Viracta Therapeutics, Inc.

Business Update – August 14, 2024

NASDAQ: VIRX

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; 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.

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Introduction:

Mark Rothera

President and Chief Executive Officer

Expert Key Opinion Leader on Today's Call: 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

Today's Presenters from Viracta

Darrel P. Cohen, MD, PhD

Chief Medical Officer

Mike Faerm

Chief Financial Officer

Today's Agenda

Vision of Nana-val in EBV+ Cancers	**Mark Rothera,** *President and Chief Executive Officer*
Unmet Medical Need in EBV+ PTCL	**Pierluigi Porcu, MD**, *Thomas Jefferson University*
NAVAL-1 Trial Combined Stages 1 and 2 PTCL Data and Updated Clinical/Regulatory Plans	**Darrel P. Cohen, MD, PhD,** *Chief Medical Officer*
Anticipated Milestones	**Mike Faerm,** *Chief Financial Officer*
Closing Remarks	**Mark Rothera**, *President and Chief Executive Officer*
Q&A	

Vision of Nana-val in EBV+ Cancers

Mark Rothera, Viracta CEO

A Precision Oncology Company Focused on the Treatment and Prevention of Virus-Associated Cancers that Impact Patients Worldwide

***First-in-class* treatment targeting Epstein-Barr virus (EBV)-associated cancers**

Lead program, Nana-val, an all-oral combination therapy of proprietary nanatinostat and valganciclovir

Lymphoma program prioritized following important update in R/R EBV⁺ PTCL

New positive Stages 1+2 data and alignment with FDA on potential approval pathway

Phase 1b/2 study in advanced EBV⁺ solid tumors

On track to determine RP2D in the second half of 2024

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

EBV+ malignancies account for ~2% or >300,000 of all new lymphoma and solid tumor 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%**

Actual number of EBV-positive cases likely underreported due to inconsistent EBV testing in the absence of an actionable EBV-targeted therapy

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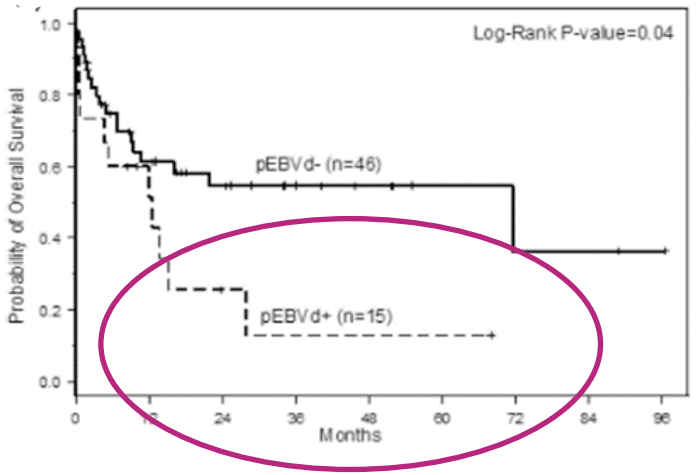
[1]Haverkos BM, et al. Int J Cancer. 2017; 140:1899-1906; Dupuis J et al. Blood. 2006;108:4163–9; [2]Swerdlow SH et al. (2017) WHO classification of Tumours of the Haematopoietic and Lymphoid Tissues; [3]EBV positivity varies by geography; [4]Wong Y, et al. Journal of Cancer Research and Clinical Oncology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

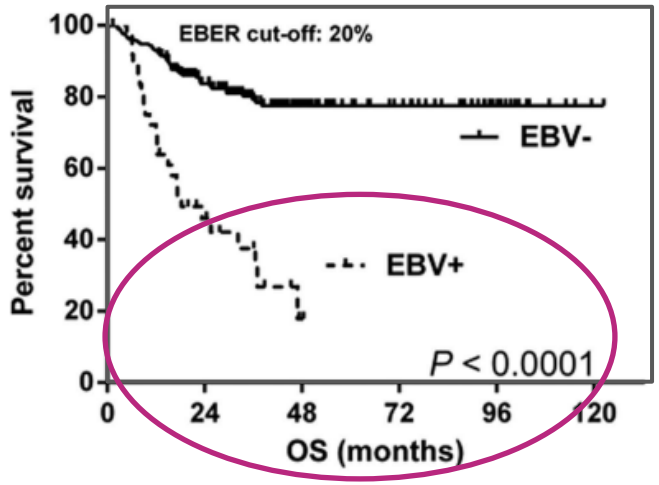
Peripheral T-cell Lymphoma[1]
(Overall Survival)



PTCL EBV+ Rate: 40-65%

Addressing patient populations with high unmet medical need

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



DLBCL EBV+ Rate: 5-15%

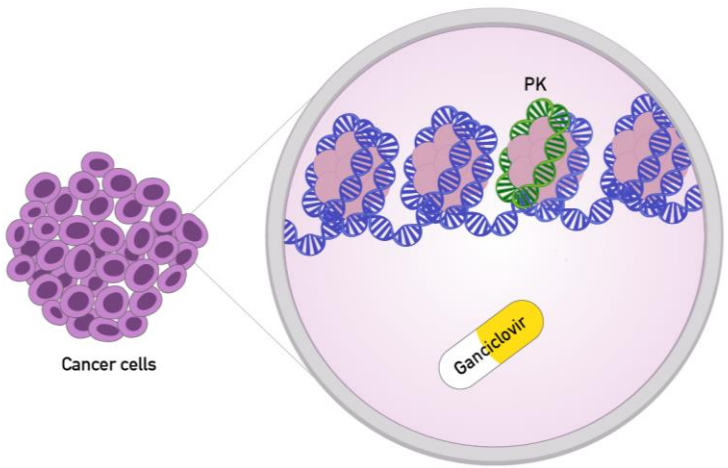
[1]Haverkos BM, et al. Int J Cancer. 2017; 140:1899-1906; Dupuis J et al. Blood. 2006;108:4163–9, [2]Lu TX et al. Sci Rep. 2015;5:1-14

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

Nanatinostat sensitizes EBV+ tumors to the cytotoxic effects of ganciclovir

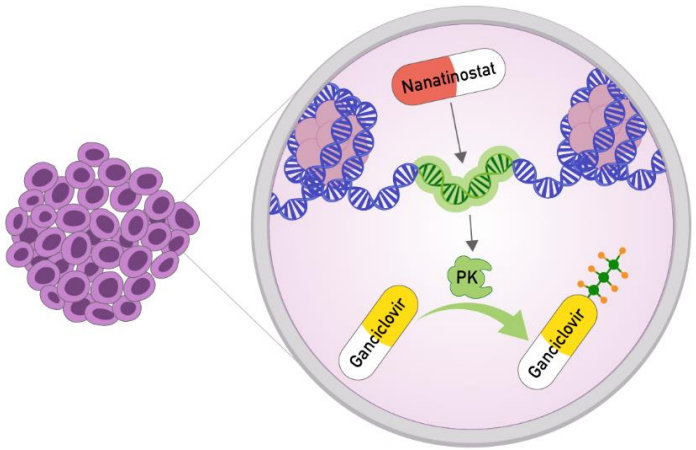
LATENCY

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



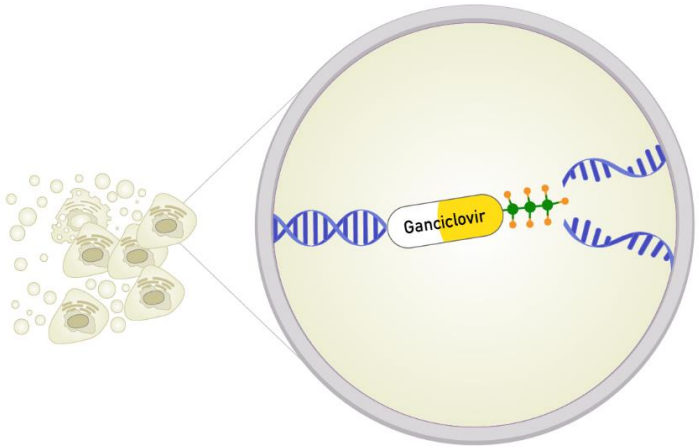
THE KICK

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



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Unmet Medical Need in EBV+ PTCL

Pierluigi Porcu, M.D.

Approximately 70% of Patients Develop Relapsed or Refractory Disease After Frontline PTCL Therapy

Therapeutic challenges in peripheral T-cell lymphoma

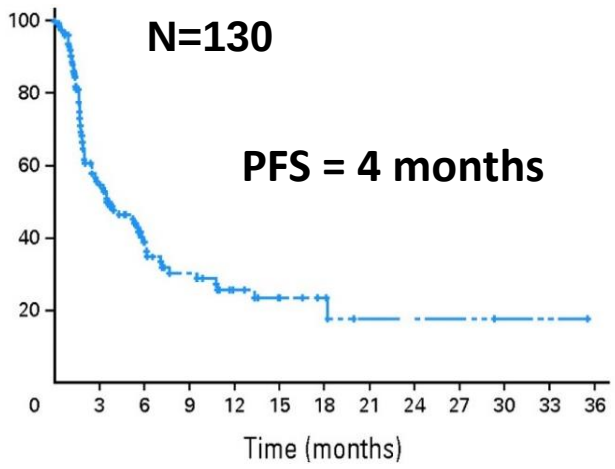
Yunpeng Luan, Xiang Li, Yunqi Luan, Junyu Luo, Qinzuo Dong, Shili Ye, Yuejin Li, Yanmei Li, Lu Jia, Jun Yang & Dong-Hua Yang

Molecular Cancer **23**, Article number: 2 (2024) | Cite this article

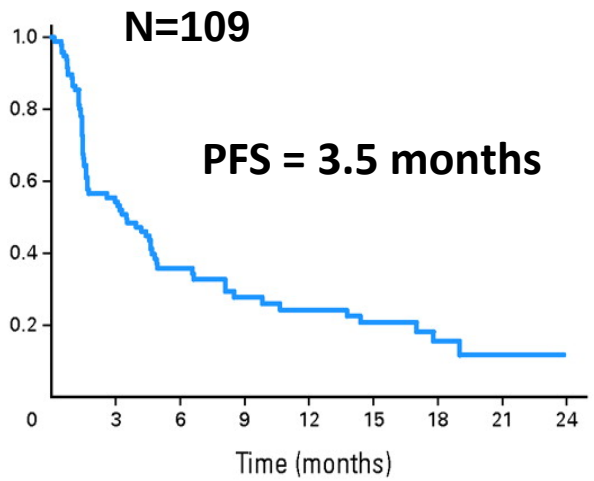
- Despite availability of various treatment options, none have been universally curative, and eventually, drug resistance may develop in response to available treatments
- Multiple mechanisms, such as tumor heterogeneity, tumor microenvironment and signaling pathways, contribute to PTCL resistance
- Most PTCL subtypes are aggressive and chemotherapy-resistant, and their prognosis remains poor

Poor Prognosis for Patients with R/R PTCL

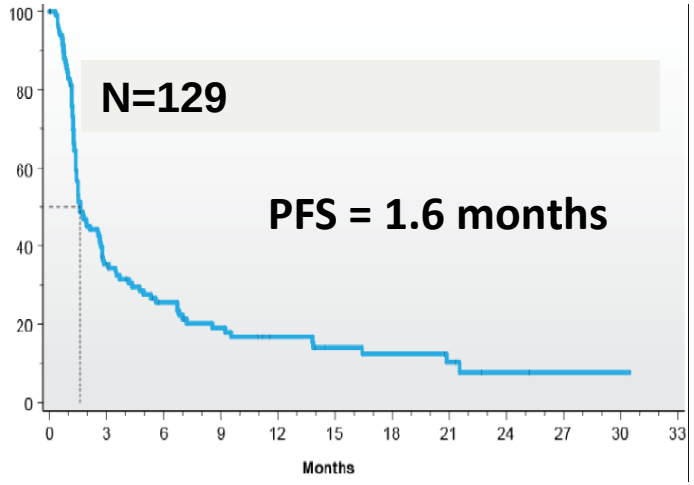
Romidepsin



Pralatrexate



Belinostat



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

Modified from Horwitz S.

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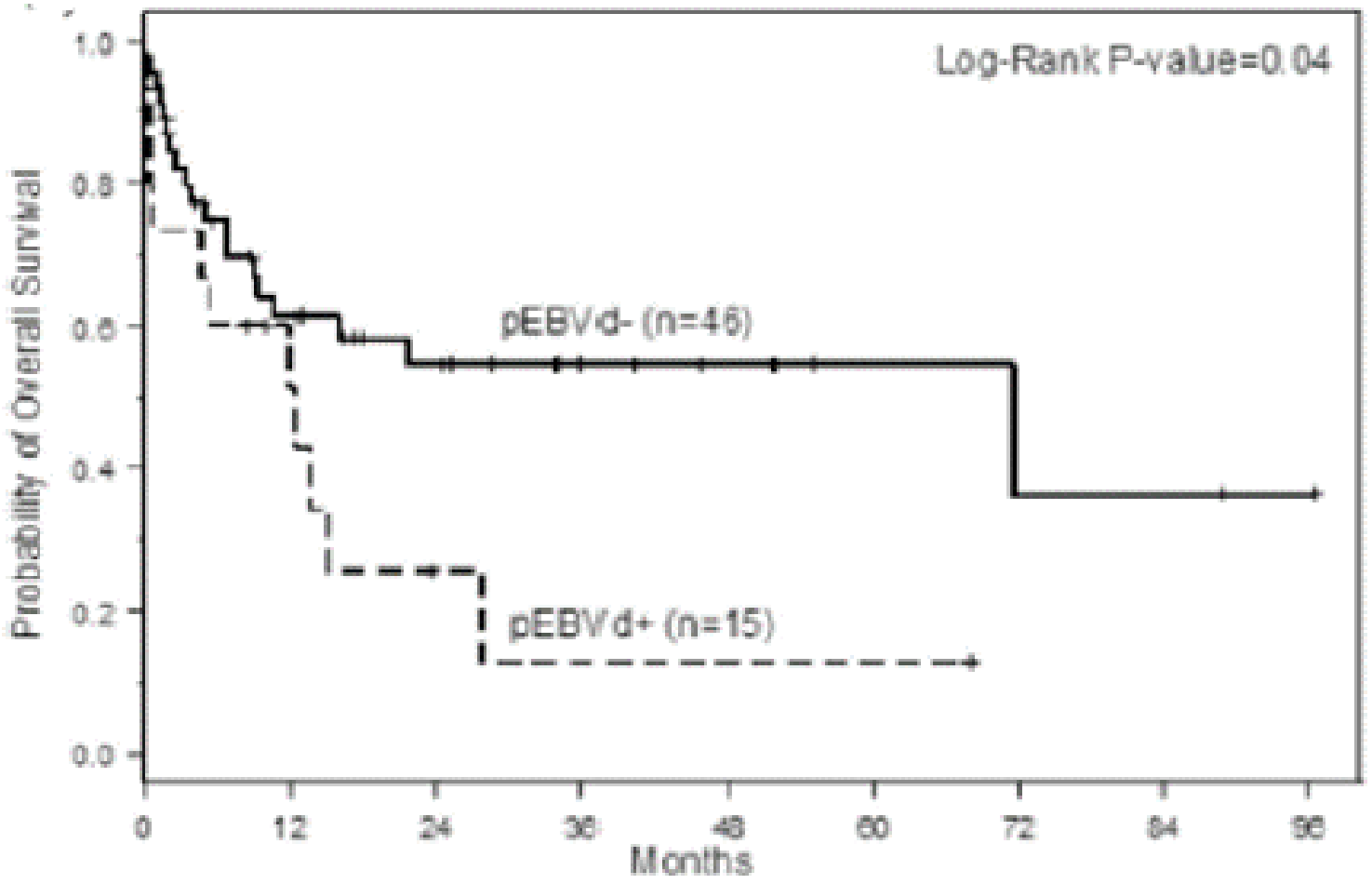
EBV Positivity Further Exacerbates Already Poor PTCL Survival Outcomes

Similarly, EBV+ PTCL may have worse available treatment outcomes than those with EBV- PTCL



EBV-positive PTCL is a **more aggressive disease** with a much poorer prognosis than EBV-negative PTCL.

EBV infection:

- contributes to oncogenesis
- inhibits apoptosis
- downregulates the innate immune response
- activates cell proliferation, angiogenesis, and metastasis.

Haverkos BM, et al. Int J Cancer. 2017; 140:1899-1906.

PTCL: Patient Journey and Treatment Options are Suboptimal*

No established second-line treatment for PTCL

1L Patients

Combination Chemotherapy

e.g. CHOP, CHOEP

CHP + CD30 antibody

R/R PTCL Patients

No Current SoC

Nana-val (2L Initial positioning)

Salvage Chemotherapy

Single agent

Combination regimen

Other Agents

HDAC inhibitors

CD30 antibody

Clinical Trial

Key Considerations[1]

- PTCL is highly aggressive with limited treatment options
- **5-year event-free survival rate:**
  - **PTCL, NOS ~25% overall**
  - **EBV+ PTCL ~11%**
- No current standard of care (SoC) for R/R PTCL
- For non-HCT candidates, chemotherapy is 1L, combination regimens preferred
- In R/R patients, single-agent chemotherapy is preferred to limit toxicity
- In R/R patients, other agents may be used guided by the subtype of PTCL and their toxicity profile

*Transplant Ineligible; [1]Trinity market research; HCT: Hematopoietic cell transplant; HDAC: Histone deacetylase

Case Study: EBV+ PTCL, subtype Angioimmunoblastic T-cell Lymphoma (AITL)

53 year old AAF, no PMH **Box A**

Diffuse LAD (max 2.3 cm), B symptoms, TLS

- Cervical LN excisional biopsy: **AITL**
- IHC: $CD3^+$, $\underline{CD4}^+$, $CD5^+$, $\underline{CD10}^+$, $\underline{BCL\text{-}6}^+$, $\underline{CD30}^+$
- EBER-ISH positive (HIV-, HBV-, HCV-)
- BM Biopsy: negative
- CT C/A/P: Diffuse adenopathy; Stage III, IPI 2
- EBV DNA PCR not done (outside hospital)

1L Therapy **Box B**

- EPOCH x 1 (inpatient) > 5 cycles of BV-CHP
- EOT PET: Complete Metabolic Response (CMR)
- Auto SCT consolidation
- Nodal Progression 10 months later

2L Therapy

- Romidepsin x 4 cycles (months)
- PET2: Stable Disease; PET4 Disease Progression
- Hypercalcemia, AKI, elevated LFTs, ECOG=2

3L Therapy

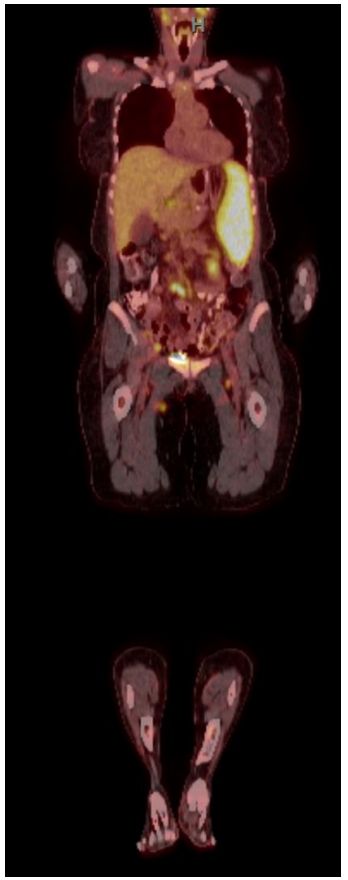
- Gem/Ox x 1 cycle > septic shock

Post-3L Therapy Progression **Box C**

- Declining PS, G4 pancytopenia, AKI
- CTAP: New splenomegaly (18 cm)
- LDH: >1,000 IU/mL
- Repeat biopsy: AITL
- IHC: $CD3^+$, $\underline{CD4}^+$, $CD5^+$, $\underline{CD10}^+$, $\underline{BCL\text{-}6}^+$, $\underline{CD30}^{NEG}$
  - EBER-ISH Positive
- BM biopsy positive (25%)

Subsequent Course **Box D**

- Steroids (Dex) for anemia and CRS
- Continuous decline of PS
- Persistent pancytopenia, elevated LFTs, Ferritin
- Diagnosis of HLH-like syndrome
- Admitted > Transitioned to hospice care



EBV viral load (c/mL)

- May: 5,147
- June: 11,798
- July: 61,982

Ferritin (ng/ml)

- May: 501
- June: 2,187
- July: 10,820

sIL-2R (pg/ml)

- May: 26,000
- June: 18,200
- July: 53,000

NAVAL-1 Trial Stages 1+2 PTCL Data and Updated Clinical/Regulatory Plans

Darrel Cohen, Viracta CMO

NAVAL-1: Pivotal Phase 2 Trial in R/R EBV$^+$ Lymphomas

Global study, with an adaptive Simon 2-stage design, focused on the largest EBV-positive lymphoma patient populations

Patient population:

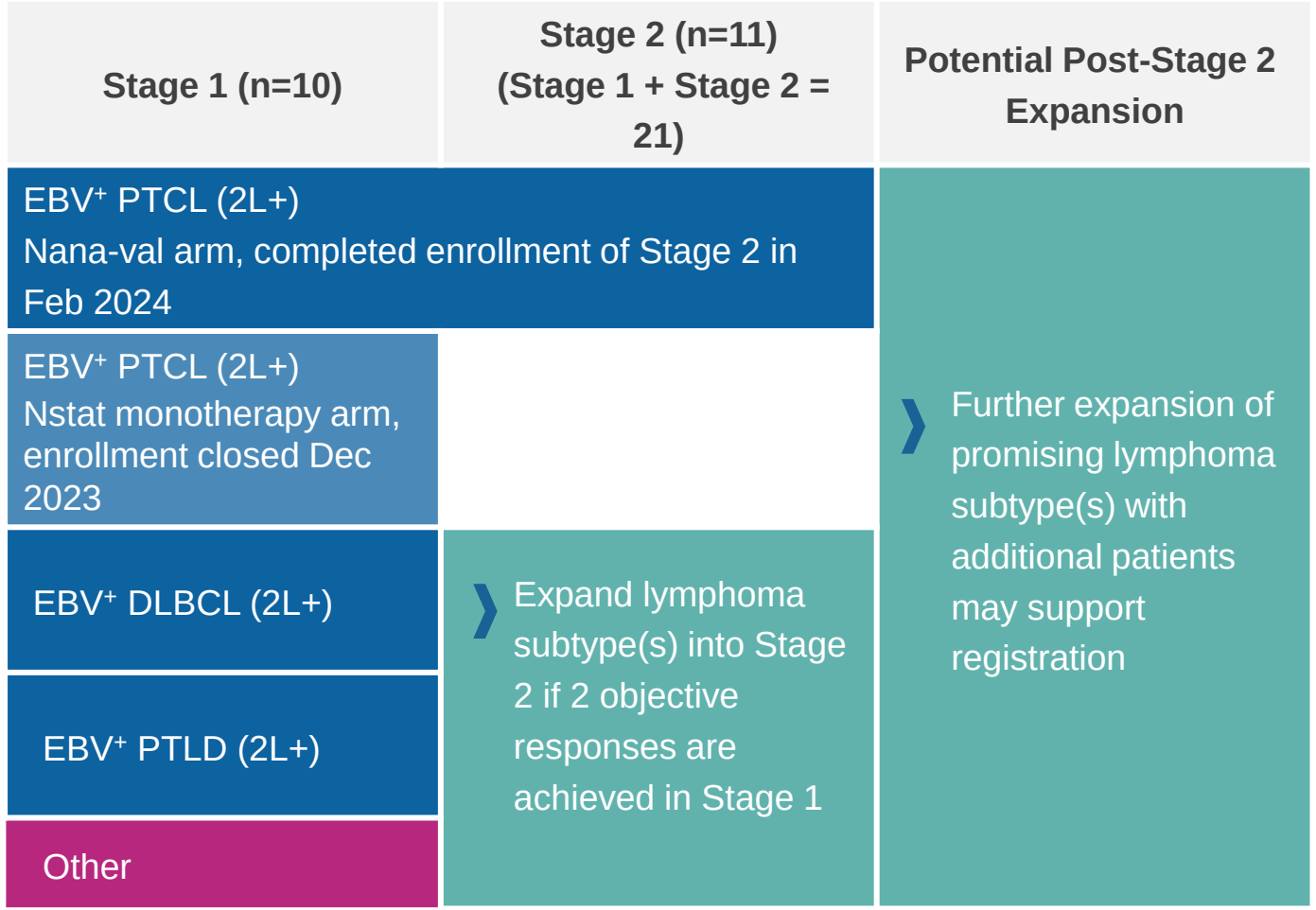
- R/R EBV$^+$ lymphoma with ≥1 prior therapies and no curative options
  - Including pediatric EBV$^+$ PTLD patients ≥12 yrs

PTCL cohort randomization:

- Patients randomized to either Nana-val or Nstat monotherapy in Stage 1

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; EBV$^+$: Epstein-Barr virus-positive; PTCL: peripheral T-cell lymphoma; DLBCL: diffuse large B-cell lymphoma; PTLD: post-transplant lymphoproliferative disorders; 2L second-line

NAVAL-1 Demographics for Patients with R/R EBV+ PTCL

NAVAL-1
Updated 28-Jun

Characteristic	Patients Enrolled in Nana-val Combination Stages 1 and 2 (N = 21)
Median age (y), [range]	69.0 [47-85]
Male / Female	13 / 8
ECOG performance status, Unknown / 0 / 1 / 2	4 / 15 / 2
Ethnicity • WHITE • ASIAN • BLACK OR AFRICAN AMERICAN • NOT REPORTED / UNKNOWN	 13 (61.9%) 4 (19.0%) 2 (9.5%) 2 (9.5%)
PTCL subtype • AITL • PTCL-NOS	 17 (81.0%) 4 (19.0%)
Prior lines of therapy • 1 • 2 • ≥3 Median number of prior therapies [range]	 10 (47.6%) 8 (38.1%) 3 (14.3%) 2 [1-4]
Stage • Unknown • I-II • III-IV	 2 (9.5%) 4 (19.0%) 15 (71.4%)

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All-Oral Regimen of Nana-val was Generally Well-Tolerated

Consistent with the known safety profile from over 150 patients treated with Nana-val

NAVAL-1

Updated 28-Jun

Most Frequently Occurring (≥10%) Treatment-Related Treatment-Emergent Adverse Events by Severity Grade and Preferred Term

Preferred Term[1]	Stages 1 and 2 Nana-val (N=21)	
	All[2]	Grade 3/4
Fatigue	4 (19.0%)	0
Nausea	4 (19.0%)	0
Decreased appetite	3 (14.3%)	0
Diarrhoea	3 (14.3%)	1 (4.8%)
Platelet count decreased	3 (14.3%)	1 (4.8%)

[1]Adverse events were coded to preferred terms using MedDRA, version 26.0
[2]One patient had Grade 5 pancytopenia and sepsis

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Response Rate Data from R/R EBV+ PTCL Cohort of NAVAL-1 Trial

NAVAL-1

Updated 28-Jun

Nana-val R/R EBV+ PTCL Stages 1 and Stage 2 Responses by Analysis Population

Analysis Population	ORR	CRR	CBR*
Intent-to-Treat[1]	7/21 (33%)	4/21 (19%)	10/21 (48%)
Efficacy-Evaluable[1,2]	7/17 (41%)	4/17 (24%)	10/17 (59%)
2L Intent-to-Treat[1]	6/10 (60%)	3/10 (30%)	8/10 (80%)
2L Efficacy-Evaluable[1,2]	6/9 (67%)	3/9 (33%)	8/9 (89%)

*Includes 2 SDs in patients with 2L PTCL at Week 16 and 1 SD in patient with 3L PTCL at Week 16
[1]Investigator assessed; [2]Eligible patients who have at least 1 post-baseline radiographic assessment

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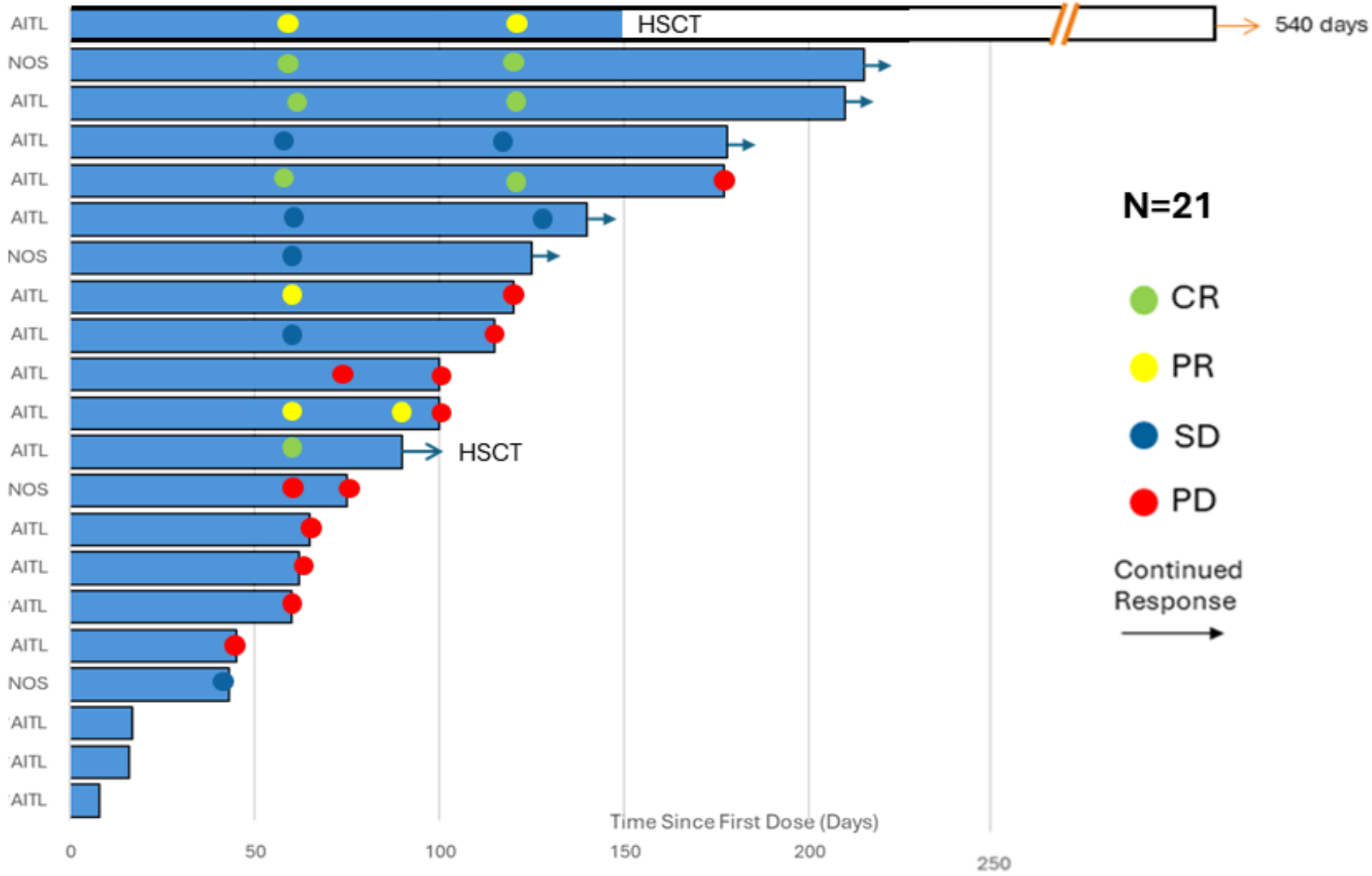
R/R: relapsed or refractory; EBV+: Epstein-Barr virus-positive; PTCL: peripheral T-cell lymphoma; ; ORR: overall response rate; CRR: complete response rate; CBR: clinical benefit rate

Nana-val 2L+ EBV+ PTCL Patient Responses (Stages 1 and 2)

Median Duration of Response not yet reached with 7 patients still on study treatment or post-HSCT

NAVAL-1

Updated 28-Jun



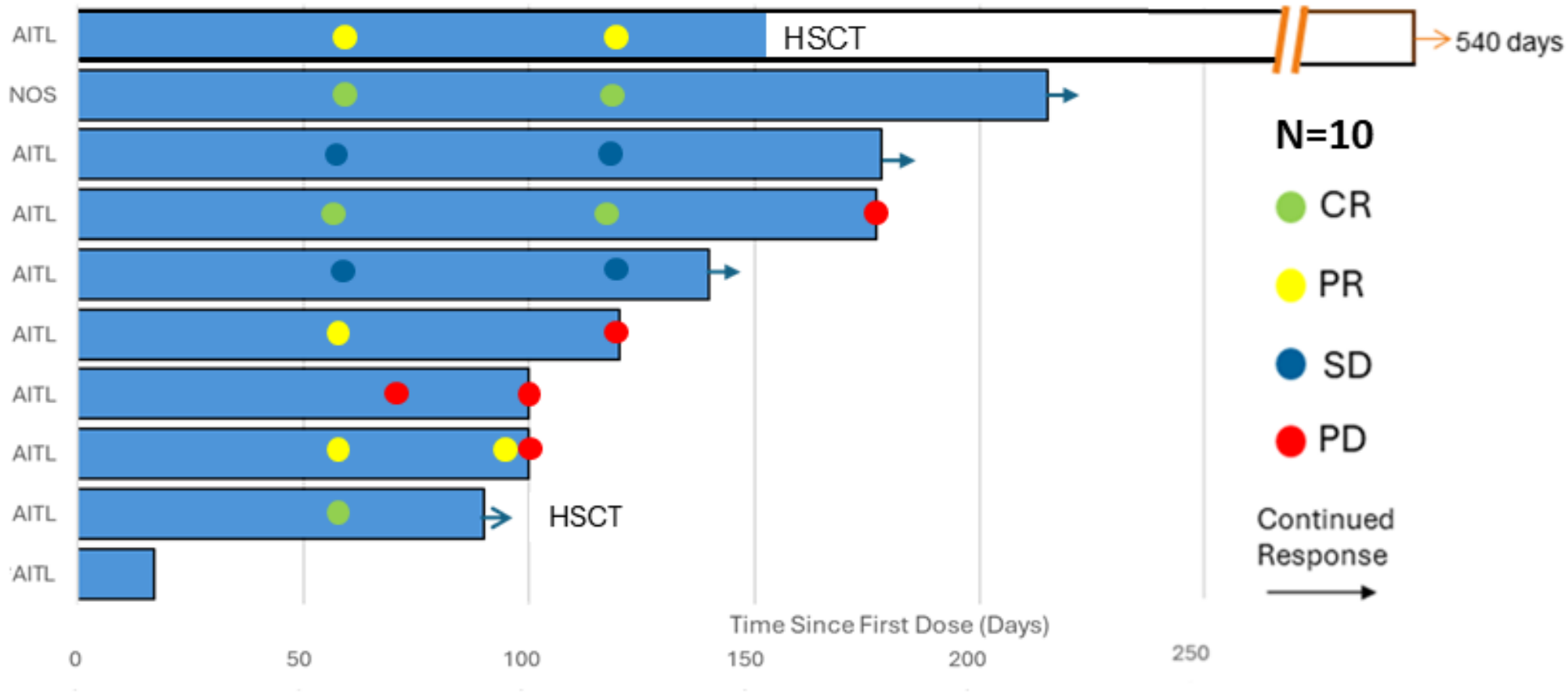
R/R: relapsed or refractory; EBV+: Epstein-Barr virus positive; PTCL: peripheral T-cell lymphoma, AITL: angioimmunoblastic T-cell lymphoma; NOS: PTCL not otherwise specified
CR: complete response; PR: partial response; SD: stable disease: PD: progressive disease; HSCT: hematopoietic stem cell transplant

Nana-val 2L EBV+ PTCL Patient Responses (Stages 1 and 2)

Median Duration of Response not yet reached with 5 patients still on study treatment or post-HSCT

NAVAL-1

Updated 28-Jun

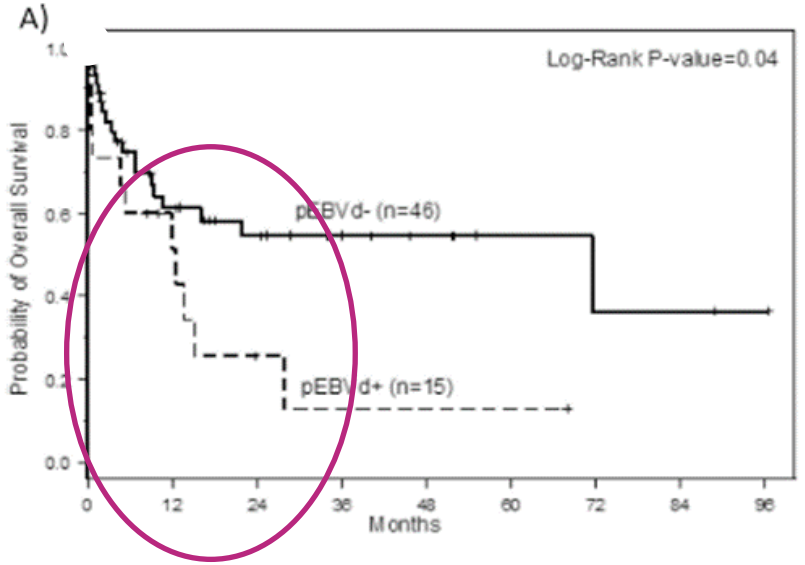


2L: second-line; EBV+: Epstein-Barr virus positive; PTCL: peripheral T-cell lymphoma, AITL: angioimmunoblastic T-cell lymphoma; NOS: PTCL not otherwise specified
CR: complete response; PR: partial response; SD: stable disease: PD: progressive disease; HSCT: hematopoietic stem cell transplant

EBV+ PTCL Patients Progress Very Rapidly, and thus Treating Early with an EBV-Targeted Treatment Is Essential

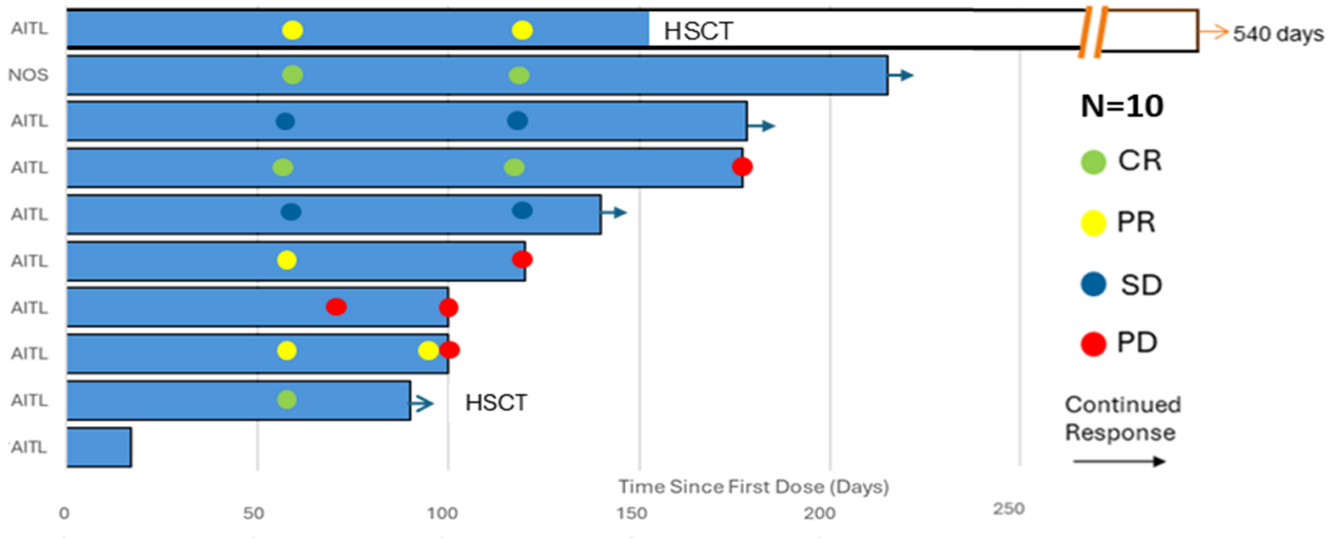
Stages 1 + 2 data shows high response rate in 2L EBV+ PTCL patients with a median DoR that has not yet been reached

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



PTCL EBV+ Rate: 40-65%

60% ORR From NAVAL-1 Stages 1 + 2 in 2L EBV+ PTCL



[1]Haverkos BM, et al. Int J Cancer. 2017.

Updated Nana-val Clinical Trial Plans in Patients with R/R EBV+ PTCL

Based on FDA Feedback and Robust NAVAL-1 Trial Stages 1 + 2 Clinical Responses

Feedback from meeting with FDA – important factors for accelerated approval NDA:

- **Compelling ORR (and DOR)**
- **Randomized controlled trial (RCT) well underway at time of NDA submission**

+

Robust clinical responses observed in 2L EBV+ PTCL patients from NAVAL-1 Trial Stages 1 and 2:

- **60% ORR (intent-to-treat)**
- **67% ORR (efficacy-evaluable)**

Best positioning for NDA submission – 4 potential opportunities:

- **NDA filing in 2026 for accelerated approval**
- **3 potential alternative opportunities**

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EBV+: Epstein-Barr virus-positive; PTCL: peripheral T-cell lymphoma; FDA: Food and Drug Administration; NDA: new drug application; R/R: relapsed or refractory; 2L: second-line; ORR: overall response rate; DOR: duration of response; RCT: randomized controlled trial

Updated Nana-val Clinical Trial Plans in Patients with R/R EBV+ PTCL

Four opportunities for potential NDA submission (1st of 2 slides)

Incorporating Data and FDA Feedback, Plan to Bring Forward Initiation of RCT While Continuing NAVAL-1 Trial

A. Based on NAVAL-1 outcomes: Continue 120-patient **NAVAL-1** post-Stage 2 R/R (2L+) EBV+ PTCL expansion cohort with focus on ***2L EBV+ PTCL***

- Reapproach FDA for potential accelerated NDA submission based on compelling ORR with mDOR ≥6 months and provided that RCT is well underway

  (1) After 40 **2L EBV+ PTCL** patients enrolled and followed for at least 6 months at **interim analysis**, or

  (2) After 120 **2L+ EBV+ PTCL** patients enrolled and followed for at least 6 months at **final analysis**

- Preserves opportunity for full approval in Japan following successful PMDA meeting

(1), (2) indicate opportunities for potential NDA submission

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EBV+: Epstein-Barr virus-positive; PTCL: peripheral T-cell lymphoma; RCT: randomized controlled trial; FDA: Food and Drug Administration; PMDA: Pharmaceuticals and Medical Devices Agency
R/R: relapsed or refractory; 2L: second-line; ORR: overall response rate; mDOR: median duration of response; PFS: progression-free survival; NDA: new drug application

Updated Nana-val Clinical Trial Plans in Patients with R/R EBV+ PTCL

Four opportunities for potential NDA submission (2nd of 2 slides)

Incorporating Data and FDA Feedback, Plan to Bring Forward Initiation of RCT While Continuing NAVAL-1 Trial

B. Based on RCT outcomes: Nana-val vs. investigator's choice available therapy in 120 patients (n=60 per arm) with ***2L EBV+ PTCL***

- Plan **interim analysis of ORR** after 60 patients (n=30 per arm) enrolled and followed for at least 6 months

  (3) Plan accelerated NDA submission if statistically significant ORR improvement with mDOR ≥6 months and favorable safety profile

- Plan **final analysis of PFS** after 120 patients with 2L EBV+ PTCL (n=60 per arm) enrolled and followed for at least 6 months

  (4) Plan full NDA submission if statistically significant improvement in PFS supported by secondary endpoints

(3), (4) indicate opportunities for potential NDA submission

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EBV+: Epstein-Barr virus-positive; PTCL: peripheral T-cell lymphoma; RCT: randomized controlled trial; FDA: Food and Drug Administration: NDA: new drug application; R/R: relapsed or refractory; 2L: second-line; ORR: overall response rate; mDOR: median duration of response; PFS: progression-free survival

Nana-val Compares Favorably to Other Therapies that Received Accelerated Approval for the Treatment of R/R PTCL

Criteria	Nana-val*	Beleodaq** (Belinostat)	Istodax** (Romidepsin)	Folotyn** (Pralatrexate)
Indication(s)	**R/R EBV$^+$ PTCL**	**R/R PTCL (EBV$^+$ & EBV$^-$)**	**R/R PTCL (EBV$^+$ & EBV$^-$)**	**R/R PTCL (EBV$^+$ & EBV$^-$)**
Overall Response Rate (ORR)	60-67% (2L) 33-41% (2L+)	25.8%	26.2%	26.6%
Complete Response Rate (CRR)	30-33% (2L) 19-24% (2L+)	10.8%	15.4%	8.3%
Duration of Response (DoR)	Not yet reached	8.4 months	<8.5 months	9.4 months
Registration Sample Size	40 (IA) 120 (FA)	120	130	109
Route of Administration	Oral	IV	IV	IV

*Covers NAVAL-1 Stages 1 + 2 responses analyzed in both the response-evaluable and ITT populations, **Per product label (response-evaluable population)

Anticipated Milestones and Closing Remarks

Mike Faerm, CFO

Mark Rothera, CEO

Anticipated 2024-2026 Milestones

Trial	Indication	Q1:2024	Q2:2024	Q3:2024	Q4:2024	2025-2026
NAVAL-1 Trial of Nana-val (R/R EBV⁺ Lymphomas)	R/R EBV⁺ PTCL	Q1:24 - Complete enrollment of Stage 2 (n=11) ✓	✓ Enroll patients into the post-Stage 2 expansion cohort to support potential accelerated approval Q2:24 - Report Stage 1 data from both arms: nanatinostat with (n=10) or without (n=10) valganciclovir ✓ Mid:24 - Meet with the FDA to discuss additional requirements for accelerated approval ✓	Q3:24 - Present Stages 1+2 data ✓	Q4:24 – Present data from expansion cohort	H1:25 – Present additional data from expansion cohort H1:25 – Meeting with FDA – RCT Alignment H2:25 – Begin RCT Enrollment 2026 – Present Interim NAVAL-1 Data 2026 – File NDA for AA Based on Interim NAVAL-1 Data
	R/R EBV⁺ DLBCL					H1:25 – Report Stage 1 Data

Related Strategic and Resource Prioritization Actions

- Pausing development of solid tumor program after RP2D determination in 2H:24
- Reduction in force of ~23% of company's employees in August 2024

R/R: relapsed or refractory; EBV⁺: Epstein-Barr Virus-positive

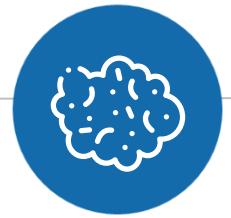
Focus is Maximizing the Nana-val Opportunity

Adverse survival outcomes are seen with many EBV-associated cancers

High unmet medical need *for targeted therapies*

Well-tolerated, all-oral combination approach to targeting EBV+ cancers

First-in-class targeted treatment; *potential tumor agnostic MOA*



NAVAL-1 trial in multiple R/R EBV+ lymphoma subtypes

Positive Stages 1 + 2 PTCL efficacy data *particularly in second-line patients*

FDA interaction provides clarity on regulatory path

Potential for NDA filing for accelerated approval in 2026; *fast track designation & 7 orphan drug designations*

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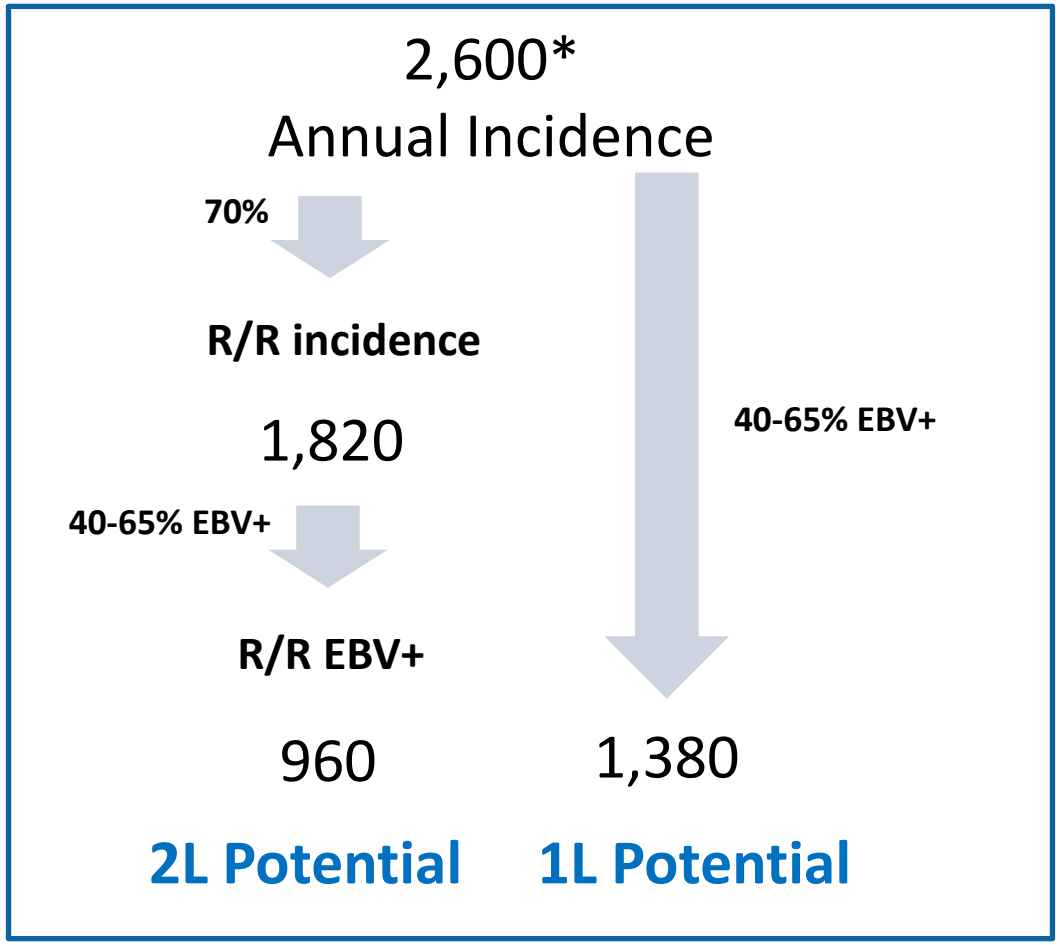
Questions and Answers

Appendix

Nana-val:
Lymphoma Market Opportunity

US EBV+ PTCL Market Opportunity*

Patients



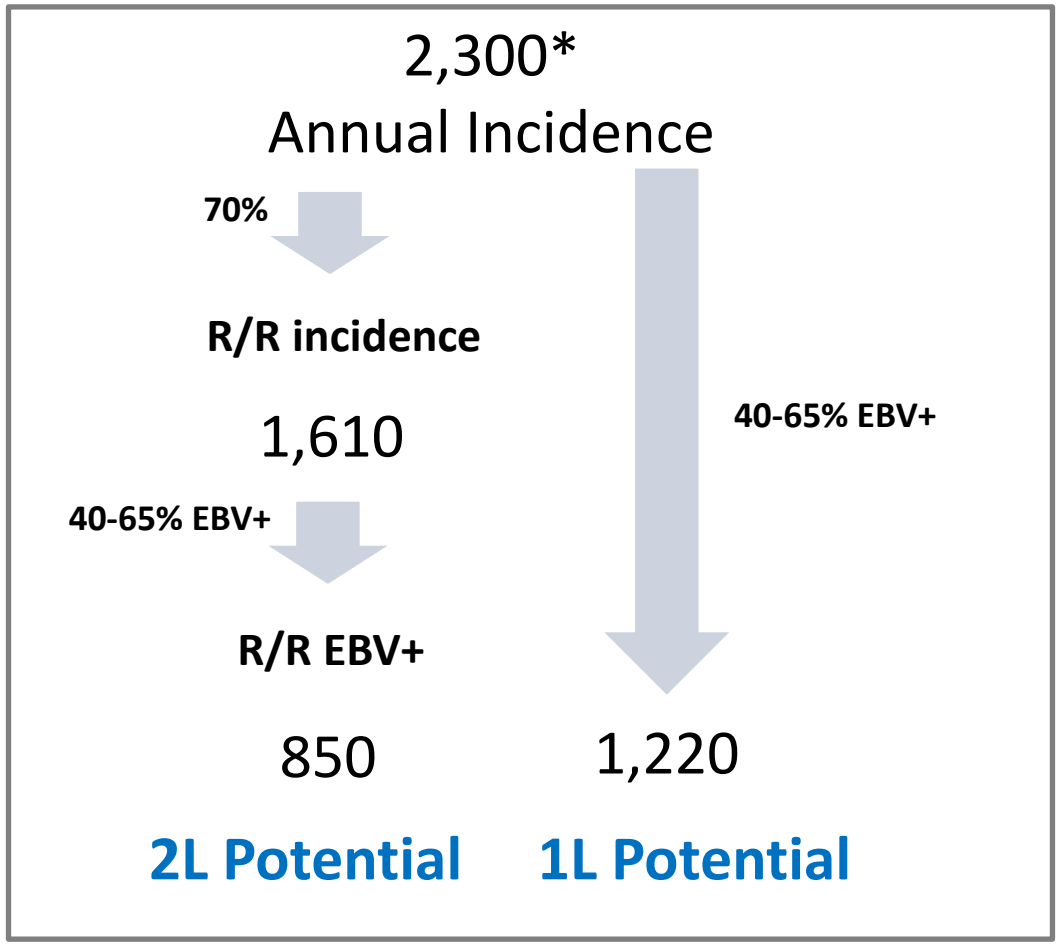
Other Key Drivers

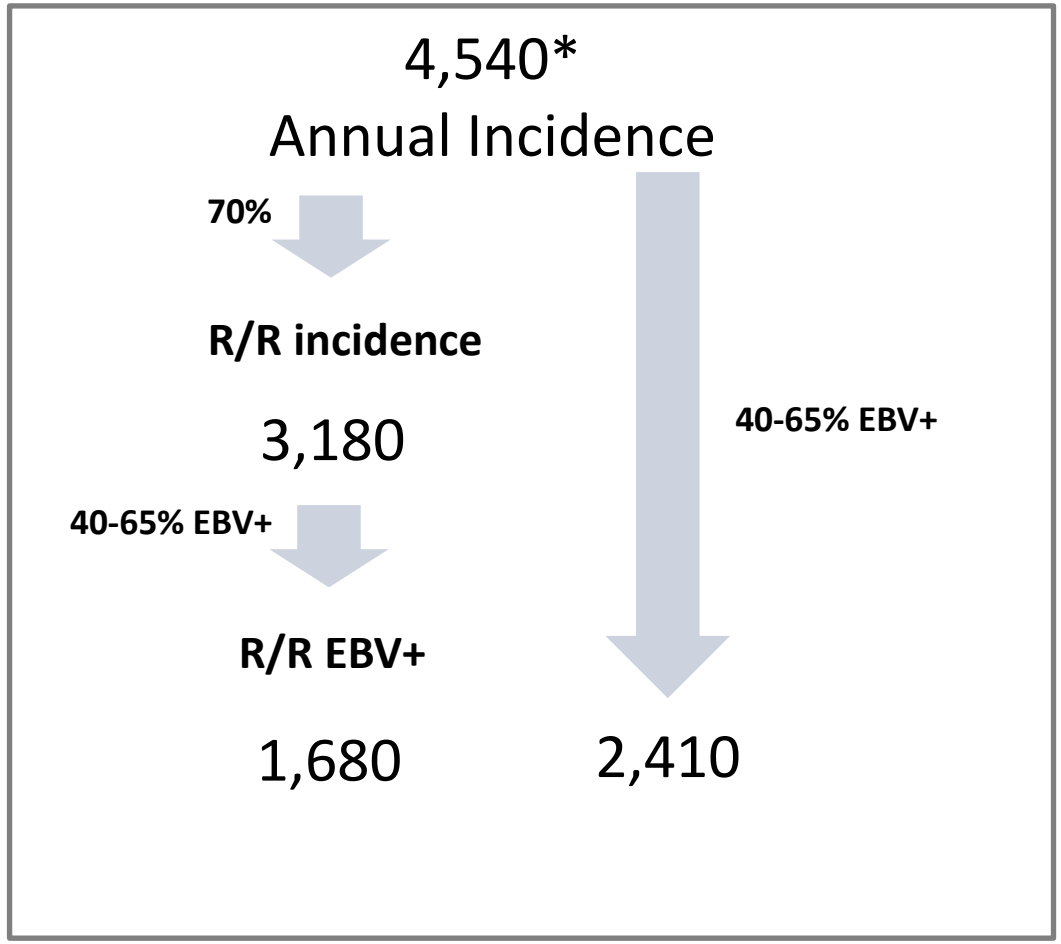
Response rate	60% ITT in 2L
Pricing Considerations	No standard of care for second line Low 5-year survival (11%) Strong preliminary Nana-val data
Line of Therapy	Potential 2L → 1L
Duration of Response	Current therapies: 4-8 months*** Nana-val: 17.3 months (201 study)** NAVAL-1 mDOR not yet reached
Market Penetration	Effective, well tolerated, targeted, easy to use (outpatient oral therapy).
EBV Testing Rate	Testing encouraged by guidelines Nana-val availability will drive testing

*Includes PTCL-NOS and AITL, Sources – Tessellon and SEER stat database
^Luan, Y., Li, X., Luan, Y. *et al.* Therapeutic challenges in peripheral T-cell lymphoma. *Mol Cancer* **23**, 2 (2024). https://doi.org/10.1186/s12943-023-01904-w

**Presented at HEMO 2023, Juliana Pereira, ***Charles River Associates Primary Research 2023

Japan and Europe EBV+ PTCL Market Opportunity*





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*Includes PTCL-NOS and AITL. For big 5 EU (includes UK), extrapolated for total EU.
Tessellon, NVS/FRANCIM Cancer Registry, Cancer Research UK, Robert Koch Institute
^Luan, Y., Li, X., Luan, Y. et al. Therapeutic challenges in peripheral T-cell lymphoma. Mol Cancer 23, 2 (2024). https://doi.org/10.1186/s12943-023-01904-w

Summary of Addressable PTCL Patients for Major Markets

				**Total**
Incidence	2,600	2,300	4,540	**9,440**
R/R	1,820	1,610	3,180	**6,610**
1L EBV+	1,380	1,220	2,410	**5,010**
2L EBV+	960	850	1,680	**3,490**

Actual number of EBV-positive cases likely underreported due to inconsistent EBV testing in the absence of an actionable EBV-targeted therapy

Includes PTCL-NOS and AITL. For big 5 EU (includes UK), extrapolated for total EU.
Tessellon, SEER Stat database, NVS/FRANCIM Cancer Registry, Cancer Research UK, Robert Koch Institute, Japan national Cancer Center

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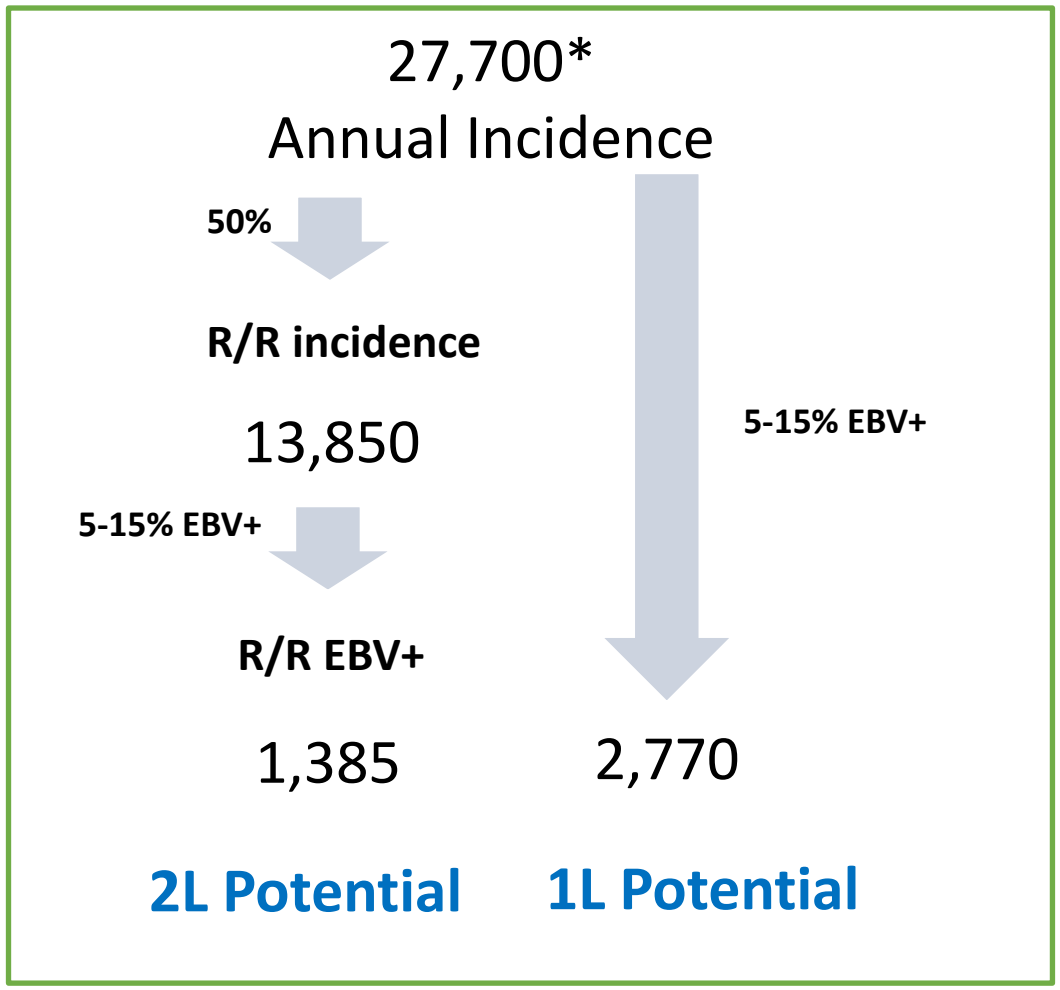
US EBV+ DLBCL Market Opportunity

Patients

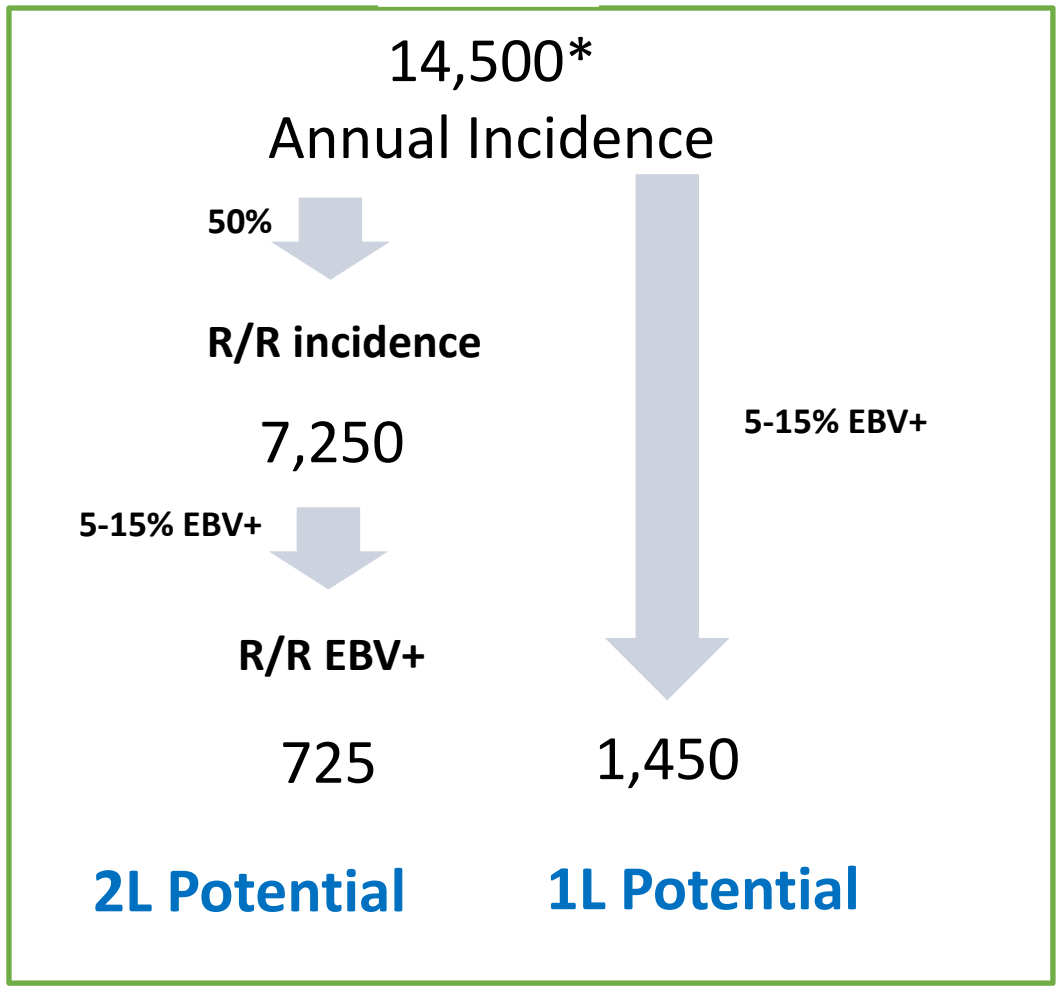


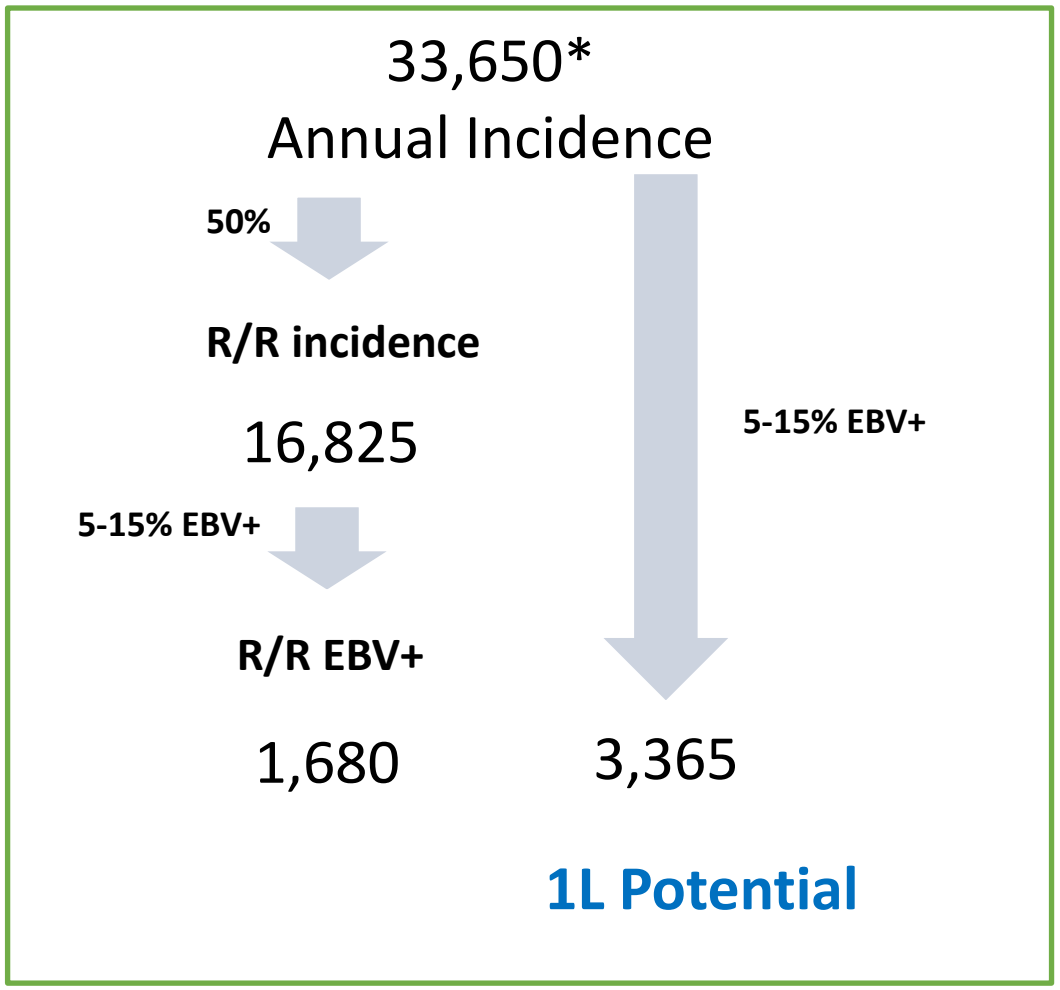
Other Key Drivers

Response rate	ORR = 67%, CR = 33%
Pricing Considerations	Separate EBV+ WHO classification Low 5-year survival Strong preliminary Nana-val data
Line of Therapy	Potential 2L → 1L
Duration of Response	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)*
Market Penetration	Effective, well tolerated, targeted, easy to use (outpatient oral therapy).
EBV Testing Rate	Opportunity to drive awareness Nana-val availability will drive testing

*Sources – Tessellon and SEER stat database

Japan and Europe EBV+ DLBCL Market Opportunity





*Sources – Tessellon and Japan National Cancer Center

*For big 5 EU (includes UK), extrapolated for total EU. Tessellon, NVS/FRANCIM Cancer Registry, Cancer Research UK, Robert Koch Institute

Summary of Addressable DLBCL Patients for Major Markets

				**Total**
Incidence	27,700	14,500	33,650	**75,850**
R/R	13,850	7,250	16,825	**37,925**
1L EBV+	2,770	1,450	3,365	**7,585**
2L EBV+	1,385	725	1,680	**3,790**

Actual number of EBV-positive cases likely underreported due to inconsistent EBV testing in the absence of an actionable EBV-targeted therapy

For big 5 EU (includes UK), extrapolated for total EU.
Tessellon, SEER Stat database, NVS/FRANCIM Cancer Registry, Cancer Research UK, Robert Koch Institute, Japan national Cancer Center

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