Building the World's Leading Neuromuscular Disease Company

COMPANY OVERVIEW | NOVEMBER 2026



Sarah, *living with DM1*

Forward-Looking Statements & Disclaimer

This presentation contains forward-looking statements that involve substantial risks and uncertainties. All statements, other than statements of historical fact, contained in this presentation, including statements regarding Dyne's strategy, future operations, prospects and plans, objectives of management, the potential of the FORCE platform, the therapeutic potential of zeleciment rostudirsen (z-rostudirsen, also known as DYNE-251), zeleciment basivarsen (z-basivarsen, also known as DYNE-101), DYNE-302, DYNE-401, DYNE-244, DYNE-245, DYNE-253, and DYNE-255, the anticipated timelines for reporting additional data from the ACHIEVE clinical trial, initiating and reporting data from additional clinical trials, including HARMONIA and FORZETTO, expectations regarding the timing and outcome of interactions with global regulatory authorities and the availability of expedited approval pathways for z-basivarsen and z-rostudirsen, expectations regarding the timing of submitting applications for U.S. Accelerated Approval, plans to provide future updates on pipeline programs, expectations regarding the commercialization of any of Dyne's product candidates, and the sufficiency of Dyne's cash resources for the period anticipated, constitute forward-looking statements within the meaning of The Private Securities Litigation Reform Act of 1995. The words "anticipate," "believe," "continue," "could," "estimate," "expect," "intend," "may," "might," "objective," "ongoing," "plan," "predict," "project," "potential," "should," "will" or "would," or the negative of these terms, or other comparable terminology are intended to identify forward-looking statements, although not all forward-looking statements contain these identifying words. Dyne may not actually achieve the plans, intentions or expectations disclosed in these forward-looking statements, and you should not place undue reliance on these forward-looking statements. Actual results or events could differ materially from the plans, intentions and expectations disclosed in these forward-looking statements as a result of various important factors, including: uncertainties inherent in the identification and development of product candidates, including the initiation and completion of preclinical studies and clinical trials; uncertainties as to the availability and timing of results from preclinical studies and clinical trials; the timing of and Dyne's ability to enroll patients in clinical trials; whether results from preclinical studies and data from clinical trials will be predictive of the final results of the clinical trials or other trials; whether data from clinical trials will support submission for regulatory approvals; uncertainties as to the FDA's and other regulatory authorities' interpretation of the data from Dyne's clinical trials and acceptance of Dyne's clinical programs and as to the regulatory approval process for Dyne's product candidates; whether Dyne's cash resources will be sufficient to fund its foreseeable and unforeseeable operating expenses and capital expenditure requirements; as well as the risks and uncertainties identified in Dyne's filings with the Securities and Exchange Commission (SEC), including the Company's most recent Form 10-K and in subsequent filings Dyne may make with the SEC. In addition, the forward-looking statements included in this presentation represent Dyne's views as of the date of this presentation. Dyne anticipates that subsequent events and developments will cause its views to change. However, while Dyne may elect to update these forward-looking statements at some point in the future, it specifically disclaims any obligation to do so. These forward-looking statements should not be relied upon as representing Dyne's views as of any date subsequent to the date of this presentation.

This presentation also contains estimates, projections and other statistical data made by independent parties and by Dyne relating to market size and growth and other data about Dyne's industry and business. This data involves a number of assumptions and limitations, and you are cautioned not to give undue weight to such estimates. Dyne has not independently verified the accuracy and completeness of the information obtained from third parties included in this presentation. In addition, projections, assumptions and estimates of Dyne's future performance and the future performance of the markets in which Dyne operates are necessarily subject to a high degree of uncertainty and risk.

Dyne is on a Mission to Deliver Functional Improvement for the Neuromuscular Community

DYNE IS AIMING TO DELIVER FUNCTIONAL IMPROVEMENT for people living with genetically driven neuromuscular diseases

Dyne was built to address one of the most significant challenges in biotech: how to effectively and broadly deliver a therapeutic payload that results in measurable and meaningful functional improvement to patients

DYNE SNAPSHOT

FORCE™ platform uses an antigen-binding fragment (Fab) to target the transferrin receptor 1 (TfR1), which is expressed on muscle cells and the blood brain barrier

The FORCE Fab harnesses TfR1 to deliver a therapeutic payload, leveraging a naturally occurring mechanism

Dyne is advancing a broad pipeline, including two clinical programs, z-rostudirsen (DYNE-251) for Duchenne muscular dystrophy (DMD) and z-basivarsen (DYNE-101) for myotonic dystrophy type 1 (DM1)

We are on a mission to deliver functional improvement for individuals, families and communities living with serious neuromuscular diseases

DYNE MILESTONES

- **2019 | RESEARCH**
  - Dyne launches
- **2020-2021 | PRECLINICAL**
  - Exon 51 DMD candidate selected
  - DM1 candidate selected
- **2022 | CLINIC**
  - FIH trials for z-basivarsen & z-rostudirsen
- **2023 | CLINICAL PROGRESS**
  - Z-basivarsen & z-rostudirsen dose escalation based on safety results
- **2024 | CLINICAL POC**
  - Z-basivarsen & z-rostudirsen early functional improvement
- **2025 | SUSTAINED FUNCTIONAL IMPROVEMENT & SAFETY RESULTS**
- **2026 | FIRST BLA SUBMISSION**
  - Z-rostudirsen for exon 51 DMD

Poised to Unlock Significant Commercial Opportunities in Multiple Rare Neuromuscular Diseases

LATE-STAGE CLINICAL PIPELINE

- BLA under Priority Review (PDUFA January 21, 2027) based on positive results from registrational cohort in exon 51 DMD
- Ongoing registrational cohort in DM1

NEAR-TERM VALUE DRIVERS

Steady cadence of expected data and regulatory milestones; first potential commercial launch in Q1 2027



DIFFERENTIATED PLATFORM

FORCE™ platform enables targeted delivery to muscle and CNS; broader pipeline includes FSHD, Pompe and additional DMD exons

STRONG FINANCIAL POSITION

Cash position of ~$1.134 billion (as of 9/30/26) with expected runway into Q2 2028; all assets fully owned

DMD = Duchenne muscular dystrophy; DM1 = myotonic dystrophy type 1; CNS = central nervous system; FSHD = facioscapulohumeral muscular dystrophy; BLA = Biologics License Application.

Transforming Dyne into a Commercial Organization as Early as 2027

Z-Rostudirsen for Exon 51 DMD		Z-Basivarsen for DM1	
March 2025	Completed enrollment of Registrational Expansion Cohort ✓	**June 2026**	Completed enrollment of Registrational Expansion Cohort ✓
December 2025	Positive topline results from Registrational Expansion Cohort ✓	**Q1 2027**	Data planned for Registrational Expansion Cohort
May 2026	BLA submitted for U.S. Accelerated Approval ✓	**Q3 2027**	Potential submission for U.S. Accelerated Approval
Q1 2027	Potential U.S. launch (PDUFA January 21, 2027) *1st potential launch for Dyne*	**H1 2028**	Potential U.S. launch, assuming Priority Review

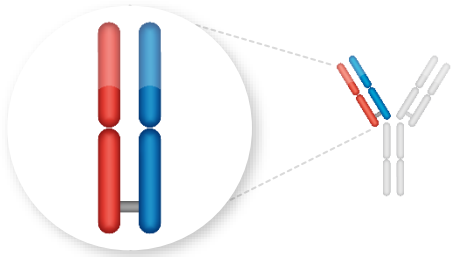
One capital efficient operating model to support multiple potential commercial launches

DMD = Duchenne muscular dystrophy; DM1 = myotonic dystrophy type 1; BLA = Biologics License Application.

Leveraging Our FORCE™ Platform for Targeted Delivery

ANTIBODY

Proprietary Fab against TfR1 to enable targeted delivery to muscle and CNS

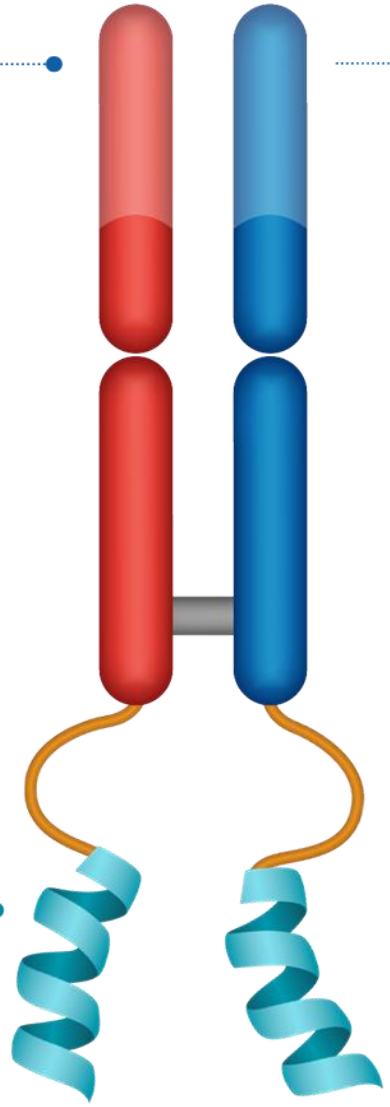


LINKER

Connects Fab and payload

PAYLOAD

Modularity enables rational selection of payload to target the genetic basis of disease (ASO, PMO, siRNA, enzyme)





Skeletal (including diaphragm) and smooth muscle



Cardiac muscle

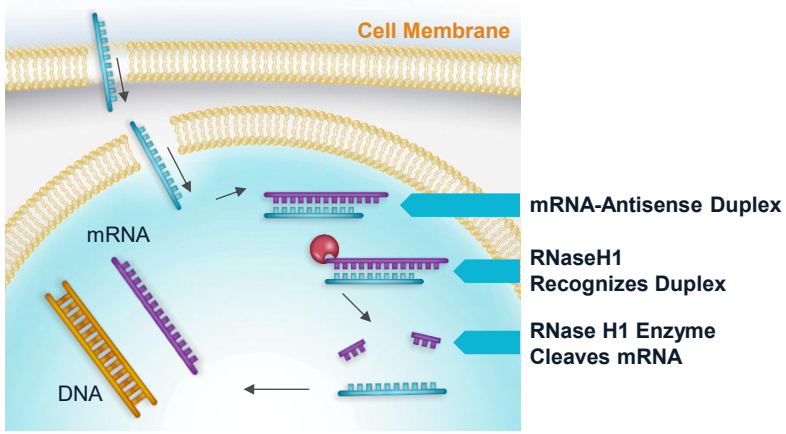


CNS

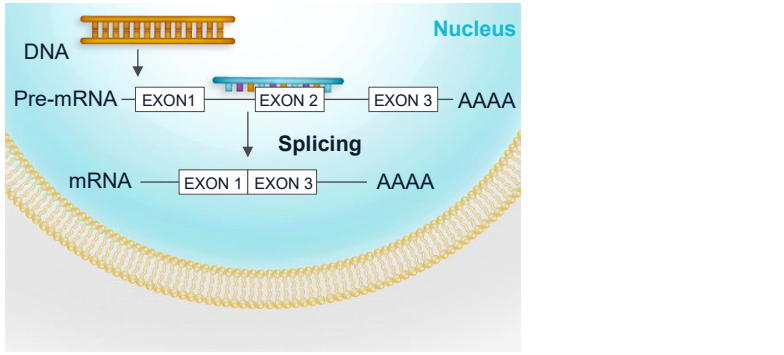
Note: Figure depicts oligonucleotide payload; ASO = antisense oligonucleotide; PMO = phosphorodiamidate morpholino oligomer; siRNA = small interfering RNA; CNS = central nervous system.

Rationally Select Payload to Target Genetic Basis of Disease

ASO acts in the nucleus and cytoplasm

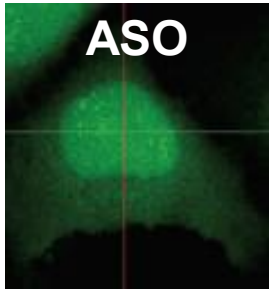


Splice-modulating ASO

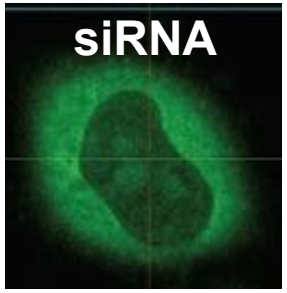


Single-Stranded Antisense

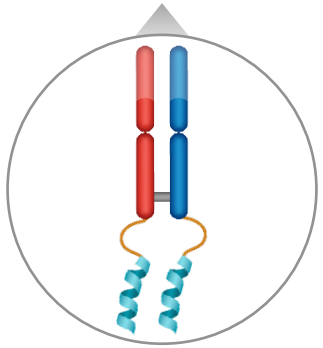
Subcellular distribution of ASO and siRNA



Nuclear localization

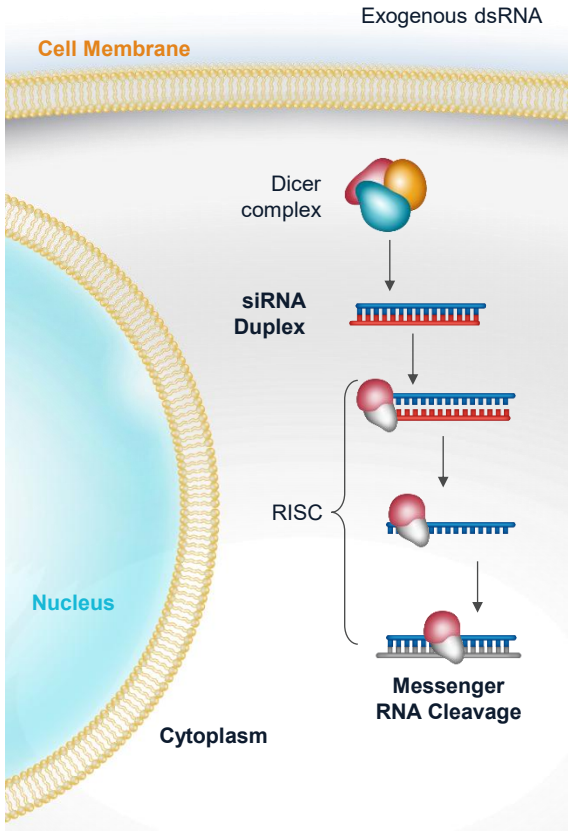


Cytoplasmic localization



FORCE delivers **ASO** payload for nuclear targets, **siRNA** payload for cytoplasmic targets

siRNA acts in the cytoplasm

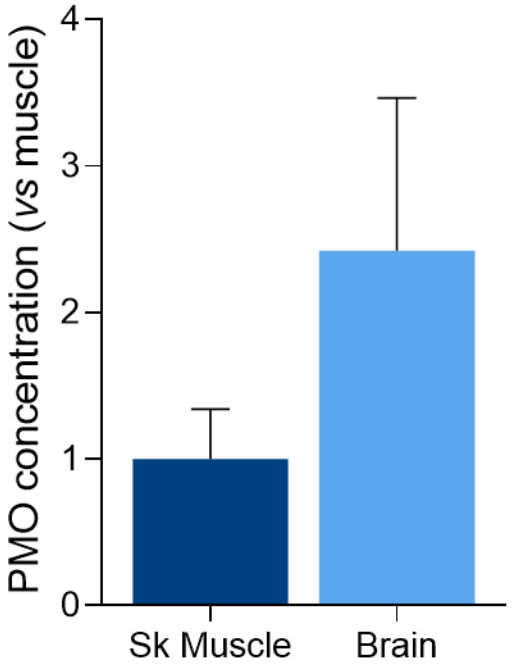


Double-Stranded Antisense (siRNA)

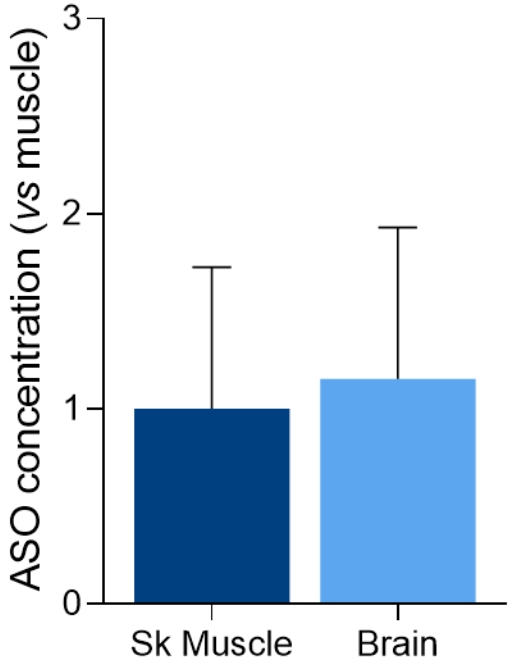
Adapted from Ohrt T., et al. *Nucleic Acids Res* 2006;34:1369.

FORCE Enabled Delivery to Muscle and CNS

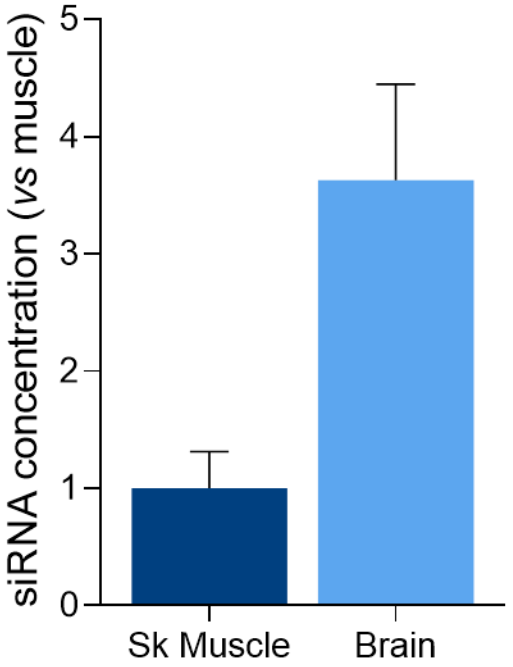
FORCE-PMO



FORCE-ASO



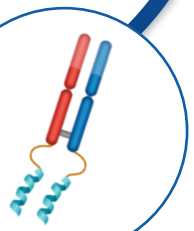
FORCE-siRNA



Notes: All data from cynomolgus monkeys. FORCE-PMO data are means + SD; n = 6; FORCE-ASO data are means + SD; n = 8; FORCE-siRNA data are means + SD; n = 2. Tissue collection for all studies between 48 – 72h. Sk Muscle = skeletal muscle (tibialis anterior).

FORCE Platform Designed to Deliver Significant Advantages

Provide Functional Improvement



Targeted Delivery

Leverages TfR1 expression on skeletal, cardiac, and smooth muscle as well as blood-brain-barrier

Targets Genetic Basis of Disease

Rationally select payloads to match target biology

Redosable administration

Durable efficacy and treatment optionality

Enhanced Tolerability

Targeted delivery limits systemic drug exposure and use of Fab minimizes disruption to TfR1 receptor

Extended Durability

Potential for prolonged disease-modifying effects, enabling less frequent dosing

Reduced Development and Manufacturing Costs

A single Fab utilized across all programs

Neuromuscular Pipeline Leveraging Clinically Validated Platform

DISEASE & PREVALENCE	TARGET	PRECLINICAL	CLINICAL	REGISTRATIONAL	COMMERCIAL
Duchenne muscular dystrophy (DMD) US: ~12,000 Europe: ~16,000	Exon 51	Zeleciment rostudirsen (z-rostudirsen)			★ *PDUFA Jan 21, 2027*
Myotonic dystrophy type 1 (DM1) US: ~40,000 Europe: ~55,000	DMPK	Zeleciment basivarsen (z- basivarsen)			
Facioscapulohumeral muscular dystrophy (FSHD) US: ~15,000-40,000 Europe: ~20,000-50,000	DUX4	DYNE-302 ★ *IND Cleared*			
Duchenne muscular dystrophy (DMD) US: ~12,000 Europe: ~16,000	Exon 44	DYNE-244			
	Exon 45	DYNE-245			
	Exon 53	DYNE-253			
	Exon 55	DYNE-255			
Pompe disease US: ~4,500 Europe: ~5,500	GAA	DYNE-401			

PIPELINE EXPANSION OPPORTUNITIES: CNS, Rare skeletal, Cardiac, Metabolic

Exon 51 Skip Amenable DMD: A More Severe Duchenne Population with Significant Unmet Need, Despite Approved Therapies

DMD Population

- ~12,000 (US)
- ~16,000 (EU)
- ~ 13% is exon 51 skip amenable[1]

Clinical Presentation

- Mutation in *DMD* gene for dystrophin
  - Exon 51 skip amenable DMD is a particularly challenging form
- Muscle weakness and gait abnormalities
- Progressive loss of function
- Cognitive issues
- Respiratory/cardiac failure
- Life expectancy ~30 years[2]

Current Treatment Limitations

- Limited delivery to muscle and CNS
- High burden due to weekly IV dosing[3]
- <1% dystrophin production with exon 51 skipping therapy[3]
- Microdystrophin lacks domains key for optimal functionality[4]
- Unknown durability and inability to redose with gene therapy
- Safety considerations



OUR APPROACH

Potential Best-in-Class Targeted Exon Skipping

Increase dystrophin expression and enable less frequent dosing to deliver **functional improvement**

1. Aartsma-Rus et al. *Hum Mutat*. 2009;30:293-299 2. Broomfield et al. *Neurology*. 2021;97:e2304-e2314; 3. Exondys 51 Prescribing Information; 4. Chamberlain et al. *Hum Gene Ther* 2023;34:404–15.
DMD, Duchenne muscular dystrophy, CNS, central nervous system; Q1W, every 1 week.

Functional Improvement in DMD Requires Therapeutic Approaches that Improve the Quantity, Quality and Distribution of Dystrophin



Increased dystrophin production[1-3]

Production of high-quality dystrophin[3-6]

Broad and effective distribution of dystrophin restorative treatments to affected muscles and the CNS[3, 7-9]

Functional improvement

CNS, central nervous system; DMD, Duchenne muscular dystrophy.

1. De Feraudy Y, et al. Ann *Neurol*. 2021;89(2):280-292; 2. Godfrey C, et al. *Hum Mol Genet*. 2015;24(15):4225-4237; 3. Roberts TC, et al. *Nat Rev Drug Discov*. 2023;22(11):917-934; 4. Waldrop MA, et al. *J Neuromuscul Dis*. 2020;7(3):217-229; 5. Torelli S, et al. *J Neuropathol Exp Neurol*. 2021;80(10):955-965; 6. Bez Batti Angulski A, et al. *Front Physiol*. 2023;14:118310; 7. Moriyama H, et al. *RNA Biol*. 2026;23(1):1-17; 8. Vacca O, et al. *J Neuromuscul Dis*. 2026;13(2):167-178; 9. Godfrey C, et al. *EMBO Mol Med*. 2017;9(5):545-557

DELIVER Trial to Support Accelerated Approval of Z-Rostudirsen in DMD

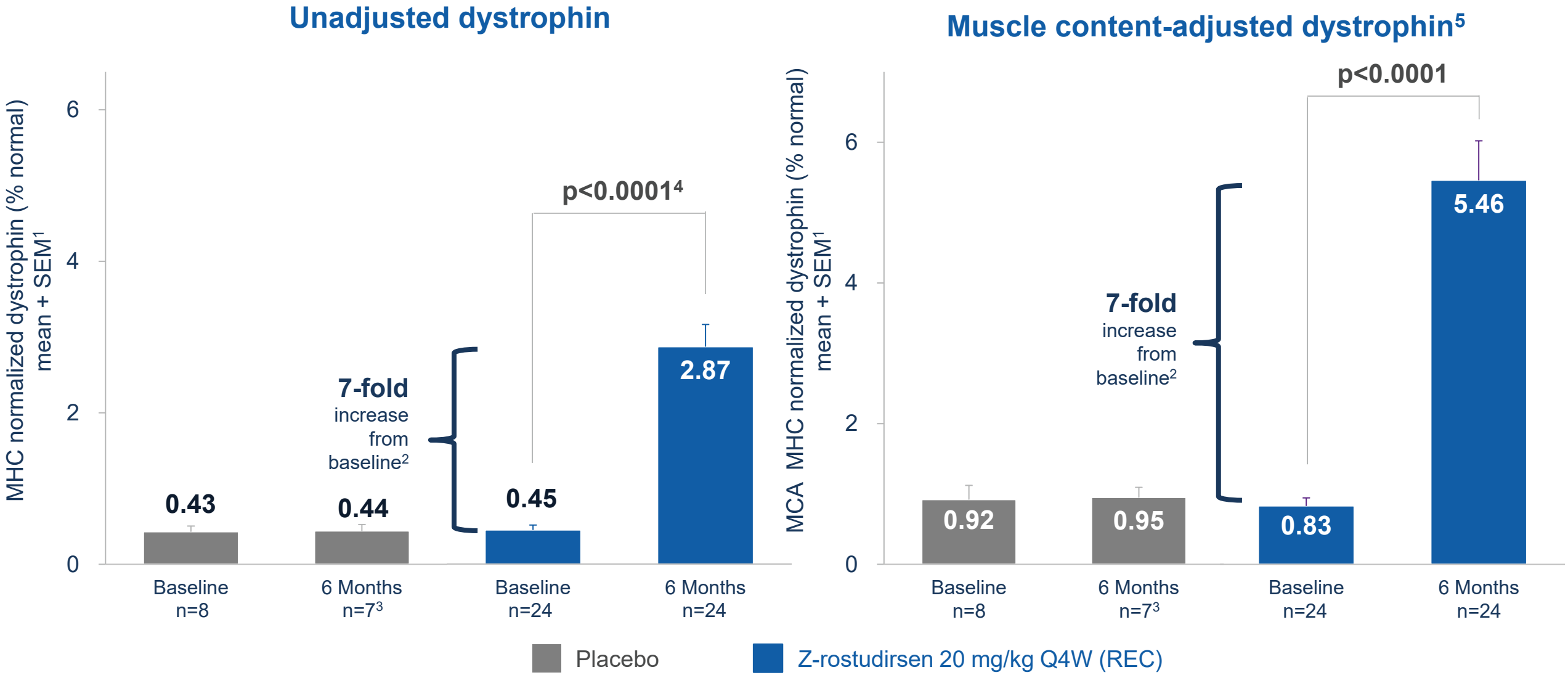


- ✓ Selection of registrational dose (20 mg/kg Q4W) based on multiple ascending dose (MAD) data
- ✓ Registrational Expansion Cohort met primary endpoint of statistically significant and robust increase in quantity of near-full length dystrophin at 6 months ($p<0.0001$)
- ✓ Functional improvement observed across multiple clinical measures out to 24 months
- ✓ Favorable safety profile[1]
- **May 2026** BLA submitted for U.S. Accelerated Approval based on positive results from Registrational Expansion Cohort

Confirmatory Phase 3 trial ongoing

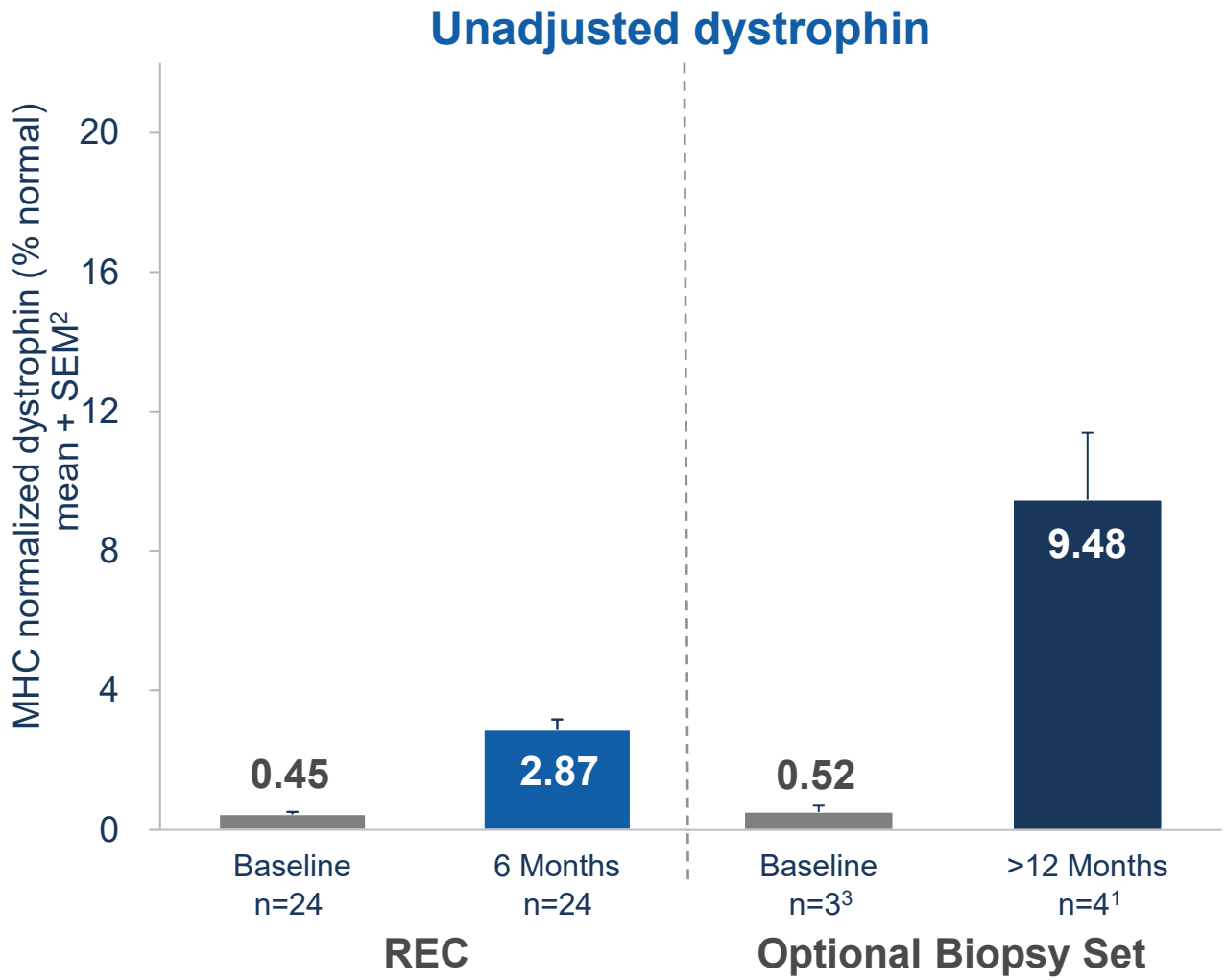
Note: DELIVER is a Phase 1/2 global placebo-controlled clinical trial evaluating multiple doses of z-rostudirsen in ambulant and non-ambulant males with Duchenne muscular dystrophy (DMD) who are ages 4 to 16 and have mutations amenable to exon 51 skipping.
1. Safety data as of August 19, 2025.

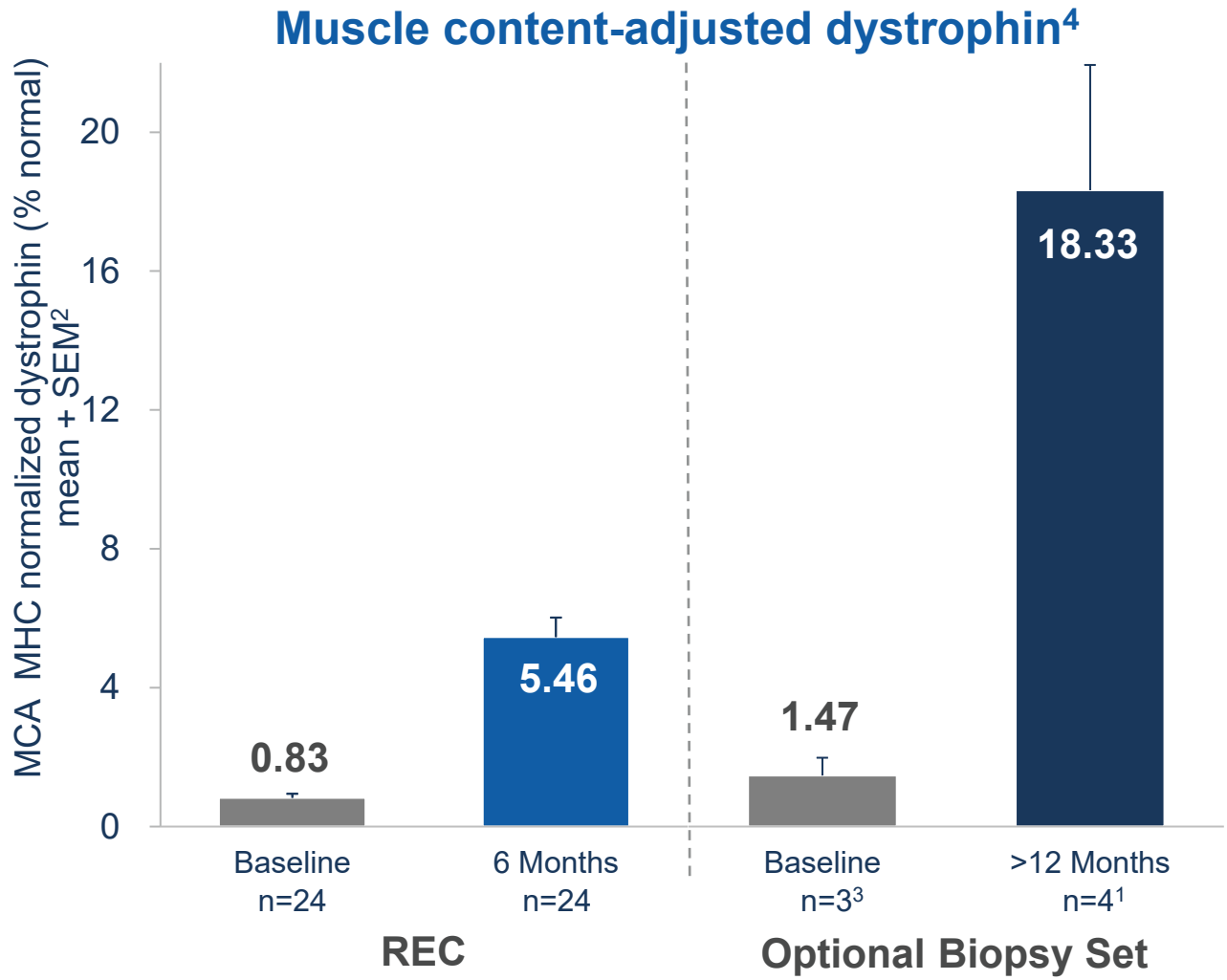
Z-Rostudirsen Achieved a Statistically Significant and Robust Increase in Dystrophin Expression at 6M in Registrational Expansion Cohort



1. Biopsies taken approximately 28 days after most recent dose. 2. Based on geometric mean. 3. One REC placebo participant sample could not be analyzed at Week 25. 4. Prespecified nominal p-value with no adjustment for multiplicity. 5. Muscle content-adjusted dystrophin = MHC normalized dystrophin / % muscle content. 6 months = Week 25 for DELIVER; REC, registrational expansion cohort; MCA, muscle content-adjusted; MHC, myosin heavy chain; Q4W, every 4 weeks; SEM, standard error of the mean.

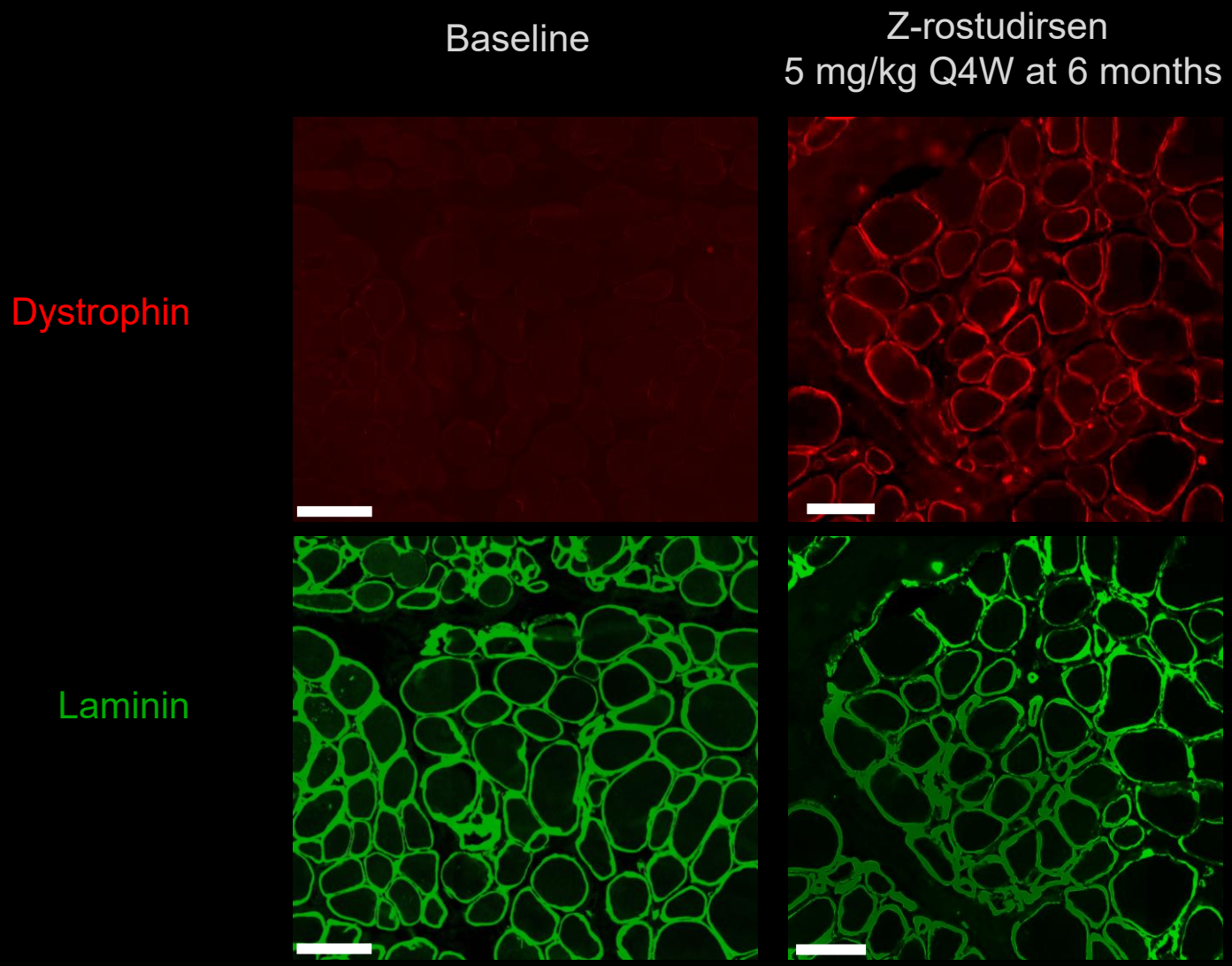
Dystrophin Levels Observed in Optional Biopsies from Participants Treated with 20 mg/kg Q4W Z-Rostudirsen for >12M[1]





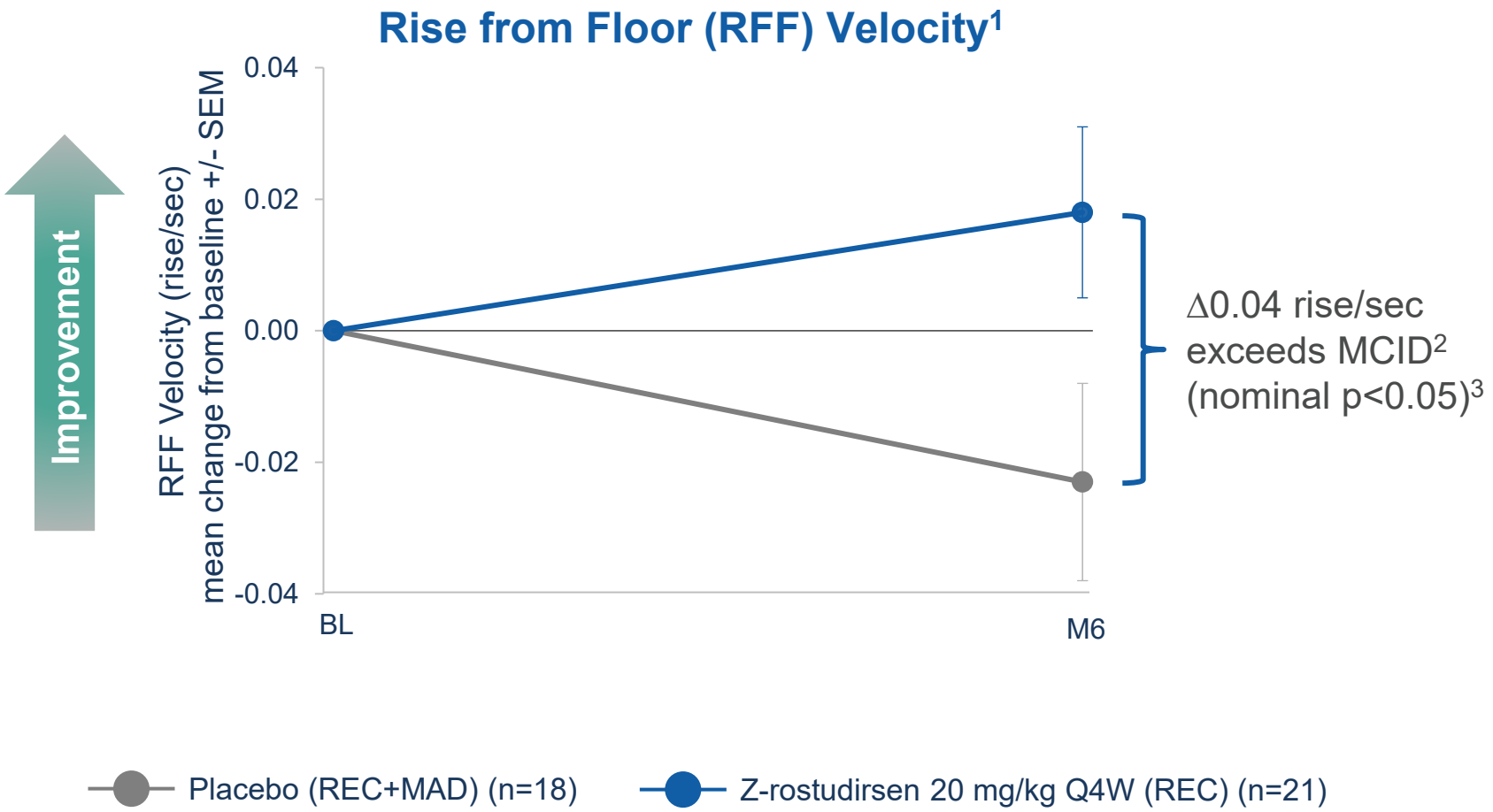
1. >12 month data reflect 4 participants who were dosed with 20 mg/kg Q4W for 67-104 weeks at the time of biopsy. This biopsy was optional per trial protocol in participants who received at least 48 weeks of 20 mg/kg Q4W z-rostudirsen treatment. The sample reported here reflects all optional biopsies collected. 2. Biopsies in REC taken approximately 28 days after most recent dose; optional biopsies taken after at least 48 weeks of 20 mg/kg Q4W z-rostudirsen treatment. 3. Baseline biopsies are pre-treatment biopsies for 3 participants with >12M optional biopsies. One participant with a >12M optional biopsy did not have a baseline biopsy. 4. Muscle content-adjusted dystrophin = MHC normalized dystrophin / % muscle content. 6 months = Week 25 for DELIVER; > 12M = Greater than 48 weeks. REC, registrational expansion cohort; MCA, muscle content-adjusted; MHC, myosin heavy chain; Q4W, every 4 weeks; SEM, standard error of the mean.

Z-Rostudirsen Led to Dystrophin Localization to Sarcolemma with Uniform Distribution



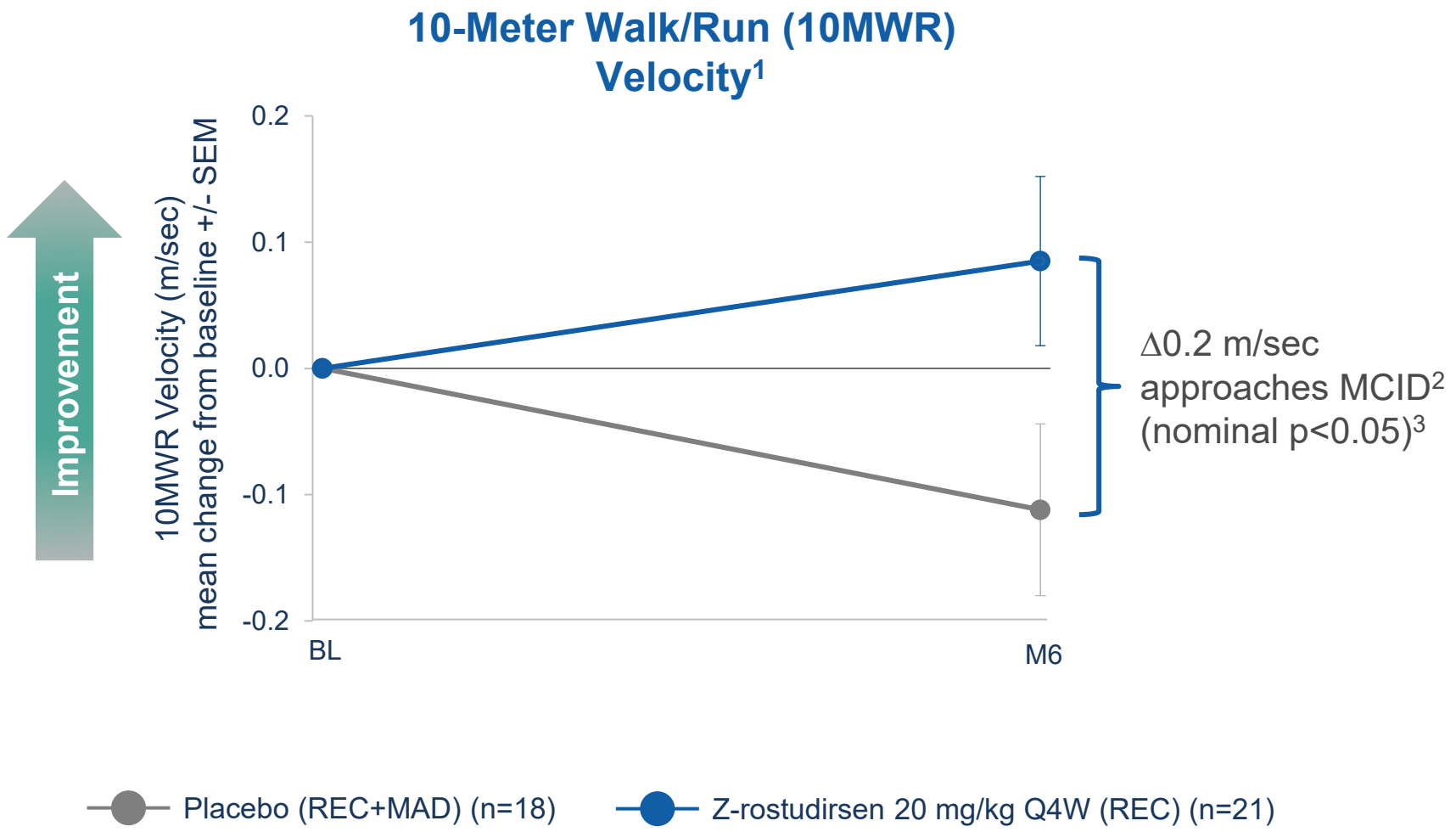
Notes: DELIVER biopsy taken approximately 28 days after most recent dose. Scale bar is 100 µm. Data from MAD portion of DELIVER.

Improvement in RFF Velocity at 6 Months Exceeded MCID Relative to Placebo with Nominal p<0.05[3]



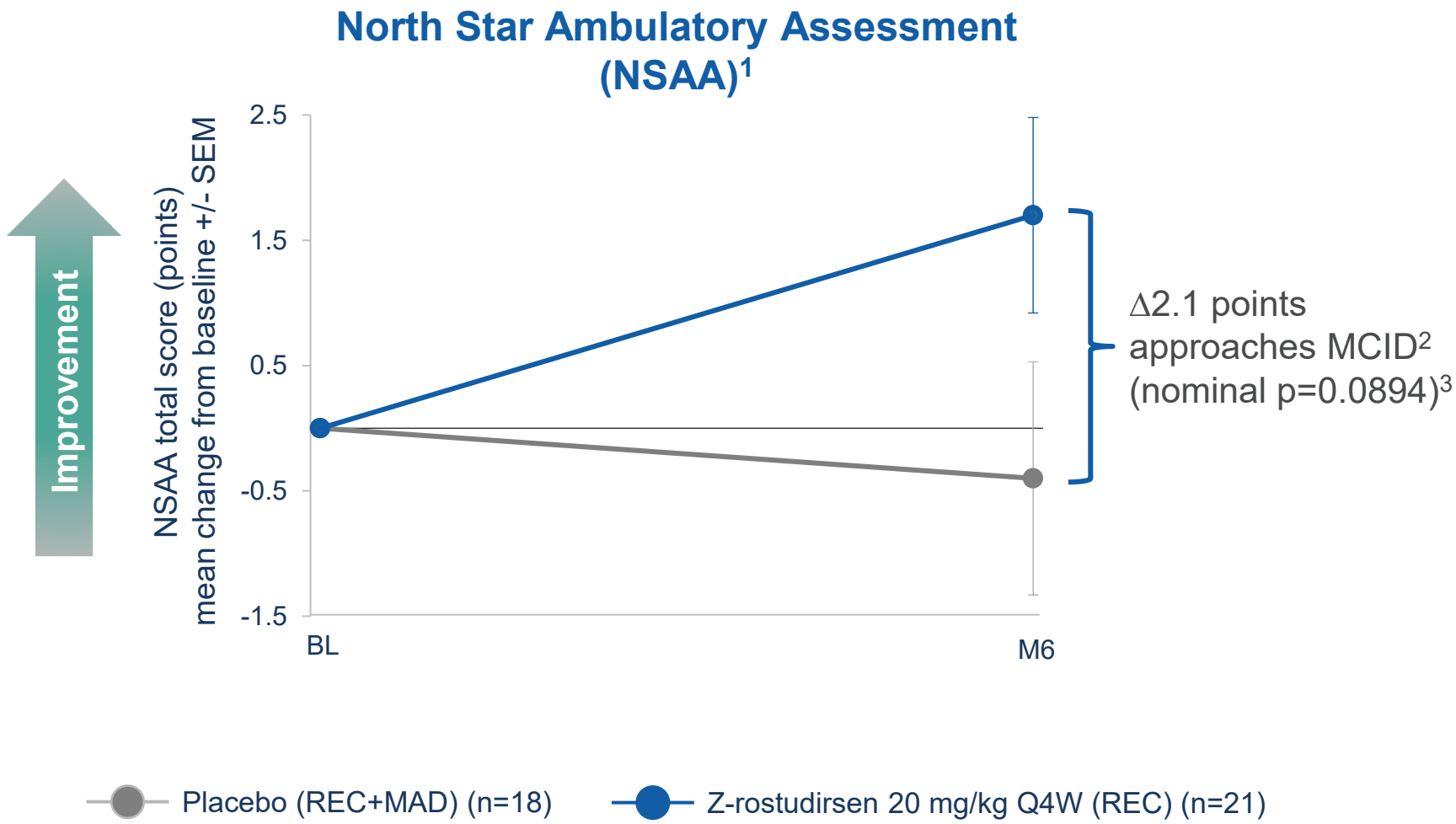
1. Ambulant participants; out-of-threshold or missing values imputed; rise from floor (RFF) velocity also known as time to rise (TTR) velocity. 2. Duong et al. *J Neuromusc Dis.* 2021; 8(6):939-948; MCID = 0.023 rise/sec. 3. Post-hoc analysis; prespecified statistical analysis plan did not include formal hypothesis testing for any functional endpoint. BL, baseline; M6 = 169 days; M, month; sec, seconds; SEM, standard error of mean; MCID, minimal clinically important difference; REC, registrational expansion cohort; MAD, multiple ascending dose; Q4W, every 4 weeks.

Improvement in 10MWR Velocity at 6 Months Relative to Baseline and Placebo with Nominal p<0.05[3]



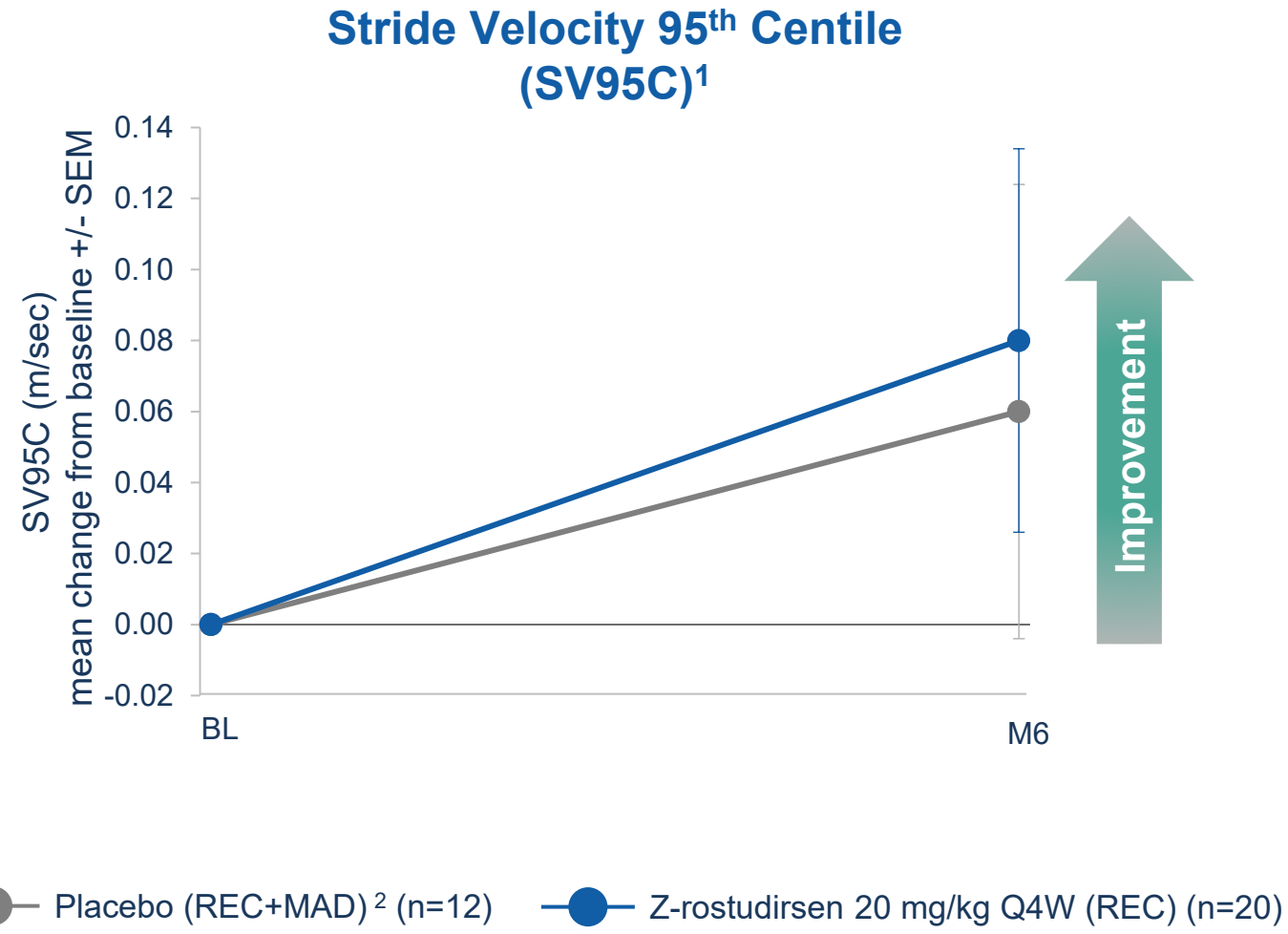
1. Ambulant participants; out-of-threshold or missing values imputed. 2. Duong et al. *J Neuromusc Dis.* 2021; 8(6):939-948; MCID = 0.212 m/sec. 3. Post-hoc analysis; prespecified statistical analysis plan did not include formal hypothesis testing for any functional endpoint. BL, baseline; M6 = 169 days; M, month; sec, seconds; SEM, standard error of mean; MCID, minimal clinically important difference; REC, registrational expansion cohort; MAD, multiple ascending dose; Q4W, every 4 weeks.

Improvement in NSAA at 6 Months Relative to Baseline and Placebo



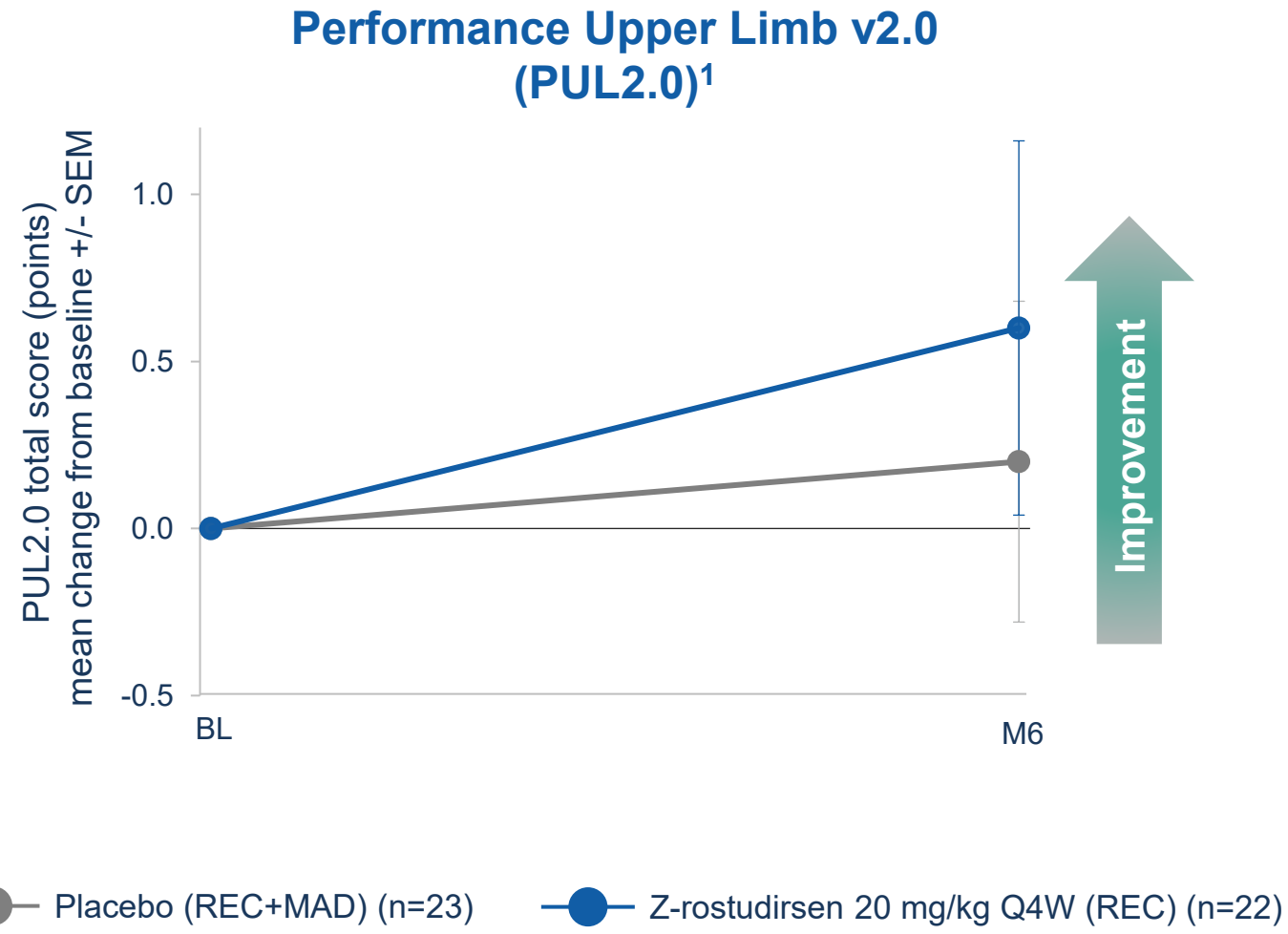
1. Ambulant participants; missing values imputed. 2. Ayyar Gupta et al. *PLoS One.* 2023 Apr 26;18(4):e0283669; MCID ≥2.3 points. 3. Post-hoc analysis; prespecified statistical analysis plan did not include formal hypothesis testing for any functional endpoint. BL, baseline; M6 = 169 days; M, month; sec, seconds; SEM, standard error of mean; MCID, minimal clinically important difference; REC, registrational expansion cohort; MAD, multiple ascending dose; Q4W, every 4 weeks.

Improvement in SV95C at 6 Months Relative to Baseline



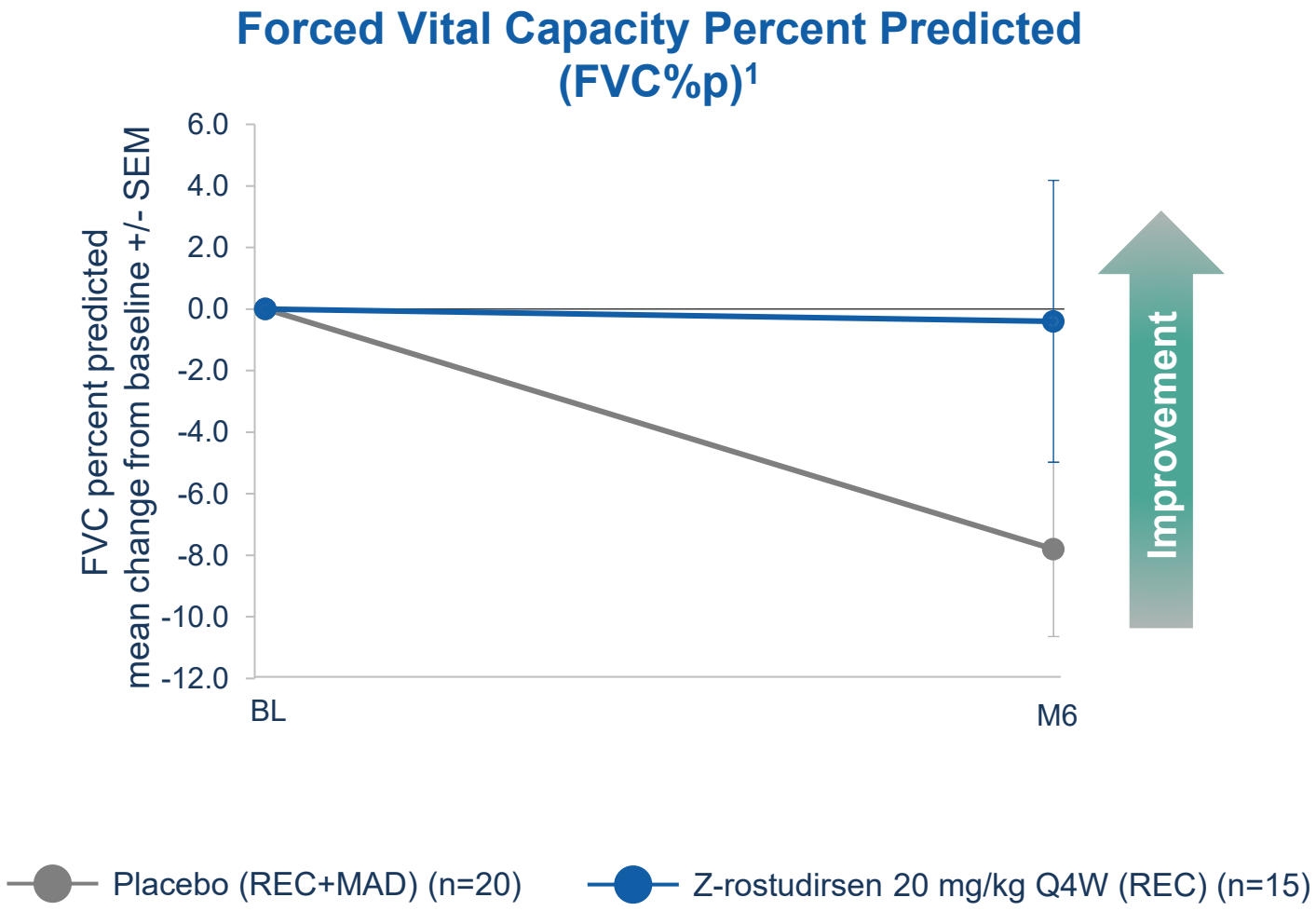
1. Ambulant participants; missing values imputed. 2. Placebo impacted by single participant with change from baseline of 0.46 m/sec at 6M; if this participant were excluded, mean change from baseline at 6M for placebo would be approximately 0.02 m/sec. BL, baseline; M6 = 169 days; M, month; sec, seconds; SEM, standard error of mean; REC, registrational expansion cohort; MAD, multiple ascending dose; Q4W, every 4 weeks.

Improvement in PUL2.0 at 6 Months in Ambulant and Non-Ambulant Participants Relative to Baseline and Placebo



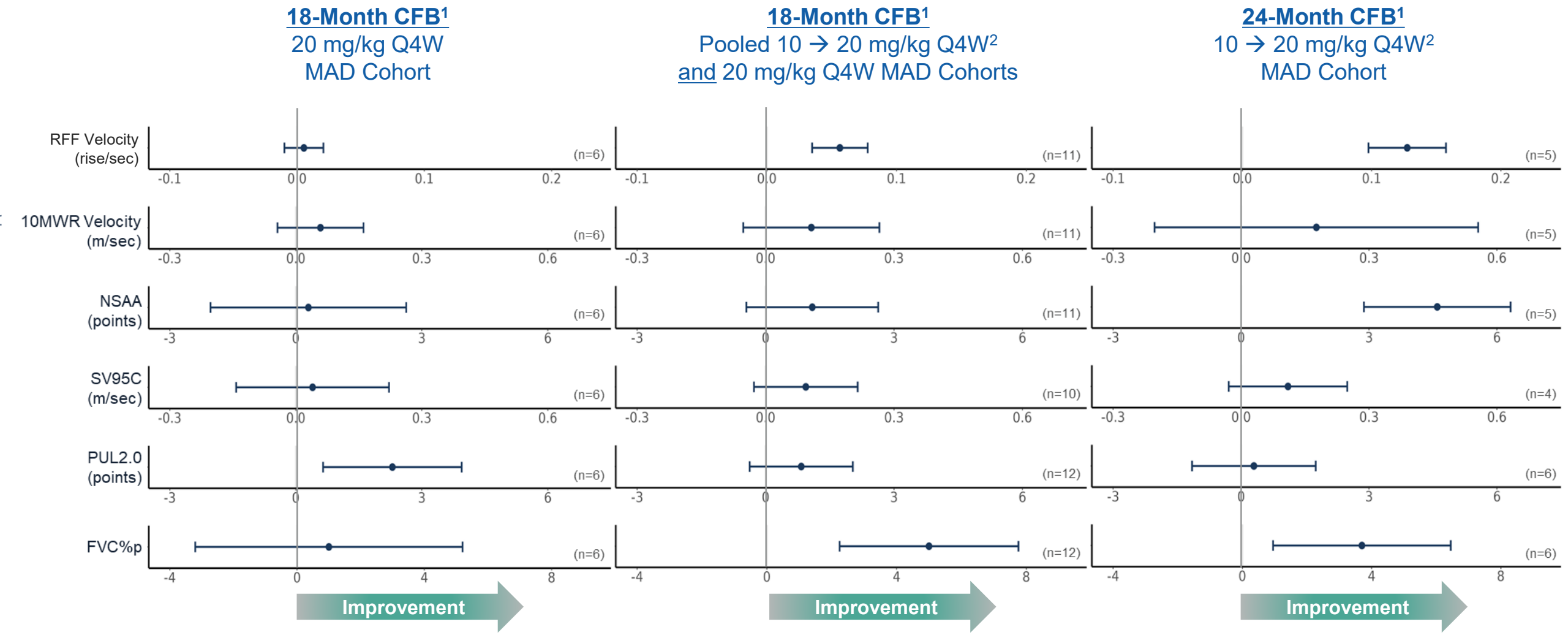
1. Ambulant and non-ambulant participants; missing values imputed. BL, baseline; M6 = 169 days; M, month; sec, seconds; SEM, standard error of mean; REC, registrational expansion cohort; MAD, multiple ascending dose; Q4W, every 4 weeks.

Preservation of Lung Function at 6 Months



1. Ambulant and non-ambulant participants. BL, baseline; M6 = 169 days; M, month; sec, seconds; SEM, standard error of mean; REC, registrational expansion cohort; MAD, multiple ascending dose; Q4W, every 4 weeks.

Sustained Functional Improvement Compared to Baseline Across All 6 Measures up to 24 Months in a Broad Participant Population



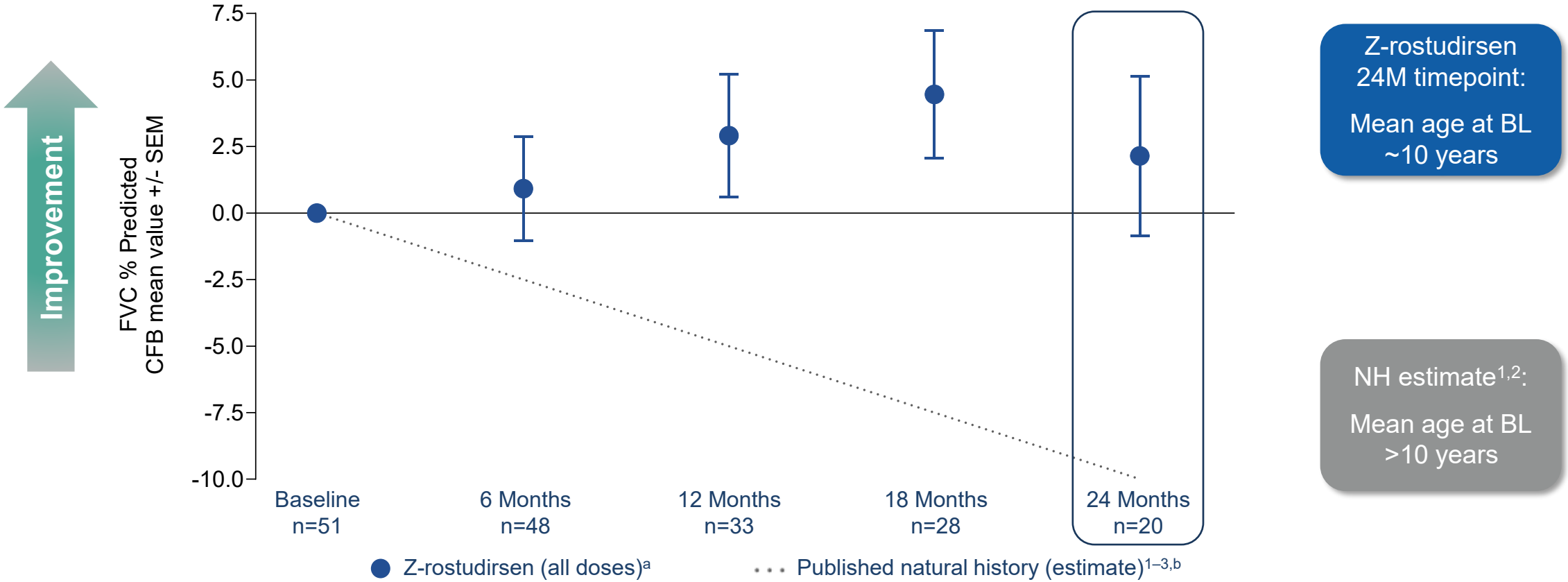
1. Mean change from baseline +/- SEM; RFF velocity, 10MWR velocity, NSAA, and SV95C analyzed from ambulant participants; PUL2.0 and FVC%p analyzed from ambulant and non-ambulant participants; Out-of-threshold and/or missing values imputed except for FVC%p. 2. Participants transitioned from 10 mg/kg Q4W to 20 mg/kg Q4W after 6M; all participants treated with 20 mg/kg Q4W for at least 12M in the 24M assessment. Q4W, every 4 weeks; CFB, change from baseline; MAD, multiple ascending dose; RFF, rise from floor, also known as time to rise (TTR); 10MWR, 10-meter walk/run; NSAA, north star ambulatory assessment; SV95C, stride velocity 95th centile; PUL2.0, performance upper limb v2.0; FVC%p, forced vital capacity percent predicted.

Unprecedented Breadth and Durability of Functional Improvement with Z-Rostudirsen

BREADTH			DURABILITY	
Endpoint	**Patient Population**	**Muscle System**	**6-month Functional Improvement vs. Placebo[1]**	**24-month Functional Improvement vs. Baseline[2]**
RFF Velocity	Ambulatory	Trunk & lower limbs	✓	✓
10MWR Velocity	Ambulatory	Lower limbs	✓	✓
NSAA	Ambulatory	Upper limbs, trunk & lower limbs	✓	✓
SV95C	Ambulatory	Lower limbs	✓	✓
PUL2.0	Ambulatory & non-ambulatory	Upper limbs	✓	✓
FVC%p	Ambulatory & non-ambulatory	Diaphragm & trunk	✓	✓

1. Reflects results from 6-month placebo-controlled Registrational Expansion Cohort of DELIVER trial with 20 mg/kg Q4W z-rostudirsen. Check mark represents numerically higher value relative to placebo (nominal $p<0.05$ for RFF Velocity and 10MWR Velocity; prespecified statistical analysis plan did not include formal hypothesis testing for any functional endpoint). 2. Reflects 24-month results from the long-term portions of the DELIVER trial for participants who transitioned from 10 mg/kg Q4W to 20 mg/kg Q4W after 6M; all participants treated with 20 mg/kg Q4W for at least 12M in the 24M assessment. Check mark represents numerically higher value relative to baseline.

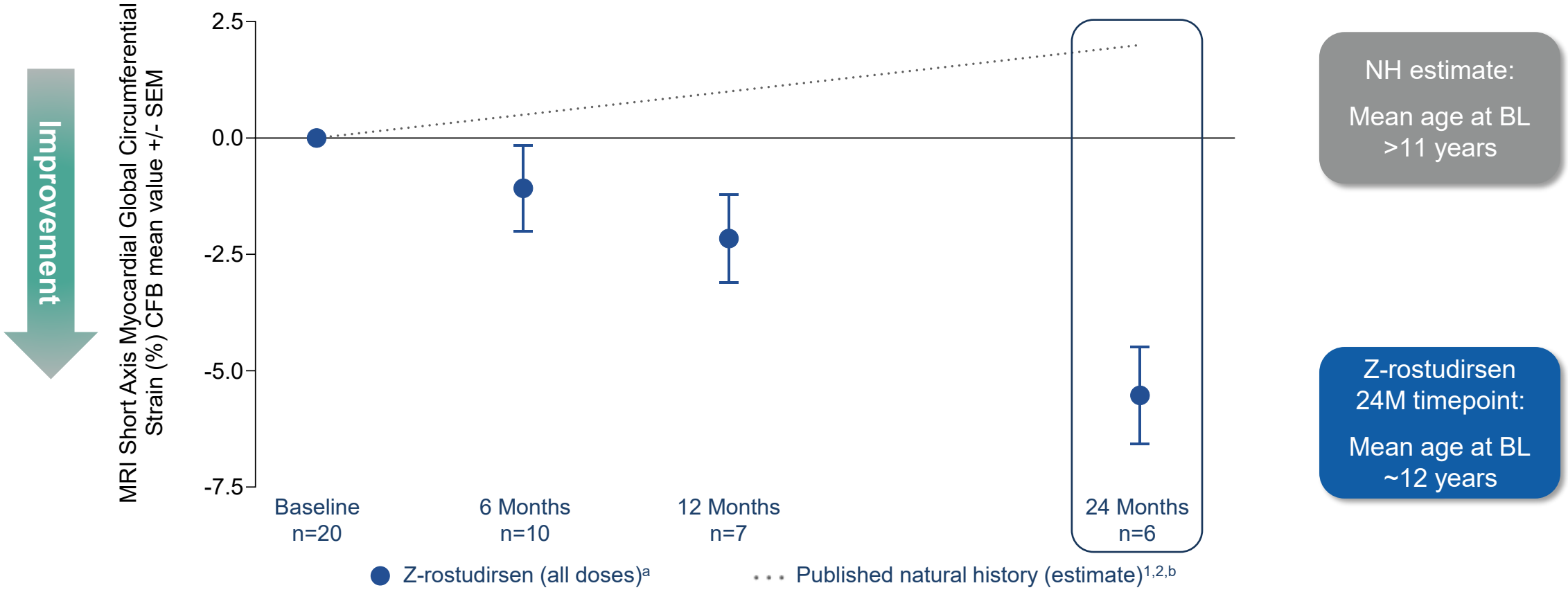
Long-term Lung Function with Z-Rostudirsen Compared to Published Natural History Data



- The majority of participants at the 24M timepoint initiated treatment at the 0.7–2.8 mg/kg Q4W dose levels. One participant initiated treatment at 20 mg/kg Q4W
- All participants at the 24M timepoint received 20 mg/kg Q4W z-rostudirsen for ≥9 months

Results are reported as mean CFB through 24 months and presented with SEM.
a. Shown are all DELIVER participants (REC + MAD) randomized to z-rostudirsen treatment at baseline (any dose, including dose escalation[s] or de-escalation) and for whom FVC%p data were available. b. Based on 2-year published natural history data; assumes ~5%/year decline in FVC%p.
BL, baseline; CFB, change from baseline; FVC%p, forced vital capacity percent predicted; MAD, multiple ascending dose; NH, natural history; REC, registrational expansion cohort; SEM, standard error of the mean.
1. Mayer OH, et al. *Pediatr Pulmonol.* 2015;50:487–494; 2. McDonald CM, et al. *Neuromuscul Disord.* 2018;28:897–909; 3. Meier T, et al. *Neuromuscul Disord.* 2017;27:307–314.

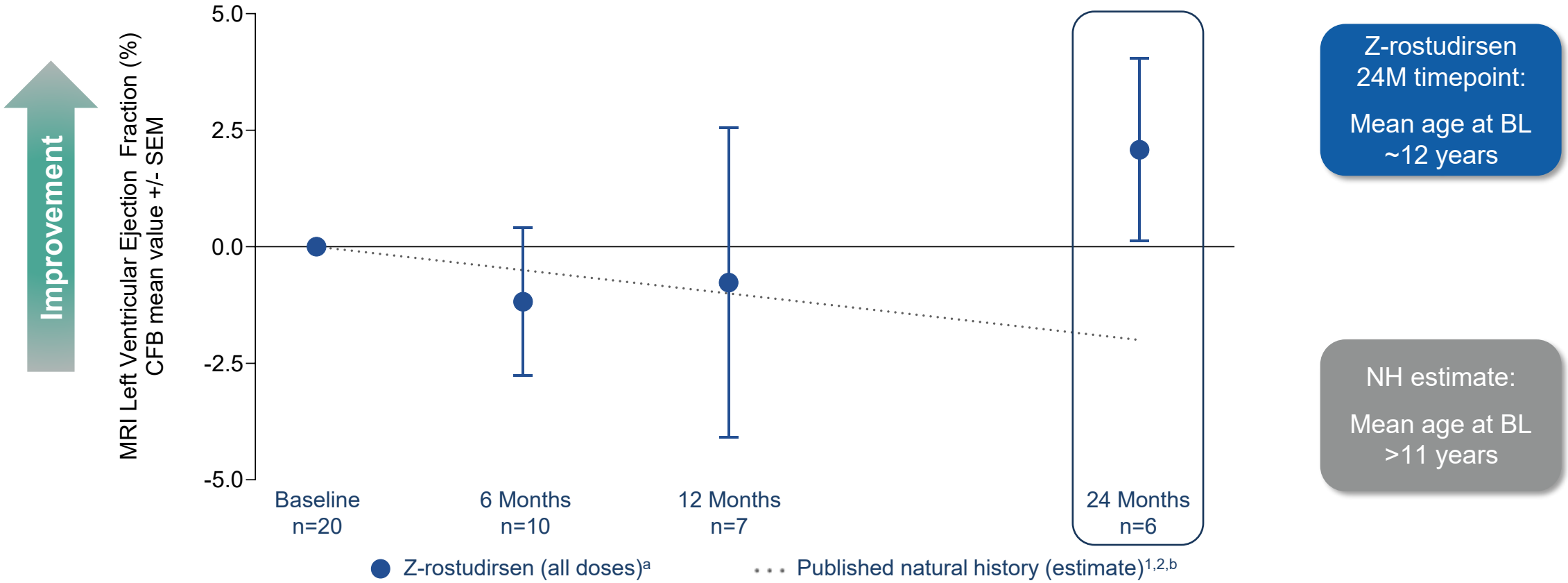
CMR-based Circumferential Strain in Z-Rostudirsen-treated Participants Compared to Published Natural History Data



- The majority of participants at the 24M timepoint initiated treatment at the 0.7–2.8 mg/kg Q4W dose levels. One participant initiated treatment at 20 mg/kg Q4W
- All participants at the 24M timepoint received 20 mg/kg Q4W z-rostudirsen for ≥6 months

Results are reported as mean CFB through 24 months and presented with SEM.
a. Shown are all DELIVER participants (REC + MAD) randomized to z-rostudirsen treatment at baseline (any dose, including dose escalation[s] or de-escalation) and for whom circumferential strain data were available. b. Based on 2-year published natural history data; assumes ~1%/year decline in strain.
BL, baseline; CFB, change from baseline; CMR, cardiac magnetic resonance; MAD, multiple ascending dose; MRI, magnetic resonance imaging; NH, natural history; REC, registrational expansion cohort; SEM, standard error of the mean.
1. Batra A, et al. BMC Cardiovasc Disord. 2022;22:260, 2. Hagenbuch SC, et al. Am J Cardiol. 2010;105:1451–1455.

CMR-based Left Ventricular Ejection Fraction in Z-Rostudirsen-treated Participants Compared to Published Natural History Data



- The majority of participants at the 24M timepoint initiated treatment at the 0.7–2.8 mg/kg Q4W dose levels. One participant initiated treatment at 20 mg/kg Q4W
- All participants at the 24M timepoint received 20 mg/kg Q4W z-rostudirsen for ≥6 months

Results are reported as mean CFB through 24 months and presented with SEM.
a. Shown are all DELIVER participants (REC + MAD) randomized to z-rostudirsen treatment at baseline (any dose, including dose escalation[s] or de-escalation) and for whom left ventricular ejection fraction data were available.
b. Based on 2-year published natural history data; assumes ~1%/year decline in LVEF.
BL, baseline; CFB, change from baseline; CMR, cardiac magnetic resonance; LVEF, left ventricular ejection fraction; MAD, multiple ascending dose; MRI, magnetic resonance imaging; NH, natural history; REC, registrational expansion cohort; SEM, standard error of the mean.
1. Batra A, et al. BMC Cardiovasc Disord. 2022;22:260, 2. Hagenbuch SC, et al. Am J Cardiol. 2010;105:1451–1455.

Z-Rostudirsen: Favorable Safety Profile

Summary of treatment-emergent adverse events (TEAEs)[1]

Study Period	Placebo-Controlled (PC) Period (0 to 6M)		All Study Periods (0 to ≤36M)
Participants with ≥1 TEAE – n (%)	Placebo (MAD+REC) N=24[2]	Z-rostudirsen 20 mg/kg Q4W (MAD+REC) N=30[3]	Z-rostudirsen Pooled doses[4] (MAD+REC) N=85[5]
Any TEAE	22 (91.7)	29 (96.7)	80 (94.1)
Any related TEAE	3 (12.5)	10 (33.3)	41 (48.2)
Any serious TEAE	1 (4.2)	2 (6.7)	10 (11.8)
Any serious related TEAE	0	0	4 (4.7)
Any TEAE leading to withdrawal from study	0	0	0
Any TEAE leading to death	0	0	0

Most related TEAEs were mild or moderate

Potentially related serious TEAEs

- 2 participants at 20 mg/kg Q4W (registrational dose)
  - Pyrexia (fever) and malaise[6]
- 2 participants at 40 mg/kg Q4W
  - Acute kidney injury; thrombocytopenia[7]
  - Pancytopenia[8]

Most frequent related TEAEs ≥10%[9]

- Pyrexia (fever) (18%)
- Headache (13%)

Additional safety data at 20 mg/kg Q4W

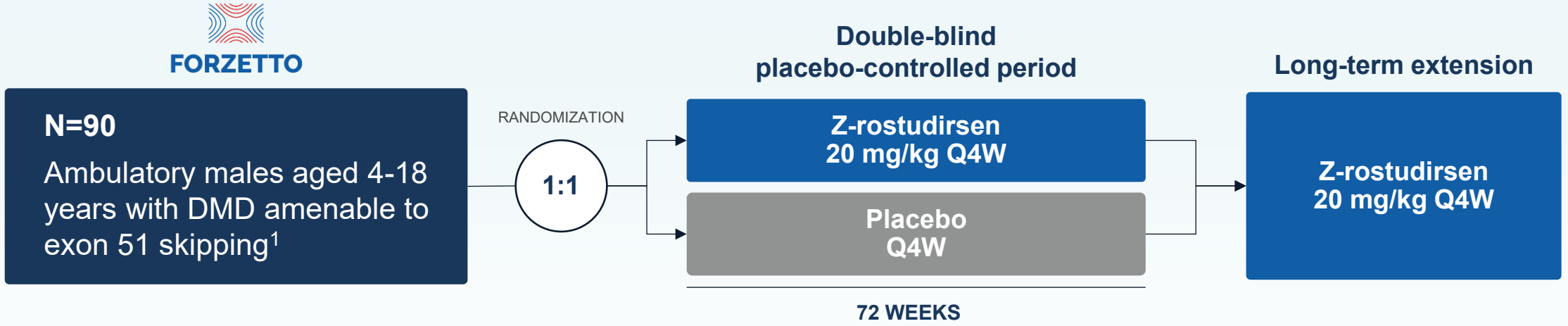
- No participants have persistent related anemia[10] or thrombocytopenia

1,441 doses of z-rostudirsen administered to date representing 113 patient-years of follow-up (up to 36 months)[1]
1,062 doses of z-rostudirsen at 20 mg/kg dose level administered to date[1]

1. Data as of August 19, 2025; all participants, placebo-controlled period, OLE, and LTE. 2. All placebo participants pooled from MAD and REC. 3. All participants randomized to z-rostudirsen 20 mg/kg Q4W in MAD and REC cohorts. 4. All doses of z-rostudirsen from MAD and REC at doses ranging from 0.7 mg/kg to 40 mg/kg every 4 or 8 weeks. 5. One participant randomized to placebo in REC not yet dosed with z-rostudirsen as of August 19, 2025. 6. One participant with same day onset of pyrexia and malaise in OLE and separate single event of pyrexia in LTE; one participant with single event of pyrexia in LTE; both participants fully recovered and have continued to receive z-rostudirsen without interruption. 7. Events had same day of onset in a single participant with a non-serious related TEAE of anemia in the context of fever, hemolysis, diarrhea, and positive blood in stool; together these events were consistent with hemolytic uremic syndrome with a possible infectious etiology. 8. Participant has a history of hemolytic anemia of unidentified etiology; presented with fever and tonsilitis; symptoms resolved without therapeutic intervention. 9. All cohorts combined; preferred terms reported. 10. No participants have persistent related anemia with Hgb levels <11.2 g/dL (threshold for anemia in children (ref: Powers JM. Approach to the child with anemia. UpToDate, Connor RF (Ed), Wolters Kluwer. Accessed December 2, 2025)). M, months; MAD, multiple ascending dose; REC, registrational expansion cohort; Q4W, every 4 weeks; OLE, open-label extension; LTE, long-term extension.

FORZETTO: Confirmatory Phase 3 Trial of Z-Rostudirsen in DMD

- The FORZETTO trial will assess the efficacy, safety and tolerability of z-rostudirsen in exon 51 DMD
- Design and protocol aligned with FDA; intended to serve as confirmatory trial for traditional approval in the U.S. and to support ex-U.S. marketing applications



PRIMARY ENDPOINT

- Change from baseline in RFF velocity[2] at Week 73 in participants treated with z-rostudirsen, as compared to placebo

SELECTED SECONDARY ENDPOINTS

- Muscle function: SV95C, NSAA total score, 10MWR velocity, 4SC velocity, functional composite score[3]
- Lung function: FVC%p
- Patient-reported: PGI-S, PGI-C
- Safety and tolerability

1. Additional eligibility criteria apply as per protocol. 2. Also referred to as time to rise (TTR) velocity. 3. Functional composite score is a global statistical test derived as the average of RFF velocity, SV95C, NSAA total score, 10MWR velocity, and 4SC velocity after standardization for each participant at each visit. 10MWR, 10-meter walk/run test; 4SC, four-stair climb; DMD, Duchenne muscular dystrophy; FVC%p, forced vital capacity percent predicted; NSAA, North Star Ambulatory Assessment; PGI-C, patient global impression of change; PGI-S, patient global impression of severity; RFF, rise from floor; SV95C, stride velocity 95th centile; Q4W, every 4 weeks.

Preparing to Launch into an Established Rare Disease Market with Well-Characterized Patient Population and Treatment Centers

Well Characterized Patient Population

>50%

Exon 51 skip amenable patients have been treated with a disease modifying therapy[1]

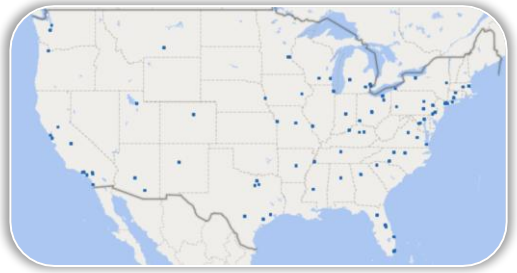
- ~12,000 US DMD population
  - ~1,600 US Exon 51 skip amenable DMD
- Active and educated patient community
- HHS added DMD to RUSP in December 2025

Concentrated Treatment Centers[1]

~80%

of DMD patients cared for at top 100 DMD centers

- Over 80% of top 100 centers have experience prescribing DMTs to exon 51 patients



- Significant overlap expected with DM1 centers

Established Market with Reimbursement

~$1M

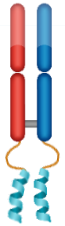
WAC price of currently approved exon skippers for average patient per year[2]

- First exon skipper approved in 2016
- Established reimbursement pathways and clear recognition of unmet need by payers
  - ~ 55% Medicaid, 40% commercial, 5% Medicare/other[1]
- Pricing precedent for exon skippers

1. Based on analysis of claims data. 2. Based on RED BOOK® (Micromedex®) which contains WAC price per vial for existing exon skippers and assumes an average patient weight of 40kg at approved dosage.
DMT, disease modifying therapy; DM1, myotonic dystrophy type 1; HHS, U.S. Department of Health and Human Services; RUSP, recommended uniform screening panel. WAC, wholesale acquisition cost.

Potential of the FORCE Platform Validated by Recent Z-Rostudirsen Topline Clinical Results

FORCE



Design Principles of the FORCE Platform

- TfR1-mediated delivery to muscle, including diaphragm and heart, and CNS with rationally selected payload to match disease biology
- TfR1-binding Fab to enable robust and widespread tissue distribution
- Designed not to interfere with TfR1 function in iron homeostasis
- Achievement of target profile with infrequent dosing

Validation with Z-Rostudirsen DELIVER Data

- Statistically significant and robust increase in dystrophin
- Early and sustained functional improvement across multiple clinical endpoints
- Favorable safety and tolerability[1] with no persistent related anemia[2] or thrombocytopenia at 20 mg/kg
- Convenient Q4W dosing

Dyne's pipeline programs utilize the same TfR1-binding Fab

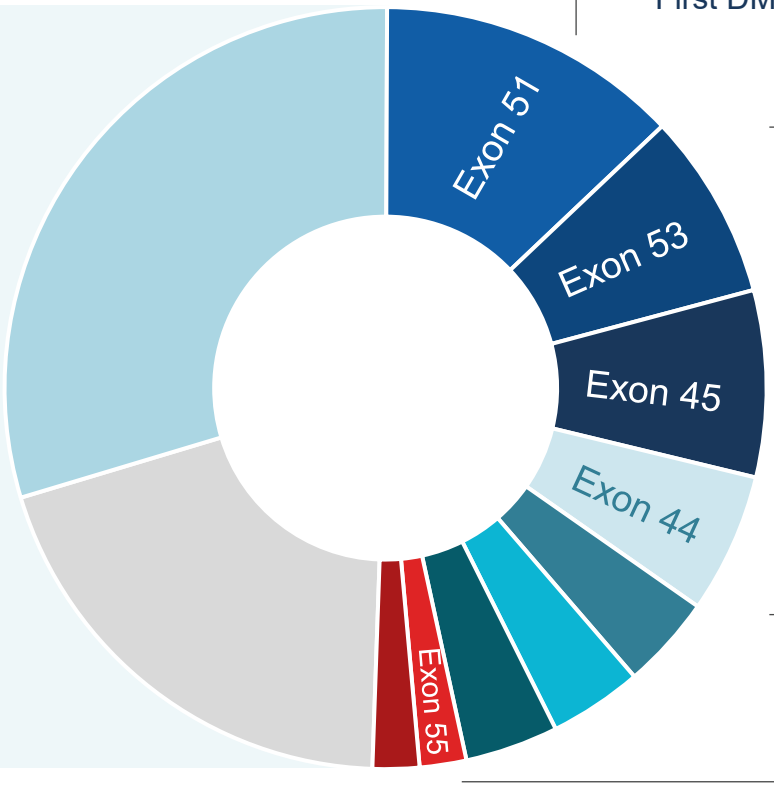
1. Data as of August 19, 2025. 2. No participants have demonstrated persistent related anemia with Hgb levels <11.2 g/dL (threshold for anemia in children (ref: Powers JM. Approach to the child with anemia. UpToDate, Connor RF (Ed), Wolters Kluwer. Accessed December 2, 2025)). TfR1, transferrin receptor 1; CNS, central nervous system; Fab, fragment antibody-binding; Q4W, every 4 weeks.

De-Risked Opportunity to Build a Broader DMD Franchise Potentially Tripling Addressable Patient Population

Approximately

80% of patients

have genotypes amenable to exon skipping



Z-rostudirsen
First DMD program clinically validated

Additional programs in development

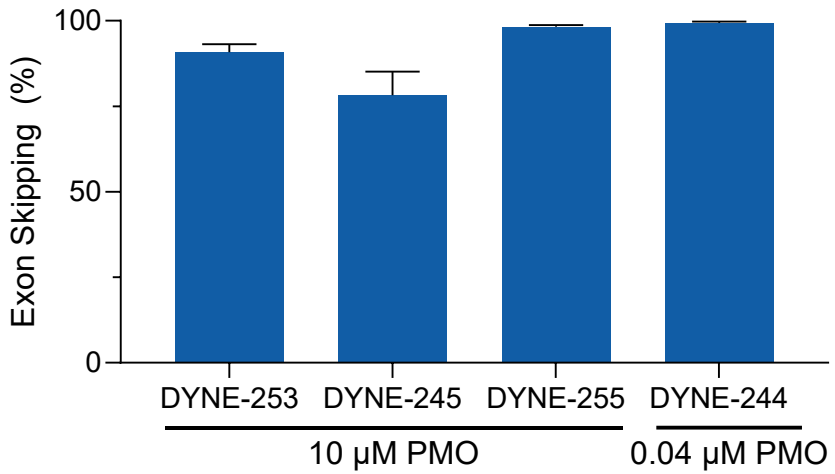
- Exon 51 – 13%
- Exon 53 – 8%
- Exon 45 – 8%
- Exon 44 – 6%
- Exon 50 – 4%
- Exon 52 – 4%
- Exon 43 – 4%
- Exon 55 – 2%
- Exon 8 – 2%
- Other exon skips – ~30%
- May not be amenable to exon skipping – ~20%

DMD franchise assets designed to leverage same Fab, linker, and payload chemistry as z-rostudirsen

Fletcher, S., et. al. Dystrophin Isoform Induction In Vivo by Antisense-mediated Alternative Splicing. The American Society of Gene & Cell Therapy. 2010;18(6):1218-1223. Aartsma-Rus, et al. Theoretic applicability of antisense-mediated exon skipping for Duchenne muscular dystrophy. Hum Mutat. 2009 Mar;30 (3):293-9. DMD = Duchenne muscular dystrophy; Fab = fragment antibody-binding.

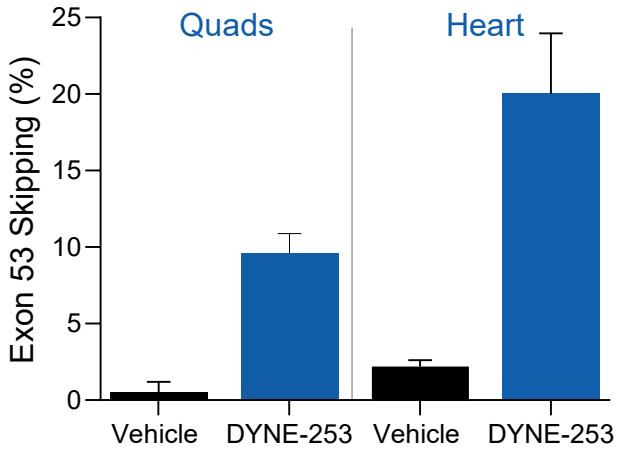
Preclinical Data Support the Ongoing Development of Four Additional DMD Programs

Potent Exon Skipping Confirmed in DMD Myotubes with Patient Relevant Mutations

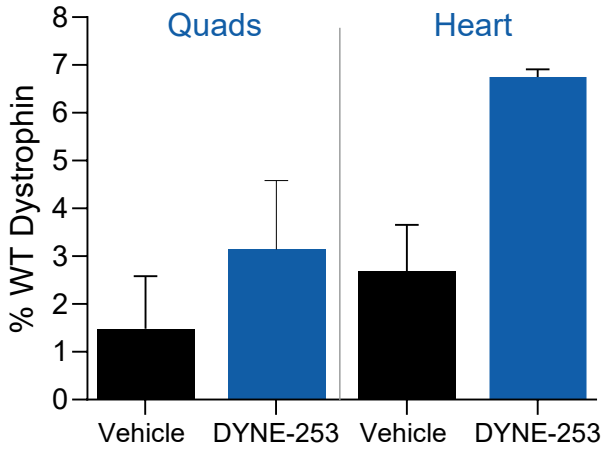


Exon skipping by **DYNE-244** saturated at 0.04 μM **(250x lower dose)**

Exon 53 Skipping



Dystrophin Restoration



Note: The ability of DYNE-253, DYNE-245, DYNE-255 (at a 10 μM payload dose), and DYNE-244 (at 0.04 μM were dose) to induce exon skipping was assessed in cell lines bearing mutations amenable to skipping of their respective payloads. Data are represented as mean ± SD.

Note: All data are after a single IV dose of 30 mg/kg PMO eq DYNE-253 in the hTfR1/hDMDDel52/mdx mouse model. Exon 53 skipping was assessed 7 days post-dose, and dystrophin protein restoration were assessed 28 days post-dose. Data are mean ± S.D.

DM1 is a Devastating Neuromuscular Splicing Disorder

DM1 Population

- ~40,000 (US)
- ~55,000 (EU)

Overview

- Mutation in *DMPK* gene leads to mis-splicing of multiple genes
- Onset at any point, depending on DM1 phenotype
- Life expectancy of 45 - 60 years

Clinical Presentation

- Muscle weakness & myotonia
- CNS manifestations including fatigue, cognition, and sleep
- Gastrointestinal issues
- Cardiac arrhythmia
- Pulmonary abnormalities



OUR APPROACH

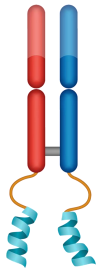
Functional Improvement via Splicing Correction in Nucleus

Restore normal RNA splicing to achieve **functional improvement** for those living with DM1

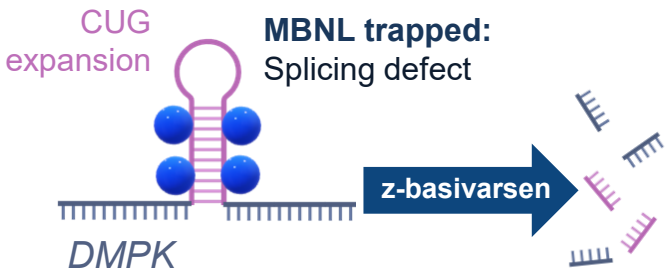
Note: DM1 = myotonic dystrophy type 1; CNS = central nervous system.

Z-Basivarsen Addressing the Central Pathobiology of DM1 to Enable Broad Functional Improvement[1]

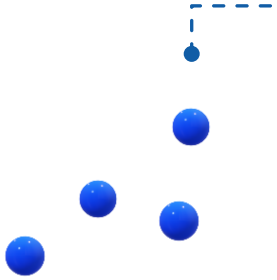
ROBUST AND WIDESPREAD DELIVERY → ***DMPK* DEGRADATION IN THE NUCLEUS** → **MBNL RELEASE AND SPLICING CORRECTION** → **EARLY CLINICAL EFFECT** → **BROAD FUNCTIONAL IMPROVEMENT**



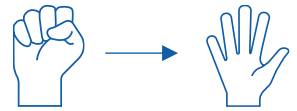
Z-basivarsen



Differentiated MOA



MBNL released:
Splicing corrected



Myotonia:
Video Hand Opening Time (vHOT)

Muscle Strength:
Quantitative Muscle Testing

Functional Assessments:
5 Times Sit to Stand;
10-Meter Walk / Run;
9-Hole Peg Test

Patient Reported Outcomes:
Myotonic Dystrophy Health Index (MDHI)

1. Image depicts the intended z-basivarsen mechanism of action (MOA); DM1 = myotonic dystrophy type 1.

ACHIEVE Trial to Support Accelerated Approval of Z-Basivarsen in DM1

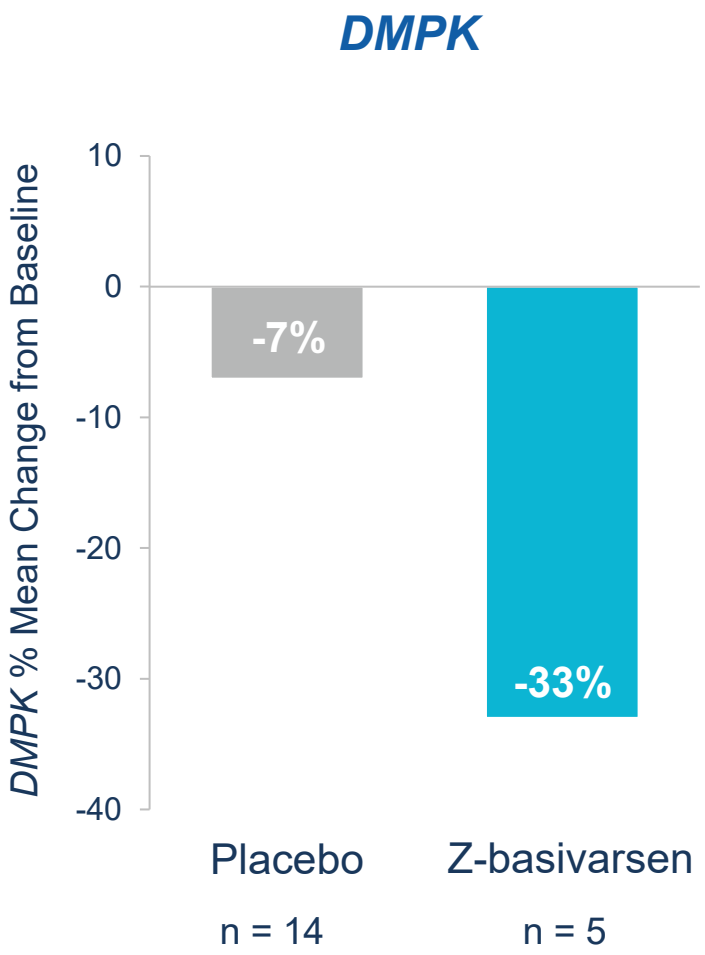


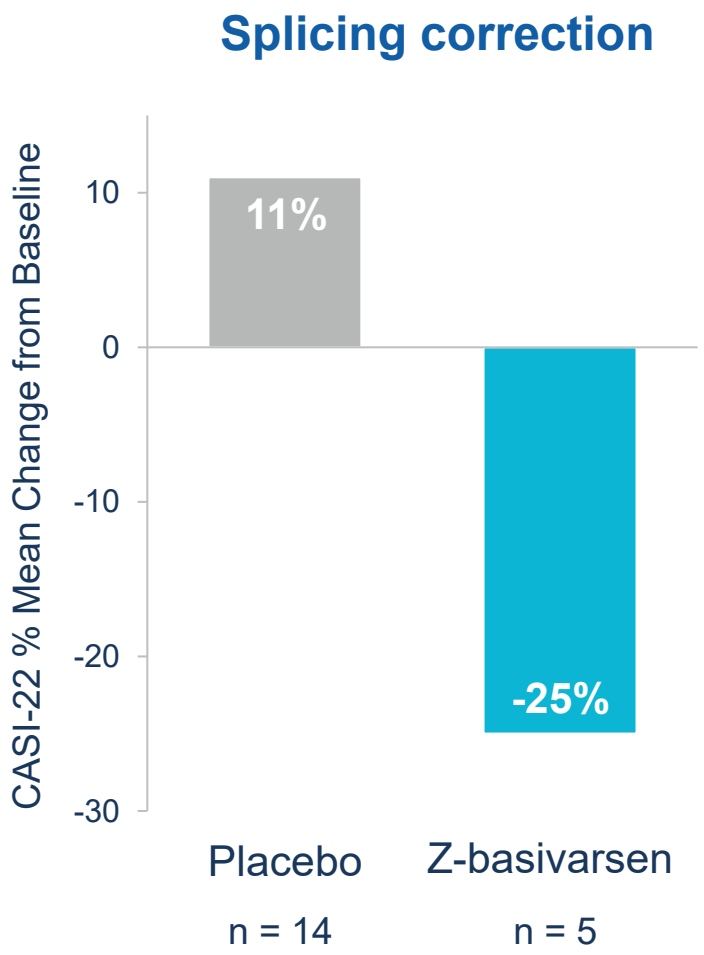
- ✓ Selection of registrational dose (6.8 mg/kg Q8W) based on multiple ascending dose (MAD) data
- ✓ Data support vHOT improvement as early indicator of clinical benefit with z-basivarsen
- ✓ Proof-of-concept that z-basivarsen can reverse disease progression across multiple functional endpoints
- ✓ Favorable safety profile[1]
- Q3 2027 Potential submission for U.S. Accelerated Approval based on data from Registrational Expansion Cohort (REC)

REC enrollment completed; Data planned for Q1 2027
Confirmatory Phase 3 trial ongoing

Note: ACHIEVE is a Phase 1/2 global placebo-controlled clinical trial evaluating multiple doses of z-basivarsen in adult patients with myotonic dystrophy.
1. Data as of April 20, 2026

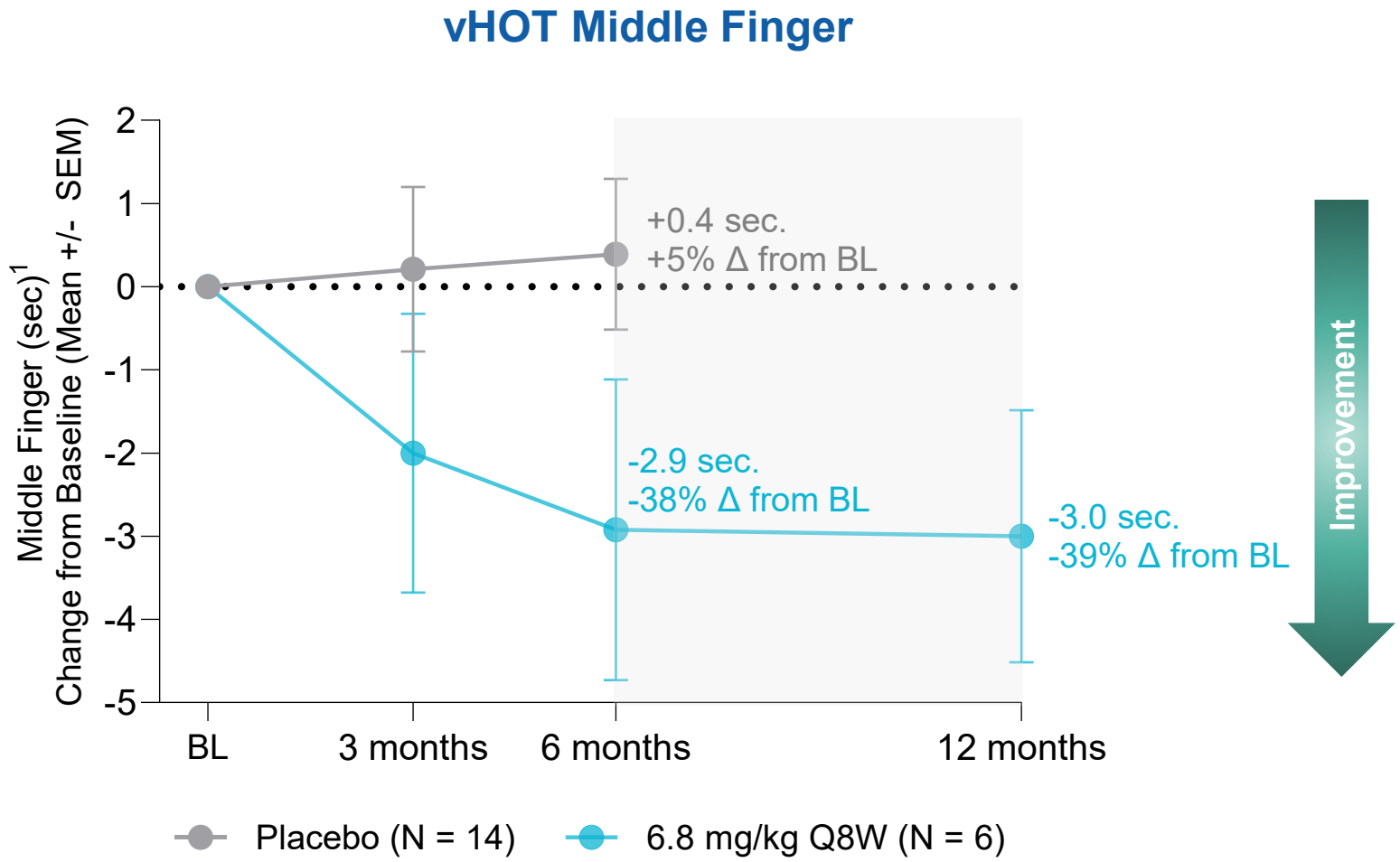
Z-Basivarsen at 6.8 mg/kg Q8W Improved Foundational Pathobiology of DM1 at 3 Months





Note: One baseline sample in 6.8 mg/kg treatment groups not included within splicing assay as the sample did not meet QC criteria. 3 months = 85 days. CASI-22 = composite alternative splicing index.

Robust and Sustained vHOT Improvement with Z-Basivarsen at 6 and 12 Months

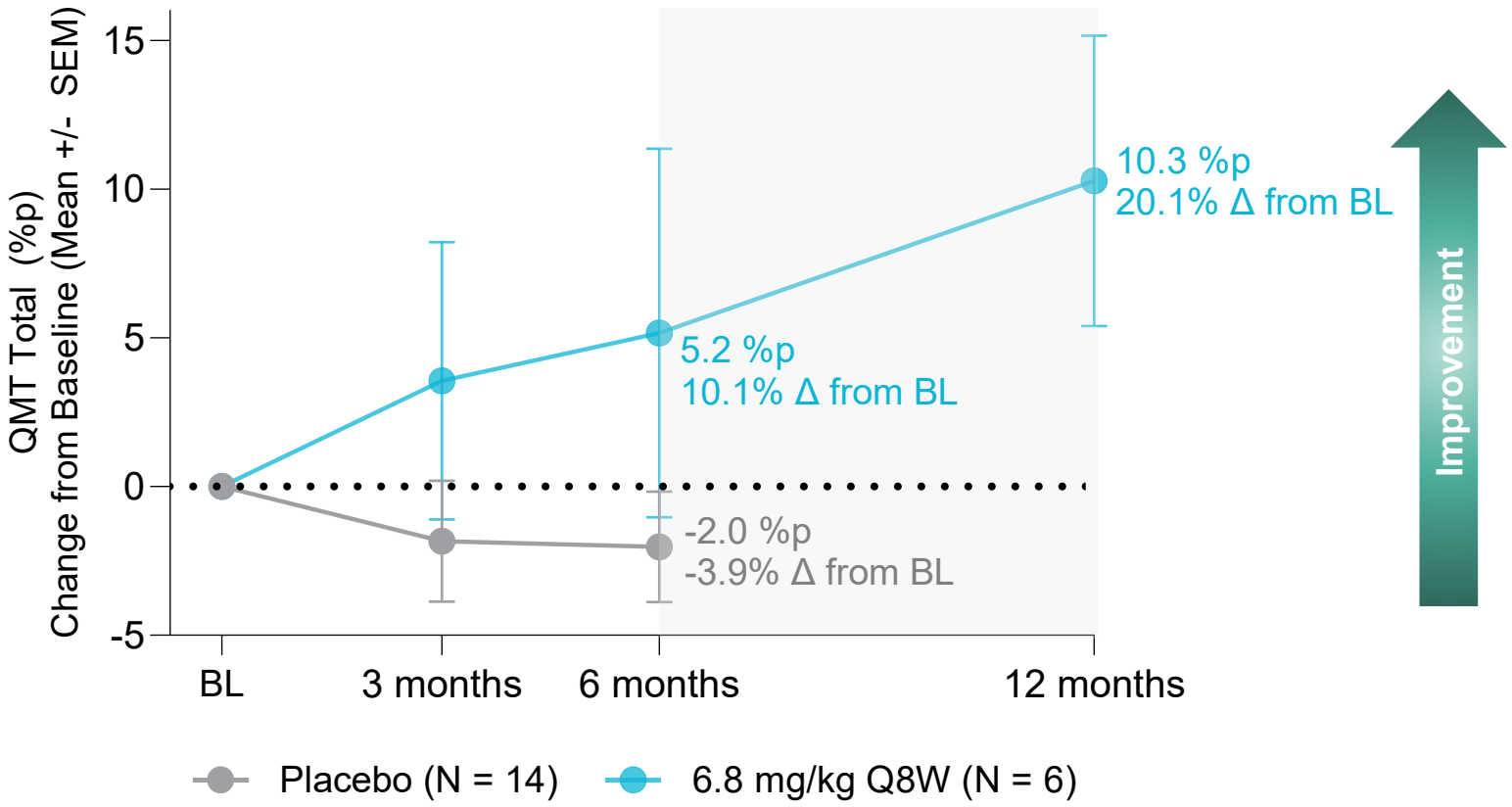


Baseline (sec), mean (SEM)	**7.5 (0.8)**	**7.8 (1.5)**

1. vHOT Middle Finger (sec) is the average of all myotonia trials for an individual participant in ACHIEVE; vHOT = video hand opening time; SEM = standard error of the mean; BL = baseline. 3 months = 85 days; 6 months = 169 days; 12 months = 337 days.

Strength Continued to Improve with Z-Basivarsen from Month 6 to Month 12

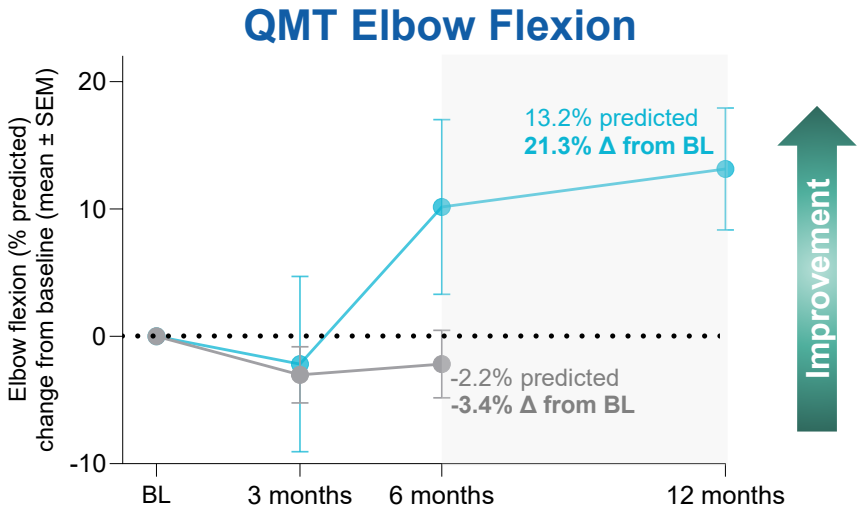
Quantitative Muscle Testing (QMT) Total Score

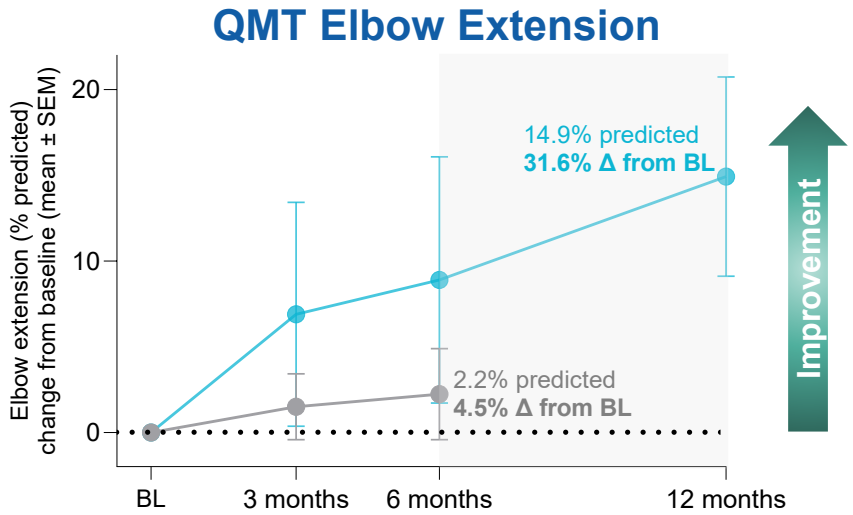


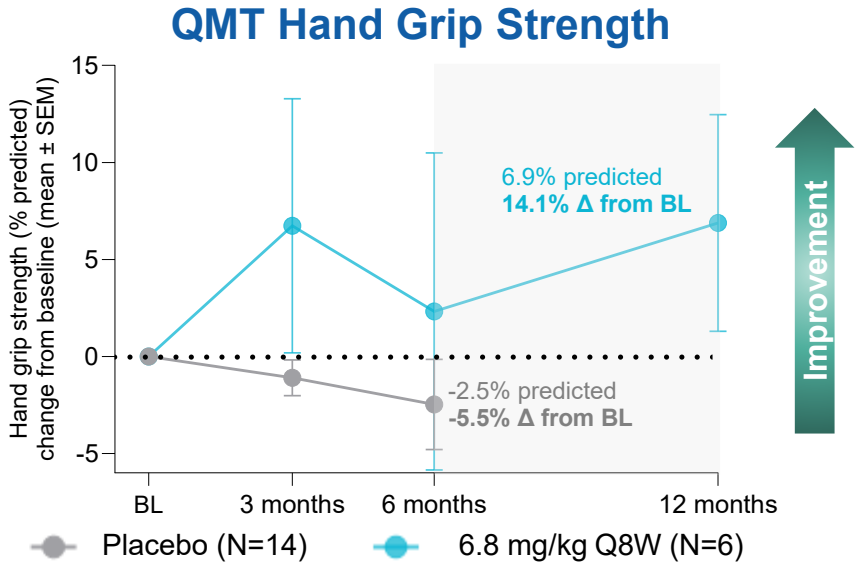
Baseline score, mean (SEM)	**51.5 (3.8)**	**51.3 (4.2)**

SEM = standard error of the mean; BL = baseline; %p = percent predicted; 3 months = 85 days; 6 months = 169 days; 12 months = 337 days.

Strength Improved with Z-Basivarsen Across Both Proximal and Distal Muscles of the Upper Body

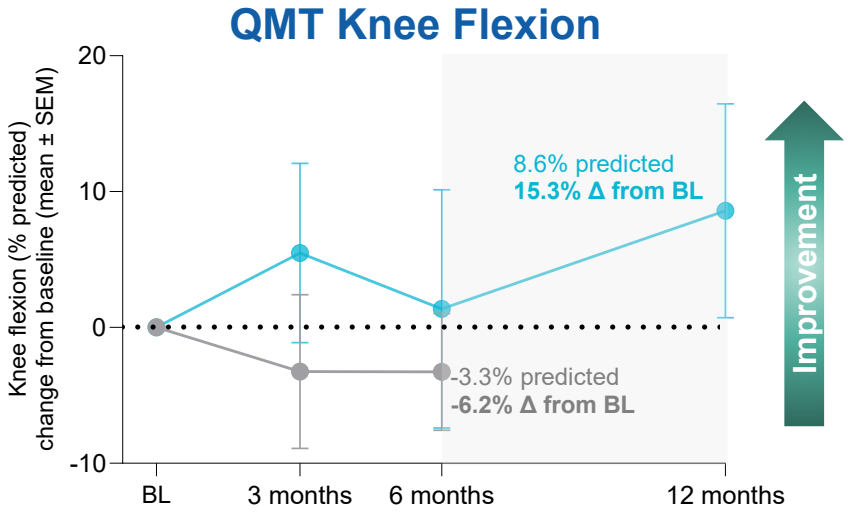


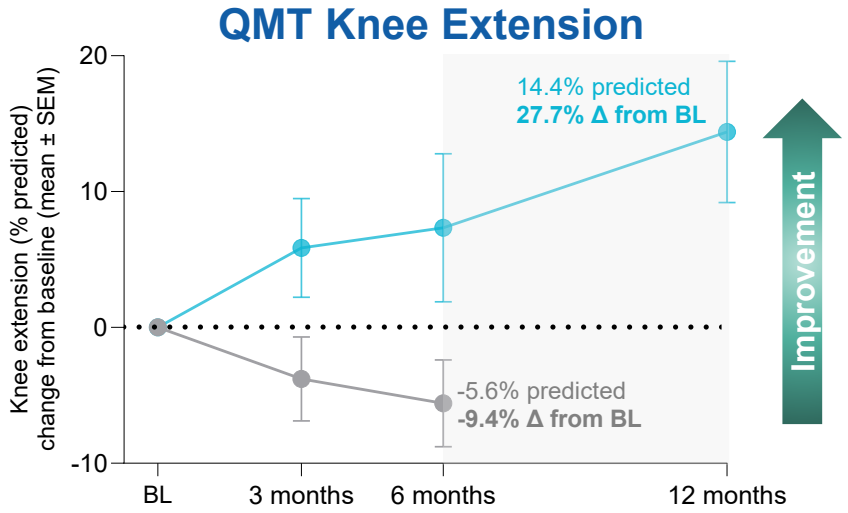


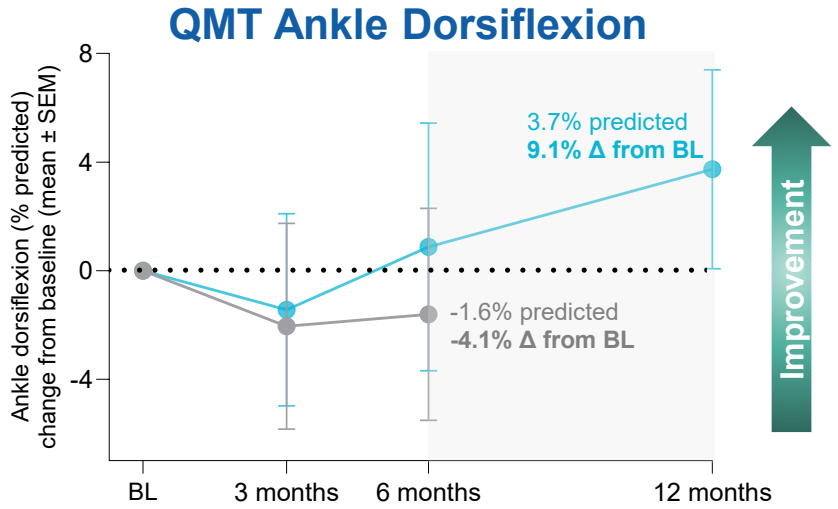


BL, baseline; QMT, quantitative muscle testing; Q8W, every 8 weeks dosing; SEM, standard error of the mean.
3 months = 85 days; 6 months = 169 days; 12 months = 337 days.

Strength Improved with Z-Basivarsen Across Both Proximal and Distal Muscles of the Lower Body



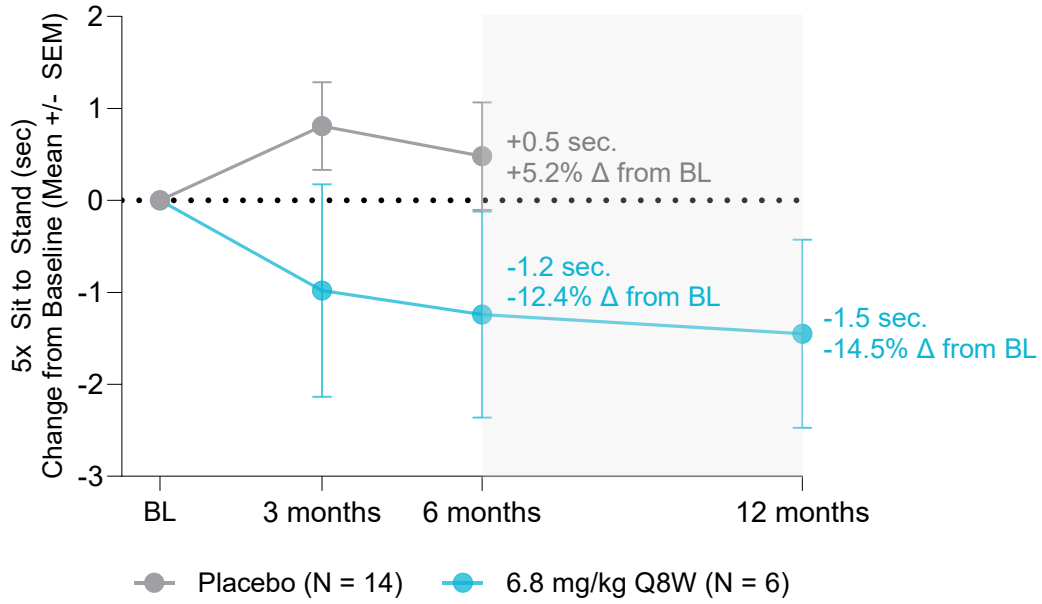




BL, baseline; QMT, quantitative muscle testing; Q8W, every 8 weeks dosing; SEM, standard error of the mean.
3 months = 85 days; 6 months = 169 days; 12 months = 337 days.

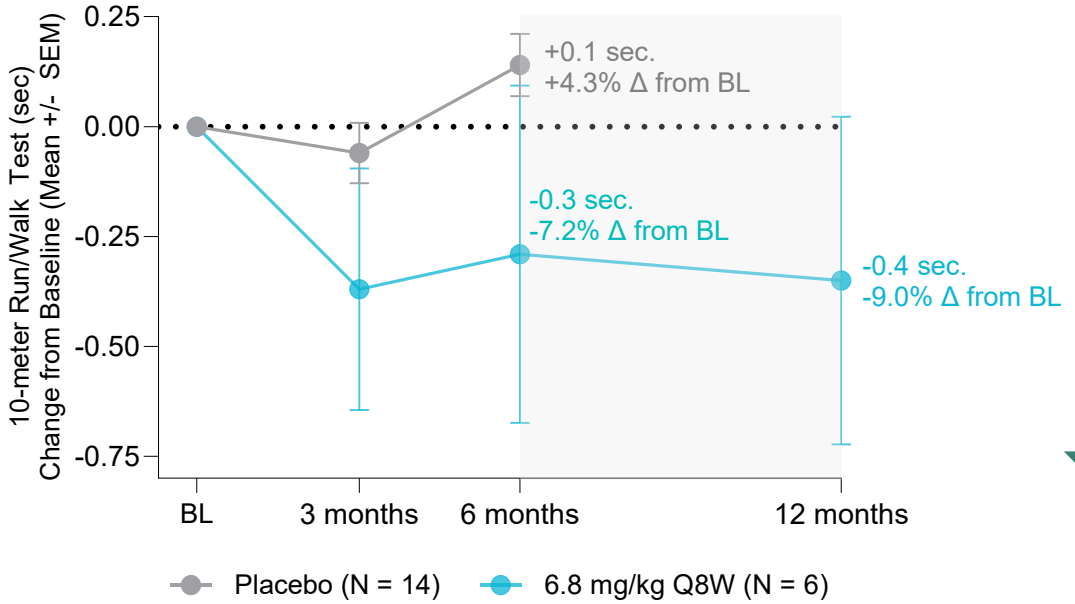
Robust Benefit Across Multiple Timed Function Tests Sustained with Z-Basivarsen at 6 and 12 Months

5 Times Sit to Stand Test



Baseline (sec), mean (SEM)	**9.2 (0.5)**	**10.0 (1.4)**

10-Meter Walk/Run Test

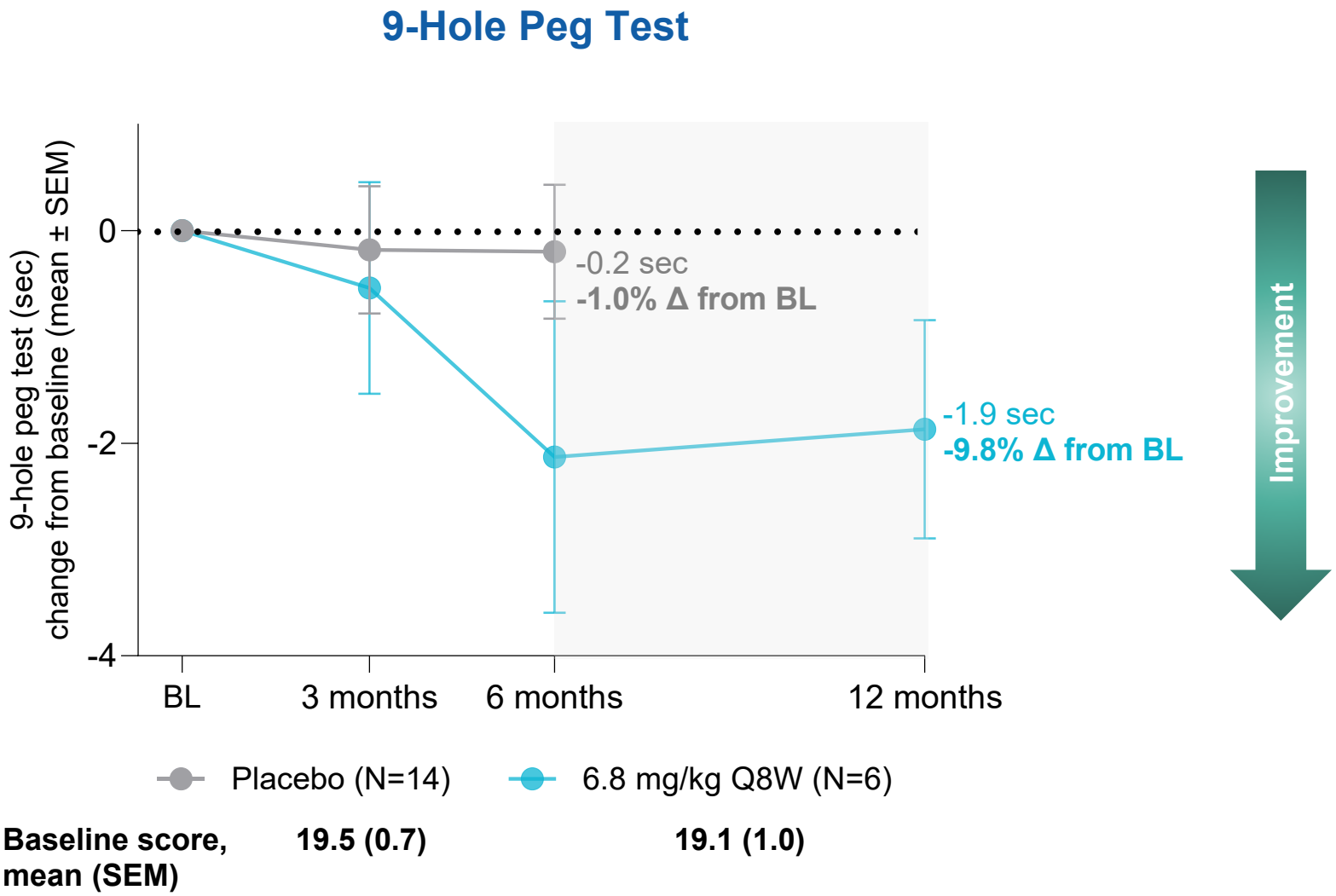


Baseline (sec), mean (SEM)	**3.3 (0.1)**	**3.9 (0.6)**

Improvement

SEM = standard error of the mean; BL = baseline; 3 months = 85 days; 6 months = 169 days; 12 months = 337 days.

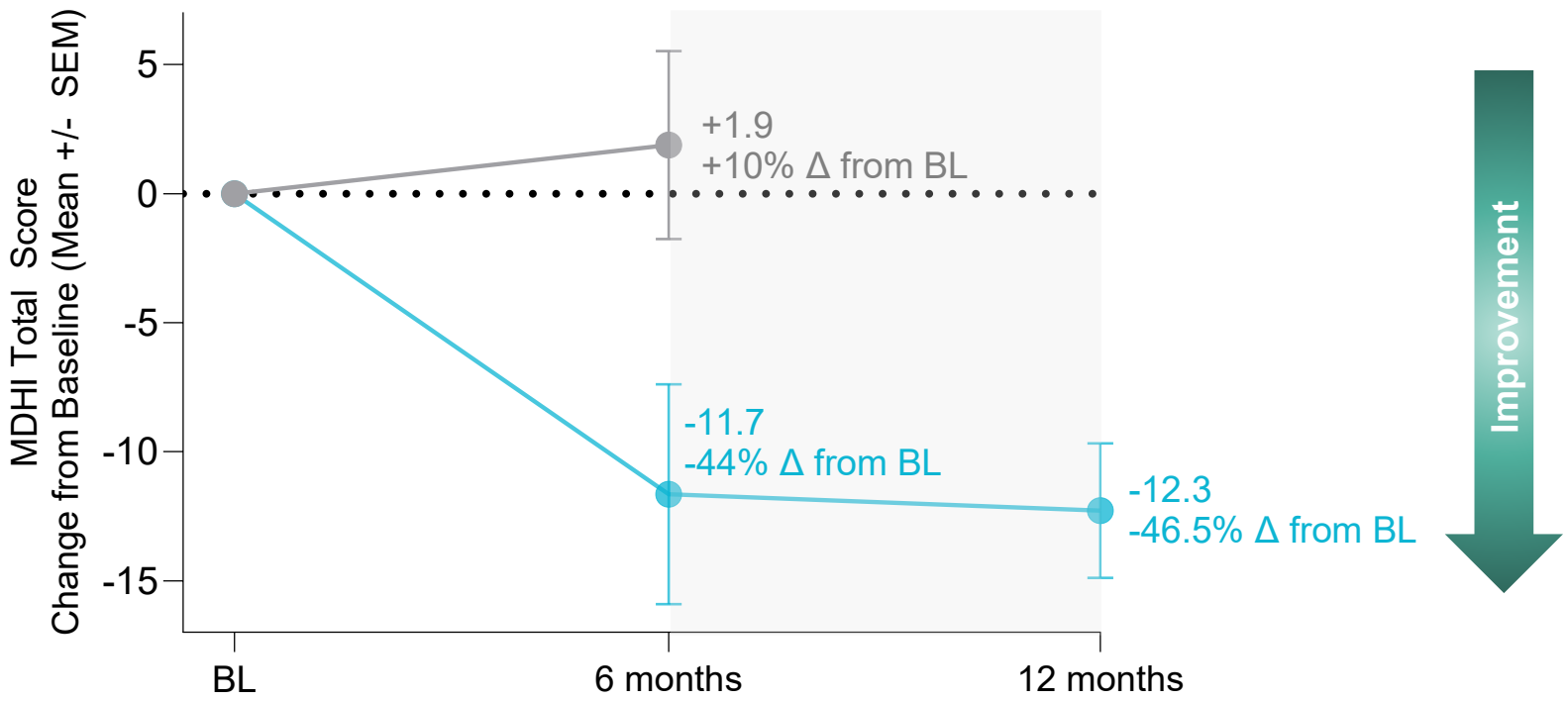
Meaningful Improvement with Z-Basivarsen in 9-Hole Peg Test, a Measure of Upper Limb Function



BL, baseline; Q8W, every 8 weeks dosing; sec, second; SEM, standard error of the mean.
3 months = 85 days; 6 months = 169 days; 12 months = 337 days.

Deep Improvement with Z-Basivarsen in Patient Reported Outcome Sustained at 6 and 12 Months

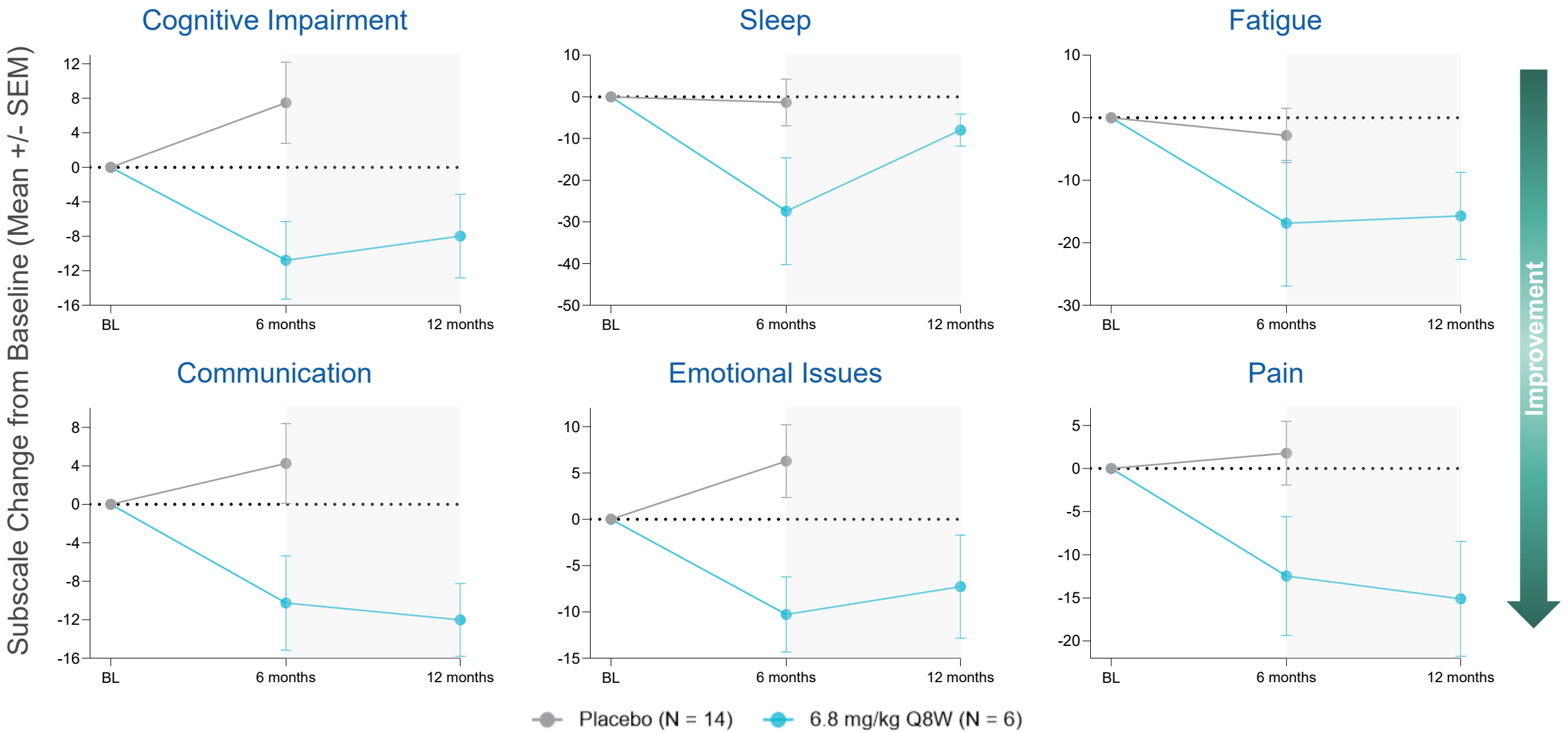
Myotonic Dystrophy Health Index (MDHI) Total Score



Baseline, mean (SEM)	18.7 (3.8)	26.5 (5.6)

SEM = standard error of the mean; BL = baseline; 3 months = 85 days; 6 months = 169 days; 12 months = 337 days.

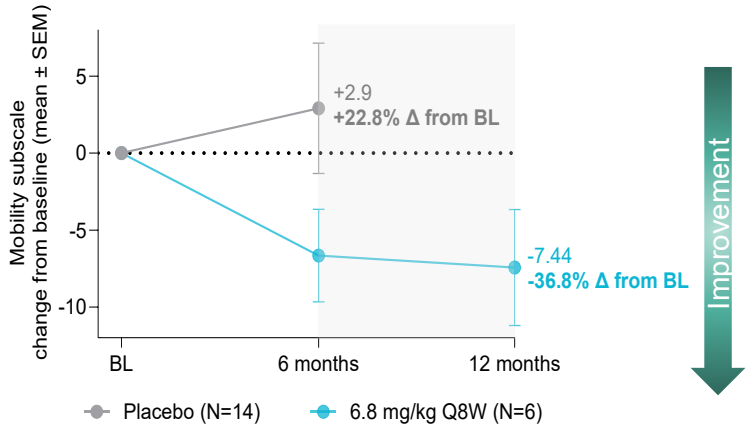
Sustained Improvement in CNS-related MDHI Subscales Over Time



SEM = standard error of the mean; BL = baseline; Patient-reported outcomes (PRO) including Myotonic Dystrophy Health Index (MDHI) collected at baseline, 6 months (169 days) and 12 months (337 days).

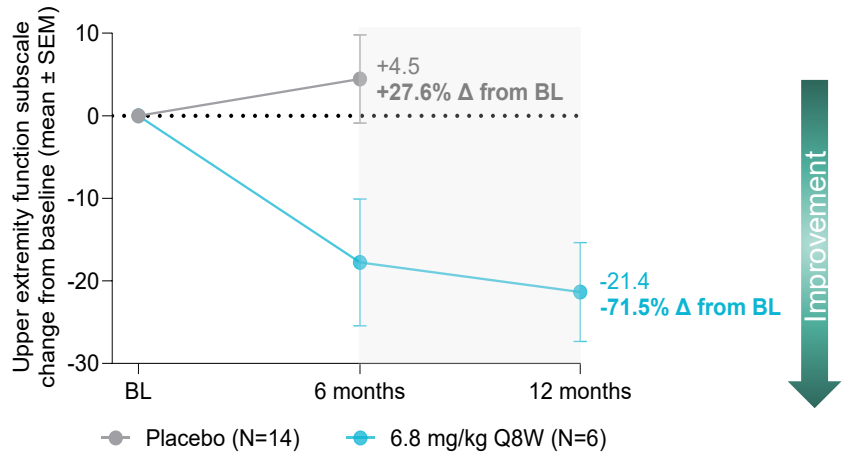
Other MDHI Subscales Show Clinical Meaningfulness of Improvements with Z-Basivarsen in Strength and Function

MDHI Mobility Subscale



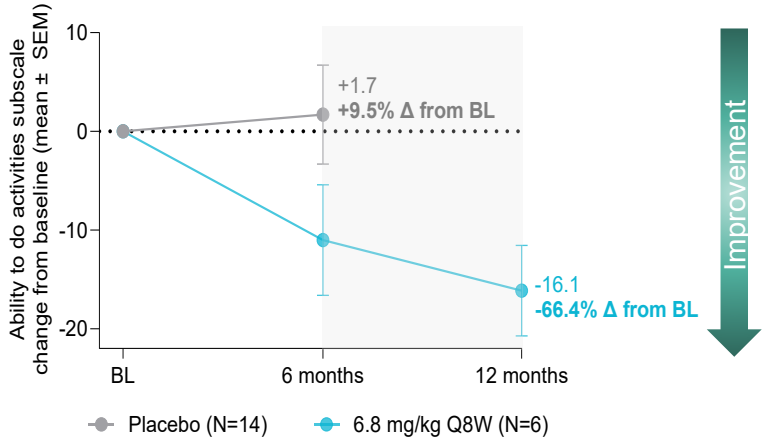
Baseline score, mean (SEM)	**12.8 (4.3)**	**20.2 (8.7)**

MDHI Upper Extremity Function Subscale



Baseline score, mean (SEM)	**16.2 (4.3)**	**29.9 (6.5)**

MDHI Ability to Do Activities Subscale

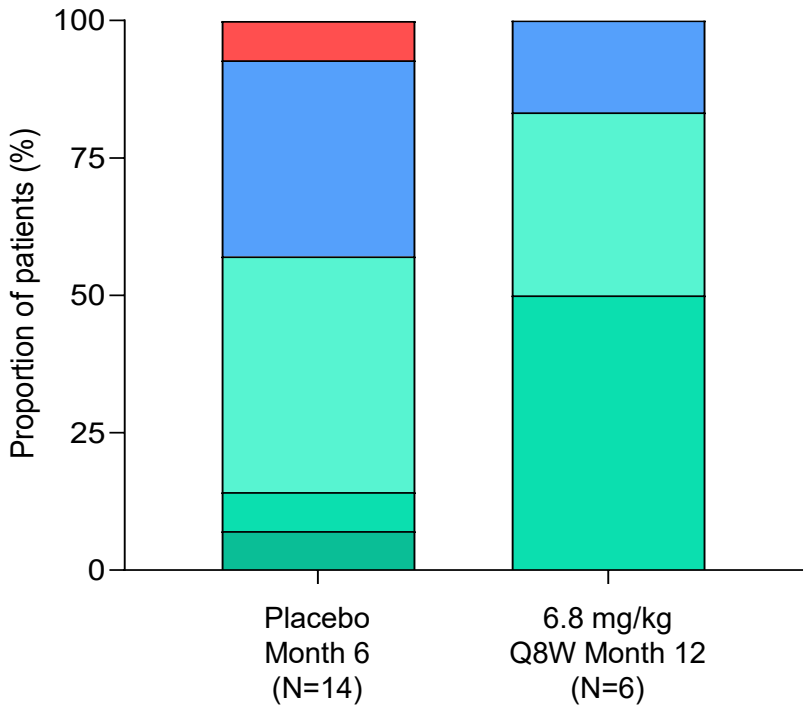


Baseline score, mean (SEM)	**18.0 (5.2)**	**24.3 (5.1)**

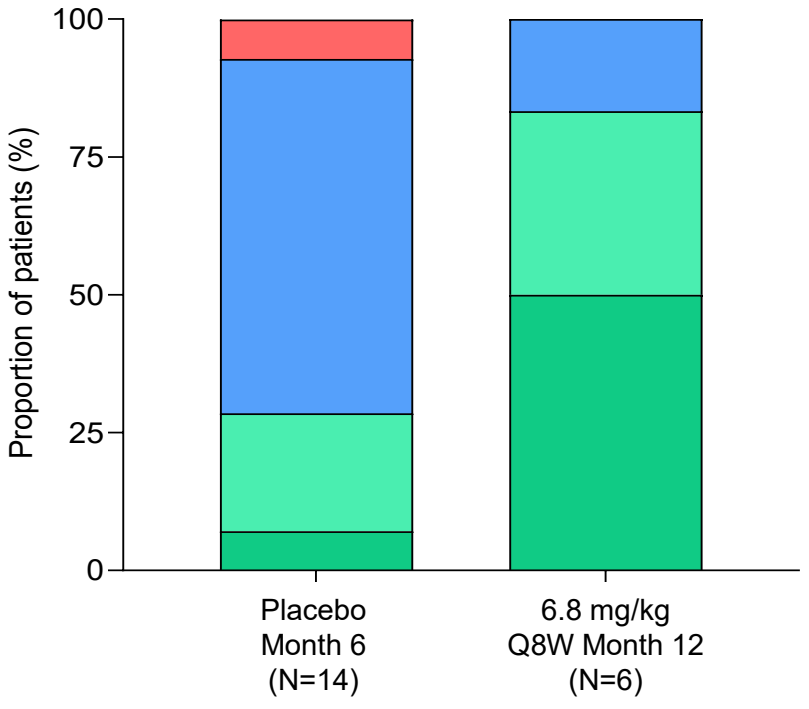
BL, baseline; MDHI, Myotonic Dystrophy Health Index; Q8W, every 8 weeks dosing; SEM, standard error of the mean. 6 months = 169 days; 12 months = 337 days.

Questionnaires Showed Improvements in Patient and Clinician Impressions of Global Functioning From Baseline with Z-Basivarsen

Patient Global Impression of Change



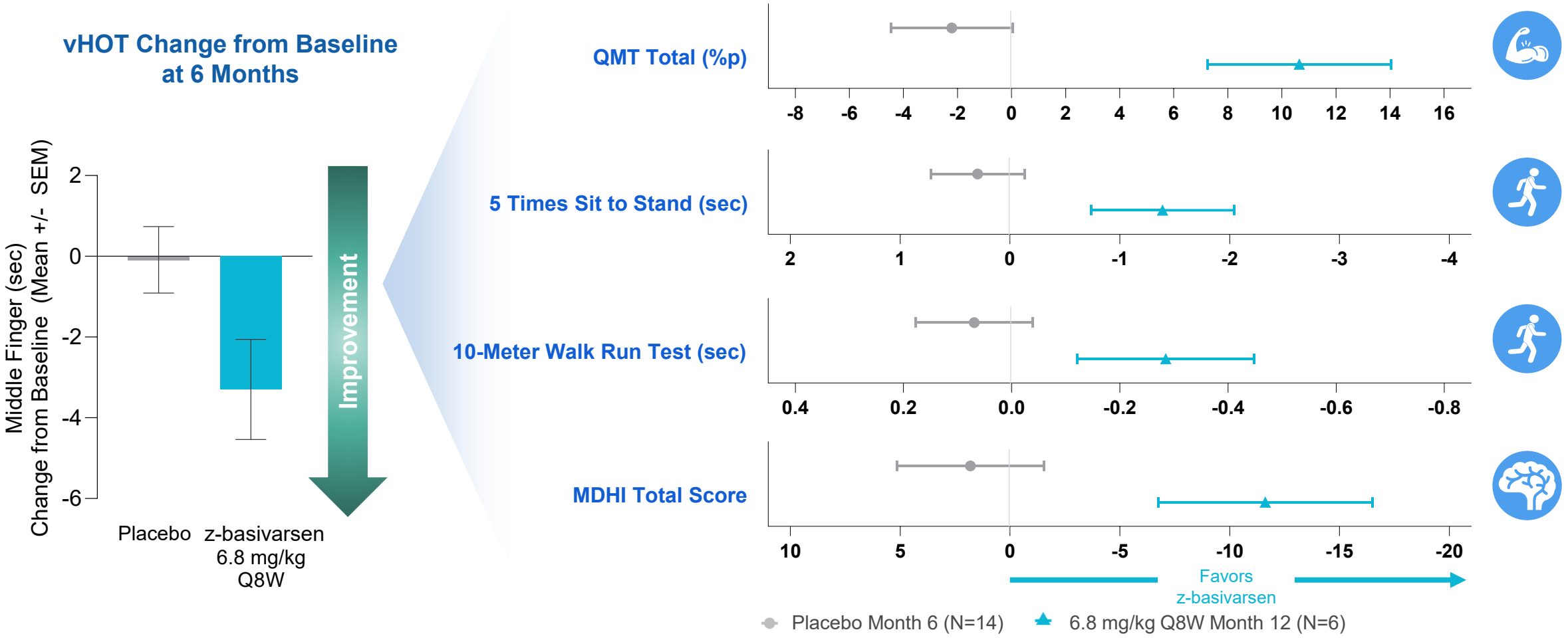
Clinician Global Impression of Change



Very much improved | Much improved | Minimally improved | No change | Minimally worse | Much worse | Very much worse

Q8W, every 8 weeks dosing. 6 months = 169 days; 12 months = 337 days.

Data Support vHOT Improvement as an Early Indicator of Clinical Benefit with Z-Basivarsen



With z-basivarsen, all participants at highest 3 doses who improved in 6M vHOT improved in 12M strength, 5xSTS, and/or 10MWR

Notes: Mixed model for repeated measures (MMRM): fixed effects: dose, visit, baseline, dose by visit interaction, baseline by visit interaction. Data: all dose groups except recovery group; excluding placebo data after 6 months; Data presented are least squares (LS) mean change from baseline ± SEM (standard error of the mean); 6 months = 169 days, 12 months = 337 days; vHOT = video hand opening time; QMT = quantitative muscle testing; 10MWR = 10-meter walk/run test; 5xSTS = 5 times sit to stand test; MDHI = Myotonic Dystrophy Health Index; %p = percent predicted.

Z-Basivarsen: Favorable Safety Profile with No Serious Related TEAEs

Summary of treatment-emergent adverse events (TEAEs)[1]

TEAE category	Participants with ≥1 TEAE, n (%)					
	1.8 mg/kg Q4W+Rec. N=16	3.4 mg/kg Q4W+Rec. N=16	3.4 mg/kg Q8W N=8	5.4 mg/kg Q8W N=8	6.8 mg/kg Q8W N=8	Overall (N=56)
Any TEAE	16 (100)	16 (100)	8 (100)	8 (100)	8 (100)	56 (100)
Any related TEAE	10 (62.5)	10 (62.5)	4 (50)	6 (75)	7 (87.5)	37 (66.1)
Any serious TEAE	5 (31.3)	0	2 (25)	1 (12.5)	0	8 (14.3)
Any serious related TEAE	0	0	0	0	0	0
Any TEAE leading to withdrawal from study	0	0	0	2 (25)	0	2[2] (3.6)
Any TEAE leading to death	0	0	0	0	0	0

Most TEAEs were mild or moderate in intensity[1]

- **10 serious TEAEs unrelated to study drug**
  - Atrioventricular block first degree (1)[3]
  - Pneumonia (2 events in same participant)
  - Pulmonary embolism (1)[4]
  - Hyponatraemia (1)
  - Influenza B virus test positive (1)
  - Fall (1)
  - Gastroenteritis (1)
  - Meningioma (1)
  - Uterine leiomyoma (1)
- **Most common TEAEs (≥30% participant incidence)[5]**
  - Infusion-related reaction (50%)[6]
  - Nasopharyngitis (46.4%)
  - Diarrhoea (35.7%)
  - Headache (33.9%)
  - Procedural pain (33.9%)
  - Influenza (32.1%)
  - Back pain (30.4%)

Additional safety data

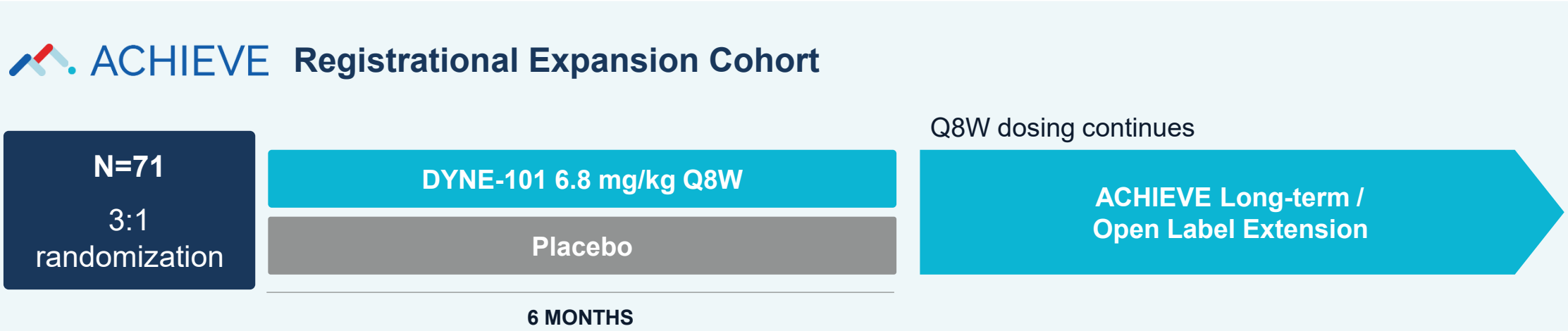
- **Liver enzyme elevations have been observed in a minority of participants**
  - No impact on liver function (bilirubin or coagulation)
  - Interpretation is complicated by underlying disease and elevated baseline values up to ~2.5x greater than the upper limit of normal
- **No participants have demonstrated persistent related anemia or thrombocytopenia**

~1,300 doses of study drug administered to date representing over 143 patient-years of follow-up[1]

1. Data as of April 20, 2026. 2. TEAEs leading to study withdrawal were IRRs that resolved within 2-3 days in 2 participants who had received z-basivarsen for over 12 months. 3. Transient worsening of atrioventricular (AV) block in a participant with ongoing medical history of first-degree AV block. 4. Attributed to risk factors for pulmonary embolism. 5. All cohorts combined. 6. Most IRRs were mild or moderate in severity. IRR, infusion-related reactions; Q4W, every 4 weeks; Q8W, every 8 weeks; Rec, Recovery Arm; TEAE, treatment-emergent adverse event; z-basivarsen, zeleciment basivarsen.

ACHIEVE Registrational Expansion Cohort (REC) to Support Potential U.S. Accelerated Approval

- ✓ ACHIEVE MAD cohorts complete; all cohorts now at 6.8 mg/kg Q8W in long-term / open label extension
- ACHIEVE REC enrollment completed in June 2026
  - Primary endpoint: Change from baseline in middle finger myotonia as measured by vHOT at 6 months compared to placebo[1]
  - Secondary endpoints include: CASI-22, QMT, 10MWR, 5xSTS, and MDHI at 6 months
- Global footprint, including U.S. sites

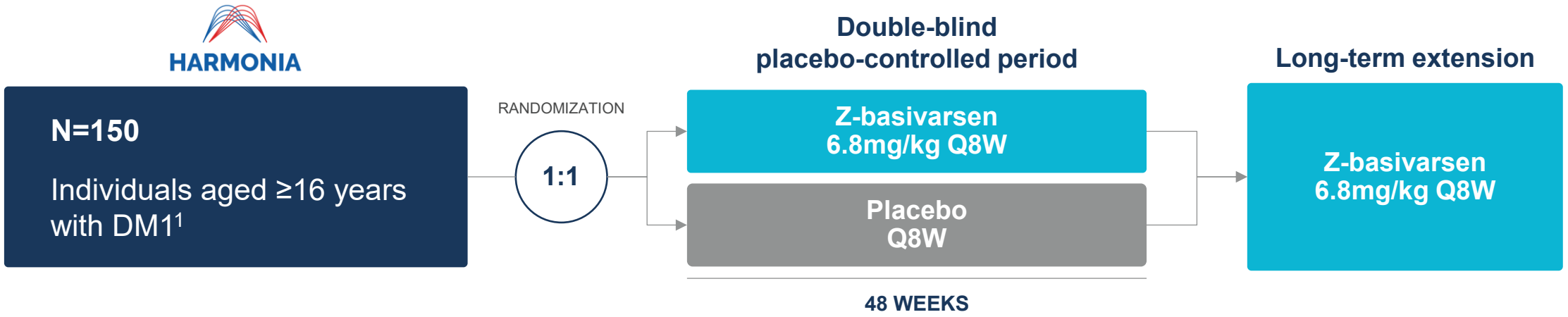


Data planned for Q1 2027 to support a potential Accelerated Approval submission in Q3 2027

1. The mean baseline value for vHOT of the 71 participants enrolled in the ACHIEVE REC is 8.3 seconds (standard deviation at baseline: 6.0 seconds). MAD = multiple ascending dose; CASI-22 = composite alternative splicing index; vHOT = video hand opening time; QMT = quantitative muscle testing; 10MWR = 10-meter walk/run test; 5xSTS = 5 times sit to stand test; MDHI = Myotonic Dystrophy Health Index; Q8W, every 8 weeks with a loading dose given 4 weeks after first dose of active drug.

HARMONIA: Confirmatory Phase 3 Trial of Z-Basivarsen in DM1

- The HARMONIA trial will assess multi-system efficacy, safety and tolerability of z-basivarsen in DM1
- Design and protocol aligned with FDA; intended to serve as confirmatory trial for traditional approval in the U.S. and support ex-U.S. marketing applications



PRIMARY ENDPOINT

- Change from baseline in 5xSTS at Week 49 in participants treated with z-basivarsen, as compared to placebo

SELECTED SECONDARY ENDPOINTS

- Muscle strength and function: vHOT, QMT total, 10MWR, 9HPT
- Patient- and clinician-reported: MDHI, DM1-ACTIV^{C}, Patient and Clinical Global Impression Scales
- Safety and tolerability

CNS-RELATED ENDPOINTS[2]

- MDHI subscales
- CogState
- Fatigue and excessive daytime sleepiness scale
- Actigraphy (wearable device)

1. Additional eligibility criteria apply as per protocol. 2. Includes exploratory endpoints. 10MWR, 10-meter walk/run test; 5xSTS, five times sit-to-stand test; 9HPT, 9-hole peg test; CGI-C, clinical global impression of change; CGI-S, clinical global impression of severity; CNS, central nervous, system; DM1, myotonic dystrophy type 1; FDSS, fatigue and excessive daytime sleepiness scale; MDHI, myotonic dystrophy health index; PGI-C, patient global impression of change; PGI-S, patient global impression of severity; QMT, quantitative muscle testing; vHOT, video hand opening time; Q8W, every 8 weeks with a loading dose given 4 weeks after first dose of active drug.

FSHD is a Progressive and Debilitating Inherited Muscle Disease

FSHD Population

- ~15,000-40,000 (US)
- ~20,000-50,000 (EU)

Overview

- Pathogenic expression of DUX4
- Onset in teen years or young adulthood

Clinical Presentation

- Progressive muscle weakness, pain, fatigue and disability
- Significant physical limitations

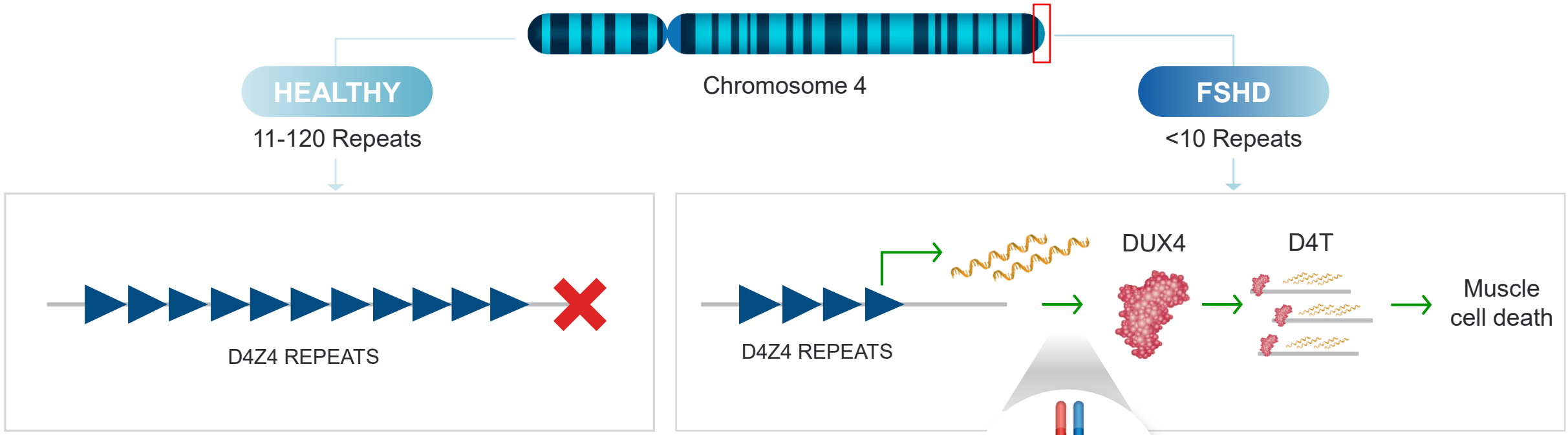


OUR APPROACH

DUX4 Knockdown to Achieve Functional Improvement

Targeting pathogenic *DUX4* mRNA expression to potentially **stop or reverse disease progression and enable functional improvement**

DYNE-302 Targets the Genetic Basis of FSHD

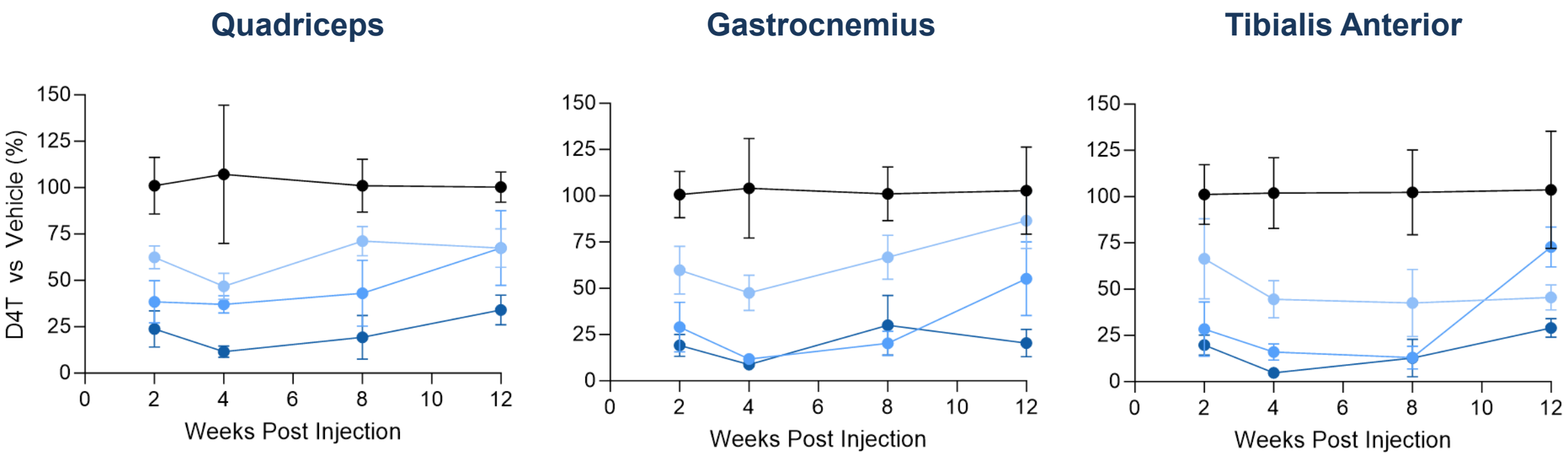


DYNE-302: a FORCE-siRNA conjugate designed to address the genetic basis of disease by **targeting pathogenic *DUX4* expression**

- Highly selective *DUX4* siRNA payload with favorable *in vitro* off-target and *in vitro* tolerability profile
- Extended duration of action intended to overcome sporadic DUX4 activation

D4T = DUX4 transcriptome.

DYNE-302 Achieved Robust, Durable, and Dose-Dependent D4T KD in Skeletal Muscle of hTfR1/iFLExD FSHD Mice

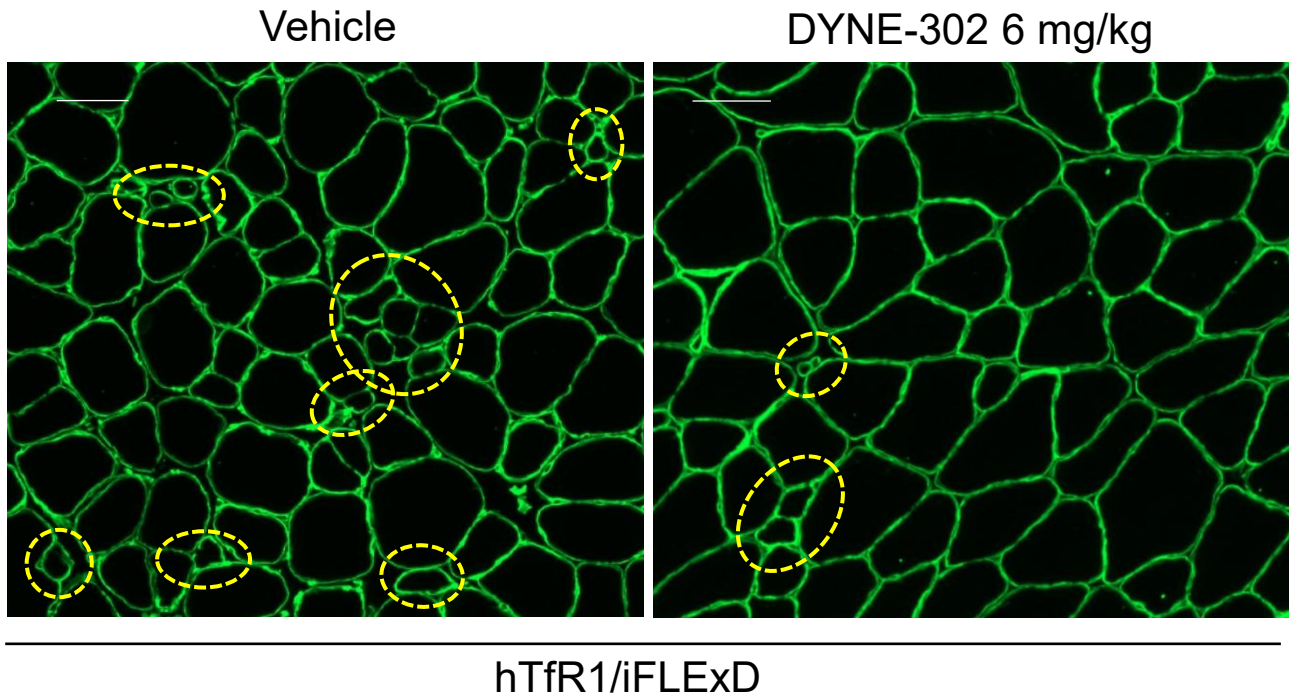


DYNE-302 demonstrates potential for infrequent dosing

Notes: Uninduced hTfR1/iFLExD mice dosed with vehicle or DYNE-302 on day 0, analyzed at indicated weeks. Data are means ± SD; n = 4 - 12. D4T is an average of mouse Wfdc3, Sord, and Serpinb6c mRNA markers. KD = knockdown.

Single Dose of DYNE-302 Corrected Muscle Pathology in Quadriceps of hTfR1/iFLExD FSHD Mice at 12 Weeks

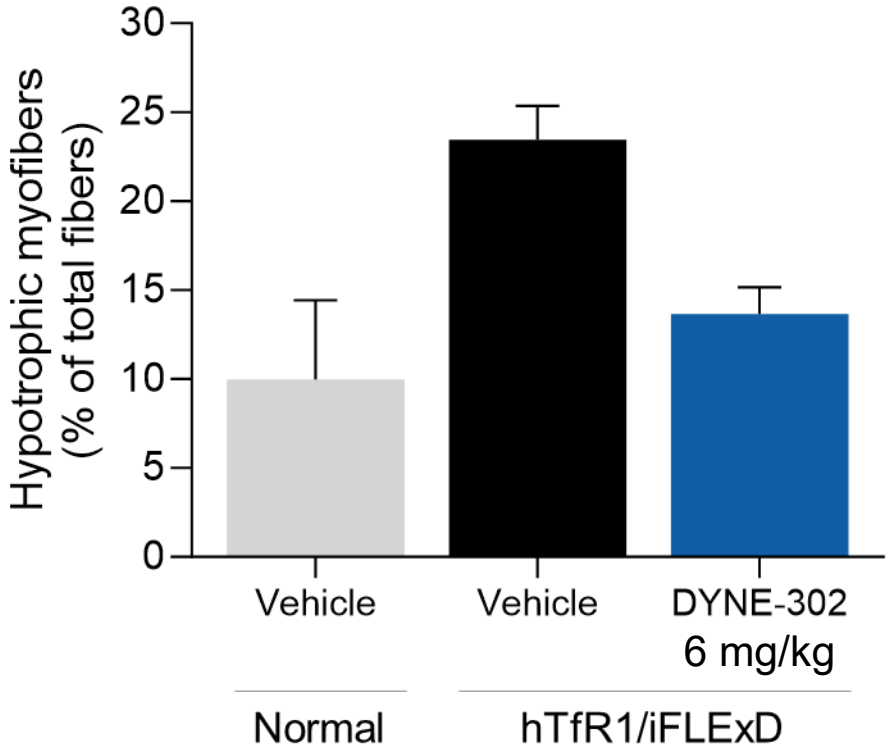
DYNE-302 Reduces Hypotrophic Myofibers



Laminin

Fiber splitting (hypotrophic myofibers)

Quantification of Hypotrophic Myofiber Reduction

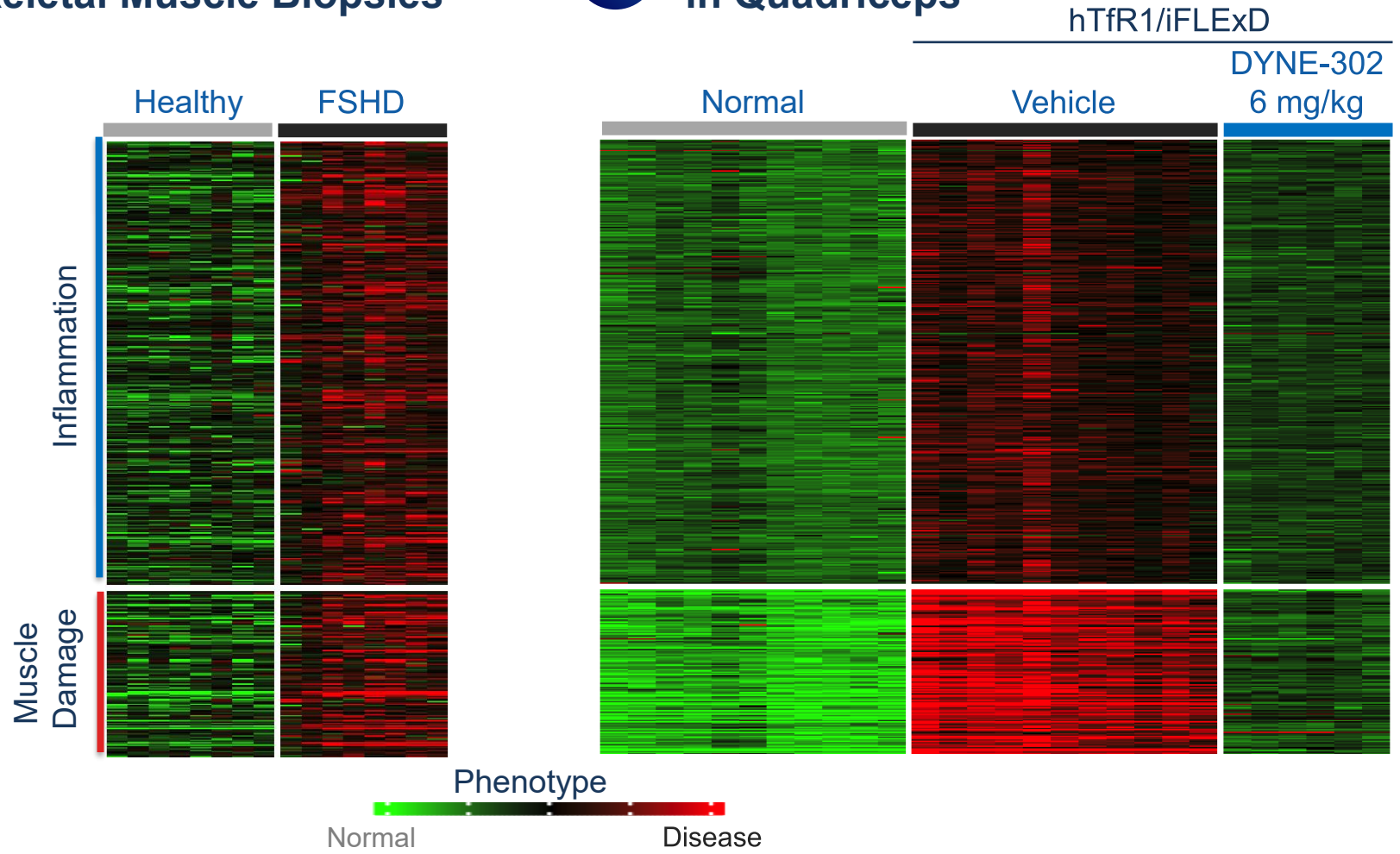


Notes: Uninduced hTfR1/iFLExD mice dosed with vehicle or DYNE-302 on day 0, analyzed on week 12. Data are means + SD; n = 4 – 9.

DYNE-302 Normalized Transcriptional Profiles of Inflammation and Muscle Damage in hTfR1/iFLExD Mice

Human Transcriptome in Skeletal Muscle Biopsies

Mouse Ortholog Transcriptome in Quadriceps

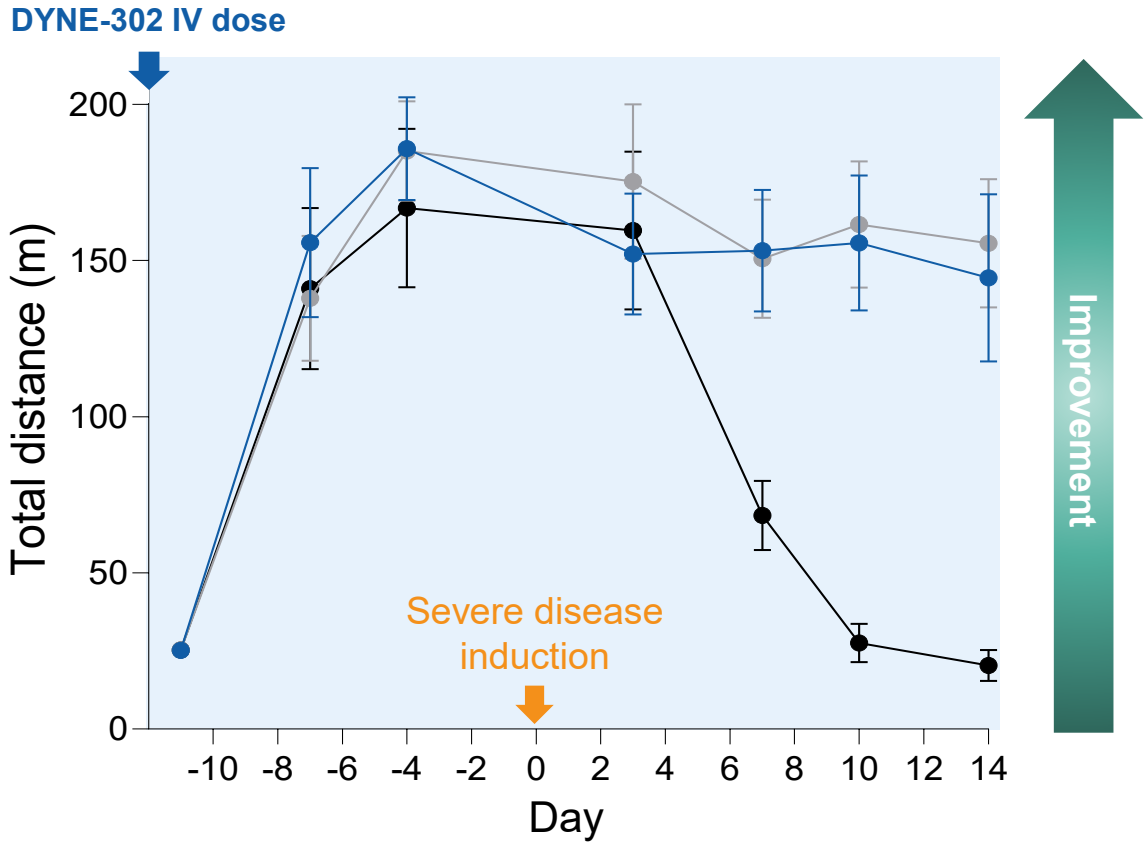


Notes: each column represents one individual, each row represents an individual gene; human data from Wang et al., 2019.

DYNE-302 Led to Functional Improvement in hTfR1/iFLExD FSHD Mice

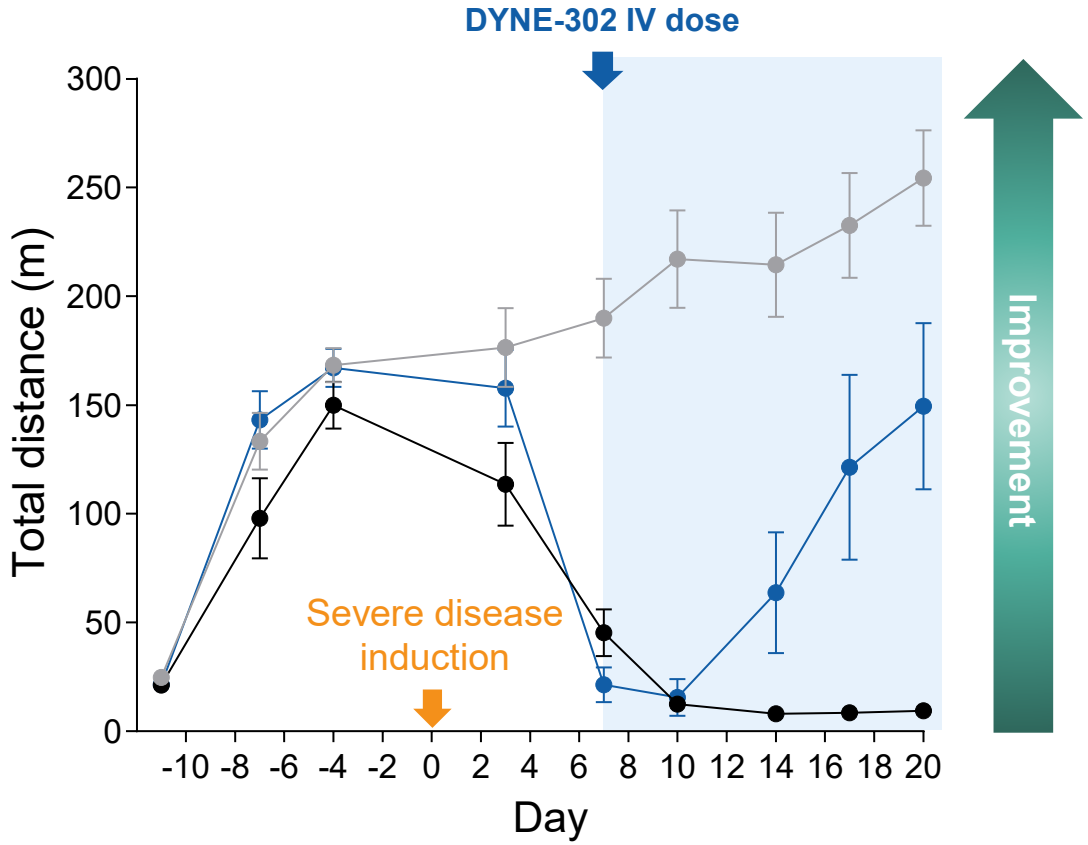
PREVENTION

DYNE-302 led to functional improvement in mice by preventing onset of severe disease



INTERVENTION

DYNE-302 led to functional improvement in mice with pre-existing, severe disease



Normal mice: Vehicle **FSHD mice:** Vehicle 6 mg/kg DYNE-302

Note: Mice tested for function on forced treadmill run test. Treatment with single DYNE-302 dose 6 mg/kg. Data shown are mean ± SEM, n = 5-7 animals/group.

Planned Phase 1 Clinical Trial of DYNE-302 in FSHD

Investigational New Drug Application Cleared by FDA

DESIGN

- Multiple ascending dose
- Double-blind
- Placebo-controlled
- Open-label long-term extension

POPULATION

- Ambulatory individuals with FSHD
- Ages 18 to 65 years

SELECTED ENDPOINTS

- Safety and tolerability
- Pharmacokinetics
- Muscle DUX4 transcriptome
- Plasma KHDC1L levels

Cohort 1

- 9 participants randomized 2:1 to DYNE-302 or placebo
- Three intravenous doses of 1.5 mg/kg Q4W
- Participants may then enter open-label long-term extension

FSHD = facioscapulohumeral muscular dystrophy; KHDC1L = KH Domain Containing 1 Like; Q4W = every 4 weeks.

Building the World's Leading Neuromuscular Disease Company