Q4 and Full Year 2024 Earnings Call

February 26, 2025

Welcome and Introduction

JOHN SCARLETT, M.D.

Chairman of the Board, President and Chief Executive Officer

MICHELLE ROBERTSON

Executive Vice President, Chief Financial Officer and Treasurer

JIM ZIEGLER

Executive Vice President, Chief Commercial Officer

JOSEPH EID, M.D.

Executive Vice President, Research and Development

FAYE FELLER, M.D.

Executive Vice President, Chief Medical Officer

Forward-Looking Statements

During the course of this presentation and question-and-answer session, there will be forward-looking statements regarding future events, performance, plans, expectations and other projections, including those relating to:

- the launch, commercial opportunity and therapeutic potential of RYTELO® (imetelstat);
- anticipated clinical and commercial events and related timelines;
- the sufficiency of Geron's financial resources; and
- other statements that are not historical fact.

Actual events or results could differ materially; refer to the discussion under the heading "Risk Factors" in Geron's most recent periodic report filed with the SEC, which identifies important factors that could cause actual results to differ materially from those contained in the forward-looking statements, and our future updates to those risk factors. Geron undertakes no duty or obligation to update our forward-looking statements.

Introductory Remarks

John Scarlett, M.D.
Chairman and Chief Executive Officer

Focused on Key Value Drivers in 2025

LR-MDS represents a **potential blockbuster market opportunity** for RYTELO based on **high unmet need** and **significant product differentiation**

Phase 3 trial in JAKi R/R MF with overall survival (OS) primary endpoint is **80% enrolled**; if positive, an approval in this indication would **potentially double the RYTELO commercial opportunity**

Strong cash position; expect to reach profitability without additional financing if current internal sales and OpEx expectations are met

LR-MDS = lower-risk myelodysplastic syndromes; JAKi R/R MF = Janus kinase inhibitor relapsed/refractory myelofibrosis

Commercial Updates

Jim Ziegler
EVP, Chief Commercial Officer

Q4 2024 Launch Performance

Launch Trajectory

$47.5M Q4 2024 net revenue

Broad Payor Coverage

~80% payor coverage

as of the end of Q4 2024^

Encouraging RYTELO Utilization

Across 1L ESA ineligible, 2L and 3L patients (RS+/RS-)

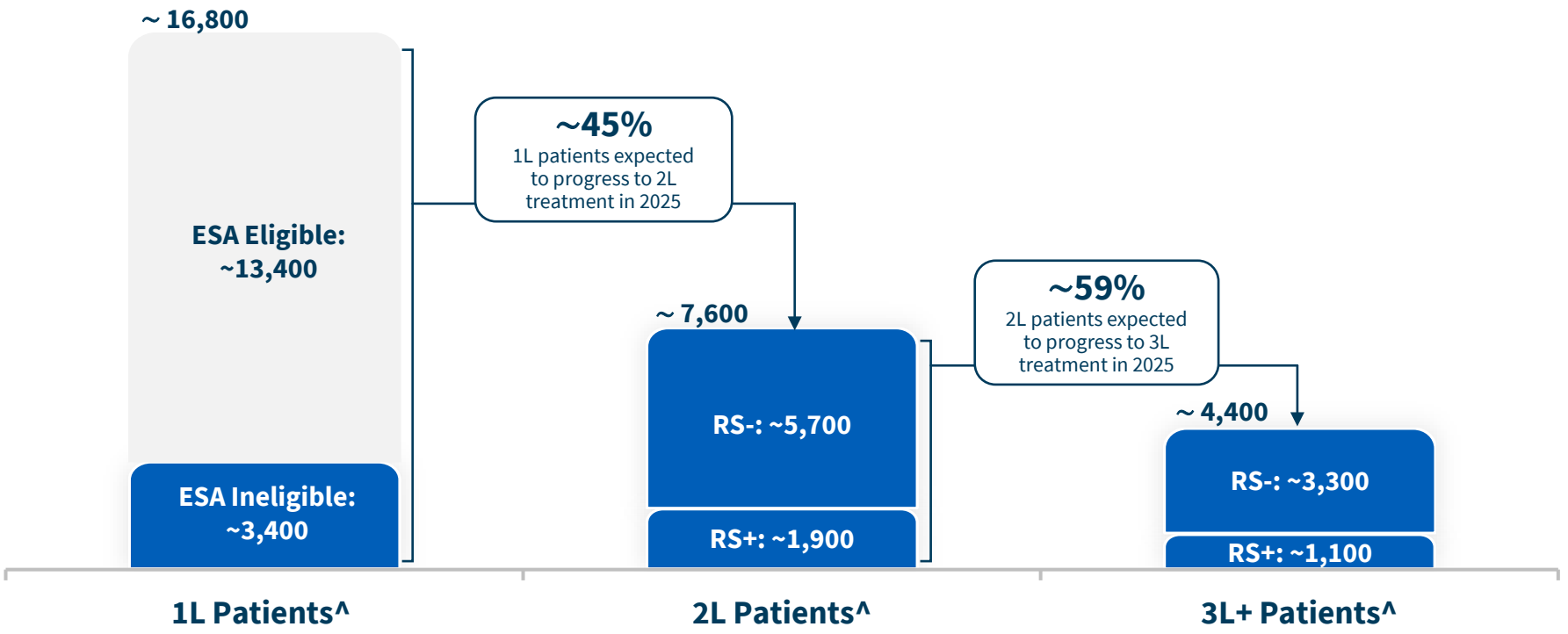
with duration of therapy consistent with IMerge Phase 3*

Focused on driving new patient starts across the breadth of eligible patients and educating on appropriate duration of therapy

^Payors responsible for ~80% U.S. covered lives have implemented RYTELO medical coverage policies consistent with FDA label, clinical trials and/or NCCN Guidelines through Q4 2024.
*Based on early launch data from patient chart audits and other data sources

Large U.S. Market Opportunity with Blockbuster Potential for RYTELO in LR-MDS

Estimated 2025 U.S. RYTELO Total Addressable LR-MDS Patient Population



~15,400

U.S. RYTELO total addressable LR-MDS patients in 2025

Potential for $1B+ in net revenue

*by treating only 1/3 of U.S. RYTELO total addressable patients**

^Non-del 5q

*Assuming the median duration of therapy observed in IMerge Phase 3 clinical trial (~8 months) and current net price.

Sources: 2025 patient volumes based on IQVIA projected new patient claims 2023, DRG LR MDS incidence projected growth rate (2022); Ring sideroblasts present in ~23% 33% of patients with MDS and are associated with anemia (references: 2.Papaemmanuil E, Gerstung M, Malcovati L, et al. Clinical and biological implications of driver mutations in myelodysplastic syndromes. Blood. 2013;122(22):36163627. 3. Malcovati L, Cazzola M. Recent advances in the understanding of myelodysplastic syndromes with ring sideroblasts . Br J Haematol . 2016;174(6):847 858.)

Total addressable patient population includes patients recommended in the National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology (NCCN Guidelines) for the treatment of MDS as a Category 1 and 2A treatment. Geron promotes RYTELO within its FDA-approved indication for patients requiring four or more red blood cell units over eight weeks who have not responded to or have lost response to or are ineligible for erythropoiesis-stimulating agents (ESAs).

Medical Updates

Joseph Eid, M.D.
EVP, Research and Development

Clinical Updates

Faye Feller, M.D.
EVP, Chief Medical Officer

First Myelofibrosis Trial with Overall Survival Primary Endpoint Based on Significant Imetelstat Clinical Experience

2015
Single Institution Pilot Study

Basis for Ph2 IMbark

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

A Pilot Study of the Telomerase Inhibitor Imetelstat for Myelofibrosis

Ayalew Tefferi, M.D., Terra L. Lasho, Ph.D., Kebede H. Begna, M.D., Mrinal M. Patnaik, M.D., Darci L. Zblewski, C.N.P., Christy M. Finke, B.Sc., Rebecca R. Laborde, Ph.D., Eminet Wassie, M.D., Lauren Schimek, B.S., Curtis A. Hanson, M.D., Naseema Gangat, M.D., Xiaolin Wang, Ph.D., and Animesh Pardanani, M.D., Ph.D.

ABSTRACT

BACKGROUND
Current drugs for myeloproliferative neoplasm–associated myelofibrosis, including Janus kinase (JAK) inhibitors, do not induce complete or partial remissions. Imetelstat is a 13-mer lipid-conjugated oligonucleotide that targets the RNA template of human telomerase reverse transcriptase.

METHODS
We sought to obtain preliminary information on the therapeutic activity and safety of imetelstat in patients with high-risk or intermediate-2–risk myelofibrosis. Imetelstat was administered as a 2-hour intravenous infusion (starting dose, 9.4 mg per kilogram of body weight) every 1 to 3 weeks. The primary end point was the overall response rate, and the secondary end points were adverse events, spleen response, and independence from red-cell transfusions.

RESULTS
A total of 33 patients (median age, 67 years) met the eligibility criteria; 48% had received prior JAK inhibitor therapy. A complete or partial remission occurred in 7 patients (21%), with a median duration of response of 18 months (range, 13 to 20+) for complete responses and 10 months (range, 7 to 10+) for partial responses. Bone marrow fibrosis was reversed in all 4 patients who had a complete response, and a molecular response occurred in 3 of the 4 patients. Response rates were 27% among patients with a *JAK2* mutation versus 0% among those without a *JAK2* mutation ($P=0.30$) and 32% among patients without an *ASXL1* mutation versus 0% among those with an *ASXL1* mutation ($P=0.07$). The rate of complete response was 38% among patients with a mutation in *SF3B1* or *U2AF1* versus 4% among patients without a mutation in these genes ($P=0.04$). Responses did not correlate with baseline telomere length. Treatment-related adverse events included grade 4 thrombocytopenia (in 18% of patients), grade 4 neutropenia (in 12%), grade 3 anemia (in 30%), and grade 1 or 2 elevation in levels of total bilirubin (in 12%), alkaline phosphatase (in 21%), and aspartate aminotransferase (in 27%).

CONCLUSIONS
Imetelstat was found to be active in patients with myelofibrosis but also had the potential to cause clinically significant myelosuppression. (Funded by Geron; ClinicalTrials.gov number, NCT01731951.)

Pilot Study in HR/Int-2 MF
(~50% of patients received prior JAKi therapy)
N=33

2021
Ph 2 Dose Finding Study

Median OS in 9.4 mg/kg arm more than double compared to BAT in RWD Study

Journal of Clinical Oncology®

original reports abstract

Randomized, Single-Blind, Multicenter Phase Study of Two Doses of Imetelstat in Relapsed or Refractory Myelofibrosis

John Mascarenhas, MD[1]; Rami S. Komrokji, MD[2]; Francesca Palandri, MD[3]; Bruno Martino, MD[4]; Dietger Niederwieser, MD, PhD[5]; Andreas Reiter, MD[6]; Bart L. Scott, MD[7]; Maria R. Baer, MD[8]; Ronald Hoffman, MD[1]; Olatoyosi Odenike, MD[9]; Alessandro M. Vannucchi, MD[10]; Jacqueline Bussolari, PhD[11]; Eugene Zhu, PhD[11]; Esther Rose, MD[11]; Laurie Sherman, BSN[12]; Souria Dougherty, BS, MBA[12]; Libo Sun, PhD[12]; Fei Huang, PhD[12]; Ying Wan, PhD[12]; Faye M. Feller, MD[12]; Aleksandra Rizo, MD, PhD[12]; and Jean-Jacques Kiladjian, MD, PhD[13]

PURPOSE Patients with myelofibrosis who are relapsed or refractory (R/R) to Janus-associated kinase inhibitors (JAKis) have poor clinical outcomes including dismal overall survival (OS) that ranges between 13 and 16 months. Imetelstat, a telomerase inhibitor, was evaluated in patients with intermediate-2 or high-risk myelofibrosis R/R to JAKi in a phase II multicenter study (ClinicalTrials.gov identifier: NCT02426086).

PATIENTS AND METHODS Patients were randomly assigned to receive either imetelstat 9.4 mg/kg or 4.7 mg/kg intravenous once every 3 weeks. Spleen response (≥ 35% spleen volume reduction) and symptom response (≥ 50% reduction in total symptom score) rates at week 24 were coprimary end points. Secondary end points included OS and safety.

RESULTS Study enrollment was closed early, and patients treated with 4.7 mg/kg were permitted to continue treatment with 9.4 mg/kg. At week 24, spleen and symptom response rates were 10.2% and 32.2% in the 9.4-mg/kg arm and 0% and 6.3% in the 4.7-mg/kg arm. Treatment with imetelstat 9.4 mg/kg led to a median OS of 29.9 months and bone marrow fibrosis improvement in 40.5% and variant allele frequency reduction of driver mutations in 42.1% of evaluable patients. Fibrosis improvement and variant allele frequency reduction correlated with OS. Target inhibition was demonstrated by reduction of telomerase activity and human telomerase reverse transcriptase level and correlated with spleen response, symptom response, and OS. Most common adverse events on both arms were grade 3 or 4 reversible cytopenias.

CONCLUSION In this phase II study of two imetelstat doses, 9.4 mg/kg once every 3 weeks demonstrated clinical benefits in symptom response rate, with an acceptable safety profile for this poor-risk JAKi R/R population. Biomarker and bone marrow fibrosis assessments suggested selective effects on the malignant clone. A confirmatory phase III study is currently underway.

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IMbark
NCT02426086

Phase 2 Dose Finding Study in JAKi R/R MF
N=59 (9.4 mg/kg), N=48 (4.7 mg/kg)

ONGOING
Pivotal Ph 3 Trial

First and only Phase 3 trial in MF with overall survival as primary endpoint

80%
enrolled as of February 2025

Interim Analysis expected 2H 2026*
Final Analysis expected 2H 2028*

IMpactMF
NCT04576156

Phase 3 Study in JAKi R/R Int-2 or HR MF
N=320

*These projections are based on expectations about event rates (deaths) and enrollment, which can change over time and may differ from our current expectations.

Part 1 Findings Suggest Tolerability of Imetelstat Combined with Ruxolitinib in Patients with MF

Actively enrolling patients for dose confirmation with imetelstat 9.4mg/kg

IMproveMF

ClinicalTrials.gov Identifier: NCT05371964

INT-1/ INT-2/ HR MF

Frontline treatment

PART 1: Dose Finding

Results Presented at ASH 2024

- **Imetelstat 4.7mg/kg** (n=3) + **Ruxolitinib doses**
- **Imetelstat 6.0 mg/kg** (n=3) + **Ruxolitinib doses**
- **Imetelstat 7.5 mg/kg** (n=4) + **Ruxolitinib doses**
- **Imetelstat 9.4 mg/kg** (n=7) + **Ruxolitinib doses**

Patients treated with imetelstat 9.4 mg/kg experienced stable hematology values over time

- Well-tolerated, and no dose-limiting toxicities were reported at any imetelstat dose level within the first 28 days of Cycle 1
- The PK profiles were consistent with previous monotherapy studies
- Preliminary results showed VAF reductions in driver mutations associated with MF across all four dose cohorts

9.4 mg/kg Imetelstat every 4 weeks selected for dose confirmation and expansion

PART 2: Dose Confirmation & Expansion Currently Enrolling

~20 JAKi naïve patients planned

Imetelstat 9.4 mg/kg

+

Ruxolitinib individualized dose per patient

- **Objective:** Confirm safety of doses and evaluate efficacy
- **Primary Week 24 Endpoints:** Safety, TSS
- **Other Week 24 Endpoints:** TSS, SVR35, fibrosis

Initial results from Part 2 expected 2026

geron

PK = pharmacokinetic profiles; VAF = variant allele frequency; SET = Study Evaluation Team; RP2D = Recommended Phase 2 Dose; DIPSS = dynamic international prognostic scoring system; INT-1 = intermediate-1; INT-2 = intermediate-2; HR = high risk; TSS = total symptom score; SVR35 = spleen volume reduction > 35%

Financial Results

Michelle Robertson
EVP, Chief Financial Officer

Financial Overview

Cash Balance

~$502.9M

Cash and marketable securities as of 12/31/24

Net Revenue

$47.5M

Q4 2024 net product revenue

$76.5M

2024 net product revenue since product availability end-June

Operating Expenses

$250.7M

2024 total OpEx

$270M to **$285M**

2025 expected OpEx range

Expect to reach profitability without additional financing if current internal sales and OpEx expectations are met

Closing Remarks

John Scarlett, M.D.
Chairman and Chief Executive Officer

Multiple Opportunities to Fuel Growth in 2025 & Beyond

2024 ACHIEVEMENTS

June 2024
FDA approval & U.S. launch of RYTELO in LR-MDS

Nov 2024
Secured up to $375M in non-equity financings

Q3 2024
$28.2M product revenue in first full commercial quarter

Q4 2024
$47.5M product revenue

Dec 2024
Positive CHMP opinion in LR-MDS

EXPECTED OPPORTUNITIES FOR VALUE CREATION

1H 2025
EU approval in LR-MDS

2026
Launch in select EU countries in LR-MDS

2H 2026
Ph3 interim analysis in R/R MF*

2026
Initial Results from Part 2 of Ph1 IMproveMF

2H 2028
Ph3 final analysis in R/R MF*

FDA = U.S. Food & Drug Administration; LR-MDS = lower-risk myelodysplastic syndromes; CHMP = Committee for Medicinal Products for Human Use; EU= European Union; R/R MF = relapsed/refractory myelofibrosis
*These projections are based on expectations about event rates (deaths) and enrollment, which can change over time and may differ from our current expectations.

Thank you!

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