

April 22, 2026

Investor & Analyst Day



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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, risks related to regulatory review and approval, including the possibility of delays, requests for additional data or analyses, restrictions or limitations on use, approval with labeling that is more limited than expected, or failure to obtain approval in the United States or other jurisdictions, 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.

Any forward-looking statement made by Definium in this Presentation is based only on information currently available to the Company and speaks only as of the date on which it is made. Except as required by law, the Company undertakes no duty or obligation to update any forward-looking statements contained in this Presentation as a result of new information, future events, changes in expectations or otherwise.

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

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Today's Agenda

Topic	Speaker(s)	Timing
Welcome & Introduction <ul style="list-style-type: none"> Definium Vision The Year Ahead 	Rob Barrow	5 min
DT120 Program Overview <ul style="list-style-type: none"> Phase 2b Results Overview of Anxiety & Depression Phase 3 Program & Readout Expectations 	Rob Barrow & Dr. Dan Karlin	35 mins
A Patient's Perspective on the DT120 Experience	Video	5 mins
Panel Discussion – Clinical Readiness & Real-World Implementation <ul style="list-style-type: none"> Unmet Need in GAD & MDD Current Treatment Paradigm Panel Q&A 	Dr. Dan Karlin Dr. Brittany Albright Andrew Penn Shannon Sarkar	25 mins
Commercial Strategy	Matt Wiley	20 mins
Building Long-Term Shareholder Value <ul style="list-style-type: none"> IP Strategy Financial Strength 2026 Anticipated Catalysts 	Brandi Roberts	5 mins
Q&A	All	25 min
Lunch & On-Site Dosing Room		90 mins

QR Code for
Q&A Session



Investor & Analyst Day Speakers



Rob Barrow
Chief Executive Officer



Dan Karlin, MD
Chief Medical Officer



**Brittany Albright, MD,
MPH, DABOM**



**Andrew Penn,
MS, PMHNP**



Matt Wiley
Chief Commercial Officer



Brandi Roberts, CPA
Chief Financial Officer



**Shannon Sarkar, PhD,
LPC, NCC**

Definium 
THERAPEUTICS

Precise science. Boundless impact.

Target Product Profile to Address Significant Unmet Need

1

Dose¹

5-8

Hours in
the Clinic²

12+

Weeks of
Durability¹

50M

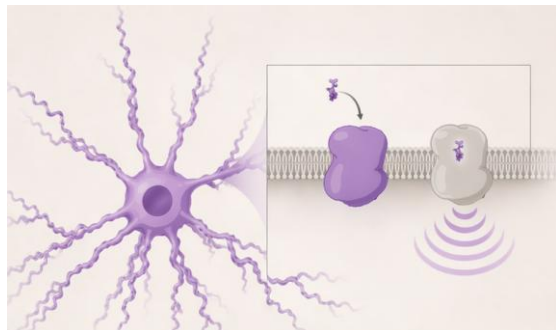
US Adults with
GAD & MDD³

1. Single dose regimen is being studied in pivotal clinical trials with primary and secondary outcome measures through 12 weeks after administration. Phase 3 studies include 40 week extension phase to characterize durability of response beyond 12 weeks in participants up until the time of discontinuation or the administration of open-label DT120.
2. Required monitoring period for all participants in pivotal studies is 8 hours and requires that participants clear the End of Session Checklist.
3. 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.

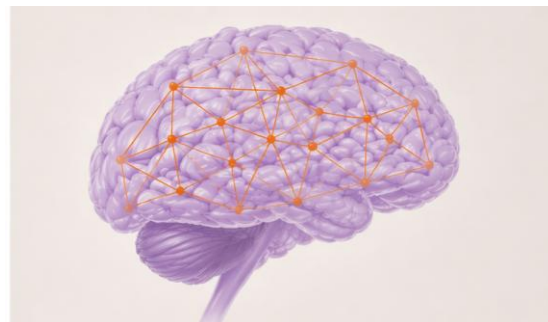
Understanding the Patient Journey



Receptor & Cellular



Neurocircuitry



Psychological

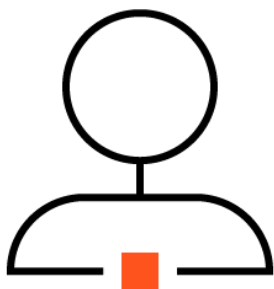


Clinical Efficacy



Bringing the field back to its origins in pursuit of best-in-class profile

Right Team,
Right Experience



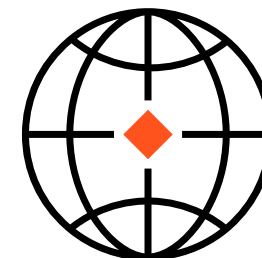
Right Strategy



Precise Science



Boundless Impact



Moving Psychiatry Forward – at a Scale Reflecting the Unmet Need

Phase 3 Program Built to Support a Broad Label

Generalized Anxiety Disorder (GAD)



Planned n=200¹
1:1 randomization

DT120 ODT
vs. Placebo

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

Planned n=250¹
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

Major Depressive Disorder (MDD)



Planned n=140
1:1 randomization

DT120 ODT
vs. Placebo

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

Planned n=175²
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

Posttraumatic Stress Disorder (PTSD)





Planned n=200²
1:1 randomization

DT120 ODT
vs. Placebo

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

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. Planned sample size indicated prior to any adjustments in accordance with the sample size re-estimation.
2. Clinical study designs subject to change based on ongoing regulatory discussion and review, including of Phase 3 clinical trial protocols.

SSREs Complete and Support Confidence in Decisive Phase 3 Outcomes

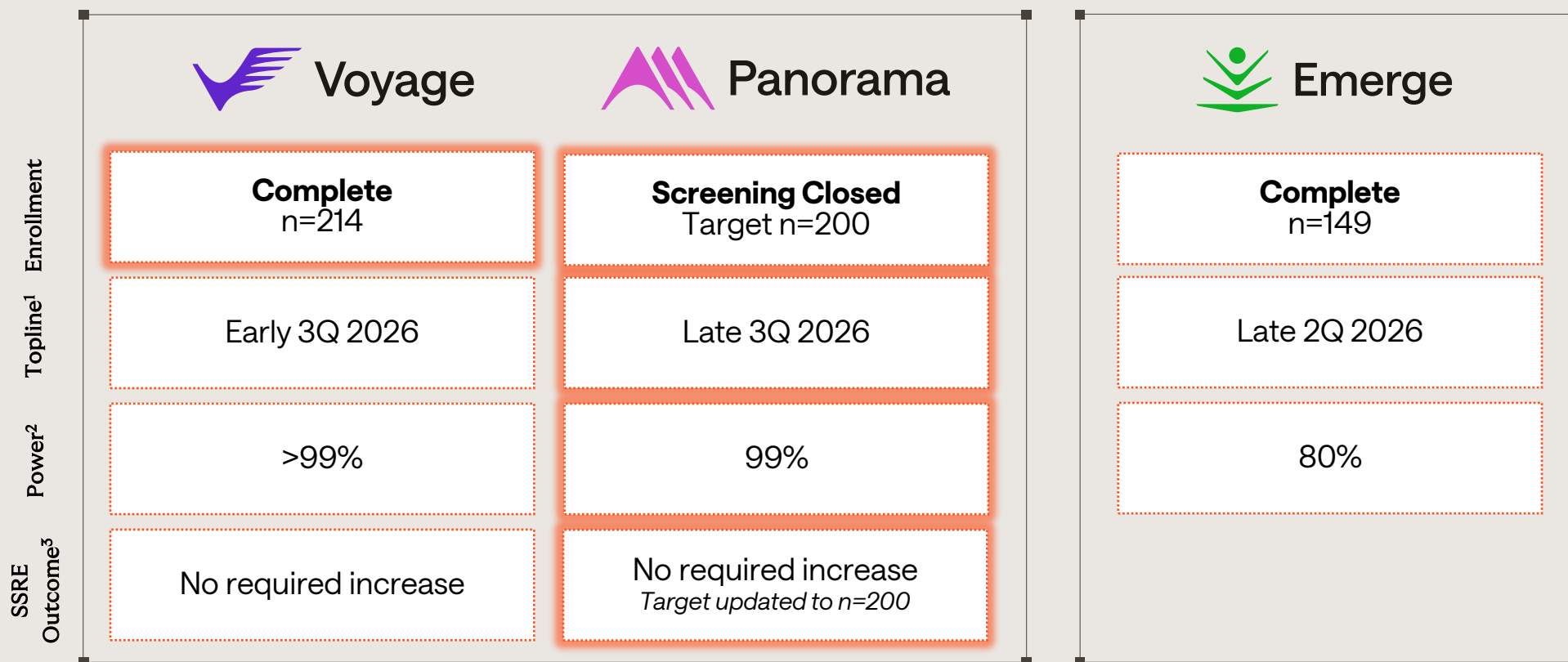
	Phase 2b Study MMED008 ^{1,2}		 Voyage		 Panorama	
	Observed	Planned	SSRE Outcome	Planned	SSRE Outcome	
Enrollment Target		200	200	250	200	
Standard Deviation	9.7	10.0	Observed: 7.8 MMRM: 6.2	10.0	Observed: 7.6 MMRM: 7.4	
Non-evaluable rate ³	25%	15%	10%	15%	6%	
Power for $\Delta=5$ points ³		90%	>99%	90%	99%	
Minimum detectable difference ⁴		3.0	1.8	3.0	2.4	

1. Internal study documents.
 2. Robison, Reid et al. "Single Treatment With MM120 (Lysergide) in Generalized Anxiety Disorder: A Randomized Clinical Trial." JAMA vol. 334,15 (2025): 1358-1372. doi:10.1001/jama.2025.13481
 3. Non-evaluable rate based on data not available within visit analysis window as defined in study statistical analysis plan.
 4. SSREs conducted 12 weeks after enrollment of 50% of target sample size. Raw standard deviation based on observed cases at timepoint of interest. MMRM SD derived from model-based residual standard error. Power calculation based on the assumption that SSRE-observed nuisance parameters and revised target enrollment are maintained in final population and analysis. Minimum detectable difference refers to the placebo-adjusted difference above which a p-value less than 0.05 could be expected in the final analysis and are based on the SSRE-observed nuisance parameters assuming such parameters are maintained in final population and analysis; based on current enrollment at time of analysis.

Three Highly Powered Pivotal Readouts Anticipated in the Next 6 Months

Generalized Anxiety Disorder (GAD)

Major Depressive Disorder (MDD)



1. Anticipated timing of topline data

2. Power to detect a 5-point placebo-adjusted change on the HAM-A scale; based on the SSRE conducted for each study.

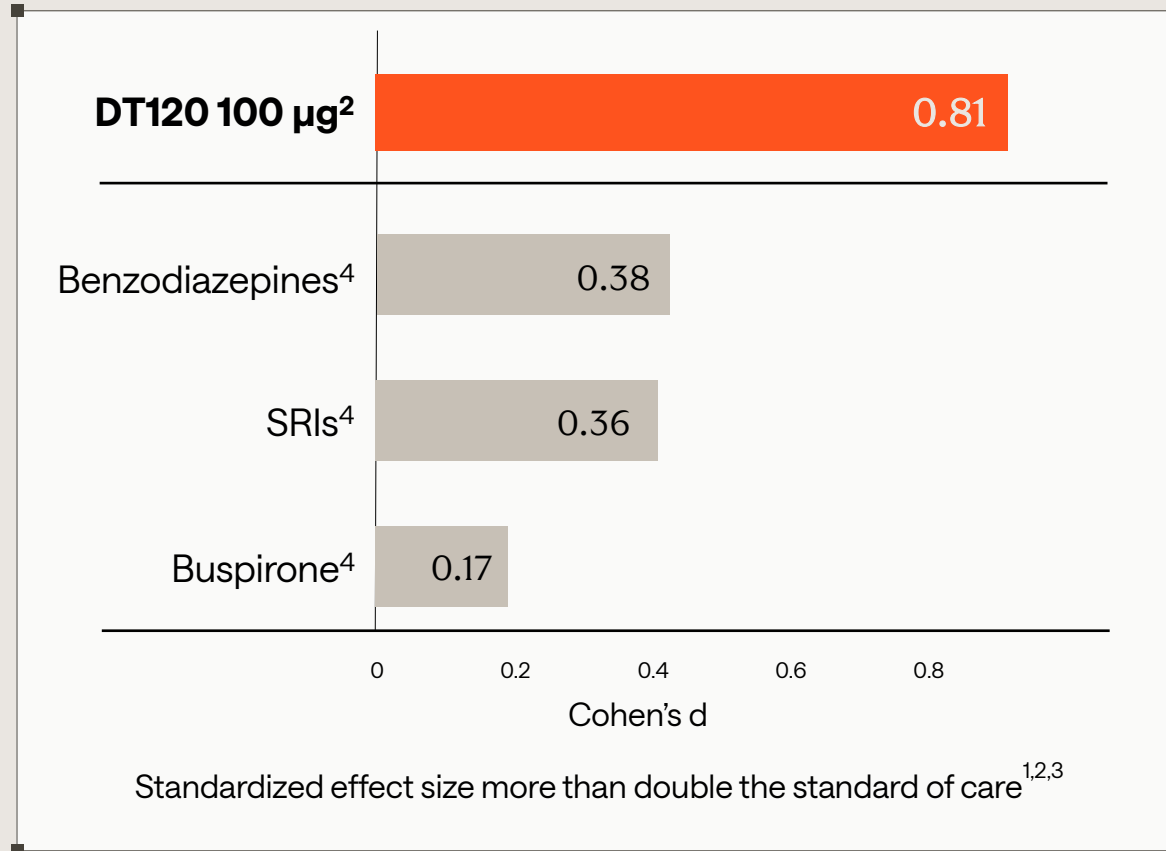
3. SSREs conducted 12 weeks after enrollment of 50% of target sample size. Power calculation and sample size requirements based on the assumption that SSRE-observed MMRM-derived nuisance parameters and are maintained in final population and analysis.

DT120
Phase 2b
Results in
GAD

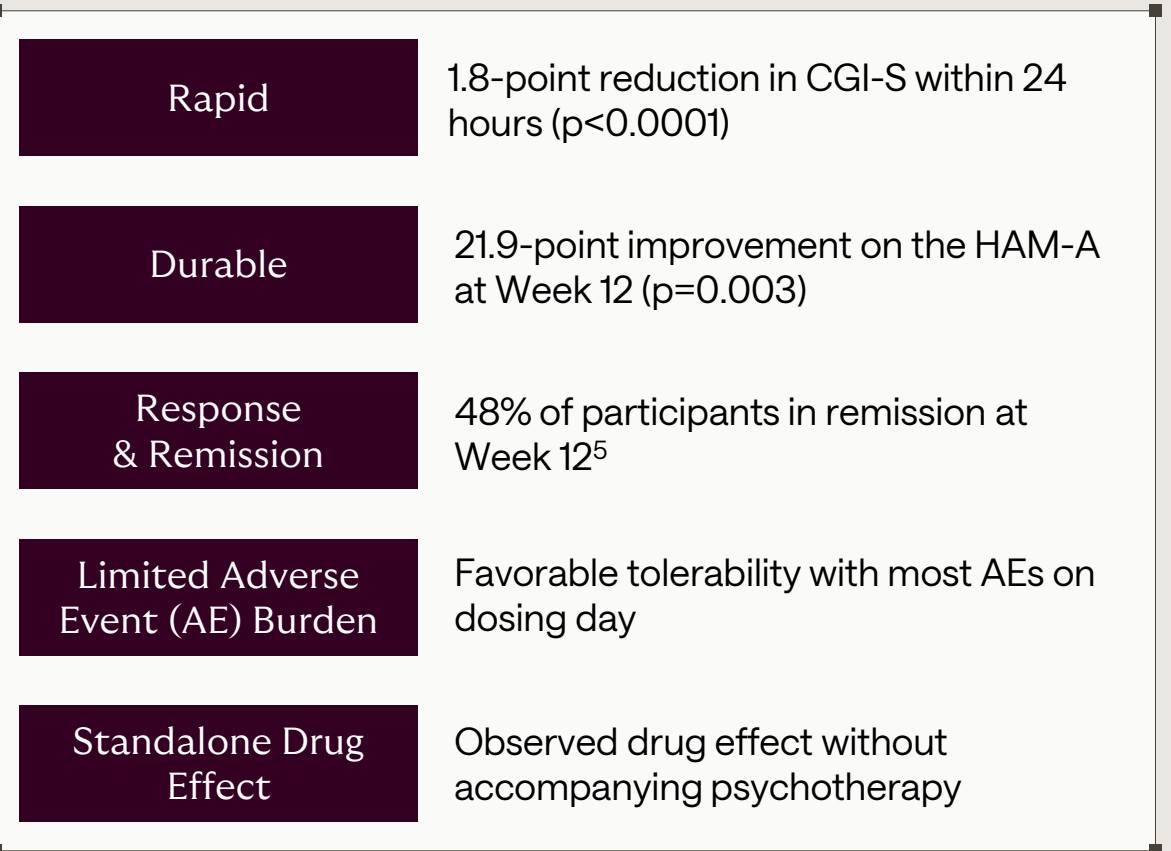


Key Phase 2b Efficacy and Safety Findings Support Best-In-Class Potential of DT120^{1,3}

Comparative Effect Sizes in GAD



Rapid and durable response after single administration³



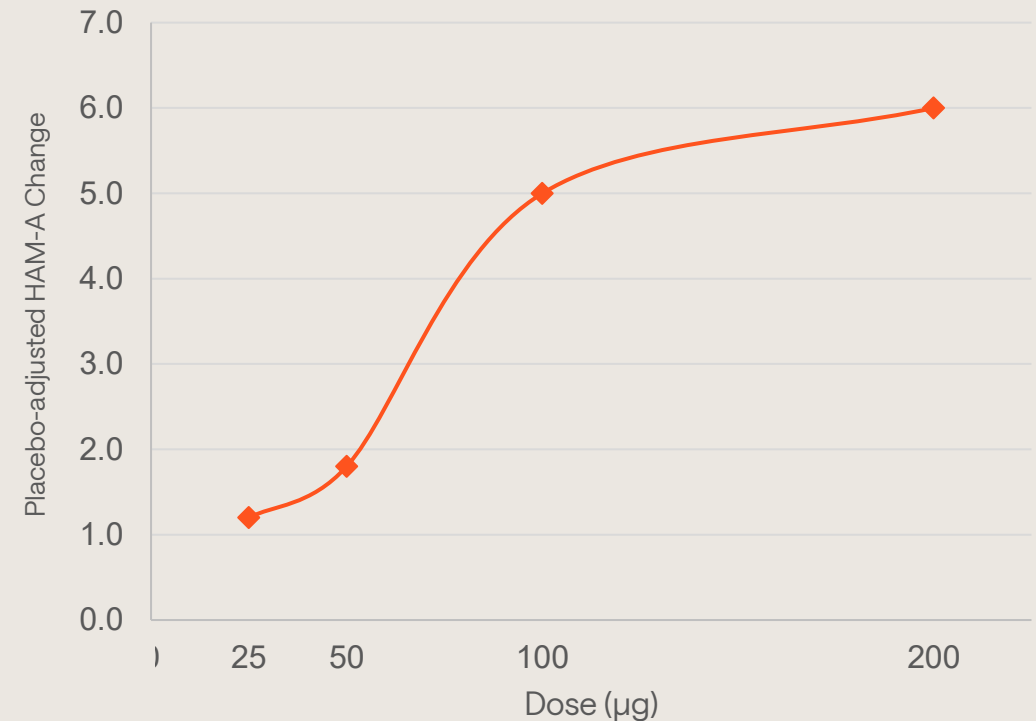
1. Study MMED008 internal study documents and calculations. Comparisons to standard of care/other drug classes based on historical comparison not head-to-head comparison trial.
 2. HAM-A scores based on ANCOVA LS Mean. In Study MMED008. Effect size based on post hoc calculation using LS Mean change between 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.

Dose Response in Phase 2b Provides Confidence in Dose Optimization & Robustness of Response

Key Findings

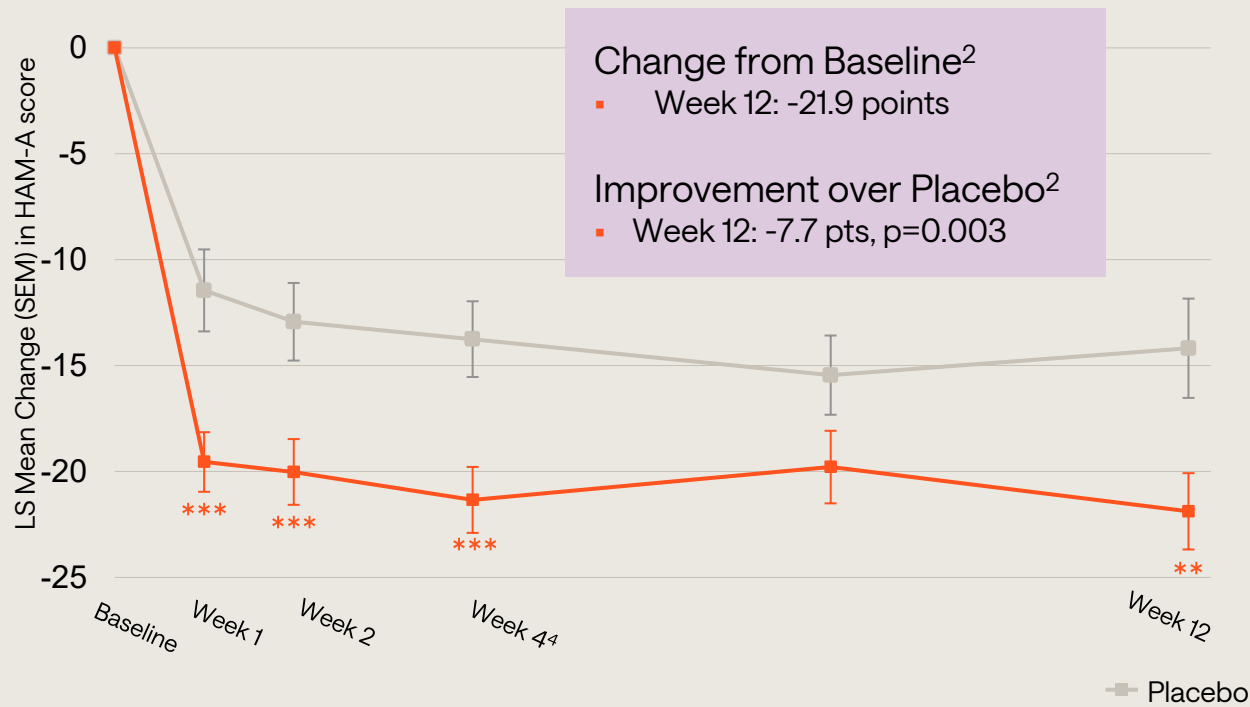
- Statistically significant dose response in Phase 2b
- Model supports 100 µg as optimal dose
- Results not explainable by “functional unblinding” supporting robustness of drug effect

Model-Based Dose-Response Curve¹

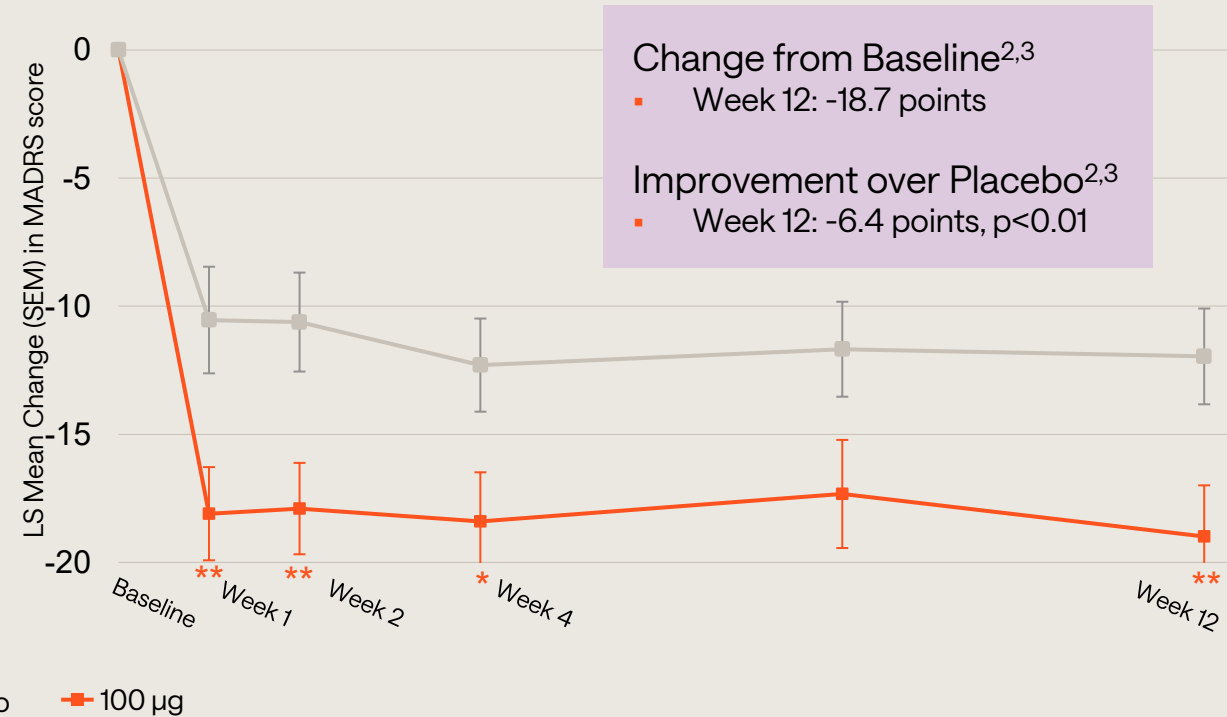


DT120 Showed Statistically & Clinically Significant Improvements on Anxiety and Depression Symptoms^{1,2}

Primary Outcome: HAM-A Change from Baseline



MADRS Change from Baseline



*p<0.05; **p<0.01; ***p<0.001

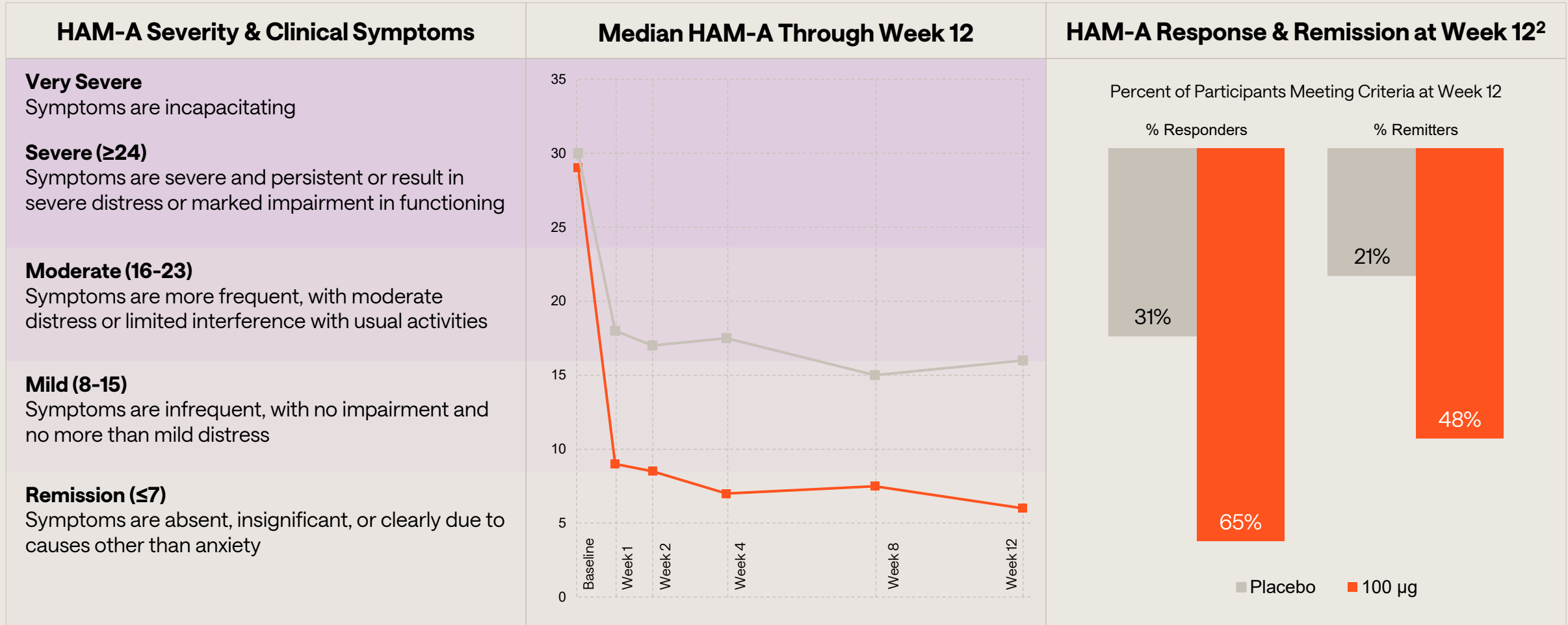
1. Source: Study MMED008 internal study documents and calculations. Full analysis set population.

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.

DT120 Demonstrated Profound Changes in GAD Severity¹

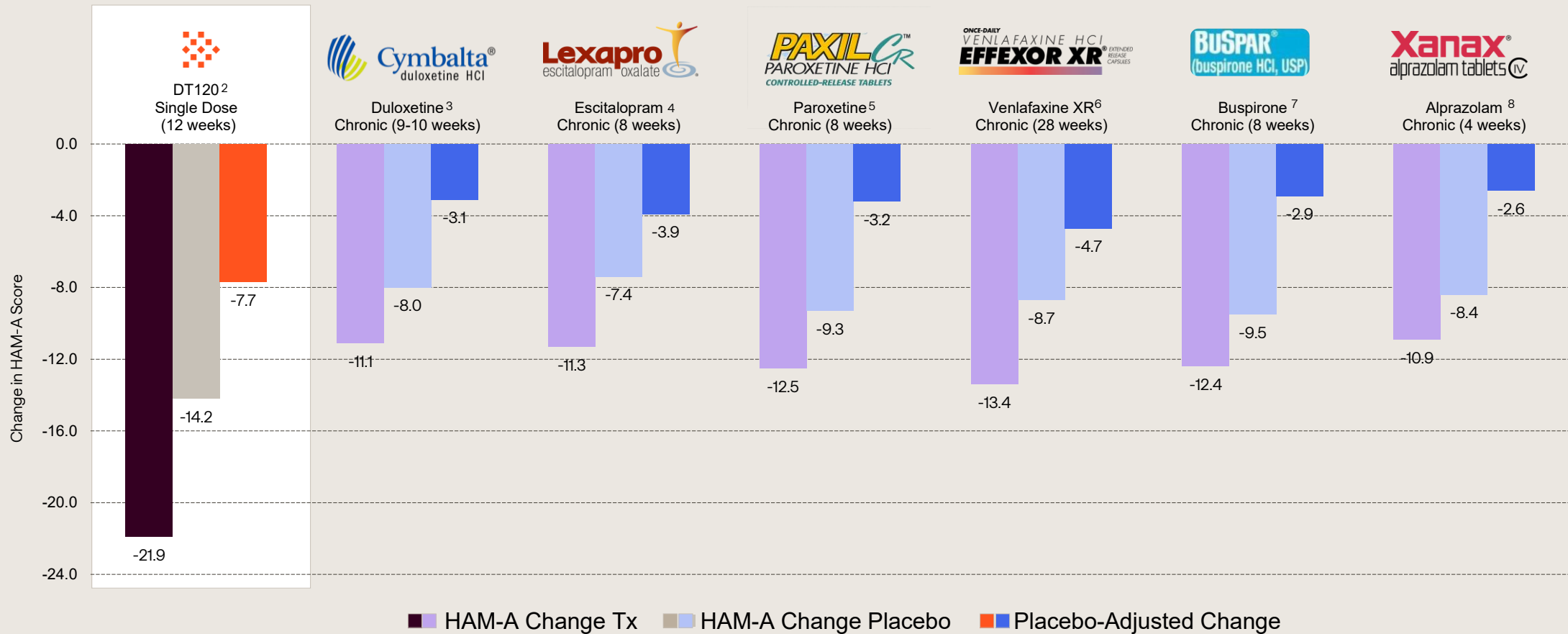


1. Source: Study MMED008 internal study documents and calculations. Full analysis set population.
 2. Response is a 50% or greater improvement on HAM-A score; Remission is a HAM-A score of ≤7; p-values not calculated.

DT120
Phase 2b
Results in
Context

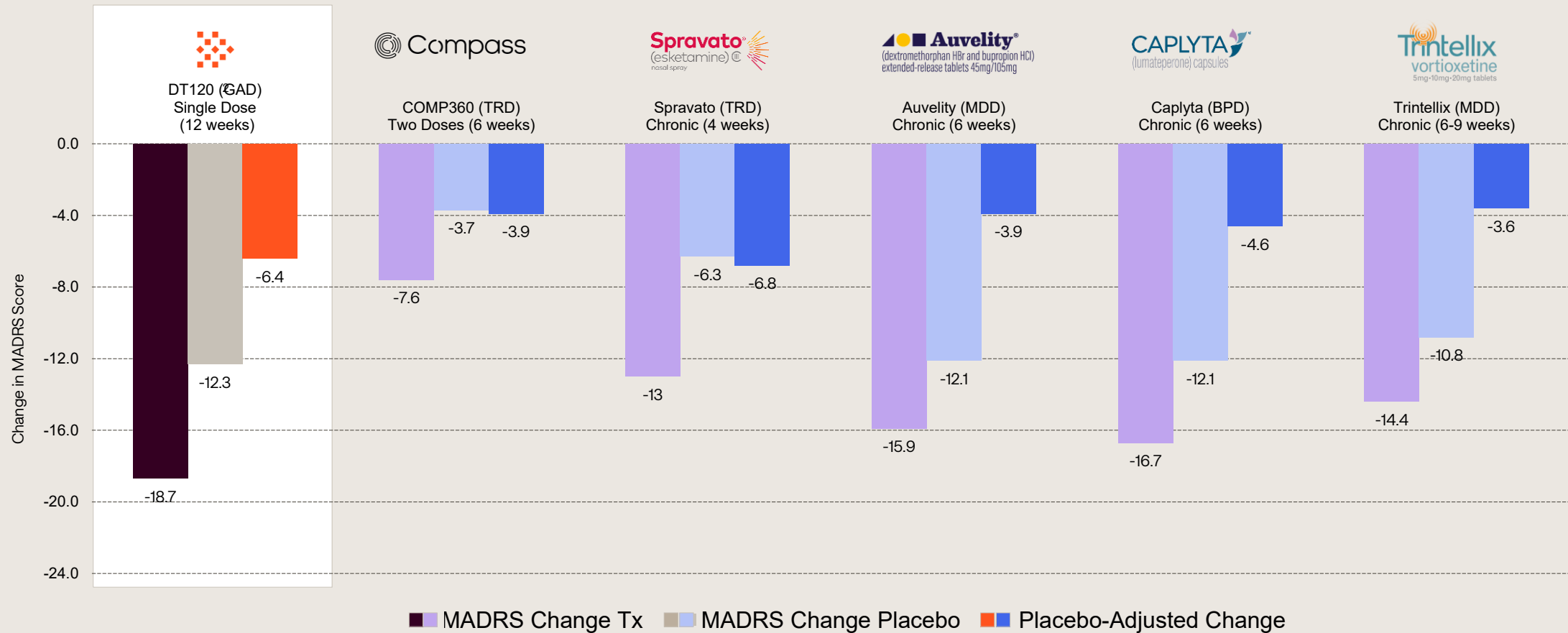


DT120 Delivers Clinical Activity that Stands Apart from Approved GAD Treatments¹



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.

DT120 Delivers Clinical Activity that Stands Apart from Latest Generation of Treatments for Depression Symptoms¹



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.

2. Depression treatments include those indicated for MDD, TRD and BPD. Only includes results from Phase 3 studies for which MADRS data are available and which were studied as a monotherapy. Results for approved drugs as reported on US Prescribing Information. In instances with multiple studies, the most favorable US study results presented. Compass Pathways results based on Study COMP005

DT120 was Well-Tolerated with Adverse Events Mostly Limited to Dosing Day¹

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
- AE profile consistent with historical studies and drug class

No SAEs related to study drug

- Only SAE was in 50 µg dose group and deemed unrelated²
- No drug-related serious AEs (SAEs)²

No suicidal behavior or suicidality signal³

- 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. Study MMED008 internal study documents and calculations. Safety population.

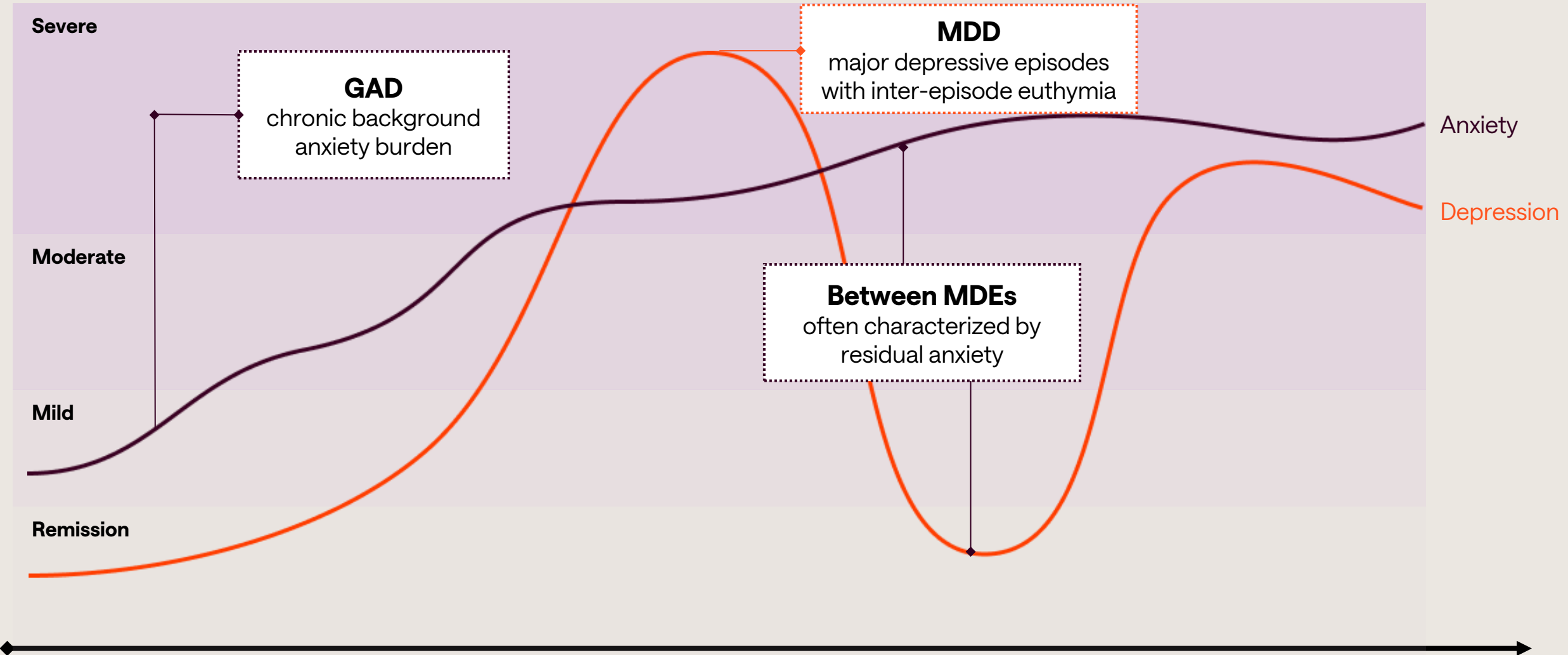
2. One serious adverse event (SAE) was observed in the 50 µg dose group: panic attack on study day 98 that was deemed not related to treatment.

3. Suicidality assessment based on reported adverse events.

Anxiety & Depression



Interplay Between GAD & MDD Highlights Opportunity for a Dual Intervention¹



1. Conceptual illustration of disease progression in comorbid GAD and MDD.

GAD: generalized anxiety disorder; MDD: major depressive disorder; MDE: major depressive episode

Diagnostic Definitions With Intersecting Symptoms

Generalized Anxiety Disorder (GAD)¹

Must have ≥ 3 of 6 symptoms:

1. Restlessness or feeling keyed up/on edge
2. Being easily fatigued
3. Difficulty concentrating or mind going blank
4. Irritability
5. Muscle tension
6. Sleep disturbance

Frequency & Duration: More days than not for ≥ 6 months

Major Depressive Disorder (MDD)¹

Must have ≥ 5 symptoms:
At least one must be #1 or #2

1. Depressed Mood
2. Markedly diminished interest or pleasure
3. Significant weight loss/gain or appetite change
4. Insomnia or hypersomnia
5. Fatigue or loss of energy
6. Feeling of worthlessness or excessive/inappropriate guilt
7. Diminished ability to think or concentrate; indecisiveness
8. Recurrent thoughts of death or suicidal ideation/behavior

Frequency & Duration: ≥ 2 weeks

Psychological effects

Physical effects

1. Source: Diagnostic and Statistical Manual of Mental Disorders, 5th edition Text Revision (DSM-V-TR)

Clinical Outcome Assessments in GAD and MDD

Share Many Domains

Hamilton Anxiety Scale (HAM-A)¹

Range: 0-56

1. Anxious mood – worry, fear
2. Tension – restlessness, inability to relax
3. Fears – of dark, strangers, being alone, etc.
4. Insomnia
5. Intellectual – concentration, memory
6. Depressed Mood
7. Somatic (muscular) – aches, twitching
8. Somatic (sensory) – tinnitus, blurred vision
9. Cardiovascular symptoms – palpitations, chest pain
10. Respiratory symptoms – shortness of breath
11. Gastrointestinal symptoms – nausea, cramps
12. Genitourinary symptoms – frequency, libido changes
13. Autonomic symptoms – dry mouth, sweating
14. Behavior during interview – fidgeting, restlessness

Montgomery-Åsberg Depression Rating Scale (MADRS)²

Range: 0-60

1. Apparent sadness
2. Reported sadness
3. Inner Tension
4. Reduced Sleep
5. Reduced Appetite
6. Concentration Difficulties
7. Lassitude
8. Inability to Feel (Anhedonia)
9. Pessimistic Thoughts
10. Suicidal Thoughts

Psychological effects

Physical effects

1. Source: Hamilton M. The assessment of anxiety states by rating. Br J Med Psychol 1959; 32:50-55.

2. Source: Montgomery, S. A., & Åsberg, M. (1979). A new depression scale designed to be sensitive to change. British Journal of Psychiatry, 134(4), 382-389.

DT120 ODT
Phase 3
Program



Phase 3 DT120 ODT Development Program Aiming for Broad Label

Generalized Anxiety Disorder (GAD)



Final n=214¹
1:1 randomization

DT120 ODT
vs. Placebo

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

Target n=200¹
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

Major Depressive Disorder (MDD)



Final n=149
1:1 randomization

DT120 ODT
vs. Placebo

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

Planned n=175²
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

Posttraumatic Stress Disorder (PTSD)



Planned n=200²
1:1 randomization

DT120 ODT
vs. Placebo

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

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. Target sample size in accordance with the sample size re-estimation.
2. Clinical study designs subject to change based on ongoing regulatory discussion and review, including of Phase 3 clinical trial protocols.

Why We Believe DT120 ODT Is Well Positioned for Phase 3 Success



Strong Phase 2b results with effects on anxiety and depression symptoms



Phase 3 design enhancements support patient retention



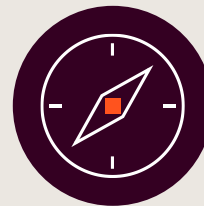
Existing and expanded key research site relationships



Continuous hands-on oversight of trial execution

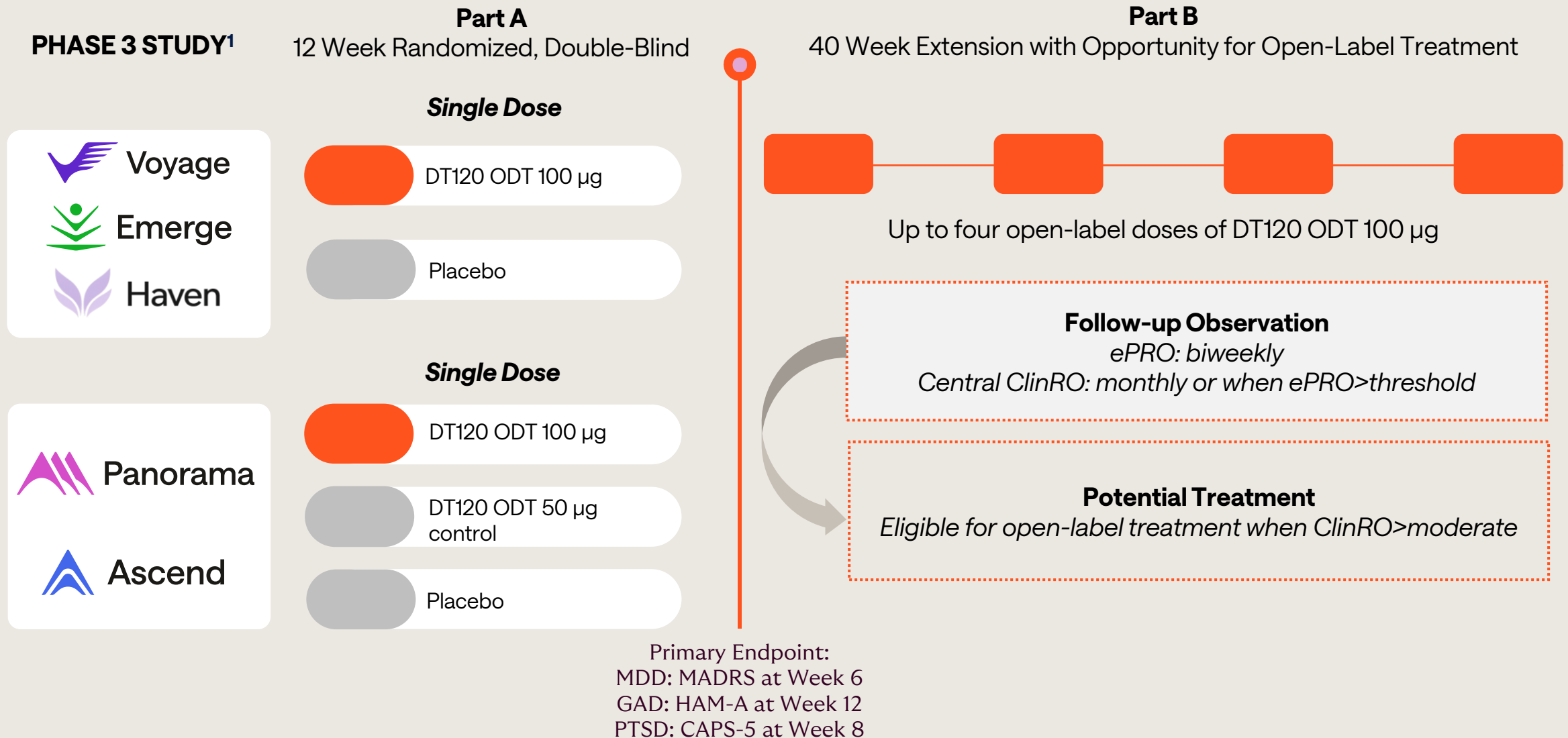


Collaborative FDA dialogue informing Phase 3 design

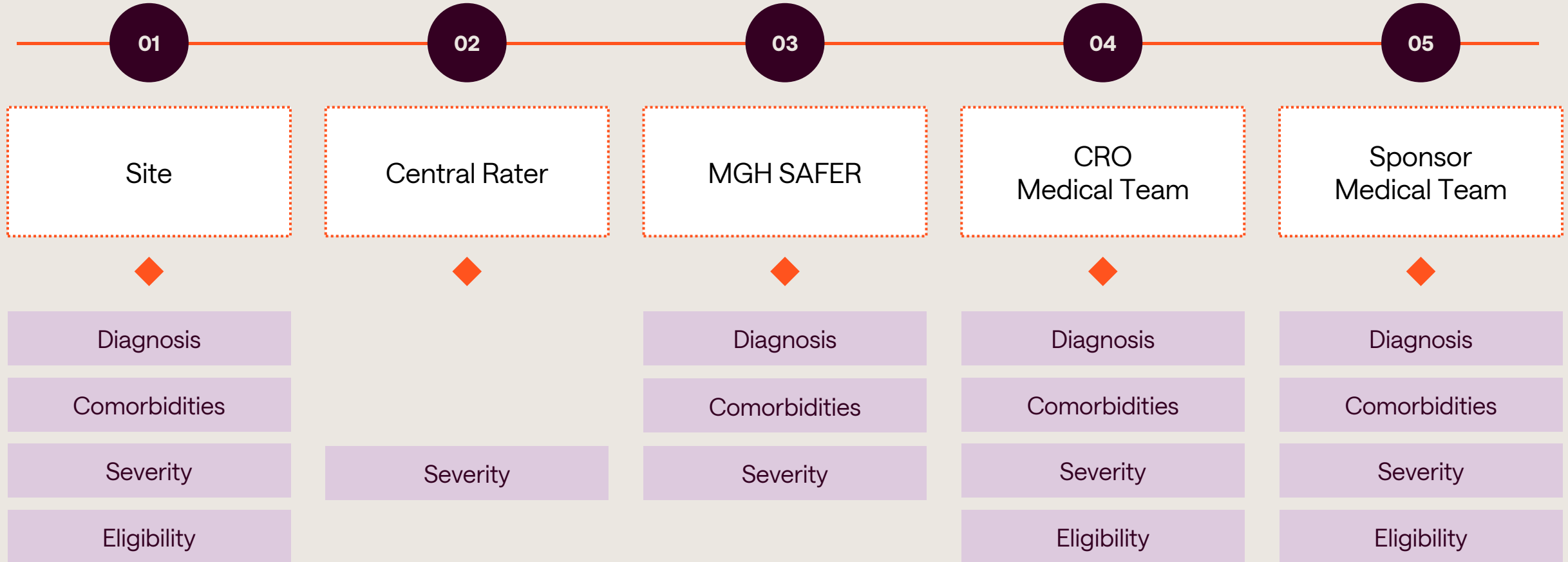


Alignment with FDA Industry Guidance & ICH Guidelines

Multiple Programs with Shared Development Strategy



Eligibility Process in Phase 3 Supports Trial and Population Integrity



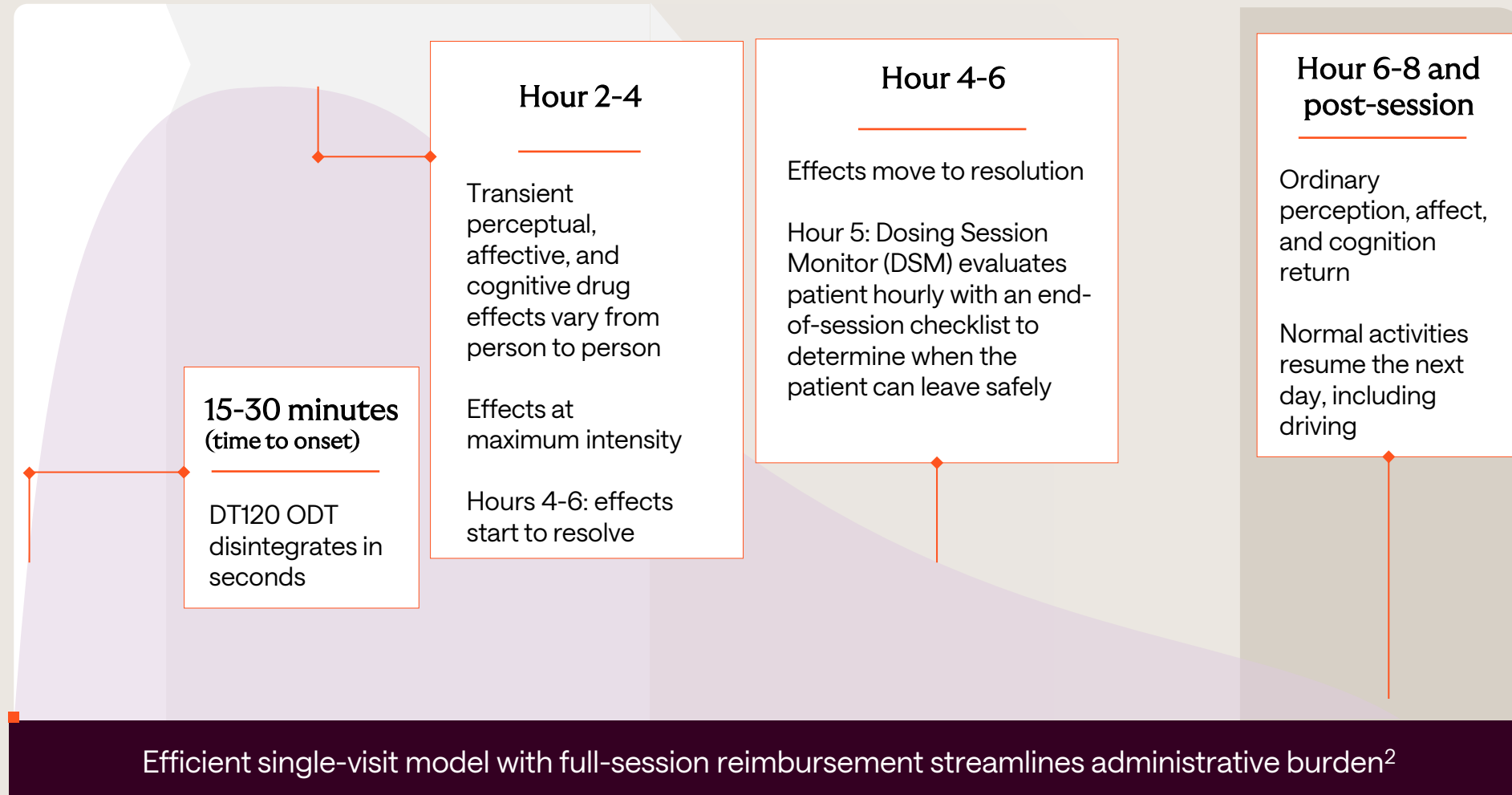
DT120 ODT Treatment Paradigm: Standalone Drug Effects with No Psychotherapeutic Intervention¹

	Pre-treatment	During treatment	Post-treatment
DT120 Patient Journey	<ul style="list-style-type: none"> ✓ Pre-treatment activities consist of a comprehensive informed consent process ✓ Eligibility evaluation 	<ul style="list-style-type: none"> ✓ Continuous monitoring by DSMs ✓ Music, eye shades, reading, writing ✓ Concludes when EOSC criteria met 	<ul style="list-style-type: none"> ✓ Follow-up visits for assessment only
Not Part of Patient Journey	<ul style="list-style-type: none"> x No “preparation” therapy 	<ul style="list-style-type: none"> x No “assisted therapy” x No psychotherapy and no therapeutic intervention beyond study drug 	<ul style="list-style-type: none"> x No “integration” therapy x No ongoing therapeutic engagement as part of clinical trial activities

1. Source: Study MMED008 internal study documents.

DSM: dosing session monitor; EOSC: end of session checklist

Clinical Dosing Paradigm with Potential Translatability to Efficient Real-World Delivery^{1,2}



1. Dosing and monitoring paradigm based on Phase 3 clinical protocols. Required monitoring period for all participants in pivotal studies is 8 hours and requires that participants clear the End of Session Checklist.
2. Existing coding systems could potentially be applied or be changed for DT120. Reimbursement and coding for DT120 have yet to be established.

Evolution of Patient Monitoring based on Clinical Evidence & Anticipating Real-World Setting

Phase 2 Study

23 Total Criteria

Expansive Research-oriented Checklist

- Patient-reported physical status
- Patient-reported mental status
- Assessed mental status (7 criteria)
- Sensory & Psychomotor status (5 criteria)
- DSM-5 Criteria for Hallucinogen Intoxication (9 criteria)

8-12 Hour Research Monitoring
to Inform Phase 3 Study Design¹

Pivotal-Stage Studies

8 Item Scale

Practice-oriented End of Session Checklist

- EOSC intended to inform & reflect requirements under potential REMS program
- Refined based on discussions with the FDA

5-8 Hour Monitoring via EOSC²
to Inform Real-World Conditions of Safe Use

1. 12-hour monitoring requirement based on inclusion of 200 µg dose of DT120 in Phase 2b

2. The required monitoring period in pivotal studies of DT120 is 8 hours and requires that participants clear the End of Session Checklist.

Few Comments on Methodology & Research with Psychedelic Treatments

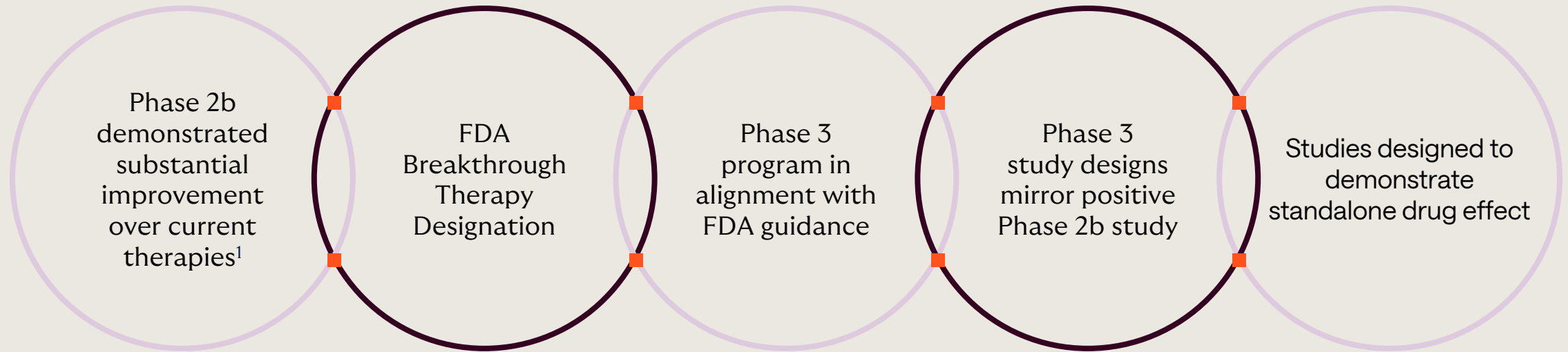
Population

Comparator

Functional Unblinding

Controls

Accelerating DT120 ODT on a Disciplined Path to NDA Submission



Ready for Expeditious Path to Submission upon Phase 3 completion

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.

DT120 ODT
Phase 3
Data
Expectations



Preview of Emerge Topline Readout

Trial & Design

- Disposition, Demographics & Baseline characteristics

Efficacy

- Primary outcome: MADRS at Week 6
- Select secondary outcomes through Week 12

Safety

- Adverse events & suicidality (C-SSRS)

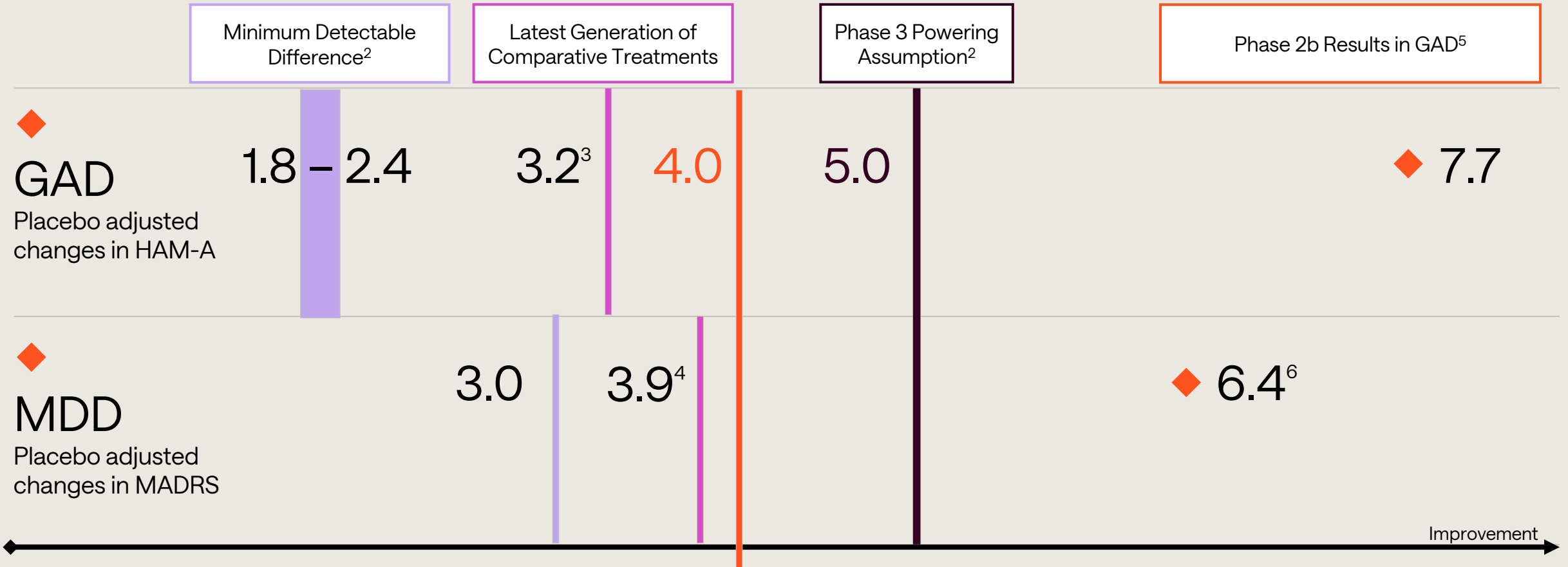
Dosing Session Dynamics

- Duration of session

Preliminary Outcomes from Extension Phase

- Time to inefficacy (i.e., return of moderate+ symptoms)
- Maintenance of MADRS improvement
- Retreatment patterns

Putting the Numbers in Perspective¹



We believe a 4.0+ point placebo-adjusted difference, along with safety and durability, could represent a **best-in-class profile**

1. The information presented in this slide on comparative treatments 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.
 2. Based on Phase 3 clinical trial protocols and SSRE results. Data on file.
 3. Median placebo-adjusted change of comparative treatments for GAD (see slide 19)
 4. Median placebo-adjusted change of comparative treatments for depression symptoms (see slide 20)
 5. R Robison, JAMA. 2025 Sep 4; e2513481. doi:10.1001/jama.2025.13481
 6. MADRS change from Baseline to week 12 was a secondary endpoint in Study MMED008.

A Patient's Perspective on the DT120 Experience



Panel Discussion



Investor & Analyst Day Speakers



Dan Karlin, MD
Chief Medical Officer

Chief Medical Officer
Definium



**Brittany Albright, MD,
MPH, DABOM**

*Psychiatrist, Addiction
Psychiatry*
Sweetgrass Psychiatry
Medical University of
South Carolina



**Andrew Penn,
MS, PMHNP**

*Psychiatric-Mental Health
Nurse Practitioner*
Salma Health
UCSF



**Shannon Sarkar, PhD,
LPC, NCC**

*Licensed Professional
Counselor*
Here We Go Therapy
Missouri Baptist University

DT120 ODT Commercial Strategy



The Building Blocks for DT120 Commercial Success Are in Place

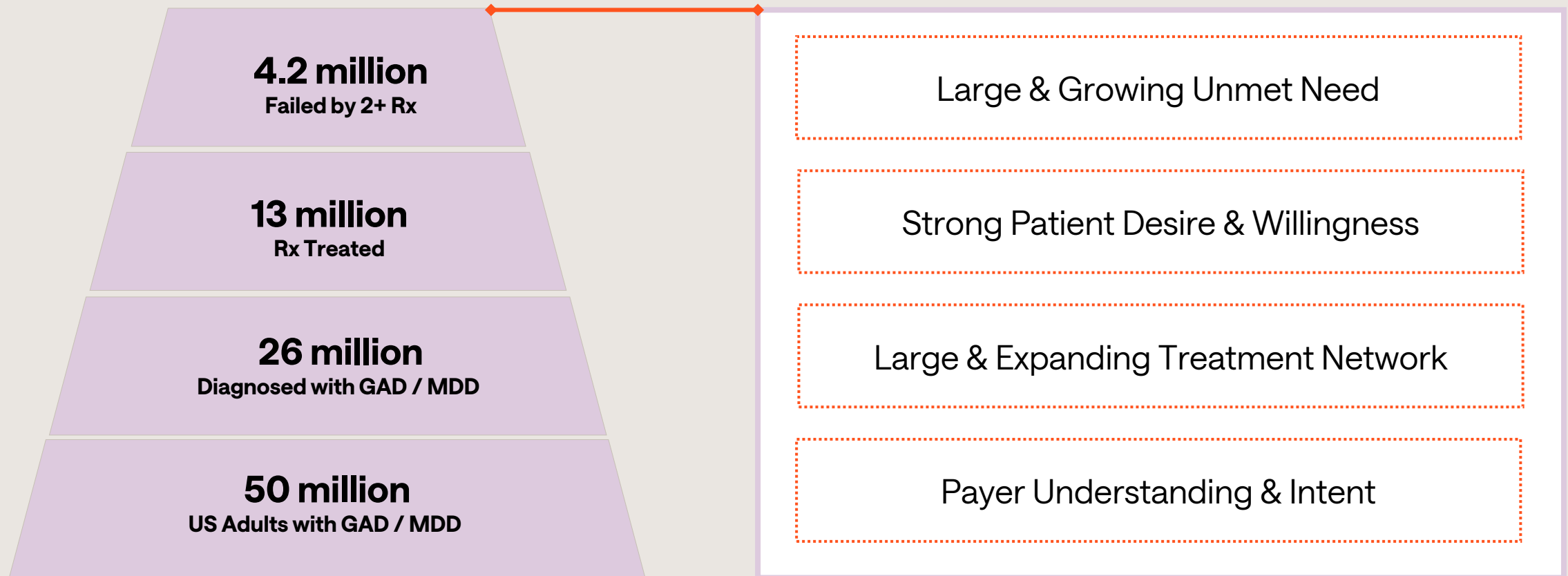
Patients Want Better

Providers are Primed for Adoption

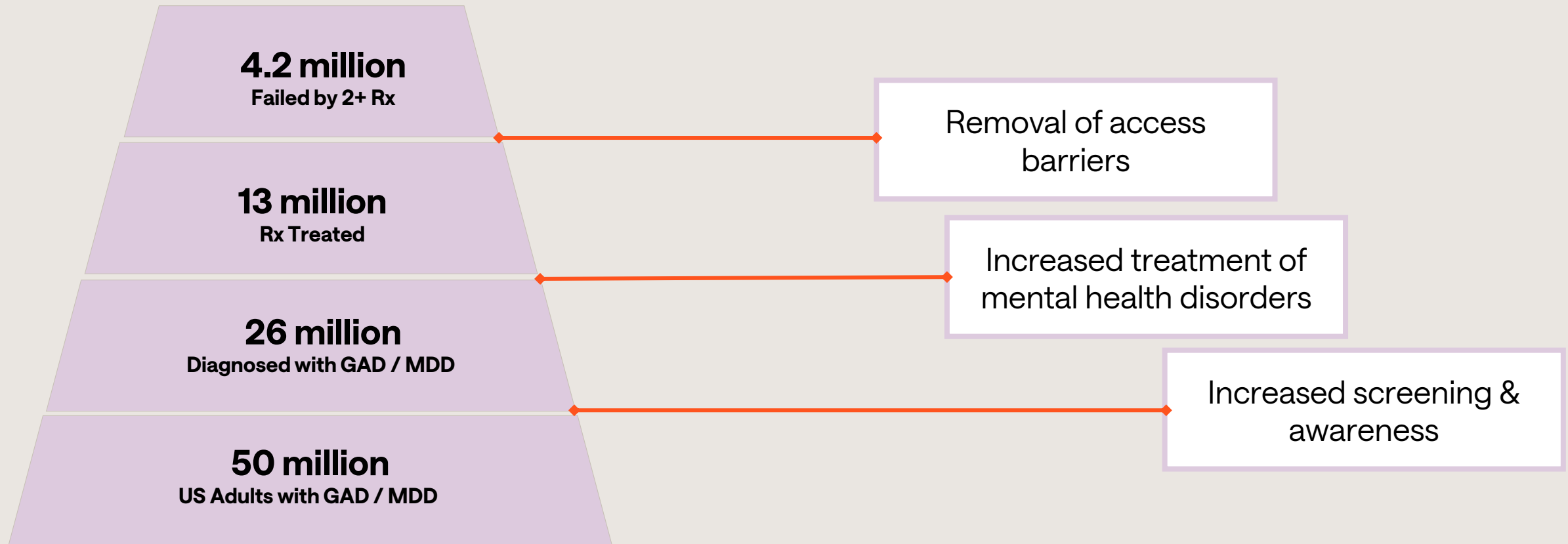
Positive Payor Indications

Our Time to Execute

The Near-Term Opportunity & Launch



Launch is Only the Starting Point for a Broader DT120 Market Opportunity



Psychiatry Continues to Evolve Toward Faster, More Targeted Intervention¹⁻⁵

Pre-1950s



Institution-centered care

Limited care in asylums.

Early ECT, sedatives

Custodial System

1950-1970



Pharmacology-based treatment

Medication options in outpatient setting.

TCA, MAOIs, antipsychotics

Outpatient Shift

1980-Early 2000s



Office-based psychiatry

Medical treatments with psychotherapy.

SRI

Chronic Disease Model

2005-2019



Interventional & digital emergence

Directly targets brain circuitry.

VNS, TMS

Episodic Care

2020-Today



Transformative care

Rapid-acting inpatient treatments with durable results.

Esketamine, psychedelics, including DT120

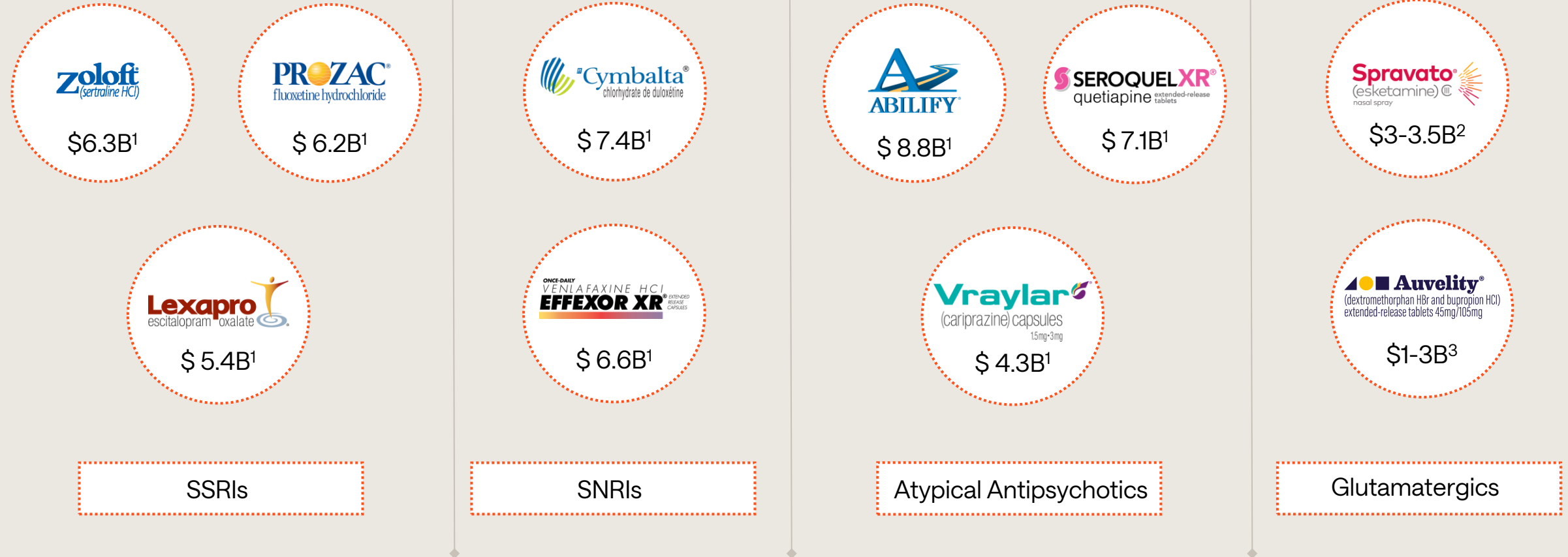
Precision Approach

From medication to devices, psychiatry has continually embraced innovation to expand treatment options

1. Potash JB et al. *Psychiatr Res Clin Pract*. 2025;7(2):80-90; 2. Karrouri R et al. *World J Clin Cases*. 2021;9(31):9350-9367; 3. Williams NR et al. *J Clin Psychiatry*. 2014;75(8):895-7; 4. Backman I. The Rise of Interventional Psychiatry. Accessed: Apr 16 2026. <https://medicine.yale.edu/news/yale-medicine-magazine/article/the-rise-of-interventional-psychiatry/>; 5. Robison R et al. *JAMA*. 2025;334(15):1358-1372.

ECT: electroconvulsive therapy; MAOIs: monoamine oxidase inhibitors; SRI: serotonin reuptake inhibitors (including selective serotonin and selective serotonin and norepinephrine reuptake inhibitors); TCAs: tricyclic antidepressants; TMS: transcranial magnetic stimulation; VNS: vagus nerve stimulation

Despite Limitations, New Classes in Psychiatry Have Represented Major Market Opportunities



We believe psychedelics could be the next significant class of treatments in psychiatry

1. Peak annual sales estimates. Peak sales from Evaluate Pharma, includes 3% annual inflation adjustment for drugs with peak years prior to 2025. Calculations on file.
 2. Johnson&Johnson Earnings Guidance, April 2025.
 3. Axsome Therapeutics February 2026 corporate presentation.

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Limitations of Current SOC Leads to Medication Cycling and Patient Discouragement

GAD

Persistent worry for years

Struggling in silence

Hope

Frustration

Desperation

Symptoms

Diagnosis

PCP or specialist confirms diagnosis and initiates plan

Treatment Initiation

First line SSRI/SNRI ± therapy

Cycling

Switching, augmentation, trial and error over months

Unresolved Symptoms

Current treatments do not address root issue

Comorbid Diagnoses

Unresolved symptoms often lead to secondary diagnoses



SSRI/SNRI ± adjunctive treatments (e.g., benzodiazepine)

Maintenance

Ongoing treatment to sustain symptom control

MDD

Lack of energy, no enjoyment in life, social withdrawal

Struggling in silence

Hope

Frustration

Desperation



SSRI/SNRI ± adjunctive treatments (e.g., atypical antipsychotics)

Treatment Resistance

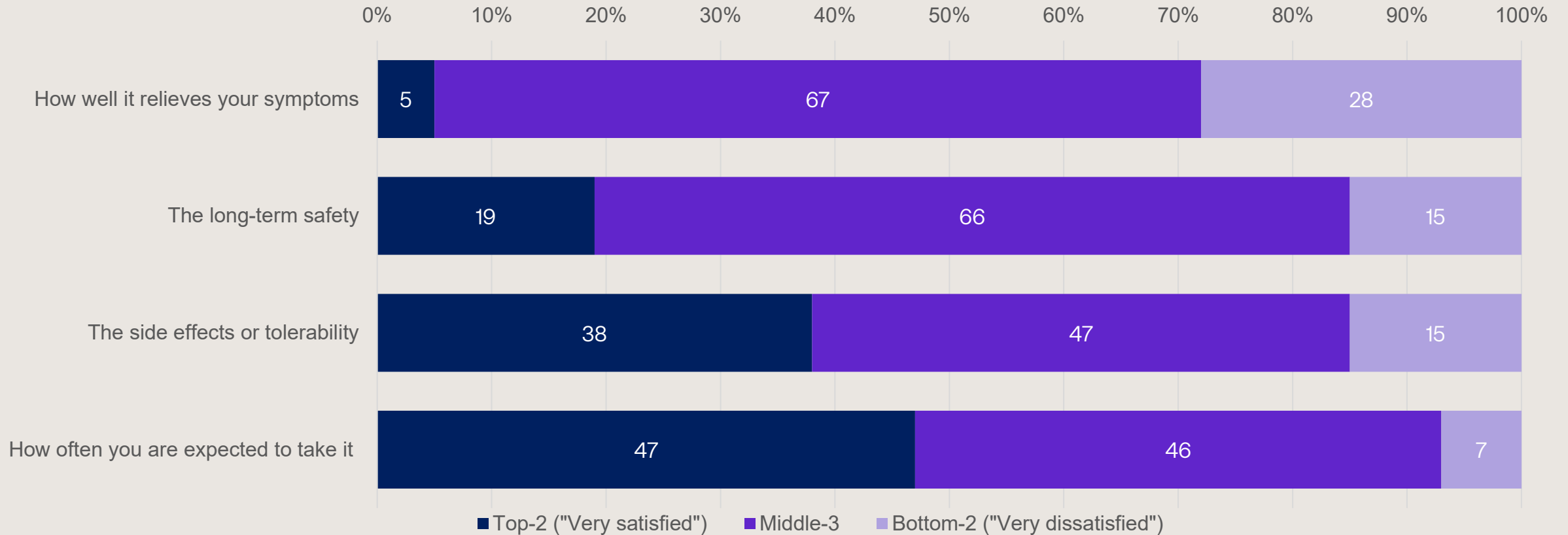
Session-Based Treatment

ECT, TMS, Spravato®

Sources: Clarivate analysis 2022
GAD Patient Journey, July 2022 (n=16 Clinicians n=24 Patients)
Depression Patient Journey, November 2023 (n=16 Clinicians n=24 Patients)

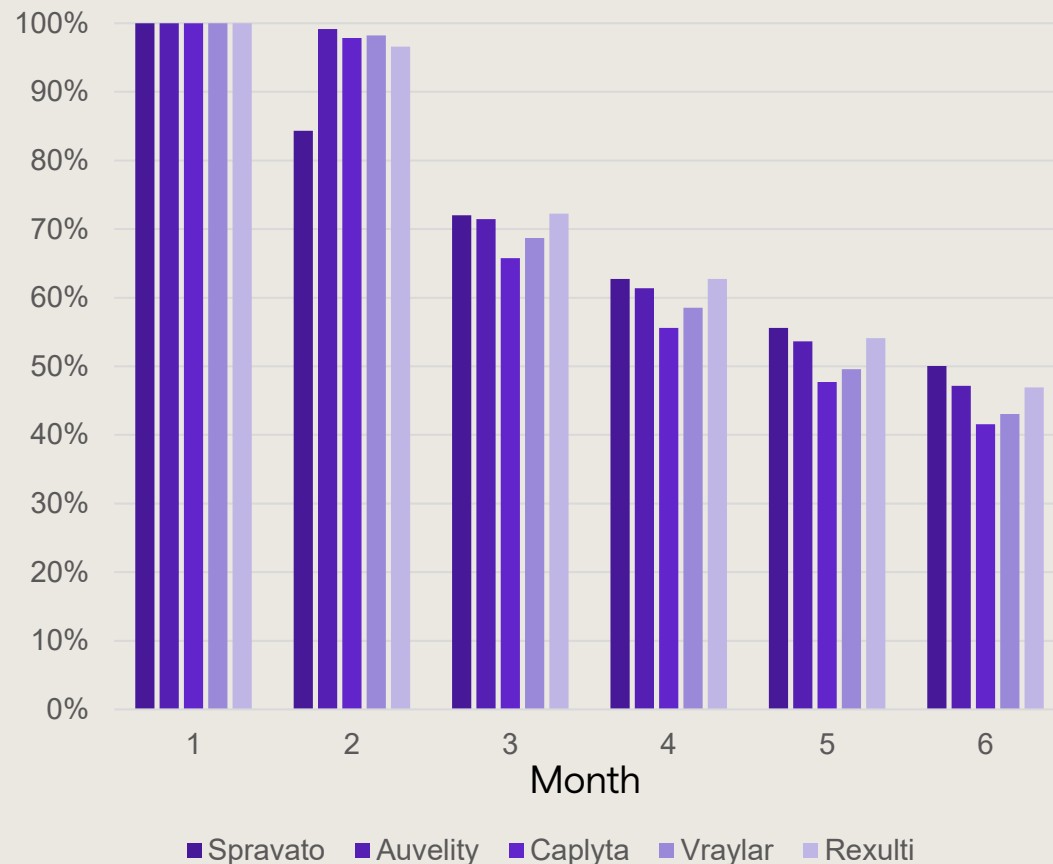
ECT: electroconvulsive therapy; PCP: primary care physician; SSRI: Selective Serotonin Reuptake Inhibitor; SNRI: serotonin and norepinephrine reuptake inhibitors; TMS: Transcranial Magnetic Stimulation

Patients With MDD and/or GAD Are Coping— They Are Not Satisfied With the Efficacy of Their Medications



Most Patients Quit Current Treatments within 6 Months

Key Insights on Early Treatment Persistence

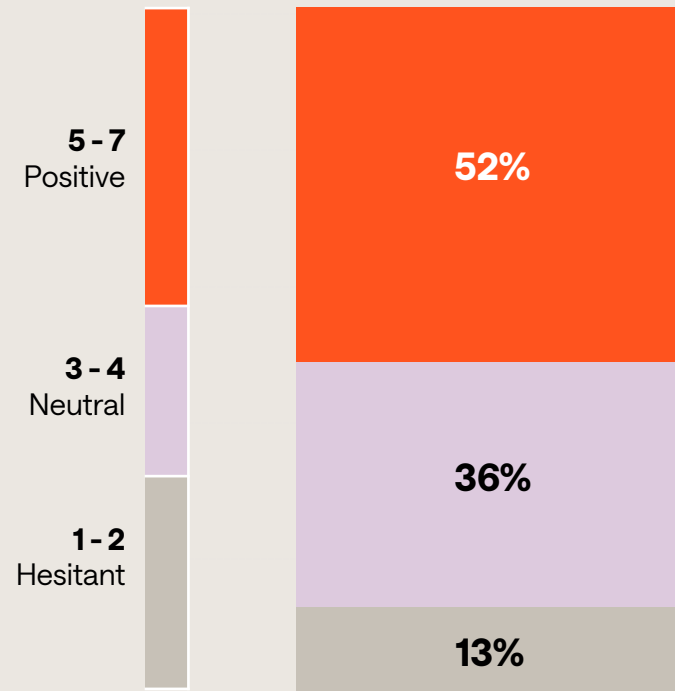


Impacts

- Physicians contend with patients leaving treatment due to side effects, inefficacy, and schedule constraints
- Discontinuation punctuates patient journey frustrations
- Payers pay for therapeutic interventions that are not sustained

Growing Psychiatrist Awareness and Positive Sentiment Support DT120 Adoption Potential

Psychiatrist Perception of Psychedelic Treatments²



Psychiatrist Perception of DT120

- 58% HCPs surveyed have positive views of DT120 profile¹
- HCPs cite quick onset of action, symptom resolution, response and MOA as top attributes¹
- Awareness of DT120 has sharply increased from 27% to 64% in the last two waves of research (2024 to 2026)²

1. GAD Demand Study 2024 Among Total HCP Respondents (n=273). Percentage based on top 3 box (scale 1-7)

2. DT120 Awareness and Perception Tracking: Wave 3, 2026. Total prescribers (n=135).

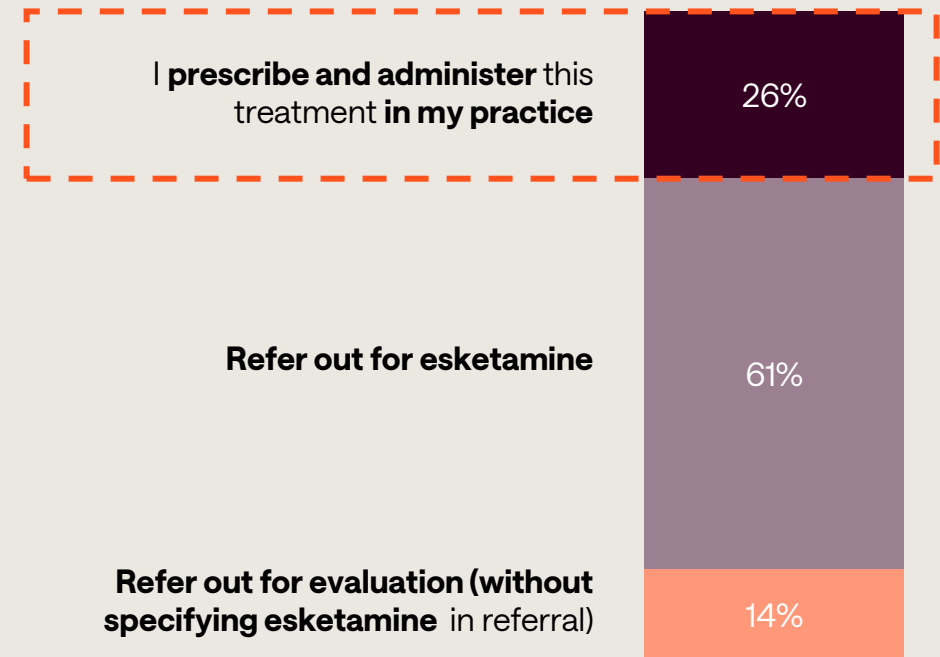
Strong In-Practice Intent Among High-Priority HCPs

DT120¹

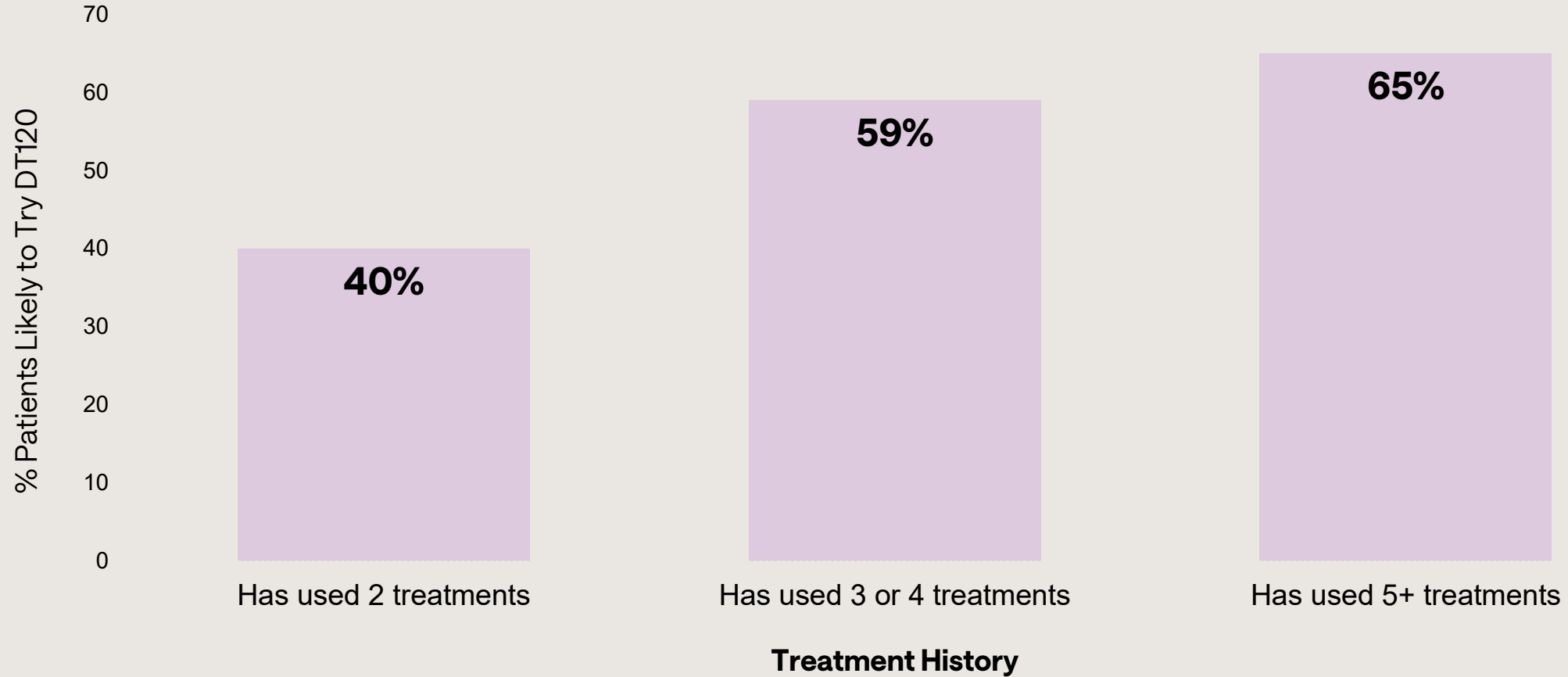


*No respondents selected would **not consider**

Esketamine¹



DT120 Appeal in Treatment-Experienced Patients



Key Strengths of DT120 Value Proposition Align with Payer Preferences

Key Strengths Noted in Payer Engagements

Rapid onset of
efficacy +
durability of effect

DT120's first-in-class
anxiolytic MoA

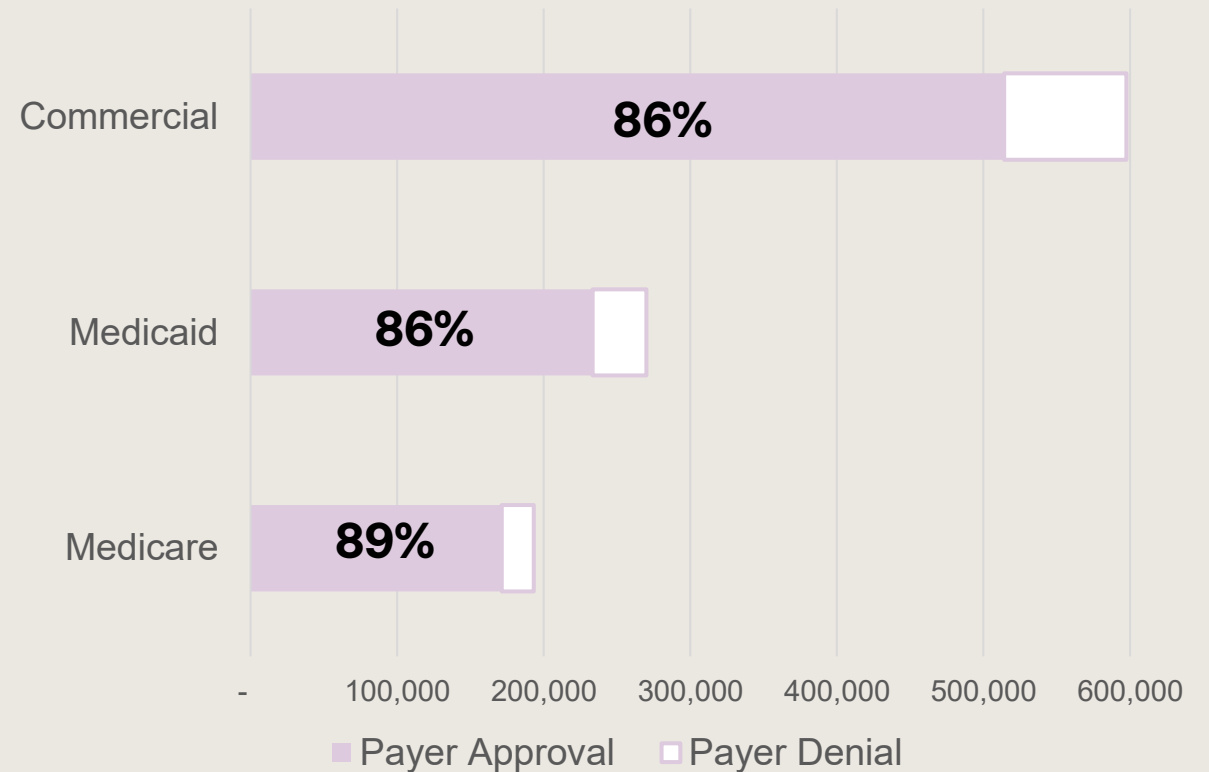
One-time oral dosing

DT120 Reimbursement Outlook Is Anchored by Spravato[®] Precedent

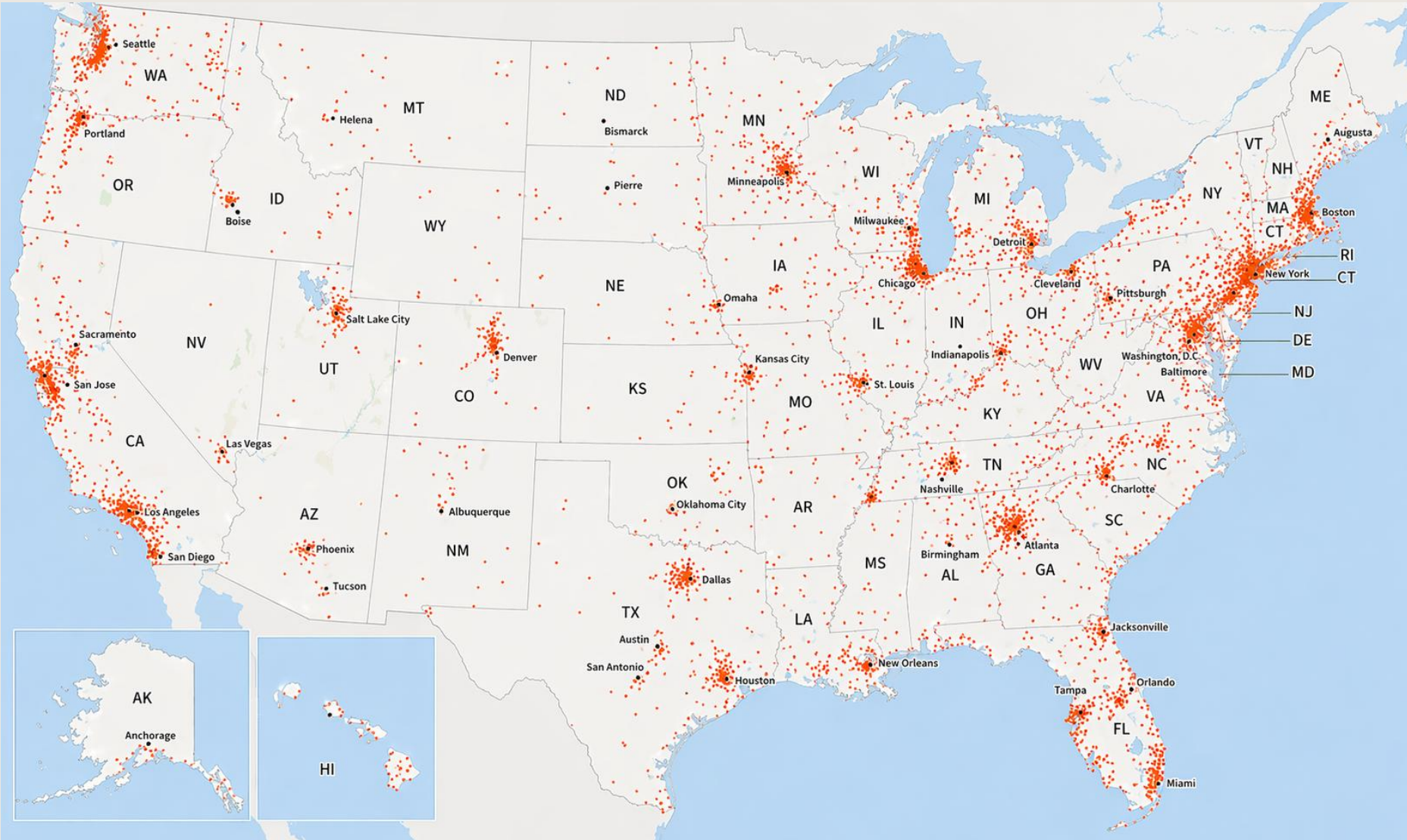
Payer Insights on Pricing & Access

- ✓ Payers reference Spravato as the primary price analog
- ✓ Payers indicate expectation that FDA-approved psychedelic treatments will be covered
- ✓ Payers expect to manage use of DT120 with prior authorizations in line with other branded psychiatric products

Esketamine Rx Approvals (Total Rx - 2025)

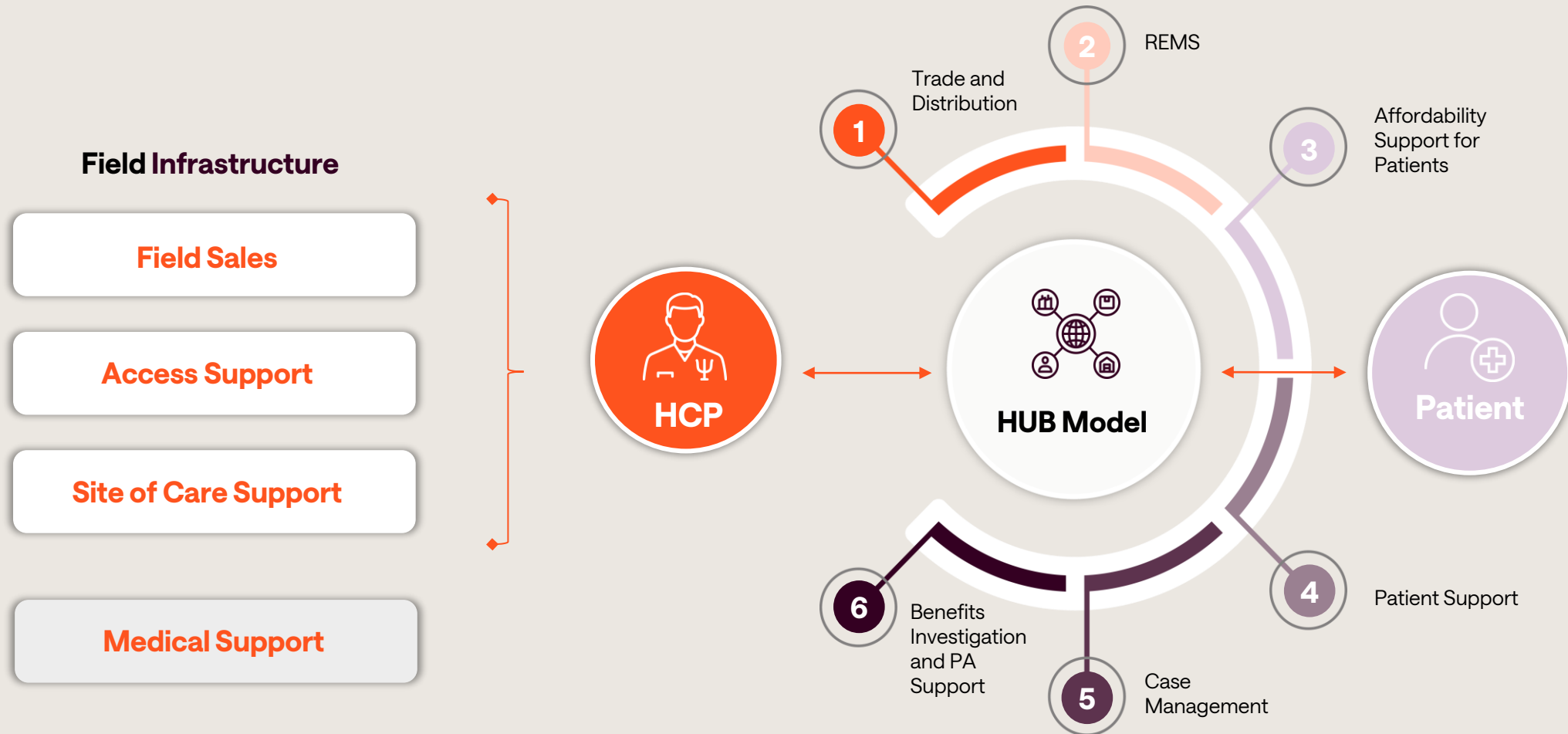


Predictive Analytics Help Focus Resources Where Adoption Potential Is Highest



● Priority GAD /
MDD Prescribers

We Aspire to Provide the Best Support Patients Have Ever Experienced

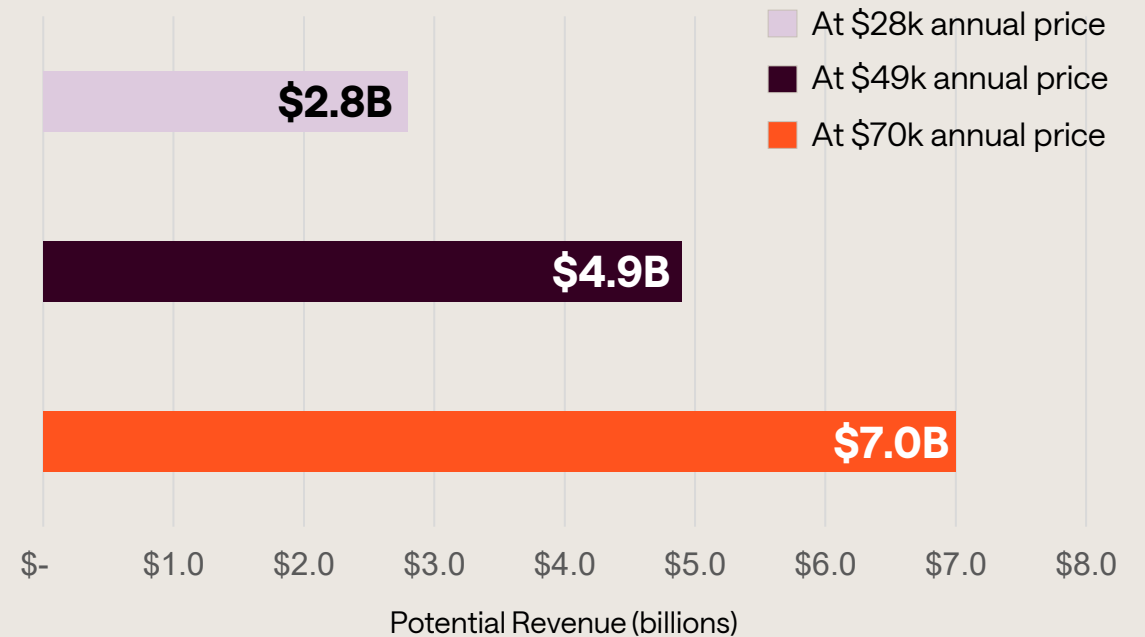


Modest Adoption in Target Population Supports Blockbuster Revenue Opportunity

4.2 million patients
have been failed by
2 or more treatments¹

\$2 billion
revenue opportunity
per 1% penetration²

**Potential Value (\$B) for every 100,000
patients treated with DT120³**



1. Source: Claims Analysis Data on File, 2026

2. Assuming median Spravato[®] surrogate pricing range; the price of DT120 has not been established.

3. Range is based on Spravato surrogate low dose, low frequency (\$28k) to high dose, high frequency (\$70k) annually. Market Research, Data on file, 2026

Building Long-Term Shareholder Value





Regulatory Protection¹

New Chemical Entity Exclusivity

30-Month Stay

+1y

+2y

+3y

+4y

+5y

+7y

+9y

...

2043+²

Potential Patent Protection

API: Polymorph, Salt Form

Method of Use / Method of Treatment: Treatment of a Disorder

Drug Product: Method of Manufacture/Process

Delivery: Delivery Method, PK / PD

Additional Potential Protections

- Supply chain availability
- Exclusive rights to key technology
- Lifecycle management with improved product performance
- Trade secrets & know-how
- Differentiated product performance
- Differentiated combination (drug and/or device products)

1. Section 505 of the Federal Food, Drug and Cosmetic Act, 21 U.S.C. § 355.

2. Definium's currently-pending applications related to DT120 ODT will, if granted, have 20-year expiration dates between 2042 and 2044, not accounting for any reductions or extensions term which may be applicable, such as terminal disclaimers, Patent Term Adjustment, or Patent Term Extension.

1

What We Believe

- Large market opportunities
- Patients want better options
- Ability to make an impact at scale
- First new GAD drug approval since 2007

2

Why We're Positioned for Success

- Compelling Phase 2b results
- Rigorous Phase 3 program
- Differentiated strategy & execution
- Experienced, credible team

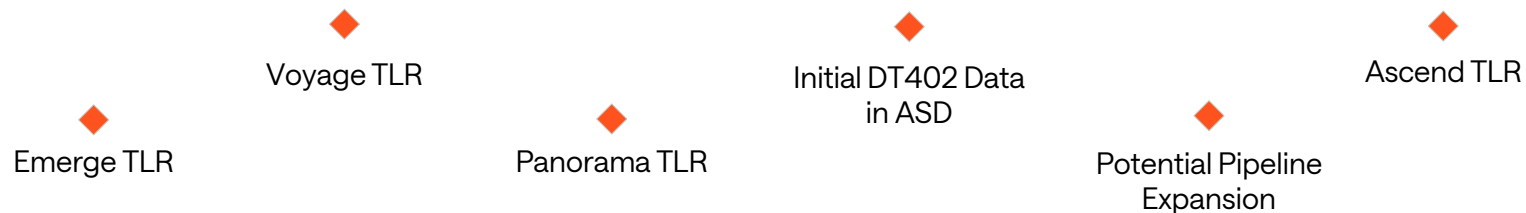
3

What to Watch

- Multiple anticipated 2026 topline Phase 3 data readouts:
 - ❖ Emerge (late 2Q 2026)
 - ❖ Voyage (early 3Q 2026)
 - ❖ Panorama (late 3Q 2026)
- Ascend Phase 3 study execution
- Evolution of commercial organization

Strong financial position with \$411.6M in cash, cash equivalents and investments at December 31, 2025¹

Clinical & Regulatory Execution



Value Creation

Optimizing Patient
Care Model

Expanding Site of Care
Engagement &
Commercial Footprint

Accelerating
Scheduling &
Reimbursement

**Commercial Launch
GAD & MDD**

Commercial Execution

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

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

Q&A Session



Precise science. Boundless impact.

Ask a Question

