



Kymera Therapeutics Third Quarter 2026 Results Call | October 29, 2026

Operator:

Good day everyone. My name is Chelle and I will be your conference operator today. At this time, I would like to welcome you to the Kymera Therapeutics Third Quarter 2026 Results Call. All lines have been placed on mute to prevent any background noise. After the speaker's remarks, there will be a question-and-answer session. If you would like to ask a question during this time and if you have joined via the webinar, please use the raise hand icon, which can be found at the bottom of your webinar application. If you have joined by phone, please press star nine on your keypad to raise your hand. At this time, I would like to turn the call over to Justine Koenigsberg, Vice President, Investor Relations.

Justine Koenigsberg:

Good morning and welcome to Kymera's quarterly update call which will also include a discussion of the KT-579 Phase 1 healthy volunteer results.

Joining me this morning with prepared remarks are Nello Mainolfi, our founder, president and CEO, Terence Rooney, our chief medical officer and Bruce Jacobs, our chief financial officer. Following our prepared remarks, we will open the call for questions from our covering analysts. In order to have as much time for as many questions as possible, please limit your questions to one.

If you would like to ask a question, please use the raise hand icon, which can be found at the bottom of your meeting window. A replay of today's call, including a copy of the corresponding presentation, will be available in the investor section of our website soon after the call concludes.

As a reminder, today's presentation will include forward-looking statements about our future expectations, plans, and prospects. These statements are subject to risks and uncertainties that may cause actual results to differ materially from those projected. A description of these risks can be found in our most recent 10-Q filed with the SEC. Any forward-looking statements speak only as of today's date, and we assume no obligation to update any forward-looking statements made on today's call.

Before we begin, we have one housekeeping item. Starting next week, we will enter our previously planned quiet period ahead of our upcoming STAT6 data. As a result, we don't expect to provide additional commentary on our STAT6 program until we report those results. With that, I'll now turn the discussion over to Nello.

Nello Mainolfi:

Thank you, Justine, and good morning, everyone. Thank you for joining us today. This is a very exciting time for Kymera.

We're seeing our scientific vision take shape across our pipeline of oral medicines to address serious inflammatory diseases with KT-621, our STAT6 degrader for atopic dermatitis, asthma and more, and KT-579, our IRF5 degrader for lupus and potentially other autoimmune diseases. Together, they reflect our goal of developing medicines grounded in strong biology, with the potential to reach many more patients than served by available treatments today.

I'll start today with an update on KT-621 as we approach its Phase 2b AD readout before year-end. I'll then briefly cover the rest of our pipeline before we turn to KT-579 Phase 1 results.

Our STAT6 program continues to advance according to plans across both AD and asthma.

As shown here, we've advanced KT-621 through a series of studies, building on what we learned at each stage to guide the next steps. In Phase 1, we evaluated KT-621 in more than 200 healthy volunteers and observing deep STAT6 degradation, effects on downstream biomarkers and a favorable safety and tolerability profile. We then treated 22 patients with AD in Phase 1b, where we saw the first evidence of strong clinical activity in patients. With each study, we've built a stronger body of evidence and further de-risked KT-621, supporting its advancement into the ongoing Phase 2b studies.

In the BROADEN2 AD study, we are excited to report that we have completed the 16-week placebo-controlled portion of the study with the last patient just recently completing their final visit. We expect that the remaining activities to close out this portion of the study will enable us, as planned, to share the KT-621 Phase 2b data by year-end. At the same time, we are well into our preparations for the first Phase 3 study in AD, which we plan to initiate, assuming both supportive data and alignment with FDA, by the middle of 2027.

Before we move to an update on asthma, as we have shared previously, patients that complete the full 16 weeks of treatment in BROADEN2 are eligible to enter a 52-week OLE. Today, we are happy to report that 98% of eligible patients have enrolled into the OLE.

Now, turning to asthma, enrollment in the BREADTH study continues to progress as planned, with topline results expected in late 2027.

In total, these studies have already enrolled hundreds of participants, providing a robust dataset to assess safety and efficacy of this exciting novel mechanism. And, as a reminder, the BREADTH study also includes an open label extension, which together with the AD OLE, are designed to further support our long-term safety database for regulatory requirements and the potential registration of KT-621.

As we approach the BROADEN2 readout, I wanted to take a moment to put the opportunity for KT-621 in AD into perspective.

As illustrated on slide 7, published epidemiological reports show that there are approximately 6 to 9 million people in the US, 12 years and up, with moderate-to-severe atopic dermatitis. Despite this high prevalence, only an estimated 400,000 receive advanced systemic therapies, a penetration of only about 5% of the total moderate-to-severe patient population.

As we have been advancing KT-621, we have also been conducting market research to better understand the market dynamics of advanced systemic therapies. What we hear from both patients and prescribers is that the main reason for the limited adoption is that many patients don't perceive that their disease state justifies an injectable biologic or a medicine carrying a boxed warning. That perception creates a significant barrier to the use of currently available advanced therapies.

Our market research tells us that patients and physicians want a safe, effective oral treatment. In fact, when we ask what level of efficacy that treatment needs to deliver, we consistently hear that it does not necessarily have to match biologics. And we have seen that opportunity play out in other markets. Otezla launched more than a decade ago with roughly half the efficacy of biologics and went on to become a multi-billion-dollar franchise. More recently, Icotyde, despite efficacy that, by cross-trial comparisons, does not quite match IL-23 biologics, is experiencing one of the strongest launches in psoriasis, bringing new patients to treatment in an already more saturated market.

Going back to KT-621, a safe effective oral is what patients are looking for, and that is the profile we aim to deliver. Our focus is to serve the largest segment of the moderate to severe AD population: those patients who are either untreated or in many cases poorly treated with non-systemic therapies. If we're successful, we believe that KT-621 would have the potential to dramatically expand the number of patients accessing advanced therapies.

All that said and based on the preclinical and Phase 1 data we've generated so far, our scientific expectation remains that BROADEN2 efficacy should land in the ballpark of what dupilumab achieved at Week 16, as compared to what was reported in the in the SOLO 1, SOLO 2 trials, while recognizing the limitations of comparing results across studies.

Beyond KT-621, we are also tracking with expectations and timelines across our broader pipeline. Our partnered programs are both progressing as planned. Sanofi continues to advance KT-485, our second-generation IRAK4 degrader, in a Phase 1 healthy volunteer study that is also expected to enroll HS patients. And Gilead is advancing KT-200, our CDK2 molecular glue, into IND-enabling activities, with an IND planned for 2027.

With respect to our research pipeline, our undisclosed programs are tracking with our expectations and to support our goal to advance one program toward development candidate annually. Regarding the disclosure of our next program, given all we have to share in the fourth quarter with today's KT-579 data and the upcoming KT-621 Phase 2b readout, we've decided to hold off on that introduction until next year.

With all that said, before I turn the call over to Terence to share the IRF5 healthy volunteer data, I wanted to talk a little bit about the importance of today's IRF5 data release.

We have now successfully advanced multiple degrader programs from target selection and drug discovery through preclinical and into the clinic. This is in fact our 7th first-in-class degrader to enter the clinic and today we are sharing that we continue to demonstrate impeccable human translation. While each target and molecule is unique and must ultimately prove itself independently, this repeated

execution is indicative of the positive and compounding effects of all of our learnings and experience across our programs.

IRF5 itself is a highly compelling and genetically validated target that has historically been difficult to drug with conventional drug discovery approaches, and this study is an important first step in establishing our IRF5 thesis in humans. As you'll hear shortly, KT-579, which was well tolerated in this study, robustly degraded IRF5. Importantly, the potent IRF5 degradation led to meaningful reductions in multiple disease relevant biomarkers.

With this data in hand, we now plan to move the program, with confidence, into a Phase 1b lupus trial. The study is designed to establish whether KT-579 can demonstrate the biological and clinical activity we would expect based on this mechanism.

Overall, the KT-579 data represent another important example of our ability to target a highly compelling but historically undruggable target, in this case a transcription factor. It also demonstrates our ability to translate our preclinical work into humans in a predictable and compelling way. We've now done this across multiple programs, and with each success, we're building on a strong and increasingly repeatable foundation for selecting the right targets, developing differentiated degraders against them, and efficiently translating those programs from discovery into the clinic.

I know everyone is eager to get into the data, so with that, I'll turn it over to Terence to walk you through the results. Terence?

Terence Rooney:

Thanks, Nello. It's a pleasure to join you all today to review the positive Phase 1 results for KT-579.

As a rheumatologist by training, I'm particularly excited by what we've demonstrated with this program.

The translation from the strong preclinical profile into humans is an important milestone and validates our confidence both in the biology and the potential of IRF5 degradation as we prepare to move KT-579 into patients.

I'll start with an overview of the Phase 1 study design and the demographics of the healthy volunteers enrolled in the study. I'll then walk through the PD data, beginning with the depth and durability of IRF5 degradation in blood. Next, I will cover the functional consequences of that degradation across three distinct IRF5-dependent immune pathways assessed using disease-relevant *ex vivo* stimulation assays. And finally, I'll review the safety profile observed and then discuss how the totality of these data inform our plans to advance KT-579 into lupus patients. As we have been saying for some time, primarily for competitive reasons, in some areas of the presentation we're sharing only limited data.

As shown on Slide 12, the Phase 1 study was designed to characterize the safety, PK and PD of KT-579 following both single and multiple ascending doses in healthy volunteers. We evaluated a range of doses up to 600 mg in the MAD cohorts. In the SAD portion of the study, 8 subjects per cohort were randomized 6:2 to receive a single oral dose of KT-579 or placebo. In the MAD portion, 12 subjects per cohort were randomized 9:3 to receive once-daily oral KT-579 or placebo for 14 days.

While the primary objective of the study was to evaluate the safety and tolerability of KT-579, the study was also designed to establish proof of mechanism in humans. In both SAD and MAD, we evaluated IRF5 degradation across dose levels, and in the MAD portion, we also assessed the downstream functional consequences of IRF5 degradation using disease-relevant *ex vivo* stimulation assays measuring inflammatory biomarkers.

Together, these endpoints allow us to address the key questions we set out to answer in this study. First, can we safely achieve deep and sustained degradation of IRF5 with KT-579? Second, does that degradation translate into the expected functional impact on IRF5-dependent biology? And as you'll hear today, the answer to both questions is yes.

Turning to Slide 13, the demographics of the volunteers enrolled in the SAD and MAD portions of the study. Overall, there were no meaningful imbalances in baseline characteristics that would impact our interpretation of the study results.

Now, before turning to the MAD degradation data, although not shown in this presentation, we did want to mention that KT-579 exhibited the predicted PK profile with dose responsive exposures in SAD and MAD cohorts. Additionally, while we generated degradation data across both the SAD and MAD portions of the study, we are only sharing the MAD degradation data here, as repeated daily dosing most closely reflects the intended clinical use of KT-579.

Now looking at Slide 14, which illustrates degradation across MAD dose cohorts, with data shown at Day 7 and 14. The top five dose cohorts all reached median IRF5 degradation greater than 90%, with saturation of degradation by dose level 3 with blood degradation achieving 94%.

Importantly, while not shown, we also observed comparable reductions in IRF5 levels in skin, demonstrating target degradation in tissue as well as blood.

Overall, KT-579 demonstrated robust degradation of IRF5 at or above levels predicted by our preclinical work in both the SAD and MAD. This profile shows that the target remains continuously suppressed with once-daily dosing, providing sustained pharmacologic coverage of IRF5 expression.

Now, in addition to degradation, we also assessed the impact of IRF5 degradation on downstream biomarkers which we believe is an important indicator of the potential biological effects.

As a reminder, IRF5 has a role in the regulation of three major immune pathways relevant to several autoimmune diseases. These include:

First, inflammatory cytokines. IRF5 promotes the production of key inflammatory cytokines by myeloid cells, including monocytes and macrophages. And when dysregulated, these responses can sustain chronic inflammation.

Second, interferon response. IRF5 helps connect nucleic-acid sensing with interferon production and associated gene-expression responses. Dysregulation of this pathway can amplify immune activation and inflammation.

And the third pathway is B-cell biology. IRF5 contributes to B-cell activation and pathways associated with plasmablast differentiation and autoantibody production.

So, this breadth of biology is an important feature of the IRF5 mechanism. By degrading IRF5, KT-579 has the potential to modulate multiple interconnected drivers of inflammation through a single oral approach.

Now, to assess this biology in healthy volunteers, we used three orthogonal *ex vivo* stimulation assays that our team developed internally. These assays activate distinct RNA- and DNA-sensing toll-like receptor pathways and measure downstream changes in inflammatory mediators and gene expression. This allowed us to assess whether IRF5 degradation translated into functional effects across all three key areas.

In the following slides, we'll focus on the impact IRF5 degradation demonstrated in each pathway. In each graph, we'll show the median of all KT-579 MAD dose cohorts combined, compared to placebo.

Shown on Slide 16, IRF5 degradation translated into deep and sustained inhibition of core inflammatory cytokines, including TNF α , IL-12/23p40 and IL-1 β . As shown here, median cytokine reduction across all MAD dose cohorts combined, ranged from 87% to as high as 94%. The kinetics of cytokine inhibition track with the kinetics of IRF5 degradation, and the magnitude of the effect is consistent or superior to what was observed preclinically. These reductions are particularly encouraging as this is a core pathway involved in lupus, through TLR7/8, and IBD, through TNF α & IL-12/23, two of our highest priority indications.

We interrogated the same inflammatory cytokine pathway more broadly with transcriptomics. The transcriptomics provide a complementary confirmation of the cytokine data, showing modulation of IRF5-dependent inflammatory biology. Though anonymized, the heatmap shows the changes in selected pathway genes with placebo and across all KT-579 dose cohorts at Day 14, in relation to their respective pre-dose sample, while the graph quantifies the overall modulation of a gene set. We observed strong gene-to-protein concordance, with genes like TNF α and IL12 β moving in the same direction as the corresponding functional cytokine readouts, as described in the previous slide.

The second major axis we tested was interferon response, another important component of IRF5-dependent inflammation and a particularly relevant pathway in heterogeneous diseases. The effect on this pathway cytokine is particularly pronounced. We demonstrated near complete reductions in TLR 7 & 8-stimulated IFN β levels, with the MAD dose cohorts showing a median inhibition of 98%. Importantly, the transcriptional data independently support and extend this result showing modulation results in broad coverage across key IFN pathway genes. These data validate the pharmacology beyond the inflammatory cytokine pathway we showed in the prior slides, demonstrating that IRF5 degradation can translate into profound functional modulation of the interferon axis, which is well-recognized as overactive in the biology of several autoimmune disorders including lupus and Sjögren's disease.

Finally, as shown on Slide 19, the effects of KT-579 reach into the third major axis of IRF5, B-cell biology. Selected TLR9-driven transcripts are significantly modulated with KT-579, including key genes associated

with DNA sensing and B-cell activation – again, important steps in the pathogenesis of autoimmune diseases including lupus.

In summary then, KT-579-driven IRF5 degradation translates into coherent functional modulation across three major pathways we set out to interrogate: inflammatory cytokines, interferon response, and B-cell biology. That breadth of pharmacology is one of the key takeaways from this first-in-human dataset.

Okay. Moving to safety, KT-579 was well-tolerated and had a safety profile comparable to placebo. As shown on Slide 20, there were no SAEs, very few mild treatment related adverse events, no adverse events leading to discontinuation of study drug or from the study, and no clinically relevant changes in vital signs, lab tests or ECGs. There were also no imbalances in the rates of infections.

It is very encouraging that KT-579 was able to robustly degrade IRF5 in blood, and also functionally modulate disease-relevant biomarkers across three key immune pathways, while demonstrating a placebo-like safety profile.

The Phase 1 data represent an important milestone for KT-579, for our IRF5 program, and for Kymera. These results establish important human proof of mechanism for KT-579. We've demonstrated that we can achieve deep and sustained degradation of IRF5 with an oral medicine, with a favorable safety and tolerability profile. Importantly, we've also seen that IRF5 degradation translates into strong and encouraging downstream effects on disease-relevant inflammatory biology.

Taken together, this gives us increased confidence that we are achieving the profile we designed KT-579 to deliver and provide a strong foundation to move into patients.

As the program following our STAT6 efforts, IRF5 is yet another example of Kymera's ability to develop potentially transformational medicines for patients.

So, on that note, we now plan to advance KT-579 into its first patient study in lupus.

Lupus remains an area of significant unmet need where many patients continue to cycle through therapies without achieving adequate or durable disease control, and treatment often requires combinations of immunosuppressive agents with meaningful safety and tolerability limitations. We see significant opportunity for a new safe and effective oral therapy.

Lupus is a compelling indication for this program given there is strong genetic evidence linking IRF5 to lupus, and IRF5 plays a central role in lupus disease biology. We've previously shown disease-modifying activity in multiple preclinical lupus models. And as you've seen today, we have now demonstrated exciting biomarker data suggesting a strong connection between IRF5 degradation and three important disease relevant pathways. So, this gives us a high degree of confidence in the underlying biology and a clear rationale for evaluating the impact of IRF5 degradation directly in patients.

The planned Phase 1b study will allow us to begin answering the next important questions, whether IRF5 degradation and downstream biology we observed in healthy volunteers carry through to patients with lupus, and whether KT-579 can affect the disease pathways that are active in those patients.

In healthy volunteers, we measured pathway effects after stimulating blood samples *ex vivo*. While in patients, we'll be able to assess those effects in the setting of active disease, as well as look for early signs of clinical benefit.

We view this as an important next step for the program and toward establishing IRF5 degradation as a potentially new therapeutic approach for patients with autoimmune disease.

Here's a snapshot of the Phase 1b study design for the trial, which we have named LUMORA. We plan to enroll approximately 30 patients with SLE, randomized 2:1 to KT-579 or placebo, and treated for 16 weeks. Oral corticosteroid background therapy is permitted. In fact, our upcoming oral presentation at the American College of Rheumatology conference demonstrates that KT-579 shows significant activity alone or in the presence of background therapies in preclinical lupus models. The Phase 1b will evaluate the impact on inflammatory cytokines, interferon signatures, B-cell subsets, and other key immune pathways implicated in lupus. And we'll also explore measures of lupus disease activity, including changes in the mucocutaneous and musculoskeletal symptoms patients experience. In this small Phase 1b study, those measures will help us look for early signs of clinical activity alongside the safety and biomarker results.

So, with that, I'll turn the call over to Bruce.

Bruce Jacobs:

Thanks, Terence.

Turning to our third quarter results, I'll quickly walk through the income statement shown here.

As expected, we did not recognize any collaboration revenue in the third quarter. And as a reminder, we do not expect additional collaboration revenue for the remainder of 2026, as the milestones and our previous deferred revenue under our collaborations with Sanofi and Gilead were fully recognized as of the second quarter.

In terms of operating expenses, reported R&D expenses for the quarter were \$128.5 million. Excluding approximately \$10.9 million in non-cash stock-based compensation, R&D expense was \$117.6 million, an increase of 8% compared to the second quarter of 2026.

Reported G&A expenses for the quarter were \$18.7 million. Excluding approximately \$7.9 million in stock-based compensation, adjusted cash G&A expense was \$10.8 million, a decrease of 14% compared to the second quarter of 2026.

We ended September with cash, cash equivalents, and investments of approximately \$1.6 billion, providing a runway into 2029 and positioning us to continue execute on a number of important value-driving milestones over the coming years.

Our financial position gives us the resources to advance both our wholly owned programs into and through their next phases of development. Specifically, it allows us to complete the KT-621 Phase 2b study in asthma and take KT-579 through our planned Phase 1b study lupus. We also expect to fund the

KT-621 Phase 3 studies in AD and the initial stages of Phase 3 development in asthma within our current runway.

Alongside these clinical priorities, we'll continue to invest in our research pipeline and build the capabilities needed as we move toward later-stage development and commercialization. We believe this puts us in a strong position to execute our plans while remaining disciplined in how we deploy capital.

I'll pause here so Nello can provide a few closing comments before we open the call to questions.

Nello Mainolfi:

Thanks, Bruce.

To wrap up, we have important milestones ahead for KT-621, building on the compelling profile observed in Phase 1 healthy volunteers and patients with AD. In dermatology, we expect Phase 2b AD data by year-end. Subject to those results and regulatory discussions, we plan to begin Phase 3 development by mid-2027, and that planning is already well underway. In respiratory, our Phase 2b asthma study is ongoing, with data expected in late 2027.

And for KT-579, today's results are an important step for the program. In healthy volunteers, we saw evidence that degrading IRF5 can modulate multiple disease-driving pathways. Along with the safety and tolerability profile observed in this study, these findings support our plans to advance KT-579 into patients with lupus by early next year. We also plan to expand beyond lupus, and we'll be sharing more on our broader development strategy next year.

These programs are emblematic of our strategy to build a world-class pipeline of wholly owned immunology programs that are directed at fundamental disease pathways with the potential to help large patient populations. In closing, I want to thank the study participants, investigators and our team for making all this progress possible. With that, we'll open the call for questions.

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