1Q26 Corporate Presentation

Oncology and Immunology Portfolio Summary

May 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 inflammation and 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 a new Phase 3 study in first-line RCC, advancement of our inflammation and immunology programs into the clinic, 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.

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.

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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 AstraZeneca

~$876M IN CASH*

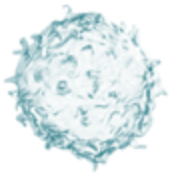
- Funded until at least 2H:28**

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 March 31, 2026

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

References and acronyms on slide 40

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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 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

AB102 MRGPRX2 antagonist

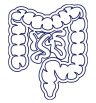
Expected in clinic in 3Q26

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

References and acronyms on slide 40

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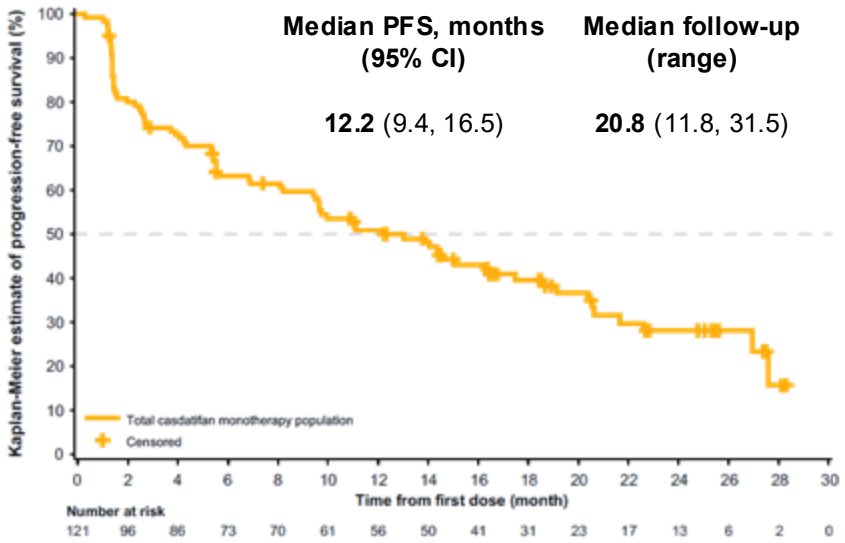
Clinical Data from >120 Patients Support Casdatifan's Potential as the Best-in-Class HIF-2α Inhibitor

ARC-20

IMPROVED CLINICAL OUTCOMES[1]

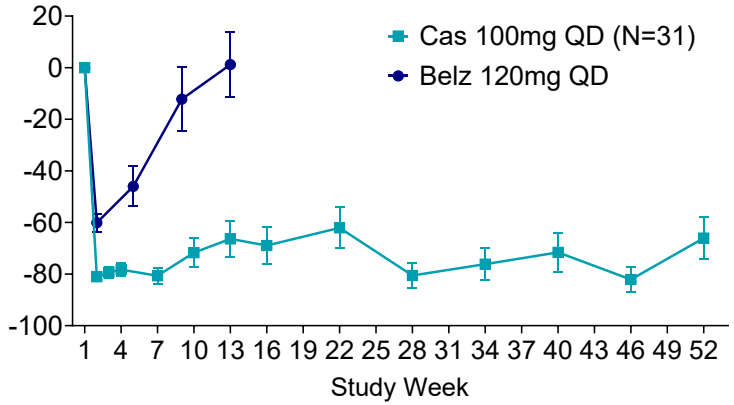
Longer PFS than other HIF-2α inhibitors and TKIs in late-line kidney cancer

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 Multiple Settings of RCC

PEAK-1	ARC-20
Post-IO metastatic cas + cabo | Phase 3	**1L TKI-free regimen**
19K patients* (2L)	**28K** patients* (1L)
~$2B+	**~$3B+**

*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.

DRG epi Major Markets, 2026. Major Markets: France, Germany, Italy, Japan, Spain, United Kingdom, United States.

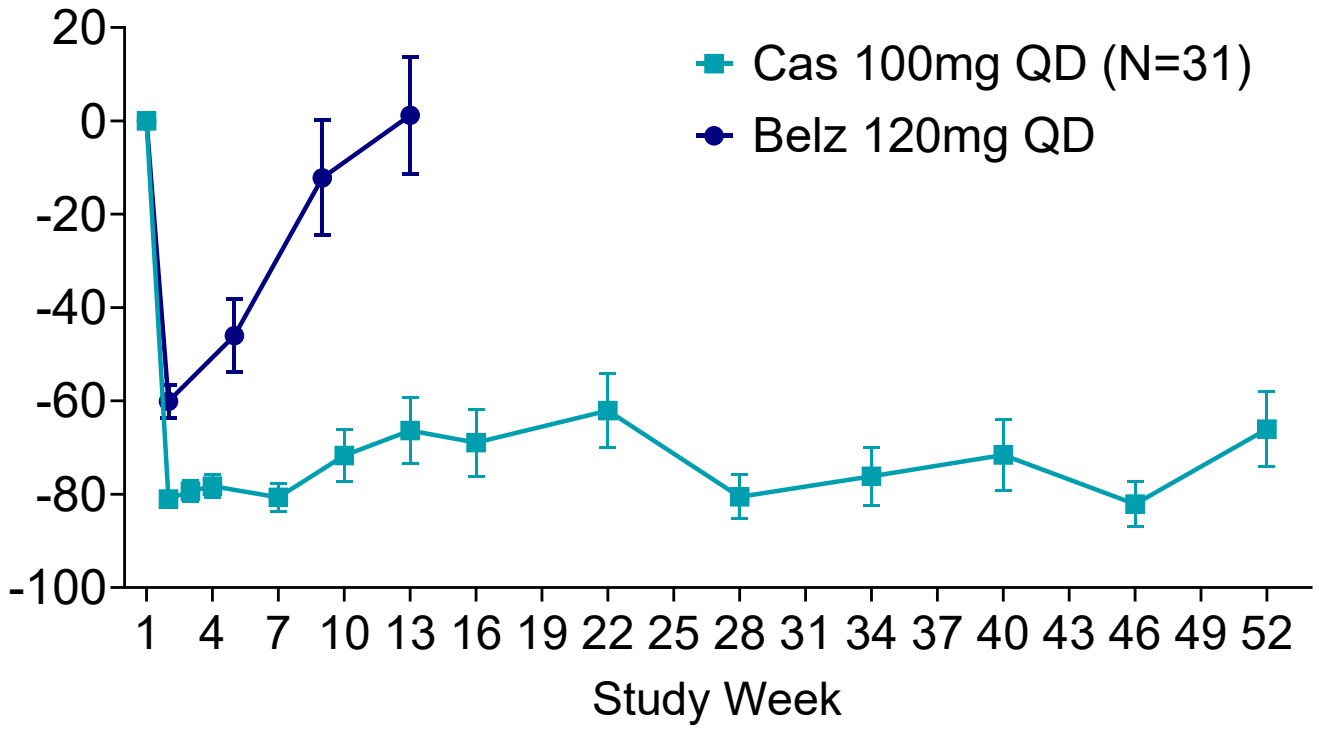
References and acronyms on slide 40

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 40

Program Updates: New Cas Data and Emerging I&I Portfolio

IMPRESSIVE CASDATIFAN MONO-TX DATA IN LATE-LINE ccRCC WERE 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 (dose and formulation selected for Phase 3)
- •cORR increased to 35% and PFS was stable at 12.2 months in a pooled analysis of all four monotherapy cohorts (n=121)

EMERGING I&I PROGRAMS

- AB102, a small molecule against MRGPRX2, will enter the clinic in 3Q26; preclinical profile to be presented in oral presentation the Society for Investigative Dermatology in May
- Oral TNF inhibitor drug candidate expected to enter the clinic in early 2027
- Drug candidate for CCR6 program expected to enter the clinic mid-2027

DOMVANALIMAB PROGRAM WIND DOWN

- The Phase 3 STAR-121 study is being discontinued due to futility; ongoing wind-down of anti-TIGIT program
- The STAR-121 study also evaluated zim and chemotherapy as an exploratory endpoint. Zim plus chemotherapy performed consistently with respect to OS as compared to pembrolizumab plus chemotherapy

References and acronyms on slide 40

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

1Q26

ARC-20

✓ **Cas monotherapy data** at ASCO GU

NEXT 3-6 MONTHS

ARC-20

Cas + cabo PFS data

Cas combinations in early-line RCC

OS data for late-line monotherapy cohorts

AB102

MRGPRX2 antagonist in clinic

NEXT 6-12 MONTHS

PEAK-1

Phase 3 fully enrolled

PRISM-1

Phase 3 data

TNF inhibitor in clinic

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

NEXT 12-24 MONTHS

AB102

POC data

TNF inhibitor

Complete Phase 1 & initiate Phase 2

CCR6 antagonist

Complete Phase 1 & initiate Phase 2

NEXT 24+ MONTHS

PEAK-1

Phase 3 data

References and acronyms on slide 40

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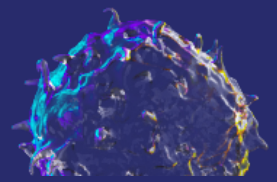
ASCO GU Casdatifan Data

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



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

DOSE ESCALATION

Patients with advanced solid tumors

Casdatifan monotherapy

- 200mg QD
- 150mg QD
- 50mg BID
- 50mg QD
- 20mg QD

DOSE EXPANSION

N = ~30 per cohort

- **2L+ ccRCC** Cas mono 50mg BID capsule
- **2L+ ccRCC** Cas mono 50mg QD capsule
- **2L+ ccRCC** Cas mono 100mg QD tablet
- **2L+ ccRCC** Cas mono 150mg QD tablet

- **Post-IO ccRCC** Cas 100mg QD + Cabo 60mg QD
- **Favorable-risk 1L ccRCC** Cas mono 100mg QD
- **1L ccRCC** Cas 100mg QD + Zim 360mg Q3W
- **1L ccRCC** Cas 100mg QD + Zim 360mg Q3W + ipi (4 cycles)
- **Post-IO ccRCC** Cas mono 100mg QD

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

References and acronyms on slide 40

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) 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
References and acronyms on slide 40

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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)

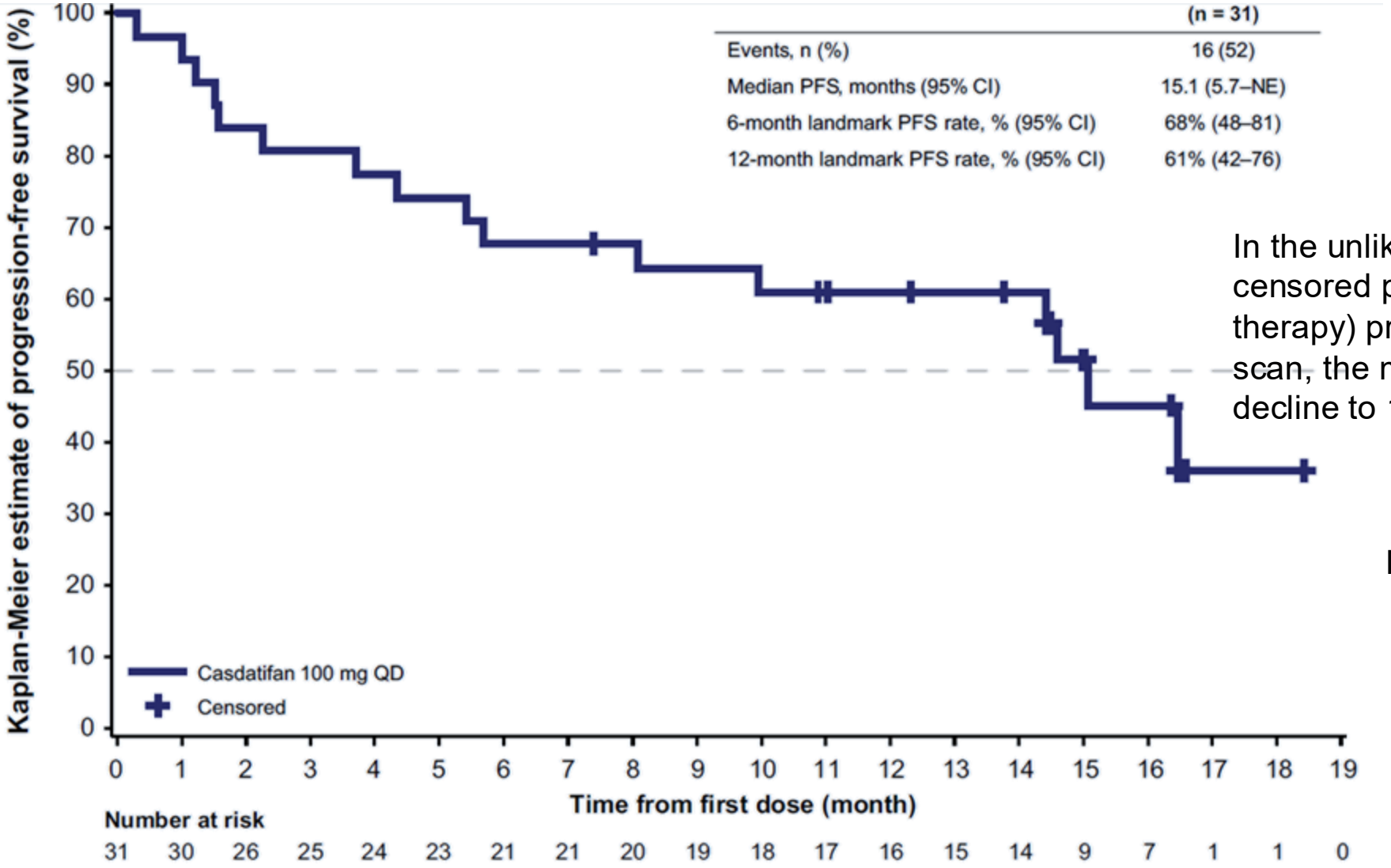
*Includes two patients in the 100mg QD Tablet cohort, and also included in the pooled analysis, who had clinical progression before the first scan and therefore did not meet criteria for progressive disease per RECIST. PD based on RECIST criteria was 10% (n=3) for the 100mg QD Tablet cohort and 17% (n=121)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

References and acronyms on slide 40

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



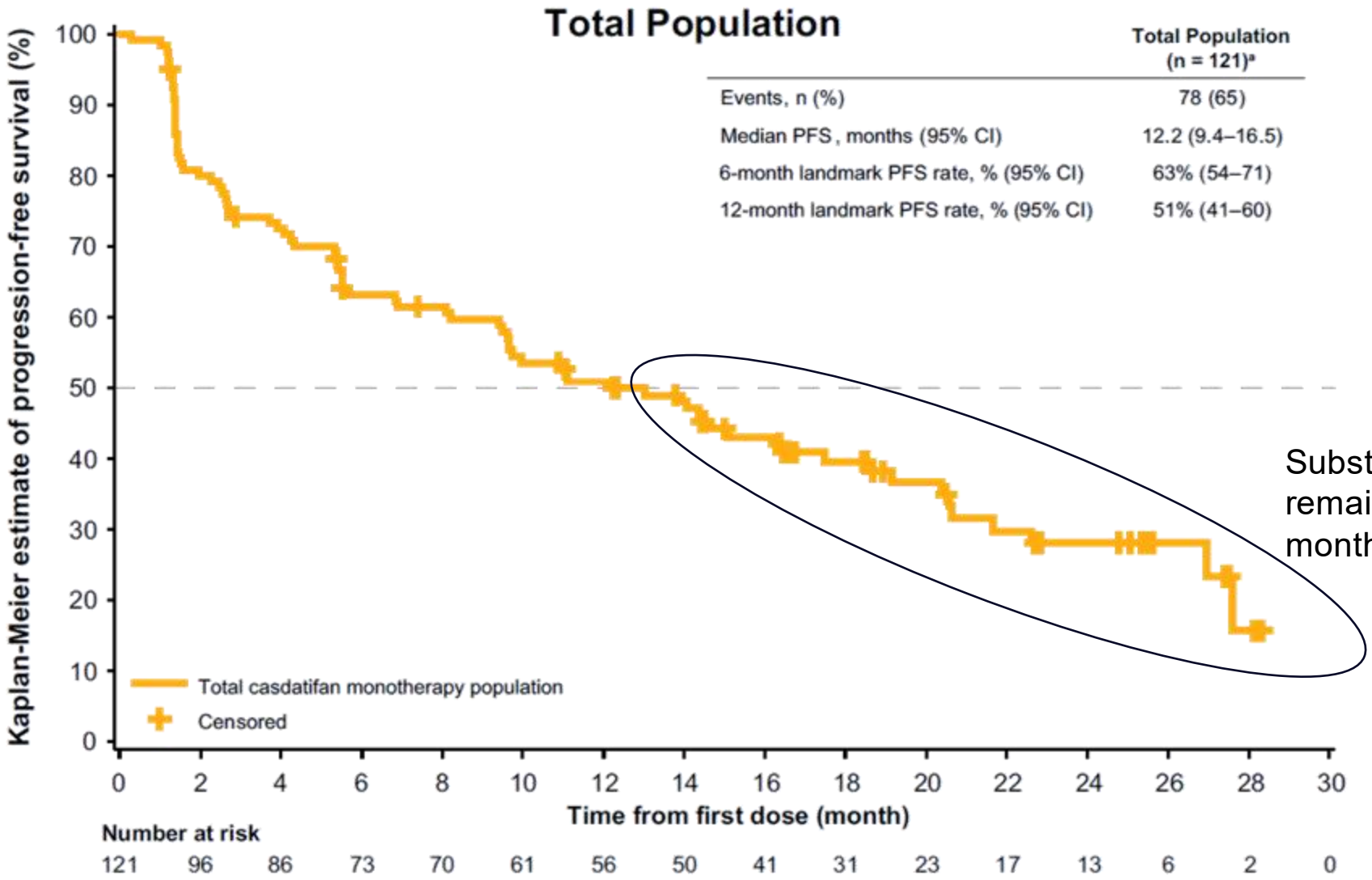
In the unlikely scenario that *all* censored patients (still on therapy) progress at the next scan, the mPFS would only decline to 14.4 months

Median Follow Up: 17.9 months

DCO date: Jan. 30, 2026

References and acronyms on slide 40

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

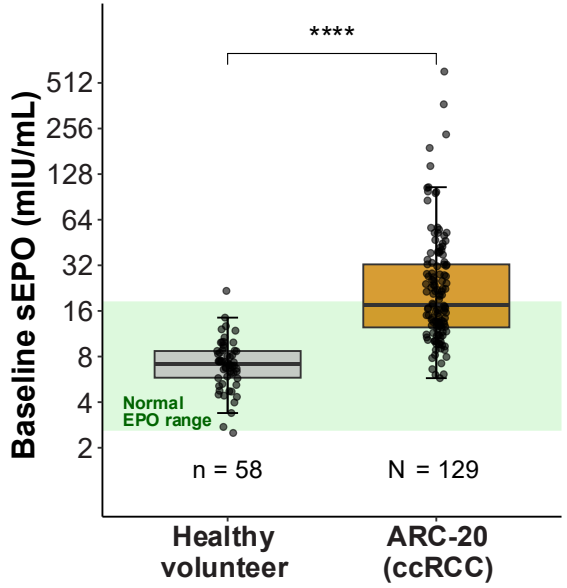
Median Follow Up: 20.8 months

DCO: Jan. 30, 2026

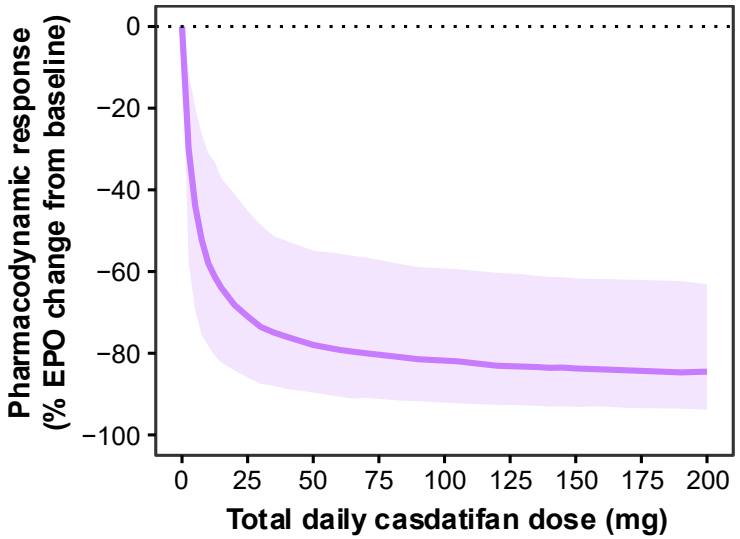
a. The efficacy evaluable population (N = 121) was defined as all eligible patients who received any study treatment and had ≥ 1 post-baseline efficacy assessment or discontinued study treatment due to progressive disease or death.

References and acronyms on slide 40

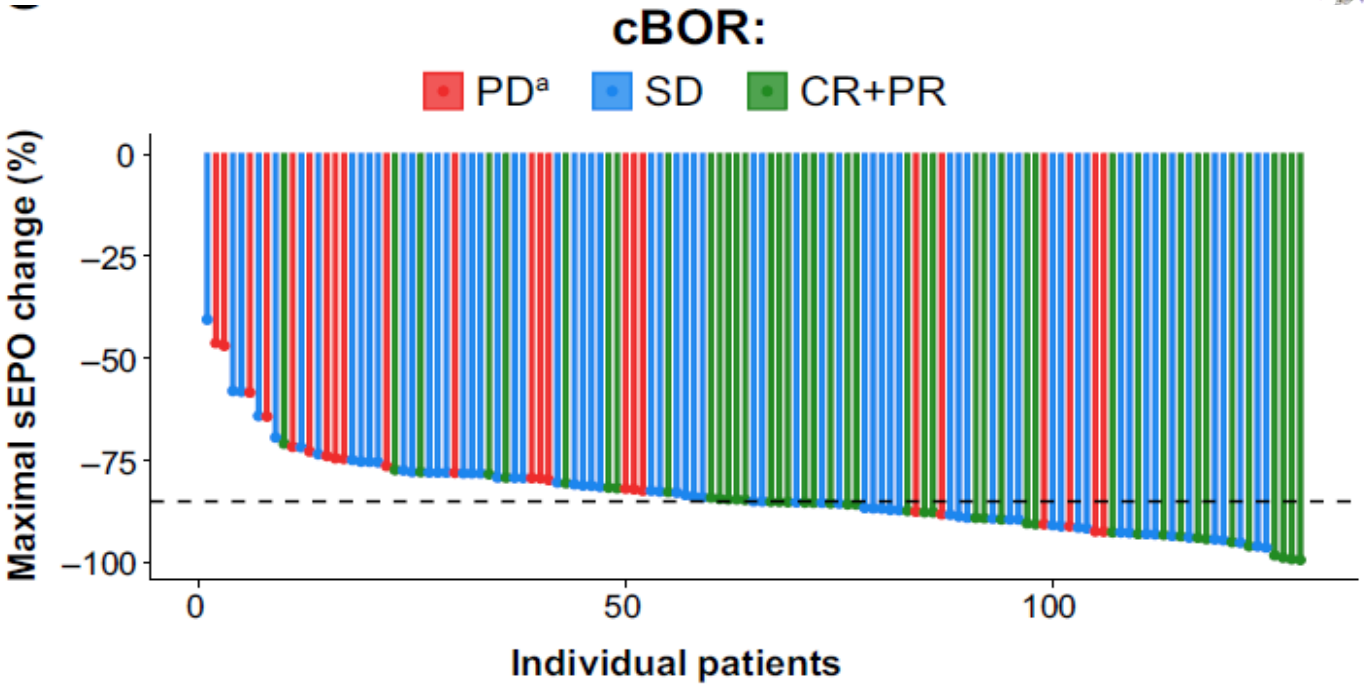
Systemic Suppression of HIF-2α–Regulated sEPO Is Highly Correlated with Clinical Benefit from Casdatifan (ORR)



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]

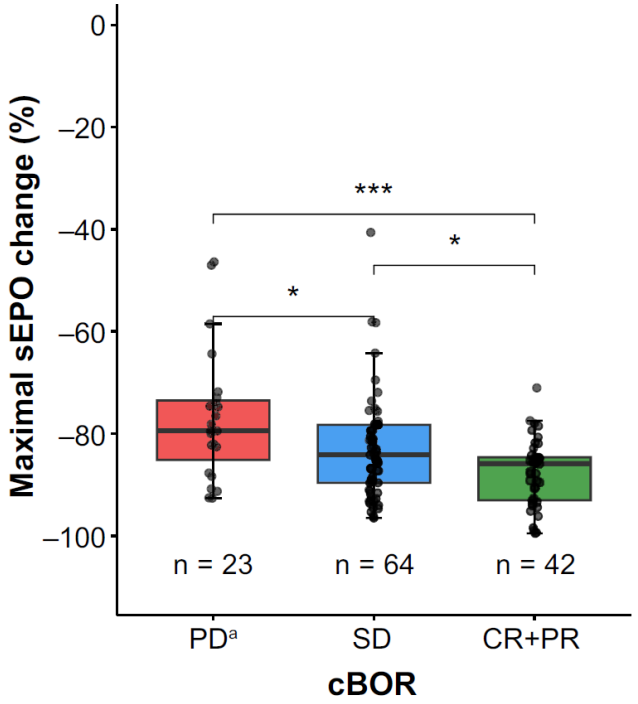


Across all doses, most patients (88/129 [68%]) experienced > 80% maximal sEPO reduction; **Deeper reductions in sEPO were highly correlated with clinical responses**[1]

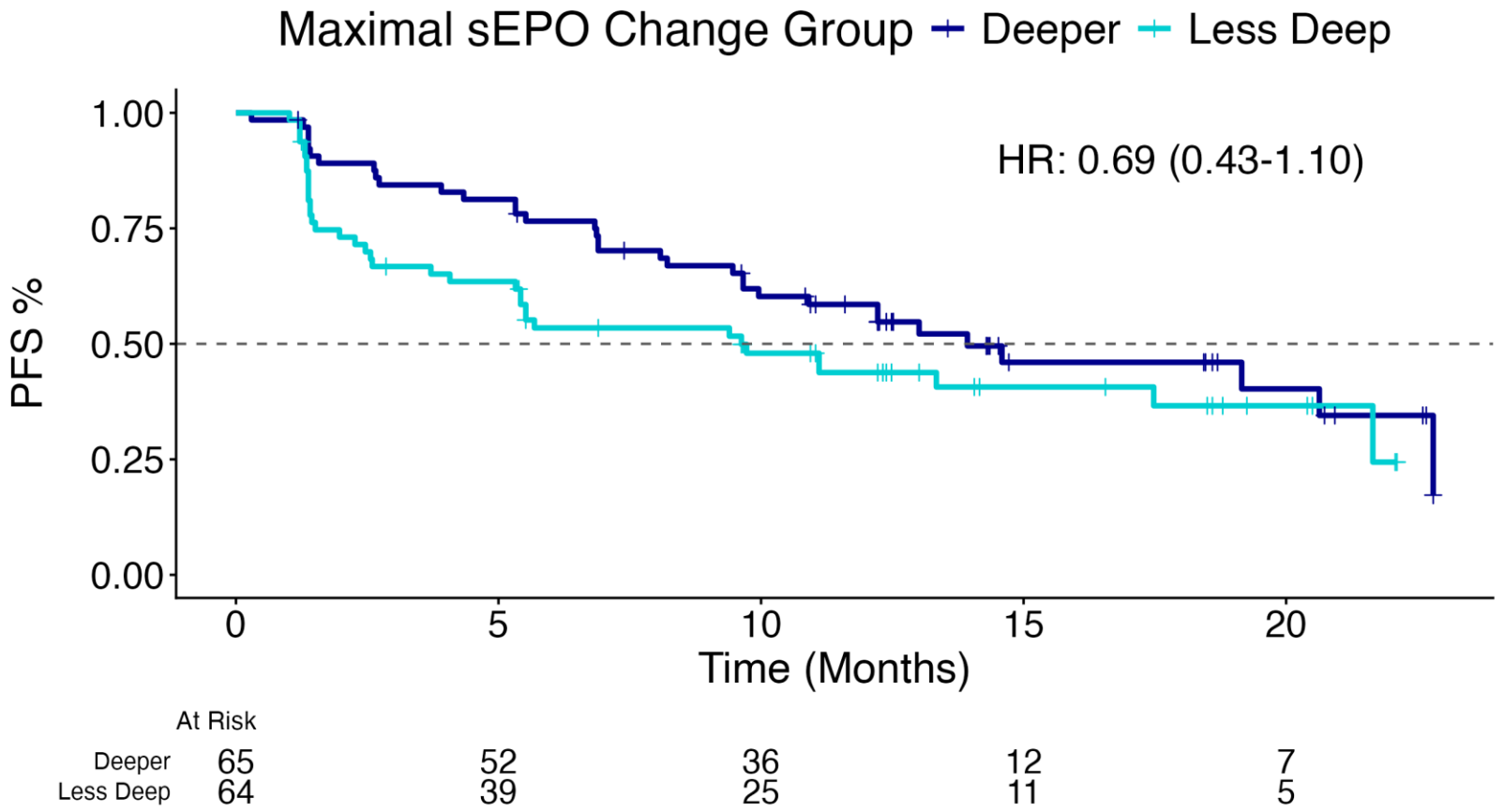
a. PD was defined according to RECIST v1.1 as a ≥ 20% increase in the sum of diameters of target lesions relative to the smallest sum on study (including baseline, if smallest), with an absolute increase of ≥ 5 mm. The appearance of 1 or more new lesions was also considered progression.

 References and acronyms on slide 40

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 ($P < .05$)[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.

References and acronyms on slide 40

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
	Study 205 (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.
References and acronyms on slide 40

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.

References and acronyms on slide 40

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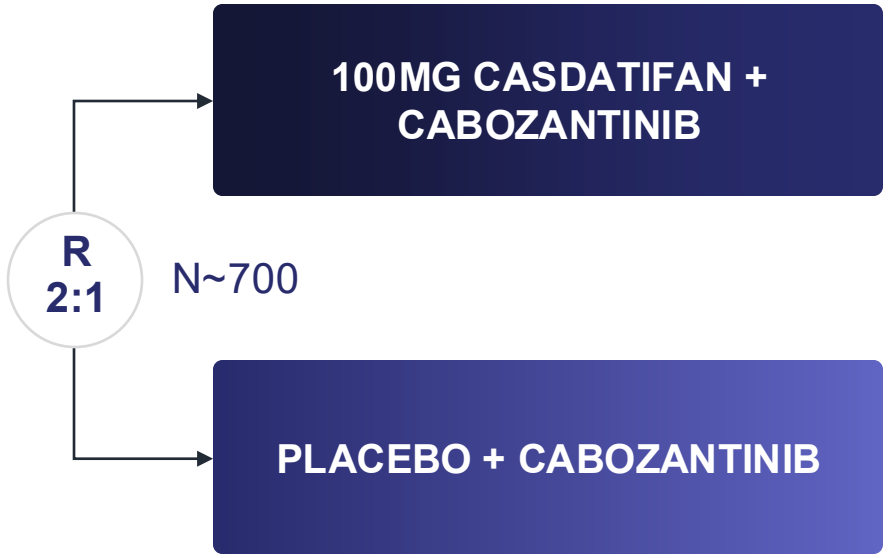
Casdatifan Development Strategy

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

References and acronyms on slide 40

1L TKI-Free Approach Is Enabled by Cas's 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)	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)**

Three TKI-Free Cohorts in the 1L Setting Will Inform Initial 1L Phase 3 Strategy for Cas with the Goal of Initiation by YE:26

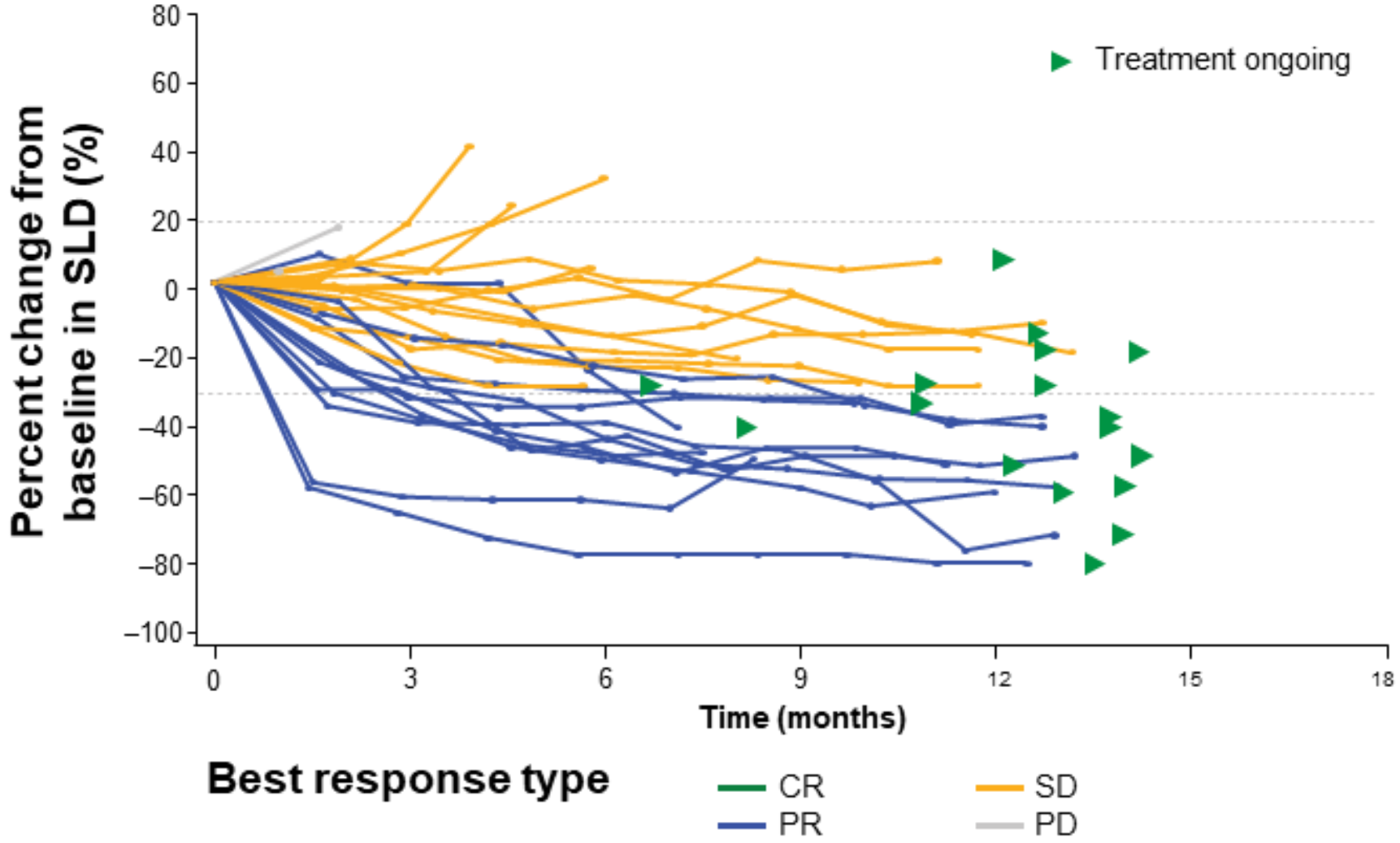
ARC-20

- **1L ccRCC** cas + zim (anti-PD-1) — *Enrollment completed*
- **1L ccRCC** cas + anti-PD-1 + ipilimumab — *Enrolling*
- **1L ccRCC** cas-based TKI-free combination — *In Planning*

Ongoing *Plan to open*

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
References and acronyms on slide 40

Half of Patients (17 of 31) Remain on Treatment with Disease Control in the 100mg Cohort of ARC-20



DCO date: Aug. 15, 2025, 12.4 months of median follow up

References and acronyms on slide 40

Future State of RCC Treatment: Every Patient to Have Opportunity to Benefit from Cas

	Current SOC	Practice-Changing Trials	Future State
1L			
TKI-Free	**IO/IO** ~1/3 market	**PEAK-20** **Cas + IO/IO study**	**Cas + IO/IO** Grow to ~50% market with DOT >12+mos
TKI-Containing	**IO/TKI** ~2/3 market	**Cas + IO/TKI study**	**Cas + IO/TKI** ~40% market with DOT >16-20+mos
Novel Combo		**Cas-based TKI-free combination**	**Cas-based TKI-free combination**
2L	**TKI mono** Cabo ~40% mkt	**PEAK-1** **Cas + Cabo study**	**Cas + Cabo (post IO)** Maintain leading share with DOT
	Belz + Lenva (LS-011) mPFS 14.8 mo. PDUFA Oct. 4, 2026		
3L+	**Belz mono or TKI mono**	**Cas + TKI Study (+/- prior Belz)**	**Cas + TKI (+/- prior Belz)**

References and acronyms on slide 40

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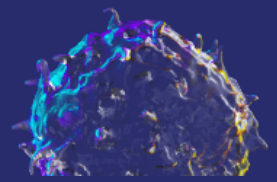
Casdatifan
Market Opportunity



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 16.4k pts	Anti-PD-1 + VEGFR-TKI			Anti-PD-1 + anti-CTLA4		
2L 11.2k pts	TKI Mono	TKI + HIF-2α	TKI + mTOR	TKI Mono	TKI + HIF-2α	TKI + mTOR
3L 7.3k pts	TKI Mono	HIF-2α	TKI + mTOR	TKI Mono	HIF-2α	TKI + mTOR

Epidemiology is US drug treatable ccRCC, per DRG, 2036

References and acronyms on slide 40

$5B+ Opportunity for Casdatifan in 1L & 2L ccRCC Market

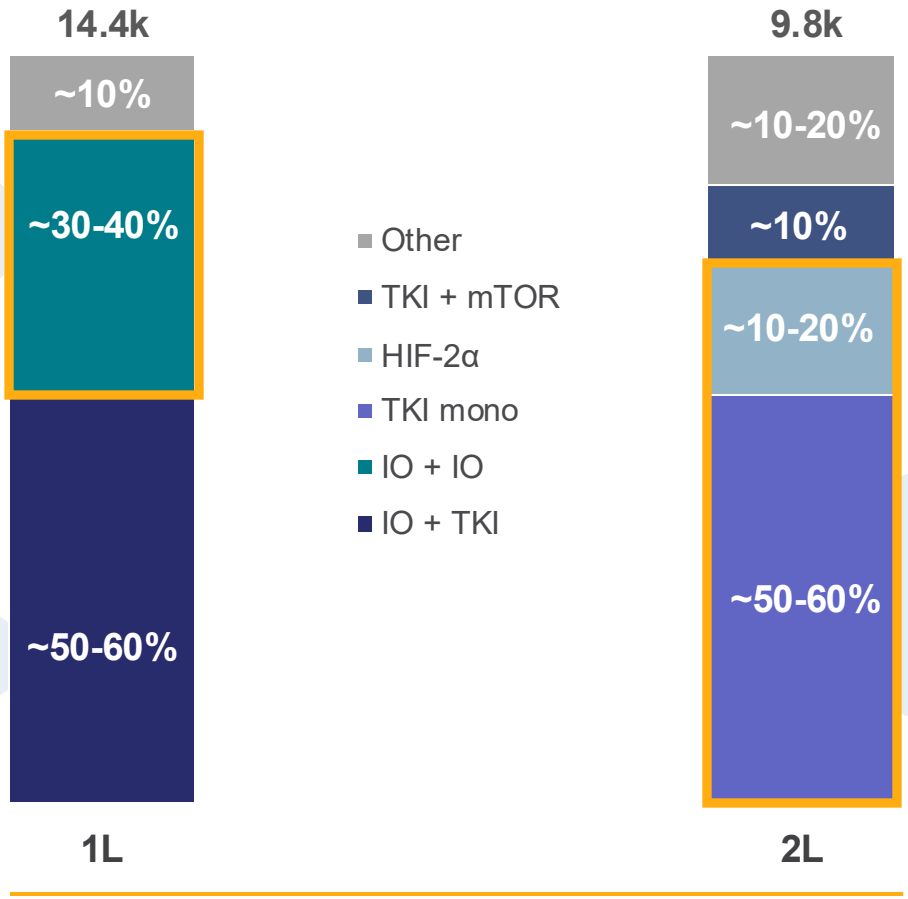
2026 US ccRCC Drug Treatable Incidence and Market Share

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

TOTAL ADDRESSABLE MARKET

~$9B Growing to $13B by 2030

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

References and acronyms on slide 40

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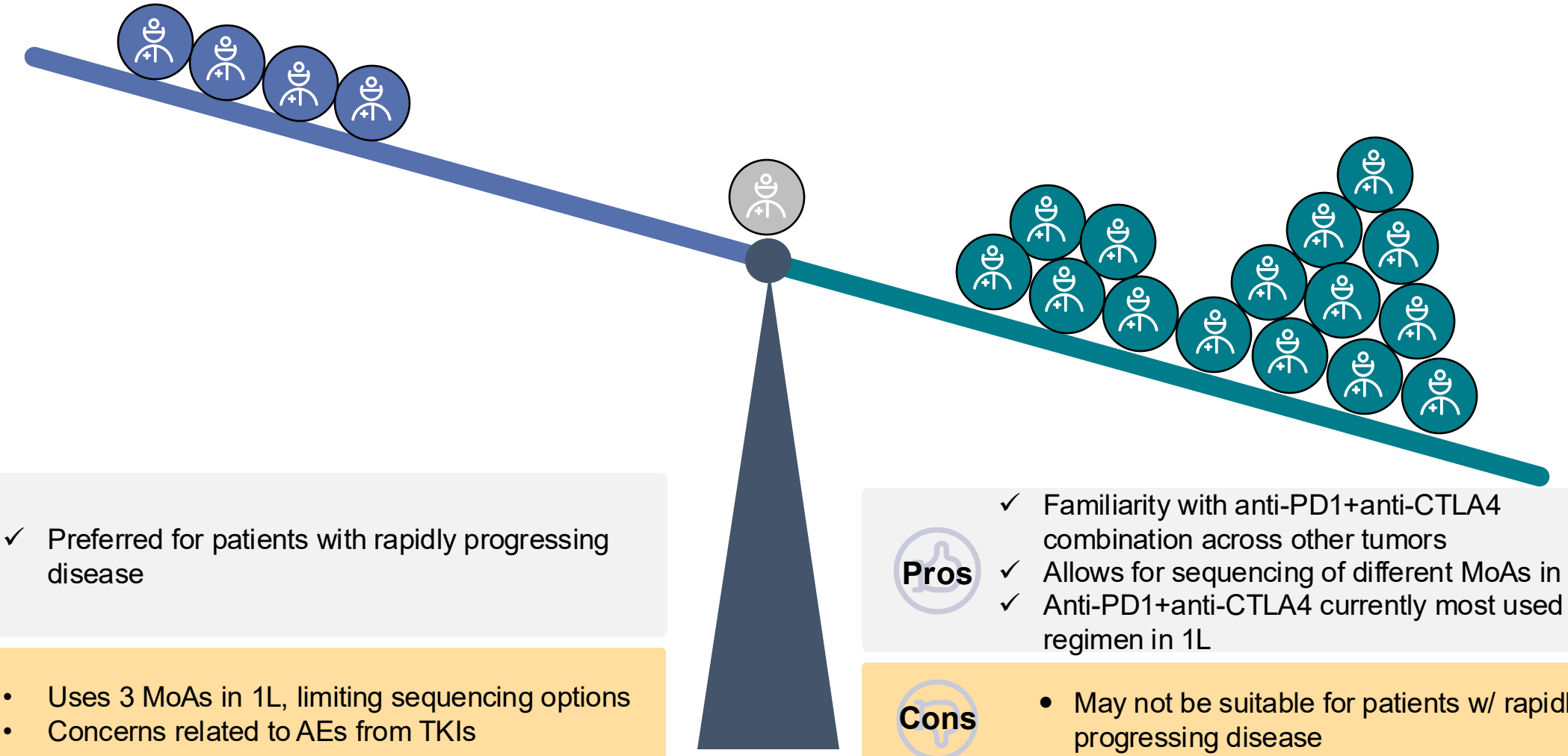
Oncologists Clearly Preferred the 1L Cas + Anti-PD1/anti-CTLA4 Regimen Over the 1L Cas + Anti-PD1/TKI Regimen When Presented With Both Options

Prefer cas+PD1+TKI (n=4) | **Neutral (n=1)** | **Prefer cas+Dual-IO (n=15)**



Pros

- ✓ Preferred for patients with rapidly progressing disease

Cons

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

Pros

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

Cons

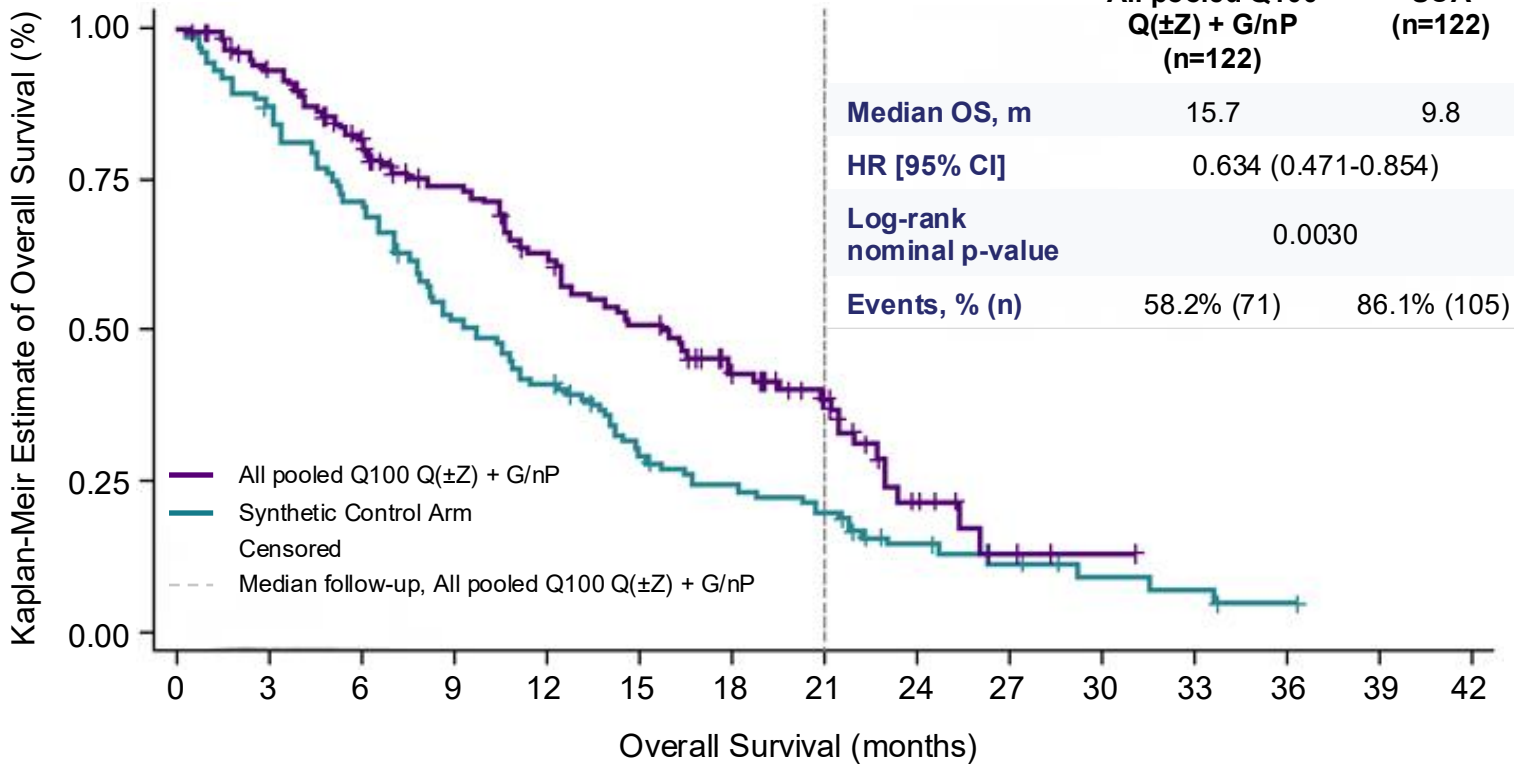
- May not be suitable for patients w/ rapidly progressing disease

Arcus primary research, 4Q25, References and acronyms on slide 40

Quemliclustat in Pancreatic Cancer

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[12]



	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

References and acronyms on slide 40

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PRISM-1

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

References and acronyms on slide 40

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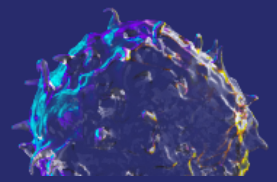
Our Emerging I&I Portfolio



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
AB102 (MRGPRX2)	SM	CSU, AD	FIH Expected in 3Q26
TNF (TNFR1)	SM	RA, Psoriasis, IBD	FIH Expected Early 2027
CCR6	SM	Psoriasis	Advanced Discovery
CD89	mAb	RA	Advanced Discovery
CD40L	SM	SLE; MS	Discovery

References and acronyms on slide 40

Potential Best-in-Class AB102 MRGPRX2 Antagonist to Treat Atopic Skin Diseases

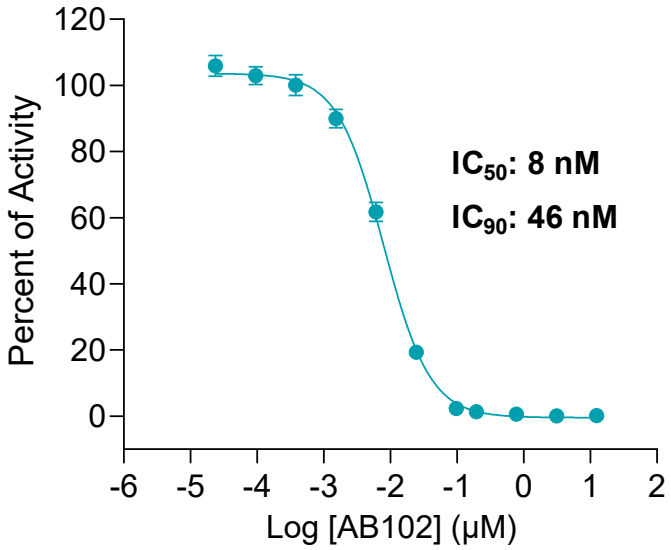
Validated biology with multi-billion dollar potential

- **Approved biologics** are **highly successful and effective** in treating AD and CSU, etc. and generate >$15B in LTM sales[13]
- 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 3Q26

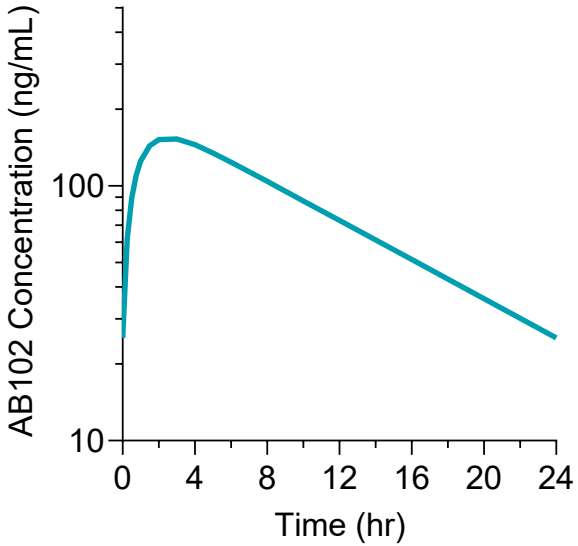
OPPORTUNITY FOR IMPROVEMENT

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



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

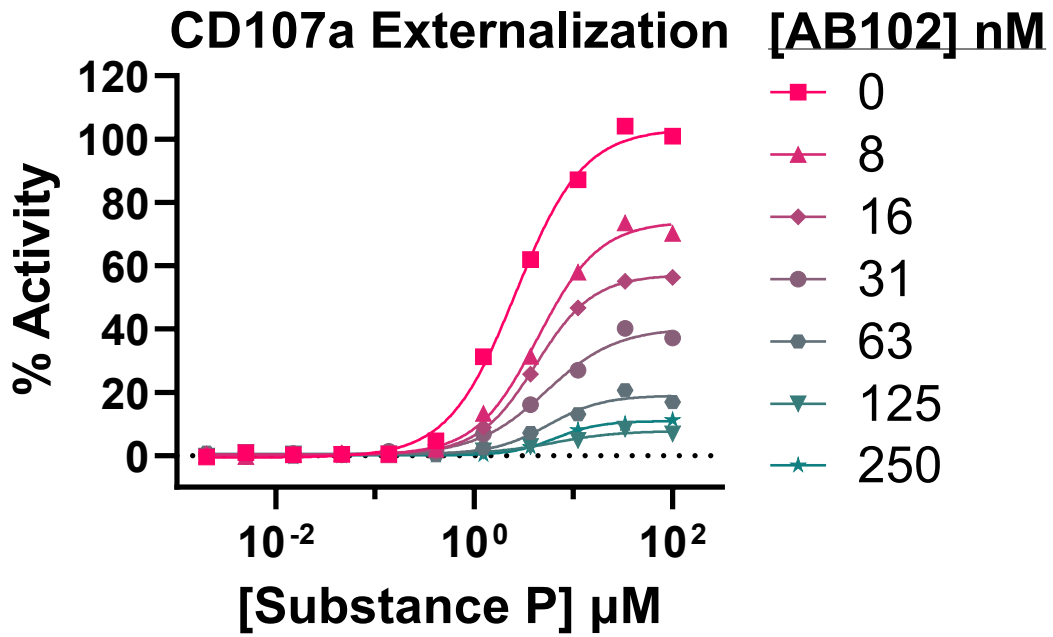
Modeled steady-state human PK

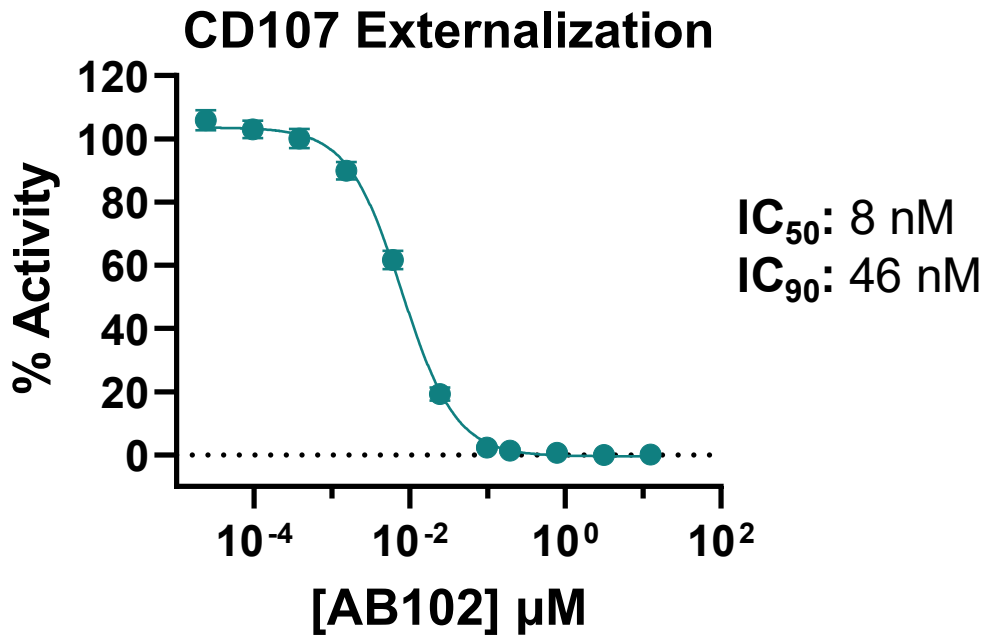


Based on the predicted human PK and potency of our leading molecule, **required clinical exposures could be >90% lower** than those associated with the leading small-molecule competitor in the clinic

References and acronyms on slide 40

AB102 is a Potent and Selective Small Molecule MRGPRX2 Antagonist[14]



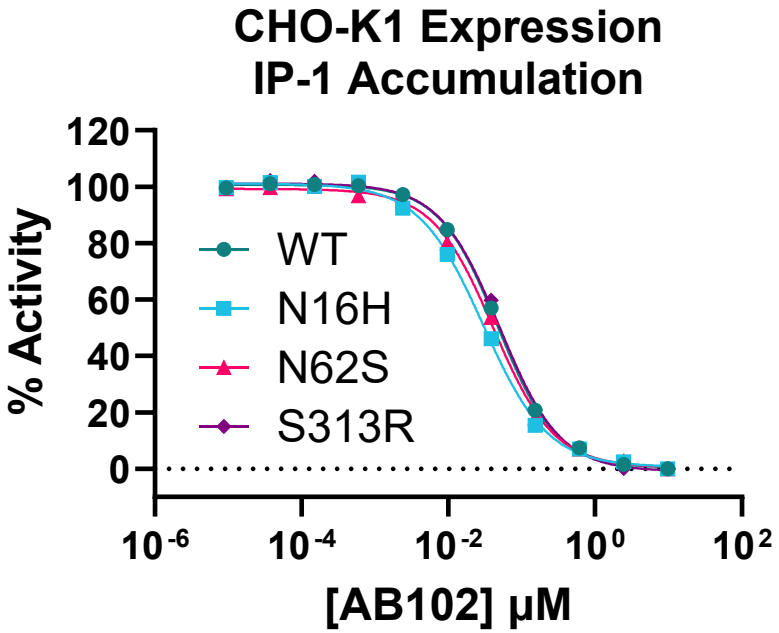


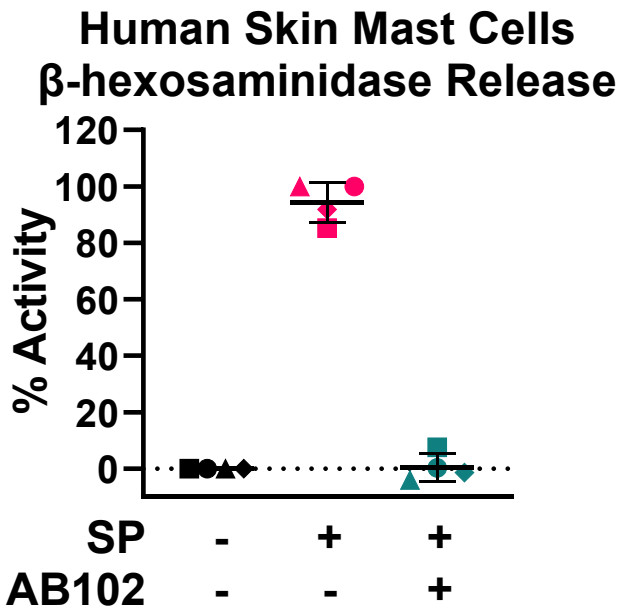
- AB102 binds MRGPRX2 in a reversible manner with an insurmountable inhibitory profile
- AB102 potently inhibits degranulation with an IC_{90} of 46 nM <u>in 100% human serum</u>

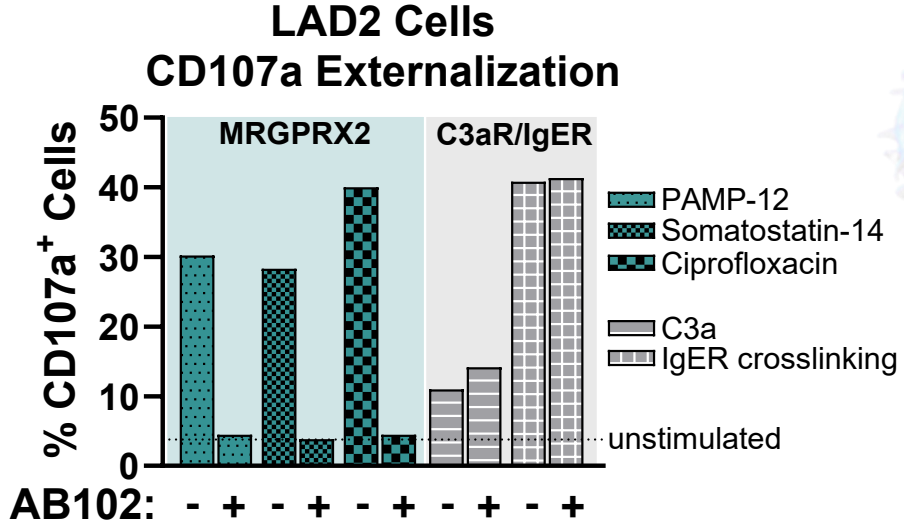
LEFT and RIGHT: LAD2 cells in 100% human serum

References and acronyms on slide 40

AB102 is a Potent and Selective Small Molecule MRGPRX2 Antagonist[14]







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

References and acronyms on slide 40

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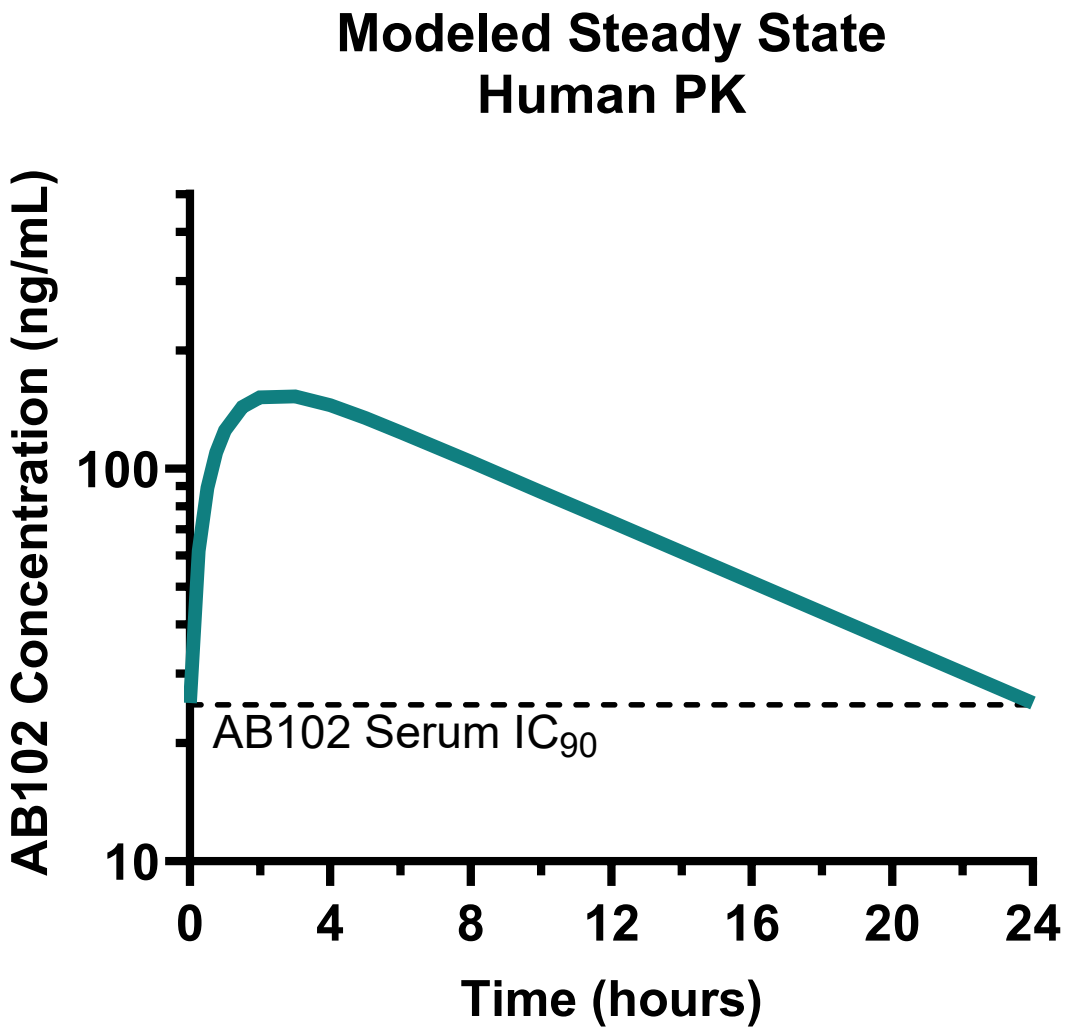
AB102 Predicted Human PK Supports MRGPRX2 Inhibition at Low Systemic Exposures[14]

- ✓AB102 potently inhibits MRGPRX2 activity under physiologically relevant conditions
- ✓Due to this potency, we expect maximal pharmacological activity at relatively low plasma levels of compound
- ✓The totality of preclinical data indicate AB102 is suitable for once-daily oral dosing in chronic mast cell-driven diseases



References and acronyms on slide 40

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 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

References and acronyms on slide 40

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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[17]
- There are currently no orally available options for dealing with the inflammatory effects of IL-17

PROGRAM STATUS:
Expect FIH by mid-2027

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
- Small-molecule CCR6 antagonists may provide **greater 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**

References and acronyms on slide 40

Appendix

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)

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

13. Sanofi earnings releases. Accessed May 3, 2026.

14. Serwas N. et al. 2026 (AB102)

15. 2022 Annual Report. Abbvie. Accessed May 3, 2026.

16. Sagonowsky E. The top 20 drugs by worldwide sales in 2020. FiercePharma. Published May 3 2021. May 4, 2026.

17. Novartis earnings releases. Accessed May 3, 2026.

1H first half

1L first-line

2H second-half

2L second-line

3L third-line

AD atopic dermatitis

AE adverse event

Axi axitinib

B billion

belz belzutifan

BID twice daily

Cabo cabozantinib

Cas casdatifan

ccRCC clear cell renal cell carcinoma

CI confidence interval

cORR confirmed overall response rate

CR complete response

CSU chronic spontaneous urticaria

DCO data cutoff

DCR disease control rate

DOR duration of response

DoT duration of treatment

ECOG Eastern Cooperative Oncology Group

EPO erythropoietin

FIH first-in-human

G/nP gemcitabine/nab-paclitaxel

HR hazard ratio

I&I inflammation & immunology

IBD inflammatory bowel disease

IO immunotherapy

Ipi ipilimumab

K thousand

Lenva lenvatinib

m months

mAb monoclonal antibody

MOA mechanism of action

Mono monotherapy

mOS median overall survival

mPFS median progression-free survival

MRGPRX2 mas-related G protein-coupled receptor member X2

MS multiple sclerosis

Med median

mg milligrams

mos months

OR objective response rate

OS overall survival

PD primary progression

PDAC pancreatic ductal adenocarcinoma

PD-L1 programmed death-ligand 1

PFS progression-free survival

Ph Phase

PK pharmacokinetics

POC proof of concept

PR partial response

Q quemliclustat

Q3 third quarter

Q2/3W every 2/3 weeks

QD once daily

quemli quemliclustat

R randomized

R&D research & development

RA rheumatoid arthritis

RCC renal cell carcinoma

RECIST Response Evaluation Criteria in Solid Tumors

SCA synthetic control arm

sEPO serum erythropoietin

SD stable disease

SLE systemic lupus erythematosus

SM small molecule

SOC standard of care

TKI tyrosine kinase inhibitor

Tivo tivozanib

YE year-end

Z zimberelimab

zim zimberelimab

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