Viracta Therapeutics, Inc.

January 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.

Experienced Leadership Team

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Ayman Elguindy, PhD

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Yale SCHOOL OF MEDICINE

(~25 yrs. studying the role of viruses in cancer)

Patric Nelson, MBA

Senior VP, Business Dev. & Corporate Strategy

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

Adverse survival outcomes are seen with most Epstein-Barr virus (EBV)-associated cancers; need for targeted therapies

EBV-associated cancer incidence >300,000 per annum (~2% of global cancer burden)

Nana-val, an all-oral combination approach targeting EBV^{+} cancers with potential tumor agnostic MOA

Novel "Kick & Kill" Mechanism of Action

Pivotal NAVAL-1 study in multiple R/R EBV^{+} lymphoma subtypes; R/R EBV^{+} PTCL cohort enrolling patients in Stage 2

Speed to market strategy for lead R/R EBV+ PTCL cohort supported by accelerating pace of enrollment

Phase 1b/2 study in advanced EBV^{+} solid tumors; evaluating new dosing regimen based on compelling preclinical data

Enrollment underway into first split daily dosing cohort, plan to determine RP2D and initiate Phase 2 dose optimization cohort in 2024

Strategic path forward with multiple value-driving milestones

Anticipate complete enrollment of Stage 2 in the R/R EBV^{+} PTCL cohort in Q1 2024 and engagement with the FDA on potential accelerated approval pathway by mid-2024

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MOA: Mechanism of action, R/R: Relapsed or Refractory, PTCL: Peripheral T-cell lymphoma; RP2D: Recommended Phase 2 dose

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

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

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

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

~90% of the adult population are infected with EBV

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

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

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

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

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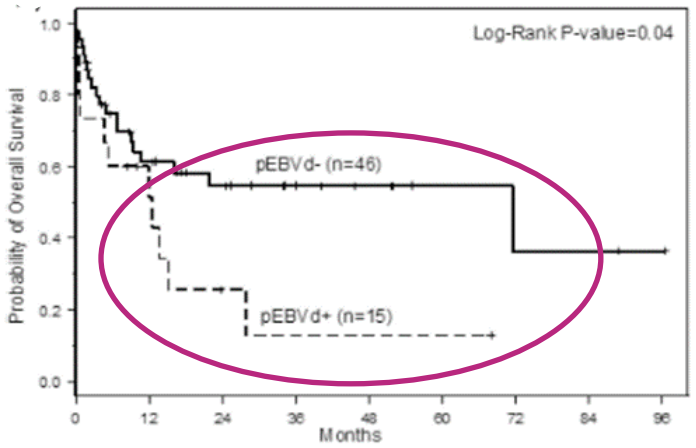
[1]Haverkos BM, et al. Int J Cancer. 2017; 140:1899-1906; Dupuis J et al. Blood. 2006;108:4163–9; [2]Swerdlow SH et al. (2017) WHO classification of Tumours of the Haematopoietic and Lymphoid Tissues; [3]EBV positivity varies by geography; [4]Wong Y, et al. Journal of Cancer Research and Clinical Oncology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

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

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

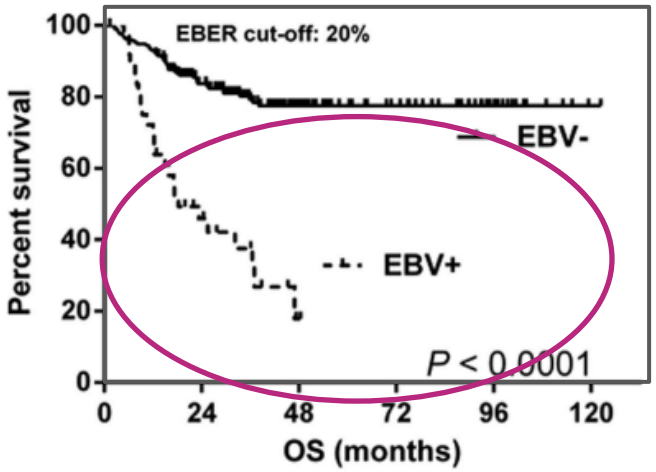
Peripheral T-cell Lymphoma[1]
(Overall Survival)



PTCL EBV+ Rate: 40-65%

Addressing patient populations with high unmet medical need

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



DLBCL EBV+ Rate: 5-15%

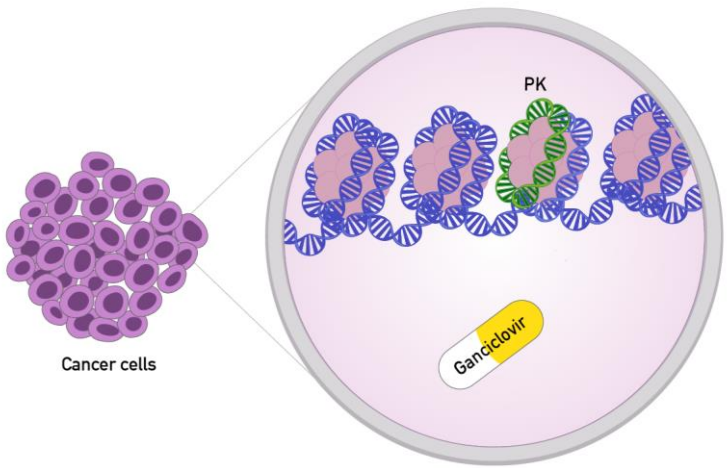
[1]Haverkos BM, et al. Int J Cancer. 2017; 140:1899-1906; Dupuis J et al. Blood. 2006;108:4163–9, [2]Lu TX et al. Sci Rep. 2015;5:1-14

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

Nanatinostat sensitizes EBV+ tumors to the cytotoxic effects of ganciclovir

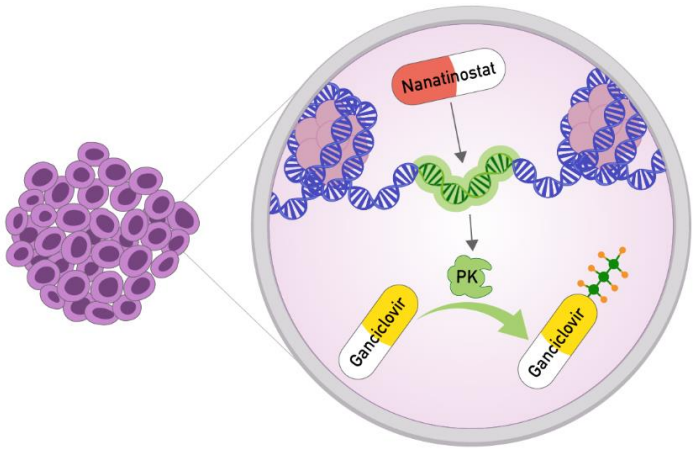
LATENCY

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



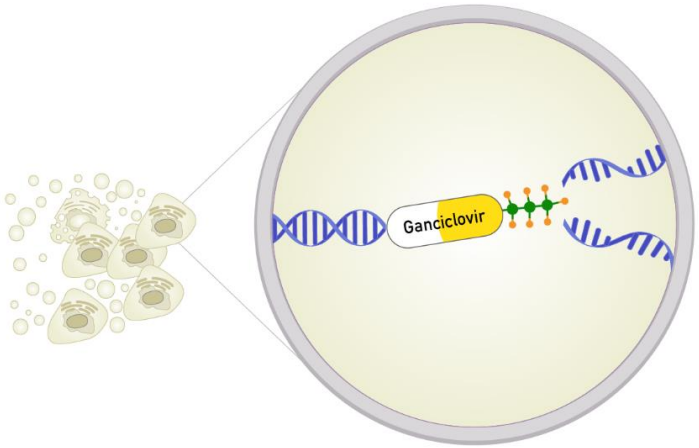
THE KICK

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:

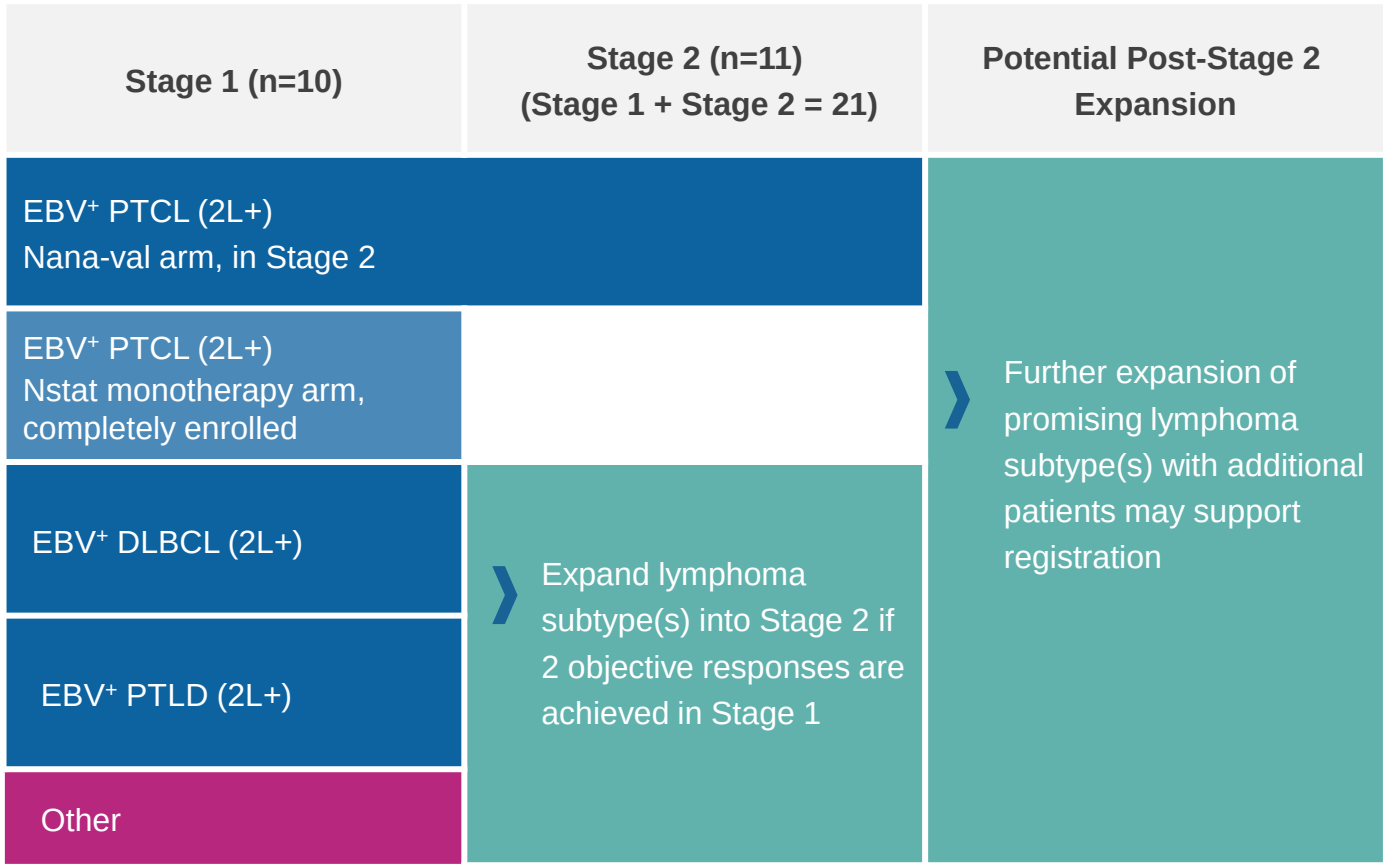
R/R EBV+ lymphoma with ≥1 prior therapies and no curative options

- Including pediatric EBV+ PTLD patients ≥12yrs

Primary endpoint:

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

***Speed to Market* strategy for lead R/R EBV+ PTCL cohort - anticipate complete enrollment of Stage 2 in Q1 2024**



R/R: Relapsed or Refractory; 2L Second-line

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

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

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

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

Treatment-emergent serious adverse events occurring in more than 1 patient (n=2 each):

- febrile neutropenia
- atrial fibrillation
- sepsis
- pneumonia (pneumonia and viral pneumonia)
- dyspnea
- acute kidney injury
- Pyrexia

There were no study treatment-related deaths

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

Data cutoff date: May 4, 2023

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

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

Completed enrollment of Stage 1 in Q4 2023; enrollment into Stage 2 continues to accelerate

- Completed enrollment of Stage 1 in Q4 2023
  - 2 cohort arms: patients treated with nanatinostat monotherapy (n=10) or with Nana-val (n=10)
- Anticipate reporting Stage 1 data at a medical meeting in H1 2024
- Anticipate complete enrollment of Stage 2 in Q1 2024
  - Nearly half of the 11 Stage 2 patients have been enrolled*
- Plan to meet with FDA to discuss additional requirements for accelerated approval in mid-2024
- Enroll patients into the post-Phase 2 expansion cohort to support potential accelerated approval
- Anticipate presenting Stage 2 data in H2 2024

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*As of January 4, 2024

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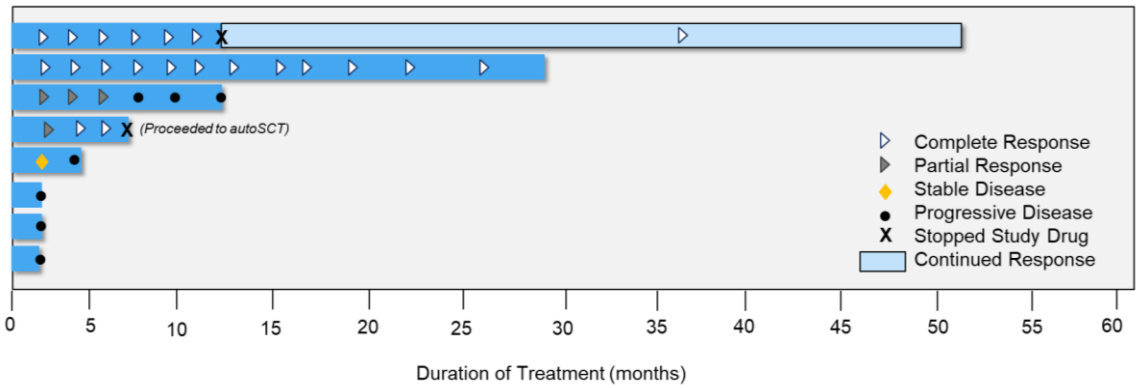
*Transplant Ineligible; [1]Trinity market research; HCT: Hematopoietic cell transplant; HDAC: Histone deacetylase

R/R EBV+ PTCL: ORR and DoR Exceeds Current Approved Therapies

Initial data from the NAVAL-1 trial are consistent with Study 201 data

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



- Median **duration of response (DoR) for Study 201** is 17.3 months as of May 4, 2023
  - Median DoRs for other R/R PTCL therapies that have received AA were ~8.5-9.5 months
- Median DoR not yet reached in NAVAL-1 trial

Study 201: Phase 1b/2 Study of Nana-val in patients with multiple subtypes of R/R EBV+ lymphoma [1]Data presented at HEMO 2023; [2]Evaluable patients: EBER-ISH+ with ≥1 post-treatment response assessment; *One patient withdrew from study due to an AE, PTCL includes: Peripheral T-cell lymphoma and Angioimmunoblastic T-cell lymphoma, ITT: Intent-to-Treat, ORR: Overall Response Rate, CR: Complete Response, PR: Partial Response, SD: Stable Disease, PD: Progressive Disease, Clinical Benefit Rate = CR + PR + SD ≥ 6 months, AA: Accelerated Approval

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

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*Trinity market research

Nana-val Compared 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

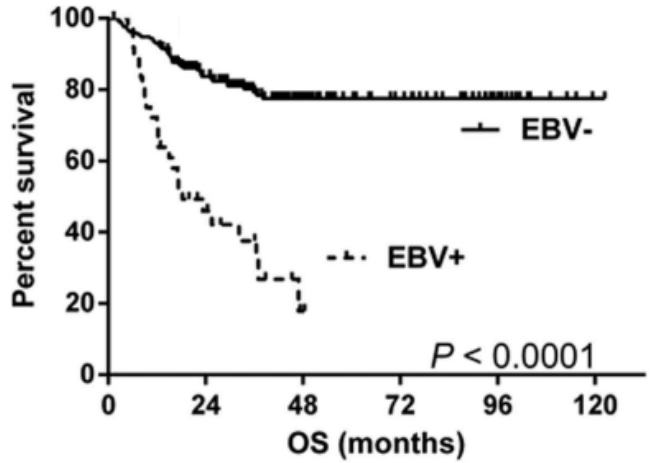
DLBCL is the most common lymphoma (~25% of all NHLs)

- ~5-15% of DLBCL cases are associated with EBV
- 5-year relative survival rate of ~64% overall
- Poor survival in R/R disease, current treatments offer modest response in 3L

EBV+ DLBCL is a clinically more aggressive subtype of DLBCL

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

Diffuse Large B-cell Lymphoma
(Overall Survival)

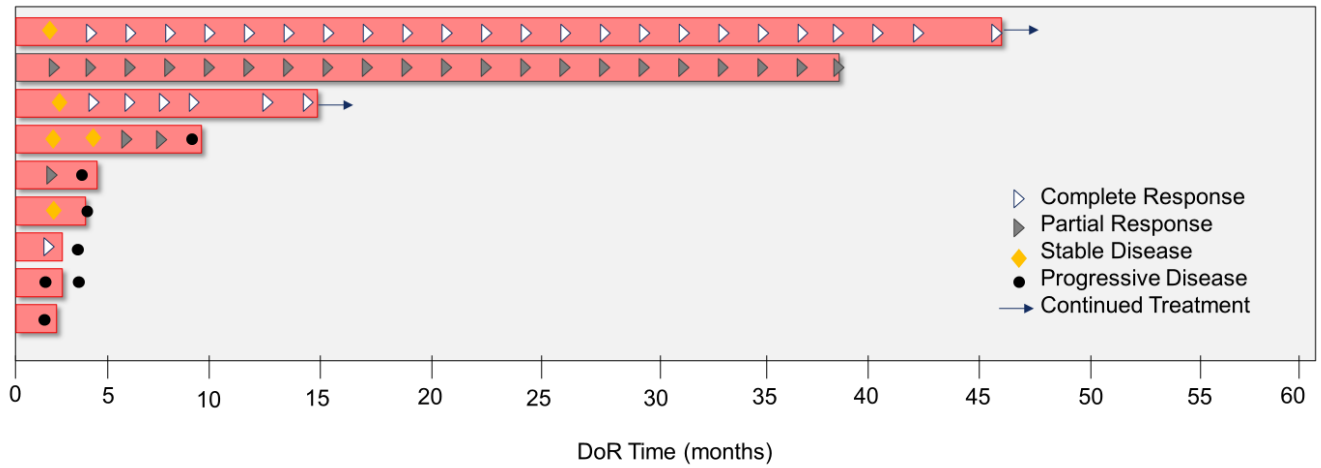


NHL: Non-Hodgkin Lymphoma, Source: Lu TX et al. Sci Rep. 2015;5:1-14, Charles River Associates Primary Research 2023

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 NAVAL-1

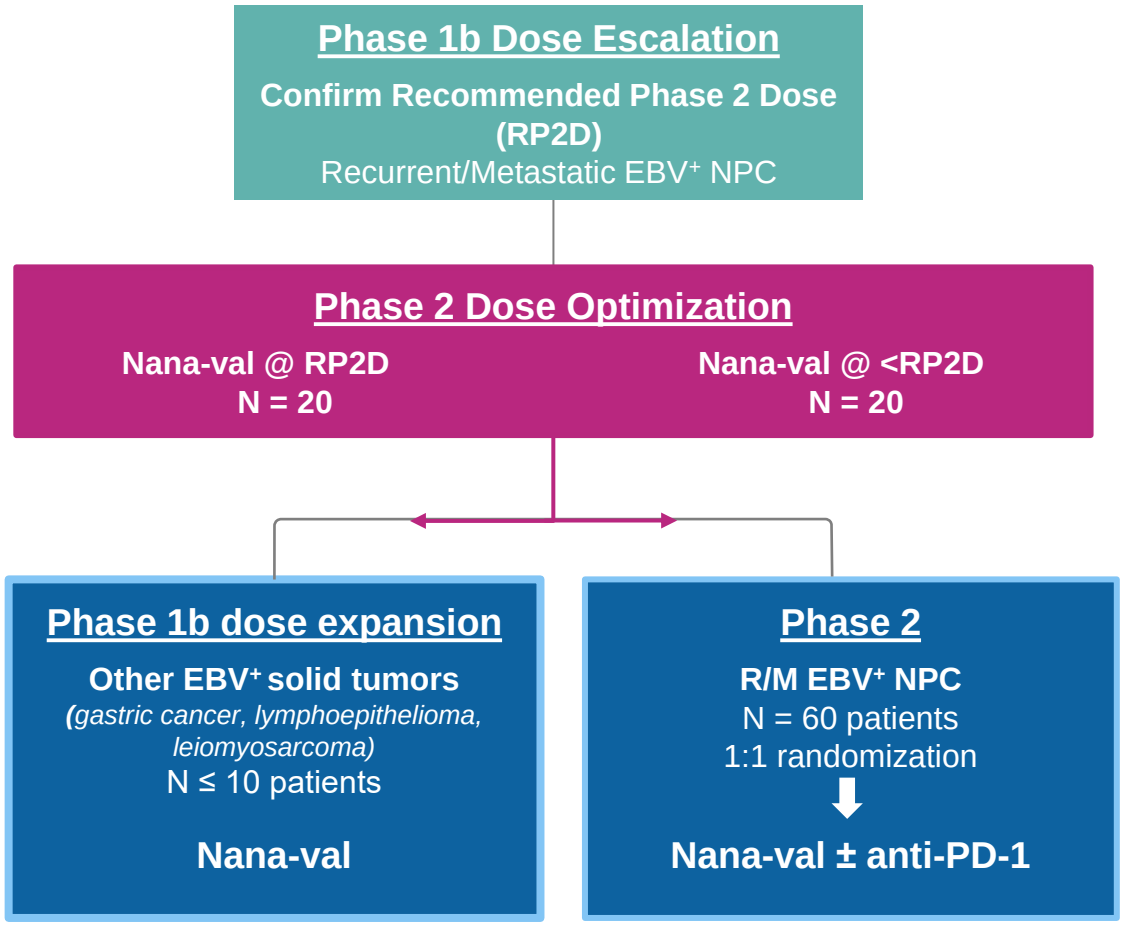
Trial	Indication	Q1:2024	Q2:2024	Q3:2024	Q4:2024
Nava-val Pivotal NAVAL-1 Trial (R/R EBV+ Lymphomas)	R/R EBV+ PTCL	Q1:2024 - Complete enrollment of Stage 2 (n=11) H1:2024 - Report Stage 1 data from both arms: nanatinostat with (n=10) or without (n=10) valganciclovir		H2:2024 - Present Stage 2 data Enroll patients into the post-Phase 2 expansion cohort to support potential accelerated approval	
	R/R EBV+ DLBCL				YE:2024 – Report Stage 1 data
	R/R EBV+ PTLD				YE:2024 – Report Stage 1 data
	Regulatory Updates		Mid:2024 - Meet with the FDA to discuss additional requirements for accelerated approval		

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

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	● ● ● ○

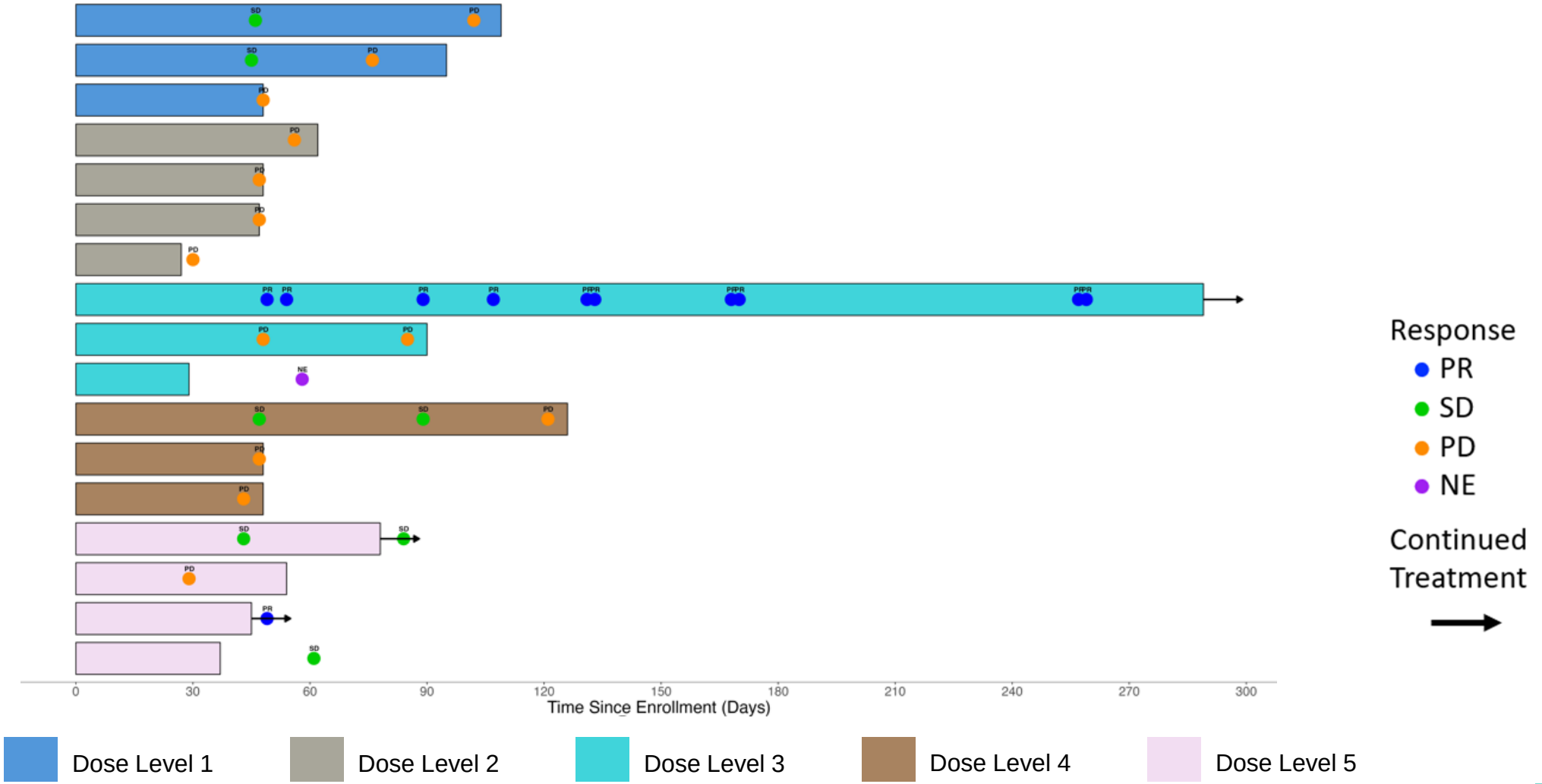
Partial responses confirmed at Dose Level 3 and Dose Level 5, both ongoing >10 months and >4 months on study treatment*

- 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: Swimmer Plot of Initial 5 Dose Cohorts

2 confirmed PRs and 5 SDs within initial 17 patients (initial 5 dose cohorts)

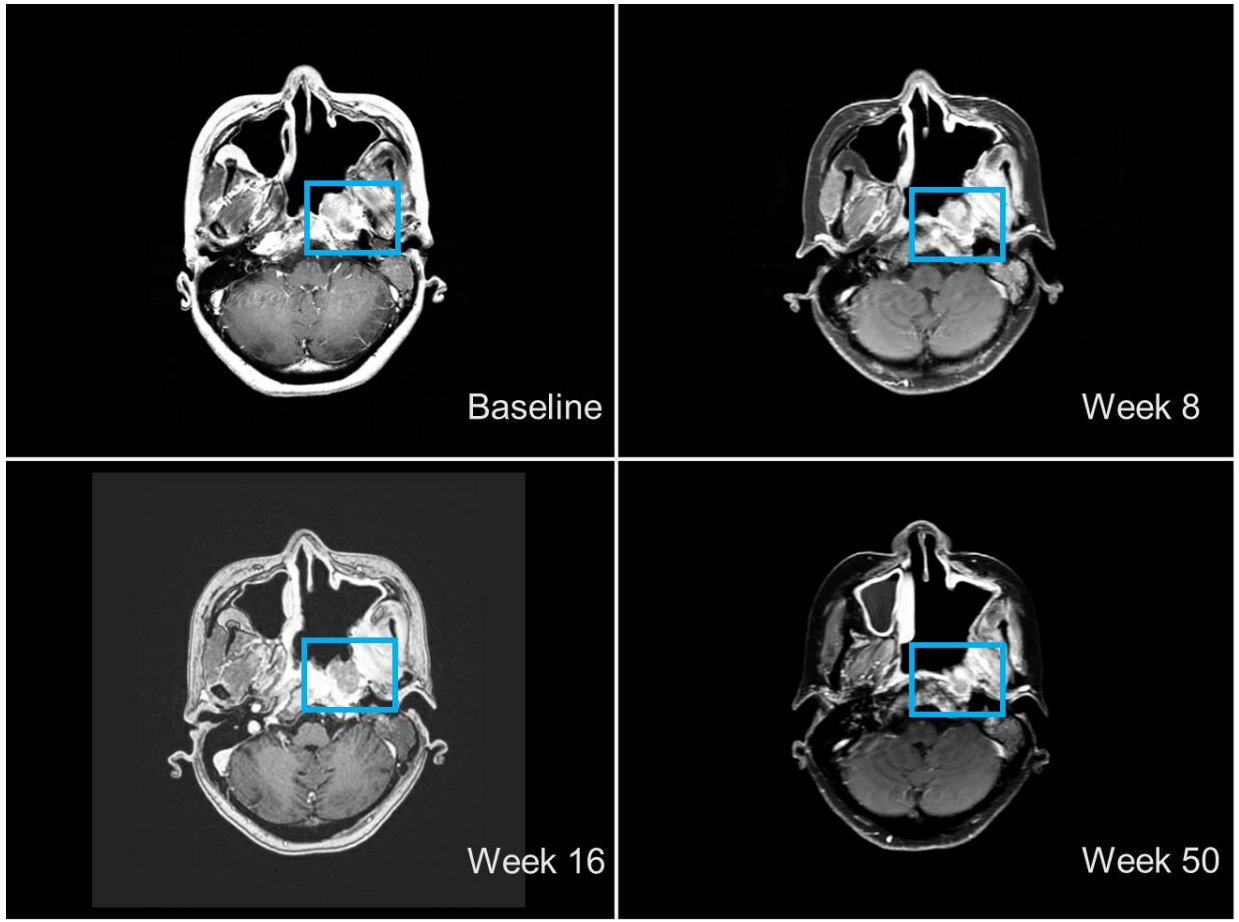


Presented at ESMO Asia Congress 2023; Data as of July 28, 2023

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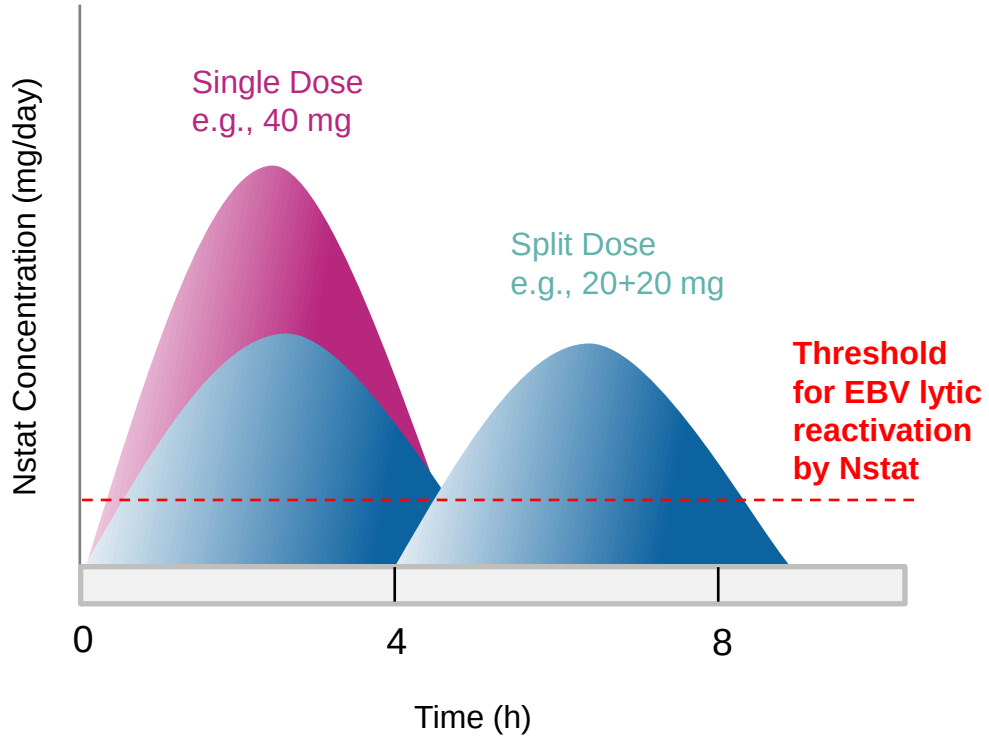
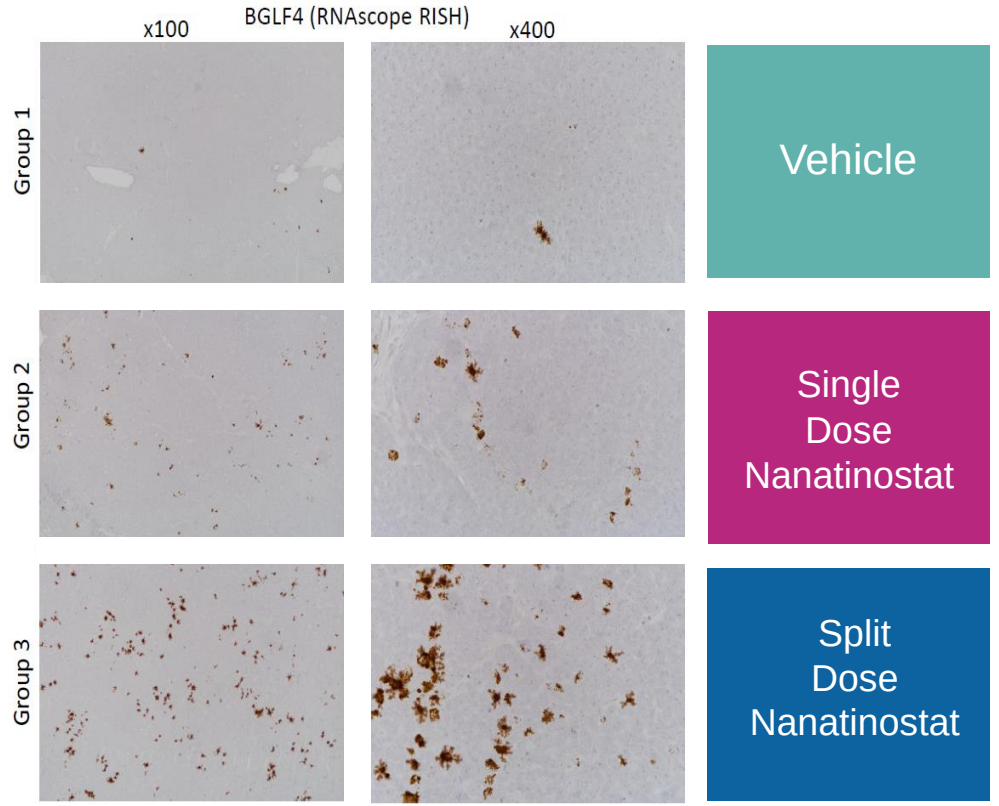
Presented at ESMO Asia Congress 2023; RP2D: Recommended Phase 2 Dose; R/R: Relapsed or Refractory

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

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

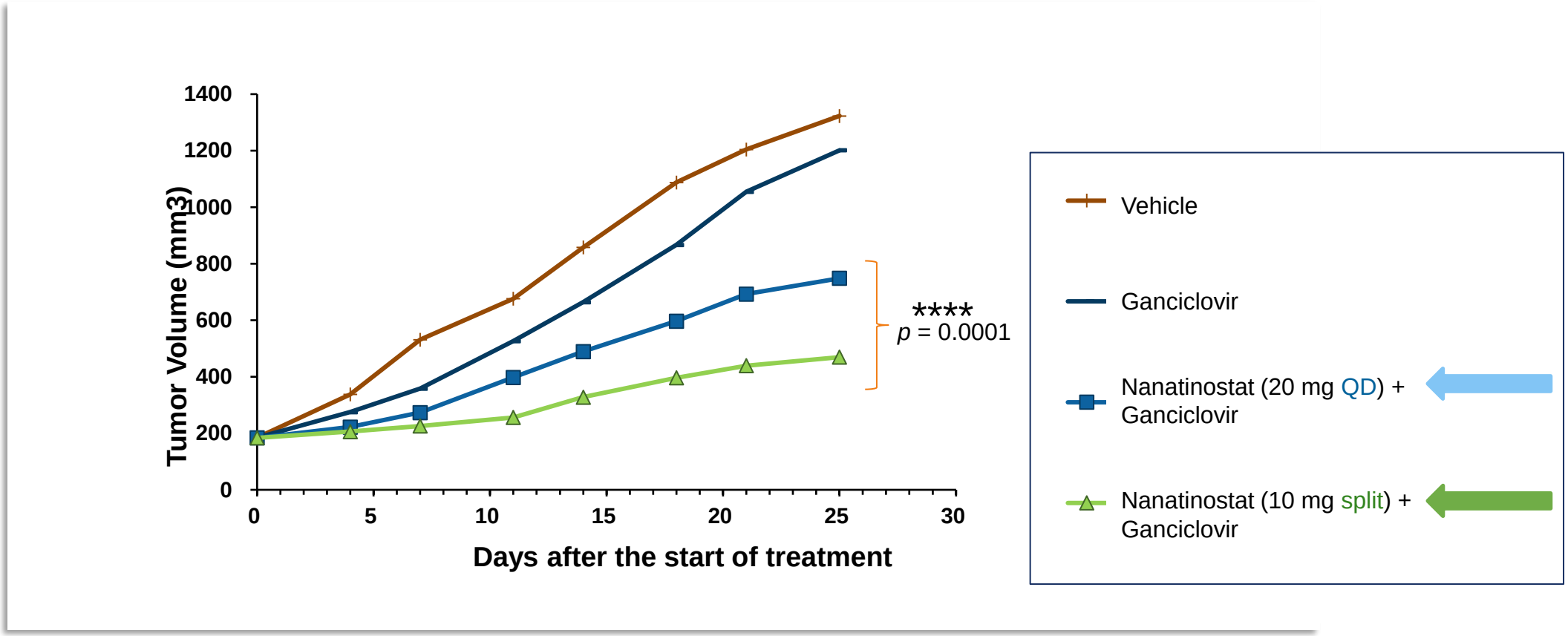




Data on file

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

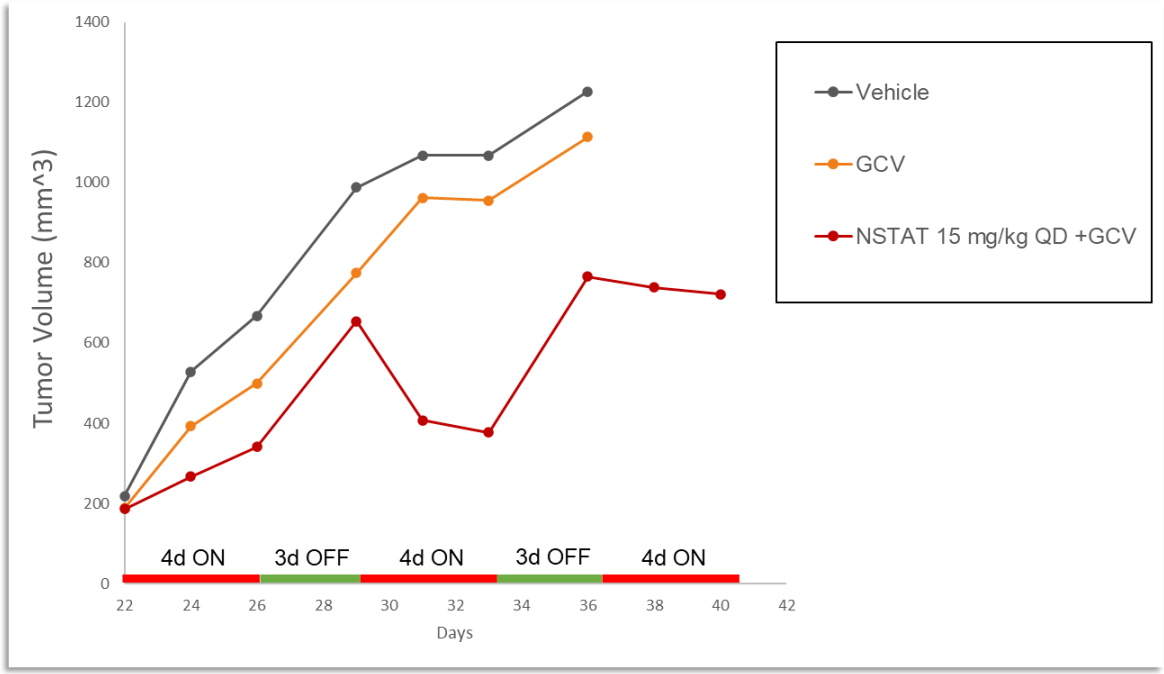
Anti-tumor activity of SNU-719 subcutaneous xenograft model in B-NDG mice



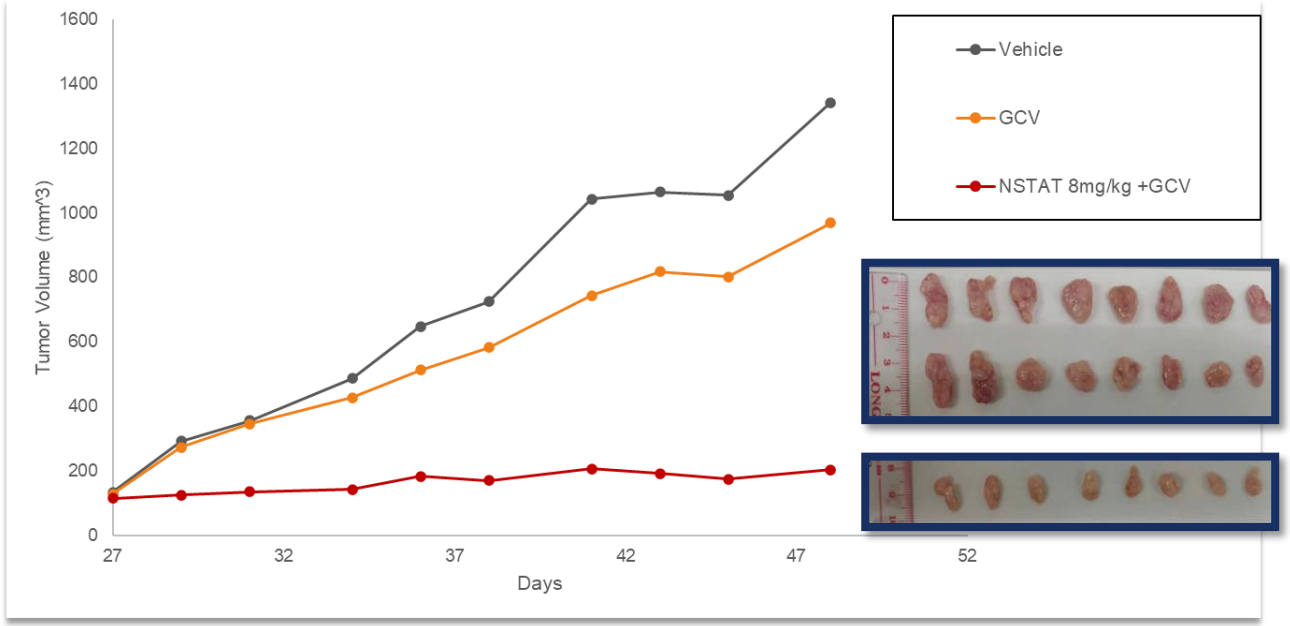
Data on file

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

4 Days ON/3 Days OFF



Daily Dosing



Data on file

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

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

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

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

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

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

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

Enrolling first cohort utilizing novel Split Daily Dosing (SDD) regimen to determine RP2D, up to 3 dose levels planned

Additional Dose Levels Planned on an SDD Schedule to Select RP2D

Enrollment into Dose Level 6 anticipated before year-end 2023

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

- 🟢 Partial Response
- 🟠 Stable Disease ≥14 wks
- 🟡 Stable Disease <14 wks
- ○ Progressive Disease

NE: Not evaluable for response, QD: Once daily; BID: Twice daily, SDD: Split Daily Dosing, RP2D: Recommended Phase 2 Dose

Anticipated 2024 Milestones for Nana-val

Trial	Indication	Q1:2024	Q2:2024	Q3:2024	Q4:2024
Nava-val Pivotal NAVAL-1 Trial (R/R EBV+ Lymphomas)	R/R EBV+ PTCL	Q1:2024 - Complete enrollment of Stage 2 (n=11) H1:2024 - Report Stage 1 data from both arms: nanatinostat with (n=10) or without (n=10) valganciclovir		H2:2024 - Present Stage 2 data Enroll patients into the post-Phase 2 expansion cohort to support potential accelerated approval	
	R/R EBV+ DLBCL				YE:2024 – Report Stage 1 data
	R/R EBV+ PTLD				YE:2024 – Report Stage 1 data
	Regulatory Updates		Mid:2024 - Meet with the FDA to discuss additional requirements for accelerated approval		
Nana-val Phase 1b/2 Study 301 (Advanced EBV+ Solid Tumors)	NPC			H2:2024 - Determine RP2D by investigating the novel split daily dosing regimen at higher dose levels of Nana-val	YE:2024 - Initiate Phase 2 dose-optimization cohort to confirm RP2D

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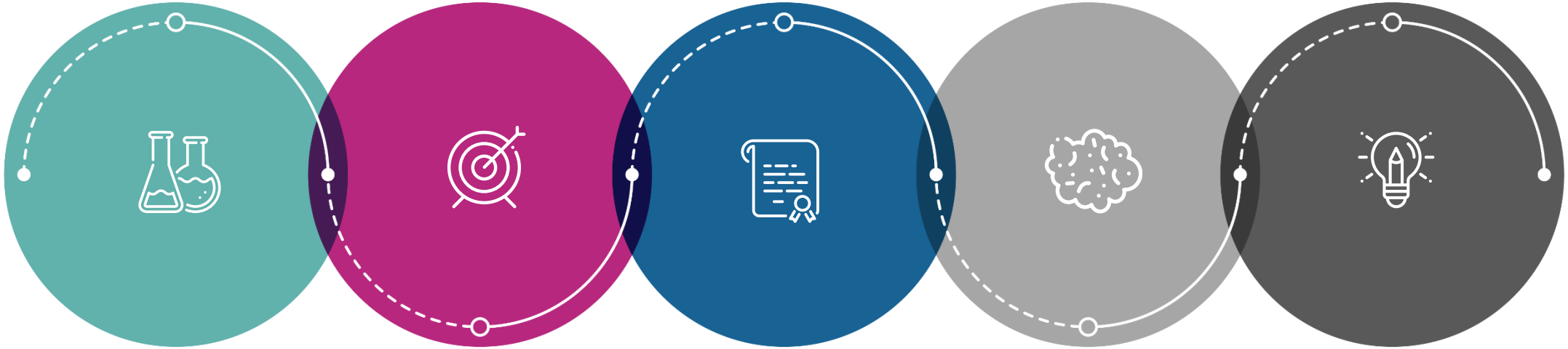
EBV: Epstein-Barr Virus positive; R/R: relapsed or refractory; RP2D: Recommended Phase 2 Dose

Focus is Maximizing the Nana-val Opportunity



Adverse survival outcomes are seen with many EBV-associated cancers	Well-tolerated, all-oral combination approach to targeting EBV+ cancers	Pivotal NAVAL-1 trial in multiple R/R EBV+ lymphoma subtypes	Phase 1b/2 study in advanced EBV+ solid tumors	Lean operating model and a speed to market strategy
Need for targeted therapies	*Potential tumor agnostic MOA; strengthened clinical data*	*Completion of Stage 2 enrollment in PTCL cohort and engagement with FDA anticipated in mid-2024*	*Plan to determine RP2D and initiate Phase 2 dose-optimization in 2024*	*Regulatory validation with orphan drug designation granted for Nana-Val (across six indications)*

Thank you

Nana-val:
Lymphoma Market Opportunity

US Incidence Estimates for EBV+ Hematological Malignancies

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

The diagnosed incidence of EBV-associated hematological malignancies is likely underestimated given inconsistent testing due to the absence of an actionable targeted and actionable therapy

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

Global Incidence Estimates for Priority EBV+ Hematological Malignancies

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

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

The diagnosed incidence of EBV-associated hematological malignancies is likely underestimated given inconsistent testing due to the absence of an actionable targeted and actionable therapy

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