Revolution Medicines

On Target to Outsmart Cancer

August 2025

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For a further description of the risks and uncertainties that could cause actual results to differ from those anticipated in these forward-looking statements, as well as risks relating to the business of Revolution Medicines in general, see Revolution Medicines' Quarterly Report on Form 10-Q filed with the Securities and Exchange Commission on August 6, 2025, and its future periodic reports to be filed with the Securities and Exchange Commission.

This presentation concerns product candidates that are under clinical investigation and which have not yet been approved for marketing by the U.S. Food and Drug Administration (FDA). These product candidates are currently limited by Federal law to investigational use, and no representation is made as to their safety or effectiveness for the purposes for which they are is being investigated.

Our Mission

To revolutionize treatment globally for patients with RAS-addicted cancers through the discovery, development and delivery of ***innovative, targeted medicines***.

Daraxonrasib
RMC-6236 | MULTI

Elironrasib
RMC-6291 | G12C

Zoldonrasib
RMC-9805 | G12D

Compelling pipeline from pioneering science

Proven execution and patient-centric strategy

Financial strength to enable global vision

Creating Industry-Leading Global Targeted Medicines Franchise for Patients with RAS-Addicted Cancers

Discovery

Sophisticated RAS cancer drug discovery and biological sciences

- Advance RMC-5127 (RAS(ON) G12V-selective inhibitor) to clinic readiness
- Progress next-generation programs

Development

Pioneering drug candidates and proven capabilities

- Execute daraxonrasib pivotal trials in previously treated PDAC and NSCLC
- Advance daraxonrasib into earlier line pivotal trials in PDAC and NSCLC
- Prepare to initiate pivotal trial(s) with mutant-selective inhibitors

Delivery

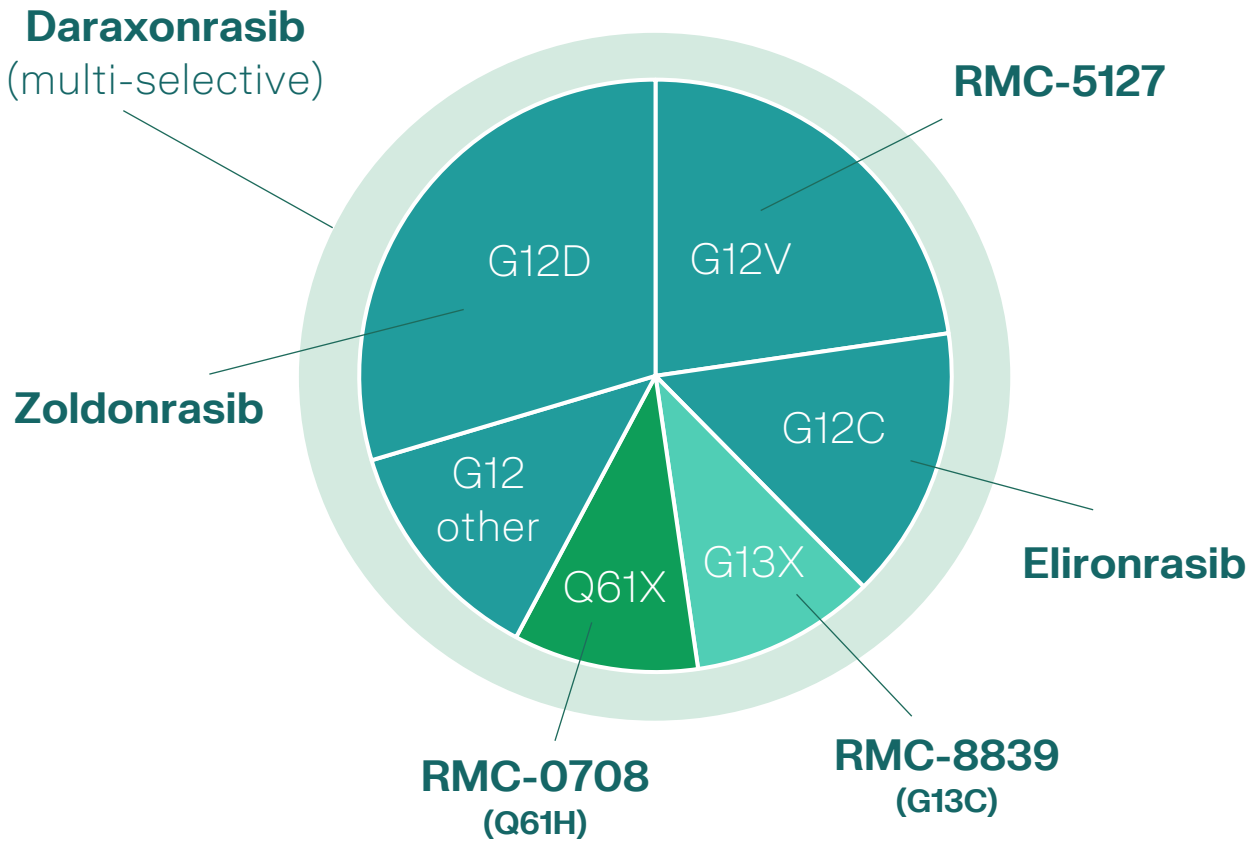
Building global capabilities for successful launch; manufacturing daraxonrasib at commercial scale

- Grow global commercialization and operational capabilities and advance launch readiness
- Expand and reinforce select partnerships

PDAC, pancreatic ductal adenocarcinoma; NSCLC, non-small cell lung cancer; 1L, first line.

RAS(ON) Proteins are Key Therapeutic Targets in RAS-Addicted Cancers

Frequency of RAS Variants Among RAS Mutant Solid Tumors



Major cancers with RAS drivers

Pancreatic ductal adenocarcinoma

- ***>90% are RAS-driven[1]***
- ***~56,000 new patients in the U.S. per year[2]***

Non-small cell lung cancer

- ***~30% are RAS-driven[1]***
- ***~60,000 new patients in the U.S. per year[3]***

Colorectal cancer

- ***~50% are RAS-driven[1]***
- ***~75,000 new patients in the U.S. per year[4]***

(1) Estimated using tumor mutation frequencies from FoundationCORE March 2022. (2) Incidence from ACS Cancer Facts and Figures 2024, mutation frequencies from FoundationCORE May 2024, includes all stages of disease. (3) Incidence from ACS Cancer Facts and Figures 2024, includes all stages of disease. (4) Incidence from ACS Cancer Facts and Figures 2023; includes all stages of disease.

Pipeline Led by Three Pioneering, Clinical-Stage, RAS(ON) Inhibitors

COMPOUND	FOCUS	STUDY DETAILS	EARLY CLINICAL DEVELOPMENT	REGISTRATIONAL TRIAL
Daraxonrasib (MULTI)	Monotherapy Studies			
	PDAC	RASolute302 2L metastatic		
		1L metastatic		*Phase 3 initiation planned*
		Adjuvant in resectable		*Phase 3 initiation planned*
	NSCLC	RASolve301 2L/3L metastatic		
	Combination Studies			
	Solid tumors	+ SOC, RAS(ON) inhibitor doublets or other investigational agents		
Elironrasib (G12C)	Solid tumors	Monotherapy		
		+ SOC, RAS(ON) inhibitor doublets or other investigational agents		
Zoldonrasib (G12D)	Solid tumors	Monotherapy		
		+ SOC, RAS(ON) inhibitor doublets or other investigational agents		

RMC-5127 (G12V) is in preclinical development. Additional clinical development opportunities include RAS(ON) mutant-selective inhibitors RMC-0708 (Q61H) and RMC-8839 (G13C) and next-generation programs.

PDAC, pancreatic ductal adenocarcinoma; NSCLC, non-small cell lung cancer; CRC, colorectal cancer; SOC, standard of care; 2L, second line; 1L, first line; 3L, third line.

Our Strategy

To maximize the impact of our RAS(ON) inhibitor portfolio for patients with RAS-addicted cancers by:

01 Commercializing daraxonrasib initially in **late-stage** disease

02 Moving aggressively to develop RAS(ON) inhibitors in **earlier lines** of therapy

03 Developing optimal, biologically rational RAS(ON) inhibitor **combinations** in earlier lines

04 Continuously innovating for patients by producing new, **differentiated drug candidates**

Daraxonrasib

RAS(ON) Multi-Selective Inhibitor

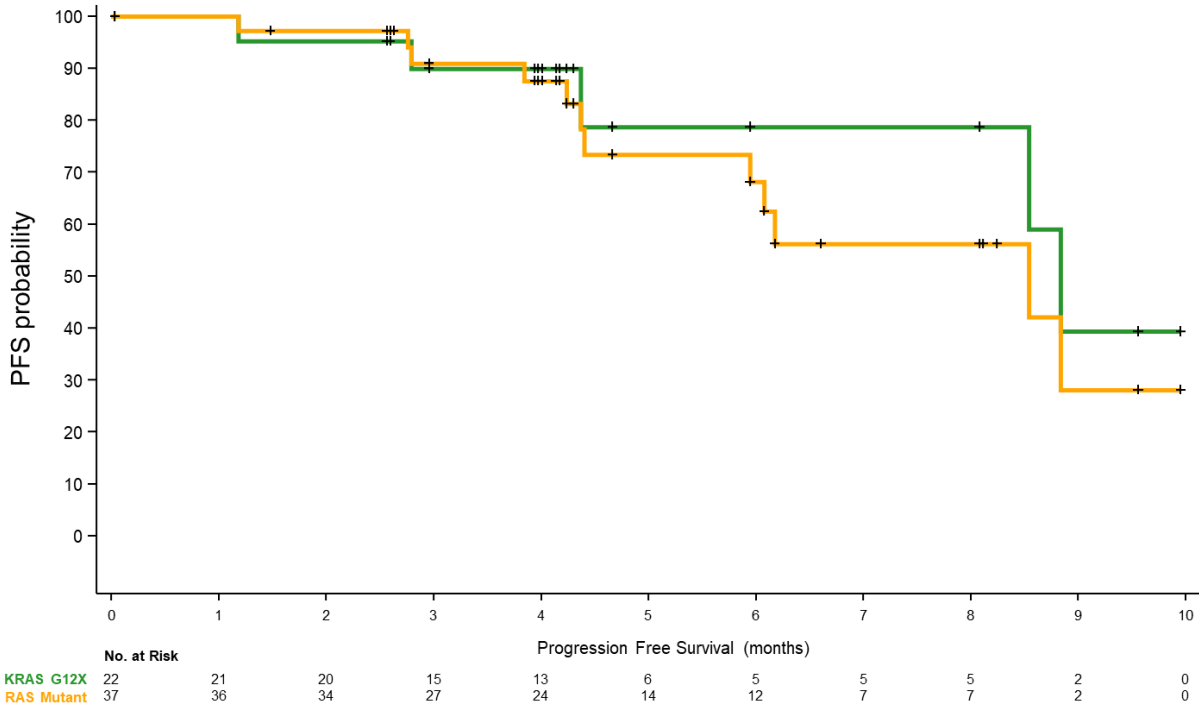
Active against

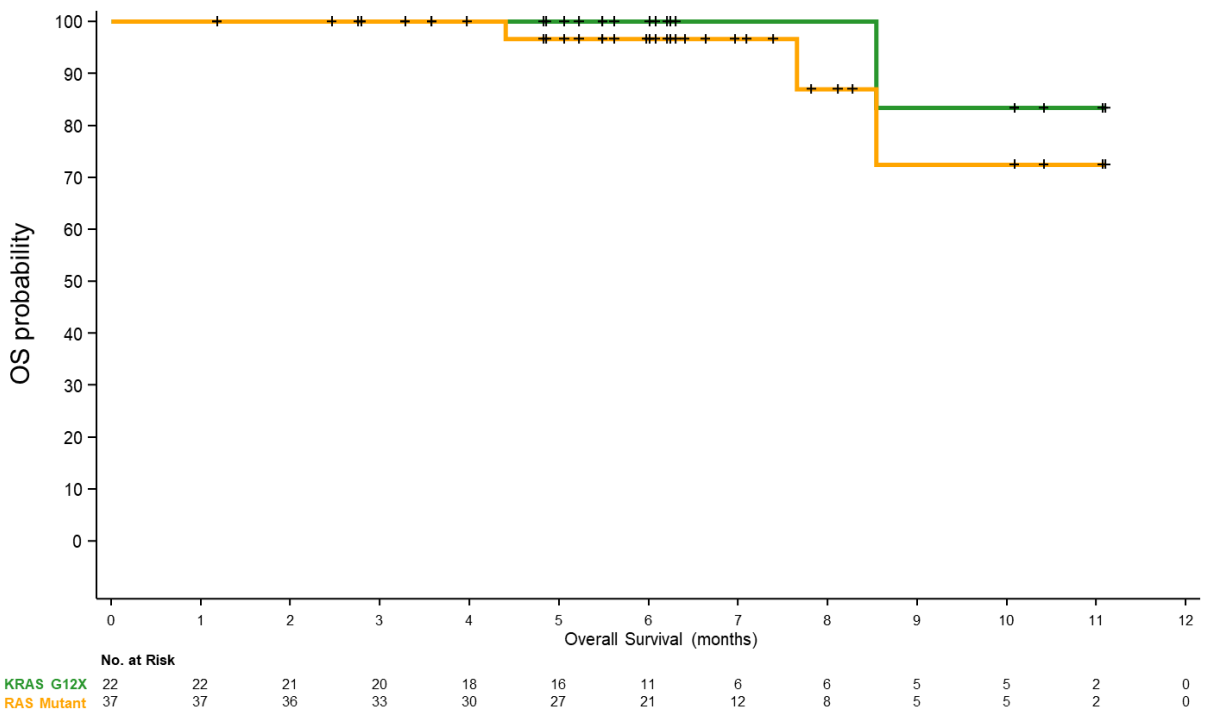
- Diverse RAS driver mutations
- Multiple drug resistance mechanisms, including secondary RAS mutations and wild-type RAS

FDA Breakthrough Therapy Designation in previously treated, metastatic pancreatic cancer patients with KRAS G12 mutations

Encouraging Durability in 2L Patients with PDAC Treated with Daraxonrasib at 300 mg Daily

	Median PFS, Months (95% CI)	Median OS, Months (95% CI)	OS Rate at 6 Months, % (95% CI)
KRAS G12X	**8.8** (8.5, NE)	**NE** (NE, NE)	**100** (100, 100)
RAS Mutant[(1)]	**8.5** (5.9, NE)	**NE** (8.5, NE)	**97** (79, 100)

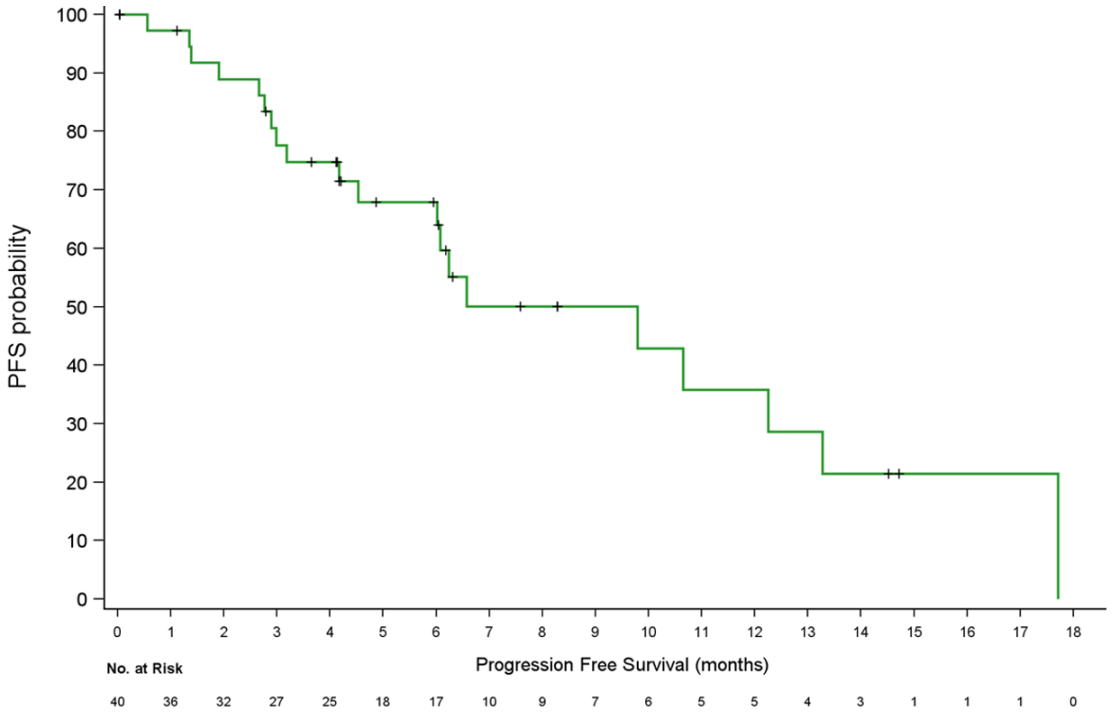


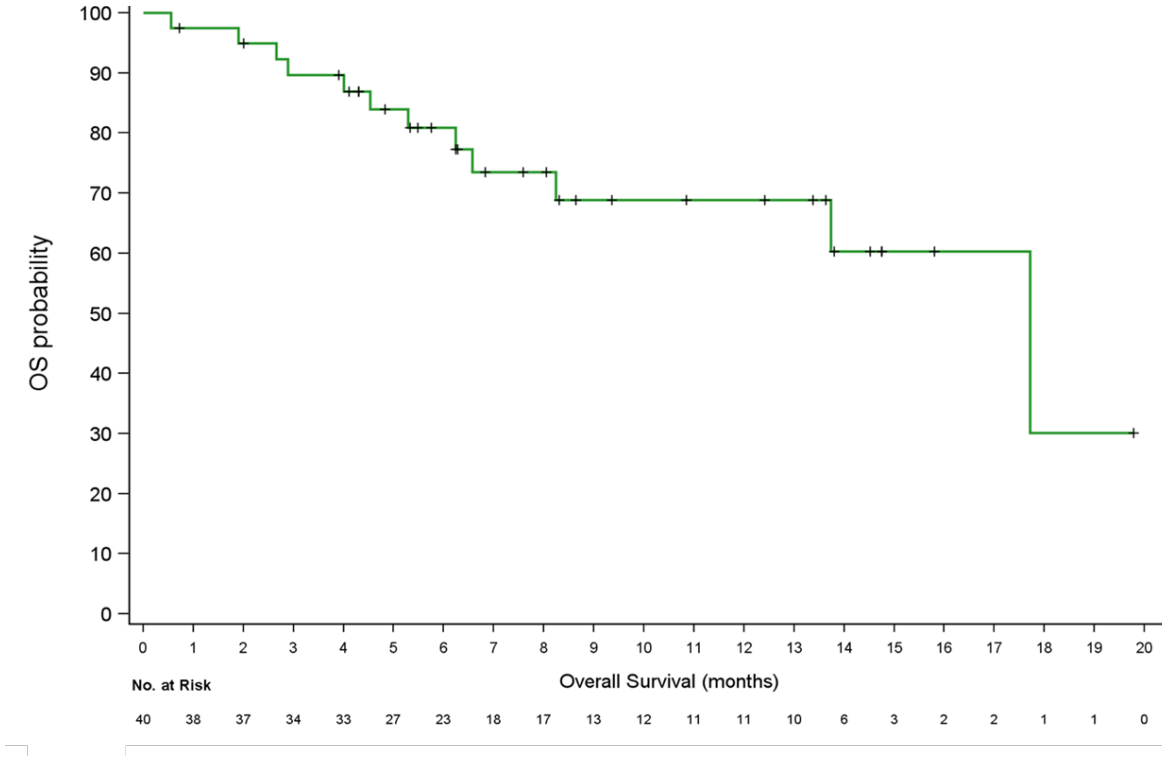


RMC-6236-001: 2L patients with KRAS G12X PDAC treated with daraxonrasib 300 mg daily (data cutoff: 7/23/2024). 2L in the metastatic setting includes patients who progressed on prior therapy in an earlier setting within 6 months of last dose. Median follow-up is 6.1 months and 6.6 months for KRAS G12 and RAS mutant in the 2L setting at 300 mg, respectively. (1) RAS Mutant defined as patients with G12X, G13X or Q61X PDAC. 2L, second line; PDAC, pancreatic ductal adenocarcinoma; PFS, progression-free survival; OS, overall survival, CI, confidence interval; NE, not estimable.

Encouraging Durability in 2L/3L Patients with RAS G12X NSCLC Treated with Daraxonrasib at 120-220 mg Daily

Median PFS, Months (95% CI)	Median OS, Months (95% CI)
9.8 (6, 12.3)	**17.7** (13.7, NE)



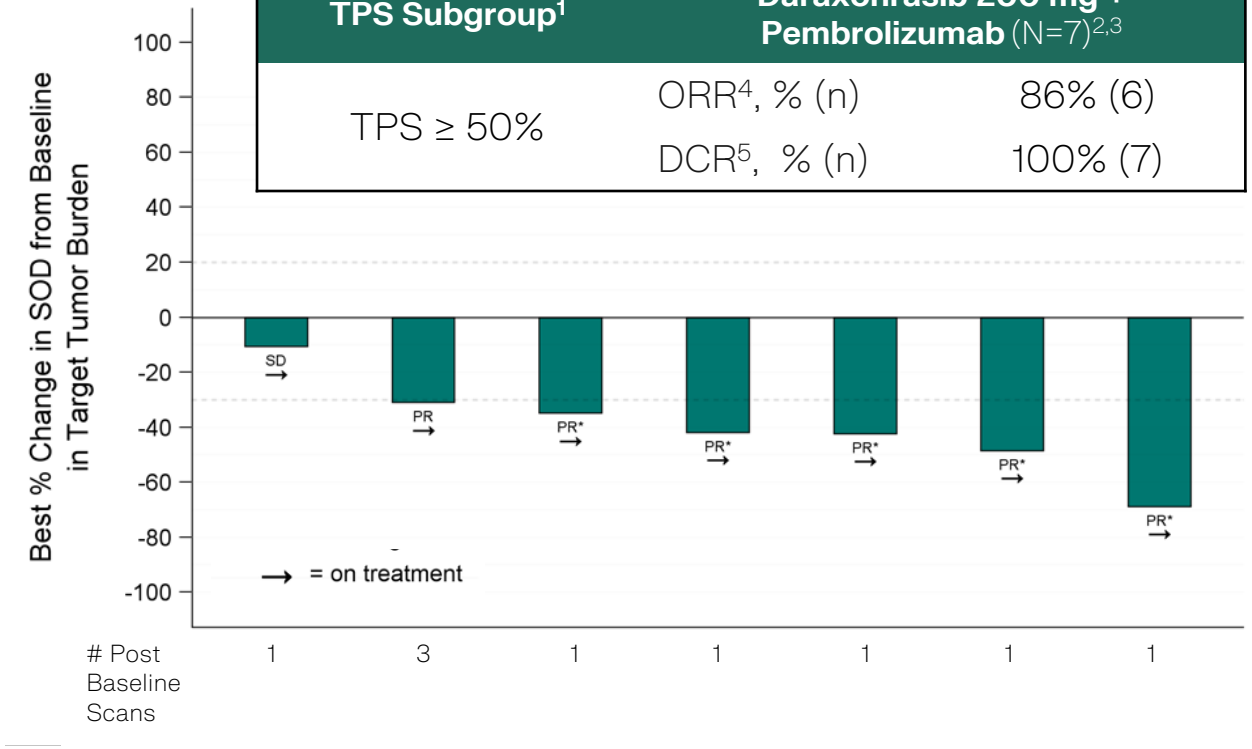


RMC-6236-001: 2L/3L patients with RAS G12X NSCLC treated with daraxonrasib at 120-220 mg daily. Population includes patients with RAS G12X mutant NSCLC who have received 1 or 2 prior lines of therapy which must include prior immunotherapy and platinum chemotherapy administered either concurrently or sequentially, and have not received docetaxel previously. Adjuvant therapy or multimodal therapy with curative intent is considered prior therapy if disease progression occurred or treatment completion was within 6 months of first dose of daraxonrasib. Median follow-up is 10.8 months. 2L, second line; 3L, third line; NSCLC, non-small cell lung cancer; PFS, progression-free survival; OS, overall survival; CI, confidence interval; NE, not estimable.

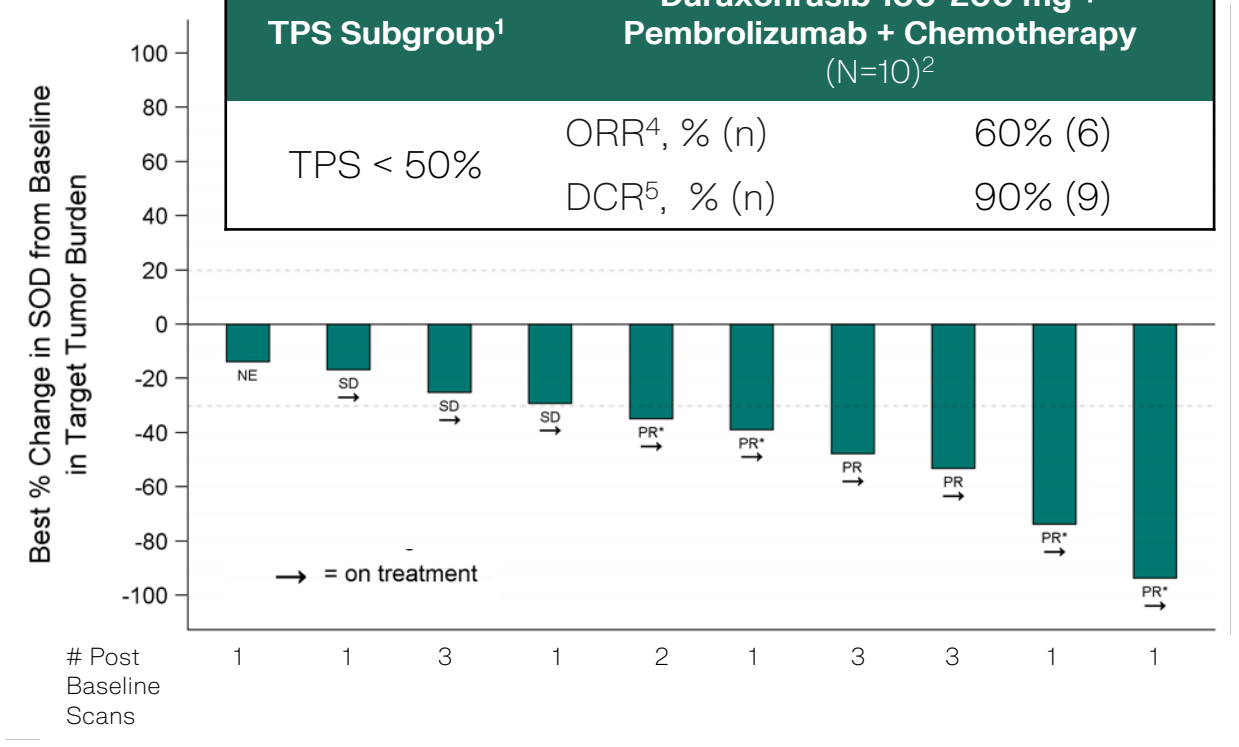
Data cutoff: Sep 30, 2024

Daraxonrasib + Pembrolizumab +/- Chemotherapy: Encouraging Preliminary Antitumor Activity in Patients with 1L RAS Mutant NSCLC

TPS Subgroup[1]	Daraxonrasib 200 mg + Pembrolizumab (N=7)[2,3]	
TPS ≥ 50%	ORR[4], % (n)	86% (6)
	DCR[5], % (n)	100% (7)



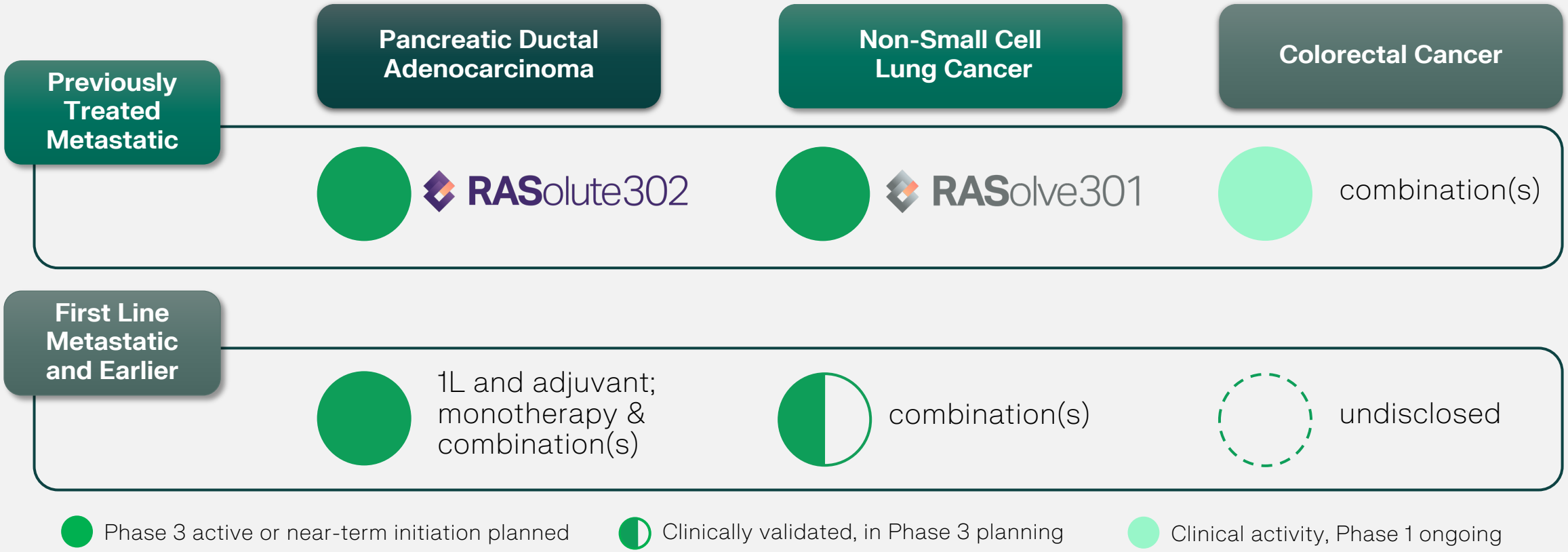
TPS Subgroup[1]	Daraxonrasib 100-200 mg + Pembrolizumab + Chemotherapy (N=10)[2]	
TPS < 50%	ORR[4], % (n)	60% (6)
	DCR[5], % (n)	90% (9)



RAS mutations includes G12D, G12V, G12A, G12F, and Q61H. The patient described as not evaluable per RECIST v1.1 (NE) on the waterfall figure discontinued study after 1 cycle of treatment but achieved an unconfirmed stable disease. (1) Tumor proportion score (TPS) is based on local testing. (2) Includes efficacy evaluable patients defined as those who had one post-baseline scan or who died or had clinical progression prior to the first post-baseline response assessment. (3) Patients treated in the daraxonrasib + pembrolizumab in TPS ≥ 50% were not evaluated at the 100 mg dose. (4) Objective response rate (ORR) (per RECIST v 1.1) includes partial responses that were confirmed (PR) or still had the potential to confirm (PR*). (5) Disease control rate (DCR) includes complete responses (CR), PR and stable disease (SD). Chemotherapy = cisplatin/carboplatin plus pemetrexed. NSCLC, non-small cell lung cancer; SOD, sum of diameters; NE, not evaluable; RECIST; response evaluation criteria in solid tumors; 1L, first line.

Data cutoff: Feb 10, 2025

Daraxonrasib: Compelling Activity and Safety/Tolerability Underscore Its Potential Across RAS Mutations, Tumor Types and Lines of Therapy



Elironrasib

RAS(ON) G12C-Selective Covalent Inhibitor

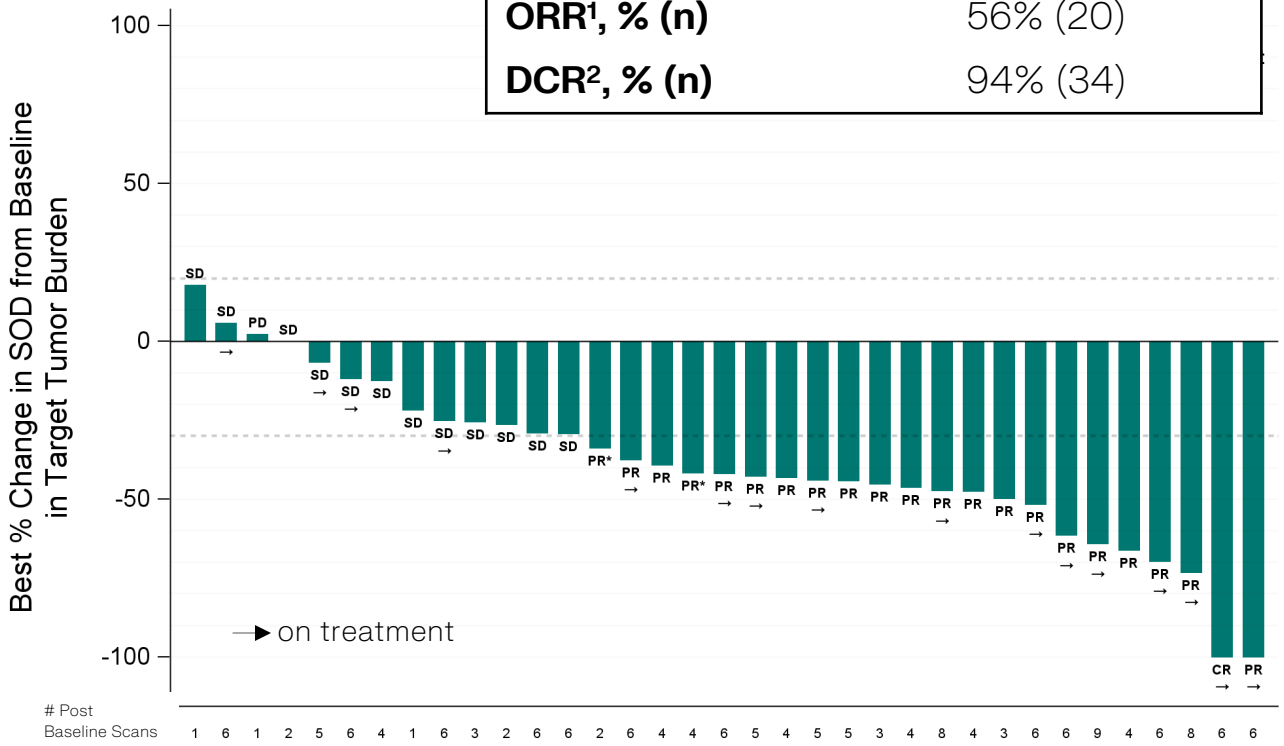
Active against

- Primary RAS G12C mutation
- Tumors in patients naïve to, or previously treated with, first-generation KRAS(OFF) inhibitors

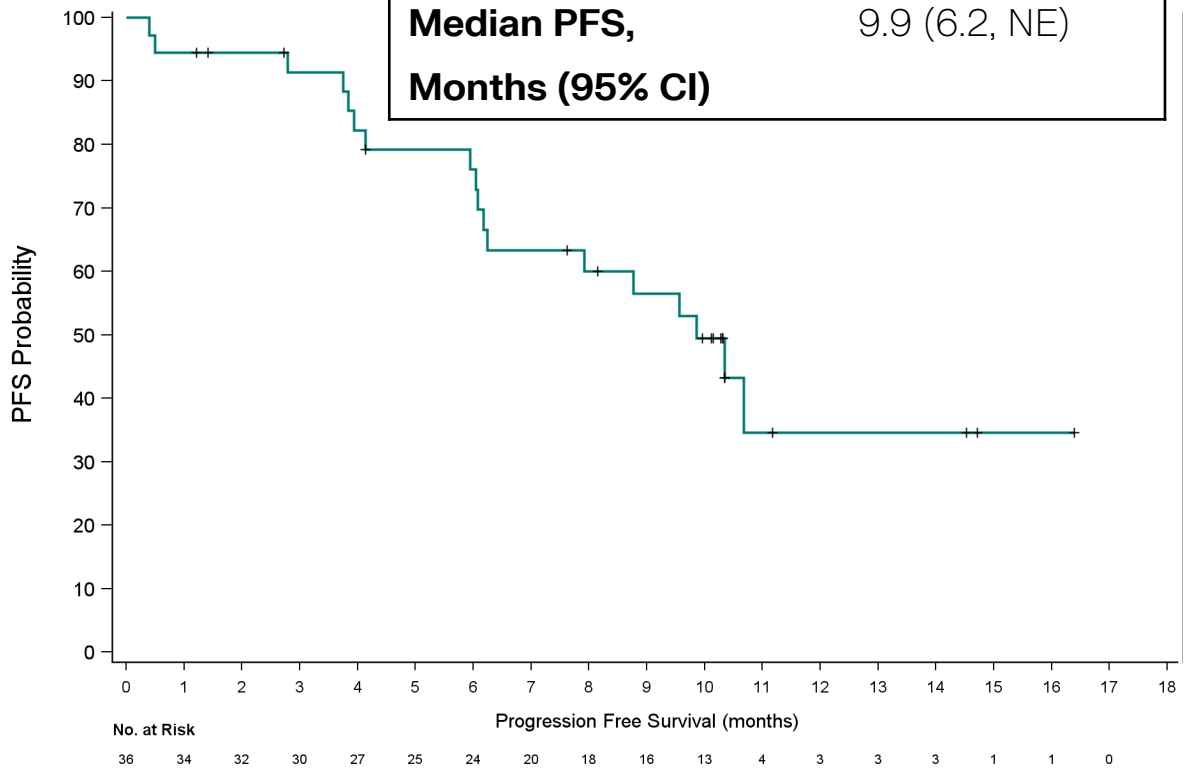
FDA Breakthrough Therapy Designation for the treatment of adult patients with KRAS G12C-mutated locally advanced or metastatic NSCLC who have received prior chemotherapy and immunotherapy but have not been previously treated with a KRAS G12C inhibitor

Elironrasib Monotherapy: Encouraging Antitumor Activity and Durability in Patients with Previously Treated RAS G12C NSCLC

Elironrasib (200 mg BID) (N=36)	
ORR[1], % (n)	56% (20)
DCR[2], % (n)	94% (34)



Elironrasib (200 mg BID) (N=36)	
Median PFS, Months (95% CI)	9.9 (6.2, NE)



Data includes patients with previously treated NSCLC who have been treated with both immunotherapy and chemotherapy but have not received a G12C(OFF) inhibitor.
(1) Objective response rate (ORR) (per RECIST v 1.1) includes partial responses that were confirmed (PR) or still had the potential to confirm (PR*). (2) Disease control rate (DCR) includes CR, PR, and stable disease (SD). NSCLC, non-small cell lung cancer; BID, twice daily; PFS, progression-free survival; CI, confidence interval; NE, not evaluable; SOD, sum of diameters; RECIST; response evaluation criteria in solid tumors; PD, progressive disease.

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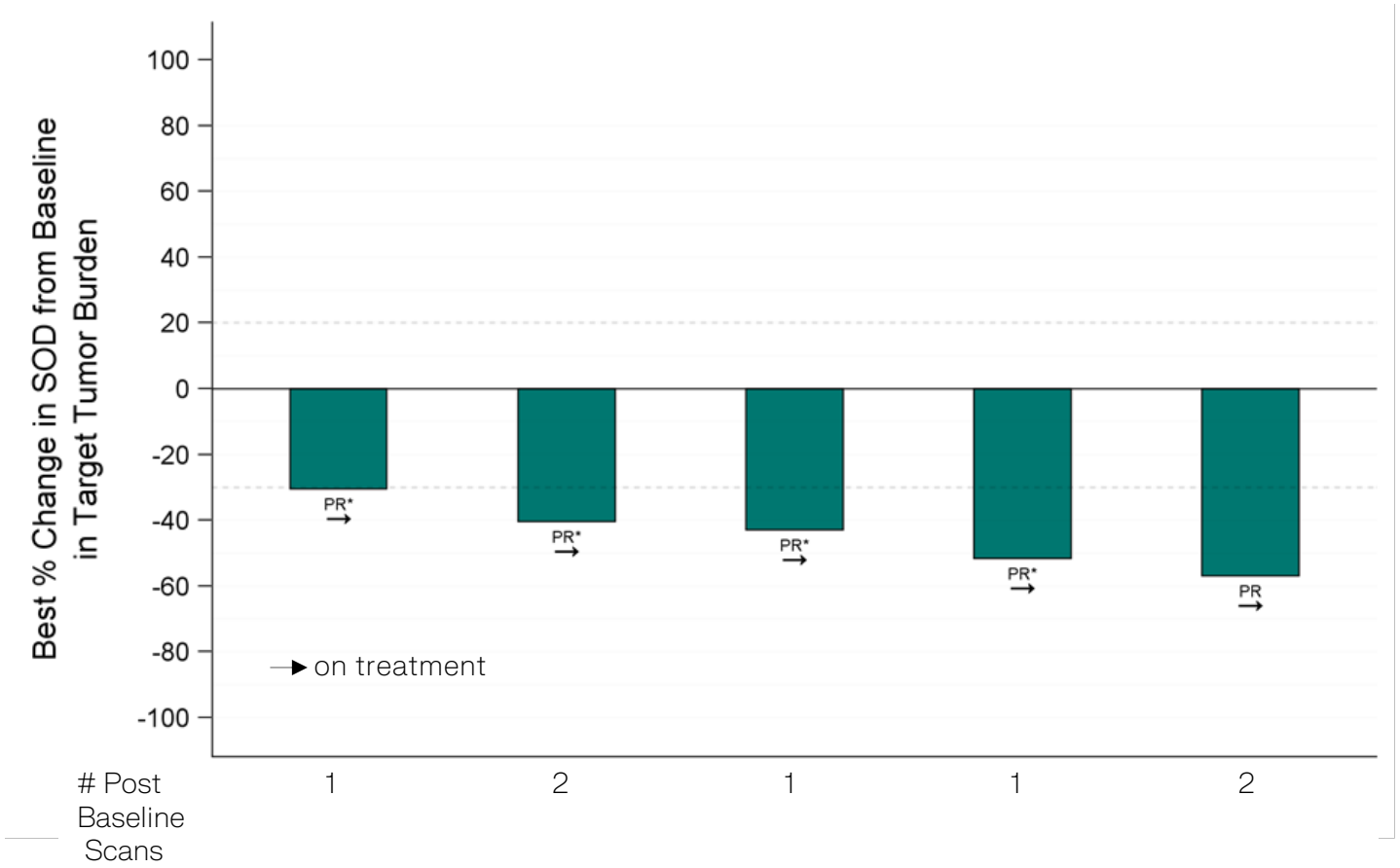
Data cutoff: Apr 7, 2025

Elironrasib + Pembrolizumab: Promising Preliminary Antitumor Activity in Patients with 1L RAS G12C NSCLC



Elironrasib 200 mg BID + Pembrolizumab in TPS[1] ≥ 50% (N=5)[2]	
ORR[3], % (n)	100% (5)
DCR[4], % (n)	100% (5)

(1) Tumor proportion score (TPS) is based on local testing. (2) Includes efficacy evaluable patients defined as those who had one post-baseline scan or who died or had clinical progression prior to the first post-baseline response assessment. (3) Objective response rate (ORR) (per RECIST v 1.1) includes partial responses that were confirmed (PR) or still had the potential to confirm (PR*). (4) Disease control rate (DCR) includes complete responses (CR), PR and stable disease (SD). NSCLC, non-small cell lung cancer; BID, twice daily; SOD, sum of diameters; 1L, first line.

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Data cutoff: Feb 10, 2025

Encouraging Preclinical and Clinical Data Support Rationale for RAS(ON) Inhibitor Doublets

Preclinical models demonstrate combinatorial effect of RAS(ON) inhibitor doublets to drive deep and durable antitumor activity

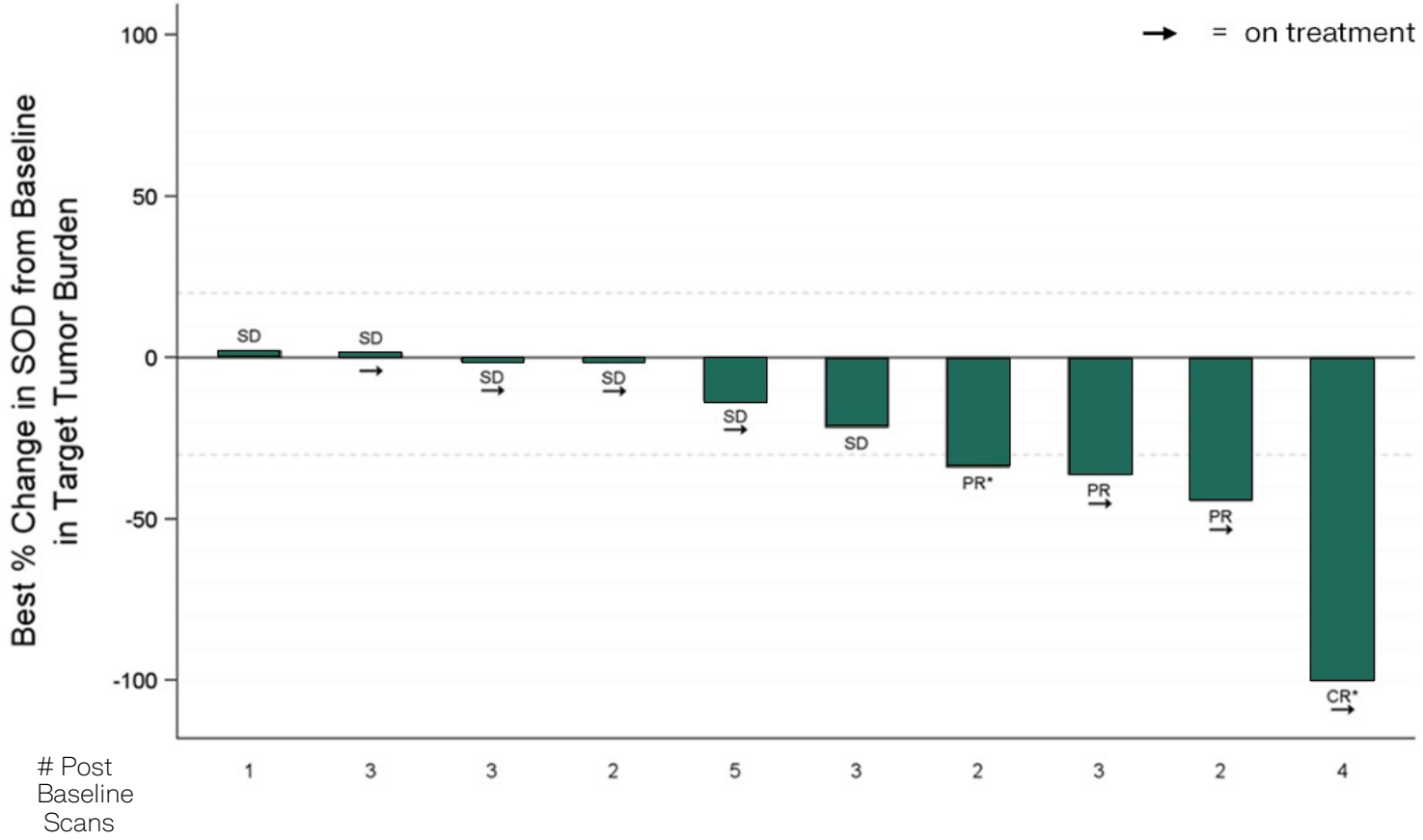
Clinical evidence in advanced KRAS G12C NSCLC and CRC, including following a KRAS(OFF) G12C inhibitor, provide proof-of-mechanism

Suppresses primary RAS mutant driver deeply;
Suppresses drug resistance mediated by wild-type RAS and common RAS escape mutations

Strong rationale for continued development of RAS(ON) inhibitor doublets across tumor types and in earlier lines of therapy

*Please see Appendix for supporting preclinical data.
NSCLC, non-small cell lung cancer; CRC, colorectal cancer.

Elironrasib + Daraxonrasib Doublet Shows Encouraging Antitumor Activity in Patients with CRC Previously Treated with KRAS(OFF) G12C Inhibitor



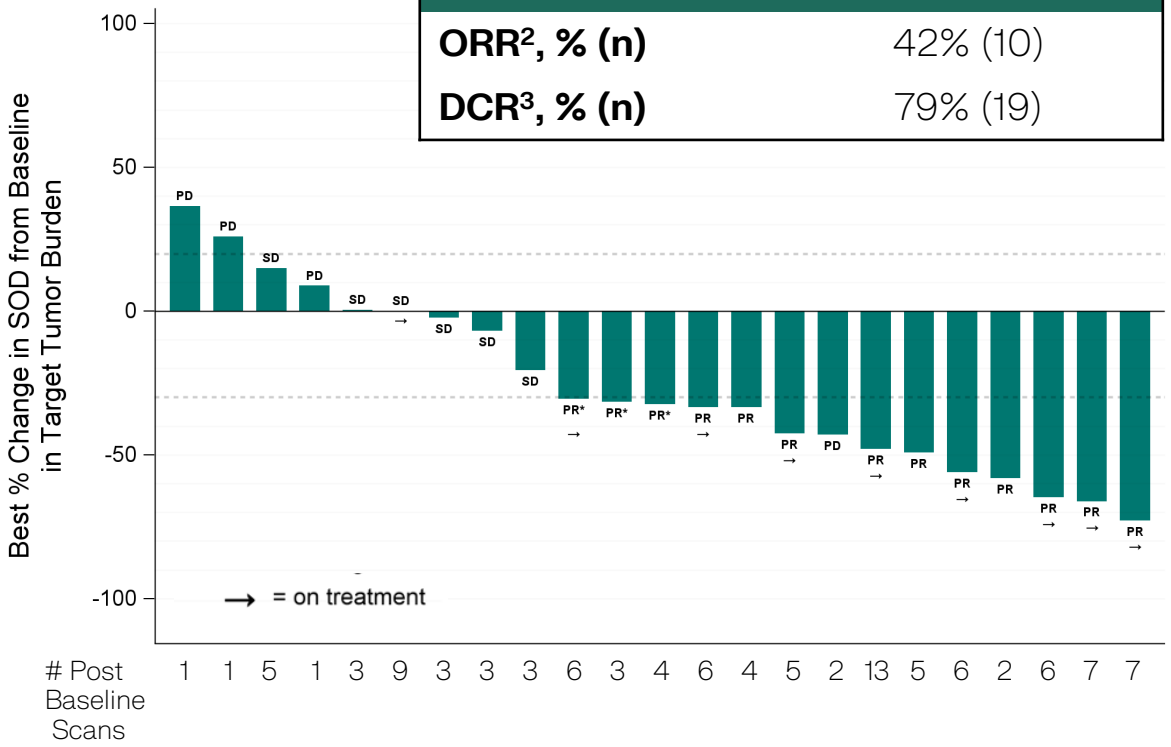
Elironrasib + Daraxonrasib[1] (N=12)	
ORR[2], % (n)	25% (3)
DCR[3], % (n)	92% (11)

Analyses include all patients who received first dose of study drug(s) at least 8 weeks prior to data cutoff date (to allow 1 potential scan). (1) The combination arm includes patients treated at elironrasib 100 or 200 mg BID + daraxonrasib (100-200 mg QD). (2) Objective response rate (ORR) (per RECIST v 1.1) includes partial responses that were confirmed (PR) or still had the potential to confirm (PR*). Some patients do not appear in the waterfall due to either missing tumor assessment for 1 or more tumor lesions or discontinuing study drug prior to first tumor assessment. One patient with CR* has confirmed PR. (3) Disease control rate (DCR) includes complete response (CR), partial response (PR) and stable disease (SD). CRC, colorectal cancer; SOD, sum of diameters; RECIST; response evaluation criteria in solid tumors.

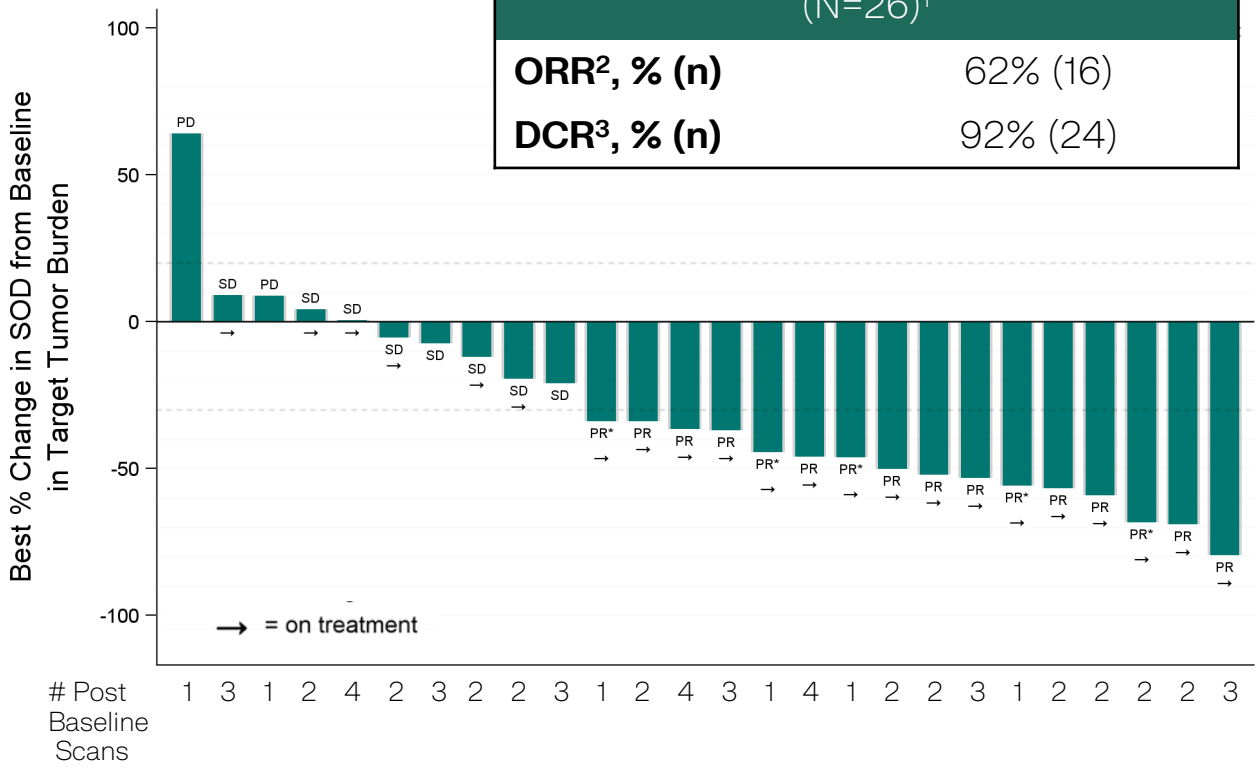
Data cutoff: Oct 28, 2024

Compelling Preliminary Activity of Elironrasib and RAS(ON) Inhibitor Doublet in 2L+ NSCLC Patients Following G12C(OFF) Inhibitor

Elironrasib (N=24)[1]	
ORR[2], % (n)	42% (10)
DCR[3], % (n)	79% (19)



Elironrasib + Daraxonrasib (N=26)[1]	
ORR[2], % (n)	62% (16)
DCR[3], % (n)	92% (24)

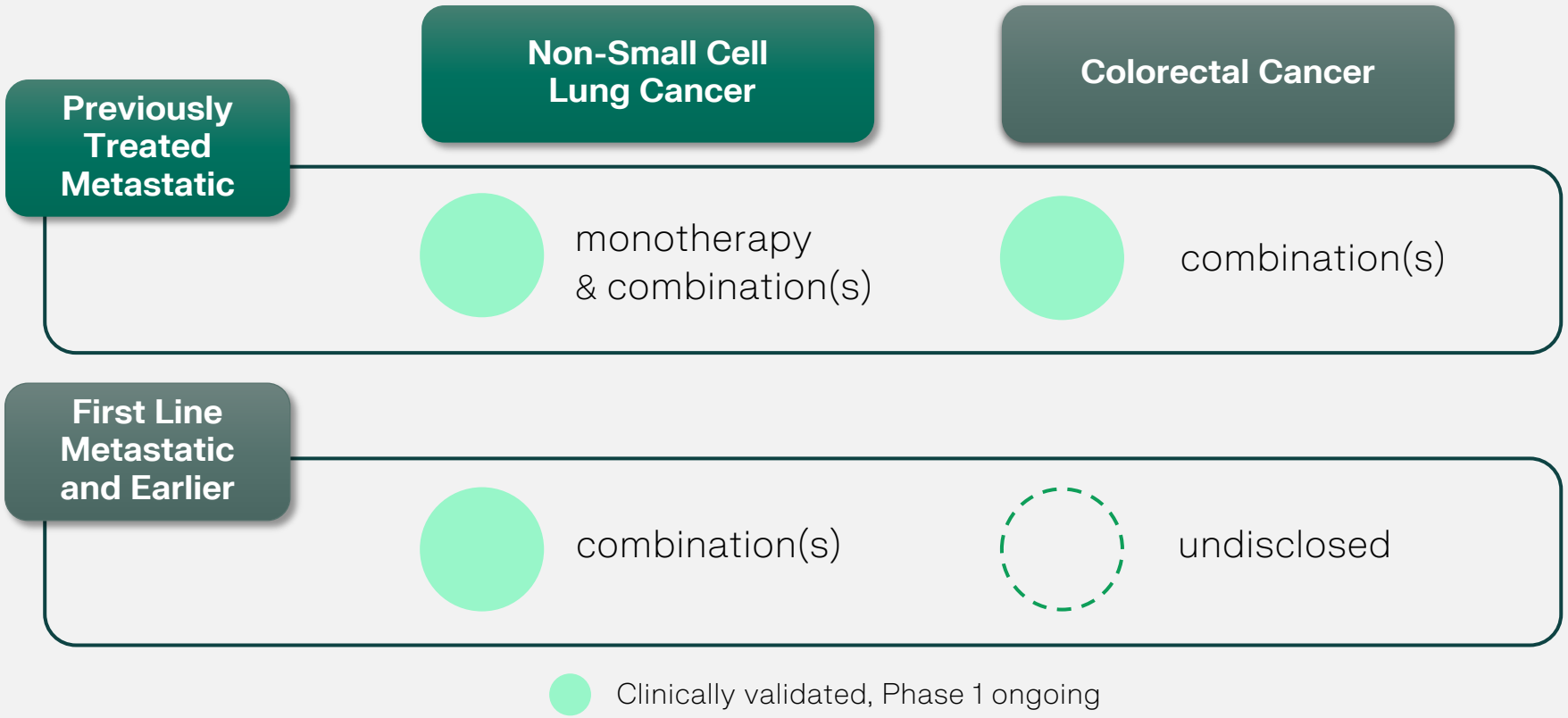


→ on treatment

The elironrasib arm includes patients treated at elironrasib 200 mg BID. The combination arm includes patients treated at elironrasib 200 mg BID + daraxonrasib (100-200 mg QD). (1) Includes efficacy evaluable patients defined as those who had one post-baseline scan or who died or had clinical progression prior to the first post-baseline response assessment. (2) Objective response rate (ORR) (per RECIST v 1.1) includes partial responses that were confirmed (PR) or still had the potential to confirm (PR*). Some patients may not appear in the waterfall due to either missing tumor assessment for 1 or more tumor lesions or discontinuing study drug prior to first tumor assessment. (3) Disease control rate (DCR) includes complete response (CR), partial response (PR) and stable disease (SD). NSCLC, non-small cell lung cancer; SOD, sum of diameters, PD, progressive disease; RECIST; response evaluation criteria in solid tumors; 2L, second line.

Data cutoff: Apr 7, 2025 for elironrasib monotherapy
Data cutoff: Feb 10, 2025 for elironrasib + daraxonrasib

Elironrasib: Encouraging Clinical Data Offer Potentially Differentiated Profile for Patients with KRAS G12C Mutant Cancers



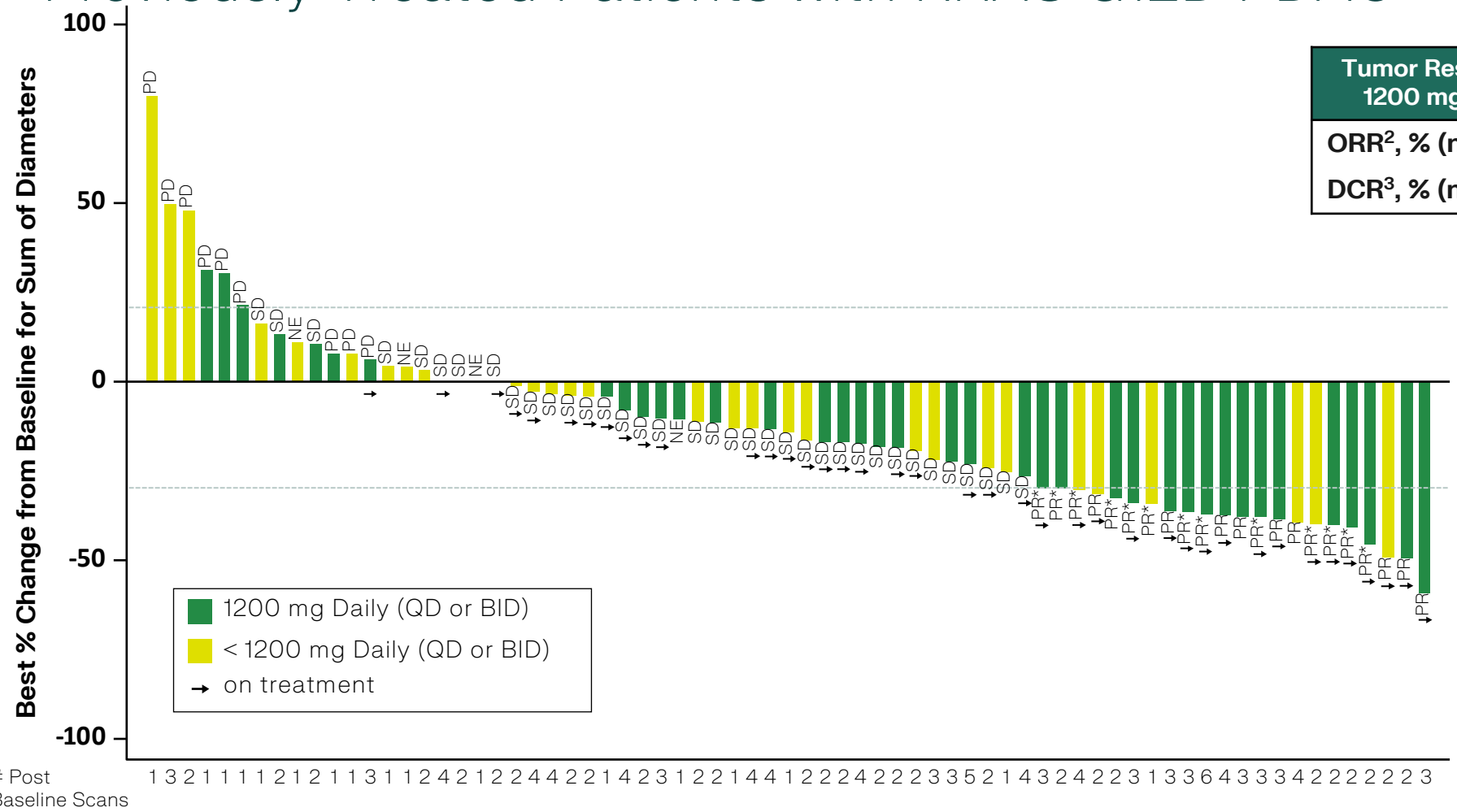
Zoldonrasib

RAS(ON) G12D-Selective Covalent Inhibitor

Active against

- Most common RAS driver in RAS-addicted solid tumors

Encouraging Initial Activity of Zoldonrasib Monotherapy in Previously Treated Patients with KRAS G12D PDAC



Tumor Response for PDAC Patients Treated with 1200 mg Daily Dose (QD, N=20 or BID, N=20)[1]	
ORR[2], % (n)	30% (12)
DCR[3], % (n)	80% (32)

David S. Hong et al., Preliminary Safety, Pharmacokinetics, and Antitumor Activity of RMC-9805, an Oral, RAS(ON) G12D-Selective, Tri-Complex Inhibitor in Patients with KRAS G12D Pancreatic Ductal Adenocarcinoma (PDAC) from a Phase 1 Study in Advanced Solid Tumors, ENA 2024. (1) All treated patients with PDAC who received a first daily dose at least 14 weeks prior to data cutoff date (applies to waterfall plot and ORR table). (2) Objective response rate (ORR) (per RECIST v 1.1) includes partial responses that were confirmed (PR) or still had the potential to confirm (PR*). (3) Disease control rate (DCR) includes complete response (CR), PR and stable disease (SD). Some patients do not appear in the waterfall due to either missing tumor assessment for 1 or more tumor lesions or discontinuing study drug prior to first tumor assessment. QD, once daily; BID, twice daily; PD, progressive disease; NE, not evaluable; RECIST, response evaluation criteria in solid tumors.

Data cutoff: Sep 2, 2024

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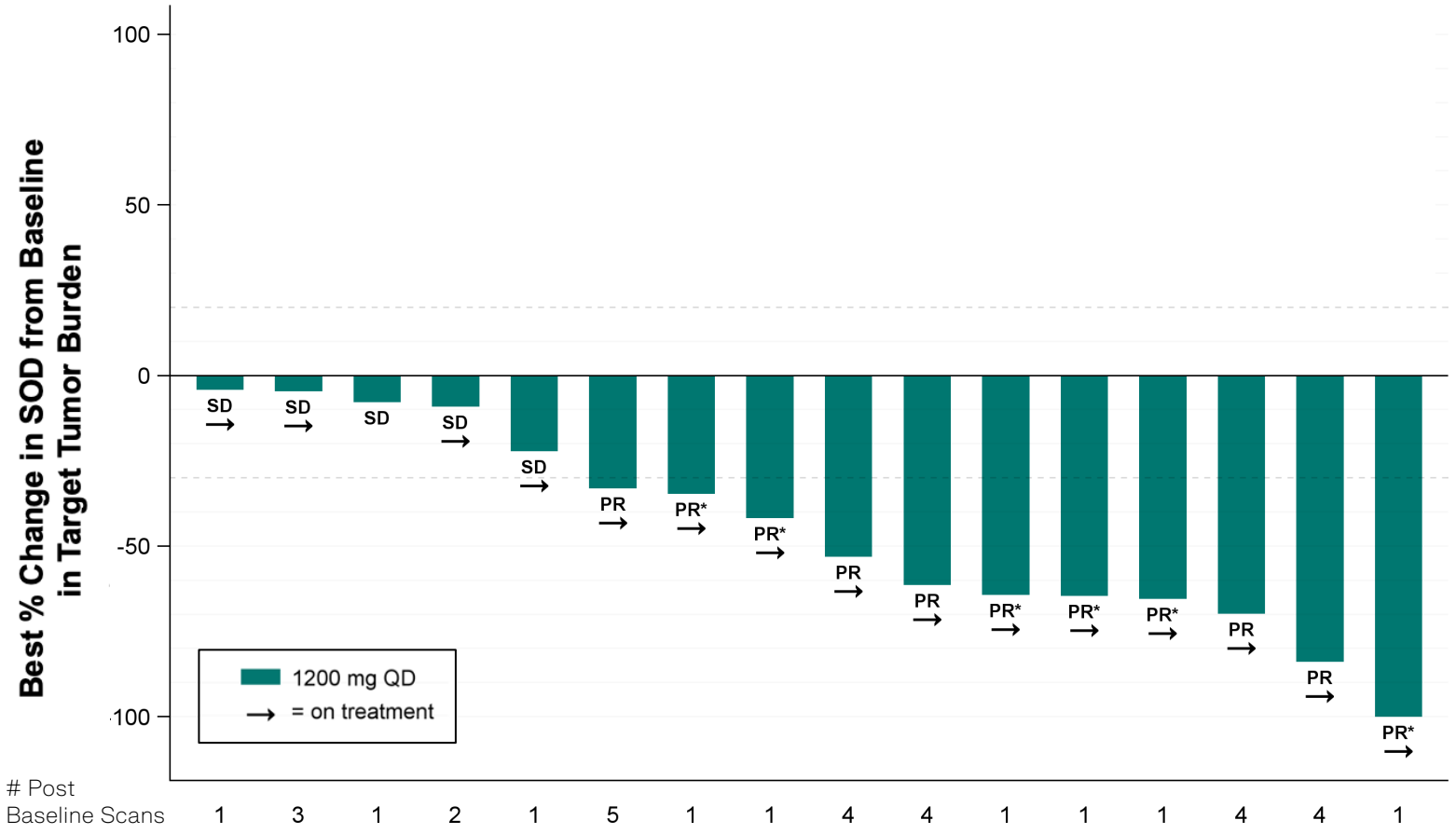
Encouraging Initial Activity of Zoldonrasib Monotherapy in Previously Treated Patients with KRAS G12D NSCLC

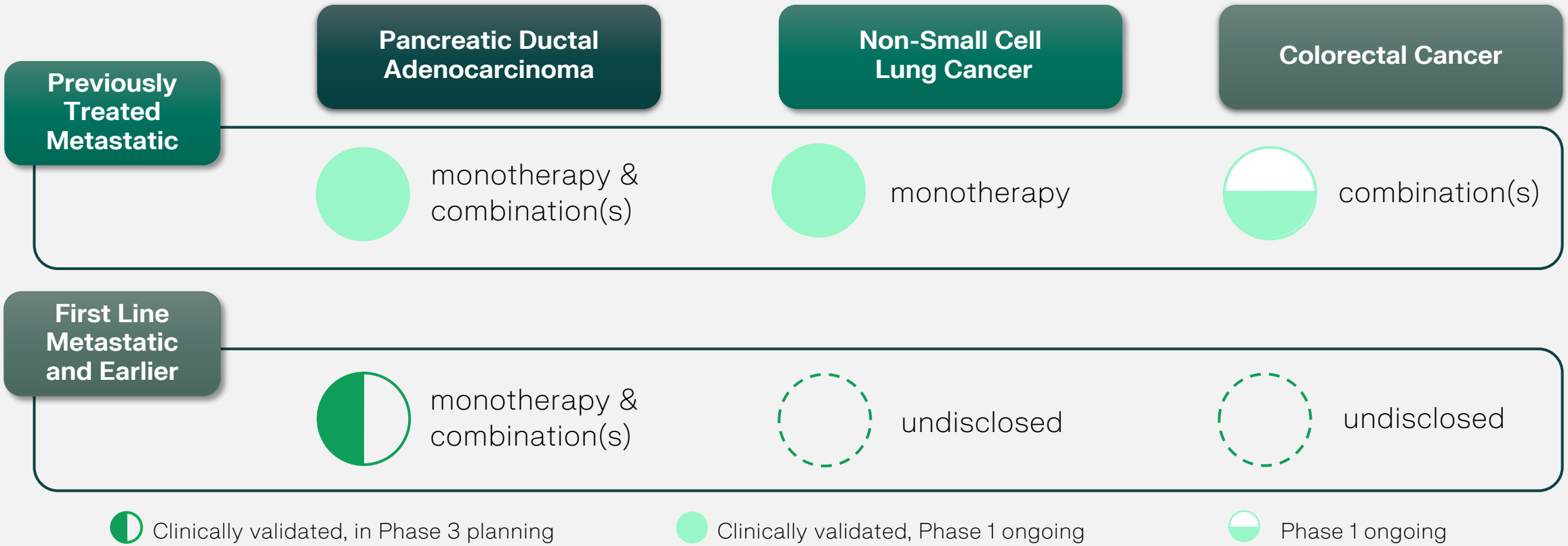


Tumor Response for Patients with NSCLC Treated with 1200 mg QD (N=18)[1]	
ORR[2], % (n)	61% (11)
DCR[3], % (n)	89% (16)

All patients with NSCLC who received first dose of zoldonrasib at least 8 weeks prior to data cutoff date (applies to waterfall plot and ORR table). Two patients treated with 1200 mg QD are not displayed on the waterfall plot (but are included in the denominator for ORR/DCR) due to death prior to the first scan (1 patient: unrelated adverse event) or due to unevaluable scan (1 patient). (1) per RECIST v1.1. (2) Objective response rate (ORR) (per RECIST v 1.1) includes partial responses that were confirmed (PR) or still had the potential to confirm (PR*). Some patients do not appear in the waterfall due to either missing tumor assessment for 1 or more tumor lesions or discontinuing study drug prior to first tumor assessment. (3) Disease control rate (DCR) includes complete responses (CR), PR and stable disease (SD). NSCLC, non-small cell lung cancer; QD, once daily; RECIST, response evaluation criteria in solid tumors.

Data cutoff: Dec 2, 2024

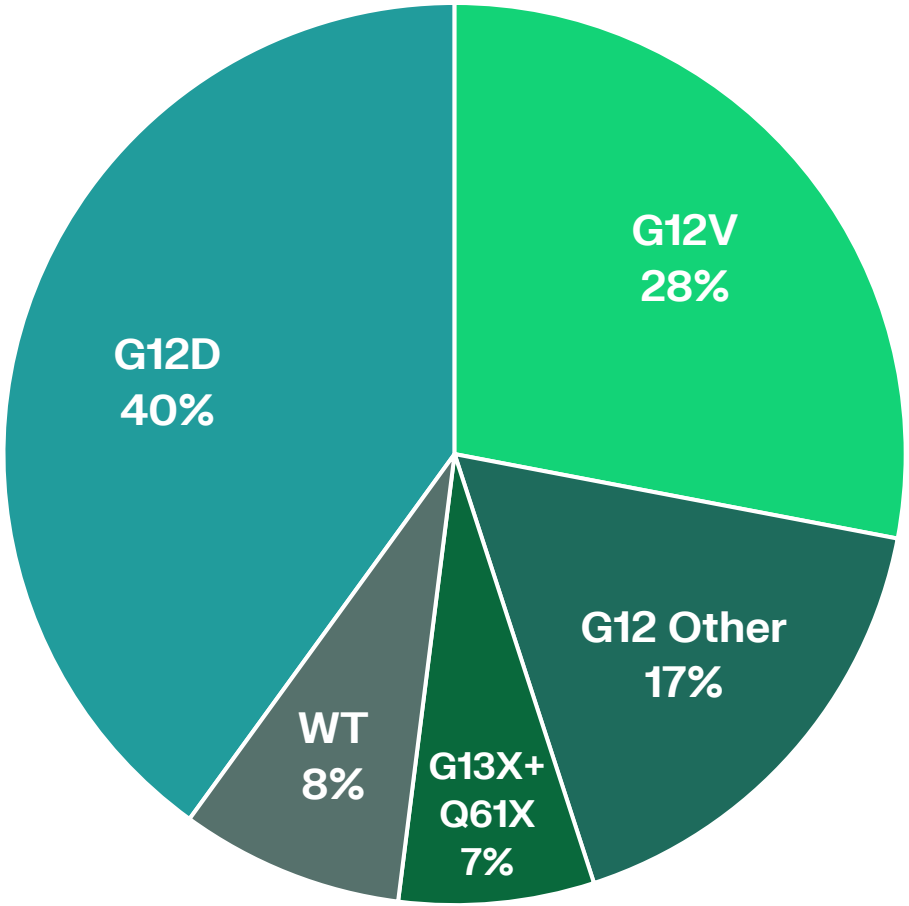
Zoldonrasib: Promising Initial Clinical Profile Drives Continued Evaluation Across Treatment Approaches, Tumor Types and Lines of Therapy



RAS Mutant PDAC: Landscape and Strategy

PDAC is a Devastating, RAS-Driven Disease with Major Unmet Medical Needs

RAS Mutant PDAC = ~92% of total



Most patients diagnosed with metastatic disease[1]

- 5-year survival is 3%[1]

Multi-agent chemotherapy is the primary treatment for most patients[2]

- Currently available targeted therapies benefit small minority of patients[3]

Pancreatic cancer is the most RAS-addicted of all major cancers

- >90% of patients with PDAC have RAS mutant tumors

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(1) ACS Cancer Facts and Figures 2024 adjusted for metastatic stage only. (2) Estimated using tumor mutation frequencies from Foundation Medicine Insights March 2022. (3) CancerMPact 2022.
PDAC, pancreatic ductal adenocarcinoma.

Current Treatment Paradigms for Metastatic PDAC

First Line (1L)

5-FU-based Regimens

- FOLFIRINOX[1]
- NALIRIFOX[2]

→ Gemcitabine + Nab-paclitaxel

Second Line and Later (2L+)

Gemcitabine-based Regimens

Gemcitabine + Nab-paclitaxel[3] →

- FOLFIRINOX
- 5-FU + LV + Nal-IRI
- FOLFIRI
- FOLFOX

Supportive care measures: IV port-a-cath, steroids, G-CSF, GI toxicity management

(1) Conroy T, et al. NEJM 2011;364:1817-25. (2) Wainberg AZ, et al. Lancet 2023;402:1272–81. (3) Von Hoff DD, et al. NEJM 2013;369:1691-703.
PDAC, pancreatic ductal adenocarcinoma; 5-FU, fluorouracil; LV, leucovorin; Nal-IRI, nanoliposomal irinotecan; GI, gastrointestinal.

Strategy in RAS Mutant Metastatic PDAC

2L

Daraxonrasib

- Phase 3 RASolute 302 study ongoing
- Compelling Phase 1 results in 2L PDAC provide confidence in approach

Zoldonrasib

- Encouraging initial monotherapy data support further evaluation in RAS G12D PDAC

Early Lines

Daraxonrasib

- 2L results provide rationale for planned earlier line registrational trials:
  - **1L metastatic:** 3-arm trial comparing chemotherapy vs. daraxonrasib or daraxonrasib plus chemotherapy
  - **Adjuvant treatment:** patients with resectable disease

Zoldonrasib

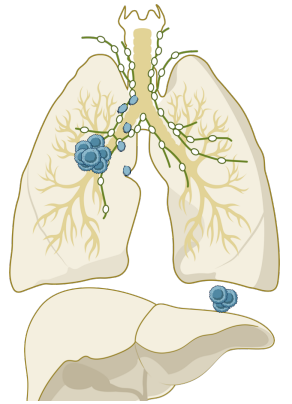
- Combinability enables multiple potential paths to 1L, including RAS(ON) inhibitor doublet and SOC chemotherapies

PDAC, pancreatic ductal adenocarcinoma; SOC, standard of care; 2L, second line; 1L first line.

RAS Mutant NSCLC: Landscape and Strategy

Therapeutic Objectives for Metastatic NSCLC

- 40-50% of patients newly diagnosed with NSCLC have metastatic disease(1)
- Considerable proportion of patients with initially localized disease will develop metastases



Reduce tumor burden

Delay progression

Prolong survival

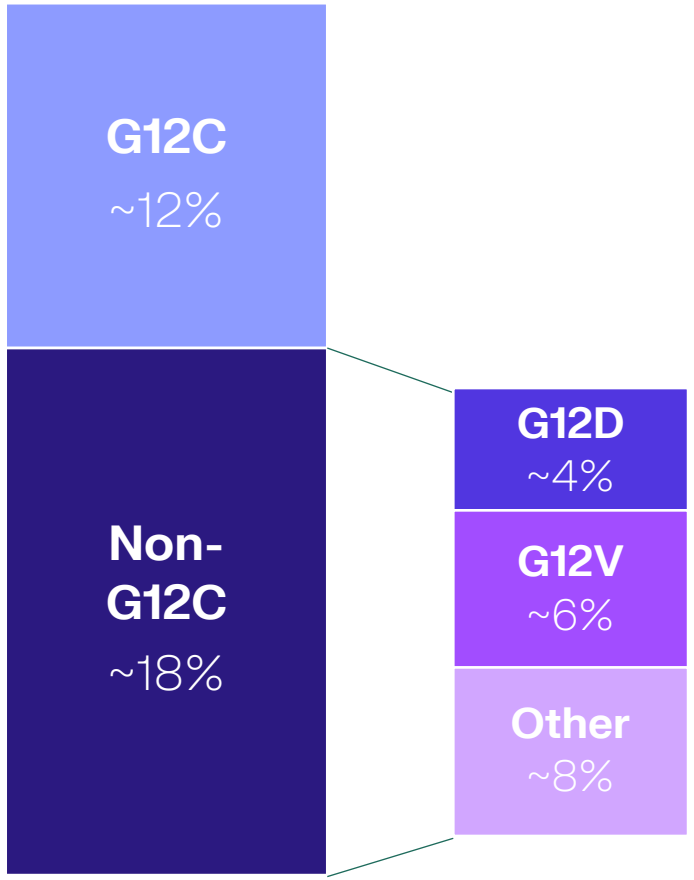
Improve QoL

(1) Source: CA Cancer J Clin. 2025;75:10–45.
NSCLC, non-small cell lung cancer; QoL, quality of life.

Treatment Landscape in RAS Mutant NSCLC Likely to Continue to Segment by Mutation Type

- Unmet need in RAS mutant NSCLC remains high across all RAS mutations
- No full approvals of RAS inhibitors in any RAS mutant NSCLC to date
- RAS inhibitor competitive landscape increasingly crowded, particularly in G12C
- RAS mutant NSCLC has evolved into two diseases and treatment paradigms: G12C vs. non-G12C

RAS Mutant NSCLC = ~30%[1] of total



RAS Other includes mutations in KRAS G12X (A,F,L,R,S), KRAS G13X, KRAS Q61X, or mutations in HRAS or NRAS at codons G12X, G13X, or Q61X.
(1) Estimated using tumor mutation frequencies from FoundationCORE March 2022. NSCLC, non-small cell lung cancer.

Strategy in RAS Mutant Metastatic NSCLC

2L+

Daraxonrasib

- Phase 3 RASolve 301 trial ongoing
- Foundation built on promising results in previously treated RAS mutant NSCLC

Elironrasib

- Encouraging monotherapy clinical data (BTD granted)

Zoldonrasib

- Encouraging initial monotherapy data support further evaluation in RAS G12D NSCLC, including combinations

1L

Combinations

- Encouraging profile with pairwise combinations in NSCLC:
  - Daraxonrasib + pembrolizumab +/- chemotherapy
  - Elironrasib + pembrolizumab
  - Elironrasib + daraxonrasib

RAS G12C	RAS Non-G12C
Elironrasib + standard of care (pembrolizumab +/- chemotherapy)	Daraxonrasib + standard of care (pembrolizumab +/- chemotherapy)
RAS(ON) inhibitor doublet + pembrolizumab (chemotherapy-sparing)	Zoldonrasib combinations

NSCLC, non-small cell lung cancer; 2L+, second line and beyond; 1L, first line; BTD, Breakthrough Therapy Designation.

Highly Active RAS(ON) Inhibitors Drive Combination Opportunities to Support Development in Earlier Lines of Therapy

RAS(ON) inhibitor doublets
Daraxonrasib + mutant-selective inhibitors

- Initial POC with elironrasib in NSCLC and CRC
- Evaluation underway with zoldonrasib
- RMC-5127 (G12V) offers third planned doublet partner

Immunotherapy
Daraxonrasib or mutant-selective inhibitor + checkpoint inhibitor or bispecific inhibitor

- Initial combinability demonstrated for daraxonrasib + pembrolizumab and elironrasib + pembrolizumab in patients with previously treated and 1L NSCLC
- Safety assessment underway for zoldonrasib + pembrolizumab
- Collaboration for combinations with PD-1/VEGF bispecific inhibitor (ivonescimab)

Targeted agents
Daraxonrasib or mutant-selective inhibitor + targeted agents

- Collaborations underway to evaluate RAS(ON) inhibitors with:
  - PRMT5 inhibitor (TNG462)
  - Cetuximab

Chemotherapy
Daraxonrasib or mutant-selective inhibitor + SOC

- Ongoing safety evaluation underway with 1L chemotherapies

POC, proof-of-concept; CRC, colorectal cancer; 1L, first line; NSCLC, non-small cell lung cancer; SOC, standard of care.

Executing Bold Plan with Momentum and Conviction

01 Execute pivotal trials with daraxonrasib monotherapy in patients with previously treated metastatic PDAC and NSCLC

- Complete RASolute 302 enrollment in 2025 to enable expected data readout in 2026

✓ Enroll patients in RASolve 301 trial

02 Advance daraxonrasib into earlier line randomized pivotal trials in patients with PDAC and NSCLC

- Initiate registrational trials in 1L treatment for metastatic PDAC and in adjuvant treatment for resectable PDAC in 2H 2025
- Initiate registrational trial(s) in 1L metastatic NSCLC in 2026

03 Generate data to inform development priorities for mutant-selective inhibitors and prepare to initiate one or more pivotal trials

✓ Share zoldonrasib clinical data in Q2
  - Expansion and follow-up

✓ Share data in Q2/Q3 that support initiation of one or more pivotal combination trials in 2026
  - Expansion and follow-up

04 Progress earlier-stage pipeline, including advancing next-generation innovations

- Advance RMC-5127 (RAS(ON) G12V-selective inhibitor) to a clinic-ready stage in 2025 to enable expected Phase 1 initiation in 2026

05 Grow global commercialization and operational capabilities and advance launch readiness

- Continue to develop understanding of PDAC and NSCLC market needs
- Expand organization with top talent, including U.S. field teams
  ✓ Hired CGCO

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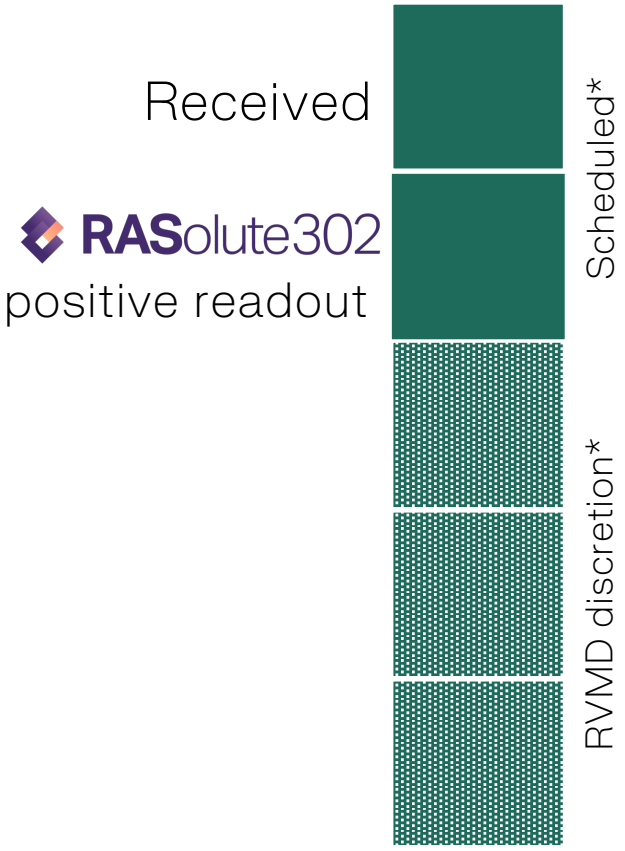
PDAC, pancreatic ductal adenocarcinoma; NSCLC, non-small cell lung cancer; 1L, first line; CGCO, Chief Global Commercialization Officer.

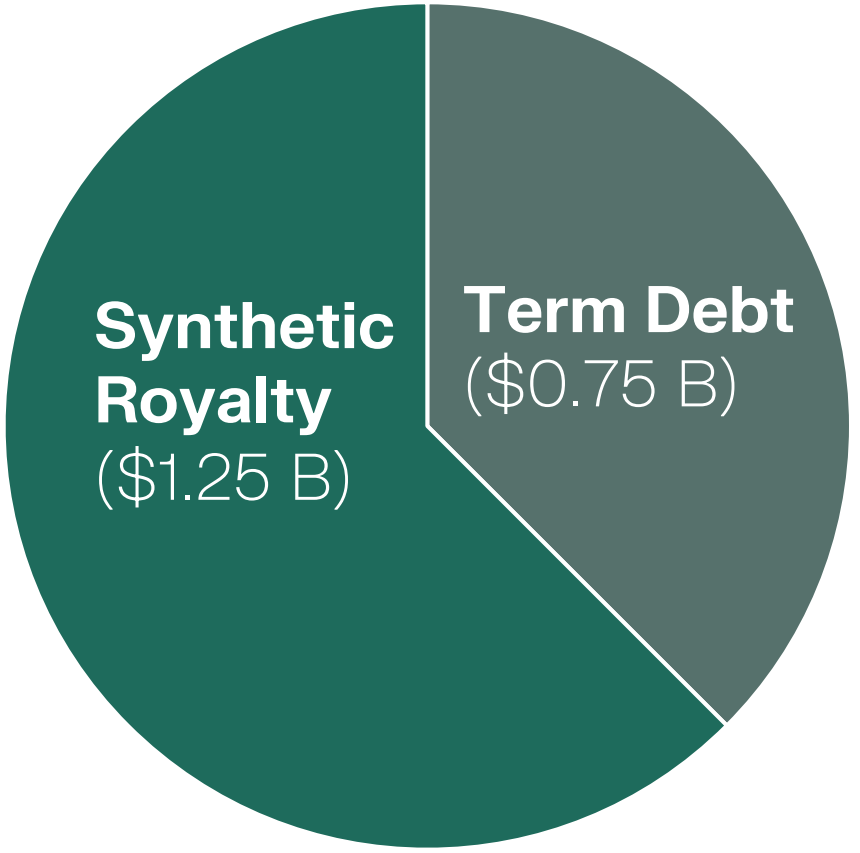
Royalty Pharma Partnership Bolsters Already Strong Financial Position by Providing $2 Billion in Flexible Committed Capital



5 Tranches

Downward tiered, single-digit royalty rates on revenue, decreasing by tranche

$2 Billion Committed



3 Tranches

Market-competitive interest rate linked to SOFR

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$250 million tranche
Up to $250 million tranche

* Future tranches can be drawn at RVMD's discretion subject to the satisfaction of the applicable development or commercial trigger.

$250 million tranche
Up to $250 million tranche

Financial Information

Financial Position

$2.1 Billion

Cash, cash equivalents and marketable securities as of June 30, 2025

Financial Guidance

$1.03 – $1.09 Billion

2025 GAAP Net Loss[1]

(1) Includes non-cash stock-based compensation expense of approximately $115 million to $130 million.

Creating Industry-Leading Global Targeted Medicines Franchise for Patients with RAS-Addicted Cancers

Discovery

Sophisticated RAS cancer drug discovery and biological sciences

Development

Pioneering drug candidates and proven capabilities; compelling clinical pipeline with early and registrational programs underway

Delivery

Building global capabilities for successful launch

Strong financial position enables continued execution

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On Target to Outsmart Cancer®

Appendix

Epidemiology

- All RAS cancer epidemiology statistics are estimated using tumor mutation frequencies from Foundation Medicine Insights March 2022 and scaled to estimated patient numbers using cancer incidence from ACS Cancer Facts and Figures 2023 (unless otherwise noted).
  - RAS mutations include: KRAS G12(A,C,D,F,L,R,S,V), KRAS G13(C,D,R,V), KRAS Q61(E,H,K,L,P,R) NRAS G12(A,C,D,R,S,V), NRAS G13(C,D,R,V), NRAS Q61(H,K,L,R), HRASG12(C,D,S,V), HRASG13(C,D,N,R,S,V), HRASQ61(K,L,R).

Reference Data Tables for Current Therapies Across PDAC, NSCLC and CRC

Significant Need for Treatment(s) with Improved Efficacy and Tolerability for Patients with Previously Treated Metastatic PDAC

Reported Efficacy

Study	Regimen	Treatment line	No. of patients	ORR (%)	Median PFS (months)	Median OS (months)
NAPOLI 1[1]	**5-FU+LV+Nal-IRI**	2L+	117	8	**3.1**	**6.1**
SWOG S1513[2]	**FOLFIRI**	2L	58	10	**2.9**	**6.5**
SWOG S1115[3]	**FOLFOX**	2L	62	7	**2.0**	**6.7**
SEQUOIA[4]	**FOLFOX**	2L	284	6	**2.1**	**6.3**
QUILT-3.010[5]	**Gemcitabine + nab-paclitaxel**	2L	40	3	**2.7**	**6.6**
Trybeca-1[6]	**Gemcitabine + nab-paclitaxel**	2L	148	NA	**3.5**	**6.9**
GEMPAX[7]	**Gemcitabine + paclitaxel**	2L	140	17	**3.1**	**6.4**
Gupta et al.[8]	**5-FU+LV+Nal-IRI**	3L+	30	3	**1.9**	**5.0**
Enzler et al.[9]	**CBP501+cisplatin+nivolumab**	3L+	36	6	**1.9**	**5.1**

Reported Safety and Dose Modifications

- 5-FU/LV/Nal-IRI dose interruptions required in 62% of patients, dose reductions in 33%, and discontinuations in 11%[1]
- Gemcitabine + nab-paclitaxel dose modifications required in 63%[6]

(1) Onivyde USPI. (2) Chiorean EG, et al. Clin Cancer Res 2021:27:6314–33. (3) Chung V, et al. JAMA Oncol 2017;3:516–22. (4) Hecht JR, et al. J Clin Oncol 2021;39:1108–18. (5) Huffman BM, et al. JAMA Network Open 2023;6:e2249720. (6) Hammel P, et al. ASCO GI 2022. (7) Fouchardiere C, et al. J Clin Oncol 2024;42:1055-1066. (8) Gupta A, et al. Frontiers Oncol 2023: 13:1250136. (9) Enzler T, et al. Eur J Cancer 2024: 113950, means of median PFS and median OS from four experimental regimens provided. PDAC, pancreatic ductal adenocarcinoma; ORR, objective response rate. PFS, progression-free survival. OS, overall survival. NA, not available.

Significant Need for Improved Treatment(s) for Patients with Previously Treated (2L+) Locally Advanced or Metastatic NSCLC

Study	Timing relative to CPI approval in 1L	Treatment arm	No. of patients	ORR (%)
REVEL[1]	prior	Docetaxel, 2L+	625	14%
CheckMate 057[2]	prior	Docetaxel, 2L+	290	12%
OAK[3]	prior	Docetaxel, 2L+	425	13%
POPLAR[4]	prior	Docetaxel, 2L+	143	14.7%
CodeBreak 200[5]	after	Docetaxel, 2L+	174	13.2%
TROPION-Lung-01[6]	after	Docetaxel, 2L+	305	13%
KRYSTAL-12[7]	after	Docetaxel, 2L+	152	9.2%
CodeBreak 200[5]	after	Sotorasib, 2L+	171	28%
KRYSTAL-12[7]	after	Adagrasib, 2L+	301	32%

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(1) Garon EB, et al. Lancet 2014;384:665-673. (2) Borghaei H, et al. N Engl J Med 2015; 373:1627-1639. (3) Rittmeyer A, et al. Lancet 2017;389:255-265. (4) Fehrenbacher L, et al. Lancet 2016;387:1837-1846. (5) de Langen AJ, et al. Lancet 2023;401:733-746. (6) Ahn MJ, J Clin Oncol. 2024 Sep 9:JCO2401544. doi: 10.1200/JCO-24-01544. (7) Mok TS, J Clin Oncol. 2024;42(17_suppl):LBA8509.
NSCLC, non-small cell lung cancer; CPI, check point inhibitor; 1L, first line; 2L, second line; ORR, objective response rate; PFS, progression-free survival; OS, overall survival.

Significant Need for Improved Efficacy and Tolerability for Late Lines of Treatment of Patients with Metastatic CRC

Study	Regimen	Treatment line	No. of patients	ORR (%)	DCR (%)	Median PFS (months)	Median OS (months)
RECOURSE[1]	**Trifluridine/tipiracil**	3L+	534	2%	44%	2.0 (1.9–2.1)	7.1 (6.5–7.8)
SUNLIGHT[2]	**Trifluridine/tipiracil + Bevacizumab**	3L	246	6%	77%	5.6 (4.5–5.9)	10.8 (9.4–11.8)
CORRECT[3]	**Regorafenib**	2L+	505	1%	41%	2.0 (1.9–2.3)	6.4 (5.8–7.3)

Revolution Medicines

(1) Mayer R, et al. N Engl J Med 2015;372:1909-19; Lonsurf USPI. (2) Prager GW, et al. N Engl J Med 2023;388:1657-67; Lonsurf USPI. (3) Grothey A, et al. Lancet 2013;381:303–12; STIVARGA USPI.
CRC, colorectal cancer; ORR, objective response rate; DCR, disease control rate; PFS, progression-free survival; OS, overall survival; 3L, third line; 2L, second line.

Daraxonrasib Safety Tables

Daraxonrasib Generally Well Tolerated in Patients with PDAC at 300 mg Daily

Maximum Severity of TRAEs	(N=76)	
	Any Grade	Grade ≥ 3
Any TRAE	73 (96%)	26 (34%)
TRAEs occurring in ≥ 10% of patients, n (%)		
Rash[1]	69 (91%)	6 (8%)
Diarrhea	40 (53%)	3 (4%)
Nausea[2]	29 (38%)	0 (0%)
Vomiting[2]	27 (36%)	0 (0%)
Stomatitis	26 (34%)	3 (4%)
Mucosal inflammation	13 (17%)	1 (1%)
Fatigue	12 (16%)	1 (1%)
Decreased appetite	10 (13%)	0 (0%)
Paronychia	10 (13%)	0 (0%)
Edema peripheral	10 (13%)	0 (0%)
Platelet count decreased	8 (11%)	3 (4%)
Dry skin	8 (11%)	0 (0%)
Other select TRAEs, n (%)		
Anemia	6 (8%)	5 (7%)
ALT increased	5 (7%)	3 (4%)
Neutrophil count decreased	5 (7%)	2 (3%)
AST increased	4 (5%)	1 (1%)

One Grade 4 TRAE observed (platelet count decreased); no Grade 5 TRAEs

Revolution Medicines

(1) Includes preferred terms of dermatitis, dermatitis acneiform, eczema, erythema, rash, rash erythematous, rash maculopapular, rash pruritic and rash pustular; multiple types of rash may have occurred in the same patient. (2) No prophylaxis for nausea or vomiting was administered. Median duration of treatment is 5.2 months. PDAC, pancreatic ductal adenocarcinoma; TRAE, treatment-related adverse event; ALT, alanine transaminase; AST, aspartate transferase.

Favorable Dose Intensity Achieved in Patients with PDAC Receiving Daraxonrasib at 300 mg

	(N=76)
TRAEs leading to dose modification, n (%)	32 (42%)
Dose interruption	30 (40%)
Dose reduction	19 (25%)
TRAEs leading to dose discontinuation, n (%)	0 (0%)
Specific TRAEs leading to dose reduction in >10% patients, n (%)	
Rash(1)	10 (13%)
Mean dose intensity	89%

(1) Includes preferred terms of dermatitis acneiform, rash and rash maculopapular.
PDAC, pancreatic ductal adenocarcinoma; TRAE, treatment-related adverse event.

ENA 2024 data set
(Data cutoff: Jul 23, 2024)

Daraxonrasib Generally Well Tolerated in Patients with NSCLC Treated at 120-220 mg Daily

	120-300 mg (N=124)		120-220 mg (N=73)		300 mg (N=51)	
	Any Grade	**Grade ≥3**	**Any Grade**	**Grade ≥3**	**Any Grade**	**Grade ≥3**
Any TRAE	121 (98%)	33 (27%)	71 (97%)	12 (16%)	50 (98%)	21 (41%)
TRAEs in ≥ 10% of patients, n (%)						
Rash[1]	110 (89%)	9 (7%)	66 (90%)	5 (7%)	44 (86%)	4 (8%)
Diarrhea	87 (70%)	10 (8%)	46 (63%)	1 (1%)	41 (80%)	9 (18%)
Nausea	68 (55%)	0 (0%)	36 (49%)	0 (0%)	32 (63%)	0 (0%)
Vomiting	55 (44%)	3 (2%)	29 (40%)	2 (3%)	26 (51%)	1 (2%)
Stomatitis	47 (38%)	3 (2%)	25 (34%)	0 (0%)	22 (43%)	3 (6%)
Paronychia	26 (21%)	0 (0%)	14 (19%)	0 (0%)	12 (24%)	0 (0%)
Fatigue	20 (16%)	0 (0%)	8 (11%)	0 (0%)	12 (24%)	0 (0%)
Dry skin	19 (15%)	0 (0%)	9 (12%)	0 (0%)	10 (20%)	0 (0%)
AST increased	17 (14%)	2 (2%)	11 (15%)	0 (0%)	6 (12%)	2 (4%)
ALT increased	15 (12%)	3 (2%)	10 (14%)	0 (0%)	5 (10%)	3 (6%)
Decreased appetite	14 (11%)	0 (0%)	4 (6%)	0 (0%)	10 (20%)	0 (0%)
Dysgeusia	12 (10%)	0 (0%)	3 (4%)	0 (0%)	9 (18%)	0 (0%)
Other select TRAEs, n (%)						
Anemia	9 (7%)	3 (2%)	4 (6%)	2 (3%)	5 (10%)	1 (2%)

- One Grade 4 pneumonitis (possibly related) observed at 300 mg dose level in patient with concomitant pneumocystis pneumonia
- No other Grade 4 TRAEs. No Grade 5 TRAEs

(1) Includes preferred terms of rash pustular, Rash papular, Rash maculopapular, Rash macular, Rash, Erythema, Dermatitis acneiform. Multiple types of rash may have occurred in the same patient.
TRAE, treatment-related adverse event; NSCLC, non-small cell lung cancer; ALT, alanine transaminase; AST, aspartate transferase.

Data cutoff: Sept 30, 2024

Daraxonrasib Favorable Dose Intensity in NSCLC Maintained at 120-220 mg

	120-300 mg (N=124)	120-220 mg (N=73)	300 mg (N=51)
TRAEs leading to dose modification, n (%)	64 (52%)	30 (41%)	34 (67%)
Dose interruption	59 (48%)	25 (34%)	34 (67%)
Dose reduction	34 (27%)	15 (21%)	19 (37%)
TRAEs leading to dose discontinuation, n (%)	7 (6%)	3 (4%)	4 (8%)
TRAEs leading to dose reductions in ≥ 10% patients			
Diarrhea	12 (10%)	4 (6%)	8 (16%)
Rash[1]	13 (11%)	6 (8%)	7 (14%)
Mucositis/stomatitis	6 (5%)	1 (1%)	5 (10%)
Mean dose intensity[2]	86%	91%	78%

- For the 120-220 mg cohort, median treatment duration was 5.5 months
- Median cumulative duration of dose interruption was 8.5 days

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(1) Includes preferred terms of Rash pustular, Rash maculopapular, Rash, Dermatitis acneiform. Multiple types of rash may have occurred in the same patient. (2) Mean dose intensity figures were updated on March 14, 2025 to correct for a programming error. Previously, the mean dose intensity was represented as 81% at the 120-300 mg dose range, 88% at the 120-220 mg dose range and 72% at the 300 mg dose. NSCLC, non-small cell lung cancer; TRAE, treatment-related adverse event.

Data cutoff: Sept 30, 2024

Daraxonrasib + Pembrolizumab +/- Chemotherapy: Generally Well Tolerated in Patients with 1L RAS Mutant NSCLC

	Daraxonrasib 200 mg + Pembrolizumab (N=10)		**Daraxonrasib (100-200 mg) + Pembrolizumab + Chemotherapy** (N=13)	
Median follow-up, mo (range)	2.3 (0.9, 6.2)		2.6 (0.7, 5.6)	
Preferred Term	Any Grade	Grade ≥ 3	Any Grade	Grade ≥ 3
Any TRAE, **≥** 25% in any subset	9 (90%)	2 (20%)	12 (92%)	6 (46%)
Rash[1]	8 (80%)	0	5 (39%)	0
Nausea	5 (50%)	1 (10%)	6 (46%)	0
Diarrhea	6 (60%)	0	7 (54%)	1 (8%)
Vomiting	5 (50%)	0	4 (31%)	0
Stomatitis/mucositis[2]	3 (30%)	1 (10%)	6 (46%)	0
Fatigue	2 (20%)	0	5 (39%)	0
Neutrophil count decreased	0	0	6 (46%)	3 (23%)
Anemia	1 (10%)	0	5 (39%)	3 (23%)
Thrombocytopenia[3]	1 (10%)	0	6 (46%)	2 (15%)
Select TRAEs				
AST increased	1 (10%)	0	1 (8%)	0
ALT increased	1 (10%)	0	2 (15%)	0
Pneumonitis	1 (10%)	0	1 (8%)	0
Colitis	0	0	0	0

(1) Includes dermatitis acneiform, rash, rash maculo-papular, rash erythematous, and rash pustular.(2) Includes mucosal inflammation and stomatitis. (3) Includes thrombocytopenia, platelet count decreased. TRAE, Any treatment-related AE, including those considered related only to chemotherapy (cisplatin/carboplatin and pemetrexed) or pembrolizumab. NSCLC, non-small cell lung cancer; ALT, alanine transaminase; AST, aspartate transferase.

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Data cutoff: Feb 10, 2025

Daraxonrasib + Pembrolizumab +/- Chemotherapy: Initial Data Support Favorable Dose Intensity in Patients with 1L RAS Mutant NSCLC

	Daraxonrasib 200 mg + Pembrolizumab (N=10)	**Daraxonrasib (100-200 mg) + Pembrolizumab + Chemotherapy** (N=13)
Daraxonrasib-related AEs:		
Leading to daraxonrasib dose reduction	1 (10%)	1 (8%)
Leading to daraxonrasib discontinuation	0[1]	1 (8%)
Pembrolizumab-related AEs:		
Leading to pembrolizumab discontinuation	0	1 (8%)
Chemotherapy-related AEs:		
Leading to chemotherapy dose reduction	-	5 (38%)
Leading to chemotherapy discontinuation	-	1 (8%)
Daraxonrasib mean relative dose intensity	93%	90%

(1) Data shown are investigator corrected from EDC.
Chemotherapy = carboplatin or cisplatin + pemetrexed; NSCLC, non-small cell lung cancer; 1L, first line; AE, adverse event.

Daraxonrasib Registrational Study Designs

Design of Ongoing RASolute 302 Trial: 2L Metastatic PDAC

Key Eligibility Criteria

- Confirmed PDAC
- 1 prior line of therapy in the metastatic setting
- ECOG PS 0-1

NCT06625320

N = 460

R
1:1

- Daraxonrasib 300 mg PO QD (N = 230)
- Investigator's Choice SOC Chemotherapy[(1)] (N = 230)

Primary Endpoints (RAS G12X)

- PFS, OS

Secondary Endpoints (All Patients)

- PFS, OS
- ORR, DOR
- QoL

Breakthrough Therapy Designation granted by the U.S. FDA to daraxonrasib for previously treated metastatic PDAC in patients with KRAS G12 mutations

(1) SOC chemotherapy options: Gemcitabine + nab-paclitaxel, modified FOLFIRINOX, NAL-IRI+5-FU+LV, or FOLFOX. 2L, second line. PDAC, pancreatic ductal adenocarcinoma; ECOG PS, Eastern Cooperative Oncology Group Performance Status; R, randomized; PO, oral administration; QD, once daily; SOC, standard of care; PFS, progression-free survival; OS, overall survival; ORR, objective response rate; DOR, duration of response; QoL, quality of life.

Ongoing RASolve 301 Phase 3 Trial in Patients with Previously Treated RAS Mutant NSCLC

Key Eligibility Criteria

- Locally advanced or metastatic NSCLC
- RAS genotypes: RAS G12X-C (core population), G12C, G13X or Q61X
- Prior therapies: 1 or 2 prior lines of therapy which must include immunotherapy and platinum chemotherapy administered concurrently or sequentially; no prior docetaxel or RAS inhibitor
- ECOG PS 0-1

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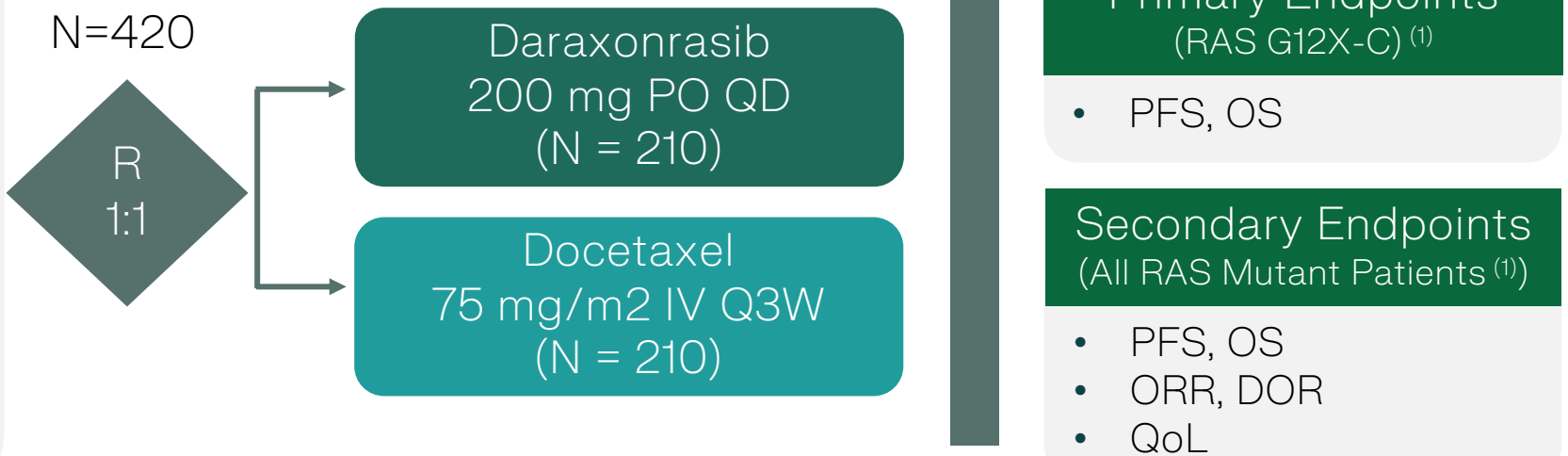

(1) Nested trial design to enable hierarchical evaluation of Core and Core + Expanded populations

NSCLC, non-small cell lung cancer; ECOG PS, Eastern Cooperative Oncology Group Performance Status; R, randomize; PO, oral administration; QD, once daily; Q3W, once every three weeks; PFS, progression-free survival; OS, overall survival; ORR, objective response rate; DOR, duration of response; QoL, quality of life.

Elironrasib Safety Tables

Elironrasib Monotherapy: Generally Well Tolerated in Patients with Previously Treated RAS G12C NSCLC

	Elionrasib 200 mg BID (N=36)	
Maximum Severity of Treatment-Related AEs	**Any Grade**	**Grade ≥3**
Any TRAE	28 (78%)	7 (19%)
TRAEs in ≥ 15% of patients, n (%)		
Diarrhea	11 (31%)	2 (6%)
Nausea	8 (22%)	0
Electrocardiogram QT prolonged	8 (22%)	1 (3%)
Other select TRAEs, n (%)		
ALT increased	2 (6%)	1 (3%)
AST increased	3 (8%)	1 (3%)
TRAEs leading to dose modification, n (%)	10 (28%)	6 (17%)
Dose interruption	8 (22%)	5 (14%)
Dose reduction	7 (19%)	5 (14%)
TRAEs leading to treatment discontinuation, n (%)	1 (3%)	1 (3%)
Mean dose intensity	94%	

No treatment-related Grade 4 or 5 AEs or SAEs have been reported

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Included NSCLC patients who have previously been treated with both immunotherapy and chemotherapy but have not received a G12C(OFF) inhibitor. Median time on treatment was 9.0 months (range: 0.0–16.7) NSCLC, non-small cell lung cancer; BID, twice daily; AE, adverse event; ALT, alanine transaminase; AST, aspartate transferase; TRAE, treatment-related adverse event.

Data cutoff: Apr 7, 2025

Elironrasib + Pembrolizumab: Generally Well Tolerated with Favorable Dose Intensity in Patients with 1L RAS G12C NSCLC

	Elironrasib 200 mg BID + Pembrolizumab (N=8)	
Median time on treatment, mo (range)	2.7 (0.7-3.2)	
	Any Grade	**Grade ≥3**
Any TRAE	6 (75%)	2 (25%)
TRAEs in ≥ 15% of patients, n (%)		
Nausea	2 (25%)	0
Diarrhea	2 (25%)	0
Electrocardiogram QT prolonged	2 (25%)	1 (13%)
Other select TRAEs, n (%)		
ALT elevated	2 (25%)(1)	0
AST elevated	1 (13%)(1)	1 (13%)[1]
TRAEs, n (%)		
Leading to elironrasib dose reduction	2 (25%)	
Leading to elironrasib dose discontinuation	0	
Leading to pembrolizumab dose discontinuation	1 (13%)	
Elironrasib mean dose intensity	85%	

(1) Increases in AST or ALT were reported to the sponsor under the term hepatic cytolysis.
NSCLC, non-small cell lung cancer; BID, twice daily; TRAE, treatment-related adverse event; ALT, alanine transaminase; AST, aspartate transferase.

Data cutoff: Feb 10, 2025

Elironrasib + Daraxonrasib: Generally Well Tolerated in 2L+ NSCLC Patients Previously Treated with G12C(OFF) Inhibitor

	Elironrasib 200 mg BID + Daraxonrasib 100-200 mg QD (N=33)	
Median time on treatment, mo (range)	3.61 (0.20-8.67)	
	Any Grade	**Grade ≥3**
Any TRAE	31 (94%)	15 (43%)
TRAEs in ≥ 20% of patients, n (%)		
Rash[1]	22 (67%)	4 (12%)
Diarrhea	19 (58%)	2 (6%)
Stomatitis/mucositis[2]	17 (52%)	3 (9%)
Nausea	15 (46%)	0
Vomiting	11 (33%)	0
Anemia	7 (21%)	0
Other select TRAEs, n (%)		
ALT increased	5 (15%)	0
AST increased	5 (15%)	0
Electrocardiogram QT prolonged	2 (6%)	1 (3%)
TRAEs leading to dose modification, n (%)	19 (58%)	12 (36%)
Dose interruption of any drug	17 (52%)	12 (36%)
Dose reduction of any drug	5 (15%)	0
Dose discontinuation of any drug	0	0
Mean dose intensity of elironrasib	95%	
Mean dose intensity of daraxonrasib	85%	

Included NSCLC patients who have previously been treated with immunotherapy, chemotherapy and a G12C(OFF) inhibitor.
(1) Includes preferred terms of rash pustular, rash papular, rash maculopapular, rash macular, rash, erythema, dermatitis acneiform, dermatitis bullous. Multiple types of rash may have occurred in the same patient. (2) Includes preferred terms of stomatitis and mucosal inflammation.
TRAE, treatment-related adverse event (to any drug); NSCLC, non-small cell lung cancer; ALT, alanine transaminase; AST, aspartate transferase.

Revolution Medicines

Data cutoff: Feb 10, 2025

Zoldonrasib Safety Table

Zoldonrasib Monotherapy: Generally Well Tolerated Across Indications

Patients Treated with 1200 mg QD Zoldonrasib (N=90)[1]				
Maximum Severity of Treatment-Related AEs	**Grade 1**	**Grade 2**	**Grade 3**	**Any Grade**
Any TRAE	49 (54%)	16 (18%)	2 (2%)	67 (74%)
TRAEs occurring in ≥10% of patients, n (%)				
Nausea	30 (33%)	5 (6%)	0	35 (39%)
Diarrhea	18 (20%)	3 (3%)	1 (1%)	22 (24%)
Vomiting	12 (13%)	4 (4%)	0	16 (18%)
Rash[(2)]	11 (12%)	0	0	11 (12%)
Other select TRAEs, n (%)				
AST increased	5 (6%)	2 (2%)	0	7 (8%)
ALT increased	4 (4%)	1 (1%)	1 (1%)	6 (7%)
Stomatitis/mucositis[(3)]	1 (1%)	0	0	1 (1%)
TRAEs leading to dose reduction, n (%)	2 (2%)	2 (2%)	0	4 (4%)
TRAEs leading to dose interruption, n (%)	3 (3%)	3 (3%)	2 (2%)	8 (9%)
TRAEs leading to treatment discontinuation, n (%)	1 (1%)	0	0	1 (1%)
Mean dose intensity		98%		

No treatment-related Grade 4 or 5 AEs or SAEs have been reported

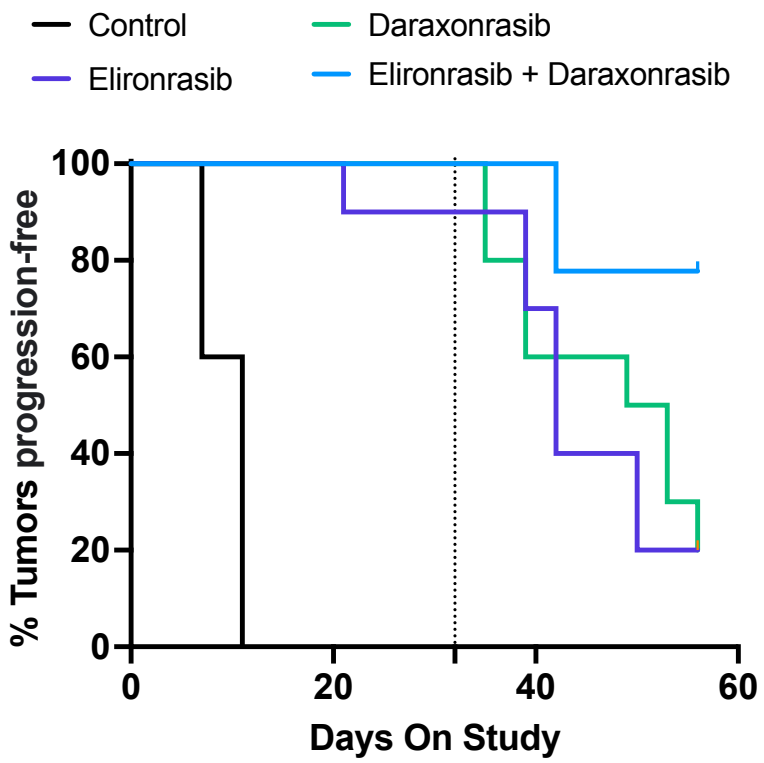
(1) Includes all tumor types (PDAC, NSCLC, CRC, and other types). (2) Includes preferred terms of Dermatitis acneiform, Rash, Rash maculo-papular. (3) Includes preferred terms of stomatitis and mucosal inflammation; Median time on treatment was 2.89 months (range: 0.03–9.66). AE, adverse event; ALT, alanine transaminase; AST, aspartate transferase; QD, once daily; TRAE, treatment-related adverse event.

Data cutoff: Dec 2, 2024

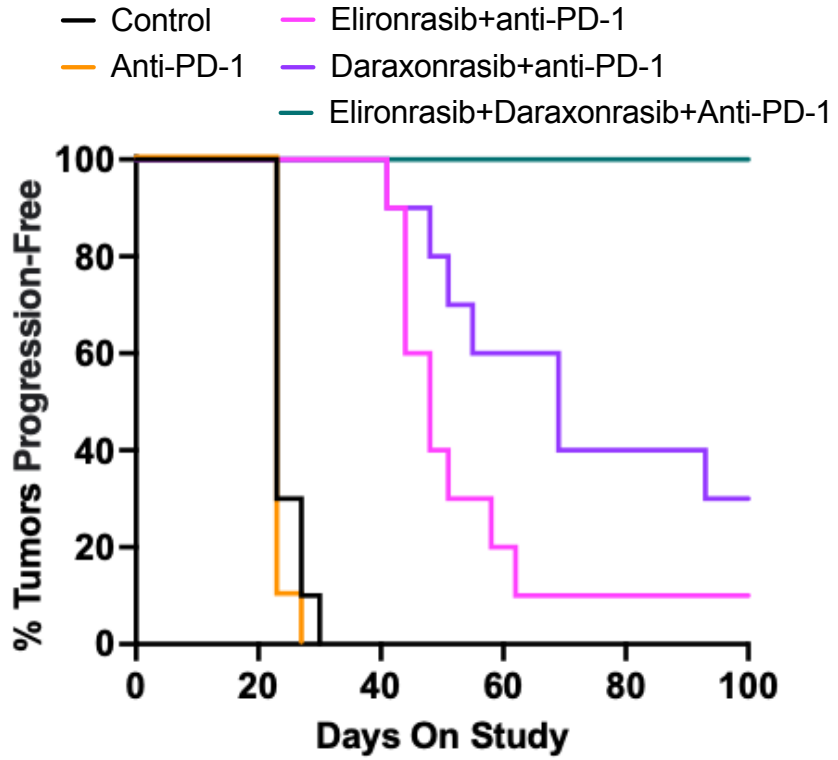
RAS(ON) Inhibitor Doublet Background

Elironrasib and Daraxonrasib Show Combination Benefit and Synergize with Anti-PD-1 in Preclinical NSCLC Models

Elironrasib and Daraxonrasib Show Combination Benefit in a NSCLC Model



RAS(ON) Inhibitor Doublet Sensitizes Immune-Refractory NSCLC to Anti-PD-1



Left Chart: KPAR (NSCLC ***KRAS G12C/G12C***), elironrasib (100 mg/kg, PO QD), daraxonrasib (25 mg/kg PO QD)). Dashed line represents treatment stop. Days on study represent days on treatment. Right Chart: e3LL (T cell excluded NSCLC, ***KRAS G12C/G12C, NRAS^{KO}***), elironrasib (30 mg/kg, PO QD), daraxonrasib (25 mg/kg PO QD)). Anti-PD-1 clone RMP1-14 CP151 (10 mg/kg IP BIW) in all graphs. Days on study represent days post tumor implant. NSCLC, non-small cell lung cancer; QD, once daily; BIW, bi-weekly.

Interim data: April 20, 2025

Limited Monotherapy Activity of Either Daraxonrasib in RAS Mutant CRC or Elironrasib in CRC Previously Treated with KRAS G12C(OFF) Inhibitor

RAS Inhibitor	Population	ORR n/N (%)
Daraxonrasib in RAS Mutant CRC[1,3] 300 mg QD	RAS inhibitor naive	2/22 (9%)
Elironrasib in KRAS G12C Mutant CRC[2] 200 mg BID	Previously treated with a G12C(OFF) Inhibitor	0/6

Revolution Medicines

(1) KRAS G12X-C; all patients treated at 300 mg QD. (2) Elironrasib 200 mg BID (RP2D). (3) ORR (by RECISTv1.1) includes confirmed CRs/PRs. The analysis is based on patients who received first dose of daraxonrasib at least 14 weeks prior to data cutoff date (to allow 2 potential scans). CRC, colorectal cancer; ORR, objective response rate; QD, once daily; BID, twice daily; RECIST; response evaluation criteria in solid tumors.

Elironrasib data cutoff: Oct 28, 2024
Daraxonrasib data cutoff: Sep 30, 2024