Adagio™ MEDICAL

May 2026

B of A Securities
2026 Health Care Conference

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Forward Looking Statements

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Nabil Jubran
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VP Global Marketing & Product Management

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Adagio Medical Overview

The Only Purpose-Built Catheter for the Large, Underserved VT Ablation Market

$5.8B

VT ABLATION MARKET
Only 6% penetrated today

2.4%

LOWEST MAJOR ADVERSE EVENT RATE
vs. 18–21% for current devices

84%

FREEDOM FROM ICD SHOCK
at 6 months

350+

PATIENTS TREATED
Ischemic & non-ischemic cardiomyopathy

Q4 ’26

FDA APPROVAL EXPECTED
209 Patients 100% Enrolled; Reimbursement in Place; Breakthrough Designation

2-Year

COMPETITIVE HEAD START
Strong IP · Next-gen device in clinical trial

VT Causes Over 70% of the 300,000 Sudden Cardiac Deaths Each Year in the U.S. Alone

[1] Based on management’s analysis and calculations using internal and third-party estimates and resources, subject to certain assumptions and limitations. As of March 31, 2026.

Adagio Medical: 2026 Value Creating Milestones

Executing on Every Front – Significant Catalysts Still Ahead Before Year End

209	<11	>13	5
Patients Enrolled	Months to Complete Enrollment	Compassionate Use Cases	Remaining 2026 Catalysts

✓ Accomplished

- ✓ *Fully enrolled 209-patient FULCRUM-VT trial — under 11 months*
- ✓ *Acute results presented at VT Symposium*
- ✓ *FDA IDE approval for vCLAS Ultra (next-gen substudy)*
- ✓ *13 compassionate use cases completed, including PVCs*
- ✓ *Pivotal results presented at HRS 2026*

◎ Upcoming — Year End 2026

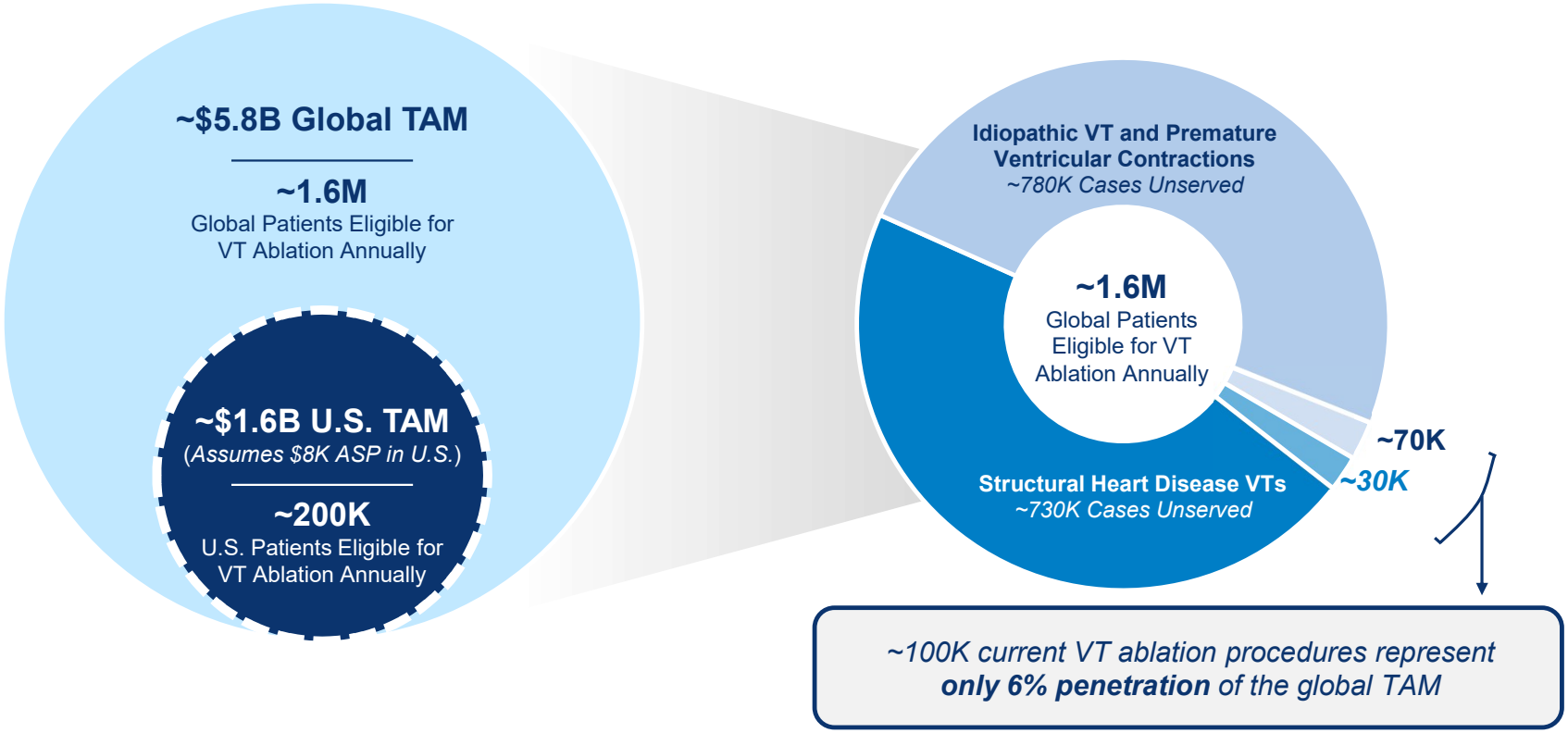
- → *First patient in — vCLAS Ultra sub-study*
- → *PMA submission to FDA for vCLAS approval*
- → *vCLAS Ultra sub-study enrollment completion*
- → *Acute results — vCLAS Ultra sub-study*
- ★ **FDA approval — vCLAS**

Building Value through Real, Achievable Near-Term Milestones

[1] Based on management's analysis and calculations using internal and third-party estimates and resources, subject to certain assumptions and limitations. As of March 31, 2026.

Estimated $5.8B Global TAM for VT Ablation

Underpenetrated Market with Meaningful Growth Potential and Established U.S. Reimbursement



Note: Market size, number of procedures and patients, and current market penetration are based on management's analysis and calculations using internal and third-party estimates and resources, subject to certain assumptions and limitations.

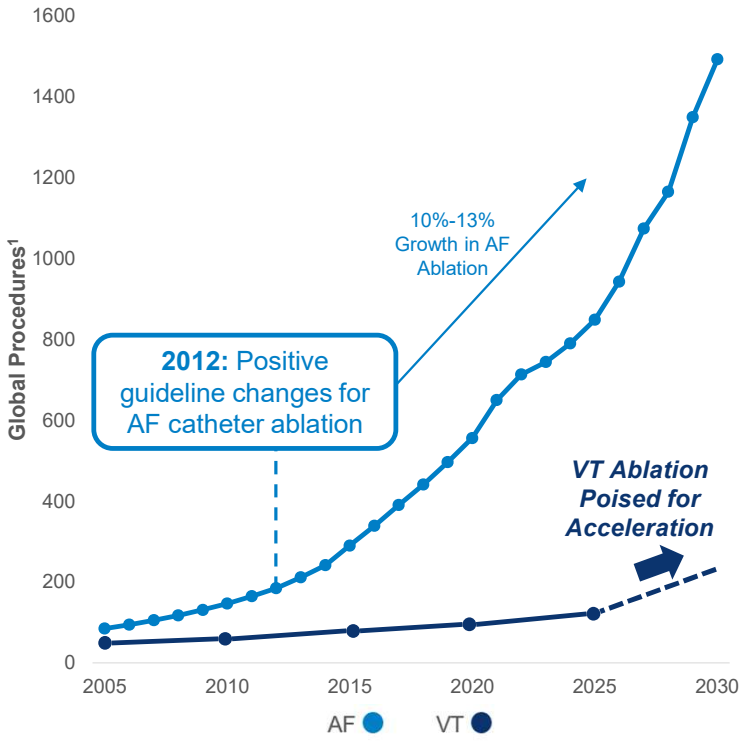
VT Market Poised for AF-Like Acceleration

Fueled by Data Supporting Guidelines and Purpose-Built VT Solution

AF: Historic 10-13% Growth[1]

- Large patient population (~12M patients)
- Significant investment in ablation and mapping technology
- Procedural standardization; stable, predictable efficacy
- Reduced complexity, complications and procedure time

Studies starting in 2010 led to guidelines now supporting AF ablation as 1st line therapy[4]



VT: Historic 5-8% Growth[1]

- Large, heterogeneous (and sick) patient population (1.6M patients)
- Market in need of purpose-built catheter addressing VT-specific requirements
  - Lower rate of complications
  - Safe ablation of large, deep lesions
  - Low-risk (endocardial) approach
  - Catheter stability
  - Hemodynamic management

VANISH 2 and PAUSE-SCD studies provide emerging evidence for VT ablation as a 1st line therapy[2,3]

1) The current catheter market size, historical and future market growth are based on management's analysis and calculations using internal and third-party estimates and resources, subject to certain assumptions and limitations.
2) Sapp JL, Tang ASL, Parkash R, Stevenson WG, et al, Catheter Ablation or Antiarrhythmic Drugs or Ventricular Tachycardia. N Engl J Med 2024 Nov 16. doi: 10.1056/NEJMoa2409501
3) Tung R, Xue Y, Chen M, Jiang C, et al. First-Line Catheter Ablation of Monomorphic Ventricular Tachycardia in Cardiomyopathy Concurrent With Defibrillator Implantation: The PAUSE-SCD Randomized Trial. Circulation. 2022;145:1839–1849
4) Ding WY, Pearman CM, Bonnett L, et al. Complication rates following ventricular tachycardia ablation in ischaemic and non-ischaemic cardiomyopathies: a systematic review. Journal of Interventional Cardiac Electrophysiology (2022) 63:59–67

Challenges of Current VT Ablation Catheters

Current Products are Repurposed Catheters Designed for Atrial Ablations

- Lack of Depth for Effective Lesions
- High Risk of Hemolysis
- Epicardial Approach Required for Deep Lesions Adds Risk
- Lack of Stability in Moving Ventricular Structures
- Irrigation Required in Fluid Compromised Patients
- Thermal Effect/Steam Pop
- Nitroglycerin Utilized to Reduce Vasospasm
- Electrical / Pulsed Current

11.5% Total Procedural Complication Rate with Current Technologies[1,2]

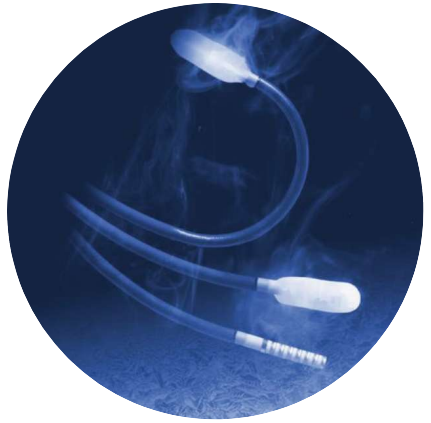
1) Ding WY, Pearman CM, Bonnett L, et al. Complication rates following ventricular tachycardia ablation in ischaemic and non-ischaemic cardiomyopathies: a systematic review. Journal of Interventional Cardiac Electrophysiology (2022) 63:59–67
2) Cheung JW, Yeo I, Ip JE, et al. Outcomes, Costs, and 30-Day Readmissions After Catheter Ablation of Myocardial Infarct–Associated Ventricular Tachycardia in the Real World. Circ Arrhythm Electrophysiol. 2018;11:e006754

vCLAS Catheter Purpose Built for VT Ablations

Clinically Tested in Patients with Ischemic and Non-Ischemic Cardiomyopathy

Overview

- Durable lesions of **titratable** depth and size
- **Endocardial ablations** of mid-myocardial scar
- **Designed to address all VTs**
- Catheter **stability** during energy delivery
- Time and effort: efficient procedures with **few lesions**
- **No irrigation** simplifies hemodynamic management
- **Open platform** works with current mapping technologies



CATHETER SPECIFICATIONS

- **15 mm long cryoablation element**
- **8 electrodes**
- **Bidirectionally deflectable**
- **Liquid nitrogen**

Ablative power to produce large footprint, depth-controlled endocardial lesions ≥10 mm, unaffected by the presence of the scar

FULCRUM-VT* Pivotal Study

84%
Freedom from ICD Shock
at 6 months

2.4%
Major Adverse Events
*vs. 10-18% for RF and PFA ablation***

72%
Reduction or Elimination of AAD
at 6 months

>50%
Reduction in Number of Lesions
*vs. RF, PFA and PFA/ RF ablation****

Overview

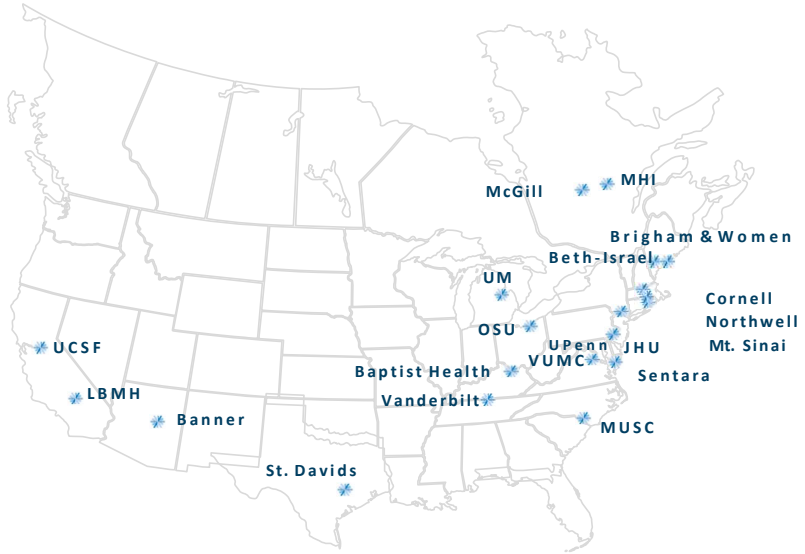
Study Design

- Single arm; 209 patients across ~20 sites
- Ischemic cardiomyopathy / Non-ischemic cardiomyopathy
- Endocardial only

Proposed Indication:

- Treatment of drug-refractory, recurrent, sustained monomorphic ventricular tachycardia in patients with ischemic or non-ischemic structural heart disease

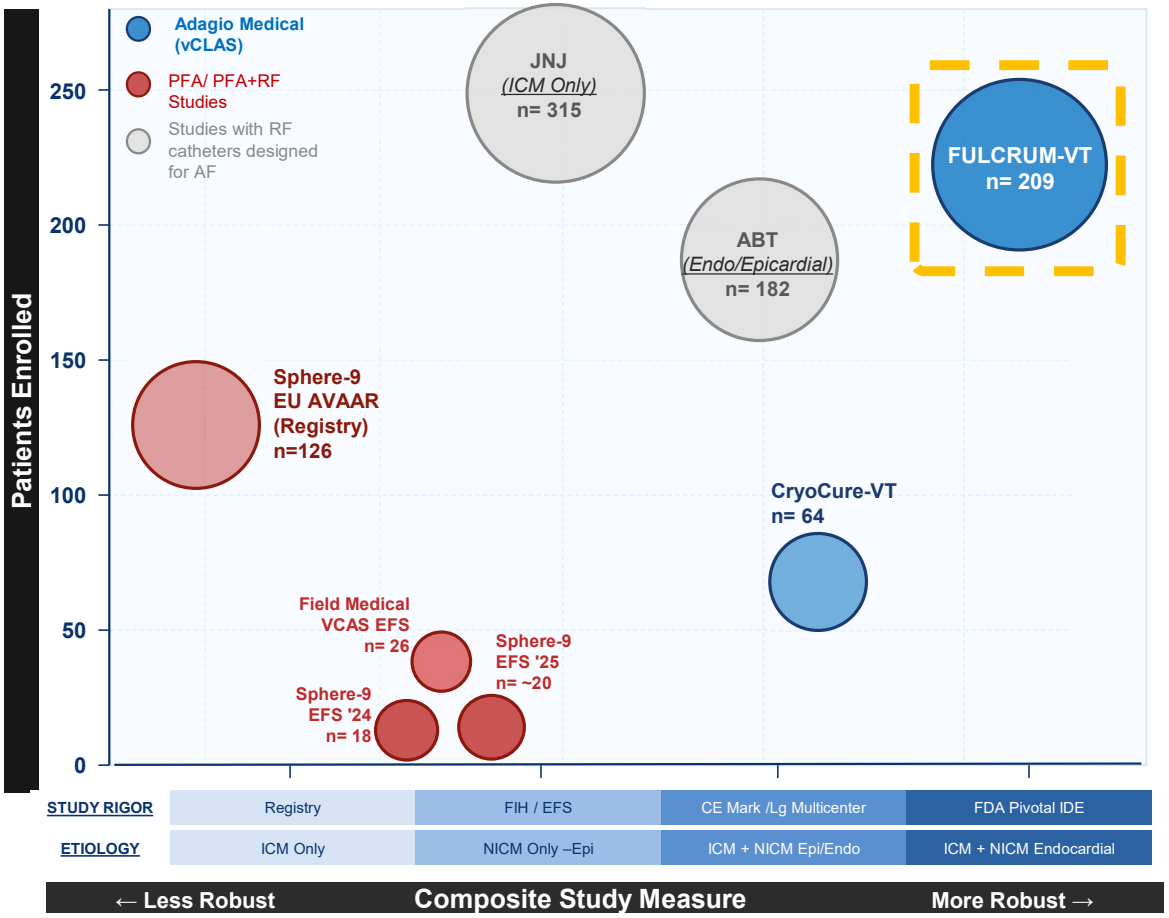
FULCRUM-VT Centers



* FEASIBILITY OF ULTRA-LOW TEMPERATURE CRYOABLATION FOR RECURRING MONOMORPHIC VT, NCT #05675865 Source: Adagio Medical CS-300. Data on File
** Excludes registry studies.
*** Per HRS 2026 late breaker sessions

Clinical Evidence Quality — FULCRUM-VT Stands Alone

Endpoints for VT Trials Have Not Been Standardized — Study Rigor / Patient Selection, Safety and Patient Scale Help Tell the Real Story



Adagio FULCRUM-VT - What We Know

- ✓ **First large-scale, rigorously executed pivotal trial in patients with both ischemic and non-ischemic cardiomyopathies**
- ✓ **20 sites, FDA IDE, independent adjudication**
- ✓ **ICM + NICM — equivalent results, endocardial only**
- ✓ **84%** freedom from ICD shock at 6 months
- ✓ **2.4%** MAEs — 5× safer than legacy RF
- ✓ **72%** amiodarone reduction or elimination

Other VT Studies – Data Interpretation Confounders

- ✗ Patient selection / procedural approaches –ICM/NICM, endo/epi
- ✗ No Controlled measure of AAD reduction or elimination
- ✗ EFS — Small numbers, underpowered, single center
- ✗ Registry — uncontrolled reporting
- ✗ No multi-site reproducibility demonstrated
- ⚠ **Multiple safety events reported**
  - ⚠ Embolic stroke, ICD generator damage from RF, 14% RF steam pops

Source: HRS 2026, Vergara et al. | Bubble size proportional to patients enrolled

Compassionate Use Cases

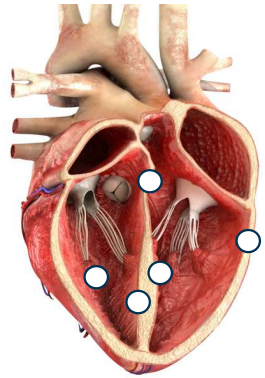
Highlights Clinical Need for vCLAS

Selected Case Details		
	Clinical Situation	**Treatment History Prior to vCLAS**
Patient 1	• Surgical repair of LV aneurism; Hypertrophic basal lateral scar	• 2 prior RF ablations, including through CS • No epicardial ablation option
Patient 2	• ARVC with moderator band VT	• 3 prior RF ablations
Patient 3	• ARVC (epicardial scar)	• 3 prior RF ablations • No epicardial ablation option due to RCA proximity
Patient 4	• Basal septal scar LV with anterior and inferior involvement • Tissue thickness 10-15 mm	• 5 prior RF ablations
Patient 5	• Hypertrophic LV with apical aneurism	• 4 prior ablations, including RF, off-label focal PFA + ethanol injection

Adagio receives vCLAS compassionate use requests regularly and cases are ongoing

Common Clinical Studies

- Multiple failed prior ablations
  - RF, PFA, Dual Energy
- Thick target tissue
- Likely mid-myocardial / sub-epicardial targets
- Lack of epicardial ablation option

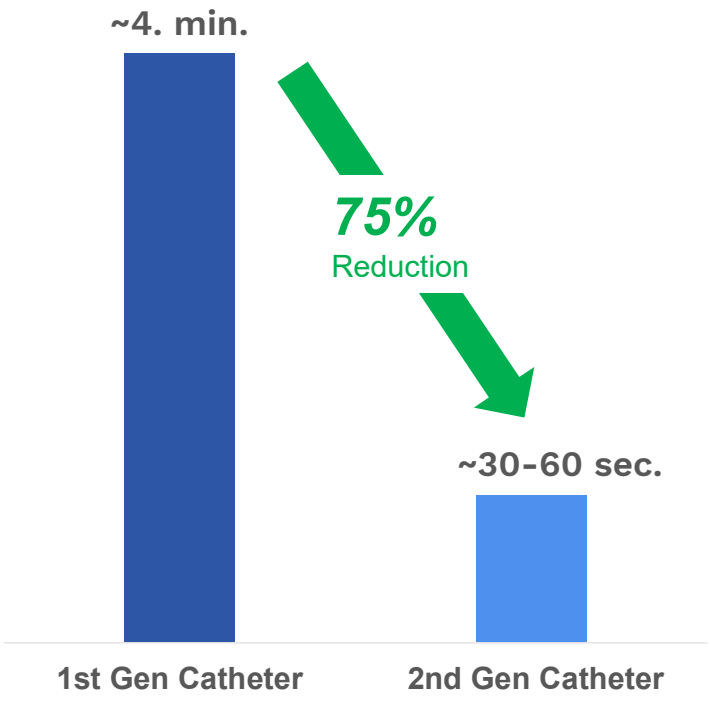


Next Generation vCLAS Ultra: Faster • Colder • Deeper

FULCRUM-VT Expansion Trial Underway

	1st Gen	2nd Gen
Sheath Compatibility	*9 Fr*	*8.5 Fr*
Shaft Stiffness Profile	*Uniform*	*Variable*
Bi-Directional Deflection	*F/F*	*D/F*
Ablation Element Length	*15 mm*	*12 mm*
Number of Electrodes	*8*	*6*
# of Freezes per Lesion	*2*	*1*
COGS	–	*> 50% reduction*

Freeze Time Per Lesion Reduction*



** K. Dyrda et al. Initial Pre-Clinical Evaluation of the Augmented Ultra-Low Temperature Cryoablation Catheter for Ventricular Ablations. J Cardiovasc Electrophysiol 2026*

Benefits of ULTA for the Patient, Provider & Physician

Purpose-Built VT Solution Without Compromise

Benefit	Patient	Provider	Physician
>80% reduction in ICD shocks	●		
>72% reduction in amiodarone dependence	●	●	
Nitroglycerin not needed — removes hypotension risk	●		
Reduced anesthesia requirements	●		●
No irrigation — shorter hospital stays	●	●	
Clinically validated safety profile	●	●	●
No ICD generator interference or valve entrapment risk	●		●
Titratable lesion depth — ischemic & non-ischemic			●
Fully endocardial approach; democratizes procedure	●		●
Low rate of 30-day readmissions	●	●	●
Single product for all VT ablation indications; streamlined inventory		●	●
Established reimbursement pathway		●	●

1) CITE FULCRUM, Compassionate use cases.

Established U.S. Reimbursement

VT Ablation Covered by Existing Codes

Existing U.S. Reimbursement

$22-27k
Inpatient (DRG) Payment Amount

~40%
% of VT Ablation Procedures

$26.7k
Outpatient (APC) Payment Amount

~60%
% of VT Ablation Procedures

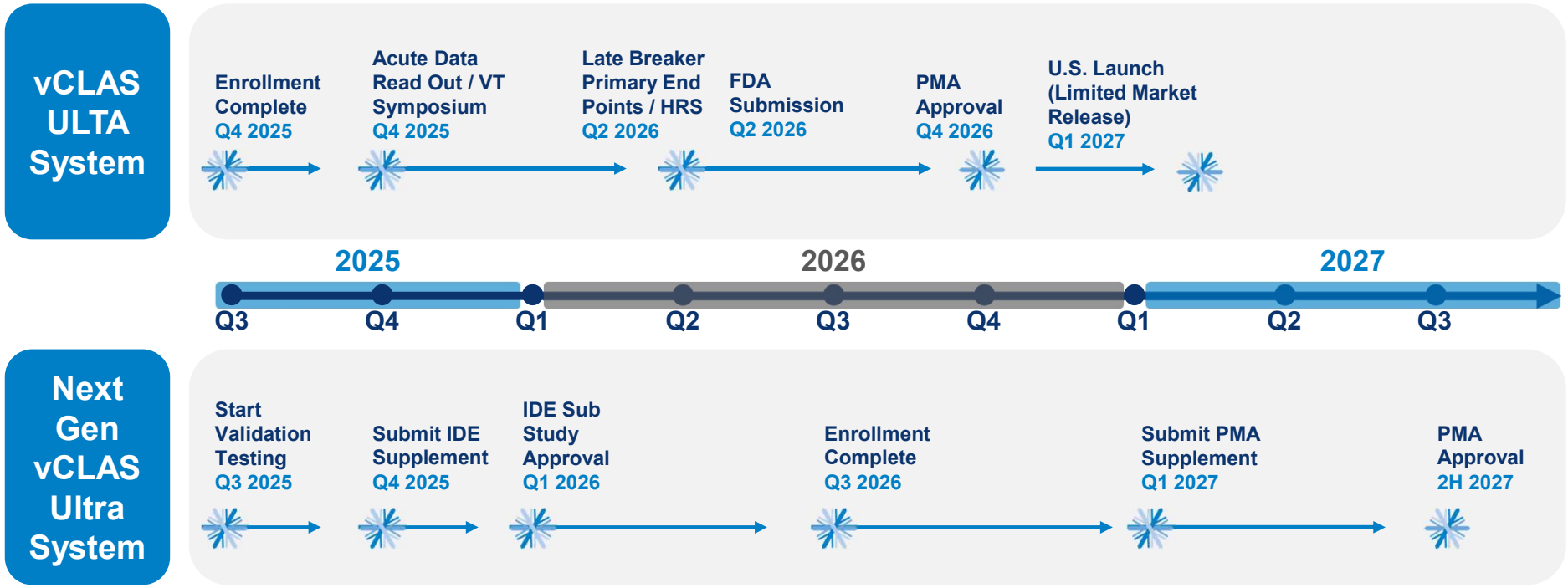
Breakthrough Designation Increases Likelihood of Additional Payment Through NTAP[1]

New Technology Add-On Payment (NTAP) for Inpatient Procedures

- Goal of NTAP is to cover the majority (up to 65%) of costs in excess of DRG[2]
- Breakthrough Designation reduces the criterion for NTAP
  - Cost – higher charge per case
  - ✓ Substantial clinical improvement – ***waived by CMS for devices with Breakthrough Designation***
  - ✓ Newness – ***waived by CMS for devices with Breakthrough Designation***

1) The incremental payment gets added to the standard payment for the intervention
2) Payment amount varies and depends on hospital specific charges and metrics

Anticipated Regulatory Timeline & Major Milestones



Select Financials and Capitalization

($ in millions)	At 03/31/26
Cash and Cash Equivalents	$12.9M
Convertible Notes Payable (including accrued interest)	$22.9M
Shares Outstanding	22.2M
Total Base Warrants ($10 ex. price)	7.5M
Total Convert Warrants ($25 ex. price)	1.5M
Total PIPE Warrants ($1.71 ex. price)	18.0M
Total Pre-funded PIPE Warrants	3.0 M

Transformational October 2025 PIPE of up to $50M

To Advance vCLAS and vCLAS Ultra Through FDA Approval and Commercialization

October 2025 Financing of Up to $50 Million

Adagio closed a private investor confidence in our proprietary, disruptive technology for VT and validating our product and FDA pathway

- **$19 million** in upfront funding
- **$31 million** tied to achievement of ***3 milestones*** ($10 million each) each expiring upon the earlier of 5 years or 30 days following the achievement of each milestone:

1.	Pivotal Data Readout	✓ *Achieved April 26, 2026*
2.	FDA Approval of vCLAS 1st generation ULTA technology	*Expected by Year End 2026*
3.	FDA Approval of vCLAS Ultra next-gen ULTA technology	*Expected by Year End 2027*

Full warrant exercise already assumed in fully diluted share count

Validation From Leading Healthcare Investors

PERCEPTIVE ADVISORS

ADAR1 Capital Management

SIO CAPITAL MANAGEMENT LLC

Additional leading healthcare investors

Investment Highlights

- Two-Year Lead with Purpose Built Catheter to Address VT Ablations without Compromises
- Addressing Underserved, 6% Penetrated, $5.8 Billion VT Ablation Market[1]
- Best-in-Class Results from Rigorous CRYOCURE-VT and FULCRUM-VT Studies
- FDA Approval of vCLAS as First Approved Purpose-Built VT Catheter Expected Q4/2026
- Breakthrough Device Designation from FDA
- Next Gen ULTA Addressing Evolving Needs of Market Enrolling; FDA Approval Expected Late 2027
- Established Reimbursement with VT Ablation Covered by Existing Codes

1) Market size and current market penetration are based on management's analysis and calculations using internal and third-party estimates and resources, subject to certain assumptions and limitations.

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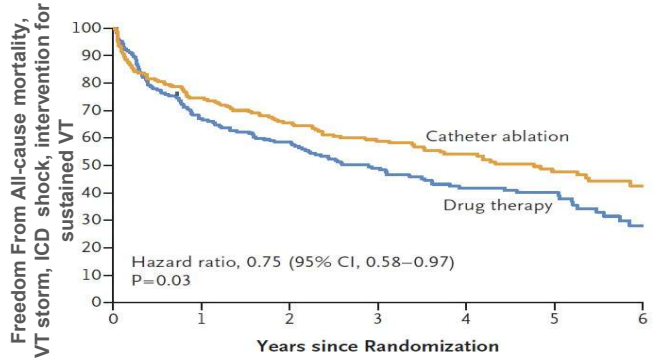
Appendix

Clinical Evidence Supporting VT Ablation as First Line Therapy is Building

VANISH-2[1]

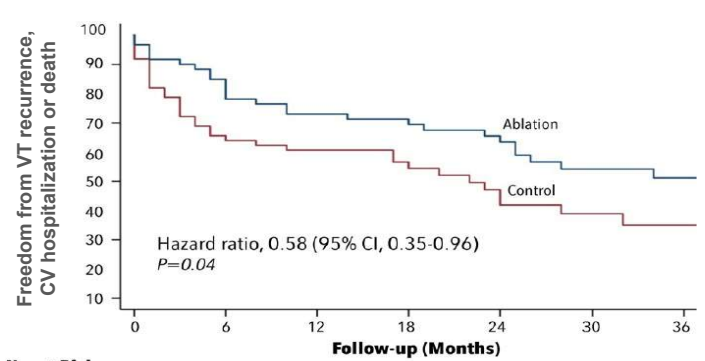
Ablation *vs* ***Antiarrhythmic Drugs (AAD)*** *in post-myocardial infarction implantable cardioverter-defibrillators (ICD) patients with prior VT events*



- Randomized trial with results published in November 2024
- Trial compared VT ablation to AAD as first-line therapy
- Study found ablation to be superior to AAD (p=.03)

PAUSE-SCD[2]

Prophylactic ablation + ICD *vs* ***AAD + ICD*** *in secondary prevention or inducible primary prevention patients*



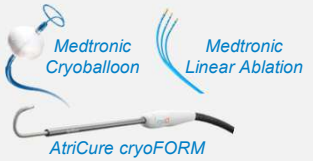
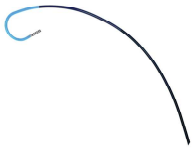
- Randomized trial published in May 2022 compared VT ablation to AAD as first-line therapy at ICD implantation
- Study found early catheter ablation reduced outcomes of VT recurrence, cardiovascular hospitalization, or death

Cardiac ablation appears superior to AAD as both prophylaxis and response to VT events in ICD population

1) Sapp JL, Tang ASL, Parkash R, Stevenson WG, et al, Catheter Ablation or Antiarrhythmic Drugs or Ventricular Tachycardia. N Engl J Med 2024 Nov 16. doi: 10.1056/NEJMoa2409501
2) Tung R, Xue Y, Chen M, Jiang C, et al. First-Line Catheter Ablation of Monomorphic Ventricular Tachycardia in Cardiomyopathy Concurrent With Defibrillator Implantation: The PAUSE-SCD Randomized Trial. Circulation. 2022;145:1839–1849

ULTA vs. Traditional Cryo

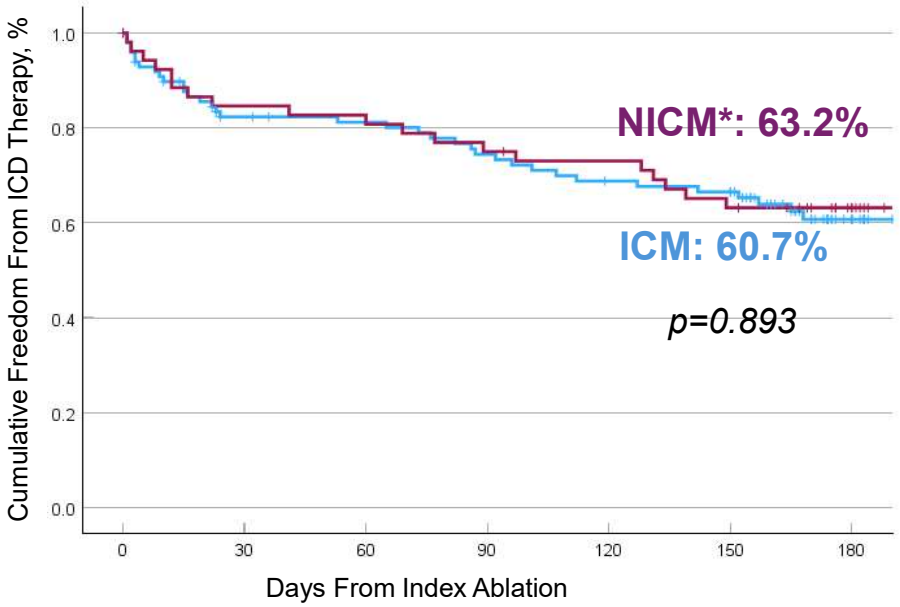
Comparison of Cryogens Used in Medical Devices for Cardiac Applications

Device	Example	Cryogen	Approx. Min. Cryogen Temp.	Approx. Ablation Element Temp.	Cooling Power	Use Case	Lesion Depth	Limitations / Advantages
Traditional Cryo (Nitrous Oxide-Based)	 *AtriCure cryoFORM*	Nitrous oxide	-85°C	-60°C	Low	**Endocardial; limited to atrial applications**	**Shallow; ineffective for ventricular ablation**	X Requires occlusion of flow; not suitable for thick myocardial tissue
ULTA	 *Adagio vCLAS*	Near-critical nitrogen	-195°C	-145°C	High	**Endocardial including ventricular ablation**	**Deep; effective even in high-perfusion areas**	✓ **Enables durable lesions in thick myocardial tissue**
Next Gen ULTA	 *Adagio Next Gen*	Critical Nitrogen with on-tip expansion cooling	-195°C	-170°C	Very High	**Endocardial and ventricular ablation**	Deep; effective in high perfusion areas	✓ **Shorter ablation times due to enhanced thermal gradient** ✓ Lower operating pressures improve procedural safety ✓ Optimized lesion control, ability to titrate treatment, and overall procedural efficiency

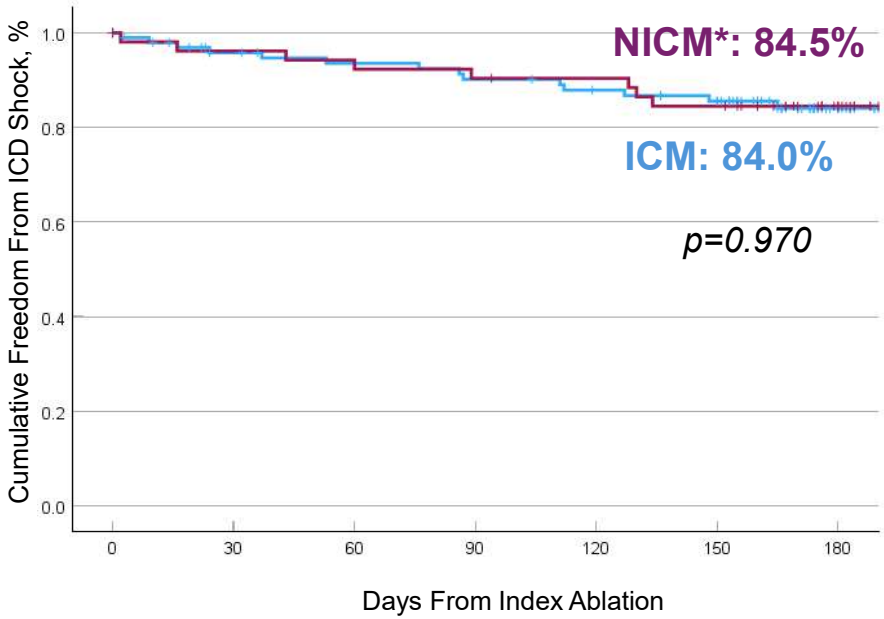
Effectiveness by Etiology – FULCRUM-VT

EFFECTIVENESS for both ICM and NICM patients

K-M FREEDOM FROM ANY ICD THERAPY: 61.8%



K-M FREEDOM FROM ICD SHOCK: 84.3%

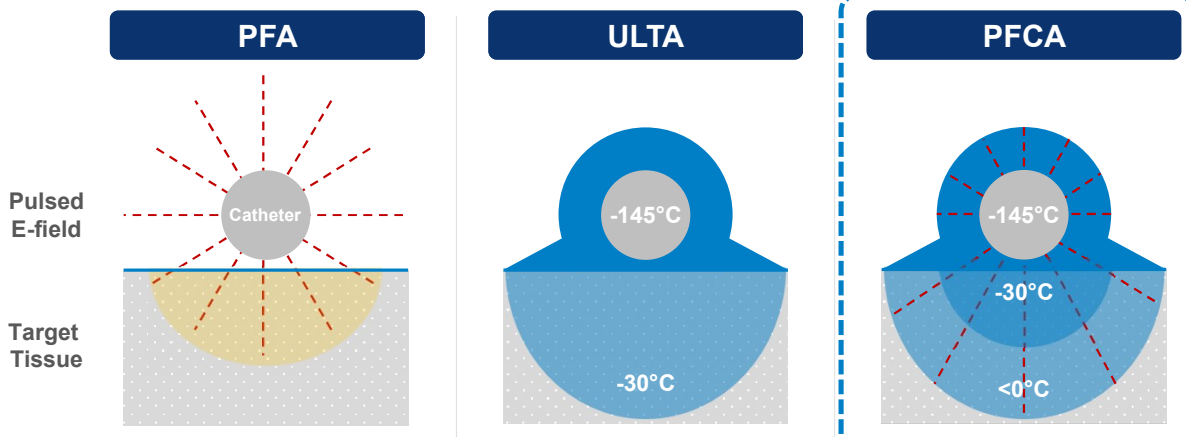


Pulsed Field Cryoablation

Desired Depth with Less Energy than PFA Alone

Increased impedance of frozen tissue dramatically reduces PFA current

- Consistent tissue contact
- No phrenic nerve capture
- No or minimal skeletal muscle activation
- No or minimized microbubbles
- No or minimized coronary spasm vs PFA



	PFA	ULTA	PFCA
Pulsed Current	~ 25 amp[2]	Zero	< 1 amp
Ablation Time	<10s of seconds[1]	~60-120 seconds[3,4]	~30 seconds[5,6]

Demonstrated in AF through the PARALLEL study – but even more applicable to VT

1) Shapira-Daniels A, et al. Circ Arrhythm Electrophysiol 2019
2) Verma A, et al. J Cardiovasc Electrophysiol 2022
3) De Potter T, et al. JACC EP 2022
4) De Potter T, et al. JACC EP 2023
5) Essebag V et al. J. Cardiovasc Electrophysiol 2025
6) Dewland T, et al. HRS 2023, submitted to JACC EP