TEMPEST

THERAPEUTICS

TPST-1120 Randomized Data in First-Line HCC

October 11, 2023

Forward-Looking Statements

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New TPST-1120 Data Support Pivotal Study in First-Line Liver Cancer Program Emerging as a Potential Franchise

Programs

Updated randomized 1L HCC data reveals substantial lead over standard of care

- ✓ ORR of 1120 arm is independent of PD-L1 or inflamed tumor status
- ✓ OS HR favors 1120 and median not reached
- ✓ Biomarker data further support dual MOA of TPST-1120

- ✓ Beyond HCC: positive data in RCC & CCA
- ✓ Three additional programs - diversified portfolio

Strategy

Focused on indications with potential for substantial impact

Programs fully owned; BD optionality

Team

Experienced in novel drug discovery, development, and delivering value

Catalysts

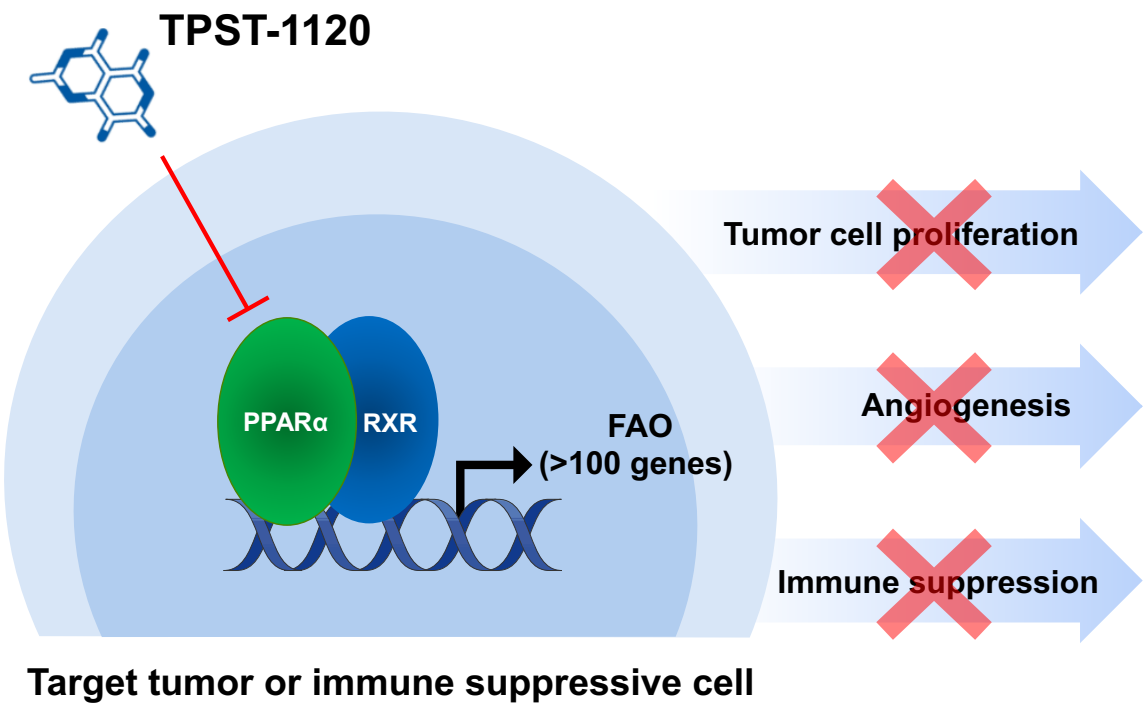
Multiple potential value-creating milestones through 2024

TPST-1120

First-in-Class PPARα Antagonist

TPST-1120: First-in-Class[1] PPARα Antagonist

Targets both tumor cells and immune suppressive cells



Targets FAO-dependent tumors
(on-tumor activity)

Targets angiogenesis distinct from VEGF inhibitors
(combination opportunity)

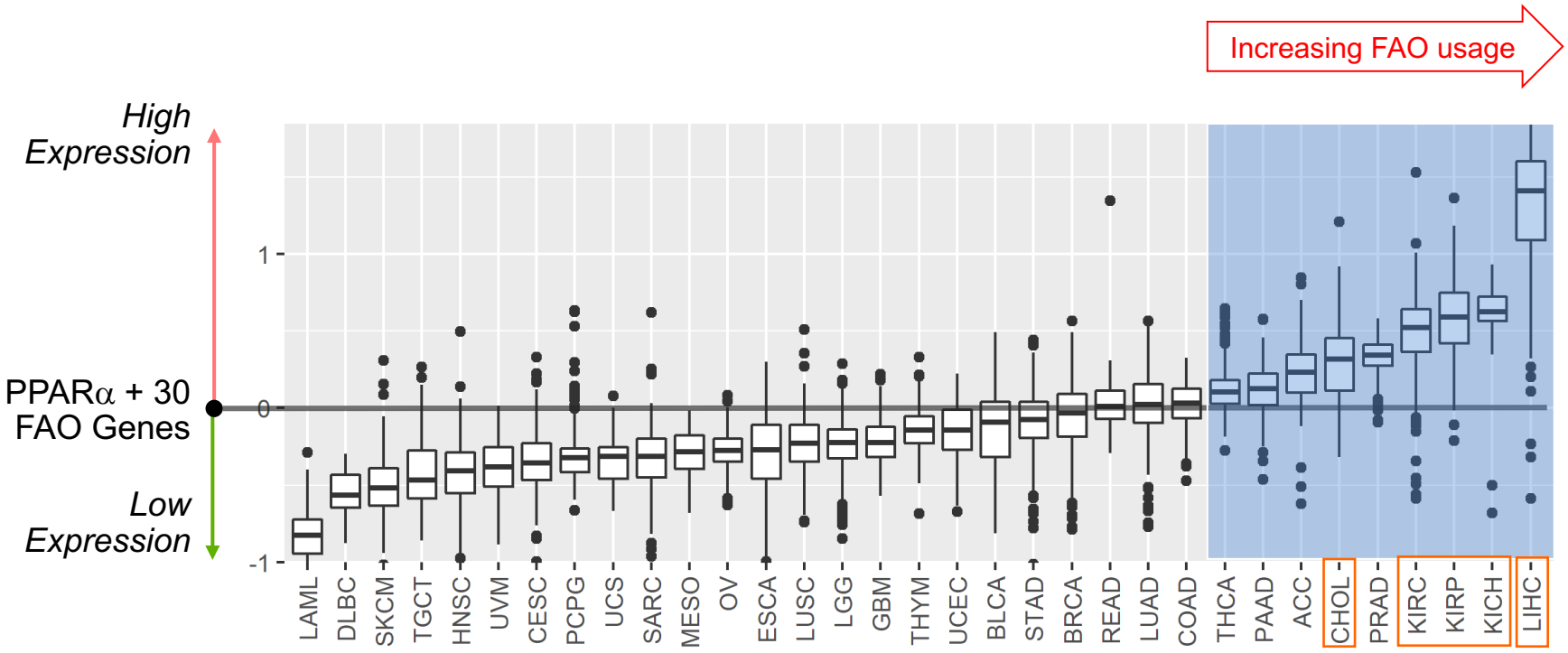
Targets FAO-dependent immune suppressor cells
(ICI combination opportunity)

PPARα: Peroxisome Proliferator-Activated Receptor alpha

[1]First-in-Class status is dependent on FDA approval

FAO-Dependent Tumors Inform Clinical Strategy

TCGA-based analysis of tumor metabolic gene expression profiles



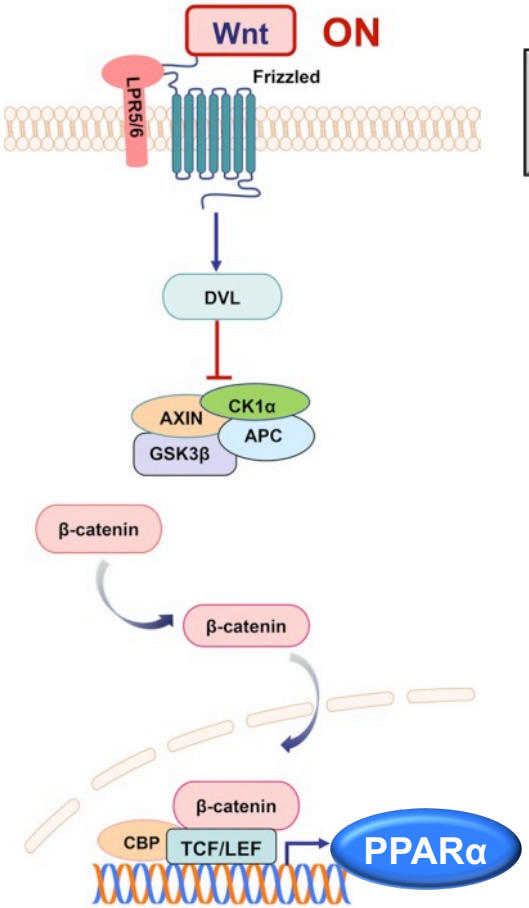
Focus on FAO-dependent tumors: **HCC**, **RCC**, prostate, **cholangiocarcinoma**, pancreas, NSCLC, CRC

Positive data in HCC, RCC & CCA

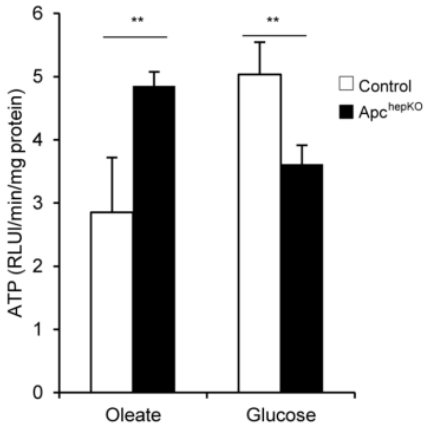
Activated β-Catenin Pathway Induces PPARα Expression and Reliance on FAO

Identifying cancers with increased sensitivity to TPST-1120

Activated β-catenin pathway

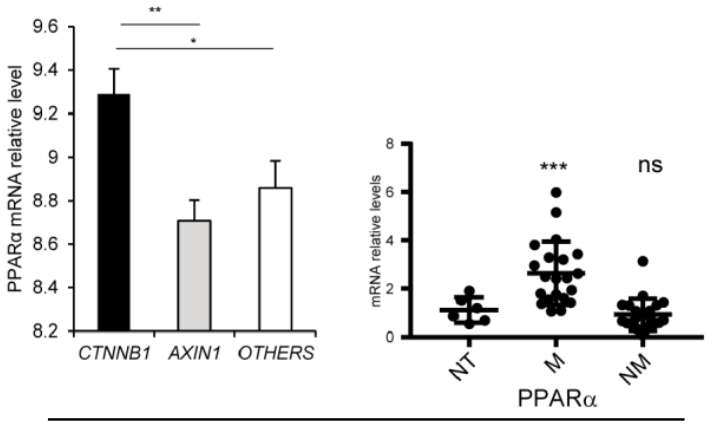


Increased FAO in β-catenin-activated hepatocytes



Mouse

Enhanced PPARα expression in β-catenin mutant HCC

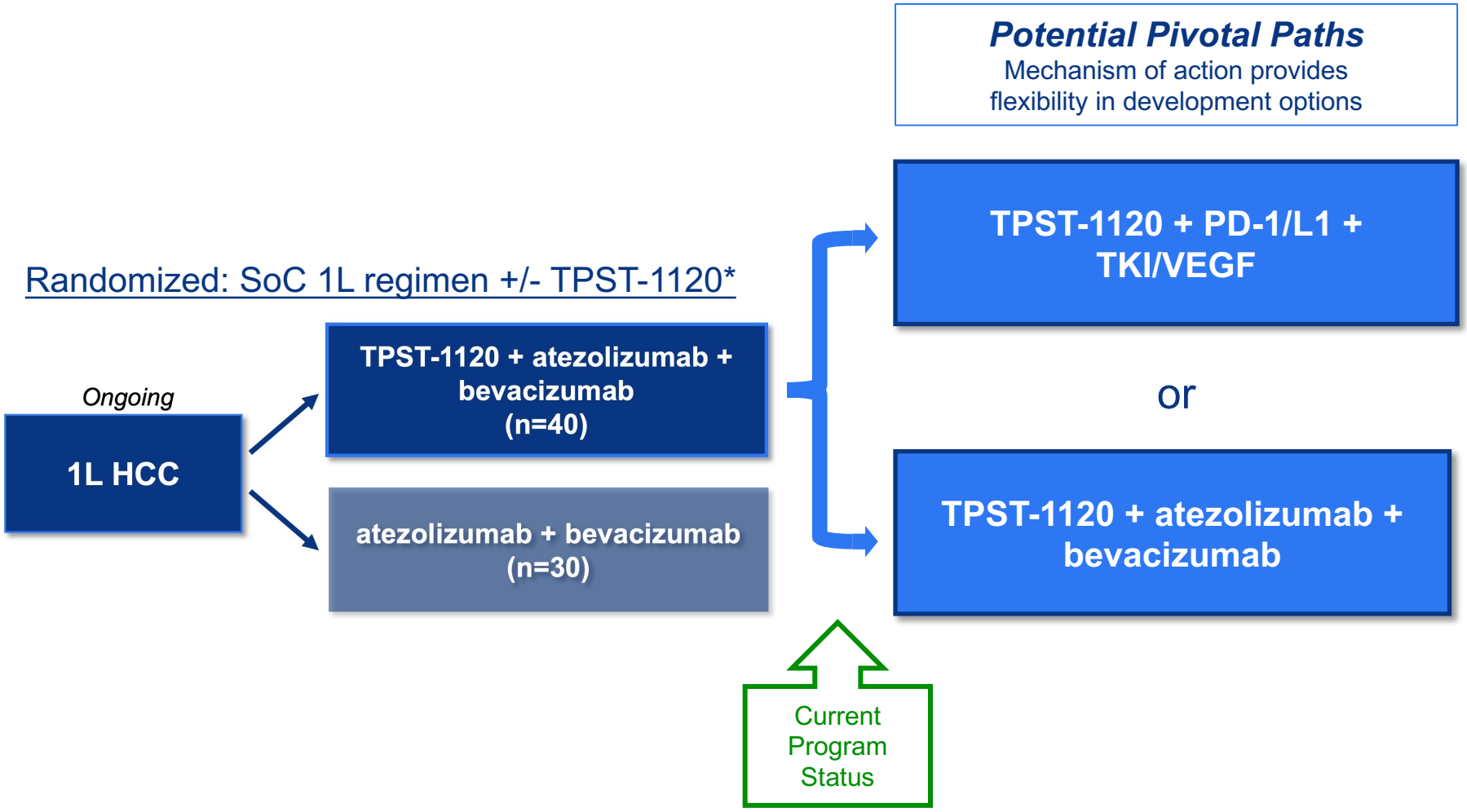


Human

Refs: Yang (2020) J. hematology and Oncology, 13:165, Senni (2019) Gut, 68:322.

TPST-1120 in Front-Line Phase 1b/2 HCC Randomized Study

Global study* accelerated program to pivotal readiness; Tempest retains all rights to program



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* Morpheus HCC study in collaboration with Roche (NCT04524871); same inclusion criteria as IMbrave 150; primary endpoint is ORR; PFS and OS secondary

TPST-1120 Randomized Clinical Data

First-Line HCC Compared to Standard of Care

TPST-1120 Arm Improves All Efficacy Endpoints vs. Control

	atezo/bev N=30	TPST-1120 + atezo/bev N=40
Confirmed ORR (overall population)	13.3%	**30%**
Confirmed ORR (β-catenin mutation)	N/A[1]	**43% (100% DCR)**
PD-L1 Neg Patients Confirmed ORR	7%	**27%**
mPFS **HR 0.7**	4.27m (2.8, 7.3)	**7m** (5.6, 13.8)
mOS **HR 0.59**	15.1m	**NR**

- **Biomarkers and pharmacodynamic data support MOA of TPST-1120**
  - Consistent with mechanism, β-catenin activation and FAO upregulation preferentially improve activity in TPST-1120 arm vs atezo+bev control
  - Consistent with mechanism, TPST-1120 improves activity of atezo+bev in PD-L1 negative and immune desert/excluded phenotype
- **Favorable safety profile**
  - No increase in high grade AEs, treatment discontinuation, or dose holds/reductions on TPST-1120 arm vs atezo + bev arm; no decrease in atezo or bev dose intensity on TPST-1120 arm
- **Pivotal study of TPST-1120 in 1L HCC is the next appropriate step**

[1] Data not provided.

Subject Disposition Continues to Favor TPST-1120 Arm

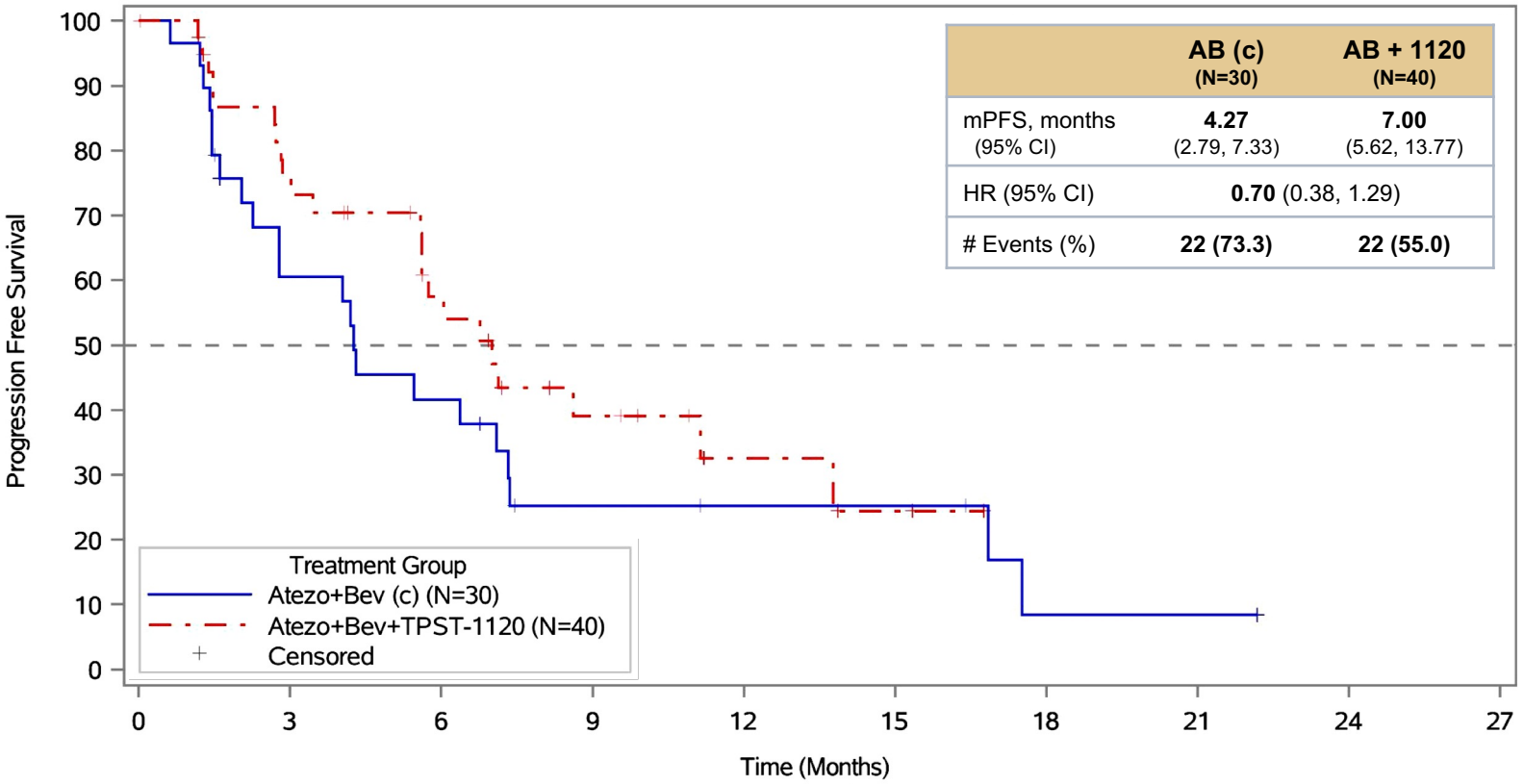
Patients are on drug and surviving longer with the addition of TPST-1120

	Atezo+Bev (c) (N=30)	%	TPST-1120+ Atezo+Bev (N=40)	%
On Study	14	46.7%	29	72.5%
On Treatment	5	16.7%	16	40.0%
Off Treatment in survival follow-up	9	30.0%	13	32.5%
Off Study	16	53.3%	11	27.5%
Death	14	46.7%	10	25.0%
Withdrew Consent	2	6.7%	1	2.5%

- On Study Treatment: 40% (16) of TPST-1120 subjects vs 16.7 (5) of control subjects
- Subjects Alive: 75% (30) of TPST-1120 subjects vs 53.3% (16) of control subjects
- Median Duration of Follow-up: TPST-1120 arm **9.23 mo,** Atezo+Bev arm **9.89 mo**

PFS: Important Endpoint Favors TPST-1120 Arm

TPST-1120 + Atezo/Bev vs. Atezo-Bev



	AB (c) (N=30)	AB + 1120 (N=40)
mPFS, months (95% CI)	**4.27** (2.79, 7.33)	**7.00** (5.62, 13.77)
HR (95% CI)	**0.70** (0.38, 1.29)	
# Events (%)	**22 (73.3)**	**22 (55.0)**

AB (c)	30	16	11	5	4	4	1	1	NE	NE
AB + 1120	40	28	17	9	4	2	NE	NE	NE	NE

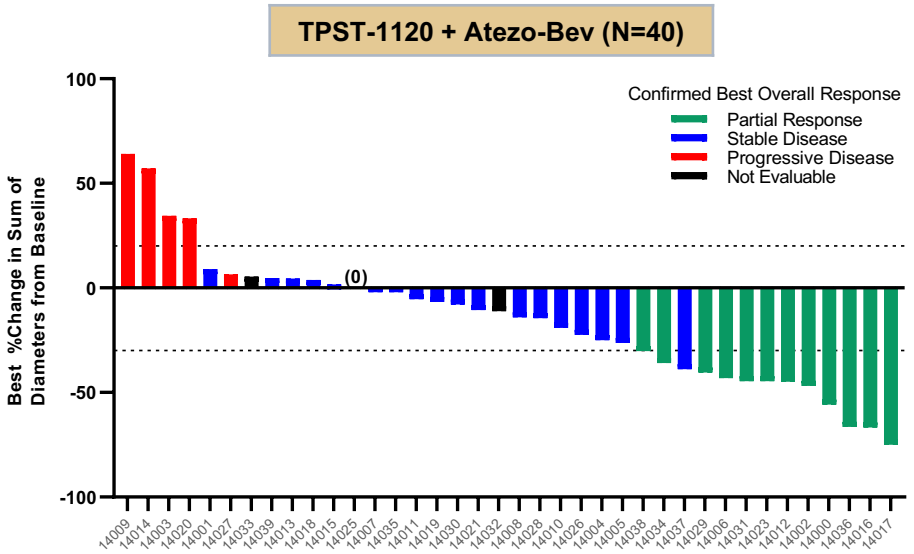
AB = Atezo + Bev; (c) indicates the control arm; AB + 1120 = Atezo + Bev + TPST-1120
CCOD: 20APR2023

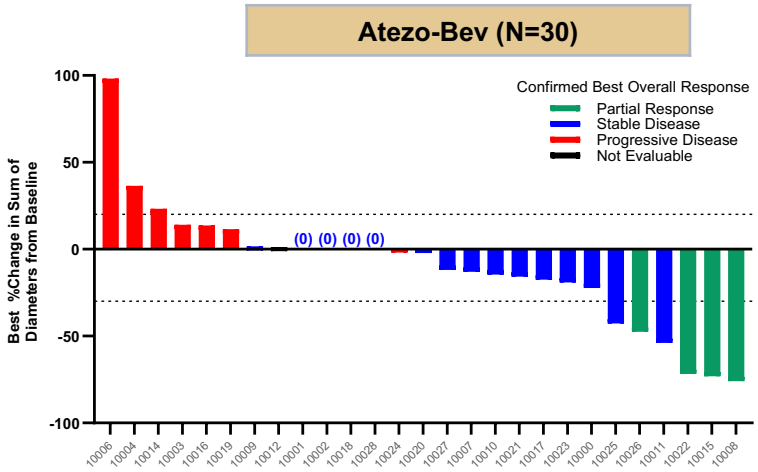
TPST-1120 More than Doubles Response Rate of Atezo+Bev

Confirmed ORR of 30% vs. 13.3%

TPST-1120 + Atezo-Bev, N=40 (% N)	
Responders	**12 (30.0)**
Partial Response	12 (30.0)
Stable Disease	18 (45.0)
Progressive Disease	6 (15.0)
Not Evaluable	3 (7.5)
Missing	1 (2.5)
Pts with tumor shrinkage	26 (65)

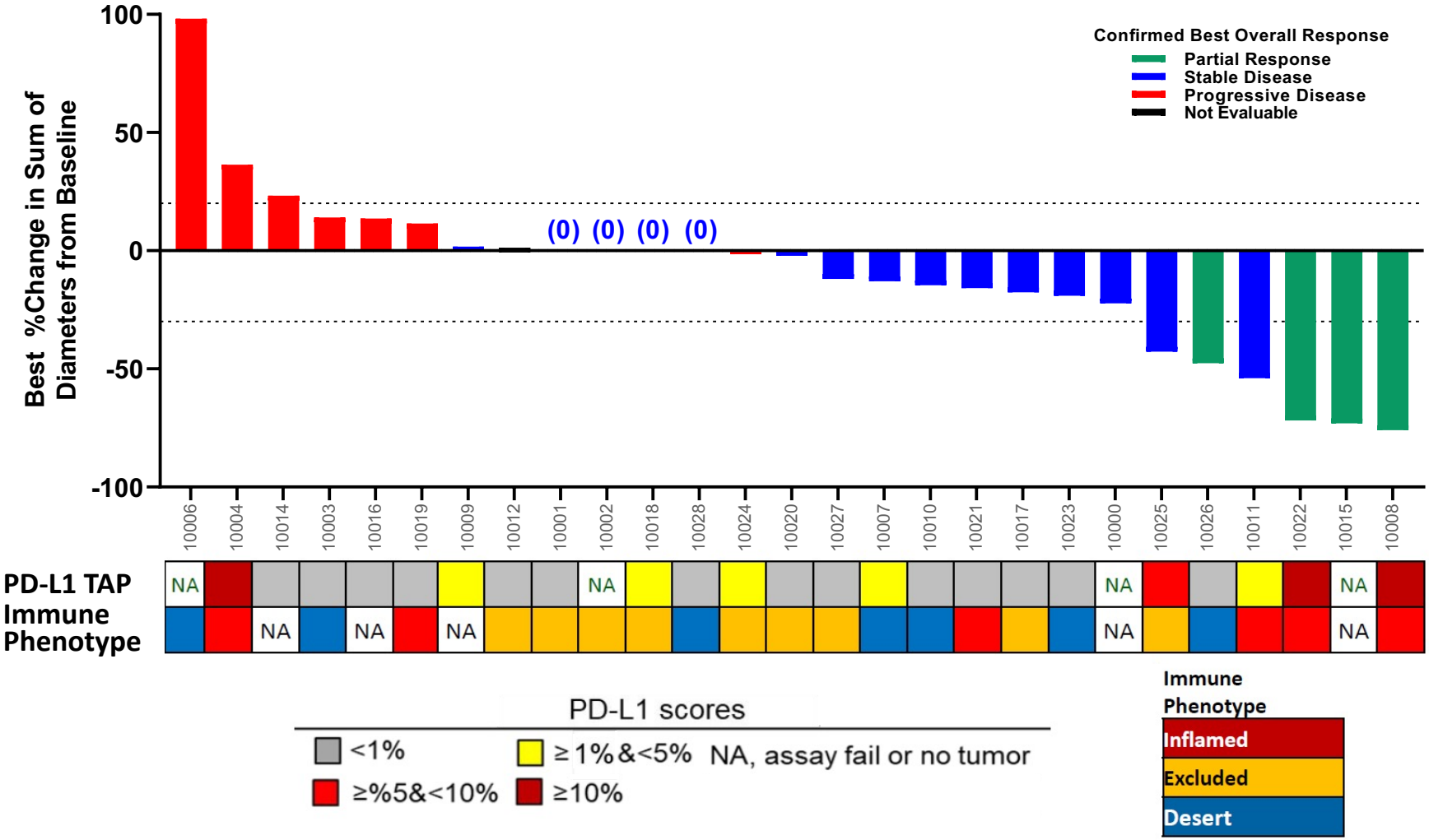
Atezo-Bev, N=30 (% N)	
Responders	**4 (13.3)**
Partial Response	4 (13.3)
Stable Disease	15 (50.0)
Progressive Disease	8 (26.7)
Not Evaluable	1 (3.3)
Missing	2 (6.7)
Pts with tumor shrinkage	15 (50)





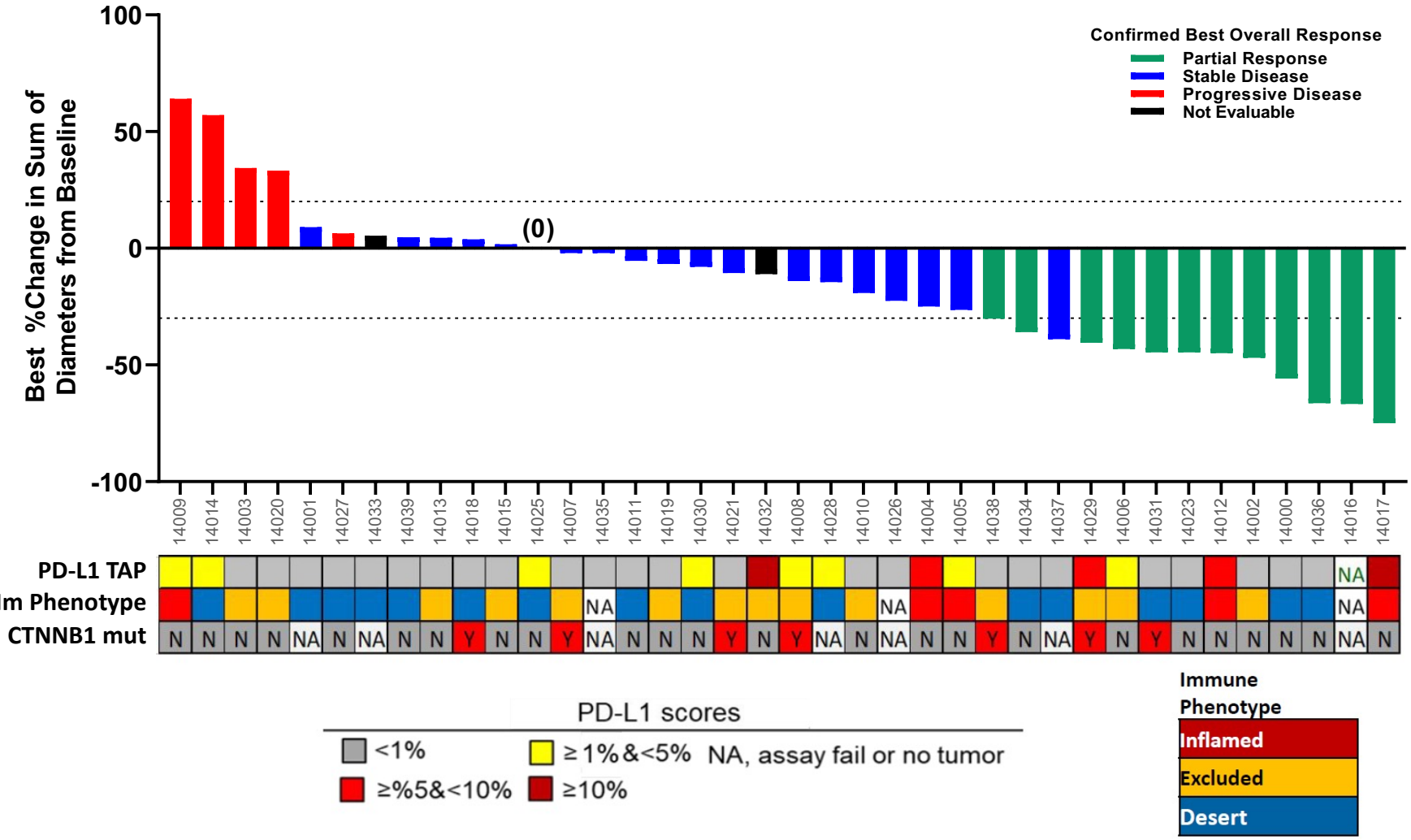
PD-L1+ and/or Inflamed Phenotype Enriched in Control Arm Responses

Atezo + Bev biomarker associations



TPST-1120 Arm Responses Independent of PD-L1+ and/or Inflamed Tumor Status

43% ORR and 100% DCR in CTNNB1-mutated disease: in-line with TPST-1120 MOA



Safety for TPST-1120 + Atezo + Bev

Triplet arm is well tolerated compared to atezo + bev doublet control arm

	Atezo + Bev (n=30)	**TPST-1120 + AB** (n=40)
Fatal AEs (Grade 5)	4 (13.3%)	3 (7.5%)
Grade 3-4 AEs	18 (60%)	21 (52.5%)
AEs leading to		
Treatment discontinuation	5 (16.7%)	3 (7.5%)
Dose Modification/Interruption	8 (26.7%)	7 (17.5%)
Related SAE	8 (26.7%)	9 (22.5%)
irAEs*	20 (66.7%)	27 (67.5%)

*hepatitis, rash, infusion rxn, colitis, hypothyroidism, hyperthyroidism, diabetes, pneumonitis

Drug Dose Intensity			
Study Arm	Atezolizumab	Bevacizumab	TPST-1120
Control	88.9%	83.3%	NA
TPST-1120	93.2%	84.5%	93.6%

Balanced Demographics and Baseline Characteristics

Generally balanced, but if "Push comes to Shove," bias should *favor* the control arm

Demographic	Result	Atezo+Bev (c) (N=30)	TPST-1120 + Atezo+Bev (N=40)
Age group (yr)	>=65	12 (40.0%)	25 (62.5%)
Sex	Male	26 (86.7%)	33 (82.5%)
ECOG Status	0[a]	22 (73.3%)	26 (65.0%)
Disease due to viral hepatitis[b]	Yes	16 (53.3%)	26 (65%)
Macrovascular Invasion and/or Extrahepatic spread	Yes	14 (46.7%)	21 (52.5%)
Baseline alpha-feto protein ≥ 400 ug/L	≥ 400 ug/L	17 (56.7%)	16 (40%)
Region of enrollment	Asia (vs ROW)	8 (26.7%)	14 (35.0%)
Baseline neutrophil to lymphocyte (NLR) ratio[c]	≥5	4 (13.3%)	11 (27.5%)
PD-L1 Negative	Neg (TAP<1)	15 (60%)[d]	26 (67%)[e]

ECOG status, MVI/EHS, Age, baseline NLR, PD-L1 status all favor the control arm, whereas AFP and region of enrollment favor the 1120 arm

[a] ECOG status 0 indicates healthier patients

[b] IMbrave150 update showed that atezo+bev regimen performed similarly in viral vs non-viral disease[1]

[c] A number of recent studies have reported that baseline NLR is predictive of ORR and/or OS in HCC with atezo + bev regimen[2]

[d]25 subjects PD-L1 evaluable; [e]39 subjects PD-L1 evaluable

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[1] Cheng AL, et al. Updated efficacy and safety data from IMbrave150: Atezolizumab plus bevacizumab vs. sorafenib for unresectable hepatocellular carcinoma. Journal of Hepatology 2022 vol. 76 862–873; Espinoza M, et al. Disease Etiology and Outcomes After Atezolizumab Plus Bevacizumab in Hepatocellular Carcinoma: Post-Hoc Analysis of IMbrave150 [published online ahead of print, 2023 Mar 7]. Gastroenterology. 2023;S0016-5085(23)00234-2. [2] Eso, Y. et al. Pretreatment Neutrophil-to-Lymphocyte Ratio as a Predictive Marker of Response to Atezolizumab Plus Bevacizumab for Hepatocellular Carcinoma. Curr. Oncol. 2021, 28, 4157–4166.; Chon YE, et al. Predictive biomarkers of survival in patients with advanced hepatocellular carcinoma receiving atezolizumab plus bevacizumab treatment. Cancer Medicine. 2023;12:2731–2738

TPST-1120 is Pivotal Study-Ready and Has Broad Potential

Direct evidence of activity: ORR, PFS, OS, safety & biomarkers **all support** moving forward

- First-line HCC pivotal study strongly warranted with anti-PD-(L)1 and anti-VEGF/TKI combination
  - Roche looking beyond atezo-bev as the standard of care: moved quickly to initiate TIGIT triplet in a pivotal study
  - TPST-1120 is poised to further strengthen current SoC or enable competition

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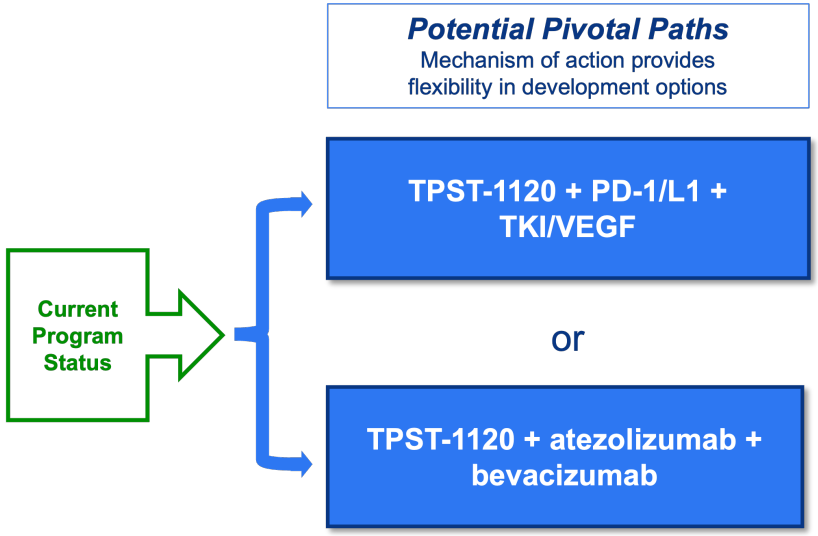
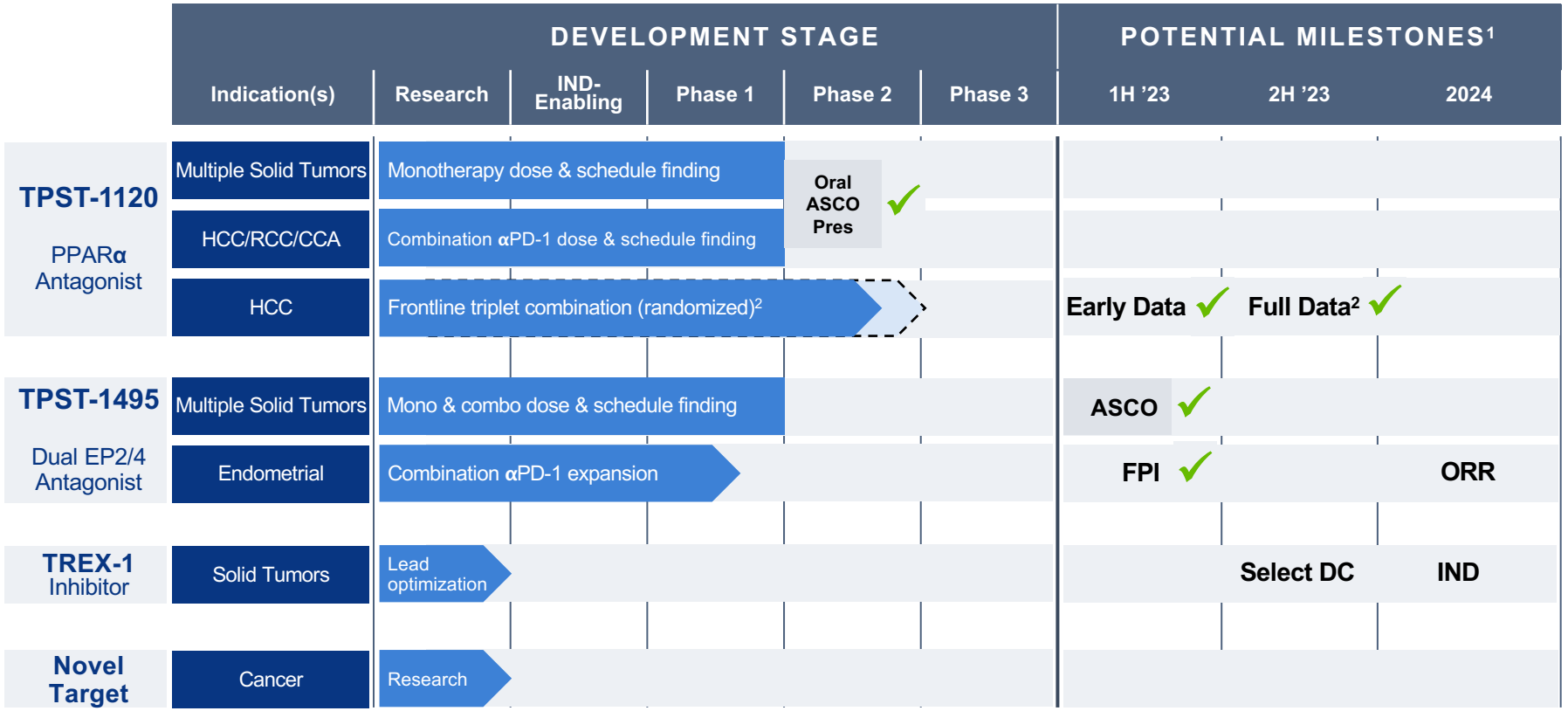


- Broader opportunity with additional indications, including RCC and CCA

[1] Data not provided.

Multiple Potential Near-Term Catalysts

Funded through planned 2023 milestones; potential catalysts through 2024



"RCC" renal cancer; "HCC" hepatocellular carcinoma; "CCA" cholangiocarcinoma; "ORR" Objective Response Rate; "PFS" Progression Free Survival; "FPI" First Patient In

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[1] Timing is an estimate based on current projections and status of programs. [2] Pursuant to a collaboration with Roche; TPST retains all product rights. Based on partner projections, the formal analysis expected in 2H23 which will include PFS and OS, if reached. Timing of data presentation to be determined.