February 2026

Corporate Presentation

Definium™ THERAPEUTICS

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There are numerous risks and uncertainties that could cause actual results, plans and objectives to differ materially from those expressed in forward-looking statements, including history of negative cash flows, limited operating history, incurrence of future losses, availability of additional capital, compliance with laws and regulations, difficulty associated with research and development, risks associated with clinical trials or studies, heightened regulatory scrutiny, early stage product development, clinical trial risks, regulatory approval processes, novelty of the psychedelic inspired medicines industry, our ability to maintain effective patent rights and other intellectual property protection for our product candidates, our expectations regarding the size of the eligible patient populations for our lead product candidates, if approved and commercialized; our ability to identify third-party treatment sites to conduct our trials and our ability to identify and train appropriate qualified healthcare practitioners to administer our treatments; the pricing, coverage and reimbursement of our lead product candidates, if approved and commercialized; the rate and degree of market acceptance and clinical utility of our lead product candidates, in particular, and controlled substances, in general; as well as those risk factors described in the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2025 under headings such as “Special Note Regarding Forward-Looking Statements,” and “Risk Factors” and “Management's Discussion and Analysis of Financial Condition and Results of Operations” and other filings and furnishings made by the Company with the securities regulatory authorities in all provinces and territories of Canada which are available under the Company's profile on SEDAR+ at www.sedarplus.ca and with the SEC on EDGAR at www.sec.gov.

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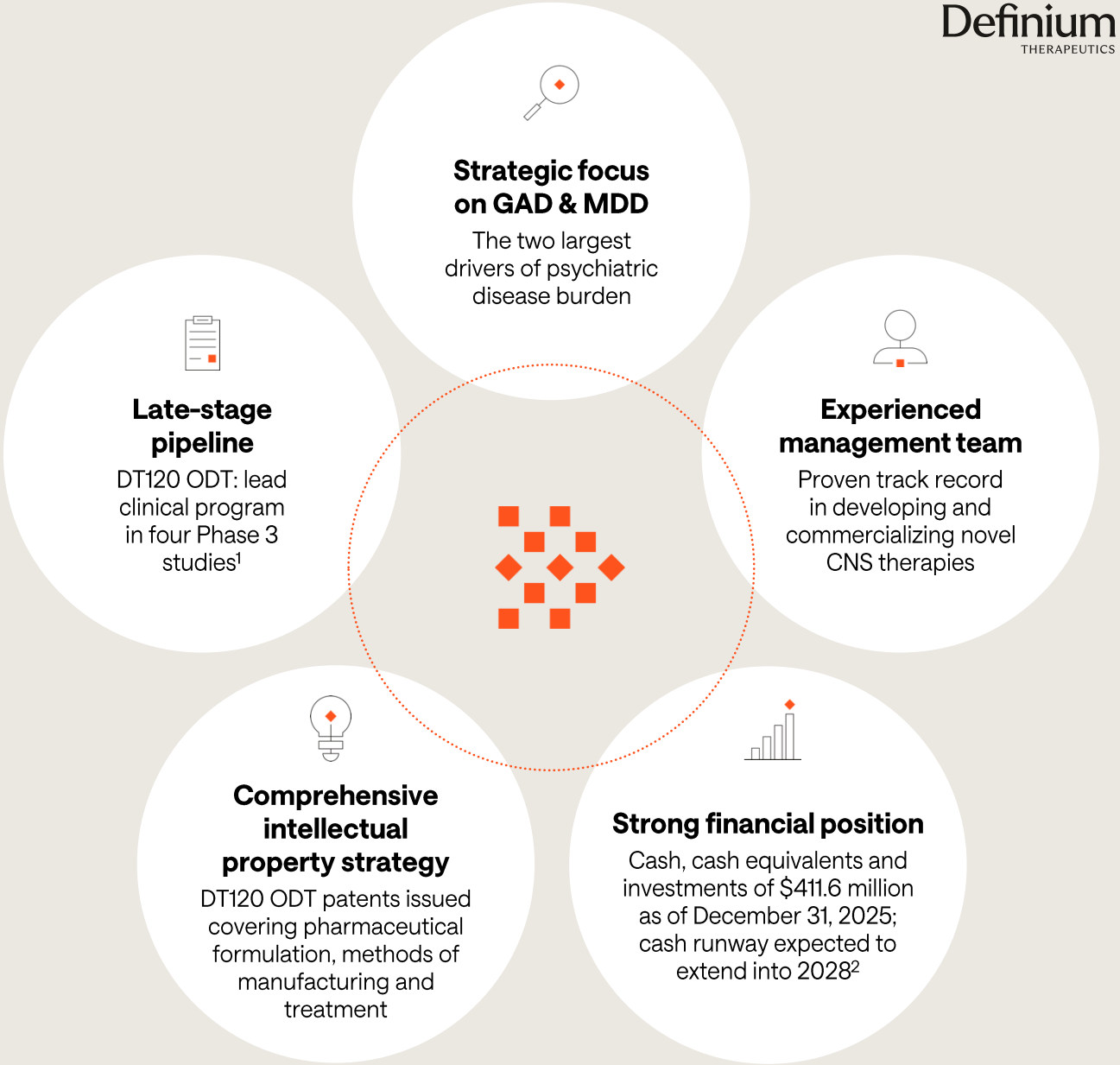
Cautionary Note Regarding Regulatory Matters
The United States federal government regulates drugs through the Controlled Substances Act. DT120 ODT is a proprietary, pharmaceutically optimized form of lysergide D-tartrate and DT402, or R(-)-MDMA, is our proprietary form of the R-enantiomer of MDMA (3,4-methylenedioxymethamphetamine). Lysergide and MDMA are Schedule I substances under the Controlled Substances Act. While the Company is focused on programs using psychedelic or hallucinogenic compounds and non-hallucinogenic derivatives of these compounds, including in DT120 ODT, DT402 and its other product candidates, the Company does not have any direct or indirect involvement with the illegal selling, production or distribution of any substances in the jurisdictions in which it operates. The Company is a neuro-pharmaceutical drug development company and does not deal with psychedelic or hallucinogenic substances except within laboratory and clinical trial settings conducted within approved regulatory frameworks. The Company's products will not be commercialized prior to applicable regulatory approval, which will only be granted if clinical evidence of safety and efficacy for the intended uses is successfully developed.

Market and Industry Data
This Presentation includes market and industry data that has been obtained from third party sources, including industry publications. Definium believes that the industry data is accurate and that the estimates and assumptions are reasonable, but there is no assurance as to the accuracy or completeness of this data. Third party sources generally state that the information contained therein has been obtained from sources believed to be reliable, but there is no assurance as to the accuracy or completeness of included information. Although the data is believed to be reliable, Definium has not independently verified any of the data from third party sources referred to in this Presentation or ascertained the underlying economic assumptions relied upon by such sources. References in this Presentation to research reports or to articles and publications should not be construed as depicting the complete findings of the entire referenced report or article. Definium does not make any representation as to the accuracy of such information.

Precise science. Boundless impact.

Three Phase 3 readouts anticipated in 2026 driving potential billion-dollar commercial opportunities in GAD and MDD



1. Includes three studies in progress and one in preparation.
2. Based on the Company's current operating plan and anticipated milestones.

CNS: central nervous system; GAD: generalized anxiety disorder; MDD: major depressive disorder; ODT: orally disintegrating tablet

Psychiatry Needs Better

Anxiety & Depressive Disorders Represent a Massive and Growing Unmet Need

GAD & MDD Prevalence

>50 million[1]

GAD & MDD Annual Growth Rate

5%+[2]

Average Time to Rx discontinuation in GAD

<90 days[3]

1. Ringeisen, H., et al. (2023). Mental and Substance Use Disorders Prevalence Study (MDPS): Findings Report, Zhou, Y,. Et al. (2017). Nature. Comorbid generalized anxiety disorder and its association with quality of life in patients with major depressive disorder. RTI International and current U.S. Census data and internal company estimates.
2. Terlizzi EP and Zablotsky B (2024). Symptoms of Anxiety and Depression Among Adults, calculations on file.
3. Data on file. Louie D, et al. Treatment Patterns for Newly Diagnosed Generalized Anxiety Disorder (GAD): Insights from Real-World Evidence. Presentation at ACNP 2026.

Psychiatry is Limited by Today's Treatment Options

Outdated Frameworks

- Language and labels reflect symptom management not recovery

Recycled Mechanisms

- New drugs, similar efficacy
- Limited differentiation over decades

Outcomes Lag Behind Need

- Large and persistent unmet demand
- Escalating societal and human cost

Advancing Our Pipeline with Broad Therapeutic Potential

PRODUCT CANDIDATE	INDICATION	PRECLINICAL	PHASE 1	PHASE 2	PIVOTAL / PHASE 3	REGISTRATION
Lysergide tartrate ***DT120***[1]	Generalized Anxiety Disorder (GAD)[3]					
	Major Depressive Disorder (MDD)[3]					
	Additional Indication(s)[4]					
R(-)-MDMA ***DT402***[2]	Autism Spectrum Disorder (ASD)[3]					

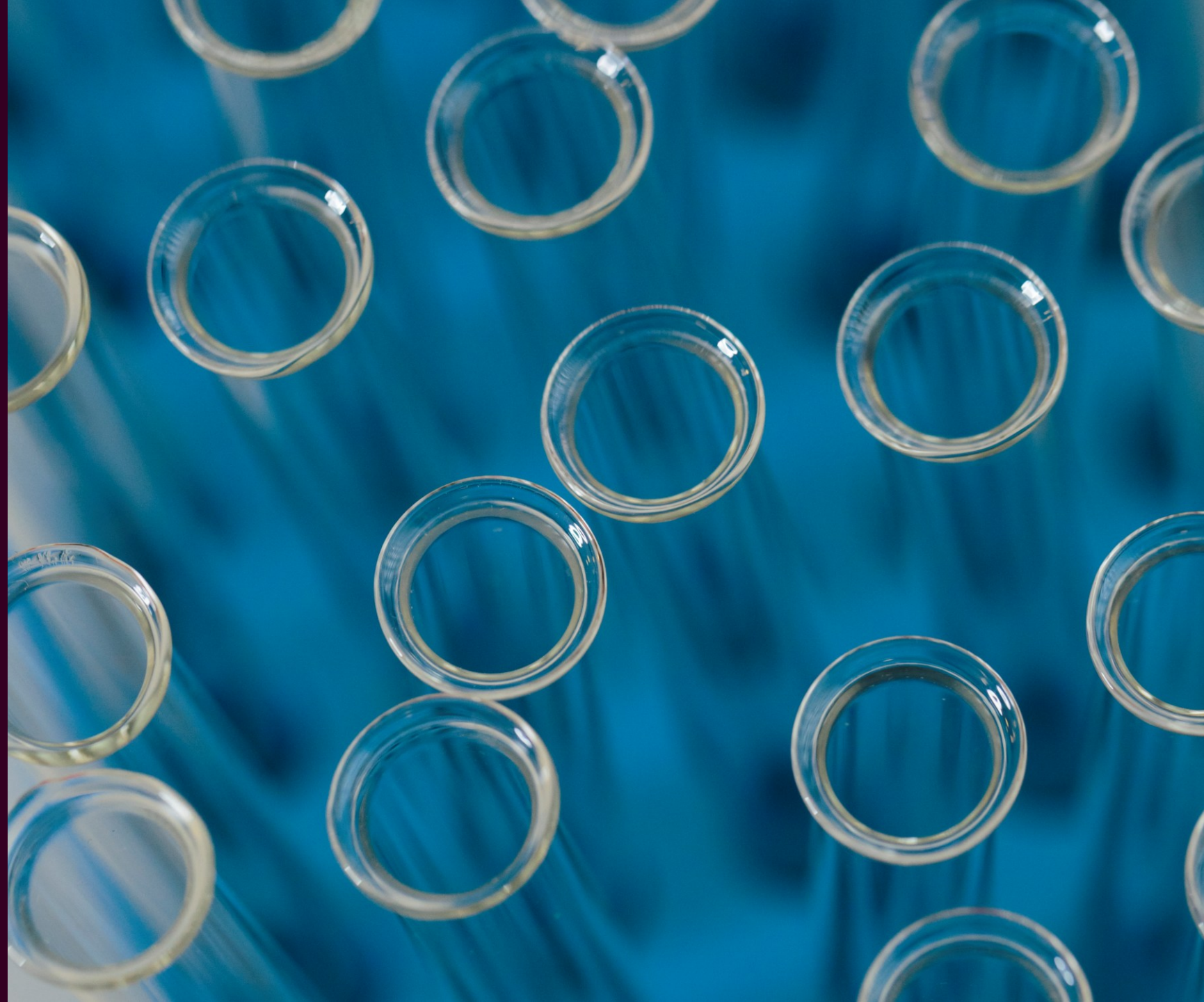
1. Formerly known as MM120; rINN: lysergide tartrate.
2. Formerly known as MM402.
3. Full trial details and clinicaltrials.gov links available at definiumtx.com/clinical-digital-trials/
4. Studies in exploration and/or planning stage.

ODT: orally disintegrating tablet; R(-)-MDMA: rectus-3,4-methylenedioxymethamphetamine

01

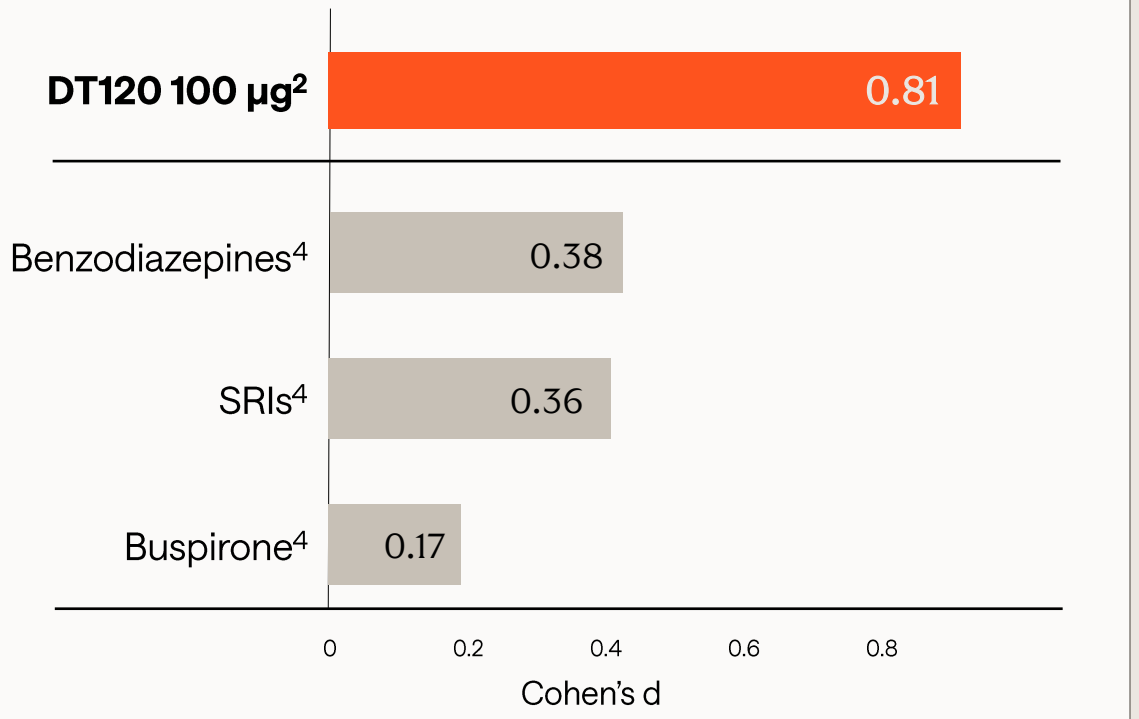
Lysergide tartrate
DT120

Program Overview



DT120 Phase 2b Efficacy and Durability Demonstrates Potential Best-In-Class Profile[1,3]

Comparative Effect Sizes in GAD



Standardized effect size more than double the standard of care[1,2,3]

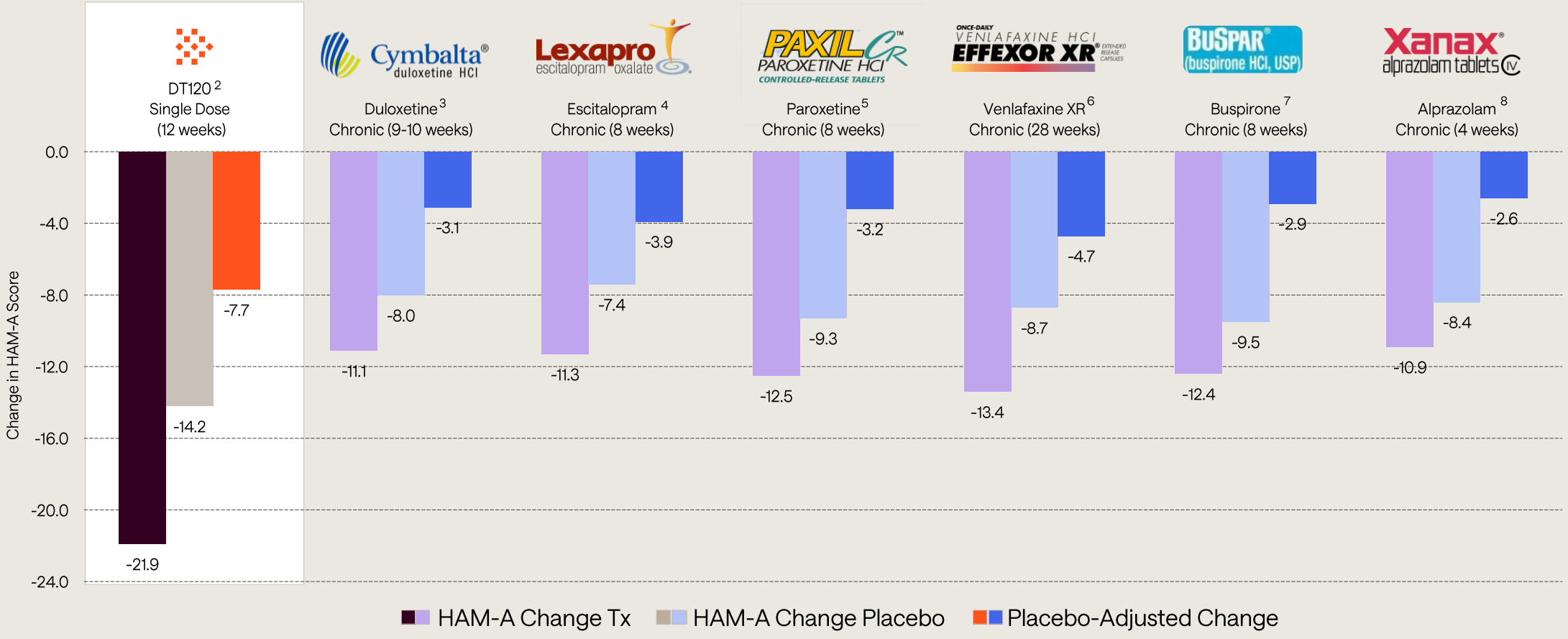
Rapid and durable response after single administration[3]

Rapid	1.8-point reduction in CGI-S within 24 hours (p<0.0001)
Durable	21.9-point improvement on the HAM-A at Week 12 (p=0.003)
Response & Remission	48% of participants in remission at Week 12[5]
Limited Adverse Event (AE) Burden	Favorable tolerability with most AEs on dosing day
Standalone Drug Effect	Observed drug effect without accompanying psychotherapy

1. Study MMED008 internal study documents and calculations. Comparisons to standard of care/other drug classes based on historical comparison not head-to-head comparison trial.
2. HAM-A scores based on ANCOVA LS Mean. in Study MMED008. Effect size based on post hoc calculation using LS Mean change between group and pooled standard deviation of week 12 HAM-A scores between groups.
3. Based on 100 µg dose group.
4. RB Hidalgo, J Psychopharmacol. 2007 Nov;21(8):864-72.
5. p-values not calculated for remission rates between groups.

CGI-S: Clinical Global Impression – Severity scale; GAD: generalized anxiety disorder; HAM-A: Hamilton Anxiety scale; SRI: serotonin reuptake inhibitor

DT120's Clinical Activity Stands Out Compared to Approved GAD Treatments[1]

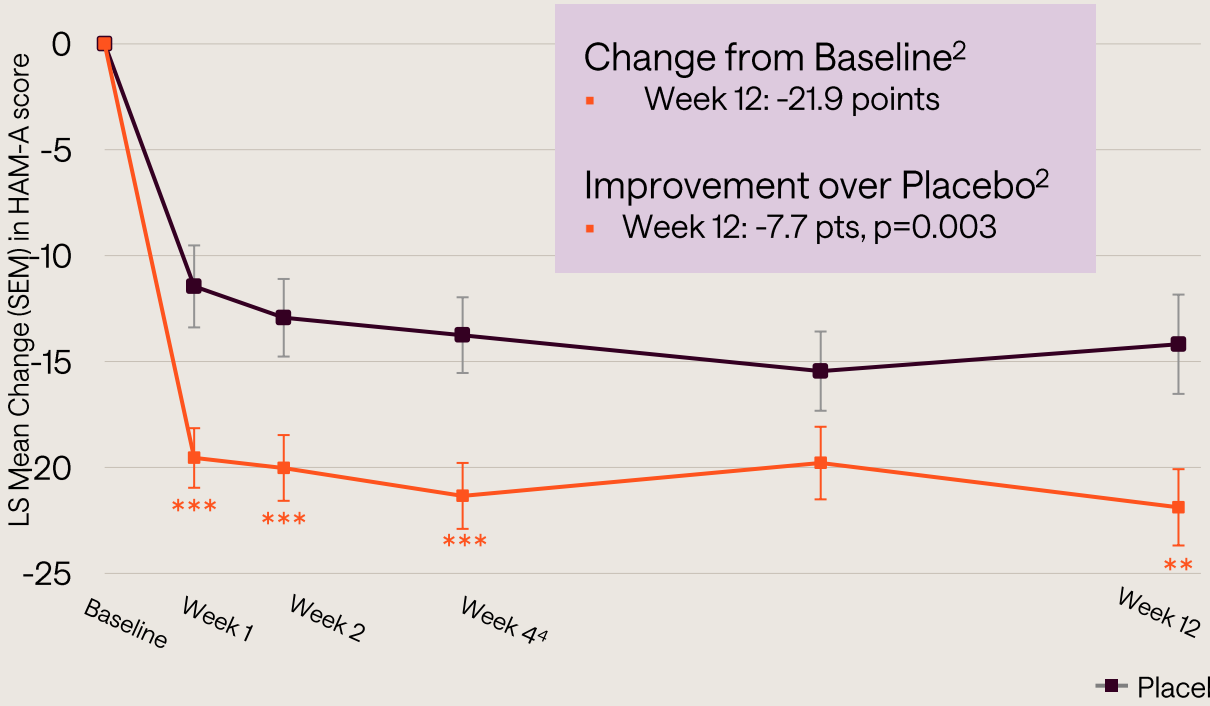


1) The information presented in this slide is derived from multiple clinical trials, each conducted under distinct protocols and settings. As such, these data may not be directly comparable due to the lack of a head-to-head comparison. Differences in trial design, patient demographics, and other variables may account for variations in the observed outcomes. Study results for each drug are intended to be representative, however, multiple trials of the approved treatments have been conducted with varying results, including results that may have demonstrated a larger or smaller treatment effect than those presented. BuSpar and Xanax are approved for anxiety disorders which include GAD.; 2) R Robison, JAMA. 2025 Sep 4; e2513481. doi:10.1001/jama.2025.13481; 3) C Allgulander, Curr Med Res Opin. 2007;23(6):1245–1252; 4) JRT Davidson, Depress Anxiety. 2004;19(4):234–240; 5) K Rickels K, Am J Psychiatry 2003; 160:749-756. 2005;62(9):1022–1030; 6) AJ Gelenberg AJ, JAMA. 2000;283(23):3082–3088; 7) JJ Sramek JJ, Journal of Clinical Psychiatry. 1996;57(7):287–291; 8) K Rickels, Arch Gen Psychiatry. 2005;62(9):1022–1030.

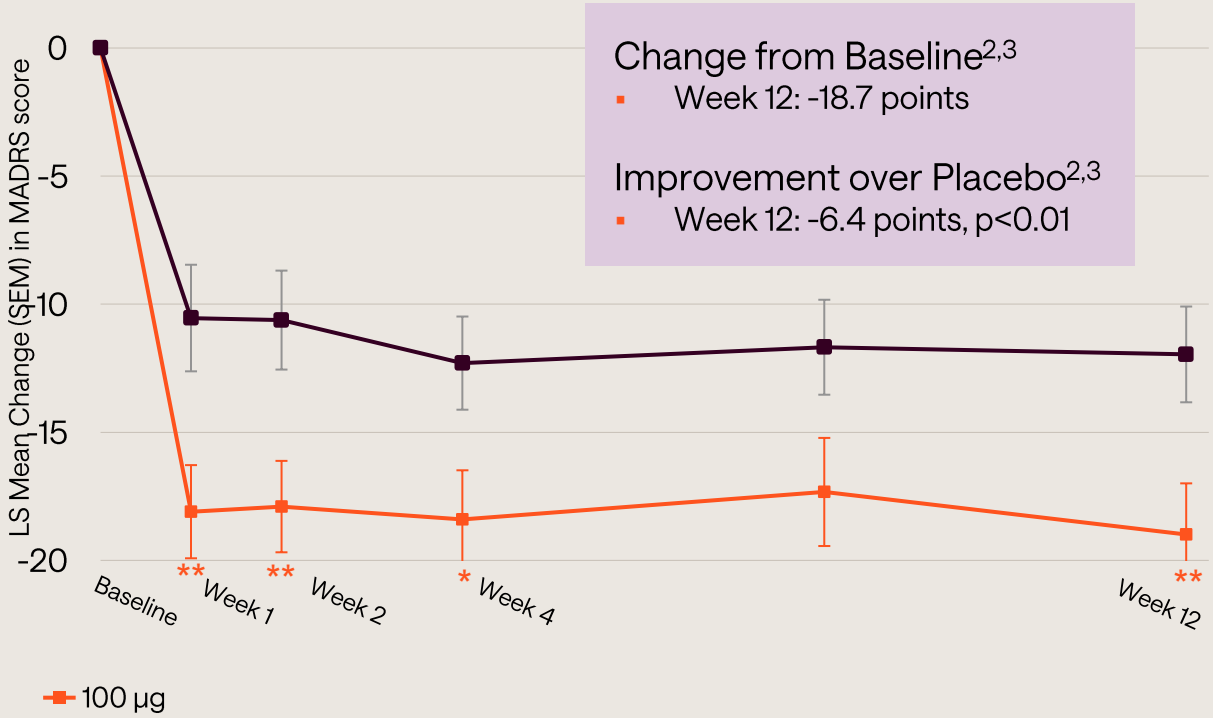
GAD: generalized anxiety disorder, Tx: treatment

DT120 Showed Statistically & Clinically Significant Improvements on Anxiety and Depression Symptoms[1,2]

Primary Outcome: HAM-A Change from Baseline



MADRS Change from Baseline



Placebo 100 µg

*p<0.05; **p≤0.01; ***p≤0.001

1. Source: Study MMED008 internal study documents and calculations. Full analysis set population.
2. Based on 100 µg dose group.
3. Based on observed MADRS score at each timepoint.
4. Primary endpoint of the study was change in Hamilton Anxiety Scale (HAM-A) at week 4 using the MCP-Mod statistical analysis. Based on the pre-specified candidate dose response curves, the MCP-Mod model-estimated difference between 100 µg and placebo was 5.0 points versus the observed difference of 7.6 points at week 4.

µg: microgram; HAM-A: Hamilton Anxiety Rating Scale; MADRS: Montgomery-Åsberg Depression Rating Scale NOTE: Significance achieved despite study not being powered for these pairwise comparisons.

DT120 Demonstrated Profound Changes in GAD Severity[1]

HAM-A Severity & Clinical Symptoms

Very Severe
Symptoms are incapacitating

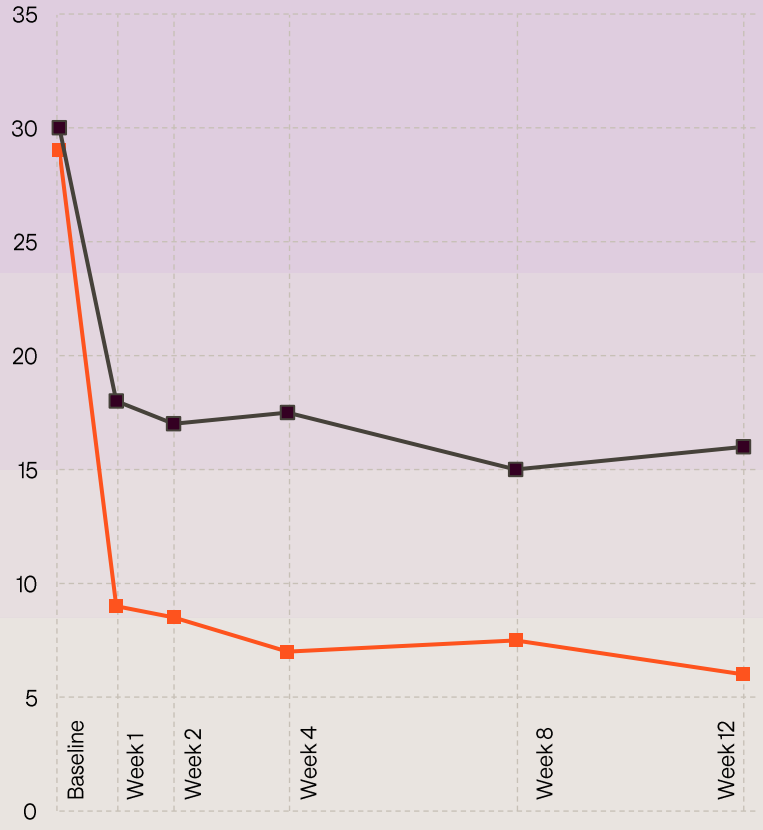
Severe (≥24)
Symptoms are severe and persistent or result in severe distress or marked impairment in functioning

Moderate (15-23)
Symptoms are more frequent, with moderate distress or limited interference with usual activities

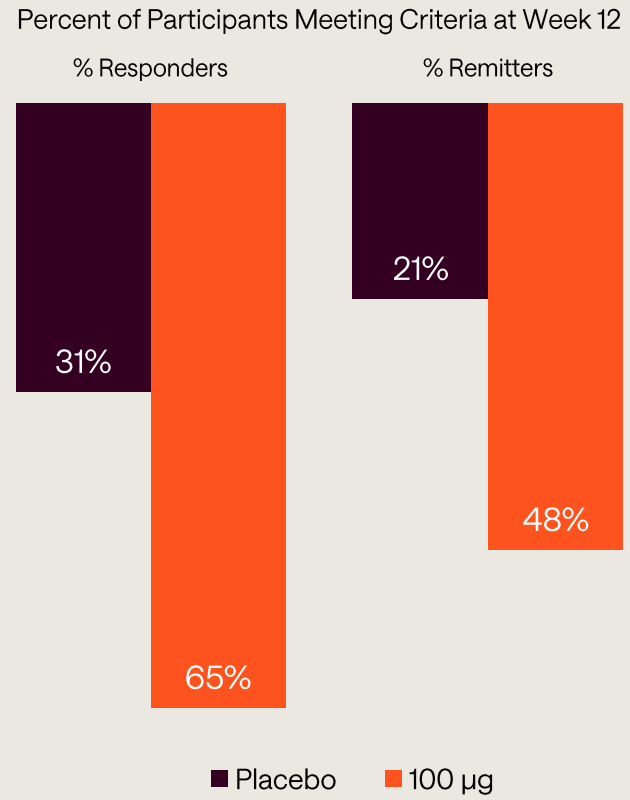
Mild (8-14)
Symptoms are infrequent, with no impairment and no more than mild distress

Remission (≤7)
Symptoms are absent, insignificant, or clearly due to causes other than anxiety

Median HAM-A Through Week 12



HAM-A Response & Remission at Week 12[2]



1. Source: Study MMED008 internal study documents and calculations. Full analysis set population.
2. Response is a 50% or greater improvement on HAM-A score; Remission is a HAM-A score of ≤7; p-values not calculated.

µg: microgram; HAM-A: Hamilton Anxiety Rating Scale

Scientific Rigor in DT120 Phase 2b Provides Confidence for Phase 3 Program

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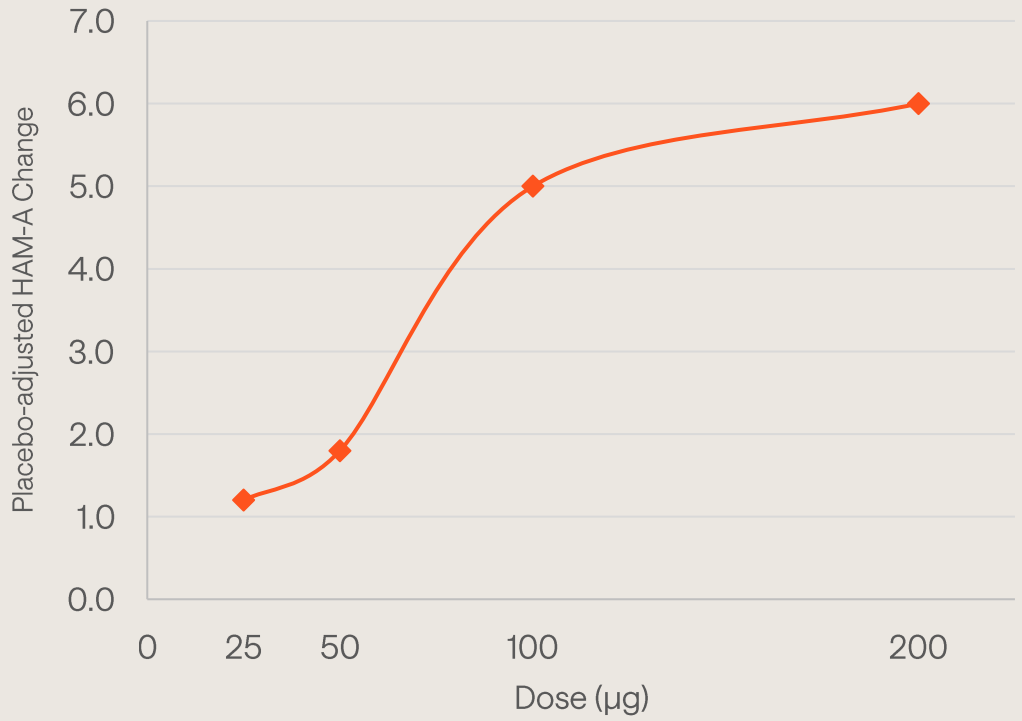
Key Findings

- Statistically significant dose response in Phase 2b
- Model supports 100 µg as optimal dose
- Results not explainable by “functional unblinding” supporting robustness of drug effect

Model-Based Dose-Response Curve[1]



1. Study MMED008 internal study documents and calculations.

DT120 was Well-Tolerated with Adverse Events Mostly Limited to Dosing Day[1]

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Favorable tolerability profile

- Virtually all (99%) adverse events (AEs) were mild-to-moderate in severity
- Minimal (2.5%) treatment emergent AEs (TEAEs) led to study withdrawal
- No drug-related serious AEs (SAEs)[2]

No SAEs related to study drug

- Only SAE was in 50 µg dose group and deemed unrelated[2]
- AE profile consistent with historical studies and drug class

No suicidal behavior or suicidality signal[3]

- No suicidal or self-injurious behavior
- No indication of increased suicidality or suicide-related risk
- ≤2 participants per arm reported suicidal ideation during the study

1. Source: Study MMED008 internal study documents and calculations. Safety population.
2. One serious adverse event (SAE) was observed in the 50 µg dose group: panic attack on study day 98 that was deemed not related to treatment.
3. Suicidality assessment based on reported adverse events.

Rigorous Development Approach Addresses Key Regulatory Considerations

Complementary clinical study designs intended to generate robust evidence

- Phase 2b and 3 studies intended to address key regulatory considerations for psychedelics
- 50 µg control dose in Panorama and Ascend intended to further mitigate effects of functional unblinding
- Central raters blinded to treatment allocation and visit number to minimize bias

First study in the field to evaluate dose-dependent efficacy

- Phase 2b study established dose-response across four doses of DT120: 25, 50, 100 and 200 µg
- 100 µg selected as optimal dose for Phase 3 program

Phase 3 program builds on Phase 2b success with optimized study designs

- Placebo response expected to moderate with 1:1 randomization in Phase 3 studies
- Offers open-label treatment opportunities which are intended to improve participant retention
- Potentially provides information on real world treatment patterns

Robust Phase 3 DT120 ODT Development Program Aiming for Broad Label

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Aligned clinical trial designs across indications maximize operational efficiencies

Generalized Anxiety Disorder (GAD)

Voyage

n=200[1,2]
1:1 randomization

DT120 ODT
vs. Placebo

- **Part A:** 12-week DB, RCT
- **Part B:** 40-week Extension with OL Treatment

Anticipated Topline Readout – early 3Q 2026
SSRE complete; no change to sample size

Panorama

n=250[1,2]
2:1:2 randomization

DT120 ODT
vs. Placebo
including 50 µg control

- **Part A:** 12-week DB, RCT
- **Part B:** 40-week Extension with OL Treatment

Anticipated Topline Readout – 2H 2026

Primary Endpoint HAM-A at Week 12
90% powered to detect a 5-point difference[4]

Major Depressive Disorder (MDD)

Emerge

n=149[3]
1:1 randomization

DT120 ODT
vs. Placebo

- **Part A:** 12-week DB, RCT
- **Part B:** 40-week Extension with OL Treatment

Anticipated Topline Readout – late 2Q 2026

Ascend

n=175[2]
2:1:2 randomization

DT120 ODT
vs. Placebo
including 50 µg control

- **Part A:** 12-week DB, RCT
- **Part B:** 40-week Extension with OL Treatment

Planned Initiation – early 2Q 2026

Primary Endpoint MADRS at Week 6
80% powered to detect a 5-point difference[4]

1. Studies employ an adaptive design with interim blinded sample size re-estimation ("SSRE") based on nuisance parameters (e.g. patient retention rate, variability of primary outcome measure) which allows for an adjustment of the sample size of up to 50% to maintain statistical power.
2. Clinical study designs subject to ongoing regulatory discussion and review, including of Phase 3 clinical trial protocols.
3. Reflects actual enrollment for the Emerge study.
4. Power analysis based on additional assumptions including variance and subject evaluability; realized study power may differ from a priori power estimation.

DB: double blind; HAM-A: Hamilton Anxiety Rating Scale; MADRS: Montgomery-Åsberg Depression Rating Scale; ODT: orally disintegrating tablet; OL: open-label; RCT: randomized controlled trial

Two Complementary Pivotal GAD Study Designs

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PHASE 3 STUDY[1]

Part A
12 Week Randomized, Double-Blind

Part B
40 Week Extension with Opportunity for Open-Label Treatment

Voyage

Single Dose

- n=100 DT120 ODT 100 µg
- n=100 Placebo

Panorama

Single Dose

- n=100 DT120 ODT 100 µg
- n=50 DT120 ODT 50 µg control
- n=100 Placebo

Up to four open-label doses of DT120 ODT 100 µg

Follow-up Observation
GAD-7 (ePRO): biweekly
HAM-A (central rater): monthly or when GAD-7≥10

Potential Treatment
Eligible for open-label treatment if HAM-A≥16

Primary Endpoint HAM-A at Week 12

1. Studies employ an adaptive design with interim blinded sample size re-estimation ("SSRE") based on nuisance parameters (e.g. patient retention rate, variability of primary outcome measure) which allows for an adjustment of the sample size of up to 50% to maintain statistical power. SSRE for Voyage is complete and no change to the sample size is required. Clinical study designs subject to ongoing regulatory discussion and review, including of Phase 3 clinical trial protocols.

GAD: generalized anxiety disorder; GAD-7: diagnostic tool used to screen for and assess the severity of generalized anxiety disorder; HAM-A: Hamilton Anxiety Rating Scale; ODT: orally disintegrating tablet

Two Complementary Pivotal MDD Study Designs

PHASE 3 STUDY[1]

Part A
12 Week Randomized, Double-Blind

Part B
40 Week Extension with Opportunity for Open-Label Treatment

Emerge

Single Dose

- n=70 DT120 ODT 100 µg
- n=70 Placebo

Ascend

Single Dose

- n=70 DT120 ODT 100 µg
- n=35 DT120 ODT 50 µg control
- n=70 Placebo

Up to four open-label doses of DT120 ODT 100 µg

Follow-up Observation
PHQ-9 (ePRO): biweekly
MADRS (central rater): monthly or when PHQ-9≥10

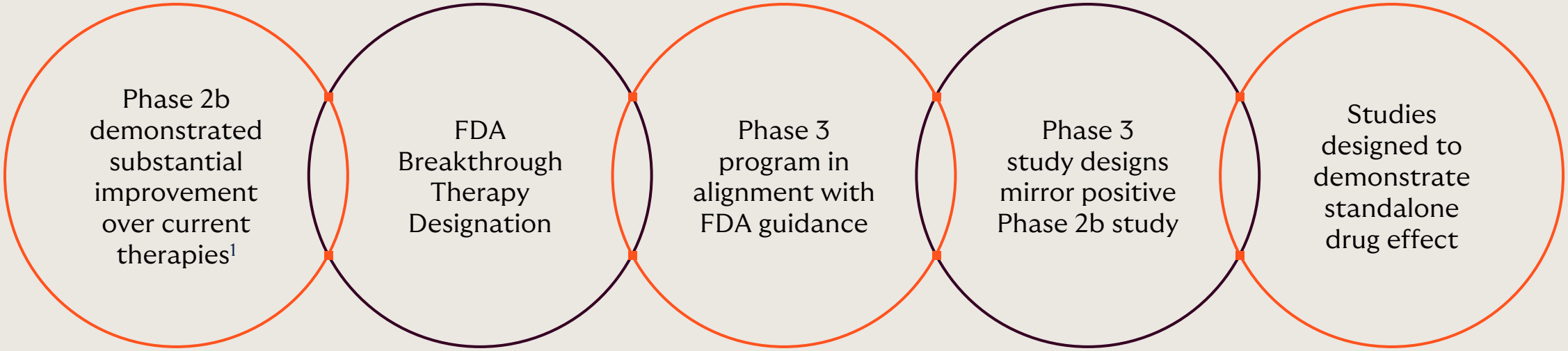
Potential Treatment
Eligible for open-label treatment if MADRS≥20

Primary Endpoint MADRS at Week 6

1. Clinical study designs subject to ongoing regulatory discussion and review, including of Phase 3 clinical trial protocols.

MADRS: Montgomery-Åsberg Depression Rating Scale; MDD: Major Depressive Disorder; ODT: orally disintegrating tablet; PHQ-9: a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression

Regulatory Elements Support DT120 ODT NDA Strategy



1. Study MMED008 internal study documents and calculations. Comparisons to standard of care/other drug classes based on historical comparison not head-to-head comparison trial.

GAD: generalized anxiety disorder; NDA: new drug application; ODT: orally disintegrating tablet

02

Lysergide tartrate

DT120 ODT

Commercial Framework

Large, Identified, Accessible Opportunity for DT120 ODT

High Unmet Need

Significant Limitations of Existing Treatments

Poor efficacy, tolerability, and persistence

Poor Efficacy

- Slow onset of effect[1]
- Low response and remission rates[2-4]
- Low Rx persistence[5]

Poor Tolerability

- Weight gain[6]
- Sexual dysfunction[6]
- Tolerance and dependence[7]

~50% Discontinue SRIs in first 4 mos. in GAD[8,9]

~22% Rx persistence at 12 mos. in MDD[5]

Potential Paradigm Shifting Clinical Profile

Potential Best-In-Class Therapy

Sustained clinical response from a single administration[10]

Rapid onset of effect

High response rates

High remission rates

Durable response

Intermittent dosing potentially reduces the risk of adverse long-term effects

Efficient Go To Market Strategy

Existing Referral Network and Administration Sites of Care

Identifiable HCPs and patients suffering from the burden of inadequate treatment

Based on claims data

~7,000
Psychiatry HCPs see >50% of likely DT120 ODT patients[11]

Anticipate scalable delivery model in diverse care settings

Positive practice economics anticipated to expand sites of care

1. Bandelow B et al. World J Biol Psychiatry. 2008;9(4):248-312. 2. Ansara ED. Ment Health Clin. 2020;10(6):326-334. 3. Fagan HA, Baldwin DS. Expert Rev Neurother. 2023;23(6):535-548. 4. Garakani A et al. Front Psychiatry. 2020;11:595584. 5. Keyloun KR et al. CNS Drugs. 2017;31(5):421-432. 6. Cascade E et al. Psychiatry (Edgemont). 2009;6(2):16-18. 7. National Institute for Health and Care Excellence. Anxiety disorders. Quality standard QS53. February 6, 2016. Accessed July 10, 2025. https://www.nice.org.uk/guidance/qs53. 8. Bull SA et al. Ann Pharmacother. 2002;36:578-584. 9. Berger A et al. BMC Psychiatry. 2011;11:193. 10. Jacobsen PL et al. American Psychiatric Association Annual Meeting. May 4-8, 2024. New York, NY; 11. Based on internal company estimates.

GAD: generalized anxiety disorder; HCP: healthcare provider; MDD: major depressive disorder; ODT: orally disintegrating tablet; Rx: prescription; SSRI: selective serotonin-reuptake inhibitor

DT120 ODT Clinical Dosing Paradigm with Potential Translatability to Efficient Real-World Delivery[1,2]

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15-30 minutes (time to onset)	Hour 1-6	Hour 5-8	Hour 6+ and post-session
DT120 ODT disintegrates in seconds	Transient perceptual, affective, and cognitive drug effects vary from person to person Hours 2-3: effects reach maximum intensity Hours 4-6: effects start to resolve	Hour 5: Dosing Session Monitor (DSM) evaluates patient hourly with an end-of-session checklist to determine when the patient can leave safely 5 to 8 hour duration offers an extended window for emotional processing and a gentle, predictable return to baseline	Ordinary perception, affect, and cognition return Normal activities resume the next day, including driving

Efficient single-visit model with full-session reimbursement streamlines administrative burden[2]

- Clinical dosing period is 8 hours for study participants; readiness to leave is evaluated from hours 5-8.
- Patients are supported by DSMs, healthcare professionals who passively observe and offer comfort care such as assistance with food or restroom breaks.
- Psychotherapy is not offered in our studies or expected to be required, if approved.
- Real world support will be based on decisions between providers and patients to support individual goals and needs.

1. Dosing and monitoring paradigm based on Phase 3 clinical protocols.
2. Existing coding systems could potentially be applied or be changed for DT120. Reimbursement and coding for DT120 have yet to be established.

ODT: orally disintegrating tablet

Psychiatry is Primed for Strong Adoption of DT120 ODT

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Healthcare Professionals

Motivated to prescribe

75%

believe there is a significant unmet need in GAD[1]

70%

of surveyed HCPs intend to prescribe or recommend DT120 ODT for GAD[1]

Patients

Eager for effective treatments

50%

are dissatisfied with current GAD treatments[1]

65%

with multiple GAD treatment failures interested in trying DT120 ODT[1]

Payors

Optimistic product reception & access roadmap

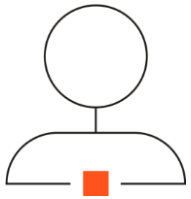
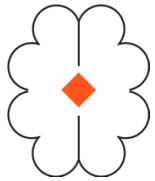
Had an overall **positive reaction** to the DT120 ODT TPP[1]

Benchmark DT120 ODT against other current interventional therapies for **access and pricing**[1]

1. Market research on file.

GAD: generalized anxiety disorder; HCP: healthcare professional; ODT: orally disintegrating tablet ; TPP: target product profile

Positioned to Leverage Existing Delivery Infrastructure, Practice Patterns & Reimbursement Pathways

	Activity	Stakeholder	Potential Reimbursement/Coding[3]
	Evaluation & Prescribing	Office-based or Telehealth Prescriber[1]	**Medical Benefit** CPT-I E&M Code (992XX)
	Session Delivery	Site of delivery HCP[2] to monitor session	**Medical Benefit** CPT-III Code[4] (0820T/0821T/0822T) *or* CPT-I Service Codes (992XX + 994XX)
	DT120 ODT	Pharmacy	**Pharmacy Benefit** J Code & Dispensing Fee

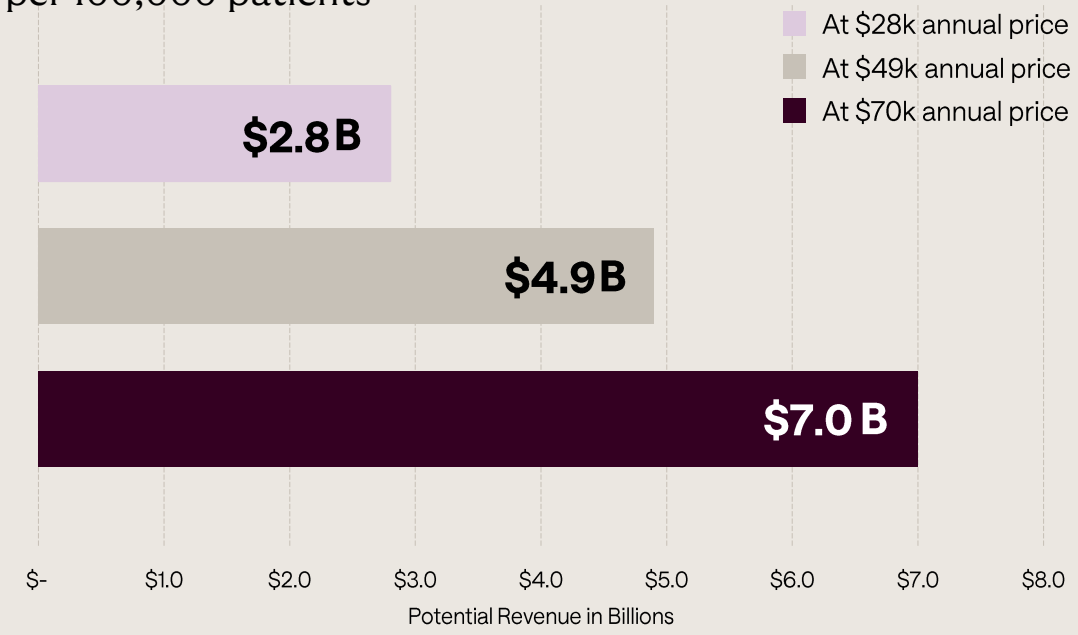
1. HCP that is licensed to prescribe medications to patients.
2. HCP that is licensed to practice, which may include physicians, clinical psychologists, nurse practitioners, nurses, licensed clinical social workers, licensed family and marriage therapists and others.
3. Existing coding systems could potentially be applied or be changed for DT120. Reimbursement and coding for DT120 have yet to be established.
4. The currently available CPT-III codes (0820T, 0821T, 0822T) describe the in-person continuous monitoring of a psychedelic medication therapy session.

CPT: Current Procedural Terminology; HCP: healthcare professional; ODT: orally disintegrating tablet

Framing the Compelling Opportunity for DT120 ODT

Potential Annual Revenue Opportunity

per 100,000 patients



Opportunity Drivers

~27.0 million[1]	US adults receiving medication for GAD or MDD
0.4%	Market penetration to treat 100,000 patients
$28k to $70k[2]	Estimated annual pricing (analogous range) Spravato® (esketamine) CIII nasal spray

1. Calculations on file; Ringeisen, H., et al. (2023). Mental and Substance Use Disorders Prevalence Study (MDPS): Findings Report. RTI International and current U.S. Census data and internal company estimates.
2. Range is based on Spravato surrogate low dose, low frequency ($28k) to high dose, high frequency ($70k) annually. Market Research, Data on file, 2025

GAD: generalized anxiety disorder; MDD: major depressive disorder; ODT: orally disintegrating tablet

A Regional Example: San Francisco

- San Francisco metro area is approximately 1.4% of the US population with 49 top HCPs at 44 clinics that could potentially prescribe DT120 ODT

Key San Francisco Metro Market Metrics[1]

- ✓ Total adult population: 3.8 million
- ✓ Population as a % of total US: 1.4%
- ✓ Top Target[2] HCPs: 49
- ✓ Top Target[2] Clinics: 44

San Francisco Metro Contribution (per 100k nationwide)

1,400	44	32	2-3
patients treated in SF metro	top target psychiatric clinics[2]	average patients treated per clinic	average patients treated per month per clinic

1. Data Calculations from Claims analysis for San Francisco MSA; 2025
2. Top targets include healthcare professionals (HCPs) in deciles 7-10 based on market research.

ODT: orally disintegrating tablet

03

R(-)-MDMA
DT402

Program Update

DT402 Phase 2a Study in Autism Spectrum Disorder (ASD)

Completed Phase 1 study in 2024

- Single-ascending dose study in healthy adult volunteers characterized the tolerability, pharmacokinetics and pharmacodynamics of DT402
- DT402 was well-tolerated at doses up to 255 mg with no SAEs or TEAEs leading to discontinuation, supporting advancement into Phase 2 clinical trials

Phase 2a study underway

- Single-dose, open-label study to assess early signals of efficacy of DT402 in treating core social and communication symptoms of ASD in up to 20 adult participants
- Study endpoints designed to characterize pharmacodynamics and clinical effects of DT402 in adults with ASD, including on multiple functional biomarkers
- Initial data anticipated in 2026

About ASD

- ASD is a neurodevelopmental condition characterized by persistent challenges with social communication, restricted interests and repetitive behavior
- US prevalence of approximately 1 in 31 children[1] with no approved pharmacotherapies for the treatment of core symptoms of ASD

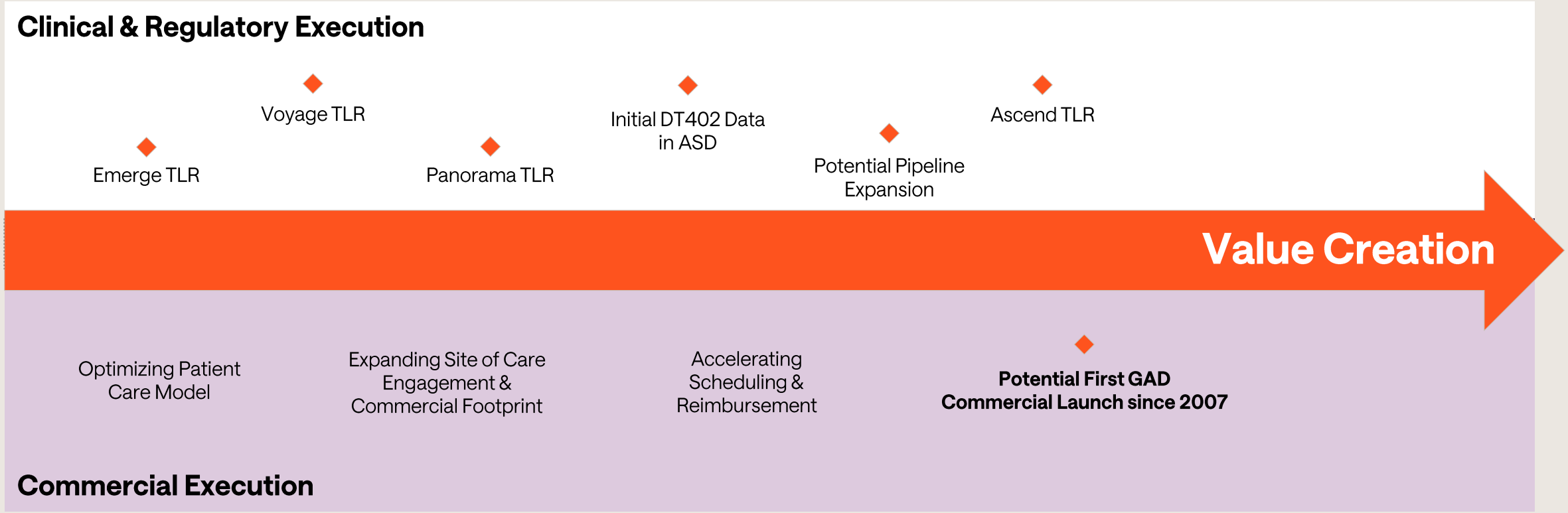
1. Shaw KA, Williams S, Patrick ME, et al. Prevalence and Early Identification of Autism Spectrum Disorder Among Children Aged 4 and 8 Years — Autism and Developmental Disabilities Monitoring Network, 16 Sites, United States, 2022. MMWR Surveill Summ 2025;74(No. SS-2):1–22. DOI: http://dx.doi.org/10.15585/mmwr.ss7402a1

SAE: serious adverse event; TEAE: treatment-emergent adverse event

04

Summary

Value Creation Opportunity Shaped by Two Distinct Drivers[1]



1. Timing estimates subject to clinical progress and regulatory interactions.

ASD: autism spectrum disorder; GAD: generalized anxiety disorder; TLR: topline data readout

Financial Summary & Anticipated Milestones

Cash, Cash Equivalents & Investments
$411.6 million
as of December 31, 2025

Credit Facility
Up to $120 million
($41 million outstanding)
as of December 31, 2025

Shares Outstanding
98.8 million[1]
as of December 31, 2025

Full Year 2025 Operating Expenses
$166.3 million
- R&D - $117.7 million
- G&A - $48.6 million

1. Excludes 9.4 million pre-funded warrants outstanding as of December 31, 2025

ASD: autism spectrum disorder; GAD: generalized anxiety disorder; G&A: general & administrative; MDD: major depressive disorder; R&D: research and development

Definium THERAPEUTICS

Topline Data Readouts

Emerge (MDD)
Topline Readout | late 2Q 2026

Voyage (GAD)
Topline Readout | early 3Q 2026

Panorama (GAD)
Topline Readout | 2H 2026

Additional Clinical Updates

Ascend (MDD)
Study Initiation | early 2Q 2026

DT402
Initial Data in ASD | 2026

We look forward to hosting an Investor & Analyst Day on April 22, 2026 in New York City

Precise science. Boundless impact.