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Aleniglipron Topline ACCESS Phase 2b Results

December 8, 2025

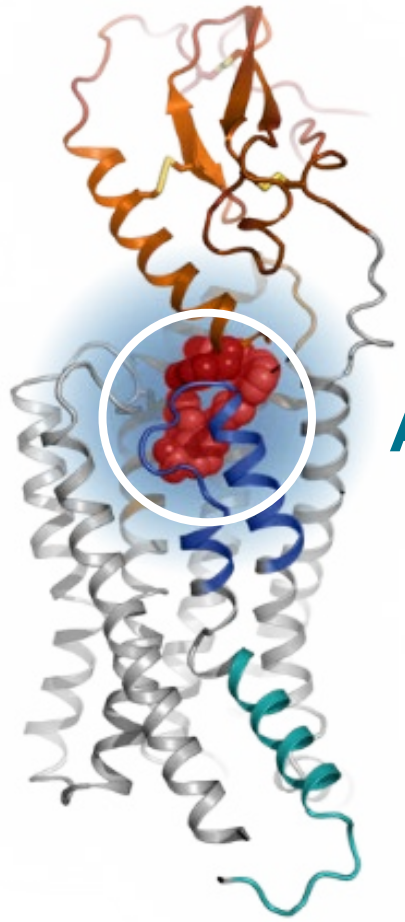
Forward-Looking Statements

This presentation contains “forward-looking statements” within the meaning of the “safe harbor” provisions of the Private Securities Litigation Reform Act of 1995. All statements other than statements of historical fact are statements that could be deemed forward-looking statements, including, without limitation, statements concerning: the estimated addressable patient population, market, and revenue opportunity for aleniglipron; any expectations regarding the potential benefits, tolerability and safety profile, accessibility, dose flexibility, scalability, cost, combinability, capability, efficacy, convenience, expected effects, and future application of aleniglipron; the Company’s belief that data to date from the ACCESS, ACCESS II, Body Composition and Open Label Extension studies provide a strong foundation for the Phase 3 clinical development of aleniglipron; the belief that all key questions have been answered by the studies to date; the expected size and design for the Phase 3 trial; any presumption that topline, interim or preliminary data will be representative of final data or data in later clinical trials; the belief that the Company is well positioned to lead with a differentiated and highly scalable pipeline of oral small molecule medicines designed to address the significant unmet needs in obesity and related metabolic diseases; the belief that there is potential for expansion beyond obesity, including chronic kidney disease, metabolic associated steatohepatitis, heart failure, sleep apnea, type 2 diabetes mellitus, osteoarthritis, and addiction; plans to conduct FDA regulatory interactions; the expected timing of topline data readouts from the Open Label Extension, ACCESS II Extension, Body Composition, SWITCH and T2DM studies; the planned initiation of the ACCG-3535 Phase 1 study and the timing thereof; the expected timing of study results from the Phase 1 ACCG-2671 study; and the Company’s future plans and prospects. In addition, when or if used, the words and phrases “believe,” “may,” “potential,” “to be,” “will,” and similar expressions and their variants, as they relate to the Company may identify forward-looking statements. Forward-looking statements are neither historical facts nor assurances of future performance. Although the Company believes the expectations reflected in such forward-looking statements are reasonable, the Company can give no assurance that such expectations will prove to be correct. Readers are cautioned that actual results, levels of activity, safety, performance or events and circumstances could differ materially from those expressed or implied in the Company’s forward-looking statements due to a variety of risks and uncertainties, which include, without limitation: risks and uncertainties related to topline results that the Company reports is based on preliminary analysis of key efficacy and safety data, and such data may change following a more comprehensive review of the data related to the clinical trial and such topline data may not accurately reflect the complete results of a clinical trial, the preliminary nature of the results due to the length of the study and sample size and results from earlier clinical studies not necessarily being predictive of future results; potential delays in the commencement, enrollment and completion of the Company’s planned clinical studies; the Company’s ability to advance aleniglipron, ACCG-2671, ACCG-3535, ANPA-0073, LTSE-2578, and its other therapeutic candidates, obtain regulatory approval of, and ultimately commercialize the Company’s therapeutic candidates; competitive products or approaches limiting the commercial value of the Company’s product candidates; the timing and results of preclinical and clinical studies; the Company’s ability to fund development activities and achieve development goals; the Company's reliance on third parties, including clinical research organizations, manufacturers, suppliers and collaborators, over which it may not always have full control; general geopolitical and macroeconomic conditions, including as a result of tariffs and various global conflicts; the Company’s ability to protect its intellectual property; and other risks and uncertainties described in the Company’s filings with the Securities and Exchange Commission (SEC), including the Company’s latest Quarterly Report on Form 10-Q and future reports the Company may file with the SEC from time to time. All forward-looking statements contained in this presentation speak only as of the date on which they were made and are based on management’s assumptions and estimates as of such date. The Company undertakes no obligation to update such statements to reflect events that occur or circumstances that exist after the date on which they were made, except as required by law.

This presentation discusses product candidates that are under clinical study and which have not yet been approved for marketing by the U.S. Food and Drug Administration. No representation is made as to the safety or effectiveness of these product candidates for the use for which such product candidates are being studied.

This presentation may incorporate publicly-available third-party data that we have not independently verified. There are risks inherent in conducting cross-trial comparisons and the results should be interpreted with caution. The presentation of such third-party data does not represent a head-to-head comparison of how our product candidates performed against any other third-party product candidate or study. Rather, such third-party data has been pulled by us from publicly-available sources for supplemental informational purposes, only. We caution you that any comparisons against third-party data set forth herein should not be viewed as a side-by-side comparison, and you should not rely on the completeness or accuracy of our presentation of the results of any third-party drug candidate in these slides, due to differences in study design, how other companies quantify or qualify eligibility criteria, and how results are recorded, among other distinguishing factors and uncertainties. Because we may be unaware of or may not adequately present various distinguishing factors and uncertainties, the comparisons set forth herein may not properly present such third-party data, which may differ materially from the data as presented here. Investors are encouraged to independently review third party data and should not rely on our presentation of such data as a single measure to evaluate our business.

Today's Update



ALENIGLIPRON

ORAL SMALL MOLECULE
GLP-1 Receptor Agonist

1. **Aleniglipron Obesity Opportunity**
   Raymond Stevens, Ph.D, *Chief Executive Officer*
2. **Topline 36 week Data from Phase 2b ACCESS and 3 Supplementary Studies**
   Blai Coll, M.D., Ph.D, *Chief Medical Officer*
3. **Aleniglipron Phase 3 Readiness**
   Blai Coll
4. **Aleniglipron: A Backbone in Structure's Oral Small Molecule Portfolio**
   Raymond Stevens
5. **Q&A**
   Blai Coll, Raymond Stevens
   Jun Yoon, *Chief Financial Officer*

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Our Mission

Making medicines more accessible to all

Aleniglipron Obesity Opportunity

Raymond Stevens

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Access to Obesity Treatments Remains a Worldwide Unmet Need

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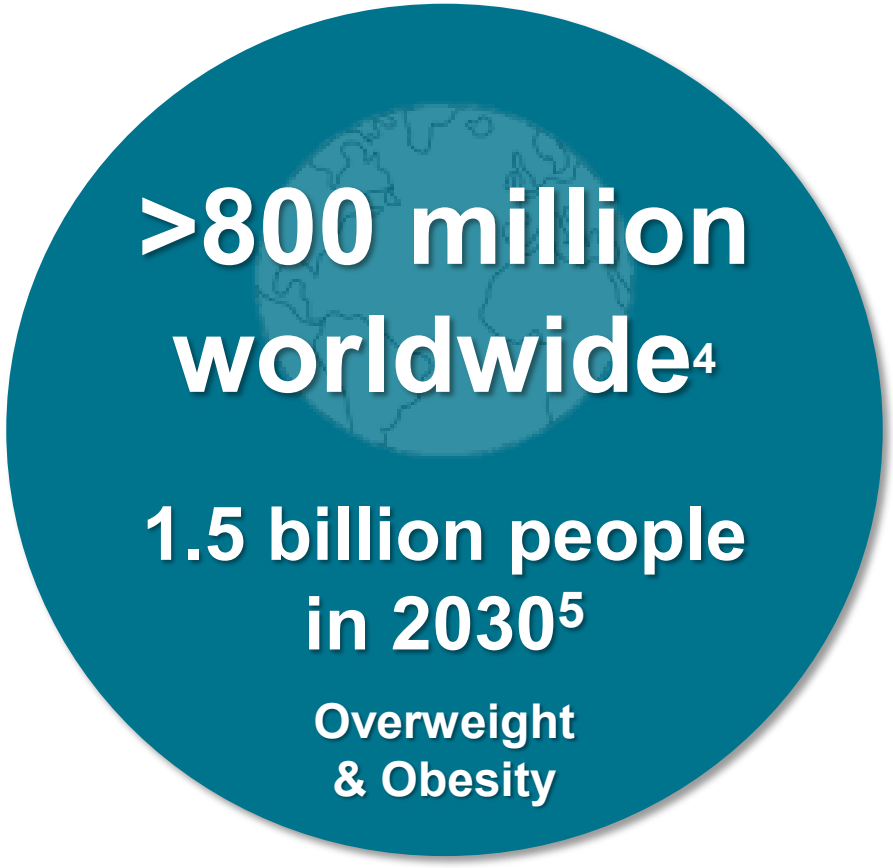
Only oral small molecules can scale to meet the needs of the global obesity patient population

Current Injectable Peptide GLP-1s

>5 million in US[1]

<5% of addressable market



>$100 billion Total Addressable Market [3]

(obesity or overweight with at least one weight-related comorbid condition)

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1. August 2025 Symphony Health prescription data and 2025 Evaluate Pharma sales data
2. Trust for America's Health Report https://www.tfah.org/report-details/stateofobesity2019/#:~:text=Obesity%20is%20a%20growing%20epidemic,100%20million%20people%20%E2%80%93%20have%20obes
3. Goldman Sachs Report https://www.goldmansachs.com/insights/articles/anti-obesity-drug-market
4. 2022 World Health Organization https://www.who.int/news-room/fact-sheets/detail/obesity-and-overweight
5. World Obesity Atlas 2024 https://s3-eu-west-1.amazonaws.com/wof-files/WOF_Obesity_Atlas_2024.pdf

Aleniglipron Represents a Potential Solution in Obesity Care to be More Accessible, Scalable, and Combinable

	Aleniglipron Oral Small Molecule	Oral Peptides	Injectable Peptides
ADMINISTRATION	Designed as once-daily pill, no fasting	Once-daily pill, typically requires pre-dose fasting	Once weekly injection
DOSE FLEXIBILITY	Patient/PCP dose range flexibility; optimal for long term maintenance	TBD maintenance dose levels (top oral semaglutide dose 25 mg)	Limited number of indicated maintenance doses (5 mg, 10 mg and 15 mg for tirzepatide)
STORAGE / SUPPLY CHAIN	Room temperature shipping and storage	Room temperature	Refrigeration required for shipping and home-storage
SCALABILITY	Simple manufacturing; ability to scale to meet global demand	High dosage requirement; may struggle to scale supply to meet demand	Historically struggled to meet demand
COST OF GOODS	Traditional small molecule COGS; if approved, potential price flexibility	Higher, limiting pricing flexibility	Higher, limiting pricing flexibility
COMBINATIONS	Observed pharmacology potentially allows for fixed-dose combinations	Lower feasibility for fixed-dose combinations	Lower feasibility for fixed-dose combinations

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Aleniglipron Obesity Data Summary

Differentiated Selective Oral Small Molecule GLP-1R Receptor Agonist

Efficacy

- **Phase 2b ACCESS**
  36 week placebo-adjusted mean weight loss:
  - **8.2% at 45 mg**
  - **9.8% at 90 mg**
  - **11.3% at 120 mg**
- **Exploratory ACCESS II**
  36 week placebo-adjusted mean weight loss:
  - **14.1% at 120 mg**
  - **14.4% at 180 mg**
  - **15.3% at 240 mg**
- **No evidence of weight loss plateau**
- **Proportional pharmacokinetic (PK) exposure up to 240 mg**
- **Clinically meaningful improvements in blood pressure and HbA1c**

Tolerability

- **Phase 2b ACCESS**:
  - GI-related AEs consistent with GLP-1RA class
  - **Overall 10.4% AE-related treatment discontinuations**
- **Exploratory ACCESS II**:
  - **For those participants who achieved re-randomization – No AE-related treatment discontinuations up to 240 mg dose**
- **Open Label Extension (OLE) & Body Composition:**
  - **Clinically meaningful improvement in tolerability when starting at 2.5 mg compared to 5 mg start**
  - **No discontinuations observed to date***

**Study ongoing and interim data from a pre-specified analysis. Interim data as of November 25, 2025*

Safety

- **> 500 participants treated across all studies up to 44 weeks**
  - **No events of drug induced liver injury**
  - **No off-target safety signals across all dose levels**
  - **No events of QTc prolongation**

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Topline 36 Week Data Phase 2b ACCESS and Three Supplementary Studies

Blai Coll

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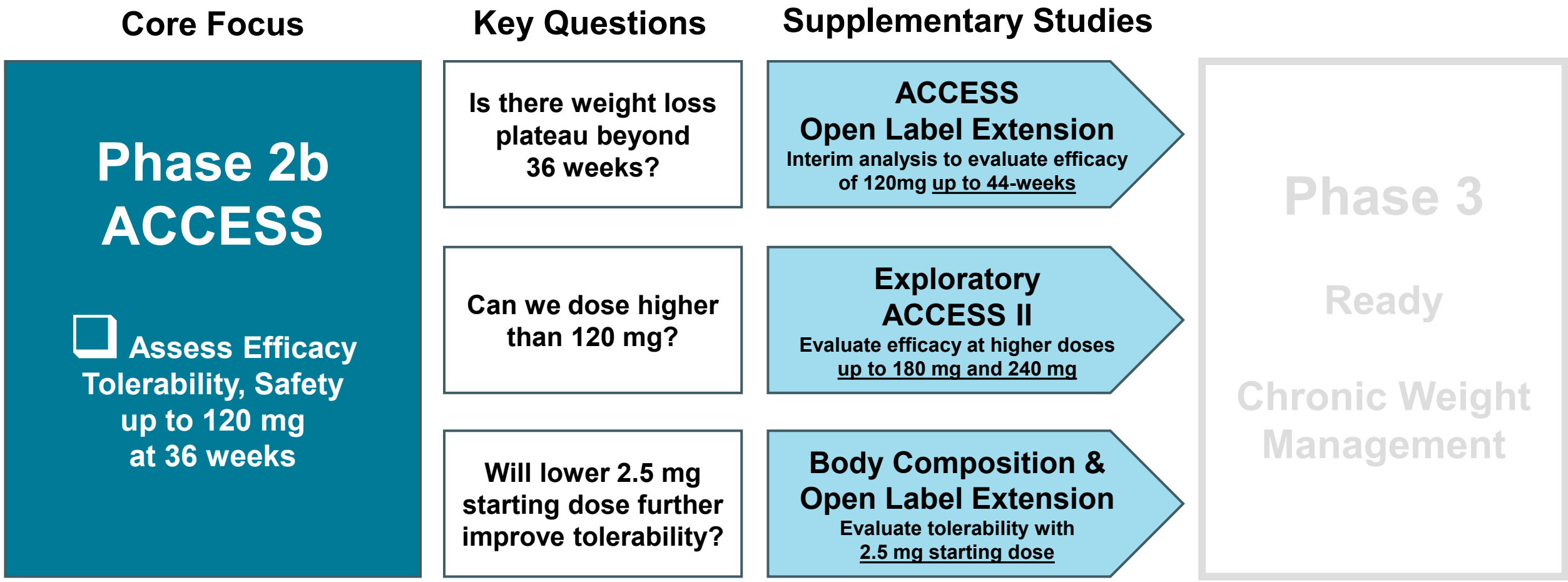
Multiple Aleniglipron Studies to Answer Key Questions



Phase 2b ACCESS Study Design

ACCESS

Study Details

N=230

Participants with:

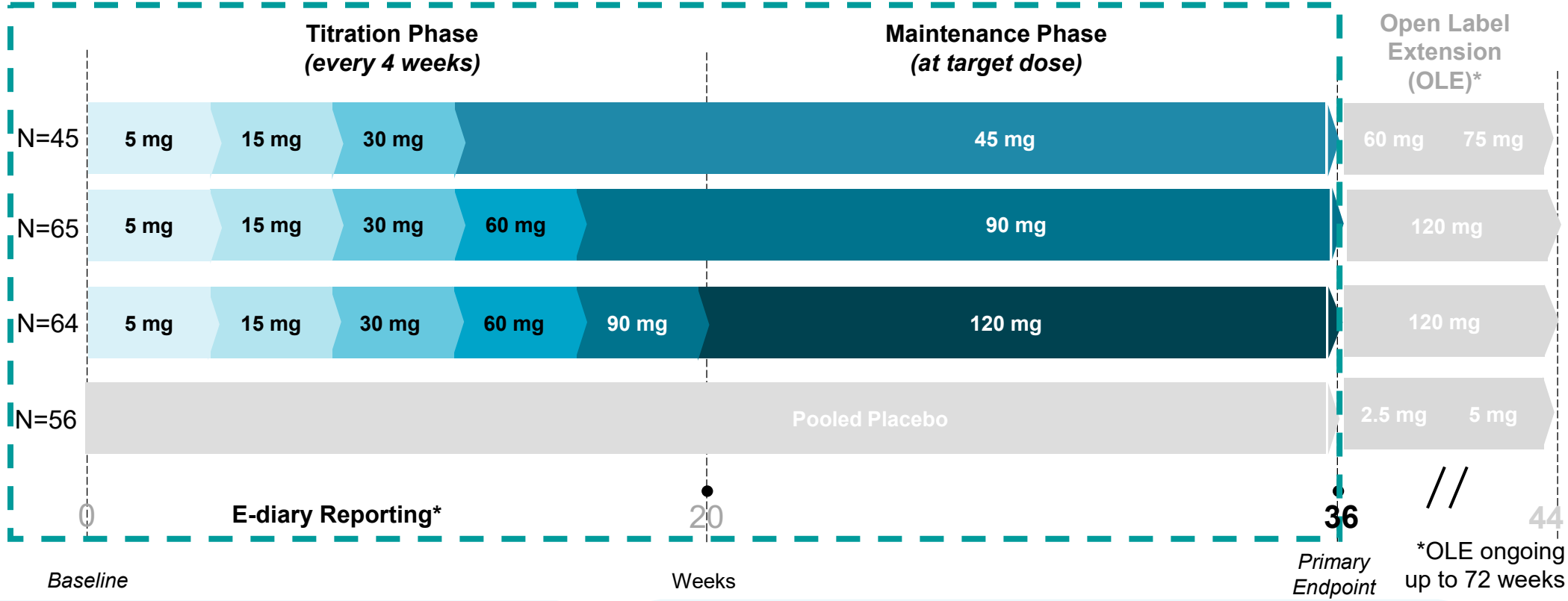
- Body mass index (BMI) **≥ 30 kg/m²**

  or

- BMI **≥ 27 kg/m² with** ≥ 1 weight-related comorbidity

Number of sites: 36

Clinicaltrials.gov ID: NCT06693843



Primary Endpoint

- % change in body weight at week 36 compared to baseline (active vs. placebo)
- Statistical analysis based on the Primary Efficacy Estimand[1]

Key Secondary Endpoints

- % of participants who achieve ≥ 5%, ≥ 10% and ≥ 15% reduction in body weight at week 36
- Safety and tolerability profile of a monthly titration scheme

[1]The primary efficacy estimand represents efficacy had all randomized participants remained on study treatment (with possible dose interruptions and/or dose modifications) for 36 weeks without initiating rescue weight management treatments or surgeries.

[2] E-diary reporting may be associated with an increase in the number of reported events

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Baseline Demographics and Characteristics (Phase 2b ACCESS)

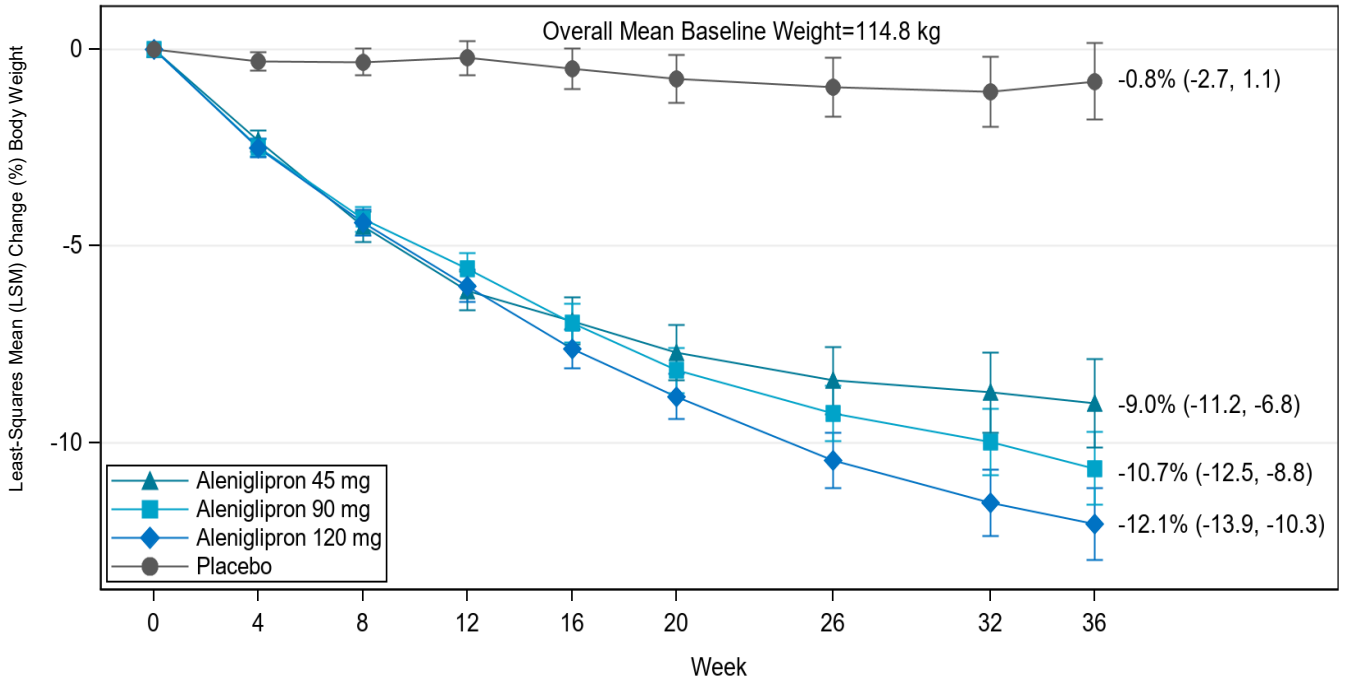
ACCESS

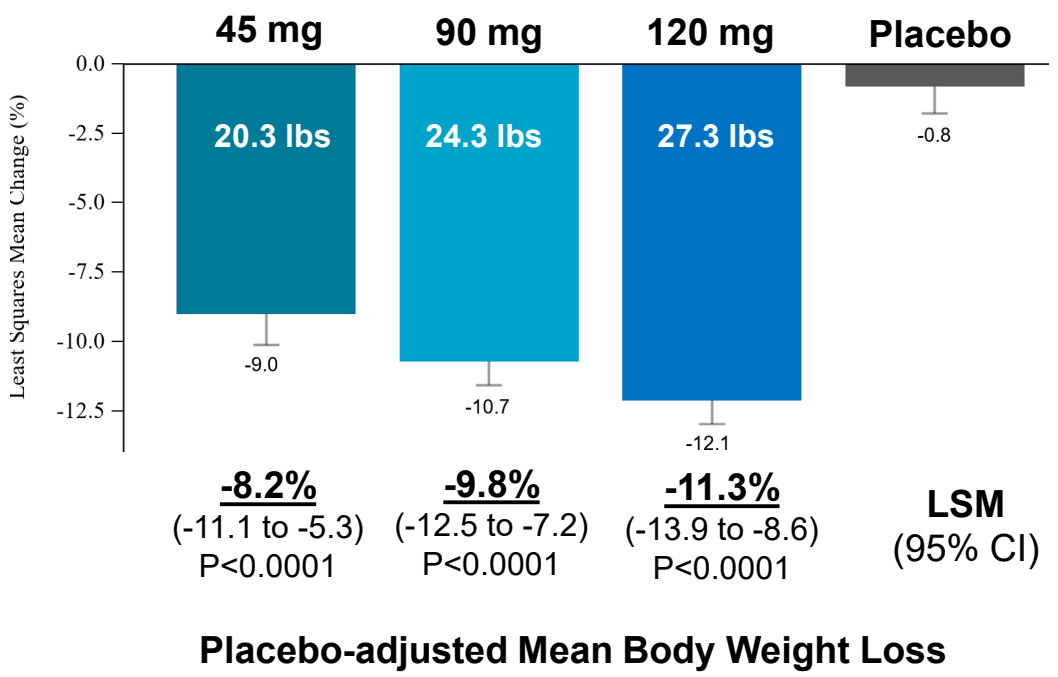
Characteristics Mean (SD) or N (%)	Aleniglipron 45 mg N=45	Aleniglipron 90 mg N=65	Aleniglipron 120 mg N=63	Placebo N=56
Age, years, mean	49.0 (12.7)	47.9 (12.5)	52.3 (13.9)	49.9 (15.8)
Sex, female	25 (55.6)	35 (53.8)	35 (54.7)	30 (53.6)
Weight, kg	115.6 (24.7)	117.9 (23.6)	113.1 (20.5)	112.3 (22.0)
Body mass index, kg/m^2	39.7 (6.9)	39.8 (7.5)	39.0 (6.4)	39.4 (7.0)
HbA1c	5.7 (0.3)	5.7 (0.4)	5.7 (0.3)	5.5 (0.4)
Systolic Blood Pressure, mmHg	127.0 (11.3)	126.4 (12.6)	125.3 (14.8)	125.3 (12.6)
Diastolic Blood Pressure, mmHg	83.3 (7.9)	81.9 (8.0)	80.2 (8.8)	80.3 (7.9)
Ethnicity (Hispanic or Latino)	7 (15.6)	9 (13.8)	9 (14.1)	11 (19.6)

Aleniglipron Achieves Primary Efficacy Endpoint (Phase 2b ACCESS)

ACCESS

- 11.3% placebo-adjusted mean weight loss at 36 weeks with 120 mg
- Dose dependent body weight reduction observed from 45 to 120 mg
- No signs of weight loss plateau through 36 weeks across all dose ranges





Placebo-adjusted Mean Body Weight Loss

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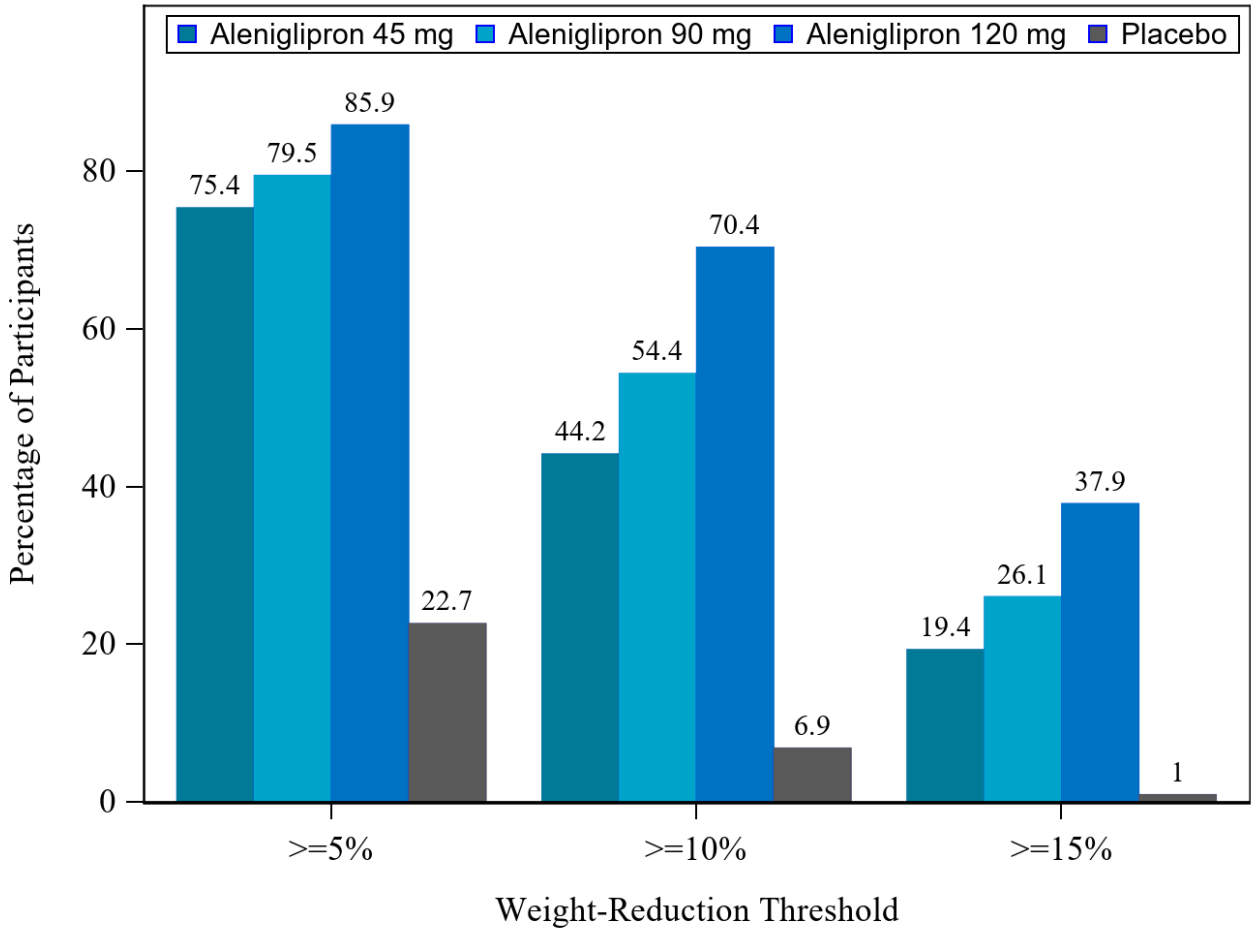
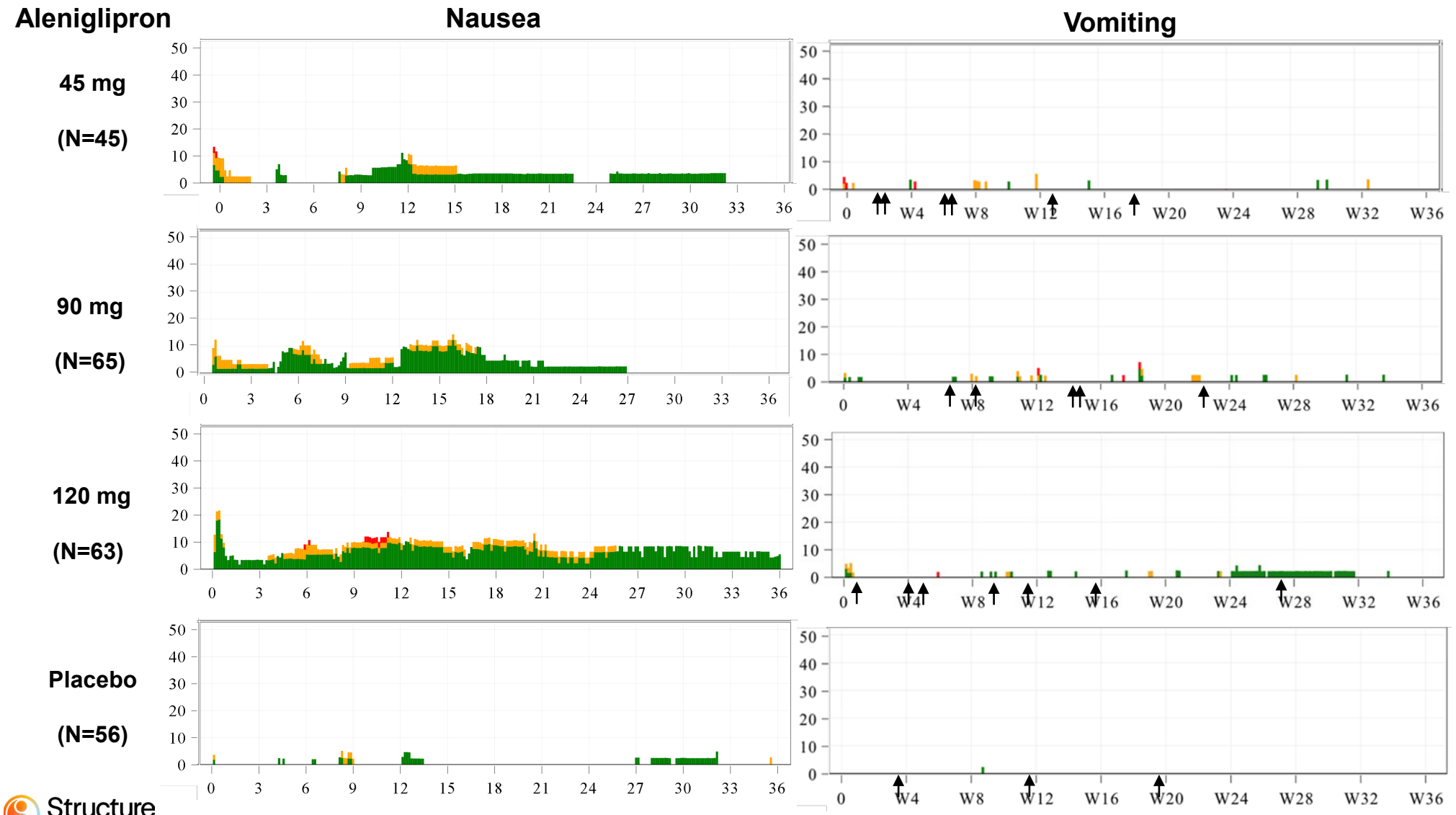
Aleniglipron Achieved Secondary Efficacy Endpoints (Phase 2b ACCESS)



- **86% of participants with 120 mg dose achieve at least 5% body weight reduction**
- **70% of participants with 120 mg dose achieve at least 10% body weight reduction**
- **38% of participants with 120 mg dose achieve at least 15% body weight reduction**
- **Clinically meaningful improvements in systolic blood pressure (-6.4 to -7.5 mmHg) and HbA1c (-0.28 to -0.37%)**

Prevalence of Nausea and Vomiting Events by Dose and Over Time (Phase 2b ACCESS)

ACCESS



- Highest nausea occurs in the first weeks of starting 5 mg dose titration, mostly mild to moderate
- No increase in prevalence as participants titrate to higher doses
- Majority of treatment discontinuations due to AEs occurring in the first titration steps

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Cumulative Tolerability Profile Consistent with GLP-1RA Class (Phase 2b ACCESS)

ACCESS

- **Overall 10.4% treatment discontinuations due to AEs**
- **No dose response in most commonly GI-reported AEs**

N (%) Reporting at least one event*	Aleniglipron 45 mg N=45	Aleniglipron 90 mg N=65	Aleniglipron 120 mg N=63	Placebo N=56
Starting Dose	5 mg	5 mg	5 mg	
Participants completed study on treatment	33 (73.3)	49 (75.4)	50 (78.1)	42 (75)
Any TEAE leading to discontinuation of treatment	6 (13.3)	5 (7.7)	7 (11.1)	3 (5.4)
Nausea	32 (71.1)	44 (67.7)	41 (65.1)	12 (21.4)
Vomiting (overall) Mild and Moderate Severe	18 (40.0) 15 (33.3) 3 (6.7)	29 (44.6) 27 (41.5) 2 (3.1)	20 (31.7) 19 (30.2) 1 (1.6)	3 (5.4) 3 (5.4) 0
Diarrhea	19 (42.2)	26 (40.0)	14 (22.2)	13 (23.2)
Constipation	18 (40.0)	20 (30.8)	19 (30.2)	8 (14.3)

* E-diary reporting may be associated with an increase in the number of reported events

Summary Aleniglipron Topline Phase 2b ACCESS Results

Core Focus

Phase 2b ACCESS

Assess Efficacy Tolerability, Safety up to 120 mg at 36 weeks

ACCESS

- **36 week placebo-adjusted mean weight loss :**
  - **8.2% at 45 mg**
  - **9.8% at 90 mg**
  - **11.3% at 120 mg**
- **No signs of weight loss plateau**
- **4 week titration to optimize tolerability:**
  - GI-related AEs consistent with GLP-1RA class
  - **Overall 10.4% AE-related treatment discontinuations**

Multiple Aleniglipron Studies to Answer Key Questions

Core Focus	Key Questions	Supplementary Studies	
Phase 2b ACCESS ❑ Assess Efficacy Tolerability, Safety up to 120 mg at 36 weeks	Is there weight loss plateau beyond 36 weeks?	**ACCESS Open Label Extension** Interim analysis to evaluate efficacy of 120mg up to 44-weeks	Phase 3 Ready Chronic Weight Management
	Can we dose higher than 120 mg?	Exploratory ACCESS II Evaluate efficacy at higher doses up to 180 mg and 240 mg	
	Will lower 2.5 mg starting dose further improve tolerability?	Body Composition & Open Label Extension Evaluate tolerability with 2.5 mg starting dose	

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QUESTION: Is there weight loss plateau?
ACCESS OLE Study Design

Study Details

N=230

Participants with:

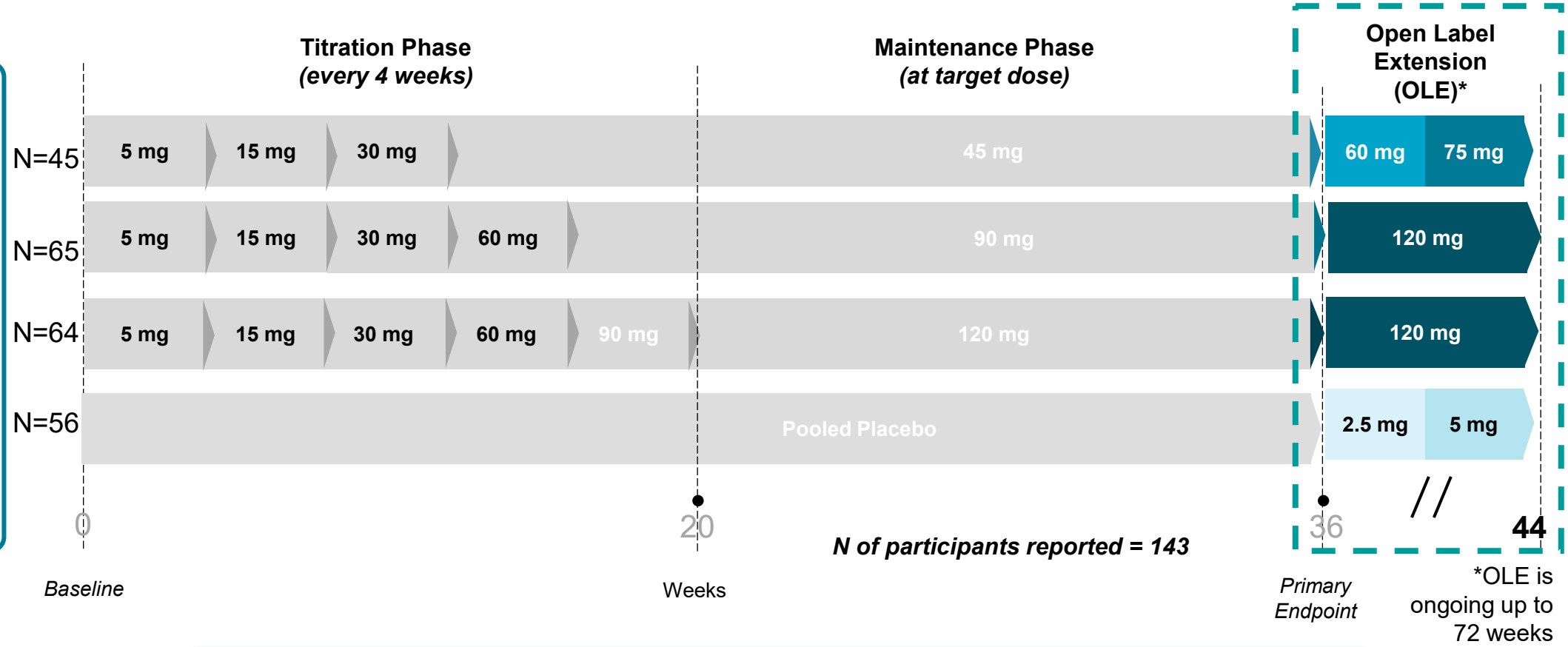
- Body mass index (BMI) **≥ 30 kg/m²**

  or

- BMI **≥ 27 kg/m² with** ≥ 1 weight-related comorbidity

Number of sites: 36

Clinicaltrials.gov ID: NCT06693843



ACCESS Open Label Extension Study Objectives

- Long-term safety
- Durability and maintenance of weight loss from Week 0 to 72 (full study), and Week 36 to 72 (OLE portion)

**Study ongoing and interim data from a pre-specified analysis. Interim data as of November 25, 2025*

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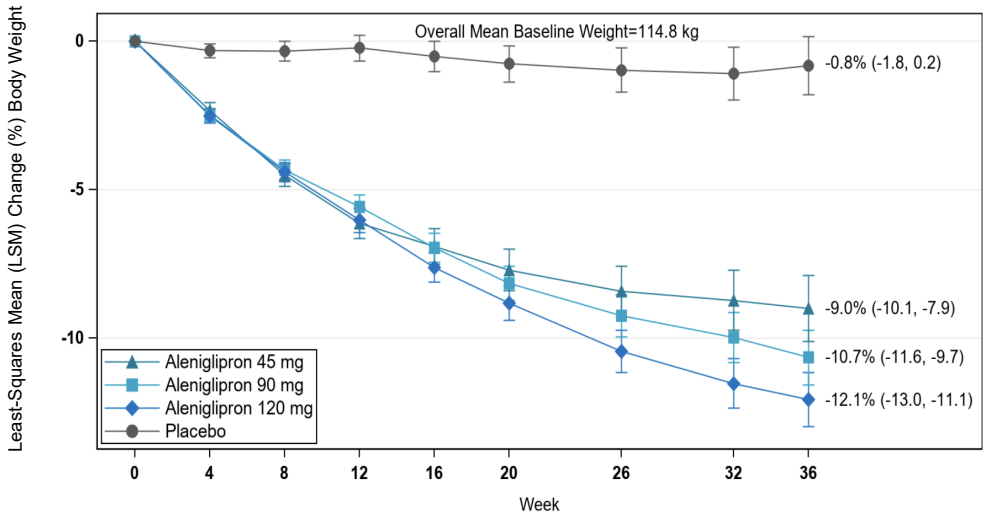
QUESTION: Is there a weight loss plateau?
ACCESS OLE: Additional Body Weight Reduction Beyond 36 Weeks

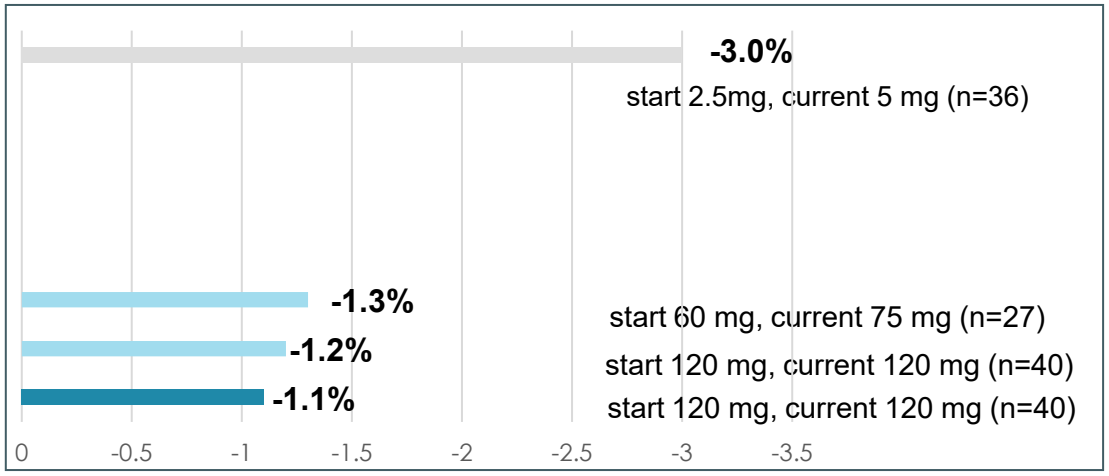
ANSWER: NO PLATEAU

- **Majority of eligible ACCESS participants enrolled in OLE**
- **Weight loss <u>continues to increase</u> in all 4 arms of OLE through Week 44**
- **No evidence of weight loss plateau with transition to open label extension following Week 36**

Phase 2b ACCESS (Week 0-36)



ACCESS OLE* (Week 36-44)



**Study ongoing and interim data as of December 2025*

Multiple Aleniglipron Studies to Answer Key Questions

Core Focus	Key Questions	Supplementary Studies	
Phase 2b ACCESS ❑ Assess Efficacy Tolerability, Safety up to 120 mg at 36 weeks	Is there weight loss plateau beyond 36 weeks?	ACCESS Open Label Extension Interim analysis to evaluate efficacy of 120mg up to 44-weeks	Phase 3 Ready Chronic Weight Management
	Can we dose higher than 120 mg?	**Exploratory ACCESS II** **Evaluate efficacy at higher doses up to 180 mg and 240 mg**	
	Will lower 2.5 mg starting dose further improve tolerability?	Body Composition & Open Label Extension Evaluate tolerability with 2.5 mg starting dose	

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QUESTION: Can we dose higher than 120 mg? Exploratory ACCESS II Study Design

Study details

N=85

Participants with:

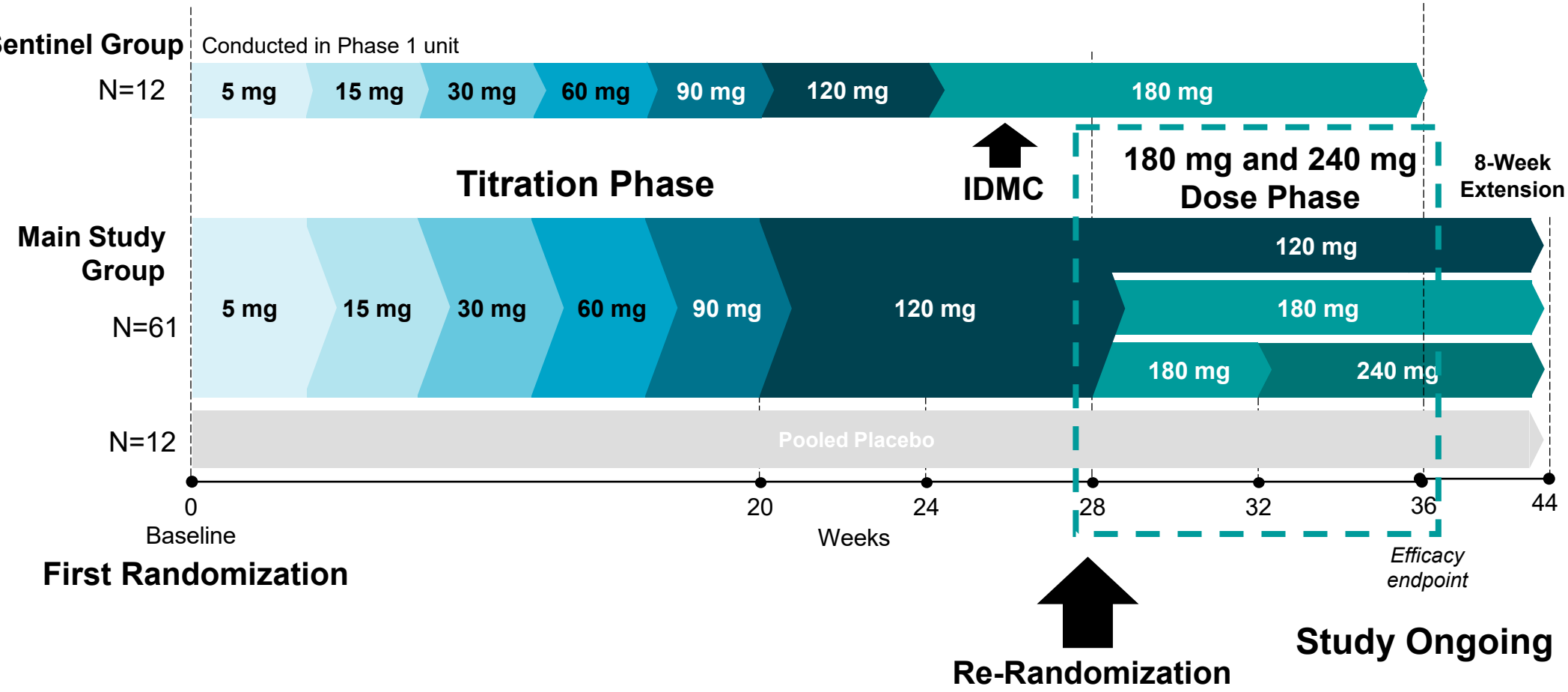
- Body mass index (BMI) **≥ 30 kg/m²**

  or

- BMI **≥ 27 kg/m² with** ≥ 1 weight-related comorbidity

Number of sites: 10

Clinicaltrials.gov ID: NCT06703021;



Exploratory ACCESS II Study

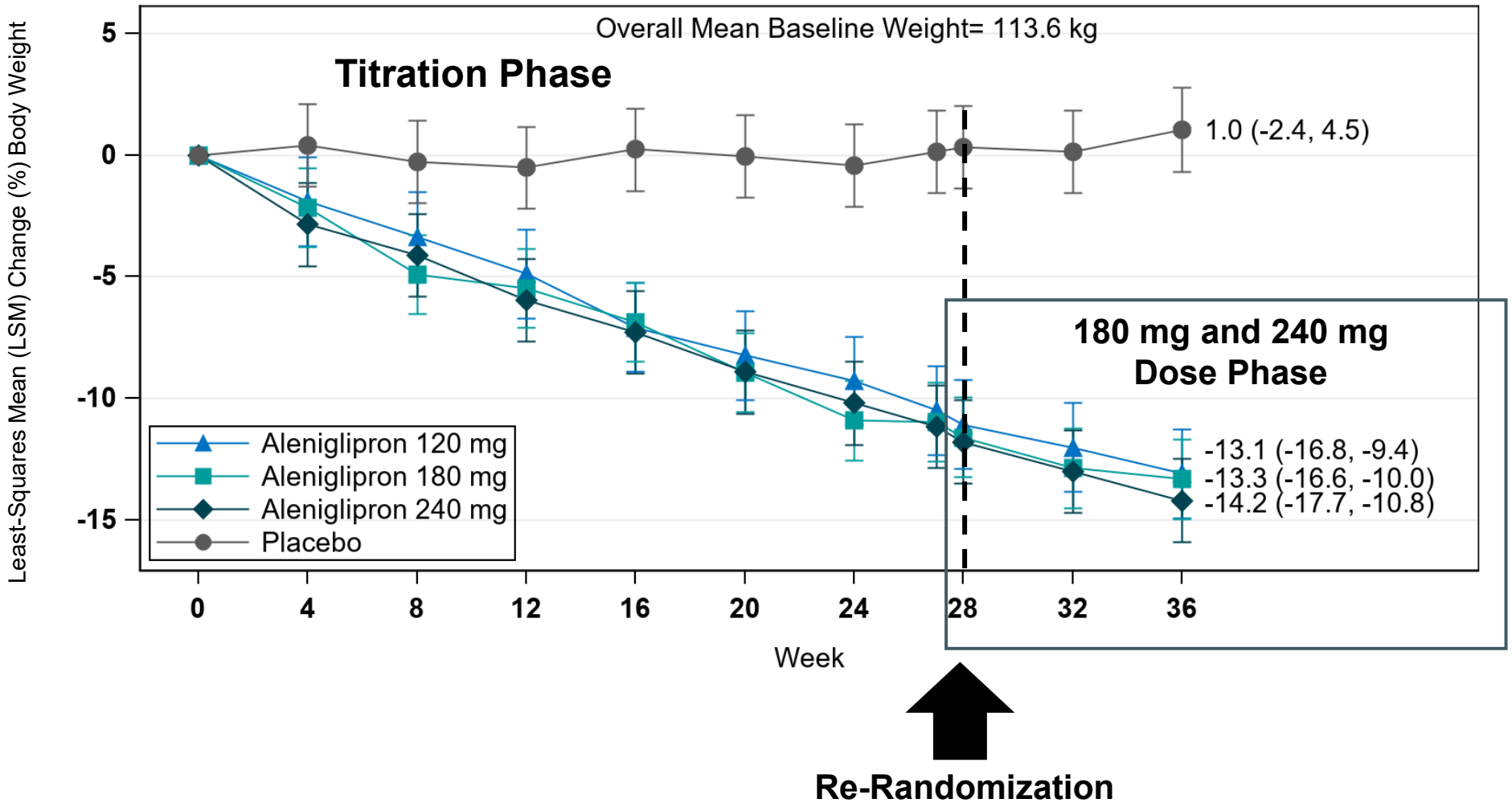
- Evaluate higher 180 mg and 240 mg dosing
- Safety and tolerability

*Study still on going

Baseline Demographics and Characteristics (Exploratory ACCESS II)

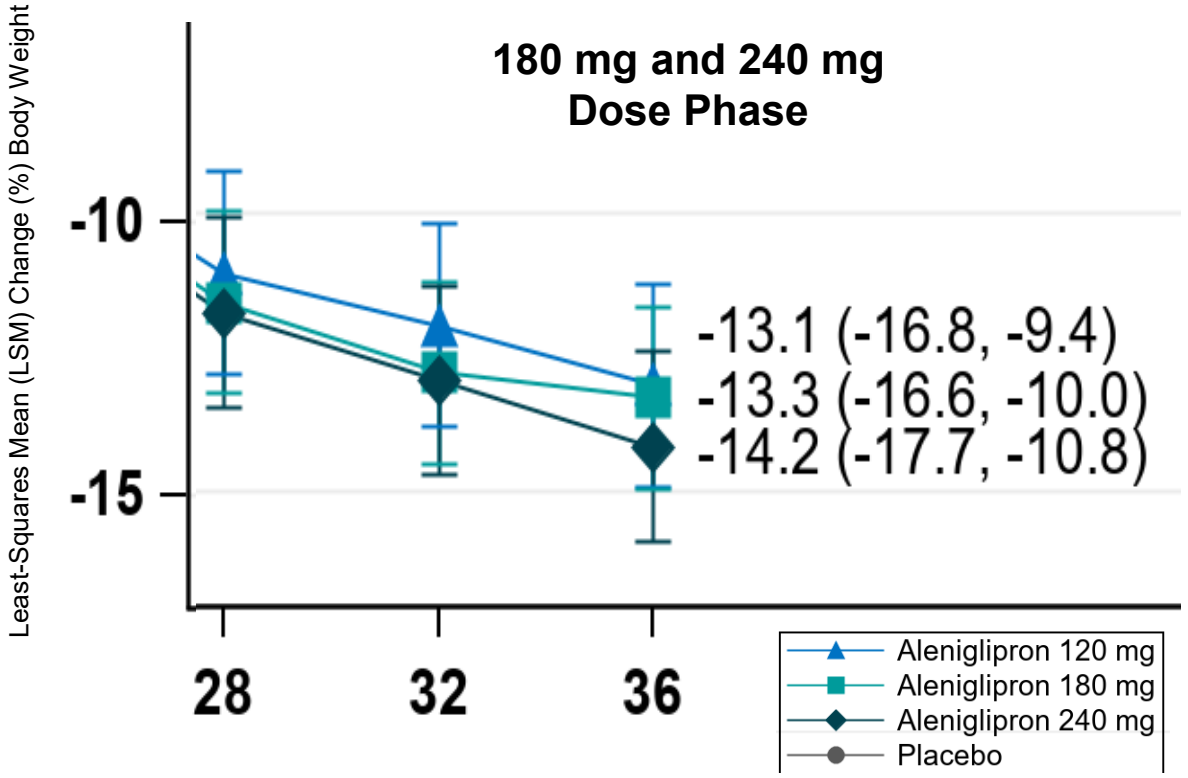
Characteristics Mean (SD) or N (%)	Aleniglipron Overall N=61	Placebo N=12
Age, years	49.8 (14.5)	51.8 (12.9)
Sex, female	38 (62.3)	8 (66.7)
Weight, kg	116.2 (31.9)	104.3 (12.38)
Body mass index, kg/m^2	39.9 (8.4)	36.8 (5.1)
HbA1c, %	5.6 (0.35)	5.4 (0.36)
Systolic Blood Pressure, mmHg	122.2 (12.2)	122.6 (11.4)
Diastolic Blood Pressure, mmHg	78.7 (7.0)	82.3 (9.2)
Ethnicity (Hispanic or Latino)	15 (24.6)	3 (25.0)

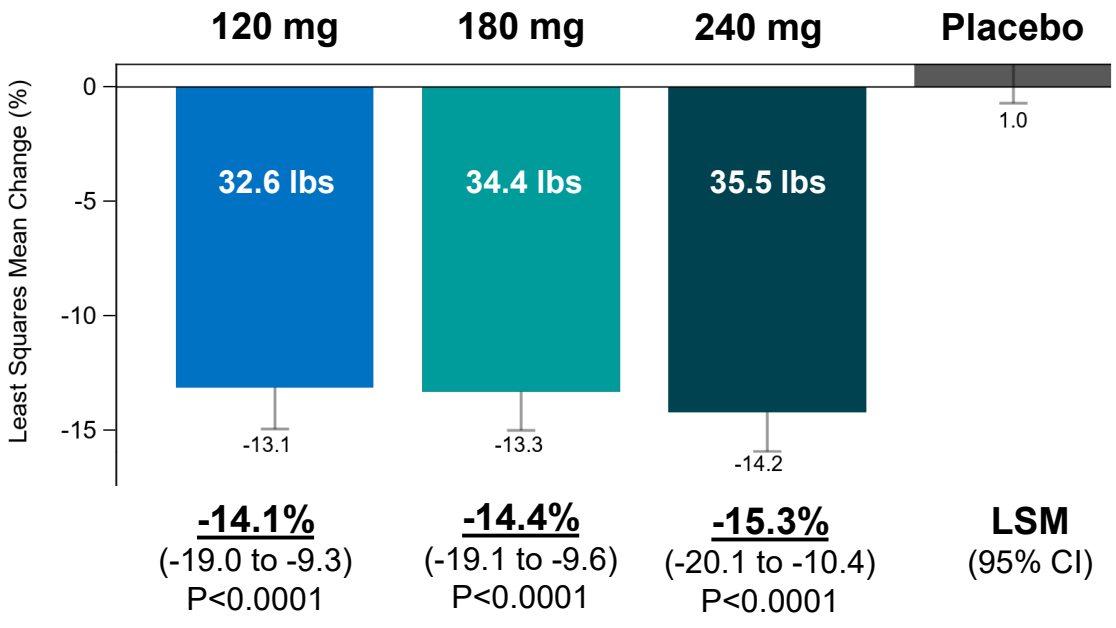
Aleniglipron Achieved Greater Weight Loss with Higher Doses (Exploratory ACCESS II)



Aleniglipron Achieves Greater Weight Loss with Higher Doses (Exploratory ACCESS II – Focusing on Post Re-randomization)

- **Participants are on 180 mg for 8 weeks and 240 mg for 4 weeks**
- **No evidence of weight loss plateau**
- **Proportional exposure PK dosing up to 240 mg**

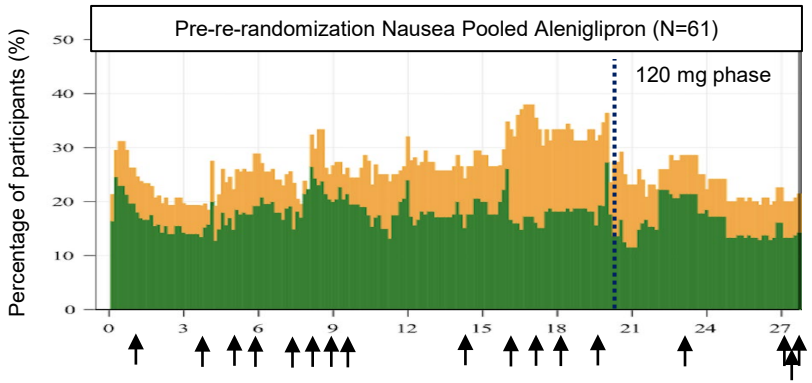




Placebo-adjusted Mean Body Weight Loss

Prevalence of Nausea by Dose Over Time (Exploratory ACCESS II)

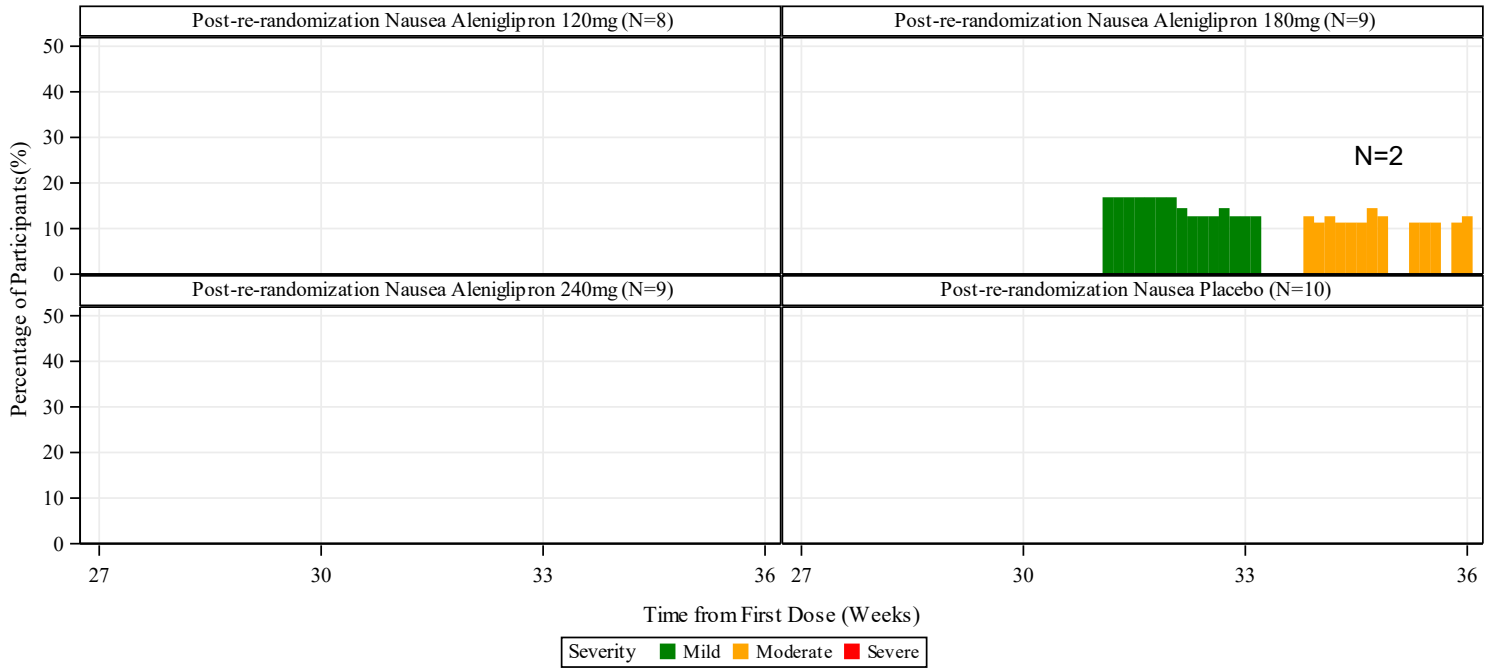
Titration Phase (Up to 120 mg)



Treatment Discontinuations due to AEs
(not limited to nausea)

Re-Randomization

180 mg and 240 mg Dose Phase



Post Re-Randomization

- Minimal number of participants with GI-events
- 2 participants with intermittent events of nausea between weeks 33-36

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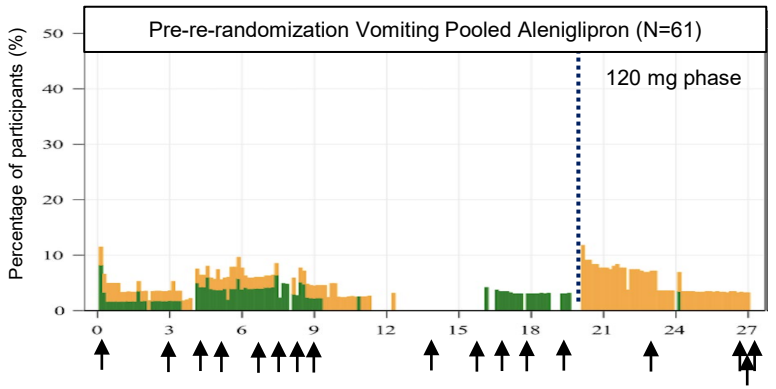
Prevalence of Vomiting by Dose Over Time (Exploratory ACCESS II)

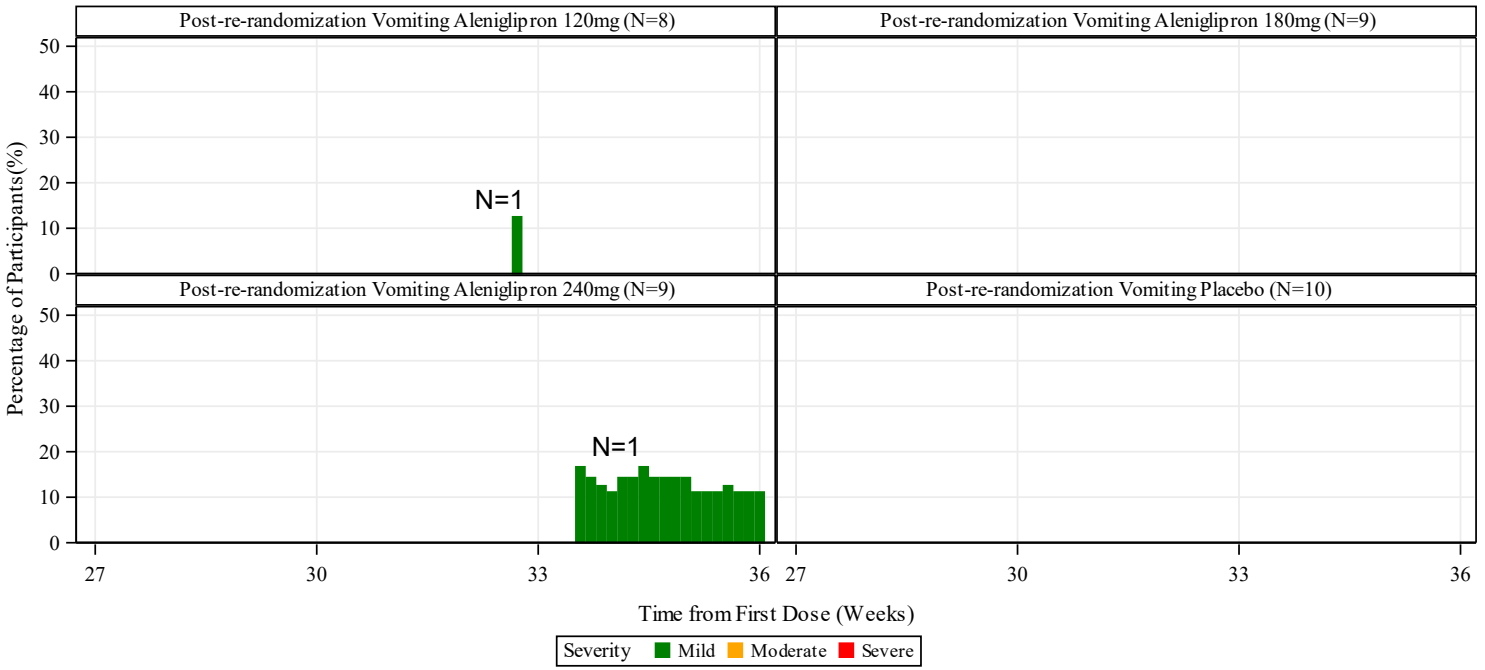
Titration Phase (Up to 120 mg)



Treatment Discontinuations due to AEs (not limited to vomiting)

Re-Randomization

180 mg and 240 mg Dose Phase



Post Re-Randomization

- Minimal number of participants with GI-events and no discontinuations
- 1 participant with intermittent vomiting during weeks 33-36 with 240 mg dose

Cumulative Tolerability Results Consistent with GLP-1RA Class (Exploratory ACCESS II)

No discontinuations at 120, 180, or 240 mg dose post re-randomization at 36 weeks; study ongoing to 44 weeks

	Titration Phase (Up to 120 mg)		180 mg and 240mg Dosing Phase (Re-randomized Study Ongoing)	
N (%) Reporting at least one event*	**Aleniglipron Up to 120 mg N=61**	**Placebo N=12**	**Aleniglipron 120 mg to 240 mg N=26**	**Placebo N=10**
Starting Dose	5 mg		120/180 mg	
Any TEAE leading to Treatment Discontinuation	17 (27.9)	0	0	0
Non-AE related Treatment Discontinuation	11 (18)	0	0	0
Non Re-randomized Participants in the Study	6 (9.8)	1 (8.3)	0	0
Nausea	42 (68.9)	0	3 (11.5)	0
Vomiting (Overall) Mild and Moderate Severe	27 (44.3) 26 (42.6) 1 (1.6)	1 (8.3) 1 (8.3) 0	3 (11.5) 3 (11.5) 0	0 0 0
Diarrhea	22 (36.1)	1 (8.3)	0	0
Constipation	13 (21.3)	2 (16.7)	0	0

* E-diary reporting may be associated with an increase in the number of reported events

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Summary Aleniglipron ACCESS II Interim Results

Can we dose higher than 120 mg?

Exploratory ACCESS II
Evaluate efficacy at higher doses up to 180 mg and 240 mg

ANSWER: Additional activity and weight loss directionality confirmed up to 180 and 240 mg

- **Directionality in efficacy**
  (placebo-adjusted mean weight loss, 36 week)
  - **14.1% at 120 mg**
  - **14.4% at 180 mg**
  - **15.3% at 240 mg**
- **Proportionality in exposure**
- **Tolerability**
  - **For those participants who achieved re-randomization – No AE-related treatment discontinuations up to 240 mg dose at week 36; study ongoing to week 44**
- **Supports dose optimization strategy for Phase 3**

Multiple Aleniglipron Studies to Answer Key Questions

Core Focus	Key Questions	Supplementary Studies	
Phase 2b ACCESS ❑ Assess Efficacy Tolerability, Safety up to 120 mg at 36 weeks	Is there weight loss plateau beyond 36 weeks?	ACCESS Open Label Extension Interim analysis to evaluate efficacy of 120mg up to 44-weeks	Phase 3 Ready Chronic Weight Management
	Can we dose higher than 120 mg?	Exploratory ACCESS II Evaluate efficacy at higher doses up to 180 mg and 240 mg	
	Will lower 2.5 mg starting dose further improve tolerability?	**Body Composition & Open Label Extension** **Evaluate tolerability with 2.5 mg starting dose**	

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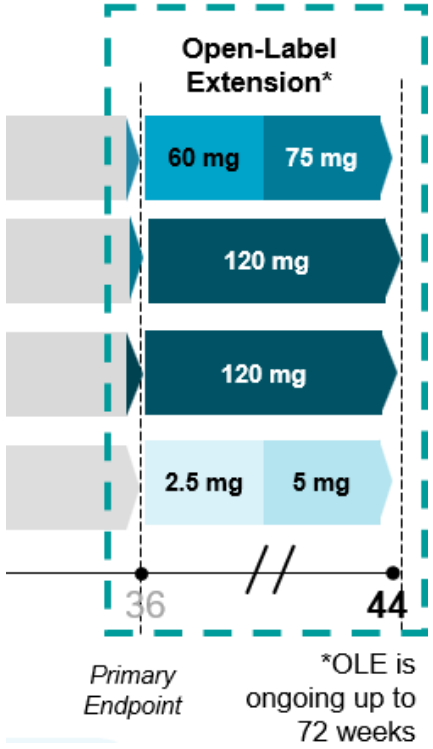
Question: Will lower 2.5 mg starting dose further improve tolerability?
OLE and Body Composition Study Design



Study Ongoing

Study Details

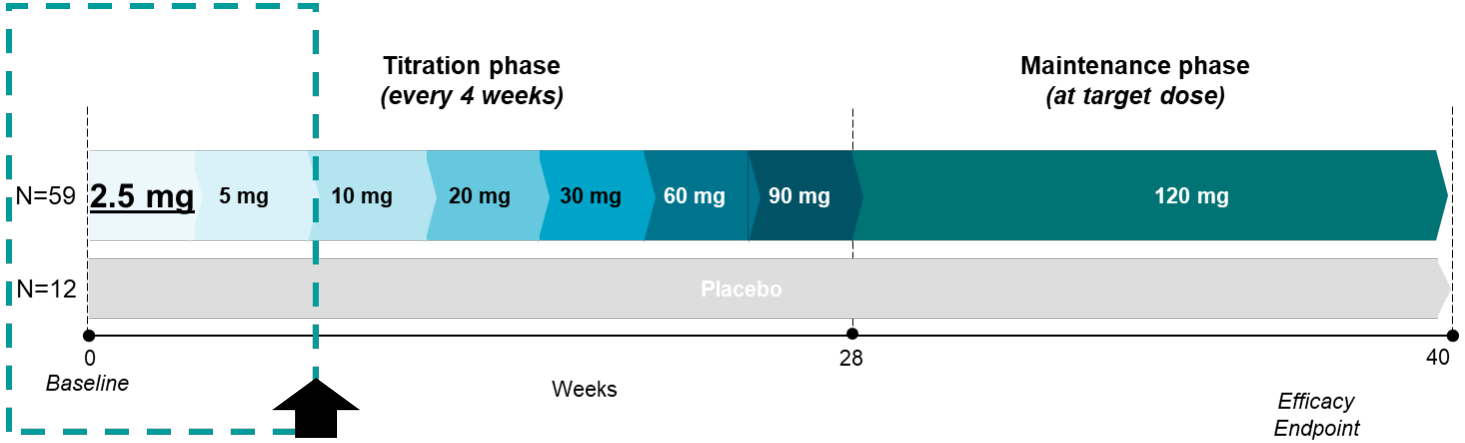
N=71

Participants with:

- Body mass index (BMI) **≥ 30 kg/m²**

Number of sites: 11

Clinicaltrials.gov ID: NCT06693843



Study Ongoing

Body Composition Study Objectives

- Evaluate tolerability with 2.5 mg starting dose
- Assess body fat loss over 40 weeks to inform body composition endpoints in Phase 3

**Study ongoing and interim data from a pre-specified analysis. Interim data as of November 25, 2025*

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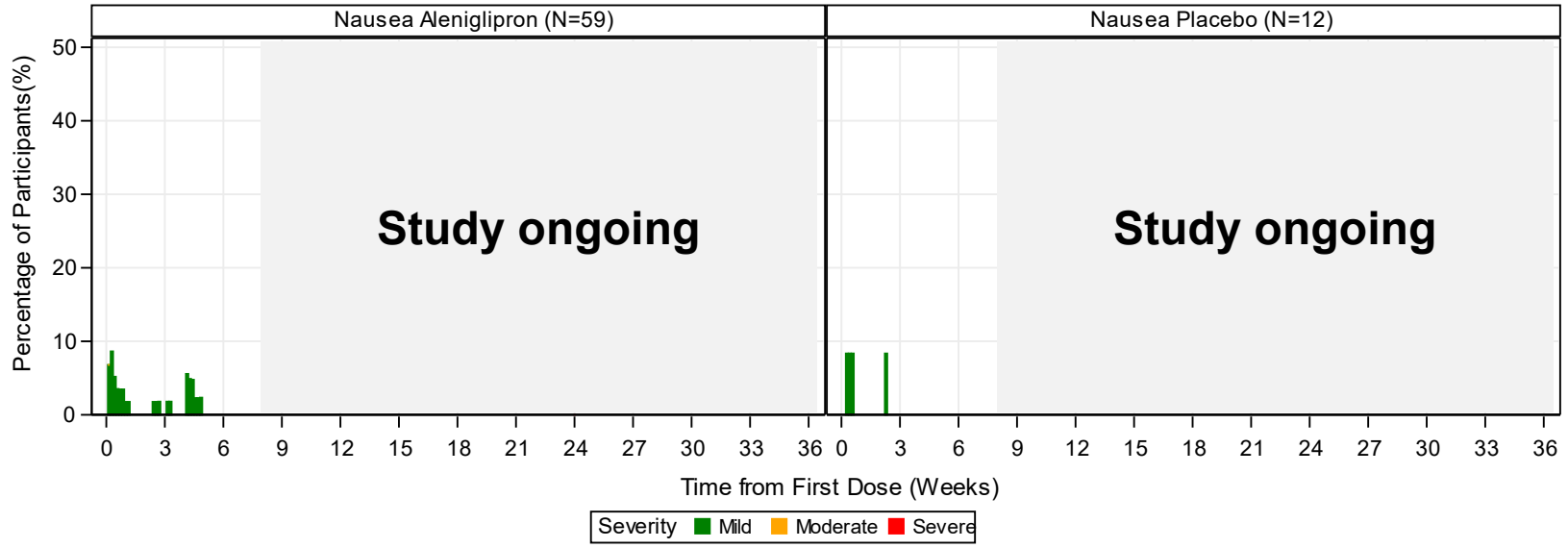
Baseline Demographics and Characteristics (Body Composition Study)

Characteristics Mean (SD) or N (%)	Aleniglipron N=59	Placebo N=12
Age, years, mean	54.5 (11.4)	48.8 (16.4)
Sex, female	38 (64.4)	8 (66.7)
Weight, kg	108.0 (20.2)	111.2 (20.8)
Body mass index, kg/m^2	38.1 (6.2)	39.6 (6.8)
HbA1c (%)	5.6 (0.3)	5.6 (0.3)
Ethnicity (Hispanic or Latino)	4 (6.8)	4 (33.3)

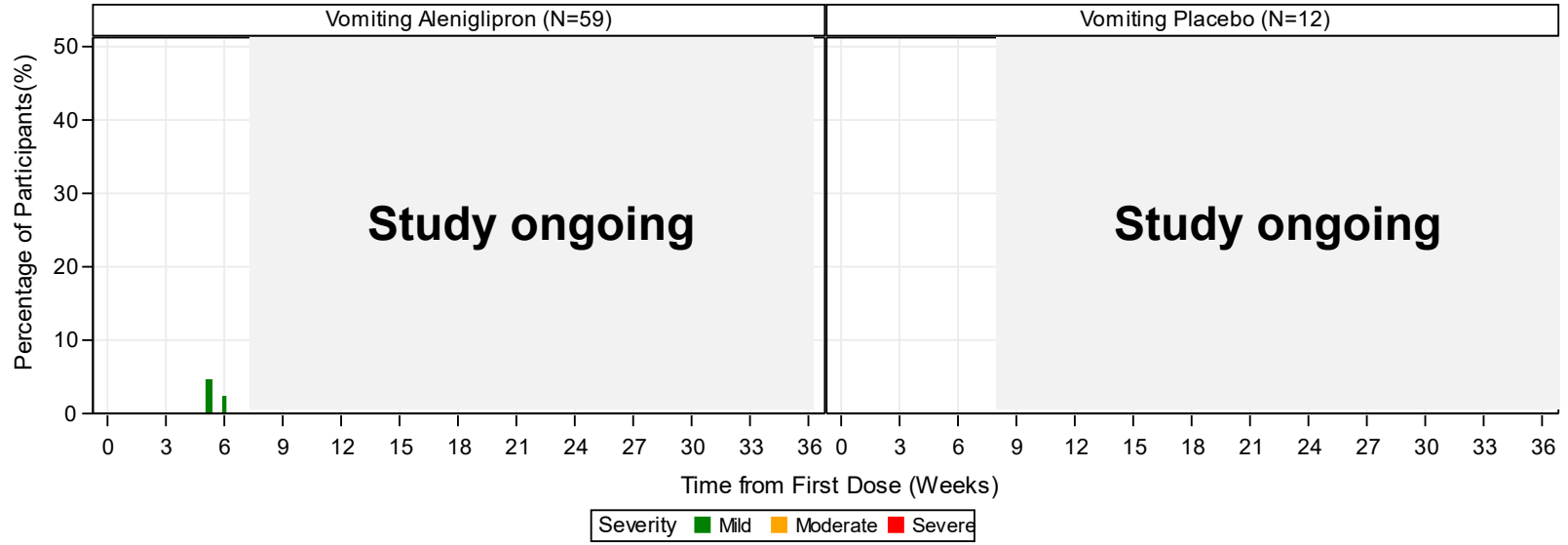
**Study ongoing and interim data from a pre-specified analysis. Interim data as of November 25, 2025*

Prevalence of Nausea and Vomiting by Dose Over Time (Body Composition Study)

Nausea



Vomiting



Nausea and Vomiting

- Low percentage

No treatment discontinuations due to AEs

Study ongoing and interim data from a pre-specified analysis. Interim data as of November 25, 2025

Cumulative Aleniglipron Tolerability Results with 2.5 mg Starting Dose (Body Composition Study)

- **No treatment discontinuations due to AEs after a median treatment of ~10 weeks***

Study Ongoing

N (%) Reporting at least one event	Aleniglipron N=59	Placebo N=12
Starting Dose	2.5 mg	
Any TEAE	42 (71.2)	9 (75.0)
Any TEAE leading to discontinuation of treatment	0	0
Nausea	21 (35.6)	2 (16.7)
Vomiting	5 (8.5)	0
Diarrhea	11 (18.6)	3 (25.0)
Constipation	15 (25.4)	3 (25.0)

**Study ongoing and interim data from a pre-specified analysis. Interim data as of November 25, 2025*

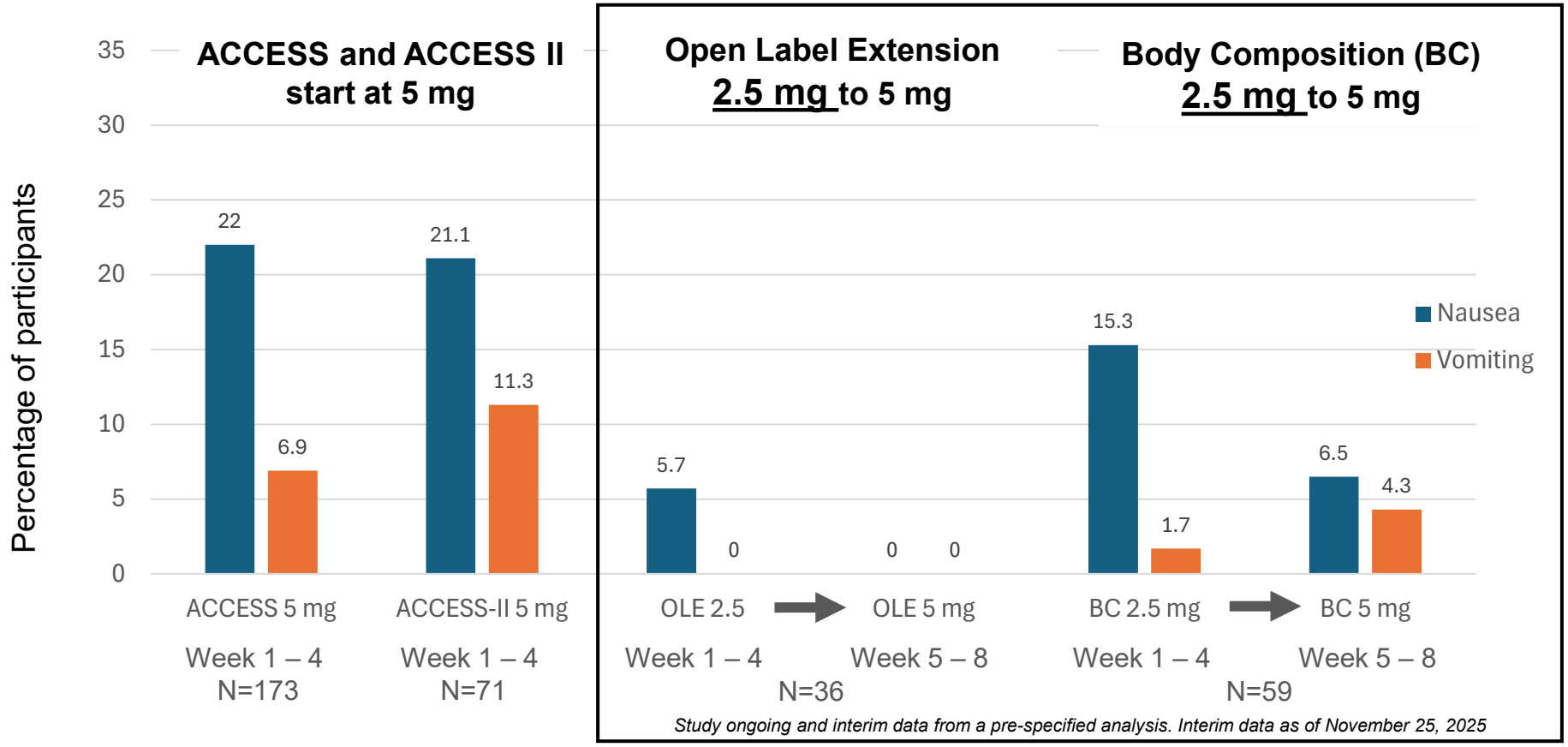
Question: Will lower 2.5 mg starting dose further improve tolerability? Aleniglipron Tolerability with 5 mg vs 2.5 mg Starting Dose

Answer:

- **Tolerability improved with lower 2.5 mg starting dose**
- **No treatment discontinuations due to AEs after a median treatment of ~10 weeks***

Rationale:

- **Peak of GI-related events in ACCESS program occurred at the 5 mg starting dose**
- **Majority of treatment discontinuations in ACCESS program occurred during the first 12 weeks**



Study ongoing and interim data from a pre-specified analysis. Interim data as of November 25, 2025

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Aleniglipron
Off-Target Safety Results

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Aleniglipron Demonstrated Favorable Off-Target Safety Results

- **No cases of drug-induced liver injury**
- **No cases of ALT or AST ≥ 10x upper limit of normal (ULN)**
- **All cases of elevated ALT and AST resolved without treatment discontinuation**

N (%)	Phase 2b ACCESS (up to 120 mg)				ACCESS OLE[1]	Exploratory ACCESS II (up to 240 mg)		Body Composition[2]	
	45 mg N=45	90 mg N=65	120 mg N=63	Placebo N=56	N=143	N=61	Placebo N=10	N=59	Placebo N=12
ALT ≥ 3x ULN	1 (2.3)	3 (4.8)	2 (3.2)	1 (1.8)	2 (1.4)	0	0	0	0
ALT ≥ 5x ULN	0	1 (1.6)	0	0	1 (0.7)	0	0	0	0
ALT ≥ 10x ULN	0	0	0	0	0	0	0	0	0
AST ≥ 3x ULN	0	0	0	1 (1.8)	0	1 (1.7)	0	0	0
AST ≥ 5x ULN	0	0	0	0	0	1 (1.7)	0	0	0
AST ≥ 10x ULN	0	0	0	0	0	0	0	0	0
ALT or AST ≥ 3 x ULN Total Bilirubin ≥ 2 x ULN	0	0	0	0	0	0	0	0	0

[1] Interim data as of November 26, 2025
[2] Interim data as of November 25, 2025

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Aleniglipron Obesity Data Summary

Differentiated Selective Oral GLP-1R Small Molecule Agonist

Efficacy

- **Phase 2b ACCESS**
  36 week placebo-adjusted mean weight loss:
  - **8.2% at 45 mg**
  - **9.8% at 90 mg**
  - **11.3% at 120 mg**
- **Exploratory ACCESS II**
  36 week placebo-adjusted mean weight loss:
  - **14.1% at 120 mg**
  - **14.4% at 180 mg**
  - **15.3% at 240 mg**
- **No evidence of weight loss plateau**
- **Proportional pharmacokinetic (PK) exposure up to 240 mg**
- **Clinically meaningful improvements in blood pressure and HbA1c**

Tolerability

- **Phase 2b ACCESS**:
  - GI-related AEs consistent with GLP-1RA class
  - **Overall 10.4% AE-related treatment discontinuations**
- **Exploratory ACCESS II**:
  - **For those participants who achieved re-randomization – No AE-related treatment discontinuations up to 240 mg dose**
- **Open Label Extension (OLE) & Body Composition:**
  - **Clinically meaningful improvement in tolerability when starting at 2.5 mg compared to 5 mg start**
  - **No discontinuations observed to date***

**Study ongoing and interim data from a pre-specified analysis. Interim data as of November 25, 2025*

Safety

- **> 500 participants treated across all studies up to 44 weeks**
  - **No events of drug induced liver injury**
  - **No off-target safety signals across all dose levels**
  - **No events of QTc prolongation**

Aleniglipron
Phase 3 Readiness

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Compelling Data Package to Advance into Phase 3*

Next Step: Conduct End of Phase 2 meeting with FDA to confirm registrational Phase 3 program

Core Focus	Key Questions	Answers
Phase 2b ACCESS ✓ Assess Efficacy Tolerability, Safety up to 120 mg at 36 weeks	**Is there weight loss plateau beyond 36 weeks?**	✓ No weight loss plateau beyond 36 weeks
	Can we dose greater than 120 mg?	✓ Additional weight loss confirmed with multiple doses up to 240 mg
	Will lower 2.5 mg starting dose further improve tolerability?	✓ 2.5 mg starting dose has demonstrated improved tolerability

Phase 3

Ready

Chronic Weight Management

Manufacturing

✓ **Phase 3 API manufacturing completed**

Phase 3 Drug Product manufacturing underway

* Subject to FDA approval

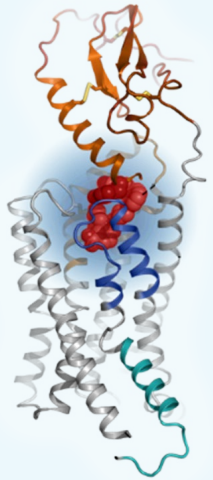
Structure THERAPEUTICS

Aleniglipron: A Backbone in Structure's Oral Small Molecule Portfolio

Raymond Stevens

Structure THERAPEUTICS

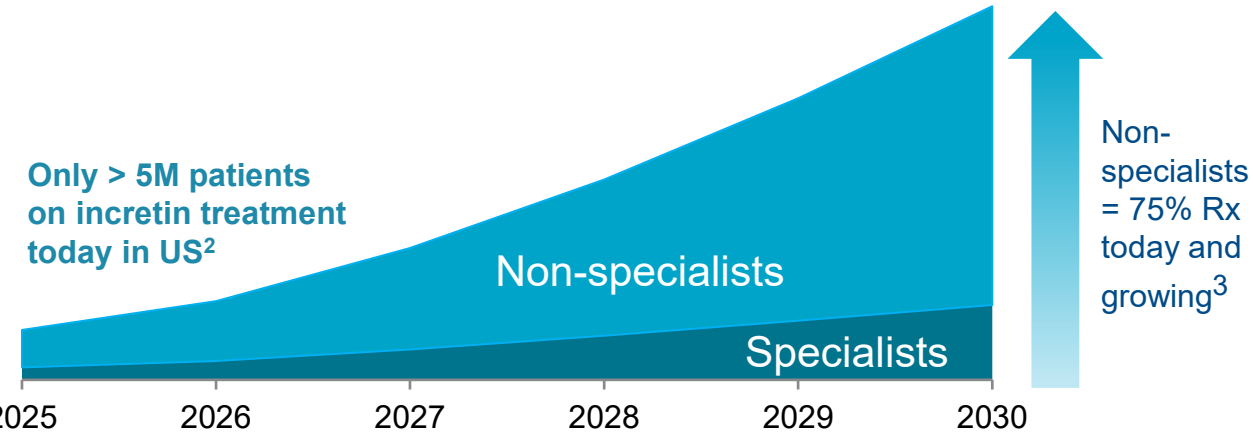
Aleniglipron is Differentiated and We Believe is Well Positioned to Capture a Significant Proportion of the Growing Obesity Market



GLP-1R Aleniglipron

- **15.3% placebo-adjusted mean weight loss at 36 weeks** with **240 mg**
- **Proportional exposure** up to 240 mg
- **No** evidence of weight loss **plateau**
- **2.5 mg** start further **improves** tolerability
- **Scaleable** to meet global **demand**

Only oral small molecules can scale and meet the needs of the global obesity patient population, estimated to be 1.5 billion by 2030[1]



- **PCPs/non-specialists indicate higher preference for orals** due to convenience & potential for broader access and coverage[4]
- **Orals represent an exciting new option for long-term maintenance;** more optionality for patients could facilitate improved persistence
- **Oral small molecules well-positioned to address unmet needs;** 25-50% of market could be orals[5]

1. World Obesity Atlas 2024 https://s3-eu-west-1.amazonaws.com/wof-files/WOF_Obesity_Atlas_2024.pdf
2. August 2025 Symphony Health prescription data and 2025 Evaluate Pharma sales data
3 Kumar et al., ISPOR (2025). https://www.ispor.org/docs/default-source/cti-meeting-21021-documents/6fe2eb97-d003-4dc0-b6d0-812e13795055.pdf?sfvrsn=45a94bc8_0. Based on July 2025 TRx data for Wegovy. Non-specialists include PCPs, Nurse Practitioners, Physician Assistants, and Family Medicine physicians
4 Based on internal physician survey and interview data
5.Triangulation between internal data, analog disease areas, and 3rd party estimates;

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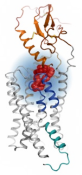
GLP-1RA and Amylin Oral Small Molecules Represent Backbones in our Future Oral Small Molecule Metabolic Portfolio

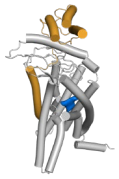
Backbones



GLP-1R

Aleniglipron: Phase 3 ready

- Oral small molecule; once-daily dosing
- Monotherapy backbone for chronic maintenance with potential best-in-class efficacy and safety
- Potential fixed-dose combination with other oral non-peptides



Amylin

ACCG-2671: IND cleared
ACCG-3535: DC selected

- Oral small molecule; once-daily dosing
- Potential for tolerability advantages
- Lean muscle mass preservation potential
- Potential fixed-dose combination with other oral non-peptides

Combination

- **GLP-1R + Amylin**
- ***Backbone* + GIPR**
- ***Backbone* + GCGR**
- ***Backbone* + GIPR + GCGR**

Important potential for:

- Greater body weight loss and enhanced tolerability
- Broader label expansion into additional clinical indications

Potential for Indication Expansion Beyond Obesity

including CKD, MASH, Hypertension, Heart Failure, Sleep Apnea, Type 2 Diabetes, Osteoarthritis, Addiction

2025: A Successful and Productive Year for Structure Therapeutics

Discovery and Development of a Strong and Broad Portfolio of Obesity related Oral Assets

Program	Molecule(s)	Study / Focus	Discovery	Lead Optimization	Development Candidate/ IND-enabling	Phase 1	Phase 2	Phase 3
Selective GLP-1 Receptor Agonist Backbone	Aleniglipron (GSBR-1290)	ACCESS (+ OLE)						
		ACCESS II (+ Extension)						
		Type 2 Diabetes						
		SWITCH Study						
		Body Composition						
Amylin Receptor Agonists Backbone	Amylin	ACCG-2671 (DACRA)				✓ IND Cleared: Phase 1 Initiation Dec 2025		
		ACCG-3535 (DACRA)			✓ Development Candidate Selected Nov 2025			
		SARA						
Combinations	GLP-1RA + Amylin	GLP-1RA + Amylin						
	Backbone + GIPR	GLP-1RA + GIPR Amylin + GIPR						
	Backbone + GCGR	Backbone + GCGR Backbone + GIPR + GCGR						

$799M[1] Cash with Multiple Anticipated Catalysts Over the Next 12 Months

Aleniglipron

H2 2025

- ✓ Initiation of ACCESS OLE, ACCESS II Extension, Body Composition, SWITCH, Type 2 Diabetes studies
- ✓ Topline results from ACCESS
- ✓ Interim results from ACCESS 2
- ✓ Interim results from Body Composition

H1 2026

- ❑ End of Phase 2 Meeting with FDA
- ❑ Topline results:
  - ❑ ACCESS OLE
  - ❑ ACCESS 2 Extension
  - ❑ Body Composition

H2 2026

- ❑ Early 2H Initiation of pivotal Phase 3 study
- ❑ Topline results from SWITCH study
- ❑ Topline results from Type 2 Diabetes

Amylin

H2 2025

- ✓ Selection of ACCG-3535 – Second DACRA Development Candidate
- ✓ ACCG-2671 IND cleared First-in-Human Phase 1 study

H2 2026

- ❑ ACCG-2671 Phase 1 study results
- ❑ ACCG-3535 Phase 1 study initiation

1. As of September 30, 2025 and includes cash equivalents and short-term investments

Structure THERAPEUTICS

Our Mission

Making medicines more accessible to all