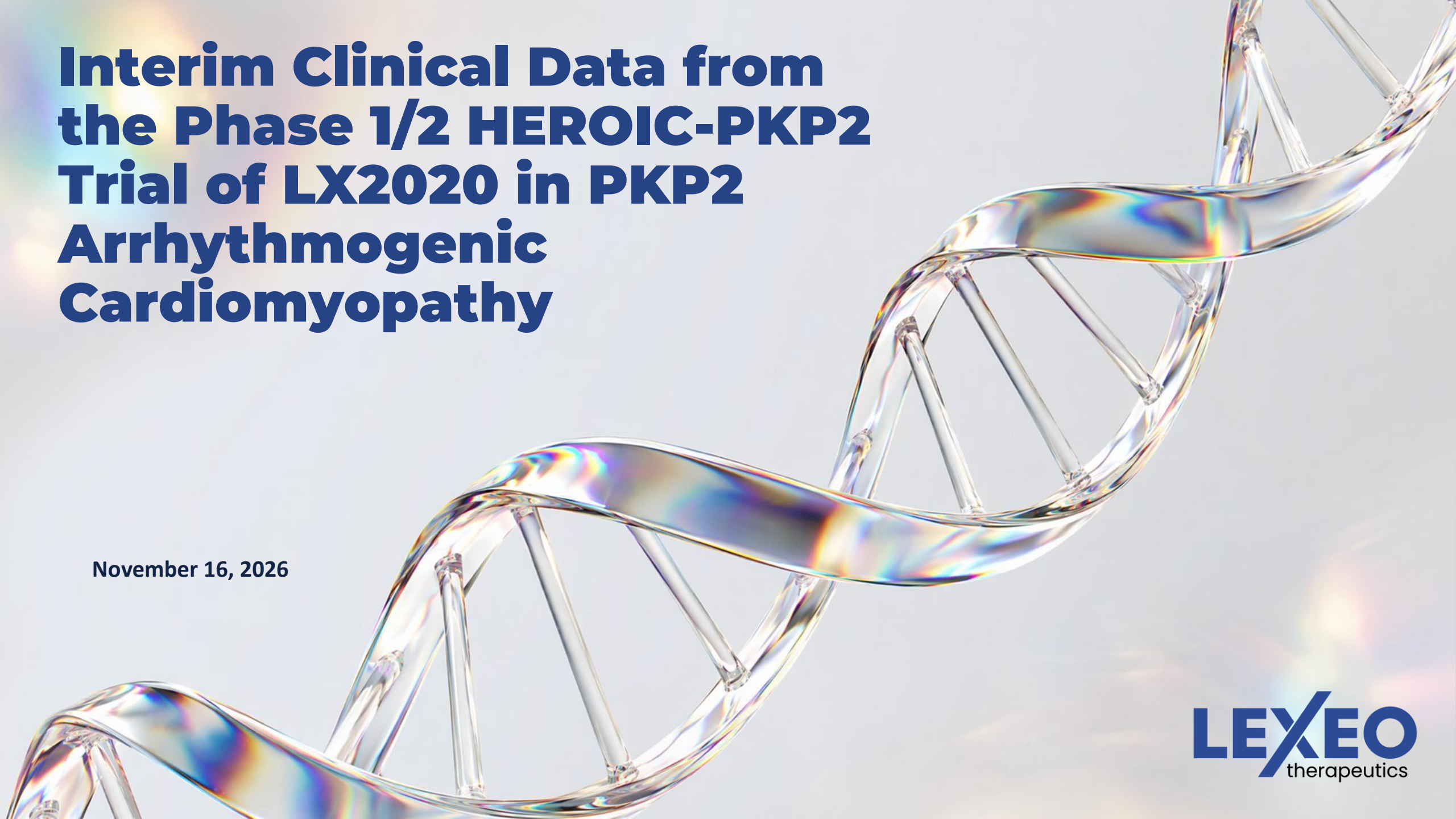
Interim Clinical Data from the Phase 1/2 HEROIC-PKP2 Trial of LX2020 in PKP2 Arrhythmogenic Cardiomyopathy



November 16, 2026

LEXEO therapeutics

Forward-looking statements

Certain statements in this presentation may constitute “forward-looking statements” within the meaning of the federal securities laws, including, but not limited to, Lexeo’s expectations and plans regarding its current product candidates and programs, the anticipated benefits of its current product candidates, and the timing and likelihood of potential regulatory developments, trial design changes and approval. Words such as “may,” “might,” “will,” “objective,” “intend,” “should,” “could,” “can,” “would,” “expect,” “believe,” “design,” “estimate,” “predict,” “potential,” “develop,” “plan” or the negative of these terms, and similar expressions, or statements regarding intent, belief, or current expectations, are forward-looking statements. While Lexeo believes these forward-looking statements are reasonable, undue reliance should not be placed on any such forward-looking statements. These forward-looking statements are based upon current information available to the company as well as certain estimates and assumptions and are subject to various risks and uncertainties (including, without limitation, those set forth in Lexeo’s filings with the U.S. Securities and Exchange Commission (SEC)), many of which are beyond the company’s control and subject to change. Actual results could be materially different from those indicated by such forward-looking statements as a result of many factors, including but not limited to: expectations regarding the initiation, progress, and expected results of Lexeo’s preclinical studies, clinical trials and research and development programs, including the outcome of ongoing discussions with the FDA regarding the design of the pivotal study to support an application for accelerated approval of LX2020, statistical analysis plan and confirmatory evidence strategy; the unpredictable relationship between preclinical study results and clinical study results; delays in submission of regulatory filings or failure to receive regulatory approval; liquidity and capital resources; and other risks and uncertainties identified in Lexeo’s Quarterly Report on Form 10-Q for the quarterly period ended June 30, 2026, filed with the SEC on August 12, 2026, and subsequent future filings Lexeo may make with the SEC. New risks and uncertainties may emerge from time to time, and it is not possible to predict all risks and uncertainties. Lexeo claims the protection of the Safe Harbor contained in the Private Securities Litigation Reform Act of 1995 for forward-looking statements. Lexeo expressly disclaims any obligation to update or alter any statements whether as a result of new information, future events or otherwise, except as required by law.

LEXEO therapeutics

Interim LX2020 data demonstrate clinically meaningful reductions in severe arrhythmia burden

1 CLINICAL EFFICACY	• ***80% mean reduction in NSVT*** *and* ***44% mean reduction in PVC burden*** *at latest assessment in participants in high-dose cohorts (n=7)* • ***Deepening reduction in mean NSVT burden over time*** *in high-dose cohorts* • *5 of 7 participants in high-dose cohorts reported symptom improvement on PGIC scale at latest visit* • *Preliminary evidence of* ***stabilization or improvement in cardiac function*** *on cardiac MRI in majority of participants in high-dose cohorts*
2 SAFETY	• *LX2020* ***generally well tolerated*** *across 10 participants dosed* • *No clinically significant complement activation and no study discontinuations*
3 REGULATORY PATH	• *FDA* ***open to guideline-defined NSVT[1,2] as a primary surrogate endpoint*** *to support potential accelerated approval of LX2020* • *Finalization of pivotal study design, statistical analysis plan and confirmatory evidence strategy expected in 1H 2027* • *Lexeo expects to initiate* ***pivotal study under accelerated approval pathway in 2H 2027***

NSVT, non-sustained ventricular tachycardia; PVC, premature ventricular contractions; PGIC, Patient Global Impression of Change.

Sources: (1) Al-Khatib SM, et al. Circulation. 2018;138:e272–e391. (2) Carrick RT, et al. Circ Arrhythm Electrophysiol. 2022;15:e011207. NSVT defined in guidelines as hemodynamically stable ventricular tachycardia at a rate of >100 beats per minute, lasting three or more beats and less than 30 seconds.

LEXEO therapeutics

Significant commercial potential for LX2020 given unmet need and global patient population

60K

Patients in the U.S.

Larger-rare, diagnosed population

>$4-6B

Total addressable market opportunity

Significant commercial upside at peak



Global prevalence

Pivotal study feasible across US, EU, Asia and other geographies



Trial ready

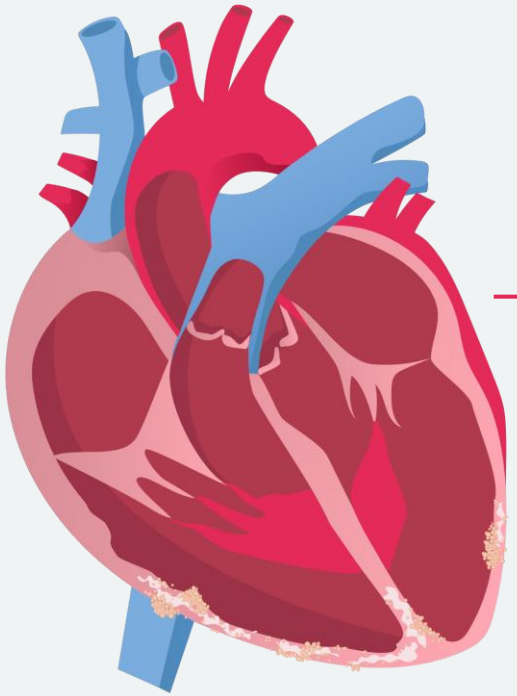
Broad patient pool expected to support rapid recruitment



Manufacturing scale

Differentiated Lexeo process will enable rapid and cost-efficient supply

Treatment response in PKP2-ACM may be reflected across complementary measures of disease activity



ACM / ARVC heart

Arrhythmic activity

- PVC burden
- NSVT burden
- Sustained VA / ICD shocks

Duration, frequency and proportion of patients experiencing events are evaluable parameters

Myocardial structure & function

- Right ventricular ejection fraction (RVEF)
- RV size and volumes
- Myocardial strain / contractility

Improvements in muscle strain may precede RV functional improvements due to existing scar tissue

Patient & clinical burden

- Patient-reported outcomes
- Treatment escalation (changes in AADs, ablation, transplant)

Despite currently available treatment options, patients continue to experience significant negative impact on quality of life

Measurements of arrhythmia and function have been assessed within individuals and across ACM populations

ACM, arrhythmogenic cardiomyopathy; PVC, premature ventricular contraction; NSVT, non-sustained ventricular tachycardia; VA, ventricular arrhythmia; ICD, implantable cardioverter defibrillator; RVEF, right ventricular ejection fraction; AAD, anti-arrhythmia drug.

Sources: (1) Cadrin-Tourigny J, et al. Eur Heart J. 2022;43(32):e1-e9. (2) Gasperetti A, et al. JAMA Cardiol. 2022;7(4):378-385; (3) Elias Neto J, et al. Arq Bras Cardiol. 2019;112(1):91-103; (4) Wang W, et al. Europace. 2019;21(1):9-21.

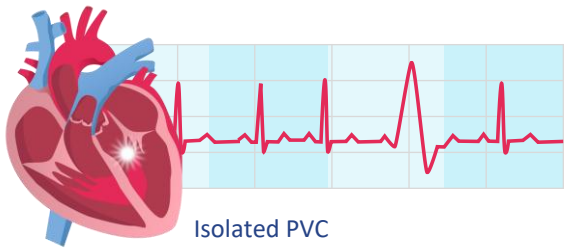
Ventricular arrhythmic activity exists along a spectrum of increasing complexity and clinical consequence

Increasing Arrhythmic Risk

Isolated PVC → NSVT → Sustained VT → ICD Firing / SCD

Premature Ventricular Contractions (PVCs)

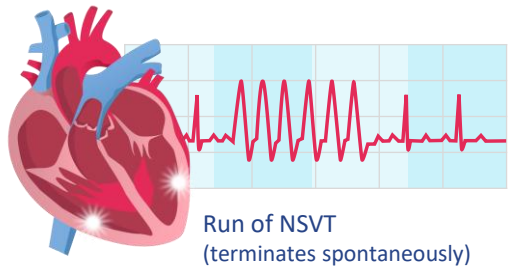
- Early ventricular beats that occur before the next expected heartbeat
- Common in the general population
- In structural heart disease (e.g., ACM), PVCs are more frequent



Isolated PVC

Non-sustained Ventricular Tachycardia (NSVT)

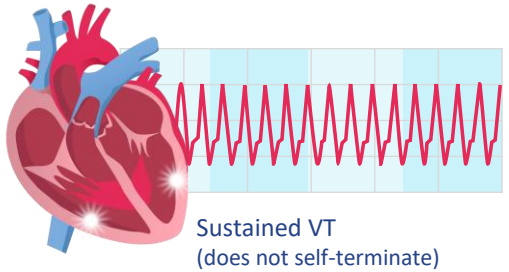
- Three or more consecutive ventricular beats lasting < 30 seconds at a ventricular rate of > 100 bpm[1]
- Indicates increased ventricular electrical instability and a higher risk of sustained arrhythmias, particularly in structural heart disease such as ACM



Run of NSVT
(terminates spontaneously)

Sustained Ventricular Tachycardia (VT)

- Continuous ventricular tachycardia either lasting ≥ 30 seconds or requiring intervention to terminate
- Associated with significantly greater risk of hemodynamic compromise, degeneration to ventricular fibrillation, and sudden death



Sustained VT
(does not self-terminate)

Serious Clinical Outcomes

ICD Firing

If sustained VT persists, an implantable cardioverter-defibrillator (ICD) can detect the arrhythmia and deliver a shock to restore a normal heart rhythm.

Sudden Cardiac Death (SCD)

If sustained VT degenerates into ventricular fibrillation (VF) or is not terminated, it can lead to sudden cardiac death.

Sources: (1) Al-Khatib SM, et al. Circulation. 2018;138(13):e272-e391. NSVT defined in guidelines as hemodynamically stable ventricular tachycardia at a rate of >100 beats per minute, lasting three or more beats and less than 30 seconds.

LEXEO therapeutics

NSVT history and incidence is high among ACM patients with ICDs

NSVT is an established criteria for ICD intervention

~1.7x

higher rate of ICD implantation in patients with a history of NSVT[1]

- NSVT is a clinically relevant marker included in major ACM risk models[2], with ≥1 NSVT per day as an established threshold to predict future sustained and life-threatening VA[3]. NSVT history is a major risk factor supporting ICD implantation[4]

Most ACM patients have ICDs

~75%

of ACM patients have ICDs[5]

- ICDs remain standard of care for most ACM patients, for both primary and secondary prevention[4]

ICD eligibility criteria may select more patients with underlying NSVT

80-100%

of patients in SNAPSHOT (n=15) and HEROIC (n=10) studies respectively had NSVT burden at baseline Holter

- Inclusion criteria that specify ICD implantation and a minimum daily threshold of PVCs select for a trial population with clinically meaningful, measurable NSVT burden

NSVT, non-sustained ventricular tachycardia; ACM, arrhythmogenic cardiomyopathy; ICD, implantable cardioverter defibrillator; VA, ventricular arrhythmia; PVC, premature ventricular contraction.

Sources: (1) Carrick RT, et al. Euro Heart Journal. 2024;45:538-548. (2) Cadrin-Tourigny J, et al. Eur Heart J. 2022;43(32):e1-e9. (3) Gasperetti A, et al. JAMA Cardiol. 2022;7(4):378-385. (4) Corrado D, et al. Circulation. 2015;132(5):441-453, (5) Bosman LP, et al. Europace. 2021;00:1-10.

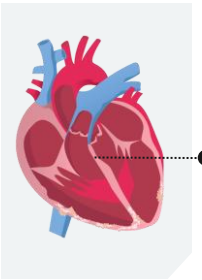
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Ejection fraction and RV free wall strain provide complementary views of systolic function in ACM

MEASUREMENT → PROGRESSION IN ACM → OUTCOMES

Ejection fraction (EF)

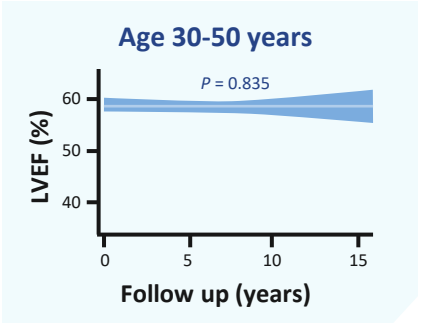
Pump output



Percentage of ventricular blood volume ejected with each contraction of the RV or LV

Global measure of systolic function

EF may remain stable in early ACM



- LVEF largely preserved in those with early-stage ACM[1]
- RV dysfunction often precedes overt LV dysfunction during ACM progression

Lower RVEF

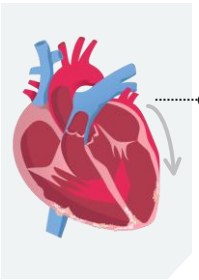
associated with increased severe ventricular arrhythmic risk in ACM[2]

Lower LVEF

represents more advanced stage of ACM, associated with increased risk of cardiac death and transplantation[3,4]

RV free wall strain

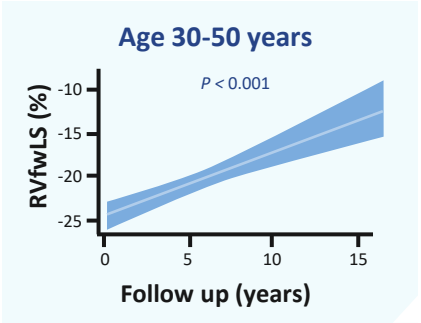
Muscle function



Percentage shortening of the RV free wall muscle during systolic contraction

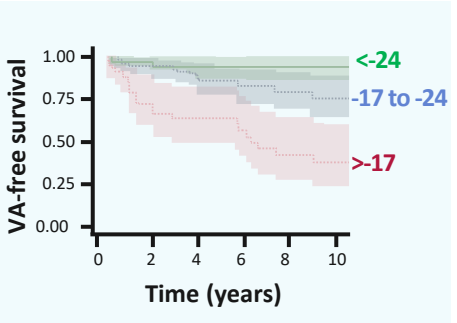
More sensitive marker of function

RV strain changes earlier and faster



- RV strain abnormalities emerge before RVEF shows any deterioration[1]
- In those with early-stage ACM, RV free wall strain **worsened by ~0.6% points per year** on average

Abnormal RV Free Wall Strain



Increased structural progression risk[5] with abnormal strain > -20%

Increased VA risk[6] with abnormal strain > −17%

RV, right ventricular; ACM, arrhythmogenic cardiomyopathy; LV, left ventricular; RVEF, right ventricular ejection fraction; LVEF, left ventricular ejection fraction; VA, ventricular arrhythmia.

Sources: (1) Kirkels FP, et al. J Am Coll Cardiol. 2023;82(9):785-797. (2) Cadrin-Tourigny J, et al. Eur Heart J. 2022;43(32):e1-e9. (3) Corrado D, et al. *Heart*. 2022;108(9):733-742. (4) Luo Y, et al. *ESC Heart Fail.* 2023;10(5):3028-3037. (5) Malik N, et al. J Am Heart Assoc. 2020;9(7):e015016. (6) Kirkels FP, et al. Eur Heart J Cardiovasc Imaging. 2023;24(12):1710-1718.

LEXEO therapeutics

LX2020 is being evaluated in an ongoing Phase 1/2 study: HEROIC-PKP2

1

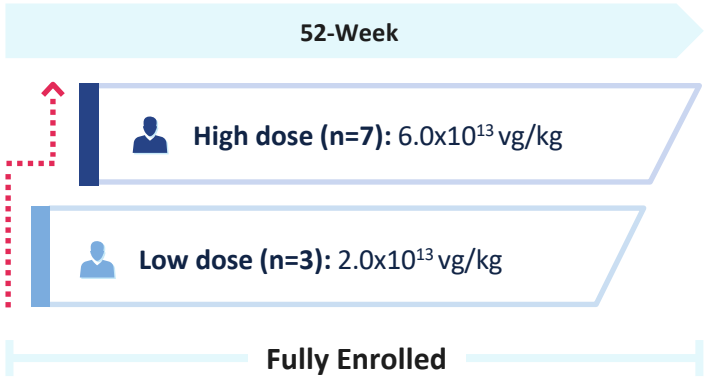
Study Design & Objective

Design:

52-week open-label study with a **4-year** long term follow up

Objective:

To assess the **safety** and **efficacy** of LX2020 in individuals with PKP2-ACM



2

Key Inclusion Criteria

- Adults (18-65 years)
- Diagnosis of ACM with documented *PKP2* mutation
- Existing ICD that is MRI compatible
- Minimum threshold of PVCs/24-hr
- Neutralizing anti-AAVrh.10 titer cutoff

3

Key Measurements

- Ventricular arrhythmias and associated measures (PVC, NSVT, VT, QRS)
- Cardiac structure & function (EF, EDV, ESV, RV strain)
- Change in symptoms (NYHA Class and PROs)
- Vector Transduction & Expression

ACM, arrhythmogenic cardiomyopathy; ICD, implantable cardioverter defibrillator; PVC, premature ventricular contraction; NSVT, non-sustained ventricular tachycardia; VT, ventricular tachycardia; EF, ejection fraction; EDV, end-diastolic volume; ESV, end-systolic volume; RV, right ventricular; NYHA, New York Heart Association; PROs, patient reported outcomes.

Note: LX2020 is administered systemically; participants receive immune suppression with prednisone and sirolimus on the day prior to treatment through ~14 weeks following LX2020 dosing.

Baseline characteristics consistent with PKP2-ACM, with more severe arrhythmia burden in high-dose cohorts

	Cohort 1 ($2.0x10^{13}$ vg/kg)			Cohorts 2 & 3 ($6.0x10^{13}$ vg/kg)						
Participant	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8[4]**	**9**	**10**
Age, years	34	22	29	44	43	30	41	41	28	39
Age at diagnosis	27	21	28	29	28	27	30	34	16	37
Gender	M	M	M	M	F	F	F	F	M	M
PVC per 24h[1]	1068	2849	2630	4780	3329	4826	4384	6308	773	5524
NSVT per 7 days[1]	1	3	2	31	8	13	24	1	5	8
T-wave inversion	5	0	2	3	3	3	3	3	4	0
QRS duration, ms	124	84	112	90	90	68	90	94	110	106
RVEF (%)[2]	43	52	42	31	34	33	42	52	43	47
NYHA class	I	I	II	I	I	I	I	I	I	I
Follow-up, months[2]	**24**	**18**	**12[3]**	**18**	**18**	**12**	**12**	**12**	**12**	**9**
Relevant medical history prior to study	Sustained VT, ICD shock, ablation	Sustained VT, syncope, ICD shock	Sustained VT, syncope	Sustained VT, VT storm, ICD shock, ablation	Sustained VT, ICD shock		Sustained VT, near syncope	Sustained VT, syncope, ablation, stable use of flecainide at study start	Sustained VT, VT storm, ICD shock, ablation	Sustained VT, syncope

ACM, arrhythmogenic cardiomyopathy; PVC, premature ventricular contraction; NSVT, non-sustained ventricular tachycardia; RVEF, right ventricular ejection fraction; NYHA, New York Heart Association; VT, ventricular tachycardia; ICD, implantable cardioverter defibrillator.

(1) NSVT and PVC baselines updated from January 2026 using guideline-defined NSVT criteria. NSVT runs <100bpm reclassified. Minor PVC count corrections also applied. See Oct. 21, 2026 event for details.

(2) Cardiac MRI conducted at 6-, 12- and 24-months of follow up but results lag Holter data. RVEF data were collected during 12-month visit, except for participant 1 at 24-months and participants 9 and 10 at 6-months.

(3) Participant 3 declined 18-month follow up visit but is expected for 24-month follow up.

(4) Participant 8 on flecainide at study start; no other participants taking background anti-arrhythmic drugs (AADs) at study start.

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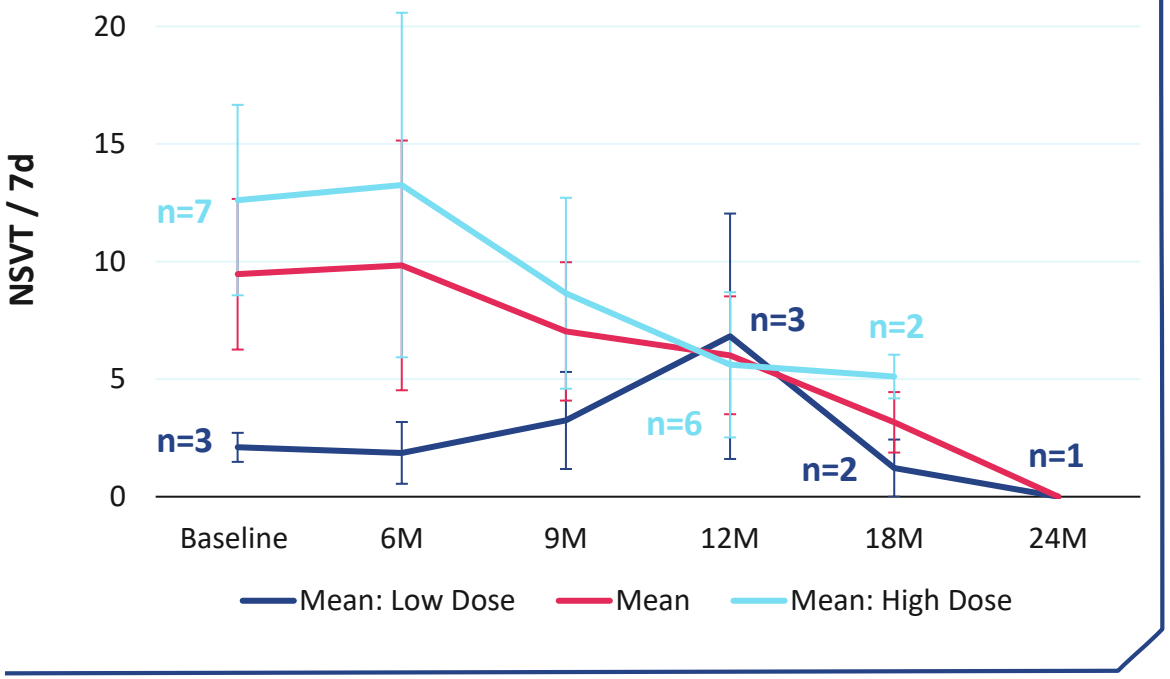
In high-dose cohorts, 80% mean improvement in NSVT and 44% mean improvement in PVCs at latest assessment

Cohort	Part. #	Latest Visit[1] (months)	Δ PVC / 24H Baseline → LV	Δ NSVT / 7d Baseline → LV	Δ RVEF %[1] Baseline → LV	Δ RV Strain %[1] Baseline → LV	Δ PGIC Scale Baseline → LV
Low Dose Cohort 1 (2E13 vg/kg)	#1 (M)	24	-57% 1068 → 460	-100% 1 → 0	43 → 40	-22 → -19	3 → 3
	#2 (M)	18	-1% 2849 → 2807	-23% 3 → 2	52 → 49	-20 → -20	3 → 1
	#3 (M)[2]	12	+82% 2630 → 4787	+717% 2 → 17	42 → 41	-20 → -22	3 → 4
	Mean		**+23%**	**+213%**	**Majority stable**		**1/3 improved**
High Dose Cohort 2 & Cohort 3 (6E13 vg/kg)	#4 (M)	18	-48% 4780 → 2472	-86% 31 → 4	31 → 40	-20 → -17	3 → 2
	#5 (F)	18	+74% 3329 → 5801	-25% 8 → 6	34 → 33	-12 → -16	3 → 3
	#6 (F)	12	-38% 4826 → 2998	-81% 13 → 2	33 → 36	-16 → -15	3 → 2
	#7 (F)[3]	12	-83% 4384 → 752	-96% 24 → 1	42 → 37	-13 → -19	3 → 3
	#8 (F)	12	-50% 6308 → 3171	+228% 1 → 3	52 → 48	-19 → -22	3 → 2
	#9 (M)	12	+47% 773 → 1138	-76% 5 → 1	43 → 39	-15 → -19	3 → 2
	#10 (M)	9	-94% 5524 → 341	-100% 8 → 0	47 → 43	-14 → -19	3 → 1
	Mean		**-44%**	**-80%**	**Majority stable or improved**		**5/7 improved**

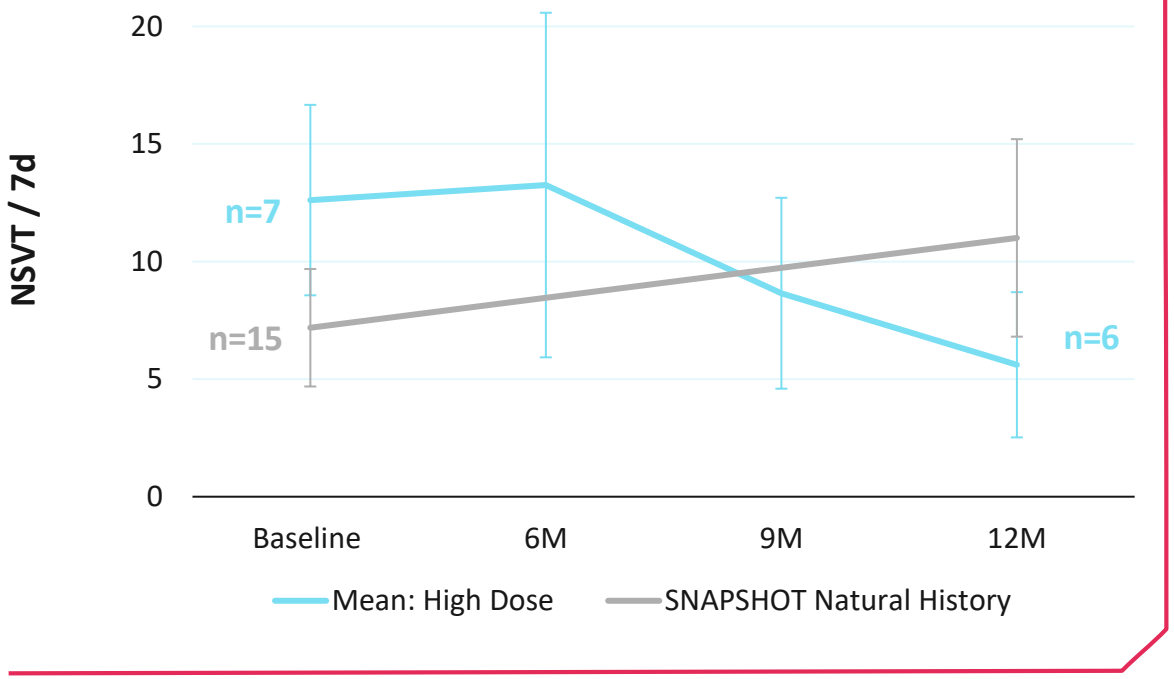
Data cutoff October 15, 2026. RVEF and RV strain values are percentages, changes reported are absolute change (percentage points). LV = latest visit.
(1) Cardiac MRI conducted at 6-, 12- and 24-months of follow up but results lag Holter data. RVEF data shown were collected during 12-month visit, except for participant 1 at 24-months and participants 9 and 10 at 6-months. RV strain data shown were collected during 12-month visit except for participants 6, 9, and 10 at 6-months.
(2) Participant 3 started background anti-arrhythmic therapy during the study period to manage a PVC spike. Participant declined 18-month follow up visit but is expected for 24-month follow up.
(3) Participant 7 started background anti-arrhythmic therapy during the study period to manage VT approximately three months after dosing.

Deepening reduction in NSVT observed, while natural history shows progressively increased arrhythmic burden

Mean NSVT Change:



Mean NSVT Change:



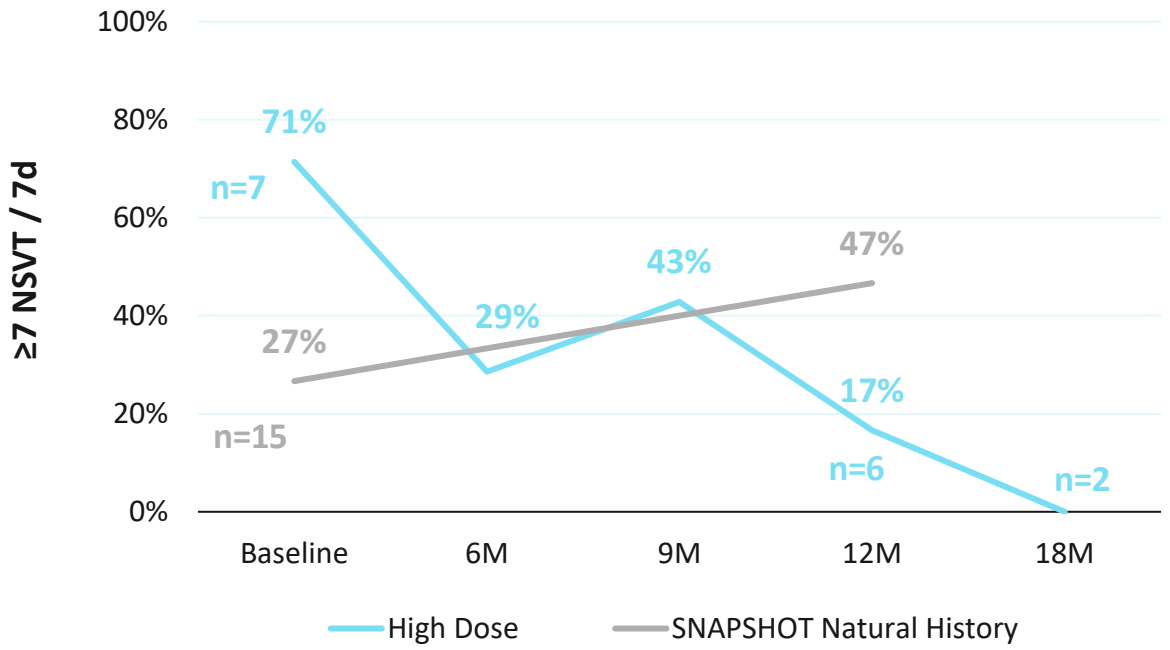
Deepening NSVT reduction over time with 80% mean reduction at latest visit in high-dose cohorts (n=7)

In contrast, participants in **SNAPSHOT natural history study demonstrated 53% increase in NSVT** at 12 months (n=15)

Participant 3 (low dose) declined 18-month follow up visit but is expected for 24-month follow up.

83% of high-dose cohort had less than 1 NSVT per day at 12 months, a clinically relevant threshold for ACM management

% Participants with Significant NSVT Burden
(at least 7 NSVT / 7d; High-dose Cohort)



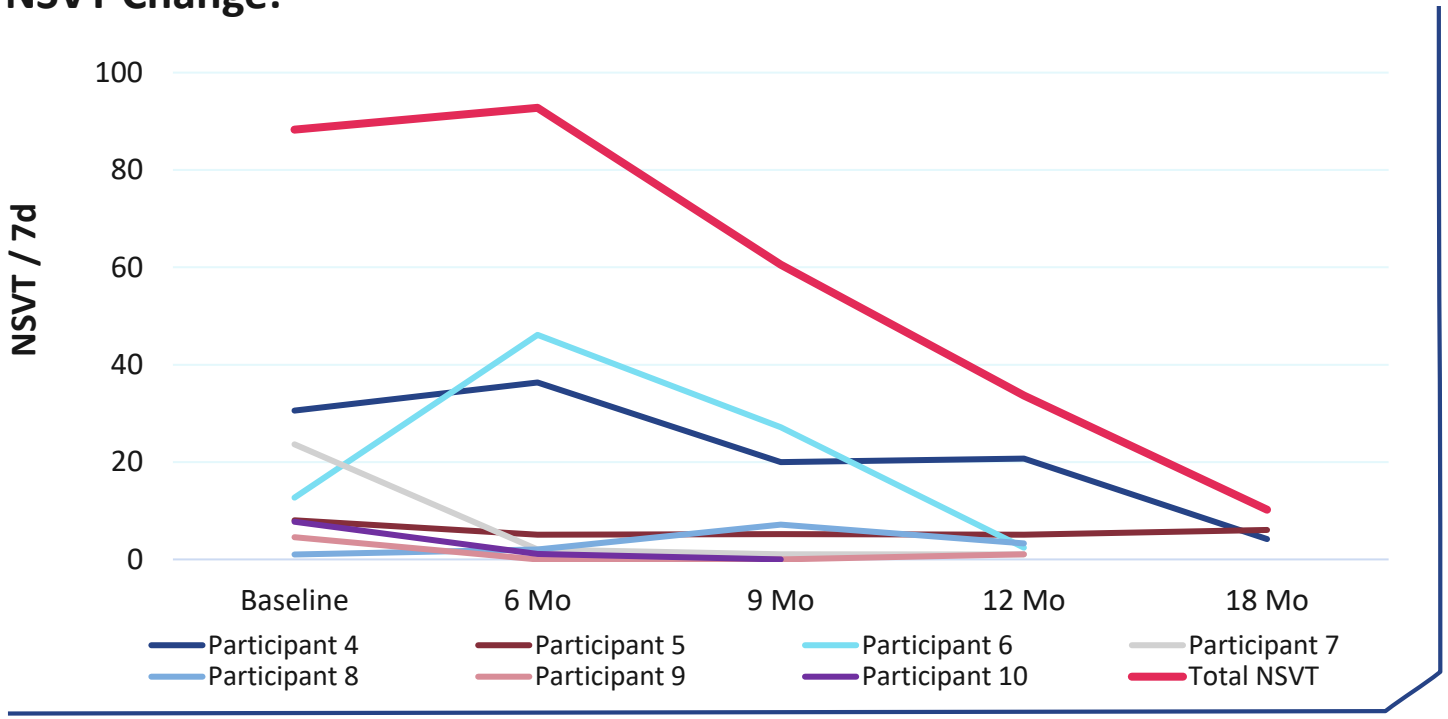
- The **presence of NSVT is a clinically relevant marker** for risk stratification, monitoring, and management, included in major ACM risk models[1]
- **≥1 NSVT per day is a strong predictor of future sustained and life-threatening ventricular arrhythmias**[2]
- While the majority of participants in high-dose cohorts exceeded this threshold at baseline, increasing future arrhythmic risk, **5 of 6 participants had fewer than 1 NSVT per day at 12 months**
- In contrast, **natural history demonstrated an increase in NSVT burden** over one year, despite existing standard of care

Sources: (1) Cadrin-Tourigny J, et al. Eur Heart J. 2022;43(32):e1-e9. (2) Gasperetti A, et al. JAMA Cardiol. 2022;7(4):378-385.

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100% of high-dose participants were below the clinically relevant threshold for NSVT (<1/day) at latest Holter

NSVT Change:



- ≥1 NSVT per day is a strong predictor of future sustained VT risk[1]
- **All high-dose participants below the clinically relevant threshold for NSVT management at latest visit;** 83% responder rate at 12 months
- **NSVT improved in 6/7 participants** at latest visit relative to baseline
- **In most participants, NSVT reductions were substantial**, greater than the relative risk reduction expected from standard of care

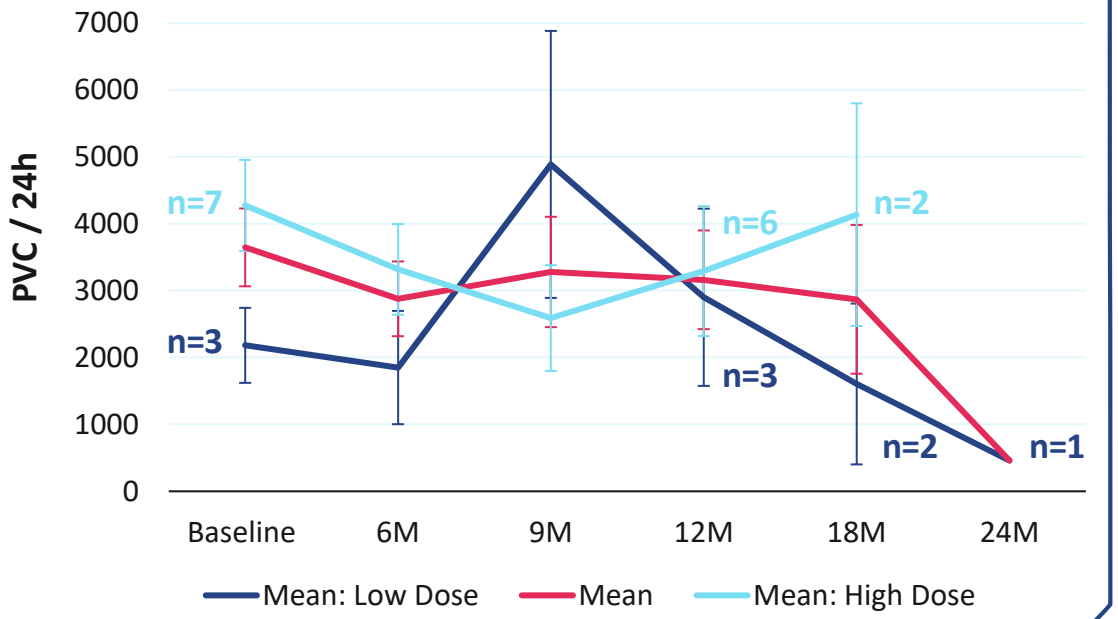
		Baseline	6 Mo (n=7)	9 Mo (n=7)	12 Mo (n=6)	18 Mo (n=2)
HEROIC	Mean change from baseline	-	**+5%**	**-31%**	**-56%**	**-59%**
	Participants below 1 NSVT/day (<7/7d)	**2/7** 29%	**5/7** 71%	**4/7** 57%	**5/6** 83%	**2/2** 100%
SNAPSHOT	Mean change from baseline	-	-	-	**+53%**	

NSVT, non-sustained ventricular tachycardia; VT, ventricular tachycardia.

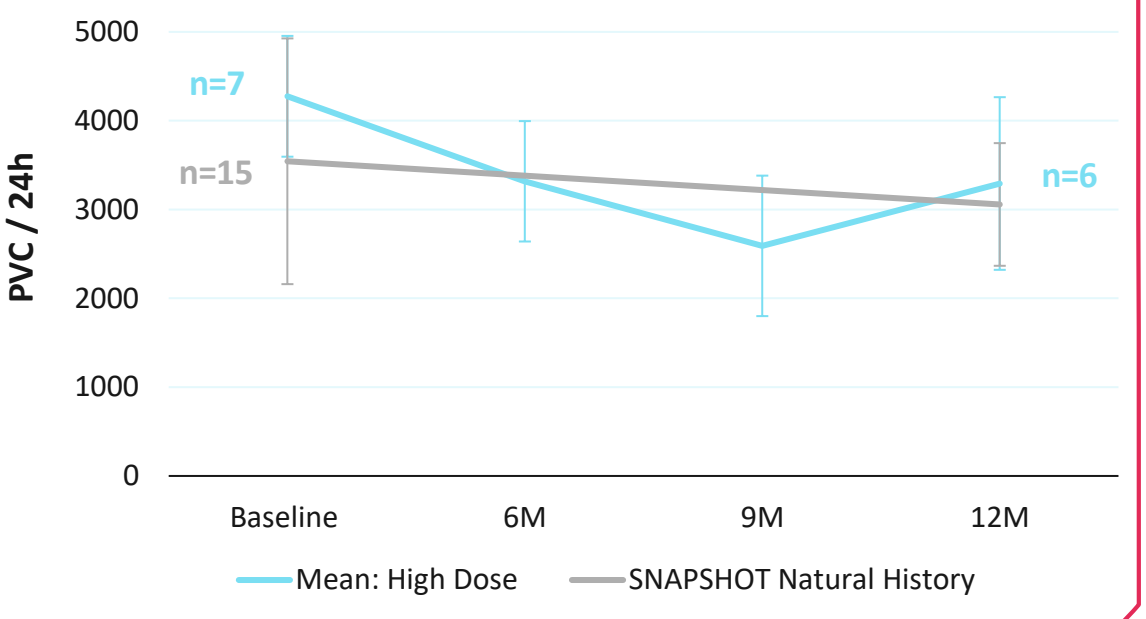
Sources: (1) Cadrin-Tourigny J, et al. Eur Heart J. 2022;43(32):e1-e9.

LX2020 reduced mean PVC burden by 44% in high-dose cohorts at latest assessment

Mean PVC Change:



Mean PVC Change:

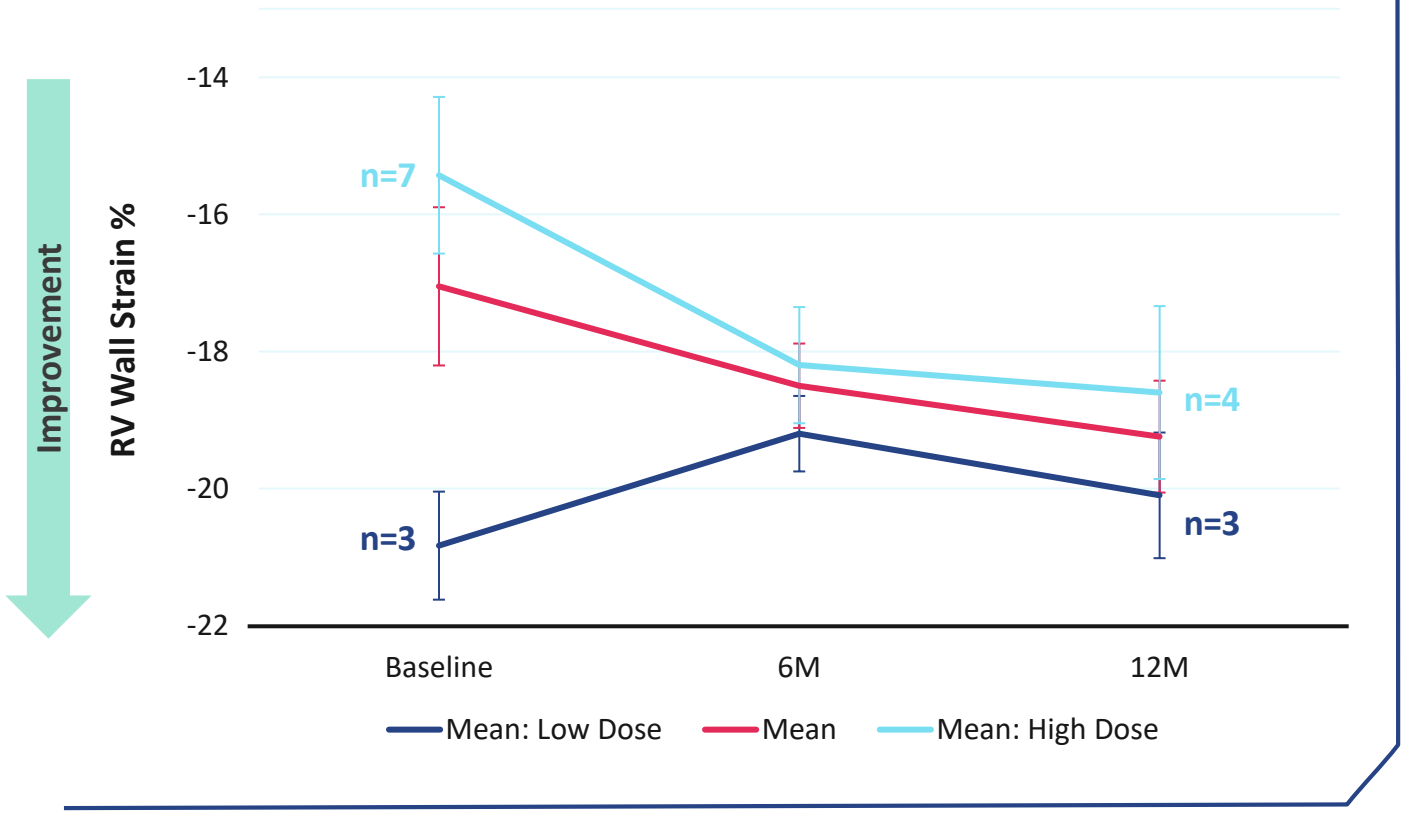


- **Mean PVC count decreased 44%** at latest assessment across participants in high-dose cohorts (n=7)
- In contrast, participants in **SNAPSHOT natural history study demonstrated a 14% decrease** in PVCs at 12 months (n=15)
- PVC reductions were observed alongside **substantial and deepening reductions in NSVT**
- **PVC burden and NSVT provide complementary measures of arrhythmic disease activity**; greater variability in PVC measurements is well recognized and may reflect the influence of physical activity and other external factors[1,2,3]

Sources: (1) Cadrin-Tourigny J, et al. Eur Heart J. 2022;43(32):e1-e9; (2) Towbin JA, et al. Heart Rhythm. 2019;16(11):e301-e372. (3) 1) Gasperetti A, et al. JAMA Cardiol. 2022;7(4):378-385.
Participant 3 (low dose) declined 18-month follow up visit but is expected for 24-month follow up.

Evidence of improved systolic function with RV free wall strain improvements and EF stabilization

Mean RV Wall Strain:



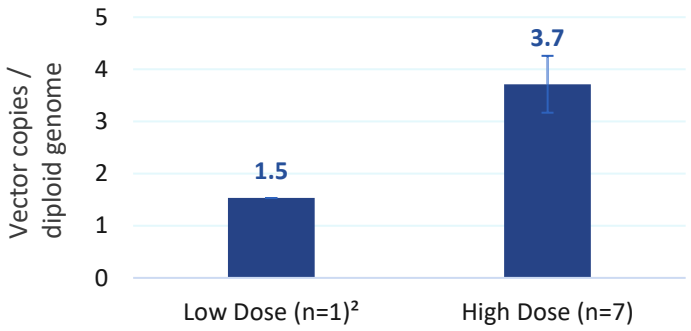
- RV free wall longitudinal strain, assessed via cardiac MRI, measures the percentage shortening of the RV free wall during systole
- RV wall strain reflects systolic performance and regional RV muscle function; **abnormal or reduced shortening reflects early RV dysfunction**[1]
- **Mean RV free wall strain improved** following gene therapy treatment in high-dose cohorts
- **RVEF and LVEF preserved or improved in the majority of participants at latest visit**, potentially indicative of slowed disease progression and improved function

Sources: (1) Kirkels FP, et al. J Am Coll Cardiol. 2023;82(9):785-797.
Cardiac MRI conducted at 6-, 12- and 24-months of follow up but results lag Holter data. RV strain data shown were collected during 12-month visit except for participants 6, 9, and 10 at 6-months.

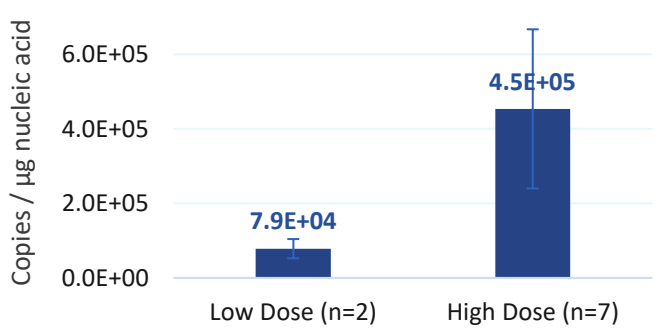
Supportive findings from cardiac biopsy and ECG

Cardiac Biopsy: Dose-dependent increases in mean VCN, mRNA and western blot

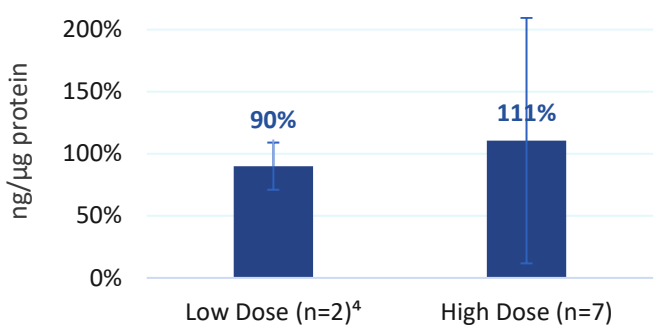
Post-Dose Vector Copy Number (VCN)[1]



Post-Dose Exogenous PKP2 (mRNA)[1]

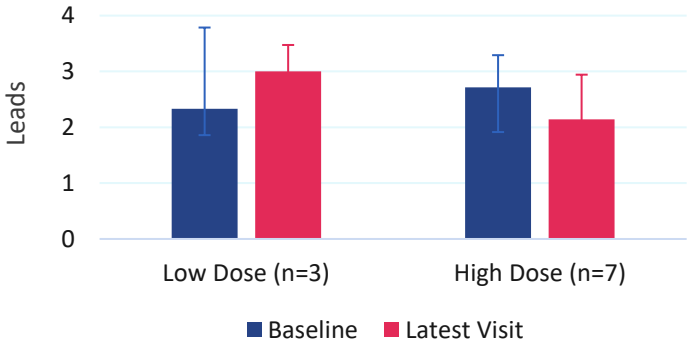


PKP2 Change from Baseline (Western Blot)[3]

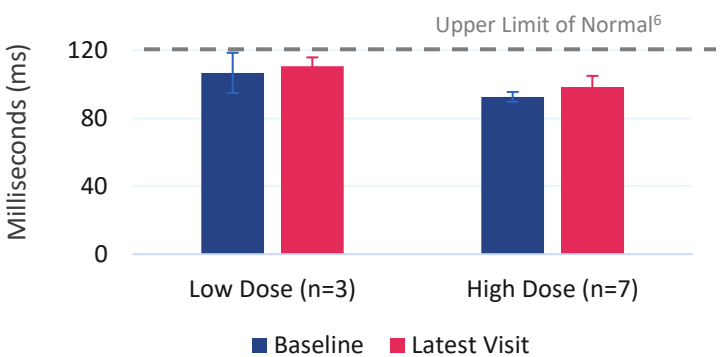


ECG: T-wave inversion and QRS duration stable across participants

T-Wave Inversion[5]



QRS Duration[5]



1. LX2020 not detected in pre-dose VCN or mRNA samples as expected. Participant 3 elected not to undergo a post-treatment biopsy.
2. Participant 1 VCN not performed due to insufficient remaining cardiac biopsy tissue following other analyses.
3. GAPDH normalized. Fibrofatty tissue (characteristic of ACM) may impact biopsy samples. Cardiac biopsy not expected in planned pivotal study.
4. Lab vendor identified an error with respect to Patient 2 in PKP2 expression data, impacting the low dose mean. Previously reported data for Patient 2 was 115% and corrected value is 109%.
5. ECG data shown were collected during latest visit except for participant 5 at 12-months, due to a site submission delay.
6. Wagner GS, et al. J Am Coll Cardiol. 2009.

Safety update: Treatment with LX2020 generally well tolerated to date

- LX2020 generally well tolerated across 10 participants dosed
- No clinically significant complement activation
- No study discontinuations
- Previously disclosed LFT elevations observed in high-dose cohorts were successfully managed per protocol with no hospitalizations or complications
- One previously disclosed Grade 3 SAE of sustained ventricular tachycardia (VT) was observed three months after dosing. This event is consistent with the natural course of PKP2-ACM and its known clinical manifestations. The participant was successfully treated with anti-arrhythmic medication and discharged with no additional intervention required

Summary of results and next steps for LX2020

1

Meaningful Clinical Activity

LX2020 continues to demonstrate improvements across multiple measures of disease burden and patient experience

2

Increasing Confidence in Dataset

Additional follow-up strengthens the durability, consistency, and overall benefit-risk profile of LX2020

3

Clear Path Forward

Regulatory feedback supports continued advancement of LX2020 toward a potential pivotal study

Interim HEROIC-PKP2 data continue to support LX2020's potential as the first disease-modifying therapy for PKP2-ACM

Thank you to the ACM community



Individuals and families impacted by genetically mediated cardiovascular diseases are at the center of our mission



We are grateful to the participants, caregivers, investigators, advocacy organizations and broader ACM community who contributed to HEROIC-PKP2



We remain committed to advancing research, awareness, diagnosis and treatment for individuals living with PKP2-ACM

Global Heart Hub

DCM Foundation
Hope *for* People with Dilated Cardiomyopathy

FIA
FOUNDATION FOR
Inherited Arrhythmias

everygene

Genetic Cardiomyopathy Awareness Consortium
Brought to you by DCM Foundation

LEXEO therapeutics

THANK YOU