C4 Therapeutics

Updated Data in Multiple Myeloma and First Data in Non-Hodgkin's Lymphoma from the Ongoing Cemsidomide Phase 1/2 Trial

American Hematology Annual Meeting (ASH)

December 8, 2024

Forward-looking Statements and Intellectual Property

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Today's Agenda

Introductions	Courtney Solberg, Senior Manager of IR
Opening Remarks	Andrew Hirsch, President and CEO
Cemsidomide Phase 1 MM & NHL Data & Next Steps	Len Reyno, M.D., CMO
Concluding Remarks & Q&A Session	Andrew Hirsch, President and CEO Len Reyno, M.D., CMO Kendra Adams, CFO

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Opening Remarks

Andrew Hirsch
President and Chief Executive Officer

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C4T Has Delivered a Steady Flow of Clinical Updates and Innovative Collaborations Over the Past 12 Months…

Significant Progress Across Clinical Programs

Cemsidomide

- ✓ Compelling activity in both multiple myeloma and non-Hodgkin's lymphoma
- ✓ Modest and manageable neutropenia
- ✓ Emerging data demonstrate positive exposure-response relationship
- ✓ Evidence of immunomodulatory effects, consistent with the class

CFT1946

- ✓ Monotherapy anti-tumor activity, including tumor reductions across various V600 mutation types
- ✓ Dose-dependent bioavailability
- ✓ Well-tolerated; no Grade ≥ 3 cutaneous adverse events commonly seen with BRAF inhibitors
- ✓ Preclinical data demonstrate ability to cross blood-brain barrier

CFT8919

- ✓ Clinical trial initiated in Greater China in partnership with Betta Pharmaceuticals

Collaborations Have Further Validated TORPEDO Platform

Biogen

- ✓ Delivered two development candidates for non-oncology targets

MERCK

- ✓ Established partnership to discover and develop degrader antibody conjugates

Merck KGaA
Darmstadt, Germany

- ✓ Announced collaboration to discover targeted protein degraders against critical oncogenic proteins

…Which Set the Stage to Unlock Value

VALUE DRIVERS	KEY CATALYSTS
Cemsidomide IKZF1/3	Further development in multiple myeloma and non-Hodgkin's lymphoma positions cemsidomide to potentially be best-in-class IKZF1/3 degrader
CFT1946 BRAF V600 Mutant	Phase 1 data updates to further validate initial anti-tumor activity and safety profile in melanoma and colorectal cancer
CFT8919 EGFR L858R	Phase 1 data from Greater China clinical trial to inform US and rest-of-world development plans
TORPEDO Platform	Develop orally bioavailable degraders in oncology and non-oncology targets through internal research and collaborations

C4T is positioned to become a **fully integrated biotechnology** company focused on **orally bioavailable degraders**

Cemsidomide First-in-Human Clinical Program

Relapsed Refractory Multiple Myeloma and Non-Hodgkin's Lymphoma

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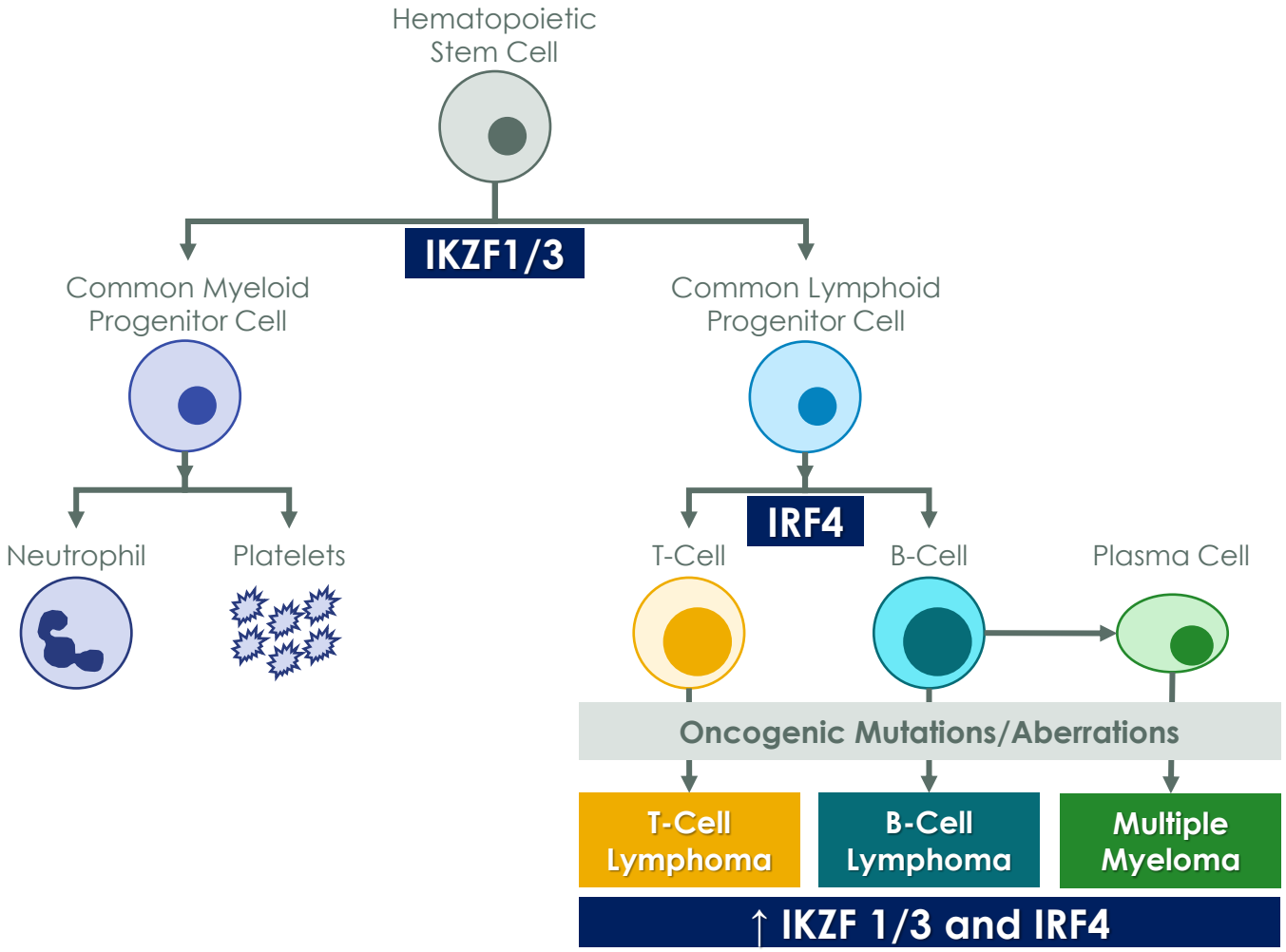
IKZF1/3 Are Key Promoters of Myeloma and Lymphoma Cell Survival and Will Remain Important Therapeutic Targets in MM and NHL



Key Roles of IKZF1/3

Physiological Functions:

- **IKZF1/3** are key transcriptional regulators of hematopoietic stem cell differentiation
- **IKZF1/3** directly regulate the activity of **IRF4**, another transcription factor that regulates downstream immune cell differentiation

Oncogenic Functions:

- Multiple myeloma and lymphoma cells rely on **IKZF1/3** and **IRF4** for survival

IKZF1/3 Degradation Leads to:

- Downregulation of **IRF4**, promoting the death of myeloma and lymphoma cells
- On-target neutropenia

Multiple myeloma (MM); non-Hodgkin's lymphoma (NHL)

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Cemsidomide First-in-Human Phase 1 Trial Continues to Progress

Data to date reinforce potential of drug to become best-in-class IKZF1/3 degrader used as a backbone therapy of choice

PHASE 1 DOSE ESCALATION TRIAL

2022

R/R MM
Monotherapy

Dosing: QD

21 days on/
7 days off

N=5

Status: Complete

2023

R/R MM
Monotherapy

Dosing: MWF & QD

14 days on/
14 days off

N=22

Status: Complete

- 14 days on/14 days off established as an effective dosing schedule
- Demonstrated monotherapy anti-myeloma and immunomodulatory effects supporting combination with other anti-myeloma agents

ASH 2024

R/R MM
Dex Combo

Dosing: MWF & QD

14 days on/
14 days off

N=~40

Status: Enrolling

- Well-tolerated with manageable neutropenia and low rates of infections and febrile neutropenia
- Wide therapeutic index with anti-myeloma activity across a broad range of doses

R/R NHL
Monotherapy

Dosing: MWF & QD

14 days on/
14 days off

N=~25

Status: Enrolling

- Well-tolerated with additional dose finding ongoing
- Compelling anti-lymphoma activity across a broad range of doses in PTCL

Monday, Wednesday, Friday dosing (MWF); once daily (QD); peripheral T-cell lymphoma (PTCL); relapsed refractory multiple myeloma (R/R MM); relapsed refractory non-Hodgkin's lymphoma (R/R NHL)

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Multiple Myeloma

Cemsidomide + Dexamethasone

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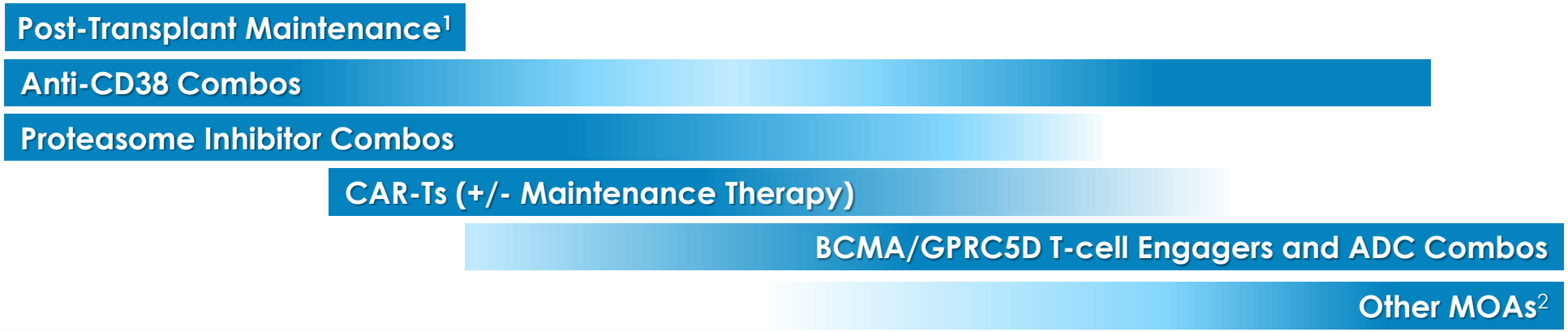
With a Potentially Best-in-Class Profile, Cemsidomide Is Positioned to Be an IKZF1/3 Degrader of Choice Across Various Combinations

EVOLVING MULTIPLE MYELOMA TREATMENT LANDSCAPE

U.S. Addressable Patients (2024)	~33,000[1]	~29,000	~25,000	~20,000	≤12,000
Treatment Line	1L	2L	3L	4L	5L+



CEMSIDOMIDE OPPORTUNITY

- IKZF1/3 degraders are currently used across lines of therapy, from post-transplant maintenance to 5L+ doublets, and will remain backbone therapies in various combination approaches
- **Cemsidomide has the potential to become the IKZF1/3 degrader of choice** in numerous regimens across lines of therapy given its potent anti-myeloma activity, differentiated safety profile, and immunomodulatory effects

[1]Approximately 30% of multiple myeloma patients undergo a hematopoietic stem cell transplant and receive post-transplant maintenance therapy.
[2]Other MOAs approved in MM include anti-SLAMF7 mAbs and XPO1 inhibitors and potential future treatment options include FcRH5 bispecific T-cell engagers, BCL-2 inhibitors, and others.
Sources: NCI SEER, NCCN guidelines, consulting engagements with Health Advances and Clearview.
B-cell maturation antigen (BCMA); G protein-coupled receptor, class C, group 5, member D (GPRC5D); monoclonal antibodies (mAbs); mechanism of action (MOA)

Cemsidomide + Dexamethasone Dose Escalation Trial in MM Continues to Progress; Have Not Exceeded the Maximum Tolerated Dose

KEY INCLUSION CRITERIA

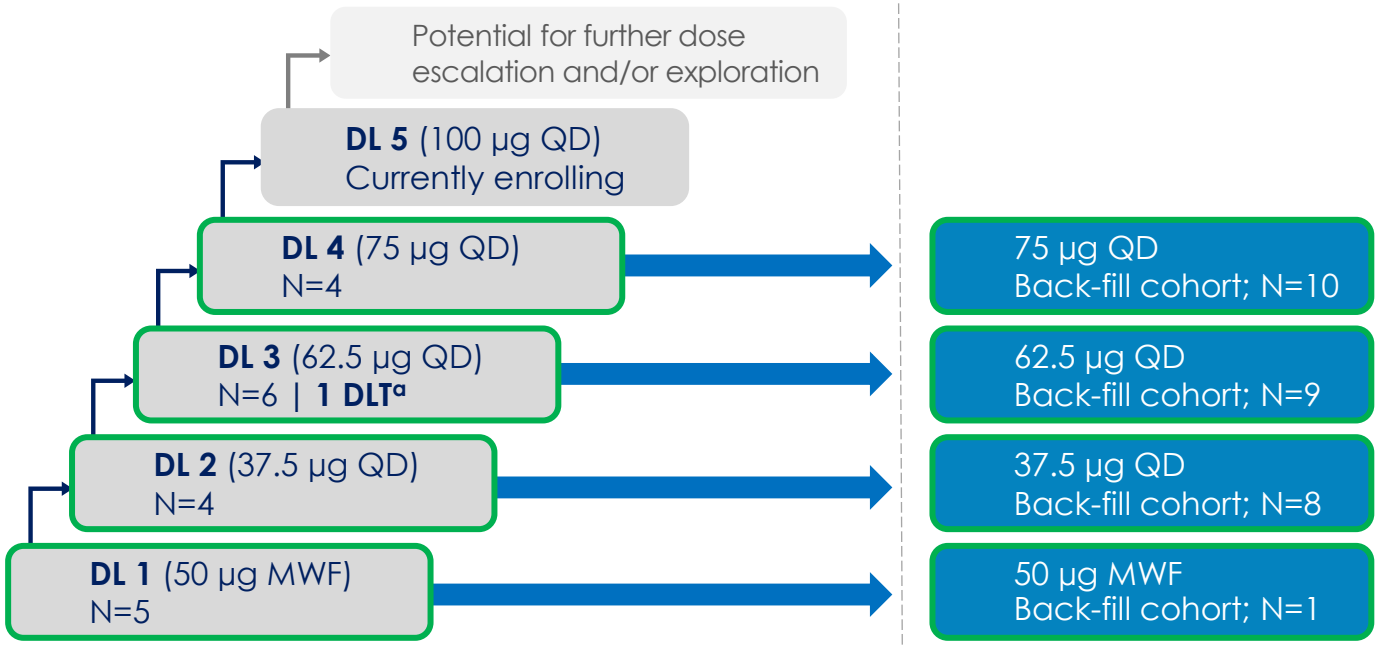
- Adults with MM, R/R to at least 3 prior lines of therapy that have included lenalidomide, pomalidomide, a proteasome inhibitor, a glucocorticoid, and an anti-CD38 monoclonal antibody
- Nonresponsive to or progressed within 60 days of prior therapy
- Creatinine clearance ≥40 mL/min
- ECOG ≤2

Phase 1 Study Endpoints

- **Primary:** assess safety, tolerability and define the RP2D/MTD
- **Secondary:** assess PK, PD, and preliminary anti-tumor activity

DOSE ESCALATION
CEMSIDOMIDE 14/14 + DEX*

Utilizing a Bayesian logistic regression model until determination of the MTD and/or RP2D



*Cemsidomide administered as 14 days on/14 days off in a 28-day cycle; Dex was dosed on days 1, 8, 15, and 22 at doses of 40 mg orally for patients ≤75 years old and 20 mg orally for patients >75 years old; 2 patients at 100 µg are excluded as they had not completed Cycle 1 as of the data cut off date.

[a]DLT at 62.5 µg QD was due to Grade 4 neutropenia lasting >7 days.

Eastern Cooperative Oncology Group (ECOG); maximum tolerated dose (MTD); Monday Wednesday Friday (MWF); multiple myeloma (MM); once daily (QD); pharmacodynamics (PD); pharmacokinetic (PK); recommended Phase 2 dose (RP2D); relapsed refractory (R/R)

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Data cutoff: 10/11/24

Heavily Pre-Treated Patient Population With Majority Having Received Prior CAR-T, BCMA, or T-Cell Engager Therapy

Baseline Characteristics

Characteristics	Safety Population (N=47)
Age, median (range)	67 (39-82 years)
Male, n (%)	25 (53)
Years since initial diagnosis, median (range)	7 (2-18)
ECOG performance status, n (%) 0 1 2	 10 (21) 34 (72) 3 (7)
Black or African American, n (%) **White, n (%)** **Other, n (%)**	9 (19) 33 (70) 5 (11)
Revised ISS at screening, n (%) Stage 1 Stage 2 Stage 3 Missing	 21 (45) 15 (32) 5 (11) 6 (13)
Presence of EMD, n (%)	14 (30)

Prior Therapies

Characteristics	Safety Population (N=47)
Prior therapies, median (range)	6 (3-22)
Prior lenalidomide, n (%)	47 (100)
Prior pomalidomide, n (%)	46 (98)
Prior anti-CD38 mAb, n (%)	47 (100)
Prior CAR-T therapy, n (%)	19 (40)
Prior TCE therapy, n (%)	21 (45)
Prior CAR-T or TCE therapy, n (%)	31 (66)
Prior CAR-T and TCE therapy, n (%)	9 (19)
Prior BCMA therapy, n (%)	33 (70)
Triple-class exposed*, n (%)	47 (100)
Penta-class exposed†, n (%)	40 (85)

*Defined as exposed to ≥1 immunomodulatory agent, ≥1 proteasome inhibitor, and 1 anti-CD38 monoclonal antibody.
†Defined as exposed to ≥2 immunomodulatory agents, ≥2 proteasome inhibitors, and 1 anti-CD38 monoclonal antibody.
B-cell maturation antigen (BCMA); Eastern Cooperative Oncology Group (ECOG); extramedullary disease (EMD); International Staging System (ISS); monoclonal antibody (mAb); T-cell engager (TCE)

Data cutoff: 10/11/24

Cemsidomide Was Well-Tolerated With Manageable Neutropenia and No Treatment Emergent Adverse Events Lead to Dose Reductions

- **1 DLT** (Grade 4 neutropenia lasting >7 days at the 62.5 µg dose level)
- **No TEAEs lead to dose reductions**
- **TEAEs leading to dose interruption: 32%** (15/47)
- **TEAEs leading to discontinuation[1]: 4%** (2/47)

Common (>20% All Grades) TEAEs and Events of Interest, n (%)	All Grades (N=47)	Grade 3 (N=47)	Grade 4 (N= 47)	Grade 5 (N=47)
Neutropenia	22 (47)	6 (13)	12 (26)	0
Infections	18 (38)	7 (15)	0	1 (2)
Pneumonia	5 (11)	5 (11)	0	0
Upper respiratory tract infection	7 (15)	1 (2)	0	0
Septic shock	1 (2)	0	0	1 (2)
Anemia	17 (36)	10 (21)	0	0
Fatigue	14 (30)	0	0	0
Thrombocytopenia	10 (21)	3 (6)	2 (4)	0
Diarrhea	10 (21)	0	0	0
Lymphopenia	9 (19)	6 (13)	0	0
Febrile neutropenia	3 (6)	3 (6)	0	0

2 patients experienced Grade 5 AEs (septic shock and subdural hematoma), both deemed unrelated to cemsidomide

[1]Primary reason of discontinuation of patient at 37.5 µg was due to withdrawal of consent; primary reason of discontinuation of patient at 75 µg was due to death unrelated to cemsidomide.
Adverse events (AEs); dose limiting toxicity (DLT); treatment emergent adverse events (TEAEs)

C4 Therapeutics

Data cutoff: 10/11/24

Grade ≥3 Neutropenia, Febrile Neutropenia and Infections Were Infrequent and Rates Did Not Increase With Higher Cemsidomide Doses

Common Hematologic and Infection Grade ≥3 TEAEs, n (%)	50 µg MWF (N=6)	37.5 µg QD (N=12)	62.5 µg QD (N=15)	75 µg QD (N=14)	Total (N=47)
Neutropenia	2 (33)	6 (50)	6 (40)	4 (29)	18 (38)
Anemia	1 (17)	3 (25)	3 (20)	3 (21)	10 (21)
Infections	0	4 (33)	1 (7)	3 (21)	8 (17)
Upper respiratory tract infection	0	0	0	1 (7)	1 (2)
Pneumonia	0	3 (25)	1 (7)	1 (7)	5 (11)
Septic shock	0	0	0	1 (7)	1 (2)
Thrombocytopenia	2 (33)	1 (8)	1 (7)	1 (7)	5 (11)
Lymphopenia	0	4 (33)	2 (13)	0	6 (13)
Febrile neutropenia	1 (17)	2 (17)	0	0	3 (6)

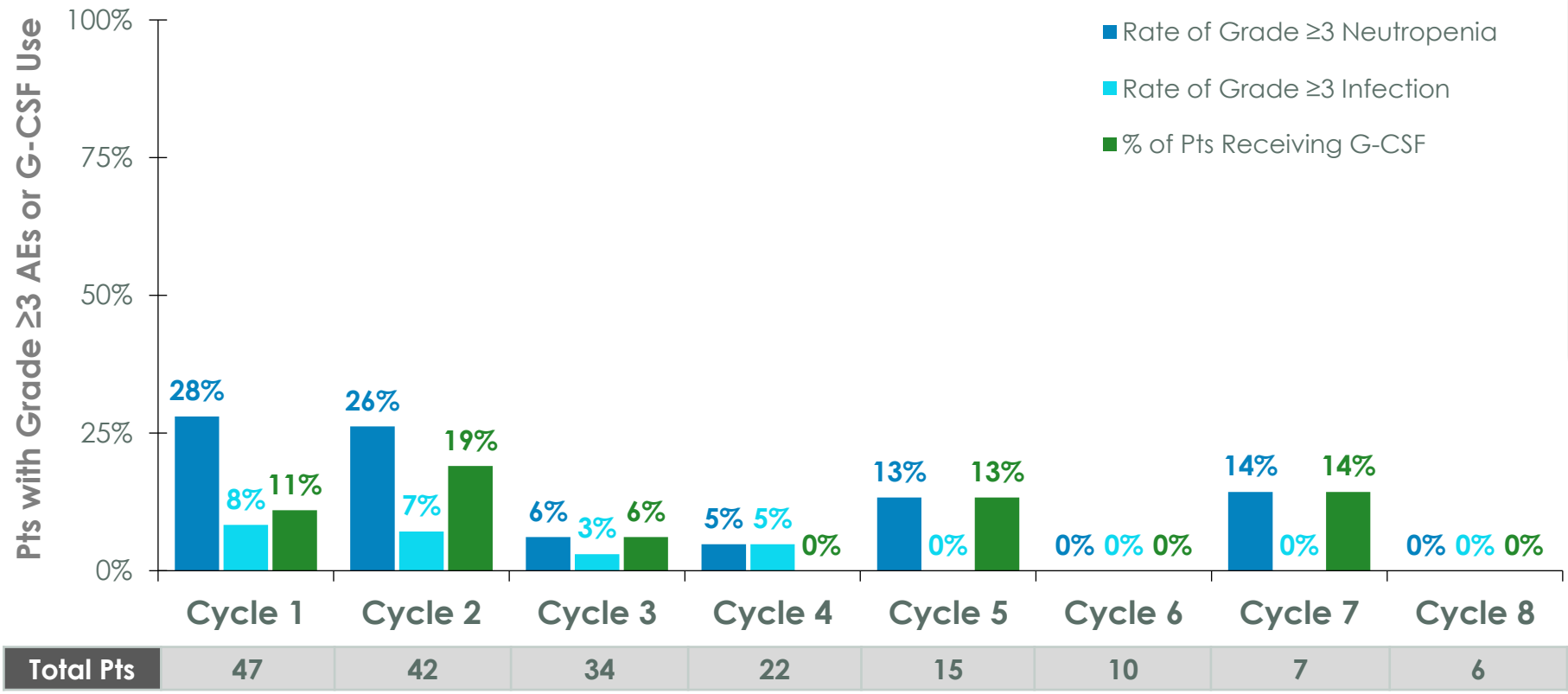
Once daily (QD); Monday Wednesday Friday (MWF); treatment emergent adverse events (TEAEs)

C4 Therapeutics

Data cutoff: 10/11/24

Compelling Cemsidomide Safety Profile With Low Rates of Neutropenia and Infections With Limited G-CSF Use

Rates of Neutropenia, Infections, and G-CSF Use by Cycle



Total Pts	47	42	34	22	15	10	7	6

- **Only 26% (12/47) of pts received G-CSF** across the study
- **Only one patient experienced Grade ≥3 neutropenia for the first time after completing cycle 2**

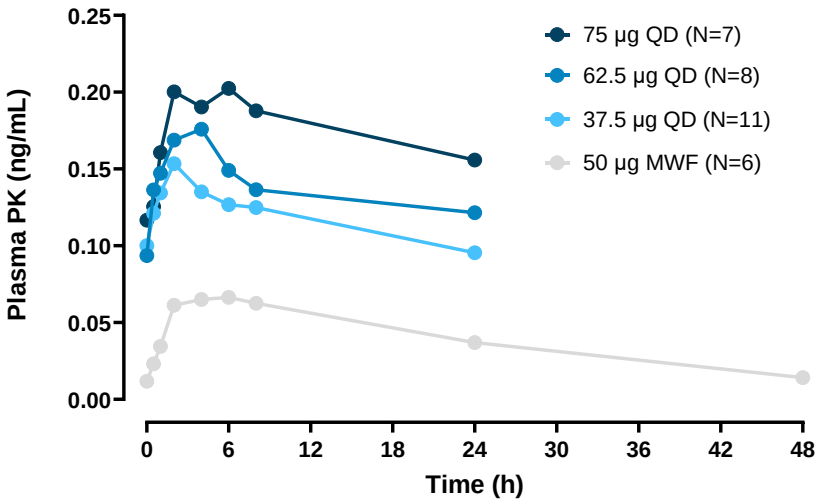
Notes: No cases of Grade ≥3 neutropenia were recorded after Cycle 7. One patient experienced a Grade ≥3 infection in a Cycle >8. G-CSF use was not permitted during Cycle 1 in escalation cohorts. One patient in the 50 µg MWF cohort came off study during Cycle 1 and received G-CSF after treatment was discontinued. No patients received G-CSF after Cycle 7.
The same patients that experienced neutropenia at Cycle 5 and Cycle 7, also received G-CSF.
Adverse events (AEs); granulocyte colony-stimulating factor (G-CSF); patients (PTs)

C4 Therapeutics

Data cutoff: 10/11/24

Across Doses, 40% (14/35) of Multiple Myeloma Patients With Elevated Light Chains Demonstrated at Least a 50% Decrease in dFLC

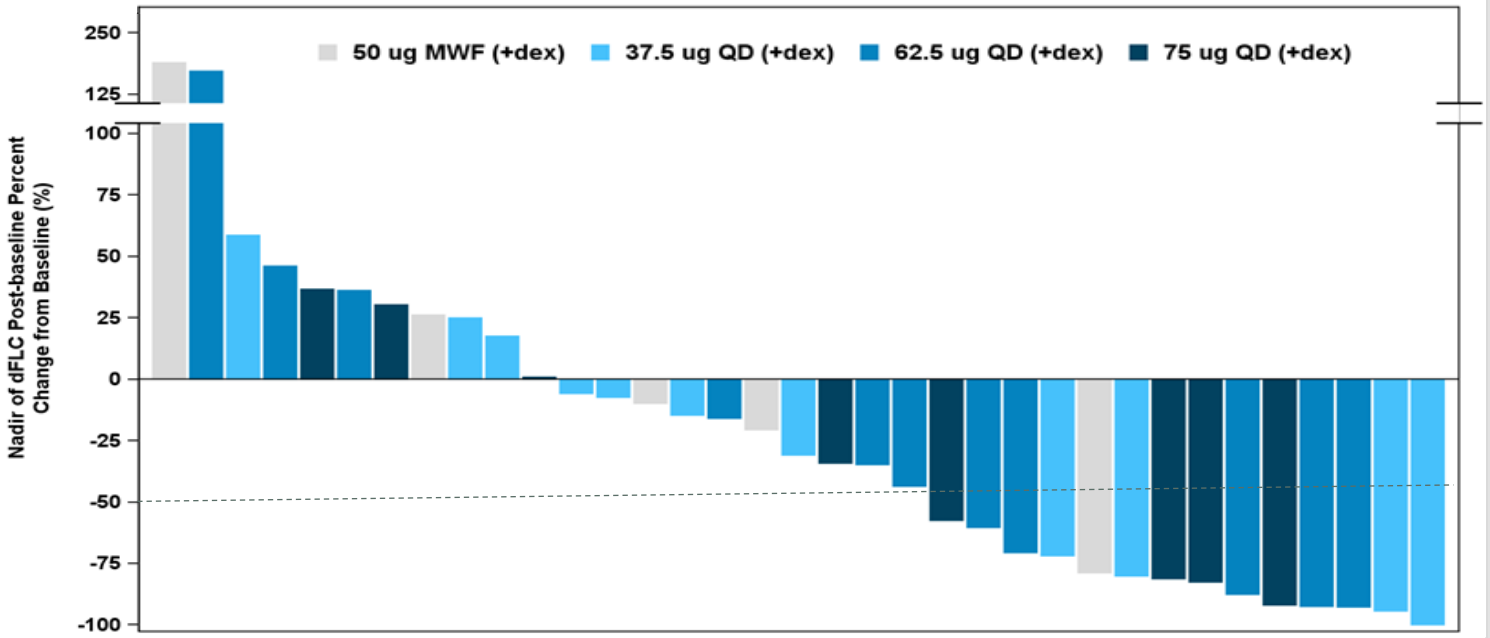
Dose Proportional Exposure



- Overall geometric mean half-life estimate is approximately 2 days

Best Change in dFLC from Baseline (Cemsidomide + Dex)

*Multiple Myeloma Patients w/ Elevated Light Chain Disease (N=35)**



- **69% (24/35)** of patients with elevated light chain disease demonstrated a **decrease in dFLC**

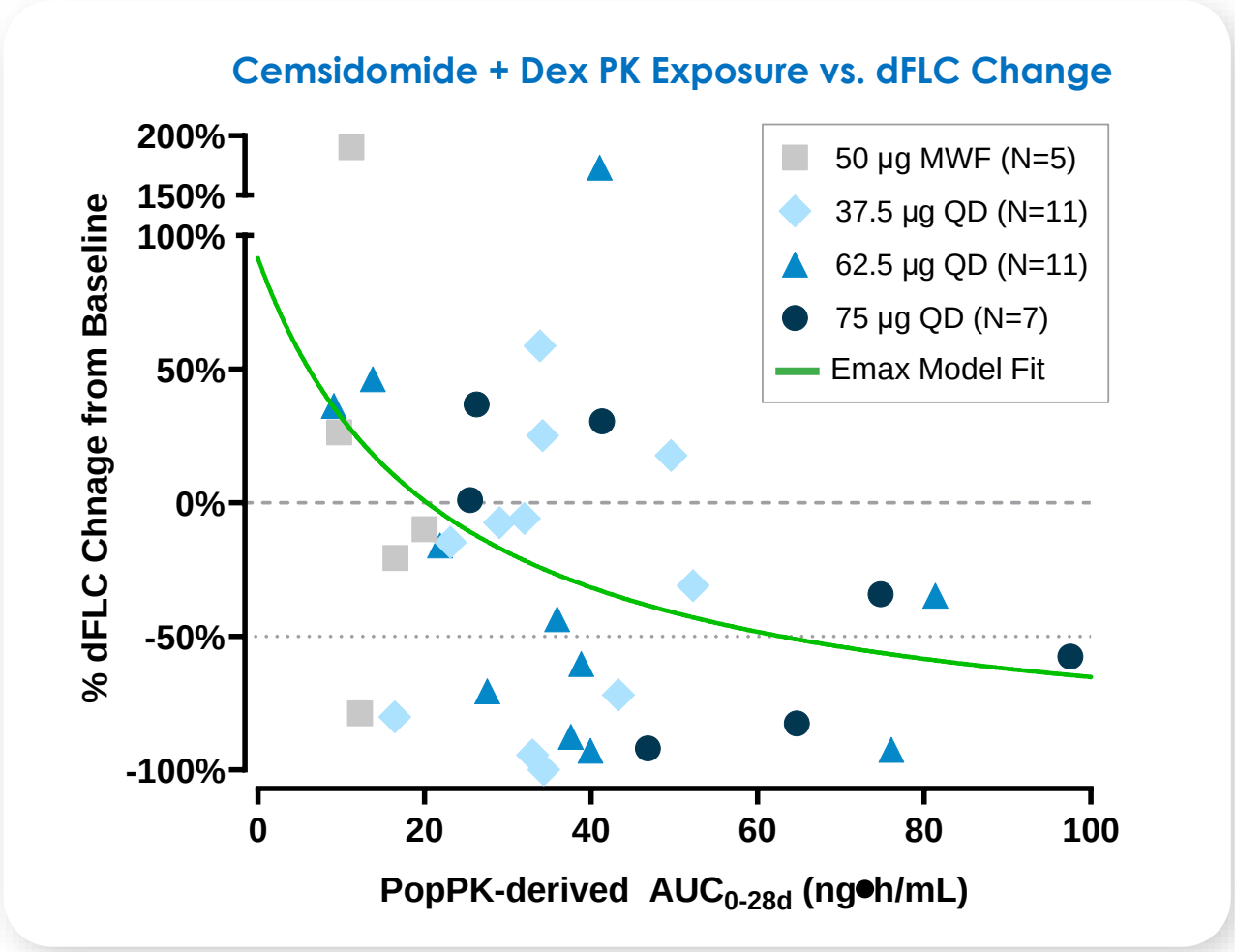
*Only included treated patients who meet both criterion (A) and (B). (A) baseline kappa free light chain value >19.4 mg/L or baseline lambda free light chain value >26.3 mg/L. (B) ratio of baseline free light chain kappa over baseline free light chain value lambda >4:1 or <1:2.

Difference in involved and uninvolved free light chain (dFLC); once daily (QD); Monday Wednesday Friday (MWF); multiple myeloma (MM); pharmacokinetic (PK)

C4 Therapeutics

Data cutoff: 10/11/24

Cemsidomide 75 µg Dose Level or Greater Drives Sufficient Exposure Resulting in Meaningful Reductions in Light Chains



Exposure (AUC) Quartiles

	<Q1 (N=9)	Q1-Q2 (N=8)	Q2-Q3 (N=8)	>Q3 (N=9)
Mean $AUC_{0\text{-}28d}$ (ng*h/mL)	14.6	28.8	37.9	**65.2**
Mean Change in dFLC from Baseline	+10%	-12%	-20%	**-53%**
Cemsidomide + Dex Dose	**~17 µg** QD	**~35 µg** QD	**~45 µg** QD	**~78 µg** QD

N=34 with abnormal baseline sFLC defined as (A) kappa FLC >19.4 mg/L or lambda FLC >26.3 mg/L and (B) kappa-to-lambda FLC ratio >4 or <0.5.
Cemsidomide dose was back-calculated based on the population PK model.
Area under the curve (AUC); difference in involved and uninvolved free light chain (dFLC); maximum response (Emax); Monday Wednesday Friday (MWF); once daily (QD); population pharmacokinetics (popPK); pharmacokinetic (PK)

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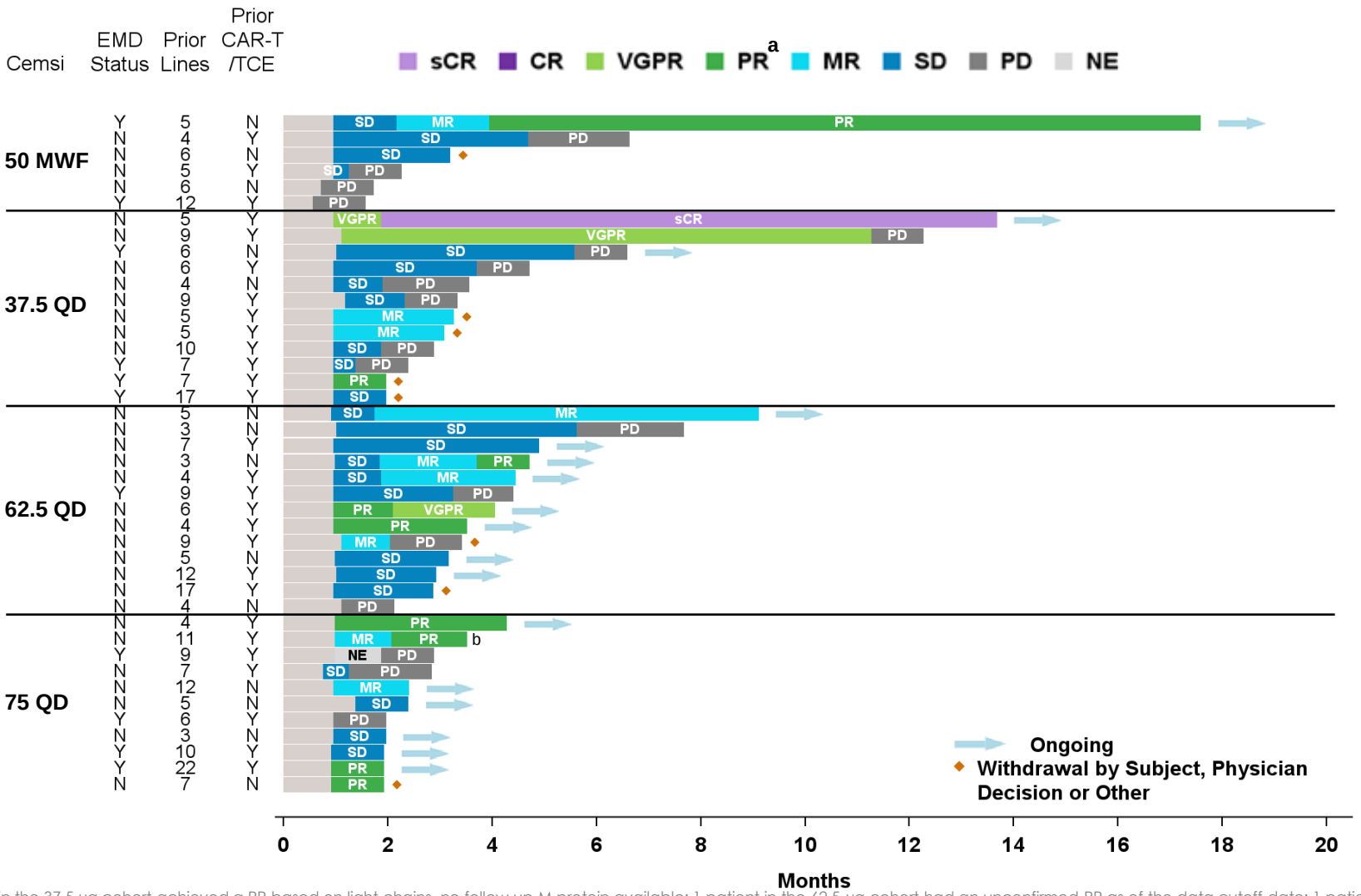
Data cutoff: 10/11/24

Cemsidomide Demonstrated Anti-Myeloma Activity Across Dose Levels



As of the data cutoff:

- **26% ORR** and **40% clinical benefit rate across all dose levels** evaluated
- At the two highest dose levels evaluated to date (62.5 µg and 75 µg), **62% of all patients remain on treatment**[1]

[a]1 patient in the 37.5 µg cohort achieved a PR based on light chains, no follow up M protein available; 1 patient in the 62.5 µg cohort had an unconfirmed PR as of the data cutoff date; 1 patient in the 75 µg cohort had an unconfirmed PR as of the data cutoff date.
[b]Patient came off study due to unrelated death. [1] Includes all 47 patients, including only safety evaluable patients.
Complete response (CR); minimal response (MR); Monday Wednesday Friday (MWF); non-evaluable (NE); once daily (QD); partial response (PR); progressive disease (PD); stable disease (SD); stringent complete response (sCR); T-cell-engaging antibodies (TCE); very good partial response (VGPR); Clinical Benefit Rate (≥ MR) (CBR)

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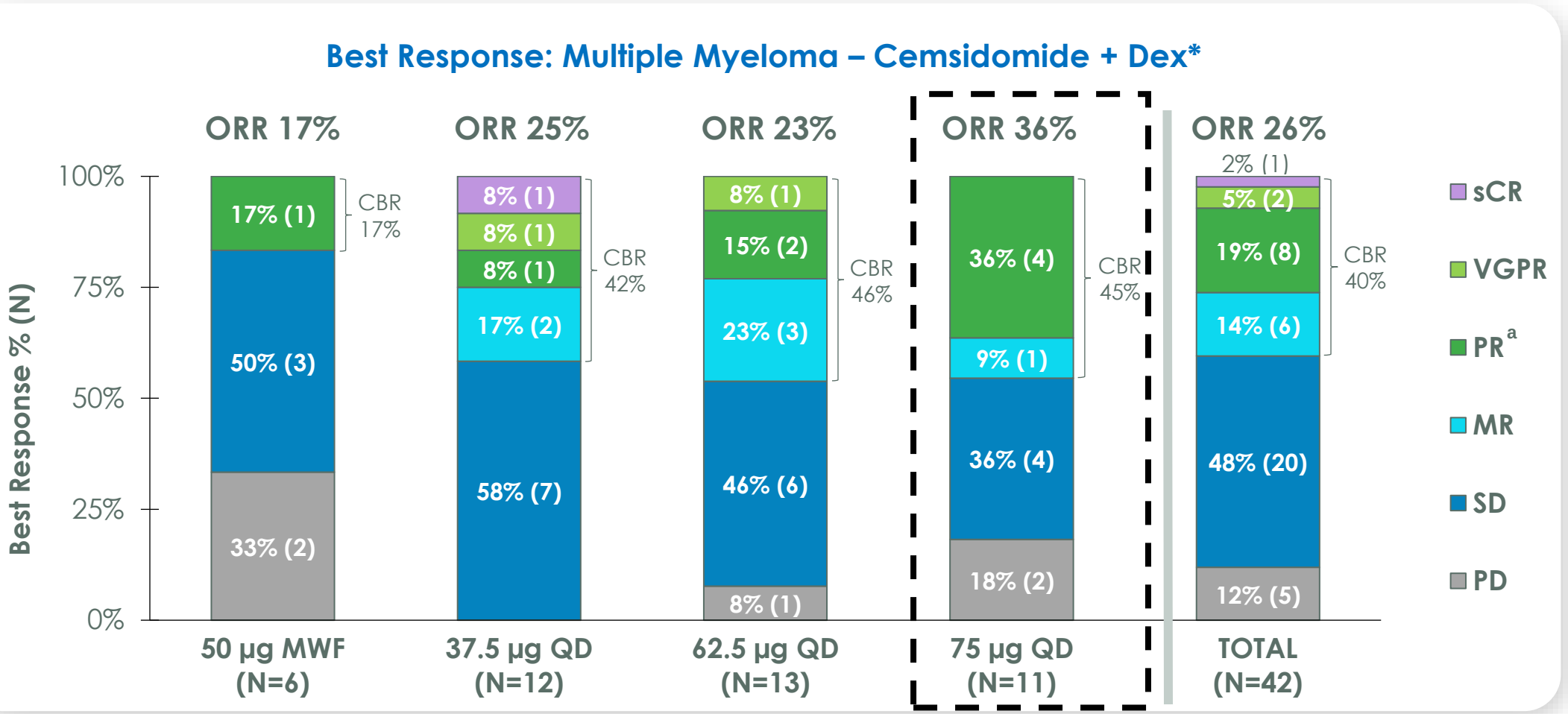
Data cutoff: 10/11/24

75 µg Cemsidomide Dose Level Resulted in Compelling Anti-Myeloma Activity With a 36% ORR and 45% CBR



*Investigator assessed response

[a]1 patient in the 37.5 µg cohort achieved a PR based on light chains, no follow up M protein available; 1 patient in the 62.5 µg cohort had an unconfirmed PR as of the data cutoff date; 1 patient in the 75 µg cohort had an unconfirmed PR as of the data cutoff date.

Minimal response (MR); Monday Wednesday Friday (MWF); once daily (QD); partial response (PR); progressive disease (PD); stable disease (SD); stringent complete response (sCR); very good partial response (VGPR)

Overall Response Rate (≥ PR) (ORR); Clinical Benefit Rate (≥ MR) (CBR)

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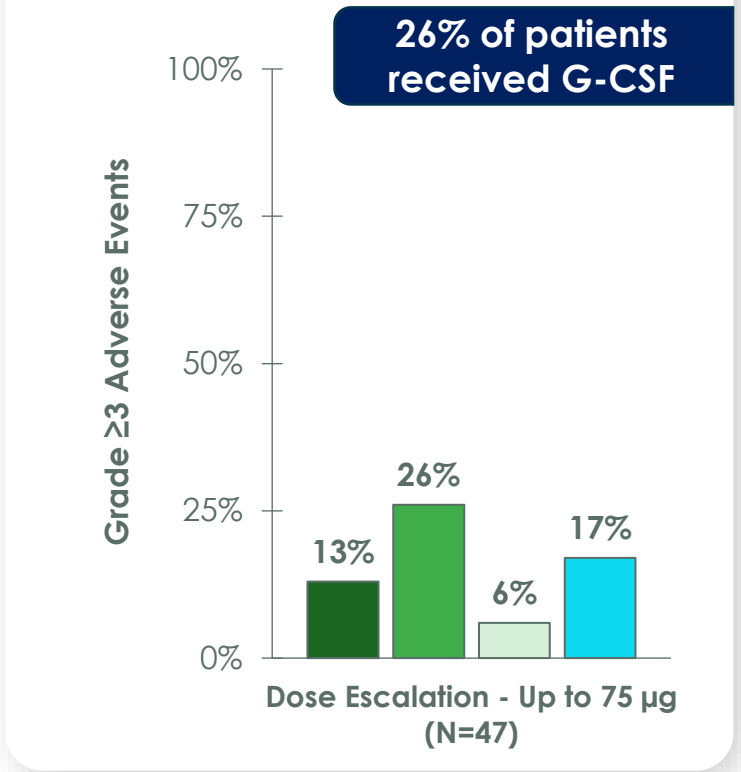
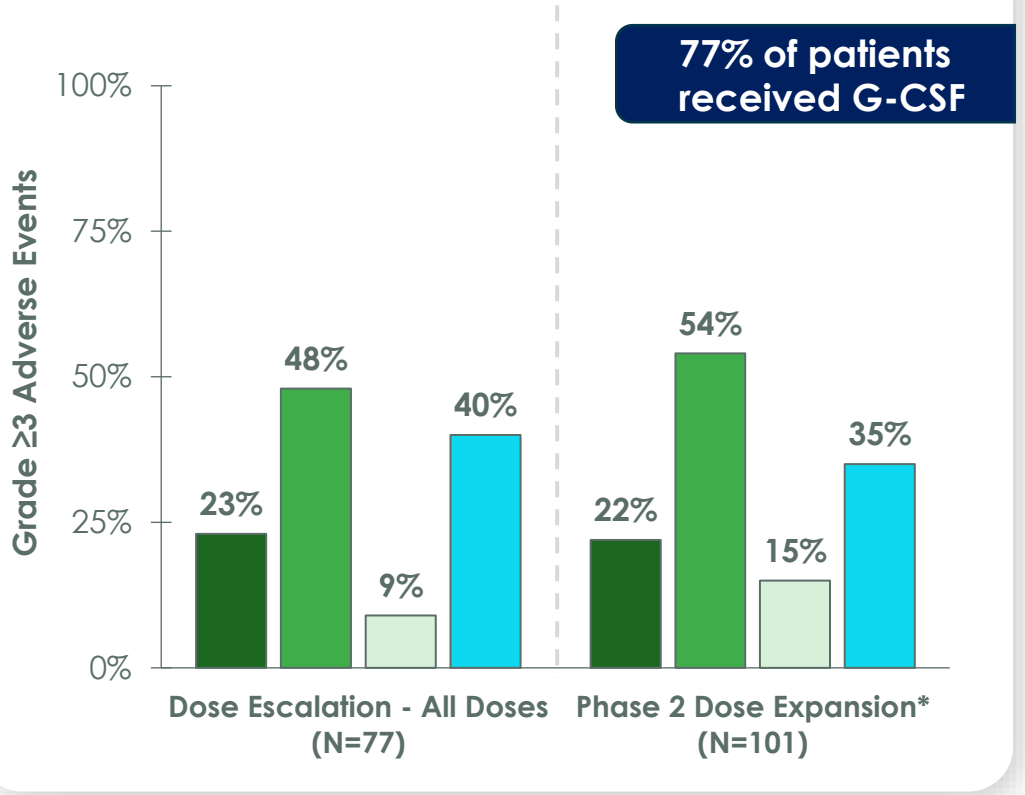
Data cutoff: 10/11/24

Cemsidomide's Differentiated Safety Profile Is Well Suited for Combination Studies, Potentially Resulting in Fewer Disruptive Adverse Events

Cemsidomide + Dex
Key Grade ≥3 Adverse Events



Mezigdomide + Dex[1]
Key Grade ≥3 Adverse Events



Cross trial comparisons only to be used as benchmarks for relative comparison

[1]Richardson 2023 NEJM.
*Mezigdomide recommended Phase 2 dose expansion dose was 1.0 mg daily dosing (QD) 21 days on/7 days off.
Note: All cases of febrile neutropenia in the cemsidomide trial were Grade 3. In the mezigdomide dose escalation and expansion cohorts, febrile neutropenia splits between Grade 3/4 were 5%/4% and 13%/2% ,respectively.

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Data cutoff: 10/11/24

Cemsidomide Has the Potential to Be a Backbone Therapy of Choice Where IKZF1/3 Degradation Is Warranted

Cemsidomide + dex demonstrated compelling anti-myeloma activity across a broad range of doses, highlighting a wide therapeutic range

- 36% ORR at the highest dose level evaluated to date (75 µg QD)
- 26% ORR across all dose levels

Cemsidomide + dex was well-tolerated with a compelling safety profile

- 38% of patients experienced Grade 3/4 neutropenia, which was manageable, and no cases resulted in cemsidomide discontinuation

75 µg is a target dose for various + dex regimens with potential for higher doses to also be considered for development as dose escalation continues

- For immune-based combination strategies, doses lower than 75 µg are optimal based on anti-myeloma activity and immune activation observed in the monotherapy data set[1]

Cemsidomide is well suited for further development across treatment lines and in combination with other anti-myeloma agents

[1]Monotherapy cemsidomide dataset in multiple myeloma was presented in December 2023
Once daily (QD); overall response rate (ORR)

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Data cutoff: 10/11/24

Cemsidomide's Profile Supports Development Across Multiple Lines of Treatment in MM, Estimated to Be ~$42B Market Opportunity by 2030[1]

INITIAL COMBINATION TRIALS:

Prior Lines of Therapy	*Trial Design*
1 – 3	**Cemsidomide + BCMA bispecific[2]** - Safety dose escalation followed by Phase 2 expansion
2 – 4 (Post anti-BCMA therapy)	**Cemsidomide + anti-CD38[3] + dex** - Safety dose escalation followed by Phase 2 expansion

Additional Combinations
(not exhaustive):

- **Proteasome inhibitors** (bortezomib, carfilzomib, ixazomib)
- **GPRC5D bispecifics** (talquetamab, RG6234)
- **BCMA ADC** (bela-maf)
- **FcRH5 bispecific** (cevostamab)
- **Anti-SLAMF7** (elotuzumab)
- **XPO1 inhibitor** (selinexor)
- **CAR-T maintenance**

NEXT STEPS:

- **Complete Phase 1 dose escalation trial** in multiple myeloma to establish go forward doses
- **Initiate initial combination trials**
- **Engage regulatory authorities** on registrational path

[1]Source: Evaluate Pharma - Multiple myeloma market opportunity
[2]Could choose from approved BCMA bispecifics teclistamab or eltranatamab. Also other BCMA bispecifics in development (e.g., linvoseltamab).
[3]Could choose from approved anti-CD38 antibodies daratumumab or isatuximab.
Antibody-drug conjugates (ADC); B-cell maturation antigen (BCMA); maximum tolerated dose (MTD); multiple myeloma (MM)

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Non-Hodgkin's Lymphoma (NHL)

Monotherapy Cemsidomide

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Cemsidomide Has the Potential to Be Developed Across NHL Subtypes and Lines of Treatment

	B-Cell Lymphomas				T-Cell Lymphomas
	DLBCL Diffuse Large B-Cell Lymphoma	**FL** Follicular Lymphoma	**MZL** Marginal Zone Lymphoma	**MCL** Mantle Cell Lymphoma	**PTCL Subtypes** Peripheral T-Cell Lymphoma
U.S. Annual Incidence (2023)[1]	~26,000	~15,000	~5,000	~4,000	~5,000
Lenalidomide FDA Approved[2]	✓	✓	✓	✓	
Lenalidomide in NCCN Guidelines	✓	✓	✓	✓	✓

Cemsidomide Opportunity

- IKZF1/3 degraders (e.g., lenalidomide) are widely used across NHL subtypes
- Cemsidomide has the potential to be developed as a **monotherapy in the R/R setting** and in **combination with frontline standard of care regimens**

[1]SEER, American Cancer Society, Lymphoma Research Foundation.
[2]FL, MZL, and MCL FDA approved in the Revlimid (lenalidomide) label and DLBCL approved in the Monjuvi (tafasitamab) label.
U.S. Food and Drug Administration (FDA); National Comprehensive Cancer Network (NCCN); non-Hodgkin's lymphoma (NHL); relapsed refractory (R/R)

C4 Therapeutics

Dose Exploration Continues for the Cemsidomide Monotherapy Dose Escalation Trial in R/R NHL

KEY INCLUSION CRITERIA

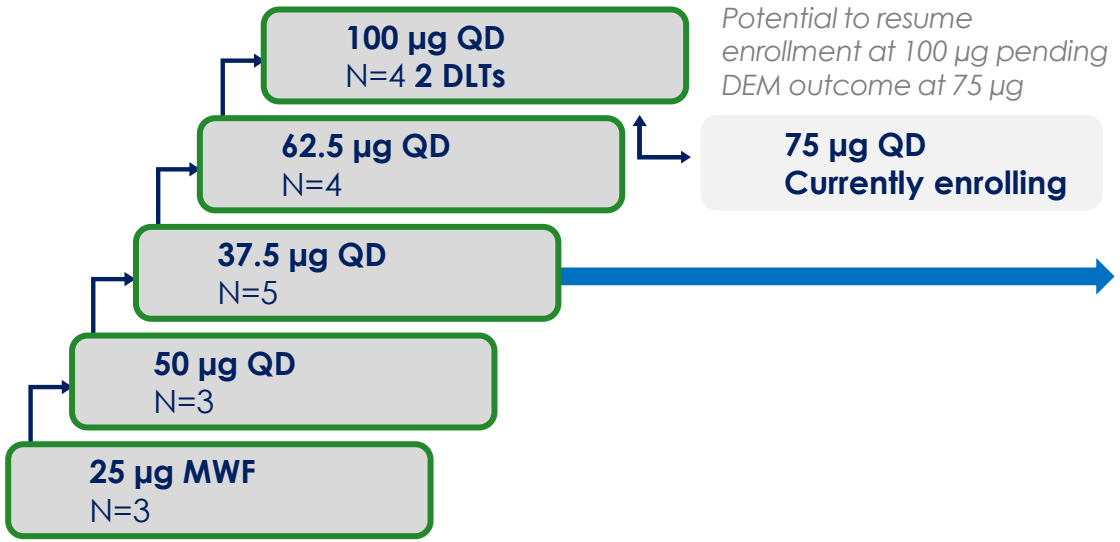
- Adults with NHL, R/R to prior therapy
  - PTCL patients must have received at least 1 prior alkylator-based chemotherapy
  - ALCL patients must have also received a CD-30 mAb
- Nonresponsive to or progressed within 60 days of prior therapy
- Creatinine clearance ≥40 mL/min
- ECOG ≤2

Phase 1 Study Endpoints

- **Primary:** assess safety, tolerability and define the RP2D/MTD
- **Secondary**: assess PK, PD, and preliminary anti-tumor activity

DOSE ESCALATION CEMSIDOMIDE 14/14

Utilizing a Bayesian logistic regression model until determination of the MTD and/or RP2D



BACK-FILL COHORT(S)

37.5 µg QD
Back-fill cohort; N=4

PHASE 2

Phase 2 Expansion

Anaplastic large cell lymphoma (ALCL); dose escalation meeting (DEM); dose limiting toxicities (DLT); Eastern Cooperative Oncology Group (ECOG); monoclonal antibody (mAb); maximum tolerated dose (MTD); Monday Wednesday Friday (MWF); non-Hodgkin's lymphoma (NHL); once daily (QD); pharmacodynamic (PD); pharmacokinetic (PK); peripheral T-cell lymphoma (PTCL); recommended Phase 2 dose (RP2D); relapsed refractory (R/R)

C4 Therapeutics

Data cutoff date: 10/11/2024

Heavily Pre-Treated Population Where Majority of Patients Were Diagnosed With PTCL, Reflecting High Unmet Need

Characteristics	Safety Population (N=23)
Age, median (range)	68 (28-85 years)
Male, n (%)	14 (61)
Years since initial diagnosis, median (range)	2 (0.4-21)
ECOG performance status, n (%)	
0	11 (48)
1	9 (39)
2	2 (9)
Missing	1 (4)
Black or African American, n (%)	6 (26)
White, n (%)	13 (57)
Other, n (%)	4 (17)
IPI at screening, n (%)	
1	2 (9)
2	6 (26)
3	7 (30)
4	3 (13)
Missing	5 (22)

Characteristics	Safety Population (N=23)
Prior therapies, median (range)	3 (1-14)
1	2 (9)
2	7 (30)
3	3 (13)
≥4	11 (48)
PTCL, n (%)	17 (74)
PTCL-NOS	5 (22)
AITL	4 (17)
ALCL	3 (13)
ATLL	5 (22)
B-cell lymphoma, n (%)	6 (26)
DLBCL	4 (17)
MCL	1 (4)
MZL/MALT	1 (4)
Prior CAR-T therapy, n (%)	4 (17)
Prior HCT, n (%)	4 (17)
Autologous	3 (13)
Allogenic	1(4)

Angioimmunoblastic T-cell lymphoma (AITL); anaplastic large cell lymphoma (ALCL); adult T-cell leukemia/lymphoma (ATLL); diffuse large B-Cell lymphoma (DLBCL); Eastern cooperative oncology group (ECOG); hematopoietic cell transplantation (HCT); International Prognostic Index (IPI); mantle cell lymphoma (MCL); marginal zone lymphoma/mucosa-assisted lymphoid tissue (MZL/MALT); peripheral T-cell lymphoma (PTCL); PTCL-not otherwise specified (PTCL-NOS)

C4 Therapeutics

Data cutoff: 10/11/24

Cemsidomide Was Well-tolerated With Manageable Incidents of On-target Neutropenia

- **2 DLTs occurred at 100 µg QD** (Grade 4 thrombocytopenia and Grade 3 febrile neutropenia)
- **TEAEs leading to discontinuation: 9%** (2/23)
- **39% (9/23) of patients received G-CSF**
  - 3 of 9 patients received G-CSF in Cycle 1

Common (>20% All Grades) TEAEs and Events of Interest*, n (%)	All Grade (N=23)	Grade 3 (N=23)	Grade 4 (N=23)
Infections	15 (65)	4 (17)	2 (9)
Upper respiratory tract infection	4 (17)	0	0
Sepsis	1(4)	0	1 (4)
Bacteremia	1(4)	0	1 (4)
Pneumonia	2 (9)	2 (9)	0
Neutropenia	11 (48)	4 (17)	7 (30)
Fatigue	11 (48)	1 (4)	0
Cough	7 (30)	0	0
Anemia	6 (26)	4 (17)	0
Peripheral edema	5 (22)	0	0
Febrile neutropenia*	4 (17)	4 (17)	0
Thrombocytopenia*	4 (17)	1 (4)	2 (9)
Maculopapular rash*	3 (13)	2 (9)	0

One patient experienced a Grade 5 AE (hip fracture resulting in transfer to hospice)

*Events of Interest
Adverse event (AE); dose limiting toxicities (DLTs); granulocyte colony-stimulating factor (G-CSF); once daily (QD); treatment emergent adverse events (TEAEs)

C4 Therapeutics

Data cutoff: 10/11/24

Cemsidomide Monotherapy Adverse Events by Dose Level

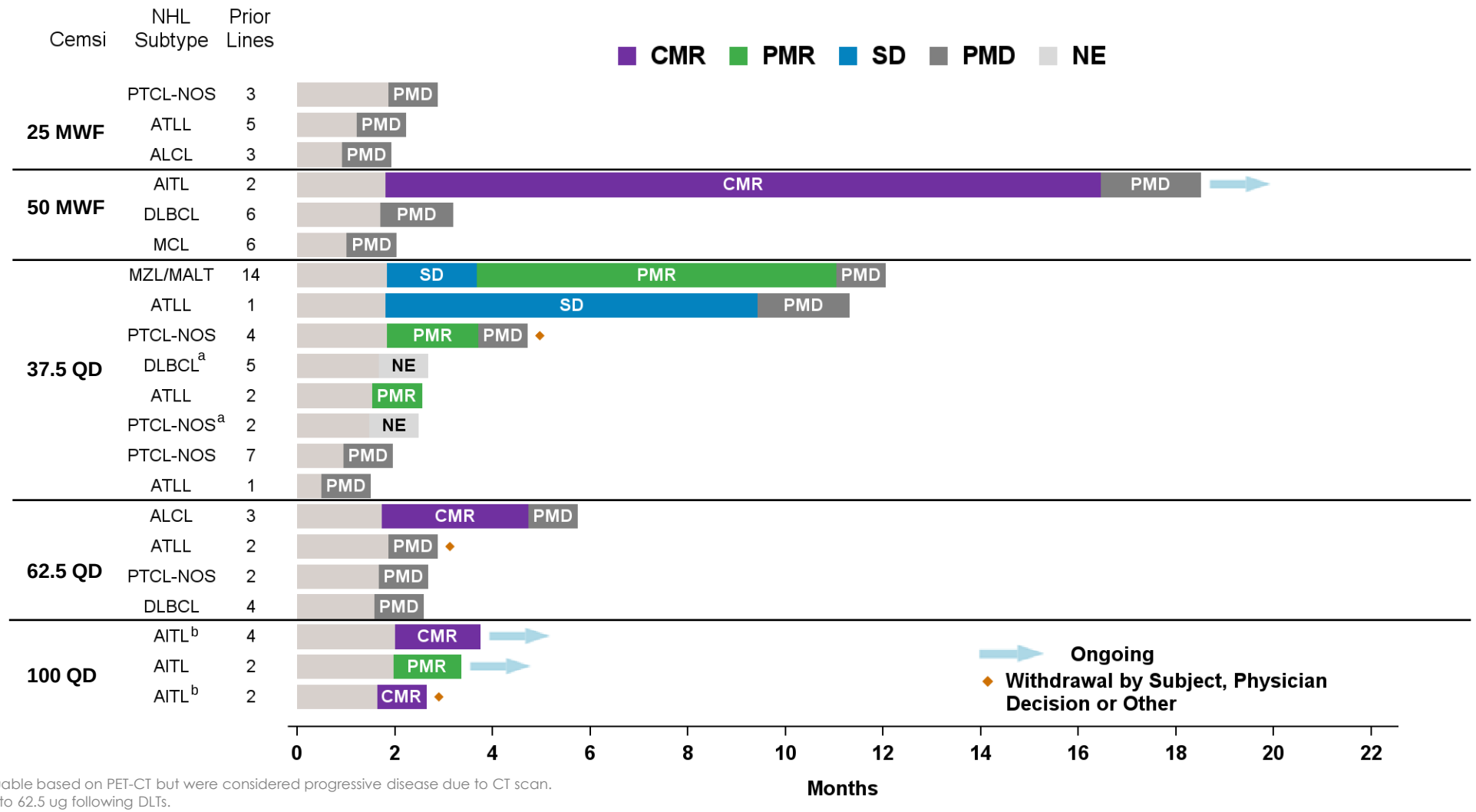
Common Grade ≥3 TEAEs, n (%)	25 µg MWF (N=3)	50 µg MWF (N=3)	37.5 µg QD (N=9)	62.5 µg QD (N=4)	100 µg QD (N=4)	Total (N=23)
Neutropenia	0	0	5 (56)	4 (100)	2 (50)	11 (48)
Infections	0	0	3 (33)	0	3 (75)	6 (26)
Pneumonia	0	0	1 (11)	0	1 (25)	2 (9)
Sepsis	0	0	1 (11)	0	0	1 (4)
Urinary tract infection	0	0	1 (11)	0	0	1 (4)
Bacteremia	0	0	0	0	1 (25)	1 (4)
Skin infection	0	0	0	0	1 (25)	1 (4)
Anemia	0	0	3 (33)	0	1 (25)	4 (17)
Febrile neutropenia	0	0	1 (11)	1 (25)	2 (50)	4 (17)
Thrombocytopenia	0	0	1 (11)	0	2 (50)	3 (13)
Maculopapular rash	0	0	1 (11)	1 (25)	0	2 (9)

Once daily (QD); Monday Wednesday Friday (MWF); Treatment Emergent Adverse Events (TEAEs)

C4 Therapeutics

Data cutoff: 10/11/24

Clinical Responses Were Observed Across a Broad Range of Doses

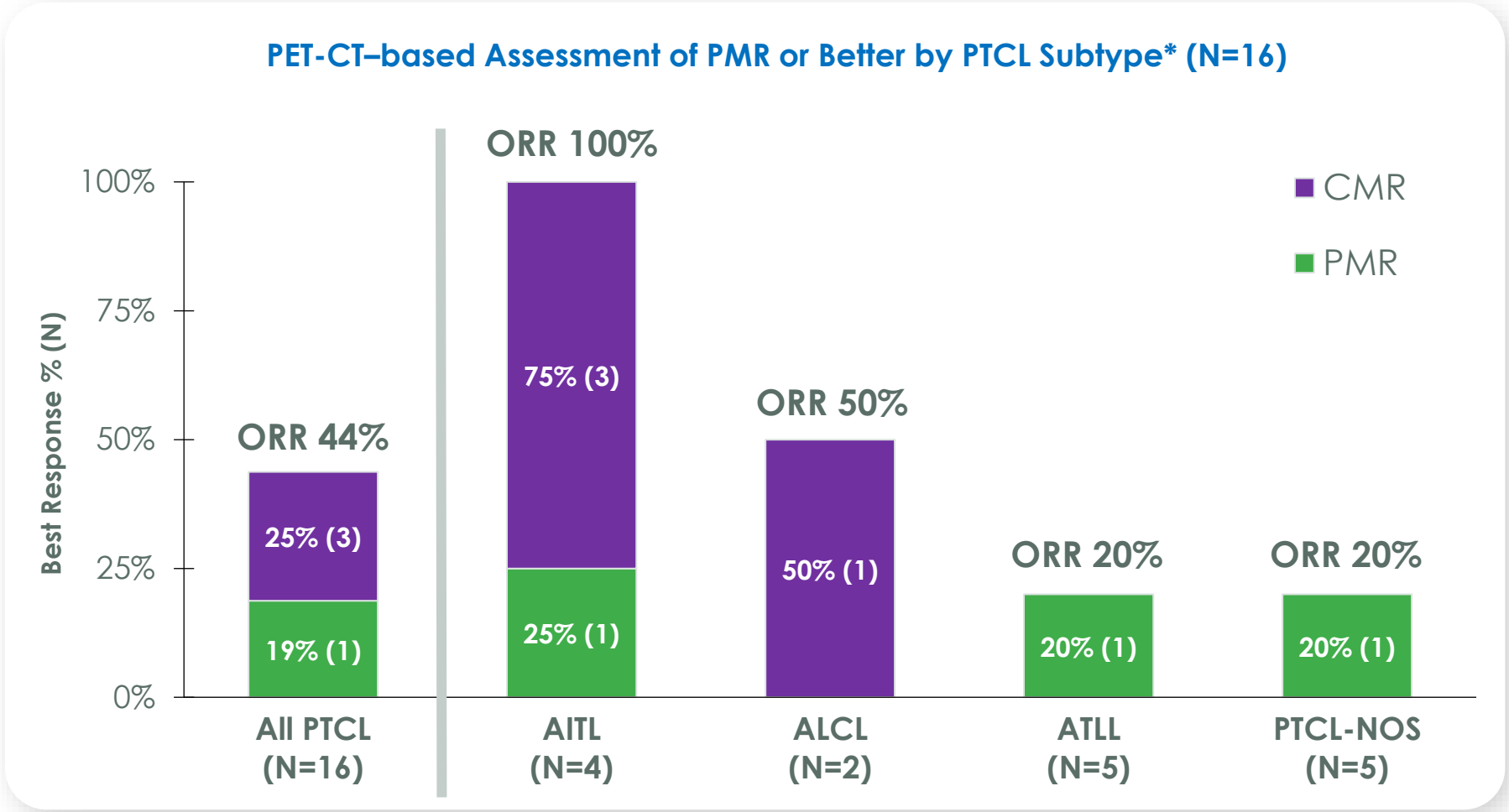


[a] Both patients were not evaluable based on PET-CT but were considered progressive disease due to CT scan.
[b] Both patients dose reduced to 62.5 ug following DLTs.
Anaplastic large cell lymphoma (ALCL); adult T-cell leukemia/lymphoma (ATLL); angioimmunoblastic T-cell lymphoma (AITL); complete metabolic response rate (CMR); diffuse large B-cell lymphoma (DLBCL); mantle cell lymphoma (MCL); marginal zone lymphoma/mucosa-assisted lymphoid tissue (MZL/MALT); Monday Wednesday Friday (MWF); non-evaluable (NE); once daily (QD); overall response rate (ORR); partial metabolic response (PMR); peripheral T-cell lymphoma (PTCL); PTCL-not otherwise specified (PTCL-NOS); progressive metabolic disease (PMD); stable disease (SD)

C4 Therapeutics

Data cutoff: 10/11/24

Compelling and Deep Responses Achieved Across PTCL Subtypes



- Cemsidomide monotherapy **produced responses in all four PTCL subtypes**
- **All AITL patients (4/4)** experienced **a metabolic response**

*Investigator assessed response; 2 patients were evaluated based on CT scan and were PD but not evaluable based on PET-CT, both patients are included as PMD for PET-CT based assessment; 2 additional subjects that came off study prior to follow up scans were not considered efficacy evaluable.
Angioimmunoblastic T-cell lymphoma (AITL); anaplastic large cell lymphoma (ALCL); adult T-cell lymphoma (ATLL); complete metabolic response (CMR); overall response rate (ORR); partial metabolic response (PMR); peripheral T-cell lymphoma (PTCL); peripheral T-cell lymphoma not-otherwise specified (PTCL-NOS)

C4 Therapeutics

Data cutoff: 10/11/24

Cemsidomide Is Well-suited for Further Development in Earlier Lines of Treatment and in Combination

Cemsidomide as a single agent demonstrated compelling anti-lymphoma activity across a broad range of doses in PTCL patients, suggesting a wide therapeutic index

- 44% ORR was observed in PTCL with a 25% CMR rate

Cemsidomide was well-tolerated with additional dose finding ongoing

- 2 DLTs at 100 µg (Grade 4 thrombocytopenia) with enrollment at 75 µg currently ongoing
  - Per BLRM, maximum tolerated dose not yet exceeded
- Grade 3/4 neutropenia cases were manageable with no cases resulting in discontinuation

Profile supports cemsidomide's development as a monotherapy in relapsed refractory settings and potentially in combination in NHL subtypes across treatment lines

Bayesian logistic regression model (BLRM); complete metabolic response (CMR); dose limiting toxicities (DLTs); overall response rate (ORR); peripheral t-cell lymphoma (PTCL)

C4 Therapeutics

Data cutoff: 10/11/24

Cemsidomide Profile Supports Development Across Multiple Lines of Treatment in NHL, Estimated to Be ~$30B Market Opportunity by 2030[1]

NEXT STEPS:

- **Complete Phase 1 dose escalation trial in NHL** and identify go forward dose
- **Initiate expansion cohort** for PTCL
- **Engage regulatory authorities** on registrational path

[1]Source: Evaluate Pharma – NHL Market Opportunity: Non-Hodgkin's lymphoma (NHL); peripheral T-cell lymphoma (PTCL)

C4 Therapeutics

Cemsidomide Is Positioned to Potentially Be a Best-in-Class Therapy in Two Distinct Indications with Opportunities Across Multiple Lines of Therapy

IKZF1/3 is a fundamental target for MM and NHL and data supports cemsidomide as a potential backbone therapy within the evolving treatment landscape

- Well-tolerated with a compelling safety profile
- Compelling anti-tumor activity across a range of dose levels

MM Market Opportunity

Estimated **~$42B** by 2030[1]

NHL Market Opportunity

Estimated **~$30B** by 2030[1]

[1]Source: Evaluate Pharma
Multiple myeloma (MM); non-Hodgkin's lymphoma (NHL)

C4 Therapeutics

Q&A

C4 Therapeutics