Determined to realize a future in which people with cancer live longer and better than ever before

Syndax

CORPORATE PRESENTATION | MAY 2023

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Revumenib and axatilimab on-track to file potential marketing applications in 2023 with several opportunities for expansion

Revumenib

Menin-KMT2A disruption

FDA BREAKTHROUGH THERAPY

Expand within acute leukemia and beyond to solid tumors

- Expect AUGMENT-101 pivotal data beginning in 3Q23
- Front-line and R/R combo trials ongoing with initial data by YE23
- Initial MSS CRC Phase 1 trial data expected by YE23

Axatilimab

Anti-CSF-1R

Expand into earlier lines of cGVHD and fibrotic disease

- AGAVE-201 pivotal cGHVD data expected mid-23
- Initiate cGVHD combo trial with Jakafi® in 2H23
- Initiate IPF Phase 2 trial in 2H23

Corporate and Pipeline

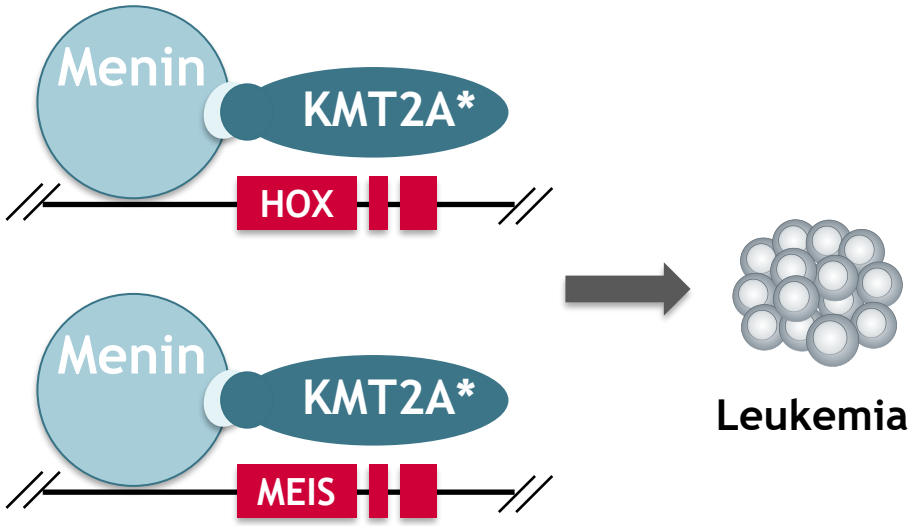
Expand pipeline through BD

- Targeting assets in late pre-clin to Phase 1
- Well-capitalized with $449M in cash and no debt

MSS CRC = Microsatellite Stable Colorectal Carcinoma, IPF = Idiopathic Pulmonary Fibrosis, cGVHD = chronic Graft-Versus-Host Disease, R/R = relapsed/refractory, BTD = Breakthrough Therapy designation Cash as of March 31, 2023; includes cash, cash equivalents and short- and long-term investments

Revumenib turns off leukemic transcriptional programs by binding to Menin and displacing KMT2A (MLL) complexes

KMT2Ar or mNPM1 acute leukemias



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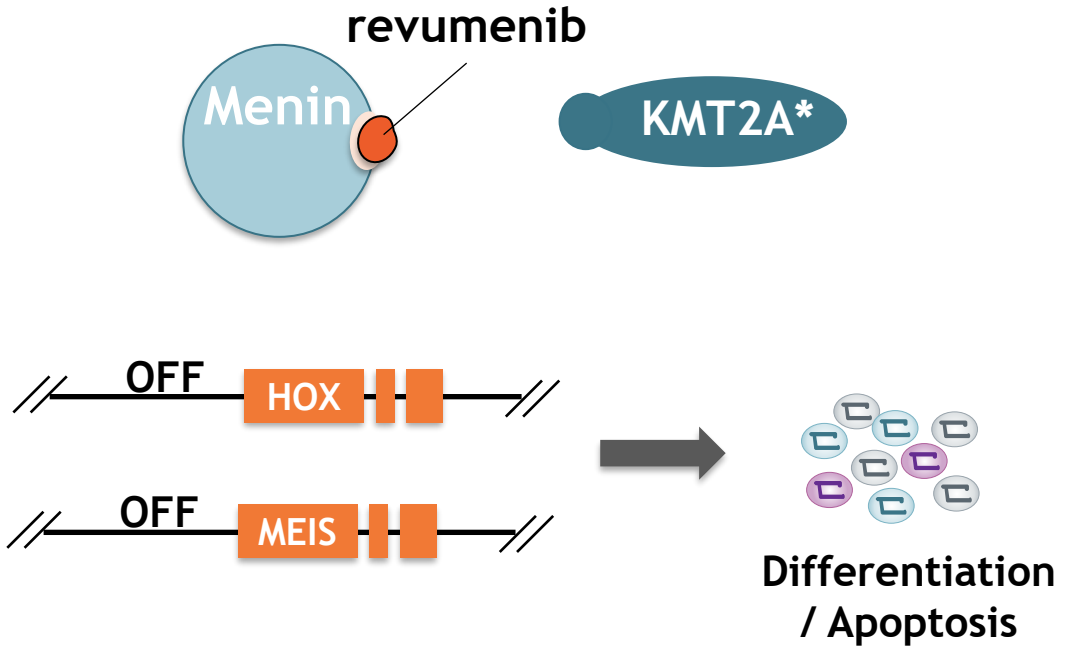
Menin inhibition with revumenib



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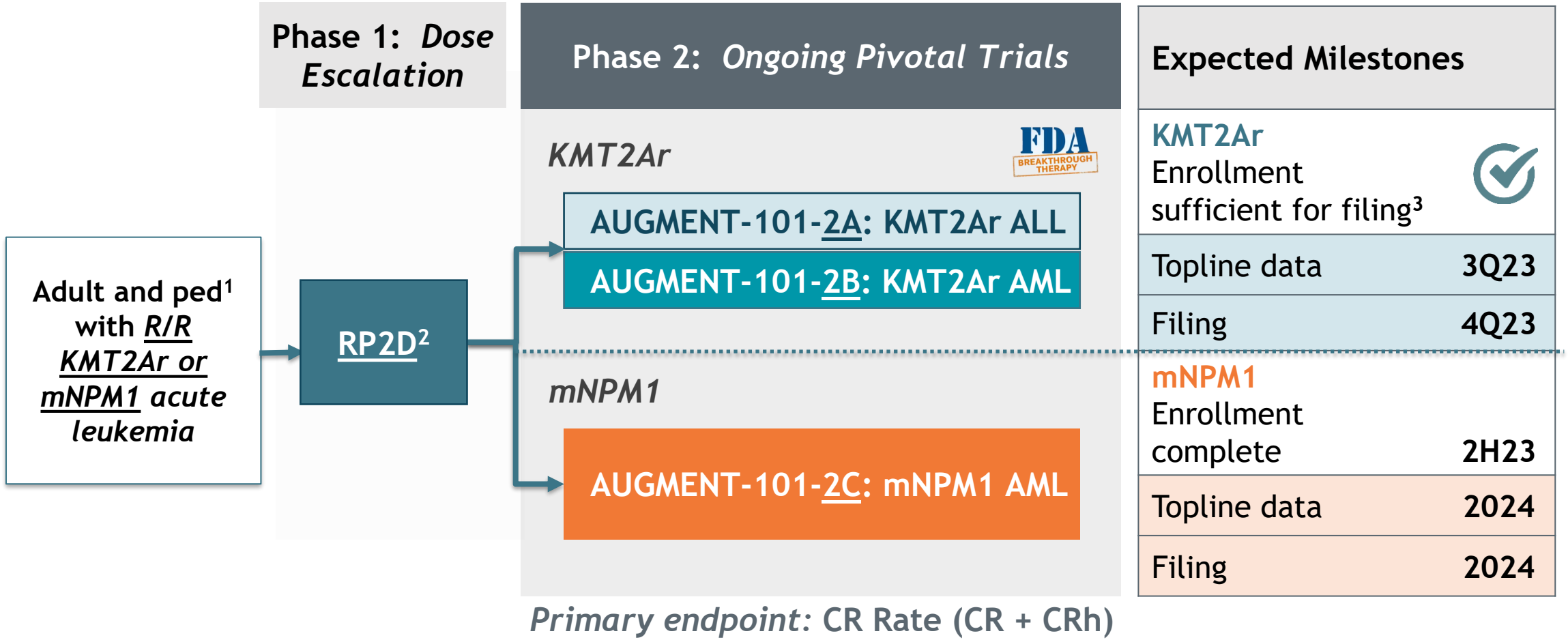
KMT2A = KMT2A rearrangement or KMT2A wildtype; Adopted from: Uckelmann HJ, et al. Presented at ASH Annual Meeting, 2018

Pivotal AUGMENT-101 trial: Expecting KMT2Ar topline data in 3Q23, enrollment completion for mNPM1 in 2H23



Note: Patients taken to HSCT can restart treatment with revumenib post-transplant; Abbreviations: KMT2Ar = KMT2A rearrangement; mNPM1 = mutated nucleophosmin
[1]Allows patients ≥30 days of age [2]276mg q12h or 163mg q12h w/ strong CYP3A4 inhibitor *[3]Completed enrollment of a sufficient number of KMT2Ar patients to support a registration filing*

AUGMENT-101 patients heavily pretreated with a poor prognosis

Phase 1 portion of AUGMENT-101 presented at ASH 2022 and recently published in Nature

Baseline Characteristics	Safety Population N=68
Median age, years (range)	42.5 (0.8, 79)
Adult (n=60)	50.5
Pediatric (n=8)	2.5
Female, n (%)	42 (62)
Leukemia type, n (%)	
AML	56 (82)
ALL	11 (16)
MPAL	1 (2)
Median prior therapies (range)	4 (1,12)
Stem cell transplant, n (%)	31 (46)
Venetoclax, n (%)	41 (60)

Baseline Characteristics	Safety Population N=68
***KMT2Ar*, n (%)**	46 (68)
t(9;11)	10 (15)
t(11;19)	9 (13)
t(4;11)	6 (9)
t(6;11)	3 (4)
t(11;17)	2 (3)
Other	16 (24)
***mNPM1*, n (%)**	14 (21)
***KMT2A* and *NPM1* wild type, n (%)**	8 (12)
Co-occurring mutations*, n (%)	
FLT3	14 (25)
RAS	12 (29)
TP53	4 (10)

**In patients for whom co-occurring mutation data were available.*
MPAL, mixed-phenotype acute leukemia. Data Cutoff of March 202
Issa, G.C. et al. Nature **615**, 920–924 (2023). 2

No patients have discontinued due to treatment related adverse events

Phase 1 portion of AUGMENT-101 presented at ASH 2022 and recently published in Nature

Any-grade treatment related AE (≥5%)	Safety Population N=68
Patients with ≥1 treatment-related AE, n (%)	53 (78)
ECG QTc prolonged	36 (53)
Nausea	18 (27)
Vomiting	11 (16)
Differentiation syndrome	11 (16)
Diarrhea	7 (10)
Dysgeusia	5 (7)
Decreased appetite	5 (7)

No treatment discontinuations for QTc prolongations, or associated arrhythmias

≥Grade 3 treatment related AE	Safety Population N=68
Patients with ≥Gr 3 treatment-related AE, n (%)	11 (16)
ECG QTc prolonged	9 (13)
Diarrhea	2 (3)
Anemia	2 (3)
Asthenia	1 (2)
Fatigue	1 (2)
Hypercalcemia	1 (2)
Hypokalemia	1 (2)
Neutropenia	1 (2)
Thrombocytopenia	1 (2)
Tumor lysis syndrome	1 (2)

10% of patients (5/52) had Gr 3 QTc prolongation at doses meeting criteria for RP2D

ECG, electrocardiogram; QTc, corrected QT interval. Data Cutoff of March 2022

Updated AUGMENT-101 data presented at the ASH meeting continues to support best-in-class profile for revumenib

Phase 1 portion of AUGMENT-101 presented at ASH 2022 and recently published in Nature

	Best Response[1]	Efficacy Population n = 60 (%)	Efficacy @ RP2D[4]
Response	**Overall Response Rate[2]**	**32/60 (53%)**	
	CR	12 (20%)	
	CRh	6 (10%)	
	CRp	5 (8%)	
	MLFS	9 (15%)	
MRD^{neg}	**MRD^{neg} Rate[3]**	**18/32 (56%)**	
	within CR/CRh MRD^{neg}	14/18 (78%)	
	within CR/CRh/CRp MRD^{neg}	18/23 (78%)	
KMT2Ar	**Overall Response Rate[2]**	**27/46 (59%)**	
	CR/CRh	15/46 (33%)	10/37 (27%)
mNPM1	**Overall Response Rate[2]**	**5/14 (36%)**	
	CR/CRh	3/14 (21%)	3/11 (27%)

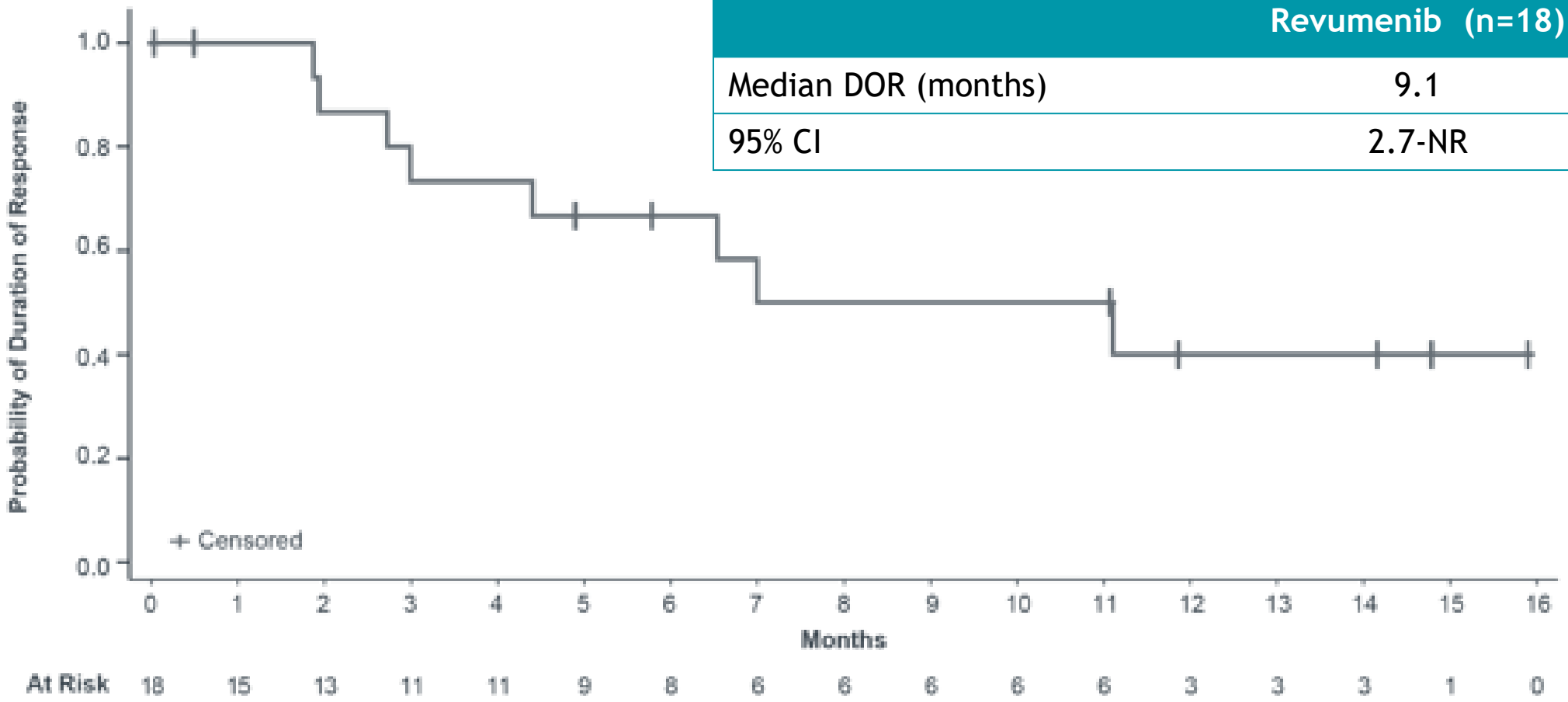
- Median duration of CR/CRh response of **9.1 mos**
- Median time to CR/CRh response of **1.9 mos**
- Median overall survival of **7.0 mos**

[1] Data Cutoff of March 2022; [2] Overall Response Rate = CR + CRh + CRp + MLFS; [3] MRD status assessed locally by PCR or MCF; [4] RP2D defined as 113mg or 163 mg q12h for pts receiving concomitant strong CYP3A4 inhibitor therapy or 226mg or 276mg q12h for pts not receiving concomitant strong CYP3A4 inhibitor therapy

Median duration of CR/CRh response of 9.1 months

Phase 1 portion of AUGMENT-101 presented at ASH 2022 and recently published in Nature

	Revumenib (n=18)
Median DOR (months)	9.1
95% CI	2.7-NR



DOR = duration of response; NR = not reached. Data Cutoff of March 2022

Durable remissions in transplant patients treated in the Phase 1 portion of AUGMENT-101 trial

Phase 1 portion of AUGMENT-101 presented at ASH 2022 and recently published in Nature

12 patients proceeded to HSCT[1]	
Patients who achieved MRD^{neg} status	11/12 (92%)
Remain in remission (1 receiving maintenance in CU[2])	9/12 (75%)
Remained in remission > 1 year	4/12 (33%)
Median follow-up	12.3 months

2 additional patients were treated under CU[2] with revumenib maintenance post HSCT or stem cell boost, and continue in remission for > 1 year

[1]As of data cutoff in March 2022 [2]CU = treated under compassionate use protocol

Significant unmet need remains in acute leukemia

No FDA-approved therapies targeting KMT2Ar or mNPM1 acute leukemias

KMT2A Acute Leukemias

FDA BREAKTHROUGH THERAPY

Annual global incidence 5,000 - 7,000

~ 10% AML or ALL

- NCCN guidelines denote KMT2Ar predict poor prognosis
- Third-line treatment: Median OS of <3 months; 5% of patients achieve CR

mNPM1 Mutant AML

Annual global incidence ~20,000

~ 30% AML

- Most frequent genetic alterations in AML
- Typically associated with favorable prognosis, however beneficial impact decreases with age
- 5-year overall survival rate for adult mNPM1 AML is ~50%

Both KMT2A and mNPM1 acute leukemias are readily diagnosed

Source: Issa, G. C., J. Zarka, K. Sasaki, W. Qiao, D. Pak, J. Ning, et al. (2021). Predictors of outcomes in adults with acute myeloid leukemia and KMT2A rearrangements. Blood Cancer J 11(9): 162. Dohner, H. et al. Blood, 2017; 129(4):424-447; Falini, B.et al. Blood 2011; 117(4):1109-1120. OS = overall response, CR = complete response

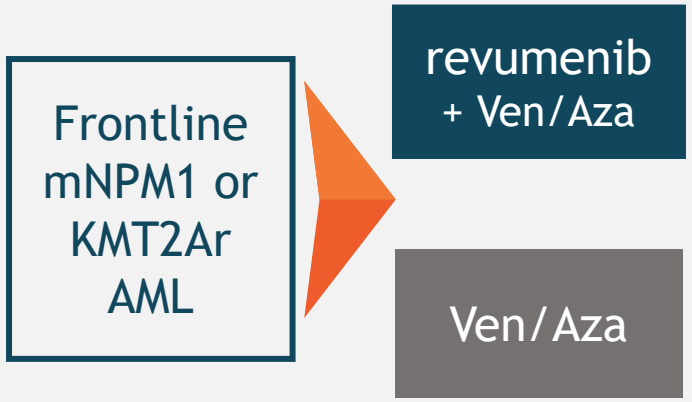
Trials underway to establish revumenib as a backbone of treatment for mNPM1 or KMT2Ar acute leukemia

	Relapsed/Refractory	Front-Line	Maintenance
Revumenib Development	AUGMENT-101 AUGMENT-102	Beat AML acute myeloid leukemia	AUGMENT-101 INTERCEPT trial
Trial Description	Validates use of menin inhibition in NPM1 and KMT2Ar acute leukemias, in monotherapy and chemotherapy combinations	Validates the use of menin inhibition with venetoclax/azacytidine, the commonly used regimen in older patients	**AUGMENT-101**: allows pts to restart Tx post-transplant **INTERCEPT**: examining conversion of MRD+ to MRD-

Multiple trials designed to expand opportunities in acute leukemia for revumenib

BEAT-AML: Frontline Ven/Aza combo

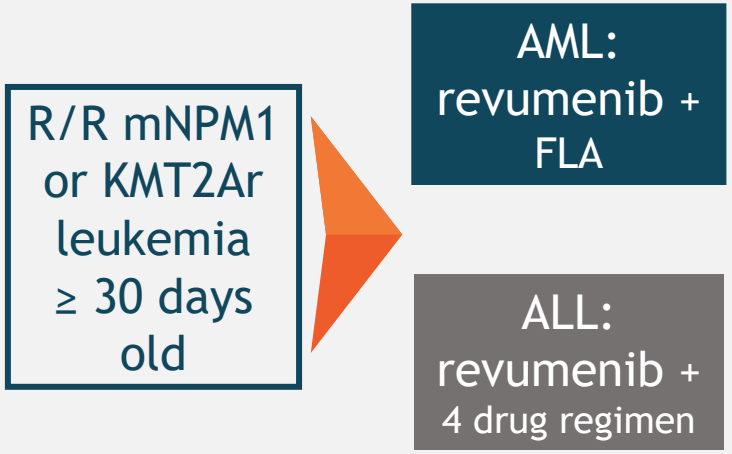
Phase 1/3; Frontline mNPM1 or KMT2Ar AML
revumenib + Ven/Aza



Primary Endpoints:
- RP2D of combo
- CR/CRh rate, MRD- rate, OS

AUGMENT-102: R/R Chemo combo

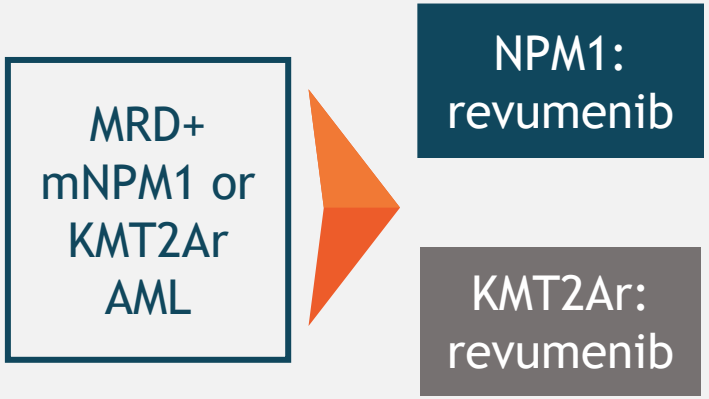
Phase 1; Relapsed or refractory mNPM1 or KMT2Ar AML/ALL
revumenib + chemo



Primary Endpoints:
- Safety, tolerability, RP2D of combo

INTERCEPT: MRD-progression in AML

Phase 1; MRD positive mNPM1 or KMT2Ar AML
revumenib monotherapy



Primary Endpoints:
- MRD- rate

Revumenib expansion opportunities in acute leukemia and solid tumors have potential to add meaningful value

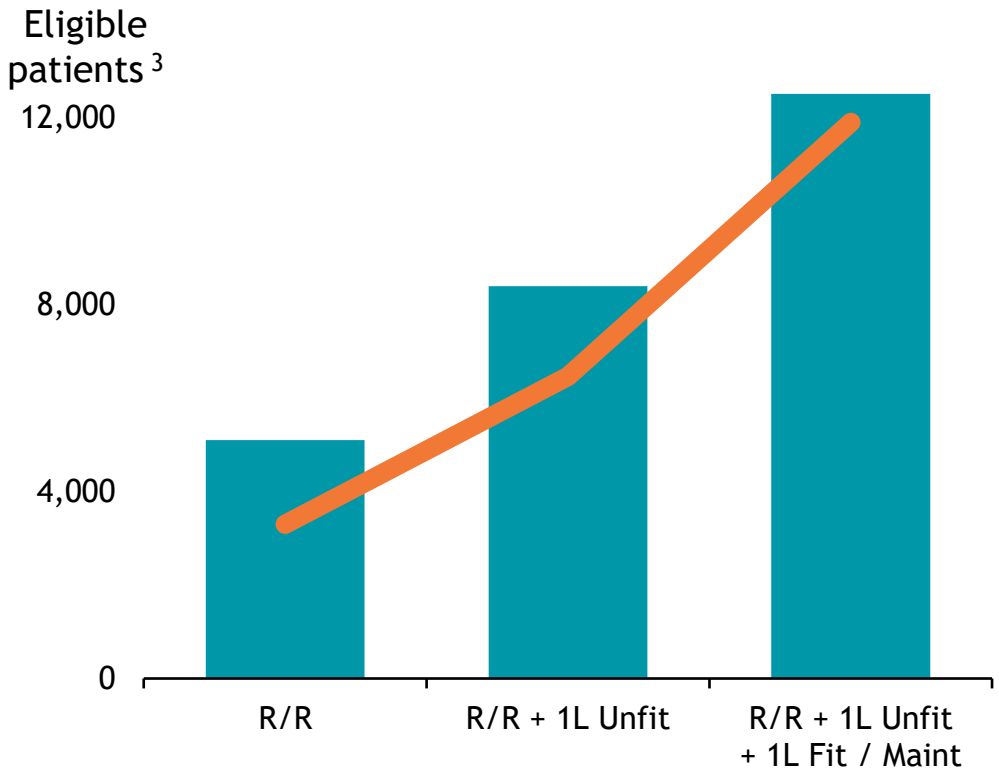
Potential first/best-in-class agent

- Clear activity in refractory, advanced mNPM1 and KMT2Ar acute leukemia
- High percentage of MRD negative responses

Profile supports potential use in front-line and maintenance

- Well-tolerated safety profile, no discontinuations due to treatment related AE
- Preclinical data supports combos with venetoclax[1], chemotherapy[2]

Est. US market opportunity for mNPM1 and KMT2Ar AML



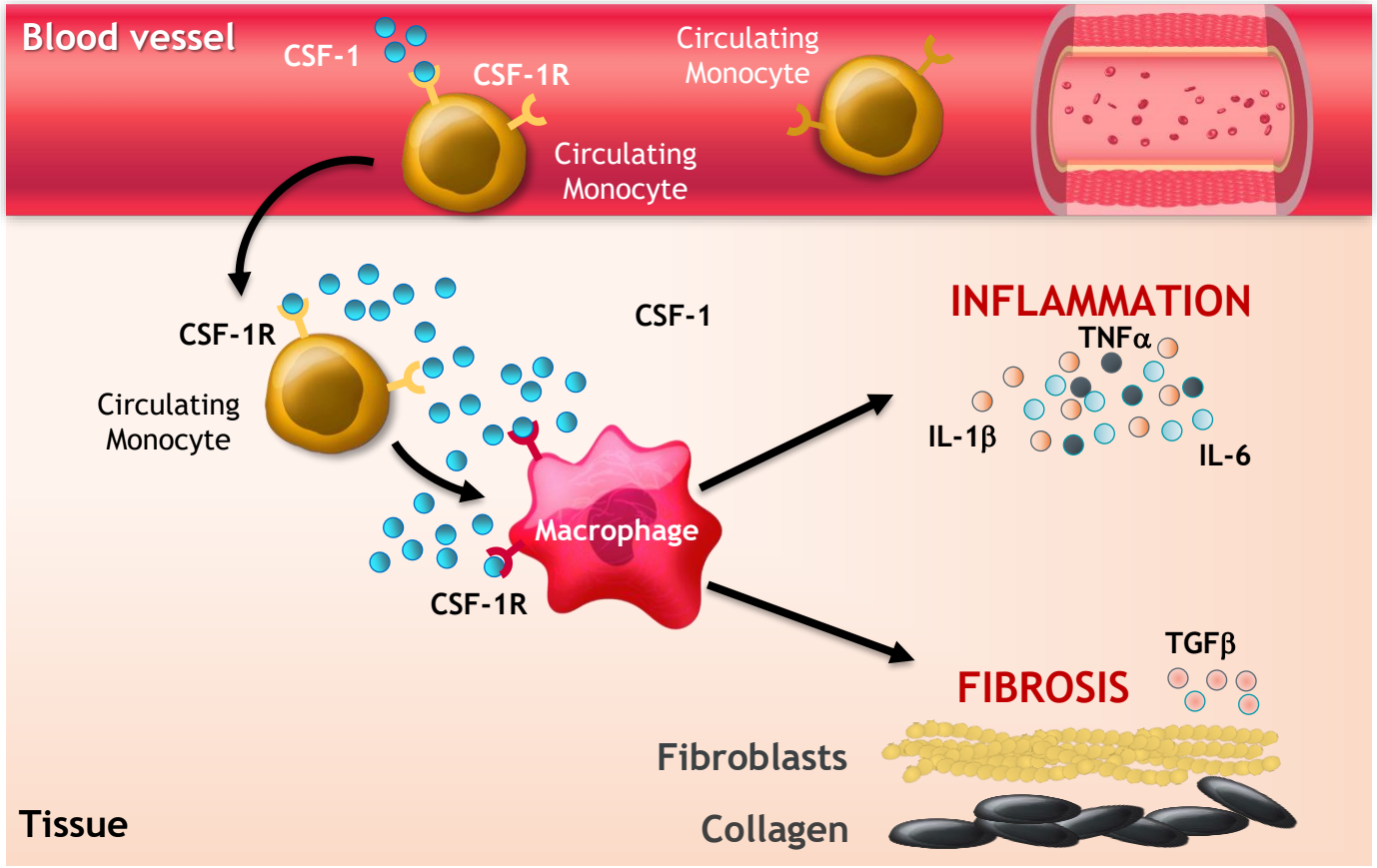
Expansion into solid tumors represents another significant opportunity for value

[1] SMARTAnalyst 2020 [1] Carter, B., et al., Blood 2021; [2] Data on file; [3] SEER + Roche IR presentation Sept 2020 AML incidence estimates.

As a CSF-1R inhibitor, axatilimab is well positioned to impact both fibrotic and inflammatory processes

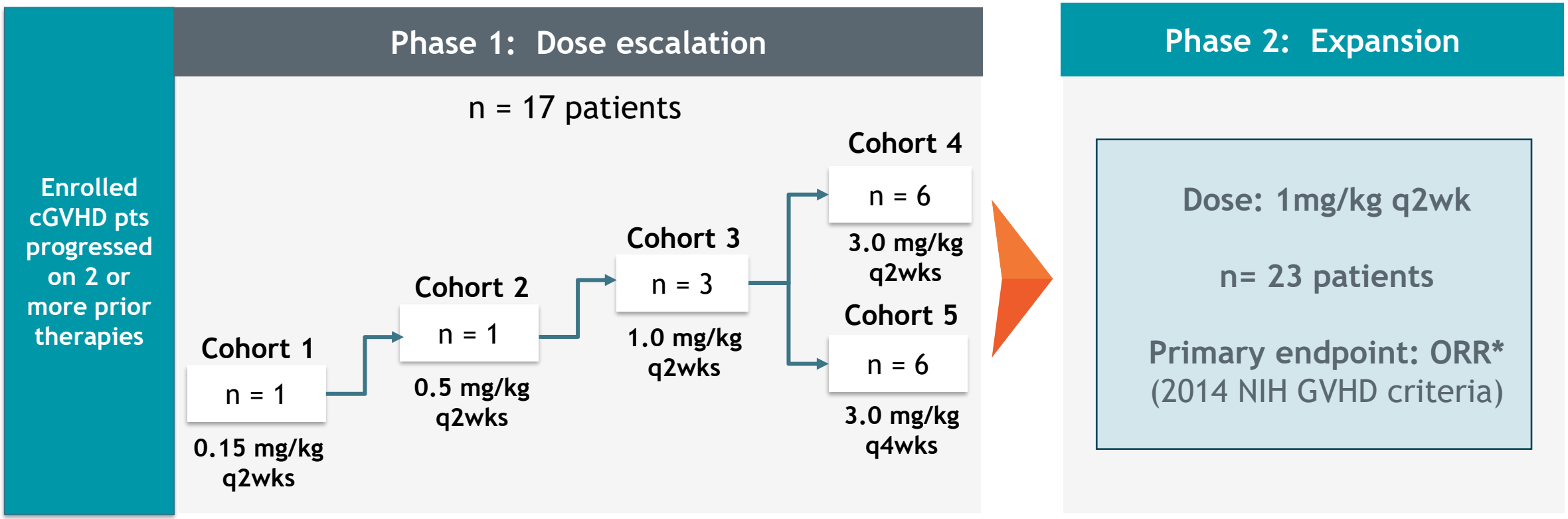
- Non-overlapping MOA offers potential to benefit patients both as monotherapy and in combination with approved agents
- Potential to benefit difficult to manage manifestations such as Lung, Skin, GI
- IV administration can help with compliance and absorption for GI manifestations

CSF-1R mediates pro-inflammatory and pro-fibrotic monocyte/macrophage differentiation and activation[1]



1. Figure Adapted from MacDonald KP et al. Blood. 2017;129(1):13-21; Chitu et al. Current Opinion in Immunology. 2006;18(1): 39-48

Phase 1/2 trial highlights the therapeutic benefit of axatilimab for patients with R/R cGVHD



*ORR at cycle 7 day 1; Data cutoff: 22Oct2021; Source: Kitko, C. L., M. Arora, et. al. J Clin Oncol. 2022, December. DOI: 10.1200/JCO.22.00958

Baseline characteristics suggest heavily pre-treated population

	Ph 1, n=17 ALL DOSES	Ph 2, n = 23 1mg/kg Q2W	TOTAL N=40
Age, median (range),yrs	60 (29, 73)	57 (16, 69)	59 (16, 73)
Female, n (%)	6 (35)	9 (39)	15 (38)
Myeloablative transplant, n (%)	9 (53)	17 (74)	26 (65)
Related Donor, n (%)	9 (53)	9 (39)	18 (45)
Peripheral blood transplant, n (%)	16 (94)	21 (91)	37 (93)
KPS at enrollment, median (range)	80 (60, 100)	80 (60, 90)	80 (60, 100)
# organs involved, median (range)	4 (1, 5)	4 (1, 9)	4 (1, 9)
≥4 organs involved, n (%)	10 (58)	16 (70)	26 (65)
Prior treatment, median n (range)	4 (1, 9)	3 (2, 11)	4 (1,11)
Ibrutinib, n (%)	13 (77)	13 (57)	26 (65)
Ruxolitinib, n (%)	10 (59)	11 (48)	21 (53)
Belumosudil, n (%)	6 (35)	2 (9)	8 (20)
cGVHD→C1D1, median (range), yrs	3.5 (0.11, 15.6)	3.0 (0.35, 6.7)	3.2 (0.11, 15.6)

No significant differences in baseline characteristics across Ph 1 & Ph 2

Abbreviations: KPS=Karnofsky Performance Score, Q=every.

Data cutoff: 22Oct2021; Source: Kitko, C. L., M. Arora, et. al. J Clin Oncol. 2022, December. DOI: 10.1200/JCO.22.00958

Axatilimab clinical profile demonstrates tolerability

AE Overview, No. (%)

	Ph 1, n=17 ALL DOSES	Ph 2, n = 23 1mg/kg Q2W	TOTAL N=40
Any AE	17 (100)	22 (96)	39 (98)
≥ grade 3 AE	13 (77)	7 (30)	20 (50)
TRAE	15 (88)	15 (65)	30 (75)
SAE	9 (53)	7 (30)	16 (40)
Deaths[1]	1 (6)	--	1 (2.5)
≥ grade 3 TRAE	6 (35)	2(9)	8 (20)
Related SAE	1 (6)	3 (13)	4 (10)
AE leading to dose modification	6 (35)	7 (30)	13 (33)
AE leading to discontinuation	5 (29)	2 (9)	7 (18)

Any ≥ grade 3 AE in ≥ 2 patients, No. (%)

	Ph 1, n=17 ALL DOSES	Ph 2, n = 23 1mg/kg Q2W	TOTAL N=40
Hypertension	3 (18)	1 (4)	4 (10)
CPK increase	4 (24)	--	4 (10)
Pneumonia	3 (18)	--	3 (8)
Acute kidney injury	1 (6)	1 (4)	2 (5)
AST increase	2 (12)	--	2 (5)
GGT increase	2 (12)	--	2 (5)
Lipase increase	2 (12)	--	2 (5)
Fever	1 (6)	1 (4)	2 (5)

- Serum enzyme elevations may reflect on-target effect of axatilimab on Kupffer cells in the liver
- No evidence of end-organ damage, myositis/pancreatitis with enzyme elevations

[1] *Only death that occurred on study was unrelated to study intervention*

Data cutoff: 22Oct2021; Source: Kitko, C. L., M. Arora, et. al. J Clin Oncol. 2022, December. DOI: 10.1200/JCO.22.00958

Axatilimab: Phase 1/2 POC trial in cGVHD showed rapid and durable responses

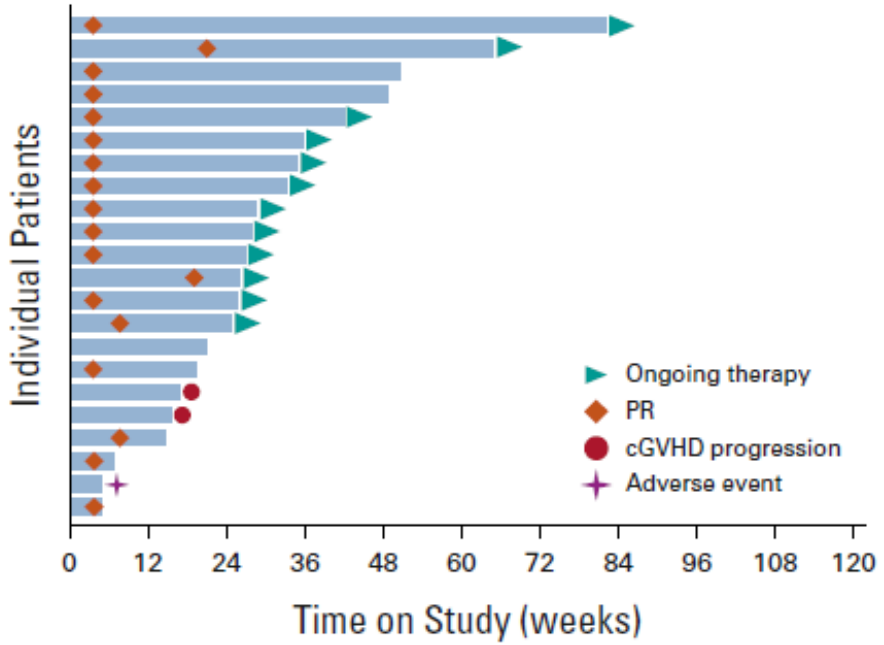
Phase 2 cohort highlights

82% ORR by cycle 7 day 1

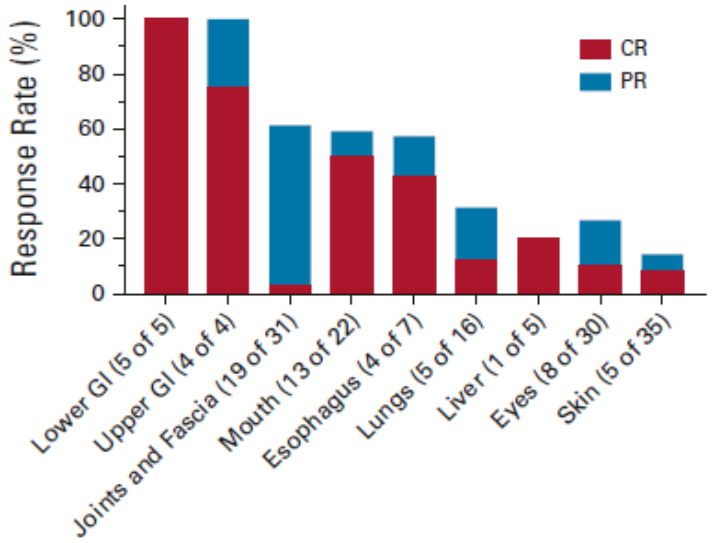
77% FFS at 12 months

4 wks Median time to response

Individual responses and durability of Phase 2 cohort



Cumulative response rate in cGVHD-involved organs

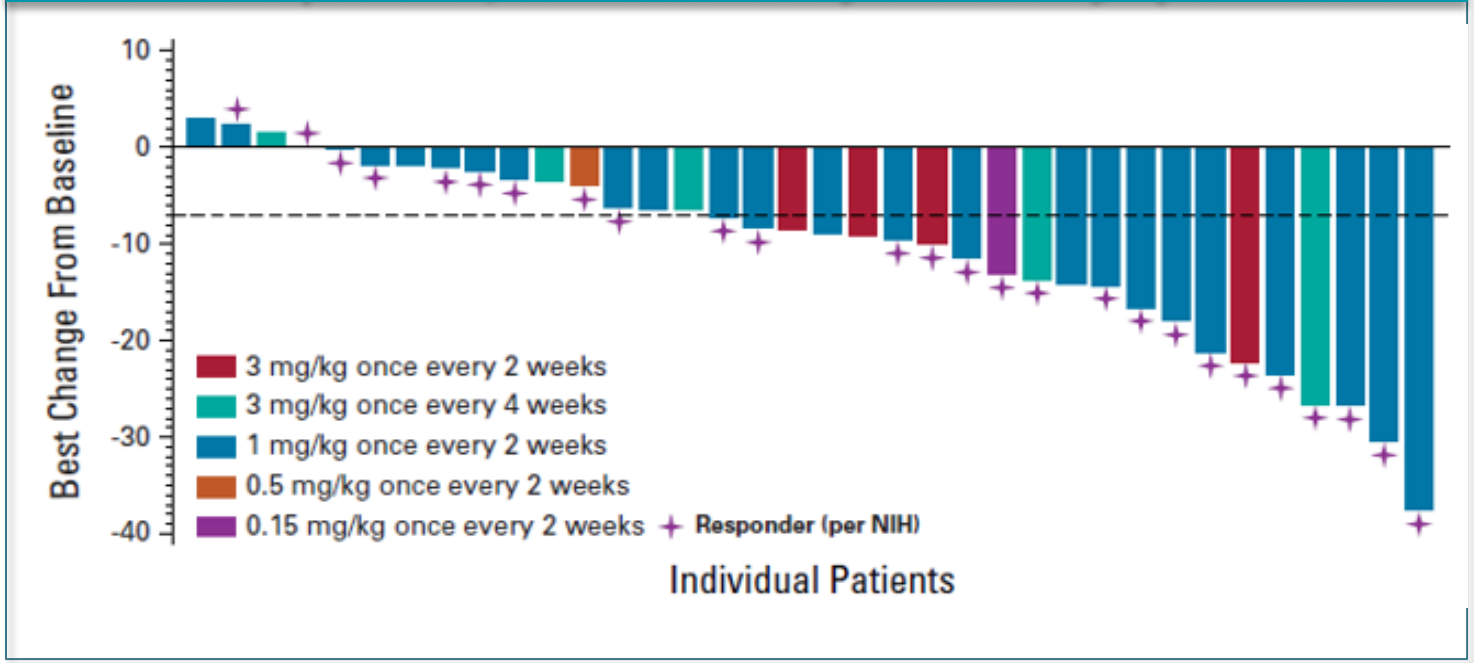


Responses observed across all organ systems

Data cutoff: 22Oct2021; Source: Kitko, C. L., M. Arora, et. al. J Clin Oncol. 2022, December. DOI: 10.1200/JCO.22.00958; FFS = failure-free survival using a broadened failure definition that incorporate toxicity-related discontinuation and cGVHD progression not included in the standard cGVHD FFS reporting; ORR = overall response rate

Axatilimab clinical responses were accompanied by a reduction in cGVHD symptom burden and improvements in all affected organs

Change in cGVHD symptoms from baseline in all evaluable patients, as measured by the Lee Symptom Scale



58% Of evaluable patients had a >7 point improvement in the Lee Symptom Scale

52% Of responding patients decreased glucocorticoid doses

Data cutoff: 22Oct2021; Source: Kitko, C. L., M. Arora, et. al. J Clin Oncol. 2022, December. DOI: 10.1200/JCO.22.00958

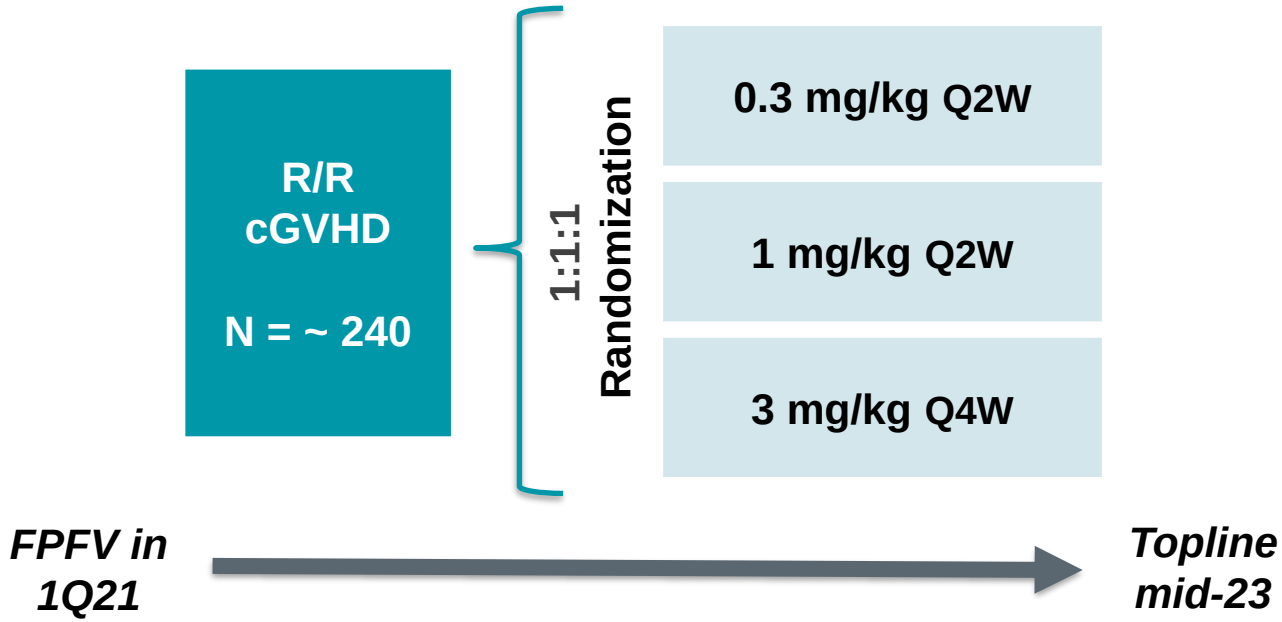
AGAVE-201: Axatilimab pivotal trial data expected in mid-2023 with a BLA filing by year-end

Inclusion criteria:

- 2 years and older[1]
- Recurrent or refractory active cGVHD after ≥ 2 lines of systemic therapy

Stratification factors:

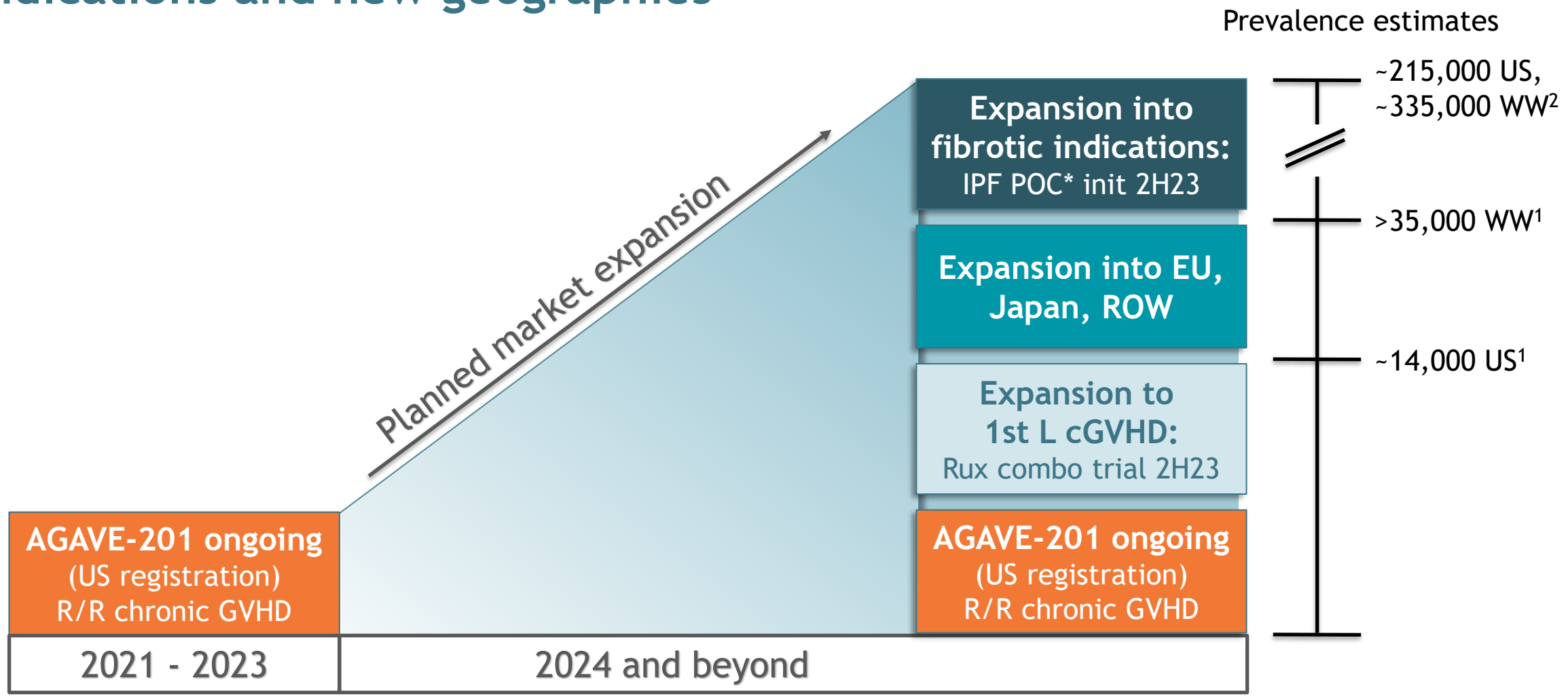
- Prior therapy (ibrutinib, ruxolitinib, belumosudil)
- Severity of cGVHD



Initiation of combination trial in cGVHD expected in 2H23

[1] *Age inclusion criteria differs by country; Front-line combination trial being conducted by Incyte*
Primary Endpoint: Objective Response Rate (ORR) by 2014 NIH GVHD Criteria; Key Secondaries: Duration of response, improvement in modified Lee Symptom Scale

Axatilimab has the potential to expand into additional high value indications and new geographies



[1] *SmartImmunology Insights cGVHD report March 2020;* [2] *SmartImmunology Insights IPF report March 2020* * *IPF trial will be conducted and funded by Syndax*

Financial highlights and financial guidance

Ticker	SNDX (NASDAQ)
Cash and equivalents (at 31 March 2023)	$449 million
Shares outstanding* (at 31 March 2023)	69.6 million

2023 Operating Expense Guidance		
	2Q 2023	FY23 (no change)
Research and development	$38 – $43 million	$160 – $175 million
Total operating expenses^	$53 – $58 million	$225 – $240 million

* *Includes pre-funded warrants to purchase 1.1 million common shares (rounded)*
^ *Includes ~$30 million non-cash stock compensation expense for the full year*

Thank you. Questions?

Syndax