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On a Journey to Erase Cancer

Erasca R&D Update Presentation

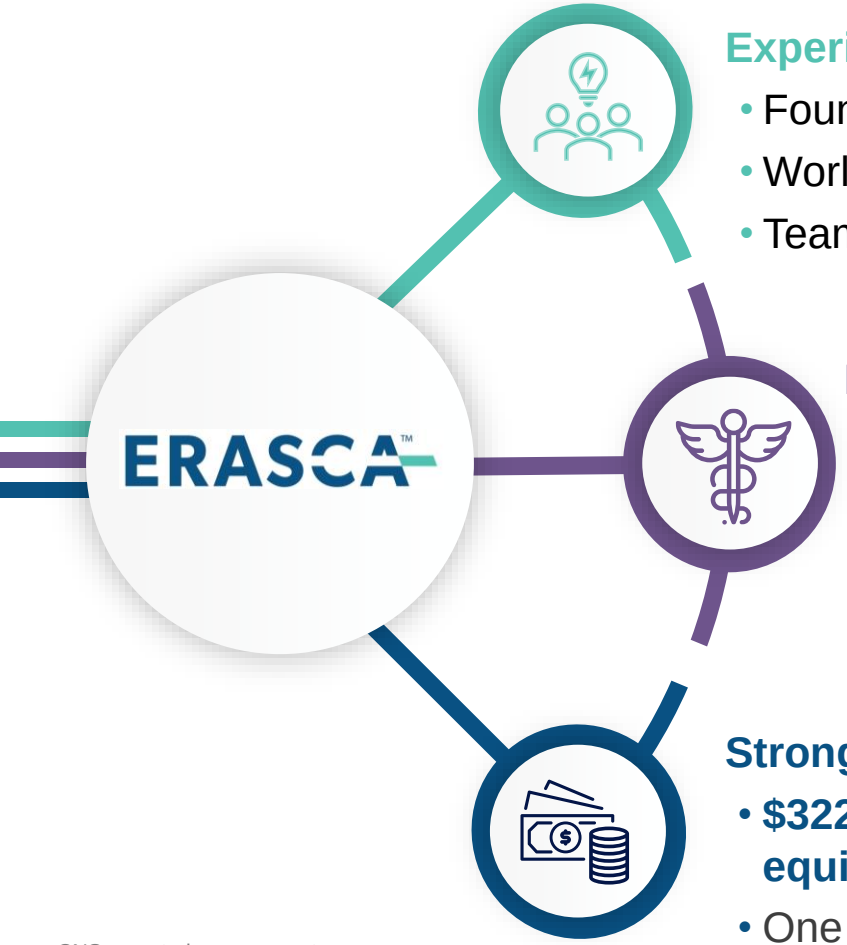
March 2024

Disclaimer: Forward Looking Statements & Market Data

We caution you that this presentation contains forward-looking statements. All statements other than statements of historical facts contained in this presentation, including statements regarding our future results of operations and financial position, business strategy, research and development plans, the anticipated timing (including the timing of initiation and the timing of data readouts), costs, design and conduct of our ongoing and planned preclinical studies and clinical trials for our product candidates, the potential benefits from our current or future arrangements with third parties, the timing and likelihood of success of our plans and objectives, the impact of the deprioritization of certain programs, and future results of anticipated product development efforts, are forward-looking statements. In some cases, you can identify forward-looking statements by terms such as "may," "will," "should," "expect," "plan," "anticipate," "could," "intend," "target," "project," "contemplates," "believes," "estimates," "predicts," "potential" or "continue" or the negative of these terms or other similar expressions. The inclusion of forward-looking statements should not be regarded as a representation by us that any of our plans will be achieved. Actual results may differ from those set forth in this presentation due to the risks and uncertainties inherent in our business, including, without limitation: our approach to the discovery and development of product candidates based on our singular focus on shutting down the RAS/MAPK pathway, a novel and unproven approach; we only have three product candidates in clinical development and all of our other development efforts are in the preclinical or development stage; the analysis of pooled phase 1 and phase 2 naporafenib + trametinib data covers two clinical trials with different designs and inclusion criteria, which cannot be directly compared, and therefore may not be a reliable indicator of efficacy data; due to differences between trial designs and subject characteristics, comparing data across different trials may not be a reliable indicator of data; preliminary results of clinical trials are not necessarily indicative of final results and one or more of the clinical outcomes may materially change as patient enrollment continues, following more comprehensive reviews of the data and more patient data become available, including the risk that an uPR to treatment may not ultimately result in a cPR to treatment after follow-up evaluations; we have not completed any clinical trials of naporafenib and are reliant on data generated by Novartis in prior clinical trials conducted by it; our planned SEACRAFT trials may not support the registration of naporafenib; our assumptions around which programs may have a higher probability of success may not be accurate, and we may expend our limited resources to pursue a particular product candidate and/or indication and fail to capitalize on product candidates or indications with greater development or commercial potential; potential delays in the commencement, enrollment, and completion of clinical trials and preclinical studies; our dependence on third parties in connection with manufacturing, research, and preclinical and clinical testing; unexpected adverse side effects or inadequate efficacy of our product candidates that may limit their development, regulatory approval, and/or commercialization, or may result in recalls or product liability claims; unfavorable results from preclinical studies or clinical trials; results from preclinical studies or early clinical trials not necessarily being predictive of future results; the inability to realize any benefits from our current licenses, acquisitions, or collaborations, and any future licenses, acquisitions, or collaborations, and our ability to fulfill our obligations under such arrangements; our assumptions around which programs may have a higher probability of success may not be accurate, and we may expend our limited resources to pursue a particular product candidate and/or indication and fail to capitalize on product candidates or indications with greater development or commercial potential; regulatory developments in the United States and foreign countries; later developments with the FDA or European health authorities may be inconsistent with the feedback received to date regarding our development plans and trial designs; fast track designation or orphan drug designation may not lead to a faster development or regulatory review or approval process, and does not increase the likelihood that our product candidates will receive marketing approval; our ability to fund our operating plans with our current cash, cash equivalents, and marketable securities into the second half of 2026; and other risks described in our prior filings with the Securities and Exchange Commission (SEC), including under the heading "Risk Factors" in our annual report on Form 10-K for the year ended December 31, 2023, and any subsequent filings with the SEC. You are cautioned not to place undue reliance on these forward-looking statements, which speak only as of the date hereof, and we undertake no obligation to update such statements to reflect events that occur or circumstances that exist after the date hereof. All forward-looking statements are qualified in their entirety by this cautionary statement, which is made under the safe harbor provisions of the Private Securities Litigation Reform Act of 1995. This presentation also contains estimates and other statistical data made by independent parties and by us relating to market size and growth and other data about our industry. This data involves a number of assumptions, and you are cautioned not to give undue weight to such estimates. In addition, projections, assumptions, and estimates of our future performance and the future performance of the markets in which we operate are necessarily subject to a high degree of uncertainty and risk. These and other factors could cause results to differ materially from those expressed in the estimates made by the independent parties and by us.

Our name is our mission: to erase cancer

Vision to one day erase cancer[1] in at least 100,000 patients annually as a leading global oncology company



Experienced leadership team and SAB with track record of serial successes

- Founded by **Jonathan Lim, MD & Kevan Shokat, PhD** around disruptive idea to target RAS
- World class scientific advisory board of **leading pioneers** in RAS/MAPK pathway
- Team with deep experience in efficient planning and execution of **global clinical trials**

Industry leading portfolio focused on shutting down the RAS/MAPK pathway

- **Naporafenib pan-RAFi** with first-in-class (FIC) potential and Fast Track Designation for NRASm melanoma & FIC potential in RAS Q61X solid tumors
- **ERAS-007 ERKi** with best-in-class potential for BRAFm CRC
- **ERAS-801, CNS-penetrant EGFRi** with FIC potential for EGFR-driven rGBM

Strong financial position with high quality investor base and industry visibility

- **$322M in cash, cash equivalents, and marketable securities[2]**, plus **$45M oversubscribed equity financing** announced on 3/27/2024; anticipated cash runway into **H2 2026**
- One of **Fierce Biotech's 2021 "Fierce 15"** most promising biotechnology companies

CNS = central nervous system

[1] Number of patients alive and free of cancer or free from cancer progression 2 yrs after starting an Erasca regimen, as measured by disease-free survival (adjuvant setting) and progression-free survival (metastatic setting)

[2] Audited, as of December 31, 2023

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Deep modality-agnostic RAS/MAPK pathway-focused pipeline

Focus of R&D update

Program/ Company	Target	Modality	Indication	Discovery	IND-enabling	Phase 1	Phase 2	Phase 3	Worldwide Rights
Naporafenib	BRAF/CRAF	small molecule	Pan-RAS Q61X tissue agnostic	SEACRAFT-1					ERASCA
			NRASm melanoma	SEACRAFT-2 (planned)					ERASCA
ERAS-007	ERK1/2	small molecule	BRAF V600E CRC	HERKULES-3					ERASCA
ERAS-801	EGFR	small molecule	EGFR-altered GBM	THUNDERBBOLT-1					ERASCA
ERAS-4	Pan-KRAS	small molecule	KRASm solid tumors						ERASCA
ERAS-12	EGFR D2/D3	large molecule	EGFR & RAS/MAPK altered tumors						ERASCA
Affini-T	KRAS G12V/D	TCR T cell therapy	KRASm solid tumors						affini

small molecule large molecule TCR T cell therapy ERASCA Ventures investment

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Research & Development Update

Naporafenib Program Overview	Naporafenib: Preclinical profile SEACRAFT-2: Naporafenib + trametinib in NRASm melanoma
Overall Survival in NRASm Melanoma	Unmet need and importance of overall survival Naporafenib + trametinib OS data vs. benchmarks
Pan-KRAS Program	Pan-KRAS inhibitor opportunity and ERAS-4 update

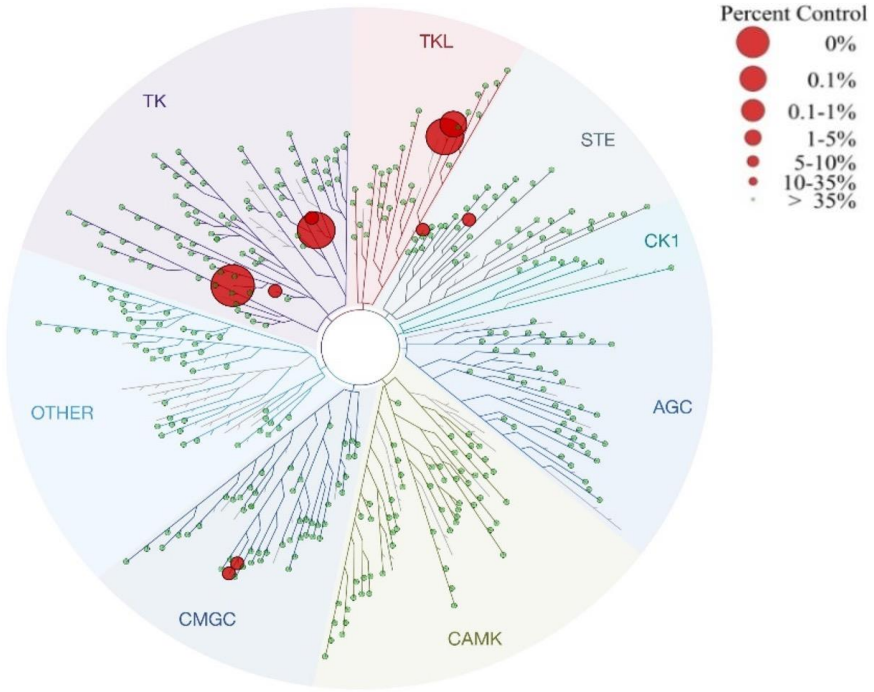
Q&A Session

Naporafenib is a potent and selective inhibitor of BRAF and CRAF with sub-nanomolar IC50 potency and most advanced pan-RAFi in development

Biochemical activity of naporafenib against RAF kinase family

Assay	Value (nM)
Biochemical CRAF IC50 (IC_{50})	0.1
Biochemical BRAF IC50 (IC_{50})	0.2
Biochemical ARAF Inhibition (IC_{50})	6.4

Biochemical activity of naporafenib across 456 kinases (KINOMEscan)



Source: Monaco K-A, Delach S, et al. LXH254, a Potent and Selective ARAF-Sparing Inhibitor of BRAF and CRAF for the Treatment of MAPK-Driven Tumors. 2021. PMID: 33355204; Ramurthy S, Taft BR, et al. Design and Discovery of N-(3-(2-(2-Hydroxyethoxy)-6-Morpholinopyridin-4-Yl)-4-Methylphenyl)-2-(trifluoromethyl)isonicotinamide, a Selective, Efficacious, and Well-Tolerated RAF Inhibitor Targeting RAS Mutant Cancers: The Path to the Clinic. 2020. PMID: 31059256

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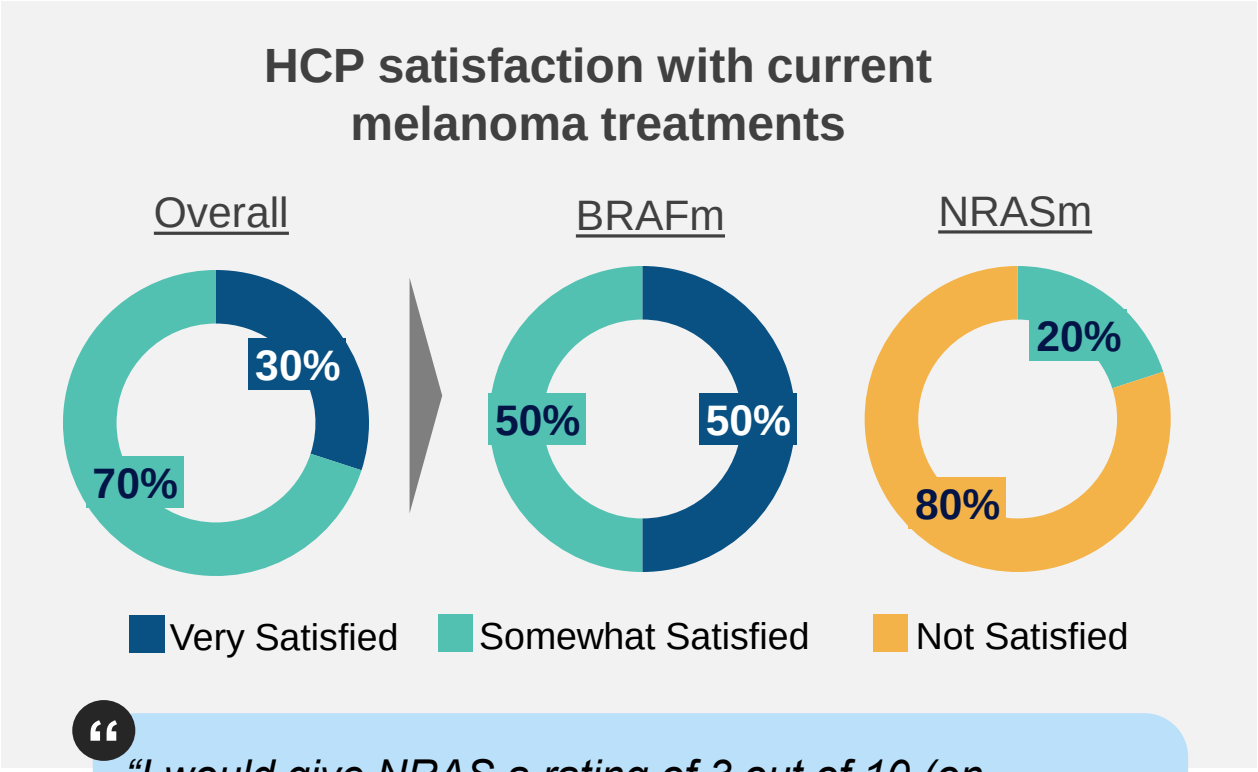
High unmet need in NRASm melanoma with limited options in 2L+ setting



> *"I would give NRAS a rating of 3 out of 10 (on satisfaction) since **after 1L, you are completely stuck."***
>
> *- Medical Oncologist, Community Hospital*

- NRAS is mutated in **~25% of patients with melanoma**
- NRAS mutation is related to **aggressive disease traits**
- **No targeted therapy** approved for NRASm melanoma

HCP: health care provider
Source: Erasca physician interviews

Compelling, reproducible clinical efficacy across studies and doses

	MEKi		SOC	Pooled Ph 1 and Ph 2[4]	
	Binimetinib[1]	Trametinib[2]	Chemo[3]	Naporafenib + Trametinib	
	45mg	2mg	1g/m² IV	200mg+1mg	400mg+0.5mg
	N=269	N=33	N=133	N=39	N=32
ORR n (%)	41 (15%)	5 (15%)	9 (7%)	12 (31%)	7 (22%)
DCR n (%)	157 (58%)	N/A	33 (25%)	28 (72%)	21 (66%)
mDOR months	6.9	*~6.9**	NE	7.4	10.2
mPFS months	2.8	*~2.8**	1.5	**5.1**	**4.9**

*Assumes trametinib efficacy is similar to published binimetinib efficacy results

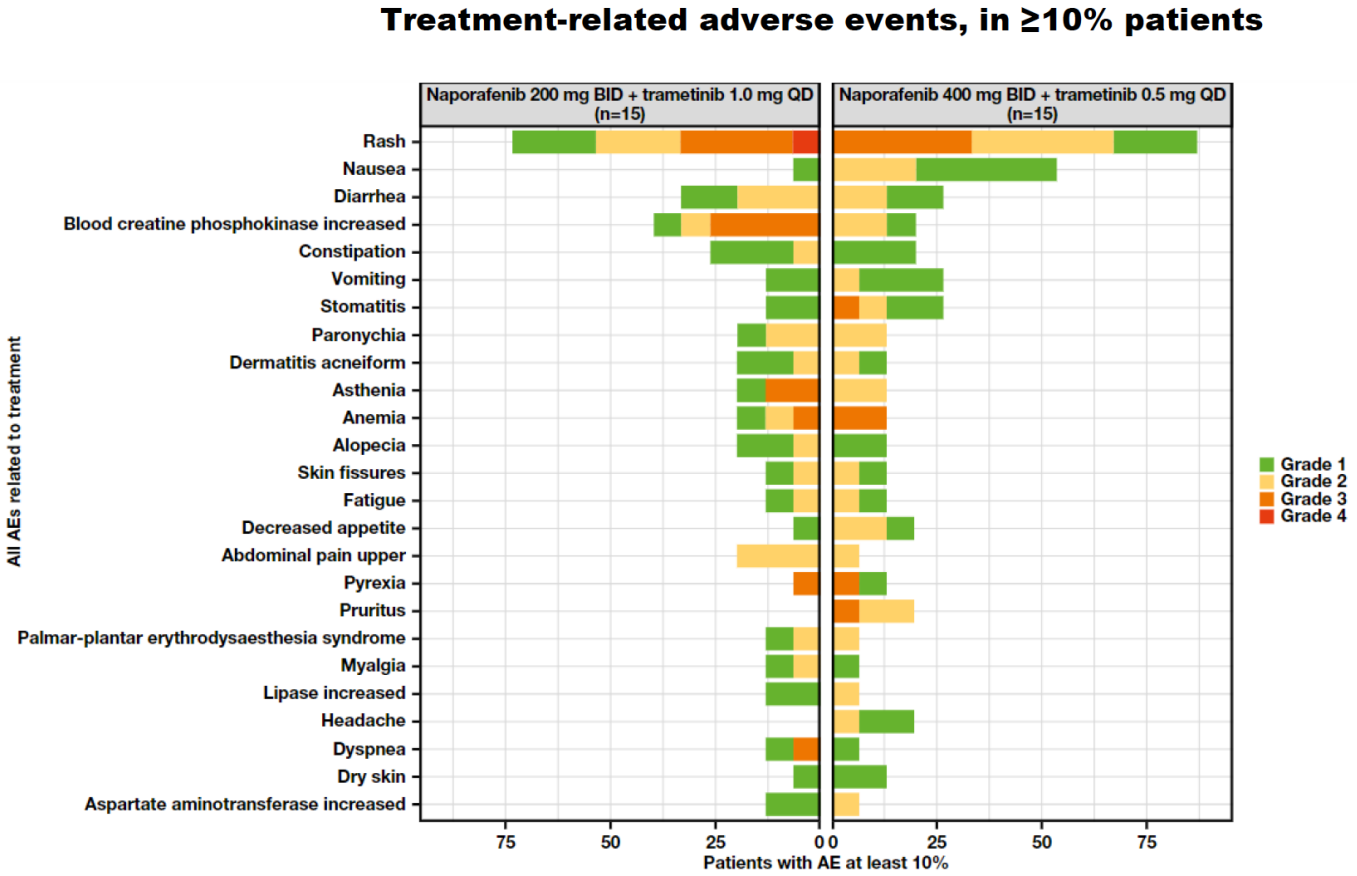
US FDA Fast Track Designation: Dec 2023

- Compelling efficacy for both doses evaluated to date
- High unmet medical need for NRASm melanoma patients post-IO

PFS for napo + tram across doses exceeds PFS for approved SOC and single agent MEKi's

1 Dummer et al 2017; binimetinib is administered BID
2 Pooled analysis from the following publications: Falchook et al, 2012; Pigne et al, 2023; Salzmann et al, 2022; trametinib is administered QD
3 Dacarbazine is the approved chemotherapy in this indication
4 Ph 1 = CLXH254X2102 with DCO 4 Aug 2022; Ph 2 = CLXH254C12201 with DCO 30 Dec 2022
PFS includes both responders and non-responders
SOC: standard of care; N/A: not available; NE: not estimable; DCO: data cutoff; DCR: disease control rate; mDOR: median duration of response; ORR: objective response rate; mPFS: median progression free survival
The pooled phase 1 and phase 2 napo + tram data covers two clinical trials with different designs and inclusion criteria, which cannot be directly compared, and therefore may not be a reliable indicator of efficacy data
Due to differences between trial designs and subject characteristics, comparing data across different trials may not be a reliable indicator of data

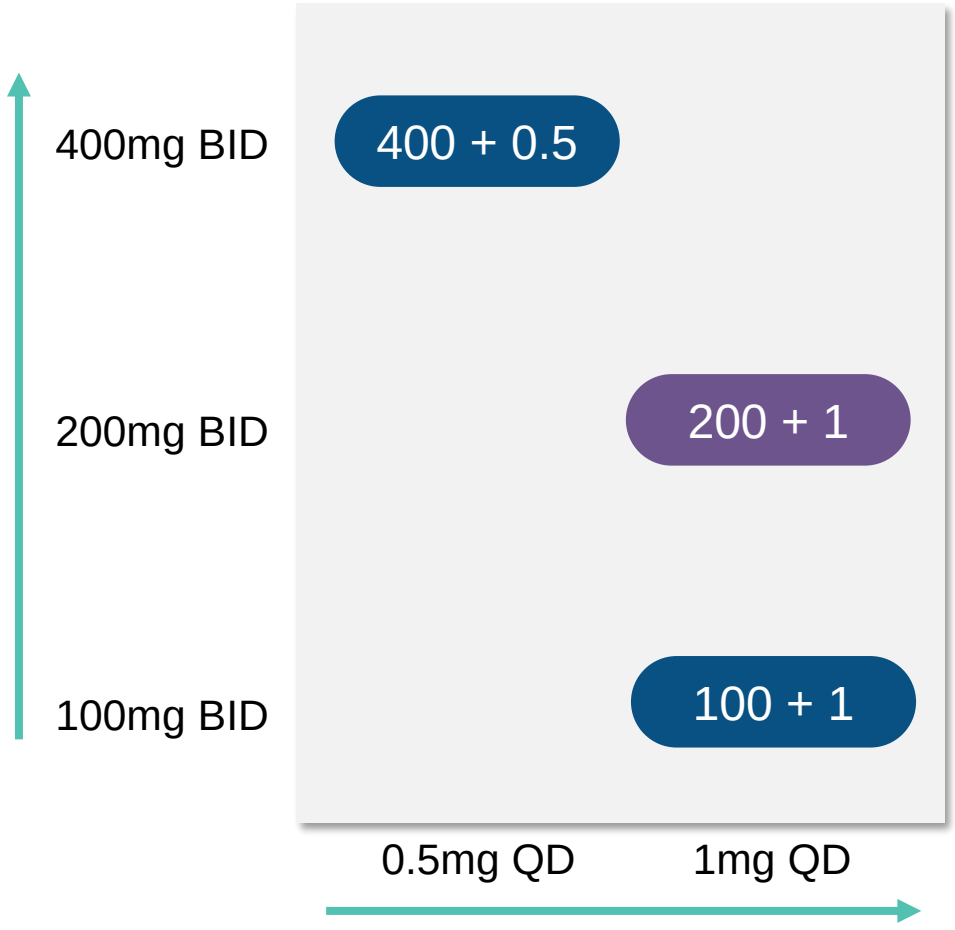
Naporafenib + trametinib demonstrated a favorable, manageable AE profile



- AE profile consistent with expected toxicities associated with RAF and MEK inhibition
  - 400+0.5 dose well tolerated
  - 200+1 dose less tolerable but we predict tolerability to increase with mandatory primary rash prophylaxis
- Primary prophylaxis of rash being implemented in both SC-1 and SC-2 provides opportunity to further improve safety and tolerability

AE: adverse event; BID: twice daily; QD: once daily; SC: SEACRAFT
Phase 1 data in NRASm melanoma from De Braud et al AACR 2022

Dose optimization designed to enhance combination benefit/risk profile to increase probability of regulatory success in light of Project Optimus



Data from **SEACRAFT-1** and **SEACRAFT-2** complement each other, allowing us to efficiently test the full effective dose range of naporafenib + trametinib within the two trials to optimize the benefit/risk profile

SEACRAFT-1 dose

SEACRAFT-2 dose

* As part of the naporafenib + trametinib combination
BID: twice a day; QD: once a day

Pivotal Phase 3 and Phase 1b trial designs capitalize on promising efficacy signals and potentially support successful registration in multiple indications

SEACRAFT-1: RAS Q61X Solid Tumors (Single-arm Phase 1b)

Solid Tumors
Post-available therapy
RAS Q61X
(NRAS, HRAS, KRAS)

naporafenib + trametinib
(200mg + 1mg)

Study Endpoints

ORR (primary), DOR

N~30 – 100

Phase 1b designed to pivot to tissue specific or tissue agnostic Accelerated Approval path

SEACRAFT-2: NRASm Melanoma (Two-stage Phase 3)

Stage 1: Dose Optimization

Metastatic Melanoma
Post-ICI
NRASm
(Q61X and non-Q61X)

R

naporafenib + trametinib
(400mg + 0.5mg)

naporafenib + trametinib
(100mg + 1mg)

trametinib (2mg)

N~60 – 120

Stage 2: Regulatory Approval

Metastatic Melanoma
Post-ICI
NRASm
(Q61X and non-Q61X)

R

naporafenib + trametinib
(Dose selected in Stage 1*)

physician's choice
(trametinib, DTIC, TMZ)

Study Endpoints

PFS, OS (dual primary)
ORR, DOR (secondary)

N~350

Positive PFS acceptable for potential initial approval

* Dose selection informed by data on 400+0.5 and 100+1 from SEACRAFT-2 Stage 1 as well as 200+1 from SEACRAFT-1
Note: Naporafenib dosed on a BID schedule; trametinib dosed on a QD schedule; crossover not allowed for SEACRAFT-2
ORR: overall response rate; DOR: duration of response; ICI: immune-checkpoint inhibitor; DTIC: dacarbazine; TMZ; temozolomide; PFS: progression-free survival; OS: overall survival

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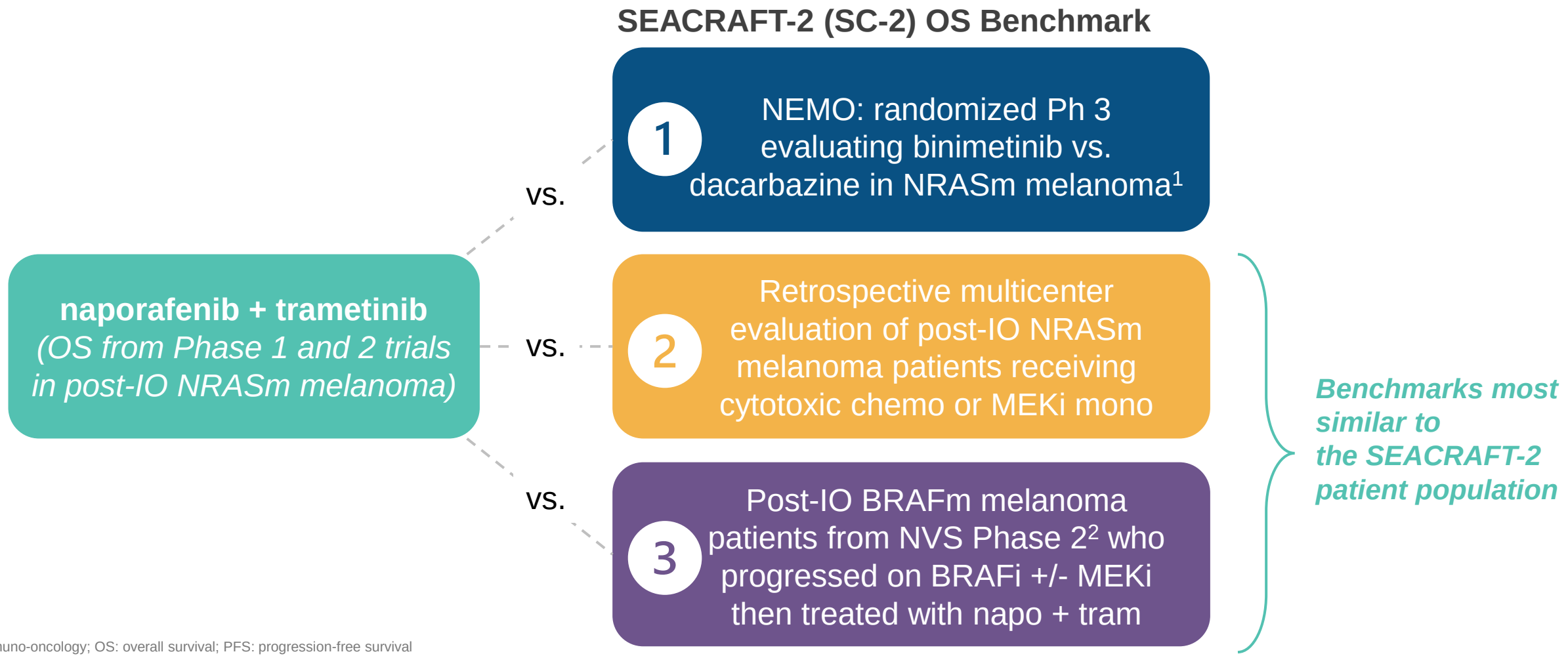
PFS is an important metric, but OS is widely considered the gold standard in oncology trials

- Represents **length of time** patient is living after start of therapy
- **Reliable and precise measure** of efficacy among clinical trial endpoints
- Provides evidence of a drug's value in **prolonging a cancer patient's life**

> *"**OS is the ultimate endpoint**, … (after that) preventing the disease from progressing, is my second most important metric. "*
>
> - Medical Oncologist, Academic Hospital

PFS: progression-free survival; OS: overall survival

Napo + tram OS data can be compared to multiple potential benchmarks



IO: immuno-oncology; OS: overall survival; PFS: progression-free survival
1 Dummer et al. (2017)
2 Novartis (NVS) sponsored C12201 Phase 2 study evaluating naporafenib + trametinib
Due to differences between trial designs and subject characteristics, comparing data across different trials may not be a reliable indicator of data

OS Benchmark #1: NEMO patient population not generalizable to SC-2

naporafenib + trametinib
(OS from Phase 1 and 2 trials in post-IO NRASm melanoma)

vs.

1 NEMO: randomized Ph 3 evaluating binimetinib vs. dacarbazine in NRASm melanoma[1]

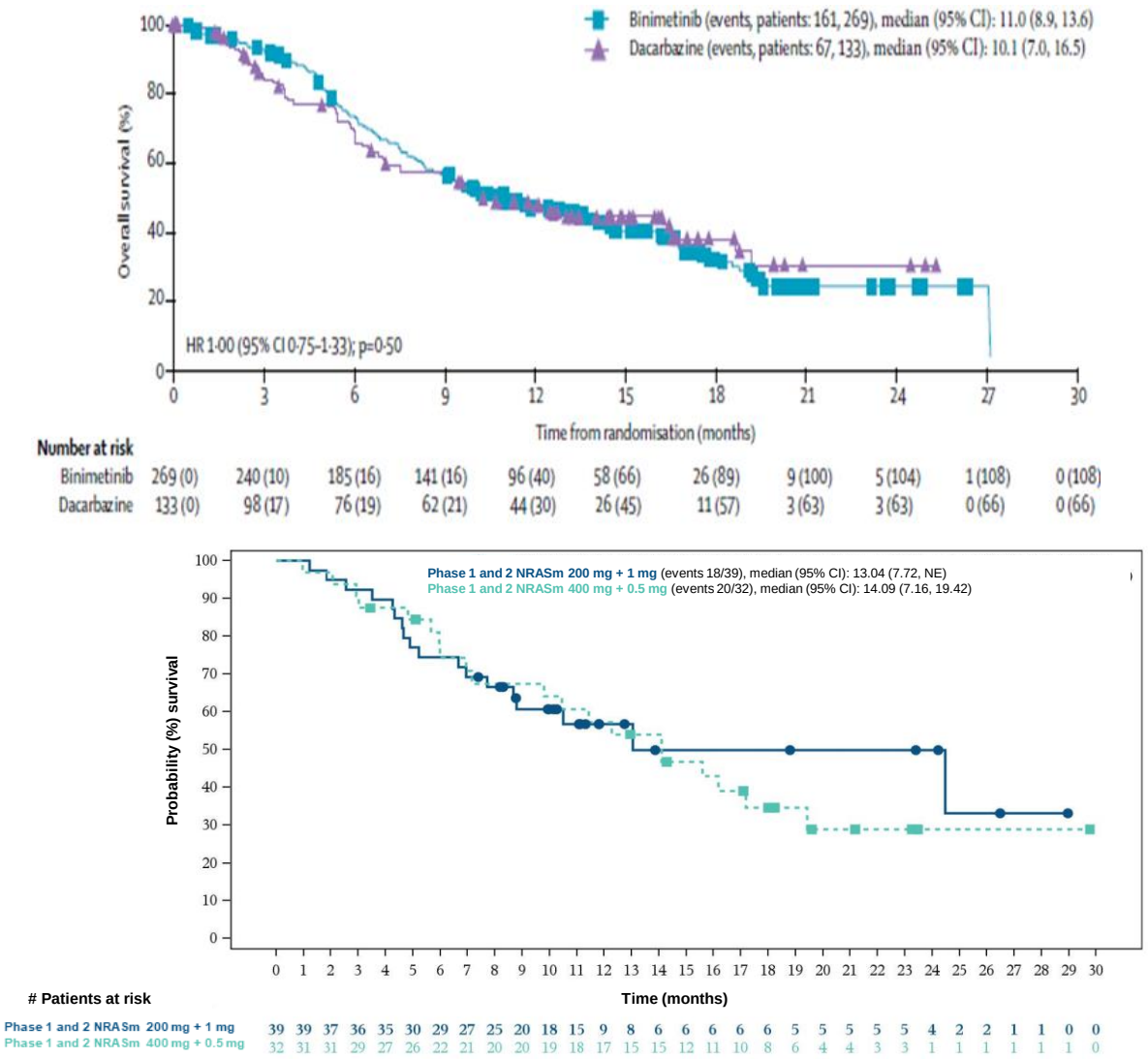
Median OS: ~10-11 months

Benchmark considerations:

- ⊕ Most rigorous trial design
  - Randomized Phase 3 with large sample size
- ⊖ Patient population not directly generalizable to SC-2 for OS
  - ~80% of patients were 1L NRASm melanoma and had not received prior IO therapy
  - ~45% of patients who progressed were reported to receive IO post-trial, which we believe likely overestimated the OS of MEKi monotherapy

IO: immuno-oncology; OS: overall survival
1 Dummer et al. 2017
2 Patients were being enrolled in 2013 through 2015; ipilumimab was approved in 2011, nivolumab and pembrolizumab were approved in 2014 (see next slide)

Napo + tram shows improved OS compared to NEMO despite potentially overestimated OS of NEMO benchmark



Binimetinib and dacarbazine in NEMO[2]

- **~ 10-11 months mOS** for each treatment arm
- 1st/2nd line NRASm melanoma patients
- We believe mOS was likely overestimated due to receipt of survival prolonging IO treatment after study drug discontinuation

Naporafenib + trametinib in Phase 1 and 2 studies[3]

- **~ 13 or 14 months mOS** for each combo dose
- ≥ 2nd line NRASm melanoma patients
- Patients enrolled in post-IO treatment paradigm

OS: overall survival; IO: immuno-oncology
[1] Adapted from Dummer et al 2017 Lancet Oncology
[2] Differences exist between trial designs and subject characteristics and caution should be exercised when comparing data across trials.
[3] The pooled phase 1 and phase 2 napo + tram data cover two clinical trials with different designs and inclusion criteria, which cannot be directly compared, and therefore may not be a reliable indicator of OS data.
Due to differences between trial designs and subject characteristics, comparing data across different trials may not be a reliable indicator of data

OS Benchmark #2: Multicenter evaluation suggests mOS of ~6-7 months in patient population observed to be similar to SEACRAFT-2 patients

naporafenib + trametinib
(OS from Phase 1 and 2 trials in post-IO NRASm melanoma)

vs.

2 Retrospective multicenter evaluation of post-IO NRASm melanoma patients receiving cytotoxic chemo or MEKi mono

Median OS: ~6-7 months

Benchmark considerations:

- ⊕ Patient population observed to be similar to SC-2 patients
- ⊕ Values likely represent the “natural history of the disease”
- ⊖ Less rigorous analysis
  - Retrospective multicenter evaluation lacks randomization and prospective enrollment

OS: overall survival
Due to differences between trial designs and subject characteristics, comparing data across different trials may not be a reliable indicator of data

Multicenter evaluation suggests mOS of ~6-7 months in patient population observed to be similar to SEACRAFT-2 patients

Post-IO Melanoma Population	Treatment	Sample Size	Median PFS (months)	Median OS (months)
All comers (20% NRASm)[1]	Cytotoxic chemotherapy	197	2.6	6.9
All comers (26% NRASm)[2]	Cytotoxic chemotherapy	50	2.6	4.4
NRAS mutant[3]	MEK inhibitor monotherapy	33	2.8	7.1
NRAS mutant[4]	MEK inhibitor monotherapy	22	2.0	6.5

Consistent mOS observed in retrospective analysis of post-IO NRASm melanoma patients treated with chemo or MEKi

IO: Immuno-oncology therapy; ICI: Immune checkpoint inhibitor; PFS: progression-free survival; OS: overall survival

[1] Goldinger et al. Eur J Cancer 2022

[2] Mangin et al. Cancer Med 2021

[3] Salzmann et al. Eur J Cancer 2022; 91% patients were post-ICI

[4] Pigne et al. Melanoma Research 2023; 91% patients were NRAS mutant

Due to differences between trial designs and subject characteristics, comparing data across different trials may not be a reliable indicator of data

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OS Benchmark #3: BRAFm melanoma patients in Novartis's Phase 2 trial C12201 offer potential insight into SC-2 control arm

naporafenib + trametinib
(OS from Phase 1 and 2 trials in post-IO NRASm melanoma)

vs.

3 Post-IO BRAFm melanoma patients from NVS Phase 2[2] who progressed on BRAF +/- MEKi then treated with napo + tram

Median OS: ~6-7 months

Benchmark considerations:

- ⊕ Patient population had ≥1 and ≤2 prior lines of IO and progression on BRAFi +/- MEKi
- ⊕ No responses observed and mPFS of ~1.8m suggests mOS of ~7m represents natural history of disease similar to OS Benchmark #2
- ⊕ Prospective contemporaneous evaluation of mOS that could be observed in SC-2 control arm
- ⊖ BRAFm melanoma patient population may have different prognostic characteristics

IO: immuno-oncology; PFS: progression-free survival; OS: overall survival
1 de Braud et al. JCO 2023
2 Novartis sponsored C12201 Phase 2 study evaluating naporafenib + trametinib

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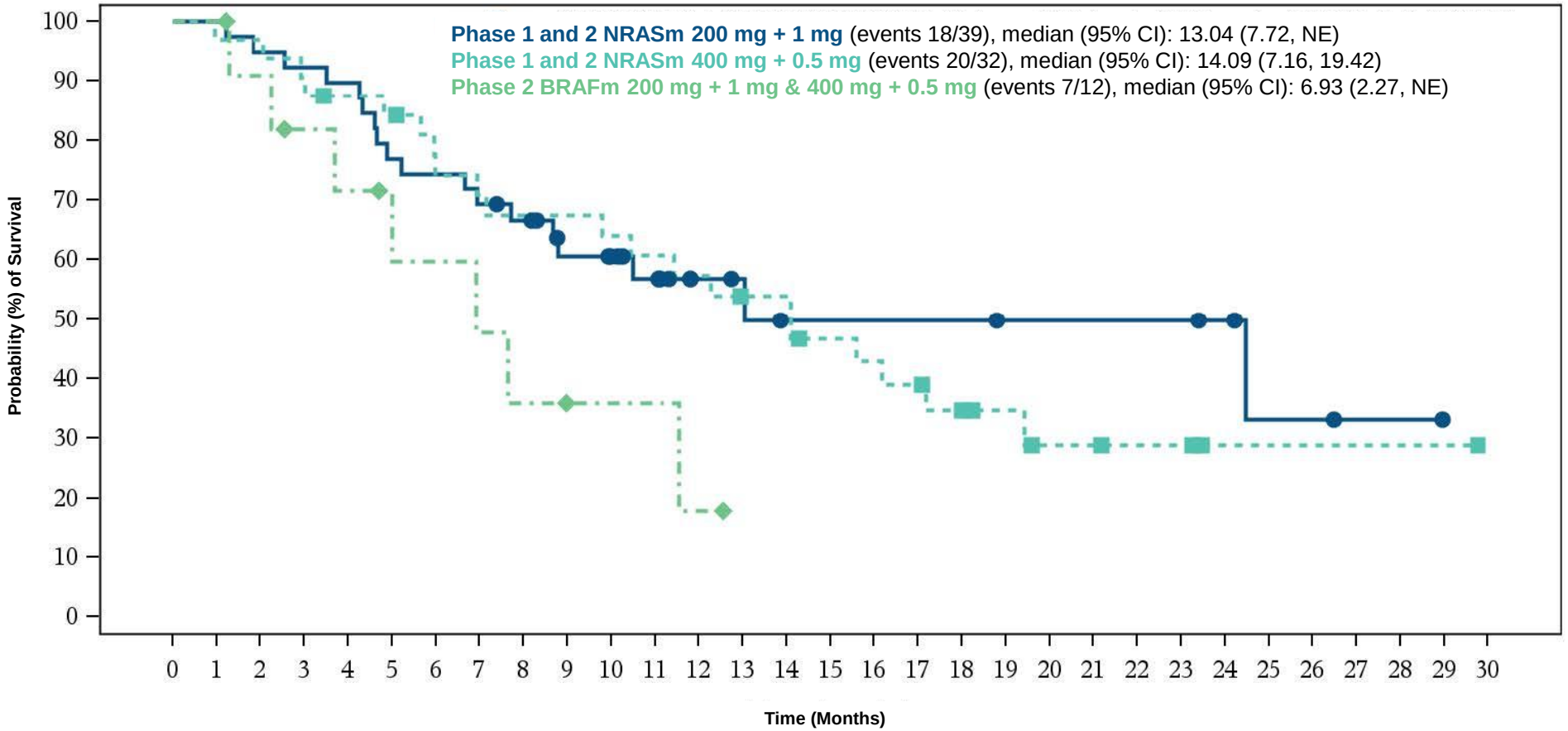
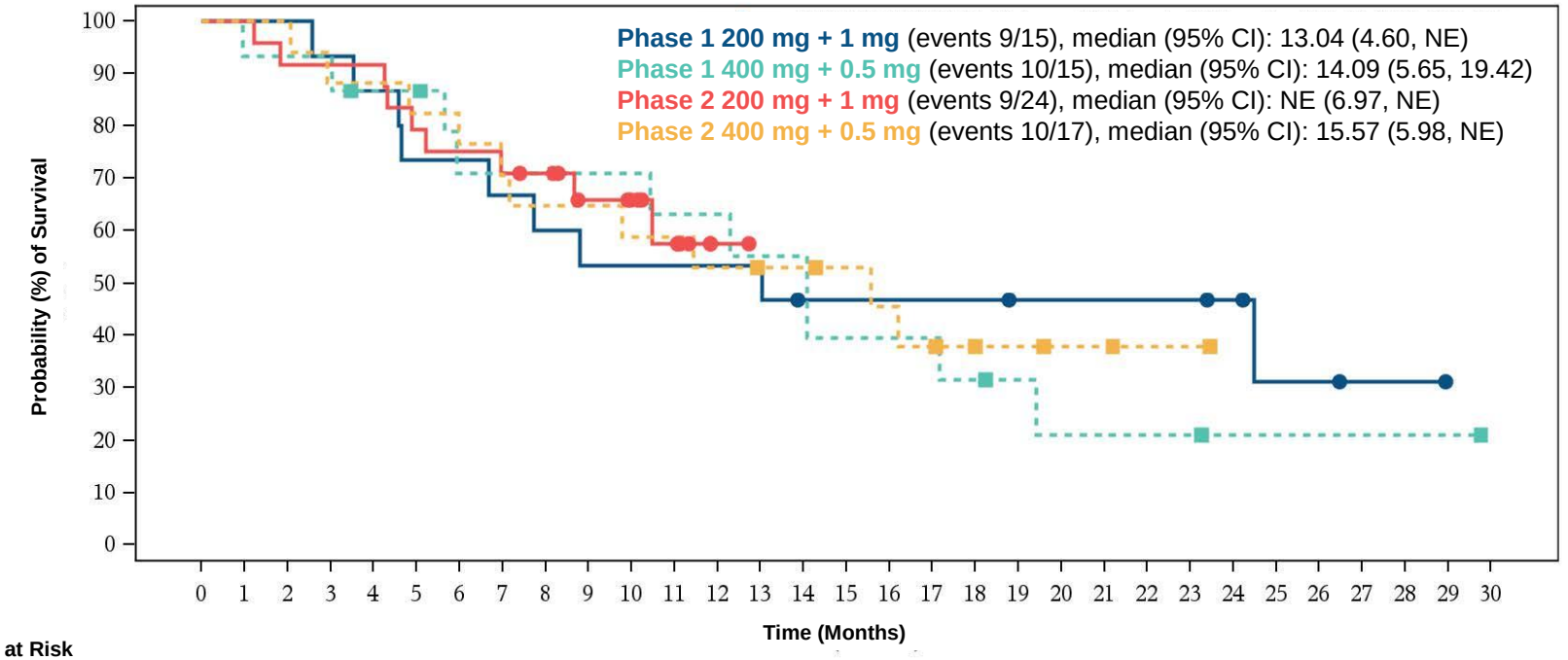
BRAFm melanoma patients in NVS's Phase 2 trial showed mOS of ~6-7 months



# Patients at Risk																													
Phase 1 and 2 NRASm 200 mg + 1 mg	39	39	37	36	35	30	29	27	25	20	18	15	9	8	6	6	6	6	6	5	5	5	5	5	4	2	2	1	1	0	0
Phase 1 and 2 NRASm 400 mg + 0.5 mg	32	31	31	29	27	26	22	21	20	20	19	18	17	15	15	12	11	10	8	6	4	4	3	3	1	1	1	1	1	1	0
Phase 2 BRAFm 200 mg + 1 mg & 400 mg + 0.5 mg	12	12	10	8	7	5	5	4	3	2	2	2	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Napo + tram OS data showed high consistency across studies and doses



# Patients at Risk																													
Phase 1 200 mg + 1 mg	15	15	15	14	13	11	11	10	9	8	8	8	8	8	6	6	6	6	6	5	5	5	5	5	4	2	2	1	1	0	0
Phase 1 400 mg + 0.5 mg	15	14	14	14	12	12	9	9	9	9	9	8	8	7	7	5	5	5	4	3	2	2	2	2	1	1	1	1	1	1	0
Phase 2 200 mg + 1 mg	24	24	22	22	22	19	18	17	16	12	10	7	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Phase 2 400 mg + 0.5 mg	17	17	17	15	15	14	13	12	11	11	10	10	9	8	8	7	6	5	4	3	2	2	1	1	0	0	0	0	0	0	0

NRASm
mOS: ~13-15 months
(across doses and studies)

Reproducibility of these results across studies and doses increases our confidence in the mOS observations

mOS: median overall survival
Differences exist between trial designs and subject characteristics and caution should be exercised when comparing data across trials.

Compelling clinical efficacy of napo + tram potentially extends to OS endpoint

	MEKi		SOC	Pooled Ph 1 and Ph 2[4]	
	Binimetinib[1]	Trametinib[2]	Chemo[3]	Naporafenib + Trametinib	
	45mg	2mg	1g/m^2 IV	200mg+1mg	400mg+0.5mg
	N=269	N=33	N=133	N=39	N=32
mPFS months	2.8	*~2.8**	1.5	**5.1**	**4.9**
mOS months	~10-11 months (Benchmark #1: *NEMO Study*)			**~13 months**	**~14 months**
	~7 months *(Benchmark #2: Chart Review)*				
	~7 months *(Benchmark #3: C12201 BRAFm Patients[5])*				

Benchmarks most like SEACRAFT-2 patient population

Potential win on both SEACRAFT-2 primary endpoints (PFS and OS)

1 Dummer et al 2017; binimetinib is administered BID
2 Pooled analysis from the following publications: Falchook et al, 2012; Pigne et al, 2023; Salzmann et al, 2022; trametinib is administered QD
3 Dacarbazine is the approved chemotherapy in this indication
4 Ph 1 = CLXH254X2102 with DCO 4 Aug 2022; Ph 2 = CLXH254C12201 with DCO 30 Dec 2022
5 BRAF/MEK inhibitor-resistant BRAFm melanoma patients in Novartis's Phase 2 trial
SOC: standard of care; mPFS: median progression free survival; mOS: median overall survival
The pooled phase 1 and phase 2 napo + tram data covers two clinical trials with different designs and inclusion criteria, which cannot be directly compared, and therefore may not be a reliable indicator of efficacy data
Due to differences between trial designs and subject characteristics, comparing data across different trials may not be a reliable indicator of data

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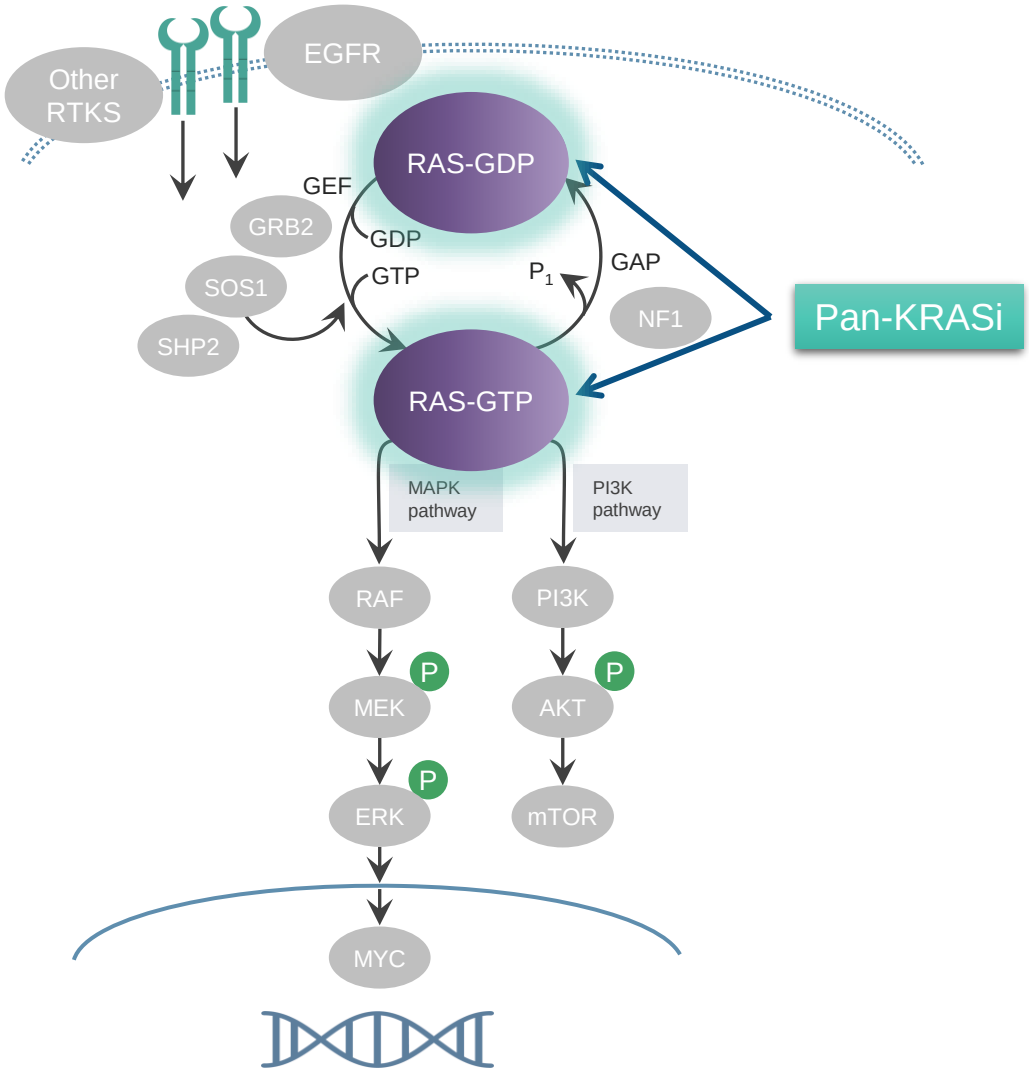
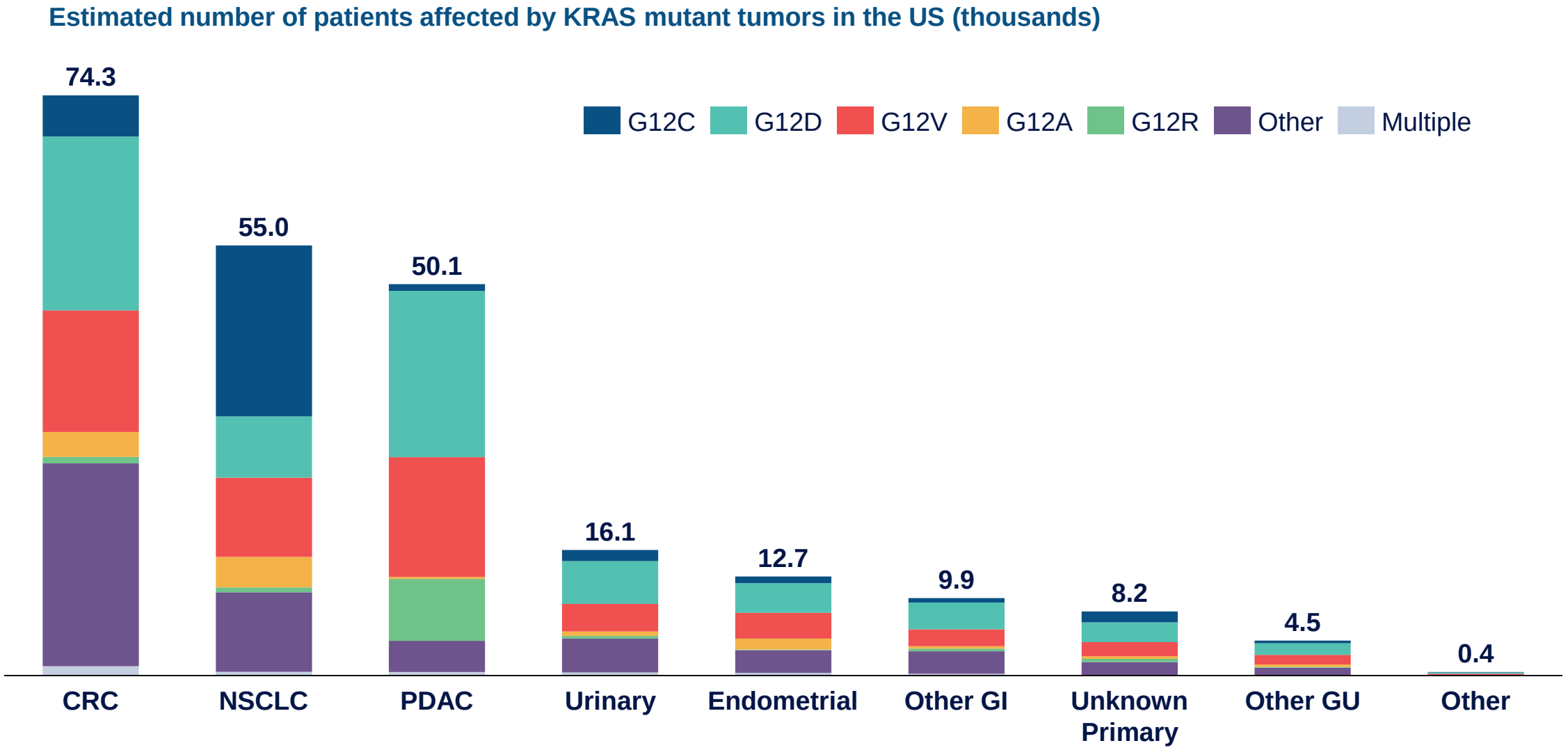
Erasca is exploring internal and external opportunities to develop a potent, KRAS-selective and orally bioavailable pan-KRAS inhibitor



- Approach inhibits KRAS by **targeting the S-IIP**
- Promising approach is designed to **target all G12X mutations**, such as G12D and G12V, **as well as G13X**
- Pan-KRAS drugs could provide **deep and durable target inhibition** with low risk of HRAS/NRAS wildtype mediated toxicity
- Pan-KRAS drugs have the **potential to address a broad patient population** including patients where:
  - Mutant-selective KRAS drugs are unavailable
  - Both **mutant and wildtype forms** of KRAS can **contribute to oncogenic signaling**
- Selectivity for KRAS over HRAS/NRAS is desired for **improved tolerability** relative to pan-RAS approach

~230k patients are diagnosed annually in the US with solid tumors harboring KRAS mutations



Adapted from Lee J., Sivakumar S., Schrock A., et al. "Comprehensive pan-cancer genomic landscape of KRAS altered cancers and real-world outcomes in solid tumors." NPJ Precision Oncology, 2022. PMID: 36494601.

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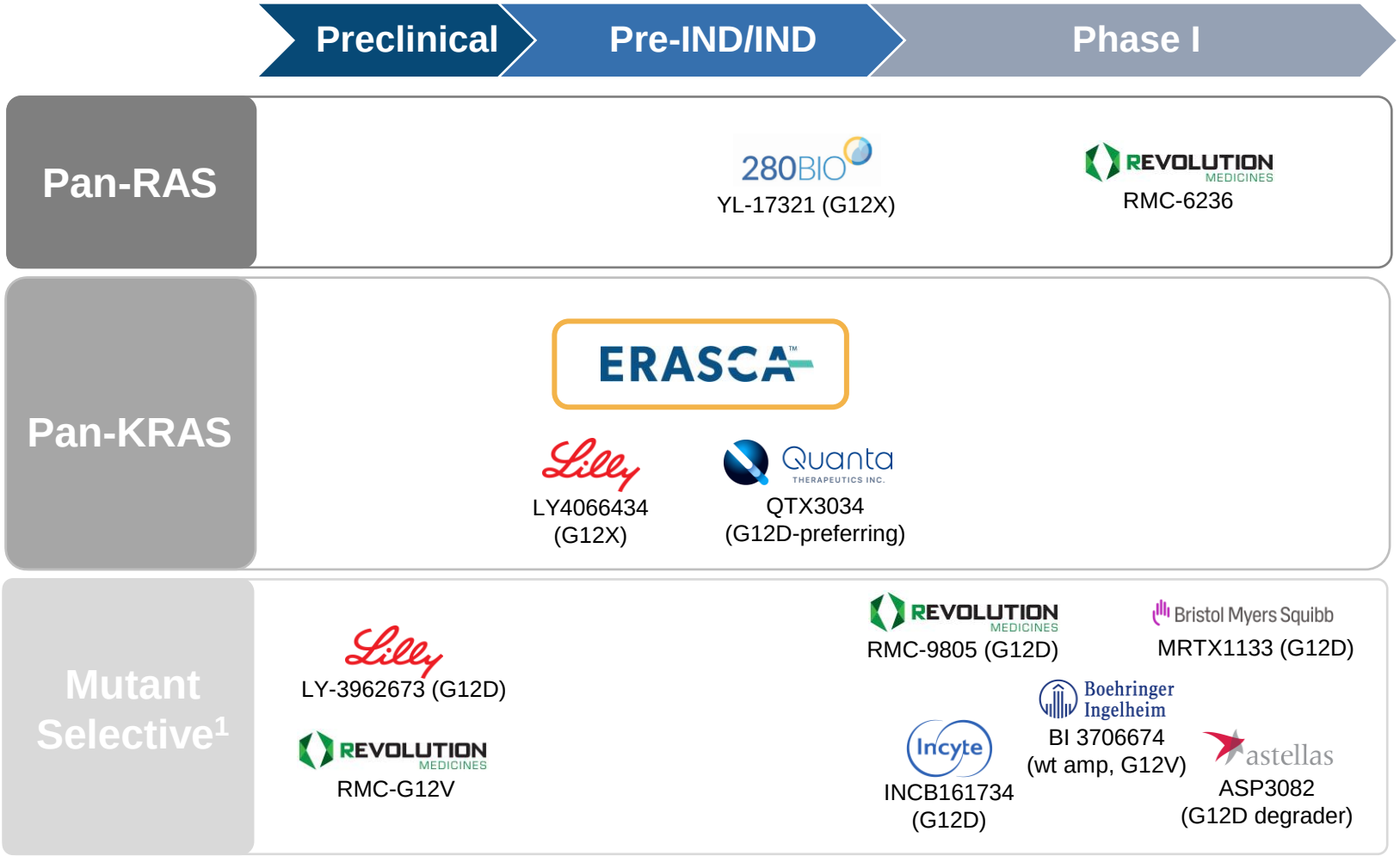
RAS targeting landscape drives importance of identifying development candidates with first-in-class or best-in-class potential



Comments on Class

- ⊕ Encouraging preliminary clinical data
- ⊖ Tolerability, combinability may be challenging

- ⊕ Opportunity for greater therapeutic window by specifically targeting KRAS
- ⊕ More straightforward mechanism via KRAS Switch II pocket binding mode
- ⊖ Translation to clinical efficacy TBD

- ⊕ Potential for greater potency against specific mutation of interest
- ⊖ Oral bioavailability and stability have proven challenging for G12Di
- ⊖ Susceptible to resistance mediated by wildtype RAS of the same isoform

Note: Select coopetitors shown; list is not intended to be exhaustive

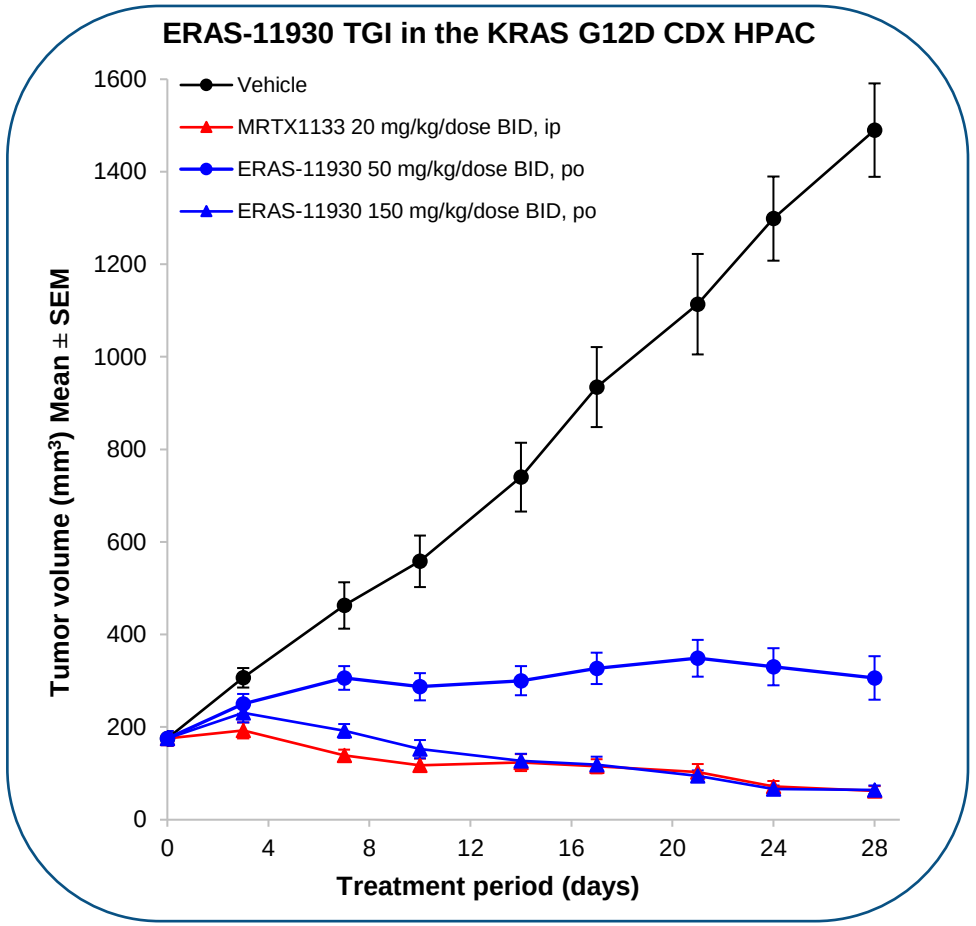
[1] Mutant selective beyond KRAS G12C inhibitors

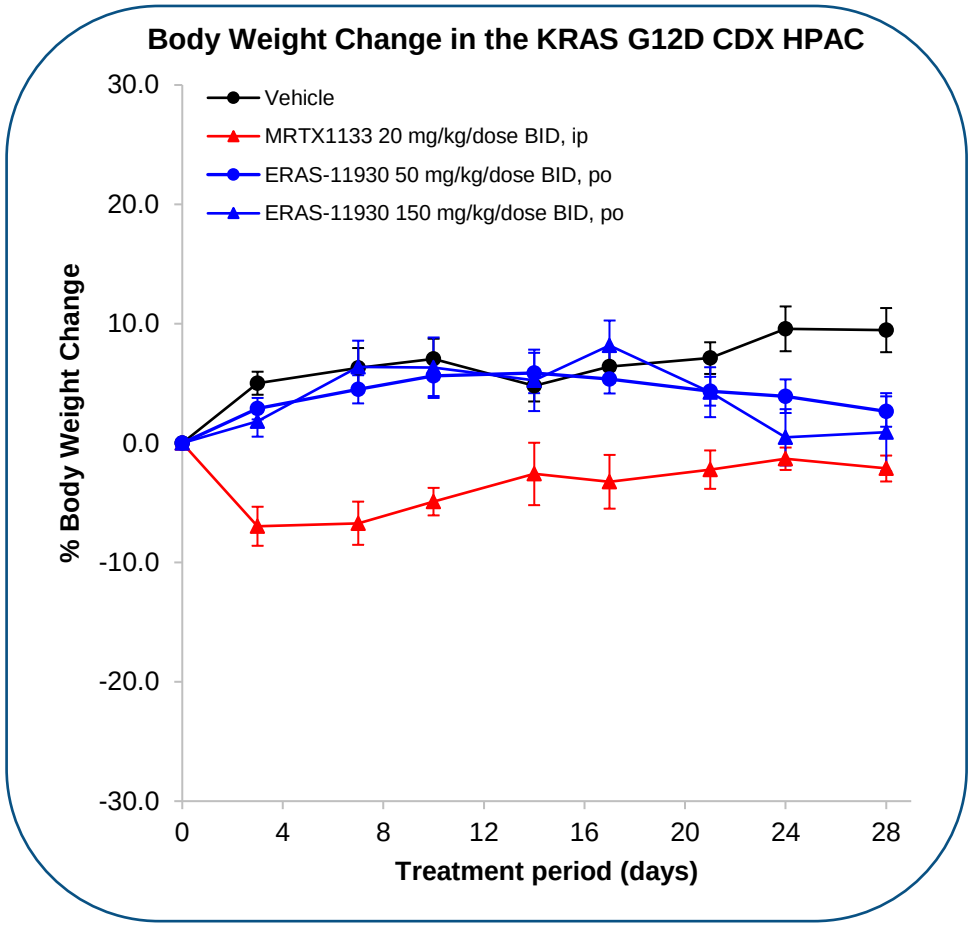
Erasca's internal pan-KRASi's showed promising in vitro potency and in vivo PK

Assay		Erasca's Internal pan-KRAS Compounds				Coopetitors' Compounds		
		ERAS-12943	ERAS-12879	ERAS-12056	ERAS-11930	MRTX1133	RMC-6236	Loxo LY-4066434
Inhibitor Class		S-IIP targeting	S-IIP targeting	S-IIP targeting	**S-IIP targeting**	S-IIP targeting	Molecular Glue (Ras and Cyclophilin A)	S-IIP targeting
Target(s)		Pan-KRAS	Pan-KRAS	Pan-KRAS	**Pan-KRAS**	KRAS G12D Selective	Pan-RAS	Pan-KRAS
KRAS G12D Kd by SPR (nM)		0.0080	0.019	0.24	**0.012**	~0.0002	Not relevant for S-IIP inhibitor comparisons	0.44
KRAS WT Kd by SPR (nM)		0.062	0.39	0.35	**0.19**	0.31	Not relevant for S-IIP inhibitor comparisons	0.26
KRAS G12D AsPC-1	4/24-hour pERK IC_{50} (nM)	1.5 / 3.6	5.4 / 6.5	6.7 / 48	**4 / 20**	6	0.4-3*	13
	5-day 3D CTG IC_{50} (nM)	1.9	5.4	17.7	**8.2**	20	1-27*	29
KRAS G12V SW620	4-hour pERK IC_{50} (nM)	Queued	2.3	8.0	**2.4**	ND	0.4-3*	8.5
	5-day 3D CTG IC_{50} (nM)	Queued	29	24.2	**20**	ND	1-27*	30
% F (PO dose)		14 (40 mg/kg)	32 (50 mg/kg)	12 (50 mg/kg)	**13.5 (50 mg/kg)**	0.2 (10 mg/kg)	24-33 (10 mg/kg)	43 (30 mg/kg)
PK Species		mouse	mouse	mouse	**mouse**	rat	mouse	mouse

* range in G12X cell line panel

Erasca's pan-KRASi showed promising in vivo activity in KRAS G12D PDAC CDX model





- MRTX1133 sets a high bar since it is the most potent S-IIP binding, G12D selective clinical compound we have observed
- ERAS-11930 showed dose dependent TGI, achieving tumor regression at the orally administered 150 mg/kg BID dose
- ERAS-11930 achieved comparable tumor regression relative to MRTX1133 at its MTD dose (20 mg/kg BID, IP)
- Mouse mortality observed when MRTX1133 was administered at higher doses (e.g., 30 mg/kg BID, IP)

Anticipated key milestones and clinical trial readouts

Program *Mechanism*	**Trial Name** *Indication* *(Combo partner if applicable)*	**Anticipated Milestone**
Naporafenib *Pan-RAF inhibitor*	**SEACRAFT-1** *RAS Q61X Solid Tumors* *(+ trametinib)*	• **Q2 2024 – Q4 2024:** Ph 1b combination data[1]
	SEACRAFT-2 *NRASm Melanoma* *(+ trametinib)*	• **H1 2024:** Ph 3 pivotal trial initiation • **2025:** Ph 3 stage 1 randomized dose optimization data[1]
ERAS-007 *ERK1/2 inhibitor*	**HERKULES-3** *EC-naïve BRAFm CRC* *(+ encorafenib and cetuximab)*	• **H1 2024:** Ph 1b combination data[1]
ERAS-801 *CNS-penetrant EGFR inhibitor*	**THUNDERBBOLT-1** *Glioblastoma*	• **2024:** Ph 1 monotherapy data[1]

[1] Data to include safety, pharmacokinetics (PK), and efficacy at relevant dose(s) in relevant population(s) of interest

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Thank You!