TYRA

Corporate Deck

November 2026

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Forward-looking statements and market data

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

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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. These and other factors could cause results to differ materially from those expressed in the estimates made by the independent parties and by us.

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

Gearing up for potential pivotal trials in 3 blockbuster indications

Validated Target

FGFR3 alterations drive conditions with high unmet needs

Differentiated Molecule

DABOGRATINIB

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

60mg PoC IR NMIBC Patients

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

3 Potential Blockbuster Indications

	EXPECTED
IR NMIBC – Adj. Ph3 initiation & SURF302 update	2027
LG UTUC – Initial results	2027
ACH – Initial results	2027

NASDAQ: TYRA

CASH: $700M (As of 3Q26)

DABO3^3

ACH: Achondroplasia; IR NMIBC: Intermediate Risk Non-Muscle-Invasive Bladder Cancer; LG UTUC: Low Grade Upper Tract Urothelial Carcinoma; ML Marker Lesion; ORR: Overall Response Rate; BOR: Best overall Response; CR: Complete Response; Adj.: Adjuvant; Cash: Cash, cash equivalents, and marketable securities as of September 30, 2026
All TYRA small molecule inhibitors are for investigational use only; Initiation of Ph3 adjuvant IR NMIBC study is subject to regulatory feedback.

Our expertise in FGFR biology creates a differentiated pipeline

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

SNAP CHEMISTRY DESIGN

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

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

TYRA retains an active FGFR3 discovery program

TYRA

TYRA's highly selective FGFR3 inhibitor

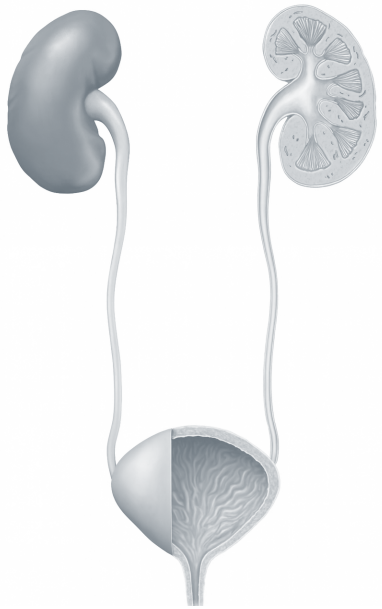
Our development paths in Urology and ACH

Large Market Potential in IR NMIBC and LG UTUC

>$18–36 BILLION[1]

Estimated Oral Maintenance Market

US Addressable



DRIVERS

ANNUAL POPULATION

~38K

Total FGFR3+ seeking treatment[2]

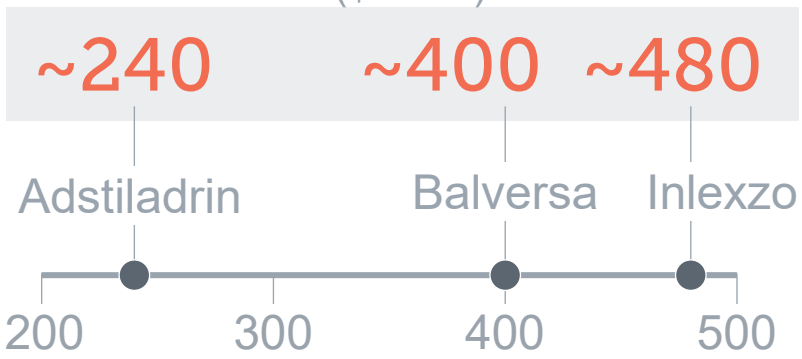
IR NMIBC
~35K | ~70% FGFR3+

LG UTUC
~3K | 85% FGFR3+

TX DURATION

2+ YRS

ANNUAL PRICE ($'000s)

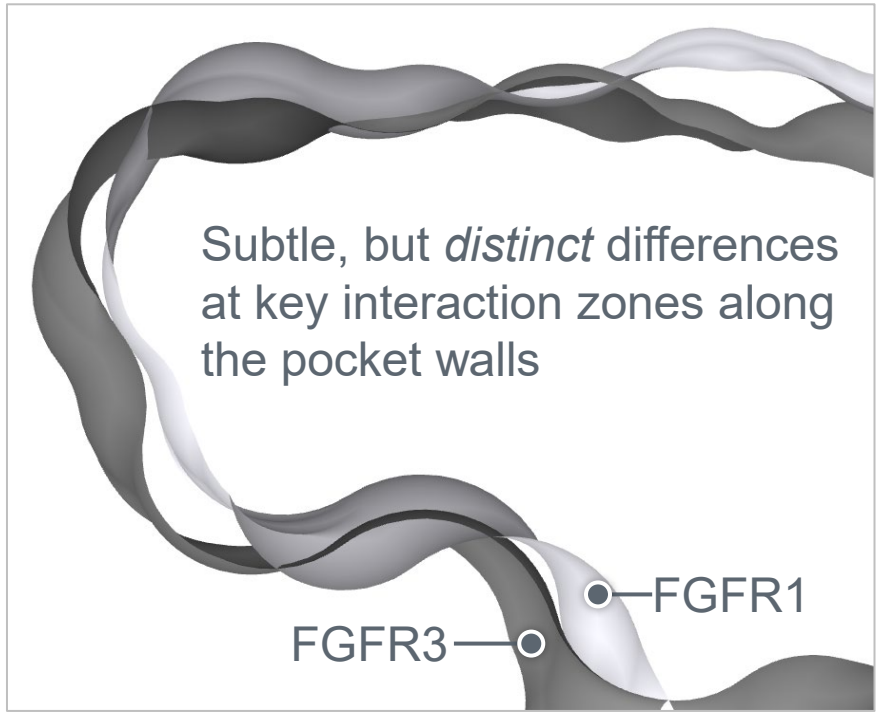


1. Range represents calculation of addressable FGFR3+ patients multiplied by duration of therapy and estimated Adstiladrin, Balversa and Inlexzo annualized wholesale acquisition costs based on package insert dosing schedules. Range roughly aligns with peak LG UTUC and FGFR3+ IR NMIBC sales projections at full market penetration of branded agents, based on LEK research, accounting for estimated potential gross to net discounts and annual price increases, without accounting for potential biomarker testing rate, compliance, persistence or market access discounts.

2. Estimated 2025 US incidence and recurrences; van Rhijn, 2010; Mayr, 2022; Sfakianos, 2015, Moss, 2017; Nassar 2019; CancerMPact® Patient Metrics and Oracle Life Sciences analysis; Ravvaz, 2019, Caputo, 2020, Check, 2019, Ritch, 2020, Lyall, 2023; Vedder, 2014.

Our SNAP platform was able to address an intractable problem

FGFR isoform selectivity



MOLECULAR MODEL

SNAP

dozens of high-resolution crystal structures

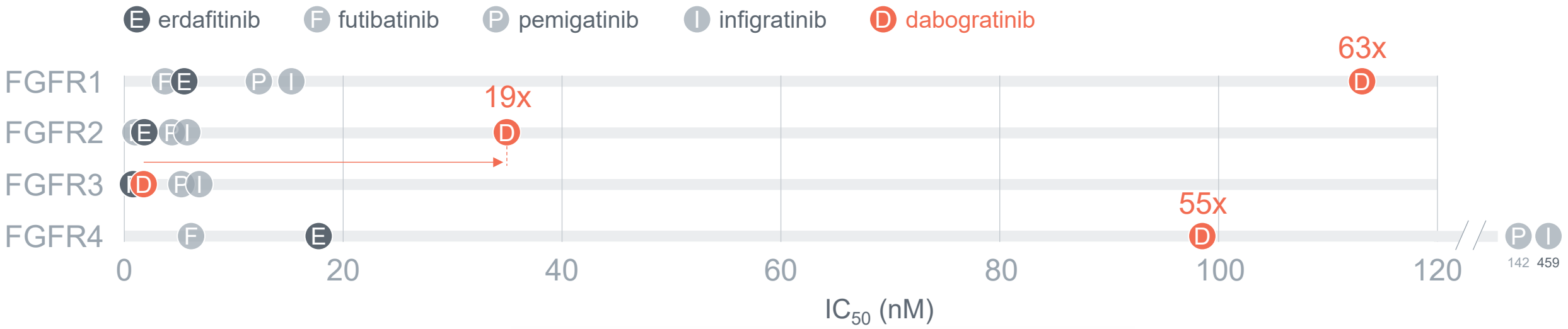


CRYSTALLOGRAPHY

3.0Å cross-sections

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

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



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

Fold selectivity from FGFR3

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

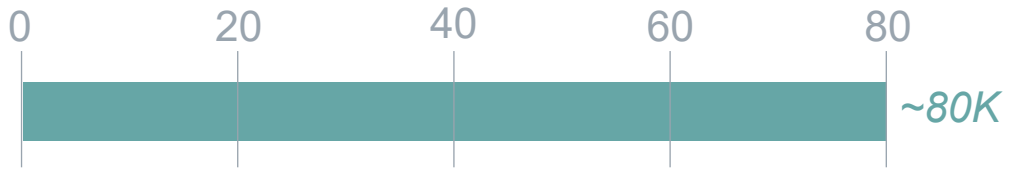
TYRA

TYRA's highly selective FGFR3 inhibitor

Our development paths in Urology and ACH

High FGFR3+ rate drives an outsized opportunity in IR NMIBC

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

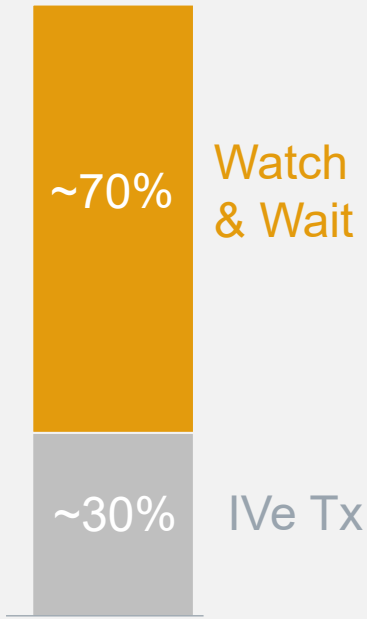


FGFR3+ Rate Sources: van Rhijn, 2010; Mayr, 2022; Kacew, 2020; Sfakianos, 2015, Moss, 2017; Nassar 2019; MIBC, mUC; All Bladder Prevalence Source: SEER; MIBC and mUC Patients Seeking New Treatment Source: DR/Decision Resources LLC 2025 Epidemiology Figures; NMIBC and UTUC Patients Seeking New Treatment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

IR NMIBC

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

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



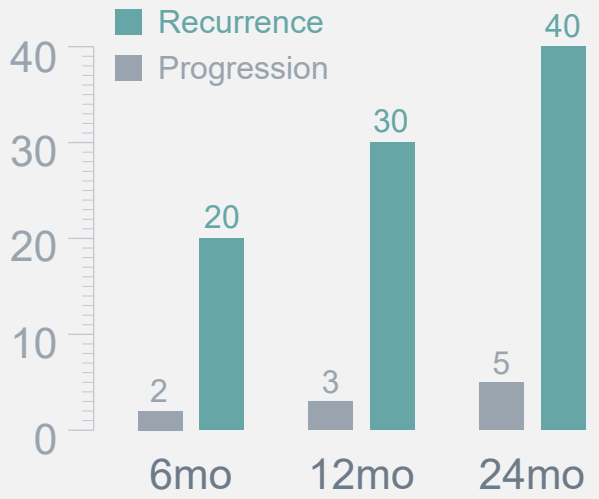
...despite efficacy[2]...

44%

Recurrence Risk Reduction

Patients Treated with Adjuvant IVe Chemo

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



This may be why



6–30 times

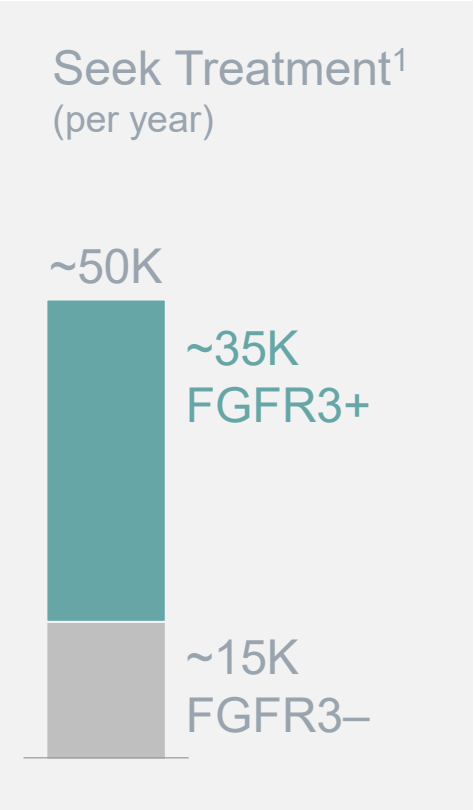
"No one likes anything shoved up their urethra"

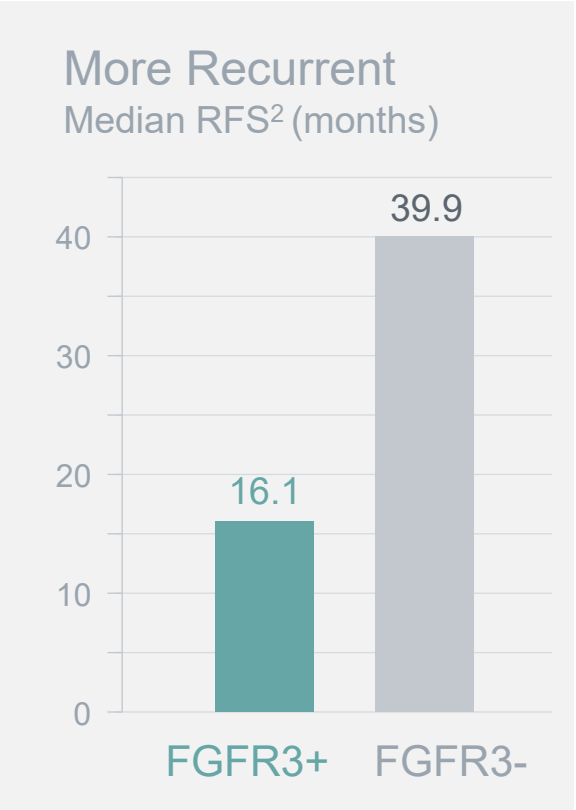
—Community urologist[4]

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

FGFR3+ patients benefit from sustained FGFR3 inhibition

FGFR3+ VALIDATED TARGET IN IR NMIBC





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

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

EVIDENCE SUSTAINED INHIBITION MAINTAINED RESPONSES

TAR-210
Pan-FGFR Pretzel

100% durability while on therapy

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

Oral Erdafitinib
Pan-FGFR

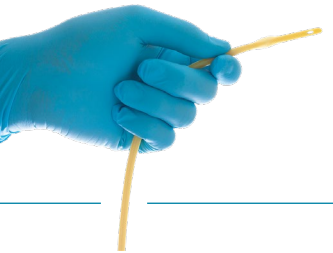
100% durability while on therapy

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

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

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

Dabo is uniquely positioned to expand Tx beyond procedures



ADJUVANT IVe Tx IN DEVELOPMENT

All five require multiple urethral violations with dwell times

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

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

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

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

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

ORAL DEVELOPMENT

Only QD *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)

Dabo has the potential to complement procedural interventions

PATIENT EXPERIENCE

ACUTE
Ablative

DABOGRATINIB

TURBT

ZUSDURI[1]

TAR-210

INDUCTION+
Adjuvant (~6-52 wks[2])

DABOGRATINIB

IVe CHEMO

ZUSDURI[1]

TAR-210

ADSTILADRIN

CRETOSTIMOGENE

NDV-01

Potential IVe Tx Fatigue

LONG TERM MAINTENANCE
Potentially Complementary Adjuvant (~2+ yrs)

Dabogratinib — Daily oral, at-home treatment



TARGET PROFILE

efficacious and tolerable to enable chronic Tx

Approved
In Development

1. Zusduri approved for IR NMIBC and disclosed plans for UGN-103 adjuvant study (Urogen Press Release, August 5, 2026)
2. All IVe agents dosed up to 12 months after induction aside from Adstiladrin which is being dosed up to 24 months

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
Enrolled

Cohort B
N=26 | 50mg QD
Enrolled

Cohort C
N=30 | 70mg QD
Enrolling

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%

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*

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

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 DFS potential

PHASE 3 ADJUVANT
ALL TUMORS REMOVED

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

Implications from Phase 2

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

See disclaimer on pooled and modeled data.

IR NMIBC

SURF302 Data and Phase 3 Dose Selection

SURF302 enrolled a highly recurrent, undertreated population

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

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

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

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

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

Favorable safety and tolerability data support chronic Tx potential

Adverse Events Were Manageable

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

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

AE-related

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

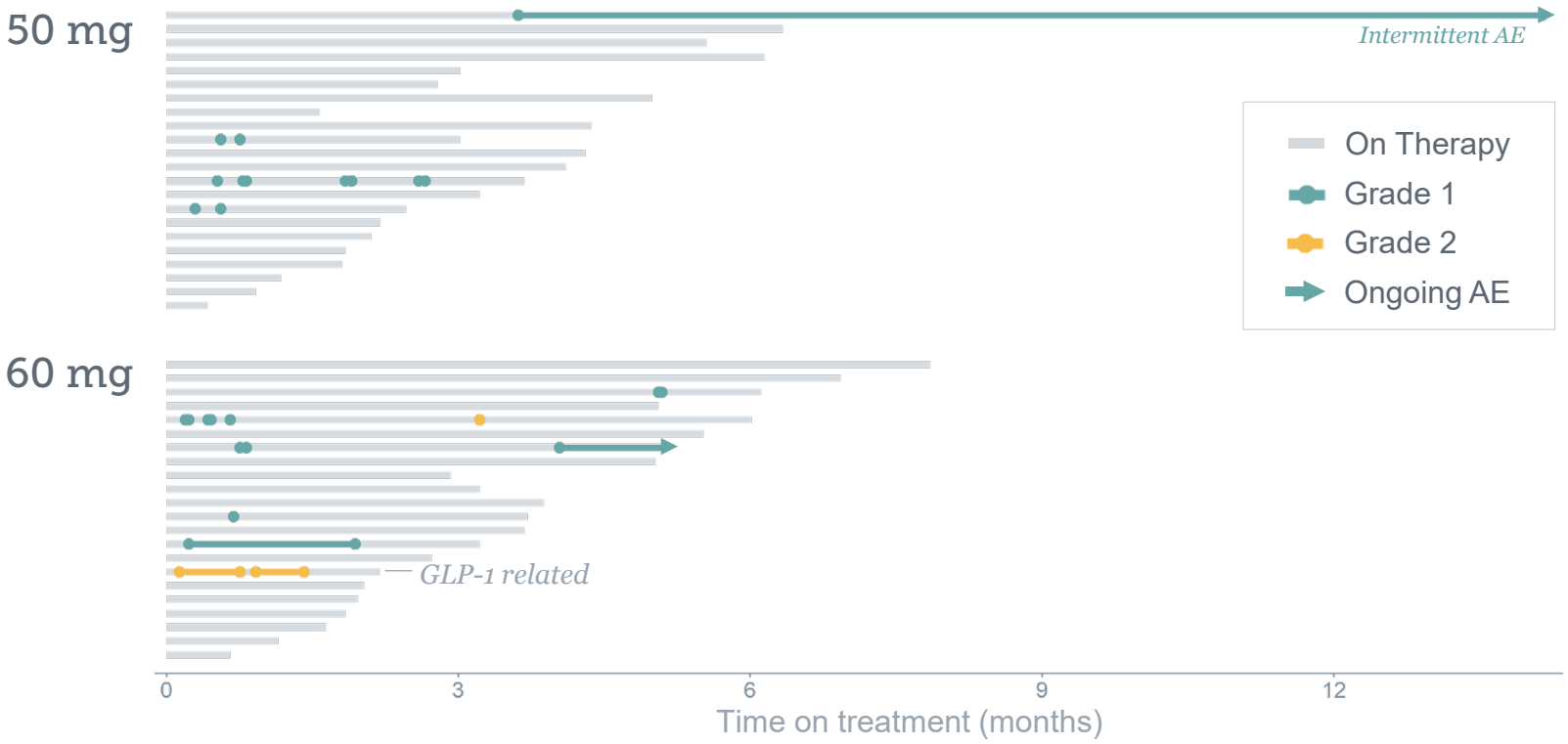
TEAEs in Patients Treated with Dabogratinib, n (%)

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

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

GI events were limited and transient

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



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

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

60mg demonstrated robust clinical activity with a dose response

60mg n=14[1]

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

50mg n=12[1]

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

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

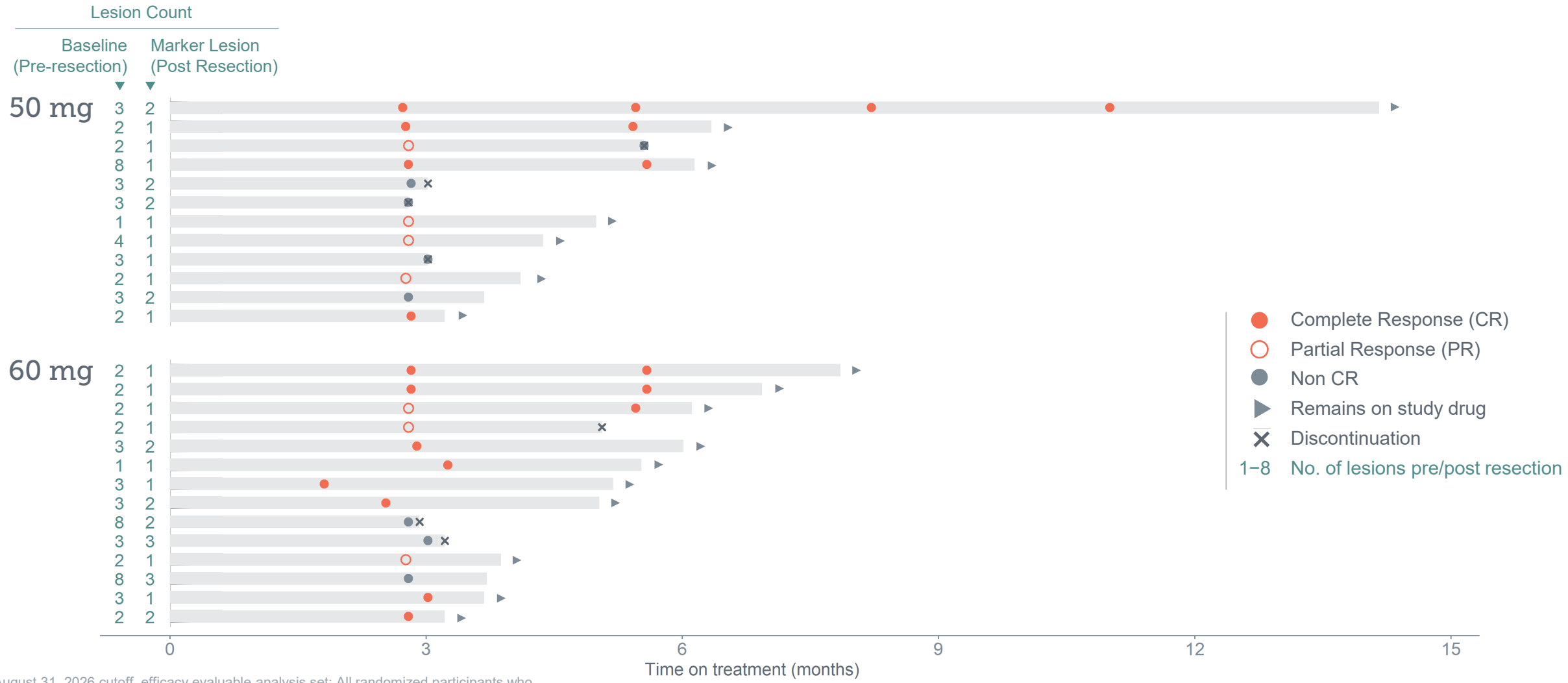
FINDINGS

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

August 31, 2026 cutoff

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

Evidence of response maintenance and maturation



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

Model projects likely plateauing of adjuvant efficacy above 60mg

Response Rate by AUC
across 50 and 60mg

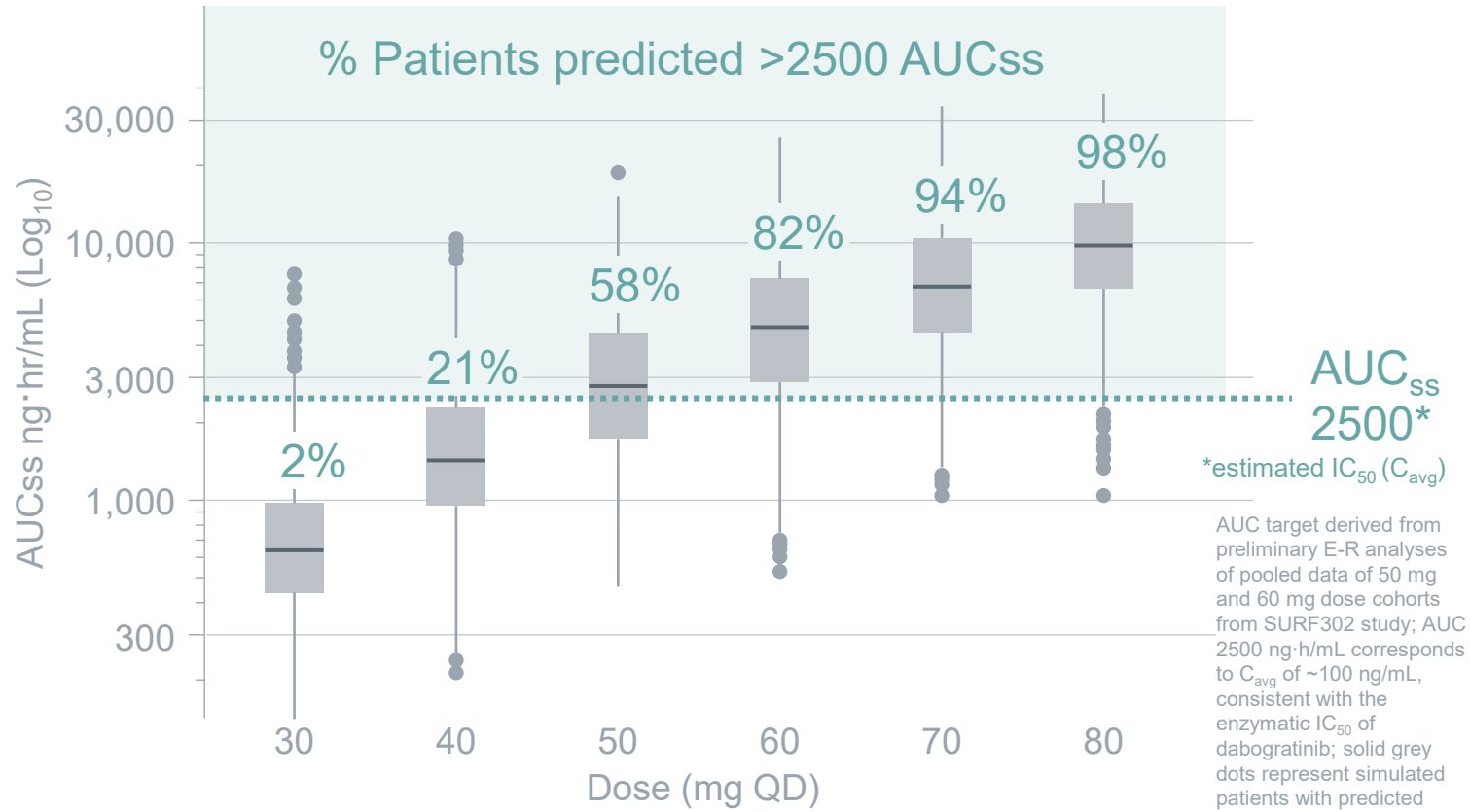
86% ORR at >2500 AUC_{ss}

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

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

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.

Predicted Steady State AUC by Dose (n=172)



AUC target derived from preliminary E-R analyses of pooled data of 50 mg and 60 mg dose cohorts from SURF302 study; AUC 2500 ng·h/mL corresponds to C_{avg} of ~100 ng/mL, consistent with the enzymatic IC_{50} of dabogratinib; solid grey dots represent simulated patients with predicted exposures that fall outside the range observed for most patients

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

Clinical activity improved in patients with single marker lesion

Response Rate by ML
across 50 and 60mg

94% ORR with 1 ML

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

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

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

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

60mg with 1 ML n=8

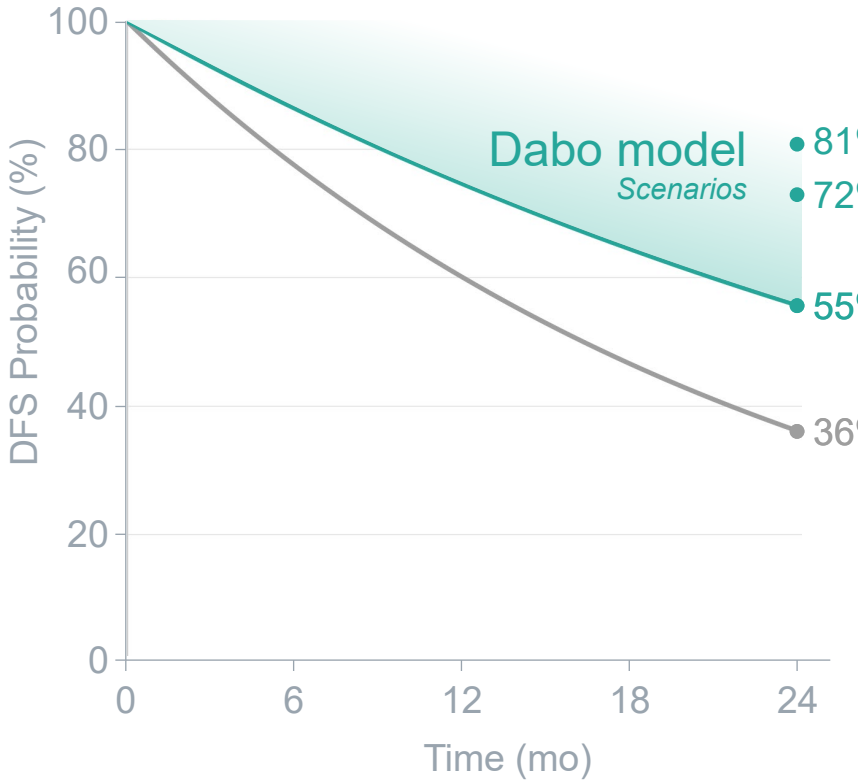
	3-mo	BOR
ORR	100% (8)	100% (8)
CR	63% (5)	75% (6)
PR	38% (3)	25% (2)

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

Modeling supports our confidence in planned adjuvant Ph3

Modeled DFS Curves[4]

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



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

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

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

Implied Hazard Ratio vs. Placebo

DFS: Disease Free Survival; DoR: Duration of Response

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

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

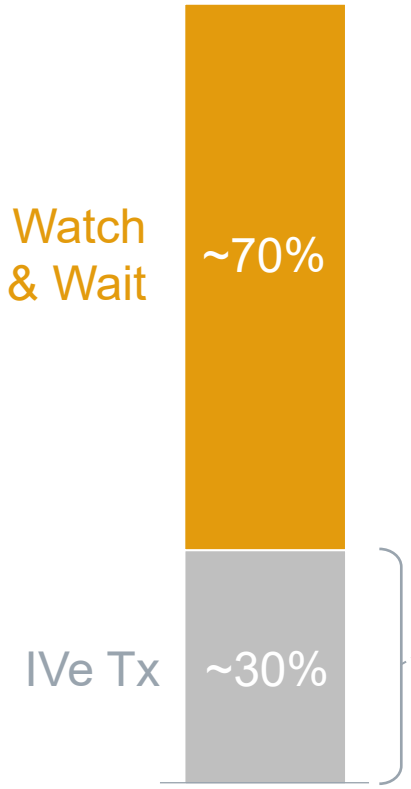
See disclaimer on pooled and modeled data.

IR NMIBC

Market Opportunity

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

LG IR NMIBC adjuvant patients[1]



WIN ON EFFICACY AND CONVENIENCE

POTENTIAL FOR A DAILY ORAL

Replace repeat catheterizations/instillations

SWITCH CONSIDERATIONS

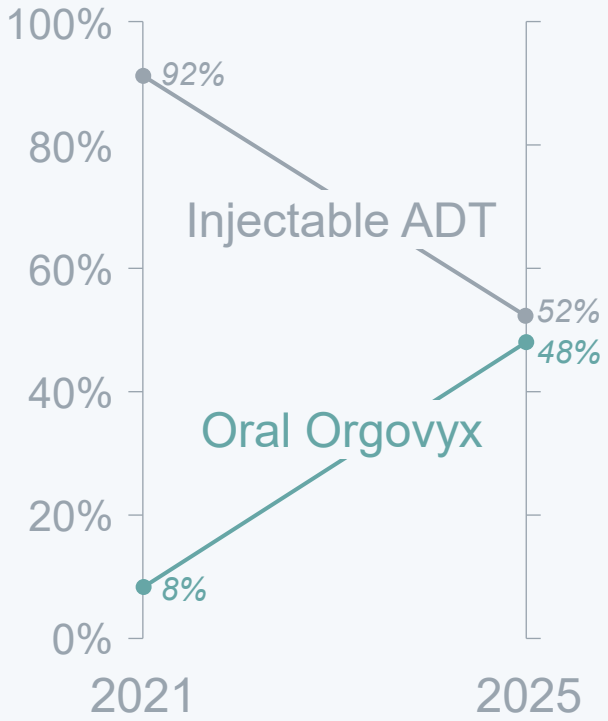
- Instrumentation fatigue
- Potential for continued DFS with oral Tx

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

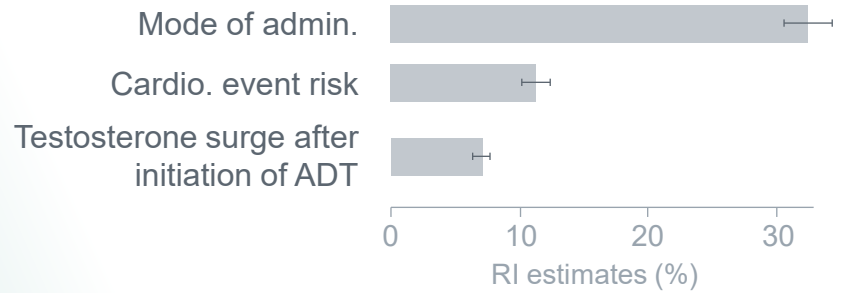
Preference for oral Orgovyx transformed the ADT market

COMPETE ON CONVENIENCE

Community Urology Patient Share[1]



1 Patient Preference[2]



2 Aligned Practice Economics

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

3 Streamlined Operations

Nurses and treatment rooms removed

ADT: Androgen Deprivation Therapy
RI: Relative Importance

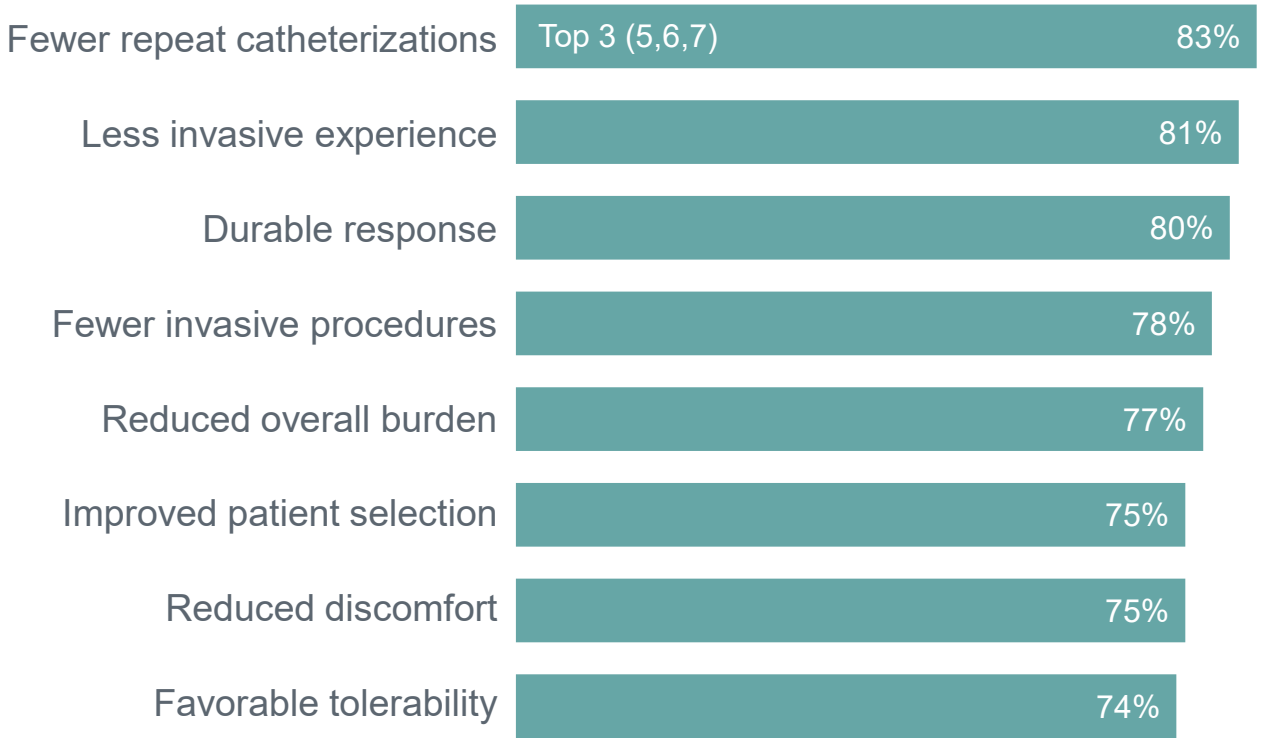
1. Data for prostate cancer patients treated with ADT captured in Cardinal Health Specialty Networks™ PPS Analytics Patient Population Health Management Platform;
2. Collins, 2025; 3. Orgovyxhcp.com accessed 5/27/26

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.	Top 3
6.	
7. Extremely high unmet need	

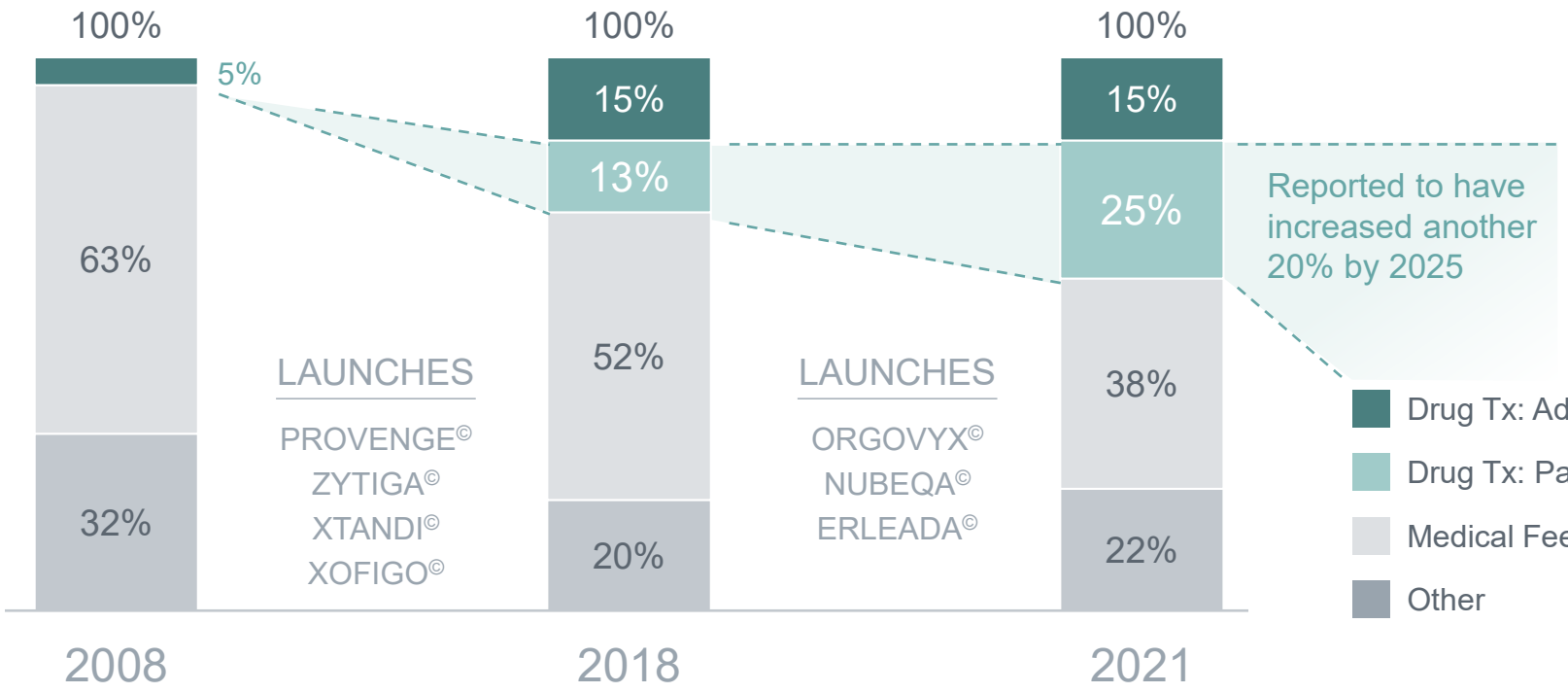
* Full prompts

- Reduction in repeat catheterization and intravesical drug administration
- A less invasive treatment experience
- 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)
- Improved patient selection/predictive biomarkers
- Reduced treatment-related discomfort for patients
- Favorable tolerability with a low toxicity burden

1. August-September 2026 survey of N=151 Urologists (82% community-based), TYRA Market Research on File.

Community urology revenue growth largely driven by drug therapy

Private Urology Practice Revenue by Category 2008-2021



~50% of urologists are a part of private practices

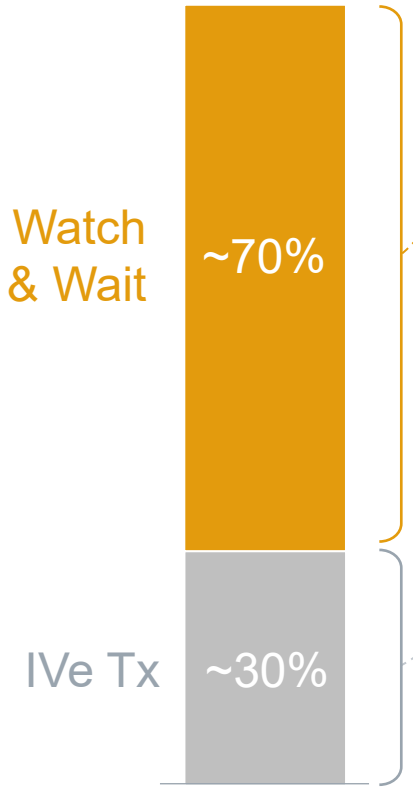
~80% of private practices are members of UroGPO[1], which supports In Office Dispensing

1. UroGPO is A Group Purchasing Organization which is part of Cardinal Health

Source: data from Specialty Networks Urology Practice Survey; AUA 2023 annual census

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

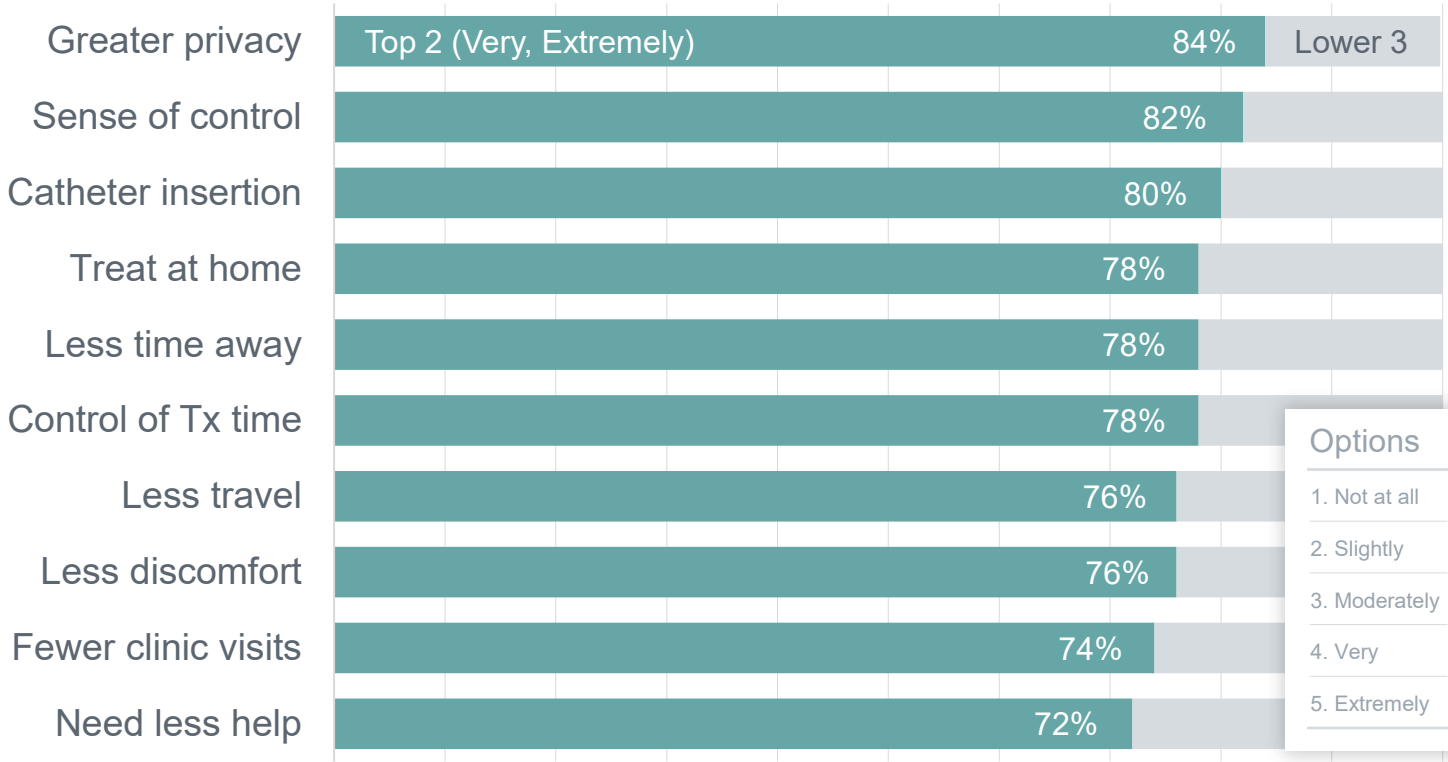
- Instrumentation fatigue
- Potential for continued DFS with oral Tx

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?*

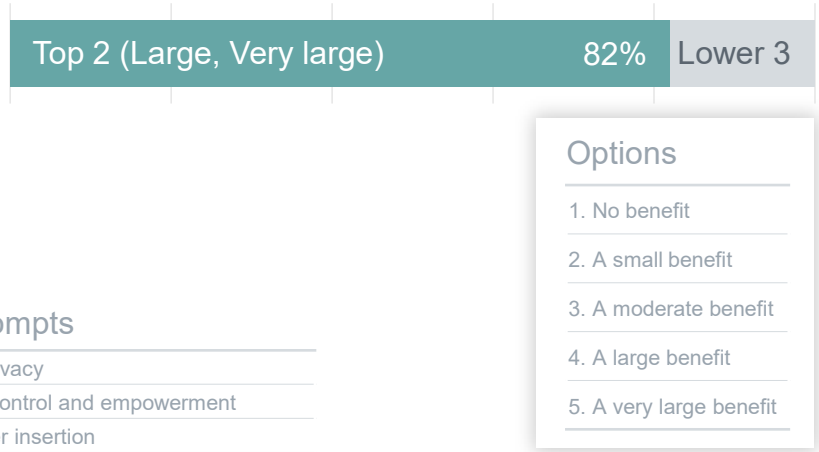


* Full prompts

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

TREATMENT APPEAL[1]

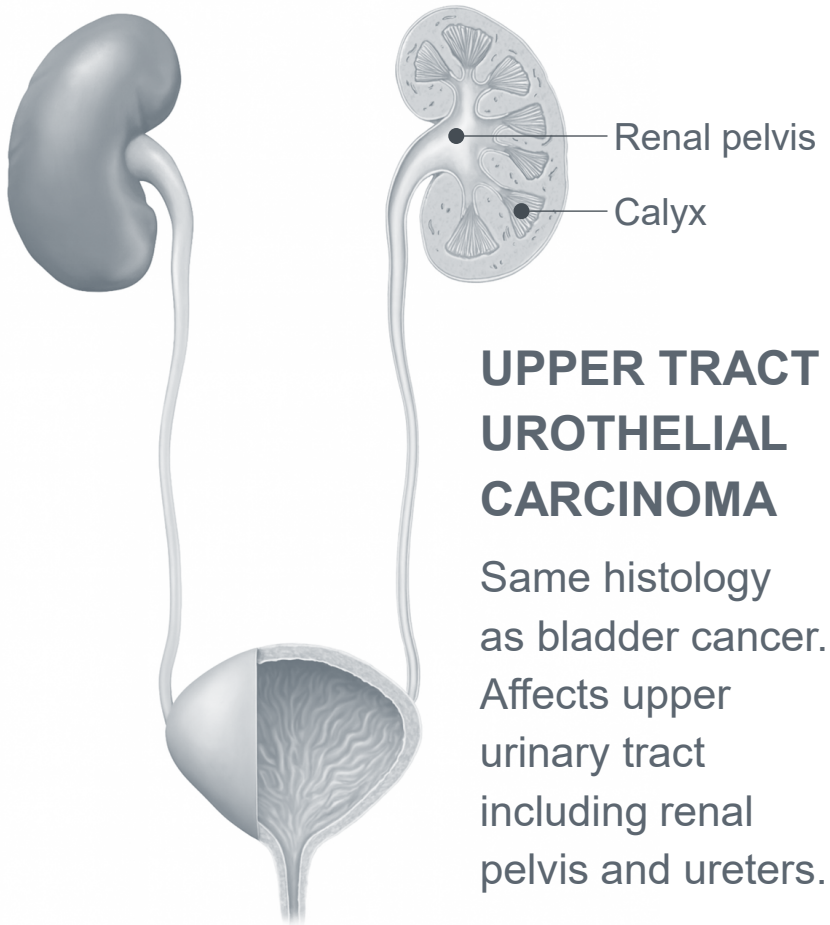
If oral treatment still required the same cystoscopy schedule for monitoring your remission, how much benefit would taking treatment at home provide?



1. August-September 2026 survey of N=50 IR NMIBC patients, TYRA Market Research on File.

UTUC

Dabogratinib could address specific unmet needs in LG UTUC



UPPER TRACT UROTHELIAL CARCINOMA

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

LOW GRADE UTUC

No high grade on biopsy or cytology

~85%
FGFR3+

~3,000
FGFR3+ seeking new treatment each year

UNMET NEED

ANATOMY

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

TREATMENT

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

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

Current kidney-sparing endoscopic surgery SoC has drawbacks



SIGNIFICANT RISKS

MISSED TUMORS

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

SURGERY

General anesthesia

Intra- and post-operative complications

POOR OUTCOMES

RECURRENCE AND PROGRESSION

ALL LG TUMORS

~35–50% recur within 3 years

LG TUMORS >2cm

90.5% recur (median 4.9 mo)

31.7% progress (median 26.3 months)

KIDNEY REMOVAL

After recurrence or progression, proceed to radical nephroureterectomy

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

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

Jelmyto, is more effective but comes with many limitations

Efficacy

58% CR rate

56% 12-month DoR

Eligibility

Renal pelvis (not ureters)

Tumors 5–15mm in size

Safety

58% Ureteric obstruction

41% Flank pain

34% Hematuria

34% UTI

25% Renal dysfunction

24% discontinuation

Administration

6 instillations:

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

Preparation

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



JELMYTO package insert and website accessed September 5, 2025

First LG UTUC patient has been dosed in Dabogratinib Ph2 Study

SURF303

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

Key Eligibility Criteria

Adults (≥18 years)

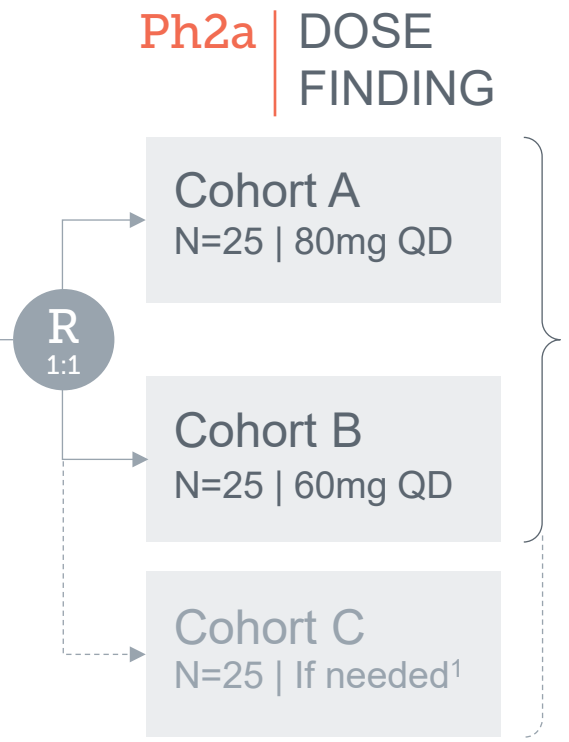
LR, LG UTUC based on AUA Guidelines, 2024

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

At least 1 marker lesion; total aggregate ≥5mm

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

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



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

Primary Endpoint

CR within 6 months in *FGFR3+* patients

Secondary Endpoints

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

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

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

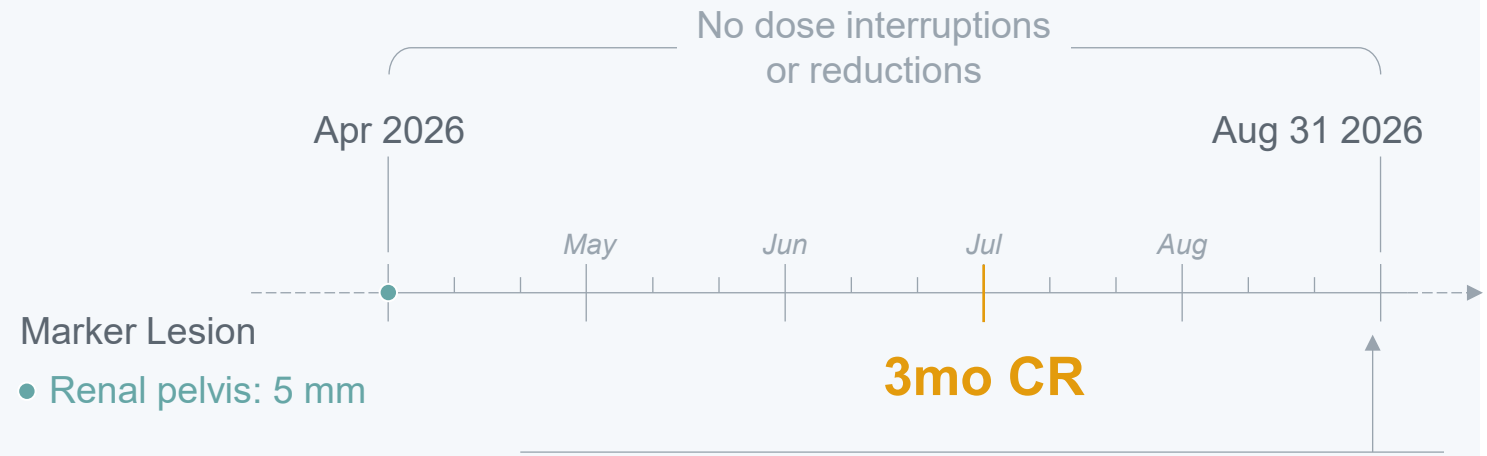
60mg activity extends from IR NMIBC to first LG UTUC patient

SURF303

COMPLETE RESPONSE

73-year-old male, 60mg QD

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



Data as of August 31, 2026

ACHONDROPLASIA

ACH can result in serious clinical complications



ACH is the most common cause of disproportionate short stature

MECHANISM

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

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

COMPLICATIONS

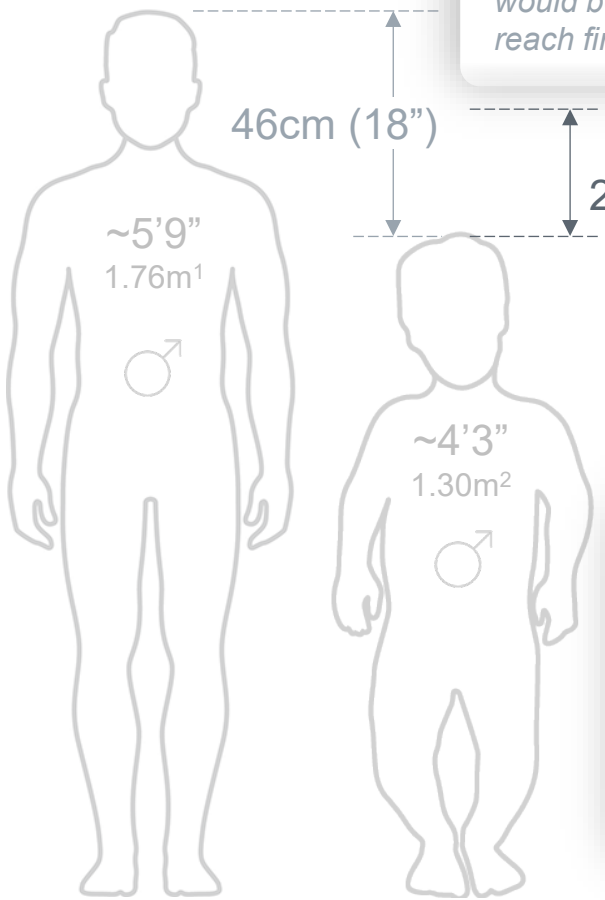
Infants can face serious complications related to critical foramen magnum stenosis[1,3]

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

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

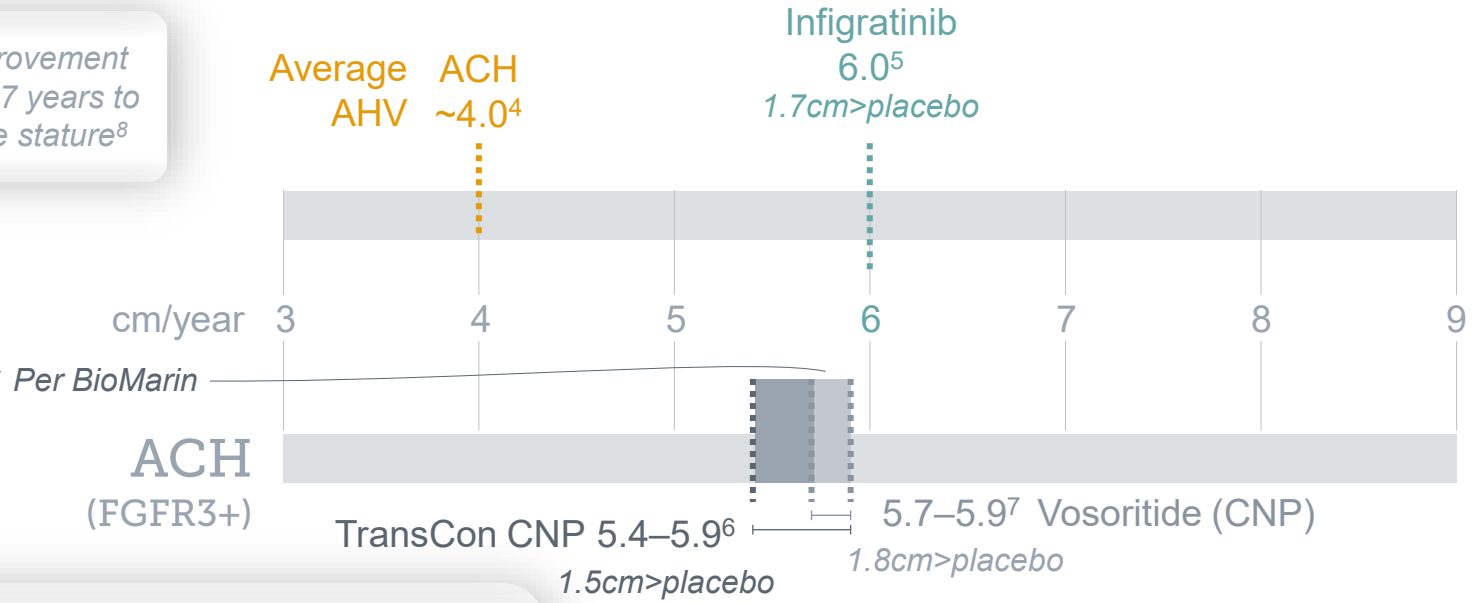
~6cm AHV is potentially leaving efficacy on the table

~2.7cm/yr avg AHV improvement would be needed over 17 years to reach final average male stature[8]



26 cm (10”)[3]

Per BioMarin



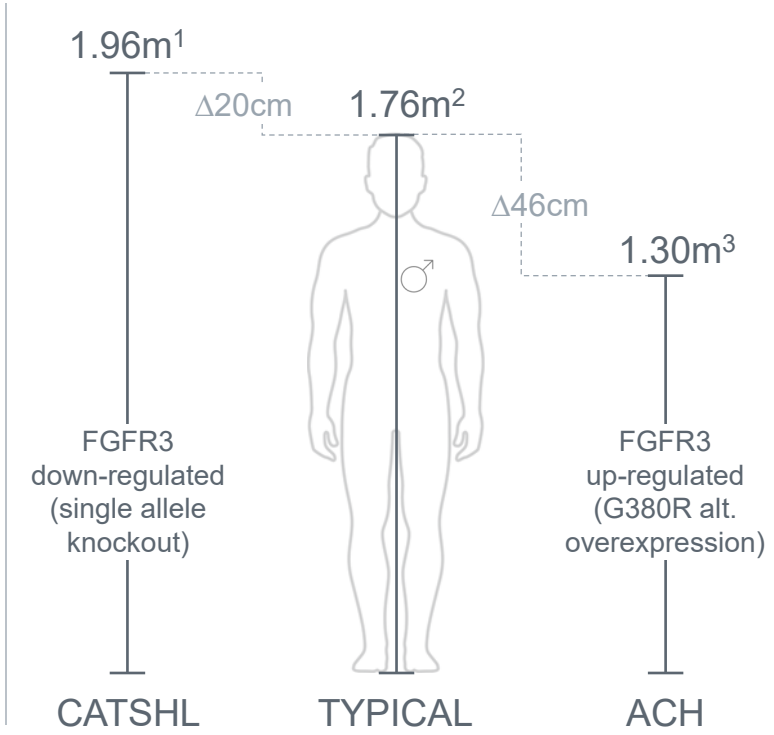
Further engaging FGFR3 and achieving a higher AHV could potentially benefit key sequelae like reach and gait, and potentially reduce spinal stenosis / surgeries.

1. CDC Vital and Health Statistics (represents average US male and female heights for ages 20-29); 2. Hoover Fong, 2021 (represents average ACH adult male height); 3. Potential total height gain from VOXZOGO BMRN 5/12/25 Press Release; 4. Savarirayan, 2021 (5 to 14yrs); 5. 6.0 AHV from Ph2 Cohort 5 12mo data, Savarirayan, 2024; 6.0 LS mean AHV and 1.7 LS mean absolute AHV improvement vs placebo data based on Ph3 study (n=114), Savarirayan, 2026; infigratinib showed 1.7cm LS mean change from baseline AHV improvement over placebo; 6. 5.4 AHV from Ph2 100 µg/kg/week cohort 6mo data (n=11) Ascendis 11/14/22 Corporate Presentation; 5.9 LS mean AHV and 1.5 LS mean absolute AHV improvement vs placebo data based on Ph3 study (n=84), Savarirayan, 2025; 7. 5.9 from Ph2 Cohort 3 12mo Data (n=10), Savarirayan, 2019; 5.7 LS mean and 1.8 LS mean absolute AHV improvement vs placebo data based on VOXZOGO prescribing information 10/2023 (n=121); VOXZOGO showed 1.6cm LS mean change from baseline AHV improvement over placebo; 8. Calculation assumes male growth plate closure at 17 years of age, Sarafoglou, 2009

Evidence points to FGFR3 inhibition potential beyond ACH

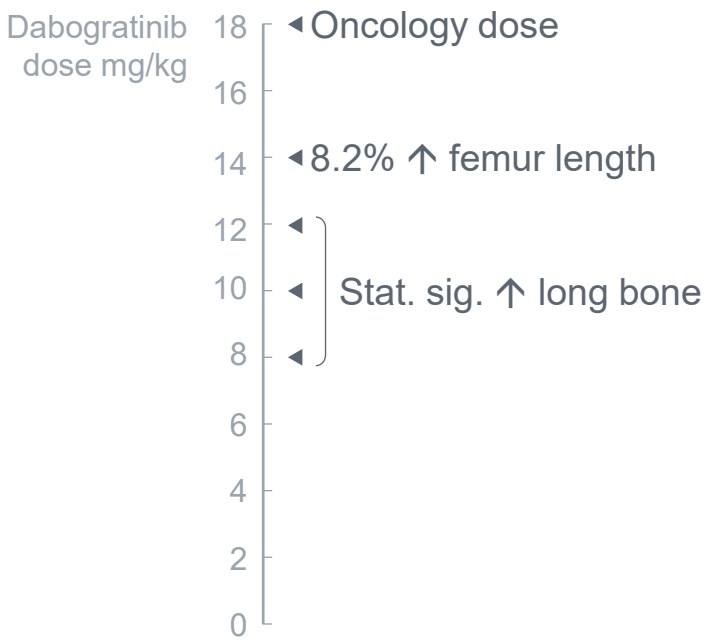
GENETIC

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



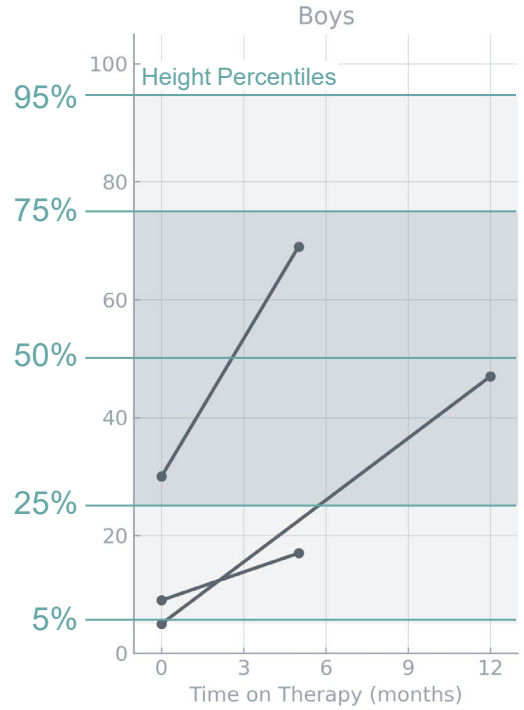
PRECLINICAL

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



CLINICAL

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



19.2cm/yr AHV
Observed in three pediatric oncology case studies with available height velocity data[5]

Pediatric oncology patients with physiologic growth plate signaling treated with Pan-FGFR inhibitors[5]

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

Safety sentinel cohort expanded with DL6 in Ph2 BEACH301

BEACH 301

Sentinel Safety Cohort

ACH age 5-10

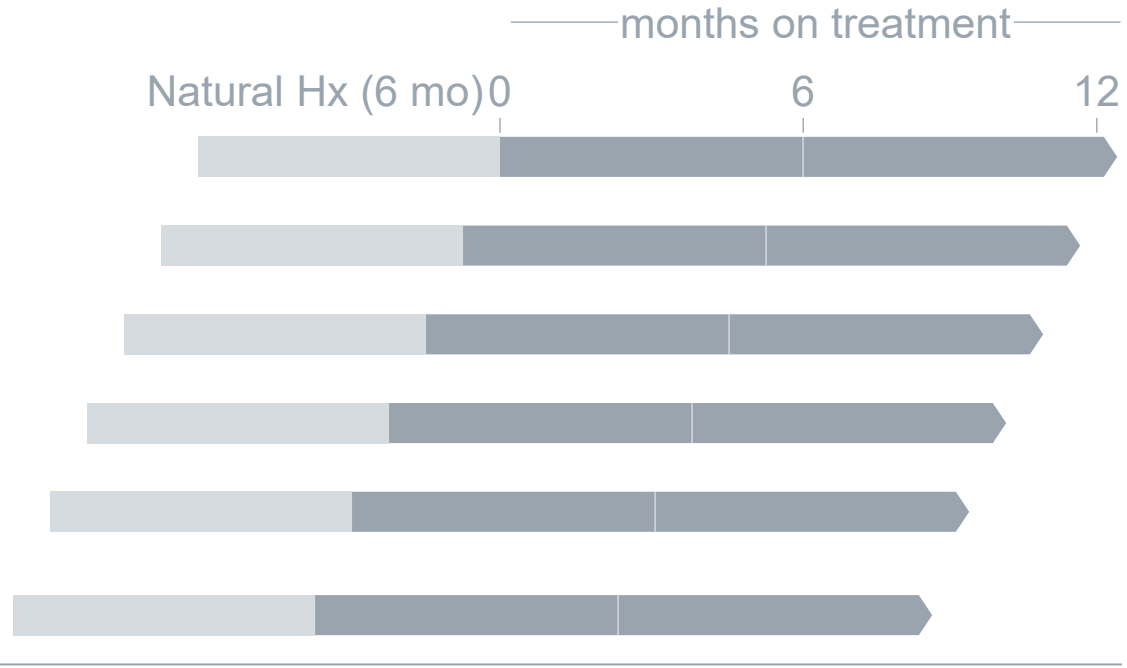
No run-in

Anticipate n=~25 total enrollment

	DOSE (mg/kg)
	0.875
✓	0.625
✓	0.50
✓	0.375
✓	0.25
✓	0.125

Cohorts 1 and 2*

N=*	DOSE (mg/kg)
6	0.875
6	0.625
6	0.50
6	0.375
6	0.25
6	0.125



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

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

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

Gearing up for potential pivotal trials in 3 blockbuster indications

Validated Target

FGFR3 alterations drive conditions with high unmet needs

Differentiated Molecule

DABOGRATINIB

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

60mg PoC IR NMIBC Patients

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

3 Potential Blockbuster Indications

	EXPECTED
IR NMIBC – Adj. Ph3 initiation & SURF302 update	2027
LG UTUC – Initial results	2027
ACH – Initial results	2027

NASDAQ: TYRA

CASH: $700M (As of 3Q26)

DABO3^3

ACH: Achondroplasia; IR NMIBC: Intermediate Risk Non-Muscle-Invasive Bladder Cancer; LG UTUC: Low Grade Upper Tract Urothelial Carcinoma; ML Marker Lesion; ORR: Overall Response Rate; BOR: Best overall Response; CR: Complete Response; Adj.: Adjuvant; Cash: Cash, cash equivalents, and marketable securities as of September 30, 2026
All TYRA small molecule inhibitors are for investigational use only; Initiation of Ph3 adjuvant IR NMIBC study is subject to regulatory feedback.