Full Year 2025 Investor Presentation

Oncology and Immunology Portfolio Summary

February 25, 2026

ARCUS BIOSCIENCES

Forward-looking Statements/Safe Harbor

Forward-Looking Statements Safe Harbor: This presentation contains forward-looking statements about Arcus Biosciences, Inc. ("we," "Arcus" or the "Company") made pursuant to the safe harbor provisions of the Private Securities Litigation Reform Act of 1995. All statements in this presentation that are not historical facts are forward-looking statements, including, without limitation, statements regarding: our anticipated cash runway (including our expectation of funding until at least the second half of 2028); our strategies, goals, opportunities, and potential advantages for our programs, including casdatifan and our inflammation and immunology programs; estimates of market potential or peak sales for our investigational products; and the timing, initiation, enrollment, advancement, conduct, and results of our clinical trials and other development activities (including, without limitation, expected timing for completion of enrollment for PEAK-1, initiation of a potential Phase 3 study in first- or early-line RCC, advancement of our inflammation and immunology programs into the clinic, and timing and results from ongoing clinical studies). Forward-looking statements are often identified by words such as "anticipate," "believe," "expect," "intend," "may," "should," "plan," "project," "target," "will," and similar expressions, although not all forward-looking statements contain these identifying words.

These forward-looking statements are subject to numerous risks, uncertainties and assumptions that may cause actual results to differ materially from those expressed or implied by any forward-looking statements, including, but not limited to: the unexpected emergence of adverse events or other undesirable side effects with Arcus's investigational products, including casdatifan; risks associated with interim or preliminary clinical data not being replicated in other studies evaluating the same investigational product, including PEAK-1 for casdatifan; difficulties or delays in conducting or completing our clinical trials due to regulatory review, site activation, patient identification or enrollment, or manufacturing and supply constraints of investigational or standard-of-care products for such clinical trials, all of which may be exacerbated by unfavorable global economic, political, public health and trade conditions; changes to Arcus's cash runway due to changes in Arcus's operating plans and expected resource allocation, including for domvanalimab; changes in the competitive landscape; our ability to obtain and maintain intellectual property protection for our product candidates; and the inherent uncertainty associated with pharmaceutical product development and clinical trials. It is not possible for our management to predict all risks, nor can we assess the impact of all factors on our business or the extent to which any factor, or combination of factors, may cause actual results to differ materially from those anticipated or implied in the forward-looking statements. Further information on these and other factors that could affect the forward-looking statements made herein is described in our most recent periodic reports filed with the U.S. Securities and Exchange Commission, including our most recent Annual Report on Form 10-K, and in other filings and reports we make with the SEC from time to time. You should not rely upon forward-looking statements as predictions of future events. Except as required by law, neither we nor any other person assumes responsibility for the accuracy or completeness of the forward-looking statements. We undertake no obligation to update any forward-looking statements for any reason after the date of this presentation to conform these statements to actual results or to changes in our expectations, except as required by law.

Important Information Regarding Data Comparisons: This presentation includes comparisons between data from our Phase 1/1b ARC-20 trial and published data from separate trials that are not head-to-head studies. Cross-trial comparisons should be interpreted with caution due to differences in study populations, sample sizes, inclusion and exclusion criteria, trial design, dosing, endpoints, follow-up, and other factors that may limit direct comparability.

Third-Party Sources Disclaimer: Additionally, this presentation contains certain information related to or based on studies, publications, surveys and other data obtained from third-party sources, and our own internal estimates and research, including without limitation relating to market size and potential sales or revenue opportunity. This information is based on a number of assumptions, projections and estimates, including with respect to our future performance and the future performance of markets in which we operate, and is necessarily subject to a high degree of uncertainty and risk, and you are cautioned not to place undue reliance onto to such estimates.

No Regulatory Approval: All of Arcus's molecules are investigational and Arcus (and Gilead for all of the molecules in each optioned program) has not received approval from any regulatory authority for any use globally, nor established the safety and efficacy of these investigational molecules.

Notice of Trademarks: The Arcus name and logo are the property of Arcus. All other trademarks used herein are the property of their respective owners and are used for reference purposes only. Such use should not be construed as an endorsement of Arcus.

© Arcus Biosciences 2026

Arcus Has Created a Robust Portfolio of Potential Best-in-Class Medicines

FOUNDED 2015

R&D ENGINE

World class medicinal chemistry

Goal of 1-2 new molecules **advancing to the clinic each year**

CAPITAL EFFICIENCY & RISK SHARING HAVE BEEN GROWTH ENABLING

AstraZeneca · TAIHO PHARMA · GILEAD

~$1B IN CASH*

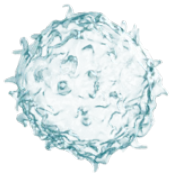
Funded until **at least 2H:28****

LATE-STAGE ONCOLOGY

Casdatifan

Quemliclustat

&



IMMUNOLOGY

MRGPRX2 TNF

CCR6 CD89

CD40L

1st immunology molecules should enter the clinic in 2026

Addressing most common diseases

Cancers with Large Patient Populations

Kidney Pancreatic

Inflammation & Autoimmune Diseases

IBD RA Psoriasis

Urticaria AD

* Cash, cash equivalents and marketable securities as of December 31, 2025

** Runway estimate based on cash, cash equivalents, marketable securities, and current planned operations

© Arcus Biosciences 2026

ARCUS BIOSCIENCES

Leveraging our Small Molecule Capabilities to Create Best-in-Class Oral Medicines

2 PHASE 3 PROGRAMS IN ONCOLOGY

CASDATIFAN

Wholly-owned* HIF-2α inhibitor with "best in class" data; target validated clinically and commercially in RCC

PEAK-1

Phase 3 enrolling

NEW Phase 3 Trial in 1L Targeted for YE:26

QUEMLI

Only small molecule CD73 inhibitor in clinical development; In Ph 3 for 1L pancreatic cancer

PRISM-1

EXPANDING ORAL SMALL MOLECULE I&I PORTFOLIO

Enormous Opportunity to Displace Injectable, Blockbuster Biologic Drugs

MRGPRX2 antagonist

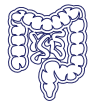
Expected in clinic in 2026

Urticaria

Atopic Dermatitis

TNF inhibitor

Expected in clinic late ‘26 / early ‘27



IBD

RA

Psoriasis

*Arcus has world-wide rights including the US, Europe and China; Taiho has rights in Japan and other Asian territories

© Arcus Biosciences 2026

ARCUS BIOSCIENCES

Key Updates: New Casdatifan Data and Emerging I&I Portfolio

IMPRESSIVE CASDATIFAN DATA IN LATE-LINE ccRCC TO BE PRESENTED AT ASCO GU

With longer follow up, data have improved even further (Jan. 30, 2026 DCO[1])

- **cORR increased to 45% with a mPFS of 15.1 months** for the 100mg QD tablet cohort (going forward dose and formulation)
- **cORR increased to 35% and PFS was stable at 12.2 months** in a pooled analysis of all four monotherapy cohorts (n=121)
- New biomarker data demonstrated that **greater EPO suppression with cas is associated with clinical benefit, including ORR and PFS**

Data support our ongoing, first phase 3 study, PEAK-1, and the initiation of our first Phase 3 in the 1L setting by year-end

DISCLOSURE OF EMERGING I&I PROGRAMS

- Arcus has had a 2+ year discovery effort focused on I&I which has now yielded **5 active programs**
- The most advanced programs are small molecules against MRGPRX2 and TNF; **initiation of first-in-human studies for MRGPRX2 and TNF expected in 2026 and late 2026 / early 2027, respectively**

DOMVANALIMAB PROGRAM

- Winding down Phase 3 STAR-221 and Phase 2 EDGE-Gastric studies
- A futility analysis of Phase 3 STAR-121 will be conducted in the next couple of months to determine next steps for the program.

© Arcus Biosciences 2026

ARCUS BIOSCIENCES

Arcus Milestones Will Generate Near- and Long-Term Value for Shareholders

NEXT 3 MONTHS

ARC-20

✓ **Cas monotherapy data** at ASCO GU

NEXT 6-9 MONTHS

ARC-20

Cas + cabo PFS data

MRGPRX2 antagonist in clinic

NEXT 9-12 MONTHS

ARC-20

Data for **cas combinations** in early-line RCC

Initiate first **Phase 3 study for cas** in 1L RCC

NEXT 12-24 MONTHS

PRISM-1

Phase 3 data

TNF inhibitor in clinic

POC data for **MRGPRX2 antagonist**

NEXT 24 MONTHS

PEAK-1

Phase 3 data

© Arcus Biosciences 2026

ARCUS BIOSCIENCES

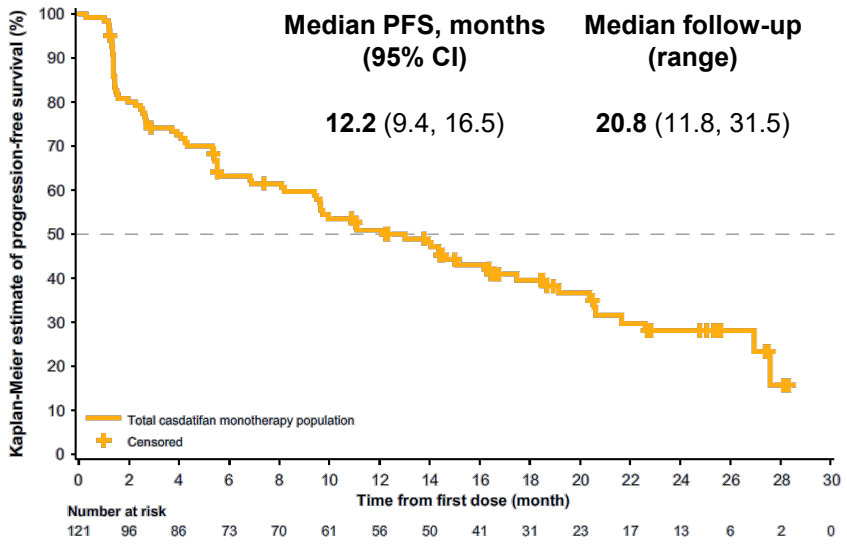
Clinical Data from >120 Patients Support Casdatifan's Potential as the Best-in-Class HIF-2α Inhibitor

ARC-20

IMPROVED CLINICAL OUTCOMES[1]

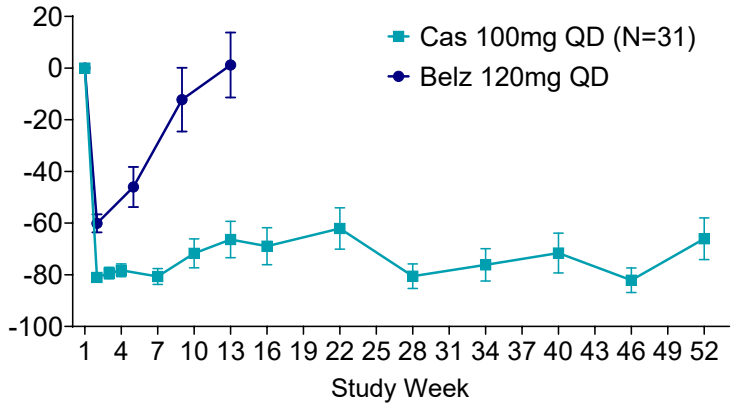
Longer PFS than other HIF-2α inhibitors and TKIs in late-line kidney cancer

12.2 months mPFS compares to 5.6 mos PFS for belzutifan in LITESPARK-005[2,3]



SUPERIOR PHARMACO-DYNAMIC PROFILE[4,5]

100mg QD of cas results in substantial and sustained EPO suppression



Top Priority is to Establish Casdatifan as the SOC Across Multiple Settings of RCC

PEAK-1	ARC-20 / eVOLVE RCC02
Post-IO metastatic cas + cabo | Phase 3	**1L TKI-free regimen**
19K patients	**21K** patients
~$2B market potential	**~$3B** market potential

Patient and sales opportunity based on drug treatable population in major markets; from Decision Resources Group and Arcus analysis.
Data are not from head-to-head studies. Cross-trial data interpretation should be considered with caution as it is limited by differences in study population, sample size, inclusion and exclusion criteria and many other factors.

© Arcus Biosciences 2026

Updated Casdatifan Data

Data Based on a January 30, 2026 DCO Unless Otherwise Stated

Copyright © Arcus Biosciences 2026

Cohorts Evaluating Cas Mono in anti-PD-1/TKI Experienced ccRCC

DOSE ESCALATION

Patients with advanced solid tumors

Casdatifan monotherapy

DOSE EXPANSION

N = ~30 per cohort

2L+ ccRCC
Casdatifan mono
50mg BID capsule

2L+ ccRCC
Casdatifan mono
50mg QD capsule

2L+ ccRCC
Casdatifan mono
100mg QD tablet

2L+ ccRCC
Casdatifan mono
150mg QD tablet

Post-IO ccRCC
Casdatifan 100mg QD +
Cabozantinib 60mg QD

Favorable-risk 1L ccRCC
Casdatifan mono 100mg QD

1L ccRCC
Casdatifan 100mg QD + Zimberelimab
360mg Q3W

Post-IO ccRCC
Casdatifan mono 100mg QD

To date, over 240 patients have received casdatifan across all cohorts of ARC-20

© Arcus Biosciences 2026

Confirmed ORR for the “Pooled” Cohort (n=121) is Now 35%

Efficacy-Evaluable Population[a]	Dose Expansion: 2L+ ccRCC					Belzutifan[2]
	50mg BID (n = 31)	50mg QD (n = 28)	100mg QD (n=31)	150mg QD (n = 31)	All Pooled (n = 121)	120mg QD (n = 374)
Median Follow-Up, mos (range)	28.3 (19.9, 31.5)	25.2 (21.4, 26.7)	17.9 (11.8, 19.0)	19.8 (18.0, 21.0)	20.8 (11.8, 31.5)	18.4 (9.4–31.7)
Median Time to Response, mos	**2.7**	**4.1**	**2.6**	**2.7**	**2.8**	**3.8**
Confirmed ORR (95% CI)	**26% (12, 45)**	**36% (19, 56)**	**45% (27, 64)**	**32% (17, 51)**	**35% (26, 44)**	**22% (18, 27)**
Complete Response, % (n)	0% (0)	4% (1)	0% (0)	0% (0)	1% (1)	3% (10)
Partial Response, % (n)	26% (8)	32% (9)	45% (14)	32% (10)	34% (41)	19% (72)
Stable Disease, % (n)	55% (17)	50% (14)	39% (12)	42% (13)	46% (56)	39% (147)
Progressive Disease, % (n)	19% (6)	14% (4)	16% (5)*	26% (8)	19% (23)*	34% (126)

*Includes two patients in the 100mg QD Tablet cohort, and also included in the pooled analysis, who had clinical progression before the first scan and therefore did not meet criteria for progressive disease per RECIST. PD based on RECIST criteria was 10% (n=3) for the 100mg QD Tablet cohort and 17% (n=121)

DCO date: Jan. 30, 2026

a. Efficacy-evaluable population for this expansion cohort is defined as all eligible participants who received any study treatment and have at least one post-baseline efficacy assessment, or who discontinued study treatment due to progressive disease or death, regardless of whether they had a scan.

© Arcus Biosciences 2026

Data Have Been Consistently Robust and Have Improved Over Time, Exceeding Benchmarks

	ASCO GU SYMPOSIUM 2025	Oct.2025 Investor Event	ASCO Genitourinary Cancers Symposium — February 26–28, 2026, Moscone West, San Francisco, CA & Online, gu.asco.org
100mg QD (n=32)	5 mos med. Follow-up **cORR: 33%** mPFS: Not reached PD: 15%	12 mos med. Follow-up **cORR: 35%** mPFS: Not reached PD: 16%**	17.9 mos med. Follow-up **cORR: 45%** **mPFS: 15.1mos** PD: 16%**
Pooled Analysis (n=121)*	--	15 mos med. Follow-up **cORR: 31%** **mPFS: 12.2 months** PD: 19%**	20.8 mos med. Follow-up **cORR: 35%** **mPFS: 12.2 mos** PD: 19%**

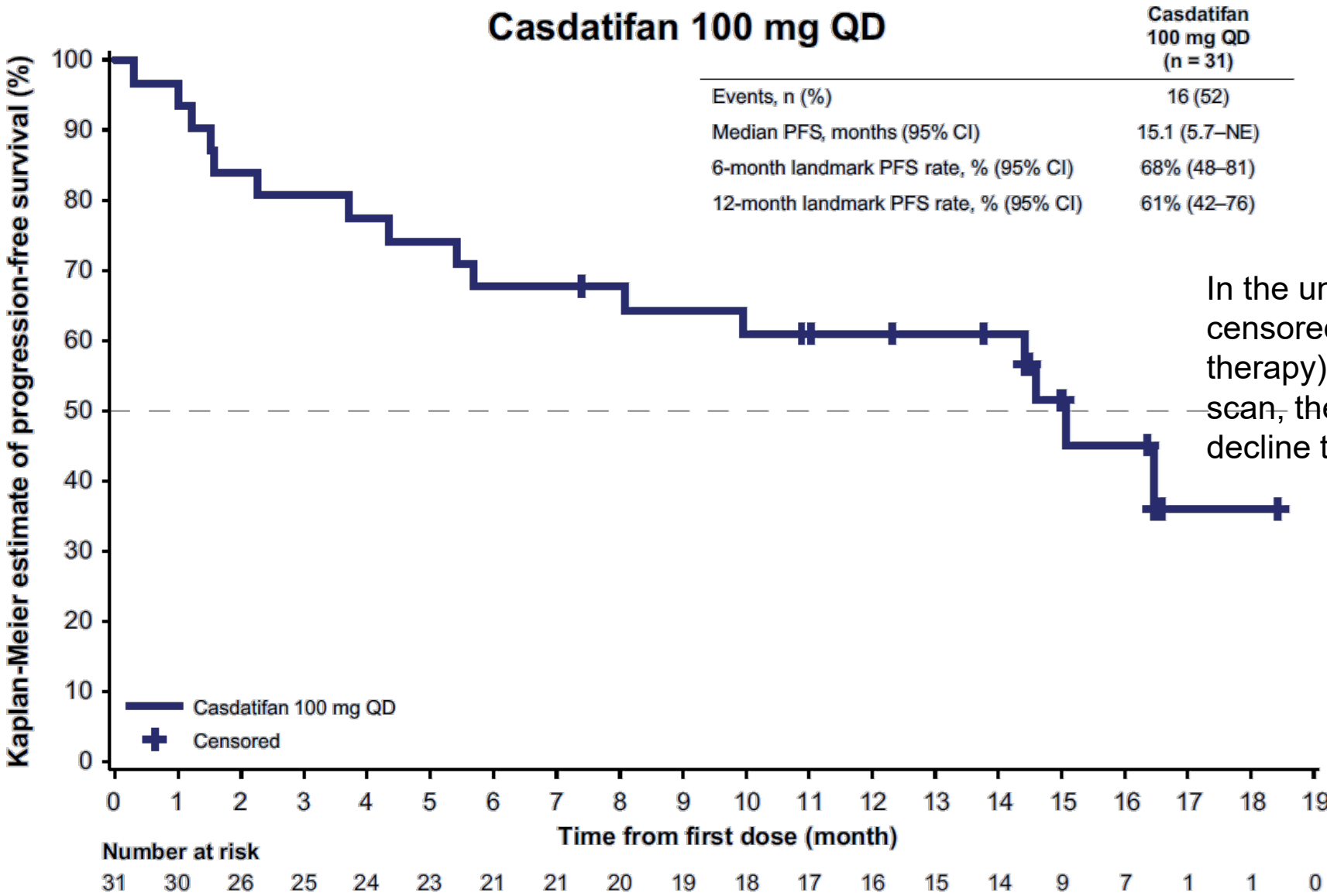
* Includes all four late-line monotherapy cohorts: 50mg BID, 50mg QD, 100mg QD, 150mg QD from the ARC-20 study

** Includes two patients in the 100mg QD Tablet cohort, and also included in the pooled analysis, who had clinical progression before the first scan and therefore did not meet criteria for progressive disease per RECIST. PD based on RECIST criteria was 10% (n=3) for the 100mg QD Tablet cohort and 17% (n=121).

ASCO GU 2025 DCO: January 3, 2025
Oct. 6 Arcus IR Event DCO: August 15, 2025
ASCO GU 2026 DCO: Jan. 30, 2026

© Arcus Biosciences 2026

15.1 Months mPFS for Patients Treated with Casdatifan Phase 3 Dose and Formulation



	Casdatifan 100 mg QD (n = 31)
Events, n (%)	16 (52)
Median PFS, months (95% CI)	15.1 (5.7–NE)
6-month landmark PFS rate, % (95% CI)	68% (48–81)
12-month landmark PFS rate, % (95% CI)	61% (42–76)

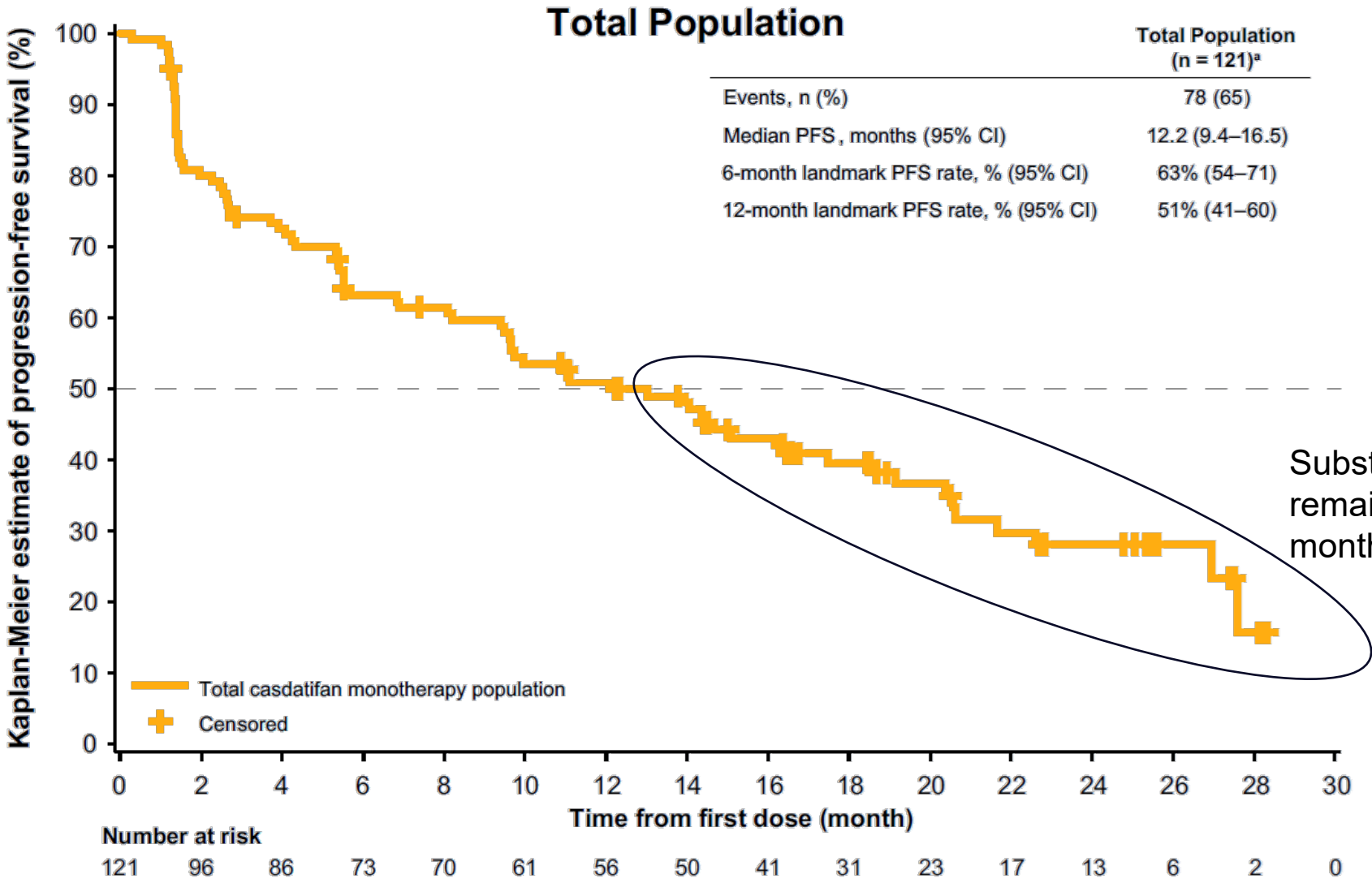
In the unlikely scenario that *all* censored patients (still on therapy) progress at the next scan, the mPFS would only decline to 14.4 months

Median Follow Up: 17.9 months

DCO: Jan. 30, 2026

© Arcus Biosciences 2026

12.2 Months mPFS for Patients Treated with Casdatifan Across All Four Monotherapy Cohorts



	Total Population (n = 121)[a]
Events, n (%)	78 (65)
Median PFS, months (95% CI)	12.2 (9.4–16.5)
6-month landmark PFS rate, % (95% CI)	63% (54–71)
12-month landmark PFS rate, % (95% CI)	51% (41–60)

Substantial number of patients remain on treatment beyond 14 months and 24 months

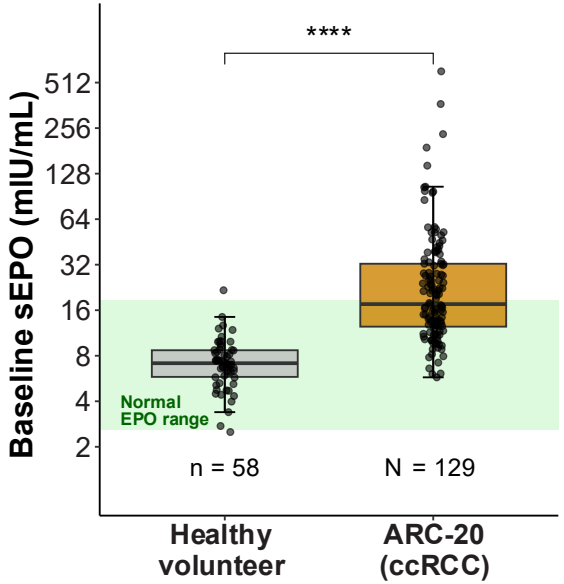
Median Follow Up: 20.8 months

DCO: Jan. 30, 2026

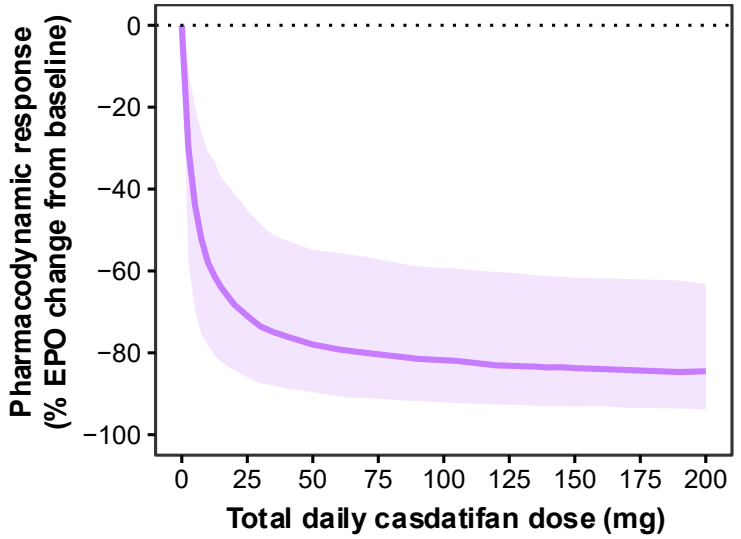
a.The efficacy evaluable population (N = 121) was defined as all eligible patients who received any study treatment and had ≥ 1 post-baseline efficacy assessment or discontinued study treatment due to progressive disease or death.

© Arcus Biosciences 2026

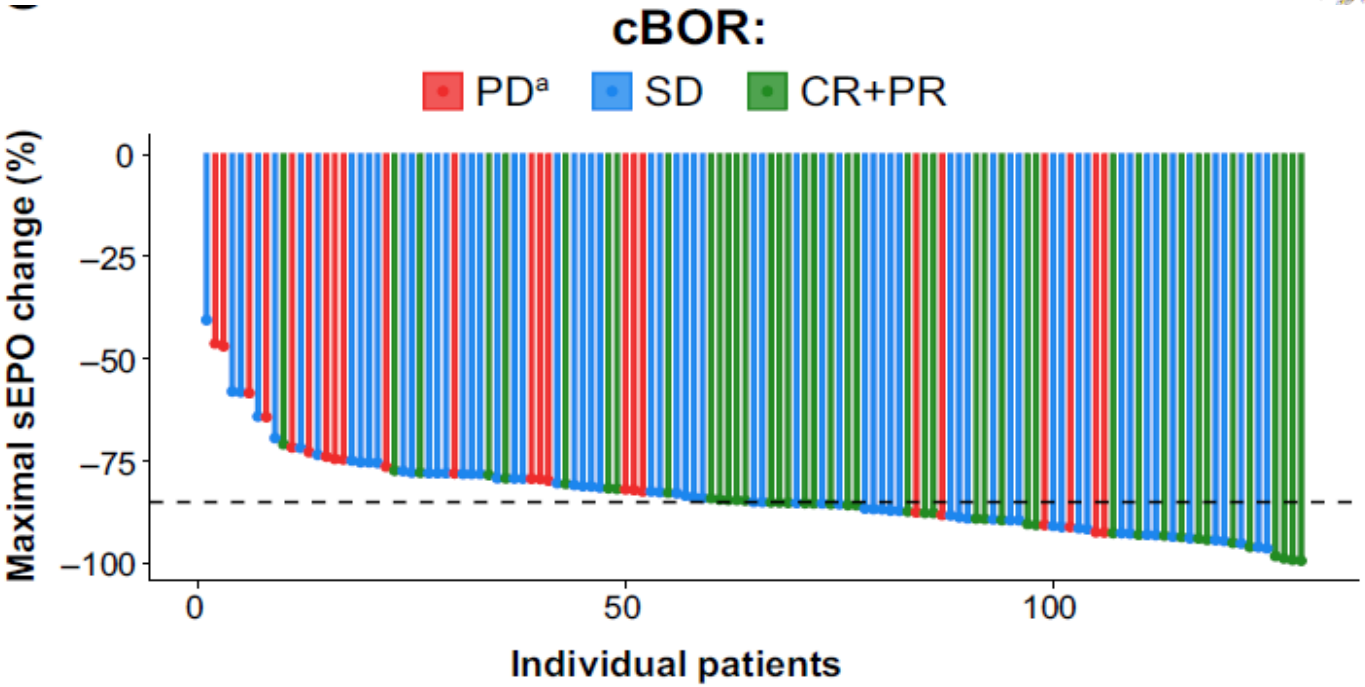
Systemic Suppression of HIF-2α–Regulated sEPO Is Highly Correlated with Clinical Benefit with Casdatifan (ORR)



Patients with ccRCC had significantly higher baseline levels of sEPO than healthy volunteers ($P < .0001$)[1]



71% (92/129) of patients reached maximal sEPO reduction during the first cycle of treatment with casdatifan[1]

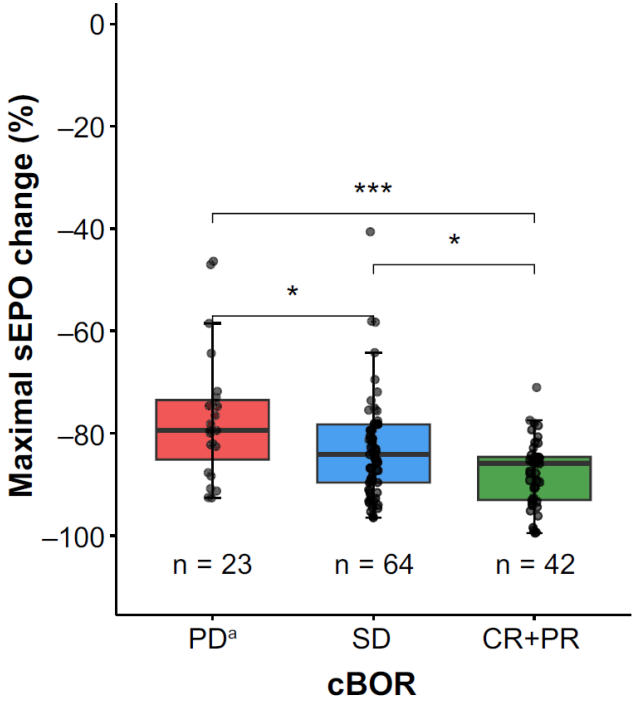


Across all doses, most patients (88/129 [68%]) experienced > 80% maximal sEPO reduction; **Deeper reductions in sEPO were highly correlated with clinical responses**[1]

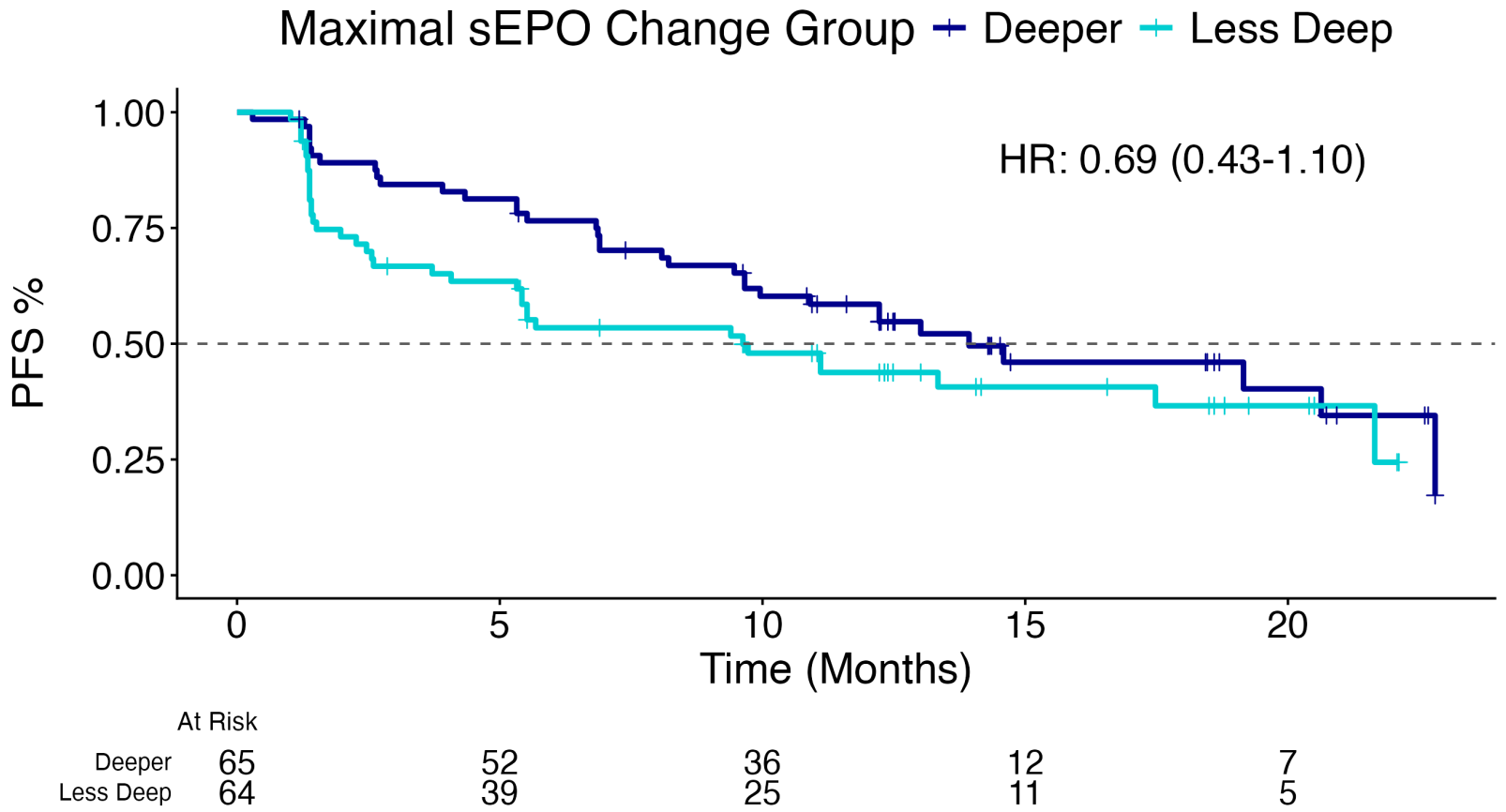
a. PD was defined according to RECIST v1.1 as a ≥ 20% increase in the sum of diameters of target lesions relative to the smallest sum on study (including baseline, if smallest), with an absolute increase of ≥ 5 mm. The appearance of 1 or more new lesions was also considered progression.

© Arcus Biosciences 2026

Systemic Suppression of HIF-2α–Regulated sEPO Is Highly Correlated with Clinical Benefit with Casdatifan (PFS)



The degree of maximal sEPO reduction was significantly greater in patients who achieved CR, PR, or SD compared with those with PD ($P < .05$)[1]



Maximal sEPO reduction was associated with longer PFS[1]

a. PD was defined according to RECIST v1.1 as a ≥ 20% increase in the sum of diameters of target lesions relative to the smallest sum on study (including baseline, if smallest), with an absolute increase of ≥ 5 mm. The appearance of 1 or more new lesions was also considered progression.

© Arcus Biosciences 2026

Casdatifan Data Exceed All PFS Benchmarks for Both Monotherapy HIF-2α Inhibition (Belz) *and* TKIs

EARLIER-LINE PATIENT POPULATIONS

SETTING	TRIAL	REGIMEN	cORR	mPFS
3L+	**ARC-20 (Phase 1b/2)**	**Cas (100mg QD)** **Cas (Pooled)**	**45%** **35%**	**15.1m** **12.2m**
	LITESPARK-005 (Phase 3)[3]	Belz	22%	5.6m
	TIVO-3 (Phase 3)[6]	Tivo	18%	5.6m
2L+	**METEOR (Phase 3)[7]**	Cabo	17%	7.4m
	Lenva + ev (Phase 2)[8]	Lenva	27%	7.4m
IO-Experienced (1L/2L)	**AXIS (Phase 3)[9]**	Axi	19%	6.7m
	CONTACT-03 (Phase 3)[10]	Cabo	41%	10.8m
	CANTATA (Phase 3)[11]	Cabo	28%	9.3m

DCO date for casdatifan: Jan. 30, 2026

Data are not from head-to-head studies. Cross-trial data interpretation should be considered with caution as it is limited by differences in study population, sample size, inclusion and exclusion criteria and many other factors.

© Arcus Biosciences 2026

ARCUS BIOSCIENCES

Casdatifan Was Well Tolerated in All Cohorts, With a Comparable Safety Profile to That of Belzutifan

Safety-Evaluable Population	100mg QD (n=32)	Pooled (n=127)	Belzutifan (LITESPARK-005)[2]
Anemia, n (%)			**Anemia:**
All grades	29 (91)	117 (92)	All grade: 83%
Grade ≥3 related to casdatifan	8 (25)	52 (41)	Grade ≥3: 33%
Related to casdatifan leading to interruptions	9 (28)	45 (35)	
Leading to dose reductions	3 (9)	18 (14)	
Leading to discontin.	**0**	**0**	
Hypoxia, n (%)			**Hypoxia:**
All grades	5 (16)	23 (18)	All Grade: 15%
Grade ≥3 related to casdatifan	3 (9)	14 (11)	Grade ≥3: 11%
Related to casdatifan leading to interruptions	3 (9)	18 (14)	
Leading to dose reductions	1 (3)	9 (7)	
Leading to discontin.	**1 (3)**	**3 (2)**	

DCO date for casdatifan: August 15, 2025; safety profile remained consistent at the Jan. 30, 2026 DCO

Data are not from head-to-head studies. Cross-trial data interpretation should be considered with caution as it is limited by differences in study population, sample size, inclusion and exclusion criteria and many other factors.

© Arcus Biosciences 2026

ARCUS BIOSCIENCES

Casdatifan Development Strategy

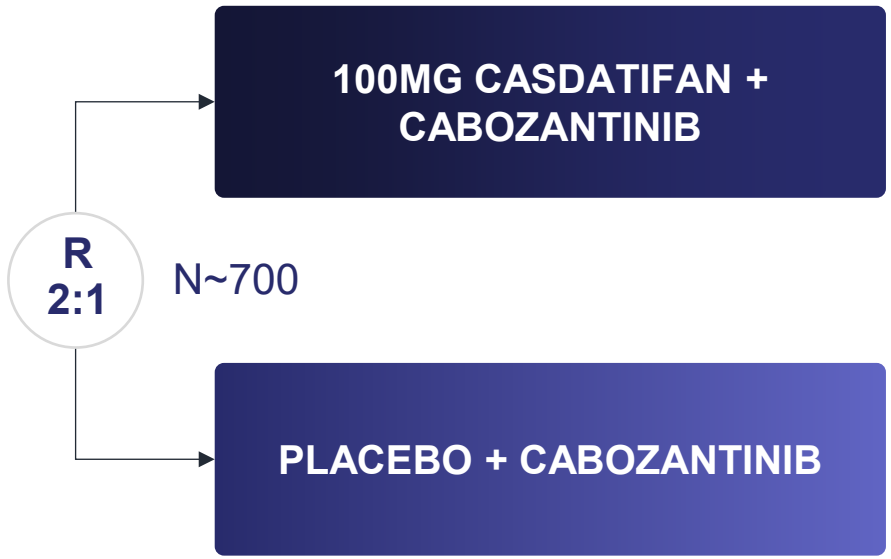
Copyright © Arcus Biosciences 2026

First Phase 3 Study Evaluating a Differentiated TKI Combination in Post-IO ccRCC is Enrolling

Only Phase 3 study evaluating a HIF-2α inhibitor with cabozantinib, the most widely used TKI in ccRCC

PATIENT POPULATION:

- Unresectable, locally advanced or metastatic ccRCC
- **Have had prior anti-PD-1/ PD-L1 (either in adjuvant or 1L metastatic setting)**
- Have not received cabozantinib



PRIMARY ENDPOINT

- PFS

KEY SECONDARY ENDPOINTS

- OS
- ORR, DOR, DCR

Goal Is to Fully Enroll by Year-End

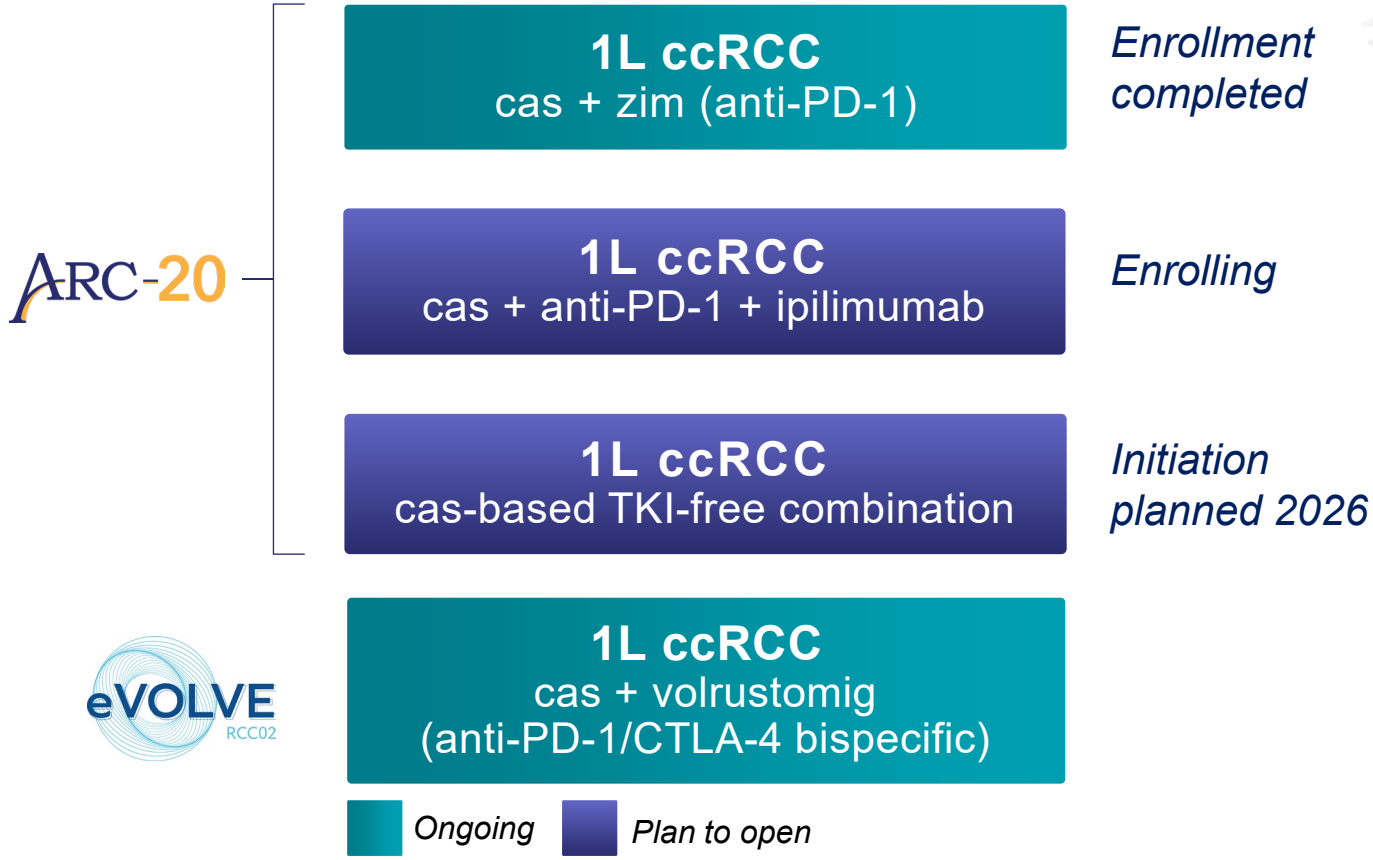
© Arcus Biosciences 2026

1L Strategy for Cas Will Focus on TKI-Free Regimens, Enabled by its Low Rate of Primary Progression

ARC-20 Data To Date Show a Consistently Low Rate of Primary PD, Avoiding the Need for a TKI

	Efficacy-Evaluable Population*	Primary PD Rate % (n)
2L+ ccRCC	cas 100mg QD (n=31)[a]	16% (5)[1]
	Monotherapy pooled (n=121)[a]	19% (23)
	cas + cabo (n=24)[b]	4% (1)
1L+ ccRCC	**1L cas + zim (n=23)[c]**	**9% (2)**
	1L cas mono, favorable risk (n=14)[c]	**0% (0)**
	cas mono, post-IO, TKI naive (n=27)[c]	**7% (2)**

Four TKI-Free Cohorts in the 1L Setting Will Inform 1L Strategy for Cas with the Goal of Initiating Phase 3 Study by YE:26



Primary PD rate: The percent of patients whose disease progressed at or before their first post-baseline scan.

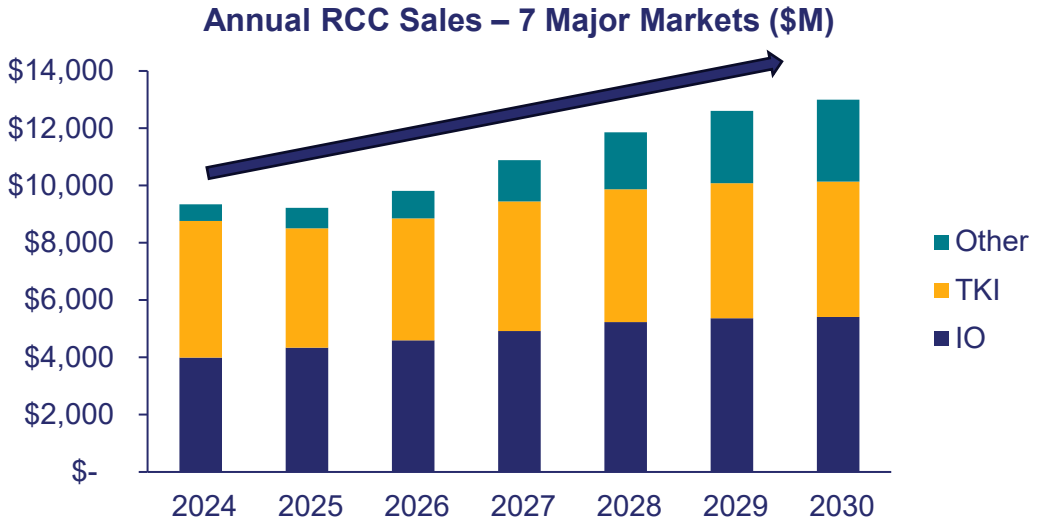
*All data from ongoing ARC-20 cohorts with DCO dates as follows: a. Jan. 30, 2026; b. March 14, 2025; c. Spotfire data as of January 7, 2026, includes patients who had received at least one scan at time of DCO.

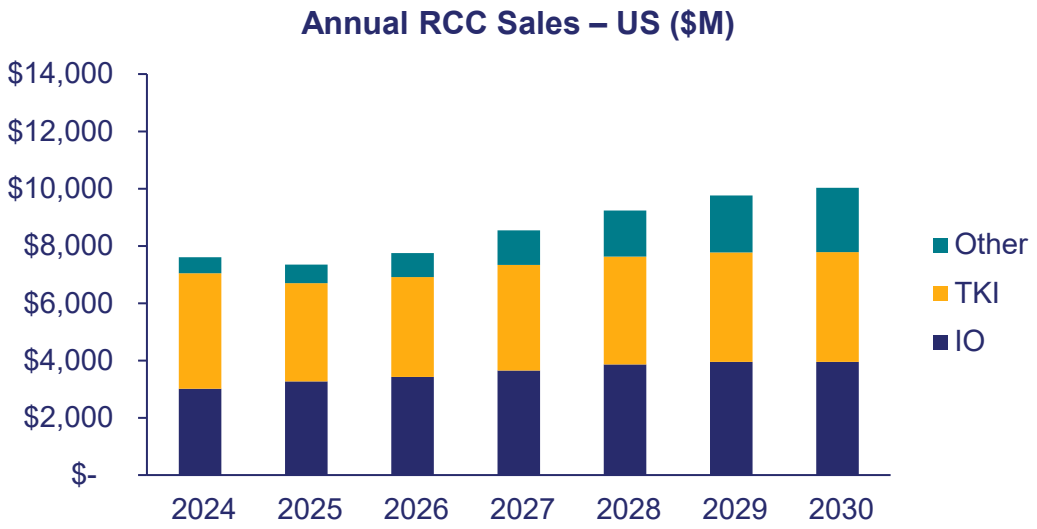
© Arcus Biosciences 2026

Casdatifan
Market Opportunity

Copyright © Arcus Biosciences 2026

RCC Is a Growing Multi-Billion Dollar Market, Driven by the Introduction of HIF-2α Inhibition and Long DoT's





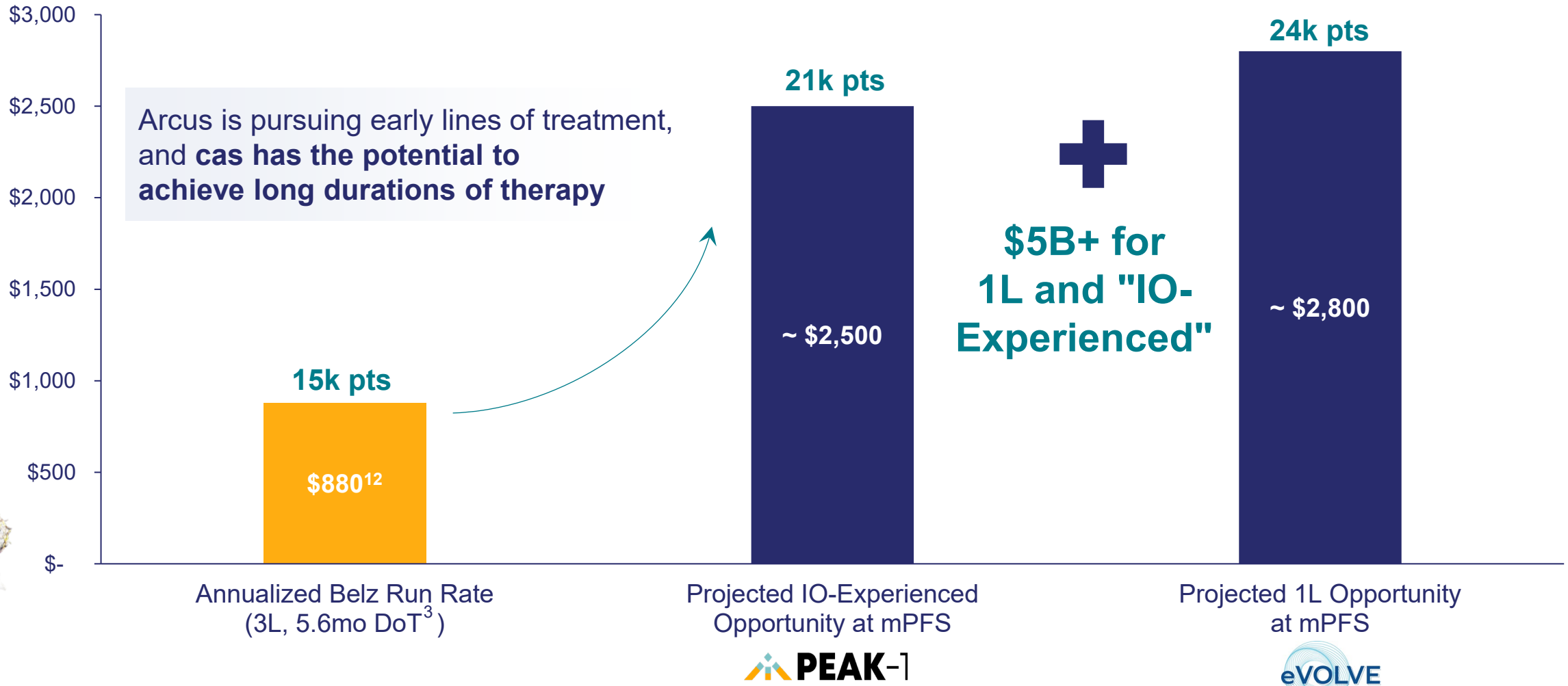
- **RCC is currently a ~$9B market in Major Markets**
  - This is despite multiple generic TKIs (e.g., axitinib, pazopanib, everolimus, sunitinib)
  - The market is almost entirely dominated by 2 classes of therapy: IO (5 approved agents) and TKI (7+ approved agents)
  - **Each class has approx. $4B in sales**
- **The RCC market is expected to grow to $13B by 2030 driven by:**
  - Increasing patient population
  - Introduction of HIF-2α MOA
  - Increasing DoT and "IO-like" durations of response for HIF-2α-containing regimens
- **There are only 2 agents currently in Phase 3 development in the HIF-2α class**

Source: DRG | 7 Major Markets = US, EU5 (France, Germany, Italy, Spain, and the United Kingdom), Japan

© Arcus Biosciences 2026

Belzutifan Today is Only "Scratching the Surface" on the RCC Opportunity (Major Markets)

Potential HIF-2α Peak Sales ($M)



Annualized run-rate belzutifan sales based on Q4 2025 results. 5.6mo DoT assumed based on LS-005 PFS.
Projected potential opportunities based on DRG (Clarivate) epi and Arcus analysis across US, EU5 & Japan in 2036. Assumes HIF-2α containing regimens capture 55-75% share of patient population.
Major Markets: France, Germany, Italy, Japan, Spain, United Kingdom, United States

© Arcus Biosciences 2026

Oncologists clearly preferred the PD1/CTLA4 + cas regimen over the PD1/TKI + cas regimen when presented with both options

Oncologist Regimen Preferences

	anti-PD-1 + anti-CTLA-4 + cas	Neutral	anti-PD1 + TKI + cas
# of Oncs Preferred	**15** out of 20	**1** out of 20	**4** out of 20

anti-PD-1 + anti-CTLA-4 + cas

Pros

- ✓ Familiarity with PD1+CTLA4 combination across other tumors
- ✓ Allows for sequencing of different MoAs in 2L+
- ✓ PD1+CTLA4 currently most used regimen in 1L

Cons

- May not be suitable for patients w/ rapid disease progression

anti-PD-1 + TKI + cas

Pros

- ✓ Preferred for patients with rapidly progressing disease

Cons

- Uses 3 MoAs in 1L, limiting sequencing options
- Concerns related to AEs from TKIs

Source: Arcus Primary Qualitative Research, n=20, Fielded December 3 2025 - January 7 2026

© Arcus Biosciences 2026

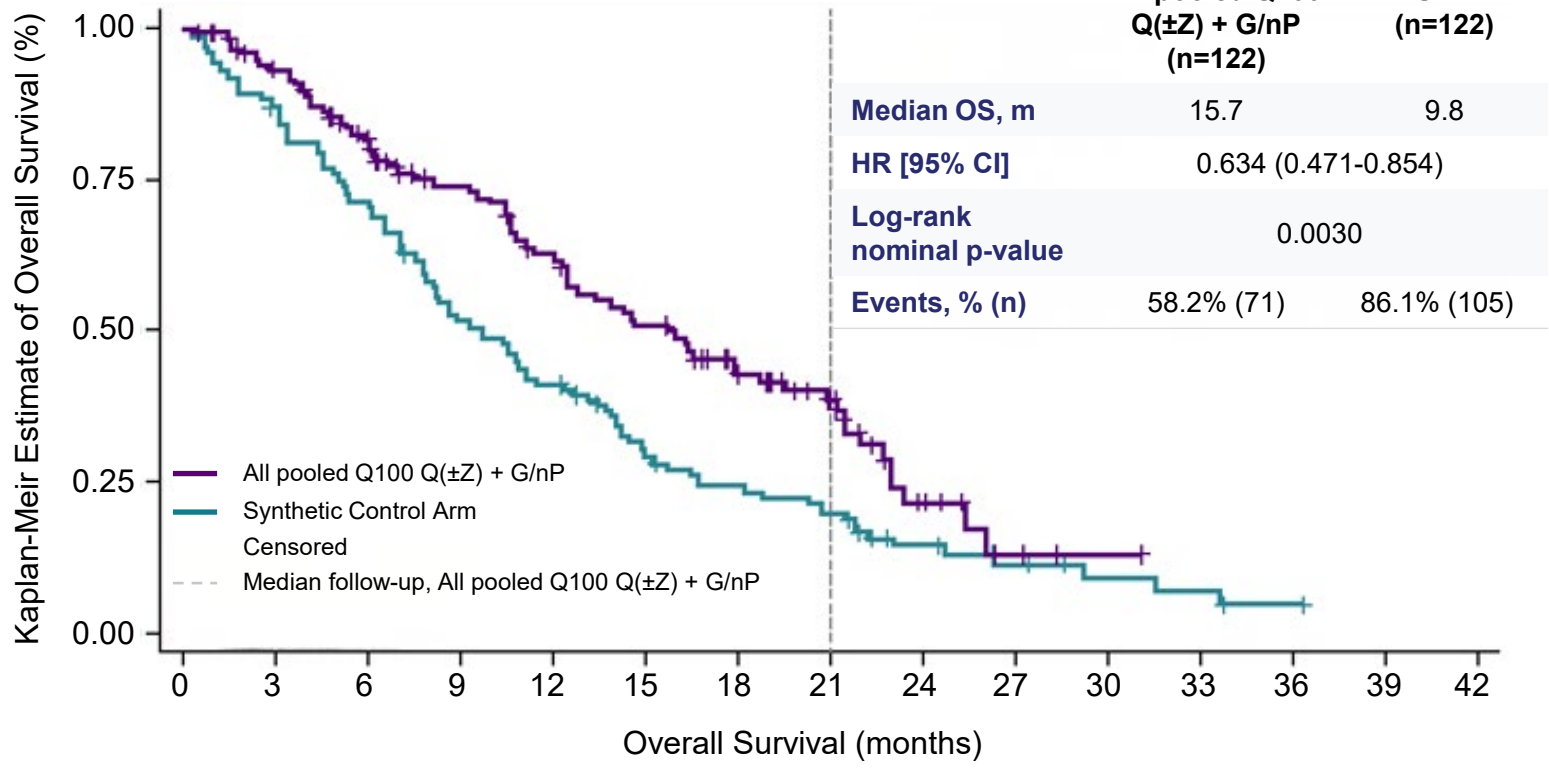
ARCUS BIOSCIENCES

Quemliclustat in Pancreatic Cancer

Copyright © Arcus Biosciences 2026

Quemli Could be the First Transformative Therapy for All-Comer 1L Pancreatic Cancer in 30+ Years

PHASE 1 STUDY SHOWED 5.9 MONTH mOS IMPROVEMENT VS G/nP[13]



	All pooled Q100 Q(±Z) + G/nP (n=122)	SCA (n=122)
Median OS, m	15.7	9.8
HR [95% CI]	0.634 (0.471-0.854)	
Log-rank nominal p-value	0.0030	
Events, % (n)	58.2% (71)	86.1% (105)

NUMBER OF PATIENTS AT RISK														
All pooled Q100 Q(±Z) + G/nP	122	108	89	72	59	47	34	23	8	3	1	0		
Synthetic Control Arm	122	104	85	61	49	32	26	21	12	7	4	3	1	0

PRISM-1

Phase 3 trial in 1L PDAC
Enrollment completed

~$4B
Market Potential

Readout in 1H 2027

GnP data constructed into a synthetic control arm, on a post-hoc basis, from Phase 2 and 3 clinical studies in 1L metastatic pancreatic cancer setting

© Arcus Biosciences 2026

PRISM-1

Phase 3 Study of Quemli + Chemo in 1L Metastatic PDAC

© Arcus Biosciences 2026

ARCUS BIOSCIENCES

Our Emerging I&I Portfolio

Copyright © Arcus Biosciences 2026

I&I Small-Molecule Strategy is Targeting Validated Blockbuster Biologics

IN-HOUSE EXPERTISE IN IMMUNOLOGY
has been a core aspect of our discovery group since Arcus's founding

MINIMIZE BIOLOGICAL RISK
by leveraging validated mechanisms with applications to common diseases with large addressable populations

2-PRONG I&I STRATEGY:

- Small-molecule improvements of cytokine-targeted therapeutics
- Target immune cell types that play key roles in human disease and have been historically "under-studied"

I&I DRUG DISCOVERY PORTFOLIO

TARGET	MODALITY	DISEASE AREA	STATUS
MRGPRX2	SM	CSU, AD	FIH Expected in 2026
TNF (TNFR1)	SM	RA, Psoriasis, IBD	FIH Expected Late 2026 / Early 2027
CCR6	SM	Psoriasis	Advanced Discovery
CD89	mAb	RA	Advanced Discovery
CD40L	SM	SLE; MS	Discovery

© Arcus Biosciences 2026

Potential Best-in-Class MRGPRX2 Antagonist to Treat Atopic Skin Diseases

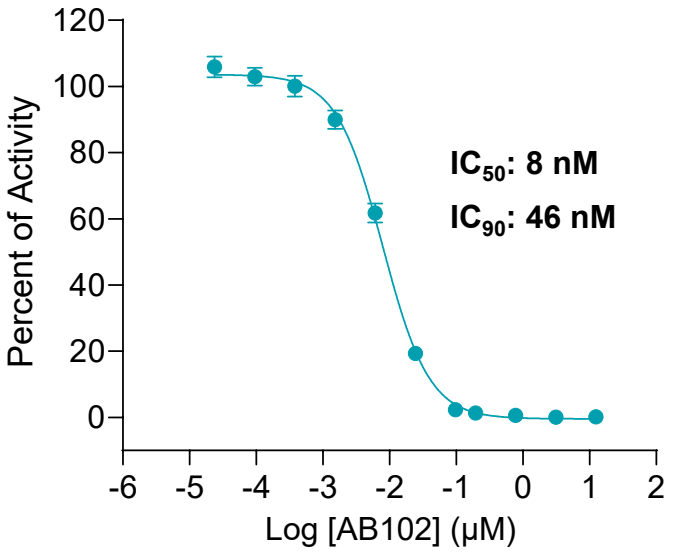
Validated biology with multi-billion dollar potential

- **Approved biologics** are **highly successful and effective** in treating AD and CSU, etc. and generate >$15B in LTM sales[14]
- Anti-IgE (e.g., omalizumab) and anti-IL-4R (e.g., dupilumab) are **not sufficient to address clinical need** in CSU and/or AD

PROGRAM STATUS:
Expect FIH in 2026

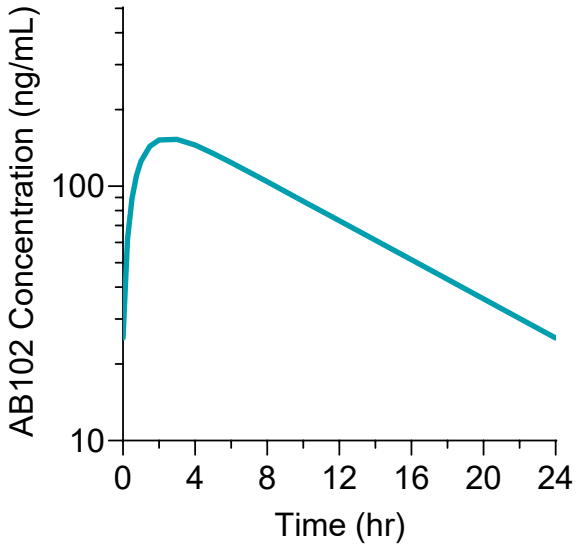
OPPORTUNITY FOR IMPROVEMENT

Mast cell (LAD2) degranulation (CD107a) in 100% human serum



Improved potency/PK relative to early small-molecule entrants into the clinic

Modeled steady-state human PK



Based on the predicted human PK and potency of our leading molecule, **required clinical exposures could be >90% lower** than those associated with the leading small-molecule competitor in the clinic

© Arcus Biosciences 2026

Small-molecule Inhibitors of TNF with Potentially Improved Efficacy/Safety Relative to anti-TNF Biologics

VALIDATED BIOLOGY **WITH MULTI-BILLION $ POTENTIAL**

- Anti-TNF antibodies are among the **most successful biologic drugs** ever developed
- Humira® was the world's top-selling drug for **nearly a decade**, with peak sales over $20B[15,16]

PROGRAM STATUS:
Expect FIH in late 2026 / early 2027

OPPORTUNITY FOR IMPROVEMENT

Anti-TNF antibodies block TNF signaling at 2 receptors:

- TNFR1 (pro-inflammatory)
- TNFR2 (pro-Treg – blocking can drive inflammation)

As a result, TNF antibodies can drive a fraction of patients to develop "paradoxical inflammation" (e.g., psoriasis)

Small-molecule disruptors of TNF **selectively block only the TNFR1** biology, with potential for efficacy & better safety

Opportunity for molecules with better potency / human PK, relative to early small-molecule entrant into the clinic

© Arcus Biosciences 2026

Multiple Programs Targeting Substantial Market Opportunities and Unmet Medical Need

	INDICATION	MARKET POTENTIAL (Major markets*)
CAS Small molecule HIF-2α inhibitor	Post-IO ccRCC	~$2B
	IO-naive ccRCC	~$3B
QUEMLI Small molecule CD73 inhibitor	1L PDAC	>$4B
MRGPRX2 Small molecule antagonist	CSU & Atopic dermatitis	Multi-Billion $
TNF Small molecule inhibitor	RA, Psoriasis & IBD	Multi-Billion $

*Major Markets (US, EU5, JP) - total projected 2034 quemli opportunity & cas opportunity

© Arcus Biosciences 2026

Multiple Catalysts are Expected over the Next 12 Months

NEXT 3 MONTHS

ARC-20

✓ **Cas monotherapy data** at ASCO GU

NEXT 6-9 MONTHS

ARC-20

Cas + cabo PFS data

MRGPRX2 antagonist in clinic

NEXT 9-12 MONTHS

ARC-20

Data for **cas combinations** in early-line RCC

Initiate first **Phase 3 study for cas** in 1L RCC

NEXT 12-24 MONTHS

PRISM-1

Phase 3 data

TNF inhibitor in clinic

POC data for **MRGPRX2 antagonist**

NEXT 24+ MONTHS

PEAK-1

Phase 3 data

© Arcus Biosciences 2026

ARCUS BIOSCIENCES

Q&A

Copyright © Arcus Biosciences 2026

References and Acronym Key

1. Choueiri T. et al 2026 (ARC-20)

2. Albiges L. et al. 2023 (LITESPARK-005)

3. Choueiri T. et al. 2024 (LITESPARK-005)

4. Choueiri T. et al. 2025 (ARC-20)

5. Marathe D. et al. 2024 (belzutifan)

6. Rini B. et al 2020 (TIVO-3)

7. Choueiri T. et al. 2016 (METEOR)

8. Motzer R. et al. 2015 (lenvatinib +everolimus)

9. Rini B. et al. 2011 (AXIS)

10. Pal S. et al. 2023 (CONTACT-03)

11. Tannir N. et al. 2022 (CANTATA)

12. Merck 4QFY 2025 earnings release. Accessed February 18, 2026.

13. Wainberg Z. et al. 2024 (ARC-8)

14. Sanofi earnings releases. Accessed February 18, 2026.

15. 2022 Annual Report. Abbvie. Accessed February 18, 2026.

16. Sagonowsky E. The top 20 drugs by worldwide sales in 2020. FiercePharma. Published May 3 2021. Accessed January 8, 2026.

1H first half	**Cabo** cabozantinib	**ECOG** Eastern Cooperative Oncology Group	**mAb** monoclonal antibody	**OS** overall survival	**Q2/3W** every 2/3 weeks	**SLE** systemic lupus erythematosus
1L first-line	**Cas** casdatifan	**EPO** erythropoietin	**mg** milligrams	**PD** primary progression	**QD** once daily	**SM** small molecule
2H second-half	**ccRCC** clear cell renal cell carcinoma	**FIH** first-in-human	**MOA** mechanism of action	**PDAC** pancreatic ductal adenocarcinoma	**quemli** quemliclustat	**SOC** standard of care
2L second-line	**CI** confidence interval	**G/nP** gemcitabine/nab-paclitaxel	**Mono** monotherapy	**PD-L1** programmed death-ligand 1	**R** randomized	**TKI** tyrosine kinase inhibitor
3L third-line	**cORR** confirmed overall response rate	**HR** hazard ratio	**mos** months	**PFS** progression-free survival	**R&D** research & development	**Tivo** tivozanib
AD atopic dermatitis	**CR** complete response	**I&I** inflammation & immunology	**mOS** median overall survival	**Ph** Phase	**RA** rheumatoid arthritis	**YE** year-end
AE adverse event	**CSU** chronic spontaneous urticaria	**IBD** inflammatory bowel disease	**mPFS** median progression-free survival	**PK** pharmacokinetics	**RCC** renal cell carcinoma	**Z** zimberelimab
Axi axitinib	**DCO** data cutoff	**IO** immunotherapy	**MRGPRX2** mas-related G protein-coupled receptor member X2	**PR** partial response	**RECIST** Response Evaluation Criteria in Solid Tumors	**zim** zimberelimab
B billion	**DCR** disease control rate	**K** thousand	**MS** multiple sclerosis	**POC** proof of concept	**SCA** synthetic control arm	
belz belzutifan	**DOR** duration of response	**Lenva** lenvatinib	**NE** not evaluable	**Q** quemliclustat	**sEPO** serum erythropoietin	
BID twice daily	**DoT** duration of treatment	**m** months	**ORR** objective response rate	**Q3** third quarter	**SD** stable disease	

© Arcus Biosciences 2026

ARCUS BIOSCIENCES