ERASCA

On a Journey to Erase Cancer

Erasca Corporate Presentation

November 2024

CONFIDENTIAL

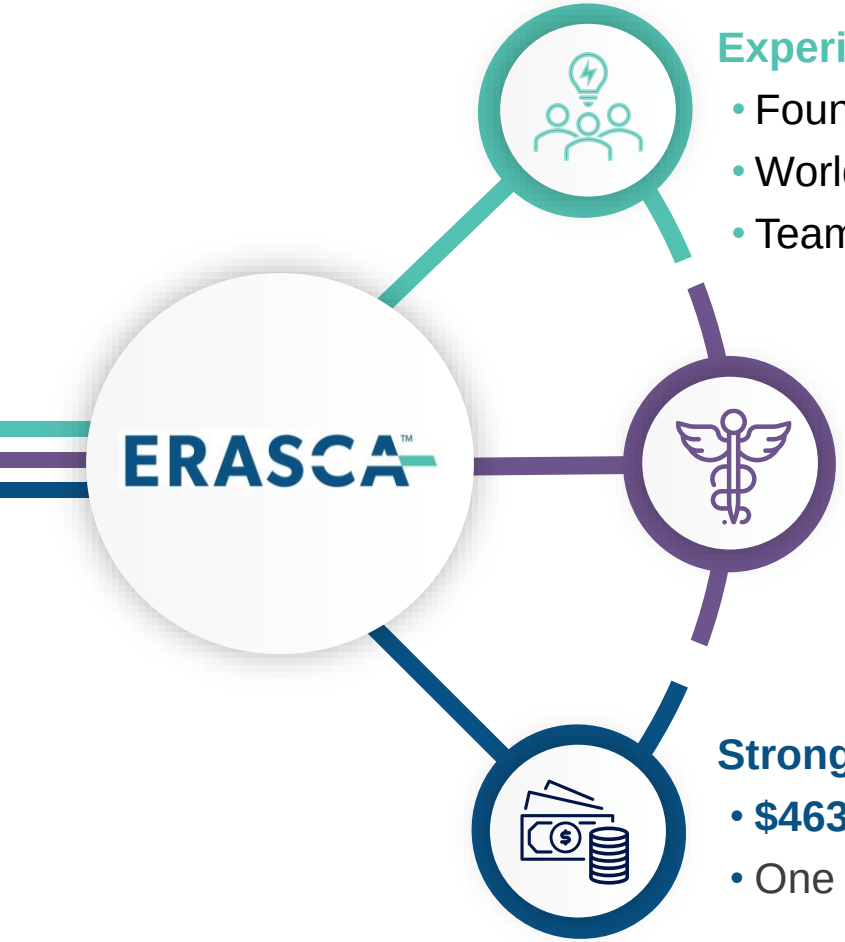
Eric N., naporafenib clinical trial participant and cancer survivor, and his wife Margaret

Disclaimer: Forward Looking Statements & 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 (including the timing of initiation and the timing of data readouts), costs, design and conduct of our ongoing and planned preclinical studies and clinical trials for our product candidates, the potential therapeutic benefits of our product candidates, the timing and likelihood of success of our plans and objectives, the impact of the deprioritization of certain programs, 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. Actual results may differ from those set forth in this presentation due to the risks and uncertainties inherent in our business, including, without limitation: our approach to the discovery and development of product candidates based on our singular focus on shutting down the RAS/MAPK pathway, a novel and unproven approach; we only have one product candidate in clinical development and all of our other development efforts are in the preclinical or development stage; the analysis of pooled Phase 1 and Phase 2 naporafenib plus trametinib data covers two clinical trials with different designs and inclusion criteria, which cannot be directly compared, and therefore may not be a reliable indicator of ORR, mPFS, or mOS data; due to differences between trial designs and subject characteristics, comparing data across different trials may not be a reliable indicator of data; preliminary results of clinical trials are not necessarily indicative of final results and one or more of the clinical outcomes may materially change as patient enrollment continues, following more comprehensive reviews of the data and more patient data become available, including the risk that an uPR to treatment may not ultimately result in a cPR to treatment after follow-up evaluations; our planned SEACRAFT trials may not support the registration of naporafenib; later developments with the FDA or EU health authorities may be inconsistent with the feedback received to date regarding our development plans and trial designs; Fast Track Designation (FTD) may not lead to a faster development or regulatory review or approval process, and does not increase the likelihood that our product candidates will receive marketing approval; our assumptions about ERAS-0015's or ERAS-4001's development potential are based in large part on the preclinical data generated by the licensors and we may observe materially and adversely different results as we conduct our planned studies; our assumptions around which programs may have a higher probability of success may not be accurate, and we may expend our limited resources to pursue a particular product candidate and/or indication and fail to capitalize on product candidates or indications with greater development or commercial potential; potential delays in the commencement, enrollment, data readout, and completion of clinical trials and preclinical studies; our dependence on third parties in connection with manufacturing, research, and preclinical and clinical testing; unexpected adverse side effects or inadequate efficacy of our product candidates that may limit their development, regulatory approval, and/or commercialization, or may result in recalls or product liability claims; unfavorable results from preclinical studies or clinical trials; results from preclinical studies or early clinical trials not necessarily being predictive of future results; the inability to realize any benefits from our current licenses, acquisitions, or collaborations, and any future licenses, acquisitions, or collaborations, and our ability to fulfill our obligations under such arrangements; regulatory developments in the United States and foreign countries; our ability to obtain and maintain intellectual property protection for our product candidates and maintain our rights under intellectual property licenses; our ability to fund our operating plans with our current cash, cash equivalents, and marketable securities into the first half of 2027; and other risks described in our prior filings with the Securities and Exchange Commission (SEC), including under the heading “Risk Factors” in our annual report on Form 10-K for the year ended December 31, 2023, and any subsequent filings with the SEC. You are cautioned not to place undue reliance on these forward-looking statements, which speak only as of the date hereof, and we undertake no obligation to update such statements to reflect events that occur or circumstances that exist after the date hereof. All forward-looking statements are qualified in their entirety by this cautionary statement, which is made under the safe harbor provisions of the Private Securities Litigation Reform Act of 1995. This presentation also contains estimates and other statistical data made by independent parties and by us relating to market size and growth and other data about our industry. This data involves a number of assumptions, and 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.

Our name is our mission: to erase cancer

Vision to one day erase cancer[1] in at least 100,000 patients annually as a leading global oncology company



Experienced leadership team and SAB with track record of serial successes

- Founded by **Jonathan Lim, MD & Kevan Shokat, PhD** around disruptive idea to target RAS
- World class scientific advisory board of **leading pioneers** in RAS/MAPK pathway
- Team with deep experience in efficient planning and execution of **global clinical trials**

Industry leading pipeline focused on shutting down the RAS/MAPK pathway

- **Naporafenib pan-RAFi** with first-in-class (FIC) potential and Fast Track Designation for NRASm melanoma + **other RAS/MAPK targeting agents**
- **ERAS-0015 Pan-RAS molecular glue** with BIC potential in RASm solid tumors
- **ERAS-4001 Pan-KRASi** with FIC potential in KRASm solid tumors

Strong financial position with high quality investor base and industry visibility

- **$463M in cash, cash equivalents, and marketable securities[2]**; cash runway into **H1 2027**
- One of **Fierce Biotech's 2021 "Fierce 15"** most promising biotechnology companies

CNS = central nervous system

[1] Number of patients alive and free of cancer or free from cancer progression 2 yrs after starting an Erasca regimen, as measured by disease-free survival (adjuvant setting) and progression-free survival (metastatic setting)

[2] Unaudited, as of September 30, 2024

ERASCA

SAB includes world's leading experts in the RAS/MAPK pathway

Erasca co-founder. World expert in RAS who pioneered development of approaches to inhibit KRAS G12C (RAS-GDP) and active states of RAS (RAS-GTP)

Kevan Shokat, PhD

UCSF University of California San Francisco

World expert in structure-based drug design; former head of research at Agouron and former head of Genentech's Research and Early Development (gRED)

Michael Varney, PhD

Genentech

World expert in functional cancer genetics and identifying new drug combinations based on genome-wide genetic approaches

René Bernards, PhD

Netherlands Cancer Institute – Antoni van Leeuwenhoek

World expert in SHP2 who helped pioneer development of the first SHP2 inhibitor with Novartis

Stephen Blacklow MD, PhD

Harvard Medical School · Dana-Farber Cancer Institute

World expert in ERK, having studied nearly every ERK inhibitor that has been or is being developed, as well as targeted therapies directed against KRAS, BRAF, and MEK mutations

Ryan Corcoran, MD, PhD

Harvard Medical School · Massachusetts General Hospital Cancer Center

World expert in RAS/MAPK pathway signaling and identifying novel combination therapies to shut it down

Karen Cichowski, PhD

Harvard Medical School · Brigham and Women's Hospital

World expert in targeted oncology therapies who pioneered the development of Gleevec®, which helped launched the precision oncology revolution

George Demetri, MD

Harvard Medical School · Dana-Farber Cancer Institute

World expert in RAS/MAPK pathway with focus on the SHOC2 phosphatase complex as a unique regulatory node required for efficient pathway activation in the context of diseases such as cancer and RASopathies

Pablo Rodriguez-Viciana, PhD

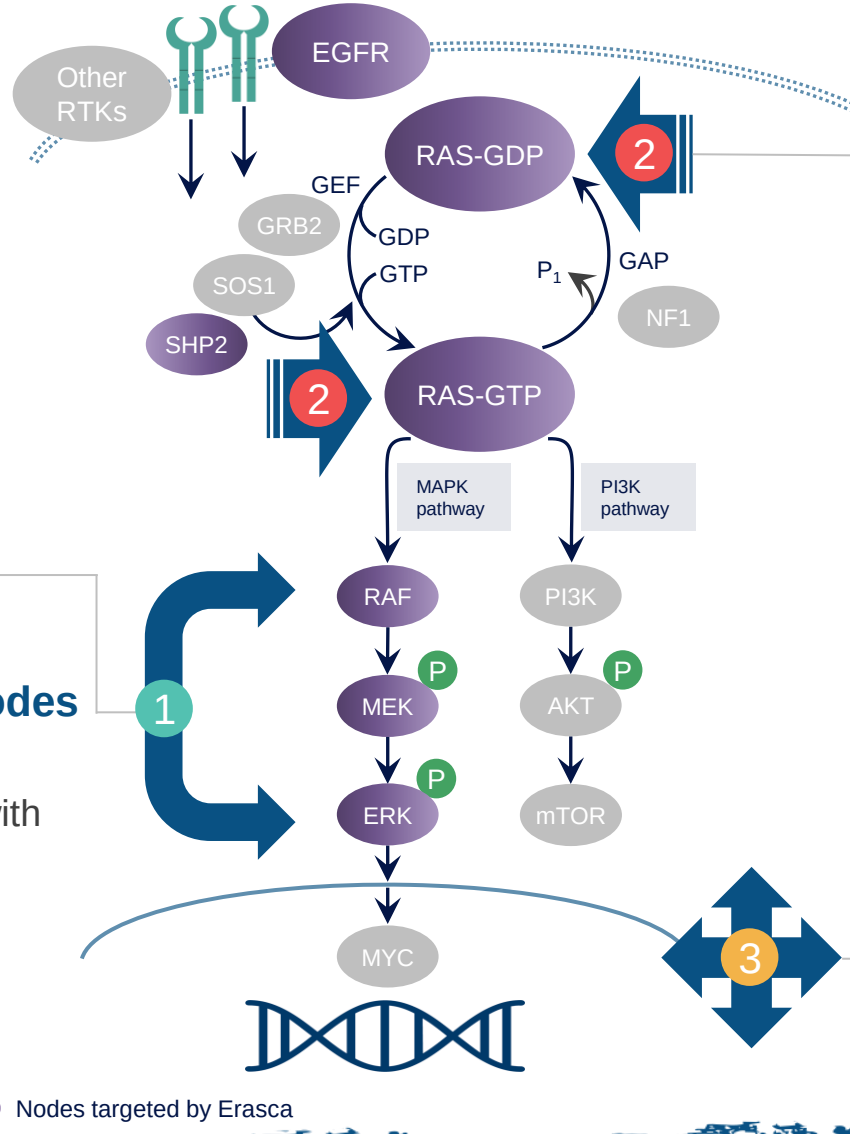
UCL Cancer Institute – UCL

ERASCA

Our singular focus is on the RAS/MAPK pathway

Our Strategy

Comprehensively shut down the RAS/MAPK pathway



1

Target upstream and downstream RAS/MAPK nodes

with single agents and clamp oncogenic drivers (MAPKlamp) with combinations

2

Target RAS directly

with single agents and combinations with upstream, downstream, and escape route targeted therapies

3

Target escape routes

enabled by other proteins or pathways to further disrupt RAS/MAPK pathway signaling

Deep modality-agnostic RAS/MAPK pathway-focused pipeline

Program	Target	Modality	Indication	Discovery	IND-enabling	Phase 1	Phase 2	Phase 3	Worldwide Rights
Naporafenib	BRAF/CRAF		RAS/MAPK solid tumors	SEACRAFT-1					ERASCA
			NRASm melanoma	SEACRAFT-2					ERASCA
ERAS-0015	RAS		RASm solid tumors	AURORAS-1 (planned)					ERASCA, JOYO[1]
ERAS-4001	KRAS		KRASm solid tumors	BOREALIS-1 (planned)					ERASCA
ERAS-12	EGFR D2/D3		EGFR & RAS/MAPK solid tumors						ERASCA

small molecule large molecule

Note: Pipeline also includes ERAS-801 brain-penetrant EGFR inhibitor for EGFR-altered GBM (for which we are concluding a Phase 1 trial and exploring advancement via investigator-sponsored trials), ERAS-007 ERK1/2 inhibitor, and ERAS-601 SHP2 inhibitor. ERAS-007 and ERAS-601 are being assessed in preclinical studies as potential combination partners with other programs in our pipeline for RAS/MAPK pathway inhibition. Via Erasca Ventures, we made an equity investment into Affini-T Therapeutics, which is developing TCR T-cell therapies against KRAS G12V, KRAS G12D, and KRAS G12C.

[1] Licensor Joyo Pharmatech, Ltd., retains rights to People's Republic of China, Hong Kong and Macau, subject to Erasca's option to convert our territory to worldwide

Pan-(K)RAS therapies: Expanding treatment options in (K)RAS-driven tumors

KRAS G12C INHIBITORS

Compelling but challenges remain

No selective inhibitors for other mutations

- KRAS G12X
- KRAS G13X
- KRAS Q61X

Susceptible to treatment resistance

Emerging clinical data suggest tumors often mount resistance to mutant-specific inhibitors[1,2]

PAN-(K)RAS APPROACHES

Designed to address current limitations

Expands patient population

(K)RAS multi-allele targeting

Less likely to develop treatment resistance

- Blocks WT RAS isoform activation
- Prevents on-target RAS mutations or re-activation

1 Awad et al. NEJM 2021
2 Li et al. JCO 2022

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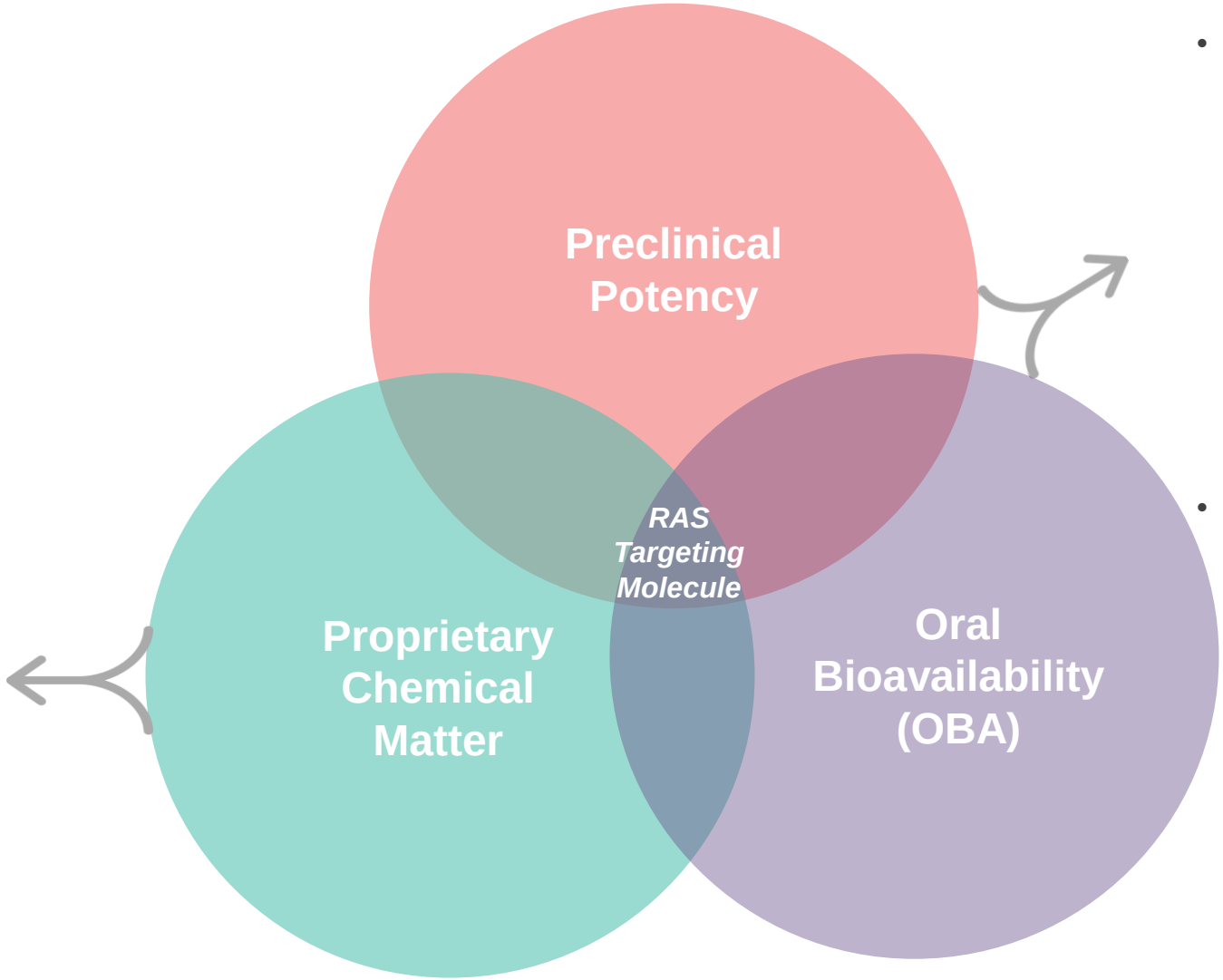
Ideal RAS targeting molecules integrate three key attributes



- Bolsters ability to **maximize clinical and commercial value** in highly competitive market

- May enable **lower clinically active dose** which could translate to:
  - Lower risk of solubility-limited absorption and exposure plateau observed with another pan-RAS MG in development
  - Better GI tolerability profile due to lower drug load
  - Improved therapeutic window for any potential off-target toxicities
- KRAS G12Ci class has demonstrated how higher potency can translate into **improved clinical activity**

MG = molecular glue

ERAS-0015 and ERAS-4001 exhibit competitive profiles that exceed our TPP

	Preclinical (in vitro and in vivo) Potency[1]		OBA[2]	IP
ERAS-0015 Pan-RAS Molecular Glue	KRAS G12D: 0.2 – 13.3 nM KRAS G12V: 0.4 – 2.5 nM KRAS G12C: 0.8 – 1.4 nM KRAS G12X: 4.1 – 7.4 nM KRAS G13D: 2.8 – 5.5 nM KRAS WT: 4.1 – 13.8 nM H/NRAS WT: Active[3]	***KRAS G12D:*** Tumor regression in PK-59 CDX model at 0.3 mpk PO QD ***KRAS G12V:*** Tumor regression in NCI-H727 CDX model at 1 mpk PO QD ***KRAS G12R:*** Tumor regression in PSN1 CDX model at 5 mpk PO QD	Mouse: 48% Rat: 38% Dog: 22% Monkey: 17%	IP (composition of matter, methods of use, and methods of making licensed compounds, incl. the current DC) has potential coverage through **2043**[4]
ERAS-4001 Pan-KRAS Inhibitor	KRAS G12D: 1.0 – 2.6 nM KRAS G12V: 0.7 – 9.1 nM KRAS G12C: 1.1 – 4.5 nM KRAS G12X: 6.5 – 37.7 nM KRAS G13D: 5.8 – 56.0 nM KRAS WT: 3.6 – 10.8 nM H/NRAS WT: No activity	***KRAS G12D:*** Tumor regression in Panc04.03, PK-59, and LU-01-1381 CDX/PDX models at 30 – 100 mpk PO BID; combo with anti-PD-1 achieved complete disappearance of tumors in all mice (7/7) on D31 at 100 mpk PO BID ***KRAS G12V:*** Tumor regression in RKN and NCI-H727 CDX models at 30 – 300 mpk PO BID	Mouse: 27% Rat: 5 – 27% (variable PK in rat) Dog: 16%	IP (composition of matter, methods of use, and methods of making licensed compounds, incl. the current DC) has potential coverage through **2043**[4]

Potential BIC Pan-RAS MG for RASm solid tumors with ~5x – 10x greater potency as well as favorable ADME properties and PK performance in animal species (vs. current Pan-RAS MG in development)

Potential FIC/BIC Pan-KRAS or "KRAS-selective" SMi that spares H/NRAS WT, predicted to provide greater therapeutic window (vs. Pan-RAS MG) for KRASm solid tumors and address KRASwt activation to prevent resistance (vs. mutant-selective inhibitors)

KRAS-selective SM + Pan-RAS MG "RASKlamp" combo could uniquely shut down MAPK signaling in KRASm solid tumors

TPP: target product profile; OBA: oral bioavailability; IP: intellectual property; FIC: first-in-class; BIC: best-in-class; WT: wildtype; SMi: small molecule inhibitor; MG: molecular glue; DC: development candidate

[1] in vitro potency assessed by CTG 2D and 3D-cell proliferation assay IC_{50}s; [2]OBA or oral bioavailability assessed by %F; [3]Predicted based on molecular profile; [4] absent any patent term adjustments or extensions

ERASCA

ERAS-0015 and ERAS-4001 exhibit competitive profiles that exceed our TPP

ERAS-0015
Pan-RAS
Molecular Glue

Best-in-class potential for RASm solid tumors

- ~5x – 10x greater potency
- Favorable ADME properties and PK performance in animals vs. Pan-RAS MG in development

ERAS-4001
Pan-KRAS
Inhibitor

First-in-class and best-in-class KRAS inhibitor

- Designed to spare H/NRAS WT
- Greater therapeutic window predicted vs. Pan-RAS MG for KRASm solid tumors
- Designed to address KRASwt activation to prevent resistance vs. mutant-selective inhibitors

TPP = target product profile; BIC: best-in-class; FIC: first-in-class; MG: molecular glue; SM: small molecule; ADME: absorption, distribution, metabolism, and excretion; PK: pharmacokinetic

ERAS-0015's higher CYPA binding affinity may be a differentiator from RMC-6236; new data reinforces potential best-in-class profile

	Assay	Study conducted by	ERAS-0015 (nM)	RMC-6236 (nM)	Fold difference: ERAS-0015/ RMC-6236
Licensor data	SPR K_D	JOYO 嘉越 PHARMA	45.2	194	**4.3**
Erasca data	SPR K_D	ERASCA™	4.5	92	**20.5**
	ITC K_D	ERASCA™	5.3	44.1	**8.3**

Stronger binding to cyclophilin A (CYPA) may enable more potent RAS inhibition

SPR: surface plasmon resonance; K_D: equilibrium dissociation constant; ITC: isothermal titration calorimetry

ERAS-0015 demonstrated significantly more potent inhibition of cellular proliferation across KRAS mutant cell lines vs. RMC-6236

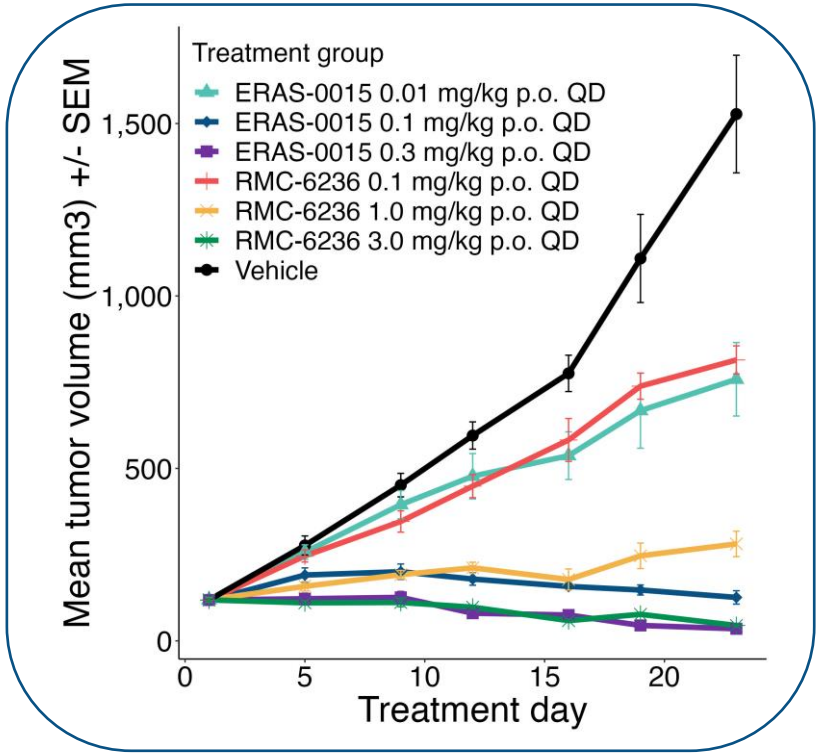
Mutation	Tumor type	Cell line	ERAS-0015 cell growth inhibition (nM)	RMC-6236 cell growth inhibition (nM)
KRAS G12C	NSCLC	H358 (adagrasib-resistant)	0.8	3.6
	NSCLC	LU99	1.4	5.4
KRAS G12D	NSCLC	A-427	13.3	59.2
	CRC	SW620	0.2	1.3
	CRC	GP2d	0.9	4.6
	PDAC	AsPc-1	2.0	26.7
	PDAC	HPAC	4.8	15.5
	PDAC	PK-59	10.7	10.7
	PDAC	KP-4	5.0	19.7
	PDAC	Panc 04.03	5.7	26.4
KRAS G12V	Lung Cancer	NCI-H727	0.4	1.7
	Lung Cancer	NCI-H441	1.4	16.7
	CRC	SW480	0.8	6.8
	PDAC	CAPAN-1	2.5	7.1
	Ovarian leiomyosarcoma	RKN	0.7	1.6
KRAS G12R	PDAC	PSN-1	5.3	17.1
KRAS G12S	NSCLC	A-549	4.1	38.3
KRAS Q61R	PDAC	Panc 02.13	7.4	44.3
KRAS G13D	CRC	LoVo	2.8	1.5
	CRC	HCT-116	5.5	26.2
KRAS WT Amplified	Gastric	MKN-1	13.8	55.8
EGFR L858R / T790M	NSCLC	H1975	6.5	11.4
MET amplified	NSCLC	EBC-1	4.4	16.9
BRAF V600E	Melanoma	A375	>6,000	>6,000

Sub-nM to nM potency against multiple KRAS wildtype and mutant cell lines and RTK altered cell lines

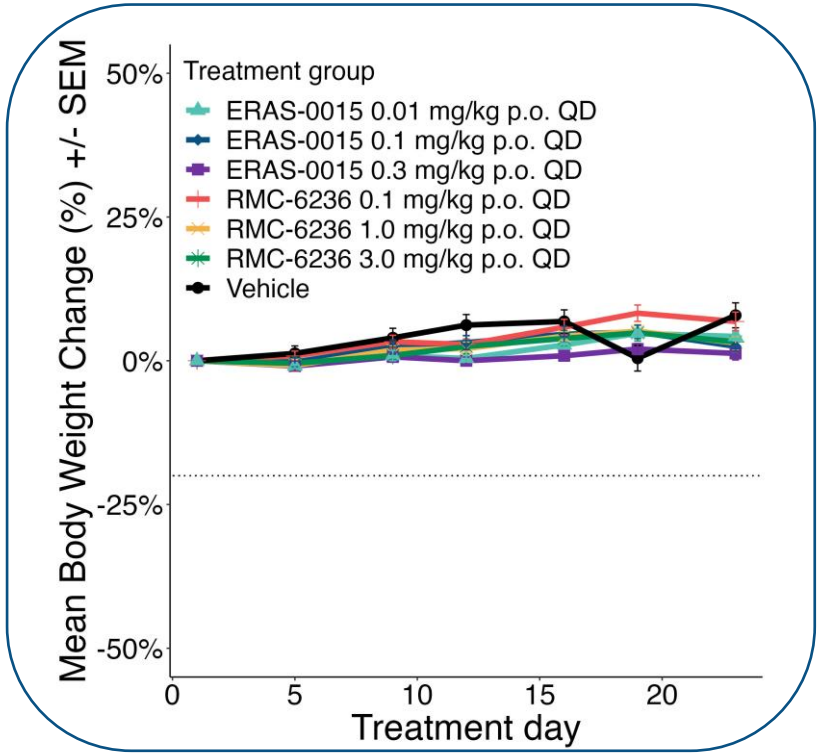
RTK = receptor tyrosine kinase

ERAS-0015: 10x higher potency than RMC-6236; achieved tumor regression in a KRAS G12D PDAC CDX model

TGI in KRAS G12D CDX PK-59



% BWC in KRAS G12D CDX PK-59

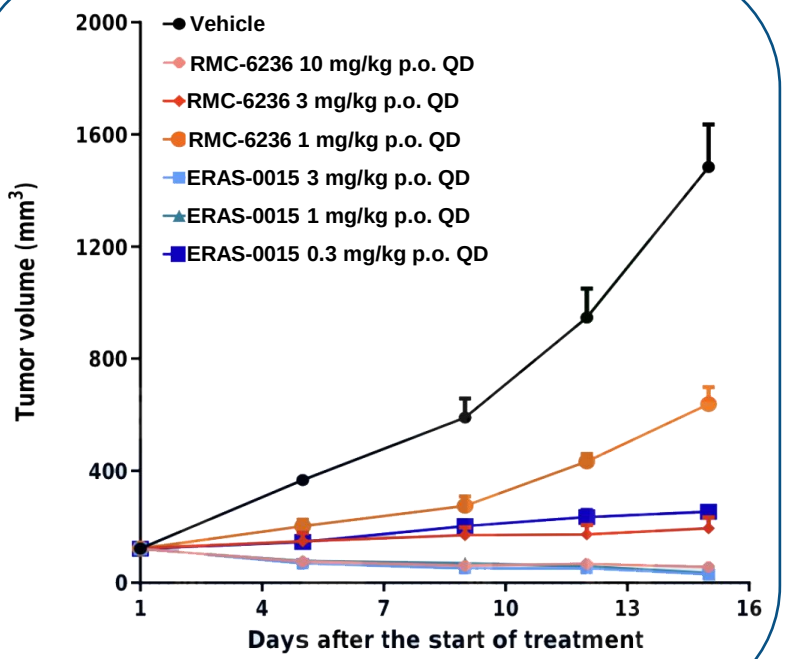


- ERAS-0015 achieved comparable tumor regression to RMC-6236 in this model at 1/10th of the dose and as low as 0.1 mg/kg p.o.
- No dose reductions or holidays and no body weight loss for all doses of ERAS-0015

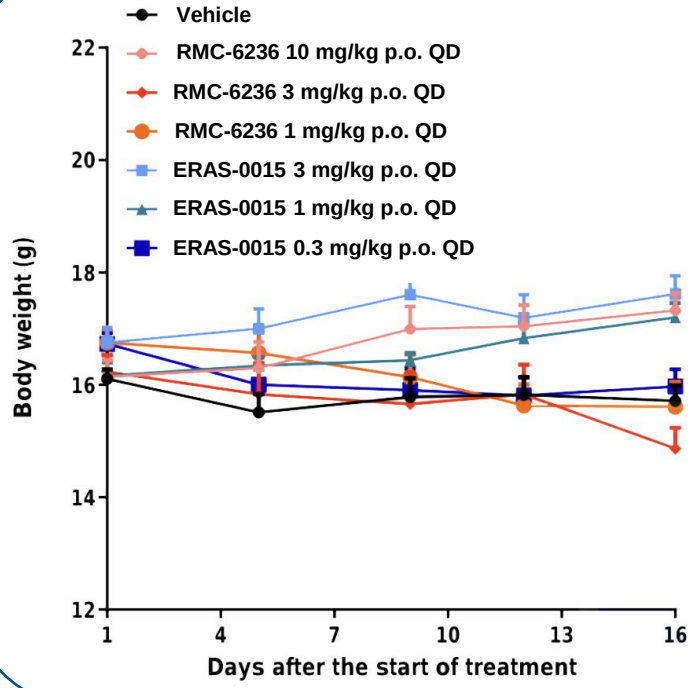
p.o.: orally administered; QD: once daily; CDX: cell line-derived xenograft; TGI: tumor growth inhibition; BWC: body weight change

ERAS-0015: 10x higher potency than RMC-6236; achieved tumor regression in an insensitive KRAS G12V NSCLC CDX model

TGI in NCI-H727



Body weight in NCI-H727



Preliminary TGI Summary

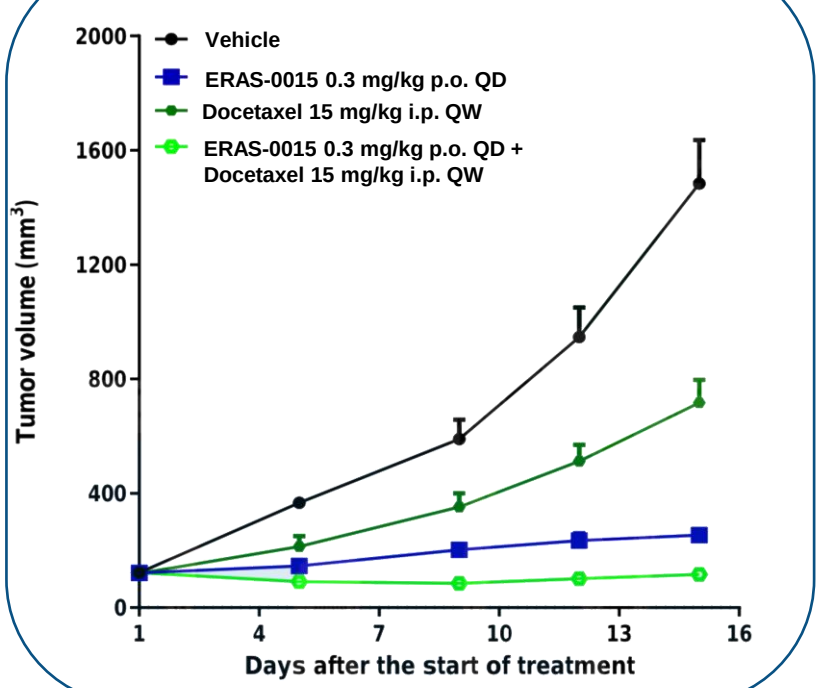
Therapy	Dose	TGI on day 15
ERAS-0015	0.3 mg/kg	90%
	1 mg/kg	106%
	3 mg/kg	107%
RMC-6236	1 mg/kg	62%
	3 mg/kg	95%
	10 mg/kg	105%

- Up to day 15 data shown in an ongoing TGI study
- ERAS-0015 tumor regression observed at 1mg/kg p.o. QD
- ERAS-0015 was well tolerated at all doses

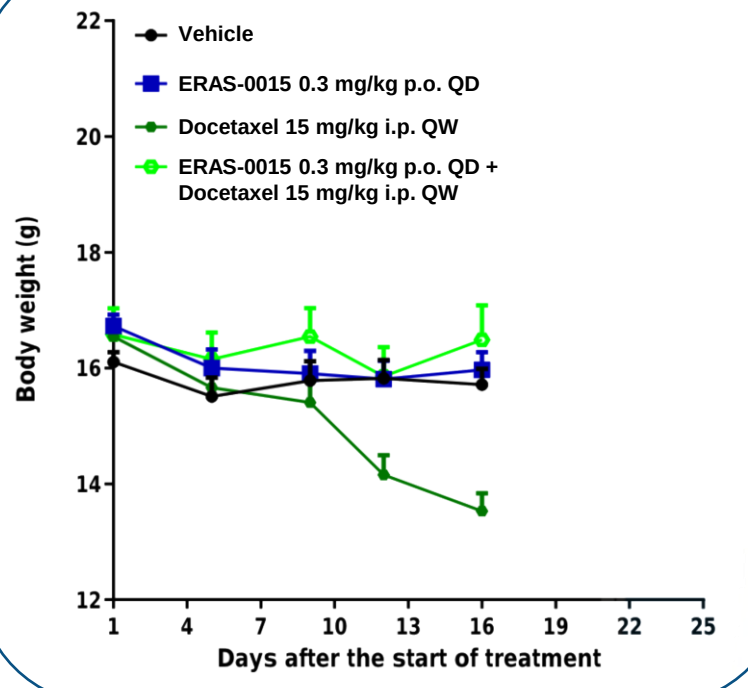
p.o.: orally administered; QD: once daily; CDX: cell line-derived xenograft; TGI: tumor growth inhibition

ERAS-0015 + docetaxel: Combination benefit and tolerability in an insensitive KRAS G12V NSCLC CDX model

TGI in NCI-H727



Body weight in NCI-H727



Preliminary TGI Summary

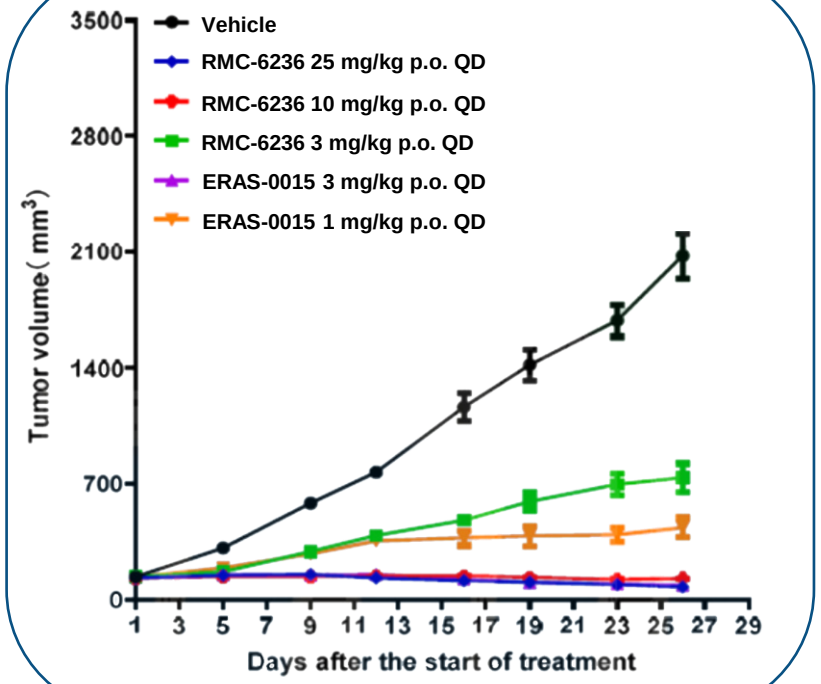
Therapy	Dose	TGI on day 15
ERAS-0015	0.3 mg/kg	90%
Docetaxel	15 mg/kg	56%
ERAS-0015 + docetaxel	0.3 mg/kg + 15 mg/kg	101%

- Up to day 15 data shown in an ongoing TGI study
- ERAS-0015 was well tolerated in combination with docetaxel

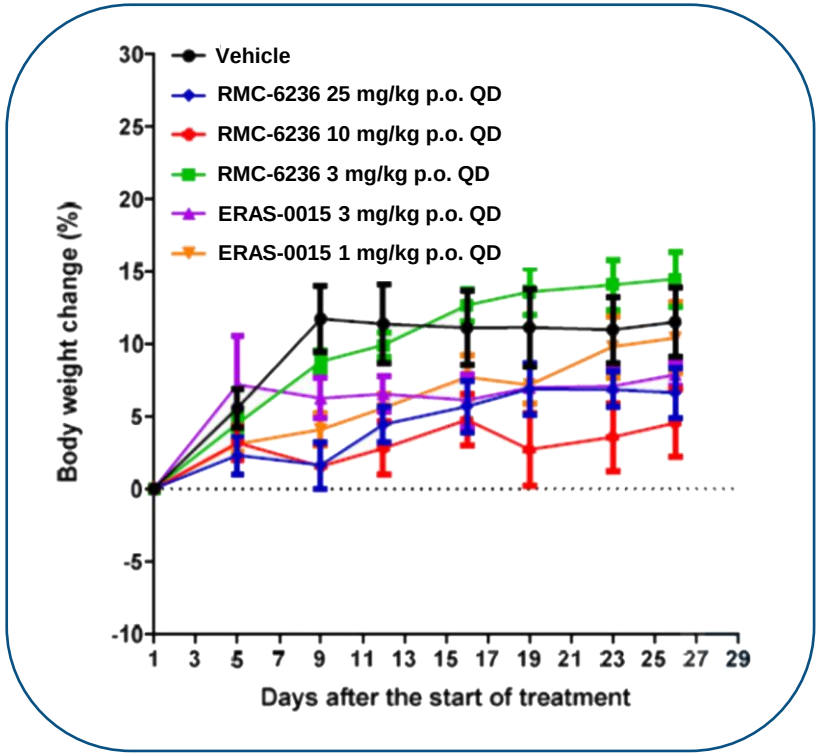
p.o.: orally administered; i.p. intraperitoneal; QD: once daily; QW: once weekly; CDX: cell line-derived xenograft; TGI: tumor growth inhibition

ERAS-0015: Achieved comparable tumor regression to RMC-6236 in a KRAS G12V CRC CDX model at a lower dose

TGI in KRAS G12V CDX SW620



% BWC in KRAS G12V CDX SW620



TGI Summary

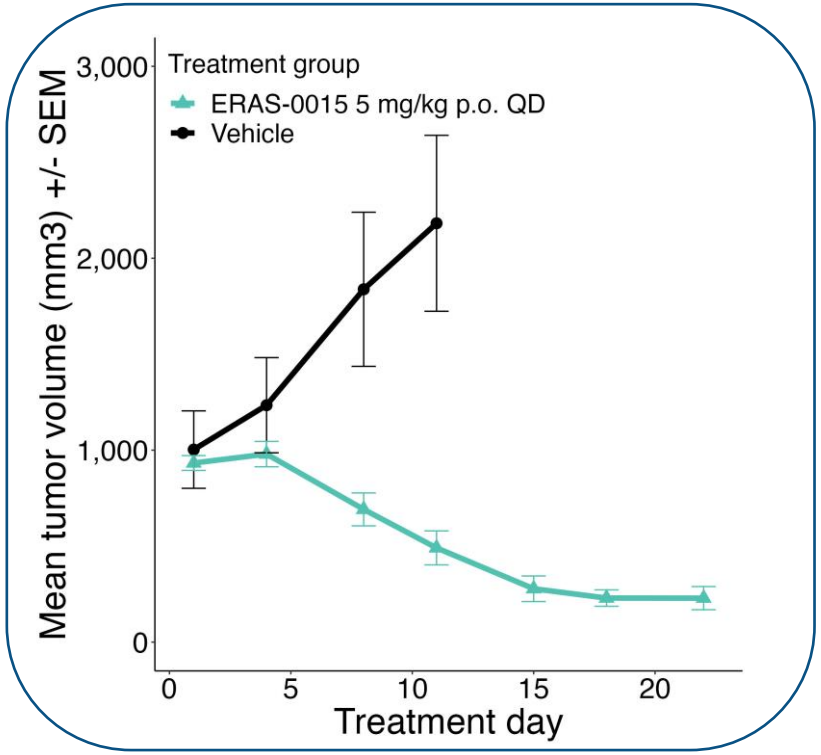
Therapy	Dose	TGI
ERAS-0015	1 mg/kg	85%
	3 mg/kg	102%
RMC-6236	3 mg/kg	69%
	10 mg/kg	100%
	25 mg/kg	103%

- Comparable tumor regression observed for ERAS-015 at 3 mg/kg p.o. QD compared to RMC-6236 at 10 – 25 mg/kg p.o. QD
- No dose reductions, holidays, or body weight loss

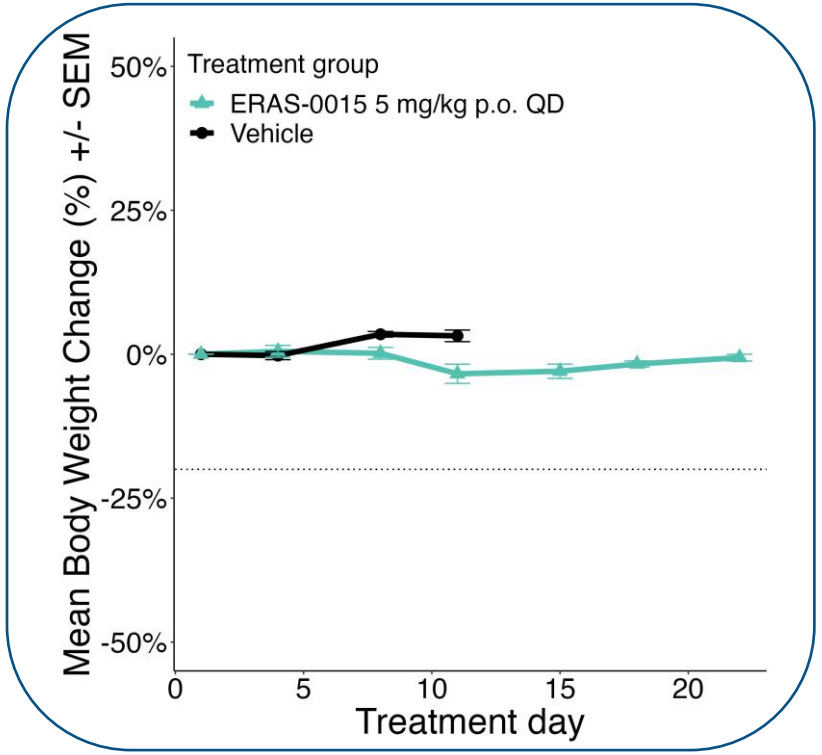
p.o.: orally administered; QD: once daily; CDX: cell line-derived xenograft; TGI: tumor growth inhibition; BWC: body weight change

ERAS-0015: Achieved tumor regression in a KRAS G12R PDAC CDX model

TGI in KRAS G12R CDX PSN-1



% BWC in KRAS G12R CDX PSN-1

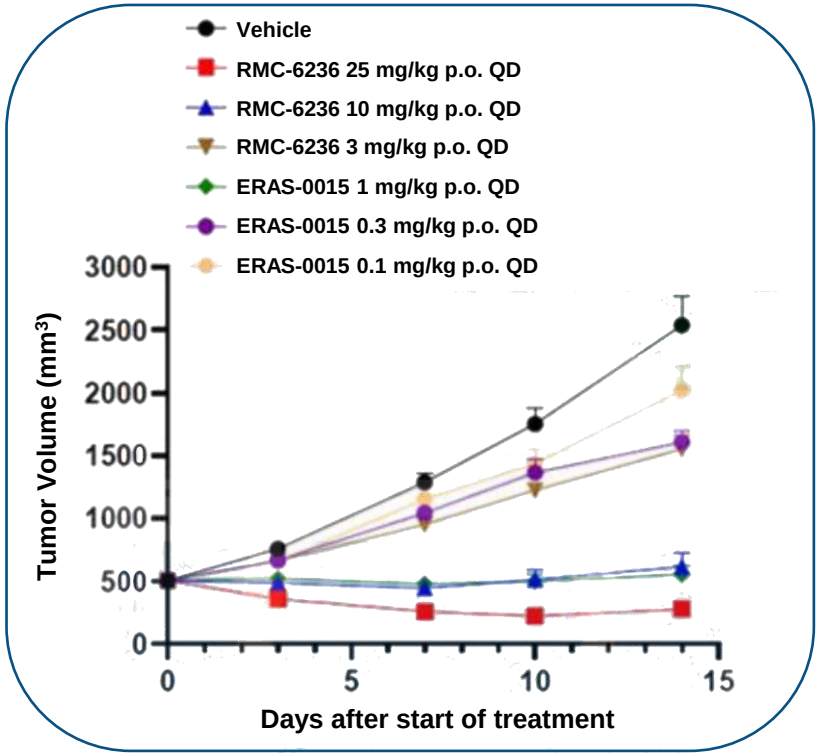


- ERAS-0015 tumor regression observed at 5 mg/kg p.o. QD
- No dose reductions or holidays and body weight loss < 1% for ERAS-0015 at 5 mg/kg p.o. QD

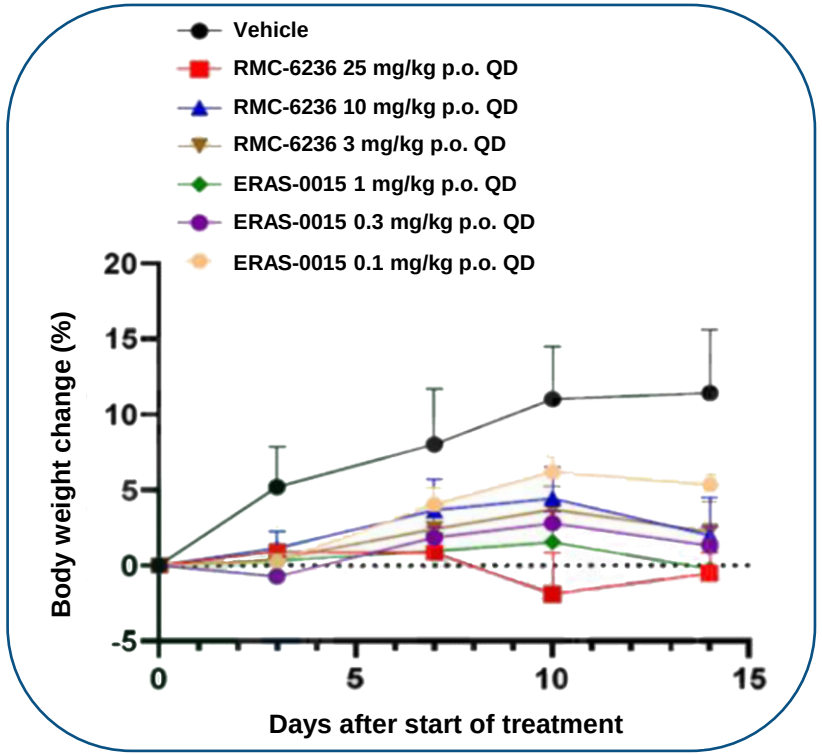
p.o.: orally administered; QD: once daily; CDX: cell line-derived xenograft; TGI: tumor growth inhibition; BWC: body weight change

ERAS-0015: Comparable TGI to RMC-6236 in a KRAS G12R PDAC CDX model at ~one-tenth the dose

TGI in KRAS G12R CDX PSN-1



% BWC in KRAS G12R CDX PSN-1



TGI Summary

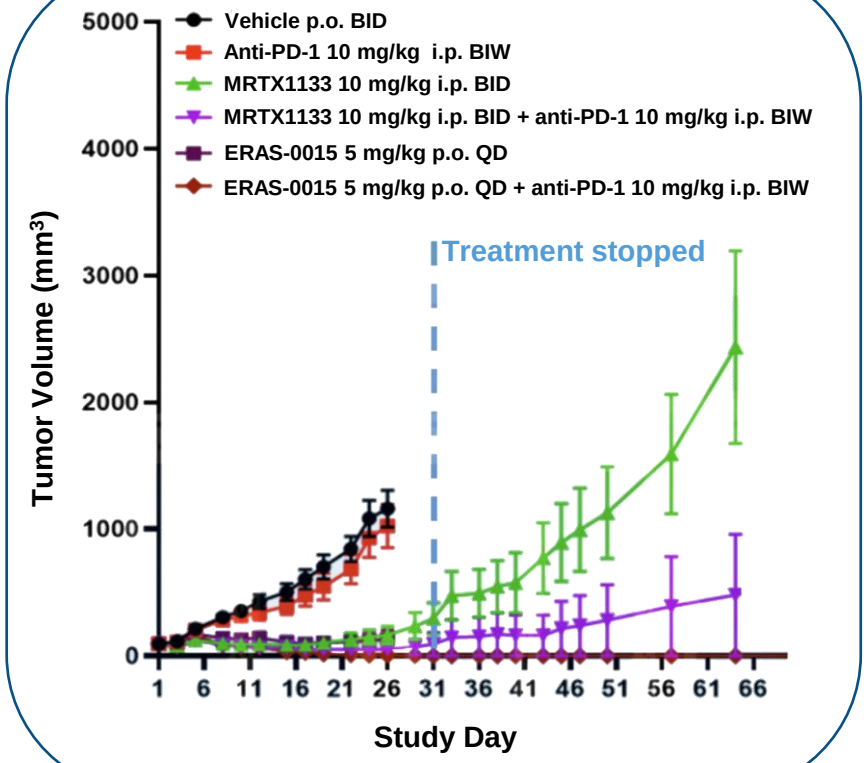
Therapy	Dose	TGI
ERAS-0015	0.1 mg/kg	25%
	0.3 mg/kg	46%
	1 mg/kg	97%
RMC-6236	3 mg/kg	49%
	10 mg/kg	95%
	25 mg/kg	111%

- ERAS-0015 achieved comparable tumor regression to RMC-6236 at 1/10th the dose
- No dose reductions or holidays and body weight loss < 2% for ERAS-0015

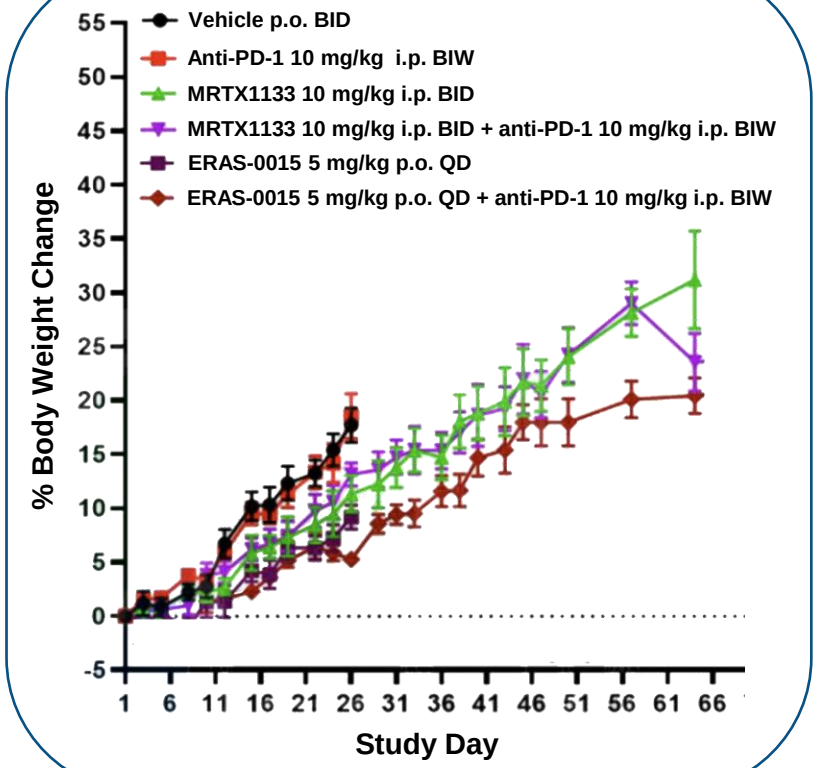
p.o.: orally administered; QD: once daily; CDX: cell line-derived xenograft; TGI: tumor growth inhibition; BWC: body weight change

ERAS-0015 + anti-PD-1: Compelling combination benefit in a syngeneic KRAS G12D PDAC model

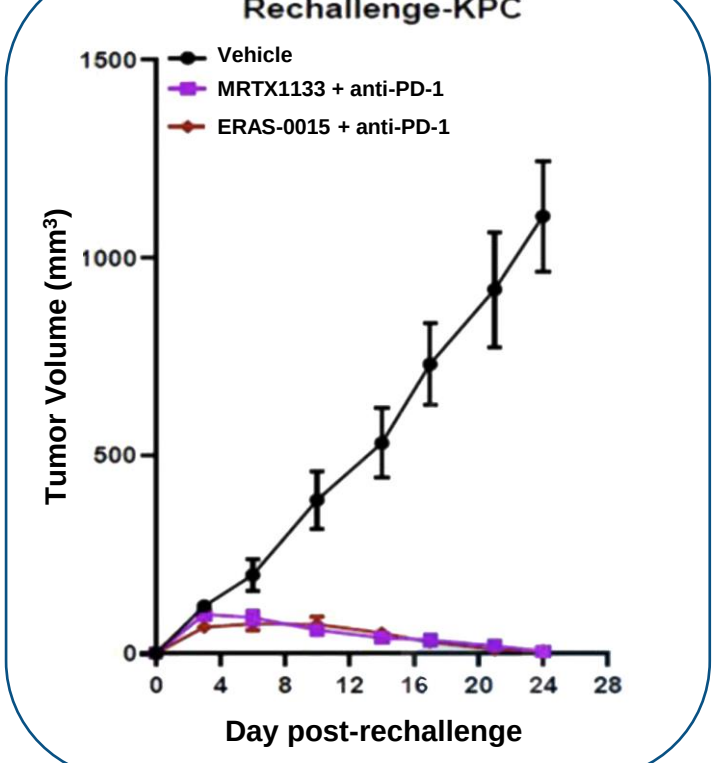
TGI in syngeneic KRAS G12D CDX KPC



% Body Weight Change



TGI after rechallenge of KPC tumor cells

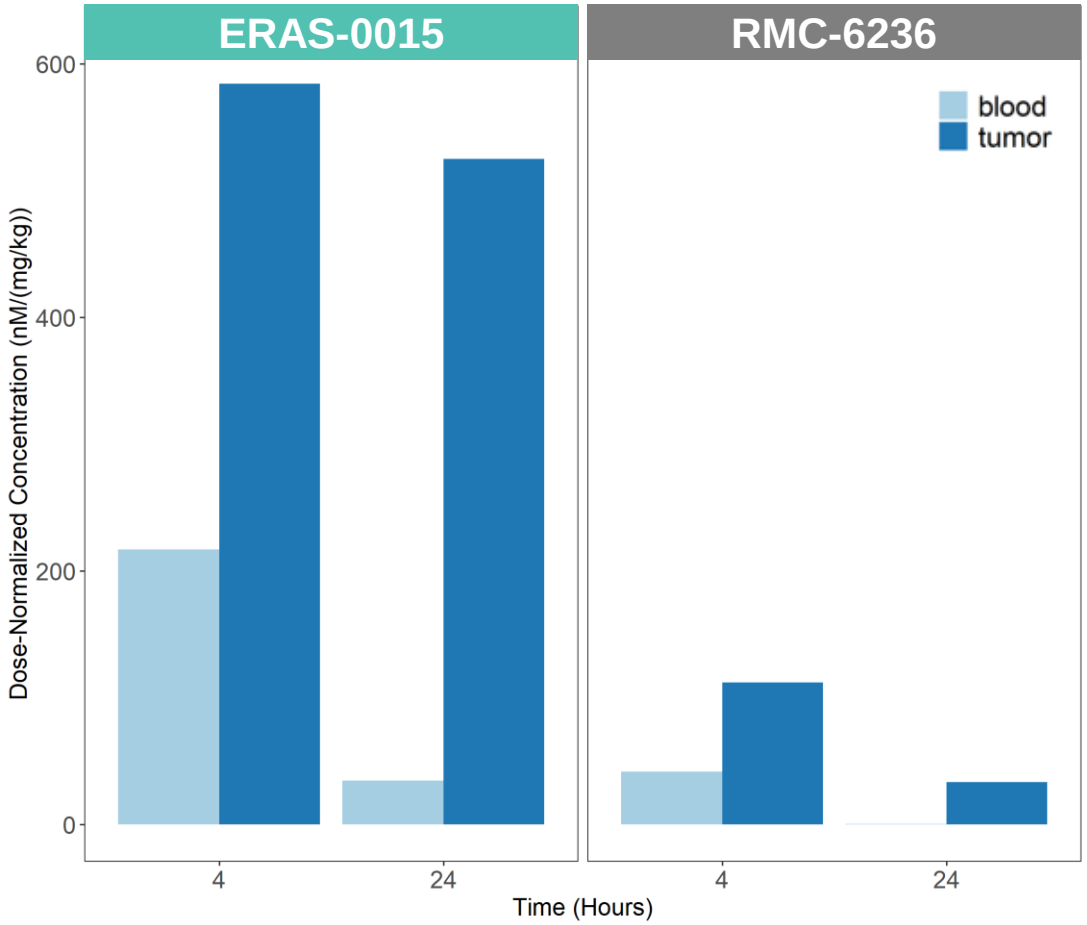


- ERAS-0015 in combination with anti-PD-1 therapy resulted in complete response in 7 out of 7 treated mice on day 31
- ERAS-0015 as a monotherapy and in combination with an anti-PD-1 was well tolerated
- Tumor formation was not observed up to 24 days after KPC rechallenge

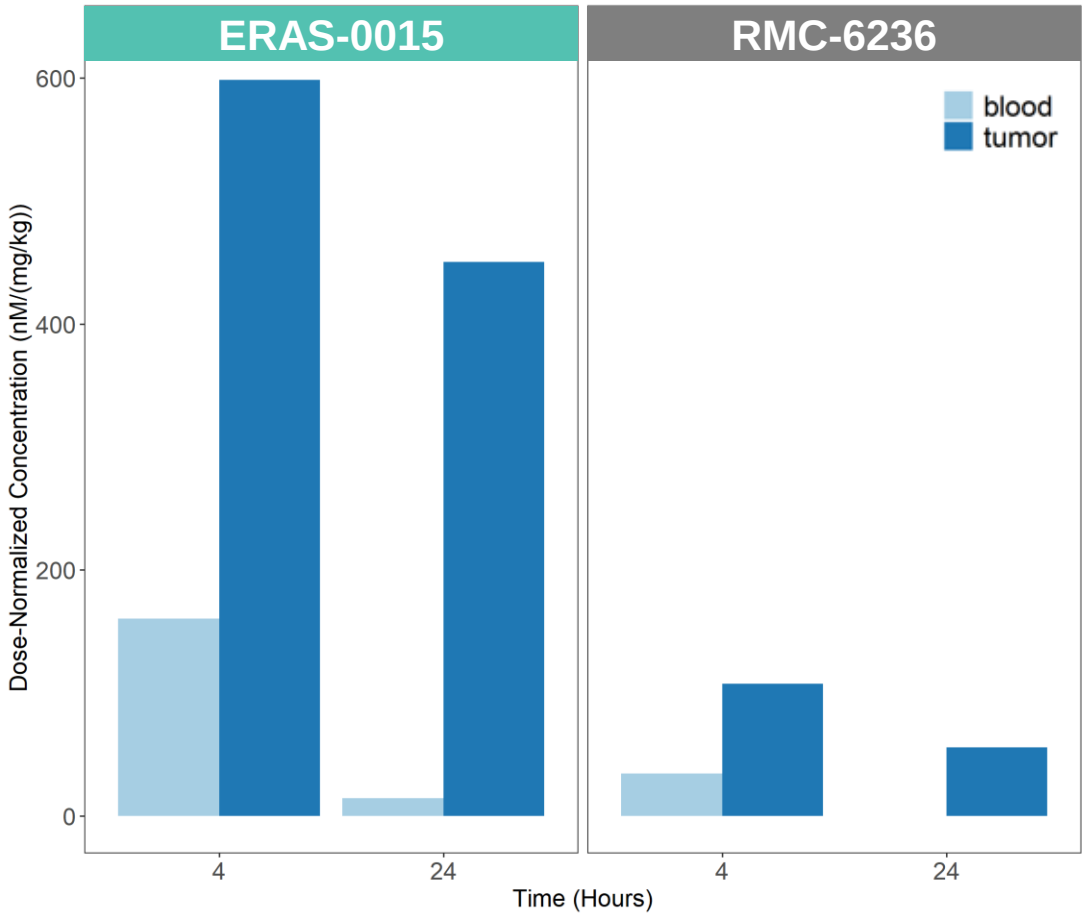
p.o.: orally administered; BIW: twice a week; BID: twice a day; QD: once daily; CDX: cell line-derived xenograft; TGI: tumor growth inhibition; BWC: body weight change

ERAS-0015 demonstrated preferential tumor distribution and longer residence time vs. RMC-6236 in vivo

Tumor PK Distribution Assessment in the KRAS G12D PDAC CDX Model, PK-59



Tumor PK Distribution Assessment in the KRAS G12R PDAC CDX Model, PSN-1



PDAC: pancreatic ductal adenocarcinoma; CDX: cell-line derived xenograft

ERAS-0015 showed promising IV and oral PK in mouse, rat, dog, and monkey

		Mouse		Rat		Dog		Monkey	
		ERAS-0015	RMC-6236	ERAS-0015	RMC-6236	ERAS-0015	RMC-6236	ERAS-0015	RMC-6236
IV	Dose (mpk)	1	1	1	1	1	1	1	No Data
	$T_{1/2}$ (h)	5.0	1.7	5.7	1.5	24.5	7.6	15.2	No Data
	Vd_{ss} (L/kg)	5.3	1.9	1.9	1.9	3.8	3.7	1.8	No Data
	Cl (mL/Kg/min)	12.8	15.6	4.6	19.2	1.9	7.9	1.6	No Data
	$AUC_{0\text{-last}}$ (nM*h)	1,337	1,274	4,125	1,123	7,910	2,630	11,479	No Data
Oral	Dose (mpk)	10	10	10	10	5	5	5	No Data
	C_{max} (nM)	745	1,443	1,620	339	472	377	723	No Data
	$T_{1/2}$ (h)	6.3	1	6.1	2.5	22.4	7.8	12.3	No Data
	$AUC_{0\text{-last}}$	6,786	4,467	15,213	1,427	8,720	2,755	10,004	No Data
	Bioavailability (F %)	48%	33%	38%	14%	22%	21%	17%	No Data

ERAS-0015 demonstrated good overall ADME properties *in vitro*

Assay	Value
Kinetic Solubility (FaSSIF, FeSSIF) (µg/mL)	127, 156
MDR1(A/B,B/A ER)	0.3, 1.7, 5.5
PPB (% Unbound)	0.4 (h), 2.1 (c), 0.4 (d), 0.2 (r), 0.6 (m)
WBS $T_{1/2}$(min)	>289 (h), >289 (d), >289 (r), >289 (m)
BPR, $K_{B/P}$	3.5 (h), 14.2 (c), 1.7 (d), 3.0 (r), 5.3 (m)
MMS(CL_{int} (liver)(mL/min/kg)	87 (h), 287 (c), 23 (d), 31 (r), 197 (m)
HMS(CL_{int} (liver)(mL/min/kg)	51 (h), 272 (c), 73 (d), 104 (r), 408 (m)
CYP450 IC50 (µM) 1A2 / 2C9 / 2C19 / 2D6 / 3A4	50, 1.3, 25, 50, 4.4
hERG (IC_{50} µM) Manual patch	> 10

ERAS-0015 and ERAS-4001 exhibit competitive profiles that exceed our TPP

ERAS-0015
Pan-RAS
Molecular Glue

Best-in-class potential for RASm solid tumors

- ~5x – 10x greater potency
- Favorable ADME properties and PK performance in animals vs. Pan-RAS MG in development

ERAS-4001
Pan-KRAS
Inhibitor

First-in-class and best-in-class KRAS inhibitor

- Designed to spare H/NRAS WT
- Greater therapeutic window predicted vs. Pan-RAS MG for KRASm solid tumors
- Designed to address KRASwt activation to prevent resistance vs. mutant-selective inhibitors

TPP = target product profile; BIC: best-in-class; FIC: first-in-class; MG: molecular glue; SM: small molecule; ADME: absorption, distribution, metabolism, and excretion; PK: pharmacokinetic

ERAS-4001 selectively bound KRAS with high affinities, long residence times

SPR-based kinetic biophysical binding characterization of ERAS-4001

Target	KD (nM)	$t_{1/2}$ (s)
KRAS G12D	0.0006	273,079
KRAS G12V	0.0069	30,159
KRAS G12C	0.016	7,724
KRAS WT	0.058	3,409
HRAS WT	117	18.1
NRAS WT	2,660	1.2

ERAS-4001 potently and selectivity inhibited cellular viability in KRAS G12X, G13D and WT cell lines

KRAS Mutation	Tumor type	Cell line	ERAS-4001 cell growth inhibition (nM)
KRAS G12D	Pancreatic	AsPC-1	1.8
	Pancreatic	Panc 04.03	1.9
	Pancreatic	HPAC	1.0
	Pancreatic	PK-59	2.6
KRAS G12V	Lung	NCI-H727	3.5
	Lung	NCI-H441	0.7
	Ovary	RKN	2.3
	Colorectal	SW620	9.1
KRAS G12C	Lung	LU99	2.7
	Pancreatic	MIA PaCa-2	1.1
	Lung	NCI-H2030	4.5
KRAS G12A	Multiple Myeloma	RPMI-8226	6.5
	Lung	NCI-H1573	37.7
KRAS G13D	Colorectal	LoVo	5.8
	Colorectal	HCT-116	56
KRAS WT	Lung	NCI-H1975	10.8
	Stomach	MKN-1	3.6
KRAS Independent	Melanoma	A375	>2,000
	Lung	NCI-H226	3,497

ERASCA

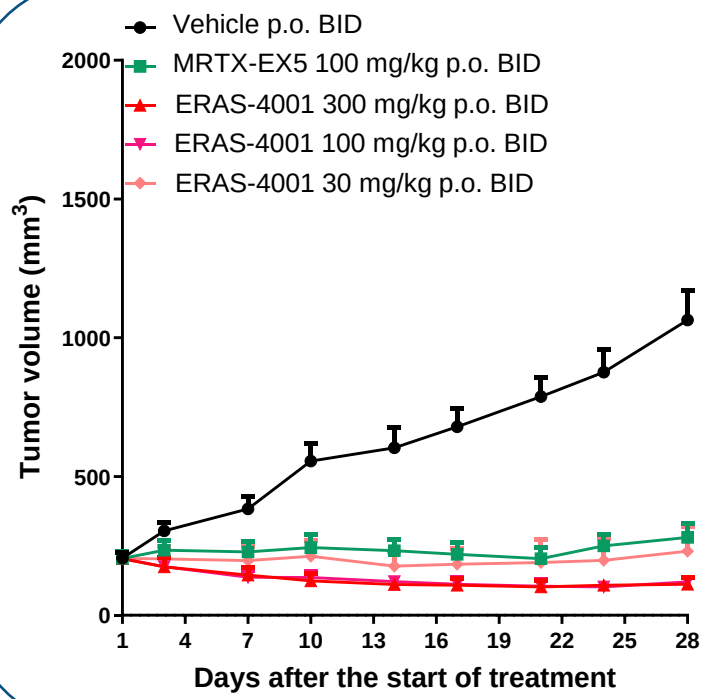
ERAS-4001 showed potent activity against both GTP- and GDP-bound KRAS

Assay Class	Assay	Target	ERAS-4001 IC50 (nM)
Biochemical Functional	RAS-RAF Binding Assay (RBD)	RBD KRAS G12D GDP	1.6
		RBD KRAS G12D GMPPNP*	6.8

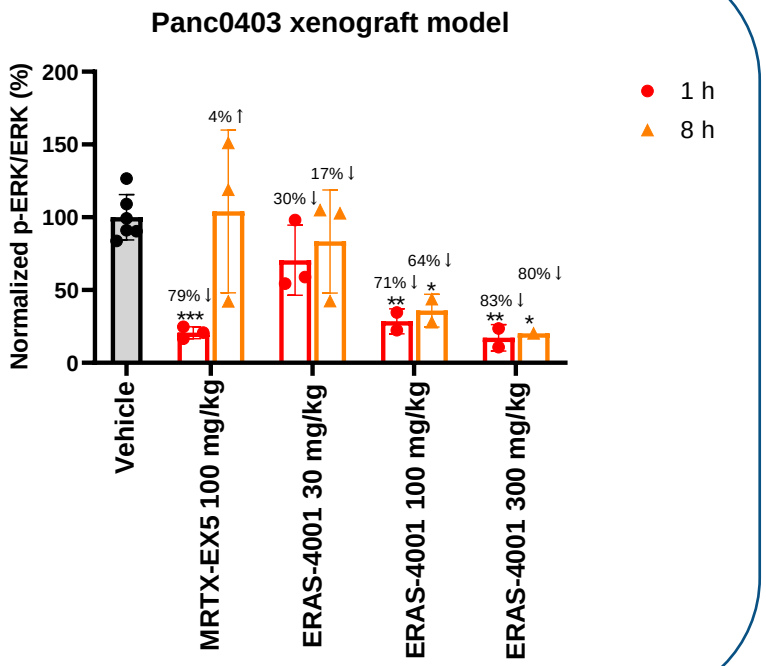
* GMPPNP is a nonhydrolyzable GTP analogue intended to approximate GTP-bound KRAS

ERAS-4001: Dose independent inhibition of pERK and TGI in KRAS G12D PDAC CDX model

KRAS G12D CDX Panc 04.03
TGI curves from 28 day repeat dose study



KRAS G12D CDX Panc 04.03
pERK inhibition after single dose (day 29)



Mouse plasma PK, single dose (day 29)

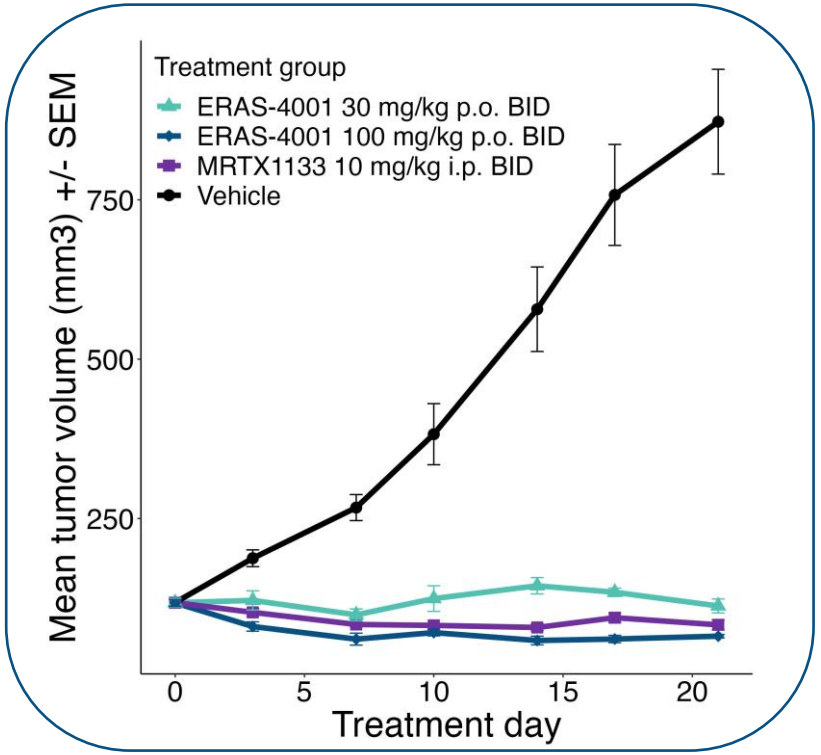
PK parameters	30 mpk p.o.	100 mpk p.o.	300 mpk p.o.
C_{max} (nmol/L)	288	1,206	1,204
$AUC_{0\text{-last}}$ (nmol/L·h)	1,547	5,153	12,971

- MRTX-EX5 represents an orally bioavailable pan-KRAS tool inhibitor disclosed in a Mirati patent
- ERAS-4001 was well tolerated at doses up to 300 mg/kg BID for 28 days (i.e., no dose reductions or holidays; no body weight loss or significant health observations)

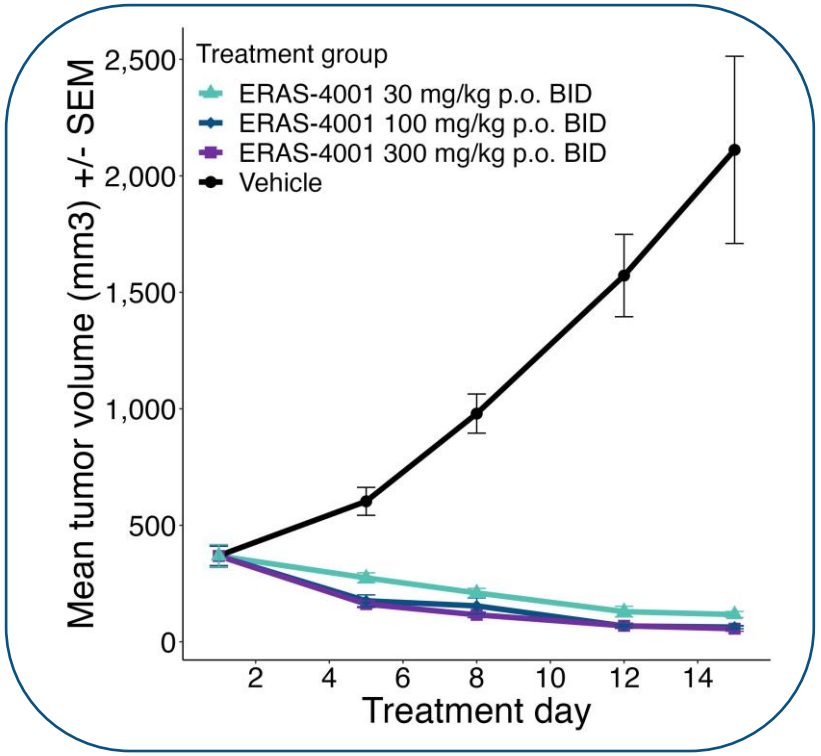
p.o.: orally administered; BID: twice a day; CDX: cell line-derived xenograft; TGI: tumor growth inhibition

ERAS-4001: Achieved tumor regressions in additional KRAS G12X CDX models at doses as low as 30 mg/kg BID

TGI in KRAS G12D PDAC CDX PK-59



TGI in KRAS G12V Ovarian CDX RKN

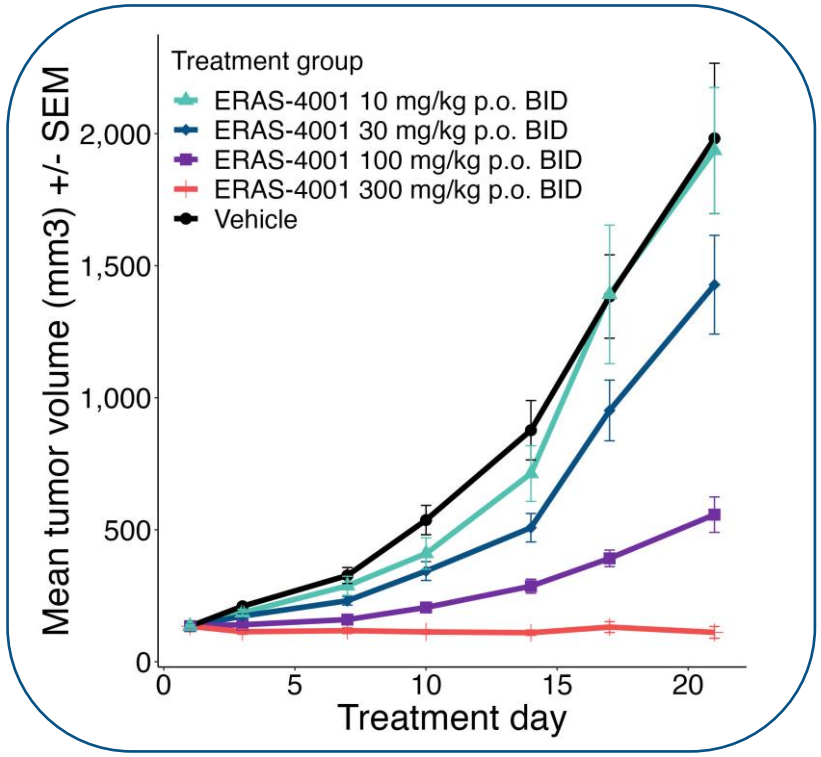


- ERAS-4001 was well tolerated in both studies at doses up to 300 mg/kg BID (i.e., no dose reductions or holidays; no body weight loss or significant health observations)

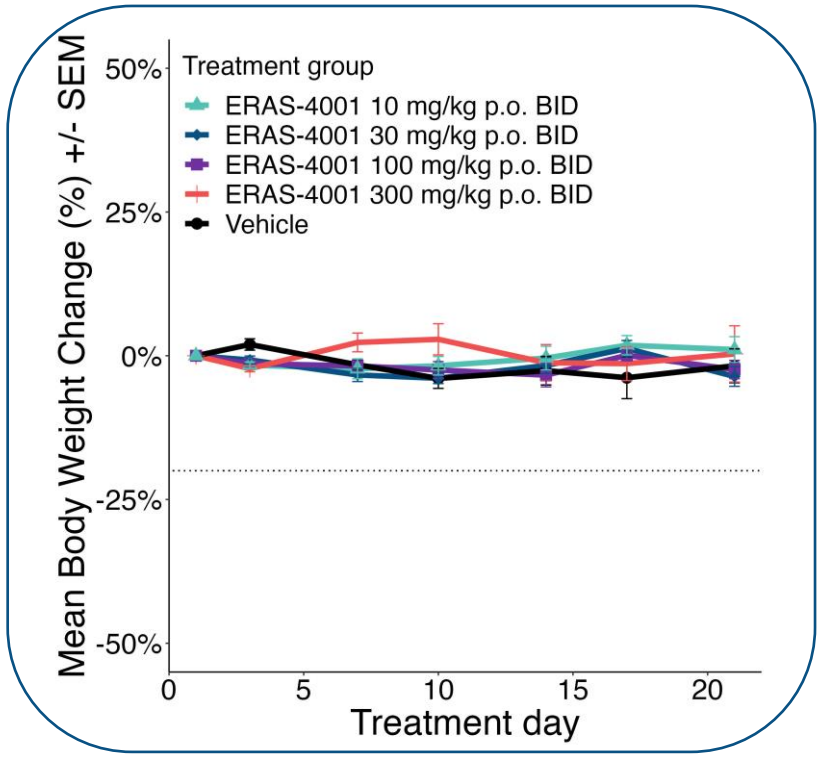
p.o.: orally administered; BID: twice a day; CDX: cell line-derived xenograft; TGI: tumor growth inhibition

ERAS-4001: Achieved tumor regression in a pan-KRASi insensitive KRAS G12V NSCLC CDX model

TGI in KRAS G12V CDX NCI-H727



% BWC in KRAS G12V CDX NCI-H727

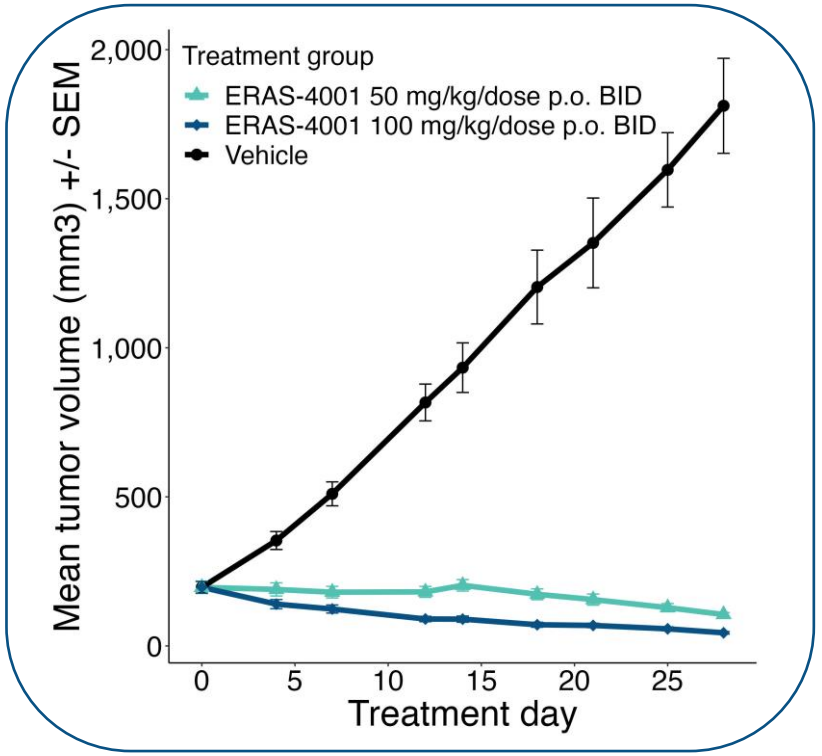


- ERAS-4001 was well tolerated at doses ranging from 10 mg/kg p.o. BID to 100 mg/kg p.o. BID (i.e., no dose holidays or mortality)
- ERAS-4001 at 300 mg/kg p.o. BID showed borderline tolerability with 4 out of 6 mice receiving continuous treatment, one mouse receiving a dose holiday due to body weight loss on days 16-21, and one mouse death on day 13
- Observed borderline tolerability may be model and/or study specific; ERAS-4001 at 300 mg/kg p.o. BID was well tolerated in the Panc 04.03 CDX TGI study (no dose holidays or mortality)

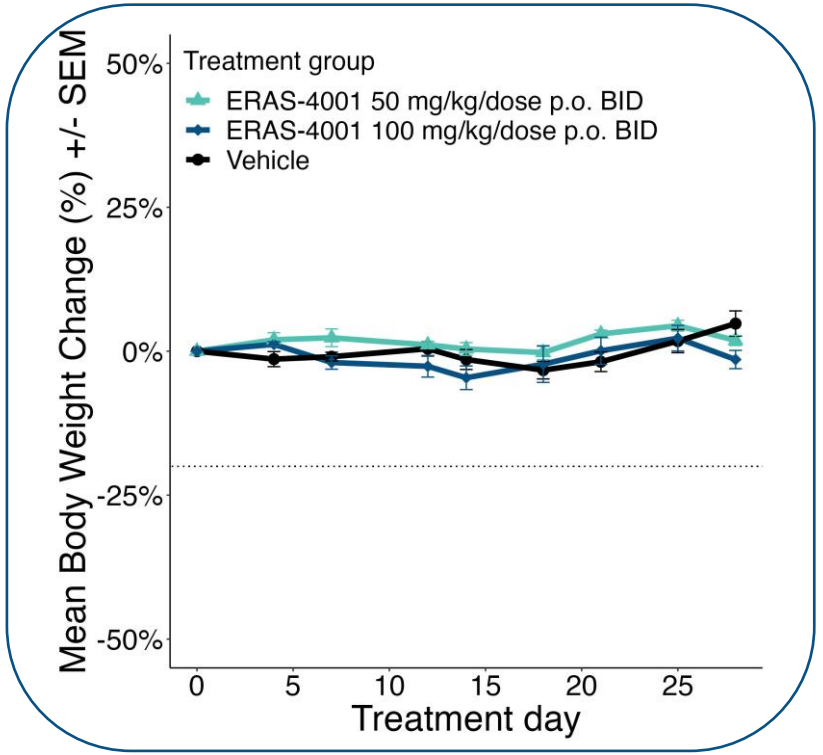
p.o.: orally administered; BID: twice a day; CDX: cell line-derived xenograft; TGI: tumor growth inhibition

Under MTA, Erasca reproduced the promising in vivo activity of ERAS-4001 in KRAS G12D PDAC CDX model

TGI in KRAS G12D CDX HPAC



% BWC in KRAS G12D CDX HPAC



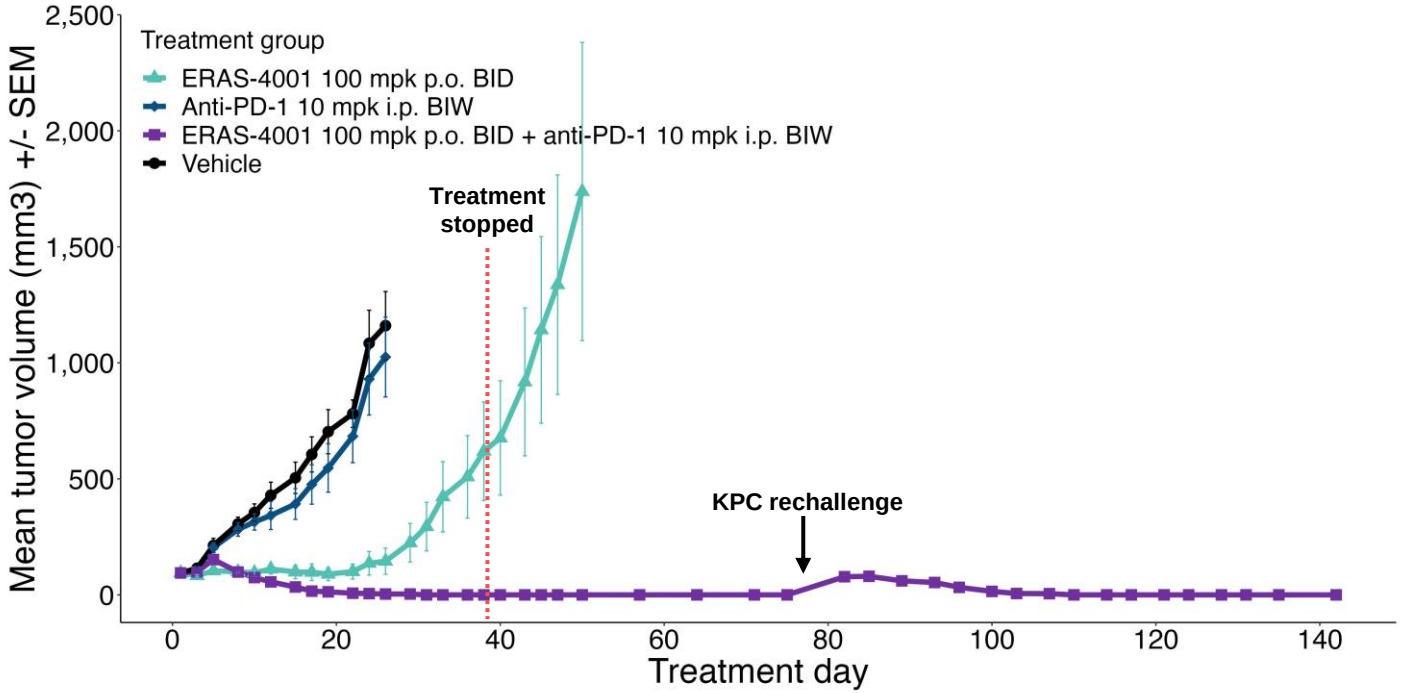
- ERAS-4001 achieved tumor regressions at 50 and 100 mg/kg p.o. BID doses, reproducing the in vivo activity previously observed in external studies
- ERAS-4001 was well tolerated at doses up to 100 mg/kg BID (i.e., no dose reductions or holidays; no body weight loss or significant health observations)

p.o.: orally administered; BID: twice a day; CDX: cell line-derived xenograft; TGI: tumor growth inhibition

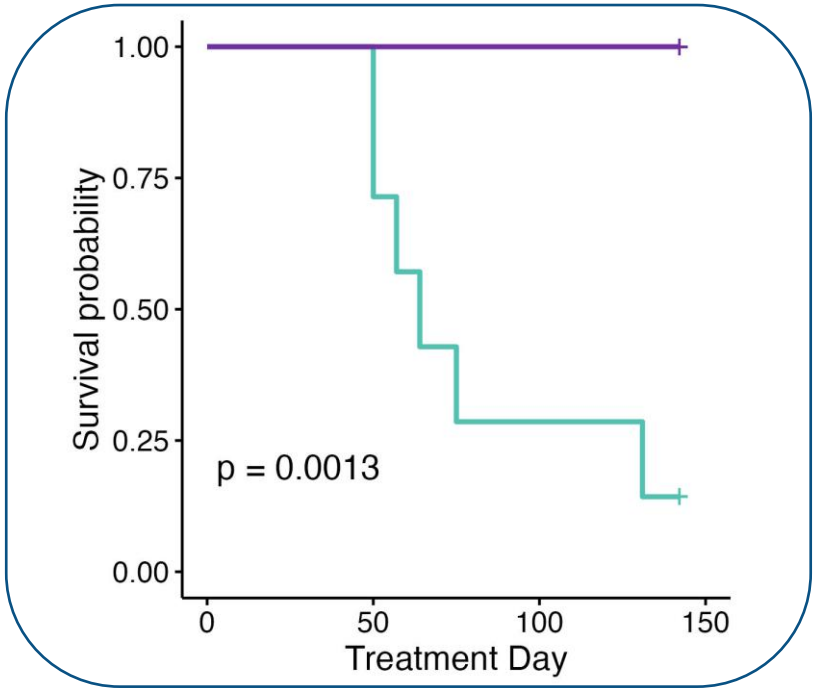
ERAS-4001 + anti-PD-1: Combination benefit in a syngeneic KRAS G12D PDAC model

TGI of ERAS-4001 +/- anti-PD-1 in KRAS G12D PDX model

Treatment stopped at day 38. KPC rechallenge demonstrated immune memory effect by a contralateral inoculation of KPC cells in combination treatment groups that resulted in tumor formation.



Survival Curves



	Anti-PD-1	ERAS-4001	Anti-PD-1 + ERAS-4001
TGI at day 26	12.7%	95.3%	108.5%
Complete response rate at day 50	0% (0/7)	29% (2/7)	100% (7/7)

p.o.: orally administered; i.p. intraperitoneally; BID: twice a day; BIW: twice a week; TGI: tumor growth inhibition

ERAS-4001 showed promising PK and oral bioavailability in mouse, rat, and dog

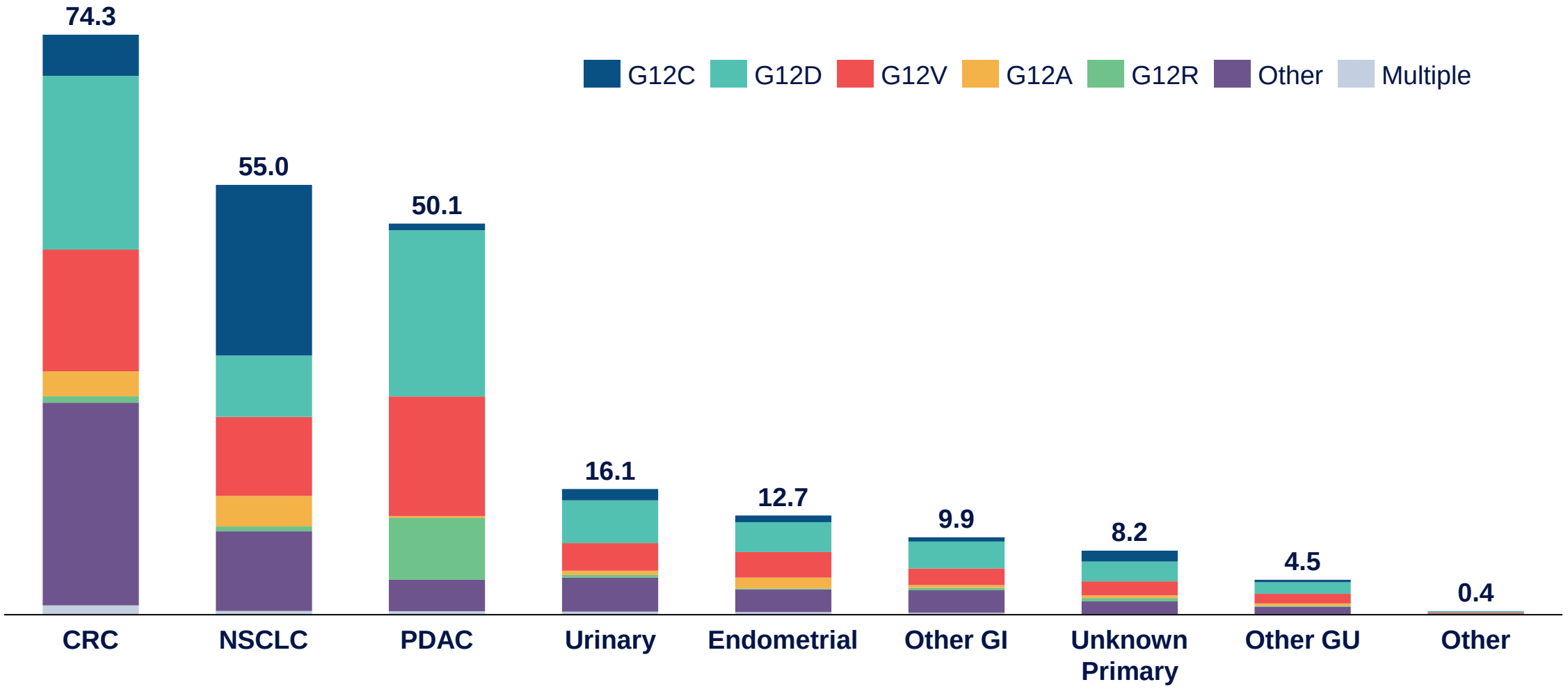
	PK Parameter	Mouse	Rat	Dog
IV	Dose (mpk)	1.7	2	2.1
	C_0 (nM)	1,722	1,083	1,669
	$T_{1/2}$ (h)	1.9	3	5.8
	V_d (L/kg)	5.16	10.1	14.1
	Cl (mL/Kg/min)	45.5	70.9	53.1
	$AUC_{0\text{-last}}$ (nM·h)	938	615	827
Oral	Dose (mpk)	30.3	30.9	15.3
	C_{max} (nM)	2,090	584	323
	T_{max} (h)	1.5	4	0.5
	$T_{1/2}$ (h)	1.5	2.3	5.4
	$AUC_{0\text{-last}}$ (nM·h)	4,498	2,562	962
	Bioavailability (F %)	27	27	16

ERAS-4001 demonstrated good overall ADME properties *in vitro*

Assay	Value
CLogP / tPSA	3.7 / 111.6
pKa / Kinetic Solubility (pH@7.4)	9.0 / 113.0 µM
PPB (Unbound %), Human/Dog/Rat/Mice	1.3 / 1.6 / 0.8 / 1.5
HMS CL_{int} (mL/min/kg), H / D / R / M	38.8 / 212.3 / 511.6 / 830
IS9 CL_{int} (mL/min/kg), H / D / R / M	<9.6 / 12.5 / - / -
MDR1 A to B (P_{app} (10^{-6} cm/s) /Efflux Ratio	0.9 / 26.7
$K_{B/P}$ H / D / M (blood/plasma)	0.6 / 0.7 / 0.9
CYP450 IC50 (µM) 1A2 / 2C9 / 2C19 / 2D6 / 3A4	>50 / 37.7 / 24.4 / 9.9 / 6.6
hERG IC_{50} (µM) / predicted hERG safety margin	~1 / 230x-740x
Mini-Ames	Negative

KRAS alterations found most commonly in CRC, PDAC and NSCLC

Estimated number of patients affected by KRAS mutant tumors in the US (thousands)



Adapted from Lee J., Sivakumar S., Schrock A., et al. “Comprehensive pan-cancer genomic landscape of KRAS altered cancers and real-world outcomes in solid tumors.” NPJ Precision Oncology, 2022. PMID: 36494601.
CRC: colorectal cancer; NSCLC: non-small cell lung cancer; PDAC: pancreatic ductal adenocarcinoma; GI: gastrointestinal; GU: genitourinary

ERASCA

Innovative CDP designed to maximize efficiency and minimize clinical and regulatory risk

01

Patients

- Focus on tumor types with largest number of potential patients to allow efficient clinical trial enrollment and potential for maximum patient benefit

02

Early combo assessment

- Parallel pursuit of monotherapy proof-of-concept & combination dose finding to expedite development

03

Data-driven

- Efficiently use clinical data to prioritize mono and combo approaches
- De-risk subsequent trials by using RWD to understand benchmarks, contribution of components

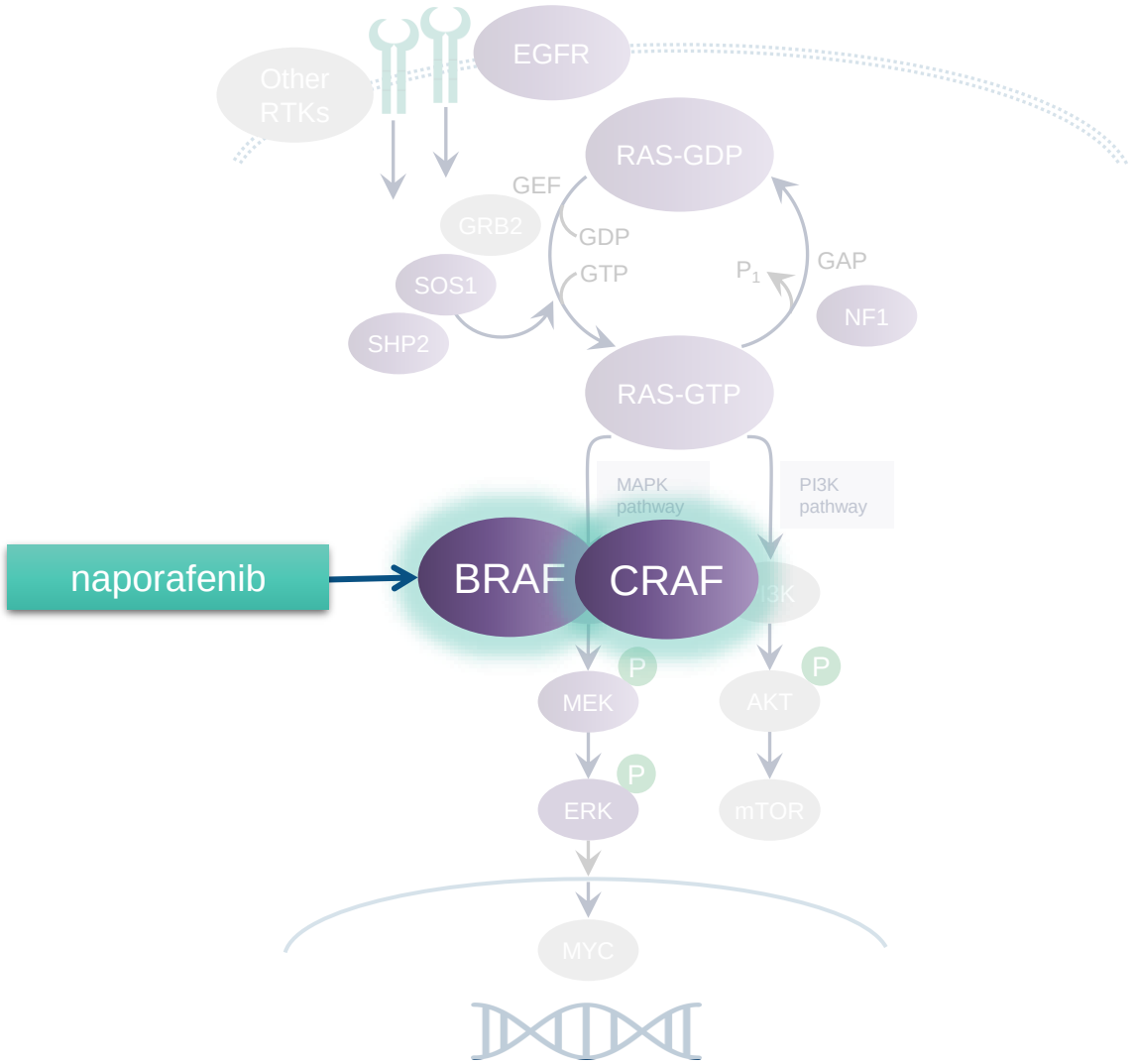
04

Portfolio

- Capitalize on unique portfolio of molecules with complementary RAS inhibitory mechanisms (S-IIP binding vs. MG) and target profiles (pan-KRAS vs. pan-RAS)

CDP: clinical development plan; RWD: real world data; MG: molecular glue; S-IIP: Switch-II pocket

Erasca's naporafenib pan-RAFi could address unmet needs in patients with both NRASm melanoma and RAS Q61X solid tumors



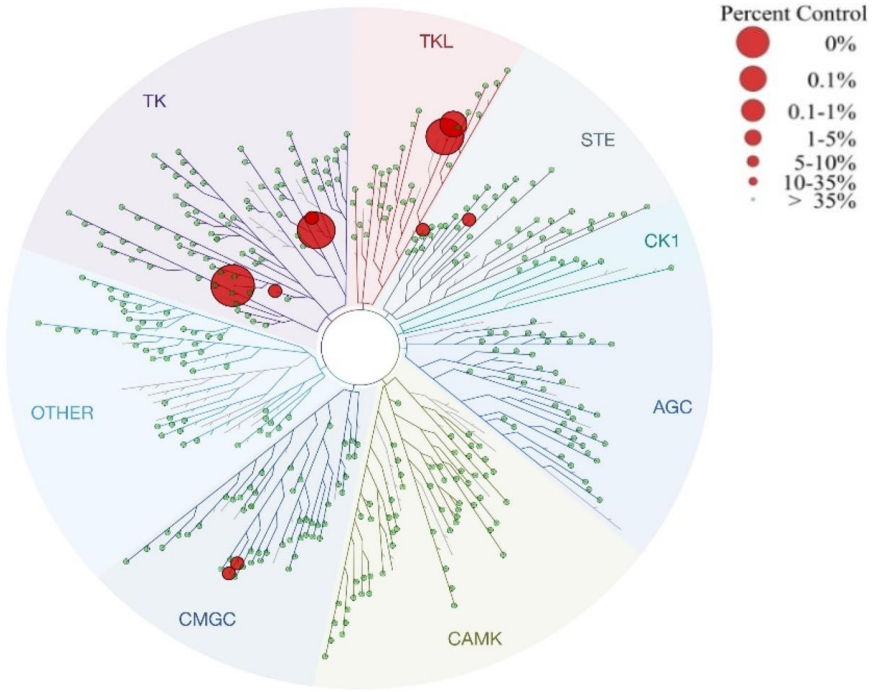
- Potently **inhibits CRAF and BRAF** and blocks downstream RAS/MAPK pathway signaling
- **Synergizes with trametinib** which targets MEK, the immediate downstream node of RAF
- Selectivity for BRAF and CRAF over ARAF is predicted to enable a **better therapeutic window**
- **Does not result in paradoxical BRAF activation**, a resistance mechanism observed with BRAF V600E inhibitors

Naporafenib is a potent and selective inhibitor of BRAF and CRAF with sub-nanomolar IC50 potency and most advanced pan-RAFi in development

Biochemical activity of naporafenib against RAF kinase family

Assay	Value (nM)
Biochemical CRAF IC50 (IC_{50})	0.1
Biochemical BRAF IC50 (IC_{50})	0.2
Biochemical ARAF Inhibition (IC_{50})	6.4

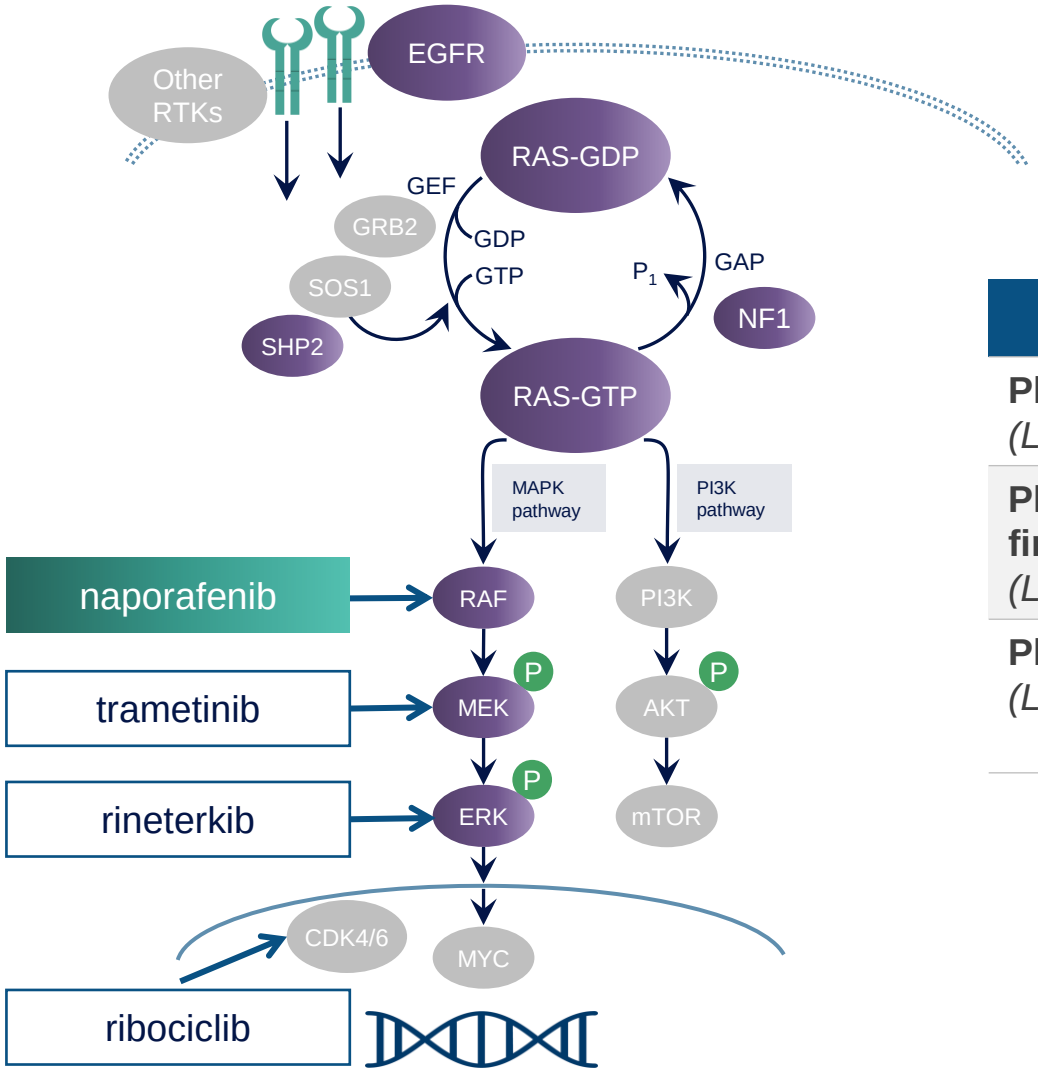
Biochemical activity of naporafenib across 456 kinases (KINOMEscan)



Source: Monaco K-A, Delach S, et al. LXH254, a Potent and Selective ARAF-Sparing Inhibitor of BRAF and CRAF for the Treatment of MAPK-Driven Tumors. 2021. PMID: 33355204; Ramurthy S, Taft BR, et al. Design and Discovery of N-(3-(2-(2-Hydroxyethoxy)-6-Morpholinopyridin-4-Yl)-4-Methylphenyl)-2-(trifluoromethyl)isonicotinamide, a Selective, Efficacious, and Well-Tolerated RAF Inhibitor Targeting RAS Mutant Cancers: The Path to the Clinic. 2020. PMID: 31059256

ERASCA

Naporafenib has been dosed in more than 500 patients to date, establishing its safety, tolerability, and preliminary PoC in multiple indications



Study (Trial #)	Description	N
Ph 1 FIH study *(LXH254X2101)*	Naporafenib dose escalation in patients with RAS/MAPK-driven solid tumors	142
Ph 1b combo dose finding *(LXH254X2102)*	Dose-finding study (+ rineterkib, trametinib, or ribociclib) in patients with NRASm melanoma, KRASm or BRAFm NSCLC	241
Ph 2 combo study *(LXH254C12201)*	Evaluating efficacy (+ rineterkib, trametinib or ribociclib) in patients with NRASm or BRAF V600X melanoma	134

Total size of safety database > 500 patients
(includes monotherapy and combinations)

PoC = proof-of concept

SEACRAFT-2: Naporafenib + trametinib has the potential to be first-in-class targeted treatment for NRASm melanoma

Standard-of-Care

NRAS mutation related to aggressive disease traits

No targeted therapy approved for NRASm melanoma

Current treatment options post-IO are dismal (see figure)

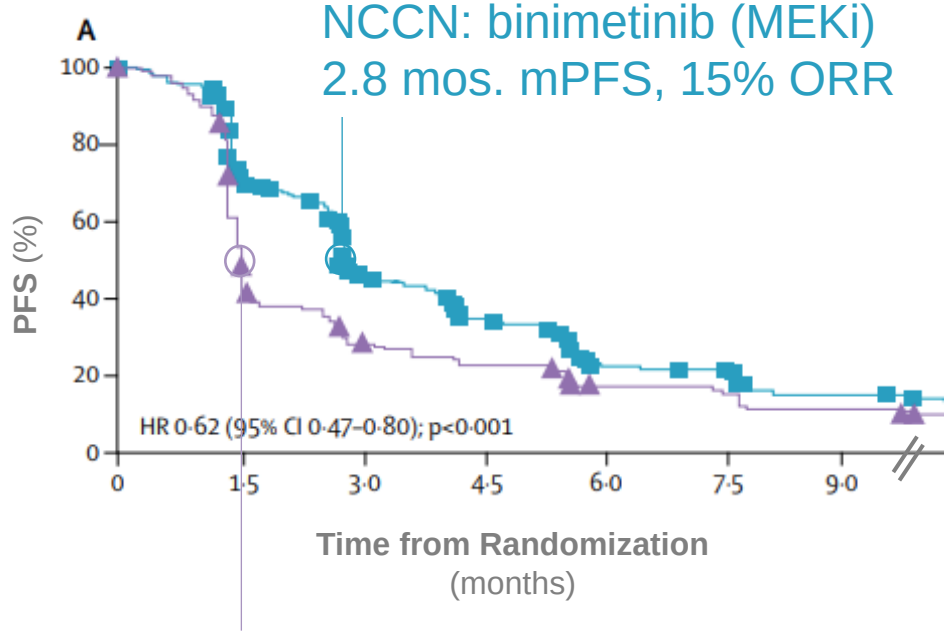
Naporafenib (pan-RAFi)

Successfully completed US, EU and UK EOP2 process for Phase 3 design

Napo + tram demonstrated compelling efficacy across Phase 1 and 2 studies (mPFS ~5 months)

FDA Fast Track Designation

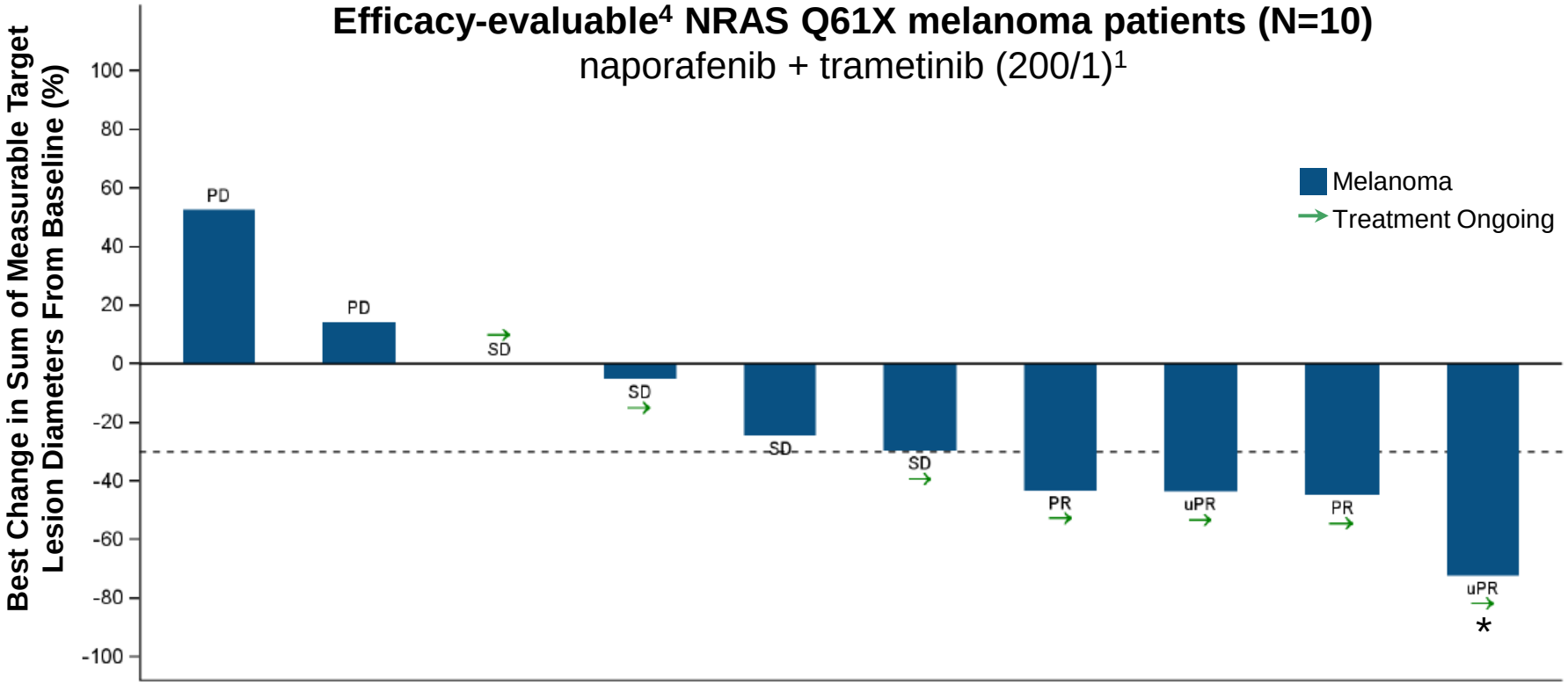
Potential to be first-to-market in NRASm melanoma



Adapted from Dummer et al. (Lancet Oncol (2017) 18:435-445)
Note: Benchmarks are most relevant for SC-2 mPFS, although study was conducted in a 1/2L setting

1 SEER Database (US) and ECIS Database (EU); AACR Genie
IO: immuno-oncology treatment; ORR: overall response rate; mPFS: median progression free survival; NCCN: National Comprehensive Cancer Network; SOC: standard of care; EOP2: end-of-Phase 2

Positive preliminary efficacy observed in SEACRAFT-1 melanoma cohort bolsters rationale for pursuing tissue-specific NRASm melanoma indication in SEACRAFT-2



40% (4/10) response rate (3 confirmed PRs, 1 uPR[2])

80% (8/10) disease control rate[3]

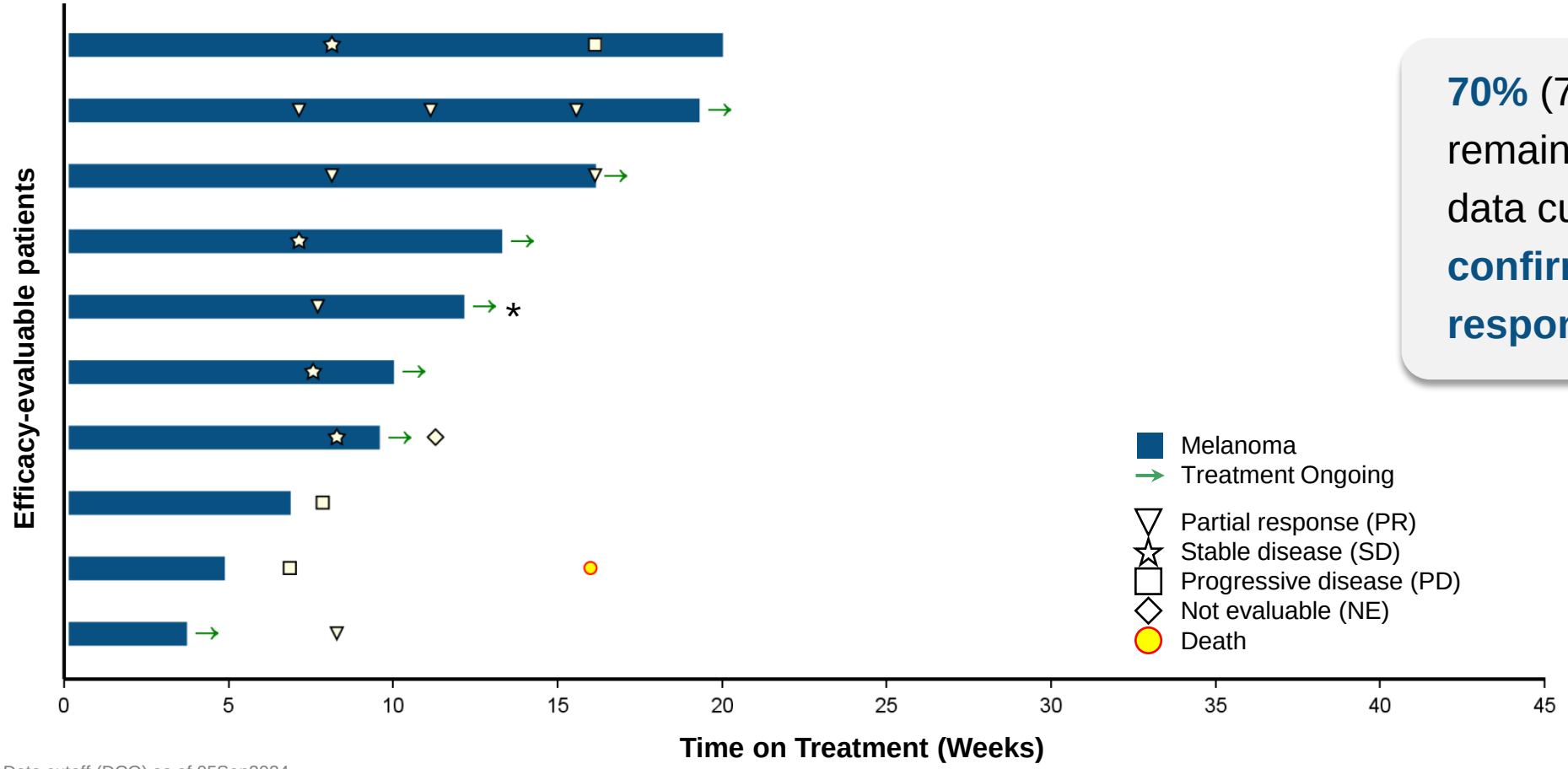
Response observed in patient with mucosal melanoma, a population that had not been enrolled in previous studies

Data cutoff (DCO) as of 05Sep2024
* Patient response was confirmed after DCO
[1] naporafenib 200 mg BID + trametinib 1 mg QD (BID: twice a day; QD: once a day)
[2] Melanoma patient with uPR continuing study treatment with next scan pending
[3] Disease control rate (DCR) = CR + PR + SD; uPR is included
[4] Defined as patients who received at least one dose of study drug, had measurable disease at baseline per RECIST, and had at least one post-baseline response assessment
NRASm: NRAS mutant; PR: partial response; uPR: unconfirmed partial response; PD: progressive disease: SD: stable disease

Early but encouraging durability observed in SEACRAFT-1 melanoma cohort

Duration of treatment in efficacy-evaluable[2] NRAS Q61X melanoma patients (N=10)

naporafenib + trametinib (200/1)[1]



70% (7/10) of patients remained on treatment as of data cutoff, including **all confirmed and unconfirmed responders**

Data cutoff (DCO) as of 05Sep2024

* Patient response was confirmed after DCO

[1] naporafenib 200 mg BID + trametinib 1 mg QD (BID: twice a day; QD: once a day)

[2] Defined as patients who received at least one dose of study drug, had measurable disease at baseline per RECIST, and had at least one post-baseline response assessment

ERASCA

Compelling, reproducible clinical efficacy across studies and doses shows potential to win on both SEACRAFT-2 primary endpoints (1/2)

	MEKi		SOC	Pooled Ph 1 and Ph 2[4]	
	Binimetinib[1]	Trametinib[2]	Chemo[3]	Naporafenib + Trametinib	
	45mg	2mg	1g/m² IV	200mg+1mg	400mg+0.5mg
	N=269	N=33	N=133	N=39	N=32
ORR n (%)	41 (15%)	5 (15%)	9 (7%)	12 (31%)	7 (22%)
DCR n (%)	157 (58%)	N/A	33 (25%)	28 (72%)	21 (66%)
mDOR months	6.9	*~6.9**	NE	7.4	10.2
mPFS months	2.8	*~2.8**	1.5	**5.1**	**4.9**

*Assumes trametinib efficacy is similar to published binimetinib efficacy results

US FDA Fast Track Designation: Dec 2023

- Compelling efficacy for both doses evaluated to date
- High unmet medical need for NRASm melanoma patients post-IO

PFS for napo + tram across doses exceeds PFS for approved SOC and single agent MEKi's

1 Dummer et al 2017; binimetinib is administered BID
2 Pooled analysis from the following publications: Falchook et al, 2012; Pigne et al, 2023; Salzmann et al, 2022; trametinib is administered QD
3 Dacarbazine is the approved chemotherapy in this indication
4 Ph 1 = CLXH254X2102 with DCO 4 Aug 2022; Ph 2 = CLXH254C12201 with DCO 30 Dec 2022
PFS includes both responders and non-responders
SOC: standard of care; N/A: not available; NE: not estimable; DCO: data cutoff; DCR: disease control rate; mDOR: median duration of response; ORR: objective response rate; mPFS: median progression free survival
The pooled phase 1 and phase 2 napo + tram data covers two clinical trials with different designs and inclusion criteria, which cannot be directly compared, and therefore may not be a reliable indicator of efficacy data
Due to differences between trial designs and subject characteristics, comparing data across different trials may not be a reliable indicator of data

PFS is an important metric, but OS is widely considered the gold standard in oncology trials

- Represents **length of time** patient is living after start of therapy
- **Reliable and precise measure** of efficacy among clinical trial endpoints
- Provides evidence of a drug's value in **prolonging a cancer patient's life**

> *"**OS is the ultimate endpoint**, … (after that) preventing the disease from progressing, is my second most important metric. "*
>
> - Medical Oncologist, Academic Hospital

PFS: progression-free survival; OS: overall survival

Compelling, reproducible clinical efficacy across studies and doses shows potential to win on both SEACRAFT-2 primary endpoints (2/2)

	MEKi		SOC	Pooled Ph 1 and Ph 2[4]	
	Binimetinib[1]	Trametinib[2]	Chemo[3]	Naporafenib + Trametinib	
	45mg	2mg	1g/m^2 IV	200mg+1mg	400mg+0.5mg
	N=269	N=33	N=133	N=39	N=32
mPFS months	2.8	*~2.8**	1.5	**5.1**	**4.9**
mOS months	~10-11 months (Benchmark #1: *NEMO Study*)			**~13 months**	**~14 months**
	~7 months *(Benchmark #2: Chart Review)*				
	~7 months *(Benchmark #3: C12201 BRAFm Patients[5])*				

Benchmarks most like SEACRAFT-2 patient population

Potential win on both SEACRAFT-2 primary endpoints (PFS and OS)

1 Dummer et al 2017; binimetinib is administered BID
2 Pooled analysis from the following publications: Falchook et al, 2012; Pigne et al, 2023; Salzmann et al, 2022; trametinib is administered QD
3 Dacarbazine is the approved chemotherapy in this indication
4 Ph 1 = CLXH254X2102 with DCO 4 Aug 2022; Ph 2 = CLXH254C12201 with DCO 30 Dec 2022
5 BRAF/MEK inhibitor-resistant BRAFm melanoma patients in Novartis's Phase 2 trial
* Assumes trametinib efficacy is similar to published binimetinib efficacy results
SOC: standard of care; mPFS: median progression free survival; mOS: median overall survival
The pooled phase 1 and phase 2 napo + tram data covers two clinical trials with different designs and inclusion criteria, which cannot be directly compared, and therefore may not be a reliable indicator of efficacy data
Due to differences between trial designs and subject characteristics, comparing data across different trials may not be a reliable indicator of data

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Mandatory primary rash prophylaxis in SEACRAFT-1 significantly decreased incidence/ severity of derm tox, reduced drug discontinuations due to AEs, and improved RDI

	CLXH254X2102 [200/1]	CLXH254C12201 [200/1]	SEACRAFT-1 [200/1]
	N = 54	N = 30	N = 52
Pts with dermatologic* toxicities, n(%)	49 (90.7)	26 (86.7)	38 (73.1)
Pts with G≥3 dermatologic* toxicities, n(%)	20 (37.0)	11 (36.7)	6 (11.5)
Pts with dermatitis acneiform, n(%)	17 (31.5)	9 (30.0)	11 (21.2)
Pts with G≥3 dermatitis acneiform, n(%)	4 (7.4)	1 (3.3)	1 (1.9)
Pts with rash, n(%)	23 (42.6)	11 (36.7)	22 (42.3)
Pts with G≥3 rash, n(%)	9 (16.7)	4 (13.3)	3 (5.8)
TEAE leading to permanent discontinuation of study treatment n(%)	10 (18.5)	6 (20.0)	5 (9.6)
	5/10 for skin tox TEAE	5/6 for skin tox TEAE	0 for skin tox TEAE
Median RDI, % [naporafenib / trametinib]	66.3 / 59.2	57.5 / 62.4	98.5 /100

With mandatory primary prophylaxis in SEACRAFT-1:

Decreased overall and Grade ≥3 frequency of dermatologic toxicities (including dermatitis acneiform and rash)

No patient has permanently discontinued naporafenib (or trametinib) due to dermatologic toxicity TEAE

Improved relative dose intensity (RDI)

200/1 = 200mg naporafenib BID + trametinib 1mg QD; G=CTCAE grade; Pts=patients; RDI=relative dose intensity; TEAE=treatment emergent adverse event

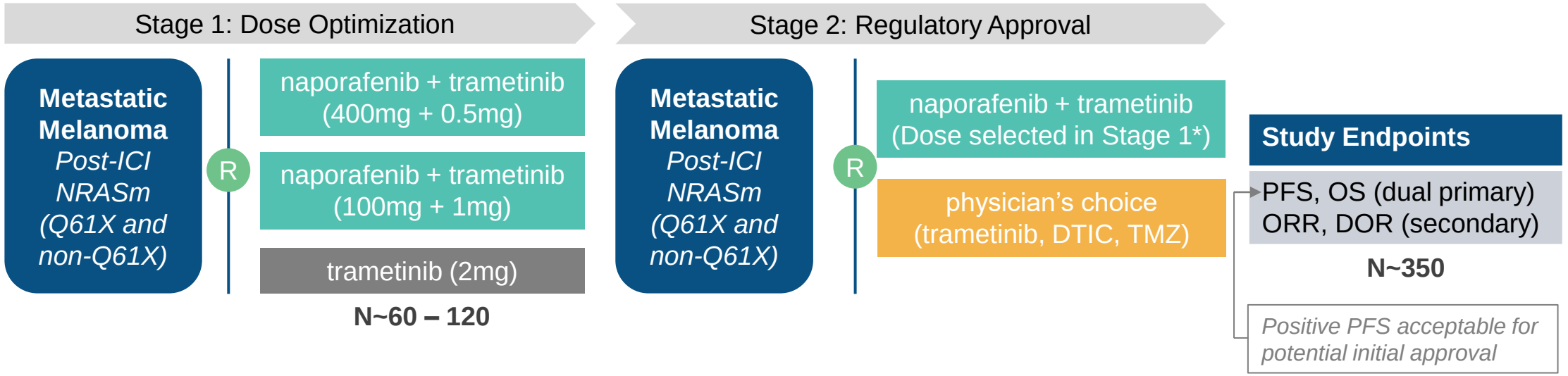
*"Dermatologic" includes MedDRA HLTs (rashes, eruptions and exanthems NEC; bullous conditions; dermatitis and eczema; exfoliative conditions) and the following PTs: dermatitis acneiform, drug eruption, drug reaction with eosinophilia and systemic symptoms, palmar-plantar erythrodysaesthesia, severe cutaneous adverse reaction, toxic skin eruption, photosensitivity reaction, skin fissures, pruritis

Data cut offs- CLXH254C12201 30Dec2022; CLXH254X2102 04Aug2022; SEACRAFT-1 03Sep2024

ERASCA

Pivotal Phase 3 trial design capitalizes on promising efficacy signals and potentially support successful registration

SEACRAFT-2: NRASm Melanoma (Two-stage Phase 3)



* Dose selection informed by data on 400+0.5 and 100+1 from SEACRAFT-2 Stage 1 as well as 200+1 from SEACRAFT-1
Note: Naporafenib dosed on a BID schedule; trametinib dosed on a QD schedule; crossover not allowed for SEACRAFT-2
ORR: overall response rate; DOR: duration of response; ICI: immune-checkpoint inhibitor; DTIC: dacarbazine; TMZ; temozolomide; PFS: progression-free survival; OS: overall survival

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Anticipated key milestones and clinical trial readouts

Program *Mechanism*	**Trial Name** *Indication* *(Combo partner if applicable)*	**Anticipated Milestone**
Naporafenib *Pan-RAF inhibitor*	**SEACRAFT-2** *NRASm Melanoma* *(+ trametinib)*	• **2025:** Ph 3 stage 1 randomized dose optimization data[1]
ERAS-0015 *Pan-RAS molecular glue*	**AURORAS-1** *RASm solid tumors*	• **H1 2025:** IND filing[2] • **2026:** Ph 1 monotherapy data[3]
ERAS-4001 *Pan-KRAS inhibitor*	**BOREALIS-1** *KRASm solid tumors*	• **Q1 2025:** IND filing • **2026:** Ph 1 monotherapy data[3]

[1] Data to include safety, pharmacokinetics (PK), and efficacy at relevant dose(s) in relevant population(s) of interest
[2] Timing of IND is subject to adjustment pending detailed program planning, driven predominantly by CMC timelines
[3] Subject to change pending detailed program planning, but assuming target US IND filing timing is achieved, data to include safety, PK, and efficacy at relevant dose(s) in relevant population(s) of interest

ERASCA

Compelling investment thesis

EXPERIENCED TEAM WITH TRACK RECORD OF SERIAL SUCCESSES

Seasoned drug developers who have advanced multiple programs from discovery to IND to global approvals

WORLD-CLASS SCIENTIFIC ADVISORY BOARD

Includes leading pioneers in: KRAS (Shokat, UCSF), the RAS/MAPK pathway (Rodriguez-Viciana, UCL; Cichowski, HMS; Blacklow, HMS; Corcoran, MGH), precision oncology (Demetri, DFCI; Bernards, NKI), and biopharma (Varney, Genentech)

BROAD PORTFOLIO TO ERASE CANCER

We have built one of the deepest pipelines in the industry to comprehensively shut down the RAS/MAPK pathway, with the potential to address unmet needs in over 5 million patients globally

PHASE 3 COMPANY WITH TWO ADDITIONAL PROGRAMS ENTERING CLINIC IN 2025

Differentiated programs including naporafenib, a Phase 3-ready pan-RAF inhibitor for NRASm melanoma, and a potential best-in-class RAS franchise composed of a pan-RAS molecular glue and pan-KRASi

MULTIPLE POTENTIAL NEAR-TERM AND LONG-TERM VALUE DRIVERS

Focused clinical development plan with multiple clinical readouts

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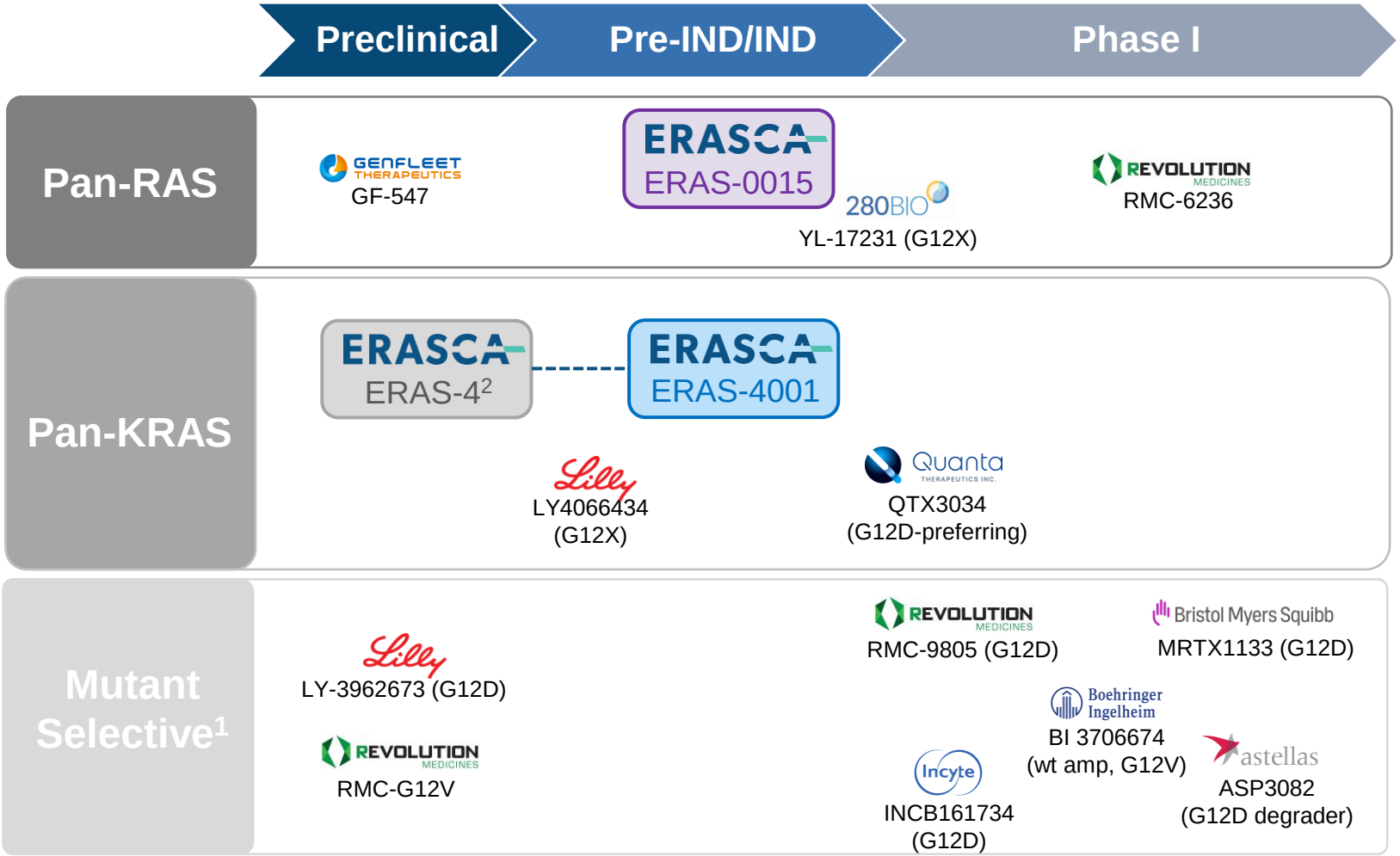
THANK YOU!

RAS targeting landscape drives importance of identifying development candidates with first-in-class or best-in-class potential



Comments on Class

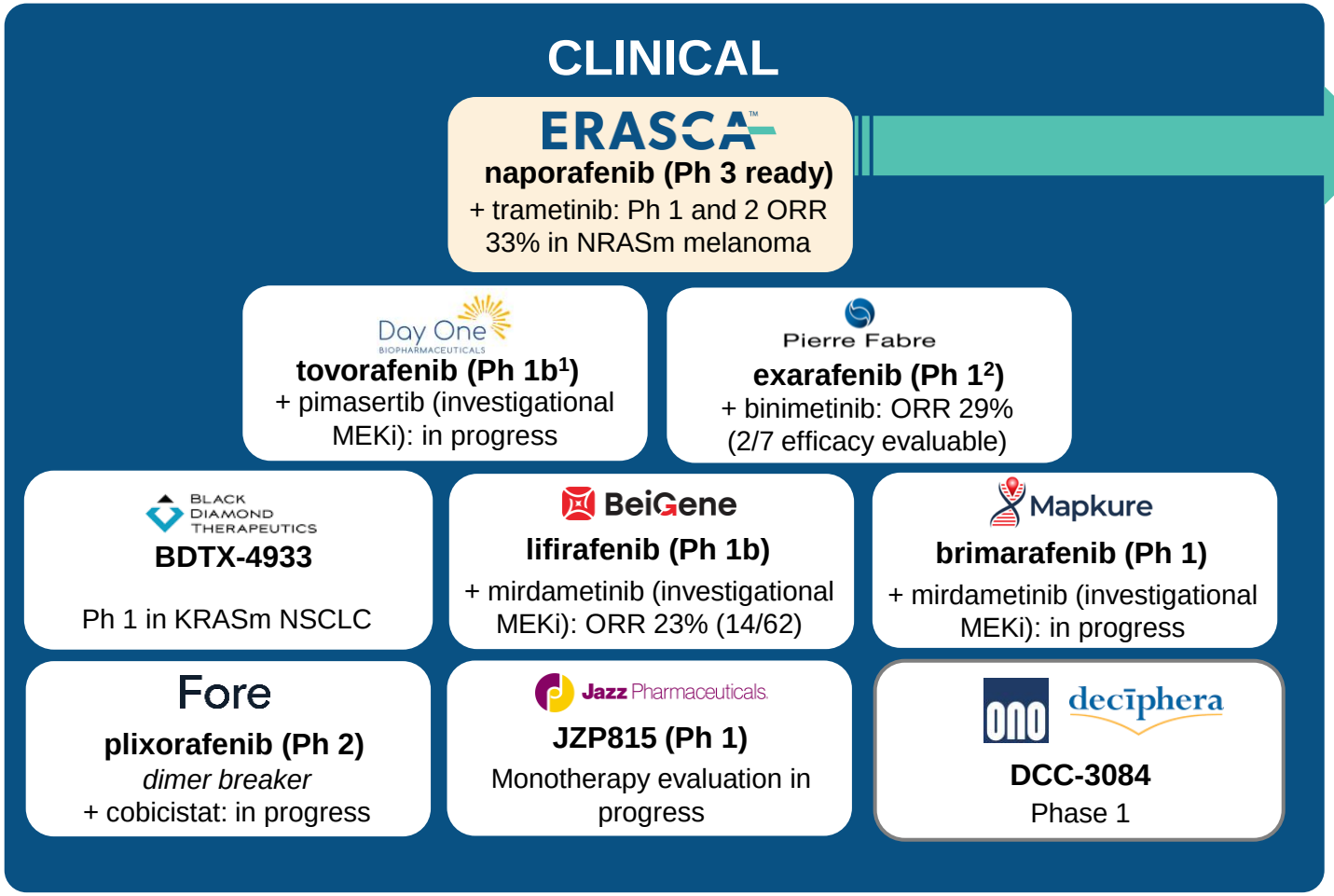
- ⊕ Encouraging preliminary clinical data
- ⊕ Complementary combination of GTP + GDP state inhibition to address pERK rebound
- ⊖ Tolerability, combinability may be challenging

- ⊕ Opportunity for greater therapeutic window by specifically targeting KRAS
- ⊕ More straightforward mechanism via KRAS Switch II pocket binding mode
- ⊖ Translation to clinical efficacy TBD

- ⊕ Potential for greater potency against specific mutation of interest and wt-sparing
- ⊖ Oral bioavailability has proven challenging for G12Di
- ⊖ Susceptible to resistance mediated by wildtype RAS of the same isoform

Note: Select coopetitors shown; list is not intended to be exhaustive
1 Mutant selective beyond KRAS G12C inhibitors
2 Select molecules from internal ERAS-4 program identified as backup for ERAS-4001

Naporafenib: Potential first-in-class pan-RAF inhibitor



Most advanced pan-RAF inhibitor

- Dosed in more patients (500+) than any other pan-RAF inhibitor in development
- Potential to be first-to-market and raise SOC in prioritized indications

PoC established

- Evaluating naporafenib in indications where it has already shown promising PoC – namely, NRASm melanoma and RAS Q61X solid tumors

Strong complementarity with Erasca pipeline

- Highly complementary, if not synergistic, with the rest of Erasca's RAS/MAPK pathway-targeting pipeline

[1] Tovorafenib has been approved in its lead indication, frontline pLGG (pediatric low-grade glioma)
[2] Exarafenib in Ph 1b for monotherapy indication in BRAF-driven tumors

ORR: overall response rate; SOC: standard of care; PoC: proof-of-concept

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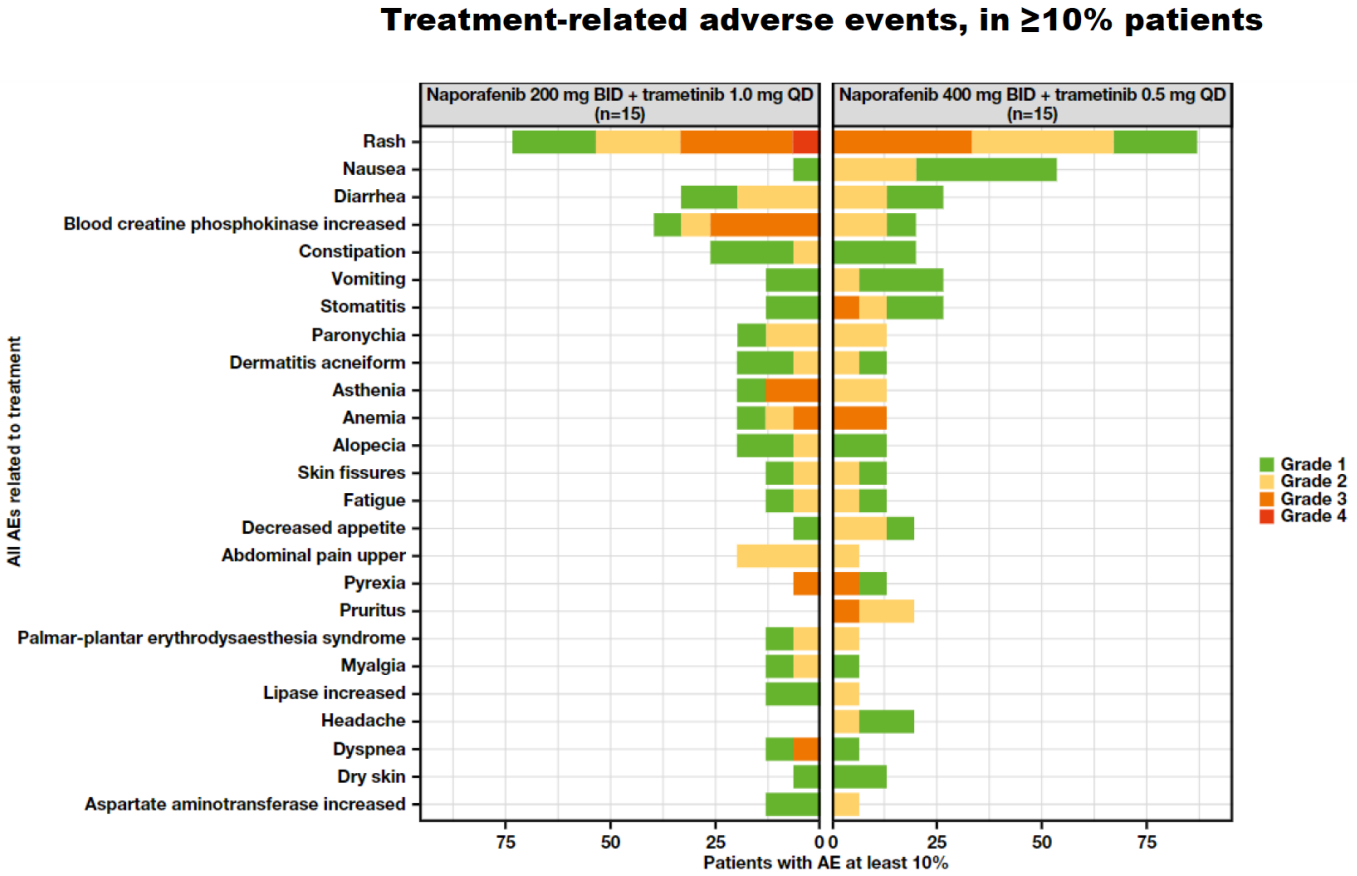
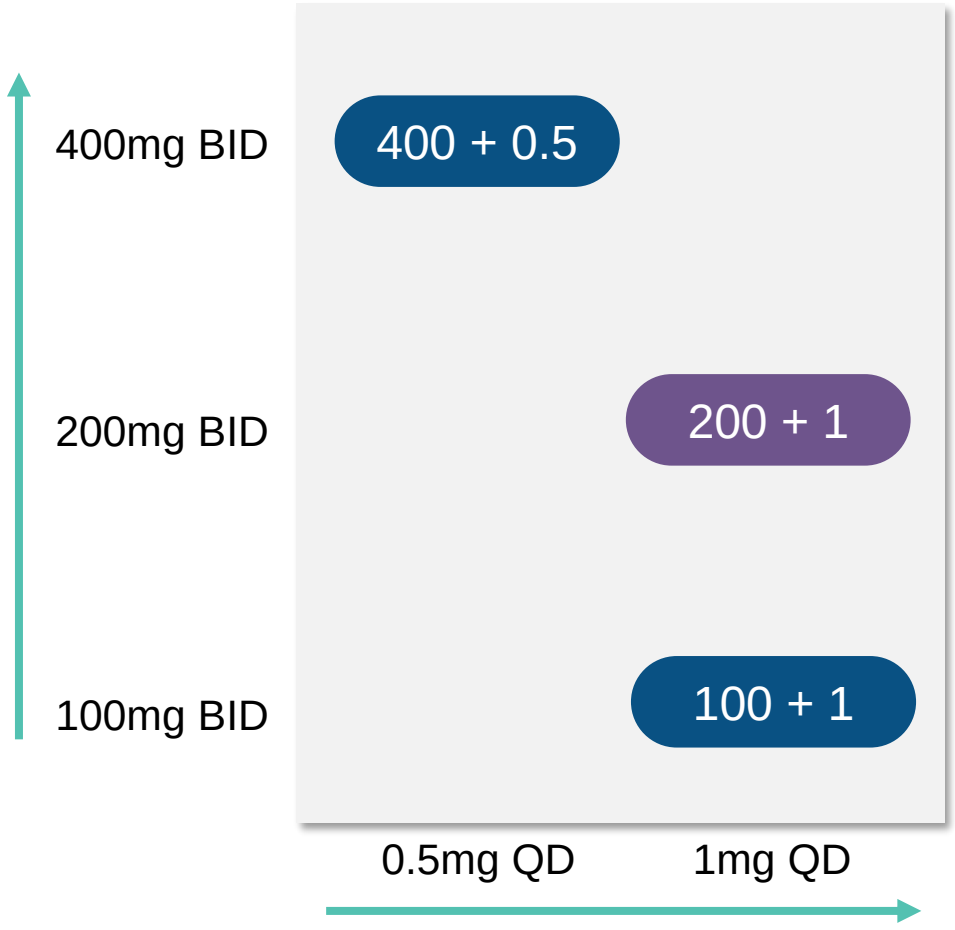
Naporafenib + trametinib demonstrated a favorable, manageable AE profile



- AE profile consistent with expected toxicities associated with RAF and MEK inhibition
  - 400+0.5 dose safe and tolerable
  - 200+1 dose safe but less tolerable without mandatory primary rash prophylaxis
- Primary prophylaxis of rash being implemented in both SC-1 and SC-2 provides opportunity to further improve safety and tolerability

AE: adverse event; BID: twice daily; QD: once daily; SC: SEACRAFT
Phase 1 data in NRASm melanoma from De Braud et al AACR 2022

Dose optimization designed to enhance combination benefit/risk profile to increase probability of regulatory success in light of Project Optimus



naporafenib
range of potentially efficacious doses*

trametinib
range of potentially efficacious doses*

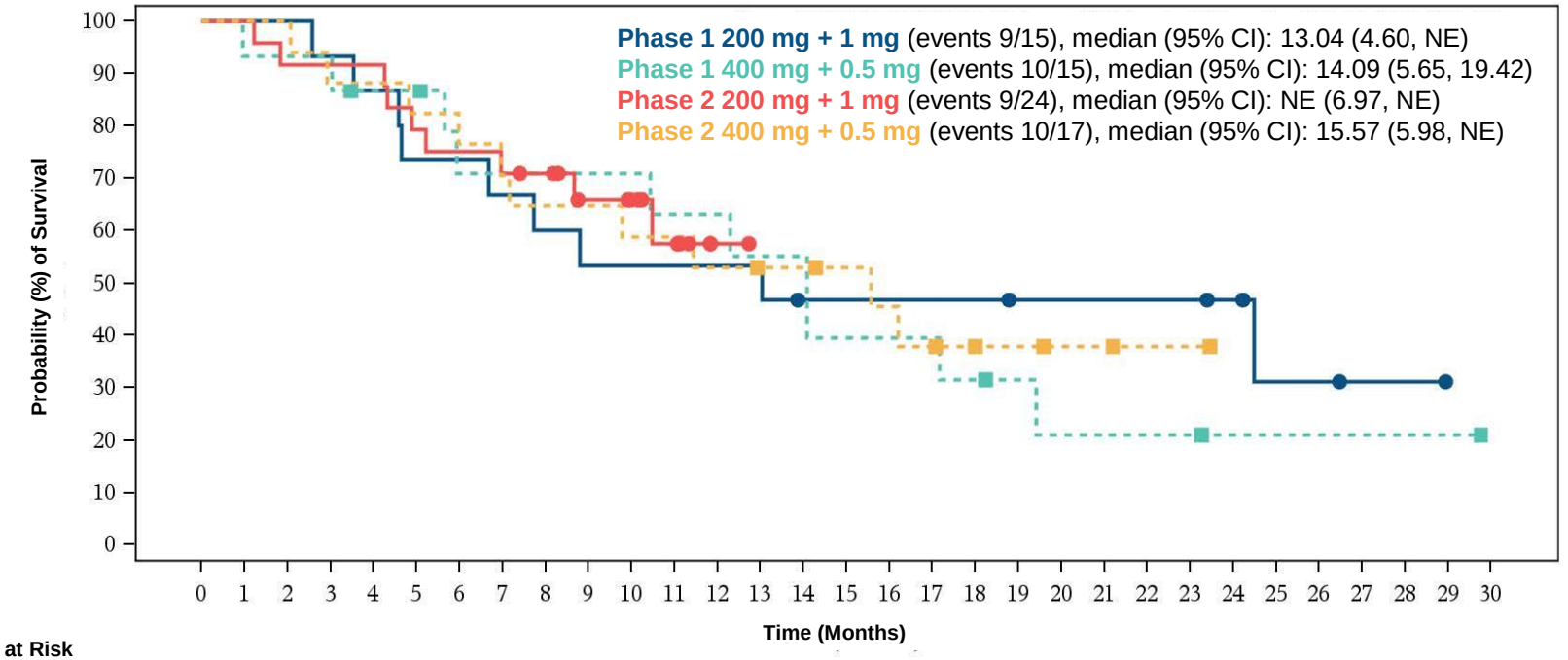
Data from **SEACRAFT-1** and **SEACRAFT-2** complement each other, allowing us to efficiently test the full effective dose range of naporafenib + trametinib within the two trials to optimize the benefit/risk profile in both indications of interest

SEACRAFT-1 dose

SEACRAFT-2 dose

* As part of the naporafenib + trametinib combination
BID: twice a day; QD: once a day

Napo + tram OS data showed high consistency across studies and doses



# Patients at Risk																													
Phase 1 200 mg + 1 mg	15	15	15	14	13	11	11	10	9	8	8	8	8	8	6	6	6	6	6	5	5	5	5	5	4	2	2	1	1	0	0
Phase 1 400 mg + 0.5 mg	15	14	14	14	12	12	9	9	9	9	9	8	8	7	7	5	5	5	4	3	2	2	2	2	1	1	1	1	1	1	0
Phase 2 200 mg + 1 mg	24	24	22	22	22	19	18	17	16	12	10	7	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Phase 2 400 mg + 0.5 mg	17	17	17	15	15	14	13	12	11	11	10	10	9	8	8	7	6	5	4	3	2	2	1	1	0	0	0	0	0	0	0

NRASm
mOS: ~13-15 months
(across doses and studies)

Reproducibility of these results across studies and doses increases our confidence in the mOS observations

mOS: median overall survival
Differences exist between trial designs and subject characteristics and caution should be exercised when comparing data across trials.