TYRA

# Corporate Deck

September 2026

# Disclaimers

## Forward-looking statements and market data

We caution you that this presentation contains forward-looking statements. All statements other than statements of historical facts contained in this presentation, including statements regarding our future results of operations and financial position, business strategy, research and development plans, the anticipated timing and phase of development, costs, design and conduct of, and data readouts from, our ongoing and planned preclinical studies and clinical trials for our product candidates, the potential to conduct an adjuvant or ablative Phase 3 trial in IR NMIBC, the timing and likelihood of regulatory filings and approvals for our product candidates, the potential to develop product candidates and for them to be first-in-class or game changers, and the potential safety and therapeutic benefits of our product candidates, including projected or modelled response rates or other data points, our ability to commercialize our product candidates, if approved, the pricing and reimbursement of our product candidates, if approved, and the potential for them to be blockbusters, the timing and likelihood of success, plans and objectives of management for future operations, and future results of anticipated product development efforts, are forward-looking statements. In some cases, you can identify forward-looking statements by terms such as “may,” “will,” “should,” “expect,” “plan,” “anticipate,” “could,” “intend,” “target,” “project,” “contemplates,” “believes,” “estimates,” “predicts,” “potential” or “continue” or the negative of these terms or other similar expressions. The inclusion of forward-looking statements should not be regarded as a representation by us that any of our plans will be achieved.

Actual results may differ from those set forth in this presentation due to the risks and uncertainties inherent in our business, including, without limitation: initial or interim results of a clinical trial are not necessarily indicative of final results and one or more of the clinical outcomes may materially change as patient enrollment continues, following more comprehensive reviews of the data, as follow-up on the outcome of any particular patient continues and as more patient or final data becomes available, including the risk that unconfirmed responses may not ultimately result in confirmed responses to treatment after follow-up evaluations; preliminary pharmacokinetic, pharmacodynamic and exposure-response analyses may not be predictive of future clinical outcomes or later-stage studies; early clinical observations from SURF303, including those from an individual participant, may not be predictive of future results; the safety and efficacy observed to date may not continue in ongoing or future studies; the potential for proof-of-concept results to fail to result in successful subsequent development of oral dabogratinib; later developments with the FDA may be inconsistent with prior feedback from the FDA; feedback from global health authorities on a potential Phase 3 trial in IR NMIBC in the adjuvant or ablative setting may not be as anticipated; we are early in our development efforts, and the approach we are taking to discover and develop drugs based on our SNÅP platform is novel and unproven and it may never lead to product candidates that are successful in clinical development or approved products of commercial value; potential delays in the commencement, recruitment, enrollment, data readouts, and completion of preclinical studies and clinical trials; results from preclinical studies or early clinical trials not necessarily being predictive of future results; our dependence on third parties in connection with manufacturing, research and preclinical testing; we may expend our limited resources to pursue a particular product candidate and/or indication and fail to capitalize on product candidates or indications with greater development or commercial potential; acceptance by the FDA of INDs or of similar regulatory submissions by comparable foreign regulatory authorities for the conduct of clinical trials of our product candidates; an accelerated development or approval pathway may not be available for oral dabogratinib or other product candidates and any such pathway may not lead to a faster development process; unexpected adverse side effects or inadequate efficacy of our product candidates that may limit their development, regulatory approval, and/or commercialization; the potential for our programs and prospects to be negatively impacted by developments relating to our competitors, including the results of studies or regulatory determinations relating to our competitors; unfavorable results from preclinical studies; we may not realize the benefits associated with orphan drug designation, including that orphan drug exclusivity may not effectively protect a product from competition and that such exclusivity may not be maintained or from the rare pediatric disease designation, including receipt of a Priority Review Voucher (PRV) or any value therefrom; regulatory and legislative developments in the United States and foreign countries; our ability to obtain and maintain intellectual property protection for our product candidates and proprietary technologies; our ability to establish marketing and sales capabilities to successfully commercialize any approved products; we may use our capital resources sooner than we expect; unstable market and economic conditions, geopolitical instability, war, inflation, interest rate increases and changes in healthcare legislation, tariffs and trade policies may adversely affect our business and financial condition and the broader economy and biotechnology industry; and other risks described in our prior filings with the Securities and Exchange Commission (SEC), including under the heading “Risk Factors” in our annual report on Form 10-K and any subsequent filings with the SEC. You are cautioned not to place undue reliance on these forward-looking statements, which speak only as of the date hereof, and we undertake no obligation to update such statements to reflect events that occur or circumstances that exist after the date hereof. All forward-looking statements are qualified in their entirety by this cautionary statement, which is made under the safe harbor provisions of the Private Securities Litigation Reform Act of 1995.

This presentation also contains estimates and other statistical data made by independent parties and by us relating to market size and growth and other data about our industry. This data involves a number of assumptions and limitations, and you are cautioned not to give undue weight to such estimates. In addition, projections, assumptions, and estimates of our future performance and the future performance of the markets in which we operate are necessarily subject to a high degree of uncertainty and risk. These and other factors could cause results to differ materially from those expressed in the estimates made by the independent parties and by us.

Pooled and Modeled Data: Certain of the safety and efficacy data described in this presentation reflect a pooled analysis of results from separate dose cohorts across our SURF301, SURF302 and healthy volunteer studies. Differences exist between subject characteristics and other factors, and caution should be exercised in drawing any conclusions from such data as pooled data is inherently limited and such data may not be directly comparable nor predictive of future results. In addition, our modeled projections for a potential adjuvant Phase 3 study rely in part on clinical activity and exposure data observed to date in SURF302, and there can be no assurance that the actual results will not materially differ from our projections, whether based on the inherent limitations of assumptions used in model extrapolation or differences in trial design, statistical powering, or the size or characteristics of subject populations or other factors.

# Gearing up for potential pivotal trials in 3 blockbuster indications

## Validated Target

FGFR3 alterations drive conditions with high unmet needs

## Differentiated Molecule

DABOGRATINIB

The first oral, once-daily, highly selective FGFR3 inhibitor

60mg PoC IR NMIBC Patients

- All MLs: 79% ORR and 64% BOR CR rate (n=14)
- Single MLs: 100% ORR & 75% BOR CR rate (n=8)

## 3 Potential Blockbuster Indications

| | EXPECTED |
|---|---|
| ACH – Initial results (n=~25 sentinel DL1-5) | End of 1Q27 |
| IR NMIBC – Adjuvant Ph3 Initiation | 2027 |
| LG UTUC – Initial results | 2027 |

NASDAQ: TYRA

CASH: $727M (Pro-forma 2Q26)*

DABO$3^3$

*TYRA ended 2Q26 with $353.9M in cash, cash equivalents, and marketable securities. Pro forma cash reflects the net proceeds from the company's offering of common stock and pre-funded warrants in September 2026

ACH: Achondroplasia; IR NMIBC: Intermediate Risk Non-Muscle-Invasive Bladder Cancer; LG UTUC: Low Grade Upper Tract Urothelial Carcinoma; ML Marker Lesion;
ORR: Overall Response Rate; BOR: Best overall Response; CR: Complete Response; DL: Dose Level

All TYRA small molecule inhibitors are for investigational use only

# Our expertise in FGFR biology creates a differentiated pipeline

| Dabogratinib | Target | Estimated Annual US Addressable[1] | Discovery | IND-Enabling | Phase 1 | Phase 2 | Phase 3 |
|---|---|---|---|---|---|---|---|
| LG UTUC | FGFR3 | ~3K | | | | SURF303 | |
| IR NMIBC | FGFR3 | ~35K | | | | SURF302 | |
| ACH | FGFR3 | ~3K | | | | BEACH/301 | |
| **Other** | | | | | | | |
| TYRA-430 HCC | FGF19 | ~15K | | | | SURF431 | |
| TYRA-200 ICC | FGFR1–3 | ~6K | | | | SURF201 | |

SNAP CHEMISTRY DESIGN

LG UTUC: Low Grade Upper Tract Urothelial Carcinoma; IR NMIBC: Intermediate Risk Non-muscle Invasive Bladder Cancer; ACH: Achondroplasia; HCC: Hepatocellular Carcinoma; ICC: Intrahepatic Cholangiocarcinoma

1. Represents FGFR3/FGFR2/FGF19+ incidence and recurrences for ONC and prevalence for ACH FDA clearance for dabogratinib Phase 2 INDs in ACH, IR NMIBC and LG UTUC based on Ph1 data from SURF301

TYRA retains an active FGFR3 discovery program

TYRA



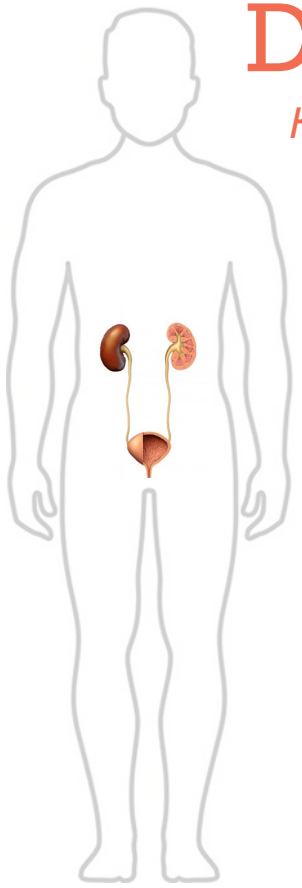
# TYRA's highly selective FGFR3 inhibitor

## Our development paths in Urology and ACH

# FGFR3 drives unmet need in multiple large market opportunities

## Dabogratinib

*Has the potential to address these indications*



### TOTAL UROTHELIAL CARCINOMA (UC)

~45% FGFR3 | ~80,000/yr (US)

### INTERMEDIATE RISK NMIBC

~70% FGFR3 | ~35,000/yr (US)

### LOW GRADE UTUC

~85% FGFR3 | ~3,000/yr (US)



### TOTAL FGFR3-RELATED SKELETAL DYSPLASIA

>40,000/yr (US)

### ACHONDROPLASIA (ACH)

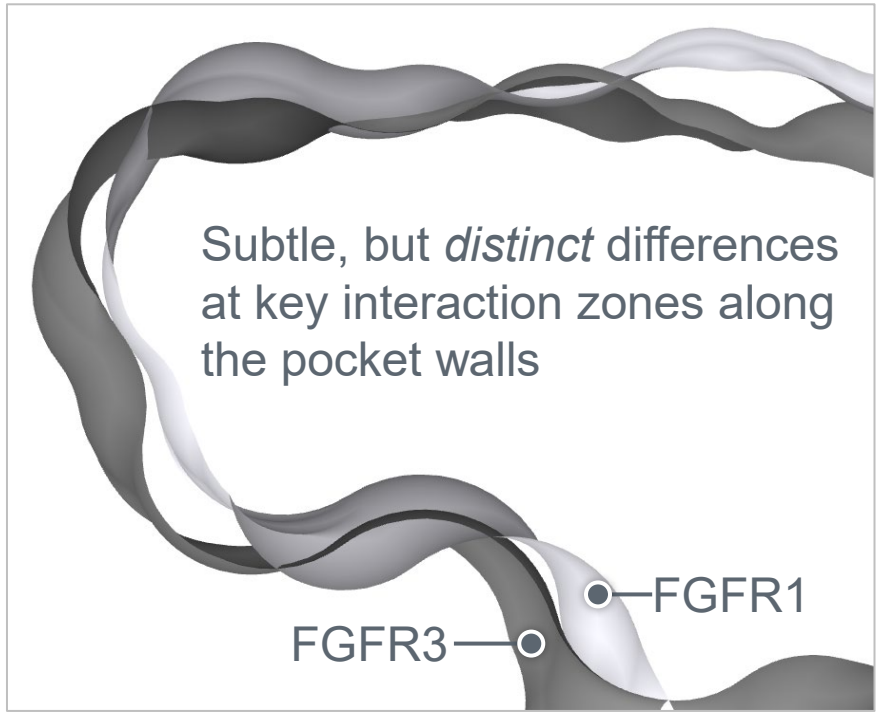
~99% FGFR3 | ~3,000/yr (US)

Oncology figures represent US incidence and recurrences; skeletal dysplasias represent US pediatric prevalence; Sources: US 2024 Census; Vajo, 2000; van Rhijn, 2010; Mayr, 2022; Kacew, 2020; DR/Decision Resources LLC 2025; CancerMPact® Patient Metrics and Oracle Life Sciences analysis; Ravvaz, 2019, Caputo, 2020, Check, 2019, Ritch, 2020, Lyall, 2023; Vedder, 2014; Sfakianos, 2015, Moss, 2017; Nassar 2019

Dabogratinib is an investigational product and has not been approved by any governmental body for any therapy or indication

# Our SNAP platform was able to address an intractable problem

**FGFR isoform selectivity**




MOLECULAR MODEL

SNAP

dozens of high-resolution crystal structures

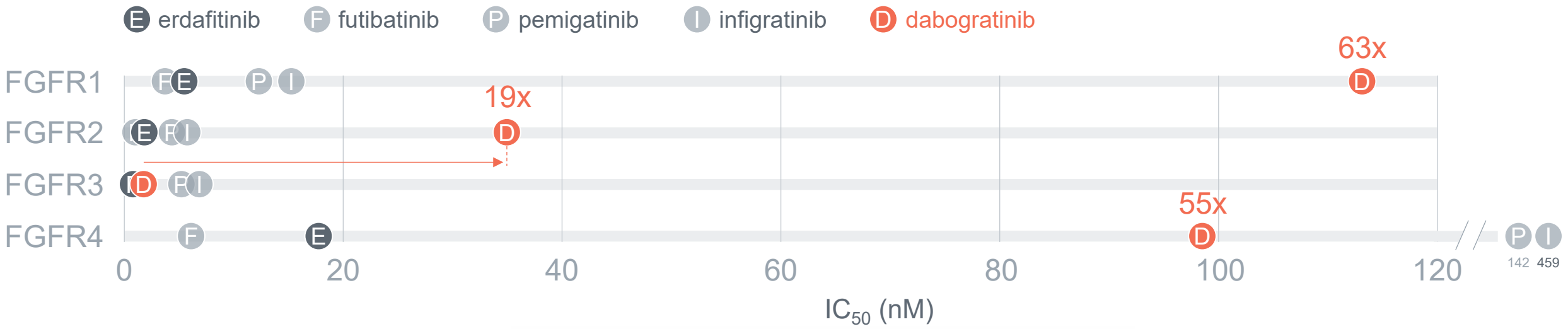



CRYSTALLOGRAPHY

3.0Å cross-sections

# Dabogratinib is a potential first-in-class, selective FGFR3 inhibitor

Selectivity observed for dabogratinib vs. approved/late-stage clinical compounds: *in vitro* Ba/F3 Cellular $IC_{50}$ (nM)




| | E | F | P | I |
|---|---|---|---|---|
| FGFR1 | 4.2x | 4.9x | 2.4x | 2.2x |
| FGFR2 | 1.4x | 1.3x | 0.8x | 0.8x |
| FGFR4 | 14x | 7.6x | 27x | 67x |

*Fold selectivity from FGFR3*

All experiments conducted under identical conditions, tested in duplicate.
Note: Dabogratinib FGFR3 selectivity is defined by its activity against FGFR3 relative to its activity against the other individual FGFR isoforms.
Erdafitinib and futibatinib are FGFR1, 2, 3, 4 or Pan-FGFR inhibitors and infigratinib and pemigatinib are selective FGFR1, 2, 3 inhibitors (Loriot, 2023; Goyal, 2023; Savarirayan, 2024; Vogel, 2024). .

TYRA

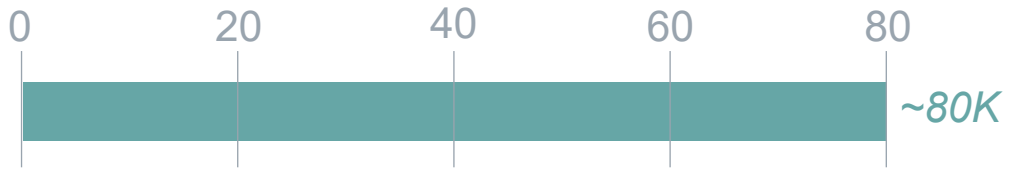


TYRA's highly selective FGFR3 inhibitor

Our development paths in Urology and ACH

# High FGFR3+ rate drives an outsized opportunity in IR NMIBC

| | Total seeking treatment each year | Percentage FGFR3+ | FGFR3+ seeking new treatment |
|---|---|---|---|
| **ALL BLADDER**<br>820K+ people living with bladder cancer and UTUC in the US | ~185K | ~45% | ~80K |
| **LG UTUC**<br>No patient-friendly oral Tx to reduce risk of renal loss | ~3.5K | ~85% | ~3.0K |
| **IR NMIBC**<br>No patient-friendly oral Tx to reduce recurrences | ~50K | ~70% | ~35K |

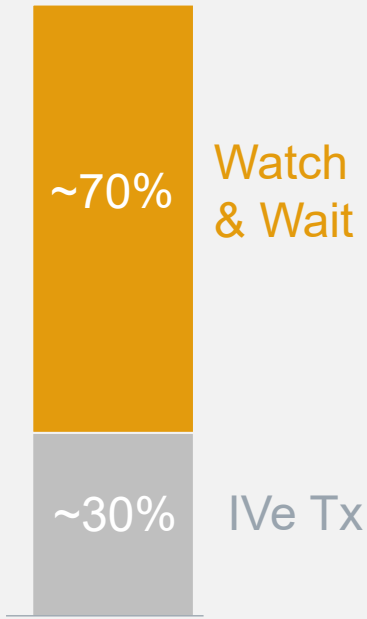



FGFR3+ Rate Sources: van Rhijn, 2010; Mayr, 2022; Kacew, 2020; Sfakianos, 2015, Moss, 2017; Nassar 2019; MIBC, mUC; All Bladder Prevalence Source: SEER; MIBC and mUC Patients Seeking New Treatment Source: DR/Decision Resources LLC 2025 Epidemiology Figures; NMIBC and UTUC Patients Seeking New Treatment Source: CancerMPact® Patient Metrics and Oracle Life Sciences analysis; Ravvaz, 2019, Caputo, 2020, Check, 2019, Ritch, 2020, Lyall, 2023; Vedder, 2014

# IR NMIBC

# Most LG IR NMIBC patients don't receive Tx to prevent recurrence

## ~70% forego adjuvant Tx[1]....



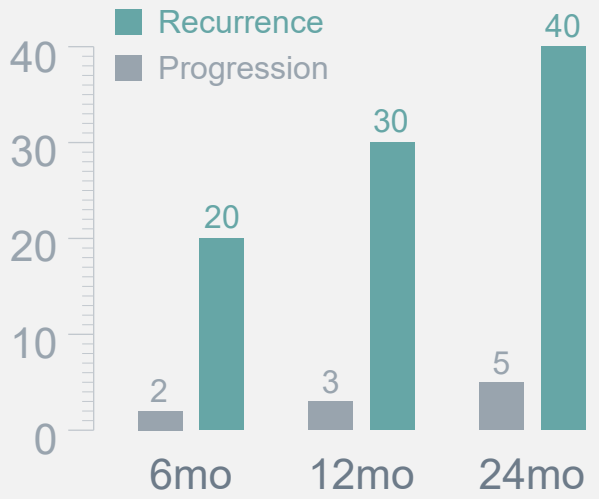

## ...despite efficacy[2]...

**44%**

Recurrence Risk Reduction

*Patients Treated with Adjuvant IVe Chemo*

## ...and a high rate of recurrence[3]




*This may be why*



**6–30 times**

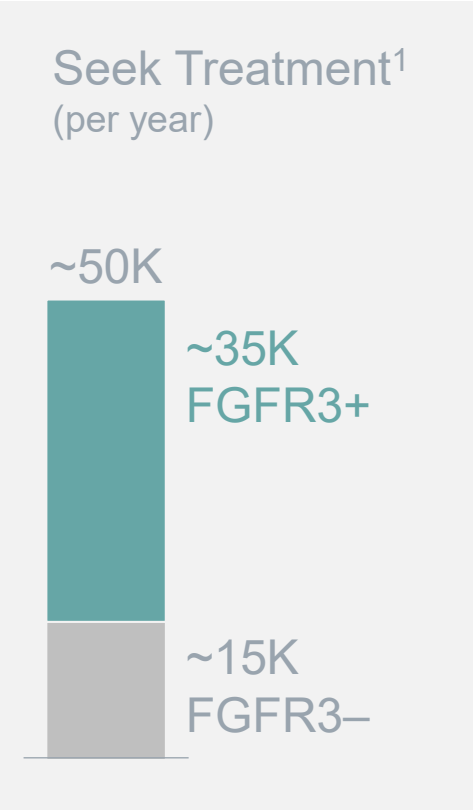
*"No one likes anything shoved up their urethra"*

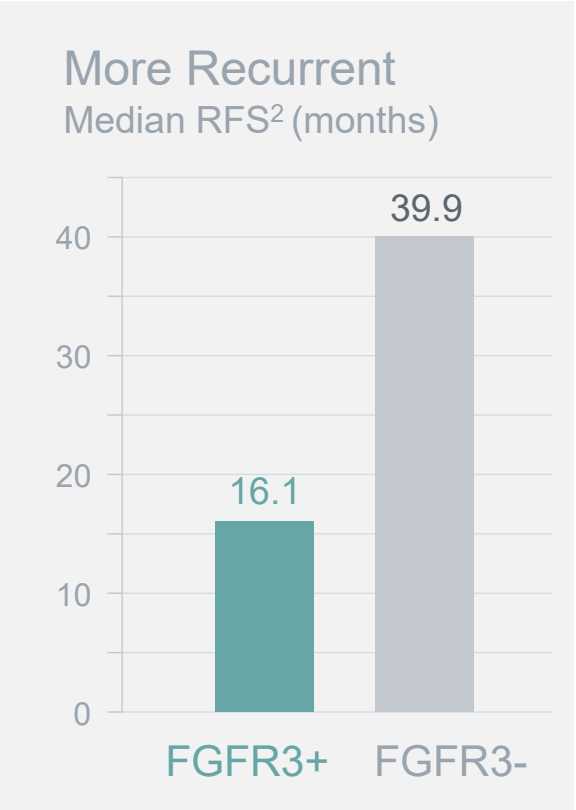
*—Community urologist[4]*

1. 2025 data for LG IR NMIBC patients who underwent bladder tumor resection captured in Cardinal Health Specialty Networks™ PPS Analytics Patient Population Health Management Platform; IVe Tx includes induction and/or maintenance 2. Data across NMIBC risk categories and IVe Chemo treatment durations (Huncharek, 2000); 3. Data for IR NMIBC patients treated with TURBT+SoC IVE chemo (Matulewicz, 2020); 4. TYRA Market Research, 2026

# FGFR3+ patients benefit from sustained FGFR3 inhibition

## FGFR3+ VALIDATED TARGET IN IR NMIBC




1. Van Rhijn, 2010; CancerMPact® Patient Metrics and Oracle Life Sciences analysis; Ravvaz, 2019, Caputo, 2020, Check, 2019, Ritch, 2020, Lyall, 2023; Vedder, 2014

2. Adapted from Meeks, 2026 (AUA); RFS across Low Grade NMIBC

## EVIDENCE SUSTAINED INHIBITION MAINTAINED RESPONSES

### TAR-210
Pan-FGFR Pretzel

**100% durability while on therapy**

3 of 4 evaluated recurred within 3 mo after 12 mo total Tx course of TAR-210[3]

### Oral Erdafitinib
Pan-FGFR

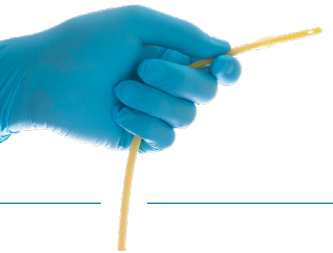
**100% durability while on therapy**

4 of 6 patients who discontinued treatment recurred within 1 year[4]

Note: the oral Erdafitinib trial was stopped early due to slow accrual in part due to concerns regarding systemic toxicities (Catto, ESMO 2023)

3. Vilaseca, 2024 (AUA)
4. Daneshmand, 2025 (European Urology)

# Dabo is uniquely positioned to expand Tx beyond procedures



## ADJUVANT IVe Tx IN DEVELOPMENT

All five require multiple urethral violations with dwell times

**ZUSDURI**[1]
(Mitomycin hydrogel)
Weekly for 6 weeks
Total instillations: 6

**CRETOSTIMOGENE**
(Oncolytic adenovirus)
Weekly for 6 weeks
Then quarterly for 1–3 weeks
Total instillations: 14

**TAR-210**
(erdafitinib "pretzel")
Quarterly for 12 months
Total instillations: 8

**NDV-01**
(gemcitabine-docetaxel)
Weekly for 12 weeks, then monthly
Total instillations: 32

**Adstiladrin**
(nadofaragene firadenovec-vncg)
Quarterly over 2 years
Total instillations: 8

## ORAL DEVELOPMENT

Only one: a *targeted* therapy

### Dabogratinib



TARGET PROFILE

efficacious and tolerable to enable chronic Tx

1. Zusduri approved for IR NMIBC and disclosed plans for UGN-103 adjuvant study (Urogen Press Release, August 5, 2026)

# SURF302 was designed to select a dose for Phase 3

SURF302

LG IR NMIBC, Marker Lesion Study
Dabogratinib (TYRA-300)
NCT06995677

## Key Eligibility Criteria

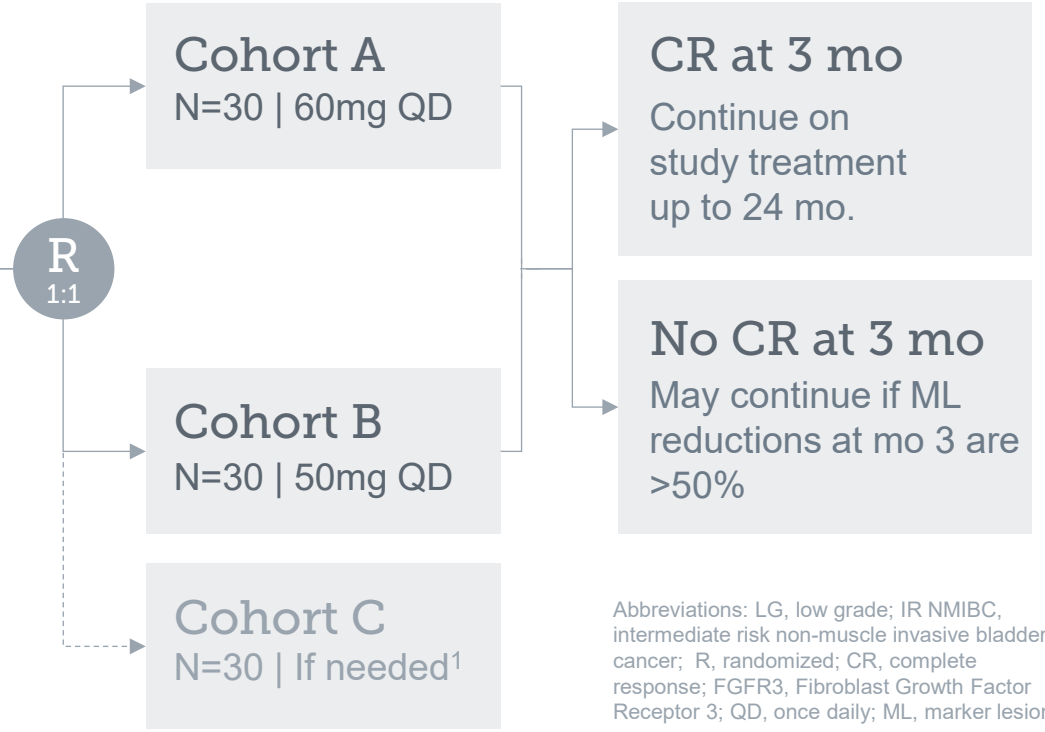
Adults (≥18 years)

*FGFR3* activating gene alterations confirmed by urine or tissue test

IR NMIBC based on AUA Guidelines, 2024

- Recurrence w/in 1 year, LG Ta
- Solitary LG Ta >3cm
- LG Ta, multifocal
- LG T1

At least 1 marker lesion;
total aggregate ≥3 mm ≤12 mm




Abbreviations: LG, low grade; IR NMIBC, intermediate risk non-muscle invasive bladder cancer; R, randomized; CR, complete response; FGFR3, Fibroblast Growth Factor Receptor 3; QD, once daily; ML, marker lesion

## Primary Endpoint

CR at 3 months

## Secondary Endpoints

- Best Overall Response (BOR)
- Time to recurrence
- Median duration of response
- Recurrence free survival (RFS)
- Progression free survival (PFS)
- Safety and tolerability

Prescreening includes: urine sample for tumor genomics and/or consent to provide prior tumor genomics report or archival tissue and consent to allow marker lesion(s) to remain *in situ*

1. Optional if needed, start after initial data review of 50 mg QD (dosed once daily) and 60 mg QD

# 100% ORR at 60mg in single marker lesion patients

## PHASE 2 ABLATIVE
TUMOR(S) REMAIN

Evaluating Dabogratinib's potential to shrink and ablate all lesions in bladder

SURF302

### 60mg Single Marker Lesion (ML) Data

1. Best Overall Response (n=8)
   100% ORR
   75% CR
2. Safety data supports chronic dosing potential
3. High confidence in adjuvant Ph3 potential

### Multiple ML (ablative expansion)

Explore upside of 70mg in ablative setting, given dabo's favorable safety data to date

## PHASE 3 ADJUVANT
ALL TUMORS REMOVED

Planned to evaluate Dabogratinib's potential to prevent new lesion growth after tumor removal

### Implications from Phase 2

Plan to take 60mg forward in Adjuvant Phase 3 study vs placebo

See disclaimer on pooled and modeled data.

# IR NMIBC

## SURF302 Data and Phase 3 Dose Selection

# SURF302 enrolled a highly recurrent, undertreated population

| | | n=44 |
|---|---|---|
| MEDIAN AGE | Range (26-82) | 70 (yrs) |
| | | n (%) |
| SEX AT BIRTH | Male | 31 (71) |
| *FGFR3* ALTERATION[1] | Mutation | 40 (91) |
| | Fusion | 5 (11) |
| DE NOVO OR RECURRENT[2] | De Novo | 2 (5) |
| | Recurrent | 38 (86) |

| | | n=44 |
|---|---|---|
| MEDIAN PRIOR: TURBT | Range (0−10) | 2 |
| Intravesical (IVe) Tx[3] | Range (0−7) | 0 |
| | | n (%) |
| MARKER LESION NUMBER[1] | 1 | 27 (61) |
| | >1 | 16 (36) |
| AGGREGATE LESION SIZE (mm)[2] PRE-RESECTION | <20 | 29 (66) |
| | ≥20 | 14 (32) |
| MARKER LESION[2] SIZE (mm) | <10 | 32 (73) |
| | ≥10 | 11 (25) |

**61%**
of patients had no prior lines of IVe Tx[2]

Safety analysis population: all randomized subjects who received study treatment as of August 31, 2026 data cutoff

1. 2 subjects had both mutations and fusions; 1 patient had neither entered yet in current database
2. Data pending database entry as of the data cutoff; categories may not sum to 100% of n=44
3. Non-wash IVe Treatment

# Favorable safety and tolerability data support chronic Tx potential

## Adverse Events Were Manageable

- No clinically significant hyperphosphatemia, nail toxicity or ocular toxicity
- Low frequency of transaminase TEAEs

| n (%) | 60 mg (n=22) | 50 mg (n=22) |
|---|---|---|
| All Discontinuations | 0 (0) | 1 (5) |
| All Dose Reductions | 0 (0) | 0 (0) |
| All Dose Interruptions | 4 (18) | 1 (5) |
| Related Interruptions | 2 (9) | 1 (5) |

AE-related

Safety analysis population: all randomized subjects who received study treatment as of August 31, 2026 data cutoff.
No grade 4 or 5 events

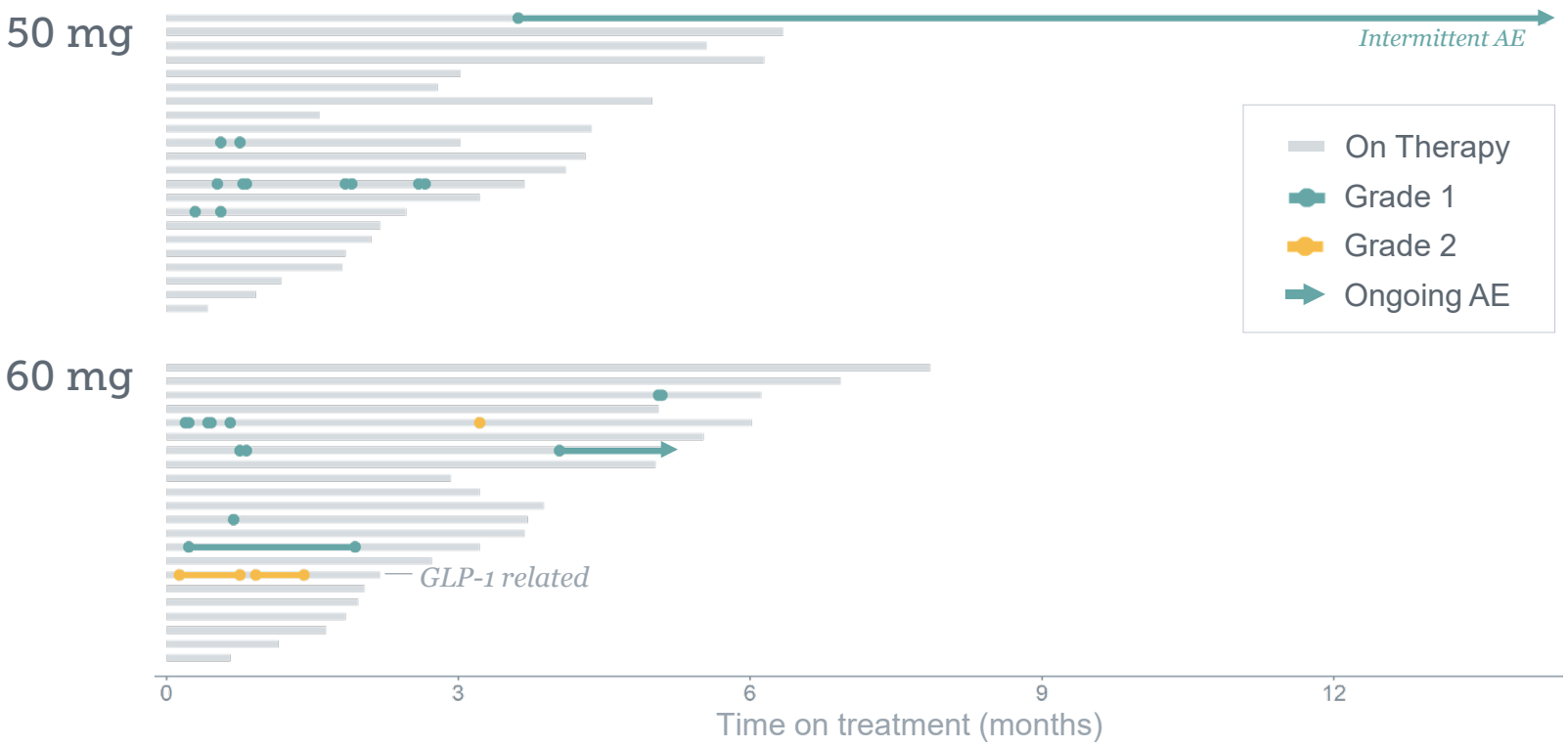
## TEAEs in Patients Treated with Dabogratinib, n (%)

| | 60 mg (n=22) | | | 50 mg (n=22) | | |
|---|---|---|---|---|---|---|
| | *Gr. 1* | *Gr. 2* | *Gr. 3* | *Gr. 1* | *Gr. 2* | *Gr. 3* |
| Participants with at least one TEAE, n(%)[1] | 7 (32) | 5 (23) | 3 (14) | 9 (41) | 4 (18) | 2 (9) |
| Gr. 3 TRAE, n(%)[1] | | | — | | | 2 (9) |
| TEAEs in >10% in each cohort, n(%) | *Gr. 1* | *Gr. 2* | *Gr. 3* | *Gr. 1* | *Gr. 2* | *Gr. 3* |
| Fatigue | 8 (36) | — | — | 4 (18) | 1 (5) | — |
| Dry eye[2] | 5 (23) | — | — | 1 (5) | — | — |
| Diarrhea | 4 (18) | 2 (9) | — | 4 (18) | — | — |
| Urinary Tract Infection[2] | — | — | 3 (14) | — | 1 (5) | — |
| Dysgeusia[2] | 3 (14) | — | — | — | — | — |
| Faeces Soft[2] | 3 (14) | — | — | 2 (9) | — | — |

1. Cutoff based on individual cohorts; represents max grade per patient
2. >10% in 60mg cohort only

# GI events were limited and transient

## Diarrhea TEAEs in all safety evaluable patients (n=44)




- No dose reductions or interruptions from treatment-related diarrhea
- All cases were transient or intermittent
- One patient with history of diverticulosis has stayed on therapy >14mo

Safety analysis population: all randomized subjects who received study treatment as of August 31, 2026 data cutoff.

# 60mg demonstrated robust clinical activity with a dose response

## 60mg n=14[1]

| | 3-mo | BOR |
|---|---|---|
| ORR | 79% (11) | 79% (11) |
| CR | 57% (8) | 64% (9) |
| PR | 21% (3) | 14% (2) |

## 50mg n=12[1]

| | 3-mo & BOR |
|---|---|
| ORR | 67% (8) |
| CR | 33% (4) |
| PR | 33% (4) |

PR: ≥50% reduction in ML aggregate size and no new lesions
BOR: Best Overall Response

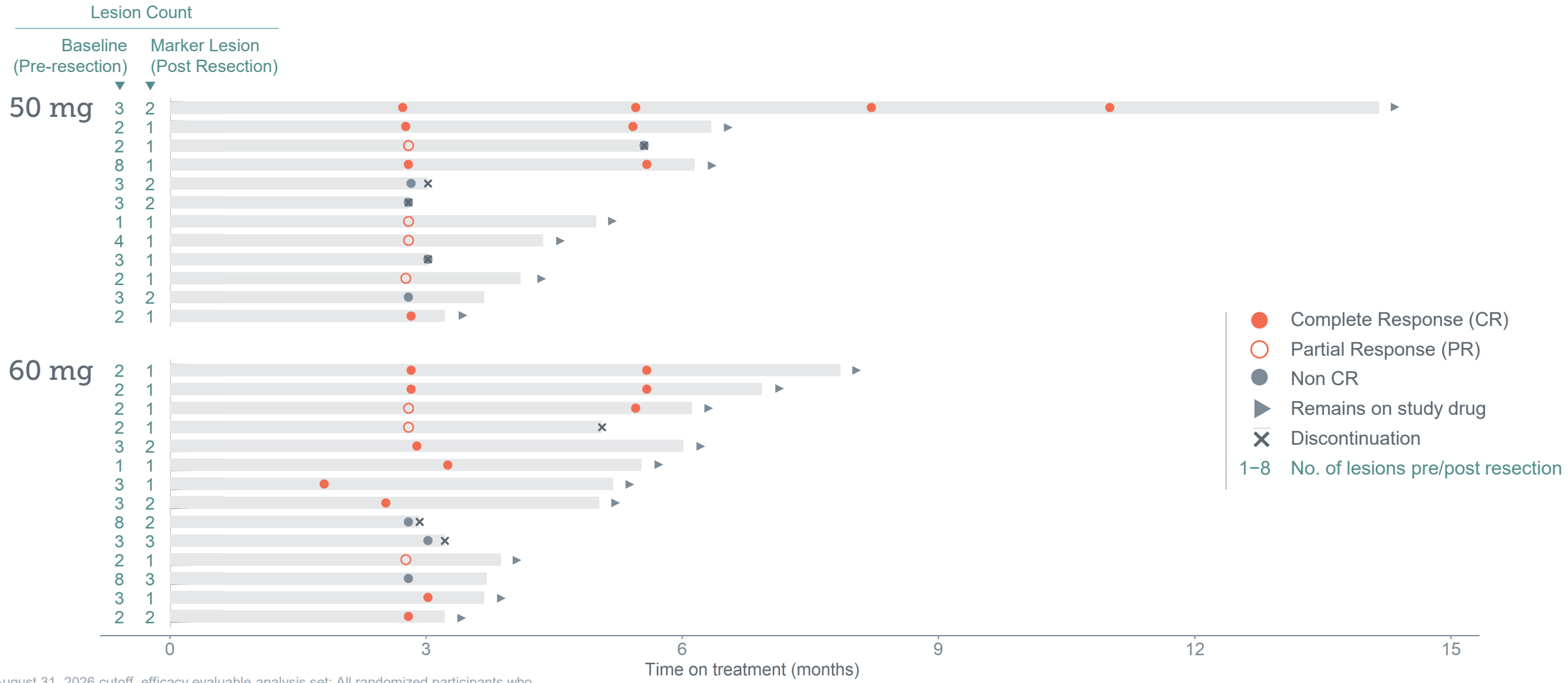
## FINDINGS

- Clear dose response observed
- Initial 60mg PR with a 6-mo assessment converted to a CR
- All 3-mo CRs with 6-mo assessment remain in response at 6-mo (n=5)

August 31, 2026 cutoff

1. Efficacy evaluable analysis set: All randomized participants who received study treatment and have undergone at least the month 3 disease assessment.

# Evidence of response maintenance and maturation




August 31, 2026 cutoff, efficacy evaluable analysis set: All randomized participants who received study treatment and have undergone at least the month 3 disease assessment.

# Model projects likely plateauing of adjuvant efficacy above 60mg

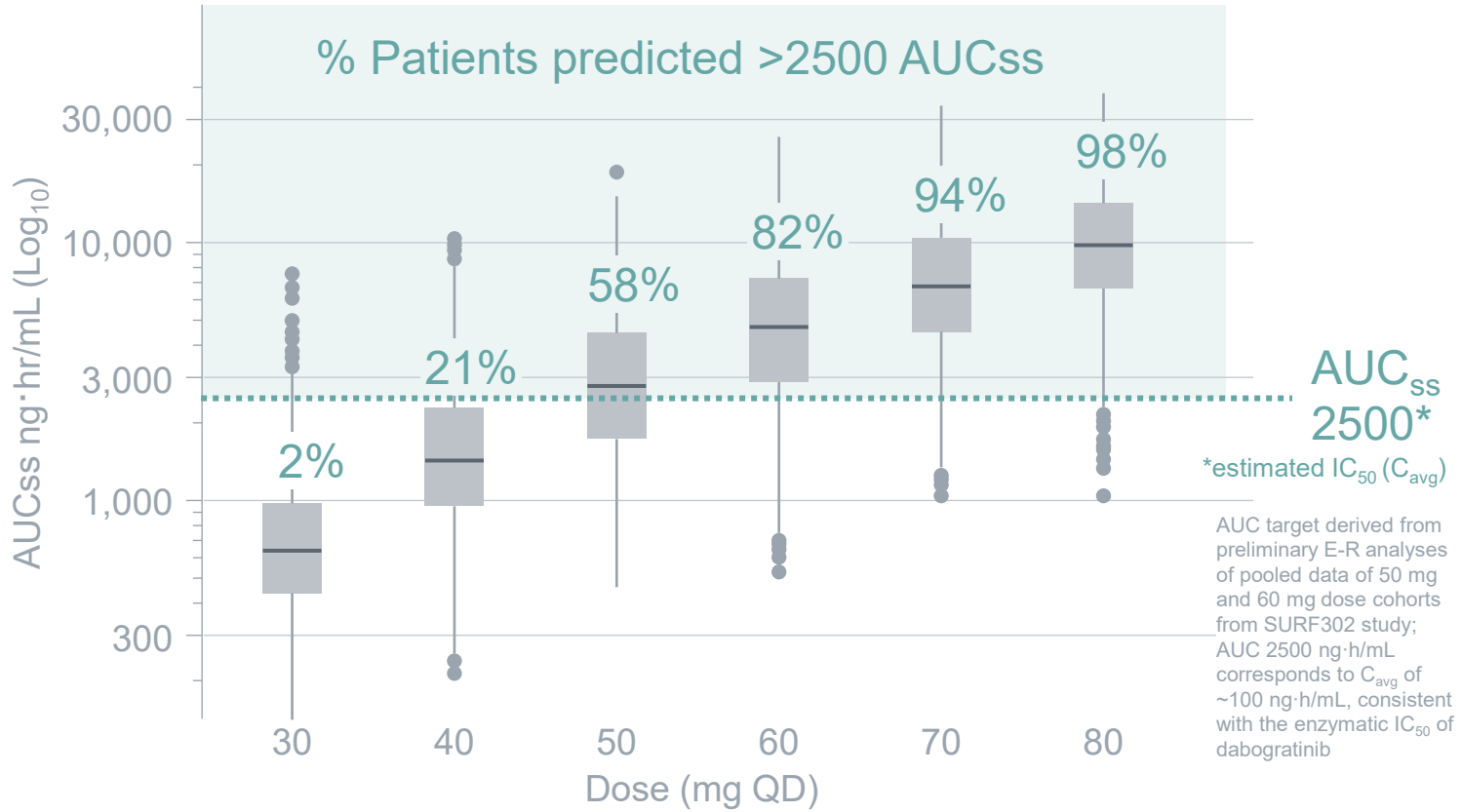
## Response Rate by AUC
across 50 and 60mg

**86%** ORR at >2500 $AUC_{ss}$

| $AUC_{ss}$ | ≤2500 n=12 | >2500 n=14 |
|---|---|---|
| BOR | 58% (7) | 86% (12) |
| CR | 25% (3) | 71% (10) |
| PR | 33% (4) | 14% (2) |

Data pooled from SURF302 50 and 60mg doses
PR: ≥50% reduction in ML aggregate size and no new lesions
BOR: Best Overall Response

## Predicted Steady State AUC by Dose (n=172)




AUC target derived from preliminary E-R analyses of pooled data of 50 mg and 60 mg dose cohorts from SURF302 study; AUC 2500 ng·h/mL corresponds to $C_{avg}$ of ~100 ng·h/mL, consistent with the enzymatic $IC_{50}$ of dabogratinib

August 31, 2026 cutoff, efficacy evaluable analysis set: All randomized participants who received study treatment and have undergone at least the month 3 disease assessment.
See disclaimer on pooled and modeled data.

Population PK model developed using data from 172 participants across SURF301, SURF302 and healthy volunteer study and used for exposure (AUC, Cmax, Cmin) prediction for individual patients in SURF302 study

# Clinical activity improved in patients with single marker lesion

## Response Rate by ML
across 50 and 60mg

**94%** ORR with 1 ML

| | 1 ML n=16 | ≥2 MLs n=10 |
|---|---|---|
| BOR | 94% (15) | 40% (4) |
| CR | 56% (9) | 40% (4) |
| PR | 38% (6) | 0% (0) |

Data pooled from SURF302 50 and 60mg doses
PR: ≥50% reduction in ML aggregate size and no new lesions
BOR: Best Overall Response

**Of the 7 non-responders across both doses**
all but one had multiple MLs; of the 6 non-responders with ≥2MLs, only one had AUC >2,500 ng·h/mL

**Of the 4 responders with multiple marker lesions**
all achieved AUC >2,500 ng·h/mL

## 60mg with 1 ML n=8

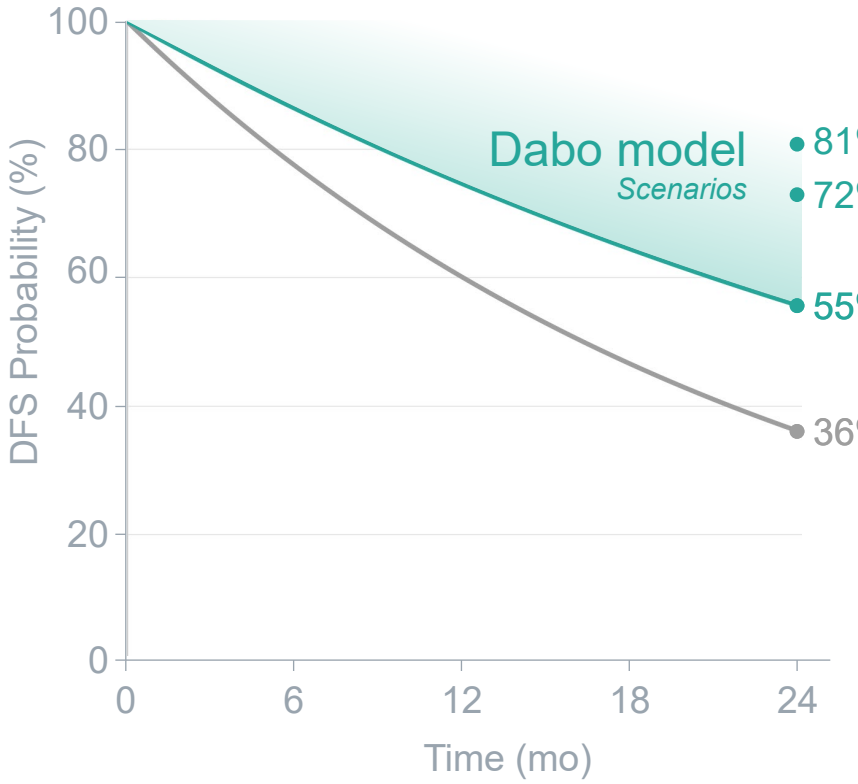
| | 3-mo | BOR |
|---|---|---|
| ORR | 100% (8) | 100% (8) |
| CR | 63% (5) | 75% (6) |
| PR | 38% (3) | 25% (2) |

August 31, 2026 cutoff, efficacy evaluable analysis set: All randomized participants who received study treatment and have undergone at least the month 3 disease assessment.
See disclaimer on pooled and modeled data.

# Modeling supports our confidence in planned adjuvant Ph3

## Modeled DFS Curves[4]

$\lambda = -\ln(DFS_{24}) / 24$




$DFS_0 + (1\text{-}DFS_0) \times [(DoR \times CR) + (DoR \times PR)] = DFS_{24}$

$DFS_0$: 36%[1] — $(1\text{-}DFS_0)$: 64%[2] — FGFR3-driven Efficacy

| | | | |
|---|---|---|---|
| 81% — 60mg with 1 ML | $[(0.8^3 \times 75\%^3) + (0.4^3 \times 25\%^3)] = 81\%^2$ | | 0.2 |
| 72% — 60mg conservative | $[(0.8^3 \times 64\%^3) + (0.4^3 \times 14\%^3)] = 72\%^2$ | | 0.3 |
| 55% — Pooled conservative | $[(0.6^3 \times 50\%^3) + (0.0^3 \times 23\%^3)] = 55\%^2$ | | 0.6 |

**Implied Hazard Ratio vs. Placebo**

DFS: Disease Free Survival; DoR: Duration of Response

1. Derived from Meeks et al., AUA 2026; 35.6%, exponential, FGFR3-alt LG NMIBC (mRFS = 16.1 mo, n = 117); 2. Calculation; 3. Assumption

4. Illustrative model based on stated assumptions; not predictive of clinical outcome

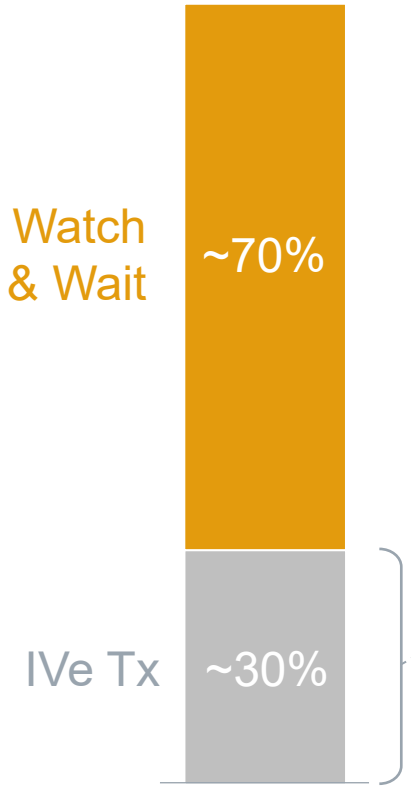
See disclaimer on pooled and modeled data.

# IR NMIBC

## Market Opportunity

# Our mission is to make dabogratinib the clear first-line choice

LG IR NMIBC adjuvant patients[1]




## WIN ON EFFICACY AND CONVENIENCE

POTENTIAL FOR A DAILY ORAL

Replace repeat catheterizations/instillations

## SWITCH CONSIDERATIONS

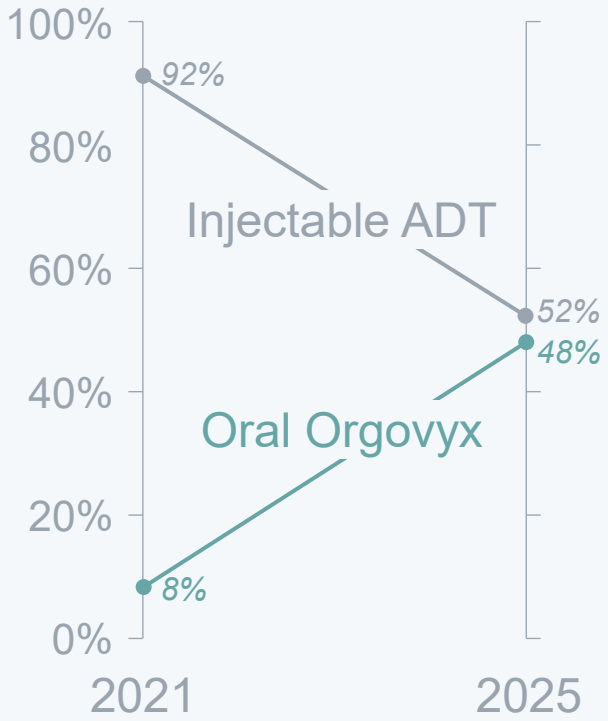
- Instrumentation fatigue
- Potential for continued DFS with oral Tx

1. 2025 data for LG IR NMIBC patients who underwent bladder tumor resection captured in Cardinal Health Specialty Networks™ PPS Analytics Patient Population Health Management Platform; IVe Tx includes induction and/or maintenance

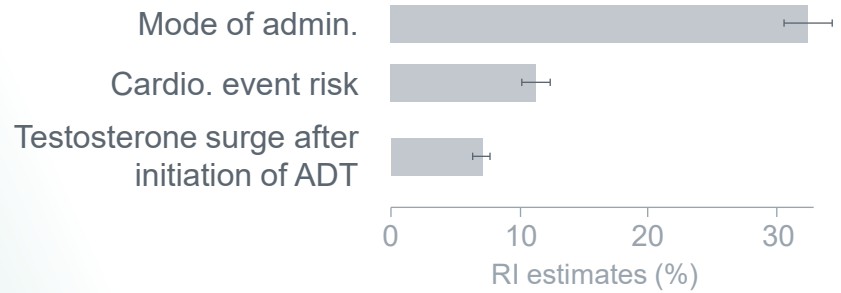
# Preference for oral Orgovyx transformed the ADT market

## COMPETE ON CONVENIENCE

### Community Urology Patient Share[1]




### 1 Patient Preference[2]




### 2 Aligned Practice Economics

IOD contracting + limited distribution[3] enable economics equivalent to Part B

### 3 Streamlined Operations

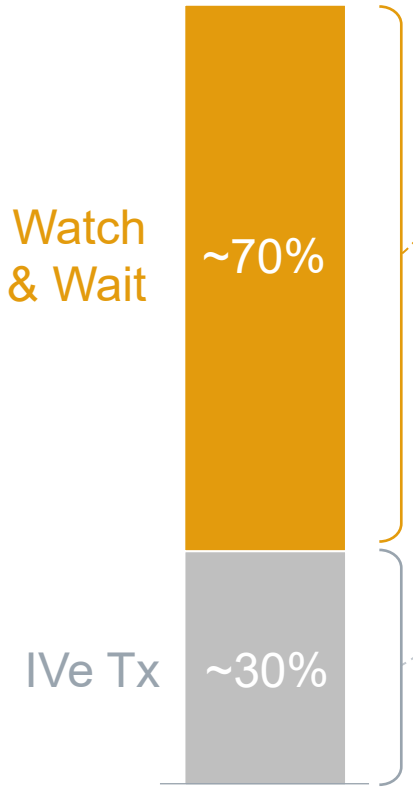
Nurses and treatment rooms removed

ADT: Androgen Deprivation Therapy
RI: Relative Importance

1. Data for prostate cancer patients treated with ADT captured in Cardinal Health Specialty Networks™ PPS Analytics Patient Population Health Management Platform;
2. Collins, 2025; 3. Orgovyxhcp.com accessed 5/27/26

# Our mission is to make dabogratinib the clear first-line choice

LG IR NMIBC adjuvant patients[1]




## EXPAND THE MARKET

POTENTIAL FOR A DAILY ORAL

Reduce recurrence and surgery

Reduce 3-month cystoscopy burden

## WIN ON EFFICACY AND CONVENIENCE

POTENTIAL FOR A DAILY ORAL

Replace repeat catheterizations/instillations

## SWITCH CONSIDERATIONS

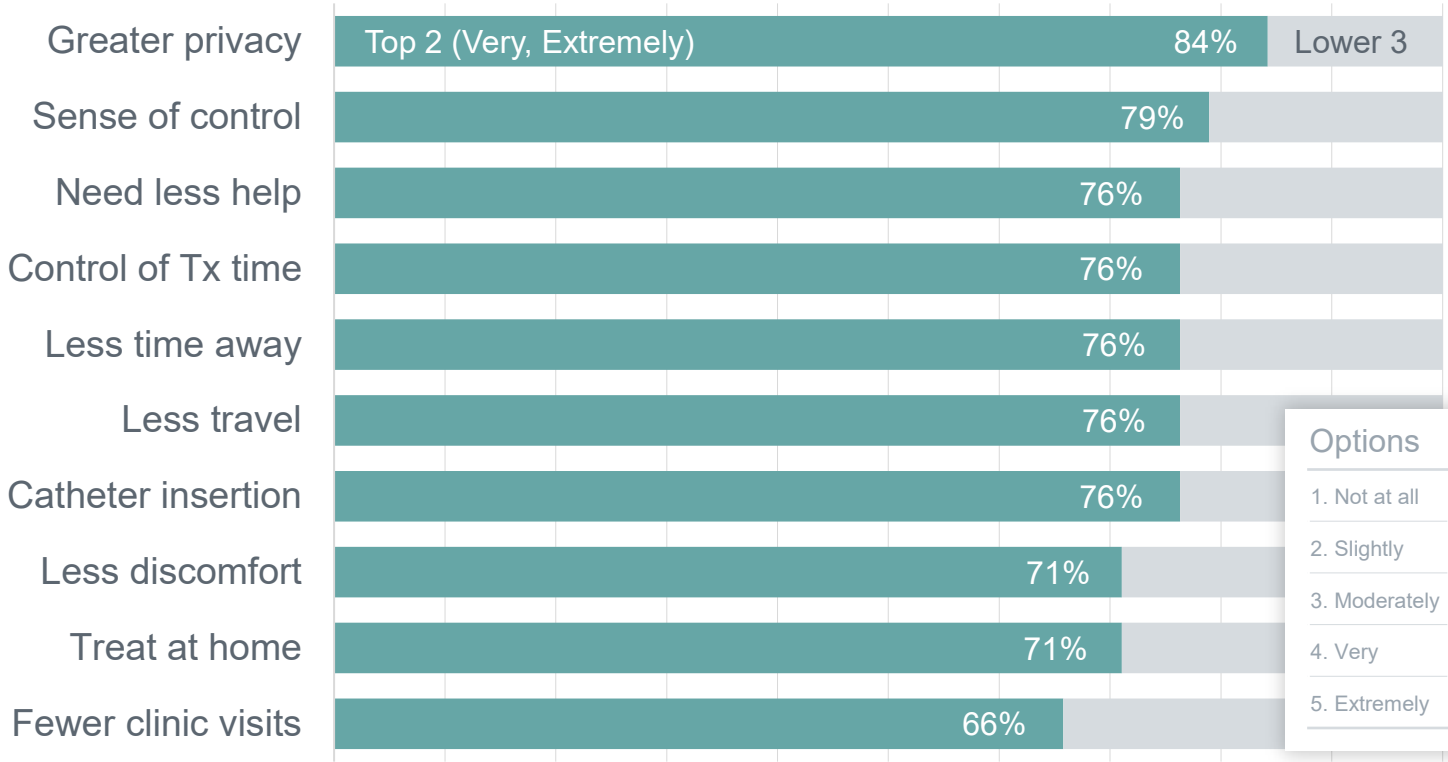
- Instrumentation fatigue
- Potential for continued DFS with oral Tx

1. 2025 data for LG IR NMIBC patients who underwent bladder tumor resection captured in Cardinal Health Specialty Networks™ PPS Analytics Patient Population Health Management Platform; IVe Tx includes induction and/or maintenance

# Research indicates patients would strongly value an oral therapy

## LIFESTYLE APPEAL OF A DAILY ORAL PILL[1]

How appealing is each of the following factors related to an oral pill that you take daily?*

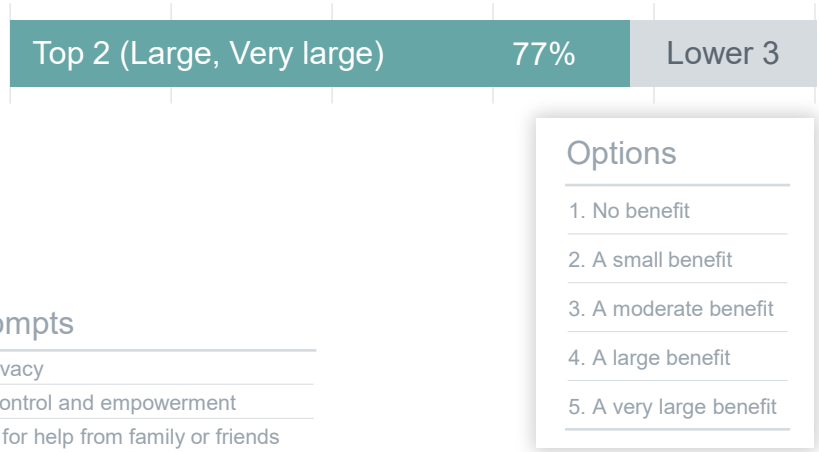



* Full prompts

- Greater privacy
- Sense of control and empowerment
- Less need for help from family or friends
- More control over when treatment is taken
- Less time away from work or other activities
- Less travel
- No catheter insertion
- Less discomfort
- Ability to take treatment at home
- Fewer clinic visits

## TREATMENT APPEAL[1]

If oral treatment still required the same cystoscopy schedule for monitoring your remission, how much benefit would taking treatment at home provide?



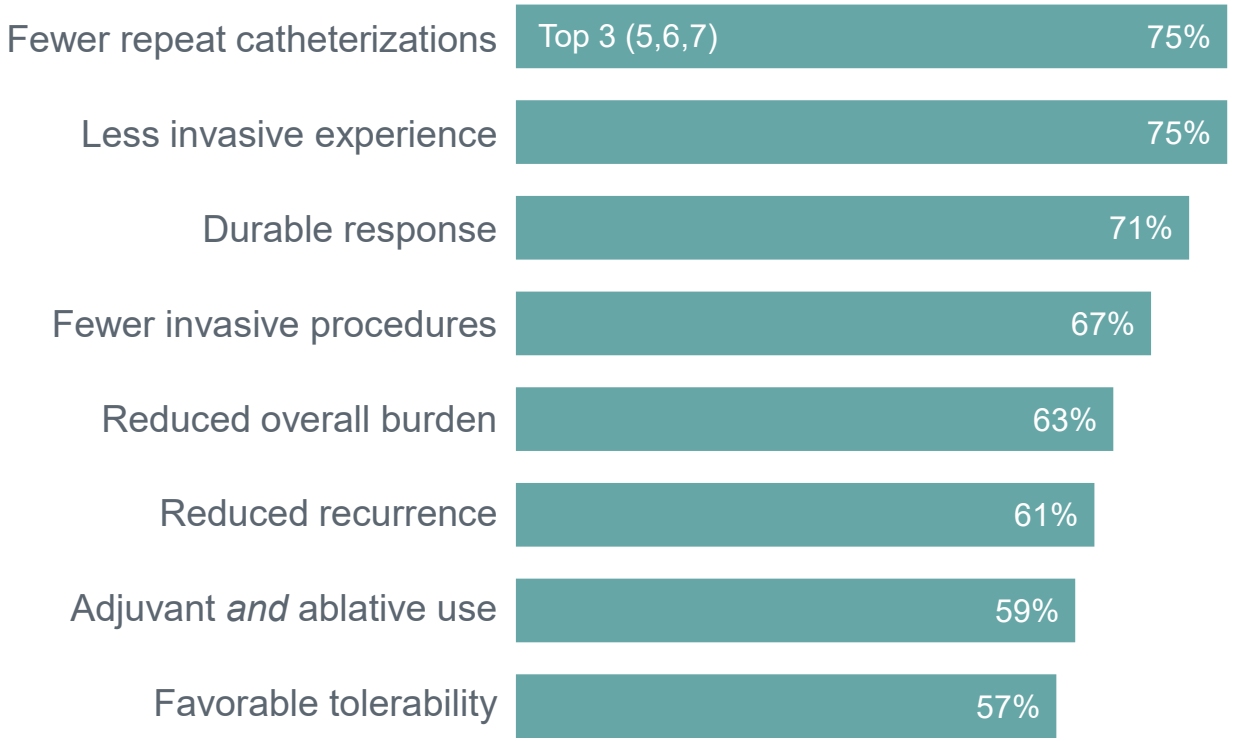

1. August 2026 survey of N=38 IR NMIBC patients, TYRA Market Research on File (study ongoing)

# Urologists prioritize efficacy *and* relief from invasive procedures

*The majority of urologists would recommend patients try oral before pretzel*

## UNMET NEEDS IN IR NMIBC[1]

To what extent, if at all, would you consider each of the following an unmet need in the management of IR-NMIBC?*




Options

1. No unmet need at all
2.
3.
4. Moderate unmet need
5.
6.
7. **Extremely high unmet need**

Top 3

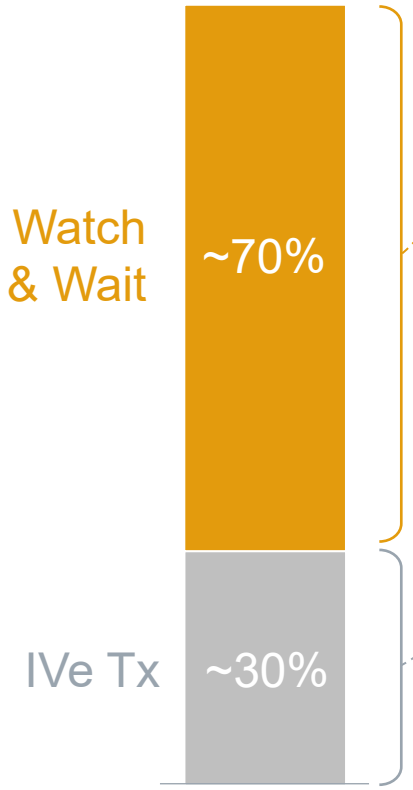
* Full prompts

- Durable responses over time in IR-NMIBC
- Reduction in invasive procedures such as TURBT/Fulguration
- A reduction in the overall burden of attending treatment appointments (travel, time, transportation, cost)
- A less invasive treatment experience
- Strong reduction in recurrence risk
- Reduction in repeat catheterization and intravesical drug administration
- Favorable tolerability with a low toxicity burden
- Ability to be used effectively in both adjuvant and ablative treatment settings

1. August 2026 survey of N=51 Urologists (78% community-based), TYRA Market Research on File (study ongoing)

# Our mission is to make dabogratinib the clear first-line choice

LG IR NMIBC adjuvant patients[1]




## EXPAND THE MARKET

POTENTIAL FOR A DAILY ORAL

Reduce recurrence and surgery

Reduce 3-month cystoscopy burden

## WIN ON EFFICACY AND CONVENIENCE

POTENTIAL FOR A DAILY ORAL

Replace repeat catheterizations/instillations

TOTAL POTENTIAL MARKET SIZE[2]

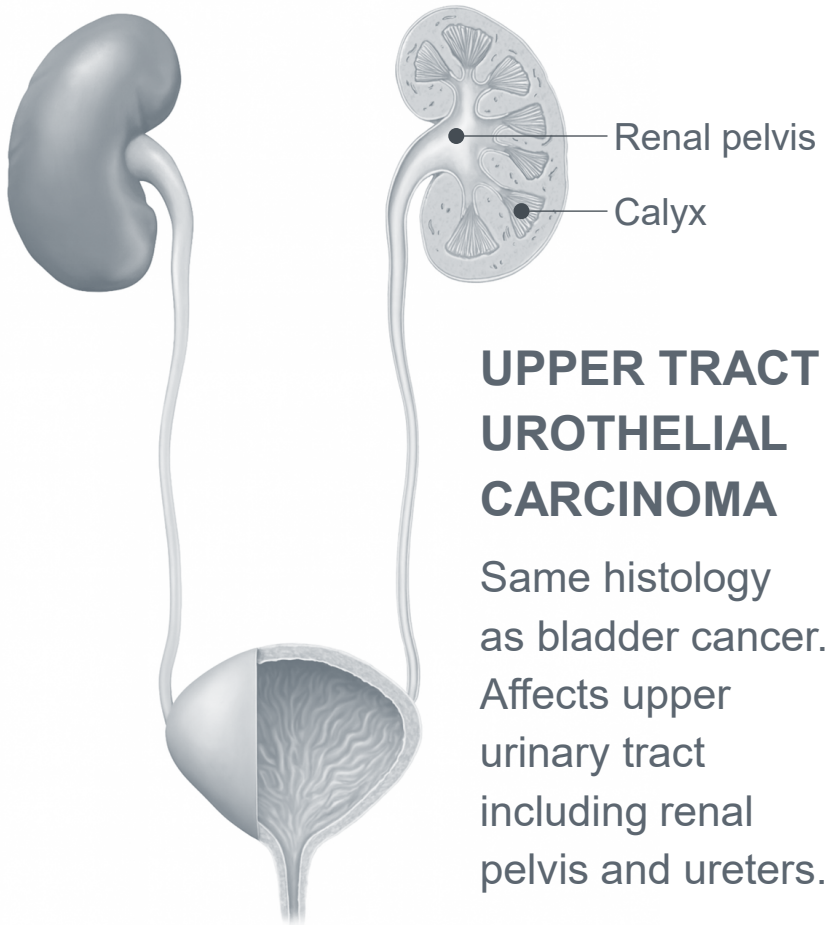
>$5 BILLION

1. 2025 data for LG IR NMIBC patients who underwent bladder tumor resection captured in Cardinal Health Specialty Networks™ PPS Analytics Patient Population Health Management Platform; IVe Tx includes induction and/or maintenance

2. Represents estimated full potential FGFR3+ IR NMIBC market at full penetration of branded agents; based on LEK research.

# UTUC

# Dabogratinib could address specific unmet needs in LG UTUC




**UPPER TRACT UROTHELIAL CARCINOMA**

Same histology as bladder cancer. Affects upper urinary tract including renal pelvis and ureters.

## LOW GRADE UTUC

No high grade on biopsy or cytology

**~85%**
FGFR3+

**~3,000**
FGFR3+ seeking new treatment each year

## UNMET NEED

### ANATOMY

Ureter length, orientation, and intra-renal anatomy presents challenges with diagnosis and treatment

### TREATMENT

Repetitive, burdensome surgeries and procedures with high rates of complications and potential for loss of kidney

Oncology figures represent US incidence and recurrences; Oracle Life Sciences analysis; Sfakianos, 2015, Moss, 2017; Nassar 2019

# Current kidney-sparing endoscopic surgery SoC has drawbacks



## SIGNIFICANT RISKS

### MISSED TUMORS

≤25% missed due to challenging anatomy and ~30% multifocality

### SURGERY

General anesthesia

Intra- and post-operative complications

## POOR OUTCOMES

### RECURRENCE AND PROGRESSION

**ALL LG TUMORS**

~35–50% recur within 3 years

**LG TUMORS >2cm**

90.5% recur (median 4.9 mo)

31.7% progress (median 26.3 months)

### KIDNEY REMOVAL

After recurrence or progression, proceed to radical nephroureterectomy

(Can result in chronic dialysis, and increased CV morbidity, mortality)

Yamany, 2015; Shvero, 2021; Scotland, 2018; Cutress, 2012

# Jelmyto, is more effective but comes with many limitations

## Efficacy

58% CR rate

56% 12-month DoR

### Eligibility

Renal pelvis (not ureters)

Tumors 5–15mm in size

### Safety

58% Ureteric obstruction

41% Flank pain

34% Hematuria

34% UTI

25% Renal dysfunction

24% discontinuation

### Administration

6 instillations:

- Ureteral catheter with fluoroscopy or antegrade nephrostomy tube
- Local anesthesia

### Preparation

- >40 steps
- Refrigeration and reconstitution
- 45–60 minutes



JELMYTO package insert and website accessed September 5, 2025

# First LG UTUC patient has been dosed in Dabogratinib Ph2 Study

SURF303

LG UTUC, Marker Lesion Study
Dabogratinib (TYRA-300)
NCT07265947

## Key Eligibility Criteria

Adults (≥18 years)

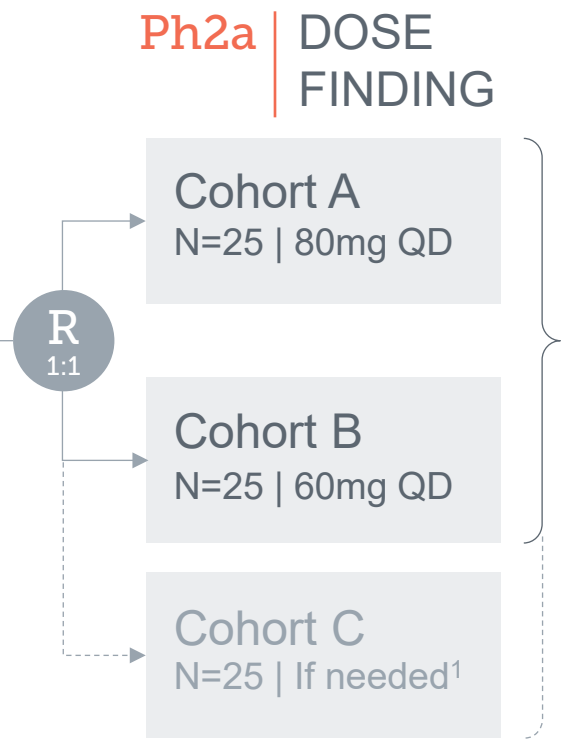
LR, LG UTUC based on AUA Guidelines, 2024

- No high-grade histology on biopsy or cytology
- No invasion or adenopathy on imaging

At least 1 marker lesion; total aggregate ≥5mm

Prescreening includes: urine sample for tumor genomics, tissue sample for retrospective sequencing for FGFR3-gene activating alterations, consent to provide prior tumor genomics report and consent to allow marker lesion(s) to remain *in situ*

Stratification by aggregate tumor baseline size prior to resection <1.5cm vs. ≥1.5cm




1. Optional if needed start after initial data review of 60 mg QD and 80 mg QD, as needed

## Primary Endpoint

CR within 6 months in *FGFR3+* patients

## Secondary Endpoints

- CR within 6 mos in all comers
- DOR
- Safety and tolerability
- Conversion of unresectable to resectable disease

Q3 month disease assessments to 18 mo; Q6 month thereafter. Treatment allowed up to 24mo. Patients who do not achieve a CR at 3mo may continue to mo 6 if ML reductions at mo 3 are ≥50%

Abbreviations: LG, low grade; LR, low risk; UTUC, upper tract urothelial carcinoma; R, randomized; CR, complete response; DOR, duration of response; FGFR3, Fibroblast Growth Factor Receptor 3; QD, once daily; ML, marker lesion

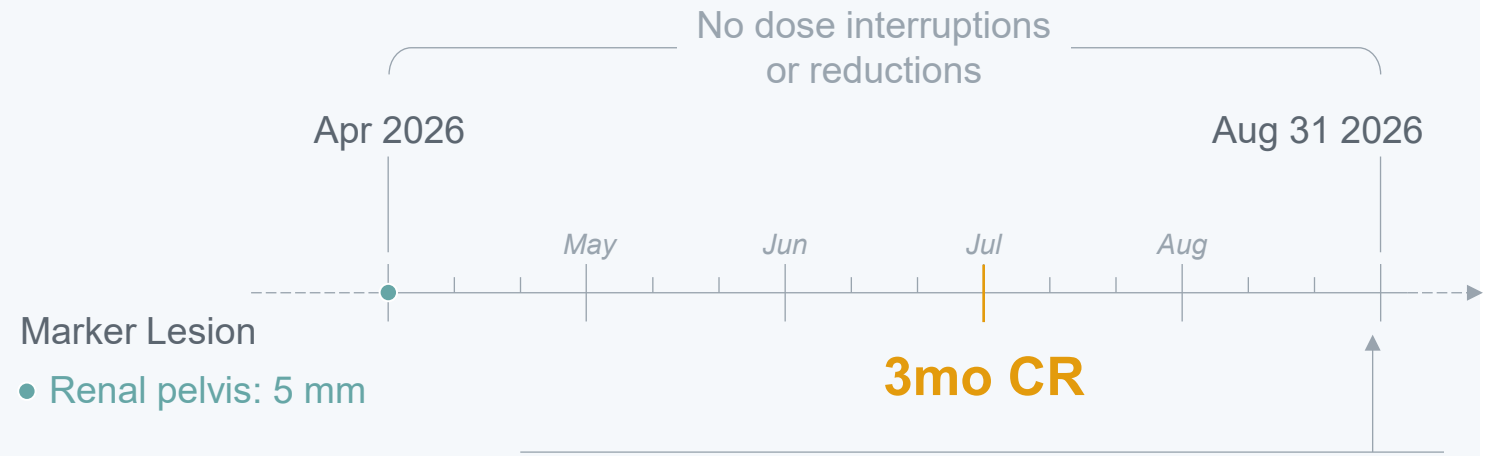
# 60mg activity extends from IR NMIBC to first LG UTUC patient

SURF303

## COMPLETE RESPONSE

73-year-old male, 60mg QD

| | |
|---|---|
| Disease History | LG UTUC, Initial diagnosis date: 2024 |
| Medical History | T2DM, BPH, CAD, cataracts, retinal pigment epithelial mottling, UTI (ongoing at C1D1) |
| Prior UTUC treatment | Fulguration (x3); Jelmyto (2025; completed Tx, recurrence 2026) |



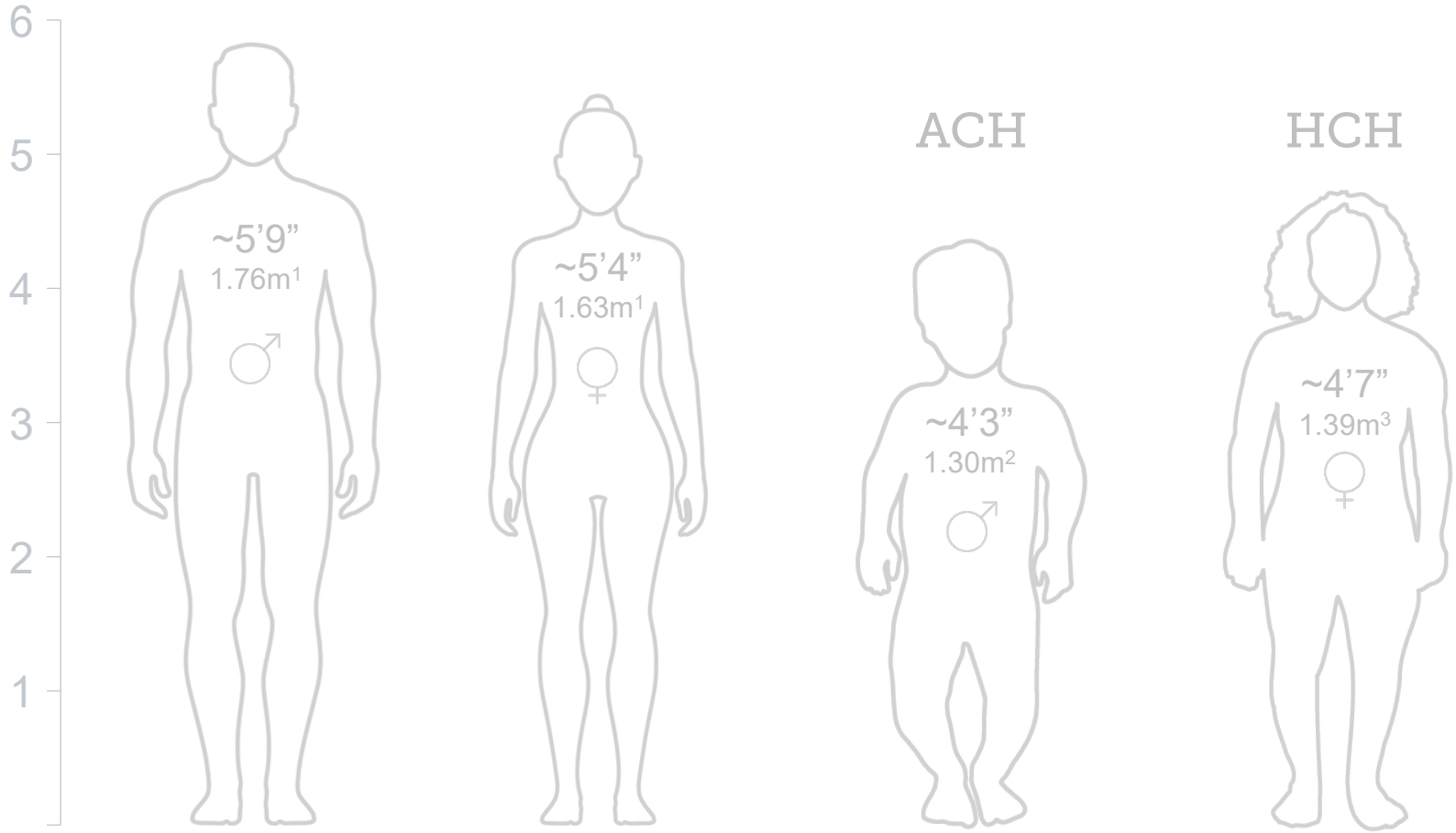

Data as of August 31, 2026

# ACHONDROPLASIA

# Inhibiting FGFR3 may benefit people with skeletal dysplasia

## FGFR3

*Over-activation of this protein in bone growth plates underlies both ACH and HCH*




1. CDC Vital and Health Statistics (represents average US male and female heights for ages 20-29); 2. Hoover-Fong, 2021 (represents average ACH adult male height);
3. Cheung, 2023 (represents average HCH female height at age 16)

# ACH can result in serious clinical complications



*ACH is the most common cause of disproportionate short stature*

## MECHANISM

*FGFR3* G380R gain of function mutation drives ~99% of ACH[1,2]

FGFR3 inhibits chondrocyte proliferation and differentiation, resulting in disorganized growth plates and dysregulated bone growth[2]

## COMPLICATIONS

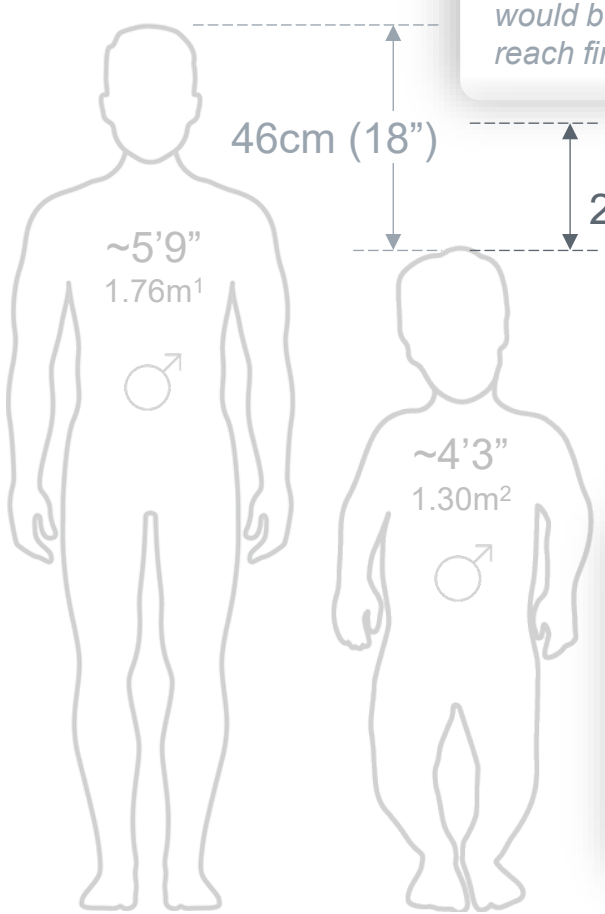
Infants can face serious complications related to critical foramen magnum stenosis[1,3]

Children and adults may experience pain, multiple surgeries, and functional limitations (e.g., reach, stride)

1. Pauli et al., 2019; 2. Ornitz and Legeai-Mallet, 2017; 3. Hecht et al., 1987

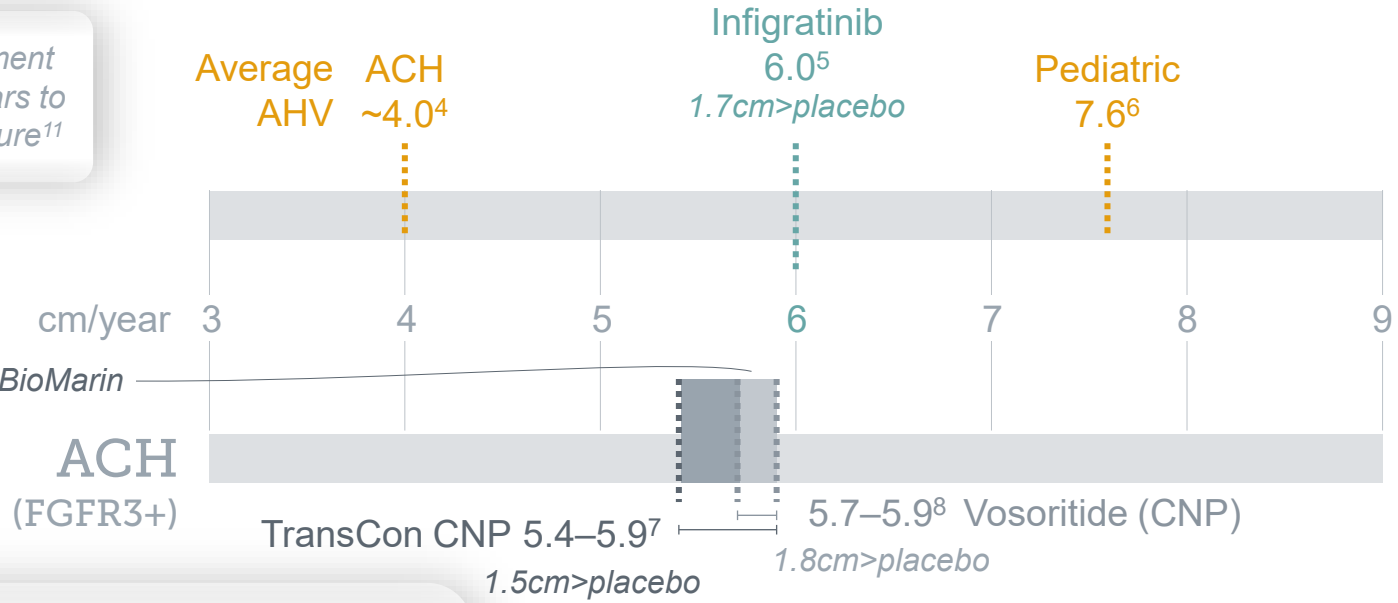
# ~6cm AHV is potentially leaving efficacy on the table

*~2.7cm/yr avg AHV improvement would be needed over 17 years to reach final average male stature[11]*




26 cm (10”)[3]

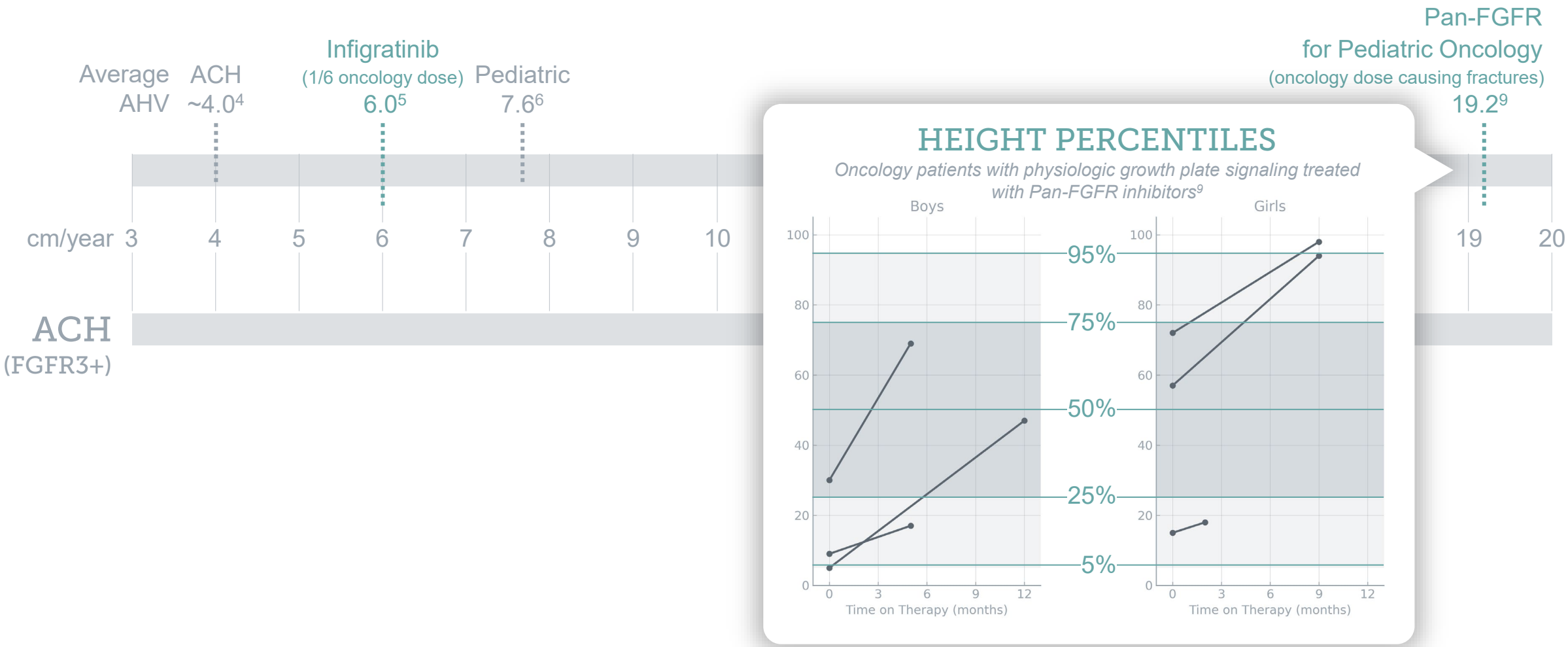
*Per BioMarin*




Further engaging FGFR3 and achieving a higher AHV could potentially benefit key sequelae like reach and gait, and potentially reduce spinal stenosis / surgeries.

1. CDC Vital and Health Statistics (represents average US male and female heights for ages 20-29); 2. Hoover Fong, 2021 (represents average ACH adult male height); 3. Potential total height gain from VOXZOGO BMRN 5/12/25 Press Release; 4. Savarirayan, 2021 (5 to 14yrs); 5. 6.0 AHV from Ph2 Cohort 5 12mo data, Savarirayan, 2024; 6.0 LS mean AHV and 1.7 LS mean absolute AHV improvement vs placebo data based on Ph3 study (n=113), BBIO 2/12/26 Corporate Presentation; infigratinib showed 1.7cm LS mean change from baseline AHV improvement over placebo; 6. Merck Manuals (12mo to 10yrs); 7. 5.4 AHV from Ph2 100 µg/kg/week cohort 6mo data (n=11) Ascendis 11/14/22 Corporate Presentation; 5.9 LS mean AHV and 1.5 LS mean absolute AHV improvement vs placebo data based on Ph3 study (n=84), Savarirayan, 2025; 8. 5.9 from Ph2 Cohort 3 12mo Data (n=10), Savarirayan, 2019; 5.7 LS mean and 1.8 LS mean absolute AHV improvement vs placebo data based on VOXZOGO prescribing information 10/2023 (n=121); VOXZOGO showed 1.6cm LS mean change from baseline AHV improvement over placebo; 9. 19.2 represents AHV for three pediatric oncology case studies with available height velocity data; Sait, 2023; 10. BioMarin 05/04/24 press release; 12mo data from Ph2 (n=8) Investigator initiated study in ISS (ACAN Deficiency, NPR2 Mutation) and Noonan Syndrome 11. Calculation assumes male growth plate closure at 17 years of age, Sarafoglou, 2009

# FGFR3 inhibition has been shown to accelerate height velocity

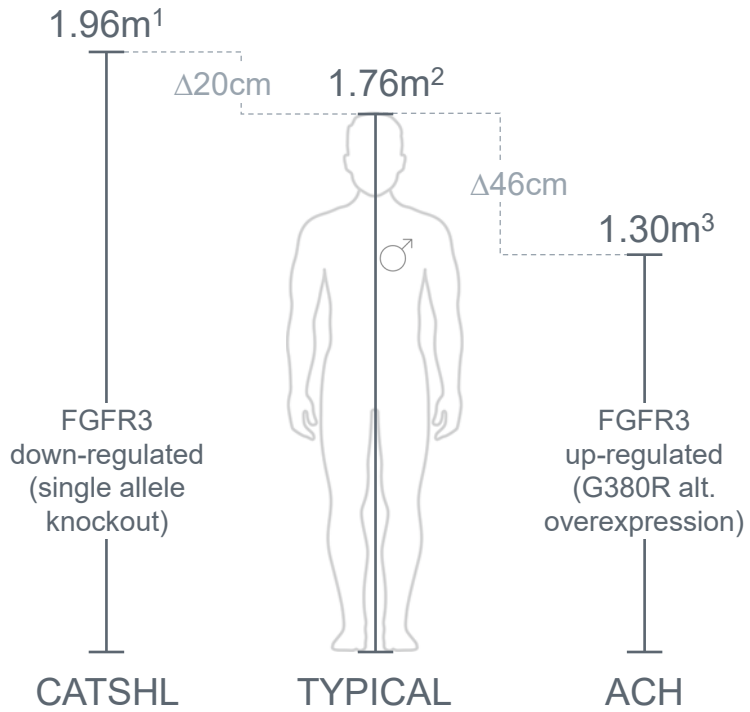



1. CDC Vital and Health Statistics (represents average US male and female heights for ages 20-29); 2. Hoover Fong, 2021 (represents average ACH adult male height); 3. Potential total height gain from VOXZOGO BMRN 5/12/25 Press Release; 4. Savarirayan, 2021 (5 to 14yrs); 5. 6.0 AHV from Ph2 Cohort 5 12mo data, Savarirayan, 2024; 6.0 LS mean AHV and 1.7 LS mean absolute AHV improvement vs placebo data based on Ph3 study (n=113), BBIO 2/12/26 Corporate Presentation; infigratinib showed 1.7cm LS mean change from baseline AHV improvement over placebo; 6. Merck Manuals (12mo to 10yrs); 7. 5.4 AHV from Ph2 100 µg/kg/week cohort 6mo data (n=11) Ascendis 11/14/22 Corporate Presentation; 5.9 LS mean AHV and 1.5 LS mean absolute AHV improvement vs placebo data based on Ph3 study (n=84), Savarirayan, 2025; 8. 5.9 from Ph2 Cohort 3 12mo Data (n=10), Savarirayan, 2019; 5.7 LS mean and 1.8 LS mean absolute AHV improvement vs placebo data based on VOXZOGO prescribing information 10/2023 (n=121); VOXZOGO showed 1.6cm LS mean change from baseline AHV improvement over placebo; 9. 19.2 represents AHV for three pediatric oncology case studies with available height velocity data; Sait, 2023; 10. BioMarin 05/04/24 press release; 12mo data from Ph2 (n=8) Investigator initiated study in ISS (ACAN Deficiency, NPR2 Mutation) and Noonan Syndrome 11. Calculation assumes male growth plate closure at 17 years of age, Sarafoglou, 2009

# Evidence points to FGFR3 inhibition potential beyond ACH

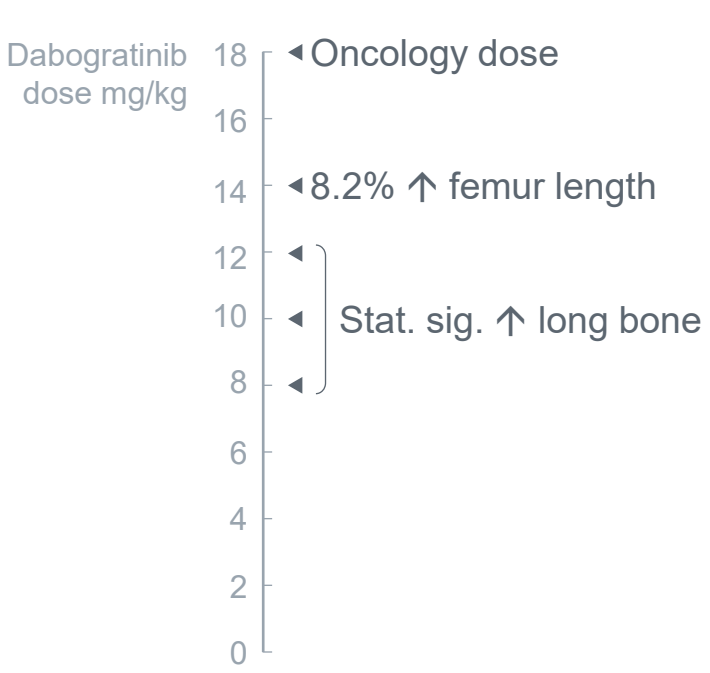
## GENETIC

FGFR3 mutation phenotypes point to a key role in regulating bone growth.



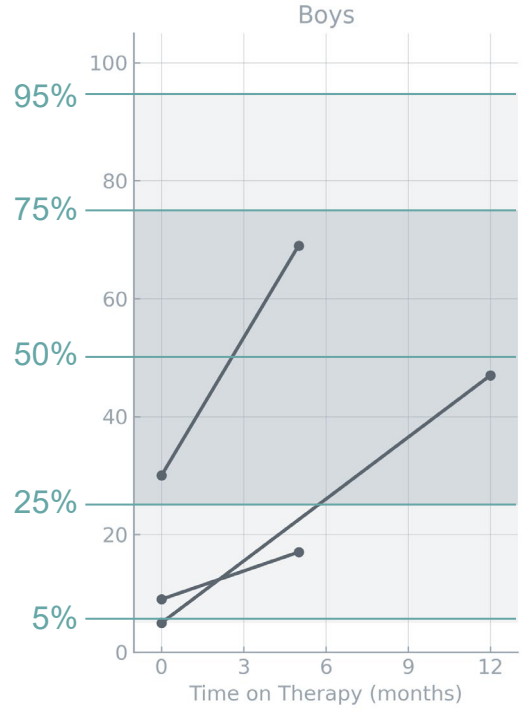

## PRECLINICAL

FGFR3 inhibition below an $IC_{90}$ drove hyper-typical growth in WT mice.[4]




## CLINICAL

Oncology doses of pan-FGFR drive hyper-typical growth in pediatric cancers.[5]




**HEIGHT PERCENTILES**

*Pediatric oncology patients with physiologic growth plate signaling treated with Pan-FGFR inhibitors*[3]

1. Toydemir, 2026; 2. CDC Vital and Health Statistics (represents average US male and female heights for ages 20-29); 3. Hoover-Fong, 2021 (represents average ACH adult male height); 4. Starett, 2025; 5. Sait, 2023

# Safety sentinel cohort expanded with DL5 in Ph2 BEACH301

BEACH 301

## Sentinel Safety Cohort

ACH age 5-10

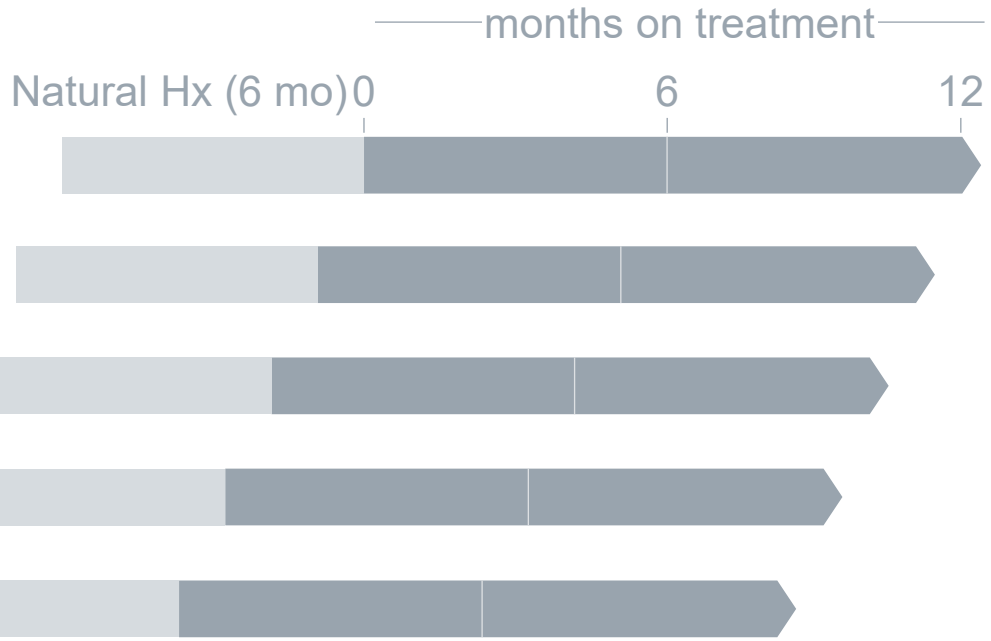
No run-in

Anticipate n=~25 total enrollment

| | DOSE (mg/kg) |
|---|---|
| ✓ | 0.625 |
| ✓ | 0.50 |
| ✓ | 0.375 |
| ✓ | 0.25 |
| ✓ | 0.125 |

## Cohorts 1 and 2*

| N=* | DOSE (mg/kg) |
|---|---|
| 6 | 0.625 |
| 6 | 0.50 |
| 6 | 0.375 |
| 6 | 0.25 |
| 6 | 0.125 |




*Cohort 1 (6-mo run-in)
Treatment naïve;
ACH age 3-10

*Cohort 2 (6-mo run-in)
Received prior growth-accelerating therapy; ACH age 3-10

*Dose decisions based on 6 participants. Additional participants may be assigned at discretion of Sponsor

# There are many development opportunities beyond ACH and HCH

## FGFR3 GERMLINE MUTATIONS

SKELETAL DYSPLASIA

**Achondroplasia (~3K)** ← *ODD & RPD granted*

**Hypochondroplasia (~2K)**

Thanatophoric dysplasia

SADDAN syndrome

Double dominant ACH

CRANIOSYNOSTOSIS

Crouzon syndrome with acanthosis nigricans

Muenke syndrome

## OTHER GENETIC SHORT STATURE

**Leri-Weill dyschondrosteosis (~26K)**

Turner syndrome (~10K)

Osteogenesis imperfecta (~4K)

Mucopolysaccharidoses IVA and VI

Laron syndrome (Growth Hormone Insensitivity)

## PEDIATRIC SHORT STATURE

Genetic and Idiopathic short stature (~700K[1])

Addressable US pediatric population; Source: company research

1. Represents children ages 4-17 under 2.25 standard deviations from mean height

# Gearing up for potential pivotal trials in 3 blockbuster indications

## Validated Target

FGFR3 alterations drive conditions with high unmet needs

## Differentiated Molecule

DABOGRATINIB

The first oral, once-daily, highly selective FGFR3 inhibitor

60mg PoC IR NMIBC Patients

- All MLs: 79% ORR and 64% BOR CR rate (n=14)
- Single MLs: 100% ORR & 75% BOR CR rate (n=8)

## 3 Potential Blockbuster Indications

| | EXPECTED |
|---|---|
| ACH – Initial results (n=~25 sentinel DL1-5) | End of 1Q27 |
| IR NMIBC – Adjuvant Ph3 Initiation | 2027 |
| LG UTUC – Initial results | 2027 |

NASDAQ: TYRA

CASH: $727M (Pro-forma 2Q26)*

DABO$3^3$

*TYRA ended 2Q26 with $353.9M in cash, cash equivalents, and marketable securities. Pro forma cash reflects the net proceeds from the company's offering of common stock and pre-funded warrants in September 2026
ACH: Achondroplasia; IR NMIBC: Intermediate Risk Non-Muscle-Invasive Bladder Cancer; LG UTUC: Low Grade Upper Tract Urothelial Carcinoma; ML Marker Lesion;
ORR: Overall Response Rate; BOR: Best overall Response; CR: Complete Response; DL: Dose Level
All TYRA small molecule inhibitors are for investigational use only