MD[10], Ayman Qasrawi, MD[11], Stephen A. Strickland, MD[12], Neil D. Palmisiano, MDMS[13], Jessica K. Altman, MD[14], Cecilia Arana Yi, MD[15], Grerk Sutamtewagul, MD[16], Yazan F. Madanat, MD[17], Suresh Kumar Balasubramanian, MD[18], Christine M. McMahon, MD[19], Hongling Zhang, MS[20], Tianle Chen, PhD[20], Marcie Riches, MD[20], Daniel Corum, PhD[20], Mollie Leoni, MD[20], Amer M. Zeidan, MBBS, MHS[21]

[1]Weill Cornell Medicine and The New York Presbyterian Hospital, New York, NY; [2]Roswell Park Comprehensive Cancer Center, Buffalo, NY; [3]Massachusetts General Hospital, Harvard Medical School, Boston, MA; [4]Duke Cancer Institute, Durham, NC; [5]Abramson Cancer Center, University of Pennsylvania, Philadelphia, PA; [6]Froedtert & Medical College of Wisconsin, Milwaukee, WI; [7]Ochsner MD Anderson Cancer Center, New Orleans, LA; [8]The Ohio State University Comprehensive Cancer Center, Columbus, OH; [9]Chao Family Comprehensive Cancer Center, University of California Irvine Health, Orange, CA; [10]Department of Leukemia, The University of Texas MD Anderson Cancer Center, Houston, TX; [11]Department of Internal Medicine, University of Kentucky, Lexington, KY; [12]SCRI at TriStar Centennial, Nashville, TN; [13]Rutgers Cancer Institute of New Jersey, New Brunswick, NJ; [14]Robert H. Lurie Comprehensive Cancer Center, Northwestern University, Chicago, IL; [15]Division of Hematology and Oncology, Mayo Clinic, Phoenix, AZ; [16]University of Iowa Health Care, Holden Comprehensive Cancer Center, Iowa City, IA; [17]The University of Texas Southwestern Medical Center, Dallas, TX; [18]Karmanos Cancer Institute, Wayne State University, Detroit, MI; [19]Anschutz Medical Campus, Division of Hematology, University of Colorado School of Medicine, Aurora, CO; [20]Kura Oncology, Inc., San Diego, CA; [21]Yale University and Yale Comprehensive Cancer Center, New Haven, CT

Presented at the 67th American Society of Hematology (ASH) Annual Meeting and Exposition on December 6–9, 2025 in Orlando, FL. Presentation ID 766.

DURATION OF TREATMENT & PRELIMINARY CLINICAL OUTCOMES IN 1L *NPM1*-m AML (VEN/AZA COMBINATION)



After a median follow-up of 26.1 weeks (range 1.6–54.1):

- Median duration of CR **not reached**[a]
- Median OS **not reached**[a]
- 5 *NPM1*-m patients underwent HSCT, and 3 went onto ziftomenib maintenance
- 68% (27/40) of patients remained alive and continued on-study[b]

N=40
Data cutoff: Sep 24, 2025.
[a] Among response-evaluable patients; [b] Patients on-treatment or in long-term follow-up.

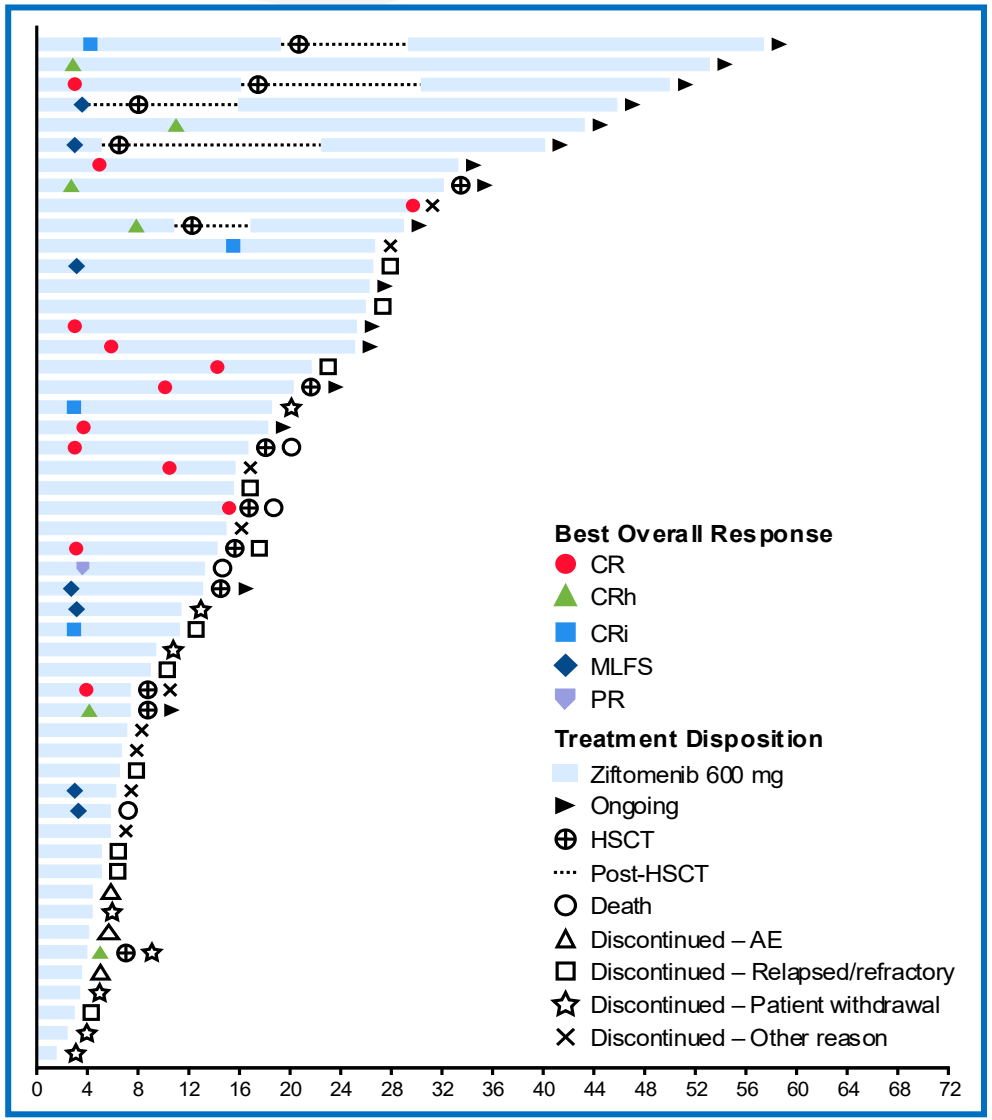
Ziftomenib in Combination with Venetoclax and Azacitidine in Relapsed/Refractory *NPM1*-m or *KMT2A*-r Acute Myeloid Leukemia: Updated Phase 1a/b Safety and Clinical Activity Results from KOMET-007

Ghayas C. Issa, MD[1], Amir T. Fathi, MD[2], Amer M. Zeidan, MBBS, MHS[3], Harry Erba, MD, PhD[4], Gail J. Roboz, MD[5], Jessica K. Altman, MD[6], Keith W. Pratz, MD[7], Mark B. Juckett, MD, MHCM[8], Tara L. Lin, MD[9], Suresh Kumar Balasubramanian, MD[10], Anjali S. Advani, MD[11], Gary J. Schiller, MD[12], Neil D. Palmisiano, MDMS[13], Marcello Rotta, MD[14], Stephen A. Strickland, MD[15], Christine M. McMahon, MD[16], Yazan F. Madanat, MD[17], Talha Badar, MBBS, MD[18], Mohamad Khawandanah, MD[19], George Yaghmour, MD[20], James McCloskey, MD[21], James K. Mangan, MD, PhD[22], Antoine N. Saliba, MD[23], Ivana Gojo, MD[24], Diaa Osman, DO, MPH[25], Hongling Zhang, MS[26], Ying Tian, PhD[26], Marcie Riches, MD[26], Daniel Corum, PhD[26], Mollie Leoni, MD[26], Eunice S. Wang, MD[27]

[1]Department of Leukemia, The University of Texas MD Anderson Cancer Center, Houston, TX; [2]Massachusetts General Hospital, Harvard Medical School, Boston, MA; [3]Yale University and Yale Comprehensive Cancer Center, New Haven, CT; [4]Duke Cancer Institute, Durham, NC; [5]Weill Cornell Medicine and The New York Presbyterian Hospital, New York, NY; [6]Robert H. Lurie Comprehensive Cancer Center, Northwestern University, Chicago, IL; [7]Abramson Cancer Center, University of Pennsylvania, Philadelphia, PA; [8]Department of Hematology, University of Minnesota, Minneapolis, MN; [9]The University of Kansas Medical Center, Kansas City, KS; [10]Karmanos Cancer Institute, Wayne State University, Detroit, MI; [11]Taussig Cancer Institute, Cleveland Clinic, Cleveland, OH; [12]David Geffen School of Medicine at UCLA, Los Angeles, CA; [13]Rutgers Cancer Institute of New Jersey, New Brunswick, NJ; [14]Colorado Blood Cancer Institute, Denver, CO; [15]SCRI at TriStar Centennial, Nashville, TN; [16]Anschutz Medical Campus, Division of Hematology, University of Colorado School of Medicine, Aurora, CO; [17]The University of Texas Southwestern Medical Center, Dallas, TX; [18]Mayo Clinic, Jacksonville, FL; [19]University of Oklahoma Health Sciences Center, Stephenson Cancer Center, Oklahoma City, OK; [20]University of Southern California Norris Comprehensive Cancer Center, Los Angeles, CA; [21]John Theurer Cancer Center, Hackensack University Medical Center, Hackensack, NJ; [22]UC San Diego Moores Cancer Center, La Jolla, CA; [23]Mayo Clinic, Rochester, MN; [24]Sidney Kimmel Comprehensive Cancer Center, Johns Hopkins University School of Medicine, Baltimore, MD; [25]Texas Oncology, Lakeway, TX; [26]Kura Oncology, Inc., San Diego, CA; [27]Roswell Park Comprehensive Cancer Center, Buffalo, NY

Presented at the 67th American Society of Hematology (ASH) Annual Meeting and Exposition on December 6–9, 2025 in Orlando, FL. Presentation ID 764.

DURATION OF TREATMENT & PRELIMINARY CLINICAL OUTCOMES IN R/R *NPM1*-m AML (VEN/AZA COMBINATION)



After a median follow-up of 27.4 weeks (range 3.3–69.1):

- Median duration of CRc **39.9 weeks** (95% CI 16.1–NE)
  - Ven-naïve: 39.9 weeks (95% CI 12.9–NE)
- 14 *NPM1*-m patients received HSCT, and 5 went onto ziftomenib maintenance
- Median OS **54.9 weeks** (95% CI 32.0–NE)

N=51
600 mg
Data cutoff: Sep 24, 2025.

DEEP AND DURABLE RESPONSES REPORTED WITH ZIFTOMENIB AND VEN/AZA IN R/R *NPM1*-m AML

RESEARCH ARTICLE | JUNE 2, 2026

Ziftomenib with venetoclax and azacitidine in relapsed/refractory NPM1-mutated acute myeloid leukemia

Clinical Trials & Observations

Eunice S. Wang, Harry P. Erba, Amer M. Zeidan, Gail J. Roboz, Jessica K. Altman, Anjali S. Advani, Tara L. Lin, Stephen A. Strickland, Mark B. Juckett, Keith W. Pratz, James K. Mangan, Christine M. McMahon, Leonard Clarkson Alsfeld, Suresh Kumar Balasubramanian, Guru Subramanian Guru Murthy, Marcello Rotta, Neil Palmisiano, James McCloskey, Antoine N Saliba, Mohamad Khawandanah, Yazan F. Madanat, Kiran Naqvi, Ayman H. Qasrawi, Gary J. Schiller, Talha Badar, Ivana Gojo, George Yaghmour, Diaa Osman, Hongling Zhang, Ying Tian, Harris S. Soifer, Marcie Riches, Daniel Corum, Mollie Leoni, Amir T. Fathi, Ghayas C. Issa

https://doi.org/10.1182/blood.2026034043

FINDINGS REPORTED IN *BLOOD* STRENGTHEN CASE FOR ZIFTOMENIB AS A BACKBONE IN *NPM1*-m AML

	Venetoclax-naïve patients	Venetoclax-experienced patients
ORR	87% (20/23)	48% (12/25)
CRc	70% (16/23)	24% (6/25)
CRc Median DOR	9.2 months (95% CI, 5.8-NE)	8.6 months (95% CI, 1.6-NE)
Median OS	Not reached (N=25)	7.4 months (N=26)
Median Follow Up	10.7 months	9.9 months

***Historical benchmark with venetoclax:**
- ORR: 6-23%
- Median OS: 3-6 months

- Ziftomenib 600 mg once daily combined with venetoclax/azacitidine demonstrated **deep molecular responses** and **durable responses** in R/R *NPM1*-m AML
- **Combination was well tolerated**, with low rates of differentiation syndrome and QTc prolongation observed

Data cutoff: April 15, 2025
*https://doi.org/10.1182/blood.2026034043 (and cited references therein)

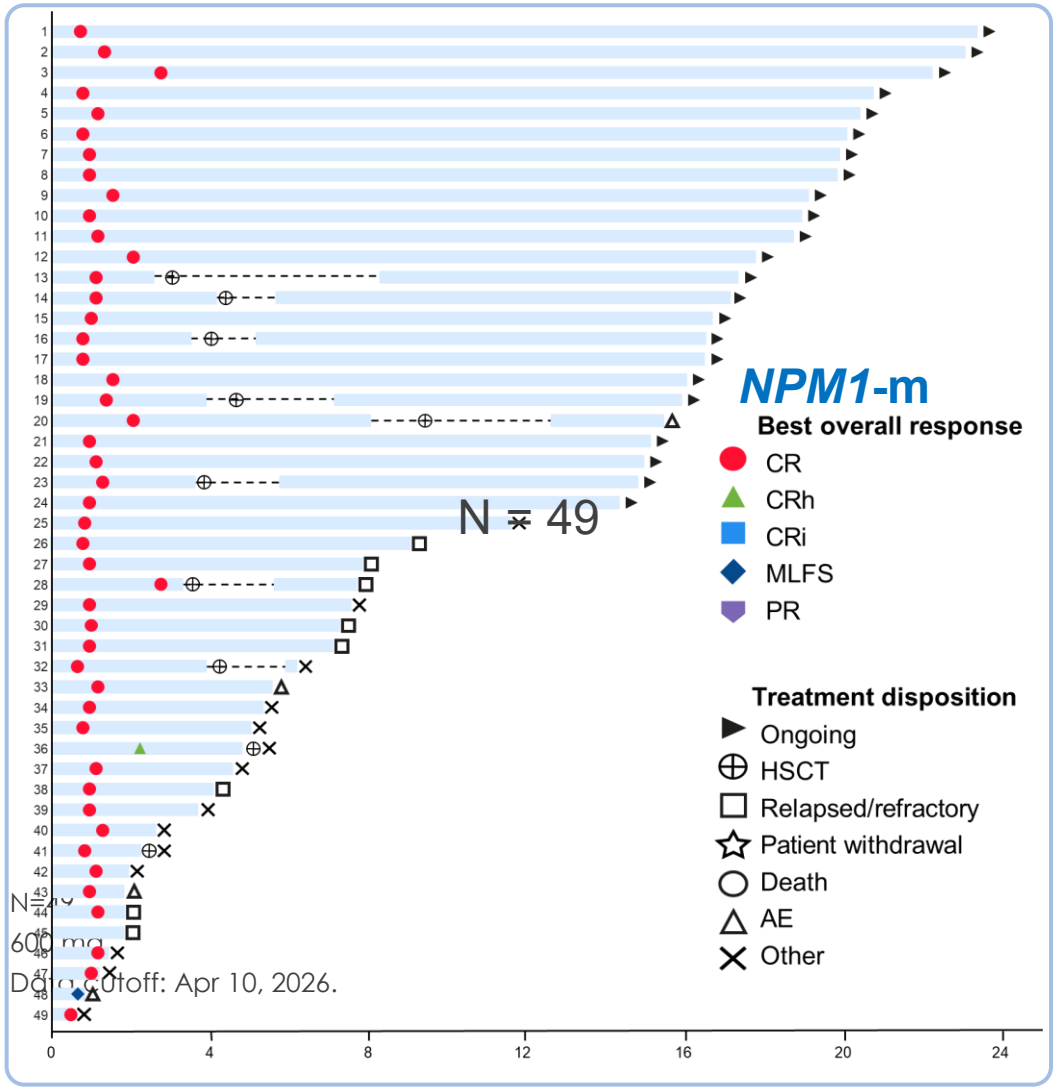
Ziftomenib Combined With Intensive Induction (7+3) for Newly Diagnosed *NPM1*-m or *KMT2A*-r Acute Myeloid Leukemia (AML): Long-Term Results From the KOMET-007 Trial

Amer M Zeidan[1], Eunice Wang[2], Harry Erba[3], Stephen Strickland[4], Ghayas Issa[5], Suresh K Balasubramanian[6], Gail J Roboz[7], Christine McMahon[8], Marcello Rotta[9], Yazan Madanat[10], Keith Pratz[11], James S Blachly[12], Tara F Lin[13], Gary Schiller[14], Talha Badar[15], Ivana Gojo[16], Jessica K Altman[17], James Mangan[18], Mark Juckett[19], Kiran Naqvi[20], Anjali Advani[21], Leonard C. Alsfeld[22], Jorge Cortes[23], Mohamad Khawandanah[24], Kalyan Nadiminti[25], Hongling Zhang[26], Tianle Chen[26], Valerie Chamberlain Santos[26], Marcie Riches[26], Daniel Corum[26], Mollie Leoni[26], and Amir T Fathi[27]

[1]Yale University and Yale Comprehensive Cancer Center, New Haven, CT, USA; [2]Roswell Park Comprehensive Cancer Center, Buffalo, NY, USA; [3]Duke Cancer Institute, Durham, NC, USA; [4]SCRI at TriStar Centennial, Nashville, TN, USA; [5]Department of Leukemia, The University of Texas MD Anderson Cancer Center, Houston, TX, USA; [6]Karmanos Cancer Institute, Wayne State University, Detroit, MI, USA; [7]Weill Cornell Medicine and The New York Presbyterian Hospital, New York, NY, USA; [8]Anschutz Medical Campus, Division of Hematology, University of Colorado School of Medicine, Aurora, CO, USA; [9]Colorado Blood Cancer Center, Denver, CO, USA; [10]The University of Texas Southwestern Medical Center, Dallas, TX, USA; [11]Abramson Cancer Center, University of Pennsylvania, Philadelphia, PA, USA; [12]The Ohio State University Comprehensive Cancer Center, Columbus, OH, USA; [13]University of Kansas Medical Center, Kansas City, KS, USA; [14]David Geffen School of Medicine at UCLA, Los Angeles, CA, USA; [15]Mayo Clinic, Jacksonville, FL, USA; [16]Sidney Kimmel Comprehensive Cancer Center, Johns Hopkins University School of Medicine, Baltimore, MD, USA; [17]Robert H. Lurie Comprehensive Cancer Center, Northwestern University, Chicago, IL, USA; [18]Moores Cancer Center, University of California, San Diego, CA, USA; [19]Department of Hematology, University of Minnesota, Minneapolis, MN, USA; [20]Chao Family Comprehensive Cancer Center, University of California Irvine Health, Orange, CA, USA; [21]Cleveland Clinic, Cleveland, OH, USA; [22]Ochsner MD Anderson Cancer Center, New Orleans, LA, USA; [23]Georgia Cancer Center, Augusta, GA, USA; [24]University of Oklahoma Health Sciences Center, Stephenson Cancer Center, Oklahoma City, OK, USA; [25]Carbone Cancer Center, University of Wisconsin-Madison, Madison, WI, USA; [26]Kura Oncology, Inc., San Diego, CA, USA; [27]Massachusetts General Hospital, Harvard Medical School, Boston, MA, USA

Presented at the European Hematology Association (EHA) 2026 Congress | June 11–14, 2026 | Stockholm, Sweden

DURATION OF TREATMENT AND CLINICAL OUTCOMES: *NPM1*-m

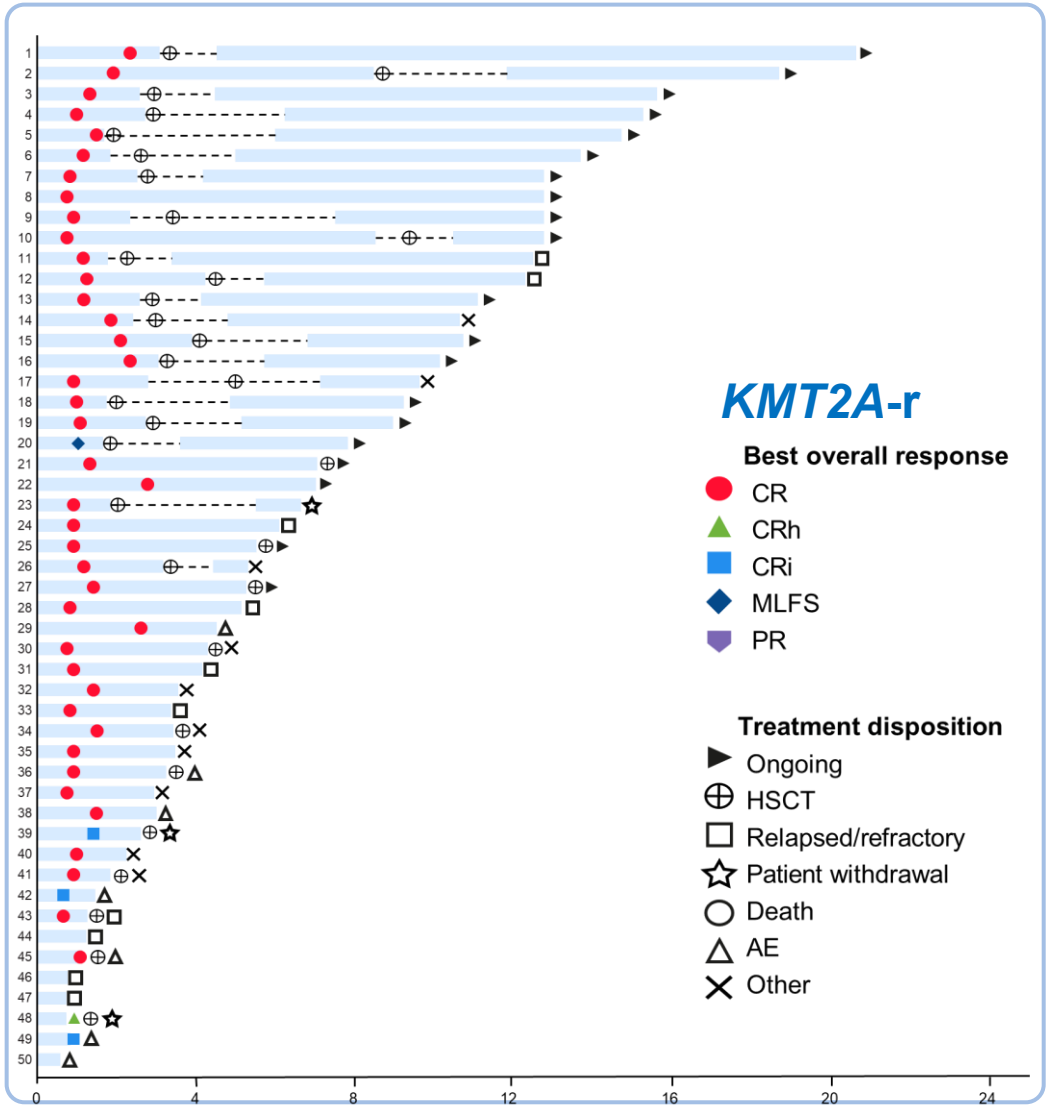


After a median follow-up of 17.6 months (range 1.0–23.5):

- Median duration of CR was **not reached**
  - 80% duration of CR at 12 months
- 10 *NPM1*-m patients received HSCT
- 31 *NPM1*-m patients entered maintenance treatment
  - 8 after on-study HSCT
  - 23 without on-study HSCT
- 8 discontinued due to relapse/refractory
- 4 discontinued due to AEs (1 ziftomenib-related)

Duration of treatment (months)

DURATION OF TREATMENT AND CLINICAL OUTCOMES: *KMT2A*-r



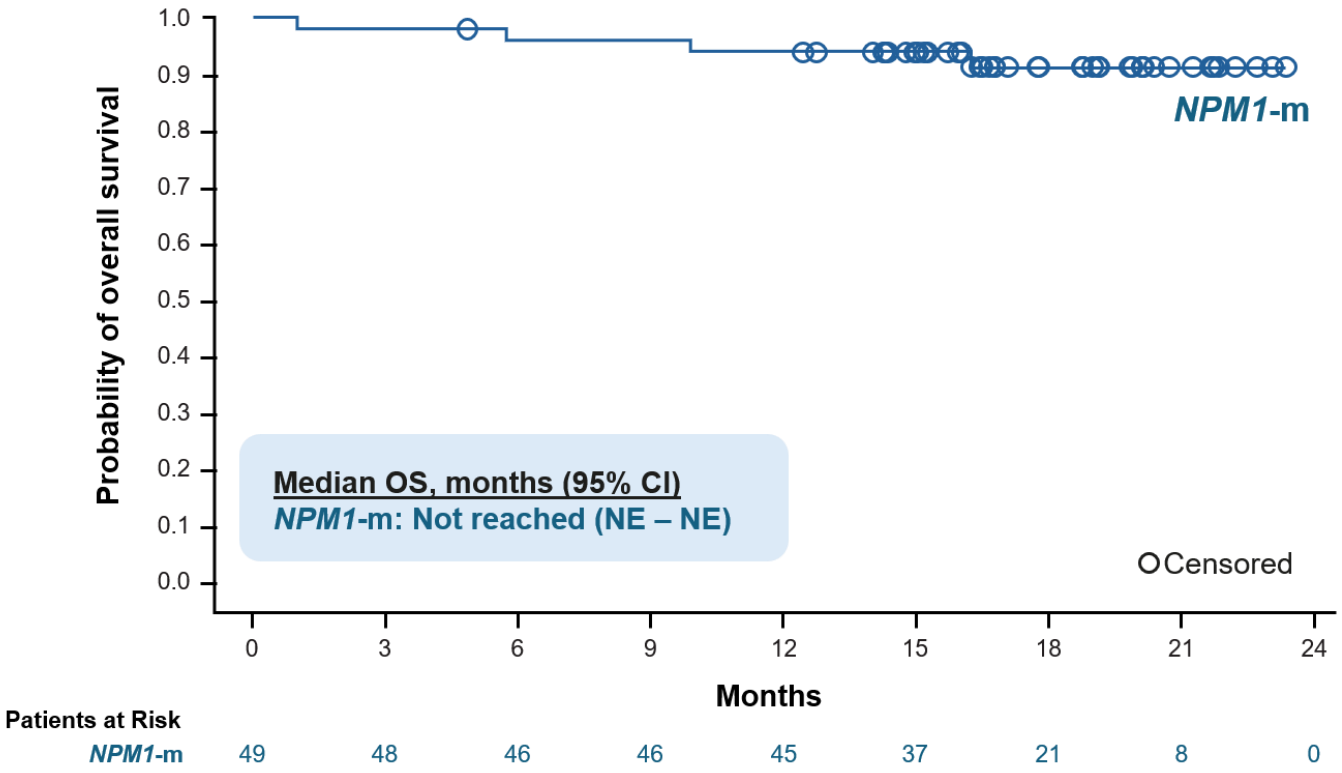
After a median follow-up of 11.0 months (range 0.9–21.9):

- Median duration of CR was **12.0 months**
- (95% CI 6.0–NE) and follow-up continues
- 32 *KMT2A*-r patients received HSCT
- 22 *KMT2A*-r patients entered ziftomenib maintenance
  - 21 after on-study HSCT
  - 1 without on-study HSCT
- 10 discontinued due to relapse/refractory
- 7 discontinued due to AEs (2 ziftomenib-related)

N=50
600 mg
Data cutoff: Apr 10, 2026.

OVERALL SURVIVAL IN *NPM1*-m PATIENT SUBSET

EHA 2026



- After a median follow-up of 17.6 months (range 1.0–23.5):
- Median EFS was not reached
- Median OS was not reached
  - *NPM1*-m: 94% OS rate at 12 months
- 60-day mortality: 2% (1/49)
- Median age was 60
- Time to count recovery: 28 days
- 90% (44/49) of *NPM1*-m patients remained alive and continued on study[a]

- 12-month OS with intensive chemotherapy-based regimens varied from ~70–80% in younger/fit patients to ~45–55% in older adults[1-5]

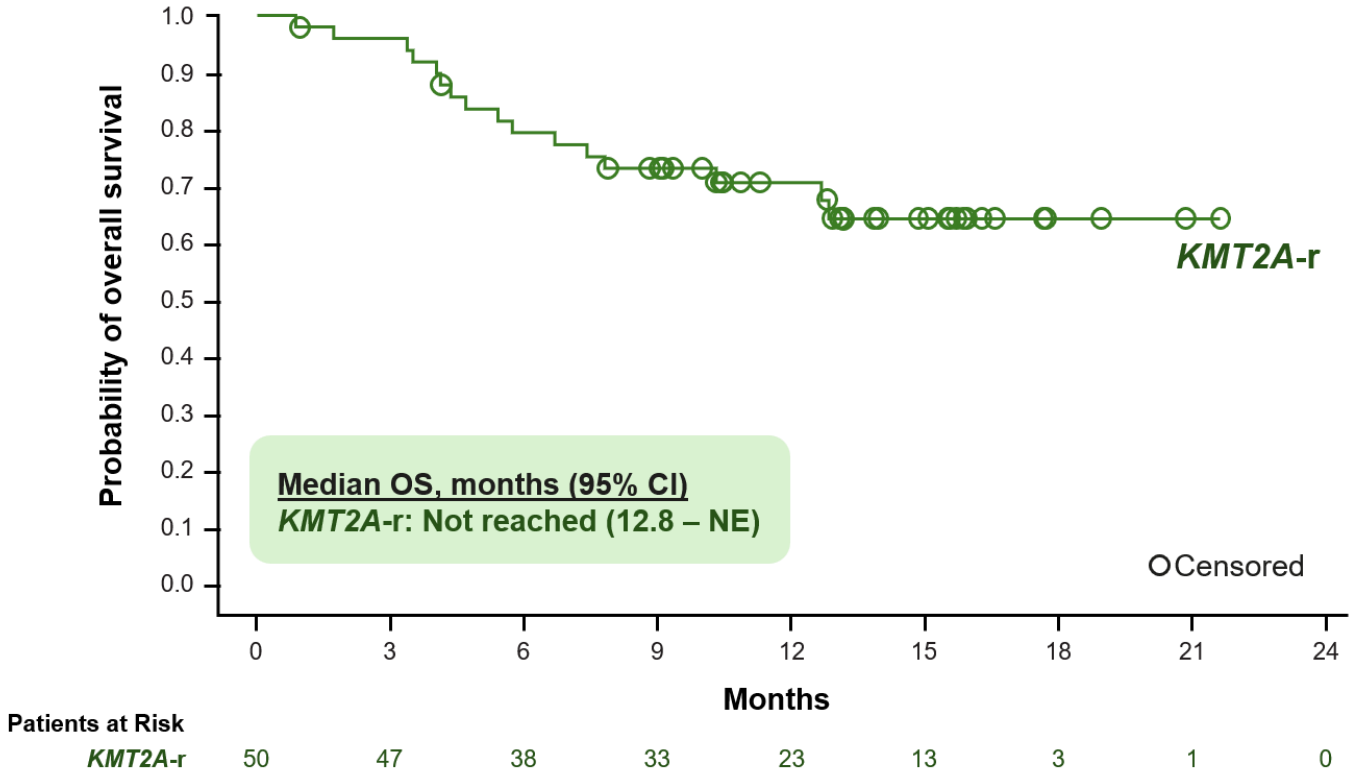
[a]Patients on treatment or in long-term follow-up

Data cutoff: Apr 10, 2026.

1. Othus *et al. Leukemia*. 2019; 33(2):371-378. 2. Othman *et al. Blood*. 2024; 144(7):714-728; 3. Lachowiez *et al. Blood Adv*. 2020; 4(7):1311–1320. 4. Hernández-Sánchez *et al. Leukemia*. 2026; 40(2):418-428. 5. Récher *et al. Leukemia*. 2022; 36(4):913-922.

OVERALL SURVIVAL IN *KMT2A*-r PATIENT SUBSET

EHA 2026



After a median follow-up of 11.0 months (range 0.9–21.9):

- Median OS was not reached
  - *KMT2A*-r: 71% OS rate at 12 months
- Median age was 43 years
- 60-day mortality: 4% (2/50)
- 62% (31/50) of *KMT2A*-r patients remained alive and continued on study[a]

[a]Patients on treatment or in long-term follow-up

Data cutoff: Apr 10, 2026.

SUMMARY OBSERVATIONS OF COMBINATION DATA PRESENTED TO DATE (1/2)

EFFICACY

Deep and durable clinical responses

Robust clinical activity with deep responses demonstrated in newly diagnosed:

- *NPM1*-m AML or *KMT2A*-r AML with 7+3 combination
- *NPM1*-m AML with ven/aza in combination

Encouraging clinical activity demonstrated with ven/aza combination in patients with R/R *NPM1*-m or *KMT2A*-r AML, including in patients with prior ven exposure

COMPATIBILITY

Excellent ability to combine with other agents

No dose modifications required due to interactions with backbone

No additional toxicity beyond that expected with ven/aza or 7+3 alone

Compatibility with anti-fungal and other supportive therapies, including potent CYP3A4 inhibitors

SUMMARY OBSERVATIONS OF COMBINATION DATA PRESENTED TO DATE (2/2)

SAFETY

Best-in-class benefit-risk profile

Low rates of investigator-assessed, ziftomenib-related cytopenias and no additional myelosuppression observed

Ziftomenib at 600 mg QD in combinations did not delay neutrophil and platelet count recovery

Combinations mitigate risk of differentiation syndrome, with rare events successfully managed

Low rates of QTc prolongation due to any cause observed in combinations

SIMPLICITY

Convenient dosing may promote beneficial compliance

Once-daily dosing,
regardless of concomitant medications

No weight-based dosing adjustments needed

No need to combine tablet strengths or for additional dosage forms

DARLIFARNIB

FARNESYL TRANSFERASE INHIBITOR (FTI)

THERE IS A NEED TO IMPROVE STANDARDS OF CARE FOR PATIENTS TREATED WITH TARGETED THERAPIES

Despite impressive progress with small molecule targeted therapies, combination strategies may be capable of delivering deeper and more durable responses

- Targeted therapies are often effective but insufficient as monotherapies
- Combinations (*e.g.*, KRAS/EGFR inhibitors in CRC) have demonstrated enhanced response

There is a significant need to identify combination therapeutics, which address mechanisms of innate and adaptive resistance

Kura Oncology is pioneering FTIs to enhance the therapeutic potential of targeted therapies

- mTOR is a clinically validated target, and FTIs reduce mTOR activation by blocking RHEB farnesylation
- RHEB/mTOR inhibition is relevant to anti-VEGF TKIs, KRAS inhibitors and PI3Kα inhibitors

Simultaneous inhibition of RHEB/mTOR using FTIs has potential to provide deeper and more durable anti-tumor activity

Farnesyl transferase inhibitor (FTI) darlifarnib (KO-2806) combined with cabozantinib (cabo) in clear cell renal cell carcinoma (ccRCC) patients after prior exposure to cabo: Preliminary phase 1 results from FIT-001

Yousef Zakharia[1], Adam E. Singer[2], Benjamin Garmezy[3], Jacob Thomas[4], Douglas E. Laux[5], Jason Henry[6], Liza Villaruz[7], Sanjay Goel[8], Paria Mahboub Johnson[9], Jenchun Kuan[10], Binaifer Balsara[9], Mollie Leoni[9], **Adanma Ayanambakkam[11]**

[1]Mayo Clinic Comprehensive Cancer Center, Phoenix, AZ, USA; [2]Division of Hematology-Oncology, University of California Los Angeles Medical Center, Los Angeles, CA, USA; [3]Sarah Cannon Research Institute, Nashville, TN, USA; [4]Division of Medical Oncology, Department of Medicine, University of Southern California Norris Comprehensive Cancer Center, Los Angeles, CA, USA; [5]Division of Hematology, Oncology and Blood & Marrow Transplantation, University of Iowa Hospitals and Clinics, Iowa City, IA, USA; [6]Sarah Cannon Research Institute at Health One, Denver, CO, USA; [7]UPMC Hillman Cancer Center, Pittsburgh, PA, USA; [8]Rutgers Cancer Institute of New Jersey, Brunswick, NJ, USA; [9]Clinical Development, Kura Oncology, Inc., San Diego, CA, USA; [10]Biometrics, Kura Oncology, Inc., San Diego, CA, USA; [11]Stephenson Cancer Center, University of Oklahoma Health Sciences Center, Oklahoma City, OK, USA

THE KIDNEY CANCER ASSOCIATION PRESENTS IKCS EUROPE

ENCOURAGING CLINICAL ACTIVITY IN RESPONSE-EVALUABLE[a] CABO-EXPOSED ccRCC PATIENTS

	Cabozantinib 40 mg			Cabozantinib 60 mg	
	Darlifarnib 3 mg n=5	Darlifarnib 5 mg n=6	Darlifarnib 8 mg n=2[b]	Darlifarnib 3 mg n=3	Total N=16
ORR (uPR + PR), n (%)	2 (40)	2 (33)[c]	1 (50)	2 (67)	7 (44)
95% CI	5.3–85.3	4.3–77.7	1.3–98.7	9.4–99.2	19.8–70.1
DCR[d], n (%)	5 (100)	6 (100)	1 (50)	3 (100)	15 (94)
95% CI	47.8–100	54.1–100	1.3–98.7	29.2–100	69.8–99.8

- All patients received prior I/O-based treatment as well as prior cabozantinib
- All responders had progression on prior cabozantinib
- 4/7 responders had cabozantinib as immediate prior line of treatment
- Historical rates of ORR with subsequent treatment after prior cabozantinib or other TKI exposure ~17% – 22% [1-3]

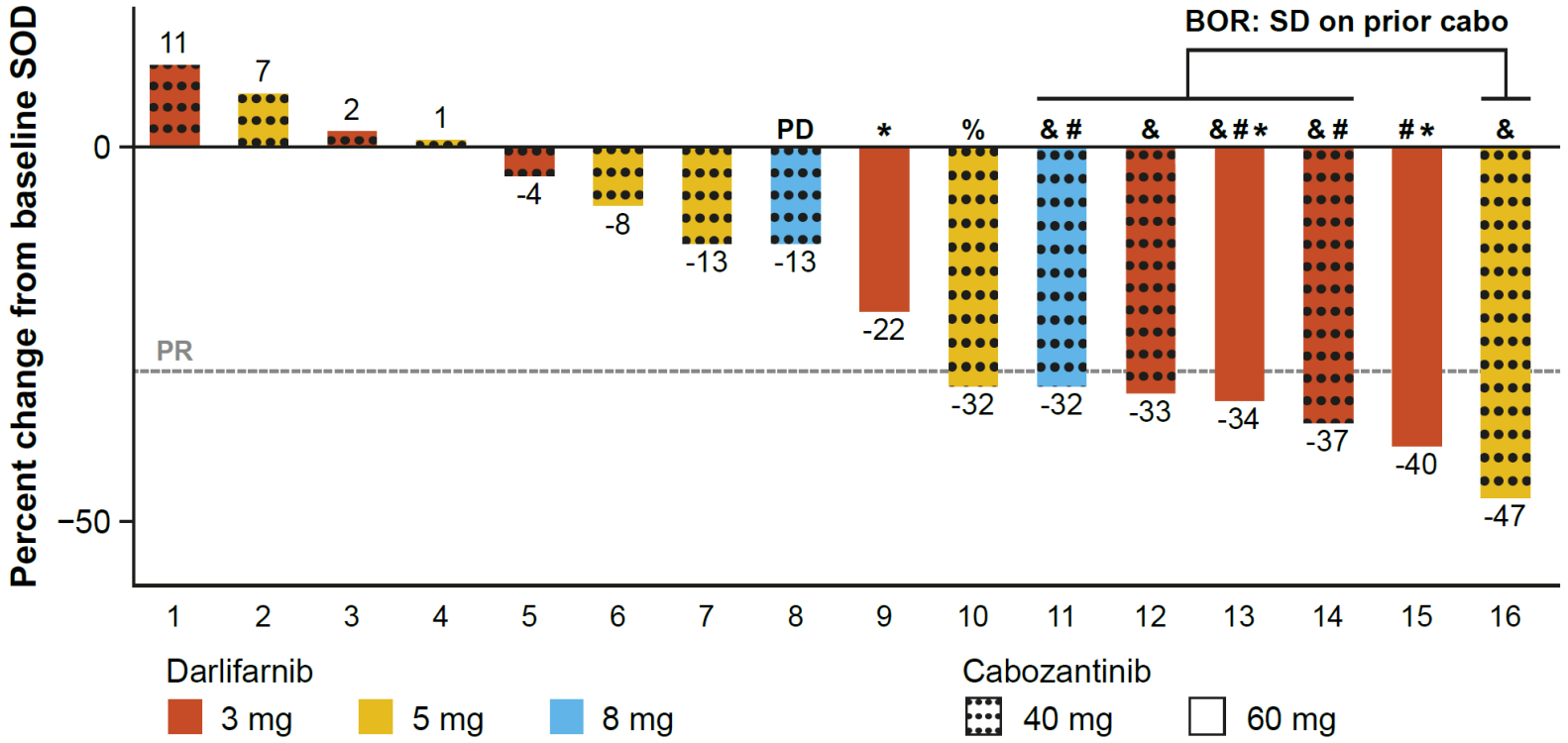
[a] Response-evaluable patients had ≥1 post-baseline scan. [b] One patient had only one disease assessment (PD as best response). [c] One patient had uPR. [d] DCR includes patients with SD and PR of any duration.

1. Choueiri *et al. Lancet Oncol.* 2016; 17:917–927. 2. Choueiri *et al. N. Engl. J. Med.* 2024; 391:710–721; 3. Rini *et al. Lancet* 2021; 21:95–104.

Data cutoff: Dec 8, 2025

ENCOURAGING ACTIVITY OF THE COMBINATION IN RESPONSE-EVALUABLE[a] CABO-EXPOSED ccRCC PATIENTS

Best overall response in all response-evaluable[a] patients across dose levels



* Received darlifarnib 3 mg + cabo 60 mg; the remaining patients received cabo 40 mg in combination with darlifarnib 3, 5, or 8 mg. # Immediate prior cabo exposure. & BOR of SD on prior cabo. % uPR. [a] Response-evaluable patients had ≥1 post-baseline scan.

Data cutoff: Dec 8, 2025.

CONCLUSIONS FROM DARLIFARNIB + CABOZANTINIB COMBO IN CABOZANTINIB EXPERIENCED RCC

Consistent Activity in 2L+ ccRCC, Including Resensitization to Cabozantinib, Supports Continued Development

- Safety and tolerability profile generally consistent with cabozantinib monotherapy, with on-target myelosuppression that could be managed with supportive care
- Combination demonstrates encouraging antitumor activity in ccRCC patients whose disease had progressed on prior cabozantinib
  - 44% ORR
  - 94% DCR
- Prolonged treatment duration observed
  - Up to 56 weeks, with 1/3 patients remaining on therapy as of data cutoff
- FIT-001 randomized Phase 1b in 2L+ ccRCC actively enrolling in US and EU

Data cutoff: Dec 8, 2025.

KCRS 2026

FARNESYL TRANSFERASE INHIBITOR (FTI) DARLIFARNIB COMBINED WITH CABOZANTINIB IN RENAL CELL CARCINOMA (RCC): UPDATED PHASE 1A RESULTS FROM FIT-001

Adanma Ayanambakkam[1], Yousef Zakharia[2], Lee S. Rosen[3], Benjamin Garmezy[4], Meredith Pelster[5], Glenn J. Hanna[6], Jason Henry[7], Jacob Thomas[8], Manish R. Patel[9], Douglas E. Laux[10], David S. Hong[11], Jamie Kuipers[12], Jenchun Kuan[12], Paria Mahboub Johnson[12], Binaifer Balsara[12], Mollie Leoni[12], Adam E. Singer[3]

[1]Stephenson Cancer Center, University of Oklahoma Health Sciences Center, Oklahoma City, OK, USA; [2]Mayo Clinic Comprehensive Cancer Center, Phoenix, AZ, USA; [3]Division of Hematology-Oncology, University of California Los Angeles Medical Center, Los Angeles, CA, USA; [4]Genitourinary Cancer Research, Sarah Cannon Research Institute, Nashville, TN, USA; [5]Gastrointestinal Cancer Research, Sarah Cannon Research Institute, Nashville, TN, USA; [6]Center for Head and Neck Oncology, Dana-Farber Cancer Institute, Boston, MA, USA; [7]Sarah Cannon Research Institute at HCA HealthONE, Denver, CO, USA; [8]Division of Medical Oncology, Department of Medicine, University of Southern California Norris Comprehensive Cancer Center, Los Angeles, CA, USA; [9]Florida Cancer Specialists, Sarah Cannon Research Institute, Sarasota, FL, USA; [10]Division of Hematology, Oncology and Blood & Marrow Transplantation, University of Iowa Hospitals and Clinics, Iowa City, IA, USA; [11]University of Texas MD Anderson Cancer Center, Houston, TX, USA; [12]Kura Oncology, Inc., San Diego, CA, USA

ENCOURAGING ANTI-TUMOR ACTIVITY

Cabozantinib-Naive ccRCC[a]

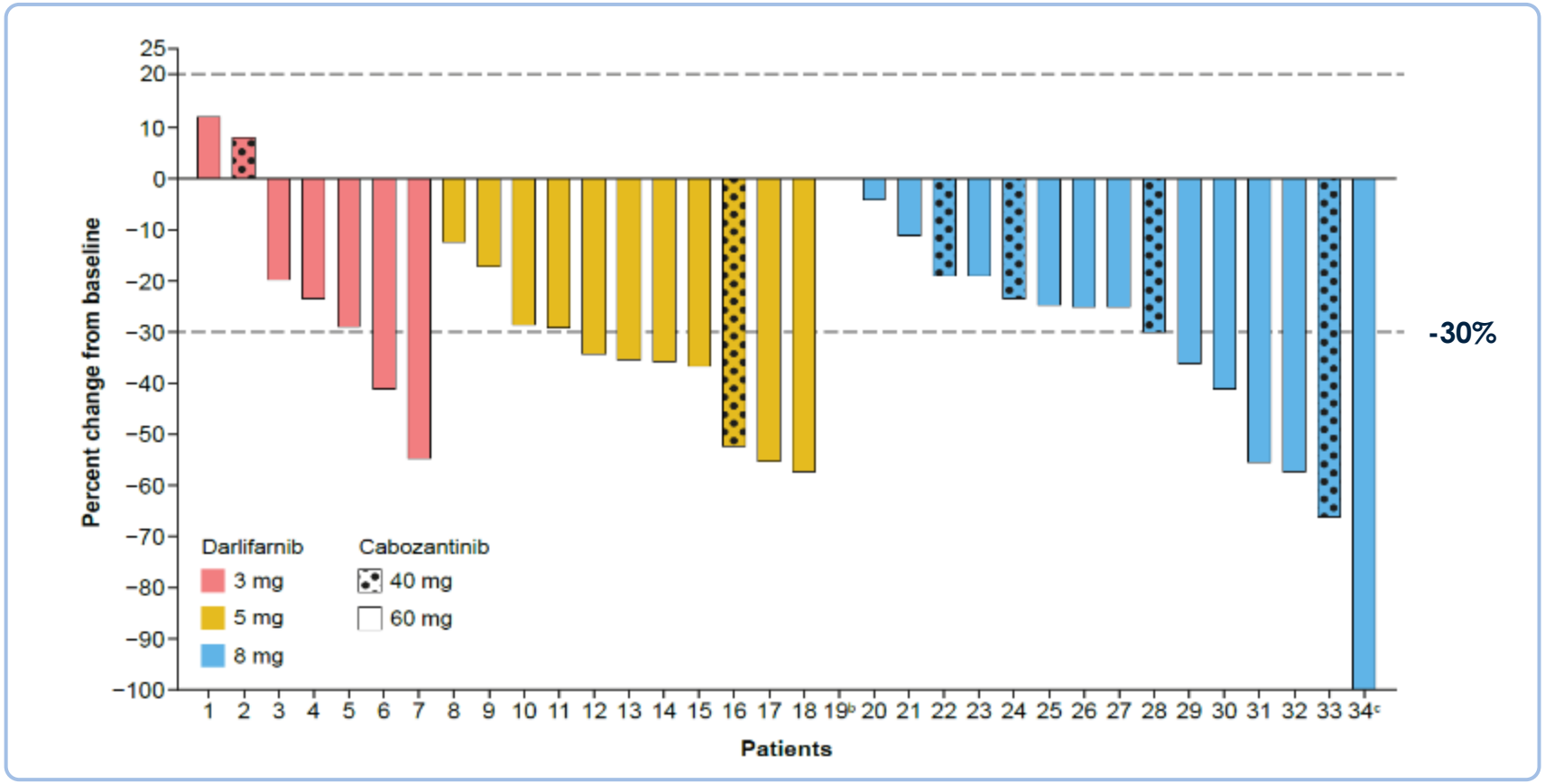
n (%) [95% CI]	Darlifarnib + Cabozantinib 40 mg (N=6)	Cabozantinib 60 mg[b]		
		Darlifarnib 3 mg (n=6)	Darlifarnib 5 mg (n=10)	Darlifarnib 8 mg (n=12)
ORR (CR+PR)	2 (33) [4.3–77.7]	2 (33) [4.3–77.7]	5 (50)[c] [18.7–81.3]	4 (33) [9.9–65.1]
DCR (CR+PR+SD)	5 (83) [35.9–99.6]	6 (100) [54.1–100]	8 (80) [44.4–97.5]	12 (100) [73.5–100]
CBR[d]	5 (83) [35.9–99.6]	2 (33) [4.3–77.7]	7 (70) [34.8–93.3]	7 (58) [27.7–84.8]

- Encouraging antitumor activity was observed in this pretreated population
  - ORRs 33%–50%, and median DOR was not estimable
  - 47% of cabozantinib-naïve patients had prior TKI

[a]Response-evaluable patients had ≥1 post-baseline scan; [b]Cabozantinib 40 mg cohorts were enrolled before cabozantinib 60 mg cohorts; [c]One PR was unconfirmed; patient withdrew consent for non-study related reason; [d]CBR defined as confirmed CR, confirmed PR, or SD duration ≥24 weeks.
Data cutoff: May 8, 2026

ENCOURAGING ANTI-TUMOR ACTIVITY (ORR AND DCR)

Cabozantinib-Naive ccRCC[a] best percent change from baseline in target lesion size



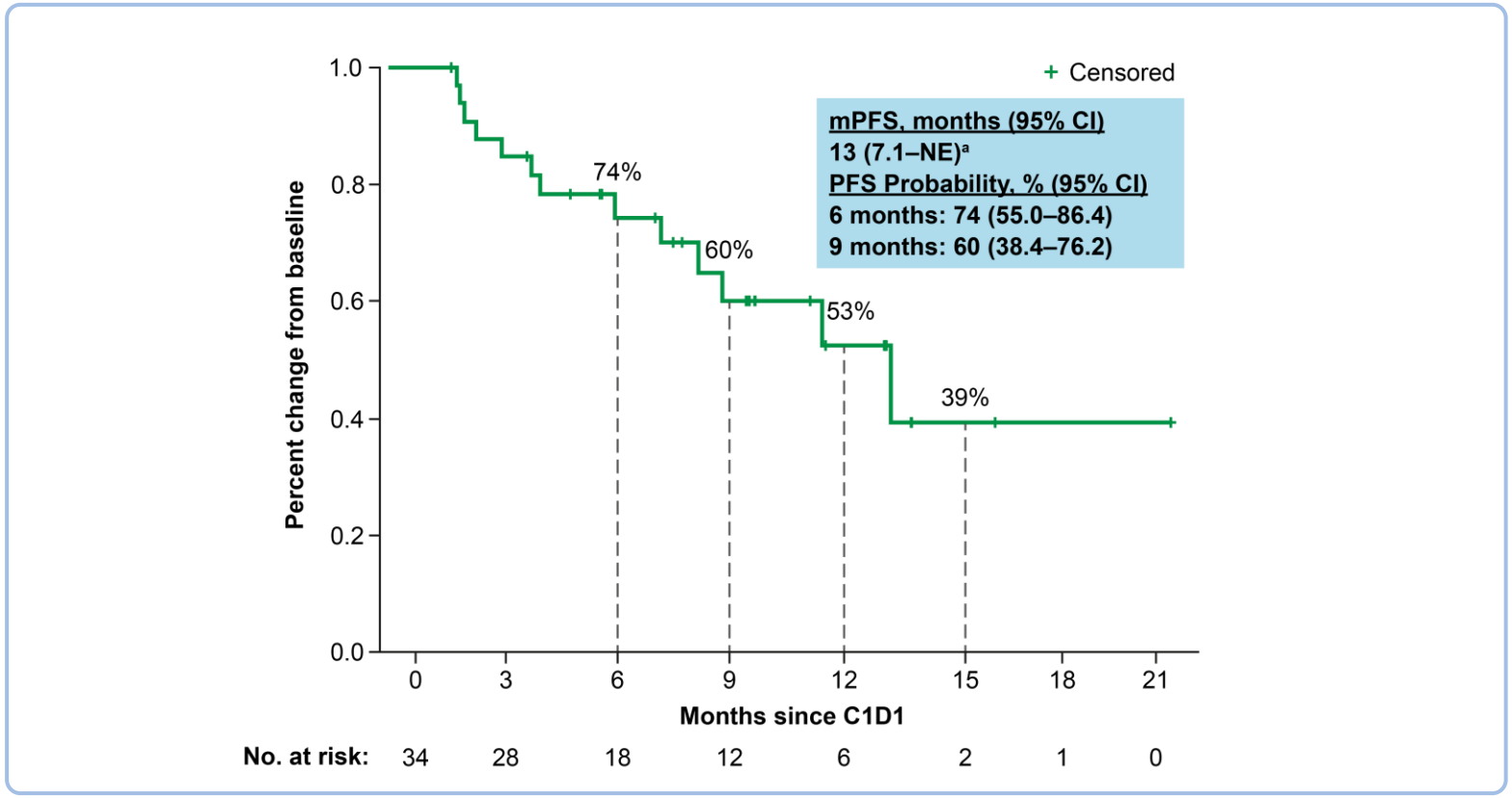
[a]Response-evaluable patients had ≥1 post baseline scan; [b]Patient received darlifarnib 8 mg + cabozantinib 60 mg; [c]Response was considered PR because 100% tumor reduction was observed in target lesion but not in non-target lesions.

Data cutoff: May 8, 2026

DURATION OF TREATMENT AND CLINICAL OUTCOMES

Cabozantinib-Naive ccRCC

Durable clinical benefit was observed across all evaluated combination dose levels, with more than half of patients remaining on treatment at data cutoff



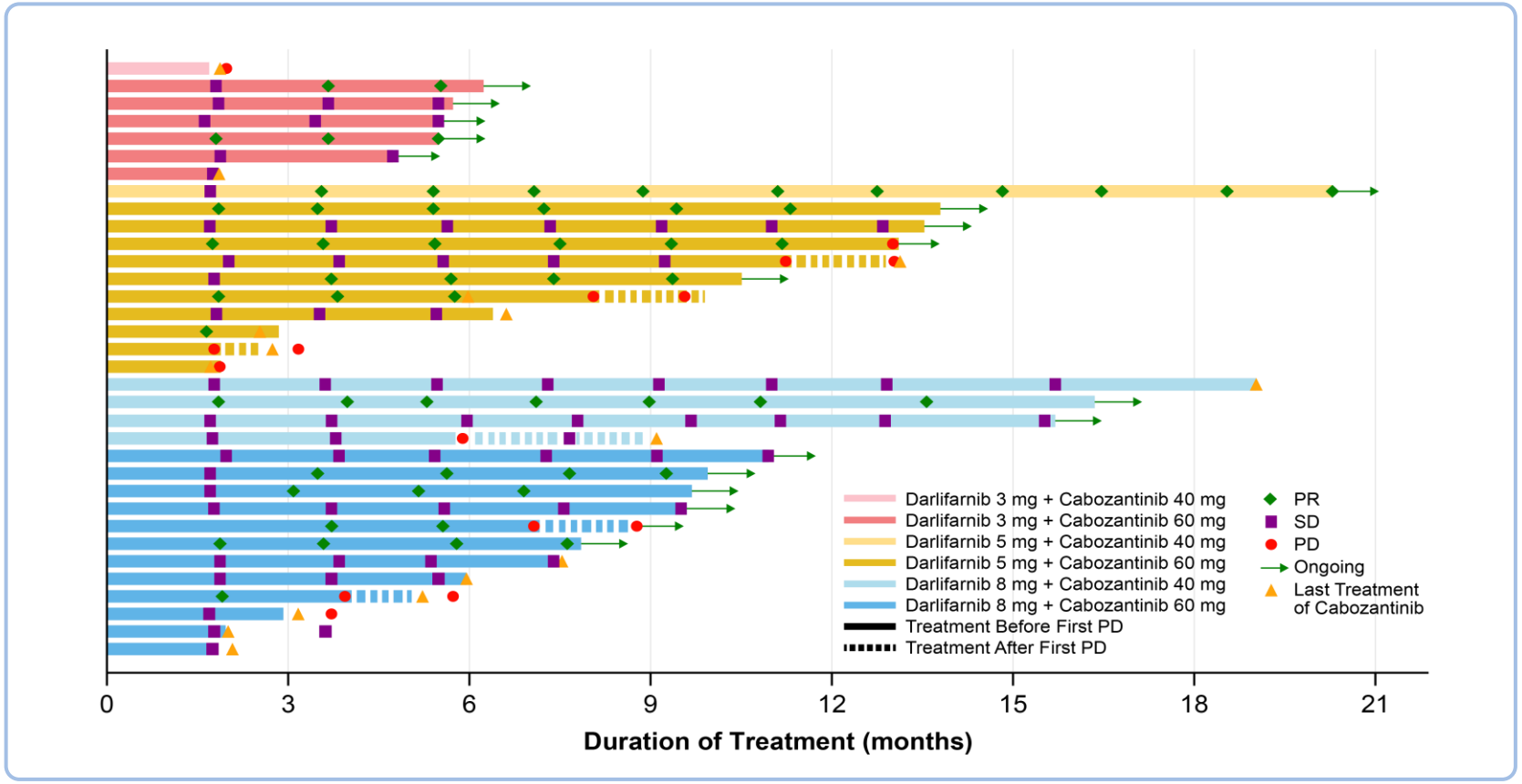
[a]Median follow up was 9.4 months (95% CI 6.9–12.8); PFS is aggregated across dose levels and follow up varied by dose level.

Data cutoff: May 8, 2026

DURATION OF TREATMENT AND CLINICAL OUTCOMES

Cabozantinib-Naive ccRCC time on treatment and response in evaluable patients

Durable clinical benefit was observed across all evaluated combination dose levels, with more than half of patients remaining on treatment at data cutoff



Data cutoff: May 8, 2026

ASCO 2025

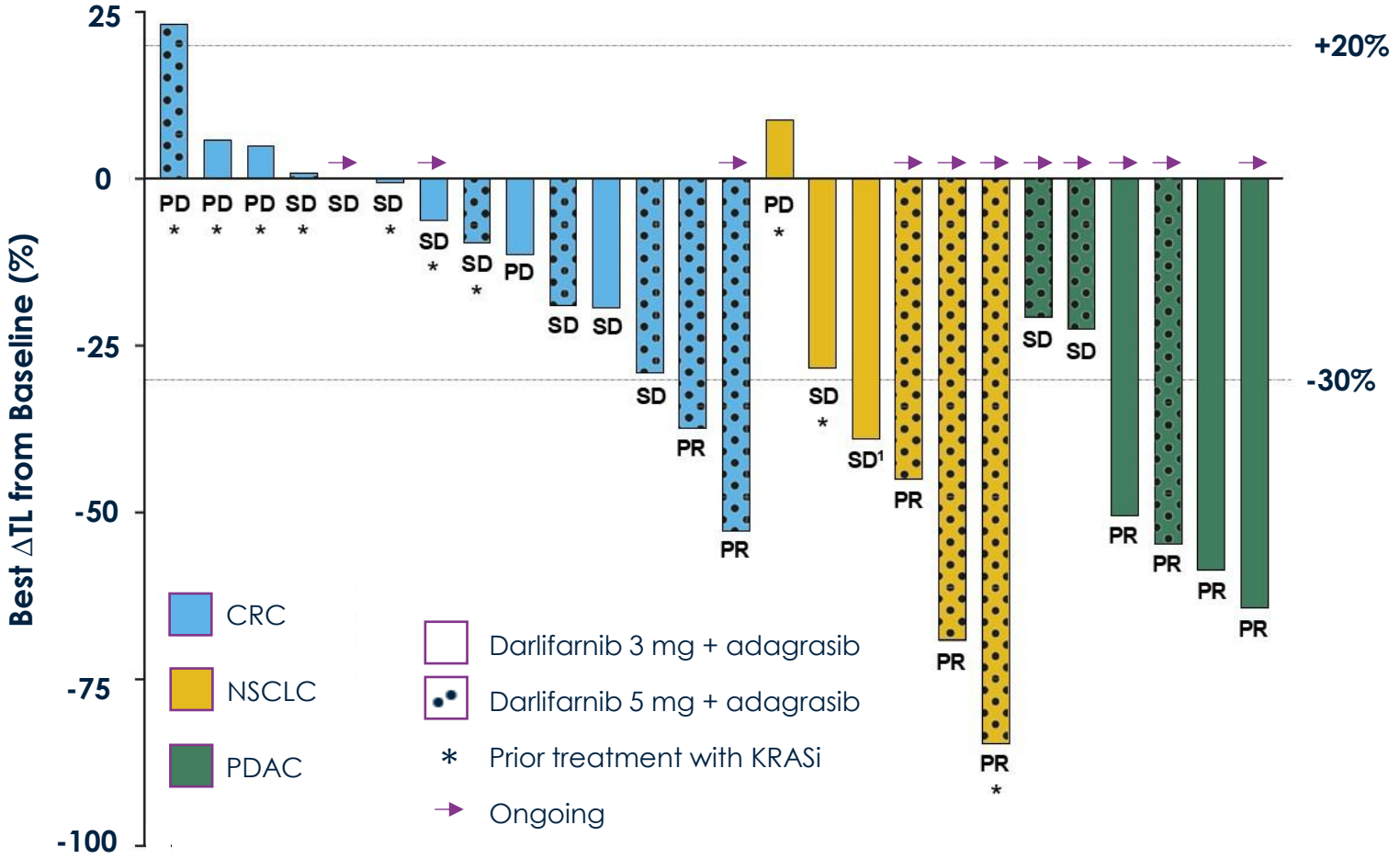
FARNESYL TRANSFERASE INHIBITOR DARLIFARNIB IN COMBINATION WITH ADAGRASIB IN *KRAS* G12C MUTATED ADVANCED SOLID TUMORS: PRELIMINARY RESULTS FROM FIT-001 PHASE 1 FIRST-IN-HUMAN TRIAL

Andrea Zivi[1], **David Hong**[2], Manish R. Patel[3], Jacob Thomas[4], Justine Y. Bruce[5], Sanjay Goel[6], Glenn J. Hanna[7], Jacques Medioni[8], Stefania Salvagni[9], Susanna Ulahannan[10], Andrew Hendifar[11], Douglas E. Laux[12], Guzman Alonso[13], Aurore Vozy[14], Ramon Yarza[15], Sabrina Marini[1], Mini Manchanda[16], Tuan Anh Tran[16], Jenchun Kuan[16], Binaifer Balsara[16], Mollie Leoni[16], **Vanesa Gregorc**[17]

[1]Centro Ricerche Cliniche di Verona, Verona, Italy; [2]The University of Texas MD Anderson Cancer Center, Houston, TX, USA; [3]Florida Cancer Specialists, Sarah Cannon Research Institute, Sarasota, FL, USA; [4]Division of Medical Oncology, Department of Medicine, University of Southern California Norris Comprehensive Cancer Center, Los Angeles, CA, USA; [5]University of Wisconsin Carbone Cancer Center, Madison, WI, USA; [6]Rutgers Cancer Institute, New Brunswick, NJ, USA; [7]Center for Head and Neck Oncology, Dana-Farber Cancer Institute, Boston, MA, USA; [8]Hôpital Européen Georges-Pompidou, Paris Cité University, Paris, France; [9]IRCCS Azienda Ospedaliero Universitaria di Bologna, Bologna, Italy; [10]The University of Oklahoma Stephenson Cancer Center/SCRI, Oklahoma City, OK, USA; [11]Cedars Sinai Medical Center, Los Angeles, CA, USA; [12]Division of Hematology, Oncology and Blood & Marrow Transplantation, University of Iowa Hospitals and Clinics, Iowa City, IA, USA; [13]Hospital Universitari Vall d'Hebron, Barcelona, Spain; [14]Hôpital Pitié-Salpêtrière, Paris, France; [15]Hospital Universitario HM Sanchinarro, START Madrid – CIOCC, Madrid, Spain; [16]Kura Oncology, Inc., San Diego, CA, USA; [17]FPO – IRCCS, Candiolo (TO), Italy

ENCOURAGING ANTI-TUMOR ACTIVITY

Best percent change from baseline in target lesion size



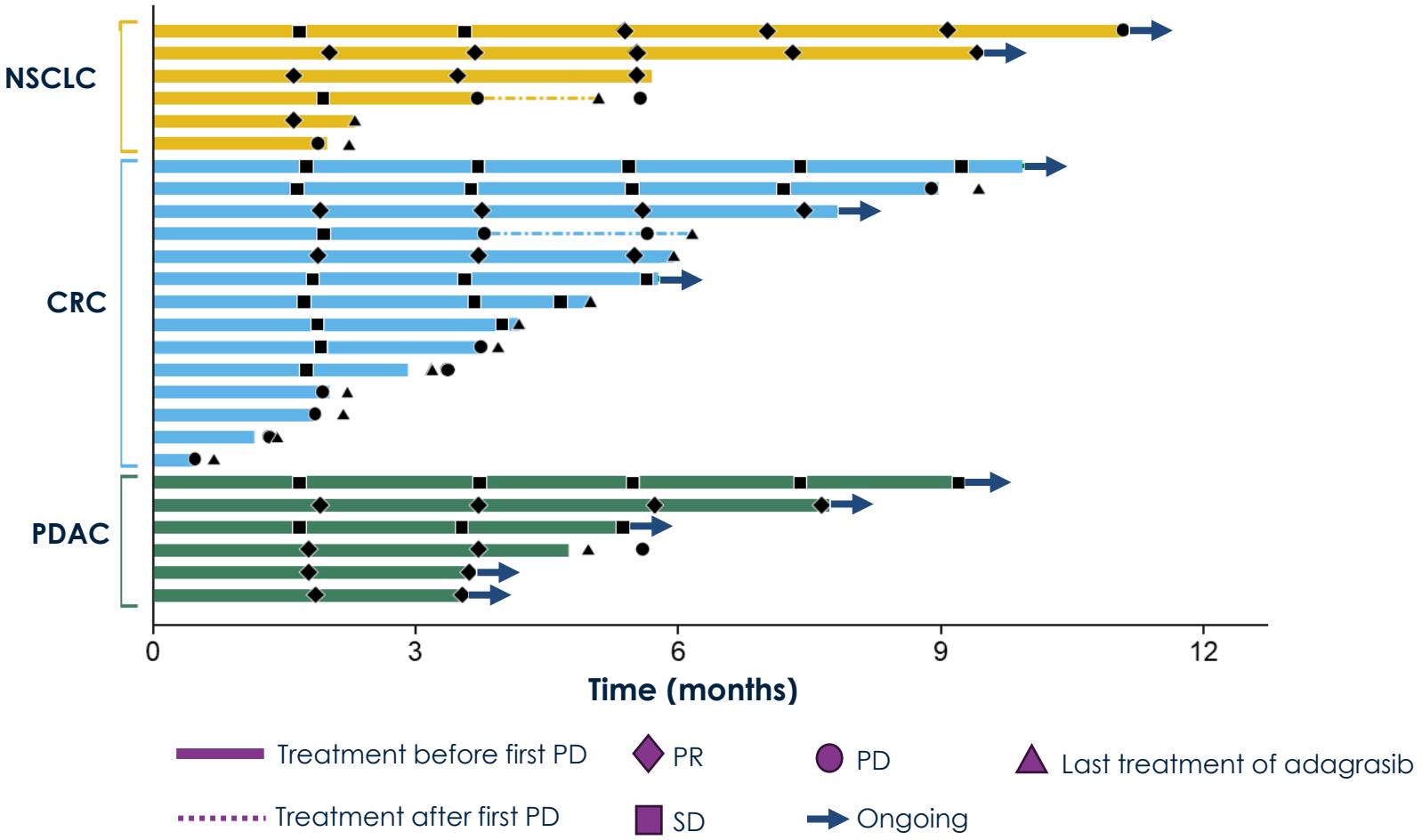
Tumor shrinkage observed:

- At both 3 mg and 5 mg darlifarnib doses
- In 77% (20/26) of all response-evaluable patients
- In 94% (15/16) of all response-evaluable KRASi-naïve patients
- In KRASi-pretreated patients

Response-evaluable patients had ≥1 darlifarnib dose and post-baseline scan. Adagrasib 400 mg BID.
Data cutoff: March 25, 2026.

ENCOURAGING CLINICAL ACTIVITY

Time on treatment and response in evaluable[1] patients



Median follow-up time in months (range):

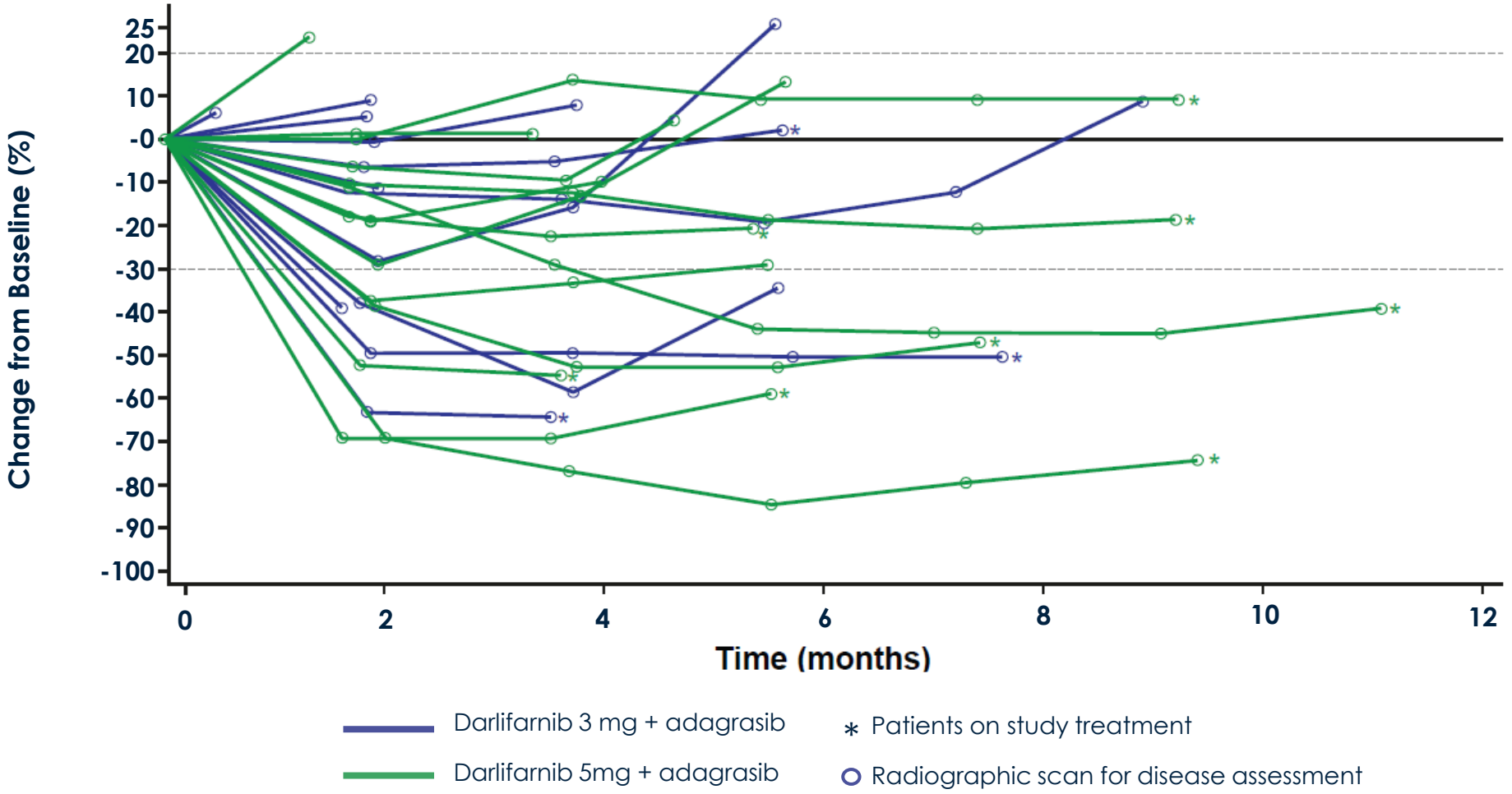
- NSCLC 6.9 (3.2–11.8)
- CRC 8.9 (1.2–13.2)
- PDAC 6.7 (4.0–10.4)

Responses observed across **all tumor types** at **both doses** of darlifarnib + adagrasib

[1]Response-evaluable patients had ≥1 darlifarnib dose and post-baseline scan.
Data cutoff: March 25, 2026.

ENCOURAGING CLINICAL ACTIVITY

Change in target lesion sum of diameters over time in evaluable[1] patients



[1]Response-evaluable patients had ≥1 darlifarnib dose and post-baseline scan.
Data cutoff: March 25, 2026.

ENCOURAGING ANTI-TUMOR ACTIVITY

% (95% CI)	n	ORR	CBR[1]	mDOR, mos
Tumor type				
PDAC (KRASi-naïve)	6	**67** (22–96)	100 (54–100)	NE (3.8–NE)
NSCLC	6	**50** (12–88)	50 (12–88)	NE (5.7–NE)
KRASi-naïve NSCLC	3	67 (9-99)	67 (9-99)	5.7 (NE–NE)
CRC	14	14 (2–43)	43 (18–71)	NE (4.4–NE)
KRASi-naïve CRC	7	**29** (3–60)	43 (8–70)	NE (4.4–NE)
Dose level				
Darlifarnib 3 mg + adagrasib	12	25 (6–57)	42 (15–72)	NE (3.8–NE)
Darlifarnib 5 mg + adagrasib	14	43 (18–71)	71 (42–92)	5.7 (4.4–NE)

- Among 26 response-evaluable[2] patients, confirmed responses and clinical benefit were observed in each tumor type and at each dose level

Data cutoff: March 25, 2026

[1] CBR is the percentage of patients who achieved confirmed CR, confirmed PR, or ≥12 weeks SD duration.[2] Response-evaluable patients had ≥1 darlifarnib dose and post-baseline scan.

DARLIFARNIB UPDATES AND DEVELOPMENT PRIORITIES

Recent Updates

- Presented Phase 1 FIT-001 data demonstrating darlifarnib's potential to overcome resistance to VEGFR-targeted therapy in cabozantinib-exposed patients with the combination of darlifarnib plus cabozantinib (IKCS 2026)
- Presented first-in-human Phase 1 FIT-001 data evaluating darlifarnib + adagrasib (ASCO 2026)
- Updated Phase 1 FIT-001 results demonstrated encouraging and durable clinical activity with darlifarnib plus cabozantinib (KCRS 2026)

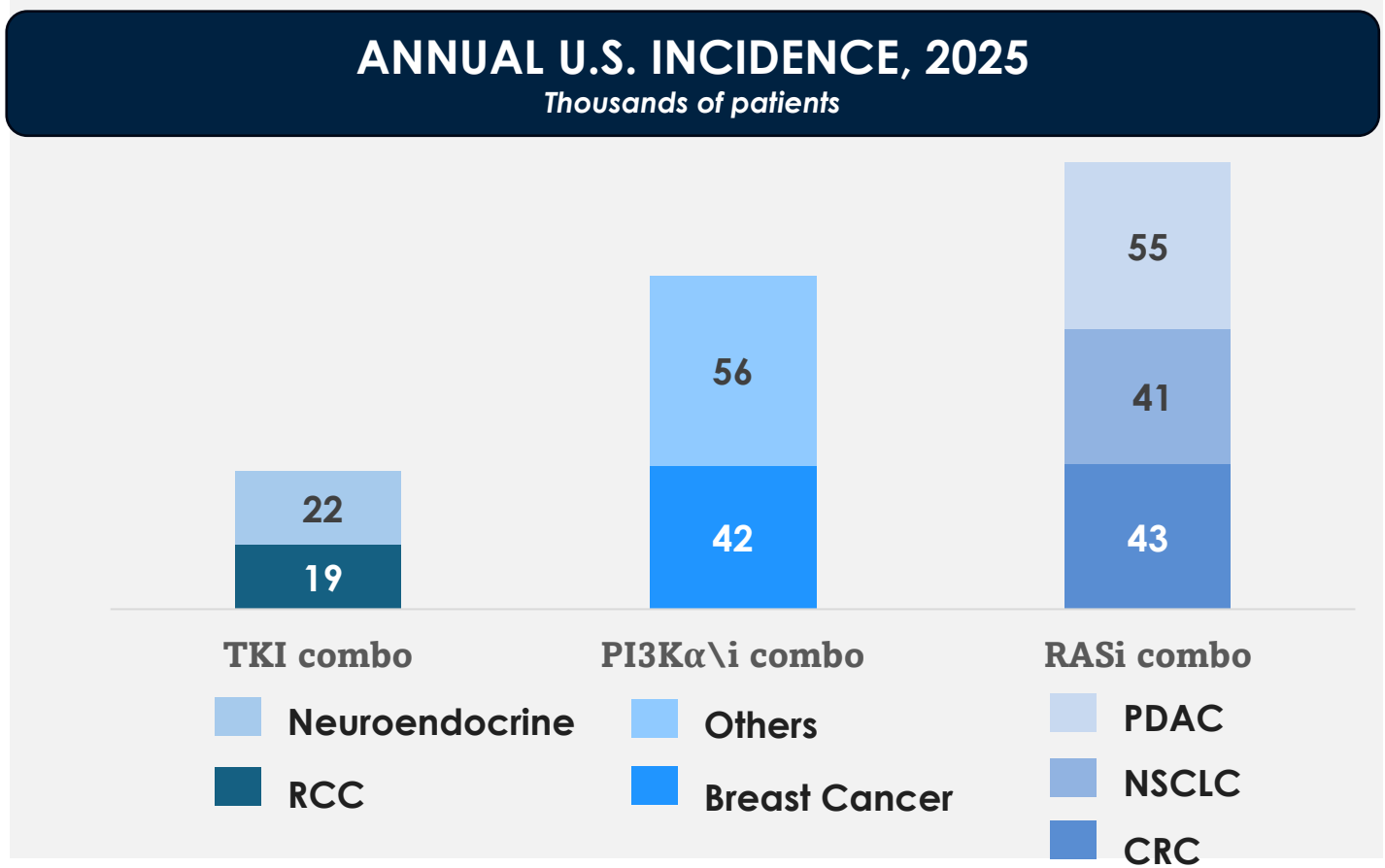
Additional Clinical Data Anticipated in 2026

- Present updated data on Phase 1a dose escalation for darlifarnib + cabozantinib in cabozantinib-naïve and –exposed RCC (2H 2026)

Anticipated Next Steps

- Complete enrollment in the randomized FIT-001 Phase 1b study evaluating darlifarnib plus cabozantinib in cabozantinib-naïve ccRCC – 1H 2027
    - Report initial clinical data – 2H 2027
- Initiate a platform study of darlifarnib plus daraxonrasib in patients with *KRAS*-mutant 2L+ PDAC – 1H 2027
- Advance darlifarnib as a precision combination platform across additional targeted therapy classes

LARGE POTENTIAL OPPORTUNITY IN DARLIFARNIB WITH ~280K ANNUAL INCIDENT PATIENTS IN THE U.S.



OPPORTUNITY AREAS

VEGFR TKI

- Potential to combine with cabozantinib and other TKIs in RCC and potentially in NET
- Potential to combine with TKI and I/O in 1L RCC

KRAS and PI3Kα

- Potential to combine with multiple agents in KRAS- and PI3Kα-driven cancers across major solid tumors
- Potential for synergistic efficacy, lifecycle management, revenue from multiple combinations

Data sources include Decision Resources Group, Market Forecast Dashboard (2025); Jalbert *et al. Oncologist.* 2020; 25(4):e644-e650; Lim *et al. Lung Cancer.* 2023:184; Cascetta *et al. Cancers* 2022; 14(21):5430.

2026: ANTICIPATED PROGRESS

komzifti ziftomenib 200 mg capsules

Accelerate U.S. adoption of KOMZIFTI in R/R *NPM1*-m AML

Drive quarter-over-quarter revenue growth

ziftomenib	
Present updated KOMET-007 data evaluating combination with 7+3 in 1L *NPM1*-m/*KMT2A*-r AML at EHA 2026	✓
Publish ven/aza combination data in R/R *NPM1-m* AML	✓
Present preliminary data from KOMET-008 cohort evaluating combination with gilteritinib in R/R *NPM1*-m/FLT3-m AML	2H
Present long-term frontline combination data with ven/aza	2H
Present preliminary data from KOMET-007 cohort evaluating combination with 7+3 and quizartinib in 1L *NPM1*-m/*FLT3*-m AML (quad)	2H
Present exploratory analysis in non-*NPM1*/non-*KMT2A* subtypes	2H
Advance enrollment of Phase 3 trials incl. IC and NIC (KOMET-017)	ongoing
Expand to non-AML indications including ongoing Phase 1a dose escalation trial evaluating combination with imatinib in GIST	ongoing

darlifarnib	
Complete Phase 1b RCC enrollment	✓
Initiate expansion cohorts of darlifarnib and cabozantinib in advanced RCC (Phase 1b)	✓
Present preliminary data from darlifarnib and adagrasib in $KRAS^{G12C}$-mutated solid tumors (NSCLC, CRC, PDAC) at ASCO 2026	✓
Present updated dose-escalation data from darlifarnib and cabozantinib in advanced RCC (Phase 1a)	✓
Initiate darlifarnib platform study with daraxonrasib	1H 2027
Present preliminary Phase 1b RCC data	2H 2027
Explore opportunities to evaluate additional indications and combination partners	ongoing

Pipeline	
Present preclinical menin inhibitor data on diabetes (differentiation from other assets/programs)	2H
Advance KO-7246, next-generation menin inhibitor, in IND-enabling studies for diabetes and cardiometabolic disease	ongoing
Advance preclinical development of next-gen menin inhibitor development candidate for use in combination therapy for solid tumors	ongoing

ABBREVIATIONS

1l: first line
2L: second line
7+3: 7 days of cytarabine + 3 days of daunorubicin
AE: adverse event
ALL: acute lymphoblastic leukemia
AML: acute myeloid leukemia
CBR: confirmed CR, confirmed PR, or SD duration ≥24 weeks
ccRCC: clear cell renal cell carcinoma
CR: complete remission
CRh / Cri: complete remission with partial hematologic recovery
CRi: complete remission with incomplete hematologic recovery
CRc: composite complete remission
CR MRD: complete response with minimal residual disease
CRC: colorectal cancer
CYP3A4: cytochrome P450 3A4
DCR: disease control rate
DOR: duration of response
EFS: event-free survival
EGFR: epidermal growth factor receptor
ER+: estrogen receptor-positive
FLAG-IDA: fludarabine, high-dose cytarabine (Ara-C), granulocyte-colony stimulating factor (G-CSF) and idarubicin
FLT3: fms-like tyrosine kinase 3
FTI: farnesyl transferase inhibitor
HSCT: hematopoietic stem cell transplant
2A
GILT: gilteritinib
GIST: gastrointestinal stromal tumors
IC: intensive chemotherapy
IDH1/2: isocitrate dehydrogenase 1 or 2
IO: immuno-oncology therapy
KMT2A: Lysine Methyltransferase
KRAS: Kirsten rat sarcoma viral oncogene homolog
KRASi: KRAS inhibitor
LDAC: low-dose cytarabine
MLFS: morphologic leukemia-free state
MTOR: mammalian target of rapamycin
NE: not evaluable
NET: neuroendocrine tumor
NIC: non-intensive chemotherapy
NPM1: Nucleophosmin 1
NSCLC: non-small cell lung cancer
OBAD: optimal biologically active dose
ORR: overall response rate
OS: overall survival
PD: progressive disease
PDAC: pancreatic ductal adenocarcinoma
PIK3a: phosphatidylinositol-4,5-bisphosphate 3-kinase catalytic subunit alpha
POC: proof of concept
PR: partial response
Quiz: quizartinib
QTc: corrected QT interval
RAS: rat sarcoma
RCC: renal cell carcinoma
RHEB: Ras homolog enriched in brain
R/R: relapsed/refractory
SD: stable disease
SOC: standard of care
TAM: total addressable market
TKI: tyrosine kinase inhibitor
TORC1: target of rapamycin complex 1
uPR: unconfirmed partial response
VEGF: vascular endothelial growth factor
Ven/aza: venetoclax + azacitidine
-m: mutated
-r: rearranged

THANK YOU

Leading the Next Era of Precision Medicine