TYRA

Dabogratinib: the first potential oral innovation in IR NMIBC

September 9, 2026

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Forward-looking statements and market data

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You are cautioned not to place undue reliance on these forward-looking statements, which speak only as of the date hereof, and we undertake no obligation to update such statements to reflect events that occur or circumstances that exist after the date hereof. All forward-looking statements are qualified in their entirety by this cautionary statement, which is made under the safe harbor provisions of the Private Securities Litigation Reform Act of 1995.

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

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

TYRA aims to change the treatment paradigm in IR NMIBC

INTRO	DATA	WHAT'S NEXT	KOL INSIGHTS	Q&A
TODD	TODD & DOUG	TODD	MARK	

TODD HARRIS, PhD
CEO, TYRA

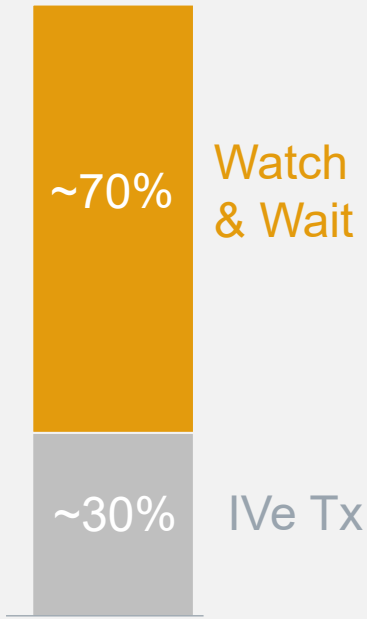
DOUG WARNER, MD
CMO, TYRA

MARK SILVA, MD
Greater Boston Urology

ALAN FUHRMAN
CFO, TYRA

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

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



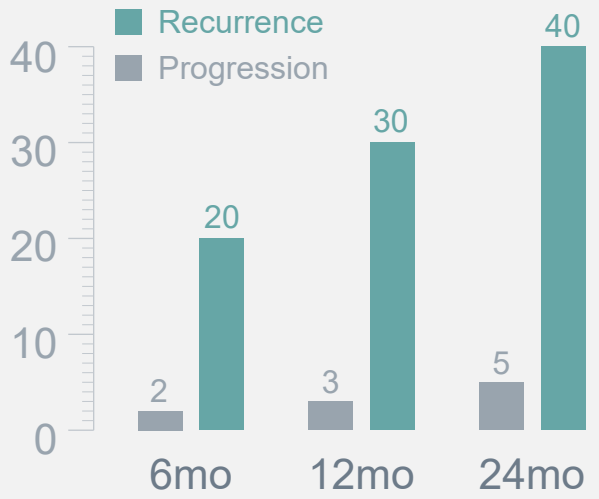
...despite efficacy[2]...

44%

Recurrence Risk Reduction

Patients Treated with Adjuvant IVe Chemo

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



This may be why

6–30 times

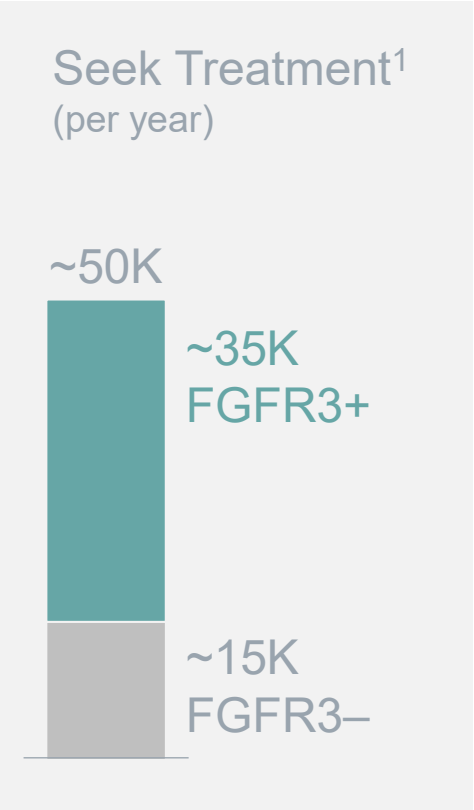
"No one likes anything shoved up their urethra"

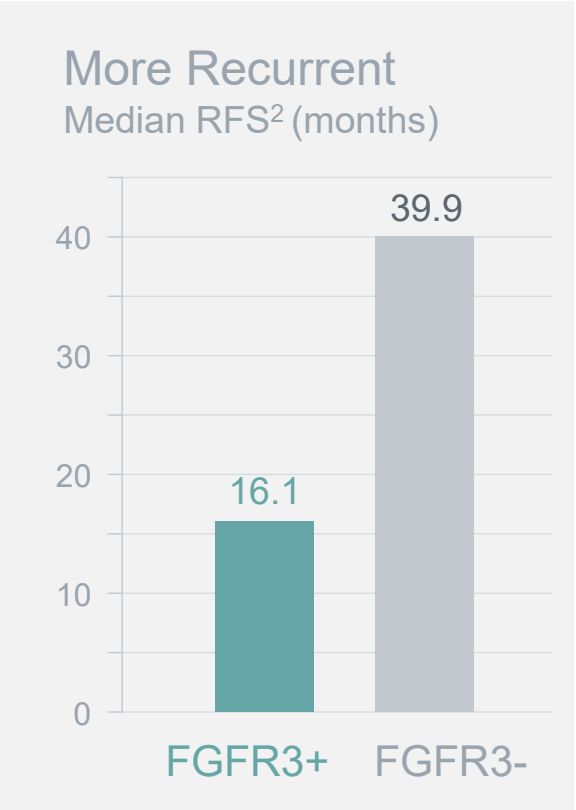
—Community urologist[4]

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

FGFR3+ patients benefit from sustained FGFR3 inhibition

FGFR3+ VALIDATED TARGET IN IR NMIBC





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

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

EVIDENCE SUSTAINED INHIBITION MAINTAINED RESPONSES

TAR-210
Pan-FGFR Pretzel

100% durability while on therapy

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

Oral Erdafitinib
Pan-FGFR

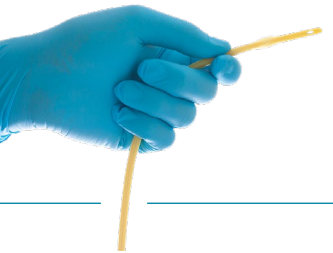
100% durability while on therapy

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

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

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

Dabo is uniquely positioned to expand Tx beyond procedures



ADJUVANT IVe Tx IN DEVELOPMENT

All five require multiple urethral violations with dwell times

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

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

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

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

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

ORAL DEVELOPMENT

Only one: a *targeted* therapy

Dabogratinib

TARGET PROFILE

efficacious and tolerable to enable chronic Tx

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

SURF302 was designed to select a dose for Phase 3

SURF302

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

Key Eligibility Criteria

Adults (≥18 years)

FGFR3 activating gene alterations confirmed by urine or tissue test

IR NMIBC based on AUA Guidelines, 2024

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

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

R
1:1

Cohort A
N=30 | 60mg QD

Cohort B
N=30 | 50mg QD

Cohort C
N=30 | If needed[1]

CR at 3 mo
Continue on study treatment up to 24 mo.

No CR at 3 mo
May continue if ML reductions at mo 3 are >50%

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

Primary Endpoint

CR at 3 months

Secondary Endpoints

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

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

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

100% ORR at 60mg in single marker lesion patients

PHASE 2 ABLATIVE
TUMOR(S) REMAIN

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

SURF302

60mg Single Marker Lesion (ML) Data

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

Multiple ML (ablative expansion)

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

PHASE 3 ADJUVANT
ALL TUMORS REMOVED

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

Implications from Phase 2

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

See disclaimer on pooled and modeled data.

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SURF302

DATA RELEASE

SEPT 2026

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Daily oral serves patients, families, and providers

Market insights

KOL perspective

Next steps

SURF302 enrolled a highly recurrent, undertreated population

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

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

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

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

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

Favorable safety and tolerability data support chronic Tx potential

Adverse Events Were Manageable

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

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

AE-related

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

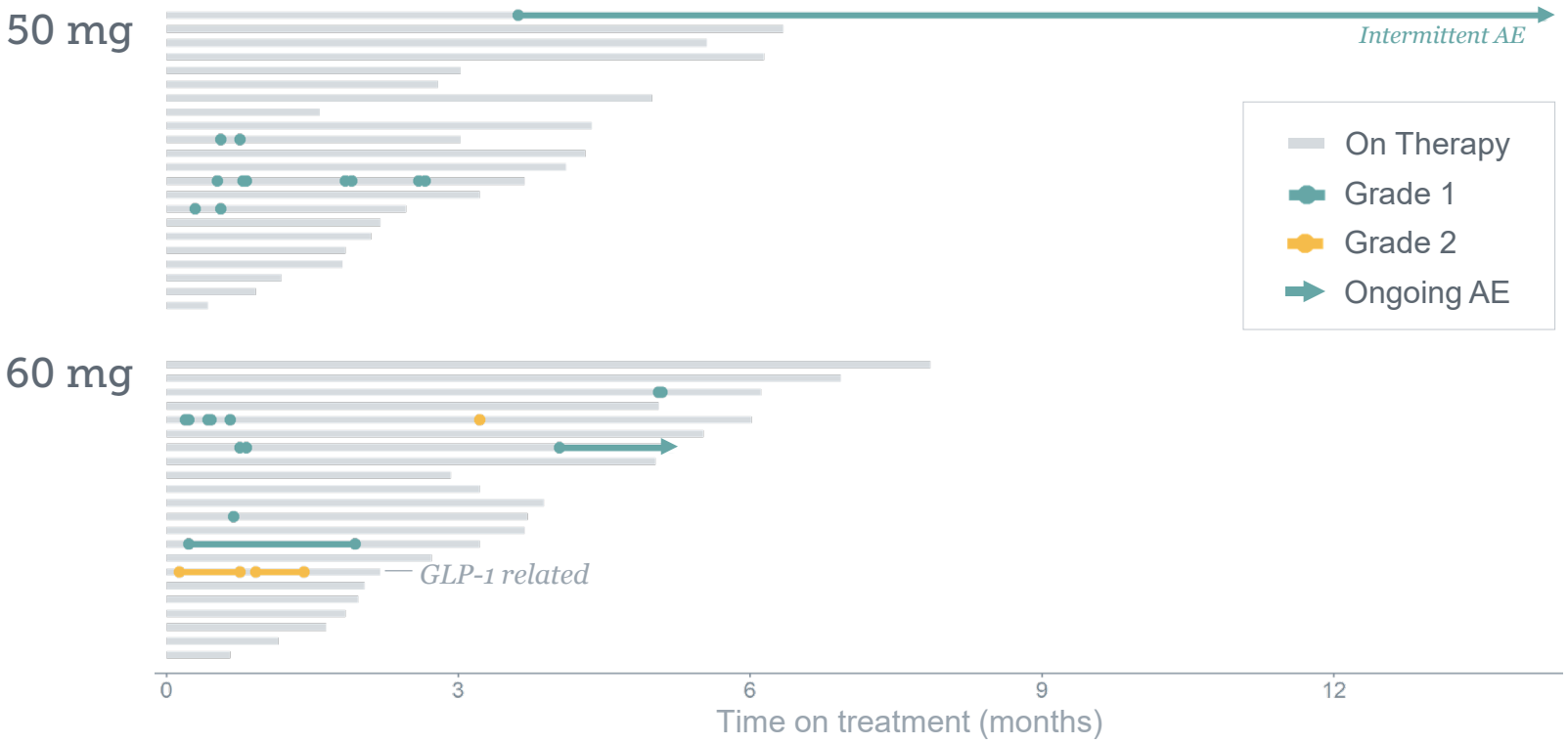
TEAEs in Patients Treated with Dabogratinib, n (%)

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

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

GI events were limited and transient

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



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

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

60mg demonstrated robust clinical activity with a dose response

60mg n=14[1]

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

50mg n=12[1]

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

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

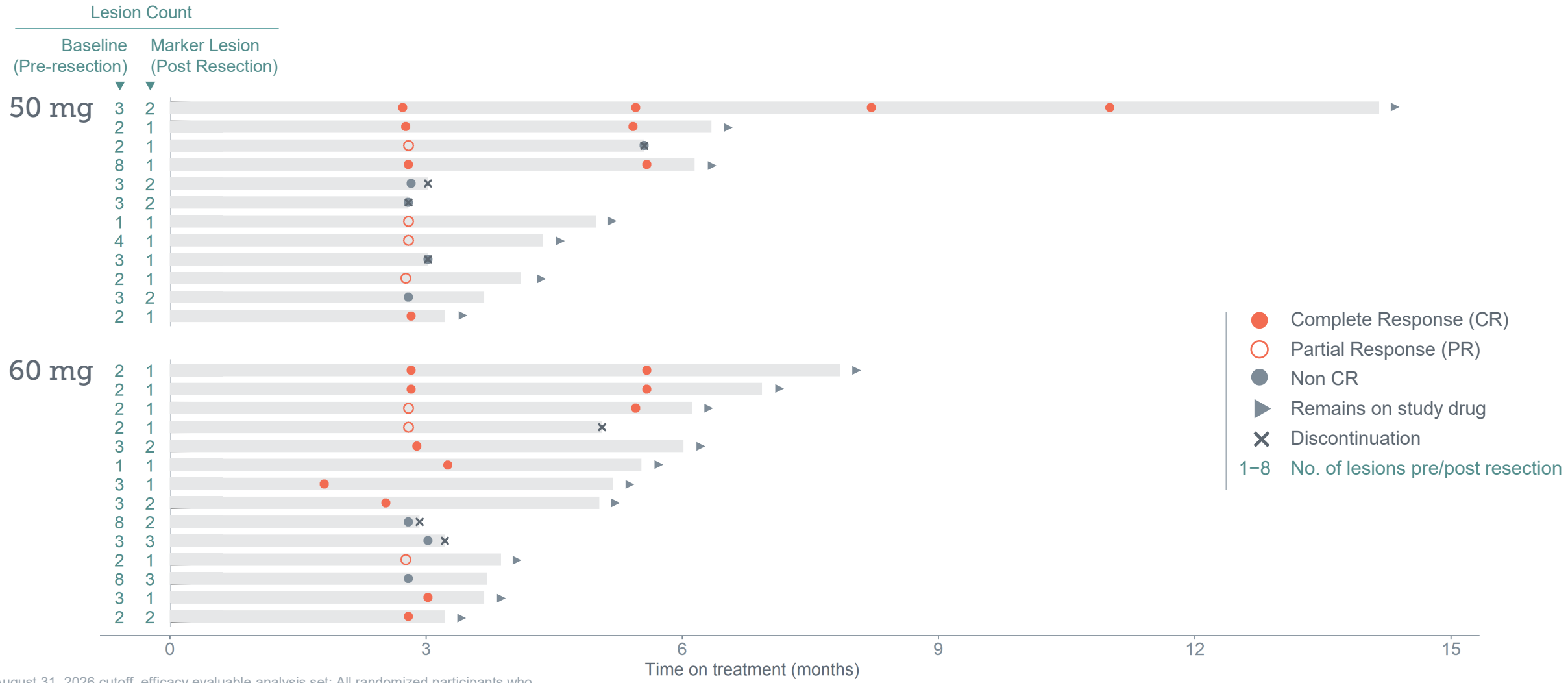
FINDINGS

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

August 31, 2026 cutoff

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

Evidence of response maintenance and maturation



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

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SURF302

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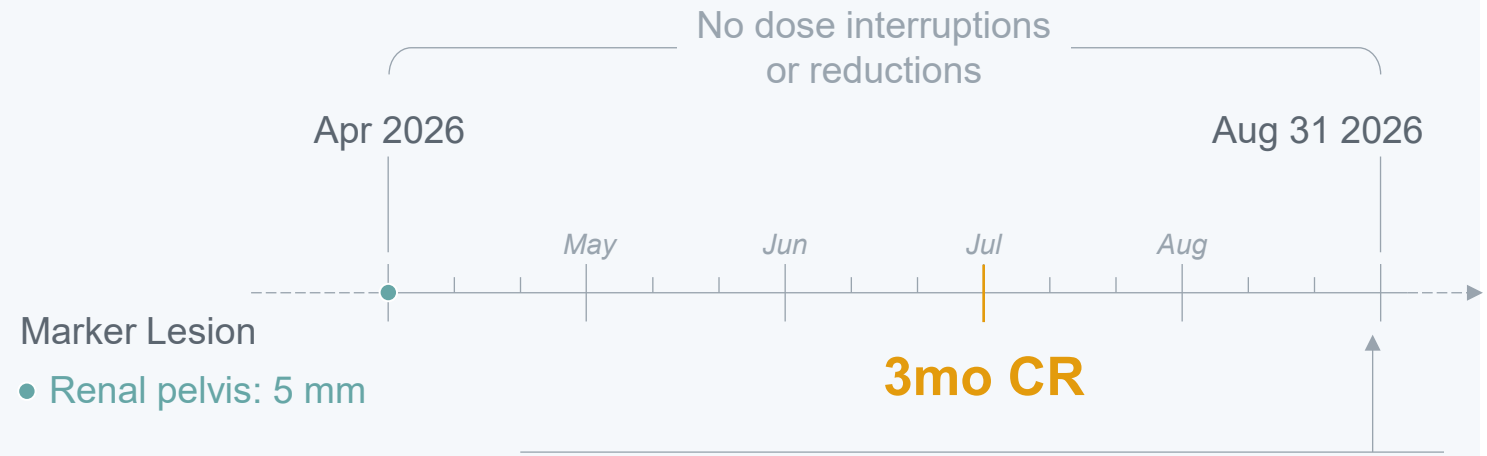
60mg activity extends from IR NMIBC to first LG UTUC patient

SURF303

COMPLETE RESPONSE

73-year-old male, 60mg QD

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



Data as of August 31, 2026

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Model projects likely plateauing of adjuvant efficacy above 60mg

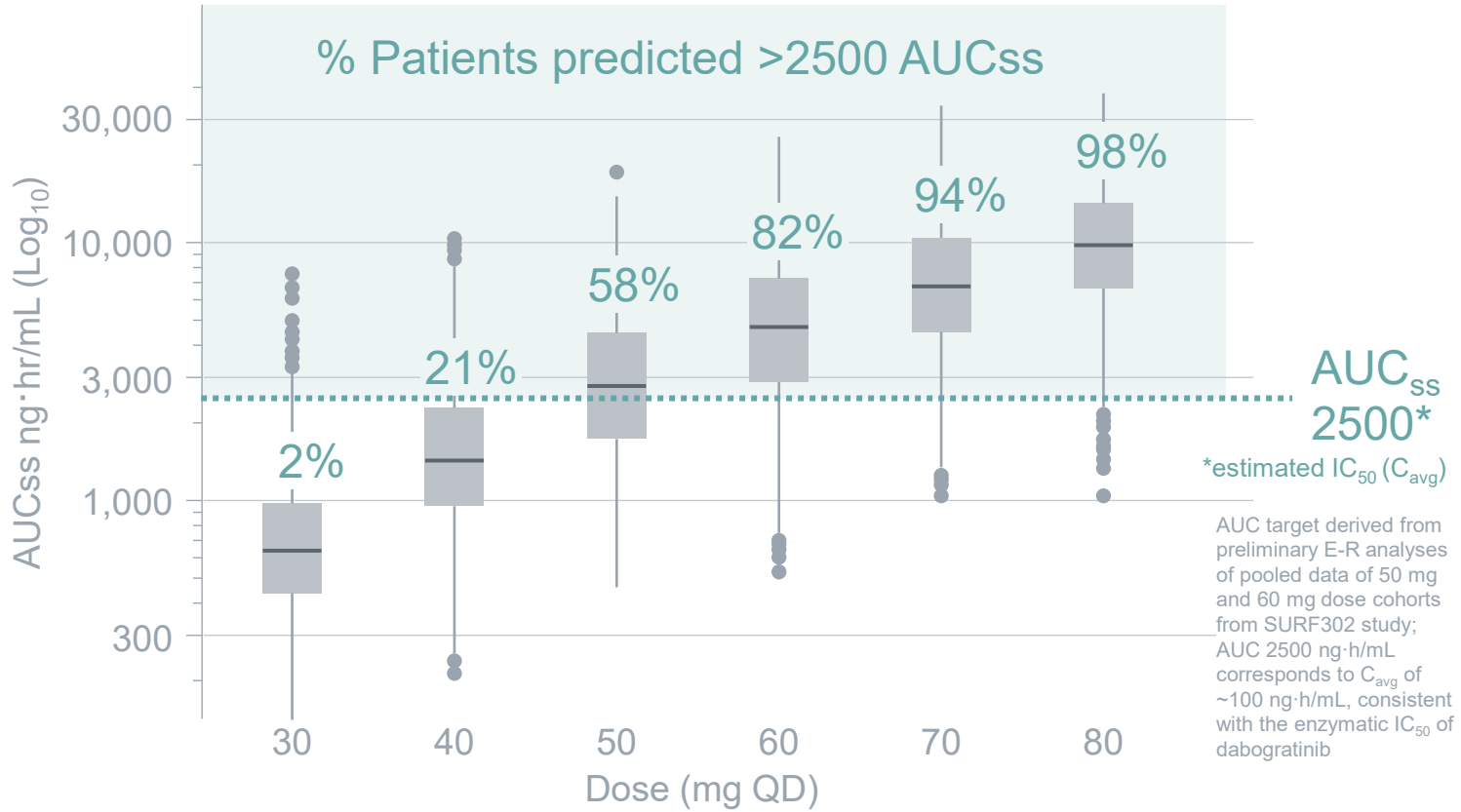
Response Rate by AUC
across 50 and 60mg

86% ORR at >2500 AUC_{ss}

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

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

Predicted Steady State AUC by Dose (n=172)



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

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

Clinical activity improved in patients with single marker lesion

Response Rate by ML
across 50 and 60mg

94% ORR with 1 ML

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

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

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

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

60mg with 1 ML n=8

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

August 31, 2026 cutoff, efficacy evaluable analysis set: All randomized participants who received study treatment and have undergone at least the month 3 disease assessment.
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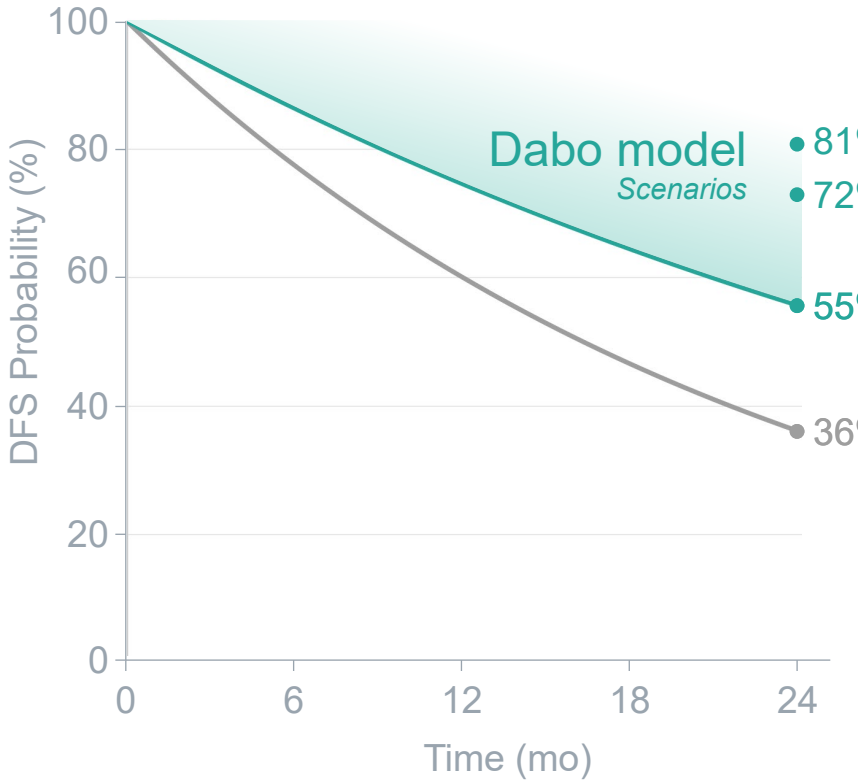
Modeling supports our confidence in planned adjuvant Ph3

Modeled DFS Curves[4]

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



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

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

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

Implied Hazard Ratio vs. Placebo

DFS: Disease Free Survival; DoR: Duration of Response

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

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

See disclaimer on pooled and modeled data.

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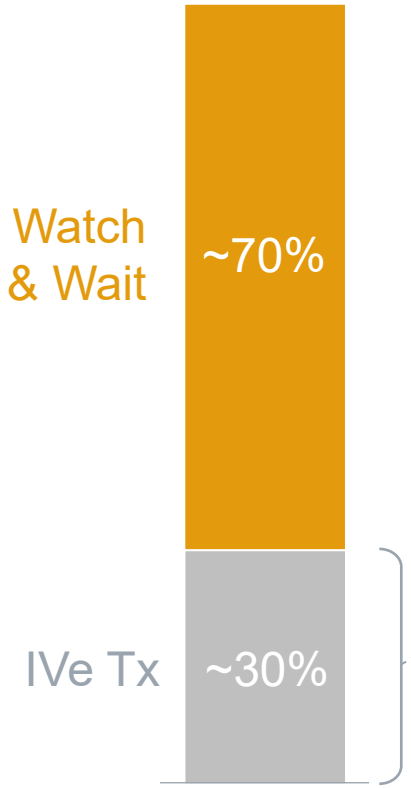
Our mission is to make dabogratinib the clear first-line choice

LG IR NMIBC adjuvant patients[1]



WIN ON EFFICACY AND CONVENIENCE

POTENTIAL FOR A DAILY ORAL

Replace repeat catheterizations/instillations

SWITCH CONSIDERATIONS

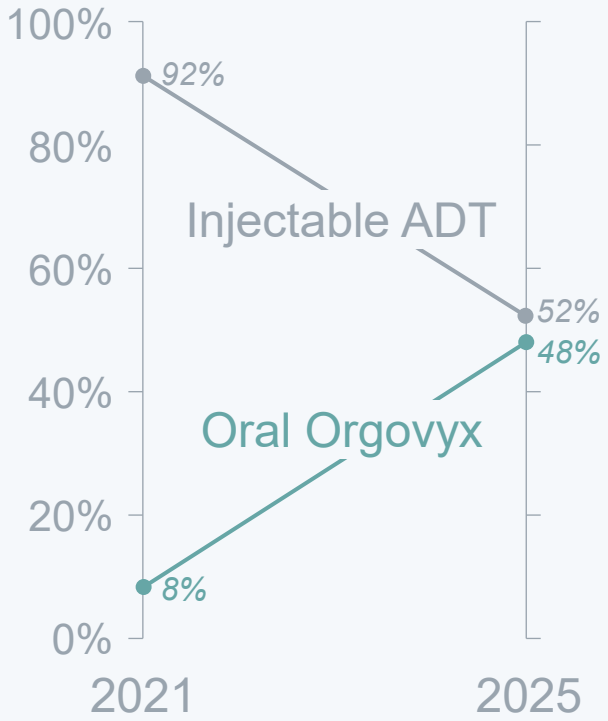
- Instrumentation fatigue
- Potential for continued DFS with oral Tx

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

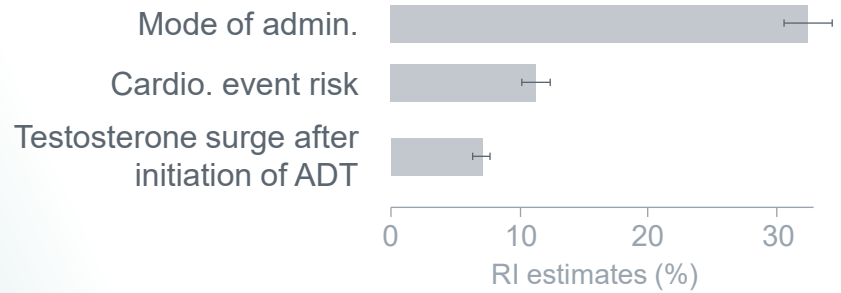
Preference for oral Orgovyx transformed the ADT market

COMPETE ON CONVENIENCE

Community Urology Patient Share[1]



1 Patient Preference[2]



2 Aligned Practice Economics

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

3 Streamlined Operations

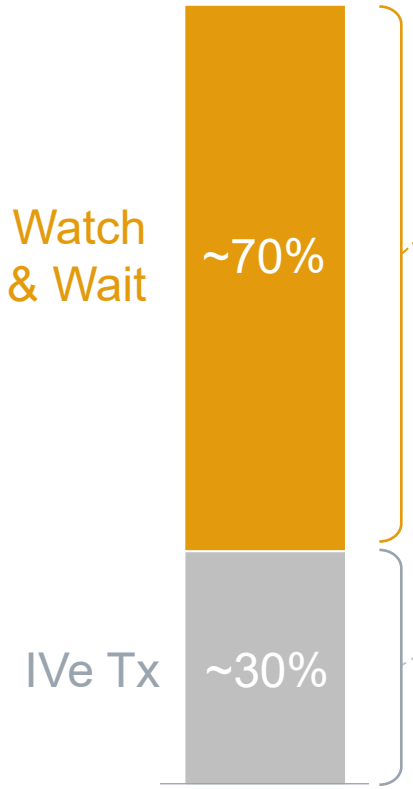
Nurses and treatment rooms removed

ADT: Androgen Deprivation Therapy
RI: Relative Importance

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

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

LG IR NMIBC adjuvant patients[1]



EXPAND THE MARKET

POTENTIAL FOR A DAILY ORAL

Reduce recurrence and surgery

Reduce 3-month cystoscopy burden

WIN ON EFFICACY AND CONVENIENCE

POTENTIAL FOR A DAILY ORAL

Replace repeat catheterizations/instillations

SWITCH CONSIDERATIONS

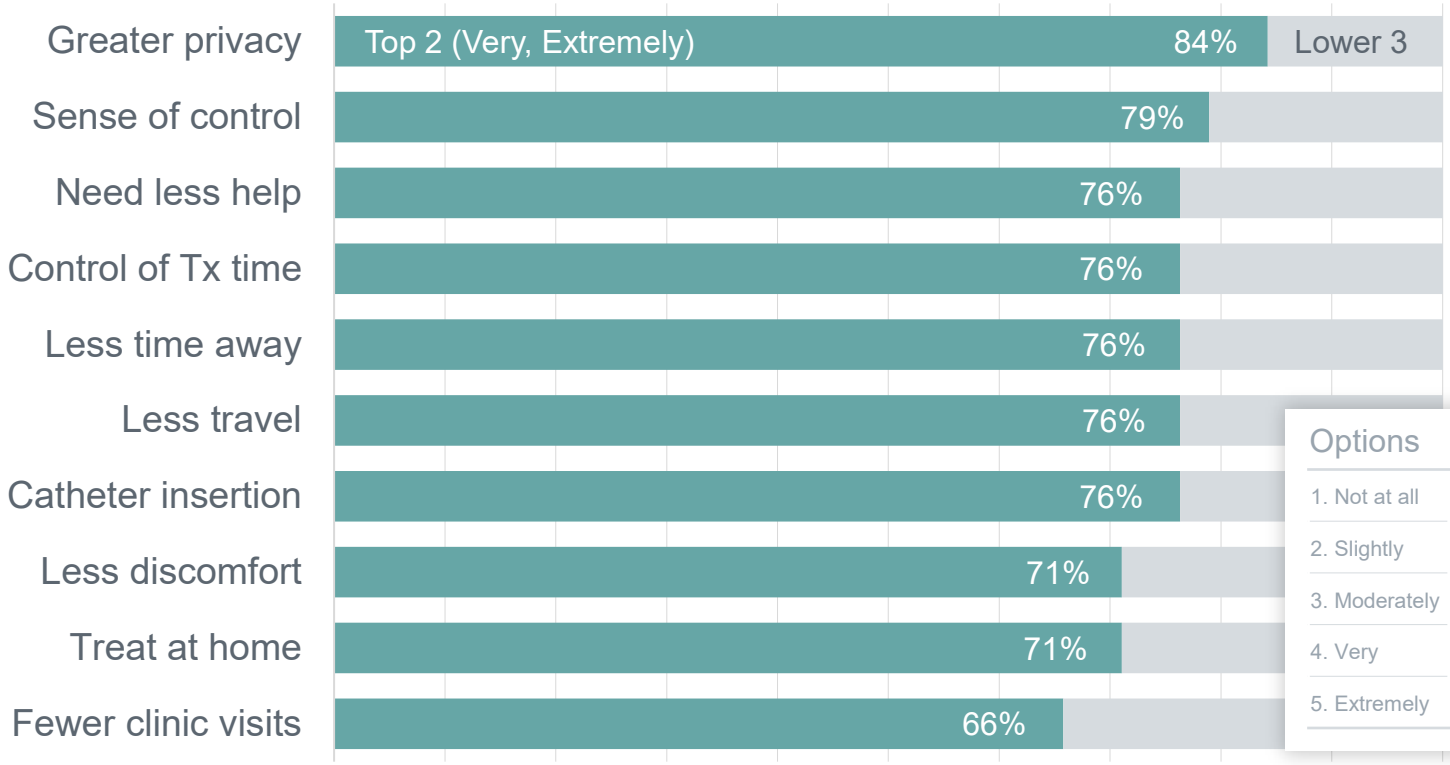
- Instrumentation fatigue
- Potential for continued DFS with oral Tx

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

Research indicates patients would strongly value an oral therapy

LIFESTYLE APPEAL OF A DAILY ORAL PILL[1]

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

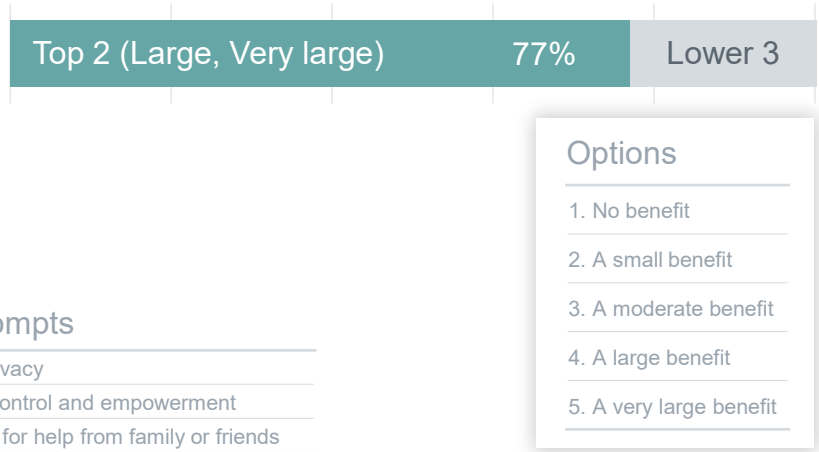


* Full prompts

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

TREATMENT APPEAL[1]

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



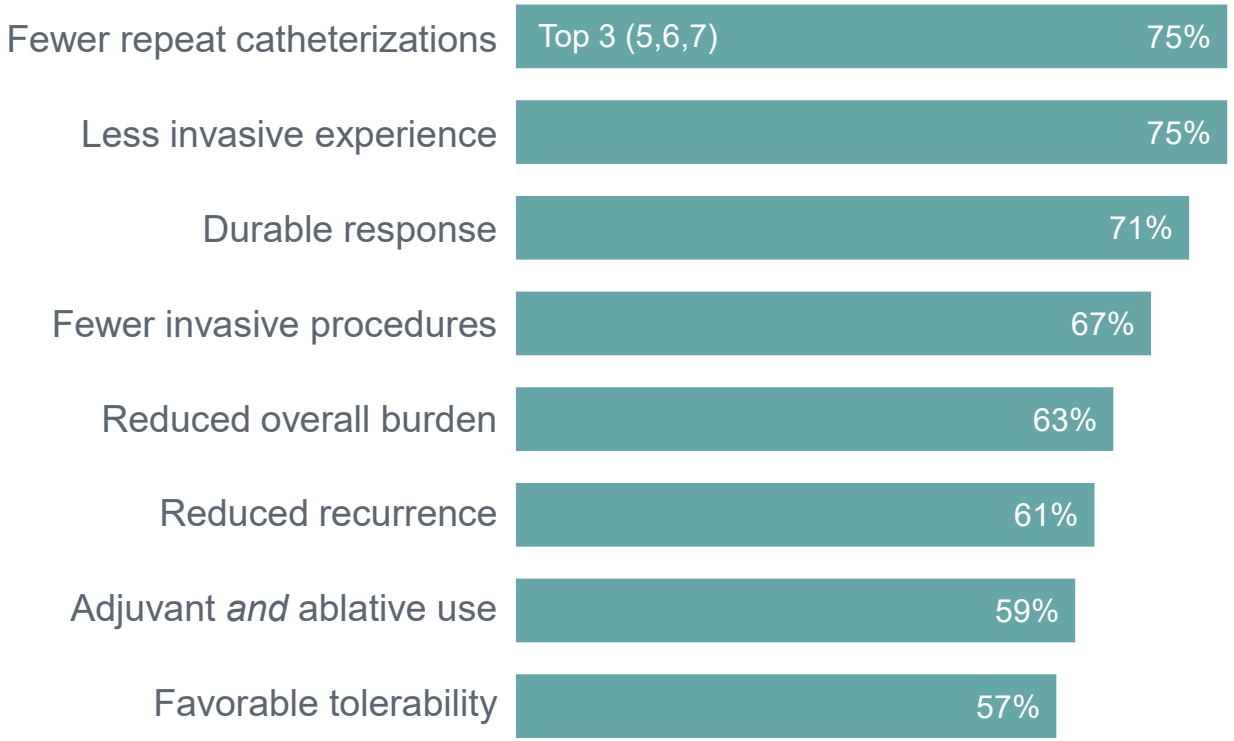
1. August 2026 survey of N=38 IR NMIBC patients, TYRA Market Research on File (study ongoing)

Urologists prioritize efficacy *and* relief from invasive procedures

The majority of urologists would recommend patients try oral before pretzel

UNMET NEEDS IN IR NMIBC[1]

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



Options

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

Top 3

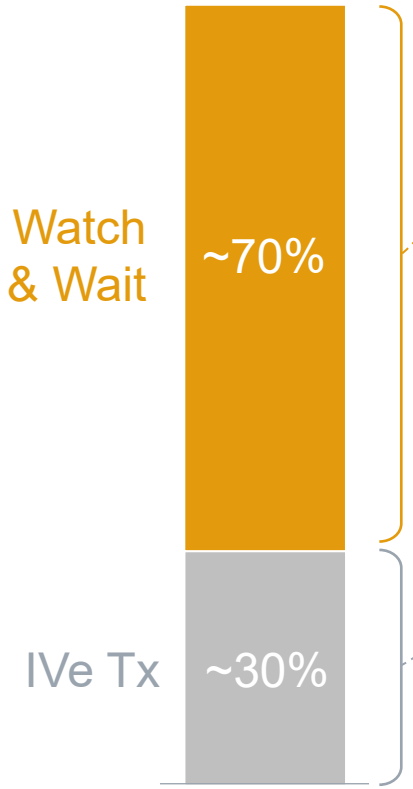
* Full prompts

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

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

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

LG IR NMIBC adjuvant patients[1]



EXPAND THE MARKET

POTENTIAL FOR A DAILY ORAL

Reduce recurrence and surgery

Reduce 3-month cystoscopy burden

WIN ON EFFICACY AND CONVENIENCE

POTENTIAL FOR A DAILY ORAL

Replace repeat catheterizations/instillations

TOTAL POTENTIAL MARKET SIZE[2]

>$5 BILLION

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

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

TYRA

SURF302

DATA RELEASE

SEPT 2026

Dabogratinib's proof of concept in IR NMIBC

Phase 2 lays foundation for potential adjuvant Phase 3 study

LG IR NMIBC data

UTUC 60mg case study

LG IR NMIBC dose selection

Dabogratinib's potential to transform the SoC

Daily oral serves patients, families, and providers

Market insights

KOL perspective

Next steps

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Clinical momentum continues across the dabogratinib franchise

DABO3^3

		ANTICIPATED NEXT STEPS
IR NMIBC	First clinical proof of concept for dabogratinib	Engage FDA on Ph3 design Prepare to initiate Ph3 in 2027
UTUC	First patient achieved a CR at 60mg QD[1]	Initial SURF303 results expected in 2027
ACH	Dose Level 5 (DL5) cleared with no safety signals[1]	Dose response data in n=~25 through DL5 sentinel participants expected end of Q1 2027

1. As of August 31, 2026 data cutoff

TYRA

Dabogratinib: the first potential oral innovation in IR NMIBC

September 9, 2026