Viracta Therapeutics, Inc.

April 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.

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

Speed to market strategy for lead lymphoma indication - R/R EBV$^+$ PTCL

Anticipated near-term data disclosures and alignment with FDA on potential accelerated approval pathway in mid-2024

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

Plan to determine RP2D and initiate Phase 2 dose optimization cohort in the second half of 2024

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%**

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

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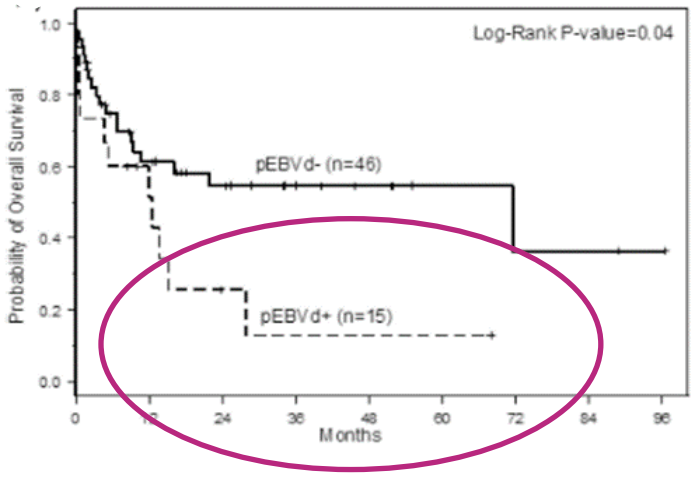
[1]Haverkos BM, et al. Int J Cancer. 2017; 140:1899-1906; Dupuis J et al. Blood. 2006;108:4163–9; [2]Swerdlow SH et al. (2017) WHO classification of Tumours of the Haematopoietic and Lymphoid Tissues; [3]Swerdlow SH et al. (2017) WHO classification of Tumours of the Haematopoietic and Lymphoid Tissues, 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

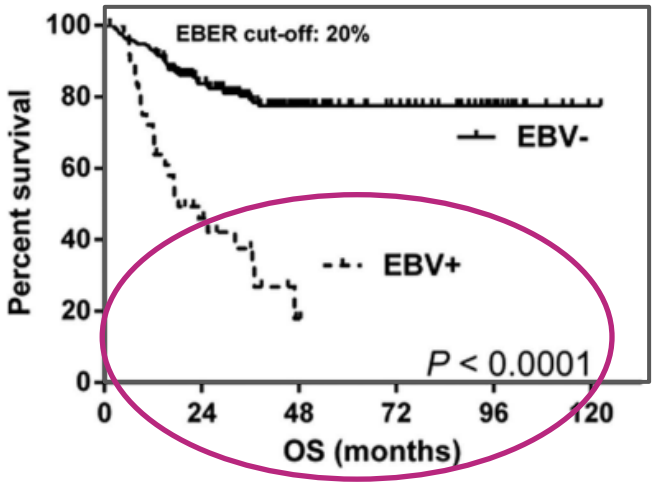
Peripheral T-cell Lymphoma[1]
(Overall Survival)



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%

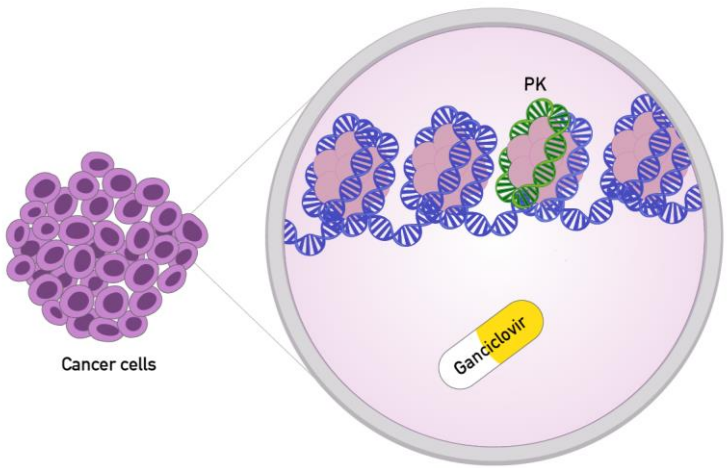
[1]Haverkos BM, et al. Int J Cancer. 2017; 140:1899-1906; Dupuis J et al. Blood. 2006;108:4163–9, [2]Lu TX et al. Sci Rep. 2015;5:1-14

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

Nanatinostat sensitizes EBV+ tumors to the cytotoxic effects of ganciclovir

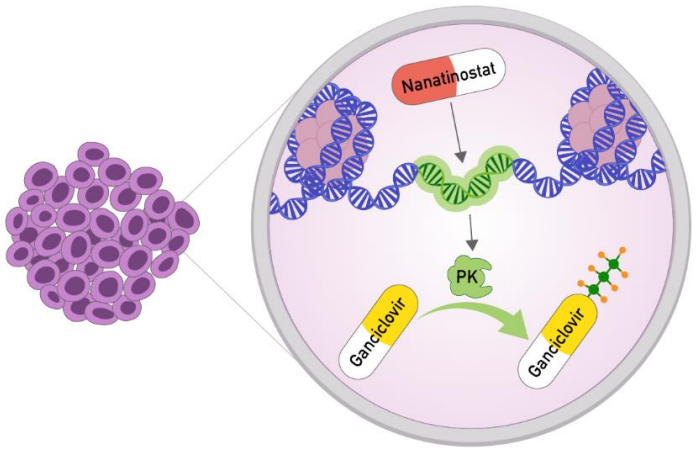
LATENCY

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



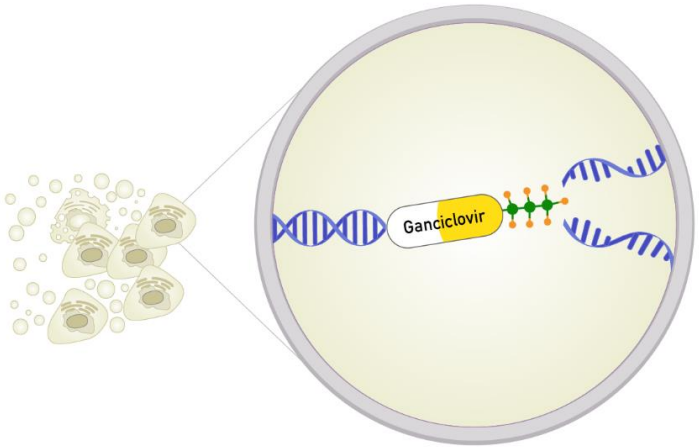
THE KICK

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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Nana-val:

R/R EBV^{+} Lymphoma Program

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:

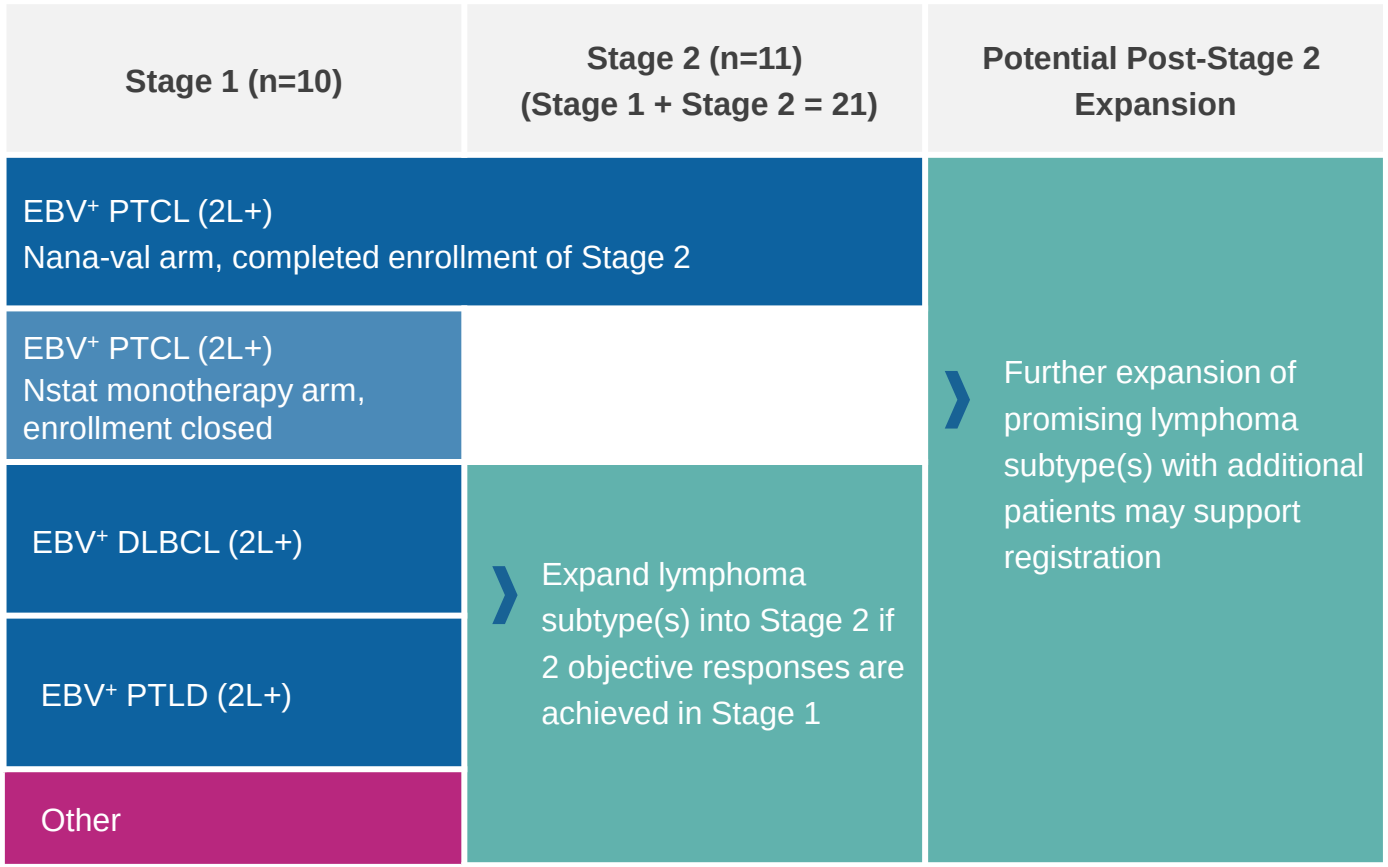
- R/R EBV+ lymphoma with ≥1 prior therapies and no curative options
  - Including pediatric EBV+ PTLD patients ≥12yrs

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; 2L Second-line

R/R EBV^{+} PTCL:
T-cell lymphoma with high unmet medical need

PTCL: Patient Journey and Treatment Options are Suboptimal*

No established second-line treatment for PTCL

Diagnosis

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

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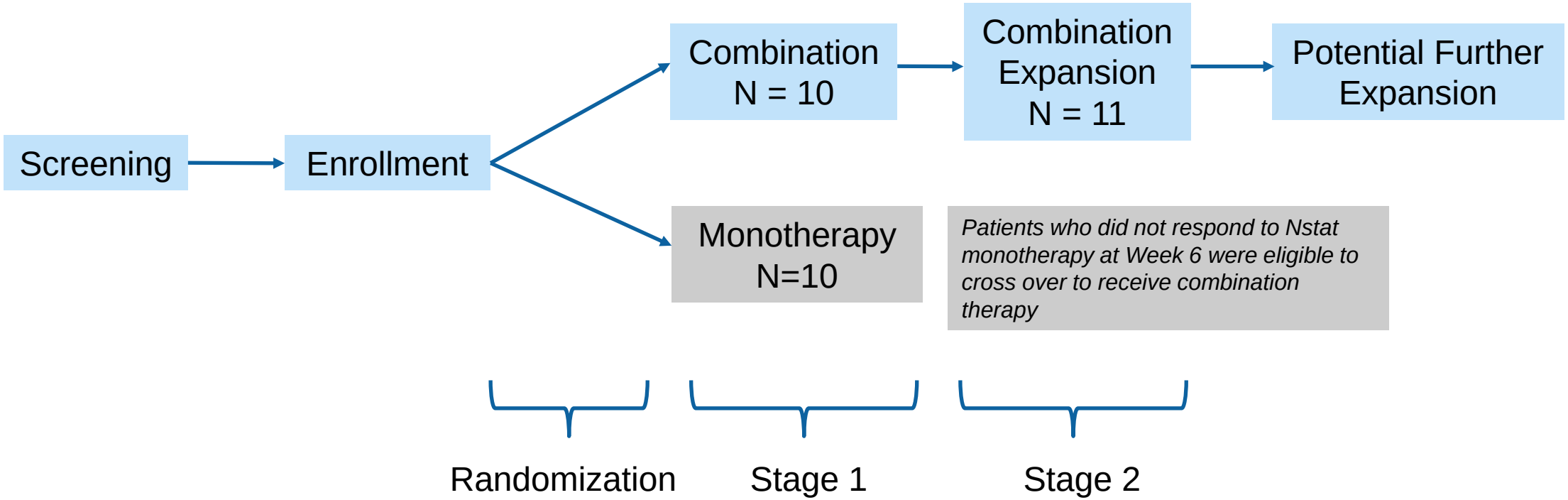
*Transplant Ineligible; [1]Trinity market research; HCT: Hematopoietic cell transplant; HDAC: Histone deacetylase

NAVAL-1 R/R EBV+ PTCL Arm Study Design



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

65% of patients with ≥2 prior lines of therapy; 75% with advanced disease

NAVAL-1

Updated 07-Feb

Characteristic	Patients Enrolled in Stage 1 (N = 20*)
Median age (y), [range]	69 [47-78]
Male / Female	16 / 4
ECOG performance status, Unknown / 0 / 1 / 2	1 / 4 / 14 / 1
Ethnicity • WHITE • ASIAN • BLACK OR AFRICAN AMERICAN • NOT REPORTED	 10 (50%) 7 (35%) 2 (10%) 1 (5%)
Prior lines of therapy • 1 • 2 • ≥3 Median number of prior therapies [range]	 7 (35%) 7 (35%) 6 (30%) 2 [1-6]
Stage • Unknown • I-II • III-IV	 2 (10%) 3 (15%) 15 (75%)

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*10 patients received Nana-val and 10 patients received Nstat monotherapy

Nana-val Provides Substantially Greater Anti-Tumor Response Than Nstat Monotherapy

NAVAL-1

Updated 07-Feb

NAVAL-1 Stage 1 Responses by Treatment Subgroup and Analysis Population

Intent-to-Treat Population[1]

PTCL Treatment Subgroup	ORR	CRR
Nana-val, Stage 1 (n=10)	5/10 (50%)	2/10 (20%)
Nstat monotherapy, Stage 1 (n=10)	1/10 (10%)	0/10 (0%)

Efficacy-Evaluable Population[1, 2]

PTCL Treatment Subgroup	ORR	CRR
Nana-val, Stage 1 (n=7)	5/7 (71%)	2/7 (29%)
Nstat monotherapy, Stage 1 (n=8)	1/8 (13%)	0/8 (0%)

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ORR, overall response rate; CRR, complete response rate

[1]Investigator assessed; [2]Eligible patients who had at least 1 post-baseline radiographic assessment

Consistent and Robust Anti-tumor Activity Demonstrated Across Nana-val Clinical Trials

Study 201 (Phase 1b/2 study) vs NAVAL-1 trial: Comparison of evaluable patients

	Study 201[1] (n=13)		NAVAL-1 (n=10)
	Evaluable Patients (n=8)		Evaluable Patients (n=7)
Response		**Response**	
ORR	**4 (50%)**	**ORR**	**5 (71%)**
CR	**3 (38%)**	**CR**	**2 (29%)**
PR	1	PR	3
SD	1	SD	0
PD	3	PD	2
Clinical Benefit Rate	5 (63%)	Clinical Benefit Rate	5 (71%)
Data Cutoff	May 4, 2023	Data Cutoff	Feb 7, 2024

CR=complete response; PR=partial response; SD=stable disease; PD=progressive disease; ORR=overall response rate, Clinical Benefit Rate=CR+PR+SD

[1]Pereira et al, Hematol Transfus Cell Ther 2023

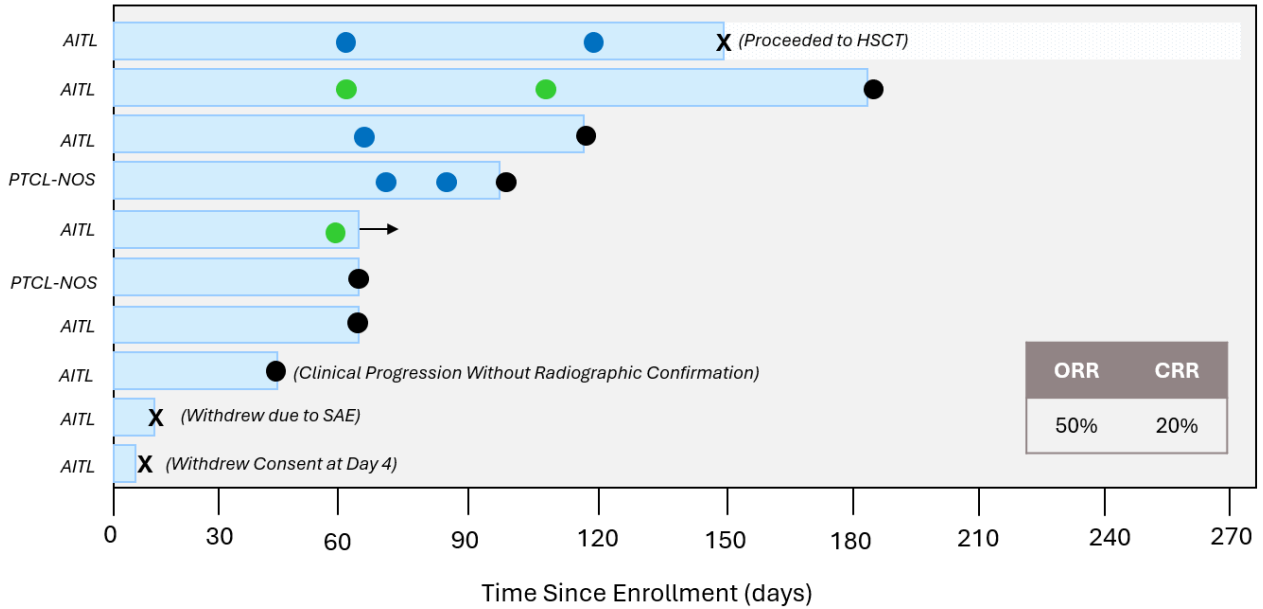
Nana-val Resulted in 5x Greater Response Rate

Randomized comparison of Nana-val to Nstat monotherapy (ITT population)

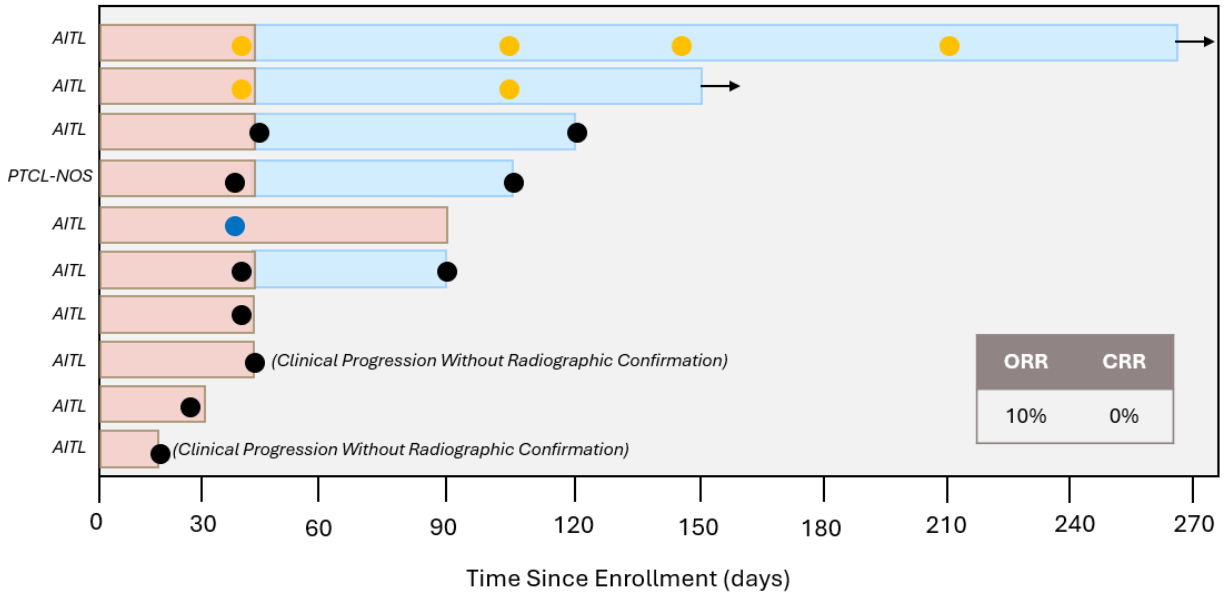
NAVAL-1

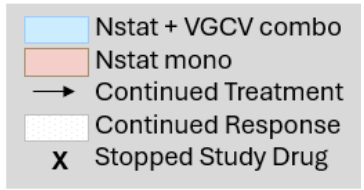
Updated 07-Feb

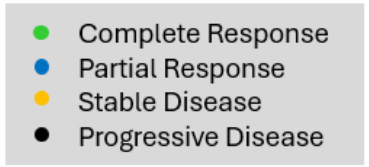
Nana-val
5/10 (50%) Responses



Nstat Monotherapy
1 PR/10 (10%)







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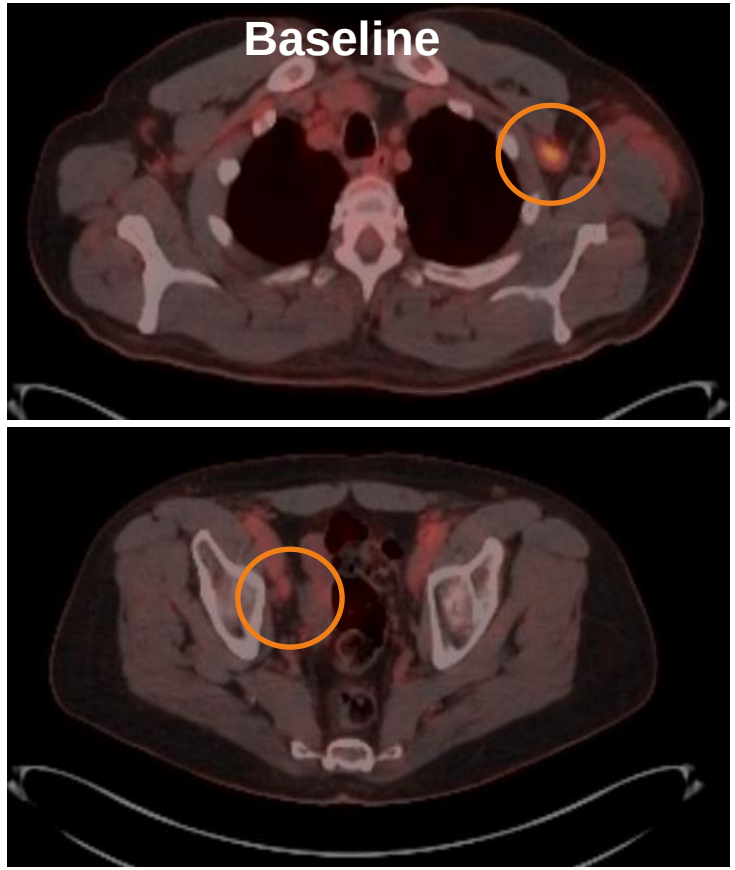
Case Study: Responder at 16 Weeks Proceeded to HSCT and Continues in Response

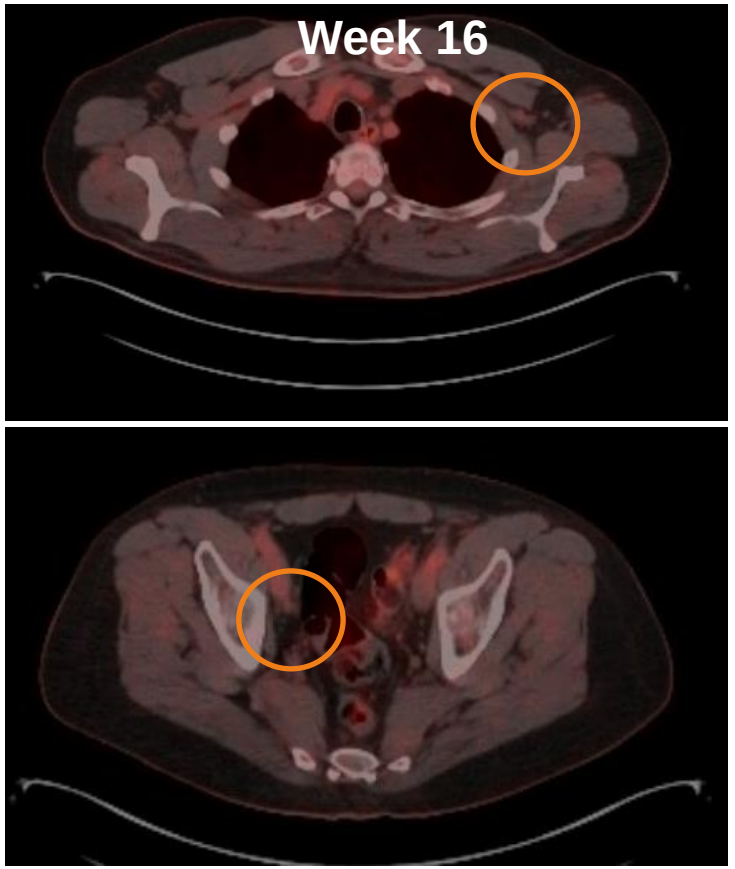
NAVAL-1

Updated 07-Feb

CT scans of confirmed PR

- 52-year-old male with R/R EBV^{+} AITL (axillary, retroperitoneal, inguinal, and pelvic lymphadenopathy)
- Previously treated with CHEOP followed by autologous stem cell transplant
- Treated with Nstat 20 mg days 1-4/week + VGCV 900 mg QD x 5 months then proceeded to allogeneic stem cell transplant
- Continues in response as of the most recent radiographic follow-up 260 days after the initial response on Nana-val





Courtesy of Dr. Brian Greenwell, Medical University of South Carolina

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All-Oral Nana-val was Generally Well-Tolerated

NAVAL-1

Updated 07-Feb

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

Preferred Term[1]	Combination Nstat + VGCV Therapy (N=10)		Nstat Monotherapy (N=10)	
	All[2]	G3+G4	All	G3+G4
Platelet count decreased	2 (20.0%)	1 (10.0%)	1 (10.0%)	0
Anaemia	1 (10.0%)	0	5 (50.0%)	4 (40.0%)
Fatigue	1 (10.0%)	0	3 (30.0%)	0
Decreased appetite	1 (10.0%)	0	3 (30.0%)	0
Nausea	1 (10.0%)	0	2 (20.0%)	0
Diarrhoea	1 (10.0%)	1 (10.0%)	2 (20.0%)	0
Weight decreased	1 (10.0%)	0	0	0

[1]Adverse events were coded to preferred terms using MedDRA, version 26.0
[2]One combination Nstat + VGCV therapy patient had G5 pancytopenia and sepsis

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R/R EBV+ PTCL: Speed to Market Strategy for Nana-val

Accelerated pace of enrollment supports speed to market strategy

Milestone	Anticipated Timing	
Complete enrollment of Stage 1 • 2 cohort arms: patients treated with nanatinostat monotherapy (n=10) or with Nana-val (n=10)	Q4 2023	✓
Complete enrollment of Stage 2	Q1 2024	✓
Present topline Stage 1 data from both arms with an aim to clearly delineate the differentiation of Nana-val's *'Kick and Kill'* MOA	Q2 2024	✓
Engage with FDA to align on requirements for regulatory approval	Mid-2024	
Enroll patients into the post-Phase 2 expansion cohort to support potential accelerated approval	Mid-2024	
Present Stage 1 + Stage 2 data (n=21)	Q3 2024	

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

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

Accelerated Approval Criteria	Nana-val: R/R EBV+ PTCL	
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 event-free 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

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)	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)

EBV+ DLBCL:
A distinct and unique subtype

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

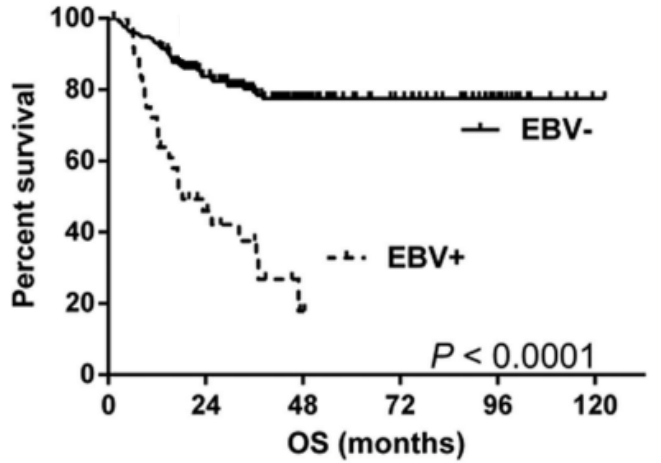
DLBCL is the most common lymphoma (~25% of all NHLs)

- ~5-15% of DLBCL cases are associated with EBV
- 5-year relative survival rate of ~64% overall

EBV+ DLBCL is a clinically more aggressive subtype of DLBCL

- Survival rate is significantly worse compared to EBV-negative 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
(Overall Survival)

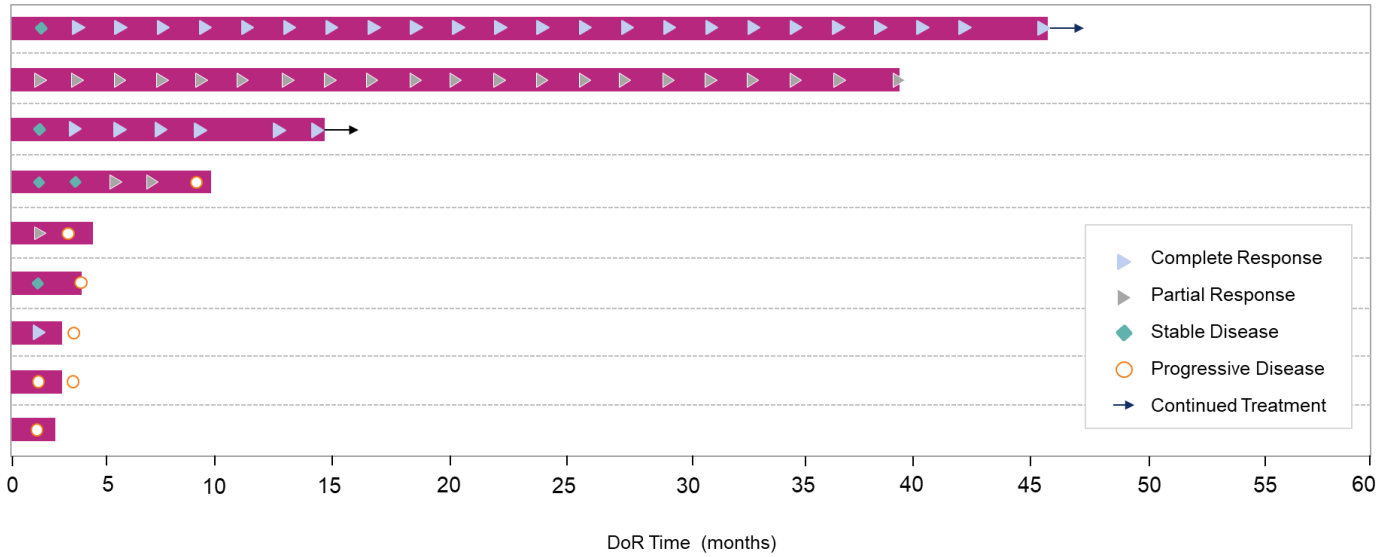


NHL: Non-Hodgkin Lymphoma, Source: Lu TX et al. Sci Rep. 2015;5:1-14, Charles River Associates Primary Research 2023

R/R EBV+ DLBCL: Expanded Clinical Response Data

Early data suggests Nana-val delivers a compelling combination of ORR and DoR

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



- Median **Duration of Response** (DoR) not yet reached
- 2 responding patients remain on study treatment with DoR times of ~11 months (CR) and ~42 months (CR) (as of May 2023)

Data cutoff: May 4, 2023, [1]Data presented at HEMO 2023; [2]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

Anticipated 2024 Milestones for Lymphoma Program

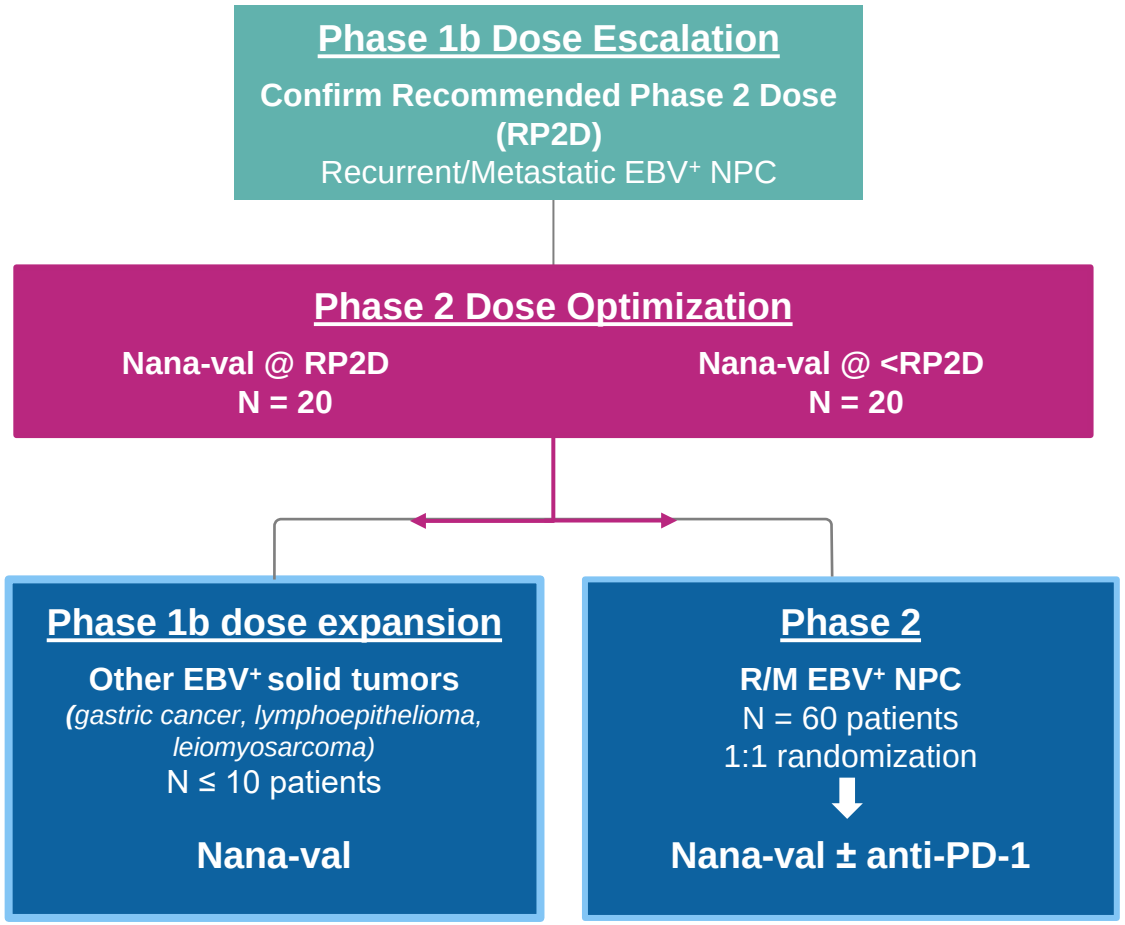
Trial	Indication	Q1:2024	Q2:2024	Q3:2024	Q4:2024
Nava-val Pivotal NAVAL-1 Trial (R/R EBV+ Lymphomas)	R/R EBV+ PTCL	Q1:24 - Complete enrollment of Stage 2 (n=11) ✓	Enroll patients into the post-Phase 2 expansion cohort to support potential accelerated approval Q2:24 - Report Stage 1 data from both arms: 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 Stage 2 data	
	R/R EBV+ DLBCL				YE:24 – Report Stage 1 data
	R/R EBV+ PTLD				YE:24 – Report Stage 1 data

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

Nana-val:
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



Endpoints:

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

Anticipate initiating Phase 2 dose optimization cohort in 2024

NCT05166577

NPC: Nasopharyngeal carcinoma, RECIST: Response Evaluation Criteria in Solid Tumors; AE: Adverse Event

Study 301: Responses to Date in Patients with R/M EBV+ NPC

Emerging evidence of dose response at higher doses and antitumor activity comparison of Dose Level 5 vs. Dose Level 2 suggest 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	● ● ● ○

Partial responses confirmed at Dose Level 3 and Dose Level 5, both ongoing >10 months and >4 months on study treatment*

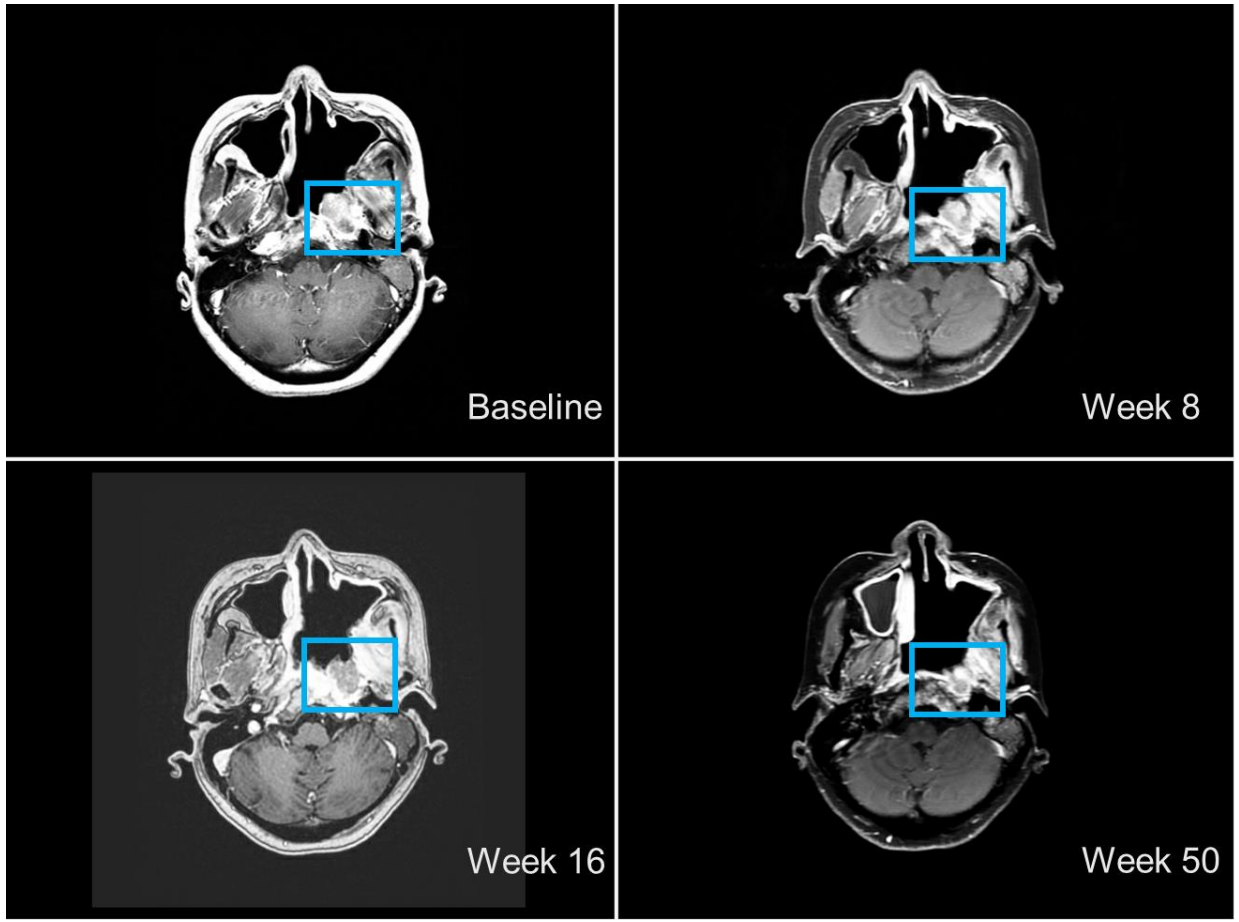
- Partial Response
- Stable Disease ≥14 wks
- Stable Disease <14 wks
- Progressive Disease

Presented at ESMO ASIA Congress 2023, *As of October 2023, NE: Not evaluable for response, R/M: Recurrent or Metastatic, NPC: Nasopharyngeal carcinoma, QD: Once daily; BID: Twice daily

Study 301: MRI Scans of Confirmed Partial Response at Dose Level 3

>50% reduction in tumor size at 8-50 weeks

- 44-year-old female with locally recurrent EBV^{+} NPC (left nasopharynx)
- Disease previously progressed through chemoradiation therapy then combination chemotherapy
- Treated with nanatinostat 40 mg QD Days 1-4/week + VGCV 900 mg QD



Courtesy of Muh-Hwa Yang, MD, PhD and Peter Mu-Hsin Chang, MD, PhD, Taipei Veterans General Hospital

Nana-val has been Generally Well-Tolerated at Initial 5 Dose Levels

Preliminary safety data support continued dose escalation to determine RP2D

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
- Majority of treatment-related adverse events were mild to moderate in severity

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Presented at ESMO Asia Congress 2023; RP2D: Recommended Phase 2 Dose; R/R: Relapsed or Refractory

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

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

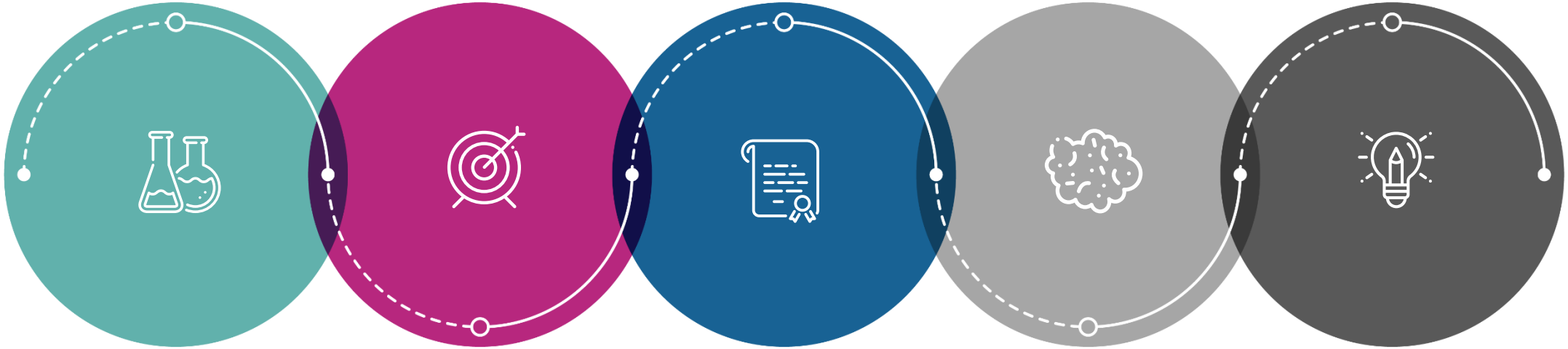
Completed enrollment of first cohort utilizing novel SDD regimen to determine RP2D, up to 3 dose levels planned

Anticipated 2024 Milestones

Trial	Indication	Q1:2024	Q2:2024	Q3:2024	Q4:2024
Pivotal NAVAL-1 Trial (R/R EBV+ Lymphomas)	R/R EBV+ PTCL	Q1:24 - Complete enrollment of Stage 2 (n=11) ✓	Enroll patients into the post-Phase 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	Q3:2024 - Present Stage 2 data	
	R/R EBV+ DLBCL				YE:24 – Report Stage 1 data
	R/R EBV+ PTLD				YE:24 – Report Stage 1 data
Phase 1b/2 Study 301 (Advanced EBV+ Solid Tumors)	NPC			H2:24 - Determine RP2D by investigating the novel split daily dosing regimen at higher dose levels of Nana-val	YE:24 - Initiate Phase 2 dose-optimization cohort to confirm RP2D

R/R: relapsed or refractory; EBV+: Epstein-Barr Virus positive; RP2D: Recommended Phase 2 Dose

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*

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

Near-term data *from PTCL cohort and alignment with FDA anticipated in mid-2024*

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

Plan to determine RP2D and ***initiate Phase 2 dose-optimization in 2024***

Lean operating model and a *speed to market* strategy

Regulatory validation with ***orphan drug designation*** *granted for Nana-Val (across six indications)*

Thank you