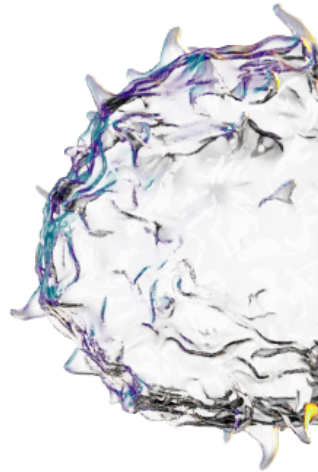
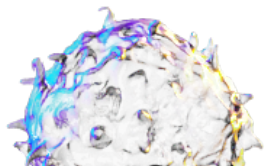
COMBINING TO CURE®

Arcus is at the forefront of designing combination therapies, with best-in-class potential, in the relentless pursuit of cures for cancer.

CORPORATE PRESENTATION

May 6, 2025





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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 regarding events or results to occur in the future contained in this presentation are forward-looking statements, including statements about: our strategy, advantages, and expectations, including regarding our productivity and competitiveness; expectation that our cash, investments and facilities are sufficient to fund operations through our initial pivotal read-outs for domvanalimab, quemliclustat and casdatifan, which includes PEAK-1; potential of our investigational products and portfolio, including our investigational products potential to be best or first in class; anticipated benefits of our collaborations with Gilead, Taiho and AstraZeneca; achievement and expected timing of clinical and developmental milestones, including the initiation of clinical trials and the timing of data readouts; excepted timing for clinical data to be available or presented and the scope of such data; launch of our investigational products and such products becoming an available treatment; formulation of our investigational products and the benefits of such formulation; market potential or patient population for any of our investigational products; and possible first to market advantage for any of our investigational products.

These forward-looking statements are subject to a number of risks, uncertainties and assumptions that may cause actual results to differ materially from those contained in any forward-looking statements we may make, including, but not limited to: risks associated with preliminary or interim clinical data or preclinical data not being guarantees that future data will be similar; the unexpected emergence of adverse events or other undesirable side effects; difficulties or delays in initiating, conducting or completing our clinical trials due to difficulties or delays in the regulatory process, enrolling subjects or manufacturing or supplying product for such clinical trials, all of which may be exacerbated by unfavorable global economic, political and trade conditions; risks associated with our collaboration arrangement with Gilead including our dependence on Gilead for the successful development and commercialization of our investigational products; changes in the competitive landscape; our limited operating history and our ability to manage our growth; 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 and adversely 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 are described in our most recent periodic reports filed with the U.S. Securities and Exchange Commission. 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 and completeness of the forward-looking statements. We undertake no obligation to update publicly 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.

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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 is Capitalized to Advance its Broad Portfolio of Late-Stage Programs Through Phase 3 Readouts

CASDATIFAN: POTENTIAL BEST-IN-CLASS HIF-2α INHIBITOR

Validated mechanism and compelling market opportunity

ARC-20

cas + cabo oral at ASCO

PEAK-1

Phase 3 initiation expected in 2Q25

DOMVANALIMAB: THREE PHASE 3 STUDIES

STAR-221

1L Gastric

Approaching Ph 3 Data

STAR-121

1L NSCLC (all comers)

Ongoing

PACIFIC-8

Stage 3 NSCLC

Ongoing

$1 BILLION IN CASH*

Funded through initial pivotal readouts for dom, quemli and cas, which include PEAK-1**

* cash, cash equivalents and marketable securities as of March 31, 2025

** runway estimate based on cash, cash equivalents, marketable securities, and available facilities

WORLD-CLASS DRUG DISCOVERY

Small molecules focused on oncology and I&I

1H25: first half of 2025; 1L: first-line; ASCO: American Society of Clinical Oncology; cabo: cabozantinib; cas: casdatifan; I&I: immunology & inflammation; NSCLC: non-small cell lung cancer; quemli: quemliclustat; R&D: research & development

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Three Late-Stage Programs Targeting Substantial Market Opportunities and Unmet Medical Need

Designed to improve upon the current standard of care

	PHASE 3 TRIAL NAME	INDICATION	PATIENTS (MAJOR MARKETS[1])	MARKET POTENTIAL (MAJOR MARKETS[2])	COMMERCIAL RIGHTS
CAS HIF-2α small molecule inhibitor	PEAK-1	Post-IO ccRCC	19K	~$2B	Arcus
	AstraZeneca eVOLVE portfolio	IO-naive ccRCC	21K	~$3B	
DOM (+ ZIM) Fc-silent anti-TIGIT mAb + anti-PD-1 mAb	STAR-221	1L Gastric/GEJ/EAC – all comers	105K	~$3B	Arcus / Gilead
	STAR-121	1L NSCLC – all comers	307K	~$10B	
	PACIFIC-8	Stage 3 NSCLC, PD-L1>1%	35K[3]	~$2B	
QUEMLI Small molecule CD73 inhibitor	PRISM-1	1L PDAC	109K	>$4B	Arcus / Gilead

1. Drug Treatable Addressable Populations (Major Markets) in 2024; Decision Resources Group, Arcus analysis – see appendix for breakout of US patients
2. Major Markets (US, EU5, JP) - total projected 2034 PD-(L)1 + TIGIT opportunity, Q opportunity & Hif2α opportunity
3. cCRT responding patients

1L: first line; 2L: second line; 3L: third line; B: billion; cas: casdatifan; ccRCC: clear cell renal cell carcinoma; dom: domvanalimab; EAC: esophageal adenocarcinoma; GEJ: gastroesophageal junction; IO: immuno-oncology; mAb: monoclonal antibody; NSCLC: non-small cell lung cancer; PD-L1: programmed death-ligand 1; PDAC: pancreatic ductal adenocarcinoma; quemli: quemliclustat; zim: zimberelimab

Multiple Data Milestones in 2025 Expected to Enhance Clarity on Multi-Billion $ Opportunities for Casdatifan and Domvanalimab

TIMING	STUDY	PRODUCT	EVENT
Early 2025	ARC-20	**Casdatifan**	✓ Updated data from 50mg BID, 50mg QD (ORR, PFS) ✓ Initial data from 100mg QD tablet (ORR) mono cohort
June 2025	ARC-20	**Casdatifan**	• Safety and initial efficacy data for the cas + cabo cohort oral presentation at ASCO
Fall 2025	EDGE-Gastric	**Domvanalimab**	• Phase 2 OS data for dom + zim + chemo in 1L gastric cancer
Fall 2025	ARC-20	**Casdatifan**	• More mature safety and efficacy data for monotherapy cohorts
2026 (event-driven)	STAR-221	**Domvanalimab**	• Phase 3 data for dom + zim + chemo vs. nivo + chemo in 1L gastric cancer

1L: first-line; BID: twice daily; chemo: chemotherapy; dom: domvanalimab; mono: monotherapy; nivo: nivolumab; ORR: overall response rate; OS: overall survival; PFS: progression-free survival; QD: once daily; zim: zimberelimab

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Our Partnerships Enable Cost-Efficiency and Greatly Expand Our Opportunities

	GILEAD	TAIHO PHARMA	AstraZeneca
R&D COST-SHARING	STAR-121 STAR-221 EDGE-Gastric EDGE-Lung VELOCITY-Lung	STAR-121 STAR-221 PRISM-1	PACIFIC-8 **Phase 1/1b:** **cas** + volru
RIGHTS / ECONOMICS	• Arcus retains co-promotion rights and profit share in the U.S. • High-teens to low-20's royalties on ex-U.S. sales • Opt-in rights to all programs (except casdatifan)	• Taiho has development / commercial rights in Japan and rest of Asia (ex-China) • Up to $275mm in milestones per program • High single-digit to mid-teens royalties	• Both parties retain economics on their respective molecules

cas: casdatifan; mm: million; R&D: research & development; volru: volrustomig

Casdatifan (HIF-2α) in ccRCC

ARC-20 Results Presented at ASCO GU Support Casdatifan Having a Potential Best-in-Class Profile for ccRCC

Across all three expansion cohorts
(approximately 90 patients)

- ✓ **Lower primary progressive disease (PD) rate** – approximately half the rate observed for belzutifan in LITESPARK-005
- ✓ **Higher ORR*, despite less maturity** – mid-20s to low-30s vs. high teens to low-20s for belzutifan
- ✓ **High DCR** – 80%+ of patients experience some clinical benefit
- ✓ **Highly durable responses** – only 2 (of 26) responders have progressed across all 3 cohorts
- ✓ **Longer mPFS** -- 9.7 mos for 50mg BID / not reached (NR) for other cohorts
- ✓ Comparable rates of on-target and SAEs

100mg QD tablet[1]
(Selected Phase 3 dose and formulation)

15%	Primary PD rate
33%	ORR** (with short follow-up)
85%	DCR
1.6 months	Time to Response
NR	mPFS not reached

**ORR throughout this presentation refers to confirmed ORR unless otherwise noted
*based on casdatifan in ARC-20, a Phase 1 study, and belzutifan in LITESPARK-005, a Phase 3 study
1. DCO date of January 3, 2025; median (range) follow-up for the 100mg QD cohort was 5 (2–6+) months (ongoing)
Source for LITESPARK-005: Albiges L. et al. Abstract LBA88, ESMO 2023
BID: twice daily; DCO: data cut-off; DCR: disease control rate; mos: months; mPFS: median profression-free survival; ORR: overall response rate; QD: once daily; SAE: serious adverse event

ARC-20 is a Phase 1 Dose-Escalation and Dose-Expansion Study of Casdatifan

DOSE ESCALATION

Patients with advanced solid tumors

Casdatifan monotherapy

DOSE EXPANSION

N = ~30 per cohort

2L+ ccRCC
Casdatifan mono
50mg BID capsule

2L+ ccRCC
Casdatifan mono
50mg QD capsule

2L+ ccRCC
Casdatifan mono
100mg QD tablet

2L+ ccRCC
Casdatifan mono 150mg QD

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

Favorable-risk 1L ccRCC
Casdatifan mono 100mg QD

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

Post-IO ccRCC
Casdatifan mono 100mg QD

KEY INCLUSION CRITERIA

- At least 1 measurable lesion per RECIST v1.1
- Adequate organ and marrow function

PRIMARY OUTCOMES

- AEs
- DLTs

SECONDARY OUTCOMES

- ORR
- PK/PD

EXPLORATORY OUTCOMES

- PFS
- Biomarkers

AE: adverse event; BID: twice daily; DLT dose limiting toxicities; mg: milligram; N: number; ORR: overall response rate; PD:pharmacodynamic; PFS: progression free survival; PK: pharmacokinetic; Q3W: every three weeks; QD: once daily; RECIST: Response Evaluation Criteria in Solid Tumors

Key Efficacy Measures All Compare Very Favorably to Contemporary Benchmark Studies Despite Shorter Follow-up

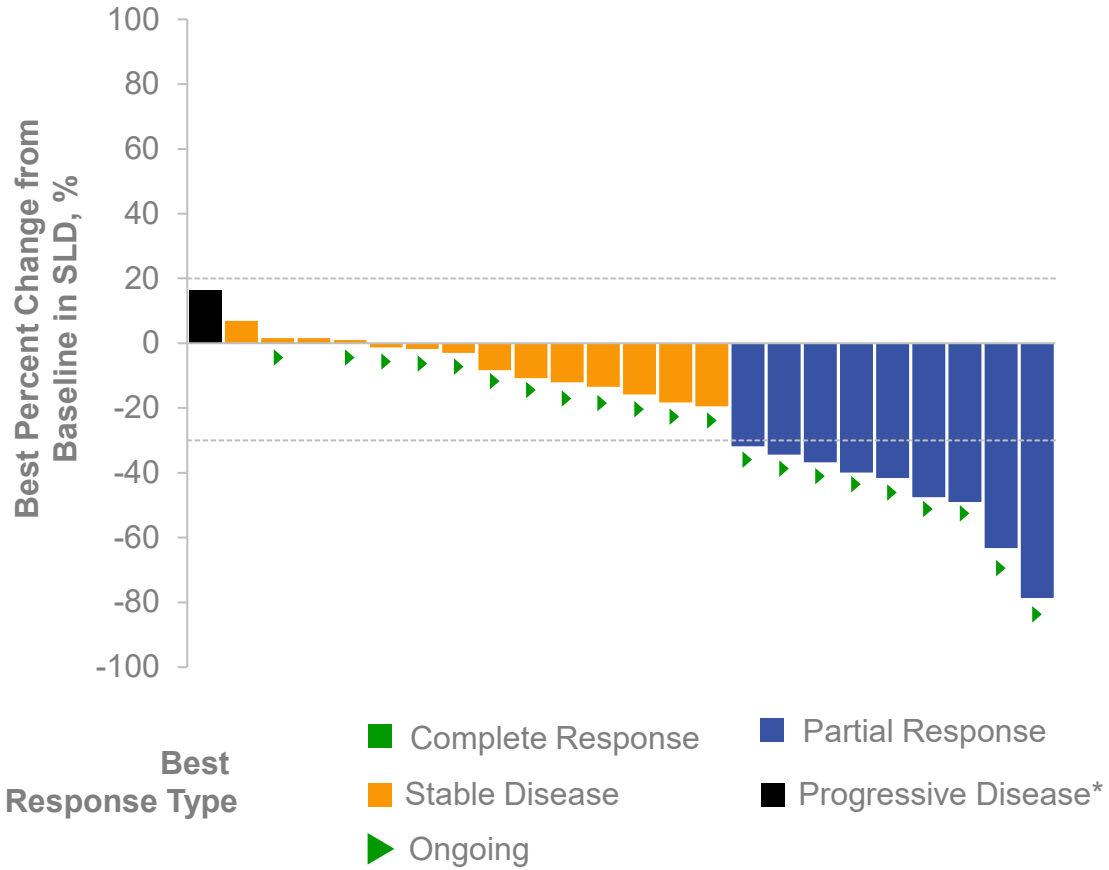
Efficacy-Evaluable Population[1,2]	Casdatifan 50mg BID (n = 32)	Casdatifan 50mg QD (n = 28)	Casdatifan 100mg QD (n = 27)
Confirmed ORR (n) [95% CI]	**25% (8)** [11.5, 43.4]	**32% (9)**** [15.9, 52.4]**	**33% (9)** [16.5, 54.0]
Med time to response, mos.	**2.8**	**4.1**	**1.6**
Best Overall Response (n)			
CR	0% (0)	4% (1)	0% (0)
PR	31% (10)*	29%(8)	33% (9)
SD	50% (16)	54% (15)	52% (14)
PD	**19% (6)**	**14% (4)**	**15% (4)[3]**
Disease control rate [95% CI]	**81%** [63.6, 92.8]	**86%** [67.3, 96.0]	**85%** [66.3, 95.8]
Median follow-up, months (range)	15 (7–19+)	12 (9–14+)	5 (2-6+)
Median progression free survival	**9.7 months**	**Not reached**	**Not reached**

*** In the 50mg BID cohort, one unconfirmed responder remains on treatment.**
****In the 50mg QD cohort, ORR includes one unconfirmed responder who became a confirmed responder after the DCO.**

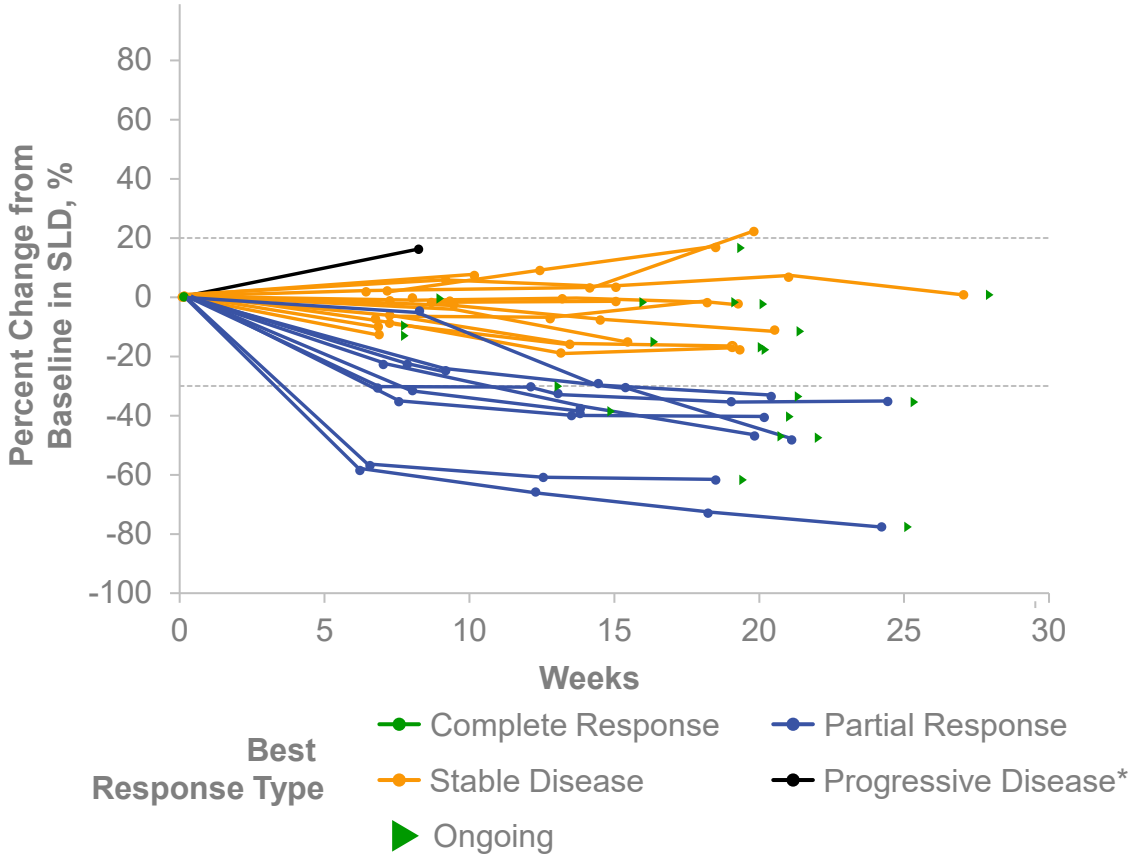
Unless otherwise noted, as of DCO date January 3, 2025
1. For the 50mg BID and 50mg QD cohorts, there were a total of four patients excluded from the efficacy evaluable population. 3 patients deemed ineligible shortly after enrollment (2 patients due to kidney function, 1 patient due to hemoglobin levels). One patient discontinued treatment before the first scan due to an unrelated AE.
2. In the 100mg QD cohort, 2 of 29 patients in the safety population were excluded from the efficacy evaluable population; 1 is ongoing treatment and has not yet received a first scan; the other discontinued prior to the first scan due to an unrelated adverse event.
3. Includes two patients with radiological progressive disease and 2 patients who had clinical progression before the first scan.
BID: twice daily; CI: confidence intervals; CR: complete response; DCO: data cut-off; n: number; ORR: overall response rate; PD: progressive disease; PR: partial response; QD: once daily

100mg QD Cohort: Rapid Response to Casdatifan Treatment With Almost All Patients Still on Therapy

100mg QD Tablet Waterfall Plot



100mg QD Tablet Spider Plot



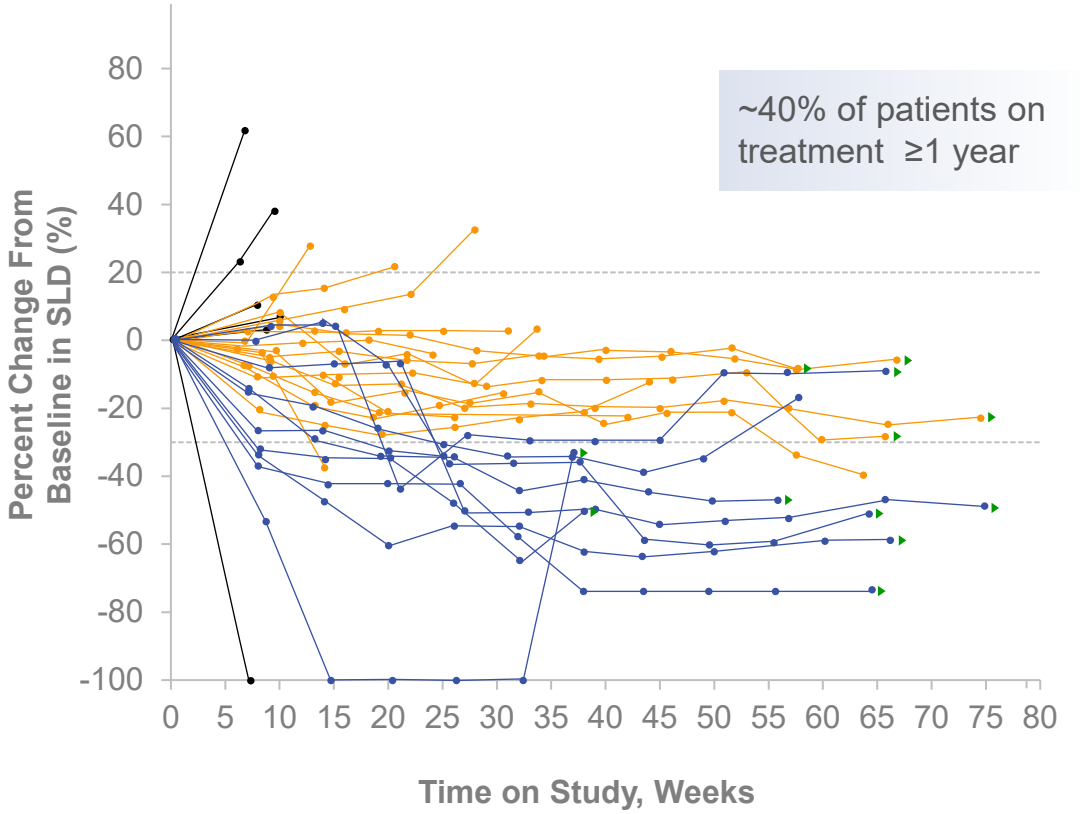
- **Median (range) follow-up for the 100mg QD cohort is 5 (2–6+) months (ongoing)**

DCO date: January 3, 2025
*Not shown in the charts are 3 patients who did not receive any scans and therefore scan information was not available. All of these patients were considered to have progressive disease and were included in the denominator for ORR on the prior slide.
mg: milligram; QD: once daily; SLD: sum of lesion diameters

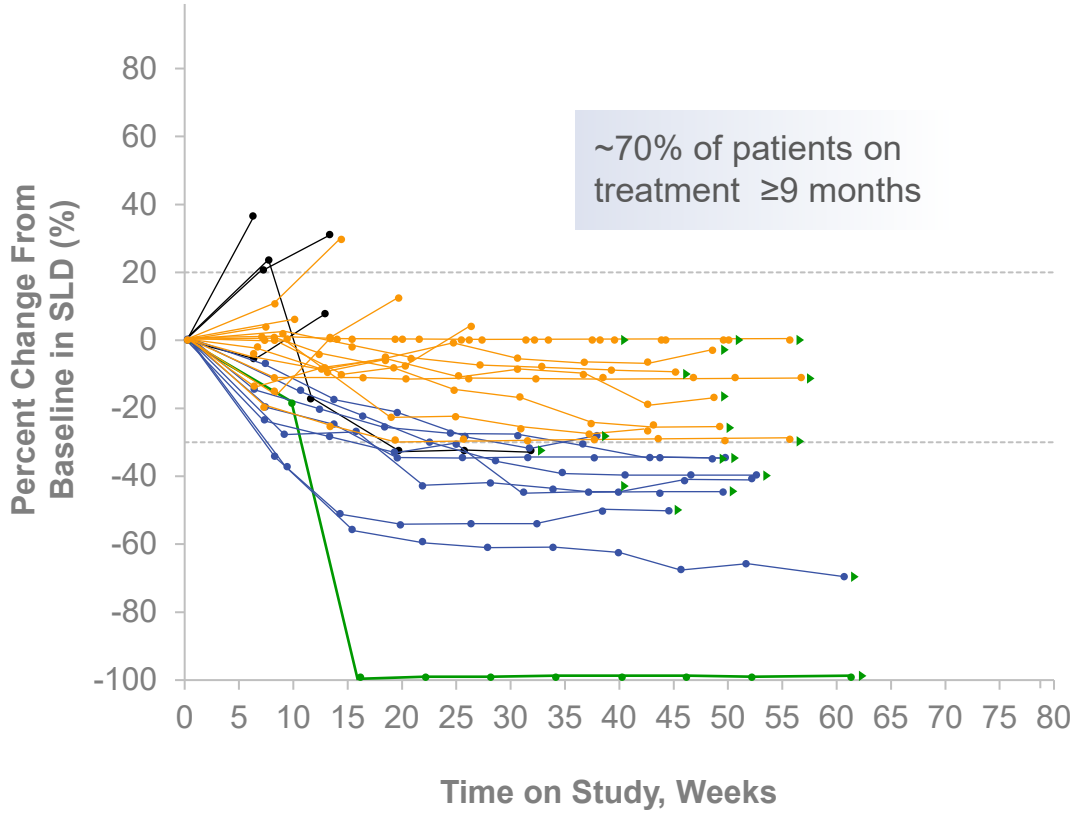
Spider Plots for 50mg BID and 50mg QD: Highly Durable Disease Control Even in SD Patients

Only two confirmed responders across all cohorts have discontinued due to progression*

50mg BID Daily Cohort



50mg QD Cohort

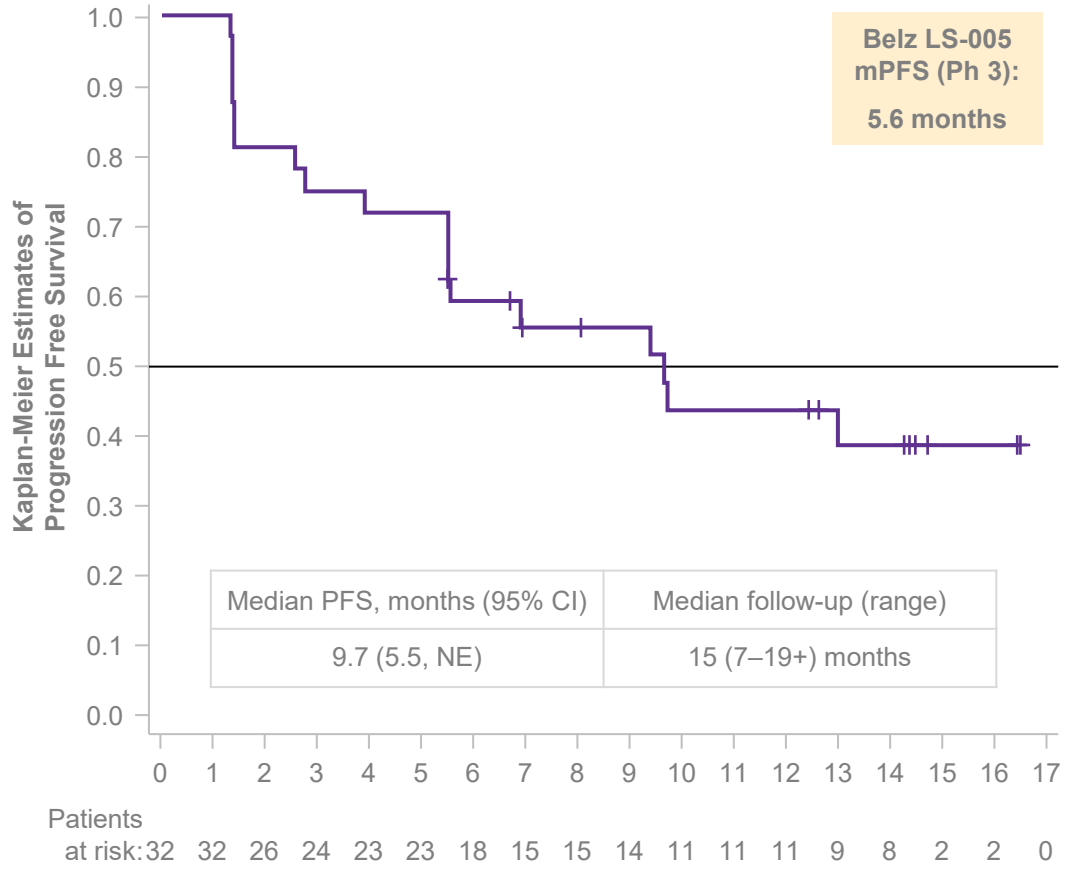


Best Response Type — Complete Response — Partial Response — Stable Disease — Progressive Disease ▶ Ongoing

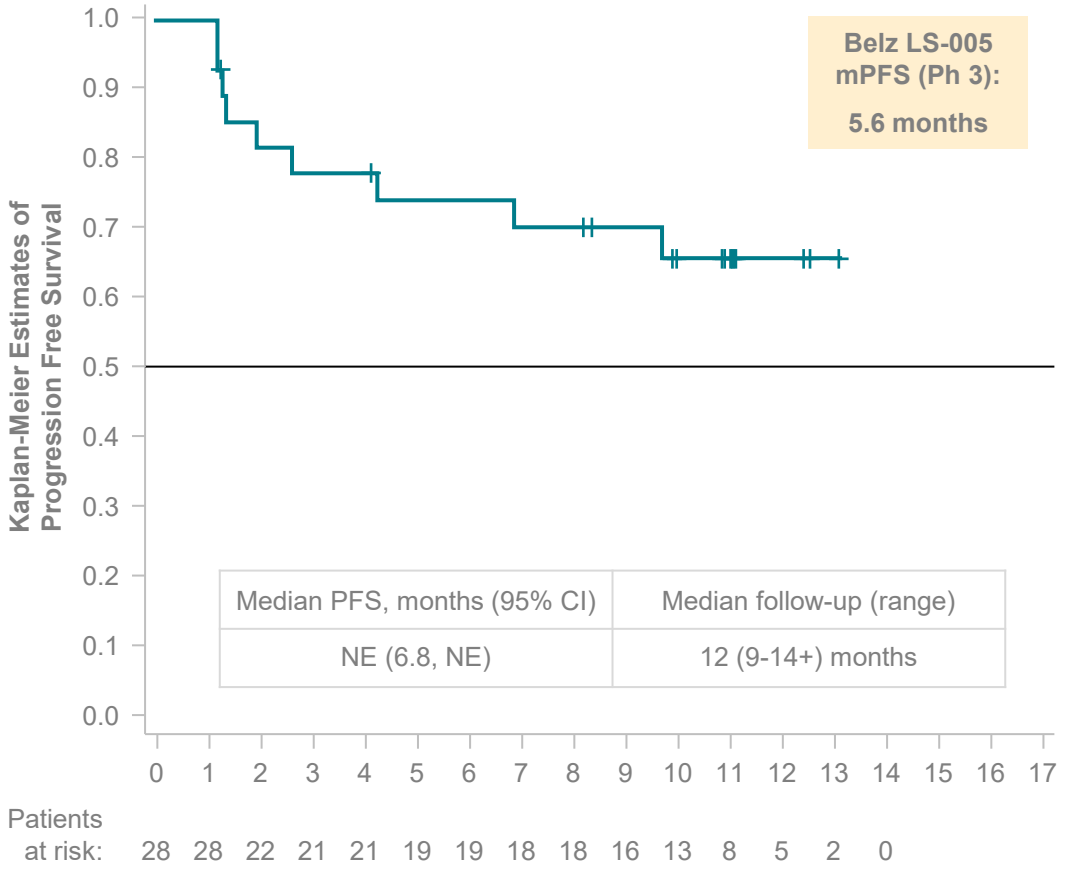
DCO date: January 3, 2025.
*As of February 15, 2025.
BID: twice daily; DCO: data cut-off; mg: milligram; QD: once daily; SD: stable disease; SLD: sum of lesion diameters

50mg BID and 50mg QD Cohorts Show Substantially Improved PFS Relative to that of LITESPARK-005

50mg BID Cohort (n=32)



50mg QD Cohort (n=28)



100 mg QD Cohort PFS is immature with 21 pts remaining on treatment

+ Censored

DCO data: January 3, 2025

1. IA1 for LITESPARK-005. Source: Albiges L. et al. Abstract LBA88, ESMO 2023;
PFS was measured according to RECIST v1.0 and estimated using Kaplan-Meier methodology.

Belz: belzufitan; BID: twice daily; CI: confidence interval; DCO: data cut-off; mPFS: median progression-free survival; NE: not estimable; PFS: progression-free survival; QD: once daily

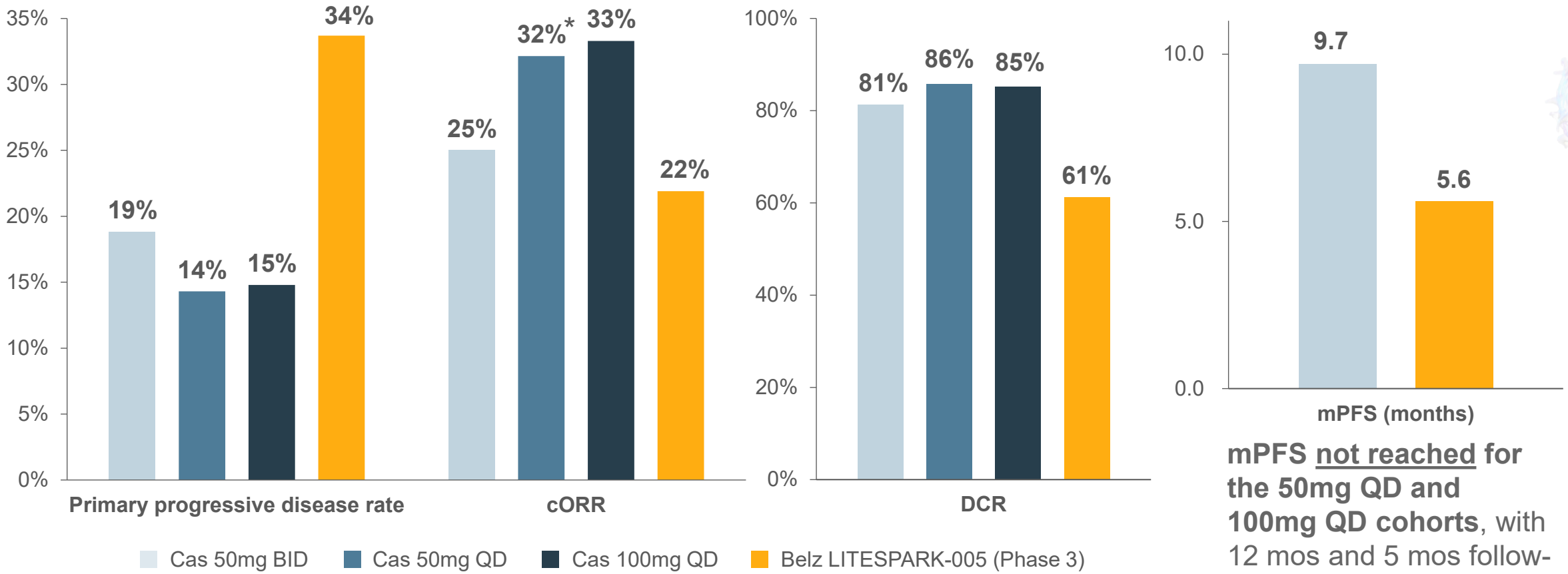
ARC-20 Data Support Casdatifan's Potential Best-in-Class Profile Across All Cohorts and Outcome Measures

Lower Primary PD

Higher ORR*

Higher DCR

Improved mPFS



mPFS <u>not reached</u> for the 50mg QD and 100mg QD cohorts, with 12 mos and 5 mos follow-up, respectively

***In the 50mg QD cohort, the one unconfirmed responder became a confirmed responder after the DCO date (January 3, 2025), increasing the ORR to 32%**

Data above 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.

Source: Efficacy data from IA1 of LITESPARK-005. Source: Albiges L. et al. Abstract LBA88, ESMO 2023

Belz: belzutifan; BID: twice daily; Cas: casdatifan; cORR: confirmed overall response rate; DCO: data cut-off; DCR: disease control rate; mg: milligram; mos: months; mPFS: median progression-free survival; PD: progressive disease; QD: once daily

Our Vision is for Every ccRCC Patient to Receive a HIF-2α Inhibitor and for Cas to be the HIF-2α Inhibitor of Choice

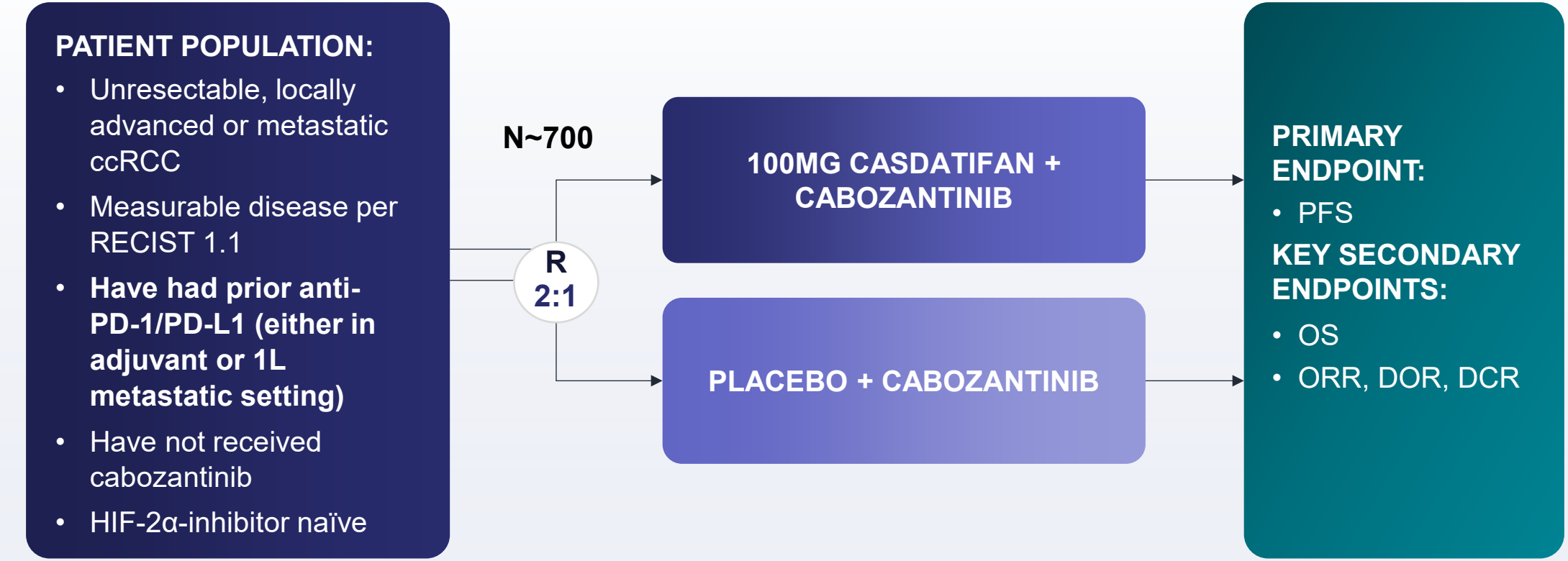
EARLIER LINES OF TREATMENT

SETTING	COMBINATION	EST. 2024 PATIENT POPULATION	DOT (MONTHS)	ARCUS APPROACH
Neoadjuvant ccRCC	**cas** + zimberelimab (anti-PD-1)	57k	3-4	**Investigator-sponsored trial** to initiate in 2H25
Adjuvant	TBD		12	TBD
1L IO-Naive	**cas** + volrustomig (anti-PD-1/CTLA-4 bsp)	21k	18+	**eVOLVE study (AZ operationalizing):** Evaluating a TKI-free regimen in 1L
1L All Comers	**cas** + zimberelimab		24+	**ARC-20:** Cohorts added to evaluate cas as a TKI-free option in 1L
1L Favorable Risk	**cas** monotherapy	9k		
Post-IO (1L-2L)	**cas** + cabozantinib	19k	12+	**PEAK-1:** Combining with the most widely used TKI
Post-IO (1L-2L)	**cas** monotherapy	19k	12+	**ARC-20:** Cohort added to evaluate cas as a TKI-free option
2L+ "Monotherapy"	**cas** monotherapy	12k	9+	TBD

Sources: DRG, Arcus primary research & analysis. Estimated eligible patient population is in "Major Markets" only (US, EU5 and Japan)

1L: first-line; 2L second-line; AZ: Astra Zeneca; bsp: bispecific; cas: casdatifan; ccRCC: clear cell renal cell carcinoma; CTLA-4: cytotoxic T-lymphocyte associated protein 4; DoT: duration of therapy; est.: estimated; HIF: hypoxia-inducible factor; IO: immuno-oncology; k: thousand; PD-1: programmed cell death protein 1; RCC: renal cell carcinoma; TKI: tyrosine kinase inhibitor

First Phase 3 Study for Cas Has a Simple Design that Utilizes the Preferred SOC in Post-IO ccRCC



PEAK-1 is On Track to Initiate in Q2 2025

1L: first-line; cabo: cabozantinib: cas: casdatifan; ccRCC: clear cell renal cell carcinoma; DCR: disease control rate; DOR: duration of response; HIF: hypoxia-induced factor; IO: immuno-oncology; mg: milligram; ORR: objective response rate; OS: overall survival; PD-1/PD-L1: programmed death protein 1/programmed death ligand 1; PFS: progression free survival; RCC: renal cell carcinoma; RECIST: Response Evaluation Criteria in Solid Tumors

Our Initial Focus Is on the IO-naive and Post-IO Settings, Both Multi-Billion Dollar Market Opportunities

	CURRENT SOC	POTENTIAL FUTURE TREATMENT	MARKET SIZE (MAJOR MARKETS[1,2])
IO-naive metastatic	PD-1 + CTLA4	AstraZeneca Part of eVOLVE portfolio of trials cas + volru	21k patients ~$3B OPPORTUNITY
Post-IO metastatic	TKI mono	PEAK-1 cas + cabo	19k patients ~$2B OPPORTUNITY
Post-IO & Post-TKI	mTOR, TKI, HIF-2α		12k patients

CAS FUTURE DEVELOPMENT

New cohorts being added to ARC-20:

- 1L (cas + zim)
- 1L favorable risk (cas mono)
- 1L/2L Post-IO / TKI-naive (cas mono)

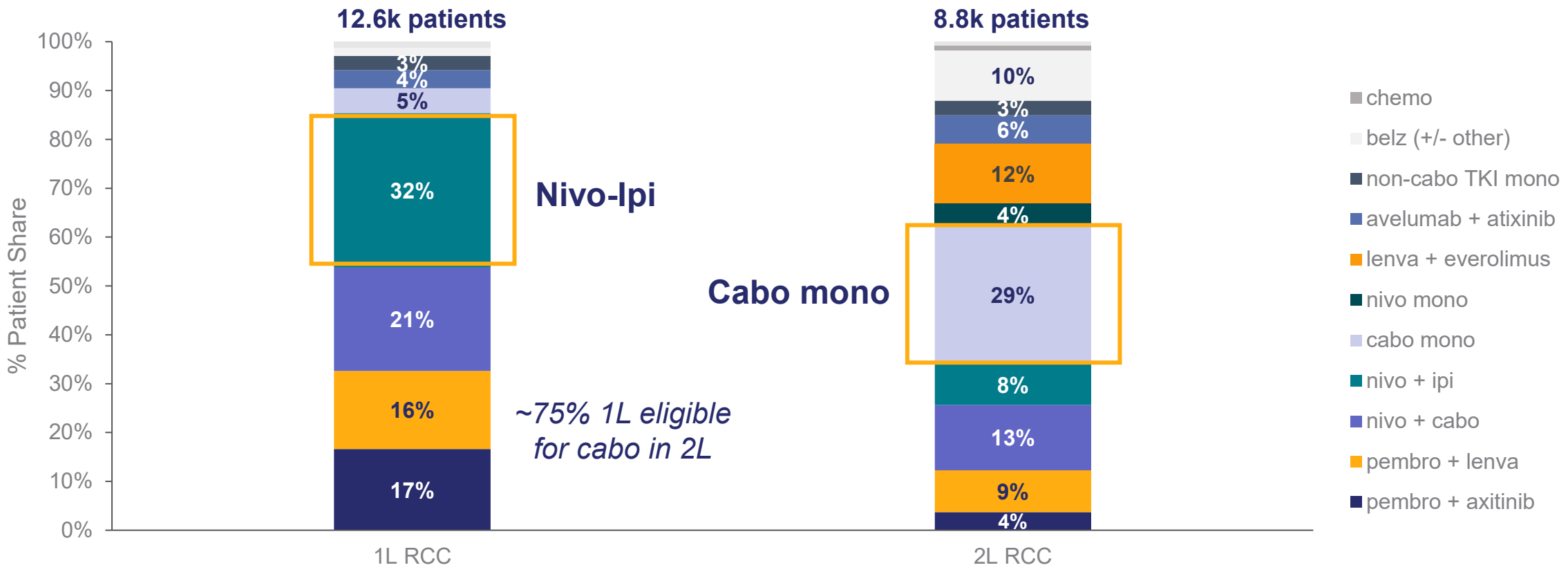
New tumor types

1. Drug Treatable Addressable Populations (Major Markets, 2024); Decision Resources Group, Arcus analysis
2. Major Markets (US, EU5, JP) - total projected 2034

1L: first-line; B: billion; cabo: cabozantinib; cas: casdatifan; ccRCC: clear cell renal cell carcinoma; CTLA4: cytotoxic T-lymphocyte associated protein 4; HIF: hypoxia-inducible factor; IO: immuno-oncology; mono: monotherapy; mTOR: mammalian target of rapamycin inhibitor; SOC: standard of care; TKI: tyrosine kinase inhibitor; volru: volrustomig; zim: zimberelimab

Initial Cas Development Plan Targets the Largest Market Segments and Could Expand Share Within These Segments

2024 ccRCC • US Market Share



Sources - Epi: DRG, GlobalData | Share: Arcus primary research, US May 2024 (n=49)
1L: first-line; 2L: second-line; belz: belzutifan; cabo: cabozantinib; cas: casdatifan; ccRCC: clear cell renal cell carcinoma; chemo: chemotherapy; ipi: ipilimumab; lenva: lenvatinib; mono: monotherapy; NCCN: National Comprehensive Cancer Network; nivo: nivolumab; pembro: pembrolizumab; RCC: renal cell carcinoma; TKI: tyrosine kinase inhibitor

Cas Will Be Offered as a Single 100mg QD Tablet

PEAK-1

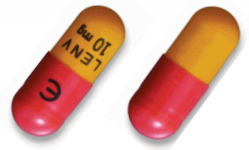
Cas 100mg
(1 x 100mg)

Cabo 20-60mg
(1 x Xmg)

LITESPARK-011 (Merck)

Belz 120mg
(3 x 40mg)

Lenva 20mg
(2 x 10mg)



- Cas tablet strength is expected to minimize pill burden while enabling dose reductions

AE: adverse event; cas: casdatifan; cabo: cabozantinib; belz: belzutifan; lenva: lenvatinib; mg: milligram; QD: once daily

ARCUS BIOSCIENCES

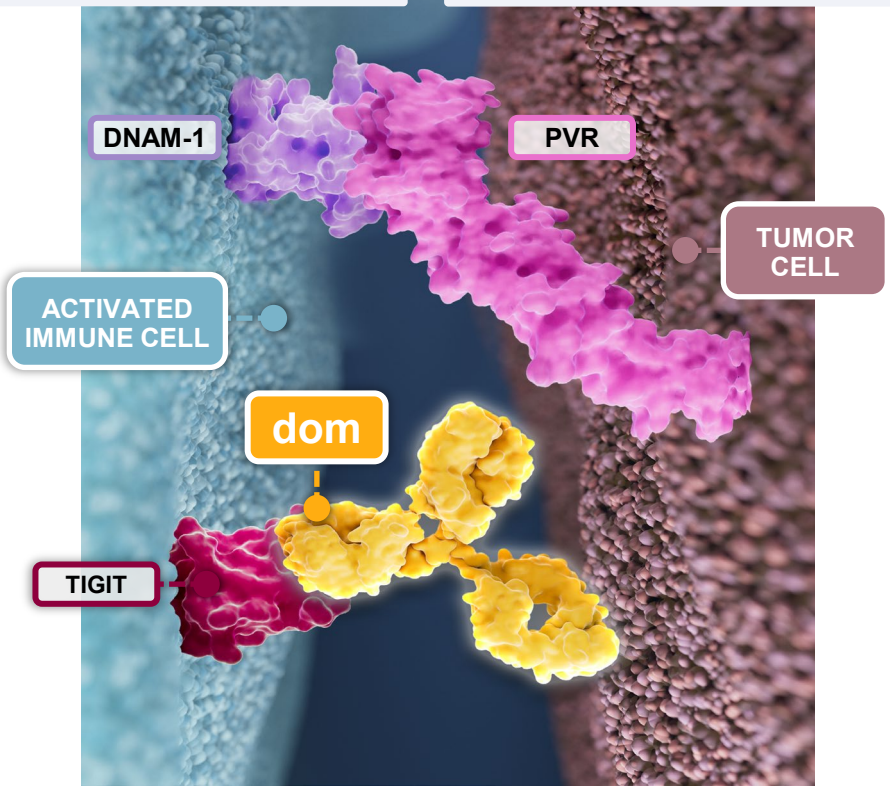
Domvanalimab in Upper GI Cancers and Non-Small Cell Lung Cancer

Dom is the Most Clinically Advanced Fc-Silent Anti-TIGIT Antibody in Development

TIGIT inhibition turns an immuno-suppressive "brake" into an accelerator of adaptive immunity

1 **Dom blocks TIGIT, an inhibitory "brake" on immune cells,** from binding to CD155 (PVR) on tumor cells

2 TIGIT blockade **enables PVR to bind CD226 (DNAM-1), an "accelerator" on immune cells,** driving tumor cell kill



First-to-Market potential in Upper GI & the only Fc-silent anti-TIGIT in Ph3 NSCLC

Fc-silent

Avoids depletion of TIGIT-bearing cells:

- Minimizes treatment interruptions by avoiding Treg depletion-related immune AEs
- Maximizes efficacy by avoiding potential depletion of cancer-fighting Teff cells

Individual Agents

Administered as individual agents (vs. co-form)

- Pursuing 30-minute co-administration infusion time for dom and zim

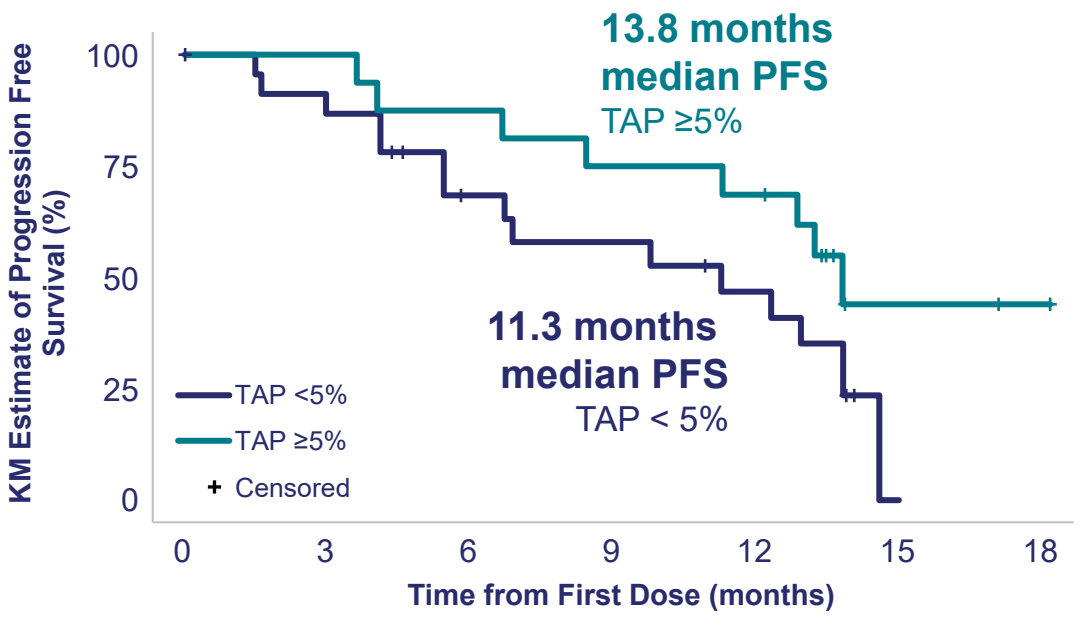
Optimized Development Strategy

Positioned to be first to market in 1L gastric, 1L NSCLC (all-comers) and Stage 3 NSCLC

Note: co-administration of dom + zim was not part of STAR-121 Phase 3 study in 1L NSCLC
DNAM-1: DNAX accessory molecule; dom: domvanalimab; GI: gastrointestinal; NSCLC: non-small cell lung cancer; Ph: phase; PVR: poliovirus receptor; TIGIT, T cell immunoreceptor with immunoglobulin and ITIM domain; Treg: regulatory T-cells; zim: zimberelimab

Dom/Zim/Chemo: Unprecedented mPFS in 1L Gastric Cancer

Phase 2 EDGE-Gastric: TAP ≥ 5% (n=16); TAP < 5% (n=24)



NUMBER OF PATIENTS AT RISK

TAP ≥5%	16	16	14	12	11	2	1
TAP <5%	24	20	13	11	8	0	

Phase 2 EDGE-Gastric Data Exceeded Phase 3 Benchmark Data

		EDGE-GASTRIC	CHECK MATE-649[1]	KEY NOTE-859[2]	RATIONALE -305[3]
mPFS	ITT	**12.9m**	7.7m	6.9m	6.9m
	PD-L1 High	**13.8m**	7.7m[4] 8.3m[5]	8.1m	7.2m
mDOR	ITT	**12.4m**	8.5m	8.0m	8.6m
	PD-L1 High	**NE**	9.5m[4] 9.6m[5]	10.9m	9.0m
ORR	ITT	**59%**	58%[6]	51%	47%
	PD-L1 High	**69%**	60%	61%	50%

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

EDGE-Gastric - Janjigian et al. ASCO 2024, Jun. 1, 2022; DCO date of March 12, 2024

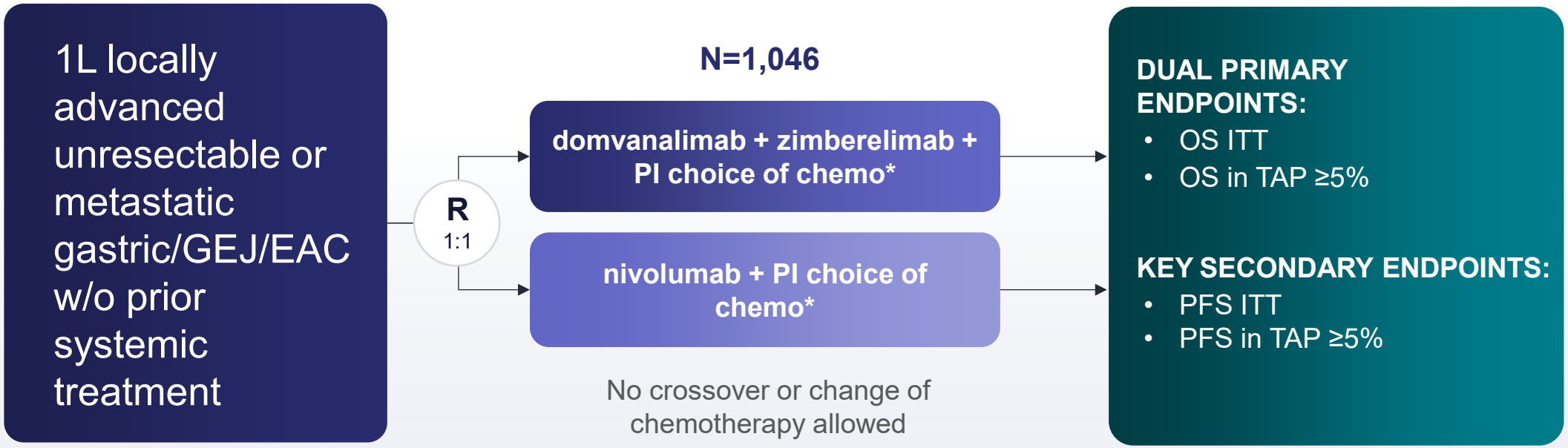
1. Phase 3: Janjigian, 2024. Shitara Nature 2022, Janjigian Lancet 2021, Moehler ASCO 2021 #4003 (36.2m, 24.0m, 12.1m, and 12.1m minimum follow up, respectively) 2. Phase 3: Rha, ESMO Virtual Plenary Feb 2023 and ASCO 2023 #4014 (31.0m median follow up) 3. Phase 3: Moehler, ASCO GI 2023 #286 (15.9m median follow up), and Xu, ESMO 2023 LBA80 (24.6m minimum follow up) 4. With 12.1 months minimum follow-up 5. With 36.2 months minimum follow-up 6. ITT population for Checkmate-649 included ~60% patients with PD-L1 high status at baseline. Note that EDGE-Gastric overall population included only 39% PD-L1 high at baseline.

1L: first-line; CI: confidence interval; CPS: combined positive score; DCO: data cut off; dom: domvanalimab; EAC: esophageal adenocarcinoma; GEJ: gastroesophageal junction; IO: immuno-oncology; ITT: intent-to-treat; KM: Kaplan Meyer; mDOR: median duration of response; mOS: median overall survival; mPFS: median progression-free survival; NE: not estimable; nivo: nivolumab; ORR: overall response rate; pembro: pembrolizumab; TAP: tumor area positivity; zim: zimberelimab

Phase 3 Study was Fully Enrolled in June 2024

Dom + zim is positioned to be the first anti-TIGIT combination approved

STAR-221 is evaluating the same regimen in the same setting as EDGE-Gastric



Stratification Factors:

- PD-L1 expression (TAP ≥5% or TAP <5%)
- ECOG PS (0 or 1)
- Region (US/Canada/EU5 vs. Asia vs. rest of world)

*PI choice of chemo: FOLFOX or CAPOX.
NCT #: NCT05568095
1L: first-line; chemo: chemotherapy; dom: domvanalimab; EAC: esophageal adenocarcinoma; ECOG PS: Eastern Cooperative Oncology Group performance status; GEJ: gastroesophageal junction; nivo: nivolumab; ITT: intent to treat; OS: overall survival; PFS: progression-free survival; PI: principal investigator; TAP: tumor area positivity; R: randomized; w/o: without; zim: zimberelimab

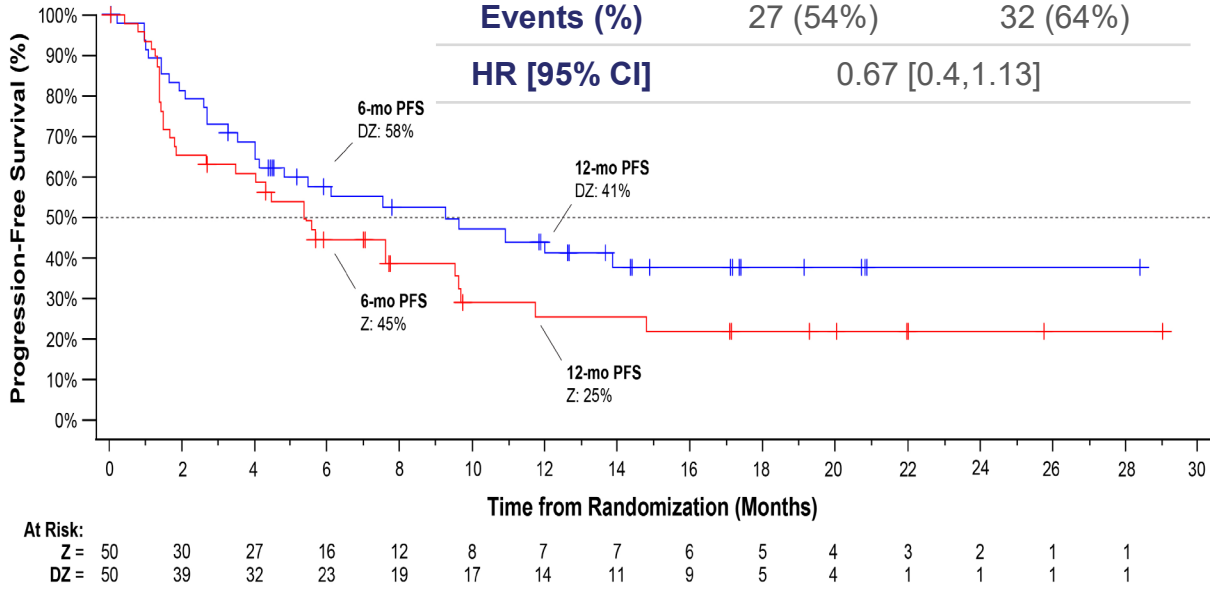
ARC-7 and ARC-10 Demonstrated Consistent Improvement for Dom + Zim in 1L PD-L1 High NSCLC

ARC-7 1L PD-L1 High NSCLC

dom + zim *vs.* zim *vs.* etruma + dom + zim (n=150)

2023 ASCO ANNUAL MEETING

	Dom + Zim	Zim
Median PFS [95% CI]	9.3 months [4.1,NE]	5.4 months [2.7,9.7]
Events (%)	27 (54%)	32 (64%)
HR [95% CI]	0.67 [0.4,1.13]	



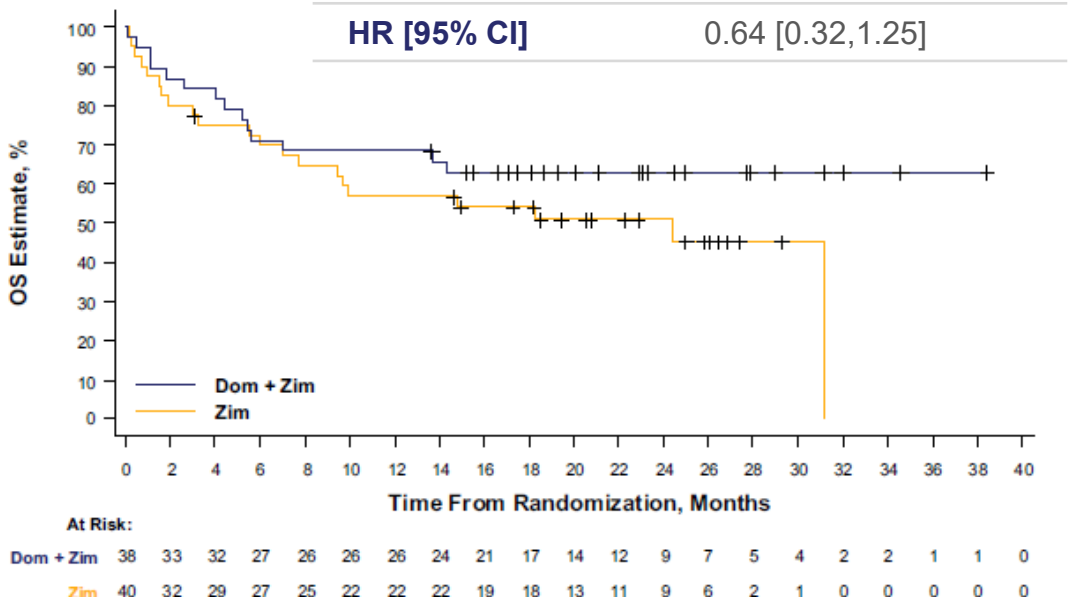
Dom + Zim vs. Zim PFS HR = 0.67

ARC-10 1L PD-L1 High NSCLC

dom + zim *vs.* zim *or* chemo (n=95)

Society for Immunotherapy of Cancer SITC 2024 NOV. 6-10 | HOUSTON

	Dom + Zim	Zim
Median OS [95% CI]	NR [13.7,NE]	24.4 months [7.8, NE]
HR [95% CI]	0.64 [0.32,1.25]	



Dom + Zim vs. Zim OS HR = 0.64

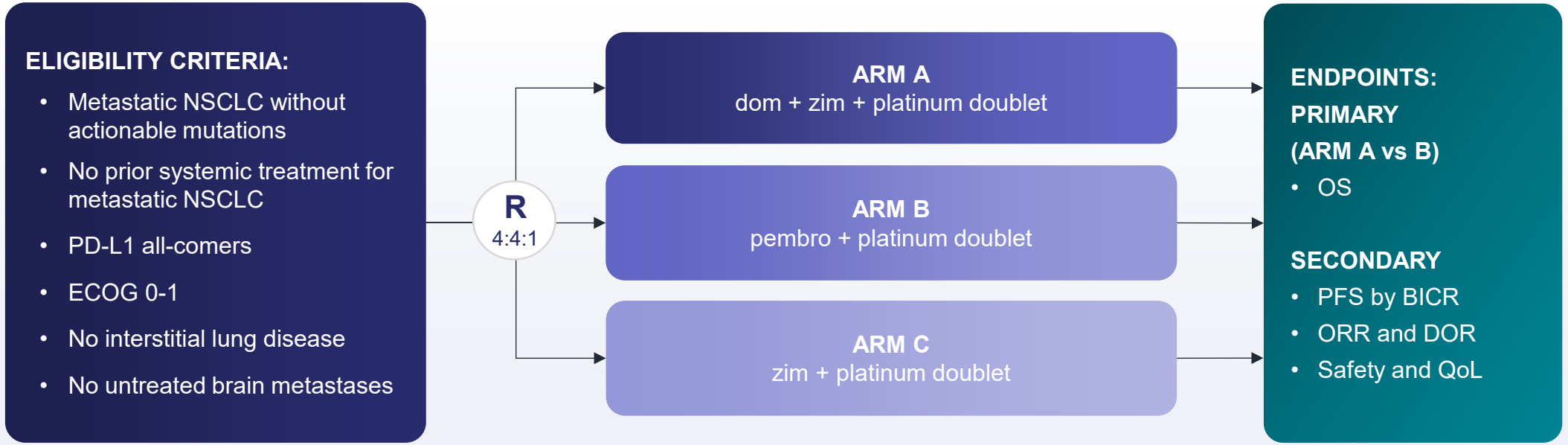
ARC-7 Johnson et al. Abstract 397600, ASCO 2023; DCO date of Feb. 7, 2023

ARC-10 – Johnson et al. SITC 2024, Nov. 5, 2024; DCO date of May 17, 2024

1L: first-line; chemo: chemotherapy; CI: confidence interval; DCO: data cut-off; D/dom: domvanalimab; etruma: etrumadenant; HR: hazard ratio; NE: not estimable; NR: not reached; NSCLC: non-small cell lung cancer; OS: overall survival; PFS: progression-free survival; Z/zim: zimberelimab

Phase 3 Evaluating Dom + Zim + Chemo vs. Pembro + Chemo in 1L NSCLC (All PD-L1 Subgroups)

- Uses standard of care, pembrolizumab, in the comparator arm



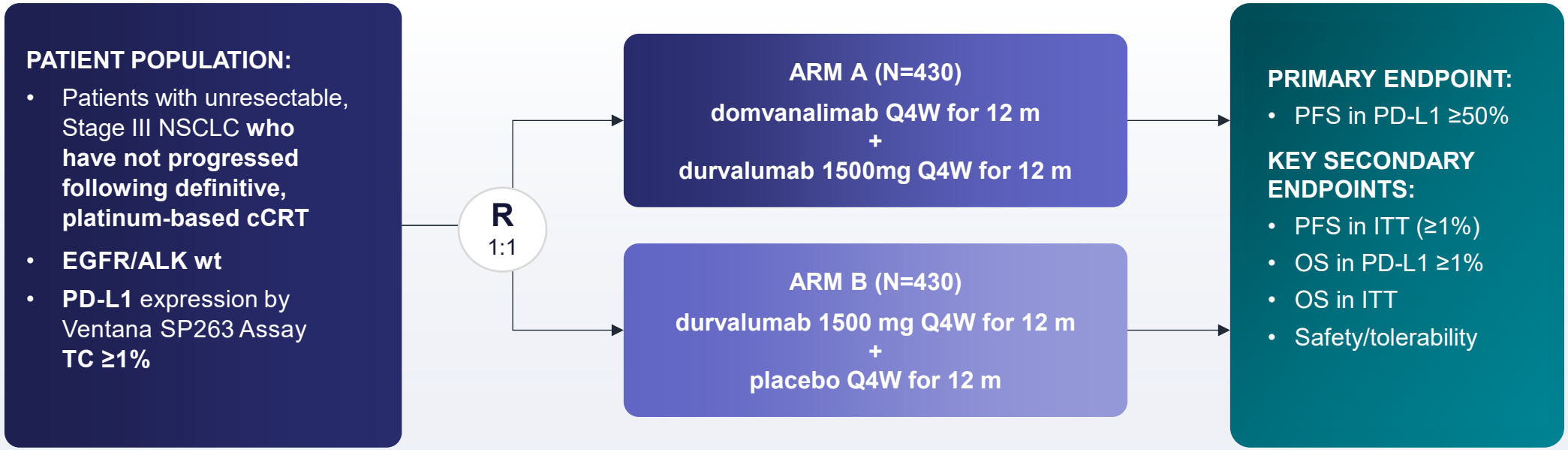
Gilead Sciences is operationalizing STAR-121.

NCT #: NCT05502237

1L: first-line; BICR: blinded independent central review; dom: domvanalimab; DOR: duration of response; ECOG: Eastern Clinical Oncology Group; NSCLC: non-small cell lung cancer; ORR: objective response rate; OS: overall survival; pembro: pembrolizumab; PFS: progression-free survival; QoL: quality of life; R: randomized; sq: squamous; zim: zimberelimab

Phase 3 Evaluating Dom + Durva vs Placebo + Durva in Unresectable, Stage III NSCLC

- Combines domvanalimab with durvalumab standard-of-care in Stage III NSCLC
- Potential to be first anti-TIGIT combination in this curative intent setting



Strat Factors:

- Disease stage prior to cCRT (IIIA vs. IIIB/IIIC)
- PD-L1 status (TC ≥ 50% vs. TC 1-49%), as assessed by a central reference laboratory using the VENTANA PD-L1 (SP263) IHC assay
- Histology (Sq vs Non-sq)

NCT #: NCT05211895

cCRT: concurrent chemoradiotherapy; dom: domvanalimab; durva: durvalumab; IHC: immunohistochemistry; ITT: intent to treat; m: months; NSCLC: non-small cell lung cancer; OS: overall survival; PFS: progression free survival; Q4W: every 4 weeks; R: randomized; TC: tumor count

Quemliclustat in Pancreatic Cancer

Quemliclustat: A Small Molecule CD73 Inhibitor with Several Key Attributes

QUEMLICLUSTAT

- Highly potent small molecule
- Target coverage achieved at doses as low as 25mg Q2W
- Extremely long (4+ days) half-life, enabling Q2W dosing by IV infusion

Biological rationale for CD73 inhibition in pancreatic cancer

- Pancreatic cancer exhibits very high expression of CD73, the main source of intra-tumor adenosine
- Immunogenic chemotherapy (e.g., gemcitabine/nab-paclitaxel) releases ATP and contributes to adenosine production
- Tumors such as pancreatic cancer become sensitive to immune attack if adenosine production (i.e., CD73 activity) is blocked by quemli while administering SOC chemotherapy

Potential advantages over CD73 antibodies[1]

- ✓ Highly potent and selective inhibition of both tumor cell-bound and soluble CD73
- ✓ Greater inhibition of enzymatic production of adenosine
- ✓ Orders of magnitude more potent
- ✓ Greater permeability of tumor tissue

Quemliclustat is an investigational molecule and its safety and efficacy have not been established.
1. Arcus Biosciences data on file; based on preclinical studies
ATP: adenosine triphosphate; IV: intravenous; quemli: quemliclustat; Q2W: every 2 weeks

Highlights from the Randomized Phase 1 Study in 1L PDAC

Median overall survival (mOS) was 15.7 months for patients treated with a quemliclustat-based regimen, which exceeds the historical benchmark data for chemotherapy alone (8.5 – 11.7 months)[1,2]

A 37% reduction in risk of death and a 5.9-month improvement in mOS was observed for patients treated with the quemli-based regimen when compared to a synthetic control arm of patients treated with G/nP alone[1]

The quemli-based regimen was well-tolerated, with no new safety signals or significant added toxicity compared to chemotherapy alone[1]

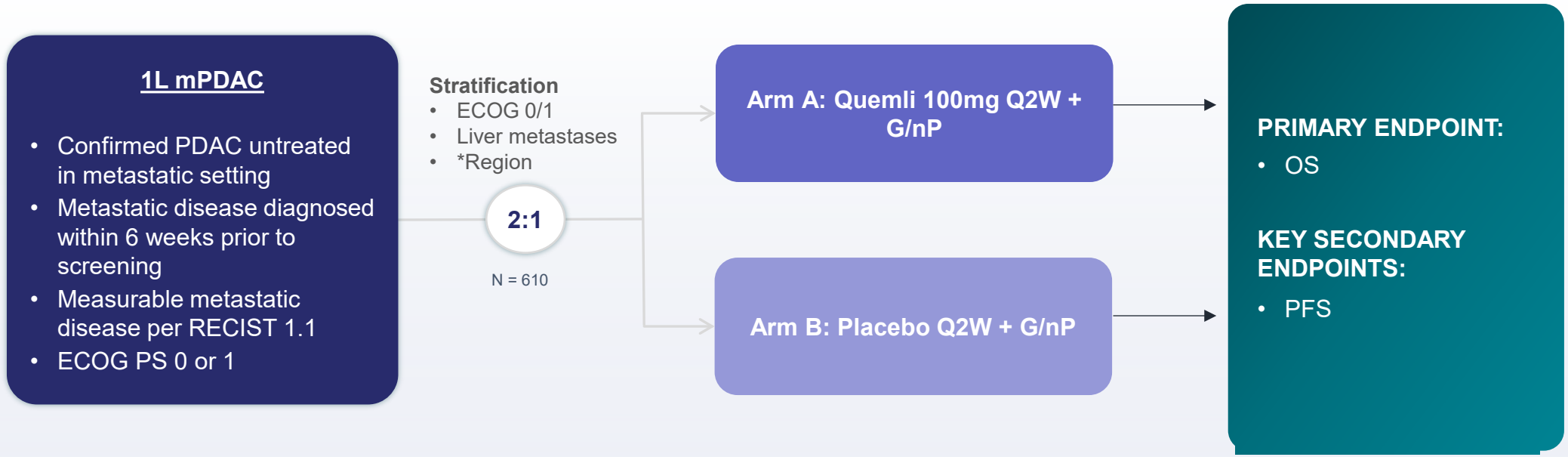
Phase 3 study is ongoing

1. Wainberg ZA, et al. ASCO GI, Jan. 19, 2024, DCO date of June 19, 2023
2. Abraxane USPI, 2020 and Wainberg ZA, Melisi D, Macarulla T, et al. NALIRIFOX versus nab-paclitaxel and gemcitabine in treatment-naive patients with metastatic pancreatic ductal adenocarcinoma (NAPOLI 3): a randomised, open-label, phase 3 trial. Lancet. 2023;402(10409):1272-1281. doi:10.1016/S0140-6736(23)01366-1

1L first-line; DCO: data cut-off; G/nP: gemcitabine/nab-paclitaxel; mOS: median overall survival; PDAC: pancreatic ductal adenocarcinoma; quemli: quemliclustat

PRISM-1

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



RAPIDLY RECRUITING WITH ENROLLMENT COMPLETION EXPECTED BY YE 2025

1L: first-line; ECOG PS: Eastern Cooperative Oncology Group performance status; GnP: gemcitabine/nab-paclitaxel; PDAC: pancreatic ductal adenocarcinoma; OS: overall survival; PFS: progression-free survival; N: number; Q2W: every two weeks; quemli: quemliclustat; YE: year end

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