GFH375/VS-7375 Program Update:
Joint Presentation by GenFleet and Verastem

Oct. 27, 2025

GFH375:
Dive in the ESMO Data and More

GENFLEET THERAPEUTICS

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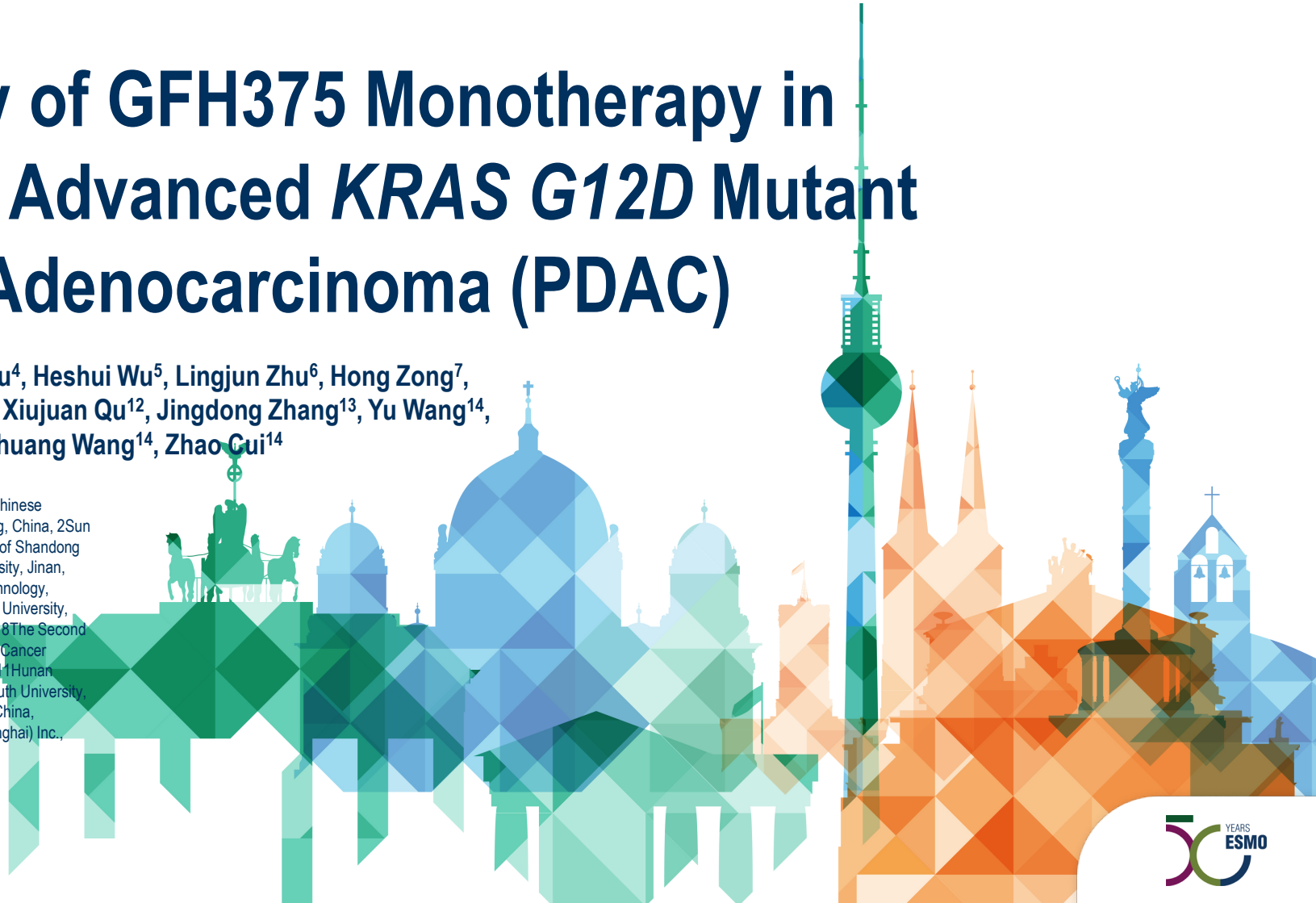
BERLIN 2025 ESMO congress

Efficacy and Safety of GFH375 Monotherapy in Previously Treated Advanced *KRAS G12D* Mutant Pancreatic Ductal Adenocarcinoma (PDAC)

Aiping Zhou[1], Zhihua Li[2], Yuping Sun[3], Zuoxing Niu[4], Heshui Wu[5], Lingjun Zhu[6], Hong Zong[7], Ying Yuan[8], Zhengbo Song[9], Ziming Li[10], Lin Wu[11], Xiujuan Qu[12], Jingdong Zhang[13], Yu Wang[14], Haige Shen[14], Huaqiang Zhu[14], Sharley Zheng[14], Shuang Wang[14], Zhao Cui[14]

1National Cancer Center/National Clinical Research Center for Cancer/Cancer Hospital, Chinese Academy of Medical Sciences (CAMS) and Peking Union Medical College (PUMC), Beijing, China, 2Sun Yat-sen Memorial Hospital, Sun Yat-sen University, Guangzhou, China, 3Cancer Hospital of Shandong First Medical University, Jinan, China, 4Cancer Hospital of Shandong First Medical University, Jinan, China, 5Union Hospital, Tongji Medical College, Huazhong University of Science and Technology, Wuhan, China, 6Jiangsu Province Hospital/The First Affiliated Hospital of Nanjing Medical University, Nanjing, China, 7The First Affiliated Hospital of Zhengzhou University, Zhengzhou, China, 8The Second Affiliated Hospital of Zhejiang University School of Medicine, Hangzhou, China, 9Zhejiang Cancer Hospital, Hangzhou, China, 10Harbin Medical University Cancer Hospital, Harbin, China, 11Hunan Cancer Hospital/The Affiliated Cancer Hospital of Xiangya School of Medicine, Central South University, Changsha, China, 12The First Affiliated Hospital of China Medical University, Shenyang, China, 13Liaoning Cancer Hospital & Institute, Shenyang, China 14GenFleet Therapeutics (Shanghai) Inc., Shanghai, China

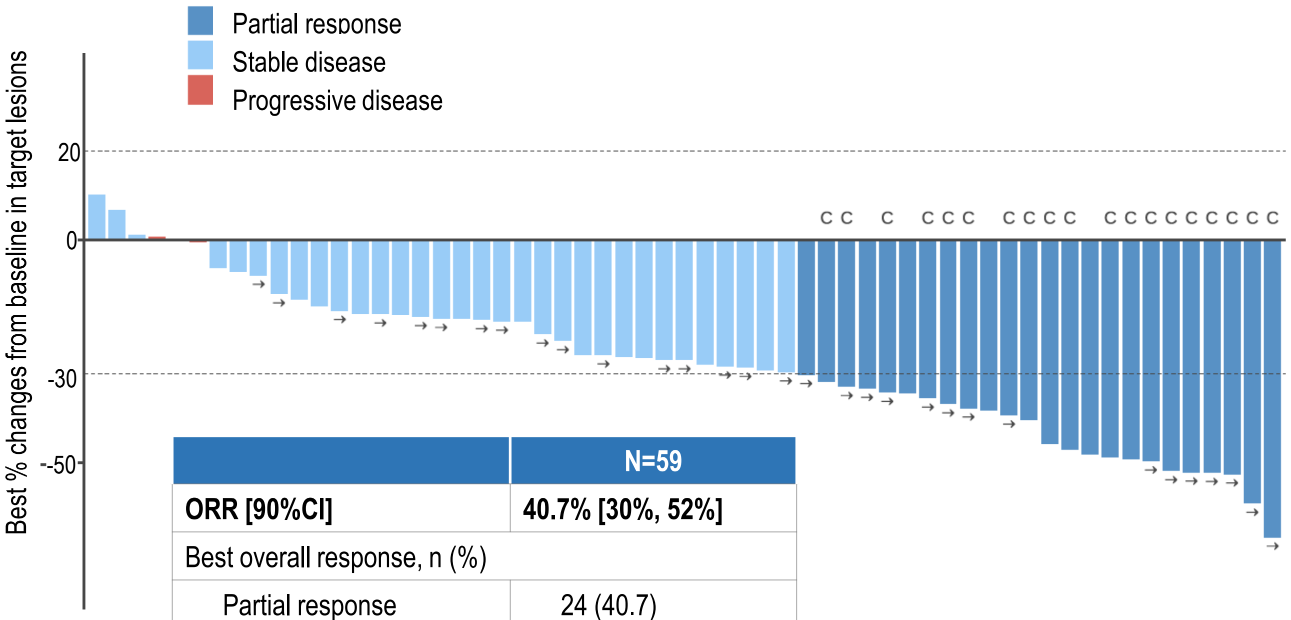


50 YEARS ESMO

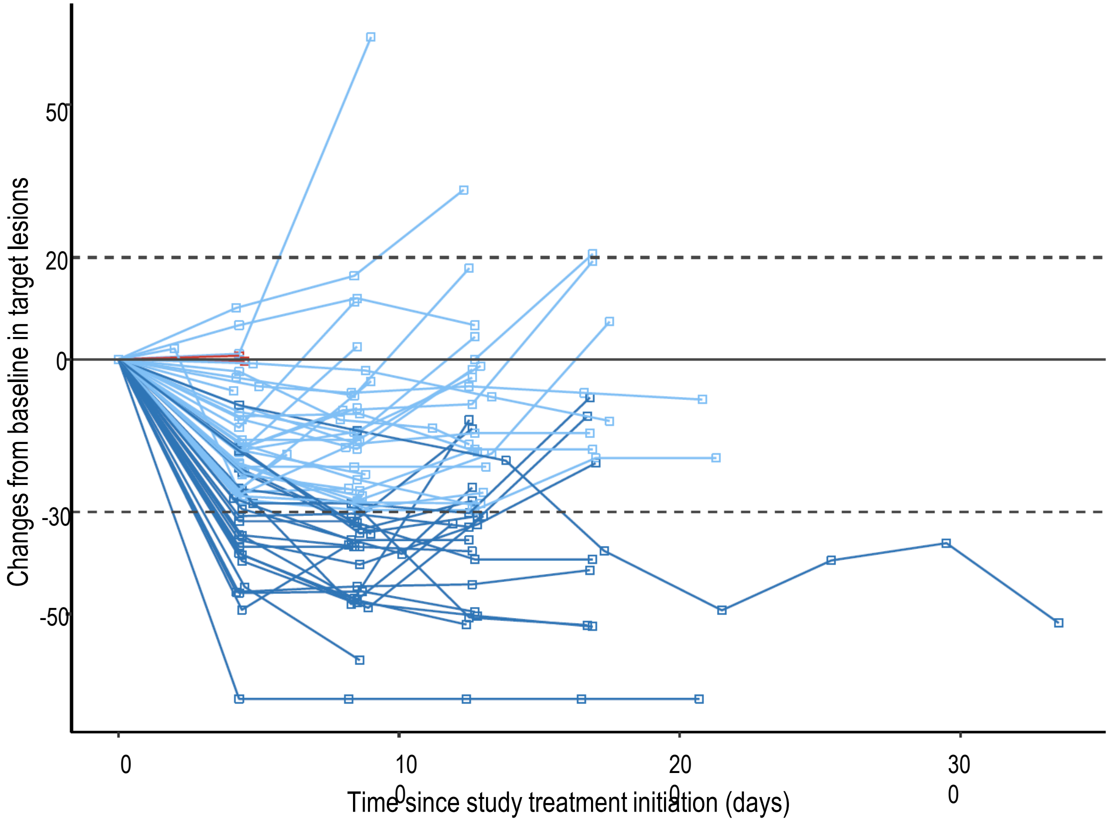
Abstract number: LBA84

Best Overall Response

- ORR was **40.7%** (24/59), 90%CI was [30%, 52%].
- DCR was **96.7%** (57/59), 90%CI was [90%, 99%]. Majority (91.5%) had reduction in target lesions.



	N=59
ORR [90%CI]	**40.7% [30%, 52%]**
Best overall response, n (%)	
Partial response	24 (40.7)
Stable disease	33 (55.9)
Progressive disease	2 (3.4)
DCR [90%CI]	**96.7% [90%, 99%]**



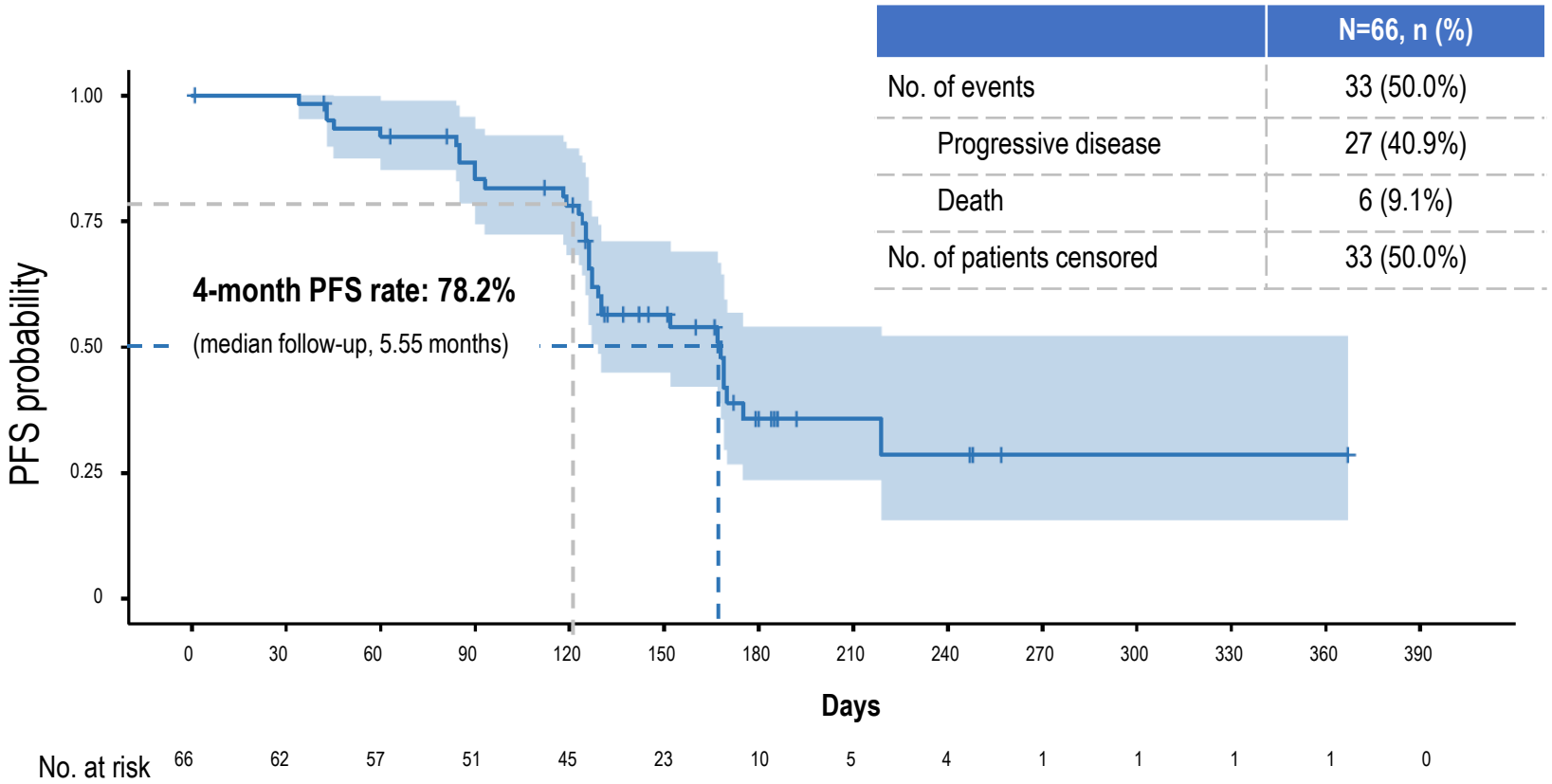
Data cut-off date: September 27, 2025. All patients received first dose of GFH375 for at least 4 months prior to the cut-off date. Seven patients had no post-treatment tumor assessments due to early dropout: 2 due to AEs not related to GFH375 (1 upper gastrointestinal hemorrhage and respiratory failure); 1 started new anticancer therapy; 4 early discontinued due to patient decision. Left figure: "C" represents confirmed responders. Arrows indicate treatment ongoing.

Abbreviations: CI, confidence interval. DCR, disease control rate. ORR, objective response rate.

Aiping Zhou, MD

Progression-Free Survival

- Median PFS was **5.52 months** (90%CI: 4.27, 7.20), with a median follow-up time 5.65 months (90%CI: 4.96, 6.08).
- 4-month PFS rate was **78.2%** (90%CI: 69.8%, 87.5%).



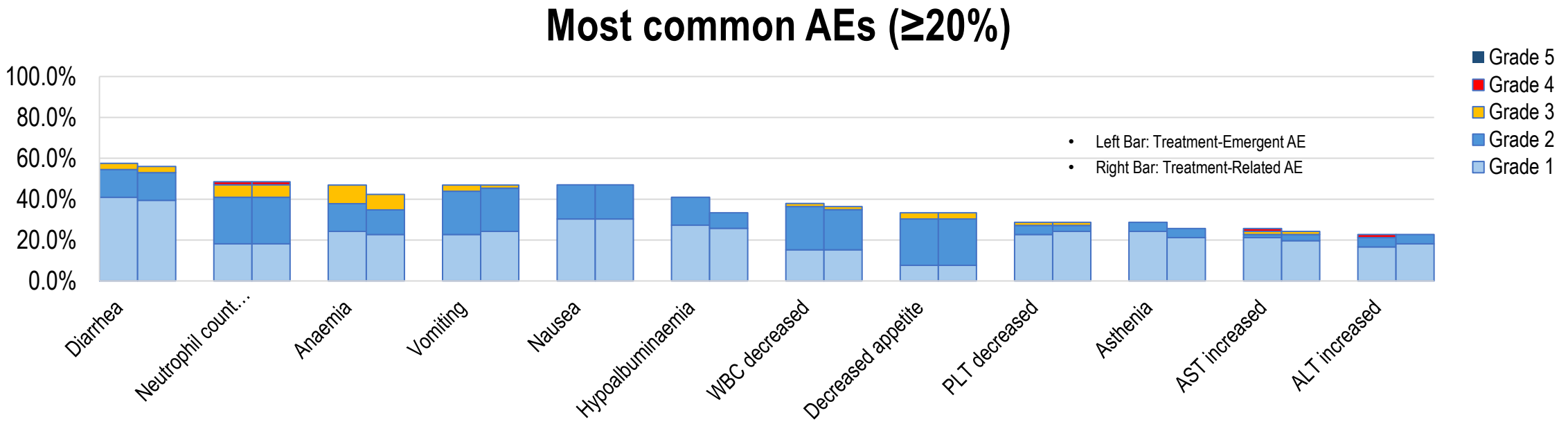
	N=66, n (%)
No. of events	33 (50.0%)
Progressive disease	27 (40.9%)
Death	6 (9.1%)
No. of patients censored	33 (50.0%)

Data cut-off date: September 27, 2025. All patients received first dose of GFH375 for at least 4 months prior to the cut-off date.

Aiping Zhou, MD

Common Adverse Events

- The safety profile of GFH375 in *KRAS G12D* mutant PDAC patients is consistent with previous report.[1,2]
  - Common TRAEs were gastrointestinal and hematological AEs; most were grade 1 or 2 and manageable with supportive treatment.
  - Most frequent TRAEs (≥20%) were diarrhea (56.1%), neutrophil count decreased (48.5%), vomiting (47.0%), nausea (47.0%), anaemia (42.4%), white blood cell count decreased (36.4%), decreased appetite (33.3%), hypoalbuminaemia (33.3%), platelet count decreased (28.8%), asthenia (25.8%), aspartate aminotransferase increased (24.2%), and alanine transferase increased (22.7%).



Data cut-off date: August 27, 2025. Using MedDRA v27.1. Graded per CTCAE 5.0.

[1] Xinghao Ai et al. J Clin Oncol. 43, 3013-3013(2025). [2] Lu S, et al. 2025 WCLC. MA02.07

Abbreviations: ALT, alanine transferase. AST, aspartate transferase. CTCAE, Common Terminology Criteria for Adverse Events. PLT, platelet. TEAE, treatment-emergent adverse event. TRAE, treatment-related adverse event. WBC, white blood cell.

Aiping Zhou, MD

Post ESMO Focus: ORR Fluctuation

Sample size

PDAC baseline

Prior treatment

Line of patients

PDAC: ESMO Reported Baseline Characteristics

10:15 - 11:45 Proffered paper session 2: GI tumours, upper digestive

CHAIRS: MAEVE LOWERY, CHRISTOPH BENEDIKT WESTPHALEN

LBA84 : GFH375 Monotherapy

Advanced, KRAS G12D mutated, previously treated PDAC, n=66 patients

Age, median (range), years	60 (35, 74)
≥60, n (%)	35 (53.0%)
Male, n (%)	35 (53.0%)
ECOG PS 1, n (%)	66 (100%)
Histological type, n (%)	
Adenocarcinoma	64 (97.0%)
Adenosquamous carcinoma	2 (3.0%)
Stage IV at study entry, n (%)[c]	63 (95.5%)
Baseline metastasis, n (%)	
Liver	52 (78.8%)
Lung	19 (28.8%)
Peritoneum	19 (28.8%)
Bone	12 (18.2%)

Number of prior lines of anticancer therapy, (range)	(1, 5)
1, n (%)	21 (31.8%)
≥2, n (%)	45 (68.2%)
Prior anticancer therapy, n (%)	
Gemcitabine-containing	61 (92.4%)
Fluorouracil-containing	50 (75.8%)
Irinotecan-containing	35 (53.0%)
Immune checkpoint inhibitors	22 (33.3%)

Real world data : < 10% of PDAC patients receive 3rd line chemotherapy*

Maeve A Lowery

*Macarulla et al, ESMO Real World Data & Digital Oncology 2025

Maeve Lowery

Invited Discussant LBA84 and 22150

BERLIN AUDITORIUM - HUB 27

PDAC: Worse Baseline Condition Compared to Competitors

		GFH375[1] 600 mg QD N = 66	Zoldonrasib[2] 150-1200 mg daily N = 104	Daraxonrasib[3] 300 mg daily N = 76
ECOG PS	**0**	0	29%	34%
	1	100%	71%	66%
Median no. of PLoT (range)		2 (1-5)	2 (0-6)	2 (1-7)
1L		31.8%	NA	49%
2L+		68.2%	NA	51%
Prior treatment lines per SoC* , n(%)				
1L		12 (18.2%)	NA	NA
2L+		54 (81.8%)	NA	NA
Prior ICI		33.3%	NA	NA
Liver metastasis at baseline		78.8%	86%	67%
Peritoneum metastasis at baseline		28.8%	NA	NA

Cross-trial comparison. Source: [1]ESMO 2025. [2]ASCO GI 2025. [3]ASCO GI 2025. *defined as participants who had received gemcitabine- or 5-Fu-based chemotherapy and without ICI.

Abbreviations: PLoT, prior lines of therapy. 2L+, second line and beyond. NA, not available.

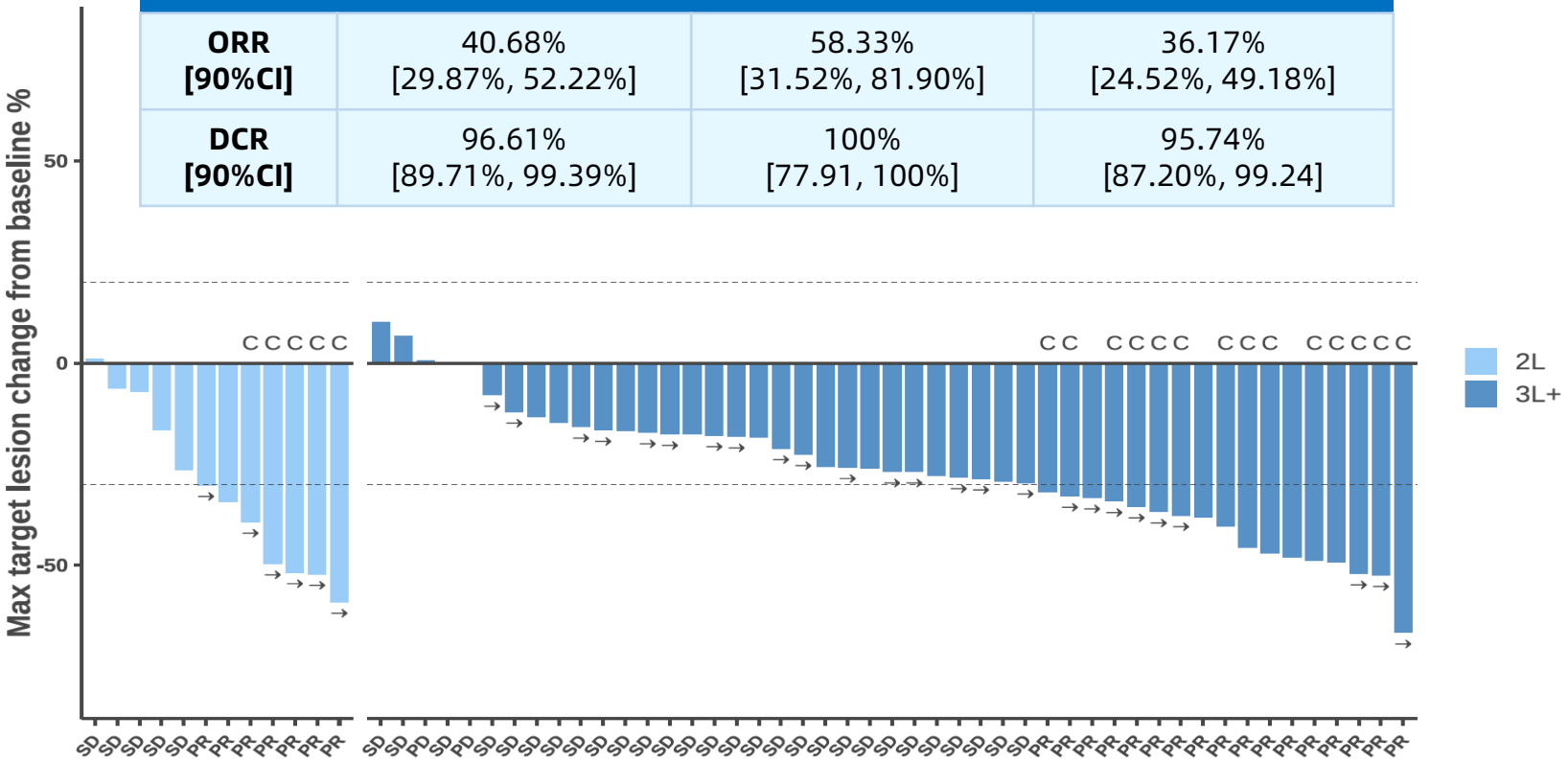
PDAC: The Non-standard 1st-line Treatments in the Study

Participant	1st line Regimen
1	AG+**S1+Nimotuzumab**
2	AG+**S1**
3	AG+**S1**
4	AG + **Sintilimab**
5	AG+ **Camrelizumab**
6	NALIRIFOX+ **Cadonilimab**
7	GEM + OXA + **Avastin + Sintilimab**
8	AG + **Lenvatinib**
9	G**S**

PDAC: Subgroup Analysis - ORR

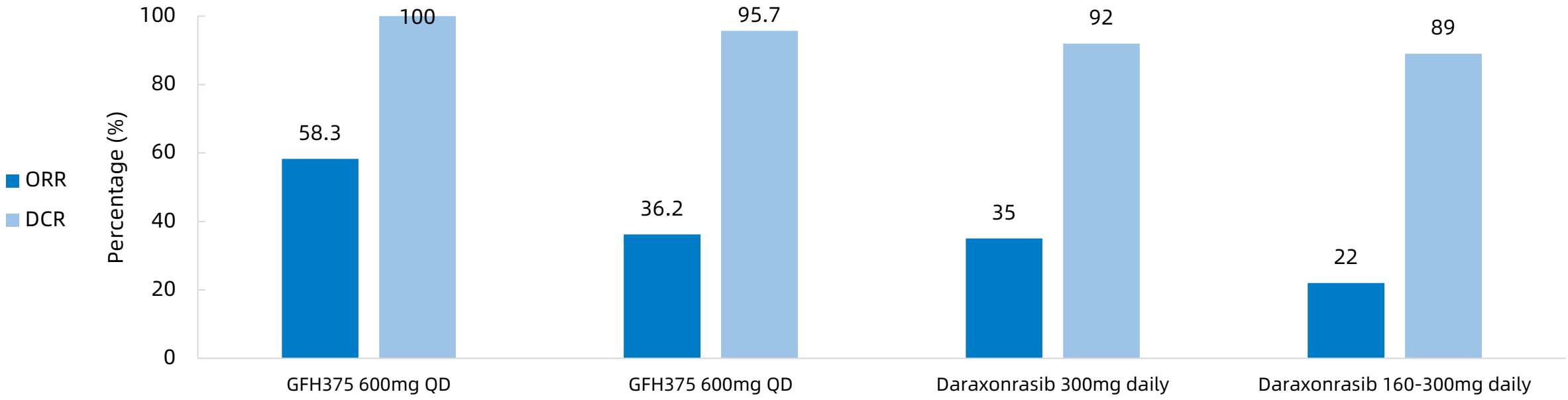
- **59 participants had measurable disease at baseline and at least one post-baseline tumor assessment**

	All PDAC (N=59)	2L (N=12)	3L+ (N=47)
ORR [90%CI]	40.68% [29.87%, 52.22%]	58.33% [31.52%, 81.90%]	36.17% [24.52%, 49.18%]
DCR [90%CI]	96.61% [89.71%, 99.39%]	100% [77.91, 100%]	95.74% [87.20%, 99.24]



Data cut-off date: September 27, 2025. All participants received first dose of GFH375 for at least 4 months prior to the cut-off date. Seven participants had no post-treatment tumor assessments due to early dropout: 2 due to AEs not related to GFH375 (1 upper gastrointestinal hemorrhage and 1 respiratory failure); 1 started new anticancer therapy; 4 early discontinued due to participant decision. Figure: "C " represents confirmed responders. Arrows indicate treatment ongoing. The bars for 3 participants are not shown in the waterfall plot: [a]1 had best overall response (BOR) as SD, and the best percentage change from baseline in was 0%. [b]2 had progressive disease as their BOR: one had a target lesion decrease by 0.4% from baseline with non-target lesion progression; the other had target lesions increase by 0.7% from baseline with non-target lesion progression. Abbreviations: CI, confidence interval. DCR, disease control rate. ORR, objective response rate.

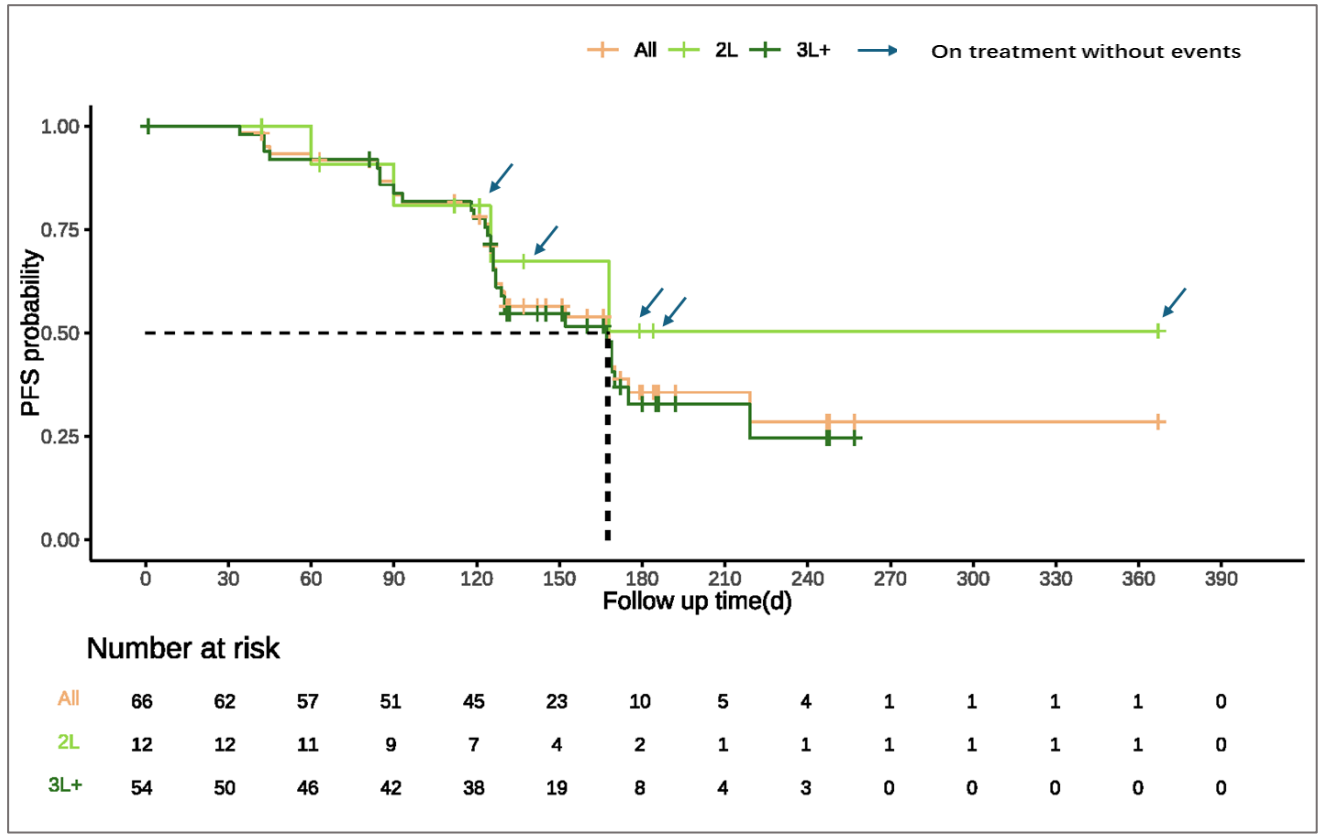
PDAC: Improved Efficacy Compared to Competitors



Population	2L PDAC with KRAS G12D$_m$[1]	3L+ PDAC with KRAS G12D$_m$[1]	2L PDAC with KRAS G12X$_m$[3]	3L+ PDAC with KRAS G12X$_m$[4]
Sample size	**12**	**47**	26	63
ORR	**58.3%**	**36.2%**	35%	22%
DCR	**100%**	**95.7%**	92%	89%
PFS	**Not reached**	**5.52 months**	8.5 months	4.4 months
OS	**Not reached**	**Not reached**	13.1 months	NA
Median follow-up time	**5.65 months**	**5.65 months**	16.7 months	5.7 months*

Cross-trial comparison. Source: [1]ESMO 2025. [2]ASCO GI 2025. [3]Events & Presentations | Revolution Medicines. [4]ENA 2024. *For both KRAS G12 and RAS mutant.
Abbreviations: 2L+, second line and beyond. ORR, objective response rate. DCR, disease control rate. PFS, progression-free survival. OS, overall survival. NR, not reached. NA, not available.

PDAC: Subgroup Analysis – PFS

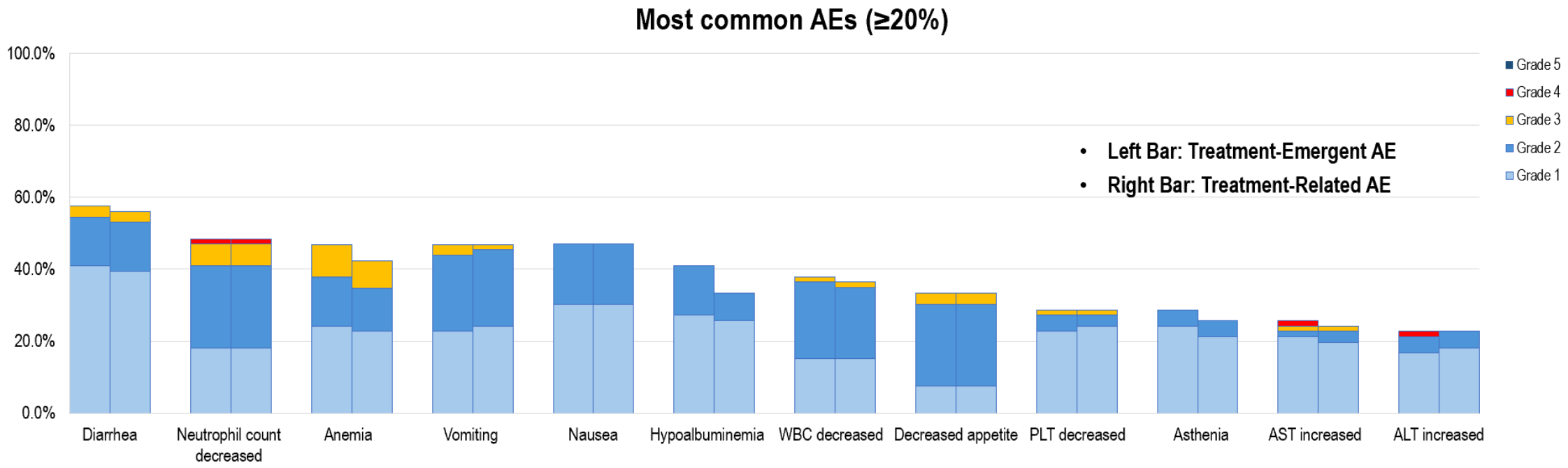


	All PDAC (N=66)	2L (N=12)	3L+ (N=54)
Median PFS (months)	5.52	Not reached	5.52
No. of Events	33	4 (maturity: 33%)	29
On Treatment without Event	25	5	20

Median follow-up time: 5.65 months

About AE Reporting in PDAC

- We reported TEAE in addition to TRAE
- The only case of G4 liver tox was TEAE, not TRAE
  - Billiary tract obstruction due to enlarged lymphode which is not drug-related
- The only case of G4 neutropenia was previously treated with immunotherapy
- No new safety signal has been found
- US patients showed initial better profile than China patients (see VSTM update)



Cross-Trial Comparisons of Safety in PDAC

- **The overall safety/tolerability of GFH375 is better than that of daraxonrasib.**

	GFH375 600mg QD[1]	Daraxonrasib 300mg daily[2]	
	2L+ PDAC, N=66	2L+ PDAC, N=83	1L PDAC, N=40
TRAE	100%	96%	95%
G3 or above	**31.8%**	34%	35%
Leading to discontinuation	**3.0%**	0	10%
Leading to reduction	**6.1%**	30%	33%
Leading to interruption	**27.3%**	43%	53%
Mean dose intensity*	**93%**	86%	85%

Source: [1]ESMO 2025. [2]Events & Presentations | Revolution Medicines. *Refers to the average amount of a drug administered per unit of time. It is used to assess treatment adherence and drug exposure and directly influences therapeutic efficacy and the risk of adverse events.
Abbreviations: 1L, first line. 2L+, second line and beyond. TRAE, treatment-related adverse event.

Common TRAEs in PDAC: GFH375 vs RMC-6236

- **GI Tox: Which one is better?**
- **Hema Tox: No significant difference in G3 and above**
- **Liver Tox: lower G3 and above**

Source: [1]ESMO 2025. [2]Events & Presentations | Revolution Medicines.
Abbreviations: 1L, first line. 2L+, second line and beyond. WBC, white blood cell. PLT, platelet. AST, aspartate transaminase. ALT, alanine transaminase. NA, not available.

	GFH375 600mg QD[1]		Daraxonrasib 300mg daily[2]			
	2L+ PDAC, N=66		2L+ PDAC, N=83		1L PDAC, N=40	
	Any grade	Grade ≥ 3	Any grade	Grade ≥ 3	Any grade	Grade ≥ 3
Gastrointestinal disorders						
Diarrhea	56.1%	3.0%	52%	4%	58%	10%
Vomiting	47.0%	1.5%	36%	0	50%	5%
Nausea	47.0%	0	39%	0	50%	3%
Decreased appetite	33.3%	3.0%	NA	NA	15%	0
Hematological toxicities						
Neutrophil count decreased	48.5%	**7.6%**	6%	**4%**	0	**0**
Anemia	42.4%	**7.6%**	8%	**7%**	5%	**3%**
WBC count decreased	36.4%	**1.5%**	NA	**NA**	NA	**NA**
PLT decreased	28.8%	**1.5%**	10%	**4%**	8%	**0**
Liver enzyme abnormalities						
AST increased	24.2%	**1.5%**	10%	**4%**	8%	**0**
ALT increased	22.7%	**0**	7%	**2%**	8%	**0**
Skin toxicities						
Rash	3.0%	0	90%	7%	88%	8%

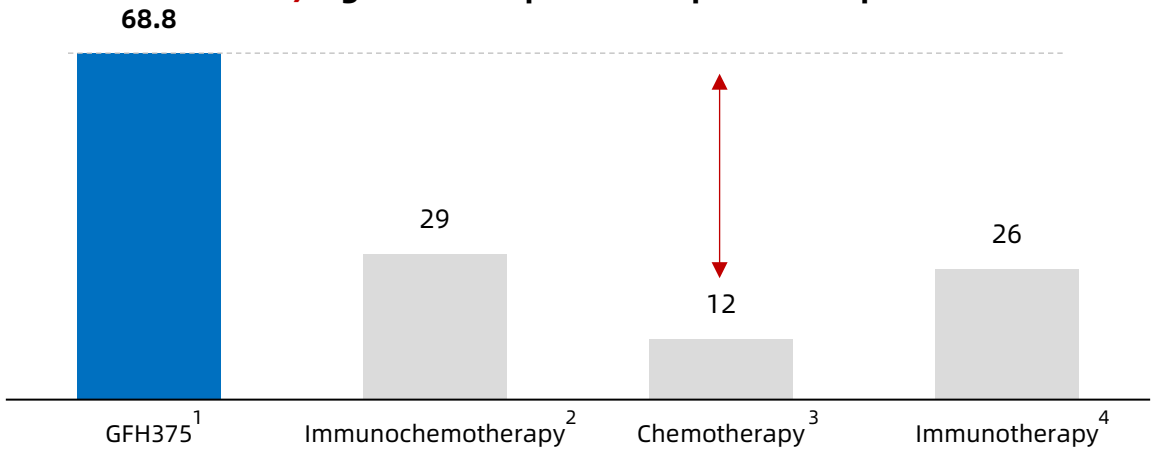
ICI Treatment is NOT Approved in PDAC, yet 33% Participants Had Prior ICI Treatment

- **The incidence of grade ≥3 TEAEs/TRAEs, TEAEs/TRAEs leading to treatment interruption, and SAEs/TRSAEs were higher in participants with prior ICI than in the ICI naïve participants (ESMO2025 data)**

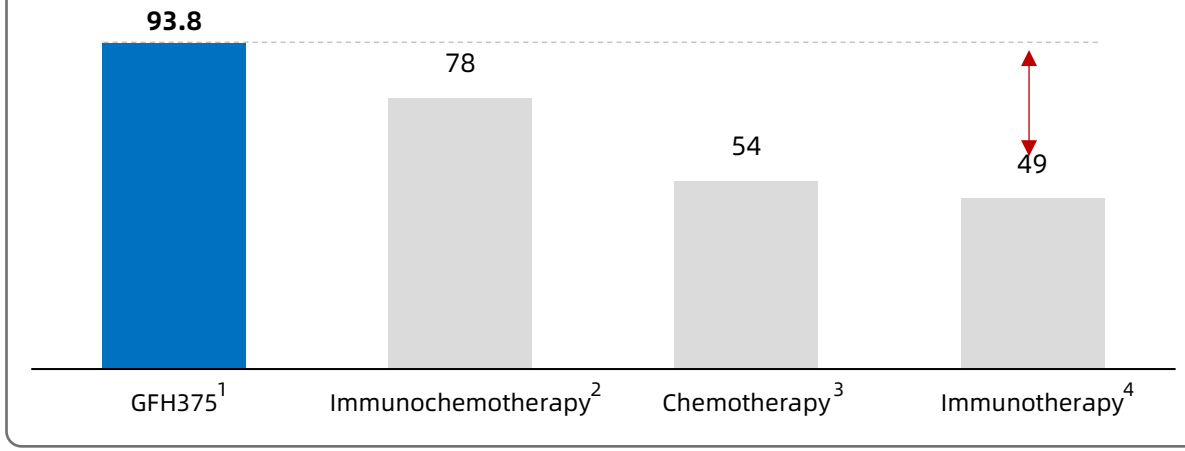
AE, n (%)	ICI pretreated (N=22)	ICI naïve (N=44)
At least one ≥Grade 3 TEAE	**15(68.2%)**	18 (40.9%)
At least one ≥Grade 3 TRAE	**10 (45.5%)**	11 (25%)
TESAE	**9 (40.9%)**	8 (18.2%)
TRSAE	**5 (22.7%)**	4 (9.1%)
Dose modification due to TEAE	**11 (50%)**	17 (38.6%)
Dose modification due to TRAE	**8 (36.4%)**	13 (29.5%)
Discontinuation due to TEAE	**2 (9.1%)**	3 (6.8%)
Discontinuation due to TRAE	**1 (4.5%)**	1 (2.3%)
Dose reduction due to TEAE	**2 (9.1%)**	2 (4.5%)
Dose reduction due to TRAE	**2 (9.1%)**	2 (4.5%)
Dose interruption due to TEAE	**9 (40.9%)**	16 (36.4%)
Dose interruption due to TRAE	**7 (31.8%)**	11 (25%)

NSCLC:
Better Efficacy in Pretreated Participants Compared to SoC

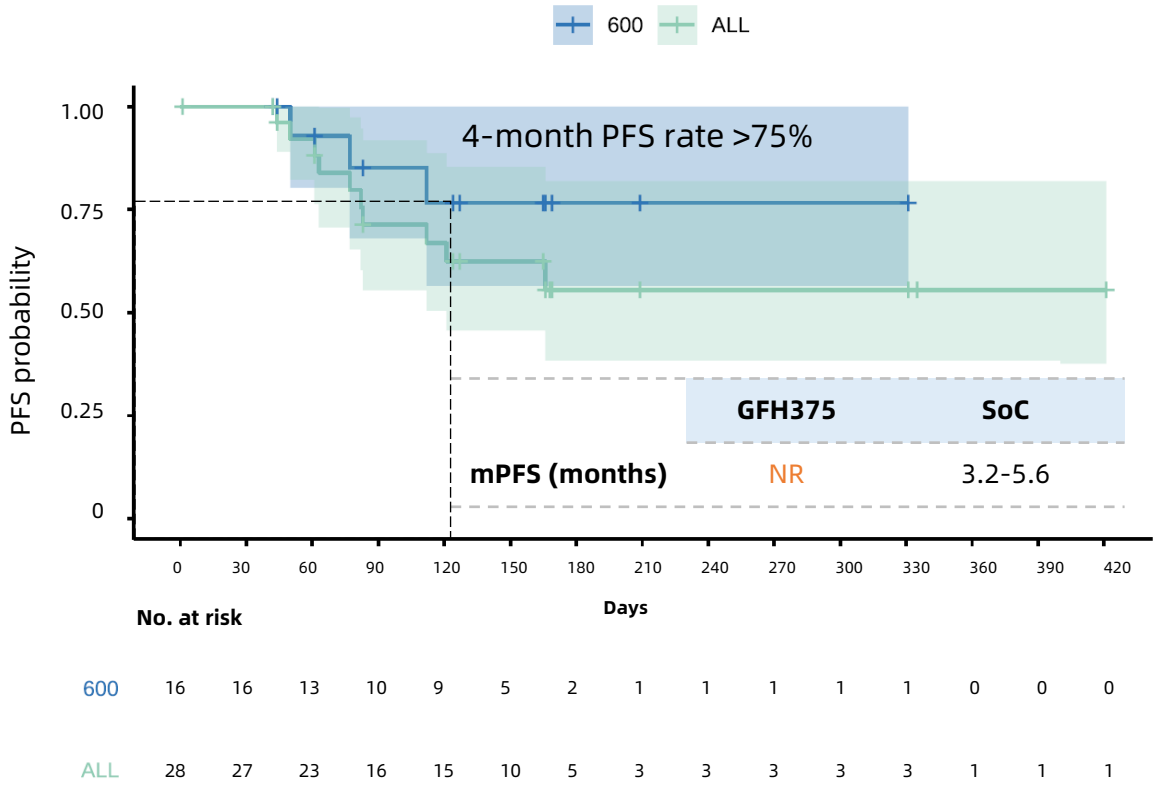
- **ORR: 68.8%, significant improved response compared to the SoC**



- **DCR: 93.8%, significantly improved compared with SoC**



- mPFS was **not reached**.

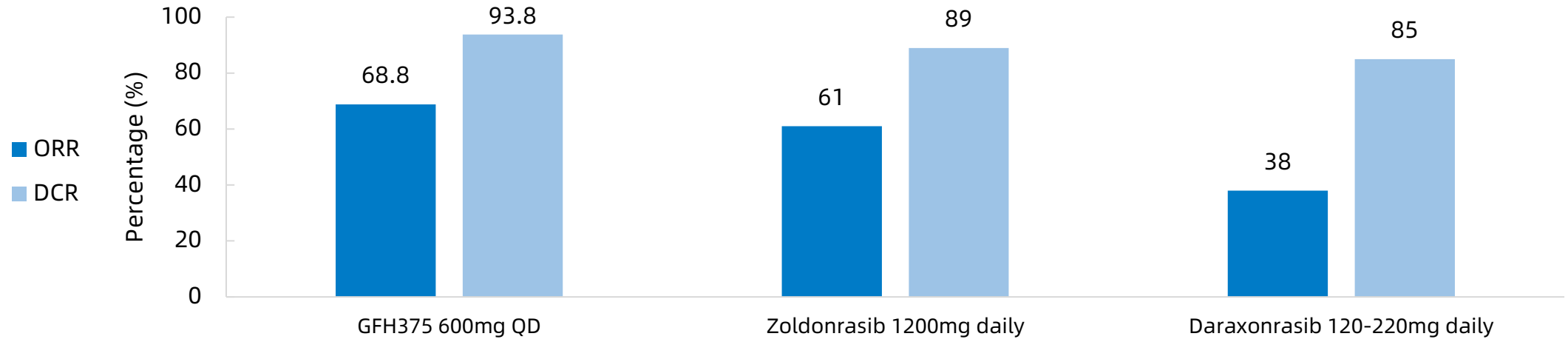


Median follow up times for participants across all dose levels and at 600 mg QD were: 5.5 and 4.2 months, respectively.

Source: [1]WCLC 2025. [2]J Clin Oncol. 2024 Dec;42(34):4029-4039. [3]N Engl J Med. 2015 October 22; 373(17): 1627–1639. [4]Annals of Oncology, Volume 30, Issue 8, 1321 – 1328.
Abbreviations: ORR, objective response rate. DCR, disease control rate. PFS, progression free survival. NR, not reached.

NSCLC: Improved Efficacy Compared to Competitors

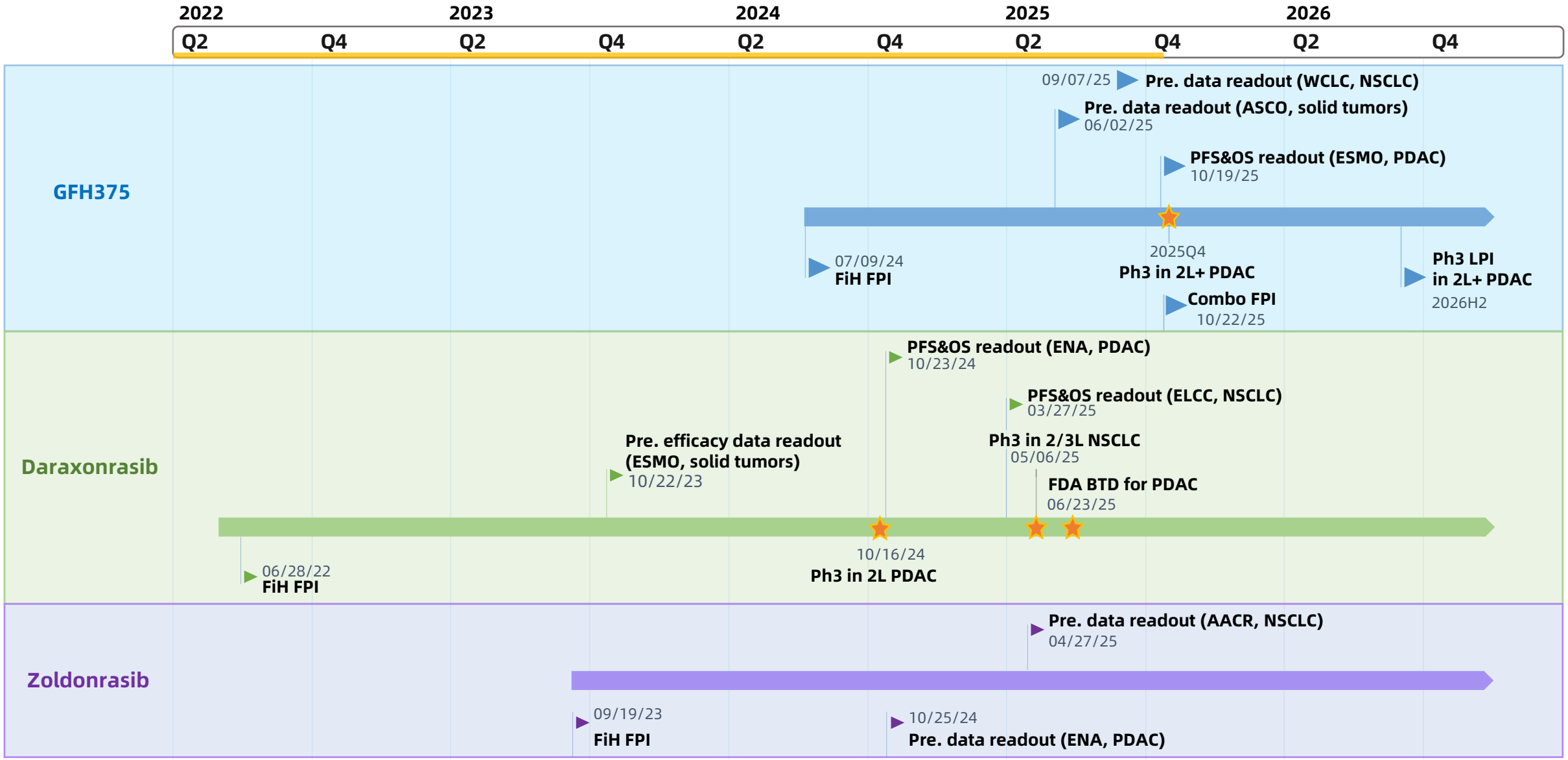
- **Best-in-class as G12D monotherapy for NSCLC**
- **Supporting single-arm accelerated approval for 2L+ NSCLC**



Population	2L+ NSCLC with KRAS $G12D_m$[1]	2L+ NSCLC with KRAS $G12D_m$[2]	2/3L NSCLC with KRAS $G12X_m$[3]
Sample size	16	18	40
ORR	68.8%	61%	38%*
DCR	93.8%	89%	85%*
PFS	NR	NA	9.8 months
OS	NR	NA	17.7 months
Median follow-up time	4.2 months	NA	10.8 months

Cross-trial comparison. Source: [1]WCLC 2025. [2]AACR 2025. [3]ELCC 2025 (participants were required not have received docetaxel previously). *confirmed.
Abbreviations: 2L+, second line and beyond. ORR, objective response rate. DCR, disease control rate. PFS, progression-free survival. OS, overall survival. NR, not reached. NA, not available.

Clinical Development Status of GFH375 and Competitors



One of Global Leaders in Developing RAS-targeted Therapeutics

GENFLEET THERAPEUTICS

GenFleet's RAS-targeted Matrix

Validation
- Marketed product
- Proven expertise in developing RAS inhibitors

Efficiency
- First-to-market speed of fulzerasib development
- Rapid enrollment in GFH375 program

Depth
- Global clinical development
- Diverse targets and modalities

Innovation
- First-in-class combo
- Next-generation ADC by FAScon

Fulzerasib **KRAS G12C**	• Mono: **First-to-market** in China, third globally • Combo: potential **1st-line NSCLC standard-of-care**
GFH375 **KRAS G12D**	• **1st-tier development of** oral G12D inhibitor • **Global clinical development:** phase II in China and phase I/IIa in the US
GFH276 **Pan RAS**	• **Differentiated RAS (ON) mechanism**: non-degradative molecular glue • **1st-tier development** of pan RAS (ON) inhibitor in China
GFS784 **FAScon**	• **Globally innovative ADC platform:** synergy between large and small molecules • Integrating therapeutic antibody and targeted payload

Marching towards a Leading Pancreatic Cancer Franchise

Diverse RAS-targeted therapies

- KRAS G12C — GFH925
- KRAS G12D — GFH375
- Pan RAS (ON) — GFH276
- EGFR-Pan RAS ADC — GFS784

World's 1st bispecific antibody for cancer cachexia

- GDF15/IL-6 — GFS202A

80-90%*
Pancreatic cancer patients with RAS mutations
**Source: Seminars in Oncology*

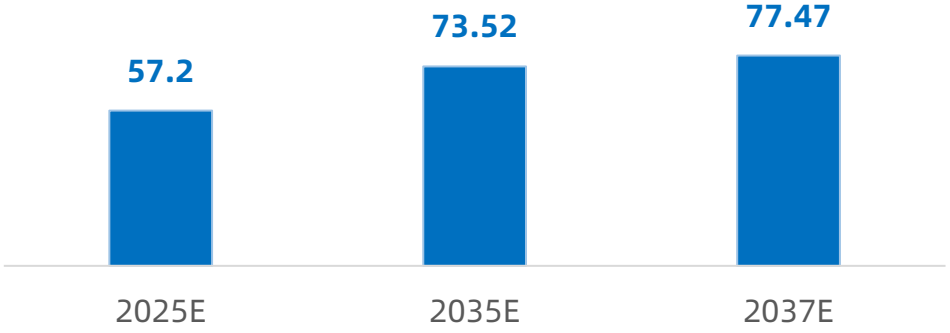
Over 700 thousand
Global incidence (2035E)

100 Bn-yuan market
Global pancreatic cancer drug sales (2037E)

Forecasted global incidence of pancreatic cancer

Source: Frost Sullivan (in 10 thousands)

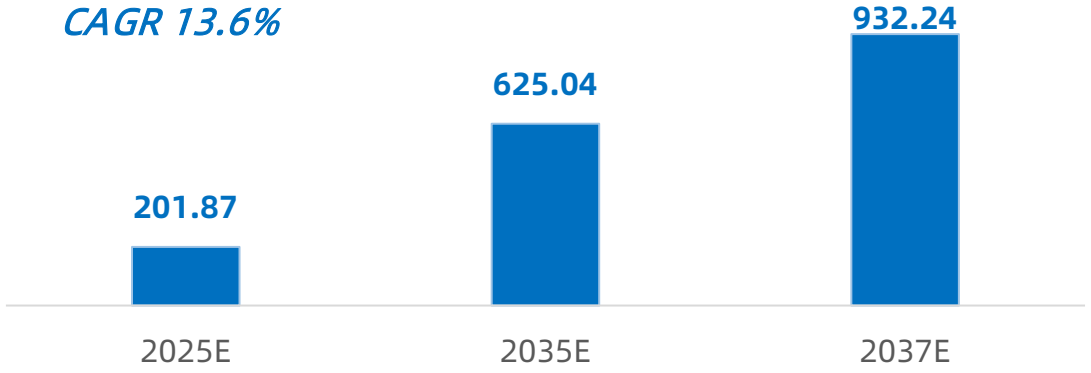
CAGR 2.6%



Forecasted global market of pancreatic cancer drugs

Source: Research Nester (100 million RMB)

CAGR 13.6%




Innovation, in expedition

Delivering Novel Therapies for RAS/MAPK Pathway Driven Cancers

October 2025

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Disclaimers

Forward-Looking Statements
This presentation includes forward-looking statements about, among other things, Verastem Oncology's (the "Company") programs and product candidates, strategy, future plans and prospects, including statements related to the approval and commercialization of AVMAPKI™ FAKZYNJA™ CO-PACK (avutometinib capsules; defactinib tablets) as a treatment for adult patients with KRAS-mutant recurrent Low-Grade Serous Ovarian Cancer (LGSOC), the expected outcome and benefits of collaborations, including with GenFleet Therapeutics (Shanghai), Inc. (GenFleet), including the conduct of a Phase 1/2a study with respect to VS-7375, the status of enrollments for and potential of the results of the RAMP 301 Phase 3 trial to confirm the results of the RAMP 201 study specific to KRAS mutant patients and to expand the indication regardless of KRAS mutation status, the structure of our planned and pending clinical trials, the potential clinical value of various of the Company's clinical trials, including the RAMP 201J, RAMP 203, RAMP 205, RAMP 301 and VS-7375 trials, the timing of commencing and completing trials, including topline data reports, interactions with regulators, the timeline and indications for clinical development, regulatory submissions, the potential for and timing of commercialization of product candidates and potential for additional development programs involving the Company's lead compound and the potential market opportunities of, and estimated addressable markets for, our drug candidates. The words "anticipate," "believe," "estimate," "expect," "may," "plan," "target," "potential," "would," "could," "should," "continue," "can" and similar expressions are intended to identify forward-looking statements, although not all forward-looking statements contain these identifying words. Each forward-looking statement is subject to risks and uncertainties that could cause actual results to differ materially from those expressed or implied in such statement.

Applicable risks and uncertainties include the risks and uncertainties, among other things, regarding: the success in the development and potential commercialization of our product candidates, including avutometinib in combination with other compounds, including defactinib, LUMAKRAS and others; the uncertainties inherent in research and development, such as negative or unexpected results of clinical trials, the occurrence or timing of applications for our product candidates that may be filed with regulatory authorities in any jurisdictions; whether and when regulatory authorities in any jurisdictions may approve any such applications that may be filed for our product candidates, and, if approved, whether our product candidates will be commercially successful in such jurisdictions; our ability to obtain, maintain and enforce patent and other intellectual property protection for our product candidates; the scope, timing, and outcome of any legal proceedings; decisions by regulatory authorities regarding trial design, labeling and other matters that could affect the timing, availability or commercial potential of our product candidates; whether preclinical testing of our product candidates and preliminary or interim data from clinical trials will be predictive of the results or success of ongoing or later clinical trials; that the timing, scope and rate of reimbursement for our product candidates is uncertain; that the market opportunities of our drug candidates are based on internal and third-party estimates which may prove to be incorrect; that third-party payors (including government agencies) may not reimburse; that there may be competitive developments affecting our product candidates; that data may not be available when expected; that enrollment of clinical trials may take longer than expected, which may delay our development programs, including delays in review by the U.S. Food and Drug Administration (FDA); the risk that our RAMP 301 trial may not confirm the results of the RAMP 201 trial specific to the use of AVMAPKI FAKZYNJA CO-PACK in adult patients with KRAS mutant recurrent LGSOC; the risks associated with preliminary and interim data, which may not be representative of more mature data, including with respect to interim duration of therapy data; that our product candidates will cause adverse safety events and/or unexpected concerns may arise from additional data or analysis, or result in unmanageable safety profiles as compared to their levels of efficacy; that we may be unable to successfully validate, develop and obtain regulatory approval for companion diagnostic tests for our product candidates that require or would commercially benefit from such tests, or experience significant delays in doing so; that the mature RAMP 201 data and associated discussions with the FDA may not support the scope of a new drug application submission for the avutometinib and defactinib combination in LGSOC including with respect to Kirsten rat sarcoma viral oncogene homolog (KRAS) wild-type (KRAS wt); that our product candidates may experience manufacturing or supply interruptions or failures; that any of our third-party contract research organizations, contract manufacturing organizations, clinical sites, or contractors, among others, who we rely on fail to fully perform; that we face substantial competition, which may result in others developing or commercializing products before or more successfully than we do which could result in reduced market share or market potential for our product candidates; that we will be unable to successfully initiate or complete the clinical development and eventual commercialization of our product candidates; that the development and commercialization of our product candidates will take longer or cost more than planned, including as a result of conducting additional studies or our decisions regarding execution of such commercialization; that we may not have sufficient cash to fund our contemplated operations, including certain of our product development programs; that we may not attract and retain high quality personnel; that we or Chugai Pharmaceutical Co., Ltd. may fail to fully perform under the avutometinib license agreement; that our total addressable and target markets for our product candidates might be smaller than we are presently estimating; that we or Secura Bio, Inc. will fail to fully perform under the asset purchase agreement with Secura Bio, Inc., including in relation to milestone payments; that we will not see a return on investment on the payments we have and may continue to make pursuant to the collaboration and option agreement with GenFleet, or that GenFleet will fail to fully perform under the agreement; that we may not be able to establish new or expand on existing collaborations or partnerships, including with respect to in-licensing of our product candidates, on favorable terms, or at all; that we may be unable to obtain adequate financing in the future through product licensing, co-promotional arrangements, public or private equity, debt financing or otherwise; that we will not pursue or submit regulatory filings for our product candidates; that, due to the recent change in presidential administration and the significant reduction in the FDA's workforce and potential reductions to the FDA's budget, we may experience a materially impact to the FDA's ability to engage in a variety of activities that may affect our business, including routine regulatory and oversight activities; and that our product candidates may not receive regulatory approval, become commercially successful products, or result in new treatment options being offered to patients.

Other risks and uncertainties include those identified under the heading "Risk Factors" in the Company's Annual Report on Form 10-K for the year ended December 31, 2024, as filed with the Securities and Exchange Commission (SEC) on March 20, 2025, and in any subsequent filings with the SEC, which are available at www.sec.gov and www.verastem.com. The forward-looking statements in this presentation speak only as of the original date of this presentation, and we undertake no obligation to update or revise any of these statements whether as a result of new information, future events or otherwise, except as required by law.

Use of Non-GAAP Financial Measures
This presentation contains references to our non-GAAP operating expense, a financial measure that is not calculated in accordance with generally accepted accounting principles in the US (GAAP). This non-GAAP financial measure excludes certain amounts or expenses from the corresponding financial measures determined in accordance with GAAP. Management believes this non-GAAP information is useful for investors, taken in conjunction with the Company's GAAP financial statements, because it provides greater transparency and period-over-period comparability with respect to the Company's operating performance and can enhance investors' ability to identify operating trends in the Company's business. Management uses this measure, among other factors, to assess and analyze operational results and trends and to make financial and operational decisions. Non-GAAP information is not prepared under a comprehensive set of accounting rules and should only be used to supplement an understanding of the Company's operating results as reported under GAAP, not in isolation or as a substitute for, or superior to, financial information prepared and presented in accordance with GAAP. In addition, this non-GAAP financial measure is unlikely to be comparable with non-GAAP information provided by other companies. The determination of the amounts that are excluded from non-GAAP financial measures is a matter of management judgment and depends upon, among other factors, the nature of the underlying expense or income amounts. Reconciliations between this non-GAAP financial measure and the most comparable GAAP financial measure are included in the footnotes to the slides in this presentation on which such non-GAAP number appears.

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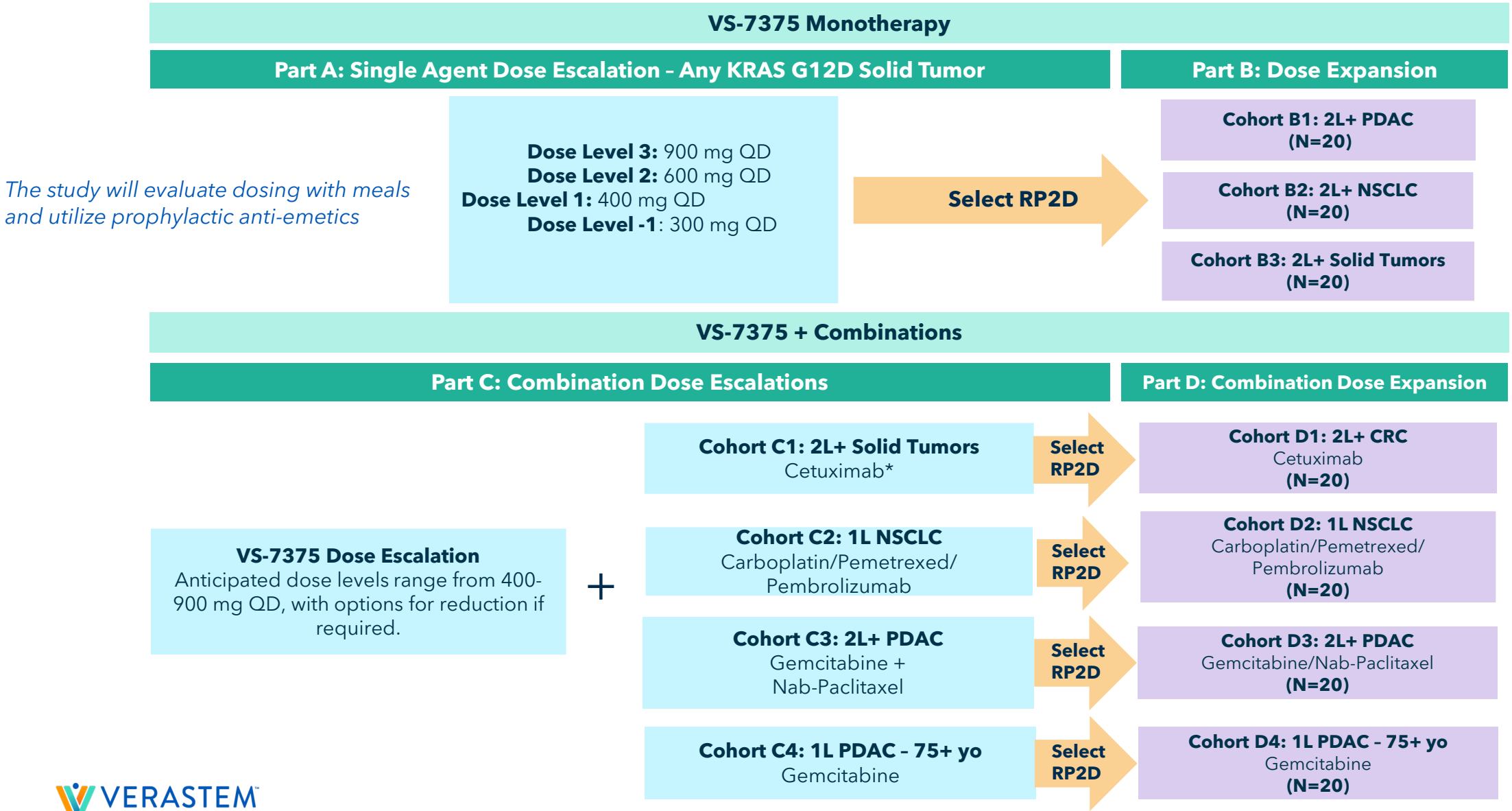
Certain information contained in this presentation, including industry and market data and other statistical information, relates to or is based on studies, publications, surveys and other data obtained from third-party sources and the Company's own internal estimates and research. While the Company believes these third-party sources to be reliable as of the date of this presentation, it has not independently verified, and makes no representation as to the adequacy, fairness, accuracy or completeness of, any information obtained from third-party sources. In addition, all of the market data included in this presentation involves a number of assumptions and limitations, and there can be no guarantee as to the accuracy or reliability of such assumptions

VS-7375-101 Study Schema, Efficiently Testing KRAS G12D+ Indications with Monotherapy and SOC Combinations



*Anticipated starting dose level for cetuximab combination once the monotherapy clears 600 mg dose level

Accelerated Development Approach Builds on Preliminary First-in-Human Study Findings

Multi-Arm Clinical Study Evaluating Monotherapy and Combinations

- **Efficacious starting dose:**
  - 400 mg starting dose supported by monotherapy efficacy/safety in FIH study
- **Evaluating GI side effect mitigations:**
  - Use prophylactic anti-emetics
  - Evaluate dosing with and without food
  - Evaluate additional formulation
- **Multiple, high-value indication strategy:**
  - Monotherapy expansion cohorts in PDAC & NSCLC
  - Combination cohorts with cetuximab for CRC, chemotherapy for PDAC, chemo plus I-O for NSCLC
- **Expand to geographies outside of U.S.**

FDA Engagement Plans

- **Granted Fast Track Designation for:**
  - First-line in patients with KRAS G12D locally advanced or metastatic PDAC and
  - Patients with KRAS G12D locally advanced or mPDAC who received at least one prior line of standard systemic therapy in July 2025
- **Plan to pursue Breakthrough Therapy Designation**
- **Accelerated clinical development with FDA input**

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VS-7375-101 Study Update as of October 23, 2025

- First two monotherapy dose levels (400 mg QD and 600 mg QD) **cleared, with no dose-limiting toxicities (DLT's) reported**
- **Promising anti-tumor activity** observed in patients with various solid tumors, including advanced pancreatic ductal adenocarcinoma
- **No nausea, vomiting, or diarrhea greater than Grade 1** was observed
- **Enrollment initiated for VS-7375 in combination with cetuximab** in patients with advanced KRAS G12D mutant solid tumors, including colorectal cancer
- Plan to report an **interim safety and efficacy** update on the Phase 1/2a trial in the **first half of 2026**

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Next Steps in VS-7375 Clinical Program

- ✓ **Reported a preliminary update** on the Phase 1 monotherapy dose escalation in Q4 2025
- **Initiate the dose escalation cohorts** in combination with cetuximab, chemotherapy, and chemotherapy with checkpoint-inhibitor for CRC, PDAC, and NSCLC, respectively, in Q4 2025
- Subject to the results of the Phase 1 monotherapy dose escalation, **initiate monotherapy expansion cohorts** in PDAC, NSCLC, and other solid tumors
- Subject to the results of the combination dose escalation cohorts with VS-7375, **initiate combination expansion cohorts** in CRC, PDAC, and NSCLC

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