2Q26 Corporate Presentation

Oncology and Immunology Portfolio Summary

August 5, 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 immunology programs; estimates of market potential or peak sales for our investigational products; 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 PEAK-20, pace and progress of advancing our immunology programs towards IND-readiness, and timing and results from ongoing clinical studies); and our expectations regarding our ability to generate value for shareholders. 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: our ability to manage the breadth and pace of our development plans for casdatifan; the unexpected emergence of adverse events or other undesirable side effects with our 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 our cash runway due to changes in our operating plans; 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.

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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

TAIHO PHARMA · Summit therapeutics · AVEO ONCOLOGY · Bristol Myers Squibb

~$775M IN CASH*

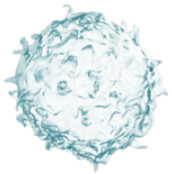
- Funded until at least 2H:28**

LATE-STAGE ONCOLOGY

Casdatifan

Quemliclustat

&



IMMUNOLOGY

MRGPRX2 TNF

CCR6 CD89

CD40L

1st immunology molecule entering the clinic this month addressing **multi-billion-dollar** market opportunities

Cancers with Large Patient Populations

Kidney Pancreatic

Inflammation & Autoimmune Diseases

IBD RA Psoriasis

Urticaria AD

* Cash, cash equivalents and marketable securities as of June 30, 2026
** Runway estimate based on cash, cash equivalents, marketable securities, and current planned operations
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Leveraging our Small Molecule Capabilities to Create Best-in-Class Oral Medicines

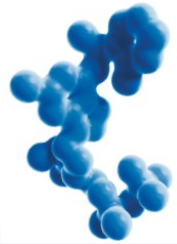
2 PHASE 3 PROGRAMS IN ONCOLOGY

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



QUEMLICLUSTAT

Only small molecule CD73 inhibitor in Phase 3 for 1L pancreatic cancer

PRISM-1

Data expected 1H27

EXPANDING ORAL SMALL-MOLECULE IMMUNOLOGY PORTFOLIO

Enormous Opportunity to Displace Injectable, Blockbuster Biologic Drugs

AB102 MRGPRX2 antagonist

Expected in clinic this month

Urticaria

Atopic Dermatitis

TNF inhibitor

Expected in clinic in 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

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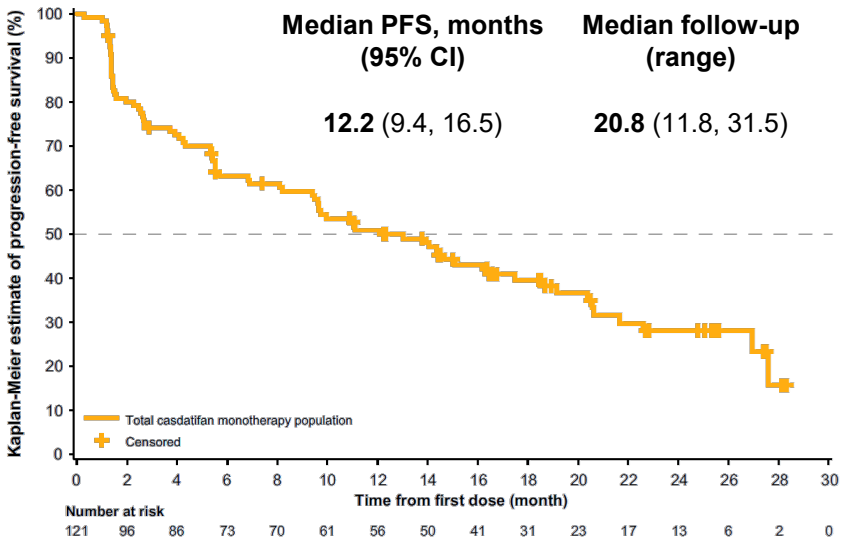
Clinical Data from >120 Patients Support Casdatifan's Potential as the Best-in-Class HIF-2α Inhibitor

ARC-20

IMPROVED CLINICAL OUTCOMES[1]

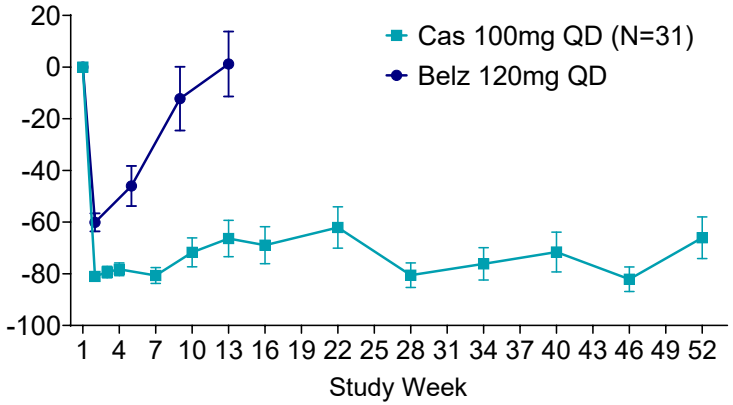
Longer PFS than other HIF-2α inhibitors and TKIs in late-line kidney cancer

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 Lines of Therapy for RCC

ARC-20
PoC Platform Study

PEAK-1
Phase 3 Study Enrolling

1L, 2L & 3L regimens

2L metastatic cas + cabo

~28K Patients*

for 1L (19k 2L, 12k 3L)

$5B+ opportunity

across lines of therapy*

*Peak sales opportunity based on drug treatable incident population in major markets per DRG and Arcus analysis. Epi (2026) per DRG. Major Markets: France, Germany, Italy, Japan, Spain, United Kingdom, United States. 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.

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Program Updates: Casdatifan and Emerging Immunology Portfolio

nature

PUBLICATION AND EMERGING RESEARCH ON HIF-2A

- *Nature* paper is first to comprehensively interconnect clinical outcomes from patients receiving a HIF-2α inhibitor with peripheral biomarker changes and associated tumor biology
  - HIF-2α inhibition with casdatifan resulted in deep and sustained suppression of serum EPO, which correlated with higher ORR and longer PFS
  - A pooled analysis from four monotherapy cohorts (n=121) showed 12.2 month mPFS despite multiple prior treatments with other standard regimens

STRATEGIC CASDATIFAN CLINICAL COLLABORATIONS

- Development strategy expanded through new clinical collaborations
  - BMS: 1L cas + pumitamig* (PD-L1/VEGF-A bispecific antibody) combinations will be added as two new arms of the BMS Phase 1/2 ROSETTA RCC-208 study
  - Summit: 1L cas + ivonescimab (PD-1/VEGF bispecific antibody), a new cohort in ARC-20
  - AVEO: cas + tivozanib (VEGFR TKI) in patients previously treated with belz, a new cohort in ARC-20

RAPIDLY ADVANCING IMMUNOLOGY PROGRAMS

- AB102, a small molecule against MRGPRX2, first-in-human this month
- Oral TNF inhibitor drug candidate expected to enter the clinic in early 2027
- Multiple additional drug candidates expected to be IND-ready by YE 2027

**Pumitamig is jointly developed by BioNTech and BMS*

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

	2H26	2027	2028
Casdatifan 1L RCC	ARC-20 **cas combo data** Initiate Phase 3 study	ARC-20 **cas combo data** cas+PD-1, cas+PD-1+CTLA4, cas+PD-1/VEGF	Initiation of additional Phase 3 studies
Casdatifan 2L ccRCC	ARC-20 **cas + cabo PFS data** PEAK-1 PEAK-1 fully enrolled	ARC-20 **cas + cabo data**	PEAK-1 **Phase 3 data**
Casdatifan 2L+ ccRCC	ARC-20 **OS data** for monotherapy cohorts	ARC-20 **cas + tivo data**	
Quemliclustat (1L PDAC)		PRISM-1 **Phase 3 data in 1H**	
AB102 (MRGPRX2 Antagonist)	First-in-human in clinic	**POC data**	
Immunology Pipeline		TNF inhibitor in clinic early 2027 Multiple additional drug candidates to be IND-ready by YE 2027	

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Summary of Casdatifan Data to Date

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

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ARC-20

Study Cohorts Provide Critical Enabling Data for Future Phase 3 Programs

Enrollment Complete n= ~30 pts

- 2L+ ccRCC monotherapy cas 50mg BID
- 2L+ ccRCC monotherapy cas 50mg QD
- 2L+ ccRCC monotherapy cas 150mg QD
- 2L+ ccRCC monotherapy cas 100mg QD
- *Post-IO ccRCC cas 100mg QD + cabo 60mg QD
- 1L Favorable-risk ccRCC monotherapy cas 100mg QD
- 1L ccRCC cas 100mg QD + zim 360mg Q3W
- Post-IO ccRCC monotherapy cas 100mg QD

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

Enrollment Open n= ~30 pts

- 1L ccRCC cas + zim + ipi

Future Cohorts n= ~30-60 pts

- 2L+ ccRCC (post HIF-2α) cas + tivo vs tivo
- 1L ccRCC cas + ivo
- 1L ccRCC cas + zim + axi

** cas+cabo cohort n=~45 pts*

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

	ASCO GU SYMPOSIUM 2025	Oct.2025 Investor Event (*Nature* manuscript data)	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) for the pooled analysis.

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

Article

Casdatifan shows durable response linked to HIF-2α biology in kidney cancer

https://doi.org/10.1038/s41586-026-10718-x

Received: 16 February 2026

Accepted: 27 May 2026

Published online: 01 July 2026

Toni K. Choueiri[1], Jamie Merchan[2], Amita Patnaik[3], Alexandra Drakaki[4], Brian I. Rini[5], Sun Young Rha[6], Jae Lyun Lee[7], Moshe C. Ornstein[8], Rohit Kumar[9], Clara Hwang[10], Yusra Shao[11], Se Hoon Park[12], Pedro C. Barata[13], Bradley A. McGregor[1], Paul Foster[14], Jianfen Chen[14], Melissa Eisen[14], Hunter Cole[14], Ben Weeder[14], Yinghui Guan[14], Jaskirat S
Angelo Kaplan[14], Soonweng Cho[14], Richard Markus[14], Omar Kabbarah[14] & Rana R. McK

- First study to comprehensively connect clinical outcomes from patients receiving a HIF-2α inhibitor with peripheral biomarker changes and associated tumor biology

  HIF-2α inhibition with casdatifan resulted in deep and sustained suppression of the hormone erythropoietin in blood (serum EPO), which correlated with higher response rates and longer progression-free survival (PFS)

https://www.nature.com/articles/s41586-026-10718-x

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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=21) for the pooled analysis.

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.

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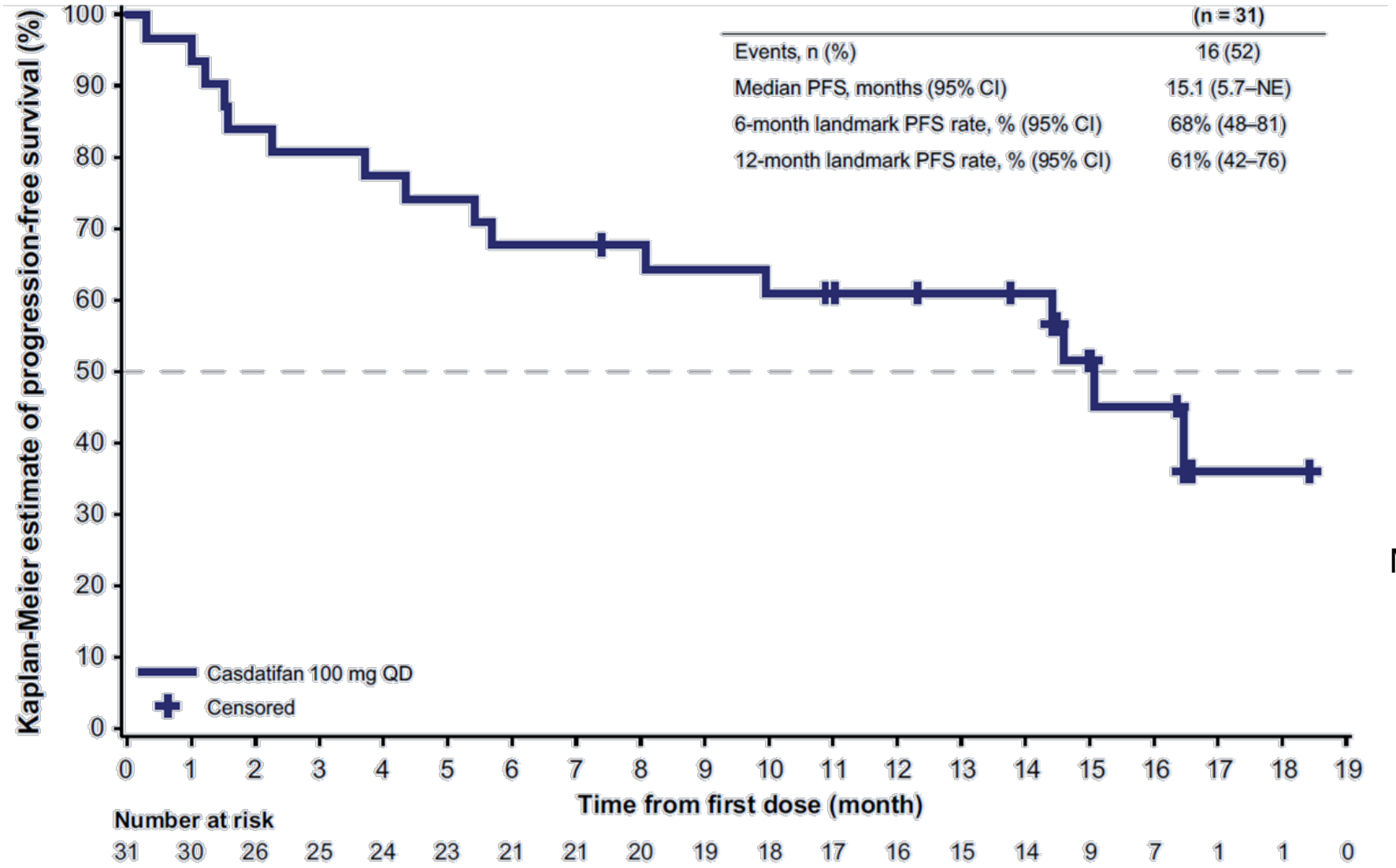
15.1 Months mPFS for Patients Treated with Casdatifan 100mg QD Phase 3 Dose and Formulation



Median Follow Up:
17.9 months

DCO date: Jan. 30, 2026

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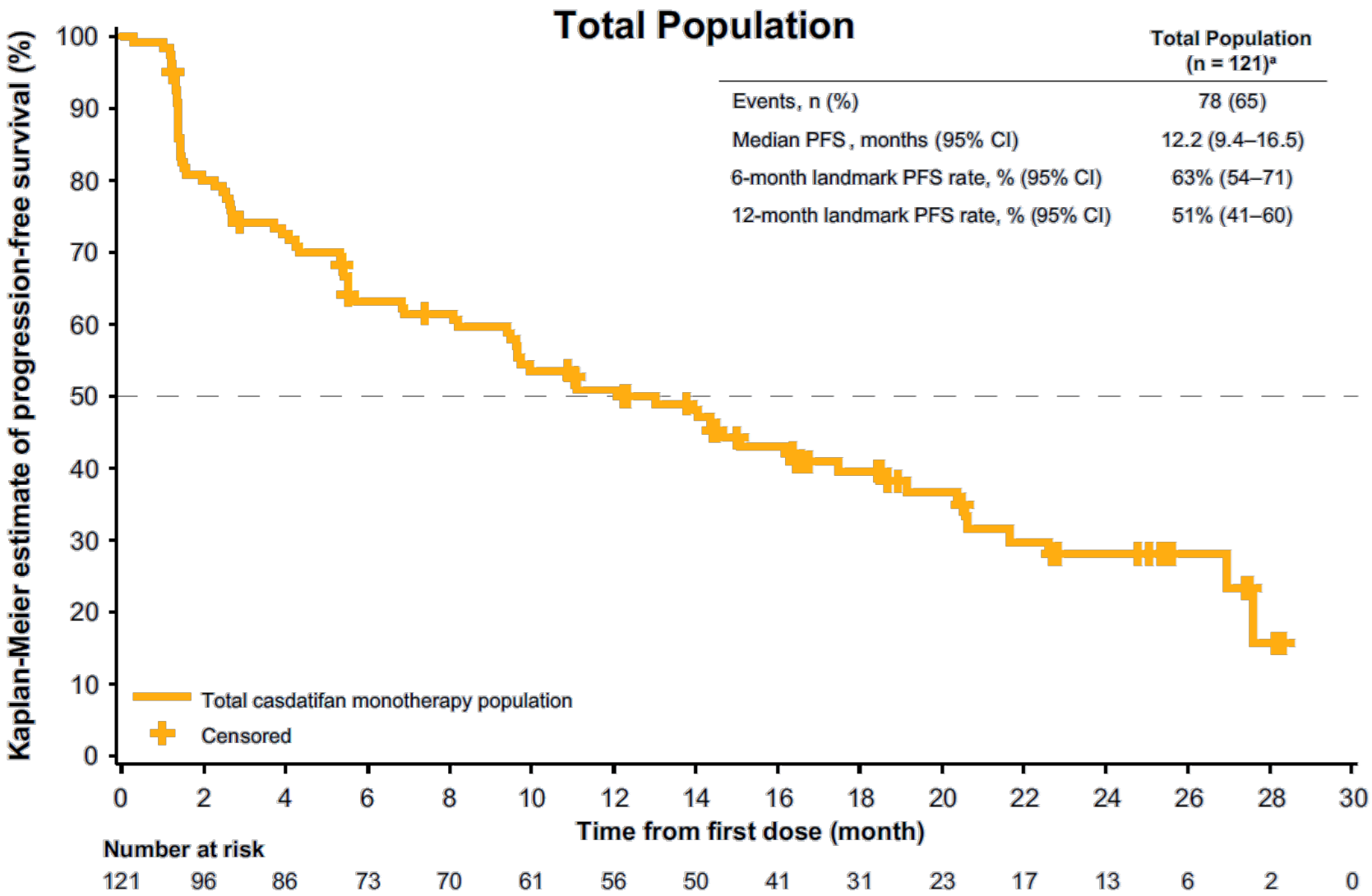
12.2 Months mPFS for Patients Treated with Casdatifan Across All Four Monotherapy Cohorts



	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)

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.

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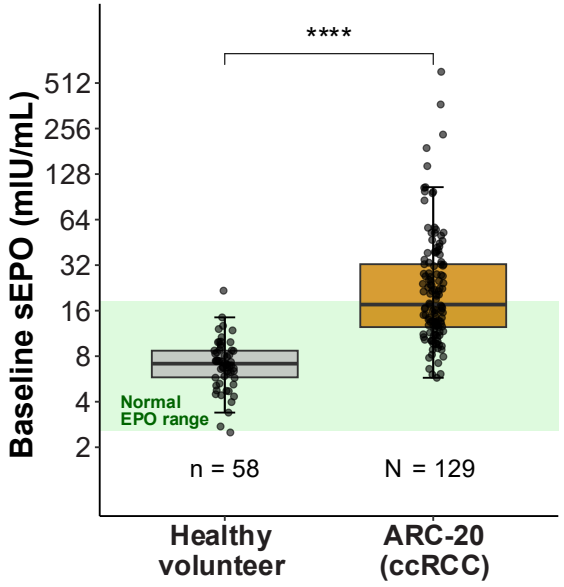
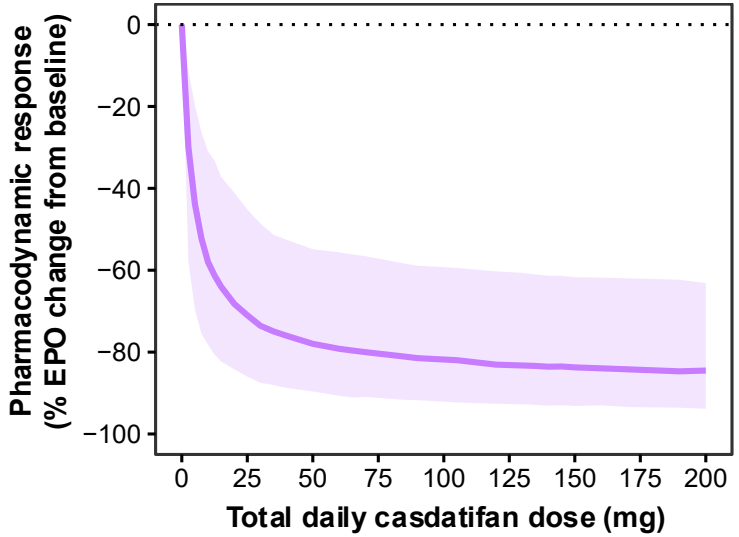
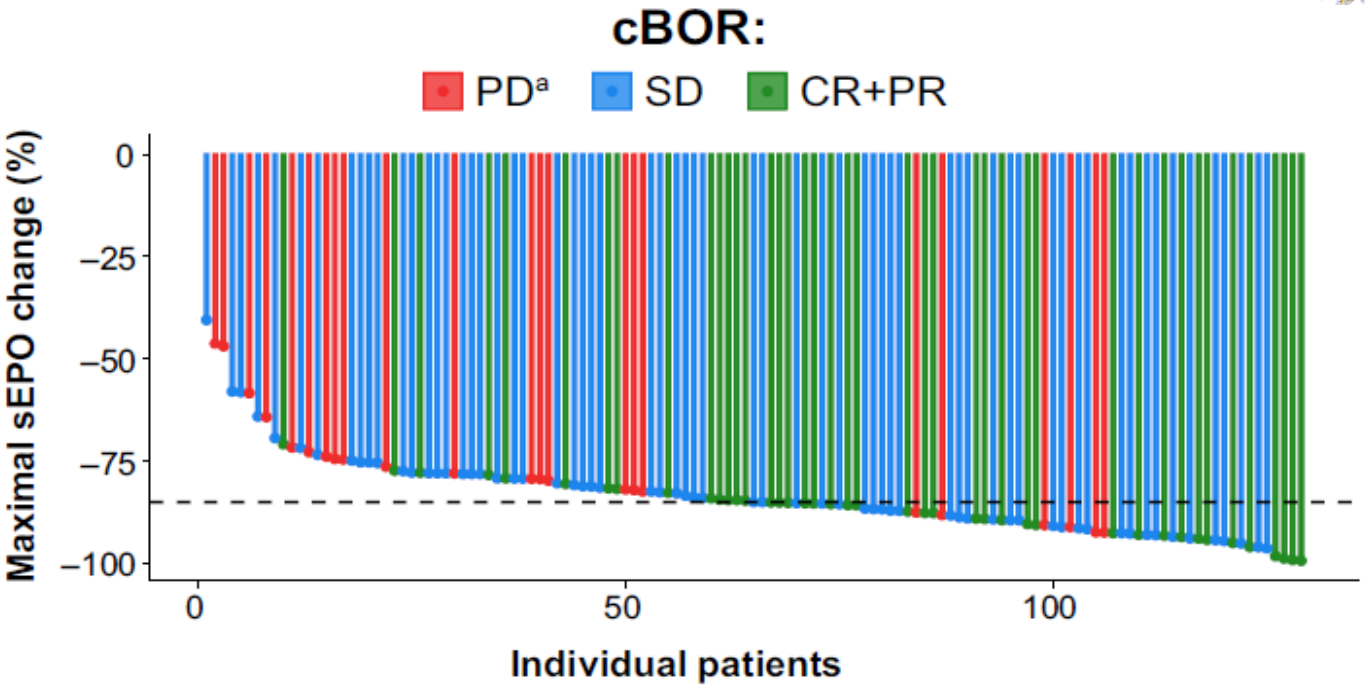
Systemic Suppression of HIF-2α–Regulated sEPO Is Highly Correlated with Clinical Benefit from Casdatifan (ORR)



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.

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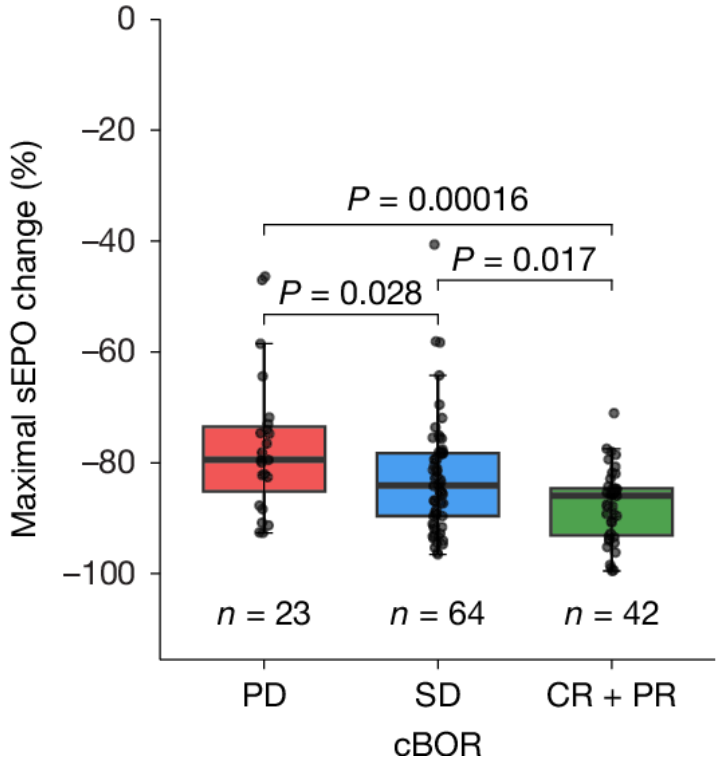
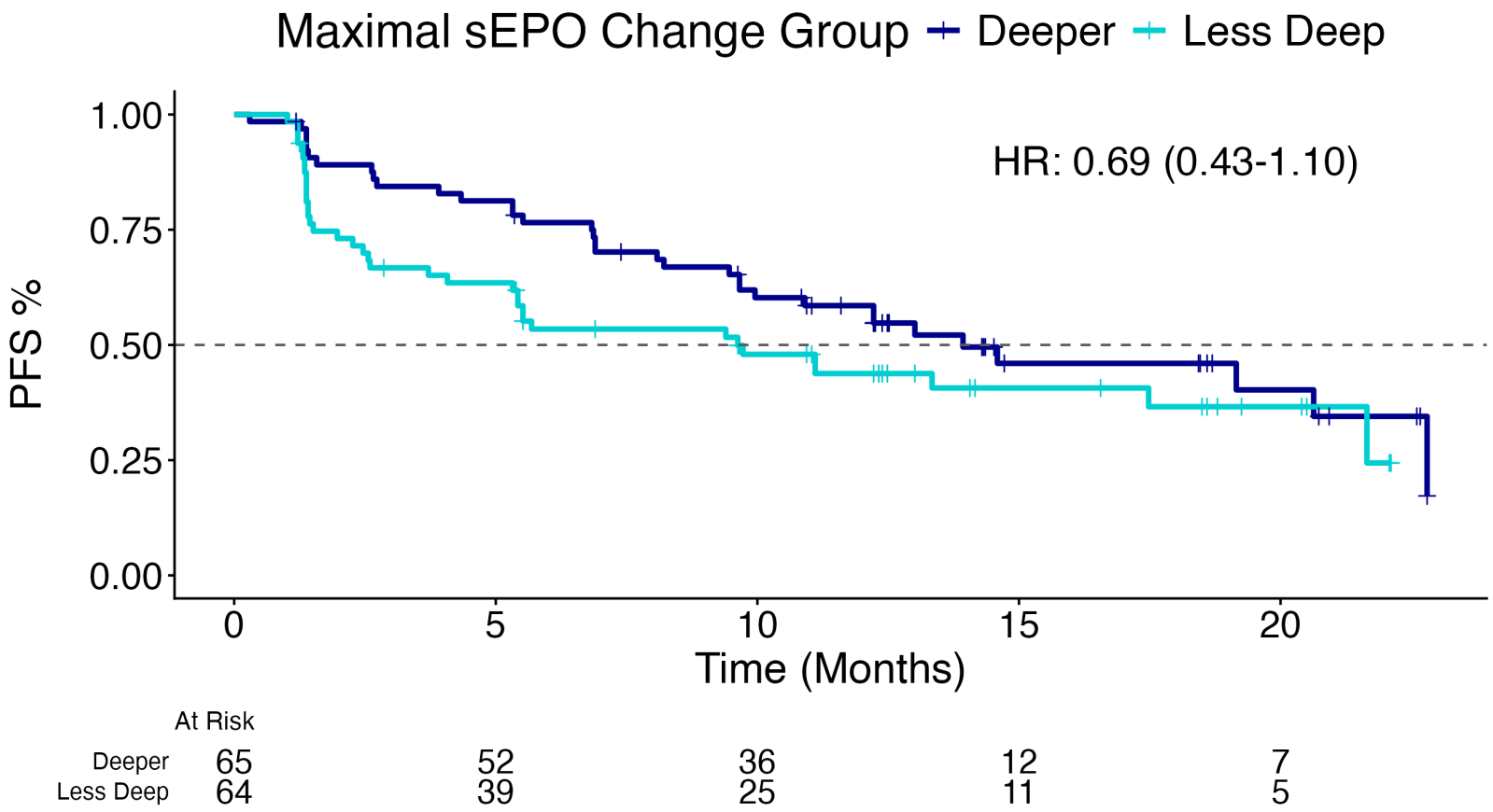
Systemic Suppression of HIF-2α–Regulated sEPO Is Highly Correlated with Clinical Benefit from Casdatifan (PFS)





The degree of maximal sEPO reduction was significantly greater in patients who achieved CR, PR, or SD compared with those with PD (P < .05)[6]

Maximal sEPO reduction was associated with longer PFS[6]

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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)[7]	Tivo	18%	5.6m
2L+	**METEOR (Phase 3)[8]**	Cabo	17%	7.4m
	Study 205 (Phase 2)[9]	Lenva	27%	7.4m
IO-Experienced (1L/2L)	**AXIS (Phase 3)[10]**	Axi	19%	6.7m
	CONTACT-03 (Phase 3)[11]	Cabo	41%	10.8m
	CANTATA (Phase 3)[12]	Cabo	28%	9.3m

ARC-20 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.

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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: Aug. 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.

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Casdatifan Development Strategy

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Our Vision is a Future in Which Every ccRCC Patient Benefits from Cas Throughout Their Treatment Journey

1L	Current SOC	Practice-Changing Trials	Future State
TKI-Free	**IO/IO = anti-PD-1 + anti-CTLA4** ~1/3 market	**PEAK-20** cas + ipi + nivo vs ipi + nivo	**cas + IO/IO** Grow to ~50% market with DOT >12+ mos
TKI-Containing	**IO+TKI** e.g. cabo + nivo, lenva + pembro, axi + pembro ~2/3 market	cas + axi + anti-PD-1 vs axi + pembro	**cas + IO/TKI** ~40% market with DOT >16-20+ mos
	~~**belz + pembro+ lenva (LS-012)** Not positive; April 2026~~		
Novel Combo		cas + anti-PD-1/VEGF bispecific	cas + anti-PD-1/VEGF bispecific
2L	**TKI mono** cabo ~40% market	**PEAK-1** cas + cabo vs cabo	**cas + cabo (post IO)** Maintain leading share with DOT
	belz + lenva (LS-011) mPFS 14.8 mos PDUFA Oct. 4, 2026		
2L+	**belz mono or TKI mono**	cas + tivo vs tivo (+/- prior belz)	**cas + tivo** (+/- prior belz)

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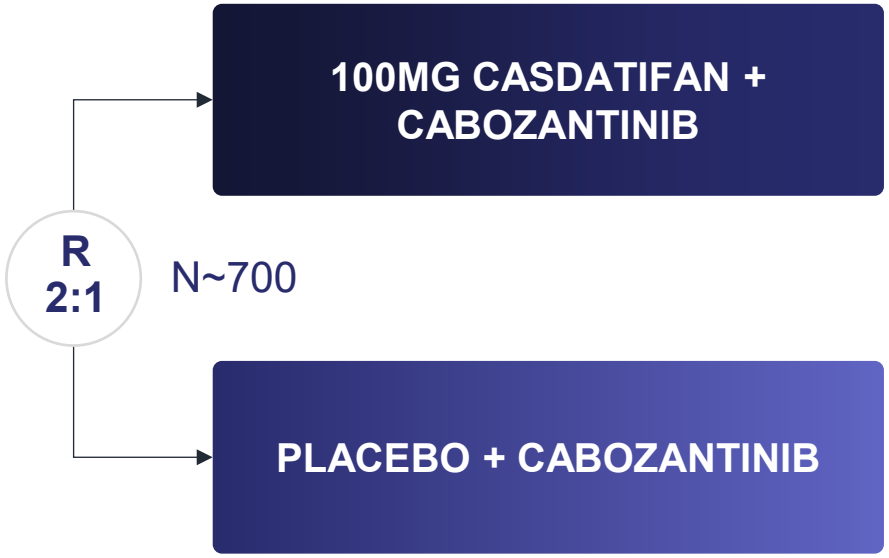
PEAK-1

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

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Foundational 1L TKI-Free Approach Is Enabled by the Low Rate of Primary Progression Seen with Cas

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)	16% (5)[1]
	monotherapy pooled (n=121)	19% (23)
	cas + cabo (n=43)	5% (2)
1L+ ccRCC	**1L cas + zim (n=30)**	**7% (2)**
	1L cas mono, favorable risk (n=22)	**0% (0)**
	cas mono, post-IO, TKI naive (n=29)	**3% (1)**

TKI-Free Cohorts Will Inform 1L Phase 3 Studies

ARC-20

- **1L ccRCC** cas + zim (anti-PD-1) — *Enrollment completed*
- **1L ccRCC** cas + anti-PD-1 + ipi — *Enrolling*
- **1L ccRCC** cas + ivo — *In Planning*

Bristol Myers Squibb™

- **1L ccRCC** cas + pumita — *In Planning*

Ongoing | *Plan to open (PD-X/VEGF bispecifics)*

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 spotfire data
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Casdatifan
Market Opportunity

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Metastatic ccRCC Treatment Algorithm (assumes LS-011 approval)

~20% of 1L patients have received adjuvant treatment

	Patients who start on anti-PD-1 + VEGFR-TKI (50-60%)			Patients who start on anti-PD-1 + anti-CTLA4 (30-40%)		
1L 14.4k pts	Anti-PD-1 + VEGFR-TKI			Anti-PD-1 + anti-CTLA4		
2L 9.8k pts	TKI mono	TKI + HIF-2α	TKI + mTOR	TKI mono	TKI + HIF-2α	TKI + mTOR
3L 6.3k pts	TKI mono	HIF-2α	TKI + mTOR	TKI mono	HIF-2α	TKI + mTOR

Epidemiology is US drug treatable ccRCC, per DRG, 2026.

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Substantial Opportunity for Casdatifan in 1L & 2L ccRCC

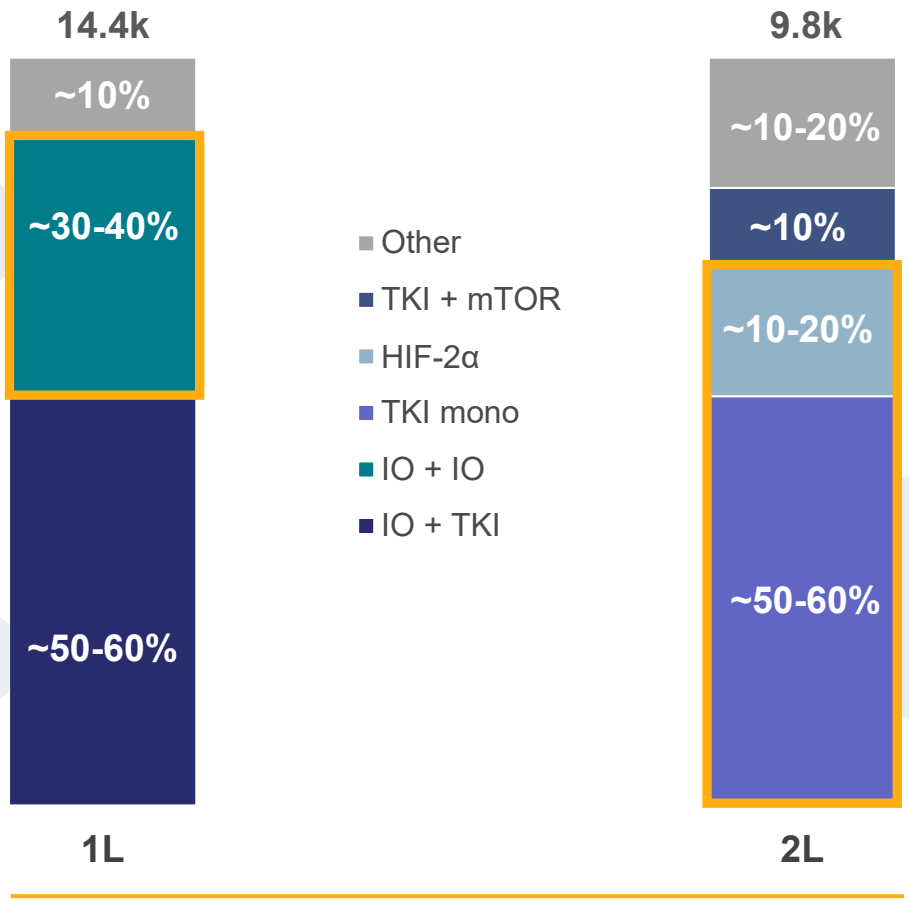
2026 US ccRCC Drug Treatable Incidence and Market Share

Grow IO+IO to >50% of 1L with addition of casdatifan

Dual IO
Anti-PD-1/anti-CTLA-4 + cas

Provide TKI-containing casdatifan regimen

IO/TKI
Anti-PD-1/TKI + cas



Secure dominant share in 2L with preferred regimen

TKI + cas
PEAK-1

Sources - Epi: DRG 2026 | Share: Arcus primary research, US March 2026 (n=50)
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Quemliclustat in Pancreatic Cancer

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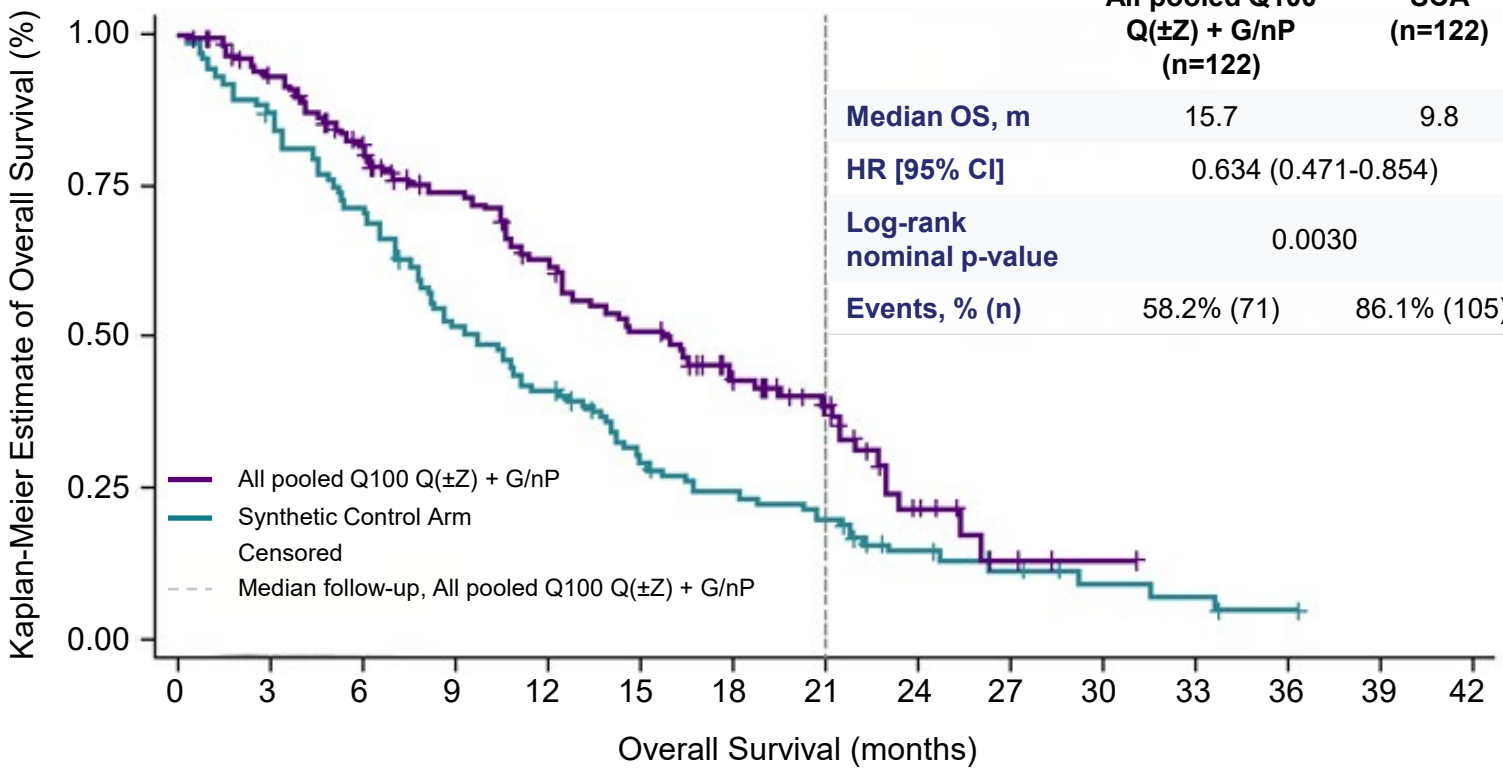
Quemli Could be the First Transformative Therapy for All-Comer 1L Pancreatic Cancer in 30+ Years

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

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

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PRISM-1

Phase 3 trial in 1L PDAC
Enrollment completed

~$4B
Market Potential

Readout
1H27

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PRISM-1

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

1L mPDAC

- Confirmed PDAC untreated in metastatic setting
- Metastatic disease diagnosed within 6 weeks prior to screening
- Measurable metastatic disease per RECIST 1.1
- ECOG PS 0 or 1

Stratification
- ECOG 0/1
- Liver metastases
- Region

2:1

N = 610

Arm A: quemli 100mg Q2W + G/nP

Arm B: Placebo Q2W + G/nP

PRIMARY ENDPOINT:
- OS

KEY SECONDARY ENDPOINTS:
- PFS

★ **ENROLLMENT COMPLETED**

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Quemli is Well Positioned to Capitalize on the $4B+ 1L PDAC Market

Strong POC Data	ARC-8 OS HR of 0.63 with ~6-month survival benefit vs. synthetic control for G/nP
Market Entry	Expected to be 1st of potential upcoming agents to launch in 1L PDAC (est. ~1+ year lead)
Tolerability	ARC-8 data indicated a limited increase in AEs relative to historical chemo benchmarks
Durability	Other developmental MOAs have demonstrated risk of mutational resistance
Target Population	Quemli is one of only a few developmental 1L agents that does not require biomarker testing
Expected Use	Near-term: potential to improve OS vs. available 1L options, presenting significant market opportunity Longer-term: study quemli with next-gen, more tolerable RAS agents in sequence or in combination

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Research Updates

HIF-2α Pathway and Emerging Immunology Portfolio

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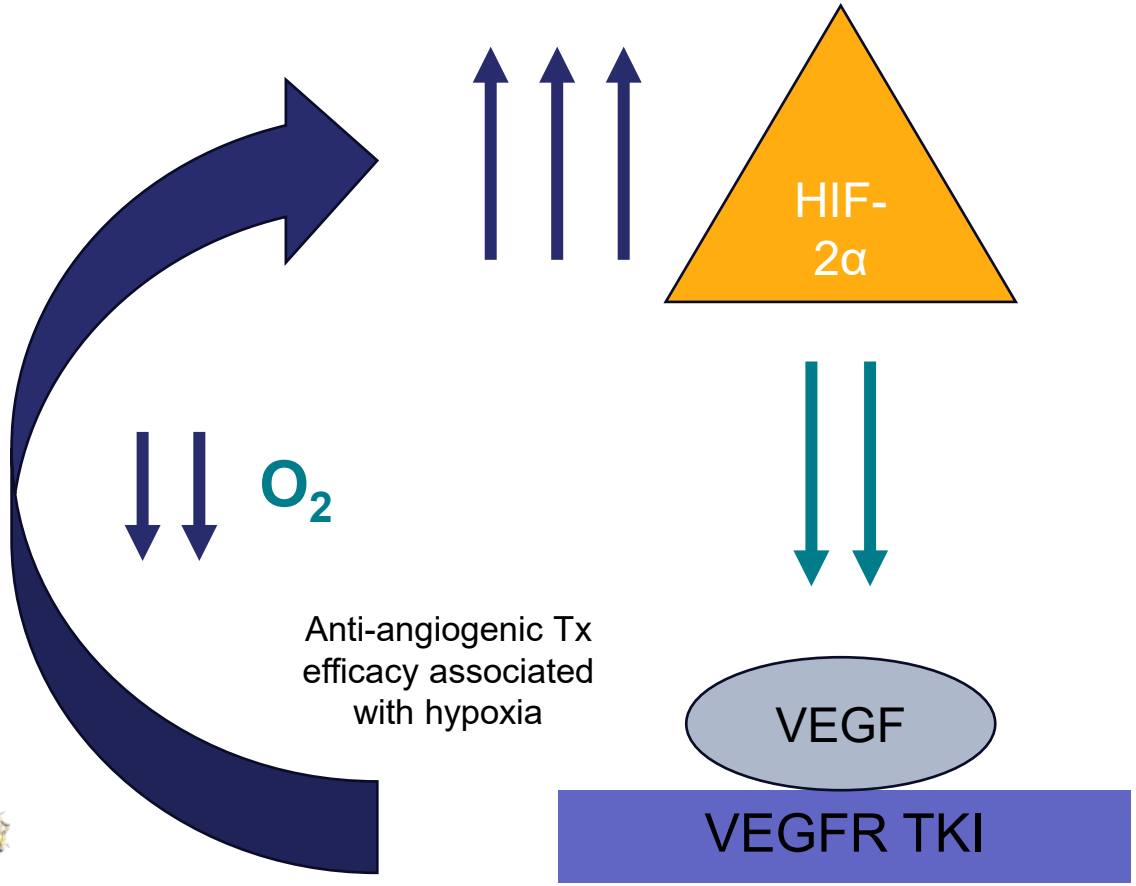
Role of HIF-2α VEGF Axis in RCC

Increasing our Understanding of the Relationship Between Anti-Angiogenic Therapy and HIF-2α



1 Innate HIF-2α

Driven by VHL deficiency, HIF-2α regulates multiple survival mechanisms, including well vascularized tumors

2 Adaptive HIF-2α

In response to TKI-induced hypoxia, survival advantage of clones with highest HIF-2α activity

3 Resulting Sensitivity

Greater HIF-2α dependence makes tumors more sensitive to cas, less responsive to anti-angiogenic TKI

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Immunology Program

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Immunology 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 IMMUNOLOGY 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"

IMMUNOLOGY DRUG DISCOVERY PORTFOLIO:

TARGET	MODALITY	DISEASE AREA	STATUS*	OWNERSHIP
AB102 (MRGPRX2)	SM	CSU, AD, Asthma	FIH expected this month	Wholly owned by Arcus
TNFR1	SM	RA, Psoriasis, IBD	FIH Expected Early 2027	Gilead Sciences holds time-limited option rights
CCR6	SM	IBD, Psoriasis	IND-Ready by YE 2027	Wholly owned by Arcus
STAT6	SM	AD, Asthma	IND-Ready by YE 2027	Wholly owned by Arcus
CD89	mAb	RA	IND-Ready by YE 2027	Wholly owned by Arcus
CD40L	SM	Lupus; MS	IND-Ready by YE 2027	Wholly owned by Arcus

**At least one additional molecule advancing to FIH in 2027*
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Potential Best-in-Class AB102 MRGPRX2 Antagonist to Treat Atopic Skin Diseases

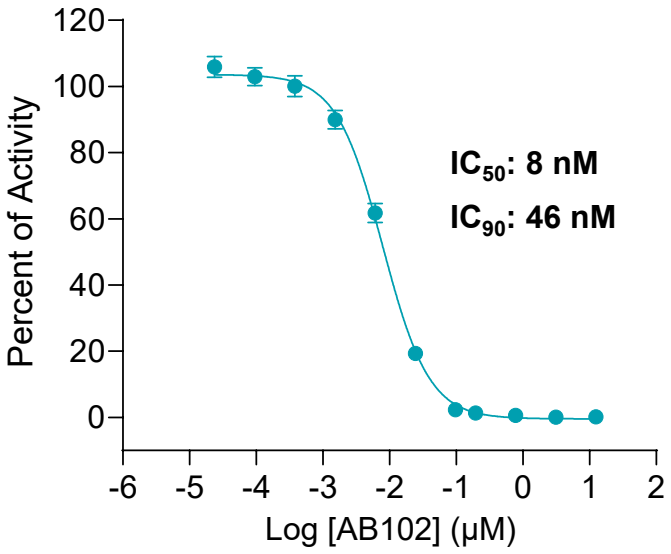
Validated biology with multi-billion dollar potential

- **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 this month

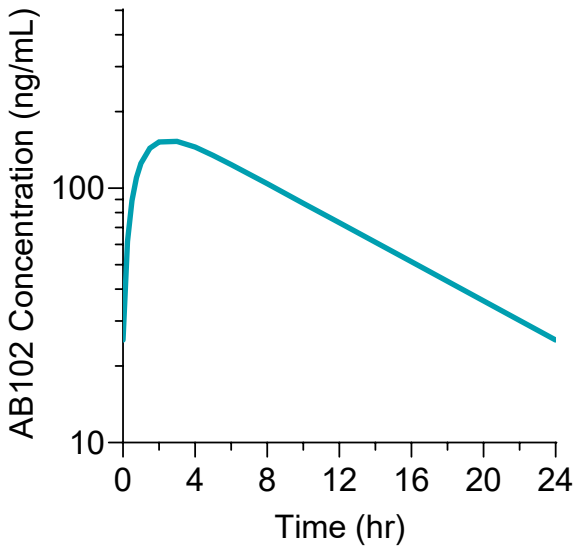
OPPORTUNITY FOR IMPROVEMENT

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

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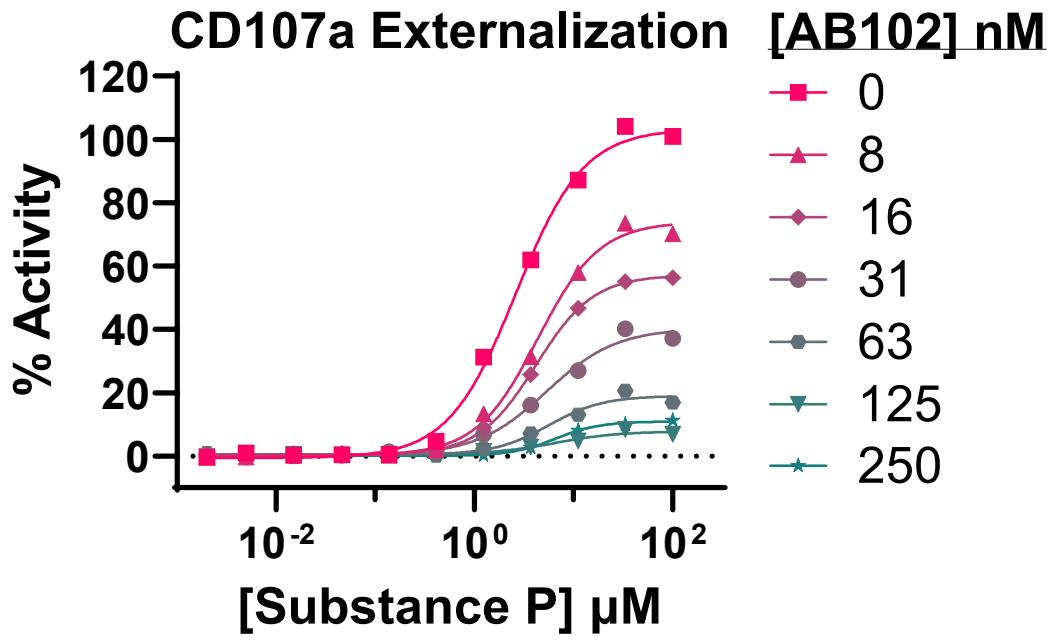
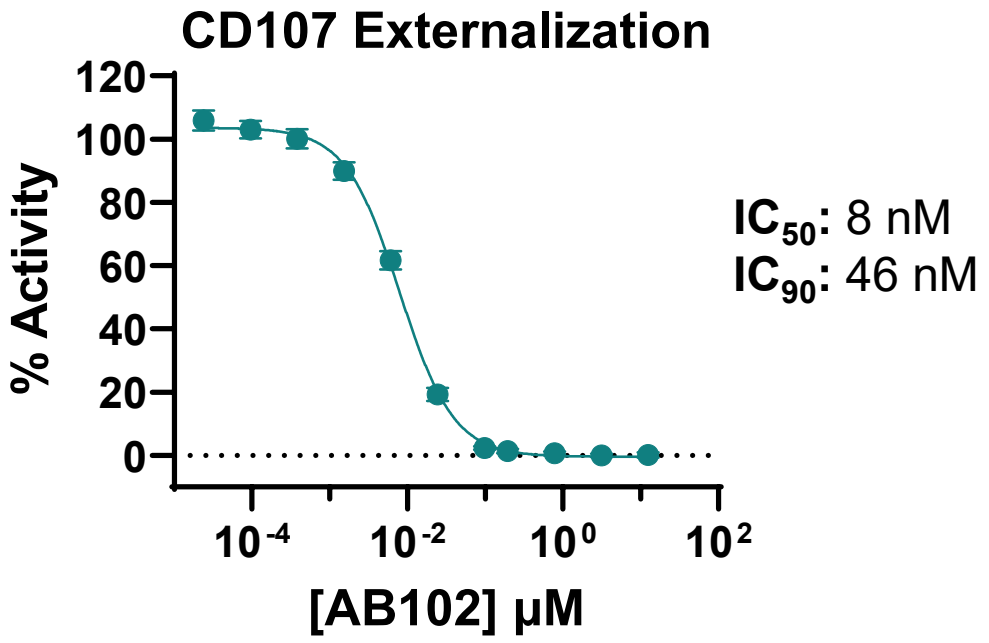
AB102 is a Potent and Selective Small Molecule MRGPRX2 Antagonist





- AB102 binds MRGPRX2 in a reversible manner with an insurmountable inhibitory profile[15]
- AB102 potently inhibits degranulation with an IC_{90} of 46 nM in 100% human serum[15]

LEFT and RIGHT: LAD2 cells in 100% human serum

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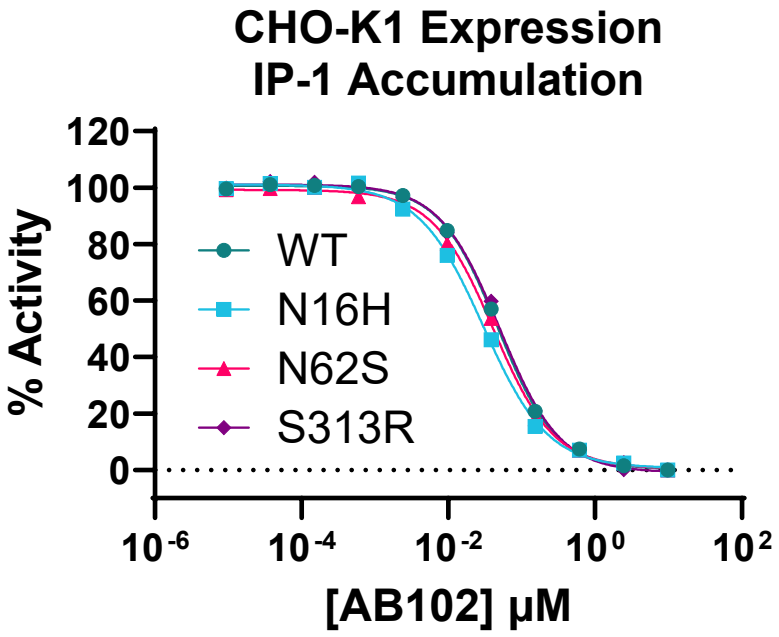
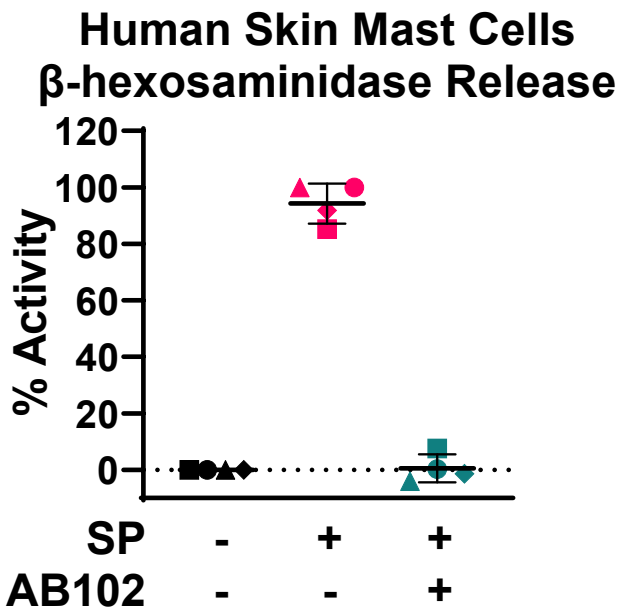
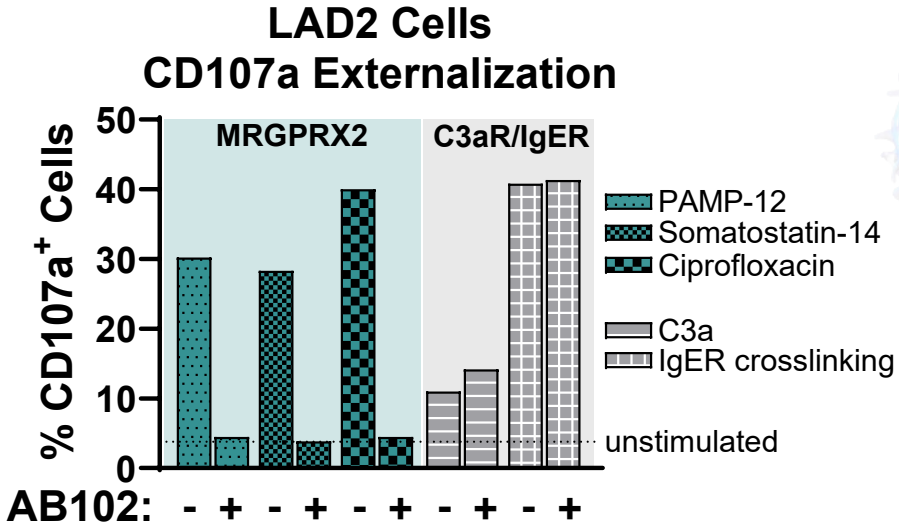
AB102 is a Potent and Selective Small Molecule MRGPRX2 Antagonist







- AB102 maintains full activity against common MRGPRX2 variants[15]
- AB102 inhibits MRGPRX2 activity in primary skin mast cells[15]
- AB102 is active against MRGPRX2 when activated by a variety of agonists[15]

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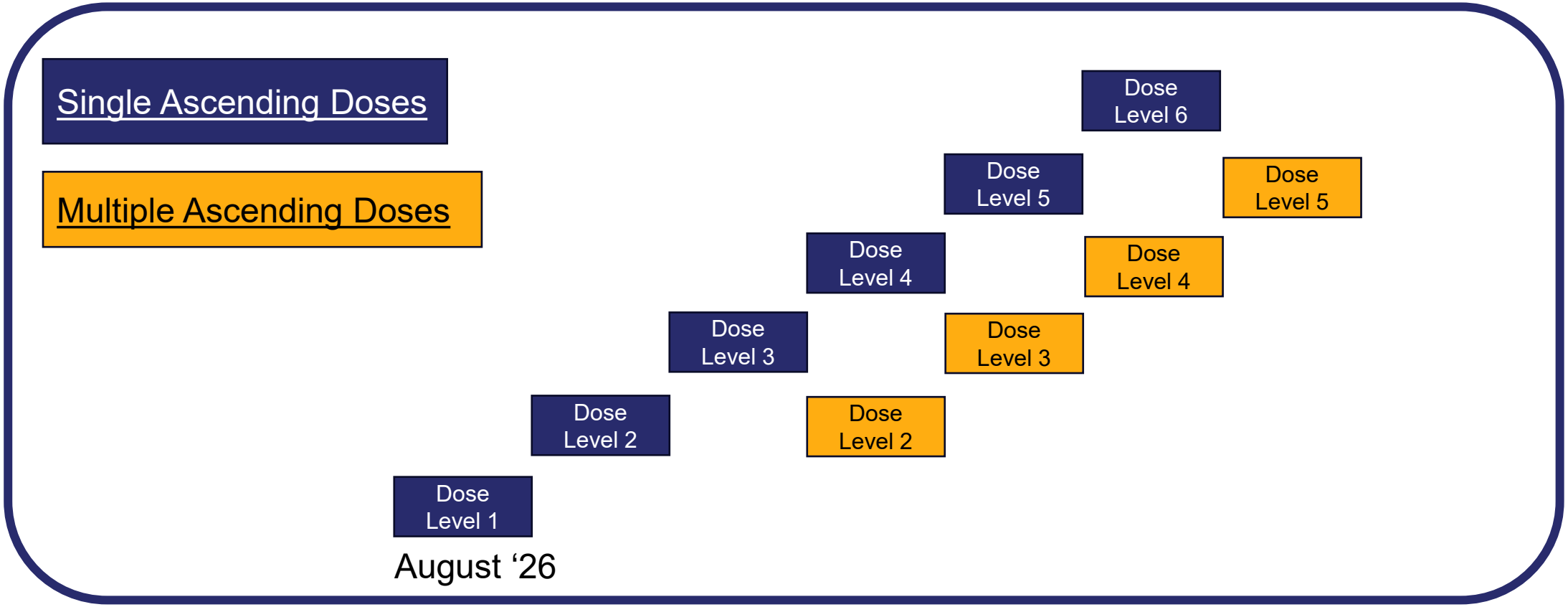
AB102 Healthy Volunteer Study
Double-Blind, Randomized, Placebo-Controlled SAD and MAD



- Primary objective is to define PK, safety, tolerability and dose achieving AUC target
- Staggered MAD cohorts lagging slightly behind SAD cohorts

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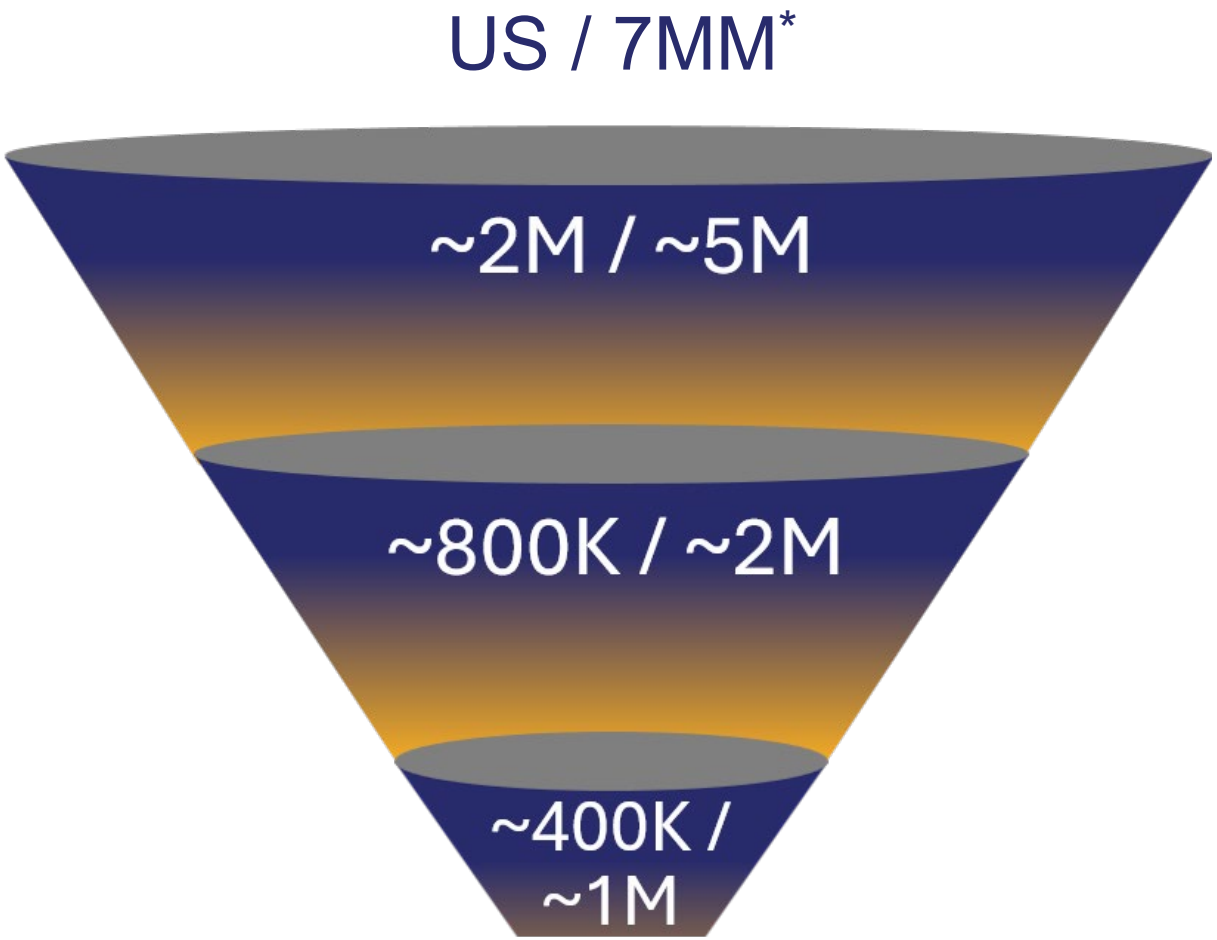
CSU is an Underserved Market with Limited Oral Treatment Options

- Estimated CSU prevalence[16,17]
- CSU patients uncontrolled on second-generation, high-dose antihistamines
- CSU patients untreated by advanced therapies
  - omalizumab (2014)
    - dupilumab (2025)
    - remibrutinib (2026)



*US, EU4, UK and Japan

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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[18,19]

PROGRAM STATUS:
Expect in clinic 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

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Small-molecule CCR6 Antagonists as Potential Therapeutic Alternatives to anti-IL-17 Biologics - Psoriasis

VALIDATED BIOLOGY WITH MULTI-BILLION $ POTENTIAL

- Anti-IL-17 antibodies have revolutionized the treatment of psoriasis and other skin diseases
  - Cosentyx® has generated $6.7B in LTM sales[20]
- There are currently no orally available options for dealing with the inflammatory effects of IL-17

PROGRAM STATUS:
Expected to be IND-ready in 2H27

OPPORTUNITY FOR IMPROVEMENT

- CCR6 inhibition creates opportunity to **interfere with a group of cytokines** (beyond IL-17) produced by key inflammatory cells (e.g., γδ T cells)
  - IL-17 is key in fighting certain infections; anti-IL-17 therapy brings with it increased risk of infection and intestinal inflammation
- Small-molecule CCR6 antagonists may provide **greater safety and flexibility for managing safety signals** secondary to IL-17 inhibition

Chemokine field **notoriously difficult to drug** (requirements for constant target engagement).

- Arcus scientists have one of the **best records in the industry**

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Appendix

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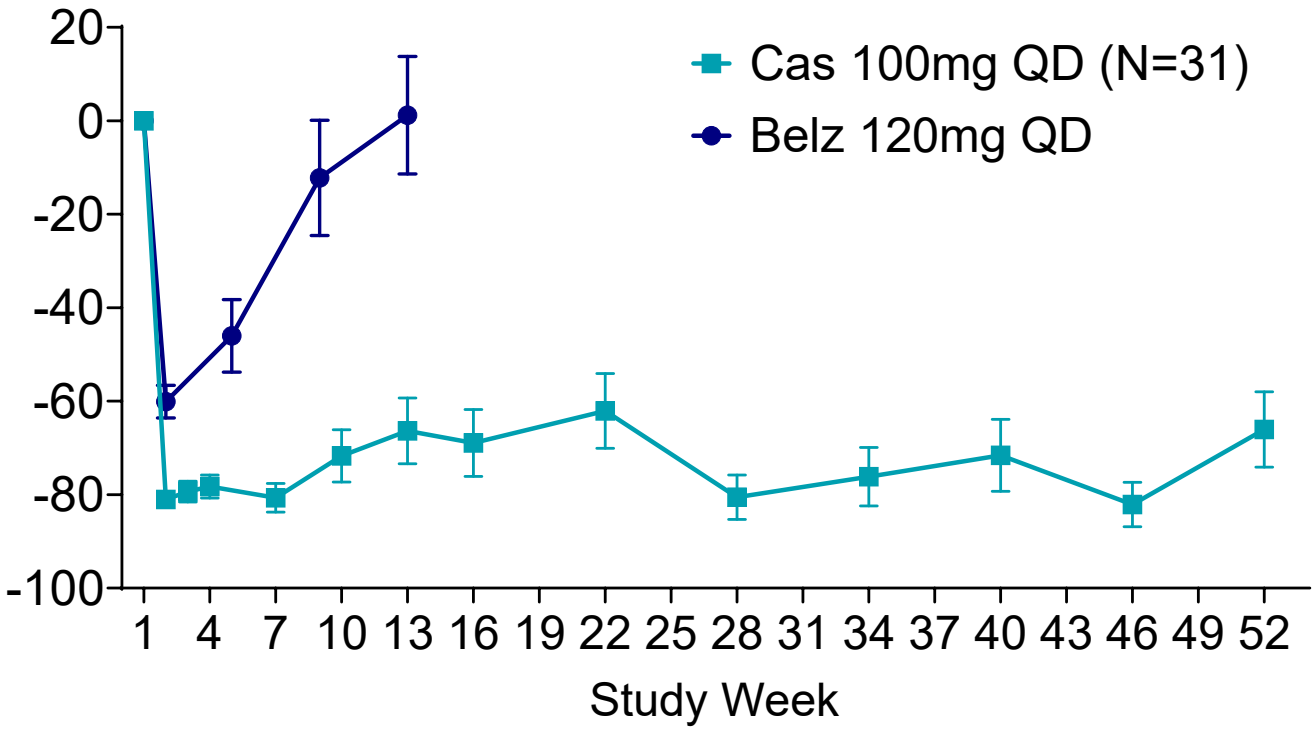
Superior Profile of Casdatifan Drives Clinical Differentiation

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

- ✓ Lower PD rate*
- ✓ Higher ORR*
- ✓ Longer PFS*
- ✓ Shorter onset to disease control*

Published data from Arcus[4] and Merck[5]



*Relative to published data from studies with belzutifan. 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.

References and acronyms on slide 43

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1H first half	**Cabo** cabozantinib	**ECOG** Eastern Cooperative Oncology Group	**Lenva** lenvatinib	**mPFS** median progression-free survival	**PR** partial response	**RECIST** Response Evaluation Criteria in Solid Tumors
1L first-line	**Cas** casdatifan	**EPO** erythropoietin	**m** months	**MS** multiple sclerosis	**POC** proof of concept	**SAD** single ascending dose
2H second-half	**ccRCC** clear cell renal cell carcinoma	**FIH** first-in-human	**mAb** monoclonal antibody	**NE** not estimable	**Pumita** pumitamig	**SCA** synthetic control arm
2L second-line	**CI** confidence interval	**G/nP** gemcitabine/nab-paclitaxel	**MAD** multiple ascending dose	**ORR** objective response rate	**Q** quemliclustat	**sEPO** serum erythropoietin
3L third-line	**cORR** confirmed overall response rate	**HR** hazard ratio	**Med** median	**OS** overall survival	**Q2/3W** every 2/3 weeks	**SD** stable disease
AD atopic dermatitis	**CR** complete response	**IBD** inflammatory bowel disease	**mg** milligrams	**PD** primary progression	**QD** once daily	**SM** small molecule
AUC areaunder the curve	**CSU** chronic spontaneous urticaria	**IND** Investigational New Drug	**mm** major markets	**PDAC** pancreatic ductal adenocarcinoma	**quemli** quemliclustat	**SOC** standard of care
Axi axitinib	**DCO** data cutoff	**IO** immunotherapy	**MOA** mechanism of action	**PDUFA** Prescription Drug User Fee Act	**R** randomized	**Tivo** tivozanib
B billion	**DCR** disease control rate	**Ipi** ipilimumab	**Mono** monotherapy	**pembro** pembrolizumab	**R&D** research & development	**YE** year-end
belz belzutifan	**DOR** duration of response	**Ivo** ivonescimab	**mos** months	**PFS** progression-free survival	**RA** rheumatoid arthritis	**Z** zimberelimab
BID twice daily	**DOT** duration of treatment	**K** thousand	**mOS** median overall survival	**PK** pharmacokinetics	**RCC** renal cell carcinoma	**zim** zimberelimab

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