Corporate Presentation

August 2026

entrada THERAPEUTICS

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All statements, other than statements of historical facts, contained in this presentation, including statements regarding Entrada's strategy, future operations, prospects and plans, objectives of management, the validation, differentiation and superiority of Entrada’s approach and EEV platform and its ability to develop best-in-class genetic medicines with the potential for competitive differentiation, expectations regarding Entrada’s Phase 1/2 MAD clinical study of ENTR-601-44, including the timing of data from the Cohort 1 open-label period by year-end 2026 and data from Cohort 2 expected in the first quarter of 2027, with Cohort 3 to follow, if needed, expectations regarding the data from the clinical study of ENTR-601-44, including the translatability of dystrophin concentrations and exon skipping based on juvenile NHP data, expected continued benefit in muscle function in the open-label period of Cohort 1 and future cohorts, expected linear (or better) increases in plasma exposure and substantially higher dystrophin levels in Cohort 2, including the potential of double-digit dystrophin levels and continued muscle function, significantly increased exon skipping and dystrophin expression for Cohorts 2 and 3, expectations regarding healthy muscle regeneration and function, muscle stabilization, and greater strength in patients as measured by Time to Rise velocity, expectations regarding the connection between EEV-PMO uptake in satellite cells and muscle regeneration, expectations of lower risk of anti-drug antibody response and lower cost of goods from EEV-PMO conjugates, translatability of current data to de-risk Entrada’s DMD clinical portfolio, support dose escalations, and its ability to support U.S. Accelerated Approval, expectations regarding Entrada’s Phase 1/2 MAD clinical study of ENTR-601-45, including the timing of data from Cohort 1 in October 2026 and data from Cohort 2 in the first half of 2027, with Cohort 3 to follow, if needed, and the potential to be the first-to-market next-generation conjugate-PMO for its patient population, expectations regarding the data from the clinical study of ENTE-601-45, including a potential best-in-class clinical profile, competitive levels of exon skipping and dystrophin with the potential for clinically meaningful functional readouts and key safety data from Cohort 1 to further de-risk the franchise, expectations regarding regulatory filings and authorizations and the timing of initiation of the planned clinical studies of ENTR-601-50, and ENTR-601-51, the ability to recruit for and complete global Phase 2 clinical studies of ENTR-601-44, ENTR-601-45, ENTR-601-50 and ENTR-601-51, the potential for ENTR-601-44 to be a transformative treatment option, the ability of EEV therapies to provide a 25-50-fold improvement in endosomal escape and lower whole drug requirements compared to antibody-based therapies, the ability to continue to expand and develop additional therapeutic programs and modalities, including further exon skipping programs, the potential therapeutic benefits of Entrada’s EEV product candidates and the ability to advance therapeutic candidates in indications beyond neuromuscular disease, including but not limited to ocular disease, expectations regarding Entrada’s ENTR-801 program, including the potential for quarterly dosing, robust exon skipping and usherin protein production, initiation of IND-enabling studies and Entrada sharing clinical strategies in 2026 and the declaration of a second clinical candidate for inherited retinal disease in the second half of 2026, expectations regarding Entrada’s next-generation exon skippers, including durable and significant access to skeletal and cardiac muscle, targeting of progenitor cells and flexibility to dose escalate and re-dose, the continued development and advancement of ENTR-601-44, -45, -50 and -51 for the potential treatment of DMD and ENTR-801 for the potential treatment of Usher syndrome type 2A and the partnered product candidate VX-670 for the potential treatment of DM1, expectations regarding the progress and success of Entrada’s collaboration with Vertex, including expected proceeds from program milestones plus royalties and completion of the MAD portion of the global Phase 1/2 study of the VX-670 program and results shared in the second half of 2026, the size of the DMD market opportunity in the U.S. and ex-U.S., and the sufficiency of Entrada’s cash resources into the third quarter of 2027, constitute forward-looking statements within the meaning of The Private Securities Litigation Reform Act of 1995. The words “anticipate,” “believe,” “continue,” “could,” “estimate,” “expect,” “intend,” “may,” “might,” “objective,” “ongoing,” “plan,” “predict,” “project,” “potential,” “should,” or “would,” or the negative of these terms, or other comparable terminology are intended to identify forward-looking statements, although not all forward-looking statements contain these identifying words. Entrada may not actually achieve the plans, intentions or expectations disclosed in these forward-looking statements and you should not place undue reliance on these forward-looking statements. 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Entrada is developing best-in-class genetic medicines to address diseases with a significant unmet need

Proprietary Modalities

Proprietary active moieties and novel delivery constructs combine to optimize therapeutic response

Clinical Validation

Favorable patient safety and functional improvement data de-risks the neuromuscular franchise

Expanding Pipeline

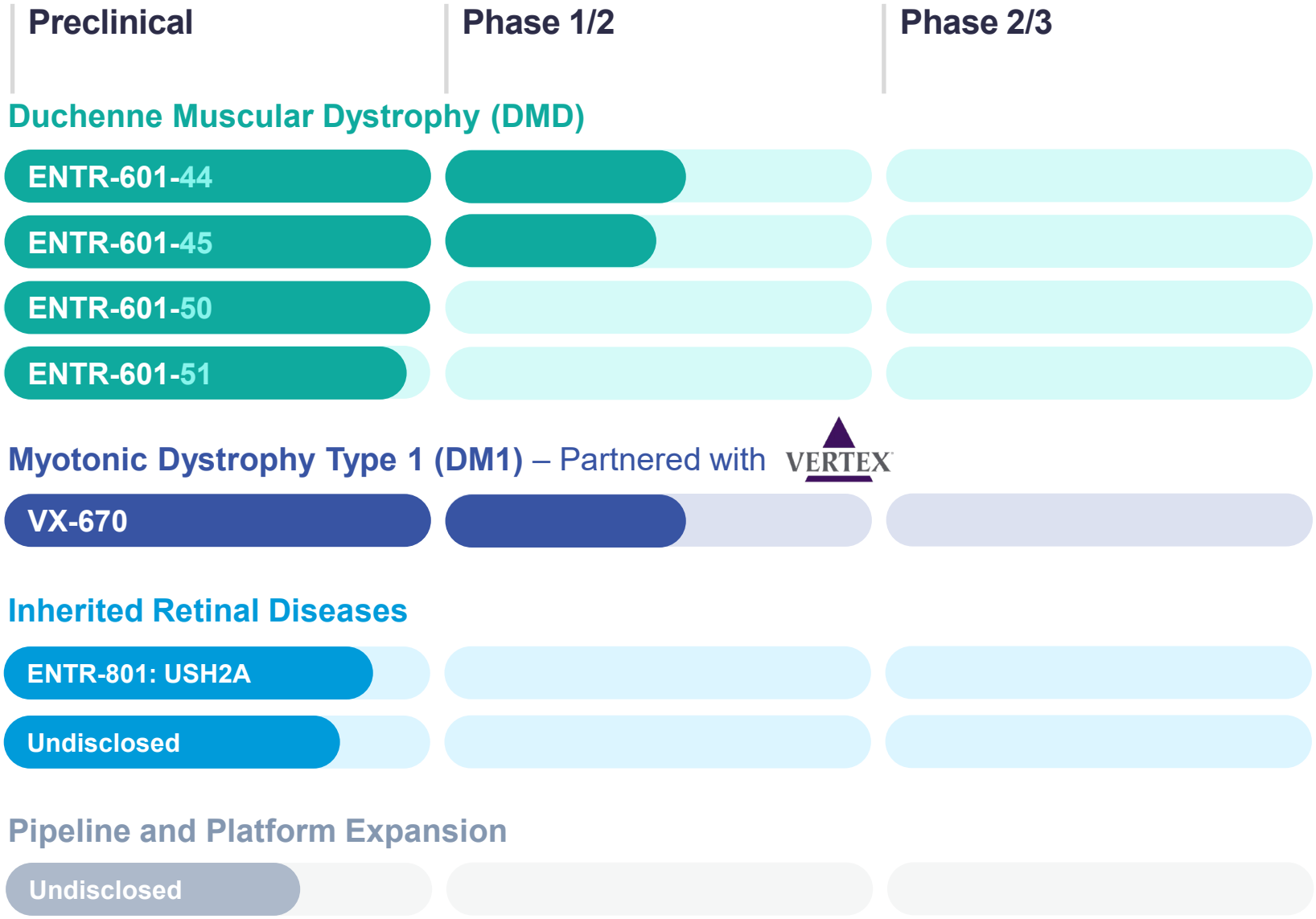
Advancing programs across DMD, DM1 and inherited retinal diseases complemented by an active discovery engine

4 clinical data catalysts in 2026

Advancing five fully owned programs and one partnered program

Phase 1/2 data from ex-U.S. DMD studies to support Accelerated Approval regulatory filings in the U.S.

Each target disease has a substantial patient population with a significant unmet medical need



August 2026

Neuromuscular Programs

Entrada's neuromuscular strategy is to clinically de-risk a differentiated portfolio and launch best-in-class drugs

Multiple clinical catalysts, growing platform validation and a differentiated pipeline position Entrada for significant value creation

Neuromuscular Strategy

- Neuromuscular programs **leverage the same EEV and ENTR-601-44 Cohort 1 safety data de-risk the franchise**
- **Novel PMO** sequences increase potential for competitive differentiation
- **Lower whole drug exposure** supports lower risk of anti-drug antibody response and lower cost of goods
- Phase 1/2 DMD data from ex-U.S. studies to support **U.S. Accelerated Approval***

Clinical Differentiation

- No serious adverse events, discontinuations or clinically relevant changes in renal markers in ELEVATE-44-201 Cohort 1 **patient safety data**
- Statistically significant improvement in functional benefit** observed in ELEVATE-44-201 Cohort 1
- Ability to **dose escalate**; Cohort 2 dosing ongoing for both ELEVATE-44 and ELEVATE-45
- Stem cell uptake supports **potential for healthy muscle cell regeneration**

Near-Term Clinical Catalysts

ENTR-601-44 (DMD)	• Cohort 1 open-label (function and safety) **data expected by year-end 2026** • Cohort 2 (12 mg/kg) enrollment complete; **Data expected in Q1 2027**
ENTR-601-45 (DMD)	• **Cohort 1 data expected in October 2026** • All Cohort 1 patients have crossed over into open-label dosing period • Cohort 2 dosing at 10 mg/kg ongoing with **data expected in H1 2027**
VX-670 (DM1)	• Vertex to share Phase 1/2 MAD **results in H2 2026**

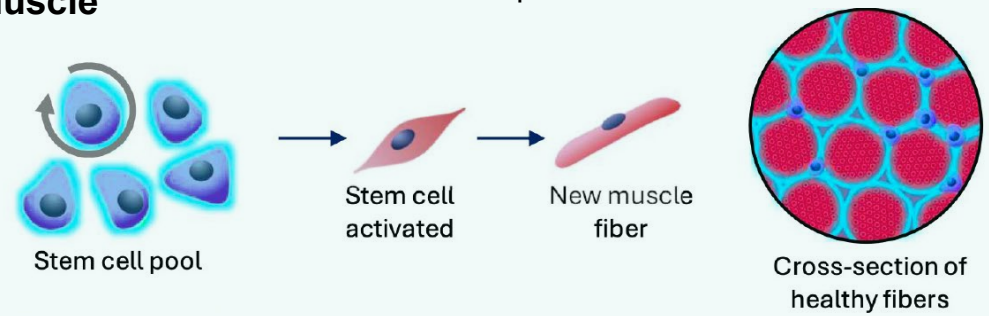
All references in this presentation regarding planned regulatory filings and clinical study designs are subject to discussion with regulatory authorities; **EEV**: Endosomal Escape Vehicle; **PMO**: Phosphorodiamidate morpholino oligomer; **DMD**: Duchenne muscular dystrophy; **DM1**: Myotonic dystrophy type 1; **MAD**: Multiple ascending dose; *Accelerated Approval is subject to regulatory feedback; **Time to Rise velocity (TTRV), nominal p-value, *post hoc* analysis.

The DMD challenge: Muscle damage and impaired repair

An ideal treatment is regenerative – replacing damaged, dystrophic muscle with healthy muscle; Requires satellite cell correction which enables asymmetric differentiation to develop healthy muscle

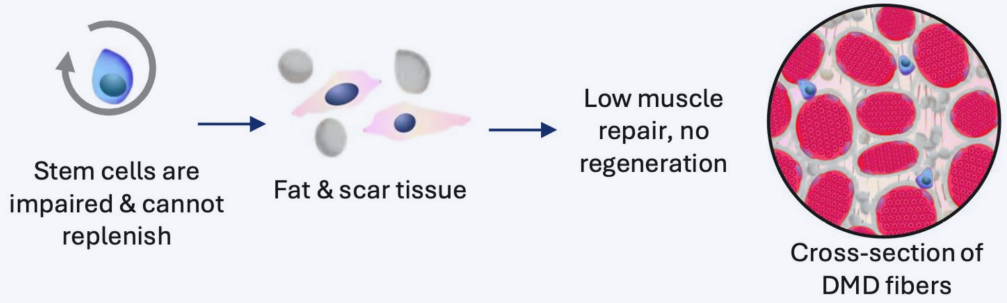
Healthy muscle

- Dystrophin supports stabilizing and repairing muscle fibers and stem cell replenishment and function



DMD muscle lacking dystrophin

- Muscle fibers susceptible to damage
- Stem cells and regeneration impaired
- Muscle replaced with fat and scar tissue



Lack of dystrophin results in a "double hit" and decline in muscle function, including:

1. Increased damage to existing muscle tissues
2. Inability to regenerate and repair with new healthy muscle fibers; Replaced with fat and fibrosis instead

Satellite (stem) cells require dystrophin to efficiently promote healthy muscle regeneration

- Deficit inhibits asymmetric differentiation and activation, thus impairing regeneration

Source: Servais L, et al. ICNMD 2026.

ELEVATE-44-201

Cohort 1: Study Results Summary

Executive summary and key takeaways
ELEVATE-44-201 Cohort 1 results

Cohort 1 achieved the objective of demonstrating safety/tolerability; Importantly, Cohort 1 achieved functional benefit at the lowest dose with dystrophin levels expected to increase in Cohorts 2 and 3

- **Favorable safety and tolerability profile at 6 mg/kg; All AEs were mild to moderate**
  - No reported SAEs nor AEs leading to discontinuation
  - Renal markers within normal range and comparable to placebo
- **Functional benefit demonstrated at 6 mg/kg via Time to Rise and Time to Rise Velocity (TTR and TTRV) measures**
  - TTR is a secondary endpoint of the ELEVATE-44-201 study
  - Cohort 1 resulted in a statistically significant* impact on TTR and TTRV versus placebo
  - TTRV levels were several fold above 12-month MCID after only 3 doses (127 days, 6 weeks after the last dose administered)
  - Additional functional measurement data to be shared at the end of the open-label period (year-end 2026)
- **Mechanistic advantages support early functional benefit observations**
  - EEV-PMO uptake in satellite cells can lead to the proliferation, activation and asymmetric division which is the basis of muscle regeneration
  - Continued benefit in muscle function expected in the open-label period of Cohort 1 and future Cohorts
- **Higher exon skipping, dystrophin and continued functional benefits projected in Cohorts 2 and 3**

Cohort 1 functional benefit response is early but a promising signal

AE: Adverse event; **SAEs**: Serious adverse events; **TTR**: Time to Rise; **MCID**: Minimal clinically important difference; **PK**: Pharmacokinetics; **PD**: Pharmacodynamics; *Wilcoxon rank-sum (one sided) test, nominal p-values, *post hoc* analysis.

ELEVATE-44-201

Cohort 1: Trial Design and Treatment Population

ELEVATE-44-201 is designed to support U.S. Accelerated Approval and forms the basis of a global registrational program*

ENTR-601-44

ELEVATE-44-201 is a global, two-part, randomized, double-blind placebo-controlled Phase 1/2 study in ambulatory patients*

Primary objective: Safety and tolerability of ENTR-601-44

Secondary objectives: Evaluation of pharmacokinetics, exon skipping, dystrophin production and measures of function

Screening	Double-Blind Period	Open-Label Period	Follow-up Period
Up to 6 weeks	19 weeks	31 weeks	6 weeks

Ambulatory participants with DMD who are exon 44 skipping amenable

Muscle biopsy #1

Part A

N=24 participants across three cohorts, n=8 per cohort

3:1 randomization in each cohort (ENTR-601-44 to placebo)

- ✓ **Cohort 1: 6 mg/kg or placebo**
- Cohort 2: **12** mg/kg or placebo
- Cohort 3: **≤18** mg/kg or placebo

x3 doses
Days 1, 43 and 85

Muscle biopsy #2
Day 127

Participants who complete Part A are able to continue into open-label period

- Receive 6 doses of ENTR-601-44 at the level that was administered in participant's Part A cohort
- Dosing initiated
- Study blinded to end of open-label period

- ✓ Complete
- Ongoing

Expansion Cohort

*Expansion cohort and potential for Accelerated Approval is subject to regulatory feedback; Global registration and approval will require Phase 3 studies to follow the Phase 1/2 studies; Phase 3 studies will likely include functional measures as the primary endpoint (U.S. confirmatory study/EU registrational study).

Demographics and baseline characteristics

ELEVATE-44-201

Baseline Characteristics	Placebo n=2	ENTR-601-44 6 mg/kg n=6
Age, mean	13.5	9.3
Body mass index, mean, kg/m^2	17.96	20.00
Corticosteroid use, n (%)	2 (100%)	6 (100%)
Ambulatory, n (%)	2 (100%)	6 (100%)
Baseline dystrophin	4.6%	4.0%
Time to Rise Velocity, mean (rises/second)[1]	0.191	0.126

[1] Time to Rise Velocity is calculated as 1/time-to-rise in seconds as an early prognostic factor for disease progression and loss of ambulation; Lower baseline number = worse.

ELEVATE-44-201

Cohort 1: Safety Data

Safety was consistent and unremarkable at the 6 mg/kg dose

ELEVATE-44-201

Participants with ≥1 TEAE, n (%)	Placebo n=2	ENTR-601-44 6 mg/kg n=6
Any TEAE	2 (100%)	6 (100%)
TEAEs related to study drug	1 (50%)	5 (83%)
Serious TEAEs	**0**	**0**
TEAEs leading to study discontinuation	0	0
TEAEs leading to death	0	0

All TEAEs were mild to moderate

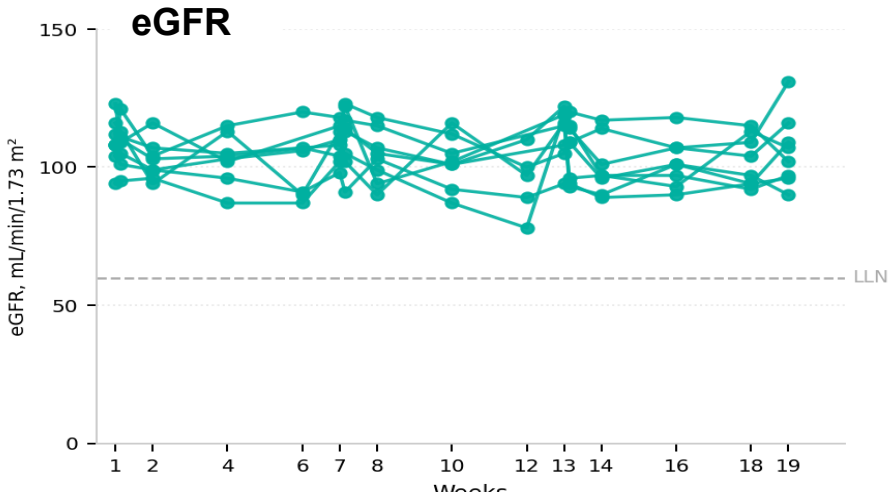
- Headache was the most common study drug–related TEAE, reported in 50% of the treatment group and 50% of the placebo group
- All events resolved
- **There were no serious TEAEs** and **no study discontinuations**
- **No hypomagnesemia** or renal safety concerns were noted
- All 8 participants, including placebo crossover, are now being dosed in the open-label treatment period

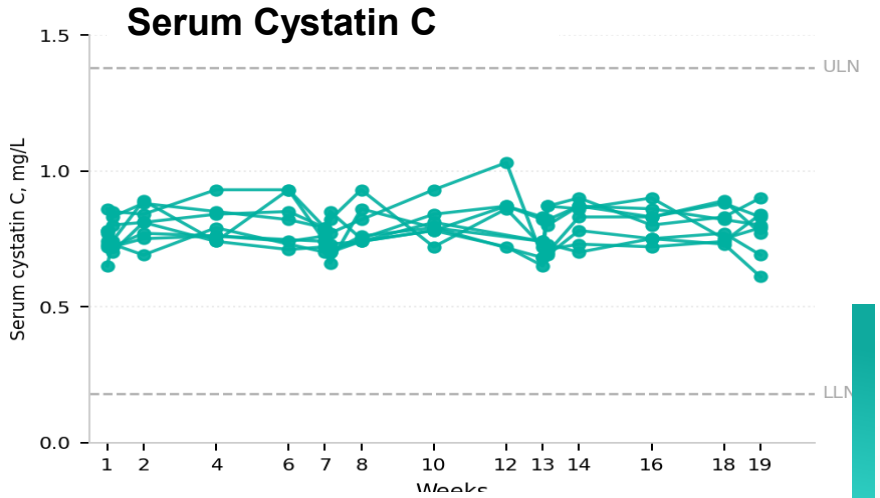
A favorable safety profile supports a de-risking of DMD programs

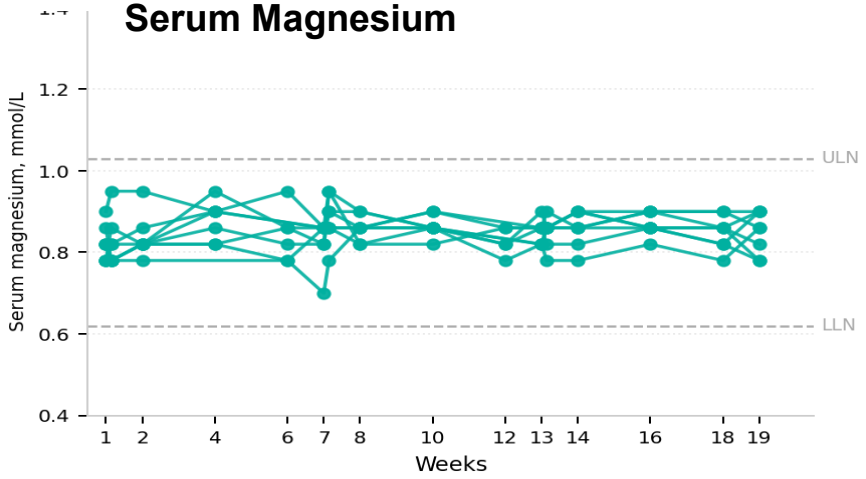
TEAE: Treatment emergent adverse event.

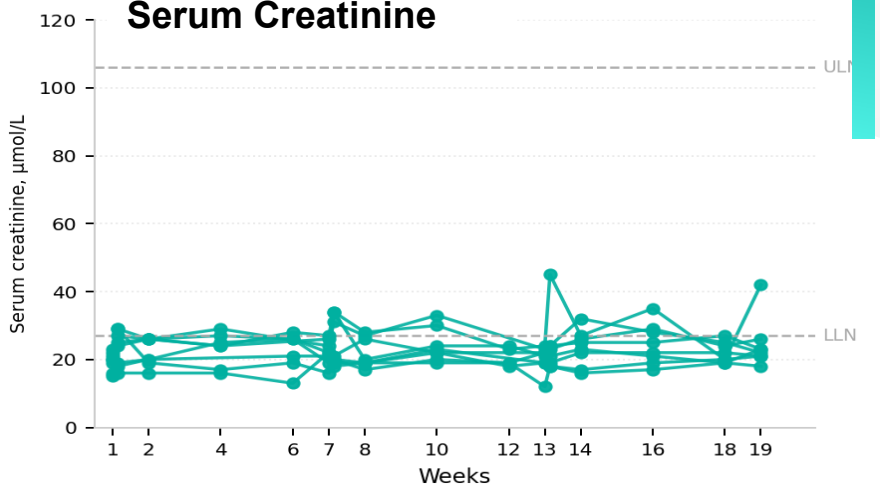
Renal markers were within normal range and treated patient observations were comparable to placebo

ELEVATE-44-201









Renal marker results further de-risk current and future DMD programs and support dose escalation to drive a higher therapeutic index

Data from ELEVATE-44-201; **eGFR**: Estimated glomerular filtration rate; **LLN**: Lower limit of normal; **ULN**: Upper limit of normal; Serum creatinine reference range shown is 27–106 µmol/L and is dependent on age of the participant enrolled in Cohort 1; Serum creatinine is below normal in participants with DMD due to reduced muscle mass.

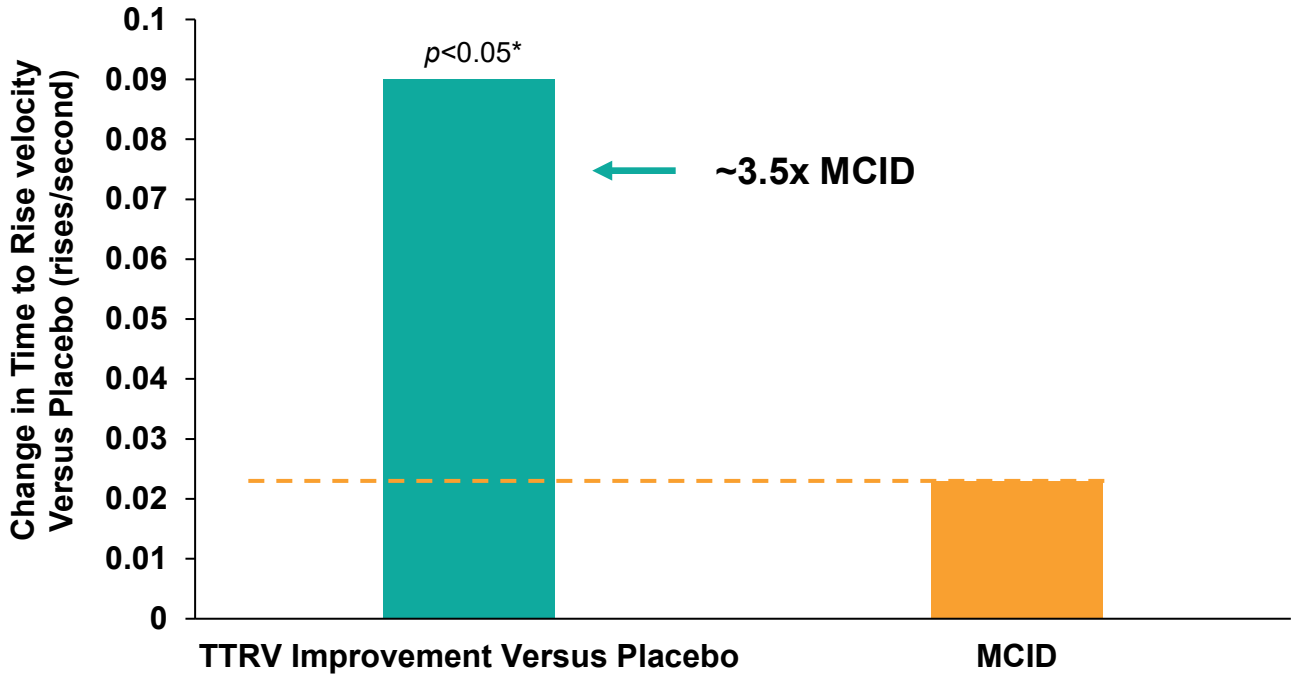
ELEVATE-44-201

Cohort 1: Functional Efficacy Data

ELEVATE-44-201 Cohort 1 functional benefit summary

Cohort 1 achieved functional benefit via statistically significant measurements in both TTR and TTRV; 10MWR trending favorably with additional metrics to be shared by year-end 2026

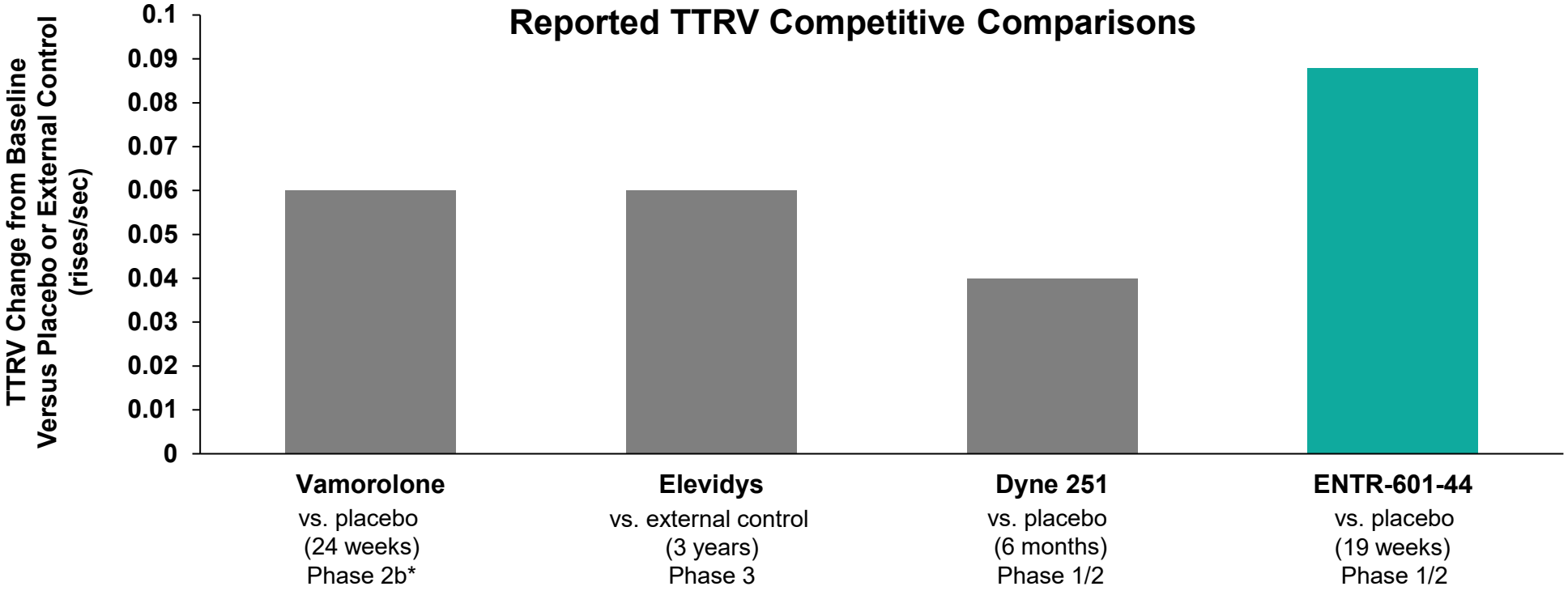
- **Improvement in TTR and in TTRV was seen across the majority of treated participants, irrespective of age**
  - Statistically significant TTR improvement versus placebo of 2.40 seconds
  - Statistically significant TTRV improvement versus placebo of 0.09 rises per second
  - Statistically significant correlation between the change from baseline in TTRV and change from baseline in MHC–normalized dystrophin levels
- **Positive trends observed in 10MWR**
- **Additional metrics and safety to be reported at the end of the open-label period (year-end 2026)**



*Wilcoxon rank-sum (one sided) test, nominal p-values, post hoc analysis; "The Minimal Clinical Important Difference (MCID) in Annual Rate of Change of Timed Function Tests in Boys with DMD," Duong T, Canbek J, Birkmeier M, Nelson L, Siener C, Fernandez-Fernandez A, Henricson E, McDonald CM, Gordish-Dressman H and the CINRG-DNHS Investigators; Journal of Neuromuscular Diseases. 2021;8(6):939–948; **10MWR**: 10-meter walk/run.

ENTR-601-44 delivered a differentiated impact on TTRV
TTRV is a validated registrational endpoint

ENTR-601-44's observed Cohort 1 (n=6) TTRV versus placebo is superior to reported numbers from steroids, gene therapy and second-generation exon skipping therapies



- **Phase 3 trials using TTRV as the primary endpoint: Novartis**: *del-zota*, Phase 3 (initiating); **Dyne:** 251/Z-rostudirsen, Phase 3 (initiating) **Solid Biosciences**: SGT-003, Phase 3 (ongoing); **Roche**: Elevidys, Phase 3 (to initiate in EU)

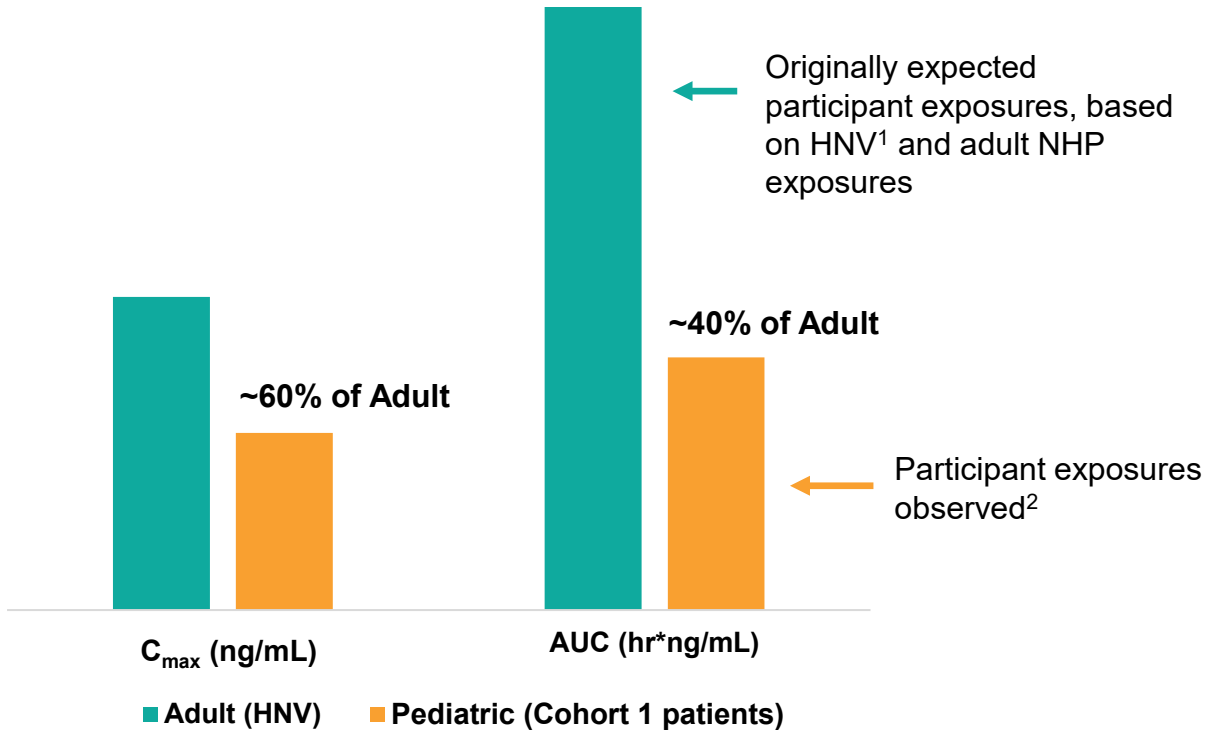
Sources: *VISION-DMD (JAMA 2022) registrational study; DELIVER (Dyne Company presentation; June 2026); EMBARK (MDA 2026); ENTR-601-44 (Cohort 1); No head-to-head trials have been conducted; Cross-trial comparisons may not be reliable based on differences in study designs, compound formulation and mechanism, patient populations, etc.

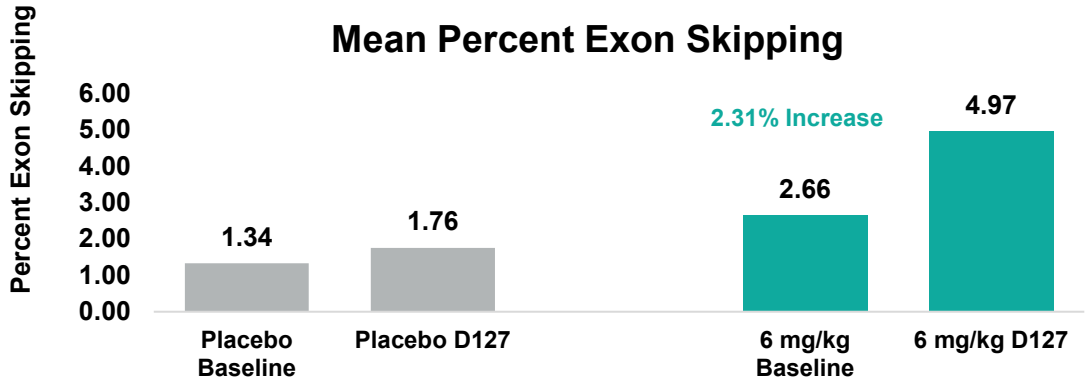
ELEVATE-44-201:

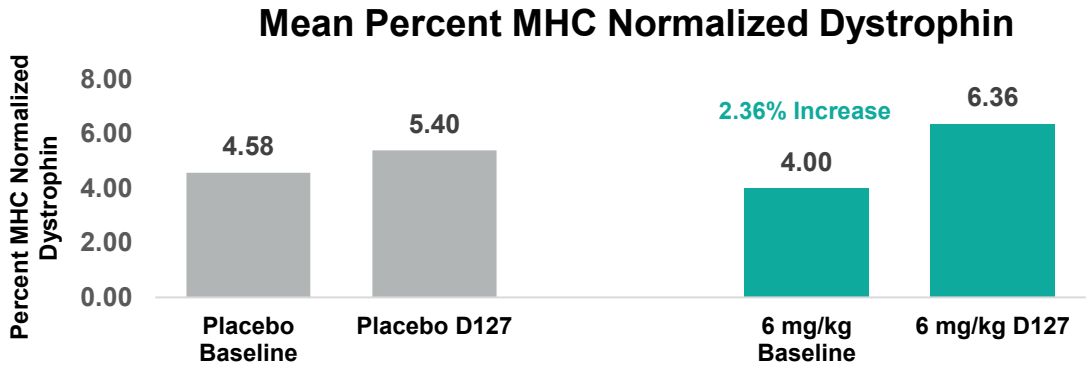
Pharmacokinetics and Biomarkers

Pediatric plasma exposures demonstrated target engagement at the lowest dose tested (6 mg/kg)

In Cohort 1 dosing, C_{max} and AUC observed in pediatric participants (versus adults) have not yet crossed the critical threshold needed to demonstrate high levels of dystrophin







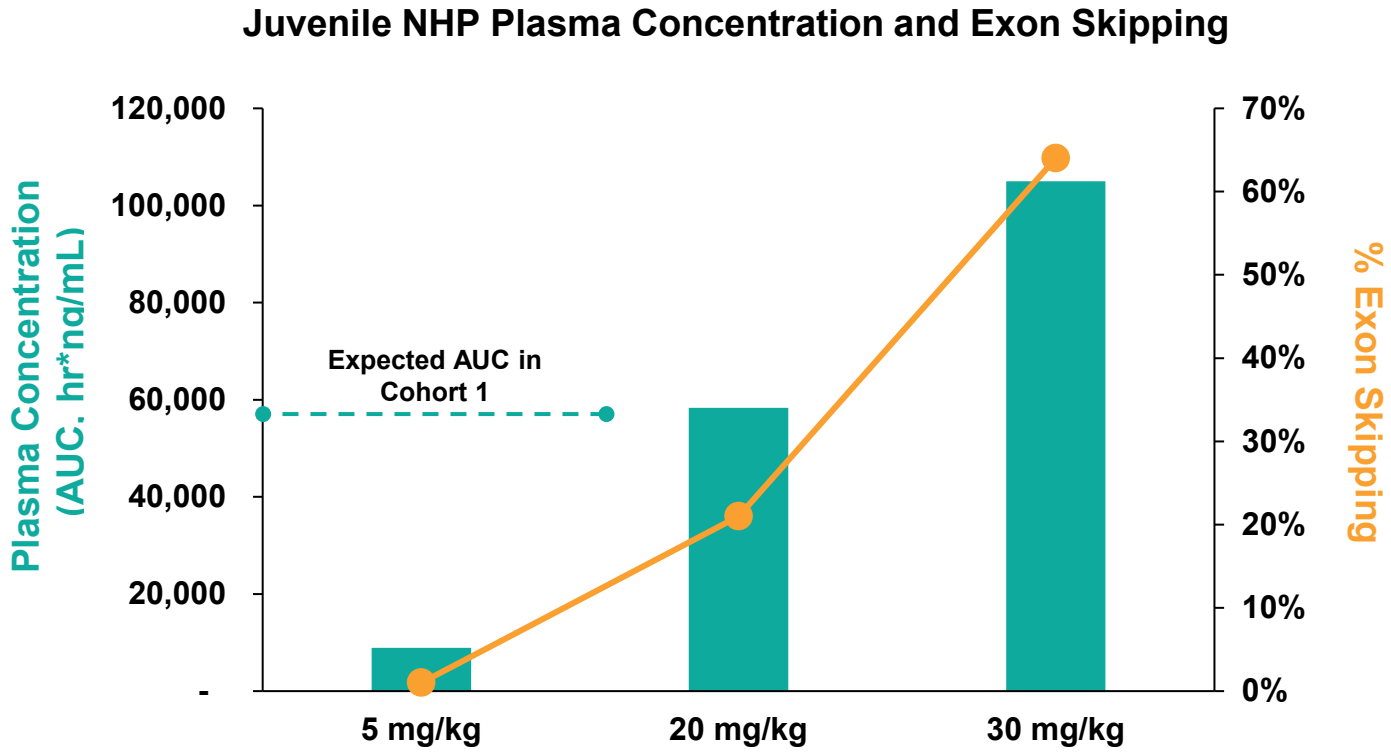
A linear (or better) increase in exposure is expected in Cohort 2 at 12 mg/kg which should result in substantially higher dystrophin levels and continued muscle function

AUC: Area under the curve (proportions are approximate); [1.] Single dose 6 mg/kg, [2.] Pediatric DMD participants following third dose of 6 mg/kg every 6 weeks (similar, proportionally lower levels seen in juvenile NHP 55-week study); Note: As biopsies were taken 6 weeks post-final dose, muscle concentration levels were 10-fold below projected peak, in line with plasma concentration and expectations.

Higher dystrophin levels expected in Cohorts 2 and 3 based on juvenile NHP data

Juvenile NHP data suggest an increase of AUC should result in substantially higher dystrophin levels and increases in muscle function

- Juvenile NHP data suggest **a right-shifted double-digit dystrophin expectation** starting at 12 mg/kg in Cohort 2
- As the exposure to exon skipping relationship has not changed, updated projections indicate **substantially increased exon skipping and dystrophin expression** expected in Cohorts 2 and 3
- Cohorts 2 and 3 dystrophin levels will be assessed for **registrational potential**, when combined with **observed functional outcomes**



NHP data from 55-week, QW6, 10 doses, chronic juvenile toxicology study.

ENTR-601-44:

Mechanistic Rationale

EEV-enabled stem cell uptake implies the potential for the return of healthy muscle and function

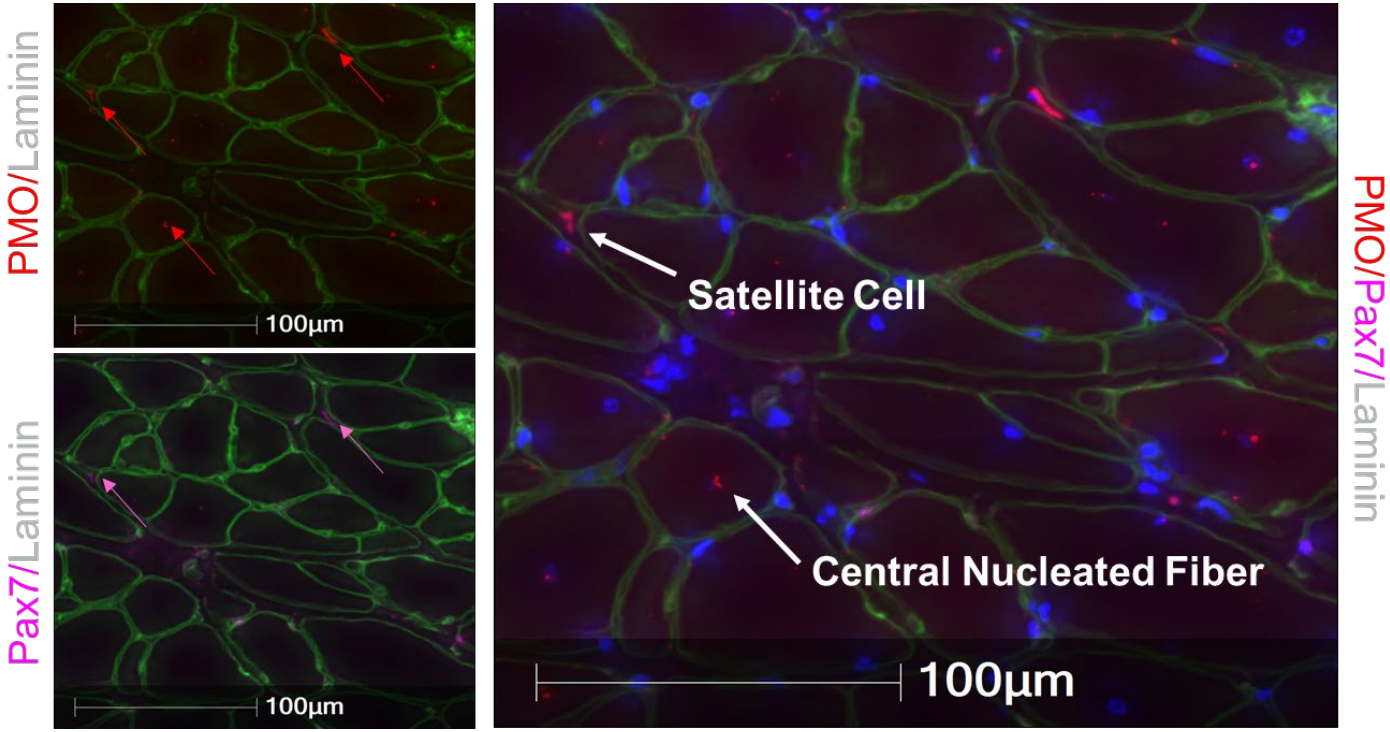
Enhanced satellite cell activity would result in the regeneration of healthy fibers and the stabilization of the overall muscle; In turn, this may convert into greater strength, as measured by TTRV

Entrada differentiation

- Immunohistochemistry data demonstrates PMO in satellite cells and newly regenerated centrally nucleated fibers 12 weeks post-washout after 3 Q6W doses (D2-*mdx* mice)

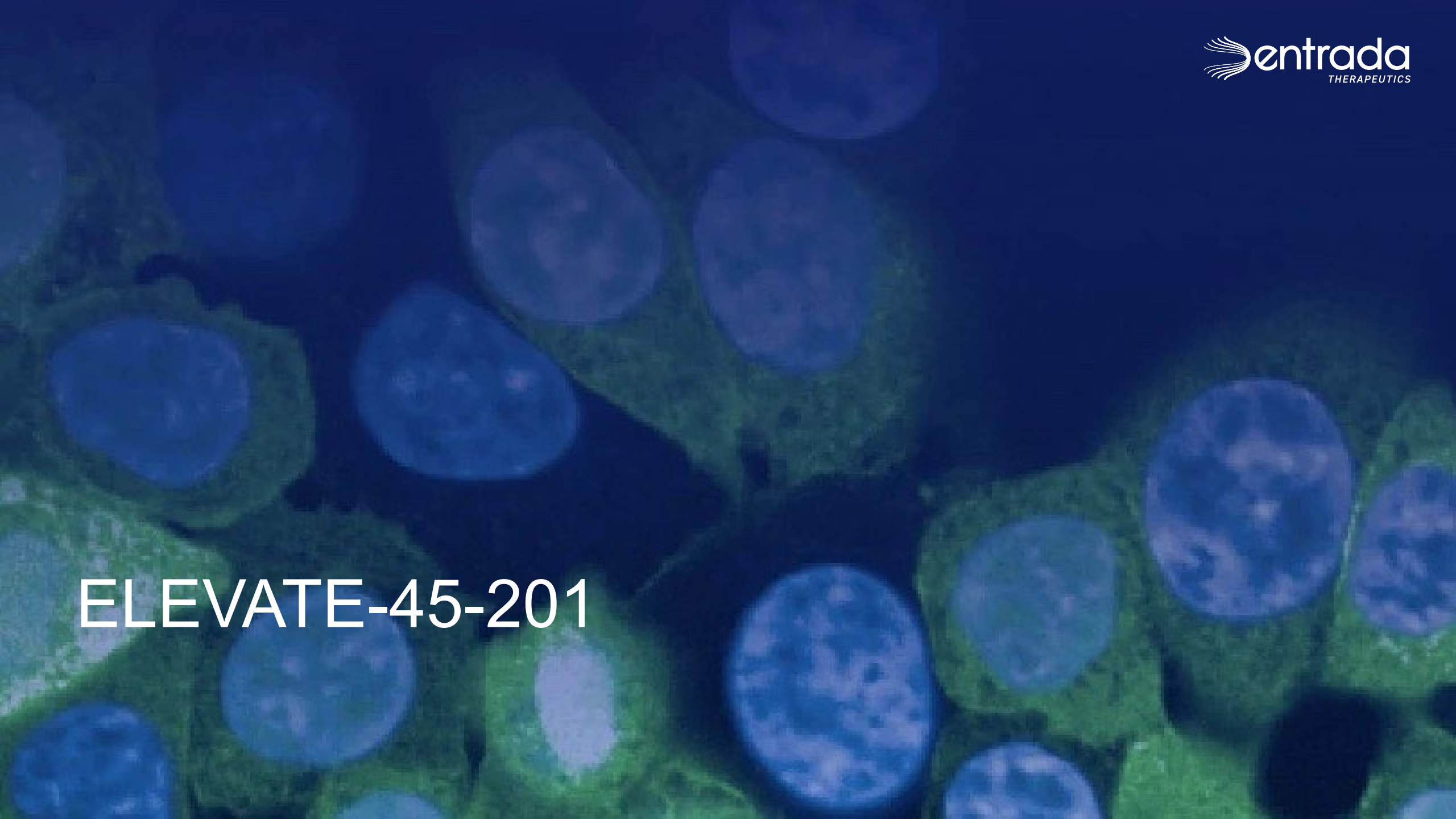
Antibody and gene therapy competitors

- Lack of transferrin receptor expressed on quiescent satellite cells so the antibodies cannot deliver PMO
- AAV-enabled gene therapies lack ability to efficiently reach satellite cells which limits response durability



Immunohistochemistry data demonstrates PMO in satellite cells and newly regenerated centrally nucleated fibers 12-weeks post-washout after 3 Q6W doses (D2-*mdx* mice)

D2-*mdx*: Dystrophic mouse model; D2-*mdx* mice were treated with 3 IV doses of EEV-PMO administered every six weeks; Gastrocnemius was collected 12 weeks after the third dose and analyzed by immunohistochemistry; Data presented at International Conference on Muscle Wasting 2025; **Q6W**: Every 6 weeks.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THERAPEUTICS
ELEVATE-45-201

ELEVATE-45-201:
Patient population, competitive treatment and data catalysts

ELEVATE-45-201 Cohort 1 is enrolled; Dosing completed and clinical data readout in October 2026; Cohort 2 is enrolling and actively dosing with clinical data readout expected H1 2027

Exon 45 Patient Population

- **Over 2,500 U.S. and EU Exon 45 skipping amenable patients** represents ~9% of the Duchenne patient population[1]
- **Aggressive course of disease** compared to 44 skip amenable patients
- Median age at loss of ambulation is between 11.2-14.0 years of age for patients on glucocorticoid corticosteroids[2]

Exon 45 Competitive Treatment

- Casimersen is the approved exon skipper in the U.S. (not approved ex-U.S.) and the only competitor to ENTR-601-45
- Casimersen dosed weekly[3] and mean dystrophin expression improvement of 0.81 over baseline of 0.93
- Casimersen failed to reach statistical significance on its primary endpoint of 4-stair ascend velocity at 96 weeks in the Phase 3 ESSENCE trial
- **ENTR-601-45** is currently the lead next-generation conjugate-PMO in clinical trials, with opportunity to be first to market and **dosed every six weeks**

ELEVATE-45-201 Clinical Data Catalysts

Cohort 1 (5 mg/kg)	• **Data readout in October 2026** • Key safety readout to further de-risk the franchise • Dosing regimen of every six weeks is a potentially compelling point of differentiation
Cohort 2 (10 mg/kg)	• **Data readout in H1 2027** • Competitive exon skipping and dystrophin expected with potential for clinically meaningful functional readouts
Cohort 3 (up to 15 mg/kg)	• Expected to follow, if needed

1. Bladen et al.; 2. Bello et. al.; 3. Casimersen label.

ELEVATE-45-201 is designed to support U.S. Accelerated Approval and forms the basis of a global registrational program*

ENTR-601-45

ELEVATE-45-201 is a global, two-part, randomized, double-blind placebo-controlled Phase 1/2 study in ambulatory patients*

Primary objective: Safety and tolerability of ENTR-601-45

Secondary objectives: Evaluation of pharmacokinetics, exon skipping, dystrophin production and measures of function

Screening	Double-Blind Period	Open-Label Period	Follow-up Period
Up to 6 weeks	19 weeks	31 weeks	6 weeks

Ambulatory participants with DMD who are exon 45 skipping amenable

Muscle biopsy #1

Part A

N=24 participants across three cohorts, n=8 per cohort

3:1 randomization in each cohort (ENTR-601-45 to placebo)

- **Cohort 1: 5 mg/kg or placebo**
- Cohort 2: **10** mg/kg or placebo
- Cohort 3: **≤15** mg/kg or placebo

x3 doses
Days 1, 43 and 85

Muscle biopsy #2
Day 127

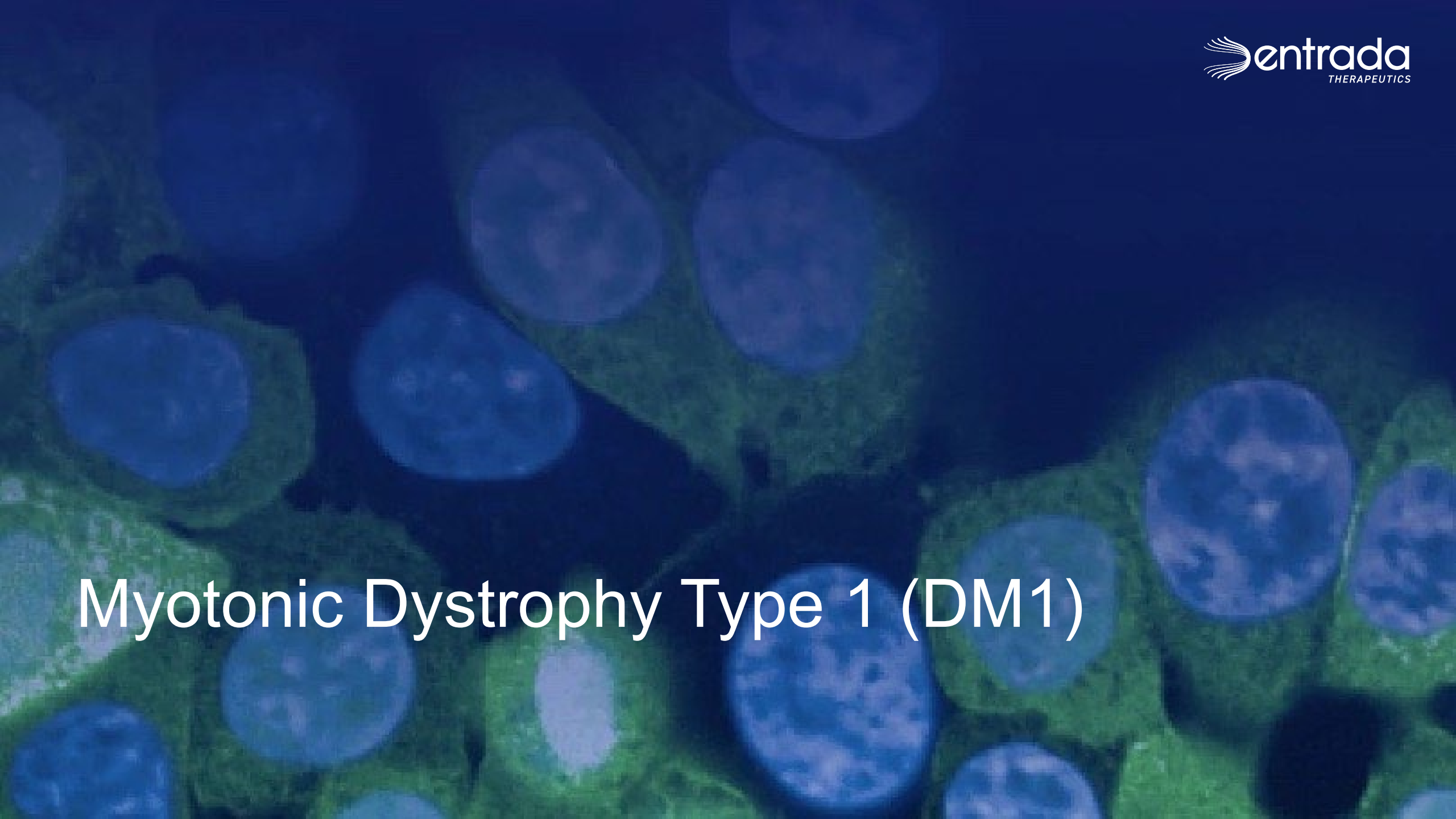
Participants who complete Part A are able to continue into open-label period

- Receive 6 doses of ENTR-601-45 at the level that was administered in participant's Part A cohort
- Dosing initiated
- Study blinded to end of open-label period

- **Dosing Complete**
- Dosing Ongoing

Expansion Cohort

*Expansion cohort and potential for Accelerated Approval is subject to regulatory feedback; Global registration and approval will require Phase 3 studies to follow the Phase 1/2 studies; Phase 3 studies will likely include functional measures as the primary endpoint (U.S. confirmatory study/EU registrational study).



Myotonic Dystrophy Type 1 (DM1)

Vertex DM1 partnership: Phase 1/2 readout expected in second half of 2026

No disease-modifying treatments are currently available for the more than 110,000 people in the U.S. and Europe living with DM1

Vertex completing a placebo-controlled Phase 1/2 clinical program at over 25 global sites

- MAD portion of the clinical study to assess safety and efficacy is on track to read out in the second half of 2026
  - Safety, splice correction and functional changes (including vHOT and QMT) will be assessed
- Open-label extension study is enrolling
- Same EEV utilized for VX-670 as in DMD franchise

VX-670 differentiation

- Unlike antibody-based approaches, VX-670's targeted and specific blocking of pathogenic CUG repeats drives global transcriptome correction while preserving healthy DMPK levels
- Satellite cell uptake may improve outcomes as CUG repeat length correlates with progenitor cell activation, proliferation and differentiation*

Significant upfront and potential future economics associated with the partnership

- Entrada received an upfront payment of $224M and an equity investment of $26M upon initiation of the collaboration
- Agreement provided for up to $485M for the achievement of milestones
- Tiered royalties on future net sales

*Hasuike et al., Front. Genet., March 2022; **CUG repeat**: Repeating sequence of cytosine, uracil and guanine in RNA; **vHOT**: Video hand opening time; **QMT**: Quantitative muscle testing; **DMPK**: Dystrophia myotonica protein kinase.

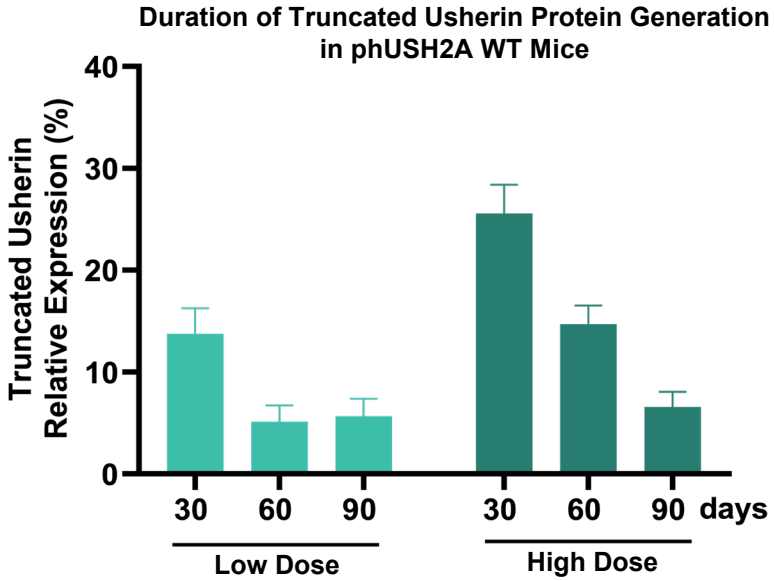
Inherited Retinal Diseases (IRDs)

Addressing areas of high unmet need in IRDs with new oligonucleotide-based therapeutics

Entrada's first IRD clinical candidate, ENTR-801, will target Usher syndrome type 2A (USH2A); Addressable population is ~15,000 patients* in the U.S. and Europe with no approved therapeutics

Usher Syndrome Type 2A (USH2A)

- An inherited eye condition caused by variants in the USH2A gene
- In approximately 30-35% of patients, mutations in exon 13 prevent production of the usherin protein
- Without usherin, photoreceptors (the light-sensing cells in the eye) progressively degenerate
- Lack of usherin leads to vision loss in early adulthood and legal blindness in mid-adulthood
- **No disease-modifying treatments are currently available that can slow or stop disease progression**



About ENTR-801

- Proprietary exon 13 skipping therapy designed to restore functional usherin protein production with the goal of preserving photoreceptor health and function
- Demonstrated robust exon skipping and truncated usherin protein production, with potential for quarterly dosing IVT
- IND-enabling studies will be initiated and clinical strategies will be shared in 2026
- **~15,000 patients in the U.S. and Europe are exon 13 skipping amenable***

Note: **IRDs**: Inherited retinal diseases; *Delmaghani et al., Hum Genet., Apr. 2022; Sanjurjo-Soriano et al., HGG Advance, Oct. 2023; Su et al., Front Aging Neurosci., Aug. 2022; **IVT**: Intravitreal.

2026 Inflection Points

Multiple 2026 near-term value drivers anticipated across expanding pipeline of intracellular therapeutics

ENTR-601-44

Global Phase 1/2 MAD

Cohort 1 safety, dystrophin, functional improvement

Cohort 1 OL data expected by YE 2026

Cohort 2 data expected in Q1 2027

ENTR-601-45

Global Phase 1/2 MAD

Cohort 1 data expected in October 2026

Cohort 2 at 10 mg/kg is enrolling and dosing, data expected H1 2027

ENTR-601-50

Received authorization for Phase 1/2 MAD study (U.K.)

EU regulatory filing expected following a review of data from the ongoing DMD clinical studies

ENTR-601-51

Clinical Trial Authorization (CTA)-enabling studies completed

Global regulatory filings expected following a review of data from the ongoing DMD clinical studies

VX-670

Global Phase 1/2 program

Vertex is on track to share results in H2 2026

ENTR-801

Initial IRD candidate focused on Usher syndrome type 2A

Additional data and clinical plans will be shared in 2026

Second IRD candidate declaration in H2 2026

Pipeline Expansion

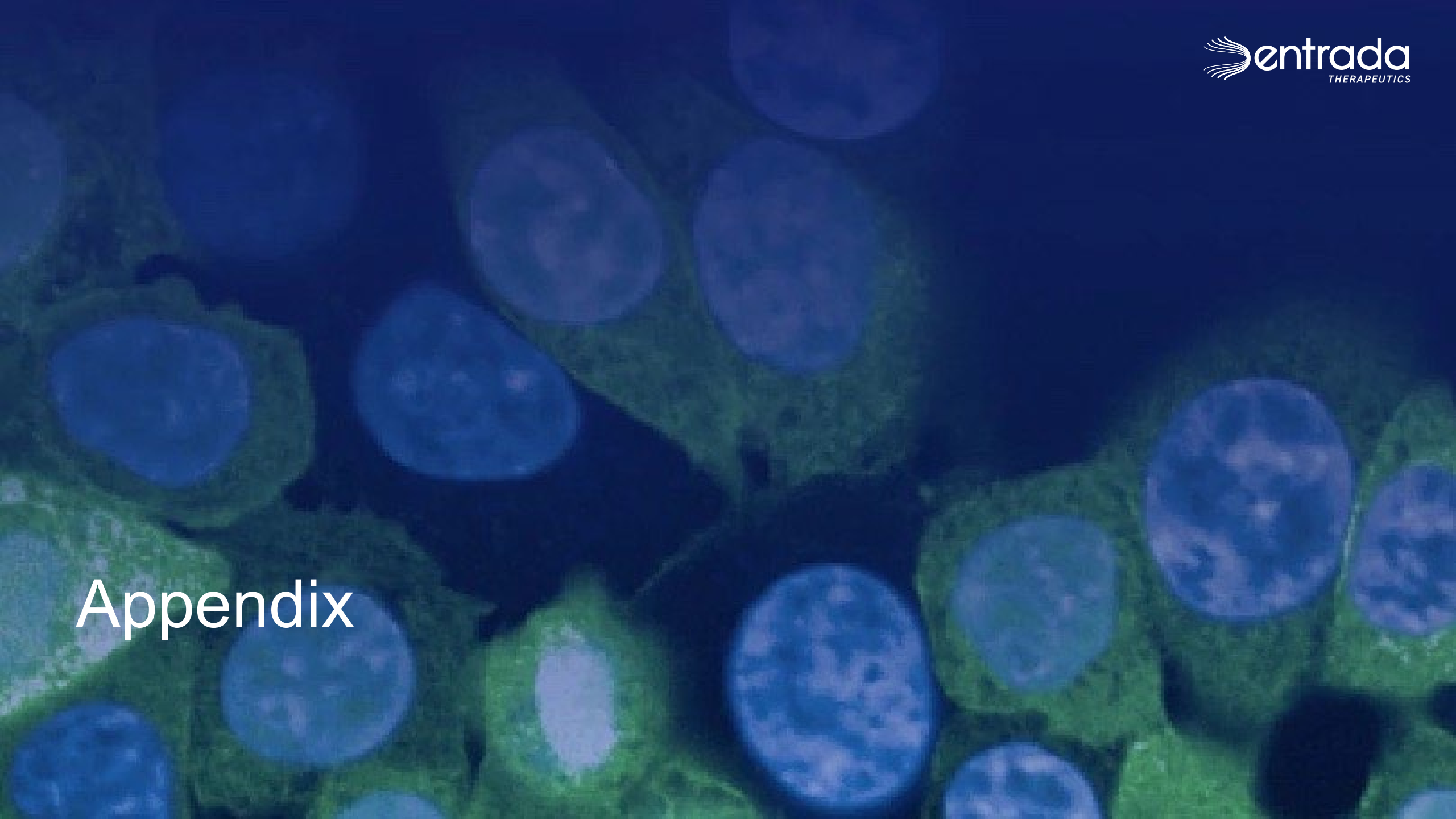
Next-generation EEVs for neuromuscular expansion

Ocular expansion into larger disease areas

Range of undisclosed diseases and modalities

Cash runway into Q3 2027*

Note: All references in this presentation regarding planned regulatory filings and clinical study designs are subject to ongoing discussion with regulatory authorities; *Based on current operating plans and ~$223M in cash, cash equivalents and marketable securities as of June 30, 2026.



Appendix

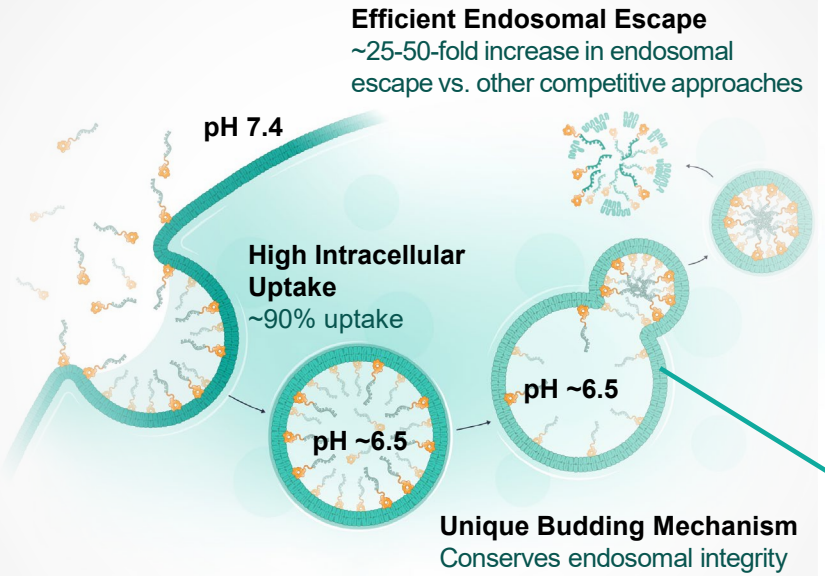
EEV™ Platform

Understanding EEV endosomal escape advantages

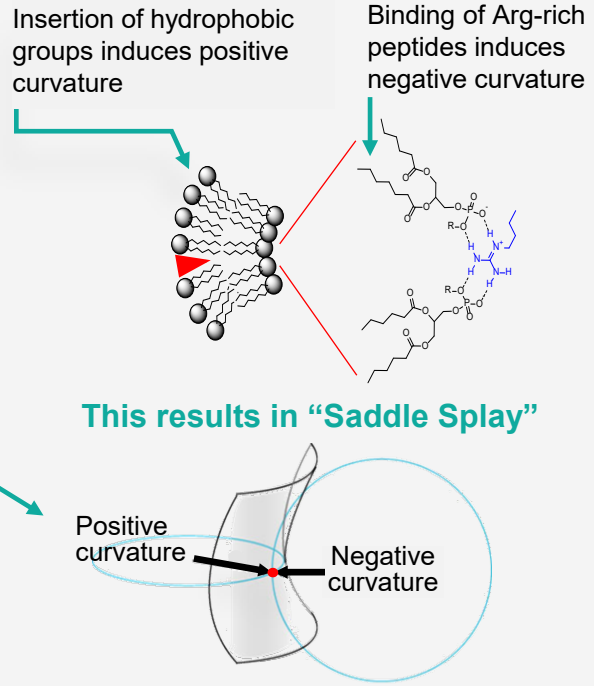
Unique pH-dependent membrane binding affinity enhances EEV endosomal escape

- EEVs have a higher affinity to phospholipids compared to traditional linear CPPs; The interaction of EEVs with phospholipids is pH-dependent
- The specific interaction of EEVs with the endosomal membrane facilitates the escape of EEVs from early endosomes, as demonstrated by the correlation between endosomal escape efficiency and endosomal membrane binding affinity

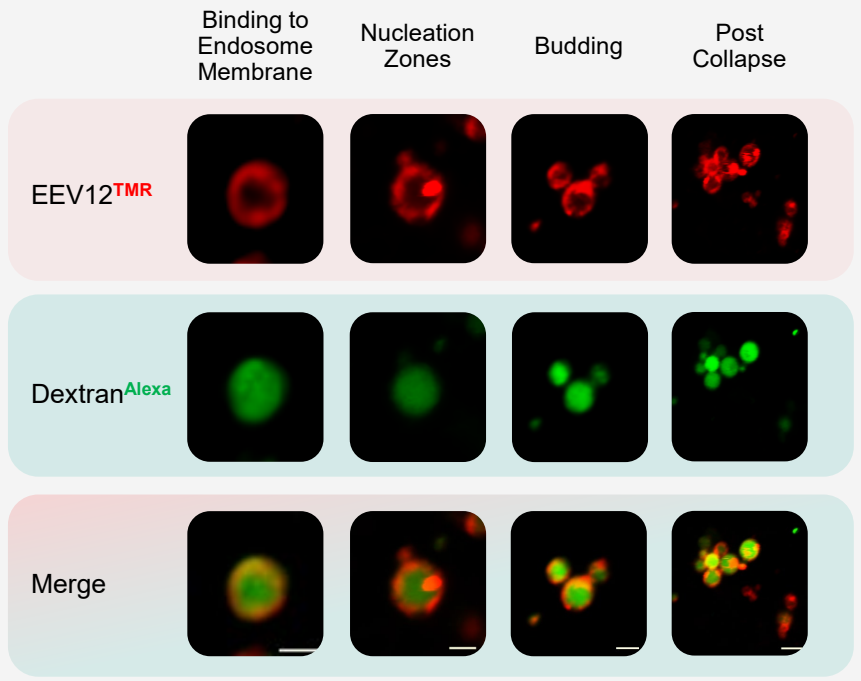
Concept



Mechanism



Visualization

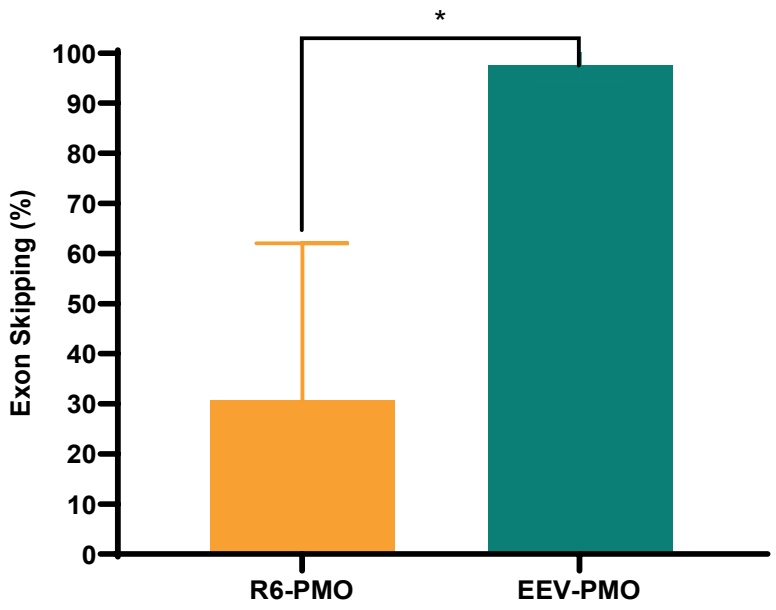


Sahni, A. et al. ACS Chem. Biol. 2021; **CPP**: Cell-penetrating peptide.

Entrada optimizes both the EEV delivery vehicle and the active conjugate to create best-in-class medicines

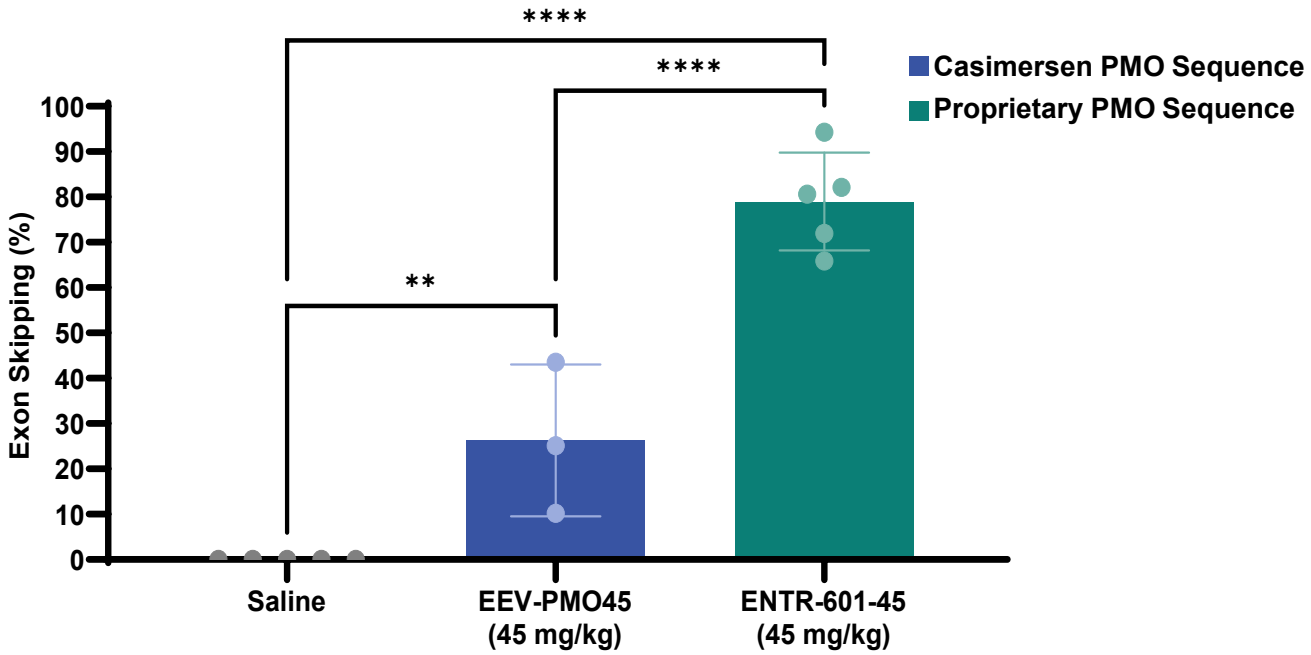
In the below DMD example, Entrada has optimized the EEV and the PMO sequence; The data represents the superiority of each component against other approaches and sequences

EEV Optimization



- PMO sequences are the same, cell penetrating peptides are different (linear vs. cyclic)
- EEV-PMO significantly improved exon skipping after 3 days in *mdx* mice as compared to competitive R6-PMO

PMO Optimization



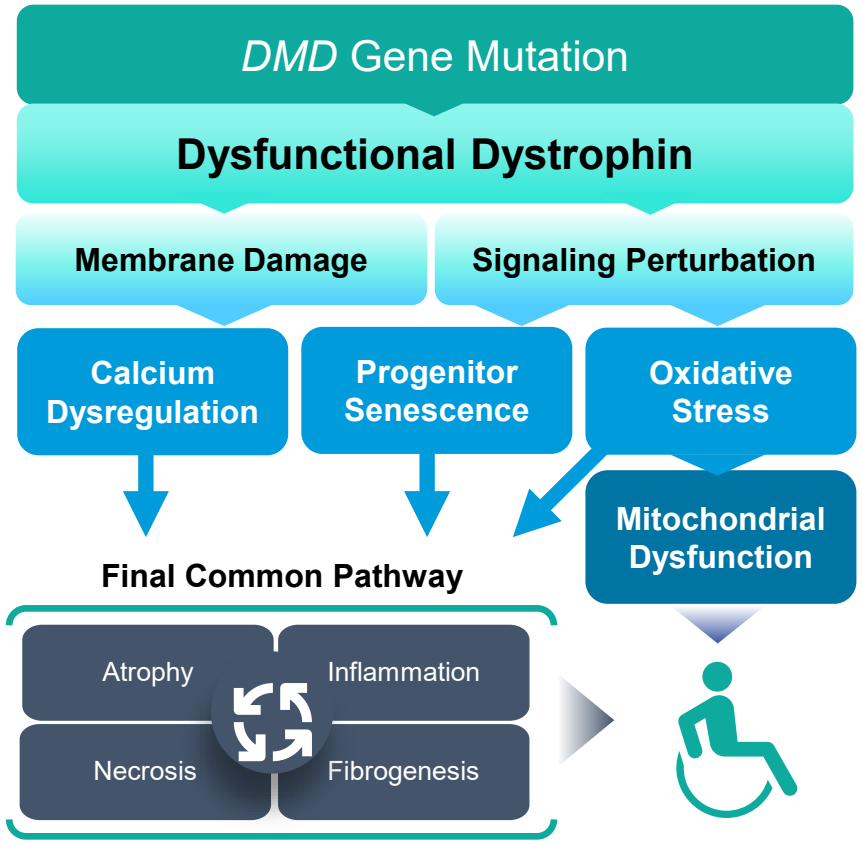
- EEVs are the same, PMO sequences are different (casimersen vs. Entrada proprietary)
- Proprietary PMO significantly improved exon skipping after 3 days in *hDMD* mice as compared to competitive casimersen sequence

*p<0.05, **p<0.01, ***p<0.001, ****p<0.0001; relative to saline; Concentrations provided are PMO equivalent; Data presented at 2024 World Muscle Society conference.

DMD Approach

Entrada addresses the underlying cause of DMD and restores dystrophin in muscle fibers and muscle stem cells

The Duchenne Disease Cascade



Current and Emerging Treatment Options

1. Disease-modifying agents address the root cause of morbidity and mortality

- High-quality dystrophin production to both mature and progenitor muscle cells protects healthy muscle and restores regenerative capacity
- Must be safe, potent, reach both mature and progenitor cells, be infrequently dosed, be redosable and dosing is weight based to meet the needs of a growing child
- **Entrada is developing the only disease-modifying agents with the potential to meet ALL of the above**[1]

2. Supportive care agents only address downstream biology

- Myosin(i), AAK1(i), HDAC(i) may potentially enhance disease-modifying therapies and complement dystrophin restoration
- Mechanisms include membrane protection/repair and stem cell proliferation
- Symptomatic care, led by steroids, have served as standard of care despite long-term tolerability and safety concerns

Entrada's next-generation exon skippers

- Established safety at a therapeutic dose of 6 mg/kg[2]
- Expected to provide durable and significant access to skeletal and cardiac muscle
- Target progenitor cells (satellite) needed to regenerate muscle and provide functional benefit
- Flexible to dose escalate and redose

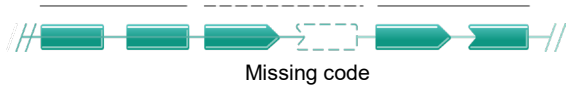
Adapted from Front. Cell Dev. Biol., 18 August 2021; Sec. Molecular and Cellular Pathology; Volume 9, 2021; [1]·No other exon skippers nor gene therapy fit all the disease-modifying criteria; [2]·ENTR-601-44 data.

Entrada is developing genetic medicines to correct the mechanism of disease and slow, halt or reverse progression

Entrada's Approach: Modulate RNA Splicing and Produce Functional Protein to Preserve and Rebuild Muscle

Individuals with Duchenne

Pre-mRNA
With exon deletion, protein program is miscoded



mRNA
Reading frame disrupted and body reads STOP!

No Translation

Protein
Resultant mRNA sequence stops the production of functional dystrophin protein

DMD

Entrada Approach

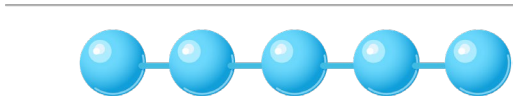
Pre-mRNA
Treatment enables skipping of exon

Splice modulation

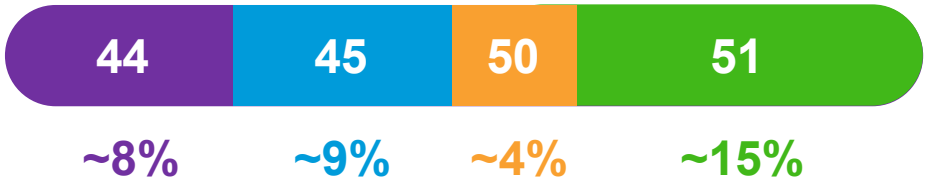
mRNA
Reading frame restored

Translation

Protein
Functional dystrophin protein is translated and muscle membrane regains integrity



DMD Mutations and Tissues of Focus in the Entrada Portfolio



~35% = ~11,500 Patients*

Entrada addresses mutations which result in a lack of dystrophin, muscle breakdown, progressive disability and death

The portfolio covers ~35% of the total population totaling ~11,500 patients in the U.S. and EU*

*Sub-mutation estimates rounded, from Bladen et al., HGVS Journal, January 2015; DMD population estimated to be ~7-8 per 100,000 males per Crisafulli et al., Orphanet J. Rare Disease, June 2020; Calculation based on estimates of U.S. and EU (defined as EU27 population).

Competitive Comparison

EEV therapies are expected to show superior dystrophin production and dose-dependent increases in therapeutic index

A 25-50-fold improvement in endosomal escape, novel PMO sequences, non-linear increases in PK/PD, satellite cell uptake and lower whole drug requirements compared to antibody-based therapies

	EEV-PMO **Entrada**	**Anti-TfR1-mAb-PMO (exon 44)** Novartis/Avidity	**Anti-TfR1-Fab-PMO (exon 51)** Dyne
Design	**Cyclic, arginine-light peptide** 2.6 kDa Tissue-specific delivery; Increases stability and half-life	**Full-length antibody** ~150 kDa TfR1 specific deliver; Non-cleavable linker	**Fragment antibody** ~50 kDa TfR1 specific delivery; Cleavable linker
Dose	✓ **Low conjugate doses** ~5 mg/kg PMO + 1 mg/kg EEV = **6 mg/kg whole drug (ELEVATE-44-201 Cohort 1 dose)**	– **Large conjugate doses** 5 mg/kg PMO (registrational dose) + ~23 mg/kg mAb = **~28 mg/kg whole drug dose**[1]	– **Large conjugate doses** 20 mg/kg PMO (registrational dose) + undisclosed mg/kg Fab = **undisclosed mg/kg whole drug dose**[2]
Uptake	✓ **No limit on dose response seen** **48.3%** increase in exon skipping from 3 to 6 mg/kg whole drug dose in HNV[3]	– **Apparent limit on dose response** No increase in dystrophin from 5 to 10 mg/kg PMO dose in DMD exon 44 patients: **25% vs. 26%**[4,5]	– **Apparent limit on dose response** No increase in dystrophin from 10 to 20 mg/kg PMO dose in DMD exon 51 patients: **2.97% vs. 3.14%**[2,4]
Target engagement	✓ **Enhanced endosomal escape** **~25-50 fold increase in endosomal escape** vs. other competitive approaches	– **No enhanced endosomal escape** Once dissociated from the mAb in the lysosome, the unconjugated PMO escapes at **<2% efficiency**[6]	– **No enhanced endosomal escape** Once dissociated from the Fab in the endosome, the unconjugated PMO escapes at **<2% efficiency**[6]

TfR1: Transferrin receptor 1; [1]Etxaniz et al., Nucleic Acid Res., 2025; [2]Dyne corporate materials from DELIVER Clinical Update investor call September 2025; [3]Total mean exon skipping; Entrada internal data from Phase 1 SAD study of ENTR-601-44 in HNV; [4]Unadjusted dystrophin, mean change from baseline; [5]Avidity corporate materials from del-zota Topline Data investor call March 2025; [6]Dowdy et al., Nucleic Acid Ther., 2022.

ELEVATE-44-201

Functional Measures:

Time to Rise and Time to Rise Velocity

Functional improvement
The importance and meaning of Time to Rise velocity

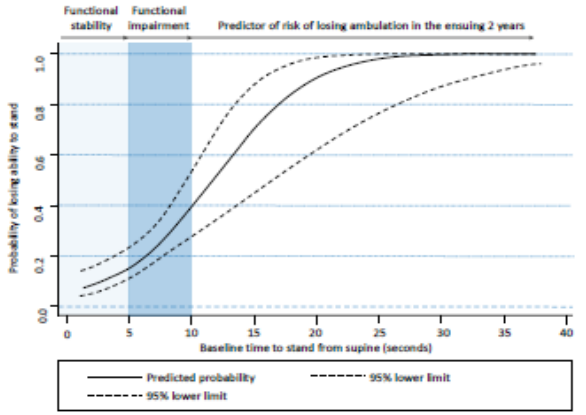
Time to Rise, a secondary endpoint in this study, is a robust, prognostic factor that predicts disease progression; Time to Rise velocity reduces the impact of imputation, outliers and noise

- **TTR declines rapidly** over time in patients with DMD and is an early **prognostic factor for disease progression and loss of ambulation**[1]
  - The largest absolute and proportional annual signal among functional measures and early prognostic factor for disease progression and loss of ambulation
  - Robust, as rising from the floor depends on proximal strength and postural control, functions affected early in disease progression[1]
  - Precedes improvements in 4-stair climb or 10-meter walk test and less complicated than NSAA[2]
- **TTRV** is calculated as 1/TTR, expressed as rises/second and is designed to reduce the impact of outliers and imputed data (illustration at right)
  - Handles the unable to perform problem by scoring that observation at zero avoiding arbitrary scoring
  - Dampens clinically meaningless scoring noise between visits
  - Compresses the long tail and produces a distribution that is much closer to normal, which matters for parametric statistics

Table 1. Clinical relevance of TTSTAND measurements[1]

TTSTAND	Clinical relevance
<5 seconds	Suggests functional stability[2,3]
≥5 seconds	Indicates functional impairment[2,3] Shown to predict disease progression over 48 weeks[2,3]
≥10 seconds	Shown to predict risk of losing ambulation in the ensuing 2 years[3]

Fig 1. Predicted probability of losing ability to stand at 24 months given baseline time to stand from supine assessment (TTSTAND). Adjustment made for baseline age and cumulative steroid use at baseline



Illustrative Data and Representative Calculation of TTRV

TTR baseline (seconds)	TTR end of study (seconds)	Improvement (seconds)	TTRV calculation	Δ TTRV (rises/sec)
6.0	3.89	2.11	1/3.89 – 1/6.0 = 0.257 – 0.167	**+0.09**
8.0	4.65	3.35	1/4.65 – 1/8.0 = 0.215 – 0.125	**+0.09**
10.0	5.26	4.74	1/5.26 – 1/10.0 = 0.190 – 0.100	**+0.09**

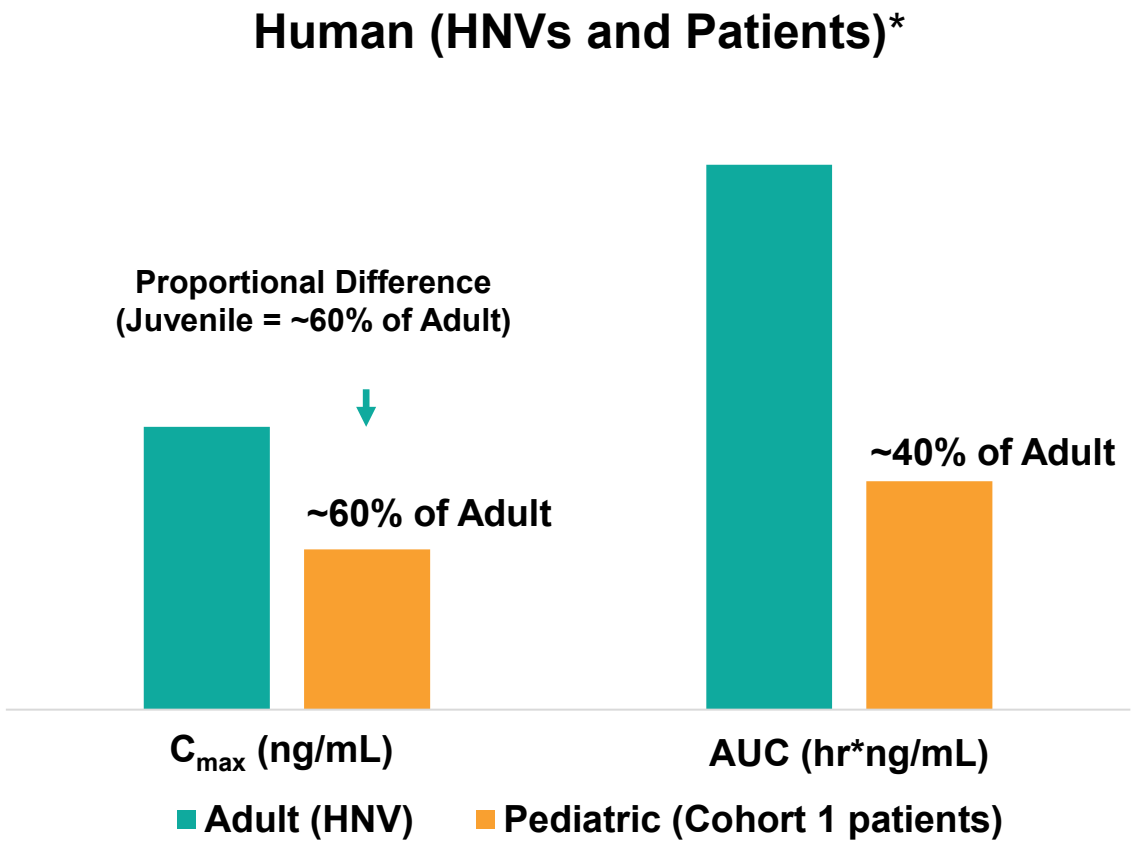
Explanation: A boy starting at a TTR of 6 seconds needs to improve by ~2 seconds to achieve +0.09 ΔTTRV, but a boy starting at a TTR of 10 seconds needs to improve by ~4.5 seconds for the same velocity change

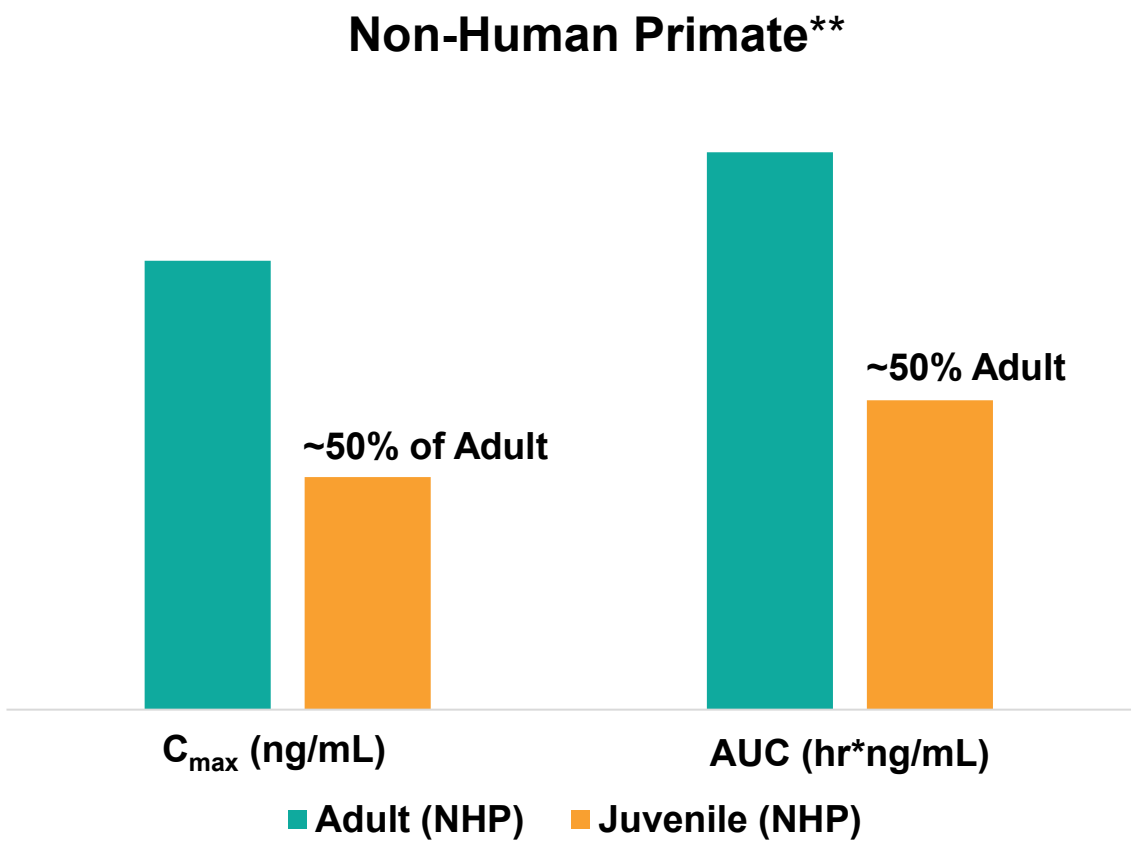
[1] Cicala et al., Italian DMD Network (WMS 2025); [2] McDonald et al., CINRG DNHS (PPMD 2021); **NSAA**: North Star Ambulatory Assessment.

Pharmacokinetic Data

Predictive pharmacokinetics

Lower C_{max} and AUC observed in juvenile humans and NHPs; A linear (or better) increase in exposure is expected in Cohort 2 at 12 mg/kg (double dose = double exposure)





*Single dose 6 mg/kg, pediatric DMD patients following third dose; **Adult: 13-week 25 mg/kg repeat dose study, Q6W, 3 doses; Juvenile: 55-week 20 mg/kg repeat dose study, Q6W,10 doses.

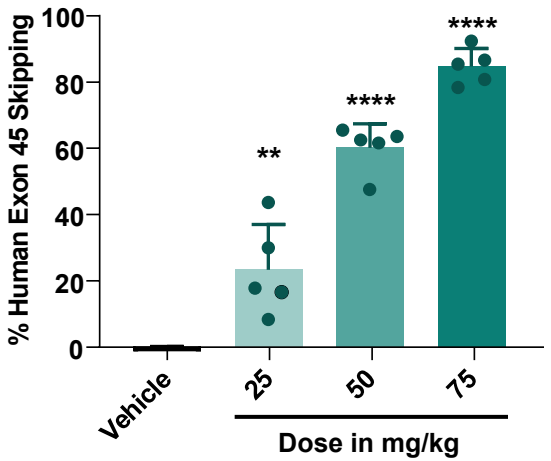
DMD Functional Data:

Preclinical Models

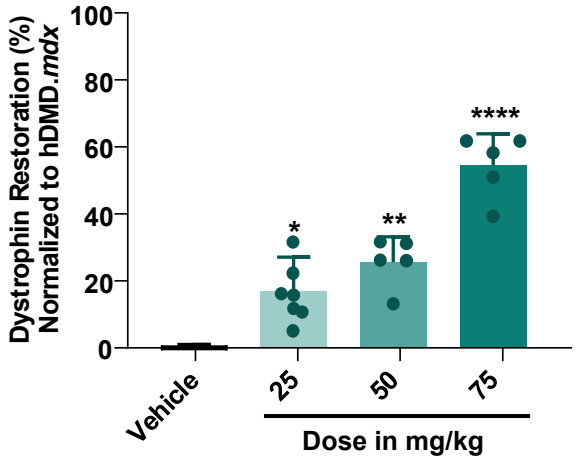
Preclinical data support potential for best-in-class clinical profile for ENTR-601-45

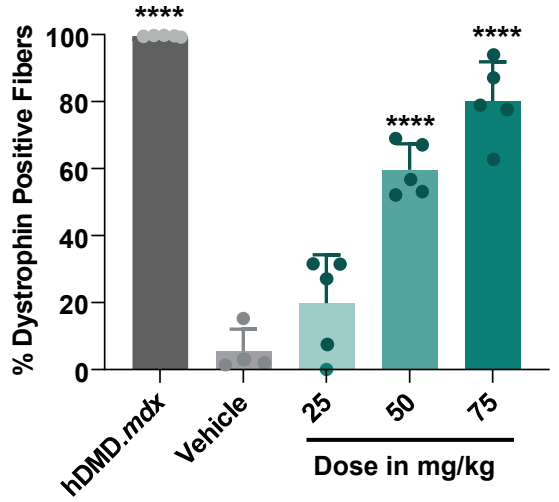
Dose-dependent increase in exon skipping and dystrophin expression correlates to complete functional correction

Exon Skipping

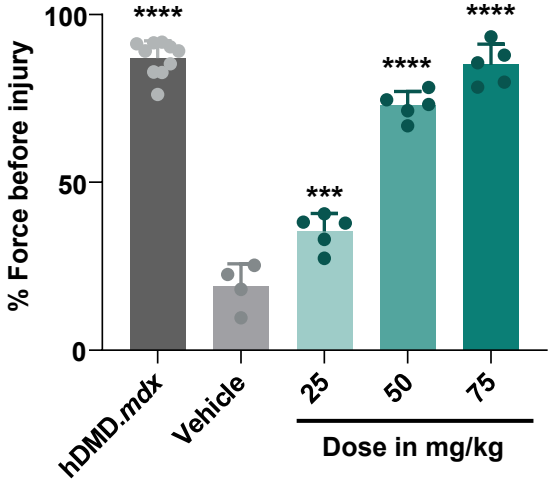


Dystrophin Restoration





Functional Correction



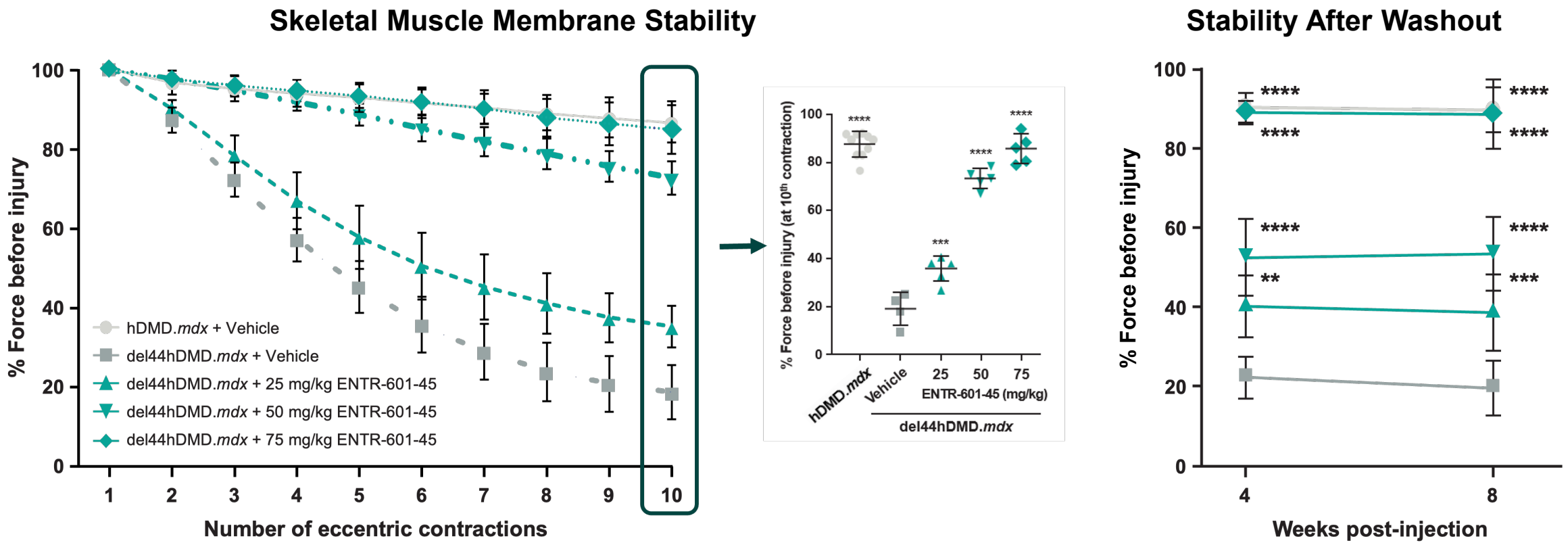
- Active and vehicle del44hDMD.*mdx* mice, n=5 per cohort, ENTR-601-45 (Q6W x 3 doses); Control saline treated hDMD.*mdx* mice, n=10 (Q6W x 3 doses)
- Skipping (ddPCR) and dystrophin production (JESS) is significantly increased 6 weeks after the third dose of ENTR-601-45 (gastrocnemius muscle shown)

Data are shown as mean ± SD; *p ≤ 0.05; **p ≤ 0.01; ***p ≤ 0.001; ****p ≤ 0.0001; 25 mg/kg correlates to ~5 mg/kg human equivalent dose (HED), 50 mg/kg correlates to ~10 mg/kg HED, 75 mg/kg correlates to ~15 mg/kg HED; Data presented at the 2024 World Muscle Society conference.

Dose-dependent and durable improvements in muscle function observed in del44hDMD.*mdx* mice

ENTR-601-45

Dose-dependent increase in percent force retention following 10 contractions; Increase maintained for at least 8 weeks after the third Q6W dose of ENTR-601-45



del44hDMD.*mdx* mice were treated with three Q6W IV injections of ENTR-601-45 or vehicle; ECC-induced muscle force loss generated by repeated eccentric force (ECC) contraction of the gastrocnemius muscle was assessed 5 weeks (left/center) or 4 and 8 weeks (right) after the third dose; Data (mean ± standard deviation) shown across 10 ECC contractions normalized into a percentage of the initial force before any ECC contractions and as the percentage of force retained after the tenth contraction; Vehicle-treated hDMD.*mdx* mice were used as a control group for normal muscle function; One-way ANOVA (Analysis of variance) was used for statistical comparison to vehicle-treated del44hDMD.*mdx* mice; **p < 0.01, ***p < 0.001, ****p < 0.0001 vs. vehicle; Data presented at the 2024 World Muscle Society conference.

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