Viracta Therapeutics, Inc.

R&D Day – October 4, 2023

NASDAQ: VIRX

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Introduction:

Mark Rothera

President and Chief Executive Officer

Forward-Looking Statements

This communication contains "forward-looking" statements within the meaning of the Private Securities Litigation Reform Act of 1995, which are based on current expectations, estimates and projections based on information currently available to management of Viracta Therapeutics, Inc. (“Viracta” or the “Company”), including, without limitation, statements regarding: Viracta’s development pipeline; the details, timeline and expected progress for Viracta’s ongoing trials; the expected ability of Viracta to undertake certain activities and accomplish certain goals with respect to its clinical program in EBV^+ lymphoma, EBV^+ solid tumors, other virus-associated malignancies or its programs; expectations regarding future therapeutic and commercial potential with respect to Viracta’s clinical program in EBV^+ lymphoma, EBV^+ solid tumors or other virus-associated malignancies; the ability of Viracta to support multiple new drug application filings and approvals from the NAVAL-1 trial; Viracta’s plans to meet with the FDA to discuss preliminary results from the NAVAL-1 trial, amending the NAVAL-1 protocol to add patients as necessary to enable registration and provide other program updates; Viracta's cash projections and the sufficiency of its cash and cash equivalents to fund operations into late 2024; the future availability of capital under Viracta’s credit facility; the expected future milestones and key upcoming events and their significance; and other statements that are not historical facts. Risks and uncertainties related to Viracta that may cause actual results to differ materially from those expressed or implied in any forward-looking statement include, but are not limited to: Viracta’s ability to successfully enroll patients in and complete its ongoing and planned clinical trials; Viracta's plans to develop and commercialize its product candidates, including all oral combinations of nanatinostat and valganciclovir; the timing of initiation of Viracta's planned clinical trials; the timing of the availability of data from Viracta's clinical trials; the possibility that previous preclinical and clinical results may not be predictive of future clinical results; the timing of any planned investigational new drug application or new drug application; Viracta's plans to research, develop and commercialize its current and future product candidates; the clinical utility, potential benefits and market acceptance of Viracta's product candidates; Viracta's ability to identify additional products or product candidates with significant commercial potential; developments and projections relating to Viracta's competitors and its industry; the impact of government laws and regulations; Viracta's ability to protect its intellectual property position; and Viracta's estimates regarding future expenses, capital requirements and need for additional financing.

These risks and uncertainties may be amplified by the COVID-19 pandemic, which has caused significant economic uncertainty. If any of these risks materialize or underlying assumptions prove incorrect, actual results could differ materially from the results implied by these forward-looking statements. Additional risks and uncertainties that could cause actual outcomes and results to differ materially from those contemplated by the forward-looking statements are included under the caption “Risk Factors” and elsewhere in Viracta’s most recent filings with the SEC and any subsequent reports on Form 10-K, Form 10-Q or Form 8-K filed with the SEC from time to time and available at www.sec.gov. The forward-looking statements included in this communication are made only as of the date hereof. Viracta assumes no obligation and does not intend to update these forward-looking statements, except as required by law or applicable regulation.

Epstein-Barr Virus (EBV): A High Global Cancer Priority

EBV+ malignancies account for ~2% of all new cancer cases globally

EBV positivity, by lymphoma subtype[1, 2,3]	
Peripheral T-cell lymphoma* (PTCL)	**40-65%**
Diffuse large B-cell lymphoma (DLBCL)	**5-15%**
Post-transplant lymphoproliferative disorders (PTLD)	**60-80%**

EBV positivity, by solid tumor subtype[4]	
Nasopharyngeal carcinoma (NPC)	**75-95%**
Gastric cancer (GC)	**8-10%**

~90% of the adult population are infected with EBV

Latency confers resistance to anti-viral therapies and facilitates evasion of immune detection

>300,000 new cases/year of EBV+ lymphomas and solid tumors[5]

Responsible for **~180,000 cancer** deaths/year[5]

The incidence of EBV-associated cancers is likely greater, impacting more cancer types

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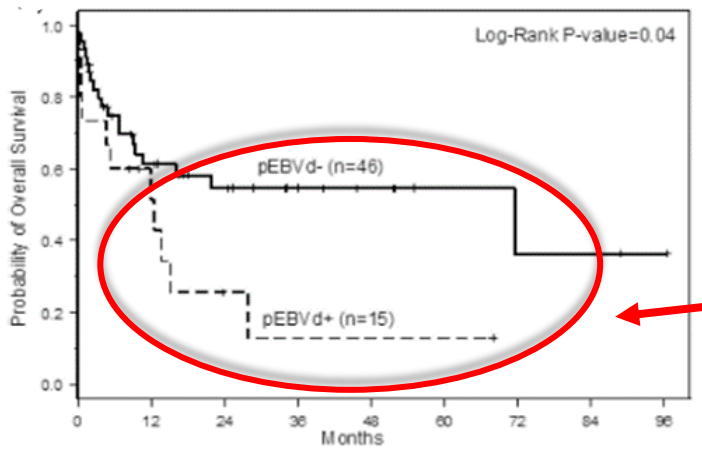
[1]Haverkos BM, et al. Int J Cancer. 2017; 140:1899-1906; Dupuis J et al. Blood. 2006;108:4163–9; [2]Swerdlow SH et al. (2017) WHO classification of Tumours of the Haematopoietic and Lymphoid Tissues; [3]EBV positivity varies by geography; [4]Wong Y, et al. Journal of Cancer Research and Clinical Oncology (2022) 148:31–46 Exp. Therapeutic Med. 15: 3687, 2018; [5]Kahn,G, et al. BMJ 10:1136, 2020.
*Includes Peripheral T-cell lymphoma, NOS and Angioimmunoblastic T-cell lymphoma

Viracta is Developing a Precision Medicine to Treat Unique Subsets of EBV+ Lymphoma with Adverse Survival Outcomes

Currently limited or no targeted therapy options for EBV-associated cancers

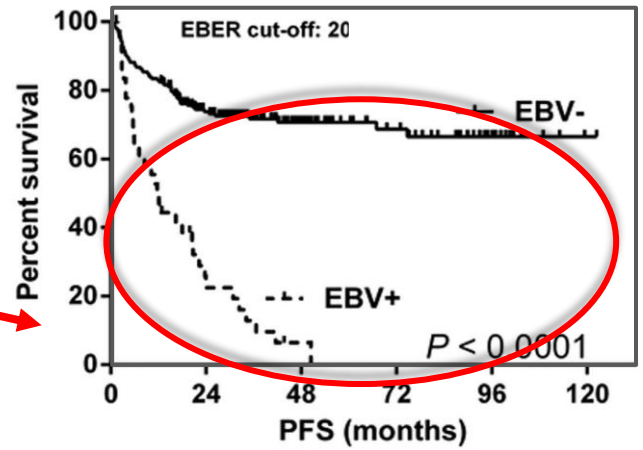
Peripheral T-cell Lymphoma[1]
(Overall Survival)



PTCL EBV+ Rate: 40-65%

Addressing patient populations with high unmet medical need

Diffuse Large B-cell Lymphoma[2]
(Progression-Free Survival)



DLBCL EBV+ Rate: 5-15%

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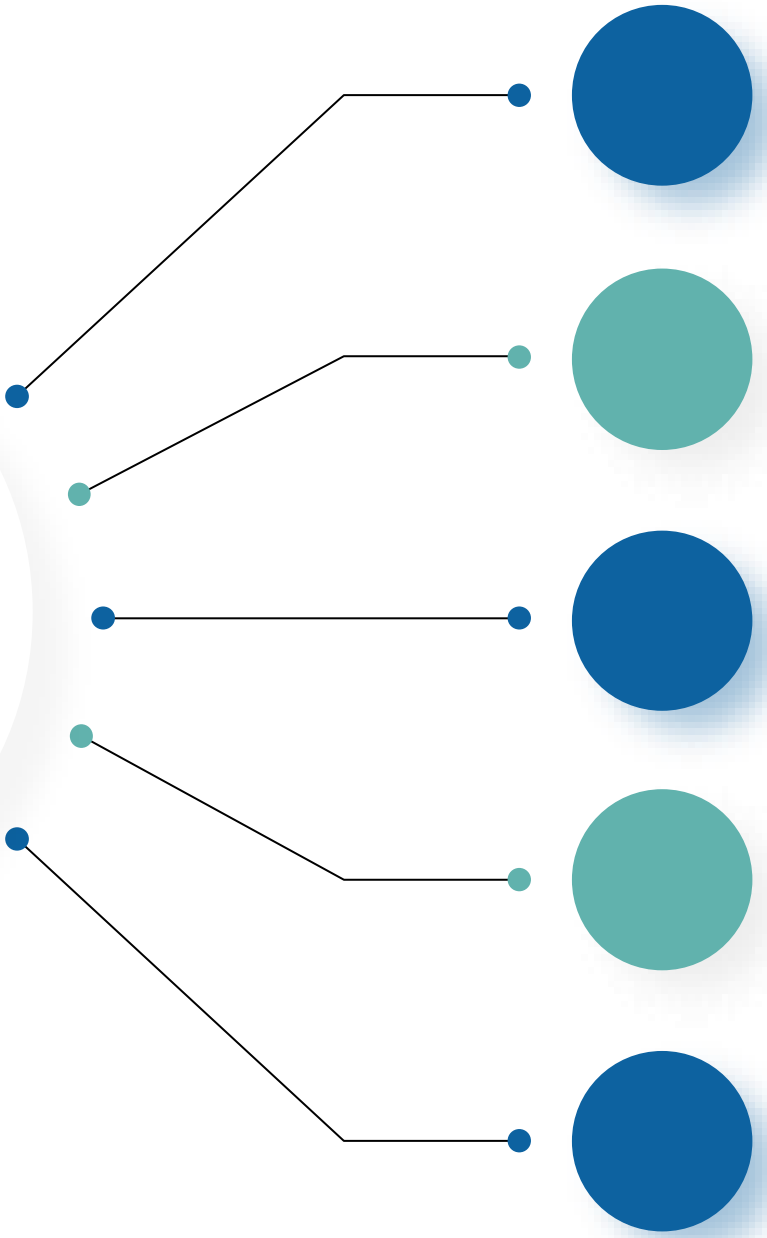
[1]Haverkos BM, et al. Int J Cancer. 2017; 140:1899-1906; Dupuis J et al. Blood. 2006;108:4163–9, [2]Lu TX et al. Sci Rep. 2015;5:1-14

Our focus is maximizing the Nana-val opportunity



- Adverse survival outcomes are seen with many EBV-associated cancers
- Nana-val - well-tolerated, all-oral combination approach to targeting EBV+ cancers
- Pivotal NAVAL-1 study prioritized to focus on 3 key R/R EBV+ lymphoma subtypes: PTCL, DLBCL, PTLD
- Phase 1b/2 study in advanced EBV+ solid tumors
- Lean operating model and a “speed to market” strategy

Expert Key Opinion Leaders Presenting Today

Pierluigi Porcu, M.D.

Professor of Medical Oncology, Director of the Division of Hematologic Malignancies and Hematopoietic Stem Cell Transplantation, Department of Medical Oncology at Thomas Jefferson University

Robert A. Baiocchi, M.D., Ph.D.

Professor of Internal Medicine, Associate Director for Translational and Clinical Science in the Division of Hematology at The Ohio State University

Today's Presenters from Viracta

Ayman Elguindy, PhD

Chief Scientific Officer

Darrel P. Cohen, MD, PhD

Chief Medical Officer

Today's Agenda

Introduction	**Mark Rothera,** *President and Chief Executive Officer*
Nana-val Mechanism of Action	**Ayman Elguindy, PhD,** *Chief Scientific Officer*
EBV⁺ Peripheral T-Cell Lymphoma (PTCL) • *"PTCL: Unmet Medical Need"* • Preliminary data from pivotal NAVAL-1 trial • Additional data cut from Phase 1b/2 study	**Pierluigi Porcu, MD**, *Thomas Jefferson University* **Darrel P. Cohen, MD, PhD,** *Chief Medical Officer*
EBV⁺ Diffuse Large B-Cell Lymphoma (DLBCL) • *"EBV⁺ DLBCL: A Unique Entity"* • Additional response and follow-up from Phase 1b/2 study	**Robert A. Baiocchi, MD, PhD**, *The Ohio State University* **Darrel P. Cohen, MD, PhD,** *Chief Medical Officer*
Advanced EBV⁺ Solid Tumors • New clinical data from Phase 1b study • Rationale for Split Daily Dosing (SDD) schedule	**Darrel P. Cohen, MD, PhD,** *Chief Medical Officer* **Ayman Elguindy, PhD,** *Chief Scientific Officer*
Closing Comments • Lymphoma market opportunity • Milestones	**Mark Rothera**, *President and Chief Executive Officer*
Q&A	

Nana-val:
Mechanism-of-Action

Nana-val: All-Oral Combination Drug Product of Nanatinostat and Valganciclovir

Precisely eradicates EBV^{+} tumor cells

Nanatinostat (proprietary molecule):

- Epigenetic agent, used to selectively activate EBV gene expression and immune enhancement
- Class I HDAC inhibitor, selective for HDACs 1, 2, and 3
- Potent inducer of EBV protein kinase (BGLF4) expression at low doses

Valganciclovir:

- Synthetic nucleoside analog
- Antiviral prodrug, converted into a cytotoxic agent by viral enzymes (kinases)

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HDACi: histone deacetylase inhibitor

Nana-val MOA Video

Nana-val: a Unique Approach to Targeting and Killing EBV+ Cancer Cells

Nanatinostat sensitizes EBV+ tumors to the cytotoxic effects of ganciclovir

LATENCY

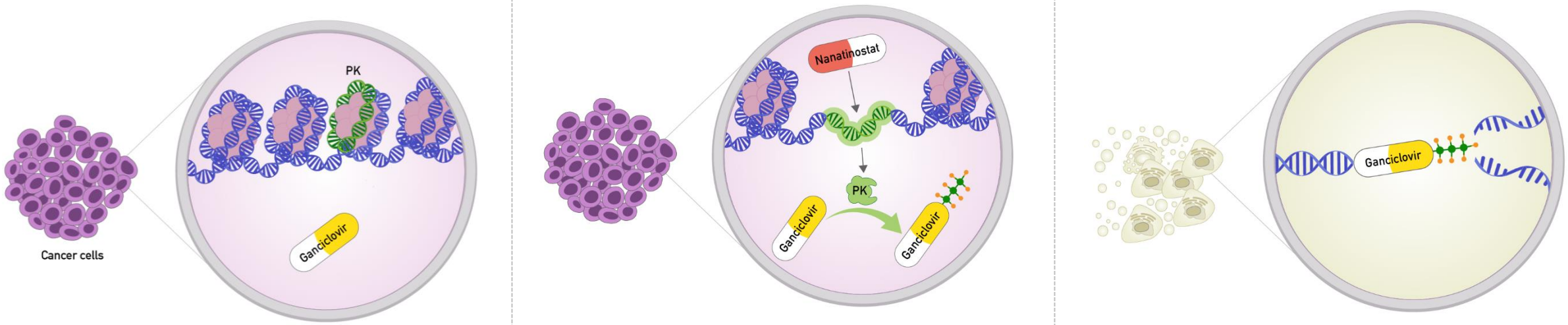
EBV is latent in cancer cells. Valganciclovir, antiviral & cytotoxic pro-drug of ganciclovir (GCV), is inactive in the absence of EBV protein kinase (PK)

THE KICK

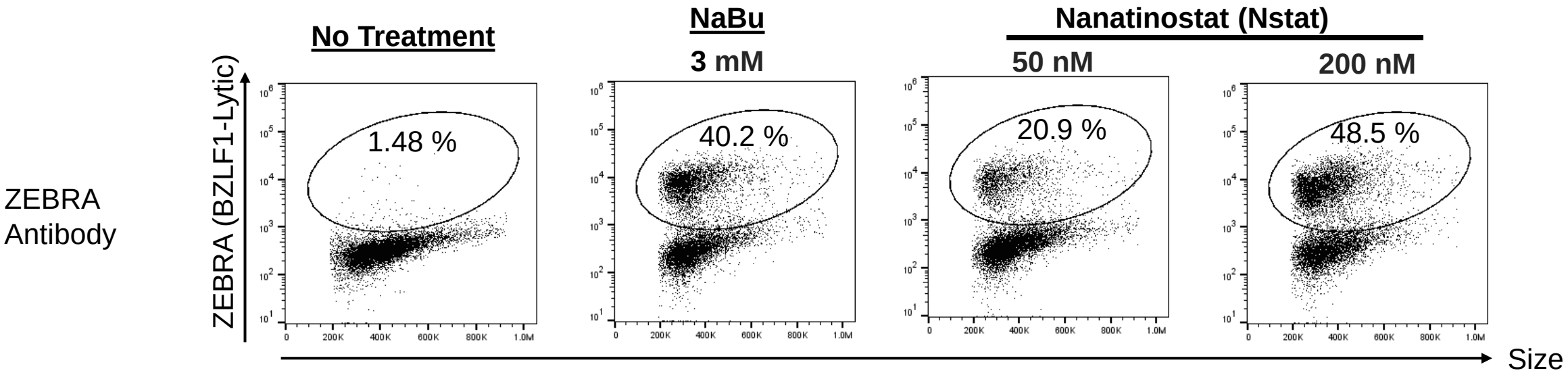
Nanatinostat potently induces expression of EBV protein kinase (PK), which activates GCV into its cytotoxic form

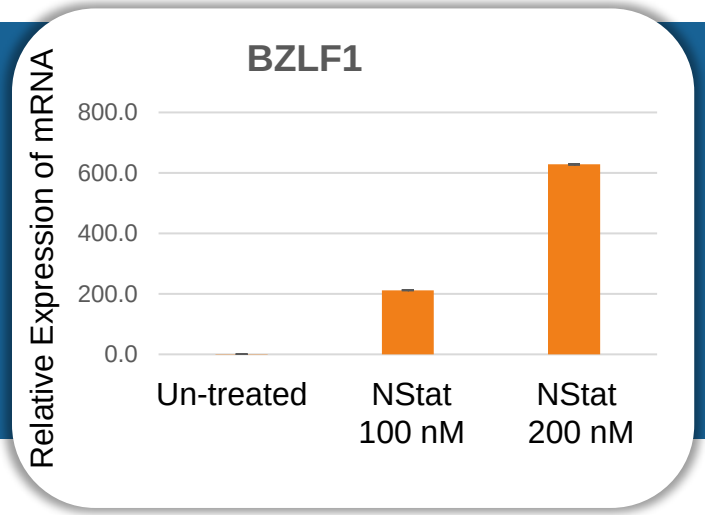
THE KILL

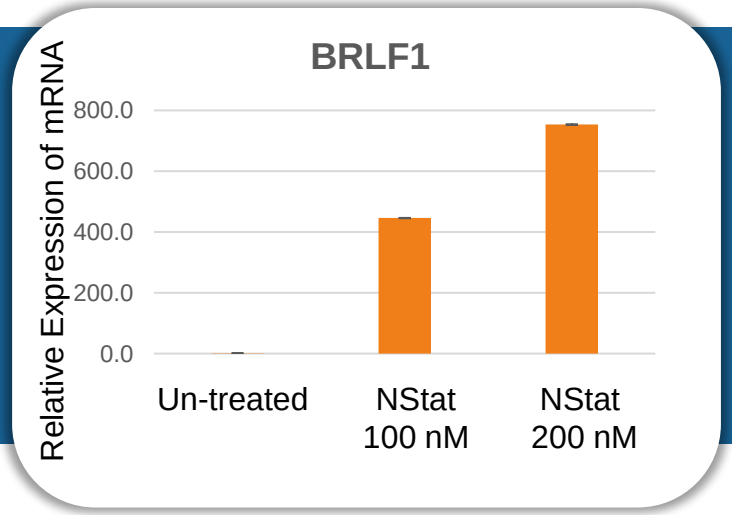
Activated GCV inhibits DNA replication leading to apoptosis of EBV+ cancer cells

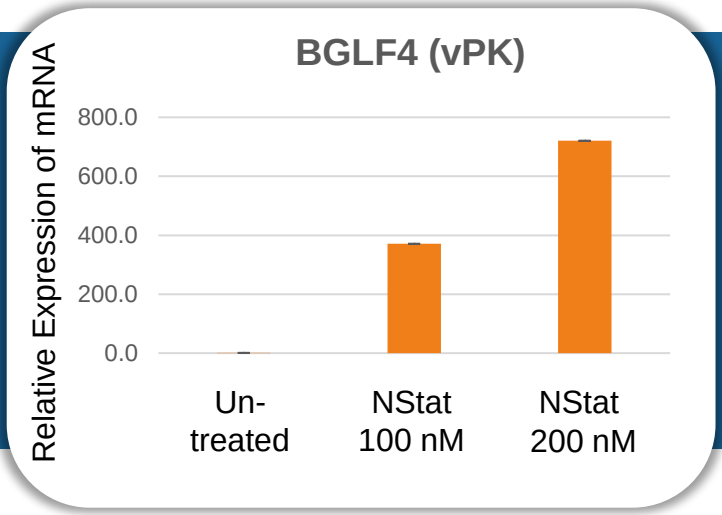


Nanatinostat is a Potent Inducer of the EBV Lytic Cycle in Lymphoma Cells









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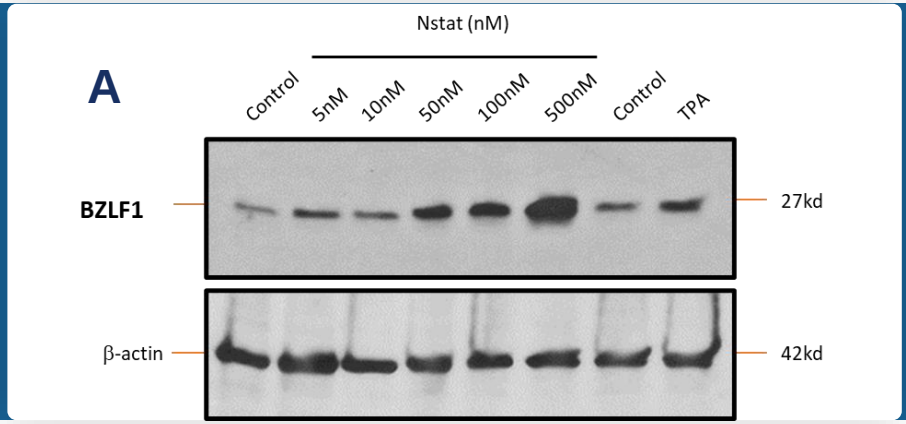
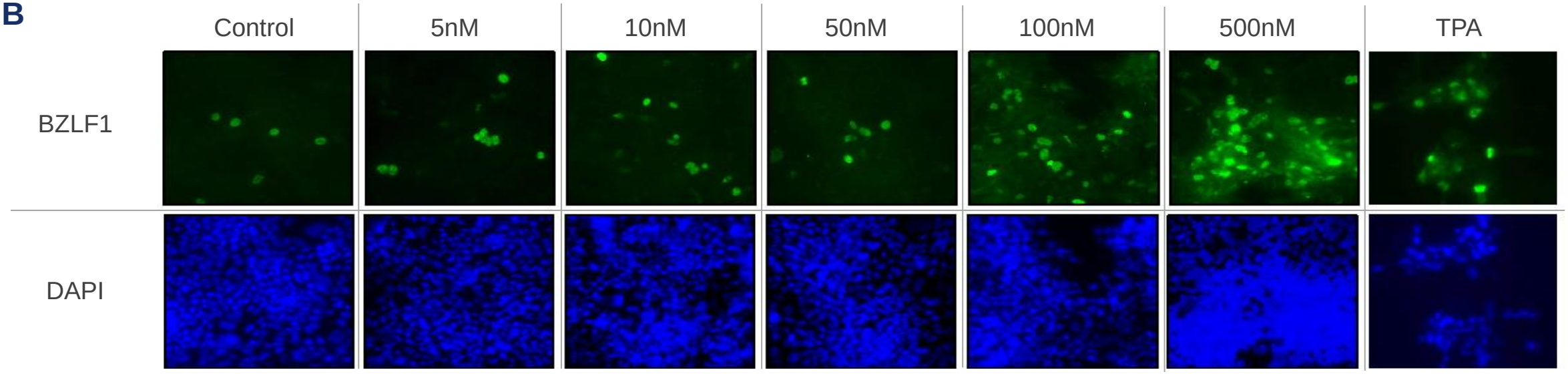
Nanatinostat Induces the EBV Lytic Cycle in EBV+ NPC Cells

Different concentrations of nanatinostat activate the expression of BZLF1, the master EBV lytic cycle switch protein

A) Western blot, **B)** Immunofluorescence, of BZLF1

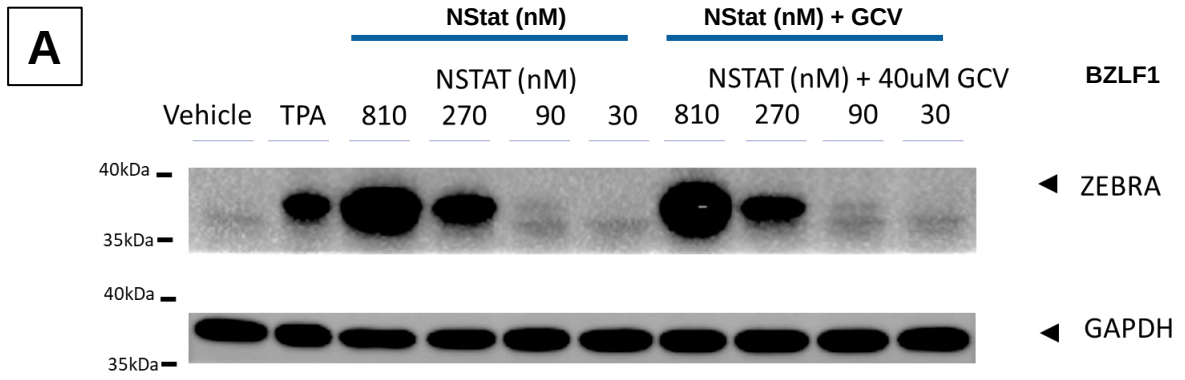
BZLF1 drives expression of lytic viral proteins including BGLF4, the viral protein kinase

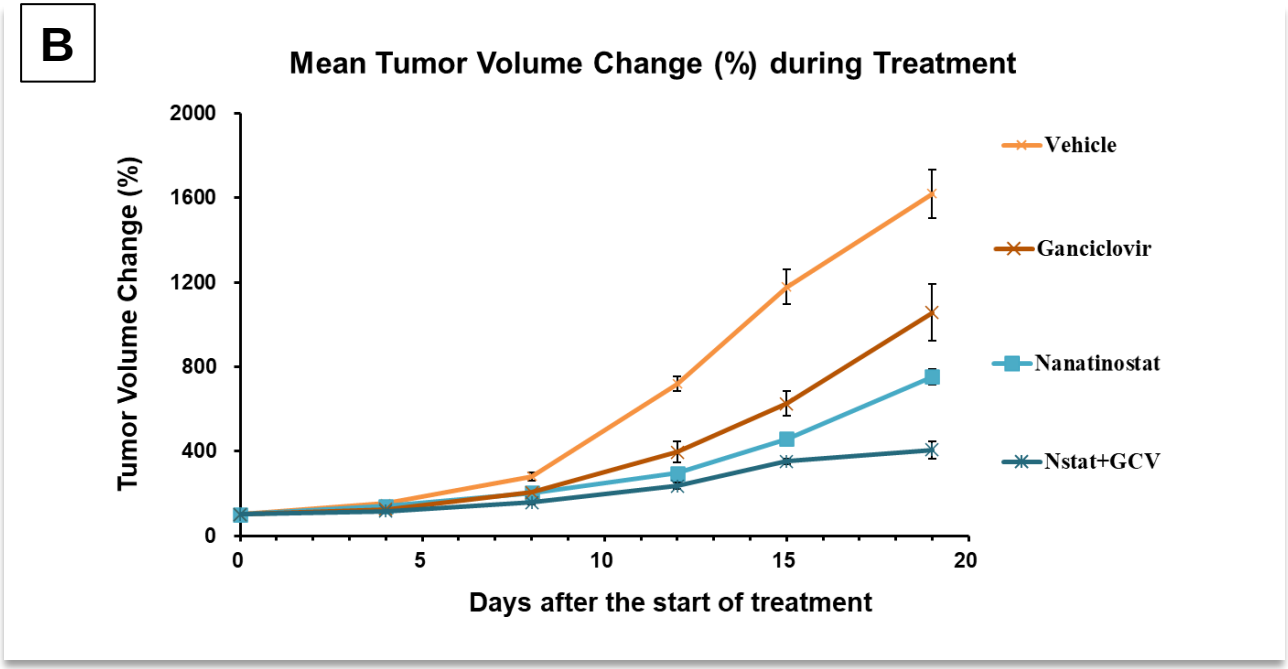


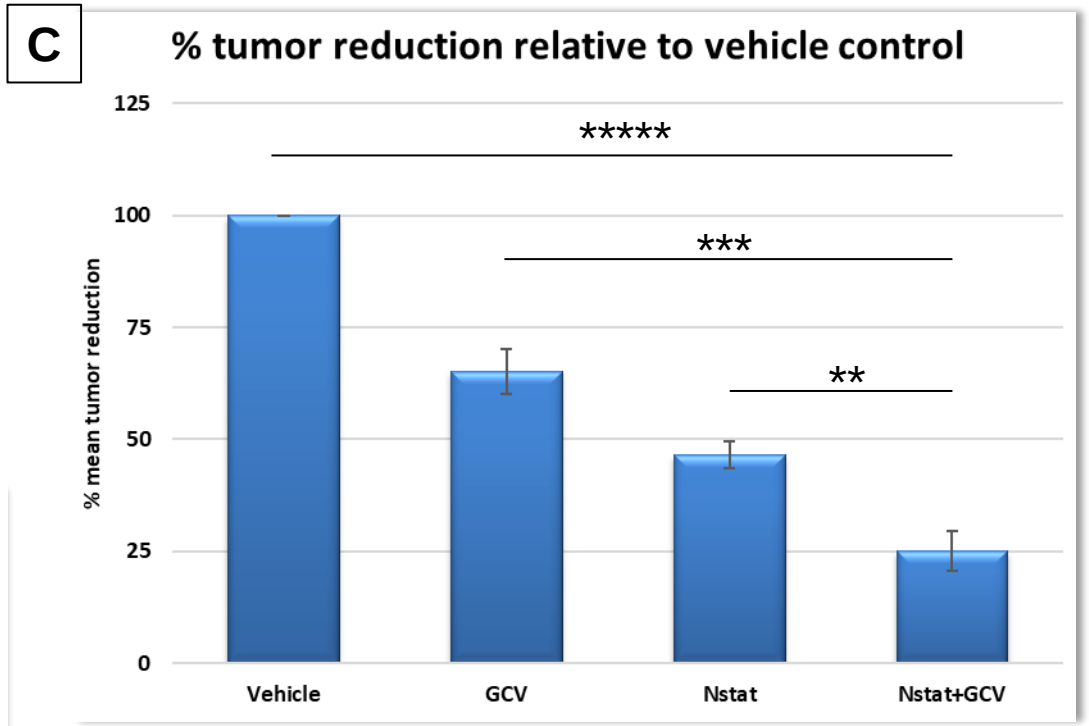


Source: Viracta Therapeutics, Inc on file – Courtsey of Dr. Lawrence Young – University of Warwick

Potent Responses to Nanatinostat and Ganciclovir Treatment in EBV+ Solid Tumor Murine Model







(* denotes *p*-value).

- **Panel A:** Treatment of EBV+ gastric cancer SNU-719 cells with NSTAT alone or together with GCV potently induces the lytic cycle; expression of BZLF1
- **Panels B and C:** *In vivo,* the combination of NSTAT+GCV results in significant reduction in gastric cancer tumor growth versus no treatment

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EBV+ Peripheral T-Cell Lymphoma:

T-cell lymphoma with high unmet medical need

SIDNEY KIMMEL CANCER CENTER | NCI-DESIGNATED

EBV-Positive Peripheral T-cell Lymphoma

Pierluigi Porcu, M.D.
Professor Medical Oncology, Dermatology, and Cutaneous Biology
Director, Division of Hematologic Malignancies and Cellular Therapy
Sidney Kimmel Cancer Center at Jefferson Health,
Director, Blood Cancer Center of Excellence (BCCE)
Thomas Jefferson University, Philadelphia

Jefferson Health
HOME OF SIDNEY KIMMEL MEDICAL COLLEGE

JeffersonHealth.org/Cancer

Some Terms and Definitions

Peripheral T-cell Lymphoma (PTCL)

- Historical all-embracing definition of lymphomas of T-cell or NK-cell lineage
- Now defines a subtype of MTCN (PTCL-NOS)

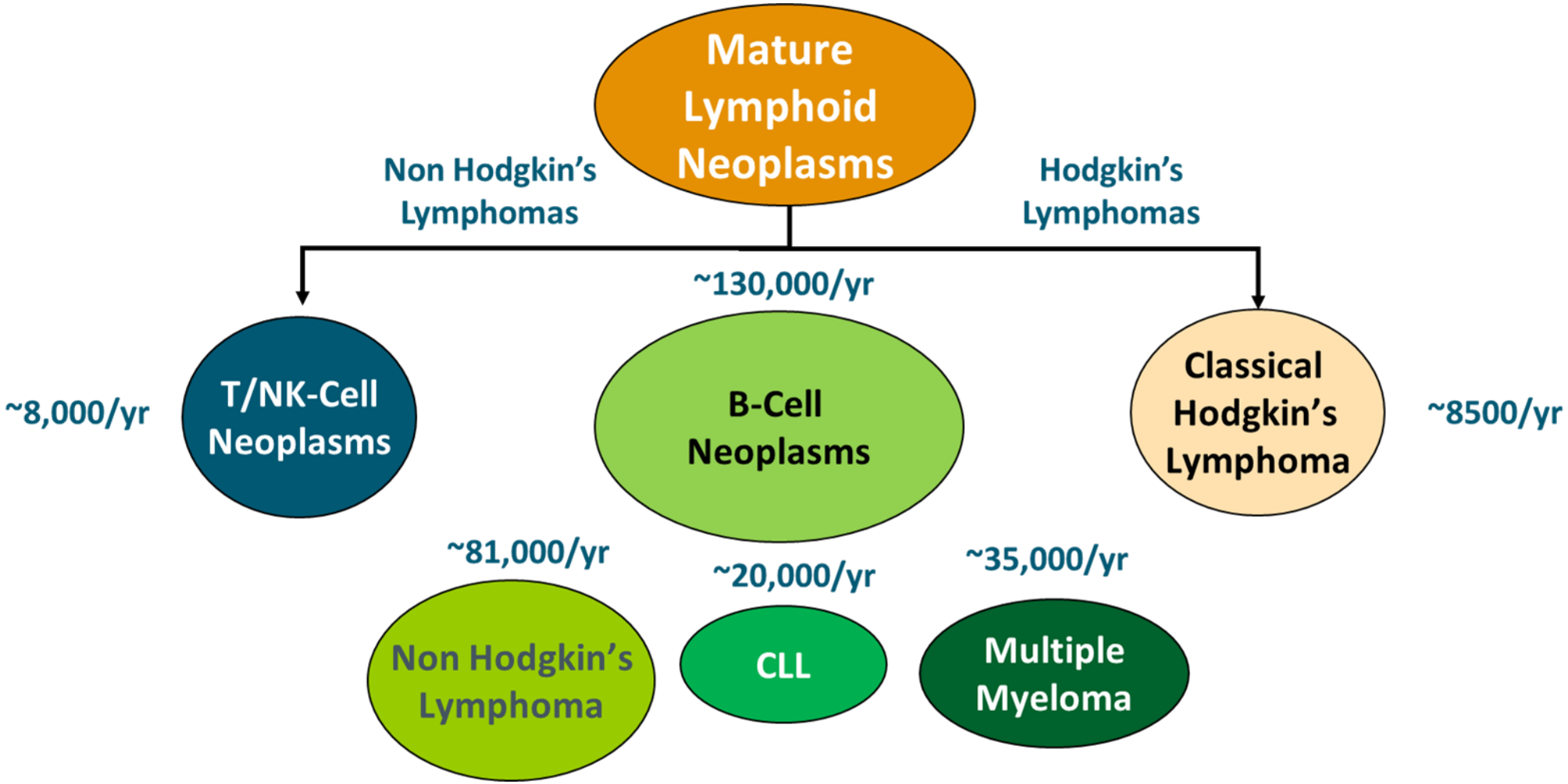
Cutaneous T-cell Lymphoma (CTCL)

- Used to describe extranodal T-cell lymphomas of the skin
- Often used in contrast with PTCL

Mature T-cell Neoplasms (MTCN)

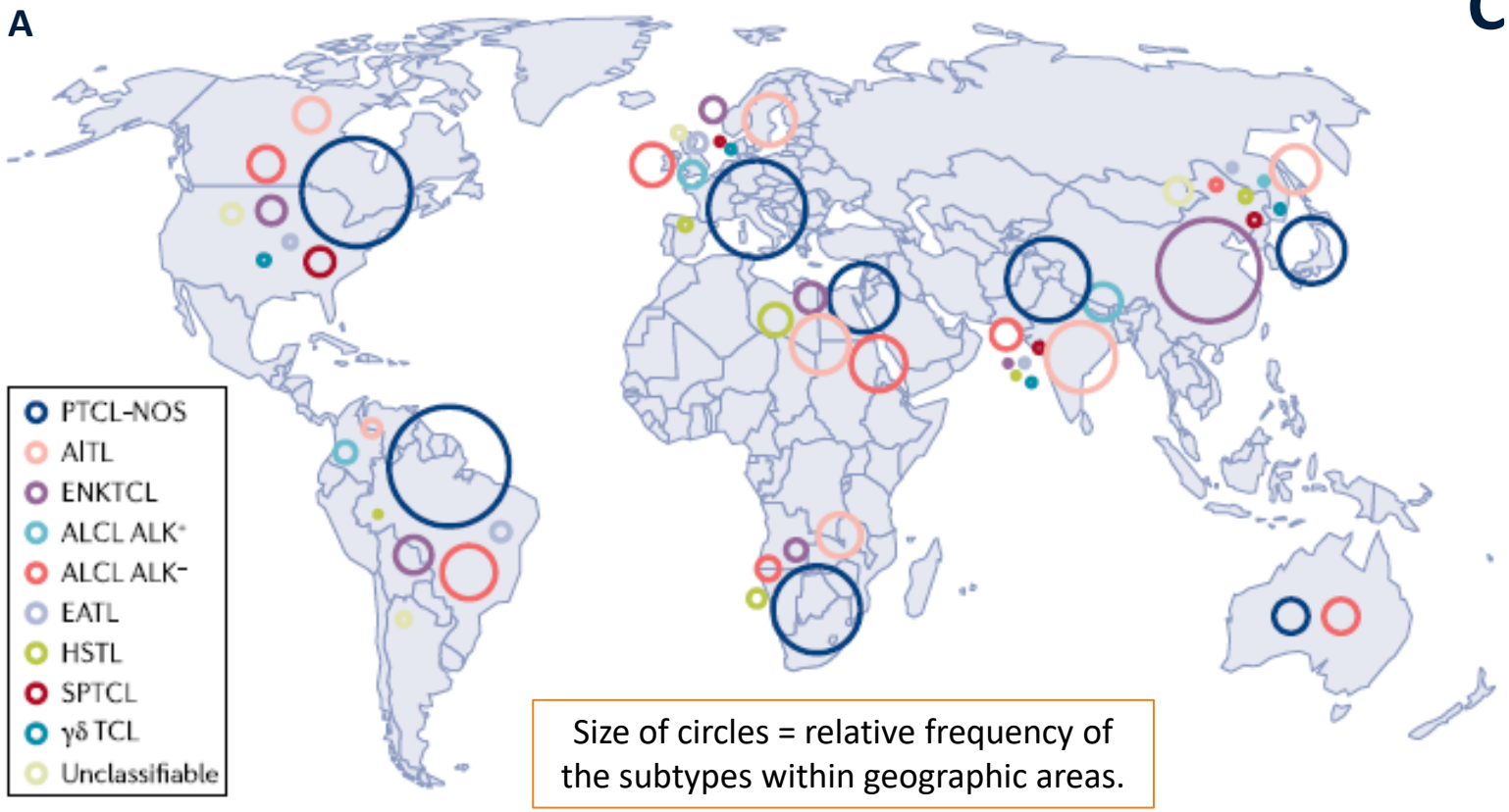
- Standard nomenclature used by WHO and ICC (>30 entities)
- Nodal, Extranodal, Leukemic, and Cutaneous

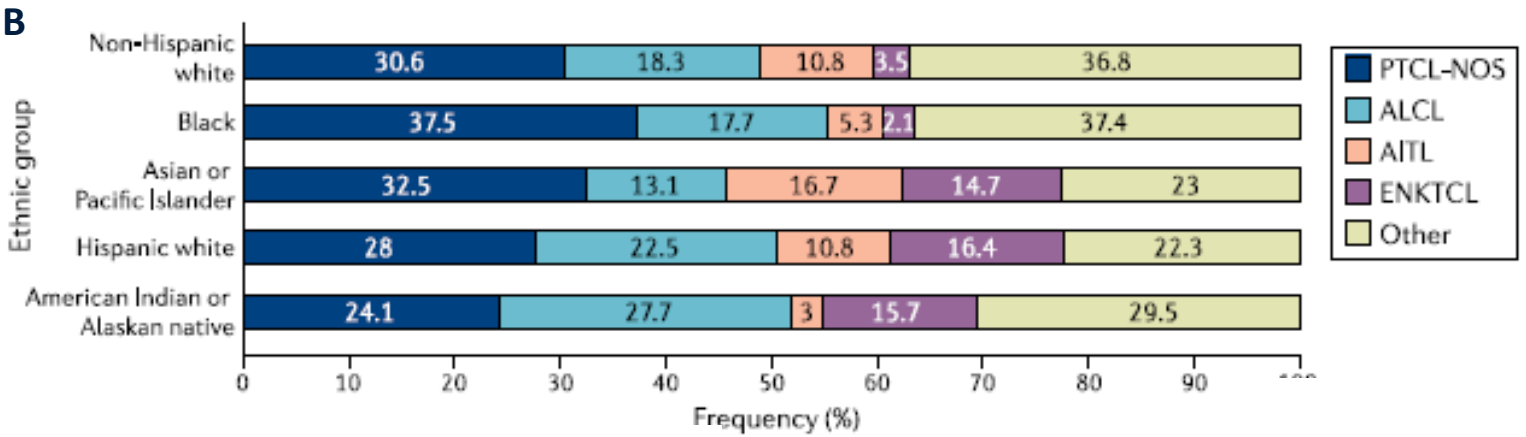
Peripheral T-Cell Lymphomas (or Mature T/NK-Cell Neoplasms) are Non-Hodgkin Lymphomas



ACS. Cancer Facts and Figures 2022. Harris. JCO. 1999;17:3835.

Classification and ethnic and geographic distribution of T-cell neoplasms





From: Fiore et al. Nat Rev Cancer 2020

(A) Worldwide distribution

PTCL-NOS: most frequent subtype, equally distributed in the world (though more common in black people). ENKTL and other subtypes: more selective geographic distribution (Asia, Central, and South America), variable frequency across ethnicities. [1,2,3,4]

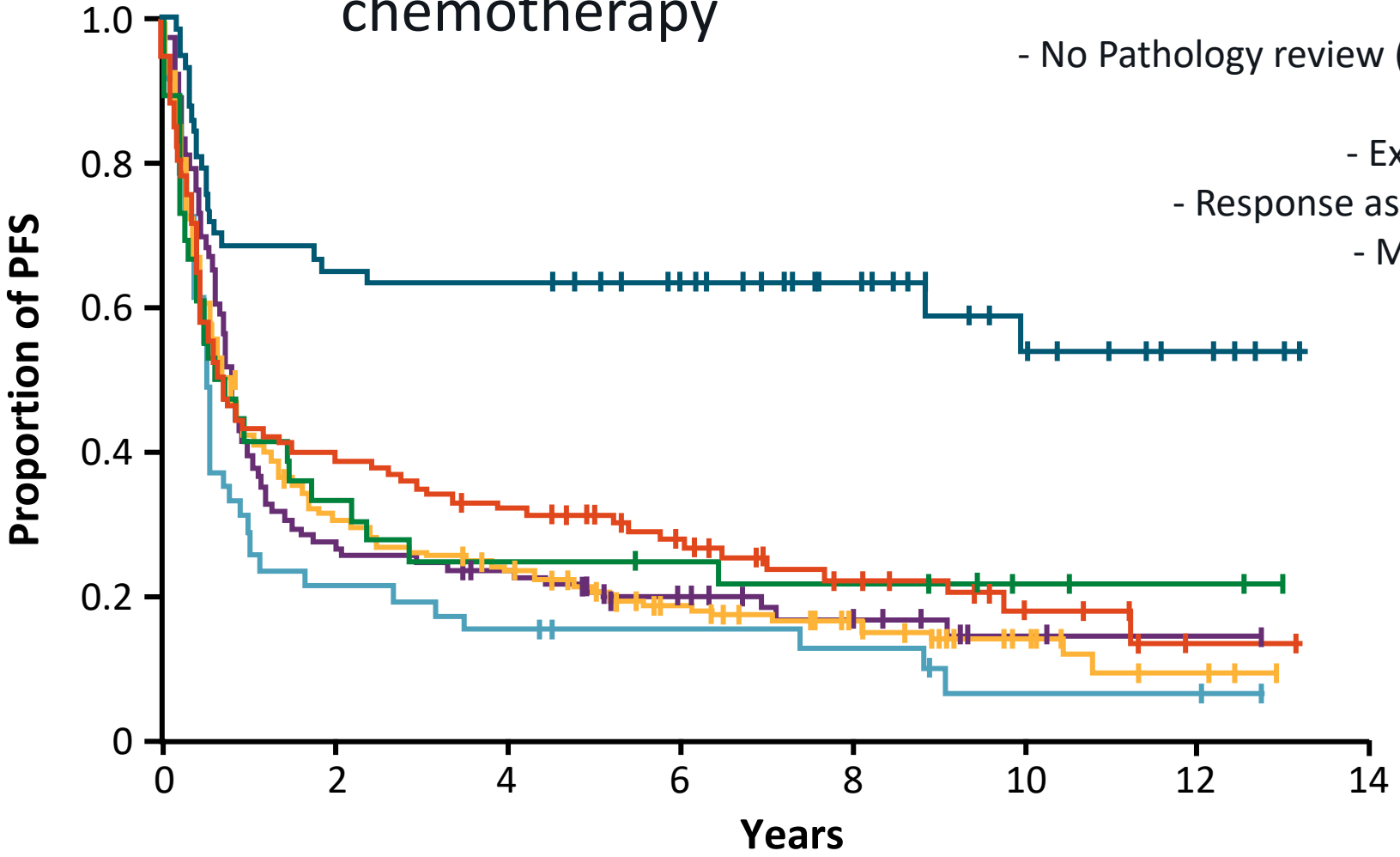
(B) Ethnic distribution in the U.S.

ENKTL less frequent in whites, Hispanics, and blacks; **ALCL** more frequent in Hispanic whites, American Indians)

[1]Adams et al. JCO 2016; [2]Bellei et al. Hematol Oncol 2017
[3]Perry et al. Ann Hematol. 2016; [4]Van Leeuwen et al. Int J Cancer 2014

Swedish Lymphoma Registry: PFS in 755 Patients with PTCL

Outcomes with 1L CHOP or CHOEP chemotherapy



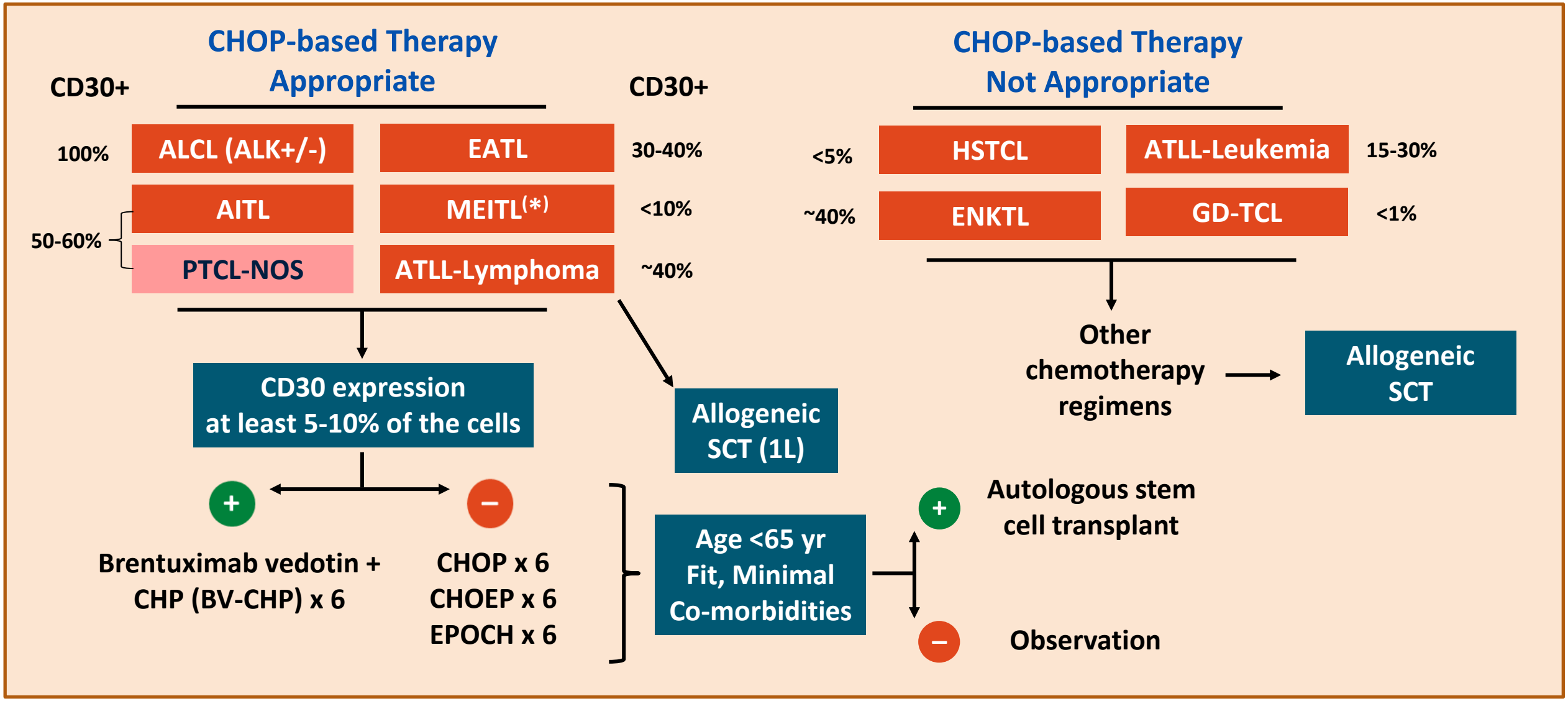
- Enrollment: 2000-2009
- ~95% of all adult lymphomas in Sweden
- PTCL: 7.4% of all lymphomas
- No Pathology review (75% seen by expert Heme Pathol)
- Classification: WHO 2008
- Exclusion: T-LBL, CTCL, leukemic TCL
- Response assessment: CT scans (Cheson 2007)
- Median follow up: 7.9 yrs (3.3-13.2)
- No treatment N=55 (8%)
- CHOP or CHOEP = 84%

ALK+ ALCL
ALK- ALCL
ALK-U ALCL
AITL
PTCL-NOS
PTCL-U

Ellin F., et al. Blood 2014;124:1570-1577

PTCL: Front-Line Therapy

1L PTCL Therapy Pathways at Jefferson/SKCC



(*) Alternative regimen if CD30-negative

Benchmarks for Frontline CHO(E)P-based Therapy

CR rates ~ 35-60% - 3 yr PFS ~35-40%

	Regimen		N	ORR	CR	EFS/PFS	OS	CHOP Gr ≥3 AEs
Retrospective	**CHOP**[1]		117 PTCL-US 33 ALCL 10 AITL	84% 76% 90%	64% 55% 70%	**5-y PFS** 29% 28% 13%	**5-y OS** 35% 43% 36%	Not Reported
Retrospective	**CHOP**[2,*]		83 (32 PTCL-NOS, 27 AITL, 13 ALCL, ALK-, 11 other)	79%	39%	**3-y PFS** CR pts: 36%	**3-y OS** CR pts: 48%	Not Reported
Retrospective	**CHOP or CHOEP**[3]		113 ALCL, ALK- 78 ALCL, ALK+ 70 PTCLU 28 AITL	—	—	**3-y EFS** 45.7% 75.8% 41.1% 50.0%	**3-y OS** 62.1% 89.8% 53.9% 67.5%	Not Reported
Prospective	**CHOP**[4]		43 (69% PTCL-NOS, 18% AITL, 13% ALCL, ALK-/3% ALK+)	70%	35%	**2-y EFS** 41%	**Median** 42 mo	8% neutropenia, 2% thrombocytopenia
Prospective	**CHOP**[5]		43 (19 PTCL-NOS, 17 AITL, 6 ALCL, ALK-, 1 EATL)	76%	CR/CRu 62%	**2-y PFS** 36.6%	**2-y OS** 51.0%	40% neutropenia, 29% febrile neutropenia; 10% thrombocytopenia
Prospective	CD30+[6]	**Ph 3**	**CHOP** 226 (105 sALCL, ALK-, 49 sALCL, ALK+, 43 PTCL-NOS, 24 AITL)	72%	56%	**3-y PFS** 44.4%	Medians not reached	34% neutropenia, 10% anemia
Prospective			BV-CHP 226	83%	68%	**3-y PFS** 57.1%		

1. Savage et al. Ann Oncol. 2004;15:1467-1475. (BCCA 1981-2000)
2. Reimer et al. J Clin Oncol. 2009;27:106-113.
3. Schmitz et al. Blood. 2010;116:3418-3425. (DSHNHL)
4. Simon et al. Br J Haematol. 2010;151:159-166. (GOELAMS-LTP95)
5. Gleeson et al. Lancet Haematol. 2018;5:e190-e200.
6. Horwitz et al. Lancet. 2019;393:229-240. (ECHELON-2)

original reports

Romidepsin Plus CHOP Versus CHOP in Patients With Previously Untreated Peripheral T-Cell Lymphoma: Results of the Ro-CHOP Phase III Study (Conducted by LYSA)

Emmanuel Bachy, MD, PhD[1,2]; Vincent Camus, MD[3]; Catherine Thieblemont, MD, PhD[4]; David Sibon, MD, PhD[5]; René-Olivier Casasnovas, MD[6]; Loïc Ysebaert, MD, PhD[7]; Gandhi Damaj, MD, PhD[8]; Stéphanie Guidez, MD[9]; Gian Matteo Pica, MD[10]; Won Seog Kim, MD, PhD[11]; Soon Thye Lim, MBBS[12]; Marc André, MD[13]; Alejandro Martín García-Sancho, MD, PhD[14]; Maria Jesus Penarrubia, MD, PhD[15]; Philipp B. Staber, MD, PhD[16]; Judith Trotman, MBChB[17]; Andreas Hüttmann, MD[18]; Vittorio Stefoni, MD, PhD[19]; Alessandro Re, MD[20]; Philippe Gaulard, MD[21]; Marie-Helene Delfau-Larue, MD, PhD[22]; Laurence de Leval, MD, PhD[23]; Michel Meignan, MD, PhD[24]; Ju Li, PhD[25]; Franck Morschhauser, MD, PhD[26]; and Richard Delarue, MD[5,27]

Target accrual (n = 420)

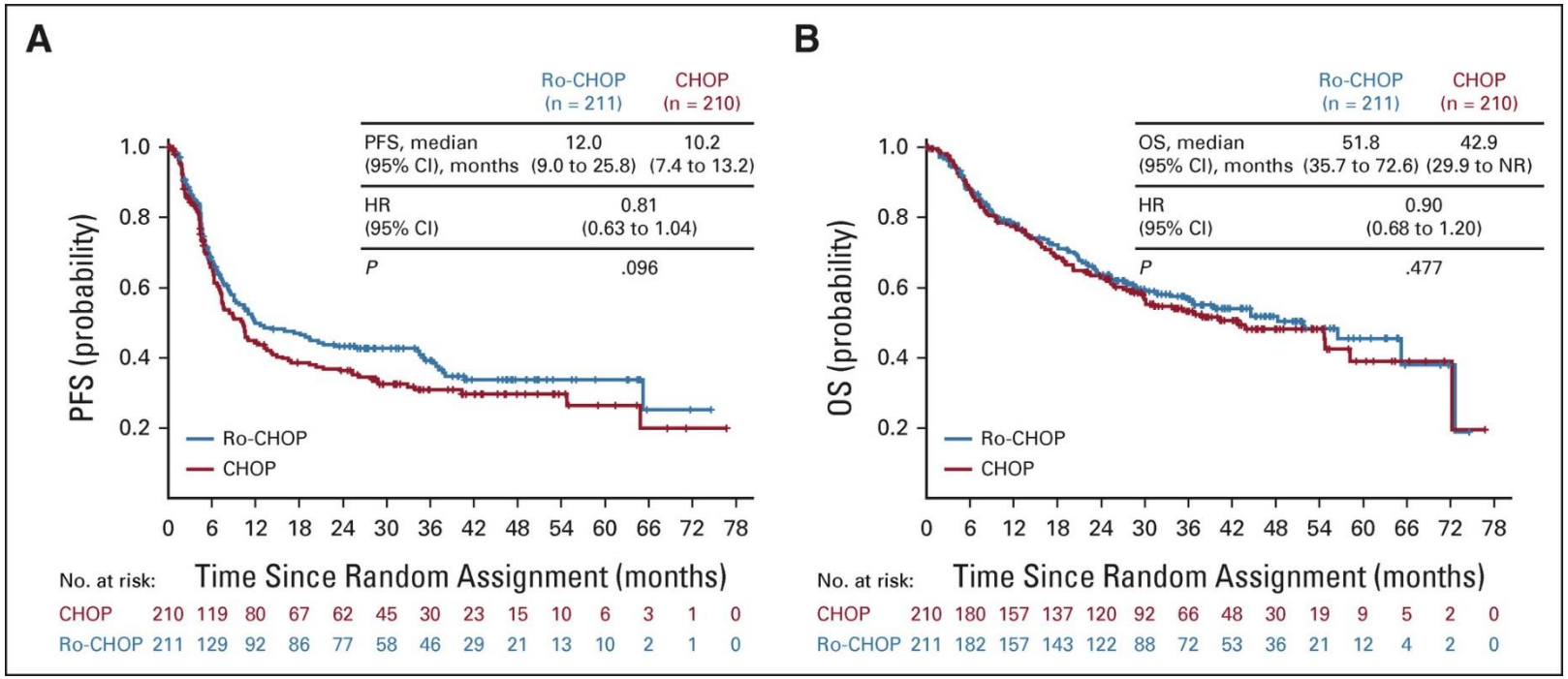
Previously untreated PTCL*
Ann Arbor Stage I-IV
Age: 18-80 years

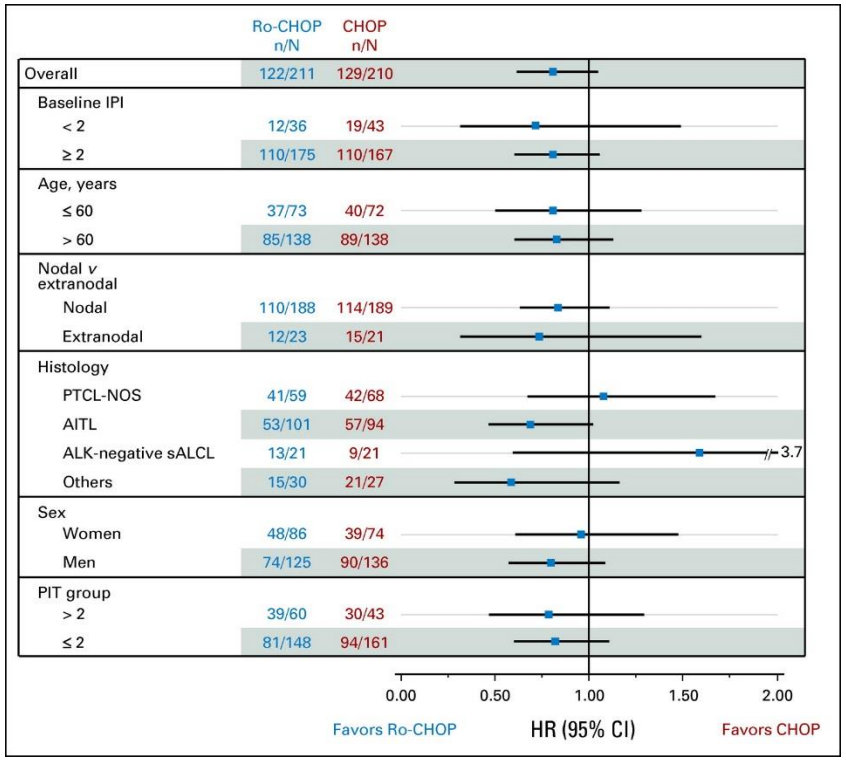
1:1 R

- **Romidepsin + CHOP** — 6 cycles or until PD
- **CHOP** — 6 cycles

Study start date: January 2013
Study completion date: July 2021

Primary endpoint: Progression-free survival (PFS) by independent review
Secondary endpoints include: OS, response rate, DoR, safety and quality of life
* Includes PTCL-NOS, AITL, ALK-ALCL, EATL, HSTCL SPTCL





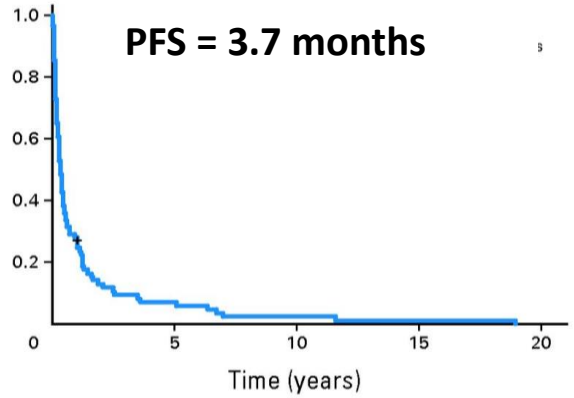
Bachy E., et al. J Clin Oncol. 2022 Jan 20;40(3):242-251

Relapsed or Refractory PTCL

Benchmarks for Relapsed/Refractory PTCL

BCCA N=153

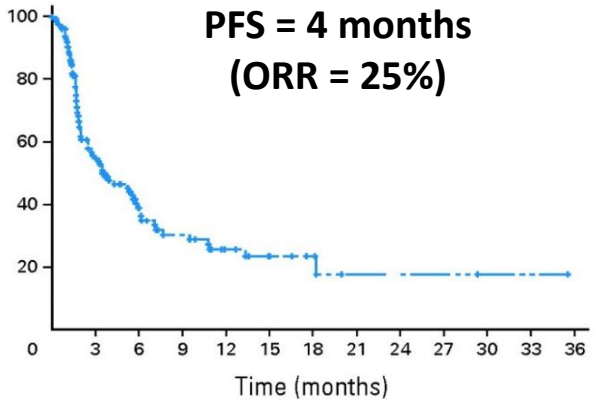
PFS = 3.7 months



Romidepsin N=130

PFS = 4 months

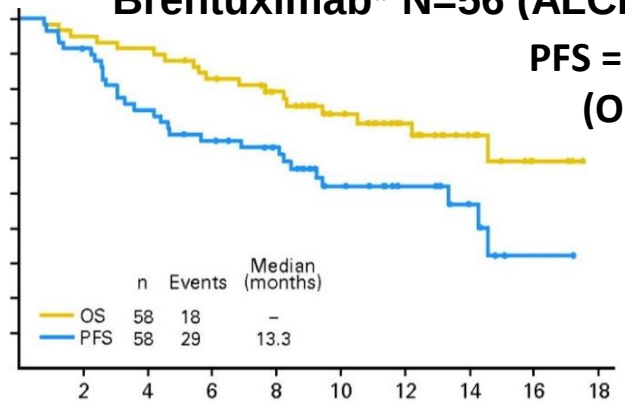
(ORR = 25%)



Brentuximab* N=56 (ALCL)

PFS = 13.3 months

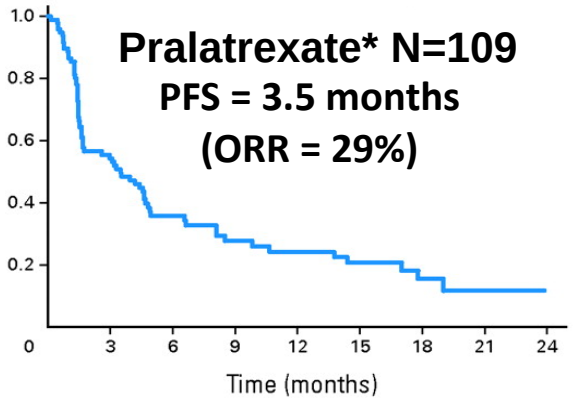
(ORR = 86%)



Pralatrexate* N=109

PFS = 3.5 months

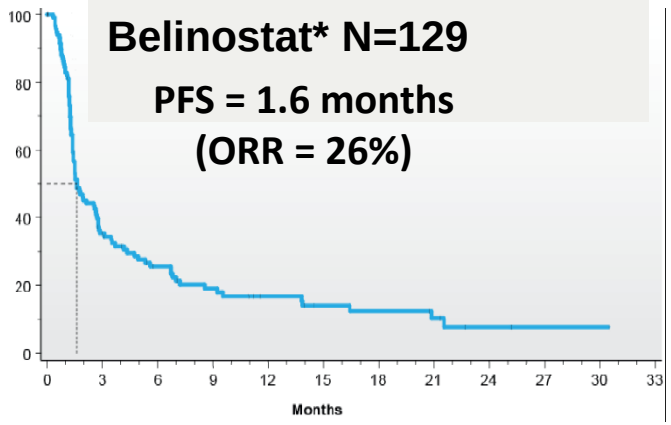
(ORR = 29%)



Belinostat* N=129

PFS = 1.6 months

(ORR = 26%)

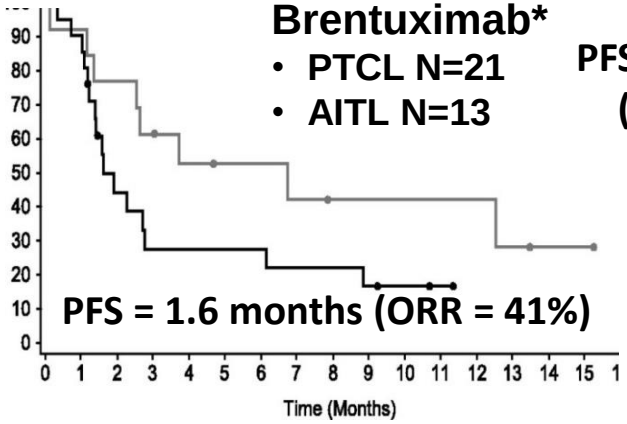


Brentuximab*

- **PTCL N=21**
- **AITL N=13**

PFS = 6.7 months

(ORR = 41%)



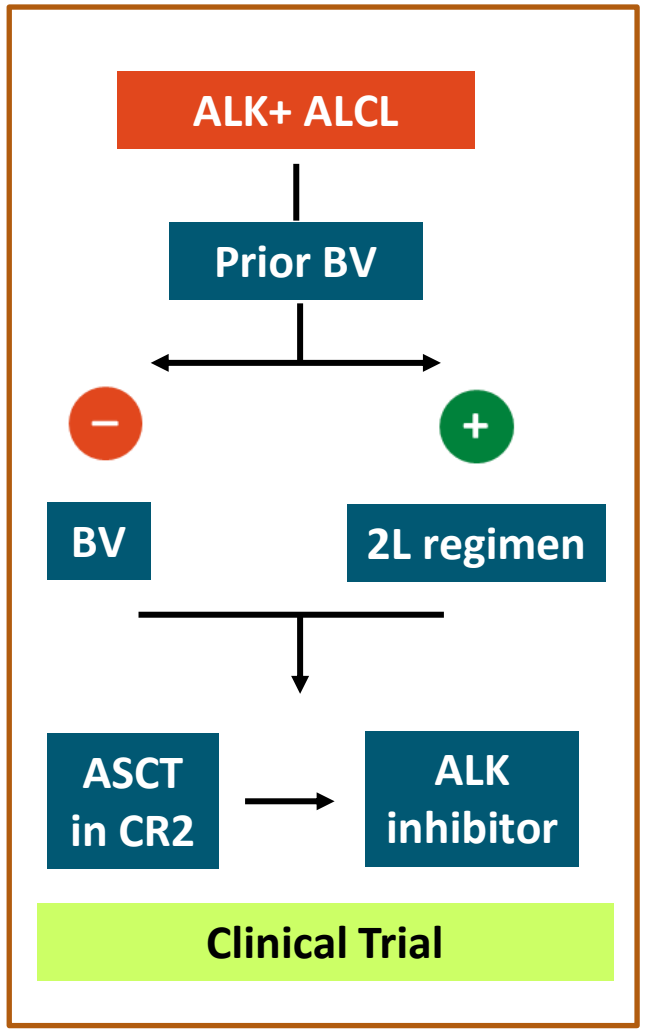
PFS = 1.6 months (ORR = 41%)

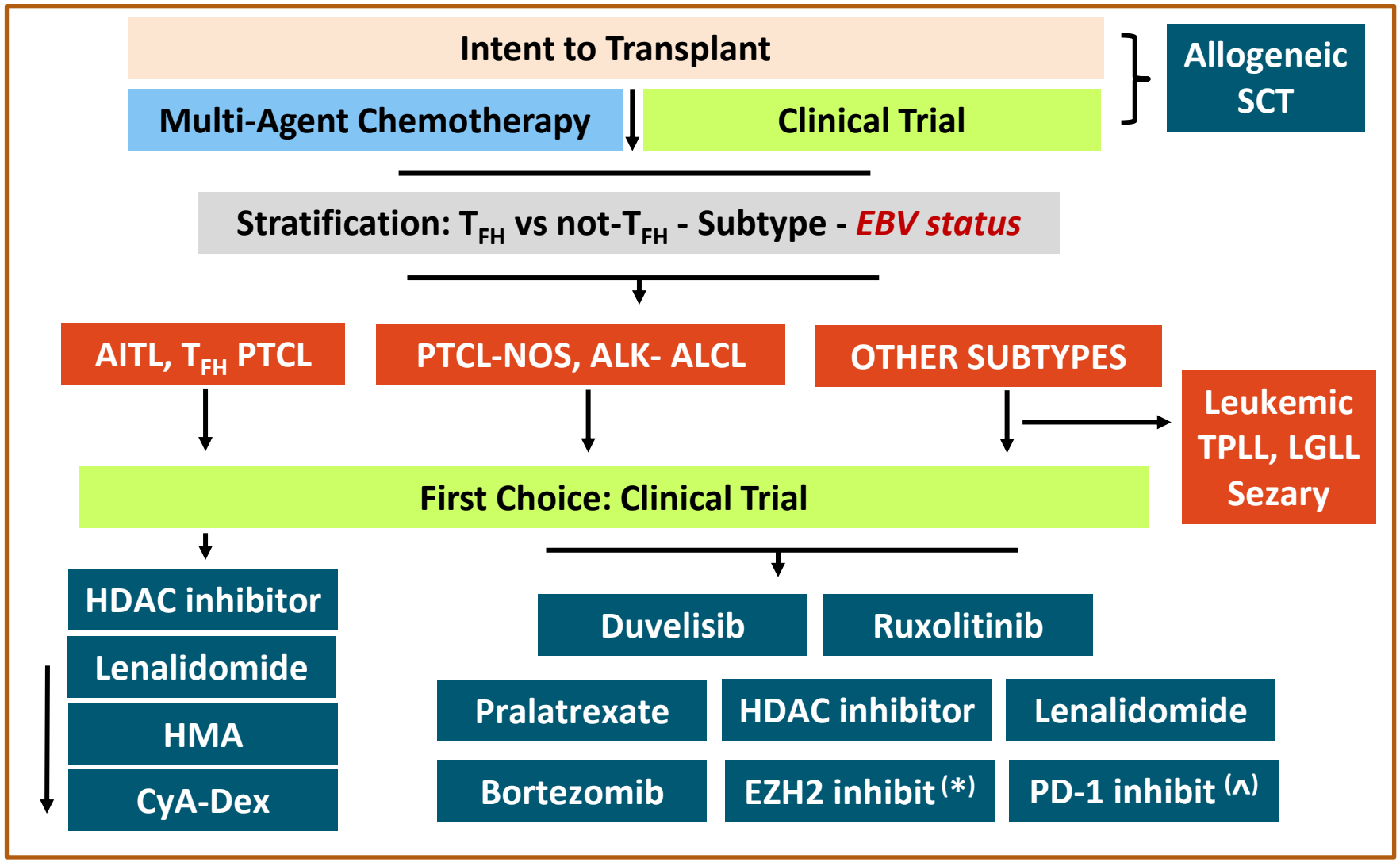
BCCA: British Columbia Cancer Agency, Mak V et al. JCO 2013;31:1970-1976; O'Connor OA, et al. *J Clin Oncol*. 2011;29:1182-1189; Coiffier B, et al. *J Clin Oncol*. 2012; 30 : 631-636; O'Connor OA et al ASCO 2013; Pro B, et al. J Clin Oncol. 2012;30:2190-2196; Horwitz S M et al. Blood 2014; 123:3095-3100, *FDA approved

Slide by Dr. Steve Horwitz

≥2L PTCL Therapy Pathways at Jefferson/SKCC

No current SOC in 2L R/R PTCL





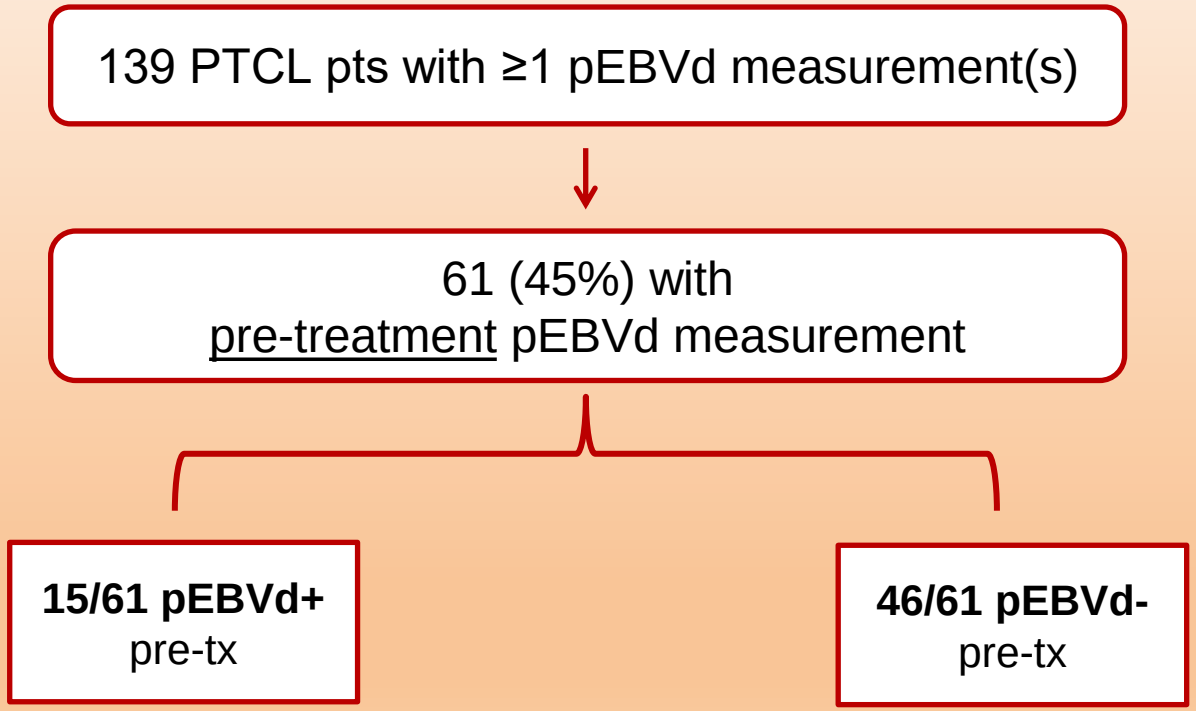
(*) Based on Valemetostat data, (^) Watch for hyper-progression

Emerging New Agents in T-Cell Lymphomas

Study Title	Phase	Target	NCT #
A Study of anti-CD94 mAb DR-01 in Subjects With LGLL or Cytotoxic Lymphomas	First in Human	**CD94**	NCT05475925
Safety, PK, PD, Clinical Activity of KT-333 in Adult Patients With Refractory Lymphoma, LGLL, Solid Tumors	Phase I	**STAT3 degrader**	NCT05225584
A Study of MT-101 in Subjects With CD5+ Relapsed/Refractory TCL (IMAGINE)	Phase I	CD5 CAR Myeloid Cells	NCT05138458
A Study of Tolinapant With Oral Decitabine/Cedazuridine and Oral Decitabine/Cedazuridine Alone in Patients with R/R PTCL	Phase I	**Dual IAP antagonist**	NCT05403450
Modified Immune Cells (AFM13-NK) and AFM13 in Patients With R/R CD30 Positive Hodgkin or Non-Hodgkin Lymphomas	First in Human	**CD30/CD16A bispecific, CB-derived NK cells**	NCT04074746
A Study to Investigate the Safety, Tolerability, PK, PD, and Efficacy of ONO-7018 in Patients With R/R NHL or CLL	First in Human	**MALT1**	NCT05515406
Trial of Nanatinostat in Combination With Valganciclovir in Patients With EBV+ R/R Lymphomas (NAVAL-1)	Phase II	**EBV**	NCT05011058

EBV-Positive PTCL

Ohio State Retrospective Study of pEBVd in PTCL

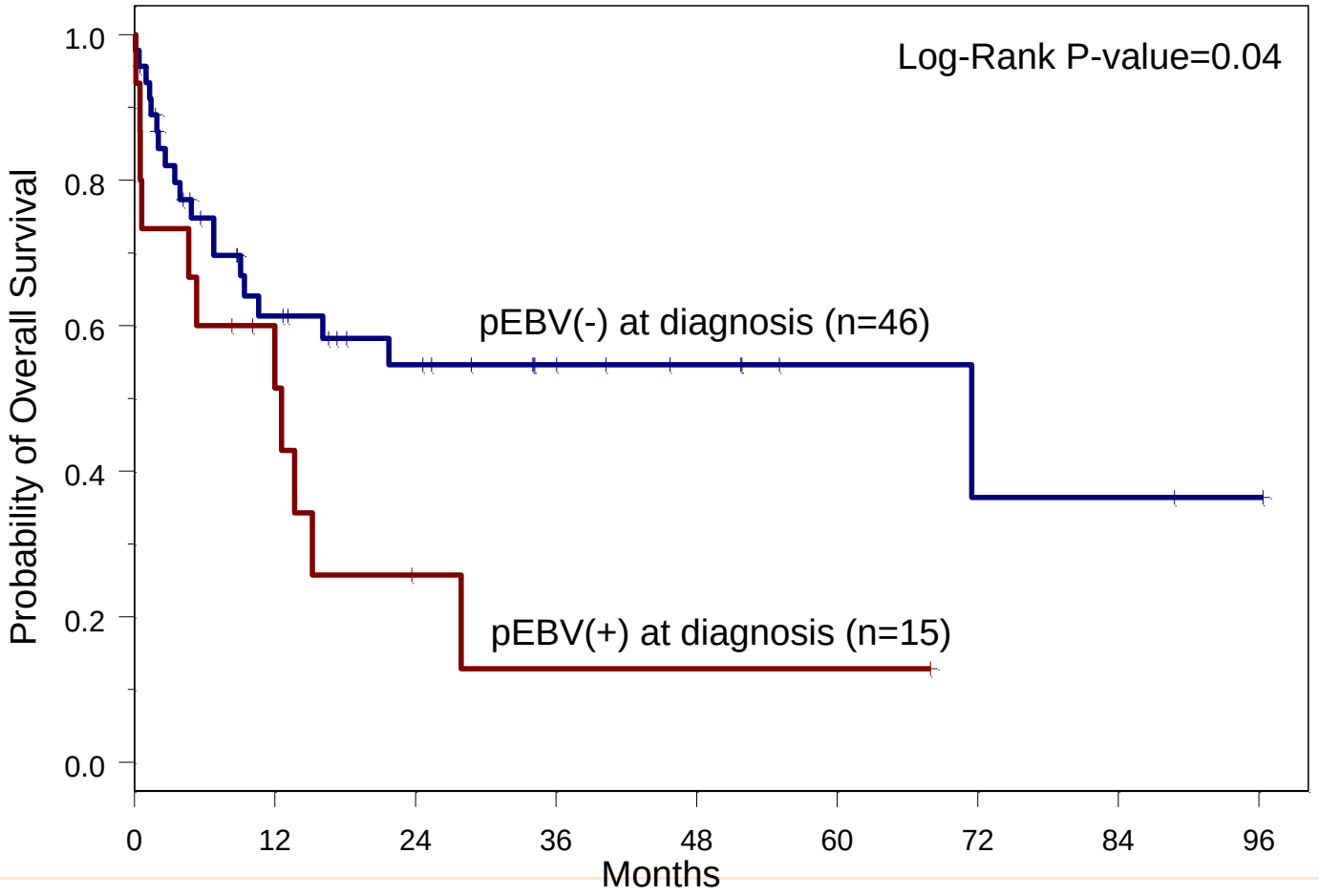


Subtype	N=61
PTCL-NOS	46%
AITL	25%
ALCL ALK-	16%
ALCL ALK+	7%
Other	6%

- No significant differences between age, sex, subtype, stage, PS, LDH, BM involvement, or extranodal disease

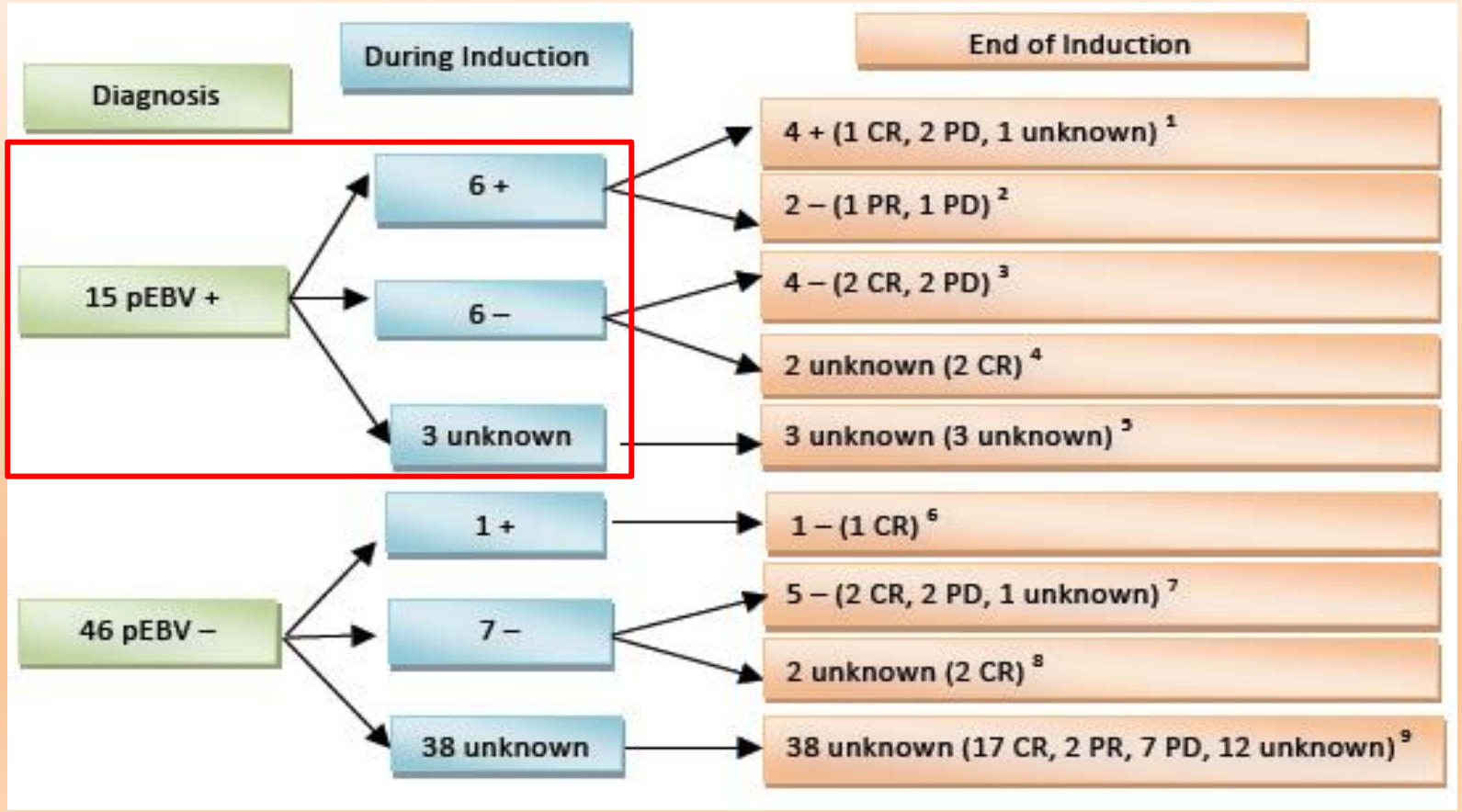
Haverkos B, et al. Int J Cancer. 2017 Apr 15;140(8):1899-1906.

Overall Survival by pEBVd Status



Haverkos B, et al. Int J Cancer. 2017 Apr 15;140(8):1899-1906.

Serial pEBVd Measurements and Outcomes in EBV+ PTCL



Status at last follow up
4/4 Dead of disease
2/2 Dead of disease
2/4 Alive disease free
2/2 Alive disease free
3/3 Dead of disease
1 Alive disease free
3/5 Alive disease free
2/2 Alive disease free
21/38 Alive disease free

pEBVd measurement reported as a dichotomous variable where "+" indicated pEBVd >2000 copies/mL. Response in accordance with Cheson criteria. pEBVd measured at th end of induction in parallel to imaging assessment. PR=partial response, CR=complete response, PD progressive disease

Haverkos B, et al. Int J Cancer. 2017; 140(8):1899-1906

Estimated Frequency of EBV+ T-cell Lymphomas

eClinicalMedicine
2022;54: 101674
Published online 1 October 2022
https://doi.org/10.1016/j.eclinm.2022.101674

		EBER-ISH Score Results			
Subtype	**N**	**Score 0**	**Score 1**	**Score 2**	**Score 3**
T-ALL	3	3	0	0	0
ALK- ALCL	12	10	2	0	0
AITL/TFH	33	8	9	2	14
PTCL-NOS	11	9	2	0	0
PTCL-Rare Subtypes	4	3	1	0	0
Intestinal TCL	4	2	2	0	0
Total	**67**	**35**	**16**	**2**	**14**

Score 0 = EBV-negative; Score 1-3 = Variously EBV-positive; **Total 32/65 = 49%**

Donzel M., et al. eClinicalMedicine 2022; 54: 101674

PTCL Conclusions

- PTCL is associated with a poor prognosis
- First-line combination chemotherapy provides moderate life extension
- EBV+ PTCL is associated with worse survival outcomes than EBV- PTCL
- There is no current standard of care in the treatment of patients with R/R PTCL
- A targeted treatment for patients with R/R EBV+ PTCL could provide an important addition, with potential eventual incorporation into the frontline treatment setting

Nana-val:
R/R EBV^{+} PTCL Data

NAVAL-1: Pivotal Phase 2 Trial in Patients with R/R EBV+ Lymphomas

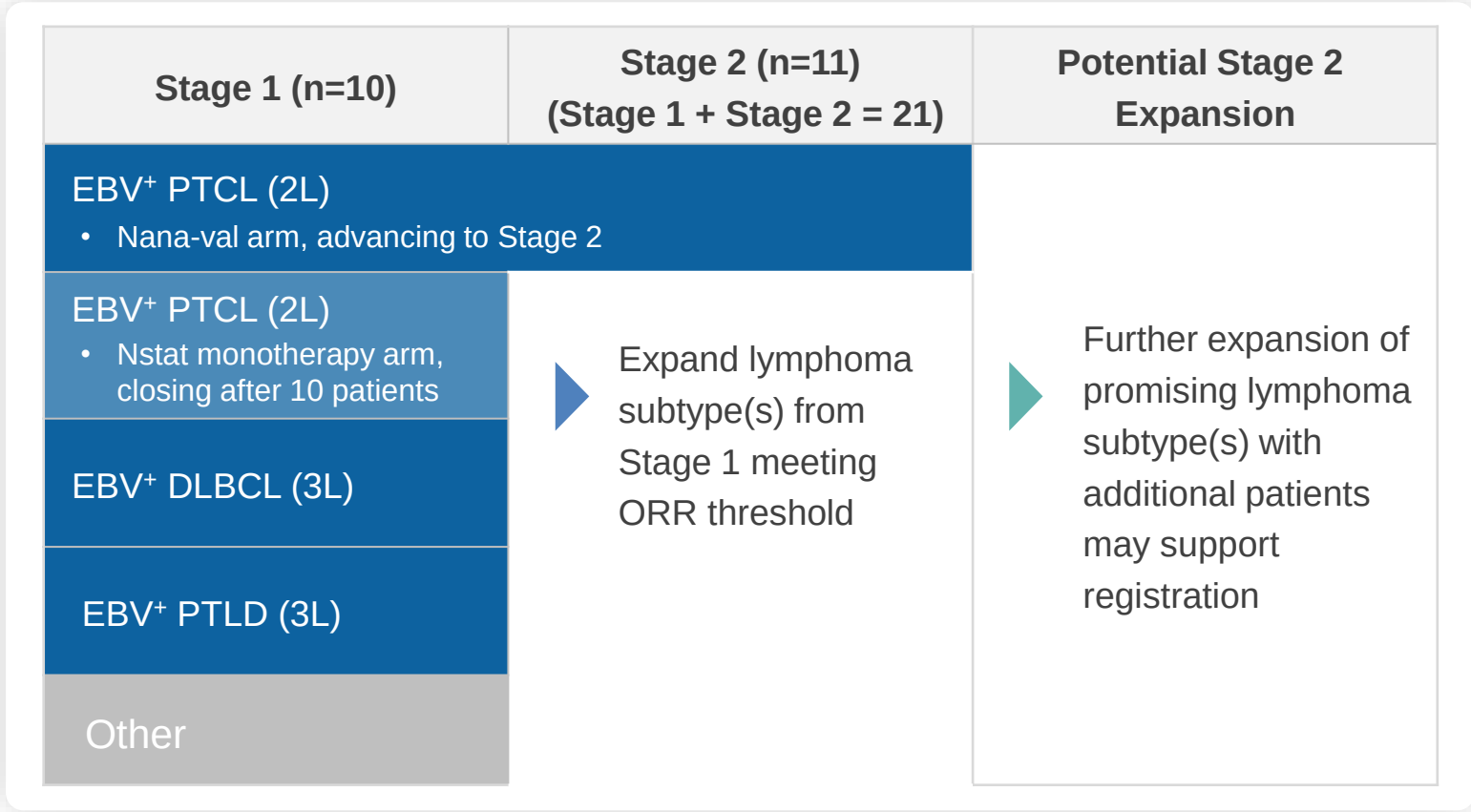
Global study, with an adaptive Simon 2-stage design, focused on the largest EBV-positive lymphoma patient populations, with high unmet medical need and positive Study 201 clinical data

Patient population:

- R/R EBV+ lymphoma with ≥2 prior therapies and no curative options (≥1 prior therapy for PTCL)

Primary endpoint:

- Objective response rate (ORR) by independent central review
- Potential to further expand indications with promising antitumor activity after Stage 2



R/R: Relapsed or Refractory; 2L Second-Line; 3L:Third-Line

R/R EBV+ PTCL: Initial Data from Pivotal NAVAL-1 Trial

Achieved Stage 1 ORR threshold in the second quarter of 2023 to advance into Stage 2

New

	NAVAL-1 (n=5*)
	ITT (n=5)
Response	
ORR	**2 (40%)**
CR	**2 (40%)**
PR	0
SD	0
PD	2
Clinical Benefit Rate	2 (40%)
Data Cutoff	June 30, 2023

- Threshold for advancing into Stage 2 is 2 responses in Stage 1, same for all indications
- Complete responses achieved ORR threshold within first 5 of 10 Stage 1 patients enrolled
- Median duration of response (DoR) not yet reached
- Anticipate completing Stage 2 (n=21) enrollment in 2024
  - 10 R/R EBV+ PTCL patients have been enrolled into combination and monotherapy arms of Stage 1 (as of June 30, 2023 data cutoff)

*One patient withdrew from study due to an AE, PTCL includes: Peripheral T-cell lymphoma and Angioimmunoblastic T-cell lymphoma, ITT: Intention-to-Treat, ORR: Overall Response Rate, CR: Complete Response, PR: Partial Response, SD: Stable Disease, PD: Progressive Disease, Clinical Benefit Rate = CR + PR + SD ≥ 6 months

R/R EBV+ PTCL: Initial Efficacy Data from NAVAL-1 Consistent with Study 201

Improved blend uniformity and stability with tablet that had comparable safety/PK with capsule

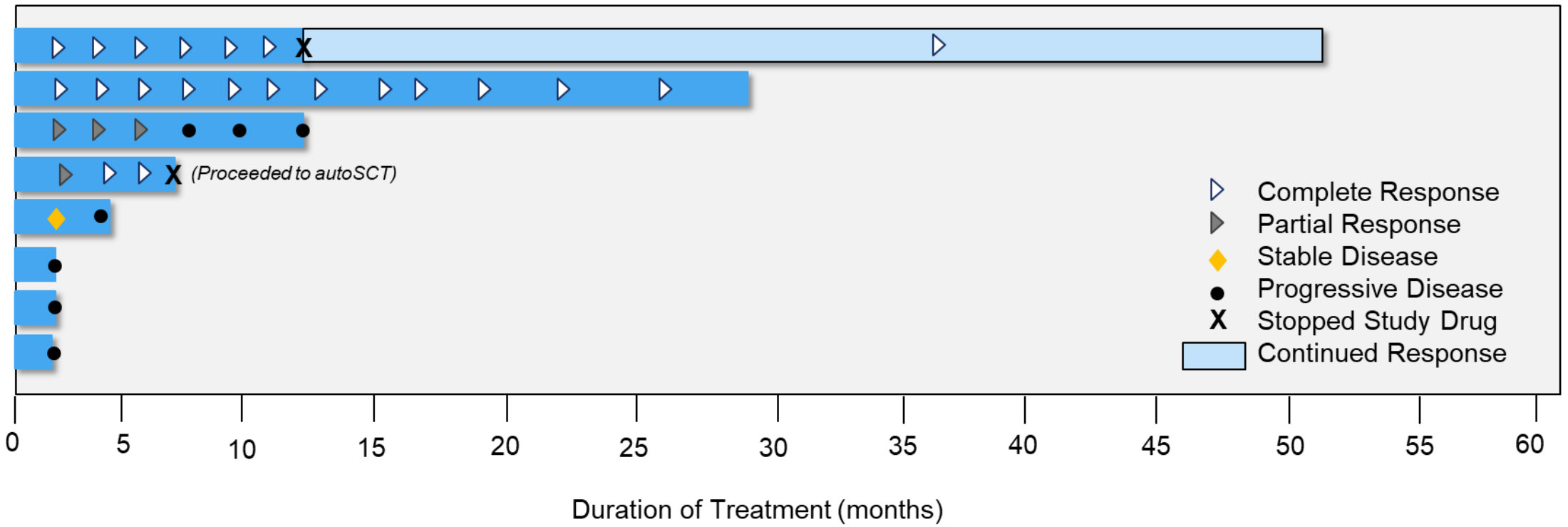
	Study 201 Capsule Data[1] (n=11)		Study 201 Tablet Data (n=2)		Study 201 Capsule + Tablet Data[2] (n=13)	NAVAL-1 (n=5*)
	Evaluable Patients[3] (n=6)		Evaluable Patients[3] (n=2)		Evaluable Patients[3] (n=8)	ITT (n=5)
Response						
ORR	**4 (67%)**	+	**0**	=	**4 (50%)**	**2 (40%)**
CR	**3 (50%)**		**0**		**3 (38%)**	**2 (40%)**
PR	1		0		1	0
SD	1		0		1	0
PD	1		2		3	2
Clinical Benefit Rate	5 (83%)		0		5 (63%)	2 (40%)
Data Cutoff	October 28, 2021		May 4, 2023		May 4, 2023	June 30, 2023

[1]Data published in *Blood Advances* 2023 [2]Data submitted to HEMO 2023; [3]Evaluable patients: EBER-ISH+ with ≥1 post-treatment response assessment; *One patient withdrew from study due to an AE, PTCL includes: Peripheral T-cell lymphoma and Angioimmunoblastic T-cell lymphoma, ITT: Intention-to-Treat, ORR: Overall Response Rate, CR: Complete Response, PR: Partial Response, SD: Stable Disease, PD: Progressive Disease, Clinical Benefit Rate = CR + PR + SD ≥ 6 months

R/R EBV+ PTCL: Median DoR in Study 201 Extended to 17.3 Months*

Exceeds ~8.5 – 9.5-month median DoR in other R/R PTCL therapies that have received AA

New



*Data cutoff: May 4, 2023; PTCL includes Peripheral T-cell lymphoma and Angioimmunoblastic T-cell lymphoma, AA: Accelerated Approval

Expanded and Extended Safety Data Demonstrated Nana-val Regimen was Generally Well-Tolerated

Treatment-Emergent Adverse Events Reported in >16 (>25%) Patients

	Study 201 Capsule + Tablet (N=64)		
	Any	G3	G4
Thrombocytopenia	27 (42%)	8 (13%)	6 (10%)
Neutropenia	25 (39%)	10 (16%)	11 (17%)
Nausea	25 (39%)	2 (3%)	0
Anemia	24 (38%)	12 (19%)	1 (2%)
Fatigue	22 (34%)	4 (6%)	0
Constipation	19 (30%)	1 (2%)	0
Diarrhea	19 (30%)	1 (2%)	0
Creatinine Increased	17 (27%)	1 (2%)	0

Treatment-Emergent Serious Adverse Events Occurred in 23 of 64 (36%) Patients

- Treatment-emergent serious adverse events occurring in more than 1 patient (n=2 each):
  - febrile neutropenia
  - atrial fibrillation
  - sepsis
  - pneumonia (pneumonia and viral pneumonia)
  - dyspnea
  - acute kidney injury
  - pyrexia
- There were no study treatment-related deaths

Safety profile suggests potential for combining with other chemo- and/or immunotherapies

viracta

Data cutoff date: May 4, 2023

Nana-val is Well Positioned for Potential Accelerated Approval in R/R EBV+ PTCL

Anticipate engagement with FDA in 2024 to align on accelerated registration pathway

Accelerated Approval Criteria	Nana-val: R/R EBV+ PTCL Program	
Unmet medical need population	No approved therapies for R/R EBV+ PTCL	✓
Rarity of the serious life-threatening disease without alternate available treatment options	EBV+ PTCL 5-year survival rate of ~11%*	✓
Magnitude of the response rate observed	ORR of 30% - 45%+ CRR of ~25% - 40%	✓
Duration of response (DoR)	17.3 months median DoR observed in Phase 1b/2 study	✓
Favorability of the safety profile	Generally well-tolerated	✓

Base Case Assumption: ~60-90 total R/R EBV+ PTCL patients may be required in the NAVAL-1 trial for potential accelerated approval

viracta

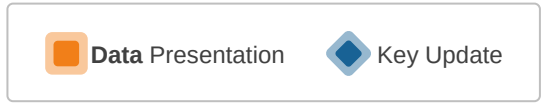
*Trinity market research

Nana-val is Well Positioned for Potential Accelerated Approval in R/R EBV+ PTCL

Criteria	Nana-val*	Beleodaq** (Belinostat)	Istodax** (Romidepsin)	Folotyn** (Pralatrexate)
Indication(s)	**EBV+ PTCL**	**R/R PTCL (EBV+ & EBV-)**	**R/R PTCL (EBV+ & EBV-)**	**R/R PTCL (EBV+ & EBV-)**
Overall Response Rate (ORR)	30-50%	25.8%	26.2%	26.6%
Complete Response Rate (CRR)	~25-40%	10.8%	15.4%	8.3%
Duration of Response (DoR)	17.3 months	8.4 months	<8.5 months	9.4 months
Sample Size	~60-90 (pending FDA confirmation)	120	130	109
Route of Administration	Oral	IV	IV	IV

*Covers Study 201 responses analyzed in both the response-evaluable and ITT populations, **Per product label (response-evaluable population)

Anticipated Program Milestones*



	Indication	2023	2024				2025
NAVAL-1 (EBV+ Lymphoma)	PTCL	Initial Stage 1 ORR **DATA**	Complete enrollment of Stage 2	Meet with **FDA** & align on potential AA pathway	Initiate Registration Phase	Present Stage 2 **DATA**	Registration Phase LPI

*Placement on calendar year does not denote specific timing, AA: Accelerated Approval, LPI: Last Patient In, ORR: Overall Response Rate

EBV+ Diffuse Large B-Cell Lymphoma:
A unique entity

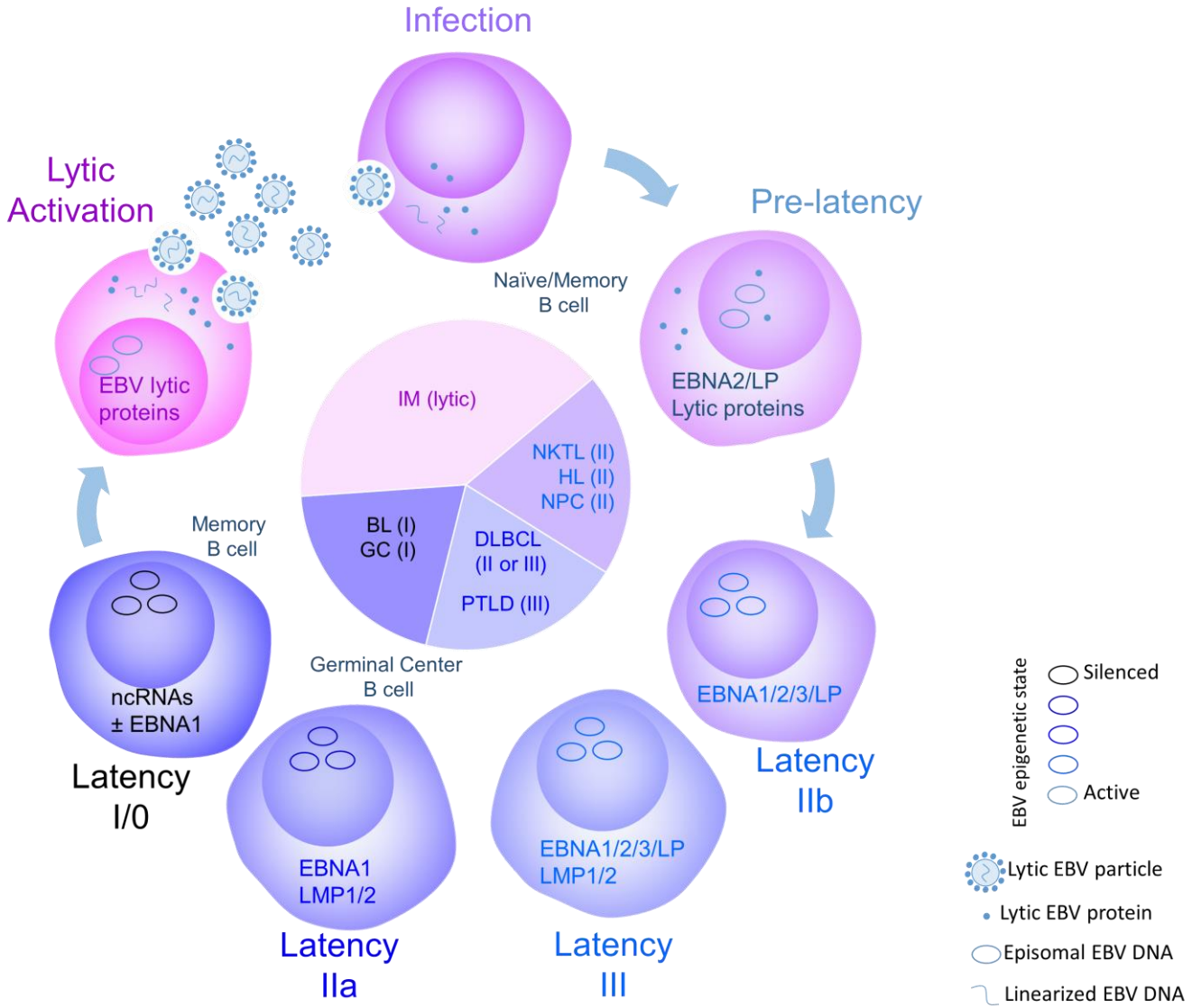
EBV-Positive DLBCL as a Unique Entity

Robert Baiocchi, MD, PhD

Division of Hematology

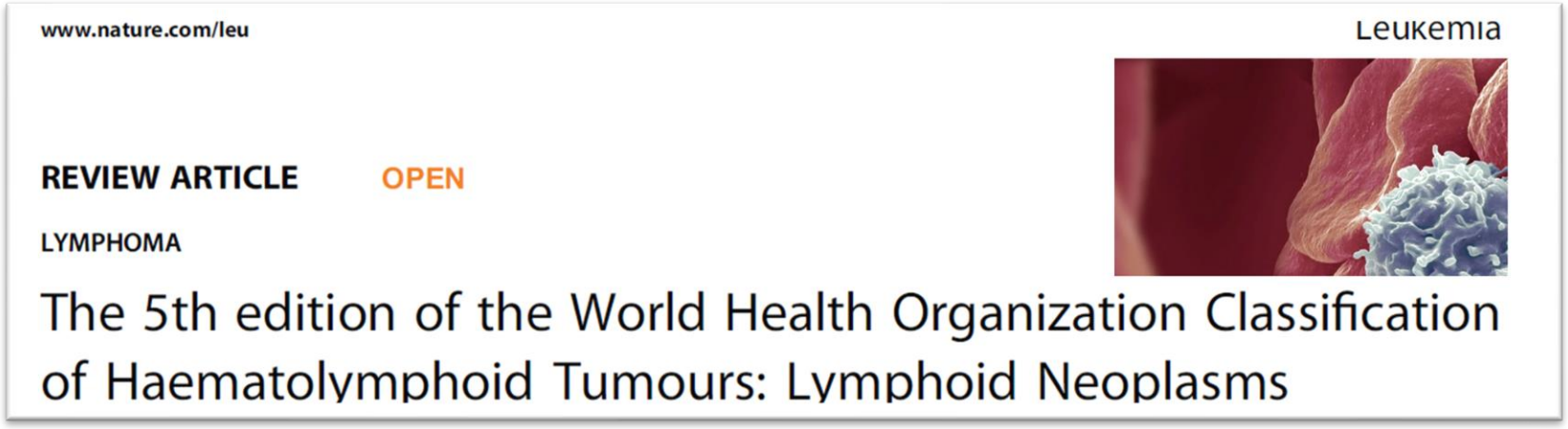
The Ohio State University

EBV Latent/Lytic States and Lymphoma



EBV-Positive DLBCL is a Unique Entity

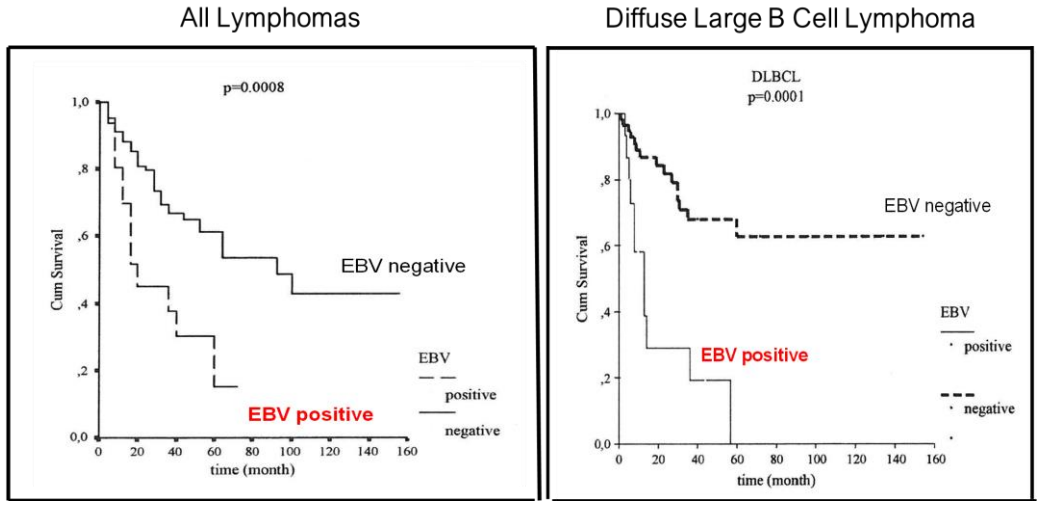
- **2003 Oyama et al first described first cases of EBV+ DLBCL in elderly patients (Am J Surg Pathol, 2003). Most patients responded poorly to standard chemotherapy**
- **2008 the WHO classification of lymphoid malignancies included EBV+ DLBCL of elderly as a provisional entity.**
- **New information on unique pathology, clinical features, common signaling pathways, immune evasion, and distinct mutational profiles have led to EBV+ DLBCL to be included in the 5th Edition of the WHO Classification of Haematolymphoid Tumors.**



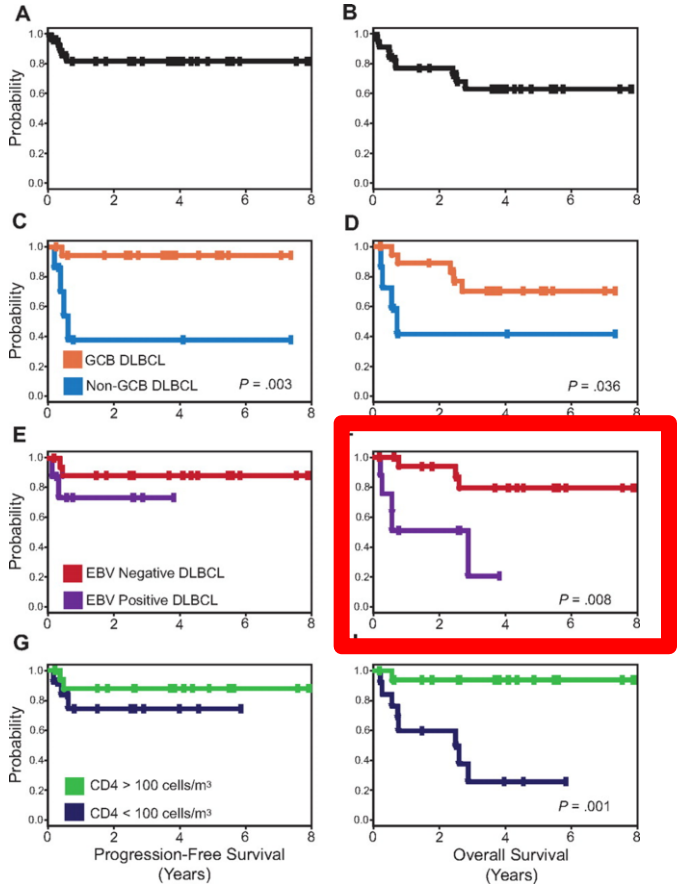
EBV-Positive DLBCL as a Unique Entity

Clinical Features:

- **Older age at diagnosis**
- **High IPI scores, extranodal presentation (GI, skin, marrow)**
- **Poor ECOG performance status**
- **Poor response/survival with standard immuno-chemotherapy**



Parks et al, Blood 2006



Dunleavy et al, Blood 2001

EBV-Positive DLBCL as a Unique Entity

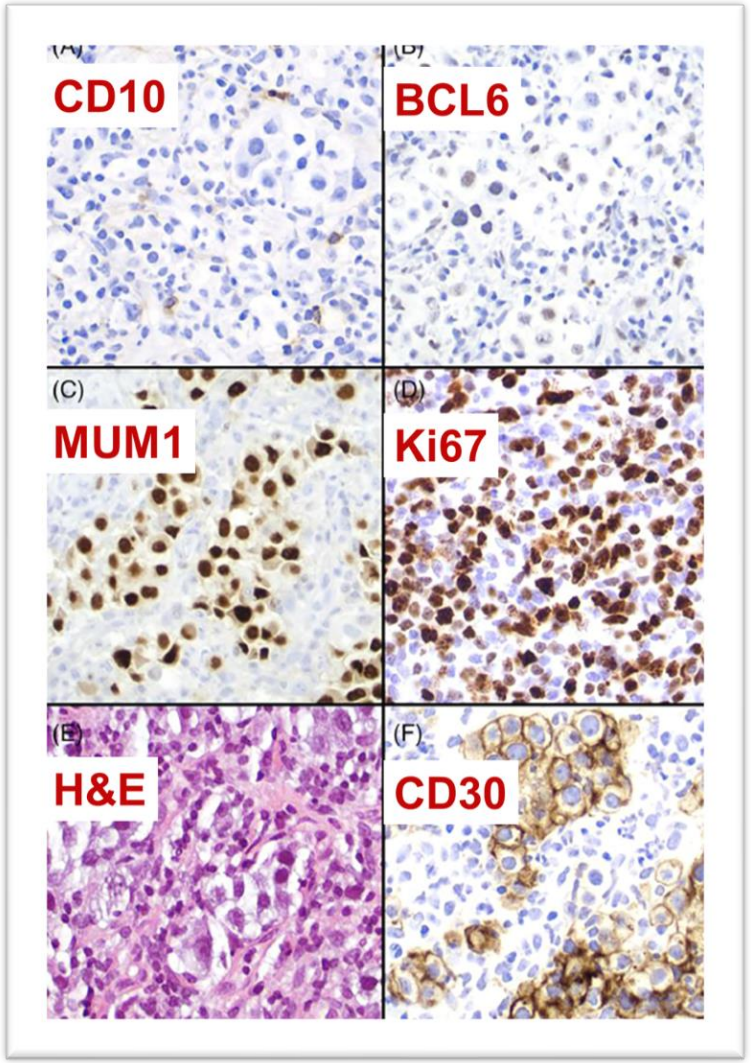
Clinical Features: Poor Outcomes with SOC Therapy

Study	EBER	Regimen	N	ORR/CR rates	OS
Oyama, 2007	>50%	CHOP	56	80%/66%	5-year: 25%
Park, 2007	>20%	R-CHOP	25	72%/NR	5-year: 45%
Beltran, 2011	>20%	R-CHOP	8	NR/66%	3-year: 40%
		CHOP	12	NR/33%	3-year: 40%
Ahn, 2014	>50%	R-CHOP	18	72%/61%	3-year: 57%
Ok, 2014	>10%	R-CHOP	28	89%/NR	5-year: 54%
Sato, 2014	>30%	R-CHOP	8	50%/25%	3-year: 38%
		CHOP	3	33%/33%	3-year: 0
Lu, 2015	>20%	R-CHOP	35	66%/NR	3-year: 30%
Song, 2015	NR	R-CHOP	8	63%/50%	3-year: 70%
		CHOP	8	50%/38%	3-year: 25%
Okamoto, 2016	>20%	R-CHOP	13	NR	4-year: 41%
Hong, 2017	>20%	R-CHOP	14	NR	Median 15 months
Beltran, 2018	>20%	R-CHOP	17	71%/59%	5-year: 54%
Liu, 2018	>50%	CHOP	16	31%/31%	5-year: 38%
		R-CHOP	6	NR/50%	2-year: 20%
		CHOP	3	NR/50%	2-year: 0
Witte, 2019	>50%	R-CHOP	62	94%/67%	2-year: 70%
Zhou, 2019	>50%	R-CHOP	22	NR	Median 29 months
Yoon, 2020	>20%	IR-CHOP	24	67%/67%	1-year: 33.3%
		R-CHOP	24	67%/63%	1-year: 50%

EBV-Positive DLBCL as a Unique Entity

Pathologic Features:

- Generally, Non-GC phenotype (CD10/BCL6 neg, MUM1+
- Diverse morphology, monomorphic, polymorphic, polymorphic w RS like cells
- Pan B cell markers CD19+/CD20+, PAX5, CD79a
- High proliferative index
- Monoclonal *IGH* signature
- EBER+ (variable)
- Latency pattern II and III (EBER, LMP1, EBNA2+) most common
- Lat II less common (varies by study)
- New data showing CD30 expression
- Immune evasion signature (PDL1/LAG2)
- Unique mutational signature



Malpica et al AJH 2022

EBV Positive DLBCL as a Unique Entity

Unique Mutational Landscape

- Frontzek et al, (Leukemia 2023)
- Targeted sequencing, recurrent somatic CNVs in 60 EBV+ DLBCL samples
- LymphGen classifier used and showed less than 20% of EBV+ DLBCL corresponded to one of the established molecular DLBCL subtypes highlighting the unique nature of this subtype of DLBCL
- Recurrent mutations involved NOTCH (*NOTCH1, NOTCH2*), JAK/STAT (*SOCS1, STAT3,* epigenetic (*KMT2D, KMT2C*), DNA repair (*SP53*), and B cell program (*FOXO1*) pathways
- Amplifications of 9p24.1 driving excessive PDL1 expression contributing toward immune escape

- Cho et al, (Cancers 2023): *TET2 (*LOF) and *LILRB1* mutations in 50% elderly EBV+ DLBCL patients.

EBV Positive DLBCL as a Unique Entity

Unique Mutational Landscape: Mutations Associated with Clonal Hematopoiesis (CHIP)

- Li et al (Blood Adv 2022)
- Compared targeted RNAseq EBV+ DLBCL (n=104) to EBV- DLBCL (n=768). 77% represented NGC histologic subtype.
- *TET2*, *ASXL1*, *DNMT3A, TP53* = top 4 CHIP related genes mutated in EBV+ DLBCL compared to EBV- DLBCL or NGC DLBCL
- MYD88 mutations found in 4% EBV+ DLBCL vs 20% EBV- DLBCL/NGC
- Genomic landscape of EBV+ DLBCL distinct from other EBV+ lymphomas including BL, ENKTL, PTLD, and carcinomas (NPC, GCA)
- Of the top 10 most frequently mutated genes in EBV+ DLBCL, 7 were of myeloid CHIP characterization. A unique feature compared to EBV- DLBCL (8/10 top mutations are lymphoid CHIP).
- The top myeloid CHIP mutations corresponded to DLBCL from patients with African ancestry (TET2, DNMT3A) primarily NGC and associated with poor prognosis, Lee et al, Cancers 2022).

EBV Positive DLBCL as a Unique Entity

Unique Mutational Landscape: Mutations Associated with Clonal Hematopoiesis (CHIP)

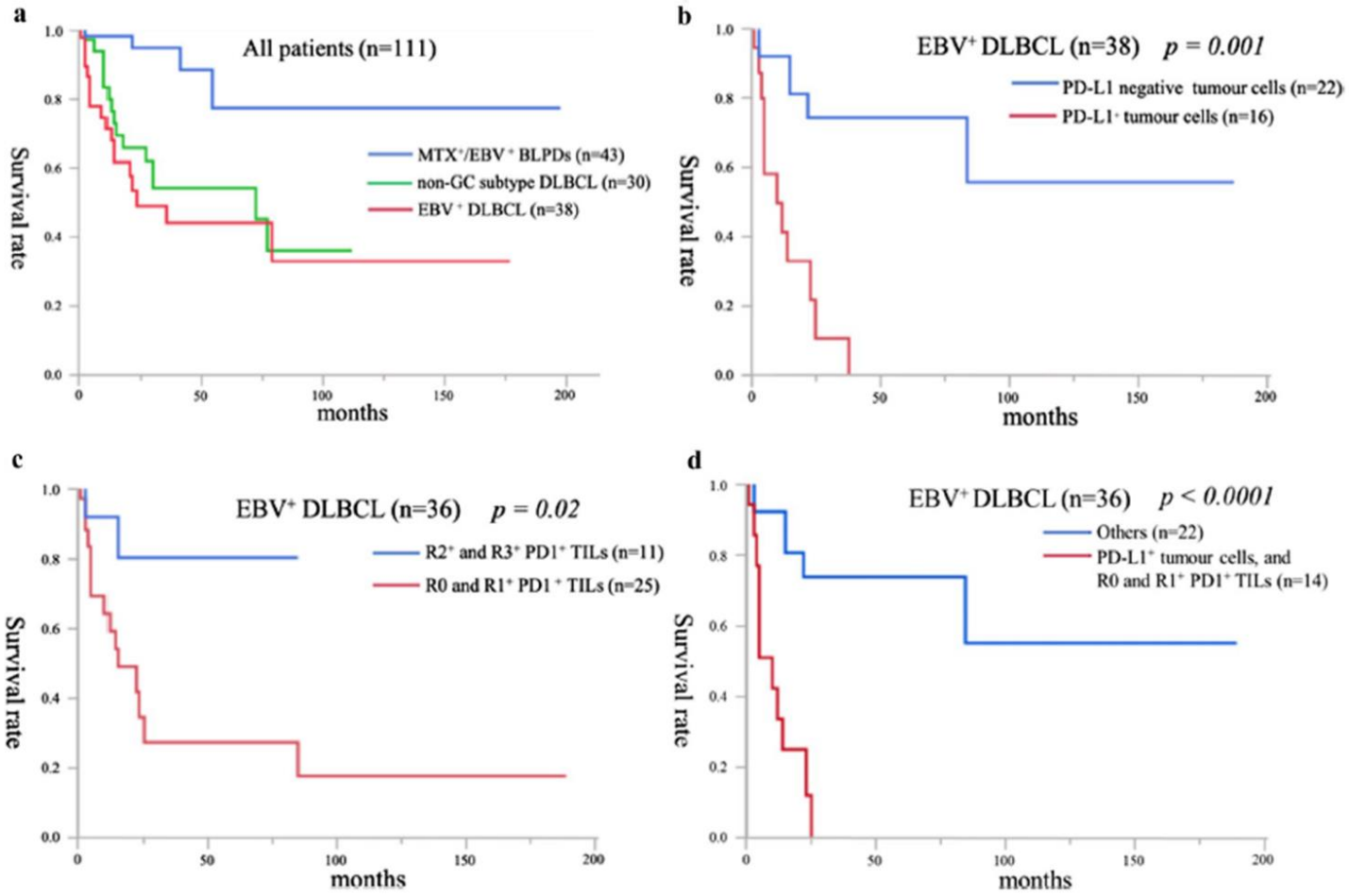
Table 1: Top 10 recurrent genetic mutations by targeted RNA-seq in our EBV-positive or -negative DLBCL cases and by DNA sequencing in other DLBCL cohorts.

Group	EBV-positive DLBCLs, n=99		EBV-negative DLBCLs, n=381		Reddy et al, 2017 n=1,001		Schmitz et al, 2018, n=574		Chapuy et al, 2018, n=304	
Rank	Gene	%	Gene	%	Gene	%	Gene	%	Gene	%
1	*TP53*	42.4	*KMT2D*	24.4	*KMT2D*	24.8	*KMT2D*	31.4	*KMT2D*	24.7
2	*TET2*	39.4	*MYD88*	16.8	*BCL2*	17.4	*PIM1*	27.5	*PIM1*	22.0
3	*APC*	31.3	*TP53*	16.5	*MYD88*	17.2	*MYD88*	26.8	*TP53*	21.4
4	*PTPN11*	20.2	*CARD11*	11.8	*HIST1H1E*	16.9	*TP53*	23.0	*MYD88*	18.1
5	*ASXL1*	19.2	*EZH2*	10.0	*PIM1*	16.6	*HLA-B*	21.6	*BCL2*	17.4
6	*DNMT3A*	18.2	*ACACA*	8.9	*CREBBP*	11.4	*BTG2*	18.3	*CREBBP*	16.8
7	*SMAD4*	18.2	*CD79B*	8.4	*CARD11*	11.3	*TMSB4X*	16.7	*CD79B*	14.5
8	*SOCS1*	16.2	*BCL10*	7.9	*SPEN*	10.1	*TNFAIP3*	16.7	*BTG1*	14.1
9	*ETV6*	16.2	*CD58*	6.6	*TP53*	9.9	*HLA-A*	16.0	*SGK1*	14.1
10	*STAG2*	15.1	*CREBBP*	6.0	*ARID1A*	9.7	*B2M*	15.9	*TNFRSF14*	13.8

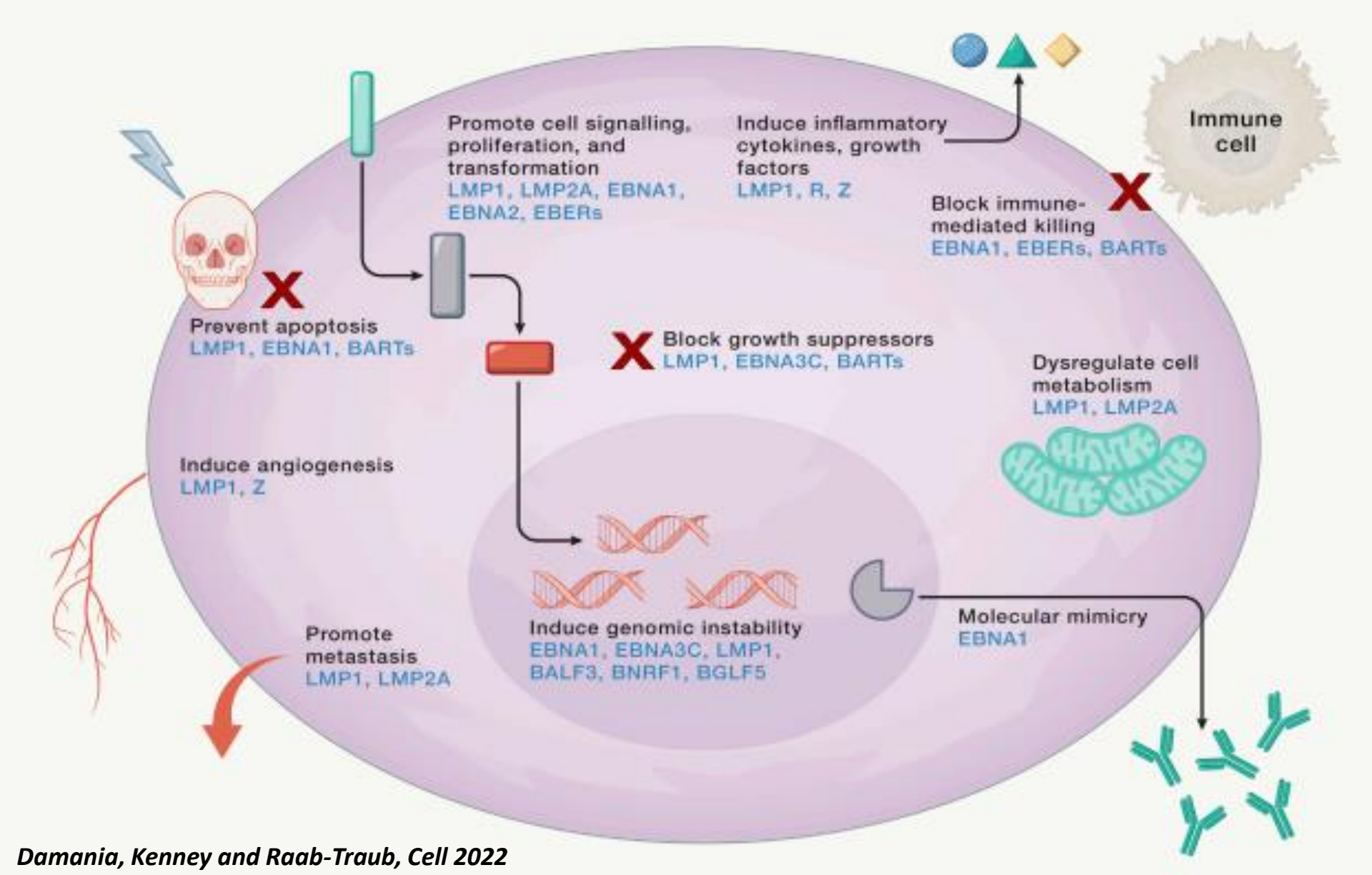
EBV-Positive DLBCL as a Unique Entity

Immune Evasion:

- Kimura et al, Clin Exp Med, 2022
- PDL1, PD1 expression (IHCS) identified unique prognostic feature of EBV+ DLBCL
- Other studies point toward PDL1, PDL2 modulation by EBV proteins (LMP1, EBNA2)

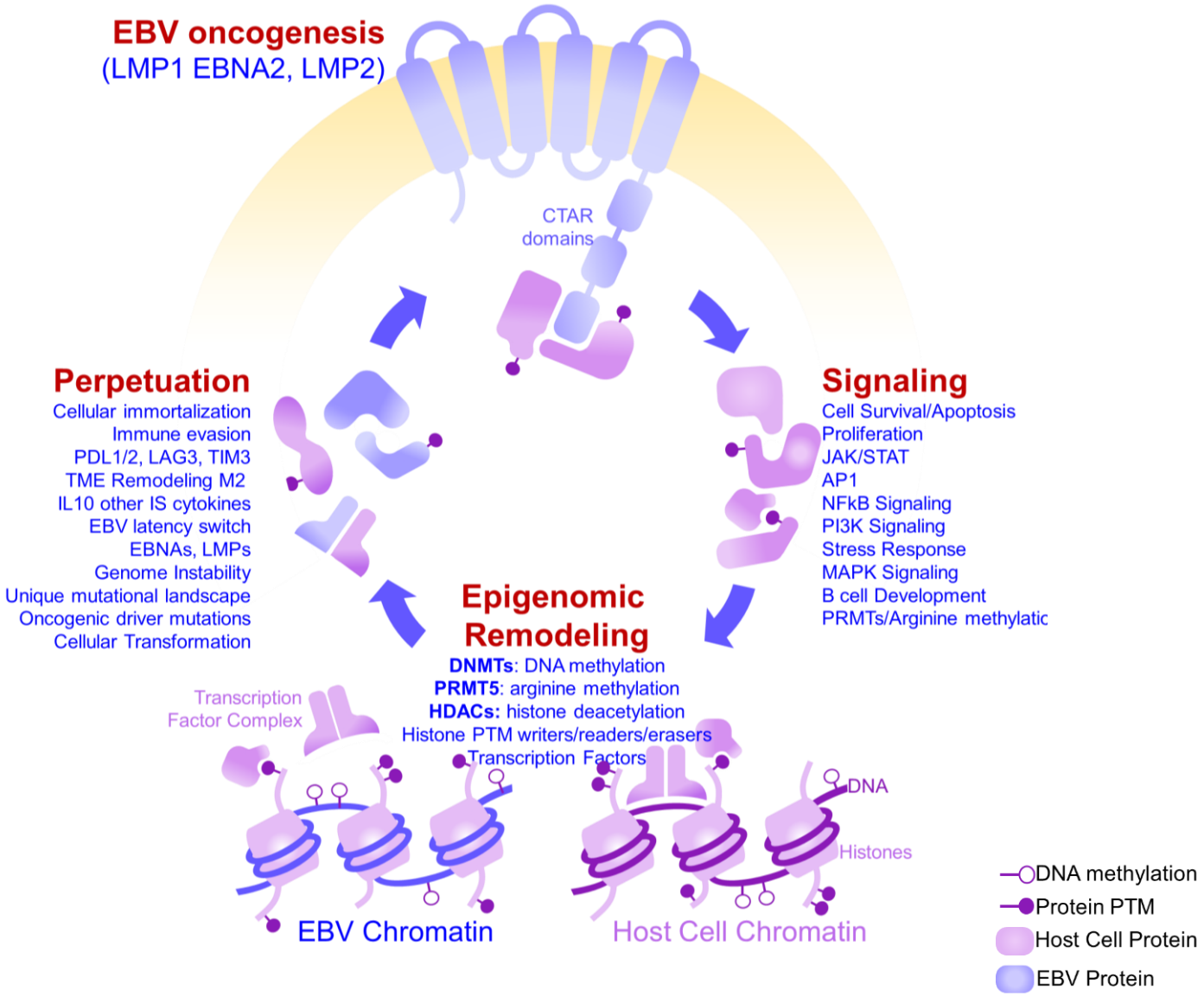


How Does EBV Contribute to Pathogenesis of DLBCL?



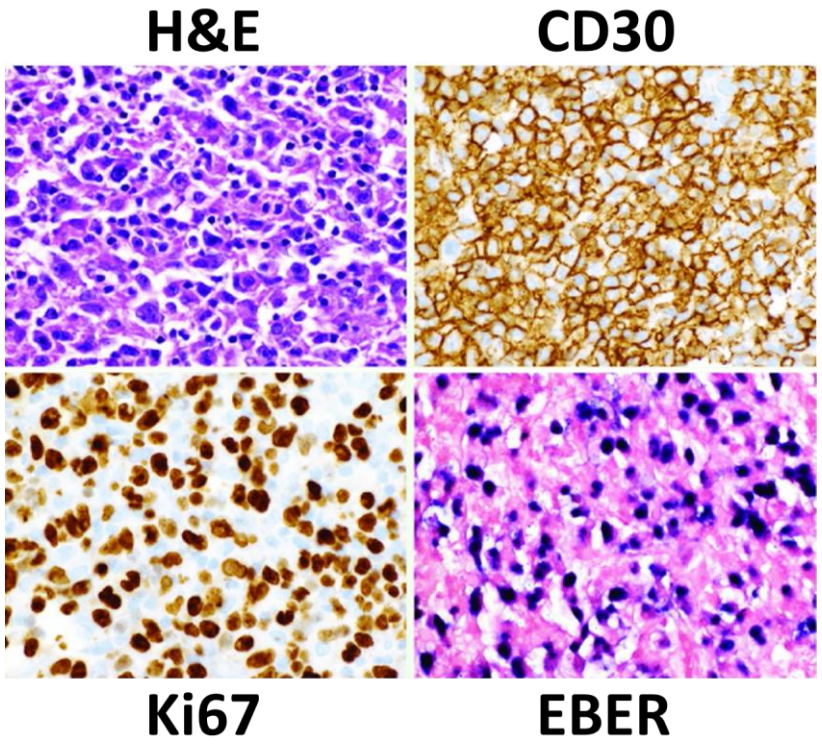
Damania, Kenney and Raab-Traub, Cell 2022

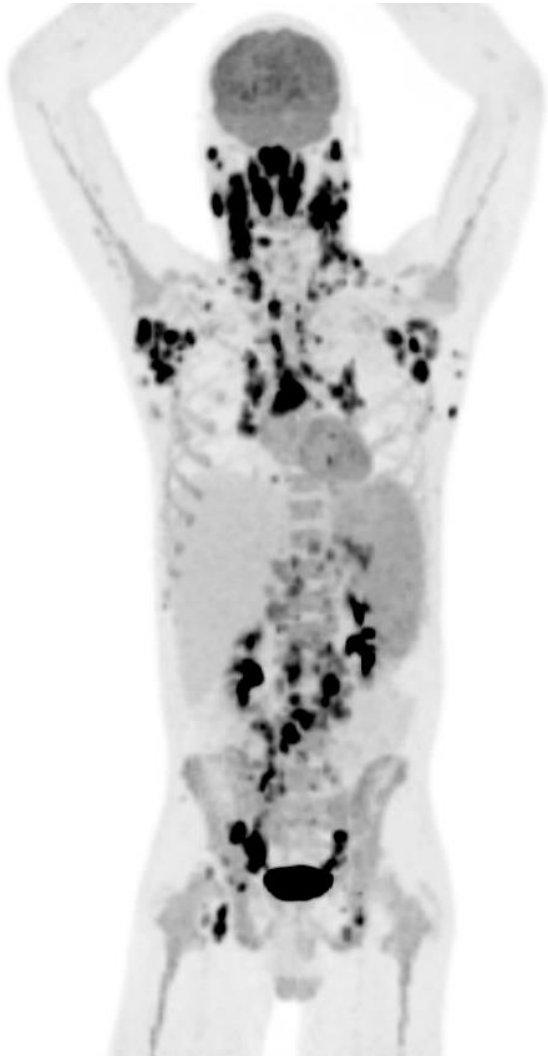
How Does EBV Contribute to Pathogenesis of DLBCL?



Case Report: EBV+ DLBCL

- **31 yo man with HIV (on cART) presented with:**
  - 60# weight loss
  - Fevers
  - Diffuse bulky lymphadenopathy
  - PET scan
  - Biopsy non GC CD30+ EBER+ DLBCL.

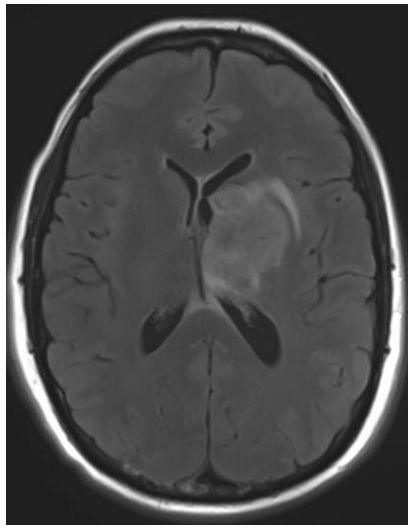


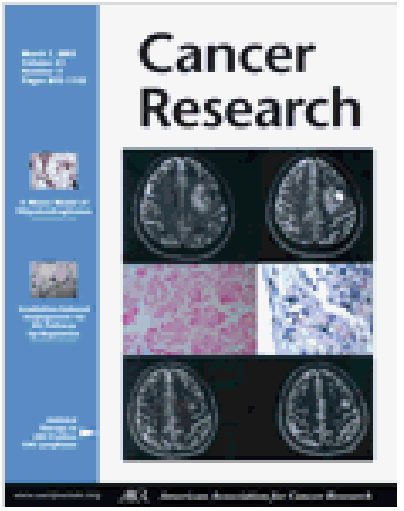


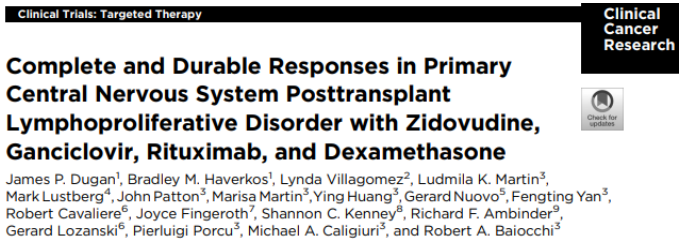
Case Report: EBV+ DLBCL

- R-EPOCH. Progressed after 2 cycles (primary refractory disease).
- Respiratory failure: Salvage therapy RICE x 1 cycle
- Continued with 4 cycles R-GDP
- CNS lymphoma w large frontal lobe mass, Bx = EBV+ DLBCL
- R-HD MTX x 2 cycles with disease progression
- Bridged to CD19 CAR-T (yescarta)
- Developed CRS and MRI with disease progression
- GARD regimen (Dugan et al Clin Ca Res 2018)
    - GCV, AZT, Rituximab, Dexamethasone
    - 5 fractions palliative XRT w rationale XRT induces EBV kinase expression (Roychowdhury et al. Ca Res, 2003, Westphal et al, Cancer Res 2000)
- 30 day post GARD MRI improved
- Continued on AZT/GCV
- 90day post GARD MRI continues to improve c/w PR.
- Recently started on ibrutinib maintenance with ASCT

•Two additional patients with R/R EBV+ plasmablastic lymphoma treated with low dose XRT + GARD achieved CRs







EBV Positive DLBCL as a Unique Entity

Summary

- EBV-positive DLBCL is now a recognized histologic subtype of large B cell lymphoma (5th Edition WHO Classification of lymphoid neoplasms 2022).
- EBV-positive DLBCL is clinically more aggressive.
- EBV-positive DLBCL is associated with distinct biologic features (epigenetic, MYC activation, somatic mutational profile/M-CHIP, PDL1 amplification, CD30.
- Most studies showed inferior outcome of EBV-positive DLBCL vs EBV-negative DLBCL treated with R-CHOP (Parks et al, Blood) or R-EPOCH (Dunleavy et al, Blood)
- The majority of EBV positive DLBCL belong to the non-GC subtype, which is a subtype with poor prognosis. EBV+ PBL is also associated with a poor prognosis.

EBV Positive DLBCL as a Unique Entity

Future Considerations

- *From a regulatory standpoint, should the efficacy of a new therapy targeting EBV+ DLBCL (like Nana-val) be compared to the SoC in all forms of DLBCL, the ABC subtype or EBV+ DLBCL?*
  - *Consider discussion with the Agency on EBV+ DLBCL as a unique entity*

- *Can we make the case that EBV+ DLBCL is not adequately treated by current SoC?*
  - *Initiative to collect real world evidence underway*

Nana-val:
R/R EBV+ DLBCL Data

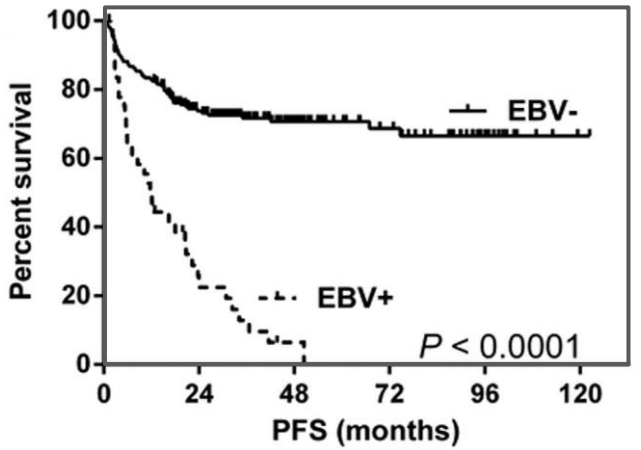
EBV+ DLBCL Has a Significantly Worse Prognosis Compared to EBV- DLBCL

Recognized as a unique subtype of DLBCL with its own classification by the World Health Organization

- **DLBCL is the most common lymphoma (~25% of all NHLs)**
  - ~5-15% of DLBCL cases are associated with EBV
  - 5-year relative survival rate of ~64% overall
  - Poor survival in R/R disease, current treatments offer modest response in 3L

- **EBV+ DLBCL is a clinically more aggressive subtype of DLBCL**
  - Survival rate is significantly less compared to EBV- disease
  - Poor response/survival with standard immuno-chemotherapy
  - Associated with distinct biologic features and mutational landscape
  - Currently, no approved treatment options specifically targeting EBV+ DLBCL

Diffuse Large B-cell Lymphoma
(Progression-Free Survival)



NHL: Non-Hodgkin's lymphoma, Source: Charles River Associates Primary Research 2023

NAVAL-1: Pivotal Phase 2 Trial in Patients with R/R EBV+ Lymphomas

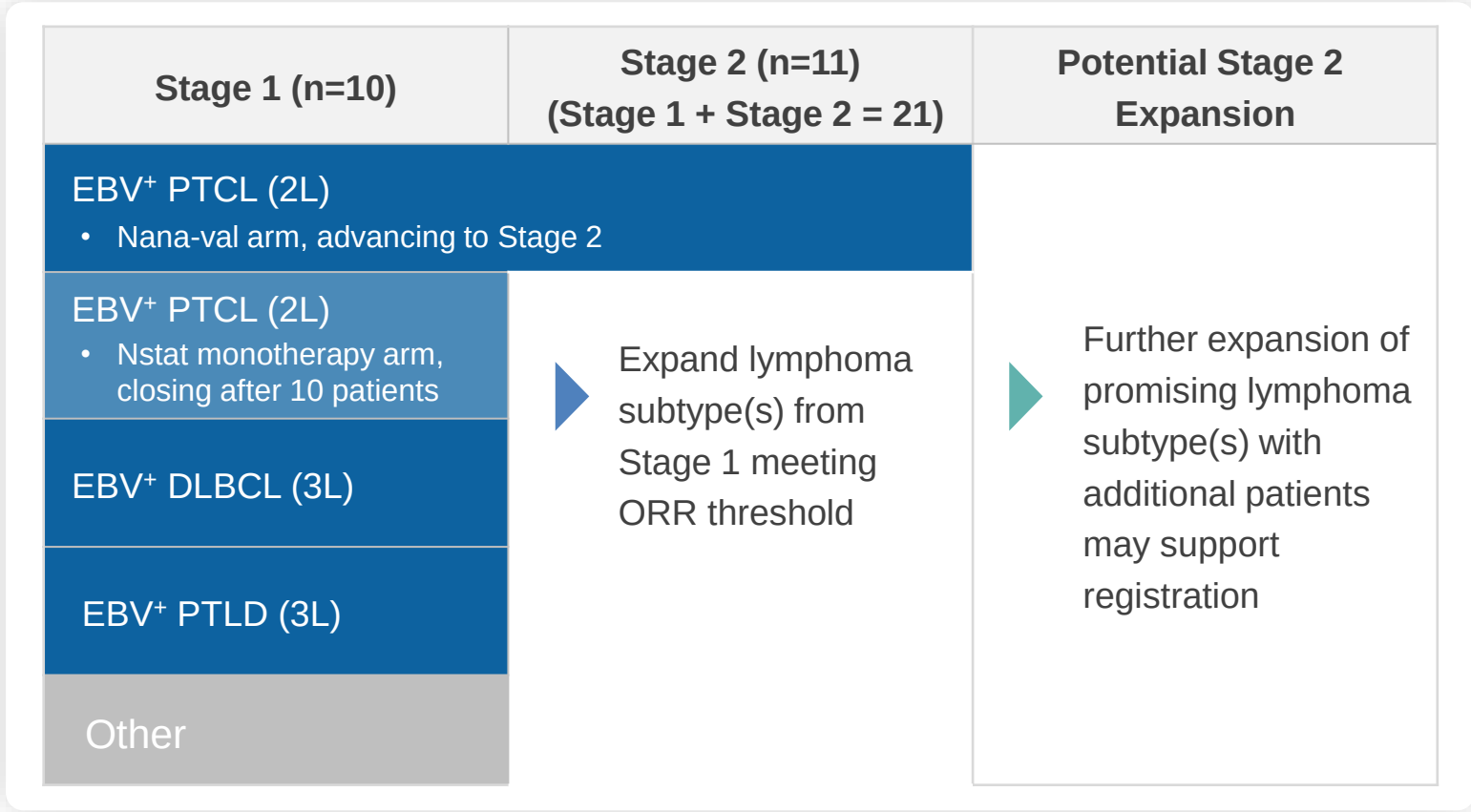
Global study, with an adaptive Simon 2-stage design, focused on the largest EBV-positive lymphoma patient populations, with high unmet medical need and positive Study 201 clinical data

Patient population:

- R/R EBV+ lymphoma with ≥2 prior therapies and no curative options (≥1 prior therapy for PTCL)

Primary endpoint:

- Objective response rate (ORR) by independent central review
- Potential to further expand indications with promising antitumor activity after Stage 2



R/R: Relapsed or Refractory; 2L Second-Line; 3L:Third-Line

R/R EBV+ DLBCL Lymphoma: Expanded Clinical Response Data (1)

ORR maintained at 67% with half of responders achieving complete response

New

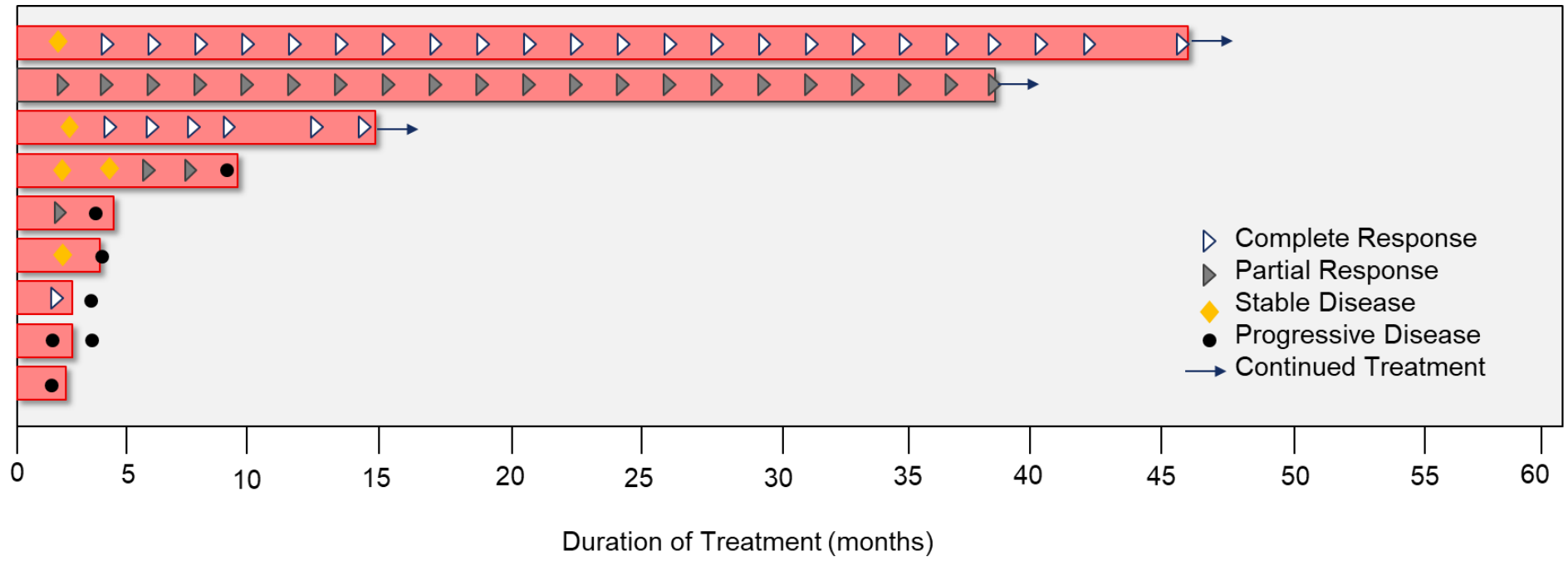
	Study 201 Capsule Data[1] (n=7)		Study 201 Tablet Data (n=3)		Study 201 Capsule + Tablet Data[2] (n=10)
	Evaluable Patients[3] (n=6)		Evaluable Patients[3] (n=3)		Evaluable Patients[3] (n=9)
Response					
ORR	**4 (67%)**	+	**2 (67%)**	=	**6 (67%)**
CR	**2 (33%)**		**1 (33%)**		**3 (33%)**
PR	2		1		3
SD	1		0		1
PD	1		1		2
Clinical Benefit Rate	5 (83%)		2 (67%)		7 (78%)
Data Cutoff	October 28, 2021		May 4, 2023		May 4, 2023

[1]Data published in *Blood Advances* 2023; [2]Data submitted to HEMO 2023; [3]Evaluable patients: EBER-ISH+ with ≥1 post-treatment response assessment; ORR: Overall Response Rate, CR: Complete Response, PR: Partial Response, SD: Stable Disease, PD: Progressive Disease, Clinical Benefit Rate = CR + PR + SD ≥ 6 months

R/R EBV+ DLBCL Lymphoma: Expanded Clinical Response Data (2)

Median duration of response not yet reached, as responding patients remain on study treatment*

New



- Median **Duration of Response** (DoR) not yet reached — 3 responding patients remain on study treatment with DoRs of ~11 months (CR), ~37 months (PR), and ~42 months (CR) (as of May 2023)

Data cutoff: May 4, 2023

Anticipated Program Milestones*

Data Presentation | Key Update

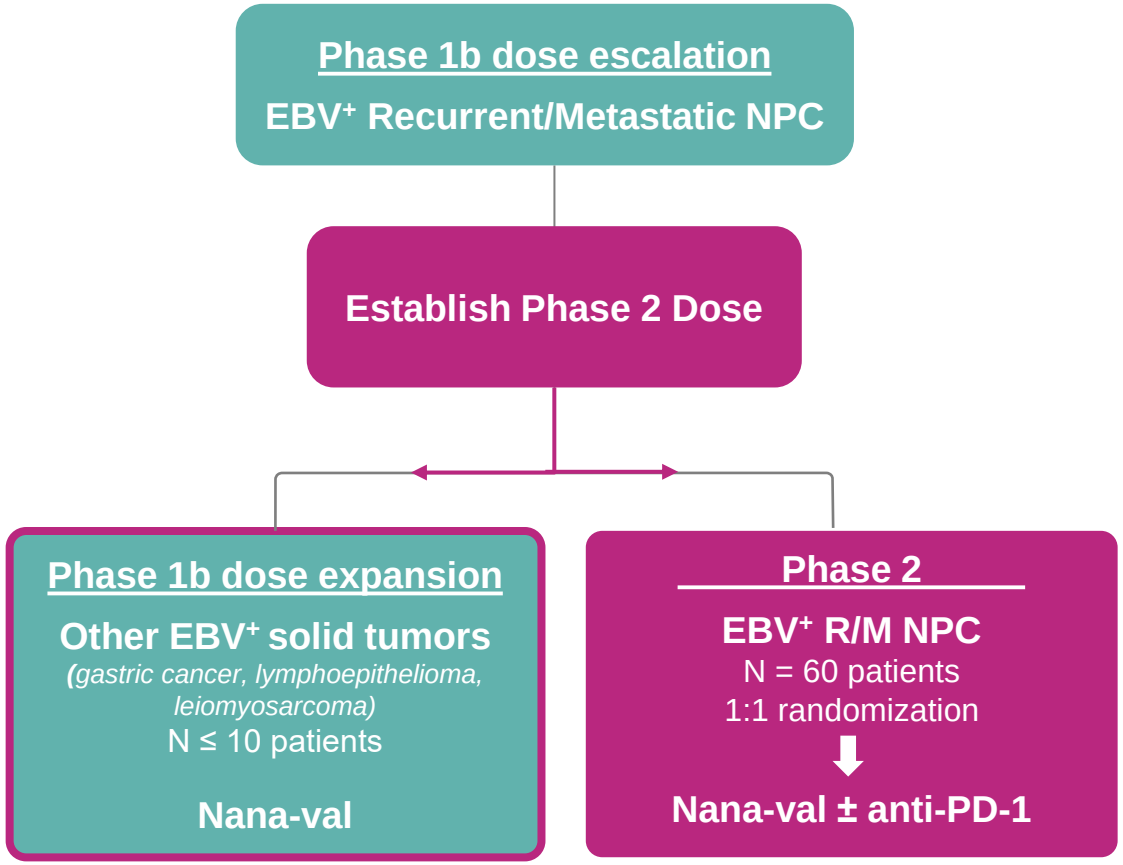
	Indication	2023	2024		2025		
NAVAL-1 (EBV+ Lymphoma)	DLBCL	201: Expanded ORR & DoR **DATA**	Potential Advancement into Stage 2	Present Stage 1 **DATA**	Complete enrollment of Stage 2	Meet with FDA & align on potential AA pathway	Present Stage 2 **DATA**

*Placement on calendar year does not denote specific timing, **R&D Day scheduled for October 4, 2023, AA: Accelerated Approval, LPI: Last Patient In, ORR: Overall Response Rate, DoR: Duration of Response

Nana-val:
Advanced EBV+ Solid Tumor Program

Nana-val Study “301”: Phase 1b/2 Trial in Advanced EBV+ Solid Tumors

Open-label, multicenter study to evaluate the safety, tolerability, PK, and preliminary antitumor activity of Nana-val in patients with advanced EBV+ solid tumors



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Endpoints:

- Primary:
  - Phase 1b: Incidence of dose-limiting toxicities
  - Phase 2: Overall response rate by RECIST v1.1
- Key Secondary:
  - Incidence and severity of AEs
  - Duration of response
  - Progression-free survival
  - Pharmacokinetic parameters

RECIST: Response Evaluation Criteria in Solid Tumors; AE: Adverse Event

R/M EBV+ NPC Initial Responses from Phase 1b Dose Escalation

First response confirmed at Dose Level 3

Dose Level	Nstat Oral Dose (Days 1-4/wk)	VGCV Oral Dose	N	Best Response
1	20 mg QD	900 mg QD	3	● ● ○
2	30 mg QD	900 mg QD	4	○ ○ ○ ○
3	40 mg QD	900 mg QD	3	● ○ NE

Started at RP2D for R/R EBV+ lymphoma

First response at 40 mg Nstat

- Partial response observed at Dose Level 3
- Dose Level 3 response is ongoing and durable, >6.9 months on treatment*

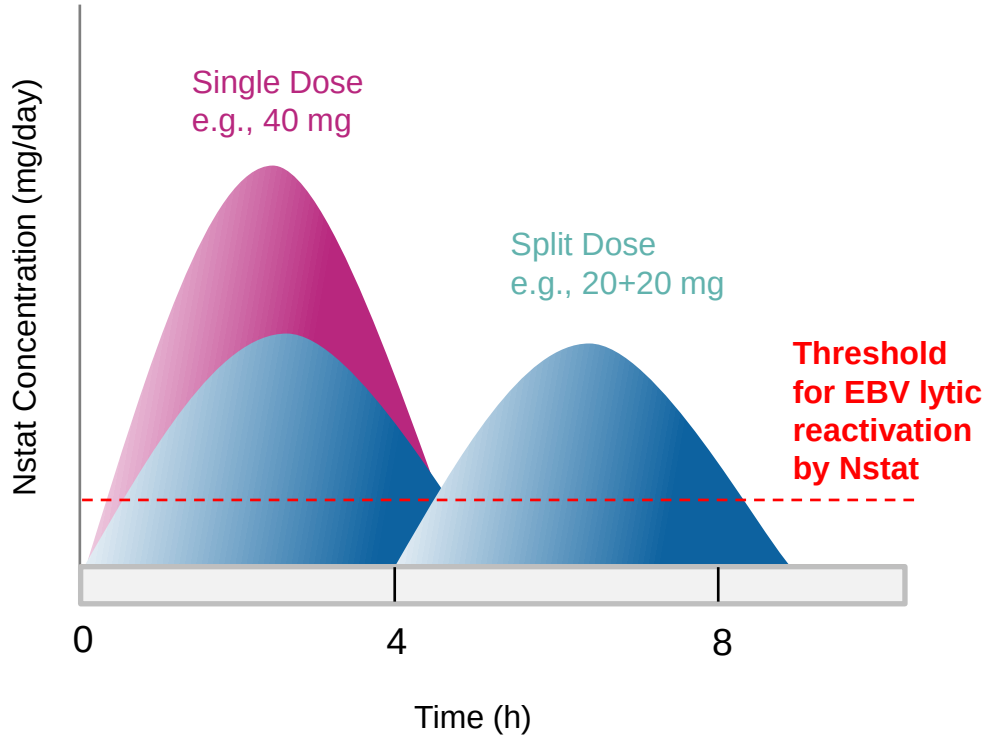
● Partial Response
● Stable Disease
○ Progressive Disease

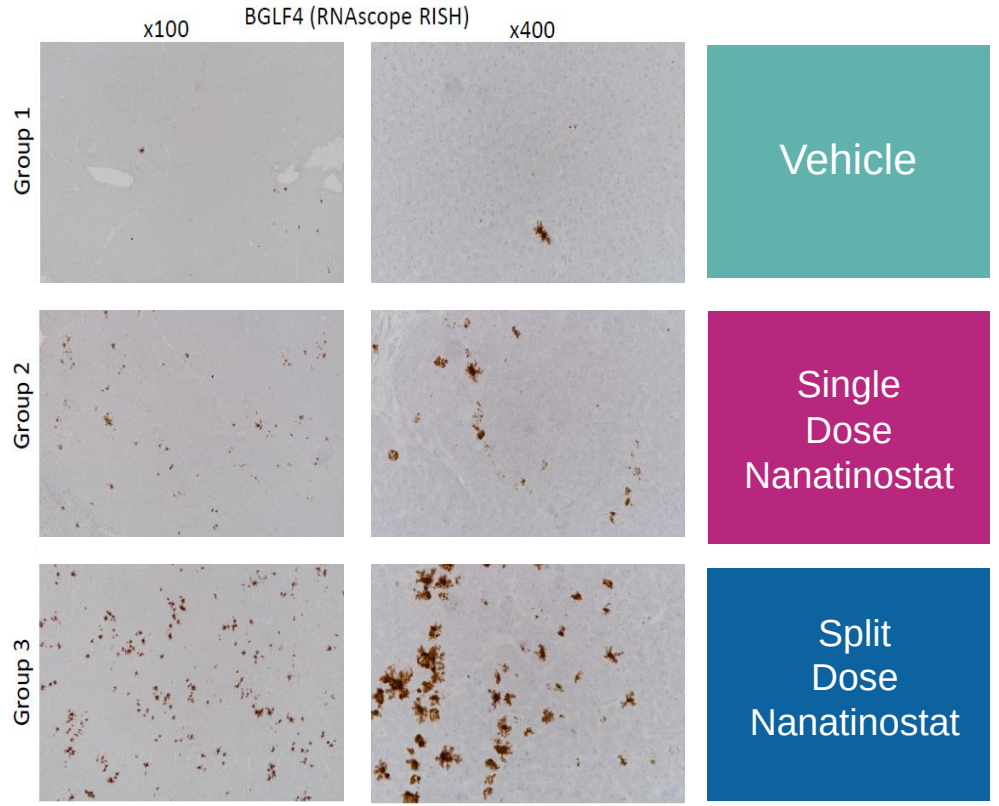
*As of July 28, 2023, NE: Not evaluable for response, R/M: Recurrent/Metastatic, R/R: Relapsed or Refractory; QD: Once a day; BID: Twice a day

New

Eight Hours Exposure to Nanatinostat Required for EBV Lytic Reactivation in Solid Tumors

Expression of EBV protein kinase (BGLF4) was markedly higher in animals treated with split dose Nstat



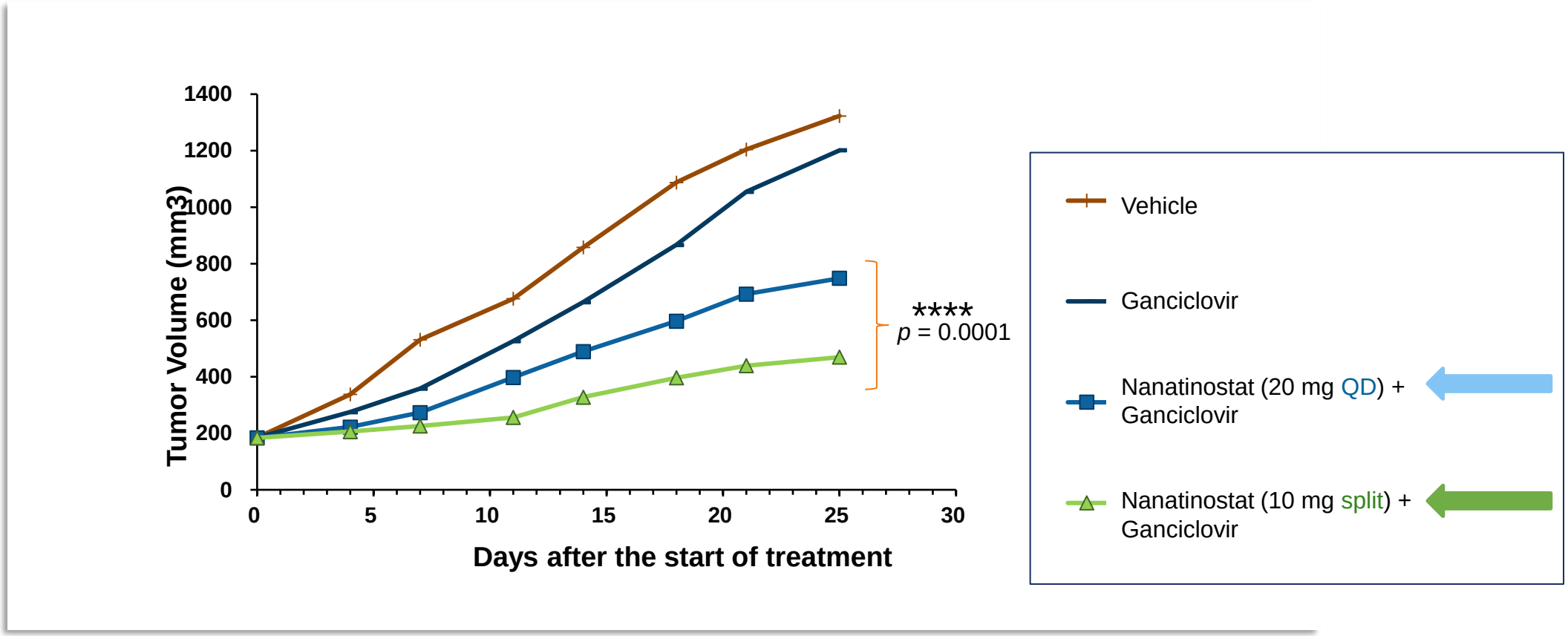


Data on file

New

Split Dosing Augments the Anti-Tumor Activity of Nana-val in Xenograft Model

Anti-tumor activity of SNU-719 subcutaneous xenograft model in B-NDG mice



Data on file

R/M EBV+ NPC Responses to Date and Phase 1b Dose Escalation Schedule

Emerging evidence of dose response at higher doses and promise of split dosing approach

Dose Level	Nstat Oral Dose (Days 1-4/wk)	VGCV Oral Dose	N	Best Response
1	20 mg QD	900 mg QD	3	● ● ○
2	30 mg QD	900 mg QD	4	○ ○ ○ ○
3	40 mg QD	900 mg QD	3	● ○ NE
4	10 mg split dose	900 mg BID x 21 d, then QD	3	● ○ ○
5	20 mg / 10 mg split dose	900 mg BID x 21 d, then QD	4	● ● ● ○

New

No responses observed at 30 mg QD dose of Nstat

Responses observed at 30 mg split dose of Nstat

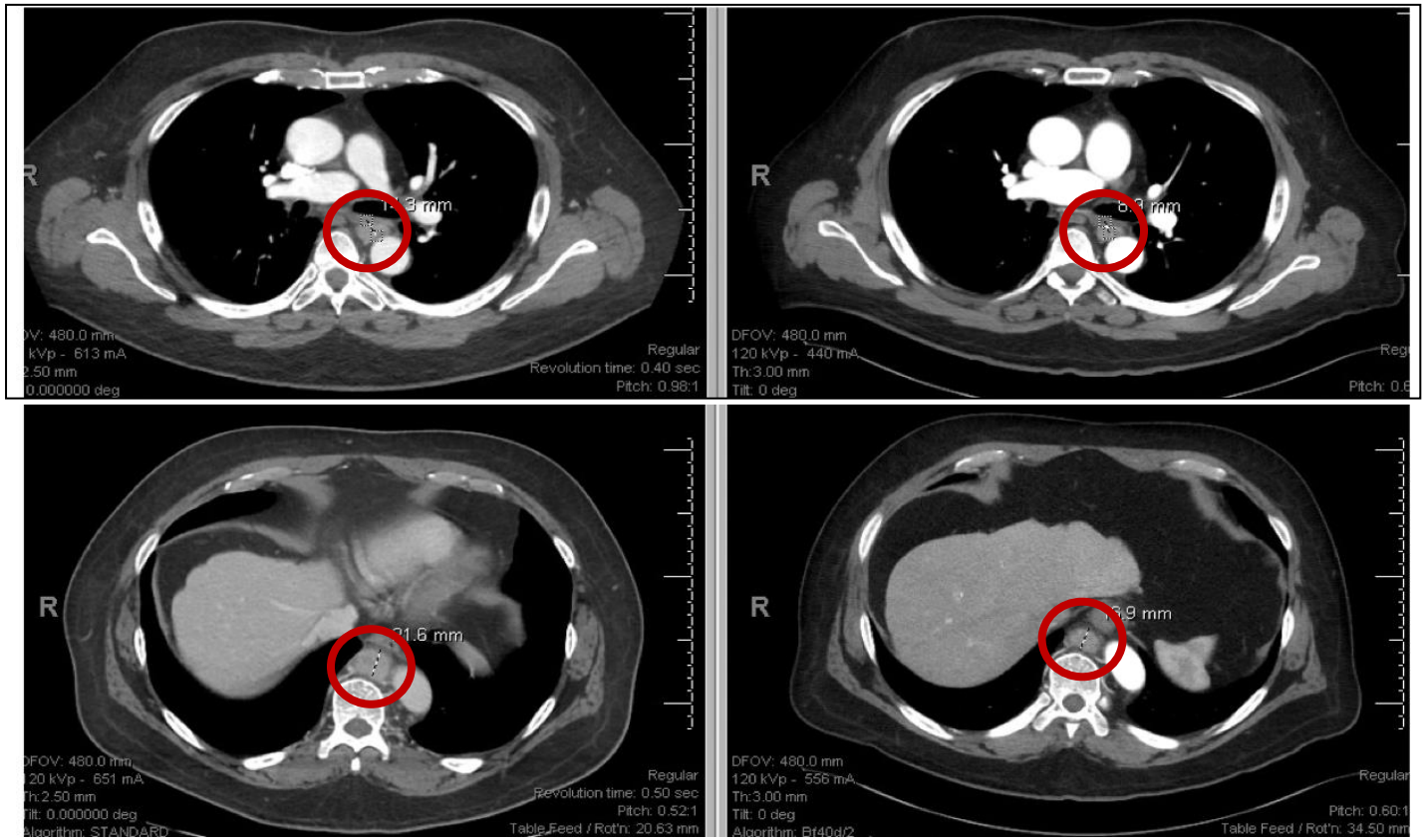
- Partial responses observed at Dose Level 3 and Dose Level 5* suggesting a dose response relationship
- Responses observed at Dose Level 5 but not at Dose Level 2, supporting clinical benefit of split dosing approach

● Partial Response
● Stable Disease
○ Progressive Disease

*Dose Level 5 PR awaiting confirmation, NE: Not evaluable for response, R/M: Recurrent/Metastatic, R/R: Relapsed or Refractory; QD: Once daily; BID: Twice daily

Study 301: CT Scan of Partial Response at Dose Level 5

~40% reduction in tumor size at 8 weeks



Baseline Week 8

- 56-year-old male with R/M EBV^{+} NPC (posterior mediastinal and midline retroperitoneal lymphadenopathy)
- Disease previously progressed through chemoradiation therapy then chemoimmunotherapy

Nana-val has been Generally Well-Tolerated at all Dose Levels

Preliminary safety data support continued dose escalation to determine RP2D

New

Treatment-Related Adverse Events in ≥3 Patients

Dose Level 1 = RP2D for R/R Lymphoma

	Dose Level 1 (n=3)		Dose Level 2 (n=4)		Dose Level 3 (n=3)		Dose Level 4 (n=3)		Dose Level 5 (n=4)	
	G1-2	G3-4	G1-2	G3-4	G1-2	G3-4	G1-2	G3-4	G1-2	G3-4
Nausea	1		2		2		1		1	
Decreased appetite	1		1		1		2		2	
Creatinine increased	1		2						2	
Fatigue	1		2			1	1			
Anemia	1		1							1
Lymphopenia			1				1	1		
Vomiting					2		1			

Safety:

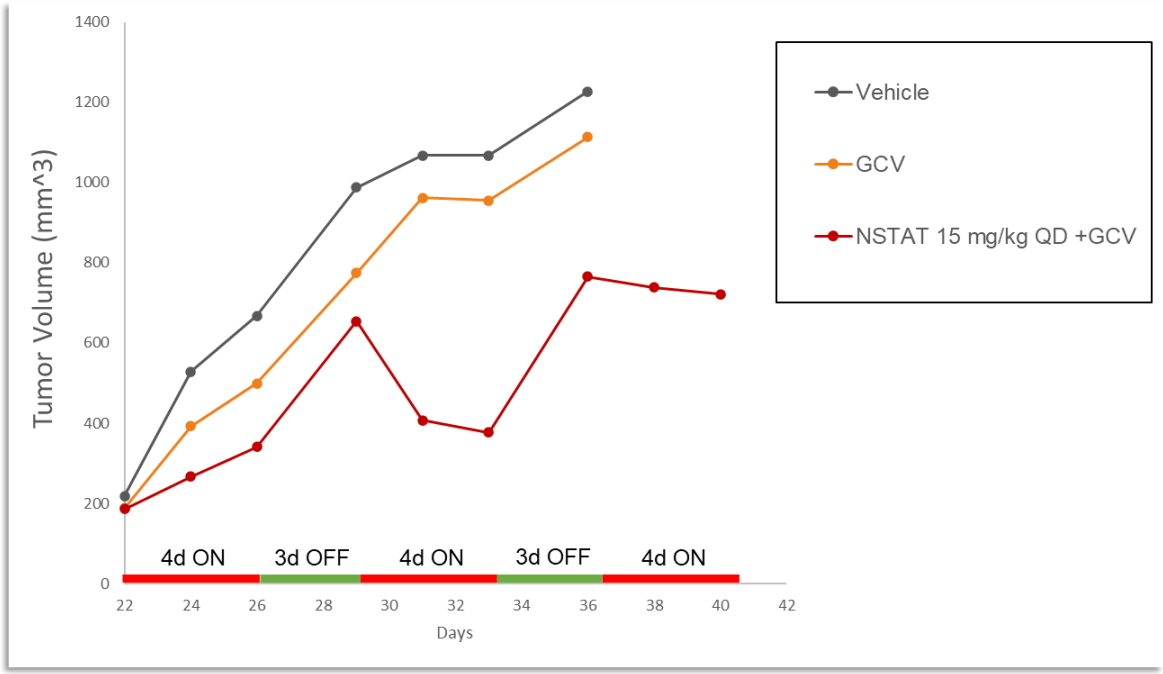
- No dose-limiting toxicities reported to date
- Majority of treatment-related adverse events were mild to moderate in severity

RP2D: Recommended Phase 2 Dose; R/R: Relapsed or Refractory

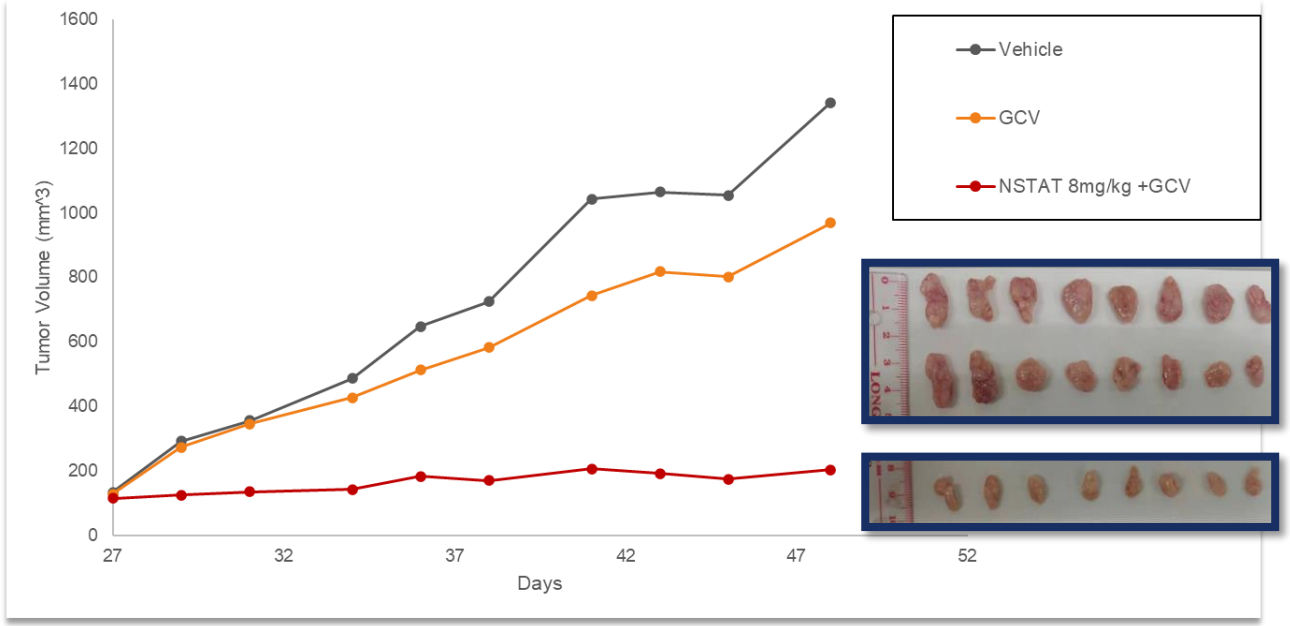
New

Dosing Schedule of 4 Days ON/3 Days OFF Allows Solid Tumor Regrowth but Daily Dosing Renders Potent Anti-Tumor Activity in Xenograft Model

4 Days ON/3 Days OFF



Daily Dosing



Data on file

Rationale for Split Daily Dosing (SDD) of Nanatinostat in Combination with Valganciclovir

Compelling preclinical data provides supporting evidence to evaluate a new dosing regimen

Split dose

(2-4 hours apart) increases expression of EBV protein kinase, BGLF4

Split dose

Significantly increased the anti-tumor activity of Nana-val in murine EBV^{+} gastric cancer xenograft model

Daily dosing

Enables increased anti-tumor activity relative to 4 days on 3 days off

Higher doses

Safety data suggest patients with NPC can withstand higher doses of nanatinostat compared to lymphoma patients

New

SDD of Nanatinostat offers a potential to extend Nana-val patent portfolio with differentiated strategy from lymphoma; US provisional application(s) have been filed

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New

Planned Incorporation of Split Daily Dosing (SDD) Strategy into Phase 1b Study

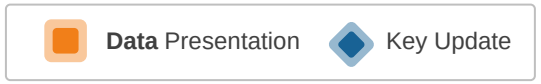
Up to 3 additional dose levels planned to determine RP2D

Dose Level	Nstat Oral Dose	VGCV Oral Dose	N	Best Response
1	20 mg QD (4 days/wk)	900 mg QD	3	🟡 🟡 ◯
2	30 mg QD (4 days/wk)	900 mg QD	4	◯ ◯ ◯ ◯
3	40 mg QD (4 days/wk)	900 mg QD	3	🟢 ◯ NE
4	10 mg split dose (4 days/wk)	900 mg BID x 21 d, then QD	3	🟡 ◯ ◯
5	20 mg / 10 mg split dose (4 days/wk)	900 mg BID x 21 d, then QD	4	🟢 🟡 🟡 ◯
6	**20 mg / 20 mg SDD**	**450 mg / 450 mg SDD**		
7	**30 mg / 30 mg SDD**	**450 mg / 450 mg SDD**		
8	**40 mg / 40 mg SDD**	**450 mg / 450 mg SDD**		

🟢 Partial Response
🟡 Stable Disease
◯ Progressive Disease

NE: Not evaluable for response, QD: Once daily; BID: Twice daily

Anticipated Program Milestones*



	Indication	2023	2024	2025
Study 301 Ph1b/2 (EBV+ Solid Tumors)	NPC	Present preliminary Phase 1b DATA; Disclose SDD dosing strategy	Complete Phase 1b dose escalation; Determine RP2D; Present final Phase 1b DATA; Initiate Phase 2 (+/- anti-PD-1)	Meet with FDA & align on potential AA pathway; Present preliminary Phase 2 DATA
	GC		Initiate Exploratory Phase 1b Study	Present preliminary Phase 1b GC DATA; Initiate Phase 2 Study

*Placement on calendar year does not denote specific timing, AA: Accelerated Approval, SDD: Split Daily Dosing, RP2D: Recommended Phase 2 Dose

Nana-val:
Lymphoma Market Opportunity

US Incidence Estimates for EBV+ Hematological Malignancies

Incidence and % EBV Positivity by Lymphoma Subtype				
Subtype	**Annual (newly diagnosed)**	**R/R**	**Total**	**EBV Positivity**
Peripheral T-cell lymphoma (PTCL)*	~2,600	~1,100	~3,600	40%-65%
Diffuse large B-cell lymphoma (DLBCL)	~27,700	~13,800	~41,500	5%-15%
PTLD	~1,300	~700	~2,000	60%-80%

We believe the diagnosed incidence of EBV-associated hematological malignancies is likely understated, given inconsistent testing due to the absence of a targeted and actionable therapy

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Tessellon epi estimates 2022: US. *PTCL includes AITL and PTCL,NOS

Global Incidence Estimates for Priority EBV+ Hematological Malignancies

Nana-val has the potential to address other EBV+ hematological malignancies

Incidence and % EBV Positivity by Lymphoma Subtype				
Subtype	**Annual (newly diagnosed)**	**R/R**	**Total**	**EBV Positivity**
Peripheral T-cell lymphoma (PTCL)*	~15,200	~6,300	~21,500	40%-65%
Diffuse large B-cell lymphoma (DLBCL)	~113,000	~56,000	~169,000	5%-15%
PTLD	~9,100	~4,600	~13,700	60%-80%

We believe the diagnosed incidence of EBV-associated hematological malignancies is likely underestimated, given inconsistent testing due to the absence of a targeted and actionable therapy

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Source: Tessellon epi estimates 2022: US, Canada, EU5, Benelux, Brazil, Japan, China, South Korea, Taiwan *PTCL includes AITL and PTCL,NOS

Summary of Key Growth Drivers for Nana-val in Lymphoma

High unmet need, targeted treatment, compelling efficacy and duration data will drive strong value

	PTCL	DLBCL	PTLD
Pricing Considerations (Unmet Need)	No standard of care for second line Low 5-year survival (11%) Strong preliminary Nana-val data	Separate EBV+ WHO classification Low 5-year survival Strong preliminary Nana-val data	Ebvallo may set a high price
Line of Therapy	Potential 2L → 1L	Potential 3L → 2L	Potential 3L → 2L
Duration of Response (DOR)	Current therapies: 4-8 months** Nana-val: 17.3 months*	DoR >12 months considered clinically meaningful** DoR for Nana-val not yet calculated, multiple patients still on long-term therapy (ranging from 11-42 months)*	DoR TBD, early data encouraging
Market Penetration	Effective, well tolerated, targeted, easy to use product (outpatient oral therapy). Can drive high penetration		
EBV Testing Rate Today**	++++	++ Opportunity to drive awareness	++++

Viracta's clinical development footprint is designed to support global registration and market access

*Submitted to HEMO 2023, Juliana Pereira, **Charles River Associates Primary Research 2023

Closing Remarks

Conclusion on Key Data and Insights

- **Lead Program EBV$^+$ PTCL**
  - High unmet medical need, no approved therapies for R/R PTCL* or EBV$^+$ PTCL
  - Pivotal NAVAL-1 trial preliminary ORR/CRR data of 40%/40% consistent with previous Study 201 data
  - Long median duration of response of >17 months

- **EBV$^+$ DLBCL**
  - EBV$^+$ DLBCL is a unique entity and an area of high unmet medical need
  - Additional Study 201 response data showed ORR/CRR remained 67%/33%
  - Long duration of response, patients on therapy for ~4 years (mDoR not yet reached)

- **EBV$^+$ Advanced Solid Tumors**
  - New interim clinical data suggestive of emerging dose response, 2 PRs & 5 SDs in 17 patients with R/M EBV$^+$ NPC
  - Opportunity to optimize RP2D by dose escalating further with an innovative split daily dosing regimen supported by new preclinical data

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*PTCL includes PTCL,NOS and AITL

Anticipated Program Milestones*

Data Presentation | Key Update

	Indication	2023	2024	2025
NAVAL-1 (EBV+ Lymphoma)	PTCL	Initial Stage 1 ORR **DATA**	Complete enrollment of Stage 2; Meet with **FDA** & align on potential AA pathway; Initiate Registration Phase; Present Stage 2 **DATA**	Registration Phase LPI
	DLBCL	201: Expanded ORR & DoR **DATA**	Potential Advancement into Stage 2; Present Stage 1 **DATA**	Complete enrollment of Stage 2; Meet with **FDA** & align on potential AA pathway; Present Stage 2 **DATA**
	PTLD		Potential Advancement into Stage 2; Present Stage 1 **DATA**	Complete enrollment of Stage 2; Meet with FDA & align on potential AA pathway; Present Stage 2 **DATA**
Study 301 Ph1b/2 (EBV+ Solid Tumors)	NPC	Present preliminary Phase 1b **DATA**; Disclose SDD dosing strategy	Complete Phase 1b dose escalation; Determine RP2D; Present final Phase 1b **DATA**; Initiate Phase 2 (+/- anti-PD-1)	Meet with **FDA** & align on potential AA pathway; Present preliminary Phase 2 **DATA**
	GC		Initiate Exploratory Phase 1b Study	Present preliminary Phase 1b GC **DATA**; Initiate Phase 2 Study

*Placement on calendar year does not denote specific timing, **R&D Day scheduled for October 4, 2023, AA: Accelerated Approval, LPI: Last Patient In, ORR: Overall Response Rate, DoR: Duration of Response, SDD: Split Daily Dosing, RP2D: Recommended Phase 2 Dose

Q&A

Thank You