Leading the Transformation of Mental Health Care

Investor Presentation

July 2026

Compass

Disclaimer

Cautionary Note Regarding Forward-Looking Statements

This presentation includes “forward-looking statements” within the meaning of the Private Securities Litigation Reform Act of 1995, as amended. In some cases, you can identify forward-looking statements by terms such as “believe,” “continue,” “could,” “estimate,” “expect,” “may,” “might,” “plan,” “potential,” “project,” “target,” “will,” “would,” or the negative of these terms, and similar expressions intended to identify forward-looking statements. However, not all forward-looking statements contain these identifying words. These forward-looking statements include express or implied statements relating to our strategic plans or objectives; our plans and expectations regarding our clinical trials, including our Phase 3 trials in TRD and our planned Phase 2b/3 trial in PTSD; any implication that preliminary results will be predictive of full safety and efficacy data from our phase 3 program; our expectations regarding the timing of our rolling submission of a new drug application, or NDA, for COMP360 psilocybin treatment in TRD and the timing ofthe review by the Food and Drug Administration, or FDA, of such NDA, including potential acceleration due to the grant of rolling review and award of a National Priority Voucher, for COMP360 psilocybin treatment in TRD; the potential for the pivotal phase 3 program in TRD to support regulatory filings and approvals on an accelerated basis or at all; our expectations regarding the timing of federal and state rescheduling decisions; our expectations regarding potential commercial launch timelines and our commercial readiness; our efforts and our ability to obtain regulatory approval and adequate coverage and reimbursement; our ability to transition from a clinical-stage to a commercial-stage organization and effectively launch a commercial product, if regulatory approval is obtained, on our expected, accelerated timeline or at all; and our expectations regarding the benefits of our investigational COMP360 psilocybin treatment, including \potential durability and dosing regimen. By their nature, these statements are subject to numerous risk and uncertainties, including the our need for substantial additional funding to achieve our business goals and if we are unable to obtain this funding when needed and on acceptable terms or at all, we could be forced to delay, limit or terminate our clinical development efforts; clinical development is lengthy and outcomes are uncertain, and therefore our Phase 3 clinical trials in TRD and our other clinical trials may be delayed or terminated; the full results and safety data from the Phase 3 trials may not be consistent with the preliminary results to date; that the rolling review process and/or the National Priority Voucher pilot program may not actually lead to a faster FDA review or approval process; our efforts to obtain FDA approval, or approval from regulatory authorities in other jurisdictions, for our investigational COMP360 psilocybin treatment on an accelerated basis, or at all, may be unsuccessful; potential for delayed or negative rescheduling decisions by the Drug Enforcement Administration and states regarding COMP360 psilocybin treatment, which contains Schedule I controlled substances and must be rescheduled, if FDA approved, before commercializing COMP360 psilocybin in the U.S.; our efforts to commercialize and obtain coverage and reimbursement for our investigational COMP360 psilocybin treatment, if approved, may be unsuccessful; and our ability to manage growth and retain key personnel; our dependence on third parties in connection with our clinical trials; negative general economic and market conditions; unfavorable geopolitical conditions; changes in policy or resources of U.S. governmental agencies; and other factors beyond our control, that could cause our actual results, performance or achievements to differ materially and adversely from those anticipated or implied in our statements. For additional disclosure regarding these and other risks we may face, see the disclosure contained under the heading "Risk Factors" and elsewhere in the Company’s most recent Annual Report on Form 10-K, Quarterly Reports on Form 10-Q and subsequent public filings with the US Securities and Exchange Commission (the “SEC”). You should not rely upon forward-looking statements as predictions of future events. Although our management believes that the expectations reflected in our statements are reasonable, we cannot guarantee that the future results, levels of activity, performance or events and circumstances described in the forward-looking statements will be achieved or occur. Moreover, neither we, nor any other person, assumes responsibility for the accuracy and completeness of these statements. Accordingly, you are cautioned not to place undue reliance on these forward-looking statements, which speak only as of the date such statements are made and should not be construed as statements of fact. Except as required by applicable law, we undertake no obligation to update these forward-looking statements to reflect any new information, events or circumstances after the date hereof, or to reflect the occurrence of unanticipated events. No representations or warranties (expressed or implied) are made about the accuracy of any such forward-looking statements.

Market & Industry Data

Market & industry data projections, estimates, industry data and information contained in this presentation, including our general expectations about our market position and market opportunity, are based on information from third-party sources, publicly available information, our knowledge of our industry and assumptions based on such information and knowledge. Although we believe that our third party-sources are reliable, we cannot guarantee the accuracy or completeness of our sources. All of the projections, estimates, market data and industry information used in this presentation involve a number of assumptions and limitations, and you are cautioned not to give undue weight to such information. In addition, projections, estimates and assumptions relating to our and our industry’s future performance are necessarily subject to a high degree of uncertainty and risk due to a variety of factors, including, but not limited to, those described above, that could cause future performance to differ materially from our expressed projections, estimates and assumptions or those provided by third parties.

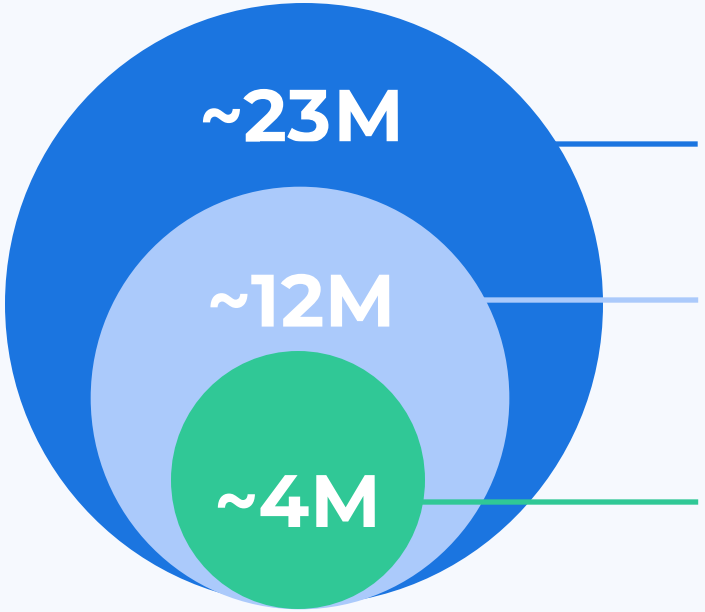
COMP360:
Transforming Mental Health Care

Consistent and Robust data	3 statistically significant positive late-stage trials in TRD in over 1,000 participants
Differentiated COMP360 Profile	Rapid onset, remarkable durability data out to 26 weeks from Phase 3 trials
Clear accelerated regulatory path	Rolling NDA submission/review underway and FDA national priority review voucher awarded (TRD)
Blockbuster opportunity[1]	Large underserved markets in TRD (4M[2] U..S. patients) & PTSD (13M[3] U.S. patients)
Launch readiness	Established site-of-care infrastructure in place and best-in-class commercial team in place to deliver COMP360

1. Expectation based on Compass estimates and current market conditions 2. Wing V, et al. Poster S97 Contemporary Estimate of the National Prevalence of Treatment-Resistant Depression in the United States. J Mood Anxiety Disord. Presentedat ADAA 2026.. 3. https://www.va.gov/columbia-south-carolina-health-care/stories/hope-and-healing-initiatives-for-ptsd-awareness-and-veteran-support/ (accessed July 6, 2026)

1 in 3 Patients Drug-Treated for MDD are Considered Treatment Resistant[1]

Epidemiology of TRD



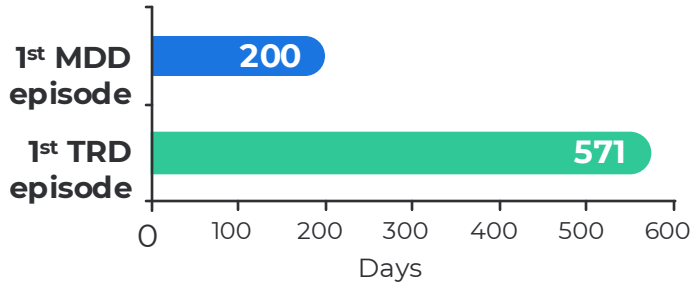
MDD	Prevalence of US adults experiencing MDD each year[1]
MDD-treated patients	Adult patients who are drug treated for MDD in the past year[1]
TRD	Generally accepted definition of TRD: MDD patients failed by ≥ 2 antidepressant regimens of adequate dose, duration, and adherence in the same depressive episode[2]

Key: M, million; MDD, major depressive disorder; TRD, treatment-resistant depression, US, United States

References: 1. Wing V, et al. Poster S97 Contemporary Estimate of the National Prevalence of Treatment-Resistant Depression in the United States. J Mood Anxiety Disord. Presented at ADAA 2026.. 2. US Food and Drug Administration. Major Depressive Disorder (MDD): Developing Drugs for Treatment. Guidance for Industry. June 2018. https://www.fda.gov/media/113988/download. Accessed March 26, 2026.

TRD is Associated with a Greater Burden Compared to MDD

Longer depressive episodes[6]

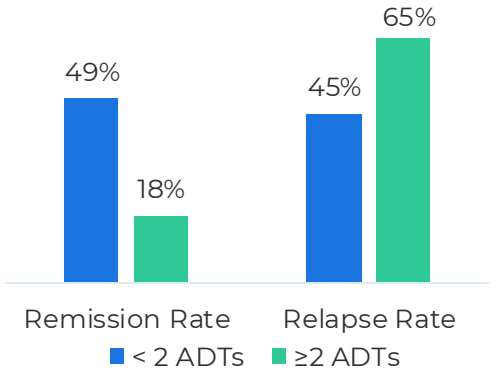


2x longer episodes

Increased relapse rates and decreased remission rates[3,4,7]

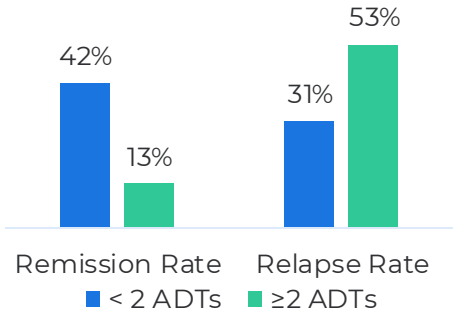
STAR*D Study (2006)[3,7∞]

N = 4,041



Real-world Claims (2024)[4†]

N = 110,406



Higher comorbidity burden[2]

61% vs **36%**
experience **pain***

50% vs **29%**
experience **anxiety***

35% vs **17%**
suffer **migraines***

Decreased productivity[5] and increased mortality[1]

70%
greater **work time loss[5]**

51%
increased risk of **mortality due to suicide[1]**

17-30%
increased risk of **all-cause mortality[1]**

Note: * p < 0.0001, ∞Data calculated for "<2 ADTs" by combining steps 1 and 2 and for "≥2 ADTs" by combining steps 3 and 4. †Real-world claims data from Discover-NOW Health Data Research Hub for Real World Evidence in the United Kingdom.
Key: ADT, antidepressant therapy; MDD, major depressive disorder; non-TRD MDD, non-treatment-resistant depression major depressive disorder; SDS, Sheehan Disability Scale; TRD, treatment-resistant depression.

References: 1. Gustafsson TT, et al. *J Affect Disord*. 2025;368:136-142 . **2.** Kubitz N, et al. PLoS One. 2013;8(10):e76882. **3.**.Rush AJ, et al. Am J Psychiatry. 2006;163(11):1905-17 **4.**. Pappa S, et al. *BJPsych Open*. 2024;10(1):e32.. **5**. Amos TB, et al. *J Clin Psychiatry*. 2018;79(2):17m11725. **6.** Wu B, et al. *PLoS One*. 2019;14(8):e0220763. **7**. Compass Pathways data on file.

TRD MDD
MDD defined as non-TRD MDD

Significant Progress Towards Potential Approval of COMP360 in TRD

- **Consistent Results across two highly statistically significant positive Phase 3 trials**
  - COMP006 and COMP005 26-week data demonstrate rapid onset and remarkable durability through at least 6 months further validating COMP360's differentiated profile in highly chronic TRD
  - COMP360 is generally well tolerated with a safe profile, with majority of adverse events transient and occurring on treatment day
- **Rolling NDA submission and initial review underway with final submission expected to be completed in Q4**
- **Commercial launch-readiness on track for end of 2026, with launch expected in first half of 2027**

We are convinced COMP360 will lead to a profound shift in mental health care - moving beyond daily or frequent administration - toward an option potentially involving just a few treatments in a year that could be life changing for patients

COMP360 Phase 3 in TRD Clinical Data

Emerging Profile of COMP360 has Potential to Revolutionize how Mental Health Conditions are Treated

Clinically meaningful efficacy in a patient population with limited treatment options

Remarkable Consistency

Deep and dramatic reduction in depressive symptoms as quickly as the day following dosing

Rapid Onset of Action

Largest Late-stage Clinical Program in Psychedelics

>1,000 participants across two Ph3 programs and a Ph2b

Durability with infrequent dosing*

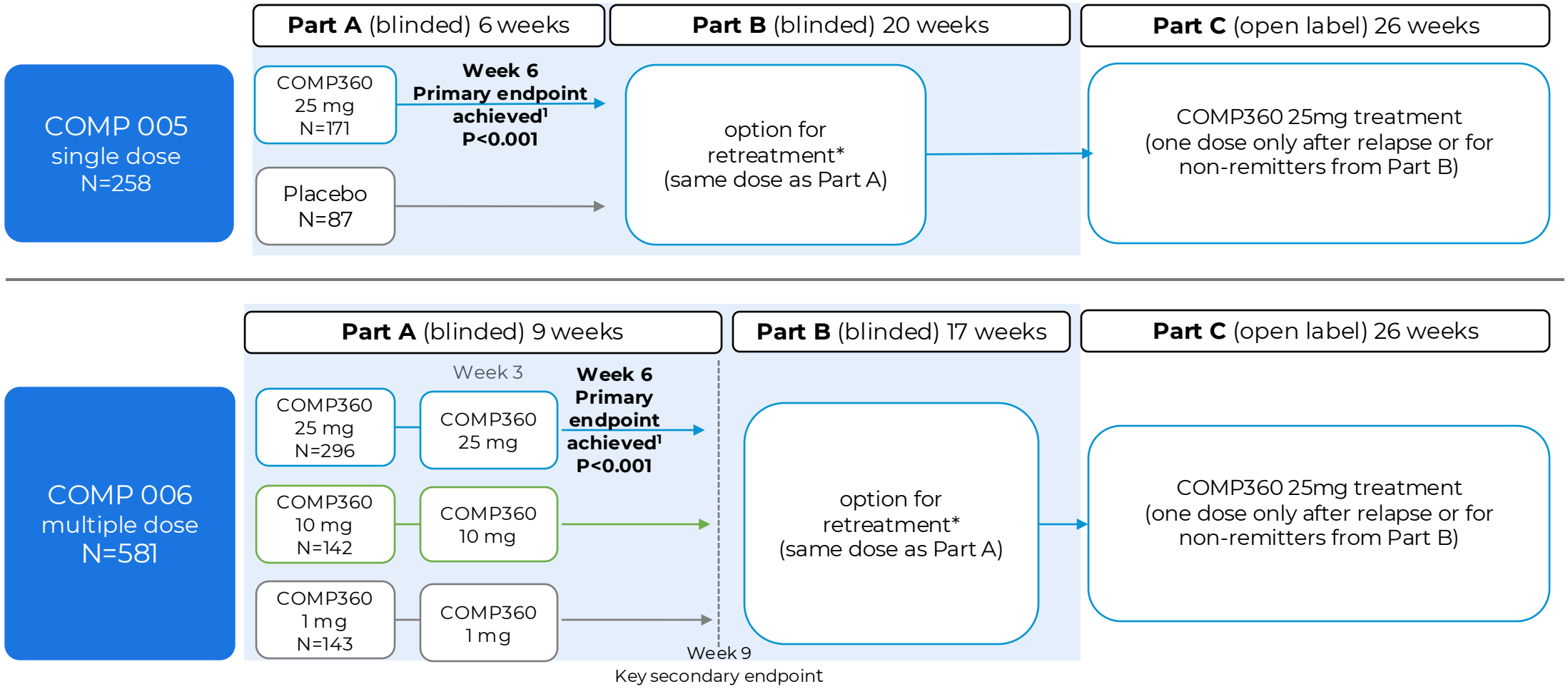
Unprecedented durability sustained through at least 6 months with only 1 or 2 additional doses after initial dose

Well Tolerated & Safe Profile

Generally well-tolerated and safe profile, potentially making it easy for patients and clinicians to try

* Durability data across the two phase 3 programs (COMP005 and COMP006)
Based on clinical trial results to date; Label has not been determined as COMP360 is not yet approved by the FDA

Phase 3 Program in TRD: Trial Designs

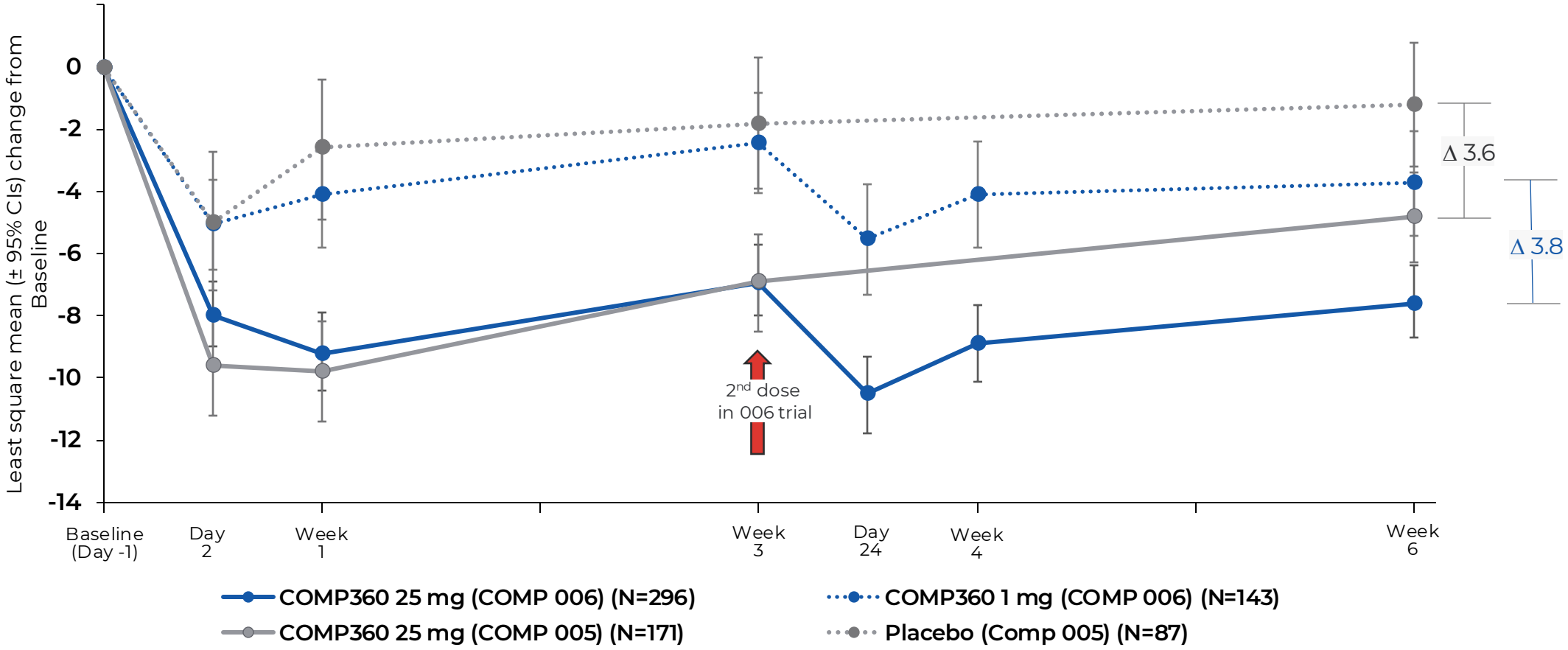


[1]Primary endpoint = change from baseline in Montgomery-Åsberg Depression Rating Scale (MADRS) total score at Week 6.1
*Retreatment for non-remitters from Part A or Part B could occur several weeks after transition to Part B or Part C, respectively, due to scheduling requirements. Participants were permitted to take protocol-allowed antidepressant treatments in Part B and C of the study.

Consistent Statistically Significant, Positive Primary Endpoints for COMP005 & COMP006 in Highly Chronic TRD Population

Consistent improvement in magnitude of MADRS total score between two Phase 3 studies

2nd administration at Week 3 shows potential for a **deeper treatment effect**



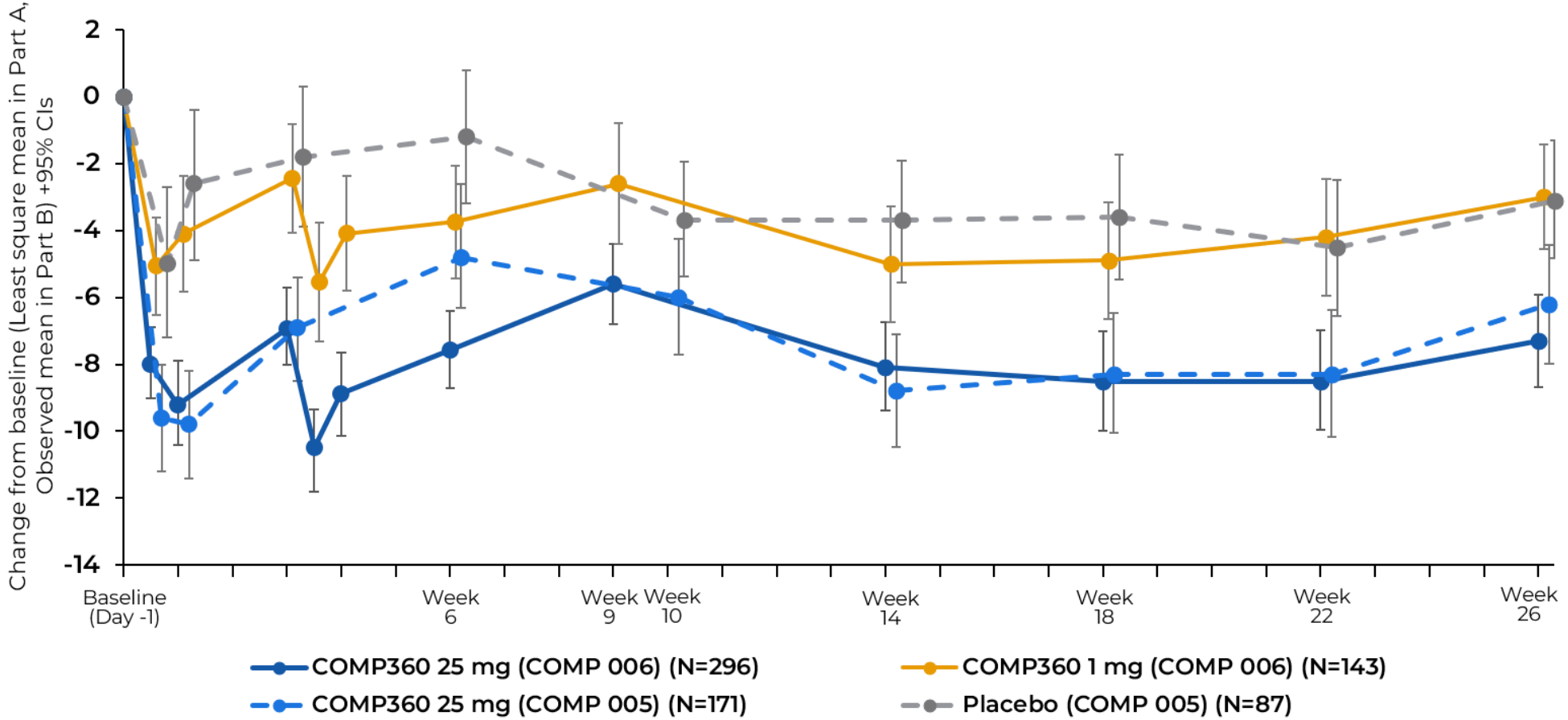
Note: : CI = Confidence Interval; LSM = Least Squares Mean; MADRS = Montgomery–Åsberg Depression Rating Scale
Note that the two phase 3 studies have different but complementary protocols .

Remarkable Consistency in COMP005 & COMP006 Through 6 Months*

Convincing separation between 25mg and control arms maintained **over 26-weeks** in both studies

Confirms validity, consistency and durability of efficacy signal over 26 weeks

Clear benefit of additional dose, either as fixed dose after 3 weeks (006) or later in 10-14 week timeframe (005)

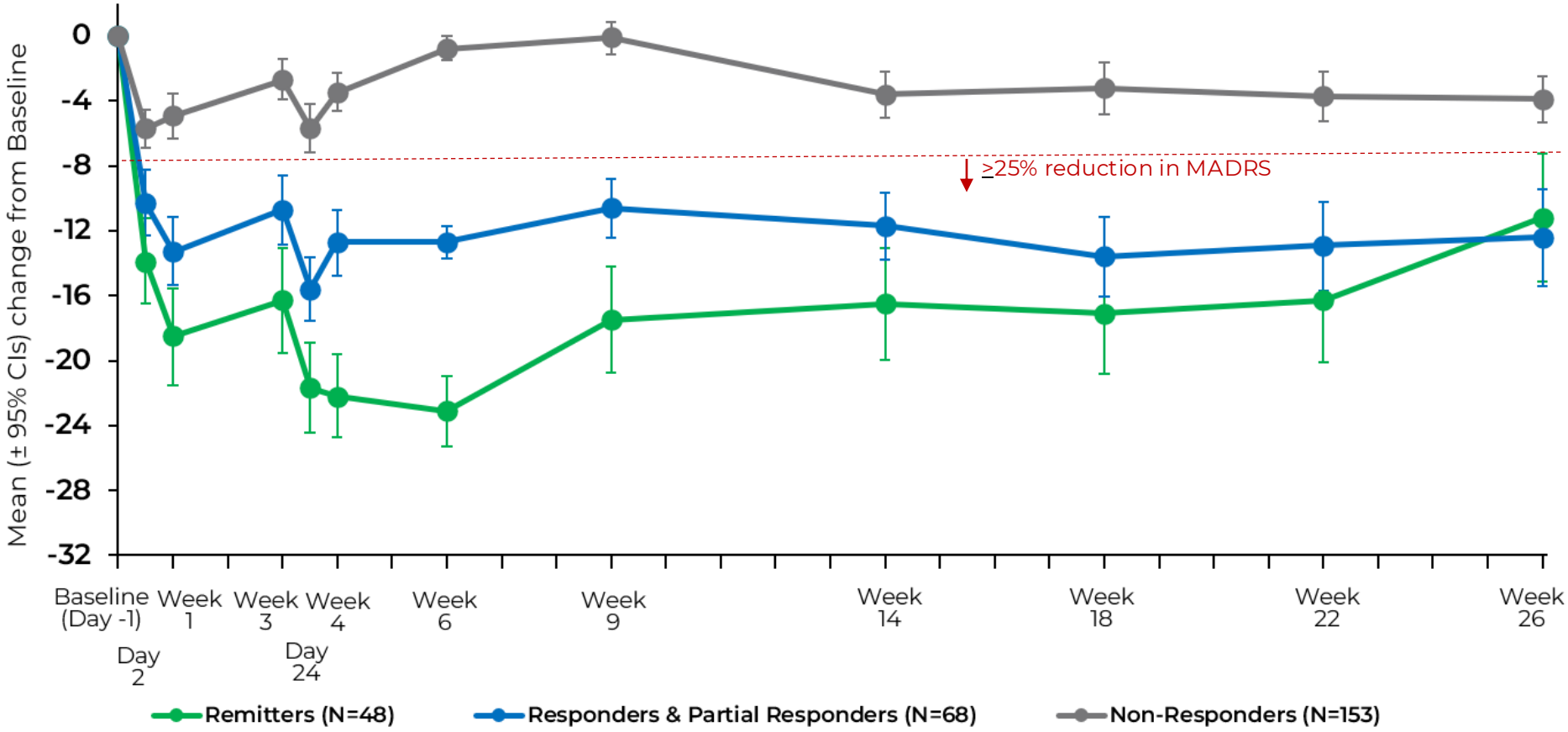


*Cross-trial comparisons should be interpreted with caution. Differences between trials, including but not limited to study designs, protocols, timing of assessments, number or timing of doses and participant populations can meaningfully influence outcomes and limit the validity of any comparison.
COMP 005 Part B (post Week 6) and COMP 006 Part B (post Week 9) results are based on observed data only (CFB Mean ± 95% CI). retreatment in Part B based on pre-specified criteria and receive either what they were randomized into or antidepressant - CI = Confidence Interval; LSM = Least Squares Mean; MADRS = Montgomery–Åsberg Depression Rating Scale

COMP006 - COMP360 Response Can Be Rapid and Durable – Unique in TRD

39% of participants in 25mg arm achieved **clinically meaningful reduction in MADRS*** at Week 6 and on average maintained response at least through Week 26

28% of those who achieved clinically meaningful reduction in MADRS but had not remitted by 6 weeks **went into remission after additional dose** in Part B



Definitions (n at Week 6):

Remitters (n=48) = MADRS ≤12 and no single item ≥4

Responders and Partial Responders (n=68) = % CFB in MADRS ≥ 25% *and* do not meet remission criterion

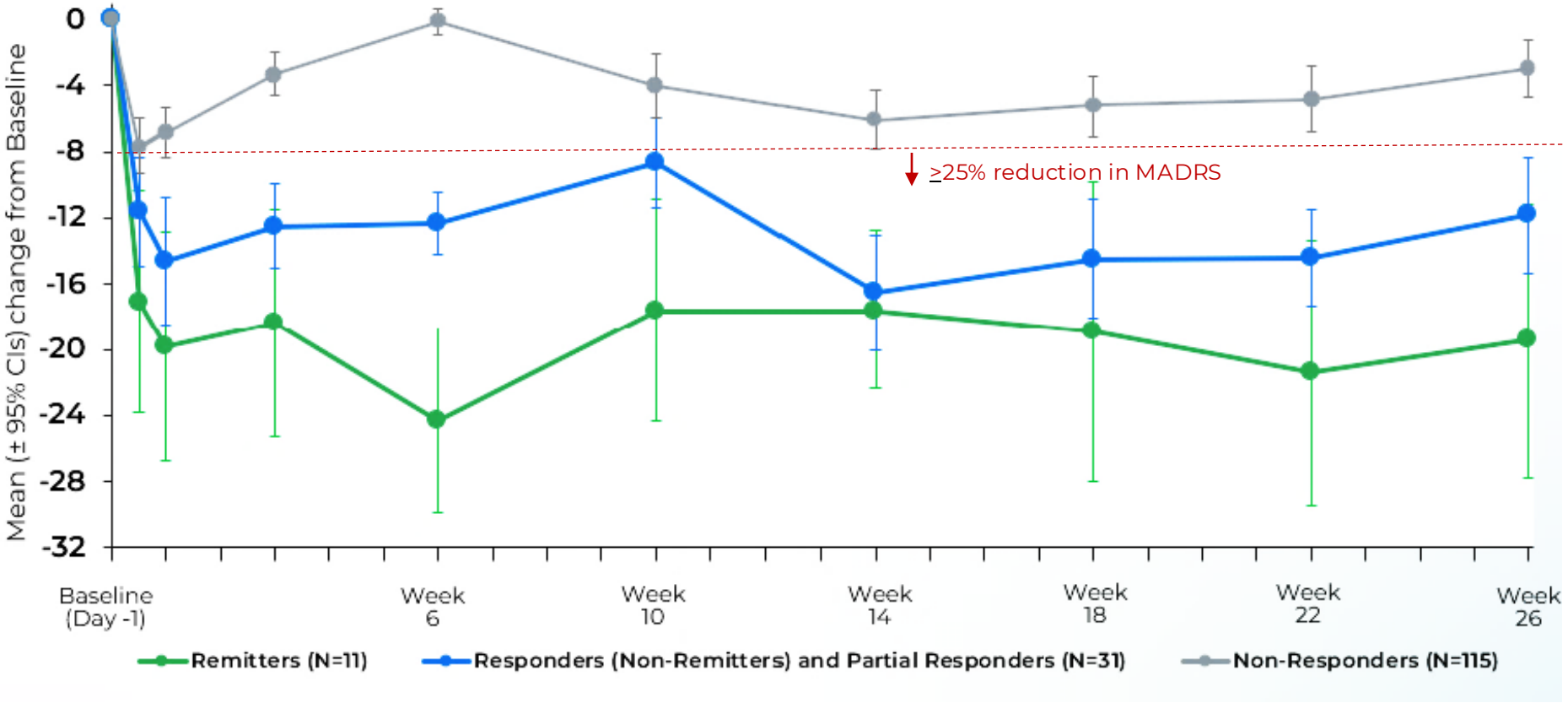
Non-Responder (n=153) = % CFB in MADRS ≤ *25%*

*Clinically meaningful reduction in MADRS defined as a >25% reduction from baseline in MADRS total score at Week 6. This graph is a post hoc analysis. Total n at 6 weeks = 269 (based on ITT)
CI = Confidence Interval; CFB = change from baseline; MADRS = Montgomery–Åsberg Depression Rating Scale

COMP005 - COMP360 Response Can Be Rapid and Durable – Unique in TRD

25% of participants in 25mg arm achieved **clinically meaningful reduction in MADRS*** at Week 6 and on average maintained response at least through Week 26

Over **40%** of those who achieved clinically meaningful reduction in MADRS but had not remitted by 6 weeks **went into remission after additional dose** in Part B



Definitions (n at Week 6):

Remitters (n=11) = MADRS ≤12 and no single item ≥4

Responders and Partial Responders (n=31) = % CFB in MADRS ≥ 25% *and* do not meet remission criterion

Non-Responder (n=115) = % CFB in MADRS ≤ *25%*

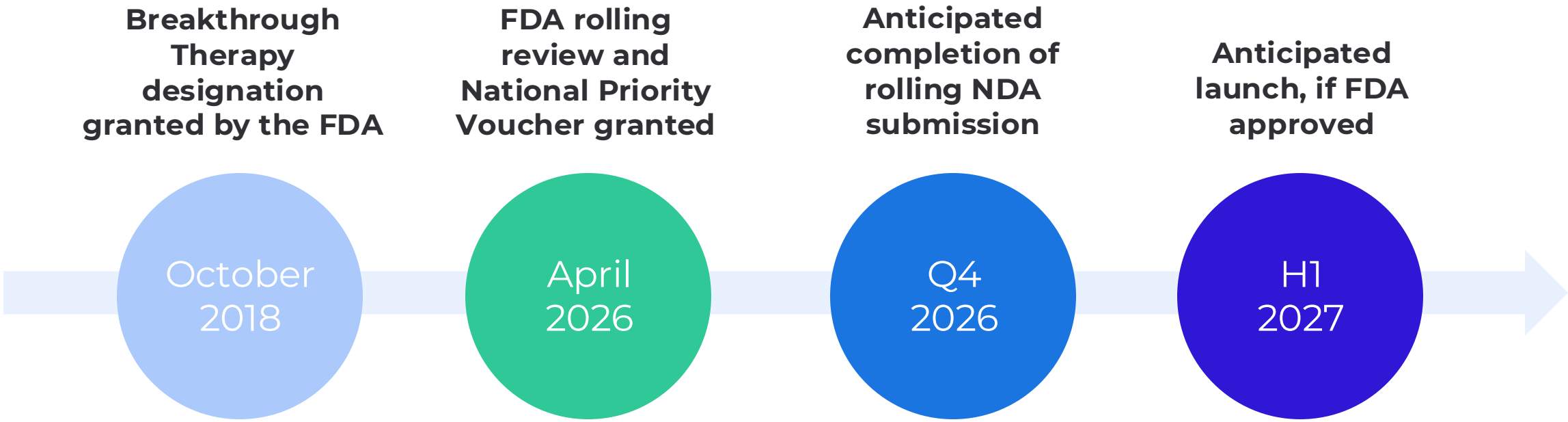
*Clinically meaningful reduction in MADRS defined as a ≥25% reduction from baseline in MADRS total score at Week 6. This graph is a post hoc analysis. Total n at 6 weeks = 157 (based on ITT)
CI = Confidence Interval; CFB = change from baseline; MADRS = Montgomery–Åsberg Depression Rating Scale

COMP360 Generally Well-Tolerated with Safe Profile

- COMP360 generally safe and well-tolerated
  - Majority of AEs transient and occurring on day of administration
- Safety data consistent with known profile of COMP360 psilocybin
  - No new safety signals identified
- SAEs similar in 25mg and 1mg arms and low overall across trial

TRD Commercial Readiness

Anticipated Timeline to COMP360 Launch, if FDA Approved



Advanced commercial launch prep work underway including payer discussions, enabling product distribution, setting up patient support mechanisms, preparing for field force execution and ongoing stakeholder education

Key: FDA, Food and Drug Administration; NDA, new drug application; Q, quarter

COMP360 Prescribing, Dosing, and Reimbursement is Expected to Easily Integrate within Current Clinical Practice

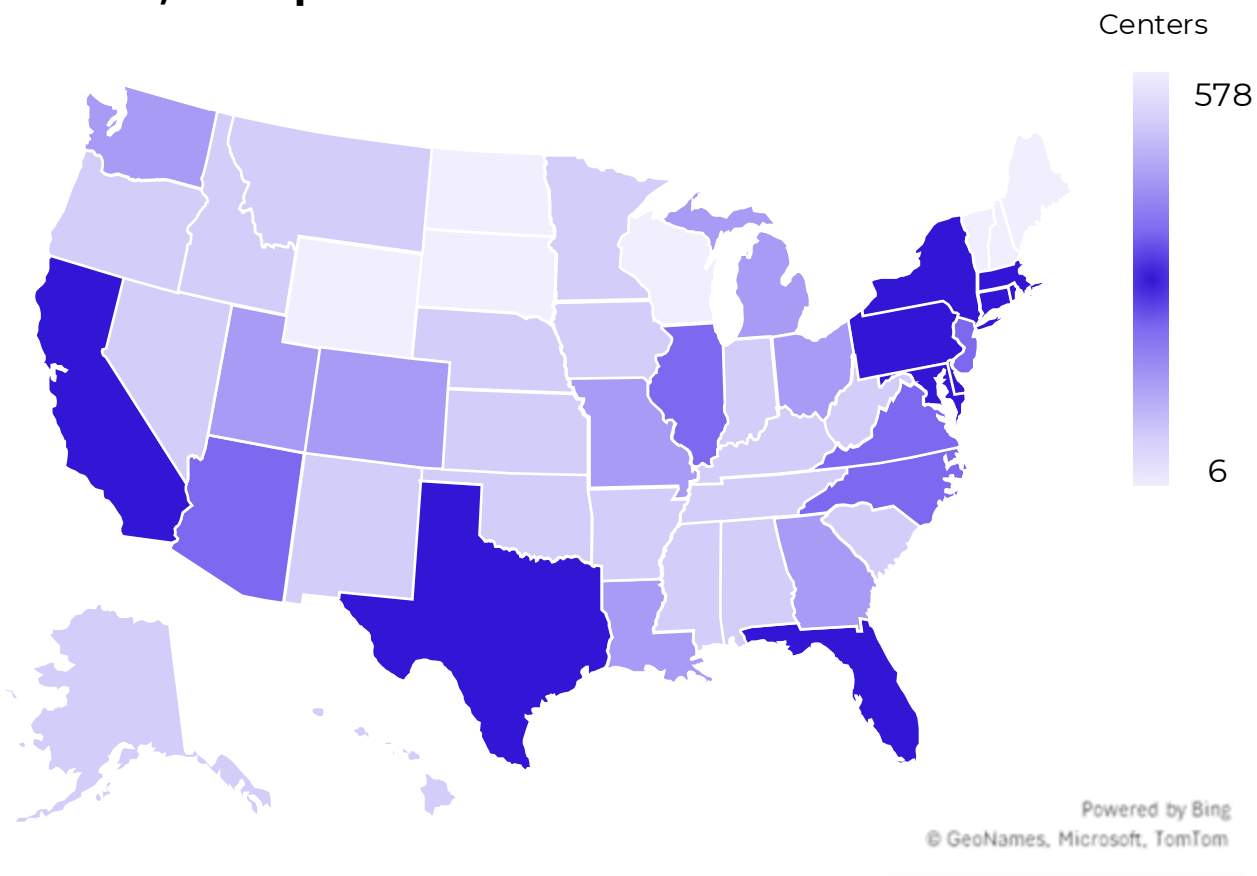
Prescribing	**Prescribed by an HCP** licensed to prescribe medication to patients
Dose administration	**Patient self-administers** oral capsule while **monitored by a licensed HCP**[1] during session Dosing and monitoring to take place at a certified treatment center
Reimbursement[2]	COMP360 expected to be available through specialty pharmacy and buy-and-bill – drug reimbursed through **pharmacy benefit.** Evaluation and Monitoring (E/M) CPTIII codes **specifically for psychedelics**- billed by the hour through **medical benefit**

1. Based on draft guidance by the FDA for psychedelic drug development (June 2023), credentials for a qualified HCP are stated as: PhD, PsyD, MD, DO, MSW, LCPC, LMFT, NP
2. Coding and reimbursement for COMP360 have not yet been established and are subject to change from current thinking
3. CPT stands for Current Procedural Terminology. It's a system of codes created by the American Medical Association (AMA) to describe medical procedures and services. These codes are used for billing purposes and are part of the national coding system under the Health Information Portability and Accountability Act (HIPAA)

Note: CPT III codes accepted, and language released by AMA for Psychedelic Drug Monitoring Services; published in the CPT Manual and effective on January 1, 2024

Well-established Infrastructure of Interventional Psychiatry Treatment Centers in Place and Preparing to Offer COMP360

~7,500 Spravato® treatment clinics in US[1]



Established Practice Patterns

Dedicated rooms/areas for treatments that require multi-hour monitoring

Operational and scheduling capabilities with team-based workforce

Scaling to meet patient demand

At approval, our top priority is site and patient experience:

- Training & education
- REMS certification
- Reimbursement assistance
- Patient support

1. www.spravatohcp.com/find-treatment-center – data pulled 03/19/2026

Gaining Launch Insights Through Our Strategic Collaborations Representing a Spectrum of Architypes

- Hackensack Meridian Health
- Neuronetics (Greenbrook)
- Mindful Health Solutions
- Reliant Medical Group
- Journey Clinical
- Healthport
- Radial Health
- Osmind

- Patient care pathways
- Provider perspectives on Spravato implementation
- Support staff training feedback
- Provider economics for multi-hour treatments
- RWE initiatives
- Treatment model development

Post-Traumatic Stress Disorder (PTSD)

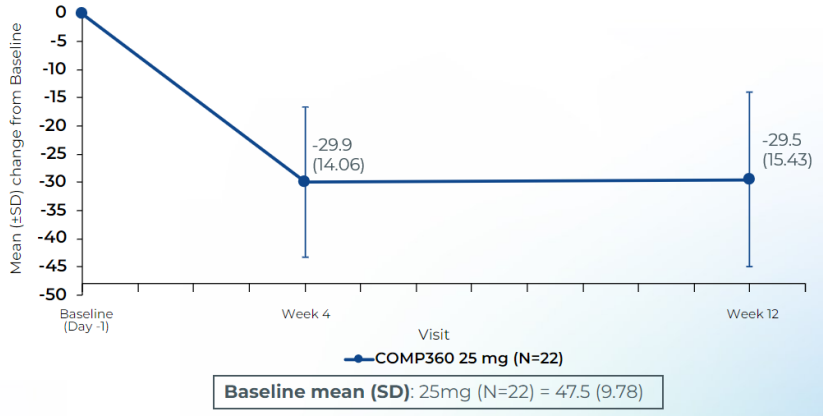
Post-Traumatic Stress Disorder (PTSD) Next Target Indication

Chronic and debilitating psychiatric condition affecting **~13 million adults** annually in the U.S.

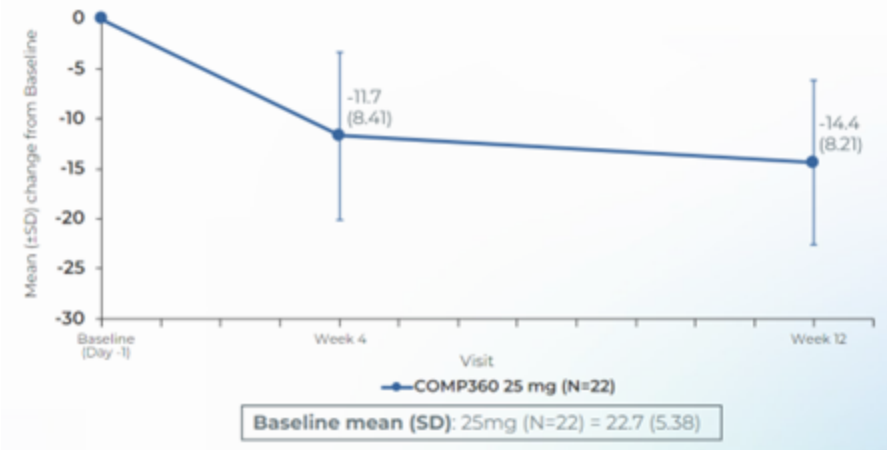
- Characterized by intrusive memories, avoidance, negative mood/cognition, and hyperarousal
- Psychotherapies are first line, but difficult to adhere to and access is limited
- Existing treatments (SSRIs such as sertraline and paroxetine) yield limited efficacy — ~60% of patients fail to achieve remission
- Lack of innovation and patient options - last medical therapeutics were approved over 25 years ago
- High comorbidity with TRD - patients treated in the same settings of care as TRD

Meaningful and Sustained Symptom Improvement in Phase 2a PTSD Study

Summary of change from baseline in CAPS-5 score



Summary of change from baseline in SDS score



N=22, multi-center open-label, single administration of 25mg COMP360 (mean baseline of 47.5 CAPS-5 total score, which is considered severe)

Early onset and sustained change from baseline in CAPS-5 observed at week 4 and week 12

COMP360 was generally safe and well tolerated with no treatment emergent serious adverse events reported; no participants re-started SSRI's or antidepressants after COMP360 administration in study. Most frequent TEAES (>10%) were headache, nausea, crying, fatigue, hallucination, muscle tightness, paraesthesia, visual impairment.

Response in CAPS-5: 81.8% at week 4, 77.3% at week 12

Remission in CAPS-5: 63.6% at week 4, 54.5% at week 12

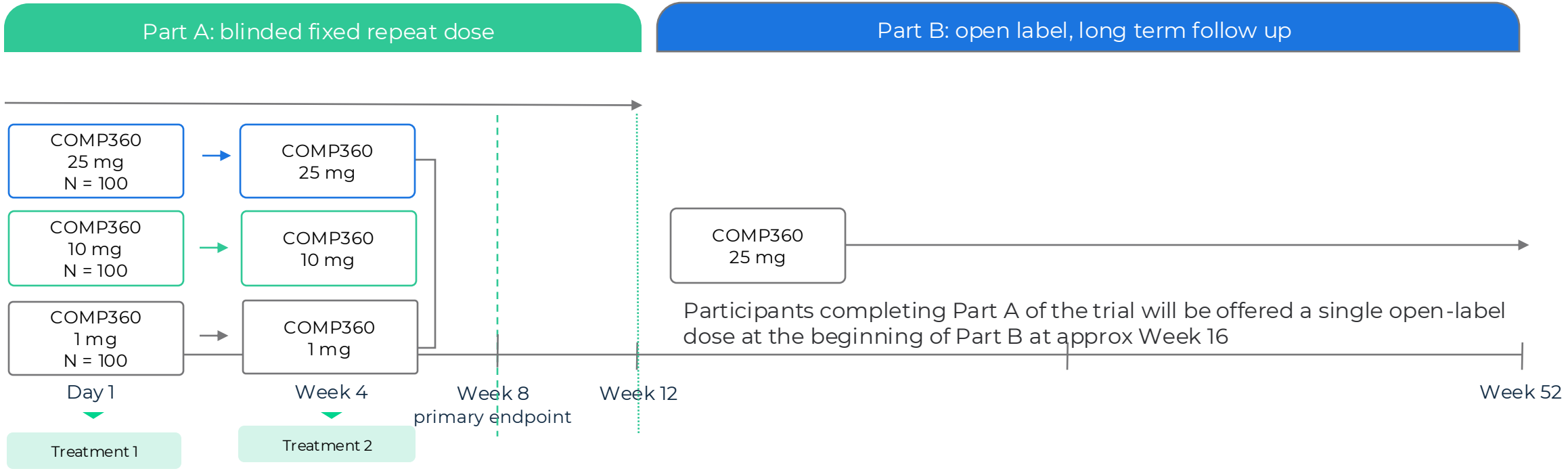
Phase 2b/3 trial start up activities well underway

Note: CAPS-5 = clinician administered PTSD scale

PTSD Late-Stage Phase 2b/3 Trial Design

Design: Multicenter, randomized, double-blind, controlled trial, with an open label extension, to investigate the efficacy, safety, and tolerability of COMP360 in 300 adult participants with PTSD

Primary Objective: To determine if two administrations of COMP360 at a dose of 25 mg compared to two administrations of 1 mg lead to improvement of PTSD symptoms (CAPS-5) at Week 8



Notes:
In both Part A and Part B COMP360 may be administered adjunctively to a single permitted oral antidepressant. 10mg arm included to help prevent unblinding and examine efficacy of this dose as a secondary outcome. In Part B, participants will receive a single open-label treatment with COMP360 25 mg if deemed clinically suitable.

First-in-Class Positioning and Team

COMP360: Transforming Mental Health Care

Blockbuster Opportunity[1]

Large underserved markets in TRD (4M U..S. patients) & PTSD (13M U.S. patients)

Upcoming Catalysts

Completion of NDA submission in Q4 2026: Expected launch H1 2027

Compelling Data

2 successful Ph3 TRD trials: rapid effect, durable efficacy, highly differentiated in TRD

Provider Scalability

Established site-of-care infrastructure in place and ramping to potentially deliver COMP360

Clear Accelerated Regulatory Path

Rolling NDA review underway and FDA National Priority Review Voucher awarded (TRD)

Confidence

Exclusivity protection & extensive IP expected >2038;
Cash runway into 2028

1. Expectation based on Compass estimates and current market conditions

Robust Patent Portfolio Supporting COMP360 Exclusivity

Composition Patents

Drug Substance (DS)

- Crystalline drug substance
- Pharmaceutical-grade purity
- Long-term stability
- Reproducibility
- Identified from first reported large scale synthesis of psilocybin

DS patents challenged at US patent office and upheld.

Drug Product (DP)

- Orally administered formulation
- Target product profile (potency, stability, content uniformity)
- Identified after extensive screening and failure of prior formulations to meet FDA requirements

Method Patents

Method of Treatment (MoT)

- Coverage of priority indications: TRD and PTSD
- Dosing regimens to achieve remission
- Adjunctive treatment with standard of care (SSRI)

Orange Book Patent Exclusivity – Expected >2038

- DS, DP, and MoT patents are listed on the FDA's "orange book"
- Provides exclusivity beyond FDA New Chemical Exclusivity (NCE)
- Generics must address all "orange book" patents before market entry

Large Orange Book Patent Portfolio

COMP360

- 9 Issued and 7 pending patents

Future Indications

- 5 issued and 5 pending patents

Seasoned Management Team with Proven Record of Delivering Visionary Innovation

Kabir Nath, Chief Executive Officer: Kabir has ~30 years of biopharmaceutical and medical device experience. Prior to Compass, he was Senior Managing Director of Global Pharmaceuticals at Otsuka and President & CEO of Otsuka's North America Pharmaceutical Business, leading development of therapies and digital solutions for mental health. He previously held senior leadership roles at Bristol Myers Squibb. Kabir holds an MA from the University of Cambridge and an MBA from INSEAD.

Dr Guy Goodwin, Chief Medical Officer: Guy trained in medicine, physiology, and psychiatry at the University of Oxford and spent 10 years as a Clinical Scientist at the MRC Brain Metabolism Unit. He later served as Head of Psychiatry at Oxford and is a Fellow of the American College of Neuropsychopharmacology and a Thomson Reuters Highly Cited Researcher. His work focuses on mood disorders and psychedelic therapies, and he contributed to the design of Compass Pathways' Phase IIb and Phase 3 studies..

Lori Englebert, Chief Commercial Officer: Lori brings deep commercial launch experience, including most recently nearly five years at Axsome Therapeutics as EVP of Commercial and Business Development, where she led the company's transition to commercial-stage and first product launch, in mental health. She previously held senior roles at Amgen and has launched multiple CNS assets across the U.S., Japan, and Europe.

Dr Michael Gold, Chief Research and Development Officer: Michael has over 28 years of experience in neuroscience drug development and previously led the Neuroscience Therapeutic Area at AbbVie, including the Allergan integration. He is a behavioral neurologist by training and has broad expertise across neurological and psychiatric disorders and multiple therapeutic modalities and has served as an industry representative to the FDA's Office of Neuroscience.

Dr Steve Levine, Chief Patient Officer: Steve is a board-certified psychiatrist and healthcare innovator. He previously founded and led Actify Neurotherapies, developing new care-delivery models for interventional psychiatry, and trained at New York-Presbyterian/Weill Cornell and Memorial Sloan Kettering.

Teri Loxam, Chief Financial Officer: Teri brings deep financial and strategic leadership experience across biopharma. She previously served as CFO of Gameto, CFO/COO of Kira Pharmaceuticals, and CFO of SQZ Biotech, where she led a successful IPO and raised over $200 million. She has also held senior IR roles at Merck, Bristol Myers Squibb, and IMAX and currently serves on the boards of Vaxcyte and Cardiol Therapeutics.

Compass

We're a biotechnology company...

...dedicated to accelerating patient access to evidence-based innovation in mental health.

Stephen Schultz, SVP, Investor Relations
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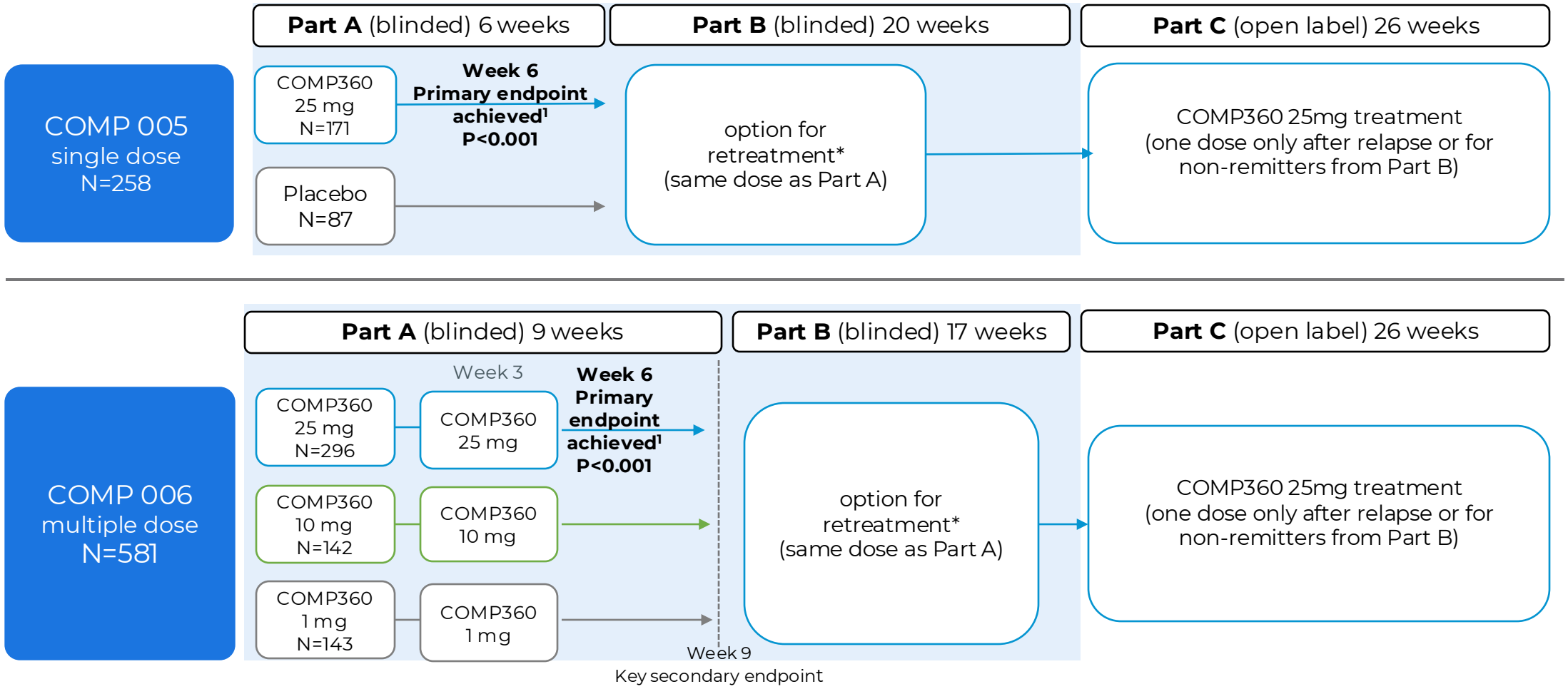
Appendix

Phase 3 Program in TRD

Phase 3 Program in TRD: Trial Designs



[1]Primary endpoint = change from baseline in Montgomery-Åsberg Depression Rating Scale (MADRS) total score at Week 6. 1
*Retreatment for non-remitters from Part A or Part B could occur several weeks after transition to Part B or Part C, respectively, due to scheduling requirements. Participants were permitted to take protocol-allowed antidepressant treatments in Part B and C of the study.

COMP005 & COMP006 – Participant Baseline Demographics In Line with Known TRD Epidemiology

COMP005	COMP360 25 mg (N=171)	Placebo (N=87)
Female, n (%)	93 (54.4)	47 (54.0)
Race, n (%)		
White	149 (87.1)	78 (89.7)
Asian	11 (6.4)	4 (4.6)
Black or African American	6 (3.5)	2 (2.3)
American Indian or Alaska Native	0	1 (1.1)
Other	5 (2.9)	2 (2.3)
Age, years, mean (SD)	45.9 (13.4)	45.3 (14.4)
Min, Max	19, 77	22, 72
Age ≥65 years old	15 (8.8)	11 (12.6)
Prior psilocybin experience, n (%)	5 (2.9)	5 (5.7)
Prior psychedelic experience including psilocybin, n (%)*	8 (4.7)	6 (6.9)
BMI kg/m^2 , mean (SD)	28.4 (6.2)	27.7 (6.1)

COMP006	COMP360 25 mg (N=296)	COMP360 10 mg (N=142)	COMP360 1 mg (N=143)
Female, n (%)	160 (54.1)	68 (47.9)	69 (48.3)
Race, n (%)			
White	255 (86.1)	123 (86.6)	129 (90.2)
Asian	14 (4.7)	6 (4.2)	6 (4.2)
Black or African American	8 (2.7)	3 (2.1)	4 (2.8)
American Indian or Alaska Native	0	0	1 (0.7)
Other/not reported	19 (6.4)	10 (7.0)	3 (2.1)
Age, years, mean (SD)	46.2 (13.7)	42.9 (12.8)	45.5 (13.1)
Min, Max	18, 79	19, 73	20, 75
Age ≥65 years old	29 (9.8)	9 (6.3)	13 (9.1)
Prior psilocybin experience, n (%)	12 (4.1)	5 (3.5)	5 (3.5)
Prior psychedelic experience including psilocybin, n (%)	20 (6.8)	8 (5.6)	9 (6.3)
BMI kg/m^2 , mean (SD)	28.0 (6.2)	28.4 (6.4)	28.0 (6.5)

*planned limit was 15%
BMI = Body Mass Index; n=number of observed participants; SD = standard deviation

COMP005 & COMP006 – Participant Characteristics Treatment History and Baseline MADRS

COMP005	COMP360 25 mg (N=171)	Placebo (N=87)
Number of failed treatments in the current depressive episode, n (%)		
1	2 (1.2)	1 (1.1)
2	114 (66.7)	62 (71.3)
3	45 (26.3)	19 (21.8)
4	10 (5.8)	4 (4.6)
5	0	1 (1.1)
Number of treatments withdrawn from the screening period, n (%)		
0	58 (33.9)	26 (29.9)
1	38 (22.2)	32 (36.8)
2	50 (29.2)	21 (24.1)
>2	25 (14.6)	8 (9.2)
MADRS total score at baseline, mean (SD)	31.5 (5.5)	31.5 (5.9)
MADRS total score severity at baseline, n (%)		
Mild (11-19)	1 (0.6)	2 (2.3)
Moderate (20-30)	73 (42.7)	33 (37.9)
Severe (≥31)	97 (56.7)	52 (59.8)

COMP006	COMP360 25 mg (N=296)	COMP360 10 mg (N=142)	COMP360 1 mg (N=143)
Number of failed treatments in current depressive episode, n (%)			
1	1 (0.3)	1 (0.7)	0
2	190 (64.2)	105 (73.9)	98 (68.5)
3	74 (25.0)	32 (22.5)	34 (23.8)
4	29 (9.8)	4 (2.8)	11 (7.7)
5	2 (0.7)	0	0
Number of treatments withdrawn from the screening period, n (%)			
0	68 (23.0)	30 (21.1)	36 (25.2)
1	127 (42.9)	62 (43.7)	62 (43.4)
2	68 (23.0)	34 (23.9)	31 (21.7)
>2	33 (11.1)	16 (11.3)	14 (9.8)
MADRS total score at baseline, mean (SD)	32.0 (5.8)	32.1 (5.8)	32.5 (5.4)
MADRS total score severity at baseline, n (%)			
Subthreshold ≤10	2 (0.7)	0	0
Mild (11-19)	0	0	0
Moderate (20-30)	115 (38.9)	54 (38.0)	49 (34.3)
Severe (≥31)	179 (60.5)	88 (62.0)	94 (65.7)

MADRS = Montgomery-Åsberg Depression Rating Scale; n=number of observed participants; SD = standard deviation.

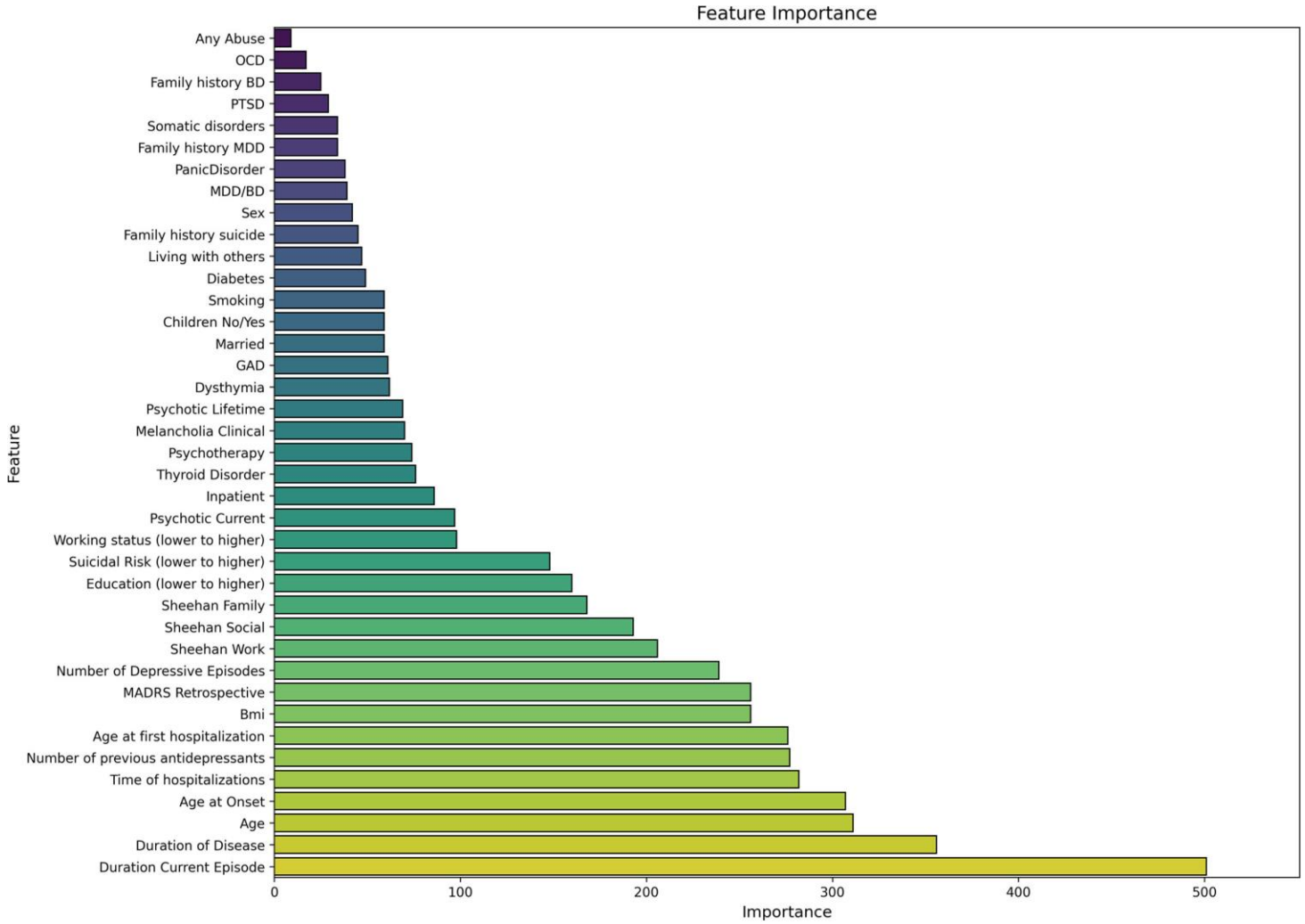
COMP005 & COMP006 – Participant Characteristics Depression Diagnosis History

COMP005	COMP360 25 mg (N=171)	Placebo (N=87)
Length of current depressive episode		
Mean Months (SD)	34.1 (29.1)	38.6 (33.0)
< 1 year	30 (17.5)	20 (23.0)
1-2 years	52 (30.4)	19 (21.8)
>2 years	89 (52.0)	48 (55.2)
Number of lifetime depressive episodes		
Mean (SD)	7.7 (10.9)	7.2 (7.6)
2-5	107 (62.6)	54 (62.1)
6-10	40 (23.4)	21 (24.1)
>10	23 (13.5)	12 (13.8)

COMP006	COMP360 25 mg (N=296)	COMP360 10 mg (N=142)	COMP360 1 mg (N=143)
Length of current depressive episode			
Mean Months (SD)	45.5 (42.7)	37.7 (38.8)	38.4 (45.0)
< 1 year	53 (17.9)	37 (26.1)	30 (21.0)
1-2 years	73 (24.7)	35 (24.6)	41 (28.7)
>2 years	170 (57.4)	70 (49.3)	72 (50.3)
Number of lifetime depressive episodes			
Mean (SD)	6.3 (7.4)	5.4 (6.6)	7.0 (12.5)
1	1 (0.3)	0	0
2-5	199 (67.2)	109 (76.8)	99 (69.2)
6-10	61 (20.6)	21 (14.8)	30 (21.0)
>10	29 (9.8)	10 (7.0)	10 (7.0)

n=number of observed participants; SD = standard deviation

Duration of Current Episode Strongest Predictor of Non-Response in TRD



Source: European Neuropsychopharmacology. Volume 98, September 2025, Pages 26-34 (https://www.sciencedirect.com/science/article/pii/S0924977X25001294)

COMP006 – Phase 3 Data

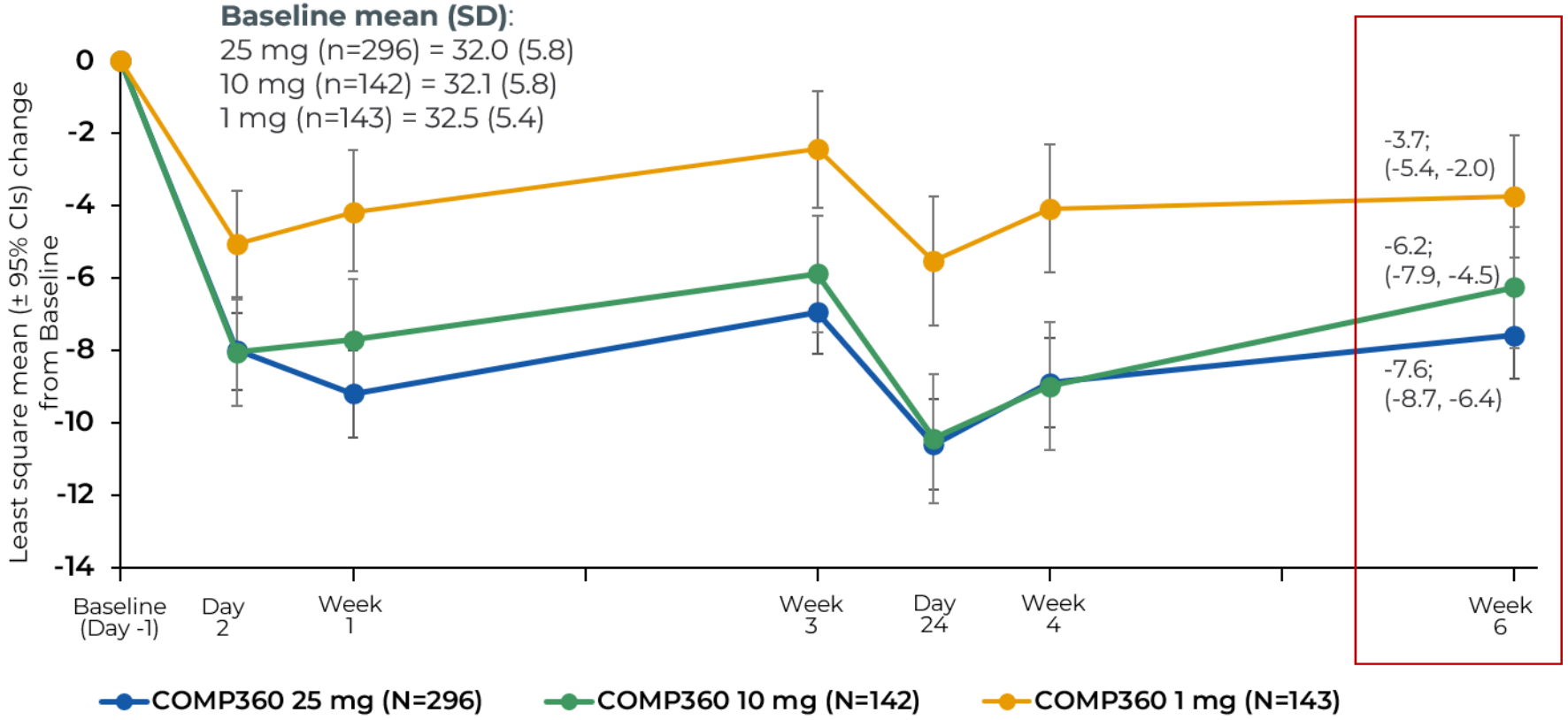
COMP006 – Primary Endpoint Met – Change in MADRS at Week 6

Statistically significant difference of -3.8 MADRS between 25mg vs 1mg at Week 6 (p<0.001)

Statistically significant treatment differences in 25mg vs 1mg and 10mg vs 1 mg found at all timepoints post administration

Rapid onset of action with the effect occurring the day after the administration (Day 2)

39% of participants in 25mg arm achieved a clinically meaningful reduction in MADRS at Week 6*



Visit	25mg vs 1 mg LS Mean Difference (95% CI) P-value	10mg vs 1 mg LS Mean Difference (95% CI) P-value
Day 2	-2.9 (-4.6, -1.2) <0.001	-3.0 (-5.0, -1.0) 0.002
Week 1	-5.0 (-7.0, -3.0) <0.001	-3.5 (-5.9, -1.2) 0.001
Week 3	-4.4 (-6.3, -2.5) <0.001	-3.4 (-5.6, -1.2) 0.001
Day 24	-5.0 (-7.1, -2.9) <0.001	-4.9 (-7.4, -2.5) <0.001
Week 4	-4.8 (-6.9, -2.7) <0.001	-4.9 (-7.3, -2.5) <0.001
Week 6 (Primary)	-3.8 (-5.8, -1.8) <0.001	-2.5 (-4.8, -0.2) 0.017

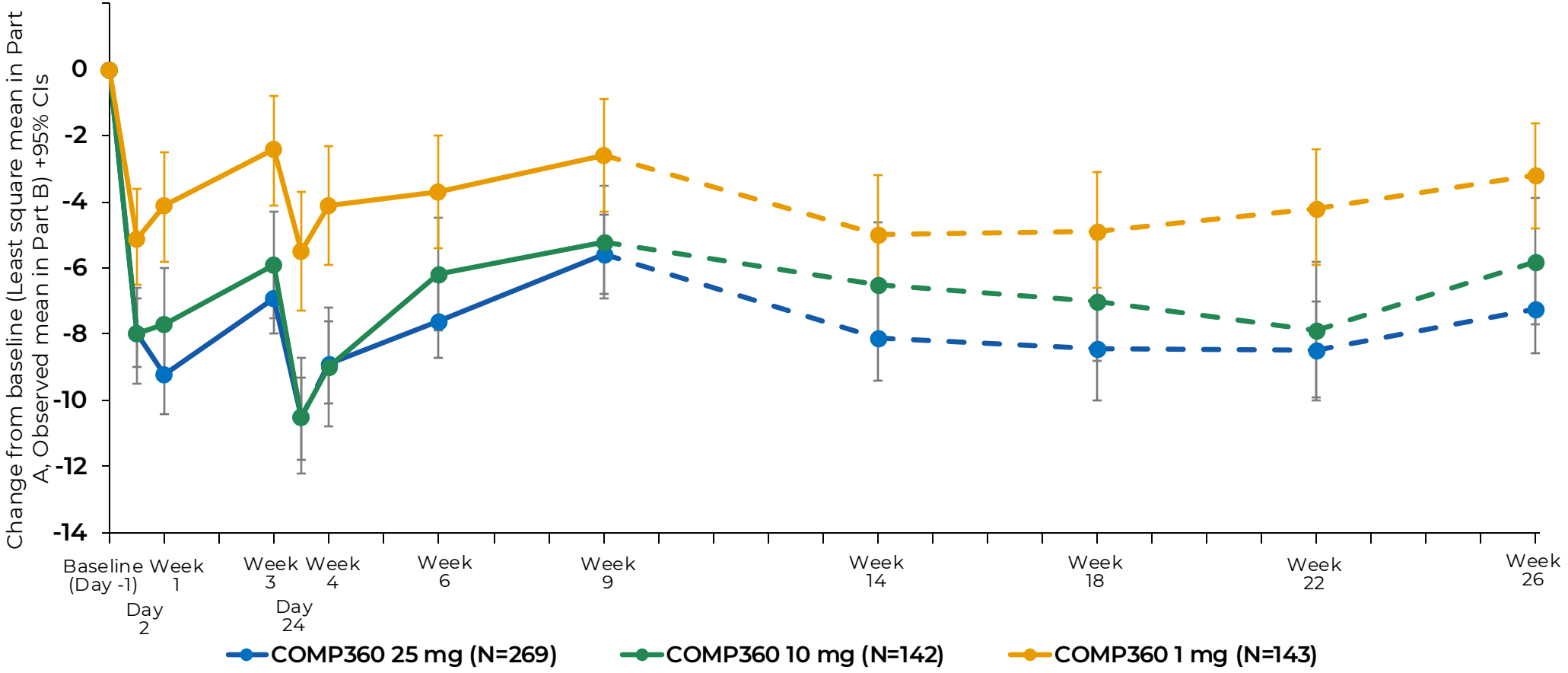
*Clinically meaningful reduction in MADRS defined as a ≥25% reduction from baseline in MADRS total score at Week 6
CI = Confidence Interval; LSM = Least Squares Mean; MADRS = Montgomery–Åsberg Depression Rating Scale

COMP006 - Rapid Onset and Sustained Durability to Week 26

Rapid effect from 25mg evident from day after administration: apparent after both first and second fixed doses in Part A

Persistent treatment effect of 25mg arm over full 26 weeks

58% of patients in 25mg arm received retreatment after Week 9

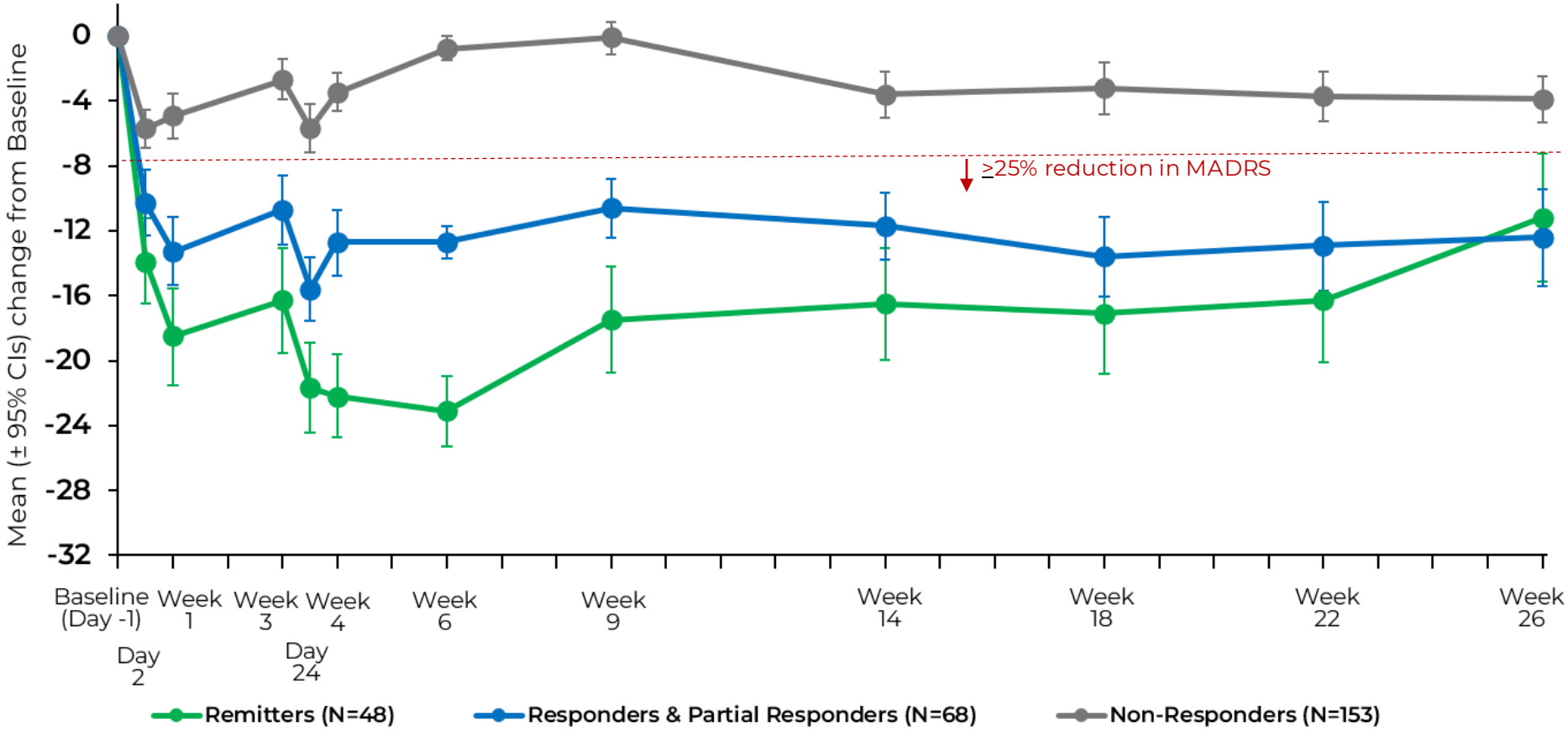


*retreatment based on pre-specified criteria and receive either what they were randomized into or antidepressant
COMP 006 Part B results (post Week 9) are based on observed data only (CFB Mean ± 95% CI)
CI = Confidence Interval; LSM = Least Squares Mean; MADRS = Montgomery–Åsberg Depression Rating Scale

COMP006 - COMP360 Response Can Be Rapid and Durable – Unique in TRD

39% of participants in 25mg arm achieved clinically meaningful reduction in MADRS* at Week 6 and on average maintained response at least through Week 26

28% of those who achieved clinically meaningful reduction in MADRS but had not remitted by 6 weeks went into remission after additional dose in Part B



Definitions (n at Week 6):

Remitters (n=48) = MADRS ≤12 and no single item ≥4

Responders and Partial Responders (n=68) = % CFB in MADRS ≥ 25% *and* do not meet remission criterion

Non-Responder (n=153) = % CFB in MADRS ≤ *25%*

*Clinically meaningful reduction in MADRS defined as a >25% reduction from baseline in MADRS total score at Week 6. This graph is a post hoc analysis. Total n at 6 weeks = 269 (based on ITT)
CI = Confidence Interval; CFB = change from baseline; MADRS = Montgomery–Åsberg Depression Rating Scale

COMP006 – Adverse Events through 26 weeks

COMP006 Through 26 Weeks	COMP360 25 mg	COMP360 10 mg	COMP360 1 mg
	N=296	N=142	N=143
	n (%)	**n (%)**	**n (%)**
Any TEAE up to Week 26	280 (94.6)	132 (93.0)	124 (86.7)
Any Serious TEAE up to Week 26	17 (5.7)	5 (3.5)	9 (6.3)
Any TEAE with onset on day of dosing	265 (89.5)	119 (83.8)	88 (61.5)
Resolved ≤ 1 Day	255 (86.1)	113 (79.6)	78 (54.5)
Resolved > 1 and ≤ 2 Days	60 (20.3)	22 (15.5)	12 (8.4)
Resolved > 2 Days	80 (27.0)	32 (22.5)	21 (14.7)

COMP006 Through 26 Weeks (≥10% Incidence in 25mg) MedDRA TEAE Preferred Term	COMP360 25 mg	COMP360 10 mg	COMP360 1 mg
	N=296	N=142	N=143
	n (%)	n (%)	n (%)
Any TEAE	280 (94.6)	132 (93.0)	124 (86.7)
Nausea	133 (44.9)	50 (35.2)	18 (12.6)
Headache	118 (39.9)	53 (37.3)	49 (34.3)
Anxiety	83 (28.0)	38 (26.8)	29 (20.3)
Hallucination, visual	51 (17.2)	27 (19.0)	5 (3.5)
Fatigue	49 (16.6)	26 (18.3)	19 (13.3)
Illusion or Perceptual Disturbance*	48 (16.2)	19 (13.4)	4 (2.8)
Dizziness	47 (15.9)	25 (17.6)	9 (6.3)
Crying	41 (13.9)	15 (10.6)	6 (4.2)
Blood pressure increased	35 (11.8)	10 (7.0)	4 (2.8)

MedDRA = Medical Dictionary for Regulatory Activities; N=number of participants in the treatment group in the Safety Analysis Set by administration; n = number of participants.
*Illusion and Perceptual Disturbance categories have been combined in this presentation due to some recent changes in MedDRA classification

COMP006 - SAEs Similar in 25mg and 1mg Arms and Low in Number Overall

MedDRA TEAE Preferred Term	COMP360 25 mg N=296 n (%)	COMP360 10 mg N=142 n (%)	COMP360 1 mg N=143 n (%)
Any TESAE	17 (5.7)	5 (3.5)	9 (6.3)
Suicidal ideation	4 (1.4)	2 (1.4)	4 (2.8)
Suicidal behaviour	0	0	1 (0.7)
Suspected suicide*	1 (0.3)	0	0
Suicide attempt	0	0	1 (0.7)
Syncope	1 (0.3)	0	1 (0.7)
Major depression	1 (0.3)	0	0
Anxiety	1 (0.3)	0	0
Flashback	1 (0.3)	0	0
Cervical spinal stenosis	1 (0.3)	0	0
Renal neoplasm	0	0	1 (0.7)
Pelvic pain	1 (0.3)	0	0
Adjustment disorder with mixed disturbance of emotion and conduct	1 (0.3)	0	0

MedDRA TEAE Preferred Term	COMP360 25 mg N=296 n (%)	COMP360 10 mg N=142 n (%)	COMP360 1 mg N=143 n (%)
Pneumonia	0	1 (0.7)	0
Radius fracture	1 (0.3)	1 (0.7)	0
Road traffic accident	1 (0.3)	0	0
Tibia fracture	1 (0.3)	0	0
Ulna fracture	1 (0.3)	0	0
Alanine aminotransferase increased	1 (0.3)	0	0
Aspartate aminotransferase increased	1 (0.3)	0	0
Brain neoplasm	1 (0.3)	0	0
Thyroid neoplasm	1 (0.3)	0	0
Cerebrovascular accident	0	0	1 (0.7)
Toxic encephalopathy	0	1 (0.7)	0
Tremor	1 (0.3)	0	0

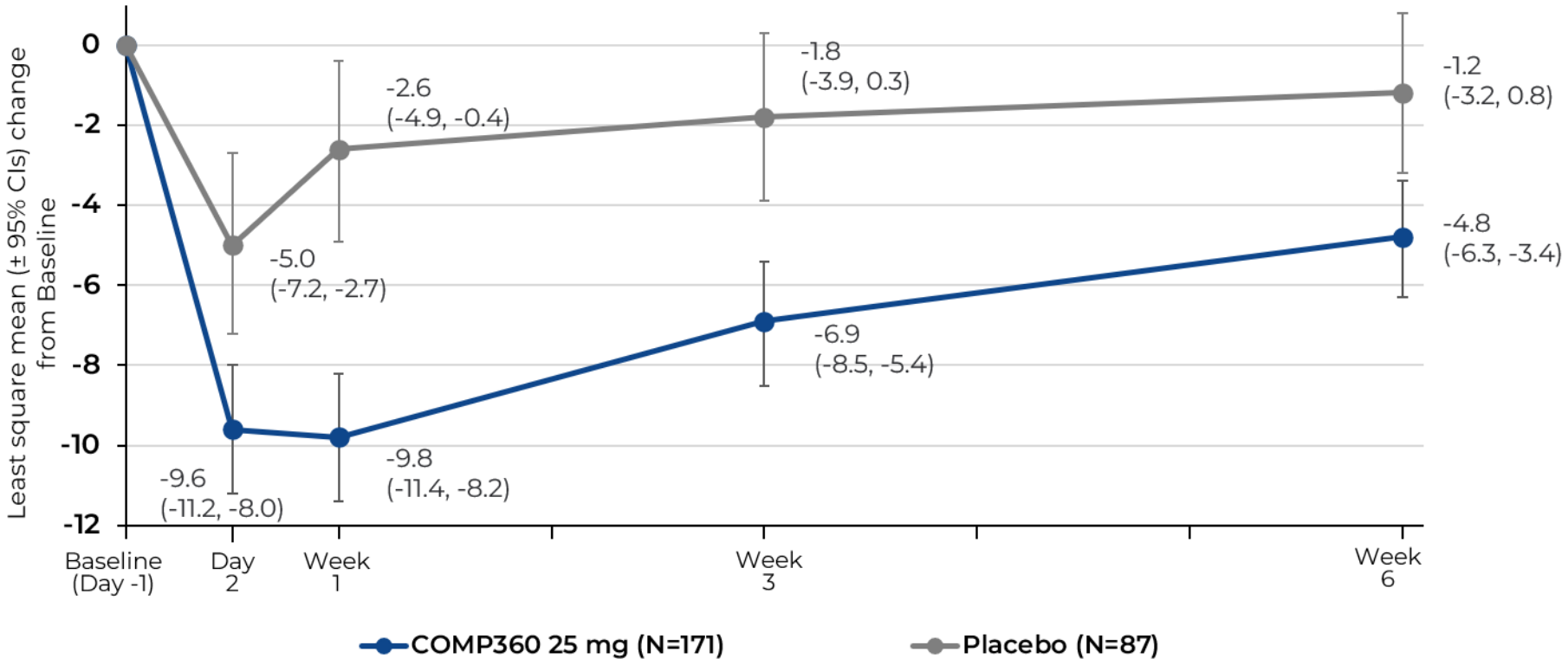
*Suspected Suicide determined by the investigator, based on the specific circumstances and timing, as not related to the treatment
MedDRA = Medical Dictionary for Regulatory Activities; N=number of participants in the treatment group in the Safety Analysis Set by administration; n = number of participants.

COMP005 – Phase 3 Data

COMP005 - Primary Endpoint Achieved – Change in MADRS at Week 6

Highly statistically significant difference of -3.6 MADRS between 25mg vs placebo at Week 6 ($p<0.001$)

Statistical significance at all timepoints beginning the day after administration (Day 2) demonstrates rapid onset of action



Baseline mean (SD):
25 mg (n=171) = 31.5 (5.5)
Placebo (n=87) = 31.5 (5.9)

Visit	LS Mean Difference (95% CI) P-value
Day 2	-4.7 (-7.0, -2.3), ***p*<0.001**
Week 1	-7.2 (-9.6, -4.8), ***p*<0.001**
Week 3	-5.2 (-7.4, -2.9), ***p*<0.001**
Week 6 (Primary)	-3.6 (-5.7, -1.5), ***p*<0.001**

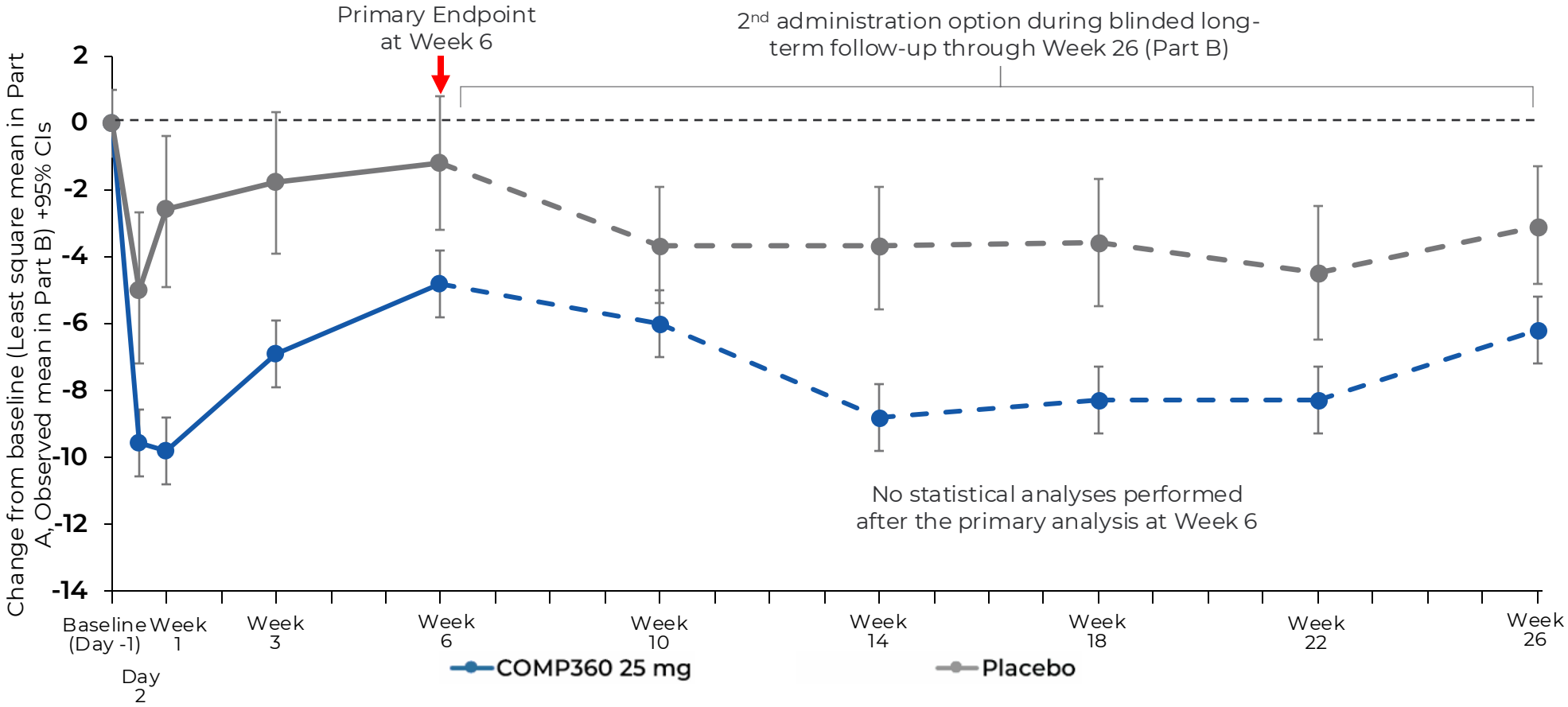
CI = Confidence Interval; LSM = Least Squares Mean; MADRS = Montgomery–Åsberg Depression Rating Scale; SD=standard deviation.

COMP005 – Sustained Durability to Week 26

Consistent separation from placebo through randomized and blinded part B up to Week 26

Option for 2nd administration* of COMP360 after Week 6 during blinded long-term follow-up (Part B)

70% of patients in 25mg arm and 53% in placebo arm received a 2nd administration after Week 6

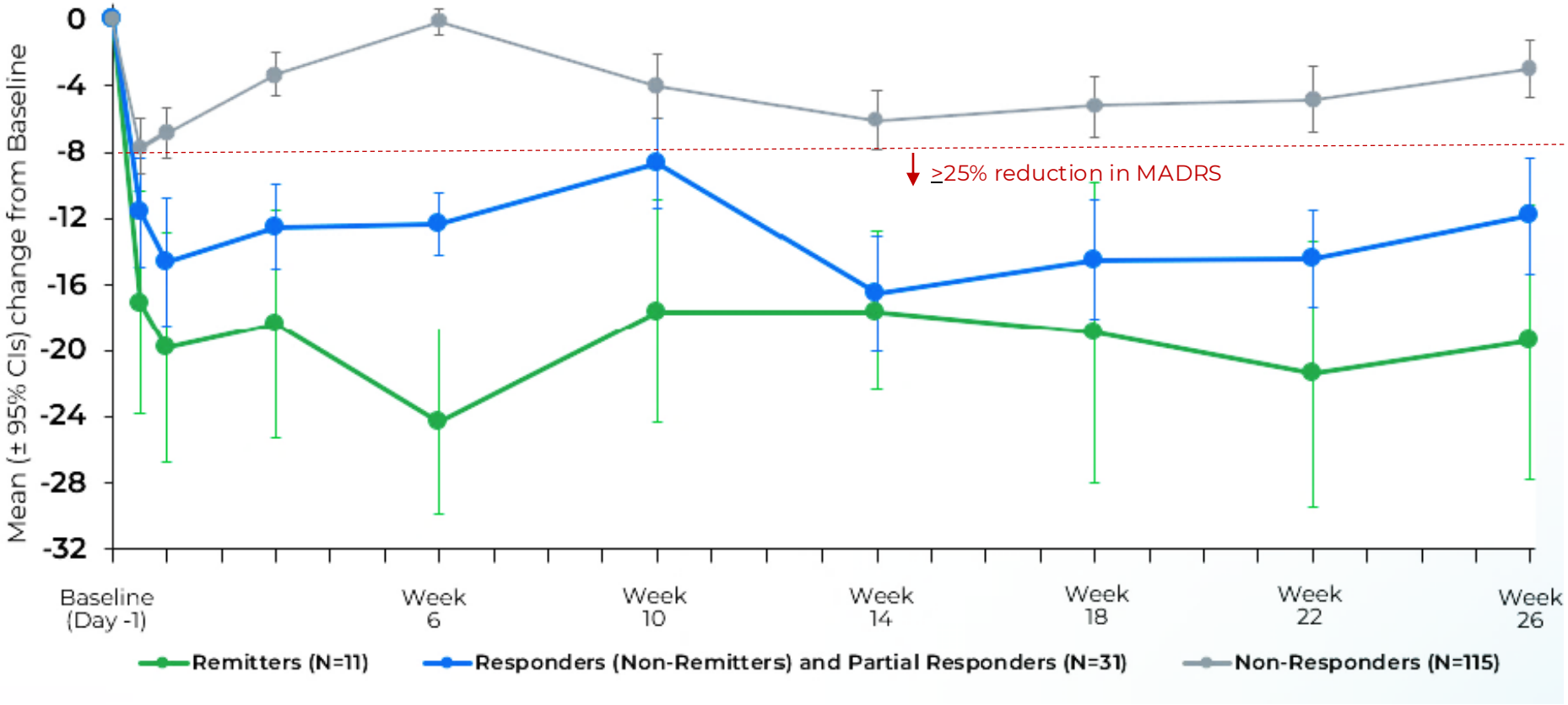


*2nd administration based on pre-specified criteria and receive either what they were randomized into or antidepressant
CI = Confidence Interval; LSM = Least Squares Mean; MADRS = Montgomery–Åsberg Depression Rating Scale

COMP005 - COMP360 Response Can Be Immediate and Durable – Unique in TRD

25% of participants in 25mg arm achieved clinically meaningful reduction in MADRS* at Week 6 and on average maintained response at least through Week 26

Over 40% of those who achieved clinically meaningful reduction in MADRS but had not remitted by 6 weeks went into remission after additional dose in Part B



Definitions (n at Week 6):

Remitters (n=11) = MADRS ≤12 and no single item ≥4

Responders and Partial Responders (n=31) = % CFB in MADRS ≥ 25% *and* do not meet remission criterion

Non-Responder (n=115) = % CFB in MADRS ≤ *25%*

*Clinically meaningful reduction in MADRS defined as a ≥25% reduction from baseline in MADRS total score at Week 6. This graph is a post hoc analysis. Total n at 6 weeks = 157 (based on ITT)
CI = Confidence Interval; CFB = change from baseline; MADRS = Montgomery–Åsberg Depression Rating Scale

COMP005 - Adverse Events through 26 weeks

COMP005 Through 26 weeks	COMP360 25 mg	Placebo
	N=171	N=87
	n (%)	n (%)
Any TEAE up to Week 26	145 (84.8)	52 (59.8)
Any Serious TEAE up to Week 26	8 (4.7)	2 (2.3)
Any TEAE time of onset day of dosing	121 (70.8	25 (28.7)
Resolved ≤ 1 Day	115 (67.3)	24 (27.6)
Resolved > 1 and ≤ 2 Days	16 (9.4)	2 (2.3)
Resolved > 2 Days	22 (12.9)	5 (5.7)

COMP005 Through 26 Weeks (>10% Incidence in 25mg) MedDRA TEAE Preferred Term	COMP360 25 mg	Placebo
	N=171	N=87
	n (%)	n (%)
Any TEAE	145 (84.8)	52 (59.8)
Headache	61 (35.7)	16 (18.4)
Nausea	44 (25.7)	5 (5.7)
Hallucination, visual	27 (15.8)	0
Anxiety	22 (12.9)	3 (3.4)

N=number of participants in the treatment group in the Safety Analysis Set by administration; n = number of participants; TEAE = treatment emergent adverse event

COMP005 – SAEs Through Week 26

MedDRA TEAE Preferred Term	COMP360 25 mg	Placebo
	N=171	N=87
	n (%)	n (%)
Any TESAE	8 (4.7)	2 (2.3)
Suicidal ideation	4 (2.3)	0
Depression suicidal	1 (0.6)	0
Major depression	0	1 (1.1)
Cellulitis	1 (0.6)	0
Diverticulitis	1 (0.6)	0
Urinary tract infection bacterial	0	1 (1.1)
Clavicle fracture	1 (0.6)	0
Rib fracture	1 (0.6)	0
Pneumothorax	1 (0.6)	0
Anaphylactic reaction	1 (0.6)	0

MedDRA = Medical Dictionary for Regulatory Activities; N=number of participants in the treatment group in the Safety Analysis Set by administration; n = number of participants.

COMP001 – Phase 2b

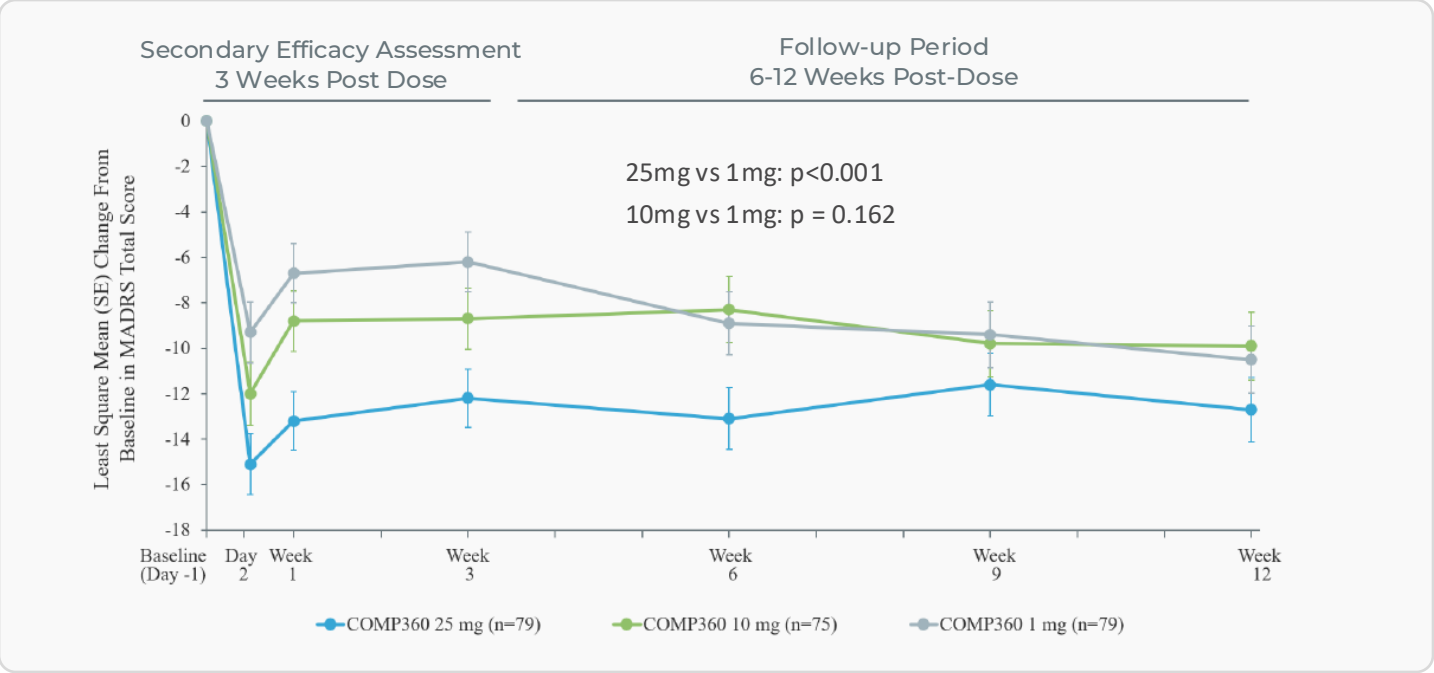
Phase 2b Trial Results Demonstrated the Potential for a Rapid, Sustained Response in TRD

Published in The NEW ENGLAND JOURNAL of MEDICINE*

In a randomized, controlled, double-blind trial, three groups of participants were given a single dose (either 1mg, 10mg or 25 mg) of COMP360 psilocybin

Results were measured as a change on the MADRS* depression scale from baseline (a day prior to administration) over 12 weeks.

The primary endpoint of this study was the change from baseline in MADRS total score at week 3 (25mg vs 1mg).



Clinical Effect: statistically significant and clinically meaningful reduction in depression (25mg vs 1 mg)

Rapid onset of action: The effect occurred the day after the administration.

Safety: 90% of TEAEs were mild and moderate and 77% of them resolved on the same or next day. most frequent TEAEs across the 10mg and 25mg doses were headaches, nausea, fatigue, insomnia and anxiety.

NOTE: **Least square mean change from baseline in MADRS total score; MADRS = Montgomery-Åsberg Depression Rating Scale; the above analysis is from the NEJM Supplement and does not include the imputation for use of anti-depressants (see appendix for the trial protocol analysis)

*N Engl J Med 2022;387:1637-48. DOI: 10.1056/NEJMoa2206443

Thank you...

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