Black Diamond Therapeutics (BDTX)

Advancing silevertinib: a potential best-in-class EGFR TKI for patients with NSCLC and GBM

BLACK DIAMOND THERAPEUTICS

November 10, 2026

Forward-Looking Statements

This presentation contains forward looking statements of Black Diamond Therapeutics, Inc. ("we," "us," "our") within the meaning of the Private Securities Litigation Reform Act of 1995. Forward looking statements include all statements that are not historical facts, and in some cases, can be identified by terms such as "may," "might," "will," "could," "would," "should," "expect," "intend," "plan," "objective," "anticipate," "believe," "estimate," "predict," "potential," "continue," "ongoing," or the negative of these terms, or other comparable terminology intended to identify statements about the future. Forward looking statements contained in this presentation include, but are not limited to, statements regarding our future financial or business performance, conditions, plans, prospects, trends or strategies and other financial and business matters; the potential of silevertinib, including its potential to be a best-in-class EGFR tyrosine kinase inhibitor and to address unmet medical need in patients with non-small cell lung cancer ("NSCLC") and glioblastoma ("GBM"); the CNS activity of silevertinib, including its potential to delay CNS progression; the timing and advancement of our current and planned clinical trials, including the submission of data from Cohort 4 of our Phase 2 trial in NSCLC to the U.S. Food and Drug Administration (the "FDA"), the initiation, design and conduct of our planned Phase 3 trial in frontline NSCLC, the enrollment and conduct of our randomized Phase 2 trial in newly diagnosed GBM, and the timing of data readouts from these trials; the timing and outcome of interactions with the FDA, including FDA feedback on registrational trial design and dose selection; the potential for accelerated or full regulatory approval of silevertinib, the timing of any related marketing applications and potential compendia listing; our ability to replicate results achieved in our preclinical studies or clinical trials, including the risk that interim or preliminary data may change as more patient data become available; research and development costs; the estimated addressable patient populations and market opportunities for silevertinib and its potential to expand into additional patient populations and lines of therapy; the competitive landscape and market for our product candidates; our ability to maintain our intellectual property portfolio; the timing and success of our development and commercialization of our product candidates, including our ability to establish and maintain collaborations or strategic relationships; and our estimates of the capital required to fund our development programs through specified milestones, our expected cash runway and the sufficiency of our capital resources. New risks and uncertainties may emerge from time to time, and it is not possible to predict all risks and uncertainties.

Except as required by law, we assume no obligation to update these forward-looking statements publicly, or to update the reasons actual results could differ materially from those anticipated in the forward-looking statements, even if new information becomes available in the future. For a discussion of these and other risks and uncertainties, and other important factors, any of which could cause our actual results to differ from those contained in the forward-looking statements, see the section entitled "Risk Factors" in our most recent annual report on Form 10-K filed with the Securities and Exchange Commission (the "SEC"), as well as discussions of potential risks, uncertainties, and other important factors in our other subsequent filings with the SEC. In addition, we have not conducted any head-to-head studies comparing our product candidates to any third-party drug products or candidates, whether investigational or approved. Information regarding other drug products in this presentation is meant to provide context for illustrative purposes only. Because there are no head-to-head studies, no conclusions should be made based on cross study comparisons. Recipients are cautioned not to place undue reliance on these forward-looking statements, which speak only as of the date such statements are made and should not be construed as statements of fact.

This presentation also contains information using industry publications that generally state that the information contained therein has been obtained from sources believed to be reliable, but such information may not be accurate or complete. While we are not aware of any misstatements regarding the information from these industry publications, we have not independently verified any of the data from third party sources nor have we ascertained the underlying economic assumptions relied on therein.

Silevertinib: Advancing a Potential Best-in-Class CNS-Penetrant EGFR TKI for NSCLC and GBM

Silevertinib's key differentiators designed to address significant unmet medical need



Broad EGFR mutational coverage: both classical and non-classical mutations (NCMs)

Potential best-in-class CNS activity: opportunity to benefit patients with NSCLC and GBM

A clear path to registrational trial initiation in 1L NSCLC, with potential for accelerated approval



Robust updated Phase 2 results and FDA feedback support potential for accelerated approval

FDA feedback received on broad patient population, endpoints, and dose justification

$2bn+ market with potential to expand patient populations and lines of therapy



Planning Phase 3 1L NSCLC trial with potential initiation in Q2 2027

Randomized Phase 2 trial in ND GBM currently enrolling

Multiple catalysts anticipated across 1L NSCLC and ND GBM in 2027 – 2029

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CNS – Central Nervous System; TKI – Tyrosine Kinase Inhibitor; NSCLC – Non-Small Cell Lung Cancer; ND – newly diagnosed; GBM - Glioblastoma

Clinical Data Support Potential Best-in-Class CNS Activity and Broad EGFRm Coverage Across NSCLC and GBM



Non-Small Cell Lung Cancer (NSCLC)

NCMs represent ~25% of newly diagnosed EGFRm NSCLC patients, or ~70,000 patients worldwide[1]

- Current treatments lack broad spectrum NCM coverage and/or have suboptimal brain penetrance[1,2]

Phase 2 data remains robust since ASCO:

- Systemic ORR and mPFS at 60% and 15 months[3]
- **86% CNS-ORR** vs. 35-36% CNS-ORR seen with afatinib and osimertinib[3,4,5,*]
- **No patients developed *de novo* brain metastases**[3,6]

Key updates since ASCO:

- **12.2-month mPFS** in patients **with brain metastases** vs. 5.1 – 6.1 months with osimertinib and afatinib[3,7,4,*]
- **23.5 months mPFS** in patients **without brain metastases** vs. 9.8 months with osimertinib[3,8]



Glioblastoma (GBM)

EGFR mutations present in ~50%[9] of GBM patients, representing ~49,000 patients worldwide[10]

- Prior attempts to drug EGFR have failed because of suboptimal brain penetrance and/or inadequate mutational coverage[1,2]

Phase 0/1 and Phase 1 data demonstrated[11,12]:

- Potential **best-in-class brain penetrance** in GBM tumors
- **PoC** in heavily pretreated GBM patients, including confirmed partial response in patient with EGFRvIII/EGFRamp

Phase 2 randomized trial in ND GBM patients enrolling at 150 mg

- **150 mg dose selected,** based on 6 patients dosed at 150 mg QD + TMZ in safety run-in (no DLTs observed)[13]

$2bn+ opportunity in 1L NCM NSCLC and EGFR+ GBM, with potential to expand to other populations/lines of therapy

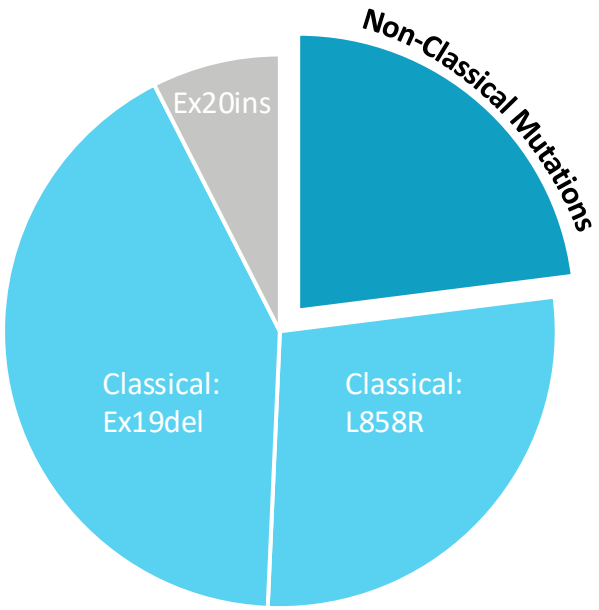
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1. See slide 19. 2. Colclough Clin Can Res 2021. 3. Data as of October 7, 2026. 4. Kang Front Oncol 2023. 5. Bar JTO 2022; 4 out of 11 Group A patients by RANO-BM. 6. Of the 24 patients without brain metastases. 7. Priantti JCO Prec Oncol 2024 and Miao JTO 2026. 8. Okuma JAMA 2024. 9. Saadeh, The International Journal of Biological Markers, 2018. 10. See slide 27. 11. Sanai SNO 2025. 12. Wen ASCO 2024. 13. Data as of September 30, 2026. EGFRm – EGFR mutation.

*No head-to-head trials have been conducted. Cross program comparisons are limited by differences in trial design, patient population, end points and dosing. DLT – dose limiting toxicity.

Silevertinib's Broad EGFR Mutational Coverage: Potential to Address Significant Unmet Medical Need for NSCLC Patients with NCMs

Non-Classical Mutations (NCMs) represent ~25% of newly diagnosed EGFRm NSCLC, with no established standard of care[1]



Silevertinib potently inhibits ~90% of EGFR mutations in NSCLC patients[2]

Clinical data demonstrate silevertinib's broad EGFR mutational coverage

Silevertinib demonstrated clinical responses in ~**5x more** EGFR mutations than firmonertinib, including known resistance mutations for firmonertinib*

Silevertinib:
Responses across **29** mutations[2]

Classical	NCM			
Ex19del	R108G	H835L	E709_T710delinsD	G719X
L858R	D191N	L861Q	E746_S752delinsV	S768I
Ex19del + C797S	H590N	H773L	H233R	E709X
L858R + C797S	G724S	E746_R748delinsKP	E746_T751delinsV	V774M
	L747_K754delinsQQ	L747S/P	L747_T751delinsP	L718X
	L833V/F	L747_A750delinsP	I740dupIPVAIK	L792X
	G779F			

Firmonertinib:
Responses across **6** mutations[3]

Classical	NCM
Ex19del	G719X
L858R	S768I
Ex19del + C797S	E709X
L858R + C797S	V774M
	L718X
	L792X

= mutation present in responder

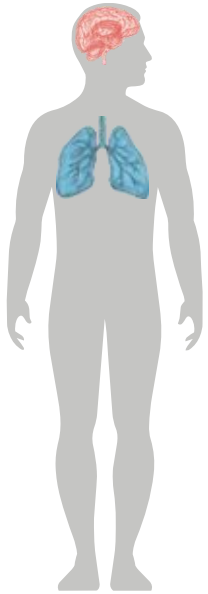
= mutation present as acquired resistance mutation following drug treatment

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1. Heymach ESMO 2024. 2. Rotow ASCO 2026 and Yu ASCO 2026. 3. Le WCLC 2025 and Shi Lancet Resp Med 2021. *No head-to-head trials have been conducted. Cross program comparisons are limited by differences in trial design, patient population, end points and dosing.

Brain Metastases Are Common in EGFRm NSCLC; Silevertinib Shows Best-in-Class CNS Potential

Brain is the most common site of distant metastasis in EGFRm NSCLC[1]

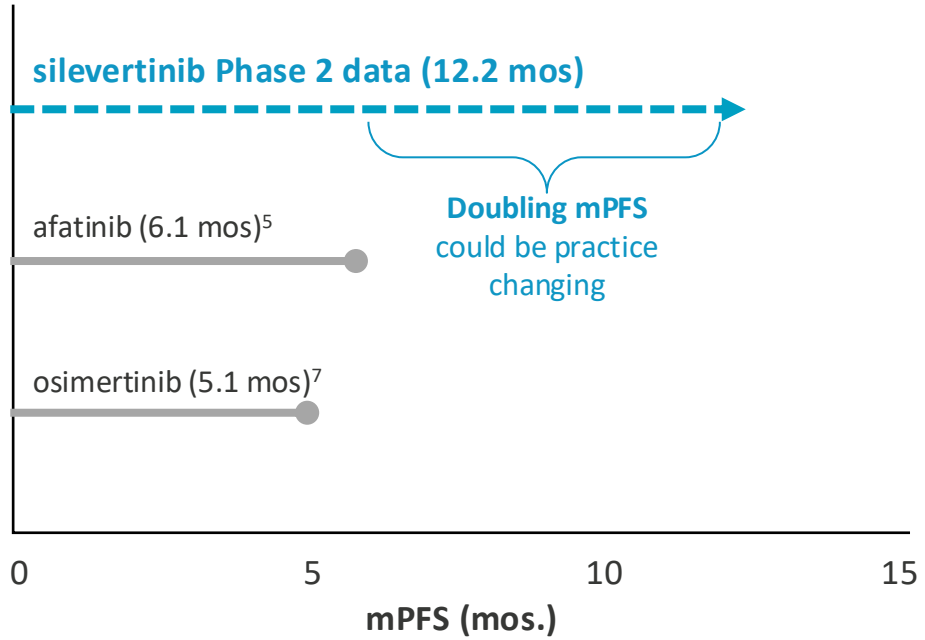


- **~40%** of patients with NCMs present with brain metastases at diagnosis[2]
- **>80%** of patients with NCMs progress in the brain[3]

Silevertinib Phase 2 data in 1L NCM NSCLC demonstrate[4]:

- **86% CNS-ORR** in patients with brain metastases vs. 35-36% CNS-ORR with afatinib and osimertinib[5,6,*]
- **12.2 mos mPFS** in patients **with brain metastases** vs. 5.1-6.1 mos with osimertinib and afatinib[7,5,*]
- **23.5 mos mPFS** in patients **without brain metastases**, potentially due to delay of CNS progression
- **No patients developed *de novo* brain metastases**[8]

Silevertinib has demonstrated robust PFS in 1L EGFR-NCM patients with untreated brain metastases*



Silevertinib's potential best-in-class CNS activity offers path to accelerated approval in frontline patients with NSCLC

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1. Wang Clin Resp J. 2025. 2. Bar JTO 2022 and Wilcox Annals Onc 2025. 3. Li Cancers 2022. 4. Data from October 7, 2026. 5. Kang Front Oncol 2023. 6. Bar JTO 2022; 4 out of 11 Group A patients by RANO-BM. 7. Priantti JCO Prec Oncol 2024 and Miao JTO 2026. 8. Of the 24 patients without brain metastases. *No head-to-head trials have been conducted. Cross program comparisons are limited by differences in trial design, patient population, end points and dosing.

Silevertinib:
Development in Patients with NSCLC

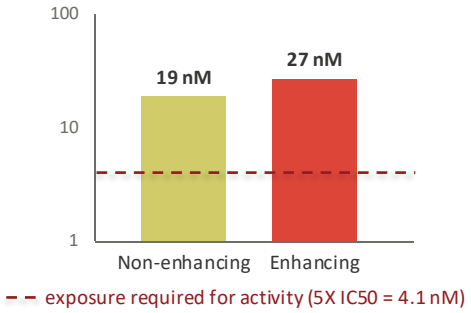
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Silevertinib's Robust CNS Activity: Critical Driver of Clinical Benefit in Patients with EGFRm NSCLC

PENETRATES THE BRAIN

Potential best-in-class CNS penetrance

Unbound silevertinib concentration in brain tumor regions[1]

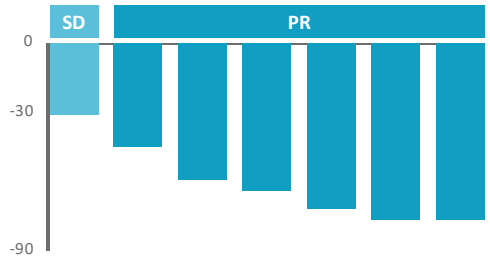


Only EGFR TKI with robust exposure observed in both brain tumor regions, measured in patients

DRIVES CNS RESPONSES

86% CNS-ORR

CNS responses in 1L NSCLC NCM patients[2]

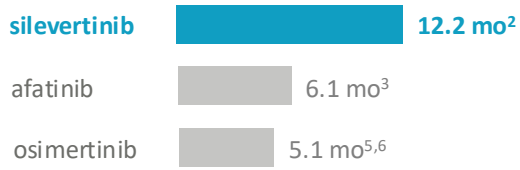


Silevertinib outperformed CNS-ORR observed for afatinib and osimertinib (35-36%)[3,4,*]

PROVIDES DURABILITY

12.2 mo mPFS in patients with brain metastases

mPFS in 1L NSCLC NCM patients with brain metastases



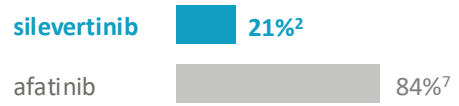
Silevertinib mPFS shown to be 2x that observed for afatinib and osimertinib[*]

DELAYS CNS METASTASES

Low rate of CNS progression

- *In 24 patients **without** brain metastases, **no** patient progressed in the brain[2]*
- *In 19 patients **with** brain metastases, **only 4** progressed in the brain[2] (vs. osimertinib: in 45 patients with brain metastases, 34 progressed in the brain[6,*])*

Overall incidence of brain progression[*]



Silevertinib shown to delay CNS progression, a key driver of treatment failure with existing TKIs

Robust Phase 2 data drove a highly collaborative meeting with FDA on the fastest path to potential approval

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BM – brain metastases. 1. Sanai SNO 2025. See slide 23. 2. Data from October 7, 2026. 3. Kang Front Oncol 2023 4. Bar JTO 2022; 4 out of 11 Group A patients by RANO-BM. 5. Priantti JCO Precis Oncol 2024. 6. Miao JTO 2026. 7. Li Cancers 2022. No data on rate of CNS progression available for osimertinib. *No head-to-head trials have been conducted. Cross program comparisons are limited by differences in trial design, patient population, end points and dosing.

Key Takeaways from October End of Phase 2 Meeting with FDA

Patient Population and Study Design

- **Treatment naïve patients with locally advanced or metastatic NSCLC with untreated brain metastases whose tumors have EGFR-NCMs**. Patients with classical mutations (ex19del, L858R) and patients with ex20ins excluded
- **Investigator's choice of afatinib or osimertinib** for the control arm

Study Endpoints

- A substantial improvement in **CNS-ORR per RANO-BM** (by BICR) may support a potential marketing application for an **accelerated approval**
- **PFS per RECIST v1.1** (by BICR) may be adequate to support **full approval**
- Systemic ORR and OS need to be evaluated to **show systemic ORR similarity vs. control and no evidence of OS detriment vs. control**

Dose Selection

- Acknowledged justification for **150 mg QD dose;** data from a sufficient number of patients at 150 mg in ongoing Cohort 4 required to be submitted prior to opening the Phase 3 trial, anticipated in Q2 2027

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RANO-BM – Response Assessment in Neuro-Oncology Brain Metastases. BICR – Blinded Independent Central Review.
Based on minutes received October 15, 2026 of in-person End of Phase 2 FDA meeting held on October 1, 2026.

Silevertinib Pivotal Development Plan Designed to Address All 1L NSCLC Patients with NCMs

Randomized trial for potential accelerated and full approvals, aligned with Project Frontrunner

1L NSCLC NCM patients **with brain metastases** (~40%)

Experimental arm (n=150)
silevertinib 150 mg QD

Control arm (n=150)
investigator's choice (afatinib or osimertinib)

CNS-ORR*
(Primary Endpoint for Accel. Approval)

CNS-ORR (historical)

silevertinib	86%[1]
afatinib	35%[2]
osimertinib	36%[3]

PFS*
(Primary Endpoint for Full Approval)

mPFS (historical)

silevertinib	12.2 mo[1]
afatinib	6.1 mo[2]
osimertinib	5.1 mo[4]

Single arm cohort to support compendia and adjuvant strategy

1L NSCLC NCM patients **without brain metastases** (~60%)

Compendia cohort (n=80)
silevertinib 150 mg QD

Compendia Listing*

mPFS (historical)[5]

silevertinib	23.5 mo[1]
osimertinib	9.8 mo[6]

Compendia study also provides data to support an adjuvant development program

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1. Data from October 7, 2026. 2. Kang Front Oncol 2023. 3. Bar JTO 2022; 4 out of 11 Group A patients by RANO-BM. 4. Priantti JCO Precis Oncol 2024 and Miao JTO 2026. 5. No data available for afatinib in this patient population. 6. Okuma JAMA 2024. NOTE: Additional 20 pt cohort in 1L NSCLC NCM patients with leptomeningeal disease (LMD) also planned per FDA feedback (see slide 29). *No head-to-head trials have been conducted. Cross program comparisons are limited by differences in trial design, patient population, end points and dosing.

Silevertinib in EGFR-NCM NSCLC Phase 2 Trial Design

Main Inclusion Criteria:

- EGFR NCM by local NGS test
- Asymptomatic brain metastases allowed
- CNS MRI surveillance required

Main Exclusion Criteria:

- Classical EGFR mutations (del19, L858R)

Cohort 1
N=41

- Recurrent NSCLC after ≤2 prior therapies
- EGFR non-classical (NCM) mutation positive

Cohort 2
N=42

- Recurrent NSCLC after ≤2 prior therapies
- EGFR acquired resistance C797S mutation positive

Cohort 3
N=43 @
200 mg QD

Cohort 4
N=20 @
150 mg QD

Treatment naïve patients with EGFR non-classical mutations (NCMs)

- Cohort 3: April 11, 2026 data presented at ASCO; updated data from October 7, 2026
- Cohort 4: FPI Q3 2026. Data from sufficient number of patients must be submitted to FDA prior to Phase 3 initiation

Primary endpoint:

ORR

Secondary endpoints:

PFS, DOR, OS, Safety, PK

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43 Frontline Patients with NSCLC Enrolled in the US and Canada

Real world demographics:

16/43 (37%) patients with untreated brain metastases

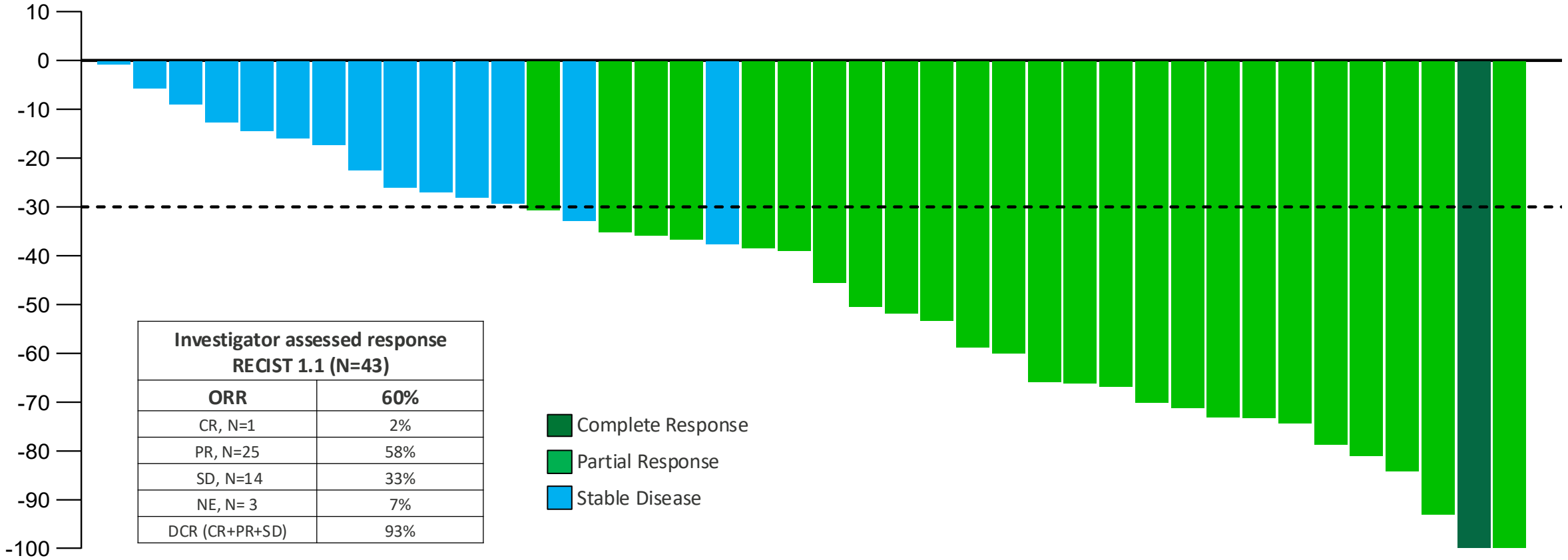
33 unique NCMs

Cohort 3 Treatment Naive 1L EGFR-NCM (N=43)	
Age in years, median (range)	70.3 (44-91)
Female, N (%)	31 (72)
ECOG 0/1, N (%)	21 (49) / 22 (51)
Non-smoker/Former or Current, N (%)	18 (42) / 25 (58)
Race: Asian/Caucasian/Other, N (%)	7 (16) / 32 (74) / 4 (9)
Visceral metastases, N (%)	10 (23)
Brain metastases	
All brain metastases, N (%)	19 (44)
Untreated brain metastases, N (%)	16 (37)
Untreated measurable brain metastases, N (%)	7 (16)
EGFR NCM Mutations	
Single, N (%)	27 (63)
Compound[1], N (%)	16 (37)

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1. presence of 2 distinct non-classical EGFR mutations. Data from Oct 7, 2026

Robust Anti-Tumor Activity in 1L NSCLC Patients (n=43, ITT Population)



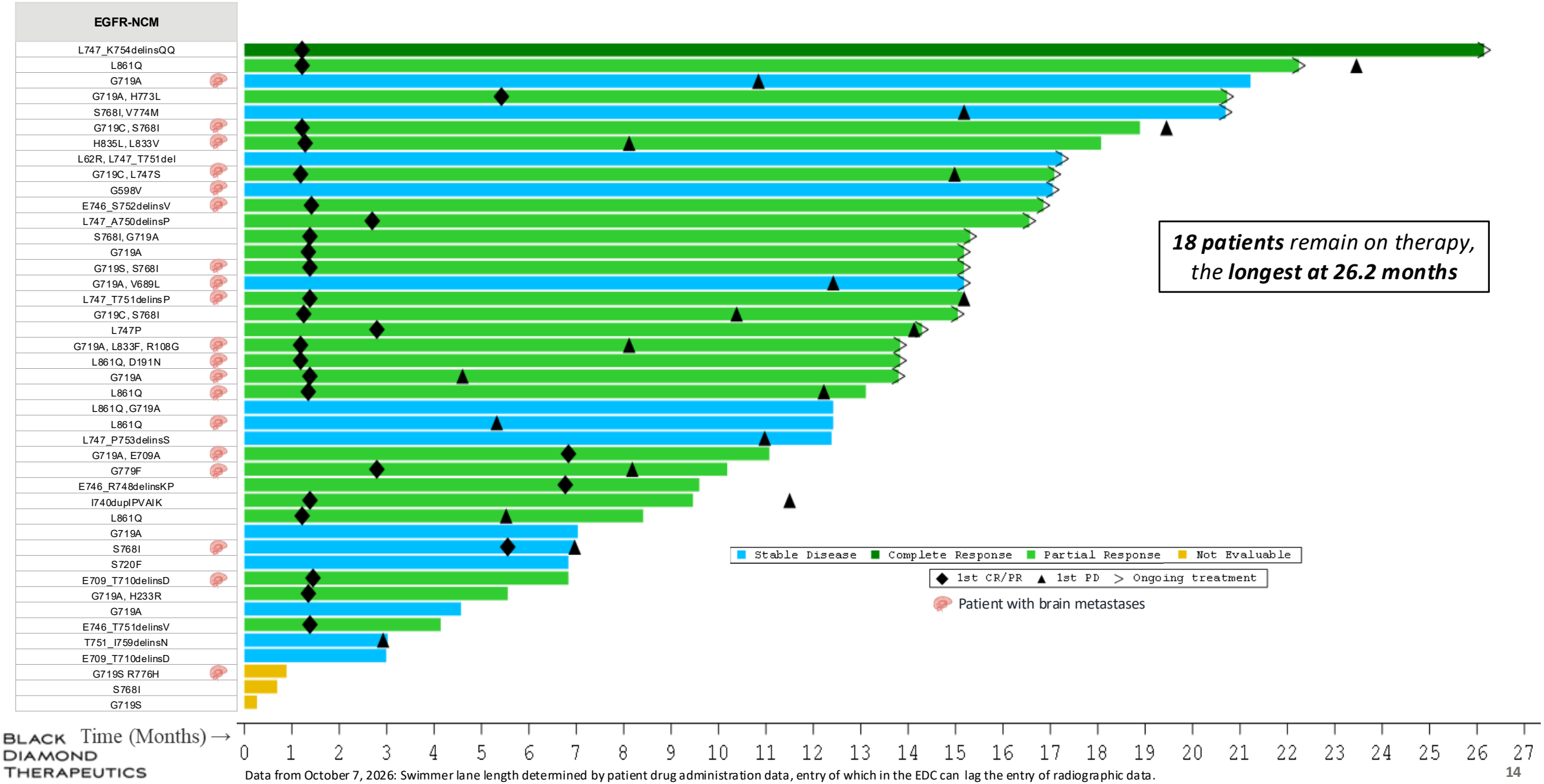
Investigator assessed response RECIST 1.1 (N=43)	
ORR	**60%**
CR, N=1	2%
PR, N=25	58%
SD, N=14	33%
NE, N= 3	7%
DCR (CR+PR+SD)	93%

EGFR-NCM	E709_T710delinsD	L62R L747_T751del	G598V	G719A	G719A	L861Q	S720F	G719A	L861Q G719A	L747_P753delinsS	S768I V774M	T751_I759delinsN	L747P	S768I	L861Q	G719A H233R	L747_A750delinsP	G719A V689L	G779F	G719A H773L	G719A E709A	E746_R748delinsKP	S768I G719A	G719A	G719A L833F	H835L L833V	G719S S768I	L747_T751delinsP	G719A	L861Q	G719C L747S	E746_T751delinsV	E709_T710delinsD	L861Q	G719C S768I	I740dupIPVAIK	E746_S752delinsV	L861Q D191N	L747_K754delinsQQ	G719C S768I
Brain metastases			●		●	●								●	●			●	●		●			●	●	●	●	●			●		●				●	●		●

● Patient with brain metastases

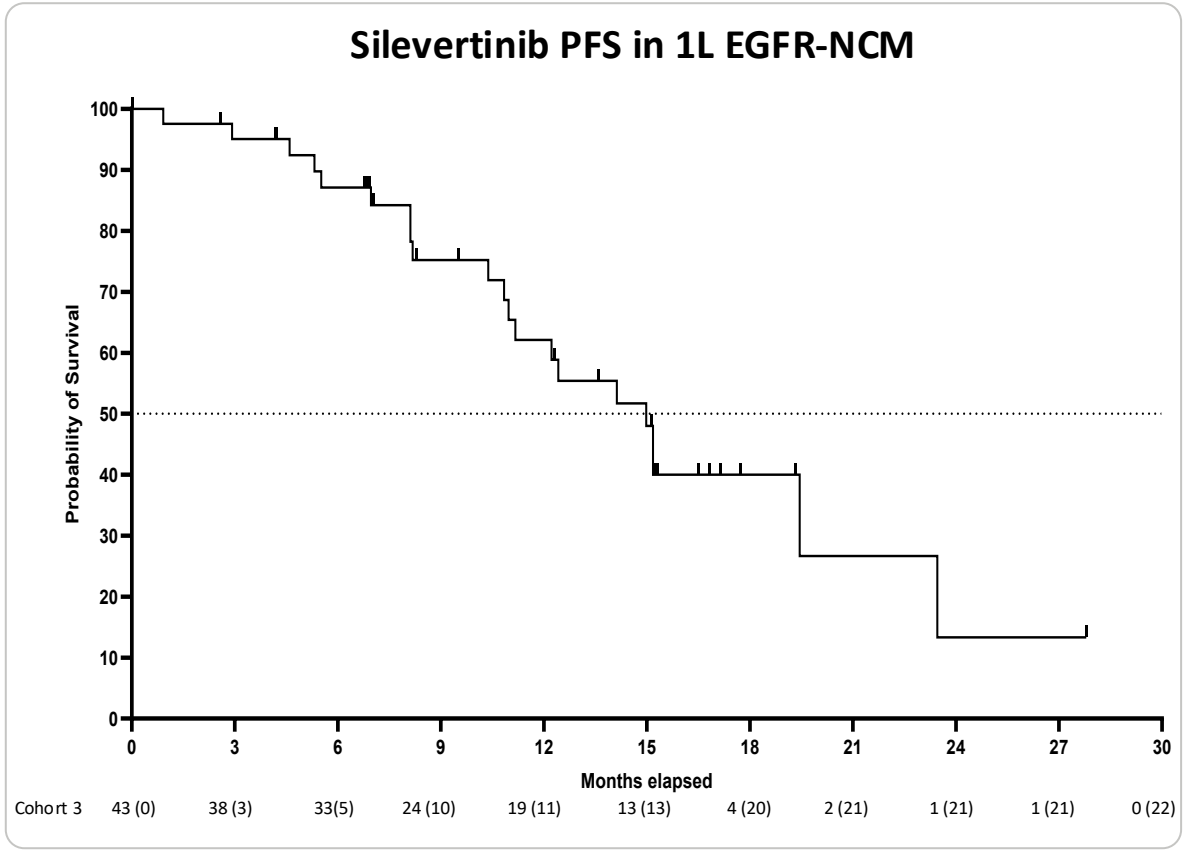
DCR – disease control rate; NE – non-evaluable. Data from October 7, 2026; median patient follow-up of 15.9 mos.

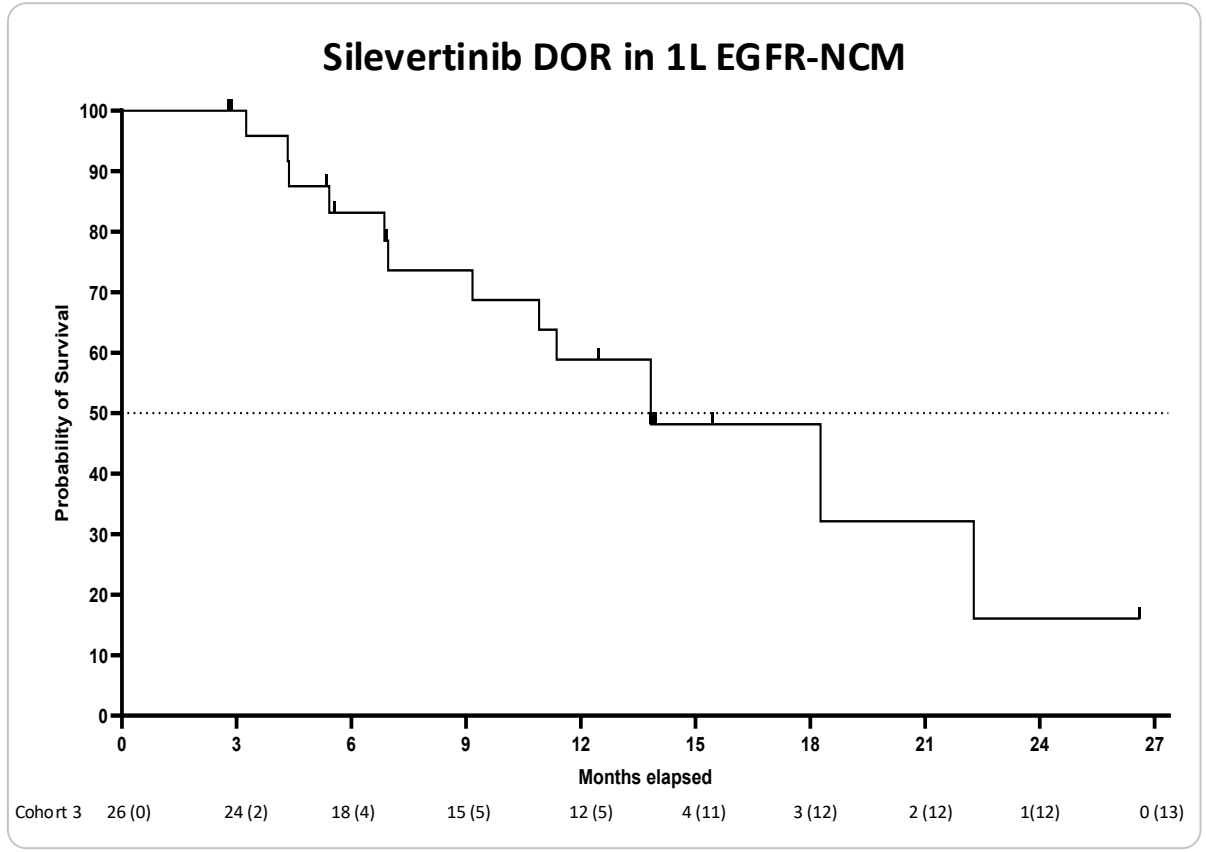
Robust Durability in 1L NSCLC Patients (n=43, ITT Population)



Data from October 7, 2026: Swimmer lane length determined by patient drug administration data, entry of which in the EDC can lag the entry of radiographic data.

Robust PFS and DOR in 1L NSCLC Patients (n=43, ITT Population)





mPFS = 15.0 months (95%CI: 11.0, 23.5)

vs. 7.0 - 10.6 months seen with osimertinib/afatinib[1,2,*]

mDOR = 13.8 months (95%CI: 9.2, 22.3)

18 patients remain on therapy, longest at 26.2 months

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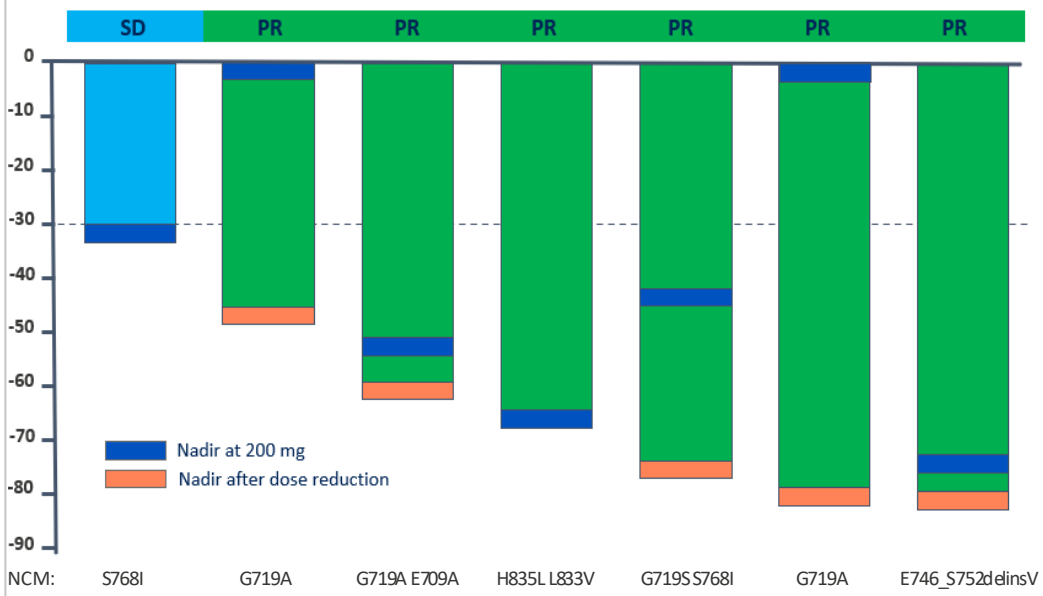
Median patient follow-up 15.9 months. DOR – duration of response. Data from October 7, 2026. 1. Bar JTO 2022; Okuma JAMA 2024; Pizzutilo ESMO Open 2024. 2. Miura JCO 2025.
*No head-to-head trials have been conducted. Cross program comparisons are limited by differences in trial design, patient population, end points and dosing.

Robust CNS Activity in 1L NSCLC Patients Treated with Silevertinib

86% CNS ORR by RANO-BM[1]

vs. 35-36% CNS-ORR seen with afatinib and osimertinib[2,3,*]

Responses Deepened Over Time



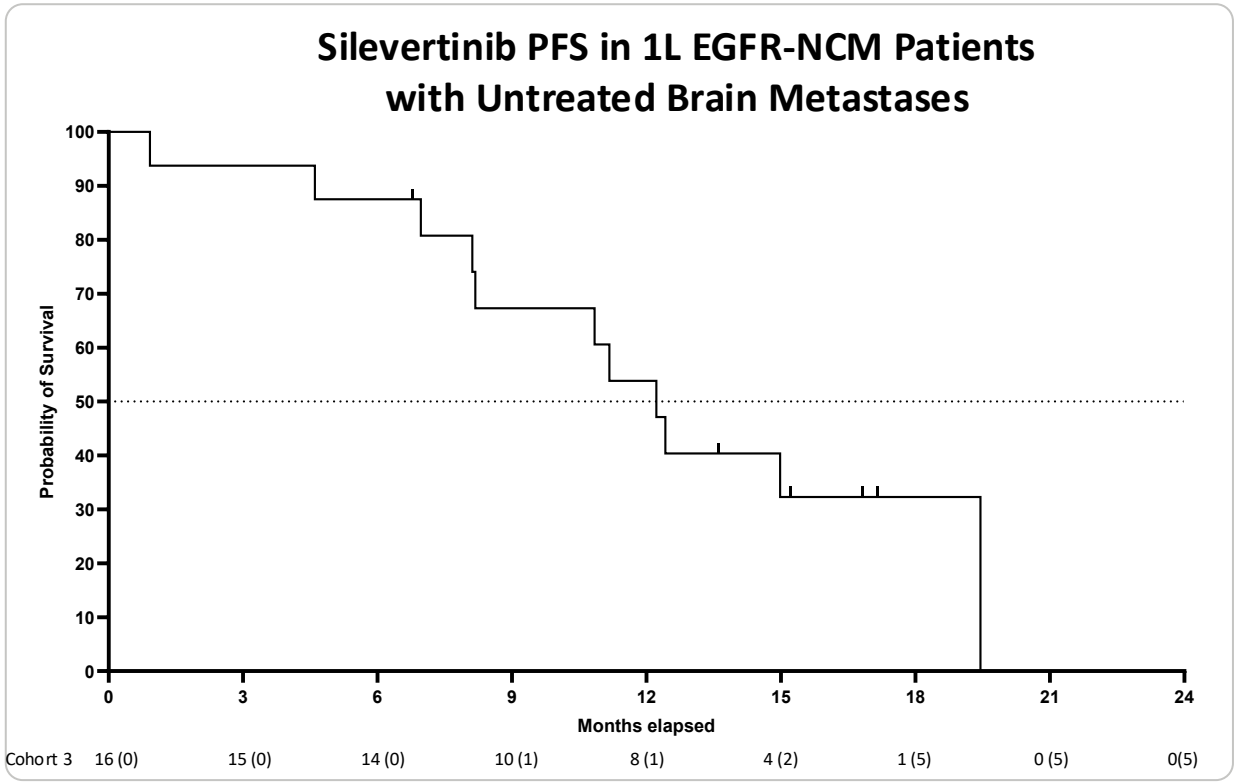
Additional Measures of Patient Benefit Driven by Silevertinib's Robust CNS Activity

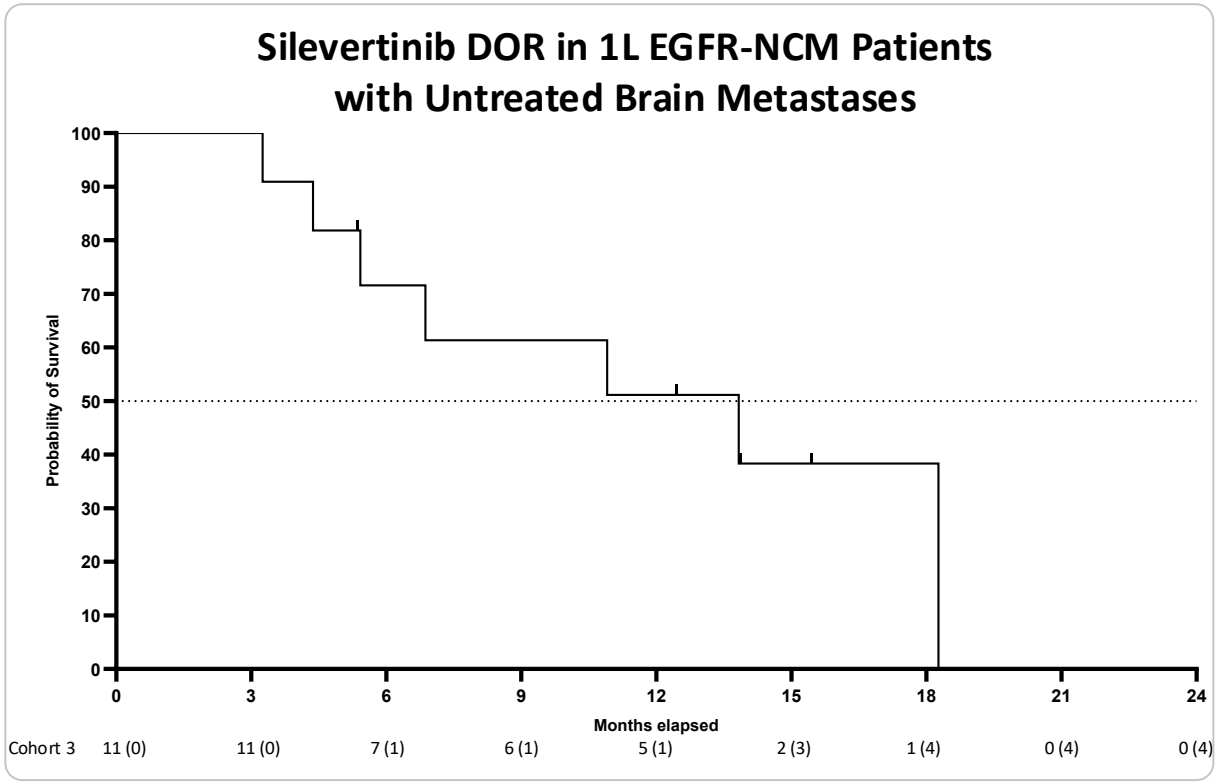
- **Complete disappearance of brain metastases** in 4/9 pts with non-measurable brain metastases[4]
- In 24 patients without brain metastases: **no patient progressed in the brain**
- In 19 patients with brain metastases: **only 4 had brain as site of progression**
- **12.2 mos mPFS in patients with brain metastases** vs. 5.1-6.1 mos seen with osimertinib/afatinib[5,6,*]

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Data from October 7, 2026. 1. 7 patients with target brain metastases and no prior radiation therapy. Data show confirmed responses per RANO-BM. 2. Kang Front Oncol 2023. 3. Bar JTO 2022; 4 out of 11 Group A patients by RANO-BM. 4. 9 patients with non-target brain metastases and no prior radiation therapy. 5. Priantti JCO Prec Oncol 2024 and Miao JTO 2026. 6. Kang Front Oncol 2023. *No head-to-head trials have been conducted. Cross program comparisons are limited by differences in trial design, patient population, end points anddosing.

Robust PFS and DOR in 1L NSCLC Patients with Untreated Brain Metastases (n=16)





mPFS = 12.2 months (95%CI: 8.1, NE)

vs. 5.1 - 6.1 months seen with osimertinib/afatinib[1,2,*]

mDOR = 13.8 months (95%CI: 4.4, NE)

8 patients remain on therapy, longest at 21.3 months[3]

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Median patient follow-up 15.9 months. Data from October 7, 2026. DOR – duration of response. 1. Priantti JCO Prec Oncol 2024 and Miao JTO 2026. 2. Kang Front Oncol 2023. 3. Patient off therapy as of October 7, 2026.

*No head-to-head trials have been conducted. Cross program comparisons are limited by differences in trial design, patient population, end points and dosing.

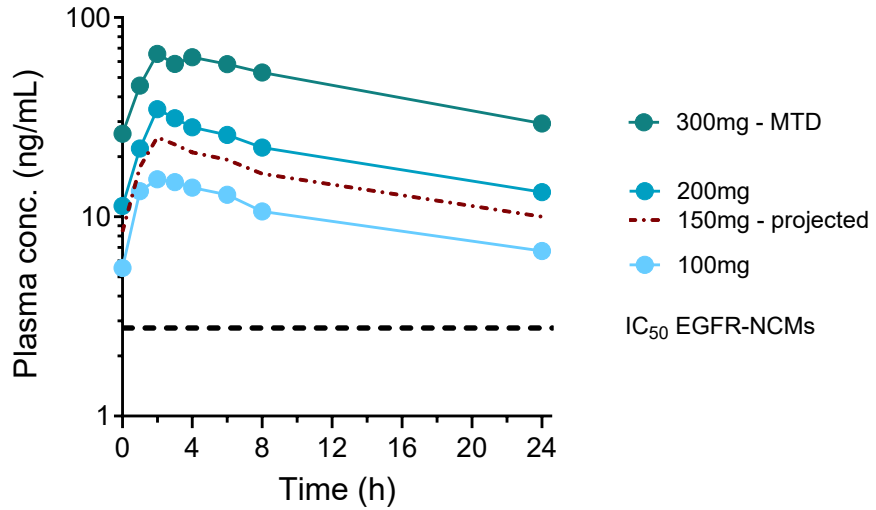
Silevertinib Demonstrated a Dose Dependent and Manageable AE Profile

Dose Dependent and Manageable AE Profile[1]

Silevertinib TRAEs Gr ≥3; 200 mg QD (N=43)		After dose reduction (N=36)
TRAE	**Gr ≥3 n (%)**	**Gr ≥3 n (%)**
Rash	8 (19)	3 (8)
Diarrhea	8 (19)	3 (8)
Stomatitis	4 (9)	0
Pneumonitis	3 (7)	2 (6)
Paronychia	2 (5)	0
Decreased appetite	2 (5)	2 (6)
Hypokalemia	2 (5)	0
Nausea	1 (2)	1 (3)

- AEs managed by supportive care / dose reduction; consistent with other EGFR TKIs
- Most patients experienced dose interruption / reduction; only 19% of patients discontinued due to AEs; no new safety signal
- Patients maintained clinical response after dose reduction; 126 mg/day median dose intensity

Silevertinib Demonstrated Dose-Proportional PK



- Dose-proportional PK observed in patients at 100 mg, 200 mg, and 300 mg QD[2]
- EGFR-NCM target coverage and clinical responses (including CNS) achieved at doses ≥ 100 mg QD
- Extensive exposure response analyses support 150 mg QD dose, which is anticipated to provide more favorable tolerability without sacrificing clinical activity

FDA acknowledged justification for 150 mg QD dose in Phase 3 trial, data to be delivered from ongoing cohort 4 prior to opening Phase 3 trial

1. Data from October 7, 2026. 2. Yu EORTC 2023; IC50 of EGFR NCMs tested in BaF3 cells.
Rash group terms: rash, rash maculo-papular, rash pustular, rash erythematous, dermatitis acneiform; stomatitis terms: stomatitis, and mucosal inflammation; AE – Adverse Event; TRAE – Treatment Related Adverse Event.

BLACK DIAMOND THERAPEUTICS

Silevertinib Market Opportunity – Current Focus on 1L NCM NSCLC; Potential to Expand to Other EGFRm Patient Populations / Lines of Therapy

Current Focus

1L non-classical mutations

~70,000

Estimated Global Total Addressable Market (annual patients)*

Additional Market Opportunities

Adjuvant/post-adjuvant	1L L858R	Recurrent setting with EGFR resistance mutations
~27,000	~87,000	~13,000

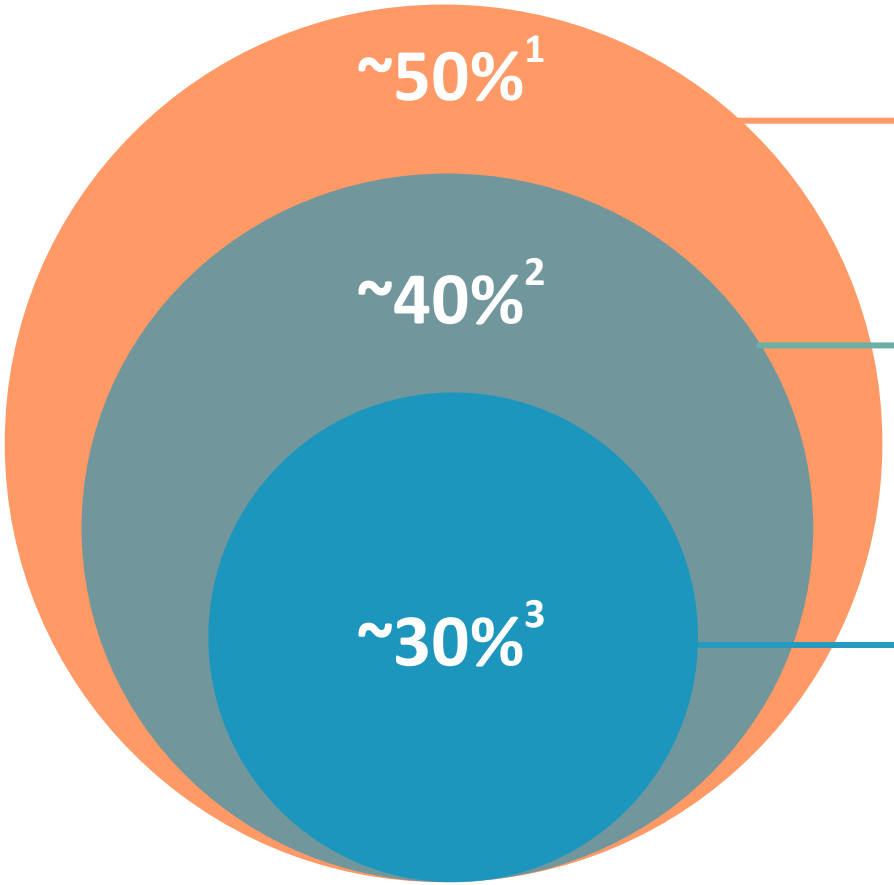
BLACK DIAMOND THERAPEUTICS

* Sung CA Cancer J Clin 2026 (GLOBOCAN 2024); Luo Lancet Respir Med 2025; Zhang Oncotarget 2016; Heymach ESMO 2024; Foundation Med AACR 2024; Soo JTO 2024; Robert Lung Cancer 2022; Ikeda Cancer Sci 2026; Hofman ESMO Open 2023; Smeltzer JTO 2025; Wang Ann Palliat Med 2024; Rotow JTO 2024.

Silevertinib:
Development in Patients with Glioblastoma

Black Diamond Therapeutics

Silevertinib was Designed to Address the Complex EGFR Mutations Found in Patients with GBM



Of all GBM patients carry oncogenic EGFR alterations

Of all GBM patients have more than one oncogenic EGFR alteration

Of all GBM patients express EGFRvIII, which has been demonstrated to be a potent oncogenic driver

~49,000

GBM patients diagnosed annually worldwide harbor EGFR mutations inhibited by silevertinib, as demonstrated in preclinical studies

BLACK DIAMOND THERAPEUTICS

1. Saadeh, F., The International Journal of Biological Markers, 2018; 2. Tempus Labs analysis of 2,540 GBM patient samples; 3. Noeuveglise ESMO OPEN 2022, French Neuro-Oncology 2019, Weller Lancet Oncology 2017

Silevertinib: Potential to Overcome Limitations of Prior Attempts to Drug EGFR in Patients with GBM

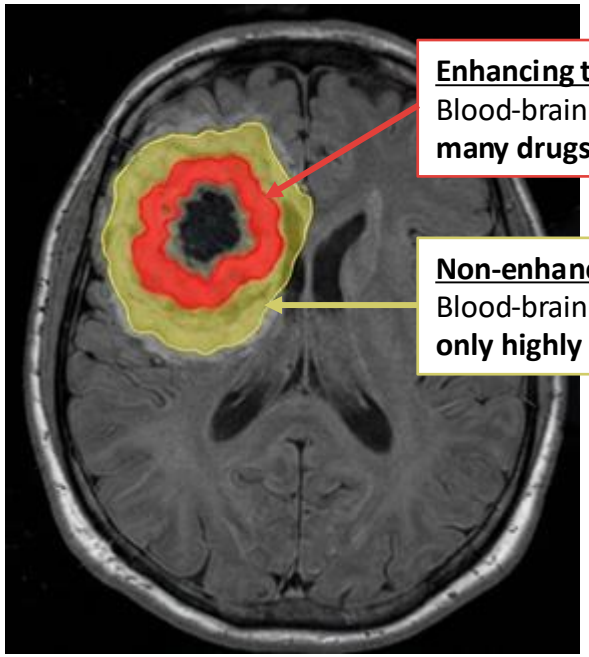
Lessons From Past Failures		Silevertinib
Low brain exposure due to a lack of CNS penetrance	›	**Potential best-in-class brain penetrance to treat CNS tumors**
Heterogeneous expression of EGFR oncogenic alterations within tumors	›	**Designed for potent inhibition of co-occurring EGFR alterations and amplification**
Paradoxical activation of EGFR GBM oncogenes induced by reversible inhibitors	›	**Covalent MOA and no paradoxical activation**
Poor tolerability driven by on target WT-EGFR activity	›	**Designed to spare WT-EGFR in normal cells while retaining potent activity against EGFR alterations**

BLACK DIAMOND THERAPEUTICS

MOA=mechanism of action; WT=Wild-Type

Silevertinib: The Only EGFR TKI Demonstrating Robust Penetration Across All Brain Tumor Regions, Including Where Blood-Brain Barrier is Intact

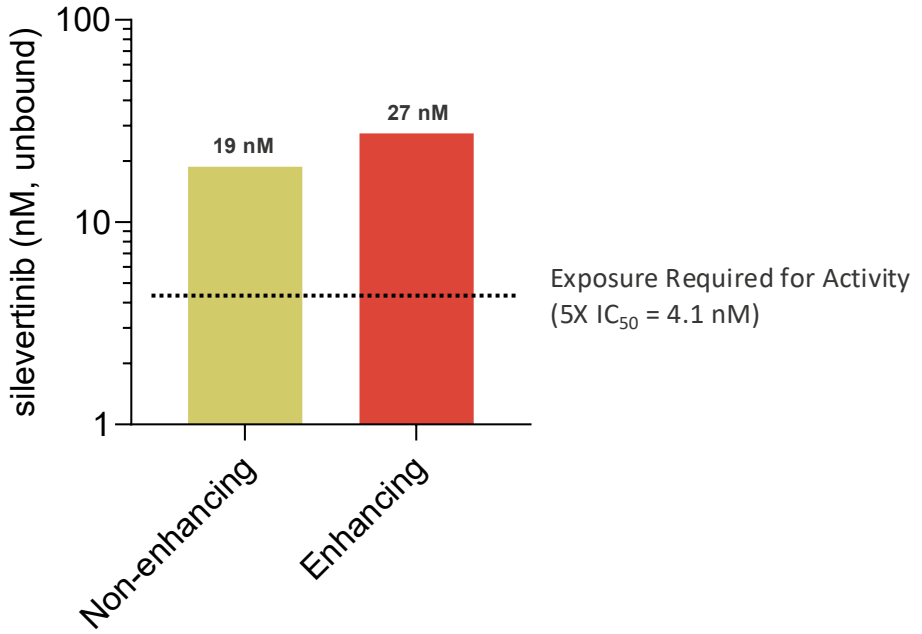
Effective treatment of brain tumors requires drug penetration into both enhancing and non-enhancing tumor regions[1]



Enhancing tumor regions:
Blood-brain barrier compromised,
many drugs can access

Non-enhancing tumor regions:
Blood-brain barrier intact,
only highly CNS penetrant drugs can access

Silevertinib shown to exceed target exposure in both tumor regions of GBM patients dosed in Phase 0/1[2]



Silevertinib penetrated BOTH enhancing and non-enhancing regions to deliver potential best-in-class CNS activity

BLACK DIAMOND THERAPEUTICS

1. Sarkaria Neuro-Onc 2018. 2. Sanai SNO 2025. Levels of unbound silevertinib are an average of 13 patients dosed at 200 mg QD for 5 days in a Phase 0/1 "window of opportunity" trial. No head-to-head trials have been conducted. Cross program comparisons are limited by differences in trial design, patient population, end points and dosing.

Phase 0/1 and Phase 1 Data Have Demonstrated Potential Best-in-Class Brain Penetrance and Preliminary Proof of Concept in Patients with GBM

Potential best-in-class brain penetrance

Silevertinib is the only EGFR TKI to demonstrate robust penetrance in GBM tumors, including sites where blood-brain barrier is intact.[1]

PoC in heavily pre-treated GBM patients

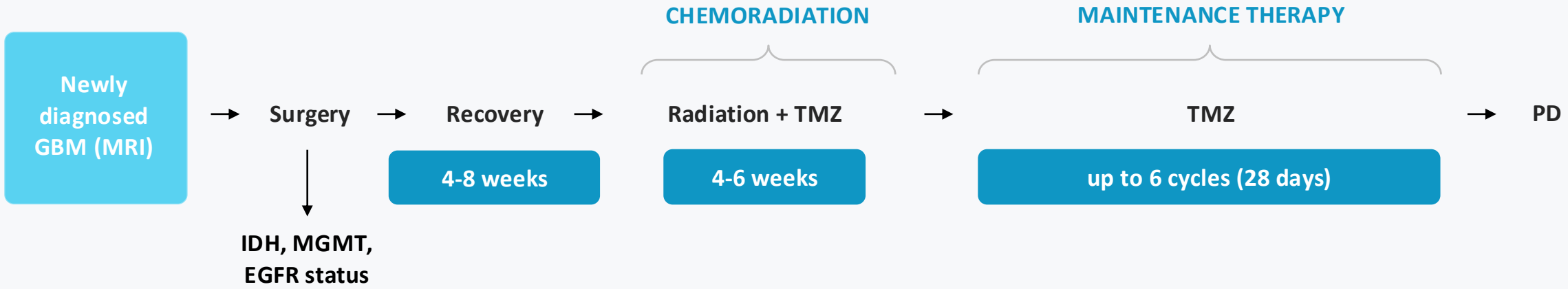
Prolonged stable disease in multiple patients and confirmed partial response in patient with EGFRvIII / EGFRamp.[2]

Encouraging clinical experience to date supports the ongoing Phase 2 trial in newly diagnosed GBM patients

BLACK DIAMOND THERAPEUTICS

1. Sanai SNO 2025. 2. Wen ASCO 2024.
No head-to-head trials have been conducted. Cross program comparisons are limited by differences in trial design, patient population, end points and dosing.

Newly Diagnosed GBM Patient Journey: Limited Options for Patients



Only two therapies approved for GBM patients in last 20 years

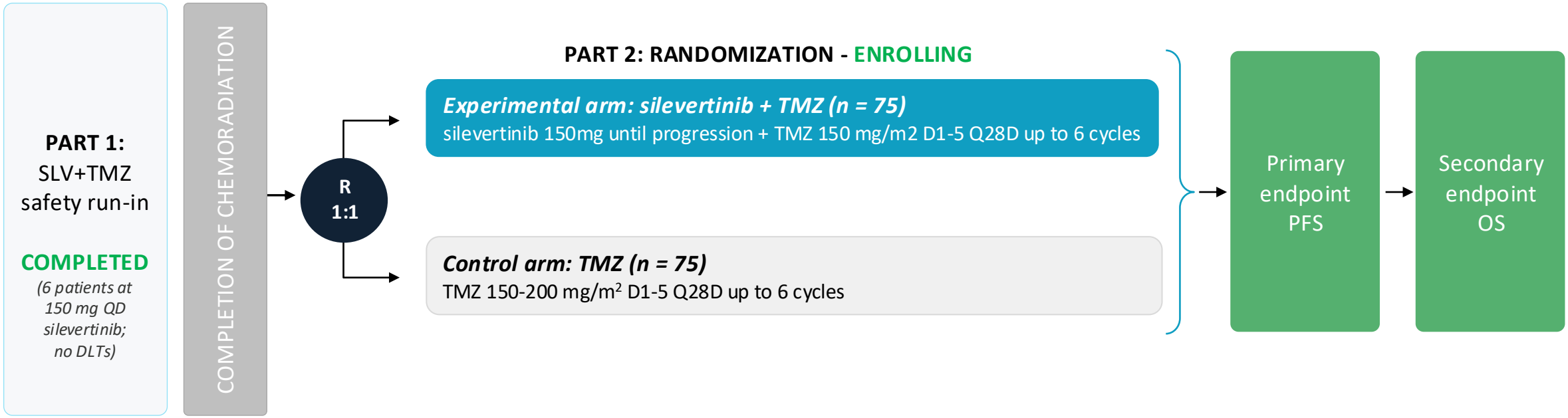
- Temozolomide (TMZ): primarily benefits methylated patients (though given to unmethylated patients as well)
- Tumor Treating Fields (TTF): device with compliance/QOL issues

Drug	N	MGMT Status	Setting	PFS	OS	Reference
TMZ	573	UM+M	CRT + MT	6.9 vs 5.0 mos; HR 0.54, p<0.001	14.6 mos vs 12.1 mos; HR 0.63, p<0.001	Stupp et al 2005
TTF	695	UM+M	MT	6.7 vs 4.0 mos; HR 0.63, p<0.001	20.9 mos vs. 16.0 mos; HR 0.63, p<0.001	Stupp et al 2017

BLACK DIAMOND THERAPEUTICS

CRT: chemoradiation; MT: maintenance therapy after CRT; HR: hazard ratio; M: methylated; UM: unmethylated; MGMT: methylguanine methyltransferase; mos: months; PD: progressive disease

Randomized Phase 2 of Silevertinib + TMZ in Newly Diagnosed GBM Patients



Study population:
unmethylated patients with EGFRvIII

IDMC analyses:
Interim futility and PFS, and final PFS

Confirmation of progression:
per RANO-BM (by BICR)

Interim PFS data expected in 1H 2028, with potential to convert to registrational Phase 3 trial (OS endpoint)

BLACK DIAMOND THERAPEUTICS

SLV: silevertinib; TMZ: temozolomide; ND – newly diagnosed; BICR: Blinded Independent Central Review; IDMC: Independent Data Monitoring Committee

Silevertinib Market Opportunity in GBM – Current Focus on EGFRvIII; Potential to Expand to All EGFR Variants

Current Focus

Newly Diagnosed
EGFRvIII
unmethylated

~20,000

Estimated Global Total Addressable Market (annual patients)*

Additional Market Opportunities

Newly Diagnosed
All EGFR alterations
unmethylated

Additional ~15,000

Newly Diagnosed
All EGFR alterations

Additional ~14,000

BLACK DIAMOND THERAPEUTICS

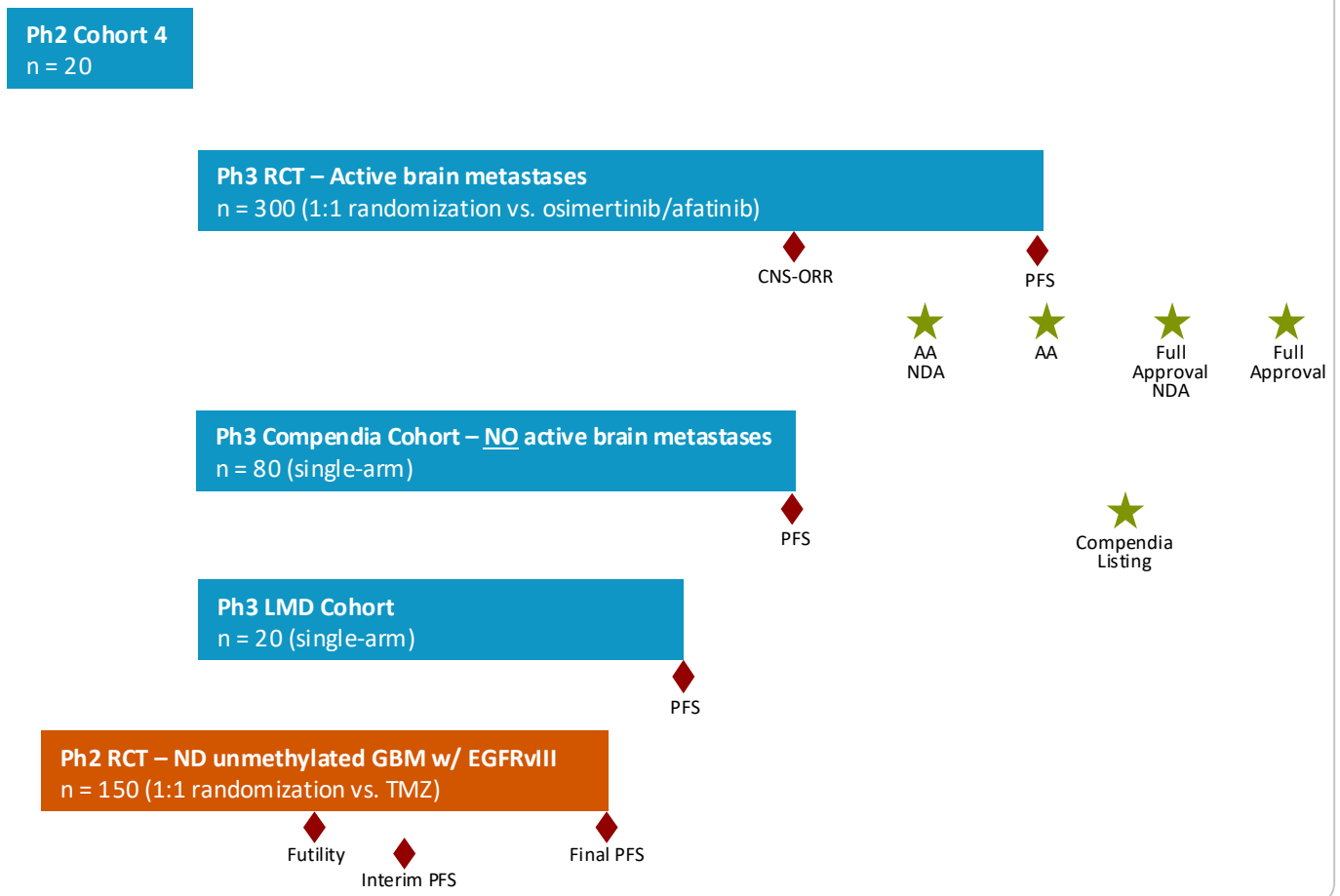
* Ostrom Neuro-Oncology 2025; IARC GLOBOCAN 2024; Girardi Neuro-Oncology 2023; Narita Neuro-Oncology 2024; Kang Cancer Research and Treatment 2021; Le Calvez Cancer Epidemiology 2025; Han Journal of the National Cancer Center 2024; Saadeh International Journal of Biological Markers 2018; Tempus Labs analysis of 2,540 GBM patient samples; Noeuveglise ESMO Open 2022; French Neuro-Oncology 2019; Weller Lancet Oncology 2017; Chen Nature Scientific Reports 2025; Lassman Journal of Neuro-Oncology 2019; Higa Cancer Medicine 2023.

Silevertinib: Broad Opportunity. Clear Path Forward.

- NSCLC
  - ✓ Potential to address all NCM patients, ~25% of the 1L EGFRm NSCLC market
  - ✓ FDA feedback supports a clear path to potential approval
  - ✓ **Planning Phase 3 trial with potential initiation Q2 2027**
- GBM
  - ✓ Potential to address ~50% of patients with newly diagnosed GBM
  - ✓ Robust CNS penetration and PoC demonstrated in Phase 0/1 and Phase 1
  - ✓ **Randomized Phase 2 trial currently enrolling**

Upcoming Catalysts in 1L NSCLC and ND GBM

Silevertinib 1L NCM-NSCLC and ND GBM Clinical Development Plan



Anticipated Milestones

- Cohort 4 data in Q2 2027
- Assuming Phase 3 1L NSCLC trial initiation in Q2 2027, we expect:
  - Preliminary open label cohort data in 2028
  - Accelerated approval endpoint data in 2029
- Existing cash expected to fund ND GBM Phase 2 trial to final PFS with interim PFS data in 1H 2028