PROTARA THERAPEUTICS

Corporate Presentation

May 2026

Forward Looking Statements

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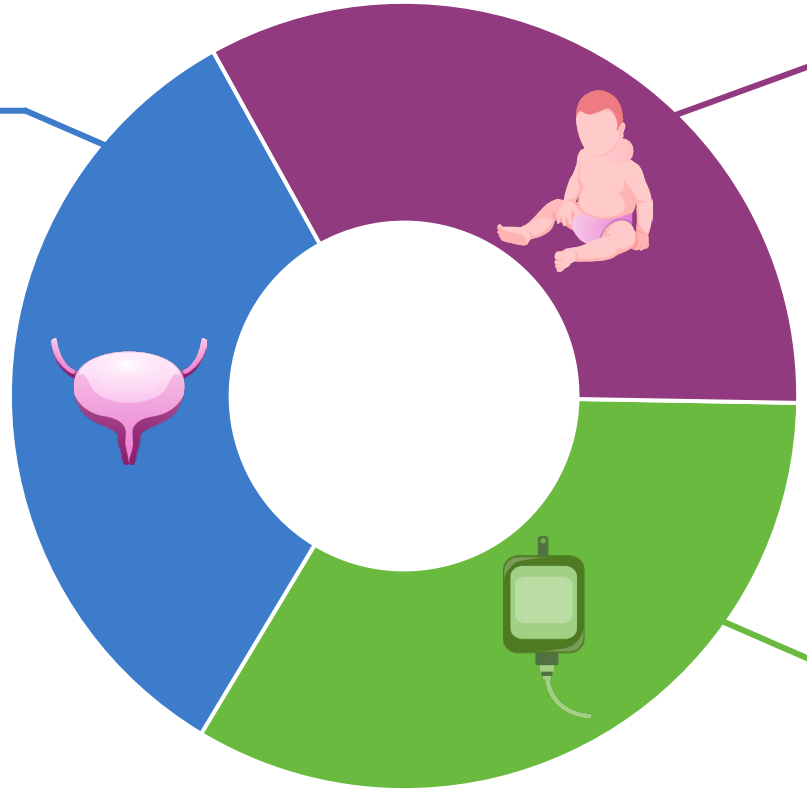
PROTARA THERAPEUTICS

Transformative Investigational Therapies in Oncology and Rare Disease

ONCOLOGY

TARA-002 in Non-Muscle Invasive Bladder Cancer

- Positive interim data in BCG-Unresponsive and BCG-Naïve patients from ADVANCED-2 trial TARA-002 in NMIBC
- FDA supported Company's BCG-Naïve registrational trial design
- Unique product characteristics anticipated to drive significant adoption in large market with high unmet need



RARE PEDIATRIC

TARA-002 in Lymphatic Malformations

- Pediatric program for indication with no currently approved therapies available in the US
- Positive interim data update from the STARBORN-1 trial assessing TARA-002 in pediatric LMs
- Intend to submit BLA in 2H'27
- Granted FDA Rare Pediatric Disease, Orphan Drug, Breakthrough Therapy and Fast Track Designations

RARE GI

IV Choline Chloride for Patients on Parenteral Support

- 78% of patients dependent on PS are choline-deficient and the majority have resulting liver damage, yet no approved IV formulations exist
- Granted FDA Orphan Drug and Fast Track designations

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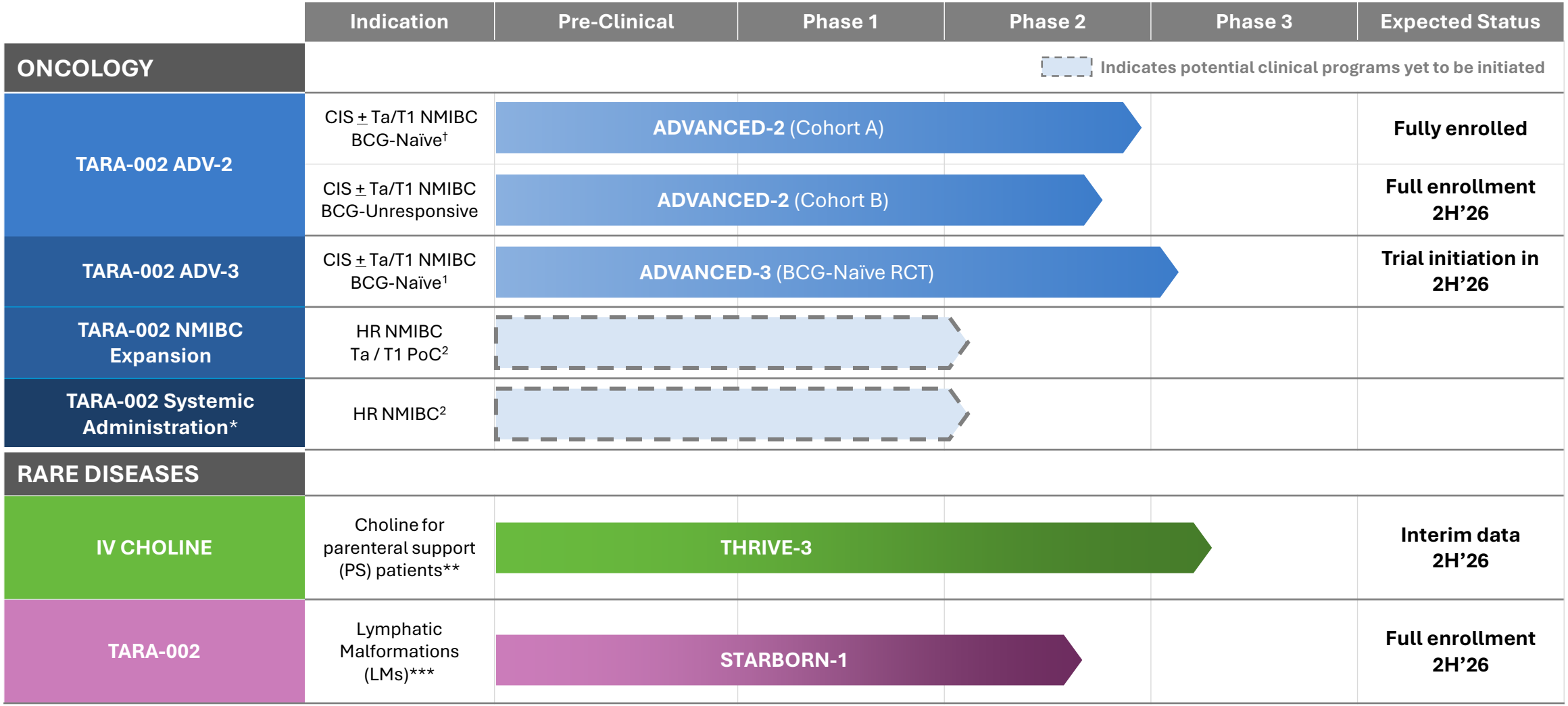
Diversified Late-Stage Pipeline



*Currently in pre-clinical studies to define dosing
**IV Choline granted Orphan Drug Designations by the U.S. FDA for the prevention and/or treatment of choline deficiency in patients on long-term PN and Fast Track Designation as a source of choline when oral or enteral nutrition is not possible, insufficient, or contraindicated.
***TARA-002 granted Rare Pediatric Disease Designation as well as Breakthrough Therapy and Fast Track Designations by the U.S. FDA and Orphan Drug Designation by the European Commission for the treatment of LMs.
†Trial also includes BCG-Exposed patients; 1Subject to regulatory clearance 2Potential expansion opportunity for NMIBC program

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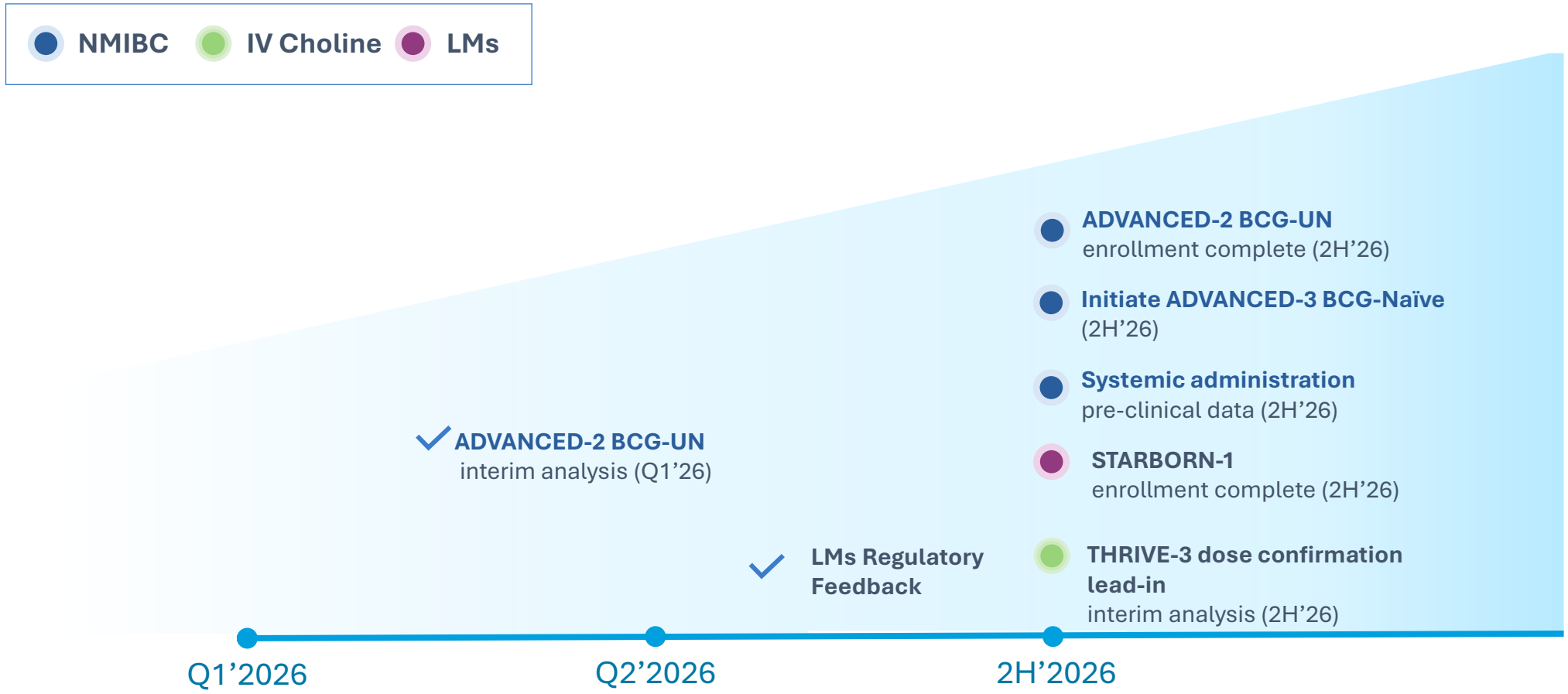
Multiple Near-Term Milestones Anticipated



BALANCE SHEET: $177M of cash, cash equivalents and investments in marketable debt securities as of March 31, 2026, with cash runway expected into 2028

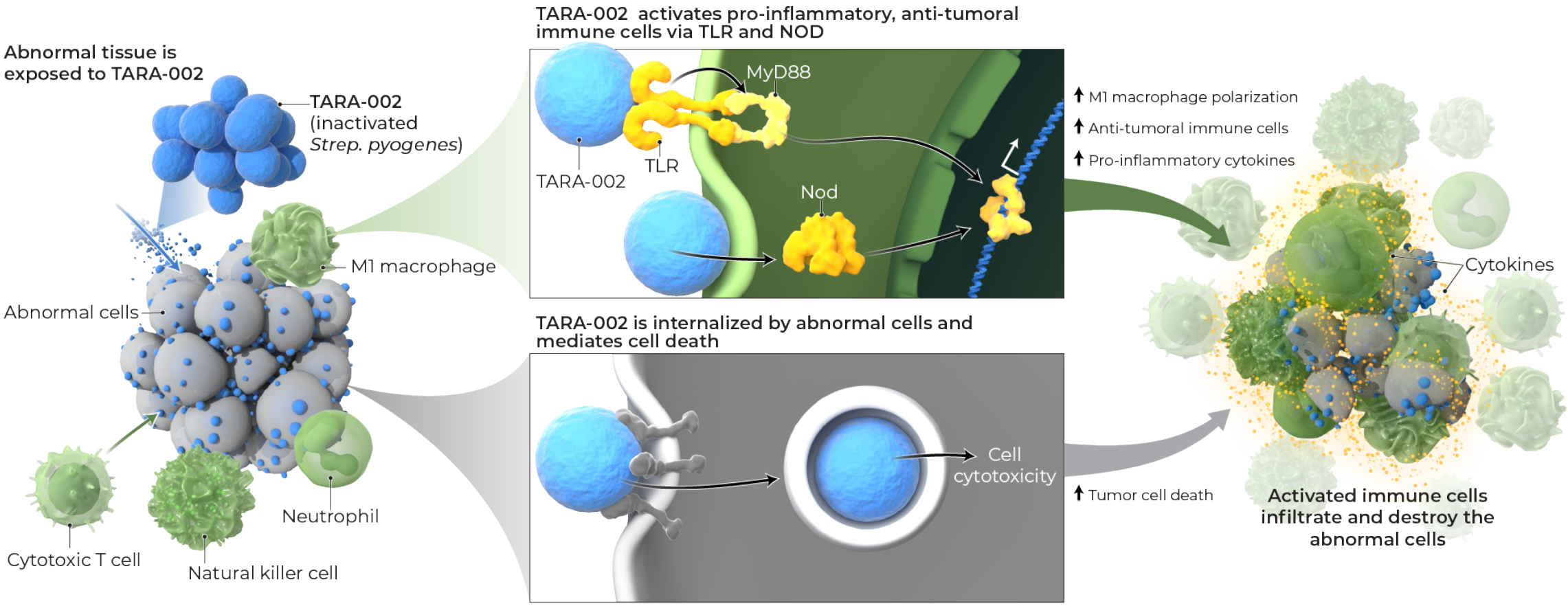
COMMON SHARE EQUIVALENTS (63.1M)*: 55.1M Common + 4.6M Preferred + 3.4M Pre-funded warrants on as converted basis as of March 31, 2026

*Does not include 9.7M common warrants outstanding from the April 2024 private placement exercisable at $5.25 per share. Termination acceleration for the outstanding warrants was triggered on March 30, 2026 and any warrants not exercised by June 29, 2026 will expire in accordance with the terms of the warrant agreements

TARA-002

Non-Muscle Invasive Bladder Cancer (NMIBC)

TARA-002: A Unique TLR2/NOD2 Agonist Derived From *Streptococcus pyogenes* That Brings a New Immunologic Mechanism to NMIBC Beyond BCG



TARA-002 ignites both innate and adaptive immunity through dual TLR2/NOD2 activation, driving potent local anti-tumor / cystic responses via fully inactivated bacteria[1, 2, 3]

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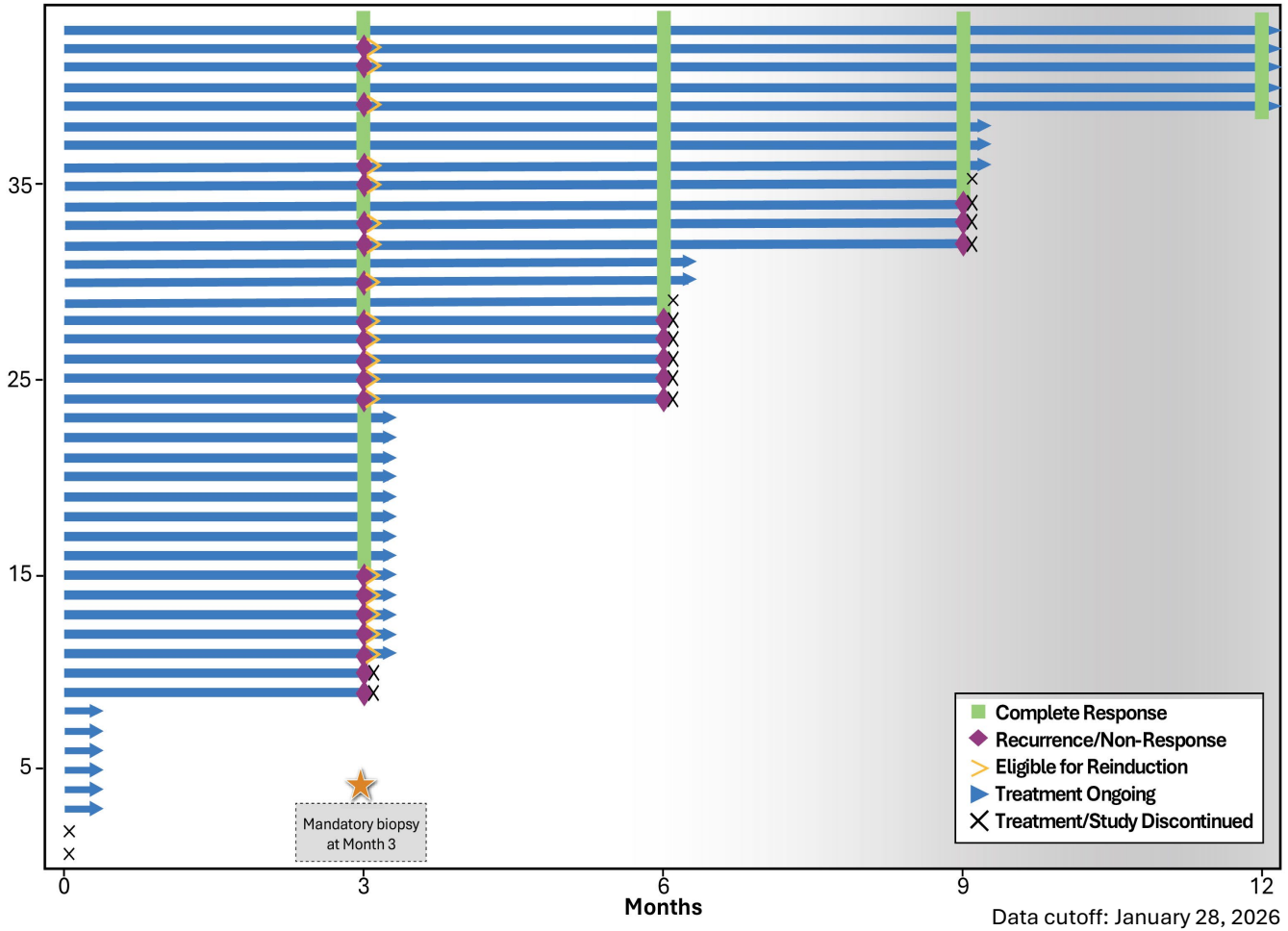
References pertain to publications on OK-432, TARA-002 predecessor therapy: [1]Fujimoto T., et al. J Immunol. 1997: 5619; [2]Ryoma Y, et al. Anticancer Res. 2004; 3295-3298; [3]Zhao H, et al. Microbiol. Immunol. 1994; 183-190

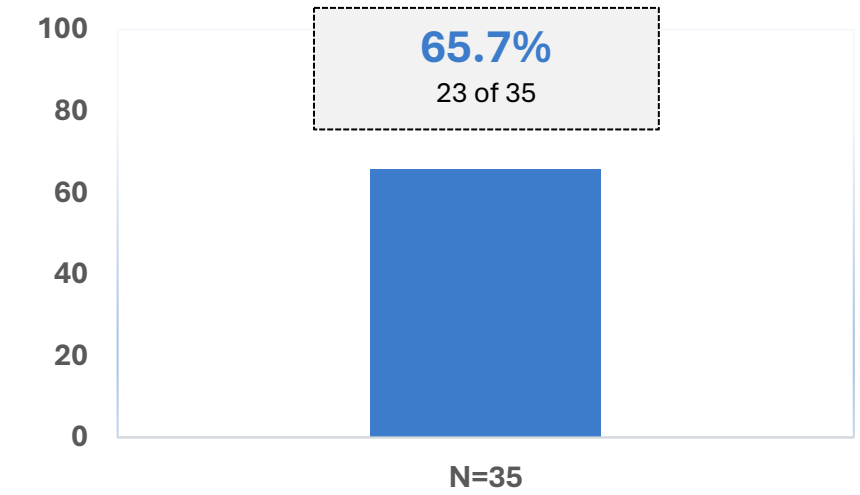
TARA-002 Monotherapy Demonstrates 68% CR at 6 Months with Durable Response Among BCG-Unresponsive Participants



Data cutoff: January 28, 2026

Abbreviations: CR = complete response
High-grade CR is based on central pathology including a mandatory biopsy at Month 3
Notes: Evaluable participants include those who had at least one dose of study drug before the response assessment time point and completed at least one response assessment; CR rates at each landmark time point include all participants who were either evaluable at that time point or had experienced disease progression or treatment failure prior to the scheduled visit. Two participants at Month 3 and 1 participant at Month 12 are pending central confirmation of response.

High-grade CR rate at any time (%)



Landmark	High-grade CR rate (%)
Month 6	**68.2** (15 of 22)
Month 12	**33.3** (5 of 15)
Reinduction Salvage	**61.5** (8 of 13)

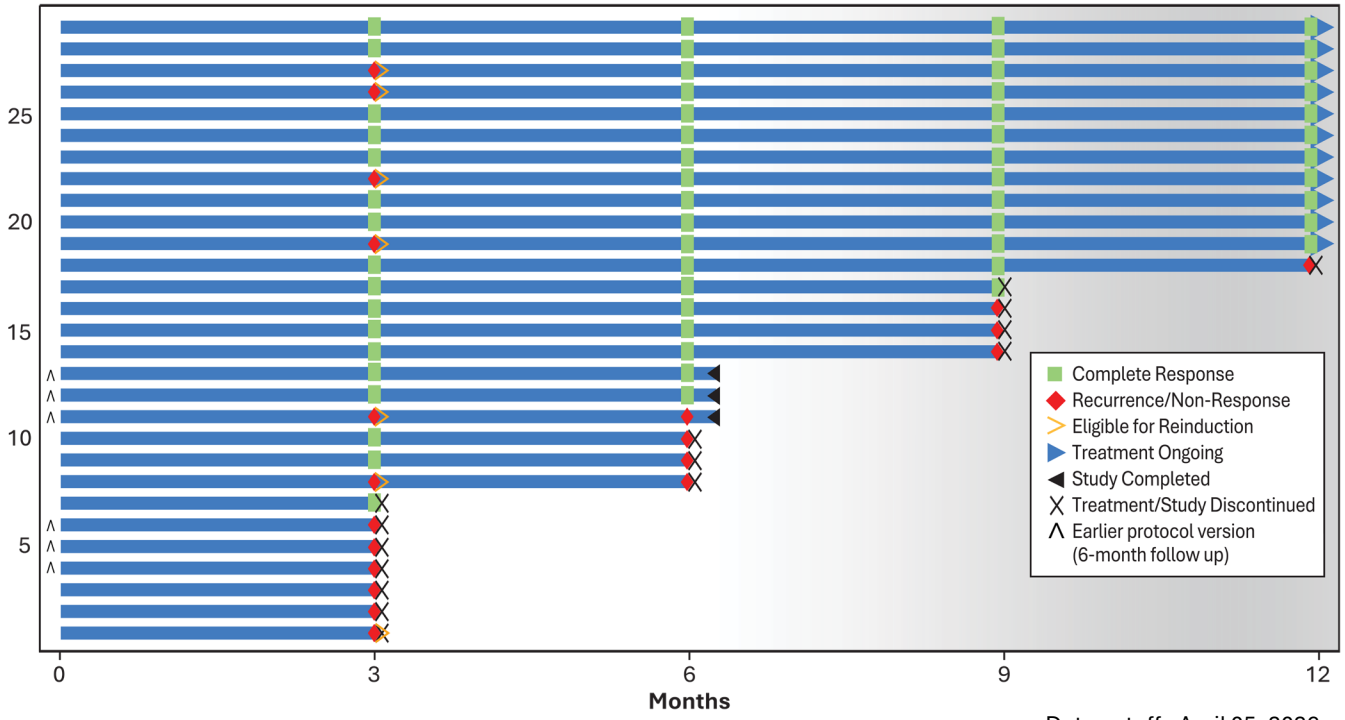
71%*
(95% CI, 46.7, 95.5)
Maintained CR for ≥ 6 Mo

100%
Maintained CR from 9 Mo -12 Mo (5 of 5)

*Based on Kaplan-Meier (KM) probability of maintaining a CR

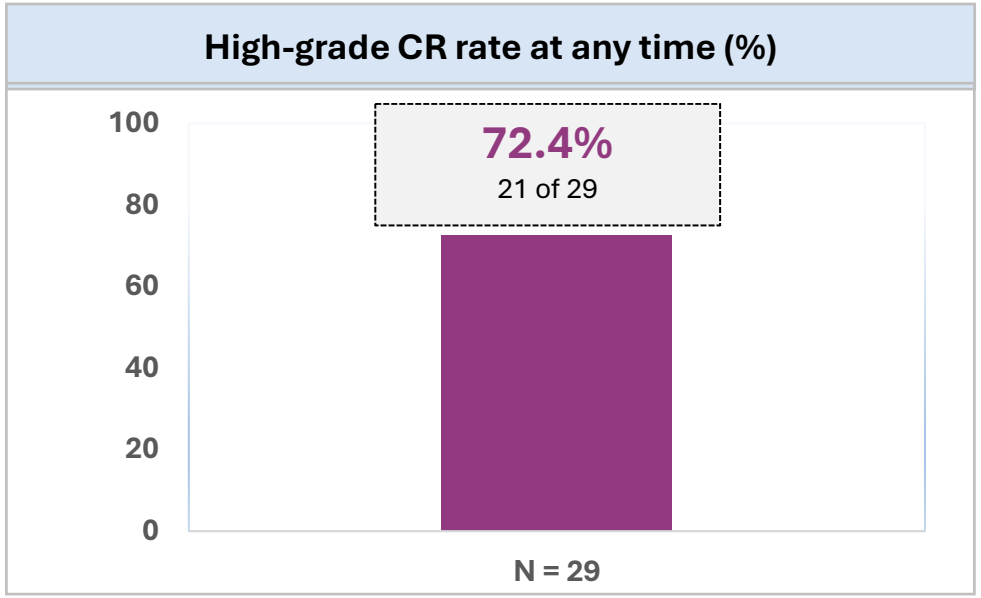
PROTARA THERAPEUTICS

TARA-002 Monotherapy Demonstrates 67% CR at 6 Months with Durable Response Among BCG-Naïve Participants



Data cutoff: April 05, 2026

Abbreviations: CR = complete response
High-grade CR is based on central pathology.
Notes: Evaluable participants include those who had at least one dose of study drug before the response assessment time point and completed at least one response assessment; CR rates at each landmark time point include all participants who were either evaluable at that time point or had experienced disease progression or treatment failure prior to the scheduled visit
^ Participants enrolled under an earlier protocol version with 6-month duration; therefore, they are not included in CR analyses from Month 9 onward.



Landmark	High-grade CR rate (%)
Month 6	**66.7** (18 of 27)
Month 12	**55.0** (11 of 20)
Reinduction Salvage	**66.7** (4 of 6)

73%*
(95% CI, 52.9, 93.4)
Maintained CR for ≥ 6 Mo

92%
Maintained CR from 9 Mo -12 Mo (11 of 12)

*Based on Kaplan-Meier (KM) probability of maintaining a CR

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BCG-Naïve: TARA-002 in NMIBC Demonstrated a Favorable Safety and Tolerability Profile with No Grade 3 or Greater TRAEs

N = 31	Any Grade	Grade 1	Grade 2	Grade 3	Grade 4/5
TRAEs, n (%)	8 (26)	8 (26)	1 (3)	0	0
TRAEs ≥5%, n (%)					
Dysuria	4 (13)	4 (13)	0	0	0
Fatigue	4 (13)	3 (10)	1 (3)	0	0
Hematuria	2 (6)	2 (6)	0	0	0
SAEs, n (%)	4 (13)	0	0	4 (13)	0
Related SAEs, n (%)	0	0	0	0	0
TRAEs leading to Study Drug Withdrawal, n (%)	0	0	0	0	0

Abbreviations: TRAE = treatment related adverse event; SAE = serious adverse event
NOTE: 31 BCG-Naïve participants were exposed to at least one dose of TARA-002.
Severity of adverse event is based on NCI-CTCAE Version 5.0 or later.

Data cutoff: April 5, 2026

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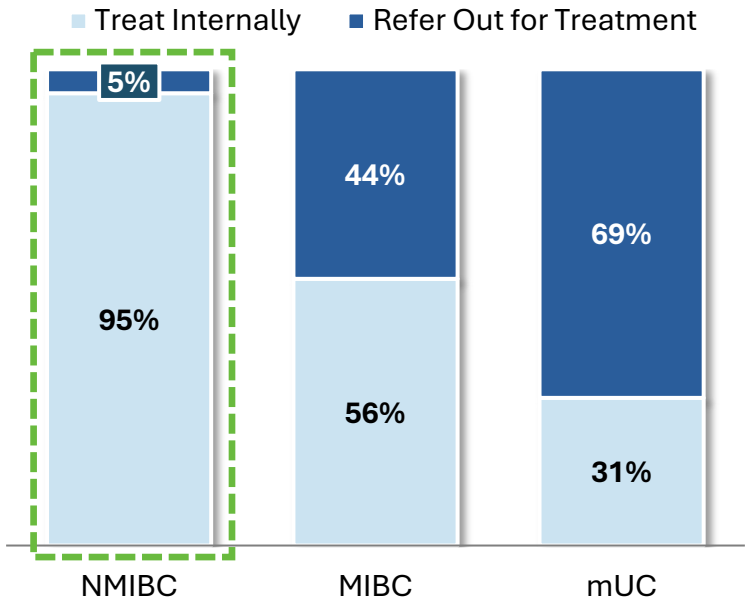
The Majority Of NMIBC Patients are Treated by Community Urologists

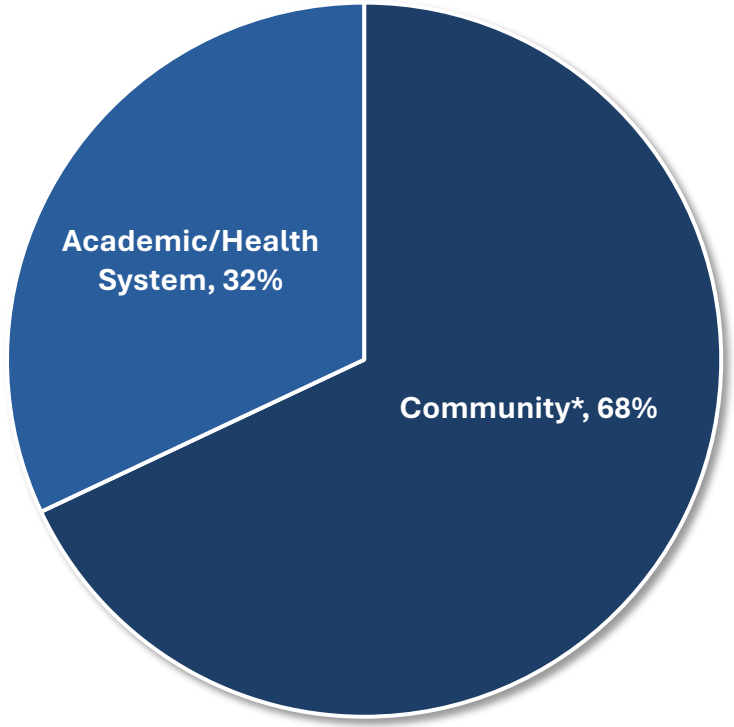
Most NMIBC patients are treated in the community – Urologists prefer to retain their patients



Up to 95% of community urology practice treat their NMIBC patients internally

Estimated NMIBC Patient Distribution by Site of Care

(TDG Prior Research BCG Utilization Data Set, 2023-2024, Estimated % of NMIBC Patients)



In community practice workflow is important. In addition to predictable safety and tolerability, key elements such as product handling, administration, preparation timing and reimbursement are critical when making treatment decisions

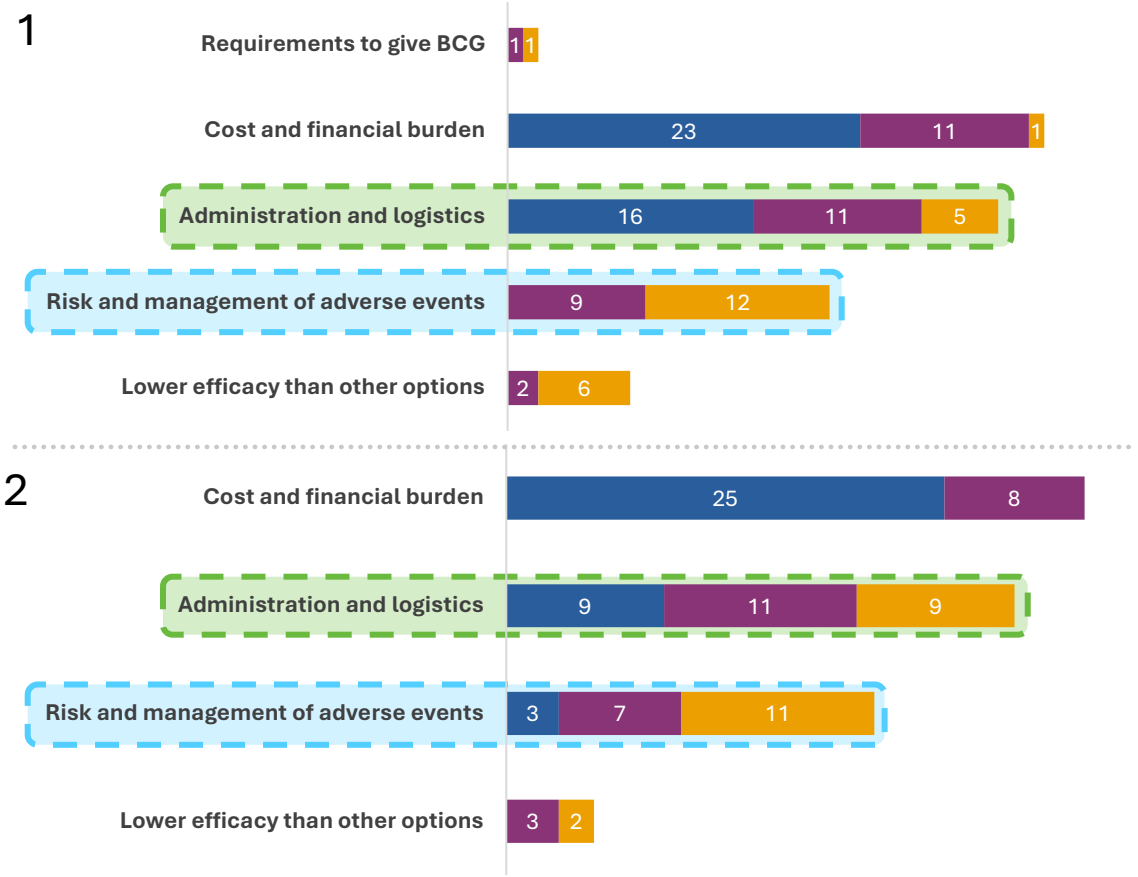
*Includes Private/Community Urology practices, Community oncology practices and other VA etc.
Source: Market research

NMIBC: Safety & Ease Of Use Are Important to Adoption

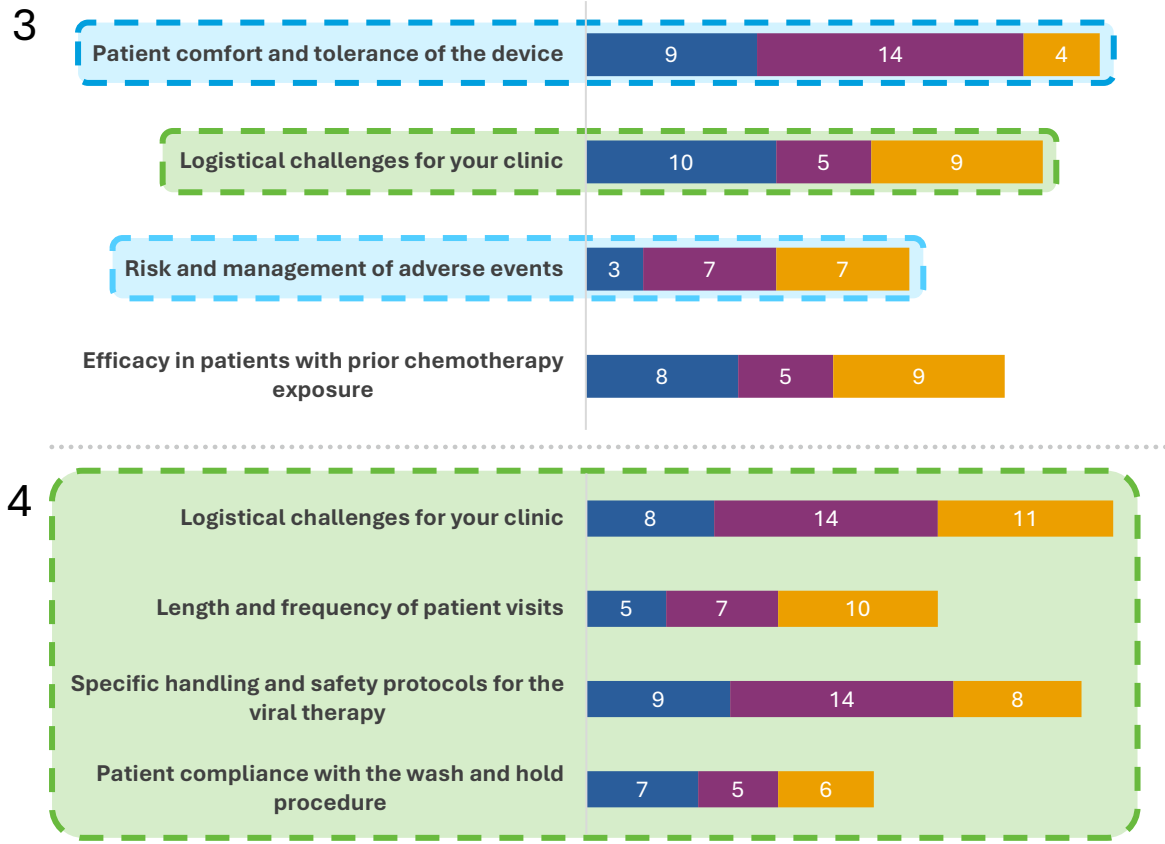
Bloomberg surveyed 51 urologists on their views of key adoption factors of approved and next-generation therapies

Bloomberg Intelligence

NMIBC products launched in the last 2 years



Products expected to launch in the next 2 years



Rank 1 – Most Primary Barrier | Rank 2 | Rank 3

Admin & Logistics

Safety & Tolerability

[1]Cytokine Superagonist. [2]AV Vectored Cytokine. [3]Enhanced Chemotherapy. [4]Oncolytic Virus

Source: BI Survey of Urologists - August 2025

TARA-002 Is Designed For Best-in-Class Ease of Use in NMIBC

TARA-002 has reduced burden for patients and physicians

TARA-002

No vial thaw, simple preparation; no pre/post treatment protocol

- Preparation: can be conducted on open table or benchtop; no special handling

Anktiva + BCG-TICE

Risk of infection for patient and caregivers; urine decontamination burden

- Preparation: mask/gown required to avoid infection
- 6-hour period of required urine bleaching

Adstiladrin

Vial thaw introduces preparation bottleneck; elevated biosafety procedures required; additional pre/post burden for patients

- Anticholinergic premedication
- 3 – 10 hour vial thaw
- Preparation: “universal biosafety precautions” required; USPI contains infection risk warning
- 48-hour period of required urine bleaching

Inlexzo

Requires insertion every three weeks, potential for patients to feel device in bladder and removal requires cystoscopy

- Assembly of the device on open table or benchtop
- Cystoscopy is encouraged prior to instillation to check for bladder mucosal integrity
- Repeat the same procedure every 3 weeks
- Removal of the device requiring cystoscopy

Cretostimogene

Complex process with unclear vial thaw, biosafety, and urine decontamination requirements

- Thaw process not disclosed
- Preparation: BSL2/2+ handling likely required
- Saline wash
- DDM wash
- Saline wash
- DDM re-infusion and dwell (15 min)
- Urine bleaching requirements not disclosed

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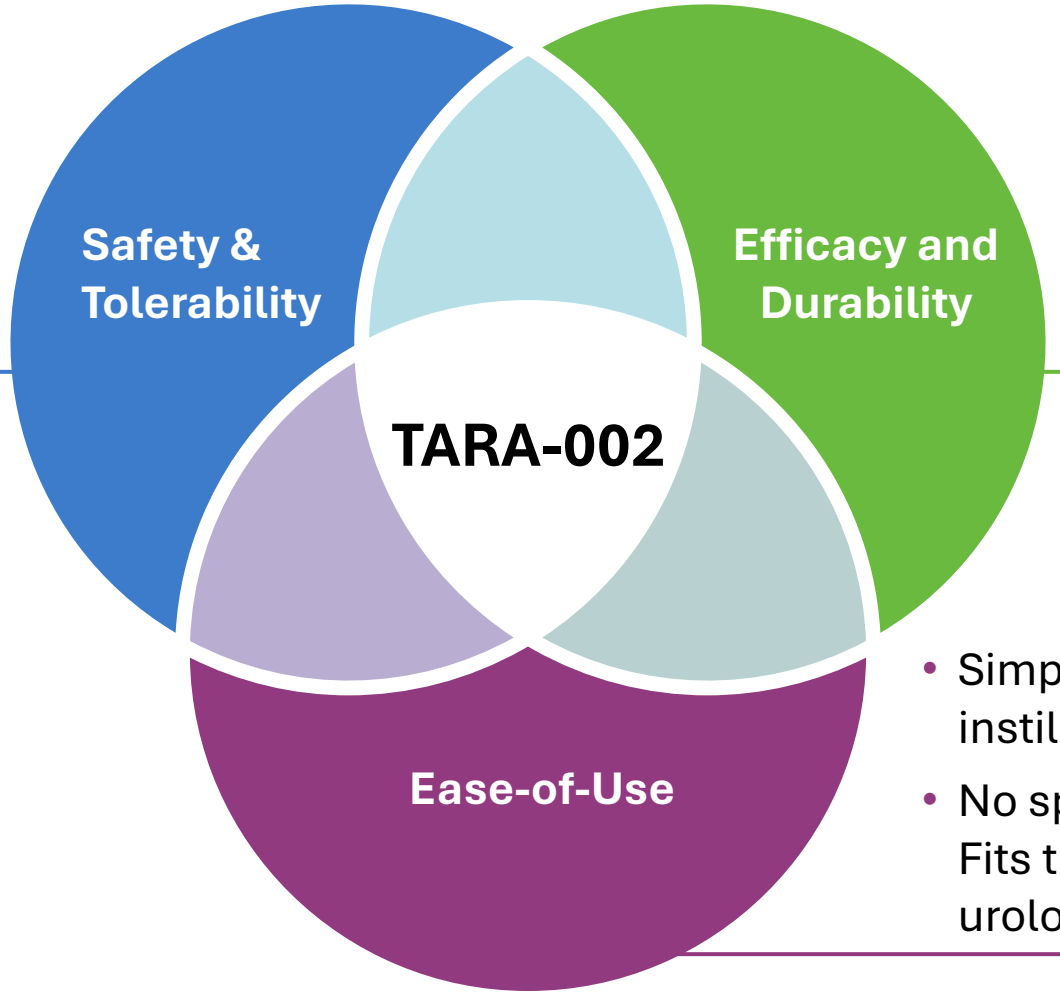
Definitions: USPI – U.S. prescribing information; DDM - dodecyl maltoside
Source: Derived from product SOPIs and clinical trial publications. Not based on head-to-head or comparator studies.

TARA-002 Target Product Profile Sits at the Intersection that NMIBC Patients and Urologists Prioritize

- Mild, self-limited local AEs
- Predictable, well-characterized safety profile



- Robust single agent activity
- Competitive CR rates
- Encouraging durability

- Simple office-based intravesical instillation
- No special handling requirements; Fits the high-volume, fast paced urology workflow

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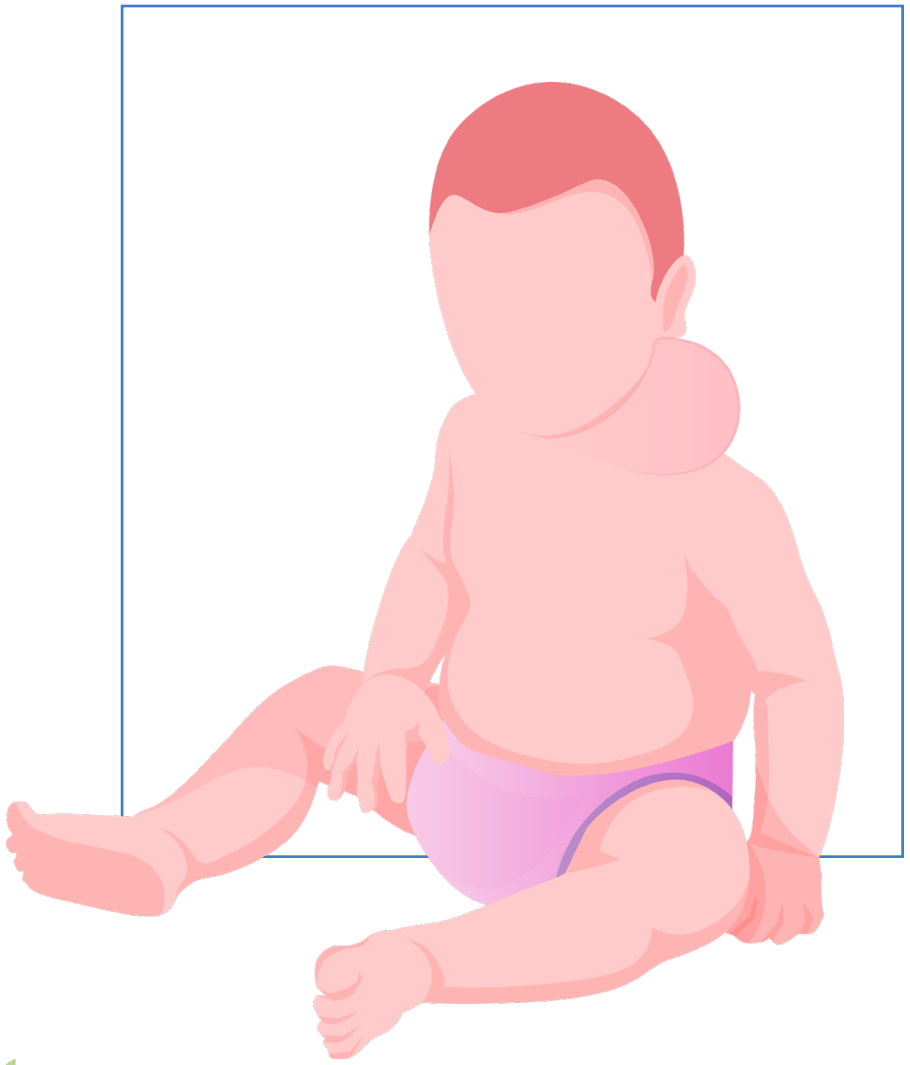
Abbreviations: CR = Complete Response; AEs = Adverse Events

TARA-002

Lymphatic Malformations (LMs)

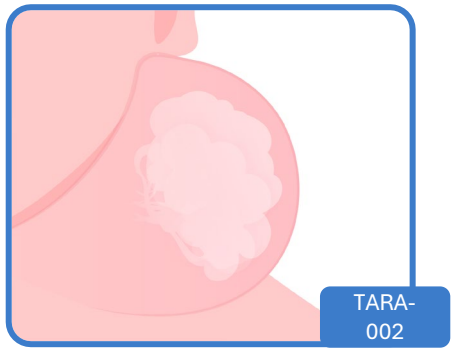
LMs Represent a Significant Pediatric Rare Disease Opportunity with No Currently Approved Therapies



Lymphatic Malformations (LMs) are rare, non-malignant, congenital malformations of lymphatic vessels resulting in the failure of these structures to connect to or drain into the venous system[1]

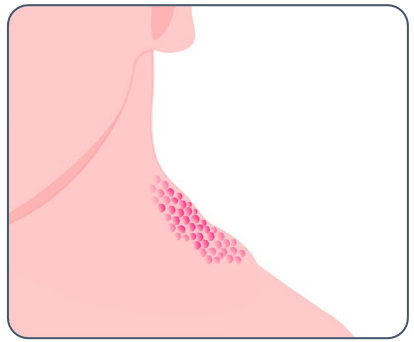
LMs are diagnosed in early childhood and can cause significant morbidity affecting breathing, swallowing, feeding, and speaking[2]

Macrocystic LMs



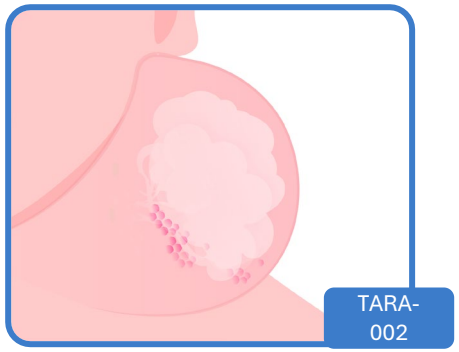
Large cysts >1-2 cm diameter, well-defined fluid-filled spaces

Microcystic LMs



Small, infiltrative lesions with tiny cystic spaces

Mixed Cystic



Combination of both macro and microcystic components

TARA-002 has the potential to treat macrocystic and mixed cystic LMs, which most often are present in the head and neck region

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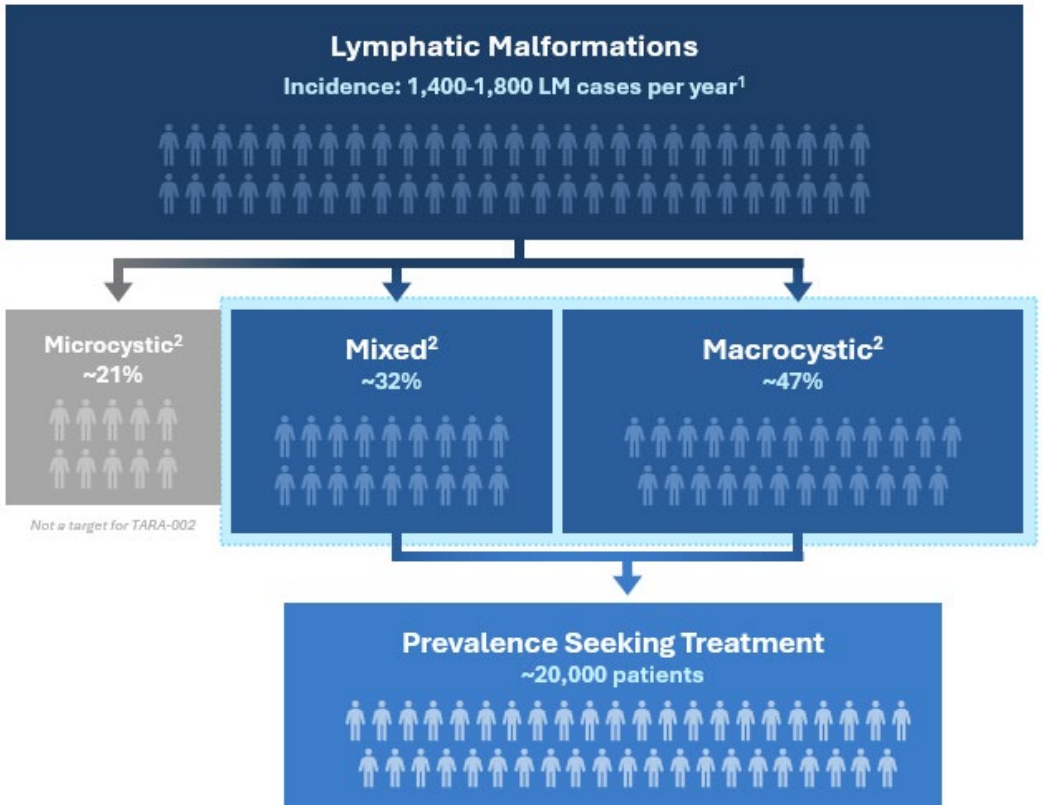
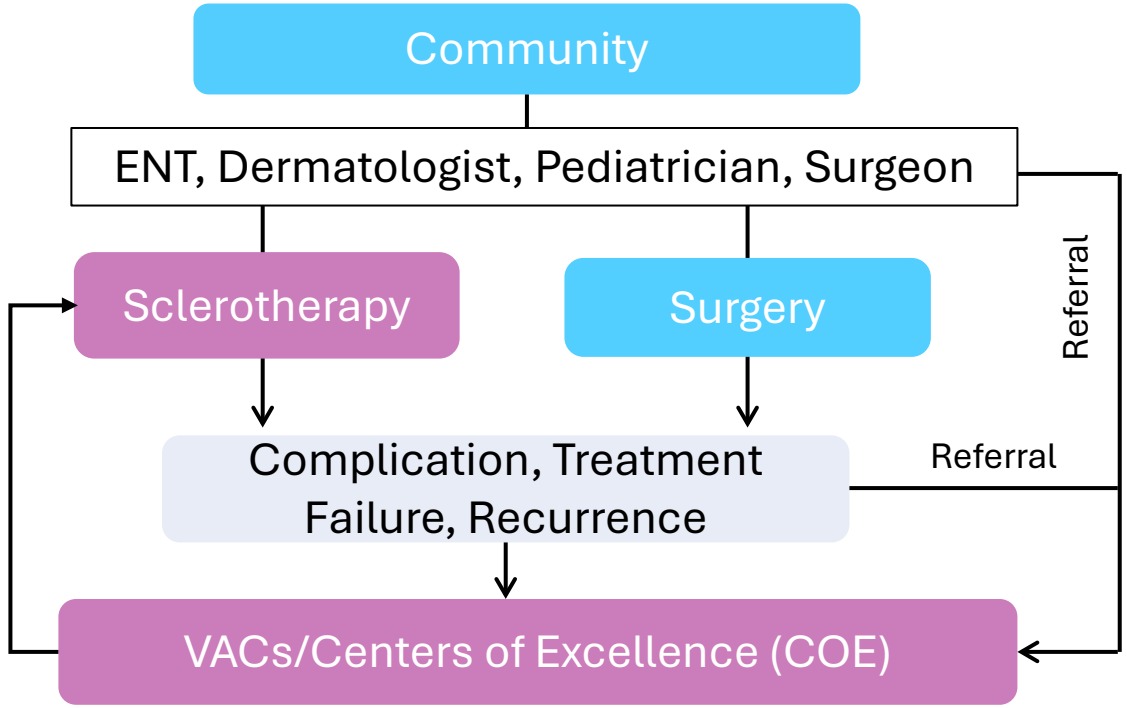
[1]Brouillard P, et al. J Clin Invest. 2014;124:898-904.; [2]Ha J, et al. Curr Ped Rev. 2014;10:238-248

1,400-1,800 Incident Patients are Typically Diagnosed in the Community Setting and Most are Referred to Vascular Anomaly Centers (VACs)

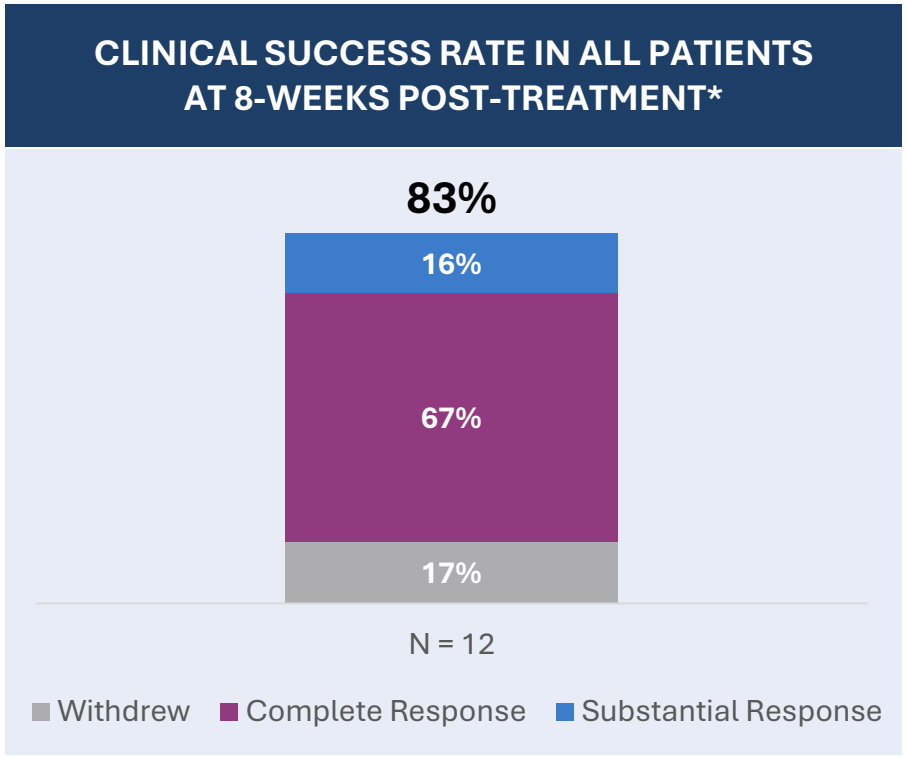


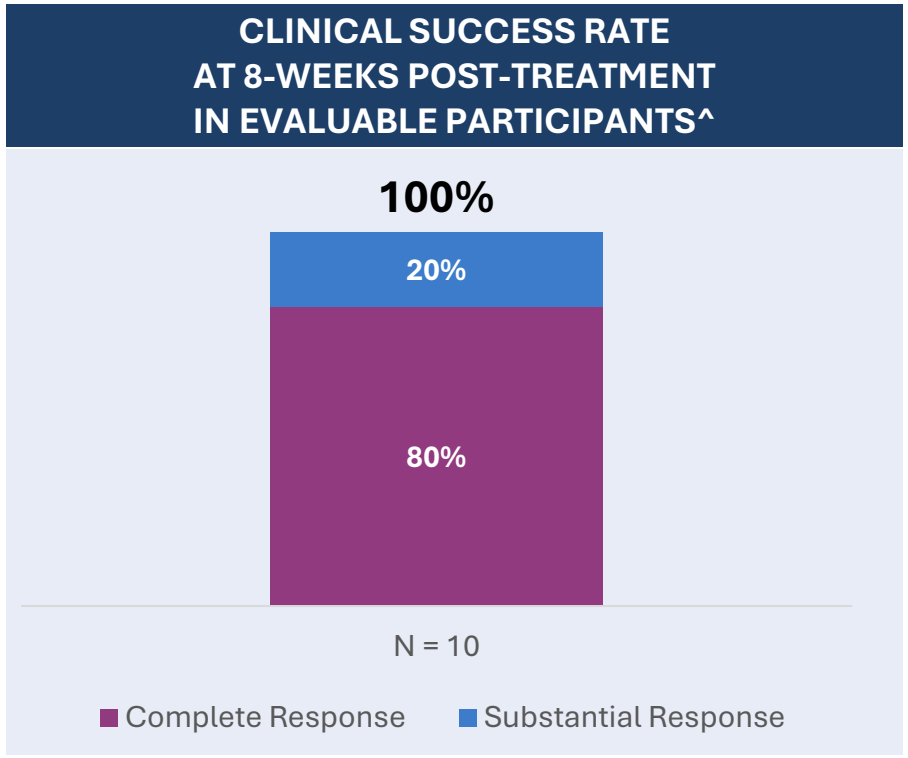
Community prefers surgery or referral and COEs/VACs prefer sclerotherapy



[1,2]Market research sclerotherapy claims analysis

TARA-002 Demonstrated Clinical Success in 83% of Participants that Completed Treatment and 100% of Evaluable Participants





2 participants withdrew before 8-week post-treatment assessment

- 1 participant was mis-diagnosed and had a rare form of cancer and did not respond to treatment
- 1 participant dropped out after achieving a marked resolution of the LM: received 2 doses (160 ml aspiration at first dose reduced to 10 ml aspiration at second dose)

Response was assessed via central imaging (MRI or CT) or via Investigator assessment (physical exam, visual inspection and ultrasound). Clinical success is defined as complete (90-100% reduction) or substantial (60-90% reduction) response of the cyst from baseline in total LM volume.
Note: Response assessment includes all participants who have completed treatment; Excludes 3 participants who are still in treatment and one whose post-treatment assessment is pending
*Participants who received at least one intracystic injection of the study intervention.
^Participants who completed the 8-week post-treatment assessment.

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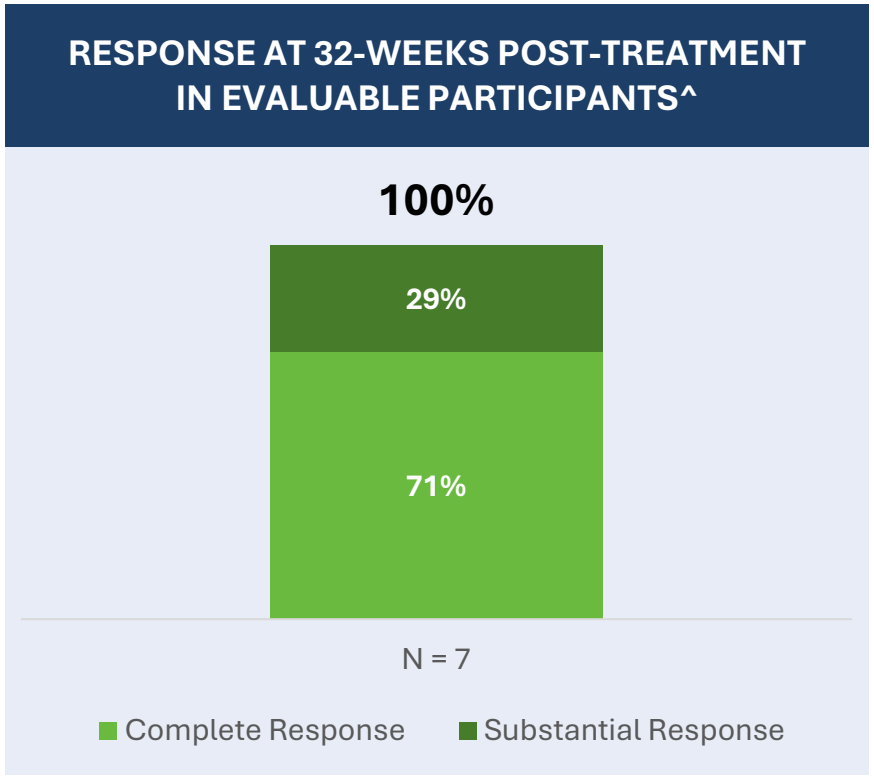
Data cut-off: 10-Apr-2026

TARA-002 Demonstrated 100% Durable Response at 32-Weeks



- **7 participants** have reached the 32-weeks post-treatment assessment and remain disease free

^Excludes ongoing participants who had not yet reached the 32-weeks post-treatment assessment as of the data cut off, and one participant who had a complete response at the 8-week assessment but discontinued prior to 32-weeks post-treatment.

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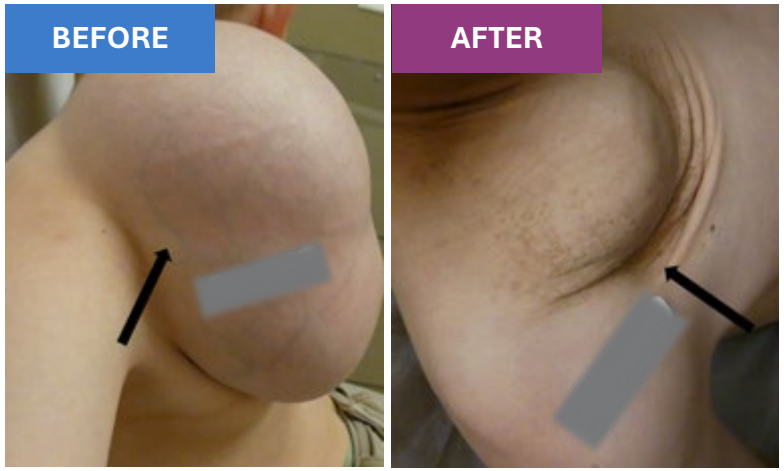
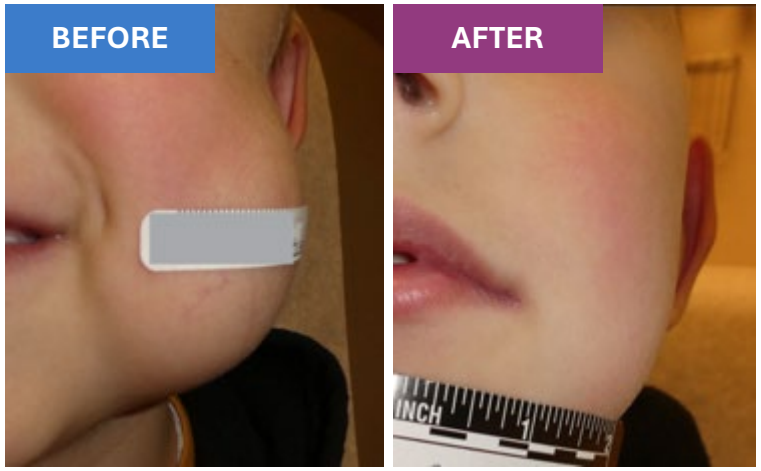
TARA-002 Has Demonstrated Meaningful Results in LMs Patients Treated in the STARBORN-1 Study

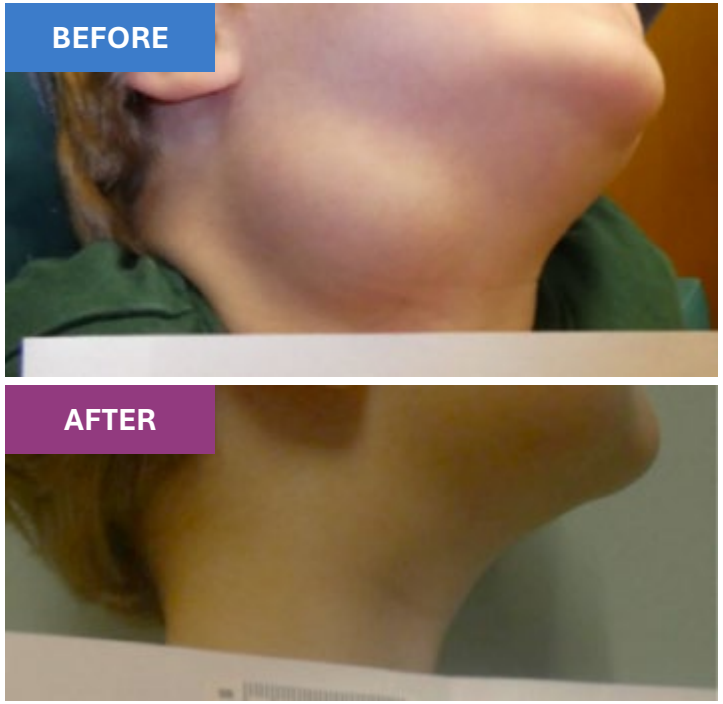
Medical photography: Baseline and 8-week post-treatment results for three participants treated with TARA-002 in the STARBORN-1 trial



Baseline 1,739mL macrocystic LM received 4 injections of TARA-002 (20mL [1], 20mL [2], 19mL [3], 1mL [4]); 8 years of age.



Baseline 58mL macrocystic LM received 2 injections of TARA-002 (20mL [1], 17mL [2]); 5 years of age.



Baseline 28mL macrocystic LM received 2 injections of TARA-002 (20mL [1], 0.5mL [2]); 3 years of age.

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TARA-002 Has a Favorable and Well-Tolerated Safety Profile

- **Most AEs were mild to moderate**
- **No serious TEAEs or AESIs have occurred to date**

Number of Participants, N = 16	Any Grade	Grade 1	Grade 2	Grade 3	Grade 4/5
TEAEs, n (%)	11 (69)	11 (69)	9 (56)	1 (6)	0 (0)
Related TEAEs, n (%)	10 (63)	10 (63)	7 (44)	1 (6)	0 (0)
Related TEAEs >10%, n (%)					
Swelling	5 (31)	0 (0)	4 (25)	1 (6)	0 (0)
Fatigue	4 (25)	3 (19)	1 (6)	0 (0)	0 (0)
Erythema	2 (13)	2 (13)	0 (0)	0 (0)	0 (0)
Headache	2 (13)	2 (13)	0 (0)	0 (0)	0 (0)
Injection site pain	2 (13)	2 (13)	0 (0)	0 (0)	0 (0)
Injection site rash	2 (13)	2 (13)	0 (0)	0 (0)	0 (0)
Pyrexia	2 (13)	2 (13)	0 (0)	0 (0)	0 (0)
Irritability	2 (13)	1 (6)	1 (6)	0 (0)	0 (0)
Neck pain	2 (13)	1 (6)	1 (6)	0 (0)	0 (0)
Somnolence	2 (13)	1 (6)	1 (6)	0 (0)	0 (0)
AESIs, n (%)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
Serious TEAEs, n (%)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
MAAEs, n (%)	6 (38)	3 (19)	5 (31)	1 (6)	0 (0)
Related TEAEs leading to study drug withdrawal, n (%)	1 (6)	0 (0)	1 (6)	0 (0)	0 (0)

AESI = adverse event of special interest; MAAE = medically attended adverse event; TEAE = treatment emergent adverse event

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Data cut-off: 10-Apr-2026

TARA-002 in LMs is a Late-Stage Opportunity with Significant Unmet Need

TARA-002 IN LMS

- FDA Rare Pediatric Disease, Orphan Drug, Breakthrough Therapy and Fast Track Designations
- Intend to submit BLA in 2H'2027 with results of STARBORN-1 pivotal trial; interim results demonstrate promising efficacy and favorable safety profile
- LMs incidence/prevalence, unmet need and TARA-002 product profile suggest rare disease pricing opportunity
- Historical literature and patient experience show TARA-002 may also be effective in treating other maxillofacial cysts including ranula and thyroglossal duct cysts

PROTARA THERAPEUTICS

IV Choline Chloride

Phospholipid substrate replacement therapy for patients dependent on parenteral support (PS)

IV Choline Chloride is a Late-Stage Opportunity with High Unmet Medical Need

Has the potential to become the first approved IV choline formulation for PS patients

HIGH UNMET NEED WITH LARGE MARKET OPPORTUNITY

- ~30K patients on PS long term at home
- 78% of PS-dependent patients are choline-deficient and 63% have some degree of liver damage[1]
- Pricing analogues suggest significant market opportunity

POSITIVE CLINICAL DATA AND ALREADY INCLUDED IN MEDICAL GUIDELINES

- Independently conducted Phase 2 data demonstrated significant improvement in serum choline concentrations and a pronounced impact on steatosis[2]
- IV choline replacement for PS patients is included in US and EU medical guidelines, even though no therapy currently exists

SINGLE PK STUDY REQUIRED FOR REGULATORY APPROVAL

- Single PK study demonstrating an increase in choline levels required for registration
- FDA granted a targeted indication of source of choline when oral or enteral nutrition is not possible, insufficient or contra-indicated

INTELLECTUAL PROPERTY PROTECTIONS

- Both a compound patent and a method of treatment patent in U.S. to 2041

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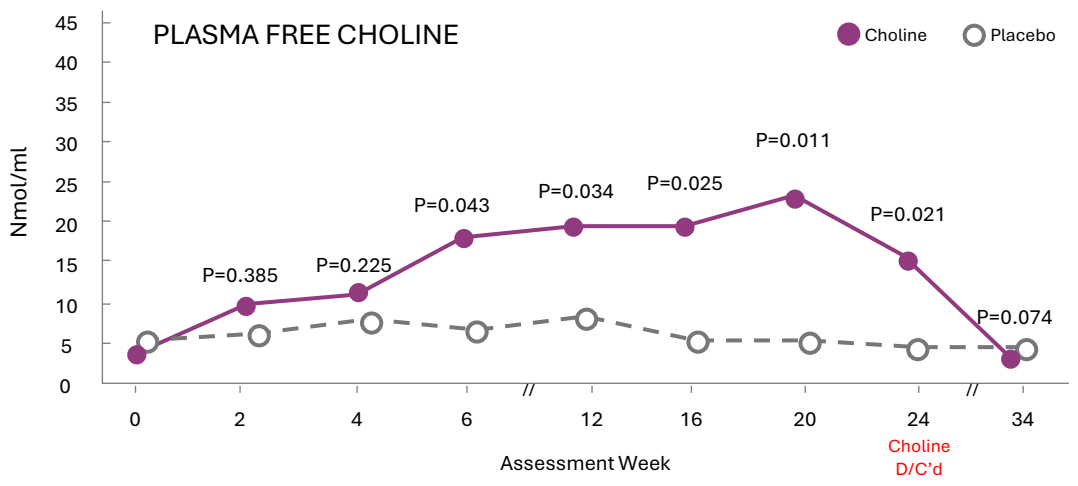
[1]Micic D, Muhic E et al., *JPEN J Parenter Enteral Nutr.* 2025;49(6):e2733.; [2]Buchman A, et al. JPEN. 2001;5:260-268

Independent Phase 2 Study Demonstrates that Treatment with IV Choline Rapidly Restores Choline Levels and Improves Steatosis

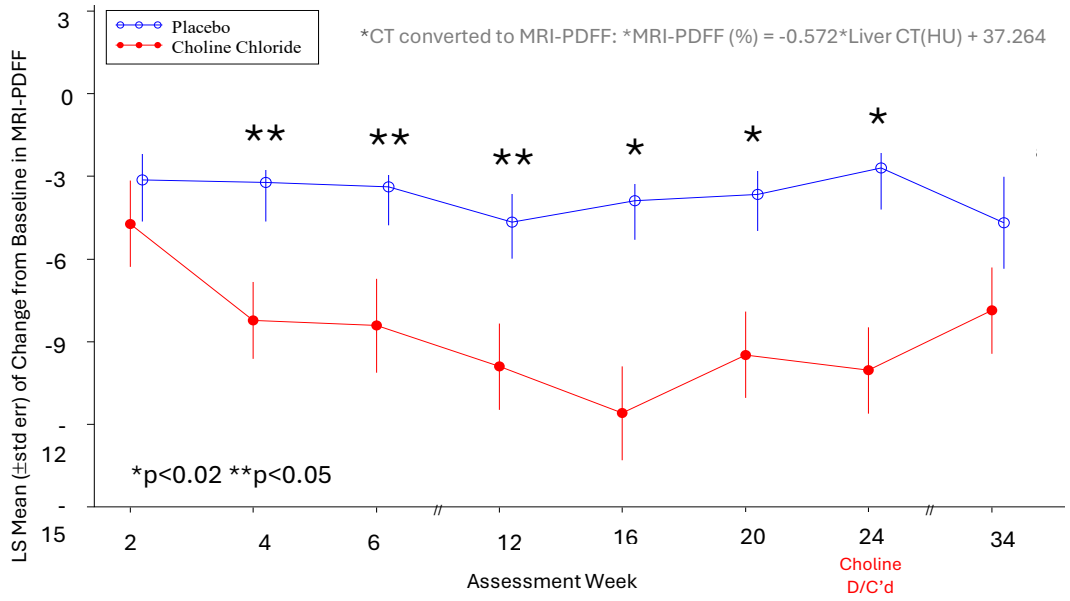
PLASMA FREE CHOLINE LEVELS: ALL PATIENTS[1]

Choline supplementation was discontinued at week 24.
Data are presented for all subjects up until time of withdrawal from the study.



Primary endpoint to replicate in registrational trial

CLINICALLY MEANINGFUL IMPROVEMENT IN STEATOSIS[1]



Secondary endpoint to replicate in registrational trial to support clinical benefit

Significant differences in the LS mean change from baseline in MRI-PDFF observed in Choline group vs. placebo at Weeks 4 - 24, demonstrating a clinically meaningful and statistically significant reduction in steatosis (range 31%-54%)

[1]Buchman et al. JPEN, 2002 - Protara Therapeutics re-analysis of patient CRFs, data on file.

Large Market Opportunity for IV Choline to Address a Clear, Guideline Supported Unmet Medical Need in PS

US Patients requiring PS
>110,000 per year

Patients on long term PS at home
~30,000

ASPEN (US) and ESPEN (EU) guidelines recommend choline for patients on PS, yet no product is available to meet this need.

aspen American Society for Parenteral and Enteral Nutrition

ESPEN The European Society for Clinical Nutrition and Metabolism

IV Choline Commercial Analogs

SMOFlipid® (lipid injectable emulsion, USP), 20% 100 grams/500 mL (0.2 grams/mL)

Omegaven® (fish oil triglycerides) Injectable emulsion

CARNITOR® levocarnitine

Gattex® (teduglutide) for injection

IV Choline Market Research – Intent to treat

HCPs expect to prescribe IV Choline to the majority of their long-term PS patients, driven by IV Choline's expected efficacy and ASPEN recommendation

Appendix

PROTARA THERAPEUTICS

TARA-002 Demonstrates Differentiated Profile to BCG

TARA-002 treatment promotes differential pro-inflammatory TH1-type cytokines than BCG in co-culture[1]

Cytokines	BCG	TARA-002
IFN-γ	**---**	**+**
TNF-α	**+**	**+++**
IL-12p70	**=**	**+**
IL-8	**=**	**-**
IL-6	+	+
IL-1β	+++	+++
IL-10	=	+
IL-4	+	+
IL-13	=	=
IL-2	--	--

TARA-002 Potent Immune Activation with a Distinct Cytokine Signature

- Distinct cytokine profile marked by strong TH1 activation (↑ IFN-γ, TNF-α, IL-12p70), defining an immune signature different from BCG
- Selectively downregulates IL-8, a cytokine linked to tumor recurrence and progression in NMIBC

= : No change
+ : 2- 5 fold upregulation
+++ : ≥ 15-fold upregulation
- : 2- 5 fold downregulation
-- : 5-14-fold downregulation
--- : ≥ 15-fold downregulation

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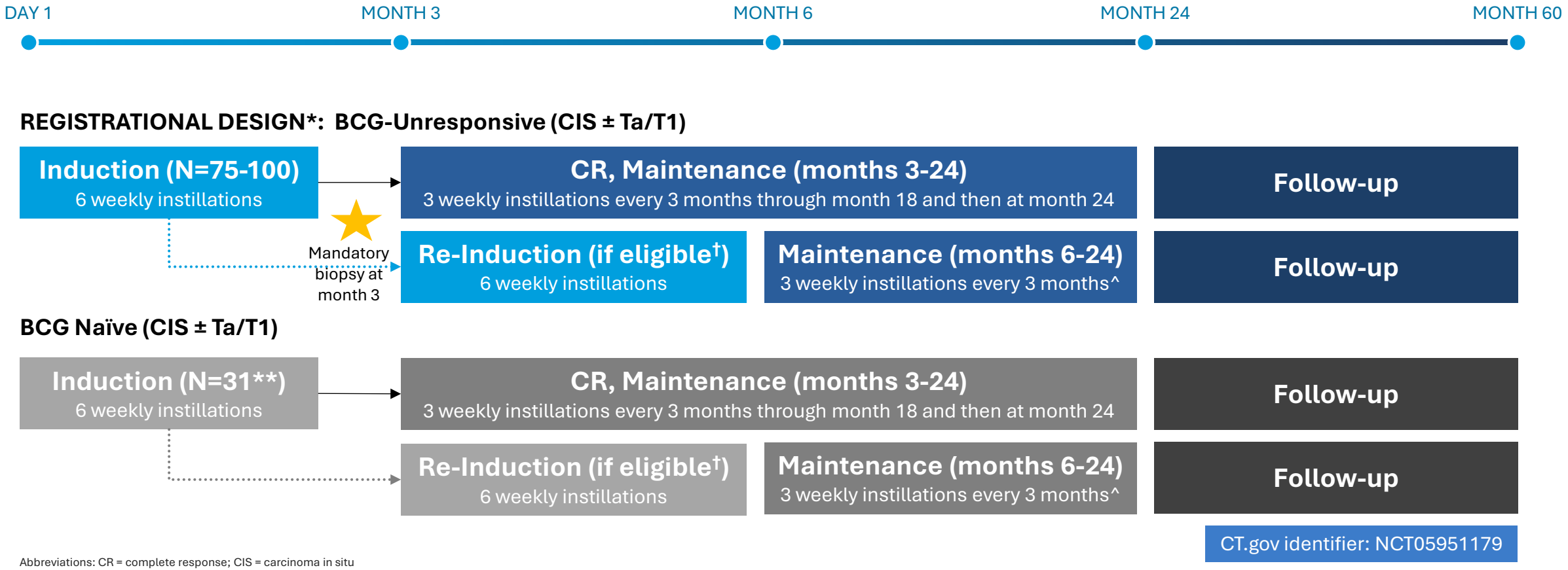
[1]Internal pre-clinical data.

TARA-002 in NMIBC: ADVANCED-2 Clinical Trial Design

Primary endpoint of high-grade complete response (CR) at any time up to 6 months; Key secondary endpoint of 12-month DOR



Abbreviations: CR = complete response; CIS = carcinoma in situ
*Aligned with the FDA's 2024 BCG Unresponsive NMIBC: Developing Drugs and Biologics for Treatment Guidance for Industry.
**Enrollment complete
†Residual CIS and/or recurrence of HGTa; ^3 weekly instillations every 3 months through month 18 and then at month 24

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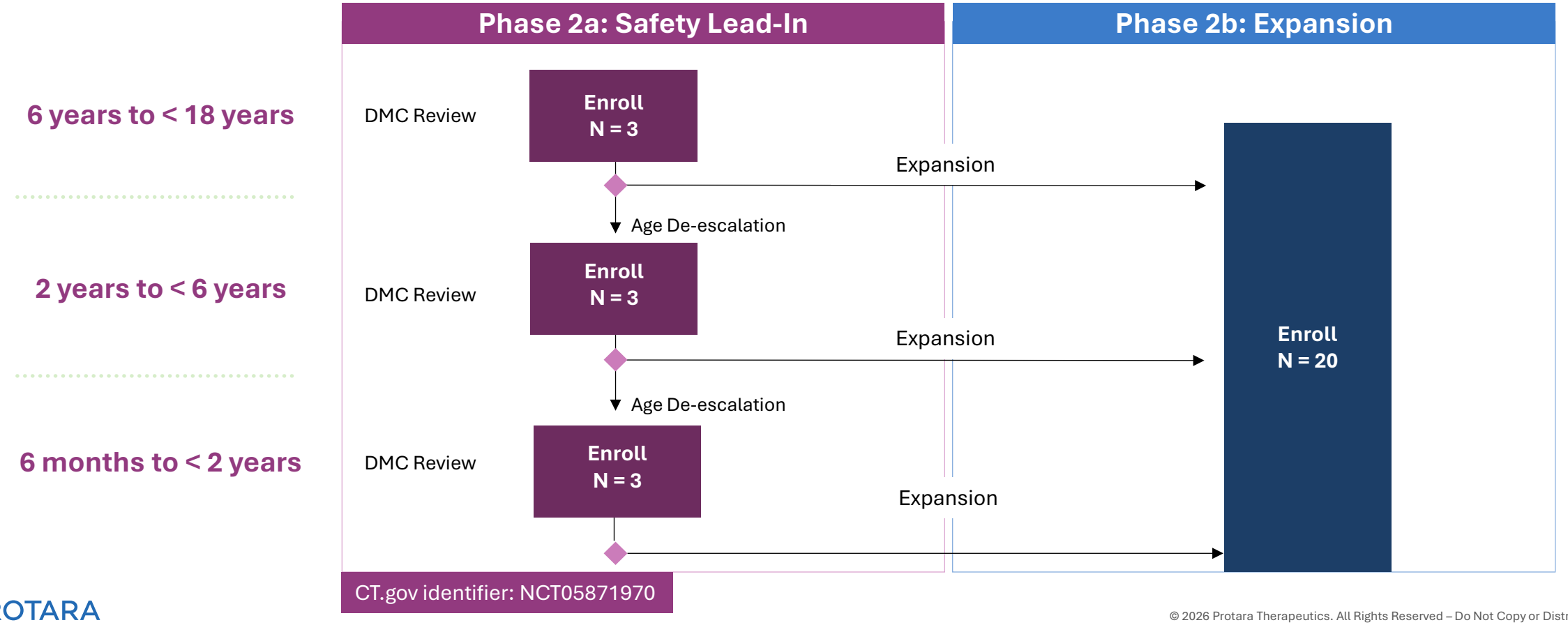
Pivotal Phase 2 STARBORN-1 Trial

STARBORN-1 is a Single Arm, Open-Label Safety and Efficacy Study of TARA-002 in Pediatric Patients with Macrocystic & Mixed cystic LMs (N=29)

- Patients receive up to four injections of TARA-002 spaced approximately six weeks apart
- DMC review with FDA for each safety lead-in cohort before expansion and age de-escalation
- ***Clinical Success*** **is defined as patients who have either a complete response (90% - 100% reduction from baseline in total LM volume) or substantial response (60% - 90% reduction)**



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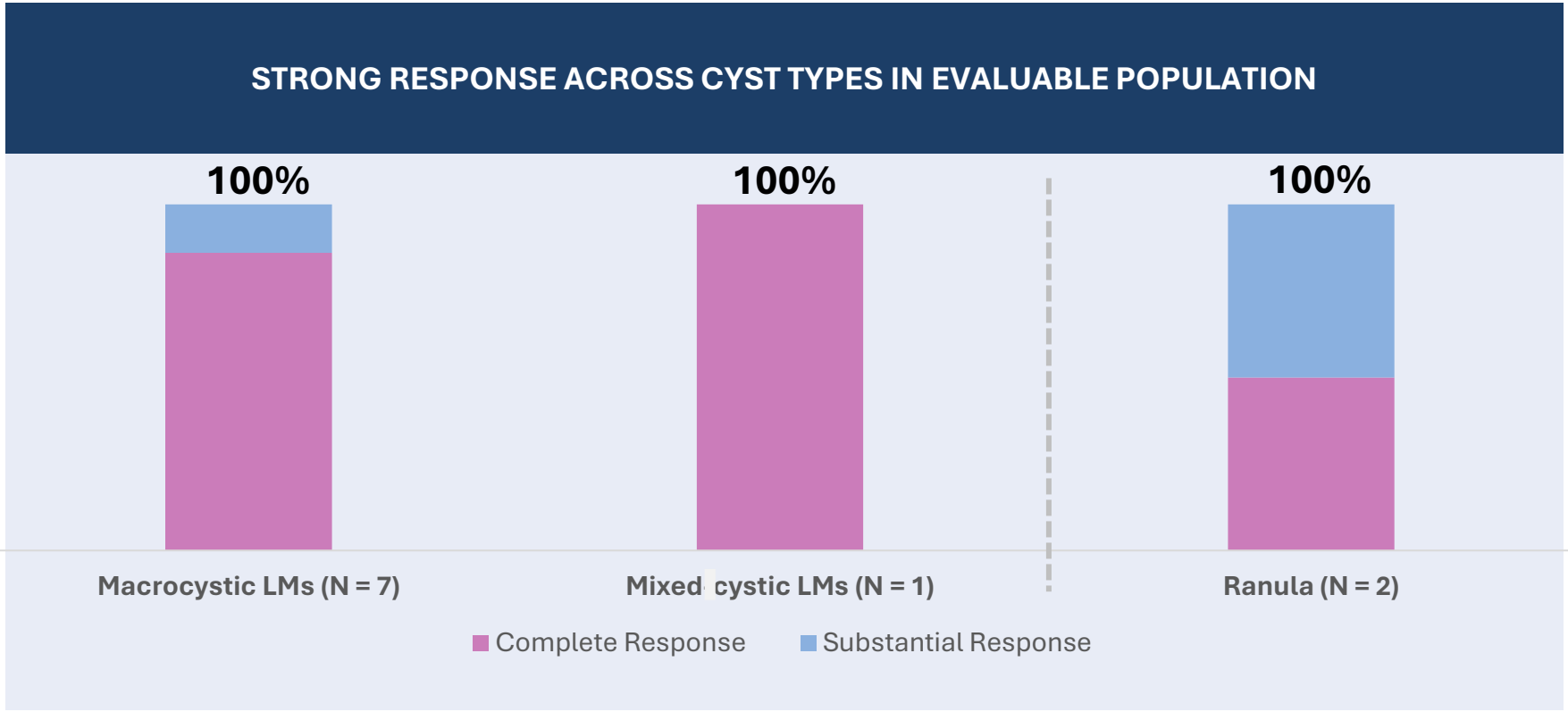
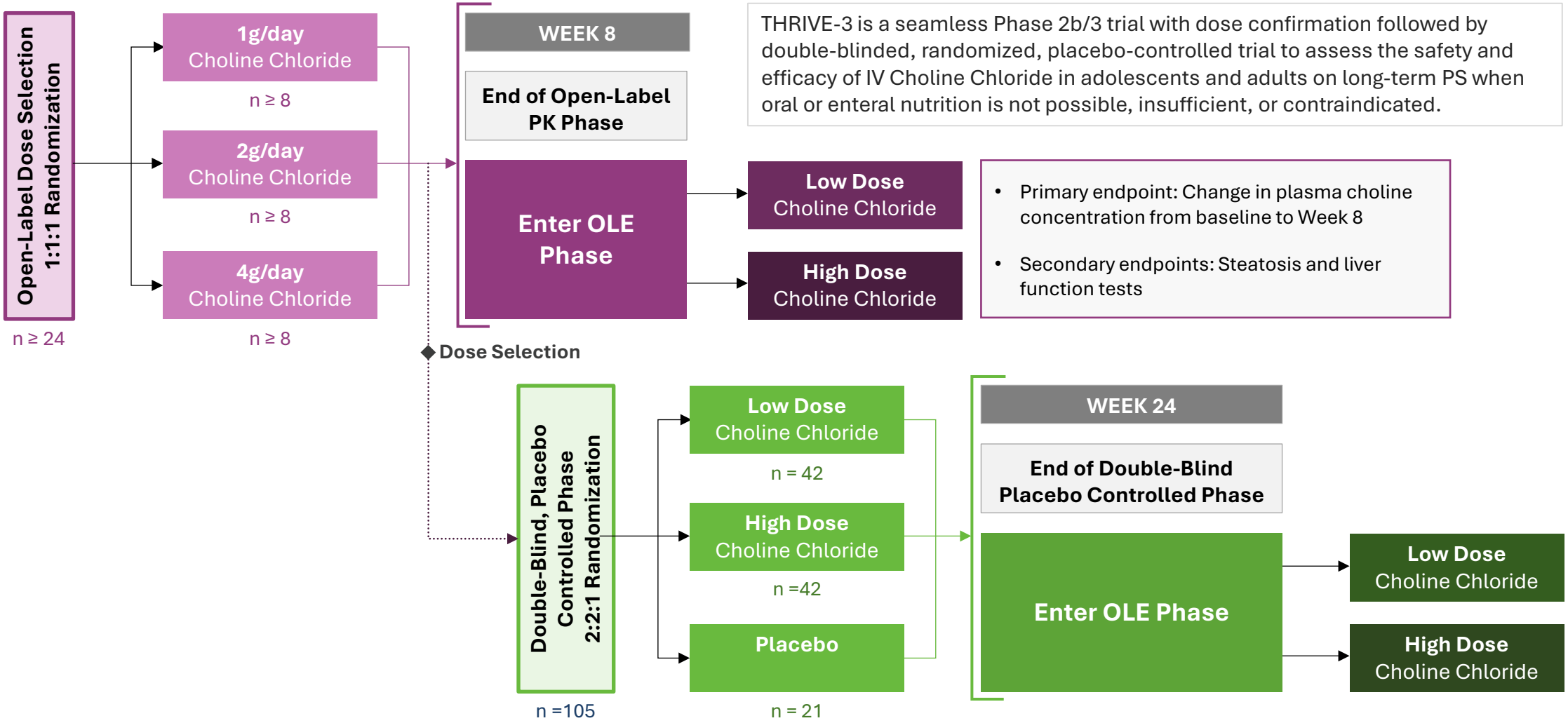
STARBORN-1 Interim Results: Evaluable Participants Across Cyst Types



- Clinical success was achieved with one or two doses of TARA-002 in 80% of participants.
- One participant with a complete response and one participant with a substantial response were subsequently diagnosed with a ranula (a different type of maxillofacial cyst from LMs)

PROTARA THERAPEUTICS Data cut-off: 10-Apr-2026

Pivotal Trial with PK and Liver Function Endpoints



THRIVE-3 is a seamless Phase 2b/3 trial with dose confirmation followed by double-blinded, randomized, placebo-controlled trial to assess the safety and efficacy of IV Choline Chloride in adolescents and adults on long-term PS when oral or enteral nutrition is not possible, insufficient, or contraindicated.

- Primary endpoint: Change in plasma choline concentration from baseline to Week 8
- Secondary endpoints: Steatosis and liver function tests

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