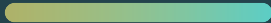


September 2026



Marea Therapeutics

*Transformative cardioendocrine
therapies*



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Rapid Path to Value Creation

Two potentially first-in-class assets with best-in-disease potential in large addressable markets

MAR001/5

Severe Hypertriglyceridemia

*Potent sHTG candidate
with a clean metabolic
profile*

>3M US patients¹

At risk of acute pancreatitis;
APOC3 drugs worsen diabetes
/ liver fat

~70% TG reduction³

Phase 2b sHTG POC
(subgroup with baseline
TG>500, n=7)
TG lowering in Phase 2 similar
to approved APOC3s

Clean metabolic profile

No HbA1c increase or liver-fat
penalty to date – potentially
differentiated from approved
APOCs

>\$10B market opportunity⁵

First choice for >1.8M²
diabetics with sHTG

MAR002

Acromegaly

*First long-acting GHR
antagonist candidate for
acromegaly*

~30K US patients⁴

Highly morbid; >70%
uncontrolled

Potential Best-in- class anti-GHR mAb

Target profile: Best-in-class
efficacy, safety and biweekly
dosing

Phase 1 proof of mechanism

Promising IGF-1 suppression
(approvable endpoint)

>\$1B in SRL sales⁵

Potential to address 3x more
patients than SRLs

1. Christian JB, et al., Am J Cardiol. 2011;107(6):891–897; 2. Zafrir B, et al. J Clin Lipidol 2018;12(4):928–936; 3. Marea data on file; 4. Burton T et al. Pituitary 2016;19(3):262–267; 5. EvaluatePharma, ClearView market research, company press releases
Abbreviations: GHR: growth hormone receptor; sHTG: Severe Hypertriglyceridemia; SRL: somatostatin receptor ligand *MAR001 is parent antibody; MAR005 formerly known as MAR001-HLE

Advancing a Late-Stage Cardioendocrine Pipeline Toward Potential 2026–27 Value Inflections

	Molecule	Target	Indication	Disc	IND-E	Ph1	Ph2	Ph3	Anticipated Near-term Milestones
Cardiometabolic	MAR001 (parent mAb)	ANGPTL4	sHTG	MAR001 Phase 2b TYDAL (mHTG/sHTG)					Q2 2026 ✓ • Phase 2/2b 12-week data
				MAR001 Phase 2b extension (sHTG)					H2 2026 • Phase 2/2b 24-week data
				MAR001 Phase 2 Mechanistic Study					H2 2027 • Phase 2 extension (sHTG) topline data
	MAR005 (half-life extended MAR001)	ANGPTL4	sHTG						Mid-2027 • Phase 3 MAR005 dose selection including additional TG efficacy/PD
Endocrine	MAR002	Growth hormone receptor	Acromegaly						H2 2027 • Phase 3 FPI
									Q1 2026 ✓ • Phase 1 (NHV) topline data
									Mid-2026 ✓ • Initiate Phase 2 study
									Mid-2027 • Interim Phase 2 data
									Q4 2027 • Phase 2 topline data
									H1 2028 • Phase 3 FPI

- MAR001 has established POC in Phase 2. **MAR005** is our Phase 3 candidate- it is an improved version of MAR001 with half-life extension and improved PK. The FDA agreed to PK bridging to Phase 3.
- Marea also has developed a SiRNA platform and is developing adipose tissue targeted SiRNAs

Abbreviations: NHV: normal healthy volunteer; sHTG: Severe Hypertriglyceridemia

MAR005 for sHTG

Potent sHTG candidate with a clean metabolic profile

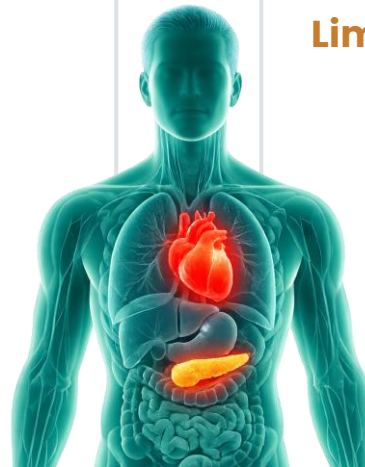
Recurrent Pancreatitis in sHTG: A Life-Altering Condition with Limited Options

➤ **3 million Americans; \$9B in healthcare costs, no approved prevention therapies until recently**



The Unmet Need

- ➤ **3M Americans** with sHTG face **recurrent AP** attacks
- **Up to 20% mortality per episode**⁴
- Cumulative attacks cause **irreversible pancreatic destruction**, chronic pain, and secondary diabetes
- **60% T2DM**¹, **30% CAD**¹, **70% fatty liver**²: a high-risk population with **➤\$9B annual cost burden**³
- **30% have poorly controlled T2DM** (HbA1c>9%)⁴



Until Recently: Limited Options

Limited Generic Options

- **Fibrates**
- **Omega-3 Fatty Acids**

The Critical Gap

- **Inadequate TG lowering**
 - ~30% reduction leaves most sHTG patients above the AP risk threshold
- **No evidence for AP prevention**
- **Poor tolerability**

1. Marston, NA, et al., N Engl J Med 2025;394:429–441; 2. Gurevitz, C et al., JACC: Advances 2024;3(5) 3. Lee PJ., Nat Rev Gastroenterol Hepatol. 2019;16(8):479–496; 4. Lu J, et al., BMC Gastroenterology. 2025;25:374. Abbreviations: SOC: standard-of-care; AP: acute pancreatitis; MI: myocardial infarction; CAD: coronary artery disease. 4. Marea claims data analysis

APOC3 Inhibition: New Treatments Driving a Potential Multi-Billion Dollar Opportunity

First class of medications to demonstrate acute pancreatitis (AP) event reduction

60–80% **TG reduction** — dramatically superior to fibrates or omega-3 fish oil

78–85% **Reduction in AP events** first proven AP reduction in sHTG

>80% **Patients reaching TG <500 mg/dL** vs. 35% placebo — bringing most patients below the AP-risk threshold at 12 months

Clinical benefit supports premium list pricing at \$40–45k

Next-Gen Rx sHTG Opportunity

PROJECTED US MARKET

>\$10B

Olezarsen (Ionis): >\$3B projected peak sales

Plozasiran (Arrowhead): \$3–4B projected peak sales

“What patients really look for is not going through [AP] again. If you can reduce it to almost zero, that’s what patients care about most.”

— Endocrinologist

“It’s more effective than 6 or 9 fish oil pills and a fibrate every day, forever ... one shot at home, every four weeks. I have no trouble convincing somebody.”

— PCP

Sources: Marston, NA, et al., N Engl J Med 2025;394:429–441; Ionis AHA 2025 press release; Arrowhead July 2026 press release; Overall NNT=20; ClearView market research; AP: acute pancreatitis; SOC: standard of care

APOC3 Class Comes at a Cost: Deterioration in Glycemia / Exclusion of the 30% Patients with Poorly Controlled T2DM

HbA1c +0.3 despite Rx; Hyperglycemia AEs were most common Plozasiran AE^{1,4}; Plozasiran excluded HBA1c>9

Population	Drug / Study	TG Reduction	Adverse Effects on Glycemic Control (in T2DM)	Source
mHTG	Plozasiran — MUIR Ph2b, Wk 24	58% (56% pbo corrected) – 25mg	+0.36% (25mg) absolute vs. placebo	Ballantyne, NEJM 2024
sHTG	Plozasiran — SHASTA-2 Ph2b, Wk 24	70% (53% pbo-corrected) – 25mg	Worsening glycemic control TEAE 16.4% (25 mg) vs 11.5% pbo	Gaudet, JAMA Cardiol 2024
sHTG + mHTG	Plozasiran — SHASTA-2 + MUIR OLE, 24 mo	-83% (SHASTA-2 OLE) – 25mg -67% (MUIR OLE) – 25mg	9.6% T2DM / 6.7% DM / 4.1% "HbA1c increased" as TEAEs; glycemic terms drove 69% of drug d/c	Ballantyne, Am J Prev Cardiol 2026
sHTG	Plozasiran — SHASTA-3/4	79-81% (52-54% pbo-corrected*) – 25mg, 12 mo	+0.2-0.3% in overall population at 6 months (T2DM subgroup not yet reported); 14% glycemic AEs vs 8.7% pbo despite active protocol- mandated management	Watts GF, ESC Congress 2026
sHTG	Olezarsen — CORE/CORE2 Ph3	63% (49-63% pbo corrected) – 50mg, 6 mo 68-73% (55-72 pbo corrected) – 80mg, 6 mo	+0.34% (50mg) / +0.25% (80mg) pbo-adj. at 12 mo, both p<0.05	Marston, NEJM 2025
sHTG	Olezarsen – approved sHTG label	As above	Hepatic fat in Warnings & Precautions Increase in glucose, worse in diabetics (clinical trial section of label)	FDA-approved USPI
FCS	Plozasiran — PALISADE, 10 mo	80% (59% pbo corrected) – 25mg	+0.36% HbA1c (25mg); FPG +9 mg/dL (diabetic+nondiabetic); hyperglycemia 40% (nondiabetic) vs 20% placebo	Redemplo USPI, Nov 2025
FCS	Olezarsen — approved FCS label	30% (43% pbo corrected) – 80mg	Hyperglycemia 52% (nondiabetic) vs 35% placebo	Tryngolza USPI

Summary: APOC3 class effect; 2 molecules, 3 populations (mHTG, sHTG, FCS); 5+ independent studies and 2 FDA labels all show the same ~0.3–0.4% HbA1c signal despite antidiabetic meds

Cross-trial comparisons are subject to inherent limitations and should be interpreted with caution; no head-to-head studies were conducted

1. Ballantyne et al, NEJM 2024 & Am J Prev Cardiol 2026; 2. Marston et al, NEJM 2025; 3. Gaudet et al, JAMA Cardiol 2024; 4. Tryngolza & Redemplo USP; 5. Watts GF, et al. SHASTA-3/SHASTA-4. ESC Congress 2026
 *Placebo correction calculated by Marea

Biology and Genetics Support Inhibition of ANGPTL4 as Potential Best-in-Disease Profile

The first physiologic sink for excess triglycerides

ANGPTL4 Inhibition (MAR001/5)



- Physiological adipose TG clearance
- No hepatic fat loading
- TG lowering scales with disease severity

APOC3 Inhibition (Olezarsen/Plozasiran)



- Forced hepatic TG clearance
- HbA1c increases in patients with T2DM
- HFF increases

Genetics predict differentiated impact on glycemic control*



A potential mechanism with no observed metabolic penalty

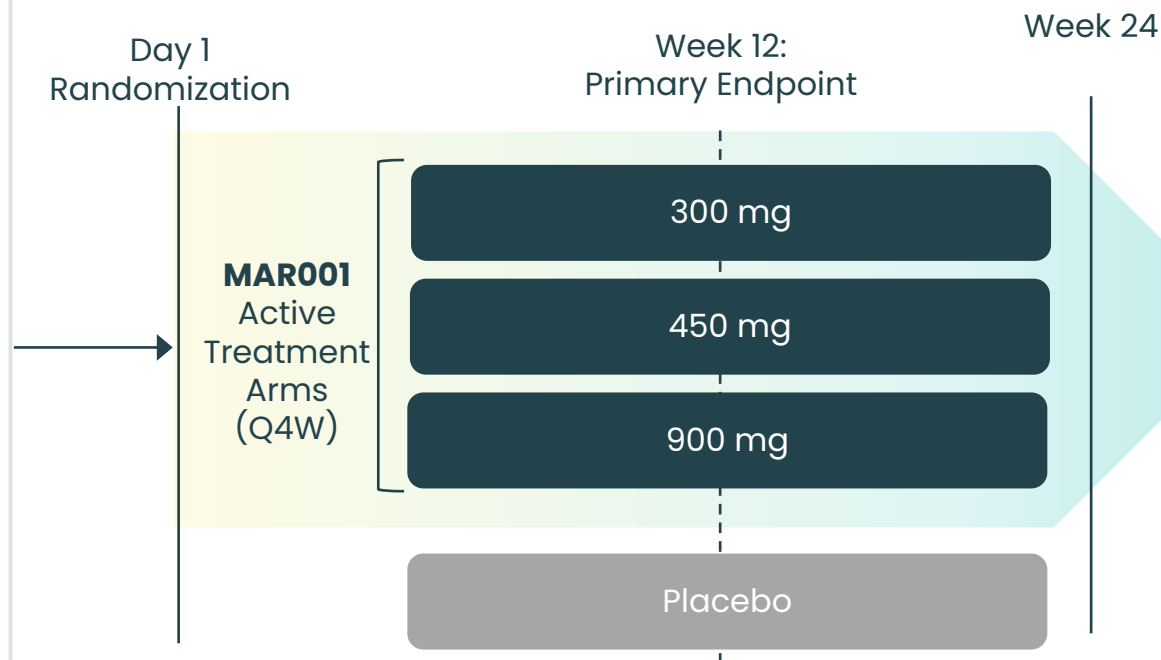
Abbreviations: LPL: lipoprotein lipase; HFF: hepatic fat fraction; * <https://academic.oup.com/ehjopen/article/4/3/oeae035/7659859>; <https://doi.org/10.1186/s12933-026-03209-w>; <https://doi.org/10.1038/s41467-018-04611-z>

TYDAL-TIMI 78 Phase 2b: Establishing a Potential Best in Disease Profile

›60% T2DM/pre-DM informs metabolic safety profile; sHTG subgroup informs clinical activity

Study Population (N=235)

- Key Inclusion Criteria:
 - TG ≥ 150 to < 880 mg/dL
- Baseline characteristics
 - ~61% pre-DM/T2DM
 - ≥ 400 mg/dL subgroup (n=25²): baseline TG = 495 mg/dL
 - ≥ 500 mg/dL subgroup (n=12): baseline TG = 606 mg/dL
- Key Endpoints:
 - Primary (at 12 weeks):
 - % Reduction in TG
 - % Reduction in RC
 - Other secondary and exploratory endpoints
 - HbA1c
 - Lipids at Week 12 and 24



Key 12-week Topline Data

- Approx 40% TG lowering overall
- TG lowering scales with baseline TG
 - >65% in TG ≥ 400 mg/dL group (n=15; MAR001 pooled)
 - ~70% in TG ≥ 500 mg/dL group (n=7; MAR001 pooled)
- Consistent effects at 24 weeks
- Safety profile consistent with placebo (overall TEAES $<$ pbo)
 - No increase in HbA1c (numeric reduction)
 - No liver enzyme elevation signal (numeric reductions)
 - Injection site reactions similar to placebo
- PK/PD supports go-forward MAR005 dose of 300mg monthly for Phase 3

1. Participants are randomized 3:1 MAR001 to placebo (~59 participants per arm); TG: triglycerides; RC: remnant cholesterol; T2DM: Type-2 diabetes mellitus; <https://timi.org/tydal-timi-78>; 2. 12-week efficacy data available for 23 patients; efficacy numbers are median change to 12 weeks

MAR001: Emerging Clinical Data Supports Potential Best-in-Disease Profile

	MAR001/005	Olezarsen ¹	Plozasiran ^{2,4,6,7}
TG Lowering	-70% + Phase 2b, pooled 450/900 mg dose; >500 mg/dL subgroup; median TG 606 mg/dL at baseline	-63 to -73% Phase 3 efficacy; median TG 793 mg/dL at baseline	-79 to -81% -27% pbo Phase 3 efficacy; median TG 677 mg/dL at baseline
HbA1c	-0.2% Decrease in Phase 2b vs. pbo (prelim. & not significant)	+0.25 to +0.34% Increase in T2D subgroup in Phase 3 vs. pbo	+0.36% Increase in T2D subgroup in Phase 2b vs. pbo; up to 20% diabetes AEs
Hepatic Fat	0% No hepatic fat increase ^{3,5}	+2 to +4% Absolute increase in hepatic fat fraction	+1.5% Absolute increase in hepatic fat fraction vs pbo in Phase 3 (NS, p=0.70)
Dosing	Q4W-Q12W SC dosing with MAR005	Q4W SC dosing	Q12W SC dosing

Cross-trial comparisons are subject to inherent limitations and should be interpreted with caution; no head-to-head studies were conducted

1. Marston, NA, et al. N Engl J Med 2025;394:429-441; 2. Gaudet D, et al. JAMA Cardiol. 2024;9(7):620-630; 3. Cummings, B, et al. The Lancet. 2025;405(10493):1923-1934; 4. Ballantyne C, et al. N Engl J Med 2024;391(10):899-912; (the SHASTA-2 study did not report HbA1c in T2DM, this data is from the MUIR study of Plozasiran in mixed dyslipidemia); 5. Marea data on file from MAR-102 and MAR-104; 6. Lepor N, et al. WCIRDC 2025; Poster #0034; 7. Watts GF, et al. SHASTA-3/SHASTA-4. ESC Congress 2026

MAR001/5 Profile: Highly Differentiated; Compelling to Physicians; Represents Large Potential Opportunity

+0.3 HbA1c difference could be clinically meaningful

- Even small, sustained HbA1c increases carry independent cardiovascular risk¹
- +0.3 HbA1c increase is estimated to lead to ~6% higher risk of diabetes-related death and ~11% higher risk of microvascular complications²

HbA1c drives physician choice in sHTG

HbA1c stabilization #1 physician weighted attribute for new sHTG drugs in T2DM patients³

Potential for 1/3 or more of a \$10B market

Driven by uptake in the 1.8 M patients with sHTG+T2DM where at least 50% have uncontrolled glucose⁴ and where competitors *excluded* poorly controlled T2DM (30% of sHTG patients)

*"Any **new starts** would probably go to the **ANGPTL4 inhibitor** ... a much cleaner profile without the hepatic-fat increase, and you don't see an A1C increase."*

— Endocrinologist

*"The **main difference** is in the **safety category**, which I put at the top ... there's no hepatic-fat issue, **there's no A1C issue**."*

— Cardiologist

*"I would **target** the use of [MAR005] for **patients who have diabetes or prediabetes**, or I think are at high risk for developing diabetes"*

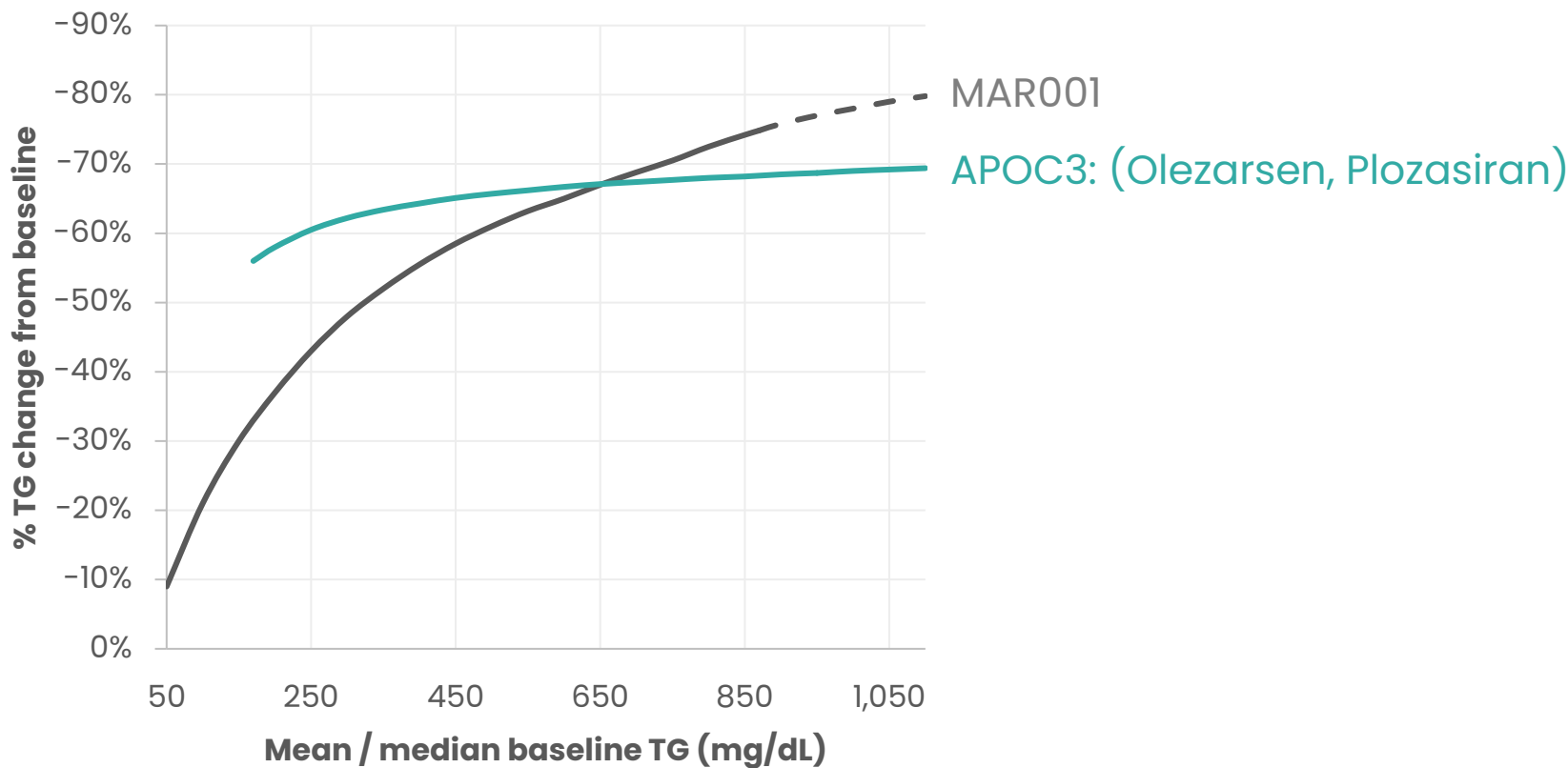
—Cardiologist

1. Luo S, et al. Diabetologia 2021;64(11):2502–2510; 2. Stratton IM, et al. BMJ 2000;321(7258):405–412. Data above are an illustrative linear scaling of this relationship to a 0.3-point change and are not a direct finding from APOC3 clinical trials.

3. Market research conducted by ClearView Healthcare Partners (Q1 2026): quantitative physician survey (N=151: 75 endocrinologists, 70 cardiologists, 6 lipidologists) plus N=15 in-depth qualitative interviews incorporating a blinded discrete-choice/conjoint exercise to isolate the relative importance of individual product attributes (efficacy, safety, dosing) on treatment share; 4. "Trends in Diabetes Treatment and Control in U.S. Adults, 1999–2018," N Engl J Med 2021;384:2219–2228

As Predicted by Biology: ANGPTL4 Inhibition Overperforms in sHTG vs. mHTG

TG lowering scales with baseline TGs: MAR001 is competitive with APOC3 inhibitors in severe patients



Notes: Clinical Data from MAR001 and APOC3 Programs; data extrapolation and curve fitting are based on the following:
Olezarsen data are from four trials (BRIDGE-TIMI 73a, ESSENCE-TIMI 73b, CORE-TIMI 72a, CORE2-TIMI 72b) at both the 50mg and 80mg Q4W doses, with overall trial populations at Month 6.
Plozasiran data are from the MUIR trial (25mg Q12W, overall population, Week 24) and the SHASTA-2 trial (25mg Q12W, overall population, Week 24). Phase 3 plozasiran data pending
MAR001 data are from three studies: the Phase 1 single-dose study (450mg, overall populations from Parts 1A, 1B, and 1C at Day 15), the Phase 1b/2a multidose study (MAR-102; 450mg Q2W, overall population, Week 12), and TYDAL-TIMI 78 (MAR-103; 900mg Q4W, overall population and baseline TG subgroups ≥ 300 , ≥ 400 , and ≥ 500 mg/dL, Week 12).

Cross-trial comparisons are subject to inherent limitations and should be interpreted with caution; no head-to-head studies were conducted

MAR-104 Study: Potential Best-in-Class Suppression of Postprandial TGs

MAR001 flattens the post-prandial TG surge, the key driver of AP risk

Study Population (N=31)

Key Inclusion Criteria

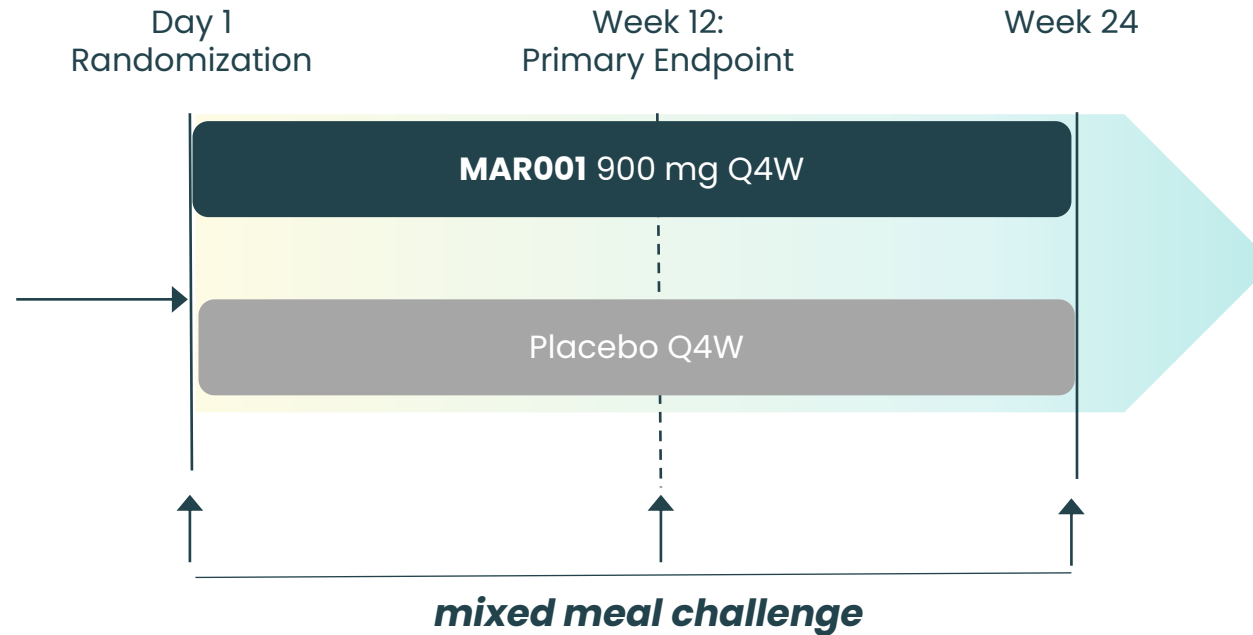
- TG ≥ 175 to < 500 mg/dL
- HbA1c: 5.5 to 9%

Key Baseline Characteristics

- % Pts with Pre-DM/T2DM: 87%
- Mean TG: 261 mg/dL

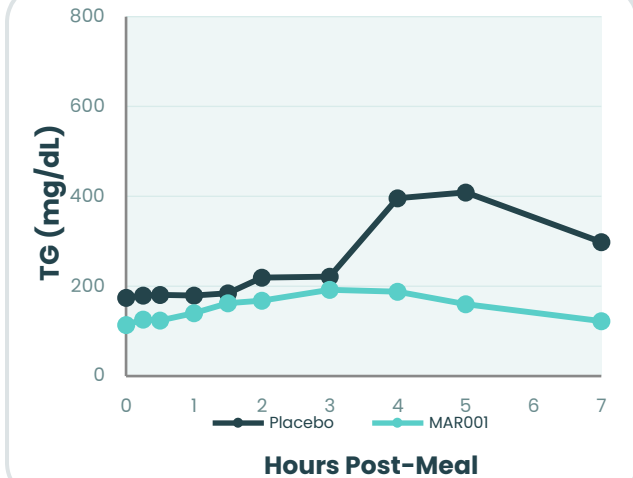
Key Endpoints

- Post-prandial TG at week 12 and 24



Key 12-week topline data

- **42% reduction in TG AUC** at 12 weeks for MAR001 vs. Pbo
- **40% reduction in TG iAUC** at 12 weeks vs pbo



Post-prandial TG suppression similar to or greater than results with Olezarsan ($\downarrow 50\%$ AUC, 28% iAUC)²

1. Participants are randomized 2:1 MAR001 to placebo (~21 participants in MAR001 arm and 10 patients in placebo arm) TG: triglycerides; AP; acute pancreatitis, iAUC is AUC corrected for baseline fasting TGs
2. Kraaijenhof JM et al. "Plasma reduction of apolipoprotein C-III with olezarsen leads to significant reductions in postprandial triglyceride levels: results from a randomized trial." Eur J Prev Cardiol 2025; Estimate from figure 1D

MAR002 for Acromegaly

First long-acting GHR antagonist candidate for
acromegaly

Acromegaly: Serious Disease with Inadequate Options for Medical Therapy

The Burden & Opportunity

~30K patients US

- caused by excess GH production from benign pituitary adenoma.

Early Mortality and High Morbidity

- Bone/organ overgrowth, cardiovascular & metabolic disease.
- Median lifespan shortened by ~10 years without effective therapy.

Medical Therapy Goals:

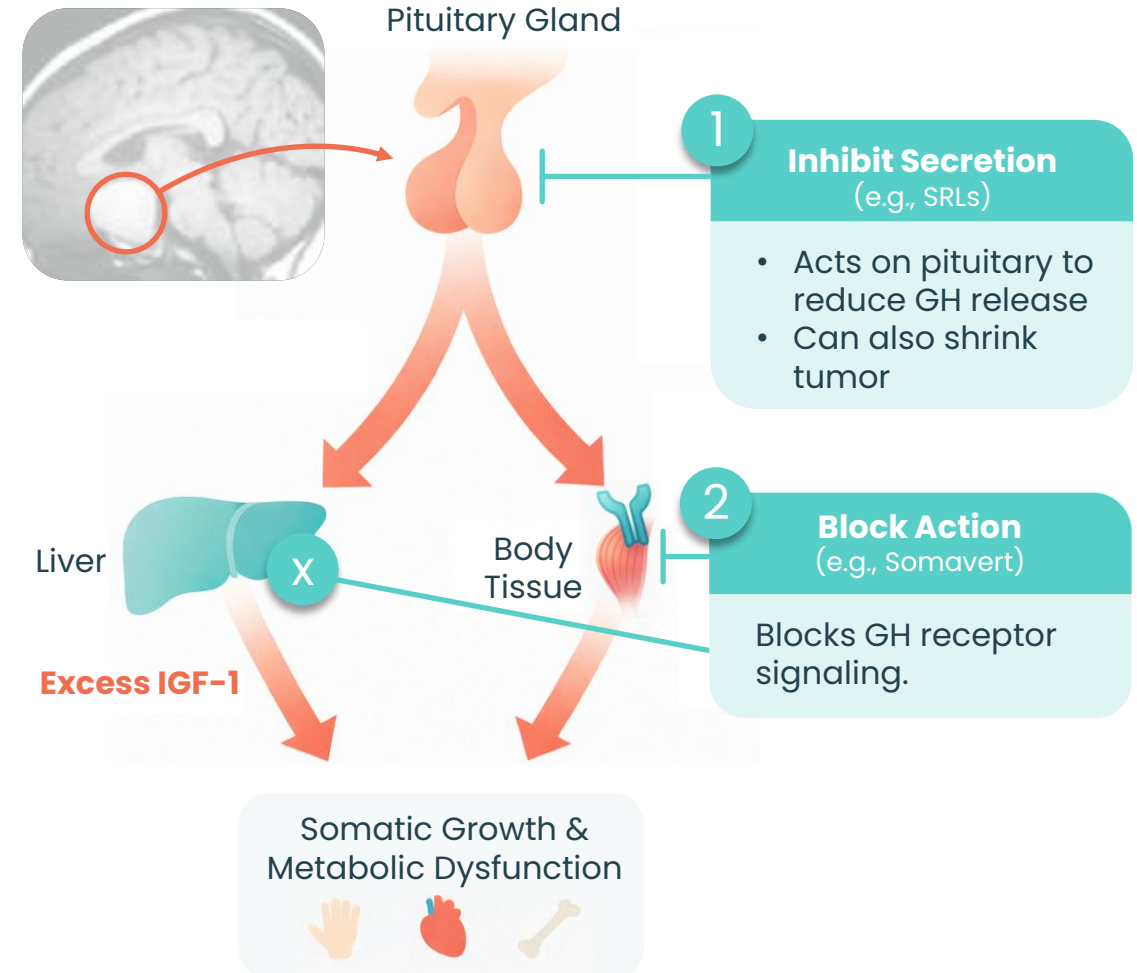
Decrease tumor volume (some patients)

Normalize IGF-1 levels (all patients)

>70% of patients are addressable: Approx 9K US patients need a better GH antagonist to achieve IGF-1 normalization

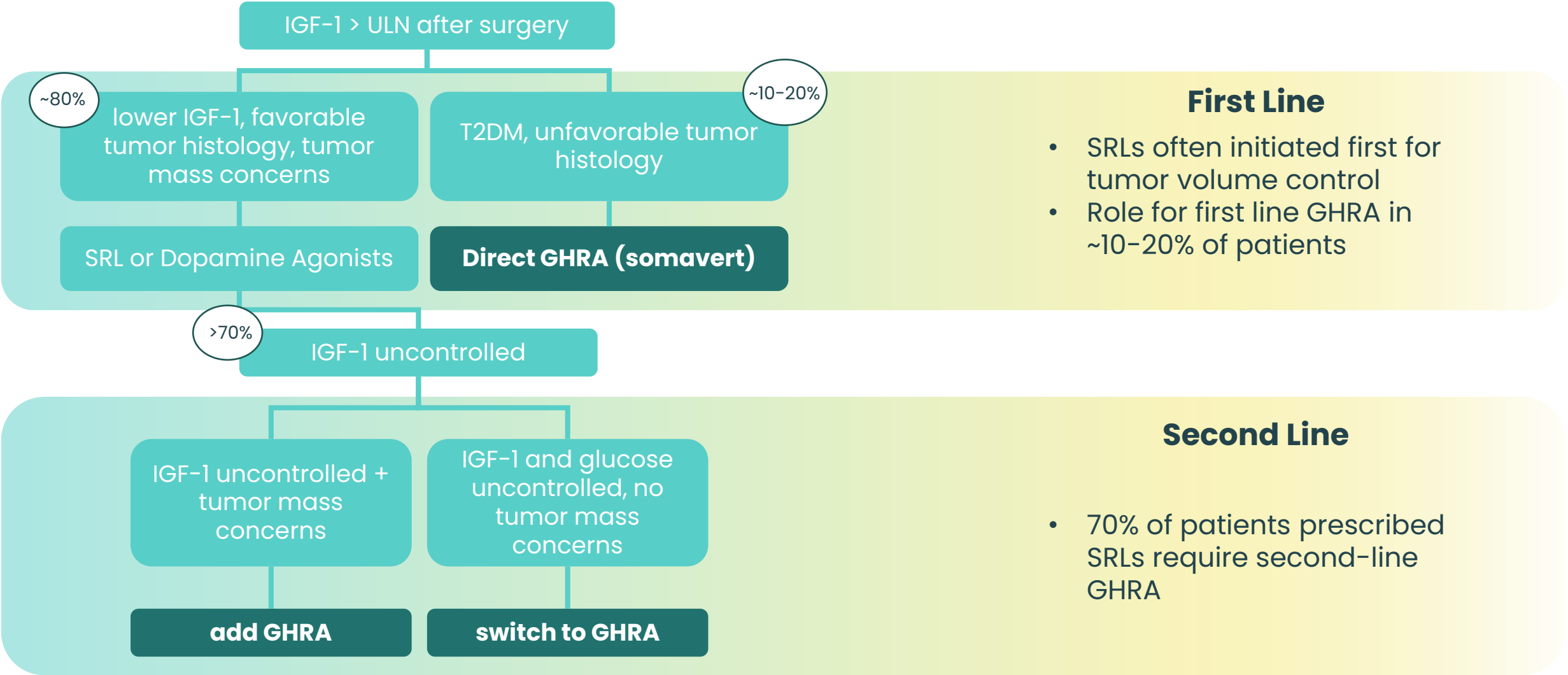
Efficient Development Path: IGF-1 is an established clinical and regulatory endpoint.

Two Approaches to Medical Therapy



Abbreviations: GH: Growth Hormone; GHR: Growth Hormone Receptor; SRL: Somatostatin Receptor Ligand
Sources: UpToDate; Holdaway et al., Eur J Endo, 2008; Moustaki et al, Endocrine, 2023; van der Lely et al., Lancet, 2001

Medical Therapy Treatment Guidelines: Direct Growth Hormone Antagonists Critical for >70% of Patients



Sources: Melmed & Giustina, Nat Rev Endocrinol, 2025; Fleseriu et al., J Endocr Soc, 2023; Moustaki et al., Endocrine, 2023; Carmichael et al., J Clin Endocrinol Metab, 2014; Colao et al., J Clin Endocrinol Metab, 2014.
Abbreviations: GHRA: growth hormone receptor antagonist; SRL: somatostatin receptor ligand.

The Marea Opportunity

Most patients are not fully controlled or cannot tolerate current therapies



Strong drive to treat patients to IGF-1 Goal

- **2.5x mortality rate in patients who do not achieve IGF-1 normalization¹**
- Guidelines mandate medical therapy to control



SRLs: First line, but limited control

- **Somatostatin receptor ligands: <30% disease control**
 - SRL class causes **GI intolerance and hyperglycemia**
 - Often used first-line for tumor mass control
 - A \$1B US market despite addressing only 30% of patients



The most effective drug class is underused

- **Direct GHRA: 81% disease² control**
- **The only approved GHRA has poor PK, tolerability**
 - **1-2 daily painful injections, LFTs**
 - **Real-world efficacy is only 50% (low compliance)**
 - \$300M global sales despite severe limitations

MAR002 (anti-GHR mAb) A Potential Optimal Direct GHRA

>60% IGF-1 max suppression³

>10x Longer duration of >45% IGF-1 suppression vs. Somavert in healthy volunteers⁴

>\$1B* Potential to address 3x more patients than SRLs

"I loved how I felt on GHR-antagonist therapy, but the daily injections were hard to sustain. Having that same level of clinical control without the daily burden would be life-changing. MAR002 isn't just a new drug; it's a chance to get our lives back."

Jill Sisco, President, Acromegaly Community

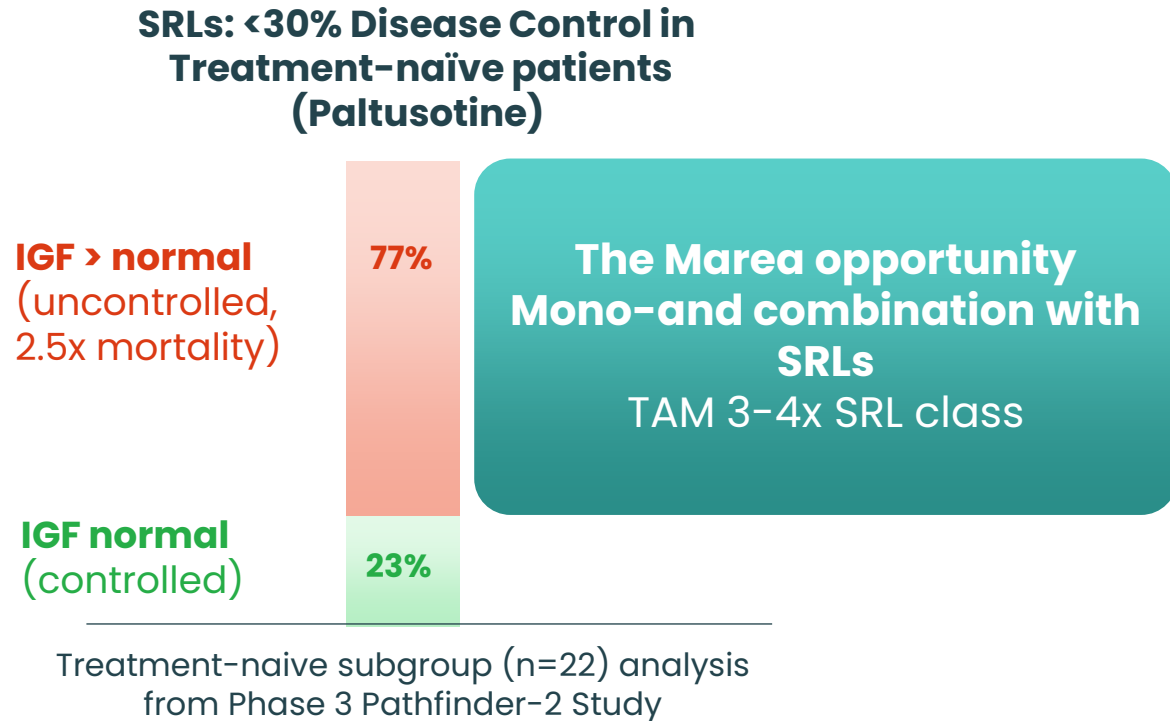
This drug could improve control in most patients, either alone or in combination with an SRL.

leading U.S. KOL

1. Holdaway IM, et al. Eur J Endocrinol 2008;159(2):89-95; 2. Trainer PJ, et al. N Engl J Med 2000;342(16):1171-1177; 3. Marea data on file; 4. Cross-trial comparisons are subject to inherent limitations and should be interpreted with caution. MAR002: Marea data on file (single 900 mg SC dose, n=8); Pegvisomant (Somavert) comparator estimated from Thorner MO, et al. J Clin Endocrinol Metab 1999;84(6):2098-2103, Fig 6 (single 1.0 mg/kg SC dose, n=6); *SRL projected market opportunity; Abbreviations: GHRA: growth hormone receptor antagonist

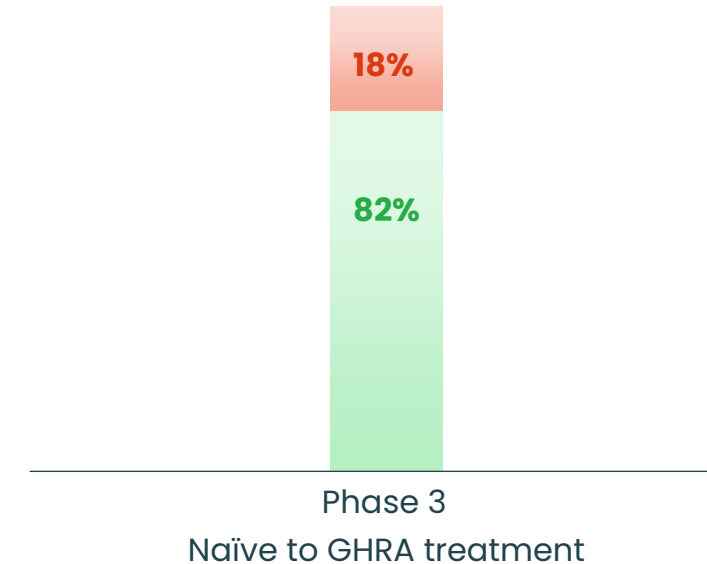
An Optimal Direct GHRA Could Address 3-4x More Patients than the SRL Class

A better GHRA than Somavert is needed to address >9K patients



Safety: mechanism-related hyperglycemia (74% of treated participants developed at least 1 incident) and GI AEs

GH Antagonist: >90% Disease Control (Somavert)

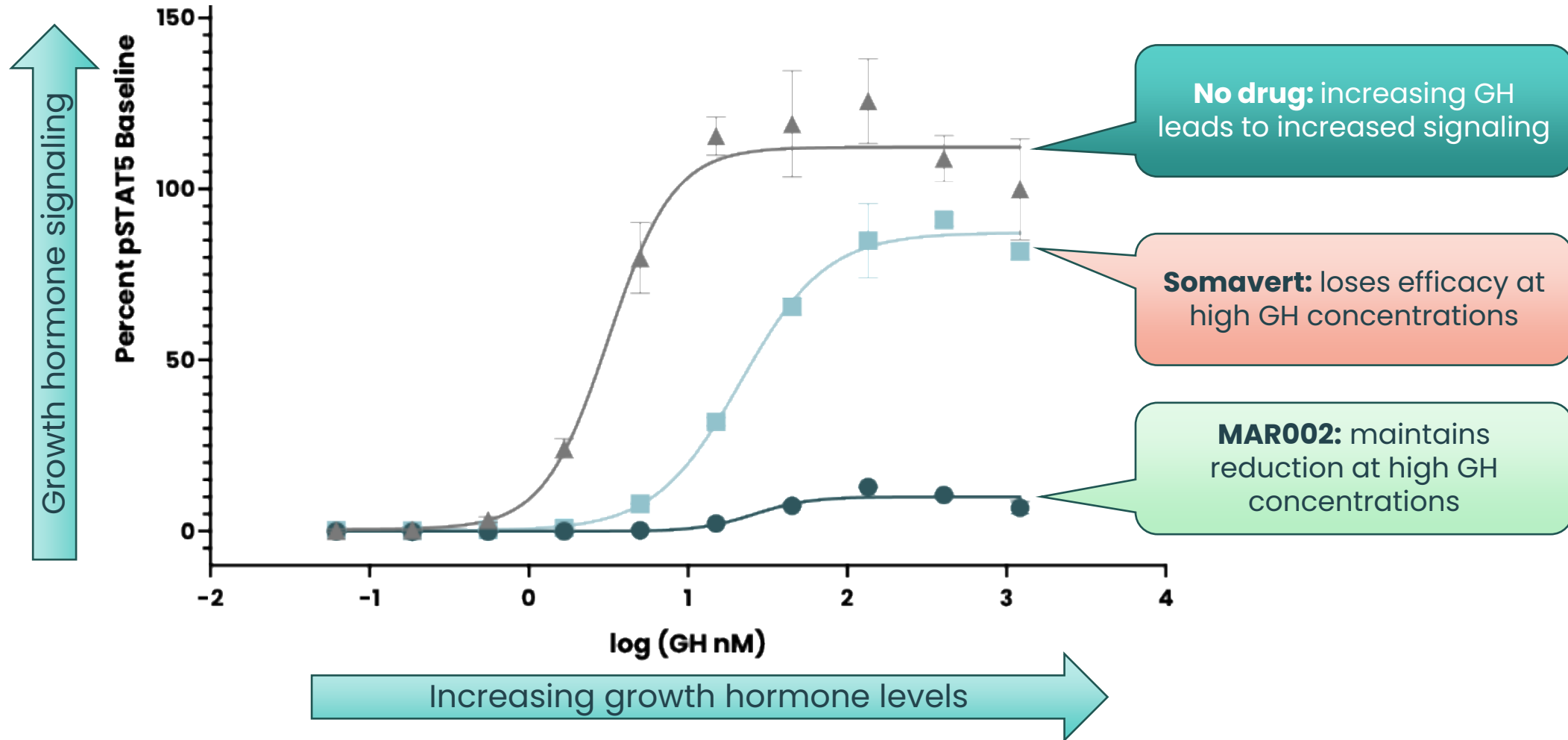


Limitations: daily, painful injections, LFT elevations related to pegylation, poor access

Sources: Crinetics, FDA Pegvisomant and Paltusotine labelling; https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/219070s000lbl.pdf; <https://labeling.pfizer.com/ShowLabeling.aspx?id=3213>

MAR002: Allosteric Mechanism, Potential for greater Efficacy than Somavert

Maintains Potent GHR Antagonism at High GH Levels (Preclinical Data)



Source: Kurylo K, et al. Development and characterization of a long-acting allosteric GHRA for acromegaly. Endocrinology 2026

Phase 1 Healthy Volunteer Study Established Potential Best-in-Class Profile

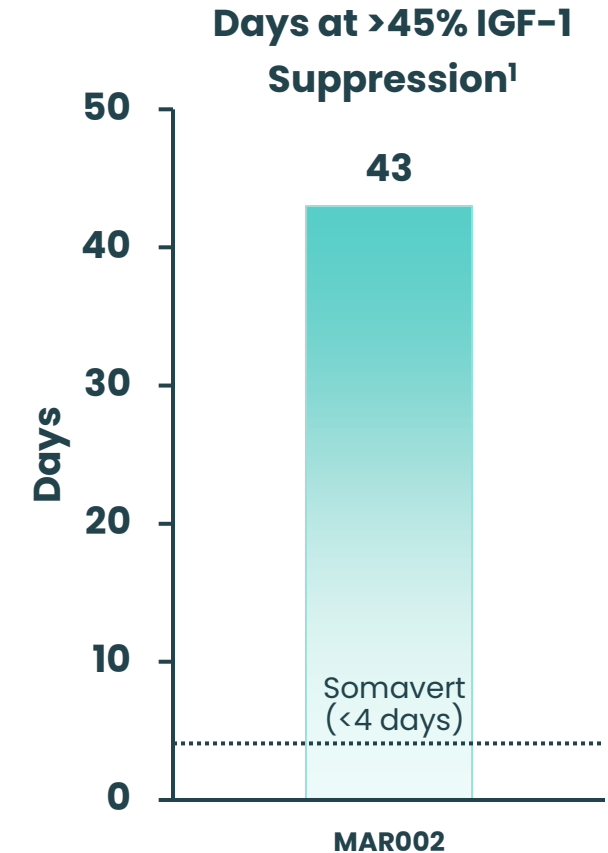
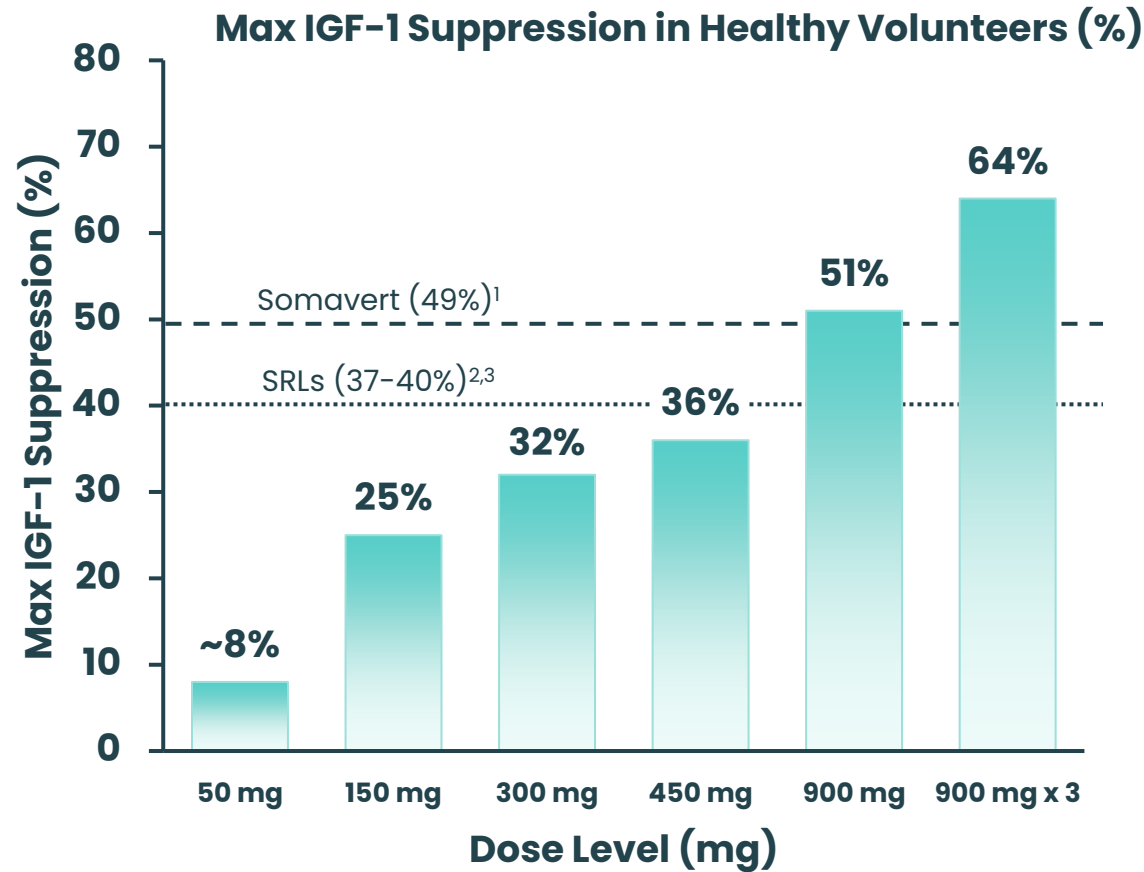
Potential best-in-disease suppression; 300 mg Q2W predicted clinical dose

Phase 1 Study Design

- Healthy men (n=45), baseline IGF-1 > 100 ng/ml

MAR002 Safety Summary to Date

- Generally well tolerated
- No serious AEs
- All doses tolerated
- No related signals



1. Cross-trial comparison, not a head-to-head study. MAR002: Marea data on file (single 900 mg SC dose, n=8); Pegvisomant (Somavert) comparator estimated from Thorner MO, et al. J Clin Endocrinol Metab 1999;84(6):2098-2103, Fig 6 (single 1.0 mg/kg SC dose, n=6); 2. Tiberg F et al. Br J Clin Pharmacol 2015;80(3):460-472. 3. Madan A et al. Pituitary 2022;25(2):328-339; Abbreviations: FIH: first-in-human; POM: proof-of-mechanism; SAD: single ascending dose; BL: baseline; SC: subcutaneous; all cohorts N = 8 (6:2); All doses of MAR002 were a single dose except for 900mgx3

MAR002: Emerging Clinical Data Supports Potential Best-in-Class Profile

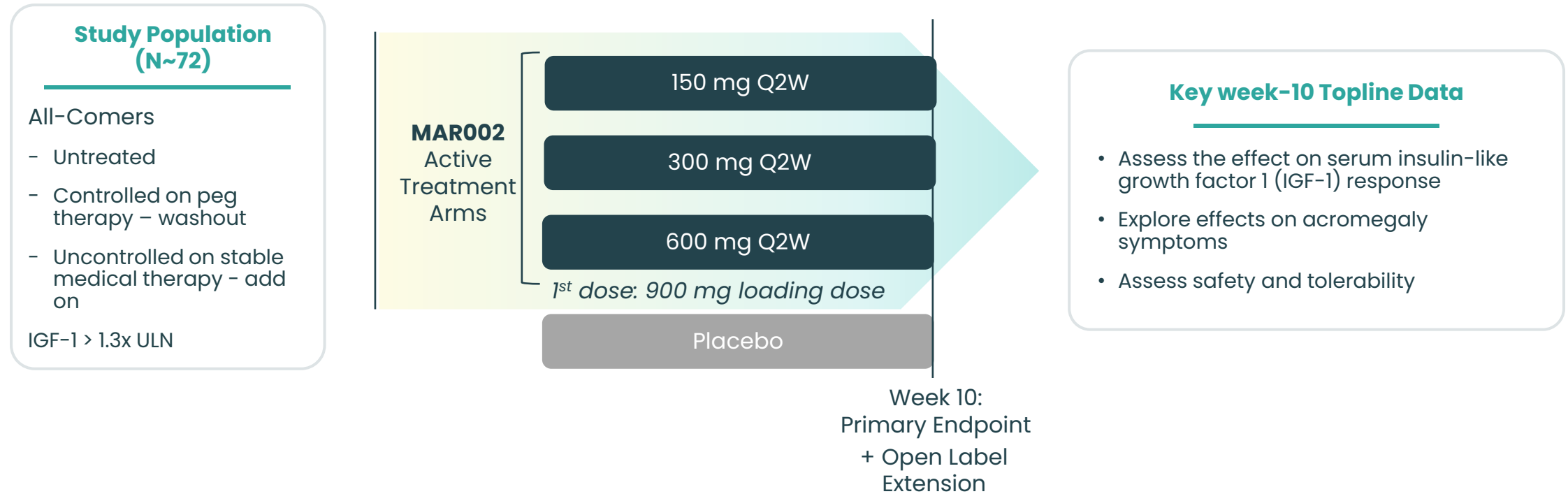
	MAR002	Somavert
Peak IGF-1 Suppression in HV	-64%	-49% ¹
In vitro potency with excess GH	90% suppression Allosteric mAb	24% suppression ² competitive peptide
IGF-1 Normalization	Expected ≥ Somavert	81% IGF-1 normalization in patients ³ (Phase 3)
Tolerability	No signals to date	Significant LFTs, ISRs ⁴
PK/Dosing	Q2W SC	Qday dosing ⁴ Painful injections Vial and syringe

Cross-trial comparisons are subject to inherent limitations and should be interpreted with caution; no head-to-head studies were conducted

1. Thorner MO, et al. J Clin Endocrinol Metab 1999;84:2098–2103 (single 1.0 mg/kg SC, day 5, n=6); 2. Kurylo K, et al. Development and characterization of a long-acting allosteric GHRA for acromegaly. Endocrinology 2026; 3. Trainer PJ, et al. N Engl J Med 2000;342:1171–1177 (15 mg/day, week 12, n=112); 4. SOMAVERT (pegvisomant) US Prescribing Information, rev. 7/2023, §§2.1, 5.2, 6.1, 16.

Efficient Development to POC to Evaluate 1st and 2nd Line Label

Phase 2 study population supports 1) first line monotherapy 2) second line combination therapy 3) second line monotherapy



Advancing a Late-Stage Cardioendocrine Pipeline Toward Potential 2026-27 Value Inflections

	Molecule	Target	Indication	Disc	IND-E	Ph1	Ph2	Ph3	Anticipated Near-term Milestones
Cardiometabolic	MAR001 (parent mAb) ↓ MAR005 (half-life extended MAR001)	ANGPTL4	sHTG	MAR001 Phase 2b TYDAL (mHTG/sHTG)					Q2 2026 ✓ • Phase 2/2b 12-week data
				MAR001 Phase 2b extension (sHTG)					H2 2026 • Phase 2/2b 24-week data
				MAR001 Phase 2 Mechanistic Study					H2 2027 • Phase 2 extension (sHTG) topline data
		ANGPTL4	sHTG	MAR005 Phase 2a (sHTG)					Mid-2027 • Phase 3 MAR005 dose selection including additional TG efficacy/PD
MAR005 Phase 2b (sHTG)				H2 2027 • Phase 3 FPI					
Endocrine	MAR002	Growth hormone receptor	Acromegaly						Q1 2026 ✓ • Phase 1 (NHV) topline data Mid-2026 ✓ • Initiate Phase 2 study Mid-2027 • Interim Phase 2 data Q4 2027 • Phase 2 topline data H1 2028 • Phase 3 FPI

- MAR001 has established POC in Phase 2. **MAR005** is our Phase 3 candidate- it is an improved version of MAR001 with half-life extension and improved PK. The FDA agreed to PK bridging to Phase 3.
- Marea also has developed a SiRNA platform and is developing adipose tissue targeted SiRNAs

Abbreviations: NHV: normal healthy volunteer; sHTG: Severe Hypertriglyceridemia

Thank You

