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

Syndax

CORPORATE PRESENTATION – DECEMBER 2022

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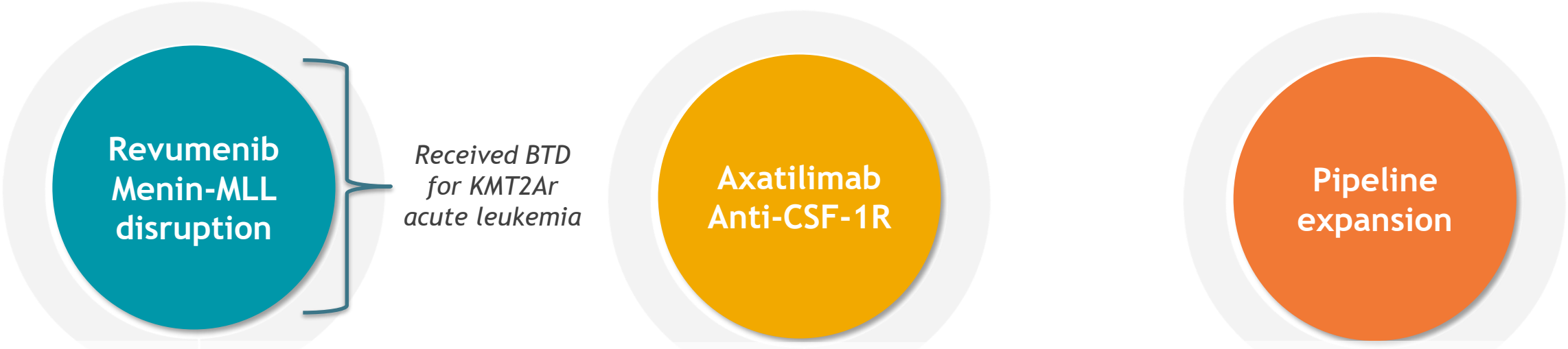
Revumenib and axatilimab on-track for potential marketing applications in 2023 with several opportunities for expansion



Expand within acute leukemia and beyond to solid tumors

- AUGMENT-101 pivotal data in acute leukemias expected beginning in 3Q23
- Front-line and R/R combo trials ongoing; MRD+ treatment trial to begin in 4Q22
- Initiate MSS CRC Phase 1 trial in 4Q22

Expand into earlier lines of cGVHD and fibrotic disease

- AGAVE-201 pivotal trial data in cGVHD expected in mid-2023
- Initiate front-line combination trial in cGVHD in 1Q23
- Initiate IPF Phase 2 trial in 4Q22

Expand pipeline through BD

- Targeting assets in late pre-clin to Phase 1
- Strong balance sheet to support BD efforts

MSS CRC = Microsatellite Stable Colorectal Carcinoma, IPF = Idiopathic Pulmonary Fibrosis, cGVHD = chronic Graft-Versus-Host Disease, R/R = relapsed/refractory, BTD = Breakthrough Designation Therapy

Revumenib

Oral menin inhibitor

No FDA-approved targeted therapies to treat MLLr or NPM1c acute leukemias

MLLr Acute Leukemias

Annual global incidence 5,000 - 7,000

4-10% AML

10-15% ALL

(80% of infant ALL)

- **5-year OS for adult MLLr <25%**

NPM1 Mutant AML

Annual global incidence ~20,000

30% AML

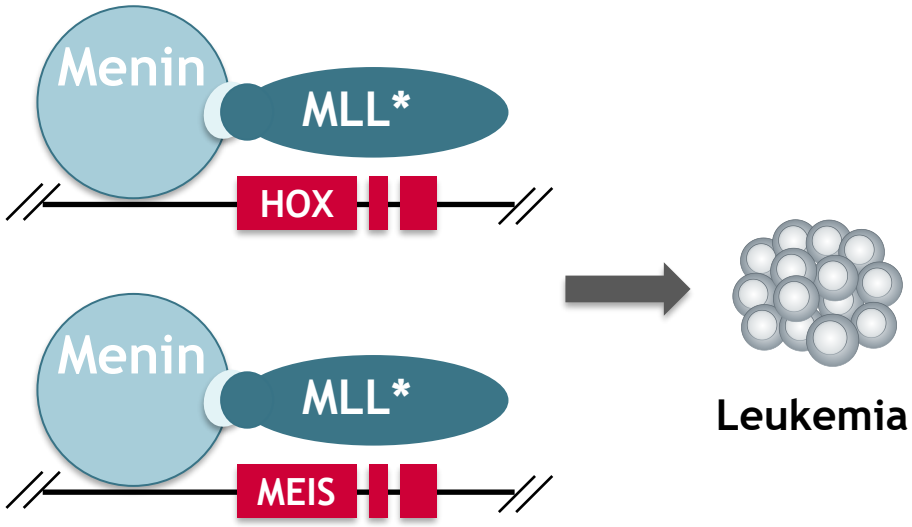
- **5-year OS for adult NPM1c AML 50%**
- **Known NPM1c co-mutations offer rational combination approaches**

Both MLLr and NPM1 acute leukemias are readily diagnosed

Sources: NCCN conference and meetings: NCCN guidelines; Dohner, H. et al. Blood, 2017; 129(4):424-447; Falini, B. et al. Blood, 2011; 117(4): 1109-1120; MLLr = mixed lineage leukemia rearranged; NPM1c = mutant nucleophosmin 1

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

MLLr or NPM1c Acute Leukemias



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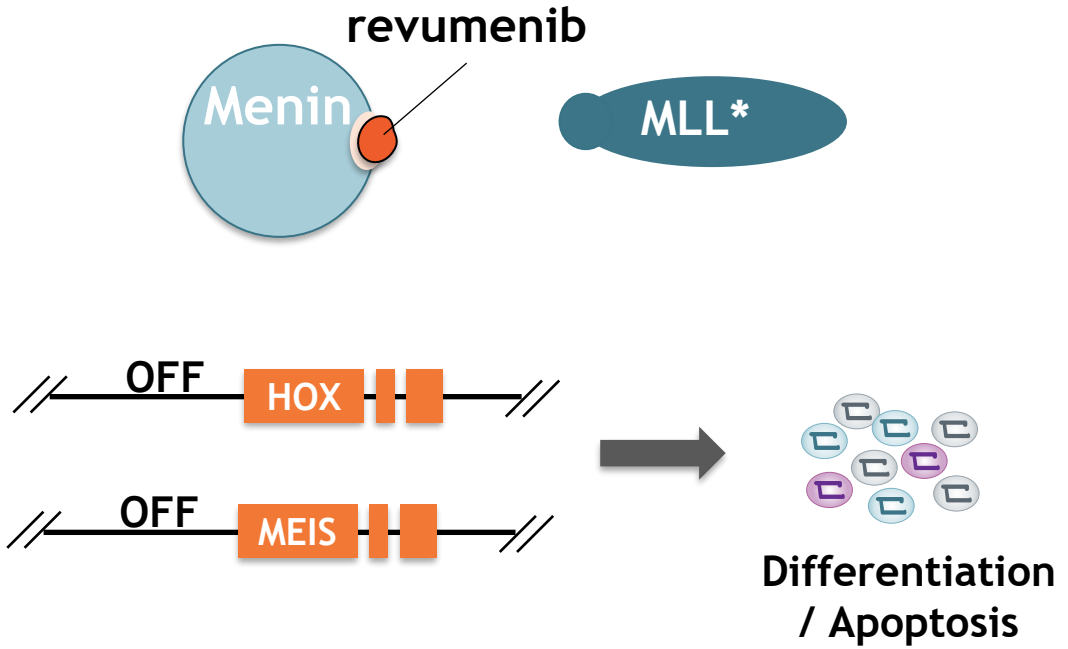
Menin inhibition with revumenib



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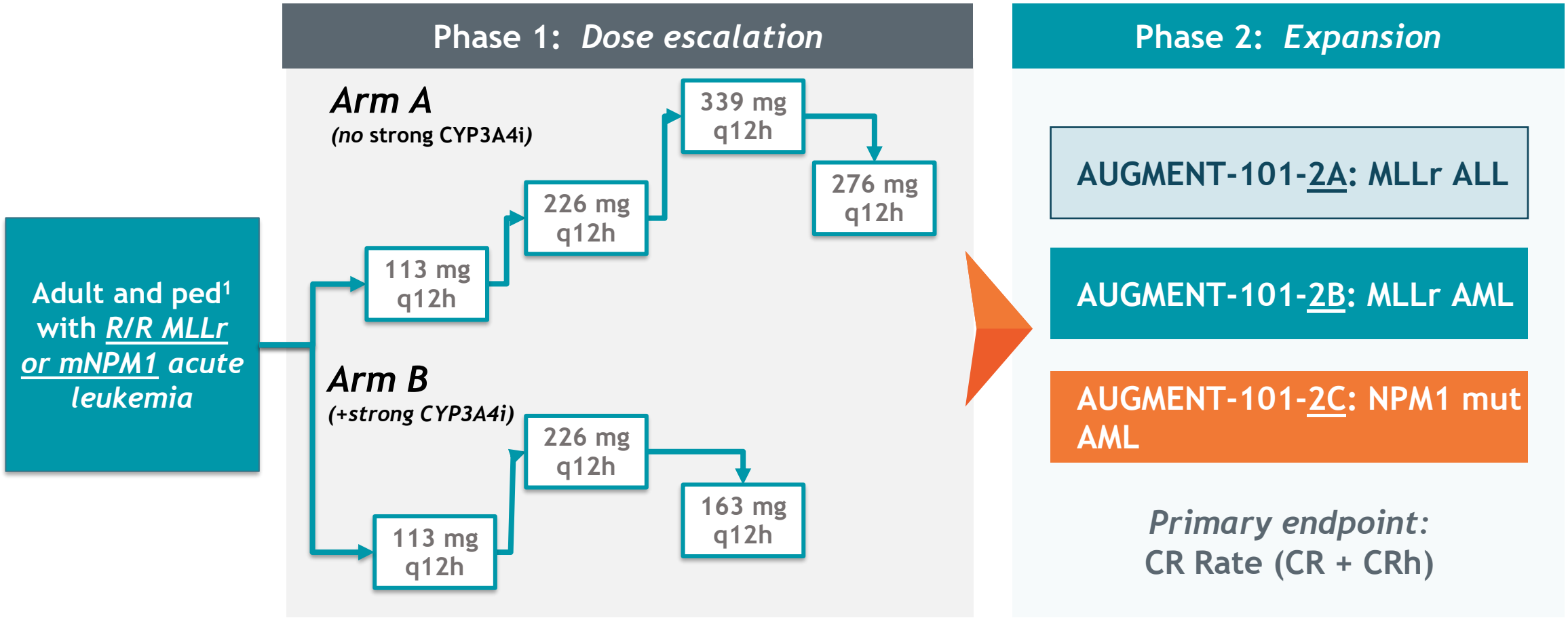
MLL = MLLr or MLL1 wildtype; Adopted from: Uckelmann HJ, et al. Presented at ASH Annual Meeting, 2018*

AUGMENT-101: Phase 1/2 trial of revumenib in patients with acute leukemias



Updated results from Phase 1 portion will be presented at ASH 2022

[1]*Allows patients ≥30 days of age; Abbreviations: MLLr = mixed lineage leukemia rearranged; mNPM1 = mutated nucleophosmin*

ASH 2022: Positive updates to Phase 1 portion of AUGMENT-101 trial

Abstract #63 – Presentation on December 10th (9:30 – 11:00 AM CT)

	Best Response[1]	Efficacy Population n = 60 (%)
Response	**Overall Response Rate[2]**	**32/60 (53%)**
	CR	12 (20%)
	CRh	6 (10%)
	CRp	5 (8%)
	MLFS	9 (15%)
MRD^{neg}	**CRc MRD^{neg} Rate[3]**	**18/60 (30%)**
	within CR/CRh MRD^{neg}	14/18 (78%)
	within CR/CRh/CRp MRD^{neg}	18/23 (78%)
MLLr	**Overall Response Rate[2]**	**27/46 (59%)**
	CR/CRh	15/46 (33%)
mNPM1	**Overall Response Rate[2]**	**5/14 (36%)**
	CR/CRh	3/14 (21%)

Median duration of CR/CRh response of 9.1 mos

- No new safety signals; AE rates not materially different from prior disclosures
- No discontinuations due to treatment-related AEs

Efficacy @ RP2D[4]
10/37 (27%)
3/11 (27%)

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

ASH 2022: Durable remissions in transplant patients treated in the Phase 1 portion of AUGMENT-101 trial

Abstract #376 – Presentation on December 10th (4:00 – 5:30 PM CT)

12 patients proceeded to HSCT[1]	
Patients who achieved MRD^{neg} status	10/12 (83%)
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

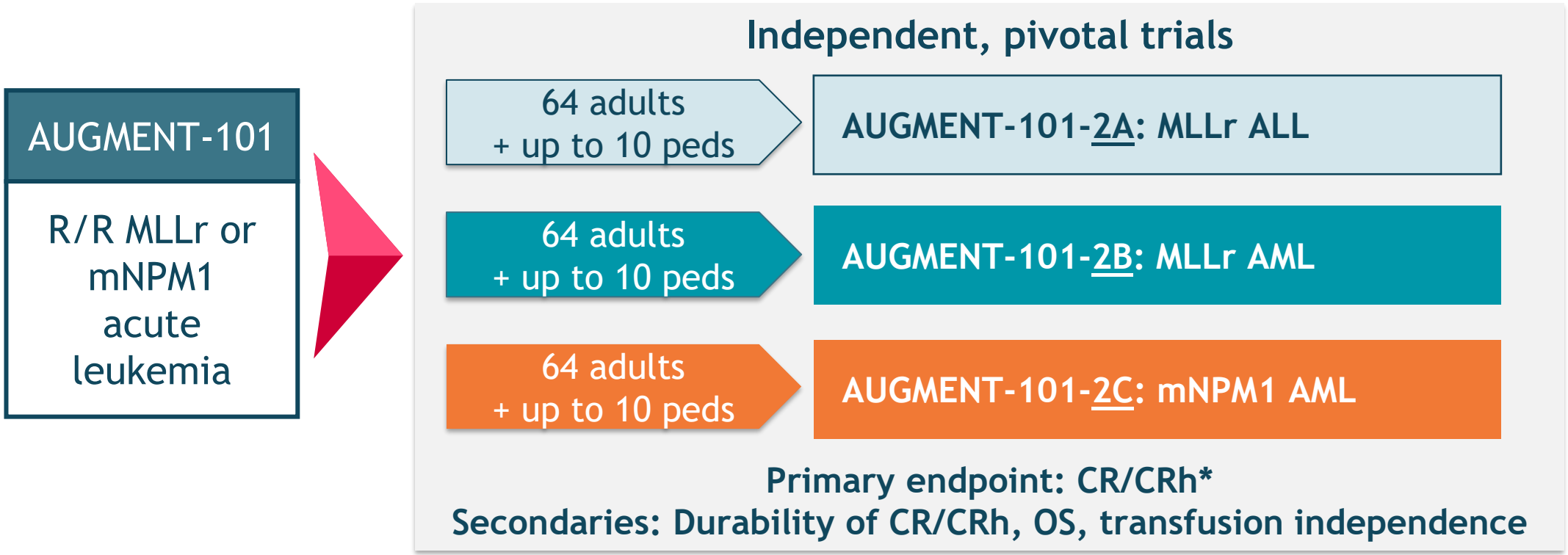
[1]As of data cutoff in March 2022 [2]CU = treated under compassionate use protocol

Revumenib is the first investigational treatment to receive BTD for R/R KMT2Ar (MLLr) acute leukemia

Breakthrough Therapy Designation Granted for Revumenib for the Treatment of Adult and Pediatric Patients with Relapsed or Refractory KMT2A- rearranged Acute Leukemia

Robust dataset	Significant unmet need	Broad designation
Supported by Phase 1 data from all KMT2A R/R acute leukemia patients at doses meeting protocol defined criteria for RP2D	KMT2Ar leukemia occurs in up to 10% of all acute leukemias, including~80% of infant acute leukemias	Recognizes KMT2Ar leukemia as one disease, regardless of pathologic designation or age of onset

AUGMENT-101: Revumenib pivotal trials in 3 acute leukemia populations are enrolling



** Patients taken to HSCT can restart treatment with revumenib post-transplant*

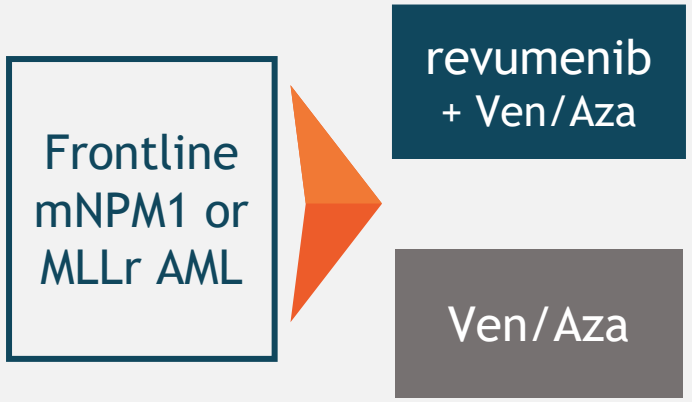
Trials underway to establish revumenib as a backbone of treatment for mNPM1 or MLLr acute leukemia

	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 MLLr 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

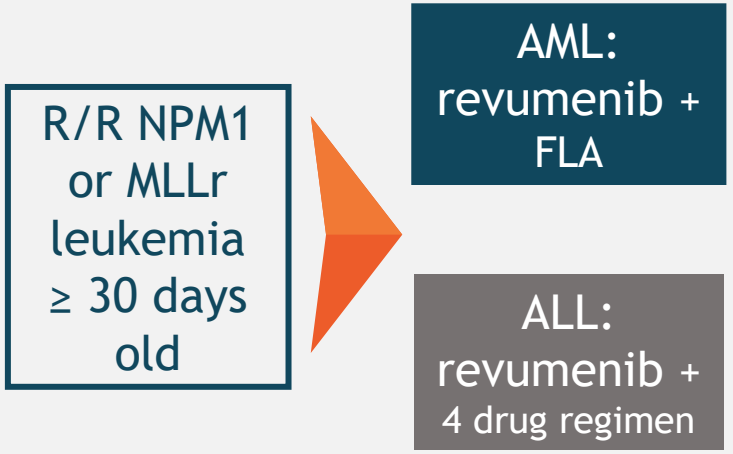
Phase 1/3; Frontline mNPM1 or MLLr AML
revumenib + Ven/Aza



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

AUGMENT-102: R/R Chemo combo

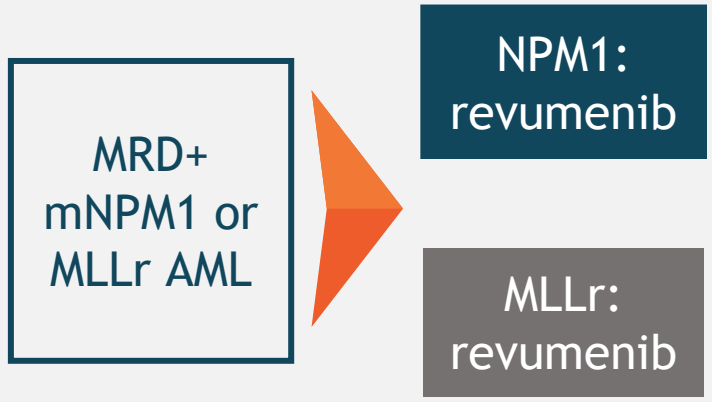
Phase 1; Relapsed or refractory mNPM1 or MLLr AML/ALL
revumenib + chemo



Primary Endpoints:
- Safety, tolerability, RP2D of combo

INTERCEPT: MRD-progression in AML

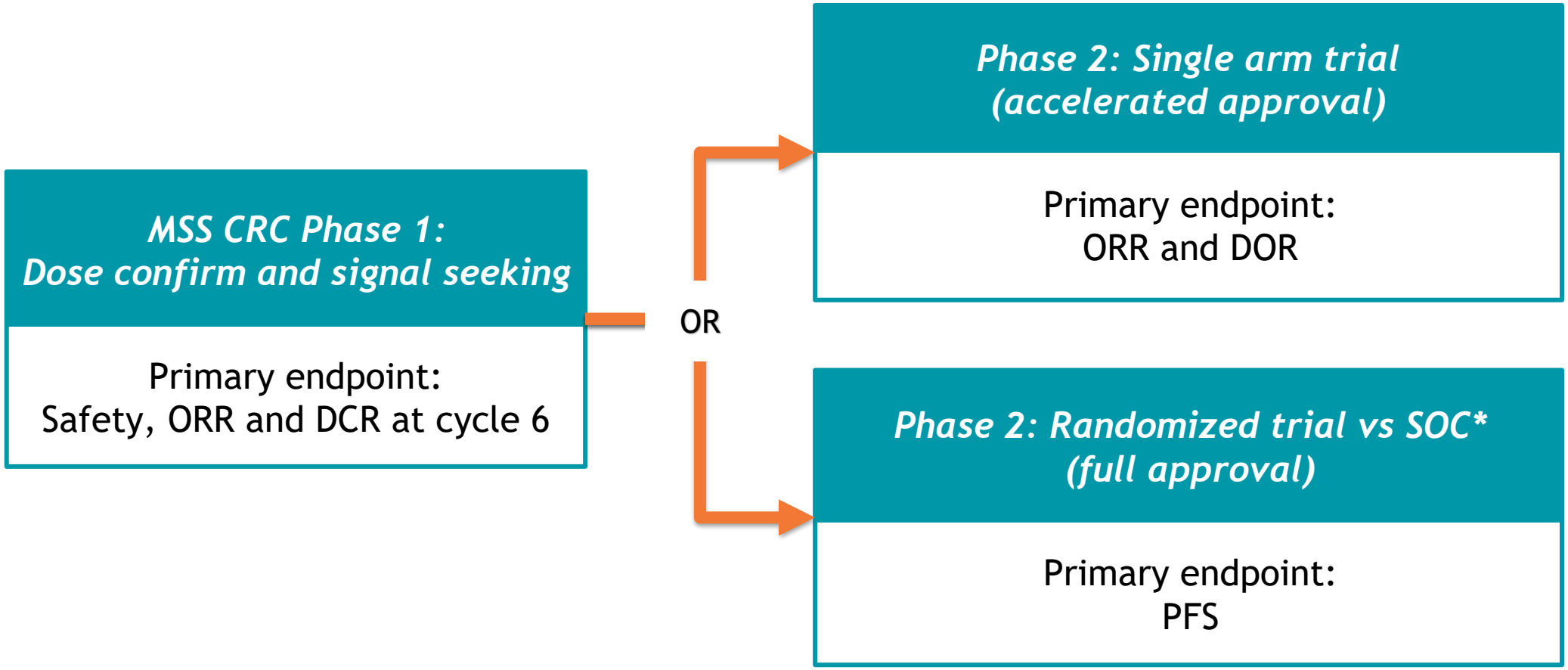
Phase 1; MRD positive mNPM1 or MLLr AML
revumenib monotherapy



Primary Endpoints:
- MRD- rate

Revumenib Phase 1 signal-seeking trial to assess efficacy in MSS CRC

First evaluation in solid tumors; initiation expected 4Q22



*ORR = Overall Response Rate, DCR = Disease Control Rate, DOR = Duration of Response; *SOC = Stivarga or Lonsurf*

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

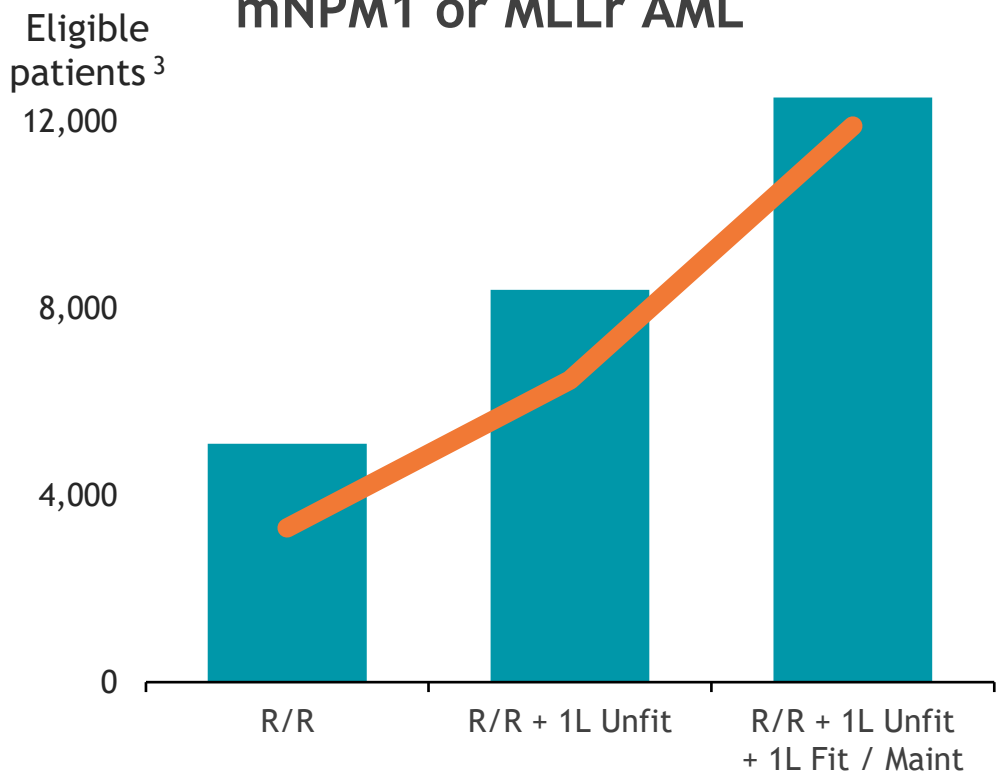
Potential first/best-in-class agent

- Clear activity in refractory, advanced mNPM1 and MLLr 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 or MLLr AML



Expansion into solid tumors represents another significant opportunity for value

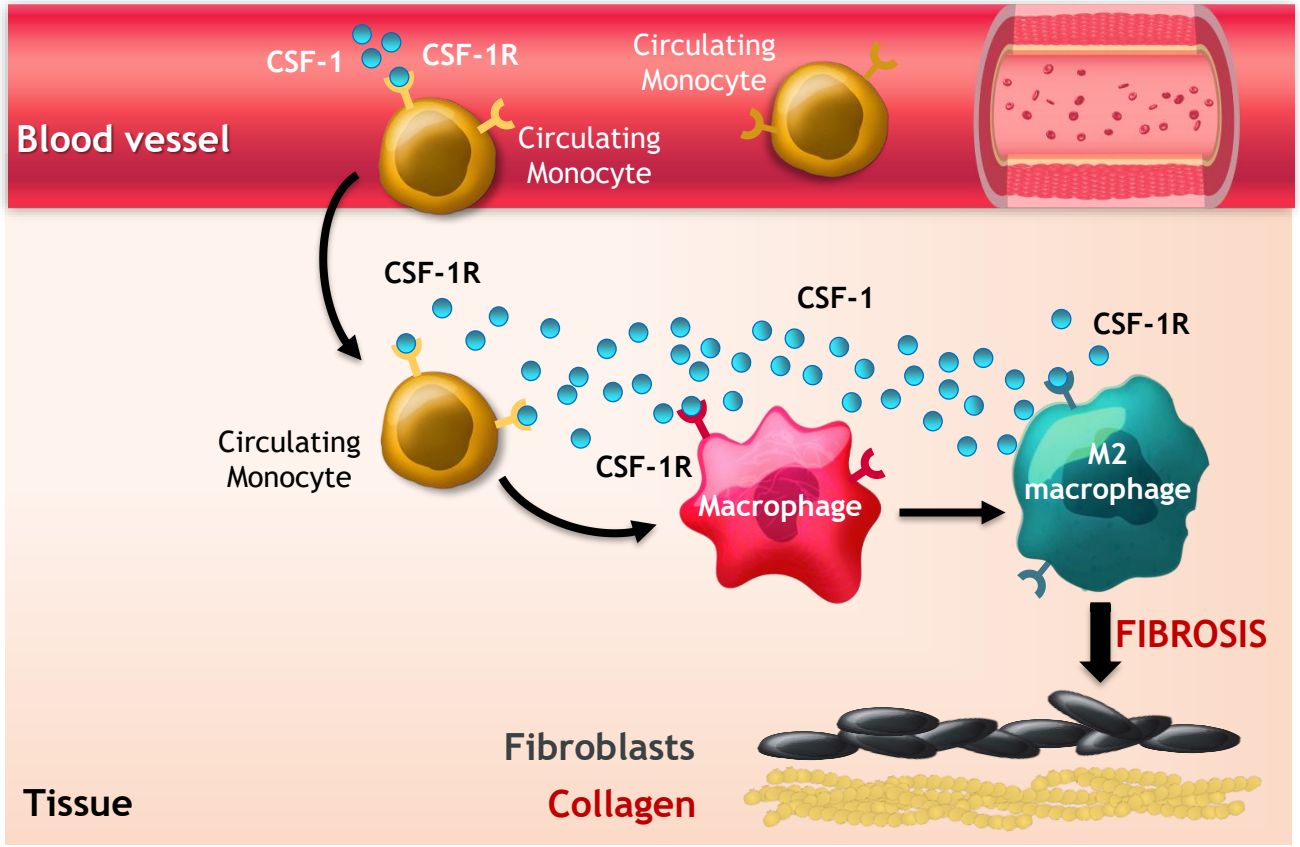
[1] SMARTAnalyst 2020 [1] Carter, B., et al., Blood 2021; [2] Data on file; [3] SEER + Roche IR presentation Sept 2020 AML incidence estimates.

Axatilimab

Anti-CSF-1R antibody

Axatilimab: CSF-1R mAB with potential best-in-class profile

Axatilimab inhibition reduces pathogenic monocytes and macrophages



Chronic graft versus host disease:

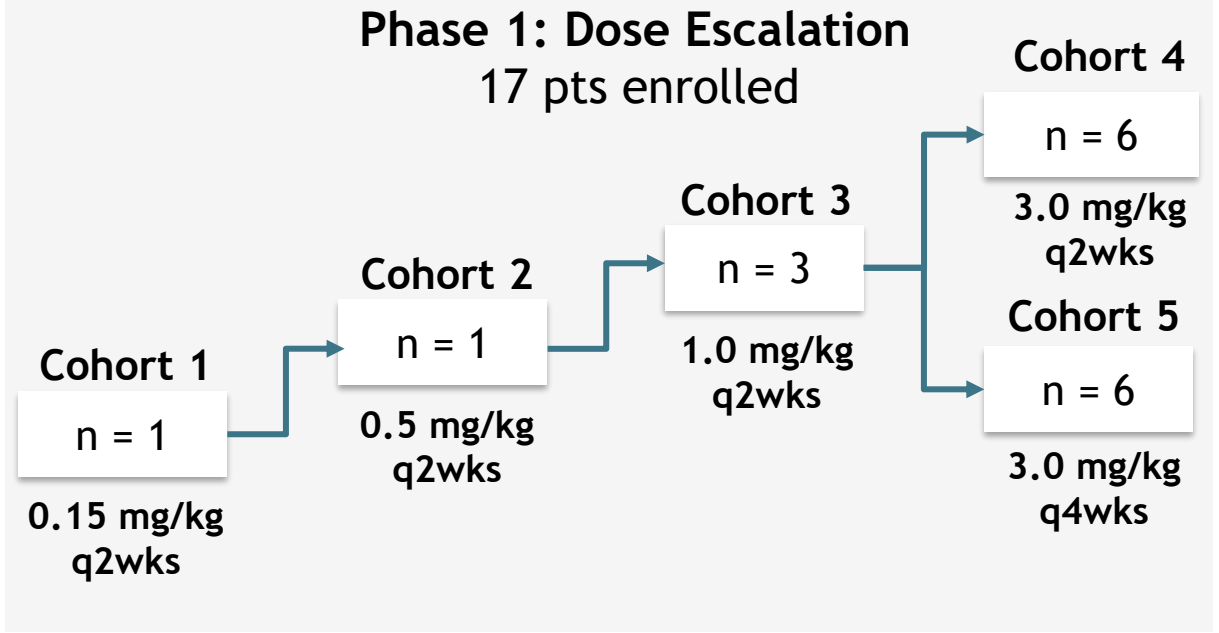
- Develops in 40% of HSCT[1]; estimated US prevalence ~14,000[2]
- Immune-mediated systemic disease with inflammatory and fibrotic features
- Manifests in multiple organs, with skin and lung being most common
- Preclinical models suggest symptoms driven by CSF-1 dependent circulating monocytes and macrophage

1. SMARTAnalyst 2020 cGVHD report; 2. Bachier, CR., ASH 2019 abstract #2109. Figure Adopted from MacDonald, K.P.A. et al., BLOOD, 5 (129) 13-21; HSCT - Hematopoietic stem cell transplantation.

Axatilimab Phase 1/2 trial design in R/R cGVHD

Enrolled cGVHD pts progressed on 2 or more prior therapies

Phase 1: Dose escalation



Phase 2: Expansion

Dose: 1mg/kg q2wk

n= 23 patients

Primary endpoint: ORR (2014 NIH GVHD criteria)

Phase 1/2 trial results published in the Journal of Clinical Oncology on 12/2/22

Kitko, C. L., M. Arora, et. al. (2022, December). "Axatilimab for Chronic Graft-Versus-Host Disease After Failure of at Least Two Prior Systemic Therapies: Results of a Phase I/II Study." J Clin Oncol. 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)
Male, n (%)	11 (65)	14 (61)	25 (63)
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 (59)	16 (70)	26 (63)
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 (51)	21 (53)
Belumosudil, n (%)	6 (35)	2 (9)	8 (20)
cGVHD→C1D1, median (range), yrs	3.5 (0.11, 15.6)	3.0 (0.3, 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; extract is from an active database

Incidence of related AEs demonstrates tolerability

All related Grades in ≥20%

	1mg/kg Q2W n=26	3 mg/kg Q4W n=6	All patients N=40
Related TEAE, n (%)	**17 (65)**	**5 (83)**	**29 (73)**
AST increased	6 (23)	3 (50)	14 (35)
CPK increased	3 (12)	4 (67)	13 (33)
ALT increased	3 (12)	2 (33)	10 (25)
Lipase increased	3 (12)	3 (50)	9 (23)
Amylase increased	4 (15)	--	9 (23)
Fatigue	6 (23)	2 (33)	12 (30)
Periorbital edema	3 (12)	3 (50)	8 (20)

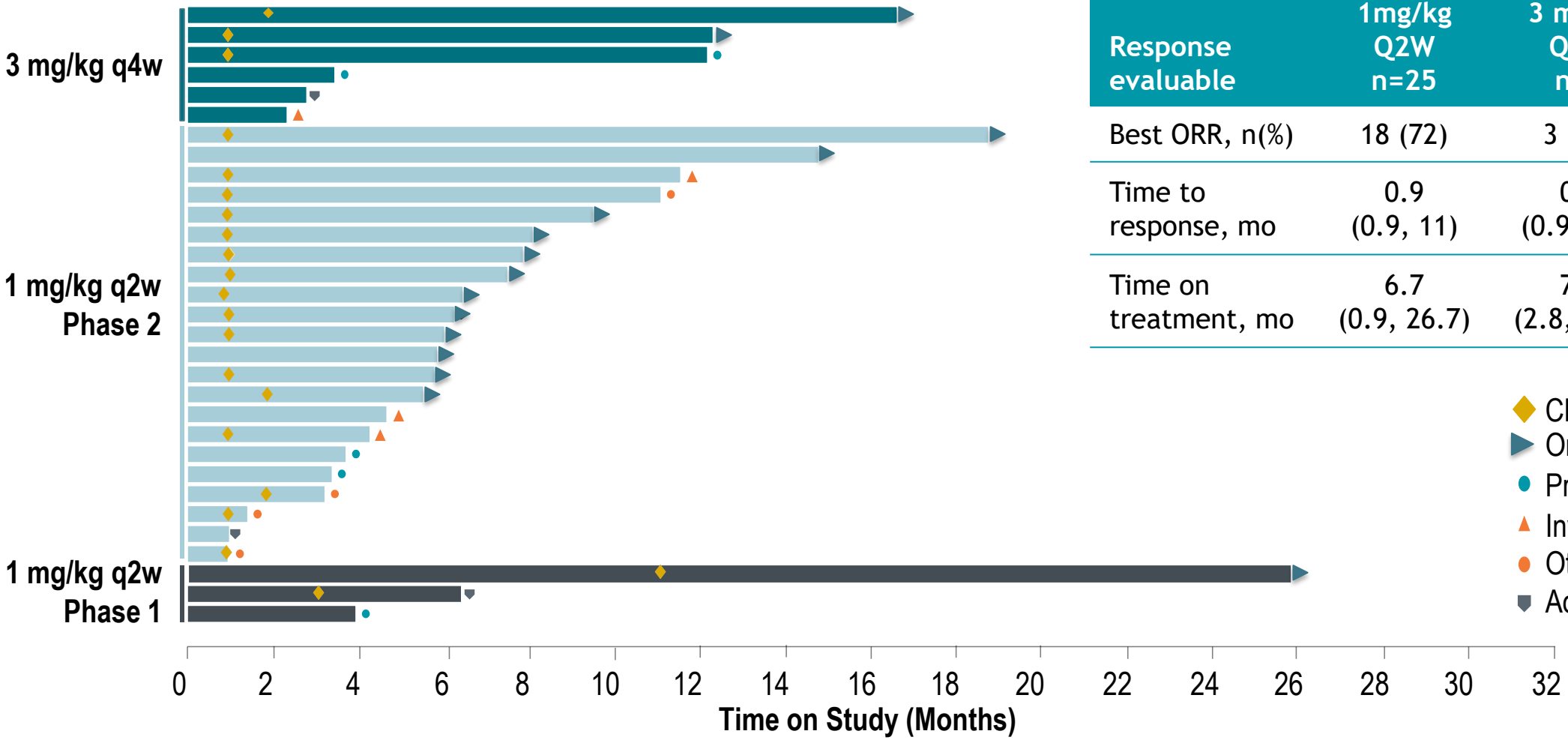
All related Grade 3/4

	1mg/kg Q2W n=26	3 mg/kg Q4W n=6	All patients N=40
Related Gr 3/4 TEAE, n (%)	**2 (9)**	**2 (33)**	**8 (20)**
CPK increased	--	1 (17)	3 (8)
Lipase increased	--	1 (17)	2 (5)
Hypersensitivity	1 (4)	--	1 (3)
Periorbital edema	--	1 (17)	1 (3)
Septic arthritis	1 (4)	--	1 (3)

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

Data cutoff 22Oct2021; extract is from an active database

Axatilimab Phase 1/2 trial showed rapid and durable responses in doses advanced to pivotal trial



Response evaluable	1mg/kg Q2W n=25	3 mg/kg Q4W n=6	Total N=31
Best ORR, n(%)	18 (72)	3 (50)	21 (68)
Time to response, mo	0.9 (0.9, 11)	0.9 (0.9, 1.9)	0.9 (0.9, 11)
Time on treatment, mo	6.7 (0.9, 26.7)	7.7 (2.8, 17.5)	6.7 (0.9, 26.7)

[1] Inclusive of patients treated in Phase 1 (1mg/kg Q2W n=3, 3mg/kg Q4W n=6) and Phase 2 (1mg/kg Q2W n=23) [2]One patient did not have a post-baseline response assessment at time of data cutoff.
Abbreviation: CR=complete response, PR=partial response, Q=every; Data cutoff 22Oct2021; extract is from an active database

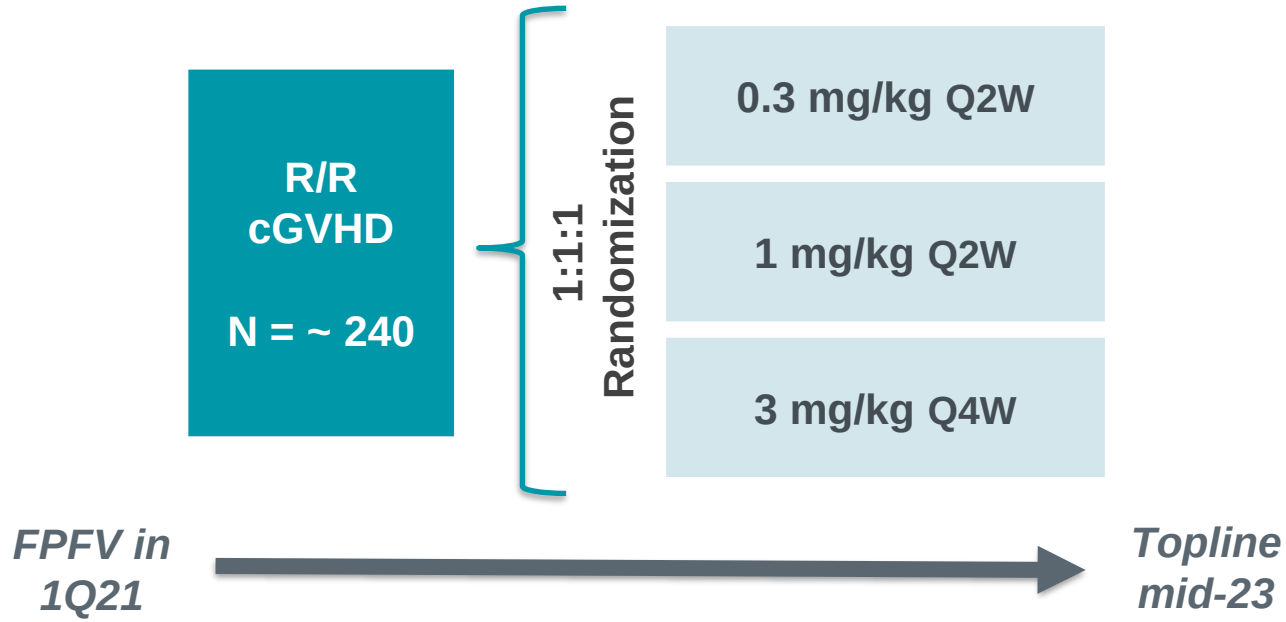
AGAVE-201: Axatilimab pivotal trial enrollment complete; data expected in mid-23

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 front-line combination trial expected in 1Q23

[1] *Age inclusion criteria differs by country*

Primary Endpoint: Objective Response Rate (ORR) by 2014 NIH GVHD Criteria; Key Secondaries: Duration of response, improvement in modified Lee Symptom Scale

Axatilimab Phase 2b Global IPF trial planned to begin in 4Q22; robust trial design includes key elements of a Phase 3 trial

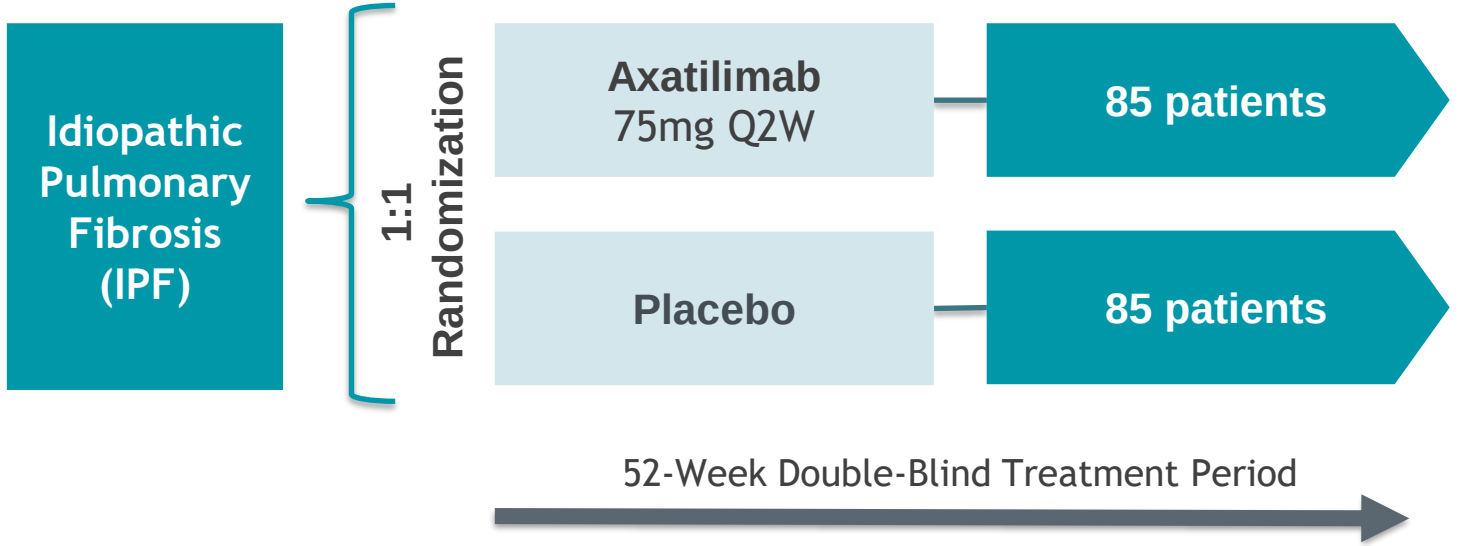
Key inclusion criteria:

- FVC ≥ 45% predicted N
- FEV1/FVC ≥ 0.7
- DLCO ≥30% PN
- Walk ≥ 150m during 6MWT

Stratification factor:

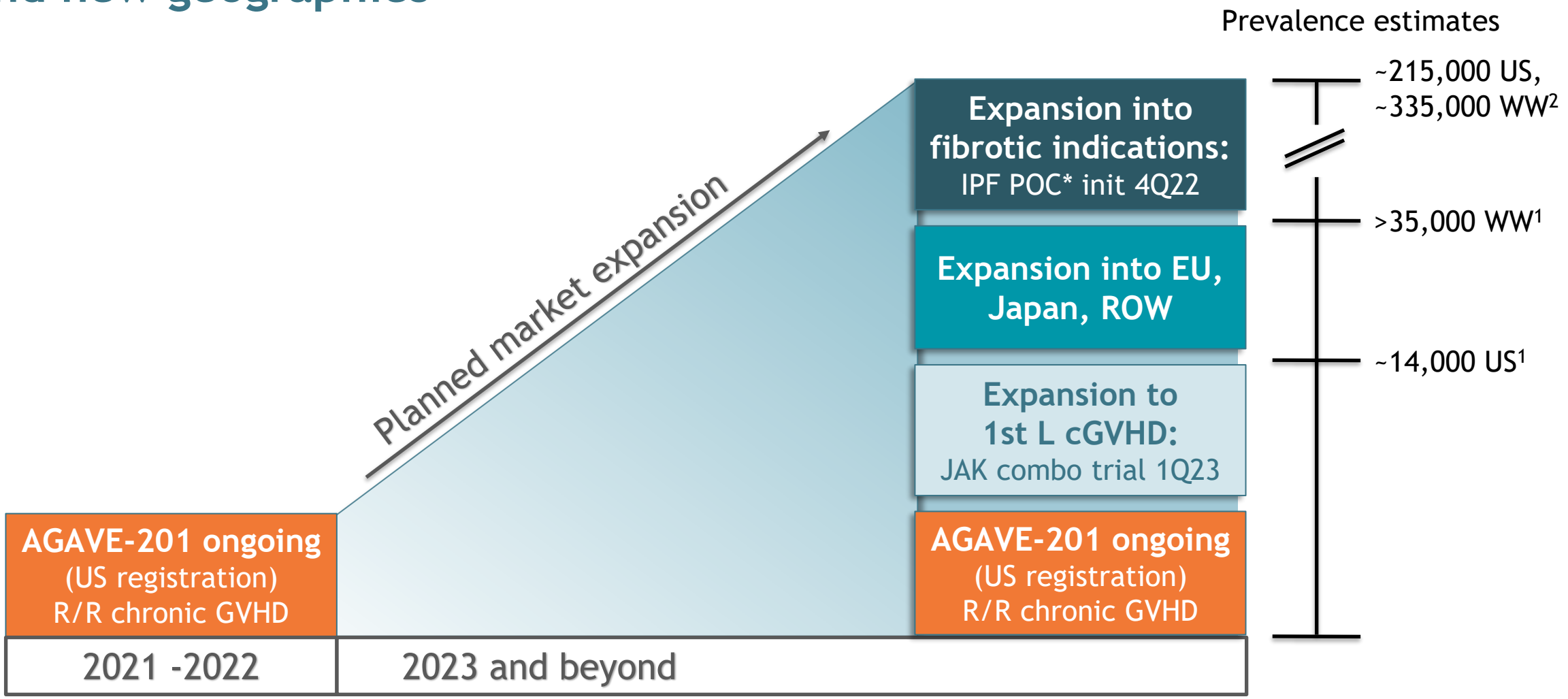
- Background IPF medication (nintedanib, pirfenidone, neither)

Patients continue treatment on standard of care



Primary endpoint: FVC
Secondary endpoints: Disease progression, SGRQ, change in FVC % predicted, 6MWT, DL_{CO}

Axatilimab has the potential to expand into additional 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*

Proven ability to build the pipeline

Business development continues to be a core strength of our business

Clinical development leadership enables competitive advantage

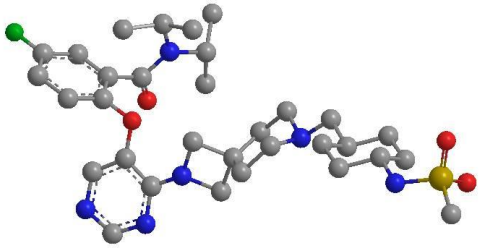
Established relationships enhance identification and access to quality assets

From UCB

Axatilimab

From Allergan/Vitae

Menin-MLL inhibitors



Financial highlights and FY 2022 financial guidance

Ticker	SNDX (NASDAQ)
Cash and cash equivalents (as of September 30, 2022)	$337.8 million
Shares Outstanding* (as of September 30, 2022)	61.3 million
2022 Operating Expense Guidance	
	FY 2022
Research and Development	$115 – 125 million
Total Operating Expenses^	$145 – 155 million

* *Includes 60.1 million common shares and pre-funded warrants to purchase 1.1 million common shares (rounded)*

^ *Includes ~$15 million non-cash stock compensation expense for the full year*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