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

FORM 8-K

CURRENT REPORT

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

Date of Report (Date of earliest event reported): July 15, 2026

Fractyl Health, Inc.

(Exact name of Registrant as Specified in Its Charter)

Delaware	**001-41942**	**27-3553477**
(State or Other Jurisdiction of Incorporation)	**(Commission File Number)**	**(IRS Employer Identification No.)**

3 Van de Graaff Drive
Suite 200
Burlington, Massachusetts **01803**
(Address of Principal Executive Offices) **(Zip Code)**

Registrant's Telephone Number, Including Area Code: (781) 902-8800

(Former Name or Former Address, if Changed Since Last Report)

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

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

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

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

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

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

Title of each class	**Trading Symbol(s)**	**Name of each exchange on which registered**
Common Stock, $0.00001 par value per share	GUTS	The Nasdaq Global Market

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

Emerging growth company ☒

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

Item 7.01 Regulation FD Disclosure.

On July 15, 2026 Fractyl Health, Inc. (the "Company" or "Fractyl") issued a press release announcing one-year results from its REMAIN-1 Midpoint Cohort, a distinct patient cohort assessing the potential of the Revita DMR System ("Revita") to maintain weight loss after GLP-1 discontinuation. A copy of the press release is furnished as Exhibit 99.1 to this Current Report on Form 8-K and is incorporated herein by reference.

As described in the accompanying press release, the Company will host a conference call and live audio webcast today, July 15, 2026 at 8:00 a.m., Eastern Time, to discuss the presentation of data described above.

The live audio webcast may be accessed through the "Events" section of the Company's website at ir.fractyl.com. A copy of the presentation to be used by the Company during the conference call is furnished as Exhibit 99.2 to this Current Report on Form 8-K and is incorporated herein by reference.

The information contained in Item 7.01 of this Current Report on Form 8-K, including Exhibits 99.1 and 99.2 attached hereto, shall not be deemed "filed" for purposes of Section 18 of the Securities Exchange Act of 1934, as amended (the "Exchange Act"), or otherwise subject to the liabilities of that section, and shall not be deemed incorporated by reference into any of the Company's filings under the Securities Act of 1933, as amended, or the Exchange Act, whether made before or after the date hereof, regardless of any general incorporation language in such filing, except as shall be expressly set forth by specific reference in such filing.

The Company's website and any information contained on the Company's website are not incorporated into this Current Report on Form 8-K.

Item 8.01 Other Events.

On July 15, 2026, the Company reported one-year data from its REMAIN-1 Midpoint Cohort, a blinded, sham-controlled study evaluating Revita for weight maintenance following GLP-1 drug discontinuation.

Key One-Year Findings

- **Dose-dependent durability confirmed at one year:** In the full modified intention-to-treat (mITT) population (N=45), a single Revita procedure reduced weight regain by approximately 40% versus sham at one year (least-squares mean weight regain of 7.8% versus 13.0% of body weight; n=29 versus 16 for Revita versus sham). Participants who received complete duodenal ablation (>14 cm) maintained approximately 81% of GLP-1-induced weight loss at one year, compared with 48% in sham participants (least-squares mean weight regain of 4.8% versus 13.0% of body weight; n=17 versus 16 for Revita versus sham), reflecting a reduction in weight regain of over 60% versus sham. This is consistent with earlier findings that more complete duodenal ablation drives greater treatment effect.

- **Greatest benefit in patients with greatest need:** In an optimized population of participants who received complete duodenal ablation (>14 cm) and had higher GLP-1 run-in weight loss (≥17.5%), Revita maintained approximately 84% of GLP-1-induced weight loss at one year versus 46% with sham (least-squares mean weight regain of 4.1% versus 13.5% of body weight; n=10 versus 8 for Revita versus sham). These results are consistent with the view that patients at greatest need may derive the greatest benefit from Revita due to their higher propensity for weight regain after GLP-1 discontinuation.

- **Weight-maintenance responder rate:** The second co-primary endpoint of the Pivotal Cohort, assessed against a U.S. Food and Drug Administration (FDA) mandated pre-specified performance goal of >50%, measures the proportion of Revita patients maintaining at least 5% total body weight loss relative to their pre-tirzepatide weight at one year. As a reference point for the Pivotal Cohort, this responder rate was 73% in the Midpoint Cohort mITT population, rising to 91% in those with complete duodenal ablation (>14 cm).

- **Excellent tolerability:** No device- or procedure-related serious adverse events occurred. No new device-related treatment-emergent adverse events (TEAEs) were observed between six and 12 months. Overall TEAE rates were comparable between arms through one year (24% Revita versus 25% sham), reflecting a generally mild peri-procedural adverse event profile that supports potentially broad outpatient use for Revita. One new diagnosis of type 2 diabetes occurred in the sham arm versus none with Revita.

Cautionary Regarding Forward-Looking Statements

This Current Report on Form 8-K contains forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995. All statements contained in this Current Report on Form 8-K that do not relate to matters of historical fact are forward-looking statements. These statements may be identified by words such as “aims,” “anticipates,” “believes,” “could,” “estimates,” “expects,” “forecasts,” “goal,” “intends,” “may,” “plans,” “possible,” “potential,” “seeks,” “will” and variations of these words or similar expressions that are intended to identify forward-looking statements, although not all forward-looking statements contain these words. Forward-looking statements in this Current Report on Form 8-K include, without limitation, statements regarding: the promise and potential impact of our clinical trial data and product candidates, including Revita’s potential for maintaining weight loss after GLP-1 based therapy discontinuation and stabilizing cardiometabolic parameters; the translatability of results and scalability of technique related to Revita; the design, initiation, timing and results of clinical enrollment and any clinical studies or readouts, including readouts from the REMAIN-1 Midpoint Cohort and the REMAIN-1 Pivotal Cohort; the potential launch or commercialization of any of our product candidates or products; our regulatory strategy, including potential use and benefits of the De Novo pathway (FDA pre-submission feedback is advisory and non-binding, and there is no assurance that FDA will accept a De Novo marketing application submission or that Revita will receive marketing authorization); the potential treatment population or benefits for any of our product candidates or products; our strategic and product development objectives and goals; and the timing of any of the foregoing. These statements are neither promises nor guarantees, but involve known and unknown risks, uncertainties and other important factors that may cause our actual results, performance or achievements to be materially different from any future results, performance or achievements expressed or implied by the forward-looking statements, including, but not limited to, the risks that are discussed more fully in our filings with the Securities and Exchange Commission (the “SEC”), including the “Risk Factors” section of our Annual Report on Form 10-K for the year ended December 31, 2025, filed with the SEC on March 24, 2026, and other documents we subsequently file with or furnish to the SEC, including our Quarterly Report on Form 10-Q for the quarter ended March 31, 2026, filed with the SEC on May 12, 2026. These forward-looking statements are based on management’s current estimates and expectations. While we may elect to update such forward-looking statements at some point in the future, we disclaim any obligation to do so, even if subsequent events cause our views to change.

Item 9.01 Financial Statements and Exhibits.

Exhibit No	Description
99.1	Press Release dated July 15, 2026
99.2	Conference Call Presentation dated July 15, 2026
104	Cover Page Interactive Data File (embedded within the Inline XBRL document)

SIGNATURES

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

Fractyl Health, Inc.

Date: July 15, 2026

By: /s/ Harith Rajagopalan

Harith Rajagopalan, M.D., Ph.D.,
Co-Founder, Chief Executive Officer and Director
(Principal Executive Officer)

Exhibit 99.1

Fractyl Health Reports Positive Randomized Data from REMAIN-1 Midpoint Cohort Demonstrating Durable Weight Maintenance One Year After GLP-1 Discontinuation

Up to 84% of GLP-1 induced weight loss retained with Revita® versus 46% with sham at one year in patients receiving complete duodenal ablations

Next anticipated Revita® milestones are topline six-month randomized data from the REMAIN-1 Pivotal Cohort in early Q4 2026 and a potential FDA De Novo marketing application submission in late Q4 2026

Company to host investor webcast today at 8:00 a.m. ET

BURLINGTON, Mass., July 15, 2026 (GLOBE NEWSWIRE) — Fractyl Health, Inc. (Nasdaq: GUTS) (the Company or Fractyl), a clinical-stage metabolic therapeutics company focused on pioneering novel approaches to treat obesity and type 2 diabetes (T2D), today announced positive one-year results from its REMAIN-1 Midpoint Cohort ("Midpoint Cohort"). The new results reinforce the potential of the Revita DMR System (Revita) to be the first durable procedural therapy for post-GLP-1 weight maintenance.

Key Findings:

- **Dose-dependent durability confirmed at one year:** In the full modified intention-to-treat (mITT) population (N=45), a single Revita procedure reduced weight regain by approximately 40% versus sham at one year (least-squares mean weight regain of 7.8% versus 13.0% of body weight; n=29 versus 16 for Revita versus sham). Participants who received complete duodenal ablation (>14 cm) maintained approximately 81% of GLP-1-induced weight loss at one year, compared with 48% in sham participants (least-squares mean weight regain of 4.8% versus 13.0% of body weight; n=17 versus 16 for Revita versus sham), reflecting a reduction in weight regain of over 60% versus sham. This is consistent with earlier findings that more complete duodenal ablation drives greater treatment effect.

- **Greatest benefit in patients with greatest need:** In an optimized population of participants who received complete duodenal ablation (>14 cm) and had higher GLP-1 run-in weight loss (≥17.5%), Revita maintained approximately 84% of GLP-1-induced weight loss at one year versus 46% with sham (least-squares mean weight regain of 4.1% versus 13.5% of body weight; n=10 versus 8 for Revita versus sham). These results are consistent with the view that patients at greatest need may derive the greatest benefit from Revita due to their higher propensity for weight regain after GLP-1 discontinuation.

- **Weight-maintenance responder rate:** The second co-primary endpoint of the Pivotal Cohort, assessed against a U.S. Food and Drug Administration (FDA) mandated pre-specified performance goal of >50%, measures the proportion of Revita patients maintaining at least 5% total body weight loss relative to their pre-tirzepatide weight at one year. As a reference point for the Pivotal Cohort, this responder rate was 73% in the Midpoint Cohort mITT population, rising to 91% in those with complete duodenal ablation (>14 cm).

- **Excellent tolerability:** No device- or procedure-related serious adverse events occurred. No new device-related treatment-emergent adverse events (TEAEs) were observed between six and 12 months. Overall TEAE rates were comparable between arms through one year (24% Revita versus 25% sham), reflecting a generally mild

peri-procedural adverse event profile that supports potentially broad outpatient use for Revita. One new diagnosis of type 2 diabetes occurred in the sham arm versus none with Revita.

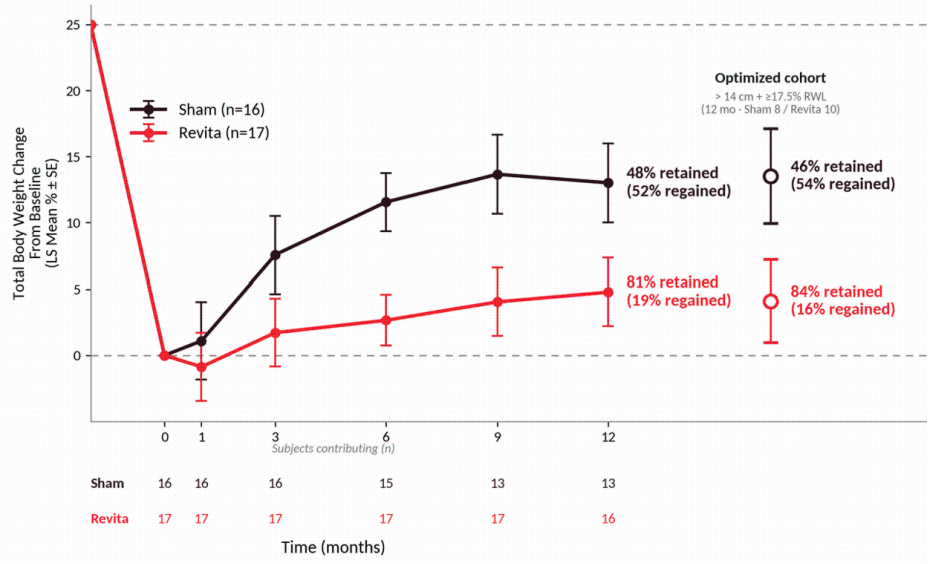


Figure 1: Change in body weight in (i) Complete Ablation population: > 14 cm duodenal ablation, no run-in weight loss restriction (Sham n=16, Revita n=17) and (ii) Optimized population: complete ablation (> 14 cm) and run-in weight loss ≥ 17.5% (Sham n=8, Revita n=10). Y-axis: LS-mean % total body-weight change from baseline; MMRM, compound-symmetry covariance, estimated at 20% run-in weight loss; error bars ± SE; n contributing shown per visit below axis. Retention = % of run-in weight loss maintained at 12 months. Exploratory REMAIN-1 Midpoint Cohort subgroup; not powered for formal inference. Abbreviations: MMRM, mixed-model repeated measures; LS-mean, least-squares mean; SE, standard error.

“The success of GLP-1 medicines has created a new unsolved problem: what happens when patients stop. Most do stop eventually, whether because of cost, side effects, or simply not wanting to inject a drug for the rest of their lives. When they stop, the weight most often comes back," said Harith Rajagopalan, M.D., Ph.D., Co-Founder and Chief Executive Officer of Fractyl. "Today's results are the first randomized, sham-controlled evidence that a single Revita procedure can keep most of the weight off for a full year after GLP-1 is stopped, without the need for ongoing medication. We eagerly anticipate an early Q4 2026 topline readout from the REMAIN-1 Pivotal Cohort with deep conviction that Revita may represent the first procedural entrant into the post-GLP-1 weight maintenance category.”

Webcast

Fractyl Health will host a webcast today, July 15, 2026, at 8:00 a.m. Eastern Time. The live webcast can be accessed by clicking this link. This webcast can also be found in the “Events” section of Fractyl’s website at ir.fractyl.com. The webcast will be archived and available for replay for at least 30 days after the event.

About REMAIN-1 Weight Maintenance Program

REMAIN-1 is Fractyl Health’s pivotal program evaluating Revita for weight maintenance in adults with obesity following discontinuation of GLP-1 therapy. The Midpoint Cohort (N=45) is a randomized, double-blind, sham-controlled study in adults who achieved at least 15% total body weight loss on tirzepatide; after discontinuing the drug, participants were randomized 2:1 to a single Revita procedure or a sham endoscopic procedure and followed for one year. The Midpoint Cohort is not powered for formal statistical significance; results are descriptive and are intended to characterize the treatment effect and inform the Pivotal Cohort design and execution. Results in the Midpoint Cohort at one year are evaluated per the pre-specified statistical analysis plan defined for the pivotal study, with GLP-1 weight loss fitted as a

covariate on treatment effects, calculated as least-square means at the 20% reference. Both a Complete Ablation cohort (defined as >14cm of duodenal ablation) and an Optimized responder population (with > 14 cm duodenal ablation and ≥17.5% run-in weight loss) are pre-specified key secondary endpoints in the pivotal study. The Pivotal Cohort is fully randomized and well powered at the expected effect size to clear both co-primary endpoints in the modified intention-to-treat (mITT) population: (i) weight regain at six months (Revita versus sham) and (ii) a responder rate defined as the proportion of participants maintaining at least 5% total body weight loss relative to their pre-tirzepatide weight at one year. Topline six-month randomized data from the Pivotal Cohort are anticipated in early Q4 2026.

About Revita

Revita is Fractyl Health's lead product candidate, designed to remodel the duodenal lining via a one-time, minimally invasive endoscopic procedure intended to restore healthy nutrient sensing and signaling disrupted by chronic metabolic disease. Revita has received Breakthrough Device designation from the FDA for weight maintenance in people with obesity who discontinue GLP-1 therapies. Revita is for investigational use only in the United States and is CE marked in the European Union and United Kingdom.

About Fractyl Health

Fractyl Health is a clinical-stage metabolic therapeutics company advancing two differentiated candidates designed to target the root causes of obesity and T2D: Revita, a procedural therapy in pivotal development for post-GLP-1 weight maintenance, and Rejuva, an AAV-based gene therapy platform with its lead candidate RJVA-001 entering first-in-human clinical studies. Fractyl's goal is to advance metabolic disease treatment from chronic management toward prevention and reversal of disease. Fractyl is headquartered in Burlington, Massachusetts.

Forward-Looking Statements

This press release contains forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995. All statements contained in this press release that do not relate to matters of historical fact are forward-looking statements. These statements may be identified by words such as "aims," "anticipates," "believes," "could," "estimates," "expects," "forecasts," "goal," "intends," "may," "plans," "possible," "potential," "seeks," "will" and variations of these words or similar expressions that are intended to identify forward-looking statements, although not all forward-looking statements contain these words. Forward-looking statements in this press release include, without limitation, statements regarding: the promise and potential impact of our clinical trial data and product candidates, including Revita's potential for maintaining weight loss after GLP-1 based therapy discontinuation and stabilizing cardiometabolic parameters; the translatability of results and scalability of technique related to Revita; the design, initiation, timing and results of clinical enrollment and any clinical studies or readouts, including readouts from the REMAIN-1 Midpoint Cohort and the REMAIN-1 Pivotal Cohort; the potential launch or commercialization of any of our product candidates or products; our regulatory strategy, including potential use and benefits of the De Novo pathway (FDA pre-submission feedback is advisory and non-binding, and there is no assurance that FDA will accept a De Novo marketing application submission or that Revita will receive marketing authorization); the potential treatment population or benefits for any of our product candidates or products; our strategic and product development objectives and goals; and the timing of any of the foregoing. These statements are neither promises nor guarantees, but involve known and unknown risks, uncertainties and other important factors that may cause our actual results, performance or achievements to be materially different from any future results, performance or achievements expressed or implied by the forward-looking statements, including, but not limited to, the risks that are discussed more fully in our filings with the Securities and Exchange Commission (the SEC), including the "Risk Factors" section of our Annual Report on Form 10-K for the year ended December 31, 2025, filed with the SEC on March 24, 2026, and other documents we subsequently file with or furnish to the SEC, including our Quarterly Report on Form 10-Q for the quarter ended March 31, 2026, filed with the SEC on May 12, 2026. These forward-looking statements are based on management's current estimates and expectations. While we may elect to update such forward-looking

statements at some point in the future, we disclaim any obligation to do so, even if subsequent events cause our views to change.

Contact

Brian Luque, Head of Investor Relations and Corporate Development
IR@fractyl.com, 951.206.1200

Exhibit 99.2

FRACTYL health

Positive One-Year Randomized REMAIN-1 Midpoint Cohort Results

July 15, 2026
NASDAQ:GUTS

Revita is for investigational use only in the United States. Revita has a CE mark in the EU/UK.

Legal disclaimer

The study database has not been locked as this is an ongoing study, and the data are subject to further cleaning and validation.

Forward-looking statements

This presentation contains forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995. All statements contained in this presentation that do not relate to matters of historical fact are forward-looking statements. These statements may be identified by words such as "aims," "anticipates," "believes," "could," "estimates," "expects," "forecasts," "goal," "intends," "may," "plans," "possible," "potential," "seeks," "will" and variations of these words or similar expressions that are intended to identify forward-looking statements, although not all forward-looking statements contain these words. Forward-looking statements in this presentation include, without limitation, statements regarding: the promise and potential impact of our clinical trial data and product candidates, including Revita's potential for maintaining weight loss after GLP-1 based therapy discontinuation and stabilizing cardiometabolic parameters; the translatability of results and scalability of technique related to Revita; the design, initiation, timing and results of clinical enrollment and any clinical studies or readouts, including readouts from the REMAIN-1 Midpoint Cohort and the REMAIN-1 Pivotal Cohort; the potential launch or commercialization of any of our product candidates or products; our regulatory strategy, including potential use and benefits of the De Novo pathway (FDA pre-submission feedback is advisory and non-binding, and there is no assurance that FDA will accept a De Novo marketing application submission or that Revita will receive marketing authorization); the potential treatment population or benefits for any of our product candidates or products; our strategic and product development objectives and goals; and the timing of any of the foregoing. These statements are neither promises nor guarantees, but involve known and unknown risks, uncertainties and other important factors that may cause our actual results, performance or achievements to be materially different from any future results, performance or achievements expressed or implied by the forward-looking statements, including, but not limited to, the risks that are discussed more fully in our filings with the Securities and Exchange Commission (the SEC), including the "Risk Factors" section of our Annual Report on Form 10-K for the year ended December 31, 2025, filed with the SEC on March 24, 2026, and other documents we subsequently file with or furnish to the SEC, including our Quarterly Report on Form 10-Q for the quarter ended March 31, 2026, filed with the SEC on May 12, 2026. These forward-looking statements are based on management's current estimates and expectations. While we may elect to update such forward-looking statements at some point in the future, we disclaim any obligation to do so, even if subsequent events cause our views to change.

Industry data

This presentation also contains estimates, projections and other information concerning our industry, our business and the markets in which we operate. Information that is based on estimates, forecasts, projections, market research or similar methodologies is inherently subject to uncertainties and actual events or circumstances may differ materially from events and circumstances that are assumed in this information. Unless otherwise expressly stated, we obtained this industry, business, market, and other data from our own internal estimates and research as well as from reports, research, surveys, studies, and similar data prepared by market research firms and other third parties, industry, medical and general publications, government data and similar sources. While we are not aware of any misstatements regarding any third-party information presented in this presentation, their estimates, in particular, as they relate to projections, involve numerous assumptions, are subject to risks and uncertainties and are subject to change based on various factors.

Trademarks

This presentation may contain trademarks, service marks, trade names and copyrights of the Company and other companies, which are the property of their respective owners. The use herein does not imply an affiliation with, or endorsement by, the owners of these trademarks, service marks, trade names and copyrights. Third-party logos herein may be provided simply for illustrative purposes only. Inclusion of such logos does not necessarily imply affiliation with or endorsement by such firms or businesses. There is no guarantee that the Company will work, or continue to work, with any of the firms or businesses whose logos are included herein in the future.

This presentation shall not constitute an offer to sell or the solicitation of an offer to buy securities, nor shall there be any sale of securities in any state or jurisdiction in which such offer, solicitation, or sale would be unlawful prior to registration or qualification under the securities laws of any such state or jurisdiction.

FRACTYL health

Agenda

REMAIN-1 Midpoint Cohort One-Year Results

01 **REMAIN-1 Midpoint Cohort One-year results**

Up to 84% of weight loss retained with Revita vs 46% with sham at one year when an adequate dose of ablation is used

02 **KOL Discussant: Dr. Adarsh Thaker**

Co-lead, UCLA Bariatric Endoscopy Program and a Principal Investigator in REMAIN-1

Four pillars driving our conviction in Revita for post-GLP-1 weight maintenance

Topline pivotal data expected early Q4 '26 and potential FDA De Novo submission late Q4 '26[1]

1

The Clinical Signal Is Real

- **Up to 84% of weight loss retained with Revita vs 46% with sham at one year in REMAIN-1 Midpoint Cohort**
- **Ablation-length dose-response drives efficacy and durability through one year**

2

Pivotal Is Built to Win

- **Powered at >95%** with conservative assumptions
- **Dose-response and high-responder subgroup** are well represented and pre-specified in pivotal SAP

3

Clear Path to Commercial Value

- **Favorable FDA De Novo feedback received**
- **Large, defined, and growing market** with new introduction of GLP-1 coverage to CMS patients via Bridge program as of July '26

4

Funded Through Definitive Data[1]

- **$63M cash on hand at end of Q1'26**
- **Cash runway extends into early 2027 and through pivotal readout in early Q4 2026**
- **Funded to key value inflection** without planned incremental capital raise

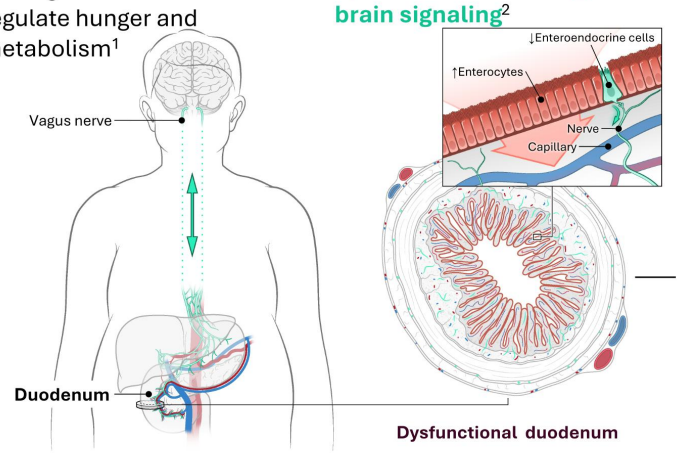
[1] These forward-looking statements are based on management's current estimates and expectations. Refer to the latest disclosures filed with the SEC for a discussion regarding Risk Factors to these and other estimates and expectations.

FRACTYL health

Duodenal mucosa: A compelling target for durable metabolic control

Nutrient signals from the duodenum travel via the vagus nerve to regulate hunger and metabolism[1]

Diet-induced mucosal changes lead to **increased** nutrient uptake and **impaired** gut-to-brain signaling[2]

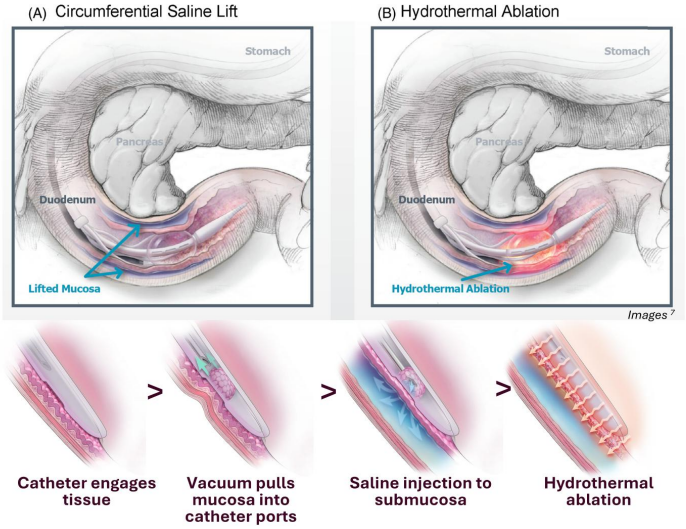


- **Duodenum:** First part of small intestine and critical metabolic signaling center in the gut.
- **Diet link:** Modern high-fat, high-sugar diets damage the duodenal mucosa, driving metabolic dysfunction.
- **Root cause:** Duodenal dysfunction, observed in animal models and in humans, is now considered a root cause of obesity and metabolic disease.[3]

[1] Kentish SJ, Page AJ. J Physiol. 2015;593(4):775-786. [2] Aliluev A, et al. Nat Metab. 2021;3(9):1202-1216. [3] D'Alessio DA, Campbell JE. Diabetes Obes Metab. 2026;28(S3):3-15.

FRACTYL health

Revita targets duodenal dysfunction: designed to durably reset abnormal weight setpoint[1-4]



- **Extent of dysfunction:** In animal models, duodenal dysfunction extends along the entire length of the duodenum, potentially into the proximal jejunum.[5]
- **Revita technical innovation:** Device development now enables routine ablation of the full duodenum to its end, allowing longer ablation lengths for profile optimization and dose-ranging.

Revita is for investigational use only in the United States; CE marked in the EU/UK. 1. Mah AT, et al. Endocrinology. 2014;155:3302-3314. 2. Mao J, et al. Diabetes. 2013;62:3736-3746. 3. de Moura EGH, et al. Endosc Int Open. 2019;7:E685-E690. 4. Haidry RJ, et al. Gastrointest Endosc. 2019;90:673-681. 5. Hoyt J, et al. Diabetes Obes Metab. 2024;1-12.

FRACTYL health

REMAIN-1 Midpoint Cohort weight maintenance pilot

Designed to inform design and execution of REMAIN-1 Pivotal Cohort

Patient population

- Adults with obesity (BMI 30-45 kg/m^2)
- GLP-1 naïve; no T2D
- n≈45

Efficacy endpoints

- % TBW change Revita vs sham at 3 and 6 months

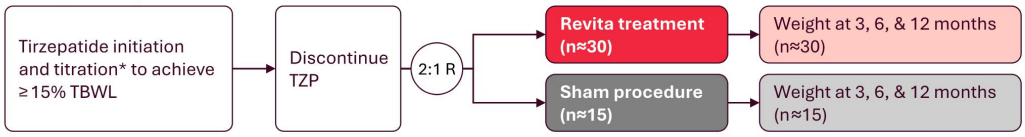
Study design

- Randomized (2:1 Revita vs Sham), double-blind, sham-controlled
- TZP administration to achieve ≥15% TBWL, then discontinued
- Diet and lifestyle counseling throughout

Key milestones

- **Midpoint cohort 3-mo data:** Sept '25
- **Midpoint cohort 6-mo data:** Jan '26
- **Midpoint cohort 12-mo data:** July '26

Study design



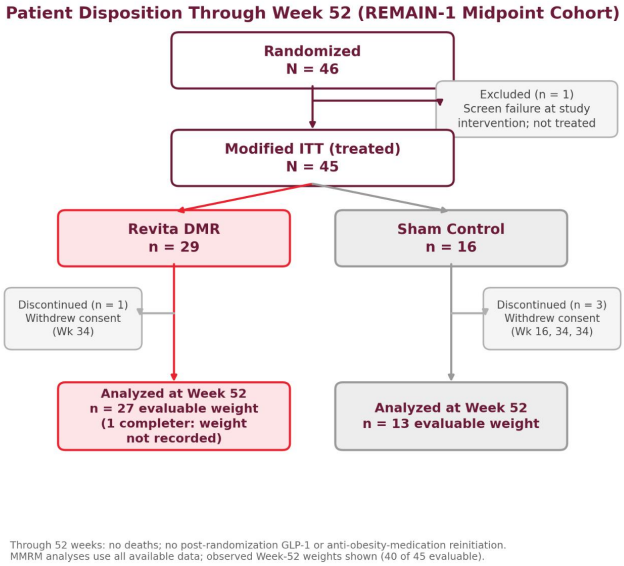
*Tirzepatide run-in modeled from SURMOUNT-4 trial. Abbreviations: BMI, body mass index; GLP-1, glucagon-like peptide 1; R, randomization; TBW, total body weight; TBWL, total body weight loss; TZP, tirzepatide; T2D, type 2 diabetes.

FRACTYL health

REMAIN-1 Midpoint Cohort patient disposition

High retention through one year of follow-up

- 41 of 45 treated participants (91%) remained on study through Week 52 (12 months)
- Only 4 discontinued (1 Revita, 3 sham): all withdrew consent
- No post-randomization GLP-1 reinitiation through 52 weeks
- Safety and efficacy analyses use all available data (n=45)
- Treatment policy estimand and efficacy estimand are identical



Through 52 weeks: no deaths; no post-randomization GLP-1 or anti-obesity-medication reinitiation. MMRM analyses use all available data; observed Week-52 weights shown (40 of 45 evaluable).

REMAIN-1 Midpoint Cohort. N=46 randomized; 1 screen-failure excluded (not treated); N=45 modified intention-to-treat (mITT). Abbreviations: DMR, duodenal mucosal resurfacing; GLP-1, glucagon-like peptide-1; mITT, modified intention-to-treat; MMRM, mixed-model repeated measures; R, randomization.

FRACTYL health

Two key observations from Midpoint Cohort 6-month results informed pivotal Statistical Analysis Plan

MIDPOINT COHORT OBSERVATION	IMPLICATION	PIVOTAL SAP DEFINITION
Dose Response: Effect size relates to ablation length: more complete ablation, more weight maintenance at 6 months (all 29 patients; consistent with prior DMR work in T2D[1]).	The procedure has a controllable 'dose response'; ablation completeness drives clinical effect.	Per-Protocol population defined as complete ablation of >14 cm; pre-specified as a key secondary endpoint
Responder Population: Effect size relates to magnitude of prior GLP-1 loss: high GLP-1 responders (≥17.5% TBWL) show widening separation vs sham.	Run-in weight loss (RWL) on GLP-1 modifies effect size; high GLP-1 responders are the patients most prone to regain after GLP-1 discontinuation.	RWL fitted as a covariate (LS means at the 20% reference) in mITT; ≥17.5% enrichment subgroup is pre-specified as a key secondary endpoint.

[1]Rajagopalan et al Diabetes Care 2016 Dec;39(12):2254-2261. MMRM model with Treatment x RWL interaction term , evaluated at RWL=20%. DMR, duodenal mucosal resurfacing; mITT, modified intention-to-treat; MMRM, mixed-model repeated measures; RWL, run-in weight loss; TBWL, total body weight loss

Midpoint Cohort analysis populations

Full cohort (mITT)

All randomized, treated participants. N = 45 (29 Revita, 16 sham); the primary analysis set for Co-Primary #1 at 6 months in pivotal study

High run-in loss

Participants who lost ≥17.5% of body weight on tirzepatide during run-in: high GLP-1 responders. Key secondary endpoint #1 in pivotal study

Complete ablation

Revita participants who received > 14cm duodenal ablation (the pivotal per-protocol 'dose'). Key secondary endpoint #2 in pivotal study

Optimized

Responder population identified in the intersection: high run-in loss and complete ablation, most consistent with ultimate clinical profile. Key secondary endpoint #3 in pivotal study

Revita reduces weight regain and benefits patients most when adequate dose of ablation is used

% Weight Change from Baseline at 12 months

- At 12 months, Revita reduced weight regain vs sham: 40% in the full cohort, rising to > 60% in patients with complete ablations > 14 cm
- Sham regain at 12 months consistent with 14% regain reported in SURMOUNT-4[1]

Full cohort (mITT): Sham n=16, Revita n=29. Complete Ablation cohort (> 14 cm ablation): Sham n=16, Revita n=17. LS-mean % total body-weight change from baseline at 12 months; MMRM, compound-symmetry covariance, estimated at 20% run-in weight loss; error bars ±SE. Exploratory REMAIN-1 Midpoint Cohort analysis; not powered for formal inference. 1. Aronne LJ, et al. Continued treatment with tirzepatide for maintenance of weight reduction (SURMOUNT-4). JAMA. 2024;331(1):38-48. Abbreviations: mITT, modified intention-to-treat; MMRM, mixed-model repeated measures; LS-mean, least-squares mean; SE, standard error.

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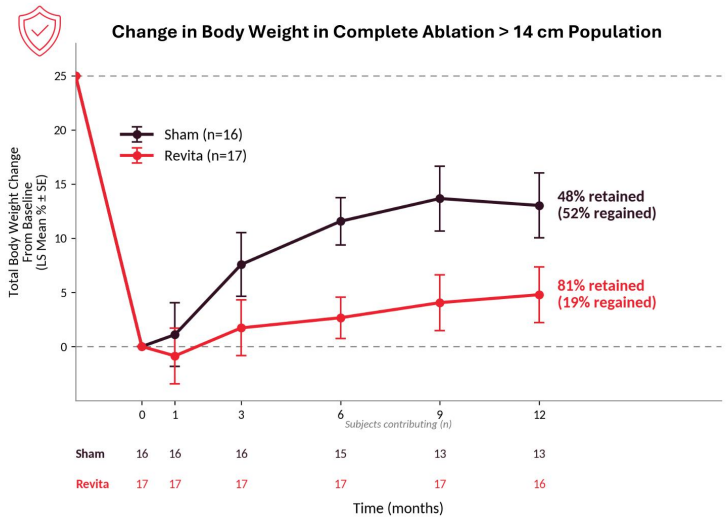
Revita cohort retained 81% of weight loss at 12 Months vs 48% in sham arm in complete ablation population



Ablation-length dose-response drives efficacy

Incorporated into Pivotal SAP as “Per Protocol” population

Pivotal Cohort implication:
Pivotal Cohort median ablation length is 16cm, implying that a majority of pivotal participants received complete ablations

Complete Ablation population: > 14 cm duodenal ablation, no run-in weight-loss restriction (Sham n=16, Revita n=17). Y-axis: LS-mean % total body-weight change from baseline; MMRM, compound-symmetry covariance, estimated at 20% run-in weight loss; error bars ± SE; n contributing shown per visit below axis. Retention = % of run-in weight loss maintained at 12 months. Exploratory REMAIN-1 Midpoint Cohort analysis; not powered for formal inference. Abbreviations: MMRM, mixed-model repeated measures; LS-mean, least-squares mean; SE, standard error; SAP, statistical analysis plan.

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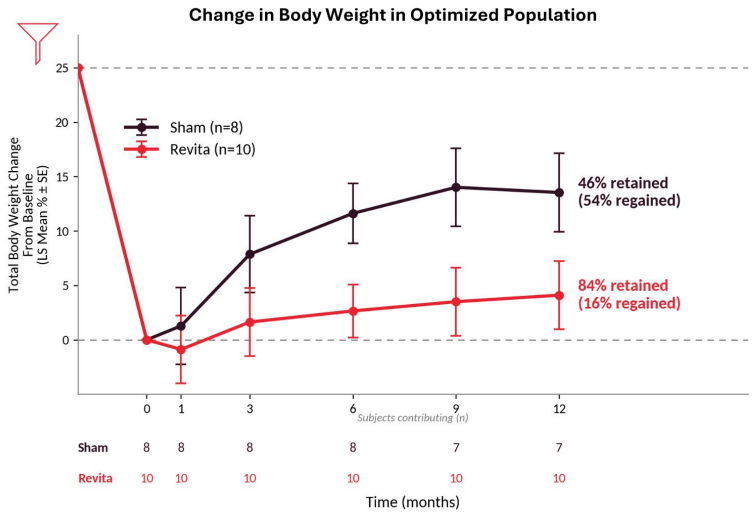
84% of weight loss retained at 12 months in Optimized Population (complete ablations & ≥ 17.5% RWL)



Right "dose" in the right patient

16% regain in Revita Cohort vs 54% regain in sham **represents > 70% reduction vs sham.**

Pivotal Cohort implication:

Pivotal Cohort mean TBWL on run-in is 18.3%, implying that a majority of pivotal participants have ≥ 17.5% RWL

Optimized population: complete ablation (> 14 cm) and run-in weight loss ≥ 17.5% (Sham n=8, Revita n=10). Y-axis: LS-mean % total body-weight change from baseline; MMRM, compound-symmetry covariance, estimated at 20% run-in weight loss; error bars ± SE; n contributing shown per visit below axis. Retention = % of run-in weight loss maintained at 12 months. Exploratory REMAIN-1 Midpoint Cohort subgroup; not powered for formal inference.
Abbreviations: MMRM, mixed-model repeated measures; LS-mean, least-squares mean; SE, standard error; RWL, run-in weight loss; TBWL, total body weight loss.

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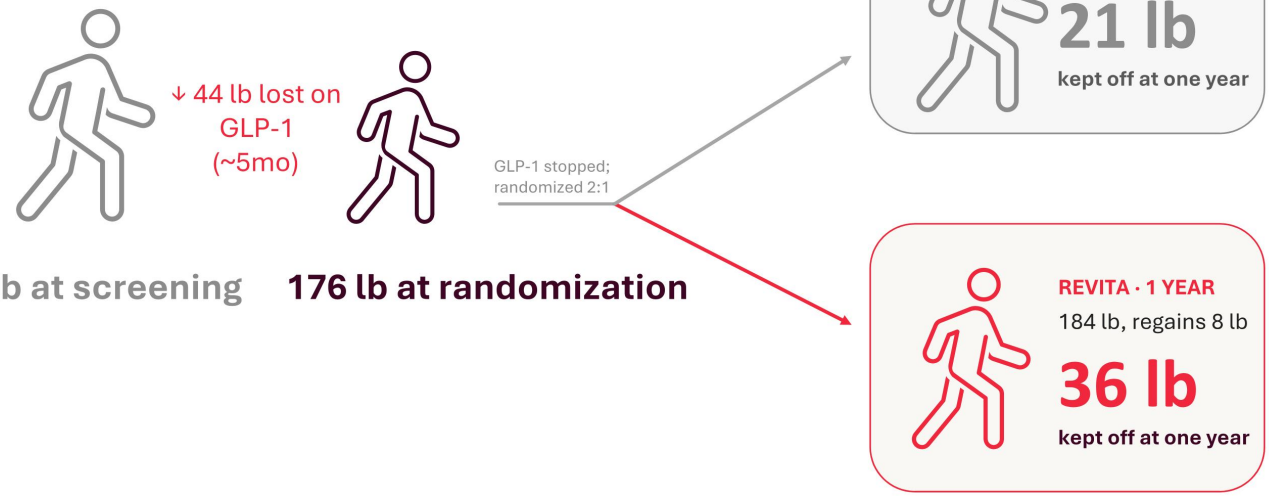
Effect size in Midpoint Cohort at 12 Mo is clinically meaningful and commercially attractive

Mean results as illustrative example[1]



1. Complete ablation population in REMAIN-1 Midpoint Cohort

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Favorable safety and tolerability through 12 months

No device-related serious AEs: a mild, periprocedural profile that supports outpatient use

- **No new device-related TEAEs between 6 and 12 months.**
- **No device-related SAEs:** one SAE (blocked bile duct) adjudicated as unrelated to the device or procedure.
- **No excess AEs with Revita:** any-TEAE rates matched sham (24% vs 25%).
- **Mild and periprocedural:** all 4 related events were Grade 1, on procedure day, and transient.
- **1 new diagnosis of Type 2 Diabetes in sham arm vs zero in Revita arm**

Treatment-Emergent Adverse Events (TEAEs)	Revita (n=29)	Sham (n=16)	Total (N=45)
Patients experiencing any TEAE, n (%)	**7 (24)**	**4 (25)**	**11 (24)**
TEAEs by grade, n (events)	**12**	**5**	**17**
Grade ≥3 TEAEs	1 (8)	0	1*
Grade 2 TEAEs	1 (8)	1 (20)	2**
Grade 1 TEAEs	10 (83)	4 (80)	14 (82)
Related TEAEs (probably related), n	**4**	**0**	**4**
Abdominal discomfort	1	0	1
Nausea	1	0	1
Dry mouth	1	0	1
Sore throat	1	0	1

*1 SAE: blocked bile duct (Grade IIIb, day 65); unrelated to device or procedure.
**2 Grade 2 AEs: Revita worsening hypertension (day 258); Sham urinary tract infection (day 239); both unrelated.
Related TEAEs = probably related to device/procedure; all Grade 1, onset day 0. Two Sham AEs previously ungraded in EDC: nausea (day 0), Type 2 diabetes (day 363) are now classified Grade 1.REMAIN-1 Stage 2a, through 52 weeks (12 months). AE, adverse event; TEAE, treatment-emergent adverse event; SAE, serious adverse event.

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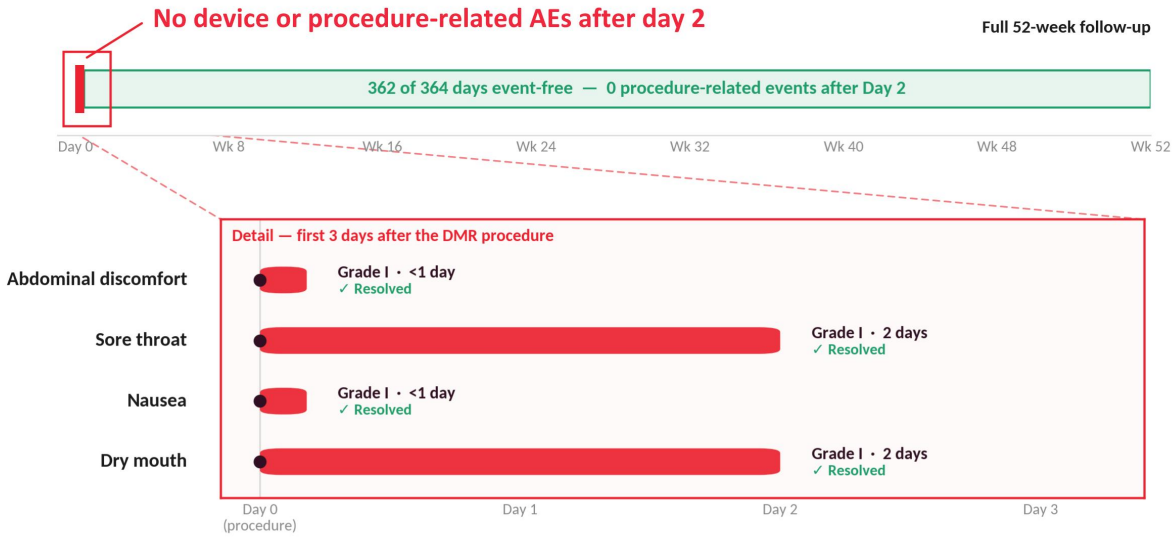
Procedure-related AEs: Mild, immediate, short-lived

No related SAEs: a mild, periprocedural profile that supports outpatient use



Abbreviations: DMR, duodenal mucosal resurfacing; AE, adverse event; SAE, serious adverse event.

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REMAIN-1 pivotal study in weight maintenance

Pivotal Cohort fully randomized; 6-mo topline pivotal data anticipated in early Q4 2026

Patient population

- Adults with obesity (BMI 30-45 kg/m^2)
- GLP-1 naïve; no T2D
- n≈315

Co-primary endpoints

- % TBW regain: Revita vs sham at 6 months *and*
- Responder rate: % participants who maintain weight loss at 12 months

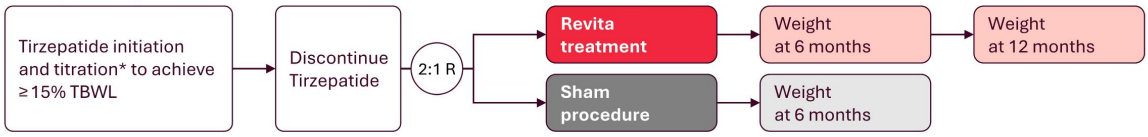
Study design

- Randomized (2:1 Revita vs Sham), double-blind, sham-controlled
- TZP administration to achieve ≥15% TBWL, then discontinued
- Diet and lifestyle counseling throughout

Anticipated milestones[1]

- **Complete randomizations:** Feb '26
- **Topline 6-month pivotal data:** Early Q4 '26
- **Potential De Novo marketing application submission:** Late Q4 '26

Study design



*Tirzepatide run-in modeled from SURMOUNT-4 trial. [1]These forward-looking statements are based on management's current estimates and expectations.Refer to the latest disclosures filed with the SEC for a discussion regarding Risk Factors to these and other estimates and expectations. Abbreviations: BMI, body mass index; GLP-1, glucagon-like peptide 1; R, randomization; TBW, total body weight; TBWL, total body weight loss; TZP, tirzepatide; T2D, type 2 diabetes.

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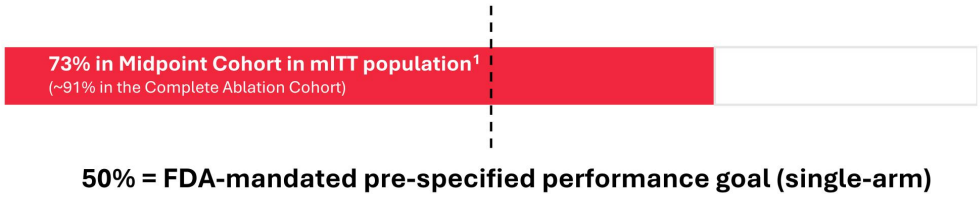
Co-primary endpoints very well powered for pivotal trial success

First co-primary: % TBW regain: Revita vs sham at 6 months

Illustrative sham 6-mo regain in mITT[1]	Revita regain needed to win[1,2]	Observed in Midpoint Cohort[1,3]	Projected pivotal p-value[4]
10%	≤ 7.4%	5.1%	*p<0.05*
11.6% (base case, current)	≤ 9.0%	5.1%	*p<0.05*
12.5%	≤ 9.9%	5.1%	*p<0.05*

Second co-primary: Responder rate: % of Revita patients maintain ≥ 5% TBWL at 12 months



50% = FDA-mandated pre-specified performance goal (single-arm)

1 Values shown are model-based estimates (mITT MMRM at the 20% run-in weight-loss reference). REMAIN-1 Midpoint Cohort, exploratory.
2 Maximum Revita weight regain at which the pivotal reaches statistical significance vs the sham scenario shown (~ 2.5-point gap at pivotal N=315).
3 5.1% = LS-mean percent total body-weight regain from post-run-in baseline at 6 months (Week 26); mITT MMRM at 20% run-in weight-loss reference; n=29 Revita. REMAIN-1 Midpoint Cohort, exploratory.
4 Two-sided; Revita vs sham, pivotal N=315, randomized 2:1 (Revita:sham). Sham values illustrative.
Abbreviations: LS-mean, least-squares mean; mITT, modified intention-to-treat; MMRM, mixed-model repeated measures; TBW, total body weight; TBWL, total body weight loss; .

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Key takeaways from REMAIN-1 Midpoint Cohort results

Substantial Weight Loss Retained at One Year

- Up to 84% of on-drug weight loss retained with Revita at one year off GLP-1 when adequate dose of ablation is used vs 46% in sham
- All physicians achieved complete ablations in the pivotal, which bodes well for commercial training program
- Given absence of any dose-limiting toxicity, there is potential room for even further profile optimization

Excellent Safety and Tolerability Profile

- Essentially no safety signal observed over sham upper endoscopy in this Cohort through 1 year.
- Periprocedural AE profile supports potential broad outpatient endoscopic use

Well-Powered Pivotal

- Pivotal study well powered to deliver clinically and commercially valuable results.
- Topline pivotal data expected in early Q4 2026, with potential De Novo regulatory filing in late Q4 2026.[1]

[1] These forward-looking statements are based on management's current estimates and expectations. Refer to the latest disclosures filed with the SEC for a discussion regarding Risk Factors to these and other estimates and expectations. AE, adverse event

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A Treating Physician's Perspective from the Endoscopy Suite

Adarsh M Thaker, MD
Assistant Professor of Medicine,
David Geffen School of Medicine at UCLA
Co-lead, UCLA Bariatric Endoscopy Program
Principal Investigator, REMAIN-1

Disclosure: Dr. Thaker is a paid Fractyl Health clinical advisor and a REMAIN-1 investigator.

A clear, near-term path to potential launch

These forward-looking statements are based on management's current estimates and expectations. Refer to the latest disclosures filed with the SEC for a discussion regarding Risk Factors to these and other estimates and expectations. Revita is investigational: commercialization is subject to REMAIN-1 results and FDA marketing authorization, neither of which is assured.

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Appendix

Revita Reduces Weight Regain and Benefits Patients Most When Adequate Dose of Ablation is Used

Complete Ablation (>14 cm)	Sham (n=16)	Revita (n=17)
Weight regain, % of baseline	13.0%	4.8%
Weight regain, % of pre-tirzepatide weight	10.4%	3.8%
GLP-1 weight loss retained	48%	81%

Full cohort (mITT): Sham n=16, Revita n=29. Complete Ablation cohort (> 14 cm ablation): Sham n=16, Revita n=17. LS-mean % total body-weight change from baseline at 12 months; MMRM, compound-symmetry covariance, estimated at 20% run-in weight loss; error bars ±SE. Exploratory REMAIN-1 Stage 2a Midpoint Cohort analysis; not powered for formal inference.

1. Aronne LJ, et al. Continued treatment with tirzepatide for maintenance of weight reduction (SURMOUNT-4). JAMA. 2024;331(1):38-48.

Abbreviations: mITT, modified intention-to-treat; MMRM, mixed-model repeated measures; LS-mean, least-squares mean; SE, standard error.

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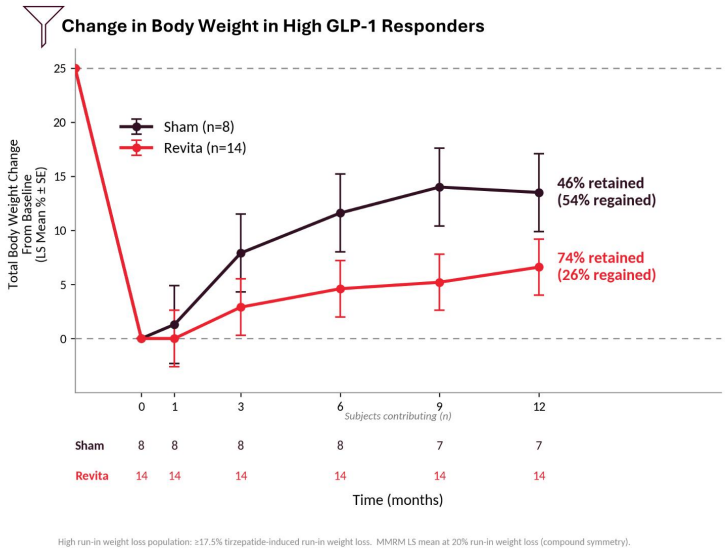
Benefit is strong in patients who lost the most on GLP-1



High run-in weight loss population: ≥17.5% tirzepatide-induced run-in weight loss. MMRM LS mean at 20% run-in weight loss (compound symmetry).

Response tracks GLP-1 weight loss

Revita retained 74% of run-in weight loss vs 46% in sham.

Pivotal Cohort implication:

Pivotal Cohort mean run-in TBWL is 18.3%, implying most pivotal participants are high GLP-1 responders.

Y-axis: LS-mean % total body-weight change from baseline; MMRM, compound-symmetry covariance, estimated at 20% run-in weight loss; error bars ± SE; n contributing shown per visit below axis. Retention = % of run-in weight loss maintained at 12 months. Exploratory REMAIN-1 Midpoint Cohort analysis; not powered for formal inference. Abbreviations: MMRM, mixed-model repeated measures; LS-mean, least-squares mean; SE, standard error; SAP, statistical analysis plan.

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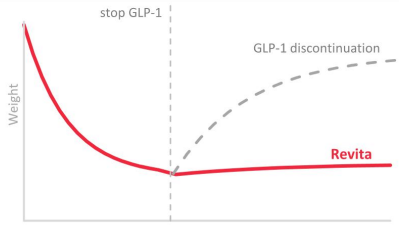
One Durable Metabolic Reset, Three Potential Use Cases in Obesity

STEP 1 · PROVE IT

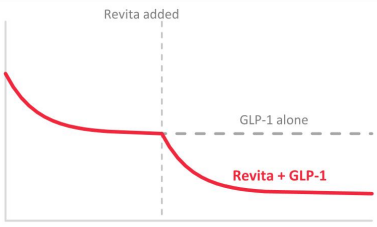
Maintenance after GLP-1



Off-ramp: preserve weight and metabolic benefit after discontinuation

STEP 2 · COMBINE

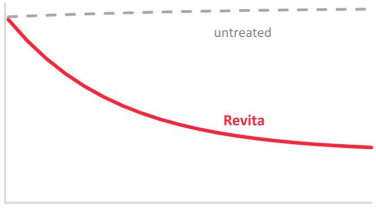
Adjunct to orals, injectables, procedures



Add-on: Pair with drugs to deepen and sustain response, enabling lower doses, drug holidays, and durable step-down

STEP 3 · FRONT LINE

Front-line, drug-free



Kick-start : An earlier one-time option for patients who can't tolerate, afford, or stay on chronic drugs.

Illustrative and hypothetical; schematic, not clinical data; contingent on pivotal results.

Illustrative, forward-looking expansion framework contingent on pivotal success and future studies; not FDA-assessed. Timelines are management estimates. Subject to the risks described in the Company's SEC filings.

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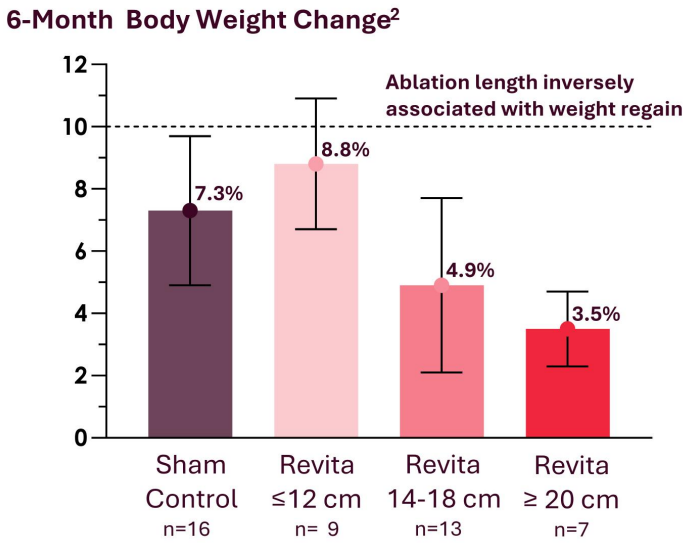
Reminder: Ablation length correlates with effect size, defining target treatment length for Pivotal Cohort

- **Dose-response:** Significant correlation between ablation length and weight maintenance treatment effect observed in Midpoint Cohort at 6 mo (p=0.048 per Pivotal Cohort key secondary endpoint; n=29 Revita arm[1])
- Participants receiving >14 cm ablations regained ~ 50% the weight of sham at 6-months

Midpoint Cohort dose-response findings defines threshold of effect dose and informs > 14 cm adopted for Pivotal Cohort Per-Protocol population



[1]Dose-response assessed by Spearman rank correlation between ablation length and weight regain at week 26 within the blinded DMR arm. [2]Observed means and SEM at Week 26. DMR patients (n=29) stratified by ablation tercile. Dashed line = expected weight regain based on SURMOUNT-4 GLP-1 withdrawal data. Mean run-in TBWL balanced across groups.

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