PRAXIS™

DARE FOR MORE®

Investor Day

November 12, 2026 – New York City

Forward Looking Statements

This presentation may contain "forward-looking statements" within the meaning of the Private Securities Litigation Reform Act of 1995 and other federal securities laws, relating to our business, operations, and financial conditions, including but not limited to express or implied statements regarding our current beliefs, expectations and assumptions regarding the future of our business and our future plans and strategies, including statements about the estimated market for our product candidates, if approved; regulatory submissions, approvals and timing thereof of any of our product candidates; our commercial launch plans and readiness; our development plans and progress across our pipeline; our clinical and preclinical results; and other future developments, including our cash runway. Any forward-looking statements in this presentation are based on management's current expectations and beliefs and are subject to a number of risks, uncertainties and important factors that may cause actual events or results to differ materially from those expressed or implied by any forward-looking statements contained in this presentation, including, without limitation, risks relating to: (i) the timing of and our ability to obtain and maintain regulatory approval of any of our product candidates, (ii) our ability to build commercial capabilities and successfully launch and commercialize our product candidates, if approved, (iii) the success and timing of our product development activities, including our ongoing clinical trials and the initiation of new clinical trials, (iv) our plans to advance our pipeline and platforms and to develop additional product candidates, (v) the success and timing of our collaboration partners' product development activities and our ability to enter into collaborations for the development of new product candidates, (vi) our ability to establish manufacturing capabilities or secure adequate commercial supply, and our reliance on third parties to manufacture, supply and scale production of our product candidates and any approved products, (vii) our ability to obtain, maintain and enforce intellectual property protection, (viii) our estimates of expenses and capital requirements, the sufficiency of our cash runway, and our need for additional financing, (ix) the potential addressable market sizes for product candidates, and (x) our ability to meet any specific milestones set forth herein. New risks and uncertainties may emerge from time to time, and it is not possible to predict all risks and uncertainties. Forward-looking statements speak only as of the date of this presentation. Except as required by applicable law, we undertake no obligation to update or revise any forward-looking statements contained herein, whether as a result of any new information, future events, changed circumstances or otherwise. Although we believe the expectations reflected in such forward-looking statements are reasonable, we can give no assurance that such expectations will prove to be correct. Accordingly, readers are cautioned not to place undue reliance on these forward-looking statements.

For further information regarding the risks, uncertainties and other factors that may cause differences between our expectations and actual results, you should review the "Risk Factors" section of our Annual Report on Form 10-K for the year ended December 31, 2025 and other filings made with the Securities and Exchange Commission.

Certain information contained in this presentation relates to or is based on studies, publications, surveys and other data obtained from third-party sources and our own internal estimates and research. While we believe these third-party sources to be reliable as of the date of this presentation, we have not independently verified, and make no representation as to the adequacy, fairness, accuracy or completeness of, any information obtained from third-party sources. In addition, all of the market data included in this presentation involves a number of assumptions and limitations, and there can be no guarantee as to the accuracy or reliability of such assumptions. Finally, while we believe our own internal research is reliable, such research has not been verified by any independent source.

Takeaways For Today

01

Ready to execute commercially at the highest level

With

- **Proven leadership**
- **State-of-the-art infrastructure**
- **Capital to execute at full force**

02

Poised to become the preeminent neurology company in the world

No other company will match our

- **Breadth of impact**
- **Depth of pipeline**
- **Scale of revenue potential**

PRAXIS' MISSION

The needs of patients with CNS disorders are devastatingly urgent. Our mission is to help patients by delivering life-altering treatments faster and more effectively than has ever been done before — and to do it again and again.

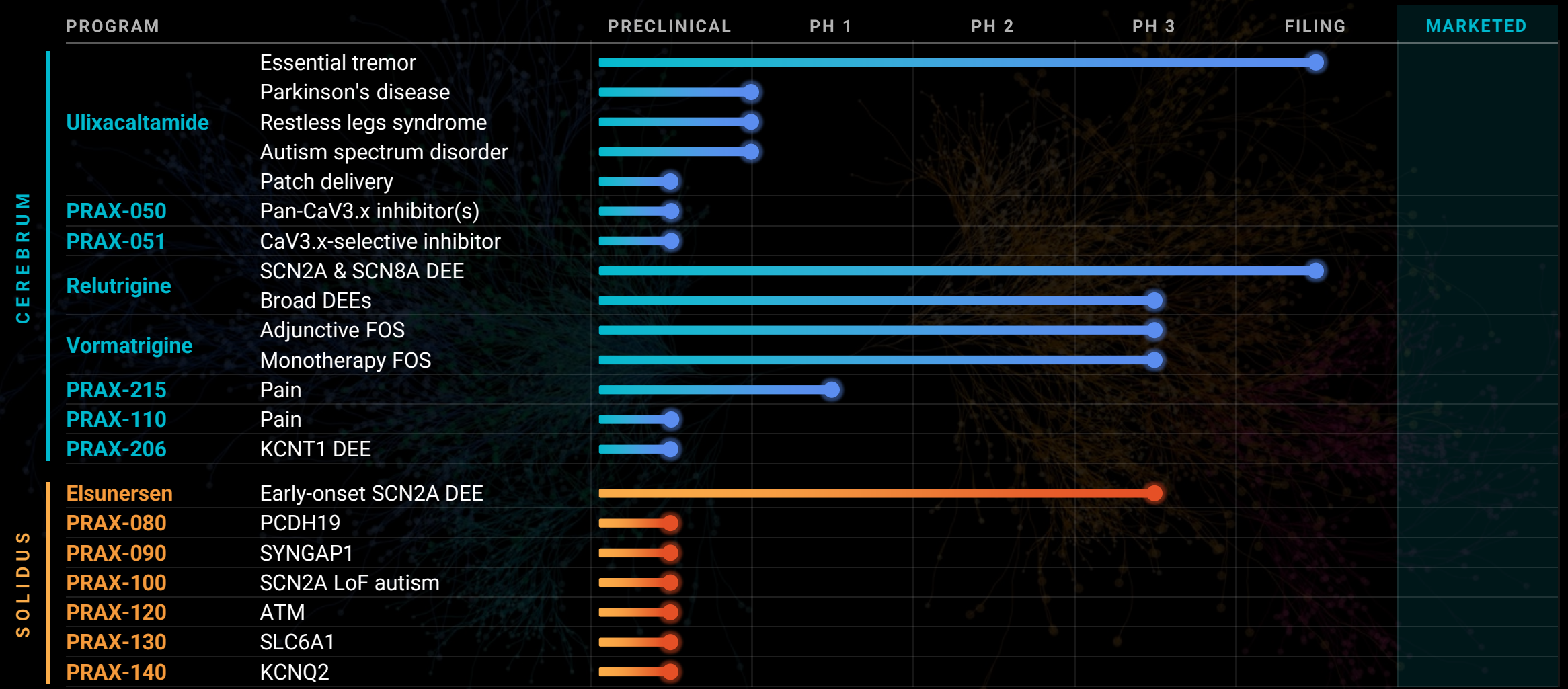
What It Takes to Do It Again and Again

PRAX daily closing share price, $ (split-adjusted)



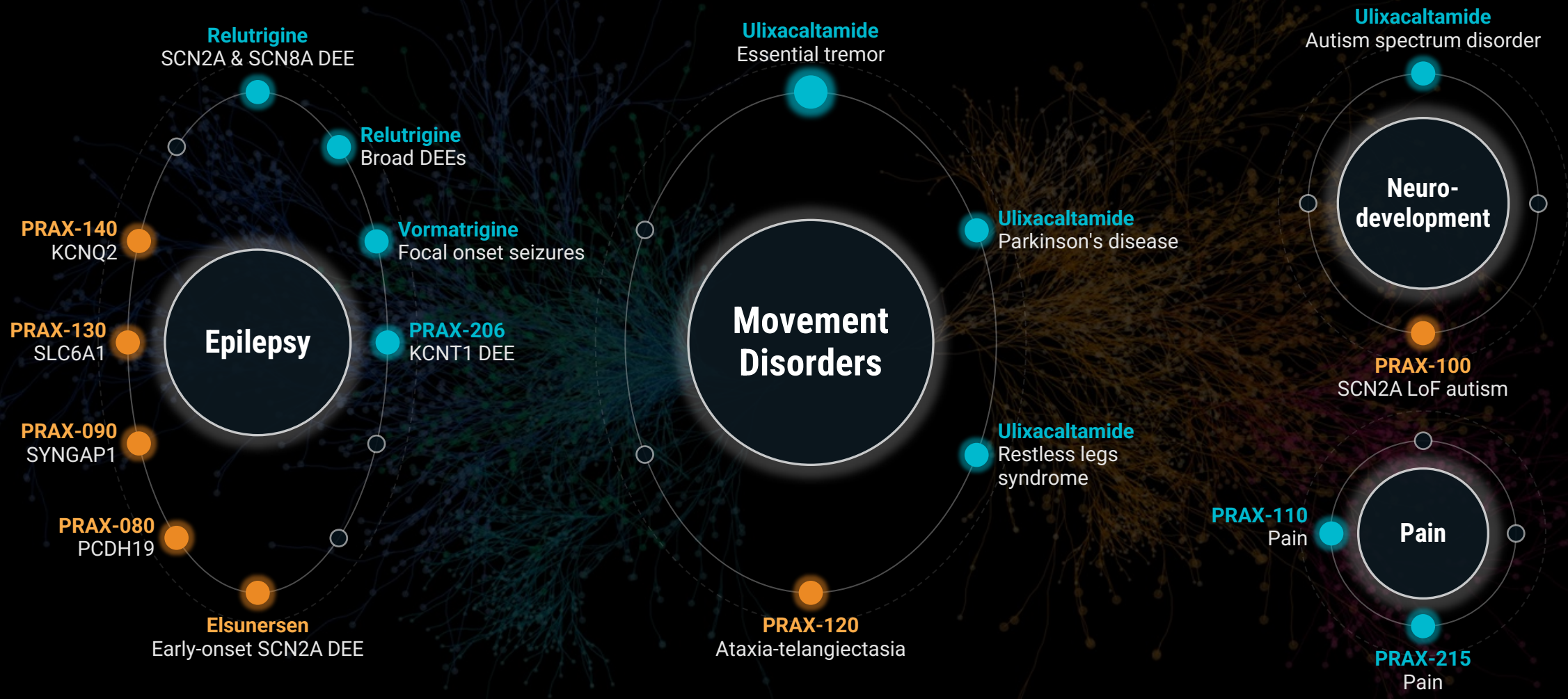
Source: FactSet daily closing prices, January 1, 2025 to November 10, 2026, adjusted for stock splits. BTD: Breakthrough Therapy Designation NDA: new drug application; Ph: Phase

Praxis' Full Pipeline Today



DEE: developmental and epileptic encephalopathy; FOS: focal onset seizures; LoF: loss of function; ATM: Ataxia-telangiectasia.

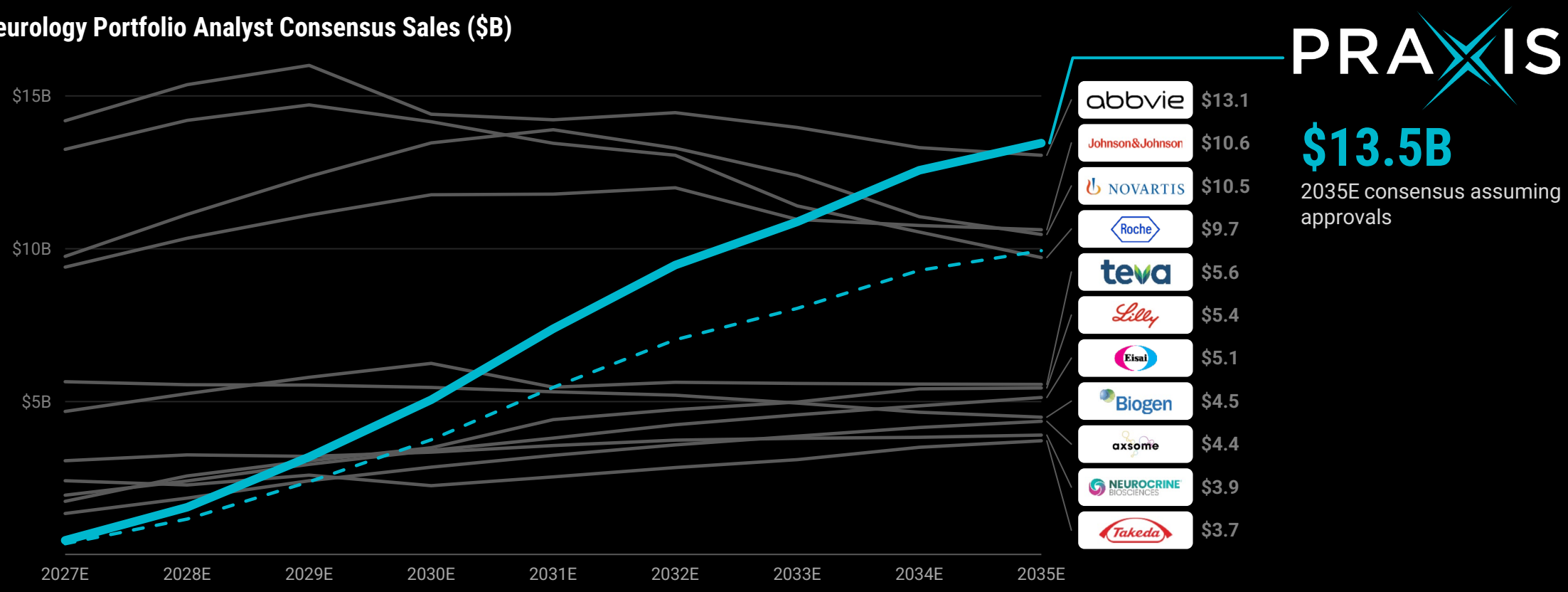
2035 Vision: Two Platforms Treating Diseases Across Four Franchises



Illustrative scenario. DEE: developmental and epileptic encephalopathy; LoF: loss of function; ATM: Ataxia-telangiectasia.

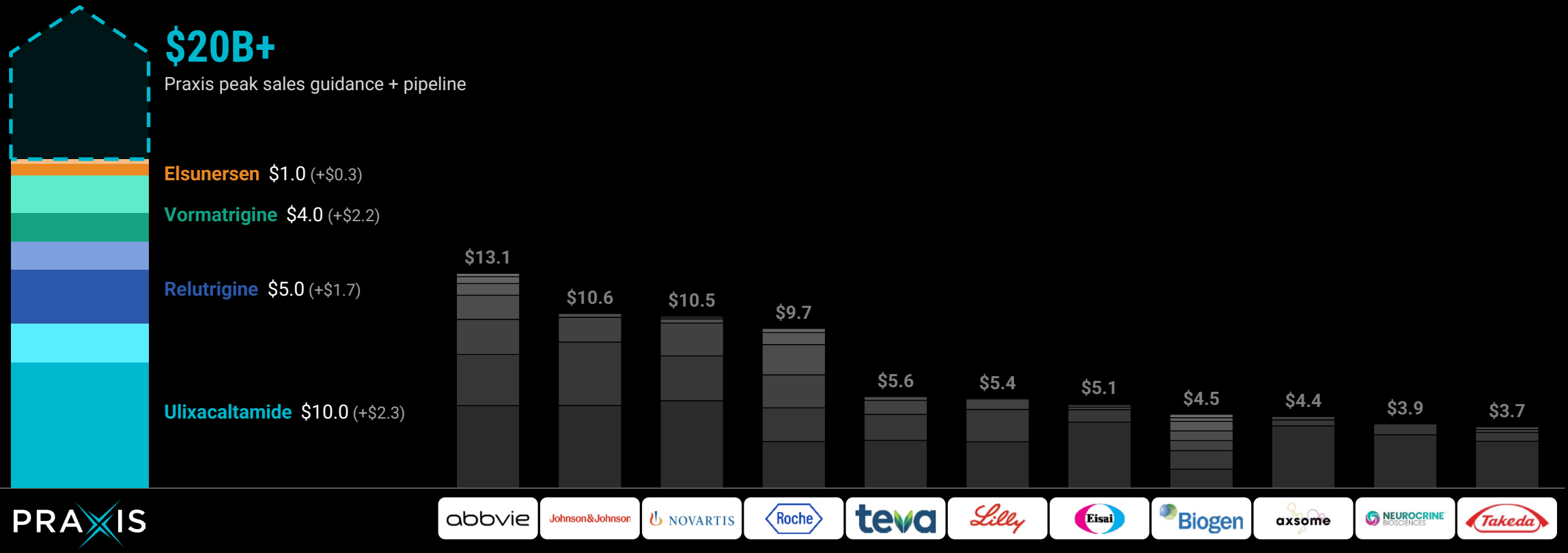
As Each of Our Late-Stage Assets Is Approved, Consensus Will Push Praxis to the Top

Neurology Portfolio Analyst Consensus Sales ($B)



Source: Bloomberg consensus. Products included: AbbVie (Vyalev, Botox, Qulipta, Ubrelvy, Vraylar, Juvmo, Duodopa); Johnson & Johnson (Invega Sustenna, Spravato, Caplyta, Concerta); Roche (Ocrevus, Evrysdi, Fenebrutinib, Enspryng, Madopar, Trontinemab); Novartis (Kesimpta, Zolgensma, Aimovig, Rhapsido, Mayzent, Gilenya); Teva (Austedo, Ajovy, Uzedy, Copaxone, Olanzapine (LAI)); Eli Lilly (Kisunla, Emgality, Remternetug, Prozac); Eisai (Leqembi, Dayvigo, Aricept, Fycompa, Methycobal); Axsome (Auvelity, Sunosi, AXS-12); Biogen (Spinraza, Tysabri, Skyclarys, Vumerity, Zurzuvae, Avonex, Qalsody); Neurocrine (Ingrezza, TAK-653); Takeda (Orzeyful, Vyvanse, Trintellix, Intuniv). Praxis consensus assuming approvals divides each asset's consensus by its consensus probability of success (ulixacaltamide 80%, relutrigine 70%, vormatrigine and elsunersen 60%).

Commitment to Commercial Excellence Coupled with a Rapidly Advancing Pipeline



Source: Bloomberg consensus. Products included: AbbVie (Vyalev, Botox, Qulipta, Ubrelvy, Vraylar, Juvmo, Duodopa); Johnson & Johnson (Invega Sustenna, Spravato, Caplyta, Concerta); Roche (Ocrevus, Evrysdi, Fenebrutinib, Enspryng, Madopar, Trontinemab); Novartis (Kesimpta, Zolgensma, Aimovig, Rhapsido, Mayzent, Gilenya); Teva (Austedo, Ajovy, Uzedy, Copaxone, Olanzapine (LAI)); Eli Lilly (Kisunla, Emgality, Remternetug, Prozac); Eisai (Leqembi, Dayvigo, Aricept, Fycompa, Methycobal); Axsome (Auvelity, Sunosi, AXS-12); Biogen (Spinraza, Tysabri, Skyclarys, Vumerity, Zurzuvae, Avonex, Qalsody); Neurocrine (Ingrezza, TAK-653); Takeda (Orzeyful, Vyvanse, Trintellix, Intuniv). Praxis consensus assuming approvals divides each asset's consensus by its consensus probability of success (ulixacaltamide 80%, relutrigine 70%, vormatrigine and elsunersen 60%).

Agenda

Marcio Souza
President and CEO



Megan Sniecinski
Chief Operating Officer



Erik Johnson
Head of Commercial



John Bullock
Head of Sales



Steve Petrou
President of R&D



Ulixacaltamide

Essential tremor

- Unmet need
- Clinical data
- Commercial strategy
- KOL panel
  Dr. William Ondo
  Dr. Daniel Kremens

Break

Relutrigine

SCN2A/8A DEE

- Unmet need
- Clinical data
- KOL panel
  Dr. Eric Segal
  Dr. Douglas Smith
- Commercial strategy

Lunch

Pipeline

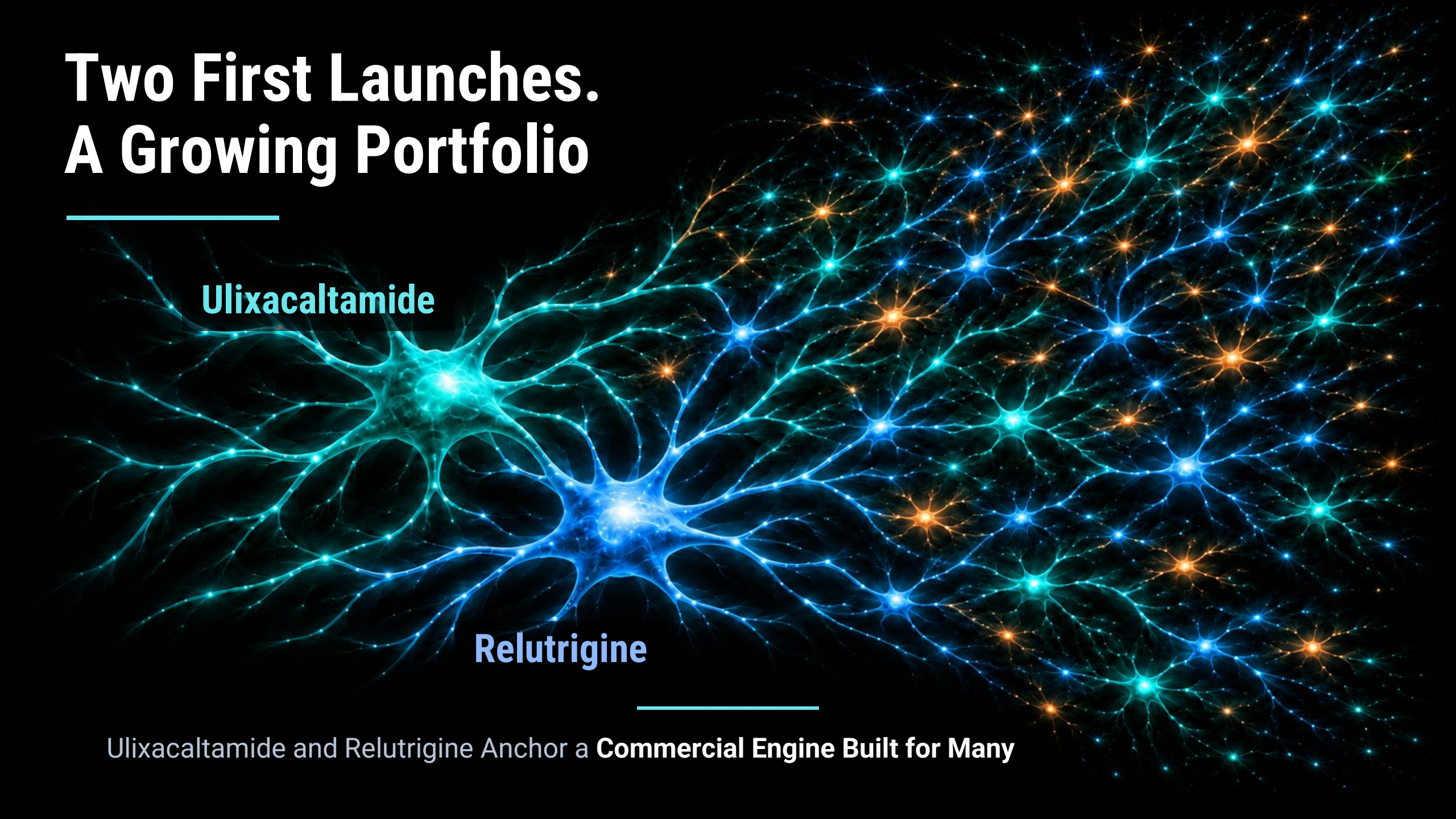
Beyond the first two launches

- Ulixacaltamide beyond ET
- Pain
- Epilepsy

Q&A

Reception to follow

Two First Launches.
A Growing Portfolio

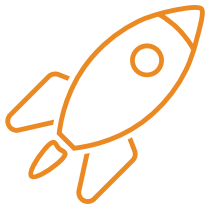


Ulixacaltamide

Relutrigine

Ulixacaltamide and Relutrigine Anchor a **Commercial Engine Built for Many**

A First-Principles, Disciplined Approach to Commercialization Built to Repeat



Invest With **CONVICTION**

Build the capabilities upfront to accelerate patient impact and maximize long-term value



Build Exceptional **TEAMS**

Build teams committed to our mindset, operating model and excellence standard



Customize the **EXPERIENCE**

Provide solutions so patients and physicians can focus on outcomes.



Execute With **INSIGHT**

Combine deep market understanding with real-time data intelligence to monitor and inform execution

Maximizing Long-Term Value by Investing Upfront to Accelerate Patient Impact

THE INVESTMENT

PRAXIS

Setting a new benchmark for launch-year investment

BIOTECH'S NOTABLE FIRST LAUNCHES

- VYVGART™ (efgartigimod alfa-fcab)
- Nurtec® ODT (rimegepant) orally disintegrating tablets 75 mg
- Auvelity® (dextromethorphan HBr and bupropion HCl) extended-release tablets 45mg/105mg
- INGREZZA® (valbenazine) capsules
- Rezdiffra™ resmetirom tablets 80mg · 100mg

WHAT IT FUNDS

MAXIMIZED FIELD FORCE

Full teams in place ahead of launch with full target coverage and dynamic capacity

vs. typical incremental build

INTEGRATED HUB AND CHANNEL NETWORK

End-to-end oversight of the entire patient and HCP experience

vs. disjointed and opaque therapy initiation

CUTTING EDGE DATA INFRASTRUCTURE

Purpose-built data foundation enabling real-time commercial capabilities

vs. retrofitted, time-lagged legacy systems

WHY WE DO IT

Accelerated patient impact

Maximized NPV

Rigorous and Disciplined Approach to Build and Deploy Dedicated Teams Ahead of Launch

HIRING

- ✓ Sequenced hiring enabled direct leaders to recruit and hire next-level
- ✓ Track record of exceptional performance

- Initial screen
- Manager interview
- Panel interview
- Role simulation
- **Culture screen**
  Executive team member interviews every lead candidate

ONBOARDING

- ✓ High-intensity onboarding
- ✓ Focus on Mindset Expectations, Operating Model and Market Education

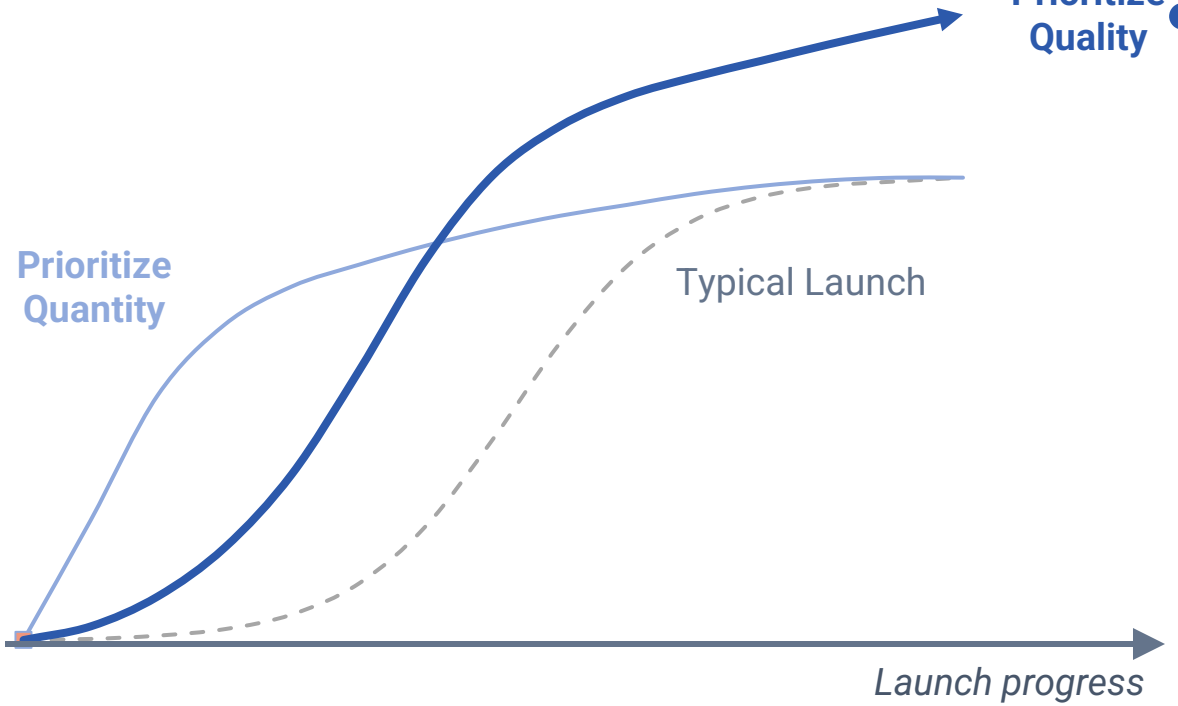


TRAINING

- ✓ Shift from Module-to-Test to an Innovative Learning and Engagement Model

1. **AI simulations**
2. **Teach it back**
3. **Certified by full simulation**

Achieving Maximum Value for all Stakeholders is the Core Launch Priority



Prioritize Quality

ULIXACALTAMIDE - ET

A Strong First Experience

RELUTRIGINE - SCN2A/8A DEE

Treatment Paradigm Shift

State-of-the-Art Infrastructure Integrates Real-Time Data to Monitor Actionable Insights and Launch Execution

DATA INPUTS

- Digital Rx Platform
- Patient Services
- Field CRM
- Marketing
- SP Channel
- Formulary
- Claims
- Medical Information
- Pharmacovigilance
- + 20 more platforms

COMMERCIAL DATA FOUNDATION (CDF)



One single, real-time, integrated view of patients, prescribers, payers and channel

DATA USES

PATIENT/PHYSICIAN SUPPORT
Access, enrollment, adherence and PA support

MARKETING STRATEGY
Omnichannel targeting and campaign analytics

SALES OPERATIONS
Call planning, Next Best Action, Dynamic targeting

CHANNEL REPORTING
Real-time dispense, inventory and gross-to-net visibility

SELF-SERVICE BI
Performance monitoring and analysis

AI layer runs through CDF to enable process automation, scale and analysis

The Hub of the Future Fully Integrates Rx Writing, Patient Services and Specialty Pharmacy, Tailored to Each Market

PRAXIS HORIZONS™
Forward Together

- **Digital Prescription Intake**
- **Office & Patient Support**
- **Specialty Pharmacy Distribution**

1. **PRESCRIBE** — Prescribe from the EHR
2. **GET ACCESS** — Coverage answered fast
3. **START THERAPY** — Engaged within minutes
4. **STAY ON THERAPY** — Continued support

COMMERCIAL DATA FOUNDATION (CDF) → **Real-time view of patients, prescribers, payers and channel**

DARING FOR MORE

Two Launches. First of Their Kind.

Dec 27, 2026

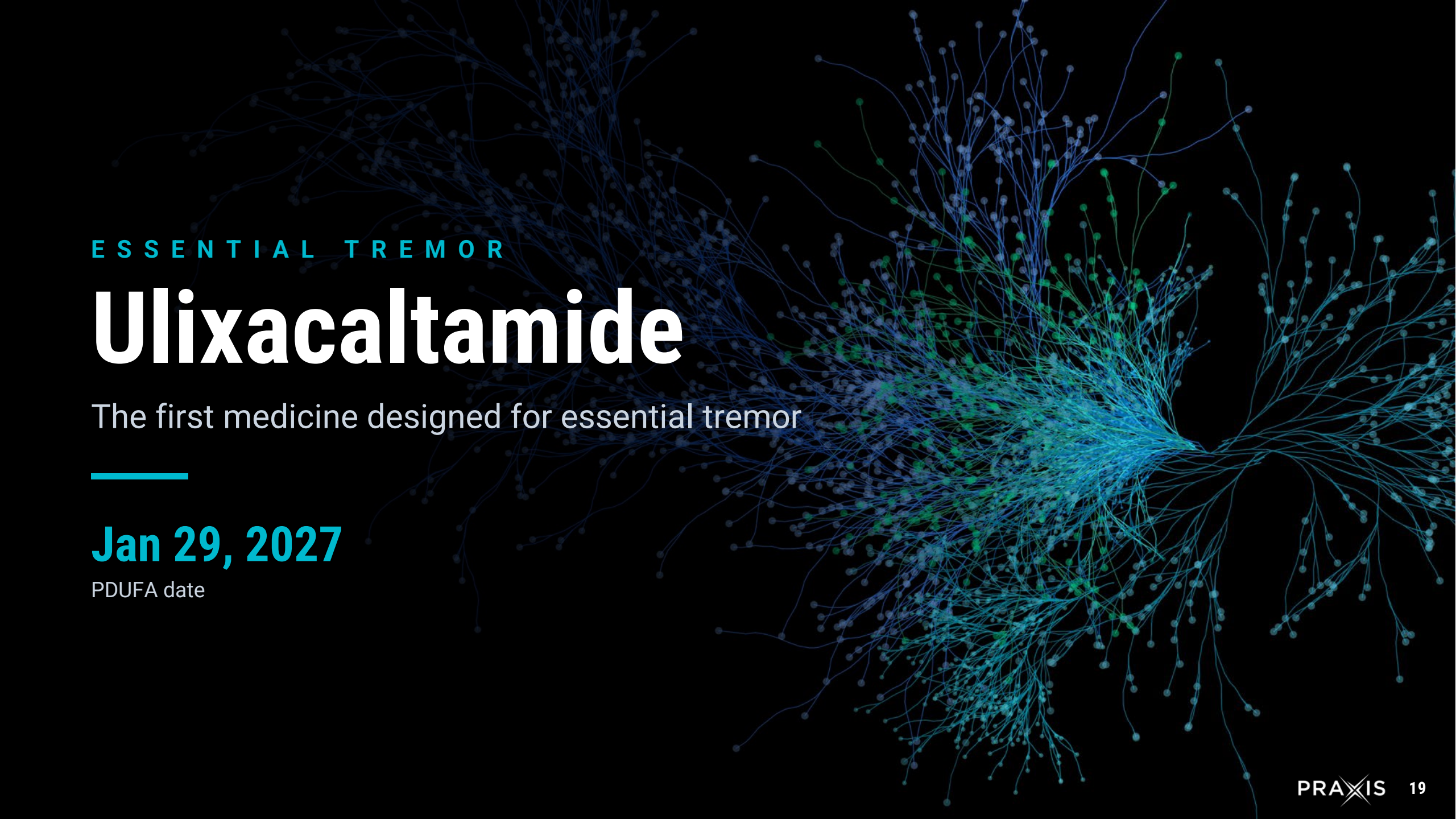
Relutrigine

SCN2A & SCN8A
Developmental and Epileptic Encephalopathy

Jan 29, 2027

Ulixacaltamide

Essential Tremor



ESSENTIAL TREMOR

Ulixacaltamide

The first medicine designed for essential tremor

Jan 29, 2027

PDUFA date

Essential Tremor Is the Sleeping Giant of Neurology: Common, Disabling and Ready for Change

HIGH DISEASE BURDEN

9 million Americans
live with ET, one of the most common movement disorders

>85% report functional disability
impacting daily activities like writing, eating, drinking and dressing

Burden beyond the tremor
Embarrassment, depression, anxiety and social isolation

LIMITED TREATMENT OPTIONS

1 approved drug with limited effect
Propranolol, a decades-old beta-blocker

~50% contraindicated
Cardiac disorders, asthma and older age rule out propranolol for half of patients

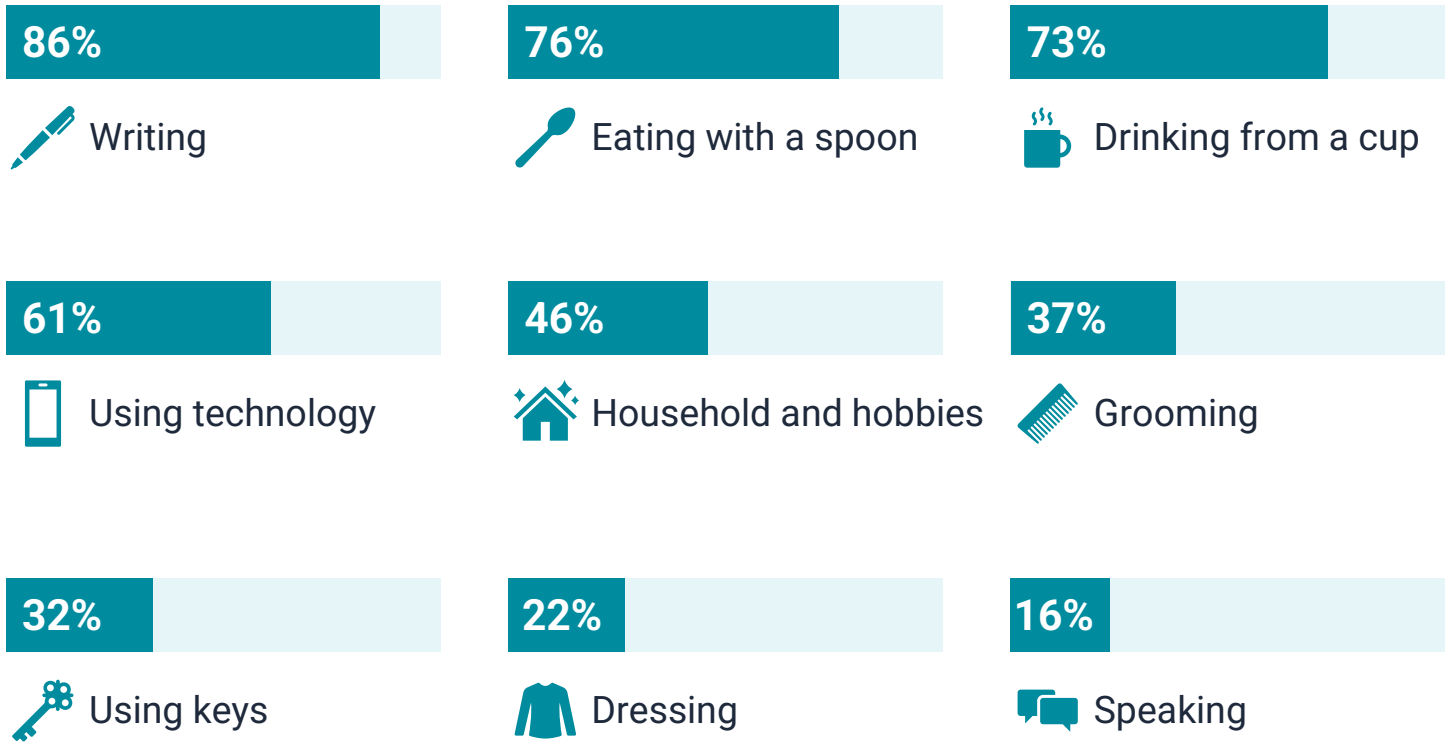
Low retention
Patients quickly stop propranolol

Sources: Louis ED, Ottman R. Tremor Other Hyperkinet Mov (N Y). 2014;4:259; Louis ED, et al. Parkinsonism Relat Disord. 2015;21(7):729-735; Louis ED, et al. Eur J Neurol. 2007;14(10):1138-46; Elble RJ. Curr Neurol Neurosci Rep. 2013;13(6):353; Komodo claims data; Praxis Data on File

ET Severely Limits Patients' Ability to Function

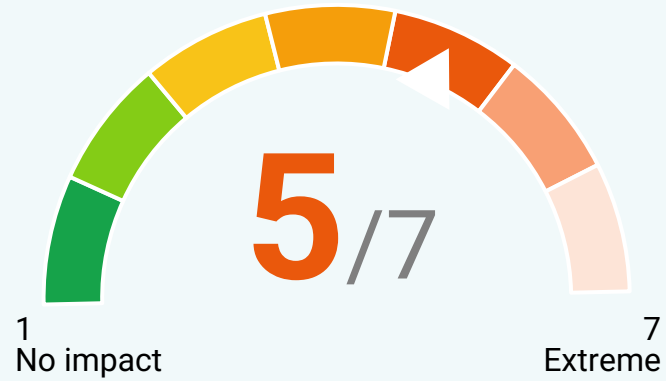
Everyday activities affected by ET, % of patients

Patients could select multiple activities



DAILY FUNCTIONAL IMPACT

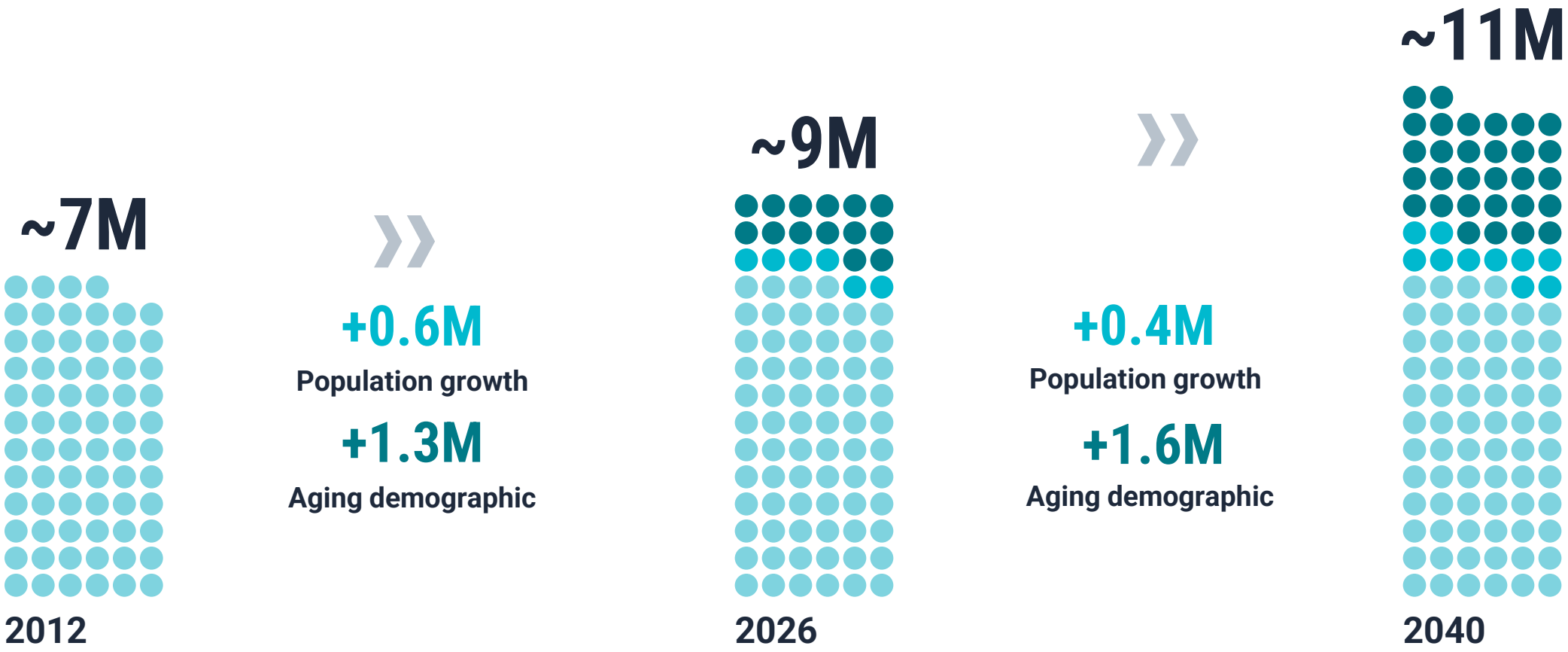
Mean score patients give ET's impact on a typical day



1,294
patients surveyed

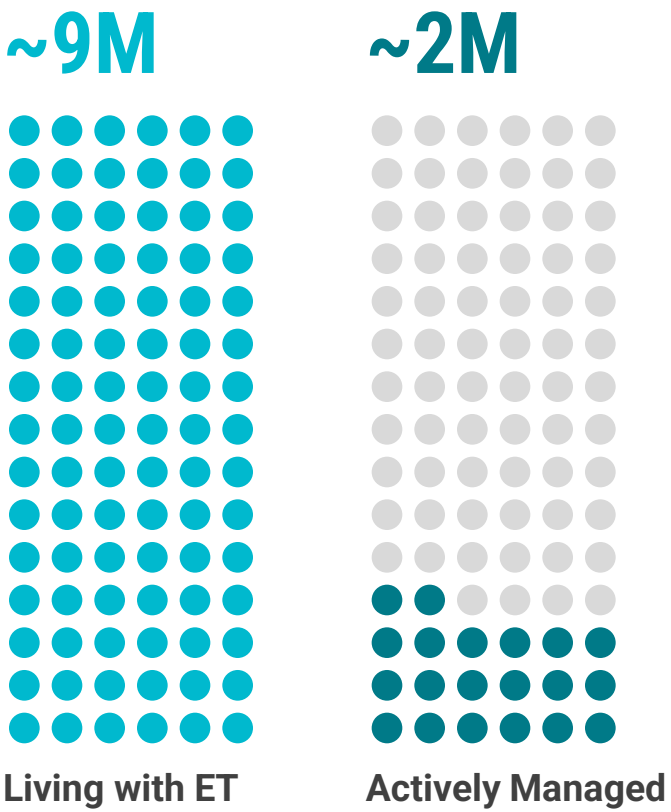
Source: Praxis data on file, ET patient survey, Mar/Apr 2026

An Aging US Demographic Drives ET Growth Faster Than the Overall Population



Each dot ≈ 100K people. Sources: 2012: Louis ED, Ottman R. Tremor Other Hyperkinet Mov. 2014;4:259; US Census Bureau intercensal estimates 2010–2020 and 2023 National Population Projections (middle series). 2026 and 2040 hold 2012 age-specific rates fixed.

Today, a Poor Standard of Care Keeps Patients From Seeking Treatment



- **Limited treatment options** with poor efficacy and tolerability
- **Often dismissed** as “running in the family” (50–70% of cases are familial)
- Learned **self-coping mechanisms** allow patients to manage tremor prior to onset of significant disability: adjusting daily activities, avoiding trigger situations or self-medicating with alcohol

Each dot ≈ 100K patients. Source: Diagnosis rate: Louis and Ottman (2014), Crawford et al. (2020); Treatment rate: Diaz & Louis (2010); Internal claims analysis; Familial History based on Ph2, Ph3, and patient survey data

Findings From an Observational Study Reinforce That Current ET Care Falls Short

WHO WAS STUDIED

>2,300 US physicians

SPECIALTY MIX



44% Neurology

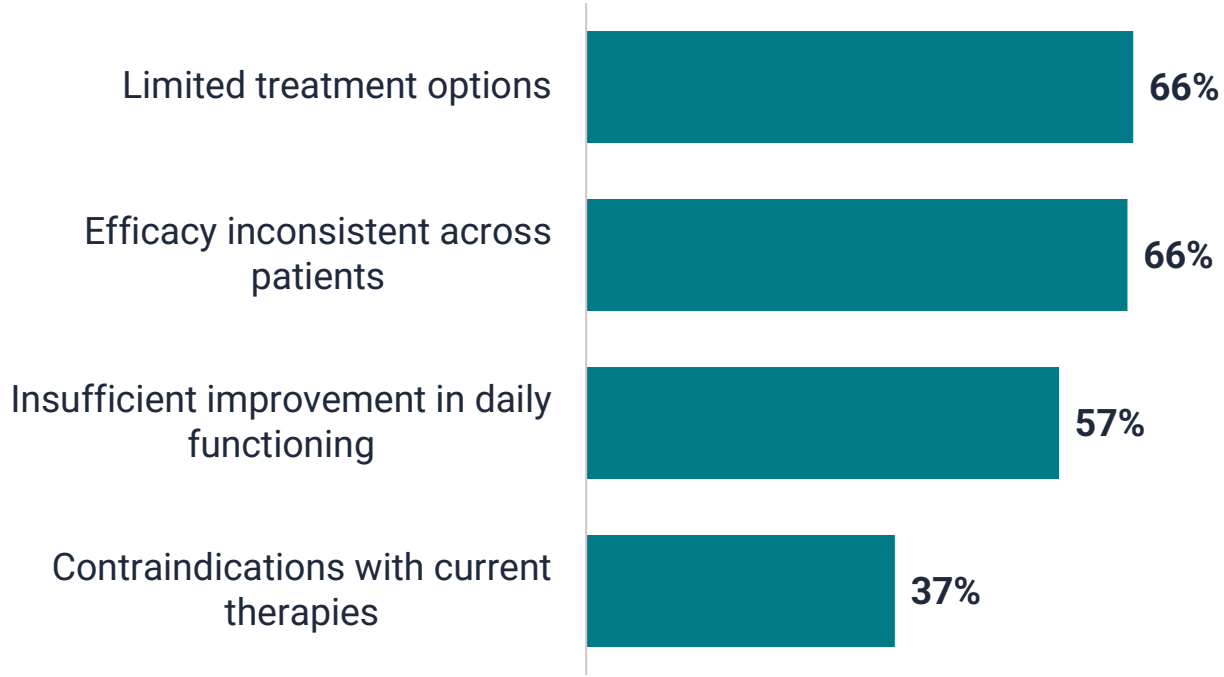
44% PCP

12% Other

>43,000 ET patients under their care

66
Mean ET patients per physician

Unmet needs with current ET therapies
% of treating physicians citing each (2303)



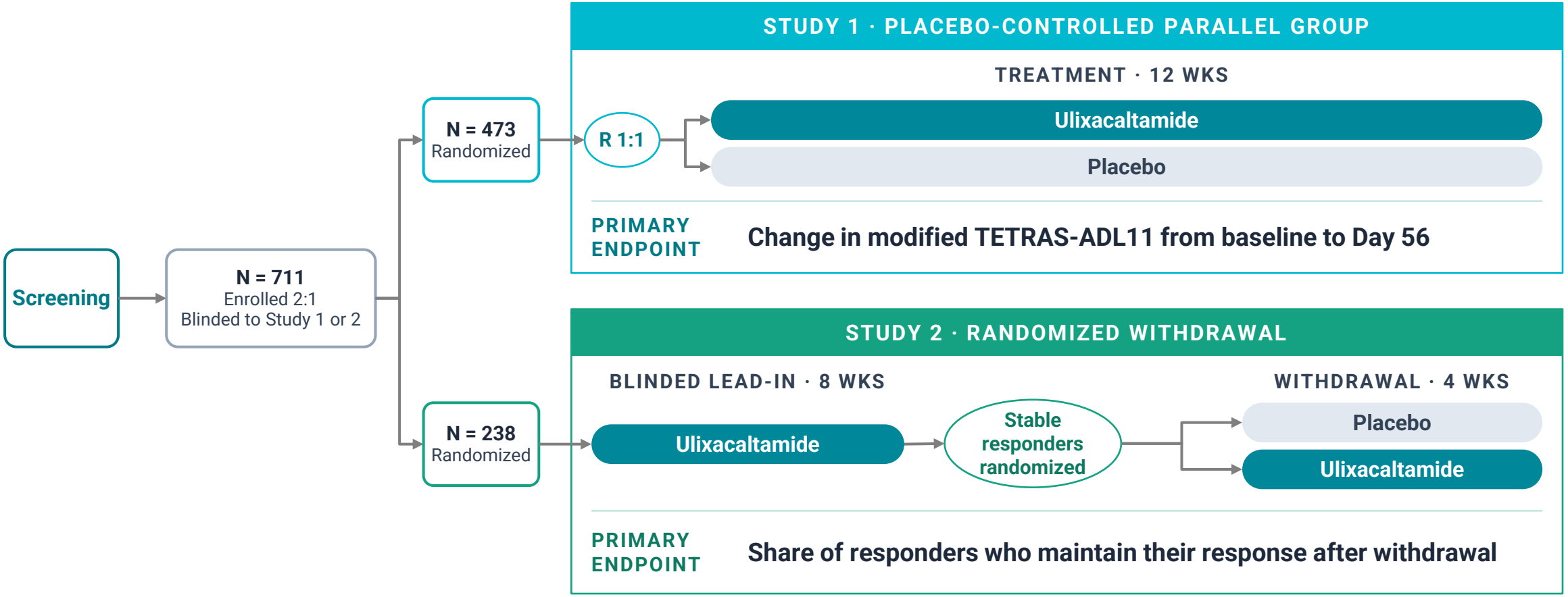
ET patients under care confirmed with active claims, linked to MD NPI: Medical Doctor National Provider Identifier Source: Praxis HCP observational quant study, 2026.

ULIXACALTAMIDE

ESSENTIAL3: First Positive Phase 3 Program in Essential Tremor

Steve Petrou

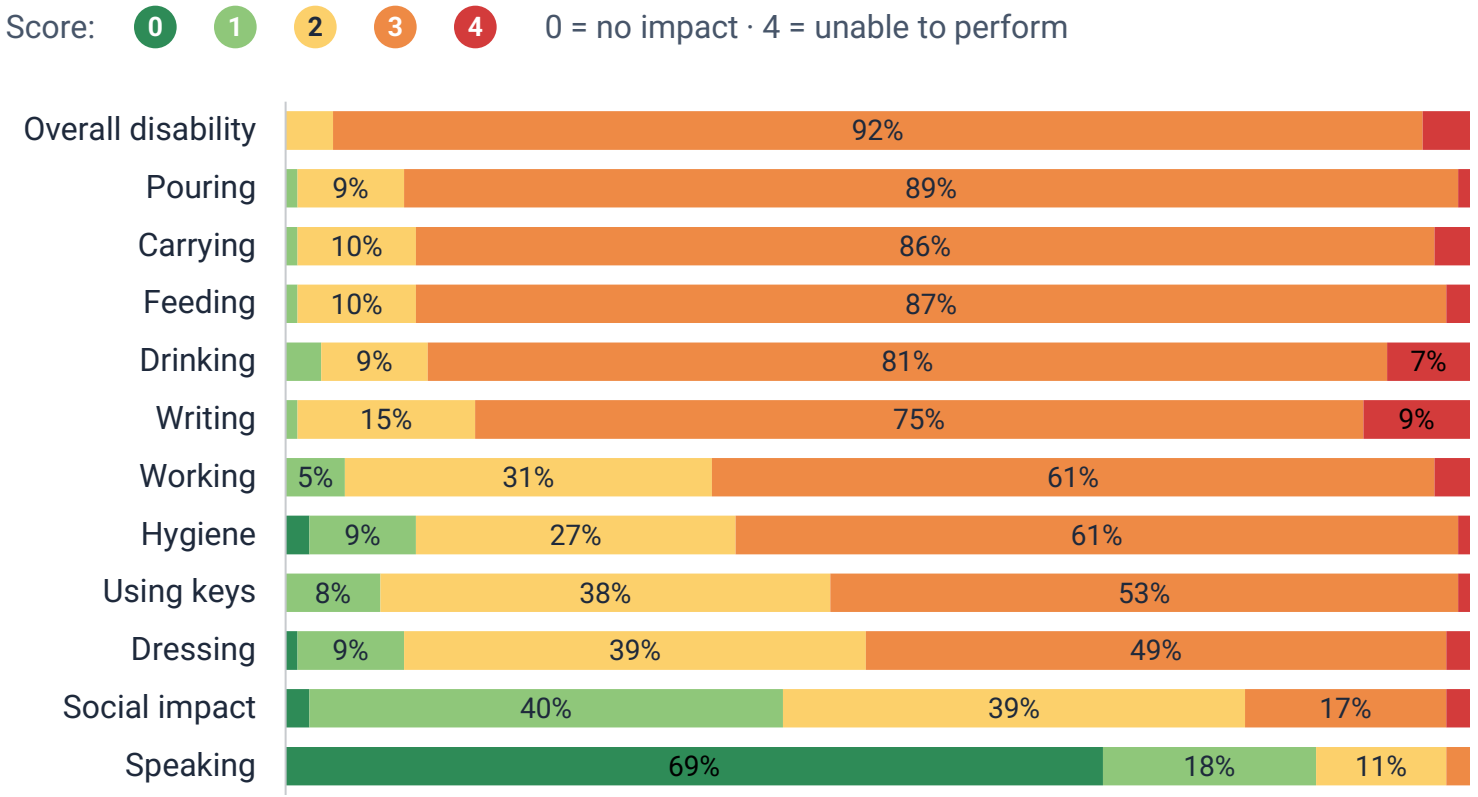
ESSENTIAL3: Innovative Program Designed to Demonstrate Ulixacaltamide Restores and Maintains Patient Function



Stable responders defined as those who met the prespecified 3-pt improvement in the mADL11 during the blinded lead-in.

ESSENTIAL3 Baseline Demographics Illustrate Functional Disability and Disease Burden

Baseline TETRAS-ADL score by activity, % of patients (n = 698)



31 / 48
mean baseline TETRAS-ADL score

30 years
average time living with ET

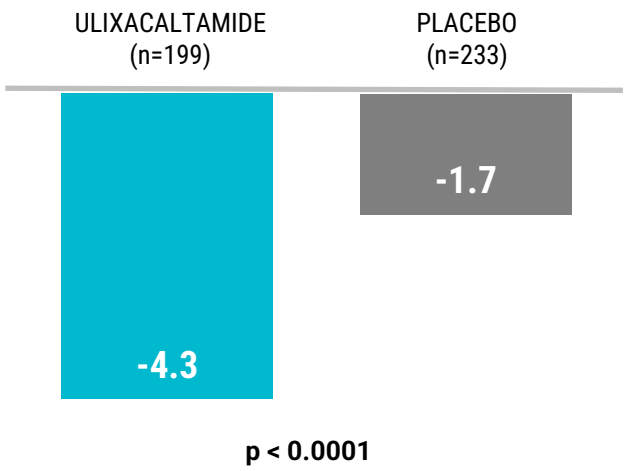
94%
had worsening symptoms in the past 3 years

Ranked by share scoring 3–4. TETRAS-ADL = Essential Tremor Rating Assessment Scale – Activities of Daily Living. Source: Farmer et al. AAN 2026 Plenary Presentation; Praxis Data on File

Clinical Program Solidifies Core Strengths of Ulixacaltamide

STUDY 1 · PARALLEL GROUP

mADL11 CFB to Day 56

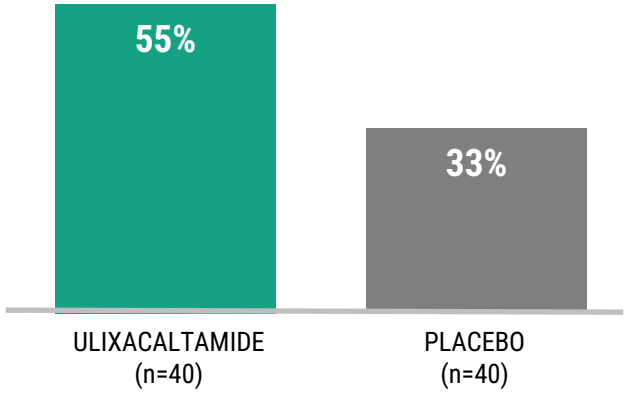


p < 0.0001

Primary endpoint met

STUDY 2 · RANDOMIZED WITHDRAWAL

% Maintain Response



p = 0.037

Primary endpoint met

RESULTS SHOW STRENGTH ACROSS FIVE DIMENSIONS OF EFFICACY

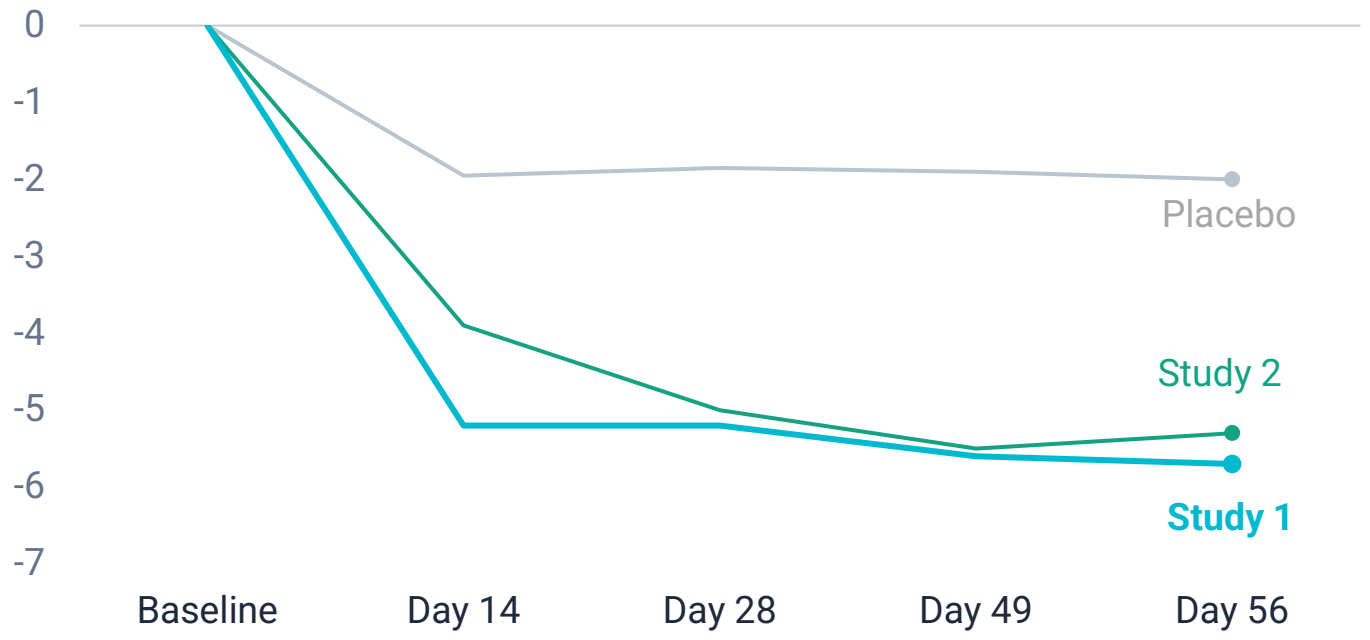
- Rapid Onset
- Maintained Effect
- Deep Response
- Consistent
- Robust Effect

mADL11: modified ADL 11-item score, CFB: change from baseline. Shtilbans et al. AAN 2026 Poster Presentation; Farmer et al. AAN 2026 Plenary Presentation

Rapid Onset of Effect Experienced by First Assessment (Day 14)

Rapid | Maintained | Deep | Consistent | Robust

TETRAS-ADL change from baseline
LS mean, points



Within 14 days

patients saw significant improvement in their disease

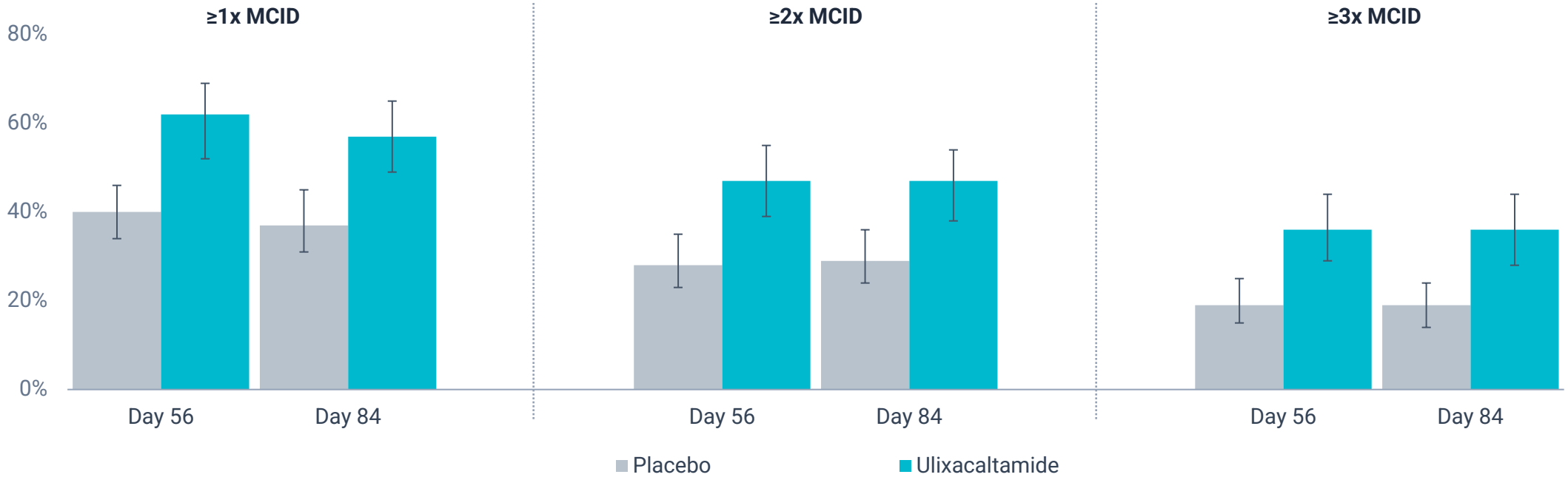
Source: Shtilbans et al. AAN 2026 Poster

Large Benefit Maintained Across 12 Weeks Across Stringent Response Thresholds

Rapid | **Maintained** | Deep | Consistent | Robust

mADL11: Proportion Achieving MCID-Based Improvement Thresholds, Study 1

MCID = −1.25 (ROC Youden J, D56) | ITT Analysis Set



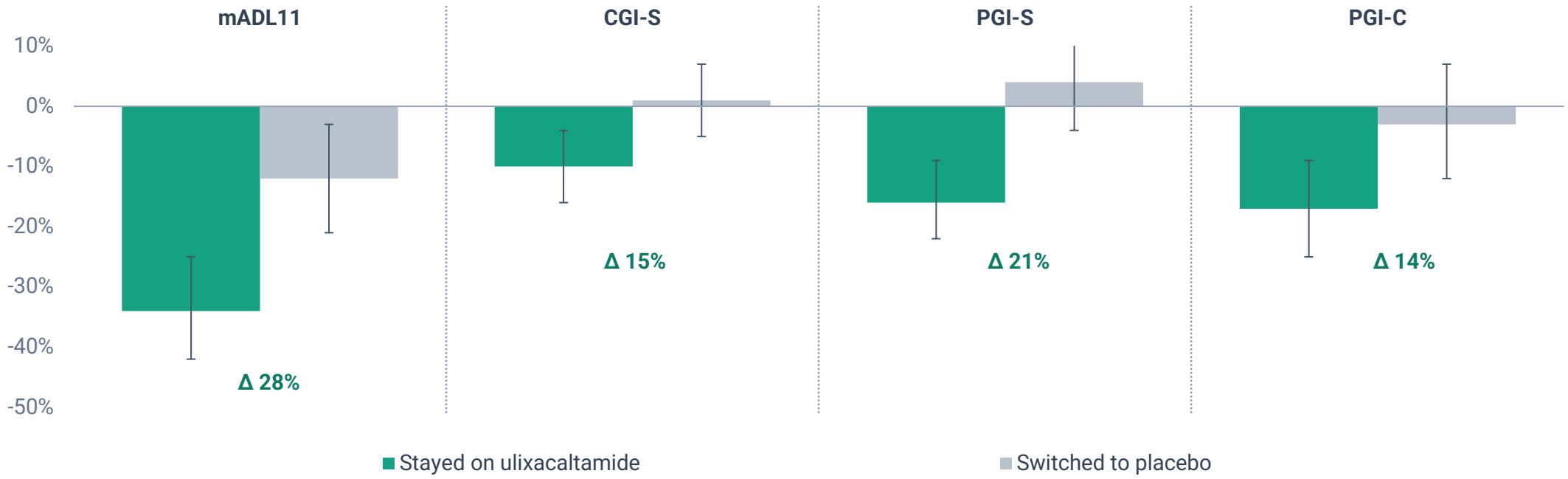
MCID = minimum clinically important difference (−1.25 mADL11 points). ROC: receiver operating characteristic. Error bars are 95% CI. Source: Farmer et al. AAN 2026 Plenary Presentation

Maintenance of Response and Pharmacological Response is Further Confirmed After Patients Switched to Placebo

Rapid | **Maintained** | Deep | Consistent | Robust

Net improvement after withdrawal, Study 2

Net % change at Day 84



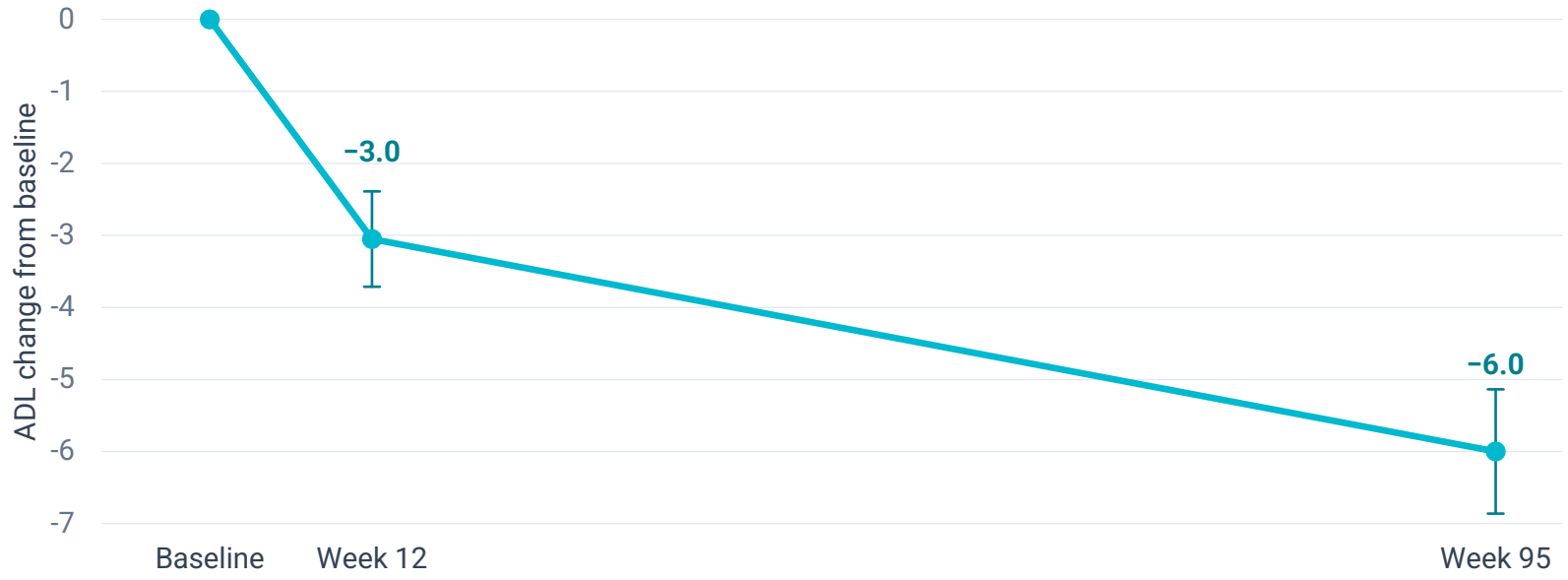
mADL11: modified 11-item TETRAS-ADL score; CGI-S: Clinical Global Impression of Severity; PGI-S: Patient Global Impression of Severity; PGI-C: Patient Global Impression of Change. Net % change = lead-in % + withdrawal %; negative means improvement retained at Day 84. Error bars are 95% CI. Source: Farmer et al. AAN 2026 Plenary Presentation.

Effect of Ulixacaltamide Treatment is Maintained Over Years, Despite ET's Progressive Course

Rapid | **Maintained** | Deep | Consistent | Robust

ADL improvement over time, ESSENTIAL3 LTSS

Change from baseline · Observed mean ± SE, n= 68



95 weeks

ADL improvement held through nearly 2 years of treatment in the ESSENTIAL3 LTSS

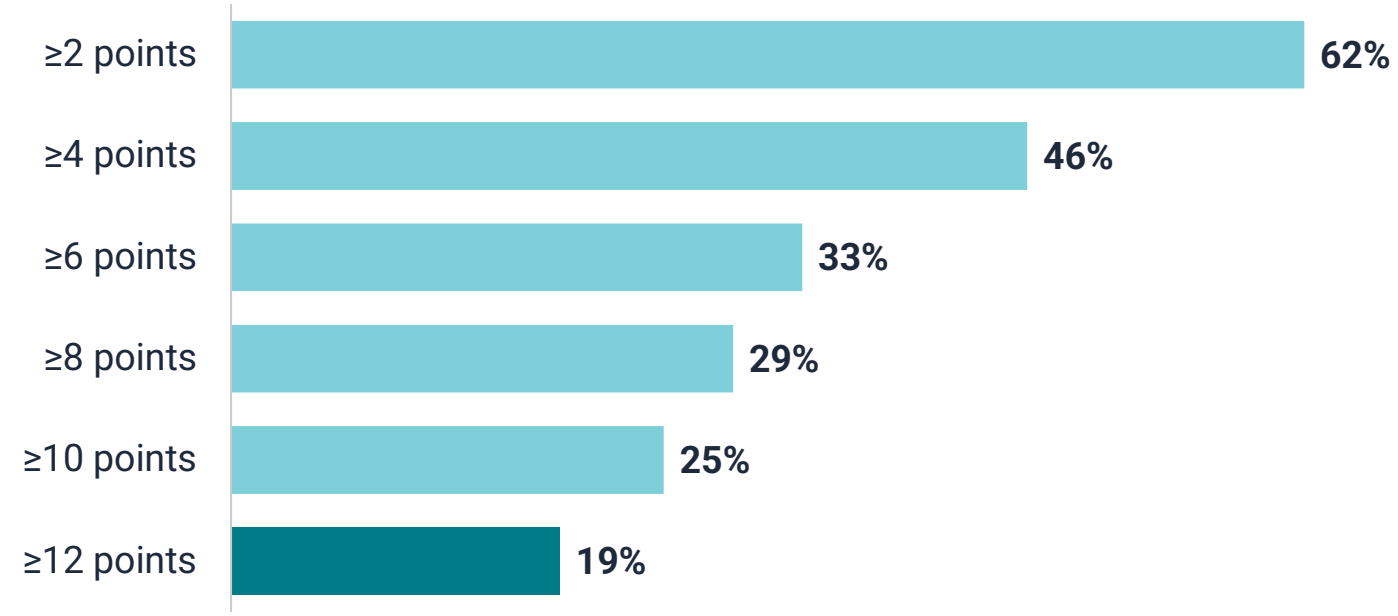
Essential3 Protocol amended to add TETRAS-ADL Assessment in Study 3 Long Term Safety Study (LTSS); Collection began November 2026 and is ongoing for participants in Study 3 who completed Study 1 or Study 2, n=68 assessed to date with average duration of 95 weeks in study.

Patients Experienced Significant Gains in Daily Functioning

Rapid | Maintained | **Deep** | Consistent | Robust

Patients reaching Responder TETRAS-ADL Thresholds at Day 56

% of ulixacaltamide patients combined Study 1 and Study 2 (N = 474)



19%

of ulixacaltamide patients improved by 12 or more TETRAS-ADL points by Day 56.

12 points

Equivalent to an improvement across each of the 12 daily activities

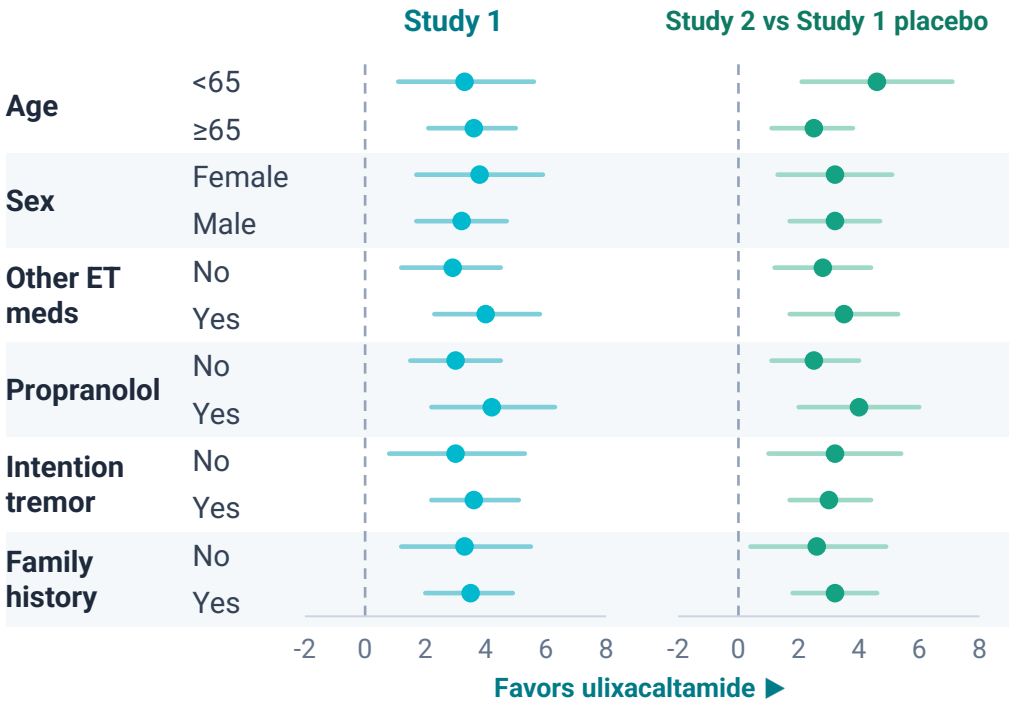
Treatment difference p < 0.01 at all responder thresholds (logistic regression). Source: Shtilbans et al. AAN 2026 Poster

Results Were Consistent Across Multiple Endpoints and Subgroups From Two Independent Studies

Rapid | Maintained | Deep | **Consistent** | Robust

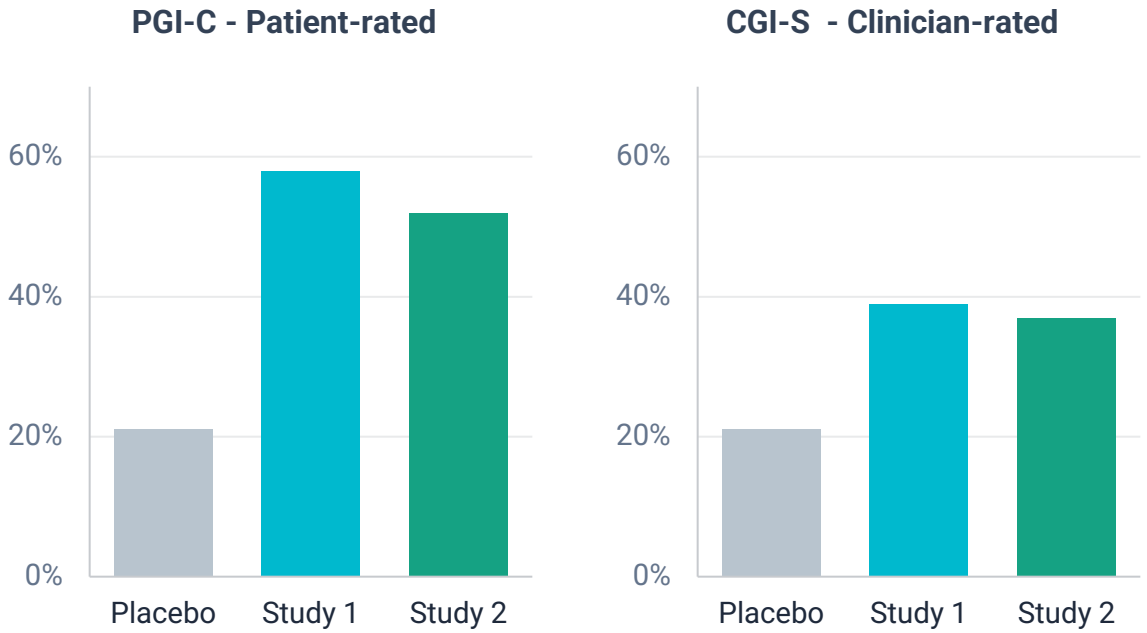
Improvement vs placebo by subgroup

LS mean difference vs placebo, TETRAS-ADL points (95% CI)



Global impression responders at Day 56

% of patients



PGI-C: Patient Global Impression of Change; CGI-S: Clinical Global Impression of Severity. Source: Shtilbans et al. AAN 2026 Poster

Primary Benefit is Robust to Sensitivity Analysis

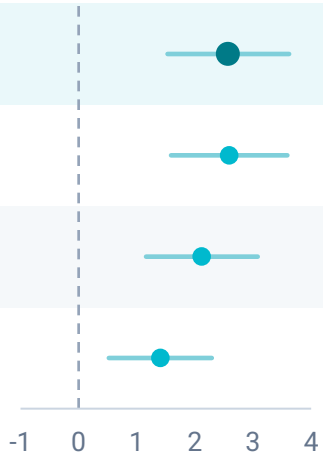
Rapid | Maintained | Deep | Consistent | **Robust**

mADL11 treatment difference vs placebo, FDA focused sensitivity analyses

LS mean difference vs placebo, points (95% CI); Day 56;

Model-based analyses, ITT

Analysis	Difference (95% CI)
Observed-data MMRM (MAR)	**2.57 (1.53, 3.62)** p < 0.0001
Multiple imputation (MAR)	2.59 (1.59, 3.59) p < 0.0001
Placebo-based imputation (MNAR; CR)	2.12 (1.16, 3.08) p < 0.0001
Baseline observation carried forward (BOCF)	1.41 (0.52, 2.29) p = 0.0019



Delta-shift tipping-point analysis, ITT

Shift (δ), points	Difference (95% CI)
δ = 2.5	1.77 (0.73, 2.80) p = 0.0009
δ = 4.5	1.15 (0.08, 2.21) p = 0.0346
δ = 5.0	0.99 (-0.08, 2.06) p = 0.0696



MMRM (MAR) included baseline mADL11, treatment, categorical visit, treatment-by-visit interaction, and randomization strata, with unstructured covariance. MAR MI, copy-reference (CR), and tipping-point analyses each used 100 multiply imputed datasets, generated using MCMC for intermittent missingness followed by monotone regression for trailing missingness. CR used placebo-fitted conditional regression models. Tipping-point analyses added δ points to MAR-imputed values in ulixacaltamide participants missing data. Each completed dataset was analyzed by MMRM, with treatment contrasts combined using Rubin's rules. BOCF replaced missing scores with baseline values before MMRM analysis.

Ulixacaltamide Delivers Compelling Efficacy Profile

Rapid	Maintained	Deep	Consistent	Robust
				
Day 14	**95 weeks**	**~1 in 5**	**Multiple Endpoints**	**4 of 4**
~5 points gained in ADL at the first assessment	benefit held through Day 84 and 95 weeks; lost when switched to placebo	patients improved 12 or more TETRAS-ADL points	consistent results from two independent studies across multiple endpoints and subgroups	model-based sensitivity analyses stayed significant

ULIXACALTAMIDE

Commercialization Strategy

Erik Johnson

The Sleeping Giant is Ready to be Awakened with The First Targeted Drug Therapy

MARKET DYNAMICS

- **Highly prevalent** disease
- Dormant market with **little innovation** in decades
- **Adult** population
- **Broad stakeholder call point**: neurologists, movement disorder specialists, neuro-like PCPs, NP/PAs
- Payer-aligned specialty pharmacy **distribution network**

KEYS TO A SUCCESSFUL LAUNCH

1 DIRECT TO PATIENT ACTIVATION

"Essential to Me" DSE campaign and subsequent DTC activate a dormant market and drive treatment discussions

2 EVERY FIRST EXPERIENCE IS FLAWLESS

A large market means high PA volume, so the integrated HUB and SP network must be smooth with minimal burden on physicians

3 PATH TO PERSISTENCE

Titration program sets clear expectations for physicians and patients at initiation, and active support during maintenance, ensuring long-term persistence

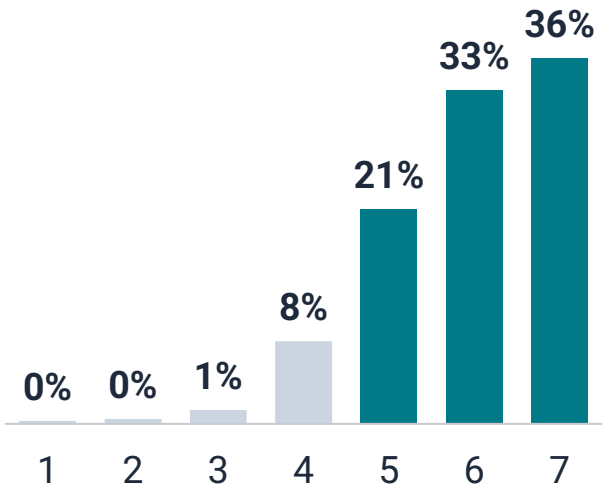
Quality over quantity: Success depends on a positive first experience for HCPs and patients

Abbreviations: DSE, disease state education; DTC, direct-to-consumer; NP/PA, nurse practitioner/physician assistant; PA, prior authorization.

HCPs are Naturally Aligned With the Profile of Ulixacaltamide

90%

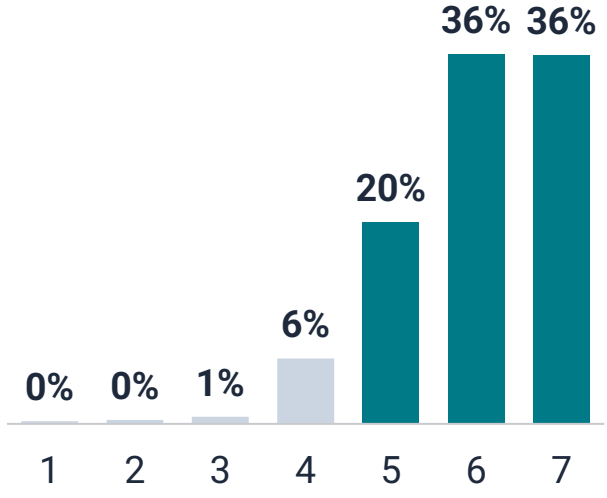
Regaining one function is meaningful (e.g. brushing teeth, pouring coffee)



1 = unfavorable · 7 = favorable

92%

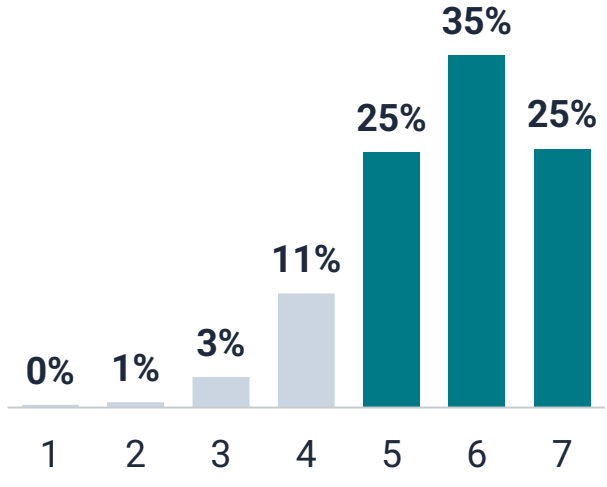
Maintaining function over time is clinically meaningful



1 = disagree · 7 = agree

85%

comfortable counseling on titration and tolerability



1 = disagree · 7 = agree

Source: HCP observational quant study, March 2026 (N = 2,303 US physicians treating ET).

HCPs View Ulixacaltamide Favorably and are Motivated to Prescribe to their ET Patients

90%

treat before symptoms become highly disruptive

Today's typical treatment approach for patients when symptoms…



18% I aim to treat as early as possible

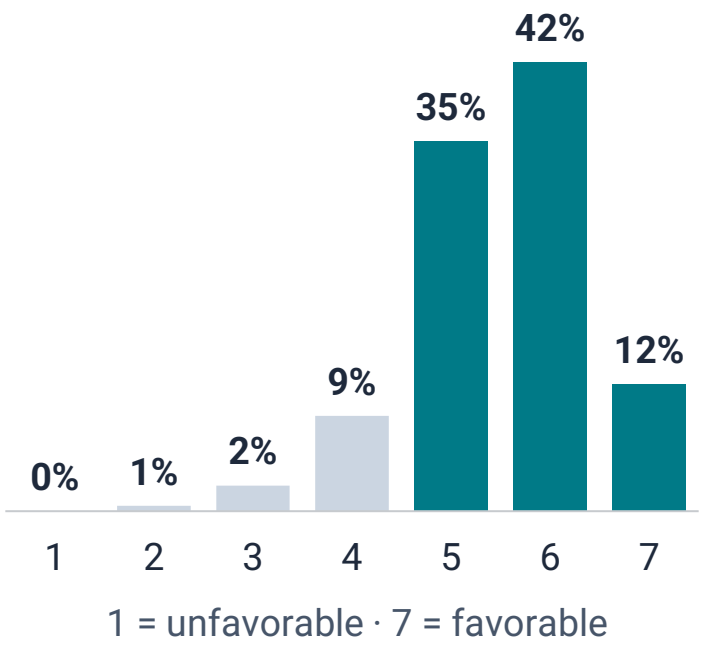
41% Begin to interfere with 1 routine daily activity

31% Interfere with multiple daily activities/work tasks

10% Are highly disruptive, substantial disability

88%

rate ulixacaltamide's overall profile as favorable



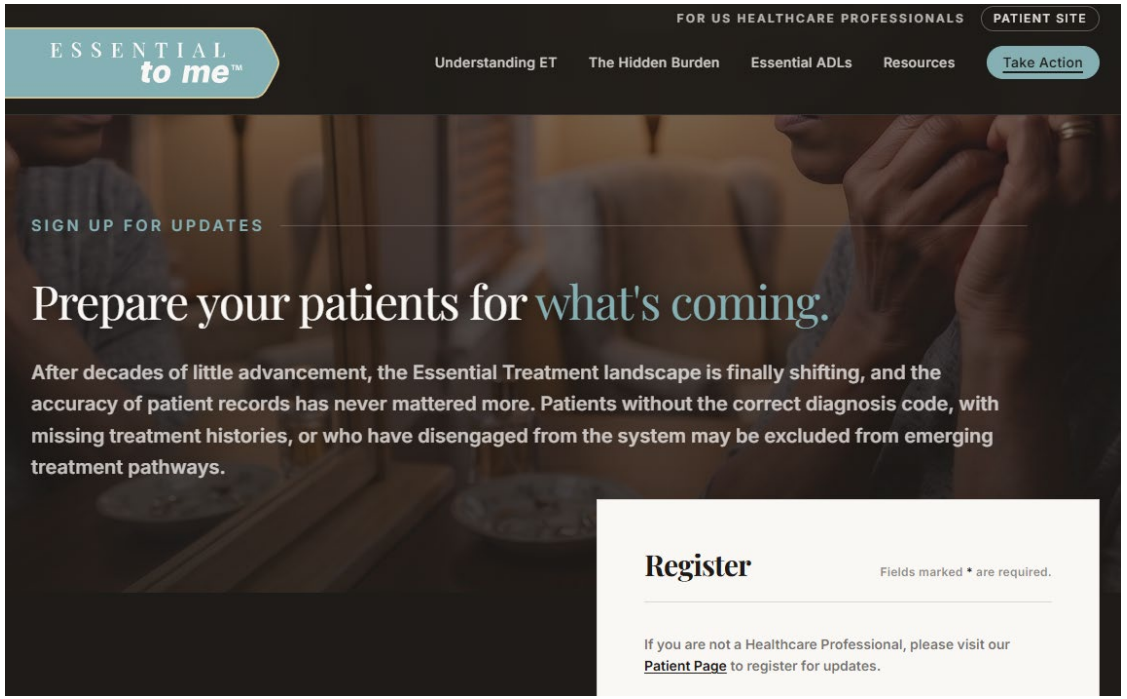
INITIAL ADOPTION INTENT

36%

Mean % of each physician's ET patients

Source: HCP observational quant study, March 2026 (N = 2,303 US physicians treating ET).

The ESSENTIAL TO ME™ DSE Campaign has been Successful in Driving Confidence to Treat and Empowering Patients to Seek Care



HCPs will recognize:

- ✓ ET as a serious disease warranting active treatment
- ✓ The importance of ADL-based functional improvement
- ✓ The importance of proper use of ICD-10 G25.0 diagnosis code at the point of care

Patients will see:

- ✓ An opportunity for better management and the confidence to re-engage with their HCPs
- ✓ Their lived experience with ET as reason enough to seek care

DTC Will Further Mobilize the Market at Launch

FOR INITIAL LAUNCH

Drives Awareness

- Empowers patients to raise ET with their HCP now

Engages Undertreated & Discontinued Patients

- Reframes ET as actionable and treatable

FOR LONG-TERM

Addresses ET Underdiagnosis

- A new treatment drives reason for diagnostic coding
- Patients often dismiss tremor as normal aging rather than a treatable condition
- Drive patient self-recognition and prompt a diagnostic conversation

ESSENTIAL 3
AN AT-HOME RESEARCH STUDY

Direct-to-patient recruitment established the capability to deploy for commercialization

DSE campaign performing better than ESSENTIAL3 metrics

With Neurologists Ready to Treat, Praxis Adds Support From the First Prescription Through Maintenance

THE NEUROLOGIST PERSPECTIVE

Strong enthusiasm for the profile

- Rapid onset
- Once-daily dosing
- Adjunctive to current ET meds

Neurologists routinely manage tolerability with titrated CNS drugs

Not viewed as a barrier to prescribing

PRAXIS SUPPORT



CONVERSATION BEFORE THE FIRST PATIENT

A Praxis conversation with each physician before their first patient starts therapy



HCP COUNSELS PATIENT

Discuss expectations for treatment and titration phase



COMPREHENSIVE SUPPORT FOR INITIATION AND PERSISTENCE

Tailored services to support titration experience and retention

The Hub of the Future Fully Integrates the Rx Writing, Patient Services and Specialty Pharmacy

PRAXIS HORIZONS™
Forward Together

Digital Prescription Intake

Office & Patient Support

Specialty Pharmacy Distribution

1 PRESCRIBE

Prescribe from the EHR

The prescription goes straight from the EHR with required info

2 GET ACCESS

Coverage answered fast

Benefits verified the same day; Hub routes eRx to correct in-network SP post-BI/BV

3 START THERAPY

Engaged within minutes

Outreach begins within minutes of the eRx; Real-time status for Patients and Offices

4 STAY ON THERAPY

Continued support

Enhanced services tailored to support titration and adherence

COMMERCIAL DATA FOUNDATION (CDF) » **Real-time view of patients, prescribers, payers and channel**

Abbreviations: EHR, electronic health record. BI/BV benefits investigation/benefits verification

Praxis Has Built Supply and Distribution Ahead of Approval so Patients Get Ulixacaltamide From Day One

Product Supply
CDMO Network

→

3PL

→

Specialty Pharmacy Network

→

Patient

SUPPLY INVESTMENT AND PREPAREDNESS

Proactively invested to ensure we are well-positioned to meet anticipated demand and distribution needs

ALIGN TO PAYER-OWNED PHARMACIES

Account for the majority of covered lives across Medicare Part D

Price Corridor Captures Value While Maintaining Access

	PRICE	DISEASE	U.S. PREV.
Austedo® (deutetrabenazine) 6 mg, 9 mg, and 12 mg tablets	~$110K	TD + HD chorea	~1.5M
ONCE-DAILY INGREZZA® (valbenazine) capsules	~$110K	TD + HD chorea	~1.5M
NUPLAZID® (pimavanserin) 34mg capsules	~$62K	PD psychosis	~1M
JUVMO™ (tavapadon) tablets	~$60K	PD	~1M
Rezdiffra™ resmetirom tablets 60mg · 80mg · 100mg	~$52K	F2–F3 MASH	~7–9M

ULIXACALTAMIDE PRICING CORRIDOR

$50K–$100K WAC per year

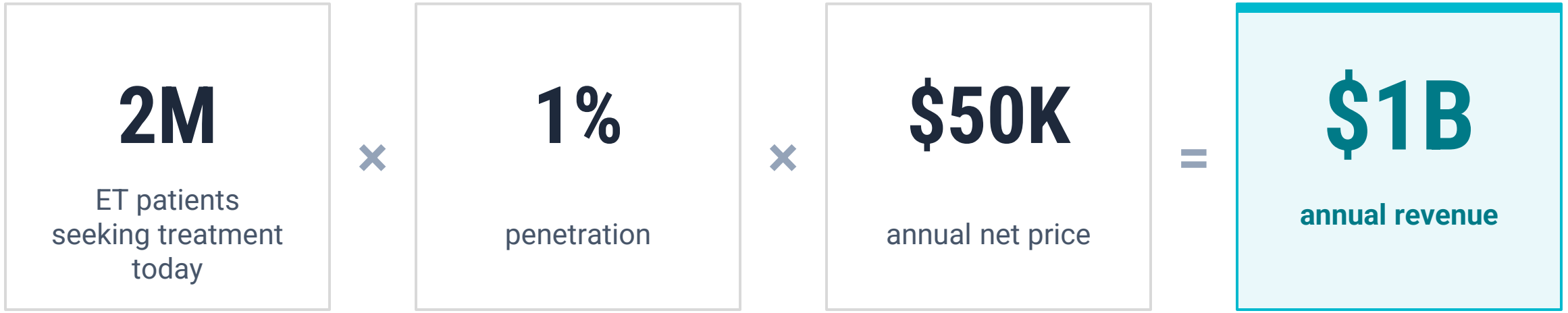
PRICING PRINCIPLES

- Responsible launch pricing to maximize drug value without restricting access
- Launch price benchmarked to in-market analogs
- Reflect first-in-class value and demonstrated clinical benefit

Gross annual price for selected analogs; not to scale. Austedo: WAC $5,278.17/60 × 6 mg tablets, $5,937.96/60 × 9 mg tablets and $7,917.14/60 × 12 mg tablets. Ingrezza: WAC $9,072/30 × 80 mg capsules. Nuplazid: WAC $5,120/30 × 34 mg capsules. Juvmo: WAC $4,900/30 tablets at each maintenance strength (5, 10 and 15 mg). Rezdiffra: WAC $4,239.38/30 tablets at each strength (60, 80 and 100 mg). Abbreviations: HD, Huntington's disease; MASH, metabolic dysfunction-associated steatohepatitis; PD, Parkinson's disease; TD, tardive dyskinesia; WAC, wholesale acquisition cost

The Scale of Unmet Need in ET Means Every Point of Penetration Generates Blockbuster Sales

ILLUSTRATIVE SALES MATH



Source: Internal claims analysis

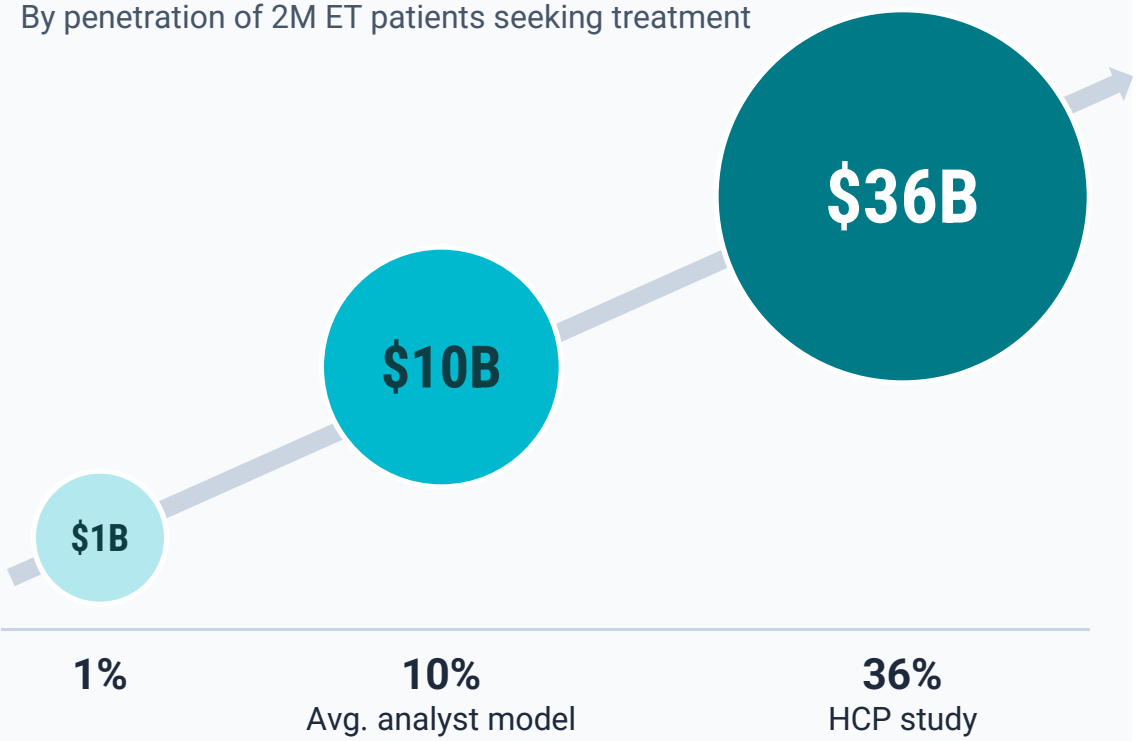
The Opportunity is Vast, and Our Launch is Built to Match It

Penetration Drivers

- First **ET-specific** therapy
- **Standard of care** is ineffective and poorly tolerated
- **No near-term competition** in clinical development
- **DTC** empowers patients to start the conversation with their physicians
- **Field team at scale** deployed from day 1

ANNUAL PEAK SALES

By penetration of 2M ET patients seeking treatment



Illustrative. Peak sales = 2M ET patients seeking treatment × penetration × $50K annual net price. Avg. analyst model: mean peak patients on drug across sell-side models ÷ 2M. HCP study: mean % of ET patients physicians would prescribe to (March 2026, N = 2,303).

ULIXACALTAMIDE

Activating Demand and Pull Through

John Bullock

Precision Targeting Puts Our Field Team in Front of the Physicians Who Matter Most – Driving Impact

STEP 1

Identify diagnosed ET patients

Through diagnosis and Rx claims

STEP 2

Map to their physicians

All specialties identified for each patient

STEP 3

Rank on ET impact

Based on factors such as treatment initiations, diagnosis, etc.

TREATING PHYSICIANS IDENTIFIED BY SPECIALTY

- Academic neurologist
- Community neurologist
- NP/PA in neurology
- Geriatric medicine
- Primary care
- Other

Every Key ET Prescriber Is Covered by a ~300 Field Team with Capacity for Dynamic Targeting

WHO WE CALL ON

~19K

target HCPs, where ET patient volume and influence are concentrated

=

13 - 15K

Neurologists

Top-tier neurologists, including movement disorder specialists

+

4.5 - 5.5K

PCPs

High-volume, high-influence primary care physicians

Offices Are Ready Before the First Patient Asks: Educated, Prepared and Connected

PRE-APPROVAL

DISEASE EDUCATION

OFFICE OPERATIONS

STANDARD Rx WORKFLOW

FDA APPROVAL

AT LAUNCH



HCP EDUCATION

First new ET therapy in decades; data consistent with label



READINESS FOR PATIENT DIALOGUE

Set expectations for rapid onset and possible common side effects



AWARENESS OF THE PRAXIS HORIZONS HUB

An integrated digital pathway supports smooth patient access while keeping burden off physicians and offices

A High-Touch Experience Supports Initiation, Maintenance and Adherence

1

WELCOME

Set expectations

Pharmacist call covers the disease, product and side effects to expect

2

EARLY TITRATION

Manage tolerability

Nurse or pharmacist check-ins

3

DOSE PROGRESSION

Confirm readiness

Confirm the patient is ready to advance; escalate to the prescriber if tolerability concerns

4

MAINTENANCE

Prevent gaps

Coordinate the maintenance refill so therapy continues without interruption

5

PERSISTENCE

Protect therapy

Refill outreach, adherence monitoring

Broad Ulixacaltamide Coverage Expected with a Predictable Path to Treatment

OUR ACCESS OBJECTIVE

Broad coverage aligned with the anticipated label



	Launch and early access	As payer policies develop
~65% Medicare Part D	Formulary exception requests available at launch; approvals depend on clinical justification	**EXPECTED REQUIREMENTS** **Prior authorization:** diagnosis confirmation and specialist consultation **Step therapy:** Propranolol first step may be required
~30% Commercial	Some plans apply new-to-market exclusions until P&T review; exception availability varies	

A Large Market, the Right Drug and a Launch Built to Win

01

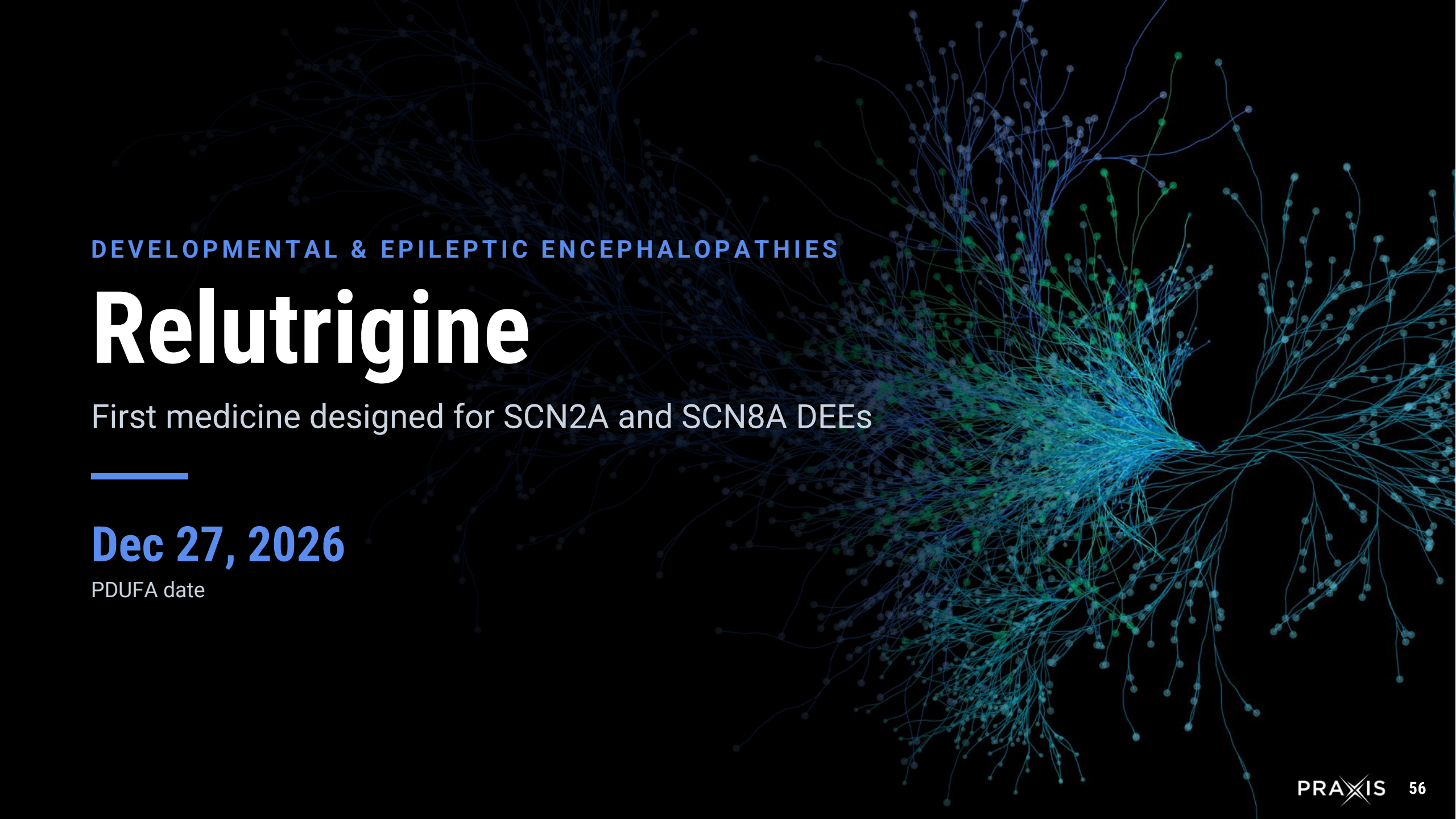
A large and growing market

02

A therapy patients need and physicians want

03

The people, systems and strategy to deliver



DEVELOPMENTAL & EPILEPTIC ENCEPHALOPATHIES

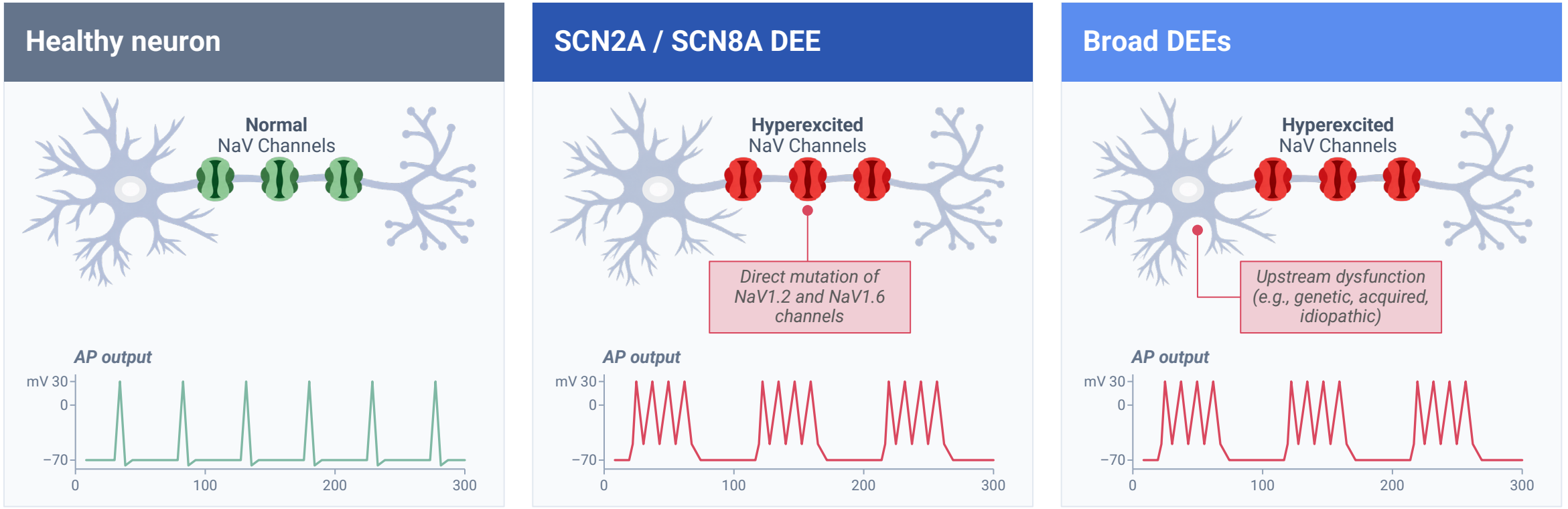
Relutrigine

First medicine designed for SCN2A and SCN8A DEEs

Dec 27, 2026

PDUFA date

Sodium Channels are Key in Seizure Activity in DEEs



NaV channels are either the primary genetic cause of hyperexcitability or the point where diverse upstream causes converge

Illustrative. Scheffer et al. Nat Rev Dis Primers. 2024; Wengert et al. J Neurosci. 2021; Guerrini et al. Physiol Rev. 2023; Berecki et al. PNAS. 2018. Abbreviations: AP, action potential; DEE, developmental and epileptic encephalopathy; NaV, voltage-gated sodium channel

Children and Families Face Severe Disease Burden Living with SCN2A and SCN8A DEEs



WHAT THE CHILD FACES	WHAT THE FAMILY SHOULDERS
Profound developmental delay	Lifelong supportive care
High seizure rate from birth	Management of multiple medications with burdensome administration
A shortened life	The risk of early loss

No medicine has ever been specifically designed for children with SCN2A or SCN8A DEEs

Photos shared at Praxis 2024 DEEP Dive Day. Sources: Zuberi SM, et al. Epilepsia. 2022; Gallop K, et al. Epilepsy Behav. 2021; Thurman DJ, et al. Epilepsia. 2014; CHOP SCN2A-related disorders.

RELUTRIGINE

EMBOLD: First Study Ever Done For SCN2A and SCN8A DEE Patients

Steve Petrou

EMBOLD Enrolled a Severe Population of SCN2A/8A Patients

PATIENT PROFILE

Heavily pre-treated pediatric SCN2A/SCN8A population

ASMs at baseline:



~1/3 1–2 ASMs

~2/3 3–6 ASMs

~55

Median motor seizures per month at baseline; highly skewed, with many patients >100

DOUBLE-BLIND TREATMENT · 16 WKS (4 × 4-WK PERIODS)

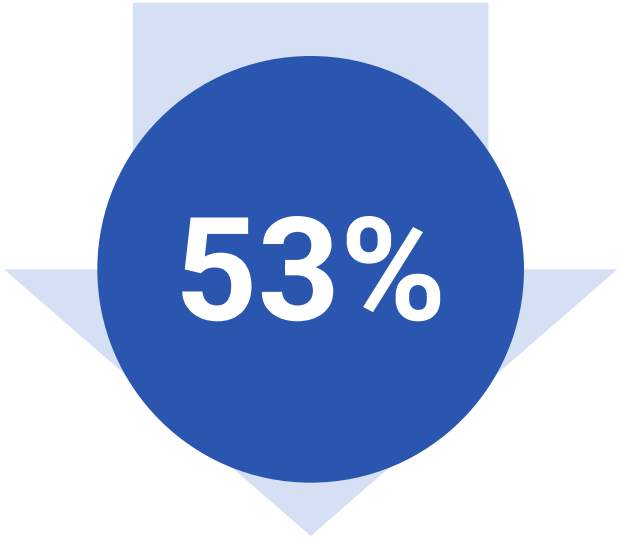


PRIMARY ENDPOINT

Change from baseline in monthly motor seizure frequency calculated as the period on relutrigine versus period on placebo

ASM=antiseizure medication; OLE=open-label extension. Source: Kamireddy et al. AES 2025; Frizzo et al. IEC 2025; NCT05818553

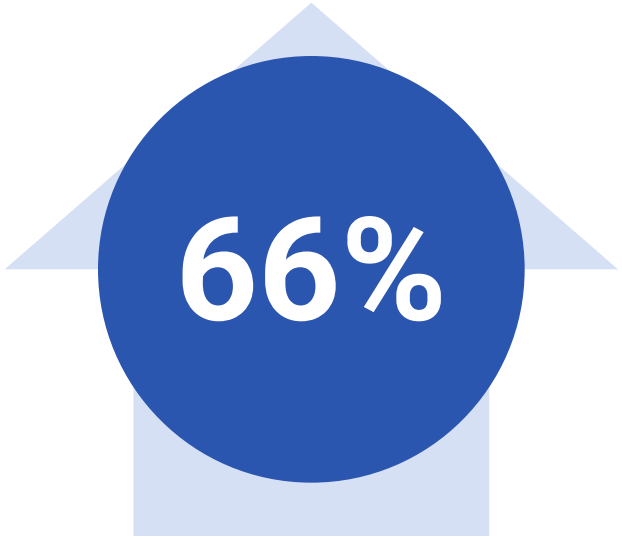
Significant Seizure Reduction in the EMBOLD Study



PRIMARY ENDPOINT

placebo-adjusted reduction in motor seizures

p < 0.0002



KEY SECONDARY ENDPOINT

increase in motor seizure-free days vs. placebo

p = 0.0340

BENEFITS ACROSS MULTIPLE DIMENSIONS

- Best-in-Disease Efficacy
- Seizure Freedom
- Functional Gains
- Well-Tolerated
- Patient Centric

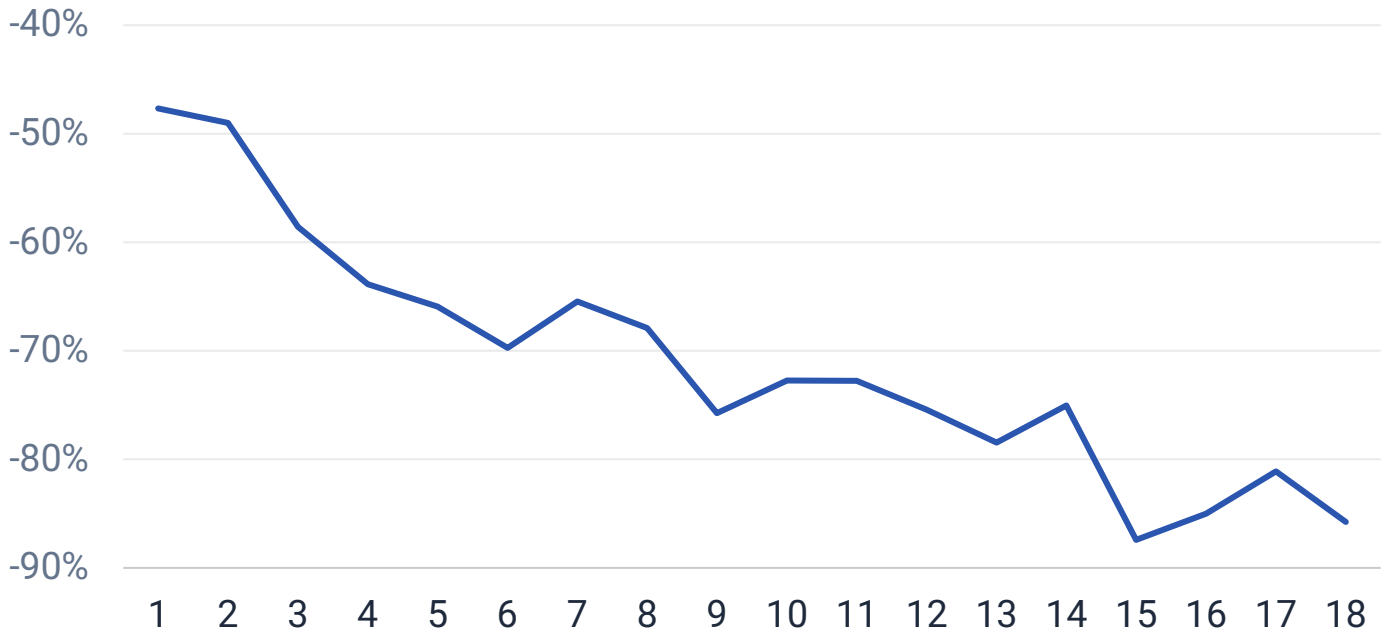
Primary endpoint: placebo-adjusted change in monthly (28-day) motor seizure frequency, Cohort 2. Primary analysis used NB1 regression, adjusted for baseline motor-seizure rate and treatment-evaluable days. Relutrigine periods from both randomized arms were compared with Arm B's placebo period: 53 participants contributed 51 relutrigine and 25 placebo treatment-period records. The two-sided interim significance boundary was 0.04. Source: Kamireddy et al. AES 2025; Bialer et al. Epilepsia 2026

Unprecedented Seizure Reduction Deepening Over Time

Deepening Response | Seizure Freedom | Functional Gains | Well-Tolerated | Patient Centric

Reduction in motor seizures by months of exposure

% change from baseline in monthly motor seizures



86%

seizure reduction at 18 months

98%

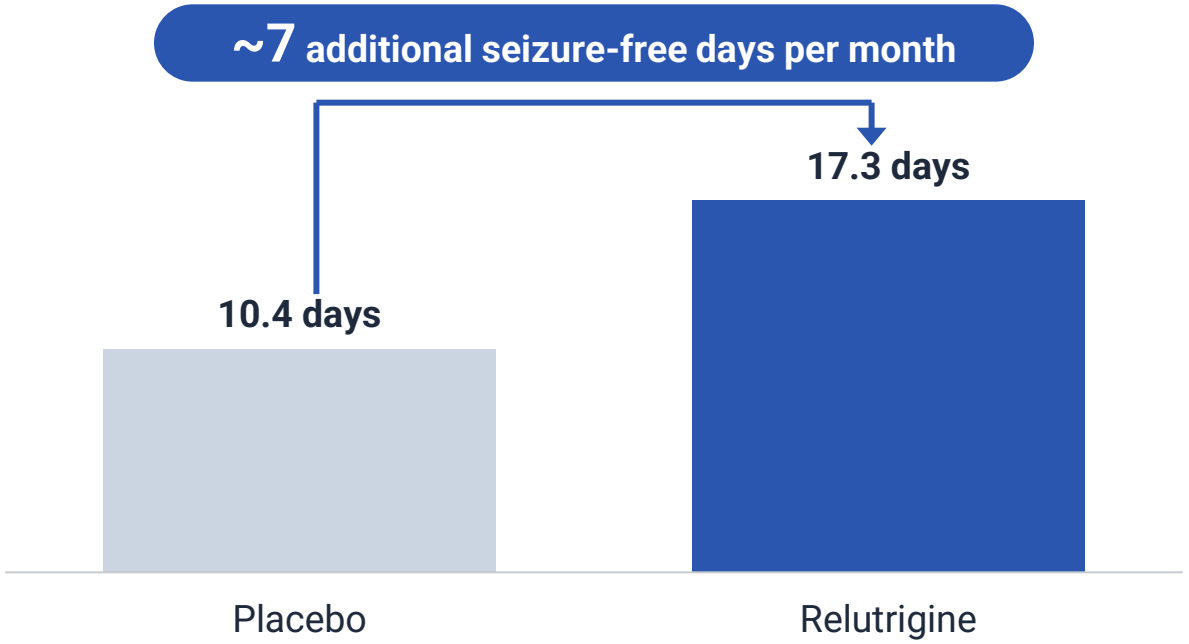
of eligible patients continued into the OLE

Months with at least 10 contributing participants are shown. Data cutoff 14 August 2026. Month 5 (start of open-label period), n=67; Month 6, n=67; Month 7, n=66; Month 8, n=65; Month 9, n=61; Month 10, n=57; Month 11, n=54; Month 12, n=49; Month 13, n=39; Month 14, n=31; Month 15, n=25; Month 16, n=21; Month 17, n=14; Month 18, n=10. OLE=open-label extension.

Patients Experienced Significant Increase in Seizure-Free Days

Best-in-Disease Efficacy | **Seizure Freedom** | Functional Gains | Well-Tolerated | Patient Centric

Days without a motor seizure
Mean days per 28 days, 16-week double-blind period



+66%

more motor seizure-free days on relutrigine than on placebo (p=0.034)

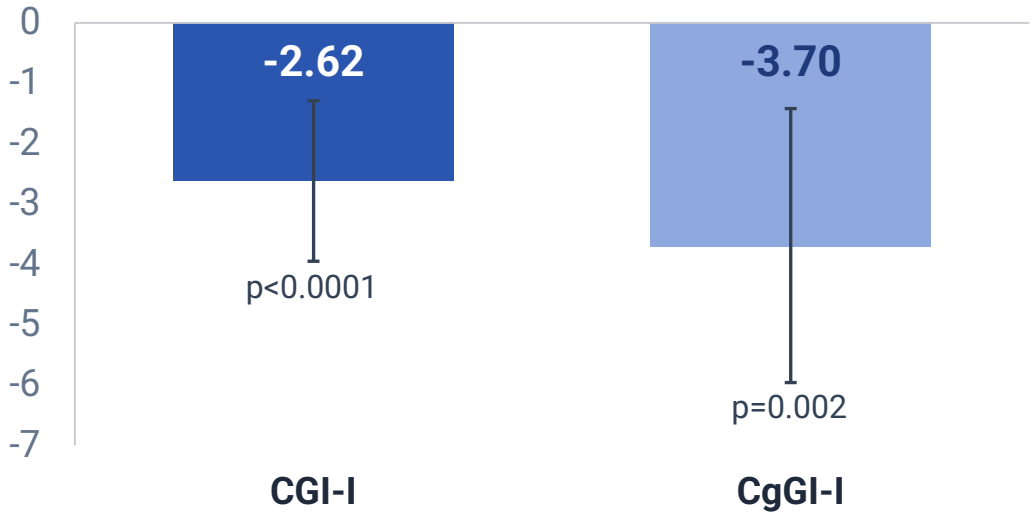
Source: Kamireddy et al. AES 2025; Bialer et al. Epilepsia 2026

Gains Observed Across Multiple Areas Beyond Seizures

Best-in-Disease Efficacy | Seizure Freedom | **Functional Gains** | Well-Tolerated | Patient Centric

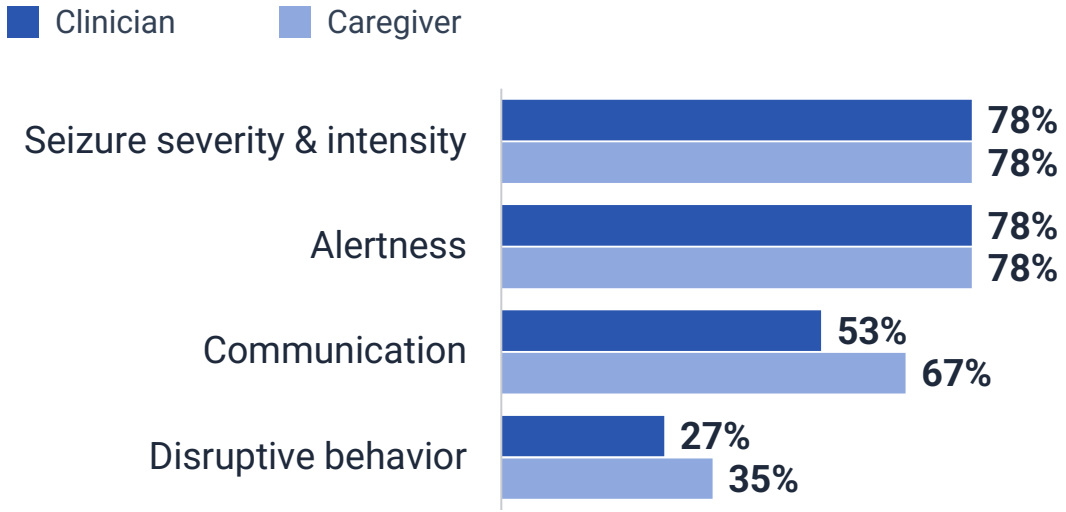
Global impression of improvement vs placebo

Adjusted difference at last visit (95% CI)



Participants improving by domain, last visit on relutrigine

% of Cohort 2 participants, clinician- vs caregiver-rated



Clinicians and caregivers both saw **statistically significant functional improvement over placebo**

Source: Kamireddy et al. AES 2025; Bialer et al. Epilepsia 2026

Relutrigine Was Well Tolerated, With No Drug-Related SAEs

Best-in-Disease Efficacy | Seizure Freedom | Functional Gains | **Well-Tolerated** | Patient Centric

Adverse event	Relutrigine	Placebo
Pyrexia	**11.7**	13.4
Upper respiratory infection	**9.8**	4.5
Somnolence	**9.1**	13.4
Irritability	**5.2**	4.5
Diarrhea	**4.6**	8.9
Constipation	**3.9**	8.9
Cough	**3.9**	0.0
Vomiting	**3.9**	8.9

Most common TEAEs, rate per 100 patient-months of exposure, Cohort 2

- **No drug-related SAEs**; all SAEs consistent with disease background
- **Mostly mild-to-moderate AEs**; no dose reductions were required
- **Tolerated with complex regimens**: 3–4 concurrent ASMs, 79% on SCBs
- **Minimal drug-drug interactions**, given relutrigine's selectivity

No clinically significant findings in vital signs, laboratory results, physical exams or ECGs. AE=adverse event; ASM=antiseizure medication; ECG=electrocardiogram; SCB=sodium channel blocker; SAE=serious adverse event; TEAE=treatment-emergent adverse event. Source: Kamireddy et al. AES 2025; Bialer et al. Epilepsia 2026

Relutrigine Offers a Patient-Friendly Dosing and Administration Paradigm

Best-in-Disease Efficacy | Seizure Freedom | Functional Gains | Well-Tolerated | **Patient Centric**



Once Daily

- One dose a day for patients and caregivers



No Titration

- No dose titration or tapering required
- Seizure reduction seen from Month 1



Flexible Administration

- Liquid formulation suitable for oral or G/J tube delivery
- Compatible with ketogenic diet
- May be taken with or without food

G/J tube=gastrostomy/gastrojejunostomy/jejunostomy tube.

Relutrigine Sets a New Bar in SCN2A/8A DEE Across Every Dimension

Best-in-Disease Efficacy	Seizure Freedom	Functional Gains	Well-Tolerated	Patient Centric
				
-86%	**7**	**78%**	**0**	**1×**
mean reduction at 18 months in the OLE	more motor seizure-free days than placebo in Cohort 2	improved in alertness, as rated by clinicians and caregivers	drug-related SAEs and no dose reductions required	daily dose with no titration, keto-friendly and given orally or by G/J tube

SAE=serious adverse event. Source: Kamireddy et al. AES 2025; Bialer et al. Epilepsia 2026

What Positions Relutrigine for Efficacy in EMERALD?

EMBOLD

COMPLETED · POSITIVE

POPULATION

SCN2A, SCN8A DEEs

NaV CHANNELS

Mutated

EMERALD

TOPLINE 4Q26

POPULATION

Broad DEEs >50 etiologies

NaV CHANNELS

Mostly normal

The unique biophysical actions of relutrigine demonstrate why it is uniquely positioned for efficacy in broad DEEs with non-NaV etiologies

Diverse DEE Genes Converge on the Common Output Stage

DEE MUTATIONS CAN DIRECTLY OR INDIRECTLY INVOLVE THE AIS

BASE CASE – EFFICACY ESTABLISHED
SCN2A, SCN8A
Changes in the spike generator itself

HARDEST CASE - SHARPEST DIFFERENTIATION
SCN1A loss of function in Dravet
Disinhibited networks burst through wild-type Na_v

KCNQ2, KCNQ3
M-current brake shares the AIS compartment

KCNA1, KCNA2
Low-threshold K^+ current raises spike threshold

KCNT1, KCNH1
More K^+ current reducing interneuron output

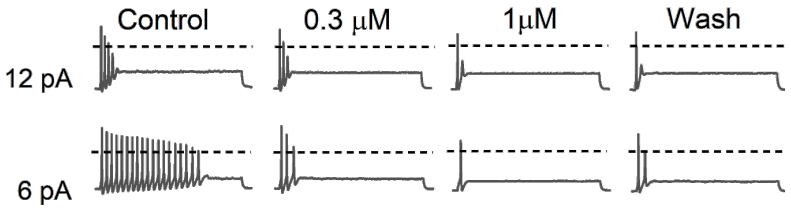
HCN1
I_h cation leak raises intrinsic excitability

STXBP1, SLC6A1, CDKL5
Synaptic and network drive onto wild-type Na_v

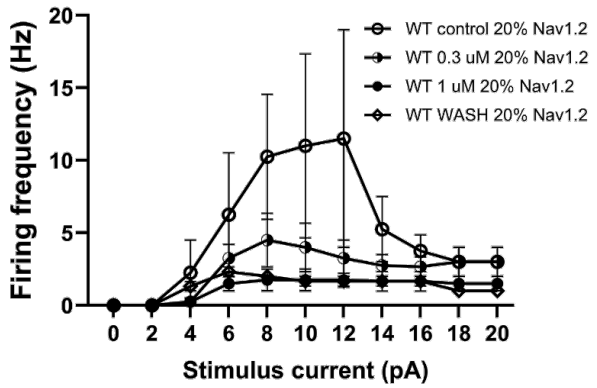
Phenotype-selected patients
Selected on firing phenotype, not gene name

AXON INITIAL SEGMENT

RELUTRIGINE REDUCES NEURONAL FIRING IN WT NAV CHANNELS



DAPC Firing evoked by 12 pA and 6 pA current injection



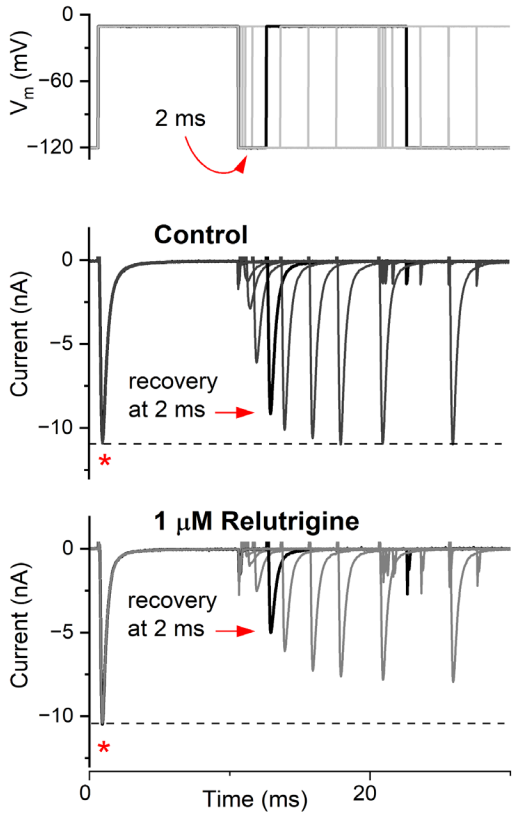
IS THE TARGET PRESENT WHEN THE NAV CHANNELS ARE NORMAL?

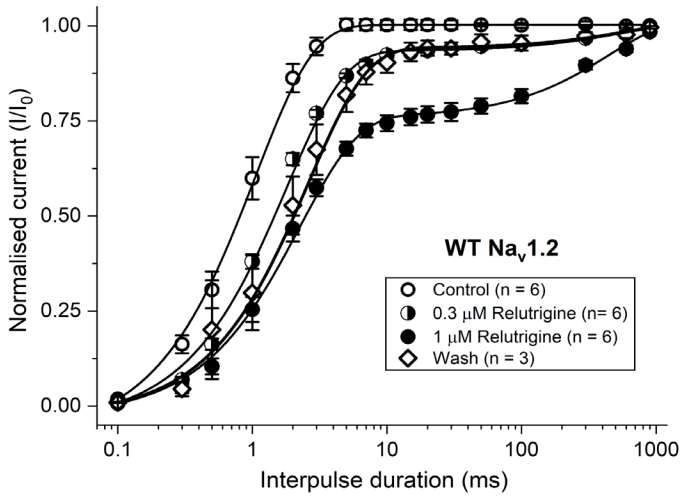
Yes, and diverse DEE genes converge on NaV-dependent spike generation at the axon initial segment

AIS, axon initial segment; DAPC, dynamic action-potential clamp; DEE, developmental and epileptic encephalopathy. Data: Berecki (Florey Institute) DAPC; AIS physiology: .

Targeting Activity-Dependent Current – Recovery from Fast Inactivation

RECOVERY FROM FAST INACTIVATION (WT NAV1.2)

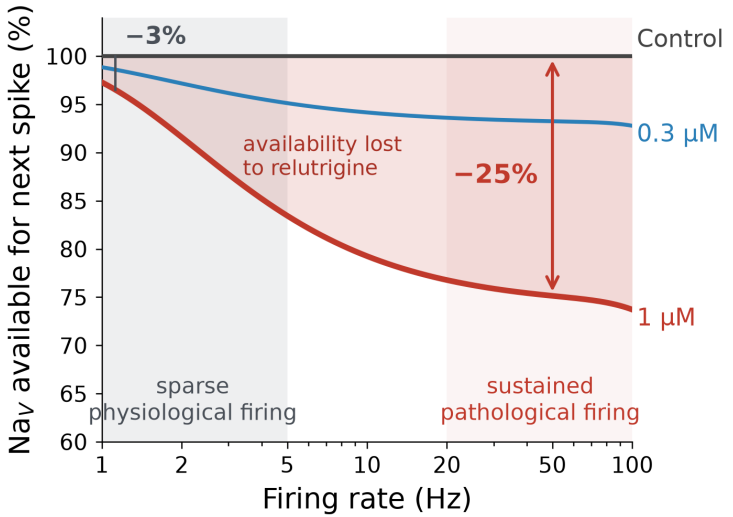




Relutrigine produces a slow component of recovery from fast inactivation corresponding to a slowly recovering channel population/state.

WT $Na_v1.2$	τ_1 (ms)	τ_2 (ms)	A_1 (fraction)	A_2 (fraction)
Control	1.05 ± 0.03	-	1.00 ± 0.03	-
0.3 μM Relutrigine	1.79 ± 0.03	554 ± 343	0.93 ± 0.01	0.07 ± 0.02
1 μM Relutrigine	2.25 ± 0.12	443 ± 88	0.74 ± 0.01	0.26 ± 0.01
Wash	2.59 ± 0.17	628 ± 488	0.93 ± 0.01	0.07 ± 0.01

WHAT THAT MEANS FOR A FIRING NEURON



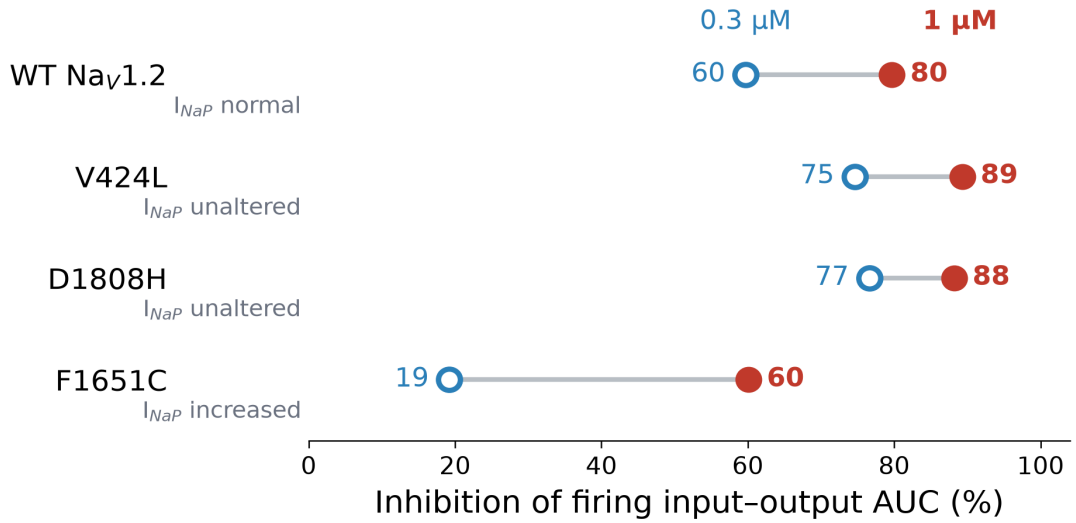
CAN THE DRUG TELL PATHOLOGICAL FIRING FROM NORMAL FIRING?

> Yes, NaV availability falls ~25% at burst rates, but only ~3% at sparse 1–2 Hz firing

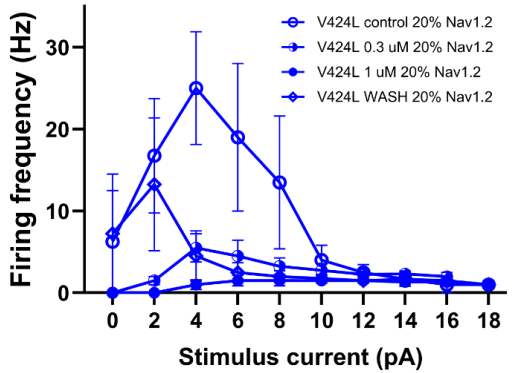
Praxis data on file. Berecki (Florey Institute)

Persistent Current Sustains Pathological Firing Whether or Not the Channel Is Mutated

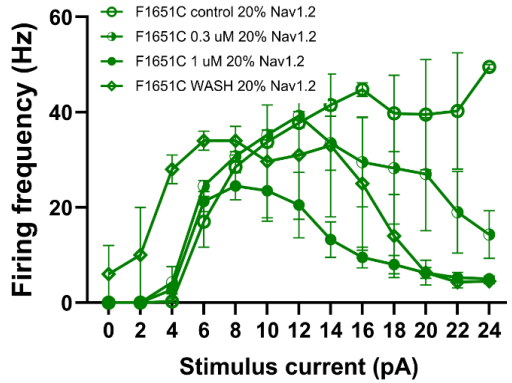
FIRING INHIBITION VS. PERSISTENT CURRENT PHENOTYPE



INHIBITION NOT DEPENDENT ON I_{NaP} BASE LEVEL



V424L · I_{NaP} unaltered
89% AUC inhibition



F1651C · I_{NaP} increased
60% AUC inhibition

IS NORMAL I_{NaP} A HARDER TARGET THAN ELEVATED I_{NaP}?

No, a lower baseline current reaches the critical level with a smaller reduction

Praxis data on file. Berecki (Florey Institute) Abbreviations: I_{NaP}, persistent sodium current.

A Severe, Diverse Population Means EMERALD Results Will Apply Across the Entire DEE Spectrum

Baseline characteristics · median age 13 years

HIGH, EARLY-ONSET SEIZURE BURDEN

58
median motor seizures per 28 days at baseline

56%
seizure onset before age 1

3
median ASMs before dosing

SIGNIFICANT FUNCTIONAL IMPAIRMENT

51%
unable to walk independently

31%
unable to sit independently

21%
tube used for food and/or medications

BROAD, REPRESENTATIVE ETIOLOGIES



>50
distinct genetically defined pathological etiologies

ASM, antiseizure medication

RELUTRIGINE

Commercialization Strategy

Erik Johnson

SCN2A and SCN8A Market Opportunity Demands a High-Touch, Specialized Execution Model

MARKET DYNAMICS

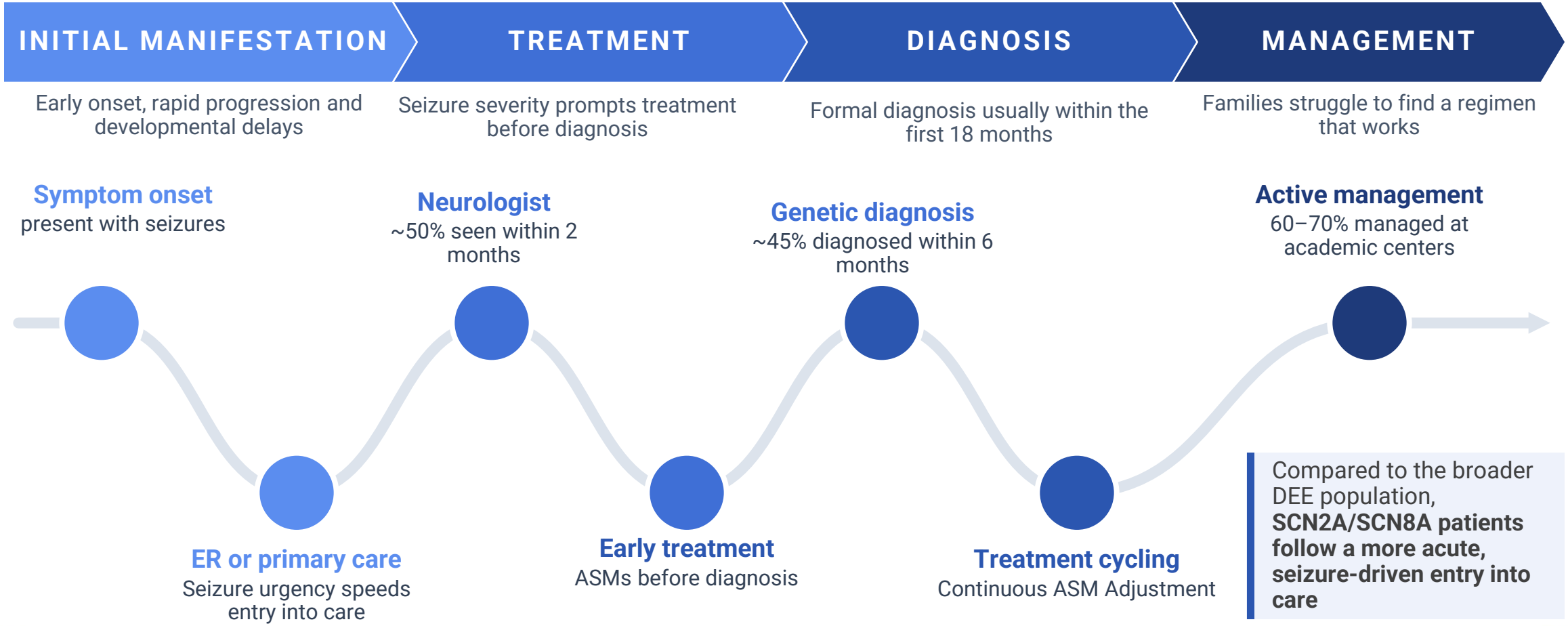
- **Ultra-rare** disease
- **Activated** and **engaged** market among those diagnosed
- Caregivers and **children**
- **Centers of excellence** and **specialized** pediatric neurologists
- **Single-specialty** pharmacy distribution

WHAT IT MEANS FOR LAUNCH

High-touch & specialized

- Every family engaged one-to-one
- Field teams built around centers of excellence
- Support from first script through refills

For SCN2A and SCN8A Families, a Long and Complicated Journey Begins at Birth



Data source: Internal claims data. Abbreviations: ASM, anti-seizure medication; DEE, developmental and epileptic encephalopathy; ER, emergency room

With No Guidelines or Targeted Options, DEE Seizures Persist Despite Aggressive Off-Label Polytherapy

THE CURRENT STANDARD OF CARE FOR DEEs

No guidelines or established treatment algorithm

Treatment reacts to seizure presentation; no defined order exists for SCN2A/SCN8A or broader DEEs

A fragmented landscape

Generic ASMs used in combination; the few branded options are used on label for Dravet, LGS, TSC and CDKL5

Seizures persist despite aggressive polytherapy

HCPs struggle to achieve monotherapy, escalating doses and adding ASMs; patients average 2.6 ASMs and 78% are not seizure-free

Quotes and ASM figures from HCP market research.

Abbreviations: ASM, anti-seizure medication; CDKL5, CDKL5 deficiency disorder; LGS, Lennox-Gastaut syndrome; TSC, tuberous sclerosis complex

HCPs Value Relutrigine Profile of Improved Efficacy and Quality of Life and Intend to Broadly Use it

PERCEIVED VALUE

Attributes HCPs rate **significantly better** than current therapies:

Efficacy

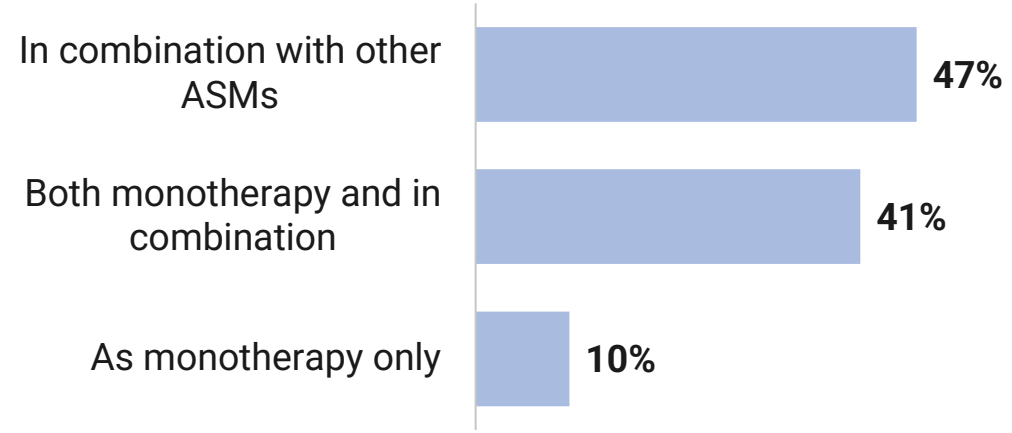
Quality of life

Tolerability

EXPECTED USE

98% of HCPs shown the blinded relutrigine profile **expect to use it**

HOW THEY EXPECT TO USE IT



Data on File; Analysis is based on DEE Treaters from Quantitative Research conducted (N=128);
Abbreviations: ASM: Anti-Seizure Medication; DEEs: Developmental and Epileptic Encephalopathies; HCP: Healthcare Provider

The Hub of the Future Accelerates Relutrigine Access and Delivers White-Glove Support for Every Family

PRAXIS HORIZONS™
Forward Together

PRESCRIPTION INTAKE
Praxis Horizons Digital Pharmacy

- Receives e-Rx via EHR
- Immediate text to patient/caregiver
- Starts BI, PA and access support the same day

COORDINATION
Praxis In-House Care Coordinator

- Case oversight
- Logistics for Patient Services Programs
- Personalized ongoing support to offices and families

EDUCATION
Praxis In-House Patient Education Liaison

- Disease and treatment education
- Dosing support
- Setting expectations
- Resource navigation

FULFILLMENT
Single Specialty Pharmacy

- PA managed by dedicated access specialists
- Dispenses and delivers medication

COMMERCIAL DATA FOUNDATION (CDF) → **Real-time view of patients, prescribers, payers and channel**

Abbreviations:; EHR, electronic health record.

Relutrigine Pricing Strategy Balances Value With Access

	PRICE	DISEASE	U.S. PREV.
Strensiq® (asfotase alfa) for injection 40 mg/mL	**~$1,800K**	HPP	~1–1.5K
Sephience™ sepiapterin	**~$622K**	PKU	~12K
Evrysdi® risdiplam	**~$430K**	SMA	~10K
SKYCLARYS® (omaveloxolone)	**~$415K**	FA	~5K

RELUTRIGINE PRICING CORRIDOR

$400K–$600K WAC per year

PRICING PRINCIPLES

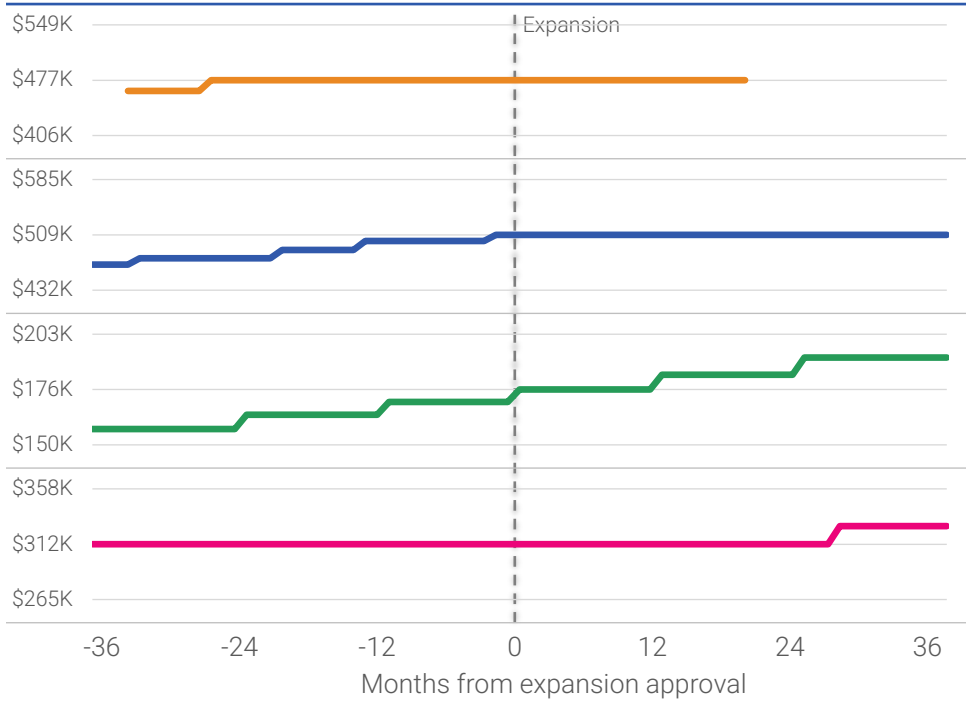
- Launch pricing to maximize drug value without restricting access
- Benchmarked to rare-disease analogs, led by SEPHIENCE as the latest launch
- Other branded DEE drugs are widely recognized as significantly underpriced, making them not the most relevant comparators

Strensiq: WAC $68,983.20/12 × 80 mg vials. Weight reference: Seefried et al. Bone. 2023; (doi:10.1016/j.bone.2023.116856). Sephience: WAC $15,735/30 × 1,000 mg packets and $3,933.75/30 × 250 mg packets. Weight reference: AMPLIPHY trial, Metabolism. 2026. Evrysdi: WAC $35,335.70/30 × 5 mg tablets. Skyclarys: WAC $34,019.51/90 × 50 mg capsules. Abbreviations: FA, Friedreich ataxia; HPP, hypophosphatasia; PKU, phenylketonuria; SMA, spinal muscular atrophy; WAC, wholesale acquisition cost

Precedents Show List Prices Held Steady Even as Labels Expanded to Populations up to 20x Larger than Launch

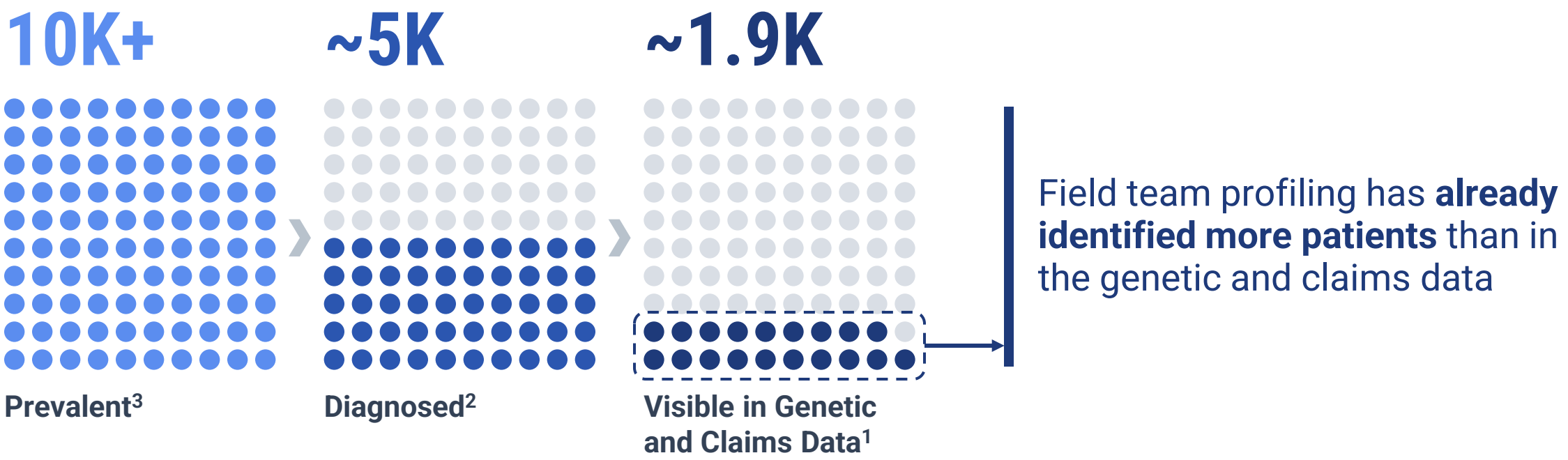
DRUG	INITIAL LABEL	EXPANDED LABEL	US PATIENTS
Amvuttra vutrisiran · Alnylam	Hereditary ATTR polyneuropathy (2022)	ATTR cardiomyopathy, incl. wild-type (Mar 2025)	**~10K → ~200K** prevalence
Soliris eculizumab · Alexion	PNH (2007)	AChR+ generalized myasthenia gravis (Oct 2017)	**5-8K → ~50K+** label-eligible prevalence
Brukinsa zanubrutinib · BeOne	Relapsed/refractory mantle cell lymphoma (2019)	CLL/SLL, including first line (Jan 2023)	**~25K → ~240K** new US cases/yr
Kalydeco → Trikafta Vertex	Kalydeco: CF gating and residual-function mutations (2012–17)	Trikafta: ≥1 F508del allele, age 12+ (Oct 2019)	**~3K → ~18K** eligible at launch

ANNUALIZED LIST PRICE PER PATIENT ($K)



Index = WAC (list price before rebates and discounts) per unit on the day before expansion approval = 100. Kalydeco → Trikafta indexed on cost per day of therapy at labeled adult dose, switching products at Trikafta approval (10/21/2019). Brukinsa's annual increase took effect 1/12/2023, one week before CLL approval. Populations approximate. Sources: Bloomberg (WAC, as of 10/21/2026); Alnylam, Alexion and Vertex estimates; published PNH and gMG prevalence; American Cancer Society.

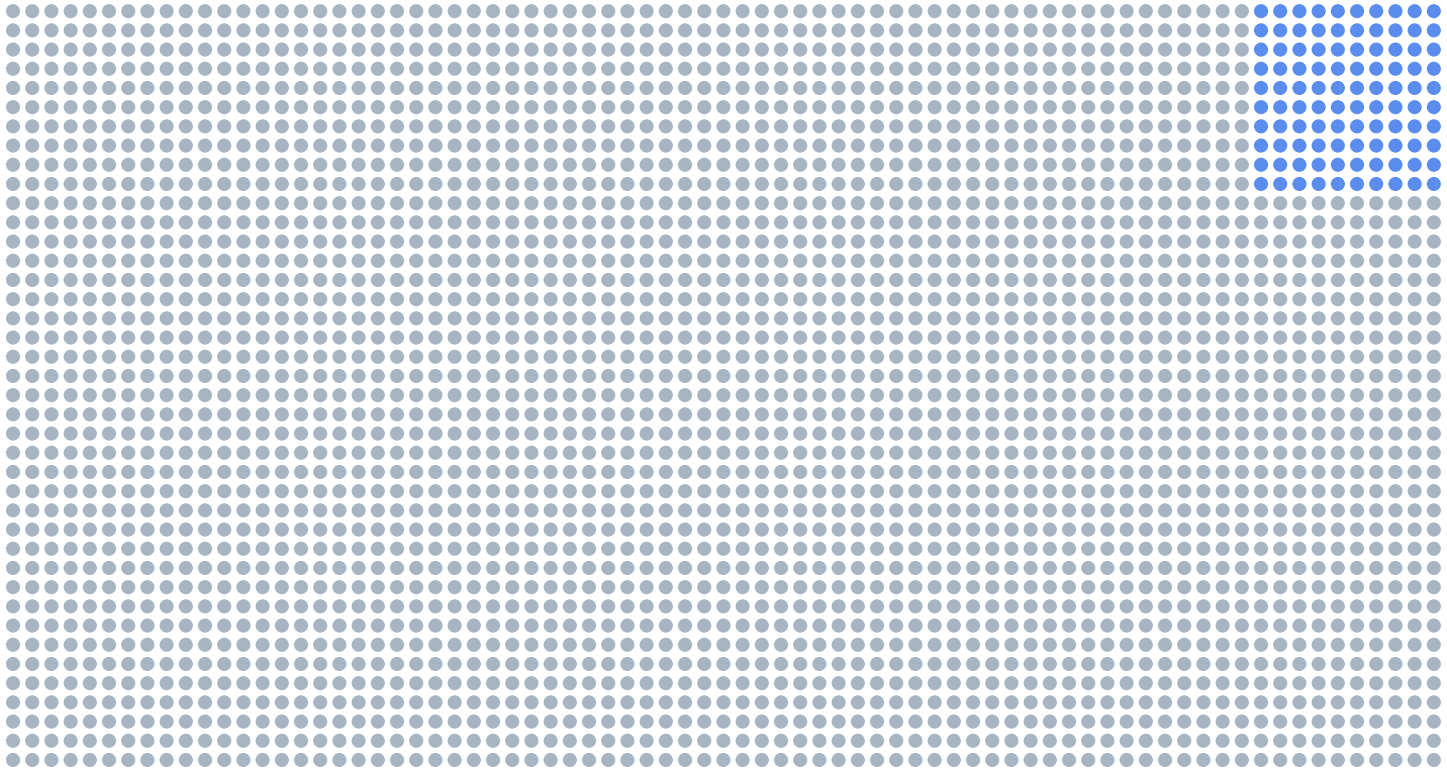
Most SCN2A/8A Patients Are Invisible in Data, Not to Our Field Team



Each dot ≈ 100 patients. 1. GeneDx and Invitae genetic testing data tokenized to Komodo claims plus 2025 GeneDx results. 2. Sederman R, et al. AES 2022 Poster 1.409: 3. Diagnosis rate from Musante L, et al. Genes 2022.

Beyond SCN2A/8A, more Than 300K DEE Patients Still Lack Effective Treatment

>300K broad DEE ‹‹‹‹ **30×** ‹‹‹‹ **~10K** SCN2A/8A



BROAD DEE POPULATION

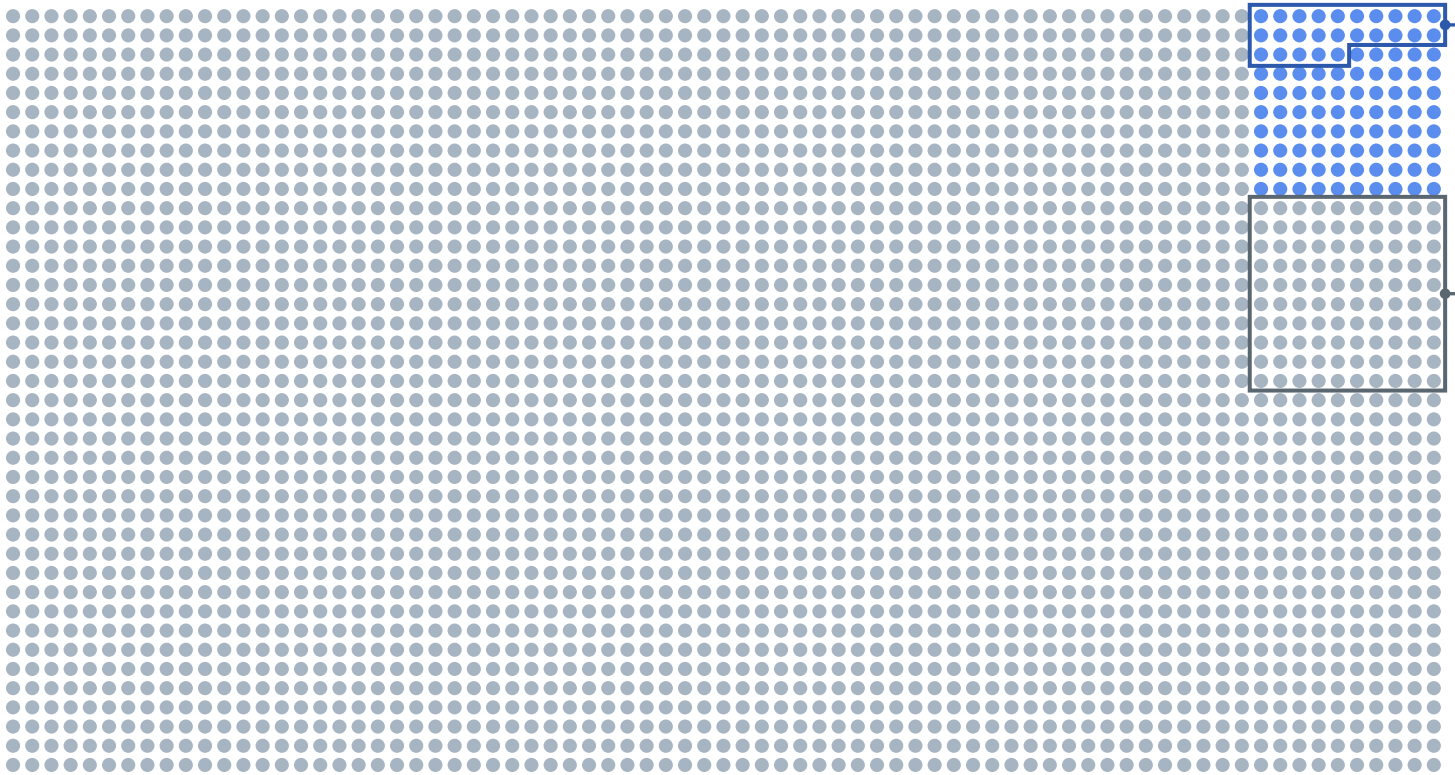
High Unmet Need Remains

Majority of DEE patients lack treatment options that are:

- **Effective**
- **Durable**
- **Targeted**

Each dot ≈ 100 patients, drawn to scale; SCN2A/8A ~10K (Musante L, et al. Genes 2022). Poke G, et al. Neurology 2023;100:e1363–e1375, Sederman R, et al. AES 2022 poster 1.409. DEE, developmental and epileptic encephalopathy.

SCN2A/SCN8A Alone Supports a $1B Peak, While Minimal Penetration into the Broad DEE Market Could Add Multi-Blockbuster Potential



ILLUSTRATIVE PEAK SALES:

2,500 SCN2A/8A patients

$1B

25% penetration
of ~10K prevalent patients

10,000 broad DEE patients

$4B

3.3% penetration
of >300K broad DEE

$5B

combined peak revenue
12.5K patients, ~4% of >300K

Each dot ≈ 100 patients. Illustrative; assumes $400K net annual price.

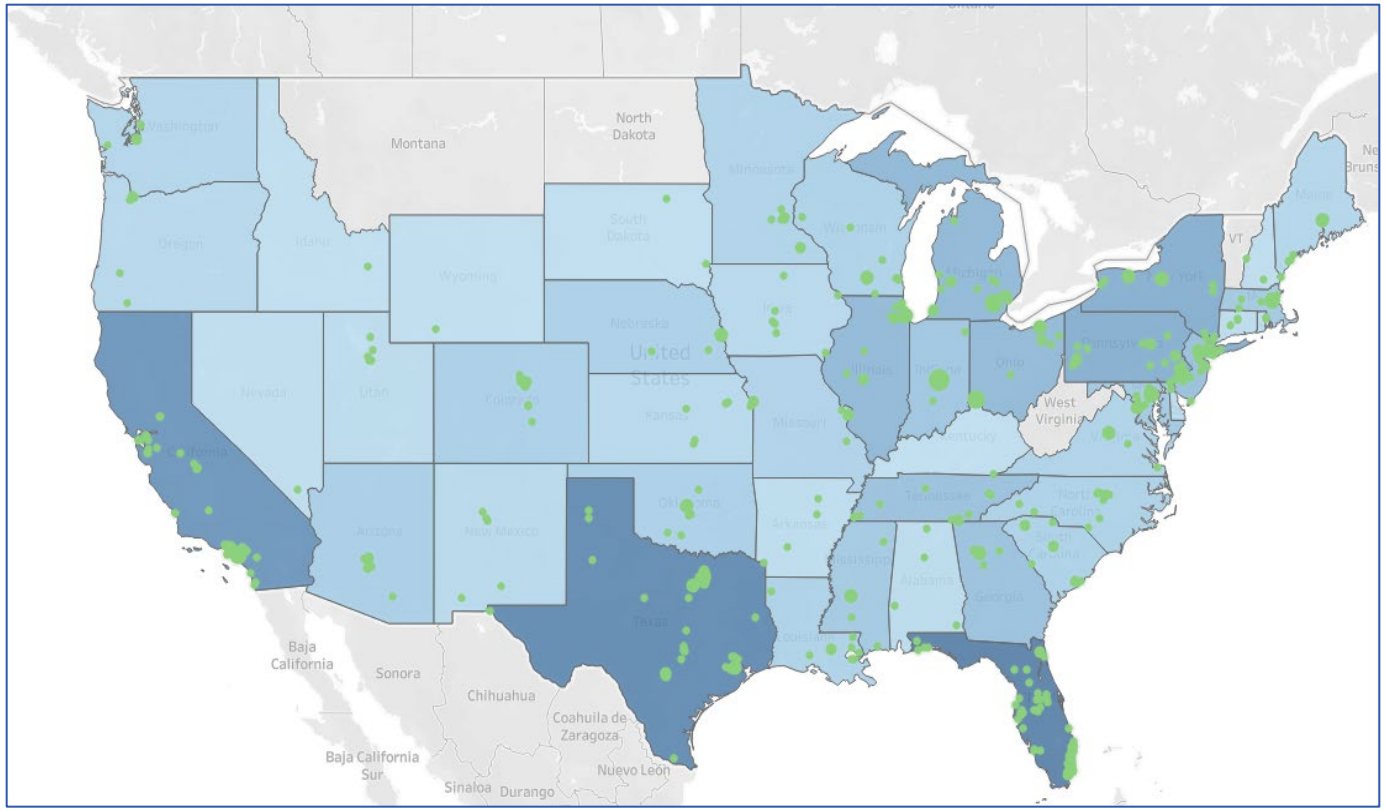
RELUTRIGINE

Field Readiness for First SCN2A & SCN8A Targeted Therapy

John Bullock

Deep Where Patients Concentrate, Broad Enough to Reach Everyone
100% Coverage From Day 1

HCOs treating known & diagnosed SCN2A/8A patients
Dots = HCOs with treating HCPs; shading = known patients by state



HCO

Known SCN2A/8A patients: low — high

Top 200 Accounts

~65%

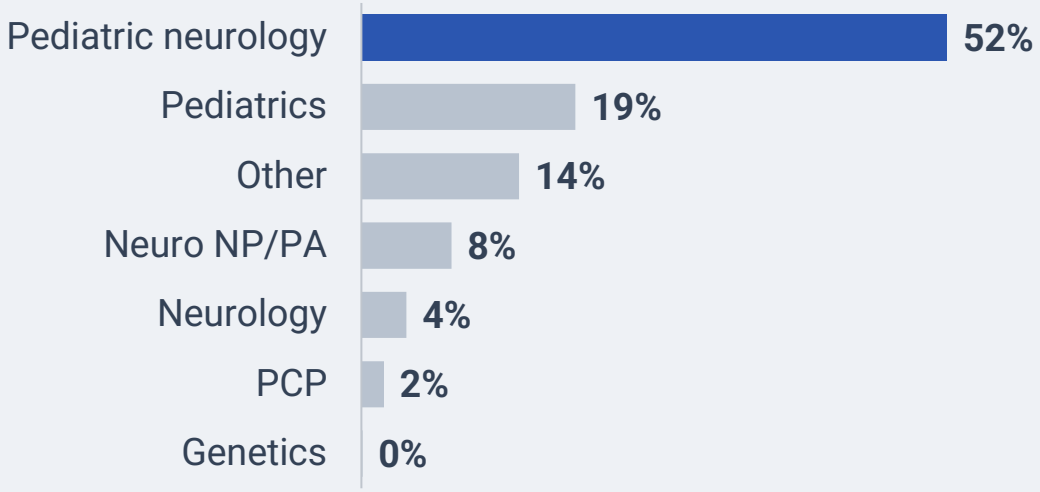
of known & diagnosed patients

Abbreviations: HCO, healthcare organization; HCP, healthcare provider, Data based on Claims Data

Prescribing Patterns Allow Us to Extend the Reach to HCPs Who Will Help Us Find Patients

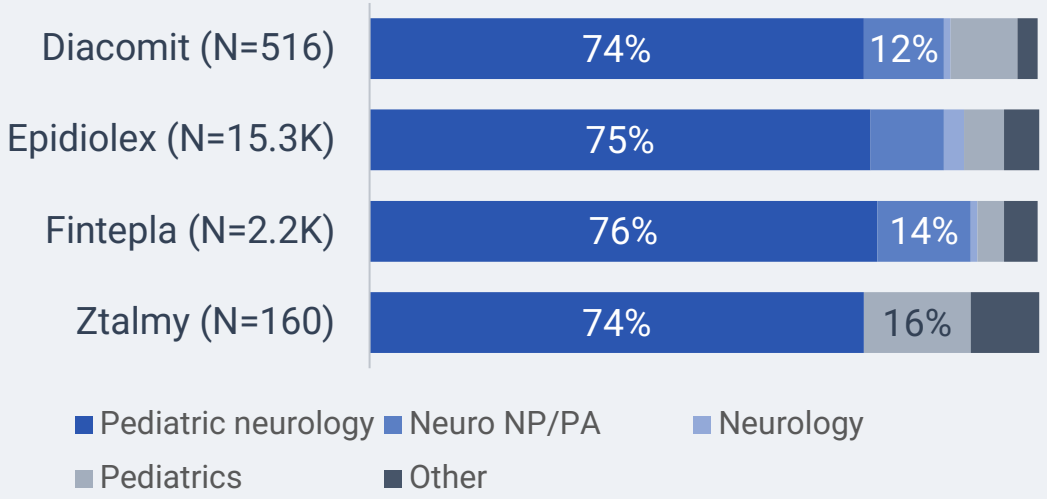
52%

of **first ASM prescriptions** come from pediatric neurologists



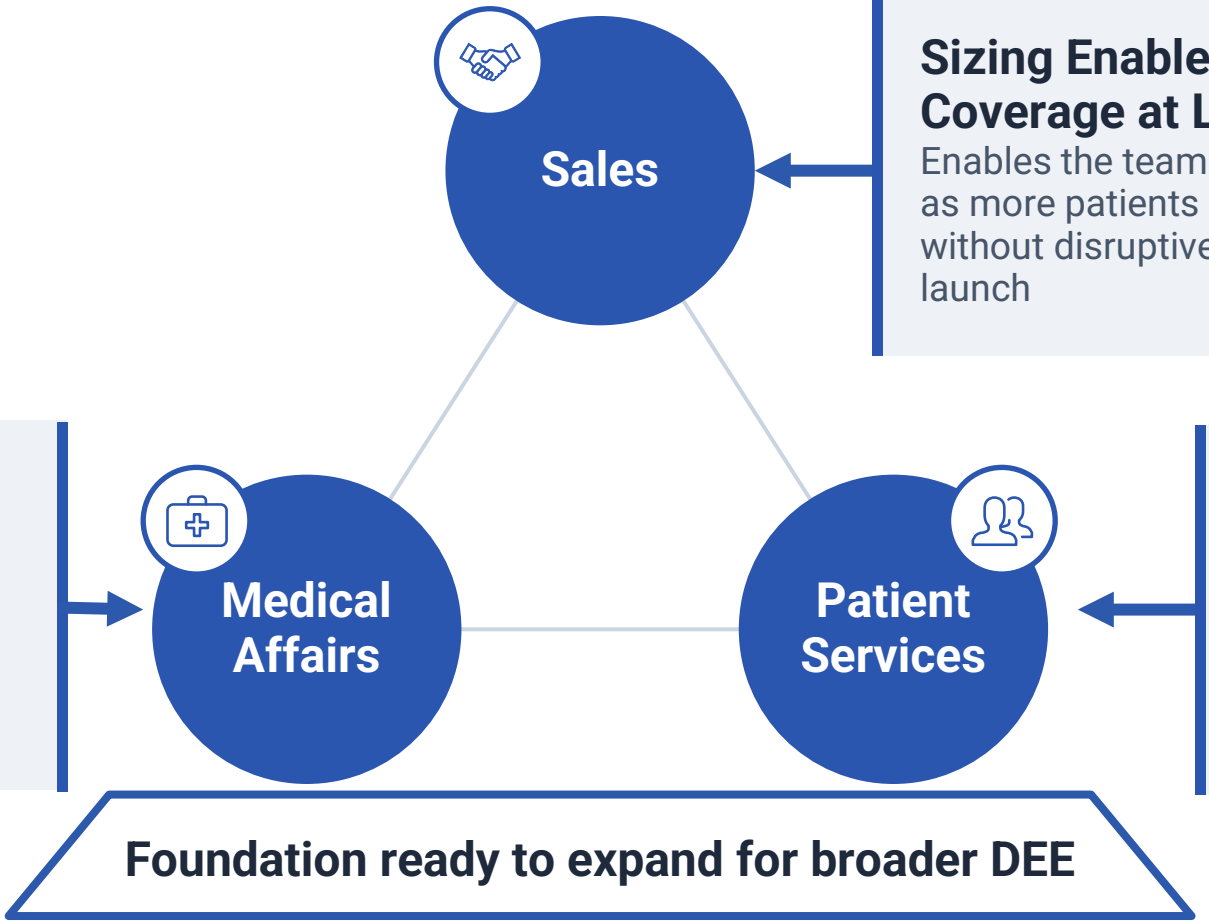
~75%

of **claims for branded ASMs** are from pediatric neurologists



Source: Internal Claims Data.

Dedicated Field Team in Place Ready to Activate and Engage Critical Stakeholders



Sizing Enables Full Coverage at Launch
Enables the team to shift coverage as more patients are identified, without disruptive changes after launch

KOL & Scientific Exchange
Profile of relutrigine as a precision sodium channel modulator, clinical results and safety profile

Supporting Caregivers and Patient Access
Experienced team to work with families and caregivers transitioning onto relutrigine

Field Team Has Reached Every Priority Account Ahead of PDUFA

As of today, the rare epilepsy field team has profiled:

100%

of top 10 accounts per territory

100%

of Tier 1 and Tier 2 target HCPs

KEY INSIGHTS FROM ACCOUNT PROFILING



SCN2A/8A and overall DEE patients under care confirmed



EMR and prescription ordering dynamics



Genetic testing workflow



Office visit scheduling and key staff

Clear Unmet Need and Pre-Qualified Patients Point to Favorable Access for Relutrigine

ACCESS LANDSCAPE

PAYER MIX

~45% Medicaid
~50% Commercial

EXPECTED PA CRITERIA

- **Prescribed by a specialist**
- **Trial of prior ASMs**
- **Diagnosis confirmation**
- **Reauthorization criteria**

PAYER ACCESS STRATEGY

High unmet need

Positions relutrigine as the only targeted therapy against the limited efficacy of current ASMs, supporting favorable placement

Patients arrive pre-qualified for PA

Early onset of disease leads to diagnosis; specialist confirmation and a prior ASM trial will usually be satisfied by the time a prescription is written

Analogs support access

Recent ultra rare pediatric analogs suggest reimbursement with manageable PA criteria

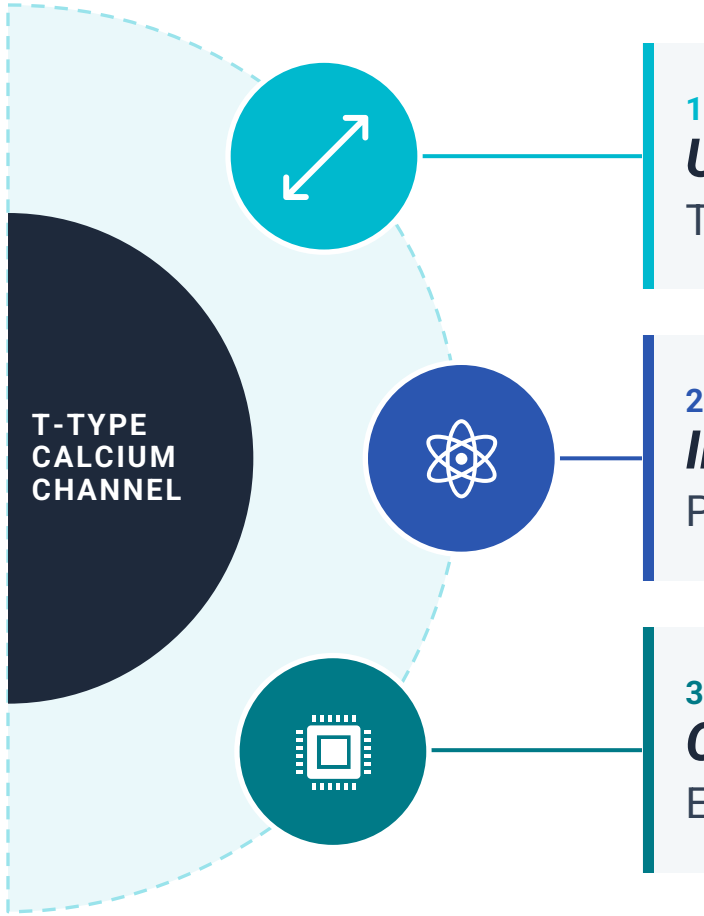


CEREBRUM™

SMALL MOLECULE PLATFORM

Cerebrum™ utilizes deep understanding of neuronal excitability and neuronal networks and applies a series of computational and experimental tools to develop orally available precision therapies

Praxis Is Building on the T-Type Calcium Channel MOA on 3 Fronts



1 · NEW INDICATIONS

Ulixacaltamide beyond ET

Trials starting in PD, RLS and ASD

2 · NEXT-GEN MOLECULES

Innovation in T-type Ca Inhibitors

Pan-Cav3.x and isoform-selective molecules

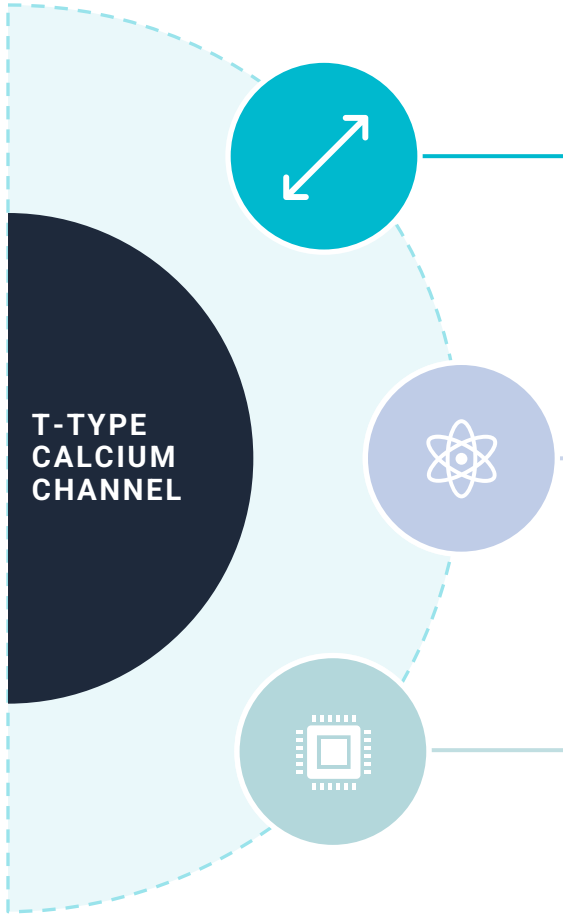
3 · BETTER DELIVERY

Once-weekly patch with Remagine Labs

Easier to take, customizable dosing, better adherence

Abbreviations: ASD, autism spectrum disorder; ET, essential tremor; PD, Parkinson's disease; RLS, restless legs syndrome.

Praxis Is Building on the T-Type Calcium Channel MoA on 3 Fronts



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Abbreviations: ASD, autism spectrum disorder; ET, essential tremor; PD, Parkinson's disease; RLS, restless legs syndrome.

Ulixacaltamide Line Extensions: One Target, Four Large Populations With Significant Unmet Needs

US prevalence, millions of people



1. Louis ED, Ottman R. How many people in the USA have essential tremor? Tremor Other Hyperkinet Mov (N Y). 2014;4:259. 2. Allen RP, Walters AS, Montplaisir J, et al. Restless legs syndrome prevalence and impact: REST general population study. Arch Intern Med. 2005;165(11):1286-1292. 3. Marras C, Beck JC, Bower JH, et al. Prevalence of Parkinson's disease across North America. NPJ Parkinsons Dis. 2018;4:21. 4. Zablotsky B, et al. Pediatrics. 2026. 5. Dietz PM, Rose CE, McArthur D, Maenner M. National and state estimates of adults with autism spectrum disorder. J Autism Dev Disord. 2020;50(12):4258-4266. 6. US Census Bureau. National population estimates by age, Vintage 2025.

ET adjusted for population growth and age mix.[1] RLS reflects the moderate-to-severe population (2–3% of US adults).[2] ASD combines pediatric[4] and adult[5] prevalence applied to US Census Bureau Vintage 2025 population counts.[6]

Ulixacaltamide's Potential to Fill Treatment Gaps in PD, RLS and ASD

INDICATION	CURRENT TREATMENT	UNMET NEED	ULIXACALTAMIDE COULD OFFER
PD Parkinson's disease	Levodopa and other dopaminergic drugs	• **Tremor** often resists dopaminergic therapy (≥38% with action tremor) • Rising doses drive motor **fluctuations** and **dyskinesia**	**Non-dopaminergic, tremor-specific option that could lower dopaminergic burden**
RLS Restless legs syndrome	Gabapentinoids first line; dopamine agonists; opioids for refractory cases	• Dopamine agonists cause **augmentation** in up to 70% of patients • Gabapentinoids and opioids bring **sedation**, **fall and misuse risk**	**Non-dopaminergic option with no mechanism for augmentation**
ASD Autism spectrum disorder	Risperidone and aripiprazole, approved for irritability only	• Antipsychotics cause **weight gain** and **movement side effects** • No approved treatment for **core symptoms** or other phenotypes	**Treatment aimed at core symptoms, beyond irritability**

Source: Pasquini et al, 2023; Silber et al, 2026; Praxis data on file

T-Type Channels Set the Thalamus's Firing Mode; When Gating Fails, Abnormal Bursts Reach the Cortex

THALAMUS

Relays converging inputs to the cortex

RELAY MODE Steady, faithful spikes



BURST MODE Clustered bursts



T-type channels set which mode the thalamus is in

WHEN INHIBITORY GATING FAILS

The thalamus loses control of the gain, timing and synchrony of signals sent to the cortex

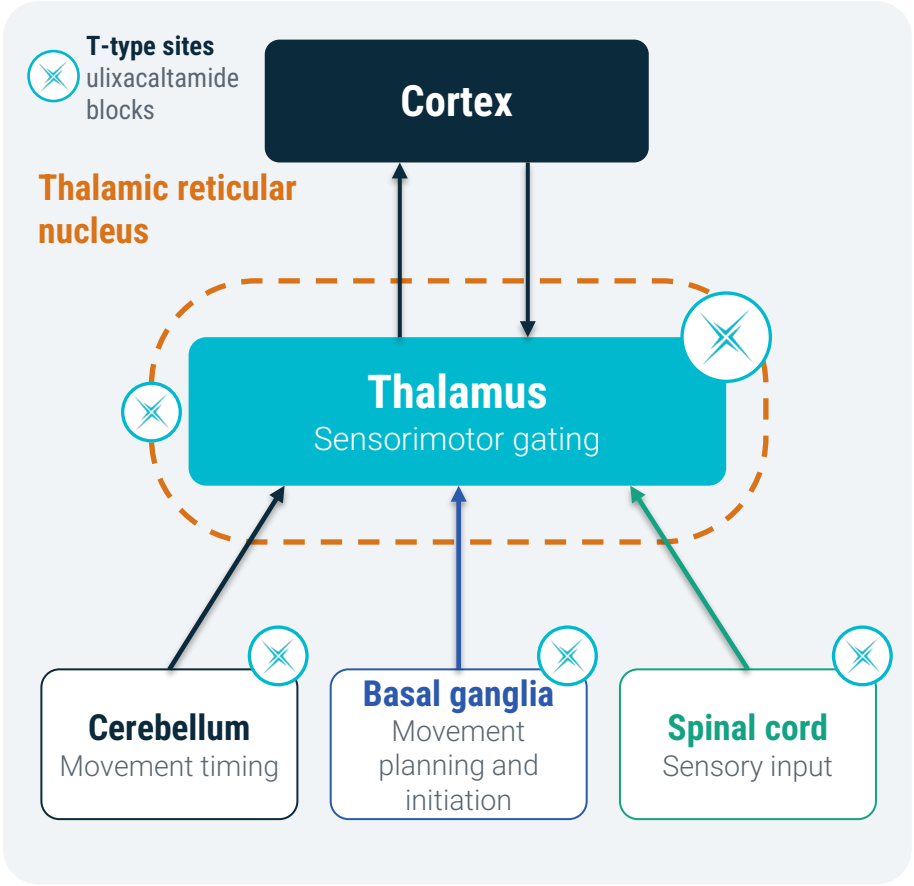
Hyperexcitability
Neurons fire too easily

Aberrant bursting
Bursts fire when they should not

Hyperconnectivity
Circuits over-synchronize

TTCC, T-type calcium channel. Spike trains are schematic, not recorded data. Matthews et al, 2023

Ulixacaltamide Blocks T-Type Channels at the Thalamus and at Each of Its Inputs



WHAT ULIXACALTAMIDE DOES

1. **Blocks T-type channels**
   All three subtypes (Cav3.1, 3.2, 3.3), dense in the thalamus, its TRN, the cerebellum and basal ganglia
2. **Dampens excess bursting**
   Resolves the abnormal rhythm
3. **Leaves relay firing intact**
   Normal signals still get through

WITHOUT TREATMENT



Aberrant bursts

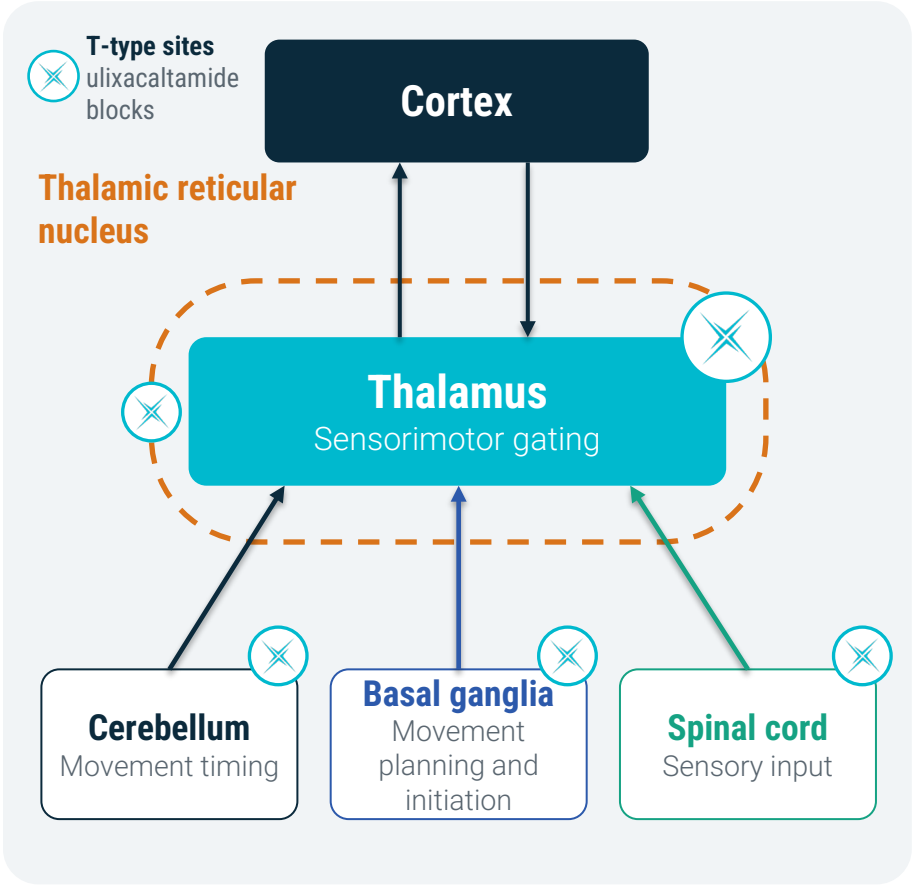
WITH ULIXACALTAMIDE



Steady relay firing

Cav3, T-type calcium channel family; TRN, thalamic reticular nucleus. Spike trains are schematic, not recorded data.

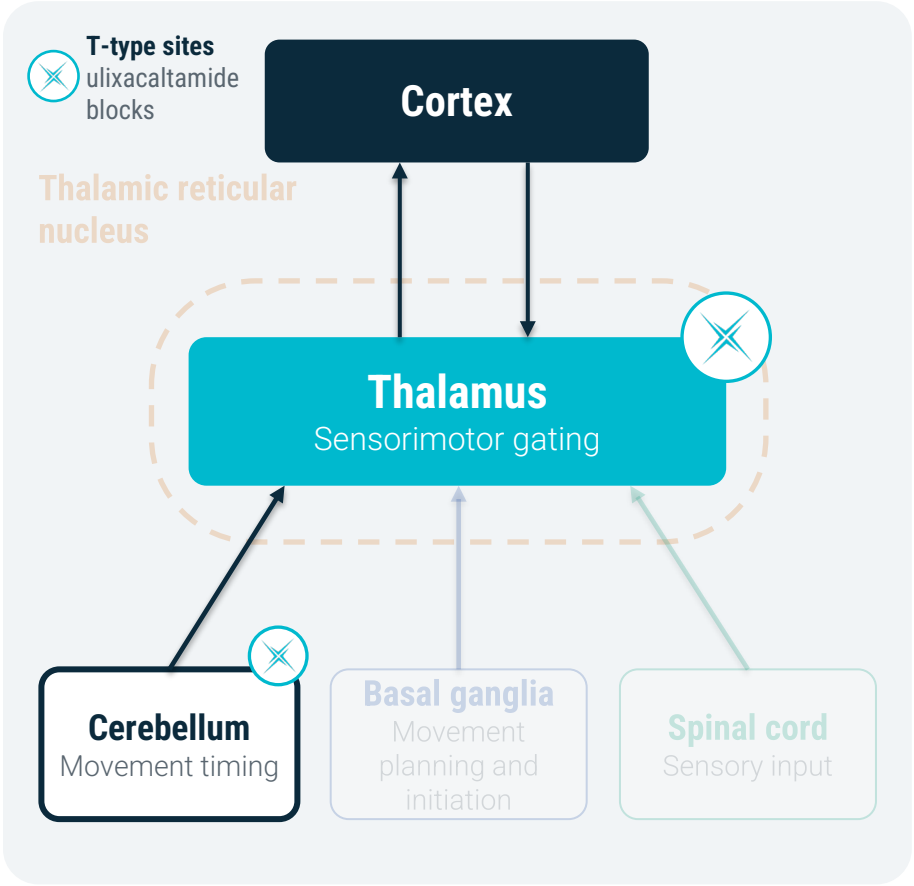
Four Diseases, Four Circuits, One Common Target



	DISEASE DRIVER	IMPLICATED CIRCUIT	DISEASE PRESENTATION
ET	Rhythmic cerebellar bursts	**CTC** Tremor oscillations in the thalamic Vim and cortical projections	→ Tremor
PD	Dopaminergic denervation	**CTC + BGTC** Vim tremor oscillations	→ Tremor
		BGTC STN bursting	→ Bradykinesia and rigidity
RLS	Iron deficiency; dopaminergic dysregulation	**Spinal cord, BGTC** Hyperactive sensory cortical activity	→ Sensory symptoms, urge to move, PLMS
ASD	TTCC gene variants	**TRN, sensory cortex** TRN hyperactivity; hyperactive sensory cortex	→ Sensory over-responsiveness; restricted, repetitive behaviors

BGTC, basal ganglia–thalamocortical; CTC, cerebello-thalamo-cortical; DBS, deep brain stimulation; PLMS, periodic limb movements in sleep; STN, subthalamic nucleus; TRN, thalamic reticular nucleus; TTCC, T-type calcium channel; Vim, ventral intermediate nucleus. Source: Matthews et al, 2023; Helmich, 2018; Ferré et al, 2019; Tai, 2022; Murata et al, 2007; Jang, Takahashi & Huguenard, Sci Adv 2025

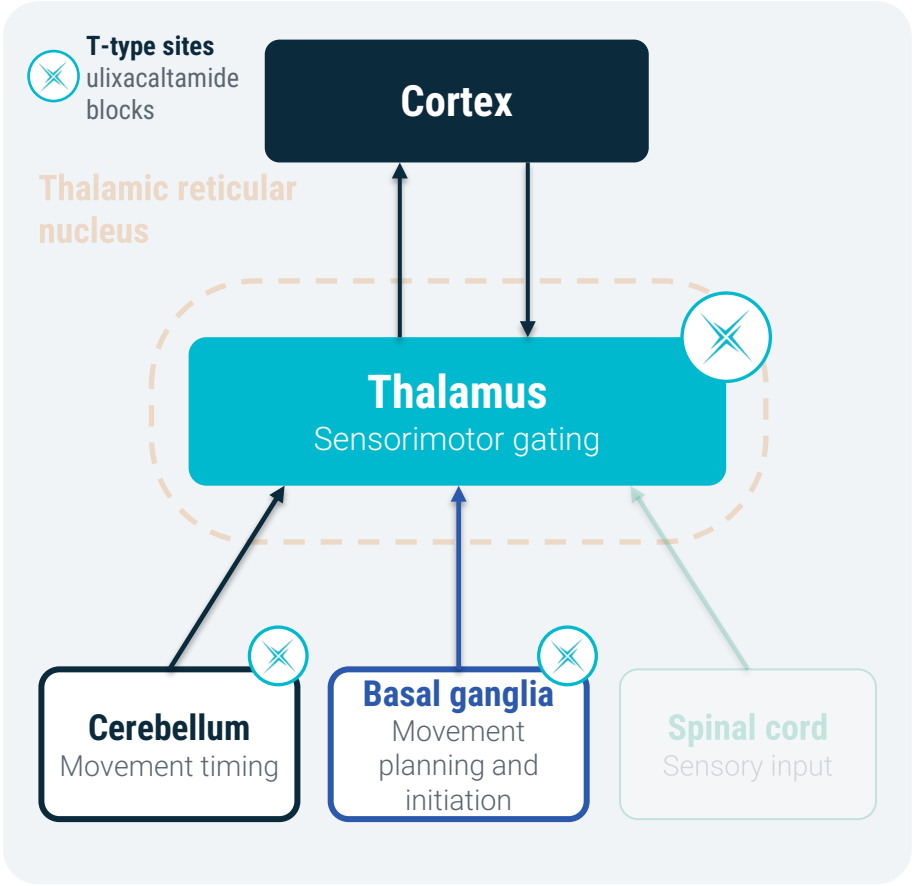
Four Diseases, Four Circuits, One Common Target



	DISEASE DRIVER	IMPLICATED CIRCUIT	DISEASE PRESENTATION
ET	**Rhythmic cerebellar bursts**	**CTC** Tremor oscillations in the thalamic Vim and cortical projections	→ Tremor
PD	**Dopaminergic denervation**	**CTC + BGTC** Vim tremor oscillations	→ Tremor
		BGTC STN bursting	→ Bradykinesia and rigidity
RLS	**Iron deficiency; dopaminergic dysregulation**	**Spinal cord, BGTC** Hyperactive sensory cortical activity	→ Sensory symptoms, urge to move, PLMS
ASD	**TTCC gene variants**	**TRN, sensory cortex** TRN hyperactivity; hyperactive sensory cortex	→ Sensory over-responsiveness; restricted, repetitive behaviors

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Both PD Motor Circuits Pass Through Ulixacaltamide Targets



Parkinson's disease

Tremor
Vim thalamus

- Dopamine loss in the BGTC **drives tremor**; the CTC sets its severity
- PD tremor **shares ET's Vim DBS response**;
- **Ulixacaltamide is effective** in a rat tacrine-induced tremor model

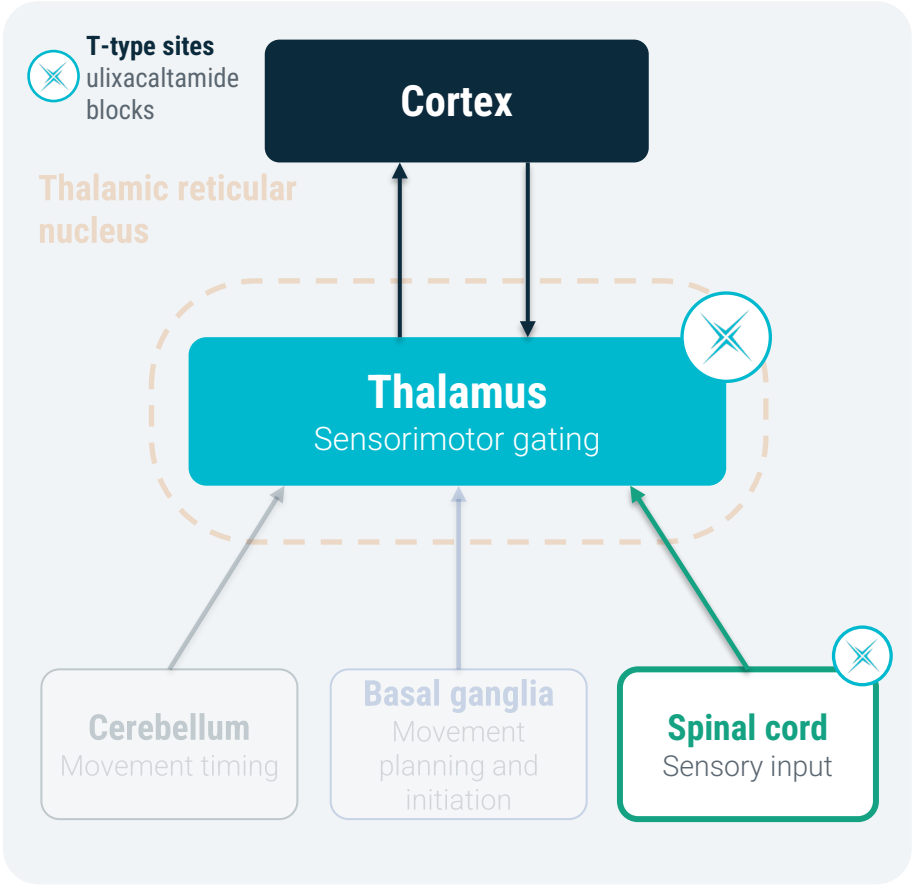
Bradykinesia and rigidity
STN and GPi bursting

- STN bursting **tracks bradykinesia and rigidity** and is **driven by T-type channels**
- Zonisamide, a partial T-type blocker, **suppressed STN bursting** in animals and **improved PD motor symptoms** in placebo-controlled trials

Potential non-surgical, non-dopaminergic treatment for PD tremor and other motor symptoms

BGTC, basal ganglia–thalamocortical; CTC, cerebello-thalamo-cortical; DBS, deep brain stimulation; ET, essential tremor; GPi, globus pallidus internus; STN, subthalamic nucleus; Vim, ventral intermediate nucleus of the thalamus. Source: Helmich, 2018; Du et al, 2018; Miwa et al, 2011; Beurrier et al, 1999; Tai, 2022; Yang et al, 2014; Murata et al, 2007

RLS Stems From Thalamic and Spinal Overexcitation



Restless legs syndrome

WHERE THE OVEREXCITATION SITS

Thalamocortical
Worse in the evening and at rest

- Low iron weakens adenosine control, so **glutamate signaling rises**
- fMRI: sensory thalamic connectivity **rises with severity**

Spinal sensorimotor
Weaker descending (A11) dopamine control

80–90%
of patients also have PLMS

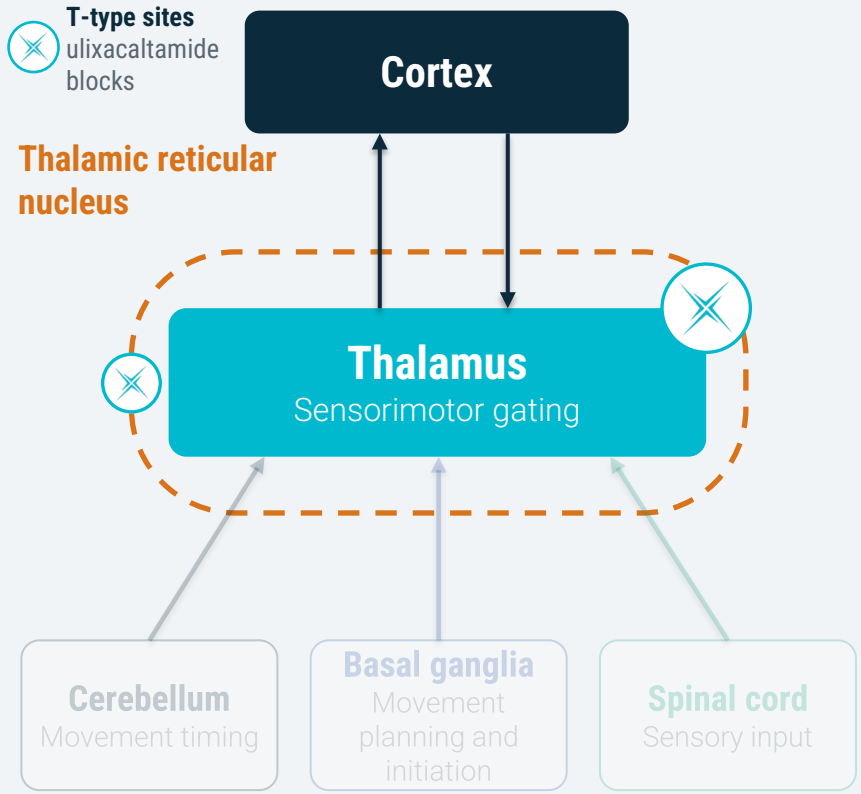
DBS CLUES: STIMULATION THAT CALMS THESE CIRCUITS EASES RLS

STN PD + RLS	Mixed, mostly favorable; new-onset RLS reported	Cohorts
Vim ET + RLS	Lower RLS severity with stimulation on	Study
GPi Refractory RLS	Sustained relief	Case report

Hypothesis: like DBS, T-type blockade with ulixacaltamide could dampen thalamocortical hyperexcitability and RLS severity

DBS, deep brain stimulation; ET, essential tremor; GPi, globus pallidus internus; PLMS, periodic limb movements in sleep; STN, subthalamic nucleus; Vim, ventral intermediate nucleus. Source: Ferré et al, 2019; Clemens et al, 2006; Gorges et al, 2016; Winkelman & Wipper, 2026; Klepitskaya, 2018; Dulski, 2022; Kedia, 2004; Evidente, 2022; Casoni, 2020

Ulixacaltamide Reversed ASD-Like Behaviors in Three Mouse Models



Autism spectrum disorder

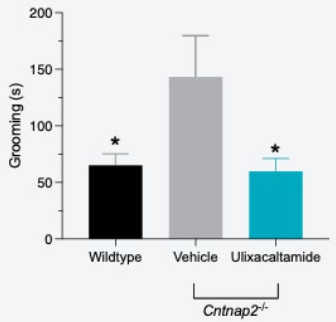
WHY T-TYPE CHANNELS

Genetics
CACNA1G/H/I variants (Cav3.1–3.3) linked to ASD risk

***Cntnap2* mice**
Higher T-type currents; ulixacaltamide calmed the overactive TRN

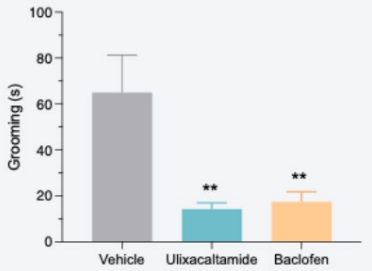
ULIXACALTAMIDE IN ASD MOUSE MODELS

Repetitive grooming
Cntnap2$^{-/-}$ · 30 mg/kg p.o.



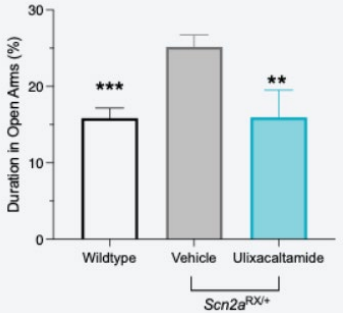
Grooming fell to wildtype level

Repetitive grooming
BTBR · 10 mg/kg p.o.



As effective as baclofen

Risk-taking
Scn2a$^{RX/+}$ · 30 mg/kg p.o.

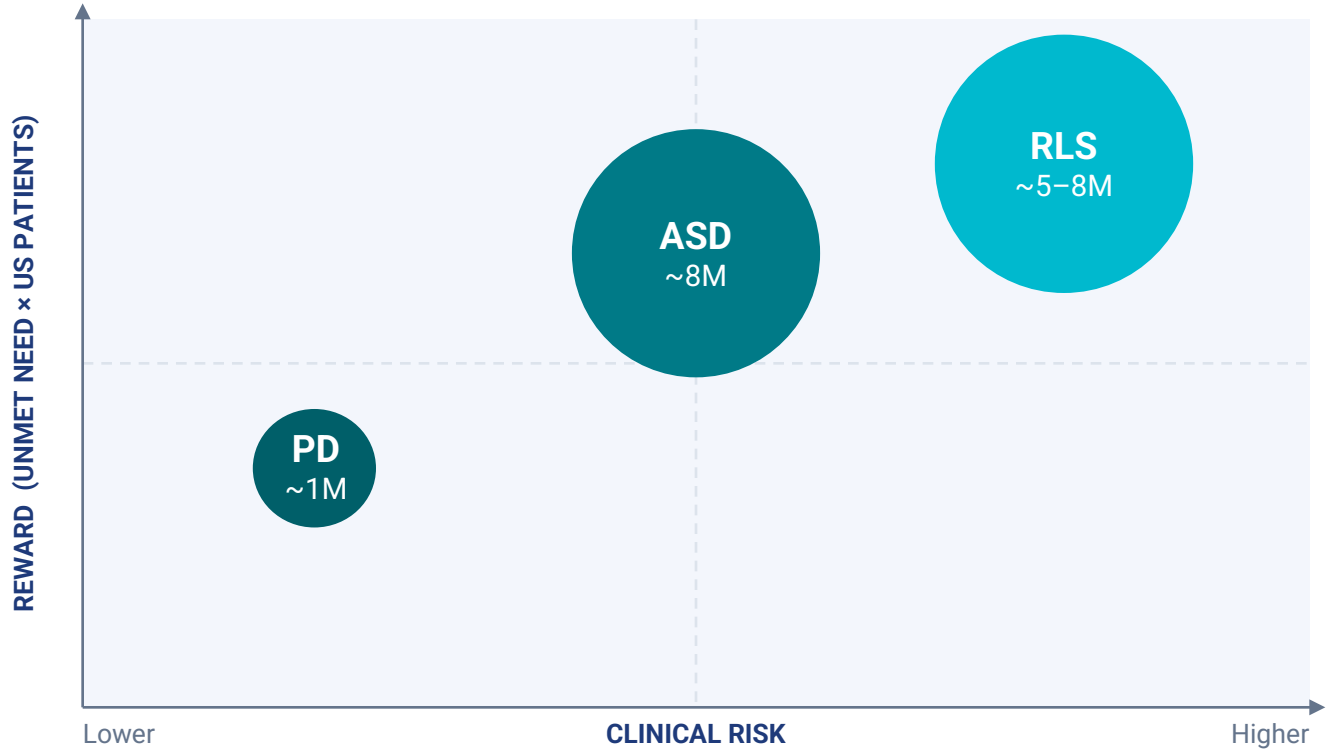


Back to wildtype level

BTBR, inbred mouse strain with ASD-like behaviors; Cntnap2, contactin-associated protein-like 2 knockout; Scn2a, sodium channel gene variant model; TRN, thalamic reticular nucleus. Grooming: 10–12 mice per group; open-arm time (elevated plus maze): 12 per group; asterisks mark significance vs vehicle, one-way ANOVA. BTBR positive control: baclofen 3 mg/kg i.p. Source: Praxis data on file

PD Is the Lowest-Risk Line Extension; RLS and ASD Offer Larger Markets at Higher Risk

Clinical risk vs. reward, ulixacaltamide line extensions



PD · LOWER CLINICAL RISK

Biology Tremor circuits shared with ET

Execution ET tremor endpoints de-risk execution

ASD · MEDIUM CLINICAL RISK

Biology Thalamic link; 3 positive animal models

Execution Untested endpoints, longer clinical program

RLS · HIGHER CLINICAL RISK

Biology Sensory driven; no reliable preclinical model

Execution High placebo response typical of RLS trials

Positioning is qualitative, based on internal assessment. Bubble area proportional to estimated US prevalence (RLS: moderate-to-severe).. Sources: Marras et al, 2018; Allen et al, 2005; Dietz et al, 2020; Pasquini et al, 2023; Silber et al, 2026; Praxis data on file

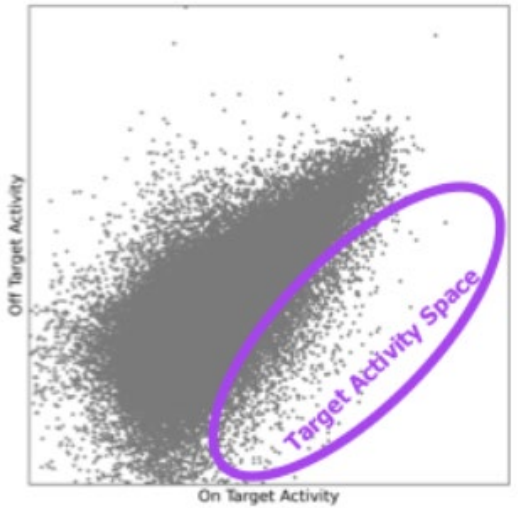
Praxis Is Building on the T-Type Calcium Channel MOA on 3 Fronts



Abbreviations: ASD, autism spectrum disorder; ET, essential tremor; PD, Parkinson's disease; RLS, restless legs syndrome.

Next-Gen T-Type Calcium Channel Inhibitors

1 · DISCOVER

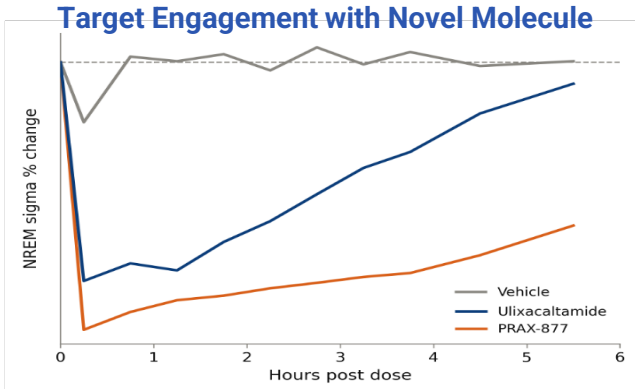


High-throughput screens for novel leads

2 · DESIGN

Pan-Cav3.x
Block all three T-type isoforms

Isoform-selective
Target Cav3 isoforms



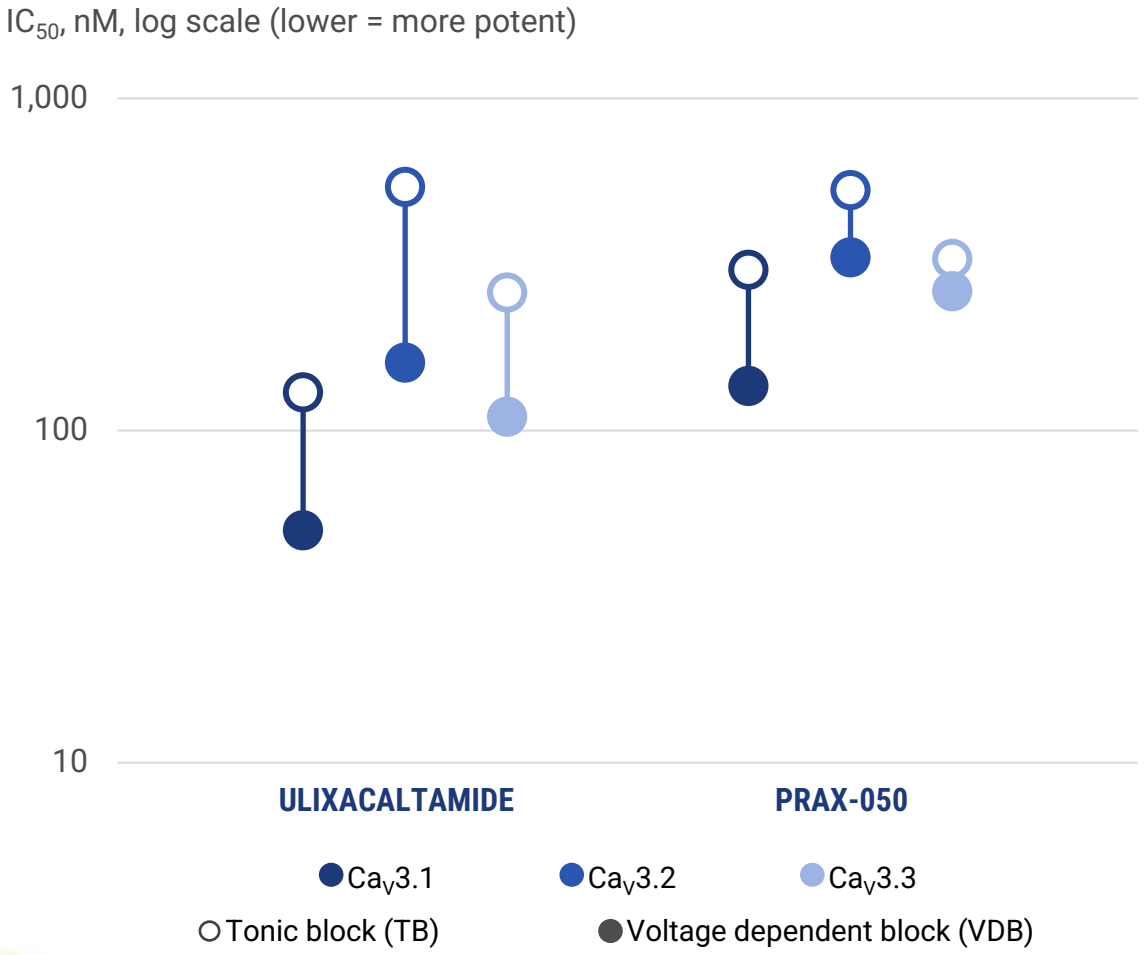
3 · DIFFERENTIATE

- CaV3.x PROFILE
- TOLERABILITY
- TITRATION

2 molecules entering first-in-human studies in 1H27

Cav3.x, T-type voltage-gated calcium channel isoforms (Cav3.1, Cav3.2, Cav3.3)

Next-Gen Molecules Show a Distinct CaV3.x Profile From Ulixacaltamide



ULIXACALTAMIDE

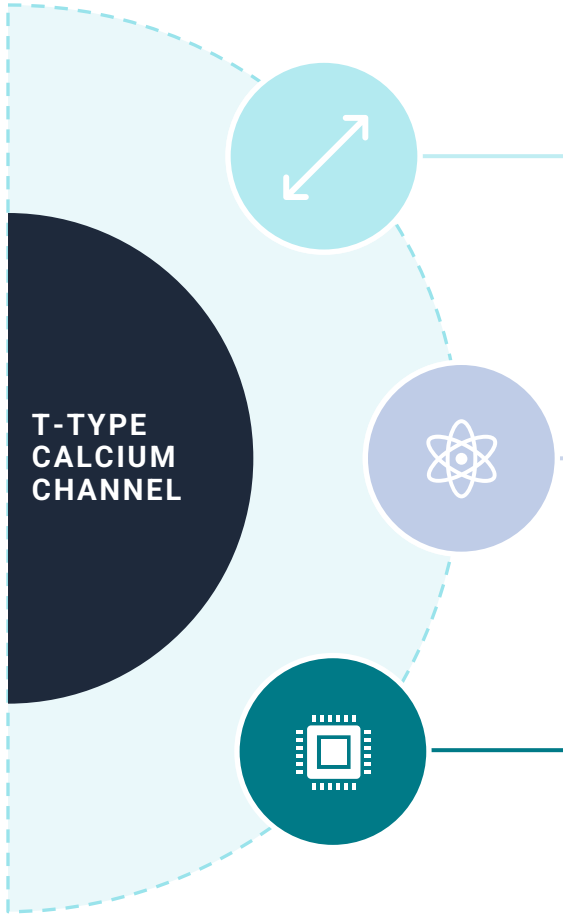
Most potent at CaV3.1, with a wide gap between tonic and voltage-dependent block

PRAX-050

Flatter across CaV3.1–3.3, with a narrower gap between tonic and voltage-dependent block

A distinct CaV3.x profile could produce a differentiated clinical profile

Praxis Is Building on the T-Type Calcium Channel MOA on 3 Fronts



1 · NEW INDICATIONS

Ulixacaltamide beyond ET

Trials starting in PD, RLS and ASD

2 · NEXT-GEN MOLECULES

Innovation in T-type Ca Inhibitors

Pan-Cav3.x and isoform-selective molecules

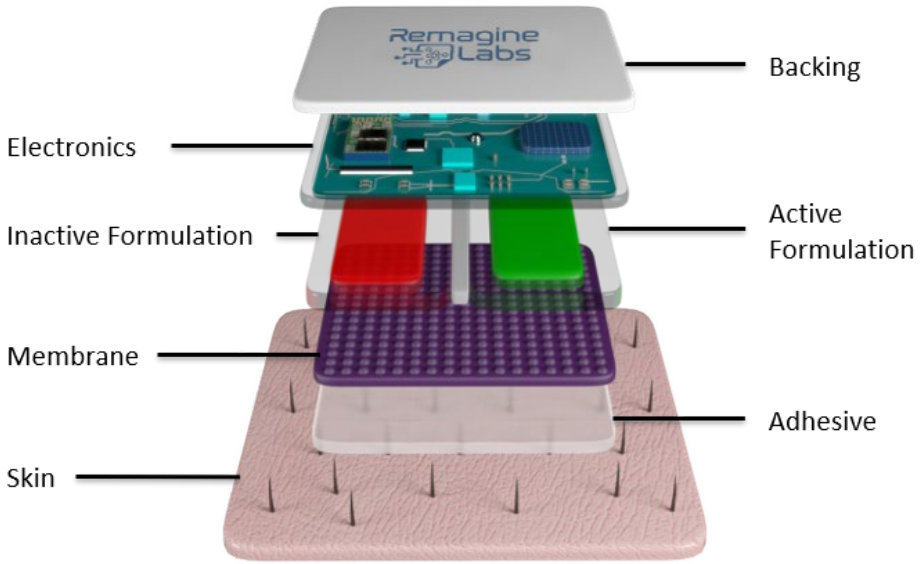
3 · BETTER DELIVERY

Once-weekly patch with Remagine Labs

Easier to take, customizable dosing, better adherence

Abbreviations: ASD, autism spectrum disorder; ET, essential tremor; PD, Parkinson's disease; RLS, restless legs syndrome.

Novel Delivery Technology Could Improve Patient Access, Dosing and Adherence: Active, Transdermal Patch



Electronic Transdermal Drug Delivery System (eTDDS). A low current controls drug delivery into the bloodstream with one patch holding about a week of drug. Drug delivery can be controlled through wireless interface.

ACCESSIBILITY

No pill bottles to open; built for a segment of the population

TITRATION

Fully customizable dosing, adjustable remotely from the physician's office

ADHERENCE

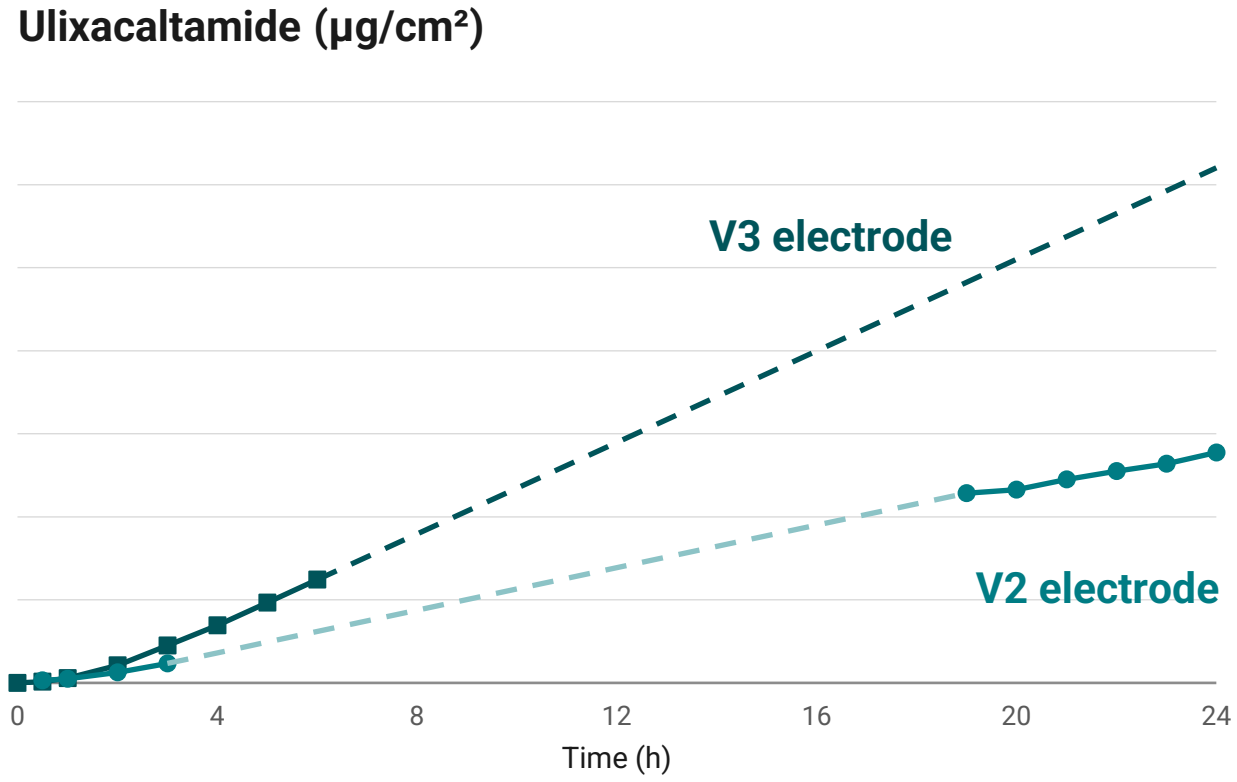
Consistent exposure with nothing to remember each day

Entering the clinic in 2027

Collaboration with Remagine Labs. Regulatory path and timing subject to FDA engagement. Abbreviations: ET, essential tremor; PK, pharmacokinetic.

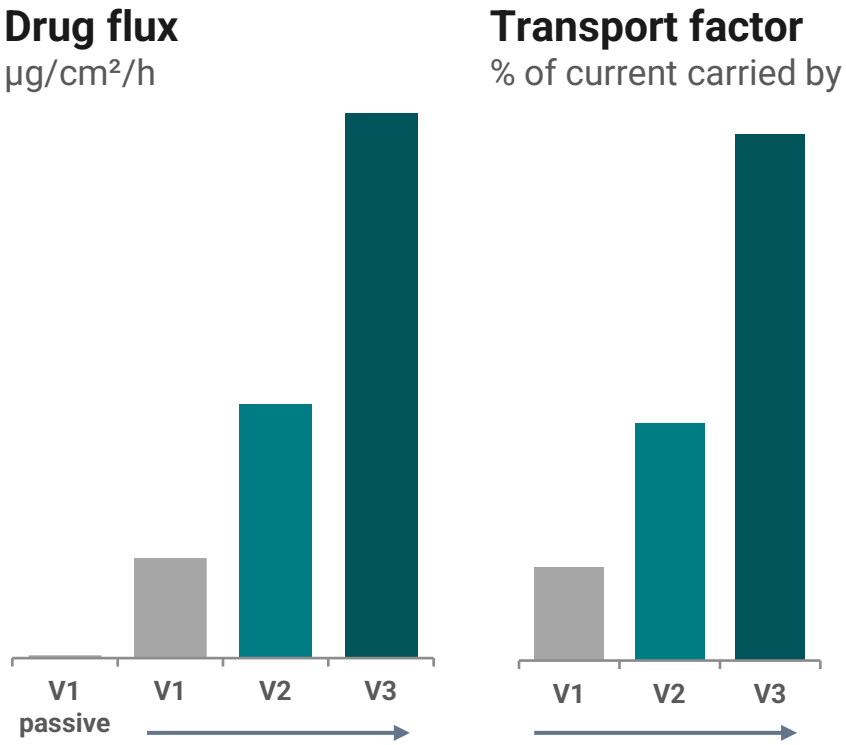
Ulixa eTDDS Flux Data Support Therapeutic Ulixacaltamide Exposure

CUMULATIVE DRUG PERMEATION



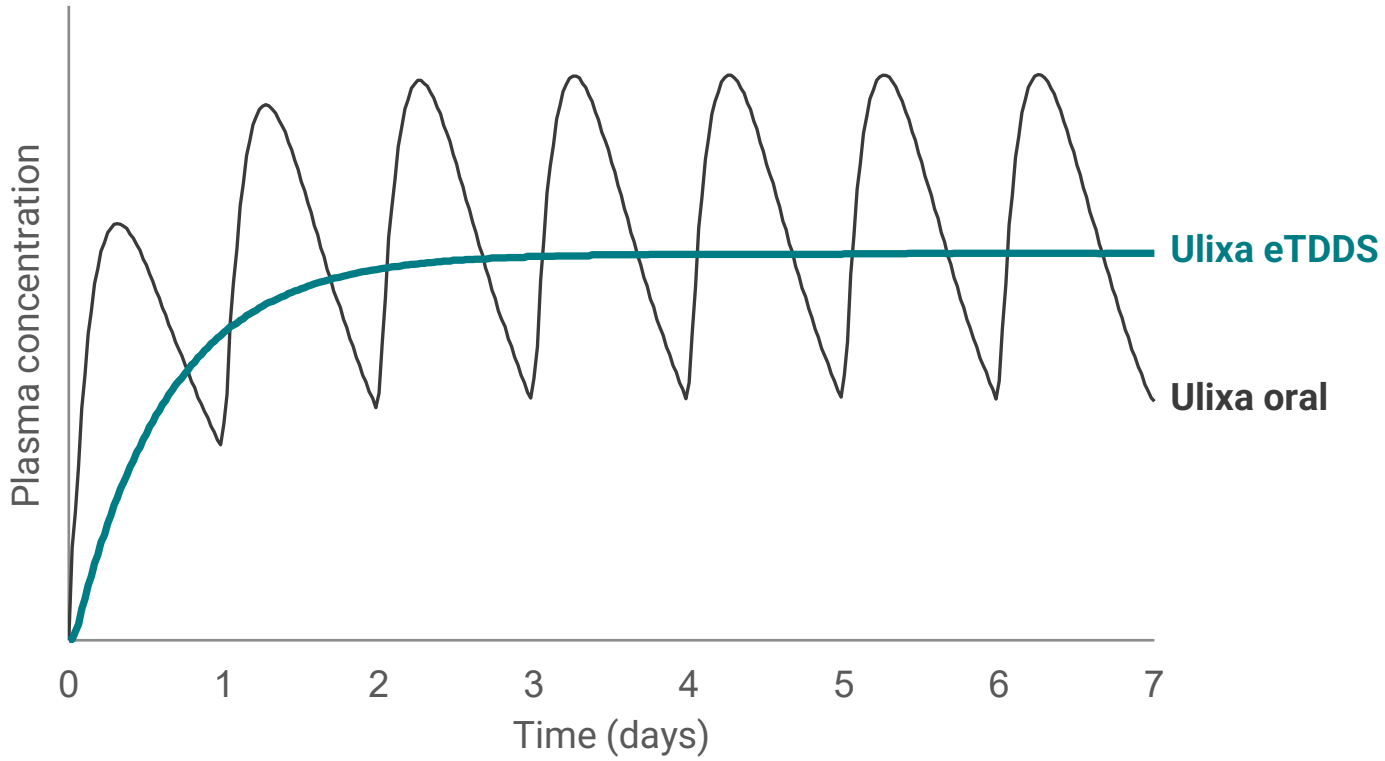
Current: mean, n=3, measured 0 to 6 h; dashed line projects to 24 h at the measured flux. V2 dotted line spans the 3 to 19 h sampling gap.

ELECTRODE GENERATION PERFORMANCE



Technology progression

Simulated Patch Exposure Sits Within Oral Dosing Concentration

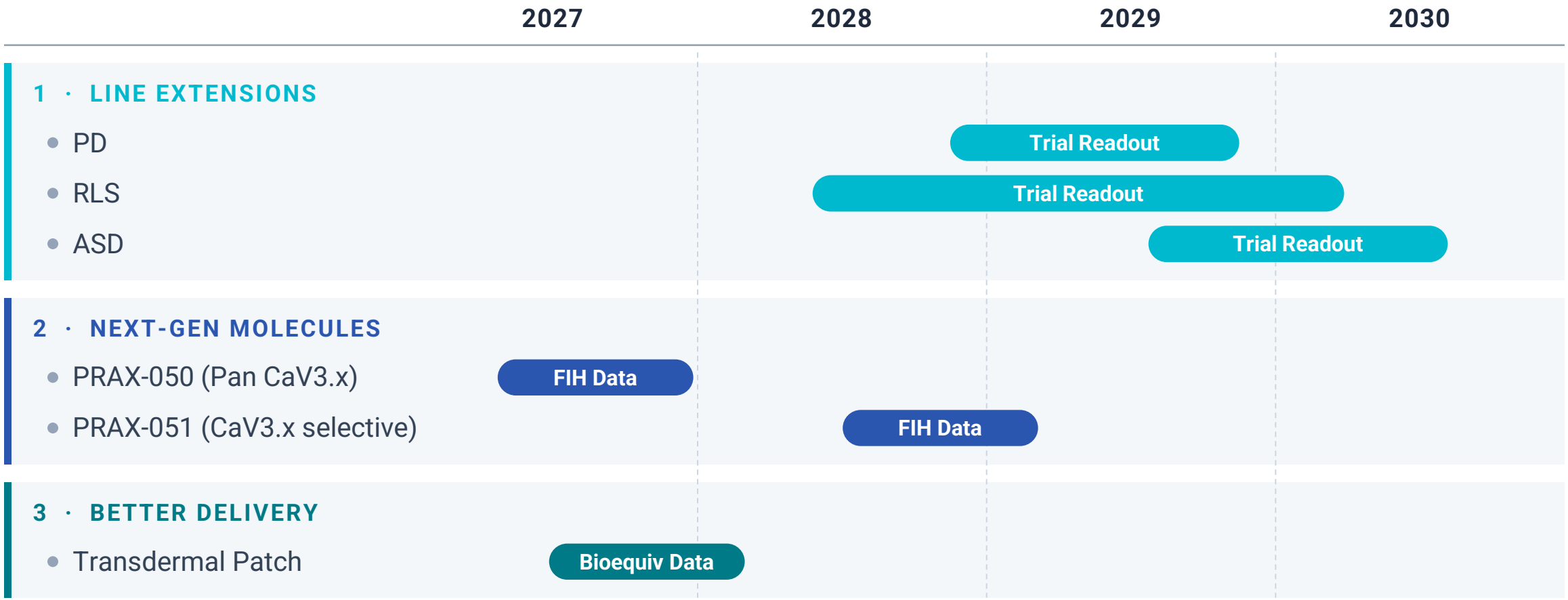


PEAK-TO-TROUGH RATIO

2.4×	1.0×
Oral once daily	Ulixa eTDDS patch

Model: oral PK parameters; patch input from in vitro porcine flux

Building the Leading T-Type Ca Channel Franchise: Timeline to Next Key Clinical Milestones



Timelines estimated based on historical studies in the respective indications



CEREBRUM™

Epilepsy Pipeline

KCNT1 Epilepsy Is Severe and Has No Approved Therapy

INFANT ONSET

KCNT1-DEE

EIMFS, EOEE, West Syndrome

1.4 mo	mean age at seizure onset
96%	have daily seizures at onset
47%	mortality median 3 years (1.5-15.4)

CHILDHOOD ONSET

SHE

Sleep-related hypermotor epilepsy

6 yrs	mean age at seizure onset
2 in 3	are drug-resistant
65%	inherit the variant from a parent

CAUSE

KCNT1 gain-of-function, autosomal dominant.

TREATMENT

No FDA-approved therapy; standard antiseizure drugs rarely help

EIMFS: epilepsy of infancy with migrating focal seizures; SHE: sleep-related hypermotor epilepsy (formerly ADNFLE). Source: Gras et al., Brain Commun 2026; Bonardi et al., Brain 2021; Mathieu Kuchenbuch et al. Brain 2019.

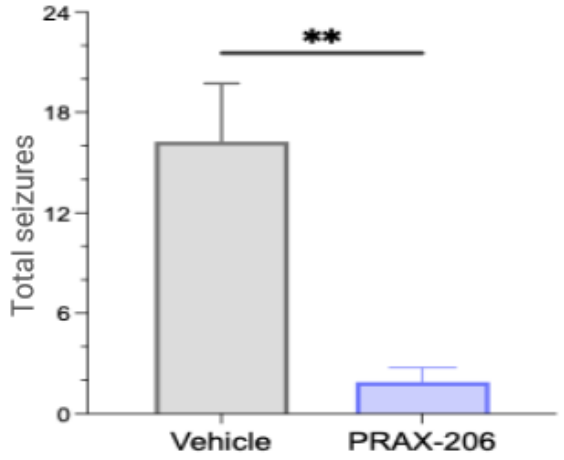
PRAX-206 Is Potent, Selective and Well Tolerated in Preclinical Models, With First-in-Human Planned for 2027

PRAX-206

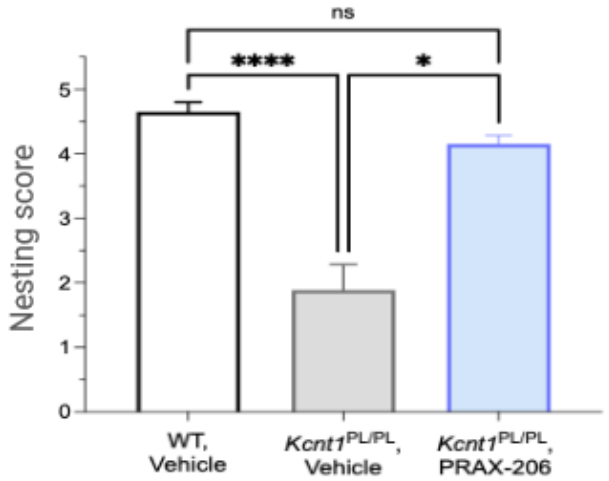
Oral, selective KCNT1 inhibitor targeting the cause of disease in KCNT1-DEE and SHE

FIRST IN HUMAN 2027

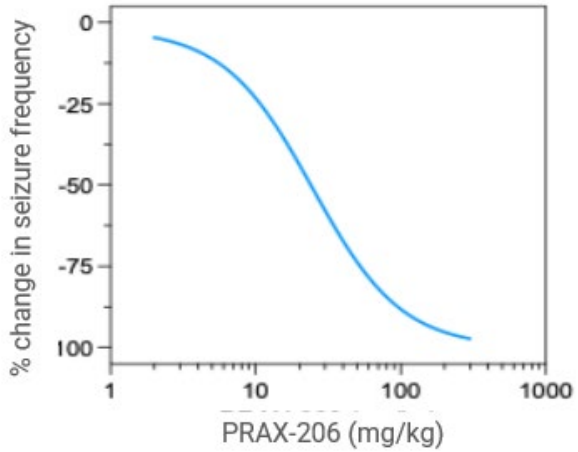
Spontaneous seizures Subchronic treatment



Nesting behavior Subchronic treatment



Spontaneous seizures Acute treatment



Number of spontaneous seizures across 9 days (quantified 12 h post-dose each day) and nesting score on Day 9; 300 mg/kg PRAX-206. Acute panel: single dose. *p<0.05, **p<0.01, ****p<0.0001; Kruskal-Wallis followed by Dunn's. WT, wild type; Kcnt1PL/PL, Kcnt1 P905L mice.

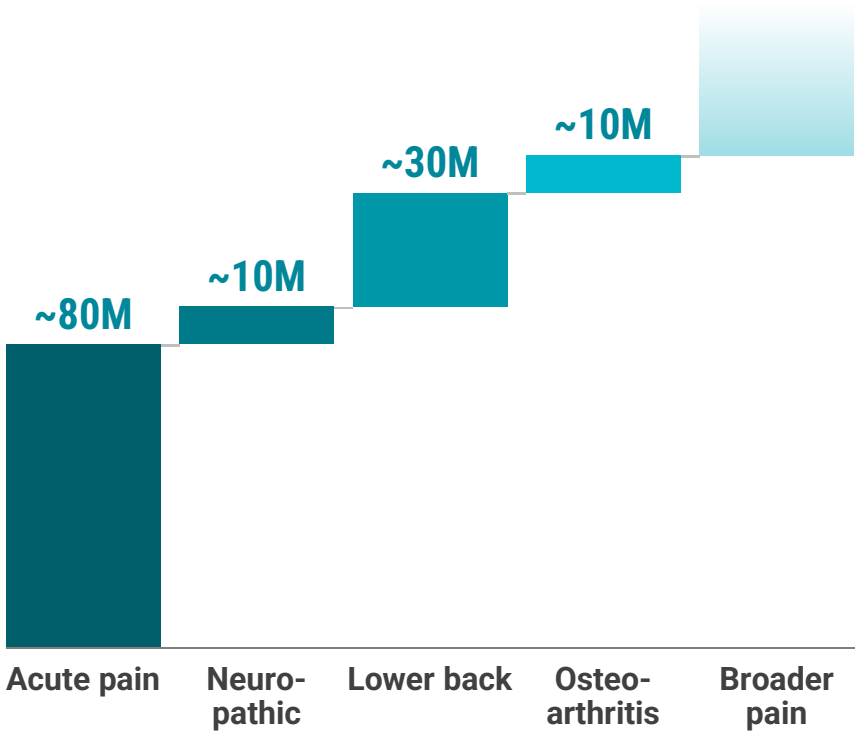


CEREBRUM™

Pain Pipeline

Why Pain: >150M US Patients With a Significant Unmet Need

>150M est. US patients across pain indications



Insufficient response to current options

- **~50–80%** of chronic pain patients are refractory to first- and second-line treatments (e.g., NSAIDs, acetaminophen, anti-seizure meds)
- **~40–60%** refractory to opioids
- **~30–70%** of acute pain patients do not achieve a favorable response

Safety, tolerability and abuse potential

- Current options, particularly opioids, cause vomiting, constipation, drowsiness, dizziness and impaired cognition
- **Opioids are highly addictive** with potential for abuse

Few novel mechanisms

- **Largely genericized market,** with very few novel MOAs approved for pain in the past 20 years

Source: Baskozos et al (2023), BioSpace (2024), CDC, Cunningham et al (1984), Dalke Meucci et al (2015), DelveInsight (2024), DiBonaventura et al (2017), EvaluatePharma (2024), Freburger et al (2009), George et al (2024), Lopez et al (2023), National Fibromyalgia Association, Osteoarthritis Action Alliance, OARSI, Shmagel et al (2017), Stefano et al (2020), US Pain Foundation (2024), Walitt et al (2015), Yawn et al (2009); BioPharma Dive, "Cancer patients are living longer than ever. Pain drugmakers haven't kept up."

Transmission of Pain Involves Multiple Na_V Isoforms in Different Compartments

CENTRAL NERVOUS SYSTEM

The brain and spinal cord relay the signal and process it into the perception of pain

- $Na_V1.2$
- $Na_V1.6$



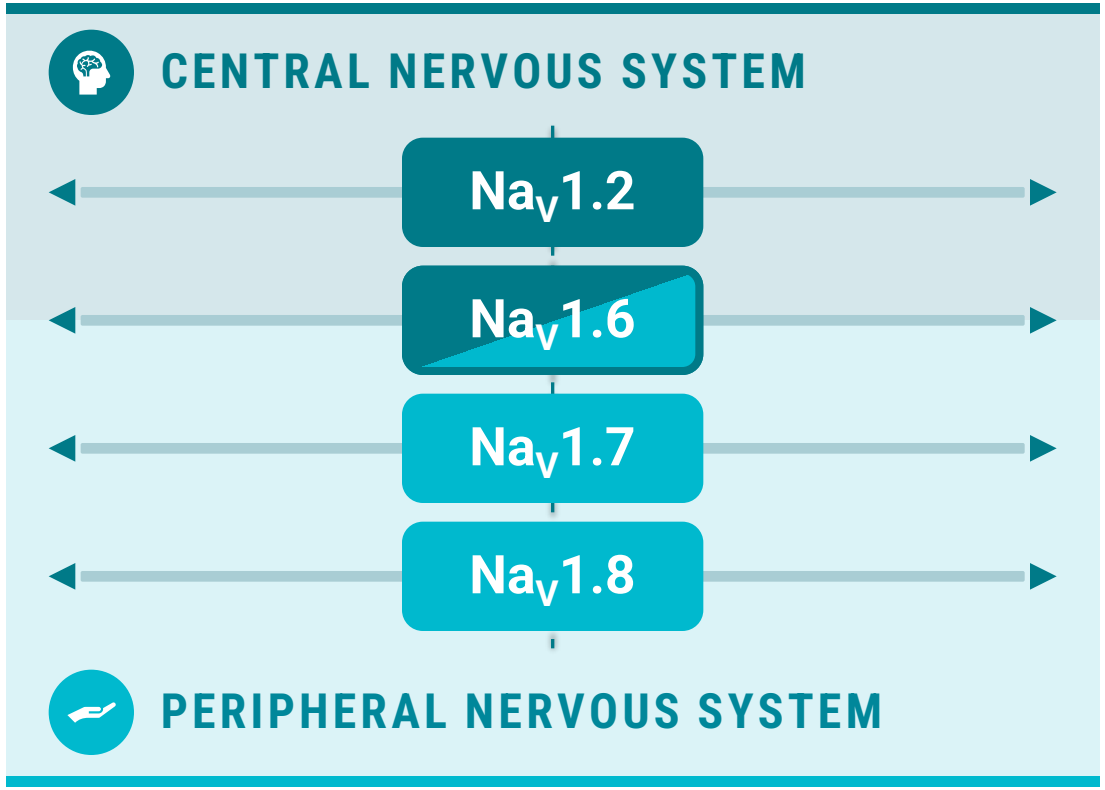
PERIPHERAL NERVOUS SYSTEM

Nerves in the skin, muscles and organs detect injury and fire the pain signal

- $Na_V1.6$
- $Na_V1.7$
- $Na_V1.8$

Designing a Wide Range of Molecules and Using a Differentiated Preclinical Development Framework to Pick the Best Candidates

TUNABLE SODIUM CHANNEL CHEMISTRY



DATA-LED DECISION-MAKING

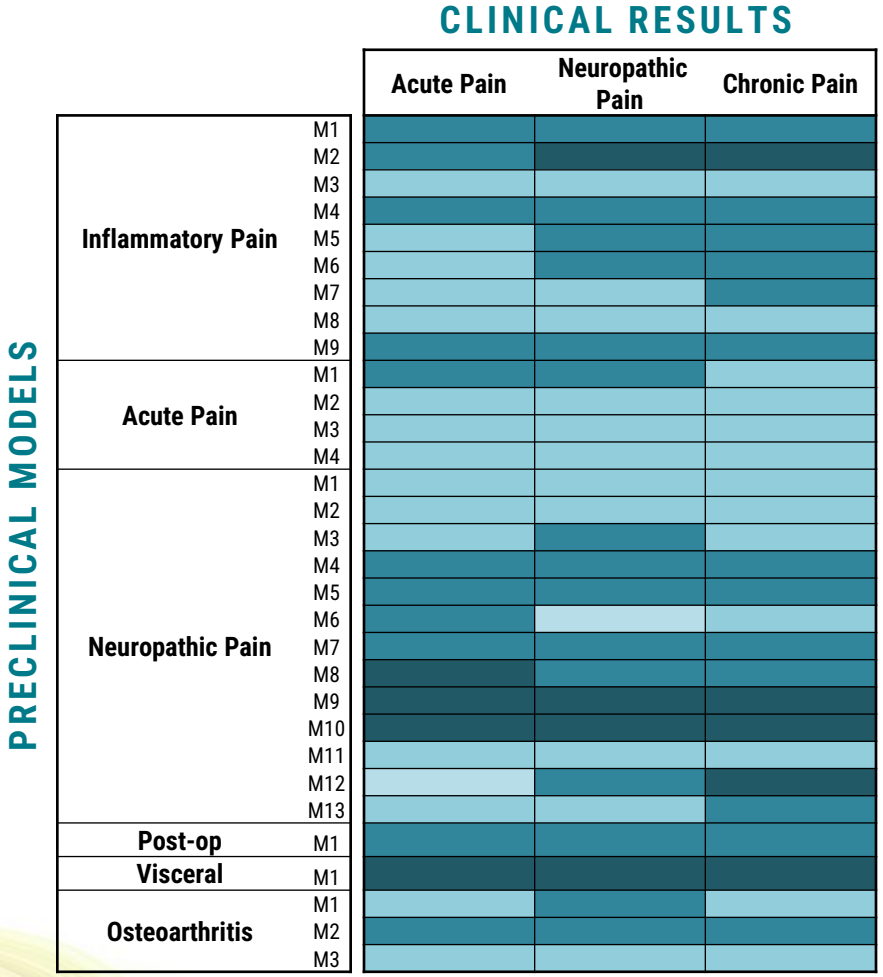
1. **Pursue multiple approaches**
   Advance several chemical series in parallel rather than betting on one

2. **Fine-tune the isoform profile**
   Dial each molecule toward the NaV isoforms we want to hit for a given pain type

3. **Test in PAC-PAIN Framework**
   Move forward only candidates that work in the preclinical models most predictive of clinical results

PAC-PAIN, Praxis Analysis of Concordance for Pain.

PAC-PAIN Develops Pain Model Cascades for Each Indication to Reduce Translational Risk



PAC-PAIN first scores how well each preclinical pain model concorded with the clinical results of **58 FDA-approved pain drugs**

Some of the most-used models are among the least predictive

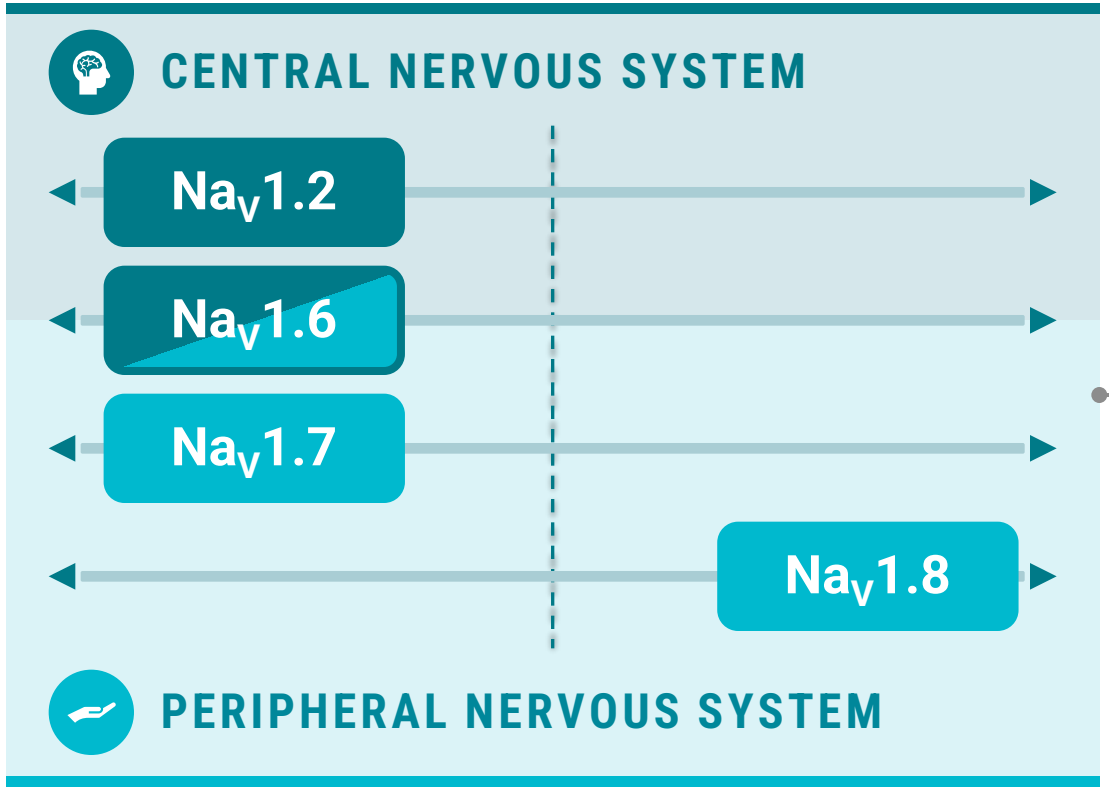
WHY IT GIVES US AN EDGE

- **Indication-specific cascades:** each pain indication can be best predicted by a cascade of pain models
- **Tolerability gated early:** compounds advance only with PI above 2
- **Proven platform:** the same framework behind our epilepsy programs

PAC-PAIN, Praxis Analysis of Concordance for Pain. Darker cells = higher concordance; models scored –1 to +1 vs. clinical outcomes. PI, protective index. Source: Anderson, et al. 2026 AAN; Praxis analysis.

Suzetrigine's Approval Clinically Validates Sodium Channel Targeting in Pain

SUZETRIGINE'S PROFILE



CLINICALLY PROVEN

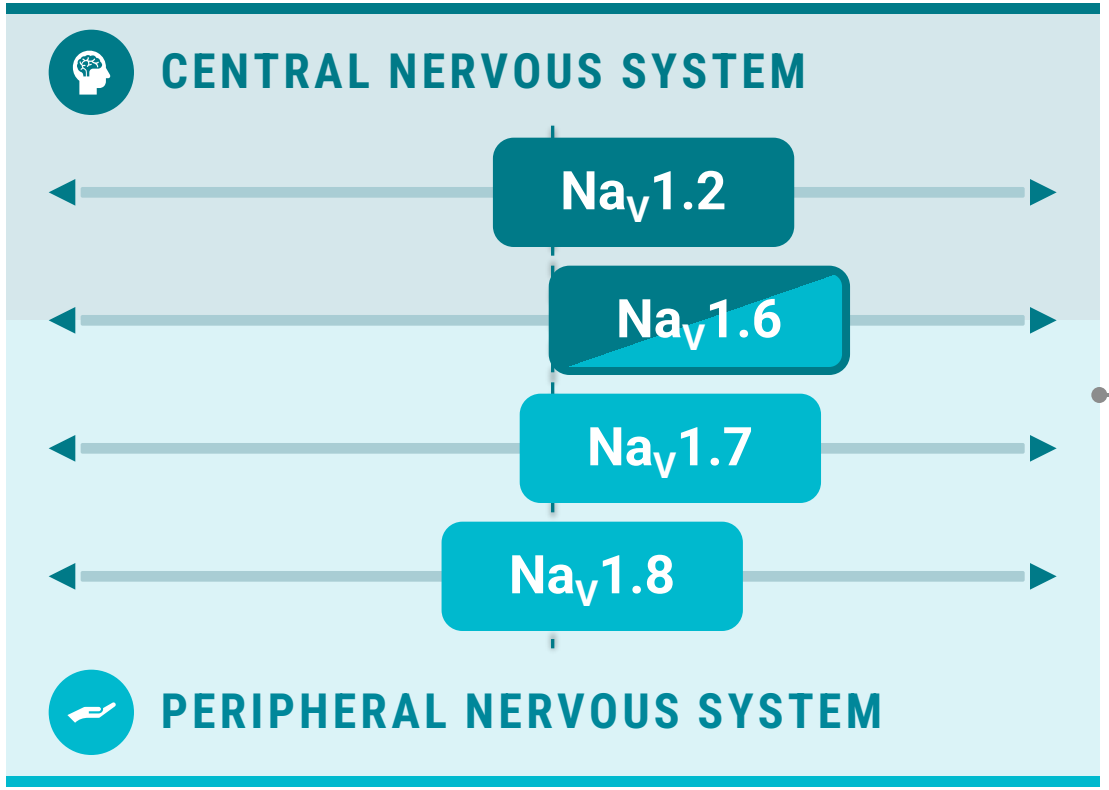
Suzetrigine (Journavx), FDA-approved January 2025

- NaV1.8 selective inhibitor
- For moderate-to-severe acute pain
- The first new acute pain drug class in over 20 years

Illustrative. Suzetrigine (Journavx, Vertex), NaV, voltage-gated sodium channel.

PRAX-215 Pairs Balanced Pan-NaV Potency With Praxis Functional State Selectivity

PRAX-215 PROFILE

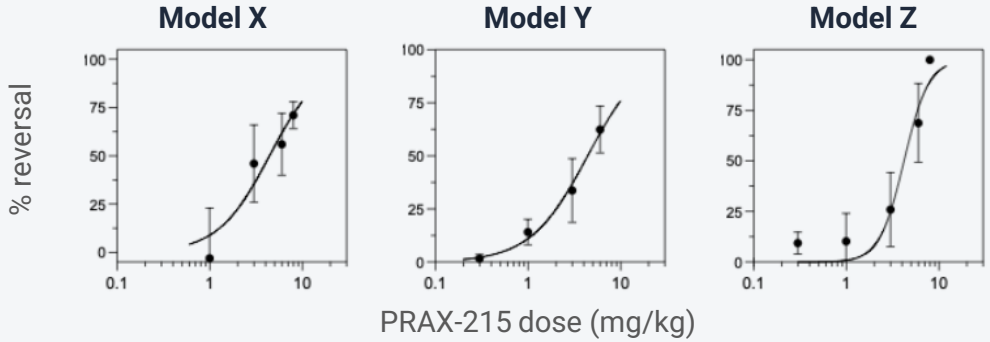


PHASE 1 ONGOING

PRAX-215

- **Balanced potency** at NaV1.2, 1.6, 1.7 and 1.8, covering both PNS and CNS pain signals
- **Functional state selectivity** acts on hyperactive neurons while sparing normal activity

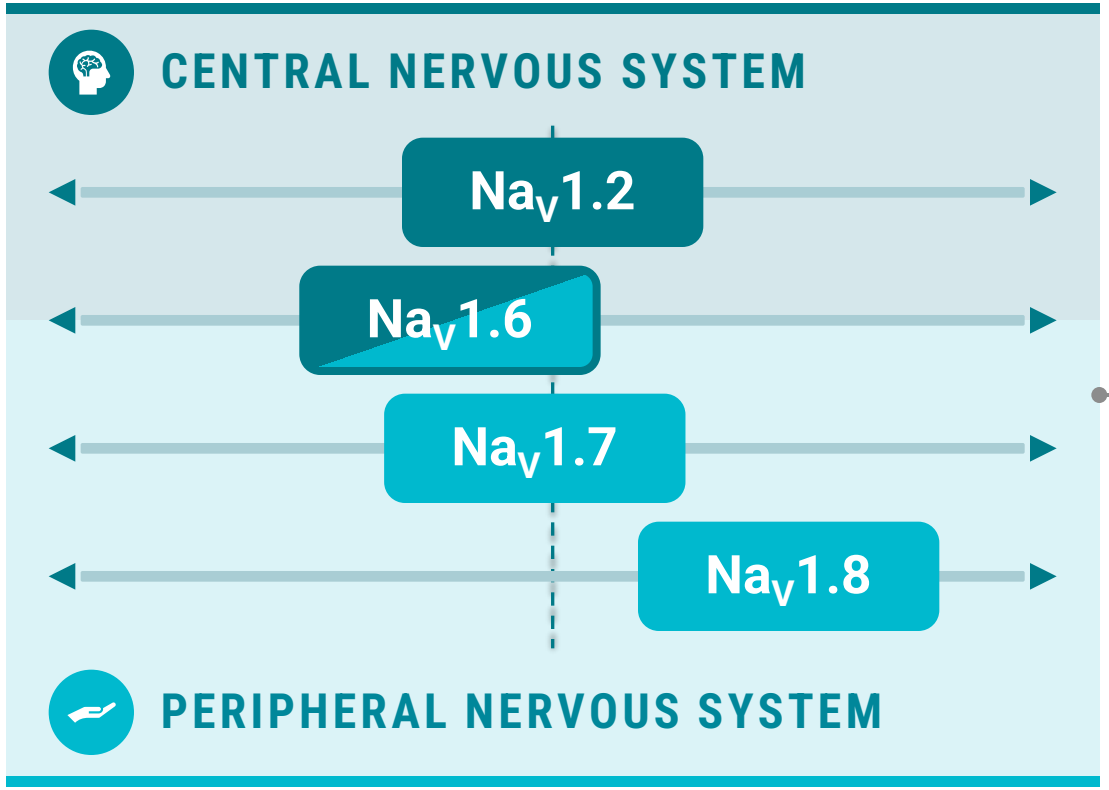
In Vivo Pain Model



Illustrative slider positions based on PRAX-215 IC50s. Model X, Y, Z: preclinical pain models.

PRAX-110 Is Biased Toward NaV1.8 While Keeping Activity Across Other Pain Isoforms

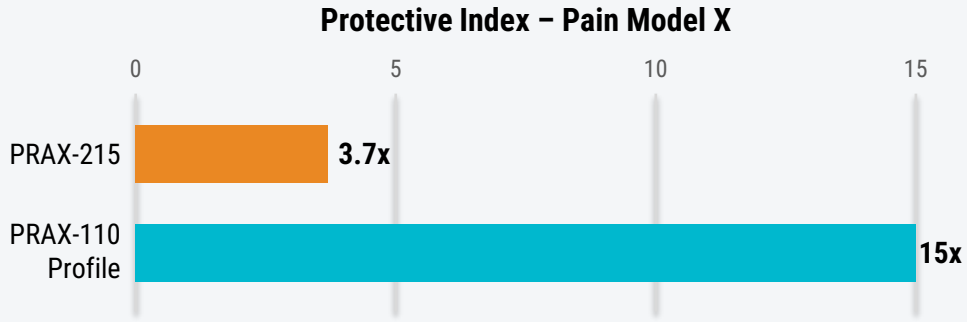
PRAX-110 PROFILE



IND SUBMISSION IN 2027

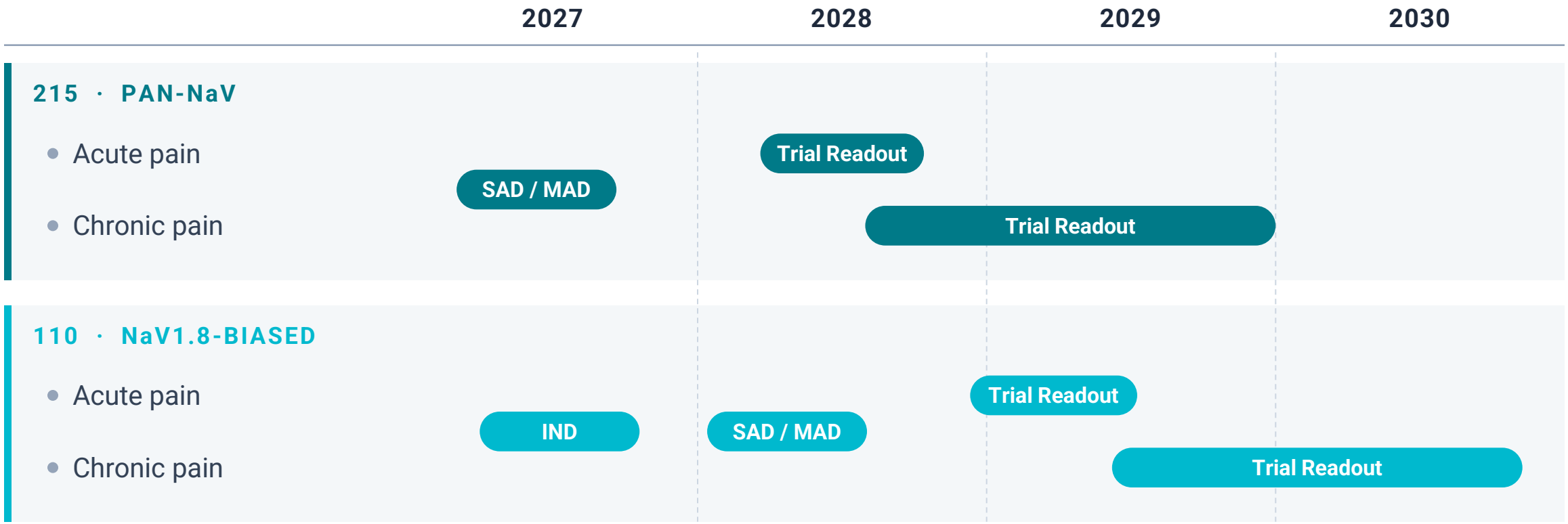
PRAX-110 Profile

- **Biased potency** at $Na_V1.8$, while maintaining functional state selectivity at other isoforms across the PNS and CNS
- **Functional state selectivity** acts on hyperactive neurons while sparing normal activity



Illustrative slider positions. Praxis data on file.

NaV1.x Pain Franchise Development Milestones

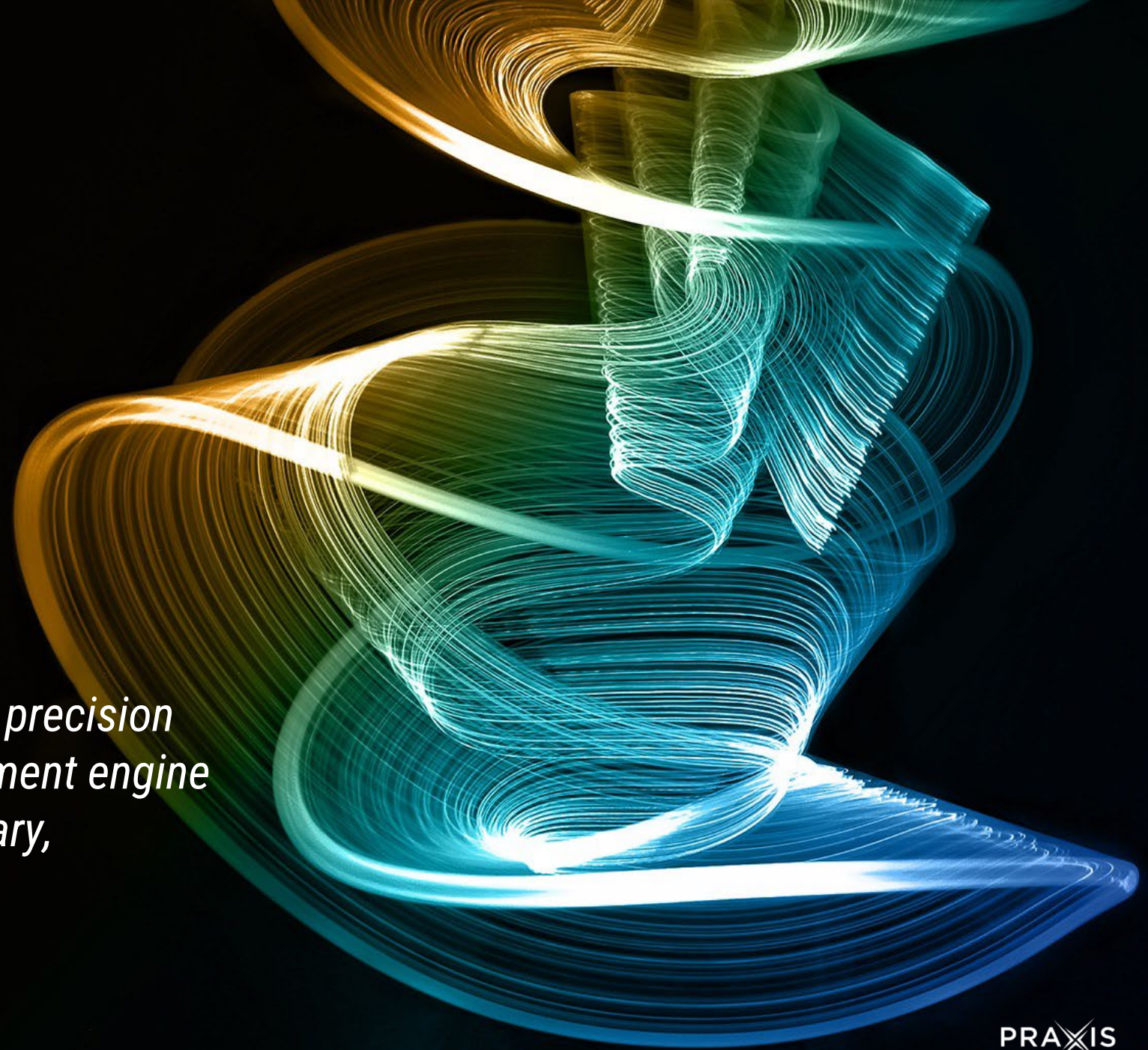


PAC-PAIN guides indication selection and preclinical model prioritization for acute and chronic pain across both programs.

SOLIDUS™

ASO PLATFORM

Solidus™ is an efficient, targeted precision medicine discovery and development engine for ASOs anchored on a proprietary, computational methodology



Multiple Routes to Address Genetically Defined Disease

1 **PIVOTAL-STAGE ANCHOR**

Elsunersen (PRAX-222) in the EMBRAVE3 registrational study

N **MULTIPLE RNA CONTROL MECHANISMS**

Silencing, splice switching, NAS suppression and other expression upregulation approaches

6 **EARLY-STAGE TARGETS**

Focused programs across genetically defined CNS disorders

REPEATABLE DISCOVERY LOGIC

Genetic cause → Mechanism selection → Optimized ASO → Translational readout → Clinical evidence

Elsunersen (PRAX-222) Targets the Source of SCN2A Gain-of-Function Disease

DISEASE BIOLOGY

SCN2A GAIN-OF-FUNCTION

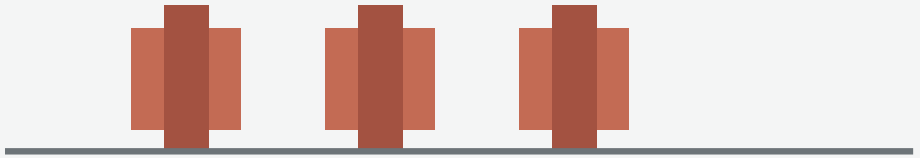
Hyperactive NaV1.2 channels contribute to neuronal hyperexcitability and severe early-onset seizures.



WITH ELSUNERSEN

RNA-LEVEL INTERVENTION

An RNase H1-active ASO reduces SCN2A mRNA, designed to decrease pathogenic NaV1.2 current.



Intrathecal

Every 4 weeks

FDA Breakthrough Therapy Designation (June 2026)

EMBRAVE Part A Showed Marked Seizure Reduction and Disease-Modifying Benefits, Earning it Breakthrough Therapy Designation

STUDY DESIGN

Ages 2–18
early-onset SCN2A GOF DEE

3:1

- **Elsunersen 1 mg Q4W** (n=7)
- **Sham procedure Q4W** (n=2)

Optional escalation up to 8 mg

→ **Open-label extension**

KEY RESULTS AT 24 WEEKS

77% PRIMARY
placebo-adjusted seizure reduction (p=0.015)

71%
of patients with >50% seizure reduction

57%
of patients with ≥28-day seizure freedom

100%
with gains in sleep, motor function, tone or attention

Well tolerated: **No drug-related SAEs** • **No discontinuations** • **No neuroinflammation signals up to 8 mg**

Q4W: every 4 weeks; GOF: gain of function; DEE: developmental and epileptic encephalopathy; SAE: serious adverse event Source: ClinicalTrials.gov NCT05737784; Praxis data on file

EMBRAVE3: Pivotal Single-arm Registrational Study with Expected 2027 Topline and NDA Filing

STUDY DESIGN

OBSERVATION

Baseline seizure frequency

ELSUNERSEN

1 mg intrathecal Q4W · 24 weeks

EXTENSION

Continued open-label treatment

PATIENT COHORTS

Ages 2–18: ~30 | **Ages 1–2:** ~5 | **Under age 1:** ~5

PRIMARY ENDPOINT

Median % change in monthly motor seizure frequency from baseline

FDA-aligned single-arm design, following removal of sham control.

Primary endpoint: % change in monthly motor seizure frequency from baseline. Q4W: every 4 weeks; DEE: developmental and epileptic encephalopathy; NDA: new drug application
Source: ClinicalTrials.gov NCT07019922

Six Genetically Defined Targets Extend Solidus Beyond Elsunersen

PRAX-080 | IND Enabling Tox

PCDH19

Mosaic expression disorder

MODALITY

Gapmer / RNA silencing

PRAX-090 | IND Enabling Tox

SYNGAP1

Haploinsufficiency DEE

MODALITY

SYNGAP1 upregulation

PRAX-100 | IND Enabling Tox

SCN2A

Loss-of-function neurodevelopmental disorder

MODALITY

SCN2A upregulation

PRAX-120 | IND Enabling Tox

ATM

Ataxia-telangiectasia

MODALITY

ATM upregulation

PRAX-130 | Lead Optimization

SLC6A1

SLC6A1-related DEE

MODALITY

GAT-1 upregulation

PRAX-140 | Lead Optimization

KCNQ2

Dominant-negative DEE

MODALITY

Allele-selective gapmer

AI-guided ASO Discovery: From Screening Data to Predictive Design

01 DESIGN

Generate ASO candidates

Use 5'UTR sequence and specificity filters to shortlist designs.

131 candidate 20-mers › 22 filtered

02 MEASURE + LEARN

Train predictive models

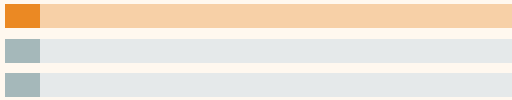
Relate sequence features to measured gene upregulation.

Sequence features + Measured activity → LR model

03 PREDICT + VALIDATE

Prioritize new designs

Use model scores to rank untested ASOs for future wet-lab studies.



PILOT 5'UTR MODEL PERFORMANCE

0.80 ROC AUC

NEXT: TEST GENERALIZABILITY

Validate on independent data and across new target sequences.

Source: Praxis pilot ASO upregulation model-development data; Pilot ROC AUCs describe model discrimination.

The Platform Opportunity Is Disciplined, Repeatable Advancement of RNA Programs

1

GENETIC INSIGHT

Causal variant and direction of dysfunction

2

MECHANISM MATCH

Silence, splice or increase expression

3

ASO DESIGN

Sequence and chemistry optimization

4

TRANSLATIONAL PROOF

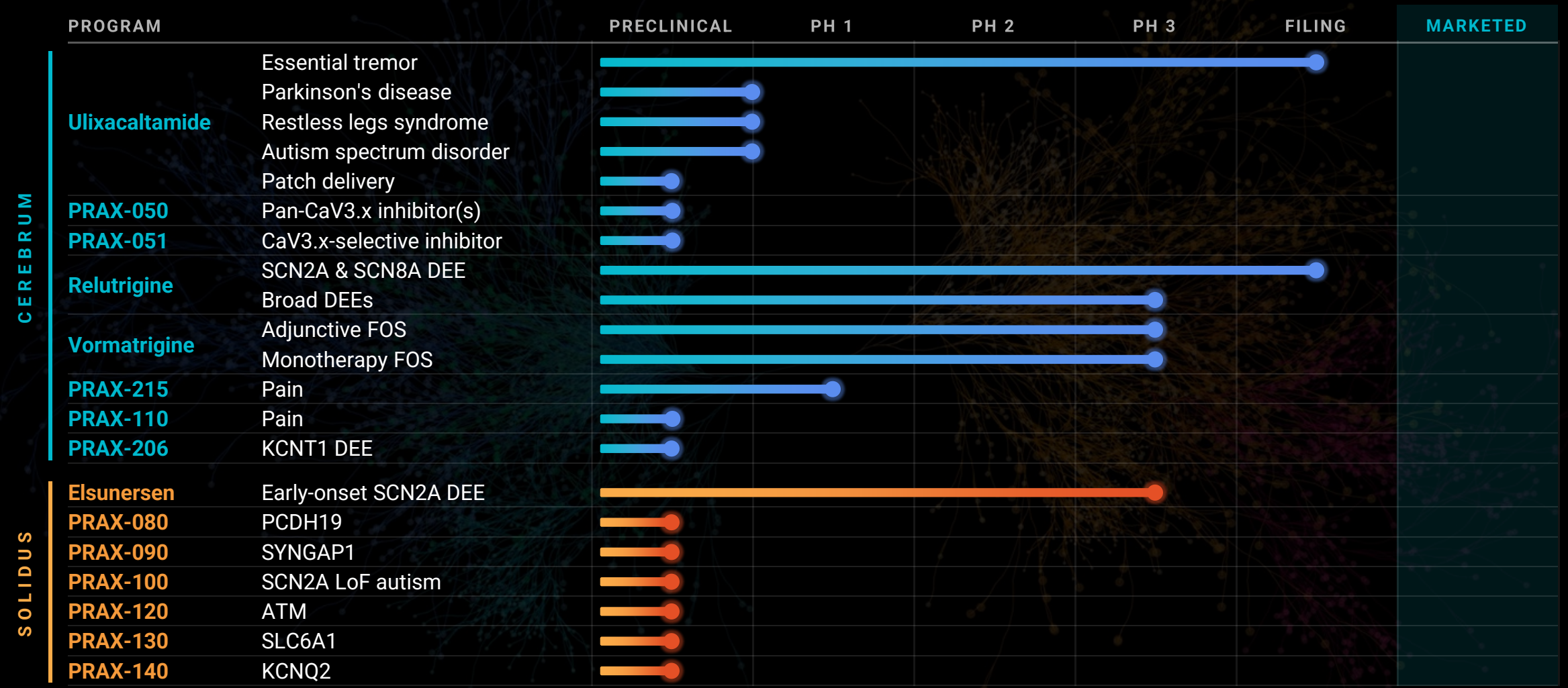
RNA/protein, functional readouts, exposure

5

CLINICAL PROGRAM

Patient selection and measurable outcomes

Praxis' Full Pipeline Today



DEE: developmental and epileptic encephalopathy; FOS: focal onset seizures; LoF: loss of function; ATM: Ataxia-telangiectasia.


DARE FOR MORE®
PRAXIS