Day One
BIOPHARMACEUTICALS

Day One Biopharmaceuticals

Targeted Therapies for People of All Ages

October 2024

Disclaimer

This presentation and the accompanying oral commentary contain forward-looking statements that are based on our management's beliefs and assumptions and on information currently available to our management. Forward-looking statements are inherently subject to risks and uncertainties, some of which cannot be predicted or quantified. In some cases, you can identify forward-looking statements by terminology such as "may," "will," "should," "could," "expect," "plan," anticipate," "believe," "estimate," "predict," "intend," "potential," "would," "continue," "ongoing" or the negative of these terms or other comparable terminology. Forward-looking statements include all statements other than statements of historical fact contained in this presentation, including information concerning our future financial performance, including the sufficiency of our cash, cash equivalents and short-term investments to fund our operations, business plans and objectives, the anticipated gross proceeds of our private placement offering, timing and success of our commercialization and marketing efforts, timing and success of our planned nonclinical and clinical development activities, the results of any of our strategic collaborations, including the potential achievement of milestones and provision of royalty payments thereunder, timing and results of nonclinical studies and clinical trials, efficacy and safety profiles of our products and product candidates, the ability of OJEMDA™ (tovorafenib) to treat pediatric low-grade glioma (pLGG) or related indications, the potential therapeutic benefits and economic value of our products and product candidates, potential growth opportunities, competitive position, industry environment and potential market opportunities, our ability to protect intellectual property and the impact of global business or macroeconomic conditions, including as a result of inflation, changing interest rates, cybersecurity incidents, potential instability in the global banking system, changes in the U.S. presidential administration, uncertainty with respect to the federal debt ceiling and budget and potential government shutdowns related thereto and global regional conflicts, on our business and operations.

Forward-looking statements are subject to known and unknown risks, uncertainties, assumptions and other factors. It is not possible for our management to predict all risks, nor can we assess the impact of all factors on our business or the extent to which any factor, or combination of factors, may cause actual results to differ materially from those contained in any forward-looking statements we may make. These factors, together with those that are described under the heading "Risk Factors" contained in our most recent Quarterly Report on Form 10-Q filed with the Securities and Exchange Commission (SEC) and other documents we file from time to time with the SEC, may cause our actual results, performance or achievements to differ materially and adversely from those anticipated or implied by our forward-looking statements.

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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.

Cancer Therapies for People of All Ages

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Our Approach

- Develop medicines for genomically-defined cancers
- Establish first-in-class position through rapid registration pathways
- Expand to adolescent and adult populations in parallel and pursue those opportunities with the same commitment we do for children

Nasdaq: DAWN IPO: 2021 Founded: 2018

Our Pipeline

Product Candidate	Therapeutic Area	Preclinical	Phase 1	Phase 2	Phase 3/ Registrational	Approved	Recent & Anticipated Milestones
Tovorafenib[3] Type II RAF Inhibitor OJEMDA brand name in U.S.[1] Ex-U.S. Rights: IPSEN Innovation for patient care	BRAF-altered relapsed pLGG	FIREFLY-1 (pivotal Phase 2)[2]				ojemda™ (tovorafenib)	**FDA approval** April 2024 **Ex-U.S. license agreement** July 2024
	Frontline RAF-altered pLGG	FIREFLY-2 (pivotal Phase 3)					**First patient dosed** March 2023
DAY301 PTK7 Targeted ADC	Adult and pediatric solid tumors						**U.S. IND cleared** April 2024 **First patient dosed expected** 4Q 2024 / 1Q 2025
VRK1 Program VRK1 Inhibitor	Adult and pediatric cancers						**In-licensed** August 2023

[1] OJEMDA has received accelerated approval by the U.S. Food and Drug Administration. [2] FIREFLY-1 is an open-label, pivotal Phase 2 trial. [3]Ex-U.S. license agreement with Ipsen to commercialize OJEMDA (tovorafenib) outside the U.S. DAY301 is a license agreement with MabCare Therapeutics for exclusive worldwide rights, excluding Greater China, for MTX-13/CB-002, a novel ADC targeting PTK7. pLGG, pediatric low-grade glioma. VRK1 Program is a research collaboration and license agreement with Sprint Bioscience AB for exclusive worldwide rights to a research-stage program targeting VRK1. The safety and efficacy of investigational agents and/or investigational uses of approved products have not been established.

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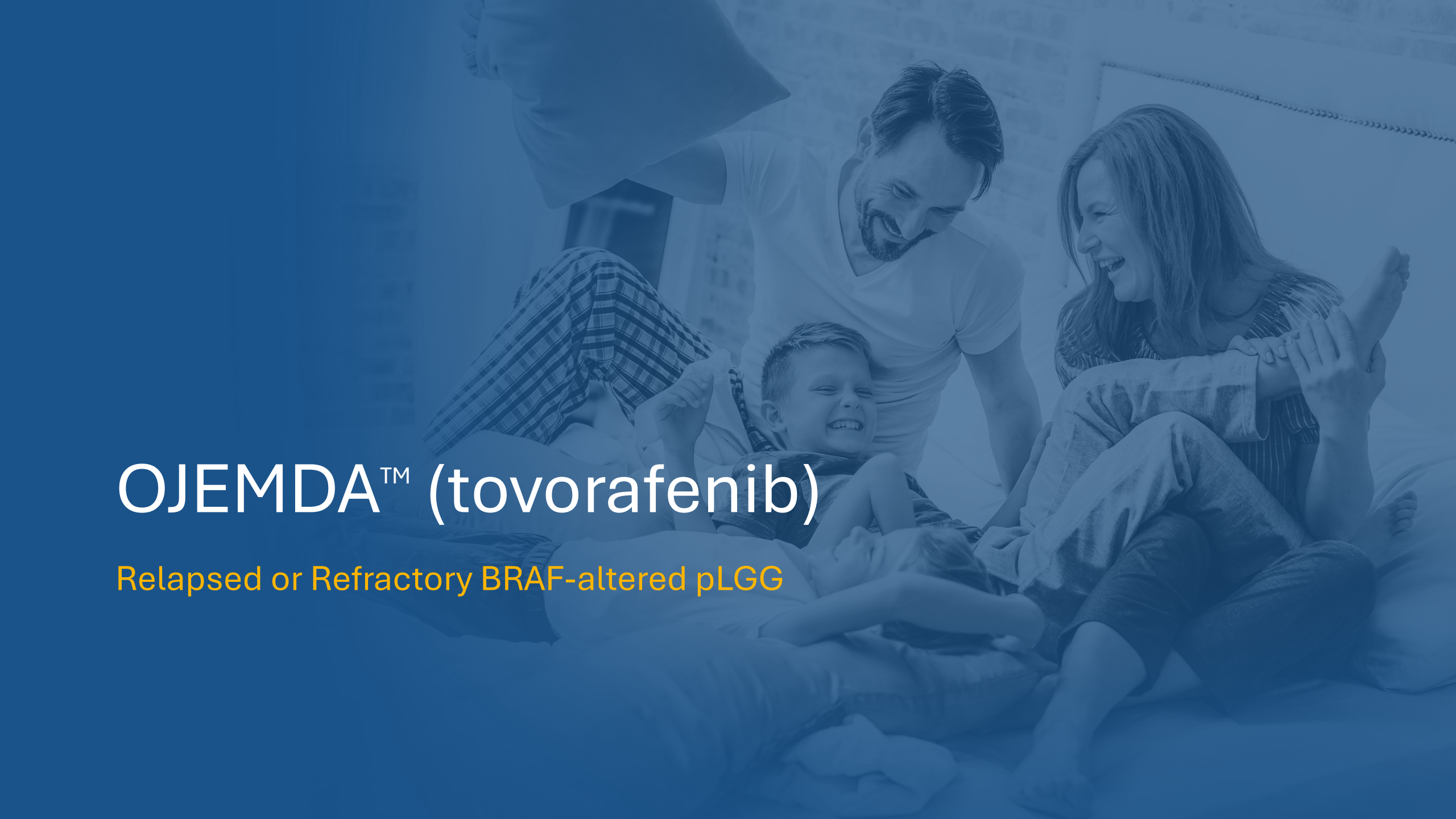

OJEMDA™ (tovorafenib)

Relapsed or Refractory BRAF-altered pLGG

Pediatric Low-Grade Glioma: The Most Common Type Of Brain Tumor In Children

pLGGs are chronic and relentless, with patients suffering profound tumor and treatment-associated morbidity that can impact their life trajectory over the long term[1]

A Serious and Life-Threatening Disease

- For the majority of pLGG patients in the relapsed setting, there is no standard of care and no approved therapies
- Up to 75% of pLGGs have a BRAF alteration*, of those ~80% are BRAF fusions and ~20% are BRAF V600 mutations[2-6]
- Despite surgery playing a significant role in treatment, the vast majority of patients still require systemic therapy[7,8]
- Due to high rate of disease recurrence, most patients will undergo multiple lines of systemic therapy over the course of their disease

*Incidence of BRAF alterations varies across pLGG subtypes. [1] Sievert AJ, Fisher MJ. Pediatric low-grade gliomas. *J Child Neurol.* 2009;24(11):1397-1408. doi:10.1177/0883073809342005. [2] Penman CL et al. *Front Oncol.* 2015;5:54. [3] Cohen AR., *N Engl J Med.* 2020;386(20):1922-1931. [4] Lassaletta A, et al. *J Clin Oncol.* 2017;35(25):2934-2941. [5] Faulkner C, et al. J Neuropathol Exp Neurol. 2015;74(9):867-872. [6] Packer RJ, et al. Neuro Oncol. 2017;19(6):750-761. [7] Ostrum QT et al., Neuro Oncol. 2015; 16(Suppl 10):x1-x36; [8] De Blank P. et al., Curr Opin Pediatr. 2019 Feb; 31(1):21-27.

Conventional Treatments Can Be Disruptive To Childhood And Can Have Significant Long-Term Consequences

Surgery

- Significant recovery times
- Risks of complications
- Resection may be limited by location of tumor
- Potential for functional deficits based on location of tumor and extent of resection

Chemotherapy

- Requirement for indwelling catheter and weekly infusions
- Risk of neutropenia, hypersensitivity reactions, nausea and vomiting and peripheral neuropathy

Radiation

- Risk of secondary malignancy
- Risk of malignant transformation
- Risk of vascular proliferation and stroke
- Neurocognitive impact, depending on location of tumor and radiation field

Goal of therapy is to control the tumor, minimize the burden of surgery, chemotherapy, and radiation, and reduce the risk of life-long treatment and disease-related effects

Source: 1. Heitzer AM, Raghubar K, Ris MD, et al. Neuropsychological functioning following surgery for pediatric low-grade glioma: a prospective longitudinal study. J Neurosurg Pediatr. 2019;1-9. doi:10.3171/2019.9.PEDS19357. 2. Bryant R. Managing side effects of childhood cancer treatment. J Pediatr Nurs. 2003;18(2):113-125. doi:10.1053/jpdn.2003.11. 3. Zahnreich S, Schmidberger H. Childhood cancer: occurrence, treatment and risk of second primary malignancies. Cancers (Basel). 2021;13(11):2607. doi:10.3390/cancers/13112607. 4. National Cancer Institute. Fertility issues in girls and women with cancer. http://www.cancer.gov. Accessed June 13, 2022. 5. Alessi I., Caroleo A.M., de Palma L., Mastronuzzi A., Pro S., Colafati G.S., Boni A., Della Vecchia N., Velardi M., Evangelisti M., et al. Short and Long-Term Toxicity in Pediatric Cancer Treatment: Central Nervous System Damage. Cancers. 2022;14:1540. doi: 10.3390/cancers14061540.

Overview U.S. Prescribing Information For OJEMDA™ (tovorafenib)

Available in tablet formulation and pediatric-friendly powder for oral suspension

INDICATION

OJEMDA is indicated for the treatment of pediatric patients 6 months of age and older with relapsed or refractory pediatric low-grade glioma harboring a BRAF fusion or rearrangement, or BRAF V600 mutation

RECOMMENDED DOSE

380 mg/m^2 administered orally once weekly (not to exceed a dose of 600mg once weekly); OJEMDA can be taken with or without food

For full prescribing information, visit dayonebio.com

*This indication is approved under accelerated approval based on response rate and duration of response. Continued approval for this indication may be contingent upon verification of clinical benefit in a confirmatory trial.

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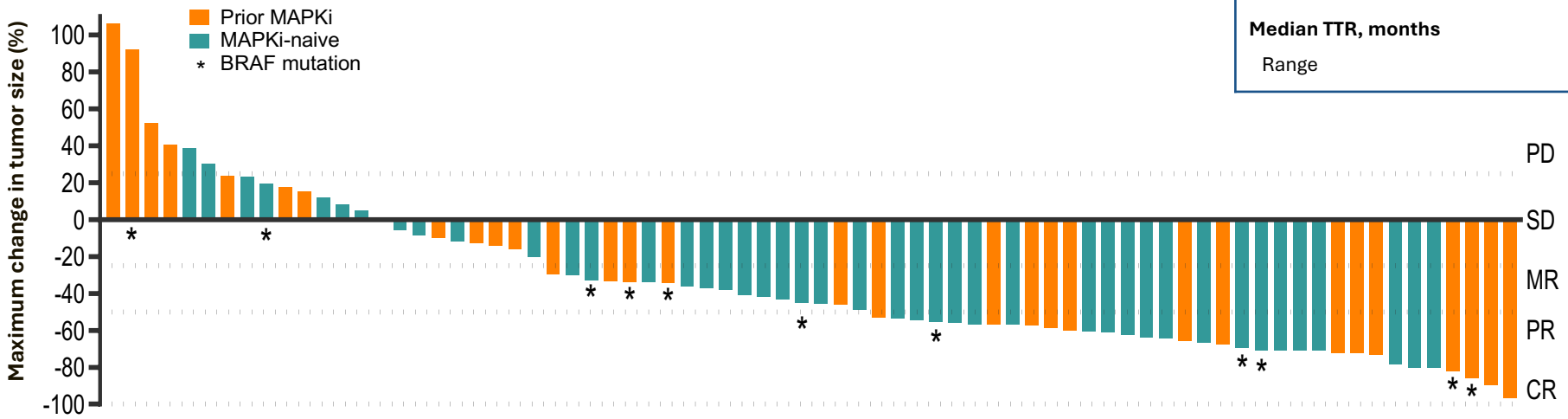
Efficacy Summary From OJEMDA™ (tovorafenib) Prescribing Information

51% **Overall response rate (RAPNO-LGG) in 76 evaluable patients**

Response (IRC)	RAPNO-LGG n	RAPNO-LGG n (%)	RAPNO-LGG 95% CI
ORR, n (%)	**76**	**39 (51)**	**40-63**
BRAF fusion or rearrangement	64	33 (52)	39-64
BRAF V600 mutation	12	6 (50)	21-79
Prior MAPKi use	45	22 (49)	31-64
MAPKi-naïve	31	17 (55)	36-73
Median DOR, months	**39**	**13.8**	**11.3-NR†**
Median TTR, months	**39**	**5.3**	
Range		1.6-11.2	



June 5, 2023 data cutoff. CI, confidence interval; DOR, duration of response; IRC, independent radiology review committee; LGG, low-grade glioma; NR, not reached; ORR, overall response rate; RAPNO, Response Assessment in Pediatric Neuro-Oncology; TTR, time to response; CR, complete response; PR, partial response; MR, minor response; SD, stable disease; PD, progressive disease. † As of the data cutoff, 66% remain on tovorafenib.

Safety Summary From OJEMDA™ (tovorafenib) Prescribing Information

Warnings and Precautions

- Hemorrhage
- Skin toxicity, including photosensitivity
- Hepatotoxicity
- Effect on growth
- Embryo-fetal toxicity
- Use in NF1- associated tumors

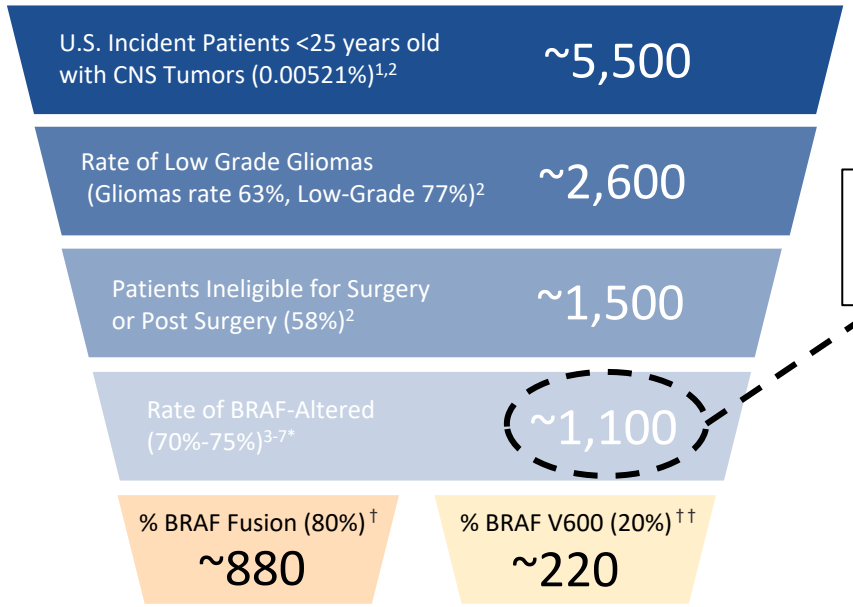
No boxed warnings or contraindications

Preferred Term, n (%)	TEAEs (≥ 30% of patients [n=137])	
	Any Grade	Grade ≥3
Any AE	137 (100)	86 (63)
Hair color changes	104 (76)	0
Anemia	81 (59)	15 (11)
Elevated CPK	80 (58)	16 (12)
Fatigue	76 (55)	6 (4)
Vomiting	68 (50)	6 (4)
Hypophosphatemia	64 (47)	0
Headache	61 (45)	2 (1)
Maculo-papular rash	60 (44)	11 (8)
Pyrexia	53 (39)	5 (4)
Dry skin	49 (36)	0
Elevated LDH	48 (35)	0
Increased AST	47 (34)	4 (3)
Constipation	45 (33)	0
Nausea	45 (33)	0
Upper RTI	43 (31)	2 (1)
Dermatitis acneiform	42 (31)	1 (1)
Epistaxis	42 (31)	1 (1)

June 5, 2023 data cutoff. OJEMDA safety data (n=137). Treatment-emergent AEs ≥20% any grade in arms 1 & 2. AE, adverse event; AST, aspartate aminotransferase; CPK, creatine phosphokinase; LDH, lactate dehydrogenase; RTI, respiratory tract infection; TEAEs, treatment-emergent adverse events.

Addressable U.S. Opportunity of OJEMDA Estimated to be ~2,000-3,000 Patients

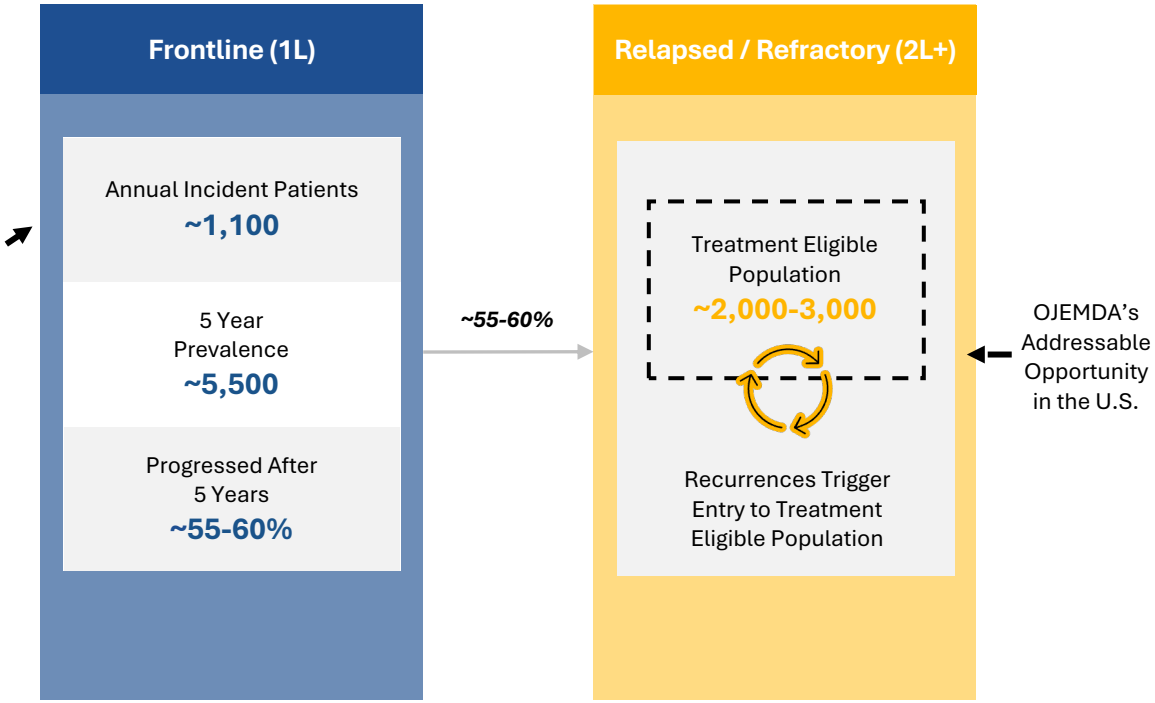
Incident Therapeutic Build for New pLGG Patients to be Treated in Frontline Setting



1L BRAF-Altered pLGG Patients Eligible for Systemic Therapy

Illustrative pLGG Patient Flow[§]

Prevalence of Systemically-Treated Patients Under 25 Years **~26,000**



Majority of pLGG patients will progress within 5 years

*[1]. US Census. [2] CBTRUS, Qaddoumi et al 2009, Schreck et al 2019, ClearView Analysis. [3] Penman CL et al. Front Oncol. 2015;5:54. [4] Cohen AR., N Engl J Med. 2020;386(20):1922-1931. [5] Lassaletta A, et al. J Clin Oncol. 2017;35(25):2934-2941. [6] Faulkner C, et al. J Neuropathol Exp Neurol. 2015;74(9):867-872. [7] Packer RJ, et al. Neuro Oncol. 2017;19(6):750-761. * Incidence of BRAF alterations varies across pLGG subtypes. † Predominantly seen in pilocytic astrocytomas. †† May vary across pLGG subtypes. BRAF, V-Raf murine sarcoma viral oncogene homolog B; MAPK, mitogen-activated protein kinase; pLGG, pediatric low-grade glioma. § Estimated annual incidence, estimated prevalence, estimated progression rates, and estimated recurrent/progressive total addressable opportunity are Day One calculations based on publicly available data. The estimated recurrent/progressive total addressable opportunity is based on progression free survival curves modeled from published literature and internal market research conducted by EpidStrategies, A Division of ToxStrategies, Inc. on behalf of Day One.*

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Product Profile Aligns With What Physicians Are Looking For In A Therapy

ojemda™
(tovorafenib)
100 mg tablets
25 mg/mL for oral suspension

Efficacy	Meaningful tumor stabilization or shrinkage may be possible with OJEMDA. In the clinical trial: • 51% of children experienced tumor shrinkage by at least 25% • 82% of children saw their tumors shrink or remain stable
Safety	Generally well-tolerated therapy, with 9 out of 10 patients staying on treatment in the clinical trial Most common grade 3 / 4 adverse events include: anemia, elevated CPK, maculo-papular rash, fatigue & vomiting
Dosing	Once-weekly, taken with or without food conveniently from home can mean fewer daily interruptions

OJEMDA is indicated for the treatment of patients 6 months of age and older with relapsed or refractory pediatric low-grade glioma (LGG) harboring a BRAF fusion, rearrangement, or BRAF V600 mutation.

Data from Pivotal Phase 2 FIREFLY-1 trial.

Strong Q3 Patient Demand Continues to Drive Performance

Revenue Drivers

Strong and steady patient demand & high continuation rates were primary growth drivers in Q3 2024

ojemda™ (tovorafenib)

$20.1M in net product revenue in 3Q 2024

Growing Utilization

616 prescriptions in Q3 2024, **158% growth vs Q2 2024***

Breadth & Depth of Prescribers

- Nearly doubled the number of HCPs who prescribed OJEMDA in Q3
- HCPs treating more than 1 patient continues to increase

Payer Coverage

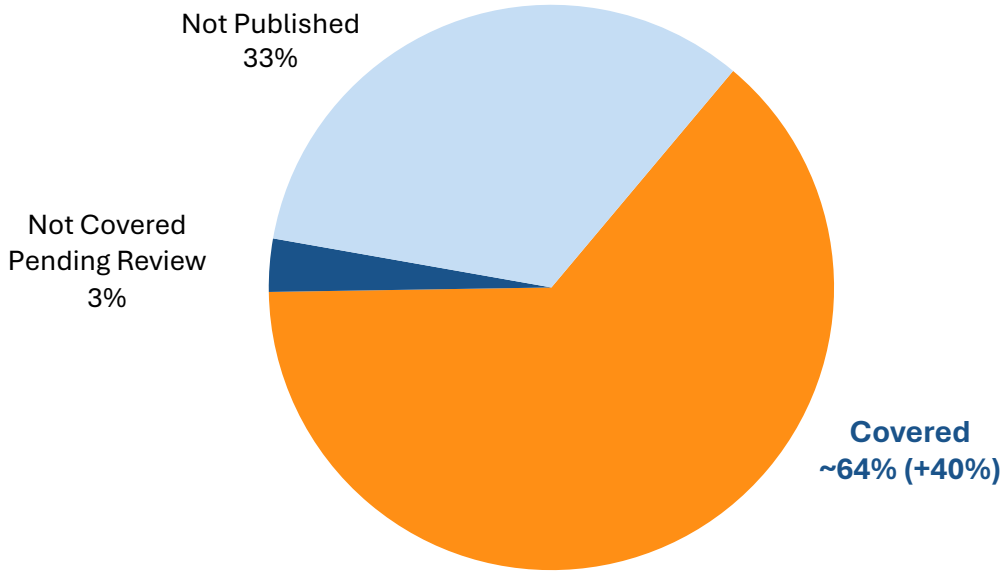
High payer approval rate enabling a high percentage of patients on paid drug

HCP, Health Care Professional. *Total prescriptions includes prescriptions for all patients (new & refill, paid & free drug and on-label & off-label patients), prescriptions are approximations based on data available on September 30, 2024.

Coverage Approval Rates are High Across both Commercial and Medicaid Payers Despite Limited Published Coverage

Reported Coverage[1,2]

Percent of Covered Lives



Payer Mix

- ~60% commercial patients
- ~40% Medicaid patients

~80% Patients Approved for Coverage, Despite Lower Reported Coverage[3]

[1] Breakaway Partners LLC – Breakaway Partners Analytics Platform. Metrics Based on 190.5M Commercial Lives . [2] Artia Solutions - Medicaid Coverage Status Report and Breakaway Partners LLC – Breakaway Partners Analytics Platform. Metrics Based on 73.9M Total Medicaid Lives. [3] Internal prescription data. Data source date 9/30/2024. Coverage comparison data 9/30/2024 vs. 6/30/24.

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Well-Positioned For Commercial Execution And Sustained Growth

Continuing Launch Trajectory

- Increase breadth & depth of prescribers
- Position OJEMDA as the standard of care in 2nd line
- Establish remaining payer coverage policies

FIREFLY-2 / LOGGIC

Pivotal Phase 3 Trial of Tovorafenib in Frontline pLGG

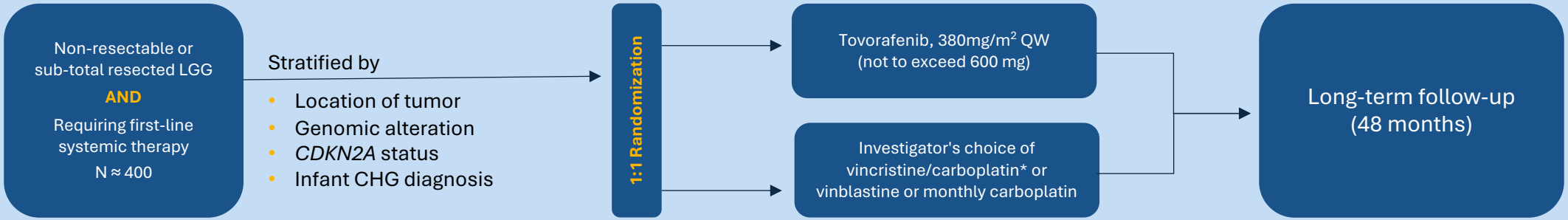
FIREFLY-2/LOGGIC Pivotal Phase 3 Trial Of Tovorafenib In Frontline pLGG

Trial Design

- Randomized, global, registrational Phase 3 trial of monotherapy tovorafenib vs SoC chemotherapy
- Eligibility: Patients aged up to <25 years with LGG harboring a RAF alteration and requiring first-line systemic therapy
- Tovorafenib available as tablets and pediatric-friendly liquid suspension
- Patients who progress after stopping tovorafenib may be re-challenged
- Patients who progress in the SoC arm during or post-treatment may cross-over to receive tovorafenib

Endpoints

- **Primary endpoint: ORR based on RAPNO-LGG criteria, assessed by blinded independent central review**
  - **The ORR primary analysis is expected to occur ~12 months after the last patient randomized**
- Key secondary endpoints: PFS and DoR by RAPNO-LGG criteria
- Other secondary endpoints: changes in neurological and visual function, safety, and tolerability
- Key exploratory objectives: QoL and health utilization measures



* COG or SIOPe-LGG regimen. Abbreviations: CHG, chiasmatic, hypothalamic glioma; DoR, duration of response; LGG, low-grade glioma; ORR, objective response rate; QoL, quality of life; QW, once weekly; SoC, standard of care.

DAY301

PTK7 Targeted Antibody Drug Conjugate (ADC)

DAY301: Next Generation ADC Targeting PTK7

PTK7: Clinically-Validated ADC Target	DAY301: Potential First-in-Class Asset	Substantial Development and Commercial Opportunities for DAY301
Anti-tumor activity of anti-PTK7 ADC demonstrated in Phase 1b trial of Pfizer / Abbvie's cofetuzumab pelidotin[1]	Novel ADC active in preclinical models, designed to maximize therapeutic window	High PTK7 expression in multiple adult and pediatric tumor histologies

U.S. IND Cleared – Target First Patient Dosed in Q4 2024 / Q1 2025

[1] Cho BC, et al. Ann Oncol. (34; Suppl 2): S460-S461, 2023.

PTK7: A Clinically-Validated ADC Target

Potential opportunity for a next-generation PTK7 ADC with improved therapeutic index

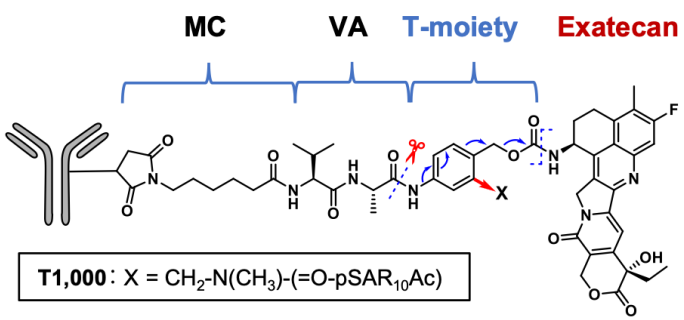
- Clinical results for cofetuzumab pelidotin[1] demonstrated proof of concept for PTK7-targeted ADCs
- Cofetuzumab pelidotin activity seen in multiple tumor types:
  - Ovarian (Pt-resistant): ORR 27% (n=63)
  - TNBC: ORR 21% (n=29)
  - NSCLC: ORR 19% (n=31)
  - mDOR: 4.2-5.7m for Ovarian (Pt-resistant)/TNBC/NSCLC
  - mPFS: 1.5-2.9m for Ovarian (Pt-resistant)/TNBC/NSCLC
- Aur0101 program limited by toxicity, resulting in reduced dose intensity and duration
- A next generation product with optimized properties and a better therapeutic index may achieve greater clinical efficacy

[1] Phase 1b study of PF-06647020/ABBV-647.

DAY301: Potential First-In-Class Asset

DAY301 has been designed to maximize therapeutic index and overcome limitations of prior programs

DAY301



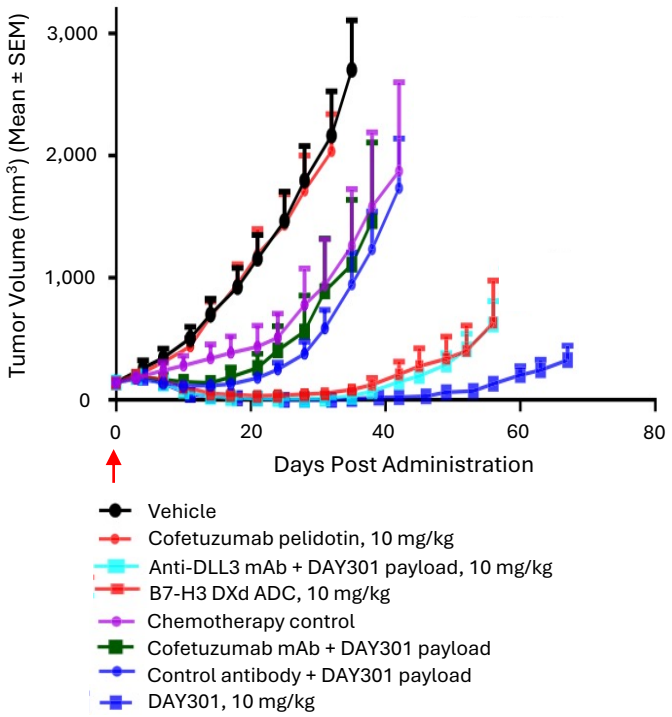
- Tumor regression at tolerable doses seen in multiple preclinical models
- Higher HNSTD in cyno toxicology studies; payload with known safety profile
- High cell permeability / bystander effect; low efflux (not a P-gp substrate)
- Novel, highly hydrophilic, cleavable linker
- Moderate-to-high affinity antibody with favorable stability and developability profile
- Drug-antibody-ratio (DAR) of 8, shown to be effective for other ADCs in solid tumors
- IP: Composition of Matter patent term expected 2044, once issued

1) Damelin M, et al. A PTK7-targeted antibody-drug conjugate reduces tumor-initiating cells and induces sustained tumor regressions. Sci Transl Med. 2017. HNSTD, Highest Non-Severely Toxic Dose; P-gp, P-glycoprotein.

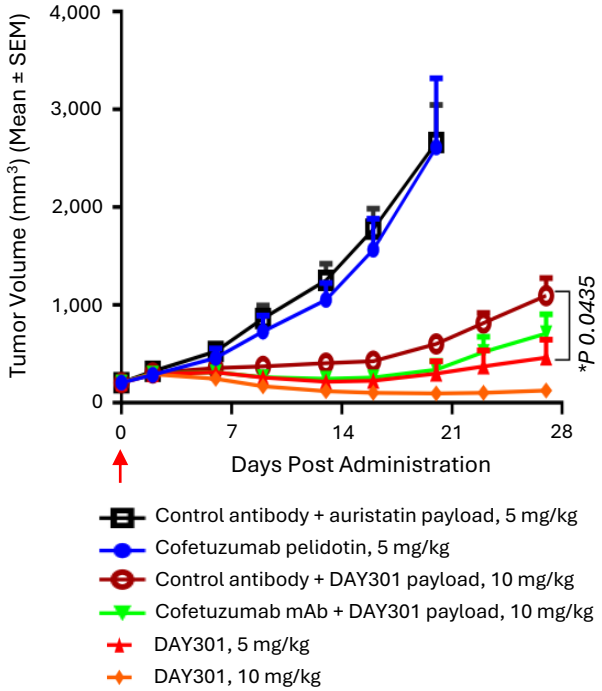
DAY301: First-in-Class Potential

Improved tumor regression activity demonstrated for DAY301 vs. benchmarks in multiple preclinical models

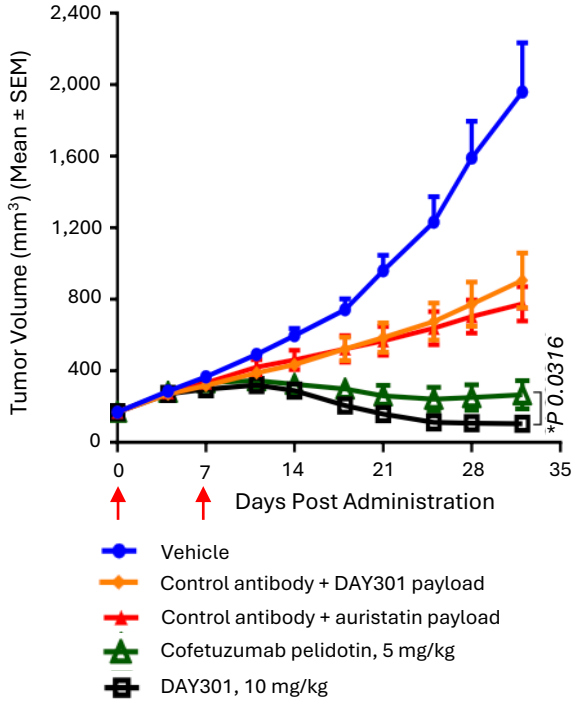
PDX 362797 SCLC
H-score 210



PDX 362310 TNBC
H-score 255



PDX LD1-200615 HNSCC
H-score 120



↑ Indicates when drug was administered

Ref: Kong C, et al. MTX-13, a Novel PTK7-Directed Antibody–Drug Conjugate with Widened Therapeutic Index Shows Sustained Tumor Regressions for a Broader Spectrum of PTK7-Positive Tumors. Mol Cancer Ther. 2023

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DAY301: Encouraging Development And Commercial Opportunities

Indication	PTK7 Expression (≥1+)	U.S. Patient Population Cases/Deaths	ORR at Relapse	Median OS at Relapse
Endometrial	100%[2]	67,880/13,250[3]	39%[7]	9 months[7]
Esophageal SCC	76%[1]	22,370/16,130[3]	5%[4]	3 months[4]
Gastric	35%[2]	26,890/10,880[3]	12%[14]	6-14 months[15]
Head & Neck SCC	75%[1]	54,540/11,580[3]	32%[5]	7.8 months[5]
NSCLC	50%[2]	199,393/106,310[3]	45-60%[8]	7-12 months[9]
Ovarian (platinum resistant)	30%[2] (95%)*	19,710/13,270[3]	20-35%[3]	17.2 months[6]
Small Cell Lung	50%[2]	35,187/18,760[3]	10-40%[10]	9-12 months[11]
TNBC	70%[2]	46,608/12,675[3,16]	5-35%[12]	28 months[13]
Potential pediatric indications include: neuroblastoma, rhabdomyosarcoma and osteosarcoma				

[1] Kong et al, 2023; [2] Protein Atlas; [3] PDQ; [4] Parry et al, 2015; [5] Vermorken et al, 2010; [6] Sehouli et al, 2008; [7] Rutten et al, 2021; [8] Park et al, 2017; [9] Assi et al, 2023; [10] Abughanimeh et al, 2020; [11] Asai et al, 2014; [12] Bardia et al, 2021; [13] Cai et al, 2023; [14] Sym et al, 2008; [15] Ji et al, 2023; [16] Saraivaet al, 2017. * MabCare data

DAY301-001: Initial Phase 1a/b Clinical Trial Design

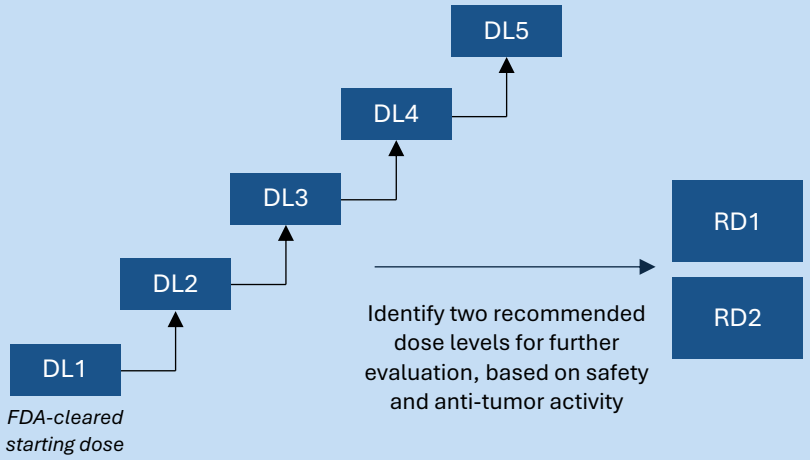
Key Design Elements

- BOIN design for efficiency of dose escalation
- Backfill active dose levels to generate additional safety data
- Enroll tumor types with known high PTK7 expression
- Advance two recommended dose levels to Phase 1b
- Final dose optimization scheme and approval path pending discussions with FDA at end of dose escalation

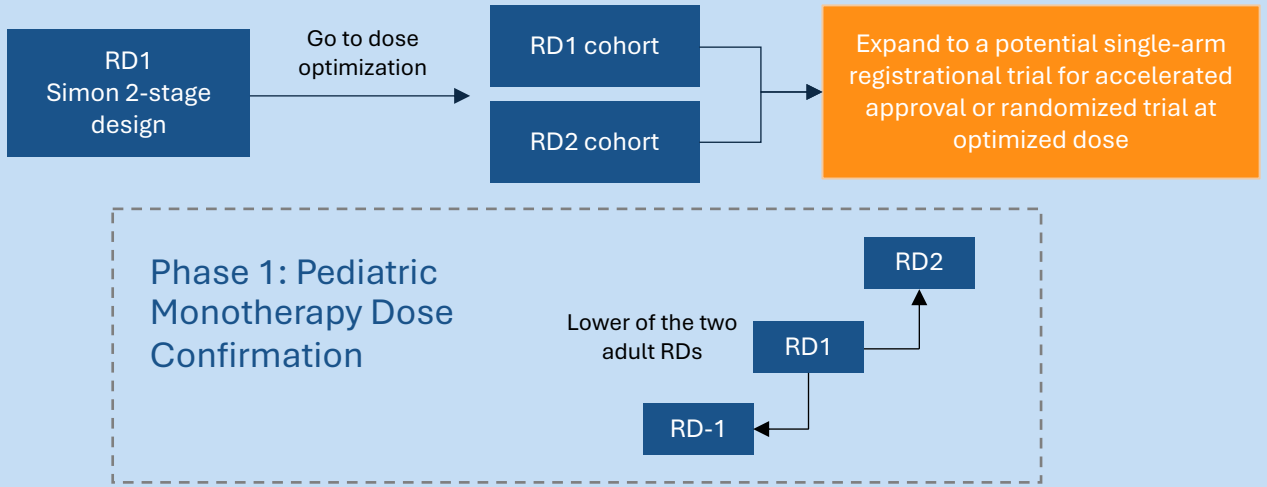
Adult & Pediatric Development

- Potential adult indications include platinum resistant ovarian cancer, squamous NSCLC, esophageal SCC, HNSCC, endometrial, and/or SCLC
  - Patients to be selected based on PTK7 expression clinical trial assay
- Pediatric dose confirmation and efficacy assessment to begin near/at the end of adult dose escalation
  - Initial target indications include neuroblastoma, osteosarcoma, rhabdomyosarcoma

Phase 1a: Monotherapy Dose Escalation



Phase 1b: Monotherapy Dose Expansion and Optimization



DL, Dose Level; RD, Recommended Dose; BOIN, Bayesian Optimal Interval; HNSCC, Head and Neck Squamous Cell Carcinoma; SCLC, Small Cell Lung Cancer; SCC, Squamous-Cell Carcinoma; NSCLC, Non-Small Cell Lung Cancer

Summary

Third Quarter 2024 Financial Results

Financial Summary *($ in millions)*	Three Months Ended 9/30/24	Three Months Ended 9/30/23	Nine Months Ended 9/30/24	Nine Months Ended 9/30/23
OJEMDA Net Revenue	20.1	--	28.3	--
License Revenue	73.7	--	73.7	--
Total Revenue	**$93.8**	**$--**	**$101.1**	**$--**
Cost of Product Revenue	1.6	--	2.3	--
Research and Development Expense[1]	33.6	33.2	165.9	93.2
Selling, General and Administrative Expense[2]	29.0	18.3	85.7	53.4
Total Cost and Operating Expenses	**$64.1**	**$51.4**	**$253.9**	**$146.5**
Non-operating Income[3]	6.5	5.3	122.8	12.1
Income Tax Benefit (Expense)	0.9	--	(0.7)	--
Net Income (Loss)	**$37.0**	**($46.2)**	**($29.8)**	**($134.4)**

	9/30/24	9/30/23
Cash, cash equivalents and short-term investments	$558.4	$405.5

All financial information is unaudited. [1] Includes stock-based compensation expense of $3.8 million and $13.2 million for the three and nine months ended 9/30/24, and $3.3 million and $10.1 million for the three and nine months ended 9/30/23, respectively. [2] Includes stock-based compensation expense of $7.8 million and $24.0 million for the three and nine months ended 9/30/24, and $6.3 million and $18.4 million for the three and nine months ended 9/30/23, respectively. [3] Includes sale of Priority Review Voucher of $108.0 million for the nine months ended 9/30/24.

Priorities as a Commercial-Stage Company

Launch OJEMDA™ (tovorafenib)

- Expand awareness amongst physicians and establish broad coverage to enable patient access
- Establish OJEMDA as the standard of care for relapsed or refractory pLGG harboring a BRAF alteration
- Provide a positive and supportive experience when initiating OJEMDA therapy for patients and families

Advance Portfolio

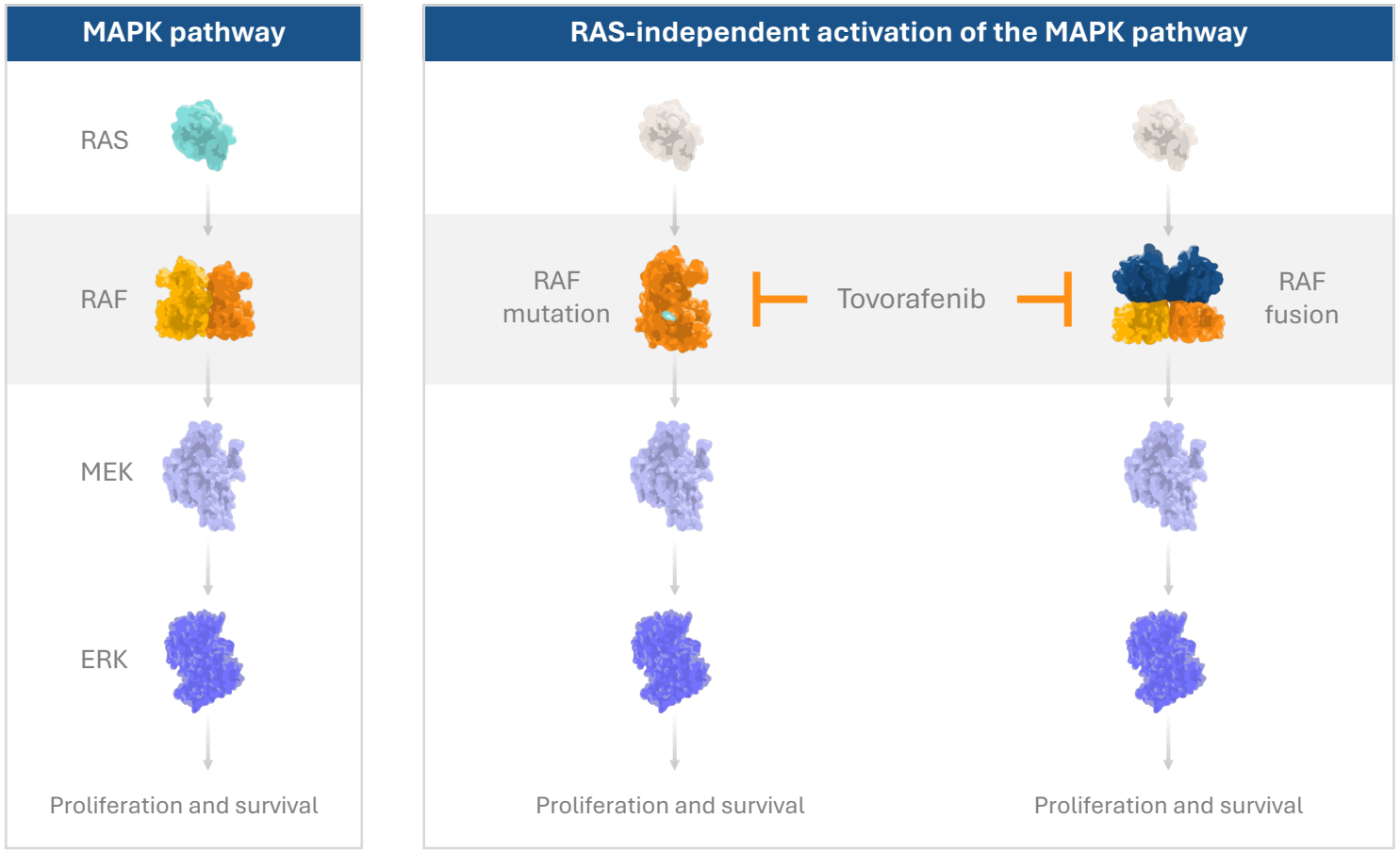
- FIREFLY-2: Study tovorafenib as a frontline therapy for treatment-naive patients with pLGG
- Develop DAY301, ADC targeting PTK7 in pediatric and adult solid tumors
- Advance early stage VRK1 program to clinical development

Expand Pipeline

- Grow Day One into a leading, biopharmaceutical company that is the partner of choice for oncology drug development
- Explore selective partnerships as a source of capital and risk sharing
- Further invest in business development activities to expand our multiple asset portfolio for both children and adults

Appendix

Tovorafenib Inhibits Both BRAF Fusions And BRAF V600 Mutations



Tovorafenib is an investigational, oral, selective, CNS-penetrant, type II RAF inhibitor that was designed to inhibit both monomeric and dimeric RAF kinase

- Activity in tumors driven by both RAF fusions and BRAF V600E mutations
- Tablet and pediatric-friendly liquid suspension
- Once weekly dosing

Currently approved type I BRAF inhibitors are indicated for use in patients with tumors bearing BRAF V600 mutations

- Type I BRAF inhibitors cause paradoxical MAPK activation in the setting of wild-type RAF, increasing the risk of tumor growth in BRAF fusion-driven

Source: 1. Sun Y et al., Neuro Oncol. 2017; 19: 774–85; 2. Sievart AJ et al., PNAS. 2013; 110:5957-62; 3. Karajannis MA et al., Neuro Oncol 2014;16(10):1408-16.

Pivotal Phase 2 Trial Of Monotherapy Tovorafenib In Relapsed Or Progressive pLGG (FIREFLY-1)

Trial Design

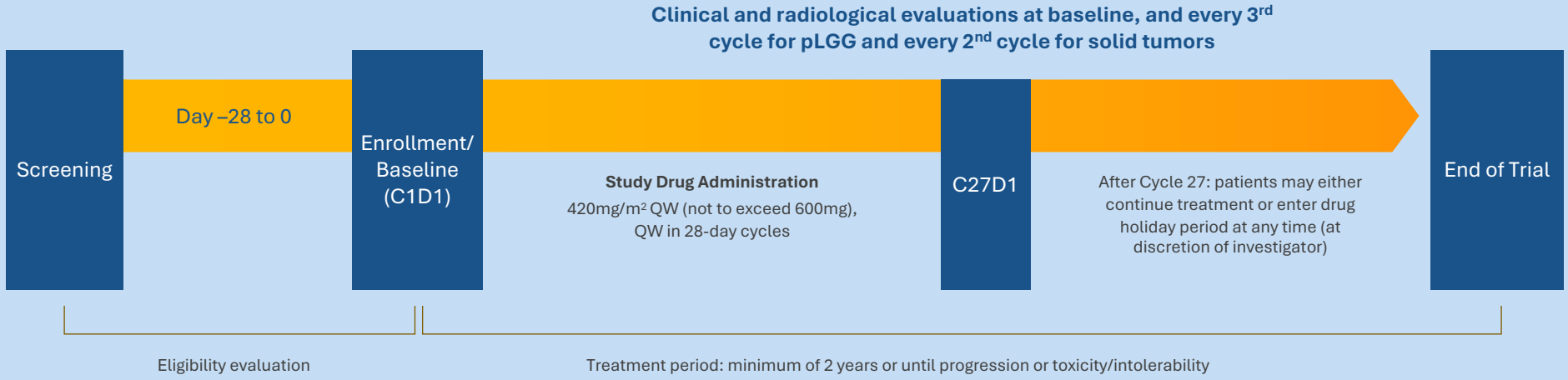
- Three arm, open-label, global registrational phase 2 trial
  - **Pivotal Arm 1 (recurrent/progressive pLGG, n=77): harboring a KIAA1549-BRAF fusion or BRAF V600E mutation**
  - Arm 2 (expanded access recurrent/progressive LGG, n=60): harboring an activating RAF alteration
  - Arm 3 (extracranial solid tumors): harboring an activating RAF fusion

Endpoints (Pivotal Arm 1)

- **Primary endpoint: ORR based on RANO-HGG[1], assessed by blinded independent central review**
- Secondary endpoints: ORR by RAPNO-LGG[2] assessed by blinded independent central review; PFS, DoR; TTR, CBR; safety
- Exploratory analyses: ORR and CBR by RANO-LGG[3] assessed by blinded independent central review

Key Inclusion Criteria

- 6 months – 25 years of age
- RAF-altered tumor
- ≥1 prior line of systemic therapy with radiographic progression
- Prior use of MAPK pathway targeted therapy was permitted



June 5, 2023 data cutoff. [1] Wen PY, et al. *J Clin Oncol*. 2010;28(11):1963-1972. [2] Fangusaro J, et al. Lancet Oncol. 2020;21(6):e305–316. [3] van den Bent MJ, et al. Lancet Oncol. 2011;12(6):583-593. Abbreviations: CBR, clinical benefit rate; IRC, independent review committee; C, cycle; D, day; LGG, low-grade glioma; ORR, objective response rate; PFS, progression-free survival; DoR, duration of response; QW, once weekly; TTR, time to response; RANO, Response Assessment in Neuro-Oncology; RAPNO, Response Assessment in Pediatric Neuro-Oncology; MAPK, mitogen-activated protein kinase. For more information, please refer to NCT04775485

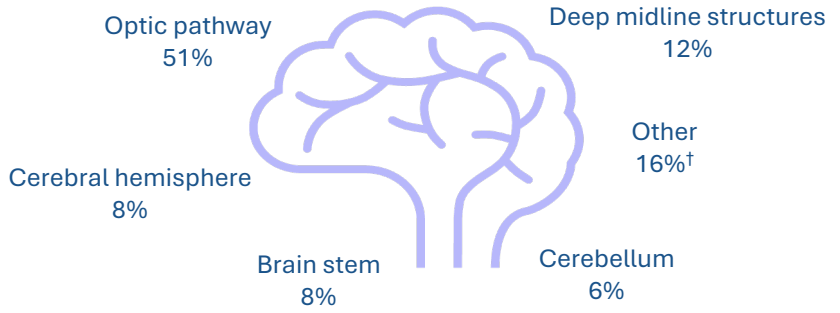
Data from Pivotal Phase 2 FIREFLY-1 Trial

June 5, 2023 data cutoff

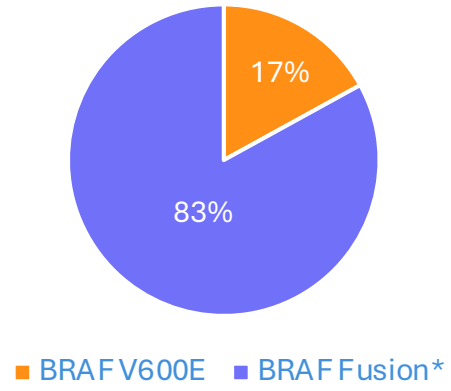
FIREFLY-1 Baseline Patient Characteristics

Characteristic	Arm 1 (n=77)
Median age, years (range)	8 (2-21)
Sex, n (%) Male Female	 40 (52) 37 (48)
Race, n (%) White Asian Black Multiple Other Not specified	 41 (53) 5 (6) 2 (3) 3 (4) 6 (8) 20 (26)
Number of lines of prior systemic therapy Median (range) 1, n (%) 2, n (%) ≥3, n (%)	 3 (1-9) 17 (22) 21 (27) 39 (51)
Prior MAPK pathway targeted therapy, n (%) Prior MEK inhibitor Prior BRAF inhibitor Prior BRAF and MEK inhibitors‡ Any MAPK inhibitor	 43 (56) 8* (10) 5 (7) 46 (60)

Location (n=77)

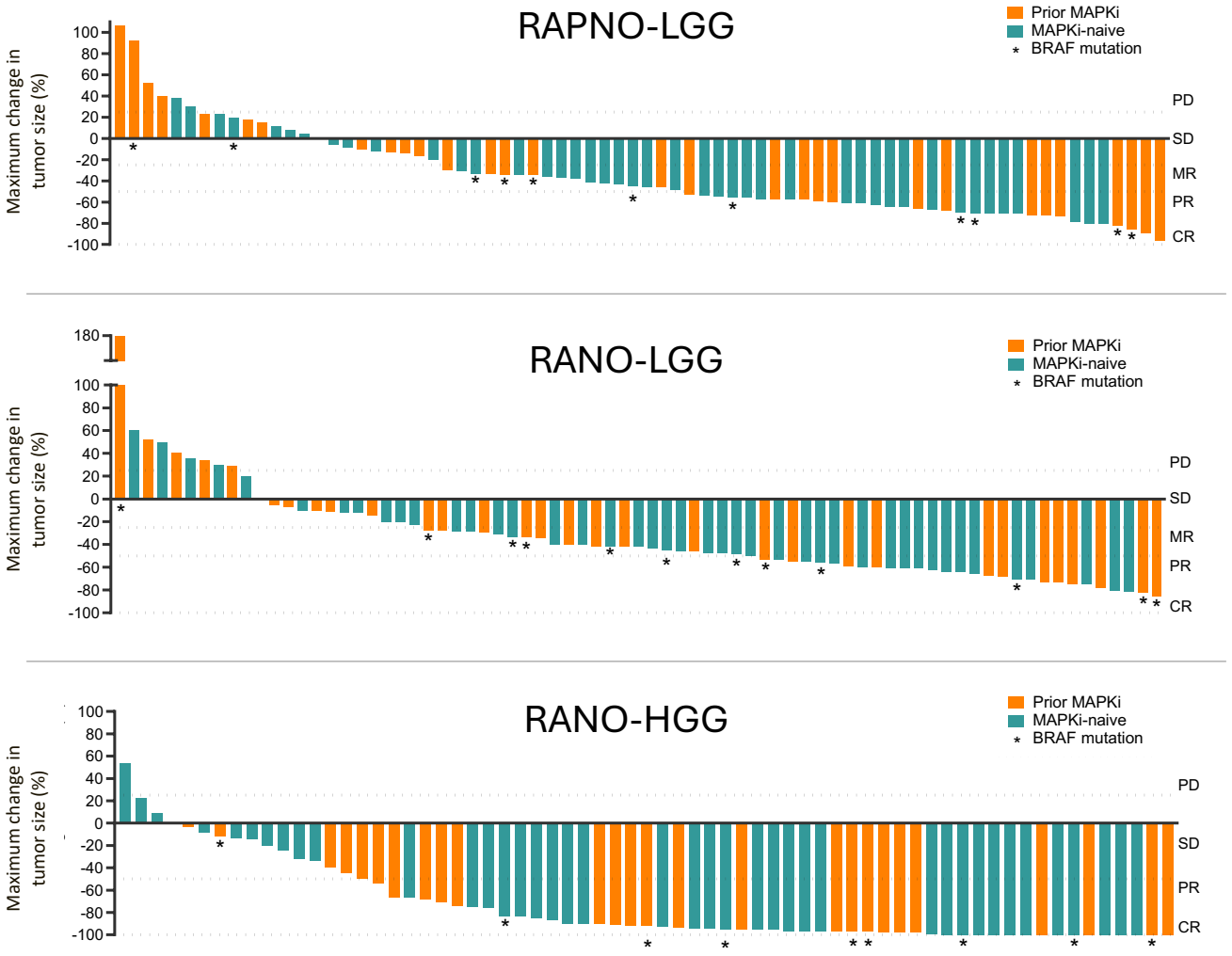


BRAF alteration (n=77)



June 5, 2023 data cutoff. *Includes 6 patients with BRAF duplication and 2 with BRAF rearrangement per fluorescence in situ hybridization or in situ hybridization. †Includes tumors that were extending into multiple regions of the brain, leptomeningeal disease, and/or spinal disease. ‡The 5 patients that had previously received both a MEK inhibitor and also a BRAF inhibitor are recorded in both the "Prior MEK inhibitor" and "Prior BRAF inhibitor" groups. MAPK, mitogen-activated protein kinase.

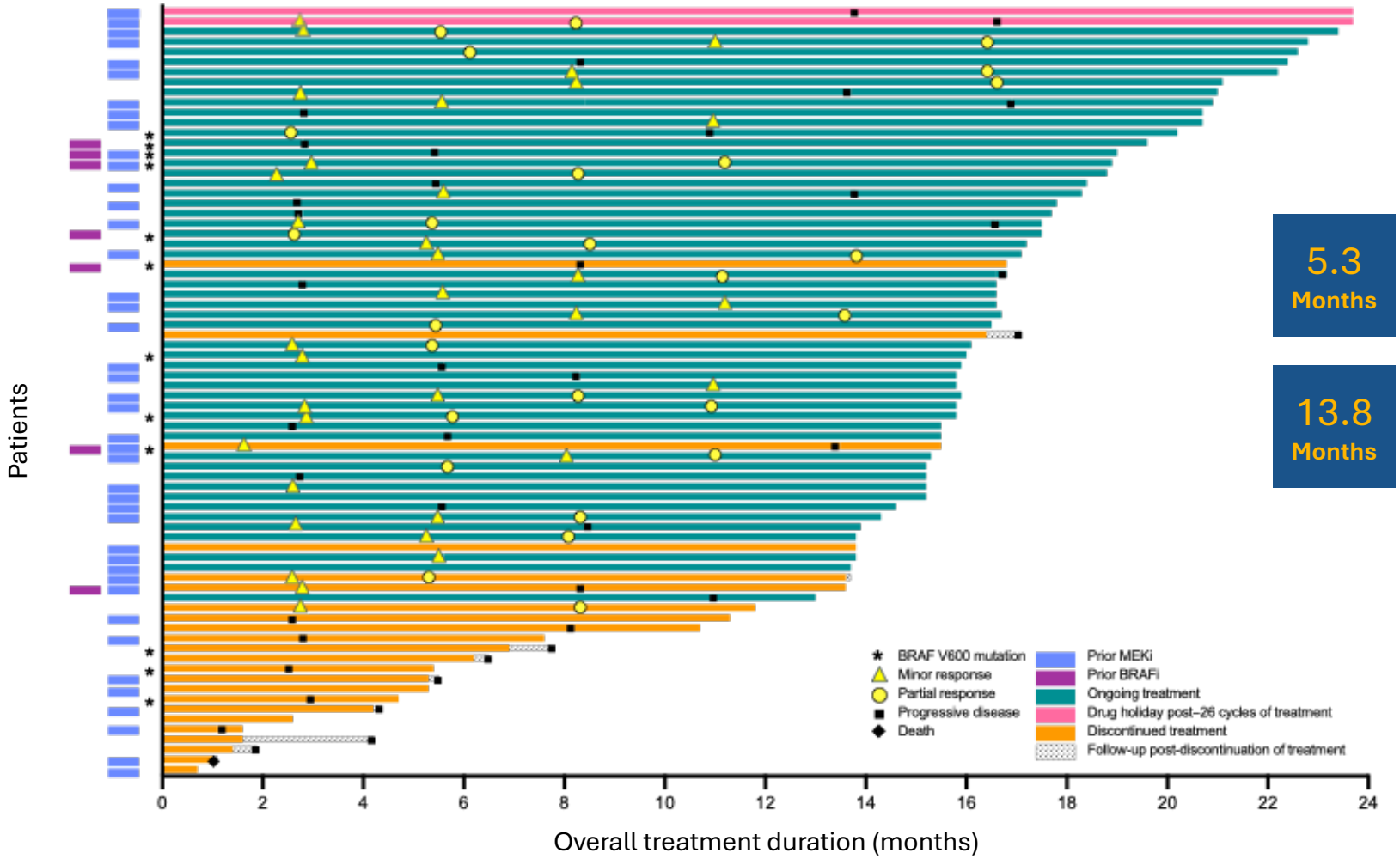
Tumor Response To Tovorafenib Using RAPNO-LGG, RANO-LGG and RANO-HGG



Response (IRC)	RAPNO-LGG n=76	RANO-LGG N=76	RANO-HGG N=69
ORR,* n (%)	**39 (51)**	**40 (53)**	**46 (67)**
95% CI	40-63	41-64	54-78
CBR,* n (%)			
SD of any length of time	62 (82)	63 (83)	64 (93)
SD ≥12 months	43 (57)	46 (61)	54 (78)
BOR,* n (%)			
CR	0	0	12 (17)
PR	28 (37)	20 (26)	34 (49)
MR	11 (14)	20 (26)	n/a
SD	23 (30)	23 (30)	18 (26)
SD <12 months	19 (25)	17 (22)	10 (14)
SD ≥12 months	4 (5)	6 (8)	8 (12)
PD	13 (17)	11 (14)	4 (6)
NE	1 (1)	2 (3)	1 (1)
Median DOR, months	**13.8**	**14.4**	**16.6**
95% CI	11.3-NR	11.0-NR	11.6-NR
Median TTR, months	**5.3**	**5.5**	**3.0**
Range	1.6-11.2	1.6-11.3	2.6-16.6

June 5, 2023 data cutoff. BOR, best overall response; CBR, clinical benefit rate; CI, confidence interval; CR, complete response; DOR, duration of response; HGG, high-grade glioma; IRC, independent radiology review committee; LGG, low-grade glioma; MR, minor response; n/a, not applicable; NE, not evaluable; NR, not reached; ORR, overall response rate; PD, progressive disease; PR, partial response; RANO, Response Assessment in Neuro-Oncology; RAPNO, Response Assessment in Pediatric Neuro-Oncology; SD, stable disease; TTR, time to response. * ORR, CBR and BOR for RAPNO-LGG and RANO-LGG included MRs.

Duration Of Tovorafenib Therapy For All Patients With RAPNO-LGG Evaluable Lesions

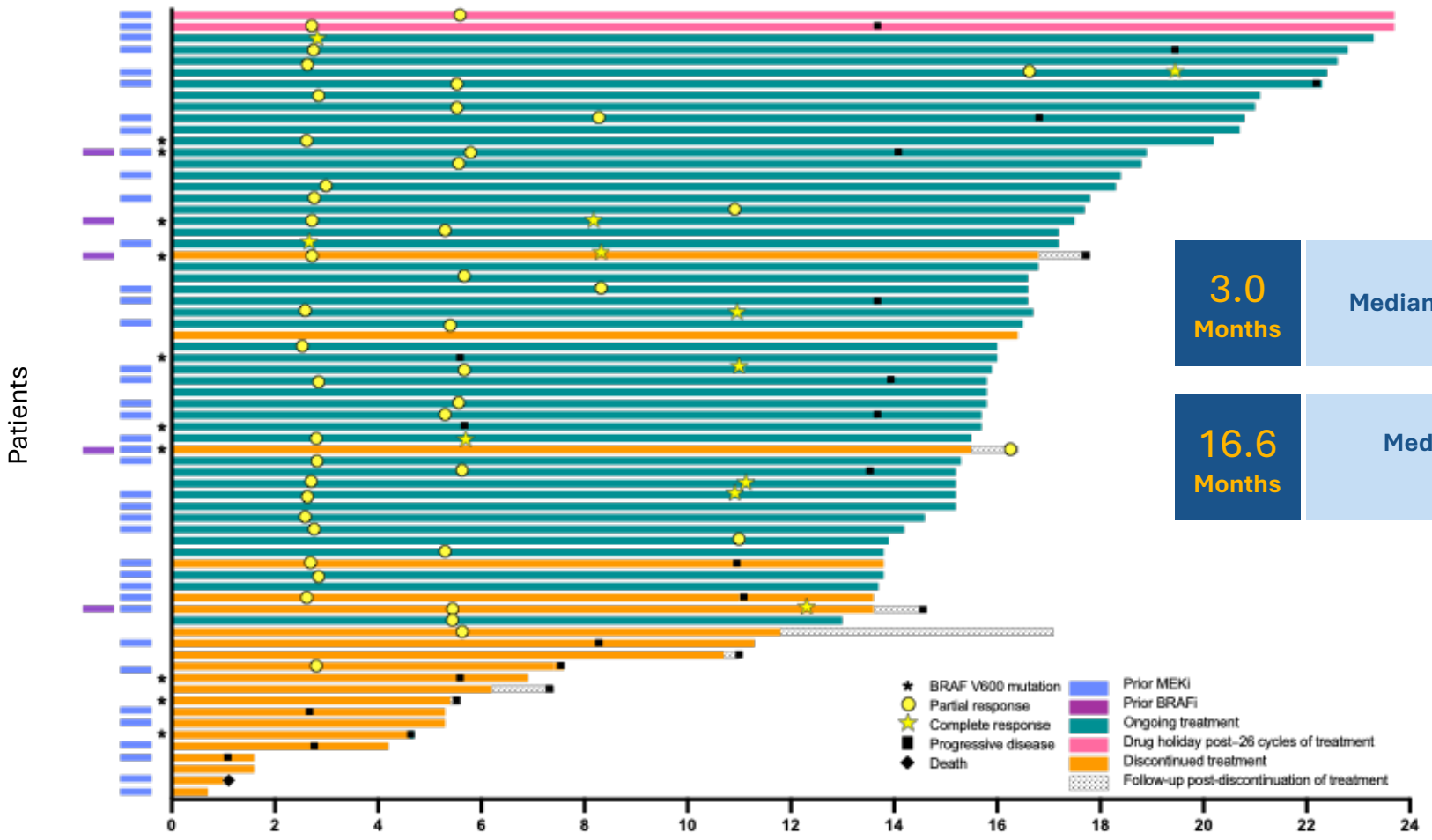


5.3 Months — Median time to response

13.8 Months — Median duration of treatment

June 5, 2023 data cutoff.

Duration Of Tovorafenib Therapy For All Patients With RANO-HGG Evaluable Lesions

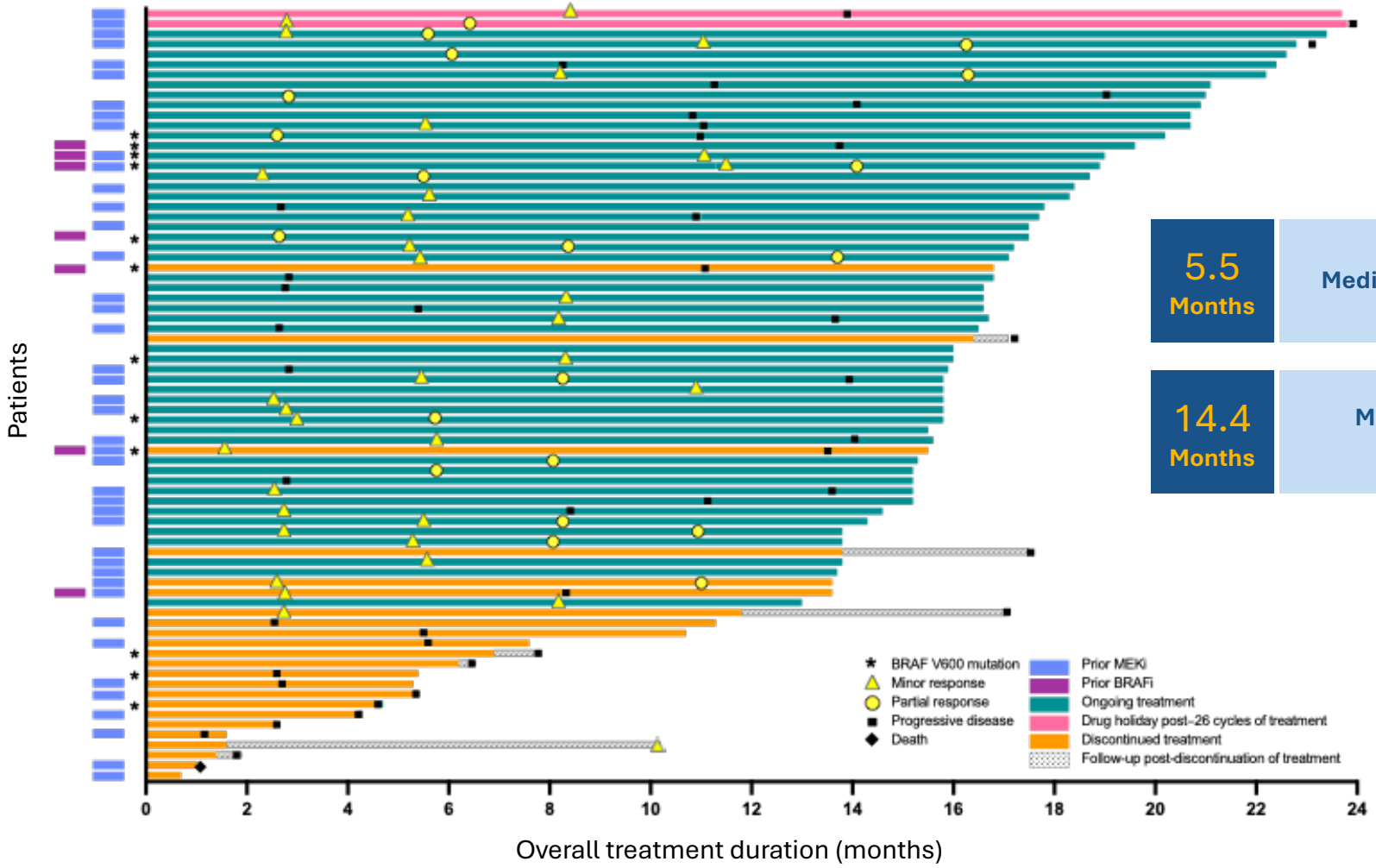


3.0 Months — Median time to response

16.6 Months — Median duration of treatment

June 5, 2023 data cutoff.

Duration Of Tovorafenib Therapy For All Patients With RANO-LGG Evaluable Lesions



5.5 Months — Median time to response

14.4 Months — Median duration of treatment

June 5, 2023 data cutoff.

Tumor Response To Tovorafenib Across Three Assessment Criteria Were Consistent Across BRAF Fusion And Mutation Patients, and Patients With Prior MAPK Treatment

Response (IRC)	RAPNO-LGG[2] n		RANO-LGG[3,4] n		RANO-HGG[1] n	
ORR,* n (%)	**76**	**39 (51)**	**76**	**40 (53)**	**69**	**46 (67)**
BRAF fusion	64	33 (52)	64	33 (52)	59	41 (69)
BRAF mutation	12	6 (50)	12	7 (58)	10	5 (50)
Prior MAPKi	45	22 (49)	45	23 (51)	41	29 (71)
MAPKi-naive	31	17 (55)	31	17 (55)	28	17 (61)
CBR,* n (%) (SD of any length of time)	**76**	**62 (82)**	**76**	**63 (83)**	**69**	**64 (93)**
BRAF fusion	64	53 (83)	64	53 (83)	59	55 (93)
BRAF mutation	12	9 (75)	12	10 (83)	10	9 (90)
Prior MAPKi	45	38 (84)	45	38 (84)	41	37 (90)
MAPKi-naive	31	24 (77)	31	25 (81)	28	27 (96)
CBR,* n (%) (SD ≥12 months)	**76**	**43 (57)**	**76**	**46 (61)**	**69**	**54 (78)**
BRAF fusion	64	37 (58)	64	39 (61)	59	49 (83)
BRAF mutation	12	6 (50)	12	7 (58)	10	5 (50)
Prior MAPKi	45	25 (56)	45	26 (58)	41	33 (80)
MAPKi-naive	31	18 (58)	31	20 (65)	28	21 (75)
Median DOR, months (95% CI)**	**39**	**13.8 (11.3-NR)**	**40**	**14.4 (11.0-NR)**	**46**	**16.6 (11.6-NR)**
BRAF fusion	33	13.8 (11.3-NR)	33	16.3 (11.0-NR)	41	16.8 (11.6-NR)
BRAF mutation	6	NR (8.4-NR)	7	12.0 (8.4-NR)	5	15.1 (8.3-NR)
Prior MAPKi	22	13.8 (11.3-NR)	23	12.0 (8.5-NR)	29	15.1 (9.0-16.8)
MAPKi-naive	17	NR (8.4-NR)	17	16.3 (8.4-NR)	17	NR (11.6-NR)

June 5, 2023 data cutoff. [1] Fangusaro J, et al. *Lancet Oncol.* 2020;21(6):e305–316. [2] Fangusaro J, et al. *Lancet Oncol.* 2020;21(6):e305–316. [3] van den Bent MJ, et al. *Lancet Oncol.* 2011;12(6):583-593. 4. Wen PY, et al. *J. Clin Oncol.* 2017;35(21),2439-2449. * ORR, CBR for RAPNO-LGG and RANO-LGG included MRs. ** the 95% CI were calculated using Kaplan-Meier method.

Tovorafenib Safety Data (n=137)

Preferred Term, n (%)	TEAEs		TRAEs	
	Any Grade	Grade ≥3	Any Grade	Grade ≥3
Any AE	137 (100)	86 (63)	134 (98)	58 (42)
Hair color changes	104 (76)	0	104 (76)	0
Anemia	81 (59)	15 (11)	67 (49)	14 (10)
Elevated CPK	80 (58)	16 (12)	77 (56)	16 (12)
Fatigue	76 (55)	6 (4)	60 (44)	6 (4)
Vomiting	68 (50)	6 (4)	28 (20)	3 (2)
Hypophosphatemia	64 (47)	0	48 (35)	0
Headache	61 (45)	2 (1)	29 (21)	0
Maculo-papular rash	60 (44)	11 (8)	56 (41)	11 (8)
Pyrexia	53 (39)	5 (4)	17 (12)	1 (1)
Dry skin	49 (36)	0	45 (33)	0
Elevated LDH	48 (35)	0	42 (31)	0
Increased AST	47 (34)	4 (3)	41 (30)	4 (3)
Constipation	45 (33)	0	31 (23)	0
Nausea	45 (33)	0	25 (18)	0
Upper RTI	43 (31)	2 (1)	2 (1)	0
Dermatitis acneiform	42 (31)	1 (1)	41 (30)	1 (1)
Epistaxis	42 (31)	1 (1)	27 (20)	0
Decreased appetite	39 (28)	5 (4)	28 (20)	4 (3)
Paronychia	36 (26)	2 (1)	32 (23)	2 (1)
Pruritus	35 (26)	1 (1)	32 (23)	1 (1)
COVID-19	34 (25)	0	0	0

- The most common reasons for discontinuation were tumor hemorrhage (3 patients) and decrease in growth velocity (2 patients)
- 33 patients (24%) had TRAEs leading to dose reduction; 50 patients (37%) had TRAEs leading to dose interruption
- Median duration of dose interruption was 2 weeks
- 9 patients (7%) had TRAEs leading to discontinuation

June 5, 2023 data cutoff. Treatment-emergent AEs ≥25% any grade in arms 1 & 2. AE, adverse event; ALT, Alanine transaminase; AST, aspartate aminotransferase; COVID-19, Coronavirus disease 2019; CPK, creatine phosphokinase; LDH, lactate dehydrogenase; RTI, respiratory tract infection; TEAEs, treatment-emergent adverse events; TRAEs, treatment-related adverse events.