



2Q26 Corporate Presentation

Oncology and Immunology Portfolio Summary

September 8, 2026

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); our expectations for our October 2026 data presentation for casdatifan; 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.

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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

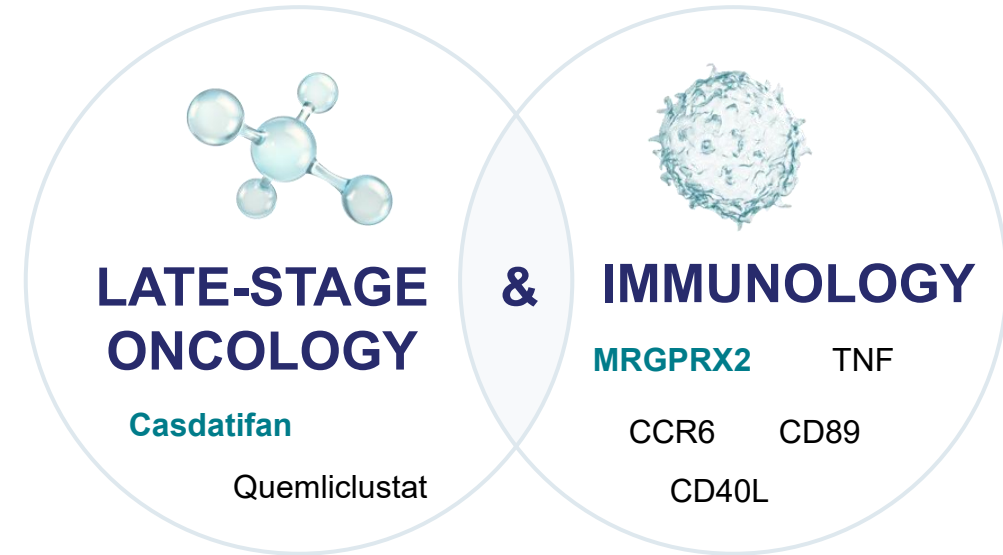
- World class medicinal chemistry
- Goal of 1-2 new molecules advancing to the clinic each year

CAPITAL EFFICIENCY & RISK SHARING
HAVE BEEN GROWTH ENABLING



~\$775M IN CASH*

- Funded until at least 2H:28**



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

References and acronyms on slide 55

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

2 PHASE 3 PROGRAMS IN ONCOLOGY



CASDATIFAN

Wholly-owned* HIF-2 α 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

Interim Analysis
Q4 2026

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

References and acronyms on slide 55

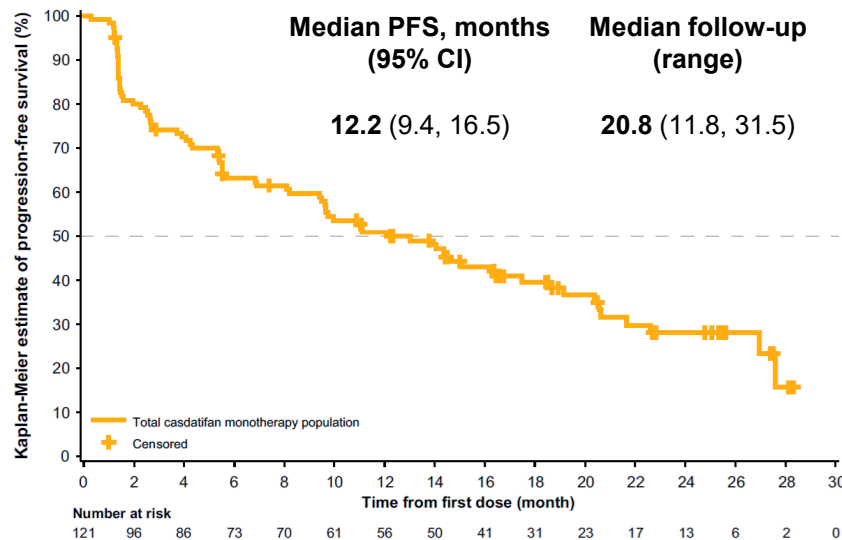
Clinical Data from >120 Patients Support Casdatifan's Potential as the Best-in-Class HIF-2 α Inhibitor

ARC-20

IMPROVED CLINICAL OUTCOMES¹

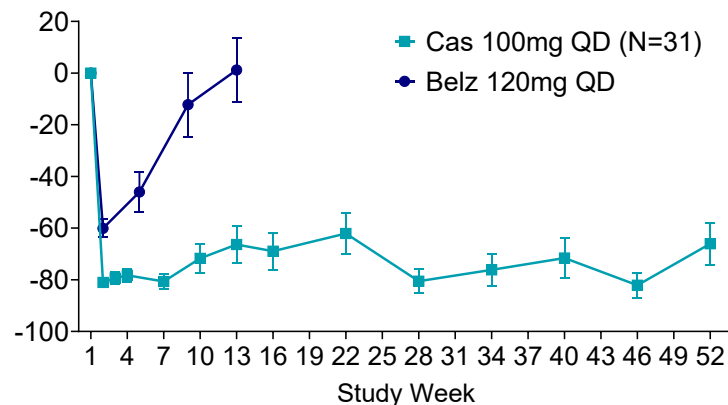
➤ **Longer PFS than other HIF-2 α inhibitors and TKIs in late-line kidney cancer**

12.2 months mPFS compares to 5.6 mos PFS for belzutifan in LITESPARK-005^{2,3}



SUPERIOR PHARMACODYNAMIC 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

1L, 2L & 3L regimens

PEAK-1
Phase 3 Study Enrolling

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.

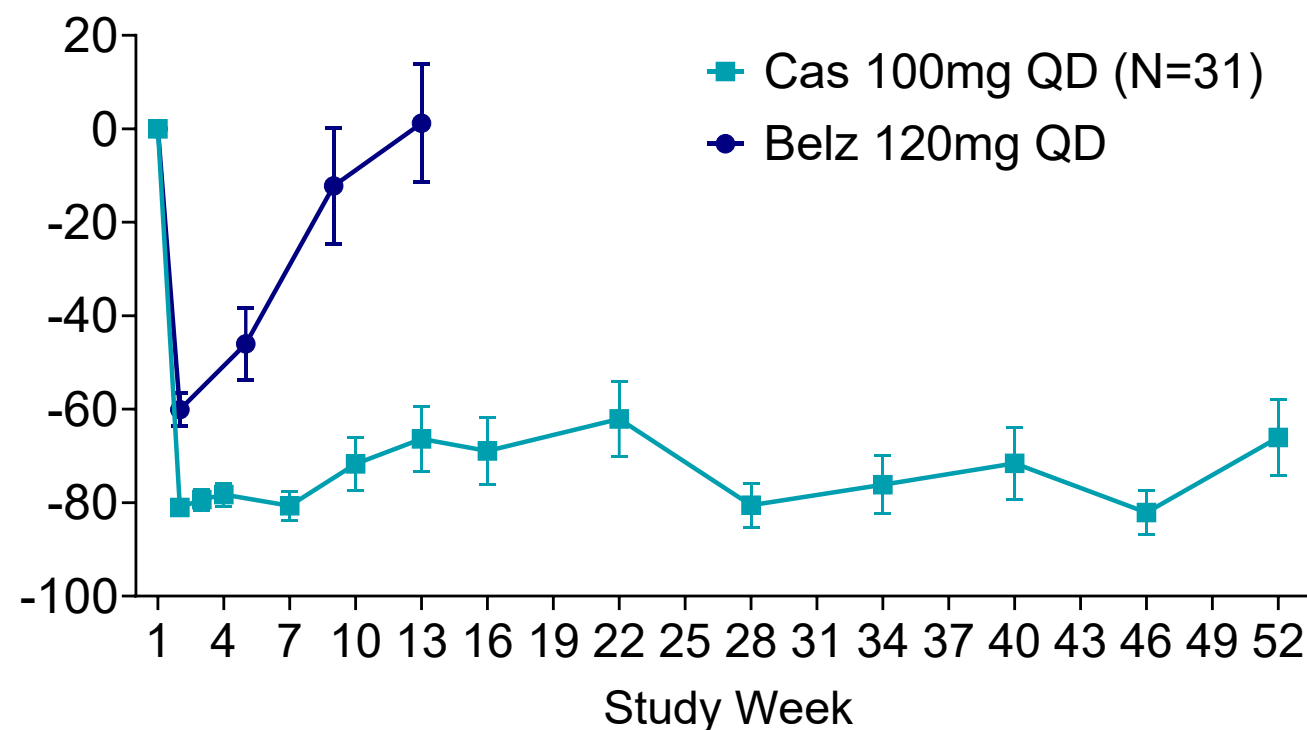
References and acronyms on slide 55

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 Arcus⁴ and Merck⁵



*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 55

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-2 α inhibitor with peripheral biomarker changes and associated tumor biology
 - HIF-2 α 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

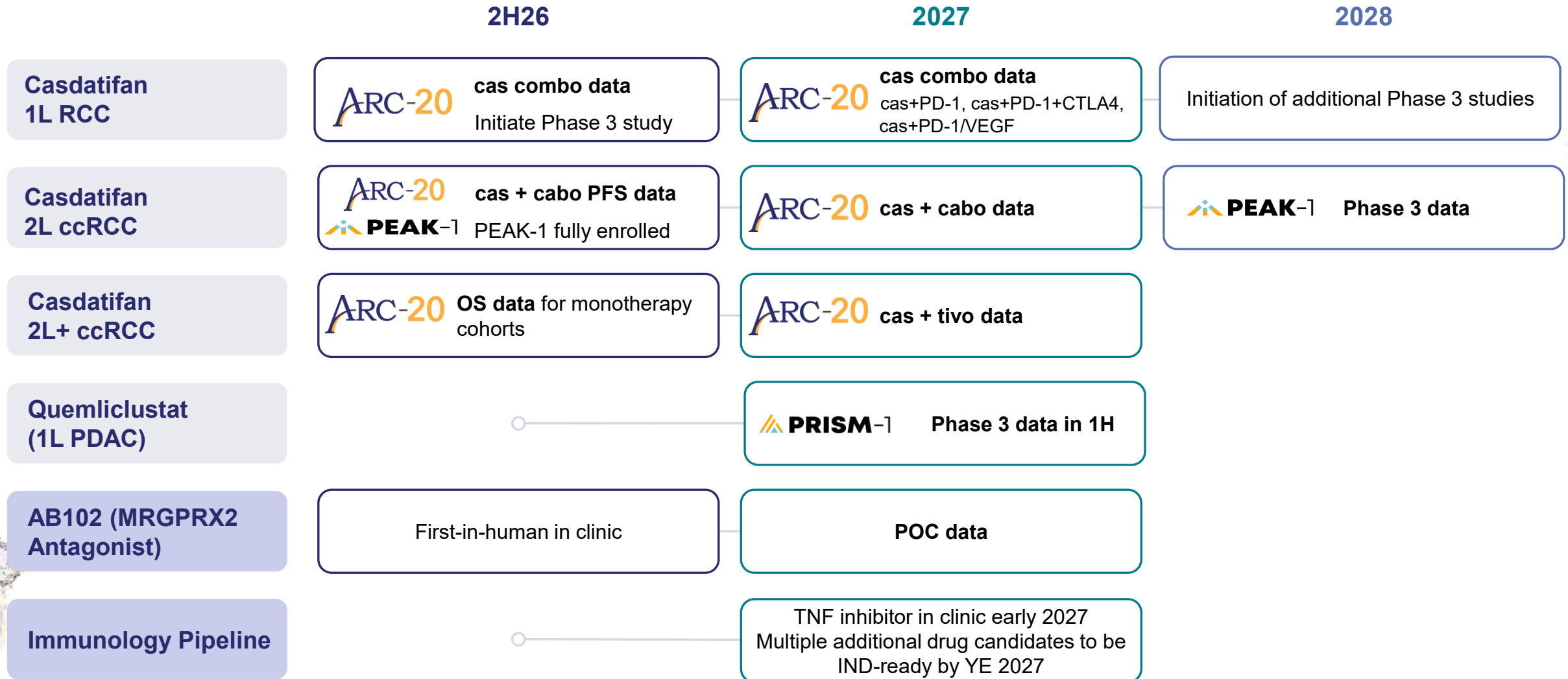
STRATEGIC CASDATIFAN CLINICAL COLLABORATIONS

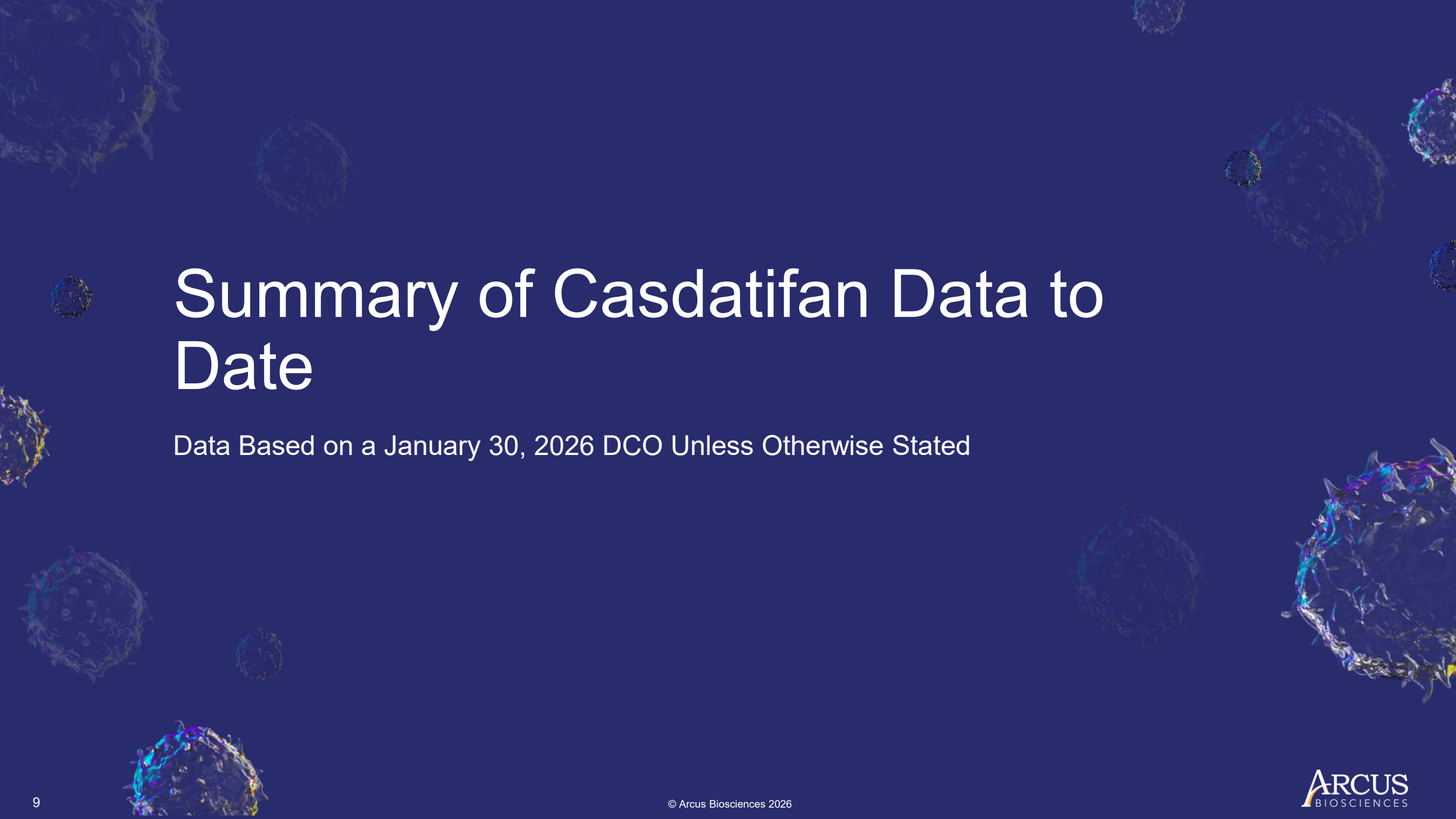
- Development strategy expanded through new clinical collaborations
 - BMS: 1L cas + pumitamig* (PD-L1/VEGF-A bispecific antibody) combinations will be added as two new arms of the BMS Phase 1/2 ROSETTA RCC-208 study
 - Summit: 1L cas + ivonescimab (PD-1/VEGF bispecific antibody), a new cohort in ARC-20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

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





Summary of Casdatifan Data to Date

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

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

References and acronyms on slide 55

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



**Oct.2025
Investor Event**
(Nature manuscript data)



	5 mos med. Follow-up	12 mos med. Follow-up	17.9 mos med. Follow-up
100mg QD (n=32)	cORR: 33% mPFS: Not reached PD: 15%	cORR: 35% mPFS: Not reached PD: 16%**	cORR: 45% mPFS: 15.1mos PD: 16%**
Pooled Analysis (n=121)*	--	cORR: 31% mPFS: 12.2 months PD: 19%**	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.

Article

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

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

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Toni K. Choueiri¹✉, Jamie Merchan², Amita Patnaik³, Alexandra Drakaki⁴, Brian I. Rini⁵, Sun Young Rha⁶, Jae Lyun Lee⁷, Moshe C. Ornstein⁸, Rohit Kumar⁹, Clara Hwang¹⁰, Yusra Shao¹¹, Se Hoon Park¹², Pedro C. Barata¹³, Bradley A. McGregor¹, Paul Foster¹⁴, Jianfen Chen¹⁴, Melissa Eisen¹⁴, Hunter Cole¹⁴, Ben Weeder¹⁴, Yinghui Guan¹⁴, Jaskirat S. Angelo Kaplan¹⁴, Soonweng Cho¹⁴, Richard Markus¹⁴, Omar Kabbarah¹⁴ & Rana R. McKee

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

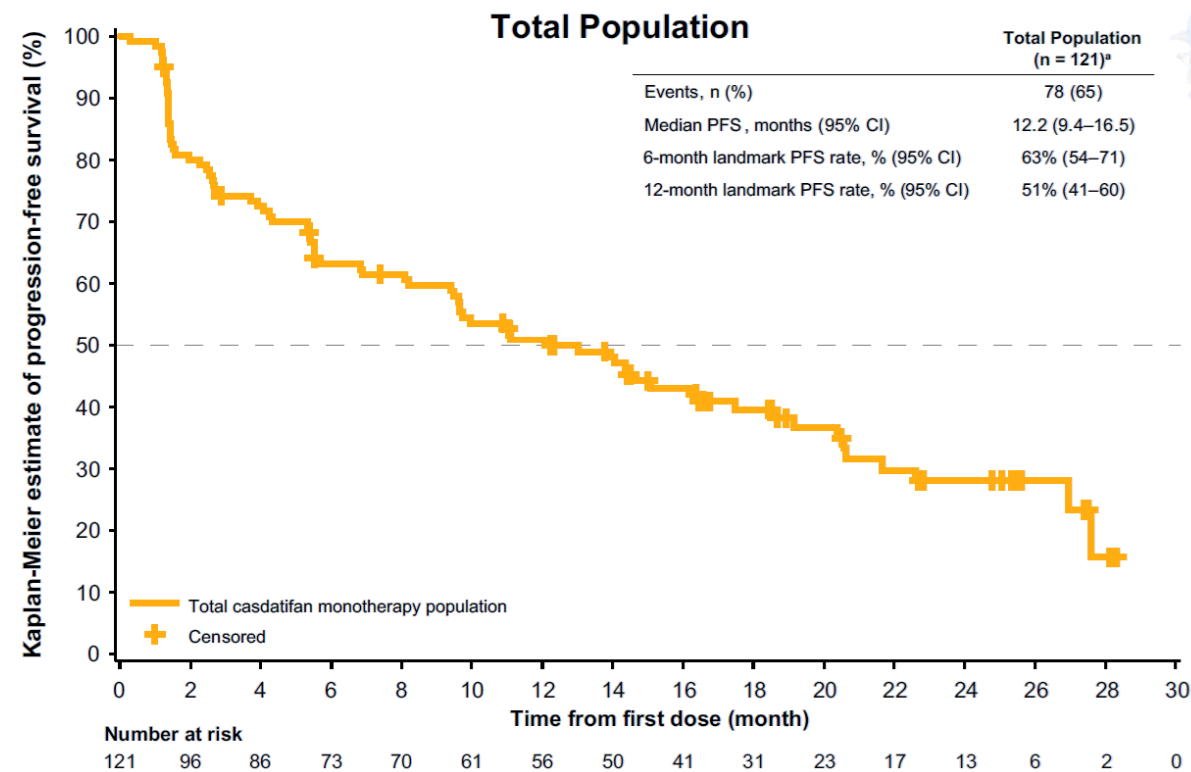
HIF-2 α inhibition with casdatifan resulted in deep and sustained suppression of the hormone erythropoietin in blood (serum EPO), which correlated with higher response rates and longer progression-free survival (PFS)

Data from the “Pooled” Casdatifan Cohort (n=121) Exceed All Key Benchmarks for Belzutifan Monotherapy

Casdatifan has a substantially lower rate of PD and higher ORR than that of belzutifan

12.2 months mPFS for casdatifan compares to 5.6 months for belzutifan in LS-005²

Efficacy-Evaluable Population ^a	Casdatifan	Belzutifan ²
	All Pooled (n = 121)	120mg QD (n = 374)
Median Follow-Up, mos (range)	20.8 (11.8, 31.5)	18.4 (9.4–31.7)
Median Time to Response, mos	2.8	3.8
Confirmed ORR (95% CI)	35% (26, 44)	22% (18, 27)
Complete Response, % (n)	1% (1)	3% (10)
Partial Response, % (n)	34% (41)	19% (72)
Stable Disease, % (n)	46% (56)	39% (147)
Progressive Disease, % (n)	19% (23)*	34% (126)



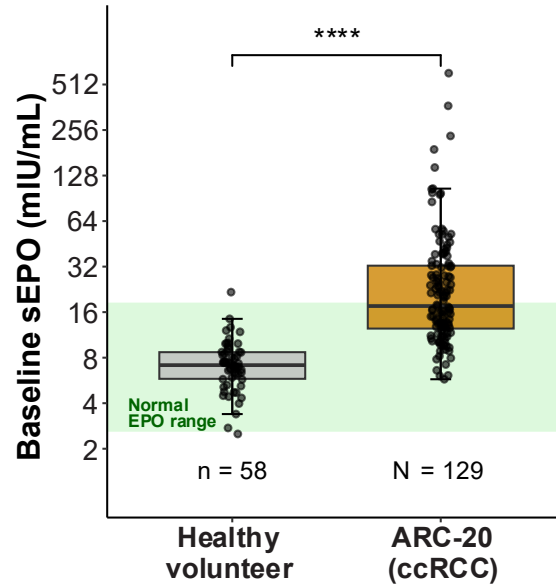
DCO date: Jan. 30, 2026

*Includes two patients in the pooled analysis who had clinical progression before the first scan and therefore did not meet criteria for progressive disease per RECIST.

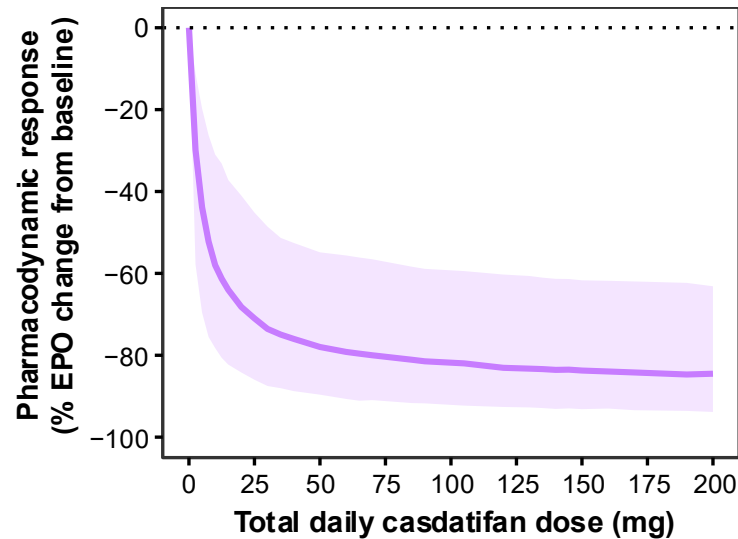
a. Efficacy-evaluable population for this expansion cohort is defined as all eligible participants who received any study treatment and have at least one post-baseline efficacy assessment, or who discontinued study treatment due to progressive disease or death, regardless of whether they had a scan.

References and acronyms on slide 55

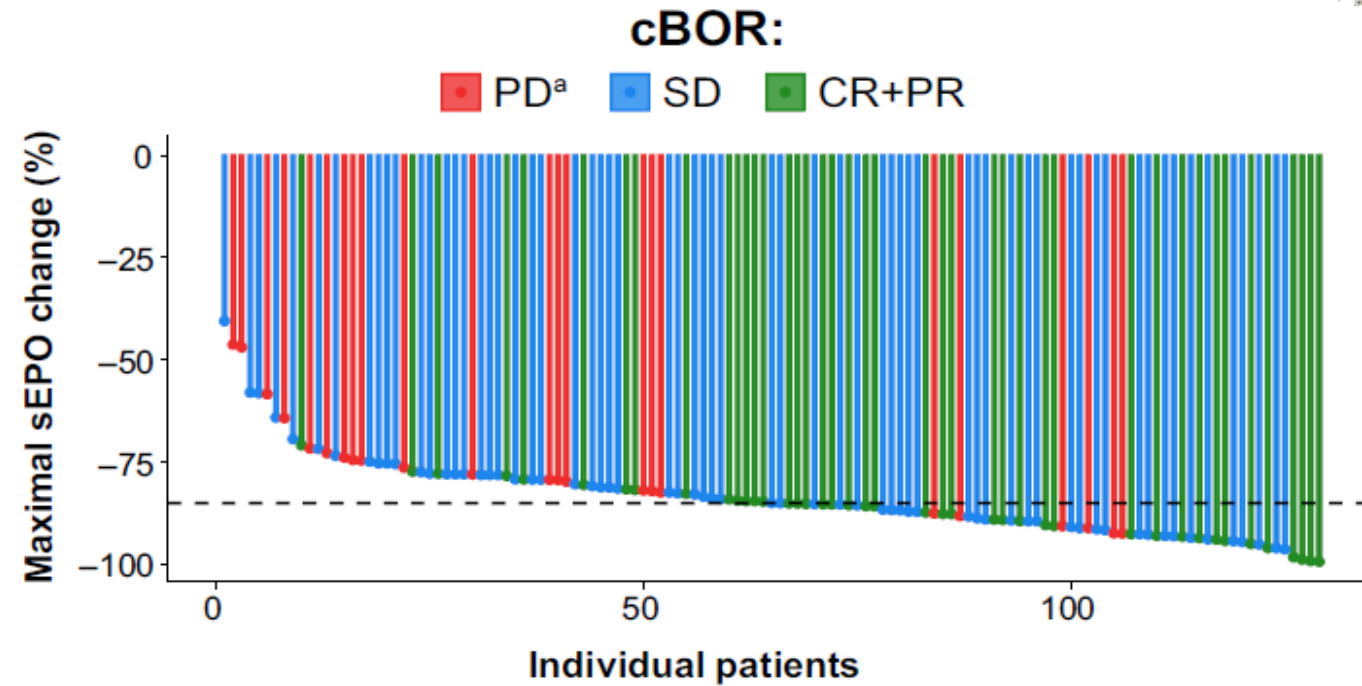
Systemic Suppression of HIF-2 α -Regulated sEPO Is Highly Correlated with Clinical Benefit from Casdatifan (ORR)



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



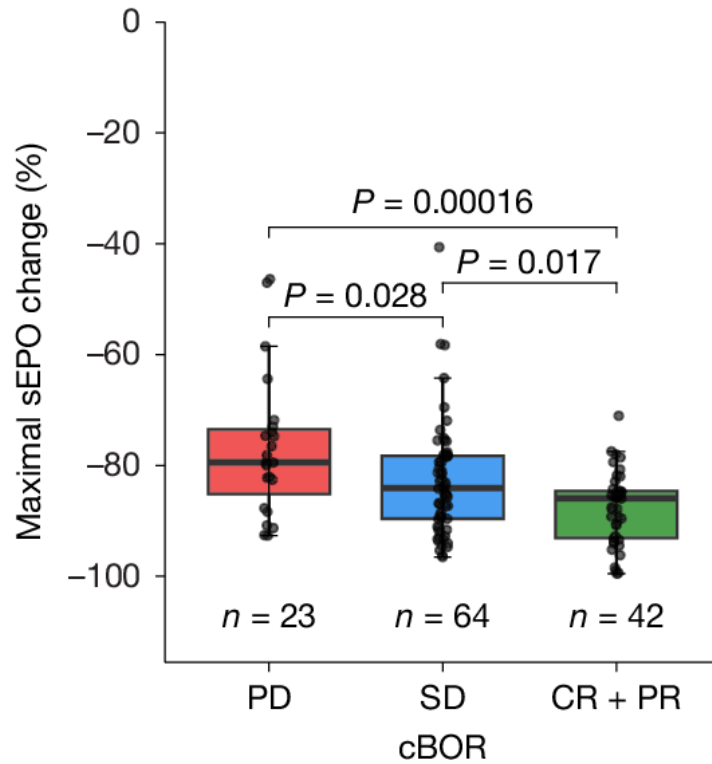
71% (92/129) of patients reached maximal sEPO reduction during the first cycle of treatment with casdatifan¹



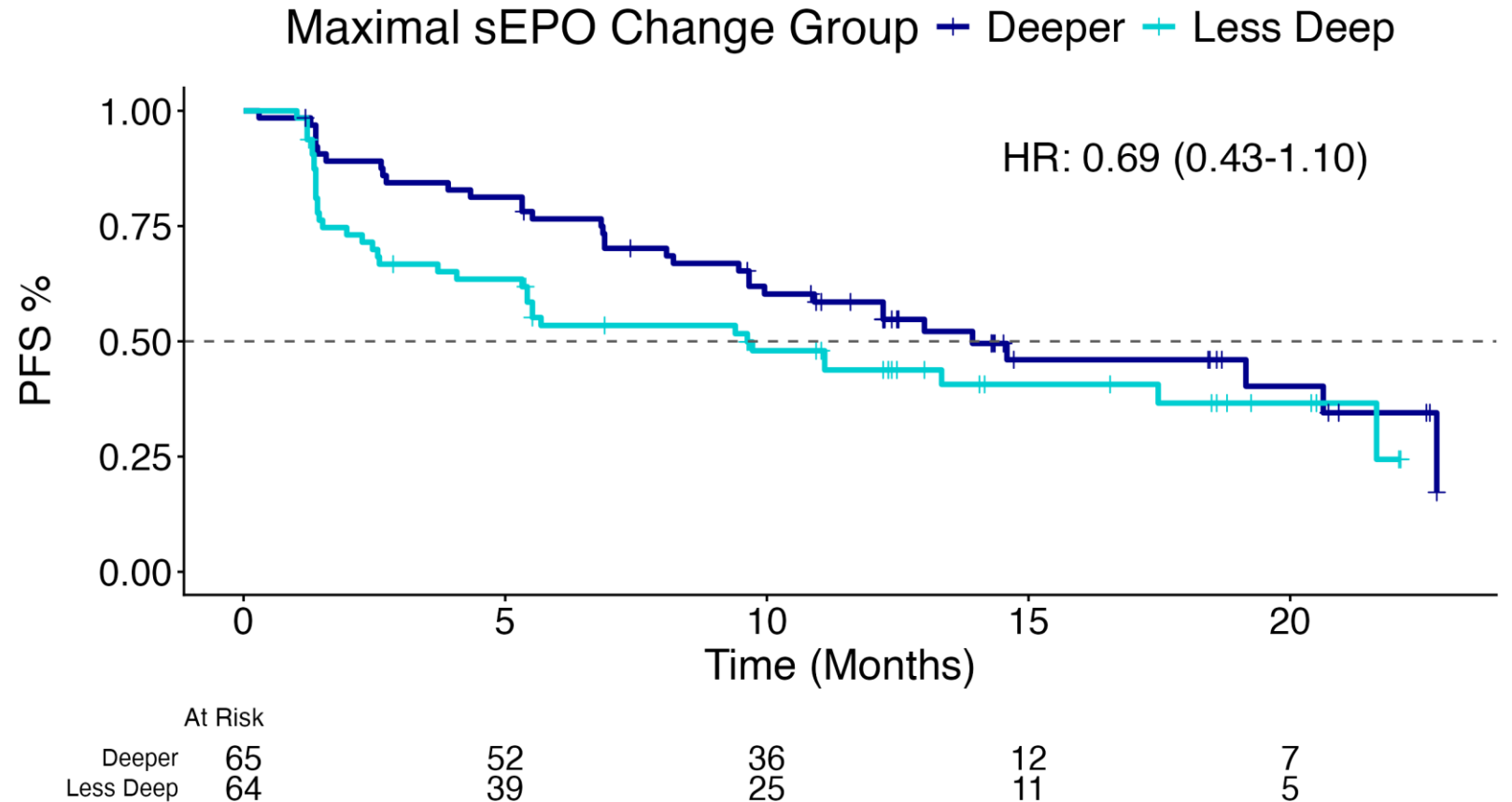
Across all doses, most patients (88/129 [68%]) experienced > 80% maximal sEPO reduction; **Deeper reductions in sEPO were highly correlated with clinical responses**¹

a. PD was defined according to RECIST v1.1 as a $\geq 20\%$ 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.

Systemic Suppression of HIF-2 α -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 PFS⁶

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.

References and acronyms on slide 55

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)	

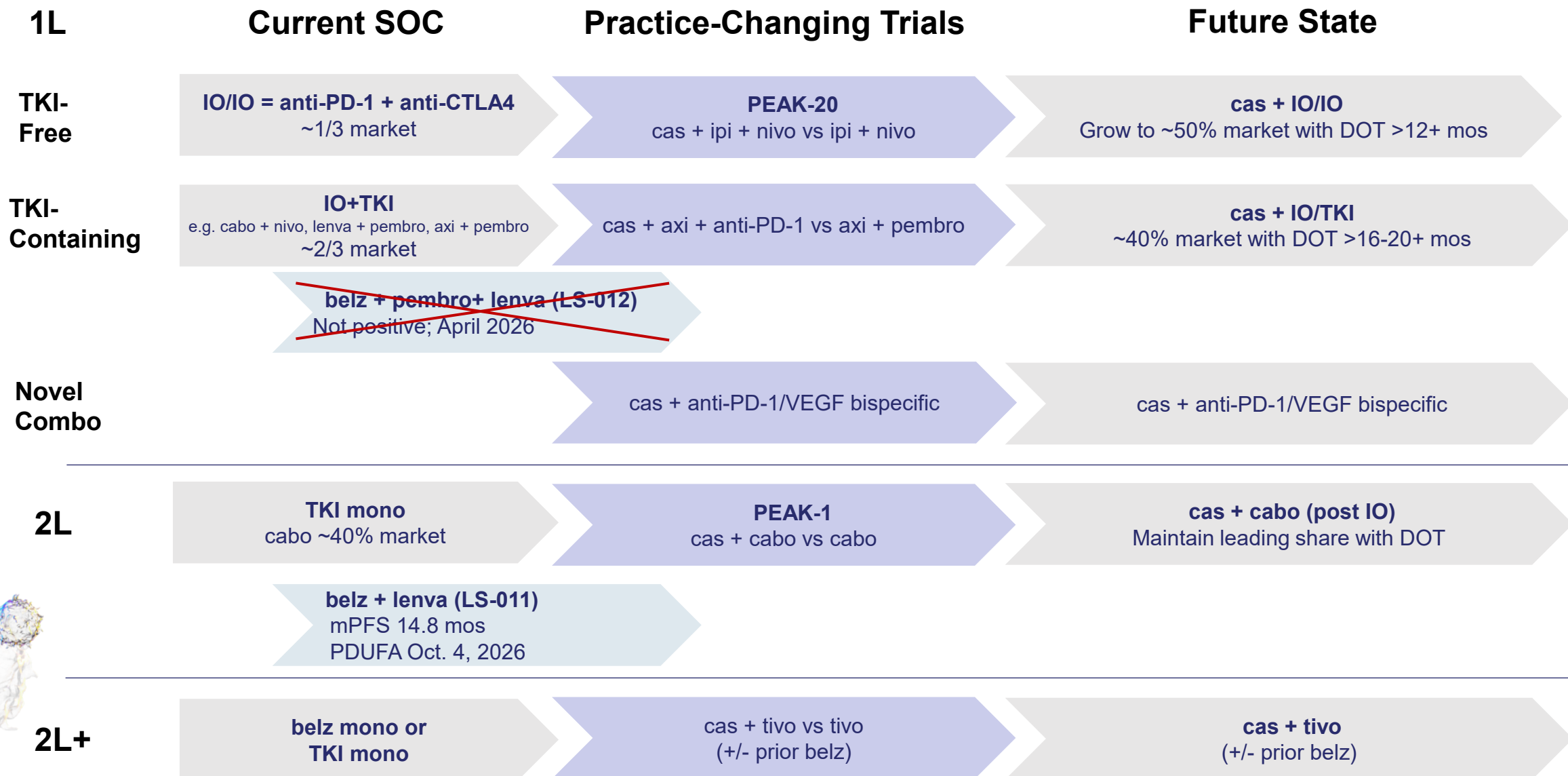
DCO date for casdatifan: Aug. 15, 2025; safety profile remained consistent at the Jan. 30, 2026 DCO
 Data are not from head-to-head studies. Cross-trial data interpretation should be considered with caution as it is limited by differences in study population, sample size, inclusion and exclusion criteria and many other factors.

References and acronyms on slide 55



Casdatifan Development Strategy

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



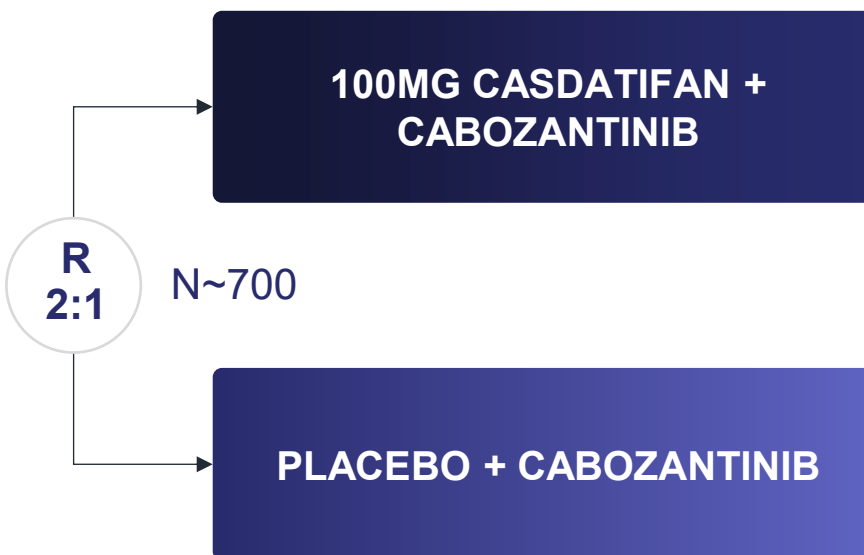
References and acronyms on slide 55

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

Only Phase 3 study evaluating a HIF-2 α 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

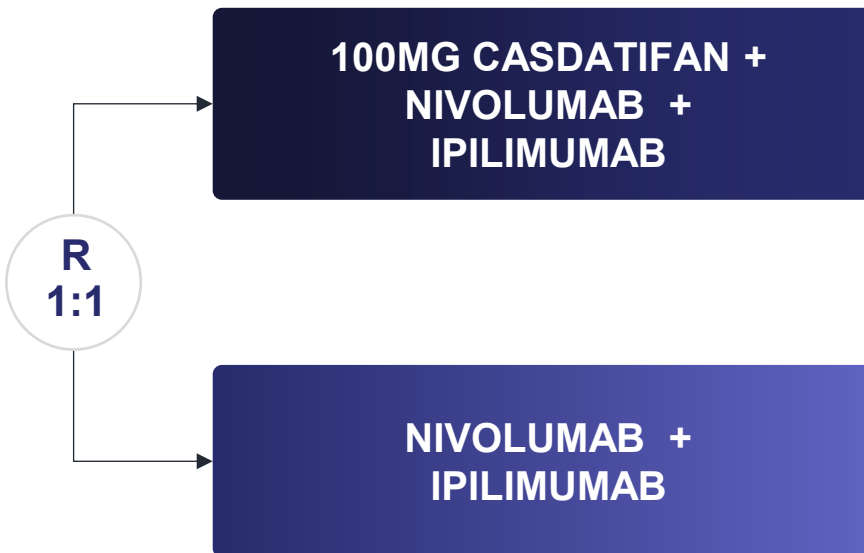
Goal Is to Fully Enroll by Year-End

1L Phase 3 Study to Evaluate Cas with TKI-Free SOC

Potential for novel treatment to combine low PD rates with survival benefit

PATIENT POPULATION:

- 1L advanced or metastatic ccRCC
- No prior systemic therapy in the metastatic setting
- All IDMC risk groups



PRIMARY ENDPOINT

- PFS

KEY SECONDARY ENDPOINTS

- OS
- ORR, DOR, DCR
- Safety

Goal Is to Initiate by Year-End

TREATMENT CYCLES:



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)

ARC-20

 Bristol Myers Squibb™

TKI-Free Cohorts Will Inform 1L Phase 3 Studies

1L ccRCC cas + zim (anti-PD-1)	<i>Enrollment completed</i>
1L ccRCC cas + anti-PD-1 + ipi	<i>Enrolling</i>
1L ccRCC cas + ivo	<i>In Planning</i>
1L ccRCC cas + pumita	<i>In Planning</i>

 *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

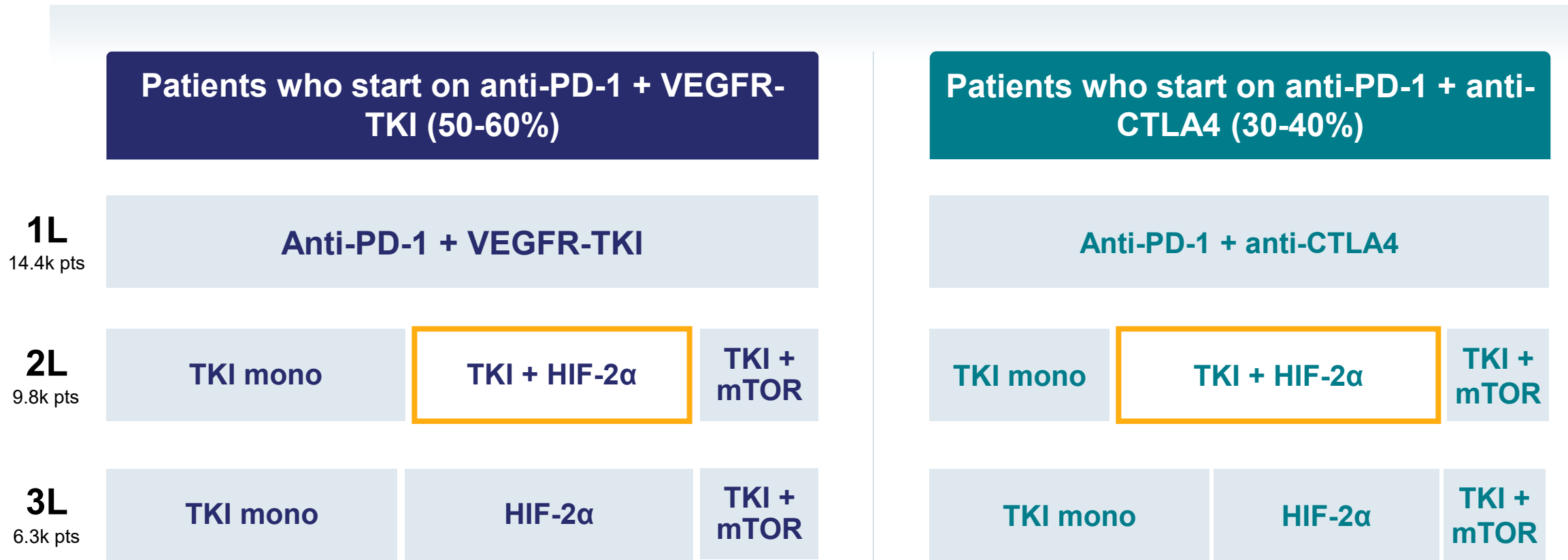
References and acronyms on slide 55

The background of the slide features several stylized, glowing blue and purple cellular or molecular structures. These structures are spherical with intricate, filamentous internal patterns, resembling complex biological or chemical models. They are scattered across the dark blue background, with some appearing larger and more detailed than others.

Casdatifan Market Opportunity

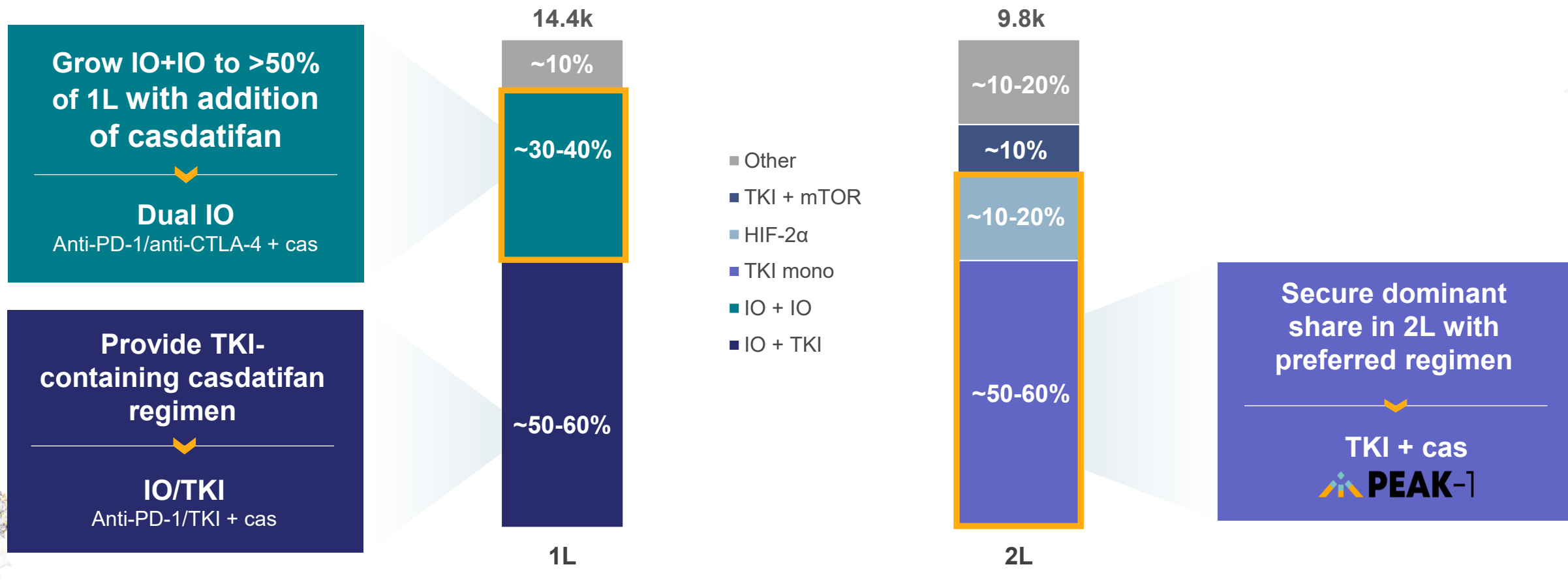
Metastatic ccRCC Treatment Algorithm (assumes LS-011 approval)

~20% of 1L patients have received adjuvant treatment



Substantial Opportunity for Casdatifan in 1L & 2L ccRCC

2026 US ccRCC Drug Treatable Incidence and Market Share

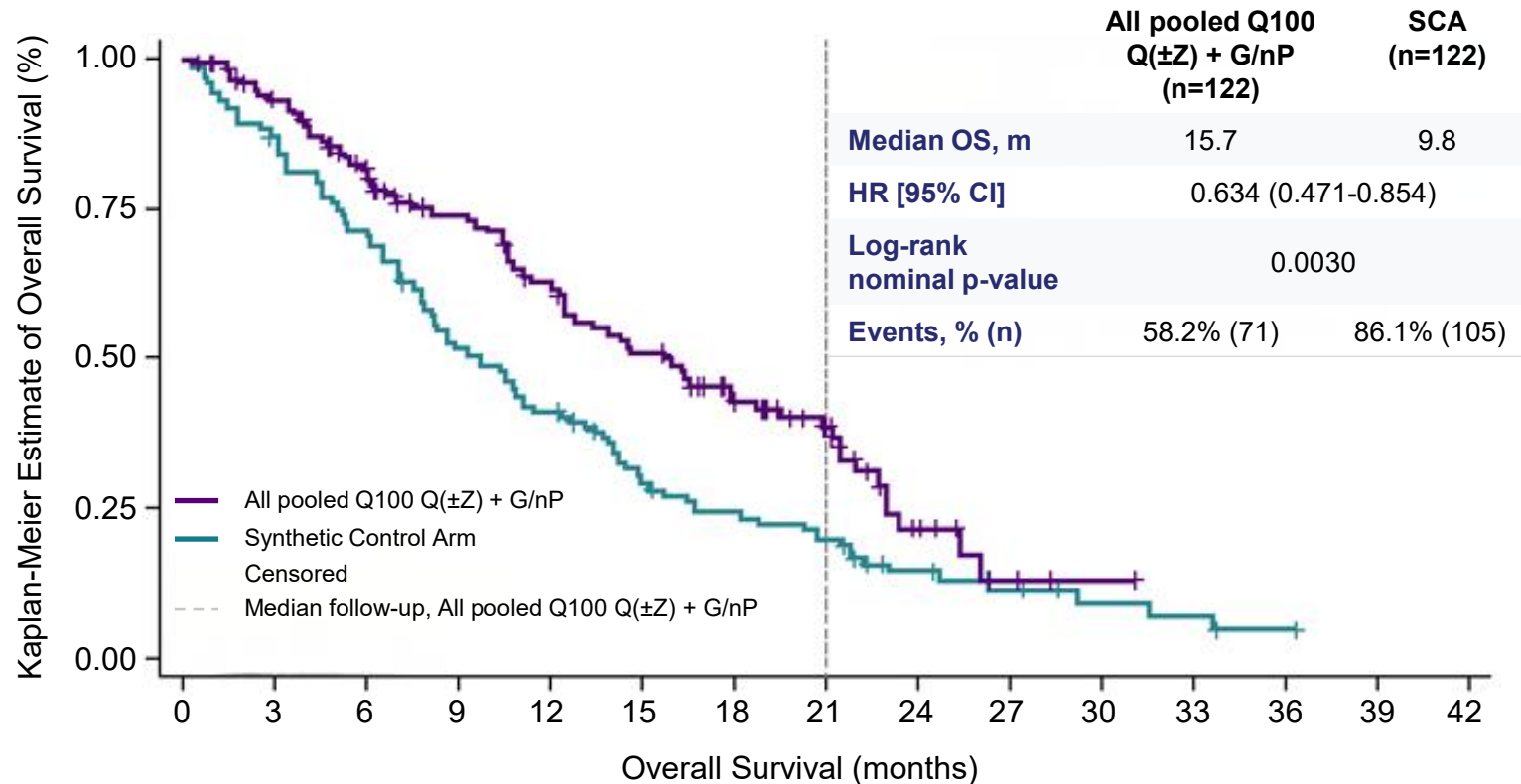




Quemliclustat in Pancreatic Cancer

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/nP¹³



NUMBER OF PATIENTS AT RISK		122	108	89	72	59	47	34	23	8	3	1	0	
		122	104	85	61	49	32	26	21	12	7	4	3	1

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 55

PRISM-1

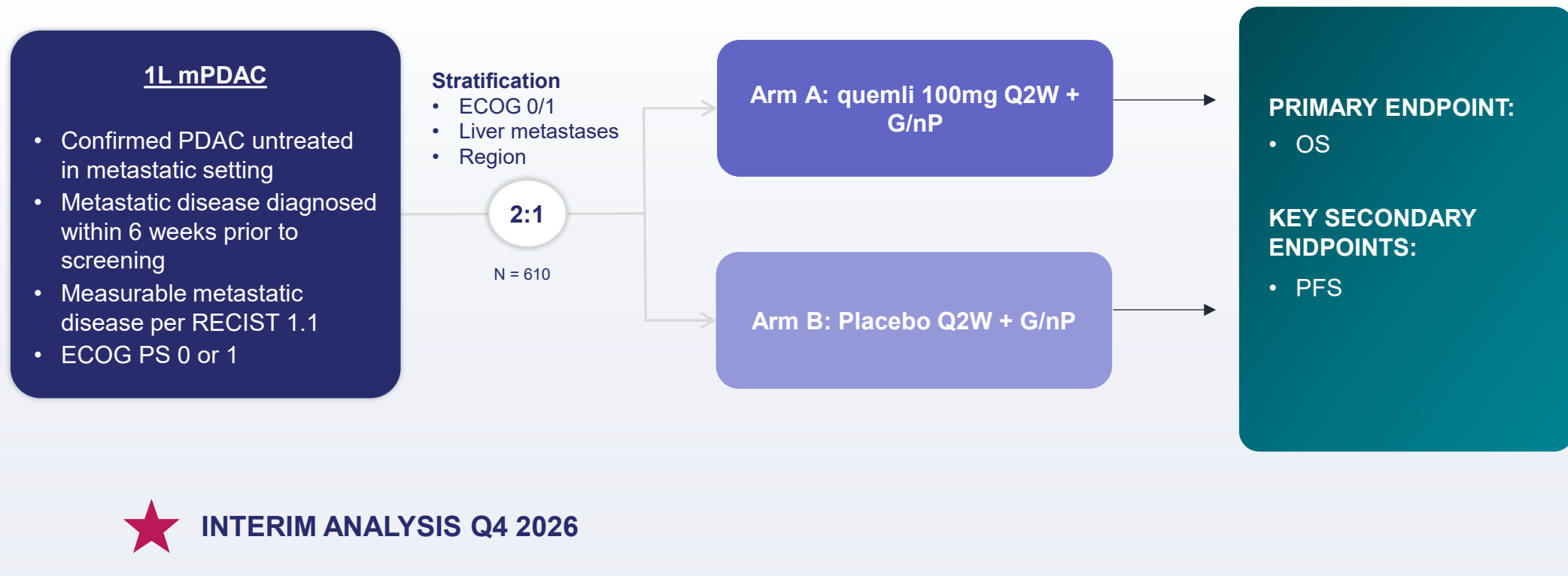
Phase 3 trial in 1L PDAC
Enrollment completed

~\$4B

Market Potential

Readout
1H27

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



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

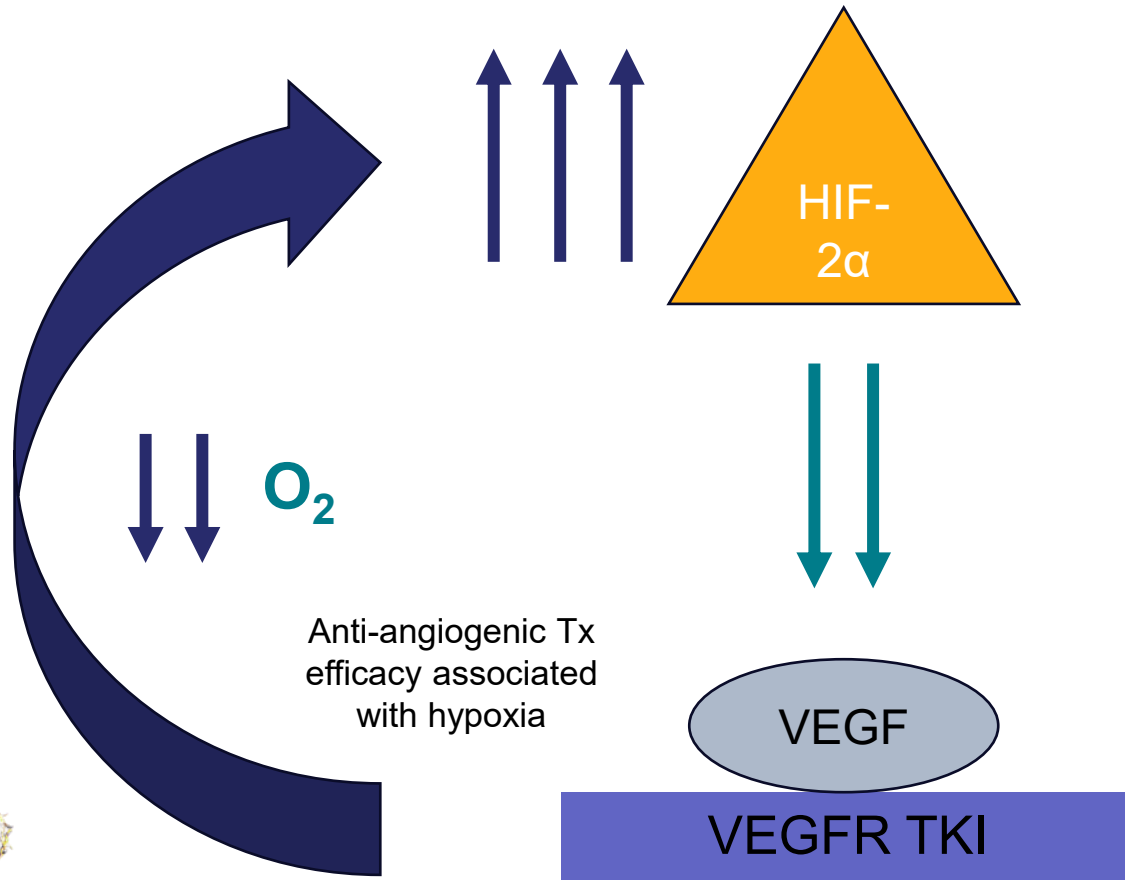


Research Updates

HIF-2 α Pathway and Emerging Immunology Portfolio

Role of HIF-2 α VEGF Axis in RCC

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



1

Innate HIF-2 α

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

2

Adaptive HIF-2 α

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

3

Resulting Sensitivity

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

Immunology Program

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
References and acronyms on slide 55

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

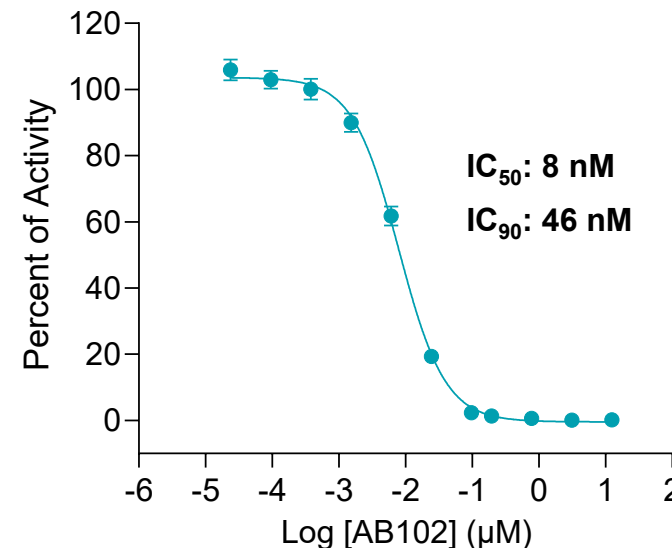
Validated biology with multi-billion dollar potential

- **Approved biologics** are **highly successful and effective** in treating AD and CSU, etc. and generate >\$15B in LTM sales¹⁴
- 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

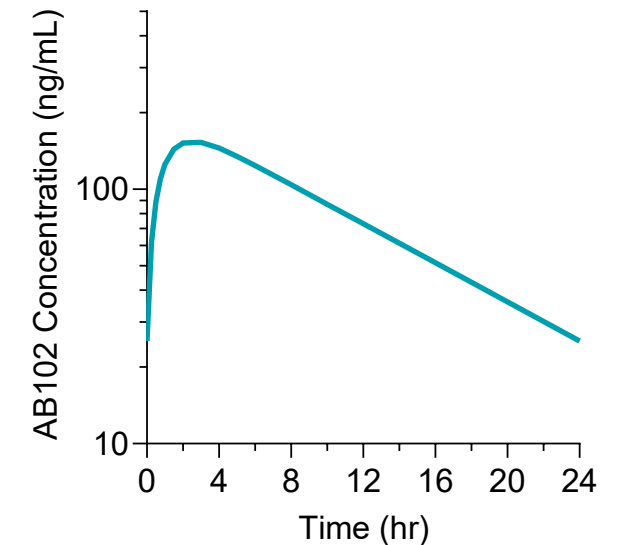
OPPORTUNITY FOR IMPROVEMENT

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



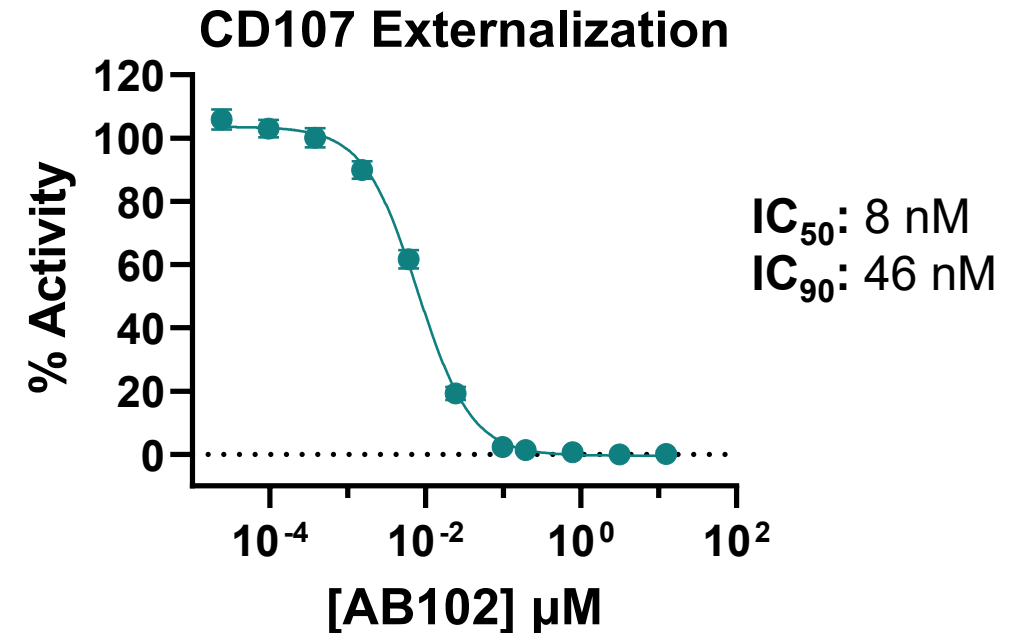
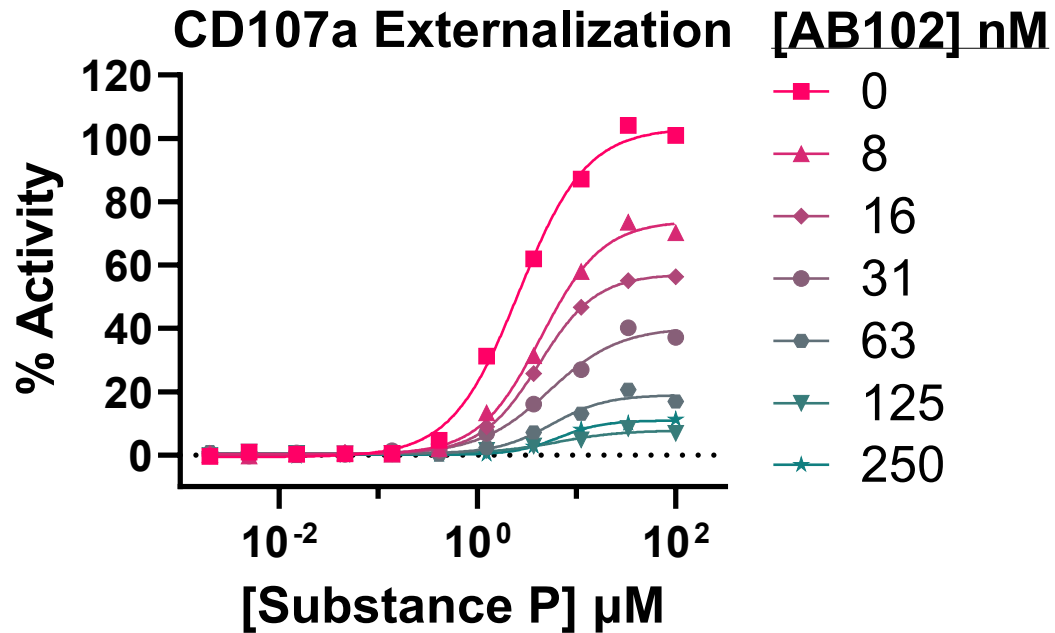
Improved potency/PK relative to early small-molecule entrants into the clinic

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

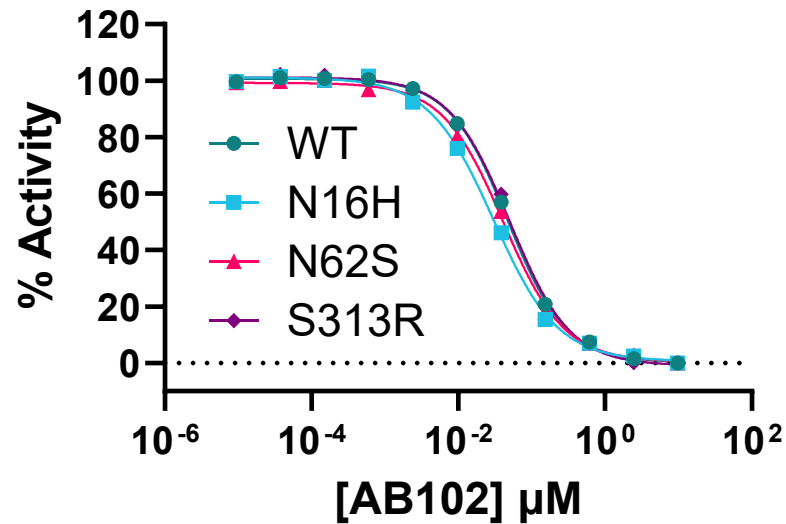
AB102 is a Potent and Selective Small Molecule MRGPRX2 Antagonist



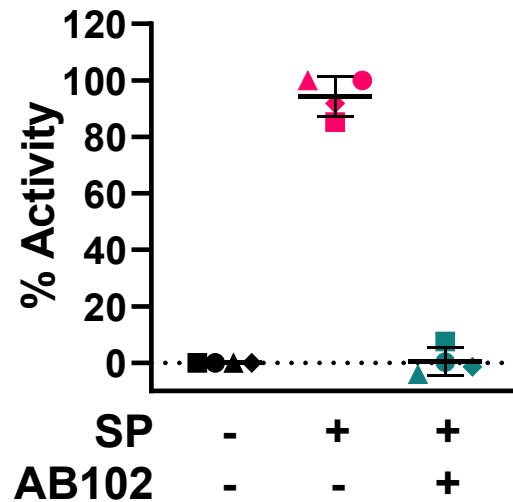
- AB102 binds MRGPRX2 in a reversible manner with an insurmountable inhibitory profile¹⁵
- AB102 potently inhibits degranulation with an IC_{90} of 46 nM in 100% human serum¹⁵

AB102 is a Potent and Selective Small Molecule MRGPRX2 Antagonist

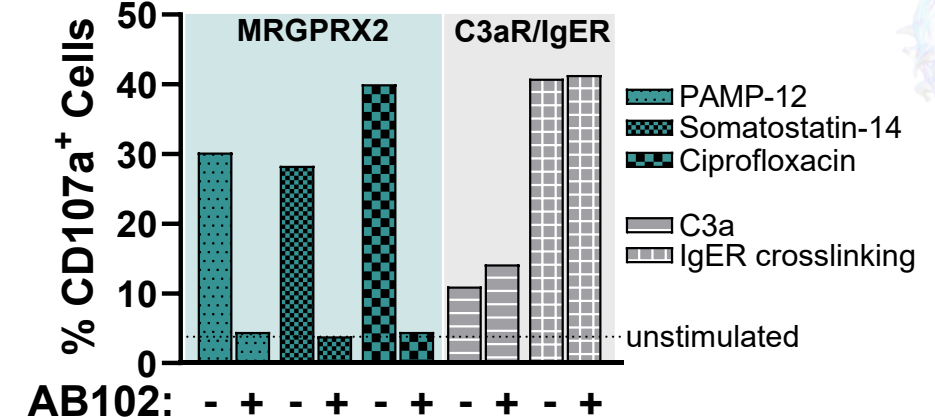
CHO-K1 Expression
IP-1 Accumulation



Human Skin Mast Cells
 β -hexosaminidase Release



LAD2 Cells
CD107a Externalization



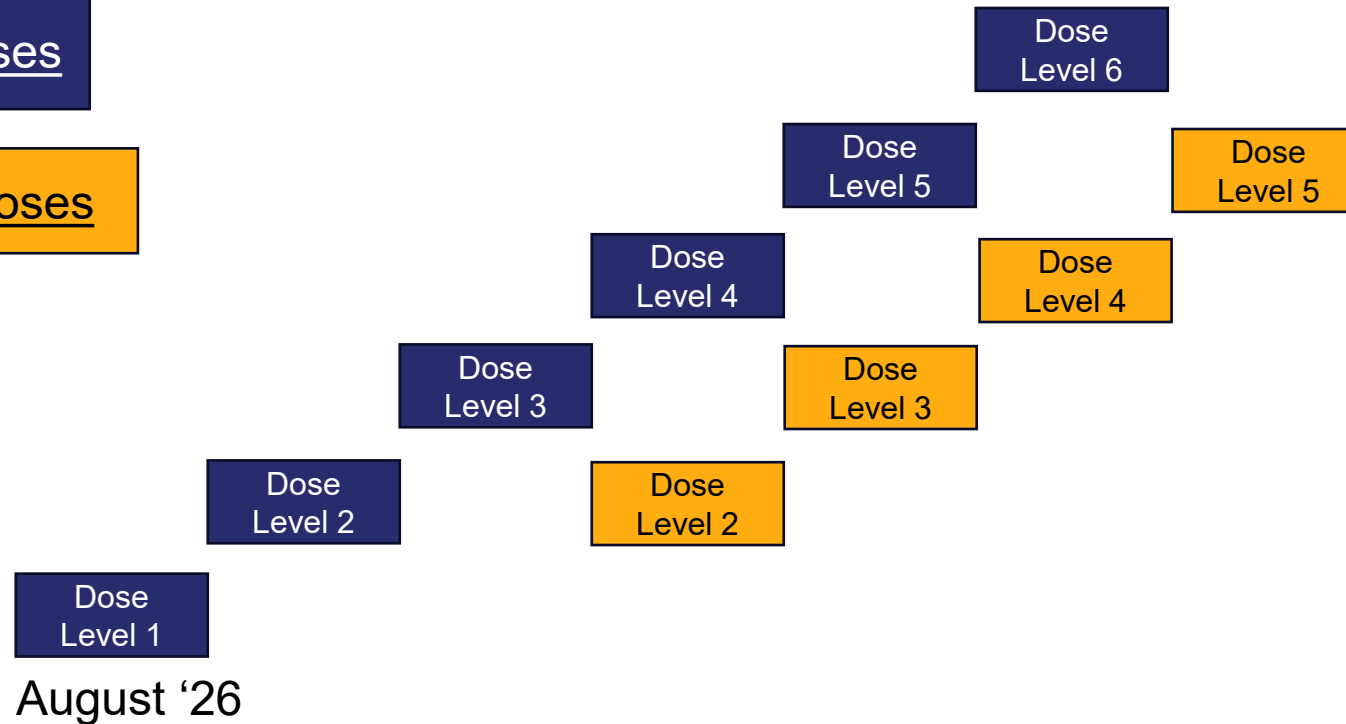
- AB102 maintains full activity against common MRGPRX2 variants¹⁵
- AB102 inhibits MRGPRX2 activity in primary skin mast cells¹⁵
- AB102 is active against MRGPRX2 when activated by a variety of agonists¹⁵

AB102 Healthy Volunteer Study

Double-Blind, Randomized, Placebo-Controlled SAD and MAD

Single Ascending Doses

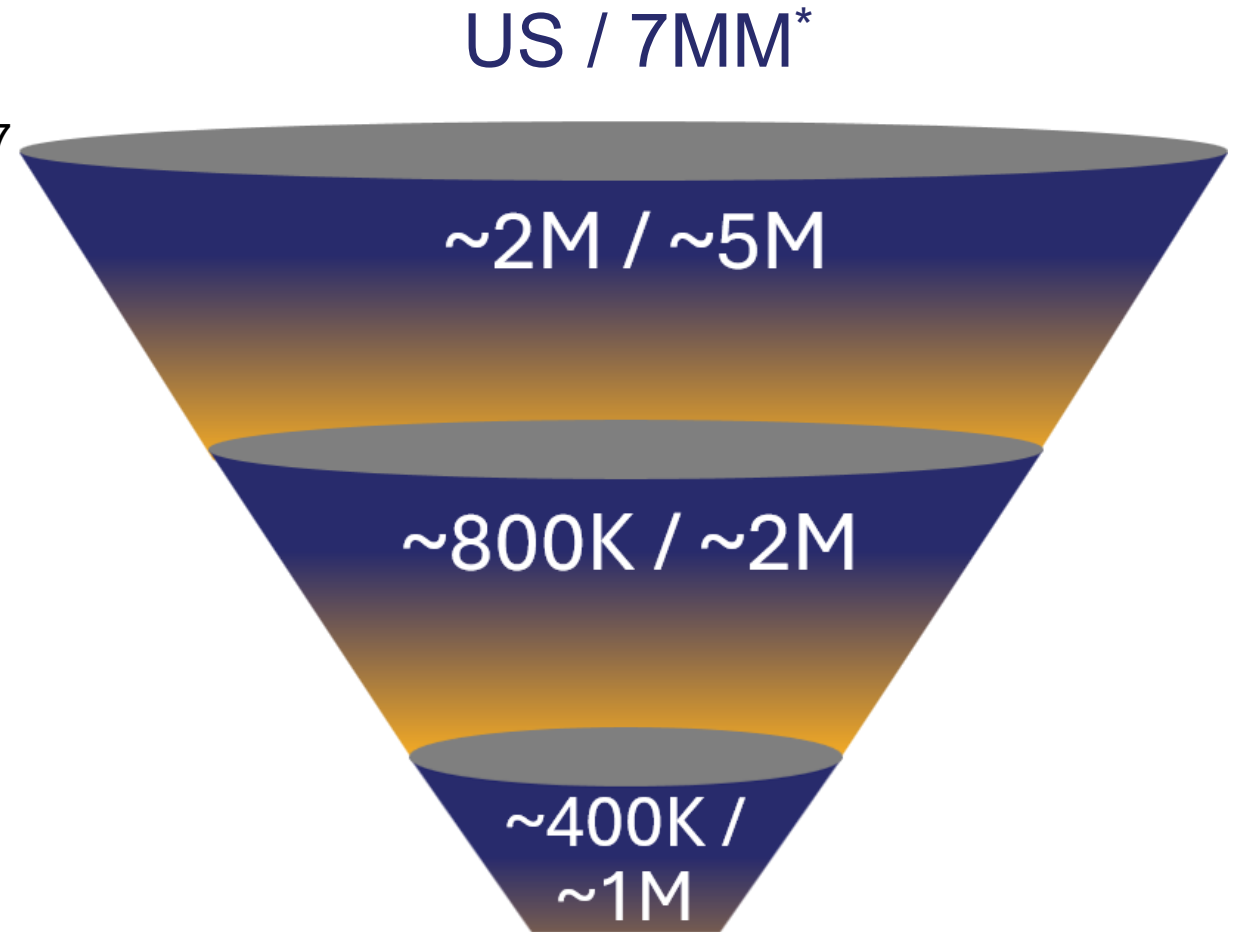
Multiple Ascending Doses



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

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)



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

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 sales²⁰
- 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

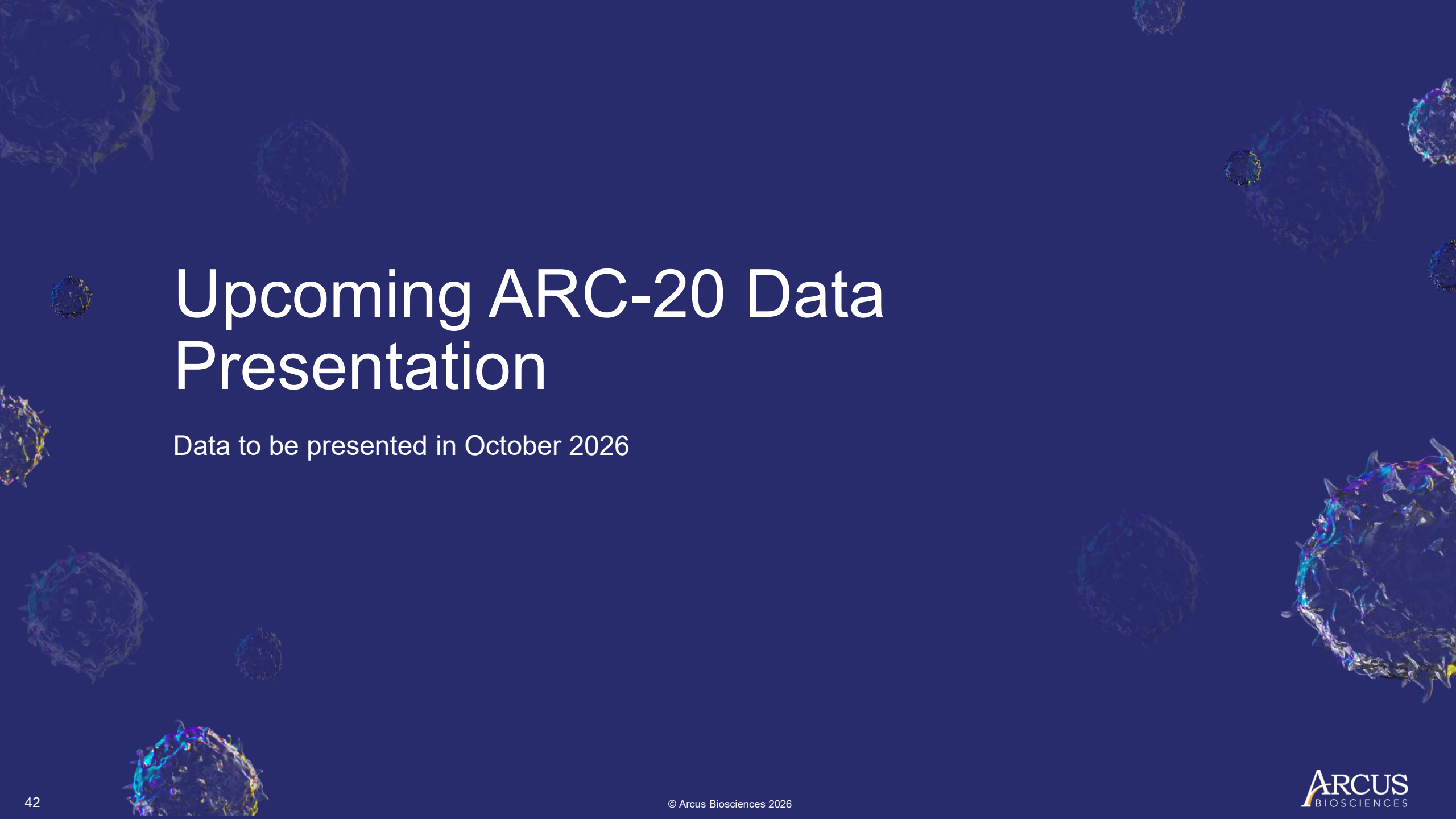
OPPORTUNITY FOR IMPROVEMENT

- CCR6 inhibition creates opportunity to **interfere with a group of cytokines** (beyond IL-17) produced by key inflammatory cells (e.g., $\gamma\delta$ 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**

Appendix



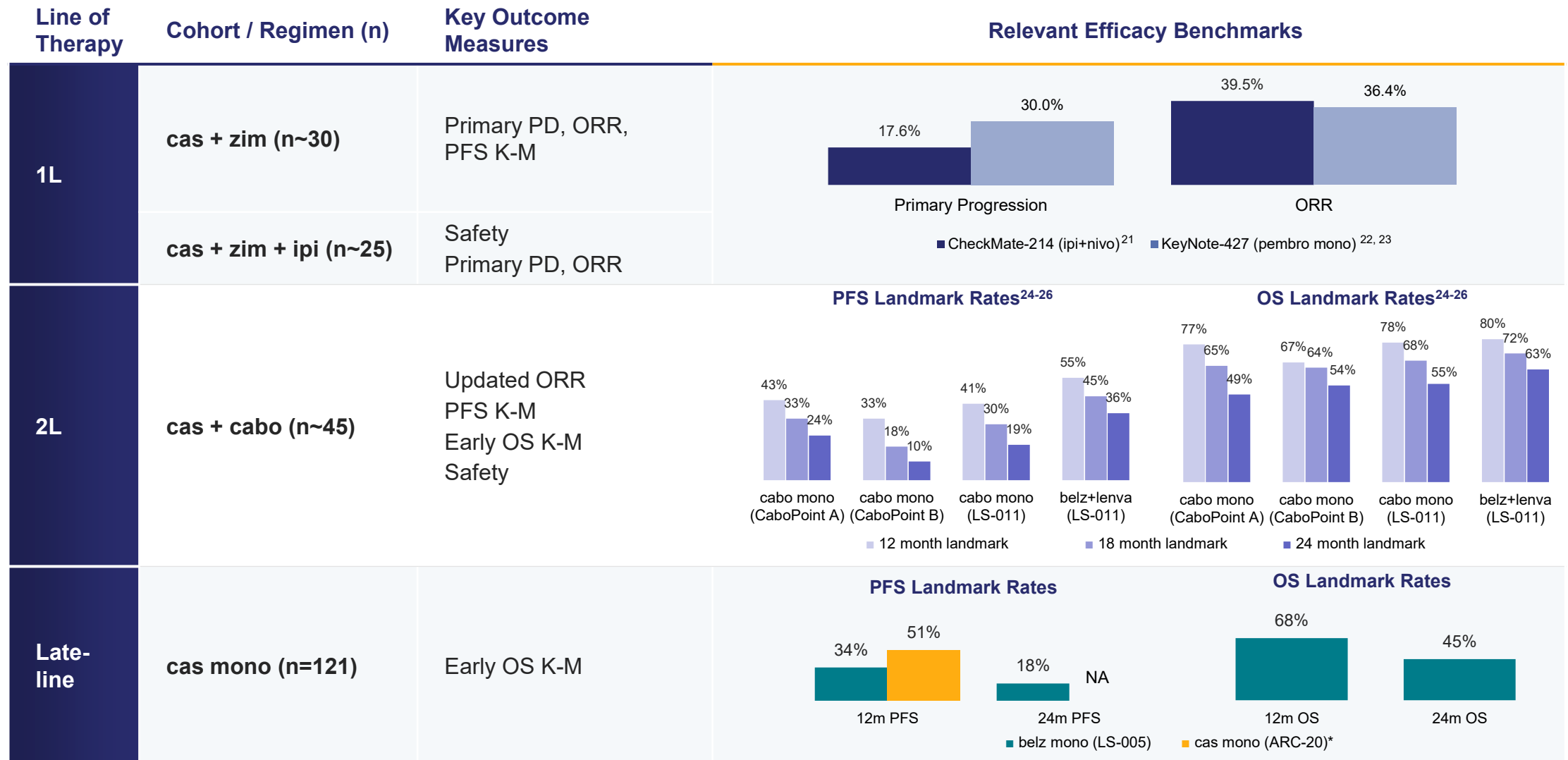
Upcoming ARC-20 Data Presentation

Data to be presented in October 2026

Summary of October Data Readouts

Line of Therapy	Cohort / Regimen (n)	Median Follow-up	Key Outcome Measures	Goal Takeaways from October Data Presentation
1L	cas + zim (n~30)	~11 months	Primary PD, ORR, PFS K-M	- Early efficacy signals, including rate of primary progression, demonstrating improvement over ipi+nivo and anti-PD-1 monotherapy, even without anti-CTLA-4 - Potential for differentiated PFS vs. CM-214
	cas + zim + ipi (n~20)	min. 12 weeks	Safety Primary PD, ORR	- Safety: AEs generally consistent with the profile of each individual agent, including historically consistent rates of anemia and hypoxia - Lower rate of primary progression than CM-214
2L	cas + cabo (n~45)	Min. 18 months; med. ~21 months	Updated ORR PFS K-M Early OS K-M Safety	- Favorable efficacy signal for cas + cabo relative to cabo monotherapy benchmarks, validating our PEAK-1 study - Demonstrate potential for PEAK-1 to achieve a better PFS HR vs LS-011, despite a meaningful portion of patients in PEAK-1 expected to have poorer prognostic factors (e.g., prior exposure to lenva)
Late-line	cas mono (n=121)	~28 months	Early OS K-M	Cas monotherapy demonstrates potential to achieve OS benefit, which would provide strong therapeutic rationale for its use as a backbone therapy across all lines of therapy

Relevant Benchmarks for Upcoming Data Readouts



*Cas monotherapy pooled cohort data (n=121), as presented at ASCO GU 2026. Median follow-up of 20.8 months

Note: Landmark PFS/OS rates are approximate, read from published Kaplan-Meier curves.

References and acronyms on slide 55

Potential to Improve the Rate of Primary Progression and Differentiate on PFS relative to Ipi + Nivo (CheckMate-214)

cas + zim (n=30) has a **7%** rate of primary progressive disease in ARC-20

cas + zim (n=30) cohort will have **~11 months** median follow-up; will provide preliminary view on PFS

Table 2. Antitumor Activity in IMDC Intermediate- and Poor-Risk Patients.*²⁷

Variable	Nivolumab plus Ipilimumab (N = 425)	Sunitinib (N = 422)
Confirmed objective response rate — % (95% CI)†	42 (37–47)‡	27 (22–31)‡
Confirmed best overall response — no. (%)†		
Complete response	40 (9)‡§	5 (1)‡§
Partial response	137 (32)	107 (25)
Stable disease	133 (31)	188 (45)
Progressive disease	83 (20)	72 (17)
Unable to determine or not reported	32 (8)	50 (12)
Median time to response (range) — mo	2.8 (0.9–11.3)	3.0 (0.6–15.0)
Median duration of response (95% CI) — mo	NR (21.8–NE)	18.2 (14.8–NE)
Patients with ongoing response — no./total no. (%)	128/177 (72)	71/112 (63)

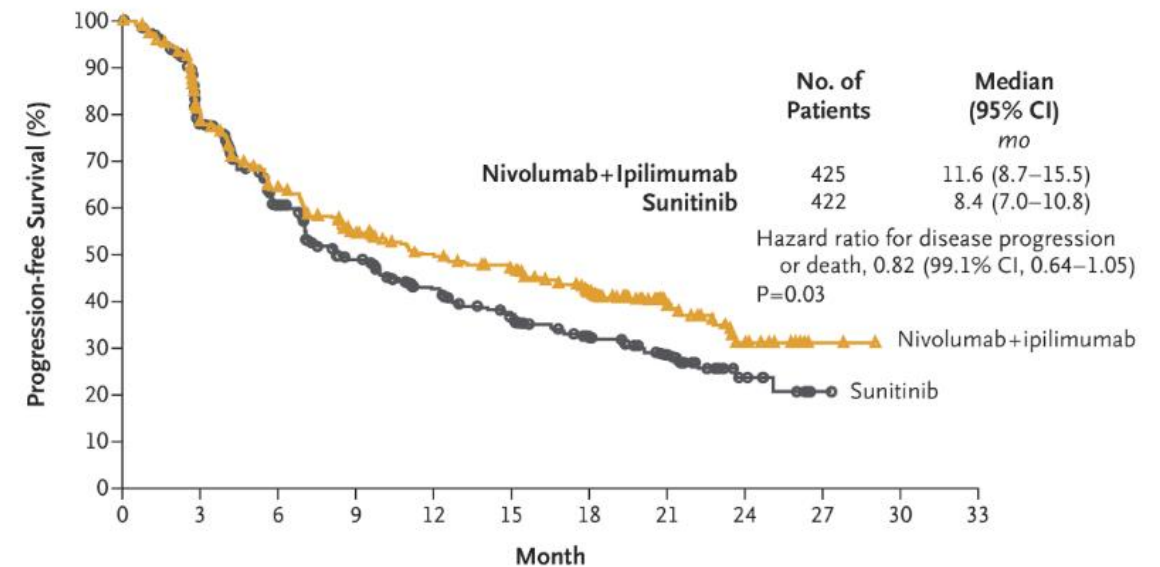
* NE denotes not estimable, and NR not reached.

† Response was assessed according to Response Evaluation Criteria in Solid Tumors, version 1.1, by an independent radiology review committee.

‡ P<0.001 for the difference between groups.

§ The analysis of the between-group difference in complete response was exploratory.

B Progression-free Survival²⁷

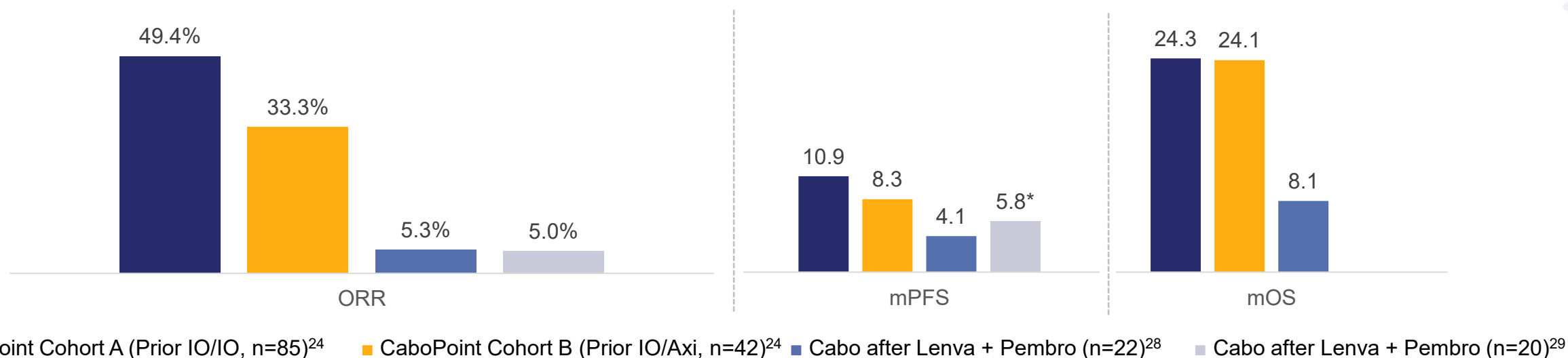


No. at Risk

Nivolumab+ipilimumab	425	304	233	187	163	149	118	46	17	3	0
Sunitinib	422	282	191	139	107	86	57	33	11	1	0

Prior TKI Exposure Impacts Cabo Performance in 2L

- CaboPoint demonstrated that patients who received prior IO + axitinib had numerically lower mPFS on cabo in 2L than those with prior IO-only
- There are at least two retrospective studies demonstrating that prior exposure to lenvatinib specifically resulted in *drastically worse clinical outcomes* when treated with cabo mono



In the ARC-20 cas + cabo cohort, 7 of 17 patients with prior TKI exposure received lenvatinib
These patients would have been excluded from LITESPARK-011 (but included in PEAK-1)

Prior TKI Exposure in LS-011 was Meaningfully Different from that of ARC-20 Cas + Cabo Cohort

PRIOR THERAPY AGENT	ARC-20		LITESPARK-011 ²⁶			
	CAS + CABO (N = 44)		BELZ + LENVA (N = 371)		CABO (N = 376)	
	N	%	N	%	N	%
Neo-adjuvant [†]	0	0%	1	0%	2	1%
Adjuvant [‡]	11	25%	23	6%	25	7%
First Line	36	82%	356	96%	358	95%
IO + axi	6	14%	107	29%	103	27%
Pembro + lenva	7	16%	0	0%	0	0%
IO only [§]	17	39%	136	37%	143	38%
Pazopanib or sunitinib	3	7%	93	25%	101	27%
Other*	3	7%	0	0%	0	0%
Second Line	5	11%	104	28%	107	28%
Nivolumab	2	5%	84	23%	98	26%
IO/IO; IO + axi	3	7%	0	0%	0	0%
Third Line	0	0%	4	1%	0	0%

Patients with prior lenva expected to perform much worse on cabo mono in 2L (ORR ~5%, PFS 4.1-5.8 months^{28,29**})

No longer commonly prescribed as 1L agents

[†]Includes avelumab/axitinib, nivolumab, and sunitinib. [‡]Includes axitinib/pembrolizumab, Bacillus Calmette-Guérin plus interferon, dendritic cells cytokine induced killer cells, everolimus, ipilimumab/nivolumab, nivolumab, pazopanib, pembrolizumab, placebo, sunitinib, and sunitinib malate.

[§]Includes ipilimumab/nivolumab and nivolumab. *Includes one patient with IO + zanzalitinib and two with IO + bevacizumab. **TOT and TTF used as proxy for PFS expectation.

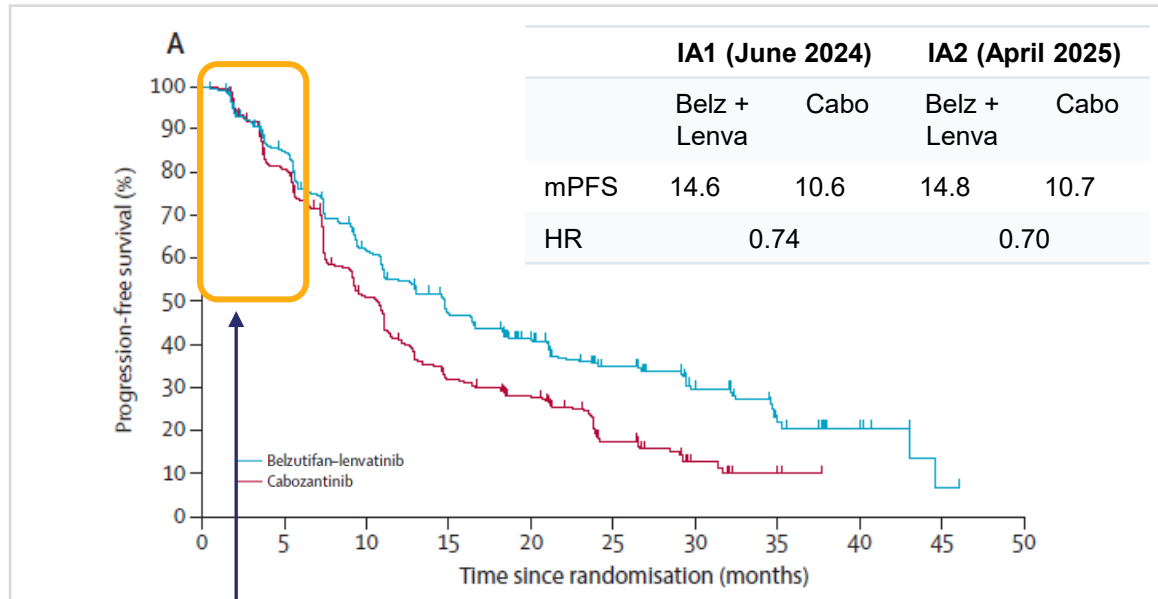
Data cut-off: March 25 2026

References and acronyms on slide 55

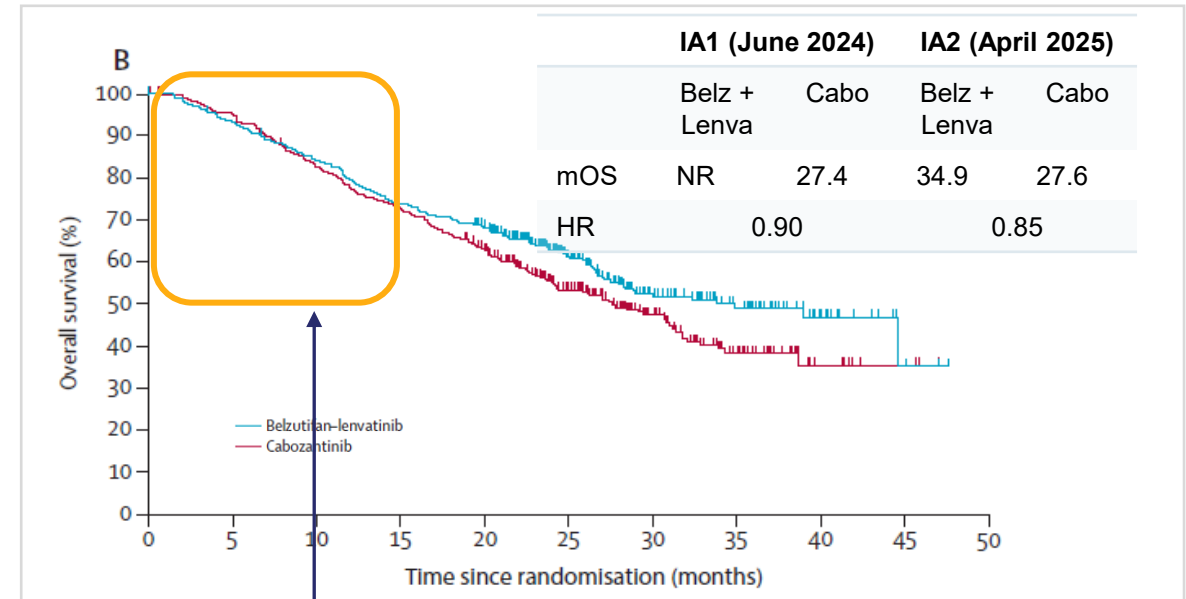
Despite Patients with Poorer Prognosis, Cas + Cabo has the Potential to Differentiate on both PFS and OS HR vs. LS-011

cas + cabo (n~45) will have a minimum follow-up of 18 months

LITESPARK-011 PFS K-M Curve²⁵



LITESPARK-011 OS K-M Curve²⁵



The Effect of HIF-2α is in the Tail

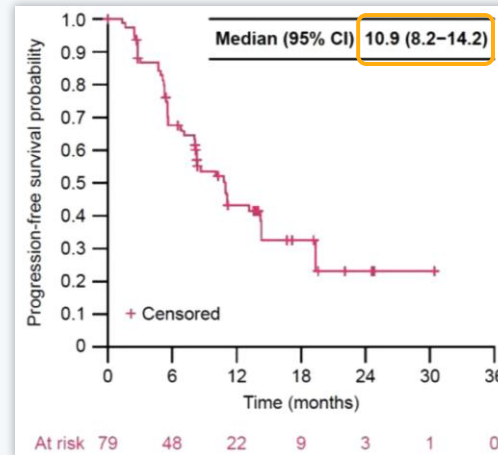
LS-011 curves overlapped for the first 6 months, with separation beginning around ~6 months for PFS and 12 months for OS. Note also that both PFS and OS HRs improved from IA1 to IA2.

Recent Cabo Mono Benchmarks have Been Consistent (LS-011 & CaboPoint)

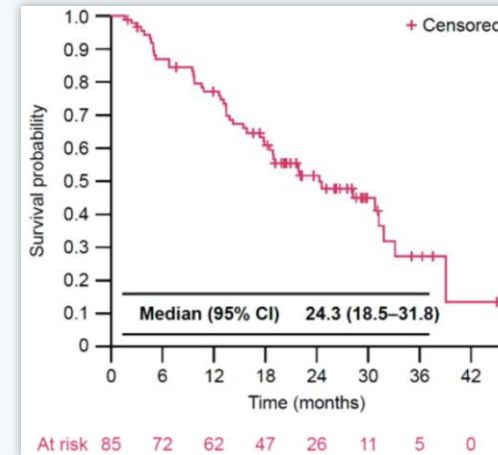
CaboPoint demonstrated numerically lower PFS for patients with prior IO/TKI vs. prior IO/IO²⁴

Cohort A
(prior IO/IO)

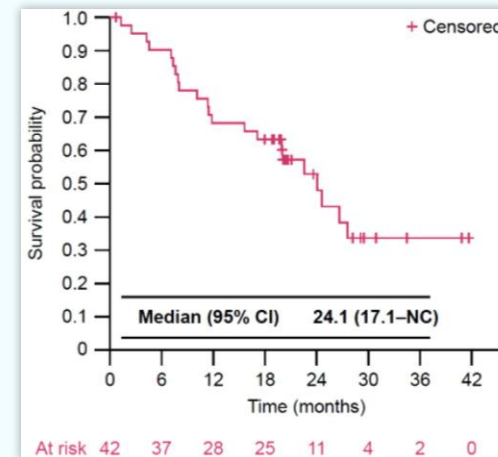
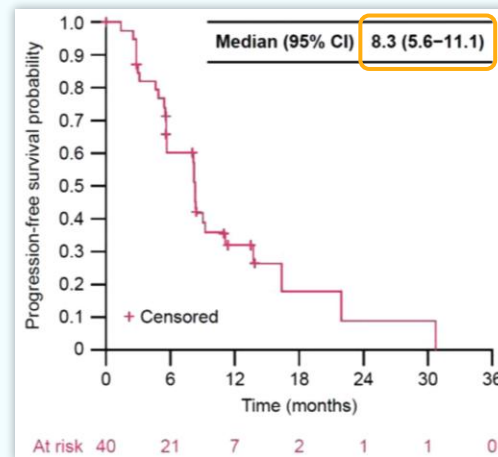
PFS K-M Curves



OS K-M Curves



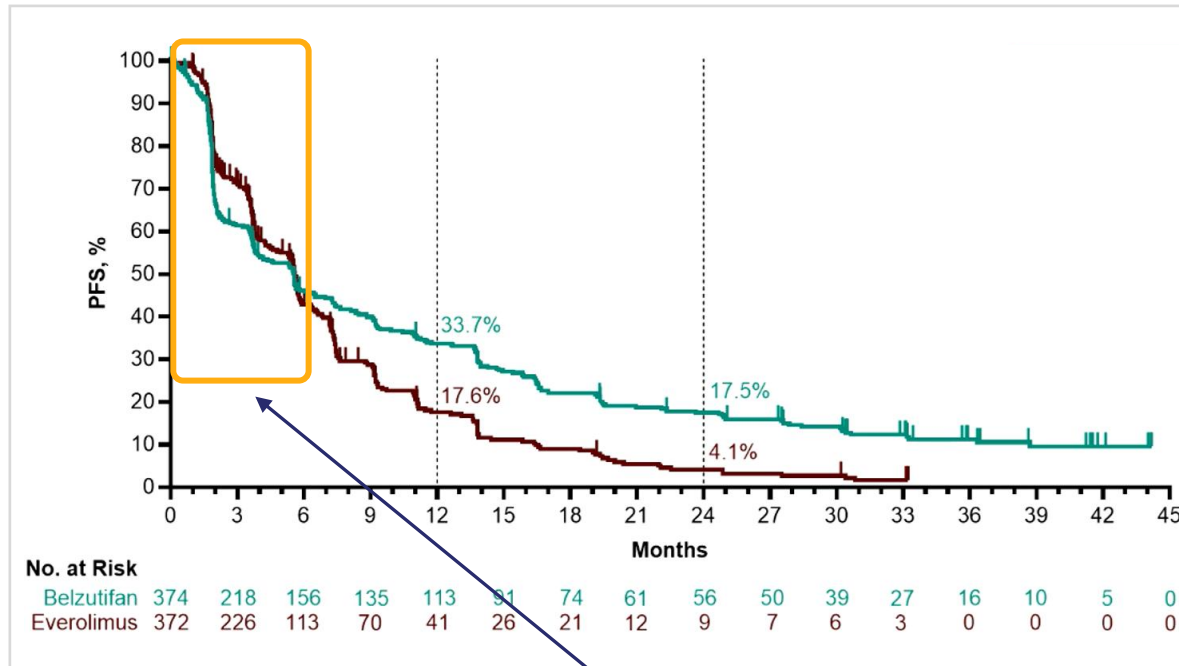
Cohort B
(prior IO/TKI)



Cas Has the Potential to be the Only HIF-2 α Inhibitor to Show an Overall Survival Benefit

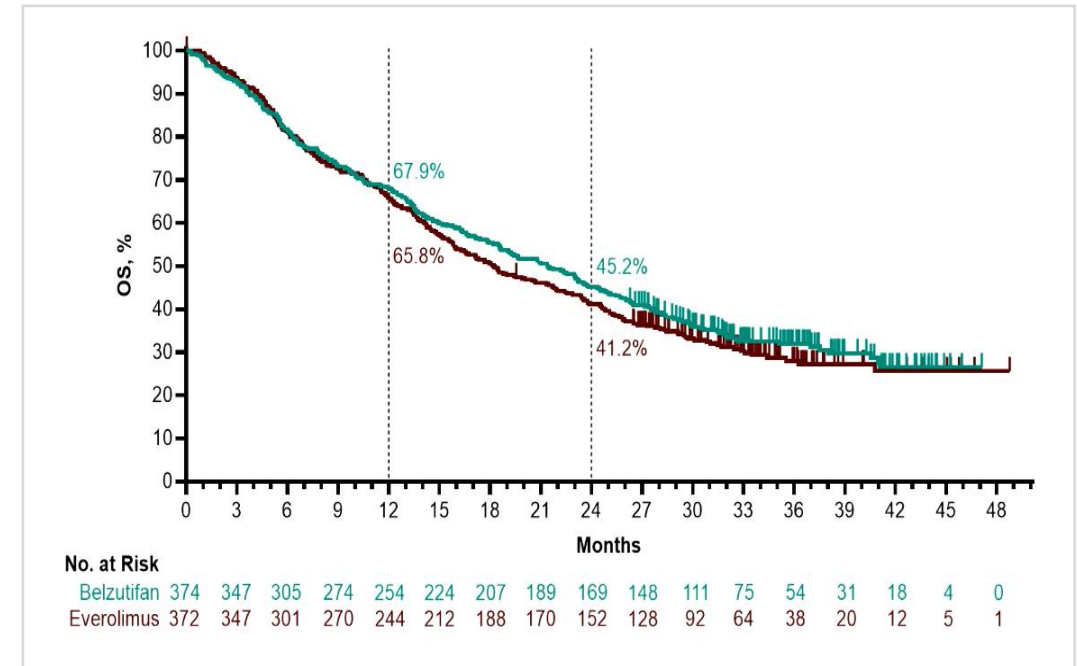
With 28 months of follow-up, the cas monotherapy pooled cohort will offer the first look at OS

PFS K-M Curve²



Note that the curves overlap in the first 6 months; separation begins beyond the median

OS K-M Curve²



cas monotherapy (n=121) pooled cohort will have a median follow-up of 28 months



Casdatifan Monotherapy Data

Data cut-off date of January 30, 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)

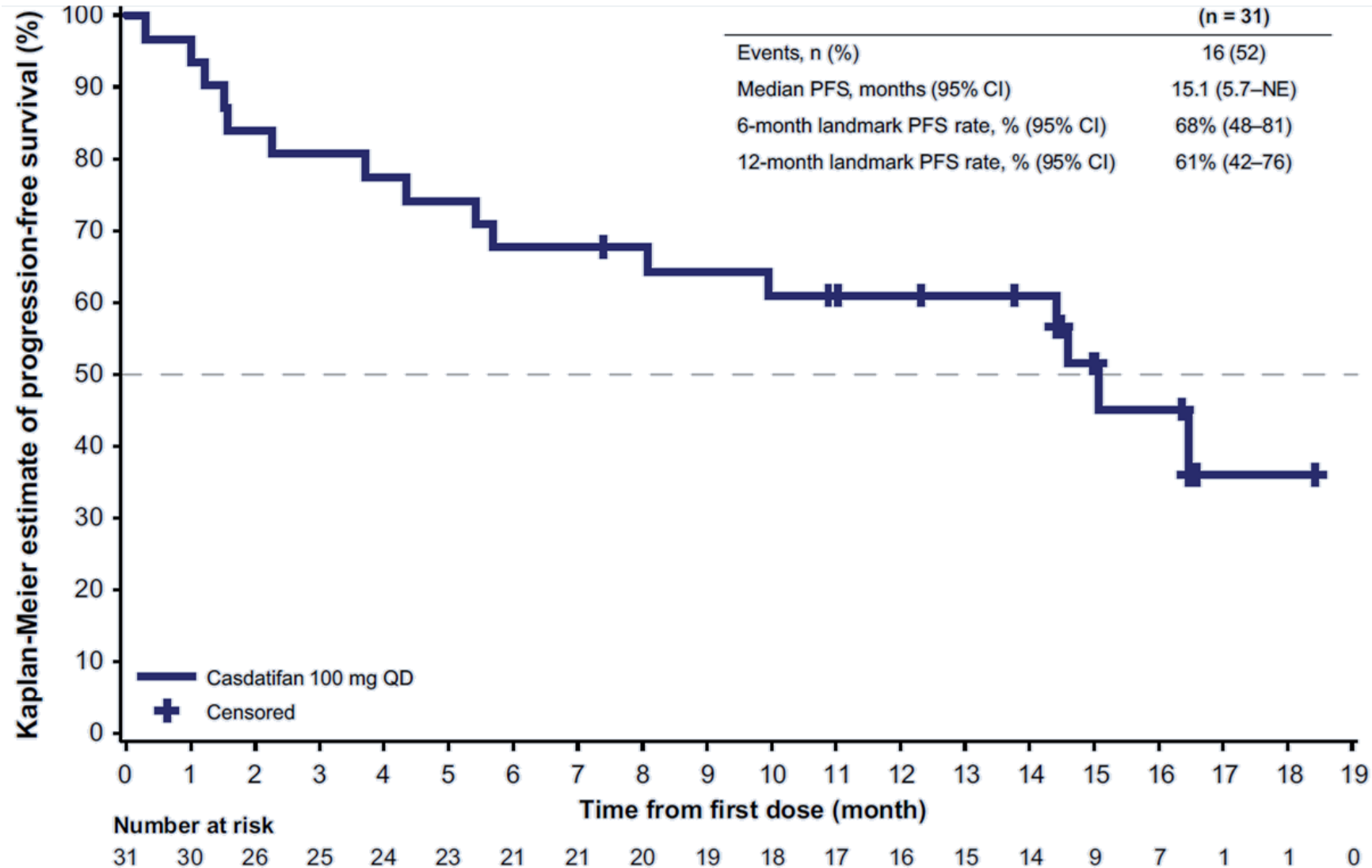
*Includes two patients in the 100mg QD Tablet cohort, and also included in the pooled analysis, who had clinical progression before the first scan and therefore did not meet criteria for progressive disease per RECIST. PD based on RECIST criteria was 10% (n=3) for the 100mg QD Tablet cohort and 17% (n=21) 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.

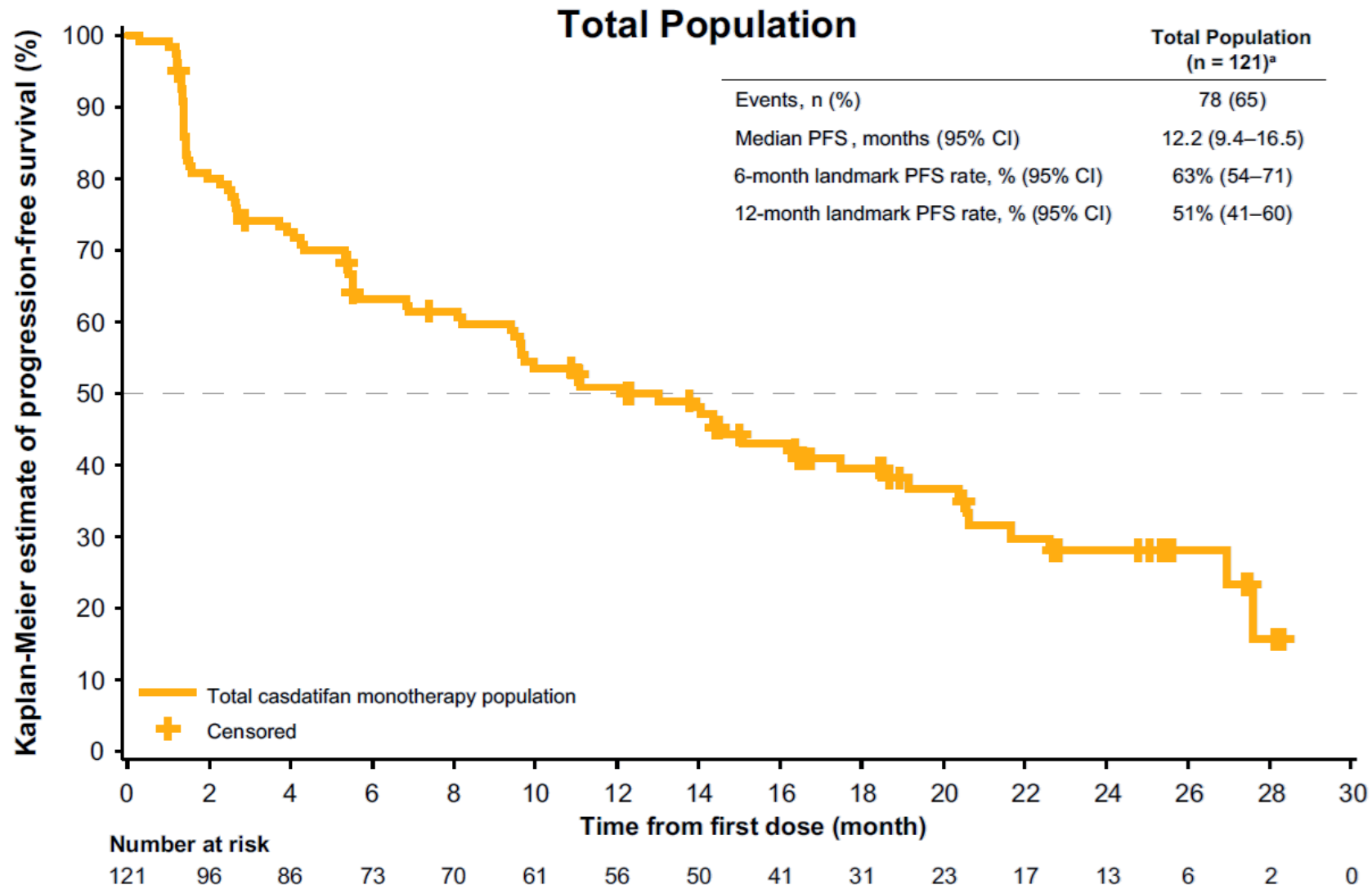
References and acronyms on slide 55

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



Median Follow Up:
17.9 months

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



Median Follow
Up: 20.8 months

References and Acronym Key

1. Choueiri T, et al. <i>J Clin Oncol</i> . 2026. (ARC-20)	11. Pal S, et al. <i>Lancet</i> . 2023. (CONTACT-03)	21. Tannir N, et al. <i>Ann Oncol</i> . 2024. (CheckMate-214)
2. Albiges L, et al. <i>Ann Oncol</i> . 2023. (LITESPARK-005)	12. Tannir N, et al. <i>JAMA</i> . 2022. (CANTATA)	22. McDermott D, et al. <i>J. Clin. Oncol</i> . 2021. (KeyNote-427)
3. Choueiri T, et al. <i>NEJM</i> . 2024. (LITESPARK-005)	13. Wainberg Z, et al. <i>J Clin Oncol</i> . 2024. (ARC-8)	23. McDermott D, ASCO GU 2026. (KeyNote-427)
4. Choueiri T, et al. <i>J Clin Oncol</i> . 2025. (ARC-20)	14. Sanofi earnings releases. Accessed July 29, 2026.	24. Albiges L, et al. <i>Eur Urol</i> . 2026. (CaboPoint)
5. Marathe D, et al. <i>J Clin Pharm</i> . 2024. (belzutifan)	15. Serwas N, et al. SID. 2026. (AB102)	25. Motzer R, et al. ASCO 2026. (LITESPARK-011)
6. Choueiri T, et al. <i>Nature</i> . 2026. (ARC-20)	16. Riedl M, et al. <i>Ann. Allergy Asthma Immunol</i> . 2025.	26. Motzer R, et al. <i>Lancet</i> . 2026 (LITESPARK-011)
7. Rini B. et al, <i>Lancet Oncol</i> . 2020. (TIVO-3)	17. Maurer M., et al. <i>Allergy</i> . 2011.	27. Motzer R, et al. <i>NEJM</i> . 2018 (CheckMate-214)
8. Choueiri T, et al. <i>Lancet Oncol</i> . 2016. (METEOR)	18. 2022 Annual Report . Abbvie. Accessed July 29, 2026.	28. Haro-Silerio J, et al. ASCO GU. 2024 (CLEAR)
9. Motzer R, et al. <i>Lancet Oncol</i> . 2015. (lenvatinib +everolimus)	19. Sagonowsky E. The top 20 drugs by worldwide sales in 2020 . FiercePharma. Published May 3 2021.	29. Panian J, et al. <i>Eur Urol Focus</i> . 2025. (Cabo after Lenva+Pembro)
10. Rini B, et al. <i>Lancet</i> . 2011. (AXIS)	20. Novartis earnings releases. Accessed July 29, 2026.	

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