KOL CALL

Unmet Need in Bipolar Mania and the RAP-219 Clinical Program

SEPTEMBER 22, 2026

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Disclaimer

This presentation contains “forward-looking statements” within the meaning of Section 27A of the Securities Act of 1933 and Section 21E of the Securities Exchange Act of 1934, each as amended. The words “anticipate,” “believe,” “continue,” “could,” “estimate,” “expect,” “intend,” “may,” “plan,” “potential,” “predict,” “project,” “should,” “target,” “will,” “would” and similar expressions are intended to identify forward-looking statements, although not all forward-looking statements contain these identifying words. These forward-looking statements include, but are not limited to, express or implied statements regarding: the clinical development of RAP-219 for the treatment of focal onset seizures, primary generalized tonic-clonic seizures, and bipolar mania, including the initiation, timing, progress and results of the ongoing and planned clinical trials; expectations for the efficacy, tolerability, and commercial potential of RAP-219; the potential multi-billion dollar market opportunity for RAP-219 in focal onset seizures, if approved; the potential multi-billion dollar market opportunity for RAP-219 in bipolar mania, if approved; expectations for the development of a long-acting injectable formulation of RAP-219; the prioritization of the Company’s α6β4 program, including the development candidate’s potential in chronic pain and migraine and the Company’s IND-enabling activities; the deferral of further investment in the RAP-219 diabetic peripheral neuropathic pain program; the potential of Rapport’s RAP technology platform; and expectations for Rapport’s uses of capital, including its cash runway into the second half of 2029. Forward looking statements are based on management’s current expectations and are subject to risks and uncertainties that could negatively affect Rapport’s business, operating results, financial condition and stock value. Factors that could cause actual results to differ materially from those currently anticipated include: risks relating to the Company’s research and development activities; Rapport’s ability to execute on its strategy including obtaining the requisite regulatory approvals on the expected timeline, if at all; uncertainties relating to preclinical and clinical development activities; the Company’s dependence on third parties to conduct clinical trials, manufacture its product candidates and develop and commercialize its product candidates, if approved; Rapport’s ability to attract, integrate and retain key personnel; risks related to the Company’s financial condition and need for substantial additional funds in order to complete development activities and commercialize a product candidate, if approved; risks related to regulatory developments and approval processes of the U.S. Food and Drug Administration and comparable foreign regulatory authorities; risks related to establishing and maintaining Rapport’s intellectual property protections; and risks related to the competitive landscape for Rapport’s product candidates; as well as other risks described in “Risk Factors,” in the Company’s Annual Report on Form 10-K and most recent Quarterly Report on Form 10-Q, as well as discussions of potential risks, uncertainties, and other important factors in Rapport’s subsequent filings with the Securities and Exchange Commission. Any forward-looking statements represent Rapport’s views only as of today and should not be relied upon as representing its views as of any subsequent date. Rapport expressly disclaims any obligation or undertaking to release publicly any updates or revisions to any forward-looking statements contained herein to reflect any change in its expectations or any changes in events, conditions or circumstances on which any such statement is based, except as required by law, and claims the protection of the safe harbor for forward-looking statements contained in the Private Securities Litigation Reform Act.

Agenda

01 — **Welcome, Company and RAP-219 Overview**

Abe Ceesay, *Chief Executive Officer*

02 — **Bipolar Mania: Disease State & Treatment Landscape**

Mauricio Tohen, MD, DrPH, MBA, *University of New Mexico Health Science Center*

03 — **RAP-219 Bipolar Mania Phase 2 Trial & Clinical Decision-Making**

Dr. Gary Sachs, MD, *Massachusetts General Hospital, Harvard Medical School*

04 — **Closing Remarks**

Abe Ceesay, *Chief Executive Officer*

05 — **Q&A**

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Rapport: building a new class of precision neuroscience medicines

NEUROSCIENCE PLATFORM

Designed for biological precision

- ✓ Differentiated pharmacology with transformative potential
- ✓ Targeting receptor-associated proteins (RAPs) enables selectivity and neuroanatomical specificity
- ✓ Designed to address long-standing challenges in neuroscience

LEAD ASSET

Pipeline-in-a-product

RAP-219

Novel forebrain-restricted TARPγ8 AMPAR modulator

RAP-219 PROGRAMS

Multiple near-term catalysts

FOCAL ONSET SEIZURES

Positive Phase 2a results reported Sep 2025

Phase 3 program initiated • Q2 2026

OLE initial data • Q4 2026

BIPOLAR MANIA

Phase 2 topline results expected • Oct 2026

LONG-ACTING INJECTIBLE

Phase 1 PK data expected • 2027

PRIMARY GENERALIZED TONIC-CLONIC SEIZURES

Phase 3 initiation expected • 2027

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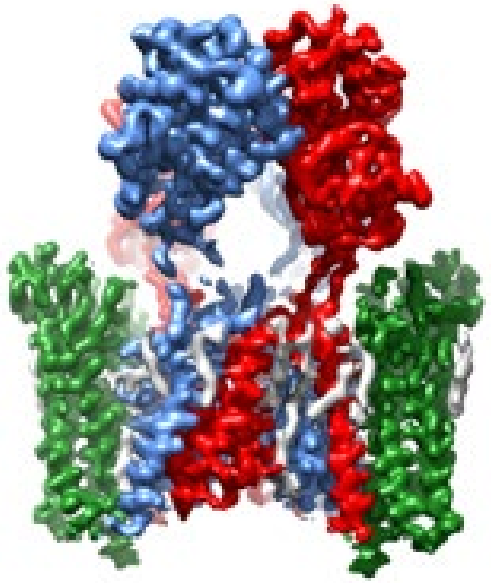
TARPγ8: transmembrane AMPA regulatory protein gamma-8; AMPAR: α-Amino-3-hydroxy-5-methyl-4-isoxazolepropionic acid (AMPA) receptors.

RAP-219 selectively binds to TARPγ8, representing a potential first-in-class precision medicine for neurological and psychiatric disorders

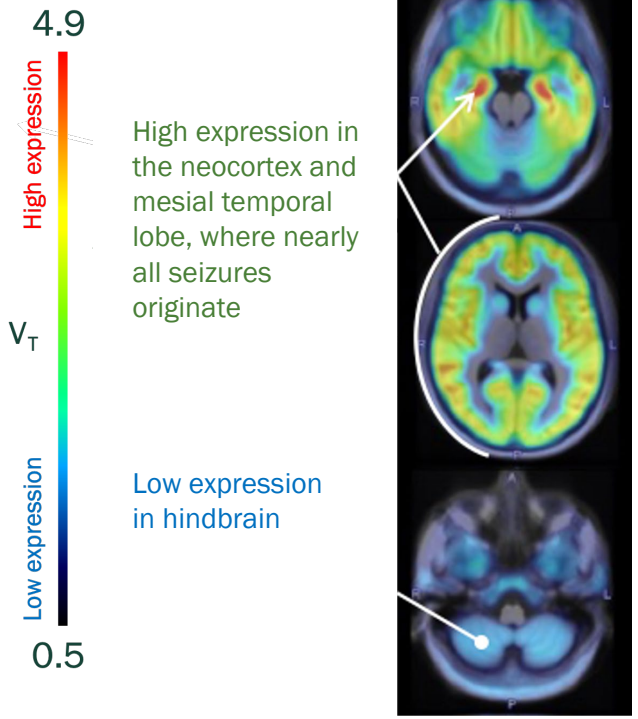
Cryogenic Electron Microscopy of GluA1/2 + TARPγ8 Complex



GluA1
GluA2
TARPγ8

TARPs regulate the trafficking, subcellular localization and gating of AMPA receptors

TARPγ8 Clinical PET



PET results confirm TARPγ8 is highly expressed in the MTL and neocortex

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RAP-219 circuit-selective approach to bipolar mania

Targets glutamatergic hyperactivity in cortico-limbic networks

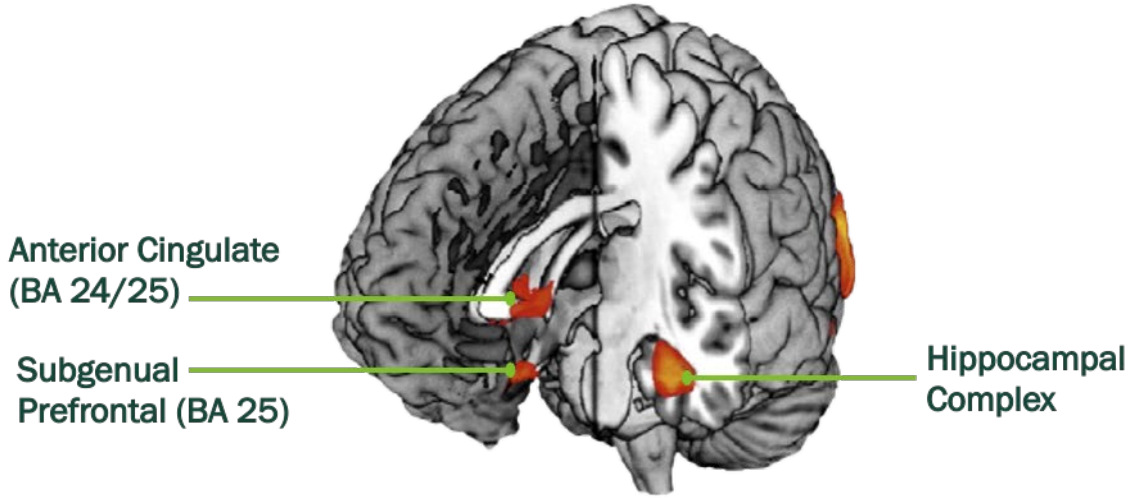
Bipolar mania is characterized by **increased glutamate levels and hypermetabolism** in cortico-limbic networks[a,b,c]

Glutamate signaling is primarily **mediated by AMPA receptors**, which accounts for most fast excitatory transmission in the brain[d]

RAP-219 selectively modulates TARPγ8-dependent AMPA receptor activity, potentially reducing excitatory glutamatergic drive in limbic neuronal populations that correspond to manic network hyperactivity

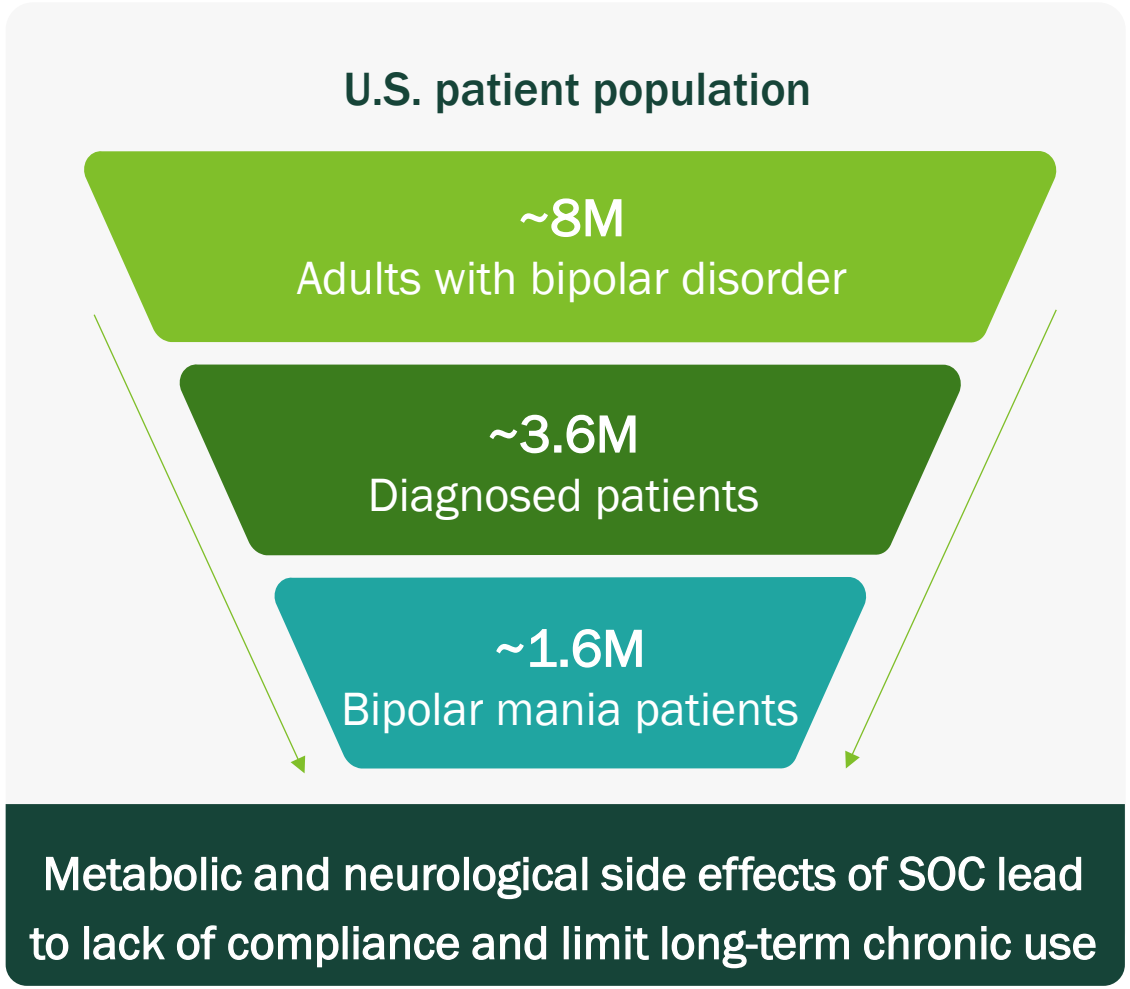
Lithium, valproate, and lamotrigine - **approved therapies for bipolar** - act in part by attenuating glutamatergic transmission, including reducing glutamate release and downregulating AMPA receptor function[e,f]

Increased Cerebral Metabolism in Manic Patients Relative to Healthy Controls

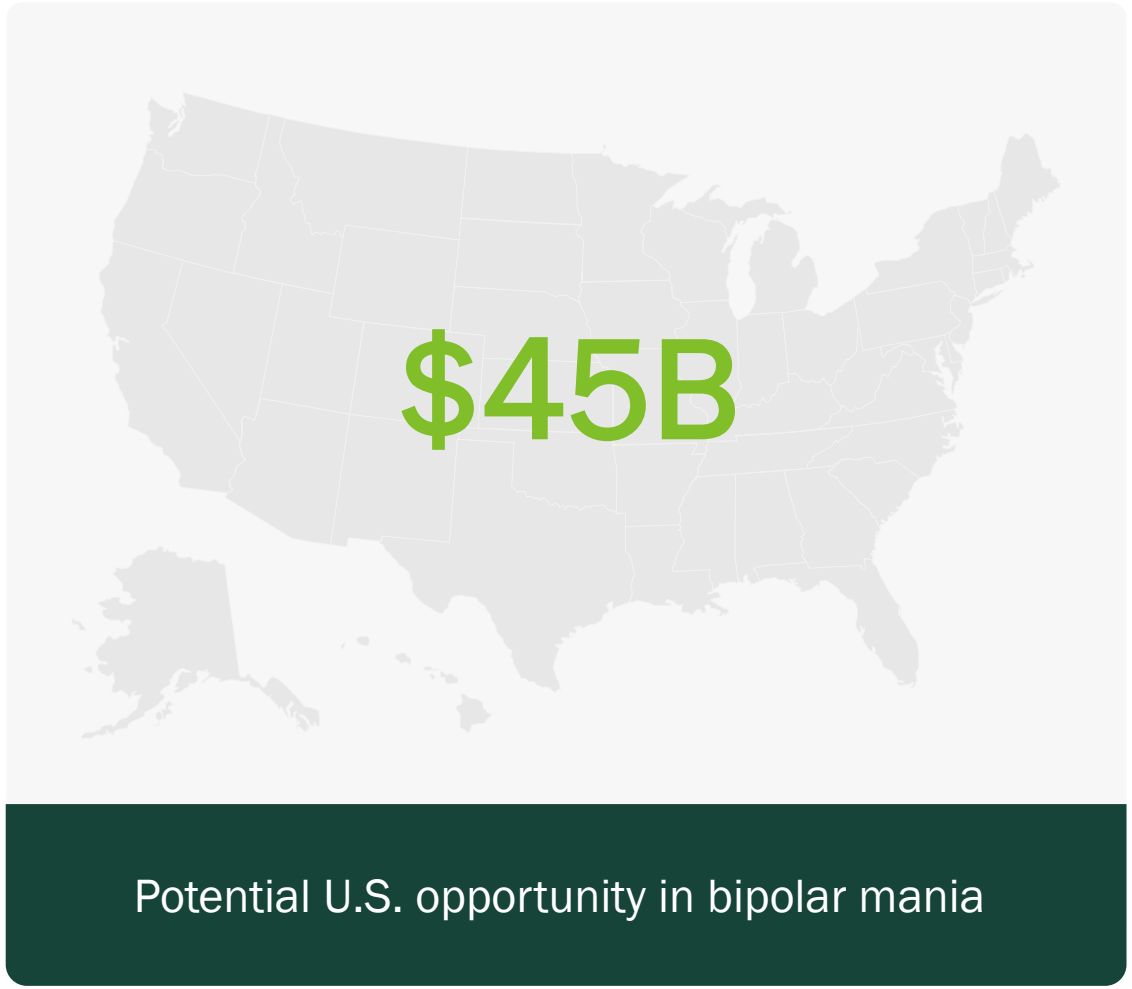


[a]Brooks III et al., *Psychiatry Res* (2010); [b]Yüksel & Öngür, *Biological Psychiatry* (2010); [c]Gigante et al., *Bipolar Disord* (2012); [d]Traynelis et al., *Pharmacol Rev* (2010); [e]Du et al., *J Neurosci* (2004); [f]Lee et al., *Epilepsia* (2008)

$45B bipolar mania market underserved by current standard of care



Metabolic and neurological side effects of SOC lead to lack of compliance and limit long-term chronic use



Potential U.S. opportunity in bipolar mania

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Merikangas et al. *Arch Gen Psychiatry* (2007); Kato et al., *J Affect Disord* (2019); Kessler et al., *Int J Methods Psychiatr Res* (2012); Ringeisen et al., *Int J Methods Psychiatr Res* (2023), Jain et al., *Adv Ther* (2022); Pompili et al., *Acta Psychiatr Scand* (2025); Internal Market Research 2026

BIPOLAR MANIA

Disease State & Treatment Landscape

Mauricio Tohen, MD, DrPH, MBA

University Distinguished Professor & Chairman, Department of Psychiatry, University of New Mexico Health Science Center

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Bipolar Disorders

Mauricio Tohen MD, DrPH, MBA

Service Chief, Behavioral Health

University of New Mexico Hospitals

Distinguished University & Regents' Professor

McMillian Endowed Faculty in Bipolar Disorders Research

Chairman Dept. of Psychiatry & Behavioral Sciences

University of New Mexico Health Sciences Center

Albuquerque, New Mexico, USA

President, America Association of Chairs of Depts Psychiatry

Disclosures

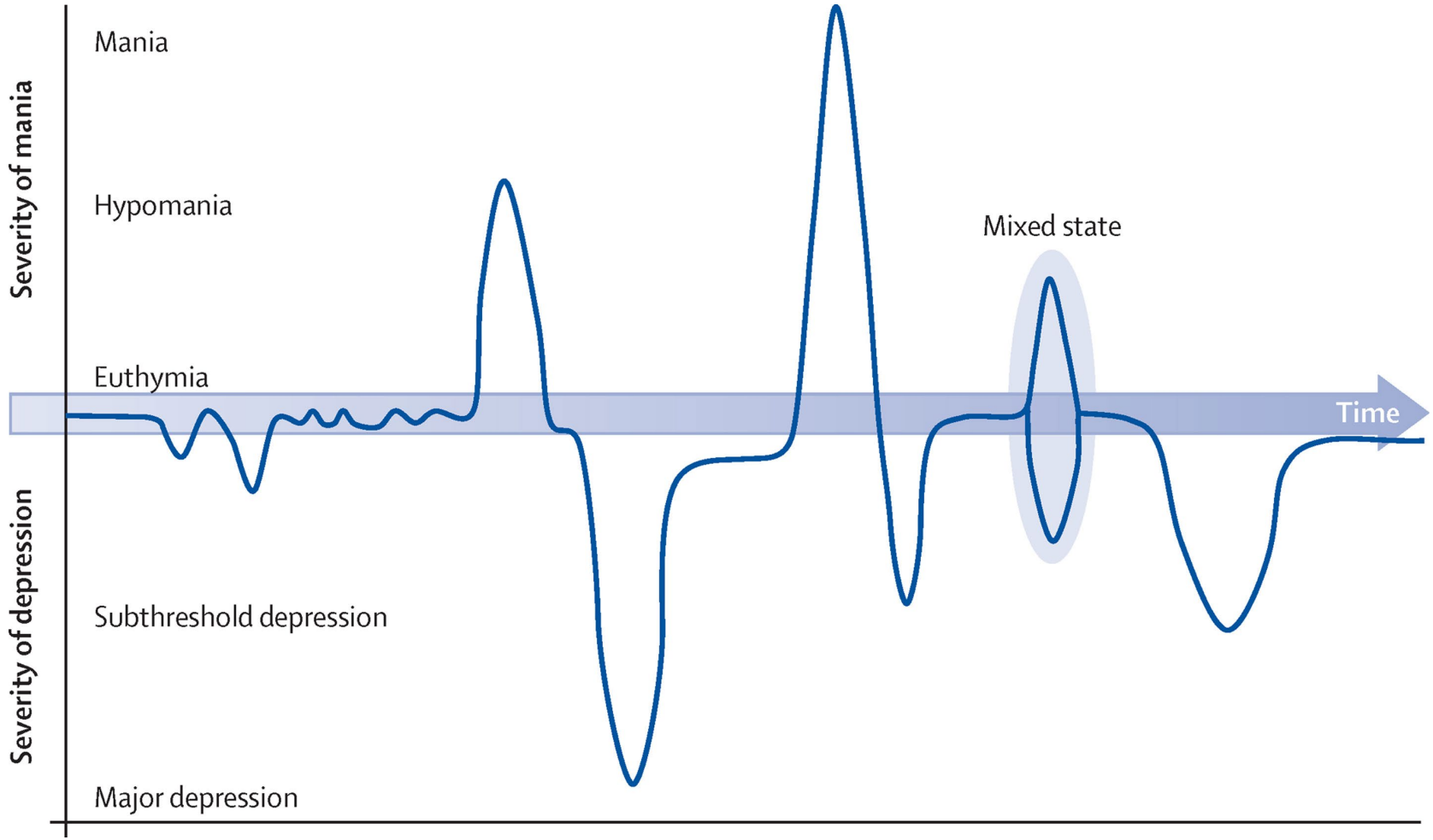
Dr. Tohen has received honoraria from or consulted for Abbott, AbbVie, AstraZeneca, Alkermes, Lilly, Johnson & Johnson, Otsuka, Merck, Gedeon Richter Plc, Sunovion, Intracellular Therapies, Rapport Therapeutics, Roche, Elan, Lundbeck, Teva, Minerva, Neurocrine, and Pfizer; Dr. Tohen was an employee at Lilly (1997–2008), and his spouse was an employee at Lilly (1998–2013).

Epidemiology

- Affects **~1%** population irrespective socioeconomic status, gender, race
- Death by suicide (prevalence 20%) -the most in Psychiatric Conditions
  - **1/3 ➔ 1/2 attempt** suicide, 20% attempts completed
  - Suicide attempts: FH suicide, female, young age, depressive polarity, co-morbid anxiety/substance use disorder
  - Completed suicides: male, first degree FH
- Co-morbidities (Psychiatric, Substance use, Medical)
- Accurate diagnosis is complicated – no valid biomarkers
- Clinical assessment- identification of /mania/hypomania/depression/mixed features
- Disability, cognitive/functional impairment
- Mean delay illness onset to diagnosis = 5-10 years

Course of illness

Mood fluctuations are common – striking and persistent – impairment →



Bipolar I Diagnosis – DSM 5 Criteria

Presence of a manic episode

A. **Mood:** Abnormal elevated, or irritable mood and abnormally and persistently increased activity or energy, lasting at least **1 week** and present most of the day, nearly every day (any duration if hospitalization is necessary)

B. **3/7 sx** including:

1. Grandiosity/self esteem
2. Decreased need for sleep
3. More talkative, racing thoughts/flight of ideas
4. Distractibility (attention drawn to unimportant stimuli)
5. Increase in goal directed activity (social, work, school, sexual)
6. Psychomotor agitation (purposeless non goal directed activity)
7. Impulsive behaviors/high potential for consequences (spending sprees, sexual indiscretions, substance)

C. **Impairment** in social or occupational functioning/ hospitalization to prevent harm to self or others, psychosis

D. Not resulting from substance, drug or medical condition

- Specifiers: Rapid cyclers (4 mood episodes <12 mo), mixed (episodes 3 sx of opposite pole)

Pathophysiology

- One of the most heritable
- Genetics + environmental
- Some alleles genome studies overlap with Schizophrenia
- Imbalance in monoaminergic neurotransmitter systems – serotonergic, noradrenergic, dopaminergic, acetylcholine, **Glutamatergic** – no singular dysfunction
- Neuronal interconnectivity: mitochondria
- Post mortem brain tissue – Cortical/Limbic changes
- **Systemic neuroinflammation**

	Mania	Depression	Maintenance	Advantages	Disadvantages
Mood stabilizers					
Valproate	+++	+	++	mixed features	not recommended in women at childbearing age
Lamotrigine	---	-	+++	Prevents Depression	Slow titration
Lithium	++	++	+++	Anti-suicidal properties prevents mania	**Long term renal side effects**
Carbamazepine	++	+	++	Good tolerance	**Interaction with other drugs**
Oxcarbazepine	+	+	+	Fewer adverse effects than carbamazepine	Better tolerated
Typical antipsychotics					
Chlorpromazine	++	---	+	Rapid efficacy	Risk of switch to depression, extrapyramidal symptoms
Haloperidol	+++	---	+	IM, Rapid efficacy, LAI	Risk of switch to depression, extrapyramidal symptoms

Atypical Antipsychotics

	Mania	Depression	Maintenance	Advantages	Disadvantages
Aripiprazole	+++	-	++	Mania, good metabolic profile Intramuscular administration - 4 weeks	Akathisia
Asenapine	+++	+	+	depressive symptoms	Moderate metabolic syndrome
Clozapine	+	+	++	Treatment Resistant patients	Agranulocytosis, sialorrhoea, postural hypotension
Lurasidone	+	+++	+	Lack of anticholinergic effects	Efficacy related to feeding, akathisia, sedation
Olanzapine	+++	+++	++	Rapid efficacy	Severe metabolic syndrome
Paliperidone	++	-	++	intramuscularly every month	High doses are often needed
Quetiapine	+++	+++	+++	Only antipsychotic indications mania Depression, maintenance	Sedation
Risperidone	++	-	++	Intramuscular administration - 4 weeks	Risk of switch to depression, extrapyramidal symptoms
Ziprasidone	++	-	++	Mania, good metabolic profile	Efficacy related to feeding
Cariprazine	+	+++			
Lumateperone	+	+++			
Antidepressants	--	+	+	Applicable in resistant bipolar depression combined with mood stabilizers	Risk of switch to mania
Electroconvulsive TMS	++	++	+	Treatment Resistant, Pregnancy	General anesthesia. Cognition Not FDA approved

Unmet Needs for Treatment of Mania

- More effective & Better tolerated
- New Mechanisms of Action
- Faster onset of action
- Effective mania/depression/mixed – Maintenance
- Long lasting option

Long Term

- Curative not just symptom amelioration
- Personalized Medicine

BIPOLAR MANIA

RAP-219 Phase 2 Trial Design & Defining Clinical Success

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Gary Sachs, MD

Founding Director, Bipolar Clinic & Research Program, Massachusetts General Hospital

Associate Clinical Professor of Psychiatry, Harvard Medical School

Clinical Vice President, Signant Health

Acute Mania RCT Challenges: a Clinical Trialist Perspective

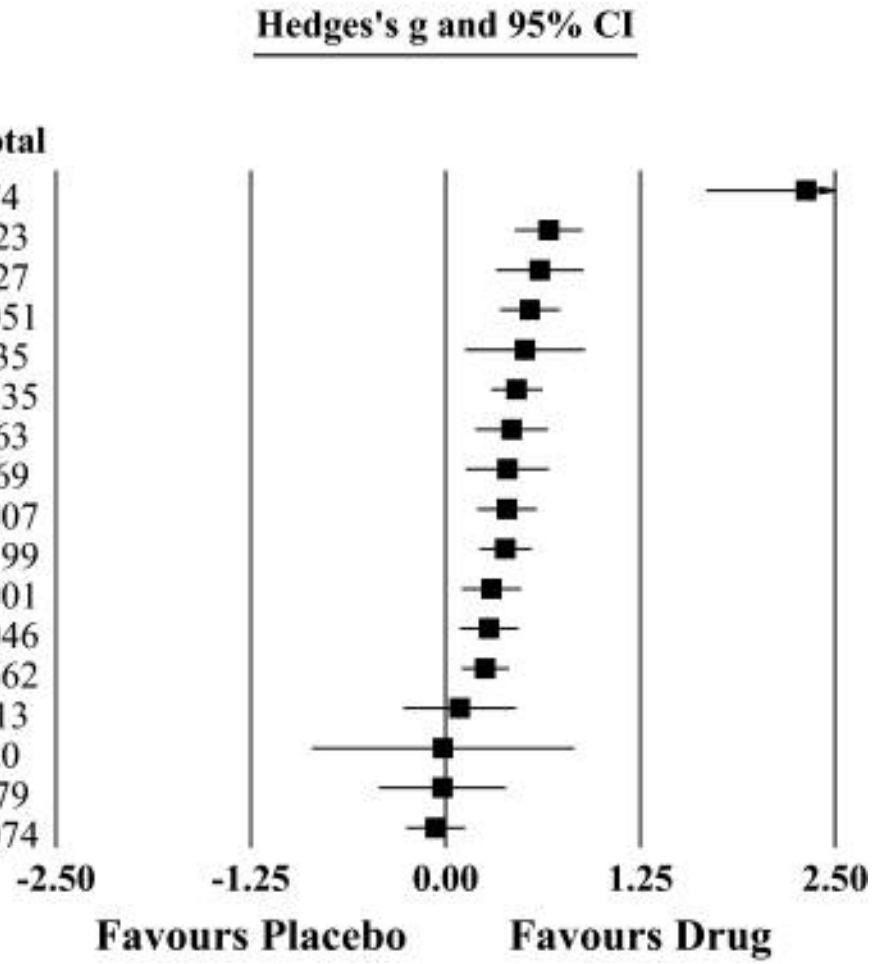
Conflict of Interest: Disclosure Past 36 Months

Full Time Employee:	Signant Health
Consulting/DSMB:	4M Therapeutics, Abbvie, Beckley, BMS, Cognitiv, IntraCellular Therapies, Kintsugi, Neumora, Merck, Rapport, Seaport, Syntropic, Xenon
Equity/Options:	Signant Health, Collaborative Care Initiative, Kintsugi

Acute Mania RCTs Have a Good Track Record of Success!

Efficacy of Antimanic Treatments: Meta-analysis of Randomized, Controlled Trials

Study name	Hedges's g	Lower limit	Upper limit	p-Value	Total
Tamoxifen	2.32	1.67	2.96	0.000	74
Risperidone	0.66	0.45	0.88	0.000	823
Carbamazepine	0.61	0.32	0.89	0.000	427
Haloperidol	0.54	0.35	0.73	0.000	1051
Cariprazine	0.51	0.13	0.89	0.009	235
Olanzapine	0.46	0.29	0.62	0.000	1335
Ziprasidone	0.42	0.19	0.66	0.000	663
Asenapine	0.40	0.13	0.66	0.003	569
Quetiapine	0.40	0.20	0.59	0.000	1007
Lithium	0.39	0.22	0.55	0.000	1199
Paliperidone	0.30	0.11	0.49	0.002	1001
Valproate	0.28	0.09	0.47	0.003	1046
Aripiprazole	0.26	0.10	0.41	0.001	1662
Licarbazepine	0.09	-0.27	0.45	0.621	313
Verapamil	-0.02	-0.86	0.83	0.970	20
Lamotrigine	-0.02	-0.43	0.39	0.927	179
Topiramate	-0.06	-0.25	0.13	0.508	1074



Forest plot of Hedges' g with its 95% upper and lower limits (confidence interval (CI)), based on mania score changes in 55 drug/placebo comparisons, based on random effects meta-analysis. Filled squares indicate pooled results of individual drugs (and their CI). Drugs are listed according to the magnitude of the pooled effect sizes (Hedges' g).

Yildiz et al. Neuropsychopharmacology. 2011 Jan; 36(2): 375–389.
Published online 2010 Oct 27. doi: 10.1038/npp.2010.192

But, at the end of 3-4 weeks, the average participant in an acute mania trial experiences symptoms of sufficient severity to meet study entry criteria.

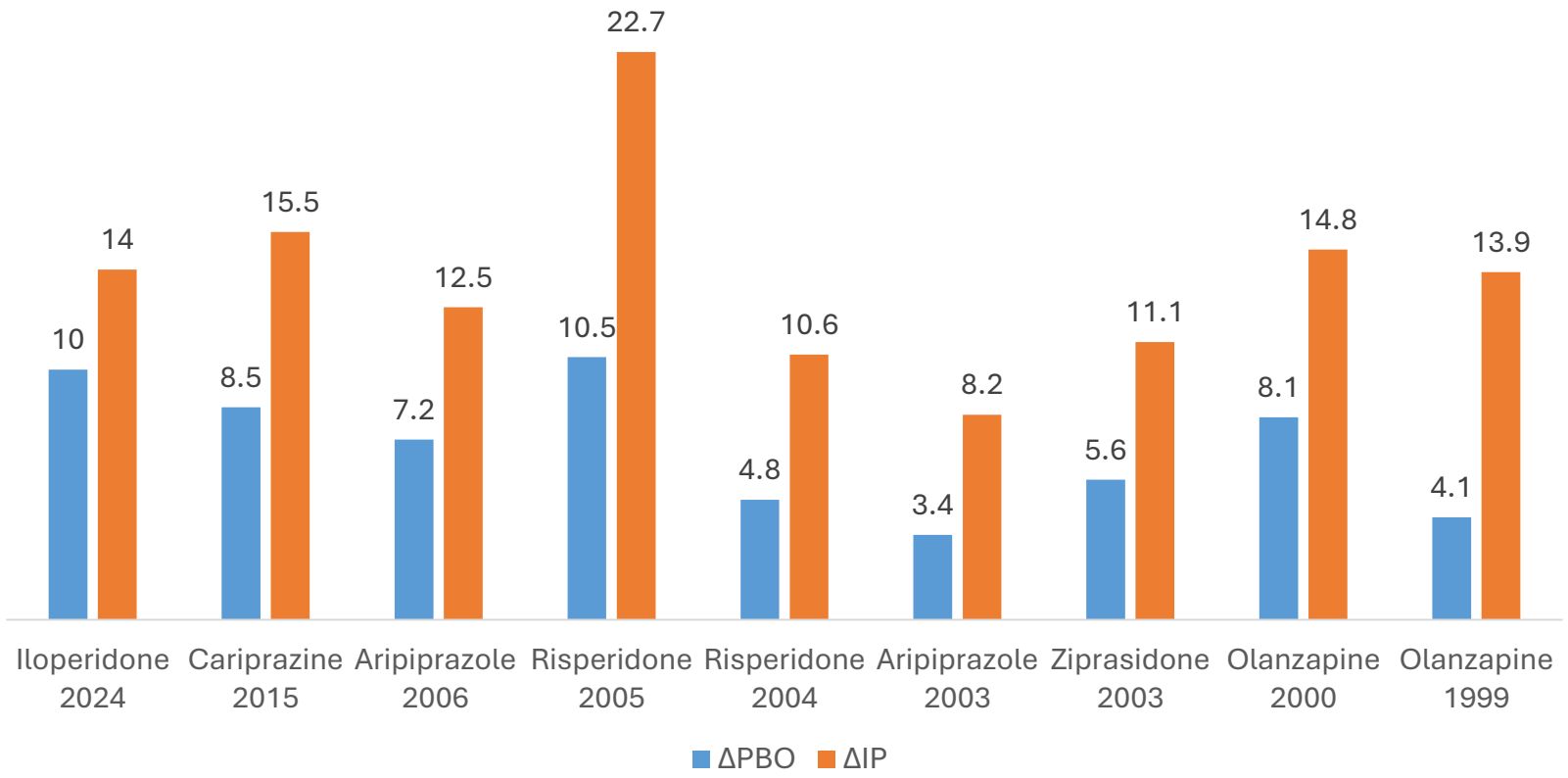
Unmet needs

Fully resolve mania

Rapid acting agent

Less burdensome agent (Weight/Metabolic, Cognition, Sedation, Lab monitoring, EPS, Tardive Dyskinesia)

Signal in Successful Acute Mania Trials
ΔYMRS Placebo and IP

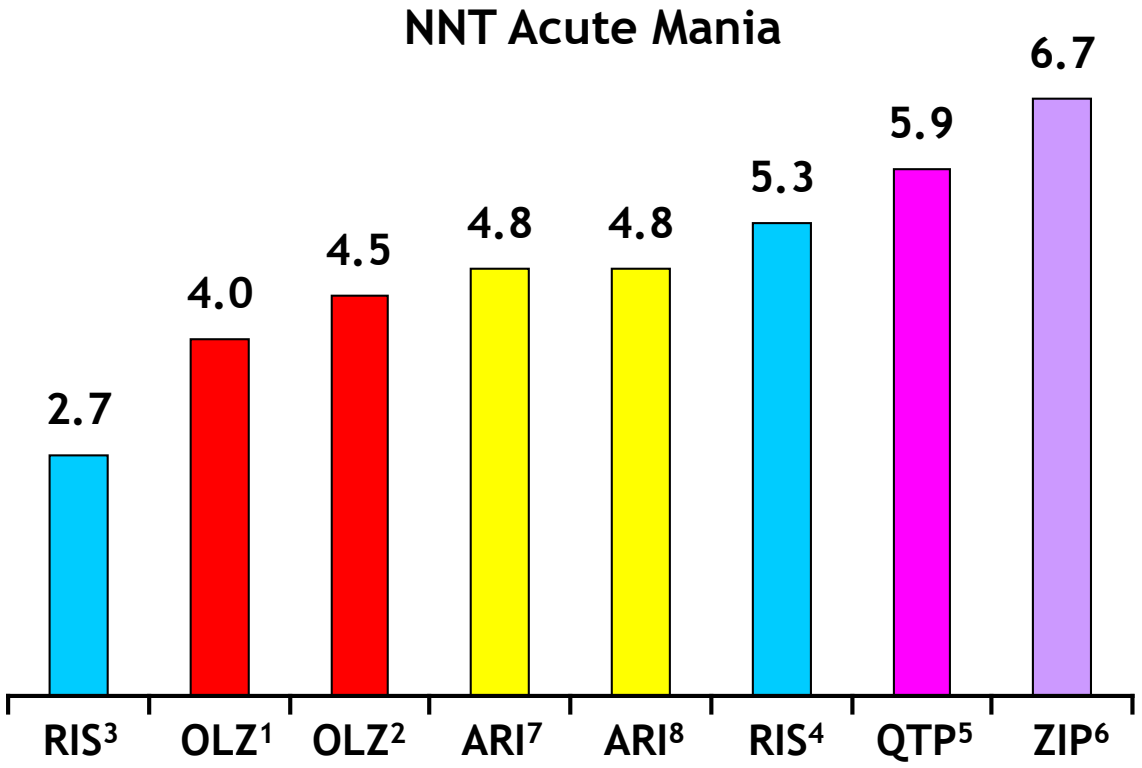


Comparisons across studies is not valid comparisons of efficacy!!!

NNT Likely Reflect Similar Effect Size but Some Interesting Differences Between Studies

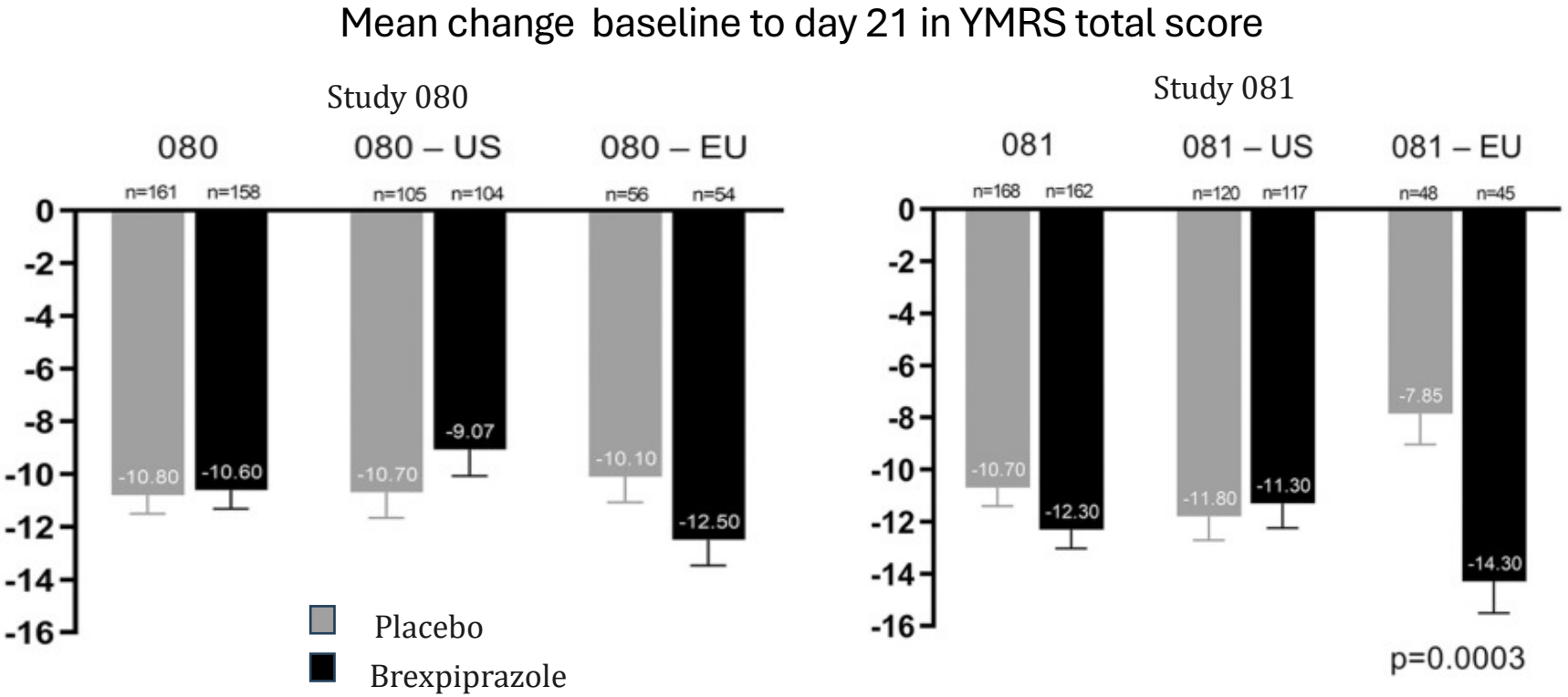
Number Needed to Treat (NNT)= 1/(Active Response Rate - Placebo Response Rate)

Study	Response Rate
Tohen 1999[1]	Olanzapine (OLZ)=49% Placebo=24%
Tohen 2000[2]	OLZ=65% Placebo=43%
Khanna 2005[3]	Risperidone (RIS)=73% Placebo=36%
Hirschfeld 2004[4]	RIS=43% Placebo=24%
Vieta 2005[5]	Quetiapine (QTP)=48% Placebo=31%
Keck 2003[6]	Ziprasidone (ZIP)=50% Placebo=35%
Keck 2003[7]	Aripiprazole (ARI)=40% Placebo=19%
Sachs 2006[8]	ARI=53% Placebo=32%



1. Tohen M et al. *Am J Psychiatry.* 1999;156:702-709; 2. Tohen M et al. *Arch Gen Psychiatry.* 2000;57:841-849; 3. Khanna S et al. *Br J Psychiatry.* 2005;187:229-234; 4. Hirschfeld RM et al. *Am J Psychiatry.* 2004;161:1057-1065; 5. Vieta E et al. *Curr Med Res Opin.* 2005;21:923-934; 6. Keck PE Jr et al. *Am J Psychiatry.* 2003;160:741-748; 7. Keck PE Jr et al. *Am J Psychiatry.* 2003;160:1651-1658; 8. Sachs G et al. *J Psychopharmacol.* 2006;epub Feb 14.

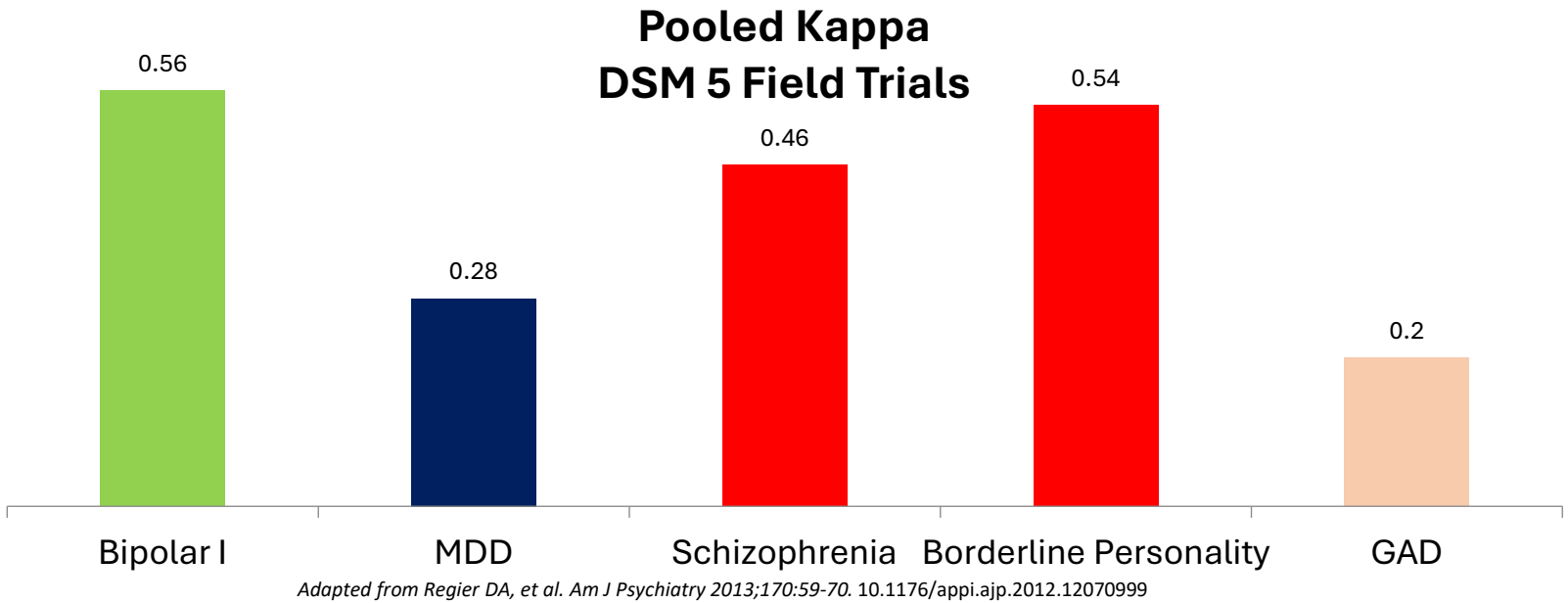
Brexpiprazole for the acute treatment of bipolar mania
Two randomized, double-blind, placebo-controlled trials



- In treatment-by-subgroup (sex, age, region, and race) interaction analyses, none of the subgroup interactions at day 21 were significant at the 0.05 level except for the treatment-by-region interaction term in study 081 ($p = 0.0016$).
- There was a difference between brexpiprazole and placebo in change from baseline to day 21 in YMRS total score in patients from the EU in study 081 (LS mean difference: −6.42 (95% CLs −9.79, −3.05)), with a nominal p-value of 0.0003, but not in study 080 (LS mean difference: −2.38 (95% CLs −5.10, 0.34); nominal p-value = 0.0858;

Reliability of MDD and Anxiety Diagnoses is Moderate to Poor:

Competent clinicians frequently differ



Adapted from Regier DA, et al. Am J Psychiatry 2013;170:59-70. 10.1176/appi.ajp.2012.12070999

Opportunity: Maximize chance of success

by utilizing low burden checks on diagnostic reliability.

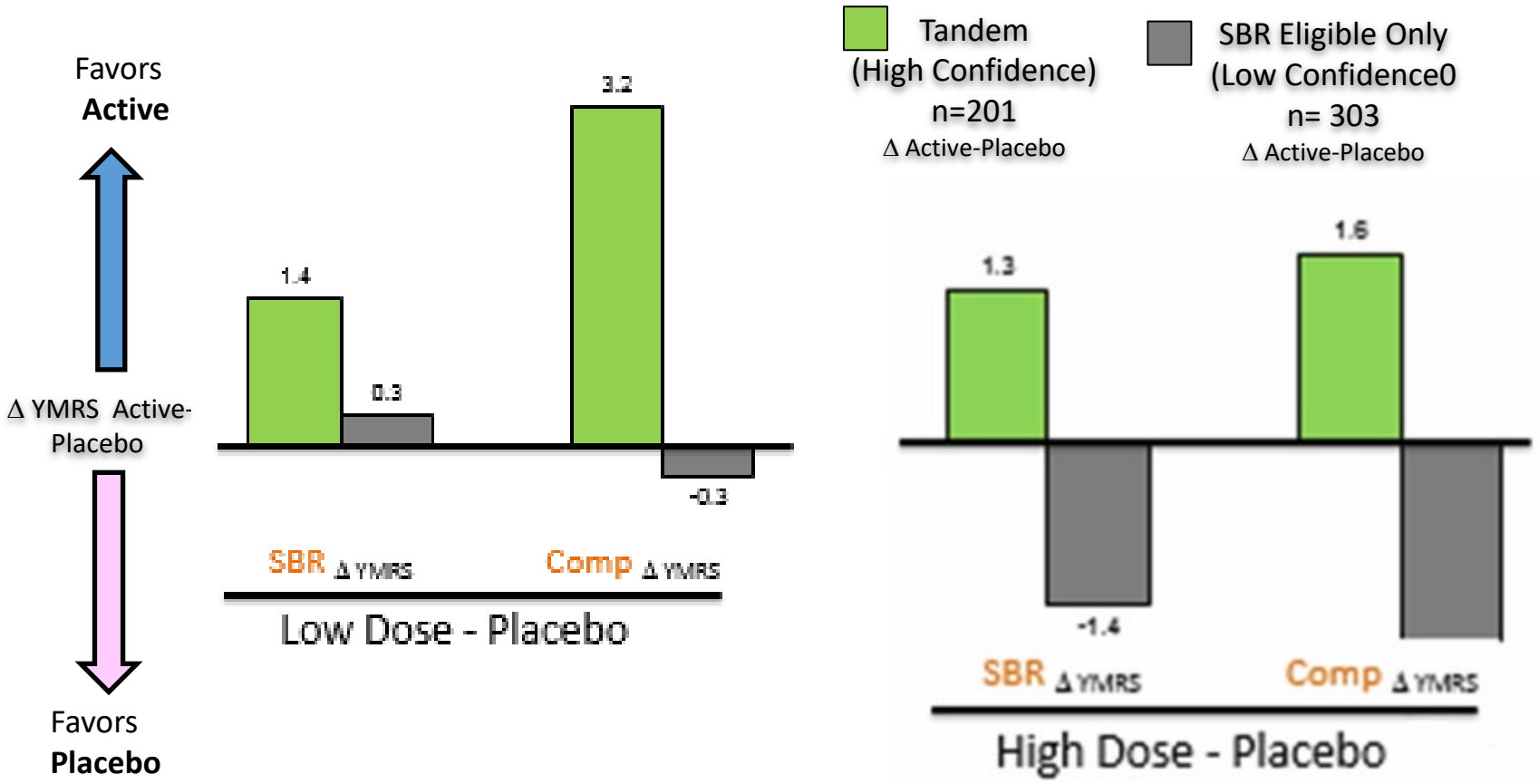
High reliability can be defined as two independent assessments with the same results.

One of these assessments could be done by a computer

Lessons from a Failed Study: Diagnosis Matters

Study of adjunctive Ziprasidone vs Placebo for treatment of BP mania or mixed episodes

Meets DSM IV Mania or Mixed Criteria by **Tandem Rating**



Sachs GS, Vanderburg D, Karayal ON, Kolluri S, Bachinsky M, Cavus I: Adjunctive Oral Ziprasidone in Patients With Acute Mania Treated With Lithium or Divalproex: 1. Results of a Randomized, Double-Blind, Placebo-controlled Trial. J Clin Psychiatry (in press)

Despite all the advances in neuroscience,

there are no lab tests for bipolar disorder

What can be done now

?

Validating Lifetime Mood Disorder Diagnosis: Five Dimensions

1. Index Episode Characteristics
2. Age of Onset
3. Course of illness
4. Family History
5. Response to Treatment

Robins E, Guze SB: Establishment of diagnostic validity in psychiatric illness: its application to schizophrenia. Am J Psychiatry 126:983-987, 1970.

20 point scale for each dimension

20	Most convincing characteristic
15	Other convincing characteristics
10	Known associated feature suggestive of the disorder
5	Nonspecific feature suggestive of the disorder
0	No evidence of the disorder

Sachs G. Strategies for improving treatment of bipolar disorder: integration of measurement and management. Acta Psychiatr Scand Suppl.;422:717. 2004

Bipolarity Index

Journal of Affective Disorders 177 (2015) 59–64

Contents lists available at ScienceDirect

Journal of Affective Disorders

journal homepage: www.elsevier.com/locate/jad

Research report

The Bipolarity index: a clinician-rated measure of diagnostic confidence

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[d] Duke University Medical Center, Durham, NC, USA
[e] Bipolar Clinic and Research Program at Massachusetts General Hospital, Boston, MA, USA
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Journal of Affective Disorders

journal homepage: www.elsevier.com/locate/jad

Research paper

Bipolar diagnosis in China: Evaluating diagnostic confidence using the Bipolarity Index

Yantao Ma [a,b,c], Huimin Gao [a,b,c], Xin Yu [a,b,c,**], Tianmei Si [a,b,c], Gang Wang [d], Yiru Fang [e], Zhening Liu [f], Jing Sun [g], Haichen Yang [h], Xueyi Wang [i], Jing Li [j], Yonghua Zhang [k], Gary Sachs [l,*]

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[d] Beijing An-ding Hospital, Beijing, China

BIPOLAR DISORDERS

Bipolar Disorders 2014: 16: 389–399

Original Article

Bipolar II disorder in patients with a current diagnosis of recurrent depression

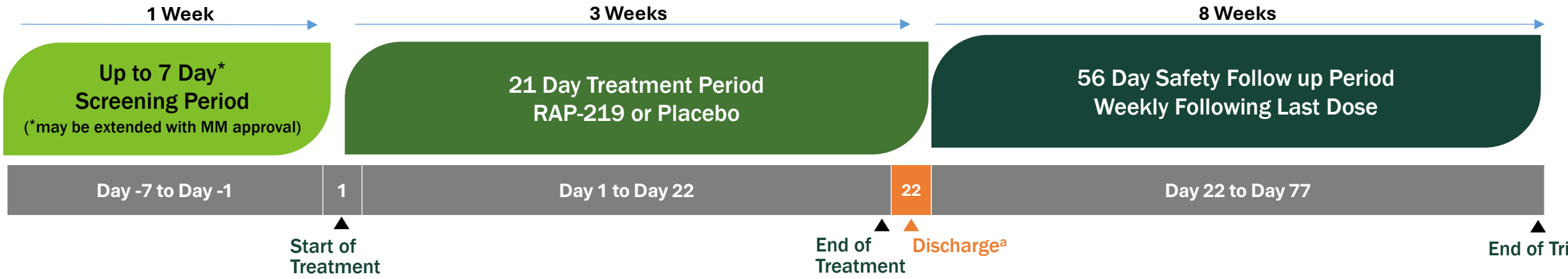
Mosolov S, Ushkalova A, Kostukova E, Shafarenko A, Alfimov P, Kostyukova A, Jules A. Bipolar II disorder in patients with a current diagnosis of recurrent depression. Bipolar Disord 2014: 16: 389–399. © 2014 John Wiley & Sons A/S. Published by John Wiley & Sons Ltd.

Objectives: The prevalence of bipolar II disorder (BD-II) in Russia has never been studied. Therefore, we sought to identify patients meeting diagnostic criteria for BD-II among patients with a current diagnosis of recurrent depressive disorder (RDD) through the use of the Russian versions of the Hypomania Checklist (HCL-32) and Bipolarity Index scales for differentiating between BD-II and RDD.

Sergey Mosolov[a], Anna Ushkalova[a], Elena Kostukova[a], Alexey Shafarenko[a], Pavel Alfimov[a], Anastasiya Kostyukova[a] and Jules Angst[b]

[a]Department for Therapy of Mental Disorders, Moscow Research Institute of Psychiatry, Moscow, Russia, [b]Department of Psychiatry, Zurich University Psychiatric Hospital, Zurich, Switzerland

RAP-219 Phase 2 Proof-of-Concept Trial in Bipolar Mania



Population

- Bipolar mania
- N = ~250

Key Entry Criteria

- Meets the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis of bipolar I disorder, with or without mixed features, with or without psychotic symptoms, as confirmed by the Structured Clinical Interview for DSM-5, Clinical Trials Version (SCID-5-CT)
- At least one prior documented manic episode (with or without psychotic symptoms) that required treatment, within 5 years prior to Visit 1

Key Endpoints

- Change from baseline to Week 3 in Young Mania Rating Scale (YMRS) total score
- Change from baseline to Week 1 in YMRS total score
- Change from baseline to Week 3 in Clinical Global Impressions–Bipolar Version (CGI-BP) Severity of Illness-Mania score

Dose Regimen

- Participants randomized 1:1:2 (RAP-219 cohorts pooled for efficacy)
  - RAP-219 with 2 or 4-day titration, then 0.75mg x 19 days
  - RAP-219 with 4-day titration, 0.75mg x 17 days
  - Placebo

NCT07046494; [a]If a participant does not meet all discharge criteria; the Investigator may reassess at their discretion for up to 1 week following the last dose or may transfer the participant to an appropriate care center in accordance with standard of care.

Key Inclusion/Exclusion Criteria

Inclusion

- Age 18-65
- Meets DSM-5 diagnostic criteria for Bipolar I disorder, with or without psychotic features and with or without mixed features
- YMRS total score ≥25 at Screening and Baseline, and no more than 20% improvement on YMRS score between Screening and Baseline
- Score of ≥4 on at least 2 of the 4 core YMRS items (irritability, speech, content, disruptive/aggressive behavior) at Screening and Baseline
- Score ≥50 on the Bipolarity Index at Screening
- Current episode has been present for ≤12 weeks prior to Screening
- MADRS total score <18 at Screening and Baseline
- Meets criteria for inpatient hospitalization
- Had at least one prior documented manic episode (with or without psychotic symptoms) that required treatment, within 5 years prior to Screening
- Previously responded to at least one course of antimanic treatment

Exclusion

- History of schizophrenia or schizoaffective disorder, moderate or severe substance use disorders, cognitive disorders, or personality disorders
- Rapid cycling (≥ 4 distinct mood episodes in the past 12 months)
- Current manic episode results from treatment with a pharmacological agent or from recreational drug use per Investigator
- Inability to reliably report symptoms of mania, as evidenced by ≥7 point discordance in YMRS total score between Investigator interview and computer simulated rater interview at Screening or Baseline
- Suicidal ideation with intent within 6 months prior to screening or at baseline; history of a suicide attempt within the year prior to screening, or at risk of suicide per the Investigator

Ensuring Data Quality

Diagnostic Confidence

SCID-5-CT confirmed diagnosis, Bipolarity Index ≥ 50, and a documented history of a prior manic episode (within 5 years) with antimanic treatment

Mania-Predominant Profile

MADRS < 18 at Screening and Baseline, limiting enrollment of patients whose presentation is more depressive than manic

Eligibility Review

Eligibility was reviewed by the study team for each patient in the study to ensure they met inclusion/exclusion criteria and confirm the diagnostic accuracy of the Bipolar mania diagnosis

Symptom Severity Threshold

YMRS ≥ 25 at both Screening and Baseline, ≥ 4 on 2 of 4 core YMRS items, and symptoms severe enough to require inpatient hospitalization

Symptom Stability Screen

No more than 20% YMRS improvement between Screening and Baseline — excludes patients whose mania is self-resolving

Site Clinician/Rules Based AI concordance

YMRS ratings reviewed for concordance between patient computer administered assessments and site clinician ratings to ensure consistent and accurate reporting of mania symptoms

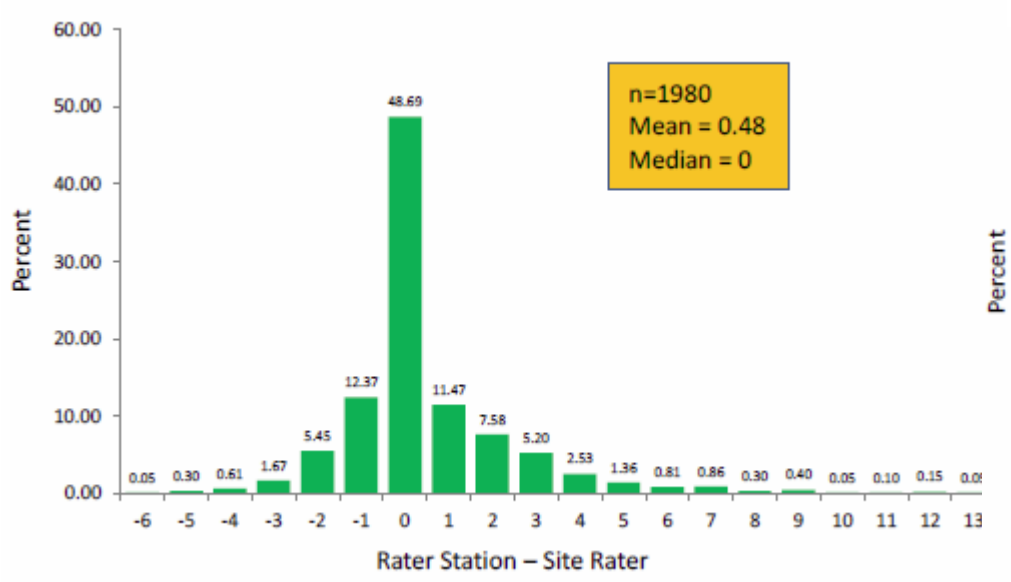
Ongoing Blinded Monitoring

Blinded data analytics run throughout the study, with a CRO dedicated to trial quality tracking site-level variability — flagging issues early while preserving the blind

SCID-5-CT= Structured Clinical Interview for DSM-5 Disorders, Clinical Trials Version, MADRS= Montgomery-Åsberg Depression Rating Scale; YMRS= Young Mania Rating Scale

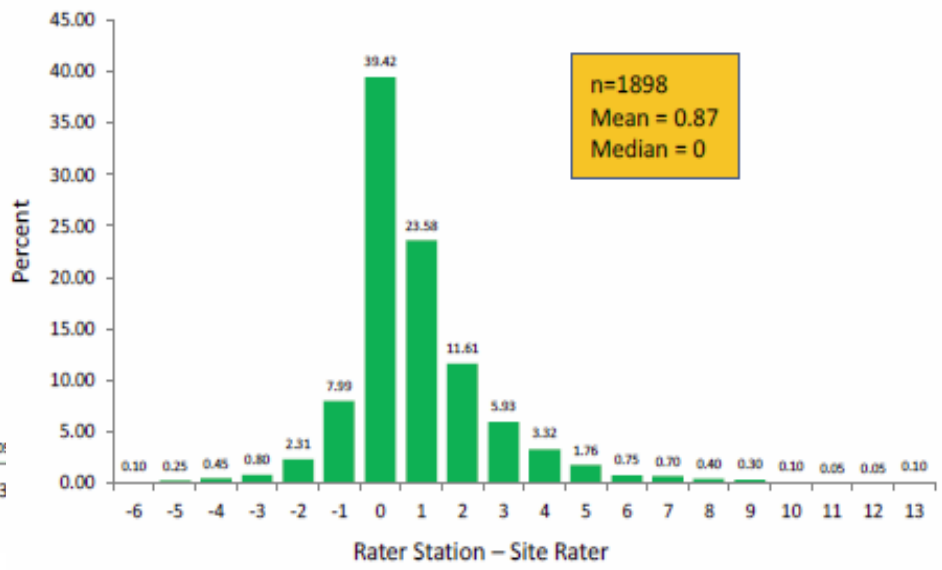
Observed Concordance: Site Based Rater and Rules-based AI

MADRS Computer-SBR



- Across all open phase visits, mean difference between computer/clinician MADRS was 0.48
- MADRS computer ratings were higher in 33% and lower in 19%

YMRS Computer-SBR



- Across all open phase visits, mean difference between computer/clinician YMRS was 0.87 YMRS ratings were higher in 48% and lower in 12%.
- % computer scores > 4 points higher < 4%

Multiple anticipated catalysts over 12-18 months

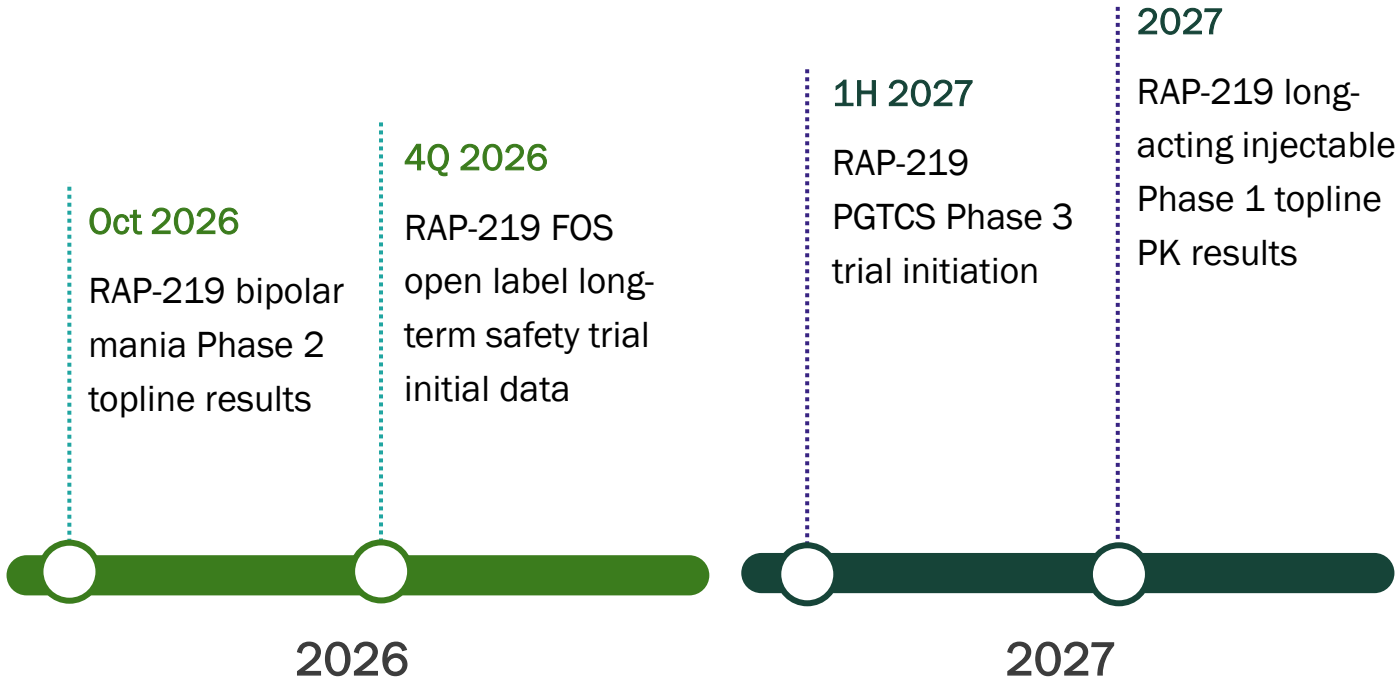
Cash balance of $436.1M[1] (as of 6/30/26) supports Rapport into 2H 2029

RAP-219 Epilepsy Portfolio

- ✓ RAP-219 Phase 3 FOCUS 1 & FOCUS 2 trials enrolling
- ✓ RAP-219 FOS open-label long-term safety trial underway
- ✓ RAP-219 NDA-enabling activities progressing
- ✓ LAI IND-enabling activities progressing

RAP-219 Bipolar Program

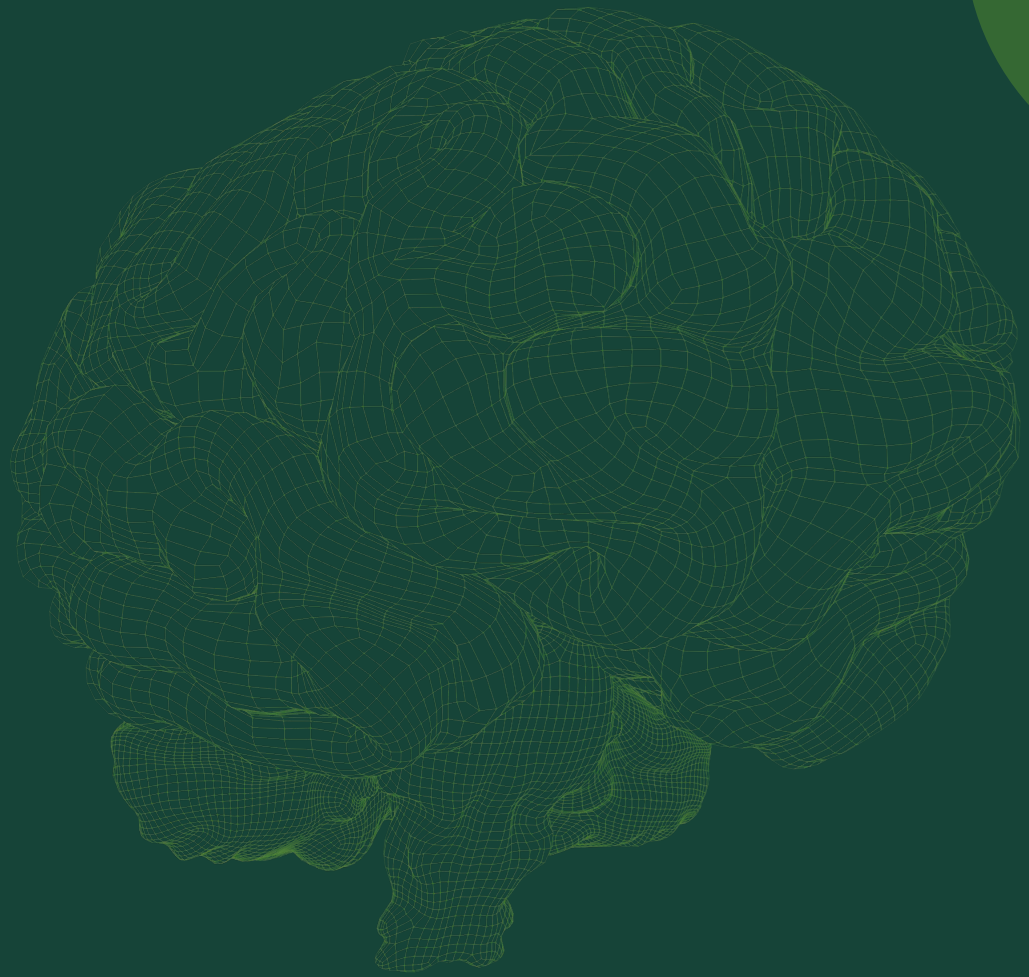
- ✓ RAP-219 Phase 2 bipolar mania trial full enrolled



Additional catalysts: RAP-641 (α6β4) Phase 1 trial initiation

[1]Includes cash, cash equivalents, and short-term investments, excluding restricted cash.

Questions & Answers



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