Viracta Therapeutics, Inc.

Key Opinion Leader Webinar on Nana-val for the Treatment of Advanced EBV$^+$ Solid Tumors

April 27, 2022

Precision Oncology for Virus-Associated Cancers

NASDAQ: VIRX | WWW.VIRACTA.COM

viracta

Introduction:

Dr. Ivor Royston

President and Chief Executive Officer

Forward Looking Statements

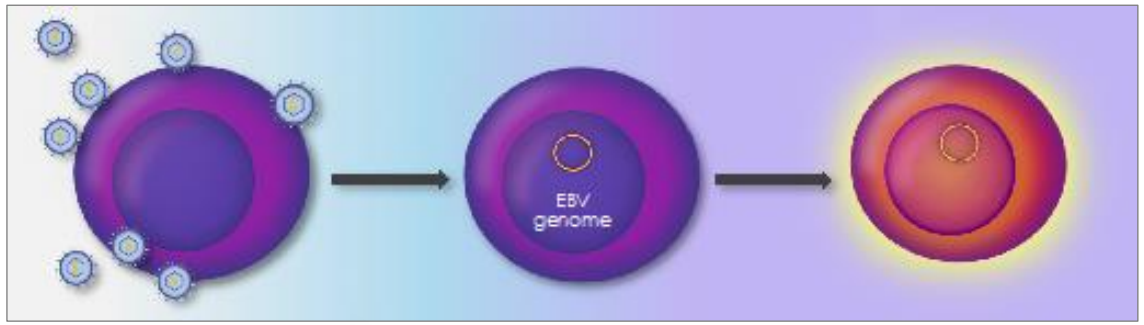
This communication contains "forward-looking" statements within the meaning of the Private Securities Litigation Reform Act of 1995, which are based on current expectations, estimates and projections based on information currently available to management of Viracta Therapeutics, Inc. (“Viracta” or the “Company”), including, without limitation, statements regarding: Viracta’s development pipeline, 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 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 cancers globally, currently no approved therapies

- ~ 90% of the adult population is infected w/ EBV
- Persists as a life-long latent infection, remaining dormant within cell nuclei
- Latency confers resistance to anti-viral therapies and facilitates evasion of immune detection
- Linked to a variety of cancers
  - ~310,000 new cases/year of lymphoma, NPC and GC
- Poor prognosis, no approved therapies
- Responsible for ~180,000 cancer deaths/year*



EBV infects cells

Latent infection established in subset of cells

Latently infected cells can continue to proliferate, evade immune detection, and become malignant

Source: Wu L, et al. Exp. Therapeutic Med. 15: 3687, 2018; Kahn, G, et al. BMJ 10:1136, 2020. NPC: Nasopharyngeal carcinoma; GC: Gastric cancer

Today's Topics and Speakers

Introduction

Ivor Royston, MD
President and Chief Executive Officer, Viracta

Nasopharyngeal Carcinoma Treatment Landscape

Ezra Cohen, MD, FRCPSC, FASCO
Chief of Hematology/Oncology and Co-director of the Gleiberman Head and Neck Cancer Center, UCSD

Nana-val MOA and its Potential in Advanced EBV$^+$ Solid Tumors

Ayman Elguindy, PhD
Chief Scientific Officer, Viracta

Nana-val Phase 1b/2 Trial in Advanced EBV$^+$ Solid Tumors

Lisa Rojkjaer, MD
Chief Medical Officer, Viracta

A Question and Answer Session with all Speakers will Follow the Formal Presentations

UC San Diego

NPC Treatment Landscape:

Dr. Ezra Cohen
Chief of Hematology/Oncology
Co-director of the Gleiberman Head and Neck Cancer Center

Nasopharyngeal Carcinoma: Current State and Medical Needs

NCI CCC
A Comprehensive Cancer Center Designated by the National Cancer Institute

Ezra E.W. Cohen, MD

UC San Diego
Moores Cancer Center

NPC EPIDEMIOLOGY

- Relatively rare in non southern Chinese populations: overall worldwide incidence rate is < 1 case per 100,000 person years
- Highest rates are in Hong Kong and among central region of Guangdong province in Southern China: incidence rate 20 – 50 per 100,000 person years

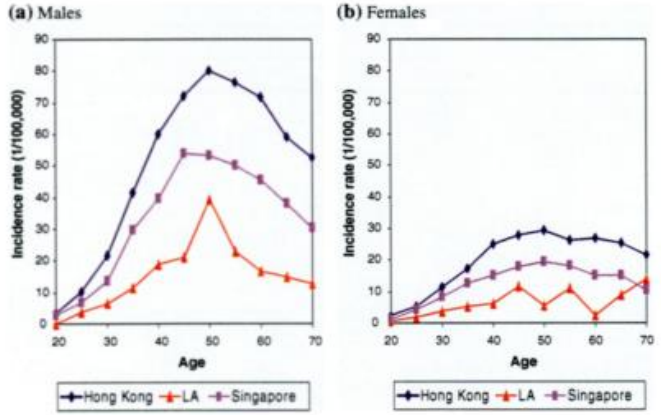


Fig. 1 Age-specific rates of NPC for combined periods among three different Chinese populations, (a) Males; (b) Females

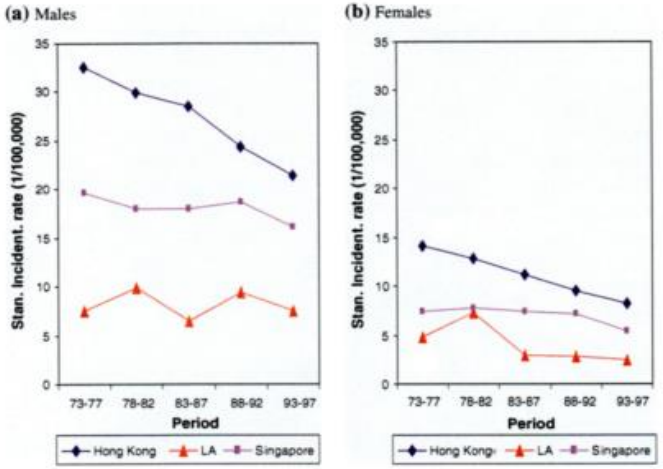
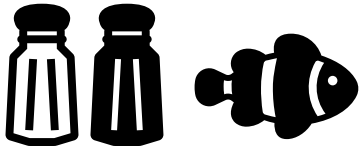


Fig. 2 Age-adjusted incidence rates of NPC in different Chinese populations, (a) Males; (b) Females

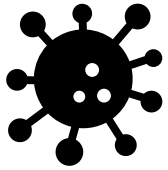
Luo, Juhua, et al. Secular Trends of Nasopharyngeal Carcinoma Incidence in Singapore, Hong Kong and Los Angeles Chinese Populations, 1973–1997. *European Journal of Epidemiology*, vol. 22, no. 8, Springer, 2007, pp. 513–21.

NPC ETIOLOGY

- Risk of NPC in a first-degree family member is as high as 8 times that of the general population
- The majority of first-degree relatives are affected are siblings rather than parents and children
- *HLA-A0207 haplotype?*
- *P16 inactivation?*



- Salted fish, eggs, and vegetables
- Nitrosamines
- Wood dust



- Epstein-barr virus
- Herpesvirus- DNA virus with a capsid
- Non-NPC pts: **IgG** VCA and EA are raised
- NPC pts: **IgA** VCA and EA are raised
- NPC cells express latent EBV proteins: **EBNA-1** and **LMP-1** and normal NP cells do not

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- Risk of NPC in a first-degree family member is as high as 8 times that of the general population
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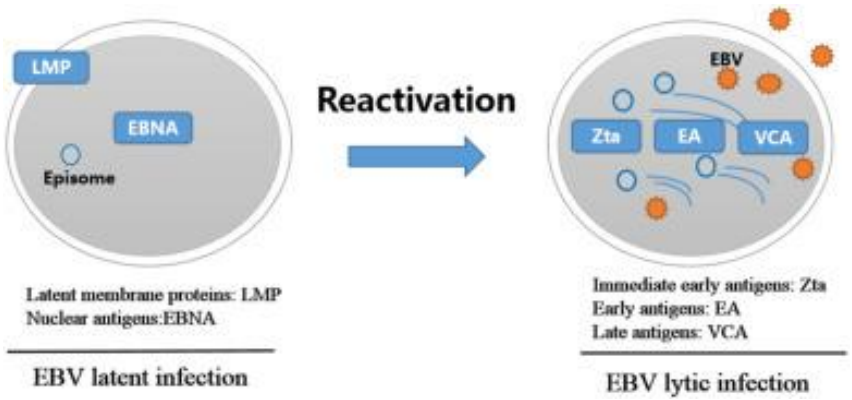

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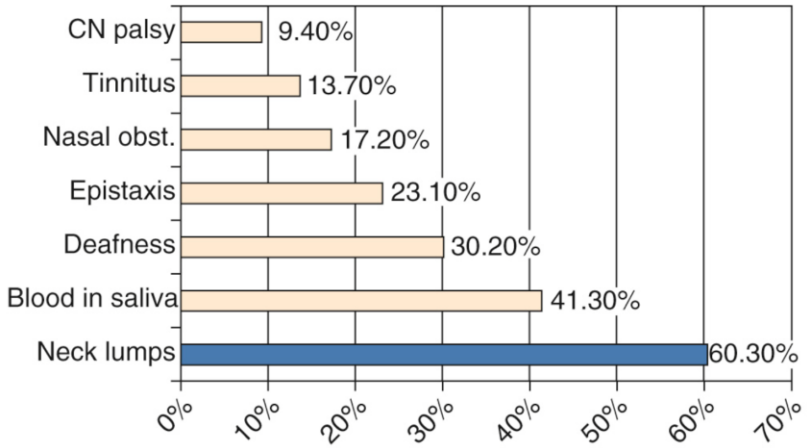
CLINICAL PRESENTATION

Table 1. Presenting symptoms and their frequencies (n=4768)

Symptom	Number of patients		
	Only symptom	First symptom*	Total No. presenting with symptom
	No. (%)	No. (%)	No. (%)
Neck mass	37 (0.8)	1777 (37.3)	3612 (75.8)
Nasal (discharge, bleeding, obstruction)	65 (1.4)	1687 (35.4)	3501 (73.4)
Aural (tinnitus, impairment of hearing)	54 (1.1)	912 (19.1)	2975 (62.4)
Headache	13 (0.3)	175 (3.7)	1657 (34.8)
Ophthalmic (diplopia, squint)	4 (0.1)	48 (1.0)	512 (10.7)
Facial numbness	3 (0.1)	22 (0.5)	361 (7.6)
Weight loss	0	1	329 (6.9)
Trismus	2	2	141 (3.0)
Slurring of speech	0	3 (0.1)	114 (2.4)
Others due to metastatic deposits	0	12 (0.3)	57 (1.2)
Skin lesions due to dermatomyositis	4 (0.1)	6 (0.1)	42 (0.9)

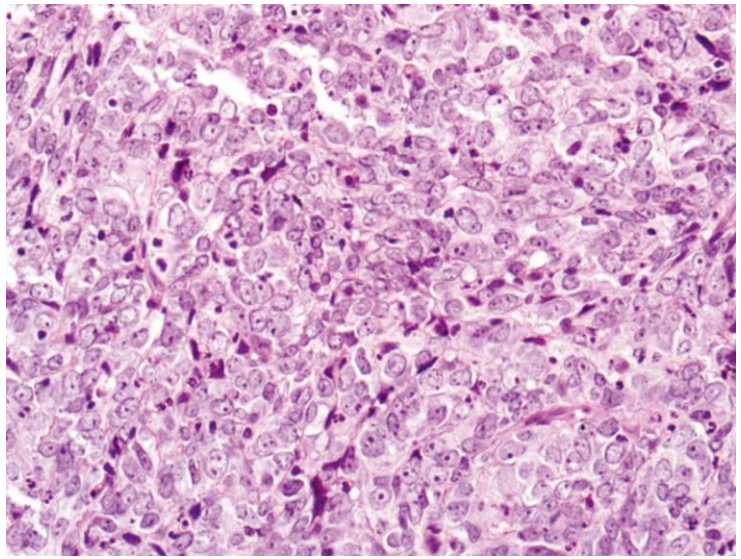
*In patients presenting with multiple symptoms



Nasopharyngeal carcinoma: presenting symptoms and duration before diagnosis.
Lee AW, Foo W, Law SC, Poon YF, Sze WM, O SK, Tung SY, Lau WH.
Hong Kong Med J. 1997 Dec;3(4):355-361.

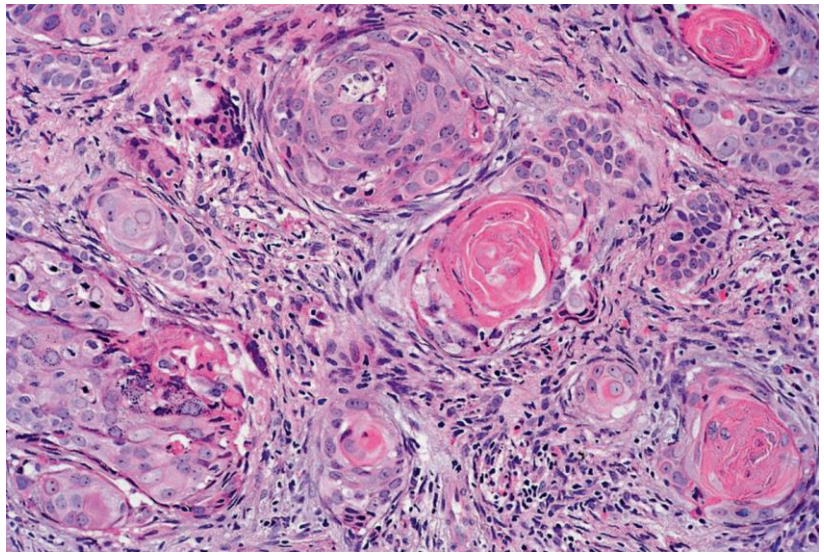
NPC HISTOPATHOLOGY

Nonkeratinizing



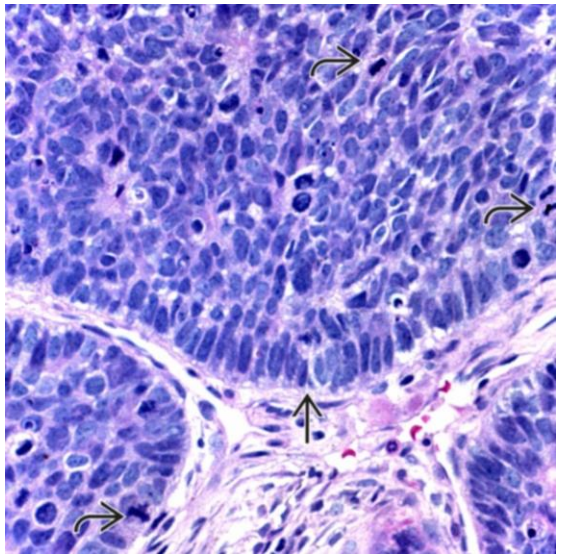
>95% of cases in endemic areas
Loosely cohesive tumor cells
Ill-defined cell borders
Large nuclei
Lymphocytes

Keratinizing



<20% of cases worldwide
Cells grow in nests
Well-defined cell borders
Intercellular bridges
Keratin pearls

Basaloid



Extremely rare
Palisaded basaloid cells

Chemotherapy in Combination With Radiotherapy for Definitive-Intent Treatment of Stage II-IVA Nasopharyngeal Carcinoma: CSCO and ASCO Guideline

Yu-Pei Chen, MD[1]; Nofisat Ismaila, MD[2]; Melvin L. K. Chua, MD PhD[3]; A. Dimitrios Colevas, MD[4]; Robert Haddad, MD[5]; Shao Hui Huang, MD, MRT(T)[6]; Joseph T. S. Wee, MD[3]; Alexander C. Whitley, MD[7]; Jun-Lin Yi, MD[8]; Sue S. Yom, MD[9]; Anthony T. C. Chan, MD[10]; Chao-Su Hu, MD[11]; Jin-Yi Lang, MD[12]; Quynh-Thu Le, MD[4]; Anne W. M. Lee, MD[13]; Nancy Lee, MD[14]; Jin-Ching Lin, MD[15]; Brigette Ma, MD[10]; Thomas J. Morgan, MR[16]; Jatin Shah, MD[14]; Ying Sun, MD[1]; and Jun Ma, MD[1]

PRIMARY SITE

Recommendation 1.1. For all patients with NPC, intensity-modulated radiotherapy (IMRT) with daily image guidance should be offered. If IMRT is unavailable, patients should be transferred to institutions that could implement IMRT whenever possible (Type: evidence based; benefits outweigh harms; Evidence quality: high; Strength of recommendation: strong).

Recommendation 1.3. For all patients with NPC, a prescribed dose of 70 Gy in 33-35 fractions (2.0-2.12 Gy per fraction) delivered over 7 weeks (once daily, 5 fractions per week) should be offered. Radiation dose may be adjusted according to tumor volume and its response to (chemo-) radiotherapy (Type: evidence based; benefits outweigh harms; Evidence quality: high; Strength of recommendation: strong).

Intensity-modulated RT (IMRT) enables delivery of tumoricidal doses of RT to irregular shapes

CHEMOTHERAPY

Chemotherapy Sequence

Recommendation 2.1. For patients with T2N0 (AJCC 8th) NPC, chemotherapy is not routinely recommended, but may be offered if there are adverse features, such as bulky tumor volumes or high EBV DNA copy number (Type: evidence based; harms outweigh benefits; Evidence quality: intermediate; Strength of recommendation: moderate).

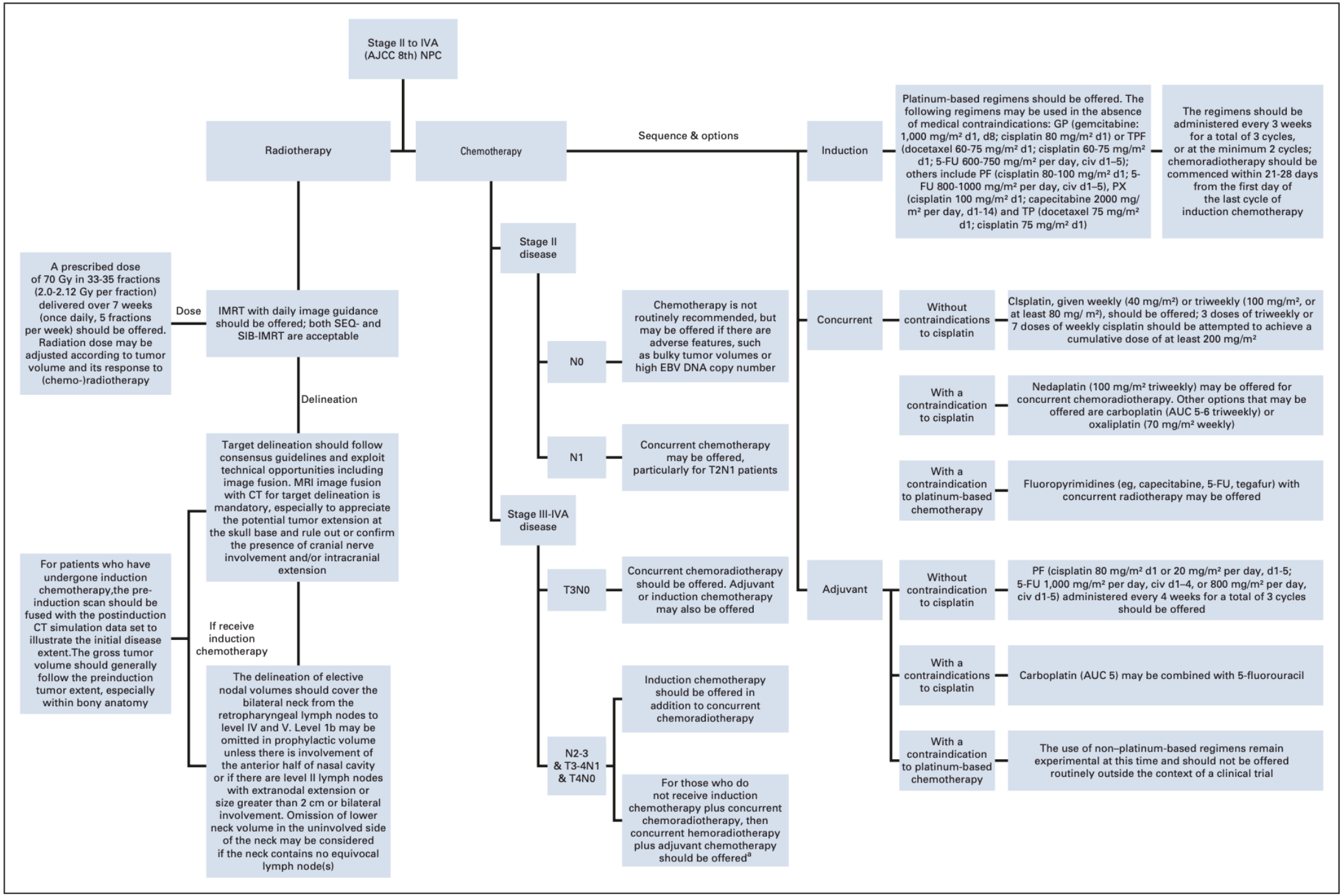
Recommendation 2.2. For patients with T1-2N1 (AJCC 8th) NPC, concurrent chemotherapy may be offered, particularly for T2 N1 patients (Type: evidence based; benefits outweigh harms; Evidence quality: intermediate; Strength of recommendation: moderate).

Recommendation 2.3. For patients with Stage III-IVA (except T3N0) (AJCC 8th) NPC, induction chemotherapy should be offered in addition to concurrent chemoradiotherapy (Type: evidence based; benefits outweigh harms; Evidence quality: high; Strength of recommendation: strong).

Recommendation 2.4. For patients with Stage III-IVA (except T3N0) (AJCC 8th) NPC who do not receive induction chemotherapy plus concurrent chemoradiotherapy, then concurrent chemoradiotherapy plus adjuvant chemotherapy should be offered (Type: evidence based; benefits outweigh harms; Evidence quality: intermediate; Strength of recommendation: moderate).

NOTE. There is a lack of head-to-head trials comparing induction chemotherapy plus concurrent chemoradiotherapy versus concurrent chemoradiotherapy plus adjuvant chemotherapy, thus which sequence performs better in the contemporary era remains uncertain.

Recommendation 2.5. For patients with T3N0 (AJCC 8th) NPC, concurrent chemoradiotherapy should be offered. Adjuvant or induction chemotherapy may also be offered (Type: evidence based; benefits outweigh harms; Evidence quality: intermediate; Strength of recommendation: moderate).


Stage II to IVA (AJCC 8th) NPC
Radiotherapy
Chemotherapy
Sequence & options
Induction
Platinum-based regimens should be offered. The following regimens may be used in the absence of medical contraindications: GP (gemcitabine: 1,000 mg/m² d1, d8; cisplatin 80 mg/m² d1) or TPF (docetaxel 60-75 mg/m² d1; cisplatin 60-75 mg/m² d1; 5-FU 600-750 mg/m² per day, civ d1–5); others include PF (cisplatin 80-100 mg/m² d1; 5-FU 800-1000 mg/m² per day, civ d1–5), PX (cisplatin 100 mg/m² d1; capecitabine 2000 mg/m² per day, d1-14) and TP (docetaxel 75 mg/m² d1; cisplatin 75 mg/m² d1)
The regimens should be administered every 3 weeks for a total of 3 cycles, or at the minimum 2 cycles; chemoradiotherapy should be commenced within 21-28 days from the first day of the last cycle of induction chemotherapy
Concurrent
Without contraindications to cisplatin
Clsplatin, given weekly (40 mg/m²) or triweekly (100 mg/m², or at least 80 mg/ m²), should be offered; 3 doses of triweekly or 7 doses of weekly cisplatin should be attempted to achieve a cumulative dose of at least 200 mg/m²
With a contraindication to cisplatin
Nedaplatin (100 mg/m² triweekly) may be offered for concurrent chemoradiotherapy. Other options that may be offered are carboplatin (AUC 5-6 triweekly) or oxaliplatin (70 mg/m² weekly)
With a contraindication to platinum-based chemotherapy
Fluoropyrimidines (eg, capecitabine, 5-FU, tegafur) with concurrent radiotherapy may be offered
Adjuvant
Without contraindication to cisplatin
PF (cisplatin 80 mg/m² d1 or 20 mg/m² per day, d1-5; 5-FU 1,000 mg/m² per day, civ d1–4, or 800 mg/m² per day, civ d1-5) administered every 4 weeks for a total of 3 cycles should be offered
With a contraindications to cisplatin
Carboplatin (AUC 5) may be combined with 5-fluorouracil
With a contraindication to platinum-based chemotherapy
The use of non–platinum-based regimens remain experimental at this time and should not be offered routinely outside the context of a clinical trial
Stage II disease
N0
Chemotherapy is not routinely recommended, but may be offered if there are adverse features, such as bulky tumor volumes or high EBV DNA copy number
N1
Concurrent chemotherapy may be offered, particularly for T2N1 patients
Stage III-IVA disease
T3N0
Concurrent chemoradiotherapy should be offered. Adjuvant or induction chemotherapy may also be offered
N2-3 & T3-4N1 & T4N0
Induction chemotherapy should be offered in addition to concurrent chemoradiotherapy
For those who do not receive induction chemotherapy plus concurrent chemoradiotherapy, then concurrent hemoradiotherapy plus adjuvant chemotherapy should be offered[a]
Dose
A prescribed dose of 70 Gy in 33-35 fractions (2.0-2.12 Gy per fraction) delivered over 7 weeks (once daily, 5 fractions per week) should be offered. Radiation dose may be adjusted according to tumor volume and its response to (chemo-)radiotherapy
IMRT with daily image guidance should be offered; both SEQ- and SIB-IMRT are acceptable
Delineation
Target delineation should follow consensus guidelines and exploit technical opportunities including image fusion. MRI image fusion with CT for target delineation is mandatory, especially to appreciate the potential tumor extension at the skull base and rule out or confirm the presence of cranial nerve involvement and/or intracranial extension
For patients who have undergone induction chemotherapy,the pre-induction scan should be fused with the postinduction CT simulation data set to illustrate the initial disease extent.The gross tumor volume should generally follow the preinduction tumor extent, especially within bony anatomy
If receive induction chemotherapy
The delineation of elective nodal volumes should cover the bilateral neck from the retropharyngeal lymph nodes to level IV and V. Level 1b may be omitted in prophylactic volume unless there is involvement of the anterior half of nasal cavity or if there are level II lymph nodes with extranodal extension or size greater than 2 cm or bilateral involvement. Omission of lower neck volume in the uninvolved side of the neck may be considered if the neck contains no equivocal lymph node(s)

UC San Diego Health

Recurrent/Metastatic Disease

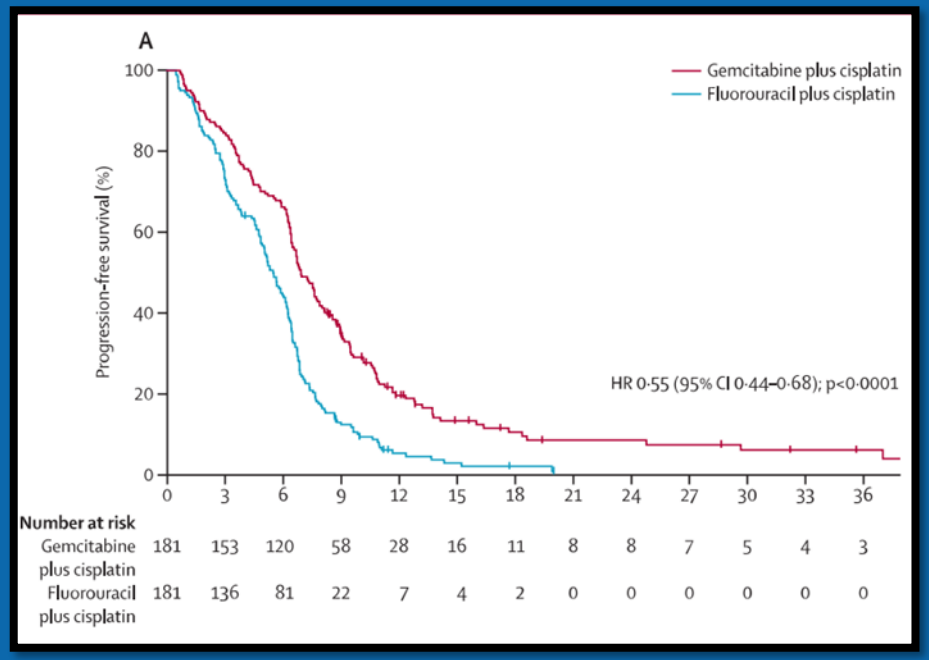
Gemcitabine plus cisplatin versus fluorouracil plus cisplatin in recurrent or metastatic nasopharyngeal carcinoma: a multicentre, randomised, open-label, phase 3 trial

Prof Li Zhang, MD, Yan Huang, MD, Shaodong Hong, MD, Yunpeng Yang, MD, Gengsheng Yu, MD, Jun Jia, MD, Peijian Peng, MD, Xuan Wu, MD, Prof Qing Lin, MD, Prof Xuping Xi, MD, Jiewen Peng, MD, Mingjun Xu, MD, Prof Dongping Chen, MD, Xiaojun Lu, MD, Rensheng Wang, MD, Xiaolong Cao, MD, Xiaozhong Chen, MD, Prof Zhixiong Lin, MD, Jianping Xiong, MD, Qin Lin, MD, Conghua Xie, MD, Zhihua Li, MD, Prof Jianji Pan, MD, Jingao Li, MD, Prof Shixiu Wu, MD, Yingni Lian, MD, Quanlie Yang, MD, Prof Chong Zhao, MD

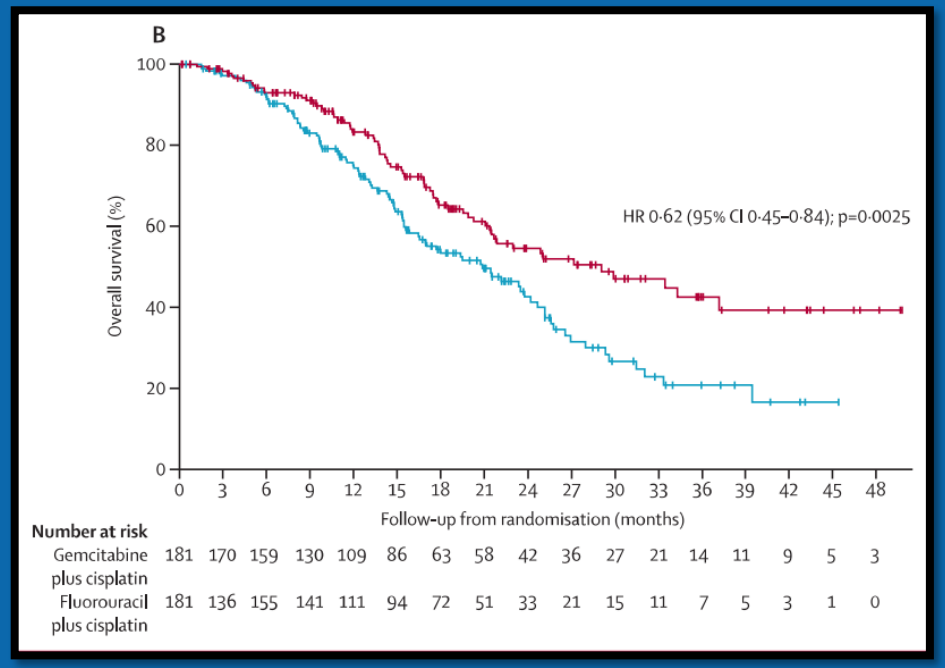
The Lancet
Volume 388 Issue 10054 Pages 1883-1892 (October 2016)
DOI: 10.1016/S0140-6736(16)31388-5

Figure 2: ***Progression-free survival and overall survival in the intention-to-treat population***

A. Progression-free survival



B. Overall survival



The Lancet 2016 3881883-1892DOI: (10.1016/S0140-6736(16)31388-5)

2021 ASCO ANNUAL MEETING

JUPITER-02: The randomized, double-blind, phase 3 study of toripalimab or placebo plus cisplatin and gemcitabine as first-line treatment for recurrent or metastatic nasopharyngeal carcinoma (NPC)

Rui-Hua Xu[1, *], Hai-Qiang Mai[2], Qiu-Yan Chen[2] Dongping Chen[3], Chaosu Hu[4], Kunyu Yang[5], Jiyu Wen[6], Jingao Li[7], Ying-Rui Shi[8], Feng Jin[9], Ruilian Xu[10], Jianji Pan[11], Shenhong Qu[12], Ping Li[13], Chunhong Hu[14], Yi-Chun Liu[15], Yi Jiang[16], Xia He[17], Hung-Ming Wang[18] and Wan-Teck Lim[19], Coherus Biosciences and Shanghai Junshi Biosciences.

[1]Department of Medical Oncology, Sun Yat-Sen University Cancer Center; State Key Laboratory of Oncology in South China; Collaborative Innovation Center of Cancer Medicine, Guangzhou, China; [2] Department of Nasopharyngeal Carcinoma, Sun Yat-Sen University Cancer Center; [3]Affiliated Cancer Hospital & Institute of Guangzhou Medical University, Guangzhou, China; [4]Fudan University Cancer Center, Shanghai, China; [5]Union Hospital Tongji Medical College Huazhong University of Science and Technology, Wuhan, China; [6]Affiliated Hospital of Guangdong Medical University, Zhanjiang, China; [7]Jiangxi Cancer Hospital, Nanchang, China; [8]Hunan Cancer Hospital and the Affiliated Cancer Hospital of Xiangya School of Medicine, Changsha, China; [9]Guizhou Cancer Hospital of Guizhou Medical University, Guiyang China; [10]Shenzhen People's Hospital, Shenzhen, China; [11]Fujian Provincial Cancer Hospital, Fuzhou, China; [12]The People's Hospital of Guangxi Zhuang Autonomous Region, Nanning, China; [13]West China Hospital of Sichuan University, Chengdu, China; [14]The Second Xiangya Hospital of Central South University, Changsha, China; [15]Taichung Veterans General Hospital, Taichung, Taiwan; [16]Cancer Hospital of Shantou University Medical College, Shantou, China; [17]Jiangsu Cancer Hospital, Nanjing, China; [18]Chang Gung Memorial Hospital, Taoyuan, Taiwan; [19]National Cancer Centre, Singapore City, Singapore

Presented by Rui-Hua Xu, MD, PhD at 2021 ASCO Annual Meeting

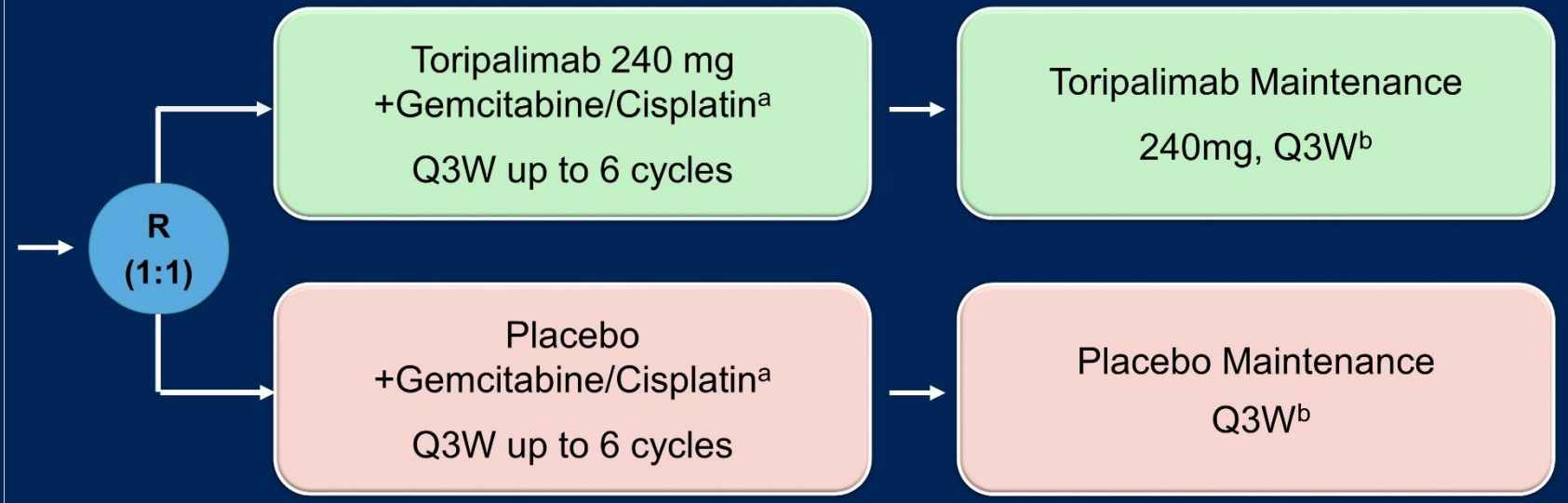
JUPITER-02：Study Design
(ClinicalTrials.gov identifier: NCT03581786)

Key Eligibility Criteria

- Primary metastatic NPC or recurrent NPC after curative-intent therapy
- Treatment naïve for recurrent or metastatic (R/M) disease
- ECOG 0-1
- 18-75 yrs
- Measurable disease per RECIST v1.1

Stratification Factors

- Recurrent vs Primary metastatic
- ECOG PS 0 vs 1



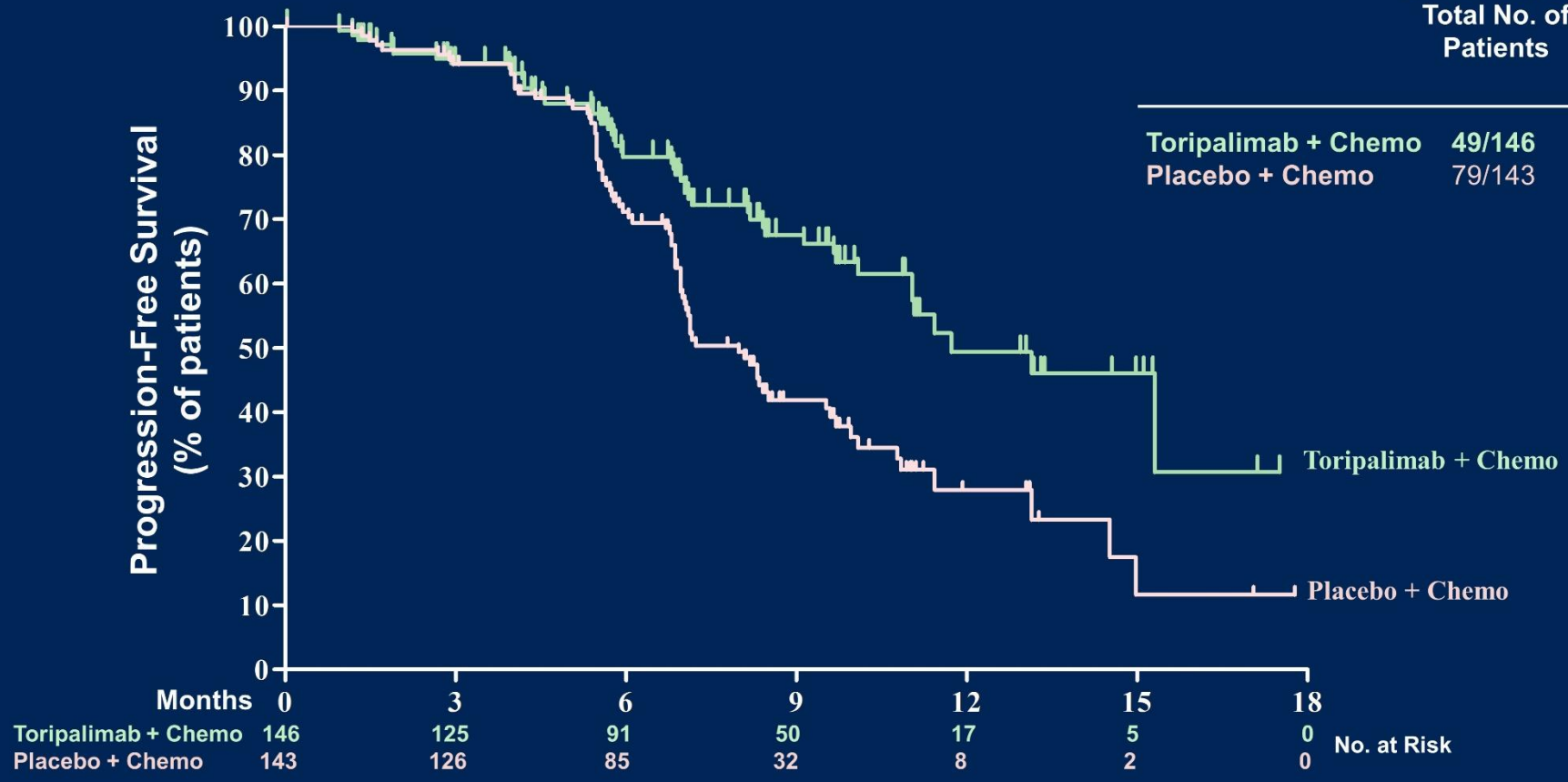
- Primary endpoint：PFS by a blinded independent review committee (BIRC) per RECIST v1.1
- Secondary endpoints：PFS by the Investigator, ORR, DoR, DCR, OS, and PFS & OS 1-year and 2-year rates

[a] Gemcitabine 1000mg/m^2 D1,8 +Cisplatin 80mg/m^2 D1
[b] Until progressive disease, excessive toxicity, withdrawal of consent or investigator's judgement or a maximum treatment of 2 years.

Progression-Free Survival by BIRC per RECIST v1.1

Interim Analysis Data cut-off Date: May 30, 2020

	No. of Events/ Total No. of Patients	Median Progression-free Survival, months (95% CI)	1-Yr Progression-free Survival Rate, % (95% CI)
Toripalimab + Chemo	49/146	11.7 (11.0, NE)	49.4 (36.4, 61.1)
Placebo + Chemo	79/143	8.0 (7.0, 9.5)	27.9 (18.0, 38.8)



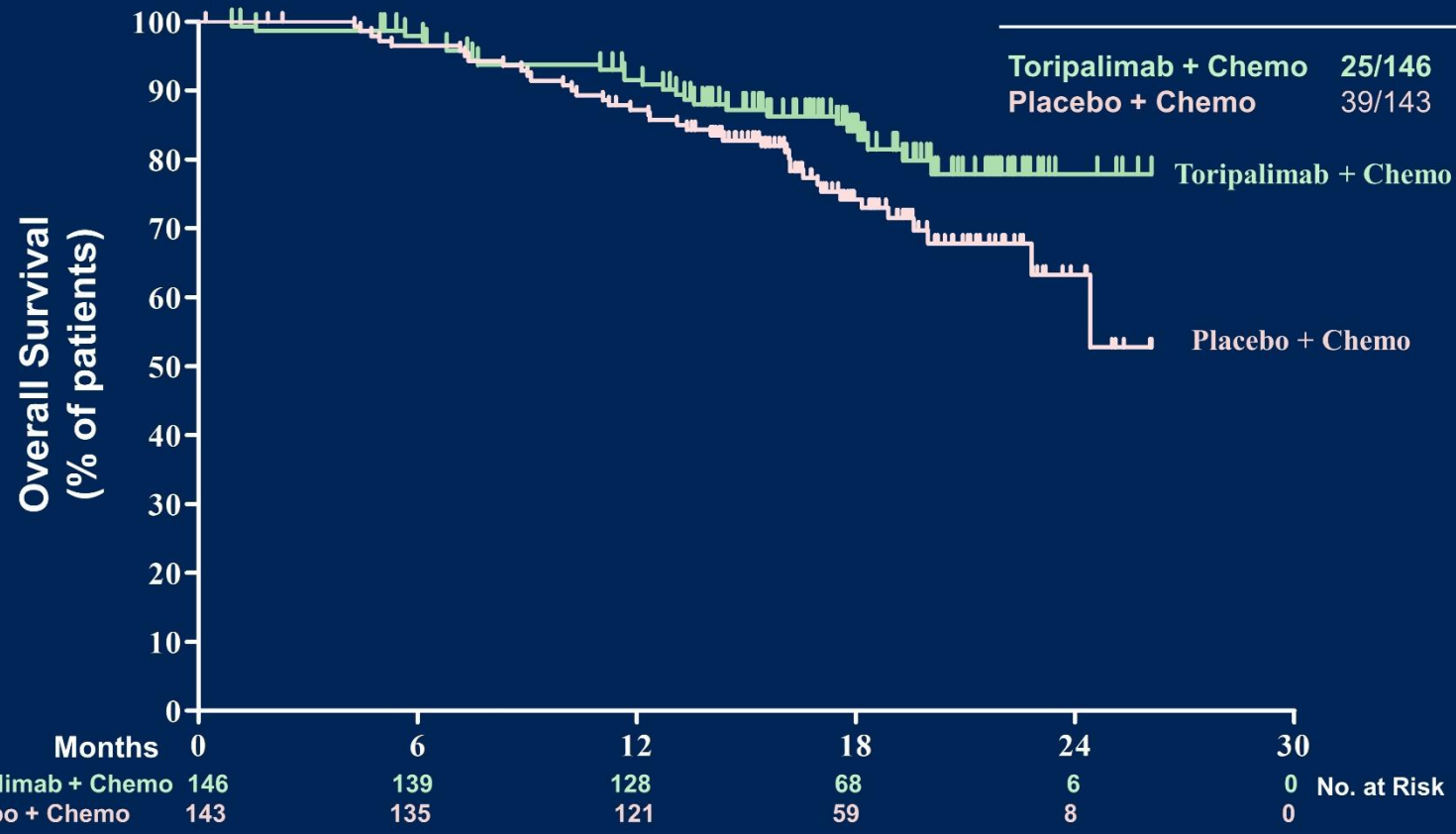
Stratified HR for disease progression or death,

0.52 (95% CI 0.36-0.74); P=0.0003

Overall Survival Update

Nine-month OS update after PFS Interim Analysis on Feb 18, 2021

	No. of Deaths/ Total No. of Patients	Median Overall Survival (95% CI) *mo*	1-Yr Overall Survival Rate % (95% CI)	2-Yr Overall Survival Rate % (95% CI)
Toripalimab + Chemo	25/146	NE (NE, NE)	91.6 (85.6, 95.1)	77.8 (68.0, 85.0)
Placebo + Chemo	39/143	NE (22.8, NE)	87.1 (80.4, 91.7)	63.3 (49.8, 74.1)



Stratified HR for death,

0.603 (95% CI 0.364-0.997); P=0.0462

Presented By: **Rui-Hua Xu, MD, PhD**

2021 ASCO ANNUAL MEETING

Response and Duration of Response by BIRC per RECIST v1.1

Characteristic (%)	Toripalimab + GP (N=146)	Placebo + GP (N=143)
Objective Response Rate [a]	77.4	66.4
95% CI	(69.8, 83.9)	(58.1, 74.1)
P value	0.0335	
Best Overall Response [a]		
Complete Response	19.2	11.2
Partial Response	58.2	55.2
Stable Disease	10.3	13.3
Progressive Disease	3.4	5.6
Not evaluable	6.2	5.6
Non-CR/non-PD [b]	2.7	8.4
No evidence of disease [c]	0	0.7
Median DoR, (95%CI), months	10.0 (8.8, NE)	5.7 (5.4, 6.8)
HR (95%CI)	0.50 (0.33-0.78)	
P value	0.0014	

[a] All CR and PR were confirmed.
[b] Non-CR/non-PD included subjects who didn't have target disease at baseline by BIRC. [c] No evidence of disease included subjects who didn't have lesion at baseline by BIRC.

Data cut-off date: 30/May/2020.

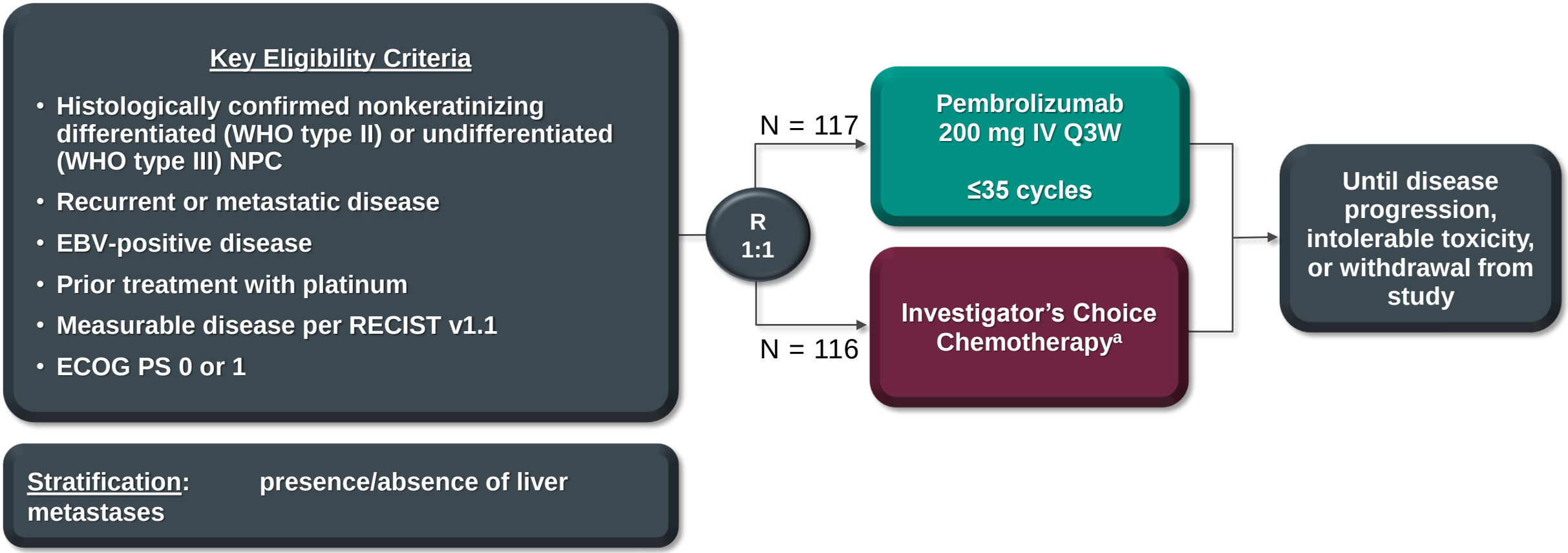
Results of KEYNOTE-122: a Phase 3 Study of Pembrolizumab Monotherapy vs Chemotherapy for Platinum-Pretreated, Recurrent or Metastatic Nasopharyngeal Carcinoma

Anthony T.C. Chan[1]; Victor Lee[2]; Ruey-Long Hong[3]; Myung-Ju Ahn[4]; Wan Qin Chong[5]; Sung-Bae Kim[6]; Gwo Fuang Ho[7]; Priscilla B. Caguioa[8]; Nuttapong Ngamphaiboon[9]; Cheryl Ho[10]; Mohamed Amir Shah Abdul Aziz[11]; Quan Sing Ng[12]; Chia-Jui Yen[13]; Nopadol Soparattanapaisarn[14]; Roger Kai-Cheong Ngan[15]; Swee Kiong Kho[16]; Ramona Swaby[17,a]; Sanatan Saraf[17]; Joy Ge[17]; Jianda Yuan[17]; Lillian L. Siu[18]

[1]The Chinese University of Hong Kong, China Hong Kong; [2]The University of Hong Kong, China Hong Kong; [3]National Taiwan University Hospital, Taipei, China Taiwan; [4]Samsung Medical Center, Seoul, South Korea; [5]National University Cancer Institute, Singapore; [6]Asan Medical Center, Seoul, South Korea; [7]University of Malaya Medical Centre, Kuala Lumpur, Malaysia; [8]St. Luke's Medical Center, University of Santo Tomas Faculty of Medicine and Surgery, Manila, The Philippines; [9]Ramathibodi Hospital, Mahidol University, Bangkok, Thailand; [10]University of British Columbia, Vancouver, BC, Canada; [11]Gleneagles Penang Clinical Research Center, Gleneagles Hospital Penang, Penang, Malaysia; [12]National Cancer Centre Singapore, Singapore; [13]National Cheng Kung University Hospital, Tainan, China Taiwan; [14]Faculty of Medicine Siriraj Hospital, Mahidol University, Bangkok, Thailand; [15]Queen Elizabeth Hospital, Kowloon, HK SAR, China; [16]Hospital Umum Sarawak, Kuching, Sarawak, Malaysia; [17]Merck & Co., Inc., Kenilworth, NJ, USA; [18]Princess Margaret Cancer Centre, University of Toronto, Toronto, ON, Canada

[a]Affiliation at the time of the conduct of the study.

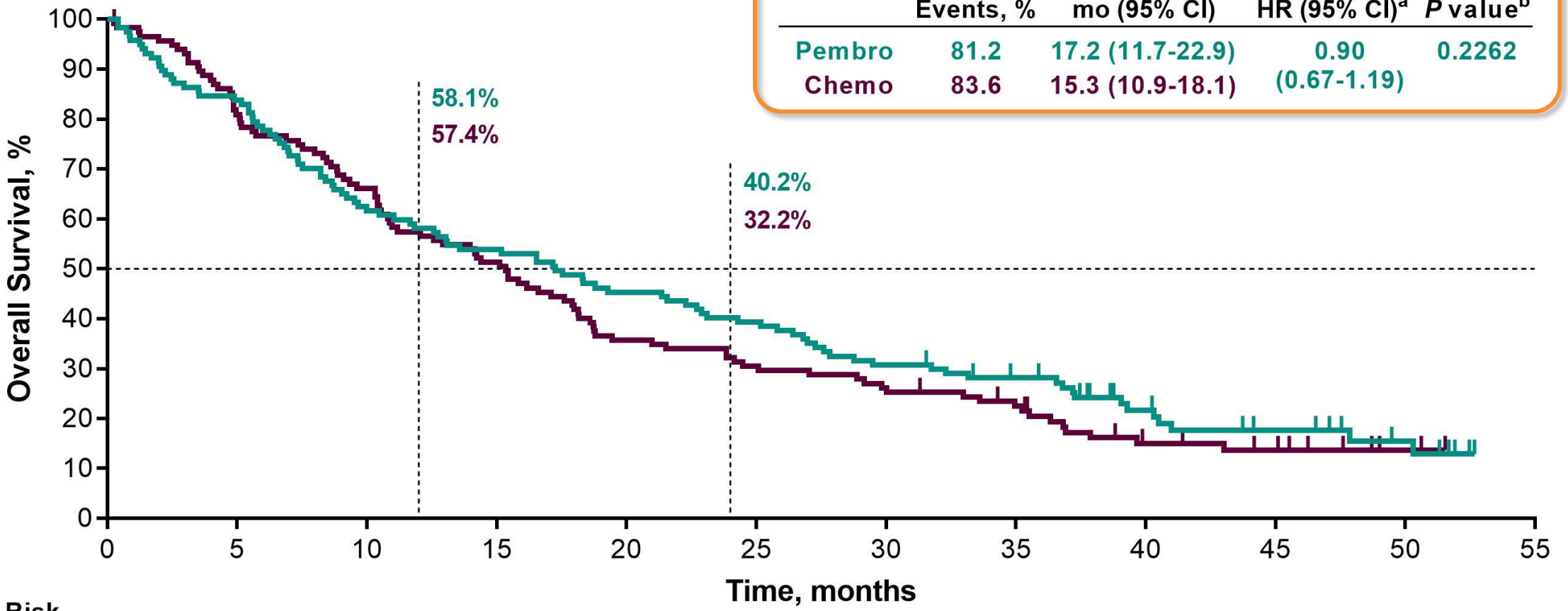
KEYNOTE-122 Study Design (NCT02611960)



ECOG PS, Eastern Cooperative Oncology Group performance status; IV, intravenous; Q3W, every 3 weeks; WHO, World Health Organization.
[a]Capecitabine 1000 mg/m^2 (up to 1250 mg/m^2 from cycle 2 based on tolerability and local practices) PO BID on days 1-14 per 3-week cycle, gemcitabine 1250 mg/m^2 IV on days 1 and 8 per 3-week cycle, or docetaxel 75 mg/m^2 IV on day 1 per 3-week cycle. Data cutoff: November 30, 2020.

Overall Survival (ITT)

	Events, %	Median OS, mo (95% CI)	HR (95% CI)[a]	*P* value[b]
Pembro	81.2	17.2 (11.7-22.9)	0.90 (0.67-1.19)	0.2262
Chemo	83.6	15.3 (10.9-18.1)		



No. at Risk

Pembro	117	98	72	63	53	46	36	30	17	11	6	0
Chemo	116	93	76	59	41	35	30	23	12	9	2	0

[a]Based on Cox regression model with Efron's method of tie handling with treatment as a covariate stratified by presence of liver metastasis. [b]1-sided *P* value based on log-rank test stratified by presence of liver metastasis. Data cutoff: November 30, 2020.

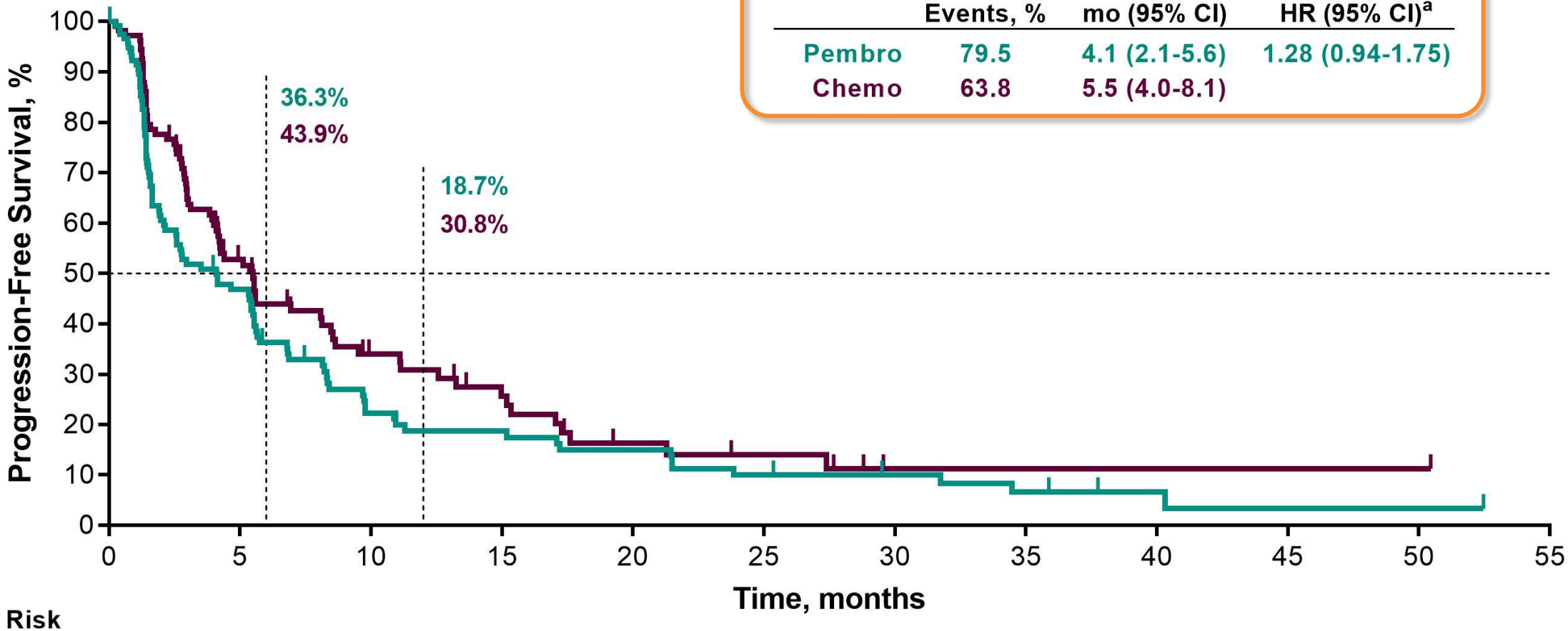
Subsequent Oncologic Therapy

n	Pembro n = 117	Chemo n = 116
≥1 subsequent therapy[a]	78	71
1 subsequent therapy		
Chemotherapy	9	8
Targeted therapy	0	0
Immunotherapy[b]	0	1
Gene therapy	0	1
≥2 subsequent therapies[c]		
Chemotherapy	204	138
Targeted therapy	12	18
Immunotherapy[b]	7	34
Gene therapy	0	0

[a]Patients could have received ≥1 therapy.
[b]Includes antibodies, cellular-based immunotherapy, and vaccines.
[c]Total number of therapies and not number of patients, in each treatment arm
Data cutoff: November 30, 2020.

PFS per RECIST v1.1 by BICR (ITT)

	Events, %	Median PFS, mo (95% CI)	HR (95% CI)[a]
Pembro	79.5	4.1 (2.1-5.6)	1.28 (0.94-1.75)
Chemo	63.8	5.5 (4.0-8.1)	



No. at Risk

Pembro	117	46	19	15	12	8	6	4	2	1	1	0
Chemo	116	43	21	14	7	5	1	1	1	1	1	0

[a]Based on Cox regression model with Efron's method of tie handling with treatment as a covariate stratified by presence of liver metastasis. Data cutoff: November 30, 2020.

Opportunities

- 3rd line R/M
  - Agents available but nothing approved → placebo comparator?
  - Many patients fit enough to receive 3rd line
- 2nd line R/M
  - Most patients will be anti-PD1 refractory
  - Single agent cytotoxic represents standard practice
  - Anti-PD1 alone did not improve survival
- 1st line R/M
  - Chemotherapy + anti-PD1 is SOC
  - High bar: 2-yr OS ~75%
  - Potential to combine
  - Potential for maintenance or adjuvant therapy for patients with persistent plasma EBV DNA post-treatment
- Locally advanced
  - Lots of possibilities, long readout
  - Potential for maintenance or adjuvant therapy for patients with persistent plasma EBV DNA post-treatment

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Nana-val MOA and its Potential in Advanced EBV+ Solid Tumors:

Dr. Ayman Elguindy
Chief Scientific Officer

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

Precisely eradicates EBV^{+} tumor cells

nanatinostat:

- Epigenetic agent, selective for EBV gene activation and immune enhancement
- Class I HDACi, selective for HDACs 1, 2 & 3
- Potent inducer of expression of the EBV protein kinase (BGLF4) at a low dose

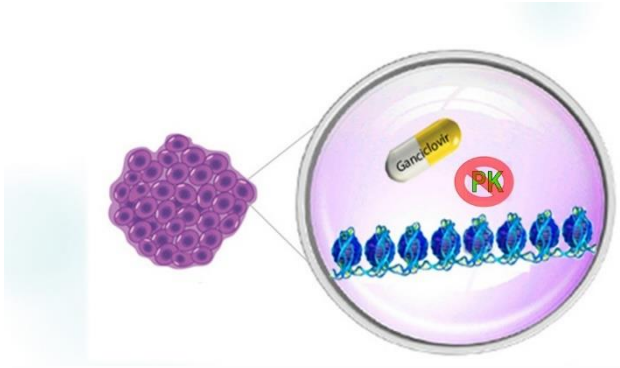
valganciclovir:

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

HDACi: histone deacetylase inhibitor

Viracta's Oral "Kick and Kill" Approach Selectively Targets EBV+ Cancer Cells

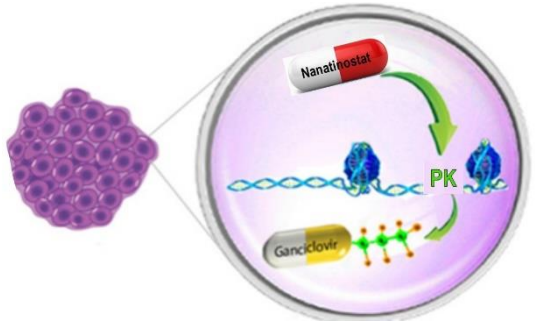
Nanatinostat sensitizes EBV+ tumors to the cytotoxic effects of ganciclovir



LATENCY

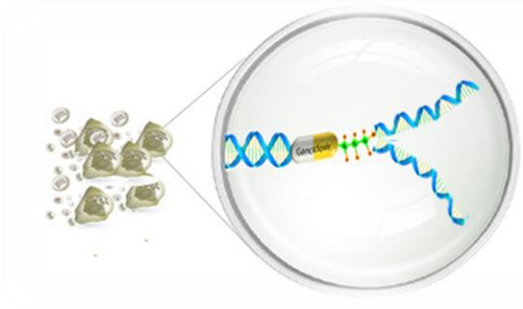
EBV is latent in cancer cells and viral kinase genes are silenced epigenetically.

Valganciclovir, an antiviral prodrug of ganciclovir (GCV), is inactive in the absence of the expression of the viral protein kinase (PK)



THE KICK

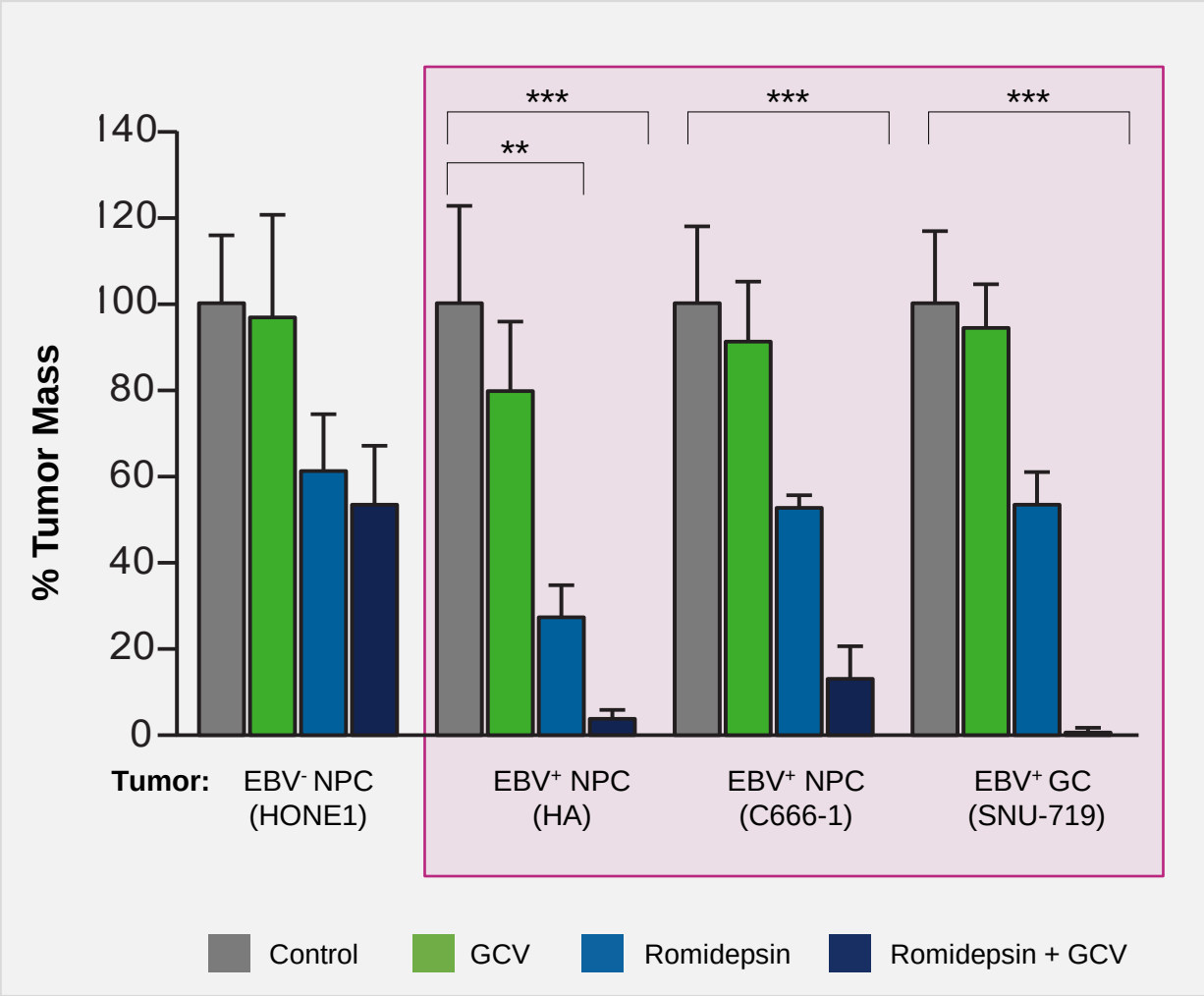
Nanatinostat selectively and potently induces expression of EBV protein kinase (PK), which activates GCV and converts it to its cytotoxic form



THE KILL

Cytotoxic GCV inhibits DNA replication by chain termination leading to apoptosis in EBV+ cancer cells. This combination approach is a form of synthetic lethality

Preclinical Proof of Concept for Nana-val in EBV+ Solid Tumors



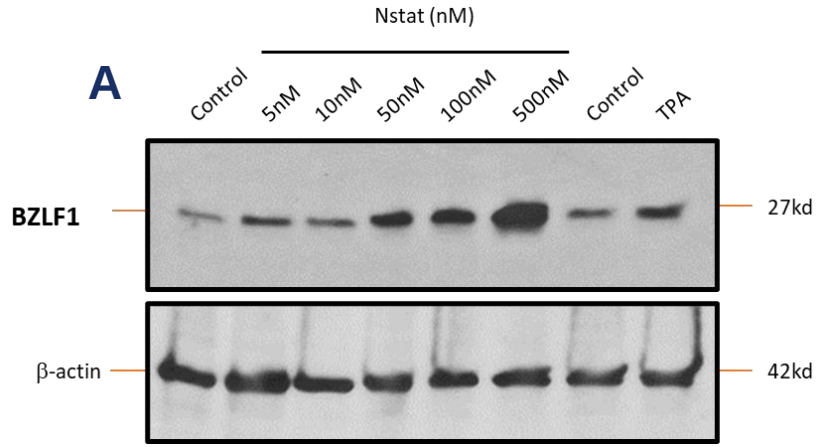
- Annual incidence of nasopharyngeal carcinoma (NPC) and gastric carcinoma (GC):
  - North America: ~5,500
  - Global: ~218,000
- High unmet need, especially for R/R disease
- Efficacy of combination approach initially reported in murine models of EBV+ NPC and GC using a first generation intravenous (IV) HDACi + IV ganciclovir

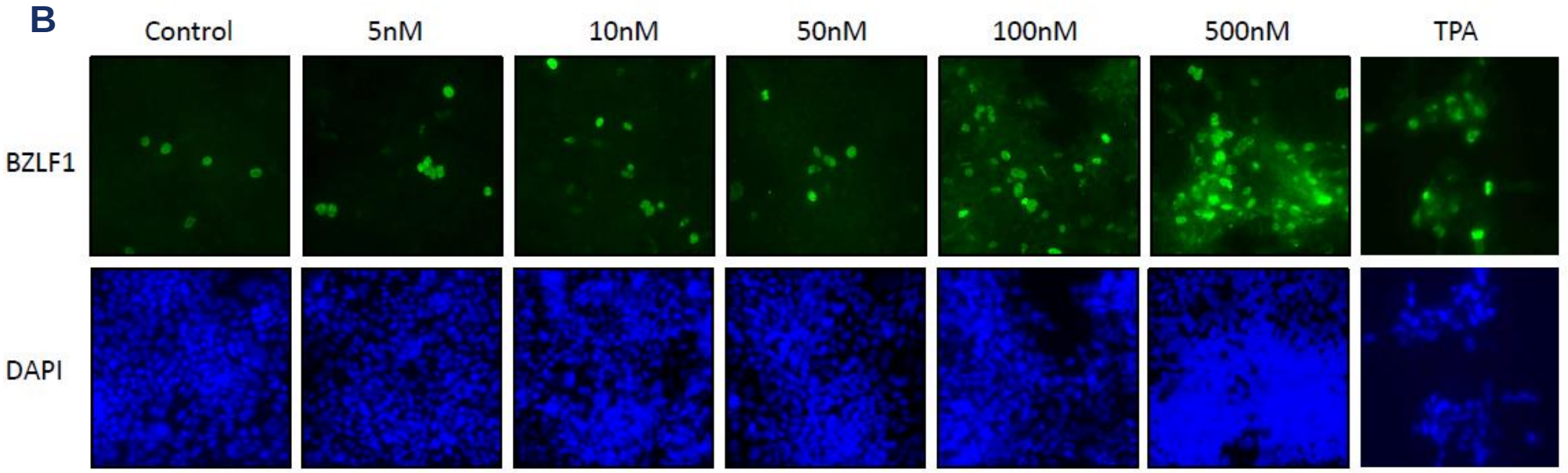
Source: Hui KW, et al. Int J Cancer:138.125-136 (2016); Epidemiology of Epstein-Barr virus Associated Cancers in the US, Tessellon, Inc., 2020; Kahn,G, et al. BMJ 10:1136,2020
R/R: Relapsed/refractory; HDACi: HDAC inhibitor

Nanatinostat Induces the EBV Lytic Cycle in 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

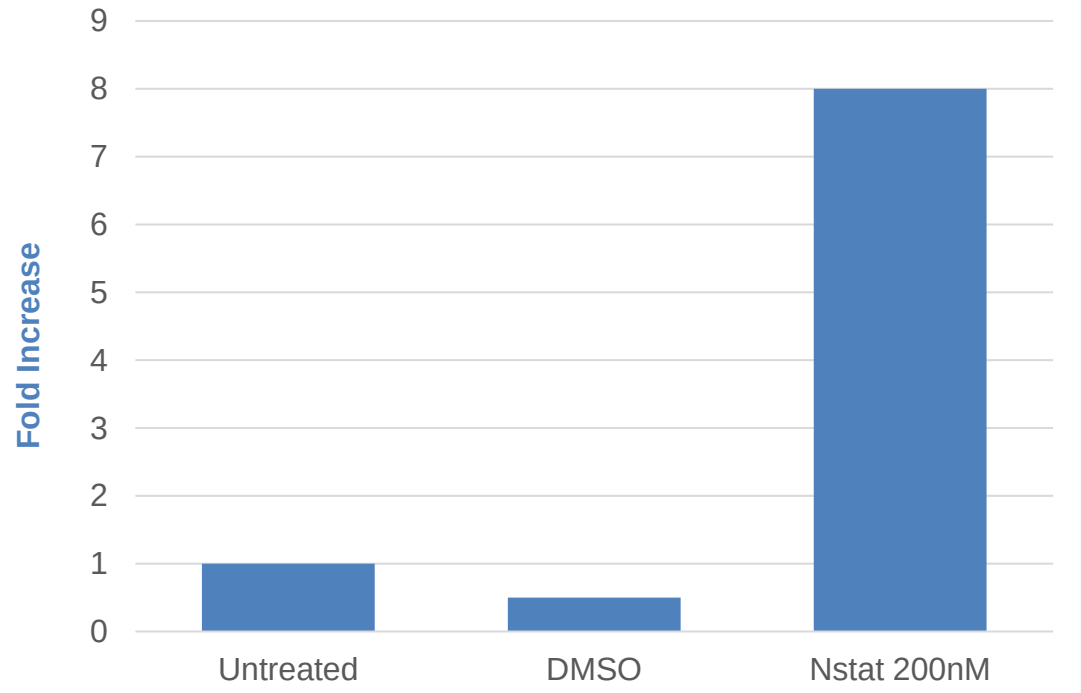




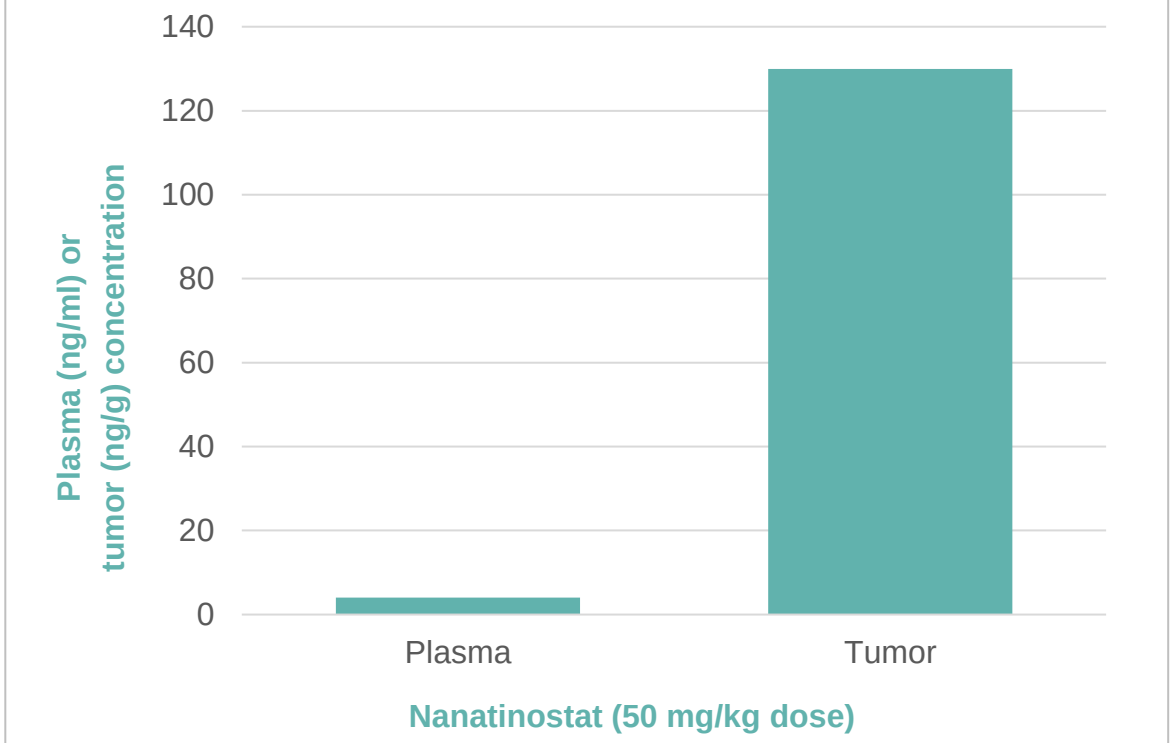
Source: Viracta Therapeutics, Inc on file – Courtsey of Dr. Lawrence Young – University of Warwick

Nanatinostat Induction of EBV Protein Kinase in Tumor Cells and Accumulation in Tumor Tissue

Induction by Nanatinostat of EBV Protein Kinase RNA in SNU-719 EBV+ Gastric Carcinoma Cell Line



High Tumor Uptake of Nanatinostat in a Murine Xenograft Tumor Model



Source: Moffat, et al. J. Med Chem. 53: 24, 2010.; Nstat: Nanatinostat

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Nana-val Phase 1b/2 Trial in Advanced EBV^{+} Solid Tumors:

Dr. Lisa Rojkjaer
Chief Medical Officer

Nana-val Clinical Activity Demonstrated in Recurrent EBV$^+$ Lymphoma

Potential tissue agnostic approach to EBV$^+$ cancers

- The all-oral combination of nanatinostat and valganciclovir (Nana-val) has demonstrated promising results in a Phase 1b/2 study in heavily pre-treated, refractory EBV$^+$ lymphoma patients (NCT03397706):
  - Nana-val was generally well-tolerated with a safety profile characterized primarily by reversible cytopenias, low grade gastrointestinal adverse events/creatinine elevations
  - Complete responses in DLBCL, T and NK-cell lymphomas, and immunodeficiency-associated lymphoproliferative disorders
  - Median duration of response of 10.4 months

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DLBCL: Diffuse large B cell lymphoma

Considerations for the Solid Tumor Study Design

Potential synergies with checkpoint inhibitors

- EBV$^+$ nasopharyngeal cancer has high PD-L1 expression
  - PD-1 inhibitors have ORR of 20-30% in R/M-NPC[1]
- Reactivation of EBV leads to the expression of highly immunogenic proteins and could induce an immune response towards the tumor cells containing the virus
- Thus, EBV antigen expression makes this disease amenable to EBV-targeted and immunotherapy approaches

The Phase 1b/2, open label, multicenter study will evaluate the safety, tolerability, pharmacokinetics and preliminary activity of Nana-val in patients with advanced EBV$^+$ solid tumors

Additionally, the combination of pembrolizumab together with Nana-val will be evaluated in EBV$^+$ R/M-NPC patients

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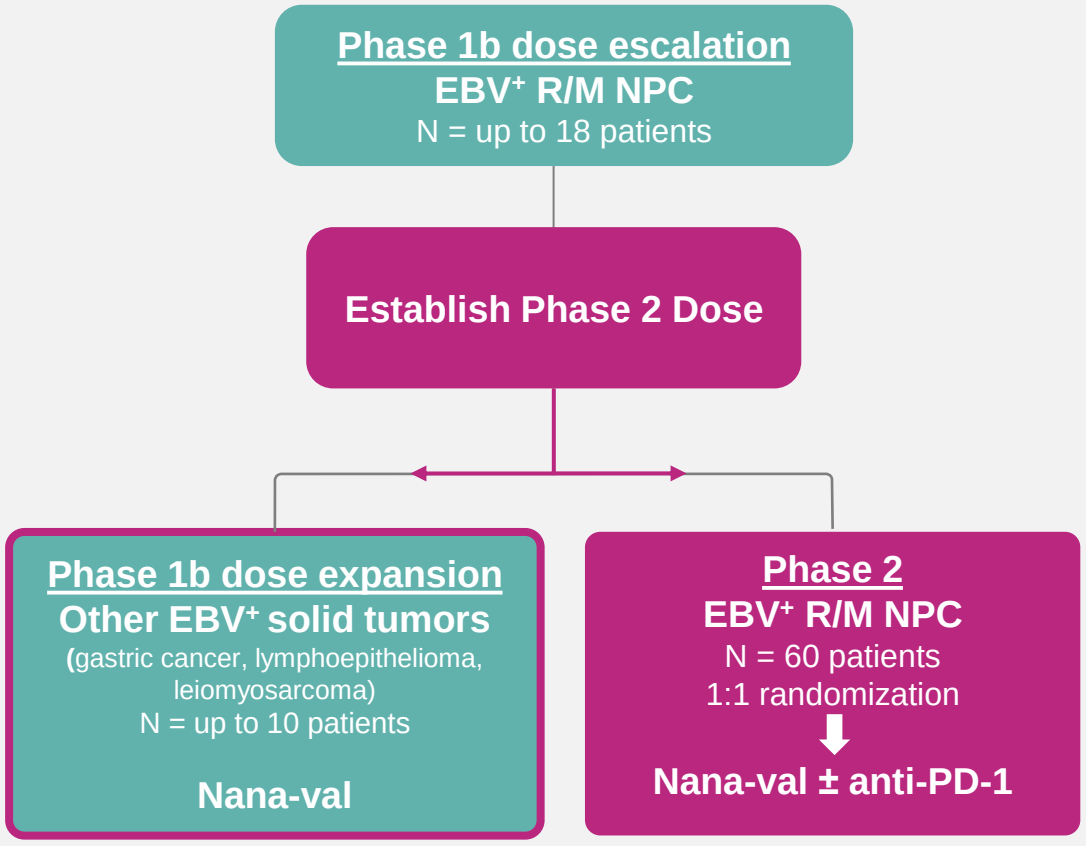
[1]Hsu et al. J Clin Oncol 2017;35, Ma et al. J Clin Oncol 2018;36(14), Wang et al. J Clin Oncol 2021;39(7)

Phase 1b/2 “301” Study in EBV+ Solid Tumors

Overview

- **Phase 1b:** N≤18 *(currently enrolling)*
  - Dose escalation to determine the recommended Phase 2 dose (RP2D) of Nana-val in patients with EBV+ R/M NPC
  - Dose expansion at the RP2D in patients with other advanced EBV+ solid tumors
- **Phase 2:** N=60
  - 1:1 randomization to Nana-val +/- pembrolizumab in patients with EBV+ R/M NPC
- **Endpoints:**
  - Primary:
    - Phase 1b: Incidence of dose limiting toxicities
    - Phase 2: ORR by RECIST v1.1
  - Secondary: Safety, efficacy, pharmacokinetics

Preliminary safety/efficacy data anticipated in H2 2022



NCT05166577

ORR: Objective Response Rate, RECIST: Response Evaluation Criteria in Solid Tumors

Ezra Cohen, MD
UCSD

Ivor Royston, MD
Viracta President & CEO

Lisa Rojkjaer, MD
Viracta CMO

Ayman Elguindy, PhD
Viracta CSO

Daniel Chevallard, CPA
Viracta COO & CFO

Question and Answer Session

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Closing Remarks:

Dr. Ivor Royston

President and Chief Executive Officer

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Thank you