



Cytokinetics®

EMPOWERING
MUSCLE
EMPOWERING
LIVES

Avonne, diagnosed with oHCM

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Our Mission

To bring forward new medicines to improve the healthspan of people with devastating cardiovascular and neuromuscular diseases of impaired muscle function.



MYQORZO™ (aficamten) 5-10-15-20mg tablets

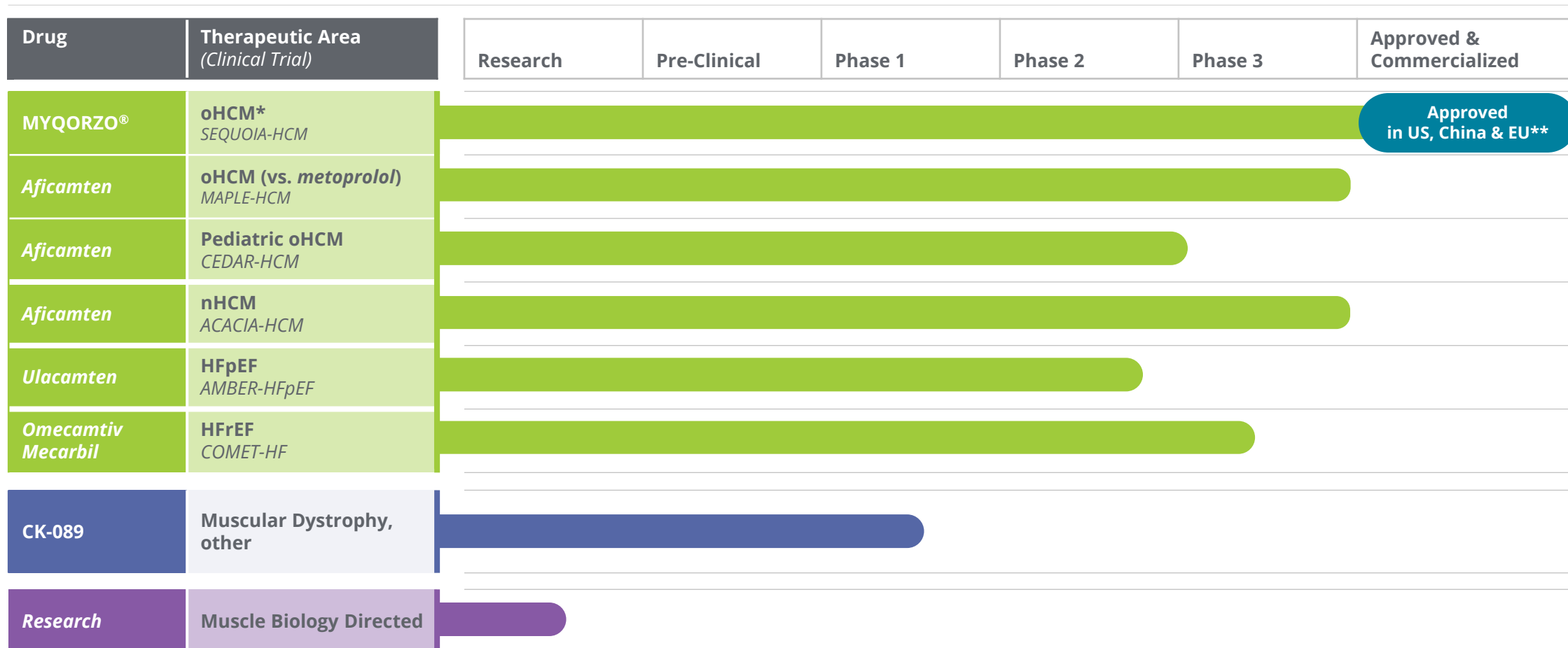
Now Available

FDA-approved for the treatment of adults with symptomatic oHCM to improve functional capacity and symptoms

FDA: U.S. Food & Drug Administration; oHCM: obstructive hypertrophic cardiomyopathy
Please see full [Prescribing Information](#), including Boxed WARNING and [Medication Guide](#)



A Commitment to Muscle-Directed Medicines



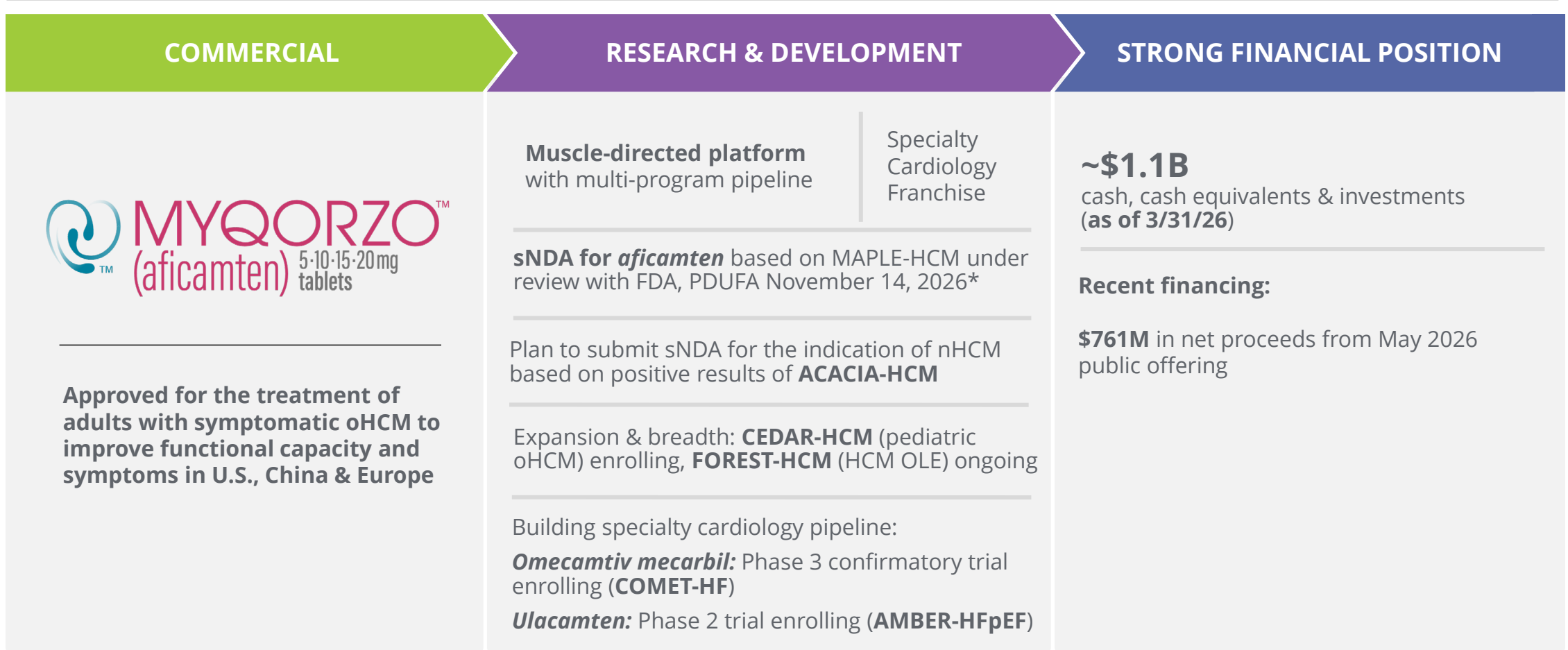
oHCM: obstructive hypertrophic cardiomyopathy; nHCM: non-obstructive hypertrophic cardiomyopathy; HFpEF: heart failure with preserved ejection fraction; HFrEF: heart failure with reserved ejection fraction

*MYQORZO is approved for the treatment of adults with symptomatic oHCM to improve functional capacity and symptoms. Please see full [Prescribing Information](#), including **Boxed WARNING** and [Medication Guide](#)

**MYQORZO is only approved in the U.S., China and the EU for the treatment of adults with symptomatic oHCM.

Ulacamten, omecamtiv mecarbil and CK-089 are investigational agents and have not been approved for use by any regulatory agency. Their safety and efficacy has not been established.

Positioned for Launch Velocity & Sustainable Growth



oHCM: obstructive hypertrophic cardiomyopathy; sNDA: Supplemental New Drug Application; FDA: Food and Drug Administration; PDUFA: Prescription Drug User Fee Act; nHCM: non-obstructive hypertrophic cardiomyopathy; OLE: open label extension
 *The results of MAPLE-HCM showed that the mean change in pVO₂ from baseline to Week 24 for aficamten was +1.1 mL/kg/min and -1.2 mL/kg/min for metoprolol (least-squares mean (LSM) difference between groups of 2.3 mL/kg/min (p<0.0001)
 MYQORZO is only approved in the U.S., China and the EU for the treatment of adults with symptomatic oHCM.
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VISION 2030

Empowering Muscle, Empowering Lives

To be the leading muscle-focused specialty biopharma company intent on meaningfully improving the lives of patients through global access to our innovative medicines



○ **INNOVATION**

Advance 2 approved products across 3 indications and 10 NMEs in our pipeline

○ **IGNITION**

Achieve broad access and rapid use of our medicines in >15 countries throughout North America and Europe

○ **IMPACT**

Reach >100,000 patients globally with our medicines

○ **INSPIRATION**

Foster a patient-centric culture with emphasis on equitable access

○ **INGENUITY**

Extend leadership in muscle biology deploying multiple therapeutic modalities

The company's Vision 2030 statements are a statement of goals and there can be no assurance that the goal indicated will be achieved or, if achieved, will be achieved on this timeline.

Strong Start to 2026

Q1 2026 & Recent Highlights

- **MYQORZO® now approved** in U.S., EU and China
- Positive topline results from **ACACIA-HCM** reported in April 2026
- **U.S. commercial launch of MYQORZO** underway with \$4.8 million in sales in first 9 weeks
- **NDS for MYQORZO** under review in Canada & MAA submitted in Switzerland; **6 HTA dossiers submitted**
- **MAPLE-HCM sNDA** on file with FDA; PDUFA date of November 14, 2026

2026 Key Activities

- **Continue U.S. commercial launch** of MYQORZO
- **Launch MYQORZO in Germany** in Q2
- Secure additional **global approvals for *aficamten*** in oHCM
- Meet with regulatory authorities, including FDA, to discuss the results of **ACACIA-HCM** and plans for submitting an sNDA
- Advance **specialty cardiology pipeline**

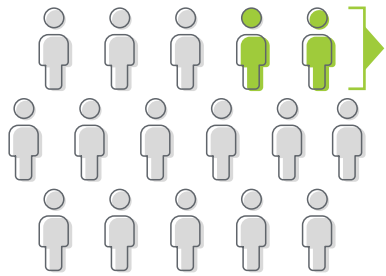
NDS: New Drug Submission; MAA: Marketing Authorization Application; HTA: Health Technology Assessment; sNDA: Supplemental New Drug Application; FDA: U.S. Food & Drug Administration; PDUFA: Prescription Drug User Fee Act; oHCM: obstructive hypertrophic cardiomyopathy
Please see full [Prescribing Information](#), including Boxed WARNING and [Medication Guide](#)

Building a Specialty Cardiology Franchise

Building Specialty Cardiology Business for High ROI

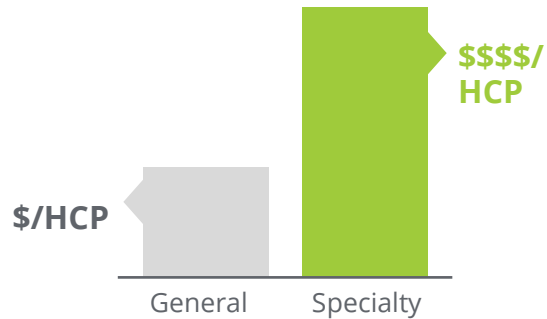
Concentrated Prescribers

~80K cardiologists/PCPs treat CV diseases

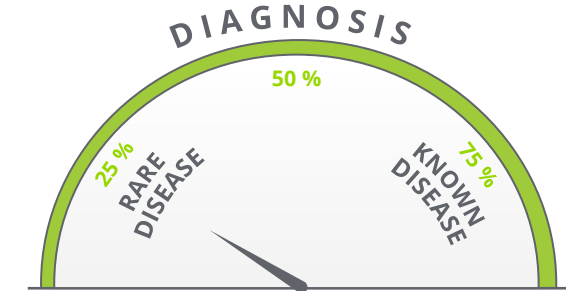


~10K
cardiologists
treat ~80%
HCM

Higher Revenue Per Prescriber



Opportunity To Grow Market Through Diagnosis



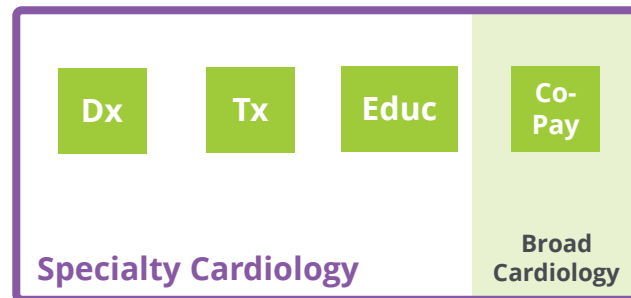
Distribution Limited to Specialty Retailers



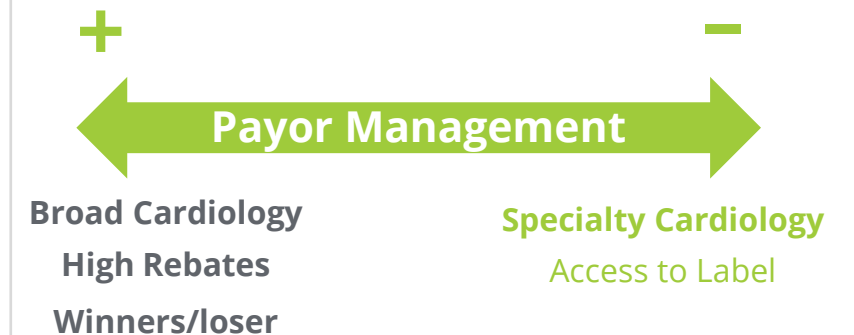
- Retail Pharmacy
- Limited Specialty Retailer

PCP: primary care provider; CV: cardiovascular; HCM: hypertrophic cardiomyopathy; HCP: healthcare provider; Dx: diagnosis; Tx: treatment

Differentiated Patient Experience

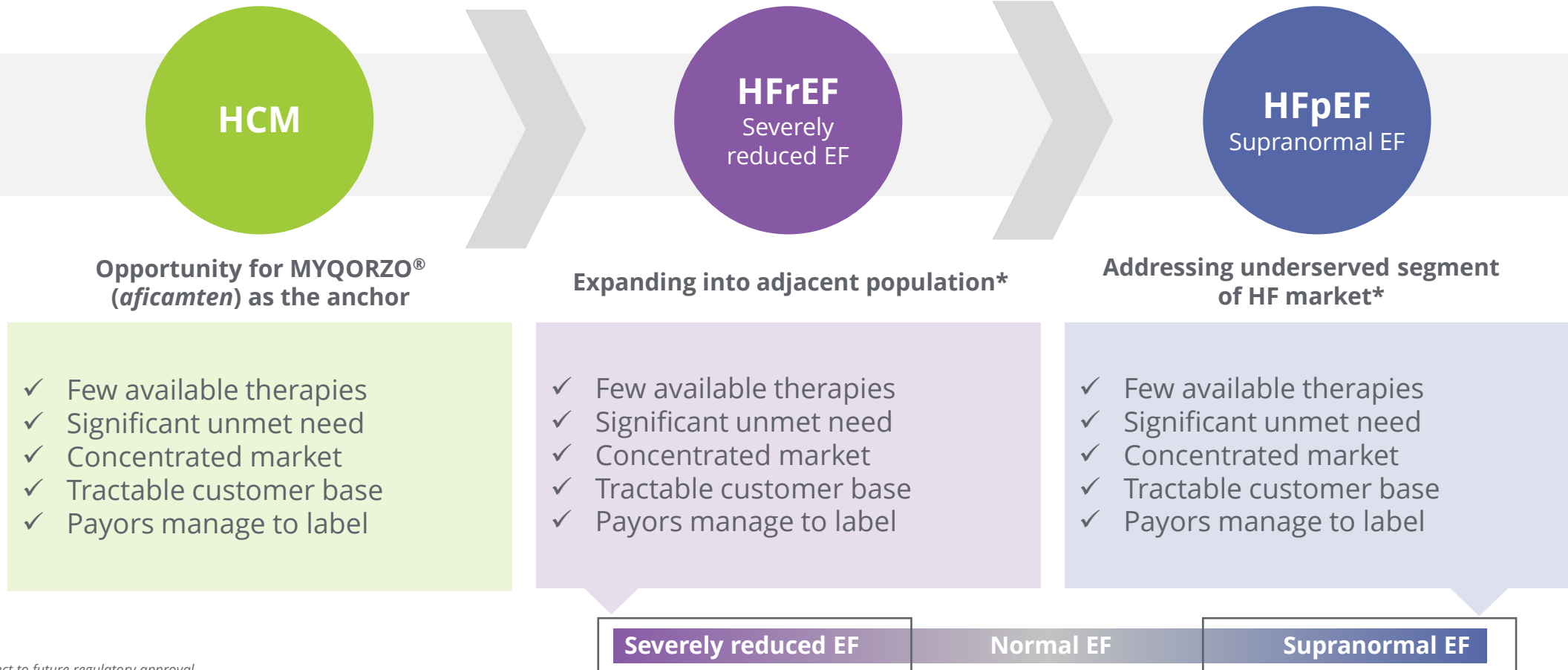


Path to Reimbursement



Addressing Difficult to Treat Populations Within Heart Failure

Specialty cardiology franchise strategy applies to markets with similar characteristics



* Subject to future regulatory approval

HCM: hypertrophic cardiomyopathy; HFrEF: heart failure with reduced ejection fraction; HFpEF: heart failure with preserved ejection fraction; EF: ejection fraction; HF: heart failure

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Potential for Multiple Specialty Cardiology Launches

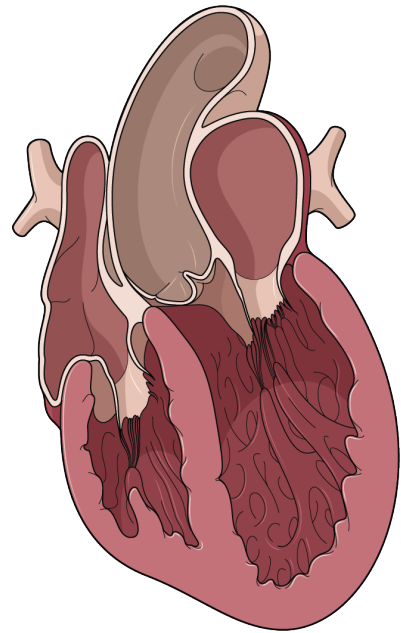
Drug Candidate	Potential Indication	2024	2025	2026	2027	2028	2029	2030+
MYQORZO® (aficamten)	oHCM		★					
	oHCM Mono (MAPLE-HCM)			★				
	nHCM (ACACIA-HCM)					★		
Omecamtiv Mecarbil	HFrEF						★	
Ulacamten	HFpEF							★

Estimated date of potential future launch of each candidate for the respective indication. The estimated launch date requires positive clinical data and regulatory approval within projected timelines. MYQORZO® (aficamten) is only approved in the U.S. and China for the treatment of adults with symptomatic oHCM. Ulacamten, omecamtiv mecarbil and CK-089 are investigational agents and have not been approved for use by any regulatory agency. Their safety and efficacy has not been established.

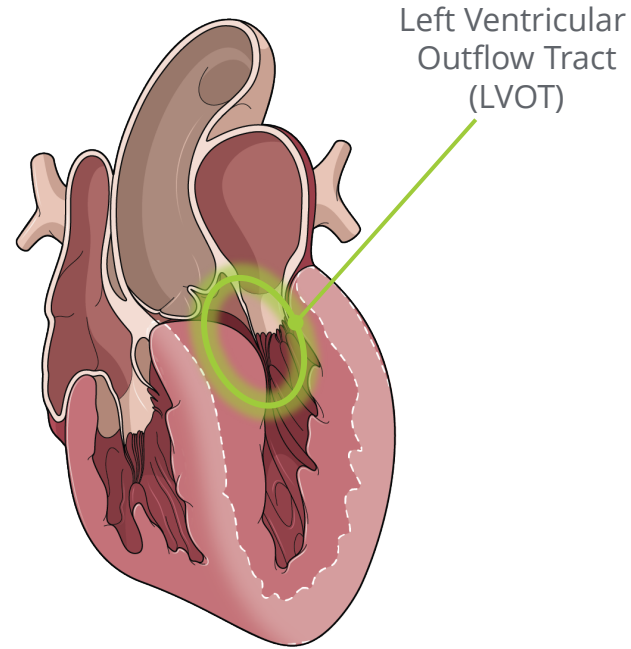
MYQORZO[®] (*aficamten*)

Clinical Evidence

About oHCM



Normal Heart



oHCM

- HCM causes the heart muscle to **abnormally thicken**.
- In obstructive HCM (oHCM), the thickened muscle causes the left ventricle to become **smaller, stiffer** and **less able to relax and fill with blood**.¹⁻⁴
- In oHCM, **obstruction of the LVOT**, blocks blood flow and **limits the heart's pumping function**, leading to reduced exercise capacity and a variety of symptoms.
- People with HCM report that it can limit their physical activities, cause feelings of **anxiety or depression** and impact their work.⁵

HCM: hypertrophic cardiomyopathy; oHCM: obstructive hypertrophic cardiomyopathy

Sources:

1. Naidu SS, Sutton MB, Gao W, et al. Frequency and clinicoeconomic impact of delays to definitive diagnosis of obstructive hypertrophic cardiomyopathy in the United States. *J Med Econ.* 2023;26(1):682-690. doi:10.1080/13696998.2023.2208966

2. Argulian E, Sherrid MV, Messerli FH. Misconceptions and Facts About Hypertrophic Cardiomyopathy. *Am J Med.* 2016;129(2):148-152. doi:10.1016/j.amjmed.2015.07.035

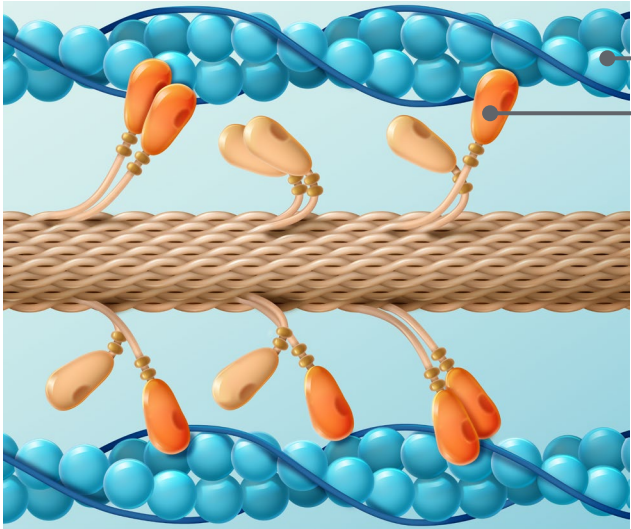
3. Ommen SR, Ho CY, Asif IM, et al. 2024 AHA/ACC/AMSSM/HRS/PACES/SCMR Guideline for the Management of Hypertrophic Cardiomyopathy: A Report of the American Heart Association/American College of Cardiology Joint Committee on Clinical Practice Guidelines. *Circulation.* 2024;149(23):e1239-e1311. doi:10.1161/CIR.0000000000001250

4. Maurizi N, Olivetto I, Maron MS, et al. Lifetime Clinical Course of Hypertrophic Cardiomyopathy: Outcome of the Historical Florence Cohort Over 5 Decades. *JACC Adv.* 2023;2(4):100337. doi:10.1016/j.jacadv.2023.100337

5. Zaiser E, Sehnert AJ, Duenas A, Saberi S, Brookes E, Reaney M. Patient experiences with hypertrophic cardiomyopathy: a conceptual model of symptoms and impacts on quality of life. *J Patient-Rep Outcomes.* 2020;4(1):102. doi:10.1186/s41687-020-00269-8

MYQORZO[®] Inhibits Cardiac Myosin Motor Activity

oHCM causes cardiac hypercontractility, impaired cardiac relaxation & increased energy consumption

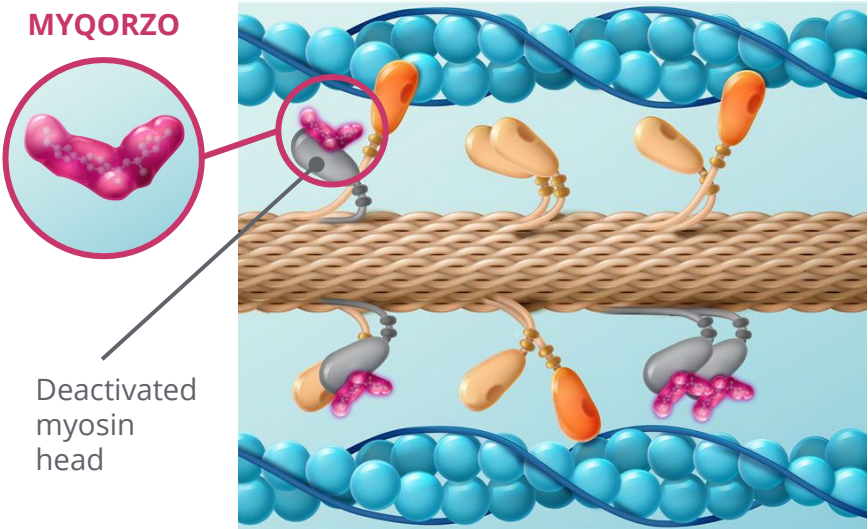


Actin

Active myosin head

This diagram illustrates the state of cardiac muscle fibers in obstructive hypertrophic cardiomyopathy (oHCM). It shows two parallel blue actin filaments with orange myosin heads attached to them. The myosin heads are in an active state, with their heads extended and interacting with the actin filaments, leading to hypercontractility.

MYQORZO binds to and inhibits cardiac myosin, reducing cardiac contractility & LVOT obstruction



MYQORZO

Deactivated myosin head

This diagram illustrates the mechanism of MYQORZO. A pink, multi-lobed MYQORZO molecule is shown binding to the active myosin heads, causing them to become deactivated (grey). A circular inset provides a magnified view of the MYQORZO molecule bound to a myosin head. The overall effect is reduced cardiac contractility and LVOT obstruction.

*oHCM: obstructive hypertrophic cardiomyopathy; LVOT: left ventricular outflow tract
Please see full [Prescribing Information](#), including [Boxed WARNING](#) and [Medication Guide](#)*

SEQUOIA-HCM: Pivotal Phase 3 Trial



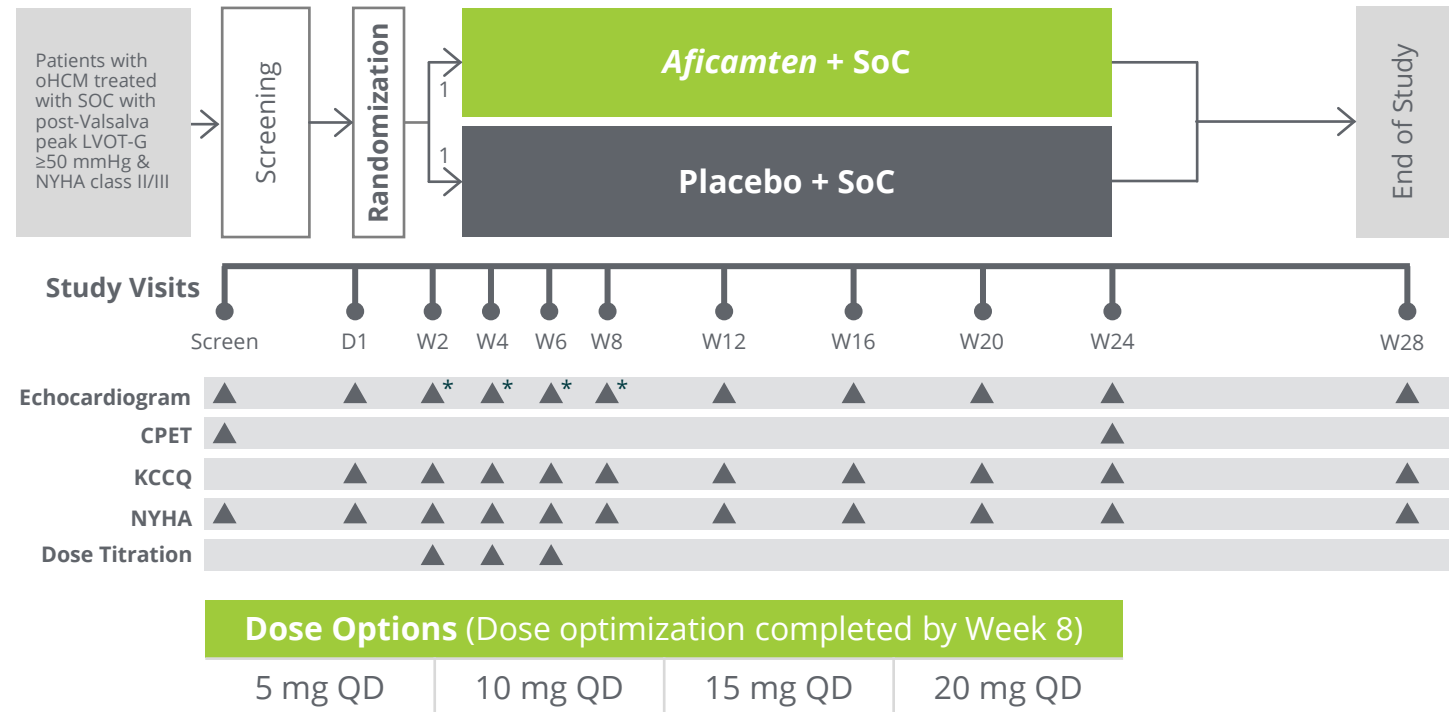
Primary endpoint: **Change in pVO₂ by CPET from baseline to Week 24**

Secondary objectives include measuring **change in KCCQ & improvement in NYHA class at week 12 and 24**

Enrolled 282 patients treated with standard of care with:

- **resting LVOT-G ≥30 mmHg,**
- **post-Valsalva LVOT-G ≥50 mmHg,**
- **NYHA Class II or III,**
- **exercise performance <80% predicted**

Individualized dose up-titration based on echocardiography: LVEF ≥55%, post-Valsalva LVOT-G ≥30 mmHg



pVO₂: peak oxygen uptake; CPET: cardiopulmonary exercise testing; KCCQ: Kansas City Cardiomyopathy Questionnaire; NYHA: New York Heart Association; LVOT-G: left ventricular outflow tract gradient; LVEF: left ventricular ejection fraction; SOC: standard of care
 * Focused echocardiogram
 Please see full [Prescribing Information](#), including Boxed WARNING and [Medication Guide](#)

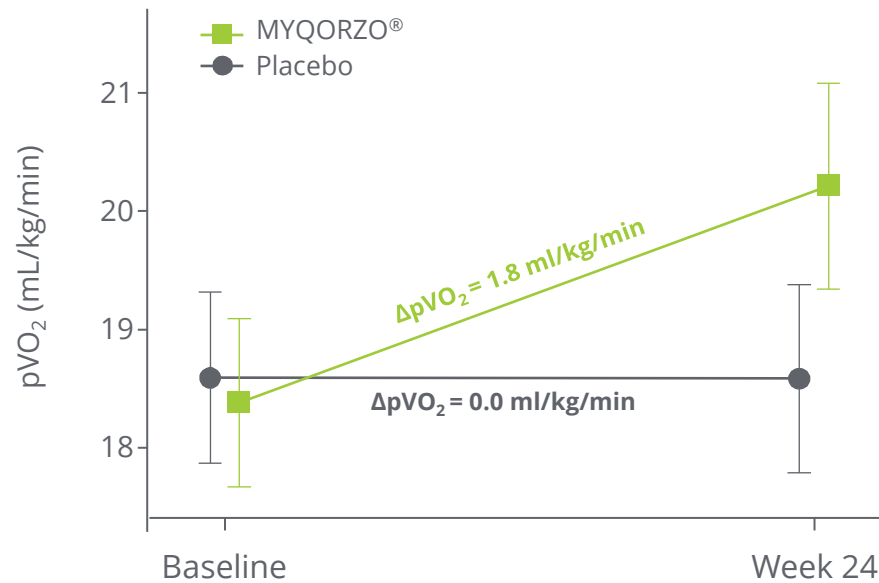
SEQUOIA-HCM: Pivotal Phase 3 Trial in oHCM

Significant improvement in exercise capacity and symptoms compared to placebo



The NEW ENGLAND
JOURNAL OF MEDICINE

Absolute Change from Baseline to Week 24



Treatment with MYQORZO for 24 weeks also significantly improved:

Gradients

-50 mmHg placebo-corrected change in post-Valsalva LVOT-G (p<0.0001)¹

Symptoms

+7.9 points in KCCQ-OSS (p<0.0001)²

+7.8 points in SAQ7-SS (p<0.0001)²

34% of patients had ≥1 class improvement in NYHA Class (p<0.0001)¹

Disease Status

78 fewer days eligible for septal reduction therapy (p<0.0001)¹

Biomarkers

80% reduction in NT-proBNP (p<0.001)¹

43% reduction in hs-cTnI (p<0.001)³

Structure, Function & Remodeling

Improvements in maximal wall thickness, septal wall thickness, inferolateral wall thickness, LV mass index, LV end systolic volume index, left atrial volume index, lateral e' velocity, lateral E/e' (all p<0.01)⁴

oHCM: obstructive hypertrophic cardiomyopathy; pVO₂: peak oxygen uptake; LS: least squares; SE: standard error; LVOT-G: left ventricular outflow tract gradient; KCCQ-OSS: Kansas City Cardiomyopathy Questionnaire Overall Summary Score; SAQ7-SS: Seattle Angina Questionnaire Summary Score, NYHA: New York Heart Association; NT-pro-BNP: N-terminal prohormone of brain natriuretic peptide; hs-cTnI: high-sensitivity cardiac troponin I; LV: left ventricular

Sources:

1. Maron M. Aficamten for Symptomatic Obstructive Hypertrophic Cardiomyopathy. *N Engl J Med* 2024 May 30;390(20):1849-1861
2. Sherrod C, et al. Effect of Aficamten on Health Status Outcomes in Obstructive Hypertrophic Cardiomyopathy: Results from SEQUOIA-HCM. *JACC*. 2024.
3. Coats CJ, et al. Cardiac Biomarkers and Effects of Aficamten in Obstructive Hypertrophic Cardiomyopathy: The SEQUOIA-HCM Trial. *Eur Heart J*. 2024
4. Hegde S, et al. Impact of Aficamten on Echocardiographic Cardiac Structure and Function in Symptomatic Obstructive Hypertrophic Cardiomyopathy. *JACC*. 2024.

Please see full [Prescribing Information](#), including Boxed WARNING and [Medication Guide](#)

SEQUOIA-HCM: Safety Data



AEs with ≥5% incidence

There were no serious adverse cardiovascular events associated with MYQORZO® treatment in SEQUOIA-HCM

Event, n (%)	MYQORZO (n=142)	Placebo (n=140)
Overall AEs	105 (73.9)	99 (70.7)
Headache	11 (7.7)	10 (7.1)
Hypertension	11 (7.7)	3 (2.1)
Palpitations	10 (7.0)	4 (2.9)
Upper respiratory infection	9 (6.3)	12 (8.6)
COVID-19	8 (5.6)	9 (6.4)
Dyspnea	8 (5.6)	8 (5.7)
SAEs	8 (5.6)	13 (9.3)
Cardiac AEs	24 (16.9)	21 (15.0)
Discontinuations	5 (3.5)	4 (2.9)
New-onset atrial fibrillation (AF)	1 (0.7)	1 (0.7)
Appropriate ICD shock	0	1 (0.7)
LVEF <50% by core laboratory ^a	5 (3.5)	1 (0.7)
Dose reduction based on site-read LVEF <50%	7 (4.9)	1 (0.7)

^a 1 placebo- and 1 MYQORZO-treated patient overlap with dose reduction based on site-read LVEF <50%.

AE: adverse event; SAE: serious adverse event; ICD: implantable cardioverter defibrillator; LVEF: left ventricular ejection fraction
 Source: Coats CJ. Dosing and Safety Profile of Aficamten in Symptomatic Obstructive Hypertrophic Cardiomyopathy. J Am Heart Assoc 2024
 Please see full [Prescribing Information](#), including Boxed WARNING and [Medication Guide](#)

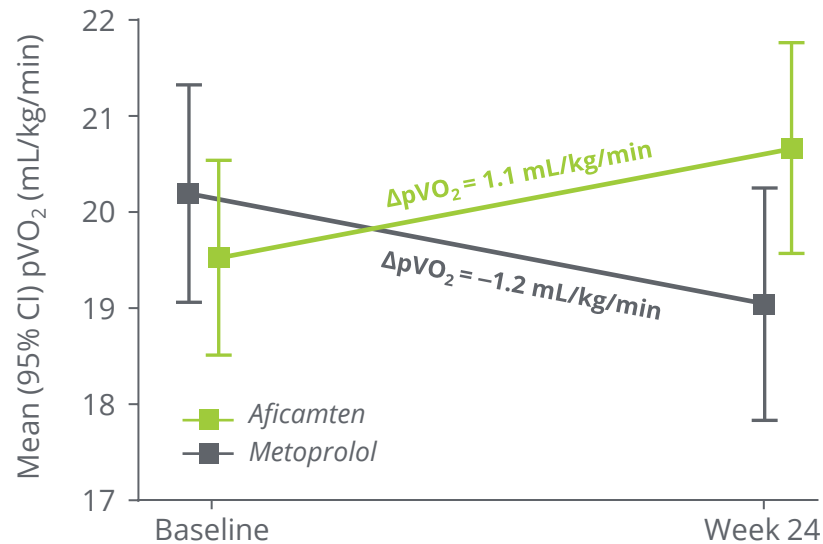
MAPLE-HCM: Phase 3 Monotherapy Trial in oHCM

Aficamten superior to standard-of-care beta blocker metoprolol



The NEW ENGLAND
JOURNAL of MEDICINE

Mean Change from Baseline to Week 24 in pVO₂



LSM difference (SE) vs. *metoprolol*
2.3 (0.39) mL/kg/min, *P*<0.0001

Relative to *metoprolol*, *aficamten* also improved:

Gradients

LSM difference of **-30 mmHg** in resting LVOT-G (*p*<0.0001)¹
LSM difference of **-35 mmHg** in post-Valsalva LVOT-G (*p*<0.0001)¹

Symptoms

LSM difference of **+6.9 points** in KCCQ-CSS (*p*<0.0001)¹
51% of patients improved ≥1 NYHA FC (vs. 26% on *metoprolol*) (*p*<0.001)¹

Biomarkers

-81% in NT-proBNP (-73% for *aficamten* vs. +42% for *metoprolol*) (*p*<0.001)²
-28% in hs-cTnI (-43% for *aficamten* vs. -17% for *metoprolol*) (*p*<0.001)²

Structure, Function & Remodeling

LSM difference of **-7.0 mL/m²** in left atrial volume index (*p*<0.0001)¹

CI: Confidence interval; pVO₂: peak oxygen uptake; LSM: least squares mean; KCCQ-CSS: Kansas City Cardiomyopathy Questionnaire Clinical Summary Score; NYHA FC: New York Heart Association Functional Class; NT-pro-BNP: N-terminal prohormone of brain natriuretic peptide; hs-cTnI: high-sensitivity cardiac troponin I

Sources:

1. Garcia-Pavia, P, et al. Aficamten or Metoprolol Monotherapy for Obstructive Hypertrophic Cardiomyopathy. *N Engl J Med*. 2025
2. Lakdawala, NK et al. The Effect of Aficamten vs. Metoprolol on Cardiac Biomarkers in Obstructive Hypertrophic Cardiomyopathy. *AHA* 2025.

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MAPLE-HCM: Safety



	Aficamten (n=88)	Metoprolol (n=87)
Patients with any SAE	7 (8.0)	6 (6.9)
Patients with any AE that led to early treatment withdrawal of <i>aficamten</i> or <i>metoprolol</i> ^a	1 (1.1)	3 (3.4)
Patients with AE that led to temporary interruption of <i>aficamten</i> or <i>metoprolol</i>	1 (1.1)	1 (1.1)
Patients with dose reduction due to adverse events	1 (1.1) ^b	4 (4.6) ^c
Patients with ≥1 dose down-titration	4 (4.5) ^d	26 (29.9) ^e
Mean (SD) change in LVEF at Week 24 vs baseline	-5.3% (4.7)	-0.50% (3.7)
LVEF <50% by core lab	1 (1.1) ^f	0

Values are n (%).

^a In the *aficamten* group, 1 patient had sudden death after a brief viral illness. In the *metoprolol* group, AEs leading to early treatment discontinuation are ischemic stroke, hypotension, and fractured humerus due to fall (n=1 each).

^b In the *aficamten* group, 1 patient had a dose reduction due to an AE of dizziness.

^c In the *metoprolol* group, 4 patients had dose reduction due to AEs of lightheadedness (n=2), bradycardia (n=1), and fatigue (metoprolol, n=1).

^d In the *aficamten* group, 3 patients had 4 down-titration events based on site-read LVEF <50% (n=3) and due to an AE (n=1).

^e In the metoprolol group, 26 patients had 31 down-titration events based on SBP <90 mmHg (n=5), HR <50 bpm (n=17), and AE (n=4).

^f No associated AE with this LVEF <50%.

SAE: serious adverse event; AE: adverse event; SD: standard deviation; LVEF: left ventricular ejection fraction

Source: Garcia-Pavia, P. et al. Aficamten vs Metoprolol as Monotherapy for Symptomatic Obstructive Hypertrophic Cardiomyopathy. ESC 2025.

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Integrated Safety Analysis in oHCM

Analysis represents nearly 700 patient-years of exposure to *aficamten*



Safety Events of Interest

	Cumulative <i>aficamten</i> treated pool ^a		Placebo/ <i>Metoprolol</i> pool ^b		
	<i>Aficamten</i> N=463		<i>Aficamten</i> N=258	Placebo N=153	<i>Metoprolol</i> N=87
LVEF <50% ^c	n (%)	EAIR ^d			
LVEF <50% with clinical heart failure	19 (4.1)	2.8	12 (4.7)	1 (0.7)	0
	3 (0.6)	0.6	1 (0.4)	1 (0.7)	0
Atrial Fibrillation					
New Onset	17 (3.7)	2.4	5 (1.9)	3 (2.0)	3 (3.4)
Recurrent	12 (2.6)	1.7	3 (1.2)	2 (1.3)	0
Heart Failure	13 (2.8)	1.9	5 (1.9)	2 (1.3)	1 (1.1)
Stroke	7 (1.5)	1.0	1 (0.4)	1 (0.7)	1 (1.1)
Myocardial Infarction	15 (3.2)	2.2	6 (2.3)	5 (3.3)	4 (4.6)
Syncope	10 (2.2)	1.4	4 (1.6)	3 (2.0)	3 (3.4)
Death	2 (0.4)	0.1	1 (0.4)	0	0

a Parent and extension studies, combined unique *aficamten* patients. b Placebo/*Metoprolol* pool of REDWOOD-HCM, SEQUOIA-HCM, and MAPLE-HCM.
c Site read. d Persons per 100 person years

oHCM: obstructive hypertrophic cardiomyopathy; LVEF: left ventricular ejection fraction; EAIR, exposure-adjusted incidence rate; AF: atrial fibrillation; HF: heart failure
Source: Masri A et al. *Aficamten in Patients with Obstructive Hypertrophic Cardiomyopathy: An Integrated Safety Analysis*. ESC 2025.
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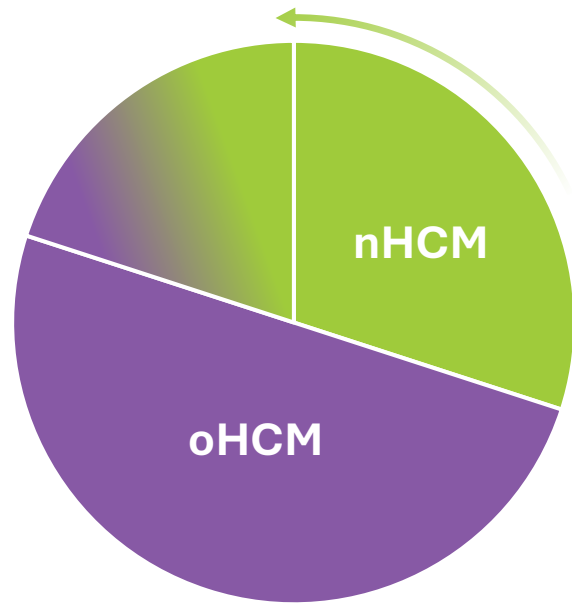
- ✓ **Low incidence of LVEF <50%**; no occurrences associated with clinical HF were corroborated by core lab, and all were successfully managed by dose reduction
- ✓ **Low incidence of new onset AF**, comparable to placebo/*metoprolol*
- ✓ **Incidence of syncope events comparable to placebo/*metoprolol*** despite much longer exposure to *aficamten*
- ✓ **No permanent discontinuations** related to *aficamten*
- ✓ Monitoring echo in the maintenance phase yielded **very few actionable results**

MYQORZO[®] (*aficamten*)

Commercial Launch

Opportunity for CMIs to Treat Symptomatic oHCM Patients

Evolving Understanding of Prevalence Rates for HCM Subtypes: oHCM and nHCM



- ✓ HCM estimated prevalence ~0.3% in the general population ~850k (approximately 1 in 350 individuals)¹
- ✓ Two HCM subtypes: obstructive HCM (oHCM) and nonobstructive HCM (nHCM)²
 - oHCM has historically represented ~65% of cases
 - nHCM diagnosis has been increasing
 - **roughly 50-50 split between HCM subtypes**³
- ✓ >100k oHCM patients are eligible for CMI treatment ^{4,5}

CMI: cardiac myosin inhibitor; HCM: hypertrophic cardiomyopathy; oHCM: obstructive hypertrophic cardiomyopathy; nHCM: non-obstructive hypertrophic cardiomyopathy

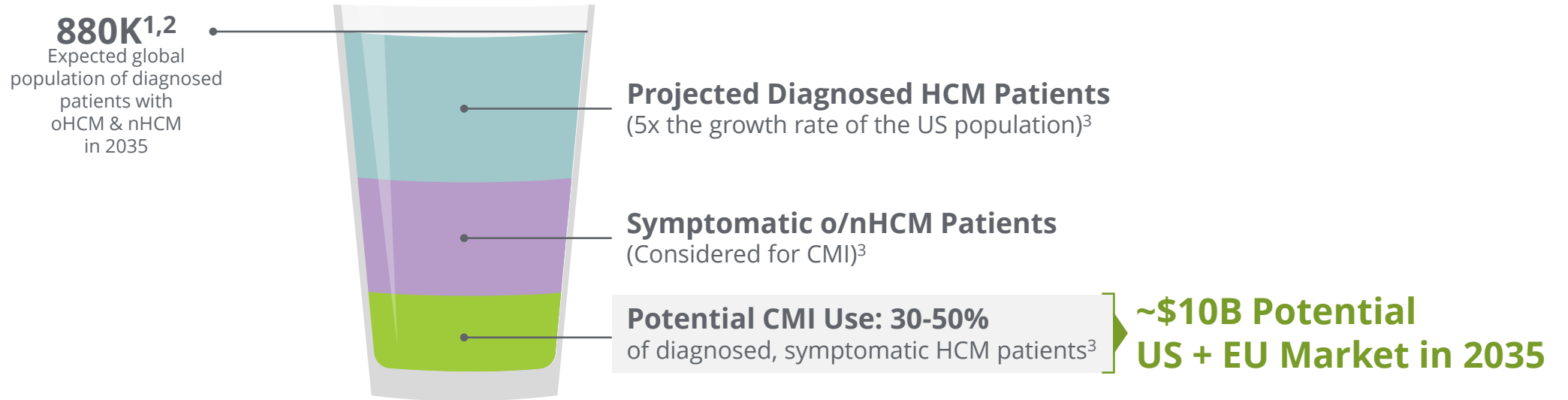
Sources:
1. Semsarian C, et al. *J Am Coll Cardiol.* 2015;65(12):1249-1254. Cardiovascular Research Group: CVrg Market Strategies: Heart Failure, p 48, Q4 2022; Maron BJ: et al.: Prevalence of Hypertrophic Cardiomyopathy In A General Population of Young Adults, *Circulation* 1995;92:785-789
2. Zaiser E, et al. *J Patient Rep Outcomes.* 2020;4(102).
3. Butzner M, et al. *Epidemiology of Hypertrophic Cardiomyopathy in the United States From 2016 to 2023.* *JACC Adv.* 2026. 2026;5(2):102552. doi:10.1016/j.jacadv.2025.102552
4. Lu DY, et al. *J Am Heart Assoc.* 2018;7.
5. DoF: SHA; Symphony PTD (Patient Transaction Data): Includes patients diagnosed since 2016 and having any HC transaction in the claims data universe in the year June 2022-May 2023)
Please see full [Prescribing Information](#), including Boxed WARNING and [Medication Guide](#)

\$10B Potential Market of CMI-Eligible Patients

Diagnosis of HCM anticipated to grow 5x the rate of the general U.S. population

US and EU HCM Patients in 2035

Illustrative



CMI: cardiac myosin inhibitor; HCM: hypertrophic cardiomyopathy; oHCM: obstructive hypertrophic cardiomyopathy; nHCM: non-obstructive hypertrophic cardiomyopathy

Sources:

1. DoF: SHA; Symphony PTD (Patient Transaction Data); Includes patients diagnosed since 2016 and having any HC transaction in the claims data universe in the last year June 2022-May 2023);

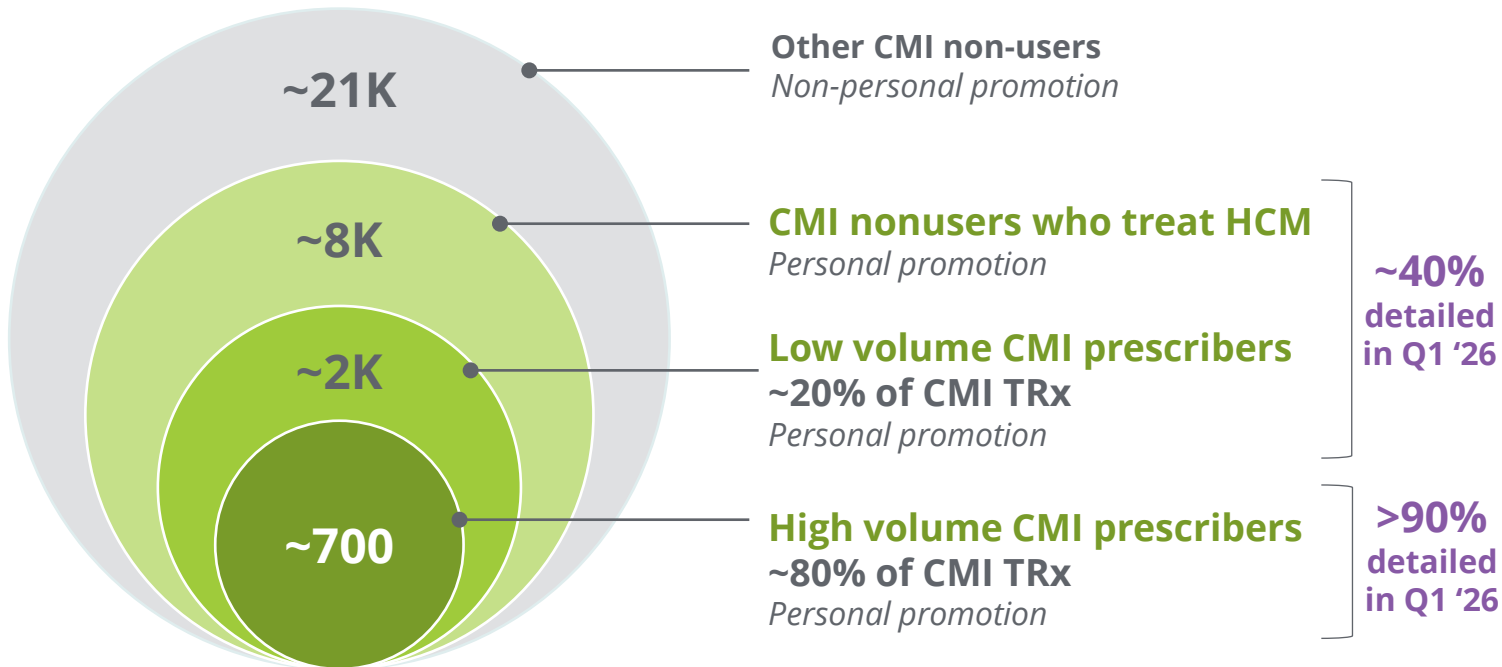
2. Butzner et al 2021 estimated a 8% growth rate in diagnosed HCM patients between 2013-2019 [https://www.ajconline.org/article/S0002-9149\(21\)00783-9/fulltext](https://www.ajconline.org/article/S0002-9149(21)00783-9/fulltext); CYTK is forecasting an average growth rate of 5% over the coming decade and a more conservative 4% growth rate in Europe due to a lack of growth of the overall population in EU5 countries.

3. Internal forecasts

Please see full [Prescribing Information](#), including Boxed WARNING and [Medication Guide](#)

Initial Focus on High Volume CMI Prescribers

HCPs for Personal and Non-Personal Engagement



- ✓ At launch, we have a **greater emphasis on the top CMI prescribers to build share and depth of prescribing**
- ✓ By end of 2026 we aim to achieve **>50% new-to-brand prescription share**

CMI: cardiac myosin inhibitor; HCP: healthcare provider; HCM: hypertrophic cardiomyopathy; TRx: total prescriptions
Source: Symphony Health Payer Prescriber Data (CAMZYOS Rx - Apr'22 - Dec'25) / Internal Data on CAS team engagement / Veeva - Call activity data
Please see full [Prescribing Information](#), including Boxed WARNING and [Medication Guide](#)

HCP & Patient-Directed Promotional Campaigns Activated

For HCPs

Office Resources

Non-Personal

HCP Website

Digital Ads

Email

Peer-to-Peer

For Patients

Patient Support Materials

In-Office Patient Materials

Social

Patient Website

HCP: healthcare professional
Please see full [Prescribing Information](#), including [Boxed WARNING](#) and [Medication Guide](#)

Highly Experienced Sales Team Deployed

125 experienced Cardiovascular Account Specialists and Area Business Managers

21

Average years of **industry experience**



14

Average years of **cardiovascular experience**



4

Average years **rare disease experience**



5

Average number of **President's Awards** for sales performance



Please see full [Prescribing Information](#), including [Boxed WARNING](#) and [Medication Guide](#)

Key Launch Drivers to Achieve High Share and Grow Category

Clinical



Rapid & sustained

symptom improvement and reduction in obstruction



Flexibility to rapidly titrate

as early as 2 weeks, with flexible monitoring schedule



No treatment interruptions

or worsening HF events observed in patients with LVEF <50% in SEQUOIA-HCM

REMS

Flexibility to rapidly titrate as early as 2 weeks

- ✓ Dose may be titrated after each echocardiogram
- ✓ Echocardiogram assessment within 2 to 8 weeks
- ✓ No monthly DDI screens required with the pharmacy

Monitor every 6 months

- ✓ Echocardiogram every 6 mo. for patients with LVEF $\geq 55\%$
 - ✓ Every 3 mo. if LVEF is $< 55\%$ & $\geq 50\%$
- ✓ No monthly DDI screens required with the pharmacy

HF: heart failure; LVEF: left ventricular ejection fraction; REMS: Risk Evaluation and Mitigation Strategies; DDI: drug-drug interaction
Please see full [Prescribing Information](#), including Boxed WARNING and [Medication Guide](#)

Key Features of REMS Monitoring Schedule for First Year of Therapy

Estimated Titration Regimen Across Dose Range

MYQORZO® (aficamten) Starting dose of 5 mg	Process Step [within 12 months]	5 mg	10 mg	15 mg	20 mg
	Echocardiogram*	3	4	5	6
	Patient Monitoring Form**	3	4	5	6
	Pharmacy DDI Checklist*	0	0	0	0
	Required DDI Screen with Patient†	0	0	0	0
Minimum # of Months to Reach Maintenance	0.5	1	1.5	2.0	

CAMZYOS® (mavacamten) Starting dose of 5 mg	Process Step [within 12 months]	5 mg	2.5 mg**	10 mg	15 mg
	Echocardiogram*	5	6	7	8
	Patient Status Form**	5	6	7	8
	Pharmacy DDI Checklist*	12	12	12	12
	Required DDI Screen with Patient†	12	12	12	12
Minimum # of Months to Reach Maintenance	3	4	6	9	

There are no head-to-head studies between MYQORZO® and CAMZYOS®; therefore, no comparisons between their safety and efficacy can be made.

	MYQORZO®	CAMZYOS®
Up-titration	Increase dose after each echo , as soon as every 2 weeks .	Increase dose after Week 12 if LVEF ≥55% and Valsalva LVOT-G ≥30 mmHg.
Echo	Echocardiogram within 2 to 8 weeks of treatment initiation or dose adjustment.	Echocardiograms at Weeks 4, 8, & 12 to increase starting dose. Weeks 16 & 24 to increase dose. Weeks 28 & 36 to confirm maximum dose.
LVOT-G	No down-titration required based on LVOT-G. Down-titration based on LVEF only.	Down-titration at Week 4 and Week 8 based on LVEF and if Valsalva LVOT-G <20 mmHg.
Dispensing	Patients can be dispensed up to 90-day supply in maintenance phase.	Patients are limited to 35-day supply in maintenance phase for first 12 months of therapy.
DDI Calls	No requirement for monthly DDI screen or checklist.	DDI screen required between patient and pharmacy prior to each dispense.***

DDI: Drug-drug interaction; LVEF: left ventricular ejection fraction; LVOT-G: left ventricular outflow tract gradient.

*CAMZYOS® is a trademark of MyoKardia, Inc., a Bristol Myers Squibb company.

!Estimated titration timing assume echocardiograms are performed as early as possible and that no down-titration is required.

**Number includes eligibility echocardiogram and patient enrollment form.

***Patients are initiated at 5mg; lowest dose is 2.5 mg. An estimated 35% of patients down titrate to 2.5 mg after starting 5mg.

***Potentially every 3 months after first year on therapy depending on insurance coverage and dispensing schedule.

*Can be faxed, emailed, or uploaded to REMS portal; enables drug dispensing.

†Assumes phone is answered on first call; calls are made per patient, not per prescriber's office. Occurs monthly for initial 12 months of therapy.

**Prescribers must submit a Patient Status Form (PSF) to the Camzyos REMS portal within 3 days of each scheduled echocardiogram.

Please see full [Prescribing Information](#), including Boxed WARNING and [Medication Guide](#)

MYQORZO & You™: Bespoke Treatment Experience



OOP: out-of-pocket

Patient Activation & Engagement

Access & Reimbursement

Support investigating patient's health insurance benefits, OOP cost, Prior Authorization and/or Appeal criteria & submission

Free Trial Program

Free drug supply during trial period for eligible government-insured patients

Limited to one use per patient per lifetime. On-label use only. Age, financial need & residency criteria apply.

Bridge Program

Free drug supply for up to 12 months for commercially insured patients due to coverage delay

Patient Affordability

Co-Pay Program

Financial assistance for commercially-insured patients to reduce out-of-pocket costs for MYQORZO and echocardiograms

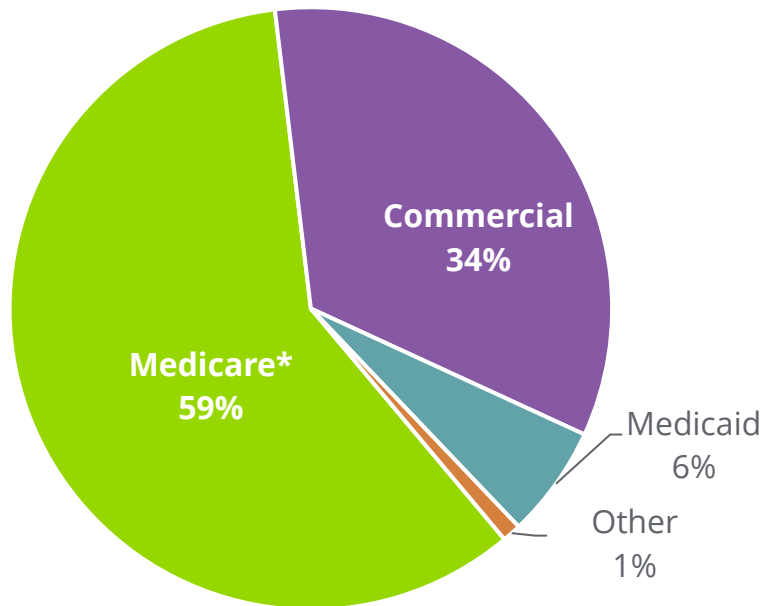
Patient Assistance Program

Free supply of MYQORZO for eligible patients meeting financial criteria

Market Access Strategy

Grow CMI class & compete via clinical differentiation

MYQORZO® Q1 Payor Mix



CMI: cardiac myosin inhibitor

*Government = 66%

Source: Managed Markets Insights & Technology, LLC (MMIT); MMIT Analytics Platform
Please see full [Prescribing Information](#), including Boxed WARNING and [Medication Guide](#)

Securing Market Access

Q1 2026

● Ongoing payor engagement

Q2 2026

● Secured comparable access for nearly 90% of Medicare lives, expect parity by end of Q2 2026

Q3 2026

● Expect to reach 50% of commercial lives covered by early Q3 2026

Q4 2026

● Expect to achieve parity commercial access by Q4 2026

Measuring Launch Velocity: 3 Key Metrics

Potential to reach >50% share of new patients by the end of 2026

Breadth and depth of HCP prescribing of MYQORZO®



Number of HCPs
prescribing MYQORZO



Volume of MYQORZO
prescriptions
each HCP writes



Volume of patients
on MYQORZO

HCP: healthcare provider
Please see full [Prescribing Information](#), including Boxed WARNING and [Medication Guide](#)
Based on internal revenue forecast informed by demand studies

Key Metrics: Breadth & Depth of HCP Prescribing



Breadth of HCP Prescribing

As of 3/31/26 **>275** → **>425** As of 4/30/26

HCPs prescribing MYQORZO

As of 3/31/26
~50%

high-volume CMI writers



Q1 Depth of HCP Prescribing

As of 3/31/26

2.4

Average prescriptions written
per HCP

2.6

Average prescriptions written
per high-volume CMI writer

Potential Leading Indicator of Future Prescribing

As of 3/31/26

1,400+

REMS-certified HCPs

Q1 Exit Share (estimated)

As of 3/31/26

>30%

New-to-Brand share

Analysis based on projected third party syndicated data

HCP: healthcare provider; CMI: cardiac myosin inhibitor; KOL: Key Opinion Leader, REMS: Risk Evaluation and Mitigation Strategies
Source: MYQORZO internal patient prescription data) through Apr'30 (Specialty pharmacies and Integrated Delivery Networks (IDNs)/REMs Data from PPD
Please see full [Prescribing Information](#), including Boxed WARNING and [Medication Guide](#)

Key Metrics: Volume of Patients



Volume of Patients

As of 3/31/26 As of 4/30/26

680 → 1,100

Patients Prescribed MYQORZO®

Paid Drug in Q1

>70%

Patients on therapy with a paid prescription*

<2 weeks

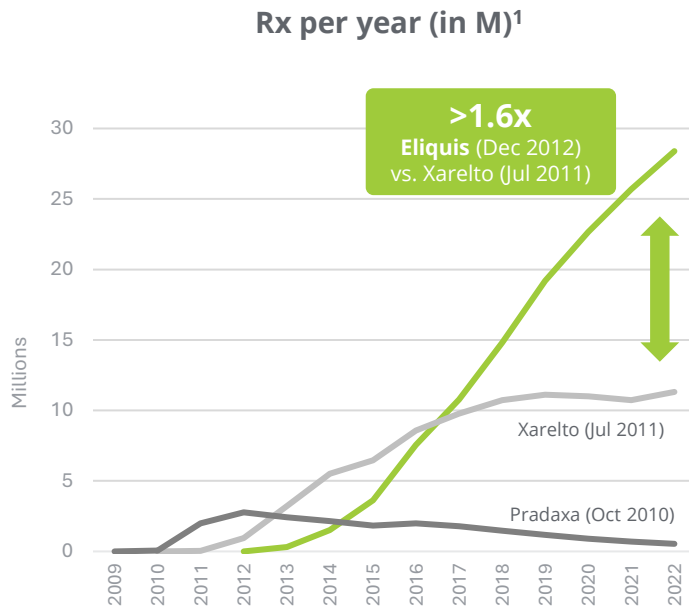
Average time to convert to paid prescription

Source: MYQORZO internal patient prescription data through Apr'30 (Specialty pharmacies and Integrated Delivery Networks (IDNs))
*Paid prescriptions calculated using dispensed Rx's
Please see full [Prescribing Information](#), including Boxed WARNING and [Medication Guide](#)

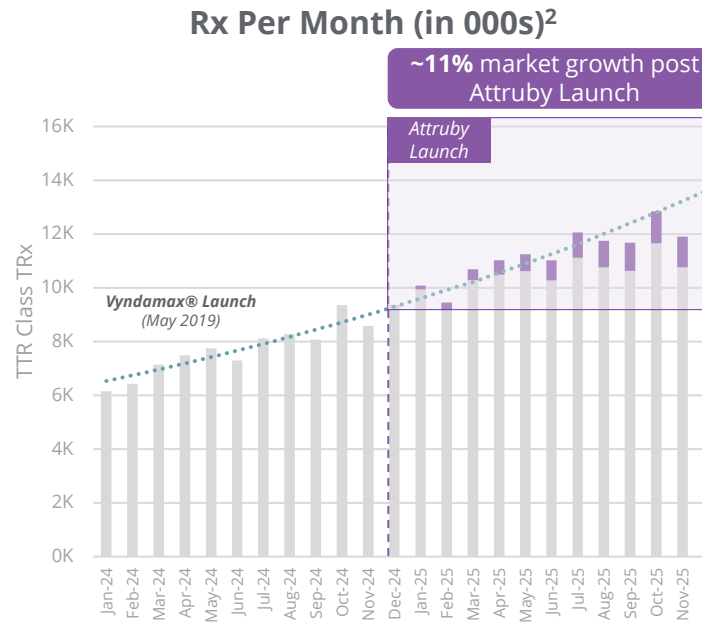
Precedents for Next-In-Class Success & Category Growth

With differentiated product profile, Eliquis® generated 1.6x more prescriptions than Xarelto®

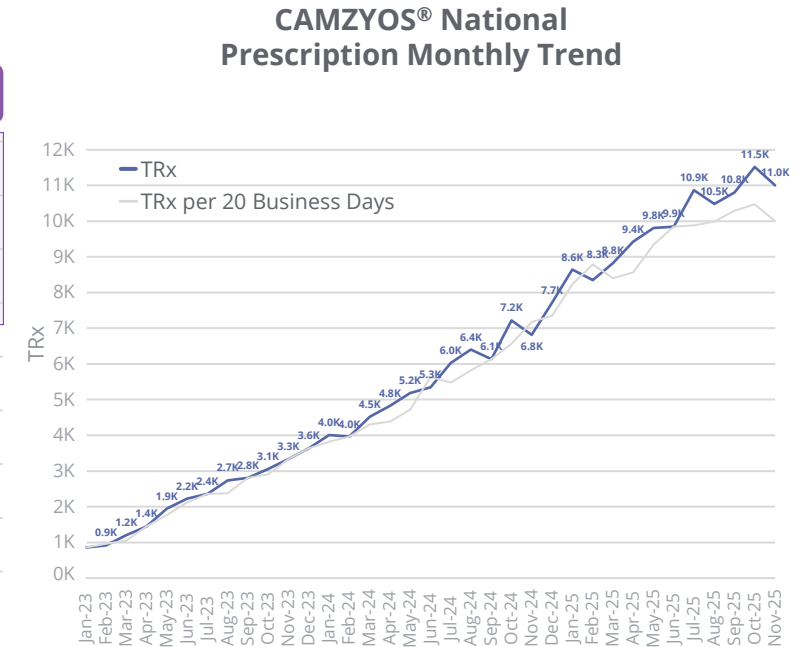
Oral anticoagulants Pradaxa® (2010), Xarelto (2011), Eliquis (2012) approved over ~3 years



ATTR Class TRx has increased since Attruby™ launch



CMI market poised for growth³



















Afib: atrial fibrillation; Rx: prescription; ATTR: Transthyretin Amyloidosis; TRx: total prescriptions
Sources:

1. Symphony National Projected Annual TRx data, 2010 – 2022
2. Symphony National Projected Annual TRx data, 2023 – 2025
3. Source: Symphony Metys national projections (TRxs) 2023-2025

Historical prescription trends for other therapeutic classes may not be predictive of future performance of MYQORZO or the CMI class. Differences in clinical profiles, market dynamics, reimbursement environment and competitive landscape may materially affect outcomes.

Advancing Global Availability in 2026

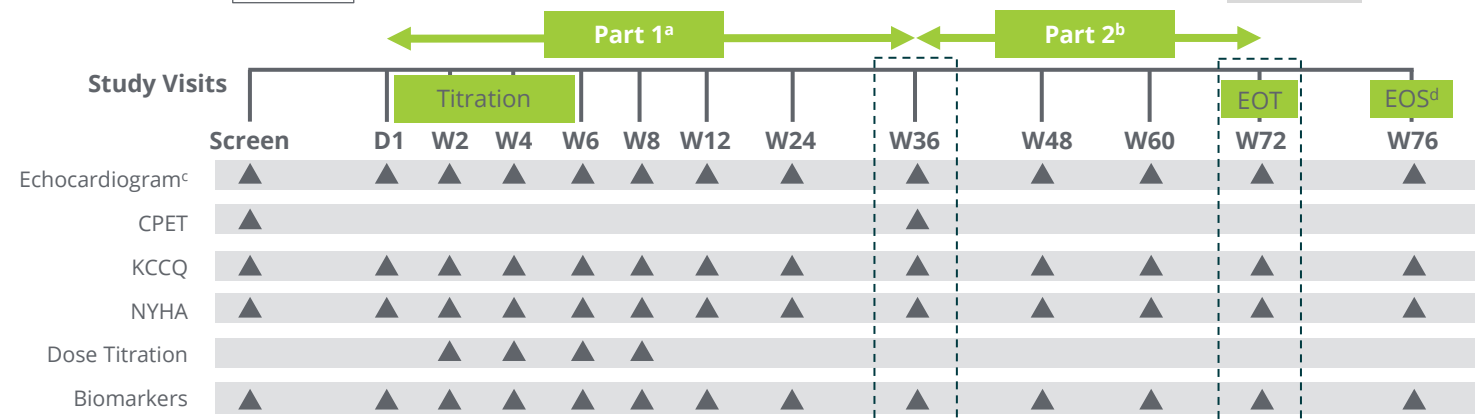
 <p>United States</p> <p>Approved by FDA for adults with symptomatic oHCM to improve functional capacity and symptoms</p> <p>LAUNCHED JAN 2026</p>  <p>Cytokinetics®</p> 	<p>Pending Regulatory Approval</p>  <p>Canada New Drug Submission under review; expect to receive decision in 2H 2026</p>  <p>Switzerland MAA submitted Q1 2026</p>  <p>Cytokinetics®</p>	<p>Clinical Trials Ongoing</p>  <p>Japan Phase 3 clinical trials ongoing in oHCM & nHCM</p>  <p>Cytokinetics®</p> 
 <p>China</p> <p>Approved by NMPA for adults with NYHA class II-III oHCM to improve exercise capacity and symptoms</p> <p>LAUNCHED MAR 2026</p>  <p>Cytokinetics®</p>  <p>sanofi</p> 		
 <p>European Union</p> <p>Approved by the European Commission for symptomatic (NYHA class II-III) oHCM in adult patients</p> <p>LAUNCH EXPECTED IN GERMANY Q2 2026</p>  <p>Cytokinetics®</p> 		

FDA: U.S. Food & Drug Administration; oHCM: obstructive hypertrophic cardiomyopathy; NMPA: National Medical Products Administration; NYHA: New York Heart Association; MAA: Marketing Authorization Application; EMA: European Medicines Agency; CHMP: Committee for Medicinal Products for Human Use; nHCM: non-obstructive hypertrophic cardiomyopathy
 MYQORZO® (aficamten) is only approved in the U.S., China and EU for the treatment of adults with symptomatic oHCM.

ACACIA-HCM: Pivotal Phase 3 Trial in nHCM



- Trial enrolled over **516 symptomatic nHCM patients**
- Dual primary endpoint: **change in KCCQ Clinical Summary Score and peak VO₂** from baseline to Week 36
- **5-20 mg doses**; 6-week titration period
- Secondary endpoints:
 - Proportion of patients with ≥ 1 class improvement in NYHA from baseline to Week 36
 - Composite z-score of ventilatory efficiency & pVO₂
 - Change in NT-proBNP
 - Change in LAVI
 - Time to first cardiovascular event



nHCM: non-obstructive hypertrophic cardiomyopathy; NYHA: New York Heart Association; KCCQ-CSS: Kansas City Cardiomyopathy Questionnaire; pVO₂: peak oxygen uptake; NT-proBNP: N-terminal pro-brain natriuretic peptide; LAVI: left atrial volume index; LVEF: left ventricular ejection fraction
MYQORZO® (aficamten) is only approved in the U.S., China and EU for the treatment of adults with symptomatic oHCM.

^a Part 1: All participants followed until week 36
^b Part 2: Participants completing Week 36 continue until either Week 72 (followed by EOS at Week 76) OR the last randomized participant in Part 1 completes Week 36.
^c Site-read focused echocardiogram for titration visit (sole criterion). Aficamten dose range 5-20 mg.
^d 4-week follow up after last dose

ACACIA-HCM: Topline Results



Full results to be presented at upcoming medical meeting

Primary Endpoints	Change from Baseline to Week 36 LSM (95% CI)		<i>Aficamten</i> vs Placebo LSM (95% CI)	p-value
	<i>Aficamten</i>	Placebo		
KCCQ-CSS	11.4 (9.6 – 13.2)	8.4 (6.6 – 10.2)	3.0 (0.5 - 5.5)	0.021
pVO₂ (ml/kg/min)	0.64 (0.32 – 0.95)	-0.03 (-0.35 – 0.28)	0.67 (0.22 - 1.1)	0.003

Statistically significant (p<0.001) improvements observed in key secondary endpoints:

1. Proportion of participants with improvements in NYHA Functional Class
2. Composite z-score of ventilatory efficiency and pVO₂
3. N-terminal pro-B-type natriuretic peptide (NT-proBNP)

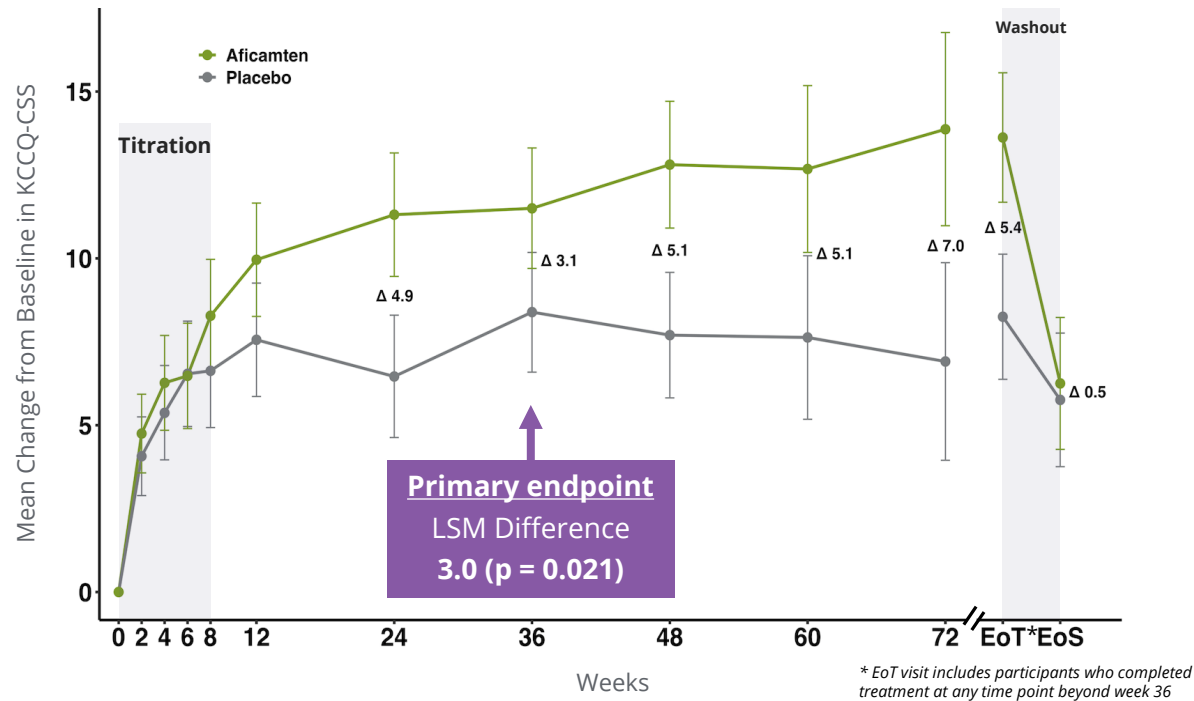
nHCM: non-obstructive hypertrophic cardiomyopathy; pVO₂: peak oxygen uptake; LSM: least squares mean; CI: confidence interval; KCCQ-CSS: Kansas City Cardiomyopathy Questionnaire Clinical Summary Score; NYHA: New York Heart Association; CV: cardiovascular
MYQORZO® (*aficamten*) is only approved in the U.S., China and EU for the treatment of adults with symptomatic oHCM.

ACACIA-HCM: Topline Results

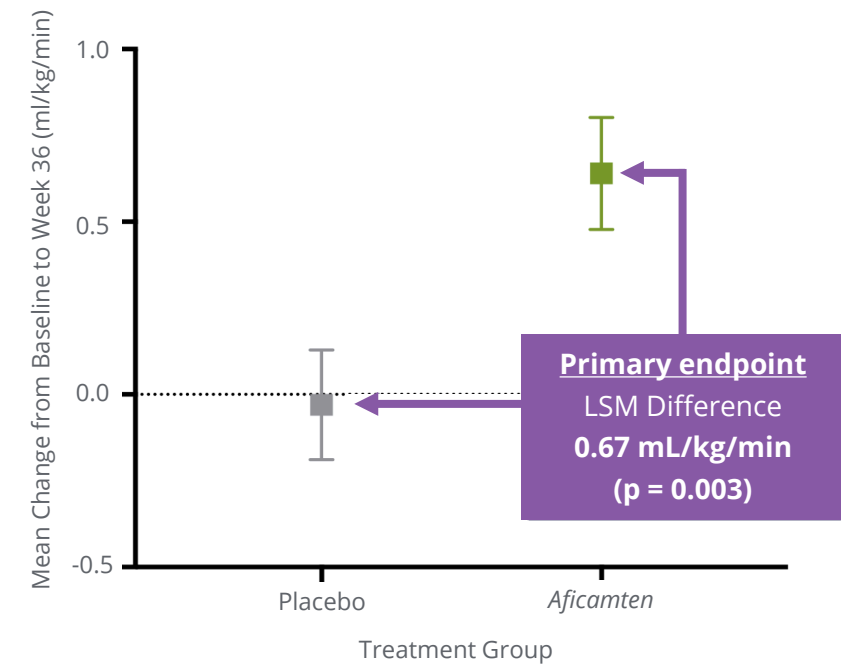


Robust & consistent improvements throughout treatment period

LS Mean Change from Baseline in KCCQ-CSS



Change from Baseline to Week 36 in pVO₂



nHCM: non-obstructive hypertrophic cardiomyopathy; LS: least squares; KCCQ-CSS: Kansas City Cardiomyopathy Questionnaire Clinical Summary Score; LSM: least squares mean; EOT: End of Treatment; EOS: End of Study; pVO₂: peak oxygen uptake MYQORZO® (aficamten) is only approved in the U.S., China and EU for the treatment of adults with symptomatic oHCM.

ACACIA-HCM: Topline Results - Safety



Full results to be presented at upcoming medical meeting

**No new safety signals
identified in ACACIA-HCM**

LVEF <50%:

27 (10%) on *aficamten* vs. 2 (1%) on placebo;

Serious Adverse Events (SAEs):

2 participants on *aficamten* had a serious AE of HF associated with LVEF <50%

Percent participants completing planned dosing:

Similar between groups
(88.4% on *aficamten* vs. 90.3% on placebo)

Treatment interruptions:

Treatment interruptions due to LVEF <40% occurred in 3% of patients on *aficamten*

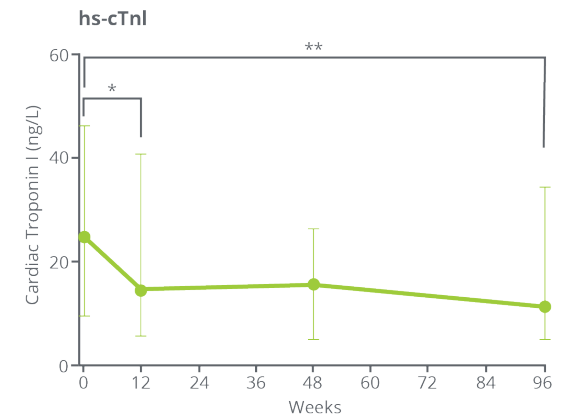
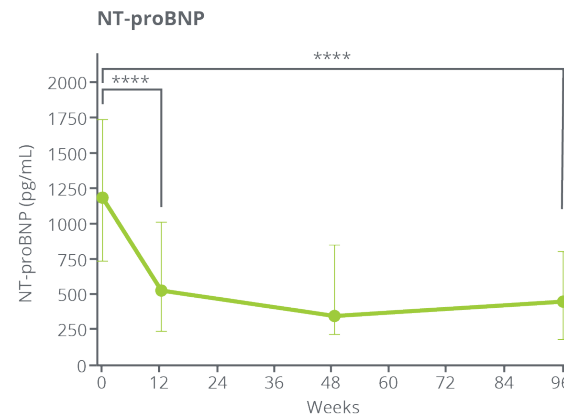
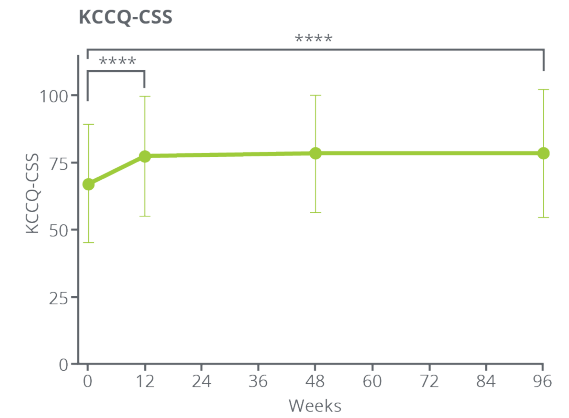
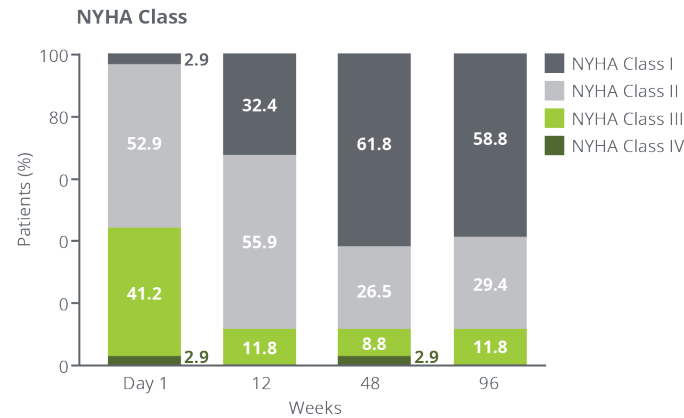
LVEF: left ventricular ejection fraction; AE: adverse event; HF: heart failure
MYQORZO® (*aficamten*) is only approved in the U.S., China and EU for the treatment of adults with symptomatic oHCM.

FOREST-HCM: 96-Week Open-Label Data in nHCM

Analysis of 34 patients enrolled in FOREST-HCM after REDWOOD-HCM Cohort 4



- ✓ No early treatment discontinuations, with sustained reductions in symptom burden
- ✓ 79% of patients improved by at least one NYHA Functional Class
- ✓ Mean increase in KCCQ-CSS of 11.2 points
- ✓ Improvements in cardiac biomarkers



****p<0.0001, **p<0.01, *p<0.05

NYHA: New York Heart Association; KCCQ: Kansas City Cardiomyopathy Questionnaire; NT-proBNP: N-terminal prohormone of brain natriuretic peptide; hs-cTnI: high-sensitivity cardiac troponin I
 Source: Masri A. et al. "Safety and Efficacy of Aficamten in Patients With Nonobstructive Hypertrophic Cardiomyopathy: A 96-Week Analysis From FOREST-HCM". *Journal of Cardiac Failure*. 2025.
MYQORZO® (aficamten) is only approved in the U.S., China and EU for the treatment of adults with symptomatic oHCM.

Omecamtiv Mecarbil

Omecamtiv Mecarbil: Potential for High-Risk Severe HF Patients Despite GDMT

Efficient, pragmatic Phase 3 clinical trial

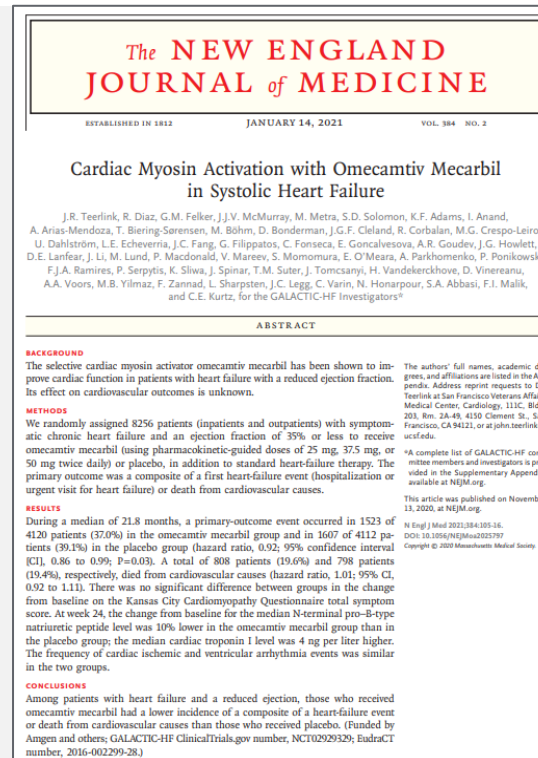
High Unmet Need

The large and growing heart failure population faces frequent hospitalizations, high mortality rates, comorbidities, and challenges staying on GDMT. Despite SGLT2 inhibitors, patients remain at significant risk.

Market Opportunity

18% of 7.1M patients with HFrEF have worsening heart failure (LVEF <30%)

Estimated 8+ years of market exclusivity



Ph 3 clinical trial results in 8,000 patients point to important treatment benefit

Planning confirmatory Ph 3 trial, n= ~1,800, ~3 years to completion

Primary endpoint: time to CV death, HF events, transplant/LVAD, or stroke

Larger treatment benefit in patients with lower LVEF and other markers of advanced HF

Pragmatic design elements including EHR screening, limited monitoring visits, remove visits, and limited safety labs & AE reporting

GDMT: Guideline-Directed Medical Therapy; SGLT2: sodium-glucose cotransporter 2; HFrEF: heart failure with reduced ejection fraction; LVEF: left ventricular ejection fraction; CV: cardiovascular; HF: heart failure; LVAD: left ventricular assist device; EHR: electronic health record; AE: adverse event

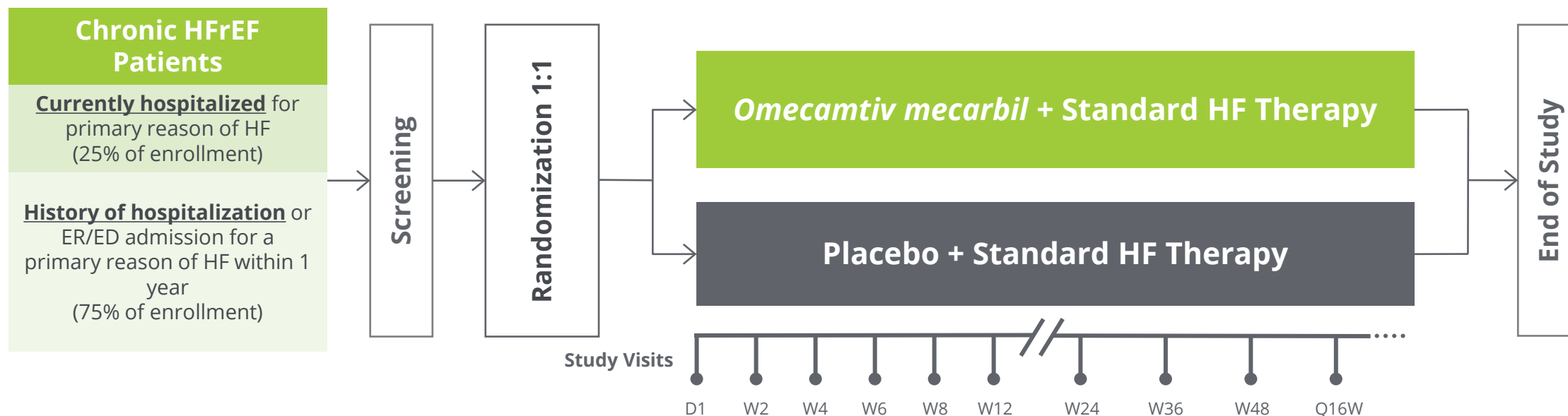
Omecamtiv mecarbil is an investigational drug and is not approved by any regulatory agency. Its safety and efficacy have not been established.

GALACTIC-HF: Clinical Trial Overview

Phase 3 clinical trial

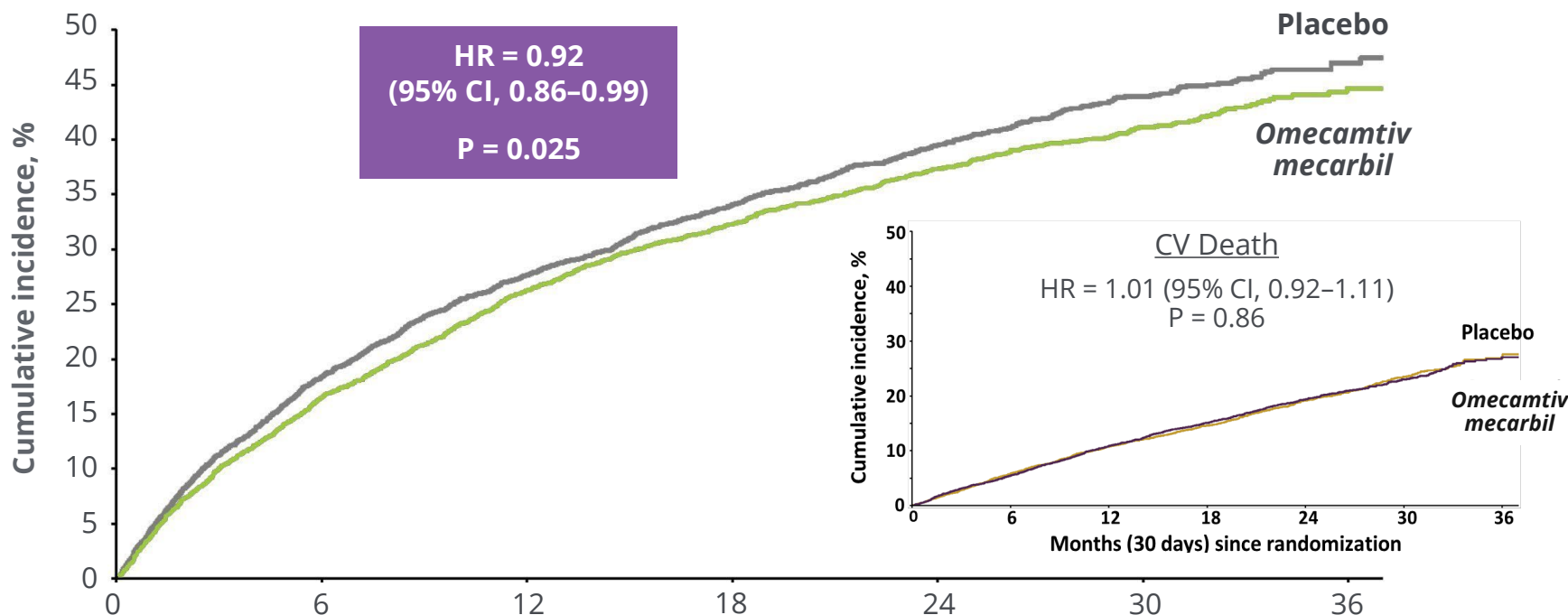


Event-driven clinical trial; 8,256 patients randomized in 35 countries at 944 clinical trial sites



HFrEF: heart failure with reduced ejection fraction; HF: heart failure; ER/ED: emergency room/emergency department; HF Omecamtiv mecarbil is an investigational drug and is not approved by any regulatory agency. Its safety and efficacy have not been established.

Primary Composite Endpoint



Patients at risk, n	Months (30 days) since randomization							
	0	6	12	18	24	30	36	
Placebo	4112	3310	2889	2102	1349	647	141	
OM	4120	3391	2953	2158	1430	700	164	

Time to first HF event or CV death

HR: hazard ratio; CI: confidence interval; CV: cardiovascular; OM: omecamtiv mecarbil

Source: Teerlink JR, et al. Cardiac myosin activation with omecamtiv mecarbil in systolic heart failure. NEJM. 2021;384:105-16.

Omecamtiv mecarbil is an investigational drug and is not approved by any regulatory agency. Its safety and efficacy have not been established.

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Cardiac Myosin Activation with Omecamtiv Mecarbil in Systolic Heart Failure

J.R. Teerlink, R. Diaz, G.M. Felker, J.J.V. McMurray, M. Metra, S.D. Solomon, K.F. Adams, I. Anand, A. Arias-Mendoza, T. Biering-Sorensen, M. Böhm, D. Bonderman, J.G.F. Cleland, R. Corbalan, M.G. Crespo-Leiro, U. Dahlström, L.E. Echeverría, J.C. Fang, G. Filippatos, C. Fonseca, E. González-Vera, A.R. Goudev, J.G. Howlett, D.E. Lanfear, J. Li, M. Lund, P. Macdonald, V. Mareev, S. Momomura, E. O'Meara, A. Pavlikomskis, P. Ponikvarski, F.J.A. Ramirez, P. Serpytis, K. Sliva, J. Spinar, T.M. Suter, J. Tomcsanyi, H. Vandekerckhove, D. Vinereanu, A.A. Voors, M.B. Yilmaz, F. Zannad, L. Sharpsten, J.C. Legg, C. Varin, N. Honarpour, S.A. Abbasi, F.I. Malik, and C.E. Kurtz, for the GALACTIC-HF Investigators*

ABSTRACT

BACKGROUND
The selective cardiac myosin activator omecamtiv mecarbil has been shown to improve cardiac function in patients with heart failure with a reduced ejection fraction. Its effect on cardiovascular outcomes is unknown.

METHODS
We randomly assigned 8256 patients (inpatients and outpatients) with symptomatic chronic heart failure and an ejection fraction of 35% or less to receive omecamtiv mecarbil (using pharmacokinetic-guided doses of 25 mg, 37.5 mg, or 50 mg twice daily) or placebo, in addition to standard heart-failure therapy. The primary outcome was a composite of a first heart-failure event (hospitalization or urgent visit for heart failure) or death from cardiovascular causes.

RESULTS
During a median of 21.8 months, a primary-outcome event occurred in 1523 of 4120 patients (37.0%) in the omecamtiv mecarbil group and in 1607 of 4112 patients (39.1%) in the placebo group (hazard ratio, 0.92; 95% confidence interval [CI], 0.86 to 0.99; P=0.03). A total of 808 patients (19.6%) and 798 patients (19.4%), respectively, died from cardiovascular causes (hazard ratio, 1.01; 95% CI, 0.92 to 1.11). There was no significant difference between groups in the change from baseline on the Kansas City Cardiomyopathy Questionnaire total symptom score. At week 24, the change from baseline for the median N-terminal pro-B-type natriuretic peptide level was 10% lower in the omecamtiv mecarbil group than in the placebo group; the median cardiac troponin I level was 4 ng per liter higher. The frequency of cardiac ischemic and ventricular arrhythmia events was similar in the two groups.

CONCLUSIONS
Among patients with heart failure and a reduced ejection, those who received omecamtiv mecarbil had a lower incidence of a composite of a heart-failure event or death from cardiovascular causes than those who received placebo. (Funded by Amgen and others; GALACTIC-HF ClinicalTrials.gov number, NCT02929329; EudraCT number, 2016-002299-28.)

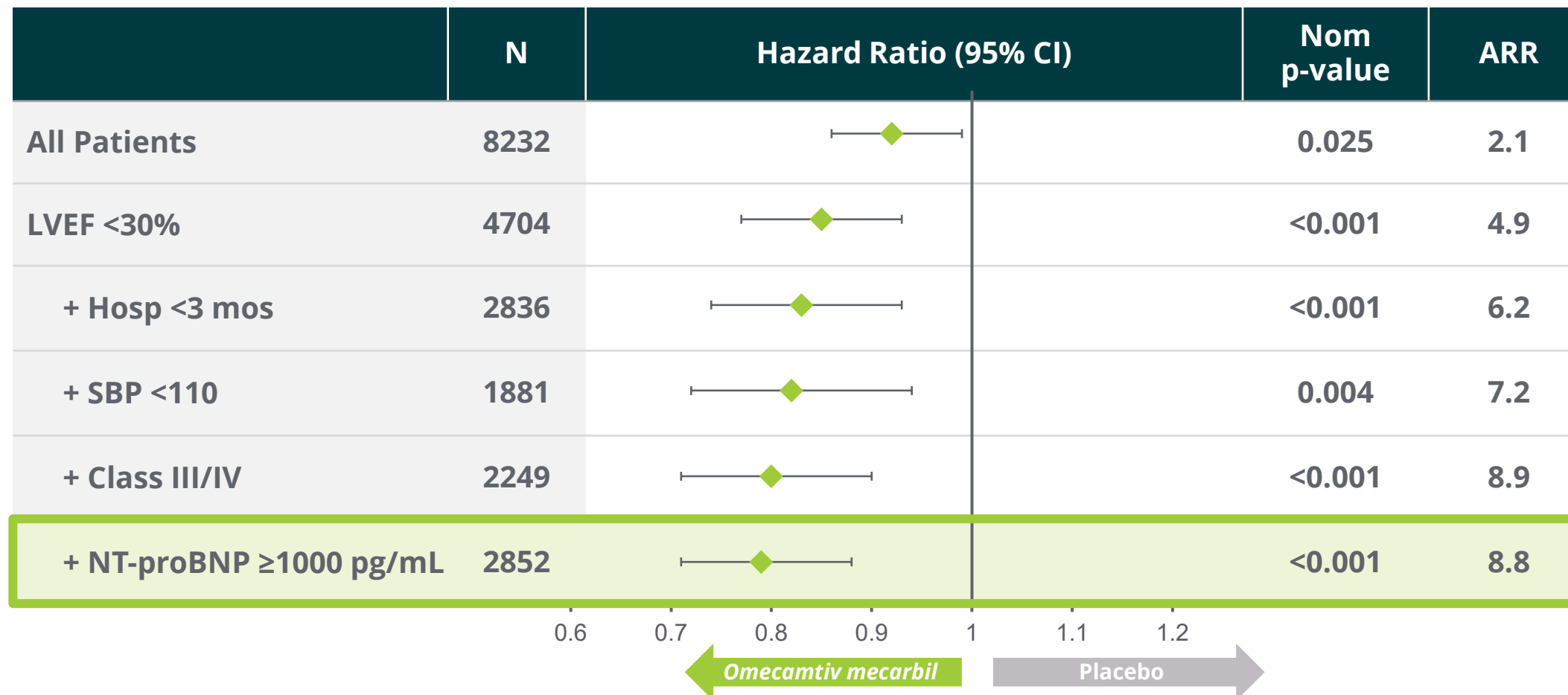
*The authors' full names, academic degrees, and affiliations are listed in the Appendix. Address reprint requests to Dr. Teerlink at San Francisco Veterans Affairs Medical Center, Cardiology, 111C, Bldg. 205, Box 20A-08, 4150 Clement St., San Francisco, CA 94121, or at john.teerlink@va.gov.

A complete list of GALACTIC-HF committee members and investigators is provided in the Supplementary Appendix, available at NEJM.org.

This article was published on November 11, 2020, at NEJM.org.

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Large Treatment Effect in Easily Defined HF Population



LVEF: left ventricular ejection fraction; SBP: systolic blood pressure; NT-proBNP: N-terminal pro-brain natriuretic peptide; CI: confidence interval; ARR: absolute risk reduction
 Source: Teerlink JR., Diaz R., Felker GM., et al. Effect of Ejection Fraction on Clinical Outcomes in Patients treated with Omecamtiv Mecarbil in GALACTIC-HF. JACC. 2021
 Omecamtiv mecarbil is an investigational drug and is not approved by any regulatory agency. Its safety and efficacy have not been established.

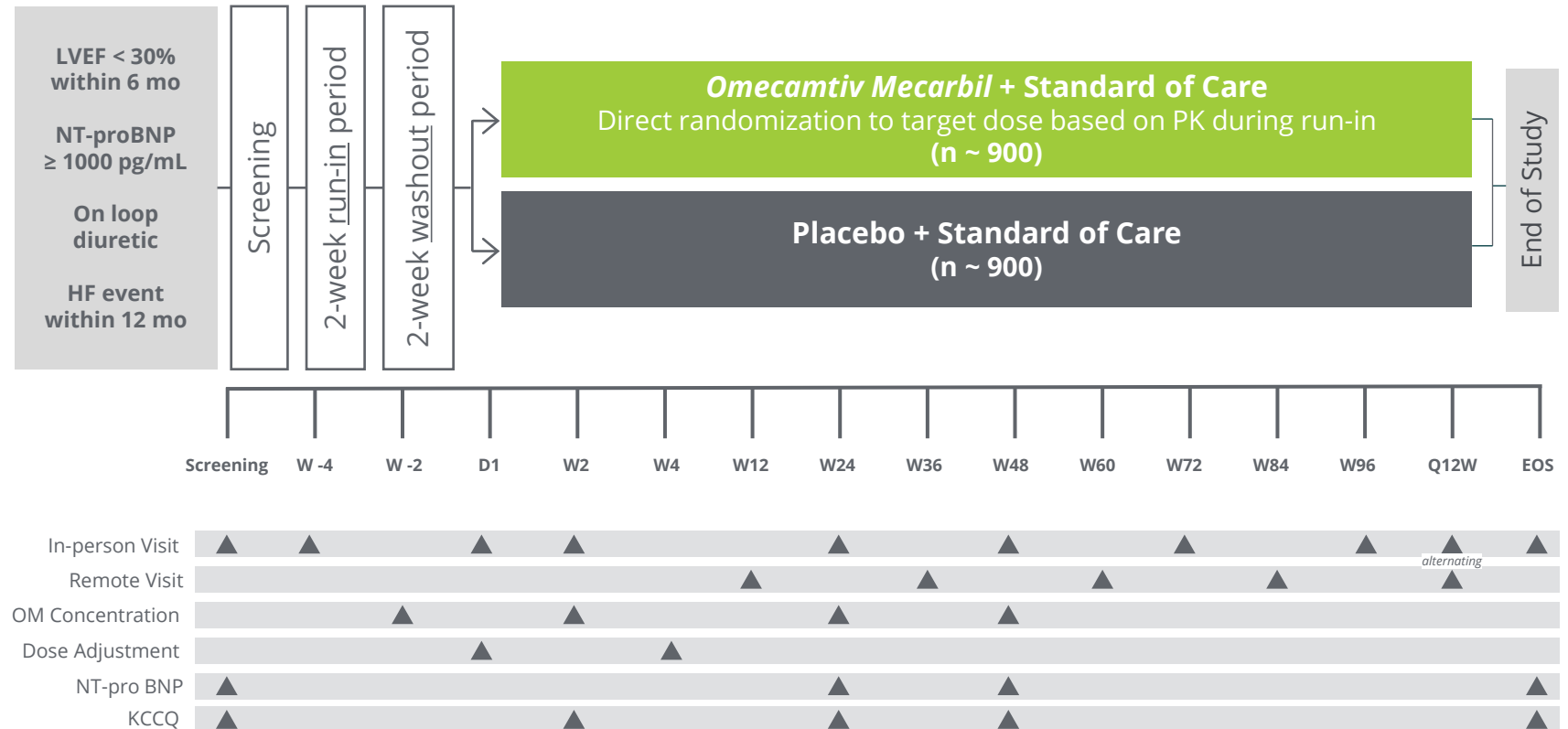
Phase 3 Confirmatory Clinical Trial Design

Currently enrolling



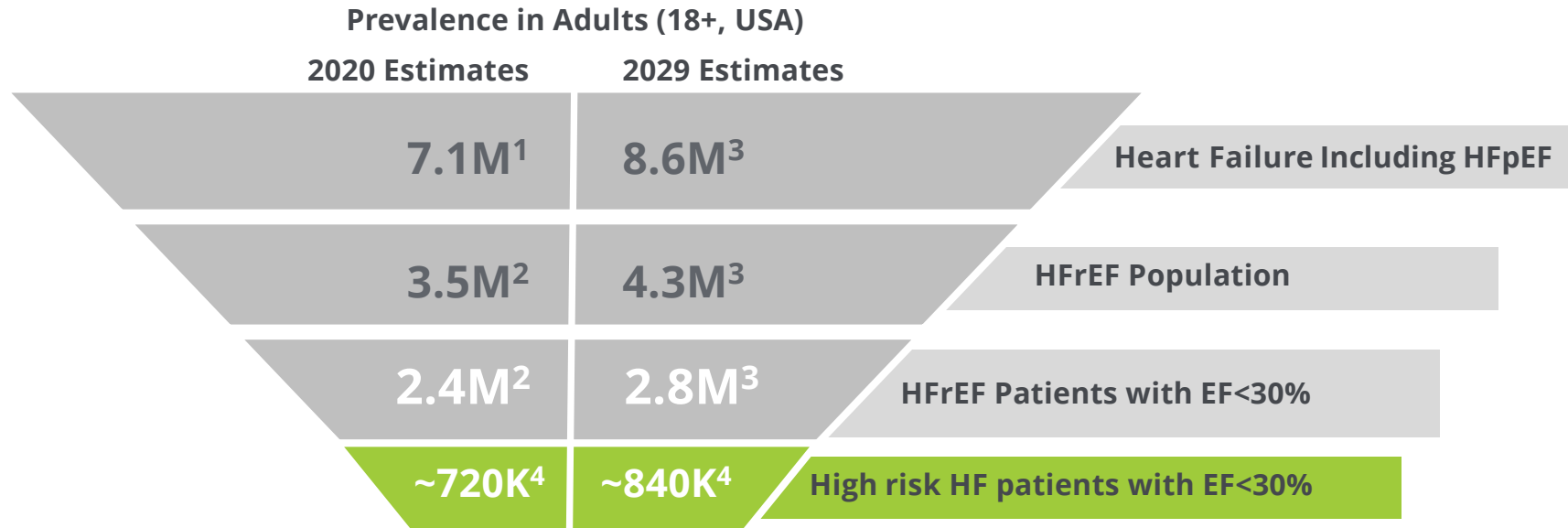
COMET-HF: Confirmation of *Omecamtiv Mecarbil* Efficacy Trial in Heart Failure

- Primary endpoint: **time to CV death, HF events, transplant/LVAD, or stroke**
- **Enriching population for adherence** with OM run-in period
- **Pragmatic design elements:**
 - Remote clinic visits
 - Limited safety labs & ECGs
 - Streamlined eligibility and study conduct
 - Streamlined AE reporting



CV: cardiovascular; HF: heart failure; LVAD: left ventricular assist device; OM: omecamtiv mecarbil; ECGs: electrocardiograms; AE: adverse event; LVEF: left ventricular ejection fraction; NT-proBNP: N-terminal pro-brain natriuretic peptide; KCCQ: Kansas City Cardiomyopathy Questionnaire
Omecamtiv mecarbil is an investigational drug and is not approved by any regulatory agency. Its safety and efficacy have not been established.

Large and Growing Target Patient Population in US



**Proposed
Omecamtiv Mecarbil
Target Patient**

Patients treated with GDMT and still experiencing severely reduced EF and symptoms of heart failure

Cardiac Function



LVEF < 30%

Markers of High-Risk HFrEF




- HF Event* within the last 12 months
- Elevated NT-proBNP
- Contraindications limiting GDMT, e.g. hypotension, renal dysfunction or hyperkalemia

* HF Event: Urgent, unscheduled outpatient visit or hospitalization

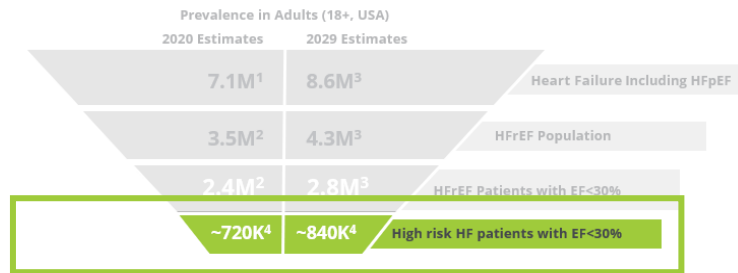
HFpEF: heart failure with preserved ejection fraction; HFrEF: heart failure with reserved ejection fraction; GDMT: Guideline-Directed Medical Therapy; LVEF: left ventricular ejection fraction; HF: heart failure; NT-proBNP: N-terminal pro-brain natriuretic peptide

Sources:

1. Tsao 2023, AHA. Racine 2022 CVrg, Bionest 2021.
2. Dunlay SM, Roger VL, Weston SA, Jiang R, Redfield MM. Longitudinal changes in ejection fraction in heart failure patients with preserved and reduced ejection fraction. *Circ Heart Fail.* 2012 Nov;5(6):720-6. doi: 10.1161/CIRCHEARTFAILURE.111.966366. Epub 2012 Aug 30. PMID: 22936826; PMCID: PMC3661289.
3. 2.1% annual growth rate: 1.9% annual growth rate of patient population 65+ (UN World Populations Prospects Nov 2019) and a 0.2% mortality impact of HF treatment (doi: 10.1136/bmj.l223 | *BMJ* 2019;364:l223)
4. Greene et al *JACC* 2023; 81:413-424

Omecamtiv mecarbil is an investigational drug and is not approved by any regulatory agency. Its safety and efficacy have not been established.

Higher Event Rate & Costs in Patients with Severely Reduced EF



Accounts for **~60%** of HFrEF hospitalizations⁵



35% of patients with severely reduced EF re-hospitalized within 1 year⁶



\$15,493 per HF re-hospitalization⁷



Direct costs from HF re-hospitalizations projected to increase from **\$3.9 billion** in 2020 to **\$4.6 billion** by 2029**

* HF Event: Urgent, unscheduled outpatient visit or hospitalization
 ** In terms of 2024 dollars

HFrEF: heart failure with reserved ejection fraction; EF: ejection fraction; HF: heart failure
 Sources:

1. Tsao 2023, AHA. Racine 2022 CVrg. Bionest 2021.
 2. Dunlay SM, Roger VL, Weston SA, Jiang R, Redfield MM. Longitudinal changes in ejection fraction in heart failure patients with preserved and reduced ejection fraction. *Circ Heart Fail.* 2012 Nov;5(6):720-6. doi: 10.1161/CIRCHEARTFAILURE.111.966366. Epub 2012 Aug 30. PMID: 22936826; PMCID: PMC3661289.
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 4. Greene et al *JACC* 2023; 81:413-424
 5. Extrapolated from Desai NR, Butler J, Binder G, Greene SJ. Prevalence and Excess Risk of Hospitalization in Heart Failure with Reduced Ejection Fraction. Poster presented at: Heart Failure Society of America (HFSA) Annual Scientific Meeting; 2022 Sep 30-Oct 3; Washington, DC.
 6. Carnicelli AP, Clare RM, Hofmann P, Chiswell K, DeVore AD, Vemulapalli S, Felker GM, Kelsey AM, DeWald TA, Sarocco P, Mentz RJ. Clinical trajectory of patients with a worsening heart failure event and reduced ventricular ejection fraction. *Am Heart J.* 2022 Mar;245:110-116. doi: 10.1016/j.ahj.2021.12.003. Epub 2021 Dec 18. PMID: 34932997.
 7. Urbich M, Globe G, Pantiri K, Heisen M, Bennison C, Wirtz HS, Di Tanna GL. A Systematic Review of Medical Costs Associated with Heart Failure in the USA (2014-2020). *Pharmacoeconomics.* 2020 Nov;38(11):1219-1236. doi: 10.1007/s40273-020-00952-0. PMID: 32812149; PMCID: PMC7546989.
- Omcamtiv mecarbil is an investigational drug and is not approved by any regulatory agency. Its safety and efficacy have not been established.**

***Ulacamten* (CK-586)**

Heart Failure with Preserved Ejection Fraction (HFpEF)

Despite broad use of standard treatments & advances in care, the prognosis for patients with HF is poor¹



~75%

HFpEF patients will die within five years of initial hospitalization²



~84%

HFpEF patients will be rehospitalized²



Subset of HFpEF patients with hypercontractility, ventricular hypertrophy, elevated biomarkers & HF symptoms **may benefit from a cardiac sarcomere inhibitor**



Significant increase in hospitalizations due to HFpEF, from 189,260 in 2008 to 495,095 in 2018⁶



Lifetime healthcare costs for HFpEF are ~ \$126,819 per patient⁵, per-patient monthly cost for healthcare is \$7,482, primarily, driven by **high rates of inpatient & outpatient visits**

HFpEF: heart failure with preserved ejection fraction

1. Jhund PS, MacIntyre K, Simpson CR, et al. Long-Term Trends in First Hospitalization for Heart Failure and Subsequent Survival Between 1986 and 2003. *Circulation*. 2009;119:515-523.

2. Bozkurt B, Ahmad T, Alexander KM, Baker WL, Bosak K, Breathett K, Fonarow GC, Heidenreich P, Ho JE, Hsieh E, Ibrahim NE, Jones LM, Khan SS, Khazanie P, Koelling T, Krumholz HM, Khush KK, Lee C, Morris AA, Page RL 2nd, Pandey A, Piano MR, Stehlik J, Stevenson LW, Teerlink JR, Vaduganathan M, Ziaeian B; Writing Committee Members. Heart Failure Epidemiology and Outcomes Statistics: A Report of the Heart Failure Society of America. *J Card Fail*. 2023 Oct;29(10):1412-1451. doi: 10.1016/j.cardfail.2023.07.006. Epub 2023 Sep 26. PMID: 37797885; PMCID: PMC10864030.

3. Dunlay SM, Roger VL, Weston SA, Jiang R, Redfield MM. Longitudinal changes in ejection fraction in heart failure patients with preserved and reduced ejection fraction. *Circ Heart Fail*. 2012 Nov;5(6):720-6. doi: 10.1161/CIRCHEARTFAILURE.111.966366. Epub 2012 Aug 30. PMID: 22936826; PMCID: PMC3661289.

4. Yancy CW, Jessup M, Bozkurt B, et al. 2013 ACCF/AHA Guideline for the Management of Heart failure: A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines. *Circulation*. 2013;128:e240-e327.

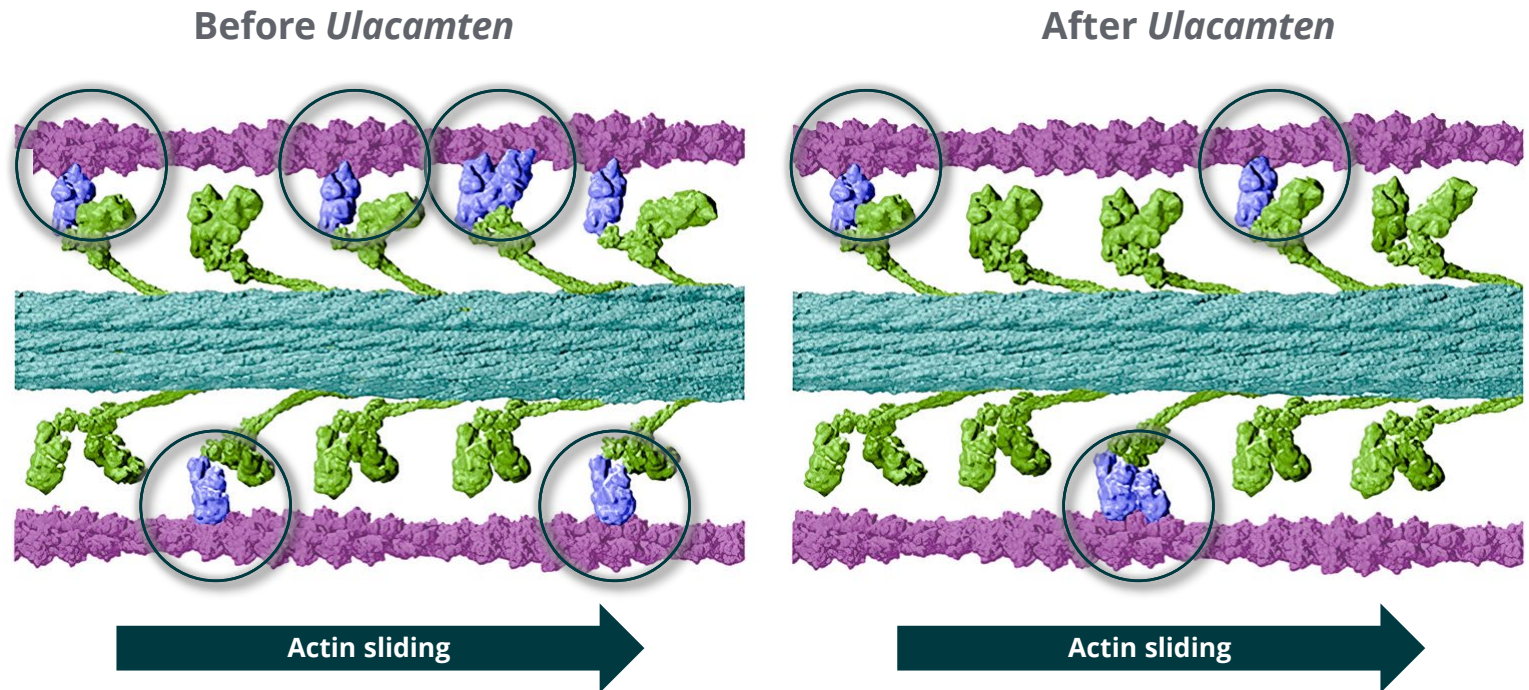
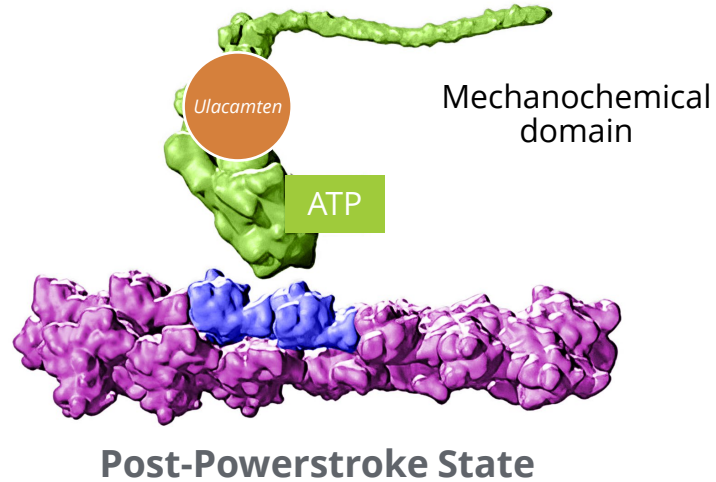
5. Kapelios, *Cardiac Failure Review* 2023

6. Clark KAA, Reinhardt SW, Chouairi F et al (2022) Trends in heart failure hospitalizations in the US from 2008 to 2018. *J Card Fail* 28(2):171-180.

7. Lam CSP, Wood R, Vaduganathan M et al (2021) Contemporary economic burden in a real-world heart failure population with Commercial and Medicare supplemental plans. *Clin Cardiol* 44(5):646-655.

Ulacamten: Distinct Mechanism of Action from Aficamten

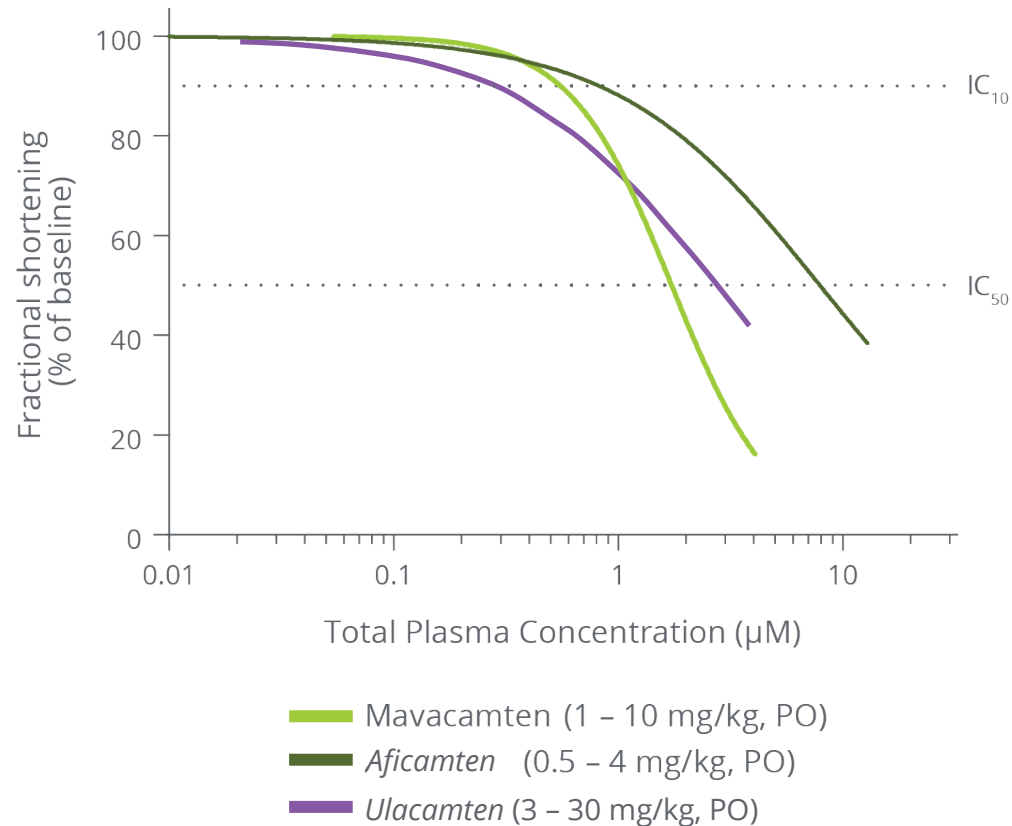
“Fewer hands pulling on the rope”



ATP: adenosine triphosphate
Ulacamten is an investigational drug and is not approved by any regulatory agency. Its safety and efficacy have not been established.

Ulacamten: Shallow *In Vivo* Concentration-Response

Ulacamten has a shorter half-life than *aficamten*



Pharmacodynamic window Fractional shortening IC₅₀/IC₁₀ ratio

<i>mavacamten</i>	2.8x
<i>aficamten</i>	9.9x
<i>ulacamten</i>	9.3x

IC₁₀: plasma concentration at 10% relative reduction in fractional shortening
 IC₅₀: plasma concentration at 50% relative reduction in fractional shortening

Compound half-life in humans	Actual	Predicted
<i>aficamten</i>	~3 days	2.8 days
<i>ulacamten</i>	~15 hours	15 hours

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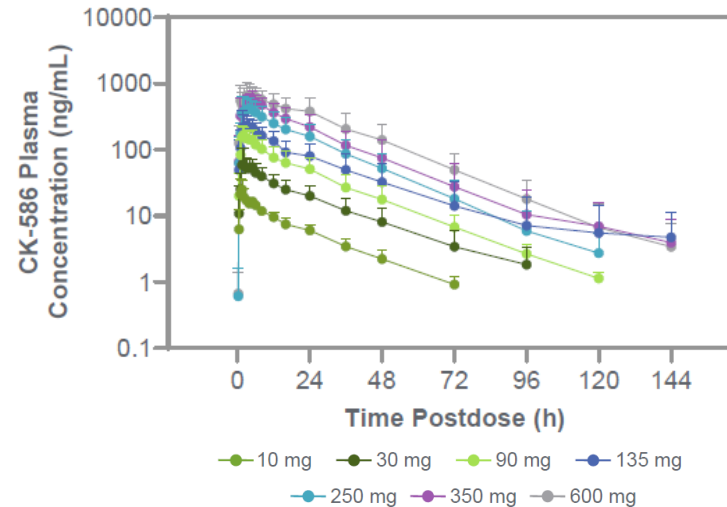
Phase 1 Data Support Advancement to Phase 2 Clinical Trial

Phase 1 study design: 7 SAD cohorts (10 mg to 600 mg) & 2 MAD cohorts (100 & 200 mg once daily), 10 participants each

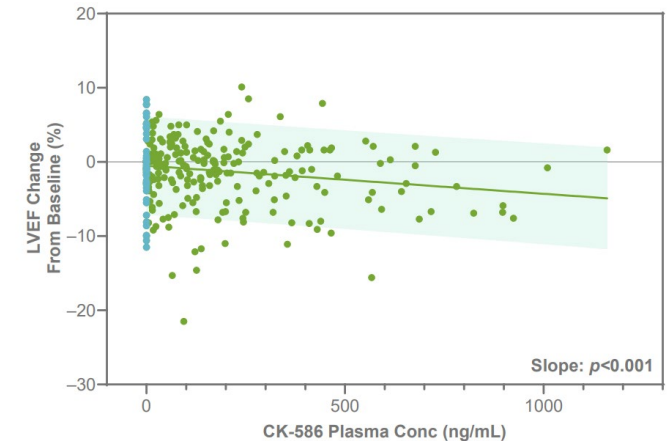
- **Less than 24-hour** half-life
- **Shallow and predictable** PK/PD relationship based on LVEF and LVFS
- **Well-tolerated** across all cohorts
- **No serious adverse events** were observed
- **Stopping criteria were not met**

Plasma Concentration

(mean [SD]) over time after single ascending doses of ulacamten



Change in LVEF vs. Ulacamten Plasma Concentration



PK/PD: pharmacokinetic/pharmacodynamic; LVEF: left ventricular ejection fraction; LVFS: left ventricular fractional shortening

Source; Lutz JD., Simpkins T., Cheplo K., et al. A First-in-Human, Single and Multiple Ascending Dose Study of CK-4021586, a Novel Cardiac Myosin. Poster, American College of Clinical Pharmacology 2024.

Ulacamten is an investigational drug and is not approved by any regulatory agency. Its safety and efficacy have not been established.

Phase 2 Study Schema

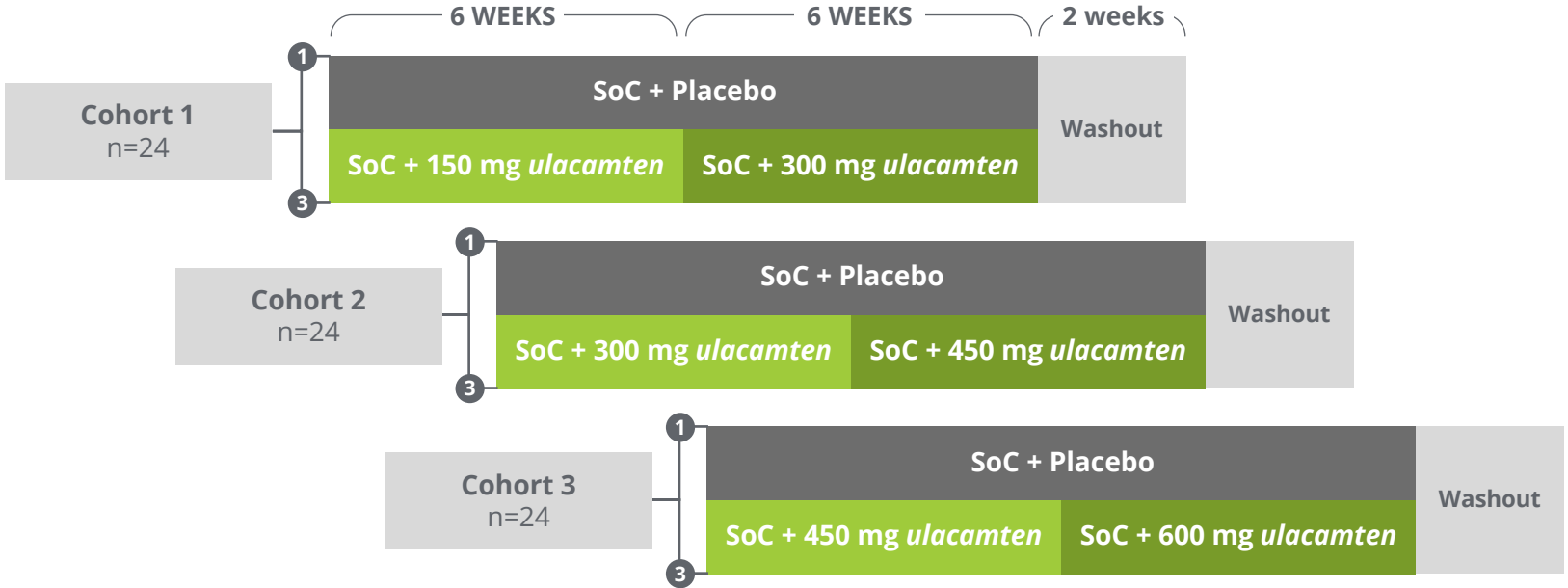
Currently enrolling



AMBER-HFpEF: Assessment of CK-586 in a Multi-Center, Blinded Evaluation of Safety & Tolerability Results in HFpEF

Enrolling HFpEF patients with:

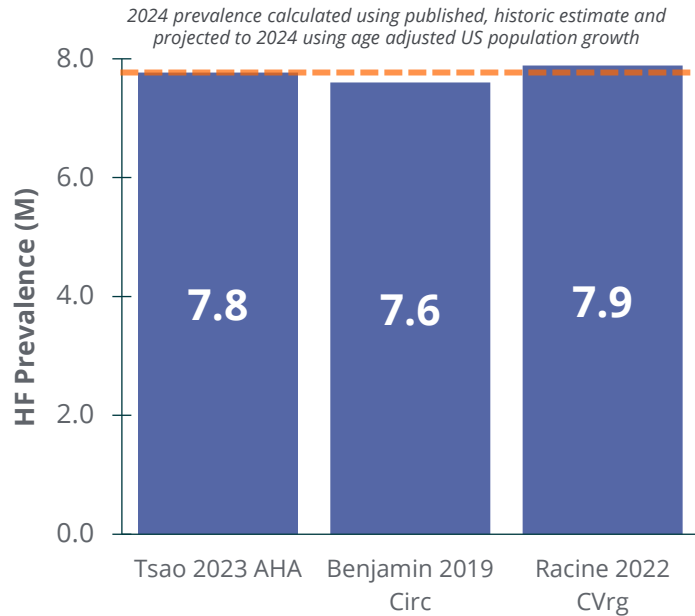
- LVEF \geq 60%
- Structural abnormality
- BMI < 40
- NYHA FC II or III
- NT-proBNP \geq 300 (or \geq 900 in AF)



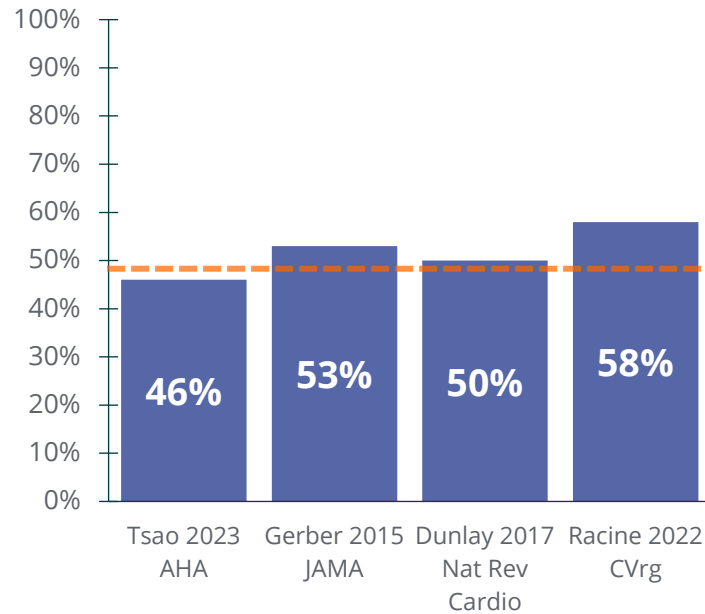
HFpEF: heart failure with preserved ejection fraction; LVEF: left ventricular ejection fraction; BMI: body mass index; NYHA FC: New York Heart Association Functional Class; AF: atrial fibrillation; SoC: standard of care. Ulacamten is an investigational drug and is not approved by any regulatory agency. Its safety and efficacy have not been established.

Ulacamten: Focusing on Patients with HFpEF and EF ≥ 60

7.9M
Heart Failure Prevalence in 2024, US



4.0M (2024)
50% of HF with HFpEF (EF ≥ 50%)



1.0M (EF ≥ 65) to 2.0M (EF ≥ 60)
~20% of HF with EF ≥ 60%

~10% of HF patients have EF ≥ 65

Additional ~10% of HF patients have EF between 60% and 65%

Study	EF ≥ 65 (%)	EF 60-65 (%)
Hsu 2017	10%	20%
Dunlay 2012	11%	22%
Kerwagen 2023	8%	16%
Delepaul 2017	14%	28%
TriNetX 2024	13%	26%

Sources: Racine et al Heart Failure 2020-2029, CVrg March 2020 p 26; includes patients in long term care settings, which NHANES epi does not incorporate; Benjamin, E. et al. Heart Disease and Stroke Statistics—2019 Update: A Report From the AHA Circulation Vol 139, Issue 10, 5 March 2019; Pages e56-e528 historic growth rate of HF 2009-2012 vs. 2013-2016: 2.1%; the population of 65+ year old is expected to grow at 1.9% according to the UN - mortality improvement of 0.2% per year.; Heidenreich P. et al: Forecasting the Impact of Heart Failure in the United States Circulation: Heart Failure Volume 6, Issue 3 May 2013; Tsao C., et al Heart Disease and Stroke Statistics—2023 Update: A Report From the American Heart Association, Circulation Volume 139, Issue 10 Mar 2019; UN Population Report Nov 2020; Dunlay SM, Roger VL, Weston SA, Jiang R, Redfield MM. Longitudinal changes in ejection fraction in heart failure patients with preserved and reduced ejection fraction. Circ Heart Fail. 2012 Nov;5(6):720-6. doi: 10.1161/CIRCHEARTFAILURE.111.966366. Epub 2012 Aug 30. PMID: 22936826; PMCID: PMC3661289, Gerber 2015 JAMA, Hsu JJ, Ziaeian B, Fonarow GC. Heart Failure With Mid-Range (Borderline) Ejection Fraction: Clinical Implications and Future Directions. JACC Heart Fail. 2017 Nov;5(11):763-771. doi: 10.1016/j.jchf.2017.06.013. Epub 2017 Oct 11. PMID: 29032140; PMCID: PMC6668914, Kerwagen F, Koehler K, Vettorazzi E, Stangl V, Koehler M, Halle T, Koehler F, Störk S. Remote patient management of heart failure across the ejection fraction spectrum: A pre-specified analysis of the TIM-HF2 trial. Eur J Heart Fail. 2023 Sep;25(9):1671-1681. doi: 10.1002/ehfj.2948. Epub 2023 Jul 31. PMID: 37368507, Delepaul B, Robin G, Delmas C, Moine T, Blanc A, Fournier P, Roger-Rollé A, Domain G, Delon C, Uzan C, Boudjellil R, Carrié D, Roncalli J, Galinier M, Lairez O. Who are patients classified within the new terminology of heart failure from the 2016 ESC guidelines? ESC Heart Fail. 2017 May;4(2):99-104. doi: 10.1002/ehf2.12131. Epub 2017 Jan 31. PMID: 28451445; PMCID: PMC5396039.

Ulacamten is an investigational drug and is not approved by any regulatory agency. Its safety and efficacy have not been established.

Ulacamten May Address Unmet Needs of HFpEF Patients



Proposed Mechanistic Benefits

- *Ulacamten* may benefit cardiac relaxation during diastole
- *Ulacamten* may reduce symptoms and improve functional capacity



Target Product Profile

- Statistically significant reduction in composite of mortality and hospitalization outcomes
- Oral QD tablet
- Minimal drug interactions
- Simple dose titration with biomarker monitoring

HFpEF: heart failure with preserved ejection fraction
Ulacamten is an investigational drug and is not approved by any regulatory agency. Its safety and efficacy have not been established.

Financials & Milestones

Strong Financial Position

Well-capitalized to execute launch & advance R&D pipeline

~\$1.1B in cash, cash equivalents and investments as of March 31, 2026

Recent financing

\$760M in net proceeds from our May 2026 public offering of ~11.3M shares of common stock at a price of \$71.00 per share

Further access to capital through term loans with Royalty Pharma (RP)

Eligible to draw up to **\$175M** from Tranche 7 loan

Potential further funding through RP opt-in

RP, at its option, can invest up to **\$150M** in a Phase 3 trial of *ulacamten* in exchange for an additional 3.5% revenue participation interest in worldwide net sales of *ulacamten**

**Add'l
\$325M**

*Royalty Pharma currently has a revenue participation interest of 1.0% of worldwide net sales of *ulacamten*.

2026 Financial Guidance

	Guidance Issued on Feb. 24, 2026
GAAP Combined R&D and SG&A Expense	\$830M to \$870M
Non-cash stock-based compensation expense included in GAAP Combined R&D and SG&A Expense	\$130M to \$120M

The financial guidance does not include: 1) collaboration expenses which can include reimbursed expenses and cost of inventory sales of *aficamten* to partners, 2) potential costs related to commercialization of *aficamten* in nHCM, and 3) the effect of GAAP adjustments as may be caused by events that occur subsequent to publication of this guidance including, but not limited to, Business Development activities.

GAAP: Generally Accepted Accounting Principles; R&D: Research & Development; SG&A: Selling, General & Administrative; nHCM: non-obstructive hypertrophic cardiomyopathy

2026 Expected Milestones



Meet with regulatory authorities to discuss results from **ACACIA-HCM** & plans for submitting sNDA

Launch MYQORZO in Germany in Q2 2026

sNDA for **MAPLE-HCM** PDUFA date
November 14, 2026

Complete enrollment in the adolescent cohort of **CEDAR-HCM** in Q4 2026

Potential **Health Canada** decision on New Drug Submission in 2H 2026

Omecamtiv Mecarbil

Continue enrollment in **COMET-HF** through 2026

Ulacamten

Complete enrollment in Cohort 1 of **AMBER-HFpEF** in 2H 2026

sNDA: Supplemental New Drug Application; oHCM: obstructive hypertrophic cardiomyopathy; PDUFA: Prescription Drug User Fee Act; HF: heart failure; HFpEF: heart failure with preserved ejection fraction
MYQORZO is only approved in the U.S., China and the EU for the treatment of adults with symptomatic oHCM.
Ulacamten, omecamtiv mecarbil and CK-089 are investigational agents and have not been approved for use by any regulatory agency. Their safety and efficacy has not been established.
Timing of regulatory approvals is subject to regulatory review and may differ materially.



THANK YOU



Vi, diagnosed with HCM