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Reimagining Cancer Treatment

Syndax Investor Meeting
American Society of Hematology Annual Meeting
December 8, 2025

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Welcome & Opening Remarks

Michael Metzger
Chief Executive Officer, Syndax

Agenda

Welcome & Opening Remarks
Michael Metzger, CEO

Niktimvo™ (axatilimab-csfr)

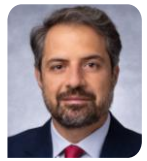
Latest R/R Chronic GVHD Data
Zachariah DeFilipp, M.D., Director of BMT Clinical Research, Massachusetts General Hospital

Panelist Discussion and Audience Q&A

Revuforj® (revumenib)

Acute Leukemia Overview & Real-World Evidence
David Sallman, M.D., Associate Member in the Department of Malignant Hematology, Moffitt Cancer Center

Post-HSCT Maintenance & SAVE Results in Frontline AML
Elias Jabbour, M.D., Professor, Department of Leukemia, Division of Cancer Medicine, MD Anderson Cancer Center



Intensive Chemotherapy Combination Data in Frontline AML
David Swoboda, M.D., Director of Leukemia, Tampa General Hospital

Developing Revuforj & Niktimvo Into Industry Leading Franchises
Nick Botwood, Head of R&D and CMO

Panelist Discussion and Audience Q&A

Syndax is a commercial-stage oncology company on the road to profitability with two drugs with multi-billion-dollar potential

Two first- & best-in-class drugs

Niktimvo™ (axatilimab-csfr)

$5B+ TAM

Revuforj® (revumenib) tablets 25 mg • 110 mg • 160 mg

$5B+ TAM

Two exceptional product launches

Strong Syndax presence at ASH 2025 highlights leadership in menin and CSF-1R inhibition

23 presentations by Syndax & collaborators

Revuforj® (revumenib) tablets	**3** oral presentations	**9** poster presentations
Niktimvo™ (axatilimab-csfr)	**3** oral presentations	**8** poster presentations

100s of engagements with HCPs

- **2** Syndax-supported CME events
- **1** product theater

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Revuforj is positioned for long-term growth & success in menin inhibition

First and only menin inhibitor FDA approved for multiple acute leukemia subtypes in adults and children ≥1 year of age

Two indications represents $2B+ U.S. TAM in R/R setting alone

Comprehensive 1L clinical development plan underway

BEST-IN-CLASS PROFILE

- Unmatched efficacy across multiple pt subtypes
- Well-tolerated with clear, flexible dosing
- Can be used concomitantly with other commonly used drugs, including gastric acid reducing agents

FIRST-MOVER ADVANTAGE

- >1,000 pts treated across commercial and clinical trial experience
- Track record of delivering for patients
- Excellent formulary coverage & reimbursement
- Included in NCCN Guidelines®

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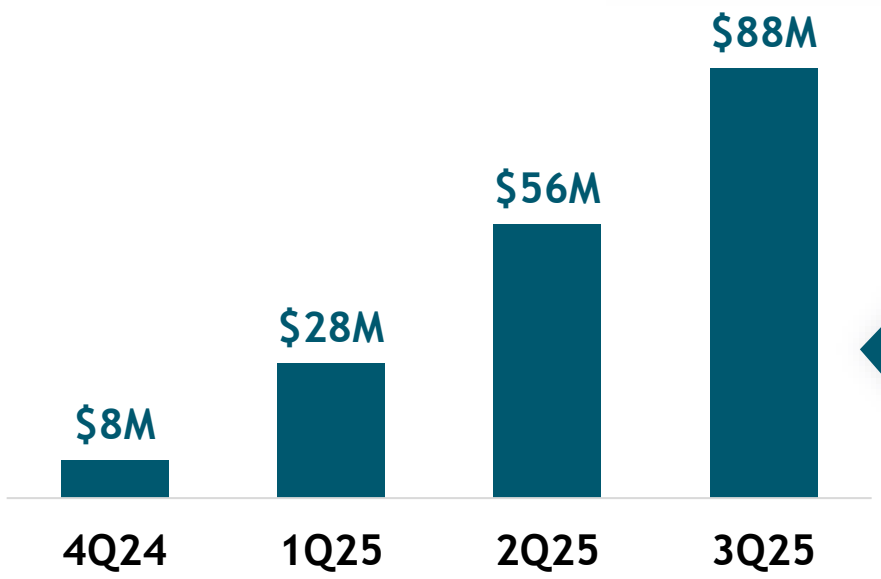
Revuforj is FDA approved for the treatment of R/R acute leukemia with a KMT2A translocation as determined by an FDA-authorized test in adult and pediatric patients 1 year and older. Revuforj is also indicated for the treatment of R/R acute myeloid leukemia (AML) with a susceptible NPM1 mutation in adult and pediatric patients 1 year and older who have no satisfactory alternative treatment options.

Growing Revuforj demand underscores exceptional product profile

Revuforj® (revumenib) tablets
25 mg • 110 mg • 160 mg

Cumulative net revenue since launch



3Q25 metrics:

- 25% growth in total prescriptions & new patient starts over 2Q25
- ~750 new patients starts since launch

Revuforj launch exceeding all other AML analogs, even with a third of KMT2A patients pausing Tx to proceed to stem cell transplant

On track to treat **1,000 KMT2A pts by YE 2025**

Building usage observed post-HSCT in KMT2A pts

Meaningful inflection in demand following FDA approval in R/R NPM1m AML

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TRx, total prescriptions; Tx, treatment; HSCT, hematopoietic stem cell transplantation; pts, patients

Niktimvo is poised to deliver on the promise of CSF-1R inhibition in chronic GVHD and beyond

First and only CSF-1R-blocking antibody FDA approved in ≥3L chronic GVHD

Initial indication represents $2B+ U.S. TAM

POSITIONED FOR SUCCESS

- Novel mechanism in chronic GVHD to address inflammation and fibrosis
- Responses were rapid, durable & observed across all organs studied in AGAVE-201
- Included in NCCN Guidelines®
- Strong commercial synergies with Revuforj
- Trials underway in 1L chronic GVHD and IPF to further unlock multi-billion-dollar opportunity

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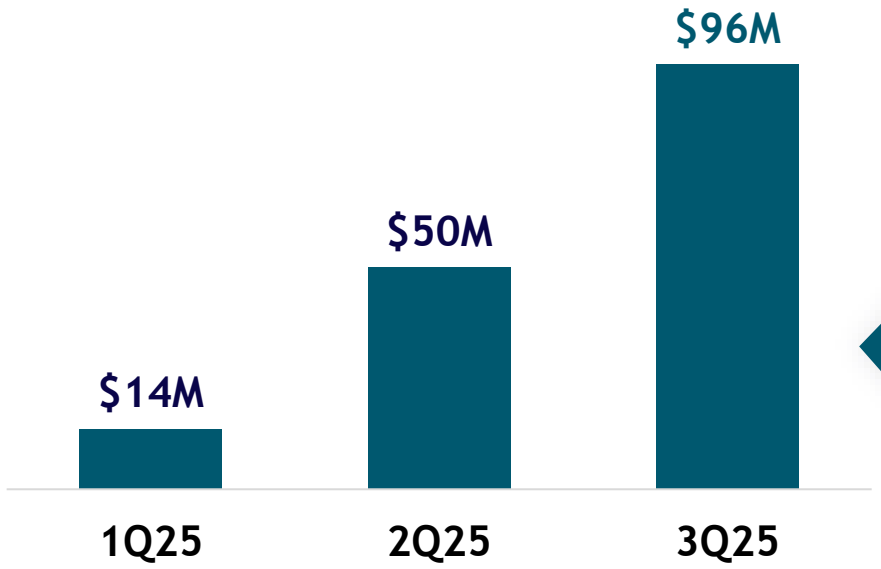
Niktimvo is FDA approved for the treatment of chronic graft-versus-host disease (GVHD) after failure of at least two prior lines of systemic therapy in adult and pediatric patients weighing at least 40 kg (88.2 lbs).

Strong Niktimvo results highlight the importance of this novel medicine to patients and Syndax

Niktimvo™ (axatilimab-csfr)

Cumulative net revenue since launch
(reported by Incyte)



3Q25 metrics:

- Usage mainly in 4L, growing in 3L
- 80% of pts that started in Q1 remained on Tx
- 1,100 new patient starts since launch

Niktimvo sales annualizing at nearly $200M within first 8 months of launch

Profitable to Syndax in first full quarter (proportion of net revenue retained by Syndax expected to materially grow over time)

First year sales tracking with another ≥3L cGVHD drug that reached **$500M in annual U.S. net sales** within first 3 full years of launch

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Tx, treatment; 4L, fourth line; 3L, third line; pts, patients

Niktimvo in Recurrent/Refractory Chronic GVHD

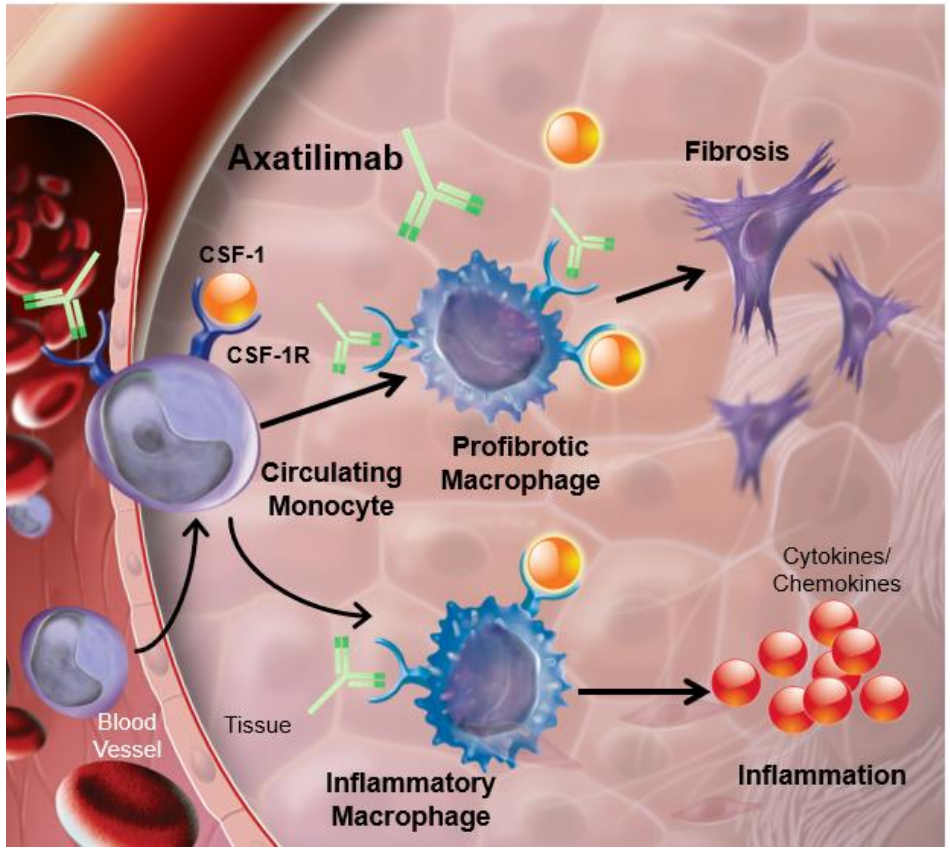
Zachariah DeFilipp, M.D.
Director of BMT Clinical Research, Massachusetts General Hospital; Associate Professor of Medicine, Harvard Medical School

Chronic GVHD (cGVHD) is an area of high unmet need

- **Occurs in ~50% of pts** who receive an allo-HSCT
- **Affects multiple organs** with inflammatory & fibrotic pathology; many organs respond poorly to traditional SOC therapies
- **Major cause of morbidity and non-relapse mortality**
- **Nearly 50% of cGVHD patients progress to 3L** treatments

Bachier CR, et al. Epidemiology and Treatment of Chronic Graft-versus-Host Disease Post-Allogeneic Hematopoietic Cell Transplantation: A US Claims Analysis. Transplant Cell Ther. 2021.

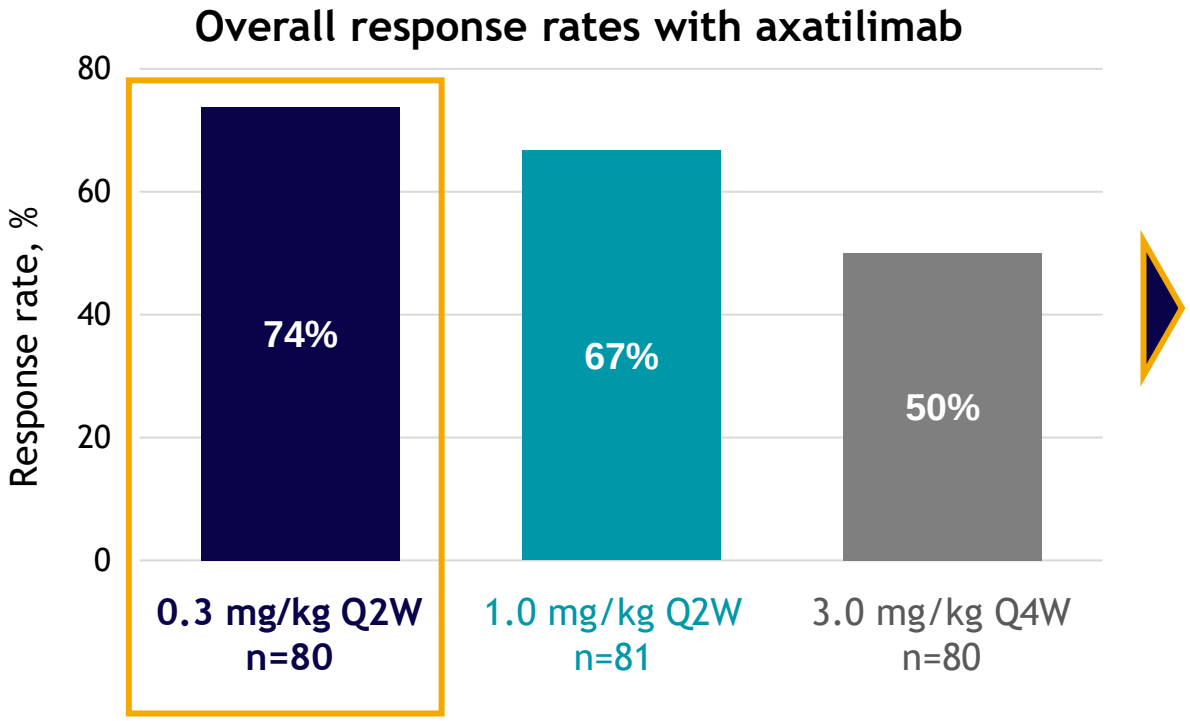
Niktimvo provides a new mechanism of action for addressing cGVHD



Niktimvo is a CSF1-R-blocking antibody which targets monocytes and macrophages, key mediators of inflammation and fibrosis in cGVHD

Data from AGAVE-201 trial of axatilimab in R/R cGVHD provide evidence of the feasibility of a less frequent dosing schedule

AGAVE-201



In the 0.3 mg/kg Q2W cohort, pts who achieved a ≥20-week sustained partial or complete response, or had not progressed, were able to transition to 0.6 mg/kg Q4W (without dose capping) per study protocol & investigator discretion

Key observations:

- 19 pts transitioned from axatilimab 0.3 mg/kg Q2W (FDA approved dose) to 0.6 mg/kg Q4W dosing
- Pts who switched doses had a **prolonged duration of therapy (median, 1.7 y), and 84% continued treatment, suggesting ongoing clinical benefit**

	0.3 mg/kg Q2W to 0.6 mg/kg Q4W (n=19)	
	Before switch	After switch
Treatment duration, median (range), months	7.4 (6–14)	20.9 (2–32)

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ASH 2025 abstract #272.

Transition to 0.6mg/kg Q4W axatilimab dosing in R/R cGVHD was well tolerated in the AGAVE-201 trial

AGAVE-201

Most common TEAEs[1], n (%)	0.3 mg/kg Q2W to 0.6 mg/kg Q4W (n=19)	
	Before switch	After switch
Fatigue	5 (26.3)	5 (26.3)
URTI	1 (5.3)	5 (26.3)
Headache	2 (10.5)	4 (21.1)
Abdominal pain	0	3 (15.8)
Cough	1 (5.3)	3 (15.8)
CPK increased	1 (5.3)	3 (15.8)
Diarrhea	1 (5.3)	3 (15.8)
Fall	0	3 (15.8)
Oropharyngeal pain	0	3 (15.8)
Pruritus	0	3 (15.8)
Pyrexia	1 (5.3)	3 (15.8)

Grade≥3 and serious TEAEs, n (%)	0.3 mg/kg Q2W to 0.6 mg/kg Q4W (n=19)	
	Before switch	After switch
TEAEs	19 (100)	18 (94.7)
Grade ≥3 TEAEs	7 (36.8)	10 (52.6)
Serious AEs	1 (5.3)	8 (42.1)
Treatment-related serious AEs	1 (5.3)	2 (10.5)
TRAEs	14 (73.7)	11 (57.9)
Grade ≥3 TRAEs	2 (10.5)	3 (15.8)
TEAEs leading to dose interruption	7 (36.8)	4 (21.1)
TEAEs leading to dose reduction	0	1 (5.3)
TEAEs leading to Tx discontinuation	0	3 (15.8)[2]
TEAEs of special interest	12 (63.2)	17 (89.5)

Grade ≥3 TEAEs and serious AEs were numerically higher following the switch; these differences were not unexpected, given the extended duration of treatment after switching to the new dosing schedule

Similar safety profile before and after the dosing change

Safety data support potential for **long-term use**

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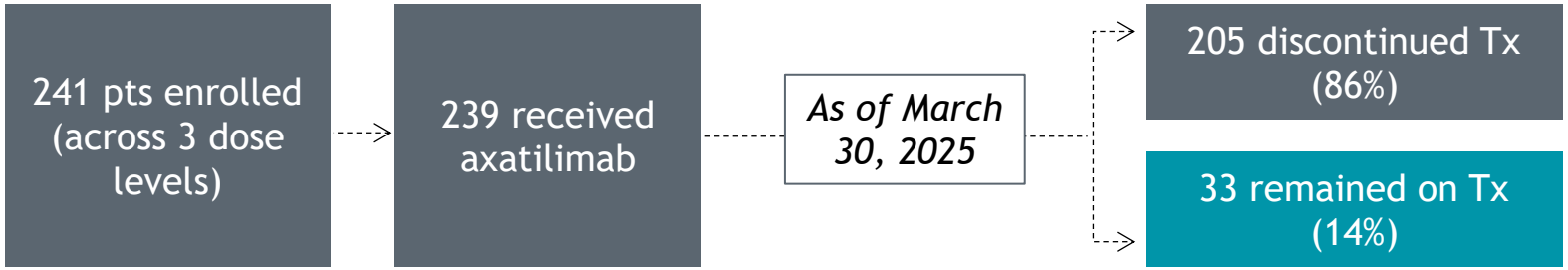
ASH 2025 abstract #272. TEAEs, treatment emergent adverse events. 1. Reported in ≥15% of patients after switching to 0.6 mg/kg Q4W. 2. Discontinuations owed to chills, squamous cell carcinoma of the skin, and squamous cell carcinoma of the tongue.

Follow-up data from AGAVE-201 trial of axatilimab in R/R cGVHD highlight potential for long-term benefit

Poster with additional data will be presented on Dec 8 at 6pm

AGAVE-201



Treatment duration & safety among pts remaining on treatment as of March 30, 2025

	0.3 mg/kg Q2W (approved dose) n=15	All dose levels n=33
Treatment duration, median (range)	**33 (31-41) months**	**34 (31-41) months**
Long-term safety		
TEAEs in ≥35% of pts	Upper respiratory infection (53%), COVID-19 (40%), headache (40%)	Headache (46%), CPK increased (42%), upper respiratory tract infection (42%), AST increased (36%)
≥1 TRAE Gr ≥3 event, n (%)	4 (27%)	12 (36%)

Of the treated pts, 14% have continued axatilimab with a **median duration of therapy of 2.8 years**

Long-term data show **continued tolerable safety profile**

Across all doses, the **46-month OS rate was 74%**

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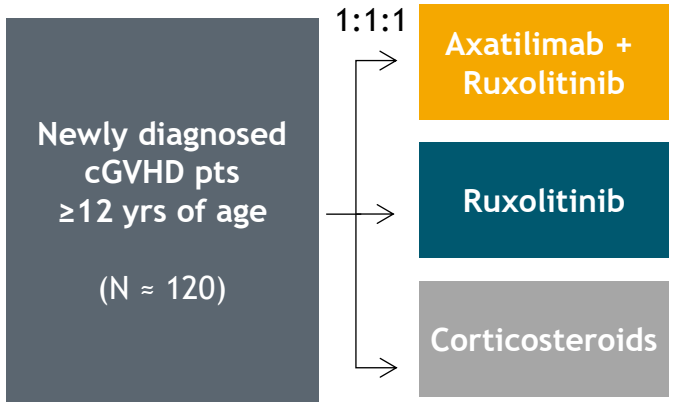
ASH 2025 abstract #6010. TEAEs, treatment emergent adverse events; TRAE, treatment-related adverse event

Interim data from Ph 2 trial of axatilimab + ruxolitinib in 1L cGVHD highlights feasibility of potential steroid-sparing regimen

Poster with additional data will be presented on Dec 8 at 6pm

Phase 2 trial design



Primary endpoint:

- Overall response (including complete or partial response) at 6 months in the absence of new systemic cGHVD therapy

Pre-specified interim safety analysis

Population:

- 44 pts enrolled; 43 pts received study treatment
- Median age: 65 years; 55% had severe disease at enrollment

Status among enrolled pts, n (%)	Axa + Rux n=15	Rux n=15	Steroids n=14
Discontinued treatment	1 (7%)	1 (7%)	6 (43%)
Insufficient response to Tx	0	0	5 (36%)
Patient withdrawal	0	0	1 (7%)
Death	0	1 (7%)[a]	0
Relapse or progression of underlying hematologic disease	1 (7%)[b]	0	0

Safety among treated pts, n (%)	Axa + Rux n=15	Rux n=15	Steroids n=13
TEAEs (any Grade)	11 (73%)	12 (80%)	9 (69%)
TEAEs Grade ≥3	2 (13%)	2 (13%)	1 (8%)

Axatilimab with ruxolitinib was **well-tolerated in 1L cGVHD**

Combination represents a **promising steroid-sparing regimen**

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ASH 2025 abstract #6012. The pre-specified interim safety analysis was planned to occur after approximately 30 patients received ≥1 cycle of study treatment.
a. Death due to bronchospastic crisis, which was considered by the investigator as unrelated to ruxolitinib; b. Relapse was not considered to be related to study treatment.

Enrollment ongoing in Ph 3 trial of axatilimab + corticosteroids in 1L cGVHD

AXemplify-357 trial design

Key eligibility criteria

- ≥12 years
- New-onset moderate to severe cGVHD

(N ≈ 240)

1:1

Treatment for ≤24 months

Axatilimab + corticosteroids

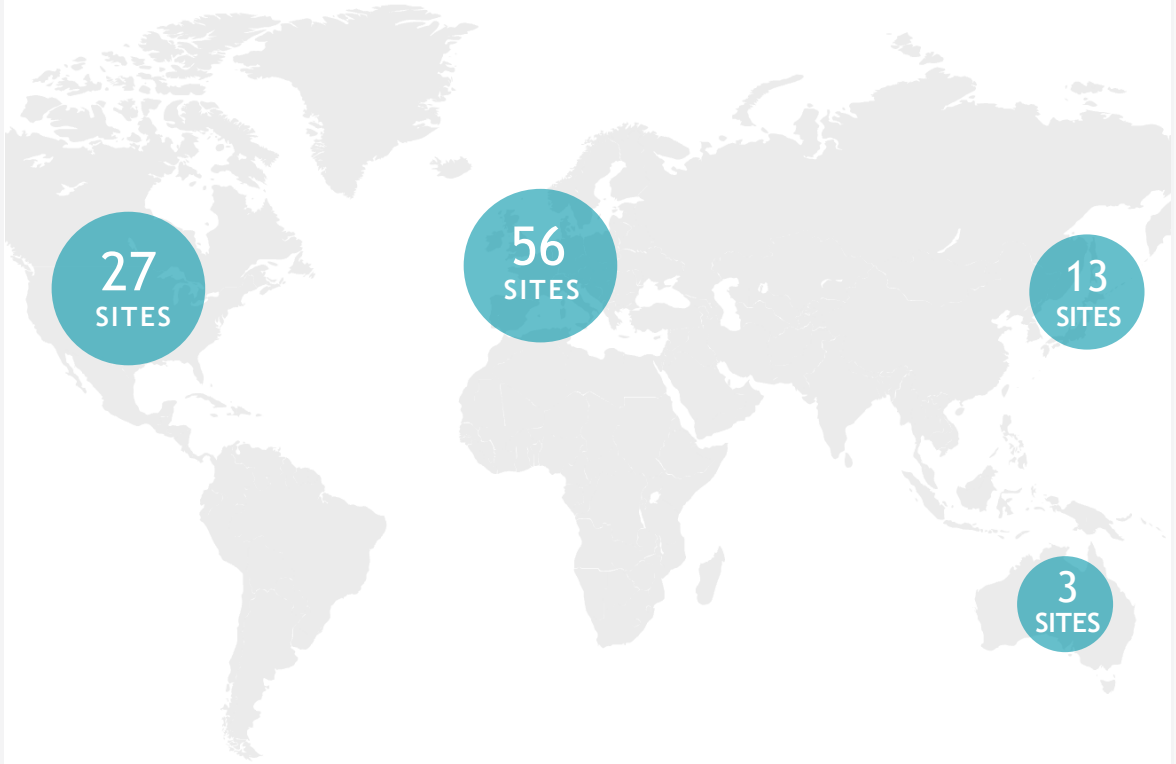
Corticosteroids

Study endpoints

Primary: Event-free survival (EFS)

Key secondary: ORR at 6 months and mLSS score (patient-reported symptoms)

Global recruitment underway



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ASH 2025 abstract #4256. Trial conducted by Incyte. mLSS, modified Lee Symptom Scale

Conclusions

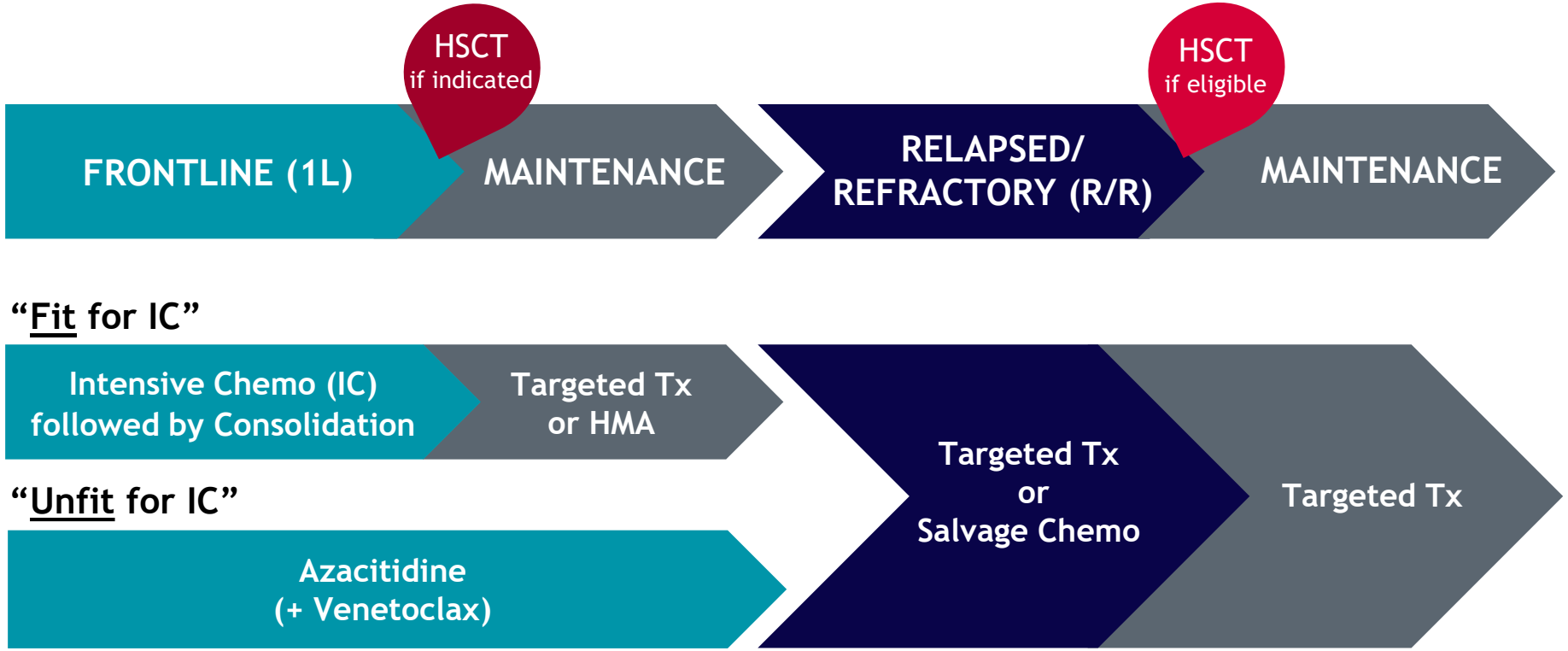
- **Transition to axatilimab 0.6 mg/kg Q4W was feasible and well tolerated** in R/R cGVHD patients treated with 0.3 mg/kg Q2W in the AGAVE-201 trial
    - **Patients had a prolonged duration of therapy, with a median of 1.7 years**, and 84% of patients continued treatment, suggesting ongoing clinical benefit
- Long-term safety follow-up from AGAVE-201 showed a **continued tolerable safety profile with prolonged duration of axatilimab therapy**
    - Of the 239 patients who received axatilimab, 14% (33) have continued on treatment with a **median duration of therapy of 2.8 years**, suggestion long-term safety and clinical benefit from treatment
- Interim safety data from ongoing Phase 2 trial show **axatilimab + ruxolitinib in newly diagnosed cGVHD was well-tolerated**
- Ongoing Phase 3 trial of axatilimab + corticosteroids in newly diagnosed cGVHD will provide insight into the efficacy and safety of the combination

Niktimvo Panelist Discussion & Audience Q&A

Acute Leukemia Treatment Paradigm & First Revuforj Real-World Evidence from Moffitt Cancer Center

David Sallman, M.D.
Associate Member in the Department of Malignant Hematology at Moffitt Cancer Center

Acute myeloid leukemia (AML) treatment paradigm



Despite recent advances, most patients will be refractory to the current SOC frontline therapies or relapse

TREATMENT GOALS VARY

Frontline:

- In KMT2Ar, HSCT is generally the goal
- In NPM1m, multiple factors impact the decision, such as fitness, MRD status, cytogenetics, etc.

R/R:

- In NPM1m & KMT2Ar, HSCT is generally the goal for all pts who can withstand a transplant

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Tx, treatment; HMA, hypomethylating agent; HSCT, hematopoietic stem cell transplantation; SOC, standard of care; MRD, measurable residual disease; CR1, first complete remission

Treatment response criteria in AML: Tumor clearance equivalent across CRc and MLFS

Response	Tumor	Platelets recovered	Neutrophils recovered	ORR	CRc	CR/CRh
CR	< 5%	Yes	Yes	✓	✓	✓
CRh	< 5%	Half normal levels	Half normal levels	✓	✓	✓
CRp	< 5%	No	Yes	✓	✓	
CRi	< 5%	Either has recovered		✓	✓	
MLFS	< 5%	Neither has recovered		✓		
PR	5-25% and a ≥50% reduction	Yes	Yes	✓		
No response	> 5%	No	No			
Non-evaluable	Lack an adequate BM response evaluation					

Clearing blasts to <5% and achieving MRD negativity are key goals

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2022 ELN recommendations for the management of AML in adults (aml-hub.com); ORR, Overall response rate; CRc, Composite complete remission; ANC, absolute neutrophil count; BM, bone marrow; CR, complete remission; CRh, CR with partial hematologic recovery; CRi, CR with incomplete hematologic recovery; MLFS, morphologic leukemia-free state; PR, partial remission.

First Revuforj real-world evidence highlights usage across multiple genetic subtypes and settings

Patient characteristics (N=17)	
Age, median (range), years	54 (23-79)
Female, n (%)	7 (41)
Molecular subtypes, n (%)	8 (47%) KMT2Ar*, 5 (29%) NPM1m, 3 (18%) NUP98r
Prior lines of therapy, median (range)	4 (0-6)
Prior venetoclax, n (%)	12 (71)
Prior HSCT, n (%)	6 (35)
Follow up, median (range), months	7.1 (2.1-20.5)
Treatment characteristics (N=17)	
Single agent revumenib, n (%)	3 (18)
Revumenib + venetoclax/HMA (triplet), n (%)	13 (76)

First RWE from Moffitt Cancer Center shows use in:

- KMT2Ar, NPM1m, & NUP98r acute leukemias
- R/R, frontline, MRD+ disease, and post-HSCT maintenance setting
- Combinations and as a single agent

ASH 2025 abstract #3448. HMA, hypomethylating agent. *Count excludes one patient who received Revuforj but was later determined to have a false positive test result for KMT2Ar.

Excellent activity observed with Revuforj in the real-world setting across lines of therapy and molecular subsets

Efficacy data[1], n/N (%)	
ORR	10/13 (77)
CRc (CR + CRh + CRi)	8/13 (62)
CR + CRh	4/13 (31)
MRD negative at best response	9/12 (75)
Proceeded to HSCT post-revumenib	4 patients (2 as 2nd HSCT)
Received revumenib post-HSCT	3/4 (75)

High rates of remission, MRD negativity, and HSCT observed among real-world cohort including KMT2Ar, NPM1m, and NUP98r pts

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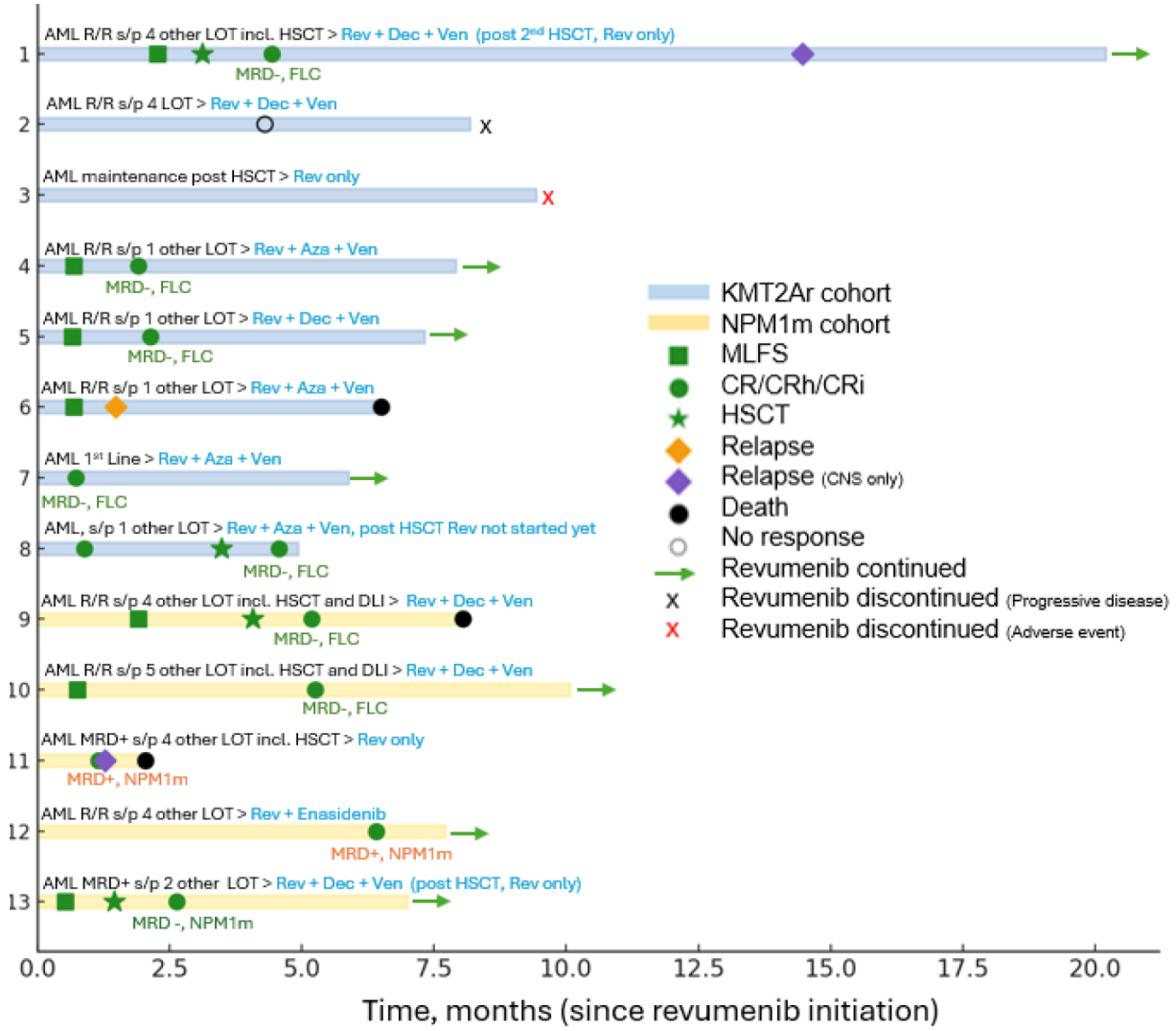
ASH 2025 abstract #3448. 1. The following 4 pts were excluded from ORR/CRc/CR+CRh analysis: 1 pt discovered to have a false positive KMT2Ar test result, 1 pt who received revumenib only as post-HSCT maintenance, and 2 pts treated for MRD+ disease. 2 pts treated for MRD+ disease were included in the HSCT and relapse analysis.

Responses were rapid and durable with Revuforj in the real-world setting, even in heavily pretreated KMT2Ar and NPM1m patients



Time to response & relapse rate	
Time to first response, median (range)	0.8 (0.5-6.5) months
Time to best response, median (range)	2.2 (0.7-6.5) months
Relapse[1], n/N (%)	3/15 (20) 2 with CNS only relapse

Median OS not reached at 7.1 months of median follow-up

ASH 2025 abstract #3448. Note: Swimmer plot does not include 3 pts treated for NUP98r. Of these, 1 R/R NUP98r AML pt responded and has MLFS (ongoing durable MLFS x 7 months+). Two NUP98r pts died due to disease progression. 1. The following 2 pts were excluded from relapse analysis: 1 pt discovered to have a false positive KMT2Ar test result, 1 pt who received revumenib only as post-HSCT maintenance.

Revuforj was well tolerated in this real-world cohort which predominantly received combination treatment

Safety data, n/N (%)	
Any Grade 3 or 4 AE (non-hematological)	4/17 (24)
Grade ≥3 QTc prolongation[a]	3/15 (20) (*Grade 3 only*)
Grade ≥3 differentiation syndrome[b]	2/17 (12) (*Grade 3 only*)
Revumenib interruption	8/17 (47)
Revumenib reduction	1/17 (6)
Revumenib discontinuation, n (%)	1/17 (6)
Deaths, n	5 (4 disease related, 1 HSCT complication)

Excellent tolerability in real-world setting

Low rate of revumenib dose reductions & discontinuations

QTc prolongation did not lead to discontinuation in any patient

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ASH 2025 abstract #3448. a. Regular QTc monitoring was available for 15 patients; 2 patients had Grade 2 QTc prolongation, 1 patient had Grade 1 QTc prolongation; b. One event of Grade 3 differentiation syndrome occurred in a patient on concomitant enasidenib. 1 patient had Grade 2 differentiation syndrome.

Revumenib in Post-HSCT Maintenance Setting

Elias Jabbour, M.D.
Professor, Department of Leukemia, Division of Cancer Medicine, MD Anderson Cancer Center

High unmet need in post-HSCT maintenance

- **Post-transplant relapse remains frequent** in HOX-driven AML
- Critical need for effective post-HSCT maintenance therapy to **prevent relapse**

Retrospective review provides insight into growing use of revumenib maintenance post-HSCT

Analysis included 10 pediatric pts treated at MD Anderson Cancer Center who underwent HSCT following response to revumenib-based therapies

Patient Characteristics	(N=10)
Age, median (range)	10 yrs (1-18)
Molecular subtypes, n (%)	8 (80%) KMT2Ar, 2 (20%) NUP98r
≥2 prior HSCT, n (%)	5 (50%)
Pre-HSCT Revumenib Therapy	
Pre-HSCT regimens, n (%)	3 (30%) AUGMENT-101 monotherapy, 5 (50%) revumenib/ven/HMA combination in SAVE, & 2 (20%) Expanded Access
Pre-HSCT cycles of rev, median (range)	2 (1-4)
Pre-HSCT MRD status	All MRD negative

ASH 2025 Abstract #3461.

Encouraging early efficacy in retrospective review of children who received revumenib maintenance post-HSCT

#	Age, years	Molecular subtype	Days from HSCT to rev	Rev maintenance cycles completed
1	3	KMT2Ar	175	3
2	12	KTM2Ar	137	25
3	1	KMT2Ar	58	12
4	18	NUP98r	111	12
5	12	KMT2Ar	117	12
6	17	NUP98r	85	12
7	17	KMT2Ar	84	10
8	14	KMT2Ar	110	9
9	2	KMT2Ar	111	4
10	16	KMT2Ar	118	5

- Pts restarted revumenib a median of **111 days post-HSCT** (range: 58-175)
  - All pts received concomitant strong CYP3A4 inhibitors
- **Study planned for revumenib post-HSCT for ≤12 months:**
  - Pts completed a median of 11 cycles post-HSCT (range: 3-25)
  - 1 pt continued for 2 yrs due to parental preference
  - 3 pts remain on treatment

At a median follow-up of 19 months (range: 4-41), all pts were alive; 1 pt had relapsed

90% relapse-free survival in a patient population at high-risk of relapse

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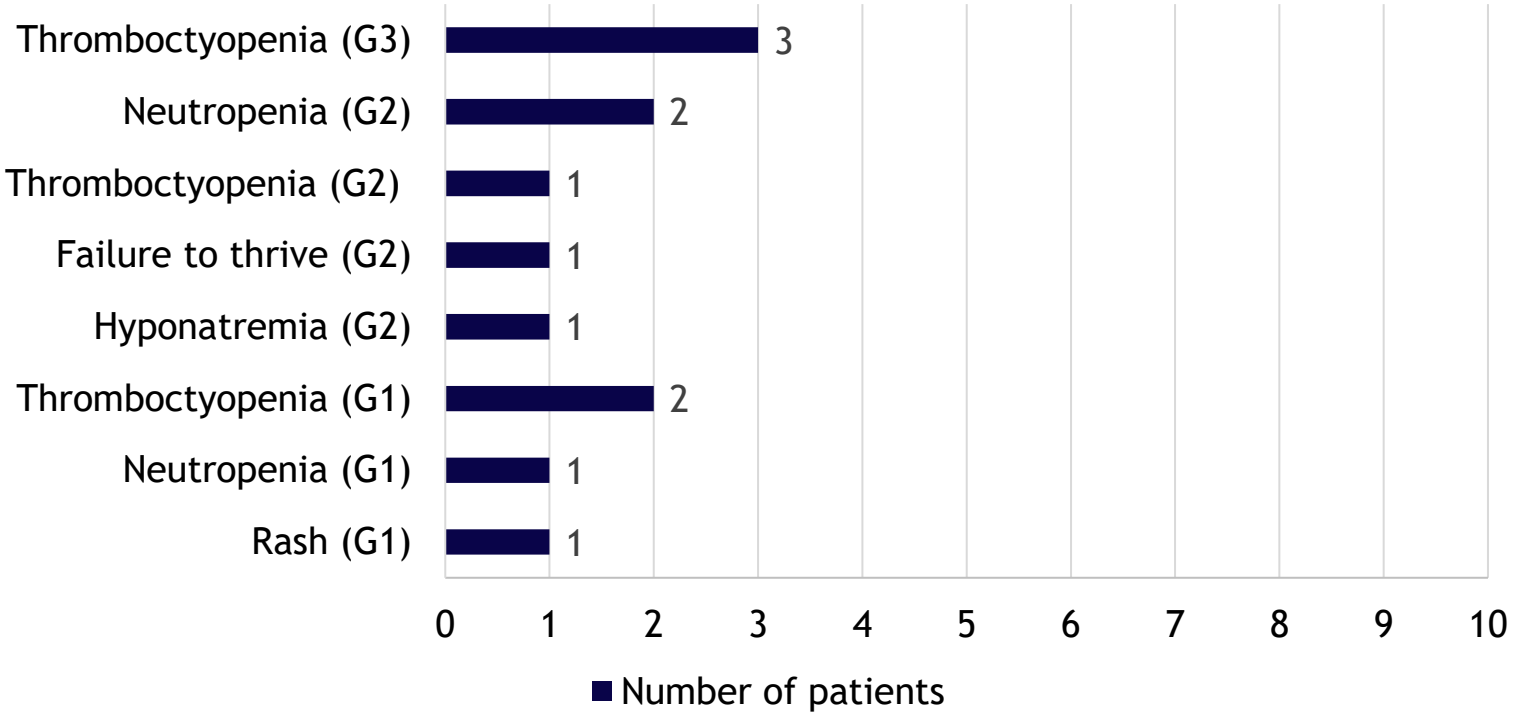
ASH 2025 Abstract #3461.

Revumenib maintenance post-HSCT was well tolerated in children with HOX-driven AML

Adverse events during revumenib maintenance post-HSCT



- 5 pts required temporary dose reductions or interruptions; 4 were successfully re-escalated

Most adverse events were low grade and manageable

No patient discontinued therapy due to drug-related AEs

Data support feasibility of long-term post-HSCT maintenance therapy

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ASH 2025 Abstract #3461.

SAVE Phase 2 Trial of Revumenib with Venetoclax and Decitabine/Cedazuridine in Newly Diagnosed AML

Elias Jabbour, M.D.
Professor, Department of Leukemia, Division of Cancer Medicine, MD Anderson Cancer Center

SAVE, a Phase 1/2 trial of the all-oral combination of revumenib + venetoclax and decitabine/cedazuridine in R/R and newly diagnosed (ND) AML

- Age ≥12 years
- AML or Myeloid MPAL with *KMT2Ar* or *NPM1m* or *NUP98r*
  - Frontline: not eligible for high-intensity chemo
  - Relapsed/refractory
- ECOG ≤2
- Adequate organ function

Revumenib*
DL 0: 110 mg/160 mg +/- CYP3A4i
DL 1: 160 mg/270 mg +/- CYP3A4i (USPI dose)
PO Q12h D1-D28

ASTX727
1 tablet (35 mg decitabine and 100 mg cedazuridine) PO daily for D1-D5

Venetoclax
400 mg target dose* with ramp up PO D1-D14
*adjusted with azoles

Objectives

Primary:
- **Phase 1 in R/R** (3+3 design): Safety, MTD and RP2D
- **Phase 2 (Frontline and R/R):** Efficacy

Secondary:
- **Phase 2:** OS, RFS, CRD, MRD

Exploratory:
- MRD at 10^{-5}, resistance

Revumenib maintenance post-HSCT for 1 year

D14 bone marrow for early response
Amendment: hold revumenib after D21 if D14 BM blasts <5%
*Revumenib: 113 mg capsule = 110 mg tablet; 163 mg capsule = 160 mg tablet. CYP3A4i indicates strong inhibitors: posa; vori.

SAVE enrolled a cohort of newly diagnosed AML patients with advanced age

Characteristic	All (N=21)	NPM1m (n=14)	KMT2Ar (n=7)
Median age, years (range)	70 (60-83)	73 (66-83)	64 (60-77)
≥70 years, n (%)	11 (52%)	10 (71%)	1 (14%)
Female, n (%)	15 (71%)	9 (64%)	6 (86%)
Secondary AML, n (%)	5 (24%)	2 (14%)	3 (43%)
Diploid CG, n (%)	9 (43%)	9 (64%)	0
Adverse CG, n (%)	7 (33%)	1 (7%)	6 (86%)
Co-mutations, n (%)			
NRAS / KRAS	4 (19%)	2 (14%)	2 (29%)
FLT3	4 (19%)	4 (28%)	0
ITD*	1 (5%)	1 (7%)	0
TKD	3 (14%)	3 (21%)	0
IDH1/2	4 (19%)	3 (21%)	1 (14%)
MDS-associated	9 (43%)	6 (43%)	3 (43%)

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ASH Abstract #47. Data cutoff November 10, 2025. *FLT3-ITD detected with a frequency of 0.03.

The SAVE combination was generally well-tolerated in newly diagnosed AML

TEAEs (any grade, >30%)	(N=21)
Vomiting	14 (67%)
Elevated AST/ALT	13 (62%)
↑K+	13 (62%)
Nausea	12 (57%)
↑Phos	11 (52%)
Hyponatremia	11 (52%)
Febrile neutropenia	10 (48%)
Constipation	10 (48%)
QTc prolonged	9 (43%)
Thrombocytopenia	8 (38%)
Headache	7 (33%)
[…]	
Differentiation syndrome	4 (19%)

TEAEs (Grade ≥3, any G4-5)	G3	G4	G5	G ≥3
Febrile neutropenia	0	10 (48%)	0	10 (48%)
Thrombocytopenia	2 (10%)	5 (24%)	0	7 (33%)
Neutropenia	2 (10%)	4 (19%)	0	5 (24%)
Bacteremia	2 (10%)	0	2 (10%)	4 (19%)
Lung infection	2 (10%)	1 (5%)	0	3 (14%)
Skin infection	3 (14%)	0	0	3 (14%)
Differentiation syndrome	2 (10%)	0	0	2 (10%)
Respiratory failure	0	2 (10%)	0	2 (10%)
Elevated AST	2 (10%)	0	0	2 (10%)
Elevated ALT	2 (10%)	0	0	2 (10%)
Sepsis	2 (10%)	0	0	2 (10%)
Bronchopulmonary hemorrhage	0	0	1 (5%)	1 (5%)
Skin infection	1 (5%)	0	0	1 (5%)
Intracranial hemorrhage	1 (5%)	0	0	1 (5%)

No QTc prolongation above Grade 2; no DS above Grade 3

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ASH Abstract #47. Data cutoff November 10, 2025. TEAEs, treatment emergent adverse events regardless of attribution to study drugs.

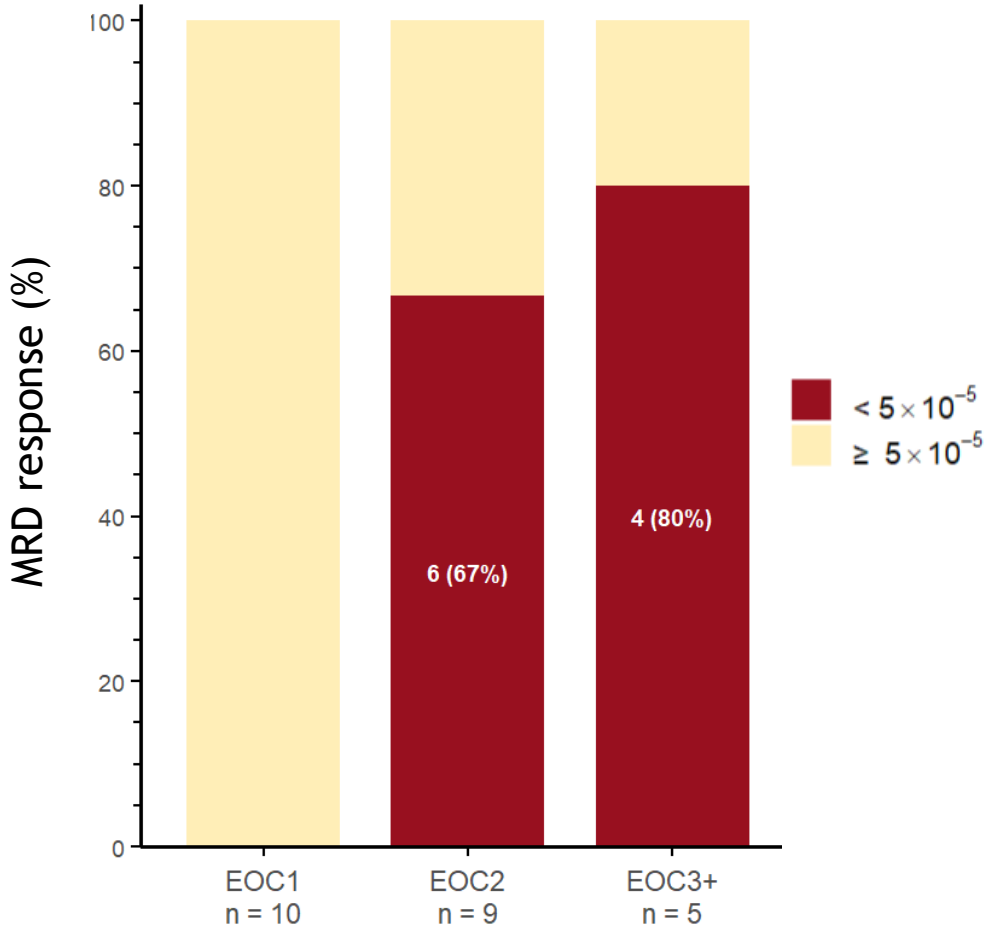
High response & MRD negativity rates observed with SAVE combination in newly diagnosed AML

Best Response	All patients (N=21)	NPM1m (n=14)	KMT2Ar (n=7)
ORR	18 (86%)	12 (86%)	6 (86%)
CR/CRh	17 (81%)	11 (79%)	6 (86%)
CR	16 (76%)	10 (71%)	6 (86%)
CRh	1 (5%)	1 (7%)	0
CRp	1 (5%)	1 (7%)	0
MLFS	0	0	0
Early death (30-day)	2 (10%)	2 (10%)	0
Not evaluable*	1 (5%)	0	1 (14%)
MRD neg by flow cytometry (10^{-4})	18 (86%)	12 (86%)	6 (86%)
Within responders	18 (100%)	12 (100%)	6 (100%)

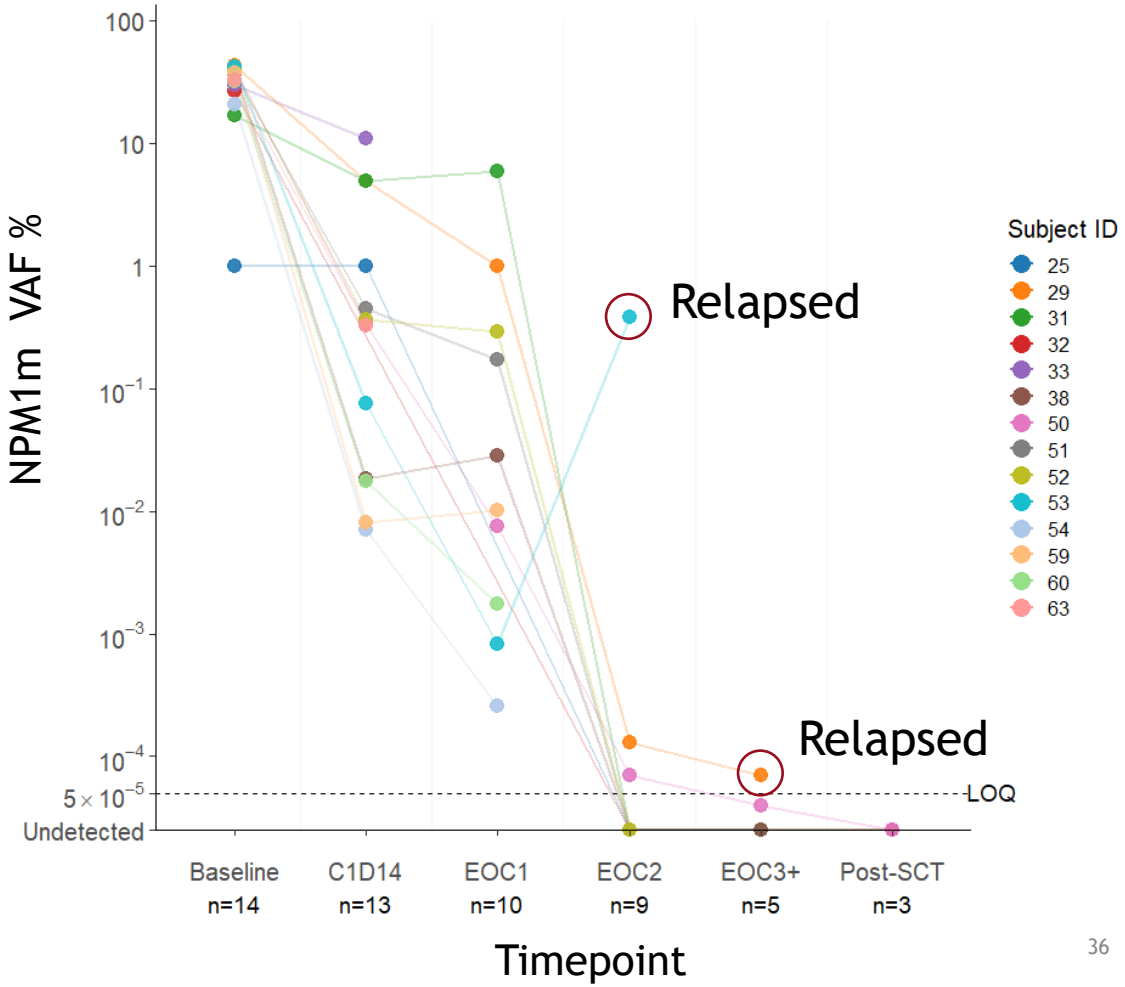
ASH Abstract #47. Data cutoff November 10, 2025. *One patient withdrew consent and proceeded to hospice care during week 1 prior to response assessment. ORR= CR+CRh+CRp+MLFS.

Within a few cycles of treatment with the SAVE combination, high rates of molecular NPM1m MRD negativity were observed in 1L patients

80% of NPM1m patients were MRD (-) in bone marrow by NGS at EOC3+



Two NPM1m patients who relapsed were MRD (+) in bone marrow by NGS



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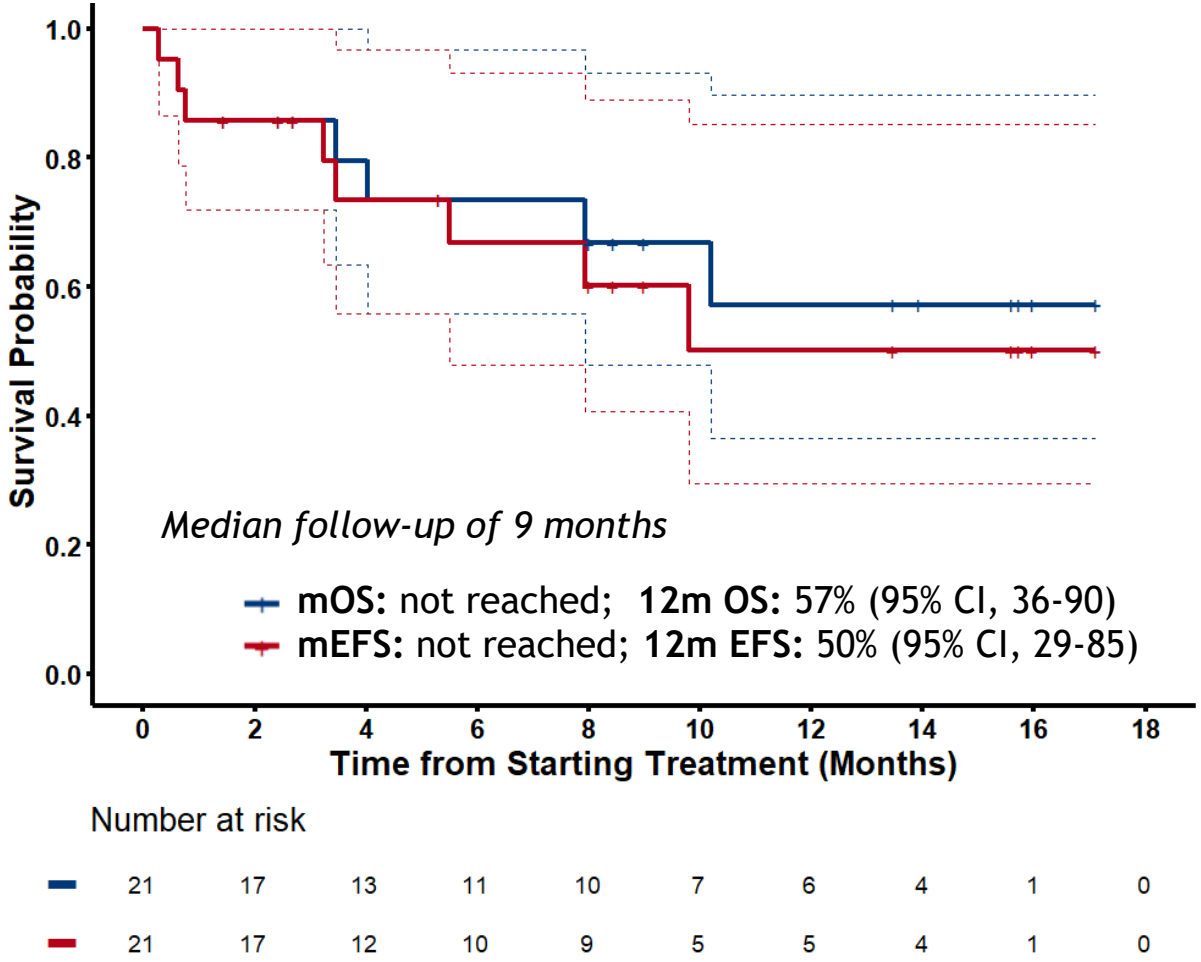
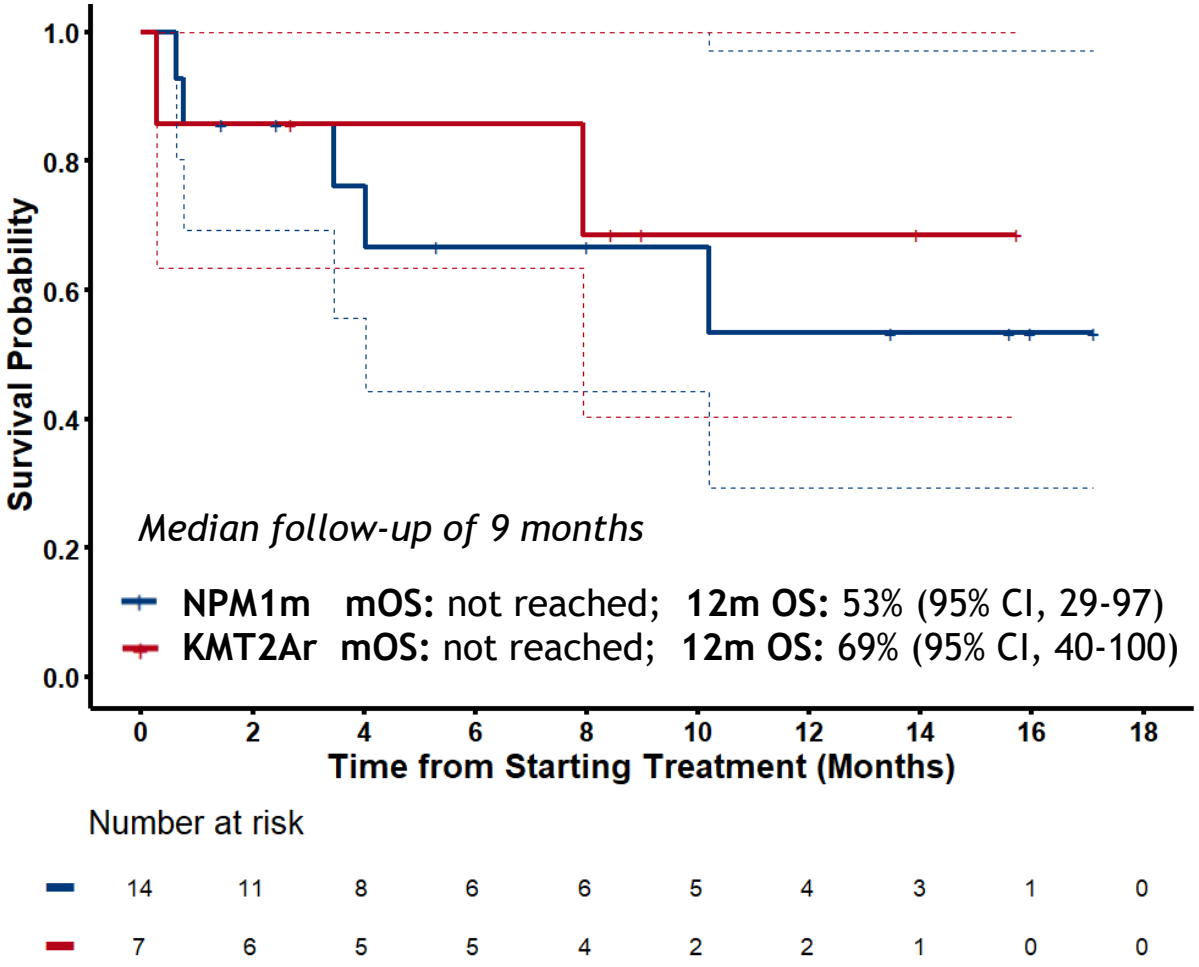
ASH Abstract #47. Data cutoff November 10, 2025.

Encouraging survival observed with SAVE combo in an older 1L population

OS and EFS in the entire cohort



OS by genotype



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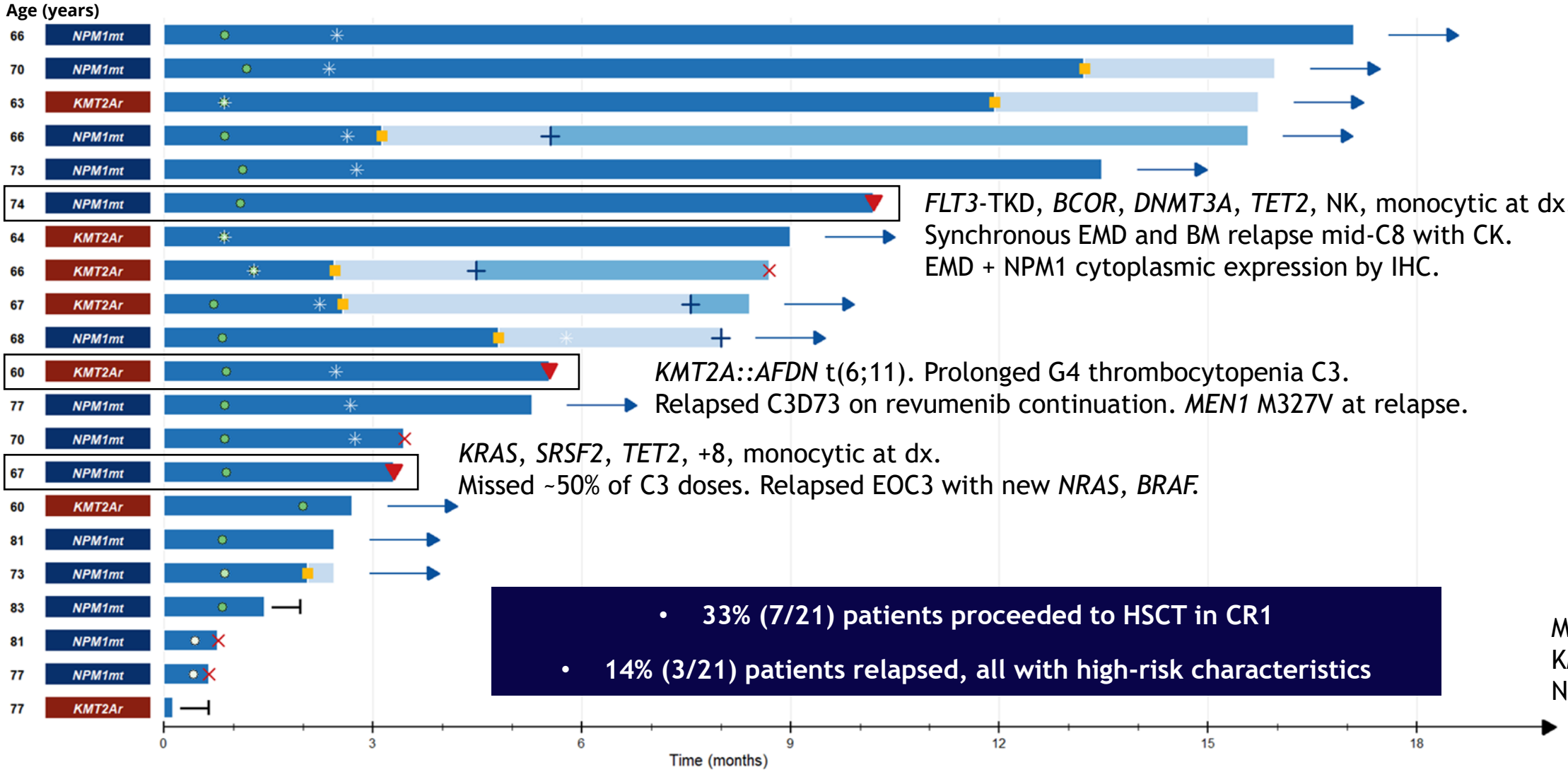
ASH Abstract #47. Data cutoff November 10, 2025. OS, overall survival; EFS, event-free survival

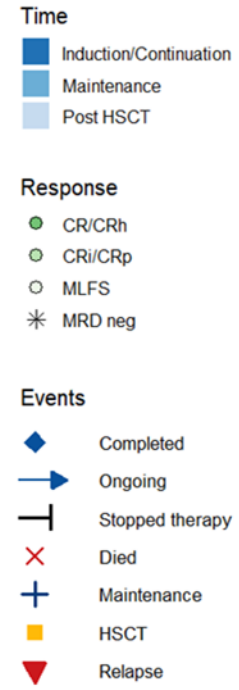
Promising duration of response in 1L patients who received SAVE combo, with majority of patients remaining on therapy



FLT3-TKD, *BCOR*, *DNMT3A*, *TET2*, NK, monocytic at dx.
Synchronous EMD and BM relapse mid-C8 with CK.
EMD + NPM1 cytoplasmic expression by IHC.

KMT2A::AFDN t(6;11). Prolonged G4 thrombocytopenia C3.
Relapsed C3D73 on revumenib continuation. *MEN1* M327V at relapse.

KRAS, *SRSF2*, *TET2*, +8, monocytic at dx.
Missed ~50% of C3 doses. Relapsed EOC3 with new *NRAS*, *BRAF*.



- 33% (7/21) patients proceeded to HSCT in CR1
- 14% (3/21) patients relapsed, all with high-risk characteristics

MRD sensitivity
KMT2A: 10^{-4} (MFC)
NPM1: 5×10^{-5} (NGS)

ASH Abstract #47. Data cutoff November 10, 2025.

Conclusions

- In the SAVE trial, the all-oral combination of revumenib + venetoclax and decitabine/cedazuridine was **generally well-tolerated in newly diagnosed NPM1m and KMT2Ar AML patients**

- **High response and MRD negativity rates observed with SAVE combination in older adults with newly diagnosed NPM1m and KMT2Ar who were ineligible for intensive chemotherapy**
    - Larger sample and longer follow-up required to further elucidate the potential therapeutic benefit of the combination
    - Need to further explore the optimal approach to combining oral HMA with BCL2 and menin inhibitors to maximize overall benefit-risk, especially in NPM1m/older patients

Phase 1 Trial of Revumenib with Intensive Chemotherapy in Newly Diagnosed AML - SNDX-5613-0708

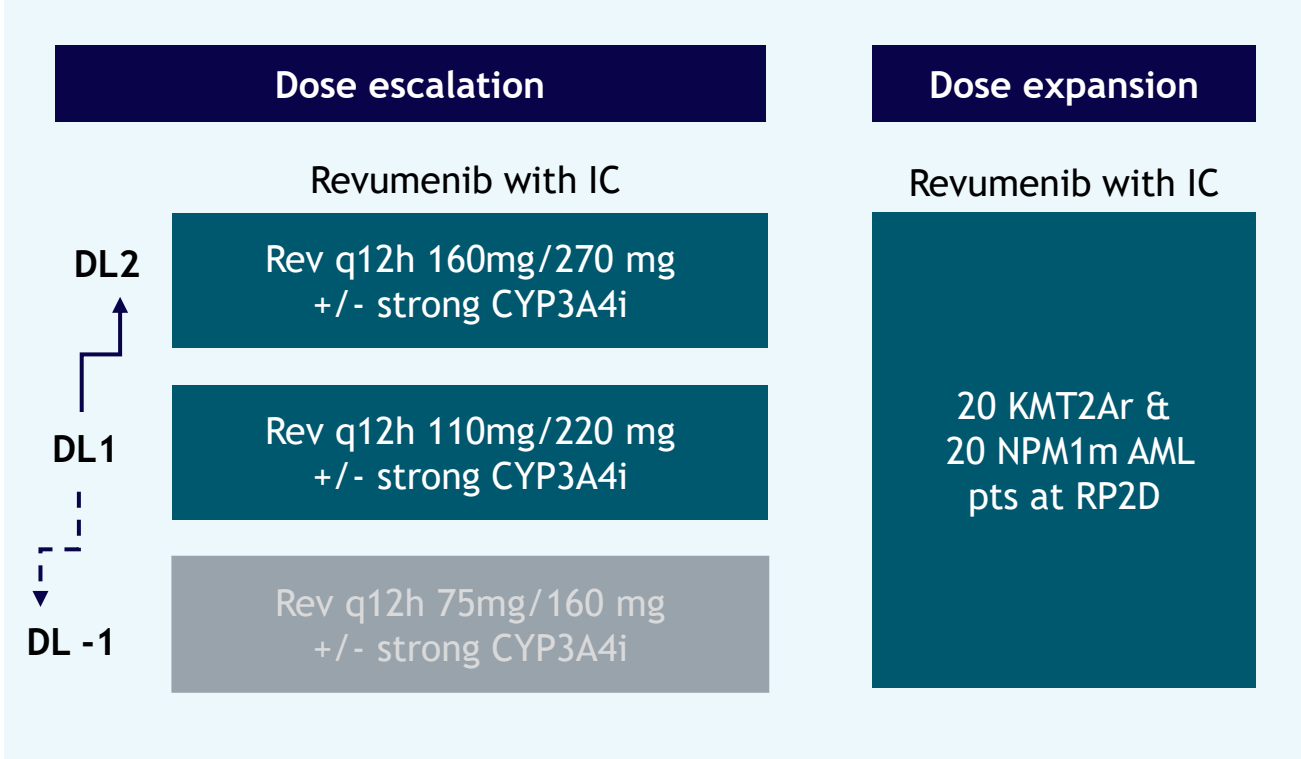
David Swoboda, M.D.
Director of Leukemia, Tampa General Hospital

Phase 1 trial of revumenib with intensive chemotherapy (IC) in newly diagnosed patients with NPM1m, KMT2Ar, or NUP98r AML (SNDX-5613-0708)

Revumenib + IC induction, IC and/or HSCT consolidation, and post-consolidation revumenib maintenance

Key eligibility criteria

- 18-75 yrs of age
- Newly diagnosed NPM1m, KMT2Ar or NUP98r AML
- Candidate for IC (7+3)



Study endpoints

Primary
- DLTs
- TEAEs, TRAEs, & SAEs

Secondary
- PK

Exploratory
- CR, CRc, ORR, & MRD-negative CR rates
- TTR

ASH Abstract #3425. DLTs, dose limiting toxicities; TEAEs, treatment-emergent adverse events; TRAEs, treatment-related adverse events; SAEs, serious adverse events; IC, intensive chemotherapy; RP2D, recommended phase 2 dose

Newly diagnosed NPM1m and KMT2Ar patients were enrolled across two dose levels of revumenib + IC

	DL1 (n = 13)	DL2 (n = 17)	Total (N = 30)
Age, median (range), years	43 (20-71)	57 (19-68)	49 (19-71)
Female, n (%)	8 (61.5)	14 (82.4)	22 (73.3)
Race, n (%)			
White	9 (69.2)	15 (88.2)	24 (80.0)
Black or African American	1 (7.7)	0	1 (3.3)
Asian	1 (7.7)	0	1 (3.3)
Not reported	2 (15.4)	0	2 (6.7)
Other	0	2 (11.8)	2 (6.7)
ECOG PS score, n (%)			
0	7 (53.8)	6 (35.3)	13 (43.3)
1	3 (23.1)	11 (64.7)	14 (46.7)
2	3 (23.1)	0	3 (10.0)
Genetic aberration, n (%)			
KMT2Ar	12 (92.3)	7 (41.2)	19 (63.3)
NPM1m	1 (7.7)	10 (58.8)	11 (36.7)

Key differences between DL1 & DL2:

DL1 cohort was >90% KMT2Ar & younger

DL2 cohort was ~60% NPM1m & older

ASH Abstract #3425. Data cutoff of September 30, 2025. IC, intensive chemotherapy

Both revumenib dose levels were generally well-tolerated in combination with IC in newly diagnosed NPM1m and KMT2Ar AML

Parameter, n (%)	DL1 (n = 13)		DL2 (n = 17)		Total (N = 30)	
	Any grade	Grade ≥3	Any grade	Grade ≥3	Any grade	Grade ≥3
Any AE	12 (92.3)	11 (84.6)	15 (88.2)	14 (82.4)	27 (90.0)	25 (83.3)
Any revumenib-related AE	7 (53.8)	4 (30.8)	7 (41.2)	6 (35.3)	14 (46.7)	10 (33.3)
AEs of special interest						
QTc prolongation	2 (15.4)	2 (15.4) *(G3 only)*	0	0	2 (6.7)	2 (6.7) *(G3 only)*
Differentiation syndrome (DS)	0	0	0	0	0	0
SAE[1]	5 (38.5)	-	8 (47.1)	-	13 (43.3)	-
Febrile neutropenia	2 (15.4)	-	1 (5.9)	-	3 (10.0)	-
Sepsis	0	-	3 (17.6)	-	3 (10.0)	-
TEAEs leading to revumenib dose modifications						
Interruption	4 (30.8)	-	6 (35.3)	-	10 (33.3)	-
Reduction	2 (15.4)	-	0	-	2 (6.7)	-
Discontinuation	3 (23.1)	-	1 (5.9)	-	4 (13.3)	-

Key observations:

- **Safety profile consistent with intensive chemotherapy alone**
- **No DS reported**
- **No QTc above G3**
- One DLT of G3 QTc prolongation was reported in DL1
  - Pt discontinued revumenib during Cycle 1; at the end of Cycle 1, the pt achieved MRD-negative CR and proceeded to HSCT

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ASH Abstract #3425. Data cutoff of September 30, 2025. IC, intensive chemotherapy; 1. Any SAE reported by ≥2 patients.

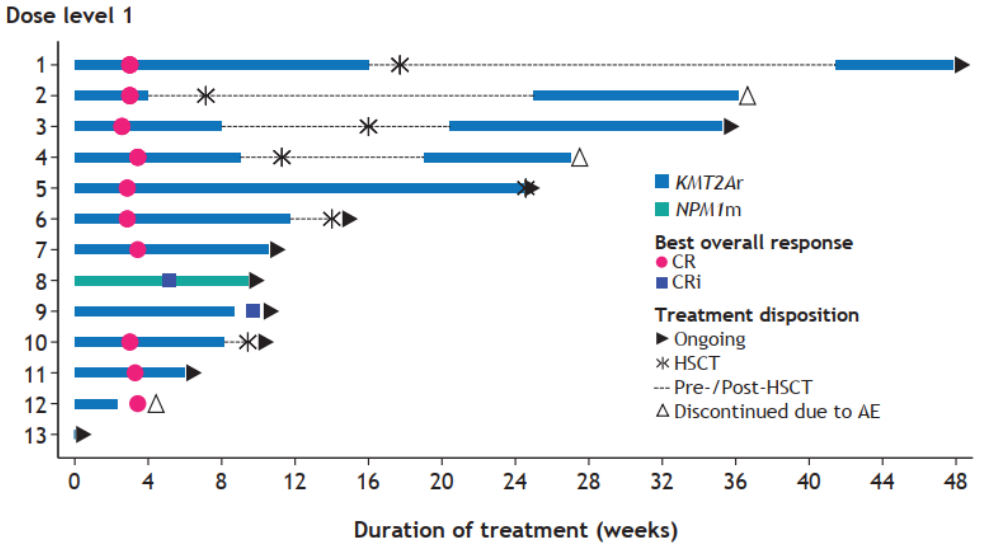
Rapid count recovery observed in responders who received revumenib + IC in the 1L setting

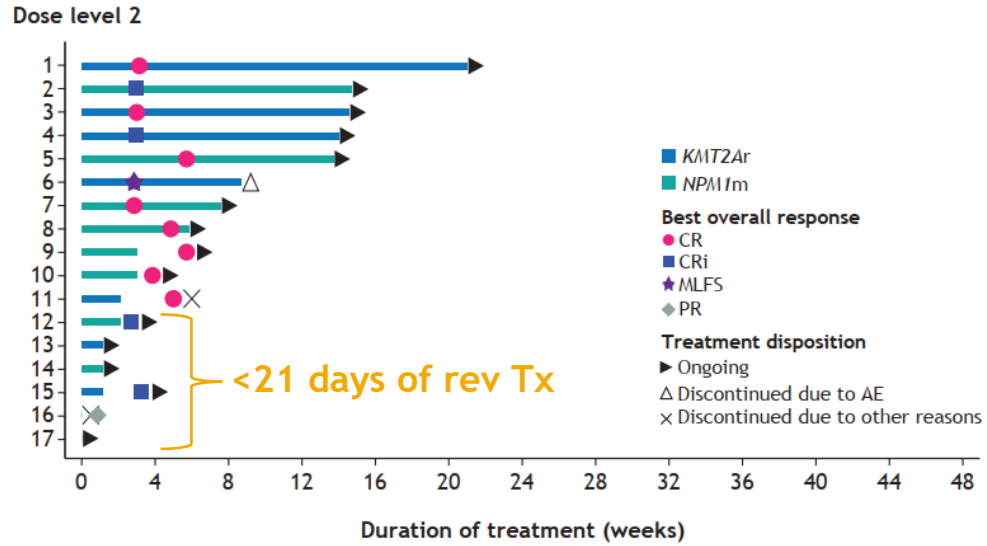
Median (range), Cycle 1	NPM1m + KMT2Ar AML with CRc	
	DL1 (n = 12)	DL2 (n = 12)
Days to neutrophil recovery (≥1,000 cells/µL)	29 (19-35)	29 (22-43)
Days to platelet recovery (≥100,000 cells/µL)	28 (22-31)	29 (22-47)

- No clinically significant myelosuppression observed with the addition of revumenib to IC in newly diagnosed NPM1m and KMT2Ar AML patients
- Higher revumenib dose did not meaningfully impact or delay count recovery

ASH Abstract #3425. Data cutoff of September 30, 2025. IC, intensive chemotherapy

Promising early results observed among both NPM1m and KMT2Ar patients who received revumenib + IC in 1L setting





Key observations:

- **Follow-up time was shorter in DL2 than DL1**
  - **5/14 pts still on treatment in DL2 had <21 days of revumenib Tx**
- Treatment was ongoing in 77% (10/13) and 82% (14/17) of pts in DL1 and DL2, respectively

Encouraging early results:

- **High response rates in both dose levels**
- **54% (7/13) of pts in DL1 proceeded to HSCT** (all pts had KMT2Ar)
  - **57% (4/7) of these pts already resumed revumenib post-HSCT**
- **No relapses observed**
- **Median duration of CR was not reached**

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ASH Abstract #3425. Data cutoff of September 30, 2025; Note: Plot shows duration of treatment among the safety population. Tx, treatment

Deep responses observed among NPM1m and KMT2Ar pts who received revumenib + IC in 1L setting

Efficacy among response-evaluable population	DL1 (n = 12)	DL2 (n = 14)	Total (N = 26)
ORR, n (%)	12 (100)	13 (92.9)	25 (96.2)
95% CI	73.5–100	66.1-99.8	80.4-99.9
CRc rate, n (%)	12 (100)	12 (85.7)	24 (92.3)
95% CI	73.5–100	57.2-98.2	74.9-99.1
CR rate, n (%)	10 (83.3)	8 (57.1)	18 (69.2)
95% CI	51.6-97.9	28.9-82.3	48.2-85.7
MRD-negative status*, n (%)			
CRc	8 (100)	7 (70.0)	15 (83.3)
CR	7 (100)	5 (71.4)	12 (85.7)

Responses in DL2 could further deepen as data continue to mature

Robust clinical activity observed at both dose levels supports further development of revumenib + IC in 1L NPM1m and KMT2Ar AML

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Data cutoff of September 30, 2025.
*For patients who had available MRD-negativity results in the response evaluable population. MRD-negative status was determined locally by flow cytometry or PCR.
ORR = CRc + MLFS. CRc = CR + CRi + CRp.

Conclusions

- **Overall safety profile of revumenib + IC is comparable to IC alone**; no new safety signals were identified at either dose level in combination with IC
    - QTc prolongation was infrequent and managed successfully using established mitigation approaches; no cases of DS were reported
- **Preliminary data suggest deep responses, with nearly all tested patients achieving MRD-negative CR**
    - Treatment ongoing in 80% of patients at data cut off
- The robust clinical activity seen with revumenib + IC in newly diagnosed KMT2Ar and NPM1m AML, regardless of DL, supports further exploration of this combination in the Phase 3 REVEAL-ND study in fit patients with NPM1m AML

Developing Revuforj and Niktimvo Into Industry Leading Franchises

Nick Botwood, M.B.B.S
Head of Research & Development and Chief Medical Officer, Syndax

Comprehensive Revuforj 1L clinical development plan designed to rapidly deliver practice-changing evidence and support global registrations

FRONTLINE | **RELAPSED / REFRACTORY**

INELIGIBLE FOR IC ('UNFIT')

BEAT AML
Rev + ven/aza in NPM1m & KMT2Ar

SAVE
Rev + ven/HMA in NPM1m, KMT2Ar, NUP98r

EVOLVE-2
Rev + ven/aza in NPM1m (primary efficacy analysis) & KMT2Ar

ELIGIBLE FOR IC ('FIT')

SNDX-708
Rev + IC in NPM1m, KMT2Ar, NUP98r

NCI trial
Rev + IC in NPM1m & KMT2Ar

RAVEN
Rev + ven/aza in KMT2Ar

REVEAL-ND NPM1
Rev + IC in NPM1m

AUGMENT-102
Rev + FLA in KMT2Ar, NPM1m, NUP98r

SAVE
Rev + ven/HMA in NPM1m, KMT2Ar, NUP98r

AUGMENT-101
Rev in KMT2Ar & NPM1m

FDA approved

Ph 3 frontline trials designed with dual primary endpoints to support potential for accelerated and full approvals

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IC, intensive chemotherapy

Syndax and Incyte are working to advance Niktimvo into earlier lines of cGVHD treatment and other fibrotic diseases, starting with IPF

Chronic graft-versus-host disease (cGVHD)

FRONTLINE → **RECURRENT/ REFRACTORY**

Phase 2 Trial	AXemplify-357 Ph 3 Trial	AGAVE-201 Ph 2 Trial
Axa + ruxolitinib	Axa + corticosteroids	Axa monotherapy

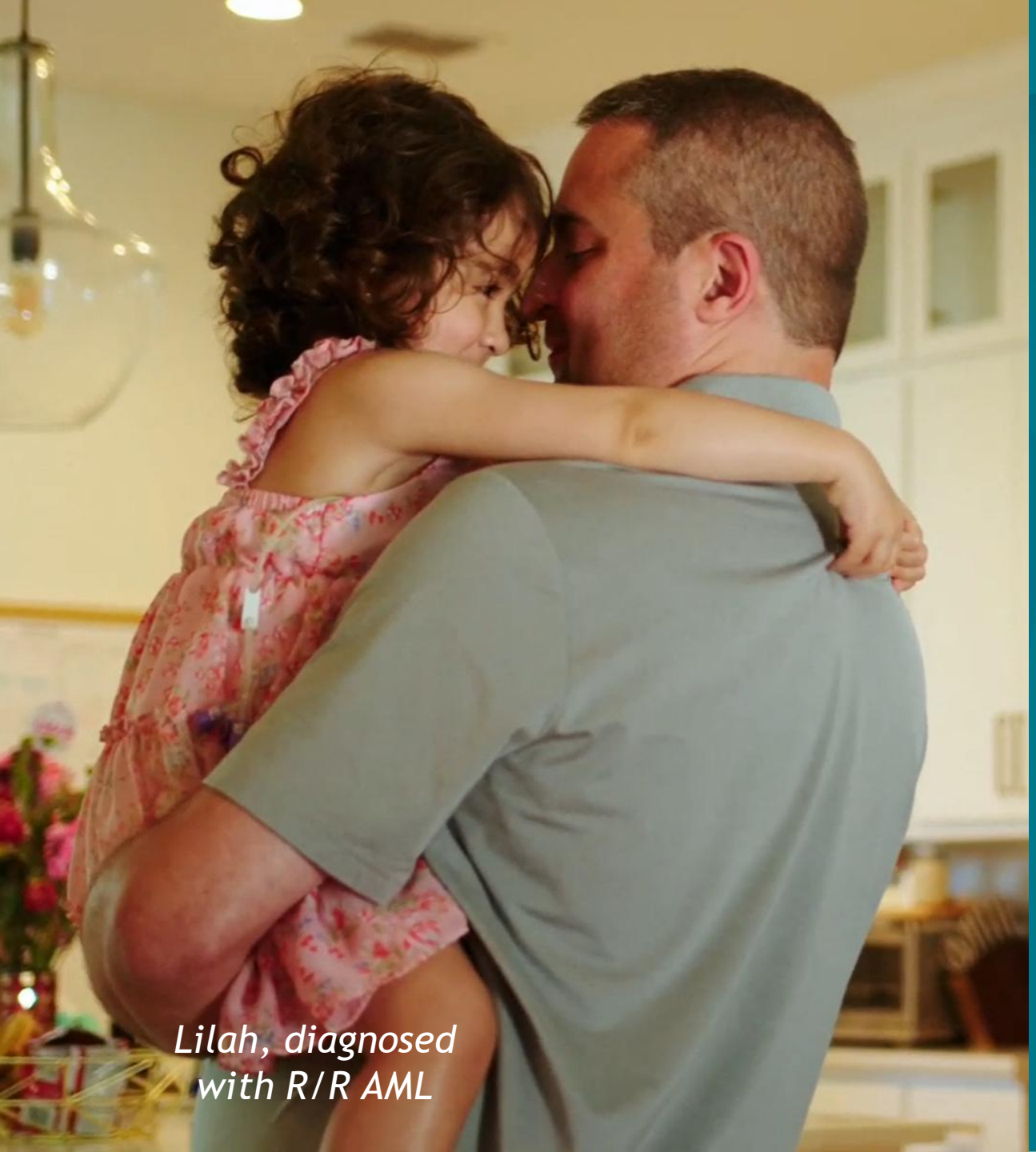
FDA approved

Idiopathic pulmonary fibrosis (IPF)

MAXPIRe Ph 2 Trial
Axa with SOC

- Advancement into IPF supported by strong preclinical and clinical evidence
- Primary endpoint: Δ FVC
- **Expected to complete enrollment in 4Q25, with topline data anticipated in 2H26**

Revuforj Panelist Discussion & Audience Q&A



Lilah, diagnosed with R/R AML

FUELED BY A PASSION FOR PATIENTS

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