UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, D.C. 20549

FORM 8-K

CURRENT REPORT
Pursuant to Section 13 or 15(d)
of the Securities Exchange Act of 1934

Date of Report (Date of earliest event reported): March 7, 2024

Mind Medicine (MindMed) Inc.
(Exact Name of Registrant as Specified in Its Charter)

British Columbia, Canada	**001-40360**	**98-1582538**
(State or Other Jurisdiction of Incorporation)	**(Commission File Number)**	**(IRS Employer Identification No.)**

One World Trade Center, Suite 8500	
New York, New York	**10007**
(Address of Principal Executive Offices)	**(Zip Code)**

Registrant's telephone number, including area code: (212) 220-6633

Not Applicable
(Former Name or Former Address, if Changed Since Last Report)

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Trading symbol(s)	Name of each exchange on which registered
Common Shares, no par value per share	MNMD	The Nasdaq Stock Market LLC

Check the appropriate box below if the Form 8-K filing is intended to simultaneously satisfy the filing obligation of the registrant under any of the following provisions:

☐ Written communications pursuant to Rule 425 under the Securities Act (17 CFR 230.425)

☐ Soliciting material pursuant to Rule 14a-12 under the Exchange Act (17 CFR 240.14a-12)

☐ Pre-commencement communications pursuant to Rule 14d-2(b) under the Exchange Act (17 CFR 240.14d-2(b))

☐ Pre-commencement communications pursuant to Rule 13e-4(c) under the Exchange Act (17 CFR 240.13e-4(c))

Indicate by check mark whether the registrant is an emerging growth company as defined in Rule 405 of the Securities Act of 1933 (§230.405 of this chapter) or Rule 12b-2 of the Securities Exchange Act of 1934 (§240.12b-2 of this chapter).

Emerging growth company ☒

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Item 7.01. Regulation FD Disclosure.

As previously announced, Mind Medicine (MindMed) Inc. (the "Company") will host a conference call and webcast to discuss the results of the Company's Phase 2b trial of MM120 in Generalized Anxiety Disorder at 8:00 a.m. ET on March 7, 2024. A copy of the presentation to be used by the Company during the conference call is furnished as Exhibit 99.1 to this Current Report on Form 8-K.

In accordance with General Instruction B.2. of Form 8-K, the information in this Item 7.01 and Exhibit 99.1 hereto shall not be deemed "filed" for purposes of Section 18 of the Securities Exchange Act of 1934, as amended (the "Exchange Act"), or otherwise subject to the liability of that section, nor shall it be deemed incorporated by reference in any of the Company's filings under the Securities Act of 1933, as amended, or the Exchange Act, whether made before or after the date hereof, regardless of any incorporation language in such a filing, except as expressly set forth by specific reference in such a filing.

Item 9.01 Financial Statements and Exhibits.

(d) Exhibits.

Exhibit	Description
99.1	Corporate Presentation, dated March 2024
104	Cover Page Interactive Data File (embedded within the Inline XBRL document).

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned hereunto duly authorized.

Date: March 7, 2024

Mind Medicine (MindMed) Inc.

By: /s/ Robert Barrow
Name: Robert Barrow
Title: Chief Executive Officer

Exhibit 99.1

MindMed

MM120 for Generalized Anxiety Disorder (GAD)

Phase 2b Full Topline Data
ODT PK Bridging Study
Breakthrough Therapy Designation

March 2024

Disclaimer

This presentation (the "Presentation") has been prepared by Mind Medicine (MindMed) Inc. ("MindMed", the "Company", "we", "our" or "us) solely for informational purposes. None of MindMed, its affiliates or any of their respective employees, directors, officers, contractors, advisors, members, successors, representatives or agents makes any representation or warranty as to the accuracy or completeness of any information contained in this Presentation and shall have no liability for any representations (expressed or implied) contained in, or for any omissions from, this Presentation. This Presentation does not constitute an offering of, or a solicitation of an offer to purchase, securities of MindMed and under no circumstances is it to be construed as a prospectus or advertisement or public offering of securities. Any trademarks included herein are the property of the owners thereof and are used for reference purposes only. Such use should not be construed as an endorsement of the products or services of MindMed. Any amounts are in USD unless otherwise noted. MindMed's securities have not been approved or disapproved by the Securities and Exchange Commission (the "SEC") or by any state, provincial or other securities regulatory authority, nor has the SEC or any state, provincial or other securities regulatory authority passed on the accuracy or adequacy of this Presentation. Any representation to the contrary is a criminal offense.

Cautionary Note Regarding Forward-Looking Statements
This Presentation contains, and our officers and representatives may from time to time make, "forward-looking statements" within the meaning of the safe harbor provisions of the U.S. Private Securities Litigation Reform Act of 1995 and other applicable securities laws. Forward-looking statements can often, but not always, be identified by words such as "plans", "expects", "is expected", "budget", "scheduled", "estimates", "forecasts", "intends", "anticipates", will", "projects", or "believes" or variations (including negative variations) of such words and phrases, or statements that certain actions, events, results or conditions "may", "could", "would", "might" or "will" be taken, occur or be achieved, and similar references to future periods. Except for statements of historical fact, examples of forward-looking statements include, among others, statements pertaining to: the development and commercialization of any medicine or treatment, or the efficacy of either of the foregoing, the success and timing of our development activities; the success and timing of our planned clinical trials; our ability to meet the milestones set forth herein; the likelihood of success of any clinical trials or of obtaining FDA or other regulatory approvals; our cash runway funding operations through key clinical readouts and into 2026; the likelihood of obtaining patents or the efficacy of such patents once granted and the potential for the markets that MindMed is anticipating to access.

Forward-looking statements are neither historical facts nor assurances of future performance. Instead, they are based only on our current beliefs, expectations and assumptions regarding the future of our business, future plans and strategies, projections, anticipated events and trends, the economy and other future conditions as of the date of this Presentation. While MindMed considers these assumptions to be reasonable, the assumptions are inherently subject to significant business, social, economic, political, regulatory, competitive and other risks and uncertainties that are difficult to predict and many of which are outside of MindMed's control, and actual results and financial condition may differ materially from those indicated in the forward-looking statements. Therefore, you should not rely on any of these forward-looking statements. Important factors that could cause actual results and financial condition to differ materially from those indicated in the forward-looking statements include, among others, the following: our ability to raise capital to complete its plans and fund its studies; the medical and commercial viability of the contemplated medicines and treatments being developed; MindMed's history of negative cash flows; MindMed's limited operating history; incurrence of future losses; compliance with laws and regulations; difficulty associated with research and development; risks associated with clinical trials or studies; heightened regulatory scrutiny; early stage product development; clinical trial risks; regulatory approval processes; novelty of the psychedelic inspired medicines industry; as well as those risk factors discussed or referred to throughout the "Risk Factors" sections of MindMed's most recently filed Annual Report on Form 10-K filed with the SEC and in other filings we make in the future with the SEC and the securities regulatory authorities in all provinces and territories of Canada, available under the Company's profile on SEDAR at www.sedar.com.

Any forward-looking statement made by MindMed in this Presentation is based only on information currently available to the Company and speaks only as of the date on which it is made. MindMed undertakes no obligation to publicly update any forward-looking statement, whether written or oral, that may be made from time to time, whether as a result of new information, future developments or otherwise.

Cautionary Note Regarding Regulatory Matters
The United States federal government regulates drugs through the Controlled Substances Act. MM120 is a proprietary, pharmaceutically optimized form of lysergide D-tartrate and MM402, or R(-)-MDMA, is our proprietary form of the R-enantiomer of MDMA (3,4-methylenedioxymethamphetamine). Lysergide and MDMA are Schedule I substances under the Controlled Substances Act. While the Company is focused on programs using psychedelic or hallucinogenic compounds and non-hallucinogenic derivatives of these compounds, including in its MM120, MM402 and other product candidates, the Company does not have any direct or indirect involvement with the illegal selling, production or distribution of any substances in the jurisdictions in which it operates. The Company is a neuro-pharmaceutical drug development company and does not deal with psychedelic or hallucinogenic substances except within laboratory and clinical trial settings conducted within approved regulatory frameworks. The Company's products will not be commercialized prior to applicable regulatory approval, which will only be granted if clinical evidence of safety and efficacy for the intended uses is successfully developed.

Market and Industry Data
This Presentation includes market and industry data that has been obtained from third party sources, including industry publications. MindMed believes that the industry data is accurate and that the estimates and assumptions are reasonable, but there is no assurance as to the accuracy or completeness of this data. Third party sources generally state that the information contained therein has been obtained from sources believed to be reliable, but there is no assurance as to the accuracy or completeness of included information. Although the data is believed to be reliable, MindMed has not independently verified any of the data from third party sources referred to in this Presentation or ascertained the underlying economic assumptions relied upon by such sources. References in this Presentation to research reports or to articles and publications should be not construed as depicting the complete findings of the entire referenced report or article. MindMed does not make any representation as to the accuracy of such information.

Today's Agenda

Topic	Speaker
Introductory Remarks	Rob Barrow Chief Executive Officer, MindMed
KOL Perspective on Unmet Need in Generalized Anxiety Disorder (GAD) & Phase 2b Trial Results	Rakesh Jain, MD, MPH Clinical Professor of Psychiatry and Behavioral Sciences, Texas Tech University School of Medicine – Permian Basin
Summary of Full Topline Results from Phase 2b Trial of MM120 in GAD	Daniel R Karlin, MD, MA Chief Medical Officer, MindMed
Commercial Opportunity	Francois Lilienthal, MD, MBA Chief Commercial Officer, MindMed
Summary Comments for MM120 Development Plan	Rob Barrow Chief Executive Officer, MindMed
Closing Remarks and Questions & Answers (Q&A)	All Presenters

Introductory Remarks

Robert Barrow
Chief Executive Officer

We Aim To Be A Global Leader In Brain Health

*The company's cash and cash equivalents of $99.7 million as of December 31, 2023 and committed credit facility are expected to fund operations into 2026.

Experienced Leadership with a Proven Track Record

Robert Barrow
Chief Executive Officer and Board Director

Daniel Karlin, MD, MA
Chief Medical Officer

Miri Halperin Wernli, PhD
Executive President

Schond Greenway, MBA
Chief Financial Officer

Mark Sullivan, JD
Chief Legal Officer and Corporate Secretary

Francois Lilienthal, MD, MBA
Chief Commercial Officer

Carrie Liao, CPA
Chief Accounting Officer

Bristol Myers Squibb · MERCK · NOVARTIS · Roche · AstraZeneca · Johnson & Johnson · Pfizer · Wyeth

Strong Experience in Brain Health Innovation[1]

Latuda (lurasidone HCl) tablets · Trintellix vortioxetine 5mg·10mg·20mg tablets · PERSERIS (risperidone) for extended-release injectable suspension 90 mg · 120 mg · Fintepla (fenfluramine) 2.2 mg/mL oral solution · Stalevo (carbidopa, levodopa and entacapone) tablets · Lamictal lamotrigine tablets · Rozerem ramelteon 8-mg tablets · Selincro nalmefene · Suboxone Sublingual Film (buprenorphine and naloxone) · Sublocade (buprenorphine extended-release) injection for subcutaneous use 100mg-300mg

MM120 Has the Potential to Address a Large Unmet Need in GAD

Opportunity in Generalized Anxiety Disorder (GAD)

- **GAD is the 2nd most common mental disorder** among adults[1], yet there are limited treatment options
- **Symptoms may be debilitating** and treatment inefficacy leads to incomplete remission and intolerable side effects.

Potential Best-in-Class Therapy with Novel MOA

Large Market Opportunity

~20 million US adults with GAD[1]
77% moderate to severe[2]

13 million
receive treatment[1]

6.5 million do not respond to first-line treatment[3]

Significant Need for New Treatments

- **SSRI/SNRIs[1]:** 50% failure rate with often undesirable side effects
- **Benzodiazepines:** addiction, tolerance risk; generally used in short-term
- **Buspirone[4]:** poor efficacy
- **Antipsychotics:** short- and long-term risks; poorly tolerated

1. Mental and Substance Use Disorders Prevalence Study (MDPSU): Findings Report 2023.
2. Kessler RC, Chiu WT, Demler O et al. Prevalence, Severity, and Comorbidity of 12-month DSM-IV Disorders in the National Comorbidity Survey-Replication. 2005 Arch Gen Psychiatry; 62(6): 617-627.
3. Ansara, Management of Treatment-Resistant Generalized Anxiety Disorder, Ment Health Clin 2020 Nov; 10(6) 326-334) United States Census Bureau, company calculations.
4. Garakani A, et al., (2020) Pharmacotherapy of Anxiety Disorders: Current and Emerging Treatment Options. Front. Psychiatry 11:595584. doi: 10.3389/fpsyt.2020.595584

MindMed Research & Development Pipeline

Product Candidate	Indication	Preclinical	Phase 1	Phase 2	Phase 3	Registration
Psychiatry Programs						
MM120 *(Lysergide D-tartrate)*	Generalized Anxiety Disorder (GAD)[1]					
	Additional Psychiatric Indication[2]					
MM402 *(R(-)-MDMA)*	Autism Spectrum Disorder (ASD)[1]					
Early Research & Collaborations						
IITs *(UHB collaboration)*	Various[1]					
Early Research *(Mindshift collaboration)*	Various					

1. Full trial details and clinicaltrials.gov links available at mindmed.co/clinical-digital-trials/
2. Study in exploration and/or planning stage.

LSD: lysergide; MDMA: 3,4-methylenedioxymethamphetamine. IIT: Investigator Initiated Trial (results are not anticipated to be used in our applications for regulatory approval); UHB: University Hospital Basel

Key Highlights of MM120 Program Updates

Positive 12-Week Durability in Phase 2b Trial of GAD[1]

- Primary and secondary endpoints met with statistical significance
- 7.7-point improvement over placebo (d=0.81; p=0.003)
- 48% clinical remission rate at Week 12

Breakthrough Therapy Designation

- Recognizes preliminary evidence of substantial improvement over SOC
- FDA organizational commitment and efficient development support

Enhanced Product Profile of MM120 ODTs

- Results from PK bridging study demonstrate differentiated profile
- Rapid absorption, better bioavailability & greater therapeutic AUC

Commercial Model & Strategy for Scalable Launch

- Broad recognition of burden and unmet need in GAD
- Enthusiasm for MM120 as potential game-changer

Market Protection Strategies and IP Portfolio

- IP-driven R&D strategies to maximize market protection potential
- Advancing IP portfolio with recent and near-term key grants

1. Source: Study MMED008 internal study documents and calculations.
2. Source: https://www.fda.gov/patients/fast-track-breakthrough-therapy-accelerated-approval-priority-review/breakthrough-therapy

Results for MM120 in GAD Delivered on Target Product Profile after Single Dose with Significant Improvement in All Endpoints[1,2]

Fast Acting	1.8-point reduction in CGI-S within 24 hours (p<0.0001)
Durable Activity	21.9-point improvement in HAM-A at Week 12 (p=0.003) represents further improvement from Week 4
Response / Remission	48% of participants in remission at Week 12[3]
Limited Side Effect Burden	Favorable tolerability profile with most AEs limited to dosing day
Scalability, Access & Value	Results achieved with no additional therapy

1. Source: Study MMED008 internal study documents and calculations. 100 µg dose group.
2. Represents all analyzed secondary endpoints in week 12 topline analysis, including HAM-A, CGI-S and MADRS.
3. p-values not calculated for remission rates between groups.

CGI-S: Clinical Global Impressions – Severity; HAM-A: Hamilton Anxiety Scale.

12-Week Durability Observed with Effect Size Over Double the Standard of Care[1,3]

Comparative Effect Sizes in GAD

Key Highlights of Phase 2b 12 Week Results

- Maximum observed **effect size of 0.81 is more than double the standard of care**[2,3]
- **Rapid and durable clinical response** observed after single administration[3]
- Clinical activity observed with **no psychotherapeutic intervention** beyond study drug

1. Source: Study MMED008 internal study documents and calculations.
2. HAM-A scores based on ANCOVA LS Mean. in Study MMED008. Effect size based on post hoc calculation using LS Mean change between group and pooled standard deviation of week 12 HAM-A scores between groups.
3. Based on 100 µg dose group.
4. Source: RB Hidalgo, J Psychopharmacol. 2007 Nov;21(8):864-72.

FDA Has Designated MM120 a Breakthrough Therapy for GAD

MM120 Granted Breakthrough Therapy Designation

- Recognizes GAD as a serious condition
- Phase 2b results demonstrate preliminary evidence that MM120 for GAD may have a substantial improvement over available therapy[2]

Benefits of Breakthrough Therapy Designation[1]

- FDA organizational commitment involving senior managers
- Intensive guidance on an efficient drug development program
- Eligibility for Accelerated Approval and Priority Review[3]
- Rolling Review of NDA[4]

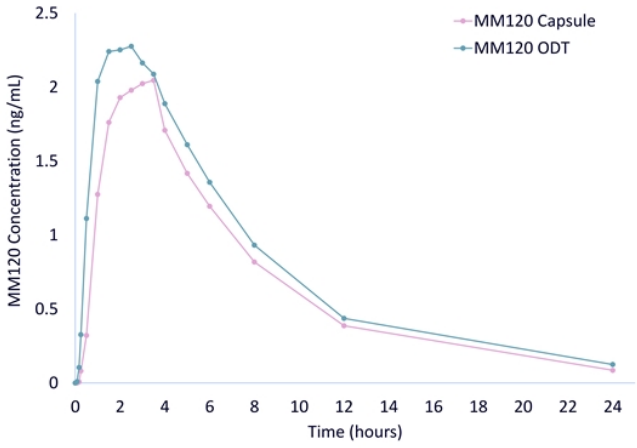
1. Additional details available at FDA website: https://www.fda.gov/patients/fast-track-breakthrough-therapy-accelerated-approval-priority-review/breakthrough-therapy
2. Based on clinically significant endpoint(s)
3. If relevant criteria are met
4. Means that a drug company can submit completed sections of its New Drug Application (NDA) for review by FDA, rather than waiting until every section of the NDA is completed before the entire application can be reviewed. NDA review usually does not begin until the drug company has submitted the entire application to the FDA.

PK Bridging Study Demonstrates Enhanced Product Profile for MM120 ODTs

Differentiated Performance of MM120 ODTs

- 50% faster onset of action[2]
- 17% improved bioavailability[3]
- 23% increase in AUC at target conc.[4]
- Reduced GI side effects[5]

Comparative PK Profile[1]



1. Company analysis of pharmacokinetic data from Study MM120-101. PK analysis based on n=24 subjects that completed both dosing sessions.
2. Based on time to reach target concentration of >1 ng/mL.
3. Based on comparison of geometric mean ratio of total area under the curve.
4. Based on ratio of mean $AUC_{>target}$. Target concentrations defined as level above which perceptual effects are present.
5. Based on a comparison between Phase 2b study of MM120 capsules in GAD versus PK bridging study of MM120 ODTs

AUC: area under the curve; GI: gastrointestinal; ODT: orally dissolving tablet; PK: pharmacokinetics

Compelling Commercial Opportunity for MM120 Driven by Significant Unmet Need and Proven Pathways to Scale

KOL Perspective on Impact and Unmet Need in GAD

Rakesh Jain, MD, MPH
Clinical Professor of Psychiatry and Behavioral Sciences, Texas Tech University School of Medicine – Permian Basin

Perspective on Impact and Unmet Need in GAD

- GAD has a negative impact on many aspects of patients' lives which Increases with severity
- GAD is chronic in nature, worsens with time and often precedes additional psychiatric disorders
- Anxiety returning to focus as a major driver of brain health disorders[1]
- Patients are underserved by current medications
- GAD patients express a desire for new treatment options[1]
- GAD has seen limited innovation in decades - Cymbalta last drug approved for GAD (February 2007)[2]
- Current treatments often aren't effective or tolerated and can require numerous cycles of switching and dosage adjustments
- Decades of LSD Clinical Research in Psychiatric Disorders Supports its Unique Potential[3]

1. "Anxiety in Children and Adolescents: Screening" (2022). The United States Preventative Services Task Force; "Anxiety Disorders in Adults: Screening" Draft Recommendation (2022). The United States Preventative Services Task Force.
2. Based on patient research conducted by MindMed in 2023.
3. https://investor.lilly.com/news-releases/news-release-details/fda-approves-cymbaltar-treatment-generalized-anxiety-disorder#.
4. Rucker 2016, Gasset 2014, Holze,Gasser et al 2022, UHB presentation April 2023.

Overview of Generalized Anxiety Disorder

Generalized Anxiety Disorder (GAD)

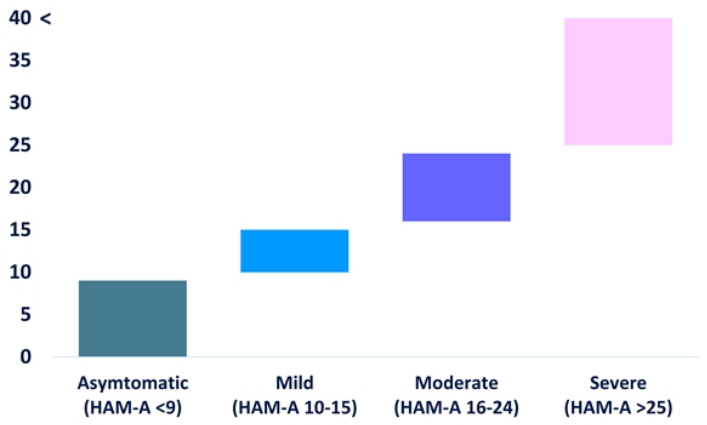
- Prevalent disorder characterized by persistent and excessive worry about various aspects of life
- Individuals with GAD often find it challenging to control their anxiety, leading to significant distress and impairment in daily functioning
- Typically manifests with restlessness, fatigue, difficulty concentrating, irritability, muscle tension, and sleep disturbances
- 2nd most common mental disorder among adults 18 to 65 years old

Epidemiology of Anxiety

- 10% prevalence has tripled in past two decades
- More prevalent in women than in men (~2:1)
- Onset typically in adolescence or early adulthood
- Common comorbid psychiatric conditions, such major depressive disorder and other anxiety disorders

GAD Has Negative Impact on Many Aspects of Patients' Lives which Increases with Severity

Mean Health Utilities Index by GAD Severity

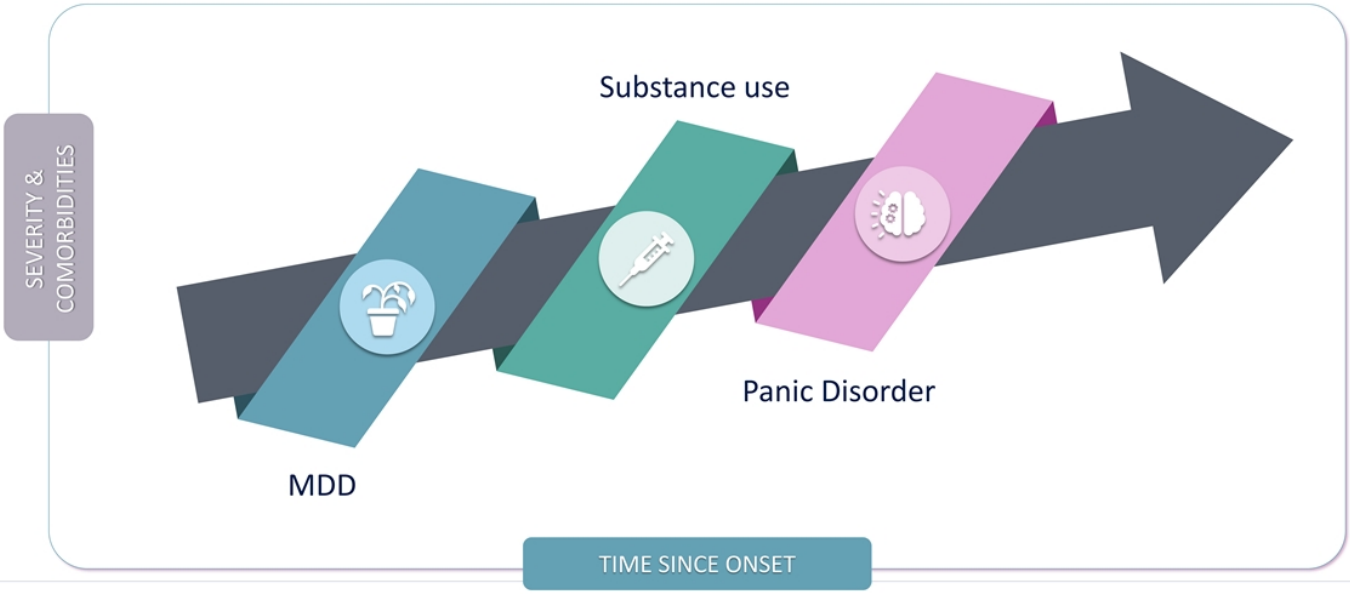


GAD Impact on Patients

- ↓ Psychological well-being
- ↓ Physical functioning
- ↓ Disease specific quality of life
- ↑ Disability in everyday life

Revicki et al. (2008)

GAD is Chronic in Nature, Worsens with Time and Often Precedes Additional Psychiatric Disorders[1]



1. The Critical Relationship Between Anxiety and Depression - 1 May 2020https://doi.org/10.1176/appi.ajp.2020.20030305

As the Mainstream Focus on Anxiety Returns, Patients Continue to be Underserved by Current Medications

Population	Recommendation	Grade
Children and adolescents aged 8 to 18 years	The USPSTF recommends screening for anxiety in children and adolescents aged 8 to 18 years.[1]	B
Adults aged 64 years or younger	The USPSTF recommends screening for anxiety in adults, including pregnant and postpartum persons.[2]	B

Grade "B" recommendations from the USPSTF indicate: "The USPSTF recommends the service. There is a high certainty that the net benefit is moderate, or there is moderate certainty that the net benefit is moderate to substantial."

	Mechanism	FDA Status in Anxiety	Comments
SSRI/SNRI	5-HT, NE (and DA) reuptake inhibitors	Approved (fluoxetine, sertraline, escitalopram, paroxetine, duloxetine, venlafaxine)	Generally front line, 50% failure rate, sexual side effects can be durable[3]
BENZODIAZEPINES	GABA-A agonists	Approved (clonazepam, alprazolam, lorazepam, chlordiazepoxide, oxazepam)	Generally used in short-term or as needed basis due to addiction, withdrawal and tolerance risk
BUSPIRONE	5-HT_{1A} partial agonist	Approved	Poor efficacy compared to SSRI/SNRI and benzodiazepines. Not well-tolerated nausea and dizziness

1. "Anxiety in Children and Adolescents: Screening" (2022). The United States Preventative Services Task Force
2. "Anxiety Disorders in Adults: Screening" Draft Recommendation (2022). The United States Preventative Services Task Force.
3. Ansara, Ment Health Clin. 2020 Nov; 10(6):326-334). Fda.gov/. United States Census Bureau, company calculations.

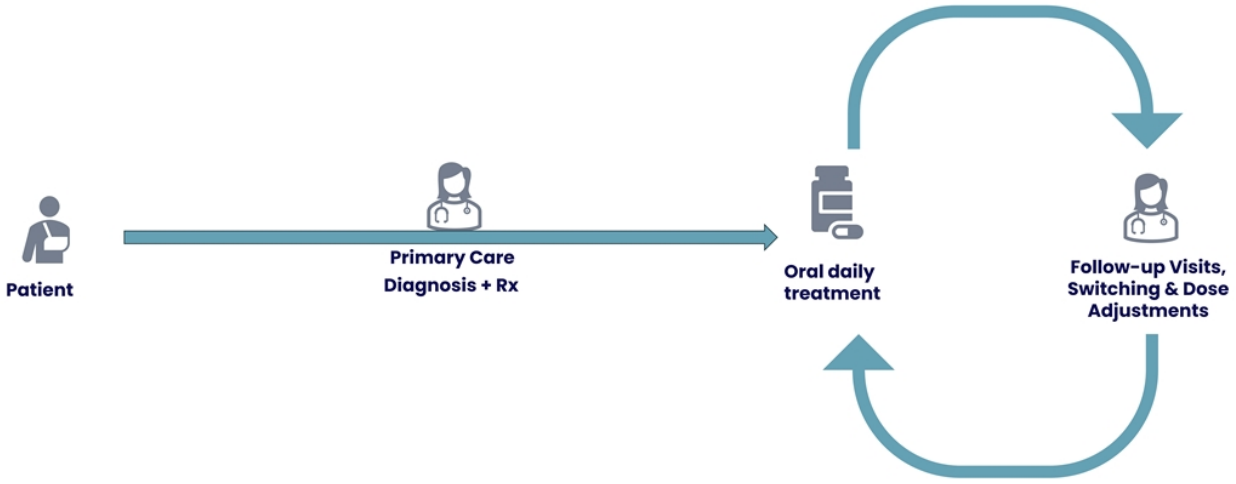
GAD Patients Express a Desire for New Treatment Options

Limitations of Current SOC	Quotes from GAD Patients[1]
Slow Acting	*"They told me the medication would take 6 weeks to work. I didn't want to feel like this for another 6 weeks*
Non-Durable Activity	*"If I'm inconsistent with medication, or run out for a day, it makes me feel terrible being off of it for one day.*
Limited Response	*"My goal is remission, I don't want to be connected to taking the pills to function.*
Side Effect Burden	*"I didn't like the sexual side effects and feeling like a zombie from the medication.*

MindMed

1. Based on patient research conducted by MindMed in 2023.
GAD: Generalized Anxiety Disorder; SOC: standard of care

Current Treatments Often Aren't Effective or Tolerated and Can Require Numerous Cycles of Switching and Dosage Adjustments



MindMed

Source:. Company market research.

Decades of LSD Clinical Research in Psychiatric Disorders Supports its Unique Potential

STUDIES	INDICATION(S)	SAMPLE SIZE	KEY FINDINGS
21 STUDIES PRIOR TO 1974	Anxiety, depression & neurotic illnesses	512 patients	Up to 95% reduction in symptoms
GASSER 2014	Anxiety in terminal illness	12 patients	Effect size of 1.1 with durable reduction in anxiety at 1 year
HOLZE 2022	Anxiety	42 patients	Rapid and durable reduction in symptoms post-treatment. Clinical response in 65% of LSD patients vs. 9% in placebo
HOLZE 2023	Major Depressive Disorder	61 patients	Significant, rapid, durable and beneficial effects, with benefit maintained for up to 16 weeks post-treatment (p=0.008)

1. Rucker 2016. J. Psychopharmacol; 30(12).
2. Gasser 2014. J. Nerv. Ment. Dis.; 202(7).
3. Holze, Gasser et. al 2022. Biological Psychiatry.
4. UHB presentation; April 2023.

MM120 LSD-D-tartrate

for Generalized Anxiety Disorder (GAD)

Summary of Full Topline Results from Phase 2b Trial

Daniel R Karlin, MD, MA
Chief Medical Officer

Positive 12-Week Topline Results from Phase 2b Study in GAD: Strong Durability of Effect after Single Dose of MM120[1]

- **Met the primary and all secondary endpoints with statistical significance[2]**
- **MCP-Mod analysis results support dose-response relationship for MM120 in GAD**
- **Large observed effect size of d=0.81 at 12 weeks is more than double the standard of care[3,4]**
  - Durability of at least 3 months after a single dose of MM120 observed
- **Statistically and clinically significant 21.9-point improvement in HAM-A score at week 12 (p=0.0025) represents further improvement from four-week topline data[3]**
  - Rapid and durable clinical activity with continued improvement at week 12
  - 48% clinical remission rate through 12-week observation period[5]
  - Clinically and statistically significant improvements on all analyzed secondary endpoints at week 12[2]
- **MM120 was well-tolerated with no related serious adverse events**
  - Mostly transient, mild-to-moderate adverse events consistent with drug class and prior studies
  - No drug-related serious adverse event (SAE) and no suicide-related safety signal[6]
- **Supports long-term durability of single administration MM120 and we believe further supports advancement of 100 µg MM120 into Phase 3 development for GAD**

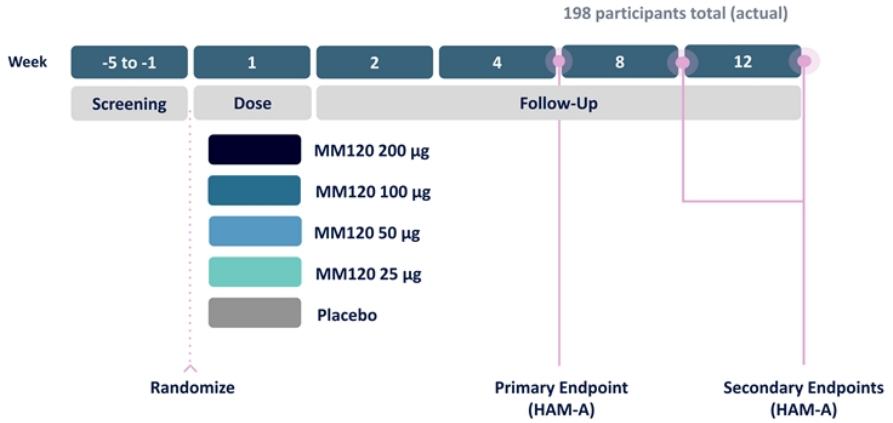
1. Source: Study MME0008 internal study documents and calculations. Individual group results reported on 100 µg dose group vs. placebo.
2. Represents all analyzed secondary endpoints in week 12 topline analysis, including HAM-A, CGI-S and MADRS.
3. Based on 100 µg dose group; HAM-A scores based on ANCOVA LS Mean. Effect size based on post hoc calculation by study statistician using LS Mean change between group and pooled standard deviation of ending HAM-A scores across groups.
4. Examination of baseline group assignment for all of the studies (20 studies utilizing the HAM-A (Hamilton Anxiety Scale) and 1 study using the PARS (Pediatric Anxiety Scale) for the primary outcome measurement. Source: RB Hidalgo, J Psychopharmacol. 2007 Nov;21(8):864-72.
5. Remission defined as HAM-A score of ≤7.
6. Suicidality assessment based on reported adverse events.

Phase 2b Trial of MM120 Utilized Standard GAD Design and Endpoints and was Aligned with FDA Draft Guidance for Drug Class[1]

- **Standard GAD study design with endpoints that have supported registration for approved drugs**
- **Randomized, double-blind, placebo-controlled, 12-week trial**
  - Single administration of MM120 or placebo
  - No psychotherapeutic intervention
  - Trial design closely aligned with subsequently issued FDA 2023 Draft Guidance[2]
  - Patients washed out of anxiety pharmacotherapy prior to randomization
- **Enrolled 198 patients with GAD**
- **Five-arm dose optimization design with 1:1:1:1:1 randomization**
- **Primary endpoint: change in Hamilton Anxiety Scale (HAM-A) at week 4**
  - Assessed by central rater blinded to treatment assignment and visit number

1. Source: Study MMED008 internal study documents and calculations.
2. FDA 2023 Draft Guidance: Psychedelic Drugs: Considerations for Clinical Investigations.

Phase 2b Trial Schematic[1]



Study MMED008 | MM120 for GAD

A Phase 2b Dose Optimization Study of a Single Dose of MM120 in Generalized Anxiety Disorder

KEY ENTRY CRITERIA

- Men and Women
- Ages 18-74
- Diagnosis of GAD
- HAM-A ≥ 20

ADDITIONAL ENDPOINTS

- MADRS
- CGI-S / I
- PGI-S / C
- SDS
- EQ-5D-5L
- PSQI
- ASEX

1. Source: Study MMED008 internal study documents.

µg: microgram; HAM-A: Hamilton Anxiety Rating Scale; MADRS: Montgomery-Asberg Depression Rating Scale; CGI-S: Clinical Global Impressions - Severity; PGI-S: Patient Global Impression - Severity; SDS: Sheehan Disability Scale; EQ-5D-5L: EuroQol-5 Dimension; PSQI: Pittsburgh Sleep Quality Index; ASEX: Arizona Sexual Experiences Scale

Phase 2b Treatment Paradigm: Standalone Drug Effects with No Psychotherapeutic Intervention[1]

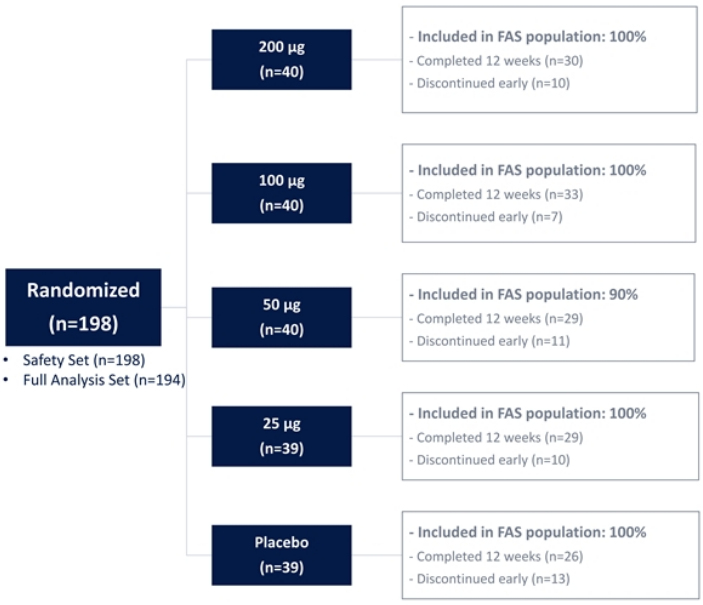
- Dosing session monitors (DSMs) in the room provide no psychotherapeutic intervention
- Delivery protocol consistent with 2023 FDA Draft Guidance[2]
- No changes planned to drug delivery between Phase 2 and Phase 3

	Pre-treatment	During treatment	Post-treatment
Patient Journey in MMED008	✓ Comprehensive informed consent process ✓ Eligibility evaluation	✓ Continuous monitoring by DSMs ✓ Music, eye shades, reading, writing ✓ Concludes when discharge criteria met	✓ Follow-up visits for assessment only
Not Part of Patient Journey in MMED008	x No "preparation" x Pre-treatment activities consisted of a comprehensive informed consent process	x No "assisted therapy" x No psychotherapy and no therapeutic intervention beyond study drug	x No "integration" x No ongoing therapeutic engagement as part of clinical trial activities

MindMed

1. Source: Study MMED008 internal study documents.
2. FDA 2023 Draft Guidance: Psychedelic Drugs: Considerations for Clinical Investigations.

Participant Disposition Aligned with Historical Expectations[1]



79% 12-week completion rate

in high dose groups[2] despite need for follow-up visits with no additional treatment

74% 12-week completion rate

of all randomized participants which is consistent with other studies in drug class

MindMed

1. Source: Study MMED008 internal study documents and calculations. Safety population.
2. High dose groups include 100 and 200 µg dose groups.

FAS: Full Analysis Set

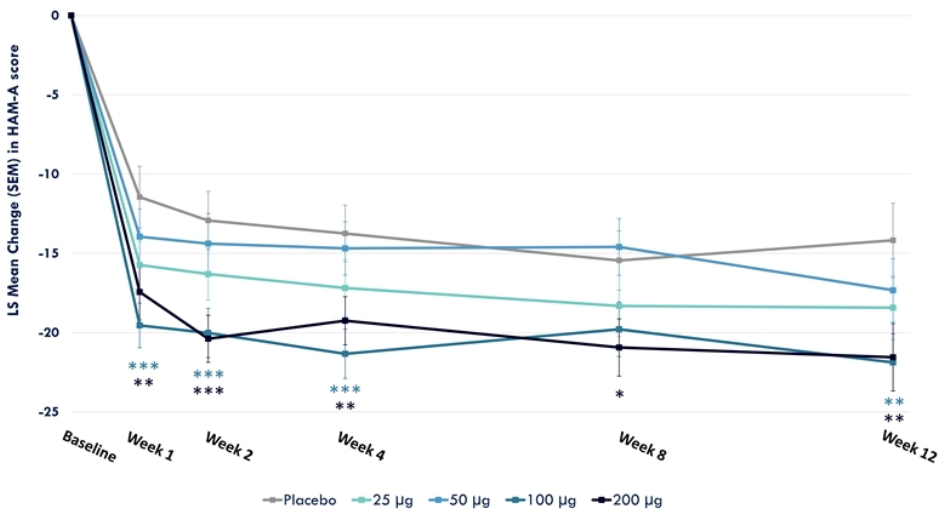
Participant Demographics and Baseline Characteristics Generally Balanced Across Groups[1]

Demographic (n=194)	MM120				Placebo
	25 µg (n=39)	50 µg (n=36)	100 µg (n=40)	200 µg (n=40)	(n=39)
Mean age (years)	38.0	45.3	42.7	42.1	38.7
Sex, female (%)	51.3%	55.6%	40.0%	70.0%	66.7%
Race (% white)	84.6%	80.6%	90.0%	82.5%	76.9%
Baseline HAM-A score	30.2	30.3	29.3	31.0	30.3
Baseline CGI-S score	4.9	4.9	4.8	5.1	4.9

1. Source: Study MMED008 internal study documents and calculations. Full analysis set population.

Statistically and Clinically Significant Reductions in HAM-A Score Continued at Week 12[1,2]

HAM-A Change from Baseline



Change from Baseline[2]

- Week 4: -21.3 points
- Week 12: -21.9 points

Improvement over Placebo[2]

- Week 4: -7.6 pts, p=0.0004
- Week 12: -7.7 pts, p=0.003

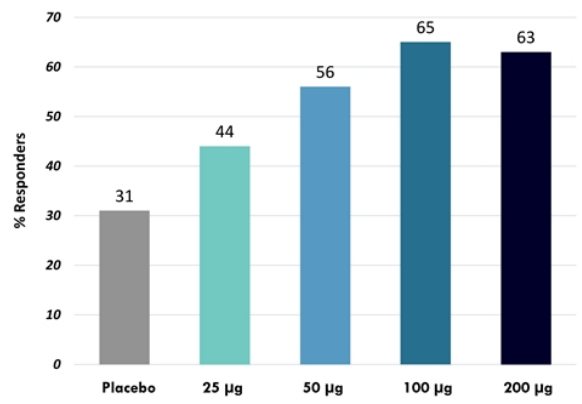
**p<0.05
**p≤0.01
***p≤0.001

1. Source: Study MMED008 internal study documents and calculations. Full analysis set population.
2. Based on 100 µg dose group.

µg: microgram; HAM-A: Hamilton Anxiety Rating Scale; NOTE: Significance achieved despite study not being powered for these pairwise comparisons.

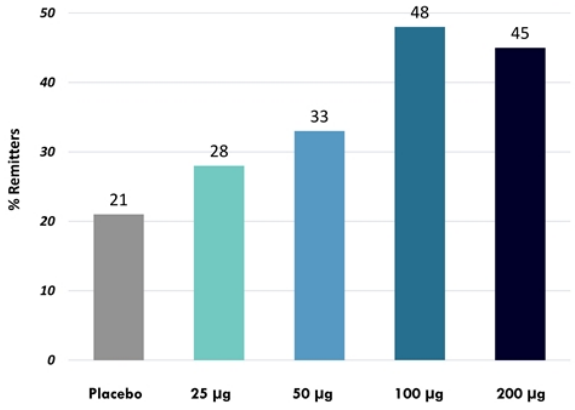
Continued Response and Remission through Week 12 with 65% Clinical Responder Rate and 48% Clinical Remission Rate[1]

HAM-A Response Rate at Week 12[2]



p-values not calculated

HAM-A Remission Rate at Week 12[2]

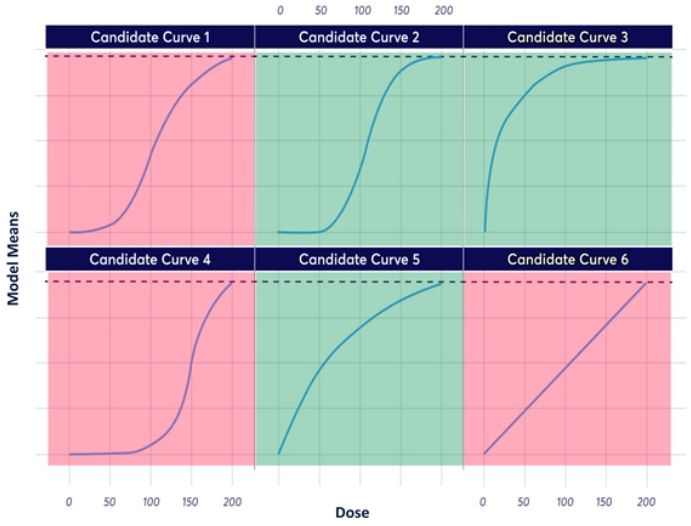


p-values not calculated

1. Source: Study MMED008 internal study documents and calculations. Full analysis set population.
2. Response is defined as a 50% or greater improvement on HAM-A score; Remission is defined as a HAM-A score of ≤ 7.

µg: microgram; HAM-A: Hamilton Anxiety Rating Scale

Primary & Key Secondary Analysis (MCP-Mod) Support Dose Response Relationship for MM120 in GAD[1]



Key Takeaways from MCP-Mod Analysis[2]

- Statistically significant dose response relationship with multiple model fits
- Supports dose selection of 100 µg for subsequent studies in GAD
- Pre-specified model estimates and observed responses drive dose selection for Phase 3 studies

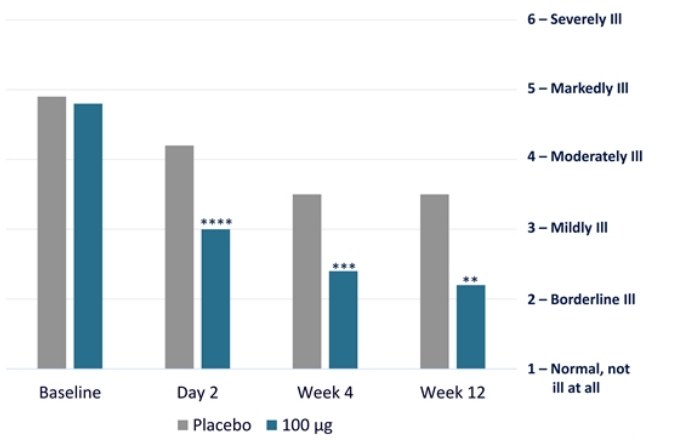
1. Source: Study MMED008 internal study documents and calculations. Full analysis set population.
2. Source: Novartis. "The MCP-Mod methodology – A statistical methodology for dose-response.

Rapid and Sustained Improvements in Clinical Global Impressions – Severity (CGI-S) Starting on Day 2 and Continuing through Week 12[1]

CGI-S Improvement in 100 µg Group

- Statistically and clinically significant improvement by Day 2 and maintained through Week 12
- Greater than 2-unit improvement in CGI-S score through Week 12
- Participants on average only borderline-to-mildly ill at Week 12

CGI-S Scores at Week 12[2]



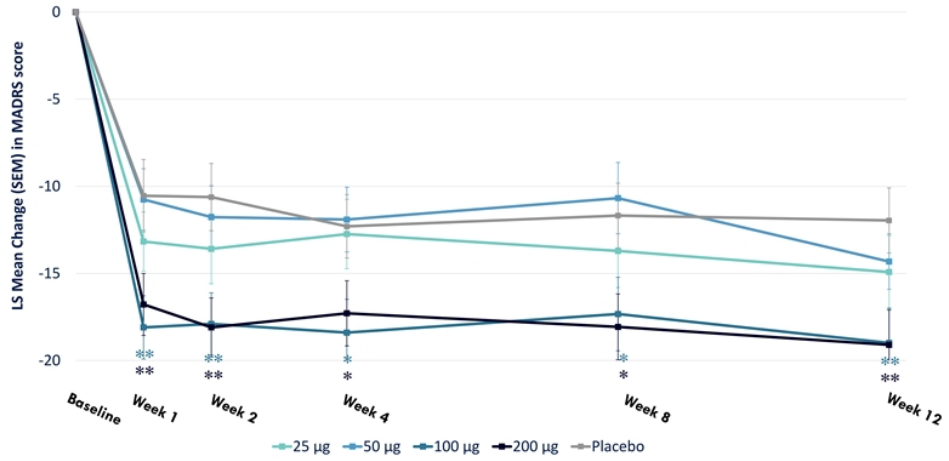
*p<0.05
**p≤0.01
***p≤0.001
****p≤0.0001

1. Source: Study MMED008 internal study documents and calculations. Full analysis set population.
2. Significance achieved despite study not being powered for these pairwise comparisons.

µg: microgram; CGI-S: Clinical Global Impressions - Severity

Statistically and Clinically Significant Reductions in Comorbid Depression (MADRS) at All Timepoints through Week 12[1,2]

MADRS Change from Baseline[3]



Change from Baseline[2,3]

- Week 4: -18.1 points
- Week 12: -18.7 points

Improvement over Placebo[2,3]

- Week 4: -5.7 points, p<0.05
- Week 12: -6.4 points, p<0.01

*p<0.05
**p≤0.01

1. Source: MindMed internal study documents and calculations. Full analysis set population.
2. Based on 100 µg dose group.
3. Significance achieved despite study not being powered for these pairwise comparisons. Based on observed MADRS score at each timepoint.

µg: microgram; MADRS: Montgomery-Åsberg Depression Rating Scale

MM120 was Well-tolerated with Mostly Transient, Mild-to-Moderate Adverse Events Consistent with Drug Class Expectations[1]

Favorable tolerability profile

- Virtually all AEs (99%) were mild-to-moderate in severity
- Minimal (2.5%) TEAEs led to study withdrawal
- No drug-related serious adverse events (SAEs)[2]

No SAEs related to study drug

- Only SAE was in 50 µg dose group and deemed unrelated
- Adverse event profile consistent with historical studies and drug class

No suicidal behavior or suicidality signal[3]

- No suicidal or self-injurious behavior
- ≤ 2 participant per arm reported suicidal ideation during the study
- No indication of increased suicidality or suicide-related risk

MindMed

1. Source: Study MMED008 internal study documents and calculations. Safety population.
2. One serious adverse event (SAE) was observed in the 50 µg dose group: panic attack on study day 98 that was deemed not related to treatment.
3. Suicidality assessment based on reported adverse events.

Most Common (≥10%) TEAEs in High-Dose Groups Demonstrate Favorable Tolerability Profile[1,2]

Preferred Term Subjects (%) with AE	MM120								Placebo (n=39)	
	25 µg (n=39)		50 µg (n=40)		100 µg (n=40)		200 µg (n=40)			
	DD	AFT	DD	AFT	DD	AFT	DD	AFT	DD	AFT
Illusion	12 (31)	1 (2.6)	18 (45)	1 (2.5)	24 (60)	1 (2.5)	30 (75)	–	3 (7.7)	–
Nausea	3 (7.7)	–	11 (28)	–	16 (40)	1 (2.5)	24 (60)	2 (5.0)	1 (2.6)	2 (5.1)
Headache	4 (10)	2 (5.1)	9 (23)	2 (5.0)	10 (25)	4 (10)	10 (25)	1 (2.5)	8 (21)	1 (2.6)
Hallucination, visual	6 (15)	1 (2.6)	9 (23)	–	9 (23)	–	6 (15)	–	1 (2.6)	–
Euphoric mood	2 (5.1)	–	5 (13)	–	11 (28)	–	6 (15)	–	1 (2.6)	–
Anxiety	1 (2.6)	3 (7.7)	3 (7.5)	3 (7.5)	4 (10)	–	5 (13)	1 (2.5)	–	2 (5.1)
Mydriasis	1 (2.6)	–	7 (18)	–	8 (20)	–	4 (10)	–	1 (2.6)	–
Hyperhidrosis	1 (2.6)	–	4 (10)	–	9 (23)	–	5 (13)	–	–	–
Paraesthesia	2 (5.1)	–	2 (5.0)	–	2 (5.0)	–	8 (20)	–	2 (5.1)	1 (2.6)
Blood pressure increased	3 (7.7)	–	5 (13)	–	4 (10)	–	4 (10)	–	–	–
Dizziness	3 (7.7)	–	2 (5.0)	–	3 (7.5)	–	5 (13)	–	1 (2.6)	–
Tremor	–	–	3 (7.5)	–	2 (5.0)	1 (2.5)	8 (20)	–	–	–
Thinking abnormal	1 (2.6)	–	2 (5.0)	–	4 (10)	1 (2.5)	5 (13)	–	–	–
Pseudohallucination	–	–	3 (7.5)	–	3 (7.5)	–	4 (10)	–	–	–
Feeling abnormal	1 (2.6)	–	2 (5.0)	–	–	–	–	4 (10)	1 (2.6)	1 (2.6)
COVID-19	–	1 (2.6)	–	2 (5.0)	–	1 (2.5)	–	4 (10)	–	–

1. Source: Study MMED008 internal study documents and calculations. Safety population.
2. High dose groups include 100 and 200 µg dose groups.

AFT: After Dosing Day; DD: Dosing Day; TEAE: Treatment-emergent adverse event.

MM120 LSD-D-tartrate
for Generalized Anxiety Disorder (GAD)

MM120 ODT PK Bridging Study

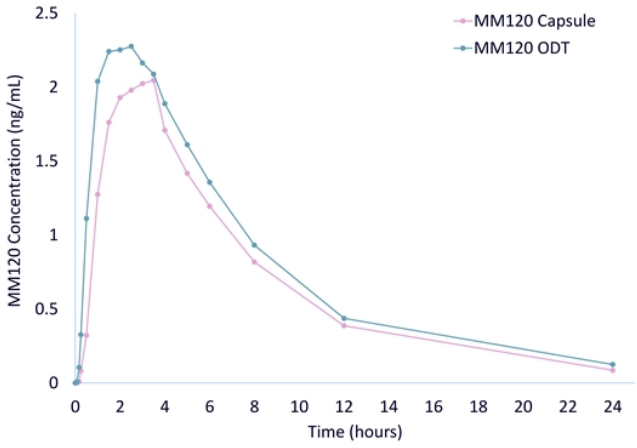
Daniel R Karlin, MD, MA
Chief Medical Officer

PK Bridging Study Demonstrates Enhanced Product Profile for MM120 ODTs

Differentiated Performance of MM120 ODTs

- 50% faster onset of action[2]
- 17% improved bioavailability[3]
- 23% increase in AUC at target conc.[4]
- Reduced GI side effects[5]

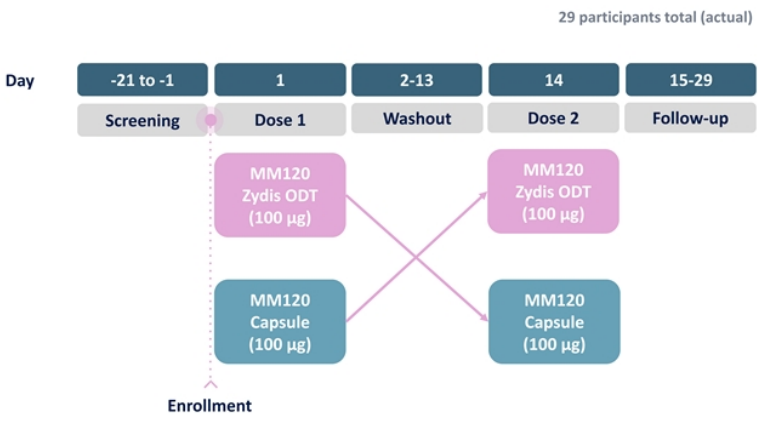
Comparative PK Profile[1]



1. Company analysis of pharmacokinetic data from Study MM120-101.
2. Based on time to reach target concentration of >1 ng/mL.
3. Based on comparison of geometric mean ratio of total area under the curve.
4. Based on ratio of mean $AUC_{>target}$. Target concentrations defined as level above which perceptual effects are present.
5. Based on a comparison between Phase 2b study of MM120 capsules in GAD versus PK bridging study of MM120 ODTs

AUC: area under the curve; GI: gastrointestinal; ODT: orally dissolving tablet; PK: pharmacokinetics

MM120 ODT PK Bridging Study Schematic[1]



Study MM120-101 | ODT-PK Bridging

A Phase 1, Open-label Study to Compare the Pharmacokinetics of Two Formulations of MM120 in Healthy Volunteers

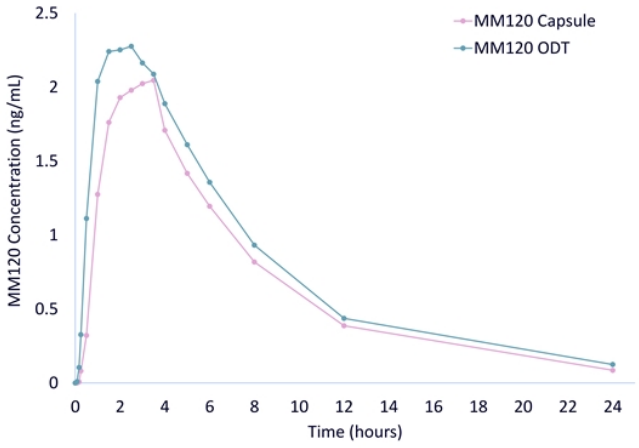
ENTRY CRITERIA

- Men and Women
- Ages 18-55
- Healthy volunteers
- No prohibited medications

1. Based on internal study documents for Study MM120-101
ODT: orally dissolving tablet

Comparative PK of MM120 ODT vs Capsule Demonstrates Favorable Profile of MM120 ODTs[1]

PK Parameter[1]	MM120 Capsule	MM120 ODT
T_{max} (hr)	2.25	2.0
C_{max} (ng/mL)	2.63	2.68
$AUC_{0-\infty}$ (ng*hr/mL)	15.7	18.7
$AUC_{>1ng/mL}$(ng*hr/mL)	9.7	12.0

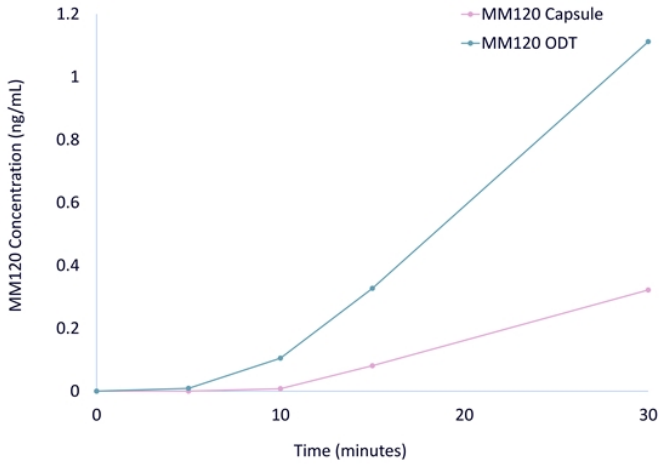


1. Company analysis of pharmacokinetic data from Study MM120-101. PK analysis based on n=24 subjects that completed both dosing sessions.
AUC: area under the curve; C_{max}: maximum achieved concentration; ODT: orally dissolving tablet; PK: pharmacokinetics; T_{max}: time to maximum concentration

MM120 ODT Demonstrates Faster Absorption and Shorter Time to Reach Target Concentrations

Differentiated PK Profile of MM120 ODTs[1]

- **50% faster onset of action[2]**
- **17% improved bioavailability[3]**
- **23% increased AUC above target conc.[4]**



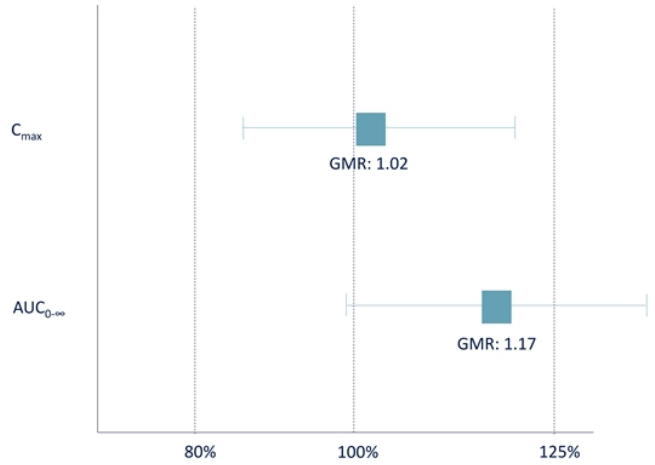
1. Company analysis of pharmacokinetic data from Study MM120-101. PK analysis based on n=24 subjects that completed both dosing sessions.
2. Based on time to reach target concentration of >1 ng/mL.
3. Based on comparison of geometric mean ratio of total area under the curve.
4. Based on ratio of mean $AUC_{>1ng/mL}$. Target concentrations defined as level above which perceptual effects are present.

AUC: area under the curve; ODT: orally dissolving tablet; PK: pharmacokinetics

MM120 ODT Demonstrates Improved Bioavailability[1]

Differentiated PK Profile of MM120 ODTs[1]

- 50% faster onset of action[2]
- **17% improved bioavailability[3]**
- 23% increased AUC above target conc.[4]



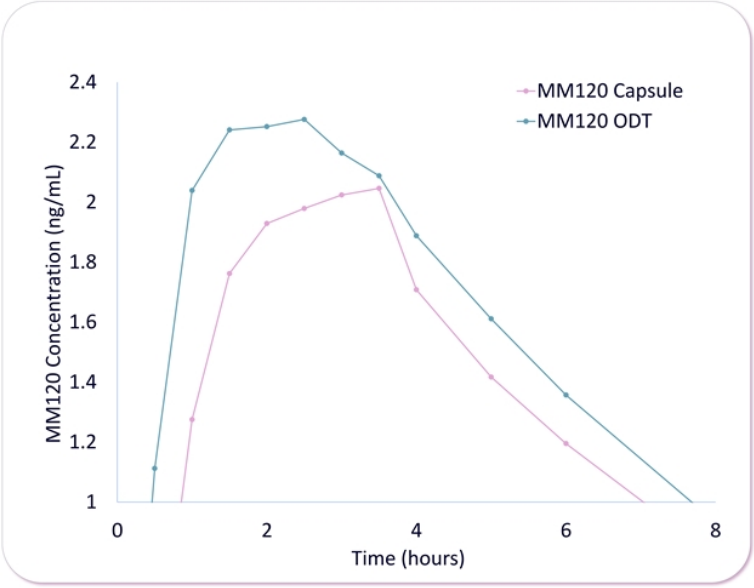
1. Company analysis of pharmacokinetic data from Study MM120-101. PK analysis based on n=24 subjects that completed both dosing sessions.
2. Based on time to reach target concentration of >1 ng/mL.
3. Based on comparison of geometric mean ratio of total area under the curve.
4. Based on ratio of mean $AUC_{>1ng/mL}$. Target concentrations defined as level above which perceptual effects are present.

AUC: area under the curve; GMR: geometric mean ratio; ODT: orally dissolving tablet; PK: pharmacokinetics

MM120 ODT Achieves Increased AUC Above Target Concentration

Differentiated PK Profile of MM120 ODTs[1]

- 50% faster onset of action[2]
- 17% improved bioavailability[3]
- 23% increased AUC above target conc.[4]



1. Company analysis of pharmacokinetic data from Study MM120-101. PK analysis based on n=24 subjects that completed both dosing sessions.
2. Based on time to reach target concentration of >1 ng/mL.
3. Based on comparison of geometric mean ratio of total area under the curve.
4. Based on ratio of mean $AUC_{>1ng/mL}$. Target concentrations defined as level above which perceptual effects are present.

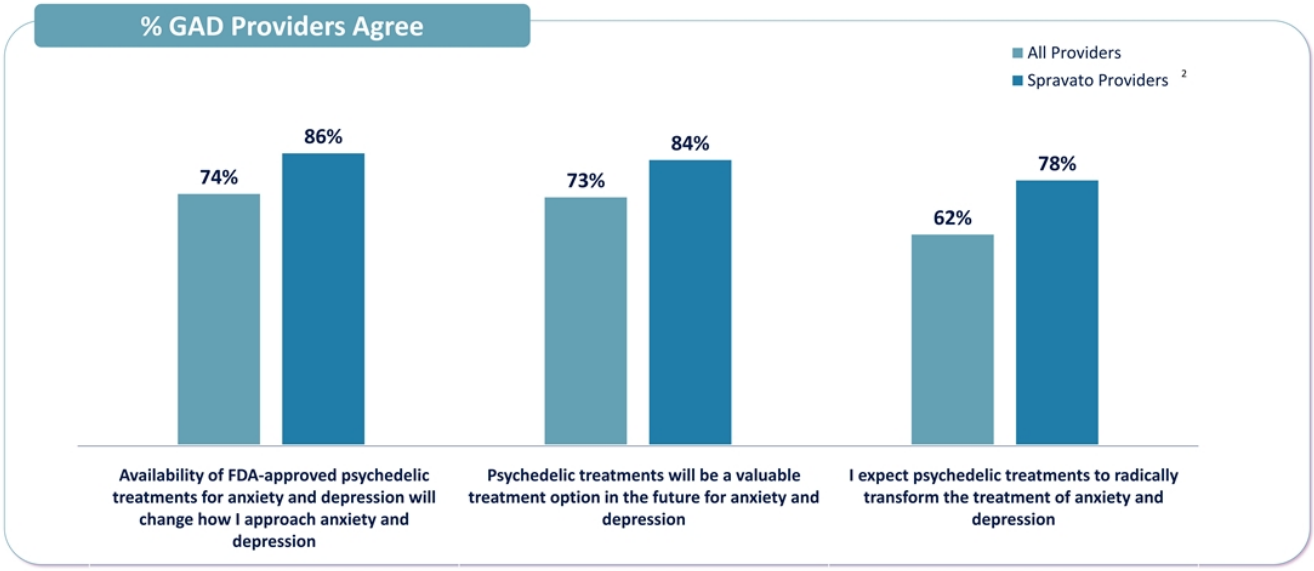
AUC: area under the curve; ODT: orally dissolving tablet; PK: pharmacokinetics

MM120 LSD-D-tartrate Commercial Opportunity

Francois Lilienthal, MD, MBA
Chief Commercial Officer

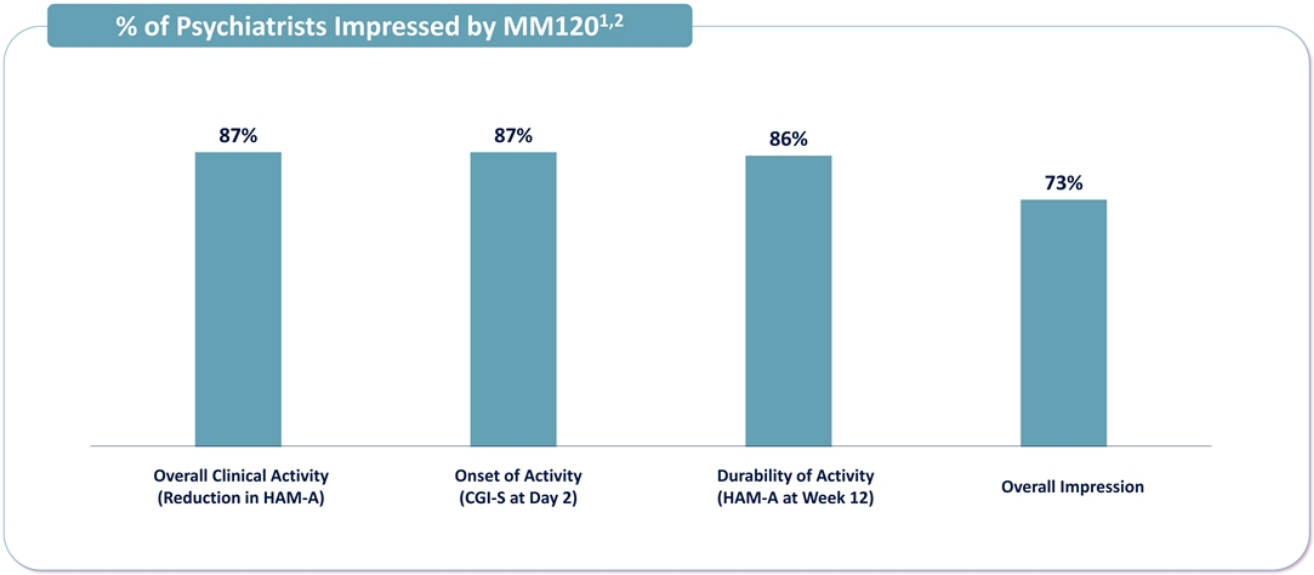
Key Factors are in Place to Drive a Significant Commercial Opportunity for MM120

Psychiatric HCPs Expect Psychedelics to Radically Transform the Treatment of Anxiety and Depression[1]



1. Psychiatrists and Psychiatry Nurse Practitioners
2. Source: MindMed Primary Market Research – Key Customer Perceptions Among Spravato® Providers and GAD Prescribers (February 2024). Total Non-Spravato® Providers (n=125), Spravato® Providers (n=50).
3. Spravato Providers: recommended, referred or prescribed Spravato® treatment and monitored or administered Spravato® treatment, personally or someone in her/his clinic or office.

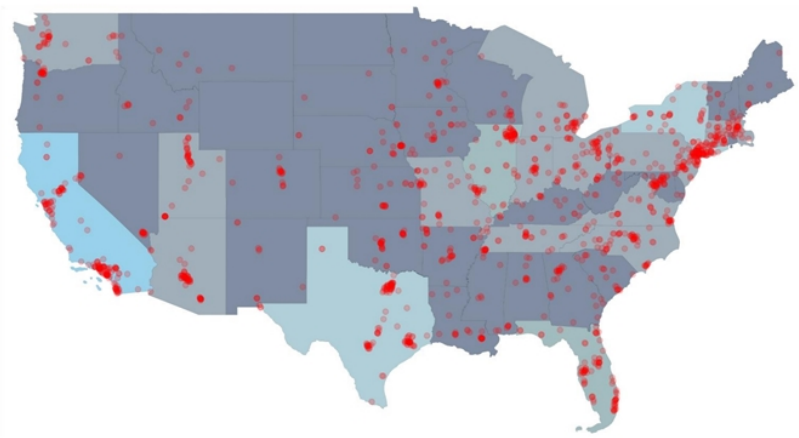
Majority of Psychiatrists Are Impressed by the Clinical Activity and Overall Profile of MM120



1. Source: MindMed Primary Market Research – Key Customer Perceptions Among Spravato® Providers and GAD Prescribers (February 2024). Total Non-Spravato® Providers (n=125), Spravato® Providers (n=50).
2. Psychiatrists and Psychiatry Nurse Practitioners

CGI-S: Clinical Global Impressions – Severity; HAM-A: Hamilton Anxiety Scale

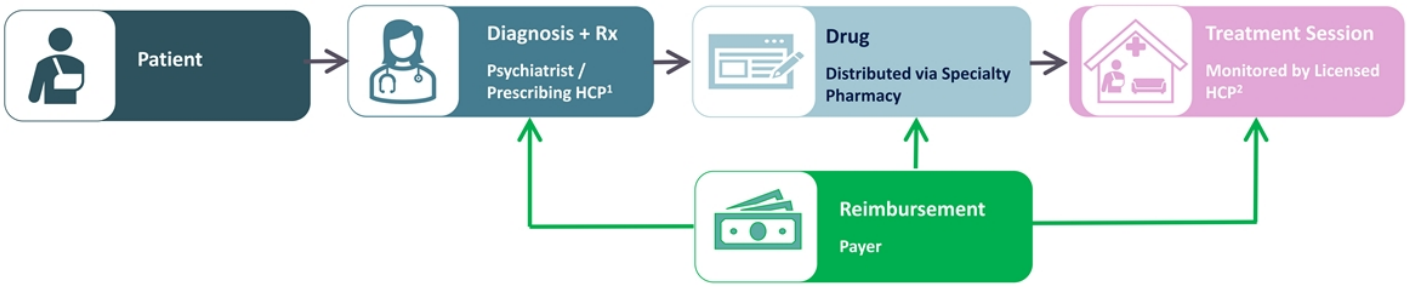
MM120 Commercial Model Leverages Proven and Rapidly Expanding Interventional Psychiatry Model Established by Spravato®



- **>3,500 certified delivery clinics for Spravato®**
- **Proven reimbursement, documentation and logistics pathways**
- **Rapidly expanding uptake with blockbuster projections**

Source: J&J Investor Day presentation, December 2023, Johnson & Johnson Spravato® website. Compiled by company.

Proven Pathways Already Exist for Patient Care & Reimbursement



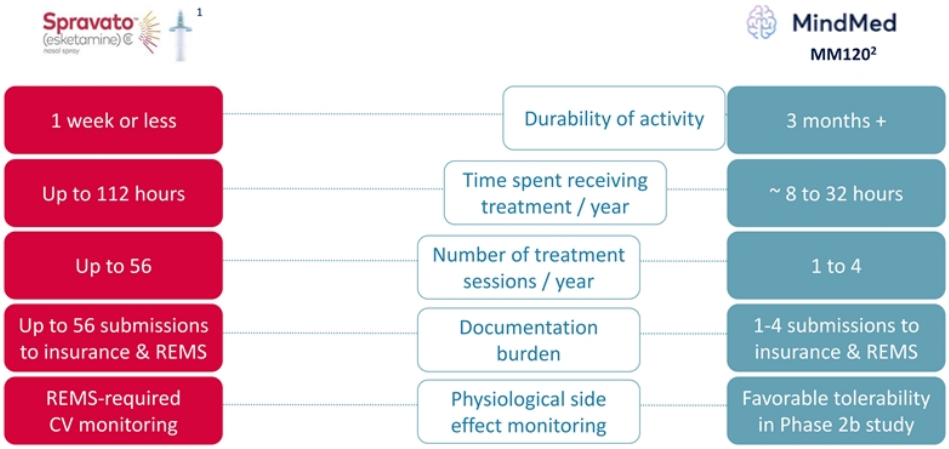
1. HCP that is licensed to prescribe medications to patients.
2. HCP that is licensed to practice, which may include physicians, clinical psychologists, nurse practitioners, nurses, licensed clinical social workers, licensed family and marriage therapists and others.

Reimbursement Pathways Are Established for All Stakeholders, Including for Both Drug and Session Delivery

	Activity	Stakeholder	Reimbursement/Coding	Annual Cost Spravato®
	Evaluation & Prescribing	Local or Telehealth Prescriber[1]	**Medical Benefit** E&M Code (992XX) or G Code	Up to $1,200[3]
	Drug	Manufacturer via Specialty Pharmacy	**Pharmacy Benefit** J or S Code + dispensing fee	~$25,000 – 62,000[4] *excluding discounts and rebates*
	Session Delivery	Local HCP[2] to monitor treatment session	**Medical Benefit** E&M Code *Reimbursed on hourly basis for prolonged clinical staff service*	Up to $17,000[5]

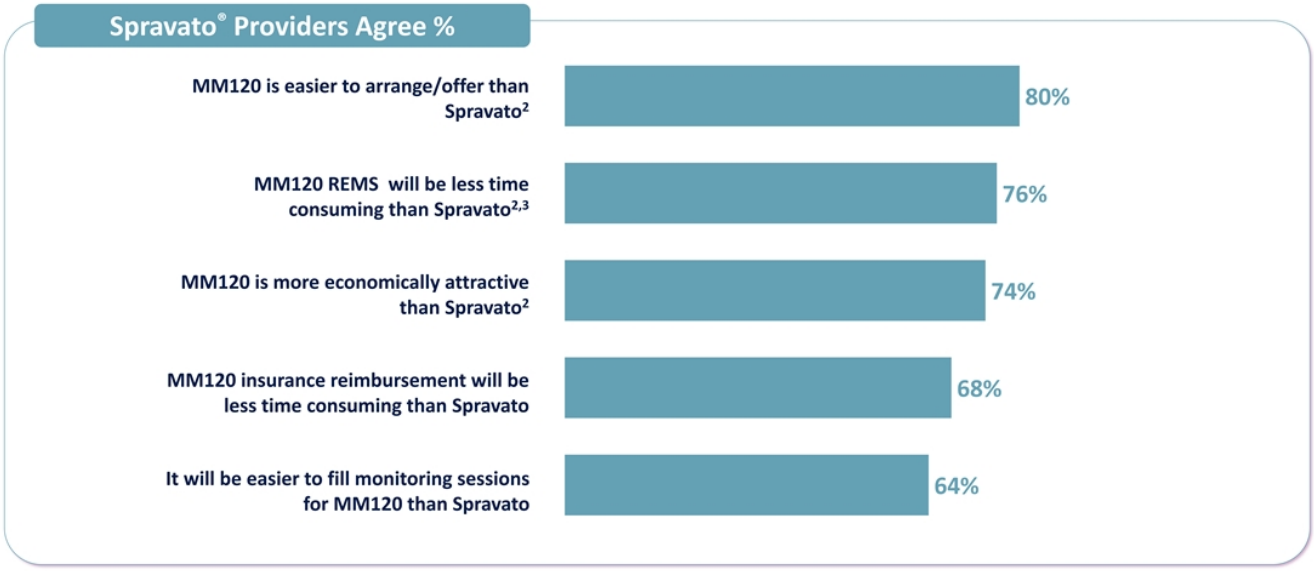
1. HCP that is licensed to prescribe medications to patients.
2. HCP that is licensed to practice, which may include physicians, clinical psychologists, nurse practitioners, nurses, licensed clinical social workers, licensed family and marriage therapists and others.
3. Based on up to 8 evaluation visits at assumed cost of $150 per visit. CPT codes and reimbursement for MM120 have not been established.
4. Manufacturer price based on 2 or 3 canisters per session times 34 to 56 sessions per year. CPT codes and reimbursement for MM120 have not been established.
5. Based on up to 112 hours of required monitoring that is reimbursed at approximately $150 per hour (Source: MindMed primary research). CPT codes and reimbursement for MM120 have not been established.

MM120 Could Offer Significant Advantages over Spravato® in both Clinical and Session Delivery Profiles



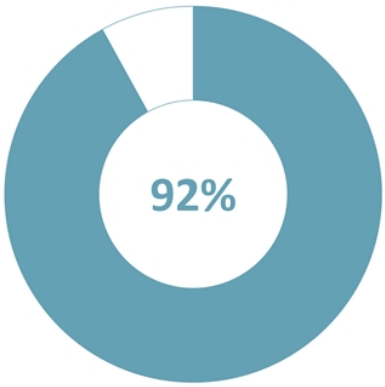
1. Based on Spravato Prescribing Information and information contained under the Spravato REMS at https://www.spravatorems.com.
2. If MM120 becomes FDA approved and marketed. Durability, tolerability and associated treatment interval assumptions based on demonstration of statistically significant reductions in HAM-A at week 12 in Phase 2b clinical trial MMED008. Assumes average 8 hour monitoring per dosing session of MM120.

Current Spravato® Providers Overwhelmingly Believe MM120 Will Be Preferable on Key Attributes of Session Delivery that Drive Adoption

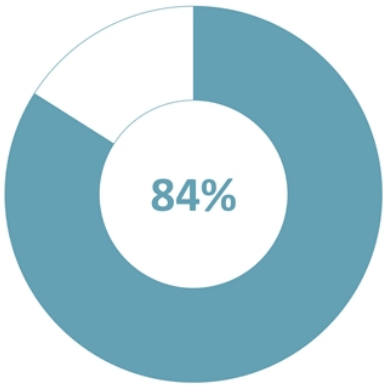


1. Source: MindMed Primary Market Research – Key Customer Perceptions Among Spravato® Providers and GAD Prescribers (February 2024). Total Non-Spravato® Providers (n=125), Spravato® Providers (n=50).
2. Based on comparison of an anticipated full year of MM120 treatment versus a full year of Spravato® treatment.
3. Based on hypothetical REMS for MM120 that is approximately equivalent to current REMS for Spravato®.

Vast Majority of Current Spravato® Providers Indicate They Are Likely To Refer, Prescribe and Administer MM120[1]



Current Spravato® Providers Likely to Refer Patient for MM120[2]



Current Spravato® Providers Likely to Prescribe and Administer MM120[2]

1. Source: MindMed Primary Market Research – Key Customer Perceptions Among Spravato® Providers and GAD Prescribers (February 2024). Total Non-Spravato® Providers (n=125), Spravato® Providers (n=50).
2. If MM120 becomes FDA approved and marketed.

Payer Perspectives on the Potential Value of MM120

1	2	3
Durable reduction of anxiety and comorbidities reduces healthcare utilization and cost burden	Predictability of response early in treatment course enables efficient use of resources	Tolerability and compliance profile supports low-waste budget impact

> Behavioral health issues drive costs….as you think about the development of the behavioral health space, all employers are interested in it. I can't say that enough….we have observation coverage, psychological evaluation coverage, E&M codes…and precedents include Spravato, sleep studies…there is an unmet need, it's going to get covered, if it's FDA approved…

– BCBS Regional Payer

Source: Company conducted qualitative research with US payers; MindMed 2023 Analyst Day.

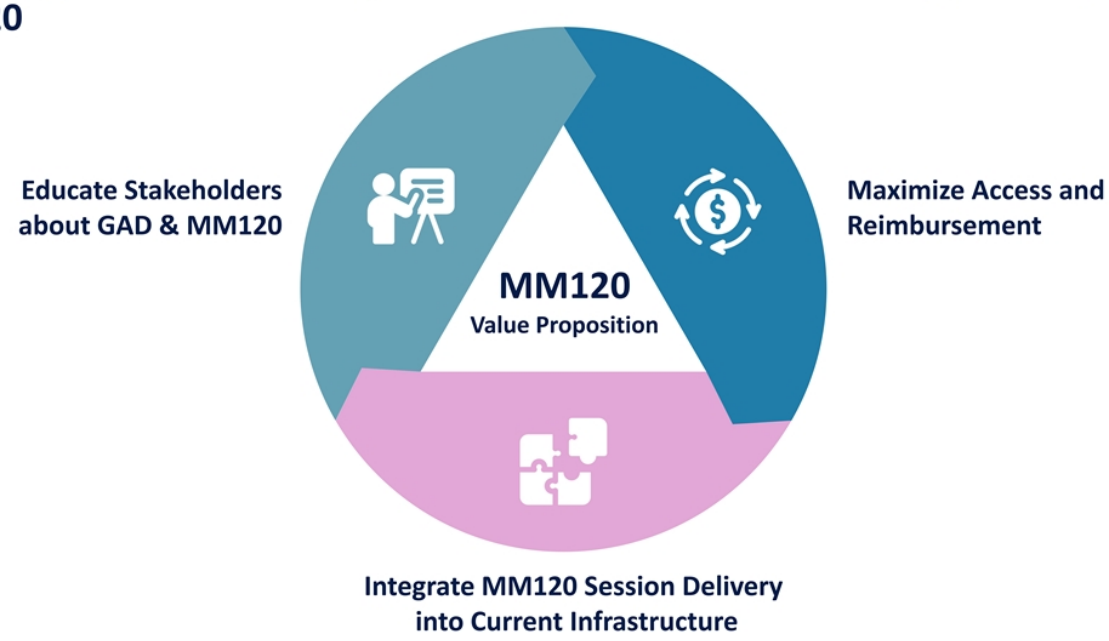
GAD Has a Major Impact on Employers by Driving Employee Disengagement and Work Productivity Loss

Group	Control[1]	Diagnosed Severe GAD[2]
Absenteeism	6.0%	21.0%
Presenteeism	14.1%	47.5%
Work Productivity Loss	16.4%	53.0%

- Potential impact of MM120 extends beyond direct health benefits and drives broad value proposition
- Employers play important role in driving reimbursement as a key stakeholder to payers

Source: NHWS 2022 annual survey
1. General population without GAD symptoms measured by GAD-7
2. Severe symptoms as measured by GAD-7

Advancing a Focused Strategy to Deliver on the Commercial Opportunity for MM120



Summary Comments for MM120 Development Plan

Robert Barrow
Chief Executive Officer

Multiple Studies Support Phase 3 Development of MM120

- **Achieved goals of Phase 2 development[1]**
  - Characterized dose-response to inform dose selection in GAD
  - Large, statistically significant and clinically meaningful effect in GAD
  - Rapid and durable therapeutic benefits on validated endpoint
  - Standalone drug effect in absence of psychotherapeutic intervention

- **Multiple double-blind, placebo-controlled studies supporting activity of MM120**
  - Phase 2b randomized, placebo-controlled dose optimization trial in GAD (Study MMED008)
  - One prior modern, randomized, placebo-controlled IIT of lysergide in anxiety disorders
  - Over twenty legacy studies of lysergide in anxiety and other neurotic disorders

- **Phase 2b data supports dose selection and advancement into Phase 3 development**

1. Source: Study MMED008 internal study documents and calculations.

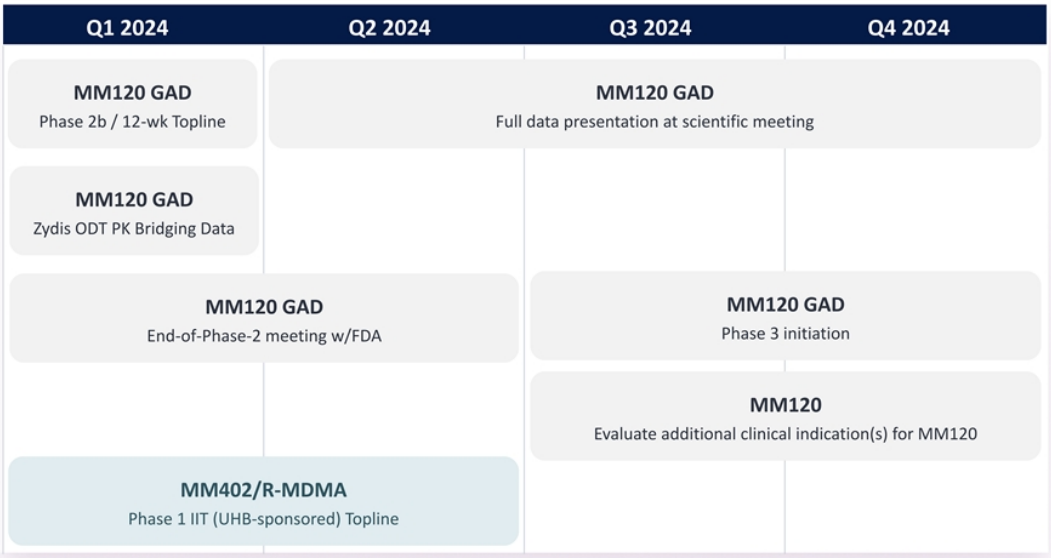
MM120 Development Pathway

- **Two Phase 3 pivotal clinical trials in planning[1]**
  - 12-week randomized, placebo-controlled primary efficacy study design
  - Open-label extension to establish retreatment parameters
  - Expect to initiate Phase 3 development in the second half of 2024

- **Key design elements expected to be consistent between Phase 2b and Phase 3 studies**
  - Hamilton Anxiety Scale (HAM-A) at week 4 expected primary endpoint
  - Limited changes to key inclusion/exclusion criteria
  - No planned change in dosing session monitoring protocol

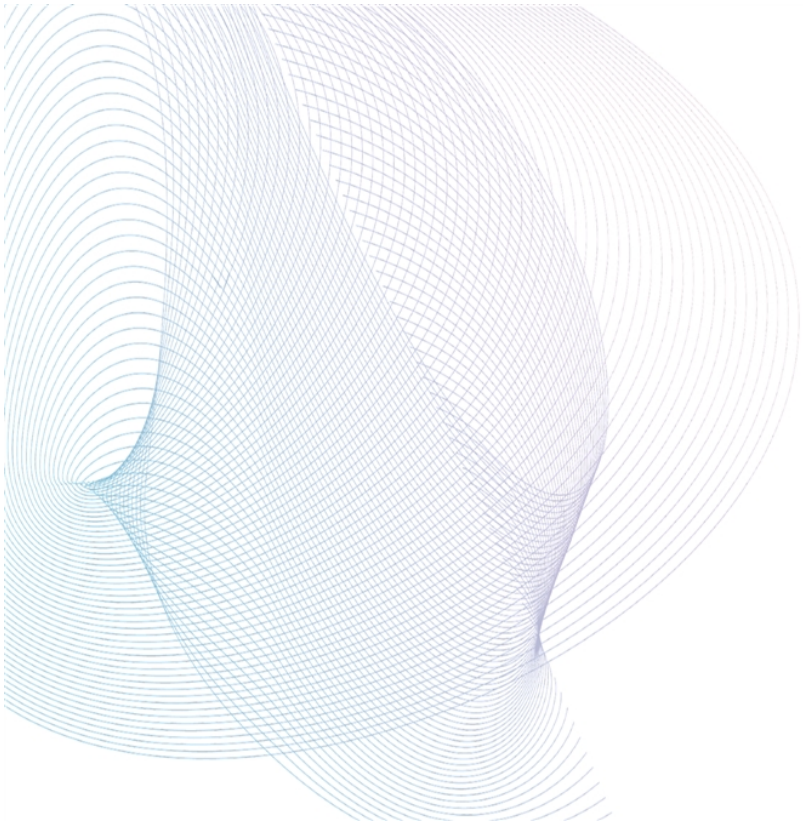
1. Phase 3 and subsequent clinical study design subject to regulatory discussion and review, including at potential End of Phase 2 meeting.

Next Steps and Anticipated Milestones for MM120 and Pipeline Programs



MindMed

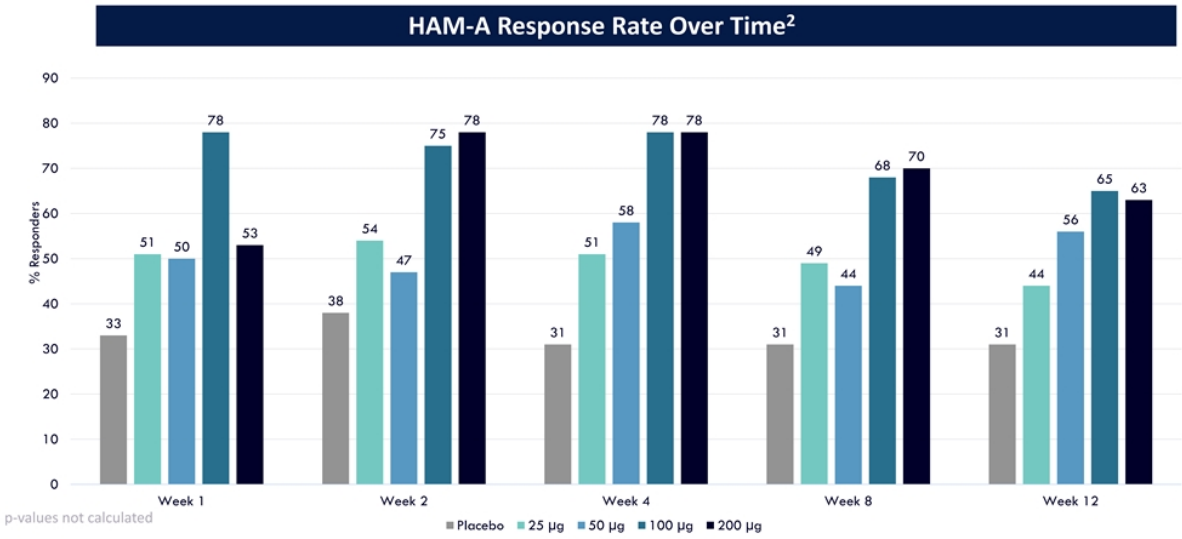
Q&A



MindMed

Appendix

65% HAM-A Response Rate (HAM-A) Achieved at Week 12[1,3]

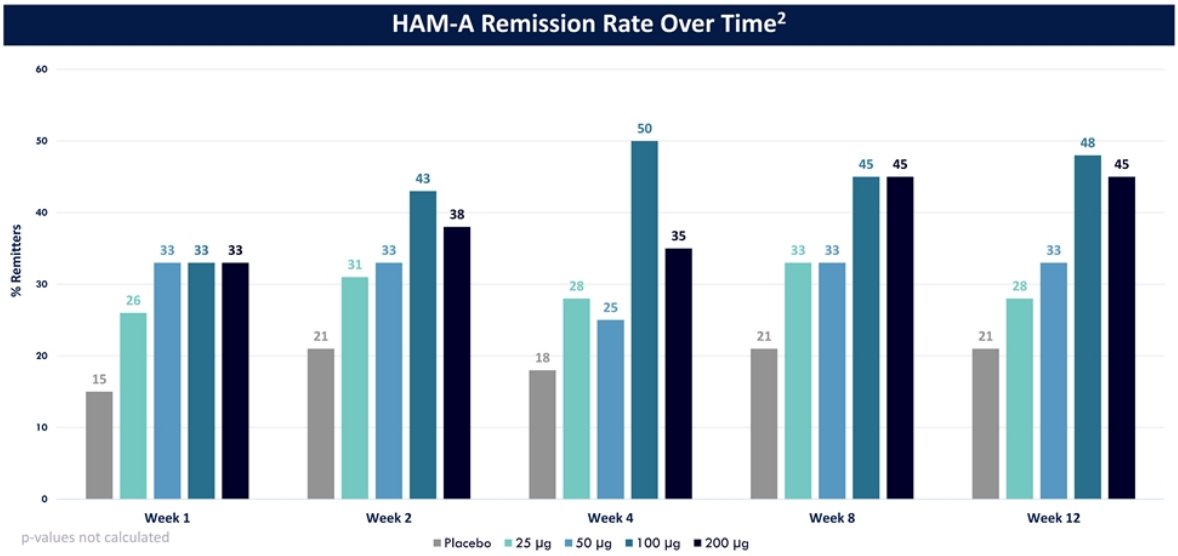


p-values not calculated

1. Source: Study MMED008 internal study documents and calculations. Full analysis set population.
2. Response is defined as a 50% or greater improvement on HAM-A score.
3. Based on 100 µg dose group.

µg: microgram; HAM-A: Hamilton Anxiety Rating Scale.

48% Remission Rate (HAM-A) Achieved through Week 12[1,3]

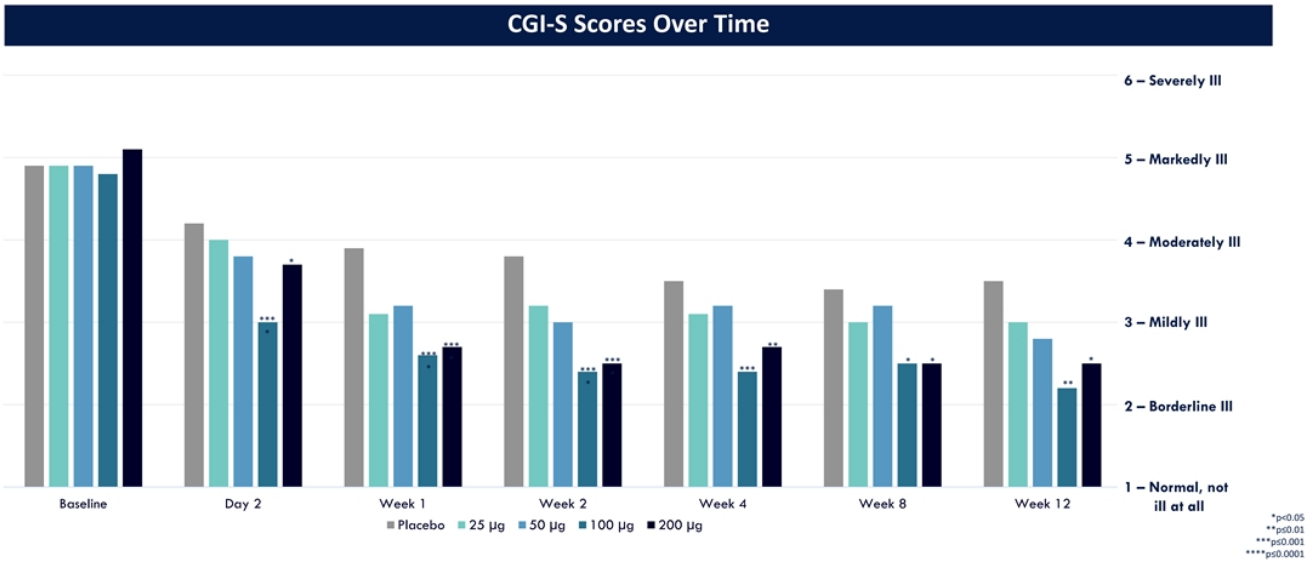


p-values not calculated

1. Source: Study MMED008 internal study documents and calculations. Full analysis set population.
2. Remission is defined as a HAM-A score of ≤ 7.
3. Based on 100 µg dose group.

µg: microgram; HAM-A: Hamilton Anxiety Rating Scale.

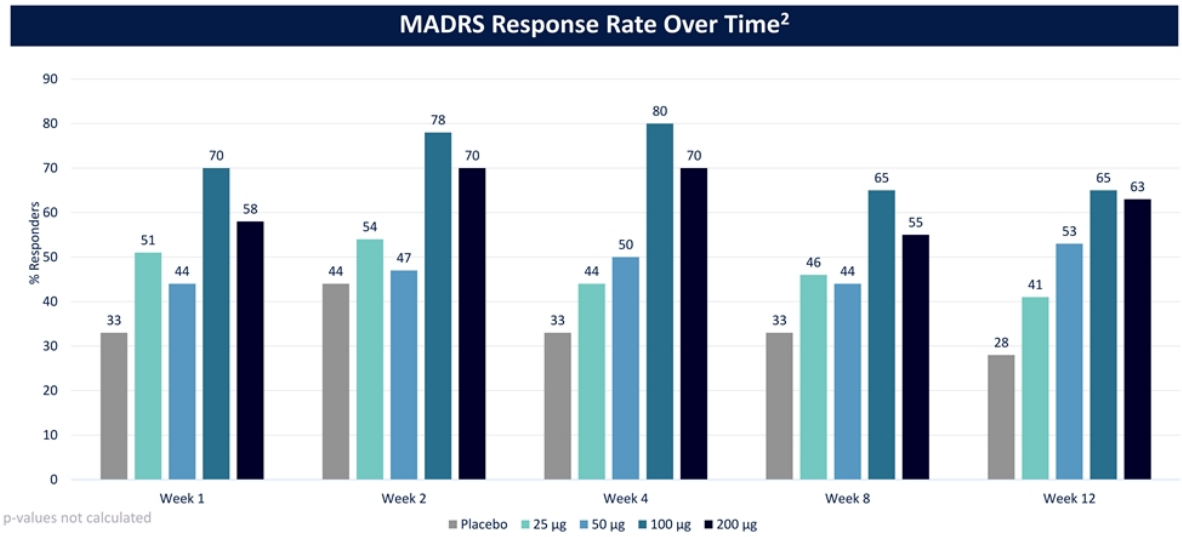
Statistically Significant Improvement in Clinical Global Impressions – Severity (CGI-S) Score Achieved by Day 2 and Sustained through Week 12[1,2]



1. Source: Study MMED008 internal study documents and calculations. Full analysis set population.
2. Based on 100 µg dose group.

µg: microgram; CGI-S: Clinical Global Impressions – Severity

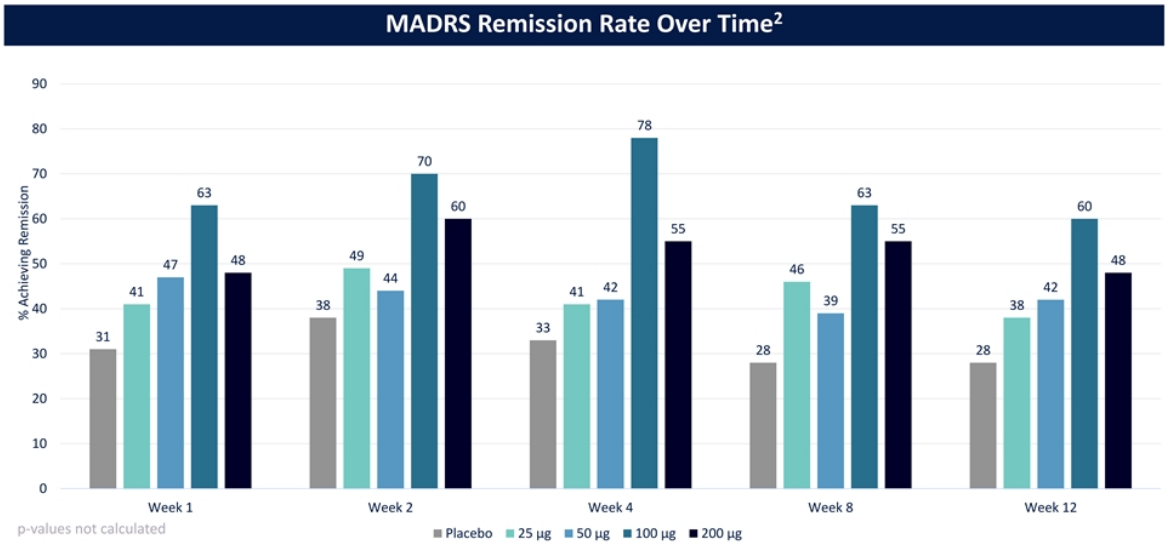
65% Response Rate for Comorbid Depression Symptoms (MADRS) Achieved through Week 12[1,3]



1. Source: Study MMED008 internal study documents and calculations. Full analysis set population.
2. Response is defined as a 50% or greater improvement on MADRS score.
3. Based on 100 µg dose group.

µg: microgram; MADRS: Montgomery-Åsberg Depression Rating Scale

60% Remission Rate from Comorbid Depression Symptoms (MADRS) Achieved through Week 12[1,3]



1. Source: Study MMED008 internal study documents and calculations. Full analysis set population.
2. Remission is defined as a MADRS score of ≤ 10.
3. Based on 100 µg dose group.

µg: microgram; MADRS: Montgomery-Åsberg Depression Rating Scale.

Most Common (≥10%) TEAEs Across All Groups[1]

MM120 was well tolerated across all dose groups with mostly transient, mild to moderate adverse events

Preferred Term Subjects (%) with AE	MM120								Placebo (n=39)	
	25 µg (n=39)		50 µg (n=40)		100 µg (n=40)		200 µg (n=40)			
	DD	AFT	DD	AFT	DD	AFT	DD	AFT	DD	AFT
Illusion	12 (31)	1 (2.6)	18 (45)	1 (2.5)	24 (60)	1 (2.5)	30 (75)	–	3 (7.7)	–
Nausea	3 (7.7)	–	11 (28)	–	16 (40)	1 (2.5)	24 (60)	2 (5.0)	1 (2.6)	2 (5.1)
Headache	4 (10)	2 (5.1)	9 (23)	2 (5.0)	10 (25)	4 (10)	10 (25)	1 (2.5)	8 (21)	1 (2.6)
Hallucination, visual	6 (15)	1 (2.6)	9 (23)	–	9 (23)	–	6 (15)	–	1 (2.6)	–
Euphoric mood	2 (5.1)	–	5 (13)	–	11 (28)	–	6 (15)	–	1 (2.6)	–
Anxiety	1 (2.6)	3 (7.7)	3 (7.5)	3 (7.5)	4 (10)	–	5 (13)	1 (2.5)	–	2 (5.1)
Mydriasis	1 (2.6)	–	7 (18)	–	8 (20)	–	4 (10)	–	1 (2.6)	–
Hyperhidrosis	1 (2.6)	–	4 (10)	–	9 (23)	–	5 (13)	–	–	–
Fatigue	2 (5.1)	–	6 (15)	2 (5.0)	3 (7.5)	1 (2.5)	3 (7.5)	1 (2.5)	–	1 (2.6)
Paraesthesia	2 (5.1)	–	2 (5.0)	–	2 (5.0)	–	8 (20)	–	2 (5.1)	1 (2.6)
Blood pressure increased	3 (7.7)	–	5 (13)	–	4 (10)	–	4 (10)	–	–	–
Dizziness	3 (7.7)	–	2 (5.0)	–	3 (7.5)	–	5 (13)	–	1 (2.6)	–
Tremor	–	–	3 (7.5)	–	2 (5.0)	1 (2.5)	8 (20)	–	–	–
Thinking abnormal	1 (2.6)	–	2 (5.0)	–	4 (10)	1 (2.5)	5 (13)	–	–	–

1. Source: Study MMED008 internal study documents and calculations. Safety population.
AFT: After Dosing Day; DD: Dosing Day; TEAE: Treatment-emergent adverse event.

Most Common (≥10%) TEAEs Across All Groups (cont)[1]

MM120 was well tolerated across all dose groups with mostly transient, mild to moderate adverse events

Preferred Term Subjects (%) with AE	MM120								Placebo (n=39)	
	25 µg (n=39)		50 µg (n=40)		100 µg (n=40)		200 µg (n=40)			
	DD	AFT	DD	AFT	DD	AFT	DD	AFT	DD	AFT
Balance disorder	–	–	4 (10)	–	3 (7.5)	–	2 (5.0)	–	1 (2.6)	–
Pseudohallucination	–	–	3 (7.5)	–	3 (7.5)	–	4 (10)	–	–	–
Vomiting	–	–	2 (5.0)	–	2 (5.0)	–	5 (13)	–	–	–
Disturbance in attention	1 (2.6)	–	5 (13)	1 (2.5)	–	1 (2.5)	–	–	–	–
Feeling abnormal	1 (2.6)	–	2 (5.0)	–	–	–	–	4 (10)	1 (2.6)	1 (2.6)
COVID-19	–	1 (2.6)	–	2 (5.0)	–	1 (2.5)	–	4 (10)	–	–

1. Source: Study MMED008 internal study documents and calculations. Safety population.
AFT: After Dosing Day; DD: Dosing Day; TEAE: Treatment-emergent adverse event.