CytomX® THERAPEUTICS

Unmasking Advances in Oncology

May 2026

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Company Snapshot

Unmasking Advances in Oncology

CytomX® Therapeutics

South San Francisco, CA

PROBODY® Platform: Leading the field of masked therapeutics

Clinical Programs:

- Varsetatug masetecan (EpCAM PROBODY® Topo-1 ADC)* for Colorectal Cancer
- CX-801 (PROBODY® IFN-α2b) for Melanoma

Financials: $347M cash as of Q1 2026; runway to 2nd half of 2028

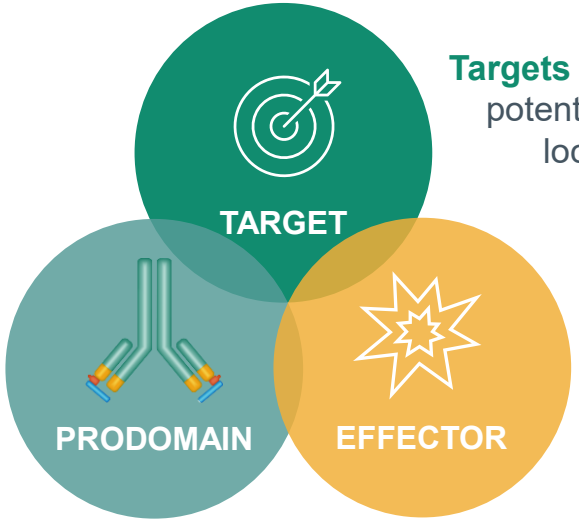
Organization: ~70 employees; integrated R&D capabilities including partnerships with Regeneron, Amgen and Moderna

*Varsetatug masetecan ("Varseta-M") - (formerly CX-2051)

PROBODY® Therapeutic Design

Right Target, Right Tumor, Right Effector Mechanism

Optimized selection of target, pro-domain and effector function



Targets with anti-tumor potential that need localization

Optimized tuning of **masking** to maximize potential therapeutic index

Matching **effector** to target to maximize anti-cancer activity

Industry Leading platform:

- **Proprietary masking technologies**
- **Applicable across multiple modalities**
- **Drives novel pipeline programs**

Varsetatug masetecan
EpCAM PROBODY® ADC

❖ *Lead Indication: Colorectal Cancer*

CX-801
PROBODY® INTERFERON ALPHA-2b

❖ *Lead Indication: Melanoma*

PROBODY® Platform Drives Highly Differentiated Clinical Pipeline

Product Candidate(s)	Indication(s)	Phase 1 / 2	Phase 3 / Registrational
Varseta-M Monotherapy EpCAM Topo-1 ADC	3L+ metastatic CRC (mCRC)	• *Phase 1 Dose Optimization Data in 2H 2026* • *Potential Registrational Study Start in 1H 2027*	
Varseta-M + bevacizumab	2L/3L mCRC	*Initiated in Q1 2026*	
Varseta-M + bevacizumab + chemotherapy[1]	1L/2L mCRC	*Initiating Phase 1 / 2 in 2H 2026*	
Varseta-M	Additional EpCAM+ indications	*Initiating in 2H 2026*	
CX-801 (IFNα2b)	Advanced Melanoma	*Phase 1 Data CX-801 + KEYTRUDA® by 2026 Year-End*	

1. *Chemotherapy combinations including Varseta-M with bevacizumab, 5-fluorouracil, and leucovorin*

Varsetatug masetecan (CX-2051)

A Novel EpCAM-Directed ADC Focused in Colorectal Cancer (CRC)

Antibody Drug Conjugates are Transforming Cancer Care

Varseta-M brings the promise of ADCs to Colorectal Cancer

PADCEV®
enfortumab vedotin-ejfv
Injection for IV infusion 20 mg & 30 mg vials

Nectin-4 / Bladder

Seagen/Pfizer

Varseta-M*
PROBODY® ADC

EpCAM / CRC

CytomX Therapeutics

ENHERTU®
fam-trastuzumab deruxtecan-nxki
20 mg/mL INJECTION FOR INTRAVENOUS USE

HER2 / Breast, Lung**

Daiichi/Astra Zeneca

ELAHERE™
mirvetuximab soravtansine-gynx
injection 100 mg

FRα / Ovarian

Immunogen/AbbVie

TRODELVY®
sacituzumab govitecan-hziy
180 mg for injection

TROP2 / Breast

Immunomedics/Gilead

CytomX THERAPEUTICS

*Varsetatug masetecan is not an approved product and is in an ongoing Phase 1 clinical trial. **Enhertu select indications only. Sources: Company announcements.

Colorectal Cancer Remains One of the Biggest Unmet Needs in Oncology

~1.9M patients per year, increasing to 3M by 2040

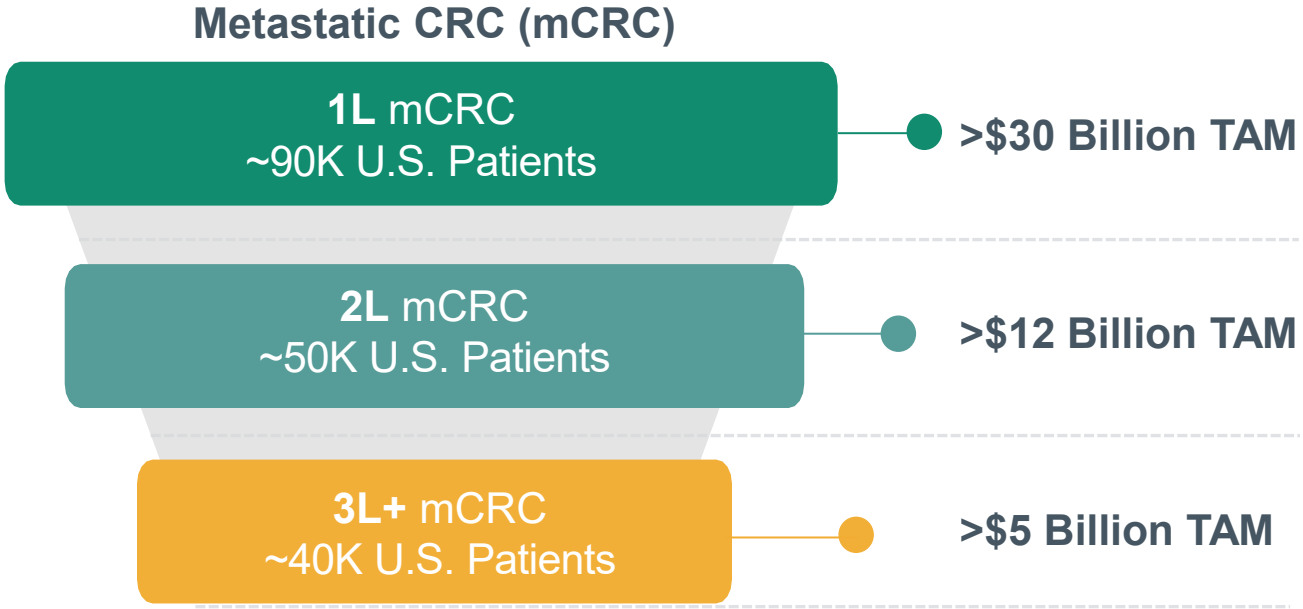
2nd leading cause of cancer death worldwide

5-year survival rate of 13% in mCRC

Abbreviation: mCRC = metastatic colorectal cancer. Sources: World Health Organization, interactive data; Biller and Schrag, 2021, JAMA; American Cancer Society

Varseta-M has the Potential to Address a Large Patient Population due to Broad and Consistent EpCAM Expression in CRC

By 2035 U.S. CRC Diagnosed Incidence Estimated to be 165K Patients Annually

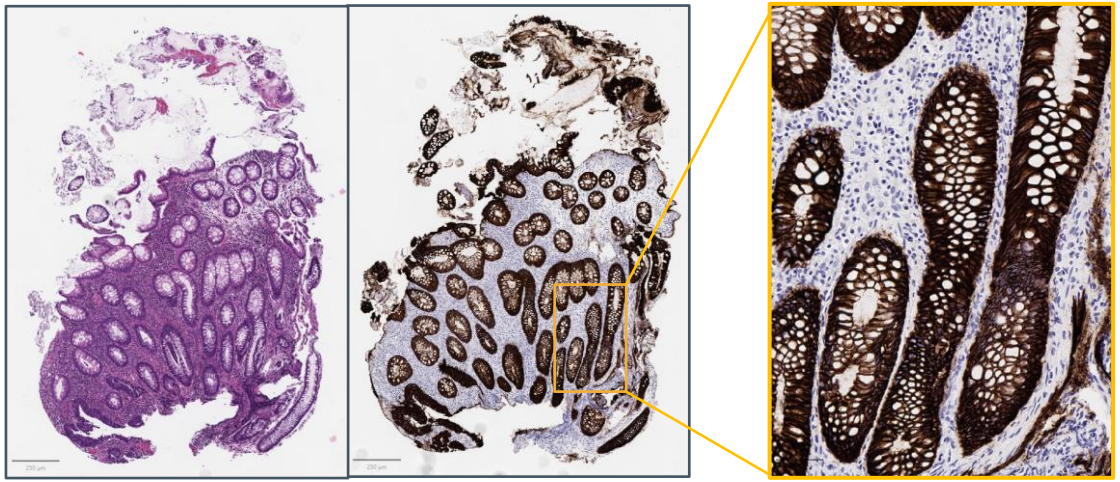


Sources and assumptions: 2035 DRG epidemiology and company estimates regarding pricing assumptions based on approved ADCs; estimated duration of treatment based on mCRC standard of care
Abbreviations: TAM=Total Addressable Market

EpCAM (Epithelial Cell Adhesion Molecule)

An ideal CRC target enabled by the CytomX PROBODY® platform

H&E Staining **EpCAM IHC**



IHC Staining of CRC Patient Biopsy from Ongoing Phase 1 Study

Maximum H-score of 300 (100% cells 3+ by IHC)

- **Uniformly high expression across CRC**
- **EpCAM expression across all stages of CRC**

Abbreviations: IHC = immunohistochemistry; H&E = hematoxylin and eosin. Source: CytomX Internal Data, CTMX-2051-101 Study Patient Biopsy.

EpCAM Has Been Clinically Validated But Not as a Systemic Therapy

Expression in normal tissue limited prior therapeutic approaches

EpCAM is clinically validated with a locally administered therapy

KORJUNY® (catumaxomab): EpCAM x CD3

- Delivered by intraperitoneal infusion
- Approved by EMA for treatment of malignant ascites
- Launched in Germany in December 2025

Pharmanovia

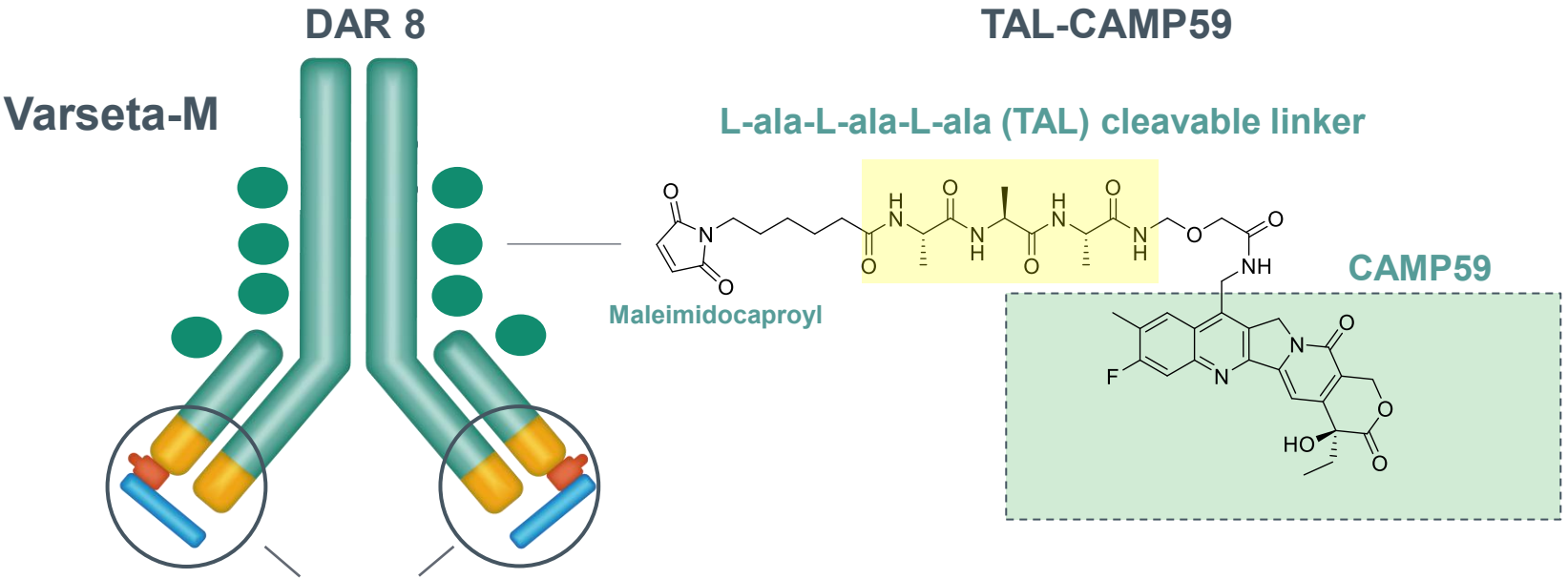
Systemic EpCAM approaches have been limited by toxicity

Asset	Company	MOA	Stage	Status
Solitomab	Amgen	EpCAM x CD3 BiTE	Ph 1	GI tox; liver tox discontinued
ING-1	XOMA	EpCAM mAb	Ph 1	Pancreatitis; discontinued
3622W94	GSK	EpCAM mAb	Ph 1	Pancreatitis; discontinued

Sources: Pharmanovia.com; de Bono et. All; de Bono et al. 2004; Gires et al. 2020

Varsetatug masetecan: A Novel EpCAM Targeting PROBODY ® ADC

The Right Target, The Right Payload



- ***EpCAM is abundant in CRC but previously undruggable due to normal tissue expression***
- ***CytomX protease cleavable masking platform reduces EpCAM binding in normal tissues***
- ***Masetecan Topo-1 payload selected to drive anti-tumor activity in CRC***

Abbreviations: DAR = drug antibody ratio.Varseta-M antibody and linker-payload licensed through collaboration with Immunogen.

The Current Standard of Care in 3L+ Metastatic CRC Is Highly Inadequate

Current therapies have poor response rates and limited survival benefit

Treatment	Treatment Line	ORR (%)	DCR (%)	Median PFS (months)	Median OS (months)
Fruquintinib	3L/4L+	2%	56%	3.7	7.4
Regorafenib	3L/4L+	1%	41%	2.0	6.4
Trifluridine/tipiracil	3L/4L+	2%	44%	2.0	7.1
Trifluridine/tipiracil + *Bevacizumab*[1]	3L	6%	77%	5.6	10.8

[1]*SUNLIGHT study total patients; Patients previously treated with prior bevacizumab had median PFS of 4.5 months and OS of 9.0 months*

Abbreviations: DCR = disease control rate; ORR = overall response rate; OS = overall survival; PFS = progression free survival.
Sources: Lonsurf® (trifluridine and tipiracil) Fruzaqla® (fruquintinib), Stivarga® (regorafenib) package inserts; Dasari et al. 2023; Grothey et al. 2013; Prager et al. 2023.

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.

Varseta-M Interim Phase 1 Dose Expansion Data

Presented March 16, 2026

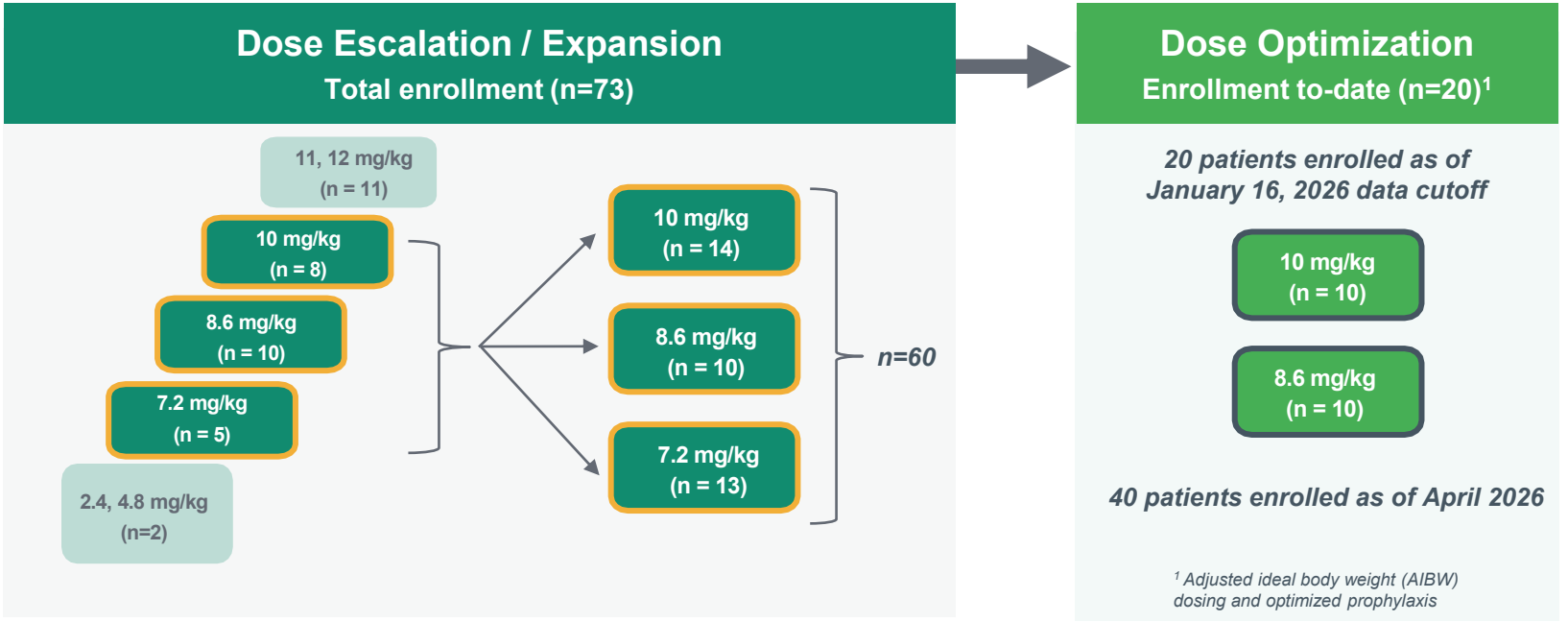
Varseta-M Phase 1 Study Focused in Metastatic Late-Line CRC

93 late-line mCRC patients enrolled as of the January 16, 2026 data cutoff

Phase 1 Study Overview:

- Phase 1 Dose Escalation (began April 2024); Dose Expansions (began May 2025); Dose Optimization (began October 2025)

Patient Enrollment: mCRC patients unselected for EpCAM expression; All doses Q3W



Varseta-M Phase 1 Baseline Characteristics

Heavily pre-treated advanced CRC population

Baseline Characteristics	n=93 n (%)
ECOG status:	
0	42 (45)
1	51 (55)
Site of primary tumor:	
Colon, Left	33 (36)
Colon, Right	23 (25)
Rectum	28 (30)
Liver metastases	71 (76)
KRAS mutation	66 (71)
MSS*	79 (85)
Number of prior lines of anti-cancer therapy:	
1	4 (4)
2	13 (14)
3	30 (32)
≥4	46 (49)
Prior therapies:	
Prior irinotecan	89 (96)
Prior VEGF inhibitor	77 (83)
Prior EGFR inhibitor	32 (34)
Prior Lonsurf + bevacizumab	27 (29)

Abbreviations: MSS = microsatellite stable

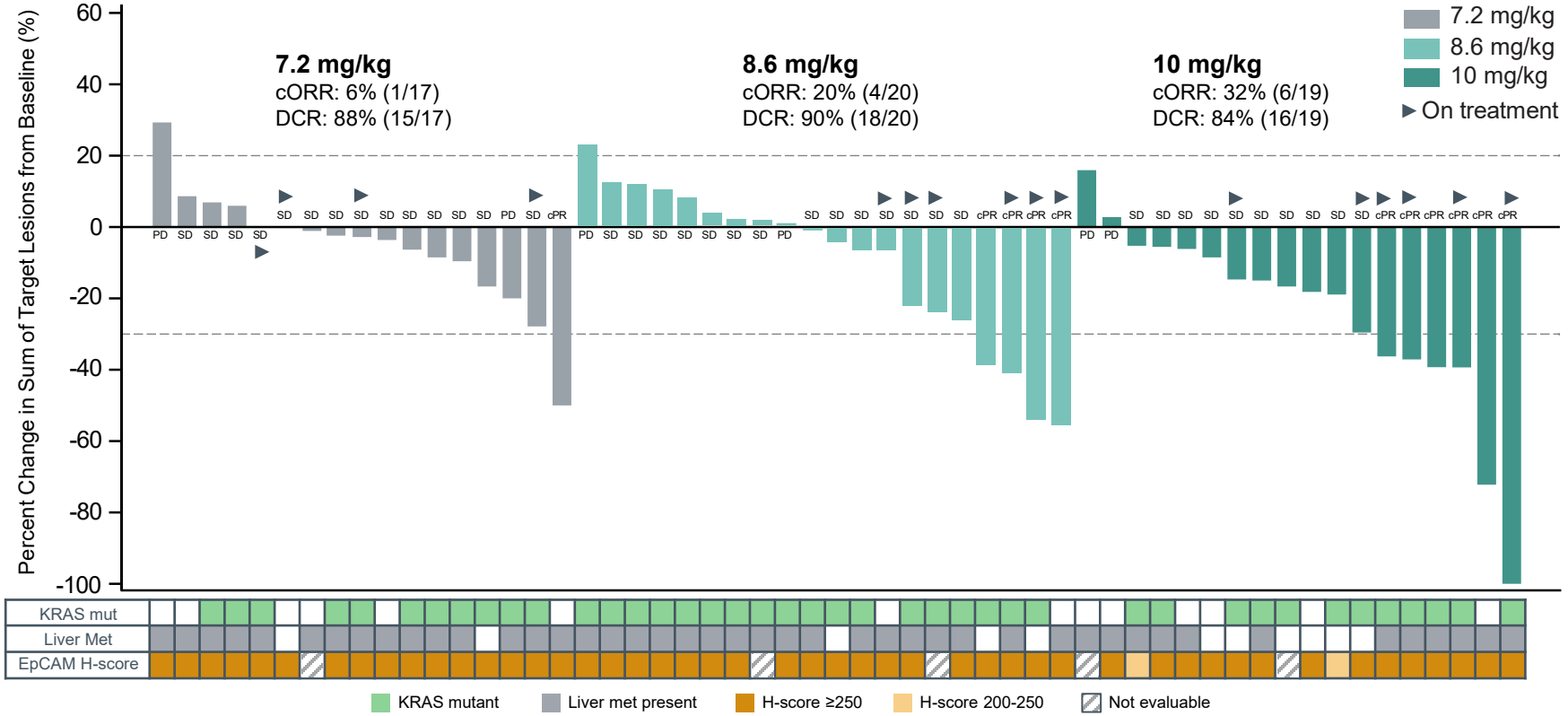
**1 patient microsatellite instability (MSI) High; 13 unknown MSS status*

CytomX Therapeutics

Data cutoff 1/16/2026

Robust Anti-Tumor Activity Confirmed at Varseta-M Expansion Doses

20% to 32% confirmed ORR at doses prioritized for late-phase development

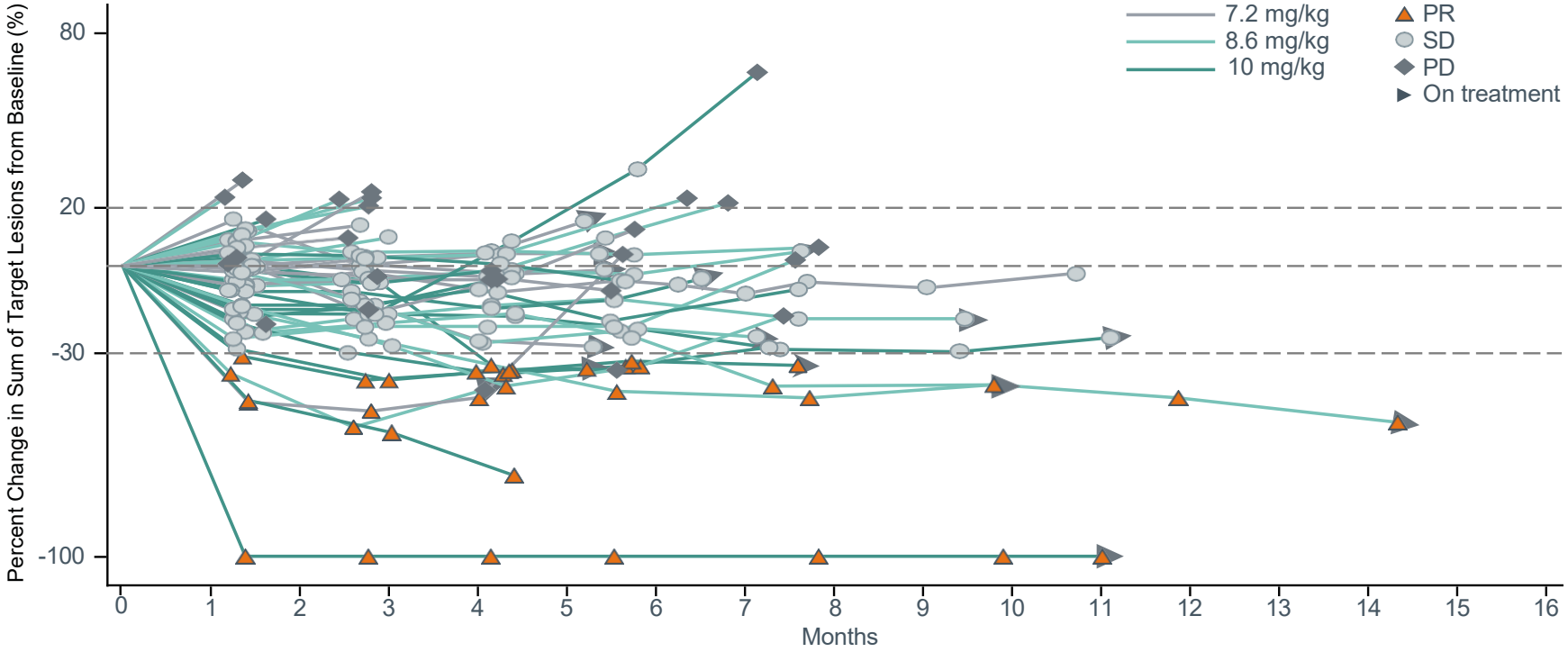


Abbreviations: cORR=Confirmed Overall Response Rate; DCR: Disease Control Rate

Data cutoff 1/16/2026

Durable Disease Control Observed Across Varseta-M Expansion Doses

Median follow-up of 8 months

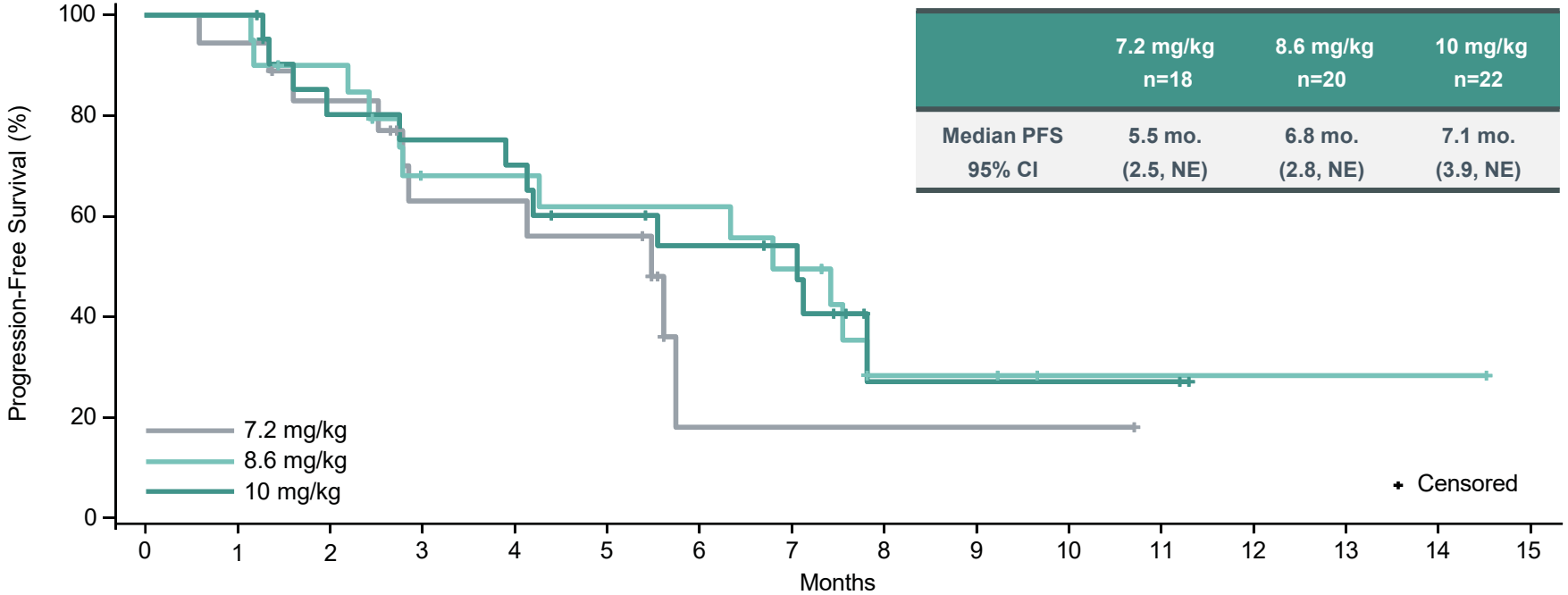


CytomX Therapeutics

Data cutoff 1/16/2026

Preliminary PFS Exceeded Standard of Care Across Expansion Doses

7.1 months at 10 mg/kg and 6.8 months at 8.6 mg/kg



	7.2 mg/kg n=18	8.6 mg/kg n=20	10 mg/kg n=22
Median PFS 95% CI	5.5 mo. (2.5, NE)	6.8 mo. (2.8, NE)	7.1 mo. (3.9, NE)

Number at risk

7.2 mg/kg	18	17	14	9	9	8	1	1	1	1	1	0		
8.6 mg/kg	20	20	17	11	11	10	10	8	3	3	1	1	1	1
10 mg/kg	22	22	16	15	14	11	9	8	2	2	2	2	0	

CytomX Therapeutics

Data cutoff 1/16/2026

Safety Profile Optimization: Key Observations and Learnings

Varseta-M positioned for late-phase dose selection

Dose Escalation
2.4 – 12 mg/kg

- No DLTs, ILD, pancreatitis or liver toxicity
- Low rates of hematological toxicity
- Diarrhea identified as the main AE of interest

Dose Expansion
7.2 – 10 mg/kg

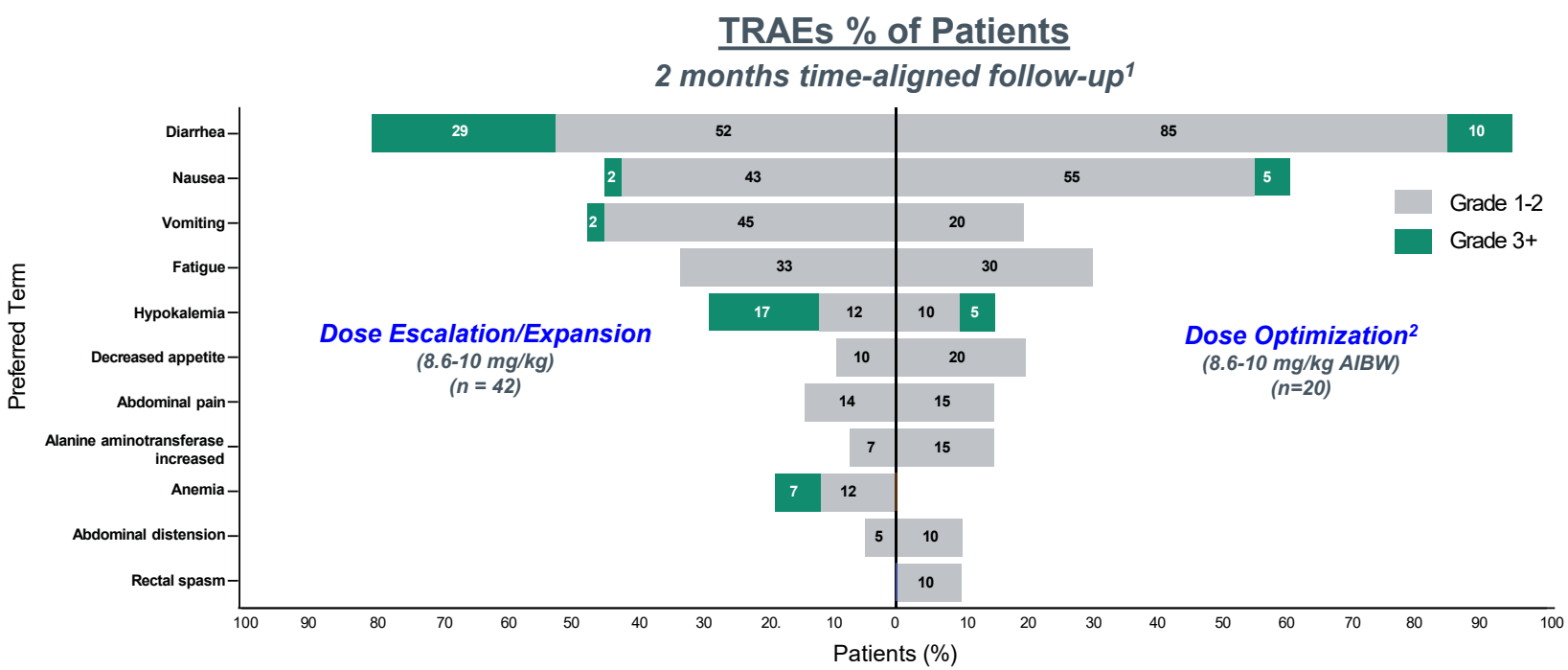
- No new safety signals
- Early experience with loperamide prophylaxis and budesonide treatment[1]
- PK analysis supports reduced variability with AIBW dosing

Dose Optimization
8.6 – 10 mg/kg

- Mandatory loperamide + budesonide prophylaxis
- Adjusted ideal body weight (AIBW) based dosing
- Reduced GI toxicity observed

1. In Dose Expansion, 12 of 14 patients treated with budesonide after the onset of diarrhea experienced at least a 1 grade decrease.

Preliminary Dose Optimization Results Support Improved Safety Data



- ***Median onset of Gr 3 diarrhea events in study to date: 4.9 weeks[2]***

1. *TRAEs >= 10% in patients occurring within two months of treatment initiation among patients with ≥2 months follow-up or who discontinued treatment earlier*
2. *Based on 1/16/2026 data cutoff in patients (n=80) treated across dose range of 7.2 – 10 mg/kg*

CytomX Therapeutics

Most Frequent Treatment-Related Adverse Events (TRAEs) Observed in Phase 1 at Expansion/Dose Optimization Cohorts 7.2 – 10 mg/kg[1]

Preferred Term, n (%)	7.2 mg/kg (n = 18)*		8.6 mg/kg (n = 30)[1]		10 mg/kg (n = 32)[1]		Overall (n = 80)[1]	
	All grade	Grade ≥3	All grade	Grade ≥3	All grade	Grade ≥3	All grade	Grade ≥3
Hematologic Adverse Events (in > 3 patients)								
Anemia	1 (6)	1 (6)	5 (17)	2 (7)	7 (22)	3 (9)	13 (16)	6 (8)
Neutropenia	2 (11)	2 (11)	0 (0)	0 (0)	2 (6)	0 (0)	4 (5)	2 (3)
Neutrophil Count Decrease	1 (6)	0 (0)	2 (7)	1 (3)	1 (3)	0 (0)	4 (5)	1 (1)
Non-Hematologic Adverse Events (in ≥ 10% of patients)								
Diarrhea	13 (72)	2 (11)	27 (90)	9 (30)	28 (88)	8 (25)	68 (85)	19 (24)
Nausea	12 (67)	2 (11)	13 (43)	0 (0)	19 (59)	2 (6)	44 (55)	4 (5)
Vomiting	6 (33)	2 (11)	9 (30)	0 (0)	14 (44)	1 (3)	29 (36)	3 (4)
Fatigue	8 (44)	2 (11)	10 (33)	0 (0)	14 (44)	0 (0)	32 (40)	2 (3)
Hypokalemia	5 (28)	4 (22)	6 (20)	3 (10)	10 (31)	6 (19)	21 (26)	13 (16)
Abdominal pain	1 (6)	0 (0)	4 (13)	0 (0)	8 (25)	0 (0)	13 (16)	0 (0)
Decreased Appetite	2 (11)	0 (0)	5 (17)	0 (0)	4 (13)	0 (0)	11 (14)	0 (0)
Hypomagnesaemia	3 (17)	0 (0)	3 (10)	0 (0)	3 (9)	0 (0)	9 (11)	0 (0)
Dehydration	3 (17)	0 (0)	3 (10)	2 (7)	3 (9)	1 (3)	9 (11)	3 (4)
Number of Patients with Serious TRAE	4 (22)		6 (20)		10 (31)		20 (25)	
Dose Reduction due to TRAE	3 (17)		7 (23)		7 (22)		17 (21)	
Discontinuation due to TRAE	2 (11)		2 (7)		5 (16)		9 (11)	

1. 8.6 and 10 mg/kg doses include patients dosed based on actual body weight and adjusted ideal body weight (AIBW). AIBW dosing utilized at 8.6 mg/kg (n=10) and 10 mg/kg (n=10).

**As reported in Aug 2025, one Grade 5 (Gr5) treatment-related acute kidney injury occurred in a patient treated at the 7.2 mg/kg dose with a complex medical history including having a solitary kidney. No other Gr 5 TRAEs reported as of the 1/16/2026 data cutoff.*

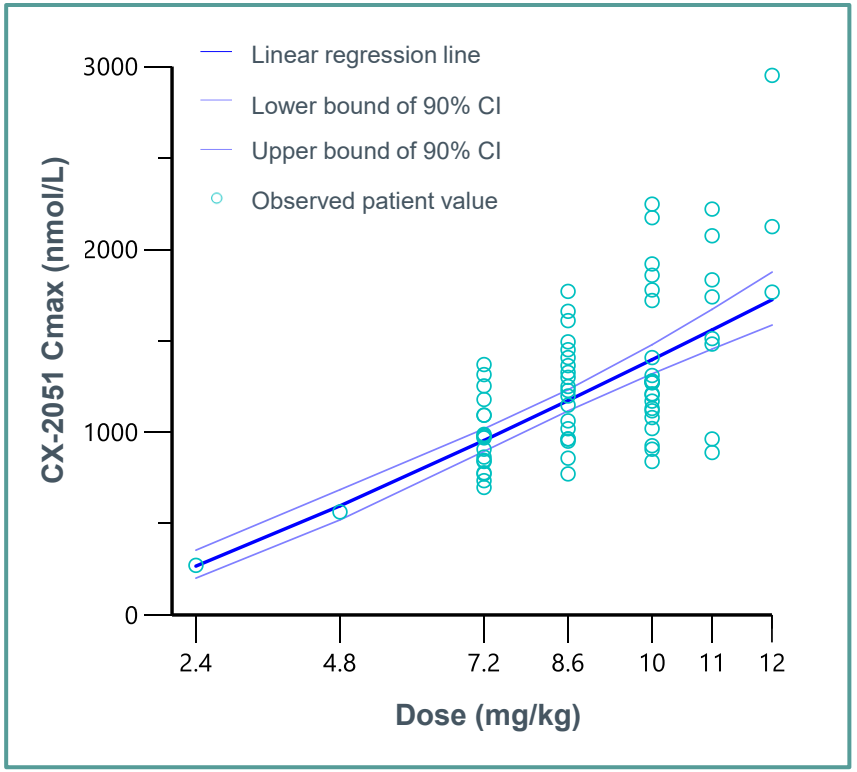
Varseta-M Demonstrated Expected Pharmacokinetics

Data from Phase 1 Escalation/Expansion prior to dose optimization (AIBW)

Pharmacokinetic Profile Summary

- Dose-proportional
- Circulates primarily in masked form
- Mean half-life 6-8 days
- Unconjugated payload ~1-3% of total

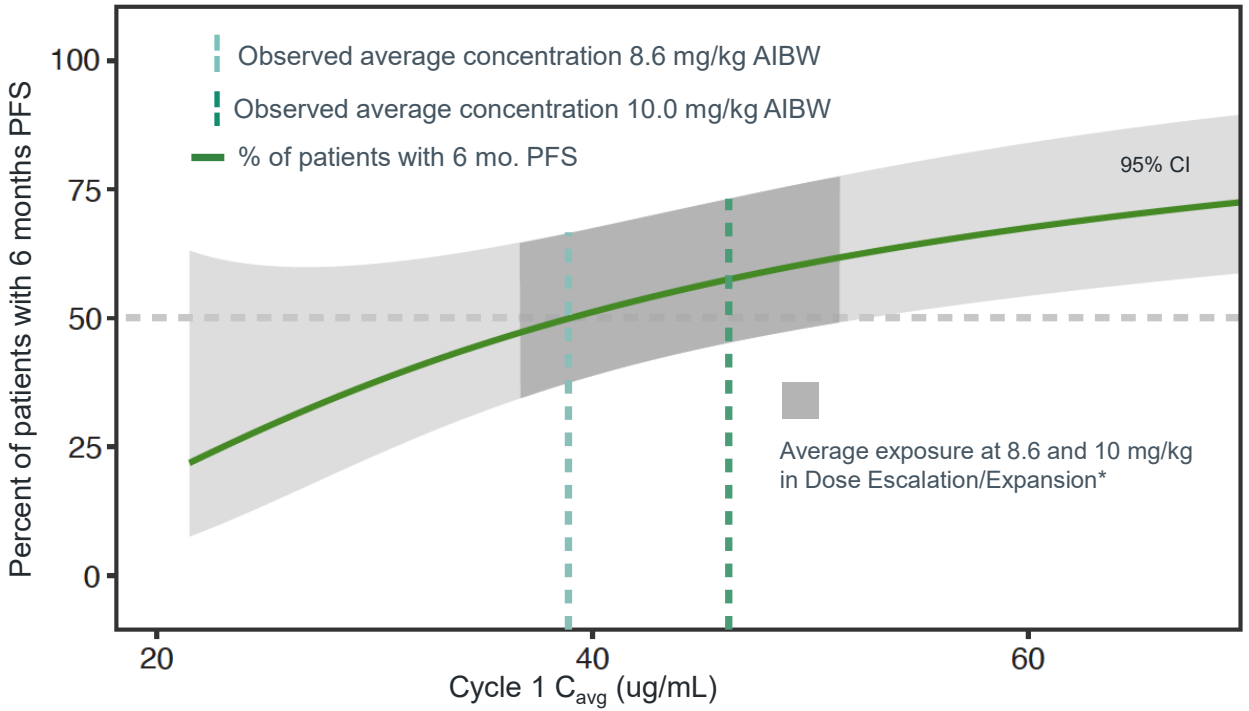
Cmax in Dose Escalation/Expansion (n=73)



PK data from dose escalation and expansion patients
Abbreviations: CI=Confidence Interval

Varseta-M Phase 1 Exposure-Response Analysis Supports >6 months PFS at Optimized Doses of 8.6 and 10 mg/kg AIBW

Exposure-Response Model[1]



1. Efficacy Model on PFS based on clinical data through 10-27-2025
** Interquartile range of Cavg for 8.6 and 10.0 mg/kg*

Phase 1 Interim Data Update Supports Varseta-M Potential to Change Standard of Care in Unselected Late-Line CRC

Robust Clinical Activity in Larger Patient Population

- Confirmed ORR of 32% at 10 mg/kg and 20% at 8.6 mg/kg
- Preliminary PFS of 7.1 months at 10 mg/kg and 6.8 months at 8.6 mg/kg

Safety Data Continue to be Encouraging

- Favorable hematological profile and no ILD as of data cutoff
- Grade 3 diarrhea rate of 10% in ongoing dose optimization cohorts[1]

Advancing Towards Registrational Study

- FDA interactions targeted for mid-2026 with goal to align on potential registrational trial
- Additional Phase 1 data to be presented at medical meeting in 2H 2026

Abbreviations: ILD= interstitial lung disease

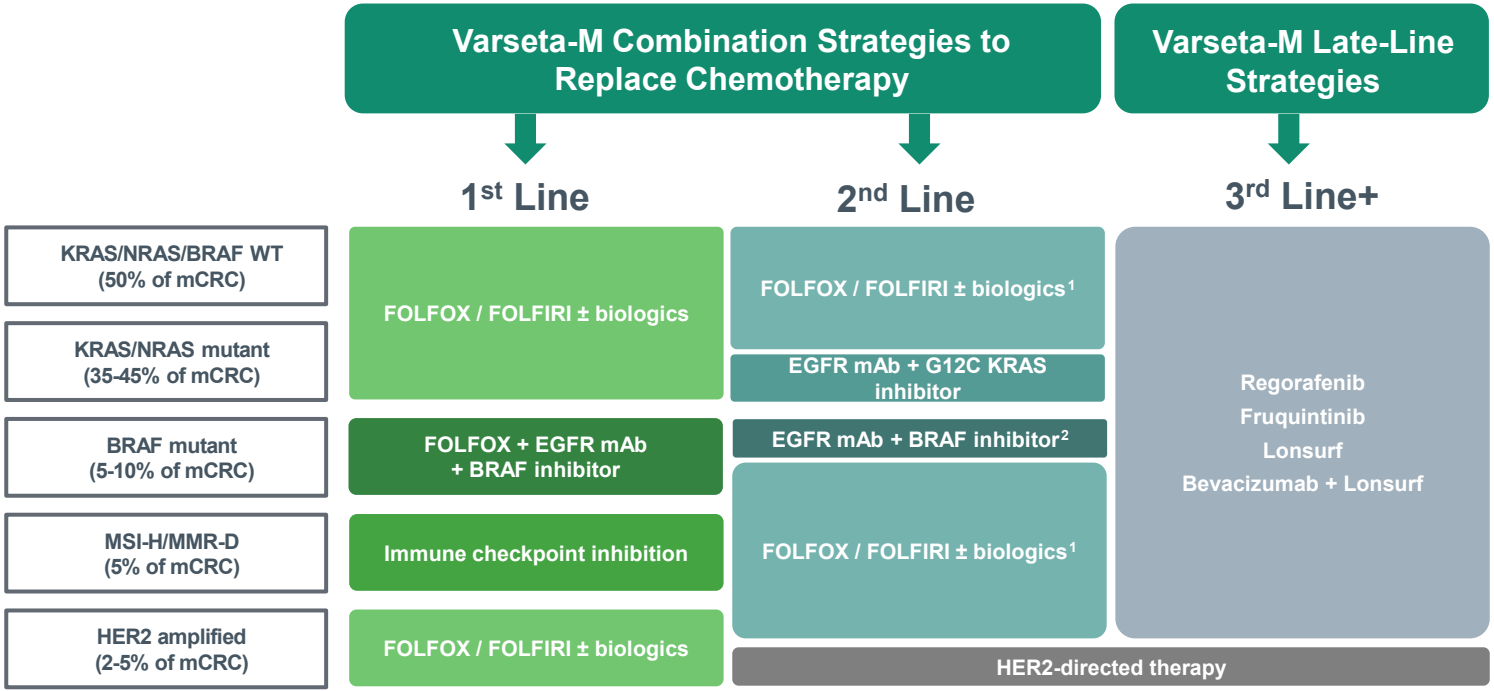
1. Based on March 2, 2026 data snapshot in 20 patients treated at 8.6 and 10 mg/kg AIBW dosing and updated prophylaxis regimen of anti-motility medication plus budesonide.

Data cutoff 1/16/2026

Varseta-M Development and Milestones

Broad Development Opportunity for Varseta-M in Metastatic CRC

Potential across the treatment paradigm as monotherapy and in combinations



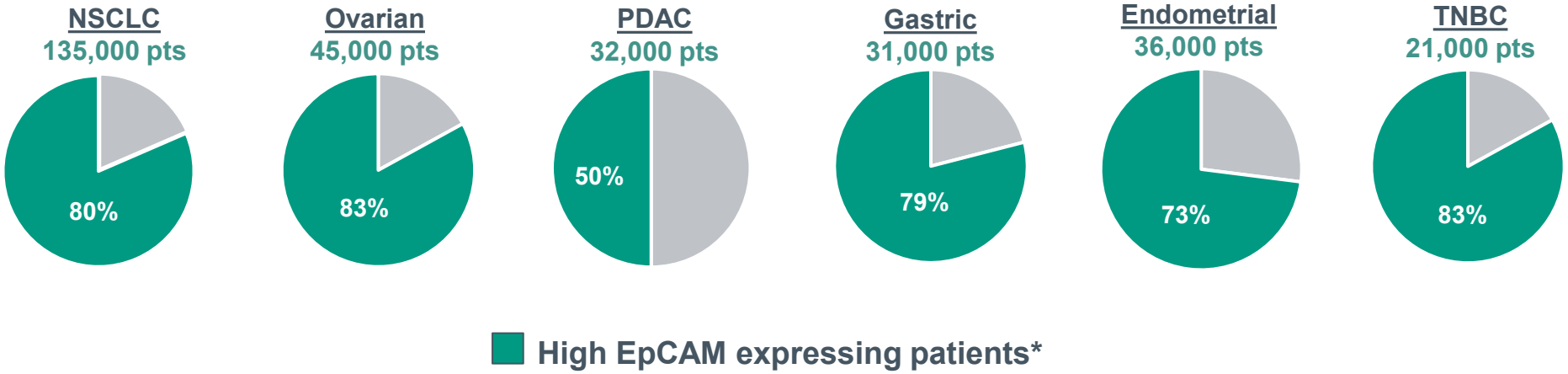
[1] Whichever regimen that was not previously given in 1L. [2] If BRAF inhibitor not previously given in 1L.
Abbreviations: FOLFIRI = fluorouracil, folinic acid, irinotecan; FOLFOX = fluorouracil, folinic acid, oxaliplatin. mAb = monoclonal antibody.
Adapted from Biller and Schrag, 2021

CytomX Therapeutics

Beyond CRC: Varseta-M is a “Pan-Tumor” Opportunity

EpCAM is broadly expressed in many solid tumors in addition to CRC

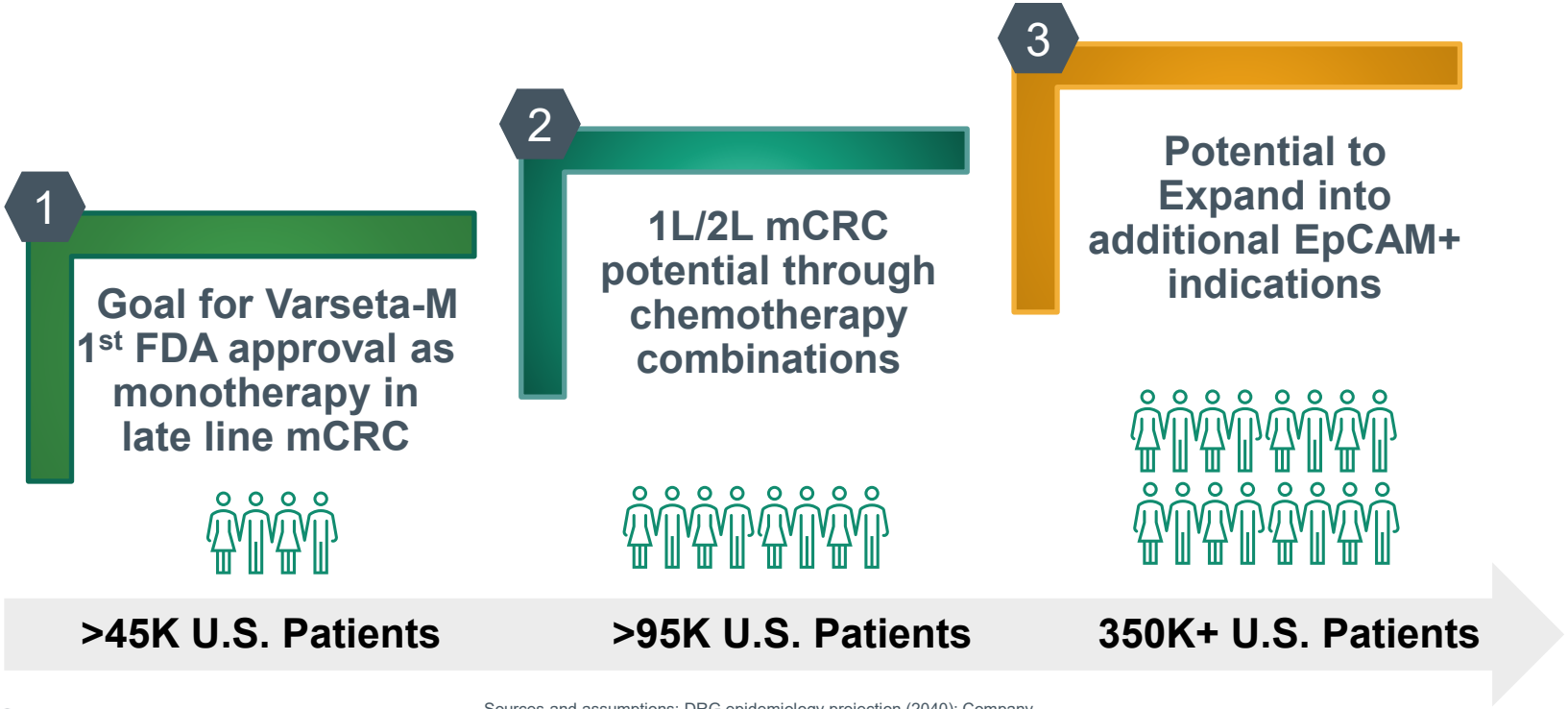
Select Non-CRC EpCAM Addressable Patients in U.S.



Sources: *CytomX Internal prevalence study, ≥50% cells with 2+/3+ EpCAM Intensity or >10% 3+; 2029 Drug-treatable patient by tumor type from DRG.

Varseta-M is a Differentiated, Potentially First-in-Class ADC Positioned to Address a Broad EpCAM+ Patient Population

Unlocking Multiple Layers of Value Creation



Sources and assumptions: DRG epidemiology projection (2040); Company estimates on CRC incidence growth, treatable patients in mCRC, other indications

CX-801 PROBODY® IFNα-2b

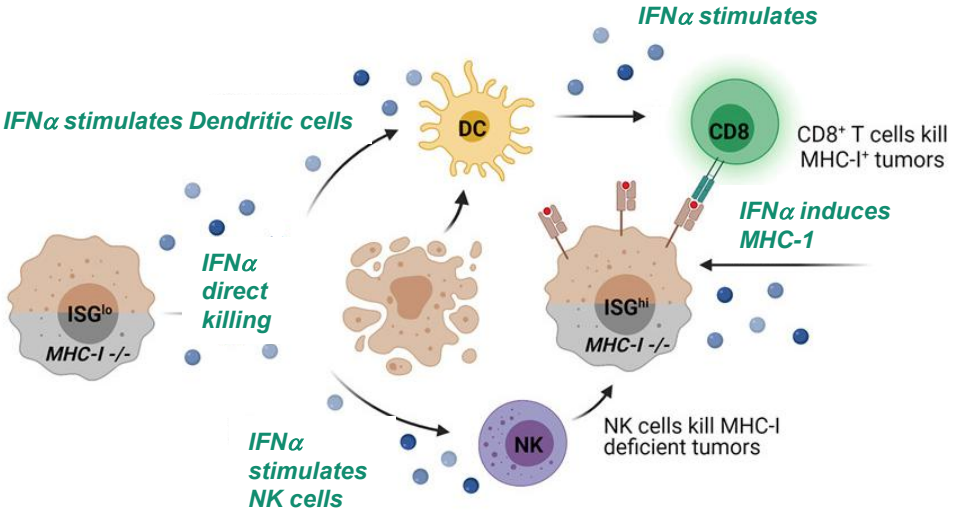
A Novel Immunotherapy Focused in Melanoma

IFNα-2b is a Powerful Cancer Immunotherapy With Ideal Properties to Combine with Checkpoint Inhibitor Therapy

Why IFNα-2b?

IFNα-2b Mechanism of Action

- Kills cancer cells directly leading to immunogenic cell death
- Stimulates antigen presenting cells to activate tumor-reactive T cells
- Modulates NK, stromal and vascular cells
- Approved for treating melanoma (Sylatron™), renal (Avastin® + IFN), and bladder cancer (Adstiladrin®)
- Potential to treat checkpoint resistant / refractory indications



Adapted from Green et al., Mol. Ther. Onc. 2021

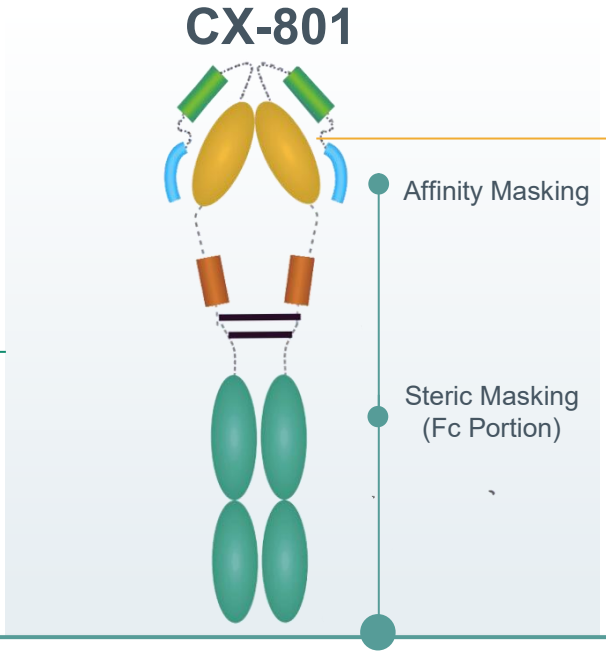
CX-801: Dually-Masked, Conditionally Activated PROBODY® IFNα2b

TARGET

Validated, High Potential Target

- Approved immunotherapy in multiple tumors
- Enhanced anti-cancer activity in combination with PD-1
- Limited clinical use due to poor tolerability

PRODOMAIN



EFFECTOR

IFNα2b

- Dual-mechanism of action
- Proven single agent activity
- Increases APCs to enhance PD-1 blockade

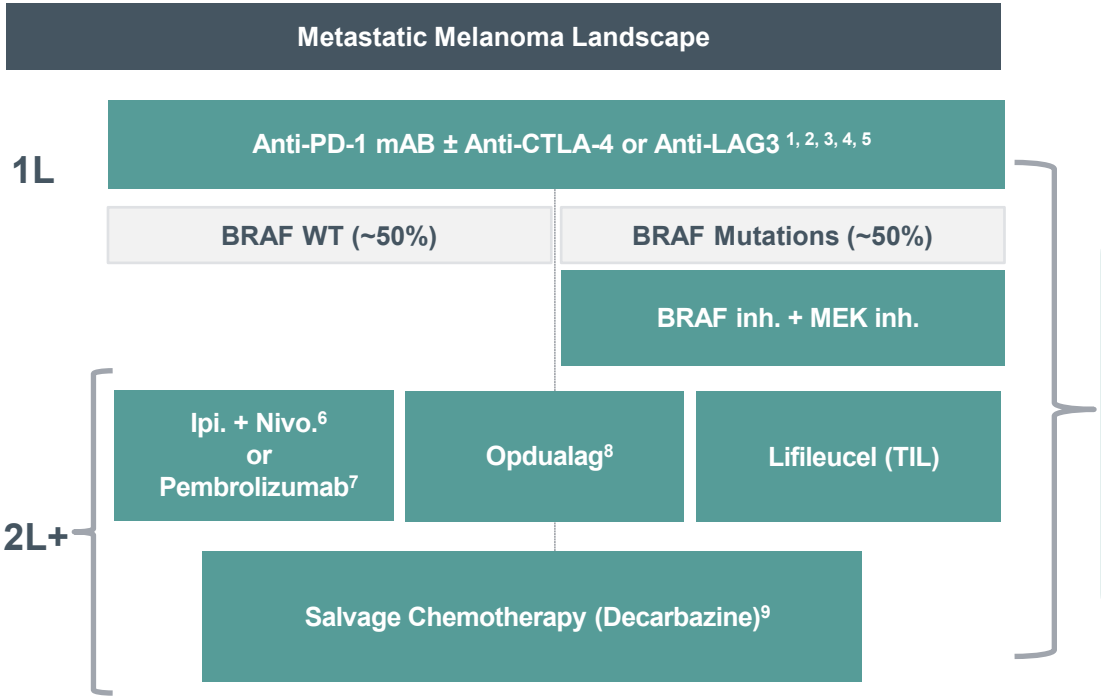
Masking & Substrates Design Strategy

- Dual-masking strategy with steric and affinity mask (peptide)
- 1000X masking efficiency based on preclinical models

CytomX Therapeutics

High Unmet Need in PD-1 Refractory Melanoma Patients

CX-801 has potential to enhance responsiveness to checkpoint inhibitors



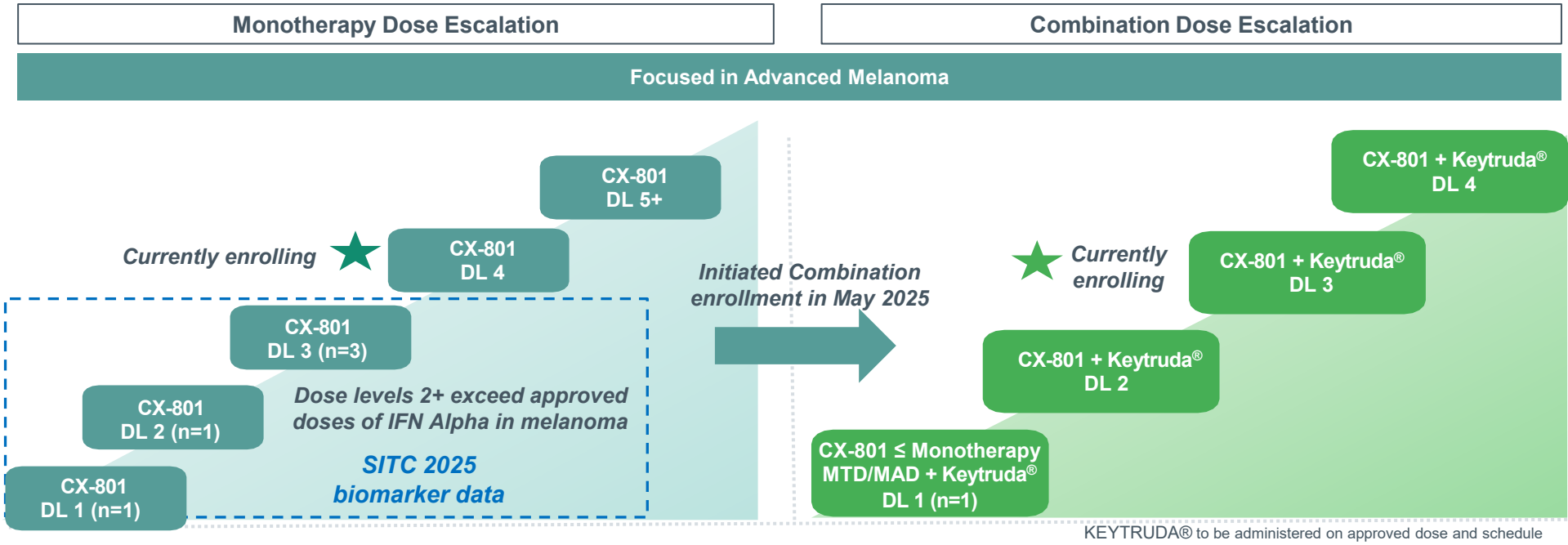
CX-801 Development Opportunities in Melanoma

- **Combine with anti-PD-1 inhibitors in post-PD-1 setting**
  - Improve on activity of PD-1 inhibitors (7% ORR)[9]
  - Safe and tolerable alternative to TIL therapy
- **Novel IO combinations to enhance activity in earlier-line settings**

[1] Robert et al. 2015; [2] Robert et al. 2023; [3] Tawbi et al. 2022; [4] Wolchock et al. 2017; [5] Wolchock et al.2022; [6] VanderWalde et al.; [7] Olson et al. 2021 2023; [8] Ascierto et al. 2023; [9] Robert et al. 2011

CytomX Therapeutics

Phase 1 Dose Escalation is Designed to Assess CX-801 Clinical Profile as Monotherapy and in Combination with KEYTRUDA®



KEYTRUDA® to be administered on approved dose and schedule

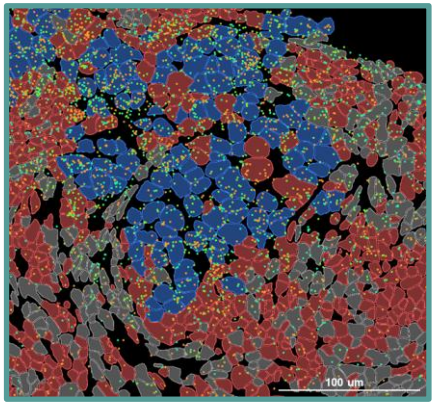
- **Combination dose escalation commenced in May 2025**
- **Initial biomarker data presented at SITC 2025**
- **Phase 1 CX-801 + Keytruda® combination data by the end 2026**

Source: Package Insert - SYLATRON™

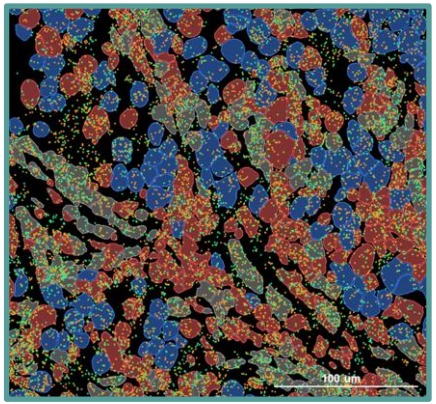
CX-801 Monotherapy Shows Intended MOA in Tumor Biopsies

Strong induction of interferon stimulated genes in multiple cell types

Baseline



On-Treatment

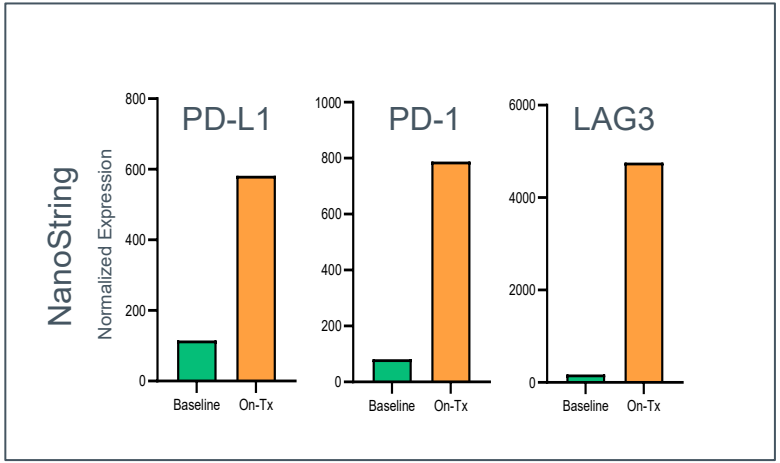


Cell Type

- Melanoma Cells
- Immune Cells
- Stromal Cells

ISG Transcript	Transcript Count Baseline	On-Tx
ISG15	1,061	2,886
MX1	1,185	5,189
IFIT3	882	2,602

Induction of Checkpoint Gene Expression



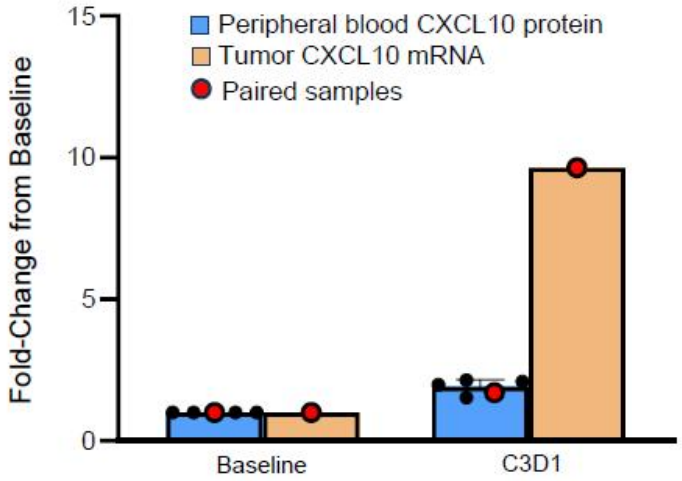
Checkpoint gene expression represented by PD-L1, PD-1, and LAG3 induced by CX-801 measured by NanoString platform (RNA).

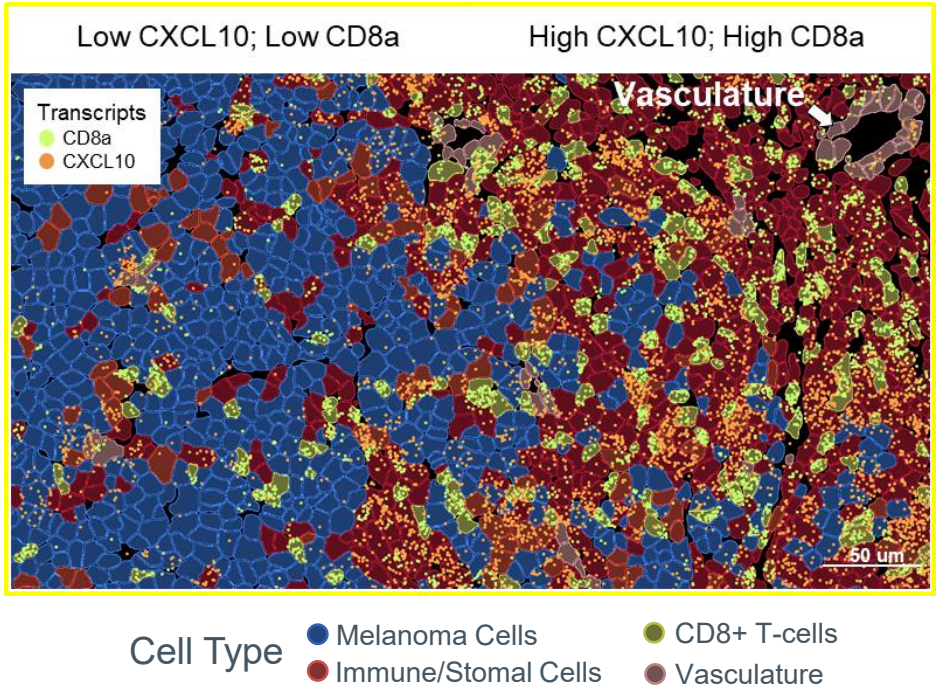
CytomX Therapeutics

40th ANNIVERSARY sitc 2025 Society for Immunotherapy of Cancer Nov. 5–9 | National Harbor, MD

CX-801 Promotes Chemokine Induction in the Tumor Microenvironment Driving Lymphocyte Infiltration into Tumor Tissue

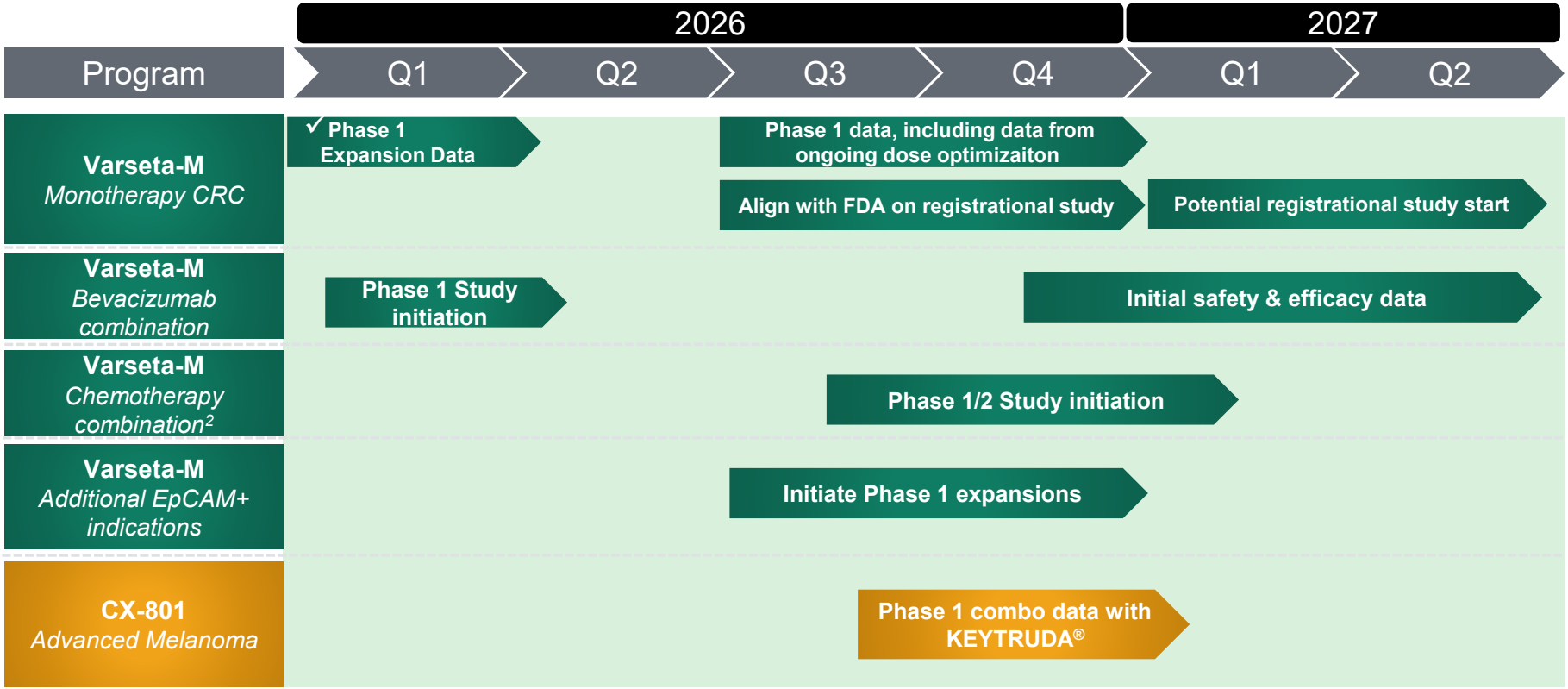
CX-801 Activates Cytotoxic T-cells





Milestones and Outlook

Multiple Milestones Anticipated Over Next 12 to 18 Months[1]



1. *Reflects current expectations, subject to change*
2. *Chemotherapy combinations including Varseta-M with bevacizumab, 5-fluorouracil, and leucovorin*