Corporate Presentation

December 2024

SpringWorks® THERAPEUTICS

Forward-Looking Statements

Note: Unless otherwise indicated, the information presented herein is as of December 2024 and made publicly available on December 12, 2024.

This presentation contains “forward-looking statements” within the meaning of the Private Securities Litigation Reform Act of 1995, as amended, relating to our business, operations, and financial conditions, including but not limited to current beliefs, expectations and assumptions regarding the future of our business, future plans and strategies, our development and commercialization plans, our preclinical and clinical results, the market potential of OGSIVEO for adult patients with desmoid tumors, expectations to transition to blister packaging for OGSIVEO by the end of the year, expectations regarding the adequacy of the data contained in the nirogacestat MAA to serve as the basis for marketing approval of nirogacestat for the treatment of desmoid tumors in the European Union, the potential for mirdametinib to become an important new treatment for adult and pediatric NF1-PN patients, expectations regarding the timing and results of the reviews by the FDA and the EMA, as applicable, of each of the NDA and the MAA for mirdametinib for the treatment of adult and pediatric NF1-PN patients, including the FDA's PDUFA target action date for the NDA, our plans to report additional data from the Phase 2b ReNeu clinical trial at an upcoming medical conference in 4Q 2024, our plans for seeking regulatory approval for and making mirdametinib available for NF1-PN patients, if approved, expectations regarding the timing and initial data from the Phase 2 trial evaluating nirogacestat in patients with recurrent ovarian granulosa cell tumors, our expectations and the timing of the Phase 1a trial of SW-682, our plans to report additional clinical data of nirogacestat in combination with BCMA-directed therapies and initiate additional planned Phase 1 collaborator studies, our expectations and the timing of the Phase 1b dose expansion phase of brimarafenib, our expectations regarding the timing of enrollment in our combination therapy oncology programs, expectations about whether our patents for our lead assets will adequately protect SpringWorks against competition, as well as relating to other future conditions. Words such as, but not limited to, “look forward to,” “believe,” “expect,” “anticipate,” “estimate,” “intend,” “plan,” “would,” “should” and “could,” and similar expressions or words, identify forward-looking statements. New risks and uncertainties may emerge from time to time, and it is not possible to predict all risks and uncertainties. Any forward-looking statements in this press release are based on management’s current expectations and beliefs and are subject to a number of risks, uncertainties and important factors that may cause actual events or results to differ materially from those expressed or implied by any forward-looking statements contained in this press release, including, without limitation, risks relating to: (i) the success of our commercialization efforts with respect to OGSIVEO, (ii) our limited experience as a commercial company, (iii) our ability to obtain or maintain adequate coverage and reimbursement for OGSIVEO, (iv) the success and timing of our product development activities, including the initiation and completion of our clinical trials, (v) our expectations regarding the potential clinical benefit of OGSIVEO for adult patients with desmoid tumors who require systemic treatment, (vi) the potential for OGSIVEO to become the new standard of care for adult patients with desmoid tumors, (vii) estimates regarding the number of adult patients who are diagnosed with desmoid tumors annually per year in the U.S. and the potential market for OGSIVEO, (viii) estimates regarding the number of adult and pediatric NF1-PN patients and the potential market for mirdametinib, if approved, (ix) the fact that topline or interim data from clinical studies may not be predictive of the final or more detailed results of such study or the results of other ongoing or future studies, (x) the success and timing of our collaboration partners’ ongoing and planned clinical trials, (xi) the timing of our planned regulatory submissions and interactions, including the timing and outcome of decisions made by the FDA, EMA, and other regulatory authorities, investigational review boards at clinical trial sites and publication review bodies, (xii) whether FDA, EMA, or other regulatory authorities will require additional information or further studies, or may fail or refuse to approve or may delay approval of our product candidates, including nirogacestat and mirdametinib, (xiii) our ability to obtain regulatory approval of any of our product candidates or maintain regulatory approvals granted for our products, (xiv) our plans to research, discover and develop additional product candidates, (xv) our ability to enter into collaborations for the development of new product candidates and our ability to realize the benefits expected from such collaborations, (xvi) our ability to maintain adequate patent protection and successfully enforce patent claims against third parties, (xvii) the adequacy of our cash position to fund our operations through any time period indicated herein, (xviii) our ability to establish manufacturing capabilities, and our and our collaboration partners’ abilities to manufacture our product candidates and scale production, and (xix) our ability to meet any specific milestones set forth herein.

Except as required by applicable law, we do not plan to publicly update or revise any forward-looking statements contained herein, whether as a result of any new information, future events, changed circumstances or otherwise. Although we believe the expectations reflected in such forward-looking statements are reasonable, we can give no assurance that such expectations will prove to be correct. Accordingly, readers are cautioned not to place undue reliance on these forward-looking statements.

For further information regarding the risks, uncertainties and other factors that may cause differences between SpringWorks’ expectations and actual results, you should review the “Risk Factors” in Item 1A of Part II of SpringWorks’ Quarterly Report on Form 10-Q for the quarter ended September 30, 2024, as well as discussions of potential risks, uncertainties and other important factors in SpringWorks’ subsequent filings.

Certain information contained in this presentation relates to or is based on studies, publications, surveys and other data obtained from third-party sources and our own internal estimates and research. While SpringWorks believes these third-party sources to be reliable as of the date of this presentation, we have not independently verified, and make no representation as to the adequacy, fairness, accuracy or completeness of, any information obtained from third-party sources. In addition, all of the market data included in this presentation involves a number of assumptions and limitations, and there can be no guarantee as to the accuracy or reliability of such assumptions. Finally, while we believe our own internal research is reliable, such research has not been verified by any independent source.

PATIENTS HAVE BEEN WAITING FOR ANSWERS.

LET'S GO

SpringWorks Therapeutics Is a Commercial-Stage Targeted Oncology Company Delivering New Advances for Patients

As first and only FDA-approved therapy for desmoid tumors, OGSIVEO is established as the systemic standard of care

NDA for mirdametinib in NF1-PN granted Priority Review, representing opportunity for a second FDA approval in early 2025

Geographic expansion for lead assets and diversified pipeline of emerging targeted oncology programs broaden opportunity set

Strong financial position expected to fund operations through profitability in 1H 2026 and durable IP protection for lead assets

SpringWorks THERAPEUTICS

Differentiated Lead Programs With Practice-Changing Potential in Rare Tumor Types and Broad Indication Expansion Opportunities

Nirogacestat
Gamma Secretase Inhibitor

- OGSIVEO (nirogacestat) launch ongoing as the first and only FDA-approved therapy for desmoid tumors[1] with $49.3M in net revenue in Q3 2024 and over $115M since approval in November 2023
- >800 unique patients filled OGSIVEO script in September 2024, with ~10,000 patients receiving care in the last year per ICD-10 claims data
- Established as systemic standard of care with novel and differentiated product profile and broad label
- Robust adoption at all stages of treatment with patients experiencing profound clinical benefits, including rapid pain resolution
- International expansion underway; MAA review is ongoing with potential for EC approval and launch in Germany in 1H 2025
- Advancing expansion opportunities as monotherapy in OvGCT and BCMA combination therapy in multiple myeloma
- Durable patent portfolio of 27 Orange Book-listed patents, with latest expiry in 2043; received Orphan Drug exclusivity from FDA and EC

Mirdametinib
Investigational MEK Inhibitor

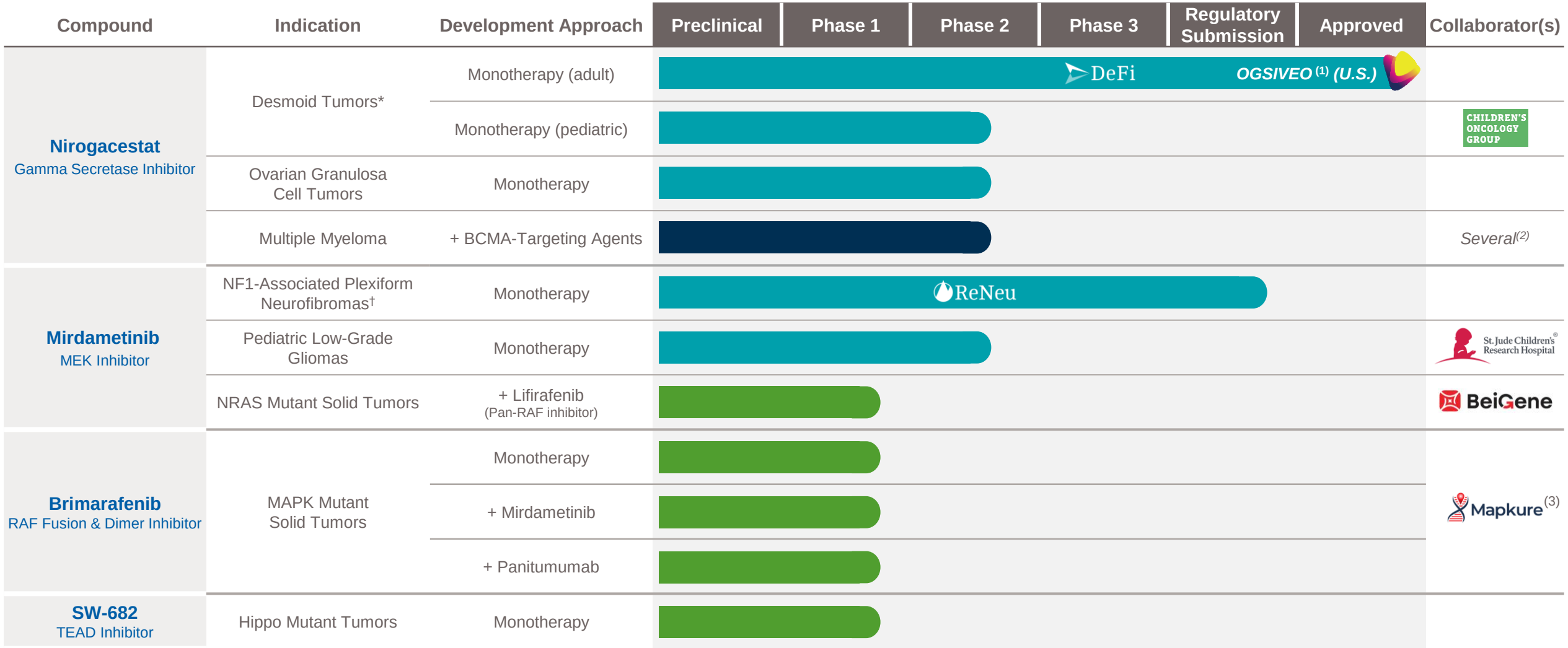
- NDA for adult and pediatric NF1-PN granted Priority Review, with PDUFA date of February 28, 2025
- Data from pivotal Phase 2b ReNeu trial showed best-in-class product potential for both pediatric and adult patients with NF1-PN
- Deep and durable responses confirmed by BICR and manageable safety profile underscore physician enthusiasm[2]
- MAA submission validated by EMA, with potential for EC approval and commercial launch in 2025
- Monotherapy and combination studies ongoing in additional indications, including pLGG and RAS/RAF-mutated solid tumors
- Fast Track and Rare Pediatric Disease designations from FDA, with eligibility to receive a priority review voucher upon approval; Orphan Drug designation from FDA and EC
- Durable patent portfolio with latest expiry in 2043

Note: OvGCT: Ovarian granulosa cell tumors; NF1-PN: Neurofibromatosis type 1-associated plexiform neurofibroma; MAA: Marketing Authorization Application; EMA: European Medicines Agency; EC: European Commission; pLGG: pediatric low-grade glioma.

(1) OGSIVEO was approved for the treatment of adult patients with progressing desmoid tumors who require systemic treatment on November 27, 2023.

(2) SpringWorks primary market research, December 2023 (N=100 HCPs, each treating an average of >20 NF1-PN patients). Respondents answered questions based on review of blinded profiles derived from FDA labeling (selumetinib) and ReNeu topline data (mirdametinib).

Diversified Targeted Oncology Pipeline Spanning Solid Tumors and Hematological Cancers



* Received Orphan Drug designation. † Received Orphan Drug, Fast Track, and Rare Pediatric Disease designations. NDA for NF1-PN granted Priority Review with PDUFA date of February 28, 2025. (1) Indicated for adult patients with progressing desmoid tumors who require systemic treatment. (2) Includes preclinical, Phase 1, and Phase 2 studies planned or ongoing with GSK, Janssen, Pfizer, Regeneron, and AbbVie. On June 6, 2024, GSK notified SpringWorks that it is terminating the collaboration agreement and winding down the study; no further enrollment is expected, though the study will continue for the patients enrolled at the time of termination notice. (3) Being developed by MapKure, LLC, jointly owned by SpringWorks and BeiGene.

Rare Oncology
BCMA Combos
Biomarker-Defined Solid Tumors

Unlocking Value Across Portfolio in 2024 and Beyond

2024 Accomplishments

- ✓ Completed MAA submission for nirogacestat to EMA in 1Q 2024
- ✓ Presented additional DeFi analyses with nirogacestat at ASCO in 2Q 2024, as well as long-term follow-up data at CTOS in 4Q 2024
- ✓ NDA submission for mirdametinib for children and adults with NF1-PN accepted and granted Priority Review in 3Q 2024
- ✓ Received validation for mirdametinib MAA in 3Q 2024
- ✓ Presented ReNeu trial data for mirdametinib at ASCO, Global NF Conference, and ISPNO in 2Q 2024
- ✓ Published manuscript of ReNeu trial data in *Journal of Clinical Oncology* in 4Q 2024
- ✓ Presented Phase 1/2 data for mirdametinib in pLGG through collaboration with St. Jude Children's Research Hospital at ISPNO in 2Q 2024
- ✓ Initiated Phase 1 trial of SW-682 (TEAD inhibitor) in Hippo-mutant solid tumors in 2Q 2024
- ✓ Initiated Phase 1b trial of brimarafenib(1) with panitumumab in CRC and pancreatic cancer patients in 1Q 2024

Anticipated Milestones

- ❑ Present additional ReNeu data analyses for mirdametinib at Society of Neuro-Oncology conference on November 22-24, 2024
- ❑ Secure FDA approval for mirdametinib in adults and children with NF1-PN (PDUFA: February 28, 2025)
- ❑ Continue to expand opportunity set for nirogacestat across indications, with initial Phase 2 OvGCT data in 1H 2025
- ❑ Potential regulatory approvals in the EU for nirogacestat in desmoid tumors and mirdametinib in NF1-PN in 2025
- ❑ Commercialize nirogacestat in Europe with first launch in Germany in 1H 2025; European commercial launch for mirdametinib expected in 2025
- ❑ Present additional data for brimarafenib(1) monotherapy in MAPK-mutant solid tumors in 2H 2025
- ❑ Advance early-stage assets and discovery work, while seeking to expand portfolio through investment in internal programs and opportunistic business development

Note: MAA: Marketing Authorization Application; EMA: European Medicines Agency; NDA: New Drug Application; ASCO: American Society of Clinical Oncology; OvGCT: ovarian granulosa cell tumors; NDA: New Drug Application; NF1-PN: neurofibromatosis type 1, plexiform neurofibromas; ISPNO: International Symposium on Pediatric Neuro-Oncology; pLGG: pediatric low-grade glioma; CRC: colorectal cancer; CTOS: Connective Tissue Oncology Society; PDUFA: Prescription Drug User Fee Act.
(1) Being developed by MapKure, a joint venture owned by SpringWorks and BeiGene. Listed milestones to be achieved through MapKure.

OGSIVEO (nirogacestat)

Desmoid Tumors

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Ogsiveo® (nirogacestat)

The First and Only FDA-Approved Therapy for Adult Patients With Desmoid Tumors

OGSIVEO is a gamma secretase inhibitor indicated for adult patients with progressing desmoid tumors who require systemic treatment

SpringWorks® THERAPEUTICS

Desmoid Tumors Are Highly Morbid and Patients Had No Approved Treatments Before OGSIVEO

Aggressive, invasive, and highly debilitating soft tissue tumors

Can cause severe and chronic pain, loss of physical function, disfigurement, and anxiety

Complications can lead to nerve compression, intestinal obstruction, and internal bleeding

High rates of surgical recurrence and suboptimal outcomes with off-label systemic therapies left a critical unmet need

OGSIVEO is already the systemic standard of care for desmoid tumors *(1)*

My desmoid tumor **wrapped around my nerves, veins and artery** behind my knee. I've had **ten surgeries total**, six to remove the tumor and four related to complications, and it **keeps growing back.**

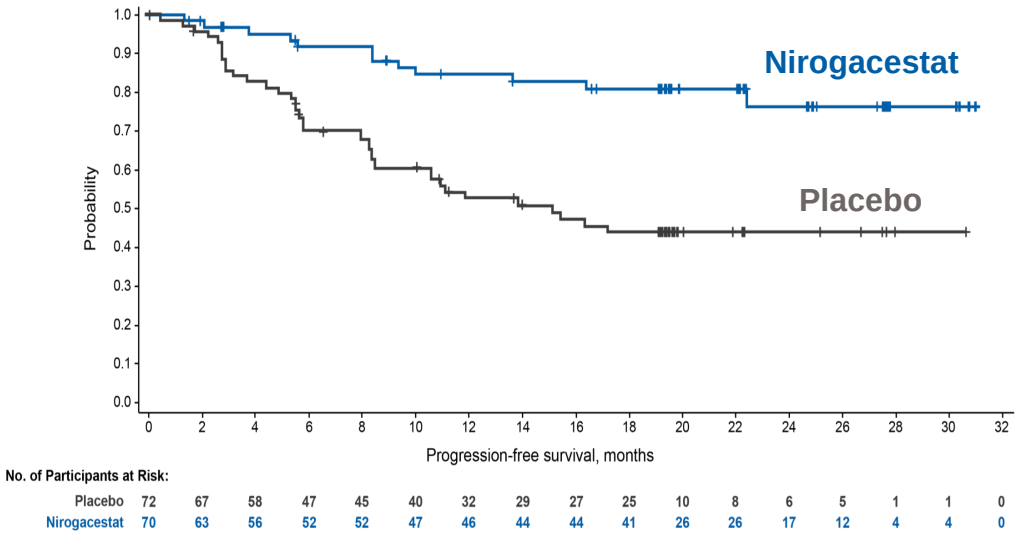
- DeAnn, desmoid tumor patient

(1) Based on SWTX proprietary analysis of claims data among desmoid tumor patients treated with systemic agents.

Strong Label Positions OGSIVEO as the Standard of Care for Desmoid Tumors

Efficacy Summary from USPI

	OGSIVEO (n=70)	Placebo (n=72)
Progression-Free Survival		
Number (%) of patients with event	12 (17)	37 (51)
Radiographic progression[a]	11 (16)	30 (42)
Clinical progression[a]	1 (1)	6 (8)
Death	0	1 (1)
Median (months) (95% CI)[b]	NR (NR, NR)	15.1 (8.4, NR)
Hazard ratio (95% CI)	0.29 (0.15, 0.55)	
p-value[c]	<0.001	
Objective Response Rate[a]		
ORR, n (%)	29 (41)	6 (8)
95% CI[d]	(29.8, 53.8)	(3.1, 17.3)
CR	5 (7)	0
PR	24 (34)	6 (8)
p-value[e]	<0.001	



"Progression-free survival results were supported by change from baseline in patient-reported worst pain favoring the OGSIVEO arm."

- OGSIVEO USPI

Safety Summary from USPI

Warnings and Precautions

- Diarrhea, ovarian toxicity, hepatotoxicity, non-melanoma skin cancers, electrolyte abnormalities, embryo-fetal toxicity

Most Common Adverse Reactions[f]

- Diarrhea, ovarian toxicity, rash, nausea, fatigue, stomatitis, headache, abdominal pain, cough, alopecia, upper respiratory tract infection, dyspnea

No Boxed Warnings, REMS Program, or Contraindications

Full prescribing information is available at www.OGSIVEO.com.; USPI: U.S. Prescribing Information; CI: confidence interval; ORR: objective response rate; CR: complete response; PR: partial response; NR: not reached.

a) Assessed by blinded independent central review.
b) Obtained using Kaplan-Meier Methodology.
c) p-value was from a one-sided stratified log-rank test with placebo as reference.
d) Obtained using exact method based on binomial distribution.
e) p-value was from a two-sided Cochran-Mantel-Haenszel test.
f) Reported in over 15% of patients.

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OGSIVEO Is Addressing the Needs of Patients at All Stages of Their Desmoid Tumor Treatment

U.S. Patient Population

~1,000-1,650
new patients diagnosed annually

Uptake among incident population driven by physician willingness and preference to use as 1L treatment option

~5,500-7,000
patients actively managed annually

Rapidly established as the systemic standard of care, with ICD-10 claims data validating size of patient population

30,000+
total diagnosed prevalent patients

Opportunity to address prevalent pool over time, as most patients require active intervention over the course of their disease

▲

Identification of ~10,000 unique patients through ICD-10 claims data (from October 2023 through August 2024) suggests higher population of actively managed patients than previously estimated

Note: 1L: first-line. ICD-10: International Classification of Diseases, Tenth Edition.
Sources: SWTX Primary Market Research; Van Broekhoven et al., Annals of Surgical Oncology, 2015; Reitamo et al., American Journal of Clinical Pathology, 1982; Anneberg et al., Cancer Epidemiology, 2022.

OGSIVEO Continues to Solidify Position as the Systemic Standard of Care for Desmoid Tumors(1)

Ogsiveo® (nirogacestat)

$49.3M in net product revenue for 3Q 2024

+23% QoQ growth

Continued growth in underlying demand and new patient starts

Most prescribed systemic therapy for adults with desmoid tumors

On track to complete blister pack transition by year-end

Durable clinical benefit with new data supporting long-term use

Evolving treatment dynamics support increased OGSIVEO use

(1) OGSIVEO is indicated for adult patients with progressing desmoid tumors who require systemic treatment.

Key Commercial Metrics After Nearly One Full Year on the Market

Patients

>800 unique patients filled an OGSIVEO script in September

~65% of patients on blister packs by end of September

~10K patients with DT ICD-10 claims between October 2023 and August 2024(1)

Prescribing Community

~420 treatment centers have prescribed OGSIVEO

~90% of sarcoma CoEs have prescribed OGSIVEO

~57% of ordering treatment centers represent community practices

Payor Coverage(2)

~98% with confirmed reimbursement of OGSIVEO

~90% have published formal policies for OGSIVEO

~95% with confirmed reimbursement of OGSIVEO blister packs

Note: all data as of September 30, 2024 unless otherwise stated; DT: desmoid tumor; ICD-10: International Classification of Diseases, Tenth Edition; CoE: Center of Excellence.
(1) Desmoid tumor-specific ICD-10 codes were introduced in October 2023. Data through September 2024 not yet available.
(2) Percentages represent proportion of aggregate commercial PBM covered lives.

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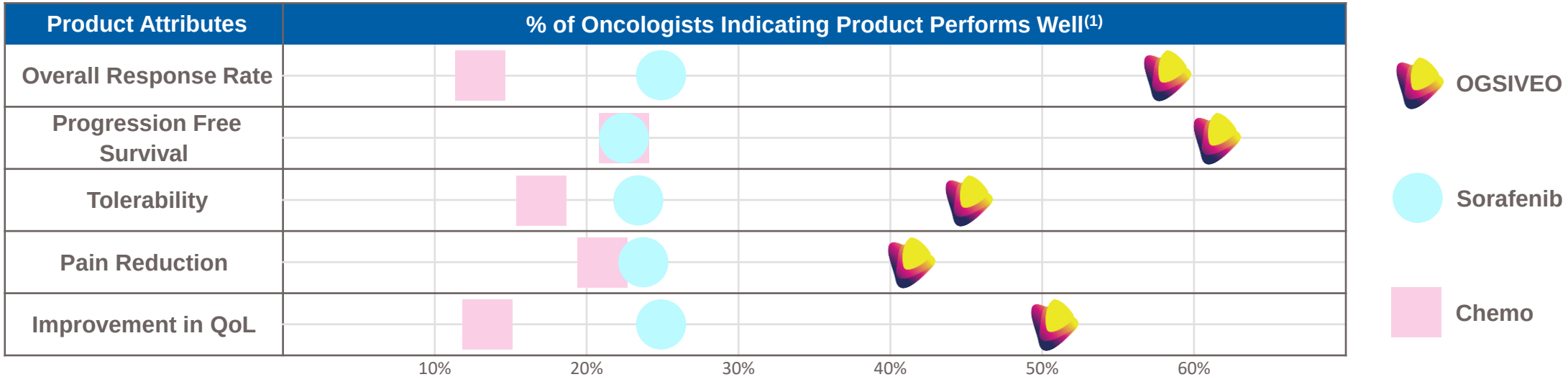
Impressive Brand Growth Driven by Strong Physician Preference for OGSIVEO

OGSIVEO Outperforms Alternative Systemic Treatment Options Across All Product Attributes



~90% of OGSIVEO prescribers are likely to use as a front-line treatment

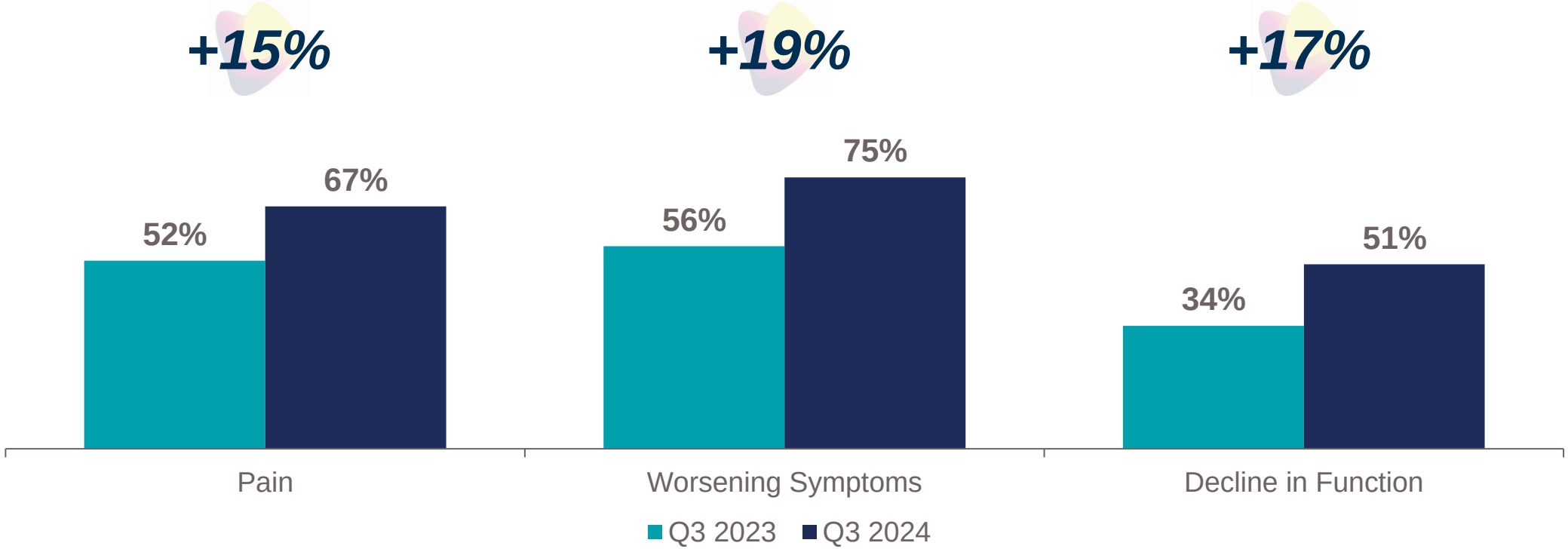
~60% of physicians expect to increase their usage of OGSIVEO in the next year(2)

Source: SpringWorks market research; survey of 150 oncologists treating desmoid tumor patients, August 2024. Note: QoL: quality of life.

(1) Represents proportion of oncologists aware of OGSIVEO who indicated a score of 6 out of 7 or 7 out of 7 in response to the question: "Considering your experience and what you may know about these products, how well do the following treatments perform on the following attributes for your patients?"

(2) Represents proportion of respondents who indicated increased usage in response to the question: "In the next year, how do you expect your usage of OGSIVEO for progressing/symptomatic adult (18+) patients to change, if at all?" Approximately 40% of respondents indicated usage would stay the same.

Growing Emphasis on Clinical Symptoms as Reason to Initiate Active Treatment



87% of surveyed physicians indicated a likelihood to use OGSIVEO for symptomatic patients without radiographic progression, consistent with FDA-approved label

Source: SpringWorks market research; survey of 150 oncologists treating desmoid tumor patients, August 2024.

Preparing to Bring OGSIVEO to Patients Outside the U.S. Beginning in 1H 2025

Europe and UK

- MAA review ongoing with anticipated approval and first launch in Germany in 1H 2025; additional European geographies to follow
- European HQ established in Switzerland; key Commercial and Medical personnel onboarded
- Significant commercial opportunity with proportionate number of DT patients to that in the U.S.
- Positive KOL experiences with OGSIVEO through DeFi
- Physicians indicate high unmet need to be addressed, and >90% are likely to prescribe OGSIVEO and believe it offers clinical benefits not offered by other therapies(1)
- >250 patients in compassionate use program validates unmet need

Japan

- Several successful PMDA interactions completed in 2024
- Single-arm ethno-bridging study initiating in 2025 that, together with DeFi, will form the basis for a potential approval

Note: MAA: Marketing Authorization Application; HQ: headquarters; DT: desmoid tumor; KOL: key opinion leader; PMDA: Pharmaceuticals and Medical Devices Agency.

(1) SpringWorks market research; survey of 214 oncologists treating desmoid tumor patients in Germany, France, and the UK, July 2024.

Factors Underpinning Confidence in OGSIVEO's Blockbuster Potential

Addressable Patient Population

- ✓ Large and growing desmoid tumor patient pool
- ✓ KOL advocacy at sarcoma centers of excellence
- ✓ Geographic expansion outside the U.S.

OGSIVEO Brand Growth

- ✓ Experience-based belief in OGSIVEO
- ✓ Long-term data supports durable treatment
- ✓ Broad payer coverage enabling access

Evolving Treatment Dynamics

- ✓ Systemic-first treatment guidelines
- ✓ Clinically-driven urgency to treat
- ✓ Physician behavior aligned with label

Note: KOL: key opinion leader.

Long-Term Follow-Up Data From DeFi Illustrate Benefit of Extended Treatment With OGSIVEO

ctos®

Long-Term Efficacy and Safety From DeFi[1]

- Median (range) duration of nirogacestat exposure was 33.6 (0.3–60.0) months
- Objective response rate (ORR) increased from 34.3% with up to 1 year of treatment to 45.7% with up to 4 years of treatment (3 new partial responses and 3 new complete responses)
- The median best percent reduction from baseline in target tumor size with continuous nirogacestat treatment was −32.3% at year 1 (n=46) and −75.8% for those patients completing at least 4 years (n=15) of treatment
- Improvement in PROs of pain, DT-specific symptom severity, and DT-specific physical functioning occurred early and were sustained with up to 45 months of treatment with nirogacestat
- Incidence and severity of frequently reported TEAEs decreased through treatment

> Female patient in her twenties with a desmoid tumor… has been on nirogacestat for over 4 years and declined discontinuing because it's working so well for her.
>
> *- Medical Oncologist*

> Duration of therapy will be more indefinite vs other systemic options due to better tolerability and efficacy.
>
> *- Medical Oncologist*

Note: PRO: patient-reported outcome; ORR: objective response rate; DT: desmoid tumors.

(1) Ratan et al. Nirogacestat treatment in adult patients with desmoid tumors: long-term efficacy and safety from the phase 3 defi trial

Mirdametinib

NF1-PN

SpringWorks® THERAPEUTICS

Mirdametinib Has the Potential to Address the Substantial Unmet Needs of NF1-PN Patients

U.S. NF1-PN Patient Population

~100,000
Individuals with an NF1 diagnosis[1]

↓

~40,000
Patients living with NF1-PN[2,3]

↓

~30,000
Adult NF1-PN patients with no approved options

~10,000
Pediatric NF1-PN patients with significant unmet need

Antwan
Living with NF1-PN

Kylie
Living with NF1-PN

NF1-PN is a disfiguring and highly morbid growth along nerves, often causing chronic, disabling pain

Currently no standard of care; highly fragmented treatment landscape with significant use of off-label systemic options

No approved options for adult patients; challenges with administration and tolerability limit use of currently available options for pediatric patients

Phase 2b ReNeu data support mirdametinib's potential to be first-in-class therapy for adult NF1-PN patients and best-in-class option for pediatric patients

Note: NF1-PN: Neurofibromatosis Type 1, Plexiform Neurofibromas.
Sources: (1) Lammert et al., Arch Dermat, 2005. U.S. Census Data; (2) Fisher et al., Neuro-Oncology, 2022. (3) SpringWorks market research.

ReNeu Data Support Mirdametinib's Potential Best-in-Class Profile in Adults and Children

Meaningful Antitumor Activity	• Robust ORRs confirmed by BICR • Deep responses, with majority of responders experiencing tumor volume reduction over 50%
Manageable Safety Profile	• Low rates of Grade 3+ toxicities and dose interruptions • Extended treatment durations
Enhanced Quality Of Life	• Statistically significant improvements in patient-reported outcomes • Early, sustained, and clinically meaningful benefits in worst tumor pain and pain interference
Significant Patient Convenience	• Intermittent dosing schedule and dispersible tablet for oral suspension • High willingness to keep taking dispersible tablet, with ease of swallowing reported by patients and caregivers

2024 ASCO ANNUAL MEETING

SNO Society for NeuroOncology

ISPNO 2024 Philadelphia

Journal of Clinical Oncology®

NDA accepted with Priority Review and PDUFA date of February 28, 2025 | MAA validated by EMA and review ongoing

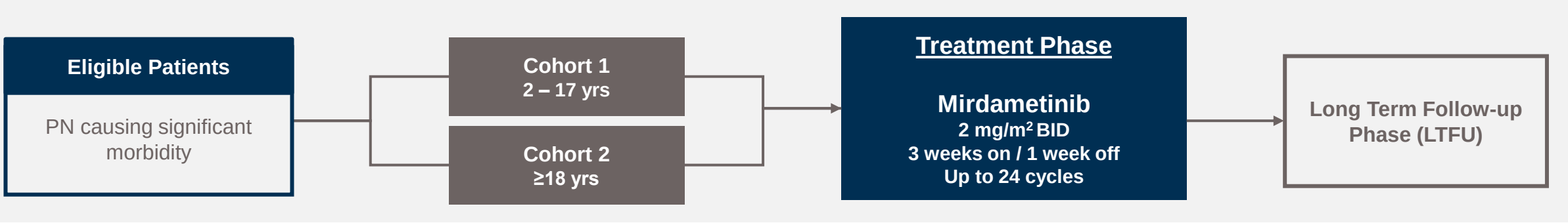
Note: ORR: Objective Response Rate; BICR: Blinded Independent Central Review.

Sources: Moertel C, Hirbe A, Shuhaiber H, et al. for the ReNeu Study Group. ASCO 2024; Babovic-Vuksanovic D, Hirbe A, Moertel C, et al. Global NF Conference 2024; Klesse LJ, Bornhorst M, Meade J, et al. ISPNO 2024.

ReNeu SpringWorks THERAPEUTICS

Phase 2b ReNeu Trial Summary

ReNeu Trial Design	▪ Phase 2b open-label; n = 114 patients in 2 cohorts (pediatric and adults) across 37 U.S. sites ▪ 2 mg/m^2 BID dosing with intermittent course (4-week cycles of 3 weeks on, 1 week off) for up to 24 cycles; maximum dose of 4 mg BID ▪ Pediatric formulation (dispersible tablet) introduced in 2H 2020
Primary Endpoint	▪ Confirmed objective response rate (% of patients with ≥20% reduction in tumor volume by MRI on consecutive scans) determined by BICR by end of treatment phase
Secondary / Exploratory Endpoints	▪ Safety and tolerability, duration of response, QoL and physical functioning assessments (including measures of pain)



Note: REiNS: Response Evaluation in Neurofibromatosis and Schwannomatosis; BICR: blinded independent central review; BID: twice daily; QoL: quality of life.

Baseline Patient Demographics and Disease Characteristics

Adult Participants (n=58)

Characteristic	n (%)
Patients enrolled	58
Median age at enrollment [range] - years	34 [18 – 69]
Sex	
Male	21 (36)
Female	37 (64)
Location of target neurofibroma	
Head and Neck	28 (48)
Lower / Upper Extremities	17 (29)
Paraspinal	5 (9)
Torso(1)	5 (9)
Other	3 (5)
Type of neurofibroma-related complication	
Pain	52 (90)
Disfigurement or Major Deformity	30 (52)
Motor Dysfunction or Weakness	23 (40)
Airway Dysfunction	3 (5)
Other	10 (17)
Volume of target PN, median [range] - mL	196 [1 – 3457]
Target PN progressing at study entry	31 (53)

Pediatric Participants (n=56)

Characteristic	n (%)
Patients enrolled	56
Median age at enrollment [range] - years	10 [2 – 17]
Sex	
Male	26 (46)
Female	30 (54)
Location of target neurofibroma	
Head and Neck	28 (50)
Lower / Upper Extremities	8 (14)
Paraspinal	4 (7)
Torso(1)	8 (14)
Other	8 (14)
Type of neurofibroma-related complication	
Pain	39 (70)
Disfigurement or Major Deformity	28 (50)
Motor Dysfunction or Weakness	15 (27)
Airway Dysfunction	7 (13)
Other	12 (21)
Volume of target PN, median [range] - mL	99 [5 – 3630]
Target PN progressing at study entry	35 (63)

Note: PN: plexiform neurofibroma. Data presented is as of September 20, 2023 data cutoff. Moertel et al., *ASCO*, 2024.
(1) Includes chest wall, mesentery and pelvis, and abdominal wall.

Best Tumor Response

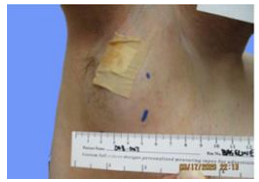
Adult Cohort

Confirmed Response Rate (BICR)	n (%)
cORR*	**24 (41)**

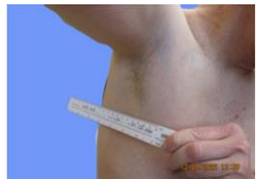
**2 patients achieved a confirmed response in long-term follow-up and are not included in the calculation of ORR*

Best Overall Confirmed Response Status (BICR)	n (%)
Partial response	24 (41)
Stable disease	26 (45)
Progressive disease	0 (0)
Missing[2]	8 (14)

Example Response: 40-Year-Old Male Patient



Baseline



Cycle 36

Target PN volume change from baseline at Cycle 36: ***-79%***

Median best change in tumor volume of -41% (n=50)

Range of -90% to 13% | 62% of confirmed responders with tumor volume reduction >50%

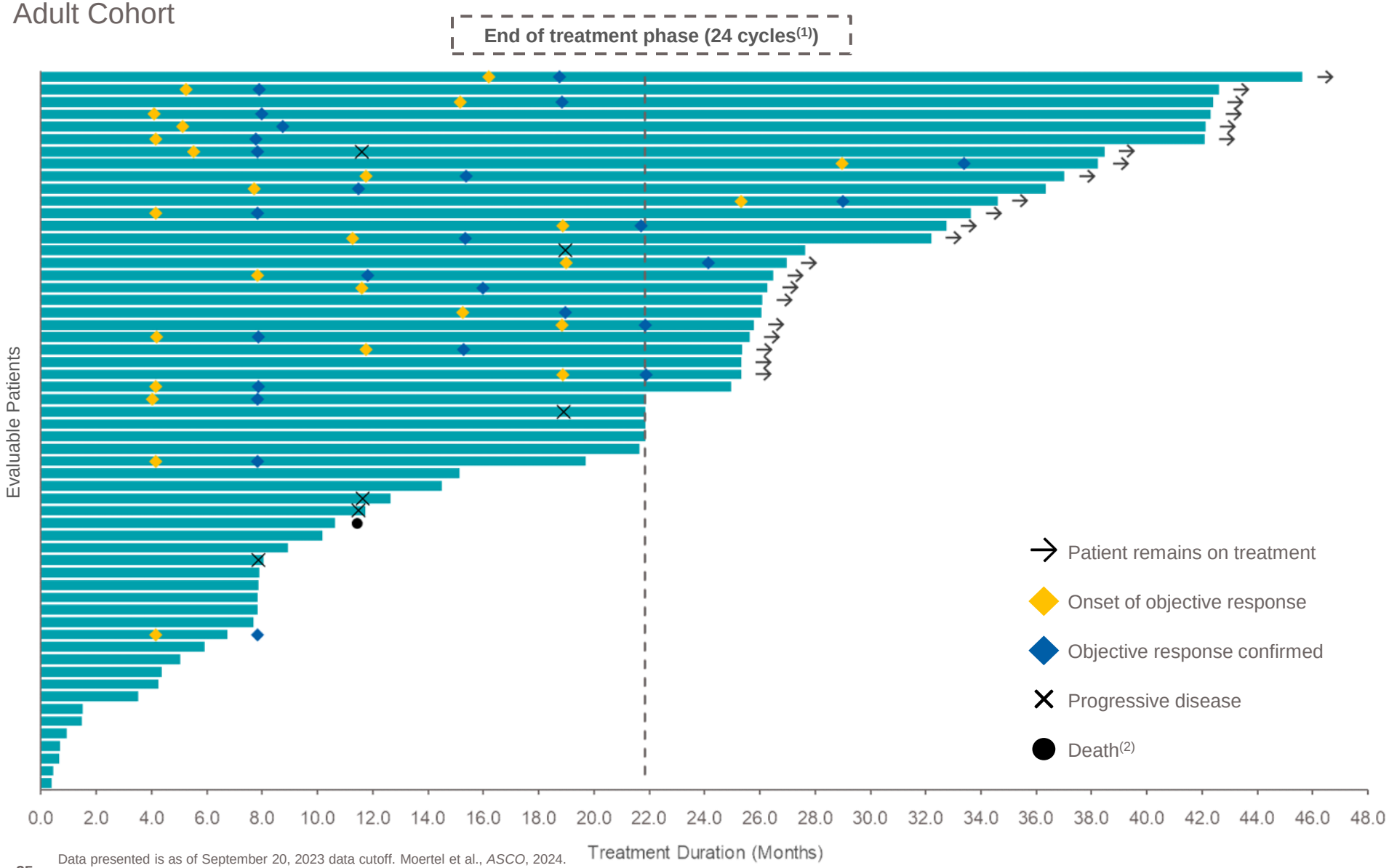
\# Patient remains on study

Data presented is as of September 20, 2023 data cutoff. Moertel et al., *ASCO*, 2024.
Note: BICR: blinded independent central review; cORR: confirmed objective response rate.
(1) Shows best change in tumor volume achieved at any point, including unconfirmed partial responses.
(2) Participants that discontinued study prior to any on-treatment MRI assessment.

ReNeu SpringWorks THERAPEUTICS

Treatment Duration and Response

Adult Cohort



- Median duration of treatment was 21.8 months
- Median time to first response was 7.8 months
  - 46% of patients had their onset of confirmed response by Cycle 5 assessment (4.2 months)
- Median duration of response was not reached
- 22 patients remained on treatment as of data cutoff
- 84% of patients that completed the treatment phase chose to continue receiving treatment in the long-term follow-up portion of the study

Data presented is as of September 20, 2023 data cutoff. Moertel et al., *ASCO*, 2024.

(1) 4-week cycles of 3 weeks on, 1 week off. Treatment phase ends 3 weeks into final cycle.

(2) One patient death due to COVID-19 occurred within 30 days of discontinuing study treatment and was deemed not related to mirdametinib.

Patient-Reported Outcomes

Adult Cohort

Scale	p-Value for Change from Baseline[1]
Target Tumor Pain – Numeric Rating Scale (NRS-11)[2] (n=21)	<0.001
Pain Interference Index (PII)[3] (n=22)	<0.001
Pediatric Quality of Life Inventory (PedsQL)[4] – Total Score (n=34)	0.018
Pediatric Quality of Life Inventory (PedsQL)[4] – Physical Functioning (n=34)	0.012

.

Data presented is as of September 20, 2023 data cutoff (updated). Moertel et al., *ASCO*, 2024.

(1) Change from baseline at Cycle 13, the pre-specified assessment for patient-reported outcome analysis per the ReNeu statistical analysis plan. Least squared means estimates using a mixed model for repeated measures (MMRM).

(2) The NRS-11 assesses target tumor pain on a scale from 0 – "no pain" to 10 – "worst pain you can imagine." NRS-11 assessments were performed for six consecutive days prior to a visit as well as on the visit day, except for the ET visit, which is done on the visit day only. The mean of these seven assessments is taken as the visit score. Baseline is defined as the most recent NRS-11 score taken on or before treatment start date.

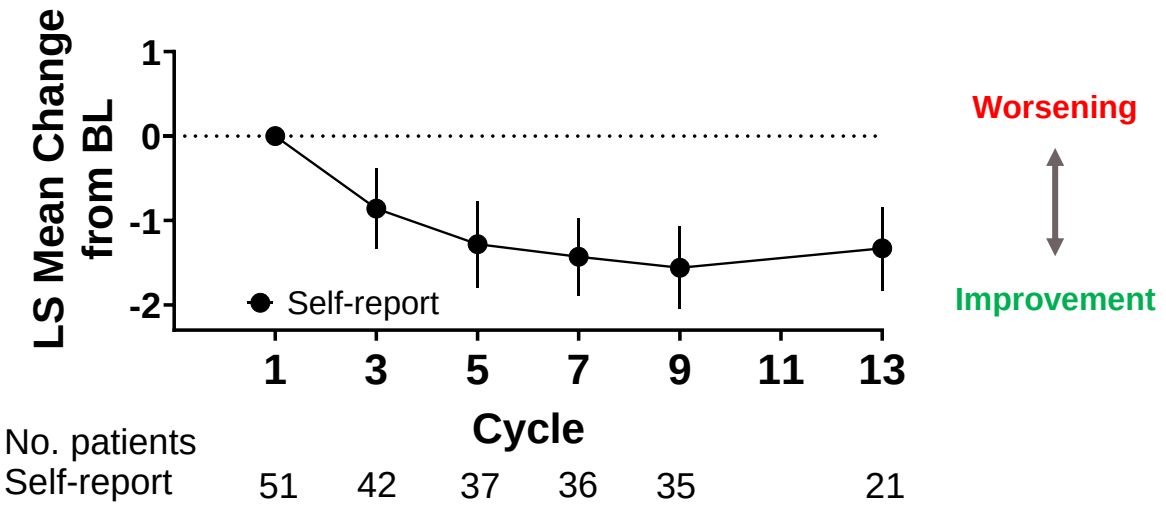
(3) The PII assesses the degree to which pain has impacted the participants' daily activities on a scale from 0 – "not at all" to 6 – "completely." PII assessments were performed on the six consecutive days prior to a visit as well as on the visit day, except for the ET visit, which is done on the visit day only. The mean of these seven assessments is taken as the visit score. Baseline is defined as the most recent PII score taken on or before treatment start date.

(4) PedsQL assess quality of life on a Likert scale from 0 to 4. These items are then reverse scored and linearly transformed to a 0-100 scale as follows: 0=100, 1=75, 2=50, 3=25, 4=0, with higher scores indicating a higher quality of life. Baseline is defined as the most recent PedsQL score taken on or before treatment start date.

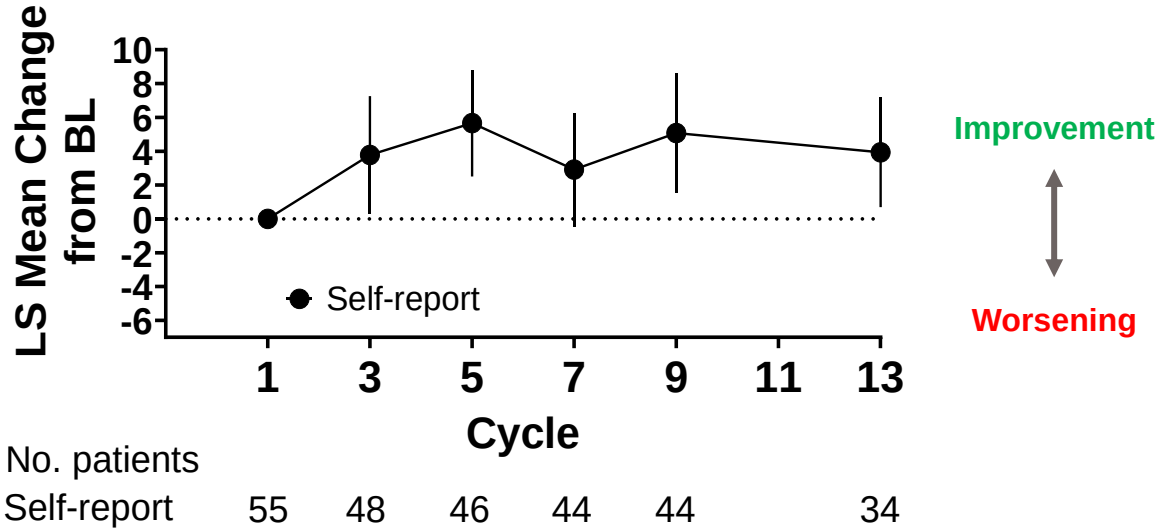
Statistically Significant Improvements in Measures of Pain and Quality of Life

Adult Cohort

Worst Tumor Pain Severity (NRS-11)[1]



Health-Related Quality of Life (PedsQL Total Score)[2]



LS mean (SE) change from baseline[3] at Cycle 13:

-1.3 (0.2) | p-value: <0.001

LS mean (SE) change from baseline[3] at Cycle 13:

3.9 (1.6) | p-value: 0.018

.

Note: LS: least squared; SE: standard error. Data presented is as of September 20, 2023 data cutoff (updated). Moertel et al., *ASCO*, 2024.

(1) The NRS-11 assesses target tumor pain on a scale from 0 – "no pain" to 10 – "worst pain you can imagine." NRS-11 assessments were performed for six consecutive days prior to a visit as well as on the visit day, except for the ET visit, which is done on the visit day only. The mean of these seven assessments is taken as the visit score. Baseline is defined as the most recent NRS-11 score taken on or before treatment start date.

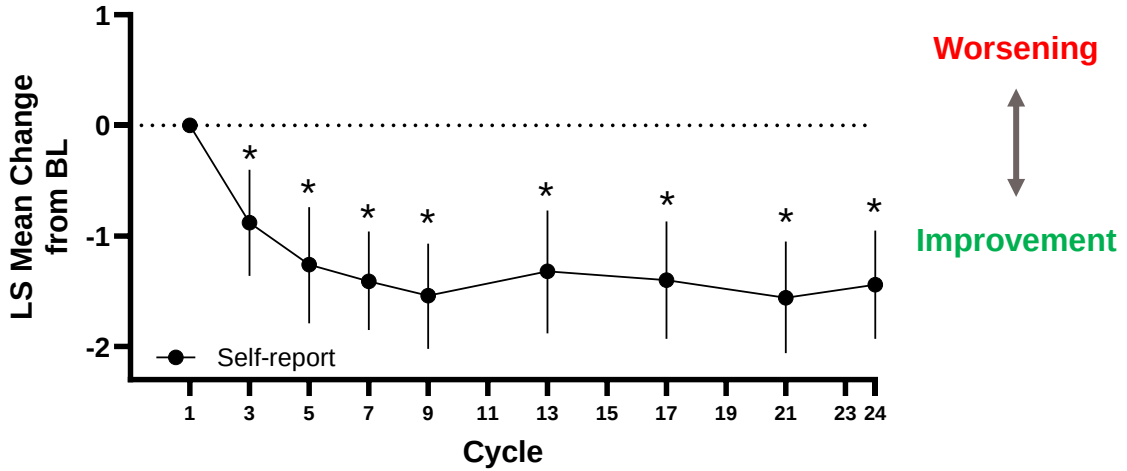
(2) PedsQL assess quality of life on a Likert scale from 0 to 4. These items are then reverse scored and linearly transformed to a 0-100 scale as follows: 0=100, 1=75, 2=50, 3=25, 4=0, with higher scores indicating a higher quality of life. Baseline is defined as the most recent PedsQL score taken on or before treatment start date.

(3) Change from baseline (Cycle 1, Day 1) at Cycle 13, the pre-specified assessment for patient-reported outcome analysis per the ReNeu statistical analysis plan. Least squared means estimates using a mixed model for repeated measures (MMRM).

Building on Evidence of Mirdametinib's Benefit With Early and Sustained Improvements in Patient-Reported Outcomes of Pain

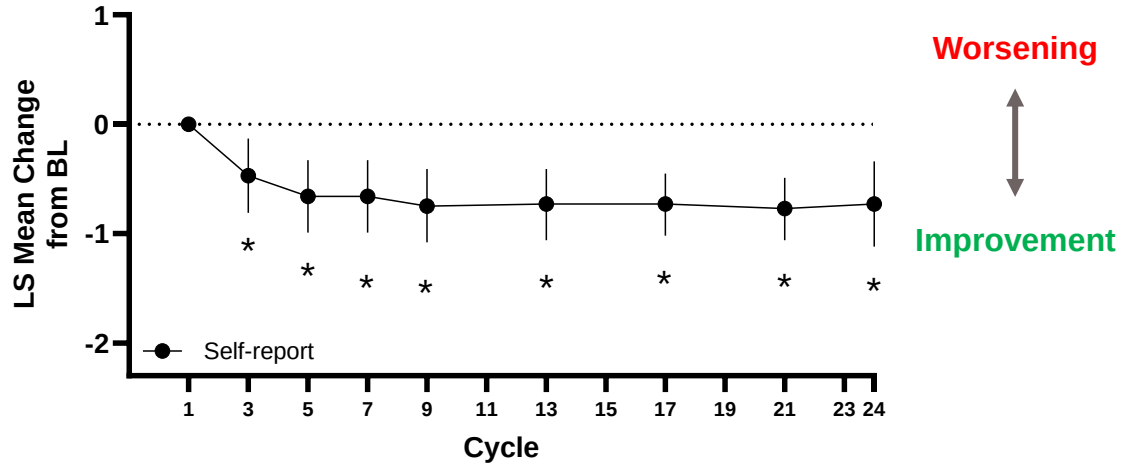
Adult Cohort

Worst Tumor Pain Severity (NRS-11)[1]



No. patients									
Self-report	51	42	37	36	35	21	21	16	17

Pain Interference (PII)[2]



No. patients									
Self-report	52	43	38	37	36	22	21	16	17

Significant improvement in worst tumor pain severity and pain interference began early (at Cycle 3, the first on-treatment assessment) and was sustained throughout the 24-cycle treatment phase

.

Note: BL: baseline; LS: least squared; SE: standard error. *P<.05 for a statistically significant change from BL. Vertical bars indicate 95% confidence intervals. Data presented is as of September 20, 2023 data cutoff (updated). Babovic-Vuksanovic et al., Global NF Conference, 2024.

(1) NRS-11 scores range from 0 (no pain) to 10 (worst pain imaginable); higher scores indicate worse pain. This was patient-reported by all patients ≥8 years of age.

(2) Pain Interference Index (PII) scores range from 0 (not at all) to 6 (completely); higher scores indicate greater pain interference (worsening). This was self-reported for all patients.

Safety Summary

Adult Cohort

(n=58)	Treatment-Related Adverse Events (TRAEs) ≥ 20% Subjects	
Preferred Term	**All Grades – n (%)**	**≥ Grade 3 – n (%)**
Any TRAE	**57 (98)**	**9 (16)**
Dermatitis acneiform	45 (78)	5 (9)
Diarrhea	28 (48)	0 (0)
Nausea	21 (36)	0 (0)
Vomiting	16 (28)	0 (0)
Fatigue	12 (21)	1 (2)
Serious TRAEs[1]	**1 (2)**	
Interruptions due to TRAEs	**5 (9)**	
Dose reductions due to TRAEs	**10 (17)**	
Discontinuations due to TRAEs[2]	**12 (21)**	

Note: There was one death due to COVID-19 in an adult (not considered to be treatment-related). Data presented is as of September 20, 2023 data cutoff. Moertel et al., *ASCO*, 2024.

(1) One treatment-related SAE in adult cohort, grade 3 RVO with confounding factors (hormonal contraception and Covid-19 vaccination). No treatment-related SAEs or RVO in pediatric cohort.

(2) TRAEs leading to treatment discontinuation in >1 patient included dermatitis acneiform (4 adults), diarrhea (4 adults), nausea (4 adults), and rash (1 adult).. The presence of more than 1 AE may have led to treatment discontinuation in a patient.

ReNeu SpringWorks THERAPEUTICS

Best Tumor Response

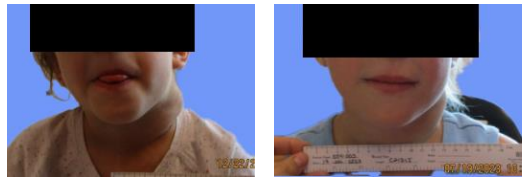
Pediatric Cohort

Confirmed Response Rate (BICR)	n (%)
cORR*	**29 (52)**

**1 patient achieved a confirmed response in long-term follow-up and is not included in the calculation of ORR*

Best Overall Confirmed Response Status (BICR)	n (%)
Partial response	29 (52)
Stable disease	22 (39)
Progressive disease	3 (5)
Missing[2]	2 (4)

Example Response: 7-Year-Old Female Patient



Baseline *Cycle 21*

Target PN volume change from baseline at Cycle 21: ***-49%***

Median best change in tumor volume of -42% (n=54)

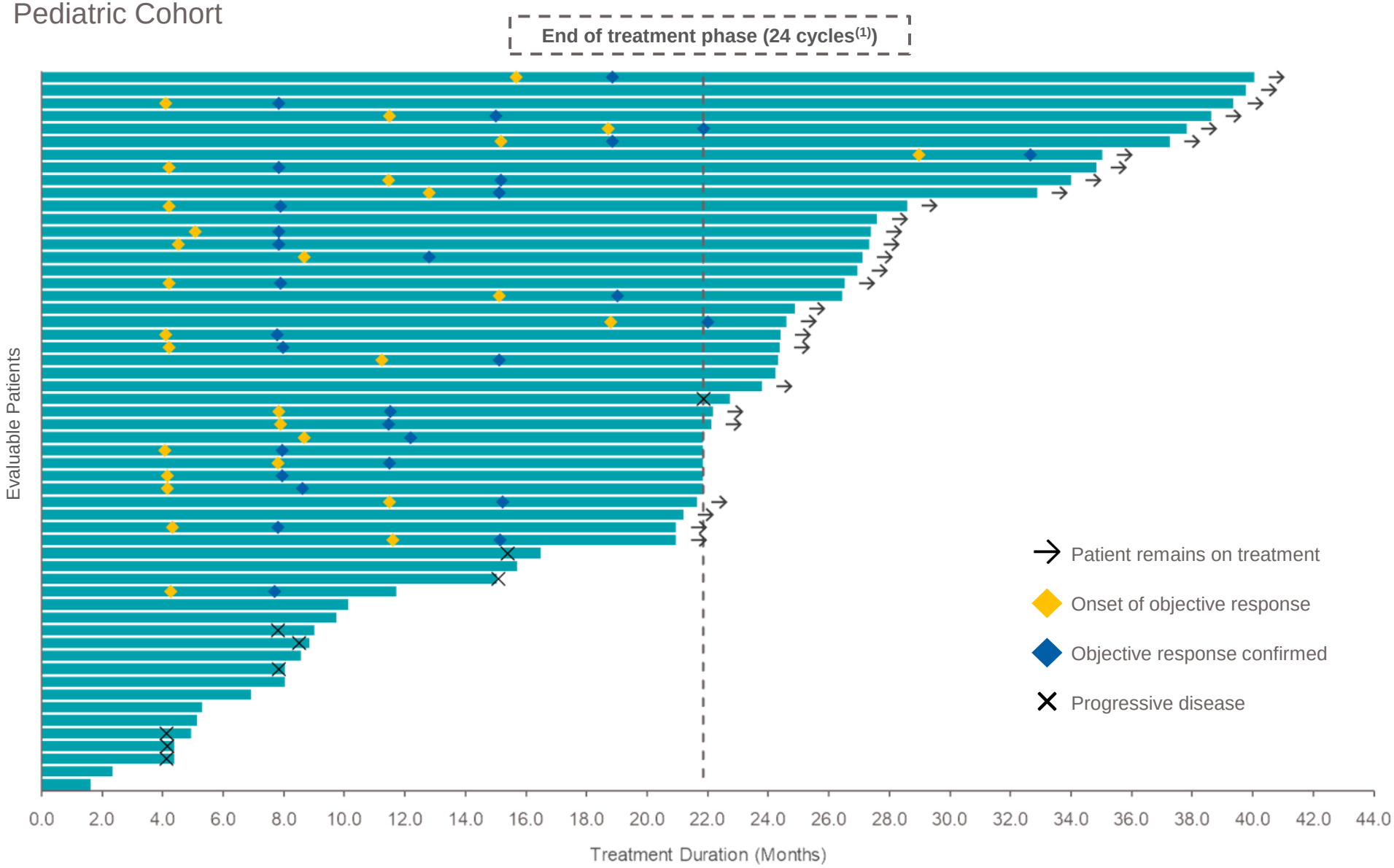
Range of -91% to 48% | 52% of confirmed responders with tumor volume reduction >50%

\# Patient remains on study

Data presented is as of September 20, 2023 data cutoff. Moertel et al., *ASCO*, 2024.
Note: BICR: blinded independent central review; cORR: confirmed objective response rate.
(1) Shows best change in tumor volume achieved at any point, including unconfirmed partial responses.
(2) Participants that discontinued study prior to any on-treatment MRI assessment.

Treatment Duration and Response

Pediatric Cohort



- Median duration of treatment was 22.0 months
- Median time to first response was 7.9 months
  - 45% of patients had their onset of confirmed response by Cycle 5 assessment (4.2 months)
- Median duration of response was not reached
- 28 patients remained on treatment as of data cutoff
- 85% of patients that completed the treatment phase chose to continue receiving treatment in the long-term follow-up portion of the study

Data presented is as of September 20, 2023 data cutoff. Moertel et al., *ASCO*, 2024.

(1) 4-week cycles of 3 weeks on, 1 week off. Treatment phase ends 3 weeks into final cycle.

Patient-Reported Outcomes

Pediatric Cohort

Scale	p-Value for Change from Baseline[1]
Target Tumor Pain – Numeric Rating Scale (NRS-11)[2] (n=17)	0.003
Pain Interference Index (PII)[3]	
Self-Report (n=22)	0.017
Parent Proxy (n=20)	0.025
Pediatric Quality of Life Inventory (PedsQL)[4] – Total Score	
Self-Report (n=38)	0.096
Parent Proxy (n=43)	0.005
Pediatric Quality of Life Inventory (PedsQL)[4] – Physical Functioning	
Self-Report (n=38)	0.033
Parent Proxy (n=43)	0.037

Data presented is as of September 20, 2023 data cutoff (updated). Moertel et al., *ASCO*, 2024.

(1) Change from baseline at Cycle 13, the pre-specified assessment for patient-reported outcome analysis per the ReNeu statistical analysis plan. Least squared means estimates using a mixed model for repeated measures (MMRM).

(2) The NRS-11 assesses target tumor pain on a scale from 0 – "no pain" to 10 – "worst pain you can imagine." NRS-11 assessments were performed for six consecutive days prior to a visit as well as on the visit day, except for the ET visit, which is done on the visit day only. The mean of these seven assessments is taken as the visit score. Baseline is defined as the most recent NRS-11 score taken on or before treatment start date.

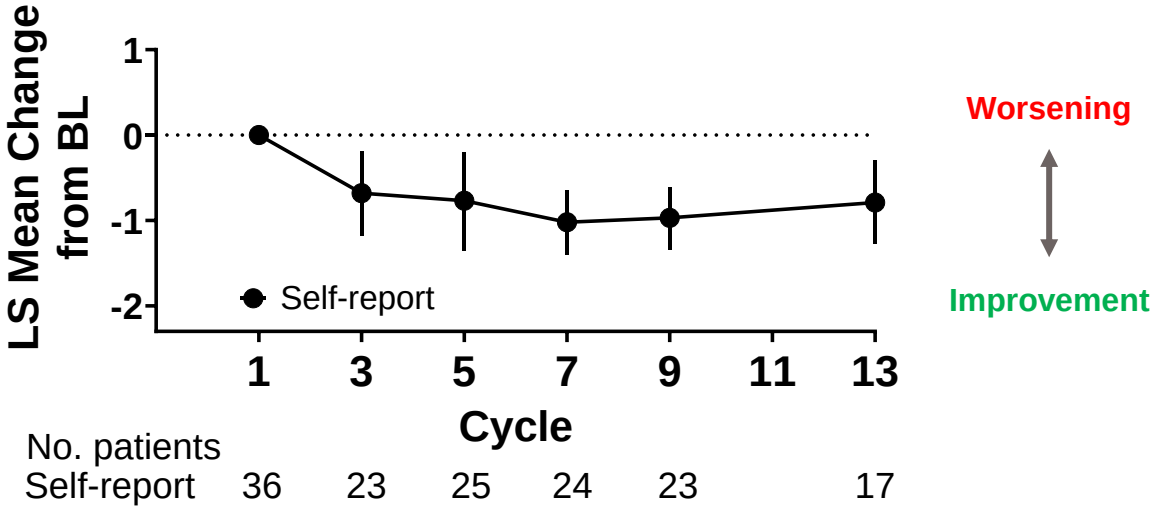
(3) The PII assesses the degree to which pain has impacted the participants' daily activities on a scale from 0 – "not at all" to 6 – "completely." PII assessments were performed on the six consecutive days prior to a visit as well as on the visit day, except for the ET visit, which is done on the visit day only. The mean of these seven assessments is taken as the visit score. Baseline is defined as the most recent PII score taken on or before treatment start date.

(4) PedsQL assess quality of life on a Likert scale from 0 to 4. These items are then reverse scored and linearly transformed to a 0-100 scale as follows: 0=100, 1=75, 2=50, 3=25, 4=0, with higher scores indicating a higher quality of life. Baseline is defined as the most recent PedsQL score taken on or before treatment start date.

Benefits in Key Patient-Reported Outcomes Also Demonstrated in Pediatric Patients

Pediatric Cohort

Worst Tumor Pain Severity (NRS-11)[1]

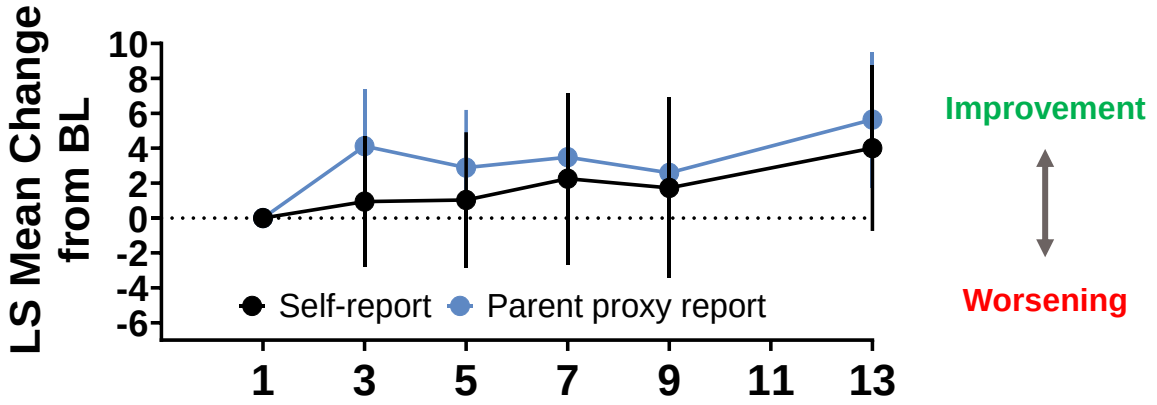


No. patients						
Self-report	36	23	25	24	23	17

LS mean (SE) change from baseline[3] at Cycle 13:

-0.8 (0.2) | p-value: 0.003

Health-Related Quality of Life (PedsQL Total Score)[2]



No. patients						
Self-report	50	48	47	41	42	38
Parent proxy report	55	52	52	48	47	43

LS mean (SE) change from baseline[3] at Cycle 13:

Self-Report: 4.0 (2.4) | p-value: 0.096

Parent Proxy: 5.6 (1.9) | p-value: 0.005

.

Note: LS: least squared; SE: standard error. Data presented is as of September 20, 2023 data cutoff (updated). Moertel et al., *ASCO*, 2024.

(1) The NRS-11 assesses target tumor pain on a scale from 0 – "no pain" to 10 – "worst pain you can imagine." NRS-11 assessments were performed for six consecutive days prior to a visit as well as on the visit day, except for the ET visit, which is done on the visit day only. The mean of these seven assessments is taken as the visit score. Baseline is defined as the most recent NRS-11 score taken on or before treatment start date.

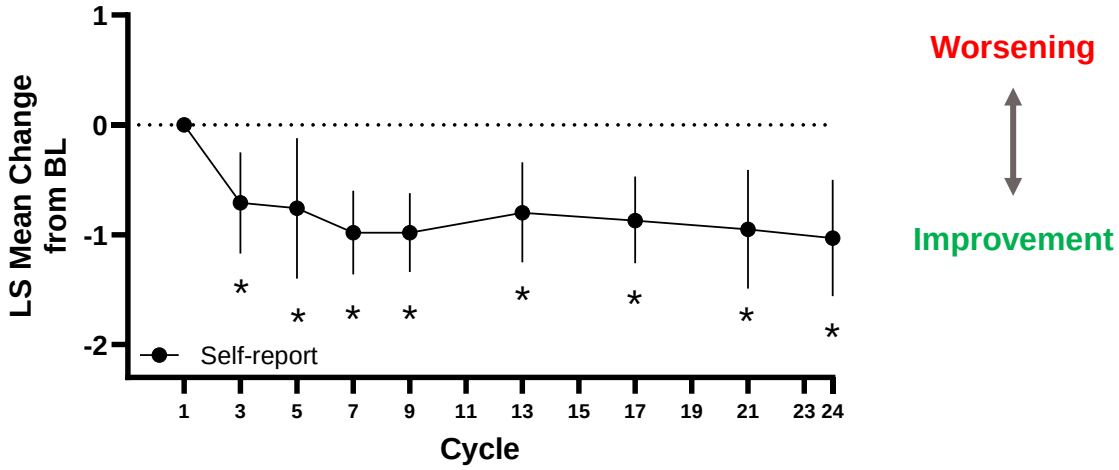
(2) PedsQL assess quality of life on a Likert scale from 0 to 4. These items are then reverse scored and linearly transformed to a 0-100 scale as follows: 0=100, 1=75, 2=50, 3=25, 4=0, with higher scores indicating a higher quality of life. Baseline is defined as the most recent PedsQL score taken on or before treatment start date.

(3) Change from baseline (Cycle 1, Day 1) at Cycle 13, the pre-specified assessment for patient-reported outcome analysis per the ReNeu statistical analysis plan. Least squared means estimates using a mixed model for repeated measures (MMRM).

Clinically Meaningful Improvements in Pain Were Reported Early and Continued Through Treatment Phase

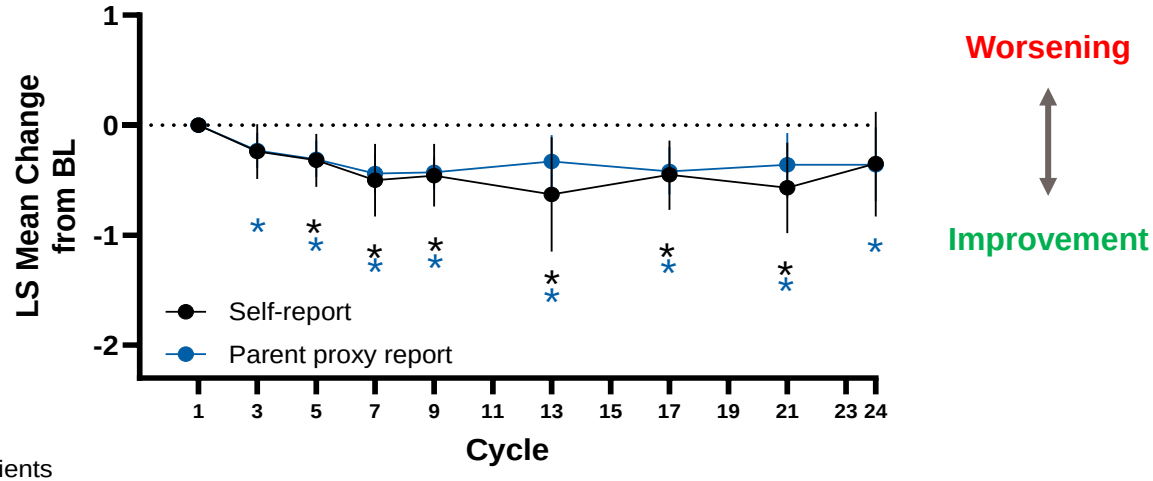
Pediatric Cohort

Worst Tumor Pain Severity (NRS-11)[1]



No. patients									
Self-report	36	23	25	24	23	17	18	11	8

Pain Interference (PII)[2]



No. patients									
Self-report	45	29	32	33	31	22	25	17	12
Parent proxy report	44	27	26	28	26	20	20	14	16

Significant improvement in worst tumor pain severity and pain interference began early (at Cycle 3, the first on-treatment assessment) and was sustained throughout the 24-cycle treatment phase

.

Note: BL: baseline; LS: least squared; SE: standard error. *P<.05 for a statistically significant change from BL. Vertical bars indicate 95% confidence intervals. Data presented is as of September 20, 2023 data cutoff (updated). Babovic-Vuksanovic et al., Global NF Conference, 2024.

(1) NRS-11 scores range from 0 (no pain) to 10 (worst pain imaginable); higher scores indicate worse pain. This was patient-reported by all patients ≥8 years of age.

(2) Pain Interference Index (PII) scores range from 0 (not at all) to 6 (completely); higher scores indicate greater pain interference (worsening). This was both self-reported for all patients ≥6 years of age and parent proxy-reported for all patients 6-17 years of age.

Safety Summary

Pediatric Cohort

(n=56)	Treatment-Related Adverse Events (TRAEs) ≥ 20% Subjects	
Preferred Term	**All Grades – n (%)**	**≥ Grade 3 – n (%)**
Any TRAE	**53 (95)**	**14 (25)**
Dermatitis acneiform	24 (43)	1 (2)
Diarrhea	21 (38)	1 (2)
Paronychia	17 (30)	0 (0)
Nausea	12 (21)	0 (0)
Blood creatinine phosphokinase increased	11 (20)	4 (7)
Ejection fraction decreased	11 (20)	1 (2)
Serious TRAEs	**0 (0)**	
Interruptions due to TRAEs	**8 (14)**	
Dose reductions due to TRAEs	**7 (12)**	
Discontinuations due to TRAEs[(1)]	**5 (9)**	

Note: Data presented is as of September 20, 2023 data cutoff. Moertel et al., *ASCO*, 2024.

(1) TRAEs leading to treatment discontinuation in >1 patient included dermatitis acneiform (1 child), diarrhea (1 child), rash (1 child), and urticaria (2 children). The presence of more than 1 AE may have led to treatment discontinuation in a patient.

Surveyed Physicians View Mirdametinib's Profile as Clinically Compelling and Differentiated

Mirdametinib Can Address Unmet Needs in NF1-PN

92% agreed there is an unmet need for pediatric NF1-PN patients

98% agreed there is an unmet need for adult NF1-PN patients

100% believed mirdametinib's clinical profile will address key unmet needs in most or some adult NF1-PN patients

Mirdametinib's Differentiation vs. Existing Treatments

96% found mirdametinib's overall clinical profile to be more compelling than selumetinib's for pediatric NF1-PN patients

89% found mirdametinib's clinical profile to be more compelling than selumetinib's on efficacy

81% found mirdametinib's clinical profile to be more compelling than selumetinib's on safety

Source: SpringWorks primary market research, December 2023 (N=100 HCPs, each treating an average of >20 NF1-PN patients). Respondents answered questions based on review of blinded profiles derived from FDA labeling (selumetinib) and ReNeu topline data (mirdametinib). No head-to-head studies have been conducted between mirdametinib and selumetinib.

Global Regulatory Progress to Bring Mirdametinib's Differentiated Profile to Patients

NDA Accepted With Priority Review

PDUFA: February 28, 2025

Orphan Drug and Fast Track designations

Rare Pediatric Disease designation with eligibility for priority review voucher upon approval

MAA Validated by EMA

Regulatory review is ongoing

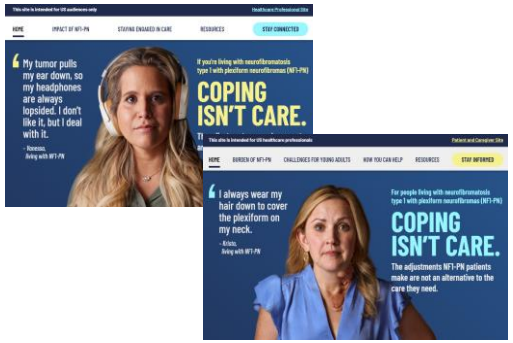
Orphan Drug designation

Progressing towards potential European regulatory approval in 2025

Note: NDA: New Drug Application; PDUFA: Prescription Drug User Fee Act; MAA: Marketing Authorization Application; EMA: European Medicines Agency.

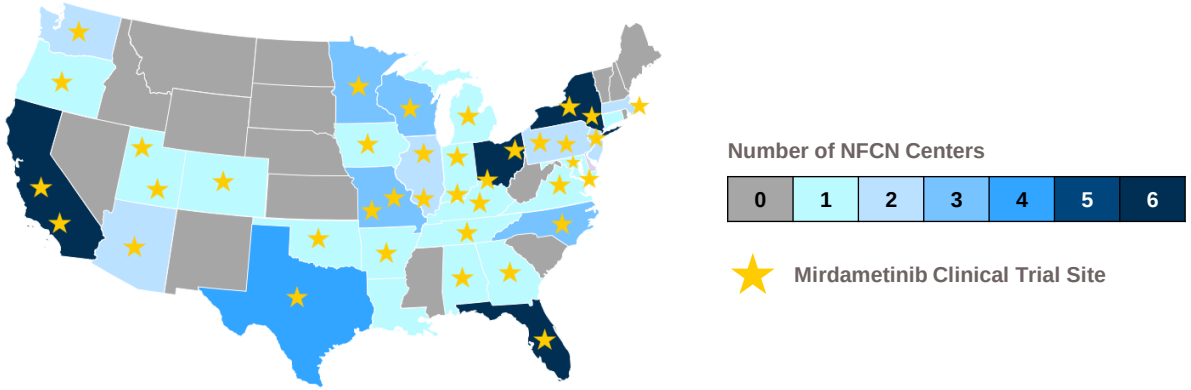
Pre-Launch Activities Underway Ahead of Upcoming PDUFA Date

Disease State Education



- High engagement from physicians and patients
- Raising awareness of the unmet needs of NF1-PN patients
- Educating physicians and increasing comfort treating patients with NF1-PN

Brand Launch Preparation and Targeted Sales Force Scale-Up



- Focus on mirdametinib's potential to be first and only approved for adult patients and differentiation vs. existing options in pediatric patients
- Robust patient service offerings designed to enhance treatment experience and support rapid access to mirdametinib
- Completed sales force hiring (35 TBMs); initial focus on ~70 NFCN centers and other key academic / community sites across the U.S.
- Multiple resources to enable efficient patient finding within well-defined patient pool

Note: NFCN: Neurofibromatosis Clinical Network; TBM: Territory Business Manager.

Emerging Portfolio

SpringWorks® THERAPEUTICS

Expanding Our Opportunity Set Across the Pipeline

Nirogacestat

Gamma Secretase Inhibitor

Advancing expansion opportunities in rare oncology, including ovarian granulosa cell tumors (OvGCT) and BCMA combinations in multiple myeloma

Mirdametinib

MEK Inhibitor

Pursuing monotherapy and combination therapy applications in pediatric low-grade glioma and MAPK mutant solid tumors, including melanoma and non-small cell lung cancer

Brimarafenib(1)

RAF Fusion & Dimer Inhibitor

Encouraging antitumor activity demonstrated across multiple MAPK mutations and tumor types supports development as monotherapy and in combination approaches

SW-682

TEAD Inhibitor

Dosing patients in Phase 1 trial enrolling patients with Hippo-mutant solid tumors

(1) Being developed by MapKure, a joint venture owned by SpringWorks and BeiGene.

Nirogacestat in OvGCT Represents a Meaningful New Expansion Opportunity

Disease Overview

Background and Rationale

- OvGCT accounts for ~5-7% of all ovarian cancers[1,2]
- >97% of OvGCT are driven by activating mutations in FOXL2, which have been shown to be sensitive to Notch inhibition[3,4]

Meaningful Addressable Population

- Median diagnosis age of 50 years
- Estimated U.S. incidence: ~1,000-1,500 per year; significant prevalent population: ~10,000-15,000[5,6]

No Approved Treatments

- Early-stage disease managed with surgery; however, ~45% of patients experience post-surgical recurrence[7]
- No currently approved therapies; limited effective treatment options in recurrent setting

Phase 2 Trial Summary

Trial Design

- Single-arm open label study, enrolled 53 patients with recurrent OvGCT with ≥ one line of prior systemic therapy (majority previously treated with bevacizumab, paclitaxel, and hormonal therapy)
- Dose: Nirogacestat 150 mg BID
- PI: Panagiotis Konstantinopoulos, MD, PhD (DFCI)
- Trial initiated in September 2022; announced full enrollment in May 2023

Primary Endpoint

- Objective response rate by RECIST 1.1 (response assessed every 2 months)

Secondary Endpoints

- Progression-free survival, overall survival, duration of response, safety and tolerability, and quality of life assessments

Initial clinical data from the Phase 2 trial in OvGCT is expected in 1H 2025

Sources: (1) Dridi et al., International Journal of Surgical Oncology, 2018; (2) Ayhan et al., Eur J Gynaecol Oncol, 1994; (3) Li et al., Journal of Ovarian Research, 2018; (4) Irusta et al., Biol Reprod, 2013; (5) SEER; (6) Torre L. et al., CA Cancer J Clin, 2018; (7) Klar et al., Journal of Surgical Oncology, 2023. DFCI: Dana-Farber Cancer Institute.

Nirogacestat in OvGCT Could Address Need for Targeted Therapy in Underserved Indication

OvGCT Are Potentially Susceptible to GSIs

- >97% of OvGCT are driven by C124W mutation in FOXL2, which alters multiple signaling pathways and gene expression of granulosa cells related to proliferation and apoptosis
- Notch signaling has been shown to block apoptosis and increase proliferation of OvGCT cells
- Preclinically, GSIs have been able to address the fundamental driver mutation in this tumor type

NCCN Guidelines Highlight Substantial Unmet Need

- Modest activity in clinical studies has been observed for single agents and combination regimens to date
- Single arm trials with published data have been sufficient to support inclusion of regimens in NCCN Guidelines

Preliminary Market Research Survey to Assess Practice Demographics, Treatment Practices, and Physician Feedback

- Key insights related to unmet need include:
  - Need for options in the post-surgical recurrent setting, placing emphasis on long-term control after first recurrence and reducing recurrence rate
  - Need for late-line options that do not involve surgery
  - Improvements in screening with better diagnosis, predictive testing for stage and risk of recurrence as well as non-invasive screening options

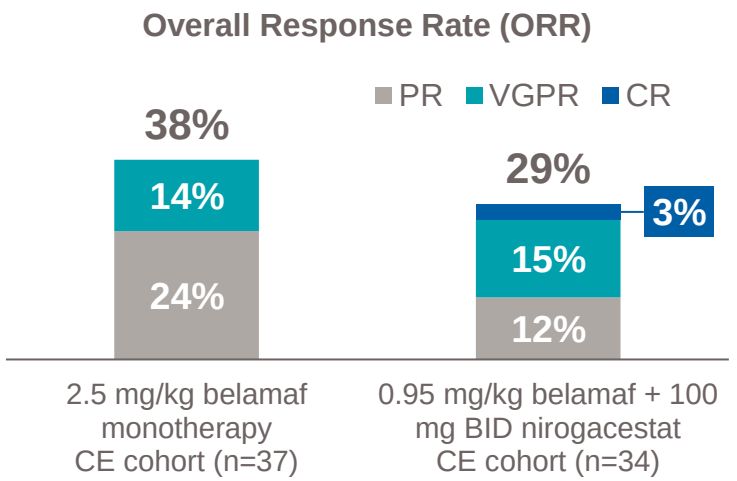
> *There are no good options for patients after relapsed disease. Surgical and radiation options are quite poor. Systemic therapy is very much needed.*
>
> *– Gynecological Medical Oncologist*

> *An oral option for treatment allows for greater access to care. Many patients will review an oral treatment favorably as compared to an IV.*
>
> *– Gynecologic Surgeon*

Note: GSI: gamma secretase inhibitor; NCCN: National Comprehensive Cancer Network; OvGCT: ovarian granulosa cell tumor; ORR: objective response rate; PFS: progression-free survival.
Sources: Li et al., *Journal of Ovarian Research*, 2018; Irusta et al., *Biol Reprod*, 2013; Ray-Coquard et al., *JAMA Oncol*, 2020; Brown et al., *Cancer*, 2014. SpringWorks market research.

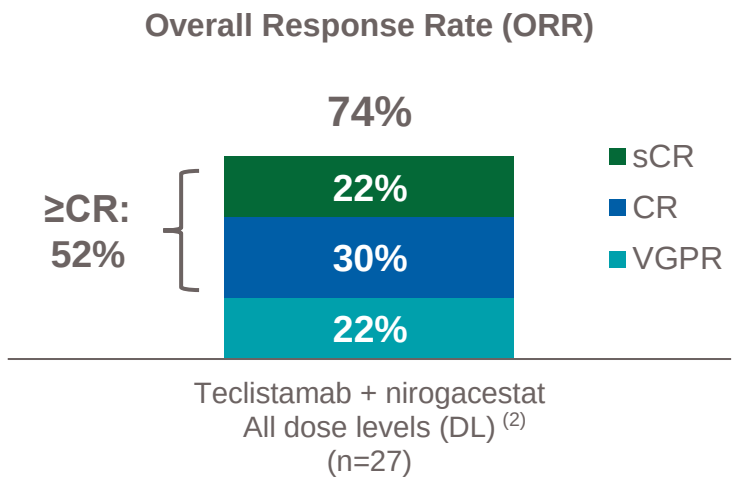
Nirogacestat in Multiple Myeloma: Emerging Clinical Data Across Modalities Validates Preclinical Hypothesis of BCMA Potentiation

Nirogacestat + Belamaf Ph 1/2



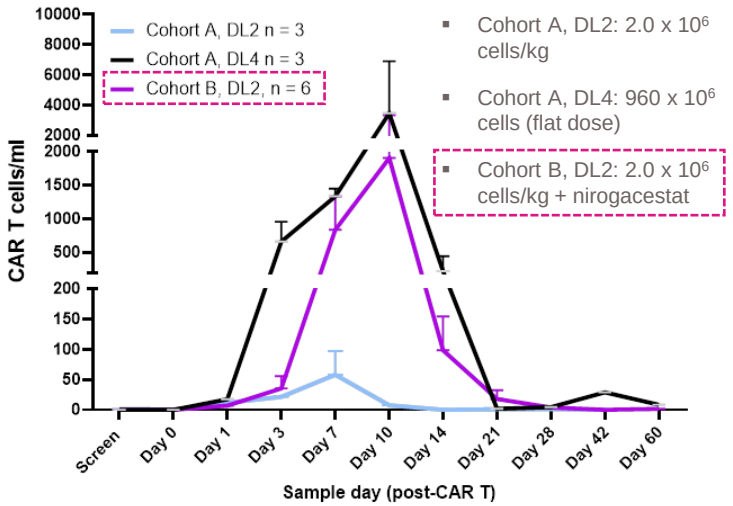
- Comparable efficacy with substantial reduction in Grade 3 ocular adverse events observed
- Posterior probability ORR(1) of 36% for nirogacestat + belamaf combo vs. 33% for belamaf alone
- Nirogacestat + belamaf has also been tested with 1L / 2L standard of care combinations (potential for future publication)

Nirogacestat + Teclistamab Ph 1b



- High and deep response rates observed with teclistamab + nirogacestat in patients with relapsed/refractory multiple myeloma
- Safety profile optimized with delayed administration of lower-dose nirogacestat
- Initial profile established for nirogacestat + BCMA bispecific combination

Nirogacestat + BCMA CAR-T Ph 1/2



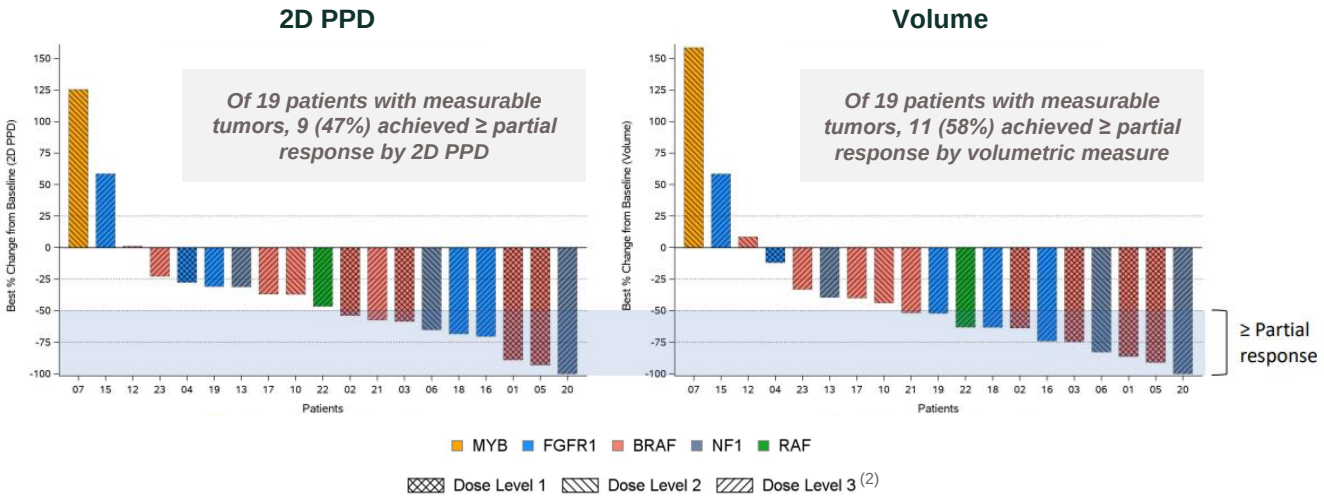
- Similar level of expansion and persistence observed with nirogacestat + low-dose allogeneic BCMA CAR-T cells vs. monotherapy CAR-T cells
- Improved cell expansion correlated with increased clinical activity

(1) Incorporating prior ORR for low-dose belamaf + nirogacestat from DREAMM-5 sub-study 3 DE cohort (observed ORR 60% [6/10]) and for monotherapy from DREAMM-2 2.5mg/kg monotherapy cohort (observed ORR 31% [30/.97] per prespecified analysis plan.
(2) Dose level 1: teclistamab SC 0.72 mg/kg QW + concurrent nirogacestat PO 100 mg BID (n=8); dose level 2: teclistamab SC 0.72 mg/kg QW + delayed nirogacestat PO 100 mg QD (n=7); dose level 3: teclistamab SC 1.5 mg/kg QW + delayed nirogacestat PO 100 mg QD (n=13).
Note: PR: partial response; VGPR: very good partial response; CR: complete response; sCR: stringent complete response; CE: cohort expansion; DE: dose exploration; BID: twice daily; SoC: standard of care.
Source: Lonial et al., EHA, 2023. Offner et al., EHA, 2023. Precision BioSciences investor materials (ASH 2021 presentation on December 11, 2021); Allogeneic CAR-T Update presentation on June 8, 2022; 3Q 2022. Earnings Release as of November 8, 2022); preliminary data from Precision-sponsored trial (NCT04171843).

Mirdametinib Expansion Opportunities in Rare Oncology and Biomarker-Defined Solid Tumors

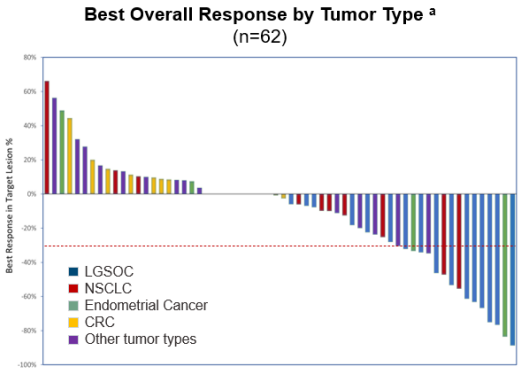
Expansion Opportunity in pLGG

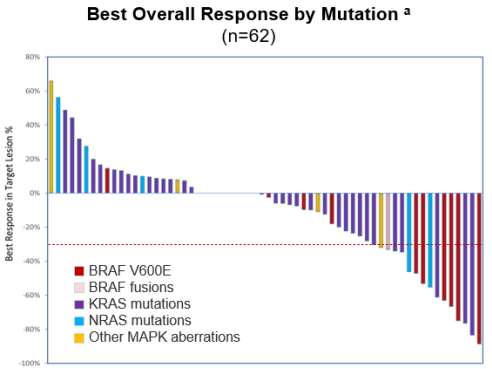
- Open-label Phase 1/2 study evaluating mirdametinib in pLGG through collaboration with St. Jude Children's Research Hospital is ongoing
- Favorable safety profile and blood-brain barrier penetration properties set the stage for a potential best-in-class profile
- Phase 1 data presented at SNO 2024 showed promising clinical activity across a variety of MAPK pathway mutations, with ORR of 79%(1)
- Ongoing enrollment in cohorts of patients with recurrent / progressive, newly diagnosed, and MEK-refractory pLGG



Lifirafenib Combo in MAPK Mutant Solid Tumors

- Lifirafenib is a pan-RAF inhibitor under study as combination therapy with mirdametinib(3)
- Sustained inhibition of MAPK pathway signaling and significant tumor regression in combo preclinical models
- Antitumor activity seen in LGSOC, NSCLC (especially with NRAS and BRAF mutations), and endometrial cancer; dose-expansion in NRAS-mutated solid tumors





Source: Robinson et al., SNO 2024. Solomon et al., AACR 2023.
Note: LGSOC: low-grade serous ovarian cancer; NSCLC: non-small cell lung cancer; pLGG: pediatric low-grade glioma; ISPNO: International Symposium on Pediatric Neuro-Oncology; ORR: objective response rate.
(1) 15 of 19 of evaluable patients achieved ≥ minor response by 2D PPD and volumetric measure. (2) Dose Level 1: 2 mg/m2/dose BID; Dose Level 2: 2.5mg/m2/dose BID; Dose Level 3: 3mg/m2/dose BID. (3) Through collaboration with BeiGene.

Brimarafenib in Biomarker-Defined Solid Tumors: Under Investigation as Monotherapy and in Combination Studies

- Brimarafenib is a RAF fusion and dimer inhibitor under development by MapKure, a joint venture owned by SpringWorks and BeiGene
- Preclinical research of brimarafenib has demonstrated activity against a broad spectrum of BRAF class I/II/III mutations and fusions
- Clinical data for Phase 1 monotherapy trial presented at AACR 2023, with encouraging antitumor activity and efficacy across mutations and tumor types

Key Highlights From Initial Phase 1b Monotherapy Clinical Data

Safety

- Manageable safety profile, with AE findings consistent with those of other MAPK inhibitors
- 40 mg was determined to be maximum tolerated dose

Efficacy

- Encouraging antitumor activity was observed in the heavily pretreated heterogeneous patients
  - ORR (confirmed): 6/33, 18%; CBR: 14/33, 42%; DCR: 26/33 (79%)
- Efficacy in patients with tumors harboring BRAF V600E progressed on prior BRAF/MEK inhibitors, BRAF Class II mutations, BRAF fusions, and NRAS mutations

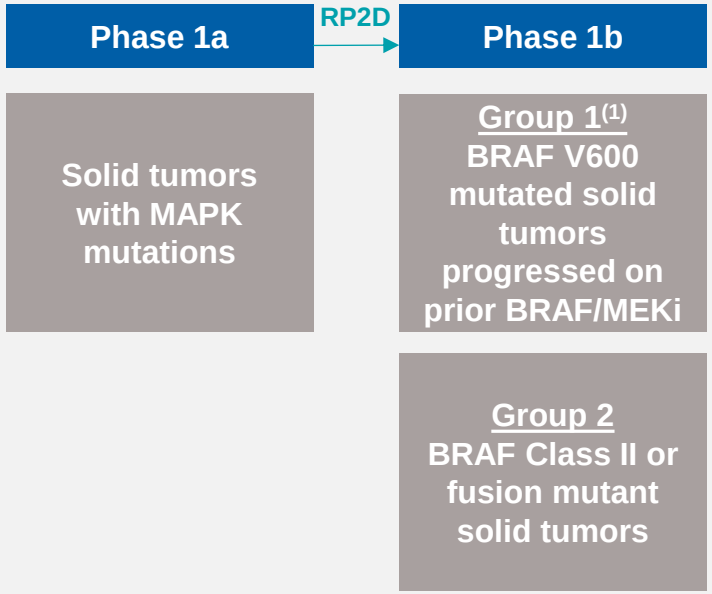
Next Steps for Brimarafenib

- Data support ongoing investigation of brimarafenib in defined cohorts
- Evaluation of brimarafenib in combination with MEK inhibitor, mirdametinib, in MAPK-altered advanced solid tumors is ongoing (NCT05580770)
- Phase 1b combination study of brimarafenib with EGFR-targeting monoclonal antibody, panitumumab, for CRC and pancreatic cancer patients with known MAPK pathway mutations initiated 1Q24 and patient dosing is underway

Source: Schram et al., AACR 2023.
Note: AE: adverse event; ORR: overall response rate; CBR: clinical benefit rate; DCR: disease control rate; CRC: colorectal cancer.

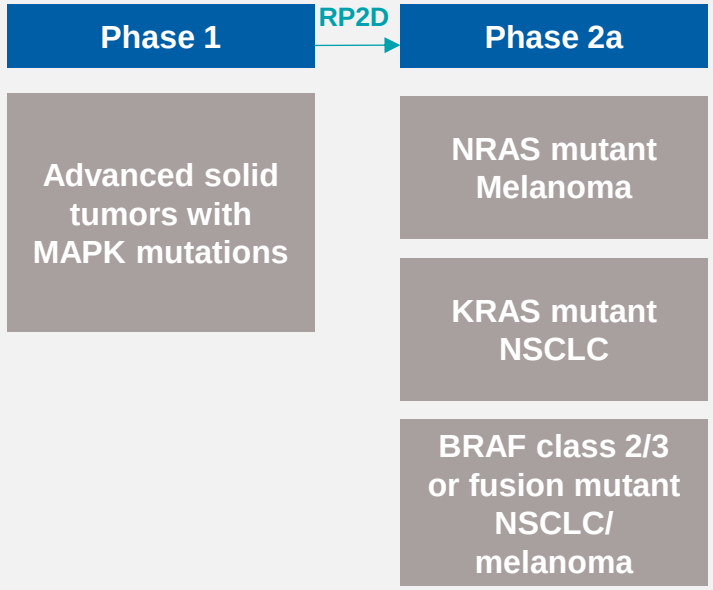
Brimarafenib in Biomarker-Defined Solid Tumors: Clinical Trial Summary

Monotherapy Development



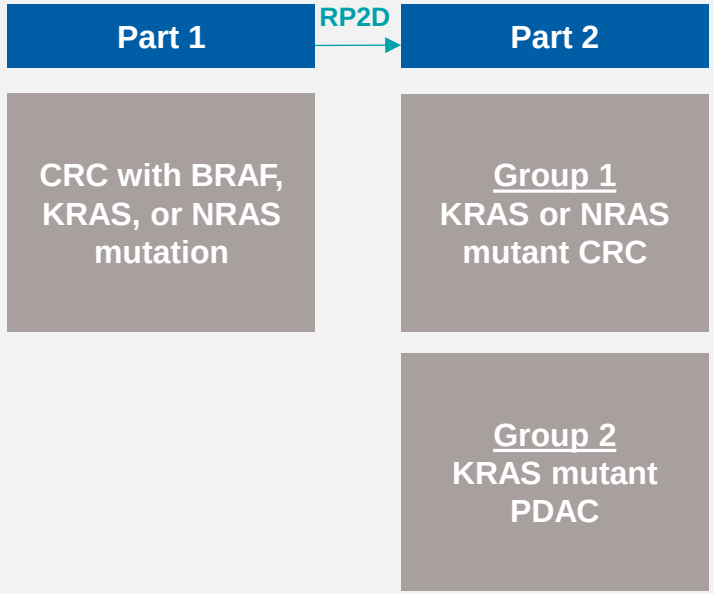
Entered Phase 1b in 3Q22; data expected 2H25

Combination Trial With Mirdametinib



Dosed first patient in Phase 1 in 1Q23

Combination Trial With Panitumumab



Trial initiated 1Q24; patient dosing underway

Note: RP2D: Recommended phase 2 dose; NSCLC: non-small cell lung cancer; CRC: colorectal cancer; PDAC: pancreatic ductal adenocarcinoma.
(1) Solid tumors other than CRC.

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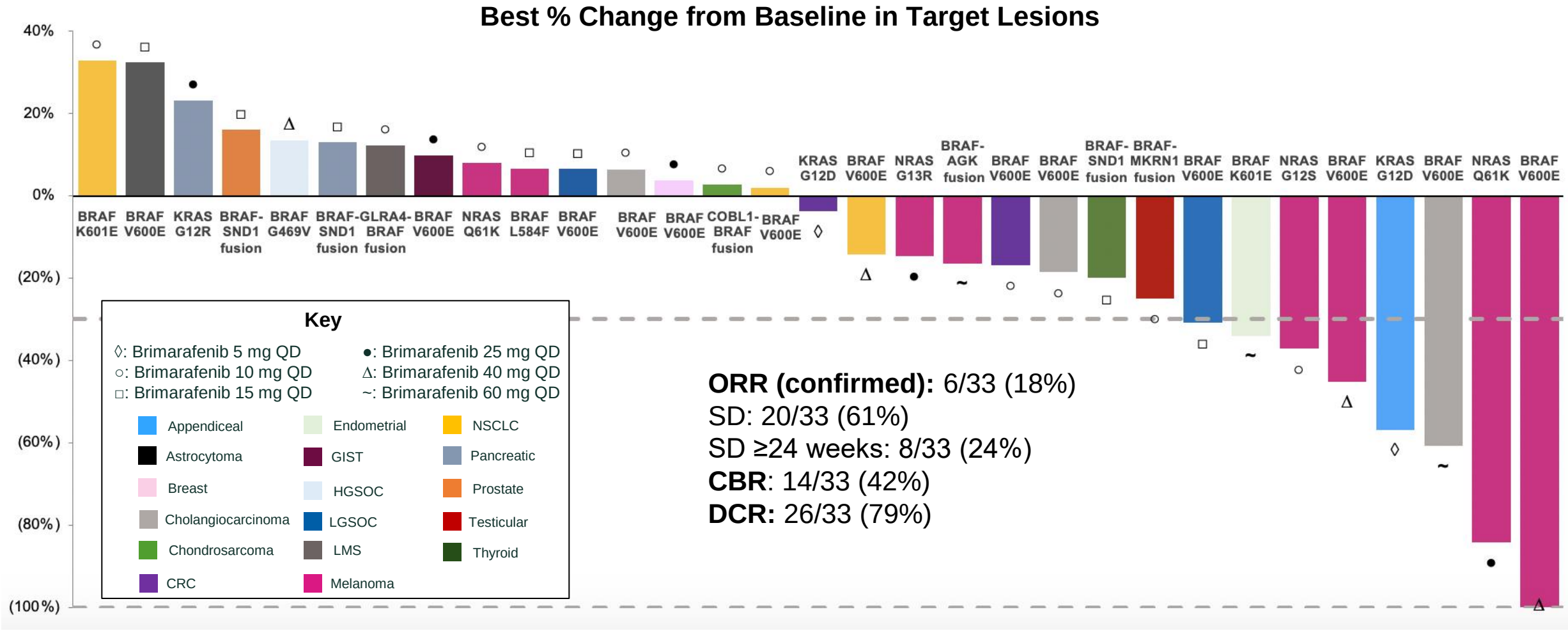
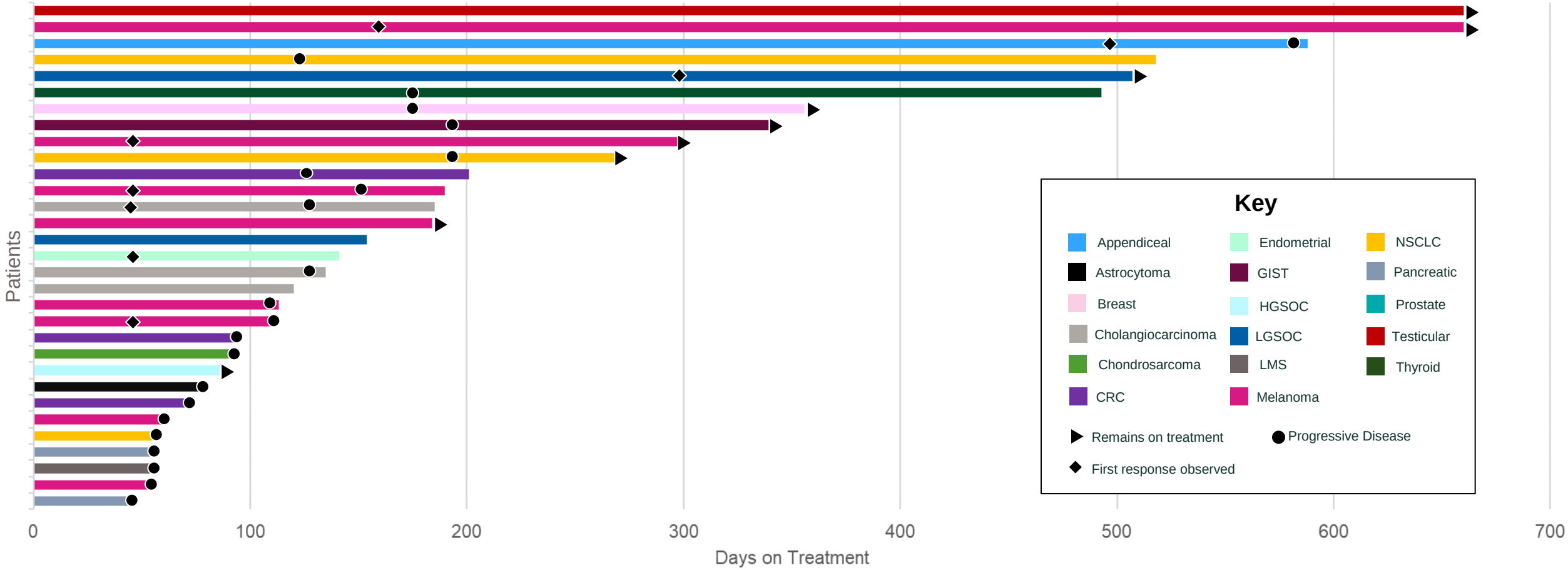
Brimarafenib Monotherapy: Anti-Tumor Activity Presented at AACR 2023



Overall data profile of brimarafenib as monotherapy supports ongoing investigation in defined cohorts

Source: Schram et al., AACR 2023.
Note: Data are preliminary, investigator assessed, and have not been centrally reviewed. Data as of September 1, 2022.
Note: Follow up scans on two patients indicated new lesions with progressive disease (PD) recorded as their best objective response. These follow-up scans did not measure target lesion and therefore are not included in the waterfall plot.
Note: CRC: colorectal cancer; GIST: gastrointestinal stromal tumor; HGSOC: high grade serous ovarian cancer; LMS: leiomyosarcoma; LGSOC: low-grade serous ovarian cancer; NSCLC: non-small cell lung cancer.

Brimarafenib Monotherapy: Time on Treatment Presented at AACR 2023



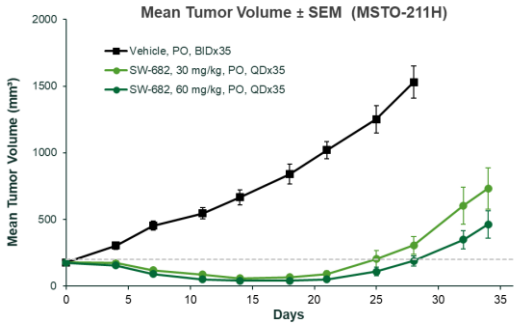
- As of data cut (September 1, 2022), median time on treatment: 154 days (range: 54 – 660 days)
- 9 patients remain on treatment

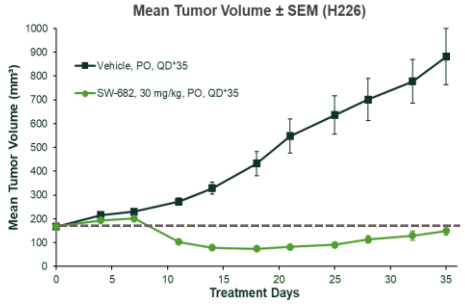
Source: Schram et al., AACR 2023.
Note: Data are preliminary, investigator assessed, and have not been centrally reviewed. Data as of September 1, 2022.

TEAD Inhibitor Program Broadens Portfolio With Monotherapy and Combination Opportunities

Program Summary

- SW-682 is an investigational novel, potent, and selective antagonist of TEAD dependent transcription, with activity against all TEAD isoforms
- TEAD family is the terminal component in the Hippo pathway, which is genetically altered in up to 10% of cancers
  - Hippo pathway dysregulation has been implicated in NF2 schwannoma, EHE sarcomas, and subsets of mesothelioma, non-small cell lung cancer, head and neck cancer, and kidney cancer
- SW-682 potently and selectively inhibits proliferation of Hippo-mutant tumor cell lines; demonstrated robust anti-tumor activity in Hippo altered xenograft models in vivo
- IND cleared by FDA in 1Q 2024, with Phase 1a trial in Hippo-mutant solid tumors initiated in 2Q 2024





Phase 1 Trial Design

Phase 1a	RP2D	Phase 1b			
Advanced solid tumors with or without Hippo pathway alterations		Mesothelioma with or without NF2 mutations	Advanced solid tumors with NF2 mutations	Advanced solid tumors with other Hippo pathway mutations	Combo with appropriate therapies in select indications

Source: Chen et al., AACR 2023.
Note: CNS: central nervous system.

The SpringWorks Opportunity

Well-Capitalized to Fully Fund Operations Through Profitability

$498.1M

Cash, Cash Equivalents & Marketable Securities(1)

No Debt

NASDAQ: SWTX

74.4M

Common Shares Outstanding(2)

(1) As of September 30, 2024.
(2) Basic common shares outstanding as of November 5, 2024.

SpringWorks THERAPEUTICS

Strong Foundation and Drivers in Place to Realize Long-Term Benefits for Patients

ROBUST OGSIVEO DEMAND	NEAR-TERM SECOND APPROVAL	GEOGRAPHIC EXPANSION	DIVERSE PIPELINE AND CAPABILITIES	STRONG FINANCIAL POSITION
OGSIVEO established as systemic standard of care	Mirdametinib PDUFA date set for February 28, 2025	MAA reviews for nirogacestat and mirdametinib ongoing	Deep pipeline of late- and early-stage programs	Strong balance sheet with $498.1M in cash(1)
Real-world evidence of significant patient benefit	Differentiated clinical data and product profile in NF1-PN	Potential approvals for both programs in 2025	Robust platform of discovery, clinical, and regulatory capabilities	Fully funded through profitability in 1H 2026
Over $115M in net product revenue since launch driven by patient demand	Potential first-in-class option for adult patients	European launch readiness is on track	Focus on underserved patient populations	Able to support disciplined portfolio expansion with capital efficient approach




(1) Cash, cash equivalents, and marketable securities as of September 30, 2024.

Appendix: Nirogacestat Clinical Trials

Desmoid Tumors

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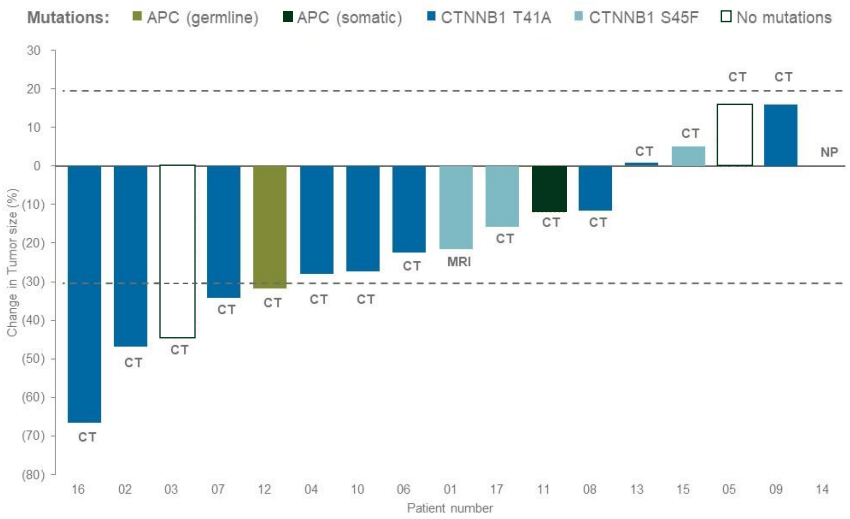
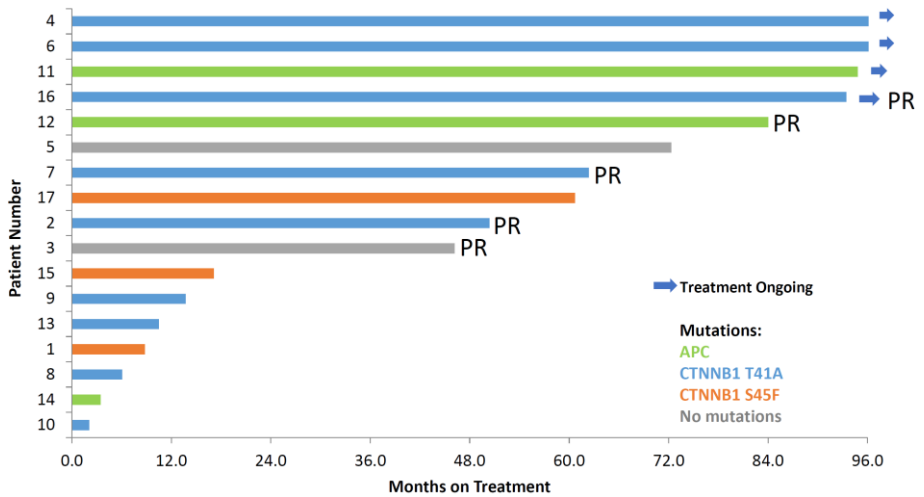
Encouraging Phase 2 Data With Extended Duration of Treatment Set the Stage for Phase 3 DeFi Trial

Clinical Responses by RECIST v1.1



- **mPFS: Not reached by publication date due to lack of tumor progression events**
  - At time of enrollment, all patients had progressing tumors
  - Patients failed a median of 4 prior lines (1-9) of systemic therapy (1)
  - ORR of 29.4% (5/17) with no progressive disease

Long-Term Progression Free Survival



- **Among 17 treated patients, median time on treatment 4.4 years (range: 0.17 – 7.99 years)**
  - 4 patients remain on study after >7 years; no PD maintained with follow-up
  - Nirogacestat was generally well tolerated
    - Most commonly (>50%) reported treatment-related AEs included diarrhea, fatigue, nausea, AST increase, lymphocyte decrease, hypophosphatemia, and rash (maculopapular)

Source: Kummar et al., 2017. O'Sullivan; Coyne et al., ASCO, 2022.

(1) 71% had received chemotherapy, 65% NSAIDs, and 59% TKIs; 4/5 partial responses had previously failed imatinib or sorafenib.

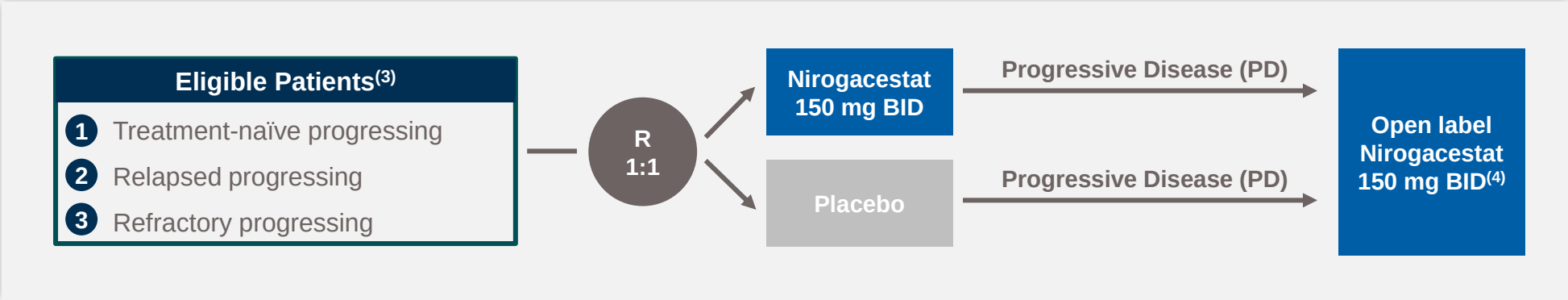
Phase 3 DeFi Trial Was Designed to Robustly Demonstrate Clinical Benefit of Nirogacestat

Trial Summary

- Global (North America and Europe), randomized (1:1), double-blind, placebo-controlled study
- 142 patients randomized with open label extension available upon radiographic disease progression
- 90% powered to show ~12-month median PFS difference between nirogacestat and placebo(1)

Summary of Endpoints

- Primary Endpoint: Progression-free survival(2)
- Secondary and Exploratory Endpoints: Safety and tolerability, objective response rate (ORR), duration of response, volumetric tumor change assessed by MRI, patient-reported outcomes (PROs)



(1) A total of 51 events will provide 90% power and a 1-sided type 1 error rate of 0.025 (1-side hypothesis) to detect a difference between nirogacestat and placebo, assuming the median PFS is 20 months in the nirogacestat group and 8 months in the placebo group.
(2) PFS is defined as the time from randomization until the date of assessment of radiographic progression as determined using RECIST v1.1, the date of assessment of clinical progression or death by any cause. Radiographic or clinical progression determined by blinded independent central review.
(3) Progression defined ≥20% increase over past 12 months by RECIST v1.1.
(4) Once the end of double-blind phase notification had been issued and the primary PFS analysis had been completed, patients remaining on study that had not achieved a radiographic progression could enroll in the OLE.

Baseline Demographics and Characteristics

Demographics/Characteristics, ITT Population	Nirogacestat (n=70)	Placebo (n=72)
Age, median (range), y	33.5 (18, 73)	34.5 (18, 76)
Sex, n (%)		
Male	25 (36)	25 (35)
Female	45 (64)	47 (65)
Somatic mutations in analyzed patients, n (%)[a]		
APC	11 (22)	11 (21)
CTNNB1	43 (84)	42 (79)
Tumor location, n (%)		
Intra-abdominal	17 (24)	18 (25)
Extra-abdominal	53 (76)	54 (75)
Focal category, n (%)		
Single	43 (61)	41 (57)
Multifocal	27 (39)	31 (43)
Desmoid tumor treatment status, n (%)		
Treatment naïve	18 (26)	14 (19)
Refractory/Recurrent	52 (74)	58 (81)
Number of lines of any prior therapy, median (range)	2 (0, 14)	2 (0, 19)
Prior therapies, n (%)		
Prior systemic therapy	43 (61)	44 (61)
Chemotherapy	24 (34)	27 (38)
Tyrosine kinase inhibitor	23 (33)	24 (33)
Sorafenib	17 (24)	18 (25)
Prior radiation therapy	16 (23)	16 (22)
Prior surgery	31 (44)	44 (61)
Patients with uncontrolled pain per BPI-SF API >4, n (%)[b]	27 (39)	31 (43)

Source: Kasper et al., *ESMO,* 2022; Gounder et al., *NEJM,* 2023. Data as of the time of primary analysis (04/07/22).
a) Evaluable samples not available for all patients. Samples were analyzed for 51 and 53 patients in the nirogacestat and placebo arms, respectively.
b) Defined as a score of >4 calculated as the average of the daily BPI–SF Item 3 “Worst Pain in Past 24 hours” over the 7-day period before the baseline visit.
Note: API, average pain index; BPI-SF, Brief Pain Inventory–Short Form ITT; intention to treat.

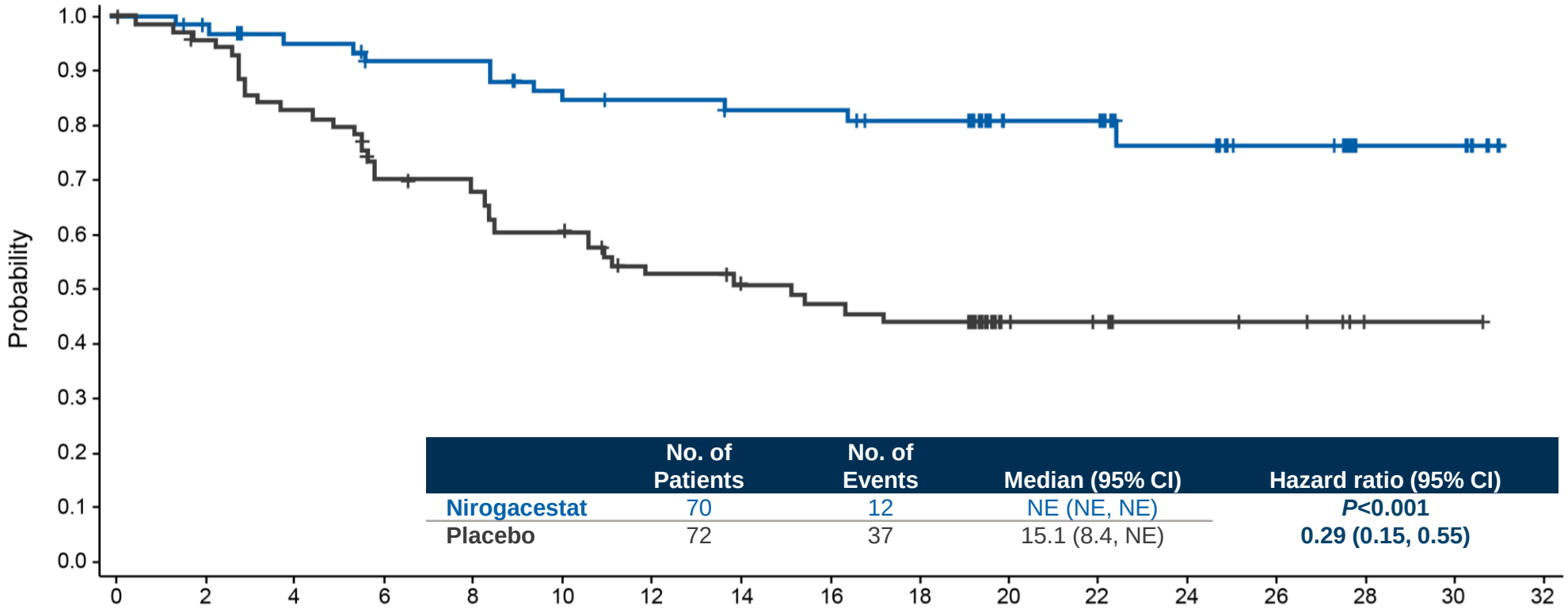
Nirogacestat Demonstrated Highly Significant and Clinically Meaningful Impact on Primary and All Key Secondary Endpoints

Clinical Outcome Measures		P-Value
Primary Endpoint	Progression-free survival	<0.001
Secondary Endpoints	Objective Response Rate	<0.001
	Brief Pain Inventory-Short Form – Average Pain Intensity	<0.001
	GODDESS Desmoid Tumor Symptom Scale – Total Symptom Score	<0.001
	GODDESS Desmoid Tumor Impact Scale – Physical Functioning Impact Score	<0.001
	EORTC QLQ-C30 Physical Functioning	<0.001
	EORTC QLQ-C30 Role Functioning	<0.001
	Global Health Status / Quality of Life	0.007

Source: Kasper et al., ESMO, 2022. Data as of the time of primary analysis (04/07/22). Gounder at al., CTOS, 2022.
Note: Differences at Cycle 10 were statistically significant and clinically meaningful. DTSS total symptom score includes pain, fatigue, swelling, muscle weakness, and difficulty moving.
Note: GODDESS: GOunder/Desmoid Tumor Research Foundation DEsmoid Symptom/Impact Scale; EORTC QLQ-C30: European Organisation for Research and Treatment of Cancer Quality of Life Questionnaire-Core 30; PRO: patient-reported outcome.

DeFi SpringWorks THERAPEUTICS

Nirogacestat Significantly Reduced Risk of Disease Progression



	No. of Patients	No. of Events	Median (95% CI)	Hazard ratio (95% CI)
Nirogacestat	70	12	NE (NE, NE)	***P*<0.001**
Placebo	72	37	15.1 (8.4, NE)	**0.29 (0.15, 0.55)**

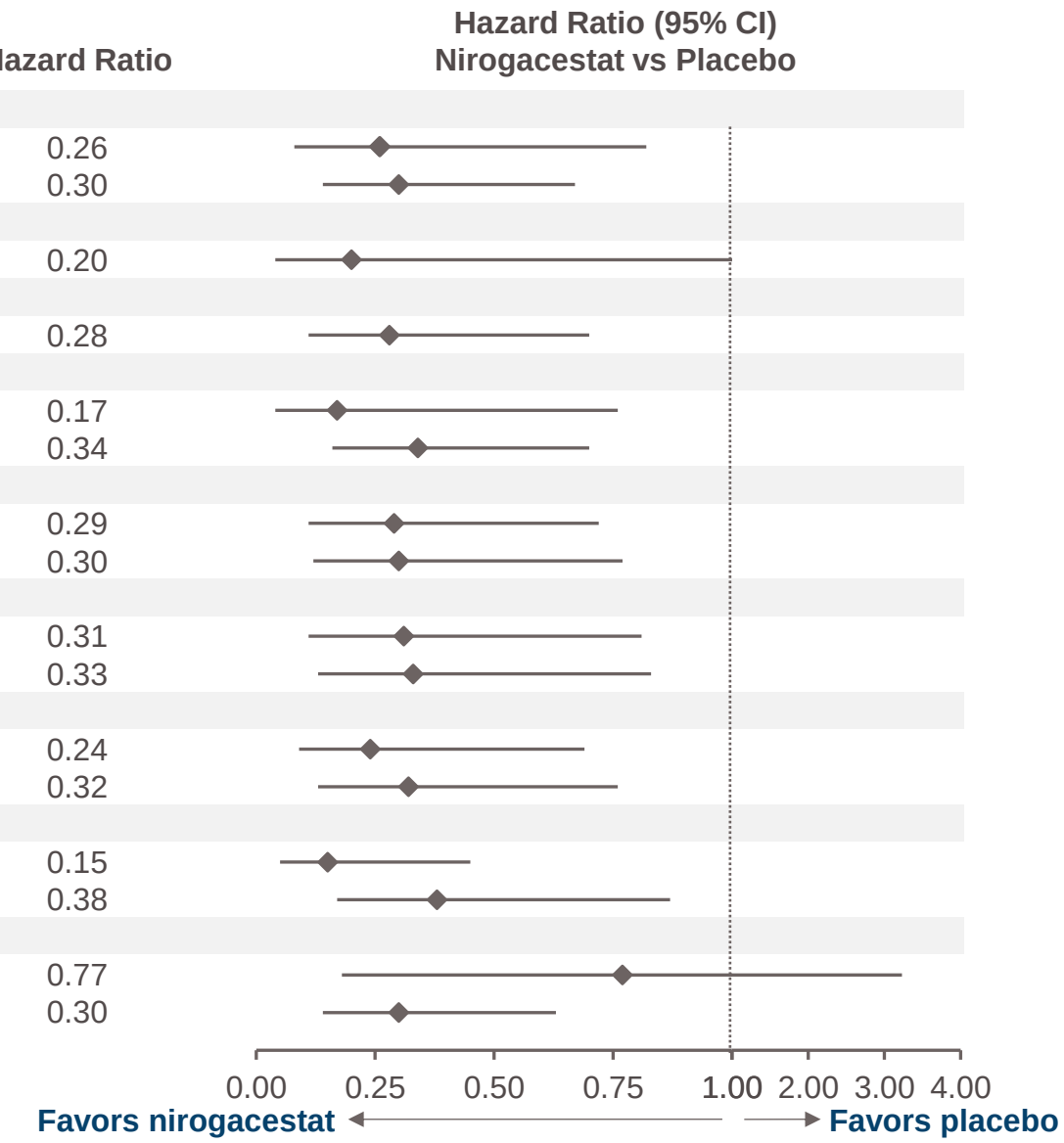
No. of Participants at Risk:

Placebo	72	67	58	47	45	40	32	29	27	25	10	8	6	5	1	1	0
Nirogacestat	70	63	56	52	52	47	46	44	44	41	26	26	17	12	4	4	0

Source: Kasper et al., *ESMO,* 2022. Data as of the time of primary analysis (04/07/22).
Note: Median follow-up time was 19.2 months for nirogacestat and 10.9 months for placebo.
Note: NE: not estimable.

PFS Benefit With Nirogacestat Was Observed Across Prespecified Subgroups

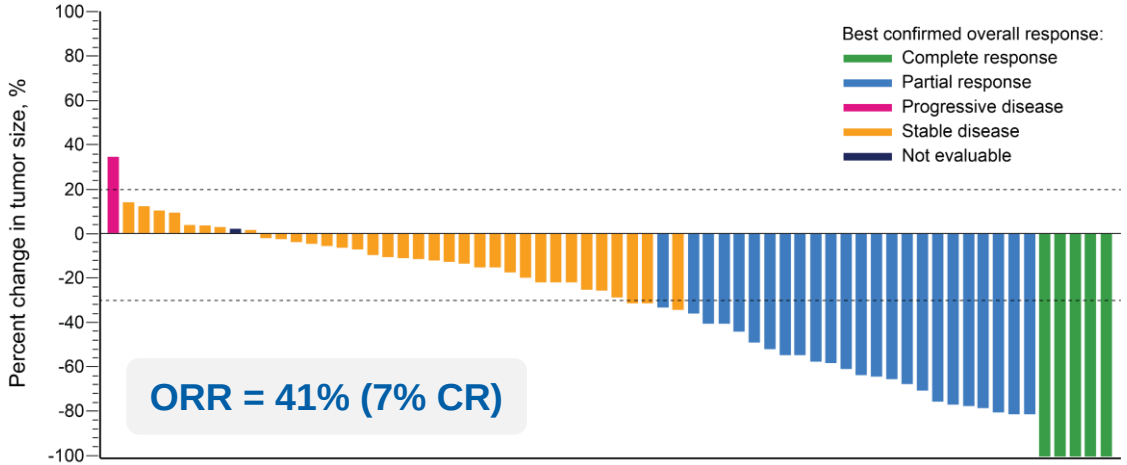
	Nirogacestat	Placebo	Hazard Ratio
	no. of events / no. of patients		
Sex			
Male	4 / 25	11 / 25	0.26
Female	8 / 45	26 / 47	0.30
***APC* mutation**			
Yes	2 / 11	8 / 13	0.20
***CTNNB1* mutation**			
Yes	6 / 43	21 / 42	0.28
Target tumor location			
Intra-abdominal	2 / 17	11 / 18	0.17
Extra-abdominal	10 / 53	26 / 54	0.34
Focality			
Single	6 / 43	19 / 41	0.29
Multifocal	6 / 27	18 / 31	0.30
Prior surgery			
Yes	5 / 31	23 / 44	0.31
No	7 / 39	14 / 28	0.33
Prior chemotherapy			
Yes	5 / 24	17 / 27	0.24
No	7 / 46	20 / 45	0.32
Prior TKI treatment			
Yes	4 / 23	16 / 24	0.15
No	8 / 47	21 / 48	0.38
Treatment status			
No previous treatment	3 / 18	5 / 14	0.77
Refractory or recurrent disease after previous treatment	9 / 52	32 / 58	0.30



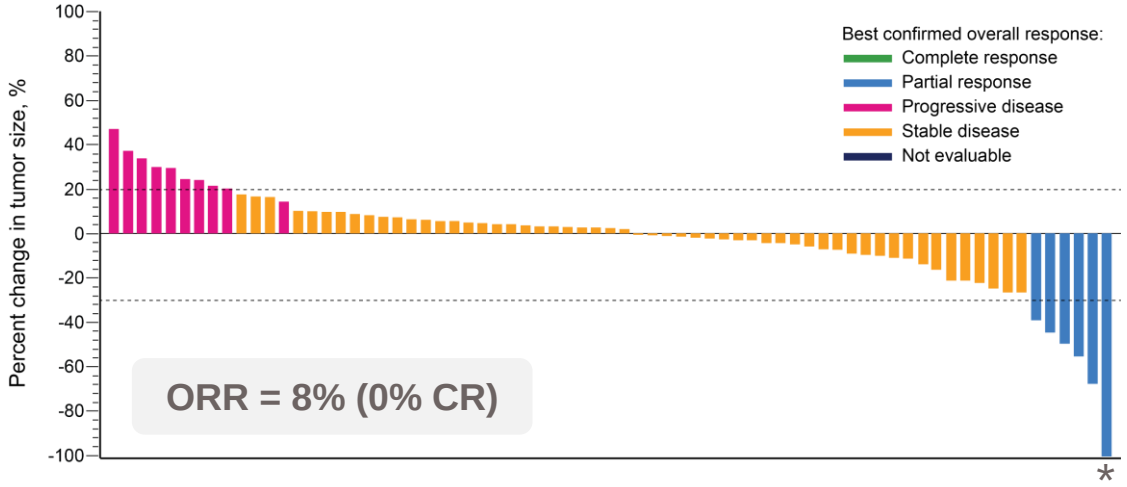
Source: Kasper et al., *ESMO,* 2022; Gounder et al., *NEJM,* 2023. Data as of the time of primary analysis (04/07/22).
Note: PFS, progression-free survival; TKI, tyrosine kinase inhibitor.

Nirogacestat Treatment Resulted in Substantial Reductions in Tumor Size

Nirogacestat (n=70)



Placebo (n=72)

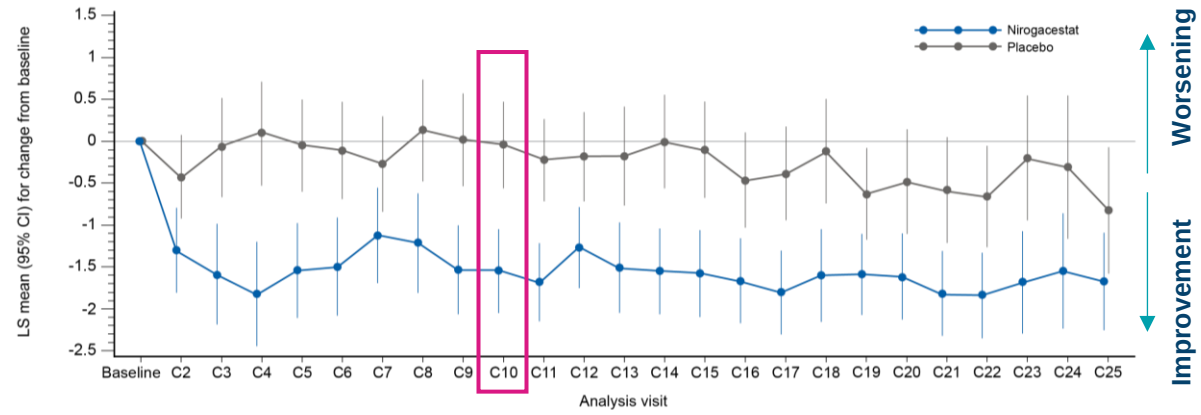


Median time to objective response of 5.6 months for nirogacestat vs. 11.1 months for placebo

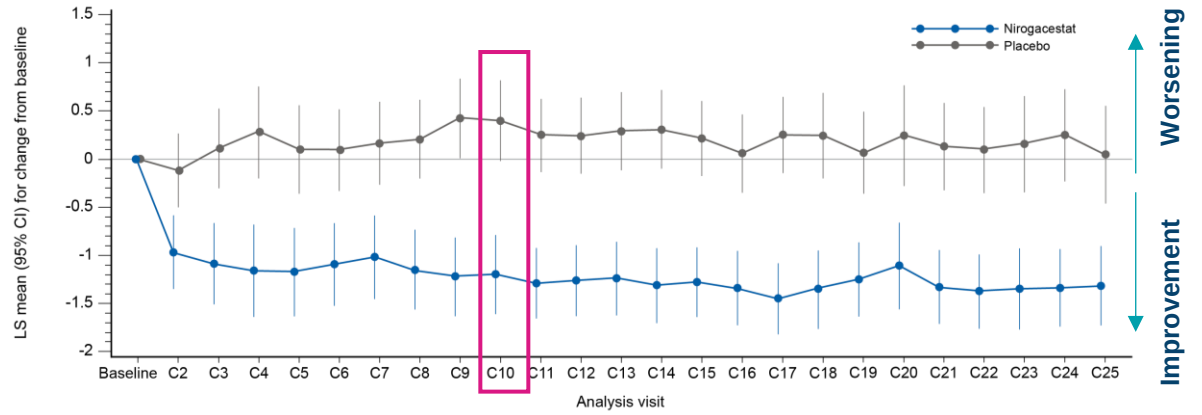
Source: Kasper et al., ESMO, 2022. Data as of the time of primary analysis (04/07/22). Gounder at al., CTOS, 2022.
* Patient had a complete resolution of the target lesion but still had documented non-target lesion; therefore, not a complete response.
Note: Best percent change values are averaged between 2 blinded independent reviewers unless a reader was selected for adjudication, in which case only the adjudicated value is presented.

Rapid, Early and Sustained Improvements Across Quality-of-Life Measures

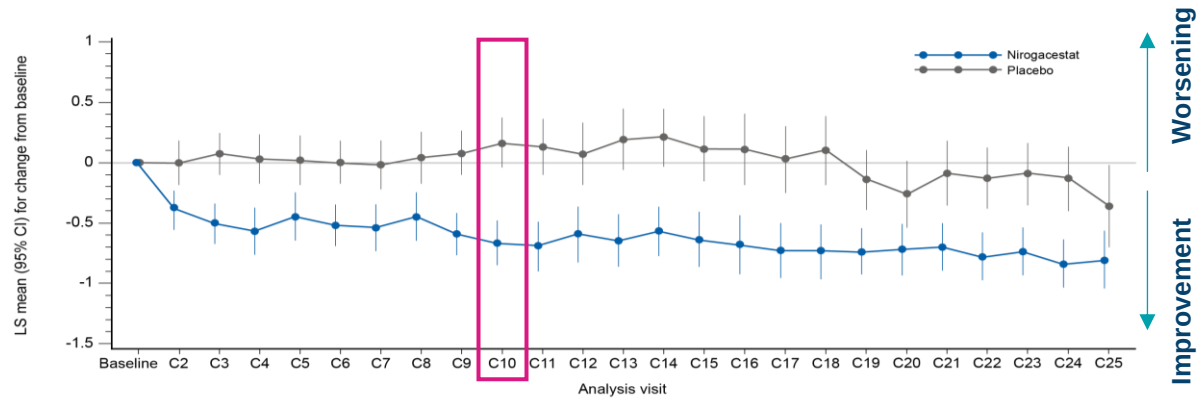
Brief Pain Inventory-Short Form – Average Pain Intensity



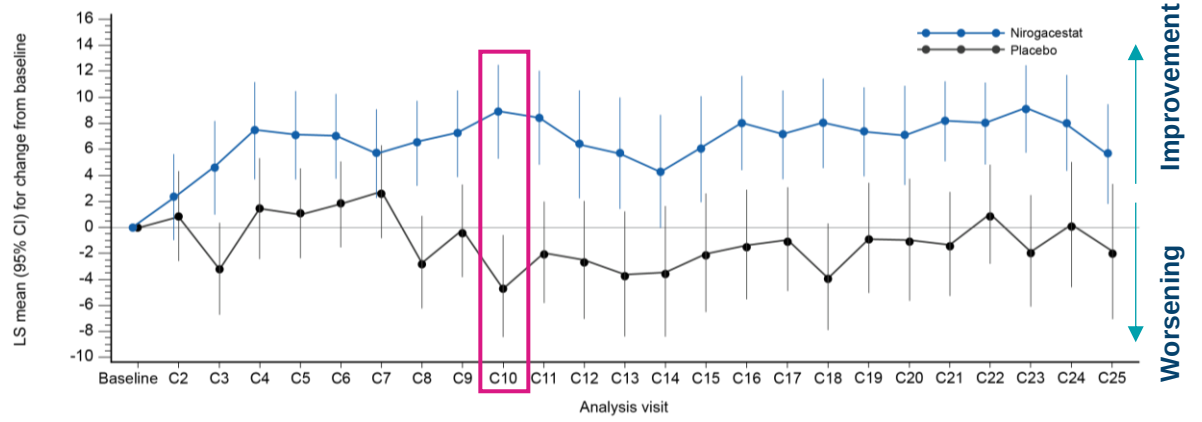
DT-Specific Symptom Severity (GODDESS DTSS)



Physical Functioning Impact Score (GODDESS DTIS)



Physical Functioning (EORTC QLQ-C30)



Source: Kasper et al., ESMO, 2022. Data as of the time of primary analysis (04/07/22).
Note: DTIS: Desmoid Tumor Impact Scale; DTSS: Desmoid Tumor Symptom Score; Symptom/Impact Scale; EORTC QLQ C30: European Organisation for Research and Treatment of Cancer Quality of Life Questionnaire Core 30; GODDESS: GOunder /Desmoid Tumor Research Foundation DEsmoid Symptom/Impact Scale; LS: least squares.
Mean (SD) baseline scores: nirogacestat, 3.2 (3.26); placebo, 3.3 (3.31). Differences at Cycle 10 were statistically significant and clinically meaningful. LS mean change from baseline represents the 7-day average.

Nirogacestat Safety Profile

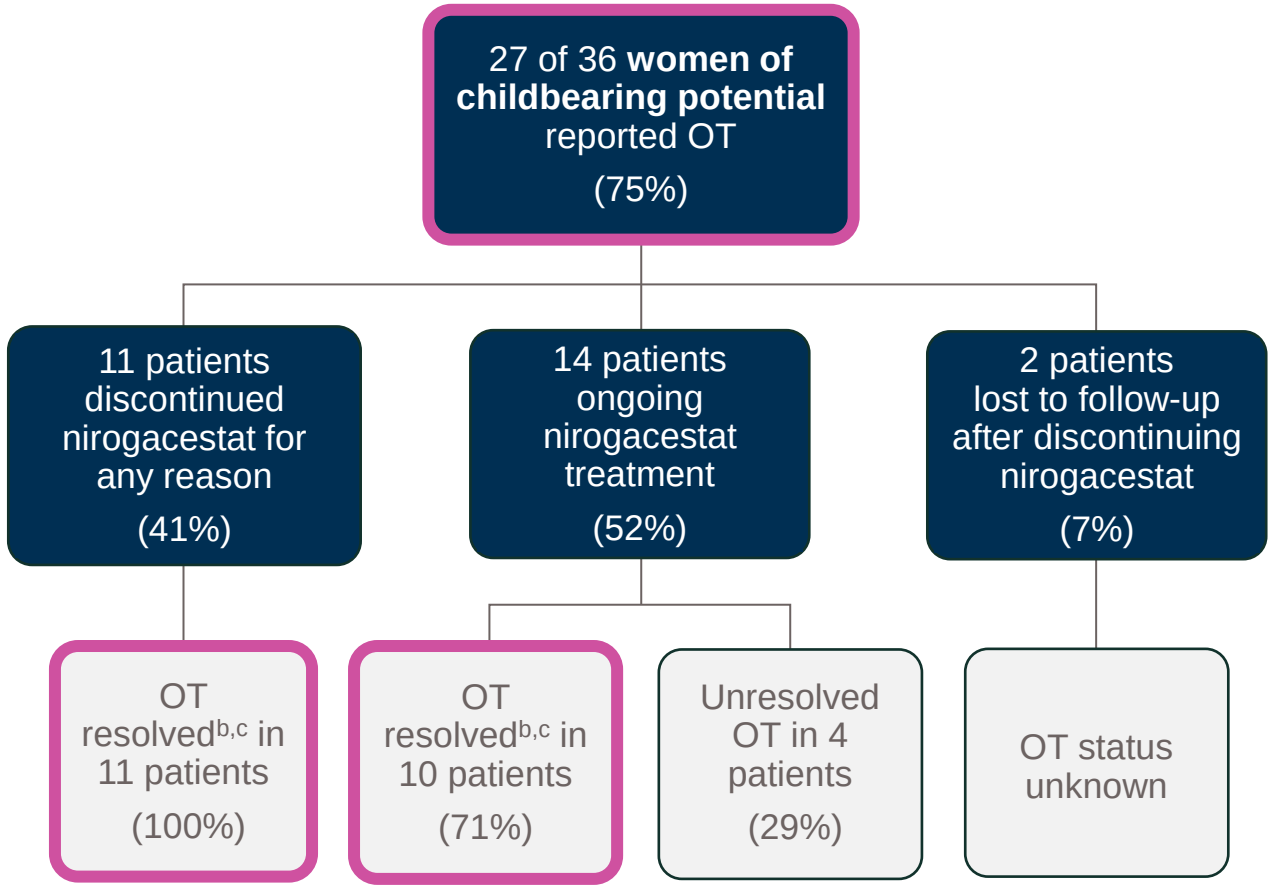
Safety population, n (%)	Nirogacestat (n=69)		Placebo (n=72)	
Duration of study drug exposure, median (range), months	20.6 (0.3, 33.6)		11.4 (0.2, 32.5)	
Dose intensity, median (range), mg/d	288.3 (169, 300)		300.0 (239, 300)	
	Any Grade	**Grade ≥3**	**Any Grade**	**Grade ≥3**
Any TEAE	69 (100)	39 (57)	69 (96)	12 (16)
TEAEs of any grade reported in ≥25% of patients in either arm				
Diarrhea	58 (84)	11 (16)	25 (35)	1 (1)
Nausea	37 (54)	1 (1)	28 (39)	0
Fatigue	35 (51)	2 (3)	26 (36)	0
Hypophosphatemia	29 (42)	2 (3)	5 (7)	0
Rash, maculopapular	22 (32)	4 (6)	4 (6)	0
Headache	20 (29)	0	11 (15)	0
Stomatitis	20 (29)	3 (4)	3 (4)	0
TEAEs leading to death	0		1 (1)[a]	
Dose reductions due to TEAEs	29 (42)		0	
Discontinuations due to TEAEs	14 (20)[b]		1 (1)[b]	

95% of TEAEs were Grade 1 or 2; the first onset of TEAEs in most patients occurred during Cycle 1

Source: Kasper et al., *ESMO,* 2022. Data as of the time of primary analysis (04/07/22).
a) Death due to sepsis.
b) TEAEs leading to discontinuations in ≥1 patient include gastrointestinal disorders (n=5 [4%]), ovarian dysfunction (n=4 [3%]), alanine aminotransferase increase (n=3 [2%]), aspartate aminotransferase increase (n=2 [1%]), and metabolism/nutritional disorders (n=2 [1%]).
Note: TEAE, treatment-emergent adverse event.

Frequency and Resolution of Ovarian Toxicity Observed With Nirogacestat

- Ovarian toxicity (OT), also referred to as ovarian dysfunction, is a composite adverse event associated with changes in female reproductive hormone levels and clinical manifestations[1,2]
- Protocol-mandated serum hormone collection at baseline and cycles 1, 2, 4, and every 3 thereafter
- Among women of childbearing potential, OT[a] was observed in 75% receiving nirogacestat and 0% receiving placebo
  - Median time to first onset of OT: 8.9 weeks
  - Median duration of OT events: 19.1 weeks
- No changes in male hormonal levels or TEAEs pertaining to male reproductive potential were reported[3]



Source: Loggers et al., *Cancer,* 2024. Data as of the time of follow-up analysis (10/24/22).
a) OT among women of childbearing potential was defined by investigators who reported the MedDRA Preferred Terms of amenorrhea, premature menopause, menopause, and ovarian failure.
b) As of October 24, 2022.
c) Resolution of OT events was defined by the investigator.
Note: TEAE, treatment-emergent adverse event.
1) Thurston et al., *Obstet Gynecol Clin North Am.* 2011;38:489-501; 2) Mauri et al., *Front Endocrinol (Lausanne).* 2020;11:572388; 3) Gounder et al., *NEJM*, 2023.

Continued Evidence Generation Demonstrating OGSIVEO's Broad Benefits to Patients

2024 ASCO® ANNUAL MEETING

Benefit in DT Patients With Poor Prognosis[1]

Consistent improvement in PFS and ORR vs. placebo in patients with characteristics associated with poor prognosis in DT

Benefit in DT Patients With APC Mutations[2]

Improvements in PFS, ORR, pain and reductions in tumor size / volume in patients with APC mutations (more aggressive DT)

2024 ASCO® ANNUAL MEETING

Cancer American Cancer Society®

Resolution of Ovarian Toxicity: Updated DeFi Analyses[3,4]

Updated DeFi ovarian toxicity outcomes showing investigator-reported resolution in 78% of females of reproductive potential (including 71% of women remaining on nirogacestat and 100% who stopped treatment), suggesting ovarian toxicity is transient with median duration of 19.1 weeks; additional analyses to characterize ovarian toxicity are ongoing

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PRO Improvements in DT Patients With Stable Disease[5]

Patients treated with nirogacestat with stable disease as best overall response had significant and clinically meaningful improvement in PROs (pain, symptom burden, quality of life) compared to patients treated with placebo

2023 ANNUAL MEETING
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Improvements in Functional Status in DT Patients[6]

Patients with progressing DT who received nirogacestat achieved a statistically significant and clinically meaningful improvement in different assessments of functional status as early as Cycle 2 and sustained through Cycle 24

Note: PRO: patient-reported outcome; ORR: overall response rate; DT: desmoid tumors; PFS: progression-free survival.

(1) Vincenzi et al., Efficacy of nirogacestat in participants with poor prognostic factors for desmoid tumors: Analyses from the randomized phase 3 DeFi study.. JCO 42, 11556-11556(2024).
(2) Kasper et al., Efficacy and safety of nirogacestat in patients with desmoid tumor and adenomatous polyposis coli (APC) mutation: Phase 3 DeFi analyses.. JCO 42, 11558-11558(2024).
(3) Loggers et al., Onset and resolution of ovarian toxicity with nirogacestat treatment in females with desmoid tumors: Updated safety analyses from the DeFi phase 3 study. Cancer. 2024 May 4.
(4) Loggers et al., Monitoring ovarian function in oncology studies: Results and insights from the DeFi phase 3 study of nirogacestat in desmoid tumor. JCO 42, 11520-11520(2024).
(5) Stacchiotti S, et al. Impact of nirogacestat (niro) on patient-reported outcomes (PROs) in adults with desmoid tumor with a best overall response (BOR) of stable disease (SD): Post hoc analysis from the DeFi study. ESMO Sarcoma 2024.
(6) Kasper et al. Impact of nirogacestat on functional status in patients with desmoid tumors: results from the Phase 3 DeFi study. CTOS 2023.

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THANK YOU