Nuvation Bio®

DRIVEN BY SCIENCE
FOCUSED ON LIFE

November 2026

Forward-looking statements

Certain statements included in this presentation (this "Presentation") that are not historical facts are forward-looking statements for purposes of the safe harbor provisions under the United States Private Securities Litigation Reform Act of 1995. Forward-looking statements are sometimes accompanied by words such as "believe," "may," "will," "estimate," "continue," "anticipate," "intend," "expect," "should," "would," "plan," "predict," "potential," "seem," "seek," "future," "outlook" and similar expressions that predict or indicate future events or trends or that are not statements of historical matters. These forward-looking statements for the quarter regarding Nuvation Bio Inc. ("Nuvation Bio" or the "Company") include, but are not limited to, statements regarding IBTROZI's and safusidenib's best-in-class therapeutic potential, IBTROZI's commercial potential including its theoretical maximum ROS1+ NSCLC market opportunity based on IBTROZI's median progression-free survival, safusidenib's commercial potential, our development plans for safusidenib including our expectations that the SIGMA study may support approval of safusidenib for the maintenance treatment of IDH1-mutant astrocytoma with high-risk features and grade 3 oligodendroglioma, our plans to share new data and updates from our clinical programs including for taletrectinib, safusidenib and our DDC programs, the potential of the DDC platform and our evaluation of DDC preclinical candidates, our expectations regarding regulatory and reimbursement developments, and strength of cash position providing a path to profitability without need to raise additional capital. These statements are based on various assumptions, whether or not identified in this Presentation, and on the current expectations of the management team of Nuvation Bio and are not predictions of actual performance. These forward-looking statements are subject to a number of risks and uncertainties that may cause actual results to differ from those anticipated by the forward-looking statements, including but not limited to the challenges associated with conducting drug discovery and commercialization and initiating or conducting clinical studies due to, among other things, difficulties or delays in the regulatory process, enrolling subjects or manufacturing or acquiring necessary products; the emergence or worsening of adverse events or other undesirable side effects; risks associated with preliminary and interim data, which may not be representative of more mature data; physician and patient behavior; and competitive developments. Risks and uncertainties facing Nuvation Bio are described more fully in its Form 10-Q for the quarter ended September 30, 2026, filed with the U.S. Securities and Exchange Commission (the "SEC") on November 4, 2026 under the heading "Risk Factors," and other documents that Nuvation Bio has filed or will file with the SEC. You are cautioned not to place undue reliance on the forward-looking statements, which speak only as of the date of this Presentation. Nuvation Bio disclaims any obligation or undertaking to update, supplement or revise any forward-looking statements contained in this Presentation.

Nuvation Bio is focused on tackling the greatest challenges in cancer treatment

Global, commercial-stage oncology company focused on innovating and developing first- or best-in-class medicines for diseases that represent particularly large unmet patient needs

IBTROZI® (taletrectinib) is a next generation, potentially **best-in-class ROS1 inhibitor approved for advanced ROS1+ NSCLC in the U.S., Japan, and China**

Safusidenib is a **potentially best-in-class**, brain penetrant, ***IDH1* inhibitor** being evaluated in studies **across all grades and risk groups within the *IDH1*-mutant glioma landscape**

Evaluating preclinical candidates from proprietary **Drug-Drug Conjugate (DDC)** platform; DDCs are designed to **bind to two targets** simultaneously

Robust cash balance of approximately **$663 million** is expected to provide **path to profitability without need for additional funding**

Nuvation Bio is a commercial-stage company with a pivotal-stage pipeline program and novel preclinical platform

Program	Target Indication(s)	Current Stage of Development	Anticipated Milestones & Recent Updates	Commercial Partners
IBTROZI taletrectinib 200mg capsules	Advanced ROS1+ NSCLC	*Approved for advanced ROS1+ NSCLC in the U.S., Japan, and China*	• Approved by the U.S. FDA, Japan's MHLW, and China's NMPA • MAA validated by the EMA • Enrolling TRUST-IV study for early-stage ROS1+ NSCLC	Innovent (Greater China) Eisai (Europe & other[2]) NIPPON KAYAKU (Japan)
Safusidenib (*IDH1*)	*IDH1*-mutant glioma	*Multiple studies ongoing across the IDH1-mutant glioma landscape*	• Enrolling pivotal SIGMA study for astrocytoma with high-risk features[1] and exploratory cohort for grade 3 oligodendroglioma • Initiating phase 3 study for grade 2 *IDH1*-mutant glioma outside the U.S. • Initiating phase 2 study post-vorasidenib	N/A
Drug-Drug Conjugate (DDC) platform	Solid tumors		• Currently evaluating preclinical candidates	N/A

EMA: European Medicines Agency; IDH1: mutant isocitrate dehydrogenase 1; MAA: Marketing Authorisation Application; MHLW: Ministry of Health, Labour and Welfare; NSCLC: Non-small cell lung cancer; NMPA: National Medical Products Administration; ROS1+: c-ros oncogene 1-positive. 1. Includes patients with grade 4 astrocytoma and patients with grade 2 or 3 astrocytoma with certain high-risk features. 2. Includes the Middle East, North Africa, Russia, Turkey, Canada, Australia, New Zealand, Singapore, the Philippines, Indonesia, Thailand, Malaysia, Vietnam, and India.

IBTROZI | ROS1i

Advanced ROS1+ NSCLC

Approved by U.S. FDA in June 2025



IBTROZI is a next generation, potentially best-in-class ROS1 TKI



Global approvals

- **Line agnostic approval in the U.S. (June 11, 2025), Japan, and China** for advanced ROS1+ NSCLC
- NDA received **Priority Review** from the U.S. FDA following **Breakthrough Therapy Designations** in 1L & 2L



Differentiated profile[1]

- Potentially best-in-class efficacy and safety profile
- Durable responses and prolonged progression-free survival
- Highly brain penetrant and active against common mutations



Robust commercial opportunity

- Annual Incidence: ~3,000 advanced ROS1+ NSCLC patients in the U.S.
- Significant potential supported by 50-month PFS in the TRUST-I study[1]
- Since launch: ~920 new patient starts and ~$94m[2] in U.S. net product revenue as of September 30, 2026

NDA: New Drug Application; FDA: Food and Drug Administration; PFS: Progression-free survival; TKI: Tyrosine kinase inhibitor. 1. Bazhenova, et al., *AACR Annual Meeting*, 2026. 2. Nuvation Bio SEC Filings. IBTROZI U.S. net product revenue in 2025 of $24.7 million.

Increasing number of patients starting IBTROZI in the first-line setting will support long-term revenue growth

IBTROZI launch highlights

As of September 30, 2026

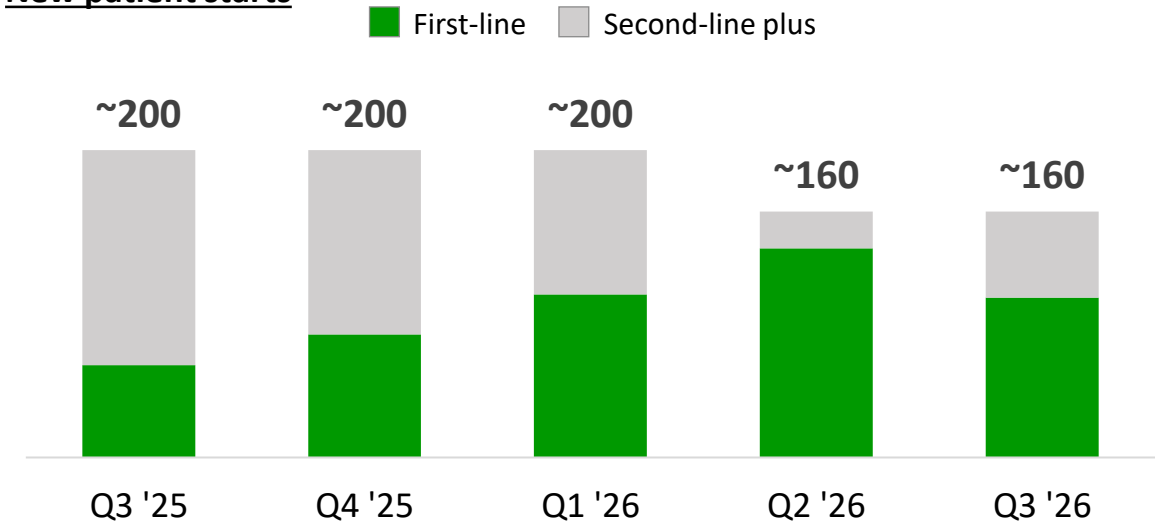
- ✓ **Market leader** in active ROS1 patients on therapy[1]
- ✓ **>60%** market share of new first-line patient starts[1]
- ✓ **~920** new patient starts since launch
- ✓ **~480** new first-line patients started since launch
- ✓ Real-world KOL feedback in line with clinical trial results including manageable tolerability profile
- ✓ Broad and favorable coverage across the U.S.

IBTROZI launch trajectory

IBTROZI U.S. net product revenue ($M)

Q3 '25	Q4 '25:	Q1 '26	Q2 '26	Q3 '26
$7.7	$15.7	$18.5	$23.2	$27.5

New patient starts



% of NPS first-line

~30%	~40%	~50%	~85%	~65%

First-line: Represents patients treated with IBTROZI as their first tyrosine kinase inhibitor (TKI); NPS: New patient starts; Second-line plus: Represents patients who have already received one or more TKIs prior to treatment with IBTROZI.
Source: Nuvation Bio data on file. 1. Based on IQVIA Claims data from January to September 30, 2026.

The efficacy bar with other approved first-line ROS1 therapies was 79% ORR and 34-month median DOR prior to the approval of IBTROZI

	First-line (TKI-naïve)		
	Repotrectinib[1]	Entrectinib[2]	Crizotinib[3]
Study	*TRIDENT-1*	*ALKA-372-001, STARTRK-1, STARTRK-2*	*PROFILE 1001*
n	71	172	53
ORR	79%	67%	72%
Median DOR	34 months	20 months	25 months
Median PFS	36 months	17 months	19 months
IC-ORR[1]	89% (8/9)	49% (25/51)	N/A

ORR: confirmed Overall response rate; DOR: Duration of response; IC-ORR: Intracranial overall response rate; PFS: Progression free survival. Note: These data are derived from different clinical studies, with differences in study design and patient populations. No head-to-head studies have been conducted. Comparisons in a head-to-head study may yield different results. 1. AUGTYRO prescribing information and Drilon et al., *New England Journal of Medicine*, 2024. 2. Fan et al., *Clinical Lung Cancer*, 2024. 3. XALKORI prescribing information and Shaw et al., *Annals of Oncology*, 2019.

IBTROZI's first-line ORR is 90% and median DOR is 50 months – unmatched in advanced ROS1 NSCLC

	August 2025 data cutoff		Aug. 2025 data cutoff
	TRUST-I (label)[1]	TRUST-II (label)[1]	Pooled[2]
n	103	54	157
cORR	90%	87%	90%
Median DOR	50 months	*Not Reached*	50 months
Median PFS	50 months	*Not Reached*	46 months
IC-cORR	88% (7/8)	57% (4/7)	77% (13/17)

cORR: confirmed Overall response rate; DOR: Duration of response; IC-cORR: Intracranial confirmed overall response rate; JCO: Journal of Clinical Oncology; PFS: Progression free survival. 1. IBTROZI prescribing information, excluding median PFS; IC-cORR is not broken out by TRUST-I and TRUST-II study in the IBTROZI prescribing information and includes patients who had measurable CNS metastases at baseline as assessed by BICR and had not received radiation therapy to the brain within 2 months prior to study entry; Median duration of follow-up of 51.0 and 30.6 months in TRUST-I and TRUST-II, respectively. 2. Bazhenova, et al., AACR Annual Meeting, 2026.

No drugs in solid tumor oncology have demonstrated the combined ORR and mDOR seen with IBTROZI in the first line (TKI-naïve) setting

Program	ORR	mPFS	mDOR
RETEVMO (selpercatinib)[1]	84%	22 months	20 months
AUGTYRO (repotrectinib)[2]	79%	36 months	34 months
ALECENSA (alectinib)[3]	79%	26 months	< 18 months
TAGRISSO (osimertinib)[4]	77%	19 months	17 months
LORBRENA (lorlatinib)[5]	76%	> 84 months	NE
XTANDI (enzalutamide)[6]	59%	20 months	--

mDOR: median Duration of response; ORR: Overall response rate; mPFS: median Progression-free survival. Note: Sorted by ORR; Each product is approved for use in their respective indications and the data shown are derived from different clinical studies with differences in cancer types, study design and patient populations. No head-to-head studies of IBTROZI to other products have been conducted. 1. RETEVMO prescribing information; Drilon et al., *Journal of Clinical Oncology*, 2022. 2. AUGTYRO prescribing information; Drilon et al., *New England Journal of Medicine*, 2024. 3. ALECENSA prescribing information. 4. TAGRISSO prescribing information; Soria et al., *New England Journal of Medicine*, 2018. 5. LORBRENA prescribing information; Mok et al., *Journal of Clinical Oncology,* 2026. 6. Beer et al., *New England Journal of Medicine,* 2014; Beer et al., *European Urology* (Final Analysis of PREVAIL study), 2016.

The efficacy bar with other approved second-line ROS1 therapies is 49% ORR, 15-month median DOR, and 48% intracranial ORR

	1 prior ROS1 TKI	
	Repotrectinib[1]	Zidesamtinib[2]
Study	*TRIDENT-1*	*ARROS-1*
n	56	117
ORR	38%	49%
Median DOR	15 months	N/A
Median PFS	9 months	N/A
G2032R ORR	59% (10/17)	54% (14/26)
IC-ORR[1]	38% (5/13)	48% (24/50)

ORR: confirmed Overall response rate; DOR: Duration of response; IC-ORR: Intracranial overall response rate; PFS: Progression free survival. Note: These data are derived from different clinical studies, with differences in study design and patient populations. No head-to-head studies have been conducted. Comparisons in a head-to-head study may yield different results. 1. AUGTYRO prescribing information and Drilon et al., *New England Journal of Medicine*, 2024. 2. JIDEYTRO prescribing information.

IBTROZI's second-line ORR is 56%, median DOR is 17 months, and intracranial ORR is 66% – unmatched in advanced ROS1 NSCLC

	August 2025 data cutoff		Aug. 2025 data cutoff
	TRUST-I (label)[1]	TRUST-II (label)[1]	Pooled[2]
n	66	47	113
cORR	52%	62%	56%
Median DOR	13 months	19 months	17 months
Median PFS	8 months	12 months	10 months
G2032R cORR	62% (8/13)		62% (8/13)
IC-cORR	75% (9/12)	50% (6/12)	66% (21/32)

cORR: confirmed Overall response rate; DOR: Duration of response; IC-cORR: Intracranial confirmed overall response rate; JCO: Journal of Clinical Oncology; PFS: Progression free survival. 1. IBTROZI prescribing information, excluding median PFS; IC-cORR is not broken out by TRUST-I and TRUST-II study in the IBTROZI prescribing information and includes patients who had measurable CNS metastases at baseline as assessed by BICR and had not received radiation therapy to the brain within 2 months prior to study entry; Median duration of follow-up of 45.2 and 30.5 months in TRUST-I and TRUST-II, respectively. 2. Bazhenova, et al., AACR Annual Meeting, 2026.

All other approved brain-penetrant ROS1 TKIs have CNS warnings and precautions in their labels – except IBTROZI

Approved ROS1 TKI	Brain penetrant	CNS label warning	CNS-related warning ADRs
XALKORI® CRIZOTINIB	✗	N/A	N/A
ROZLYTREK™ entrectinib 100 mg | 200 mg capsules	✓	✓	• Patients experienced one or more events of cognitive impairment, including mood disorders, dizziness, and/or sleep disturbances
AUGTYRO™ (repotrectinib) 40 mg capsules	✓	✓	• Patients experienced one or more events of dizziness, ataxia, and/or cognitive disorders
Jideytro™ (zidesamtinib) 25 mg 100 mg tablets	✓	✓	• Patients experienced one or more events of dizziness, ataxia, cognitive and/or psychiatric disorders

ADR: Adverse reaction; TKI: Tyrosine kinase inhibitor. Note: These data are derived from different clinical studies, with differences in study design and patient populations. No head-to-head studies have been conducted. Comparisons in a head-to-head study may yield different results. Sources: Warnings and precautions section of all FDA approved labels including: XALKORI prescribing information, ROZLYTREK prescribing information, AUGTYRO prescribing information, and JIDEYTRO prescribing information.

IBTROZI's safety profile is favorable as only 6.5% of 337 patients with ROS1+ NSCLC had a TEAE leading to drug discontinuation in pivotal studies

Select Adverse Reactions ≥20%

Adverse Reaction: n (%)	Any grade	Grade 1	Grade 2	Grade ≥3
Diarrhea	214 (64)	169 (50)	38 (11)	7 (2)
Nausea	159 (47)	123 (36)	31 (9)	5 (1)
Vomiting	146 (43)	114 (34)	27 (8)	5 (1)
Dizziness	75 (22)	67 (20)	7 (2)	1 (0)
Rash	75 (22)	43 (13)	26 (8)	6 (2)
Constipation	71 (21)	61 (18)	10 (3)	0 (0)
Fatigue	67 (20)	49 (15)	15 (4)	3 (1)

Select Laboratory Abnormalities[1] (Grade 3/4 ≥ 5%)

Lab Abnormality: n (%)	Any grade	Grade 1	Grade 2	Grade ≥3[1]
AST increased	293 (87)	191 (57)	68 (20)	34 (10)
ALT increased	284 (85)	170 (51)	70 (21)	44 (13)
CPK increased	179 (53)	55 (37)	16 (11)	8 (5)
Neutrophils decreased	81 (25)	37 (11)	26 (8)	18 (5)

Key takeaways from IBTROZI's safety profile

- **Discontinuation rate is lowest of approved ROS1 TKIs**
  - 6.5% of patients discontinued at 11 months of median treatment exposure
  - Only 1 patient (0.3%) discontinued due to the top 6 most common adverse events
- **Adverse event profile does not include persistent clinical issues that will impact uptake of IBTROZI**
  - 1/337 patients discontinued due to increased AST/ALT
  - ~80% of diarrhea was grade 1, occurred within ~2 days of starting therapy, and resolved in ~1 day
  - >90% of dizziness was grade 1 and transient, lasting ~3 days, and label does not include CNS warning

ALT: alanine aminotransferase; AST: aspartate aminotransferase; CPK: creatinine phosphokinase; TEAE: treatment-emergent adverse event. Source: IBTROZI prescribing information. Note: IBTROZI safety population includes 337 patients with ROS1+ NSCLC who received > 1 dose of IBTROZI (600mg). 1. The denominator used to calculate the rate varied from 149 to 336 based on the number of patients with a baseline value and at least one post-treatment value.

IBTROZI is well-tolerated with only 1 of 337 patients (0.3%) discontinuing treatment due to the 6 most common adverse events seen in pivotal studies

TEAE	Median Time to Onset (Days)	Median Time to Resolution, (Days)	Dose Interruption, n (%)	Dose Reduction, n (%)	Treatment Discontinuation, n (%)
Increased AST	16	50	23 (7)	17 (5)	1 (0.3)
Increased ALT			23 (7)	29 (9)	
Diarrhea	2	1	6 (2)	8 (2)	0
Nausea	2	3	5 (2)	4 (1)	0
Vomiting	3	1	10 (3)	5 (2)	0
Dizziness	34	3	2 (1)	1 (0.3)	0

ALT: Alanine aminotransferase; AST: Aspartate aminotransferase; TEAE: Treatment-emergent adverse event. Source: IBTROZI prescribing information and Li, et al., WCLC Presentation, 2025. Note: IBTROZI safety population includes 337 patients with ROS1+ NSCLC who received > 1 dose of IBTROZI (600mg). Please refer to the IBTROZI prescribing information for additional safety data.

IBTROZI has 11 – 20x selectivity for ROS1 over TRKb in enzymatic assays and cell growth inhibition assays

Kinase selectivity

	IC50 nM		Fold selectivity
	ROS1	TRKb	
IBTROZI[1]	0.207	2.28	11x
IBTROZI[2]	0.073	1.47	20x
Repotrectinib[3]	1.1	1.2	1x

In vitro cell growth inhibition in ROS1 and TRKb-fusion driven cell lines

	IC50 nM					Fold selectivity
	CD74-ROS1	SLC34A-ROS1	GOPC-ROS1	**ROS1 average**	**ETV6-NTRK2 (TRKb)**	
IBTROZI	1.7	11.1	3.8	**5.5**	**103**	19x
Repotrectinib	0.8	6.5	2.2	**3.2**	**3.3**	1x

Source: Nuvation Bio internal preclinical research data on file; Katayama et al, *Nature Communications*, 2019. 1. ATP concentration at Km. 2. ATP concentration at 10 uM. 3. ATP concentration at 1 mM.

ROS1+ NSCLC market represents a sizeable global commercial opportunity – IBTROZI now approved in U.S., Japan, and China

Key takeaways

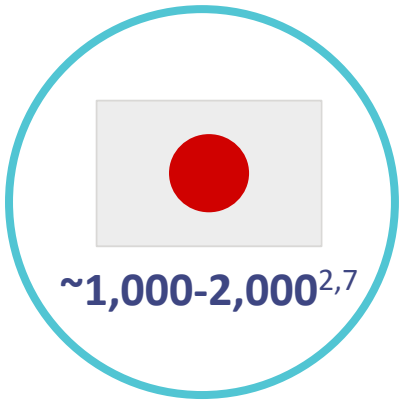
- NSCLC accounts for ~87%[1] of all lung cancers
- ROS1+ lung cancer represents ~2%[2] of new NSCLC cases each year
- There are four therapies other than IBTROZI approved in the U.S. to treat ROS1+ NSCLC:

1st gen.
- Crizotinib (Pfizer, approved 2016[3])
- Entrectinib (Roche, approved 2019[4])

2nd gen.
- Repotrectinib (Bristol Myers, approved 2023[5])
- Zidesamtinib (GSK, approved 2026[6] in TKI-pretreated patients only)

Estimated new cases per year









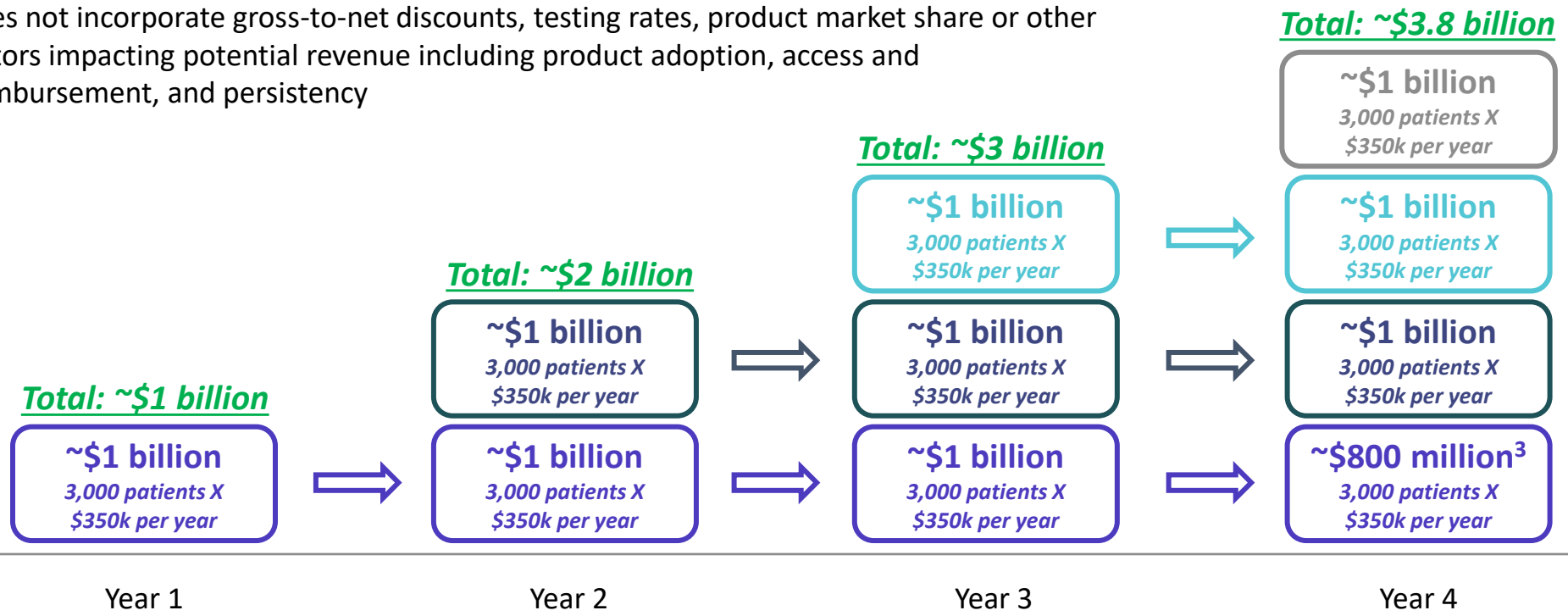
mPFS: median progression-free survival; TKI: tyrosine kinase inhibitor. 1. American Cancer Society (2025). 2. National Center for Biotechnology Information: Gendarme et al., Curr Oncol (2022). 3. Initially approved by U.S. FDA in 2011 for the treatment of patients with advanced or metastatic ALK-positive NSCLC; later approved in 2016 for the treatment of patients with metastatic ROS1+ NSCLC. 4. Approved by U.S. FDA in 2019 for the treatment of patients with metastatic ROS1+ NSCLC and the treatment of patients with neurotrophic tyrosine receptor kinase (NTRK) gene fusion without a known acquired resistance mutation. 5. Approved by U.S. FDA in 2023 for the treatment of patients with advanced or metastatic ROS1+ NSCLC. 6. Approved by U.S. FDA in 2026 for the treatment of patients with advanced or metastatic ROS1+ NSCLC who received a prior ROS1 TKI. 7. National Cancer Center Japan (2019). 8. European Cancer Information Systems (2021). 9. Gao et al., J Thorac Oncol (2020). 10. Zhang et al., Thorac Cancer (2019).

IBTROZI's strong clinical profile turns the commercial opportunity from an incidence story to a prevalence story

Theoretical maximum U.S. ROS1+ NSCLC market opportunity

Key assumptions and commentary

- Incidence: ~3,000[1] advanced ROS1+ NSCLC patients in the U.S. each year based on current DNA testing (RNA + DNA testing will detect ~30% more ROS1 fusions)
- Pricing: ~$350,000[2] per year, based on gross IBTROZI annual price
- Does not incorporate gross-to-net discounts, testing rates, product market share or other factors impacting potential revenue including product adoption, access and reimbursement, and persistency

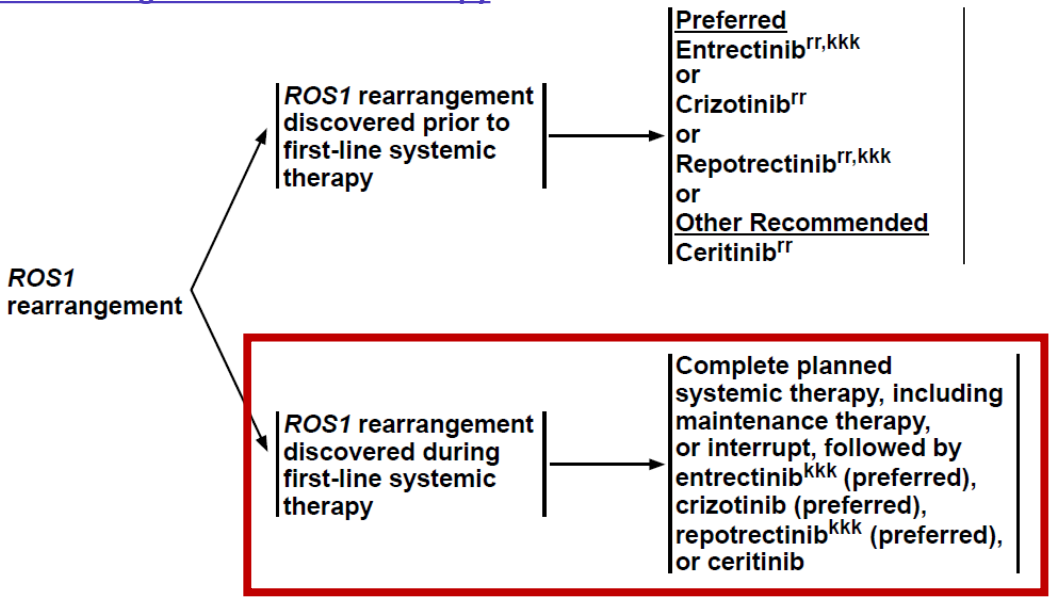


NSCLC: Non-small cell lung cancer. Note: Based on median progression-free survival demonstrated by IBTROZI in the first line setting (Pooled TRUST-I and TRUST-II data: Perol et al., *Journal of Clinical Oncology*, 2024). 1. Reflects midpoint of epidemiology assumptions based on ROS1+ lung cancer representing approximately 2% of new NSCLC cases annually; American Cancer Society (2025), National Center for Biotechnology Information: Gendarme et al., Curr Oncol (2022). 2. Nuvation Bio pricing information. 3. Reflects full market potential for 10 of 12 months in final year given median progression-free survival of 46 months in the pooled TKI-naïve dataset (Bazhenova, et al., AACR Annual Meeting, 2026).

New NCCN Guidelines now include taletrectinib as a preferred therapy, while also contraindicating IO/chemo and recommending ROS1 TKIs for ROS1+ NSCLC

NCCN Guidelines 2024

ROS1 Rearrangement: First Line Therapy

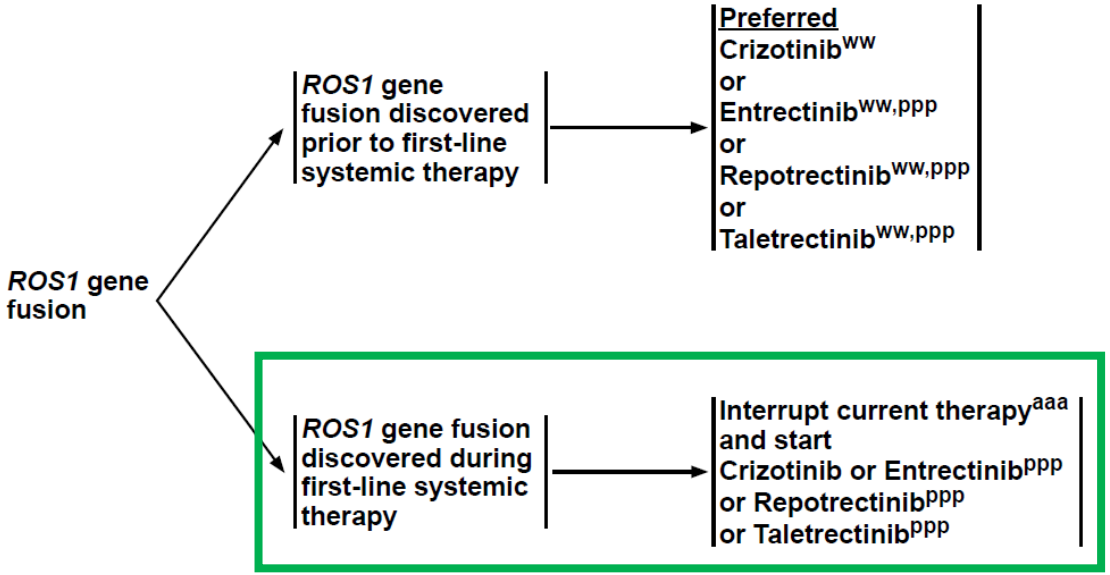


PD-L1 Positive (>1%): First Line Therapy

CONTRAINDICATIONS *for treatment with PD-1/PD-L1 inhibitors may include active or previously documented autoimmune disease and/or current use of immunosuppressive agents; some oncogenic drivers* ***(ie, EGFR exon 19 deletion or L858R, ALK rearrangements)*** *have been shown to be associated with less benefit from PD-1/PD-L1 inhibitors.*

NCCN Guidelines 2026

ROS1 Rearrangement: First Line Therapy



PD-L1 Positive (>1%): First Line Therapy

CONTRAINDICATIONS *for treatment with PD-1/PD-L1 inhibitors may include active or previously documented autoimmune disease and/or current use of immunosuppressive agents; some oncogenic drivers* ***(ie, EGFR exon 19 deletion or L858R; ALK, RET, or ROS1 gene fusions)*** *have been shown to be associated with less benefit from PD-1/PD-L1 inhibitors.*

Source: National Comprehensive Cancer Network 2026 and 2024.

Based on its clinical profile, IBTROZI has the potential to multiply the size of the ROS1+ NSCLC market, similar to precedent growth seen in ALK and EGFR

Precedent NSCLC markets (First line)[1]

	mPFS		ORR	
ALK+ NSCLC	XALKORI (crizotinib)	ALECENSA (alectinib 150 mg capsules)	XALKORI (crizotinib)	ALECENSA (alectinib 150 mg capsules)
	10 mo.	26 mo.	72%	79%
	ALECENSA (alectinib 150 mg capsules)	LORBRENA (lorlatinib)	ALECENSA (alectinib 150 mg capsules)	LORBRENA (lorlatinib)
	26 mo.	NR @ 7-yrs	79%	76%
EGFR+ NSCLC	IRESSA (gefitinib 250mg tablets) / Tarceva (erlotinib)	TAGRISSO (osimertinib)	IRESSA (gefitinib 250mg tablets) / Tarceva (erlotinib)	TAGRISSO (osimertinib)
	10 mo.	19 mo.	69%	77%

ROS1+ NSCLC (First line)[2]

mPFS

IBTROZI (taletrectinib 200 mg capsules)

50 mo. – Not Reached

ORR

IBTROZI (taletrectinib 200 mg capsules)

87% – 90%

mo.: months; ORR: Overall response rate; mPFS: median Progression-free survival. Note: These data are derived from different clinical studies, with differences in study design and patient populations. No head-to-head studies have been conducted. Comparisons in a head-to-head study may yield different results. 1. ALECENSA prescribing information (ALEX study results comparing alectinib to crizotinib); LORBRENA prescribing information and Mok et al., *ASCO Annual Meeting*, 2026; TAGRISSO prescribing information. 2. IBTROZI prescribing information and Bazhenova, et al., *AACR Annual Meeting*, 2026.

Five full quarters into launch, IBTROZI U.S. net revenue is in line with LORBRENA and ALECENSA despite a smaller patient population

U.S. net revenue ($MM): First five full quarters after launch vs. today[1]

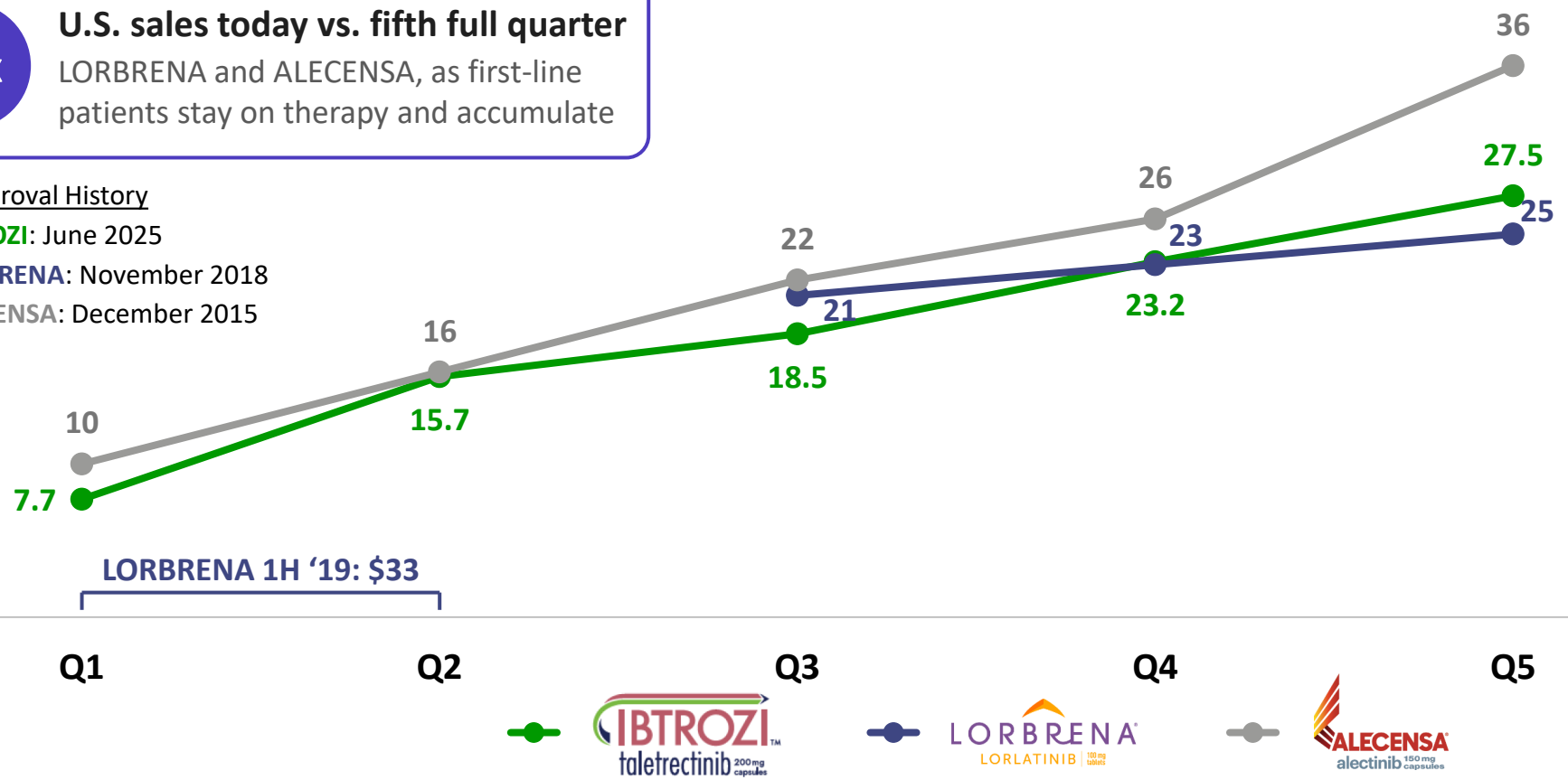
~5x

U.S. sales today vs. fifth full quarter

LORBRENA and ALECENSA, as first-line patients stay on therapy and accumulate

FDA Approval History

- **IBTROZI**: June 2025
- **LORBRENA**: November 2018
- **ALECENSA**: December 2015



~$1.2 billion[2] combined net revenue annual run-rate

LORBRENA LORLATINIB 100 mg tablets — **Q3 '26: $151M**

ALECENSA alectinib 150 mg capsules — **Q3 '26: $160M**

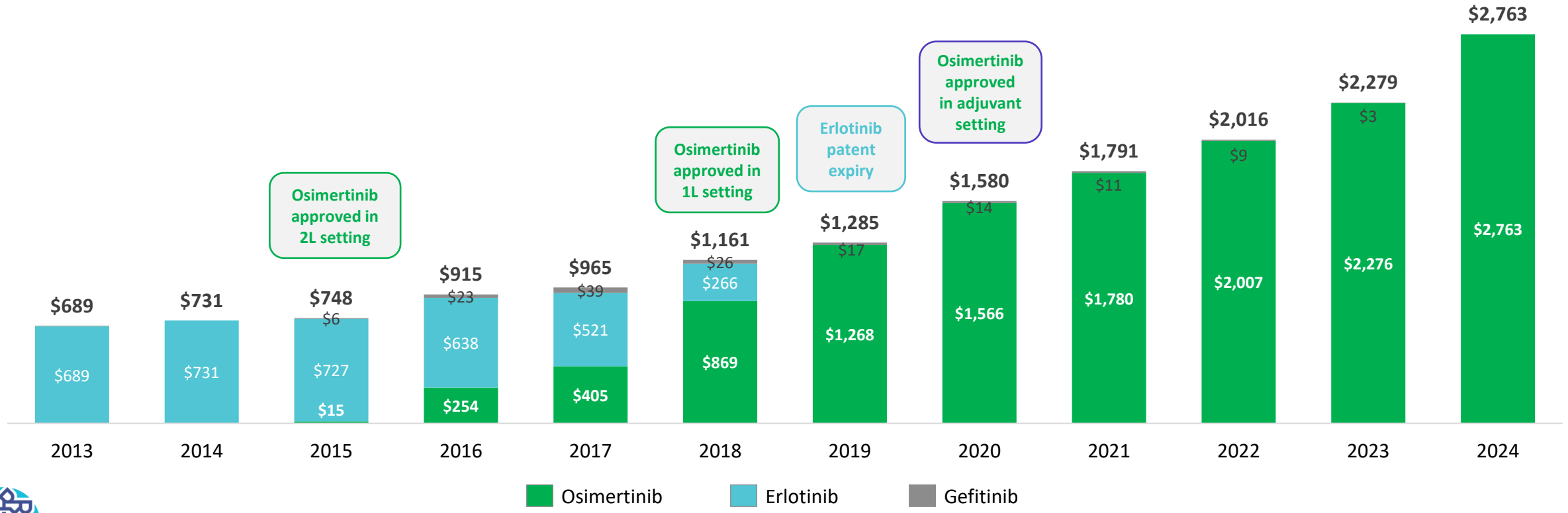
Notes: Sales figures in millions of U.S. dollars. LORBRENA and ALECENSA approved for the treatment of ALK-positive non-small cell lung cancer. Both programs launched at lower price totals than IBTROZI and were initially approved in the TKI-pretreated population. ALECENSA U.S. net sales converted from CHF at the average of Roche's published monthly CHF/USD rates for each quarter. 1. Pfizer earnings releases; Roche sales releases. 2. Assumes LORBRENA and ALECENSA complete four consecutive quarters of $151 million and $160 million in U.S. net product sales, respectively.

Osimertinib captured >95% market share after incremental, but meaningful improvements over 1st gen. TKIs; U.S. EGFR market has grown >3x since launch

Total Net U.S. Revenue (EGFR+ NSCLC TKIs)

$ in millions

Osimertinib TKI Market Share:	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9
	1%	21%	32%	61%	83%	92%	95%	95%	95-100%



Source: Evaluate Pharma, Earnings Reports from AstraZeneca (osimertinib, gefitinib) and Roche (erlotinib) from 2013 to 2024. Note: Net revenue of afatinib is not available as Boehringer Ingelheim is a private company. Net revenue of dacomitinib in EGFR+ NSCLC is minimal and therefore not included in this analysis.

Safusidenib | IDH1i

IDH1-mutant glioma

Enrolling multiple studies across *IDH1*-mutant glioma landscape



Safusidenib is a potentially best-in-class *IDH1* inhibitor for *IDH1*-mutant glioma



Unmet need in *IDH1*-mutant glioma

- People diagnosed with *IDH1*-mutant glioma are in need of additional treatment options
- Vorasidenib is approved to treat low-grade, but not high grade *IDH*-mutant glioma[1]



Vorasidenib has validated *IDH1* as a target

- 15% royalty on U.S. sales of vorasidenib acquired by Royalty Pharma for $905M[2]
- Early launch of vorasidenib has shown potential >$1B U.S. net sales run rate



Safusidenib has shown a compelling profile

- **36-month PFS rate of 79%** in a Phase 2 low-grade study[3]
- Encouraging Phase 1 high-grade data **including 2 CRs**[4]
- Manageable and consistent safety profile
- Received **Fast Track Designation** from U.S. FDA



Nuvation Bio owns global rights

- Acquired Japan rights from Daiichi Sankyo in April ’26
- AnHeart originally in-licensed worldwide rights ex-Japan in 2020

BID: Twice-a-day dosing; CR: Complete response; IDH1: isocitrate dehydrogenase 1; RP2D: Recommended Phase 2 dose. 1. In August 2024, the U.S. FDA approved Servier Pharmaceuticals’ vorasidenib for the treatment of IDH1- or IDH2-mutant grade 2 astrocytoma or oligodendroglioma following surgery. 2. In May 2024, Royalty Pharma agreed to acquire a 15% royalty on U.S. net sales of vorasidenib in low-grade diffuse glioma for $905 million from Agios Pharmaceuticals; Agios will retain 3% of the 15% royalty on sales above $1 billion and the right to receive a $200 million milestone payment from Servier Pharmaceuticals upon U.S. FDA approval. 3. Arakawa et al., *Neuro-Oncology*, 2025. 4. Natsume et al., *Neuro-Oncology*, 2022; two complete responses represent one complete response in a grade 4 astrocytoma and one complete response in the target lesions of a grade 3 oligodendroglioma (with stable disease in non-target lesions).

The *IDH1*-mutant glioma market represents a sizeable commercial opportunity, particularly because patients can remain on therapy for years

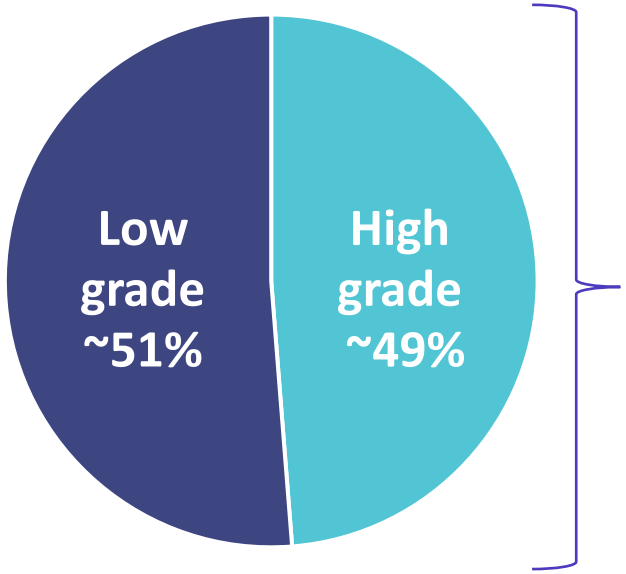
IDH-mutant glioma epidemiology overview

Annual Incidence: *IDH*-mutant glioma

- New cases per year: **~2,500**
- *IDH1* mutations make up **>95%** of *IDH* mutations
- Median age at diagnosis: **~38 – 45 years old**
- Low-grade survival time: **~12 – 20+ years**
- High-grade survival time: **~2 – 14+ years**

IDH-mutant glioma classification

Low-grade: Grade 2
High-grade: Grades 3 – 4



Low- and high-grade can be further divided into low- and high-risk groups

Source: 2025 CBTRUS Statistical Report: Primary Brain and Other Central Nervous System Tumors Diagnosed in the United States in 2017–2021; UpToDate – a Wolters Kluwer Company.

Patients with *IDH1*-mutant glioma are still in need of additional treatment options, especially those with high-risk and high-grade disease

High

Grade and Risk

Low

Classification	Incidence[1]	Median Survival[2]	SoC following surgery[3]	Approved *IDH*i[4]	Safusidenib
Grade 4 astrocytoma	~280 – 300	~2 – 6+ years	Radiation + chemotherapy	--	• **SIGMA** *(IDHi-naïve)*
Grade 3 astrocytoma	~490 – 520	~12+ years	Radiation + chemotherapy	--	• **SIGMA** *(IDHi-naïve)* • **Phase 2** (*post-vora)*
Grade 3 oligodendroglioma	~380 – 400	~12 – 14+ years	Radiation + chemotherapy	--	• **Exploratory cohort** *(IDHi-naïve)* • **Phase 2** (*post-vora)*
Grade 2 astrocytoma	~675 – 715	~12 – 15+ years	*IDH* inhibitor or radiation + chemotherapy	VORANIGO (vorasidenib)	• **SIGMA** *(IDHi-naïve)* • **Phase 3** *(IDHi-naïve)* • **Phase 2** *(post-vora)*
Grade 2 oligodendroglioma	~540 – 570	~13 – 20+ years	*IDH* inhibitor or radiation + chemotherapy	VORANIGO (vorasidenib)	• **Phase 3** *(IDHi-naïve)* • **Phase 2** (*post-vora)*

IDHi: IDH inhibitor; SoC: Standard of care; vora: VORANIGO (vorasidenib). 1. 2025 CBTRUS Statistical Report: Primary Brain and Other Central Nervous System Tumors Diagnosed in the United States in 2017–2021 (implied using 5-year total cases); 2. Reflects median overall survival statistics following standard of care therapy (pre-vorasidenib): Lasica et al., *Neuro-Oncology*, 2025; Wetzel et al., *Neuro-Oncology*, 2025; Pinson et al., *Neuro-Oncology*, 2024; Van den Bent et al., *Lancet Oncology*, 2026; Lassman et al., *Journal of Clinical Oncology*, 2022; Vaz-Salgado, et al., *Brain Communications*, 2025; Minniti et al., *Neuro-Oncology*, 2023; Karschnia et al., *Lancet Oncology*, 2025; Carstam et al., *Neuro-Oncology*, 2023; Ng et al., *The Lancet Regional Health – Europe*, 2024. 3. Mohile et al., *Journal of Clinical Oncology*, 2021; Blakeley et al., *Journal of Clinical Oncology*, 2025. 4. VORANIGO prescribing information.

Safusidenib data readouts will fall into two categories: shorter term based on ORR and longer term based on PFS

Shorter term: ORR primary endpoint

B

SIGMA: Grade 3 *IDH1*-mutant oligodendroglioma

Subgroup: High-grade, low-risk

Setting: Post-surgery

Key endpoints: ORR, Tumor growth rate

Potential data update: 2027

Safusidenib 250 mg BID (n=40)

D

C

B

Announced in July 2026

Phase 2: Grade 2 or 3 *IDH1*-mutant glioma post-vorasidenib

Subgroup[2]: Low-grade (all-risk) & high-grade, low-risk

Setting: Post-surgery and vorasidenib

Key endpoints: ORR, Tumor growth rate

Potential data update: 2027

Safusidenib 250 mg BID (n=40)

Longer term: PFS primary endpoint

A

C

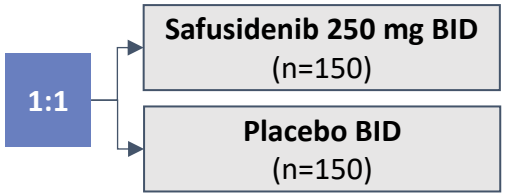
SIGMA (pivotal): High-risk *IDH1*-mutant astrocytoma

Subgroup: High-grade, high-risk & low-grade, high-risk

Setting[1]: Post-surgery, radiotherapy, and chemotherapy

Key endpoints: PFS, ORR

Potential data update: 2029



D

Announced in July 2026

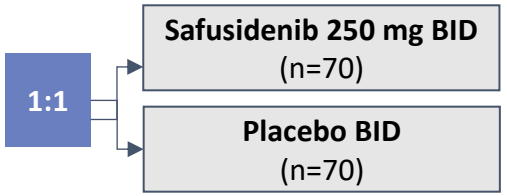
Phase 3: Grade 2 *IDH1*-mutant glioma

Subgroup: Low-grade, low-risk

Setting: Post-surgery

Key endpoints: PFS, ORR

Potential data update: 2029



A High-grade, high-risk B High-grade, low-risk C Low-grade, high-risk D Low-grade, low-risk

BID: Twice-a-day dosing; ORR: Overall response rate; PFS: Progression-free survival. Note: All clinical studies are for different types of *IDH1*-mutant glioma. 1. Maintenance setting after completing surgery, radiotherapy or chemoradiotherapy, and 6 to 12 cycles of adjuvant temozolomide. 2. Grade 3 (high-grade, low-risk) patients included to capture all patients that have progressed from grade 2 to grade 3 or received vorasidenib off-label.

Vorasidenib is the only *IDH* inhibitor approved for the treatment of *IDH-mutant* glioma – early launch suggests >$1 billion peak sales potential

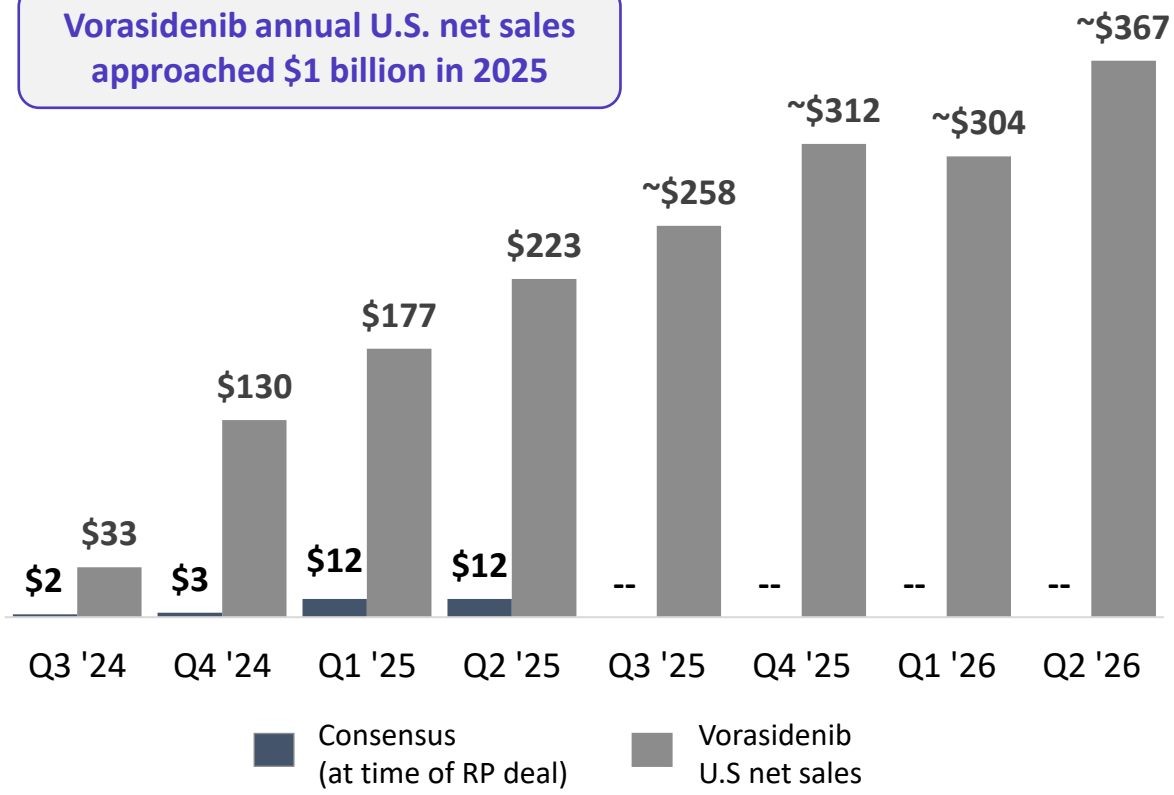
Vorasidenib history

- Servier acquired vorasidenib through its 2021 acquisition of Agios' oncology business
- In May '24, Royalty Pharma acquired Agios' 15% royalty[1] on U.S. net sales of vorasidenib for $905M
  - Implies vorasidenib valuation of ~$6 billion
  - Royalty Pharma forecasted peak U.S. net sales of >$1 billion at time of transaction
- Vorasidenib was **approved in August 2024** and has materially outperformed initial estimates[2]

Vorasidenib U.S. launch

U.S. net sales ($ in millions)[2]

Vorasidenib annual U.S. net sales approached $1 billion in 2025

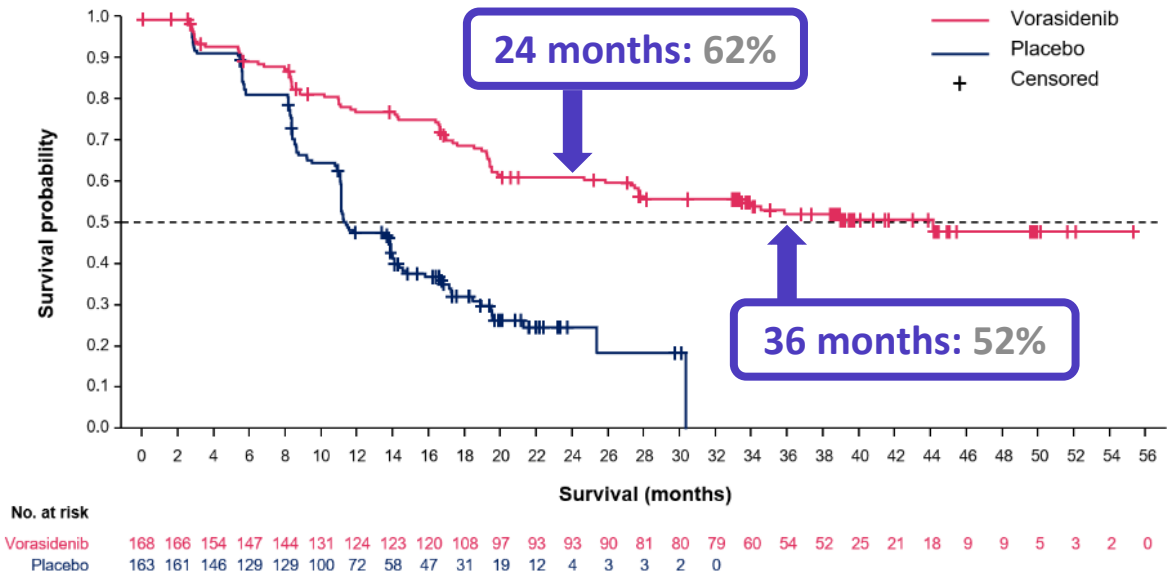


Source: Royalty Pharma September 2025 investor presentation, Royalty Pharma and Agios Pharmaceuticals press releases at time of royalty transaction. 1. Agios will retain 3% of the 15% royalty on annual sales above $1 billion.
2. Vorasidenib U.S. net sales in Q3 & Q4 2025 implied based on Royalty Pharma portfolio receipts per SEC filings; consensus sales estimates derived from Royalty Pharma analysis of Agios analyst models at time of deal (May 2024).

Vorasidenib showed a 36-month landmark PFS of 52% in a pivotal study of low-grade *IDH*-mutant glioma; 0% cORR was reported in a phase 1 high-grade study

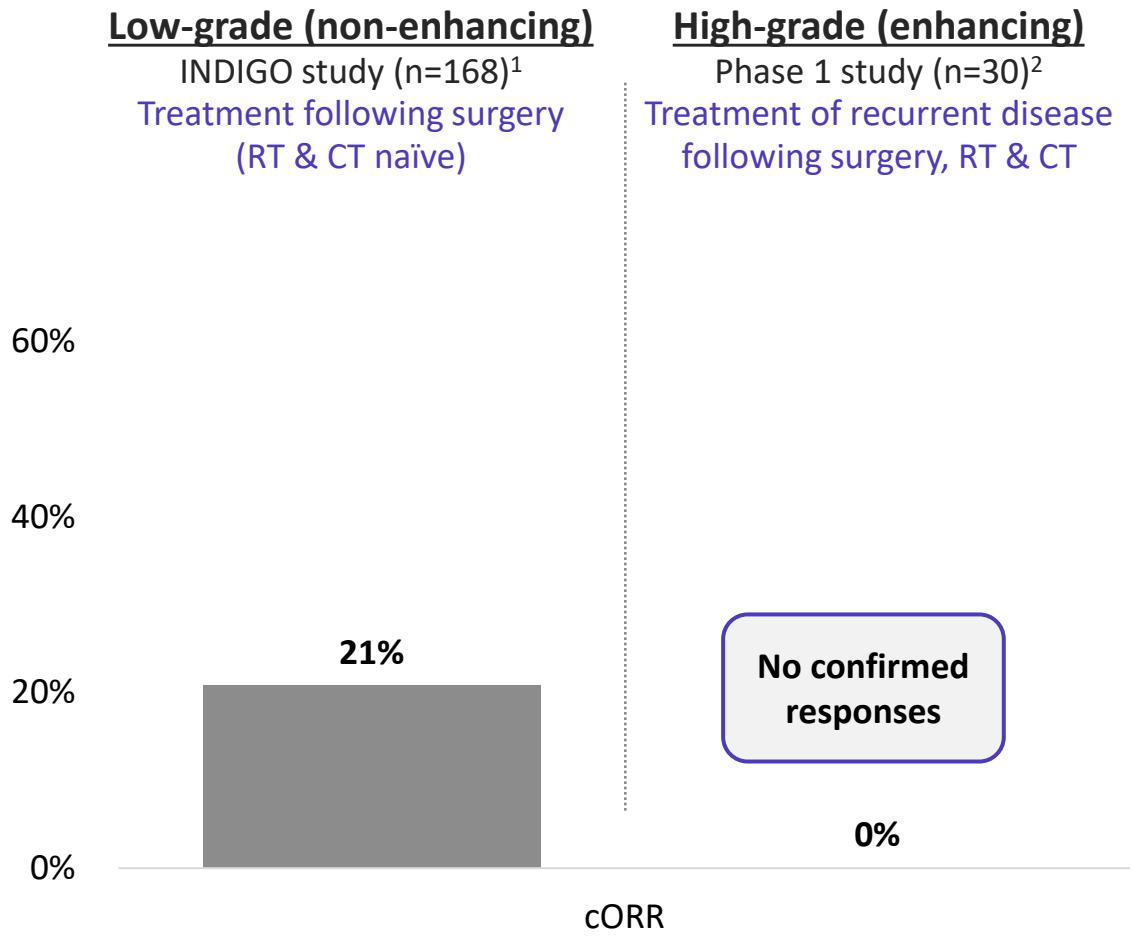
Progression-free survival (INDIGO study)[1]

Low-grade (non-enhancing) (vorasidenib n=168; placebo n=163)



- Median PFS: **44.1 months**
- Median follow-up: **42 months**
- 12-month PFS rate: **77%**
- 24-month PFS rate: **62%**
- 36-month PFS rate: **52%**

Confirmed objective response rate

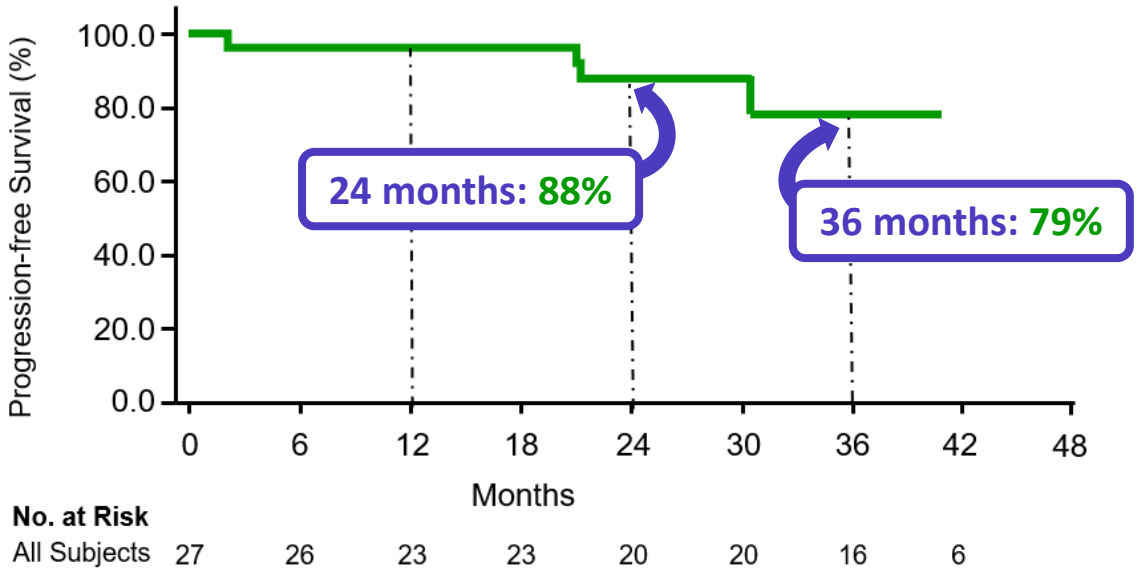


CT: Chemotherapy; cORR: confirmed Objective response rate; PFS: Progression-free survival; RT: Radiotherapy. Note: These data are derived from different clinical studies, with differences in study design and patient populations. 1. Cloughesy, et al., ASCO 2026; Includes patients with non-enhancing IDH1/2-mutant grade 2 glioma (primary endpoint: PFS). 2. Mellinghoff et al., *Clinical Cancer Research*, 2021; includes patients with enhancing IDH1/2-mutant gliomas.

Safusidenib has shown promising efficacy signals, including a 36-month landmark PFS of 79% in low-grade and 17% cORR including 2 CRs in high-grade *IDH1*-mutant glioma

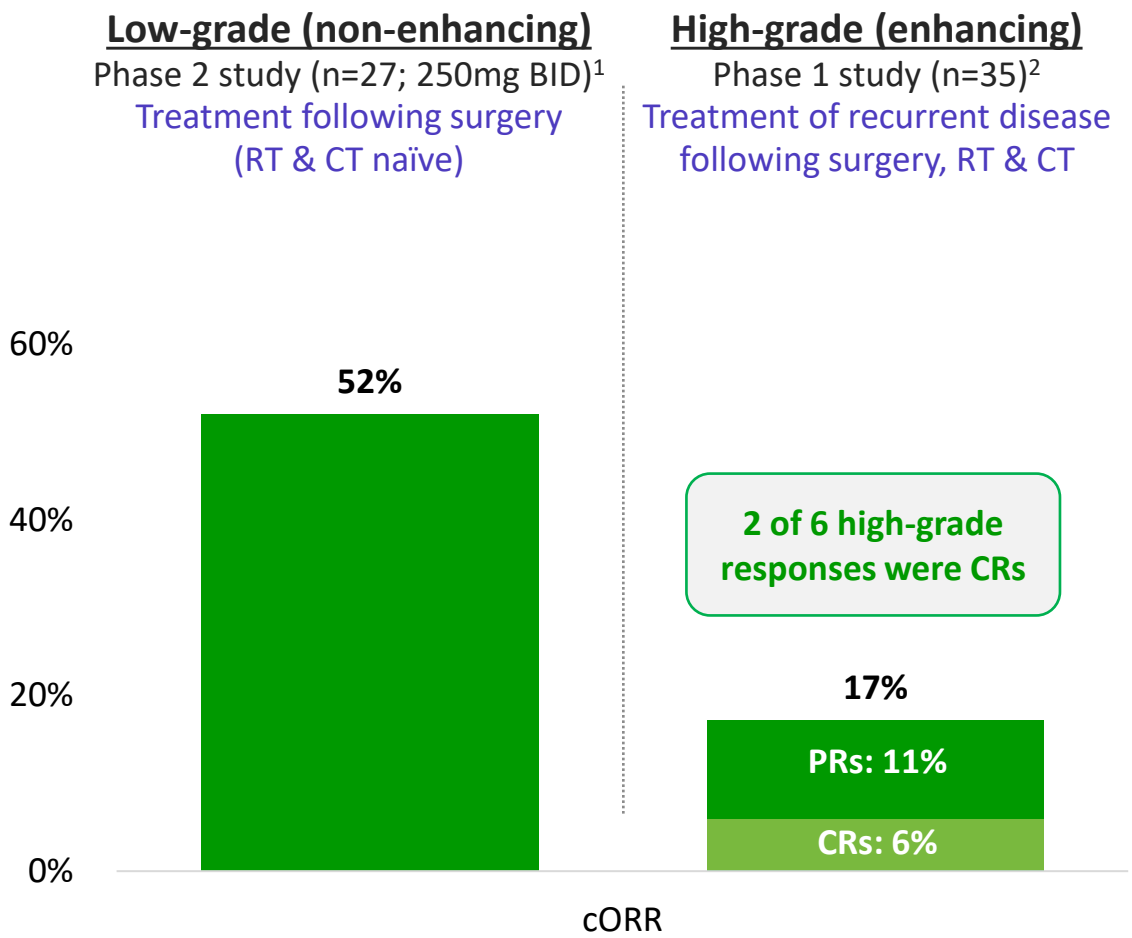
Progression-free survival (Phase 2 study)[1]

Low-grade (non-enhancing) (n= 27; 250mg BID)



- Median PFS: **Not reached**
- Median follow-up: **39 months**
- 12-month PFS rate: **96%**
- 24-month PFS rate: **88%**
- 36-month PFS rate: **79%**

Confirmed objective response rate



BID: Twice-a-day dosing; CR: Complete Response; CT: Chemotherapy; cORR: confirmed Objective response rate; PFS: Progression-free survival; PR: Partial response; RT: Radiotherapy. Note: These data are derived from different clinical studies, with differences in study design and patient populations. 1. Nuvation Bio data on file (data cut off March 2024); includes patients with non-enhancing grade 2 *IDH1*-mutant glioma (primary endpoint: ORR). 2. Natsume et al., Neuro-Oncology, 2023; includes patients with enhancing IDH1-mutant gliomas; two complete responses represent one complete response in a grade 4 astrocytoma and one complete response in the target lesions of a grade 3 oligodendroglioma (with stable disease in non-target lesions).

TEAEs were mostly mild to moderate and manageable, suggesting a favorable risk-benefit profile that allows for meaningful long-term disease control

≥20% of pts. in either study

	Phase 1 (n=47)		Phase 2 (n=27)	
TEAEs	**All Grades**	**≥ Grade 3**	**All Grades**	**≥ Grade 3**
All TEAEs	**45 (96)**	**20 (43)**	**27 (100)**	**10 (37)**
Alopecia	13 (28)	0 (0)	16 (59)	0 (0)
Arthralgia	13 (28)	1 (2)	15 (56)	1 (4)
Skin hyperpigmentation	25 (53)	0 (0)	14 (52)	0 (0)
ALT increased	4 (9)	3 (6)	11 (41)	2 (7)
Rash	11 (23)	0 (0)	10 (37)	0 (0)
AST increased	3 (6)	2 (4)	9 (33)	1 (4)
Pruritus	14 (30)	0 (0)	9 (33)	0 (0)
Back pain	10 (21)	0 (0)	9 (33)	0 (0)
Neutrophil count decreased	7 (15)	6 (13)	8 (30)	0 (0)
Diarrhea	22 (47)	2 (4)	7 (26)	0 (0)
Nausea	12 (26)	0 (0)	6 (22)	0 (0)
Dry skin	10 (21)	0 (0)	4 (15)	0 (0)
Headache	11 (23)	1 (2)	5 (19)	1 (4)
COVID-19	0 (0)	0 (0)	7 (26)	0 (0)
Upper RTI	0 (0)	0 (0)	6 (22)	0 (0)

Key Observations

Across Phase 1 and Phase 2 studies

- Unique TEAEs (i.e. dermatologic) may suggest different pharmacological profile vs. other IDH inhibitors
- No grade 5 events were reported

In the Phase 2 study (250mg BID):

- Only three patients (11%) had TEAEs that led to treatment discontinuation
- Of these three patients, two TEAEs (7%) were considered related to drug, and both events resolved with dose interruption and appropriate management

BID: Twice-a-day dosing; MOA: Mechanism of action; RTI: Respiratory tract infection; TEAE: Treatment emergent adverse event. Source: Nuvation Bio data on file (data cut off October 2024) and Natsume et al., *Neuro-Oncology*, 2023. Note: Good Clinical Practice (GCP) noncompliance issue regarding the collection of adverse events was identified during the Phase 2 study. Therefore, all safety data presented is based on a subsequent re-investigation and re-collection of adverse events performed in strict accordance with the study protocol to ensure data integrity. The GCP noncompliance issue related only to safety reporting.

DDC Platform

Advanced solid tumors

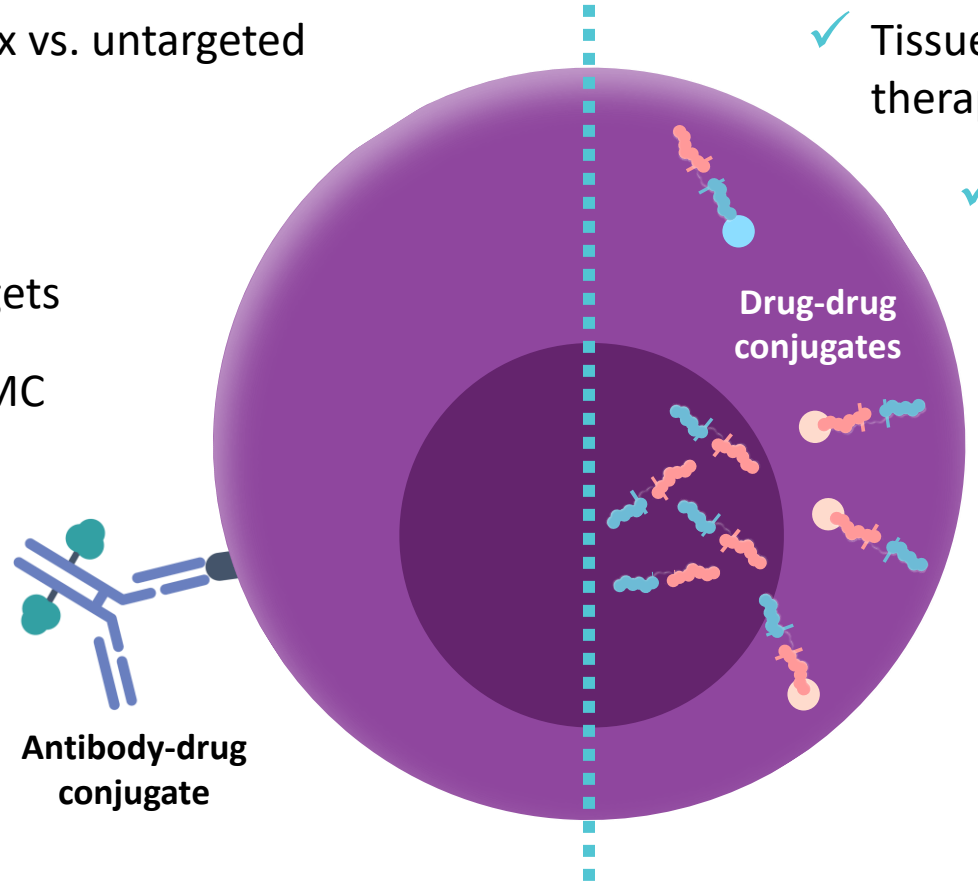
Evaluating preclinical candidates



Nuvation Bio is developing a new type of targeted oncology candidate through its Drug-drug conjugate (DDC) platform

Antibody-drug conjugates

- ✓ Improves therapeutic index vs. untargeted warhead
- × IV delivery
- × Limited to cell-surface targets
- × Complex and expensive CMC

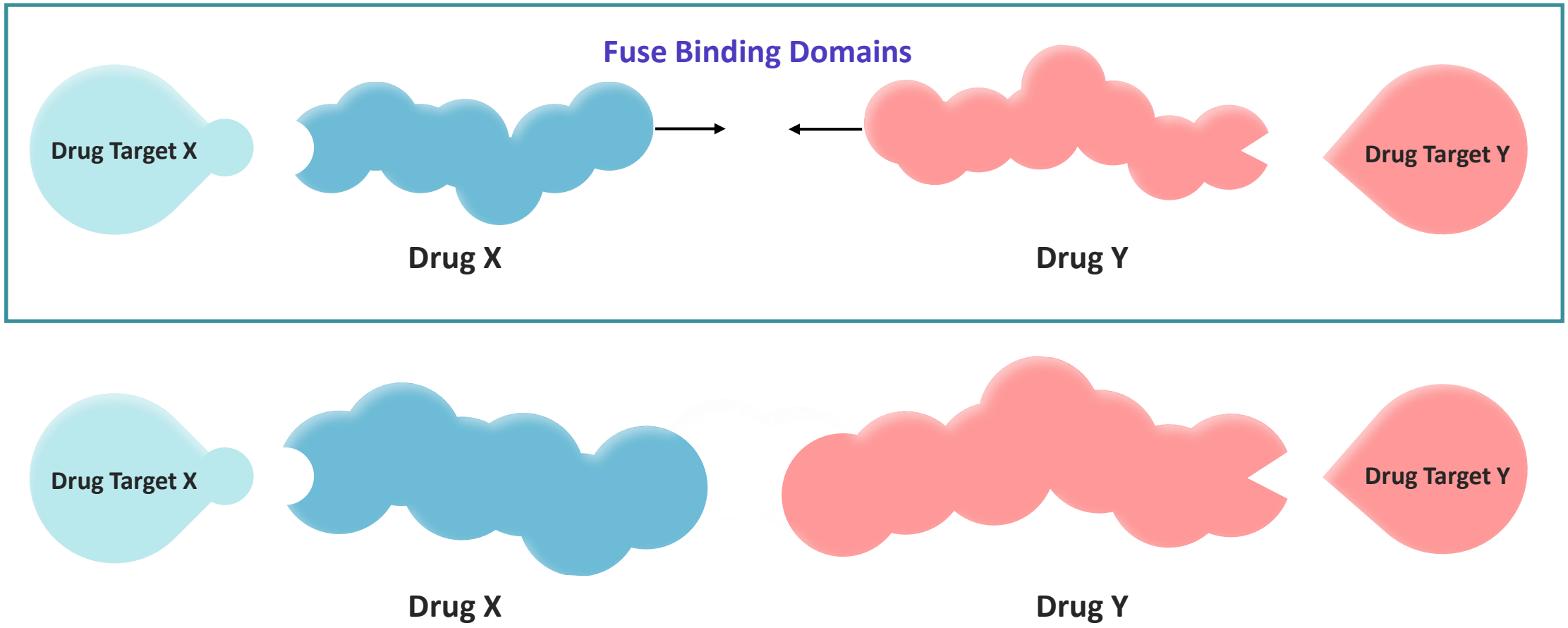


Drug-drug conjugates

- ✓ Tissue-selective targeting improves therapeutic index vs. untargeted warhead
- ✓ Oral or IV delivery
- ✓ Binds intracellular and cell membrane targets
- ✓ Highly cell permeable
- ✓ Simpler and less expensive to manufacture

DDCs are designed to bind TWO different targets simultaneously

Two separate drugs with two separate targets



Nuvation Bio is focused on tackling the greatest challenges in cancer treatment



Experienced biotech leadership team

- Founded by Dr. David Hung, the founder and CEO of Medivation, who successfully developed and commercialized XTANDI®
- Management team has broad expertise from development through commercialization



IBTROZI approved in the U.S., Japan, and China for advanced ROS1+ NSCLC (line agnostic)

- **Approved by the U.S. FDA on June 11, 2025**
- **~920 new patient starts since U.S. approval**
- Approved by Japan's MHLW in September 2025
- Approved by China's NMPA in January 2025



Strong cash position provides path to potential profitability

- Robust cash balance of ~$663 million
- No need to raise additional capital to fund IBTROZI launch or pipeline programs



Nuvation Bio pipeline is led by safusidenib

- **Safusidenib | *IDH1* inhibitor:**
  Evaluating in studies across all grades and risk groups within the IDH1-mutant glioma landscape
- **Drug-drug conjugate platform:**
  Evaluating preclinical candidates