Nuvation Bio®

DRIVEN BY SCIENCE
FOCUSED ON LIFE

January 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 include, but are not limited to, statements regarding IBTROZI's and safusidenib's best-in-class therapeutic potential, our expectations for a MAA filing for IBTROZI in Europe and the timing thereof, and the receipt and timing of a regulatory and commercial milestone payment under our license and collaboration agreement with Eisai, IBTROZI's commercial potential including its theoretical maximum ROS1+ NSCLC market opportunity based on IBTROZI's median progression-free survival, 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 patient enrollment, our expectations that the 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 for taletrectinib and safusidenib, 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 for advanced ROS1+ NSCLC in the U.S., Japan, and China**

Safusidenib is a **potentially best-in-class**, brain penetrant, **mIDH1 inhibitor** being evaluated in a **pivotal study** for **high-grade and high-risk IDH1-mutant glioma**[1]

NUV-868 is a **BD2-selective BET inhibitor** that has completed **Phase 1 and Phase 1b studies;** Company is also evaluating preclinical candidates from its proprietary **Drug-Drug Conjugate (DDC)** platform

Robust pro forma cash balance of approximately **$589 million**[2] is expected to provide **path to profitability without need for additional funding**

1. Includes patients grade 4 astrocytoma and patients with grade 2 or 3 astrocytoma with certain high-risk features. 2. Includes approximately $60 million received as an upfront payment from our recently announced partnership with Eisai; an additional $50 million under a term loan with Sagard Healthcare Partners is available to the Company until June 30, 2026; Pro forma cash balance is based on preliminary estimates.

Nuvation Bio is a commercial-stage company following approval of IBTROZI in the U.S., and is also enrolling a pivotal study for safusidenib

Program	Target Indication(s)	Current Stage of Development					Anticipated Milestones & Recent Updates	Commercial Partners	
		Preclinical	Phase 1	Phase 2	Pivotal	Approved			
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 • Enrolling TRUST-IV study for early-stage ROS1+ NSCLC	Eisai (Europe & other[1])	Innovent (Greater China) NIPPON KAYAKU (Japan)
Safusidenib (IDH1)	Diffuse IDH1-mutant glioma						• Enrolling pivotal study for high-grade and high-risk IDH1-mutant glioma[2]	N/A	
NUV-868 (BET)	Currently under internal evaluation						• Completed Phase 1 monotherapy and Phase 1b combination studies in advanced solid tumors	N/A	
Drug-Drug Conjugate (DDC) platform	Solid tumors						• Currently evaluating preclinical candidates	N/A	

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. Includes the Middle East, North Africa, Russia, Turkey, Canada, Australia, New Zealand, Singapore, the Philippines, Indonesia, Thailand, Malaysia, Vietnam, and India. 2. Includes patients grade 4 astrocytoma and patients with grade 2 or 3 astrocytoma with certain high-risk features.

Recently announced partnership with Eisai further validates the global commercial potential and differentiated clinical profile of IBTROZI

Transaction overview

- Exclusive licensing agreement for IBTROZI in Europe and additional countries[1] outside U.S., China, and Japan
- Total cash consideration of up to ~$230 million including:
  - Upfront payment of ~$60 million
  - Near-term milestone payment of ~$30 million upon conditional or full approval in Europe
- Nuvation Bio will also receive double-digit tiered royalties up to the high-teens on taletrectinib net sales in the licensed territories
- Eisai will receive exclusive development, registration, and commercialization rights in the licensed territories

Strategic rationale

- Strategic collaboration with leading oncology partner brings IBTROZI to patients globally; allows Nuvation Bio to remain focused on U.S. launch
- Significant upfront payment to be invested into Nuvation Bio's programs
- Further validates and creates additional value from the 2024 acquisition of AnHeart Therapeutics
- Eisai to lead submission of an MAA to the EMA in the first half of 2026, with Nuvation Bio support
- Eisai selected after robust process including receipt of multiple term sheets from oncology focused companies

EMA: European Medical Agency; MAA: Marketing Authorization Application. Note: Cash consideration from deal to be paid in Euros. U.S. dollar amounts reflected based on conversion ratio of 1 EUR : 1.2 USD. 1. 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 obtained from the April 2024 acquisition of AnHeart Therapeutics

Global approvals

- **Line agnostic approved 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

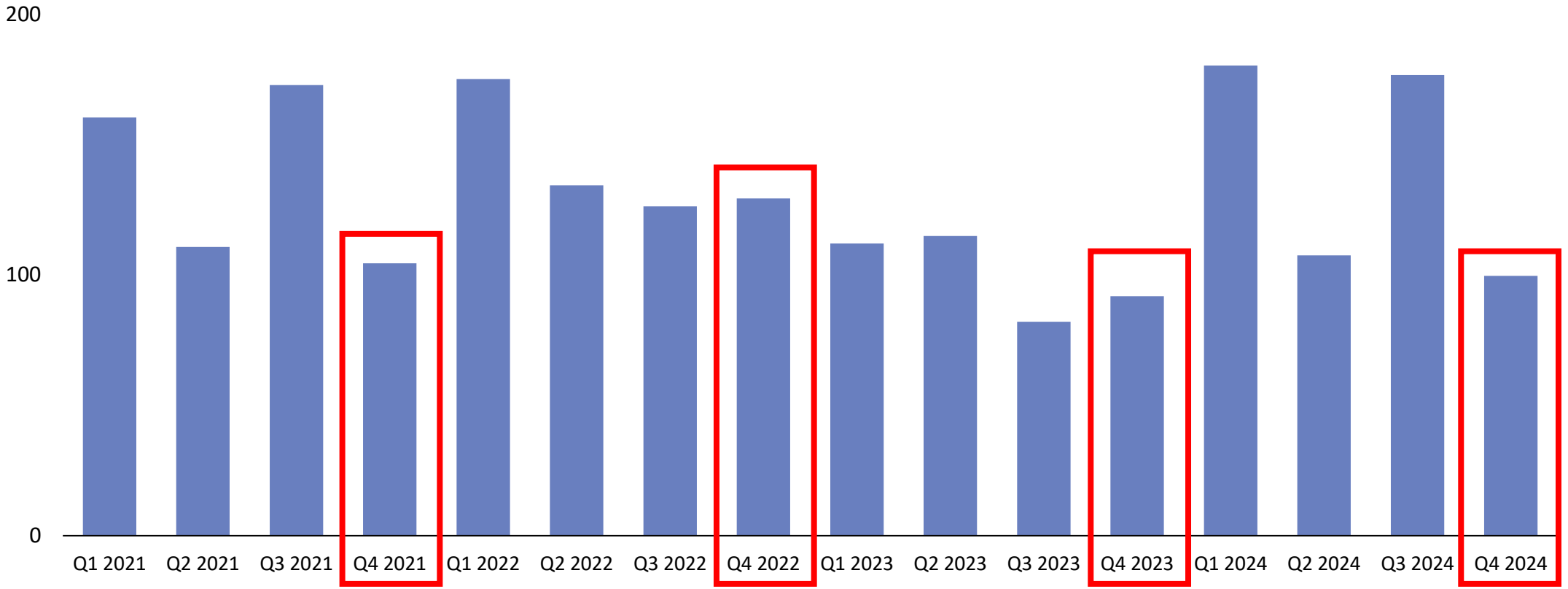
Robust commercial opportunity

- ~3,000 newly diagnosed ROS1+ NSCLC patients in the U.S. each year
- Theoretical maximum gross market opportunity of ~$4 billion[2]
- 432 new patient starts and ~$25m[3] in U.S. net revenue since FDA approval

NDA: New Drug Application; FDA: Food and Drug Administration; TKI: Tyrosine kinase inhibitor. 1. IBTROZI prescribing information; Perol et al., *Journal of Clinical Oncology*, 2025. 2. Based on ~3,000 newly diagnosed ROS1+ NSCLC patients in the U.S. each year, gross price of IBTROZI of ~$350,000 per patient per year, and median progression-free survival of 46 months in TKI-naïve patients (Perol et al., *Journal of Clinical Oncology*, 2025). 3. IBTROZI U.S. net revenue is based on preliminary estimates and has not yet been reviewed by auditors.

New patient starts for ROS1 TKIs have typically declined in the fourth quarter due to the impact of the holiday season

Estimated ROS1 TKI new patient starts per quarter per IQVIA



Source: IQVIA NPA NBRx monthly data through 2024 for Augtyro, Rozlytrek, and Xalkori.

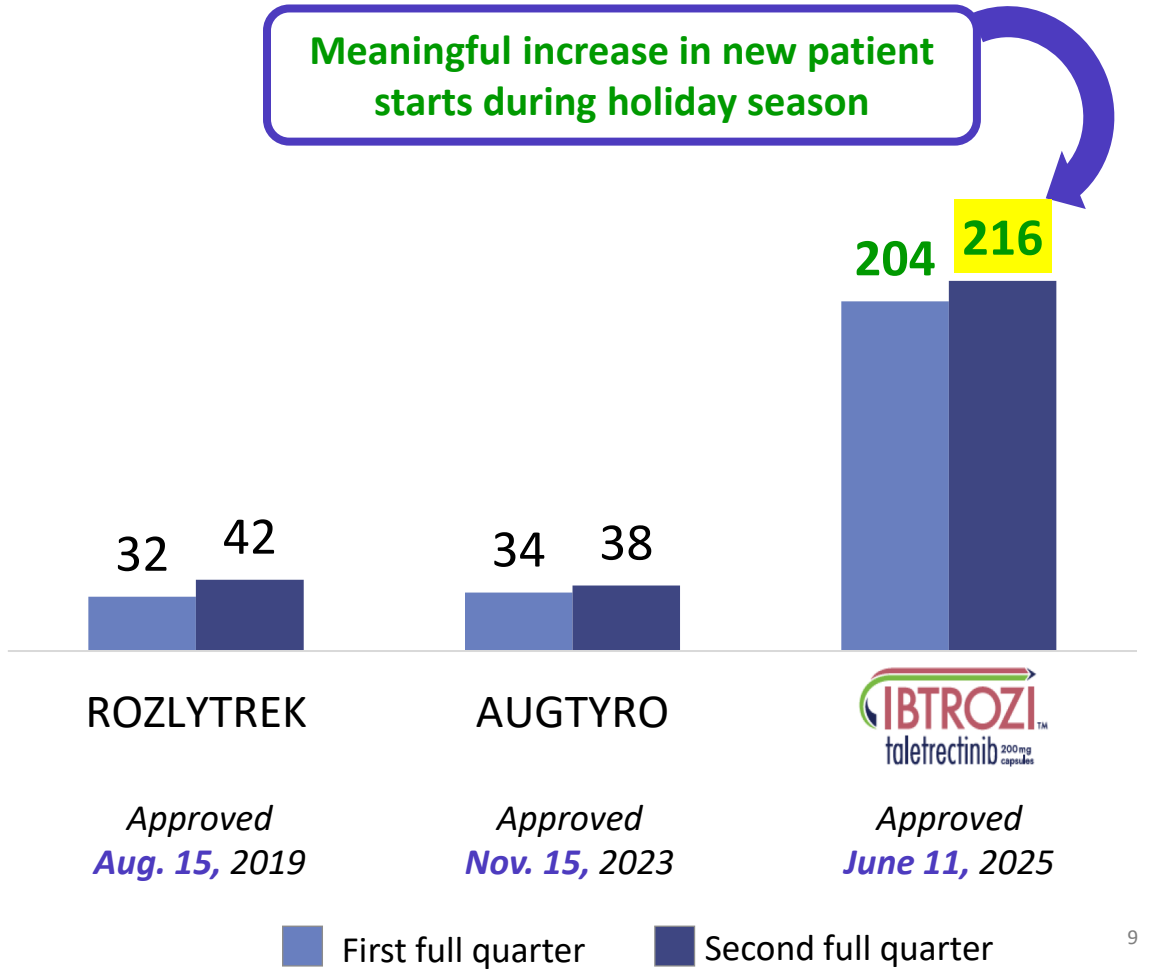
U.S. launch of IBTROZI continued to grow despite seasonality, reinforcing its compelling clinical profile and Nuvation Bio's commercial expertise

Key metrics

As of December 31, 2025

- **432 new patient starts since launch –** a rate of **~6x faster** than prior ROS1 TKIs
- **IBTROZI is now the preferred TKI** for advanced ROS1+ NSCLC
- **Multiple repeat prescribers** across the U.S.
- Scripts from **100%** of all 47 sales territories
- **>90%** of lives covered to label

Recent launches in ROS1+ NSCLC



Source: Nuvation Bio data on file and IQVIA. Competitor data for Rozlytrek and Augtyro based on IQVIA NPA NBRx monthly data.

There was an opportunity to improve upon the landscape of approved ROS1 TKIs prior to the launch of IBTROZI

	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)

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. Drilon et al., *JTO Clinical Research Reports*, 2022. 3. XALKORI prescribing information and Shaw et al., *Annals of Oncology*, 2019.

IBTROZI demonstrated high and durable responses in TKI-naïve patients – median DOR is now 50 months

	June 2024 data cutoff	October 2024 data cutoff		Aug. 2025 data cutoff
	Pooled (JCO)[1]	TRUST-I (label)[2]	TRUST-II (label)[2]	Pooled
n	160	103	54	
cORR	89%	90%	85%	**Median DOR: 50 months**
Median DOR	44 months	*Not Reached*	*Not Reached*	*Additional updates from August 2025 data cutoff to be presented at Medical conference in 2026*
Median PFS	46 months	45 months	*Not Reached*	
IC-cORR	77% (13/17)	88% (7/8)	57% (4/7)	

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.

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%	> 60 months	NE
VITRAKVI (larotrectinib)[6]	75%	--	33 months
XTANDI (enzalutamide)[7]	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. 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.

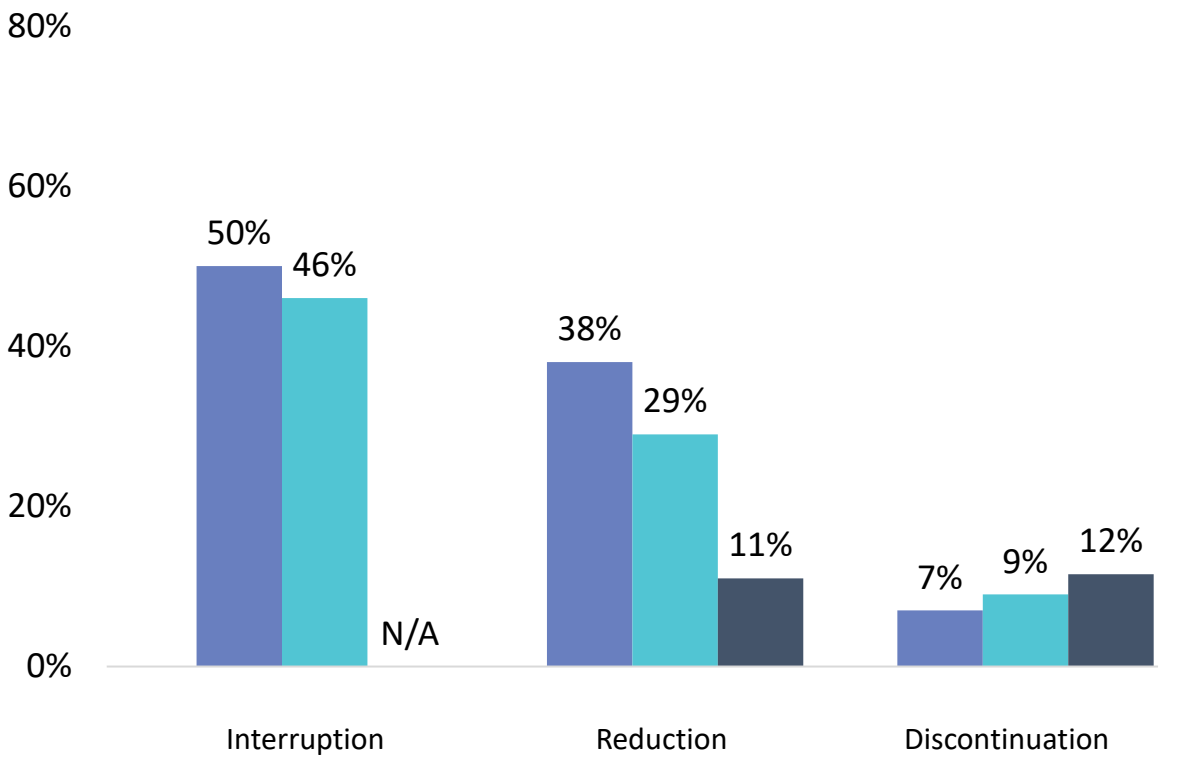
IBTROZI's cORR and IC-cORR in the second- line setting are unmatched

	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)

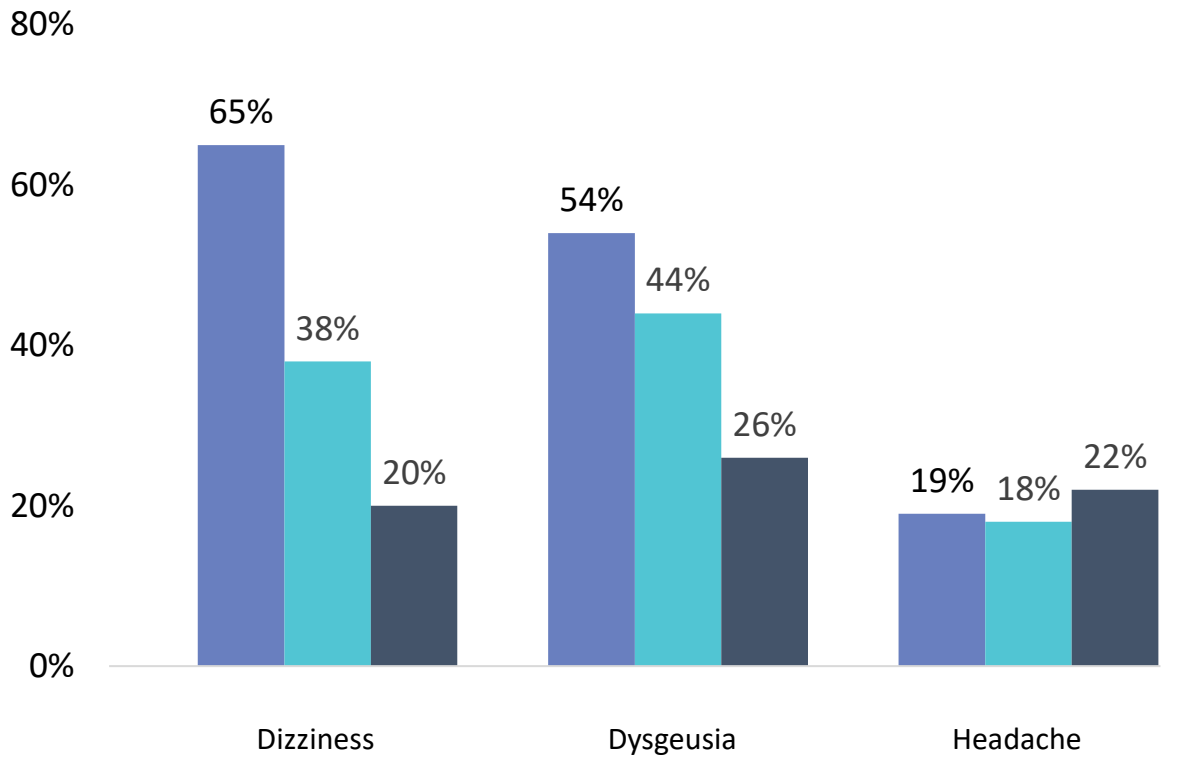
cORR: confirmed Overall response rate; DOR: Duration of response; IC-cORR: Intracranial confirmed overall response rate; PFS: Progression free survival; TKI: Tyrosine kinase inhibitor. 1. Perol et al., *Journal of Clinical Oncology*, 2024; Median duration of follow-up of 21.0 months for the pooled data 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.

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

AE: Adverse event; 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: 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'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 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

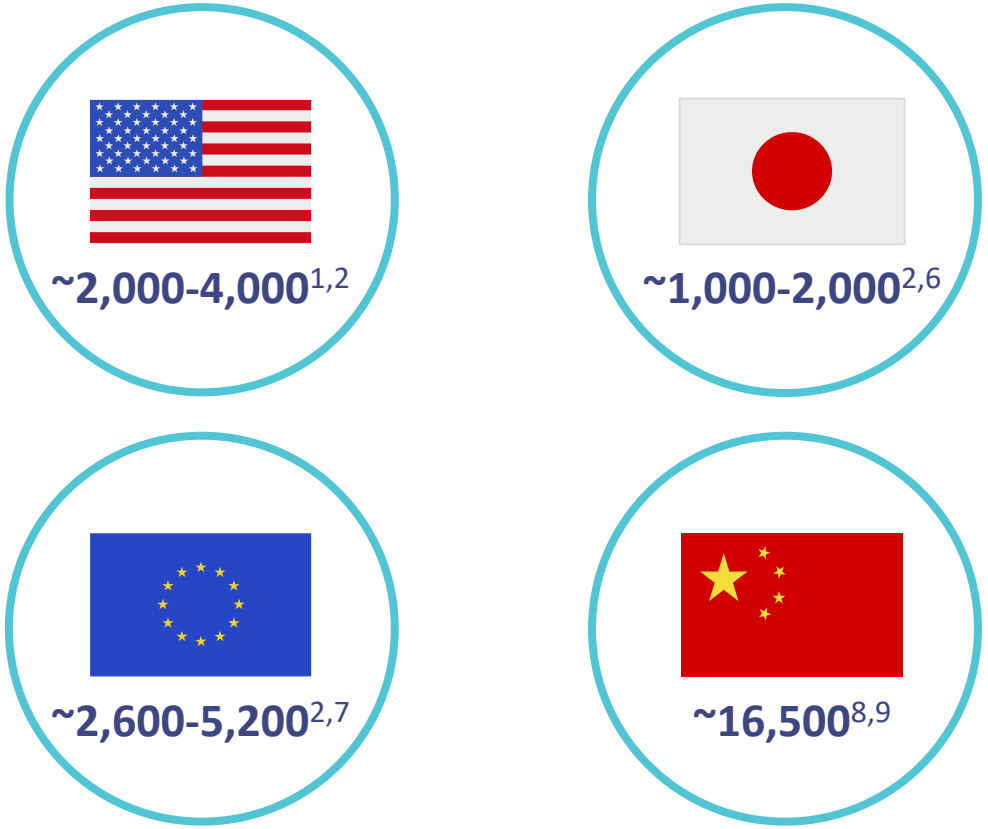
Key takeaways

- NSCLC accounts for ~87%[1] of all lung cancers
- ROS1+ lung cancer represents ~2%[2] of new NSCLC cases each year
- There are 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



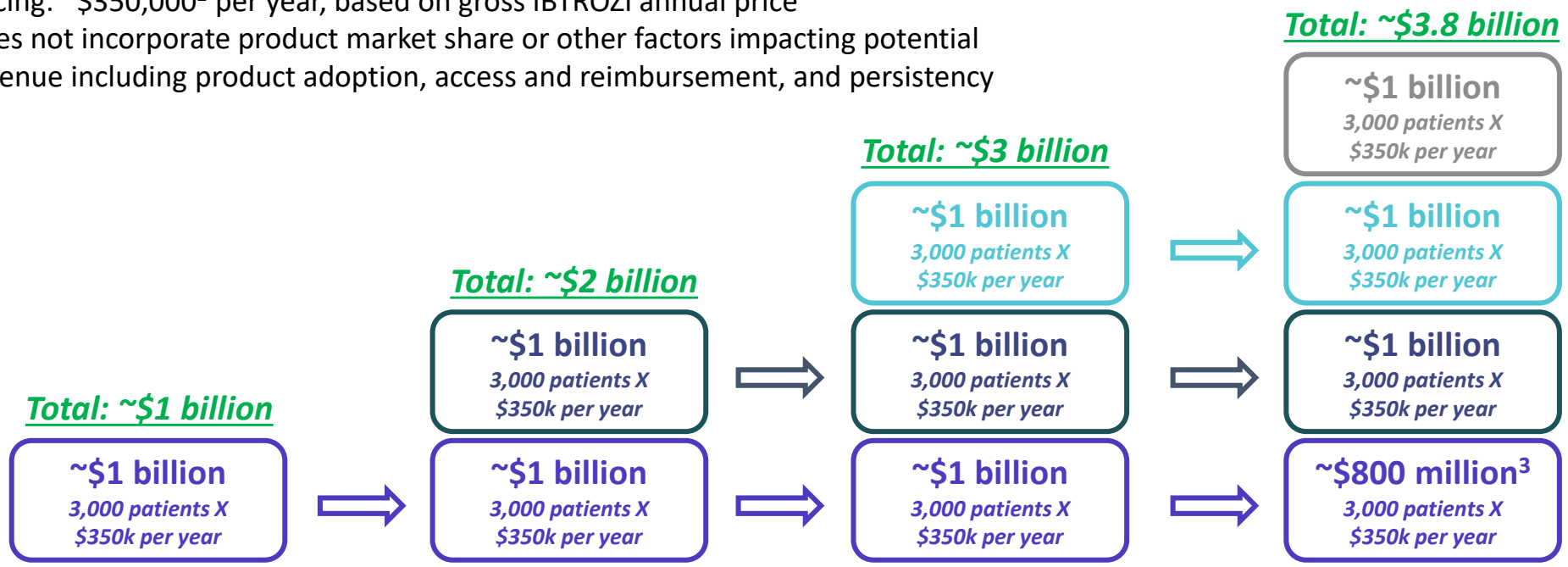
mPFS: median progression-free survival; TKI: tyrosine kinase inhibitor. 1. American Cancer Society (2025). 2. National Center for Biotechnology Information: Gendarme et al., Curr Oncol (2022). 3. Initially approved by U.S. FDA in 2011 for the treatment of patients with advanced or metastatic ALK-positive 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

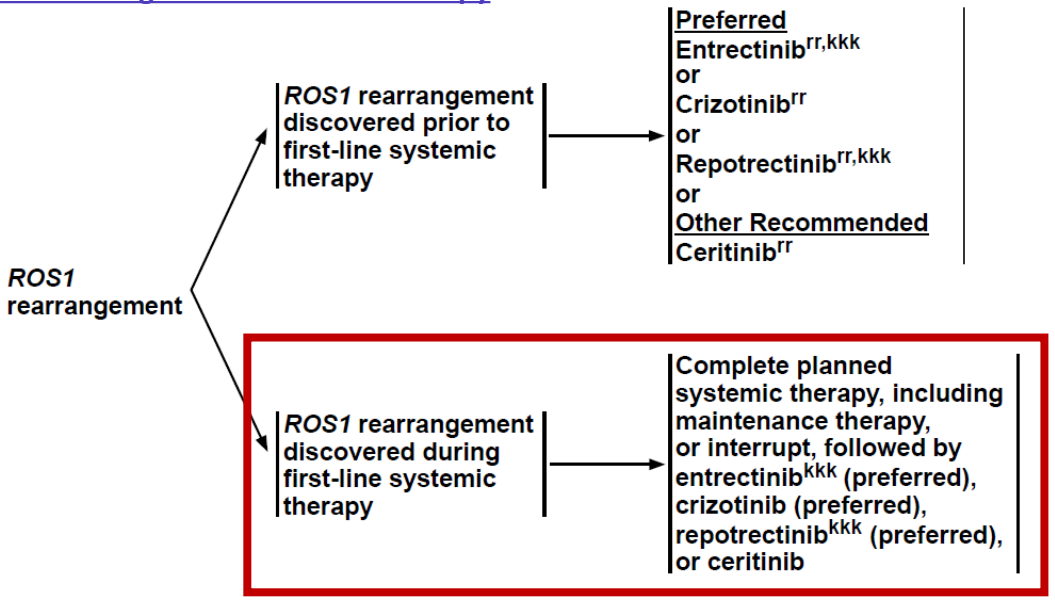


NSCLC: Non-small cell lung cancer. Note: Based on median progression-free survival demonstrated by IBTROZI in the first line setting (Pooled TRUST-I and TRUST-II data: Perol et al., *Journal of Clinical Oncology*, 2024). 1. Reflects midpoint of epidemiology assumptions based on ROS1+ lung cancer representing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

NCCN Guidelines 2024

ROS1 Rearrangement: First Line Therapy

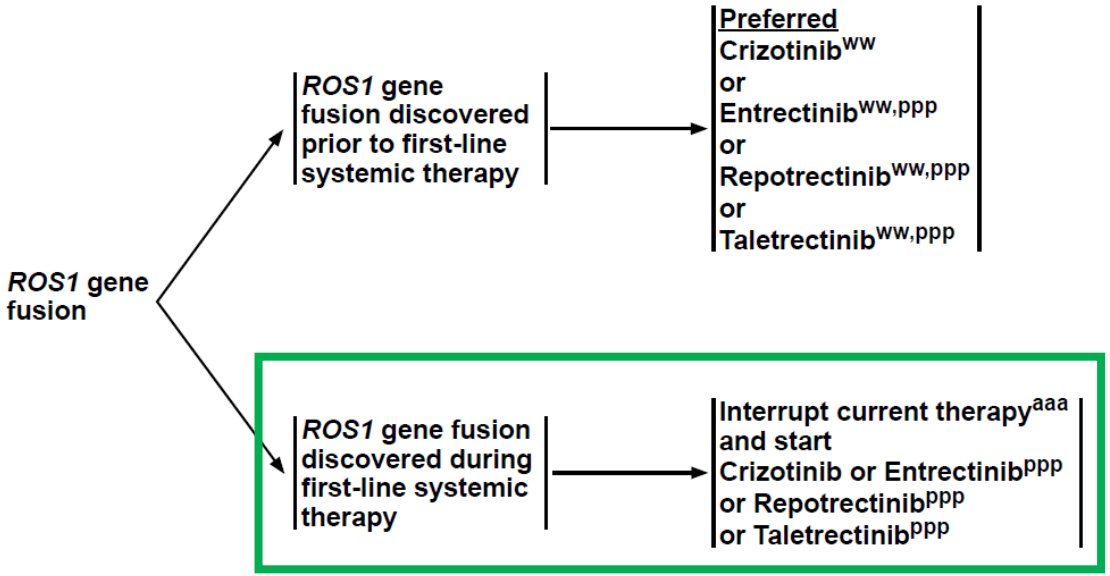


PD-L1 Positive (>1%): First Line Therapy

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 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	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 @ 5-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

45 mo. – Not Reached

ORR

IBTROZI taletrectinib 200 mg capsules

85% – 90%

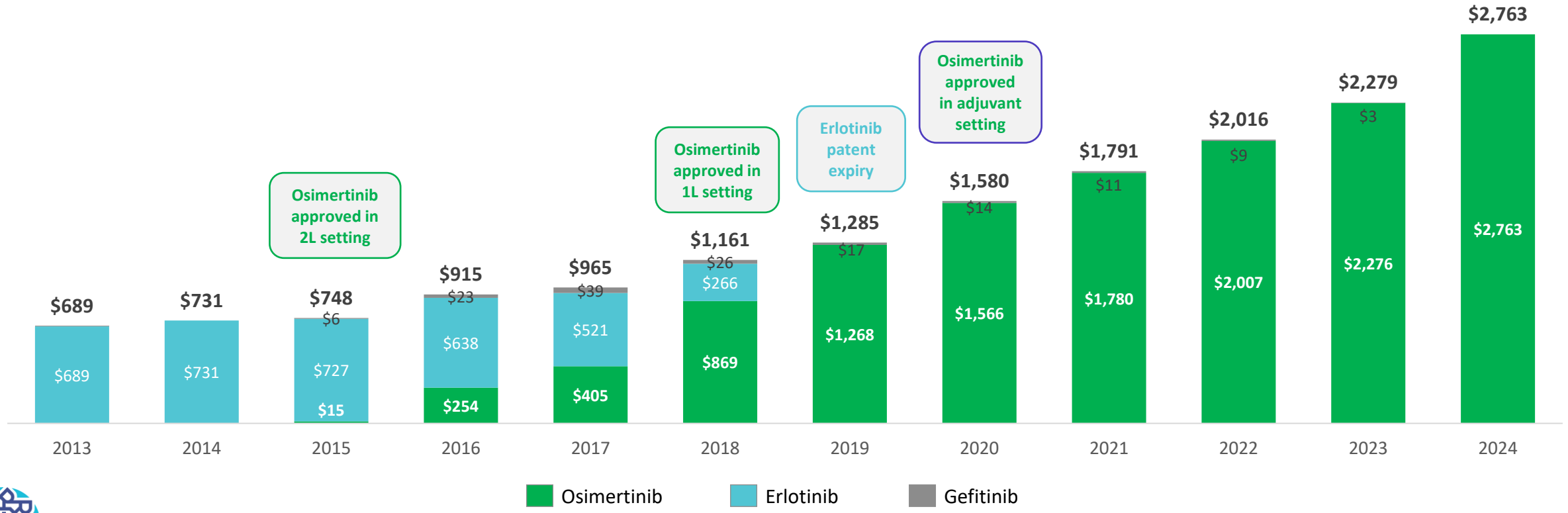
mo.: months; ORR: Overall response rate; mPFS: median Progression-free survival. Note: These data are derived from different clinical studies, with differences in study design and patient populations. No head-to-head studies have been conducted. Comparisons in a head-to-head study may yield different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

Enrolling pivotal study

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

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]
- Manageable and consistent safety profile

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).

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

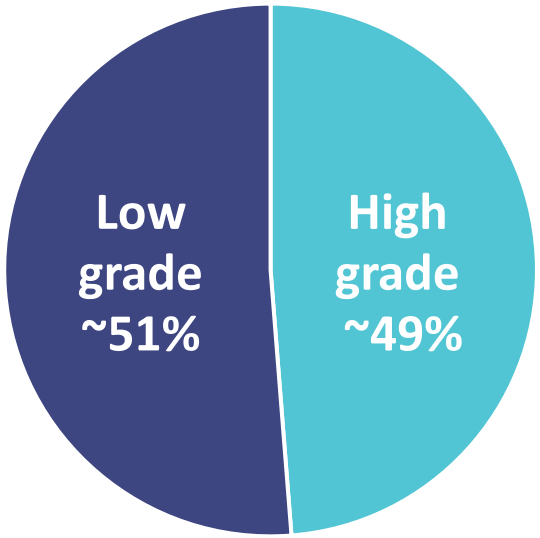
IDH-mutant glioma epidemiology overview

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



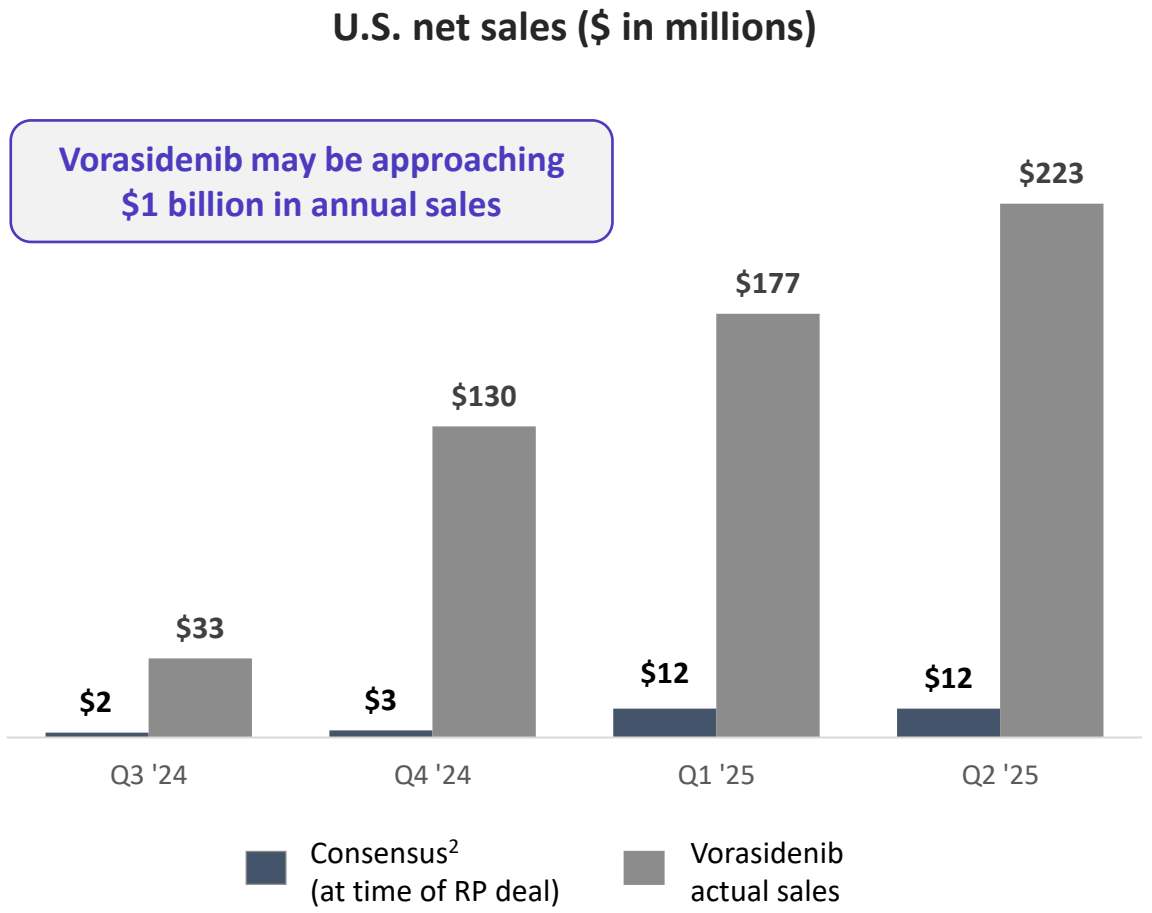
Source: 2025 CBTRUS Statistical Report: Primary Brain and Other Central Nervous System Tumors Diagnosed in the United States in 2017–2021; UpToDate – a Wolters Kluwer Company.

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]
- **Safusidenib has shown a compelling clinical profile in early-stage IDH1-mutant glioma studies**

Vorasidenib U.S. launch

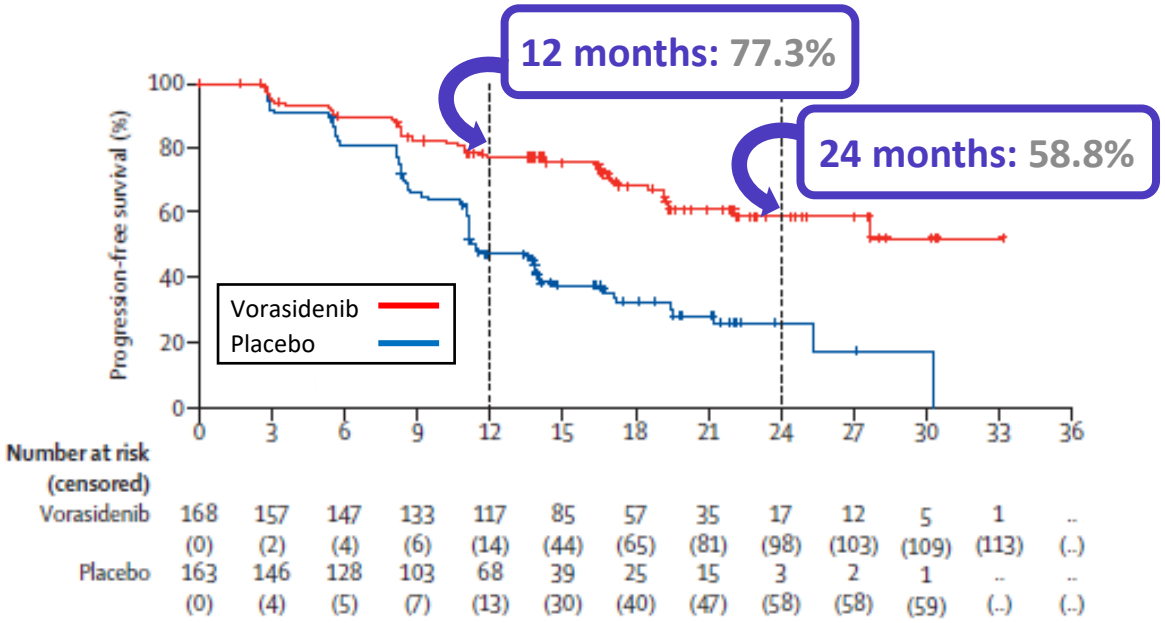


Source: Royalty Pharma September 2025 investor presentation, Royalty Pharma and Agios Pharmaceuticals press releases at time of royalty transaction. 1. Agios will retain 3% of the 15% royalty on sales above $1 billion.
2. Vorasidenib consensus sales estimates derived from Royalty Pharma analysis of Agios analyst models at time of deal (May 2024).

Vorasidenib showed a 24-month landmark PFS of 59% in a pivotal study of low-grade IDH-mutant glioma; 0% cORR was reported in a phase 1 high-grade study

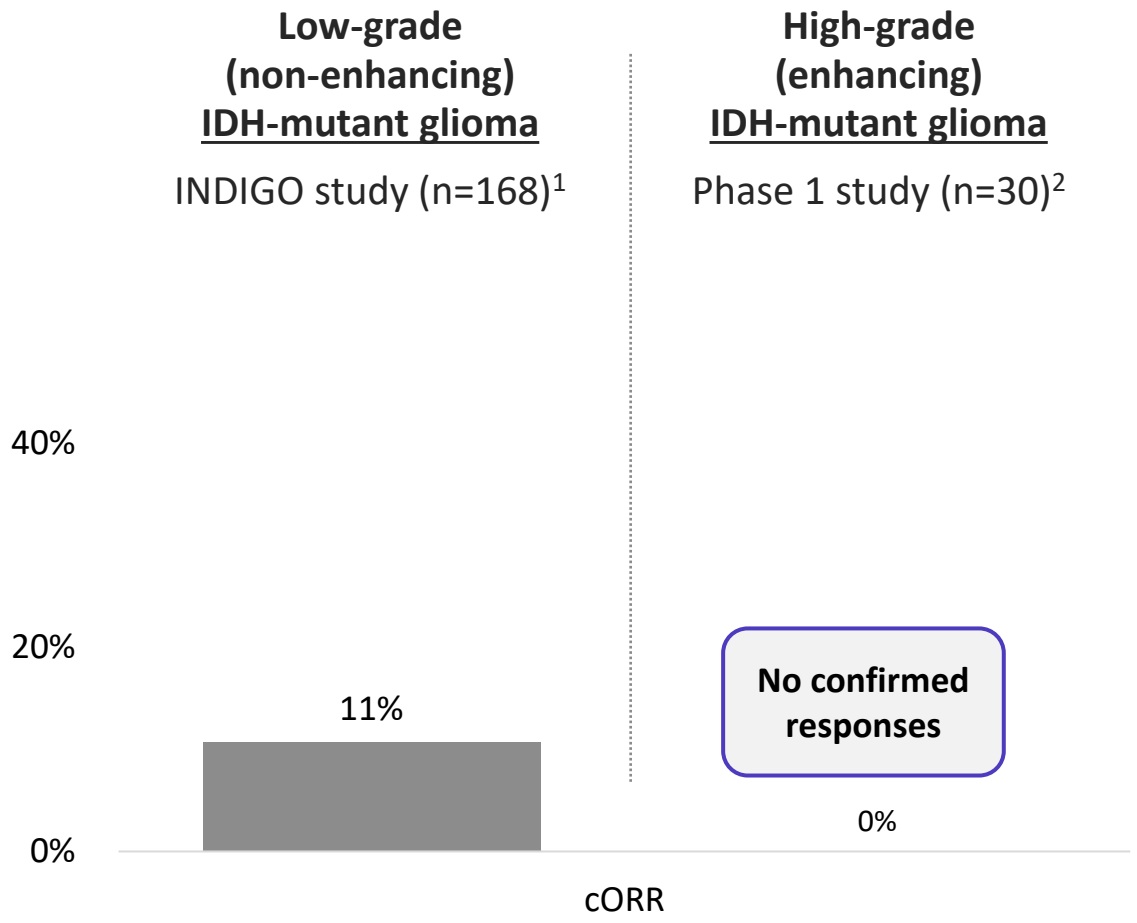
Progression-free survival (INDIGO study)[1]

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%**

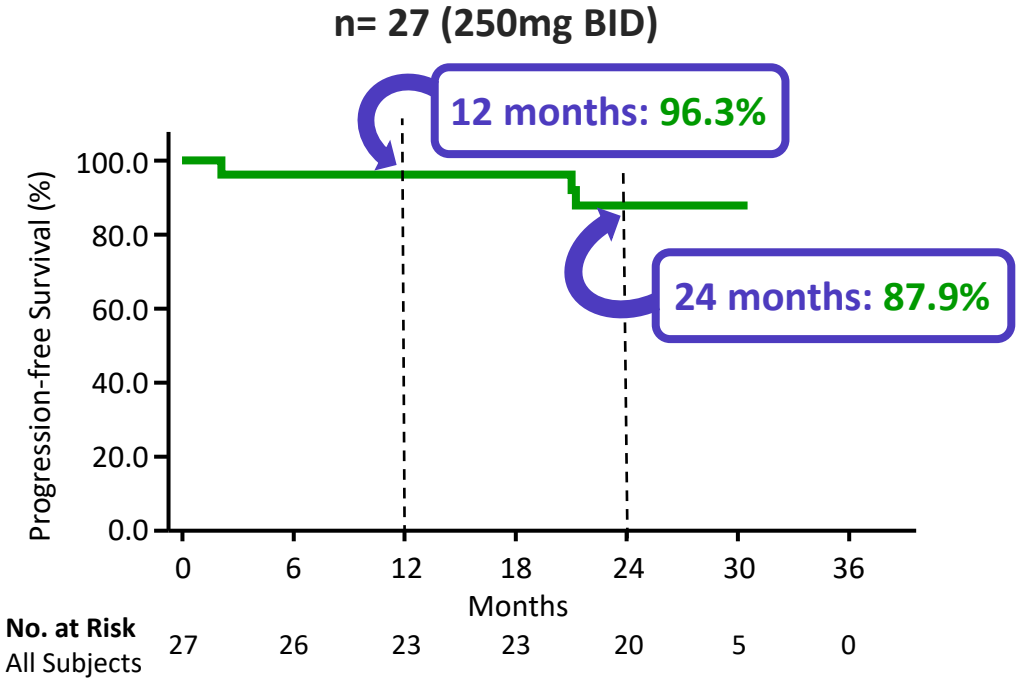
Confirmed objective response rate



cORR: confirmed Objective response rate; PFS: Progression-free survival. Note: These data are derived from different clinical studies, with differences in study design and patient populations. 1. Cloughesy, et al., *Lancet Oncol,* 2025; 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.

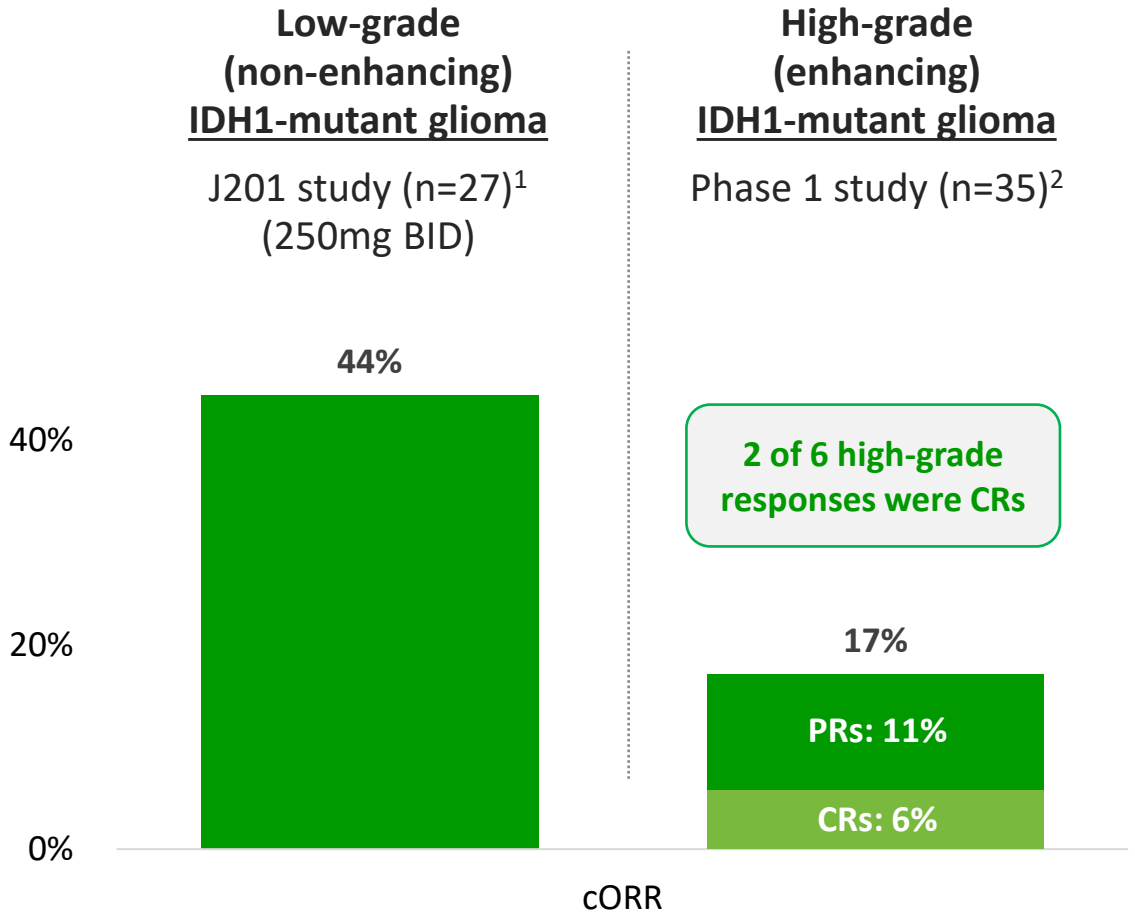
Safusidenib has shown promising efficacy signals, including a 24-month landmark PFS of 88% in low-grade and 17% cORR including 2 CRs in high-grade IDH1-mutant glioma

Progression-free survival (J201 study)[1]



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

Confirmed objective response rate



BID: Twice-a-day dosing; CR: Complete Response; cORR: confirmed Objective response rate; PFS: Progression-free survival; PR: Partial response. Note: These data are derived from different clinical studies, with differences in study design and patient populations. 1. Arakawa et al., Neuro-Oncology, 2025; includes patients with non-enhancing IDH1-mutant grade 2 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).

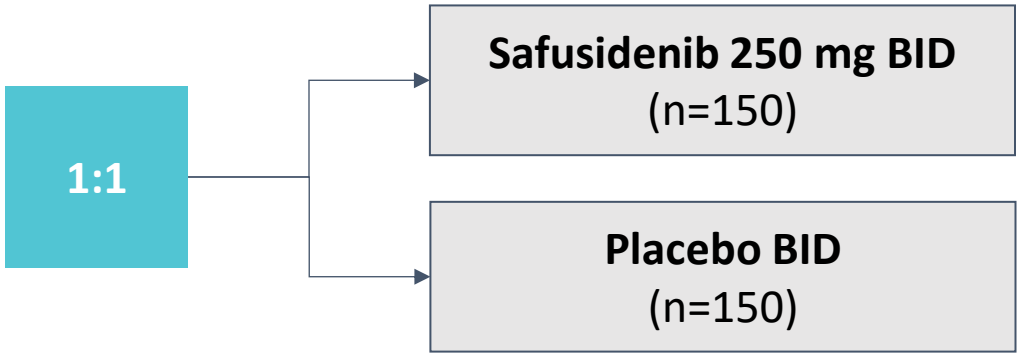
Ongoing pivotal study is evaluating safusidenib for patients with high-grade and high-risk IDH1-mutant gliomas in the maintenance setting

Key eligibility criteria

- Patients with **IDH1-mutant grade 2 or grade 3 astrocytoma (both with high-risk features)**
  - Additional cohort enrolling to evaluate safusidenib in IDH1-mutant grade 3 oligodendroglioma
- Patients with **IDH1-mutant grade 4 astrocytoma**
- 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

Pivotal study design

Randomized study design:



Endpoints and timing

- **Primary Endpoint:** Progression-free survival by BICR per RANO 2.0
- **Potential data update:** 2029

BID: Twice-a-day dosing; BICR: Blinded Independent Central Review; IDH1: isocitrate dehydrogenase 1; RANO: Response Assessment in Neuro-Oncology. 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. Efficacy Assessment: Based on RANO 2.0 guidelines, with MRI assessments every 8 weeks (±8 days), independent from study drug schedule.

New cohort evaluating safusidenib in grade 3 oligodendroglioma – a portion of the high-grade population – may provide an earlier data readout (2028)

Key eligibility criteria

- Patients with **IDH1-mutant grade 3 oligodendroglioma** with residual / recurrent disease following surgery
- Age > 18 years; Karnofsky Performance Status > 60
- No prior anticancer therapy except for resection
- Not in need of immediate chemotherapy or radiotherapy
- At least 3 months from the most recent surgery (within 5 years)
- At least 1 measurable lesion per RANO 2.0

Additional cohort design

Single arm cohort design:

Safusidenib 250 mg BID
(n=40)

Endpoints and timing

- **Primary Endpoint:** Objective response rate by BICR per RANO 2.0
- **Potential data update: 2028**

BID: Twice-a-day dosing; BICR: Blinded Independent Central Review; IDH1: isocitrate dehydrogenase 1; KPS: Karnofsky Performance Status; RANO, Response Assessment in Neuro-Oncology. 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.

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

BID: Twice-a-day dosing; MOA: Mechanism of action; TEAE: Treatment emergent adverse event. Source: Arakawa et al., *Neuro-Oncology*, 2025 and Natsume et al., *Neuro-Oncology*, 2023. 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-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.

DDC Platform

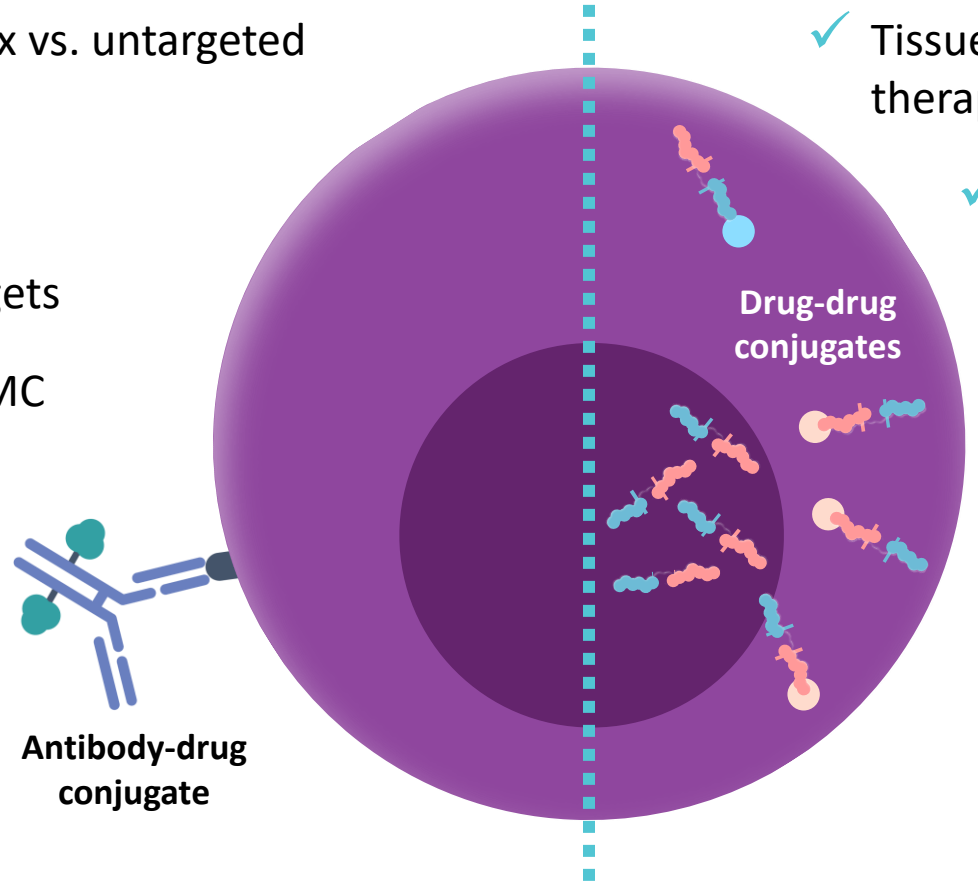
Advanced solid tumors

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

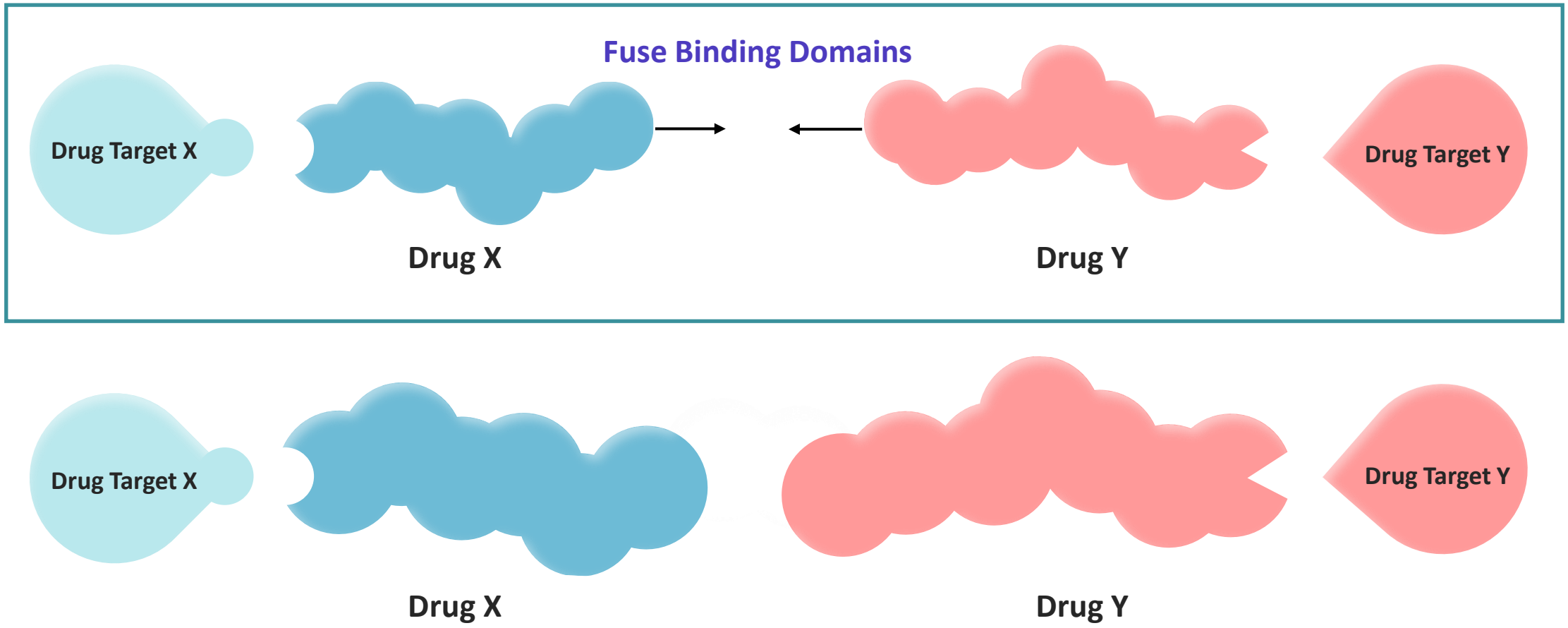


Drug-drug conjugates

- ✓ 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

Strong pro forma cash position provides path to potential profitability

- Pro forma cash balance of ~$589 million[1]
- Includes approximately $60 million received as an upfront payment from our recently announced partnership with Eisai
- 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**
- **432 new patient starts since U.S. commercial launch**
- Approved by Japan's MHLW in September 2025
- Approved by China's NMPA in January 2025

Nuvation Bio pipeline is led by safusidenib

- **Safusidenib | mIDH1 inhibitor:**
  Enrolling pivotal study in high-grade and high-risk IDH1-mutant glioma[2]
- **NUV-868 | BD2-selective BET inhibitor:**
  Completed Phase 1 and Phase 1b studies
- **Drug-drug conjugate platform:**
  Evaluating preclinical candidates

1. An additional $50 million under a term loan with Sagard Healthcare Partners is available to the Company until June 30, 2026; Pro forma cash balance is based on preliminary estimates. 2. Includes patients grade 4 astrocytoma and patients with grade 2 or 3 astrocytoma with certain high-risk features.