Nuvation Bio®

DRIVEN BY SCIENCE
FOCUSED ON LIFE

November 2025

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 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 mPFS, our expectations that updated median duration of response results from taletrectinib TRUST-I and TRUST-II studies can support a supplemental NDA for IBTROZI, our plans for safusidenib G203 study protocol amendment and patient enrollment, our expectations that such amended G203 study may support approval of safusidenib for the maintenance treatment of high-grade IDH1-mutant glioma, our plans to share new data and updates from our clinical programs including taletrectinib and NUV-1511, the potential of the DDC platform, our expectations regarding regulatory and reimbursement developments, and strength of pro forma 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 filed with the SEC on November 3, 2025 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 in June 2025 for advanced ROS1+ NSCLC in the U.S., Japan, and China; 204 new patient starts in Q3 2025**

Safusidenib[1] is a **potentially best-in-class**, brain penetrant, **mIDH1 inhibitor** entering a **pivotal study** for **high-grade IDH1-mutant glioma**; potential to extend study into high-risk, low-grade patients

NUV-1511, the Company's **first clinical-stage drug-drug conjugate (DDC)**, is being evaluated in a **Phase 1/2 study**; **NUV-868** is a **BD2-selective BET inhibitor** that has completed **Phase 1 and Phase 1b studies**

Robust cash balance of $549 million[2] as of 9/30/25 **is expected to provide path to profitability without need for additional funding**

1. Protocol amendment to upsize to a pivotal trial and include patients with grade 2 high-risk IDH1-mutant glioma are forthcoming. 2. An additional $50 million under a term loan with Sagard Healthcare Partners is available to the Company until June 30, 2026.

Nuvation Bio has four differentiated oncology programs ranging from approved in the U.S., Japan, and China to Phase 1 ongoing

Program	Target Indication(s)	Current Stage of Development	Anticipated Milestones & Recent Updates
IBTROZI[1] taletrectinib 200mg capsules	Advanced ROS1+ NSCLC (treatment line agnostic)	*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 • Enrolling TRUST-IV study for early-stage ROS1+ NSCLC
Safusidenib[2] (mIDH1)	Diffuse IDH1-mutant glioma	Phase 1	• Entering pivotal study in high-grade IDH1-mutant glioma[2]
NUV-1511 (DDC)	Advanced solid tumors[3]	Preclinical	• Phase 1/2 dose escalation study ongoing
NUV-868 (BET)	Currently under internal evaluation	Preclinical / Phase 1	• Completed Phase 1 monotherapy and Phase 1b combination studies in advanced solid tumors

BET: Bromodomain and Extra-Terminal motif; ESMO: European Society of Medical Oncology Congress; MHLW: Ministry of Health, Labour and Welfare; mIDH1: mutant isocitrate dehydrogenase 1; NSCLC: Non-small cell lung cancer; ROS1+: c-ros oncogene 1-positive. 1. Worldwide development and commercial rights in-licensed from Daiichi Sankyo; rights to IBTROZI have been out-licensed in China (Innovent Biologics) and Japan (Nippon Kayaku). 2. Worldwide development and commercial rights in-licensed from Daiichi Sankyo, excluding Japan where Daiichi Sankyo retains development and commercial rights. Protocol amendment to upsize to a pivotal trial and include patients with grade 2 high-risk IDH1-mutant glioma are forthcoming. 3. Includes patients with advanced solid tumors who previously received and progressed on or after treatment with Enhertu® and/or Trodelvy® per approved U.S. FDA labeling, human epidermal growth factor receptor 2-negative (HER2-) metastatic breast cancer, metastatic castration-resistant prostate cancer (mCRPC), advanced pancreatic cancer, and platinum-resistant ovarian cancer.

IBTROZI | ROS1i

Advanced ROS1+ NSCLC

Approved by U.S. FDA in June 2025

Approved by U.S. FDA on June 11, 2025

Nuvation Bio

Launch of IBTROZI is off to a positive start, reinforcing its compelling clinical profile and Nuvation Bio's commercial expertise

As of September 30, 2025:

- **204** patients started on IBTROZI in Q3 2025 (~15/week)
- **Multiple repeat prescribers** across the United States
- Face-to-face engagement with **nearly all Tier 1-2 target accounts**
- Scripts from **100%** of 6 sales regions and **98%** of 47 sales territories
- Confirmed payor coverage representing **80%** of lives covered to label

Source: Nuvation Bio data on file.

IBTROZI is a next generation, potentially best-in-class ROS1 TKI obtained from the April 2024 acquisition of AnHeart Therapeutics

Commercial opportunity

- **Approved in the U.S., Japan, and China** for advanced ROS1+ NSCLC (line agnostic)
- Previously received Breakthrough Therapy Designations in 1L & 2L (U.S. and China)

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

Strong partnerships

- AnHeart in-licensed IBTROZI from Daiichi Sankyo in 2018
- Maintain global rights except in Japan and China where rights have been out-licensed[2]
- Discussions to partner in EU and other ex-US territories ongoing

1. IBTROZI prescribing information; Perol et al., *Journal of Clinical Oncology*, 2025. 2. Worldwide development and commercial rights in-licensed from Daiichi Sankyo; rights to IBTROZI have been out-licensed in China (Innovent Biologics) and Japan (Nippon Kayaku).

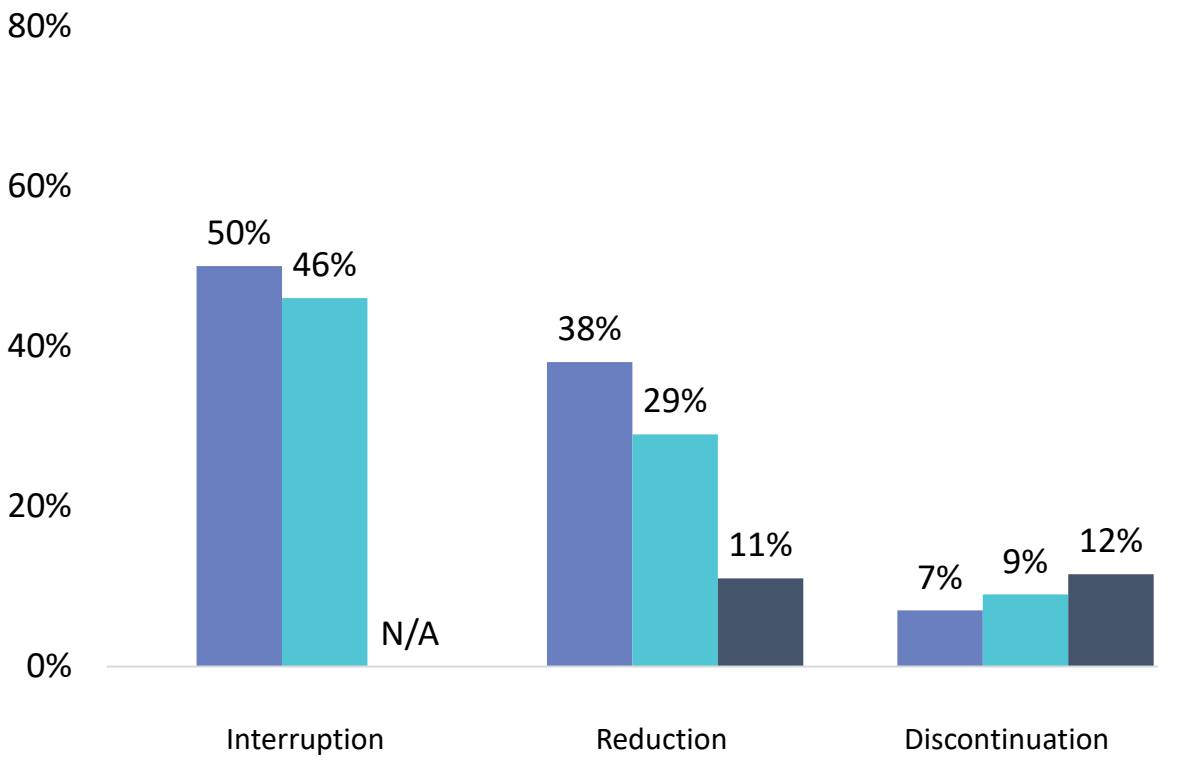
While ROS1+ NSCLC treatment has evolved since IO/chemo, there remains an opportunity to improve upon the current landscape of approved therapies

	First-line (TKI-naïve)			1 prior ROS1 TKI
	Repotrectinib[1]	Entrectinib[2]	Crizotinib[3]	Repotrectinib[1]
Study	*TRIDENT-1*	*ALKA-372-001, STARTRK-1, STARTRK-2*	*PROFILE 1001*	*TRIDENT-1*
n	71	168	53	56
ORR	79%	68%	72%	38%
Median DOR	34 months	21 months	25 months	15 months
Median PFS	36 months	16 months	19 months	9 months
G2032R ORR	--	--	--	59% (10/17)
IC-ORR[1]	89% (8/9)	80% (20/25)	N/A	38% (5/13)

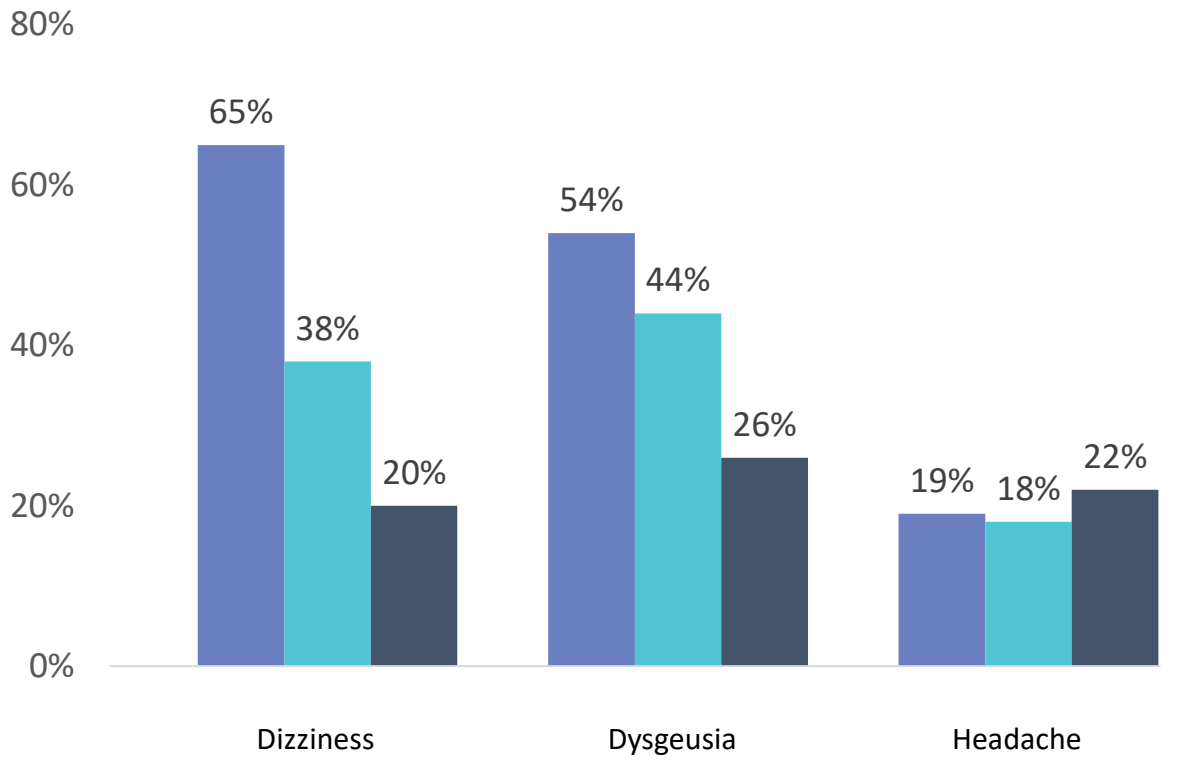
Note: These data are derived from different clinical studies, with differences in study design and patient populations. No head-to-head studies have been conducted. Comparisons in a head-to-head study may yield different results. ORR: confirmed Overall response rate; DOR: Duration of response; IC-ORR: Intracranial overall response rate; PFS: Progression free survival. 1. AUGTYRO prescribing information and Drilon et al., *New England Journal of Medicine*, 2024. 2. Drilon et al., *JTO Clinical Research Reports*, 2022. 3. XALKORI prescribing information and Shaw et al., *Annals of Oncology*, 2019.

Dose modification rates of previously approved TKIs are elevated, while neurological AEs remain a significant issue for patients in the real-world setting

Dose Modification



Neurological Adverse Events



Repotrectinib Entrectinib Crizotinib

Note: These data are derived from different clinical studies, with differences in study design and patient populations. No he ad-to-head studies have been conducted. Comparisons in a head-to-head study may yield different results.
AE: Adverse Event. Sources: AUGTYRO prescribing information (includes patients with NTRK+ solid tumor), ROZLYTREK prescribing information (includes patients with NTRK+ solid tumor), and XALKORI prescribing information (combined analysis of Study 1 & 2 of patients with ALK+ NSCLC patients; Headache adverse event rate from Study 1 only).

IBTROZI demonstrated high and durable responses in TKI-naïve patients – Median DOR increased to 50 months in new August 2025 data cutoff to support planned sNDA

	June 2024 data cutoff	October 2024 data cutoff		Aug. 2025 data cutoff
	Pooled (JCO)[1]	TRUST-I (label)[2]	TRUST-II (label)[2]	Pooled (planned sNDA)[3]
n	160	103	54	
cORR	89%	90%	85%	
Median DOR	44 months	*Not Reached*	*Not Reached*	**Median DOR: 50 months**
Median PFS	46 months	45 months	*Not Reached*	
IC-cORR	77% (13/17)	88% (7/8)	57% (4/7)	

Additional updates from August 2025 data cutoff to be presented at Medical conference in 2026

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; sNDA: supplemental New Drug Application.
1. Perol et al., *Journal of Clinical Oncology*, 2024; Median duration of follow-up of 20.7 months for the pooled data set. 2. 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 40.9 and 20.5 months in TRUST-I and TRUST-II, respectively. 3. Supplemental NDA (sNDA) based on August 2025 data cutoff to be filed by year end 2025.

No drugs in solid tumor oncology have demonstrated the combined efficacy profile 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%	> 60 months	NE
VITRAKVI (larotrectinib)[6]	75%	--	33 months
XTANDI (enzalutamide)[7]	59%	20 months	--

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. mDOR: median Duration of response; ORR: Overall response rate; mPFS: median Progression-free survival. Source: 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; Solomon et al., Journal of Clinical Oncology, 2024. 6. VITRAKVI prescribing information. 7. Beer et al., New England Journal of Medicine, 2014; Beer et al., European Urology (Final Analysis of PREVAIL study), 2016.

IBTROZI also demonstrated notable results in the TKI-pretreated setting, especially in the majority western TRUST-II study which is still maturing

	June 2024 data cutoff	October 2024 data cutoff	
	Pooled (JCO publication)[1]	TRUST-I (label)[2]	TRUST-II (label)[2]
n	113	66	47
cORR	56%	52%	62%
Median DOR	17 months	13 months	19 months
Median PFS	10 months	8 months	12 months
G2032R cORR	62% (8/13)	62% (8/13)	
IC-cORR	66% (21/32)	75% (9/12)	50% (6/12)

cORR: confirmed Overall response rate; DOR: Duration of response; IC-cORR: Intracranial confirmed overall response rate; PFS: Progression free survival. 1. Perol et al., *Journal of Clinical Oncology*, 2024; Median duration of follow-up of 21.0 months for the pooled data set. 2. IBTROZI prescribing information, excluding median PFS and median DOR (median DOR excluded from the label due to immature follow-up); prescribing information includes response after resistance mutations in addition to G2032R (n=15); 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 35.1 and 20.4 months in TRUST-I and TRUST-II, respectively.

IBTROZI's safety profile remained favorable and only 6.5% of 337 patients with ROS1+ NSCLC had a TEAE leading to drug discontinuation

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 treatment exposure
  - 1 patient (0.3%) discontinued for top 6 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

Source: IBTROZI prescribing information. ALT: alanine aminotransferase; AST: aspartate aminotransferase; CPK: creatinine phosphokinase; TEAE: treatment-emergent adverse event.
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 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

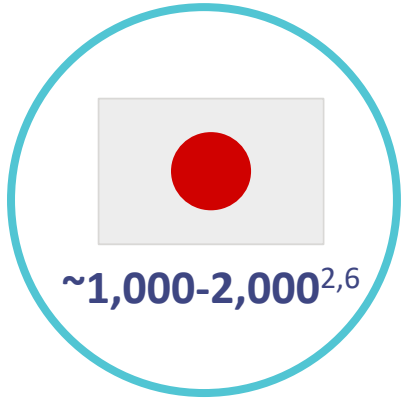
Key takeaways

- NSCLC accounts for ~87%[1] of all lung cancers
- ROS1+ lung cancer represents ~2%[2] of new NSCLC cases each year
- There are three 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 Squibb, approved 2023[5])

Estimated new cases per year



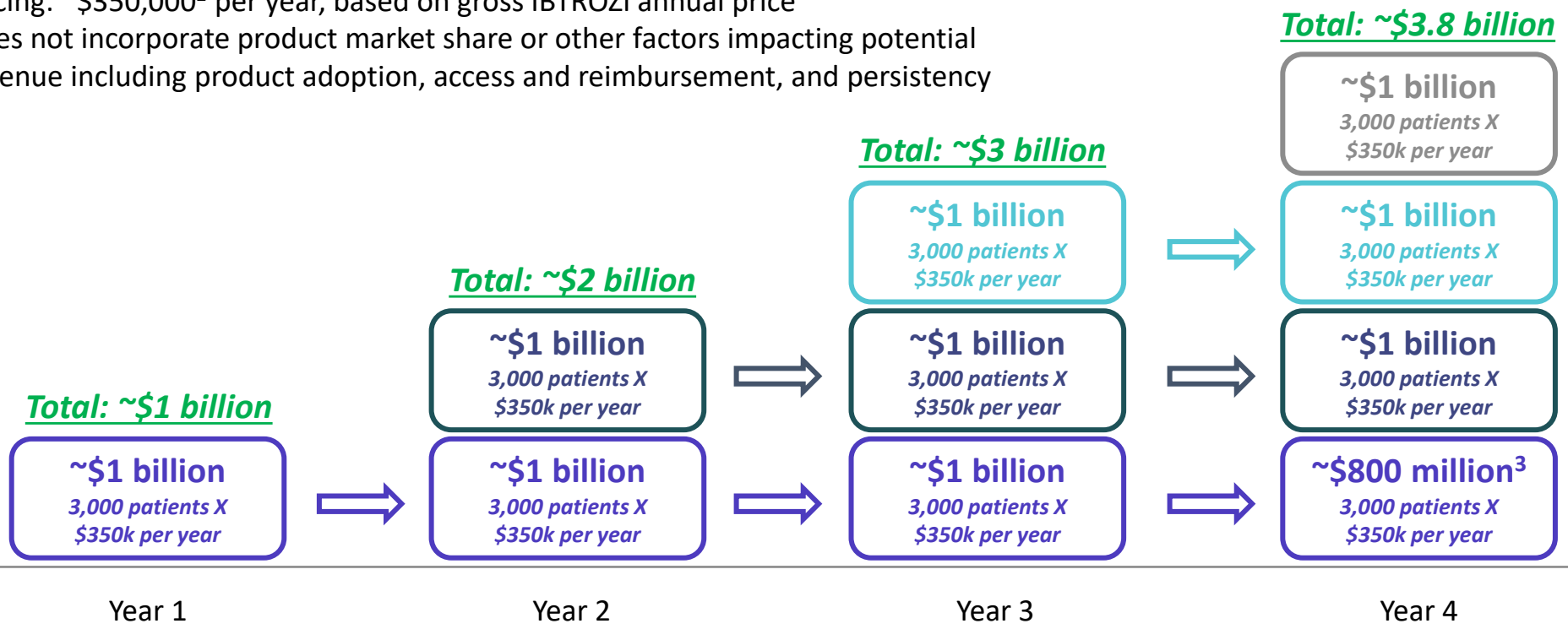
mPFS: median progression-free survival; TKI: tyrosine kinase inhibitor. 1. American Cancer Society (2025). 2. National Center for Biotechnology Information: Gendarme et al., Curr Oncol (2022). 3. Initially approved by U.S. FDA in 2011 for the treatment of patients with advanced or metastatic ALK-positive 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. National Cancer Center Japan (2019). 7. European Cancer Information Systems (2021). 8. Gao et al., J Thorac Oncol (2020). 9. 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] newly diagnosed ROS1+ NSCLC patients in the U.S. each year based on current DNA testing (RNA testing will detect ~30% more ROS1 fusions)
- Pricing: ~$350,000[2] per year, based on gross IBTROZI annual price
- Does not incorporate product market share or other factors impacting potential revenue including product adoption, access and reimbursement, and persistency

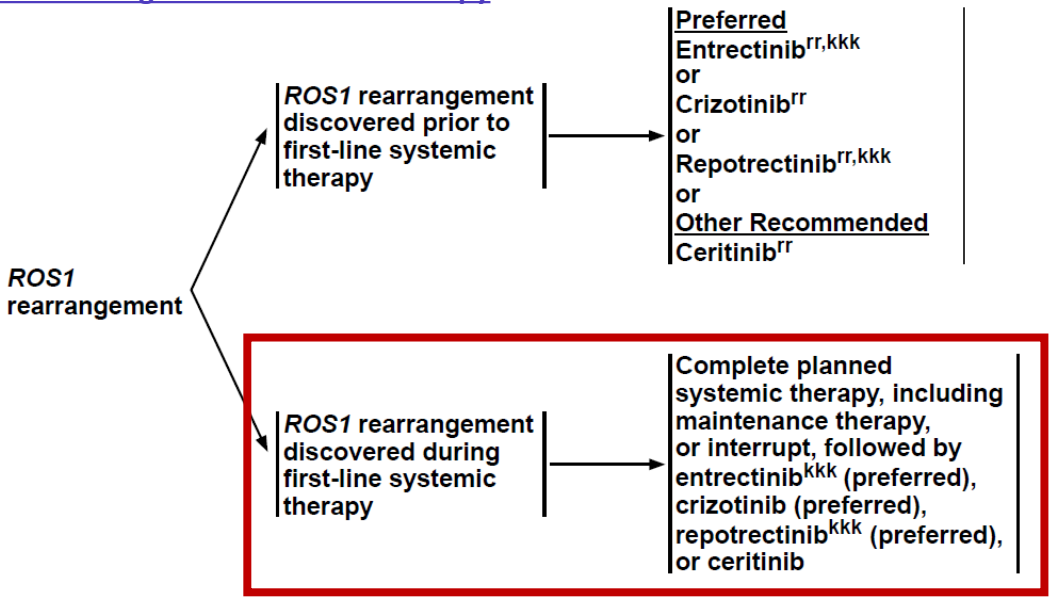


NSCLC: Non-small cell lung cancer. Note: Based on median progression-free survival demonstrated by IBTROZI in the first line setting (Pooled TRUST-I and TRUST-II data: Perol et al., *Journal of Clinical Oncology*, 2024). 1. Reflects midpoint of epidemiology assumptions based on ROS1+ lung cancer representing 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.

New NCCN Guidelines now include taletrectinib as a preferred therapy and specifically contraindicate IO/chemo and recommend ROS1 TKIs for ROS1+ NSCLC

NCCN Guidelines 2024

ROS1 Rearrangement: First Line Therapy

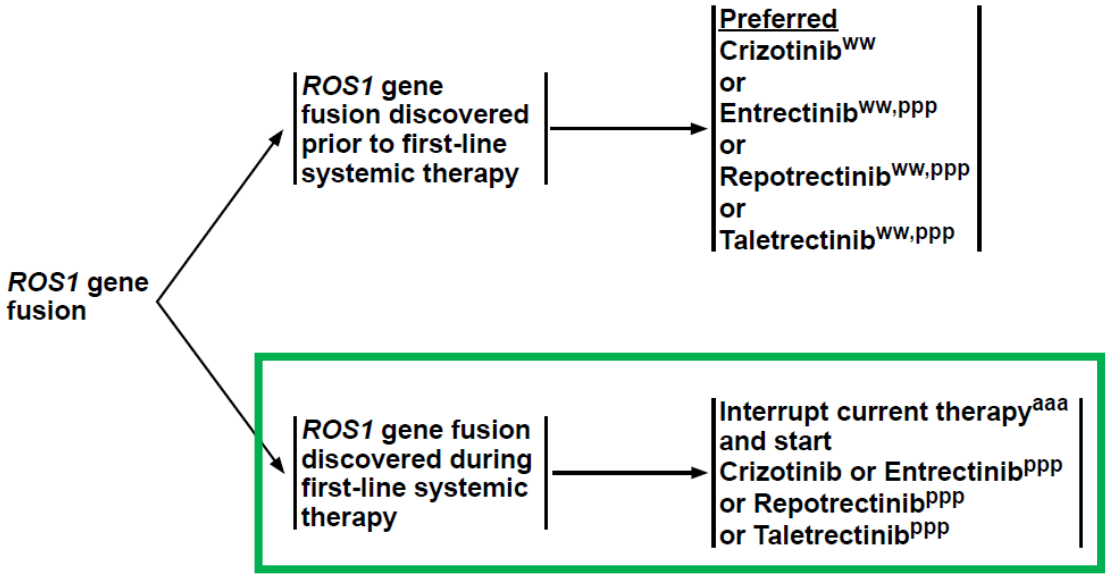


PD-L1 Positive (>1%): First Line Therapy

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 rearrangements)*** *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)	10 mo. → 26 mo.	XALKORI (crizotinib) → ALECENSA (alectinib 150 mg capsules)	72% → 79%
	ALECENSA (alectinib 150 mg capsules) → LORBRENA (lorlatinib)	26 mo. → NR @ 5-yrs	ALECENSA (alectinib 150 mg capsules) → LORBRENA (lorlatinib)	79% → 76%
EGFR+ NSCLC	IRESSA (gefitinib 250mg tablets) / Tarceva (erlotinib) → TAGRISSO (osimertinib)	10 mo. → 19 mo.	IRESSA (gefitinib 250mg tablets) / Tarceva (erlotinib) → TAGRISSO (osimertinib)	69% → 77%

ROS1+ NSCLC (First line)[2]

mPFS

IBTROZI (taletrectinib 200 mg capsules)

45 mo. – Not Reached

ORR

IBTROZI (taletrectinib 200 mg capsules)

85% – 90%

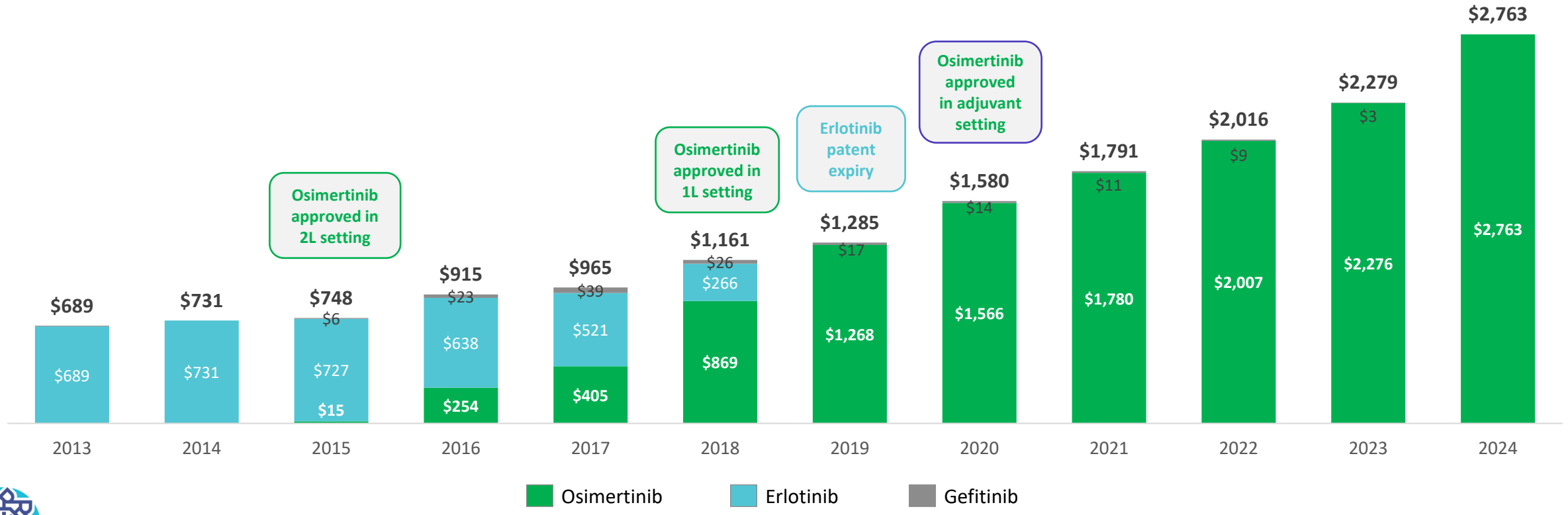
Note: These data are derived from different clinical studies, with differences in study design and patient populations. No he ad-to-head studies have been conducted. Comparisons in a head-to-head study may yield different results. mo.: months; ORR: Overall response rate; mPFS: median Progression-free survival. 1. ALECENSA prescribing information (ALEX study results comparing alectinib to crizotinib); LORBRENA prescribing information; TAGRISSO prescribing information. 2. IBTROZI prescribing information and Li, et al., WCLC Presentation, 2025.

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, Earning Reports from AstraZeneca (osimertinib, erlotinib) and Roche (gefitinib) 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 | mIDH1i

Diffuse IDH1-mutant glioma

Entering pivotal study in high-grade IDH1-mutant glioma

Safusidenib is a potentially best-in-class mIDH1 inhibitor for diffuse IDH1-mutant glioma, which was also obtained from the acquisition of AnHeart Therapeutics

Unmet need

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

Validated 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

Differentiated profile

- **24-month PFS rate of 88%** in a Phase 2 low-grade study at RP2D (250mg BID)[3]
- Encouraging Phase 1 high-grade data **including 2 CRs**[4]
- Limited competition

Global rights

- AnHeart in-licensed worldwide rights to safusidenib from Daiichi Sankyo in 2020
- Daiichi Sankyo retains rights in Japan

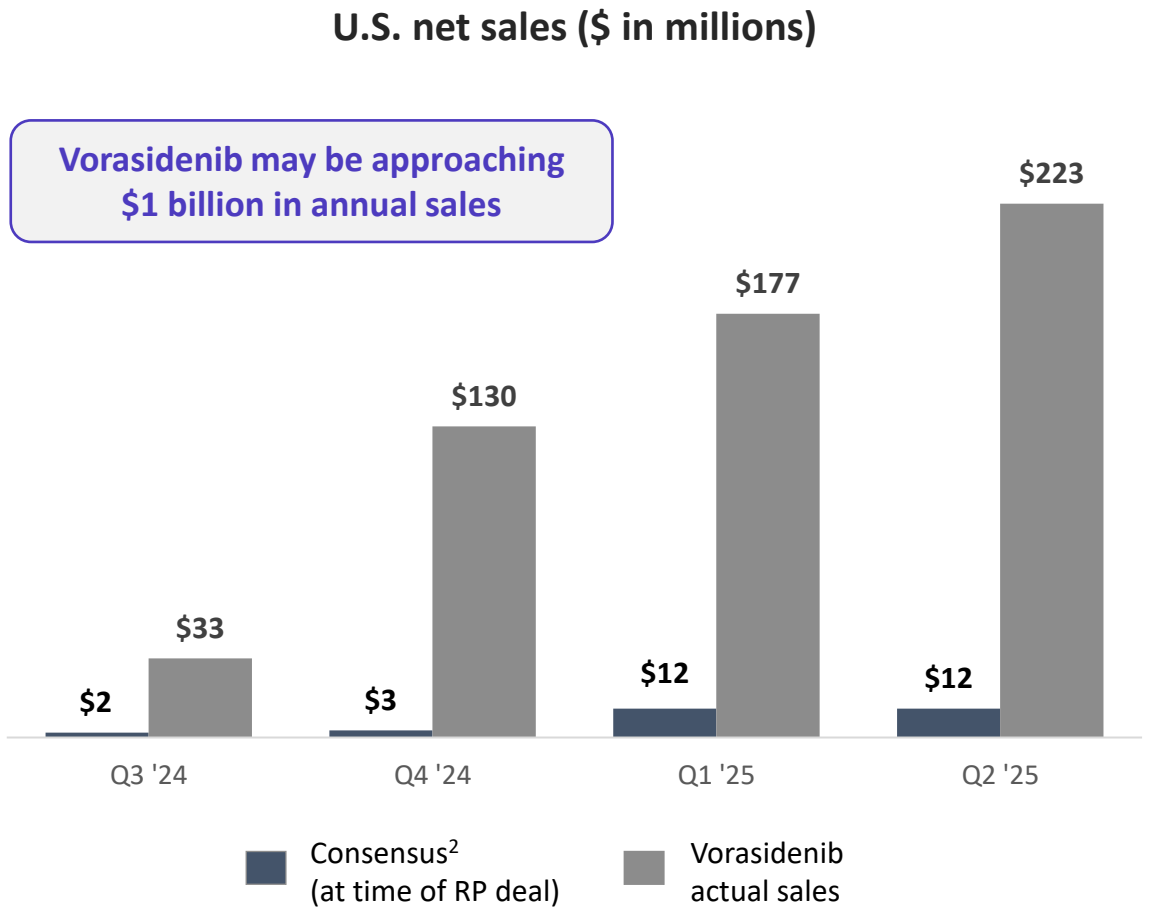
BID: Twice-a-day dosing; CR: Complete response. mIDH1: mutant IDH1. RP2D: Recommended Phase 2 dose; 1. In August 2024, the U.S. FDA approved Servier Pharmaceutical's vorasidenib for the treatment of IDH1- or IDH2-mutant grade 2 astrocytoma or oligodendroglioma following surgery. 2. In May 2024, Royalty 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).

Vorasidenib is the only IDH1 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]
- **Safusidenib has shown a differentiated profile in early-stage clinical studies**

Vorasidenib U.S. launch



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 sales above $1 billion. 2. Vorasidenib consensus sales estimates derived from Royalty Pharma analysis of Agios analyst models at time of deal (May 2024).

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

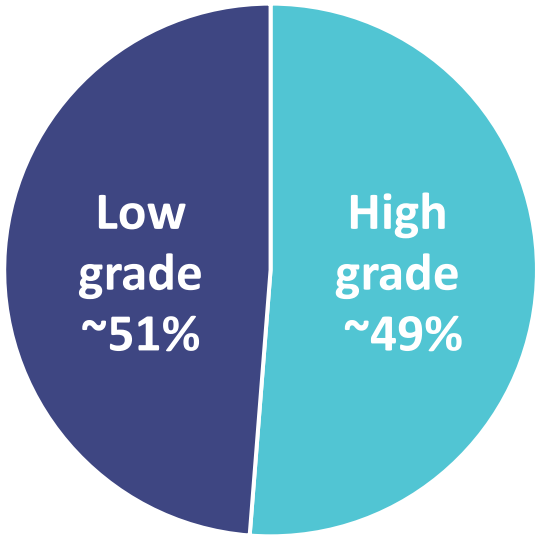
IDH-mutant glioma epidemiology overview

Annual Incidence: IDH-mutant glioma

- New cases per year: **~2,500**
- IDH1 mutations make up **>95%** of mIDH gliomas
- Low-grade survival time: **~10 – 15+ years**
- High-grade survival time: **~3 – 7+ years**

IDH-mutant glioma classification

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



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.

Ongoing study for maintenance treatment of high-grade IDH1-mutant glioma will officially become pivotal once protocol amendment to upsize trial is complete

Key eligibility criteria

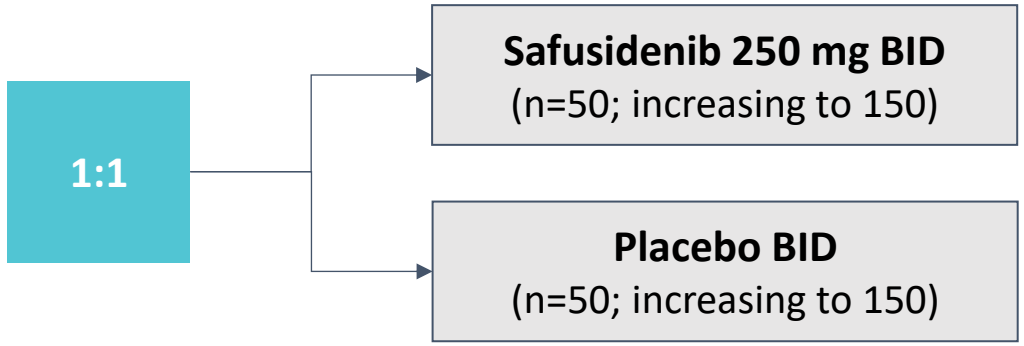
Newly diagnosed grade 3 high-risk and grade 4 IDH1-mutant gliomas[1]

- Age > 18 years; Karnofsky Performance Status > 60
- Completed surgery, radiotherapy, and 6 to 12 cycles of adjuvant temozolomide
- Enroll within 75 days of completing adjuvant temozolomide
- No evidence of progressive disease

Primary Endpoint

- **Progression-free survival** by BICR per RANO 2.0

Planned pivotal study design



Below amendments to ongoing study are underway:

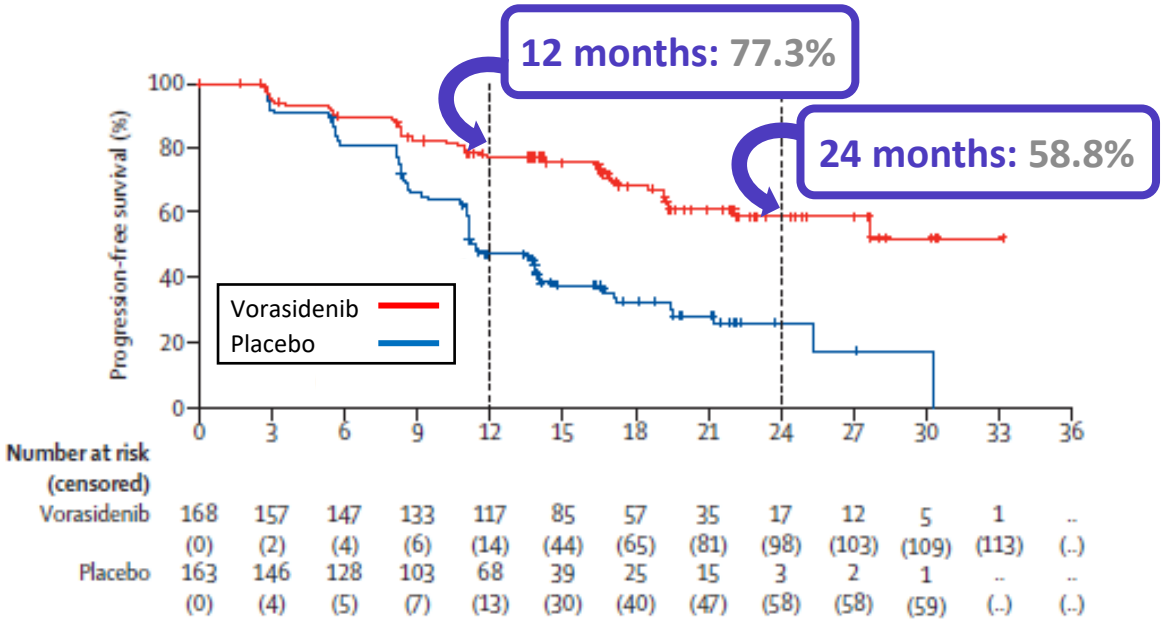
- Increase size of study to 300 patients (150 in each arm)
- Include patients with low-grade (grade 2) high-risk IDH1-mutant glioma[1]

BID: twice daily; BICR: Blinded Independent Central Review; IDH1: isocitrate dehydrogenase 1; KPS: Karnofsky Performance Status; RANO, Response Assessment in Neuro-Oncology. 1. IDH1-mutant Grade 2 and 3 "high-risk" or Grade 4 astrocytoma, per WHO 2021 classification; Additional Notes: Participants will take safusidenib 250 mg BID or dose-matched placebo in continuous 28-day cycles, until disease progression or another reason for discontinuation occurs, as specified in protocol. Patients with grade 2 or 3 astrocytoma are included if they have one or more "high-risk" features described in the protocol. Efficacy Assessment: Based on RANO 2.0 guidelines, with MRI assessments every 8 weeks (±8 days), independent from study drug schedule.

Safusidenib demonstrated a 24-month landmark progression free survival rate of 88% in a phase 2 study of IDH1-mutant grade 2 glioma

Vorasidenib (INDIGO study)[1]

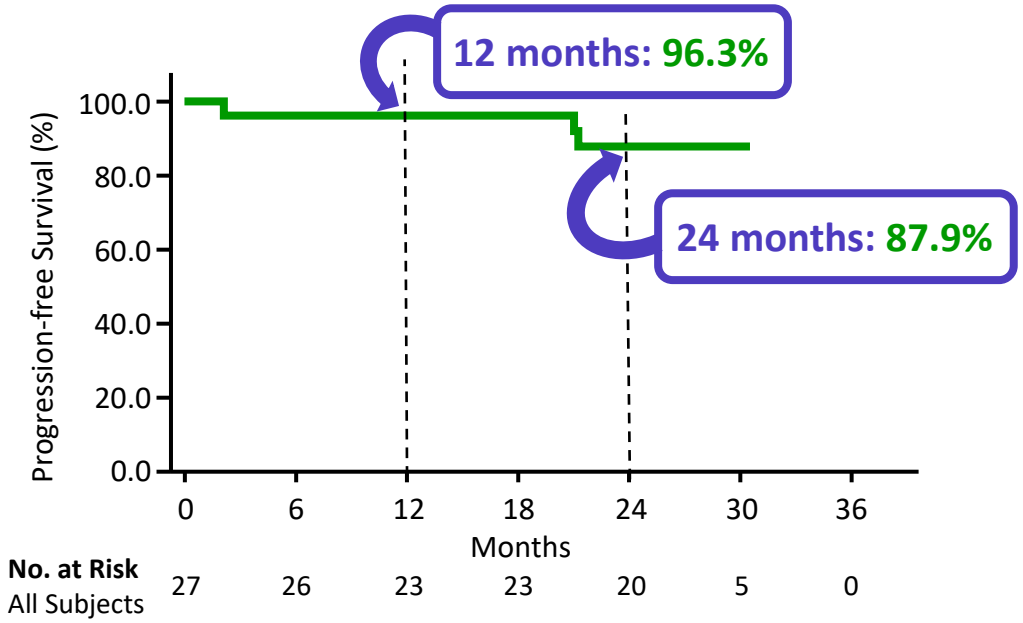
Vorasidenib n=168; Placebo n=163



- Median PFS: **Not reached**
- Median follow-up: **20 months**
- 12-month PFS rate: **77%**
- 24-month PFS rate: **59%**

Safusidenib (J201 study)[2]

n= 27 (250mg BID)

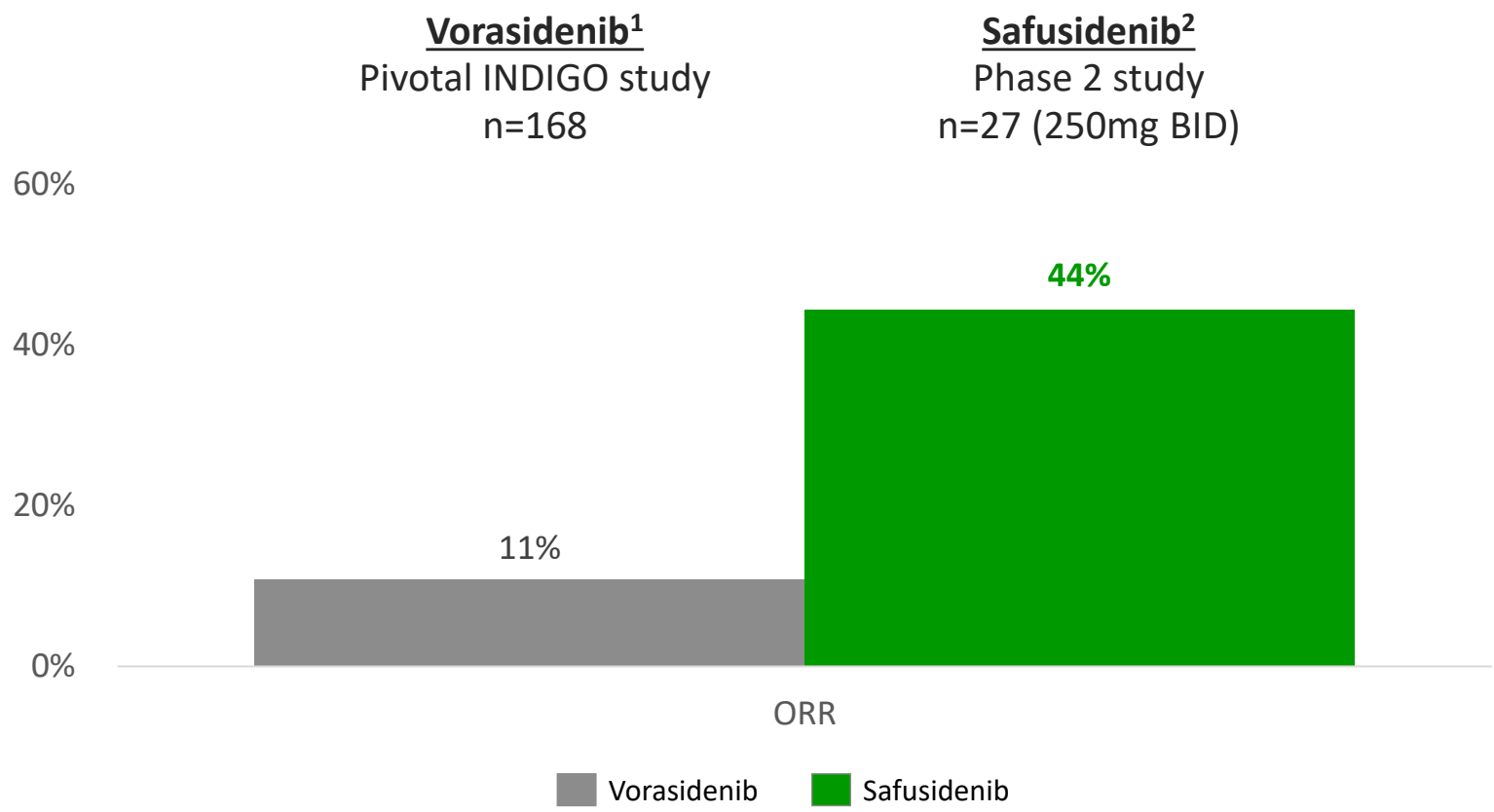


- Median PFS: **Not reached**
- Median follow-up: **28 months**
- 12-month PFS rate: **96%**
- 24-month PFS rate: **88%**

BID: Twice-a-day dosing of safusidenib. PFS: Progression-free survival; Note: These data are derived from different clinical studies, with differences in study design and patient populations. No he ad-to-head studies have been conducted. Comparisons in a head-to-head study may yield different results. 1. Cloughesy, et al., *Lancet Oncol,* 2025; Includes patients with IDH1/2-mutant grade 2 glioma. 2. Arakawa et al., *Neuro-Oncology*, 2025; includes patients with IDH1-mutant grade 2 glioma

Safusidenib's response rate in a phase 2 study of low-grade glioma is 4x the response rate demonstrated by vorasidenib in its pivotal INDIGO study

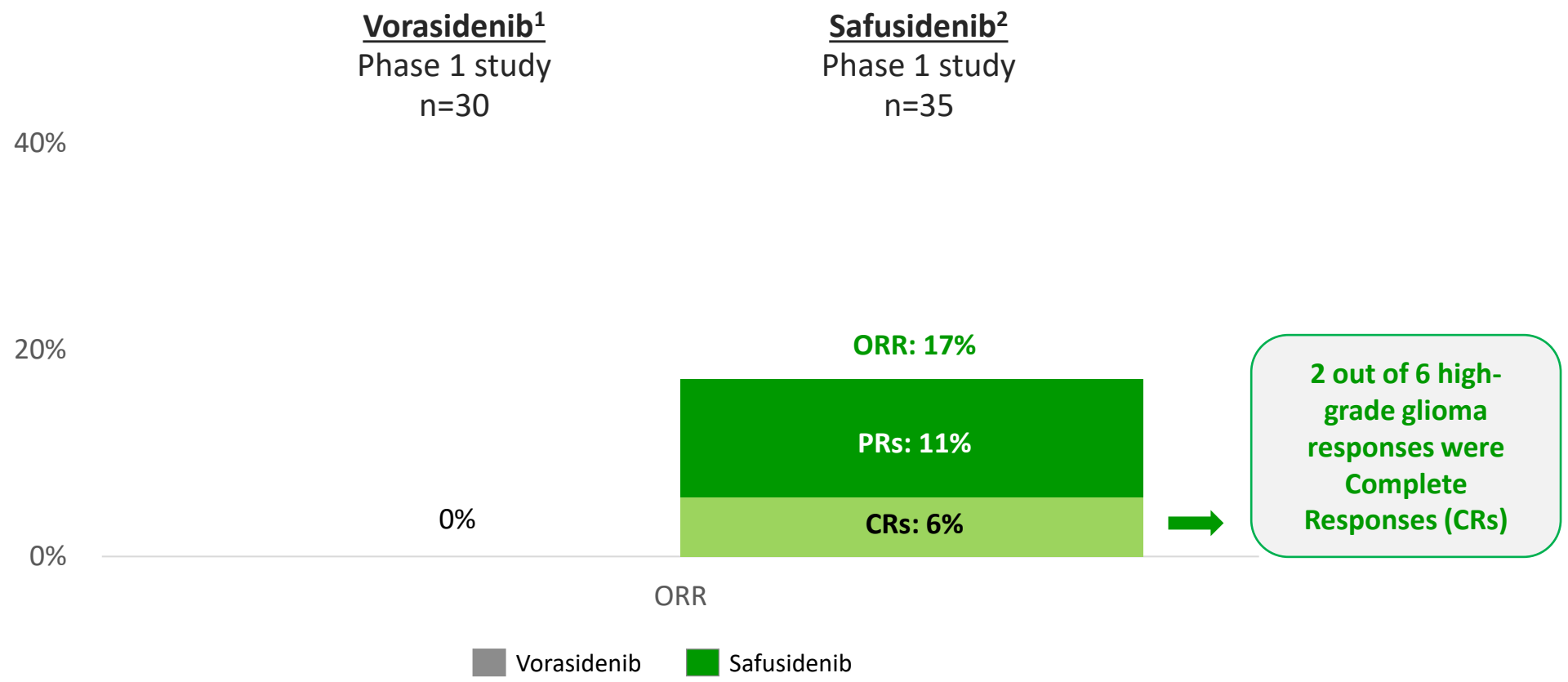
Low-grade IDH-mutant glioma (vorasidenib vs. safusidenib)



BID: Twice-a-day dosing; ORR: Overall response rate. Response was assessed by Response Assessment in Neuro-Oncology (RANO) – LGG. 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. Mellinghoff et al., *New England Journal of Medicine*, 2023; includes patients with IDH1/2-mutant grade 2 glioma. 2. Arakawa et al., *Neuro-Oncology*, 2025; includes patients with IDH1-mutant grade 2 glioma.

In high-grade glioma, two CRs were observed lasting 174 weeks (glioblastoma) and 95 weeks (oligodendroglioma), with patients still on treatment at data cutoff

High-grade IDH-mutant glioma (vorasidenib vs. safusidenib)



CR: Complete Response; ORR: Overall response rate. Note: All data shown are for the enhancing populations, the majority of which are high-grade (grade 3 or 4). Response was assessed by Response Assessment in Neuro-Oncology (RANO). 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. Mellinghoff et al., *Clinical Cancer Research*, 2021; includes patients with enhancing IDH1/2-mutant gliomas. 2. Natsume et al., *Neuro-Oncology*, 2023; includes patients with enhancing IDH1-mutant gliomas.

Treatment emergent adverse events were mostly mild to moderate, and manageable, and consistent across the Phase 1 and Phase 2 studies

≥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)**	**26 (96)**	**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)	13 (48)	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)	7 (26)	0 (0)
Neutrophil count decreased	7 (15)	6 (13)	7 (26)	0 (0)
Diarrhea	22 (47)	2 (4)	6 (22)	0 (0)
Nausea	12 (26)	0 (0)	5 (19)	0 (0)
Dry skin	10 (21)	0 (0)	4 (15)	0 (0)
Headache	11 (23)	1 (2)	4 (15)	1 (4)

Key Observations

Across Phase 1 and Phase 2 studies

- Five of the top seven TEAEs are consistent with an immune-related MOA
- No grade 5 events were reported

In the Phase 2 study (250mg BID):

- Five (19%) patients had ≥ Grade 3 TEAEs deemed as related to drug
- Only three patients (11%) had TEAEs that led to treatment discontinuation
  - Of these three patients, two TEAEs were considered related to drug, and both events resolved with dose interruption and/or appropriate management

Source: Arakawa et al., *Neuro-Oncology*, 2025 and Natsume et al., *Neuro-Oncology*, 2023.
BID: Twice-a-day dosing. MOA: Mechanism of action. TEAE: Treatment emergent adverse event; Note: Good Clinical Practice (GCP) noncompliance issue regarding the collection of adverse events was identified during the study. Therefore, all safety data presented in this manuscript was 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.

NUV-1511 | DDC

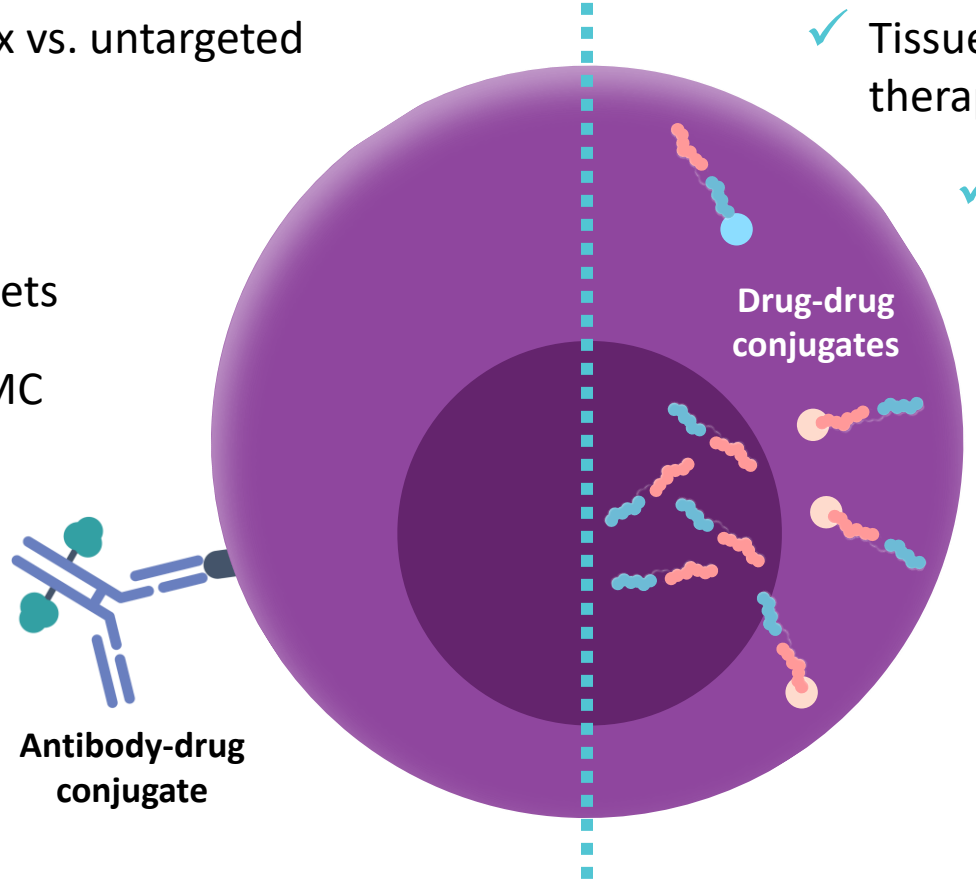
Advanced solid tumors

Phase 1/2 study ongoing

Nuvation Bio's drug-drug conjugate (DDC) platform is a potentially revolutionary advance beyond ADCs

Antibody-drug conjugates

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

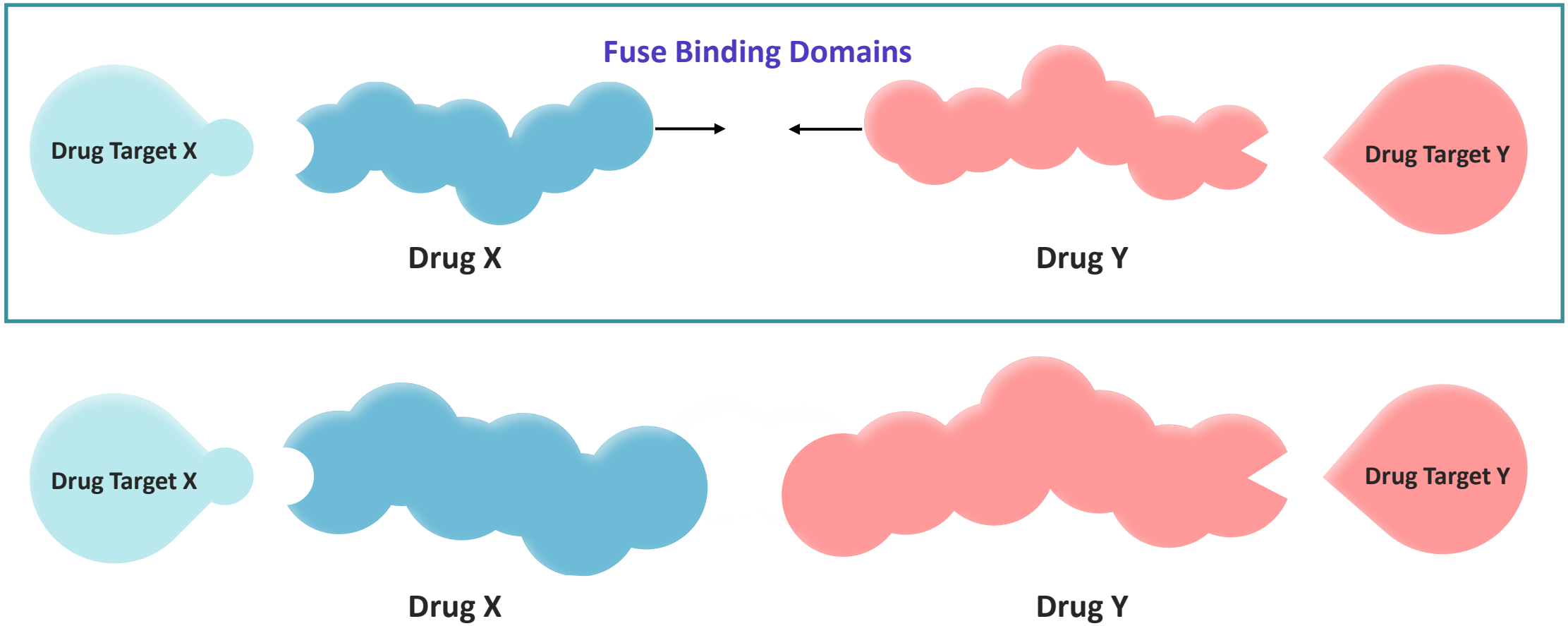


Drug-drug conjugates

- ✓ 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

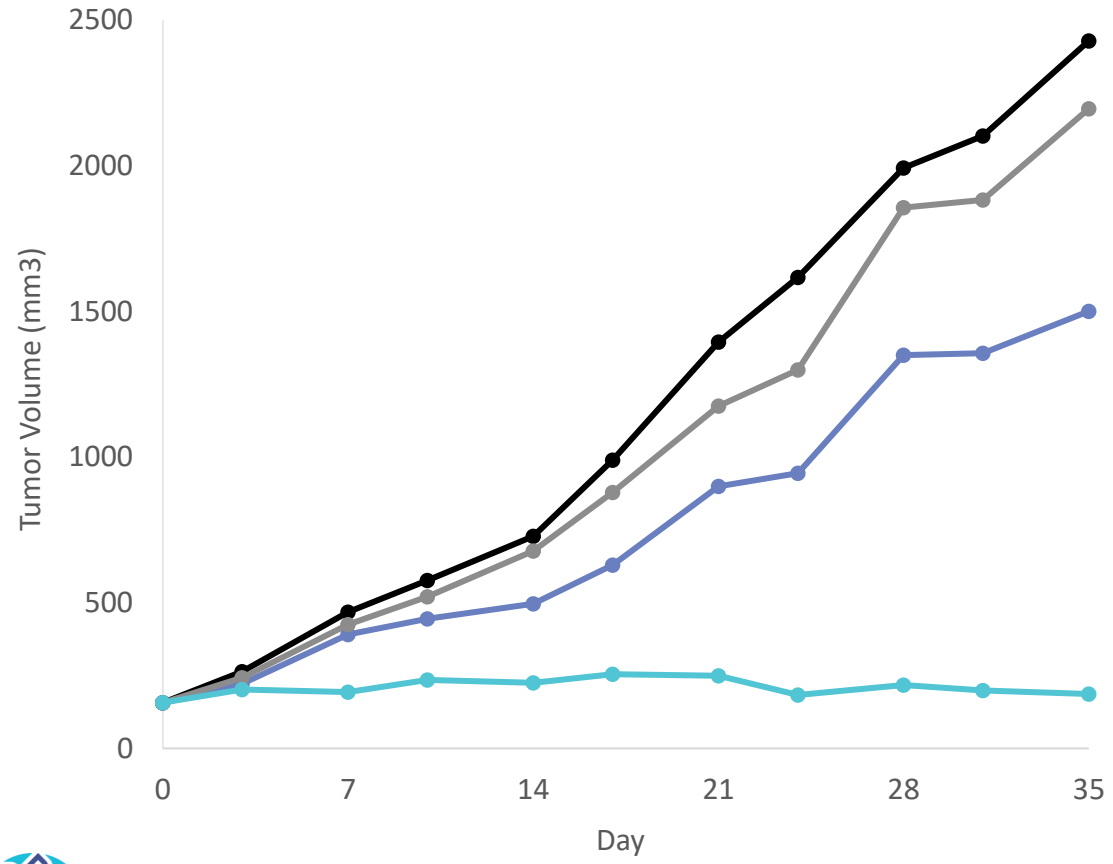
DDCs are designed to bind TWO different targets simultaneously

Two separate drugs with two separate targets

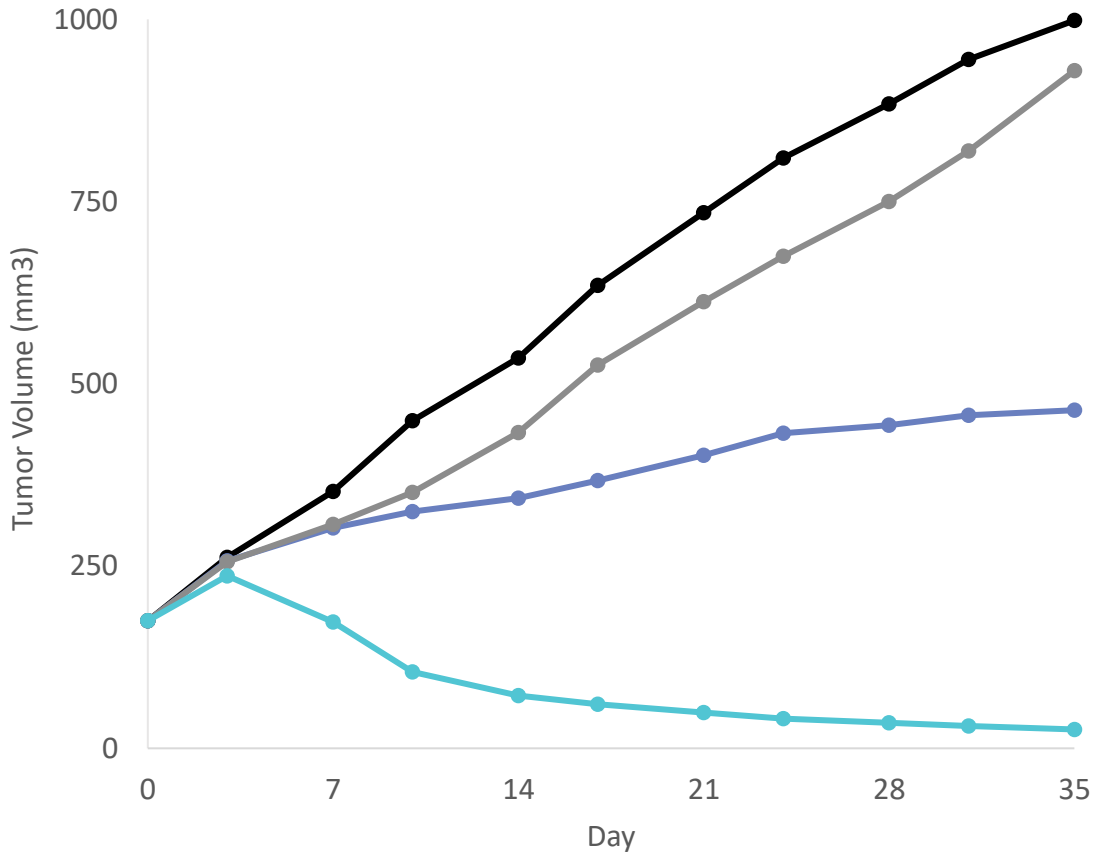


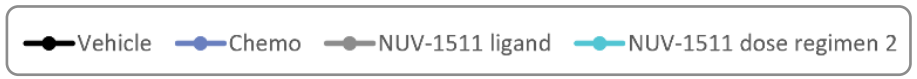
NUV-1511, a DDC derivative of a widely used chemotherapy agent, suppresses prostate and breast cancer growth in xenografts

Prostate cancer CDX (LNCAP)



ER+ breast cancer CDX (T47D)

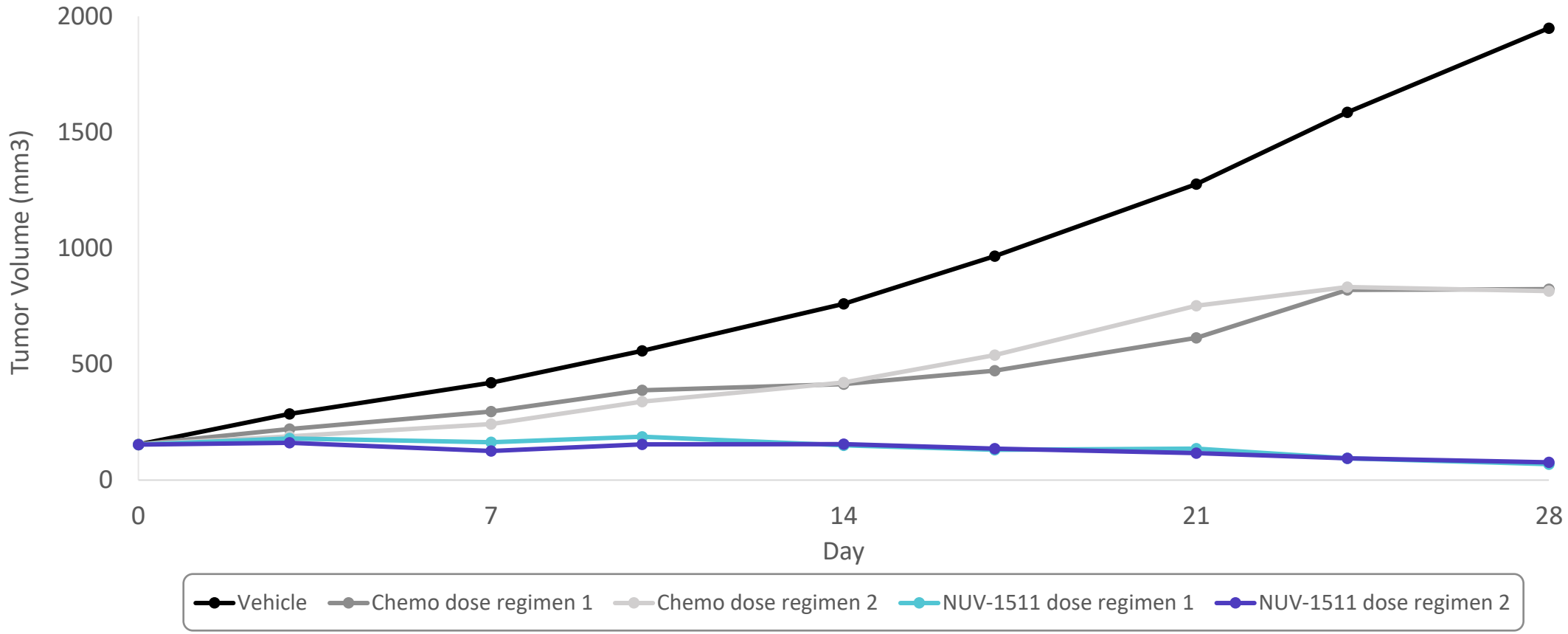




Source: Nuvation Bio internal preclinical research data on file.
CDX: Cell-line derived xenograft; ER: Estrogen receptor.

Intermittent dosing of NUV-1511 leads to sustained tumor inhibition for weeks

Prostate cancer CDX (LNCAP)



Source: Nuvation Bio internal preclinical research data on file.
CDX: Cell-line derived xenograft.

NUV-1511 is initially being evaluated in five indications for which there is a significant unmet need and large market potential

Nuvation Bio initiated a Phase 1/2 study evaluating NUV-1511 for the treatment of patients with:

1. Advanced solid tumors who previously received and progressed on or after treatment with Enhertu® and/or Trodelvy® per approved U.S. FDA labeling
2. Human epidermal growth factor receptor 2-negative (HER2-) metastatic breast cancer
3. Metastatic castration-resistant prostate cancer
4. Platinum-resistant ovarian cancer
5. Advanced pancreatic cancer

NUV-868 | BETi

Advanced solid tumors	Completed Phase 1 and Phase 1b studies
Future indications	Currently evaluating next steps for program

First generation BET inhibitors have been toxic and poorly effective; NUV-868 is the most BD2-selective BET inhibitor in development

NUV-868 is the most selective BD2 vs BD1 BET inhibitor in development

- BET proteins regulate the expression of many oncogenes, including cMYC – an oncogene that has not been targetable directly with a drug
- Non-selective BD1/2-inhibitors have been associated with tolerability issues, many apparently due to BD1 inhibition[1]
- **NUV-868 inhibits BD2 almost 1,500 times more potently than BD1, which may improve efficacy and tolerability**

	BRD4 Affinity[2]		
	BD2 (nM)	BD1 (nM)	Selectivity
NUV-868*	2	2920	1460x
ABBV-744[3]	1.05	340	324x
Pelabresib[3]	17	85	5-6x
ABBV-075[1]	3	11	3.7x
MK-8628/OTX-015[5]	17	26	1.5x
BI-894999[6]	41	5	0.1x
ZEN-3694[7]	Non-selective		

LESS BD2 SELECTIVE → MORE BD2 SELECTIVE

*high plasma protein binding, > 1% free fraction

1. Faivre et al 2020. 2. Various assays used. 3. Internal Nuvation Bio data. 4. https://ash.confex.com/ash/2020/webprogram/Paper140138.html. 5. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5474678/.
6. https://www.nature.com/articles/s41388-018-0150-2. 7. 2016-EORTCposter-ZenithEpigenetics.pdf.

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

Strong pro forma cash position provides path to potential profitability

- $549 million as of September 30, 2025
- Cash balance includes $200 million from Sagard financings[1], with an option for additional $50 million under a term loan
- No need to raise additional capital to fund IBTROZI launch or pipeline programs

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**
- **204 new patient starts in Q3 2025**
- Approved by Japan's MHLW in September 2025
- Approved by China's NMPA in January 2025

Broad clinical-stage pipeline led by safusidenib

- **Safusidenib | mIDH1 inhibitor:**
  Entering high-grade pivotal[2] study supported by Phase 2 and Phase 1 results
- **NUV-1511 | Drug-drug conjugate:**
  Update on Phase 1/2 study by year end
- **NUV-868 | BD2-selective BET inhibitor:**
  Completed Phase 1 and Phase 1b studies

1. Includes $150 million of royalty interest financing and $50 million under a term loan funded after U.S. FDA approval of IBTROZI. An additional $50 million under the term loan is available until June 30, 2026. 2. Protocol amendment to upsize to a pivotal trial and include patients with grade 2 high-risk IDH1-mutant glioma are forthcoming.

$250 million non-dilutive financing with Sagard validates IBTROZI's commercial potential and provides Nuvation Bio with path to profitability

$150 million royalty financing

- Tiered, declining mid-single-digit royalty on annual U.S. net sales of IBTROZI:
  - **$0 – $600M:** 5.5%
  - **$600M – $1B:** 3.0%
- Nuvation retains all annual U.S. net sales above $1B (0% royalty) and after 1.6x – 2.0x return cap is met

$100 million senior term loan

- $50M was funded upon U.S. FDA approval of IBTROZI
- $50M available at Company's option for 12 months[1]
- Interest-only to 5-year maturity at SOFR + 6.00%
- Single financial covenant: $25M of minimum liquidity

Opportunistic transaction solidifies financial position without need to raise additional capital

- *Royalty financing funds U.S. launch of IBTROZI*
- *Pro forma cash funds clinical-stage pipeline*
- *Improves flexibility for strategic capital deployment*
- *Extracts value from ~$260M[2] acquisition of AnHeart*

Source: Nuvation Bio press release and financing agreements.
1. $50 million in debt is available at the company's option for 12 months following first commercial sale. 2. Based on closing price of $2.31 per Nuvation Bio share prior to announcement on March 25, 2024. Nuvation Bio acquired AnHeart Therapeutics for ~113 million shares of common stock.