PROTARA THERAPEUTICS

Corporate Presentation

May 2026

Forward Looking Statements

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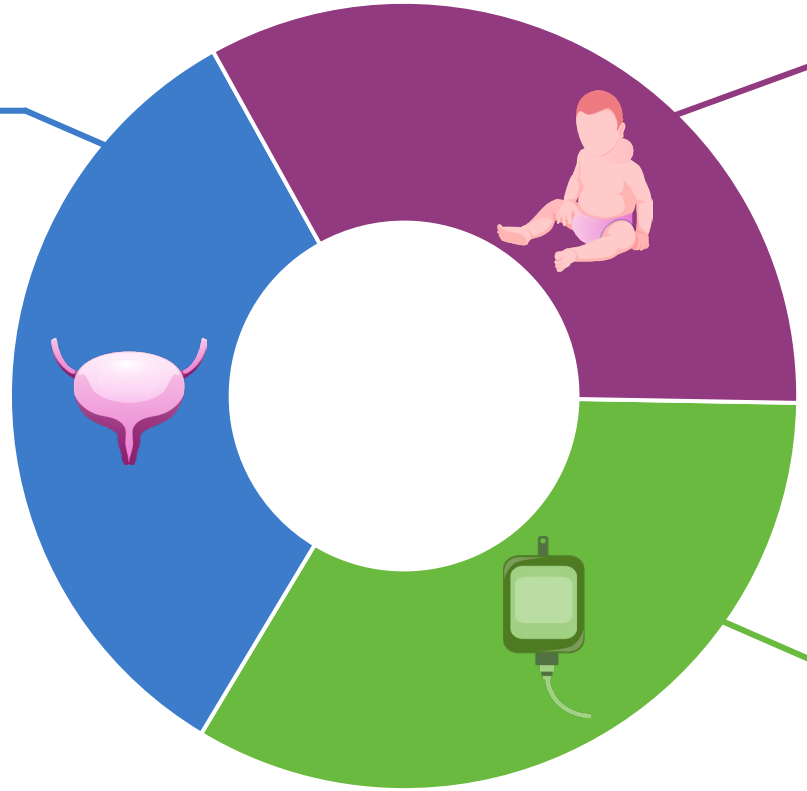
PROTARA THERAPEUTICS

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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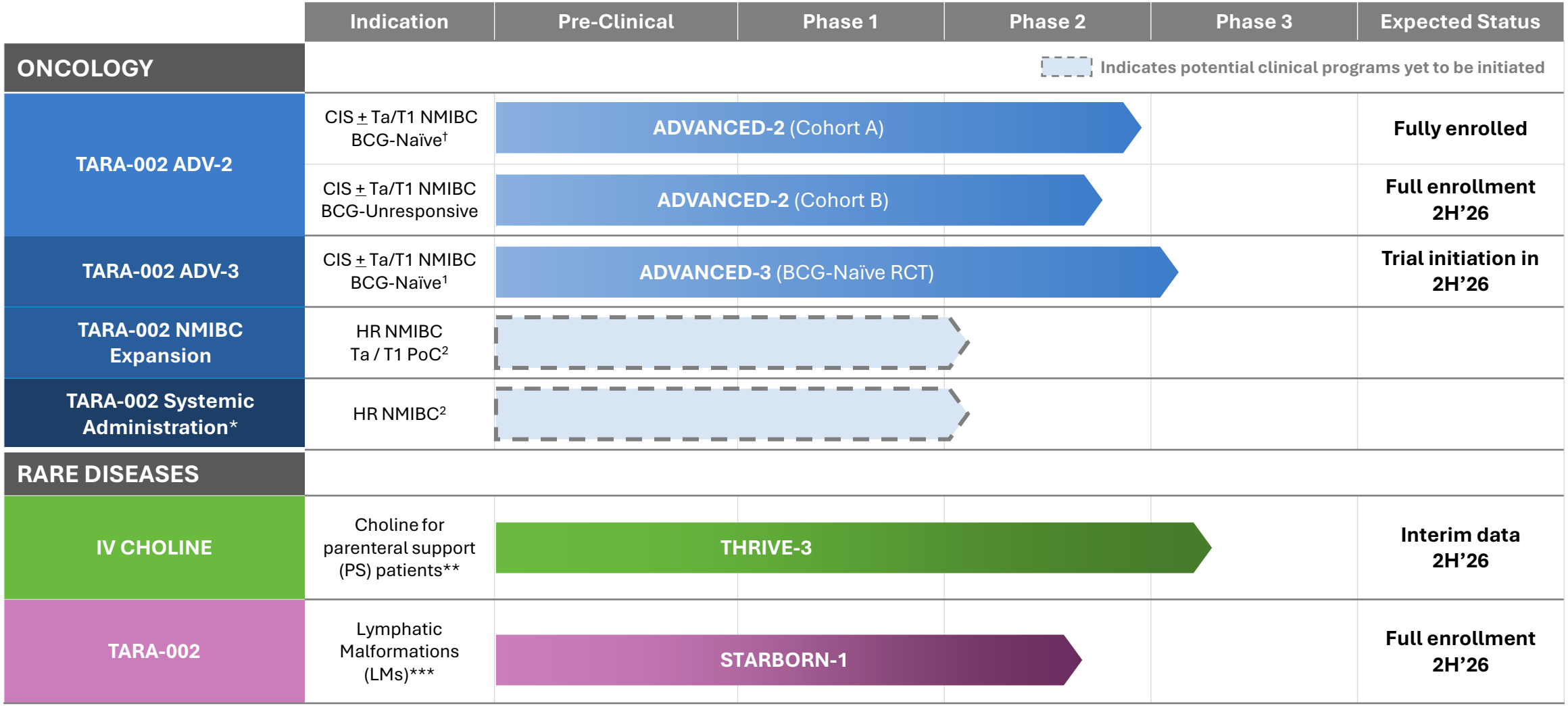
Diversified Late-Stage Pipeline



*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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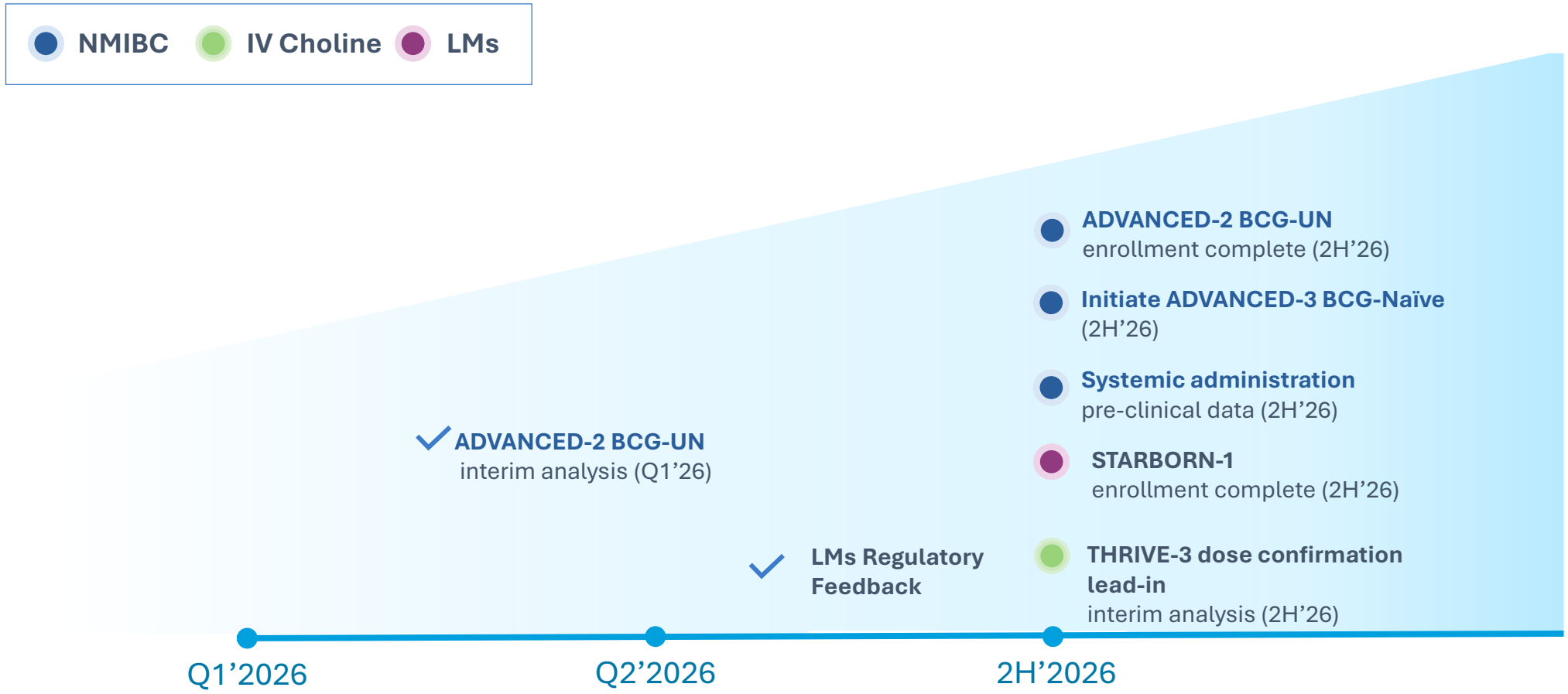
Multiple Near-Term Milestones Anticipated



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

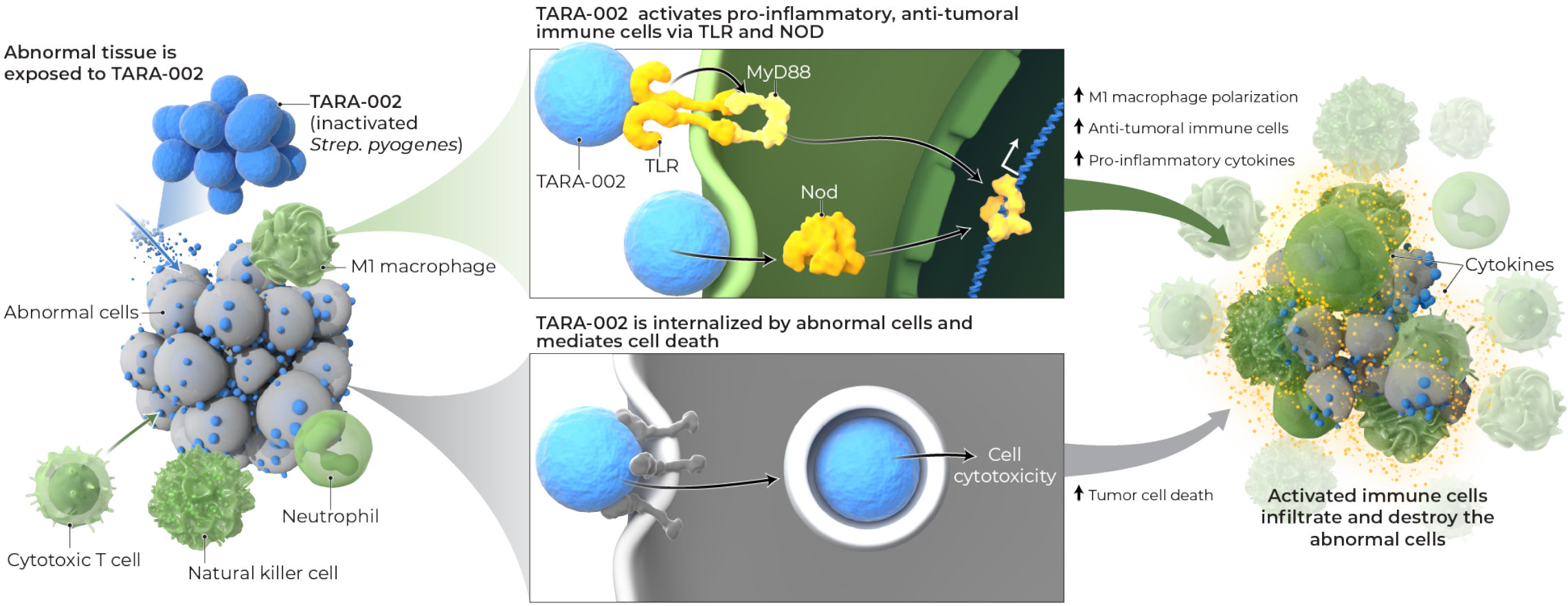
COMMON SHARE EQUIVALENTS (63.1M)*: 55.1M Common + 4.6M Preferred + 3.4M Pre-funded warrants on as converted basis as of March 31, 2026

*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)

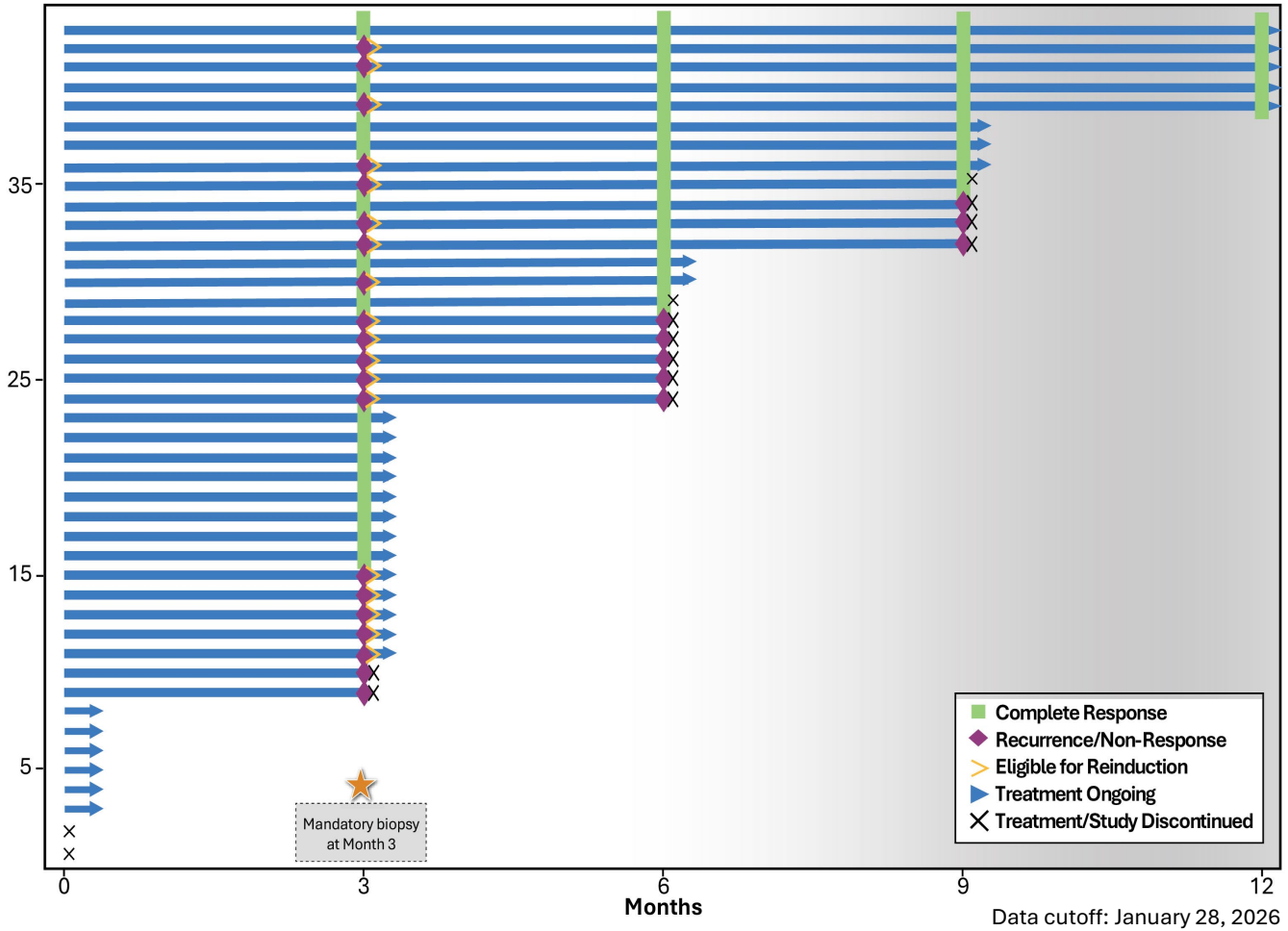
TARA-002: A Unique TLR2/NOD2 Agonist Derived From *Streptococcus pyogenes* That Brings a New Immunologic Mechanism to NMIBC Beyond BCG



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]

[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

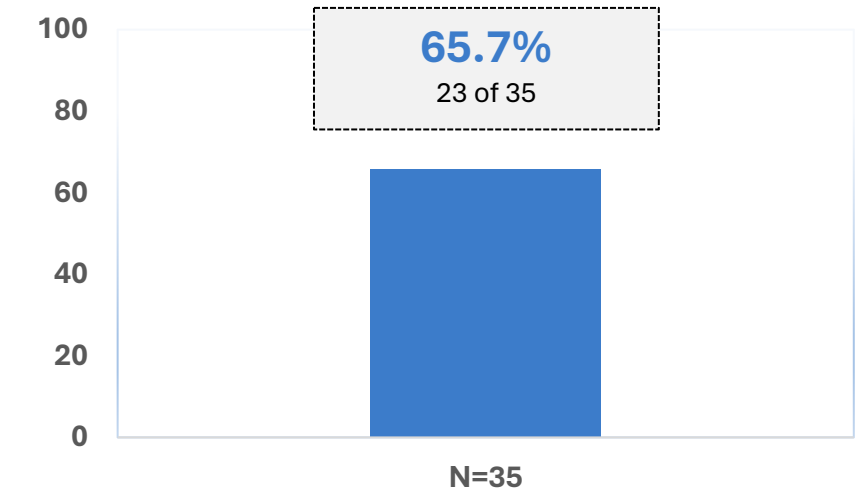
TARA-002 Monotherapy Demonstrates 68% CR at 6 Months with Durable Response Among BCG-Unresponsive Participants



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

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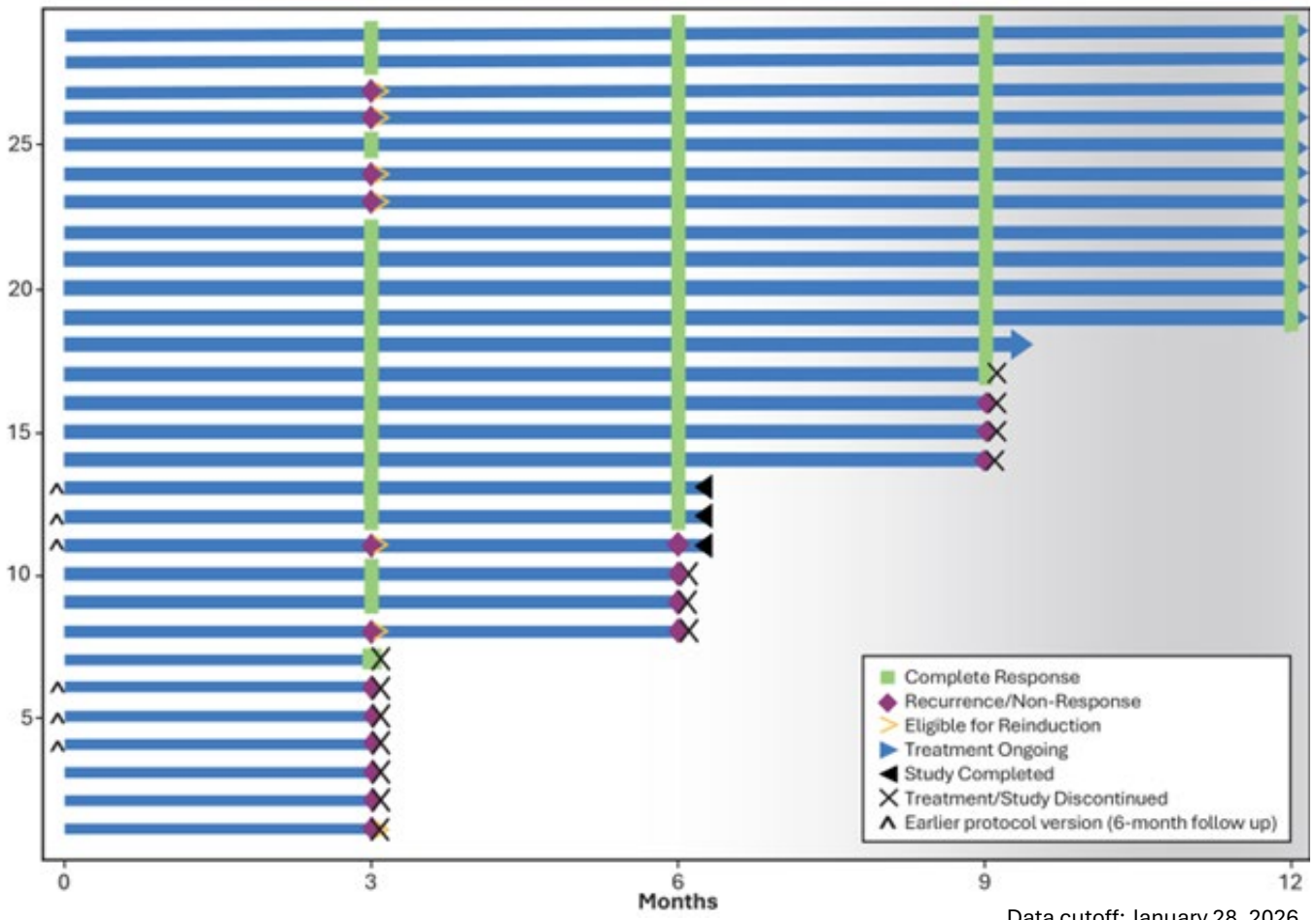
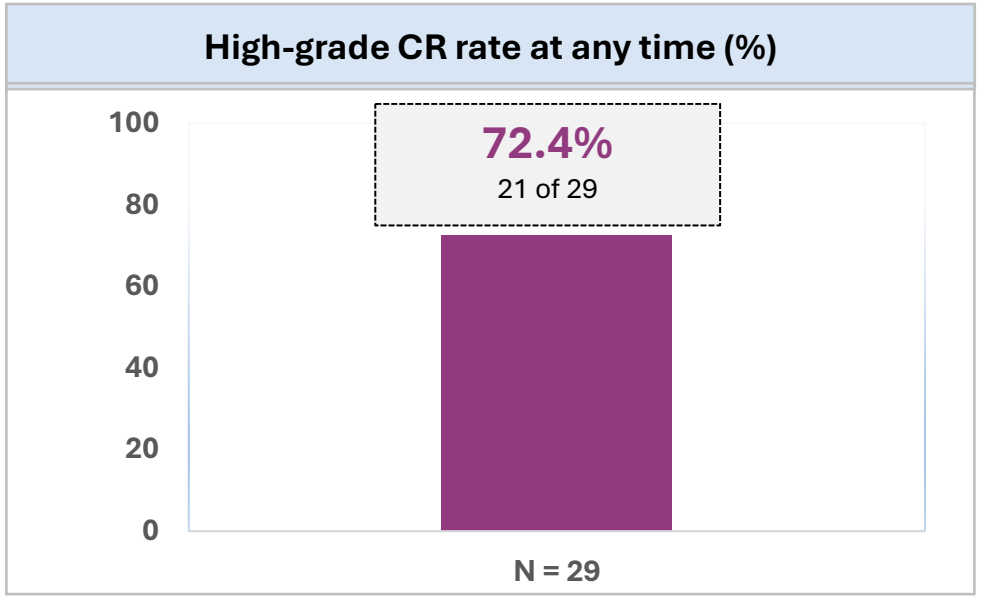
TARA-002 Monotherapy Demonstrates 67% CR at 6 Months with Durable Response Among BCG-Naïve Participants



Data cutoff: January 28, 2026



Landmark	High-grade CR rate (%)
Month 6	**66.7** (18 of 27)
Month 12	**57.9** (11 of 19)
Reinduction Salvage	**66.6** (4 of 6)

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

100%
Maintained CR from 9 Mo -12 Mo (11 of 11)

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.

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

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

N = 74	Any Grade	Grade 1	Grade 2	Grade 3	Grade 4/5
TRAEs, n (%)	19 (26)	19 (26)	4 (5)	0	0
TRAEs ≥5%, n (%)					
Dysuria	10 (14)	10 (14)	0	0	0
Bladder spasm	7 (9)	4 (5)	3 (4)	0	0
Fatigue	5 (7)	4 (5)	1 (1)	0	0
Micturition urgency	4 (5)	4 (5)	0	0	0
SAEs, n (%)	11 (15)	0	3 (4)	10 (14)	1 (1)
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

Data cutoff: January 28, 2026

NOTE: A total of 74 participants were exposed to at least one dose of TARA-002; 43 were BCG-unresponsive and 31 were BCG-naïve.

Severity of adverse event is based on NCI-CTCAE Version 5.0 or later.

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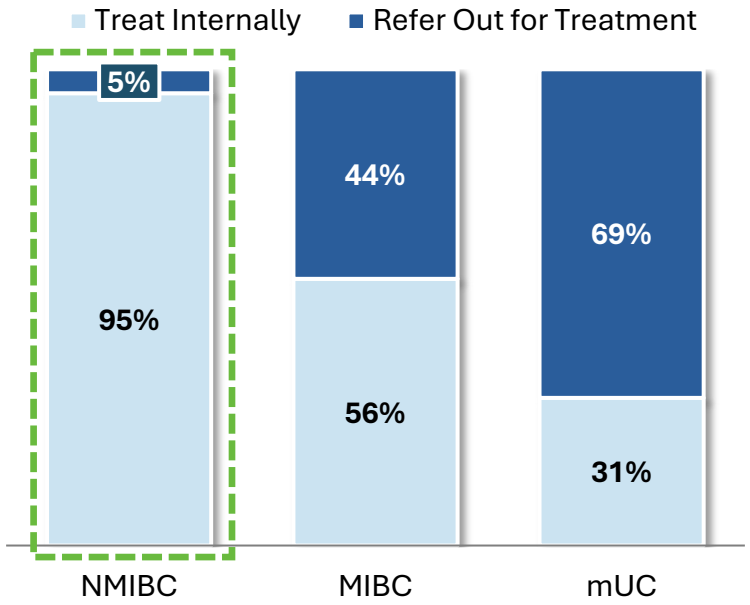
The Majority Of NMIBC Patients are Treated by Community Urologists

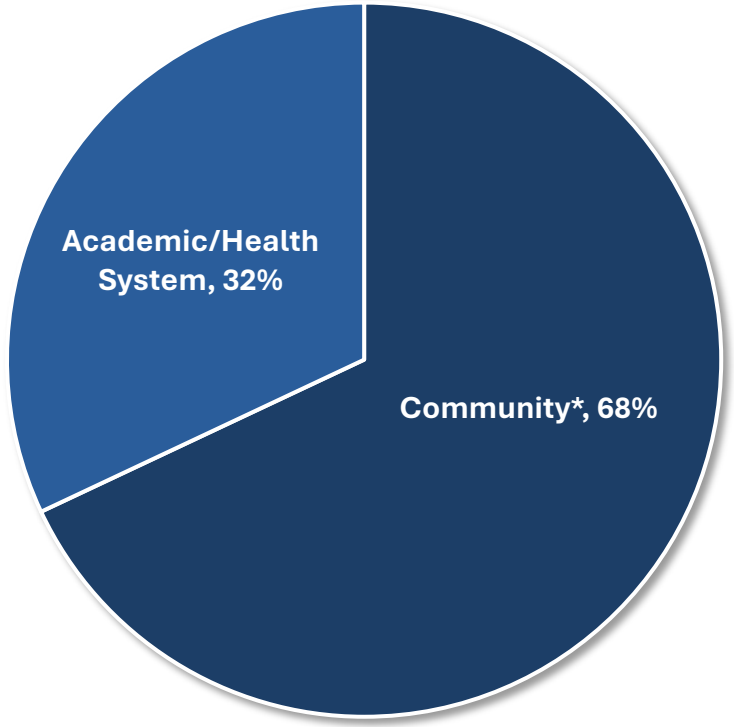
Most NMIBC patients are treated in the community – Urologists prefer to retain their patients



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

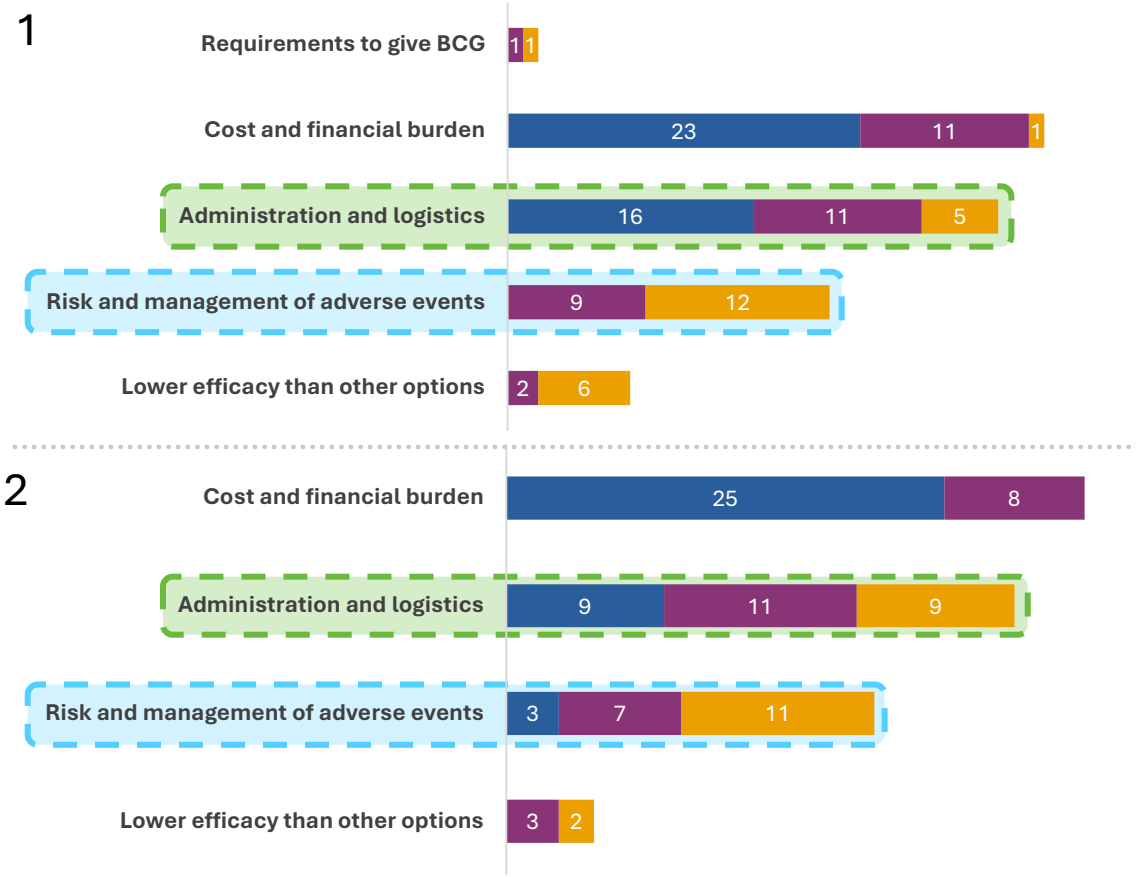
*Includes Private/Community Urology practices, Community oncology practices and other VA etc.
Source: Market research

NMIBC: Safety & Ease Of Use Are Important to Adoption

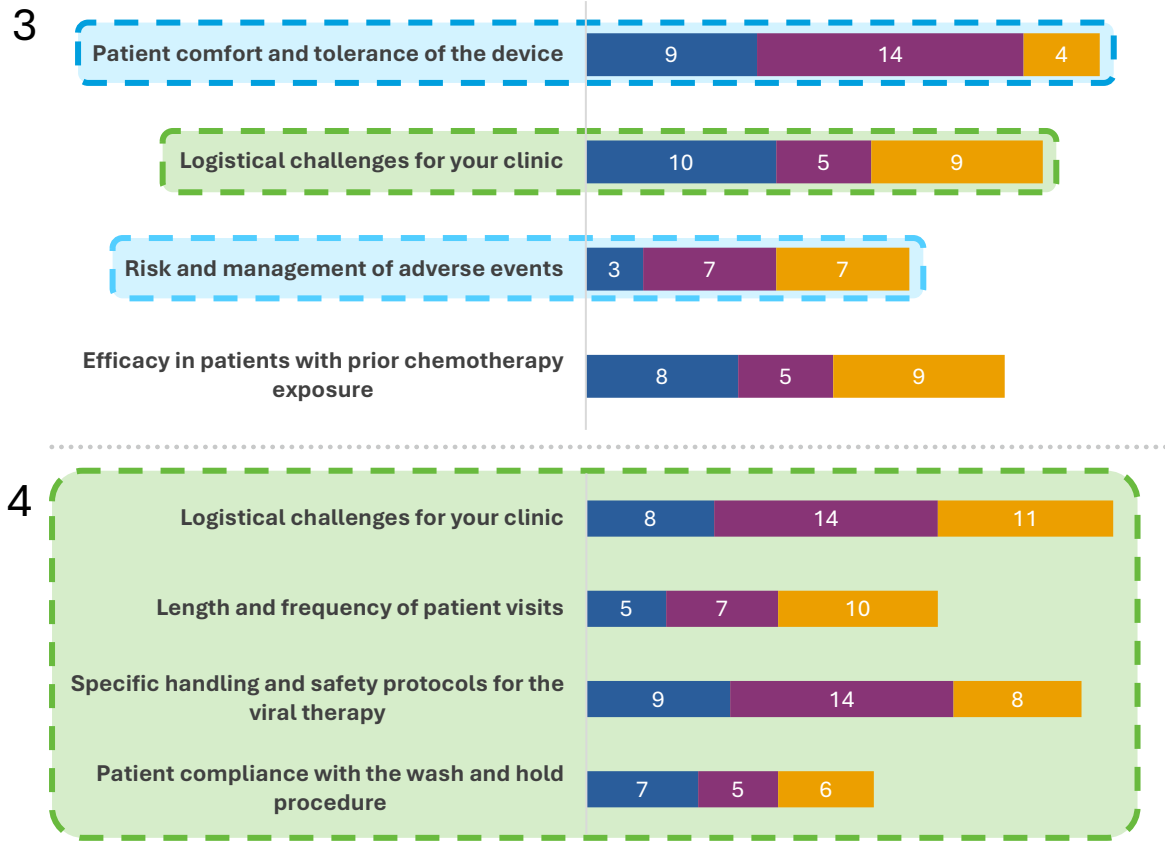
Bloomberg surveyed 51 urologists on their views of key adoption factors of approved and next-generation therapies

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

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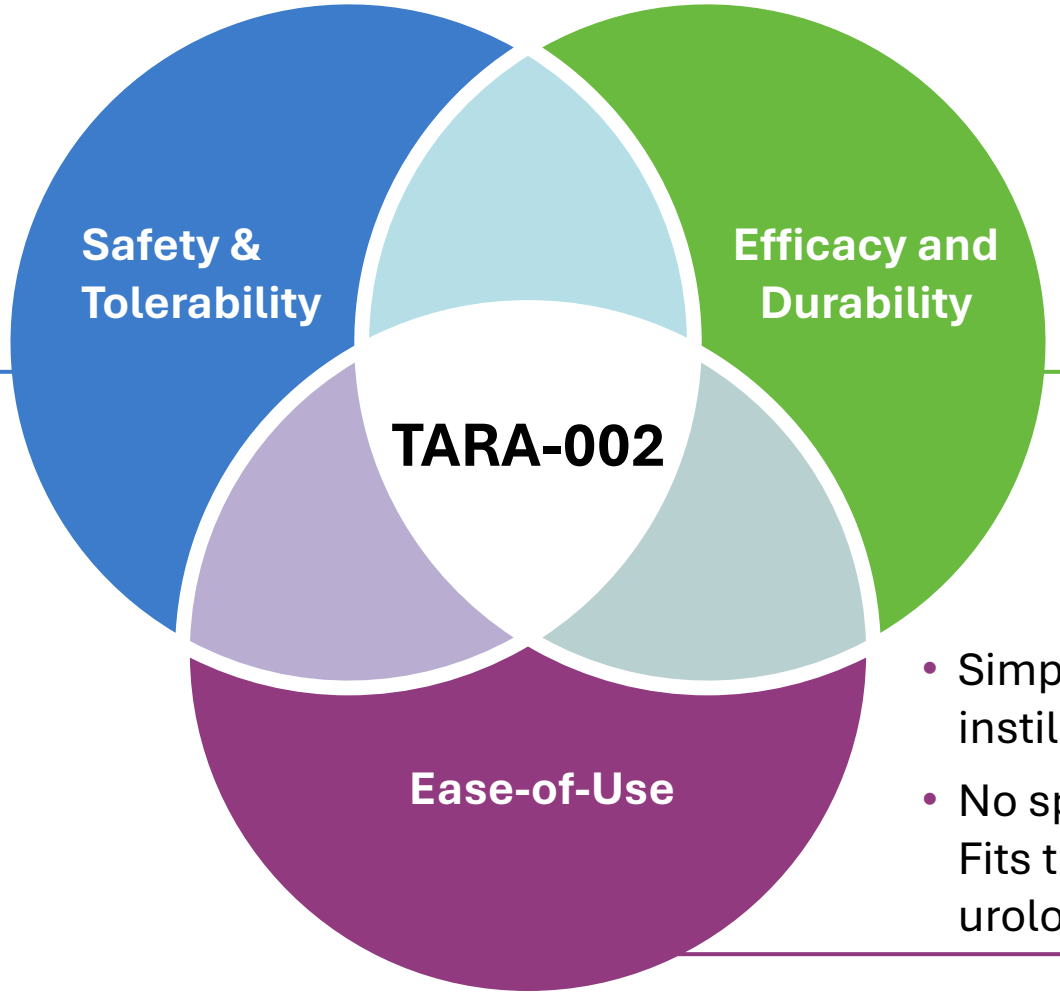
Definitions: USPI – U.S. prescribing information; DDM - dodecyl maltoside
Source: Derived from product SOPIs and clinical trial publications. Not based on head-to-head or comparator studies.

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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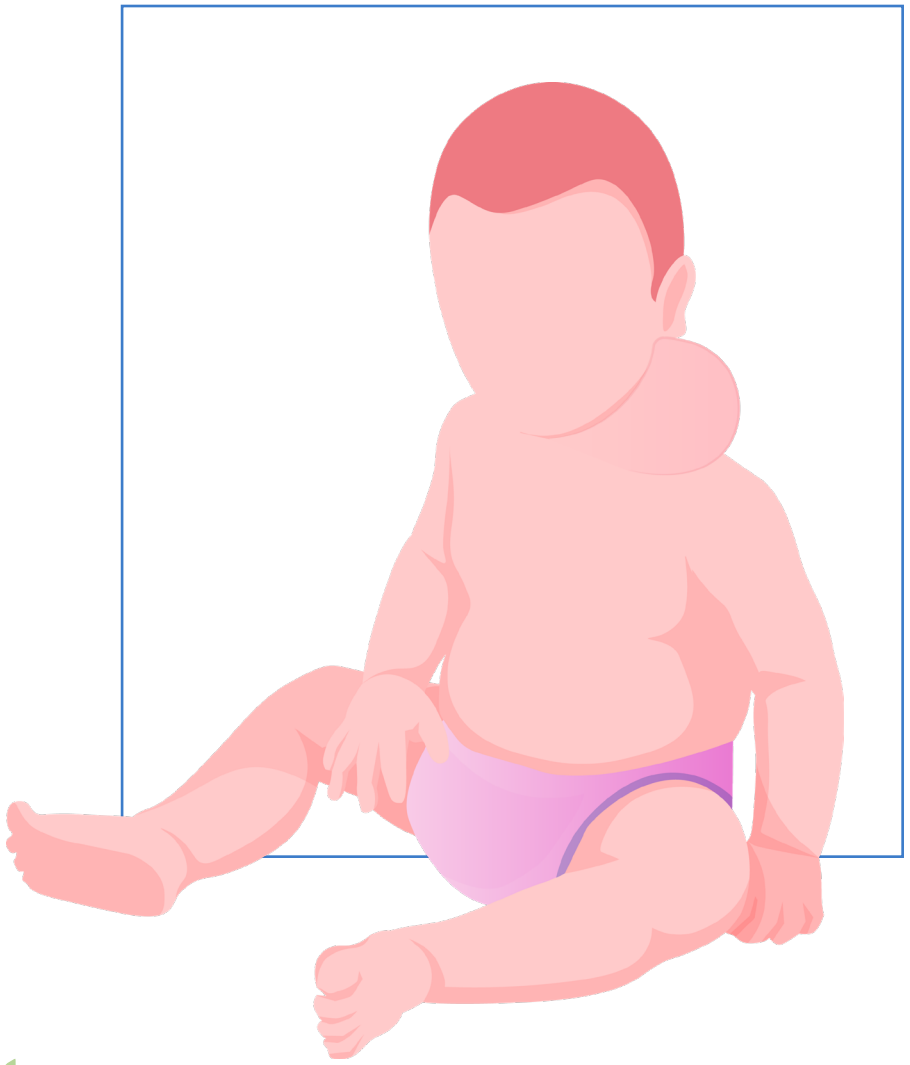
Abbreviations: CR = Complete Response; AEs = Adverse Events

TARA-002

Lymphatic Malformations (LMs)

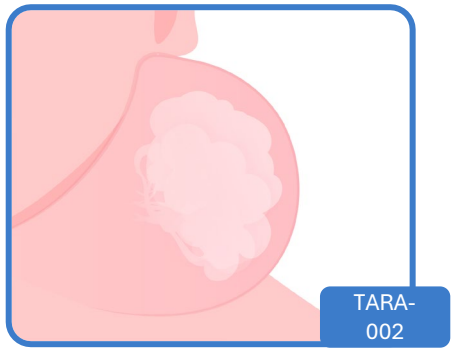
LMs Represent a Significant Pediatric Rare Disease Opportunity with No Currently Approved Therapies



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]

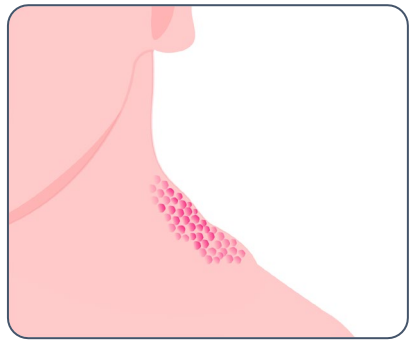
LMs are diagnosed in early childhood and can cause significant morbidity affecting breathing, swallowing, feeding, and speaking[2]

Macrocystic LMs



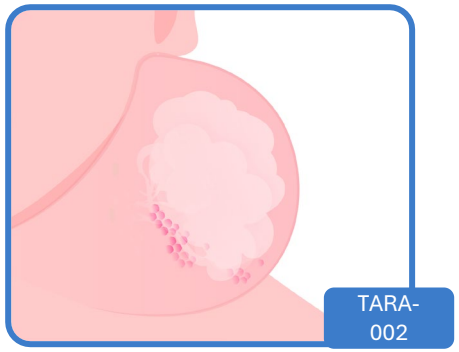
Large cysts >1-2 cm diameter, well-defined fluid-filled spaces

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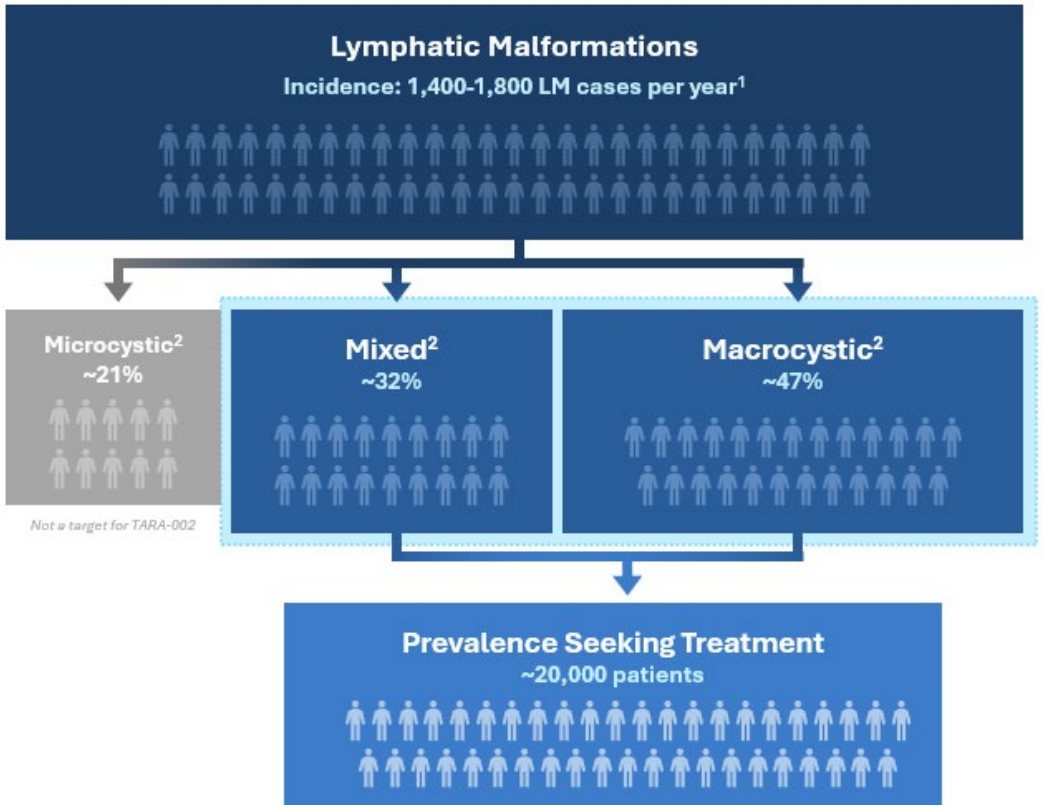
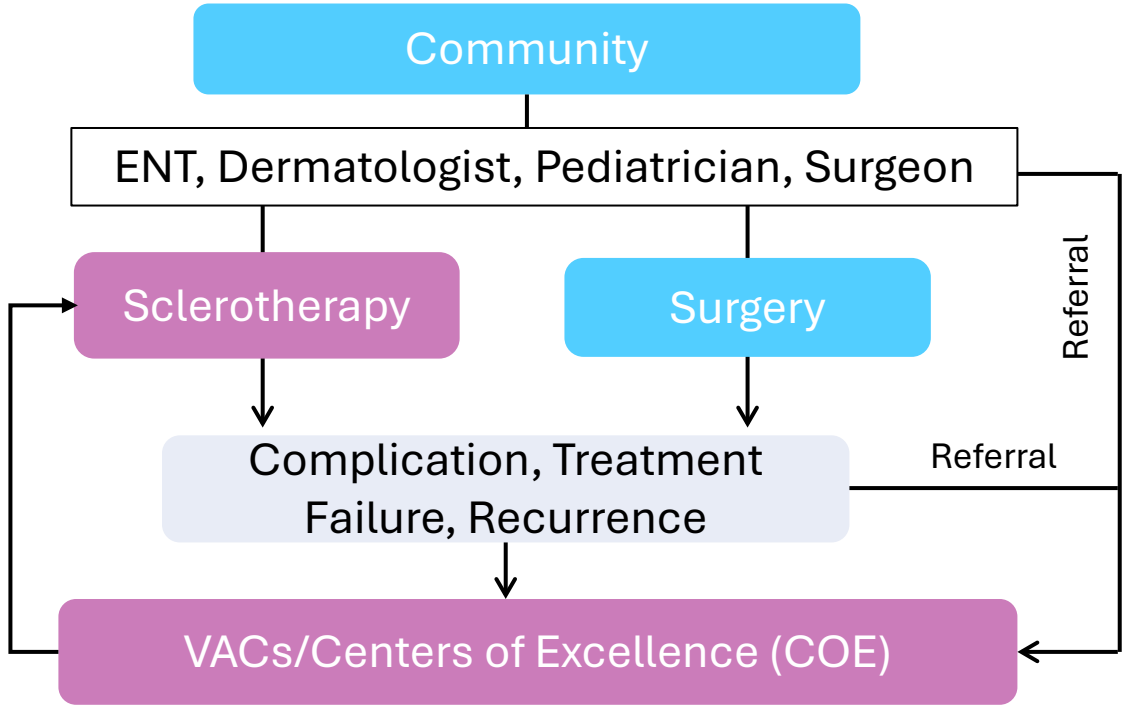
[1]Brouillard P, et al. J Clin Invest. 2014;124:898-904.; [2]Ha J, et al. Curr Ped Rev. 2014;10:238-248

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

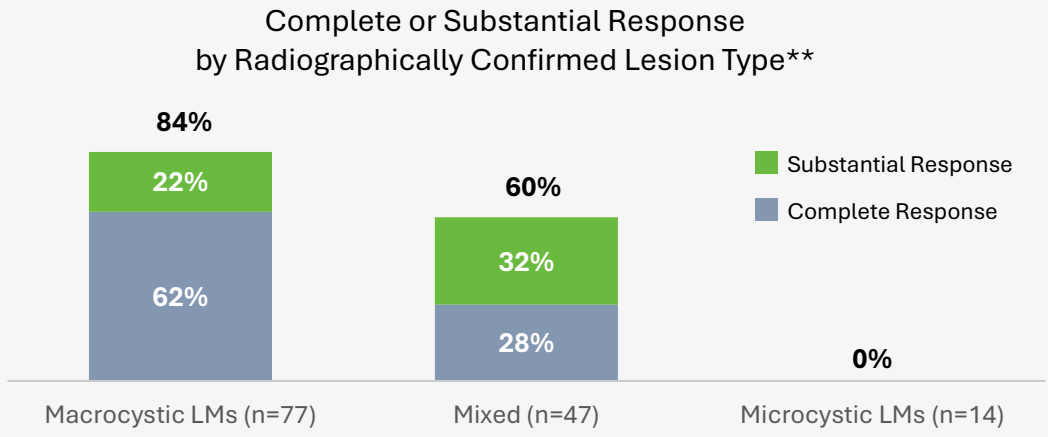


[1,2]Market research sclerotherapy claims analysis

Robust Clinical Results from OK-432[1], Predecessor to TARA-002

University of Iowa study results potentially supportive of regulatory filing and are consistent with STARBORN-1

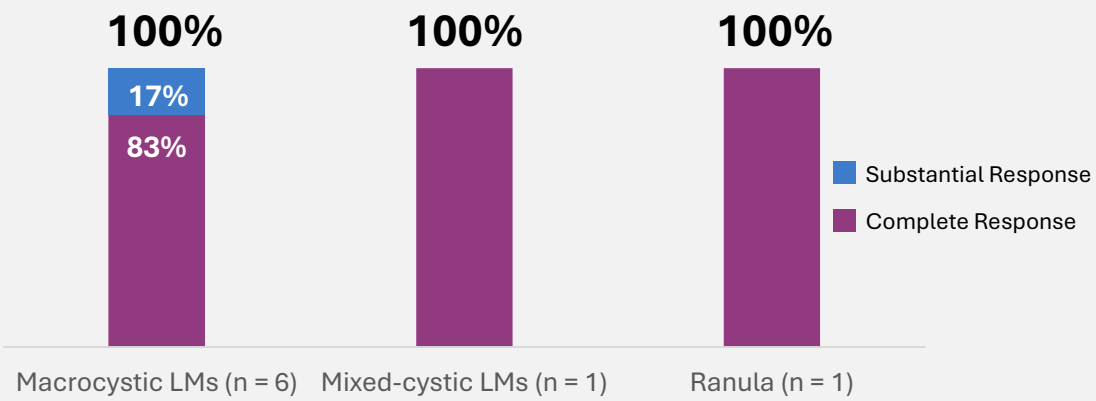
UNIVERSITY OF IOWA RESULTS: 84%* CLINICAL SUCCESS‡ IN PATIENTS WITH MACROCYSTIC LESION TYPES



- Patients with radiographically confirmed macrocystic lesions had the greatest clinical success
- In those patients with mixed lesions, clinical success was also achieved

[1]Results based on retrospective analysis of source verified data that included the full dataset of subjects enrolled in randomized study between January 1998 and August 2005, including data in the published study (Smith et al. 2009) which included subjects enrolled between January 1998 and November 2004.

STARBORN-1 INTERIM RESULTS: STRONG RESPONSE ACROSS CYST TYPES IN EVALUABLE POPULATION: MACROCYSTIC LMs, MIXED CYSTIC LMs



- 2 patients have reached the 32-weeks post-treatment assessment and remain disease free
- One patient deemed a complete response was subsequently diagnosed with a ranula (a different type of maxillofacial cyst from LMs)

‡ Clinical Success was defined as complete or substantial response.

*Reflects data prior to dosing with OK-432. After dosing, the clinical success rate was 66%, which was not statistically different from the Immediate Treatment Group.

**Results were analyzed by lesion type across all treatment groups.

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[1]TARA-002 is developed from the same master cell bank as OK-432
Data cutoff: 12-Nov-2025

TARA-002 in LMs Has a Favorable Safety Profile and is Well-Tolerated

- **Most AEs were mild to moderate.**
- **No SAEs or AESIs have occurred to date.**
- **Related AEs and systemic reactions are in line with typical systemic responses to bacterial immunopotentiation and the established safety profile of OK-432.**

Number of Patients, n = 12	Any Grade	Grade 1	Grade 2	Grade 3	Grade 4/5
TEAEs, n (%)	8 (66.7)	8 (66.7)	6 (50.0)	1 (8.3)	0 (0.0)
Related TEAEs, n (%)	7 (58.3)	7 (58.3)	4 (33.3)	1 (8.3)	0 (0.0)
Related TEAEs >10%, n (%)					
Swelling	3 (25.0)	0 (0.0)	2 (16.7)	1 (8.3)	0 (0.0)
Fatigue	3 (25.0)	2 (16.7)	1 (8.3)	0 (0.0)	0 (0.0)
Headache	2 (16.7)	2 (16.7)	0 (0.0)	0 (0.0)	0 (0.0)
Injection site pain	2 (16.7)	2 (16.7)	0 (0.0)	0 (0.0)	0 (0.0)
Injection site rash	2 (16.7)	2 (16.7)	0 (0.0)	0 (0.0)	0 (0.0)
Pyrexia	2 (16.7)	2 (16.7)	0 (0.0)	0 (0.0)	0 (0.0)
AESIs, n (%)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
Serious TEAEs, n (%)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
Related TEAEs leading to study drug withdrawal, n (%)	1 (8.3)	0 (0.0)	1 (8.3)	0 (0.0)	0 (0.0)

AESI = adverse event of special interest; TEAE = treatment emergent adverse event

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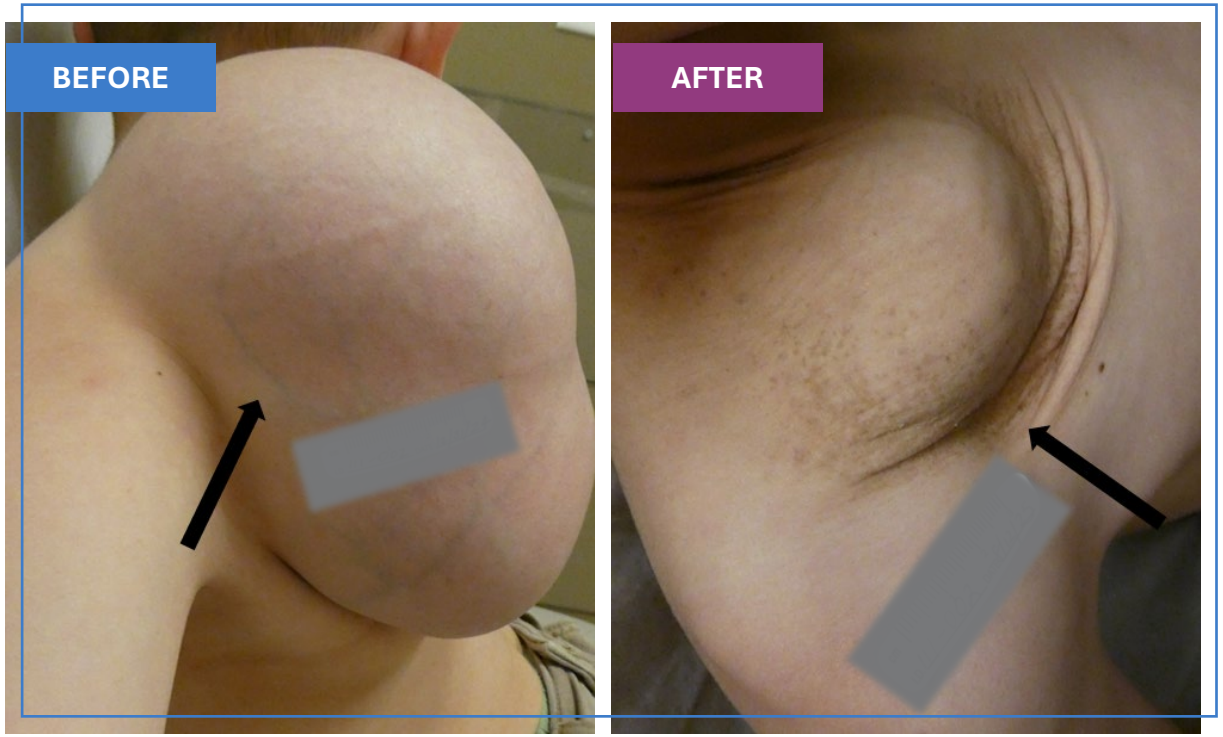
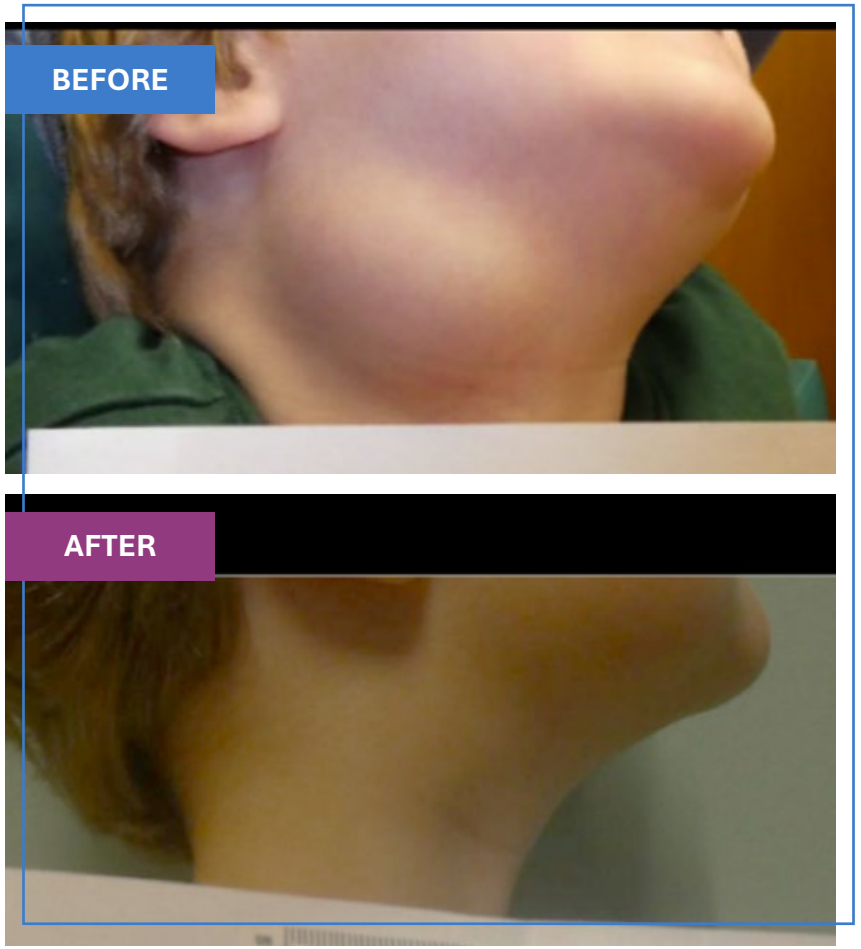
Data cutoff: November 12, 2025

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





Medical photography from 2 patients pre- and post-treatment with TARA-002 in STARBORN-1 trial

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

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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

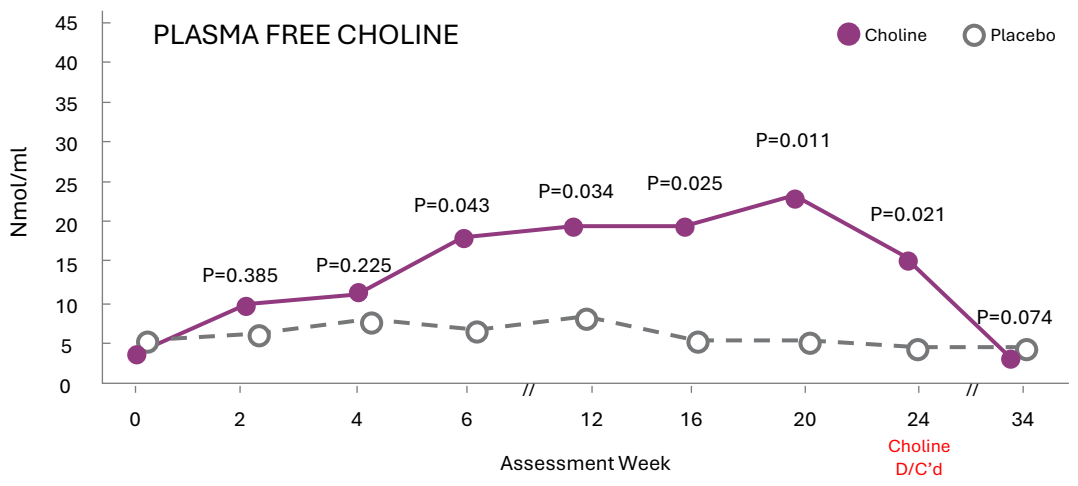
PROTARA THERAPEUTICS

[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

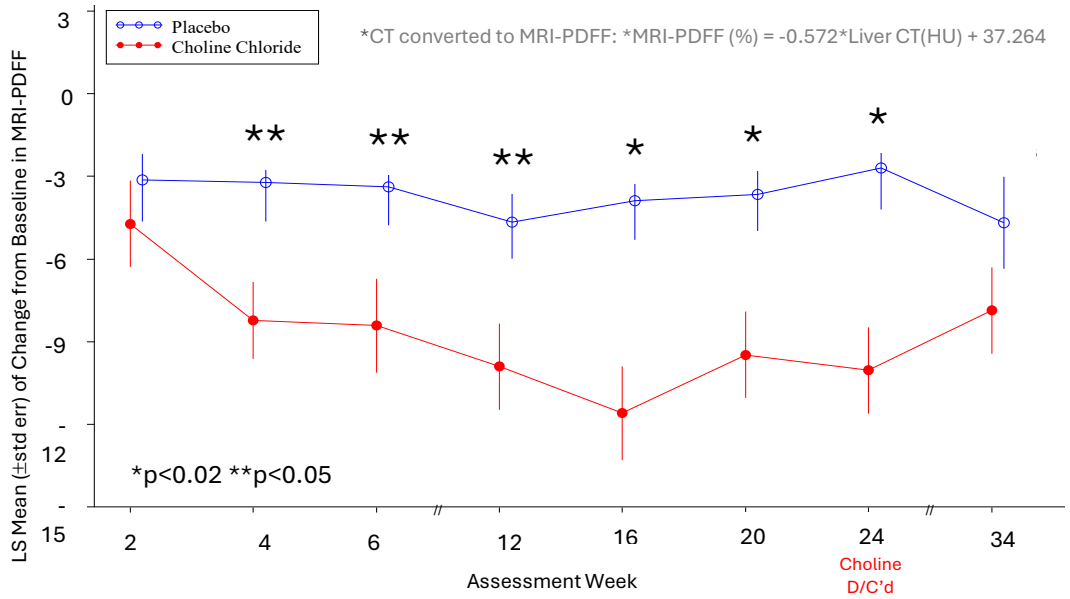
PLASMA FREE CHOLINE LEVELS: ALL PATIENTS[1]

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

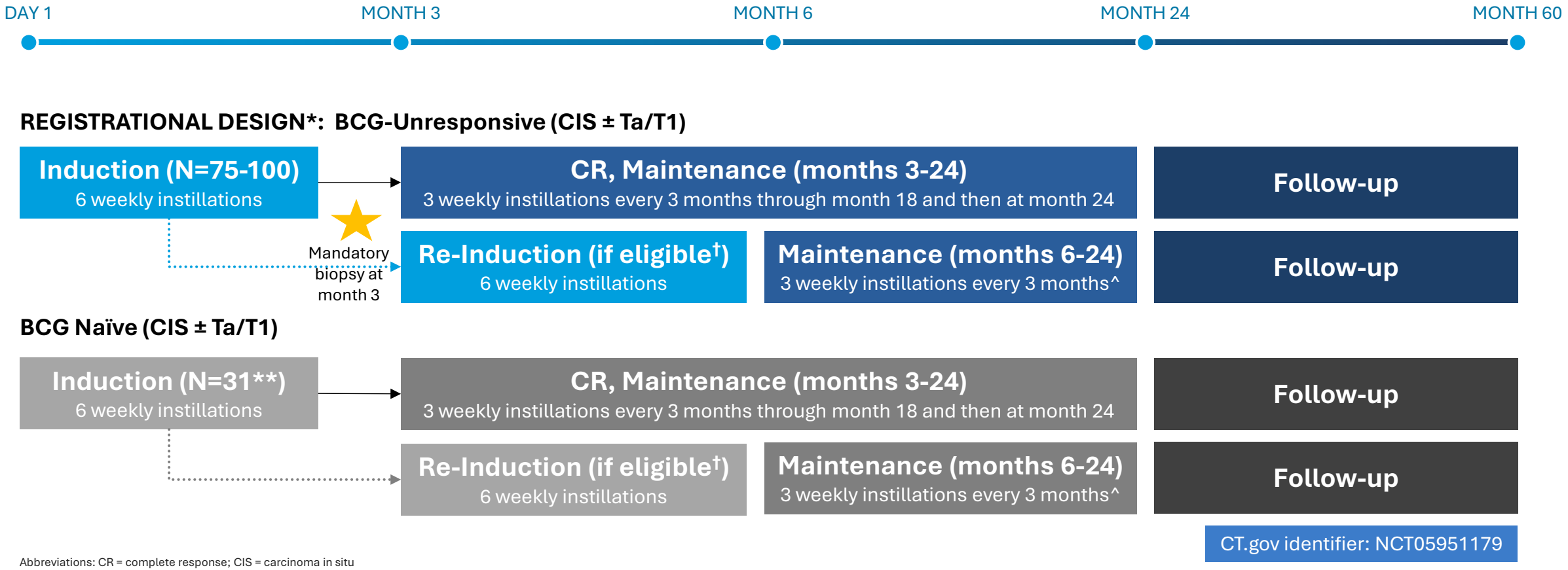
= : No change
+ : 2- 5 fold upregulation
+++ : ≥ 15-fold upregulation
- : 2- 5 fold downregulation
-- : 5-14-fold downregulation
--- : ≥ 15-fold downregulation

PROTARA THERAPEUTICS

[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

PROTARA THERAPEUTICS

BCG-Unresponsive Cohort Demographics and Baseline Characteristics

Baseline Demographics	Cohort B N = 43
Age (years)	
Median (Min, Max)	75 (47, 92)
Sex, n (%)	
Male	31 (72.1)
Female	12 (27.9)
Race, n (%)	
Asian	5 (11.6)
Black or African American	1 (2.3)
White	35 (81.4)
Other	1 (2.3)
Not Reported	1 (2.3)

Baseline Characteristics	Cohort B N = 43
ECOG PS, n (%)	
0	39 (90.7)
1	4 (9.3)
2-5	0
Diagnosis, n (%)	
CIS (only)	40 (93.0)
CIS + Ta	3 (7.0)
CIS + T1	0
BCG Exposure, n (%)	
BCG-unresponsive	43 (100.0)

ECOG PS = Eastern Cooperative Oncology Group Performance Status.

Data cutoff: January 28, 2026

PROTARA THERAPEUTICS

BCG-Naïve Cohort Demographics and Baseline Characteristics

Baseline Demographics	Cohort A N = 31
Age (years)	
Median (Min, Max)	71 (45, 89)
Sex, n (%)	
Male	25 (80.6)
Female	6 (19.4)
Race, n (%)	
Black or African American	1 (3.2)
White	29 (93.5)
Not Reported	1 (3.2)

Baseline Characteristics	Cohort A N = 31
ECOG PS, n (%)	
0	26 (83.9)
1	4 (12.9)
2	1 (3.2)
3-5	0
Diagnosis, n (%)	
CIS (only)	18 (58.1)
CIS + Ta	9 (29.0)
CIS + T1	4 (12.9)
BCG Exposure, n (%)	
Never exposed	24 (77.4)
BCG exposed >24 months	7 (22.6)

ECOG PS = Eastern Cooperative Oncology Group Performance Status.

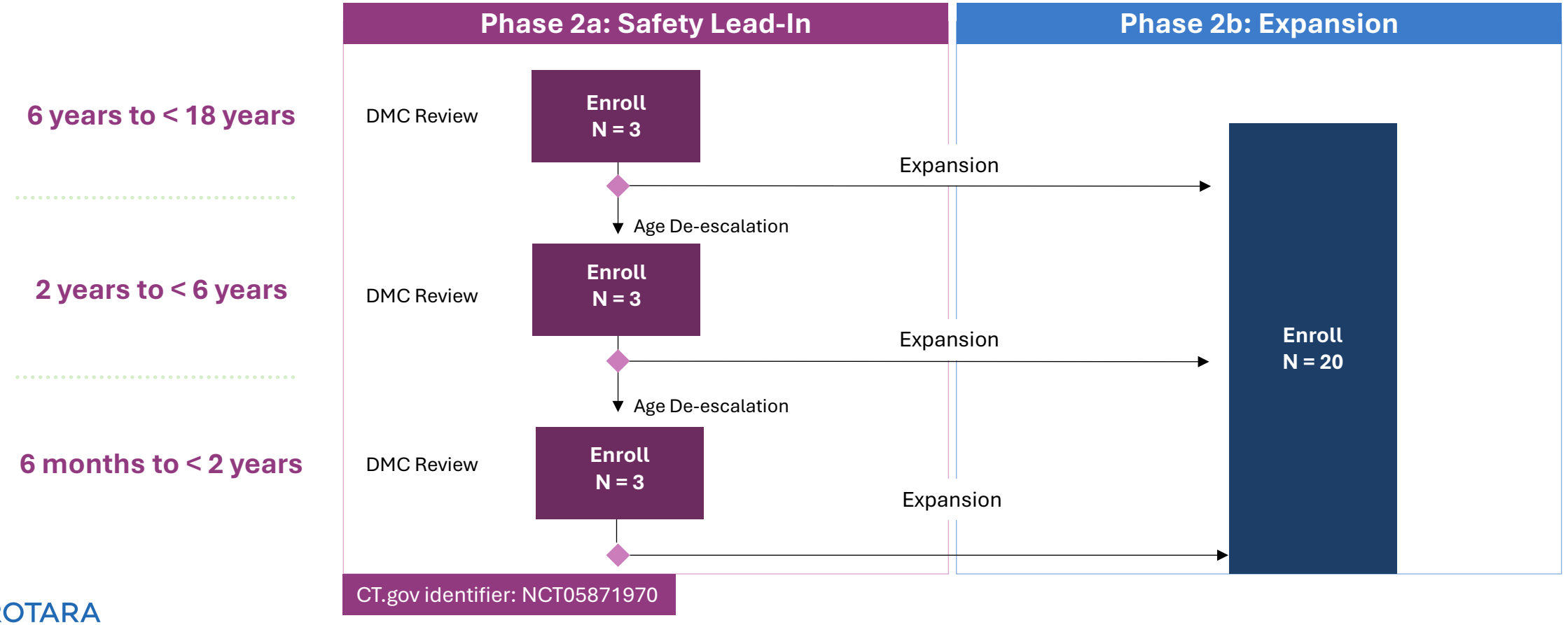
Data cutoff: January 28, 2026

PROTARA THERAPEUTICS

Phase 2 STARBORN-1 Trial

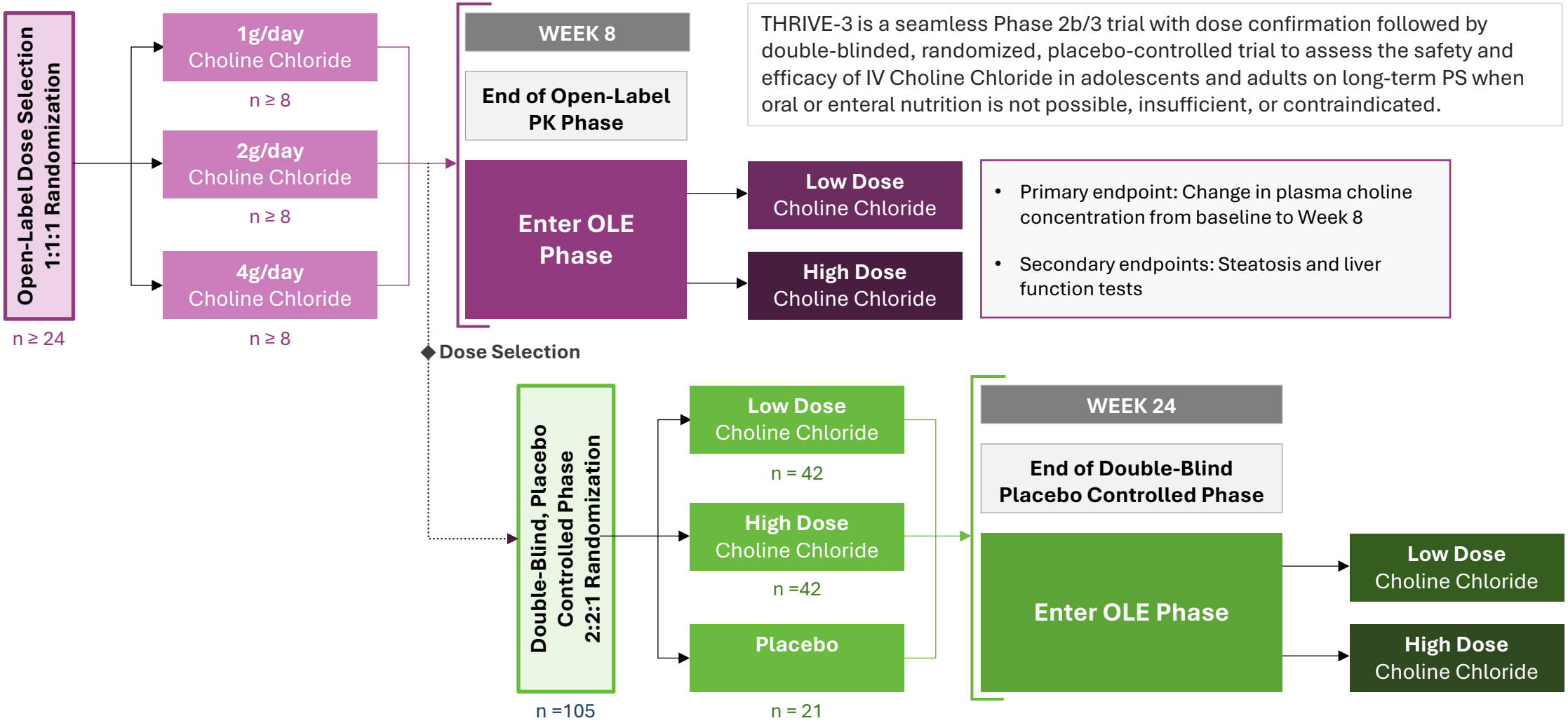
STARBORN-1 is a Single Arm, Open-Label Safety and Efficacy Study of TARA-002 in Pediatric Patients with Macrocystic & Mixed-cystic LMs (N=29)

- 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 the proportion of patients who have either a <u>complete response</u> (90 - 100% reduction from baseline in total LM volume) or <u>substantial response</u> (60% - 90% reduction)**



PROTARA THERAPEUTICS

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

PROTARA THERAPEUTICS