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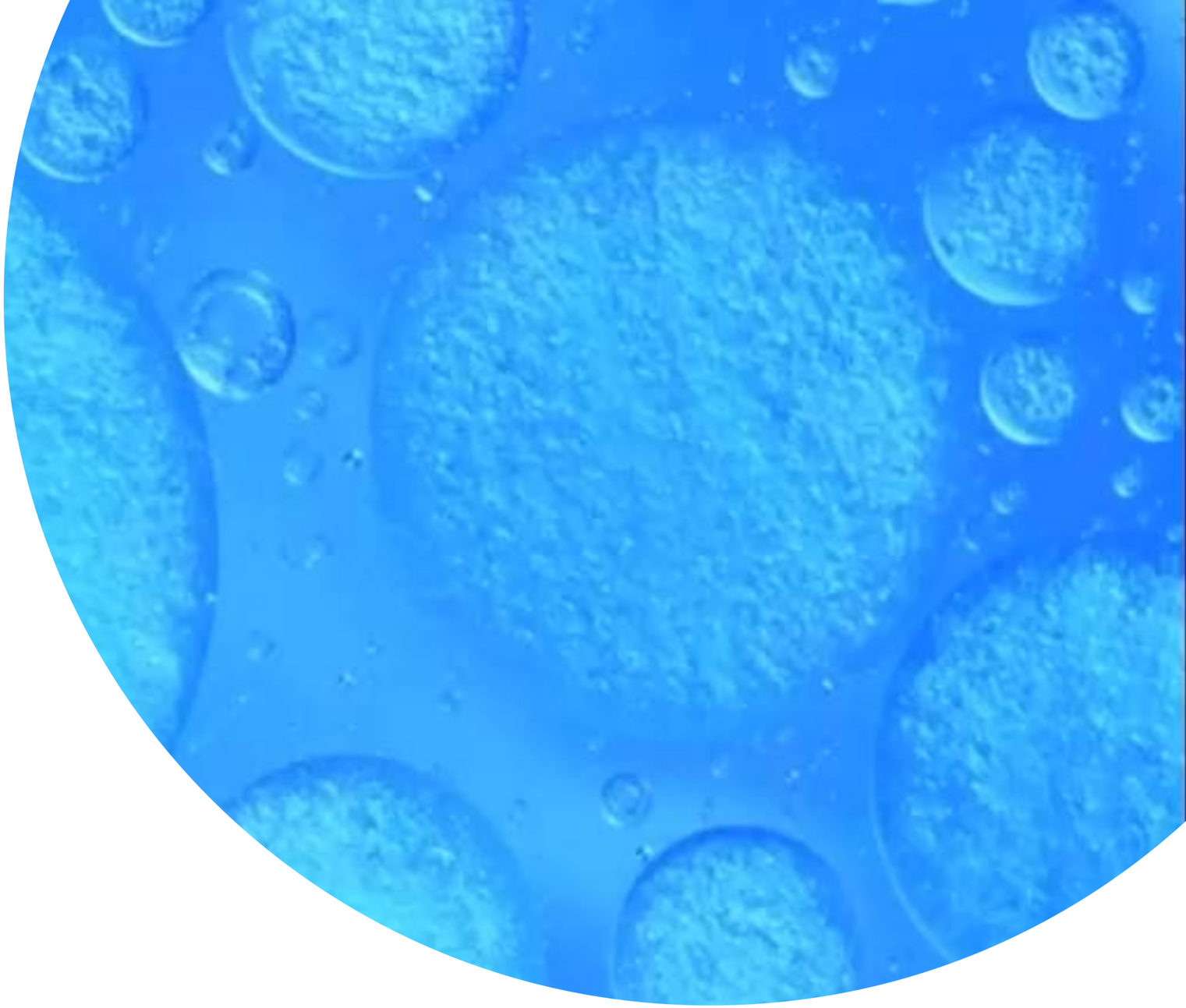
Corporate Presentation

NASDAQ: CLRB



October 2026

Forward-Looking Statements and Disclaimers

This presentation contains forward-looking statements. Such statements are valid only as of today, and we disclaim any obligation to update this information. These statements are only estimates and predictions and are subject to known and unknown risks and uncertainties that may cause actual future experiences and results to differ materially from the statements made. These statements are based on our current beliefs and expectations as to such future outcomes. Factors that might cause such a material difference include our ability to pursue strategic alternatives; our current views with respect to our business strategy, business plan and research and development activities; the progress of our product development programs, including clinical testing and the timing of commencement and results thereof; our projected operating results, including research and development expenses; our ability to continue development plans for CLR 121225, CLR 121125, CLR 1900 series, CLR 2000 series, and iopofosine I 131 (also known as CLR 131 or iopofosine); our ability to continue development plans for our Phospholipid Drug Conjugates (PDC); our ability to maintain orphan drug designation in the U.S. for iopofosine as a therapeutic for the treatment of lymphoplasmacytic lymphoma/Waldenström macroglobulinemia multiple myeloma, neuroblastoma, osteosarcoma, rhabdomyosarcoma, and Ewing's sarcoma, and the expected benefits of orphan drug status; any disruptions at our suppliers; our ability to advance our technologies into product candidates; our enhancement and consumption of current resources along with ability to obtain additional funding; our current view regarding general economic and market conditions, including our competitive strengths; uncertainty and economic instability resulting from conflicts, military actions, terrorist attacks, natural disasters, public health crises, including the occurrence of a contagious disease or illness, cyber-attacks and general instability; the future impacts of legislative and regulatory developments in the United States on the pricing and reimbursement of our product candidates; our ability to meet the continued listing standards of Nasdaq; assumptions underlying any of the foregoing; any other statements that address events or developments that we intend or believe will or may occur in the future; our ability to receive NDA approval for our iopofosine I 131 program and our ability to commercially manufacture and launch our product candidate if we receive regulatory approval. A complete description of risks and uncertainties related to our business is contained in our current and periodic reports filed with the Securities and Exchange Commission, including our Form 10-K for the year ended December 31, 2025, and Form 10-Q for the quarter ended June 30, 2026.

This presentation includes industry and market data that we obtained from industry publications and journals, third-party studies and surveys, internal company studies and surveys, and other publicly available information. Industry publications and surveys generally state that the information contained therein has been obtained from sources believed to be reliable. Although we believe the industry and market data to be reliable as of the date of this presentation, this information could prove to be inaccurate. Industry and market data could be wrong because of the method by which sources obtained their data and because information cannot always be verified with complete certainty due to the limits on the availability and reliability of raw data, the voluntary nature of the data-gathering process, and other limitations and uncertainties. In addition, we do not know all of the assumptions that were used in preparing the forecasts from the sources relied upon or cited therein.

Overview

Discovering and Developing the Next Generation of Phospholipid Drug Conjugates (PDC's)

- **Initiated Phase 3 Confirmatory Trial of iopofosine I 131 in Waldenstrom's macroglobulinemia (WM)**
  - Achieved statistically significant response rate (primary endpoint) in Phase 2b CLOVER WaM pivotal trial
  - Granted WM U.S. FDA Breakthrough & Fast Track Designations, received EU EMA PRIME designation
  - Initiating Phase 3 Confirmatory Trial with First Patient Enrolled projected for 1Q27
  - 1H27 planned submission of U.S. FDA accelerated approval application utilizing Phase 2b data and ongoing Ph 3
- **Initiated Phase 1b/2a Dosimetry WM Trial of Iopofosine I 131 in "All Comers"**
  - Dosimetry as primary endpoint with efficacy and safety as secondary
- **Validated PDC platform possessing the capacity to deliver a broad array of oncology therapeutic modalities; capable of conjugating any radioisotope; overcomes typical drug conjugate development challenges**
  - Initiated CLR 125 Phase 1b Triple Negative Breast Cancer (TNBC) Trial – Auger-emitting therapeutic
  - Completed IND package for CLR 225 (actinium) program - Phase 1 ready, targeting pancreatic cancer
  - Preclinical data with targeted radiotherapies including Lu177, Pb212, and At211

Formula for Value Creation

Strategic Growth and Expansion

- **Optimize global WM regulatory approval pathway for iopofosine I 131**
  - Phase 3 confirmatory trial supports global approval; potential US accelerated approval 2H27
  - EMA Conditional Marketing Authorization submission based upon U.S. potential approval timing
- **Determine US and EU iopofosine I 131 development and commercialization partnerships / approaches**
- **Execute WM Phase 1b/2a Dosimetry Trial of I 131 in “All Comers” – Data updates & NCCN support**
- **Leverage novel PDC platform - advance Phase 1 solid tumor studies**
  - CLR 125 TNBC trial initiated, enrollment ongoing ~ r/r global market potential ~$11B
  - CLR 225 Ph. 1 ready for pancreatic cancer trial, initiation TBD, r/r global market potential ~$10B
- **Secure additional platform collaborations for accelerated asset development and non-dilutive funding**
- **Established competitive advantage – unique radio-therapeutic manufacturing & supply chain model**
- **Extensive IP portfolio; radio-conjugates, small molecules, oligonucleotide payloads and linker technology**

Pipeline

Compound	Disease State	Preclinical	Phase 1	Phase 2	Phase 3
Iopofosine I 131 Iodine-131 β-emitting radioconjugate	Waldenström macroglobulinemia			IRIS WaM* Phase 3 Confirmatory Trial Ongoing	
	b-cell Malignancies			DLBCL, MM & NHL	
	Pediatric High-grade Glioma		Phase 1b		
CLR 121125 Iodine-125 Auger-emitting radioconjugate	Solid Tumor - TNBC		Phase 1b/2		
CLR 121225 Actinium-225 α-emitting radioconjugate	Solid Tumor - Pancreatic	Phase 1a/b Ready			
Early Pipeline	Alpha Emitters (^{211}At, ^{212}Pb, ^{223}Ra)	Phase 1 Ready			
	Beta Emitters (^{177}Lu, ^{90}Y, ^{67}Cu)	IND Enabling			

IRIS WaM = Iopofosine Radiopharmaceutical Improving Survival in Waldenstrom's Macroglobulinemia*

Phospholipid Drug Conjugate (PDC)

Platform Mechanism of Action (MOA)

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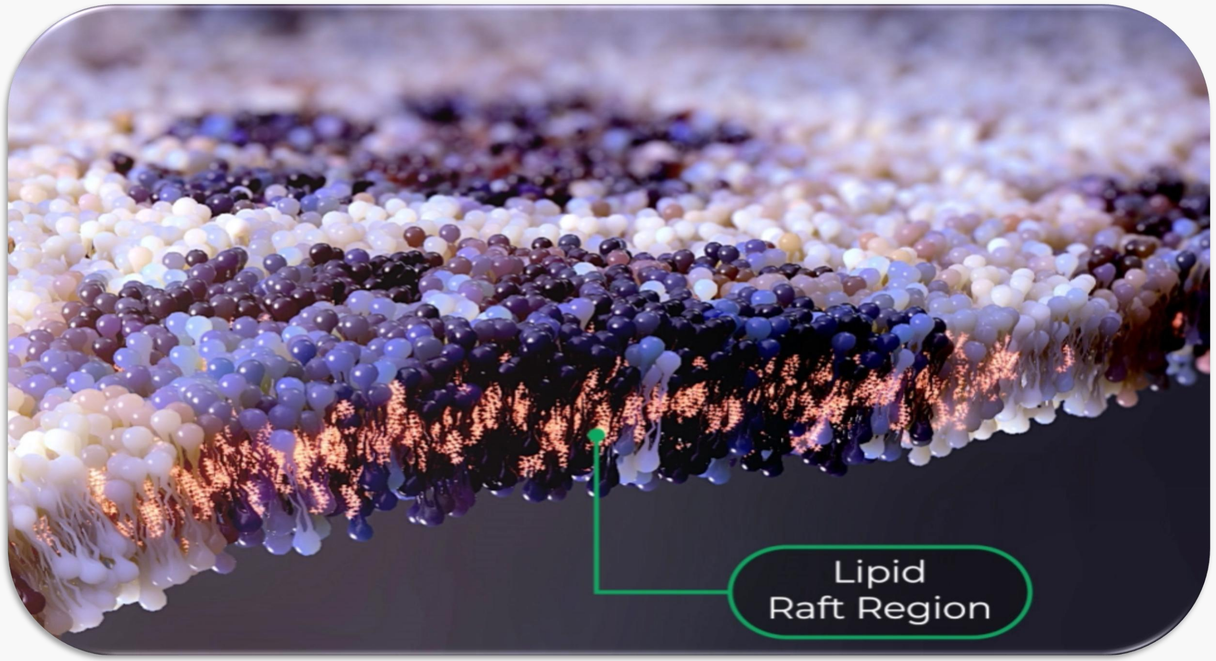
PDC Platform MOA: Lipid Rafts

The Role of Lipid Rafts as a Universal Target in Cancer



Lipid Rafts:

Specialized microdomains within the plasma membrane play a significant role in cancers by facilitating processes like cell signaling, proliferation, survival, invasion, metastasis, and drug resistance. The enriched presence of cholesterol, sphingolipids, and specific proteins in these microdomains enhances the ability of tumor cells to thrive in challenging environments

Lipid Rafts Play an Influential Role in Cancer

Enhanced oncogenic signaling

- Concentrate and stabilize growth factor receptors

Survival and resistance to apoptosis

- Help cancer cells survive and escape programmed cell death

Cancer invasion and metastasis

- Facilitate cancer cell migration, invasion, and metastasis

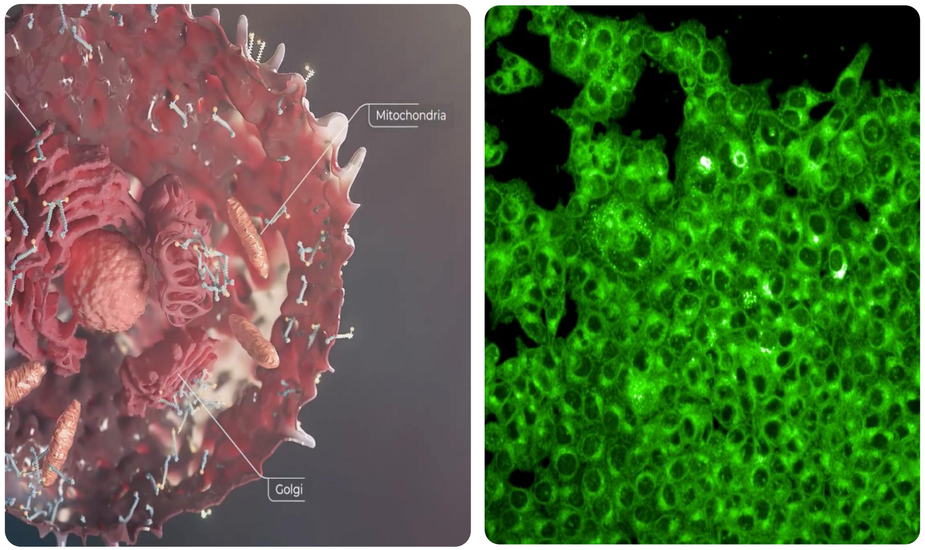
Targeting cancer

- High prevalence on tumor cells vs. healthy tissue
- Stabilize for approximately 10 days in tumor cells compared to milliseconds for healthy tissue
- Uniformly present across tumor cells and tumor types

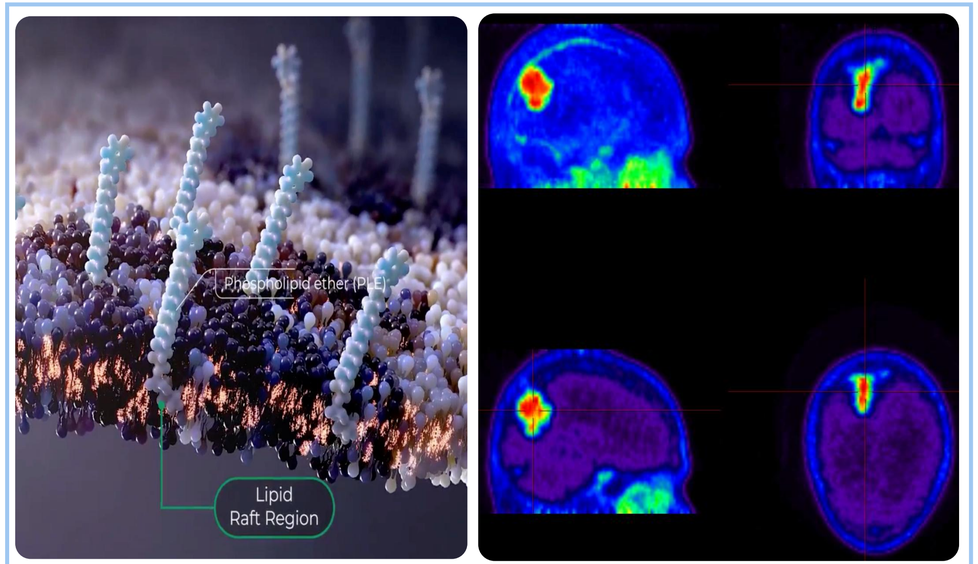
PDC Platform MOA: Universal, Intracellular Targeting with Diverse Payloads

Enhanced Targeting, Limited Resistance, No Need for Bystander Effect, Improved Toxicity

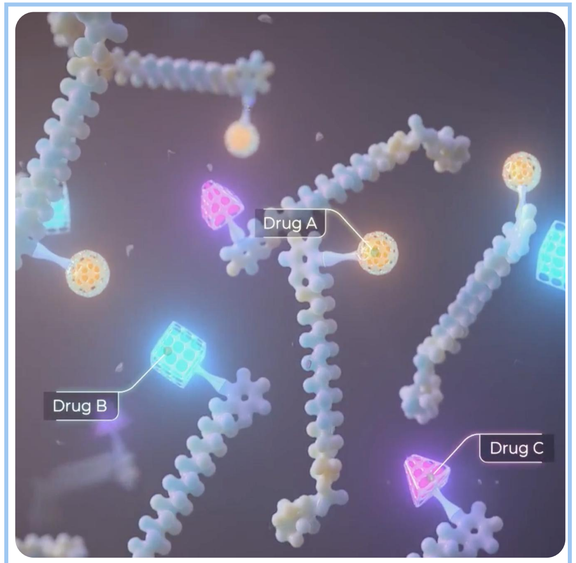
INTERCELLULAR DELIVERY AND RELEASE OF PAYLOAD BY TRANSMEMBRANE FLIPPING OF LIPID RAFT



SPECIFIC TARGETING OF LIPID RAFT ON CANCER CELL MEMBRANE



PDC CONTAINING DESIRED PAYLOAD WITH TUMOR-TARGETING PHOSPHOLIPID ETHER



PROFILE	DIVERSE PAYLOAD	PAN-CANCER TARGETING	CANCER SPECIFIC TARGET	RAPID UPTAKE	CNS PENETRATION	CYTOPLASMIC ENTRY
Phospholipid Drug Conjugate[1] (PDC)	✓	✓	✓	✓	✓	✓

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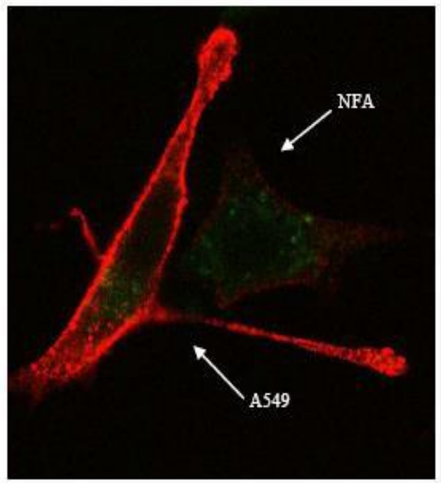
PDCs Overcome Drug Conjugate Challenges

PDC Platform MOA: Lipid Rafts Mediate Entry into Tumor Cells

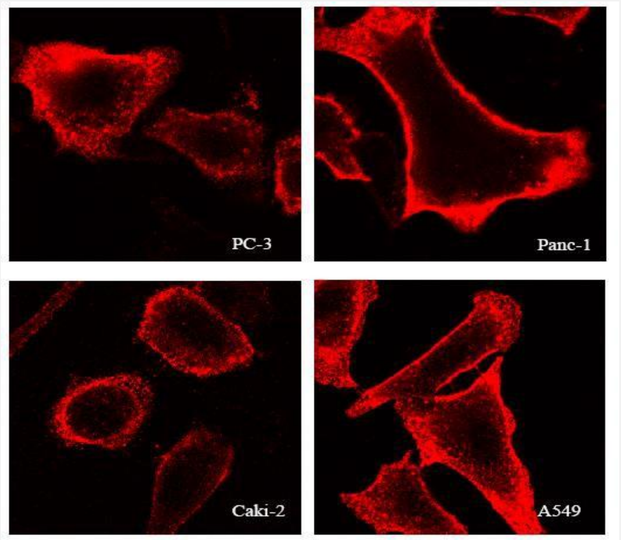
Overabundance of Lipid Rafts on Tumor Cells

Lipid Rafts Fluorescent-labeled with Cholera Toxin Subunit

A549 labeling vs Fibroblast Co-cultured



Prostate **Pancreatic**

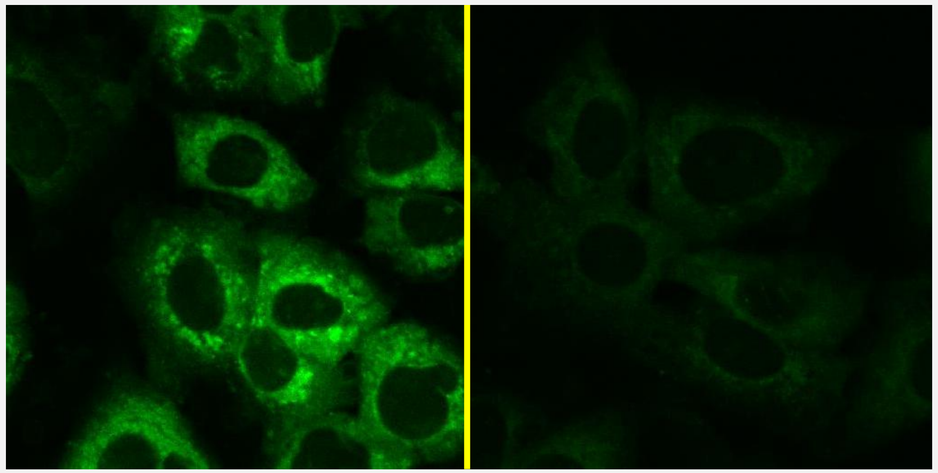


Kidney **Lung**

Red = labeled lipid rafts

Methyl-β-cyclodextrin (MBCD) Selectively Disrupts Lipid Rafts

A549 NSCLC



No MBCD pretreatment
Intact lipid rafts

MBCD pretreatment
Disrupted lipid rafts
Uptake decreased by ~60%

Green = fluorescent tagged PDC

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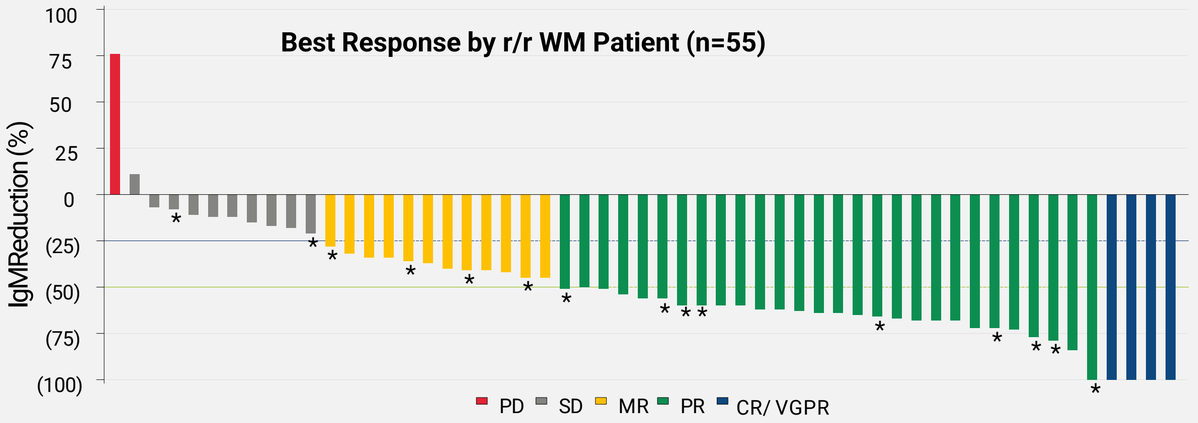
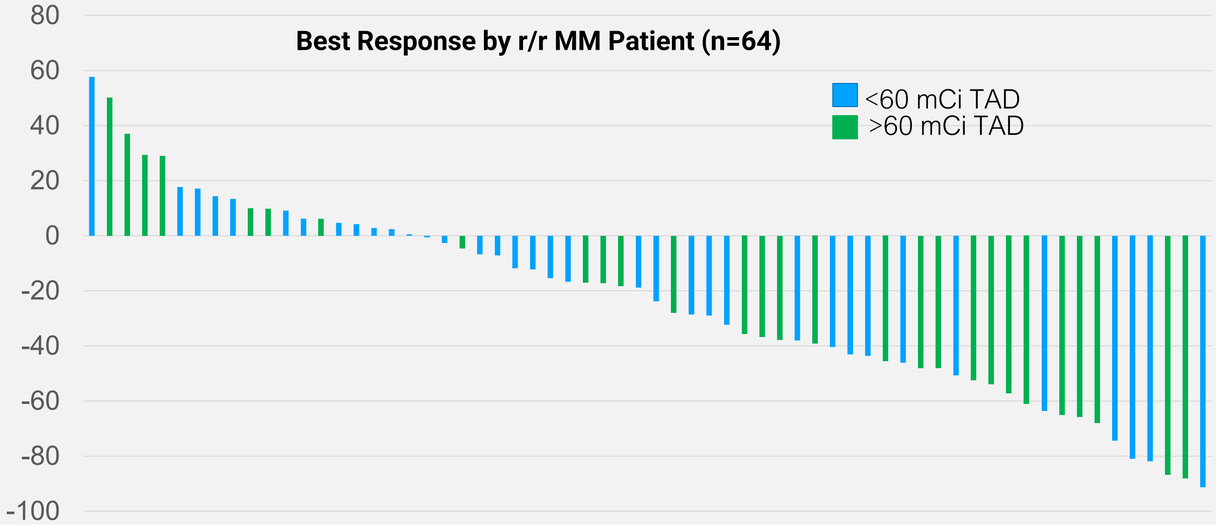
Targeting and Uptake by Lipid Rafts Proof of Concept

PDC Platform MOA: Lipid Rafts Mediate Entry into Tumor Cells

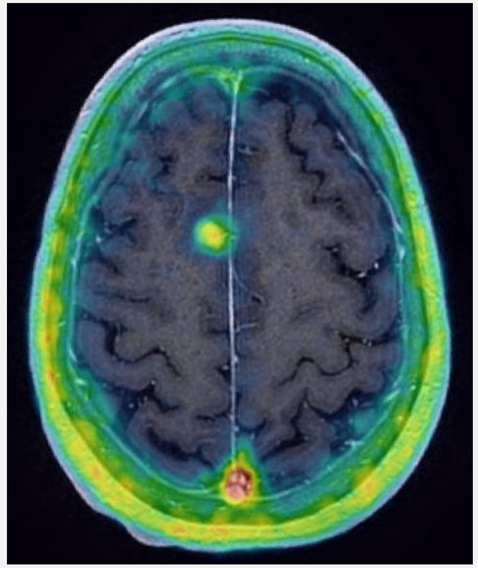
Clinically Validated Platform and Payload Flexibility

Iopofosine I 131





Iopofosine I 124



Metastatic Melanoma, 2 Brain Metastasis

Metastatic Colorectal Cancer, Lung Metastasis

- Same chemical structure; different isotope
- Clinical validation of pan-targeting, uptake and activity
- Allows selection of right isotope for the right tumor

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Clinical Validation of Platform Capacity to Interchange Isotopes and Maintain Effectiveness

Phospholipid Radioconjugate (PRC) program

Beta Emitter
Iopofosine I 131
Waldenstrom Macroglobulinemia

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PRC Iopofosine I 131: Phase 2b Global CLOVER-WaM Pivotal Trial

Schema

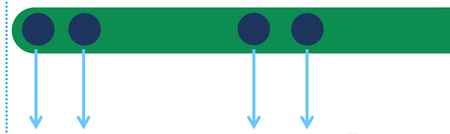
Enrollment Criteria

WM Patients who received 2 Prior lines of therapy, including failed or suboptimal response to BTKi n=50

Treatment and Primary Evaluation Period

Endpoints:
Major Response Rate

Key Secondaries:
DoR, TFR, ORR



- 4 doses over two cycles (71 days)
- Active evaluation period for up to 12 months from initial dose (every 3 weeks)

Long Term Follow-up (3 years)

- Intermittent evaluations
  - Minimum once every 3 months for 1 year
  - Every 6 months post 1 year

MRR Primary Endpoint of 20% Achieves Statistical Significance

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PRC Iopofosine I 131: Phase 2b Global CLOVER-WaM Pivotal Trial

Demographics - Patient Characteristics Data Cut-off September 30, 2024

Patient Characteristics	
Safety population, n	65
Median age, years (range)	70 (50-88)
Sex, n (%)	
Male	48 (73.8)
Female	17 (26.2)
IPSSWM score n (%)	
Low	28 (43.1)
Medium	20 (30.8)
High	17 (26.2)
Median IgM, mdl (range)	2115 (252 – 7400)
Extramedullary Volume, mm³ (range)	2303 (210 – 17185)
Bone Marrow Burden at Baseline, n (%) 52	
< 20%	21 (40.4)
20 – 50%	17 (32.7)
> 50%	14 (26.9)

Patient Characteristics	
Median Prior Lines of Therapy, n (range)	4 (2-15)
Prior Treatment/Refractory n (%)	
BTKi	48 (73.8) / 37 (77.1)
Rituximab	60 (92.3) / 45 (75.0)
Chemotherapy	55 (84.6) / 33 (60.0)
BTKi & Rituximab (Dual Refractory)	43 (66.2) / 25 (58.1)
BTKi, Rituximab & Chemo (Triple Refractory)	37 (56.9) / 18 (46.4)
Genotype (%)	
MYD88 WT/Mut (n=65)	18 (27.7) / 47 (72.3)
CXCR4 WT/Mut (n=53)	45 (84.9) / 8 (15.1)
P53 WT/Mut (n=52)	42 (80.8) / 10 (19.2)

Most Refractory WM Patient Population Studied in Clinical Trials

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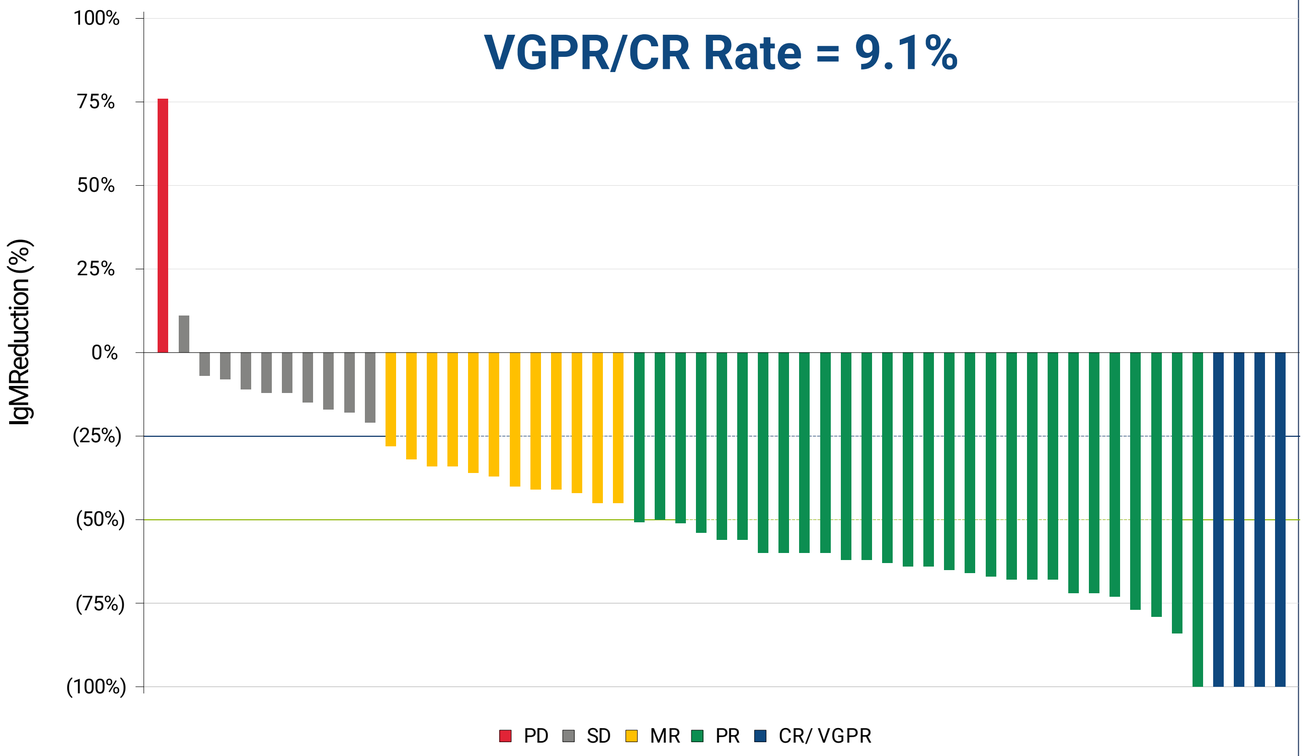
PRC Iopofosine I 131: Phase 2 b CLOVER-WaM Pivotal Trial

Efficacy Data - Best Serum IgM Response by Patient

Evaluable Efficacy Population (n=55)

ORR = 80% **MRR = 58.2%** **DCR = 98.2%**

VGPR/CR Rate = 9.1%

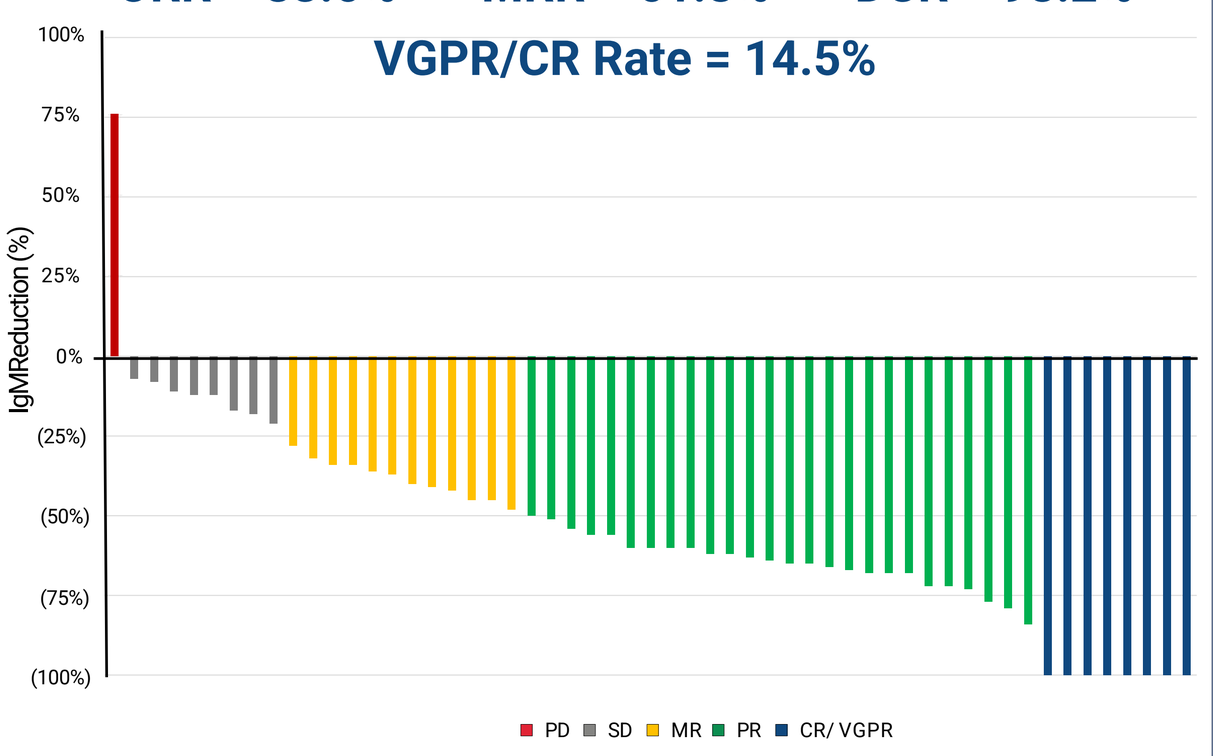


Data Cut Date = Sept 2024

Evaluable Efficacy Population (n=55)

ORR = 83.6% **MRR = 61.8%** **DCR = 98.2%**

VGPR/CR Rate = 14.5%



Data Cut Date = Dec 2025

Depth of Response Continues to Increase Over Time;

All Patients Followed a Minimum of 12 Months

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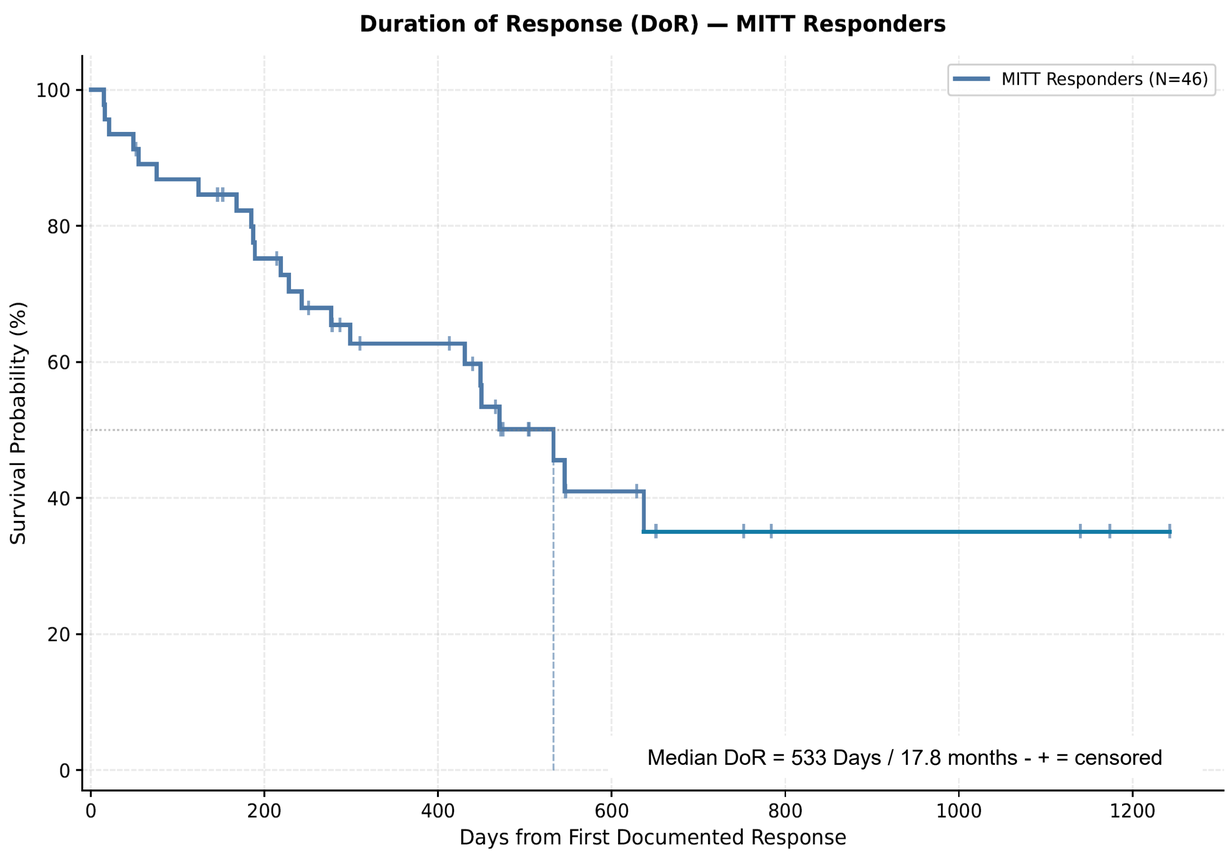
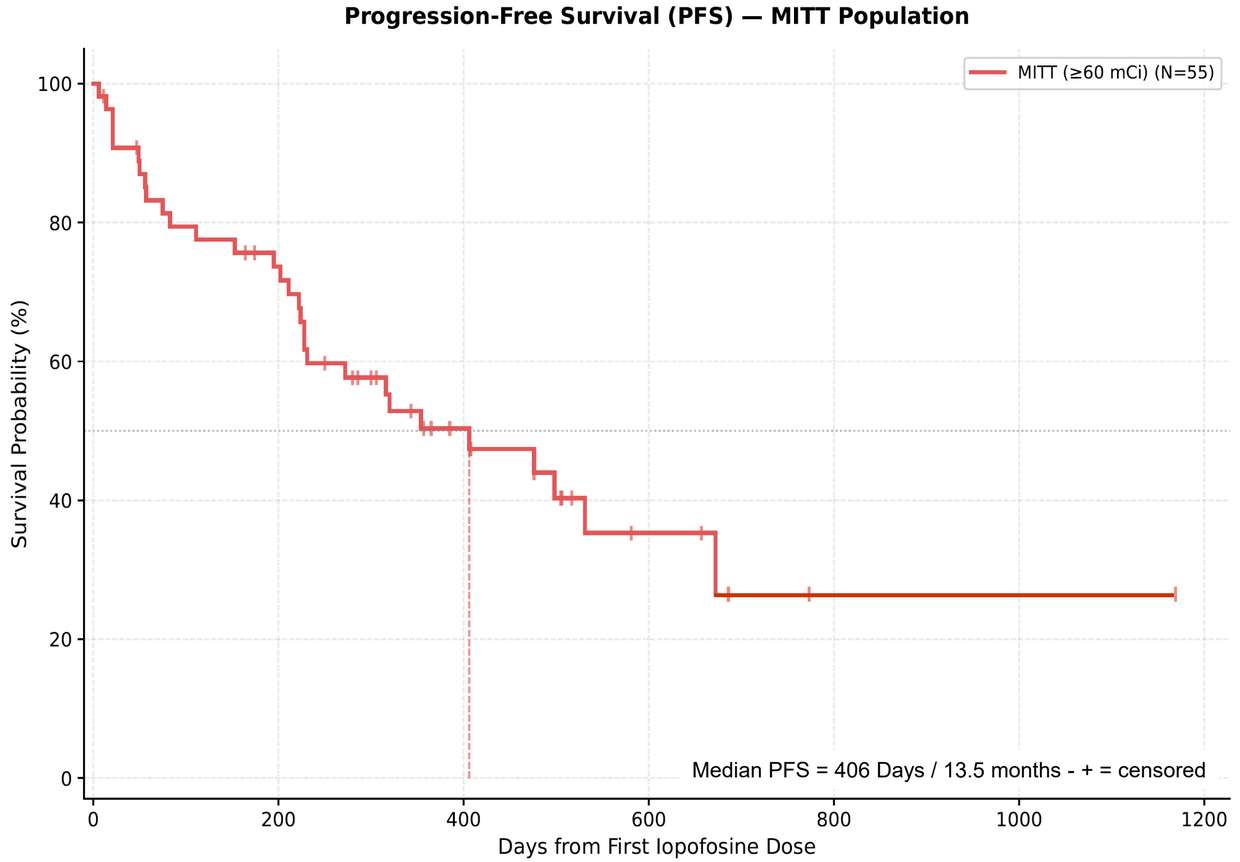
PRC Iopofosine I 131: Phase 2b CLOVER-WaM Pivotal Trial

Efficacy Data - Duration of Response & Progression Free Survival Analysis (mITT)– Data cutoff Dec 2025





With only Four ~20-minute Infusions, Iopofosine Achieves 17.8 Months DoR with a PFS of 13.5 Months

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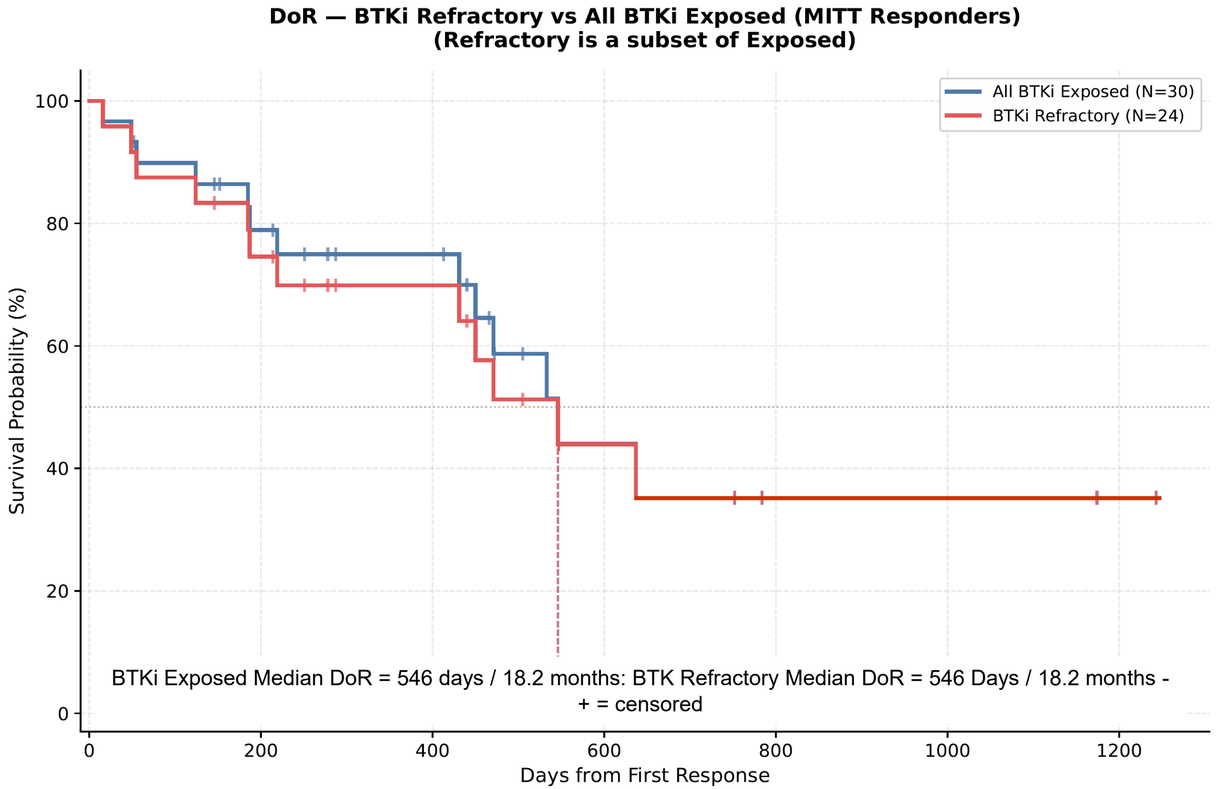
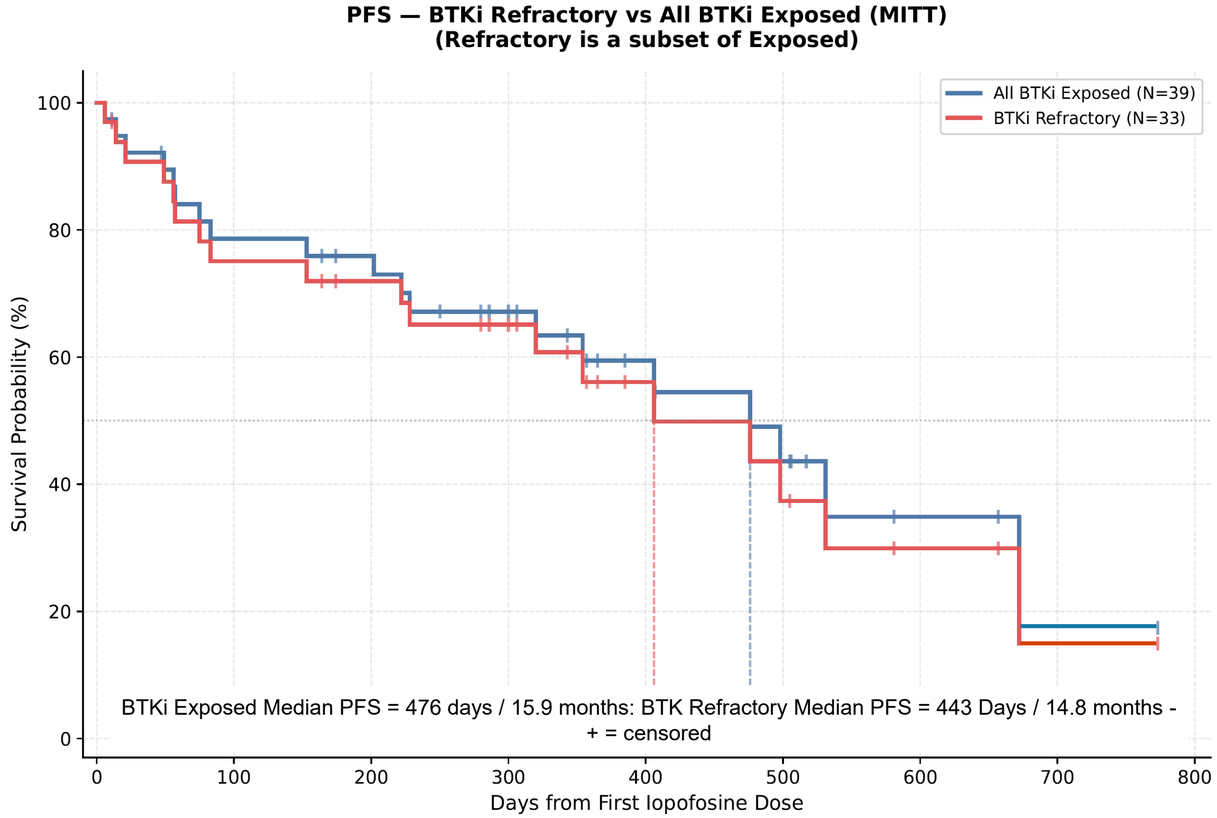
PRC Iopofosine I 131: CLOVER-WaM Efficacy Data

Sub-analysis of BTKi Refractory vs BTKi Exposed: DoR and PFS in Patients (mITT) – Data cut-off Dec 2025





Iopofosine Demonstrates 18.2 months of DoR in BTKi Refractory and BTKi Exposed Patients; PFS achieves 14.8 and 15.9 months respectively

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PRC Iopofosine I 131: CLOVER-WaM Efficacy Data

Sub-analysis of BTKi Refractory vs BTKi Exposed: Comparison to only published data set

Comparison of Patient Populations

Frustaci Study

- Median Age 75.5
- **Refractory to BTKi – 69.2%: Intolerant to BTKi – 30.2%**
- **Median Prior Therapies 3 (range: 1 – 7)**
- **MYD88 WT – 17%: MYD88 mut – 83%**
- Median IgM – 2849
- IPSSWM Score – Low 21.8%: Intermediate 47.4%: High 30.8%

CLOVER WaM Trial

- Median Age 70
- **Refractory to BTKi – 84.6%: Intolerant to BTKi – 15.4%**
- **Median Prior Therapies 4 (range: 2 – 15)**
- **MYD88 WT – 27.7%: MYD88 mut – 72.2%**
- Median IgM – 2115
- IPSSWM Score – Low 43.1%: Intermediate 30.8%: High 26.2%

	Frustaci et al. 2025 (BTKi Exposed n=78)	Iopofosine I 131 (BTKi Exposed n=39)	Frustaci et al. 2025 (BTKi Refractory n=54)	Iopofosine I 131 (BTKi Refractory n=33)
ORR	50%	76.9%	38%	72.7%
MRR	ND (predicted <30%)	64.1%	ND	63.6%
VGPR/CR	7.7%	15.4%	ND	18.2%
DoR	18 months	18.2 months	ND	18.2 months
PFS	8.1 months	15.9 months	5.8 months	14.8 months

Frustaci et al. demonstrated that only two factors impacted patient outcomes:

- BTKi-refractory status and
- Number of prior lines of therapy
- Choice of salvage regimen did not affect outcomes (immunochemotherapy, BCL-2 inhibitor, non-covalent BTKi, or proteasome inhibitor)

Iopofosine Outperforms All Salvage Therapies in a Similar Refractory Patient Population

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PRC Iopofosine I 131: Phase 2b CLOVER-WaM Pivotal Trial

Safety data - Observed Cytopenias Consistent with Treatment of Hematologic Malignancies

Most common TEAE* (>10% patients), n (%)	Any grade n=65
Hematologic Toxicities	
Thrombocytopenia	56 (86.2)
Neutropenia	52 (80.0)
Anemia	42 (64.6)
White blood cell count decreased	21 (32.3)
Lymphocyte count decreased	9 (13.8)
Febrile neutropenia	7 (10.8)
Non-hematologic Toxicities	
Fatigue	22 (33.8)
Nausea	19 (29.2)
Diarrhea	13 (20.0)
Dyspnea	11 (16.9)
Headache	11 (16.9)
Dizziness	10 (15.4)
Epistaxis	9 (13.8)
Decreased appetite	9 (13.8)
Constipation	8 (12.3)

Most common TEAE* (>10% patients), n (%)	Grade ≥3 n=65
Thrombocytopenia	53 (81.5)
Neutropenia	43 (66.2)
Anemia	31 (47.7)
White blood cell count decreased	18 (27.7)
Lymphocyte count decreased	8 (12.3)
Febrile neutropenia	7 (10.8)

- No significant bleeding
- Limited rate of infection (<10%)
- All hematologic AEs were manageable
- All patients recovered from cytopenias
- All non-hematologic AEs < Grade 2

TEAE, treatment-emergent adverse event.*

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PRC Iopofosine I 131: Adverse Event Comparison to BTKi's

Safety data – Treatment Emergent Adverse Events of Iopofosine as Compared to the Only Approved WM Therapies

Adverse Event Occuring in ≥10% All Grades	Zanubrutinib (n=101)		Ibrutinib (n=98)		Iopofosine I 131 (n=227)	
	All Grades (%)	Grade ≥3 (%)	All Grades (%)	Grade ≥3 (%)	All Grades (%)	Grade ≥3 (%)
All Infection	67	4	79	14	NA	NA
Musculoskeletal Pain	45	9	39	1	0	0
Upper respiratory infection	44	0	40	2	0	0
Hemorrhage	42	4	43	9	0	0
Fatigue	31	1	25	1	35	4
Rash	29	0	32	0	0	0
Diarrhea	22	3	34	2	NA	NA
Bruising	20	0	34	0	NA	NA
Nausea	18	0	13	1	17	1
Headache	18	1	14	1	NA	NA
Constipation	16	0	7	0	0	0
Pyrexia	16	4	13	2	0	0
Cough	16	0	18	0	0	0
Dyspnea	14	0	7	0	NA	NA
Hypertension	14	9	19	14	0	0
Dizziness	13	1	12	0	0	0
Pneumonia	12	4	26	10	NA	NA
Vomiting	12	0	14	1	NA	NA
Edema (peripheral)	12	0	20	0	0	0
UTI	11	0	13	2	NA	NA
Pruritus	11	1	6	0	0	0
Muscle spasms	10	0	28	1	0	0
Neutropenia	50	24	34	9	61	53
Thrombocytopenia	35	8	39	5	80	71
Anemia	20	7	20	7	60	43
Bilirubin increased	12	1	33	1	0	0
Calcium decreased	27	2	26	0	NA	NA
Creatinine increased	31	1	21	1	0	0
Glucose increased	45	2.3	33	2.3	0	0
Potassium increased	24	2	12	0	0	0
Urate increased	16	3.2	34	6	0	0
Phosphate decreased	20	3.1	18	0	NA	NA
Atrial fibrillation	2	0	15	4	0	0
Key Adverse Events Occurring 12-24 months						
Neutropenia	17.8		8.5		0	
Infections	43.3		54.9		0	
Atrial fibrillation	3.3		13.4		0	
Hypertension	12.2		24.4		0	
Bleeding	32.3		46.3		0	

NA = Adverse events <10%

Data for BTKi's directly from Brukinsa (Zanibrutinib) website

Iopofosine I 131 data from 2025 investigator brochure

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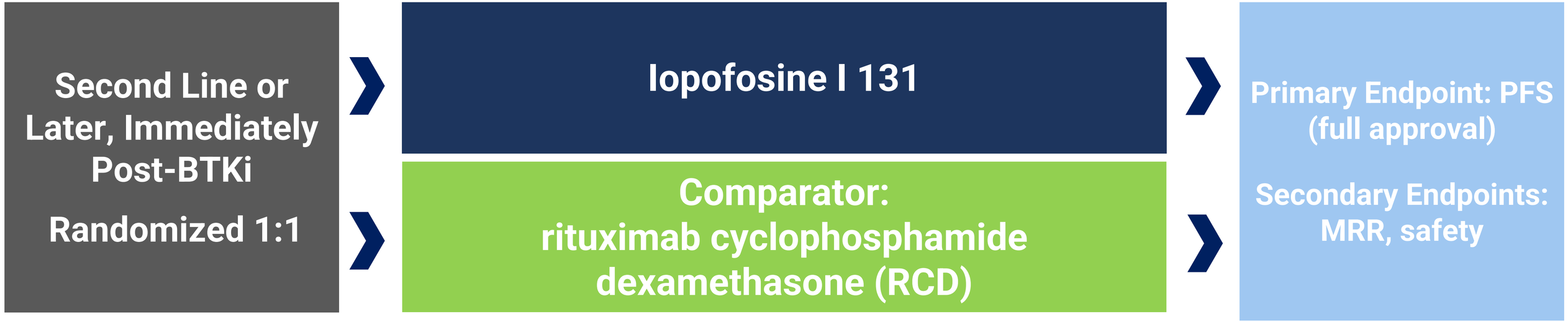
PRC Iopofosine I 131: Phase 3 IRIS WaM Confirmatory Trial for Full Approval

Waldenstrom's macroglobulinemia



- **Enrollment:** ~200 patients (100/arm)
- **Dosing:** Iopofosine I 131 (4 doses of 15 mCi/m2); package insert for RCD
- **Primary Endpoints:** Superiority for PFS
- **Secondary Endpoint:** MRR & Safety; Overall survival assessed for harm and futility
- **Phase 3 Top line data:** Full enrollment 18 – 24 months; PFS expected 24 – 30 months post first patient enrolled
- **Estimated Total Cost $42M:** ~ $15M to accelerated approval and $30M to full approval (PFS data)

Phase 3 Confirmatory Trial Designed for U.S and EU Full Approval

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PRC Iopofosine I 131: U.S. & E.U. WM Market Opportunity

Addressable Patients in a Concentrated Market with High Unmet Need

US Prevalent Patient Population Based Upon Claims = 26,000 [5]

~11,500
2nd line

~4,700
3rd line or greater

~1,000
Exhausted treatment options – currently not seeking Rx

- Patients are concentrated geographically in large community and academic accounts[6]
- **~80%** of patients will receive 3rd line treatment
- **~50%** of patients are retreated with the same or similar treatment from prior lines of therapy
- **>60%** of therapies utilized are not FDA-approved and cannot be promoted
- **~80%** of WM patients located in 15 states[7]

EU Prevalent Patient Population = ~36,000[8]

~12,600
2nd line

~5,000
3rd line or greater

Concentrated
Specialist Care Centers

- Forecast is based upon the EU 27 countries only and patients are concentrated in referral centers
- **~80%** of patients will receive 3rd line treatment
- Specialty referral center patient concentration limit's infra-structure needed to access patients
- **>60%** of therapies utilized are not EMA-approved; limited options results in patient remaining on ineffective therapy
- **>80%** of WM patients located in DE, FR, IT, SP, UK, GR, Nordics

Concentrated Market with Limited Treatment Options

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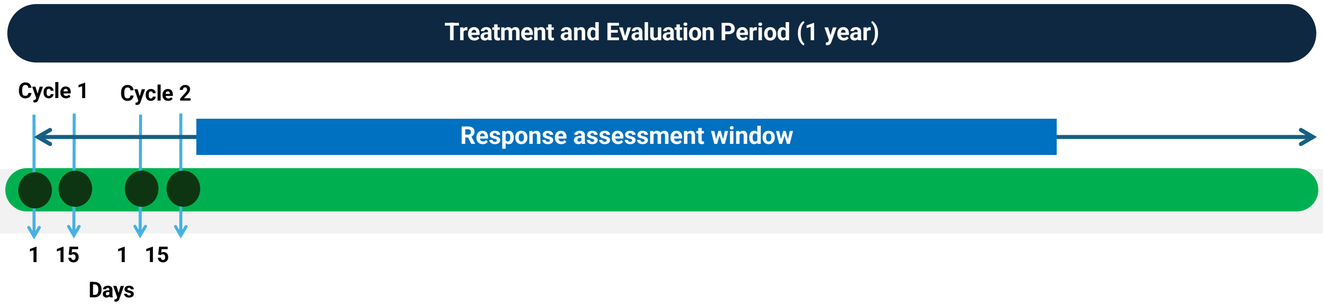
PRC Iopofosine I 131: Phase 1b/2a Dosimetry Trial

Patient Selection: All Comers Waldenstrom's macroglobulinemia

Trial Overview

- Imaging and therapy study
- Population: Front line or later WM patients
- Primary Endpoint: Dosimetry outcome
- Secondary Endpoints: Efficacy and Safety
- Target 20 – 30 patients

Trial Schematic
2 cycles (4 doses – 15mCi/m^2 per dose): 20 - 30 patients



- Dosimetry to occur following first dose of iopofosine in each cycle
- Safety and efficacy will be captured for all patients

Trial Initiation Planned in 4Q26

Addresses FDA Requests and Provides Front Line Efficacy Support for NCCN

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Phospholipid Radioconjugate (PRC) program

Beta Emitter
Iopofosine I 131
Additional Indications

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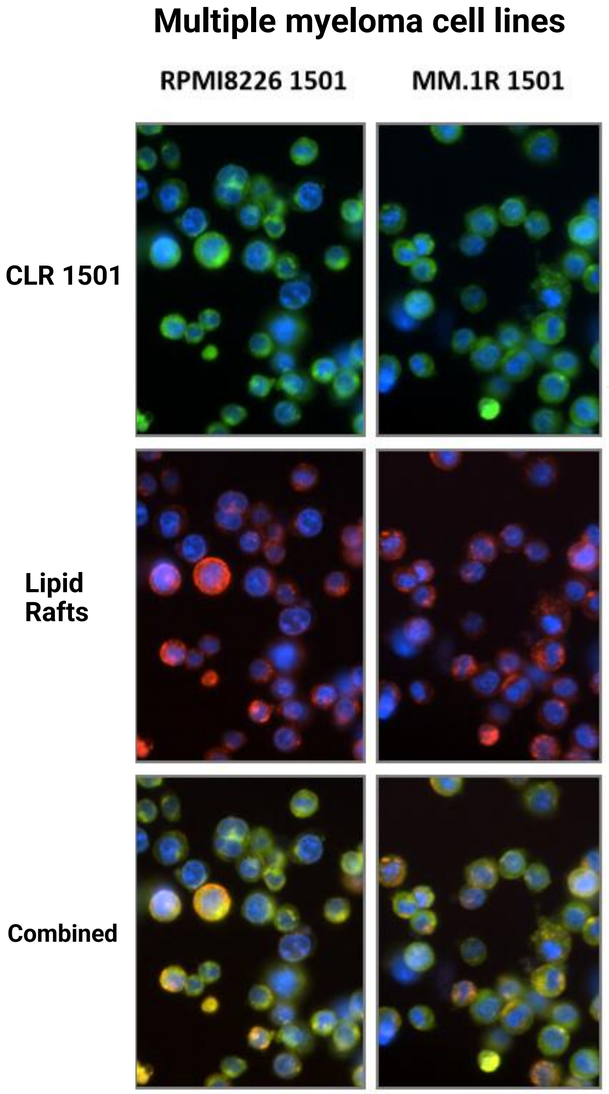
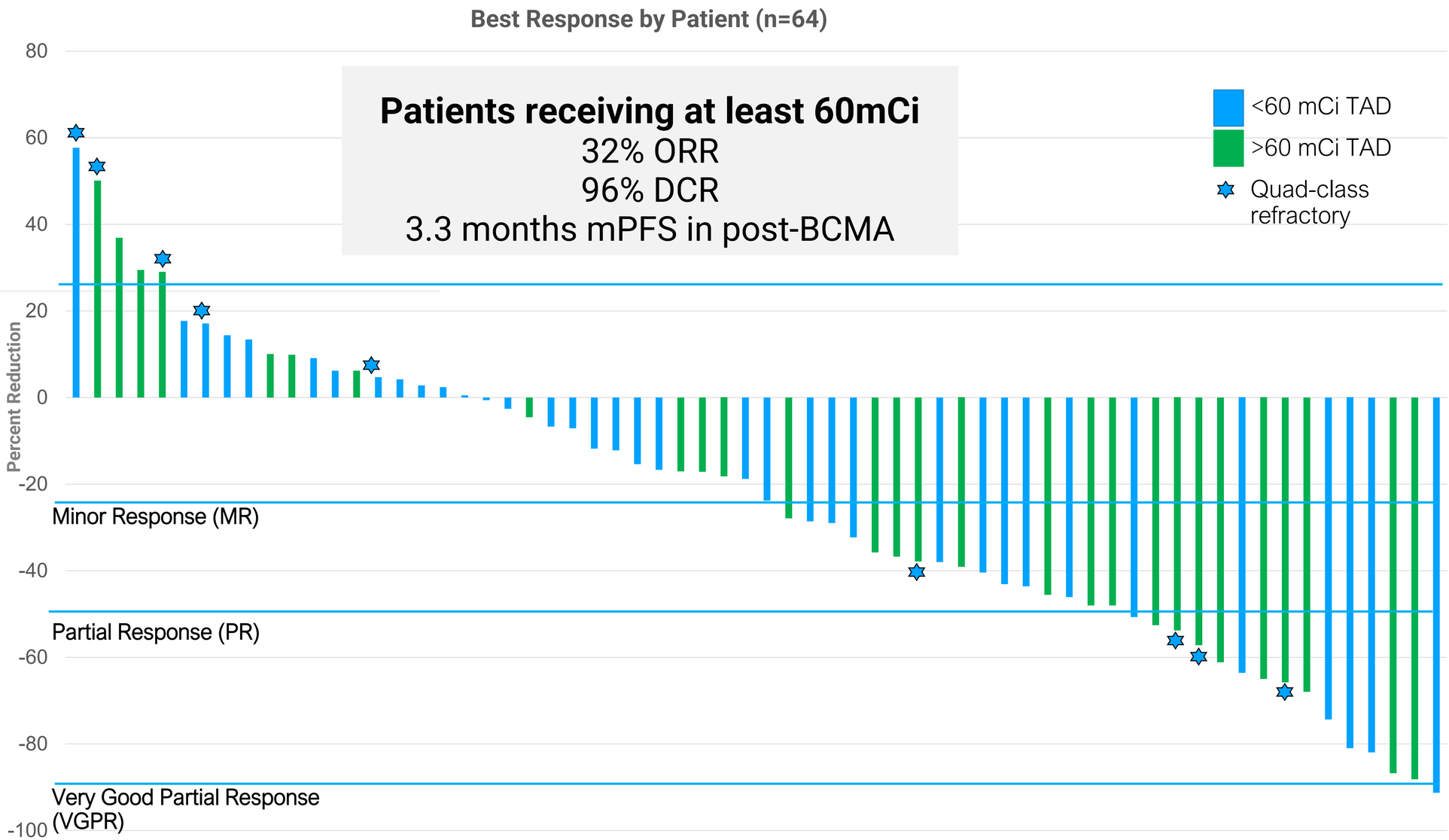
PRC Iopofosine I 131: r/r Multiple Myeloma Best Response

Waterfall Plot of All Multiple Myeloma Patients





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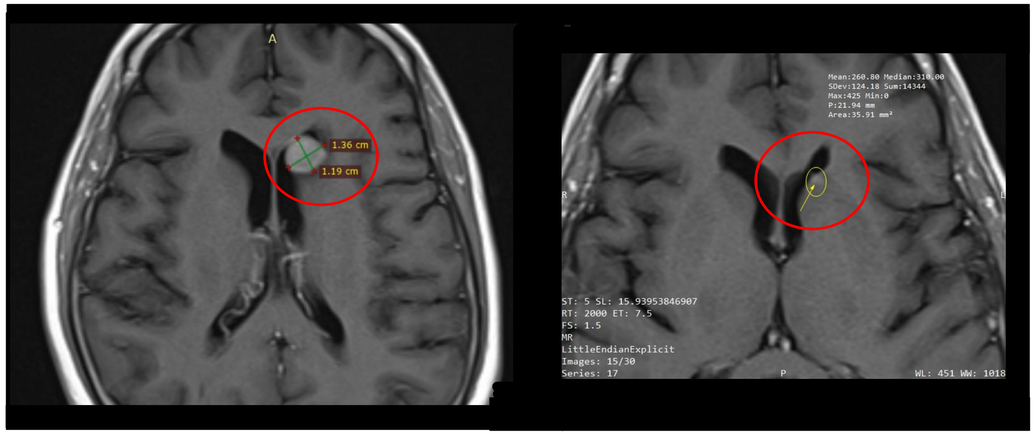
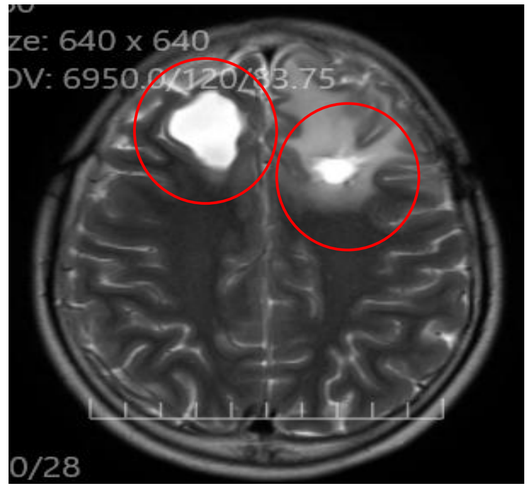
PRC Iopofosine I 131: Broad Clinical Activity Beyond WM

Refractory Primary CNS Lymphoma



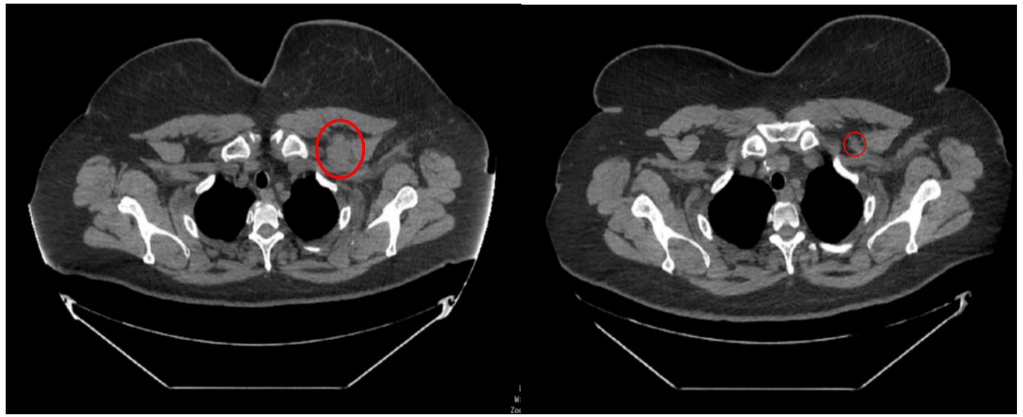
Complete Response

Relapsed Pediatric High-Grade Glioma



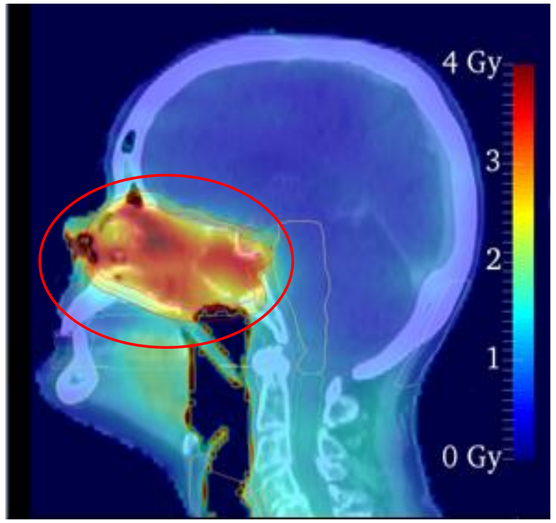
Extended PFS (~12 months)

Refractory Diffuse Large B-cell Lymphoma



30% ORR with 10% CRR – CR PFS 6.8 years

Recurrent Head & Neck Cancer



73% ORR with 64% CRR

Phospholipid Radioconjugate (PRC) Program

Auger Emitter – CLR 125 (TNBC)

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PRC CLR 12125 (CLR 125): Auger Emitter (^{125}I)

Microenvironment, Tumor Biology & Isotope Properties Drive Safety and Efficacy

	Composition	Primary Mechanism of Cell Death	Penetrating Power (Emission Distance)	Relative Biologic Effect
Alpha Particles	2 protons 2 neutrons	Double strand DNA breaks	50 – 100um (80-100 keV/μm)	~5
Beta Particles	1 electron	Single strand DNA breaks	12mm (~0.2 keV/mm)	1
Auger Electrons	Multiple electrons	Double strand DNA breaks	2 – 500nm (4-26 keV/μm)	1 – 5

- Short penetrating power, requires intracellular delivery to be effective
- Similar cell damage as alpha emitters – double strand and multi-base pair DNA breaks
- Additional activity from reactive oxygen species, designed to provide enhanced immune stimulation
- Short emission distance limits off target effects and adverse events

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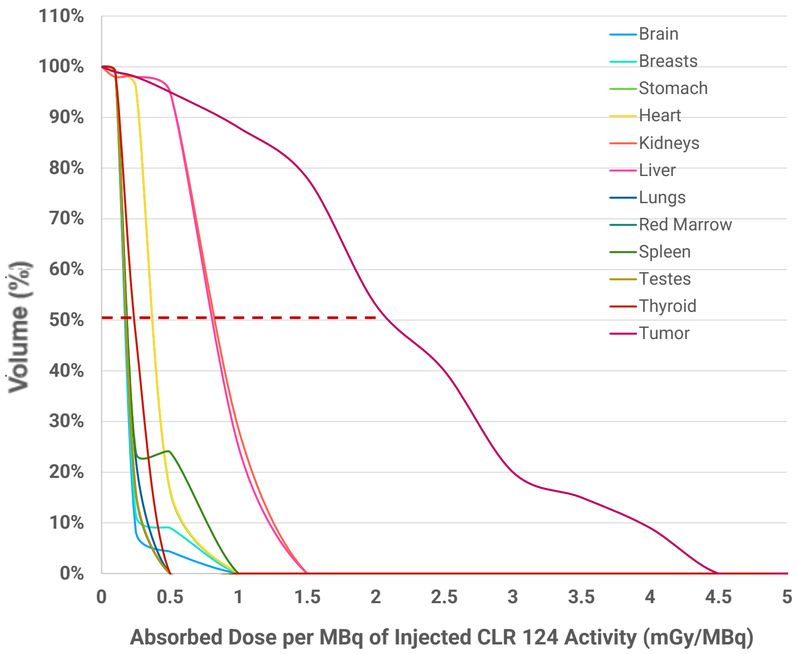
Properties of Different Emitters Provide Enhanced Outcomes

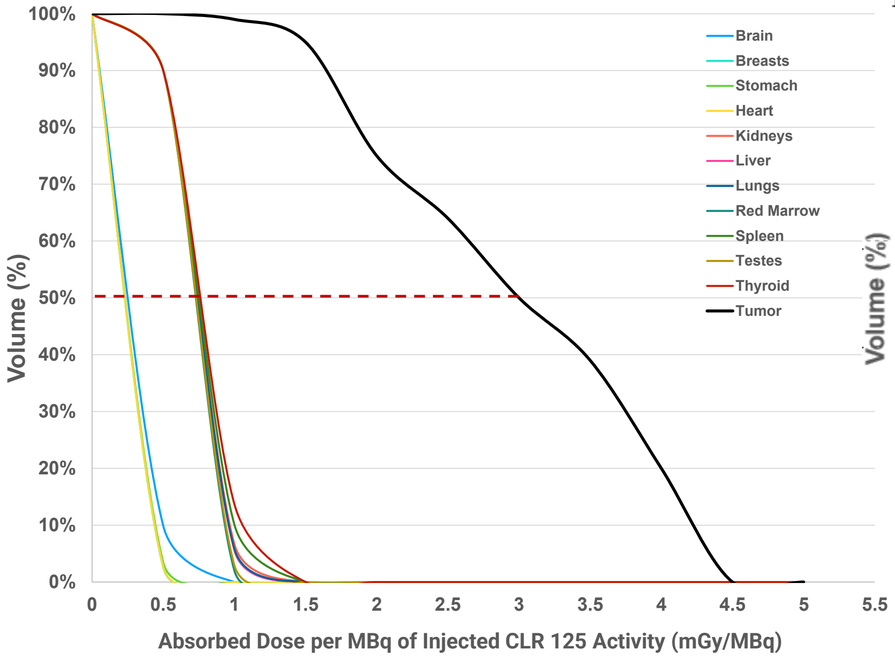
PRC CLR 121125 (CLR 125): Auger Emitter (^{125}I)

Enhanced Tumor Absorbed Dose Results in Increased Cell Killing

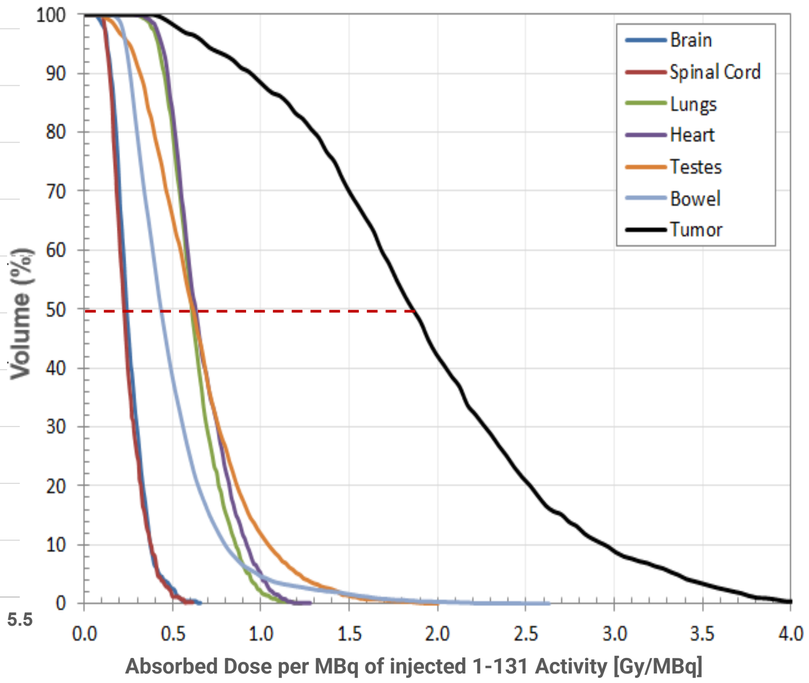
CLR 124



CLR 125



CLR 131



- Isotope half-life can drive absorbed dose (targeting ligand PK, uptake and retention key)
- Tumor absorbed dose versus normal tissue = therapeutic window

CLR 121125 Demonstrated Greatest Tumor and Lowest Normal Tissue Absorbed Dose

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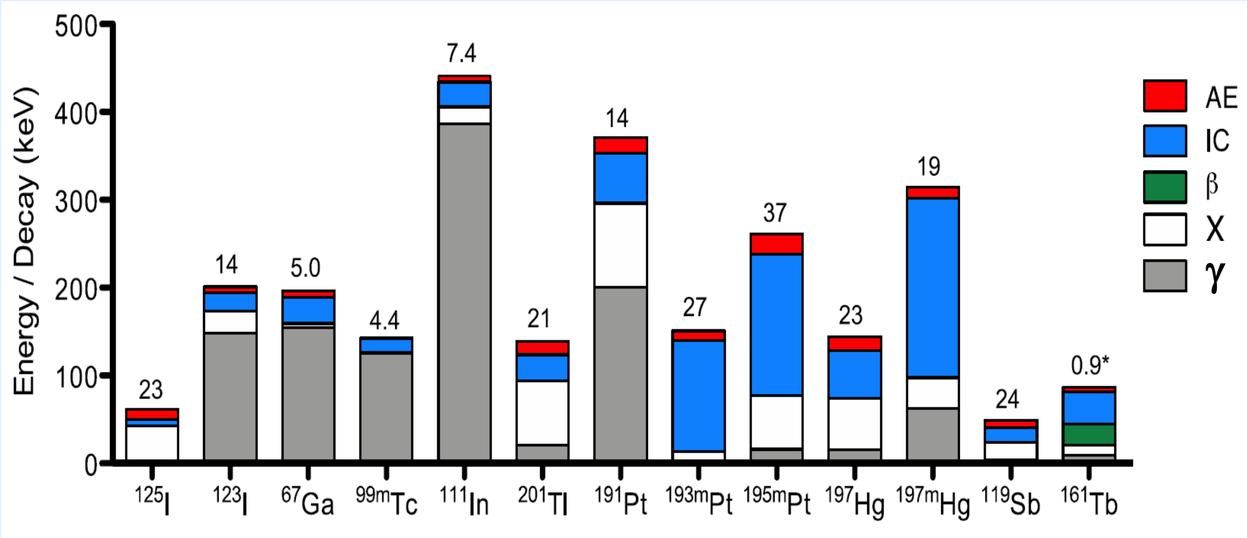
PRC CLR 121125 (CLR 125): Auger Emitter (^{125}I)

Offers Benefits Vs Other Auger Emitters



AE = Auger electron

X = X-ray

IC = internal conversion

γ = gamma emission

β = beta electron emission

Why I-125?

- One of the highest Auger electron emitters
- 57-day half-life enhanced outcomes
- No Beta or Gamma emissions observed

Existing data set supports Phase 1b/2 clinical Trial

- Initial indication triple negative breast cancer
- 3 dosing groups exploring multiple cycles with an expansion arm
- Primary endpoint: Phase 2b dose selection

High Electron Delivery With Cleaner Emissions, Optimized Safety and Ease of Use

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PRC CLR 121125 (CLR 125): Auger Emitter (^{125}I)

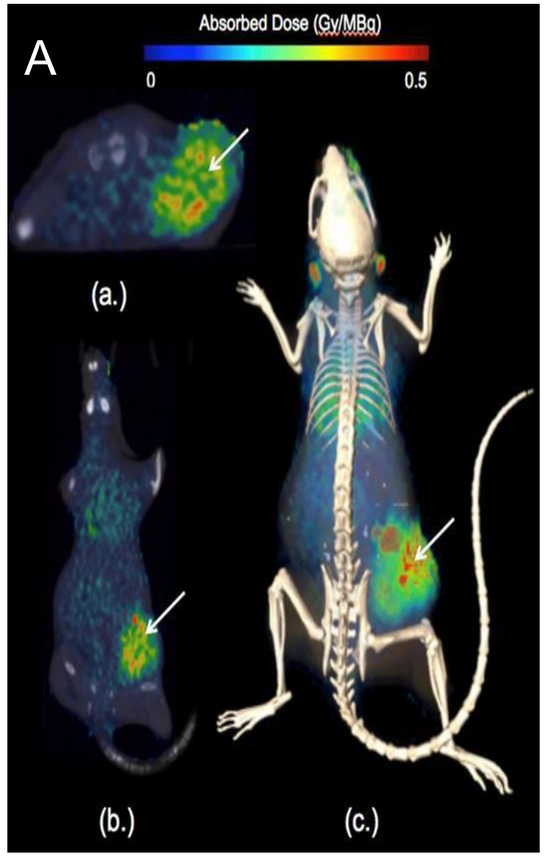
TNBC - Observed Statistically Significant Activity and Well Tolerated *In Vivo*

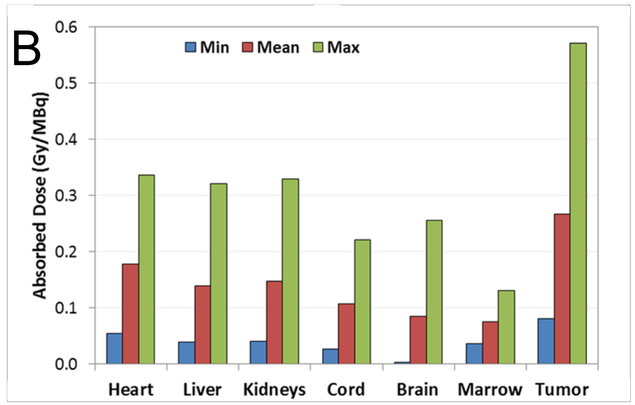
CLR 125 structurally identical to iopofosine I 131; potentially reduced development risk

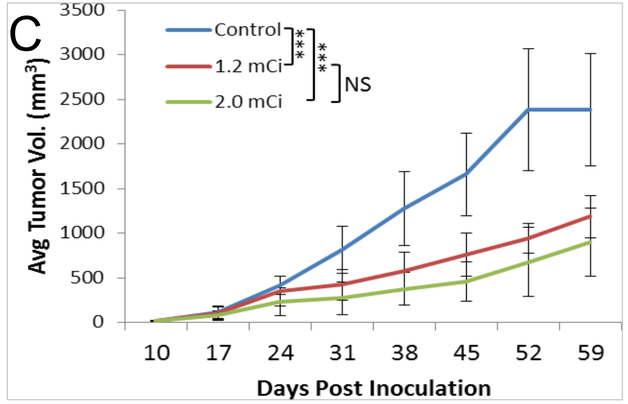
CLR 125 tested in MDA-MB-231 triple negative breast cancer

- Observed significant tumor uptake (images A & B)
- Single infusion resulted in growth inhibition at both tested doses (1.2mCi and 2mCi) – Image C
- Observed statistically significant activity at 2mCi dose - data not shown

No signs of end-organ toxicity, including hematologic toxicity







Validated Intracellular Deliverv with CLR 121125

PRC CLR 121125 (CLR 125): Auger Emitter (^{125}I)

Phase 1b Dose Finding Trial in Relapsed Triple Negative Breast Cancer

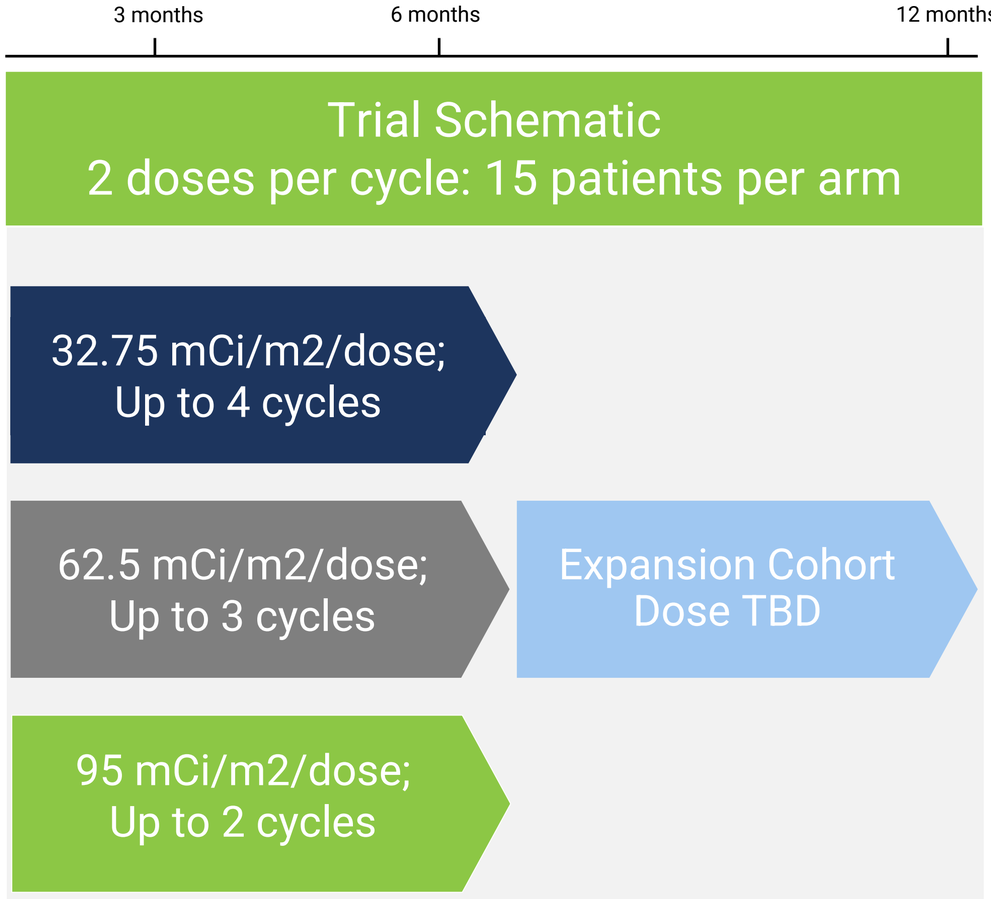
Phase 1 Trial Overview

- Imaging and therapy study
- Population: TNBC patients with progressive disease and no treatment option
- Primary Endpoint: Recommended Phase 2 dose
- Secondary Endpoints: Safety & tolerability; initial response assessment (RECIST v1.1 and PFS); distribution
- Dose determination based upon preclinical data and imaging results

Key Inclusion/Exclusion Criteria

- Confirmed TNBC
- Relapsed from at least 1 prior treatment
- At least 1 measurable lesion of >10mm
- No ongoing Grade 2 or greater adverse events
- At least 2 weeks since prior antitumor treatment

Trial Schematic
2 doses per cycle: 15 patients per arm



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Mayo Clinic Network to Lead TNBC Clinical Trial

Phospholipid Radioconjugate (PRC) Program

Alpha Emitters – CLR 225 (Pancreatic)

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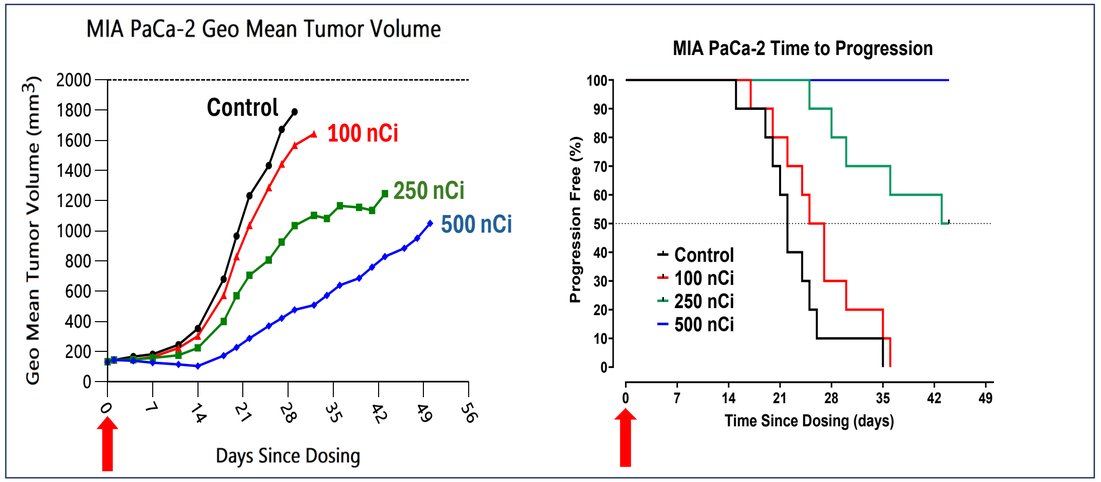
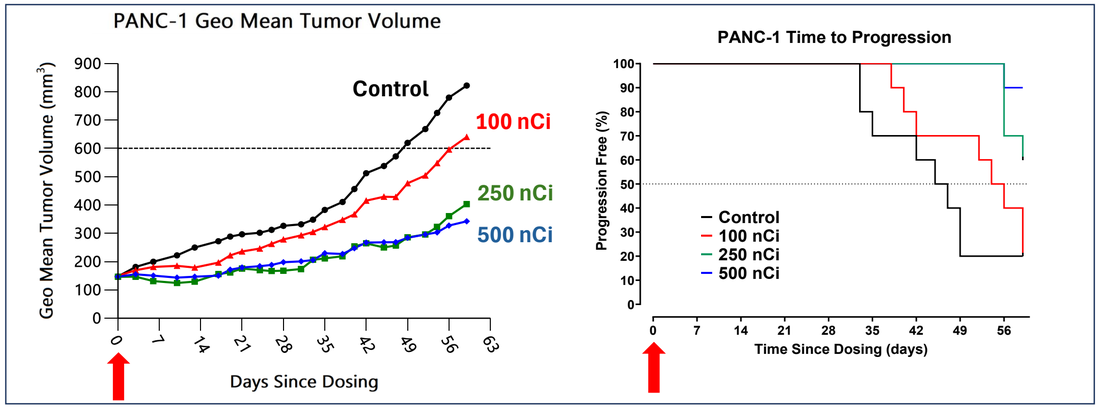
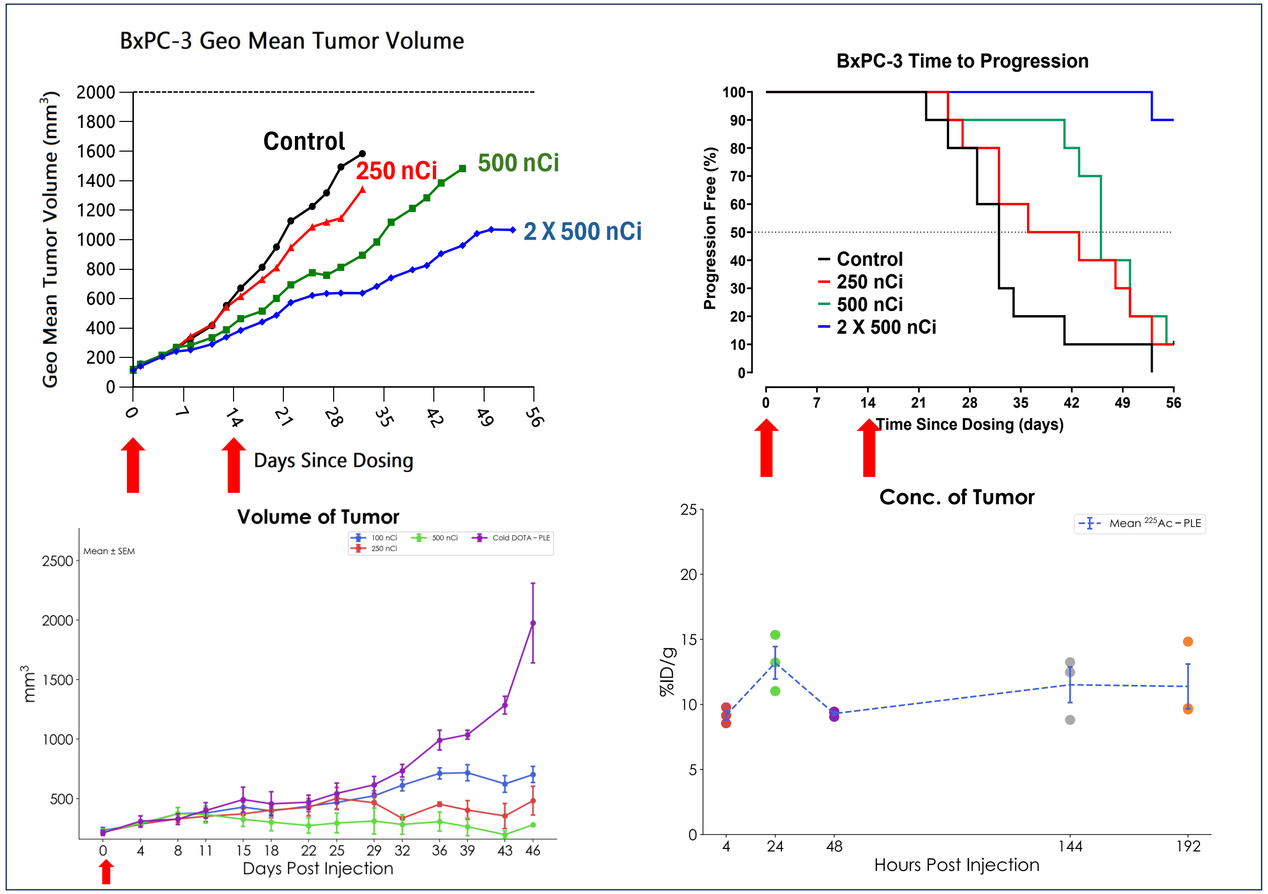
PRC CLR 121225 (CLR 225): Alpha Emitter (^{225}Ac)

Tumor Volume Reduction and Survival Benefit in Pancreatic Cancer







- 3 xenograft models of pancreatic cancer
- Dose response exhibited in all models (Cold, 100nCi, 250nCi and 500nCi)
- All doses well tolerated

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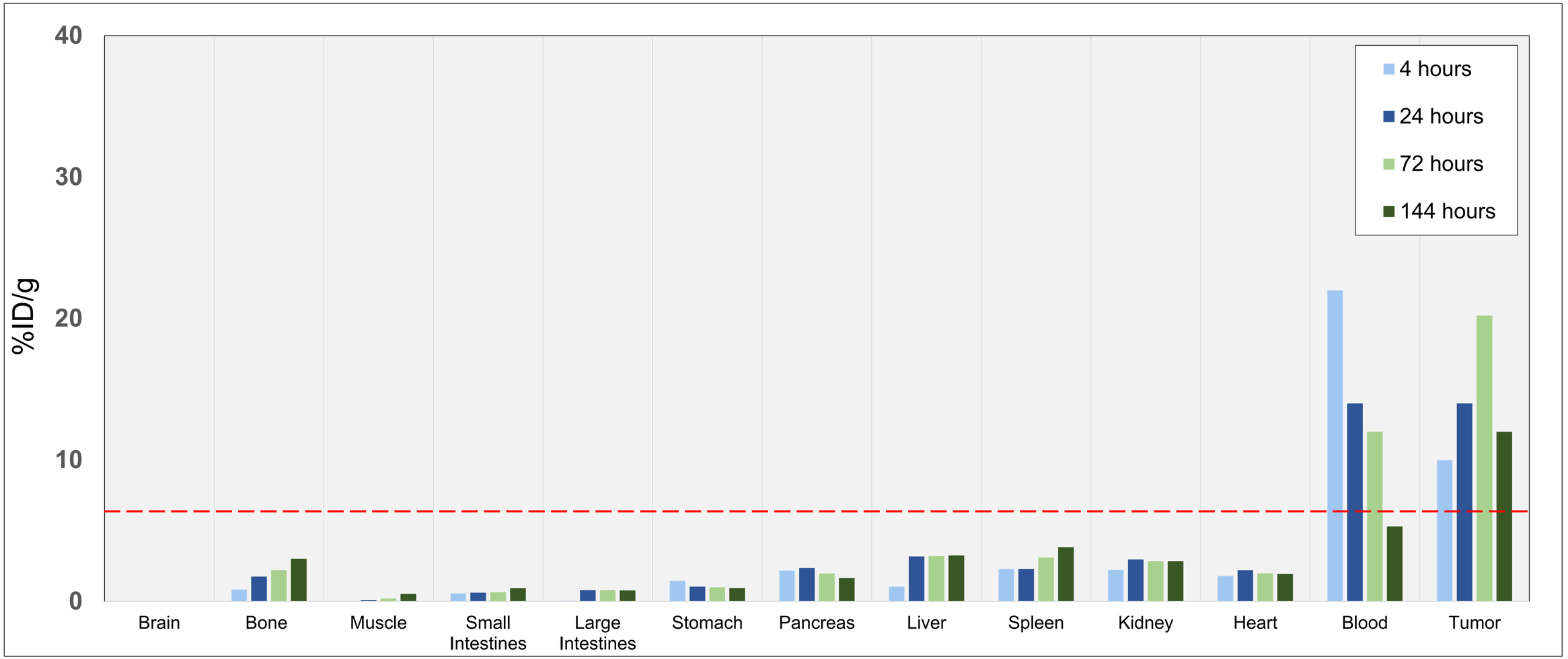
Tumor Volume Reduction and Survival Benefit Observed in Every Model

PRC CLR 121225 (CLR 225): Alpha Emitter (^{225}Ac)

Biodistribution in Pancreatic Model



High and Prolonged Tumor Uptake with Low Normal Tissue Uptake

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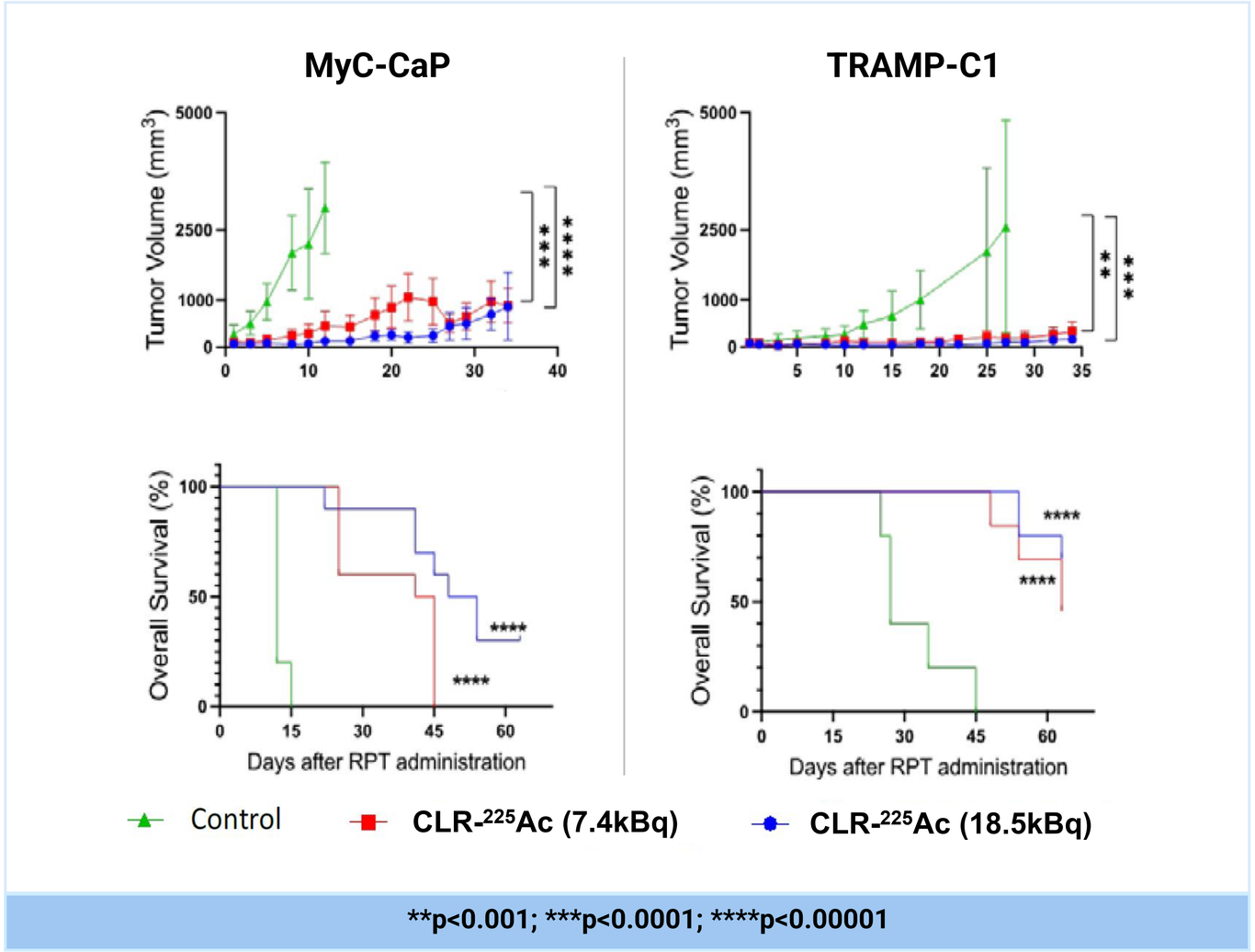
PRC CLR 121225 (CLR 225): Alpha Emitter (^{225}Ac)

Tumor Volume Reduction and Survival Benefit in Prostate Cancer

- MyC-CaP and TRAMP-C1 prostate cancer xenograph models dosed after tumors reached 200mm3
- Doses of 200nCi or 500nCi
- Dosimetry data showed increased uptake in TRAMP-C1 (0.58Gy/kBq) versus MyC-CaP (0.25Gy/kBq) model
- Distribution and percent uptake into tumors consistent with other models and isotopes
- Observed statistically significant tumor volume reduction and survival benefit in both models at both doses



**p<0.001; ***p<0.0001; ****p<0.00001

PRC CLR 121225 (CLR 225): Alpha Emitter (^{225}Ac)

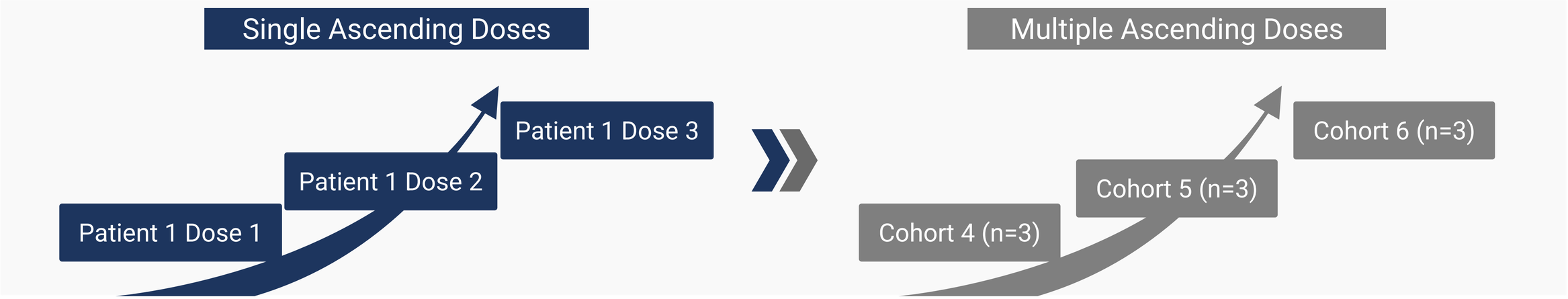
Phase 1 Clinical Trial in Pancreatic Cancer Prepared – Initiation TBD

Excellent labeling efficiency with ^{225}Ac

- Simplified reaction process
- Preferred formulation for toxicity studies (no polysorbate needed)

Phase 1 trial design

- Imaging and therapy trial
- Dose escalation utilizing an accelerated titration design (allows intrapatient dose escalation for more rapid dose escalation); dose limiting toxicities to be assessed post-cycle 1 day 57
- Dose escalations = 40% increases until first moderate toxicity; then standard 3+3 escalation



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Financials

Capitalization

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Financial Summary

Cash Position as of June 30, 2026 (millions)	$34.0M
Capitalization as of August 13, 2026	
Common Stock Outstanding	**9,452,108**
Pre-Funded Warrants	**8,010,790**
May 2026 Series A Common Warrant ($2.65 strike)	**13,206,026**
May 2026 Series B Common Warrant ($2.65 strike)	**13,206,026**
May 2026 Series C Common Warrant ($2.65 strike)	**13,206,026**
May 2026 Placement Agent Common Warrant ($4.1075 strike)	**792,362**
October 2025 Common Warrant I (Exercise Price $6.00)	**1,048,094**
October 2025 Common Warrant II (Exercise Price $6.00)	**1,048,094**
July 2025 Warrants (Exercise Price $5.25)	**436,000**
July 2025 Representative Warrants (Exercise Price $7.75)	**82,800**
Warrants (Weighted Avg Exercise Price $105.33)	**417,904**
Options	**898,099**
Fully Diluted	**61,804,329**

Formula for Value Creation

Strategic Growth and Expansion

- **Optimize global WM regulatory approval pathway for iopofosine I 131**
  - Phase 3 confirmatory trial supports global approval; potential US accelerated approval 2H27
  - EMA Conditional Marketing Authorization submission based upon U.S. potential approval timing
- **Determine US and EU iopofosine I 131 development and commercialization partnerships / approaches**
- **Execute WM Phase 1b/2a Dosimetry Trial of I 131 in “All Comers” – Data updates & NCCN support**
- **Leverage novel PDC platform - advance Phase 1 solid tumor studies**
  - CLR 125 TNBC trial initiated, enrollment ongoing ~ r/r global market potential ~$11B
  - CLR 225 Ph. 1 ready for pancreatic cancer trial, initiation TBD, r/r global market potential ~$10B
- **Secure additional platform collaborations for accelerated asset development and non-dilutive funding**
- **Established competitive advantage – unique radio-therapeutic manufacturing & supply chain model**
- **Extensive IP portfolio; radio-conjugates, small molecules, oligonucleotide payloads and linker technology**

Thank You

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Executive Management Team

Greater than 95 years combined leadership experience

James Caruso
President, CEO and Director

ALLOS™ THERAPEUTICS

NOVARTIS

Bristol Myers Squibb™

BASF

Jarrod Longcor
Chief Operating Officer

AVILLION

Melinta THERAPEUTICS

ADVANCIS PHARMACEUTICAL CORP™

Chad Kolean
Chief Financial Officer

VIVEX BIOLOGICS

PIONEER® SURGICAL

TITAN SPINE

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