Unraveling the Mysteries of the Brain to Treat Neuroscience Diseases

August 2022

2Q 2022 Financial Results & Business Update

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Forward-Looking Statements

This presentation contains forward-looking statements that are based on management's beliefs and assumptions and on information currently available to management. In some cases, you can identify forward-looking statements by the following words: "may," "will," "could," "would," "should," "expect," "intend," "plan," "anticipate," "believe," "estimate," "predict," "project," "potential," "continue," "ongoing" or the negative of these terms or other comparable terminology, although not all forward-looking statements contain these words. These statements involve risks, uncertainties and other factors that may cause actual results, levels of activity, performance or achievements to be materially different from the information expressed or implied by these forward-looking statements. Although we believe that we have a reasonable basis for each forward-looking statement contained in this presentation, we caution you that these statements are based on a combination of facts and factors currently known by us and our projections of the future, about which we cannot be certain.

Forward-looking statements in this presentation include, but are not limited to, statements about: the potential attributes and benefits of our product candidates; the format and timing of our product development activities and clinical trials, including the timing, details and objectives of the emraclidine Phase 2 program, nonclinical and clinical pharmacology studies, ambulatory blood pressure monitoring trial, Phase 1 elderly healthy volunteer trial and plans for future development in other indications, including Alzheimer's disease psychosis, the timing for the darigabat Phase 2 proof-of-concept trial in focal epilepsy, the timing and details of the darigabat Phase 2 proof-of-concept trial in panic disorder, and other statements regarding the design of clinical trials and preclinical studies and the timing of initiation, completion and data readouts for clinical trials; the timing and outcome of regulatory interactions, including whether trials meet the criteria to serve as pivotal; the ability to compete with other companies currently marketing or engaged in the development of treatments for relevant indications; the size and growth potential of the markets for product candidates and ability to serve those markets; the rate and degree of market acceptance of product candidates, if approved; and the sufficiency of our cash, cash equivalents and marketable securities.

We cannot assure you that the forward-looking statements in this presentation will prove to be accurate. Furthermore, if the forward-looking statements prove to be inaccurate, the inaccuracy may be material. Actual performance and results may differ materially from those projected or suggested in the forward-looking statements due to various risks and uncertainties, including, among others: that clinical trial results may not be favorable; uncertainties inherent in the product development process (including with respect to the timing of results and whether such results will be predictive of future results); the impact of COVID-19 on the timing, progress and results of ongoing or planned clinical trials; other impacts of COVID-19, including operational disruptions or delays or to our ability to raise additional capital; whether and when, if at all, our product candidates will receive approval from the FDA or other regulatory authorities, and for which, if any, indications; competition from other biotechnology companies; uncertainties regarding intellectual property protection; and other risks identified in our SEC filings, including those under the heading "Risk Factors" in our Quarterly Report on Form 10-Q filed with the SEC on May 10, 2022 and our subsequent SEC filings.

In light of the significant uncertainties in these forward-looking statements, you should not regard these statements as a representation or warranty by us or any other person that we will achieve our objectives and plans in any specified time frame, or at all. The forward-looking statements in this presentation represent our views as of the date of this presentation. We anticipate that subsequent events and developments will cause our views to change. However, while we may elect to update these forward-looking statements at some point in the future, we have no current intention of doing so except to the extent required by applicable law. You should, therefore, not rely on these forward-looking statements as representing our views as of any date subsequent to the date of this presentation.

Agenda

Introduction		**Matthew Calistri** *Vice President, Corporate Strategy and Investor Relations*
Overview		**Tony Coles, M.D.** *Chairperson & Chief Executive Officer*
Lead Program Updates		**Raymond Sanchez, M.D.** *Chief Medical Officer*
Early Pipeline Updates		**John Renger, Ph.D.** *Chief Scientific Officer*
Q2 Financial Performance		**Mark Bodenrader** *Interim Chief Financial Officer*
Also available for Q&A		**Abraham Ceesay** *President*

Business & Pipeline Updates

Pipeline Progress & Update

- Initiated **Phase 2 EMPOWER program in schizophrenia** in June 2022
  - Two adequately-powered placebo-controlled Phase 2 trials
  - Data for both trials expected in first half of 2024
  - 52-week open-label safety extension trial expected to initiate in third quarter of 2022
- Phase 1 trial of emraclidine to be initiated by year-end to support **future development in Alzheimer's disease psychosis**
  - Will evaluate safety, tolerability and pharmacokinetics of emraclidine in elderly healthy volunteers 65-85 years old
- **Panic disorder selected as second indication for darigabat**
  - Planning underway for Phase 2 proof-of-concept

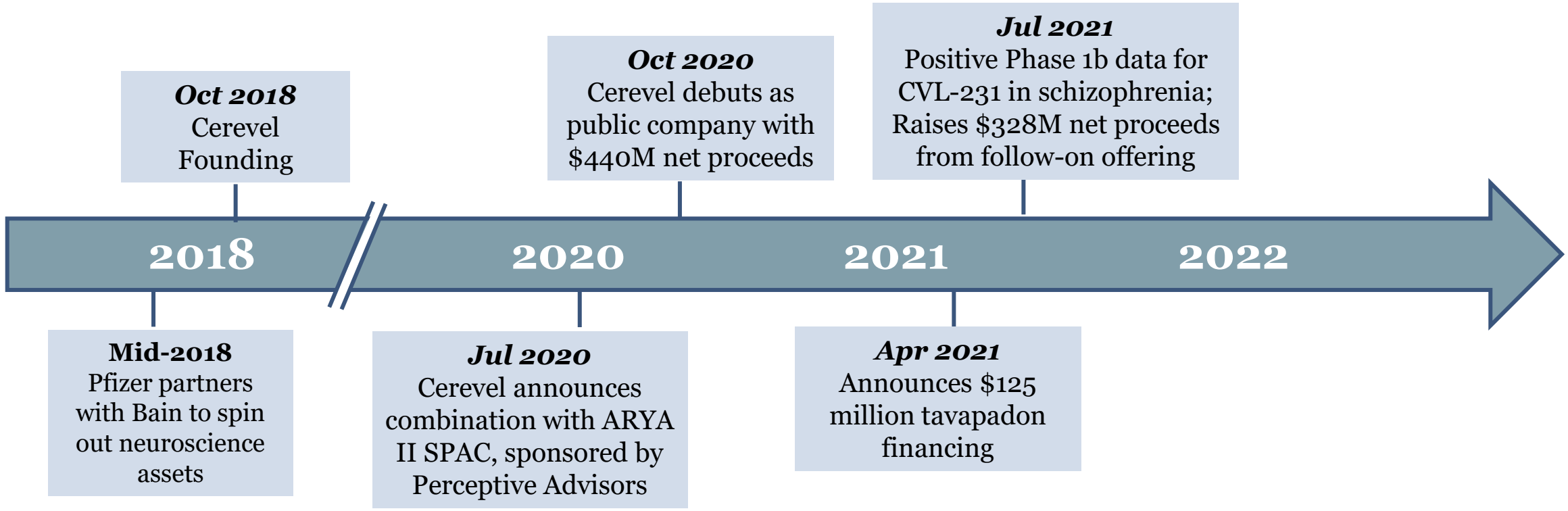
Capital

- Cash, cash equivalents and marketable securities of **$531.2M** as of 6/30/2022
- Cash resources expected to support Cerevel's operations into **2024**

Making Rapid Progress: Accomplishments To Date

- History of innovative deal-making - unique Bain & Pfizer transaction, ~$440M go-public transaction and ~$125M tavapadon financing
- Positive Phase 1b data readout in 2021 for emraclidine in schizophrenia and positive Phase 1 data readout in 2022 for darigabat in acute anxiety
- Multiple near- and medium-term catalysts, including five expected readouts in 2023
- Experienced management team with a strong track record of over 20 prior drug approvals and launches

History of Innovative Dealmaking



Led by a Seasoned Life Sciences Management Team

Tony Coles, M.D.
Chairperson &
Chief Executive Officer

Abraham Ceesay
President

Raymond Sanchez, M.D.
Chief Medical Officer

John Renger, Ph.D.
Chief Scientific Officer

Kenneth DiPietro
Chief Human
Resources Officer

Kathleen Tregoning
Chief Corporate
Affairs Officer

Scott Akamine
Chief Legal Officer

Mark Bodenrader
Interim Chief Financial
Officer

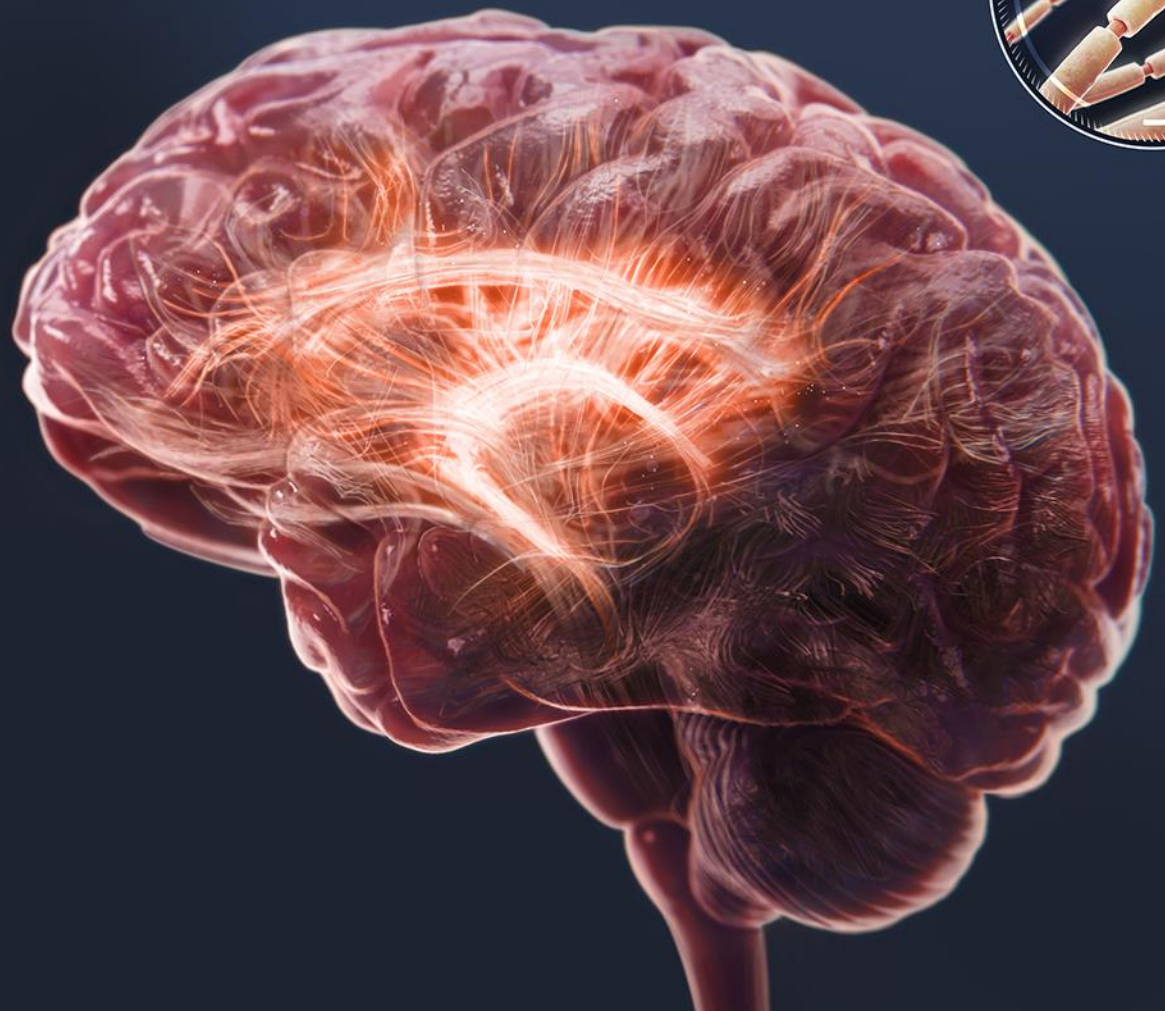
Yumanity Therapeutics · NPS Pharma · Vertex · sanofi · Otsuka · Avanir pharmaceuticals
Onyx Pharmaceuticals · Biogen · Merck · Bristol-Myers Squibb · Imbrium Therapeutics · Allergan

Strong Track Record of Approvals

- Abilify® (aripiprazole)
- Abilify MyCite® (aripiprazole tablets with sensor) 2, 5, 10, 15, 20, 30 mg
- Abilify Maintena® (aripiprazole) for extended release injectable suspension
- Belsomra® (suvorexant) 5, 10, 15, 20 mg tablets
- JYNARQUE® (tolvaptan) tablets
- Nexavar® (sorafenib) tablets
- Samsca® (tolvaptan)
- Kyprolis® (carfilzomib) for injection
- REXULTI® brexpiprazole
- ADHANSIA XR™ (methylphenidate HCl) extended-release capsules
- BLINCYTO® (blinatumomab) for injection

CEREVEL: Unraveling the Mysteries of the Brain

A Deliberate and Differentiated Approach to Treating Neuroscience Diseases

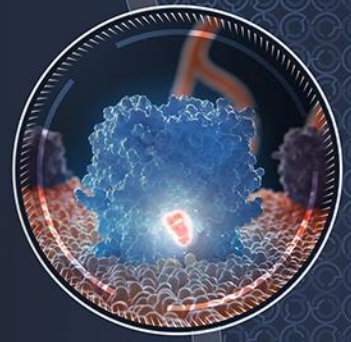


Targeted Neurocircuitry

Cerevel unlocks new treatment opportunities by precisely identifying and targeting the neurocircuitry that underlies a given neuroscience disease.

Receptor Subtype Selectivity

Cerevel is selectively targeting only the receptor subtype(s) related to the disease physiology, to minimize undesirable off-target effects while maximizing activity.



Differentiated Pharmacology

Cerevel designs full and partial agonists, antagonists, and allosteric modulators that can precisely fine-tune the receptor pharmacology and neurocircuit activity without over-activation or over-suppression of the endogenous physiologic range.

Deep Pipeline with Multiple Upcoming Value Inflections

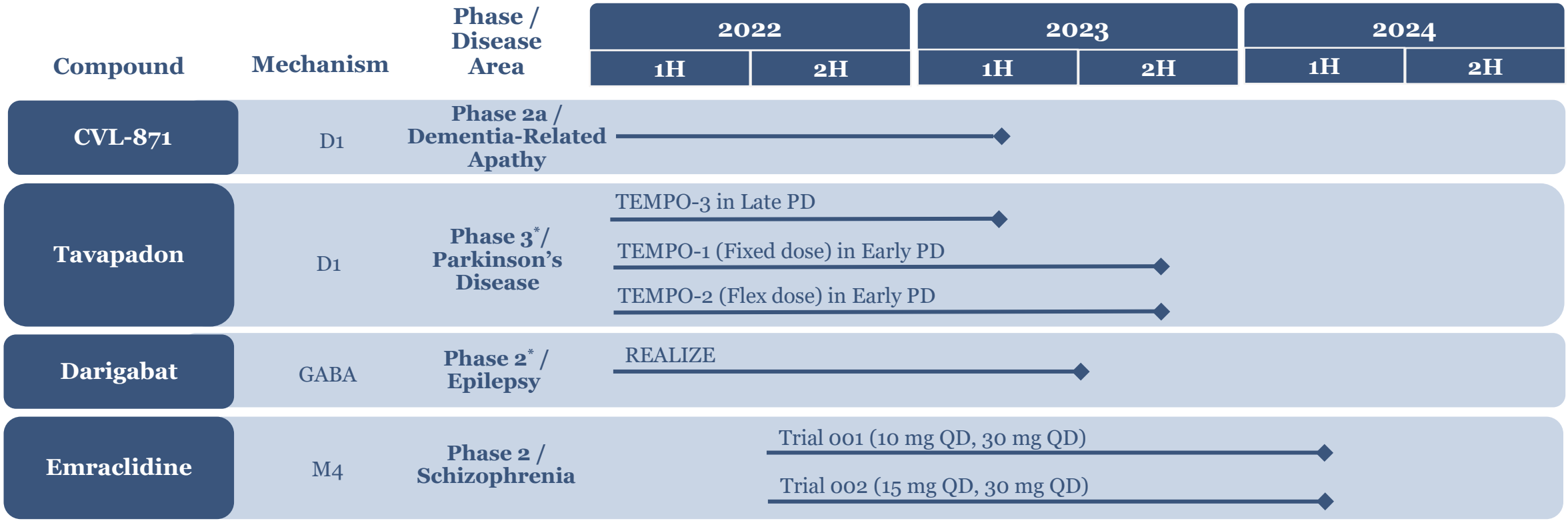
Multiple Assets Across All Stages of Development

Clinical Programs	Tavapadon	*Phase 3*
	Emraclidine	*Phase 2*
	Darigabat	*Phase 2*
	CVL-871	*Phase 2a*
	CVL-354 (KORA)	*Phase 1*
+ Preclinical Programs	CVL-047 (PDE4)	*IND Accepted*
	M4 Agonist	*Candidate Selection*
	LRRK2	*Candidate Selection*
+	Several undisclosed targets, including some with disease-modifying potential	

Large Patient Populations with High Unmet Need

- Early Parkinson's
- Late Parkinson's
- Schizophrenia
- Alzheimer's Disease Psychosis
- Epilepsy
- Panic Disorder
- Dementia-Related Apathy
- Major Depressive Disorder
- Substance Use Disorder

Key Milestones – Upcoming Data Readouts



* In addition, there are two open-label extension trials ongoing (REALIZE OLE for darigabat in epilepsy and TEMPO-4 for tavapadon)

EMRACLIDINE

Selectively targeting the M4 muscarinic receptor with the goal of effectively treating psychosis-related symptoms and improving tolerability compared to standard of care

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Unraveling the mysteries of the brain

Emraclidine: A Potential Next Generation Antipsychotic

Opportunity for Innovation in Schizophrenia

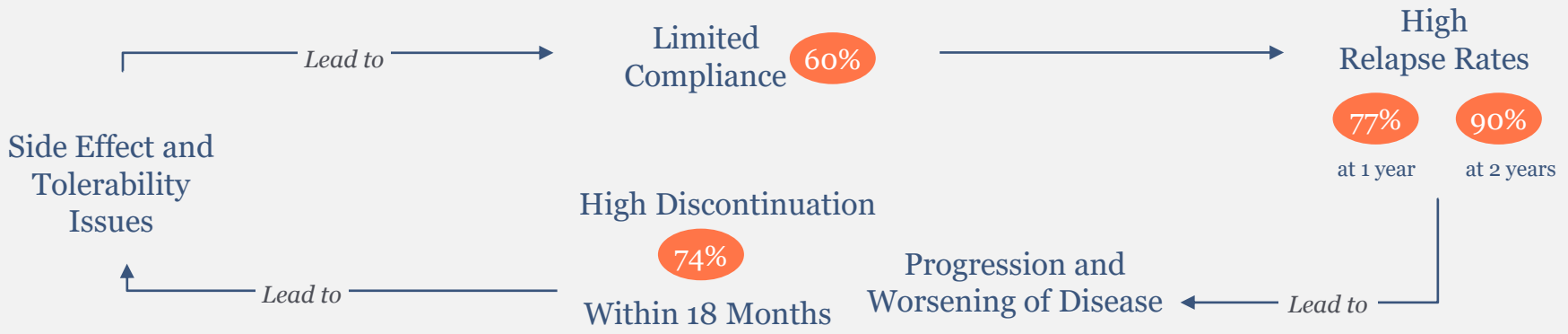
Current Standard of Care Uses Same Basic Mechanism of Action as Therapies from the 1950s

Potential Best-in-Class Therapy with Novel MOA

Large Market Opportunity

- ~20M Patients Worldwide
- ~$7B G7 Revenues in 2018
- ~3.5% Growth Per Year

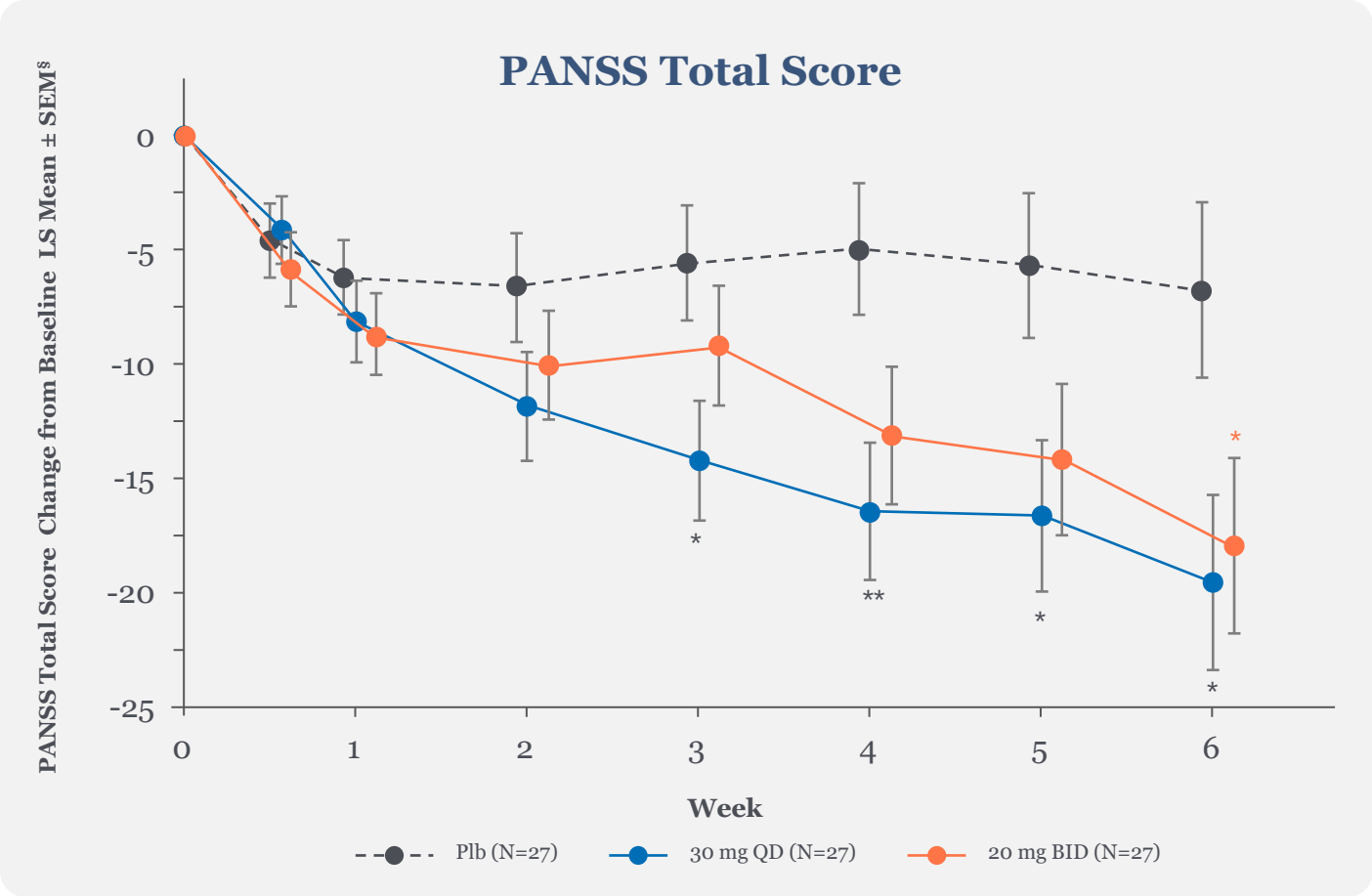
Significant Need for New Treatment Options



Debilitating side effects of atypicals often lead to discontinuation and relapse, driving a vicious cycle of disease progression

Source: World Health Organization, DRG Market Research

Emraclidine: Phase 1b Data Demonstrated Antipsychotic Activity



* P<0.05 vs Placebo ** P<0.01 vs Placebo

- Clinically meaningful improvements in PANSS total score
- Statistically significant difference in PANSS total score versus placebo*
- Clinically meaningful improvements in both PANSS Positive and PANSS Negative subscales
- Generally well-tolerated

§ Derived from a mixed model for repeated measures (MMRM) with treatment group, visit, treatment group-by-visit interaction as fixed effect, baseline value as a covariate and the measurements within subject as repeated measures. An unstructured covariance matrix was used.

What's Next: Emraclidine Phase 2 Clinical Development

Comprehensive Ph 2 program to characterize dose range, assess efficacy and tolerability

Overview of Phase 2 Program

Two adequately-powered 3-arm Phase 2 trials

- N=372 per trial
- Two doses of emraclidine in each trial
  - Trial 001: 10 mg / 30 mg once-daily & pbo
  - Trial 002: 15 mg / 30 mg once-daily & pbo
- Designed to fully characterize the dose range

Prioritizing key registration-enabling activities

- Hepatic and renal insufficiency clinical trials
- 8-week ambulatory blood pressure monitoring trial
- CMC manufacturing scale-up
- Nonclinical safety pharmacology

Will initiate 52-week OLE trial with both roll-over and de novo patients**

Key Features of Phase 2 Trials

Inclusion criteria

- Adults (18-65) with schizophrenia who are experiencing an acute exacerbation or relapse of psychotic symptoms
- PANSS total score 85-120, inclusive
- CGI-S ≥4

Primary endpoint

- Change from baseline in PANSS total score at Week 6

Key secondary endpoint

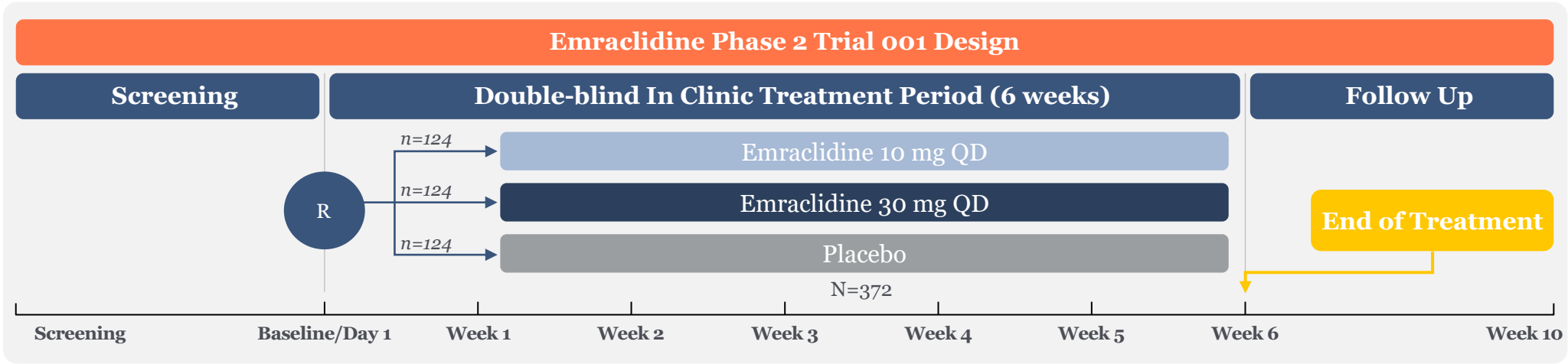
- CGI-S

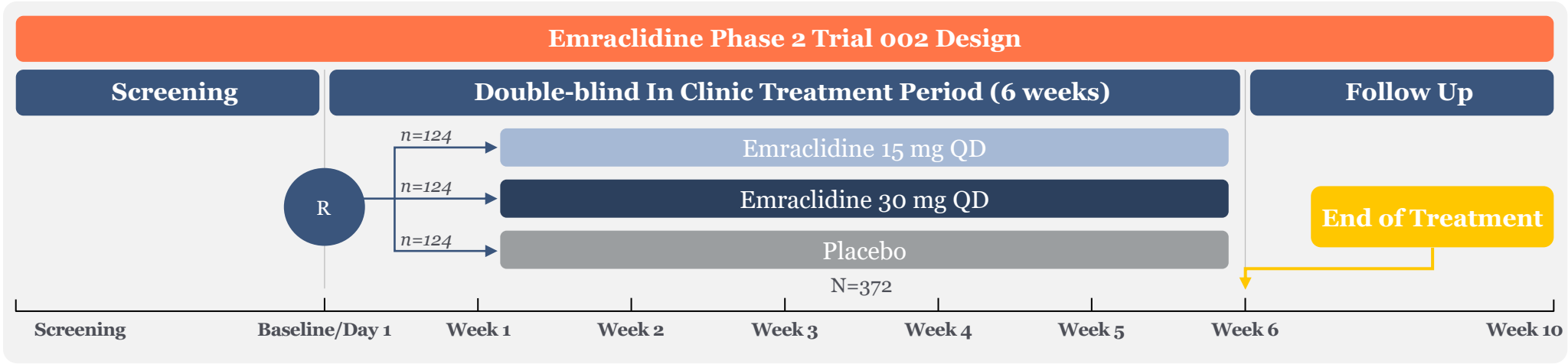
Other endpoints

- PANSS subscale scores and Marder Factor scores
- PANSS responder rate*
- SF-6D (QOL) and BACS (cognition)

*Defined as percentage of patients with ≥30% reduction from baseline in PANSS total score
**Open-label extension trial

Emraclidine Phase 2 Clinical Trial Designs: Data Expected 1H 2024





To initiate 52-week open-label extension trial to begin development of safety database

DARIGABAT

Selectively targeting specific subunits of the $GABA_A$ receptor with the goal of providing anticonvulsant and anxiolytic activity with enhanced tolerability and potential for reduced abuse liability

Darigabat: Potential To Become 1st Line and Adjunct Therapy in Epilepsy

Darigabat

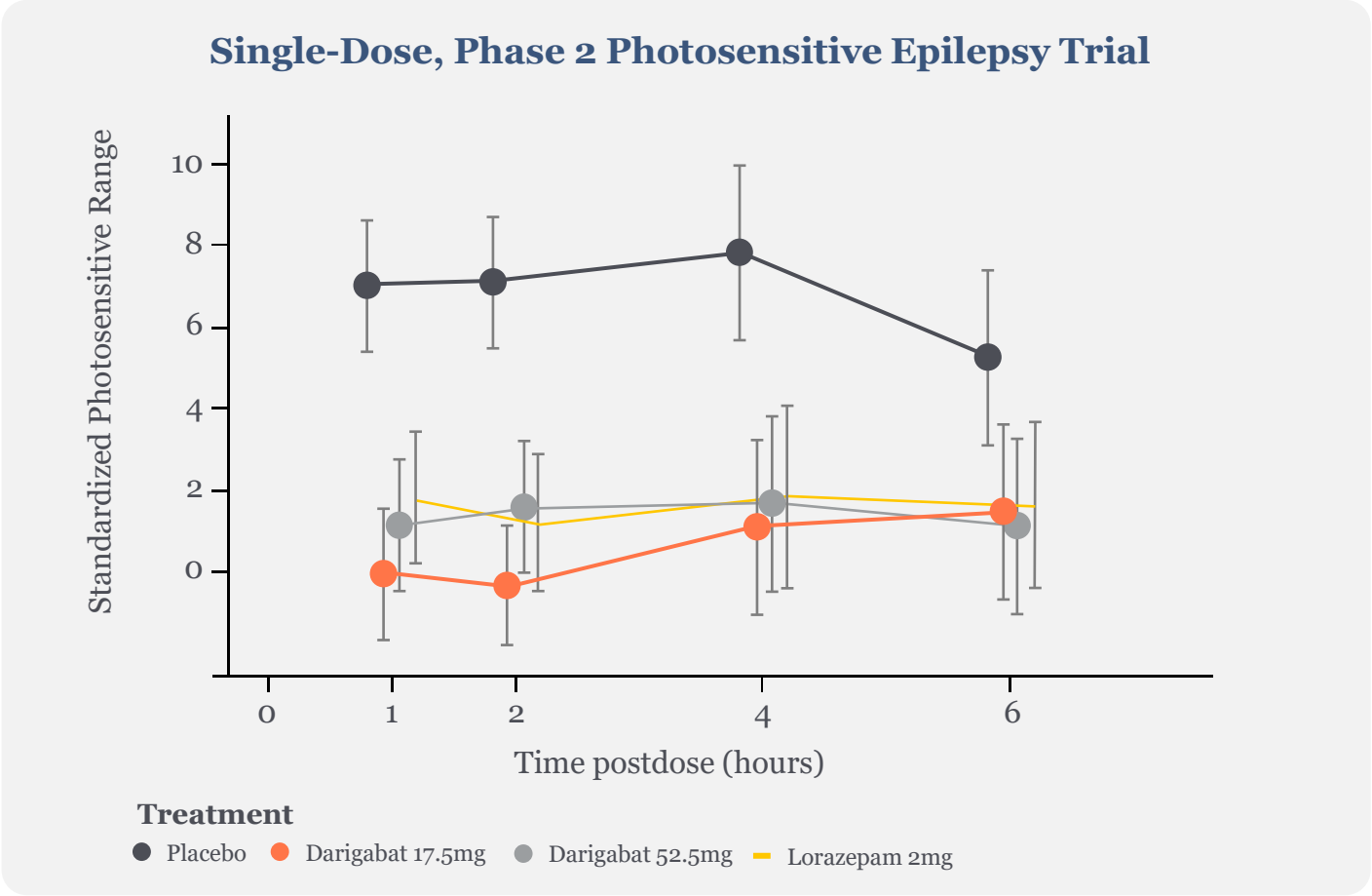
A potential daily maintenance treatment with an improved side effect profile compared to traditional benzodiazepines

Large Market Opportunity

~65M — Patients Worldwide

>$6B — G7 Revenues in 2018

~6% — Branded AED[1] Market Growth Per Year Through 2025



Source: World Health Organization, DRG Market Research
1. AED: Anti-Epileptic Drug

Darigabat Data Showed a Favorable Side Effect Profile Relative to Benzodiazepines

Multiple doses of darigabat

Phase 1 MAD Study – only mild AEs and limited somnolence up to 42.5 mg BID

Able to achieve >80% receptor occupancy without significant somnolence observed

Benzodiazepines achieve 10% to 15% receptor occupancy with significant somnolence observed

No evidence of withdrawal effects

Phase 1 MAD Study (Protocol: B7431011)

	Reaction	Week 1 (Titration)	Week 2 (Maintenance)	Week 3 (Maintenance)	Follow-up
Placebo	**No Reaction**	**4 / 4**	**4 / 4**	**3 / 4**	**4 / 4**
	Dizziness	-	-	1 / 4	-
	Somnolence	-	-	-	-
25 mg BID (~80% RO(1))	**No Reaction**	**5 / 8**	**7 / 8**	**8 / 8**	**8 / 8**
	Dizziness	2 / 8	1 / 8	-	-
	Somnolence	3 / 8	-	-	-
42.5 mg BID (>80% RO(1))	**No Reaction**	**4 / 7**	**6 / 7**	**6 / 7**	**6 / 7**
	Dizziness	3 / 7	1 / 7	1 / 7	1 / 7
	Somnolence	-	-	-	-

No somnolence observed following titration through doses of 42.5 mg BID

(1) Receptor Occupancy

Phase 2 POC Trial Evaluating Darigabat in Focal Epilepsy (REALIZE): Data Expected Mid-Year 2023

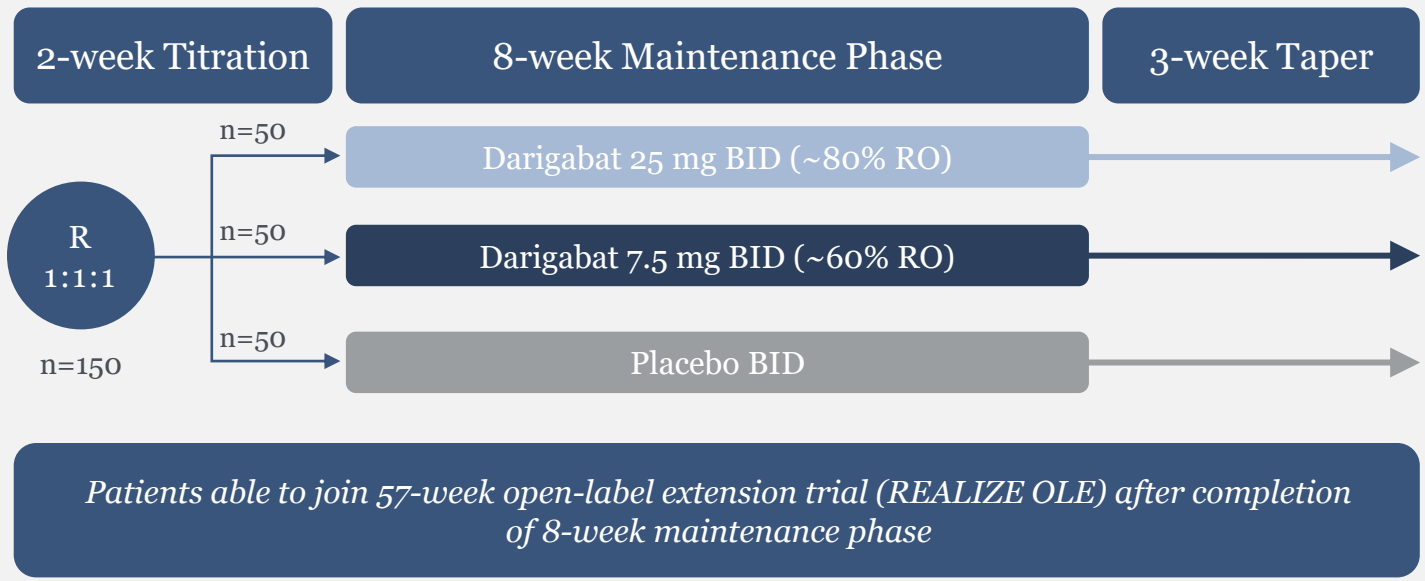
Focal epilepsy trial intended to establish proof of concept and tolerability profile to support development in broader epilepsy indications

Inclusion criteria

- Adults (18-75) with drug-resistant focal onset seizures
- History of 4+ seizures per month for at least 3 months
- 1-3 stable background AEDs allowed

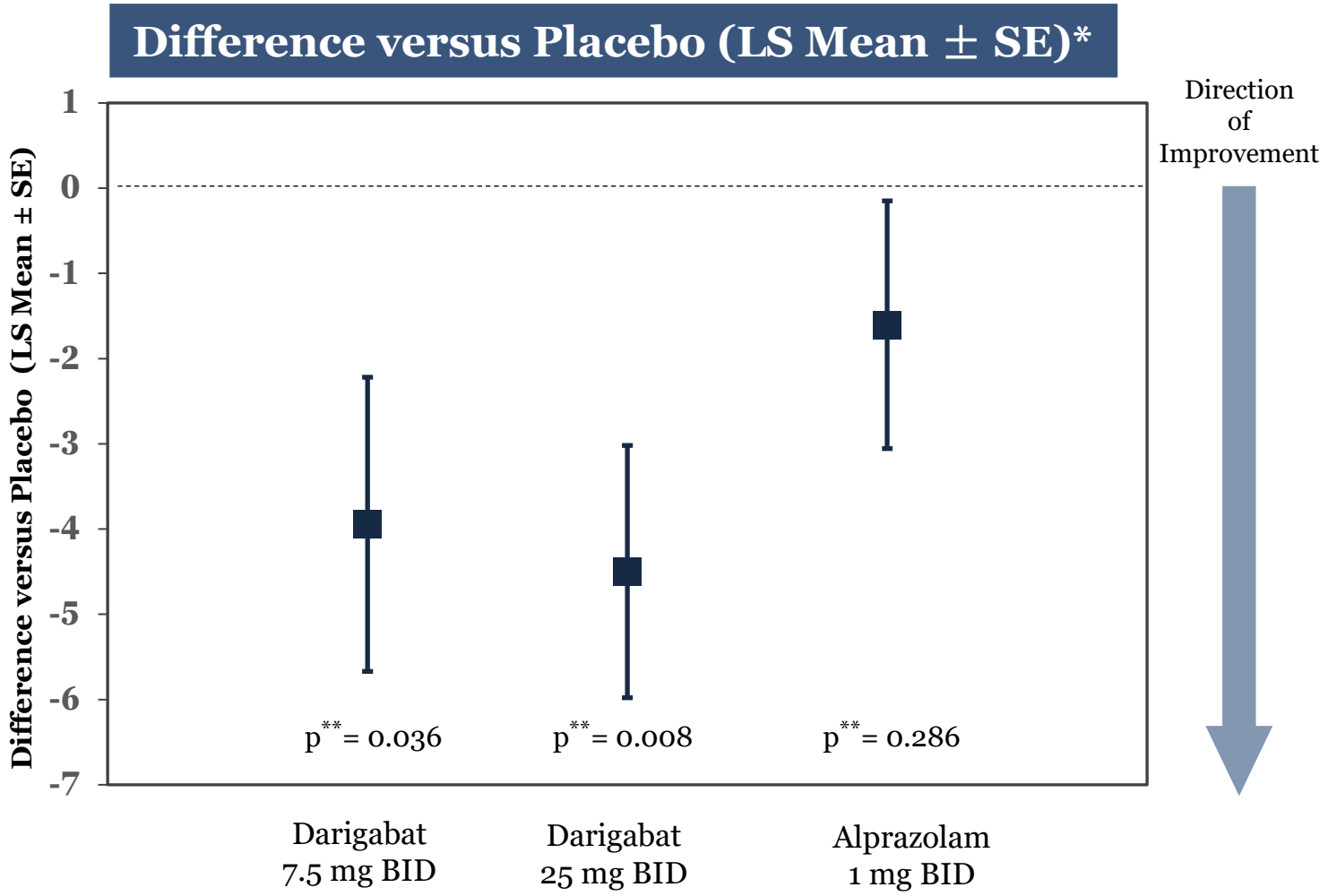
Primary endpoint

- Reduction in focal onset seizure frequency



RO = Receptor Occupancy

Positive Data in Phase 1 Acute Anxiety Trial: Change in Panic Symptoms List Score (PSL-IV) at Day 8



- **Darigabat 7.5 mg BID:**
  3.9-point improvement versus placebo at the end of 8-day treatment (9.9 on 7.5 mg BID versus 13.8 on placebo in PSL-IV total score increase following CO_2 challenge) with p^{**}=0.036
- **Darigabat 25 mg BID:**
  4.5-point improvement versus placebo at the end of 8-day treatment (12.5 on 25 mg BID versus 17.0 on placebo in PSL-IV total score increase following CO_2 challenge) with p^{**}=0.008
- **Alprazolam 1 mg BID:**
  1.6-point improvement versus placebo at the end of 8-day treatment (14.5 on alprazolam 1 mg BID versus 16.1 on placebo in PSL-IV total score increase following CO_2 challenge) with p^{**}=0.286

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* Based on a separate linear mixed effect model for each cohort with treatment, period, and sequence as fixed effects, the baseline change score as covariate, and subject within sequence as a random effect. Compound symmetry covariance is utilized. Each subject serves as his/her own control in this model.
** p-value should be considered as nominal as no hypothesis testing was planned in the protocol.

Phase 1 Healthy Volunteer Trial in Acute Anxiety: Conclusions

- **Pharmacodynamic Results**
  - Both doses of darigabat exhibited clinically meaningful and statistically significant anxiolytic activity compared to placebo based on the primary endpoint, PSL-IV total score
  - Results were supported by improvements in the secondary endpoint, VAS Fear score
  - Positive control alprazolam 1 mg BID confirmed validity of the clinical model and exhibited anxiolytic activity compared to placebo in line with expectations for the model
- **Safety & Tolerability**
  - Darigabat was generally well-tolerated in this trial, with no serious adverse events and no discontinuations in the darigabat cohorts
- **Conclusions and Next Steps**
  - Trial demonstrated the anxiolytic potential of darigabat based on reduction of acute anxiety/panic evoked by CO_2 inhalation in healthy subjects
  - Cerevel intends to advance development of darigabat in anxiety-related disorders

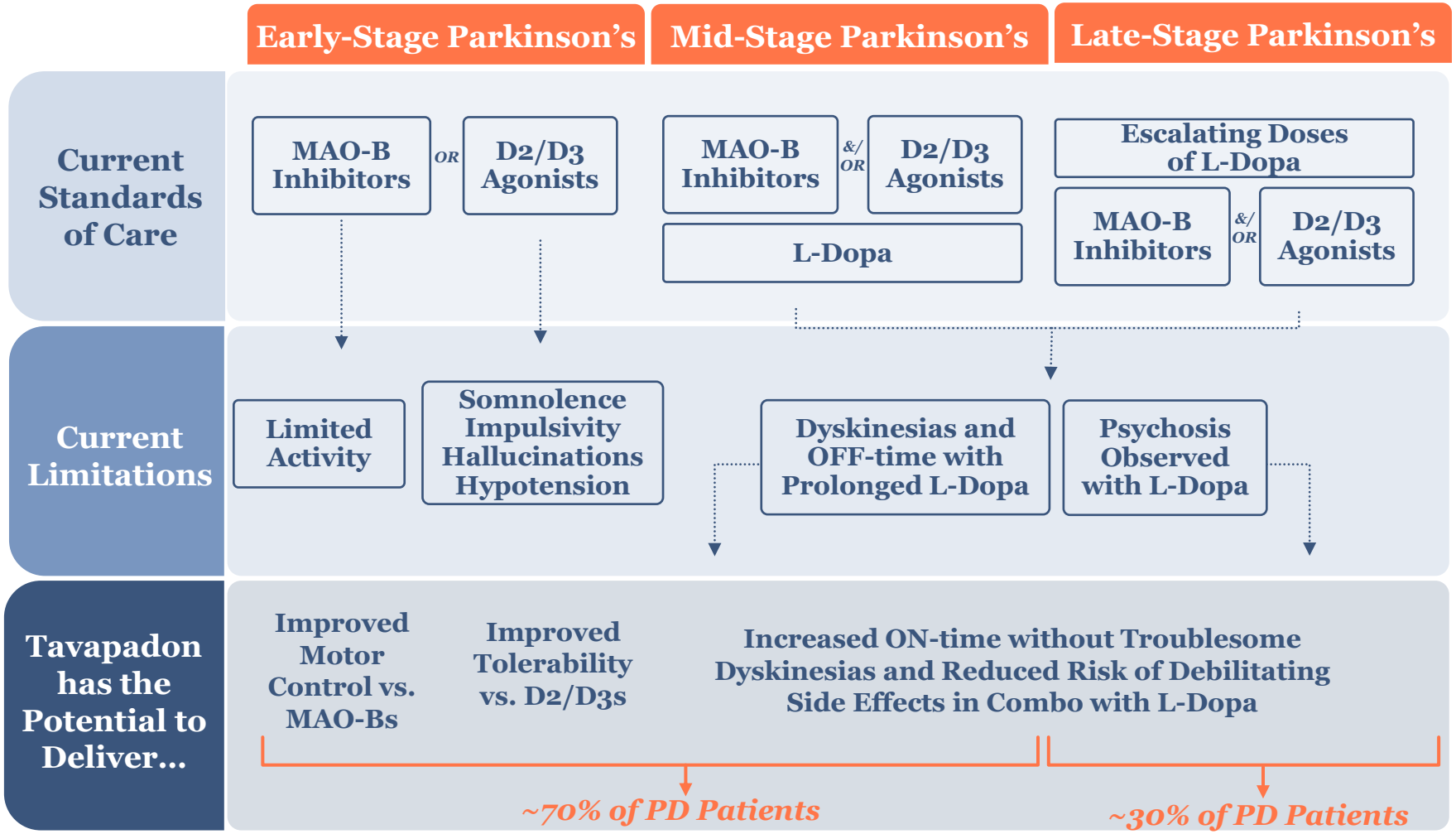
TAVAPADON

Partial agonist selectively targeting the dopamine D1/D5 receptor with the goal of enhancing motor control and improving tolerability compared to standard of care

Tavapadon Designed To Treat Patients Across All Stages of Parkinson's

Tavapadon, a Potential First-in-Class Therapy

- First and only* D1/D5 selective molecule
- First partial agonist for Parkinson's
- Selective direct motor pathway activation
- Predictable 24-hour activity

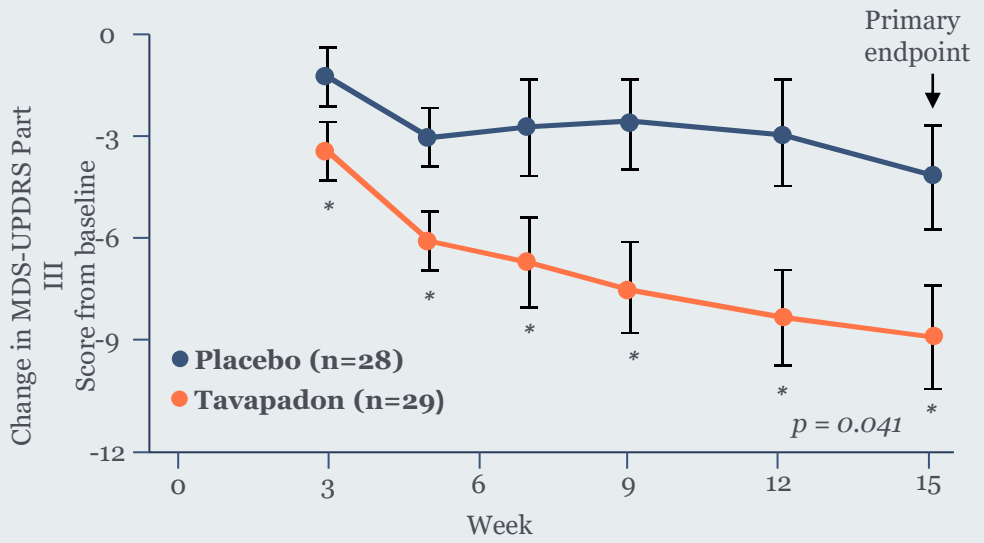


* To our knowledge

Sources: PD MED Collaborative Group. Lancet 2014; 384: 1196–205. Ahlskog JE, Mov Disord 16:448–458

Targeted Direct Motor Pathway Activation Designed To Provide Improved Treatment Option in Early Parkinson's: Phase 2 Data

Tavapadon demonstrated 4.8 point MDS-UPDRS III difference vs. placebo at week 15 (p=0.04)



Tavapadon demonstrated 5.8 point improvement over placebo at week 15 on MDS-UPDRS Part II + III (p = 0.02)

Additional Key Findings

- When adjusted to exclude patients with baseline MDS-UPDRS II of 0 or 1, **showed improvement of ~2 points over placebo on MDS-UPDRS Part II[2]**
- Most common AEs included headache and nausea (can be mitigated with titration)
- Tavapadon's incidence of known D2/D3 side effects:
  - Somnolence: 14%
  - Nausea: 31%
  - Hallucinations: 0%[3]
  - Hypotension-Related Events: 7%
  - Dizziness: 7%

Note: Average dose of tavapadon = 9 mg; 11 patients on 15 mg top dose at week 15. Baseline Part III scores of 24.3 (tavapadon) and 25.8 (placebo).

1. Study B7601011: (n=57) 15-week, Phase 2, double-blind, randomized, placebo-controlled flexible dose study to investigate the efficacy, safety, and tolerability of Tavapadon in subjects with early-stage Parkinson's Disease. Primary endpoint: Change from baseline in the MDS-UPDRS Part III total score at week 15. Allowed concomitant MAO-B inhibitors. 2. Excluding 8 participants (6 treatment, 2 placebo) with baseline MDS-UPDRS Part II scores of 0 or 1 resulted in an improvement on MDS-UPDRS II at week 15 of -2.4 points for the tavapadon arm (n=19) vs -0.6 points for the placebo arm (n=20), resulting in a placebo-adjusted difference of 1.8 points (raw data, completers at week 15). Raw data placebo-adjusted difference is 1.3 points (including 8 participants). 3. Also observed 0% hallucinations in late-stage PD Phase 2 study B7601003 as adjunct to l-dopa.

Tavapadon TEMPO-1 & -2 in Early PD: Data Expected 2H 2023

Registration-directed program includes three global Phase 3 trials optimally designed to maximize treatment effect

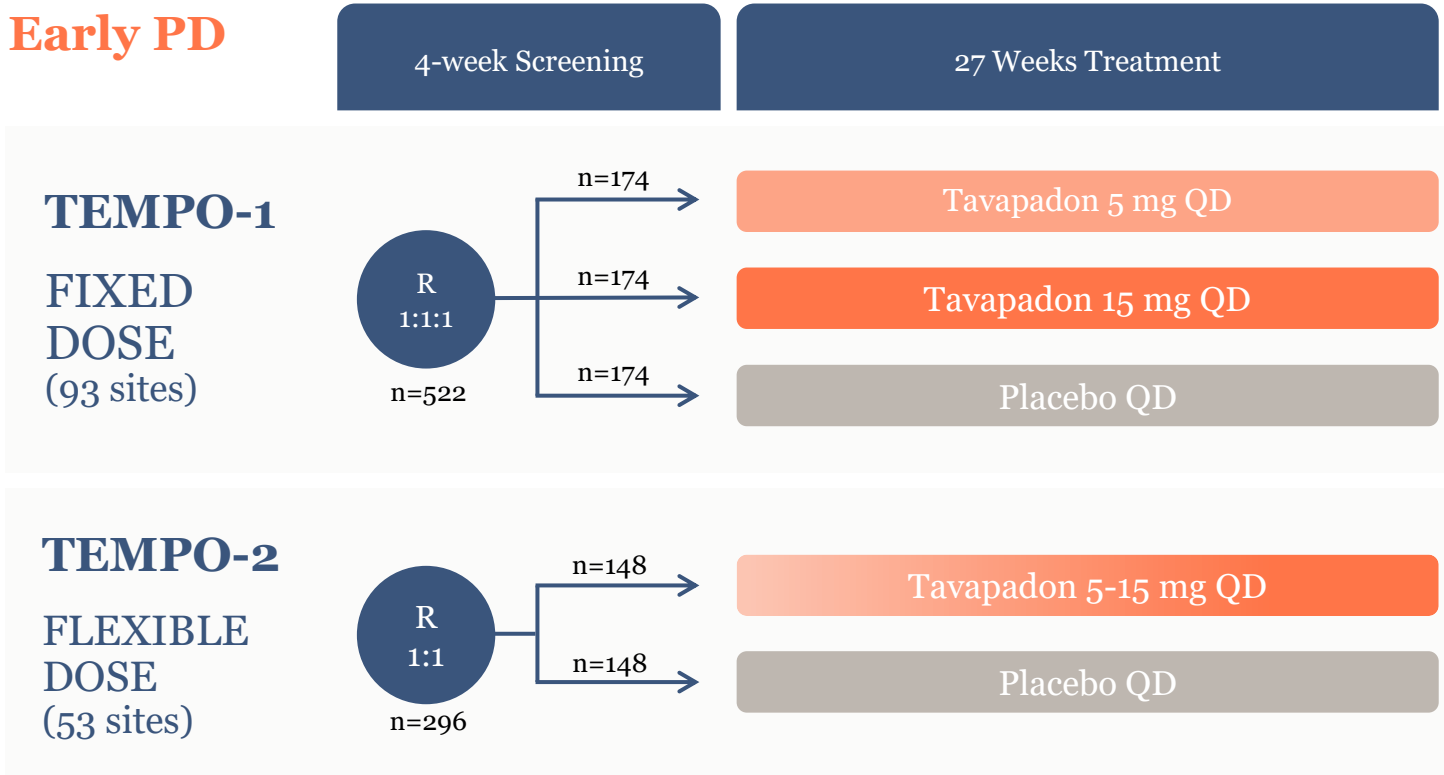
TEMPO-1 & TEMPO-2: Phase 3 in Early PD

Key inclusion criteria

- Adults 40-80 years old
- Baseline MDS-UPDRS(1) Part III Score ≥10 and Part II Score ≥2
- Modified Hoehn & Yahr(2) stage 1 to 2
- No concomitant meds except MAO-B inhibitors

Primary endpoint

- Change in MDS-UPDRS Parts II+III

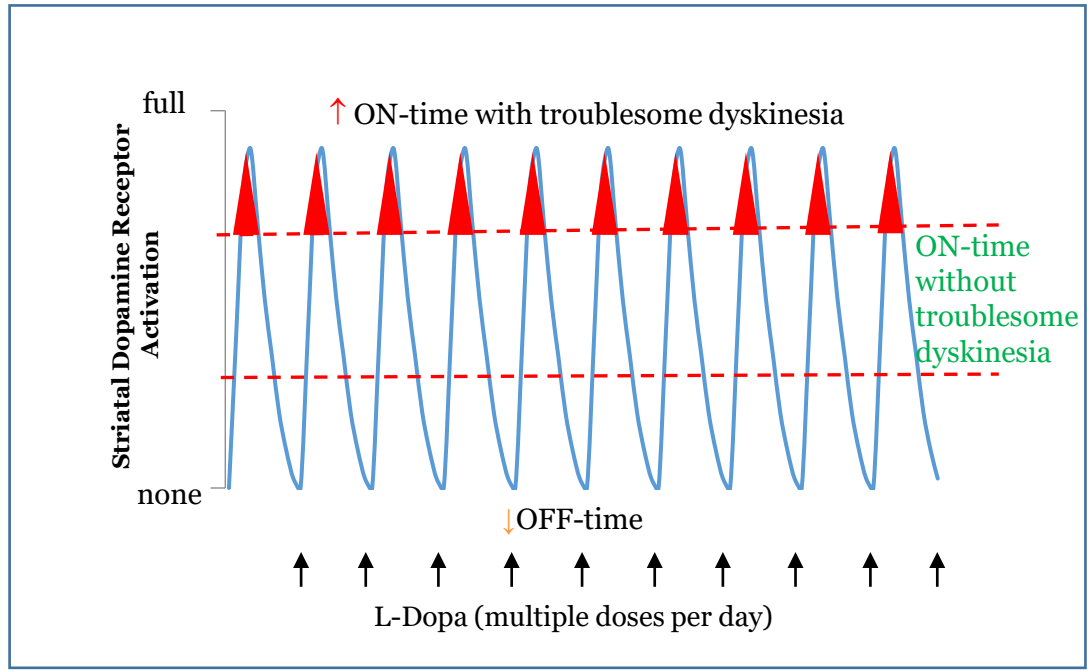


(1) MDS-UPDRS – Movement Disorder Society Unified Parkinson's Disease Rating Scale
(2) Hoehn & Yahr – staging system for characterizing the progression of symptoms for Parkinson's Disease
Note: All studies will include an open-label extension, which will further support the safety database

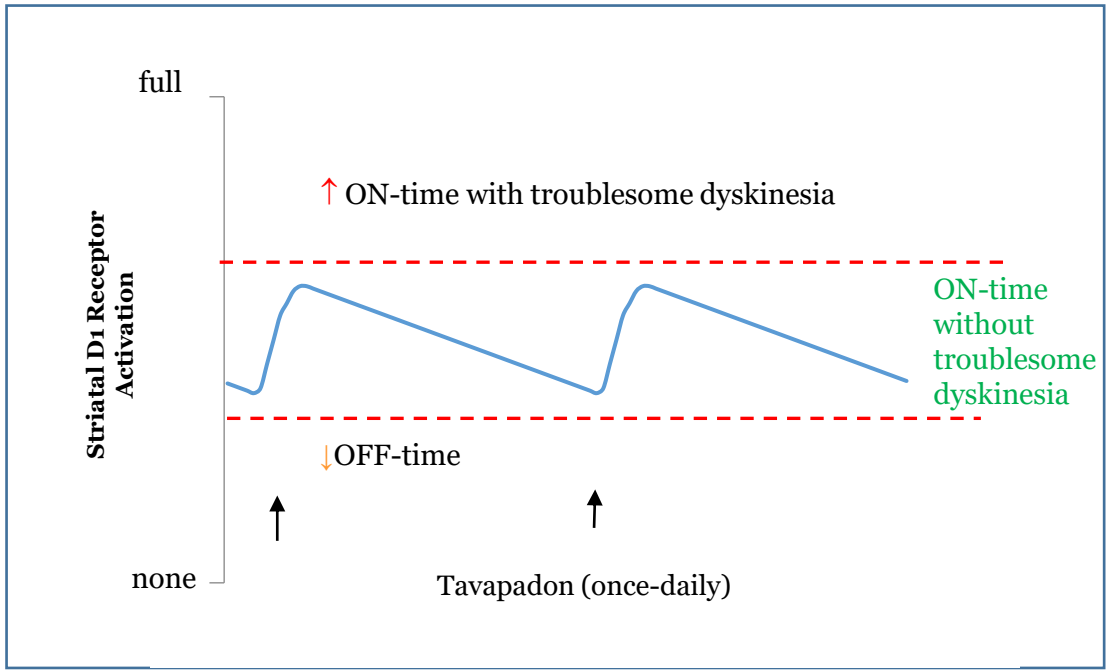
In Late PD, Goal is to Control Motor Fluctuations and Dyskinesias Driven by L-Dopa

L-Dopa vs. Tavapadon in Late-Stage PD[1]

L-Dopa is a **FULL** agonist with **SHORT** half-life



Tavapadon is a **PARTIAL** agonist with **LONG** half-life



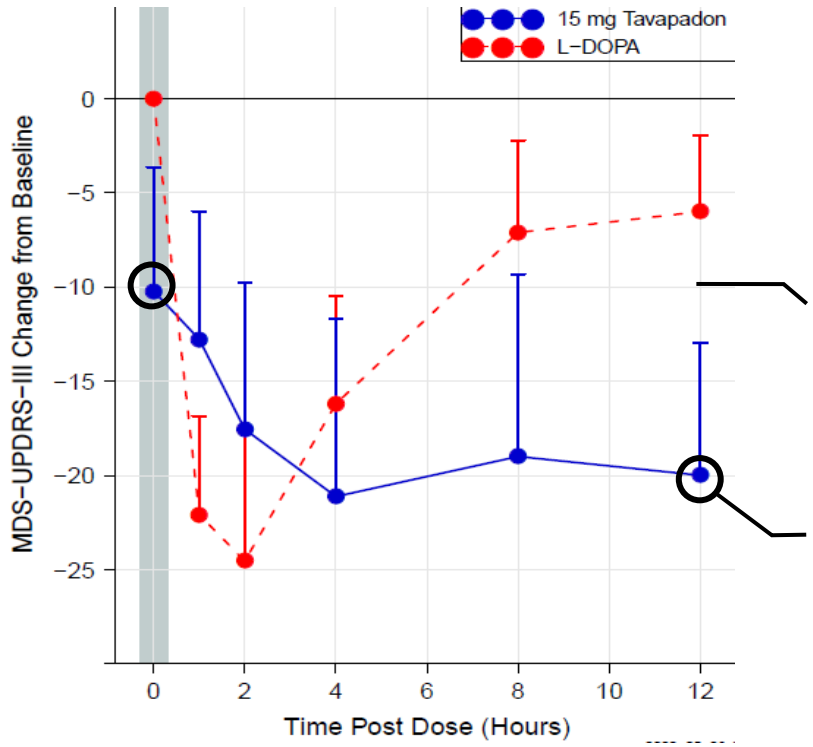
30-40% of patients experience dyskinesias within 5 years on L-Dopa[2]
40% experience OFF-time within 3-5 years on L-Dopa[2]

1) Bastide ME, et al. Prog Neurobiol. 2015;132:96-168
2) Ahlskog JE, Mov Disord 16:448–458

Predictable 24-hour Activity ➔ Sustained Effect: Once Daily, Oral Dosing

In an open-label Phase 1b trial, Tavapadon demonstrated motor improvement on par with L-Dopa, sustained due to its 24-hour half-life

Study 1005: Tavapadon in Late-Stage PD[1]



Designed to provide sustained motor benefit during crucial morning wake period…

… and throughout the day

1) Study B7601005: (n: l-dopa arm= 50, 15 mg = 11). One-sided 90% CI. Phase 1b, two-period open label dose escalation study in patients with Parkinson's disease and motor fluctuations; In period 1 of the study, l-dopa responsiveness was assessed. In period 2, levodopa was washed out and tavapadon was dosed QD over 21 days

Tavapadon TEMPO-3 in Late PD: Data Expected 1H 2023

Registration-directed program includes three global Phase 3 trials optimally designed to maximize treatment effect

TEMPO-3: Phase 3 in Late PD

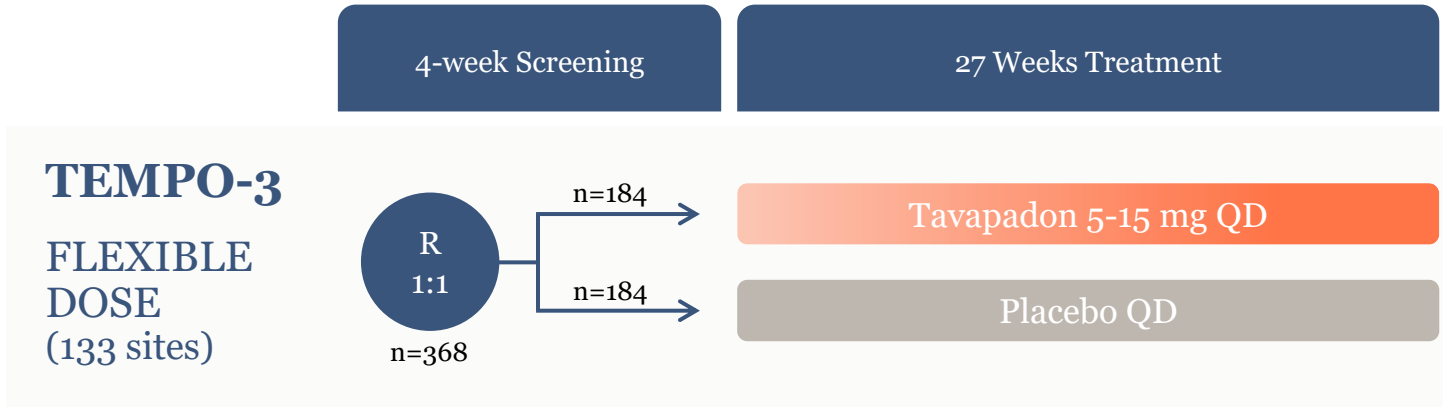
Adjunct to levodopa

Key inclusion criteria

- Adults 40-80 years old
- At least 2.5 hours OFF-time on 2 consecutive days at baseline
- Modified Hoehn & Yahr[1] stage 2 to 3, with response to L-Dopa

Primary endpoint

- Change in ON-time without troublesome dyskinesia



Appendix

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Emraclidine

Additional Slides

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M4 Receptor Activation Reduces Dopamine in the Striatum

Cholinergic Neuron

M4 Auto-Receptor

Emraclidine enhances M4 auto-receptor activation in the presence of Ach

Emraclidine (PAM)

Dopaminergic tone is reduced ***without*** direct antagonistic activity on post-synaptic dopamine receptors

M4 auto-receptor activation prevents additional Ach release

Acetylcholine (Ach)

Dopamine

Nucleus Accumbens

Nicotinic Receptors

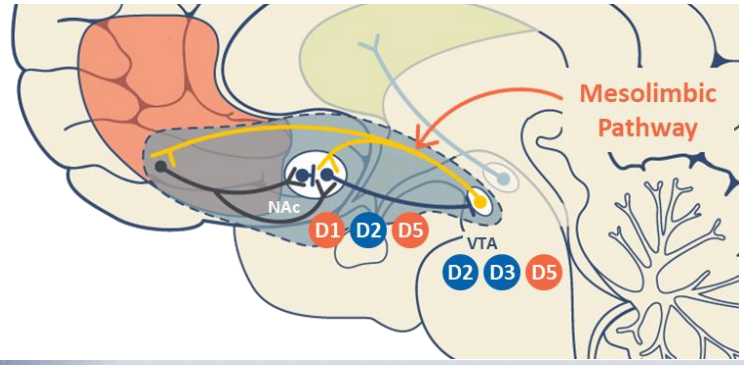
Dopamine Neuron

Originates from Ventral Tegmental Area (VTA)

In the absence of Ach, dopamine output decreases, which ***dampens hyperdopaminergic activity*** in striatum

Potential for Decreased Psychosis

Schizophrenia symptoms driven by ***overactivity of the dopaminergic*** mesolimbic pathway



Emraclidine Phase 1b Trial in Schizophrenia

Phase 1b in Schizophrenia: Topline Results

- **Clinically meaningful improvements in PANSS Total Score:**
  - 30 mg QD: -19.5 pts at week 6
  - 20 mg BID: -17.9 pts at week 6
- **Statistically significant difference in PANSS Total Score versus placebo*:**
  - 30 mg QD: -12.7 pts (p=0.023) at week 6
  - 20 mg BID: -11.1 pts (p=0.047) at week 6
- **Clinically meaningful improvements in both PANSS Positive and PANSS Negative subscales**
- **Generally well-tolerated:**
  - Discontinuation rates similar between treatment and placebo (22% for each arm including placebo)
  - Not associated with extrapyramidal side effects, akathisia, or weight gain
  - Gastrointestinal (GI) side effects were infrequent and were similar between treatment and placebo
  - Serious adverse events included COVID-19, accidental overdose (cocaine), and exacerbation of schizophrenia (one instance of each); none considered related to study medication

Emraclidine Phase 1b Trial Design

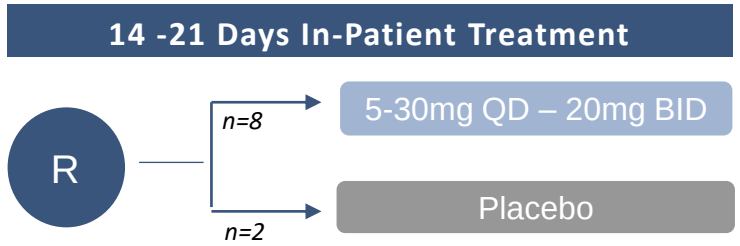
Part A: Safety Assessment

Multiple Ascending Dose

Up to 5 Cohorts (n=10 each)

Primary Objective
- Safety & tolerability

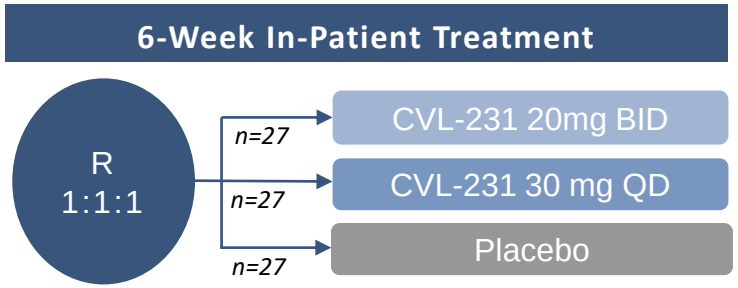
Secondary Objective
- PK



Target Patient Population
- Male and female subjects, ages 18 to 50 years
- CGI-S ≤ 4 (normal to moderately ill) at screening and Day-1
- PANSS total score of ≤ 80 at the time of screening and Day-1

Part B: Pharmacodynamics

Exploratory PD Assessment
- Positive and Negative Syndrome Scale (PANSS)*
  - PANSS Positive Score
  - PANSS Negative Score
- Clinical Global Impression – Severity Scale (CGI-S)*
- Brief Assessment of Cognition in Schizophrenia (BACS) symbol coding test*



Target Patient Population
- Male and female subjects, ages 18 to 55 years
- PANSS total score of ≥80 at screening and Day -1
- CGI-S ≥4 (moderately to severely ill) at screening and Day -1
- History of relapse and/or exacerbation of symptoms when not receiving antipsychotic treatment, excluding the current episode
- Experiencing an acute exacerbation or relapse of symptoms, with onset less than 2 months prior to screening
- Population was enriched for key positive symptoms

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* Trial not designed to demonstrate statistical significance

Phase 1b Part B: Demographics & Baseline Characteristics

	PBO N= 27	Emraclidine 30 mg QD N= 27	Emraclidine 20 mg BID N= 27	All Emraclidine N= 54	Total N= 81
Demographics					
Age (years) at Screening: Mean (SD)	41 (9.7)	41 (8.1)	38 (9.8)	40 (9.0)	40 (9.2)
% Male: N (%)	19 (70%)	23 (85%)	21 (78%)	44 (81%)	63 (78%)
Race: N (%)					
Black or African American	17 (63%)	20 (74%)	19 (70%)	39 (72%)	56 (69%)
White	9 (33%)	7 (26%)	7 (26%)	14 (26%)	23 (28%)
Other	1 (4%)	0	1 (4%)	1 (2%)	2 (2%)
Weight (kg) Prior to Dosing: Mean (SD)	90.0 (16.0)	85.4 (13.3)	85.4 (15.4)	85.4 (14.3)	86.9 (14.9)
Disease Characteristics at Baseline: Mean (SD)					
PANSS Total Score	93 (8.8)	93 (7.3)	97 (7.9)	95 (7.7)	95 (8.1)
PANSS Positive Score	24 (2.7)	25 (3.0)	26 (2.6)	26 (2.8)	25 (2.8)
PANSS Negative Score	23 (3.3)	22 (3.7)	24 (3.8)	23 (3.8)	23 (3.6)
CGI-S Score	5 (0.6)	5 (0.5)	5 (0.7)	5 (0.6)	5 (0.6)

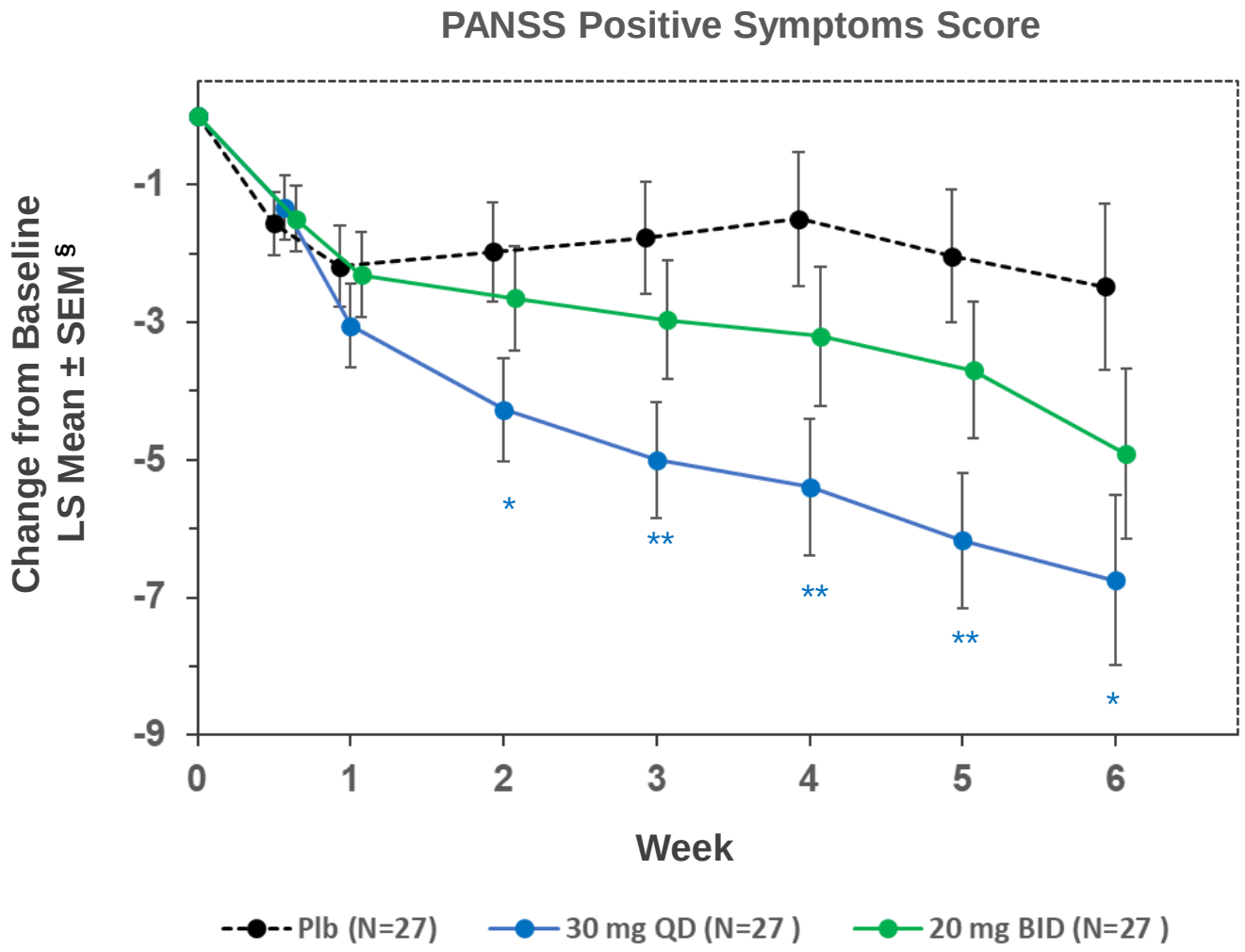
Phase 1b in Schizophrenia: Pharmacodynamic Results*

Week 6 (Day 42)	Placebo N=27	Emraclidine 30 mg QD N= 27	Emraclidine 20 mg BID N= 27	Combined Emraclidine N=54
PANSS Total Score				
LS Mean Change from Baseline	-6.8	-19.5	-17.9	-18.7
Difference vs Placebo (p-value)†		-12.7†	-11.1†	-11.9†
		p = 0.023	p = 0.047	p = 0.014
PANSS Positive Score				
LS Mean Change from Baseline	-2.5	-6.8	-4.9	-5.8
Difference vs Placebo (p-value)		-4.3	-2.4	-3.3
		p = 0.016	p = 0.166	p = 0.028
PANSS Negative Score at Baseline				
LS Mean Change from Baseline	0.1	-3.0	-3.6	-3.3
Difference vs Placebo (p-value)		-3.1	-3.7	-3.4
		p = 0.009	p = 0.002	p = 0.001

*Trial originally designed to be 59% powered to detect 7 point difference in PANSS total score vs. placebo

†Corresponds to Cohen's D effect sizes at Week 6 of -0.68 for CVL-231 30 mg QD, -0.59 for CVL-231 20 mg BID, and -0.64 for the two doses combined

Phase 1b: PANSS Positive Symptoms Score

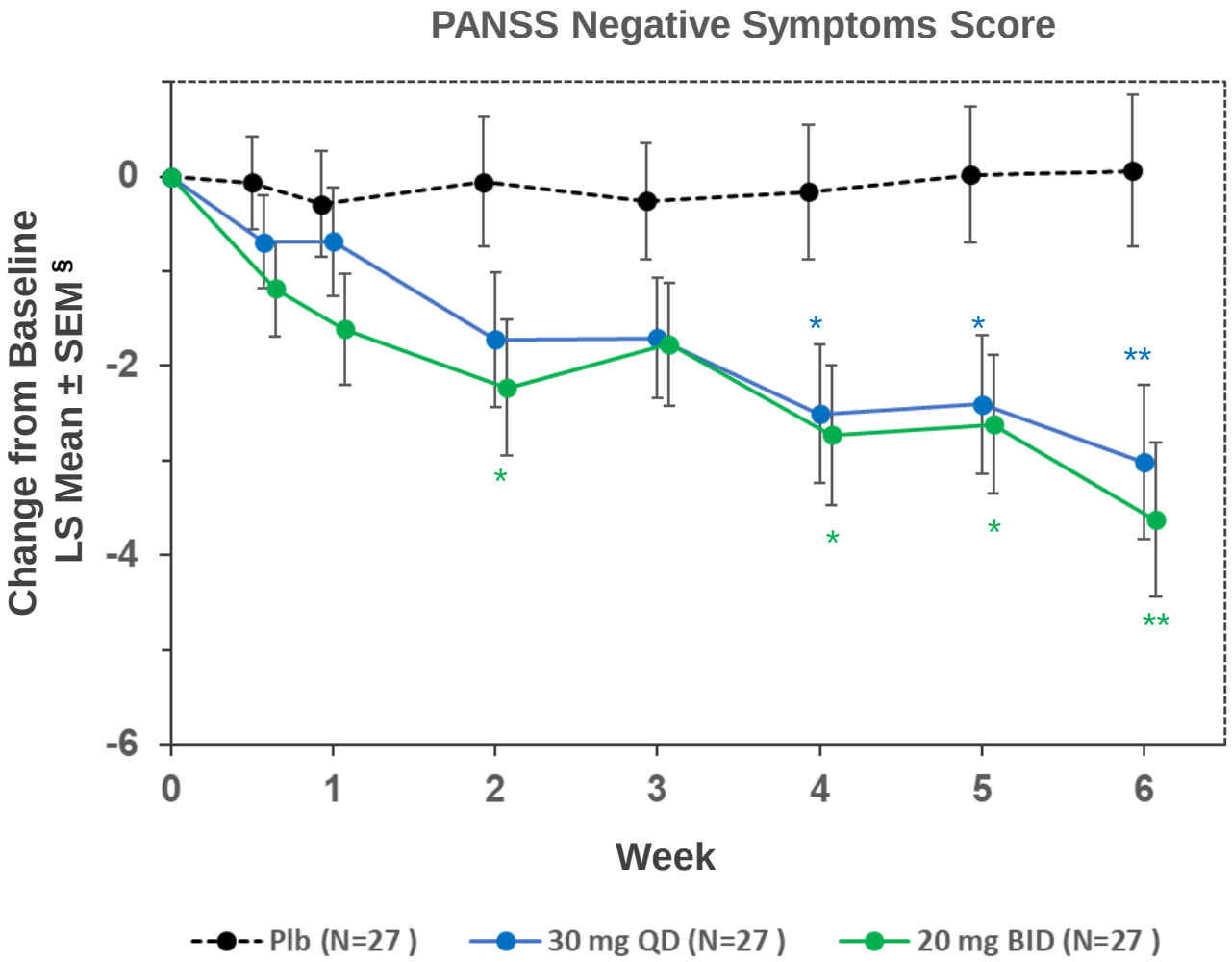


- 30 mg QD: 4.3 Point improvement versus placebo at Week 6 (6.8 of 30 mg QD vs 2.5 placebo) with P=0.016
- 20 mg BID: 2.4 Point improvement versus placebo at Week 6 (4.9 of 20 mg BID vs 2.5 placebo) with P=0.166
- Combined Emraclidine: 3.3 Point improvement versus placebo at Week 6 (5.8 of Emraclidine vs 2.5 placebo) with P=0.028

* P<0.05 vs Placebo ** P<0.01 vs Placebo

§ Derived from a mixed model for repeated measures (MMRM) with treatment group, visit, treatment group-by-visit interaction as fixed effect, baseline value as a covariate and the measurements within subject as repeated measures. An unstructured covariance matrix was used.

Phase 1b: PANSS Negative Symptoms Score



- 30 mg QD: 3.1 Point improvement versus placebo at Week 6 (3.0 of 30 mg QD vs -0.1 placebo) with P=0.009
- 20 mg BID: 3.7 Point improvement versus placebo at Week 6 (3.6 of 20 mg BID vs -0.1 placebo) with P=0.002
- Combined Emraclidine: 3.4 Point improvement versus placebo at Week 6 (3.3 of Emraclidine vs -0.1 placebo) with P=0.001

* P<0.05 vs Placebo ** P<0.01 vs Placebo

§ Derived from a mixed model for repeated measures (MMRM) with treatment group, visit, treatment group-by-visit interaction as fixed effect, baseline value as a covariate and the measurements within subject as repeated measures. An unstructured covariance matrix was used.

Phase 1b: Safety & Tolerability – Adverse Events

	PBO N= 27	Emraclidine 30 mg QD N= 27	Emraclidine 20 mg BID N= 27	All Emraclidine N= 54
Days on IMP				
Mean (SD)	37 (9.6)	36 (12.8)	35 (13.6)	36 (13.1)
Range	8, 42	4, 42	2, 42	2, 42
Number (%) Subjects with TEAE	14 (52%)	14 (52%)	15 (56%)	29 (54%)
Number (%) Subjects with TEAE Related to IMP	10 (37%)	7 (26%)	12 (44%)	19 (35%)
Number (%) Subjects with Serious TEAE	0	2 (7%)	1 (4%)	3 (6%)
Number (%) Subjects with AE of Special Interest (AESI)	3 (11%)	2 (7%)	4 (15%)	6 (11%)
Number (%) Subjects with TEAE Leading to Discontinuation of IMP	0	2 (7%)	1 (4%)	3 (6%)

Phase 1b: Safety & Tolerability - Adverse Events

Incidences of All Emraclidine ≥ 2% and > Placebo

	PBO N= 27	Emraclidine 30 mg QD N= 27	Emraclidine 20 mg BID N= 27	All Emraclidine N= 54
Number (%) Subjects				
Headache	7 (26%)	8 (30%)	7 (26%)	15 (28%)
Nausea	1 (4%)	2 (7%)	2 (7%)	4 (7%)
Back pain	1 (4%)	2 (7%)	1 (4%)	3 (6%)
Blood creatine phosphokinase increased	0	1 (4%)	2 (7%)	3 (6%)
Dizziness	0	1 (4%)	2 (7%)	3 (6%)
Dry mouth	0	3 (11%)	0	3 (6%)
Somnolence	0	1 (4%)	2 (7%)	3 (6%)
Pruritus	0	1 (4%)	1 (4%)	2 (4%)

Serious AEs (SAEs) and AEs of Special Interest (AESIs)

	PBO N= 27	Emraclidine 30 mg QD N= 27	Emraclidine 20 mg BID N= 27	All Emraclidine N= 54
Number (%) Subjects with SAE				
COVID-19	0	0	1 (4%)	1 (2%)
Accidental overdose**	0	1 (4%)	0	1 (2%)
Schizophrenia**	0	1 (4%)	0	1 (2%)
Number (%) Subjects with AESI*				
Blood pressure increased	2 (7%)	0	0	0
Heart rate increased	1 (4%)	0	1 (4%)	1 (2%)
Blood pressure diastolic increased	0	0	1 (4%)	1 (2%)
Sinus tachycardia	0	0	1 (4%)	1 (2%)
Psychotic disorder**	0	0	1 (4%)	1 (2%)
Schizophrenia**	0	1 (4%)	0	1 (2%)
Accidental overdose**	0	1 (4%)	0	1 (2%)

***AEs leading to discontinuation of treatment with IMP. No other AE leading to discontinuation of IMP*

* AESIs specified in the protocol include 1. AEs that result in the discontinuation of treatment with IMP, 2. events that satisfy the criteria for suspected Hy's Law (ALT or AST >3 × ULN, AND serum bilirubin ≥2 × ULN, AND alkaline phosphatase <2 × ULN), 3. events of heart rate >120 bpm, and confirmed by ECG, 4. events of confirmed QTcF is >500 msec or the increase from baseline is >75 msec in subjects without significant hypokalemia, 5. events of mean triplicate blood pressure reading >160 mmHg systolic or >100 mmHg diastolic with confirmation.

Safety & Tolerability

Cardiovascular AESI Summary

- Vital sign and ECG abnormalities defined in the AESI section of the protocol required immediate reporting to the sponsor for collection and risk characterization regardless of clinical significance.
  - Protocol defined CV abnormality thresholds included HR >120 bpm, systolic BP >160 mmHg, or diastolic BP >100 mmHg.
- Six (6) subjects had CV abnormality threshold AESI's reported (3 on active treatment, 3 on placebo). No subjects were symptomatic, and no events were considered clinically significant or associated with other reported AEs.

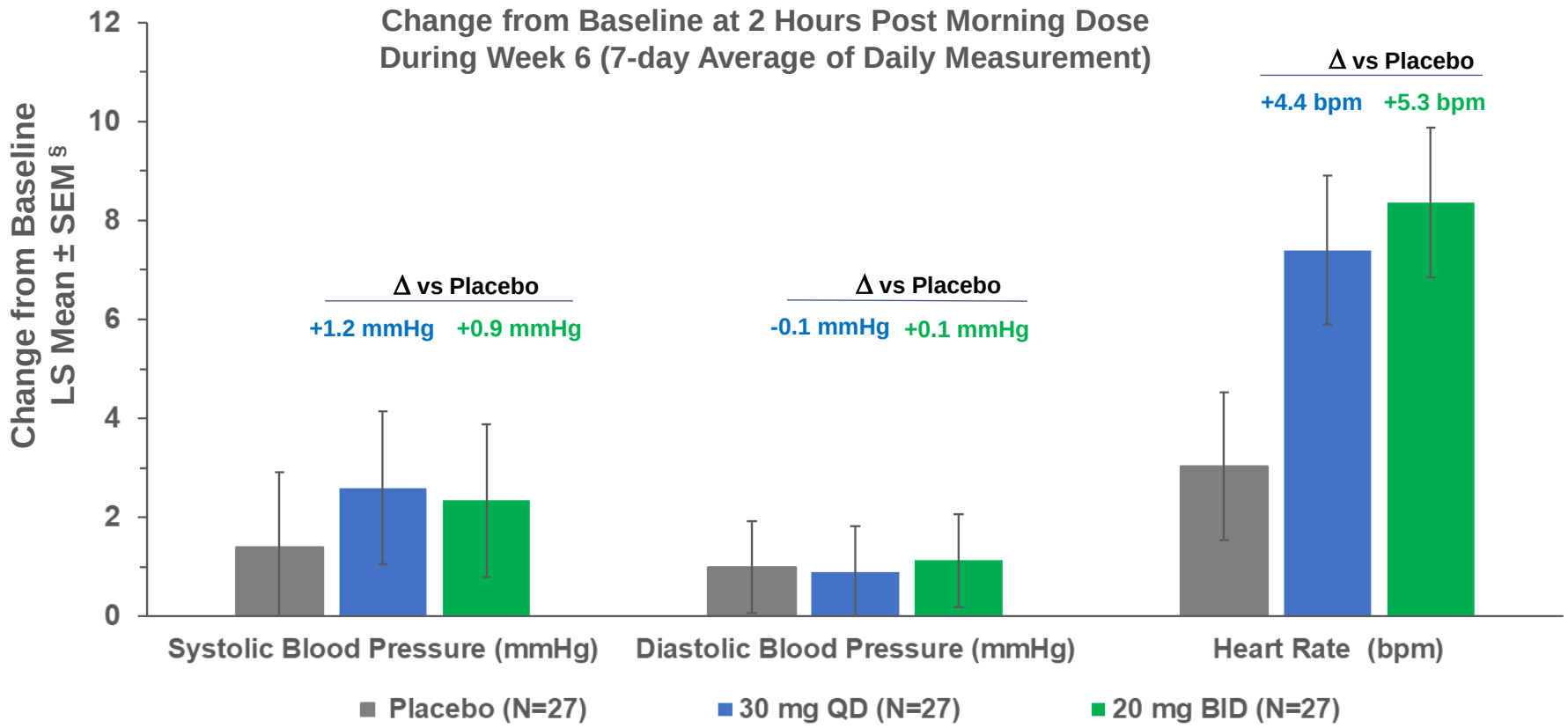
	Subject	Treatment	AESI PT (severity)	Start Date	End Date	Baseline value	Vital Sign Abnormality
Placebo	1	Placebo	Blood pressure increased (mild)	Day 23 (2 hrs post a.m. dose)	Day 23	Systolic BP: 121 mmHg	Systolic BP: 168 mmHg
	2	Placebo	Blood pressure increased (mild)	Day 10 (2 hrs post a.m. dose)	Day 10	Systolic BP: 127 mmHg	Systolic BP: 162 mmHg
	3	Placebo	Heart rate increased (mild)	Day 21 (2 hrs post p.m. dose)	Day 22	HR: 75 bpm	HR: 128 bpm
Emraclidine (20 mg BID)	4	Emraclidine 20 mg BID	Heart rate increased (mild)	Day 21 (2 hrs post p.m. dose)	Day 22	HR: 78 bpm	HR: 121 bpm
	5	Emraclidine 20 mg BID	Sinus tachycardia (moderate)	Day 1 (2 hrs post a.m. dose)	Day 1	HR: 83 bpm	HR: 123 bpm
	6	Emraclidine 20 mg BID	Blood pressure diastolic increased (mild)	Day 25 (2 hrs post p.m. dose)	Day 26	Diastolic BP: 81 mmHg	Diastolic BP: 111 mmHg
				Day 28 (2 hrs post p.m. dose)	Day 29	Diastolic BP: 81 mmHg	Diastolic BP: 103 mmHg
				Day 39 (2 hrs post p.m. dose)	Day 40	Diastolic BP: 81 mmHg	Diastolic BP: 104 mmHg

* AESIs specified in the protocol include 1. AEs that result in the discontinuation of treatment with IMP, 2. events that satisfy the criteria for suspected Hy's Law (ALT or AST >3 × ULN, AND serum bilirubin ≥2 × ULN, AND alkaline phosphatase <2 × ULN), 3. events of heart rate >120 bpm, and confirmed by ECG, 4. events of confirmed QTcF is >500 msec or the increase from baseline is >75 msec in subjects without significant hypokalemia, 5. events of mean triplicate blood pressure reading >160 mmHg systolic or >100 mmHg diastolic with confirmation.

Safety & Tolerability

Blood Pressure and Heart Rate Effects

- Modest elevations in SBP, DBP, and HR that were observed with emraclidine compared to placebo that decreased over time, with the average change from baseline during Week 6 in SBP, DBP, and HR for both the 30 mg QD and 20 mg BID groups showing no clinically meaningful difference versus placebo



§ Derived from a mixed model for repeated measures (MMRM) for weekly average with treatment group, visit, treatment group-by-visit interaction as fixed effect, baseline value as a covariate and the measurements within subject as repeated measures. An unstructured covariance matrix was used.

Darigabat

Additional Slides

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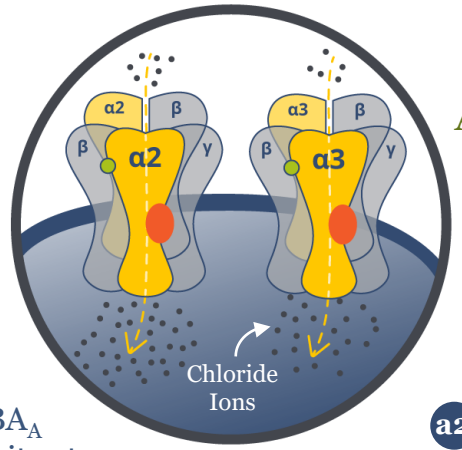
Darigabat Mechanism: Selective α2/3/5 $GABA_A$ Receptor PAM



a2 a3 a5

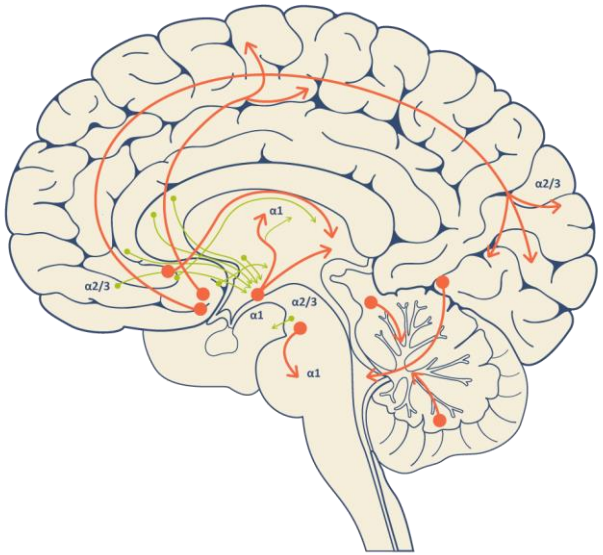
Darigabat is designed to selectively enhance $GABA_A$ receptor activity at α2/3/5 subunits

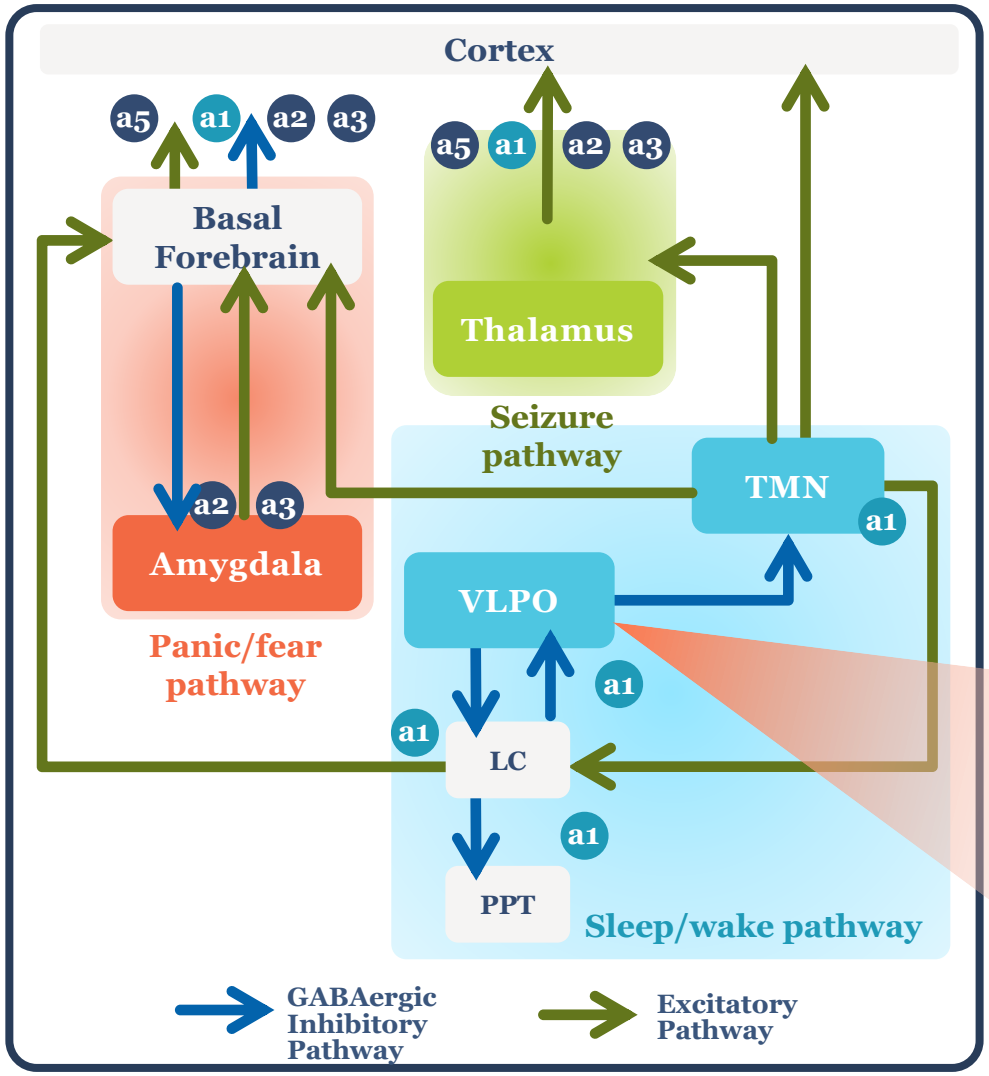
a1 a2

Anticonvulsant effect

a2 a3

Anxiolytic effect

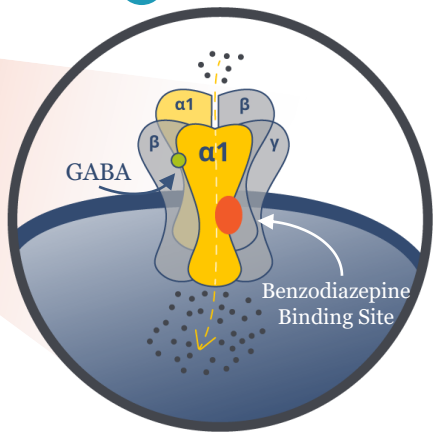




a1 Benzodiazepines ***non-selectively*** enhance $GABA_A$ receptor activity, which can cause side effects primarily driven by α1 subunit activation

- Sedation
- Cognitive impairment
- Addiction

a1 **Sedative effect**



Selective GABAA Receptor PAM: Potential for Lower Seizure Rates, Reduced Side Effects

GABA α-2/3/5 Can Differentially Address Symptoms

Darigabat

GABA subtype predicted effects:	α1	α2	α3	α5
Anti-convulsant	✓✓	✓✓		
Anxiolysis		✓✓	✓✓	
Analgesia		✓✓	✓	✓✓
Muscle Relaxation		✓✓	✓✓	
Sedation	✓✓			
Cognitive Impairment	✓✓	?	?	✓
Addiction	✓✓	✓		

Benzodiazepine side effects

Role for Targeted GABA α 2/3/5 Receptor Selectivity

- >10 benzodiazepines (BZDs - broad-spectrum GABA modulators) widely prescribed for anxiety, seizures and other indications
- Significant need for better-tolerated, less sedating and less addictive GABA modulators
- BZD Rx's increased >95% from 2003-2015

To our knowledge, darigabat is the only GABA α-2/3/5 selective PAM in clinical trials for epilepsy and anxiety

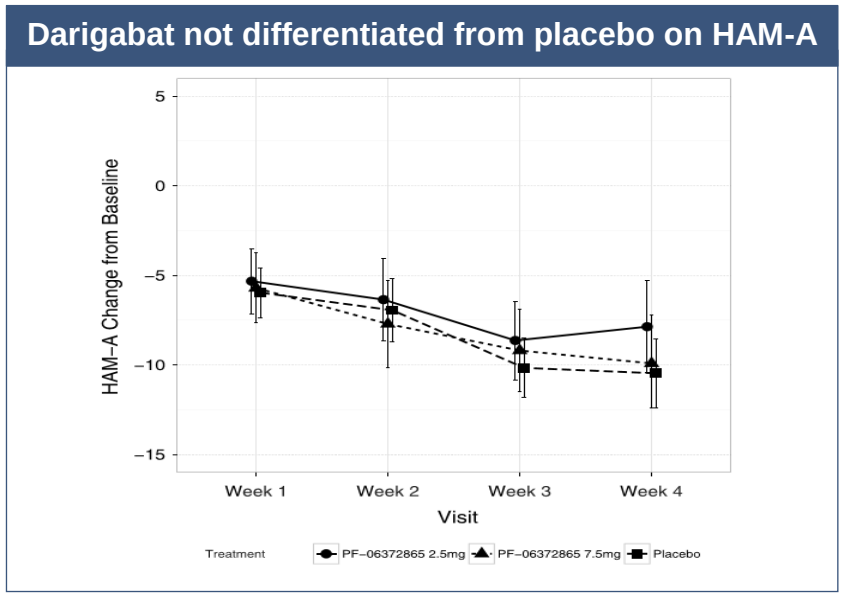
Prior Clinical Studies in Anxiety and Chronic Low Back Pain

Use of subtherapeutic doses believed to account for lack of activity in prior trials

Phase 2: Generalized Anxiety Disorder

- Included drug-resistant patients on continued background treatment
- Sequential parallel comparison design
- Primary endpoint: HAM-A (minimum score at entry 20-22)
- 4 weeks on treatment: 2.5 mg BID darigabat, 7.5 mg BID darigabat, placebo
- Study stopped early for project prioritization - 90 enrolled of planned 384

Darigabat not differentiated from placebo on HAM-A

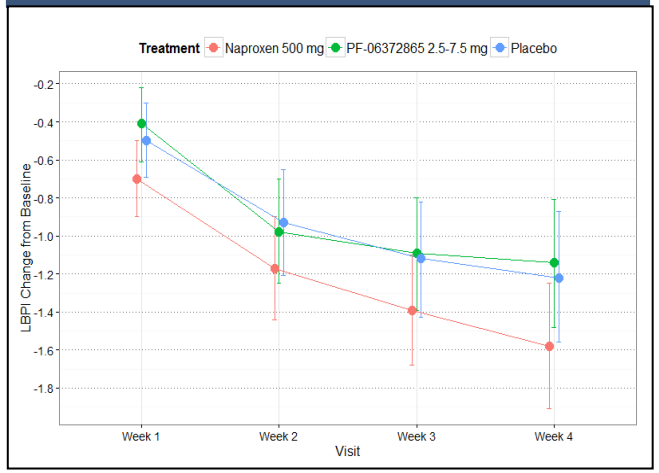


> 50% receptor occupancy remains unexplored in anxiety

Phase 2: Chronic Low Back Pain

- Included patients with > 6 months low back pain without radiculopathy
- Primary endpoint: change from baseline in low back pain score (measured on numerical rating scale)
- 4 weeks on parallel treatment: 7.5 mg BID darigabat, placebo, 500 mg naproxen BID (positive control)
- Study stopped early for futility following a planned interim analysis after 50% subjects had completed treatment

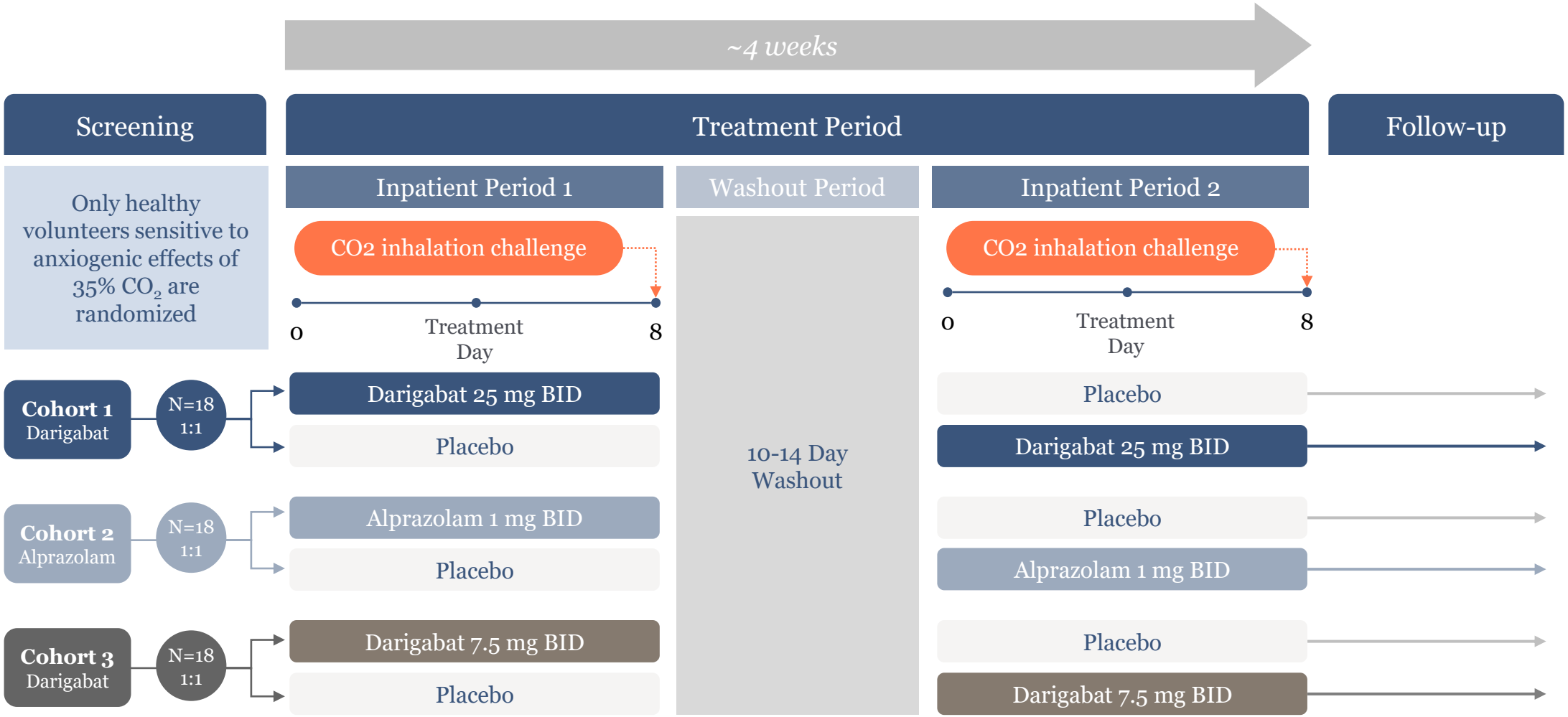
Darigabat not differentiated from placebo, naproxen



> 50% receptor occupancy remains unexplored in pain

Darigabat Phase 1 Healthy Volunteer Trial in Acute Anxiety

Trial Design: Phase 1 Trial Evaluating Darigabat in Acute Anxiety



1. The Panic Symptom List (PSL) includes 13 symptoms scored across a range of 0 (absent) to 4 (very intense) that is used to assess panic anxiety. Liebold et al. Trans Psychiatry. 2016.; Bailey et al. J Psychopharm. 2011.; Malizia et al. Arch Gen Psychiatry. 1998.; Salvatore et al. Translational Psychiatry 2020.

Phase 1 Trial of Darigabat in Acute Anxiety: Summary of Treatment Emergent Adverse Events (TEAE)

	Number (%) of Subjects*			
			Darigabat	
	Placebo (Combined) (N=56)	Alprazolam 1 mg BID (N=20)	7.5 mg BID (N=18)	25 mg BID (N=18)
Subjects with TEAE	28 (50%)	18 (90%)	13 (72%)	17 (94%)
Mild	26 (46%)	18 (90%)	12 (67%)	16 (89%)
Moderate	1 (2%)	0	1 (6%)	1 (6%)
Severe	1 (2%)	0	0	0
Subjects with Serious TEAE	0	0	0	0
Subjects with TEAE Leading to Discontinuation	1 (2%)	0	0	0
Subjects with TEAE Related to IMP	15 (27%)	17 (85%)	13 (72%)	17 (94%)

* Number of subjects with at least 1 AE reported

Phase 1 Trial of Darigabat in Acute Anxiety: Subject Disposition

Number of Subjects	Cohort 1 (Darigabat 25 mg BID / PBO)	Cohort 2 (Alprazolam 1 mg BID/PBO)	Cohort 3 (Darigabat 7.5 mg BID / PBO)	Overall
Screened				241
Randomized	18	20	18	56
Discontinued	0	2	0	2
Adverse Event	0	1[a]	0	1
Withdrawal by Subject	0	1[b]	0	1
Completed Period				
Period 1	18	20	18	56
Period 2	18	18	18	54

[a] Subject discontinued during placebo treatment period (Period 2) due to adverse event of COVID-19 infection.

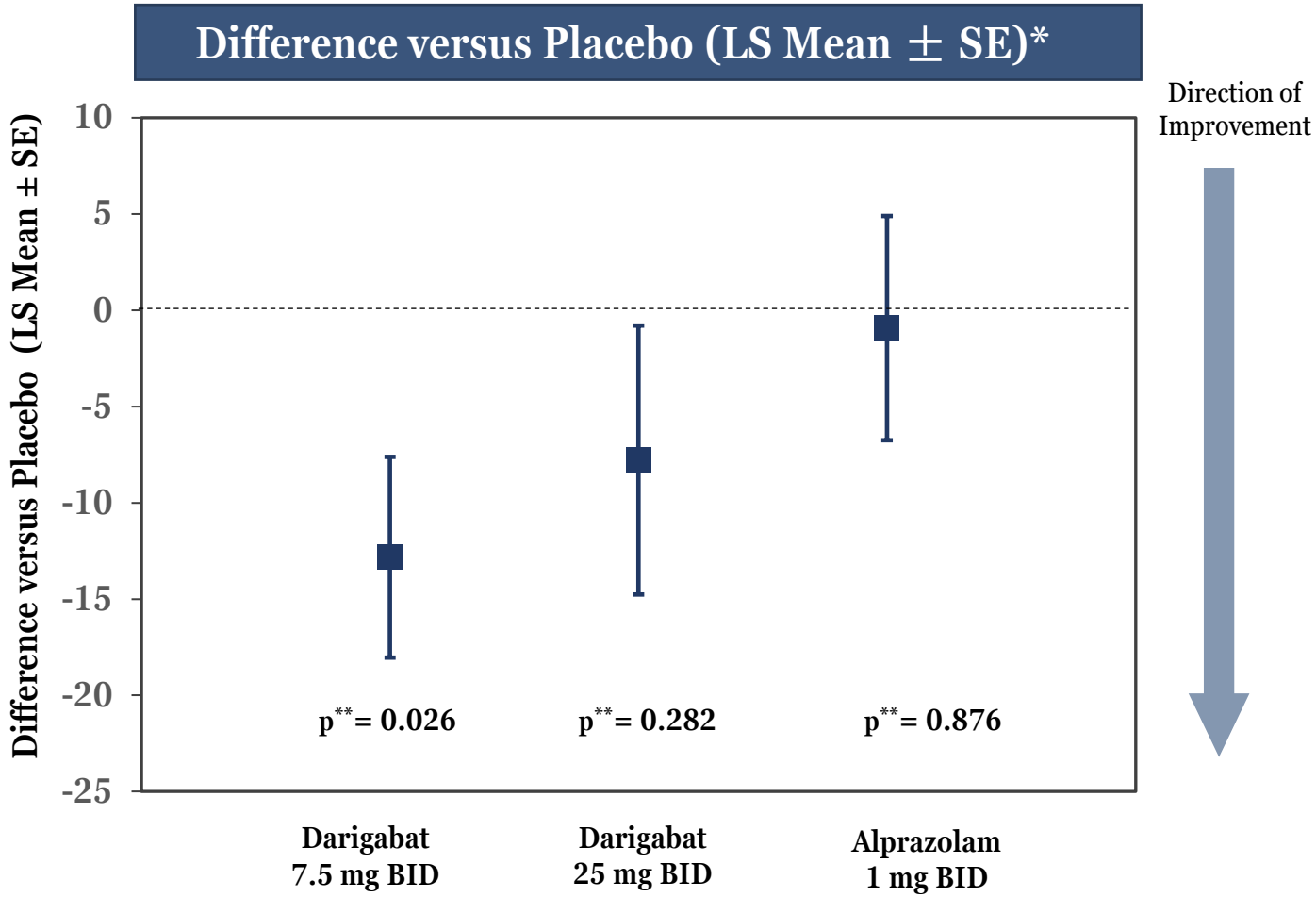
[b] Subject withdrew during placebo treatment period (Period 2).

Phase 1 Trial of Darigabat in Acute Anxiety: Demographic Characteristics*

	Cohort 1 N= 18 (Darigabat 25 mg BID / PBO)	Cohort 2 N= 20 (Alprazolam 1 mg BID / PBO)	Cohort 3 N= 18 (Darigabat 7.5 mg BID / PBO)	Overall N= 56
Age (years) at Screening				
Mean ± SD	26.4 ± 9.7	22.9 ± 4.7	27.7 ± 8.0	25.5 ± 7.8
Median	23.0	20.5	25.5	24.0
Sex N (%)				
Male	6 (33%)	6 (30%)	12 (67%)	24 (43%)
Female	12 (67%)	14 (70%)	6 (33%)	32 (57%)
Race N (%)				
Asian	0	0	1 (6%)	1 (2%)
Black	0	1 (5%)	0	1 (2%)
White	17 (94%)	18 (90%)	15 (83%)	50 (89%)
Other or Multiple	1 (6%)	1 (5%)	2 (11%)	4 (7%)
Weight (kg)[a]				
Mean ± SD	69.6 ± 14.3	68.8 ± 12.2	73.1 ± 12.0	70.4 ± 12.8
Body Mass Index (kg/m²)[a]				
Mean ± SD	23.6 ± 3.1	22.9 ± 2.9	23.0 ± 3.1	23.1 ± 3.0
Median	23.2	22.4	22.4	22.5

*Study population characteristics consistent with that expected of healthy volunteers.
Racial distribution reflects local population of the single site in the Netherlands.
[a] At screening visit.

Phase 1 Trial of Darigabat in Acute Anxiety: Secondary Endpoint - Change in Fear Visual Analog Scale (VAS) at Day 8



- **Darigabat 7.5 mg BID**:
  12.8-point improvement versus placebo at the end of 8-day treatment (23.6 on 7.5 mg BID versus 36.4 on placebo in VAS Fear score increase following CO_2 challenge) with $p^{**}=0.026$
- **Darigabat 25 mg BID**:
  7.8-point improvement versus placebo at the end of 8-day treatment (33.2 on 25 mg BID versus 41.0 on placebo in VAS Fear score increase following CO_2 challenge) with $p^{**}=0.282$
- **Alprazolam 1 mg BID**:
  0.9-point improvement versus placebo at the end of 8-day treatment (42.5 on alprazolam 1 mg BID versus 43.4 on placebo in VAS Fear score increase following CO_2 challenge) with $p^{**}=0.876$

* Based on a separate linear mixed effect model for each cohort with treatment, period, and sequence as fixed effects, the baseline change score as covariate, and subject within sequence as a random effect. Compound symmetry covariance is utilized. Each subject serves as his/her own control in this model.
** p-value should be considered as nominal as no hypothesis testing was planned in the protocol.

Adverse Events with Incidence ≥ 10%* and > Placebo with Any Active Treatments (1 of 2)

Preferred Term	Number (%) of Subjects			
			Darigabat	
	Placebo (Combined) (N=56)	Alprazolam 1 mg BID (N=20)	7.5 mg BID (N=18)	25 mg BID (N=18)
Bradyphrenia	1 (2%)	1 (5%)	2 (11%)	9 (50%)
Dizziness	1 (2%)	3 (15%)	6 (33%)	8 (44%)
Somnolence	2 (4%)	10 (50%)	4 (22%)	8 (44%)
Disturbance in attention	0	0	2 (11%)	6 (33%)
Fatigue	6 (11%)	11 (55%)	5 (28%)	5 (28%)
Headache	12 (21%)	0	3 (17%)	5 (28%)
Balance disorder	1 (2%)	2 (10%)	2 (11%)	3 (17%)
Abdominal pain upper	0	0	0	2 (11%)
Dizziness postural	0	1 (5%)	0	2 (11%)
Euphoric mood	0	0	2 (11%)	2 (11%)
Insomnia	0	1 (5%)	0	2 (11%)

* Equivalent to ≥ 2 subjects out of 18 or 20

Adverse Events with Incidence ≥ 10%* and > Placebo with Any Active Treatments (2 of 2)

Preferred Term	Number (%) of Subjects			
			Darigabat	
	Placebo (Combined) (N=56)	Alprazolam 1 mg BID (N=20)	7.5 mg BID (N=18)	25 mg BID (N=18)
Musculoskeletal pain	0	0	0	2 (11%)
Nausea	3 (5%)	2 (10%)	3 (17%)	1 (6%)
Feeling of relaxation	0	0	3 (17%)	0
Drug withdrawal syndrome	0	3 (15%)	0	0
Nasopharyngitis	1 (2%)	0	2 (11%)	0
Dry mouth	1 (2%)	0	2 (11%)	0
Abnormal dreams	0	2 (10%)	0	0
Listless	0	2 (10%)	0	0
Dysmenorrhoea	2 (4%)	2 (10%)	0	0

* Equivalent to ≥ 2 subjects out of 18 or 20

Tavapadon

Additional Slides

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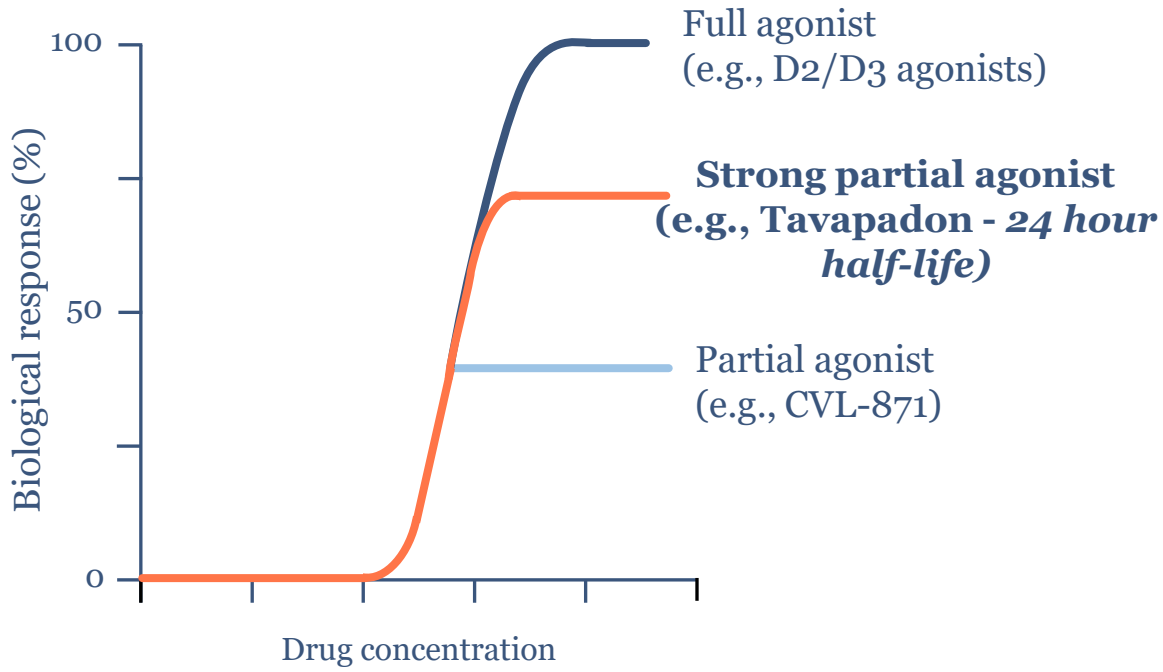
Selectively Targeting Partial Agonism Designed to Improve Motor Control and Tolerability

D1/D5 Receptor Selectivity

D2/D3 Activation *(Indirect Pathway)*	Potential Effect	D1/D5 Activation *(Direct Pathway)*
+	Motor Control	++
	Cognition	++
	Motivation / Drive	++
-	Dose-Limiting Hypotension	
-	Impulse Control Disorders	
-	Sudden Daytime Sleepiness	

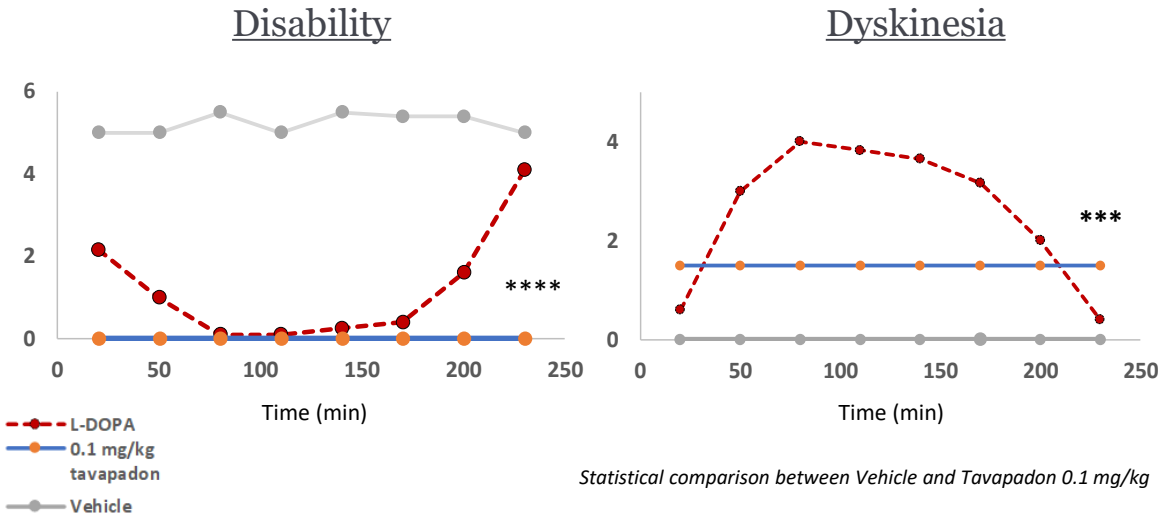
Degrees of Agonism (Illustrative)



First ***Partial Agonist*** for Parkinson's ➔ Avoids Dyskinesias

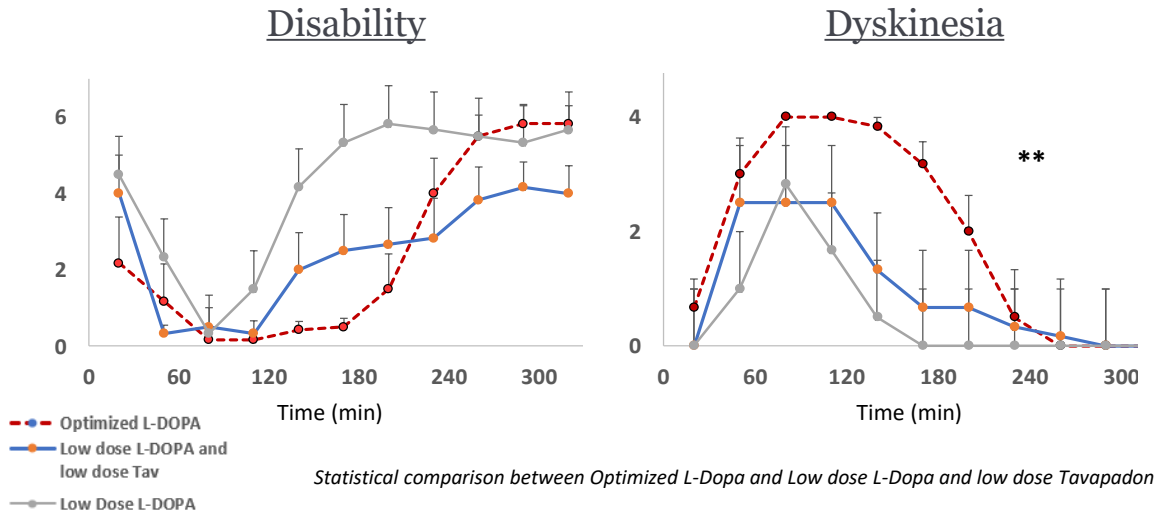
Unique and attractive combination of activity and low dyskinesias in highly translatable model of Parkinson's

Effect of Tavapadon vs. L-dopa on Disability and Dyskinesia



Statistical comparison between Vehicle and Tavapadon 0.1 mg/kg

Potential to Reduce L-dopa Dose to Achieve Motor Control with Reduced Dyskinesia



Statistical comparison between Optimized L-Dopa and Low dose L-Dopa and low dose Tavapadon

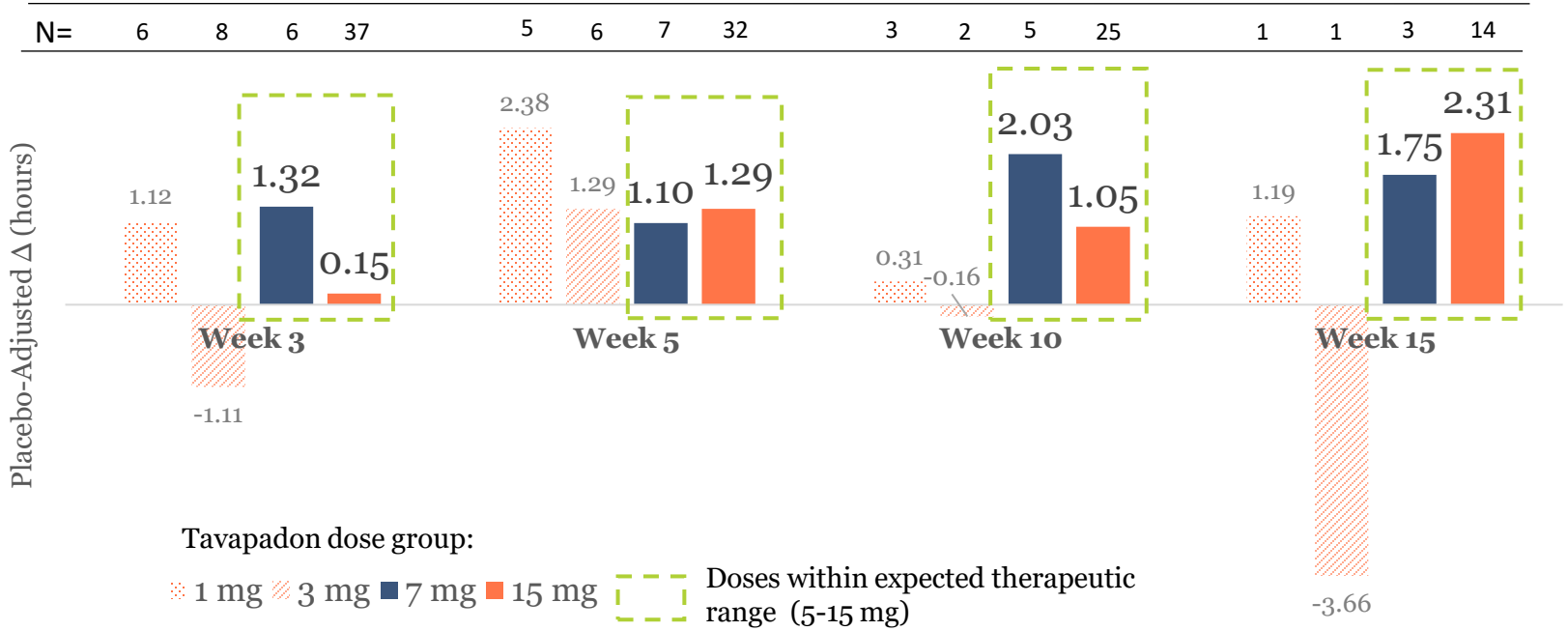
Compared to L-dopa, tavapadon robustly reduced parkinsonian symptoms in the MPTP-lesioned primate model with a more ***durable effect*** and ***lower dyskinesia*** levels

The combination of 33% L-dopa dose with 40% tavapadon dose showed ***similar activity to L-dopa alone with statistically significant reduction in dyskinesia***

Tavapadon Phase 2 Results: Clinically Meaningful ON-Time without Troublesome Dyskinesias

Tavapadon showed clinically meaningful benefit within therapeutic dose range of 5 mg to 15 mg

Tavapadon generally demonstrated at least 1 hour of improvement in ON-time without troublesome dyskinesias in late-stage PD



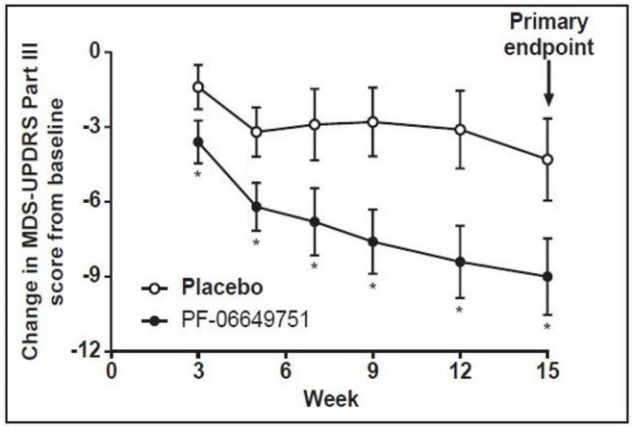
Note: Tavapadon showed -0.6 hour reduction on the primary endpoint, change in OFF-time at week 10

Phase 3 Program Designed to Show Superior Treatment Profile

Phase 2 Results Inform Phase 3 Design

Phase 2 Results

MDS-UPDRS III



MDS-UPDRS II+III

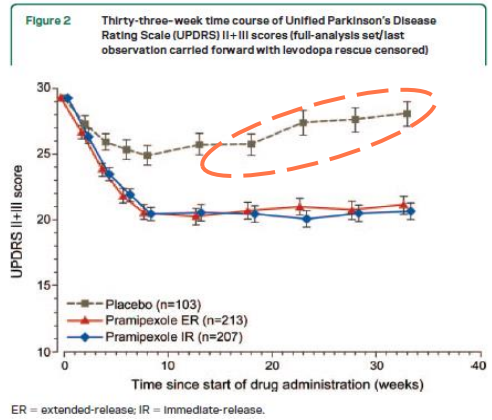
5.8 point improvement vs. placebo at week 15 on MDS-UPDRS II + III

Phase 3 Design

Baseline score of 2 or greater on MDS-UPDRS II

~2 point improvement vs. placebo on Part II, excluding participants with baseline score of 0 or 1 in Phase 2*

Placebo Attenuation at 6 Months



Further upside from forced titration to achieve maximum tolerated dose of tavapadon (less than 40% of patients were on the top dose in Phase 2)

* Based on informal post hoc analysis

Thank You

Contact:

Matt Calistri
Investor Relations
matthew.calistri@cerevel.com

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