CORBUS PHARMACEUTICALS®

Connecting Innovation to Purpose

Corporate Presentation
March 28, 2024

Forward-Looking Statements

This presentation contains certain forward-looking statements within the meaning of Section 27A of the Securities Act of 1933 and Section 21E of the Securities Exchange Act of 1934 and Private Securities Litigation Reform Act, as amended, including those relating to the Company's restructuring, trial results, product development, clinical and regulatory timelines, market opportunity, competitive position, possible or assumed future results of operations, business strategies, potential growth opportunities and other statements that are predictive in nature. These forward-looking statements are based on current expectations, estimates, forecasts and projections about the industry and markets in which we operate and management's current beliefs and assumptions. These statements may be identified by the use of forward-looking expressions, including, but not limited to, "expect," "anticipate," "intend," "plan," "believe," "estimate," "potential," "predict," "project," "should," "would" and similar expressions and the negatives of those terms. These statements relate to future events or our financial performance and involve known and unknown risks, uncertainties, and other factors, including the potential impact of the recent COVID-19 pandemic and the potential impact of sustained social distancing efforts, on our operations, clinical development plans and timelines, which may cause actual results, performance or achievements to be materially different from any future results, performance or achievements expressed or implied by the forward-looking statements. Such factors include those set forth in the Company's filings with the Securities and Exchange Commission. Prospective investors are cautioned not to place undue reliance on such forward-looking statements, which speak only as of the date of this presentation. The Company undertakes no obligation to publicly update any forward-looking statement, whether as a result of new information, future events or otherwise.

Investment Summary

Focus on developing precision oncology + differentiated assets

Nectin-4 targeting ADC for treatment of solid tumors

CB1R inverse agonist to treat obesity

TGFβ blocker Anti-αvβ8 integrin mAb for treatment of solid tumors

CRBP
Ticker

$127 Million

Cash & investments as of Feb 2, 2024
10.3M Common Shares Outstanding
(11.1M Fully-Diluted Shares)

A diversified pipeline with differentiated clinical risk profiles

<table>
<tr><th colspan="5">Next-Generation Nectin-4 targeting ADC</th></tr>
<tr><td rowspan="2">CRB-701
Next-generation
Nectin-4 targeting ADC</td><td rowspan="2">Nectin-4 positive solid tumors</td><td>CSPC
(China)</td><td>Dose Escalation
Cohorts 1-6 completed
Cohort 7 added and recruiting</td><td>Dose Confirmation / Expansion
Cohort 6 expanding</td></tr>
<tr><td>Corbus
(US + Europe)</td><td>Dose Escalation</td><td>Dose Confirmation / Expansion</td></tr>
<tr><th colspan="5">Anti-Integrin mAb</th></tr>
<tr><td>CRB-601
Anti-αvβ8 mAb
(TGFβ-targeting)</td><td colspan="2">αvβ8 enriched solid tumors</td><td colspan="2">IND Cleared in January 2024</td></tr>
<tr><th colspan="5">Highly peripherally-restricted CB1R inverse agonist</th></tr>
<tr><td>CRB-913
CB1R inverse agonist</td><td colspan="2">Obesity and related conditions</td><td colspan="2">IND
Expected in Q4 2024</td></tr>
</table>

CRB-701

Next Generation Nectin-4 Targeting ADC

Padcev® projected to reach up to ~$5B in global sales by 2028

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

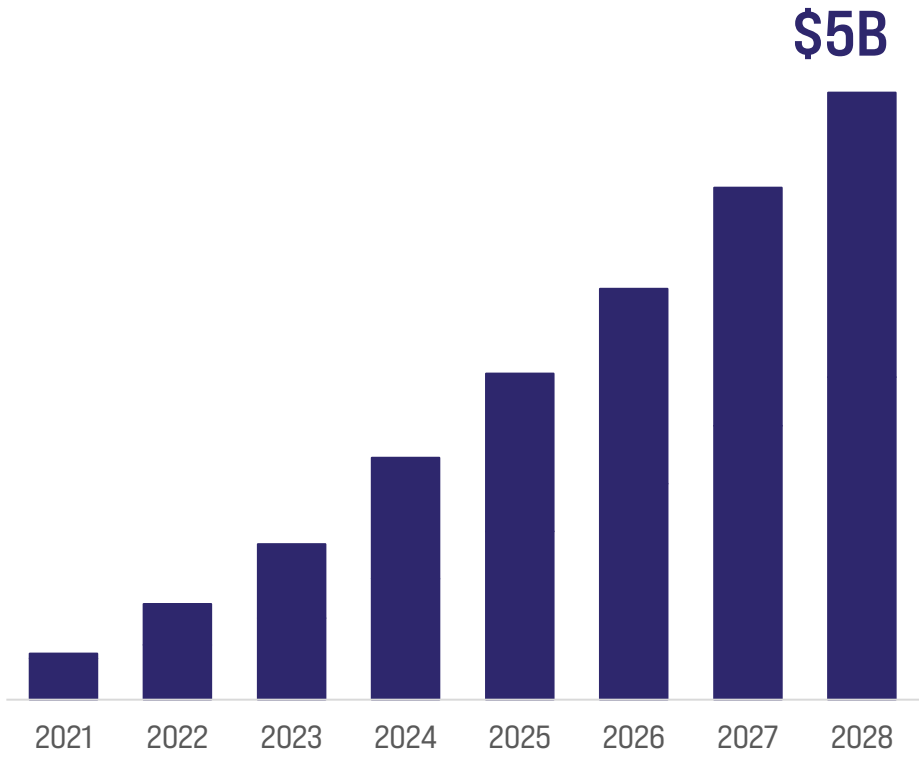
Latest Padcev® Q3 revenues [1]

	Three months ended September 30,			Nine months ended September 30,		
(dollars in millions)	2023	2022	% Change	2023	2022	% Change
Total Net Product Sales	**$ 571**	**$ 428**	**33 %**	**$ 1,583**	**$ 1,243**	**27 %**
ADCETRIS	$ 246	$ 219	13 %	$ 751	$ 601	25 %
PADCEV	$ 200	$ 105	89 %	$ 479	$ 329	46 %
TUKYSA	$ 102	$ 88	16 %	$ 289	$ 267	8 %
TIVDAK	$ 23	$ 16	40 %	$ 64	$ 45	42 %

22nd October 2023 [2]

Groundbreaking EV-302 Trial Significantly Extends Overall Survival and Progression-Free Survival in Patients Treated with PADCEV® (enfortumab vedotin-ejfv) and KEYTRUDA® (pembrolizumab) in First-Line Advanced Bladder Cancer

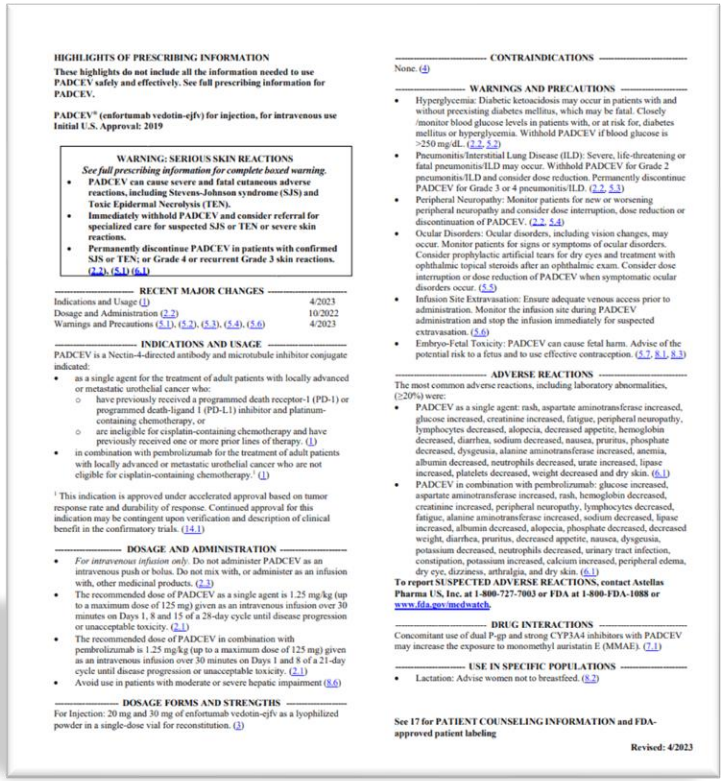
PADCEV® Global Projected Revenues in UC/Bladder[3]



Sources: 1. SGEN Q3 earnings report, 2. SGEN press release, October 2023, 3. Evaluate Pharma

Does tolerability for Padcev® impact clinical adoption?

PADCEV® Prescribing Information



HIGHLIGHTS OF PRESCRIBING INFORMATION

These highlights do not include all the information needed to use PADCEV safely and effectively. See full prescribing information for PADCEV.

PADCEV® (enfortumab vedotin-ejfv) for injection, for intravenous use
Initial U.S. Approval: 2019

WARNING: SERIOUS SKIN REACTIONS
See full prescribing information for complete boxed warning.
- **PADCEV can cause severe and fatal cutaneous adverse reactions, including Stevens-Johnson syndrome (SJS) and Toxic Epidermal Necrolysis (TEN).**
- **Immediately withhold PADCEV and consider referral for specialized care for suspected SJS or TEN or severe skin reactions.**
- **Permanently discontinue PADCEV in patients with confirmed SJS or TEN; or Grade 4 or recurrent Grade 3 skin reactions.** (2.2), (5.1) (6.1)

RECENT MAJOR CHANGES

Indications and Usage (1)	4/2023
Dosage and Administration (2.2)	10/2022
Warnings and Precautions (5.1), (5.2), (5.3), (5.4), (5.6)	4/2023

INDICATIONS AND USAGE

PADCEV is a Nectin-4-directed antibody and microtubule inhibitor conjugate indicated:
- as a single agent for the treatment of adult patients with locally advanced or metastatic urothelial cancer who:
  - have previously received a programmed death receptor-1 (PD-1) or programmed death-ligand 1 (PD-L1) inhibitor and platinum-containing chemotherapy, or
  - are ineligible for cisplatin-containing chemotherapy and have previously received one or more prior lines of therapy. (1)
- in combination with pembrolizumab for the treatment of adult patients with locally advanced or metastatic urothelial cancer who are not eligible for cisplatin-containing chemotherapy.[1] (1)

[1] This indication is approved under accelerated approval based on tumor response rate and durability of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in the confirmatory trials. (14.1)

DOSAGE AND ADMINISTRATION
- *For intravenous infusion only.* Do not administer PADCEV as an intravenous push or bolus. Do not mix with, or administer as an infusion with, other medicinal products. (2.3)
- The recommended dose of PADCEV as a single agent is 1.25 mg/kg (up to a maximum dose of 125 mg) given as an intravenous infusion over 30 minutes on Days 1, 8 and 15 of a 28-day cycle until disease progression or unacceptable toxicity. (2.1)
- The recommended dose of PADCEV in combination with pembrolizumab is 1.25 mg/kg (up to a maximum dose of 125 mg) given as an intravenous infusion over 30 minutes on Days 1 and 8 of a 21-day cycle until disease progression or unacceptable toxicity. (2.1)
- Avoid use in patients with moderate or severe hepatic impairment (8.6)

DOSAGE FORMS AND STRENGTHS

For Injection: 20 mg and 30 mg of enfortumab vedotin-ejfv as a lyophilized powder in a single-dose vial for reconstitution. (3)

CONTRAINDICATIONS

None. (4)

WARNINGS AND PRECAUTIONS
- Hyperglycemia: Diabetic ketoacidosis may occur in patients with and without preexisting diabetes mellitus, which may be fatal. Closely monitor blood glucose levels in patients with, or at risk for, diabetes mellitus or hyperglycemia. Withhold PADCEV if blood glucose is >250 mg/dL. (2.2, 5.2)
- Pneumonitis/Interstitial Lung Disease (ILD): Severe, life-threatening or fatal pneumonitis/ILD may occur. Withhold PADCEV for Grade 2 pneumonitis/ILD and consider dose reduction. Permanently discontinue PADCEV for Grade 3 or 4 pneumonitis/ILD. (2.2, 5.3)
- Peripheral Neuropathy: Monitor patients for new or worsening peripheral neuropathy and consider dose interruption, dose reduction or discontinuation of PADCEV. (2.2, 5.4)
- Ocular Disorders: Ocular disorders, including vision changes, may occur. Monitor patients for signs or symptoms of ocular disorders. Consider prophylactic artificial tears for dry eyes and treatment with ophthalmic topical steroids after an ophthalmic exam. Consider dose interruption or dose reduction of PADCEV when symptomatic ocular disorders occur. (5.5)
- Infusion Site Extravasation: Ensure adequate venous access prior to administration. Monitor the infusion site during PADCEV administration and stop the infusion immediately for suspected extravasation. (5.6)
- Embryo-Fetal Toxicity: PADCEV can cause fetal harm. Advise of the potential risk to a fetus and to use effective contraception. (5.7, 8.1, 8.3)

ADVERSE REACTIONS

The most common adverse reactions, including laboratory abnormalities, (≥20%) were:
- PADCEV as a single agent: rash, aspartate aminotransferase increased, glucose increased, creatinine increased, fatigue, peripheral neuropathy, lymphocytes decreased, alopecia, decreased appetite, hemoglobin decreased, diarrhea, sodium decreased, nausea, pruritus, phosphate decreased, dysgeusia, alanine aminotransferase increased, anemia, albumin decreased, neutrophils decreased, urate increased, lipase increased, platelets decreased, weight decreased and dry skin. (6.1)
- PADCEV in combination with pembrolizumab: glucose increased, aspartate aminotransferase increased, rash, hemoglobin decreased, creatinine increased, peripheral neuropathy, lymphocytes decreased, fatigue, alanine aminotransferase increased, sodium decreased, lipase increased, albumin decreased, alopecia, phosphate decreased, decreased weight, diarrhea, pruritus, decreased appetite, nausea, dysgeusia, potassium decreased, neutrophils decreased, urinary tract infection, constipation, potassium increased, calcium increased, peripheral edema, dry eye, dizziness, arthralgia, and dry skin. (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact Astellas Pharma US, Inc. at 1-800-727-7003 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

DRUG INTERACTIONS

Concomitant use of dual P-gp and strong CYP3A4 inhibitors with PADCEV may increase the exposure to monomethyl auristatin E (MMAE). (7.1)

USE IN SPECIFIC POPULATIONS
- Lactation: Advise women not to breastfeed. (8.2)

See 17 for PATIENT COUNSELING INFORMATION and FDA-approved patient labeling

Revised: 4/2023

Revised: 4/2023

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

Duration of Response
~5 months

47%
Rate of Serious Adverse Events (SAEs)

61%
Dose interruptions

34%
Dose reductions

17%
Dose Discontinuations

EV-301: The safety of PADCEV was evaluated as a single agent in EV-301 in patients with locally advanced or metastatic urothelial cancer (n=296) who received at least one dose of PADCEV 1.25 mg/kg and who were previously treated with a PD-1 or PD-L1 inhibitor and a platinum-based chemotherapy

Source(s): PADCEV® Prescribing Information as of Apr 2023.

Padcev® is associated with skin toxicities and peripheral neuropathy

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

A Black Box warning [1]

WARNING: SERIOUS SKIN REACTIONS

- **PADCEV can cause severe and fatal cutaneous adverse reactions including Stevens-Johnson syndrome (SJS) and Toxic Epidermal Necrolysis (TEN), which occurred predominantly during the first cycle of treatment, but may occur later.**
- **Closely monitor patients for skin reactions.**
- **Immediately withhold PADCEV and consider referral for specialized care for suspected SJS or TEN or severe skin reactions.**
- **Permanently discontinue PADCEV in patients with confirmed SJS or TEN; or Grade 4 or recurrent Grade 3 skin reactions *[see Dosage and Administration (2.2), Warnings and Precautions (5.1) and Adverse Reactions (6.1)]*.**

- Greater than 25% of PADCEV® discontinuations are linked to peripheral neuropathy [2]
- PADCEV® + Keytruda® patients who experienced neuropathy:
  - 13% complete resolution
  - 87% patients had residual neuropathy (45% had Grade ≥2)[1]

Adverse Events (% of patients)

	PADCEV® monotherapy[1]		PADCEV® + Keytruda®[1]	
	All Grades	≥ Gr 3	All Grades	≥ Gr 3
Skin Reactions	58%	14%	70%	17%
Peripheral Neuropathy	53%	5%	67%	7%

NR = not reported

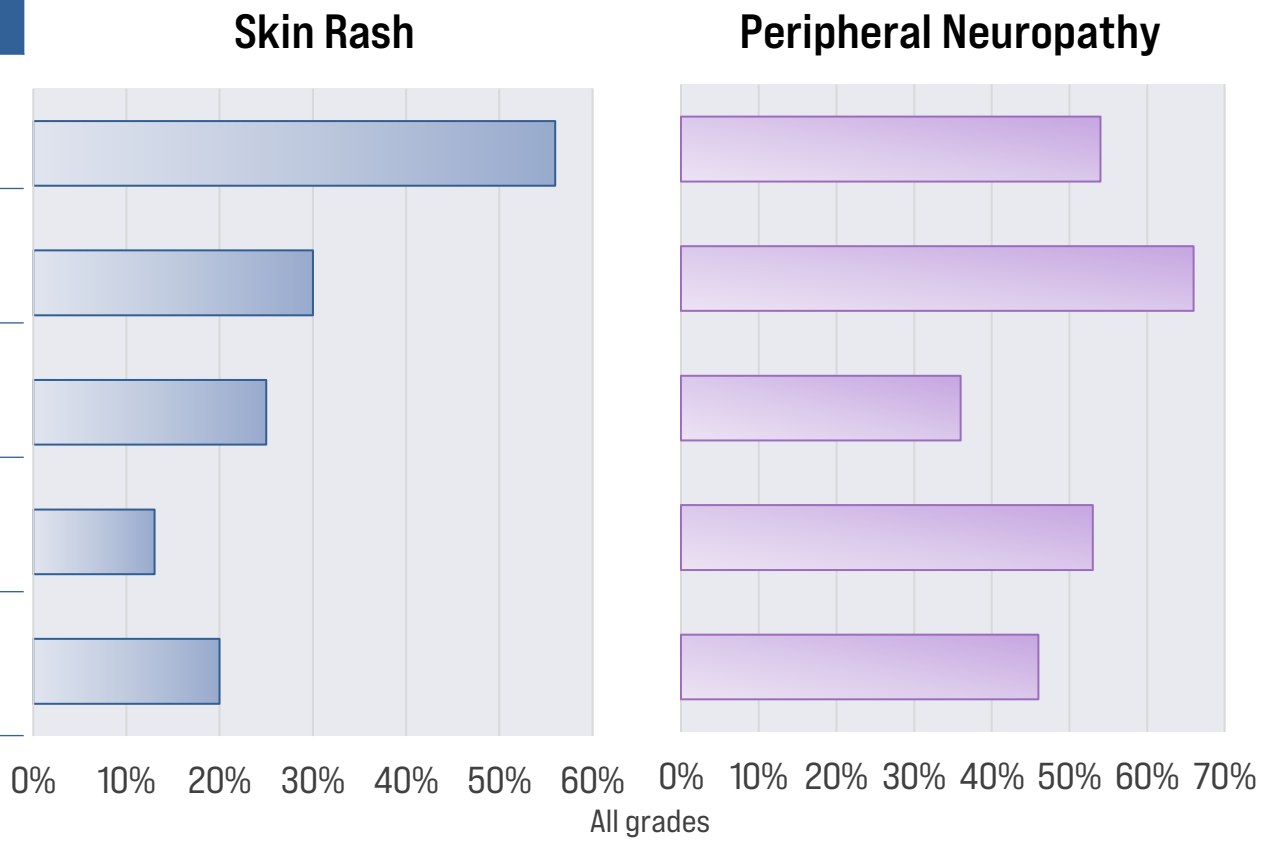
Source(s): 1. PADCEV® Prescribing Information Dec 2023. 2.. Rosenberg et al., 2020

Is the 2nd generation Seagen linker the cause?

Similar dose limiting toxicities seen across divergent ADCs that share same constellation of 'linker + payload'

Val-Cit linker + vedotin (MMAE) payload

ADC drug	TAA	Average DAR
Padcev® Enfortumab vedotin	Nectin-4	3.8
Adcetris® Brentuximab vedotin	CD30	4
Tivdak® Tisotumab vedotin	TF	4
Polivy® Polatuzumab vedotin	CD79B	3.5
Aidixi® Disitamab vedotin	HER2	4

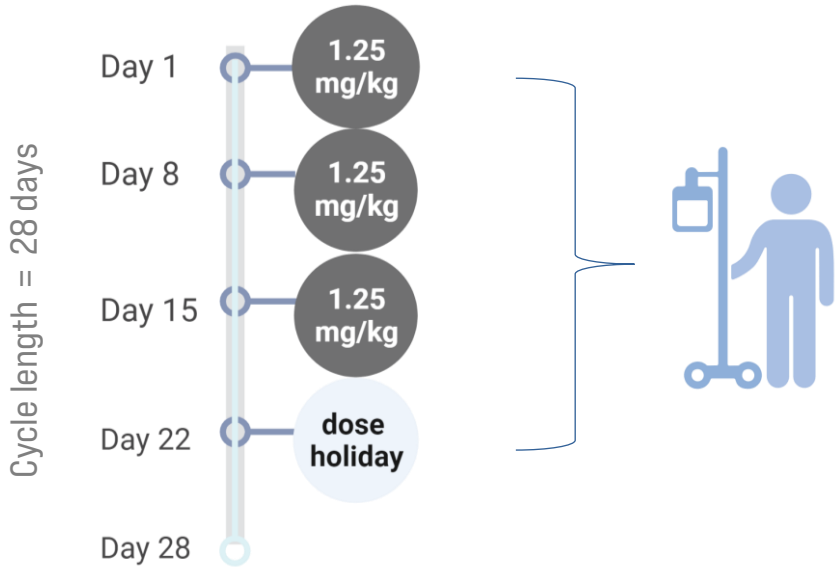


Padcev® Val-Cit linker + payload = mc-VC-PABC = Maleimidocaproyl-L-valine-L-citrulline-p-aminobenzyl alcohol p-nitrophenyl carbonate

Source(s): 1. Fu et al., Science. 2023 doi: 10.1016/j.isci.2023.107778. Padcev® Prescribing information, Adcetris ® Prescribing Information, Tivdak ® Pescribing Information, Polivy ® Prescribing Information. Shi et al., 2022 https://doi.org/10.1080/10717544.2022.2069883 Aidix ® https://www.adcreview.com/drugmap/disitamab-vedotin

Padcev® requires frequent dosing and real-world usage differs from label

Monotherapy Padcev®



6 months of therapy =
~ 54 hours of total clinic time / patient

Real-world use, dose intensity, and adherence to Padcev®

Metric	Result (N = 416)
EV use	
Number of cycles (median, IQR)	5 (2,8)
EV dose intensity	
Treatments per patient month (mean [SD])	2.6 [0.6]
Dosing frequency; treatments per cycle (mean [SD])	2.4 [0.5]
Dose (mean, mg/kg [SD])	1.1 [0.2]
Change in average dose (mg) from baseline (%)	-9.6 [20.2] %
EV treatment adherence	
Received on average > 2 treatments per cycle (%)	58.8 [34.4] %

Source(s): 1. PADCEV® Prescribing Information as of Dec 2019, 2. Redacted from Tsingas et al., ASCO 2023

Emerging clinical-stage competition is not solving for existing challenges

Limitation	Padcev®	BT8009	9MW-2821
Upper dose limit	1.25 mg/kg [1]	5 mg/m^2 [4]	1.25 mg/kg [3]
Schedule	D1, D8, D15 /28 days	Q1W	D1, D8, D15 /28 days
≥ Grade 3 AE rate	51% (n=155) [2]	65% (n=20) [6]	35% (n=85) [3]
Peripheral neuropathy	38%	30%	17%
Skin reactions	25%	10%	18%
Neutropenia (Gr 3)	5% [3]	10% #	19%
Dose reduction	34%	16%	3.5%
Dose interruptions	64%	24%	28%

1 Rosenberg, et al., "EV-101 JCO, 2020 Apr 1; 38(10): 1041–1049, 2. Powles et al., EV-301 2021, 3. Zhang et al., ESMO 2023, 4 Rigby et al., 2023, 6 Bicycle corporate deck Nov 2023 # - combined frequency of Grade 3 neutropenia/ low neutrophil count

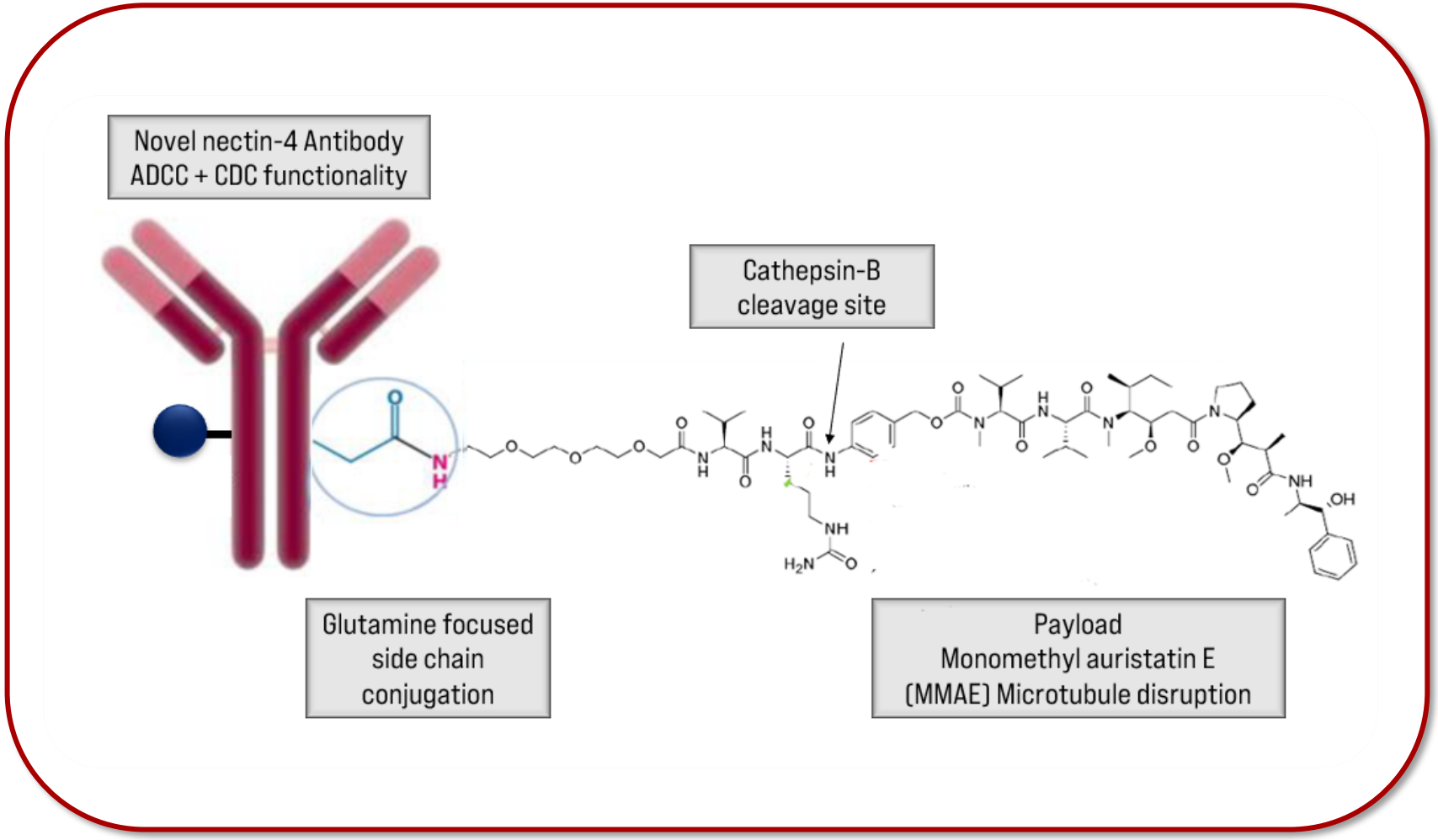
Designing a Nectin-4 ADC intended to address Padcev® unmet needs

Toxicity: 3rd gen ADC w/stable linker → Reduce free circulating MMAE

Compliance: Extend ADC half-life → Reduce dosing frequency

Efficacy: Lower DAR + longer half-life → Dose higher than Padcev®

CRB-701: Next generation site-specific Nectin-4 targeting ADC



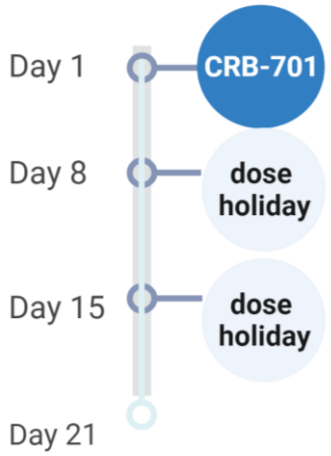
MMAE = Monomethyl auristatin E **ADCC** = antibody-dependent cellular cytotoxicity
CDC = complement dependent cytotoxicity **DAR** = Drug Antibody Ratio

Source(s): Modified image from Corbus data on file; Corbus data on file

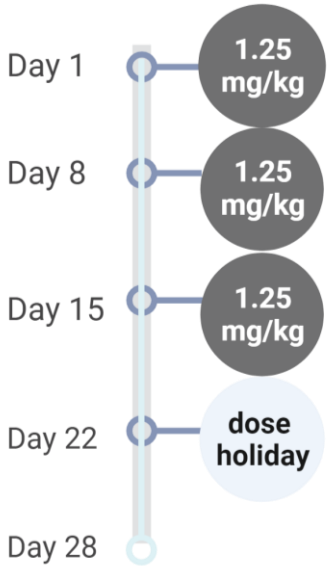
CRB-701: One dose every 21 days expected to offer advantages over more frequent dosing

Clinical cycle comparison

CRB-701



Padcev®



Patient / physician convenience

Combination flexibility

Source(s): Corbus data on file; PADCEV® Prescribing Information as of Dec 2019

Phase 1 dose escalation study (China): ASCO-GU 2024

KEY ELIGIBILITY

Age ≥18 years
Advanced urothelial carcinoma or
Nectin-4 positive
Advanced solid tumors
ECOG 0-1
Adequate organ function
No uncontrolled diabetes
No active CNS metastasis

ESCALATION DESIGN

Bayesian Optimal Interval (BOIN) design with accelerated titration at DL-1
IV Q3W over a 21-day cycle
0.2 mg/kg
0.6 mg/kg
1.2 mg/kg
1.8 mg/kg
2.7 mg/kg
3.6 mg/kg
4.5mg/kg (recruiting)

KEY END POINTS

- Safety / tolerability
- Pharmacokinetics
- Anti tumor activity

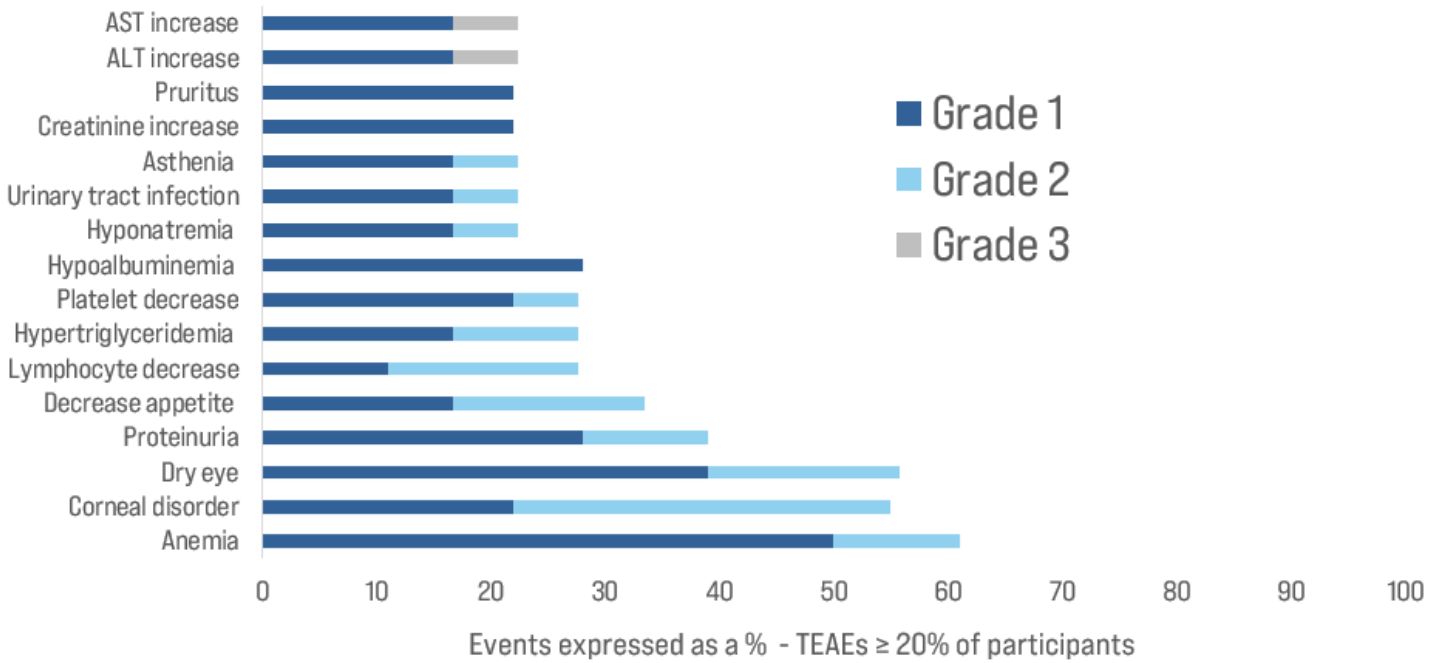
NEXT STEPS

- Continue escalation
- PK expansion at 3.6mg/kg
- MTD or RP2D
- Specific expansion

Demographics & Key Characteristics

Characteristic	Value	Characteristic	Value
Median Age (Range)	58 (35-76)	**Primary tumor type**	n=18
Sex (M/F)	5/13	Urothelial	7
ECOG PS of 1	18 (100%)	Cervical	6
Weight in kg (Range)	55 (36-84)	Breast	4
Prior therapy (Range)	5 (1-10)	TNBC	3 of 4
Creatine Cl <60 µmol/L	7 (39%)	CRC	1
Visceral metastasis	15 (83%)	HbA1C levels ≤ 6.5%	18 (100%)

Safety and Dose Modifications



Dose Modifications (n=18)	Value
Discontinuations	0
Reductions	0
Interruptions	1 (5.5%)

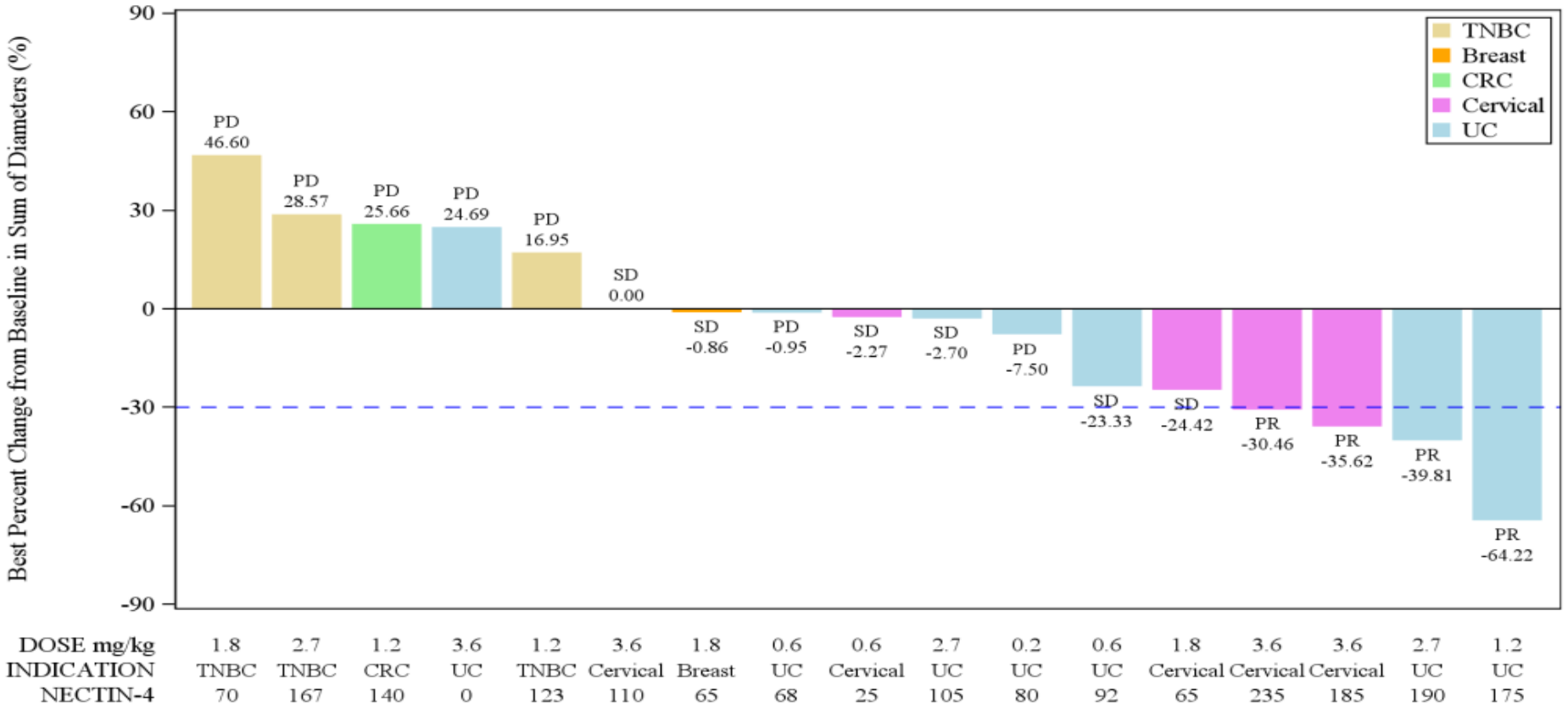
- SYS6002 (CRB-701) was well tolerated with mainly grade 1 or 2 AEs
- No DLTs or Grade 4 or 5 AEs have been observed to date
- Anemia and eye-related adverse events were the most common treatment emergent AEs (TEAE)
- Four subjects reported 7 SAEs, 3 of which were considered probably related to SYS6002 (CRB-701)
  - Two Grade 3 SAEs (ILD and pulmonary infection) were reported in a single participant
  - One Grade 3 (ALT increase) reported in a separate participant
- To date no cases of skin rash or peripheral neuropathy have been observed

Clinical Pharmacology

21 Day PK	Comparison	% ADC		% Free MMAE	
		Cmax	AUC_{21d}	Cmax	AUC_{21d}
Enfortumab vedotin (EV) 1.25 mg/kg Q1W x3	EV benchmark	100%	100%	100%	100%
SYS6002 (CRB-701) 1.2 mg/kg Q3W	Matched ADC dose	79%	106%	33%	29%
SYS6002 (CRB-701) 2.7 mg/kg Q3W	Matched MMAE dose	177%	183%	79%	68%

- After single IV infusion of SYS6002 (CRB-701), the exposure of TAb, ADC and MMAE generally increased in a dose proportional manner
- Clearance and volume of distribution were similar across doses
- The half-lives of TAb, ADC, and MMAE were 4-6 days, 4-5 days and 5-10 days, respectively
- No obvious accumulation was observed on C3D1
- Time-to-peak concentration of MMAE was about 3-7 days
- When compared to EV exposures SYS6002 (CRB-701) consistently demonstrates lower free MMAE

Phase 1 Dose Escalation - Disease Response

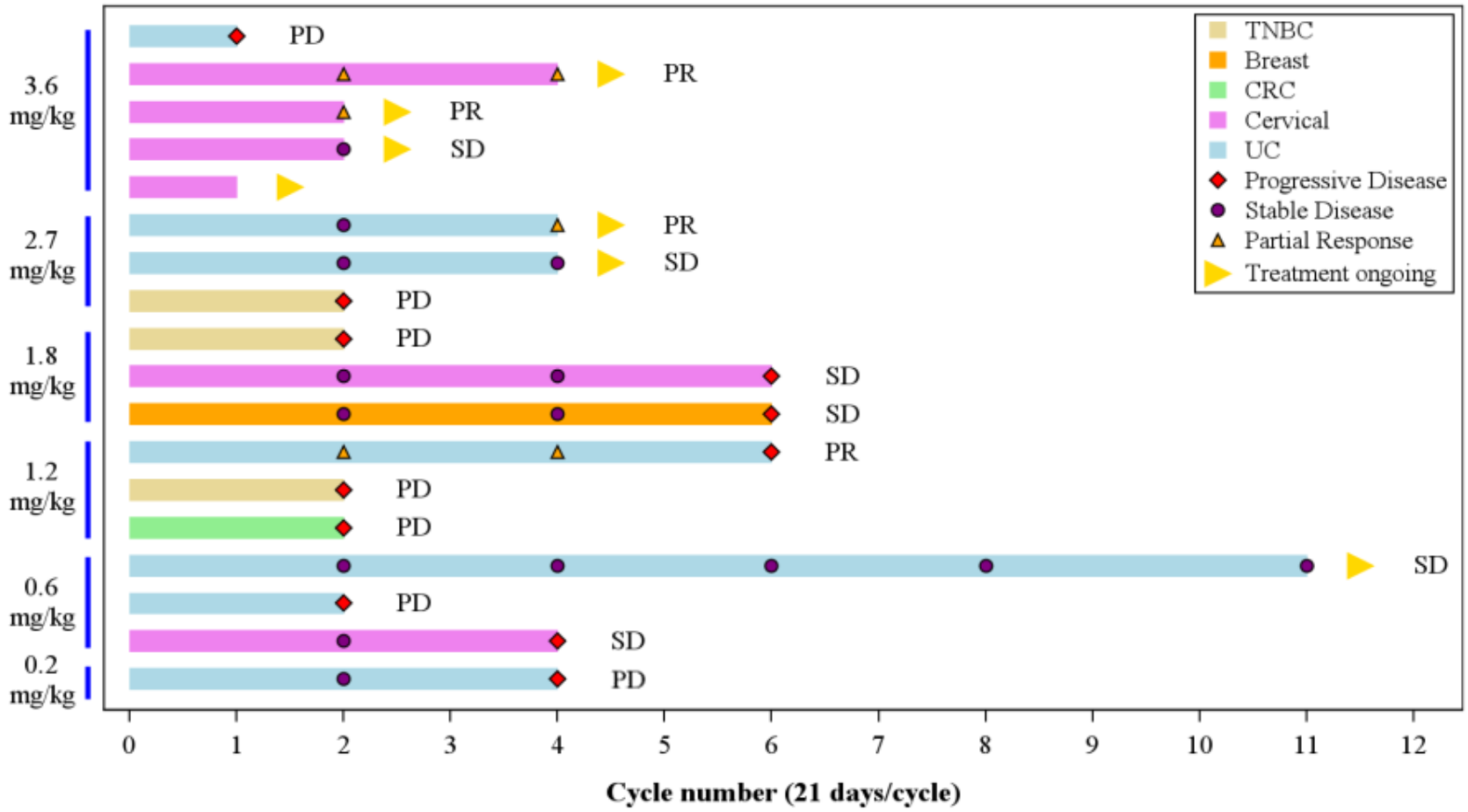


Disease response in 3.6 mg/kg and 2.7 mg/kg doses:

ORR 43%

DCR 71%

Phase 1 Disease Responses



Note: Of the 4 PRs reported, 2 PRs are confirmed and 2 remain unconfirmed

Phase 1 Summary - Data cutoff December 2023

Predicted therapeutically relevant doses in Ph. 1 study	Seven patients treated at 2.7mg/kg and 3.6 mg/kg on Q3W schedule
Objective Response Rate	43%: 3 out of 7 patients with PR's (2 unconfirmed)
Disease Control Rate	71%: 5 out of 7 patients
Tumor shrinkage across all nectin-4 positive mUC and cervical patients in study	9 out of 10 patients
Dose for first observed SD	0.6 mg/Kg
Dose for first observed PR	1.2 mg/Kg
Longest observed response duration to-date	11 cycles (still ongoing)
Participants still on CRB-701	7/18 (38%)
First expansion dose chosen	3.6 mg/Kg (cohort 6)

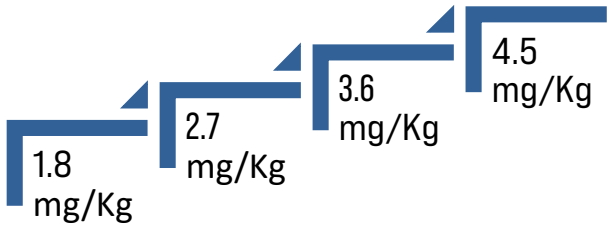
CRB-701: A differentiated clinical development approach to competitors

Proprietary insights are driving indication selection for CRB-701

mUC	New reality of Padcev® + Keytruda® 1L therapy	Under-served niche mUC populations remain and are attractive targets
Other Nectin-4 solid tumors	Emerging clinical data from current dose escalation is informative	Focus on unexplored Nectin-4 solid tumors

CRB-701-01 Study Design (Corbus)

Dose escalation (IND open: FPI Expected Q1 2024)	Project Optimus (dose optimization)	Dose expansion at RP2D



Randomized to 2 doses of CRB-701 monotherapy

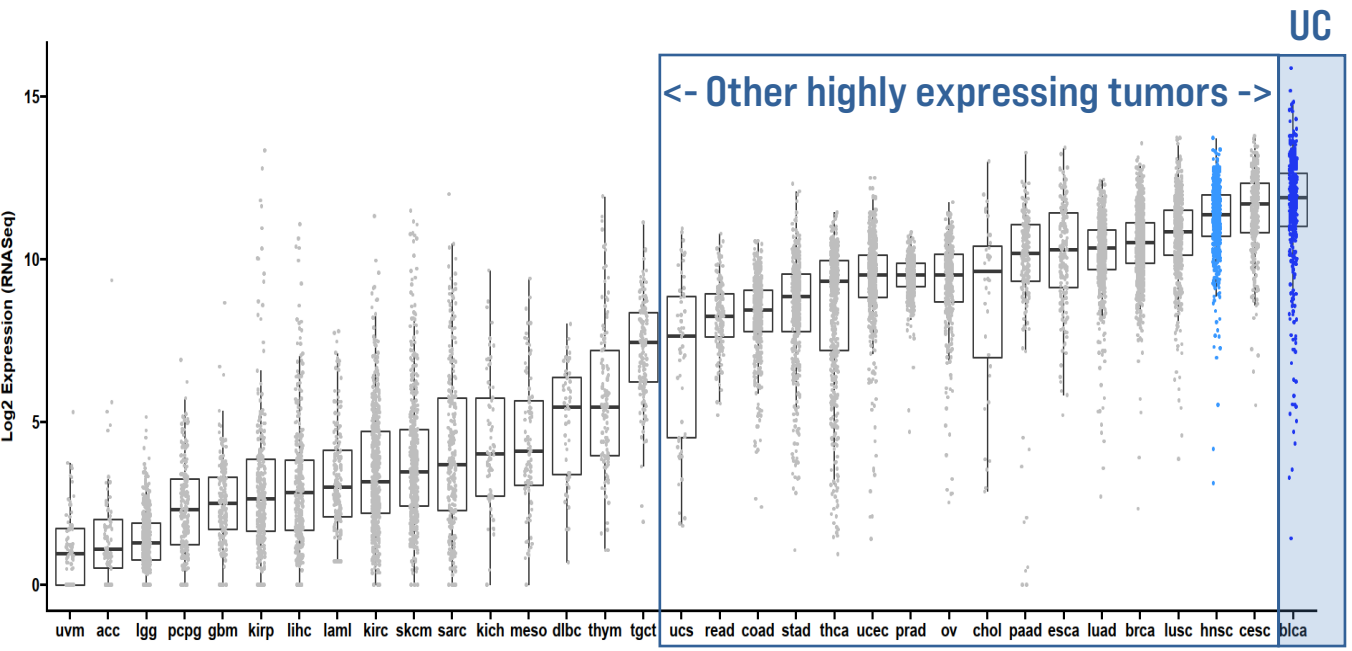
Randomized to 2 doses of CRB-701 +CPI

Bladder cancer niche population(s)

Non-UC tumors:
A
B
C

Basket of nectin-4 positive tumors

Validation of Nectin-4 as a Tumor Associated Antigen beyond mUC



Elevated Nectin-4 expression: urothelial, breast, ovarian, cervical, colorectal, rectal, esophageal, gastric, lung, thyroid, prostate, cholangiocarcinoma, pancreatic cancer, testicular cancer

PADCEV enfortumab vedotin-ejfv — 2023 ASCO Annual Meeting

H&NSCC (1)

June 2023

Mabwell 迈威生物 — SGO

Cervical (2)

March 2024

Parameter	Patients (N=46)	Patients (N=37)
Confirmed ORR	11 (23.9%)	15 (40.5%)
CR	1 (2.2%)	1 (2.7%)
PR	10 (21.7%)	14 (37.9%)
DCR	26 (55%)	33 (89.2%)
PFS	3.94 months	Too early
Neutropenia (Grade 3+4)	4.3%	40%
Skin Rash	All grades: 45.7%	Grade 3+4: 17.5%
All grade 3+4 AEs	Not disclosed	70%

EV monotherapy 2019 FDA review (3)	Patients (N=310) 1.25mg/kg
Skin rash (grade 3+4)	10%
Any Grade 3-4 TEAE	58%

References
1. https://ascopubs.org/doi/abs/10.1200/JCO.2023.41.16_suppl.6017
2. Efficacy and safety of 9MW2821, an antibody-drug conjugate targeting Nectin-4, monotherapy in patients with recurrent or metastatic cervical cancer: A multicenter, open-label, phase I/II study. SGO 2024 –source www.mabwell.com
3. NDA/BLA Multi-disciplinary review and Evaluation – BLA 761137

Expected Milestones

First patient dosed in U.S. dose escalation study	Q1-2024
Clinical data update on China dose escalation study	Mid-2024
Complete U.S. dose escalation study	Fall-2024
Present U.S. dose escalation data	Q4-2024/Q1-2025

CRB-701: Summary

Emerging clinical safety and potential for superior therapeutic index

Dose expansion has started (China); dose escalation in US Q1 2024

3rd generation ADC with improved linker stability-reduces MMAE in circulation

CRB-913

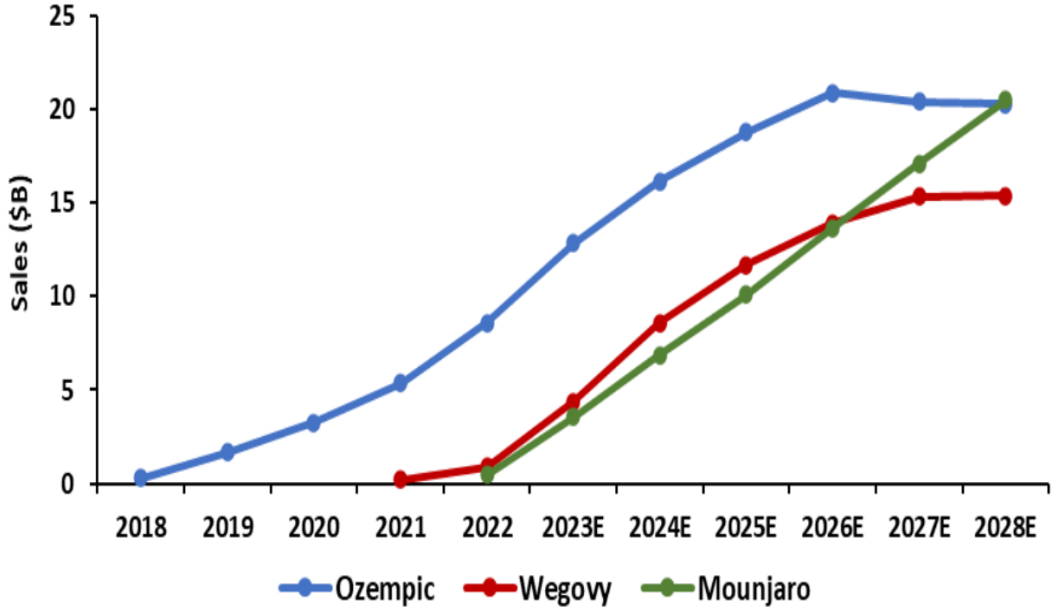
Oral cannabinoid Type-1 inverse agonist for superior incretin therapy in obesity

Incretin analogs have transformed the field of obesity and its commercial value

But…

- Muscle loss
- Tolerability
- Accessibility
- → Long-term compliance is ~ 27%

Sales (2018-2022) and sales estimates (2023-2028) for Ozempic, Wegovy, and Mounjaro reflect significant uptake and expectations



Source(s): RBC report Oct 2023

The obesity landscape is evolving to address these issues

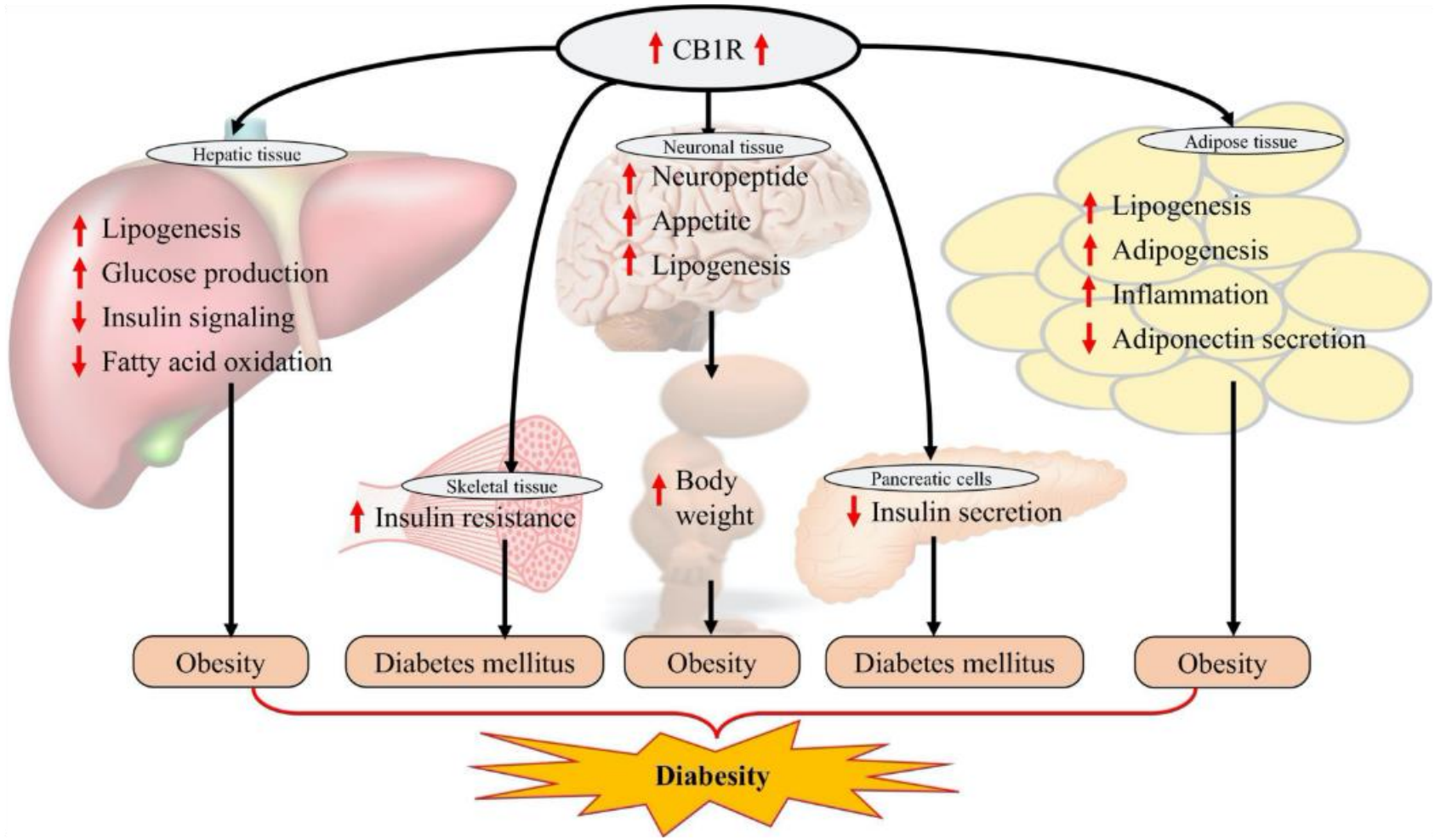
Muscle loss: Degree of weight loss → Quality of weight loss

Tolerability: Single MOA → Multiple orthogonal MOAs

Accessibility: Injectables → Oral small molecules

CB1 inverse agonism:
The return of a clinically-validated obesity drug class

CB1 contribution to “Diabesity” is well understood

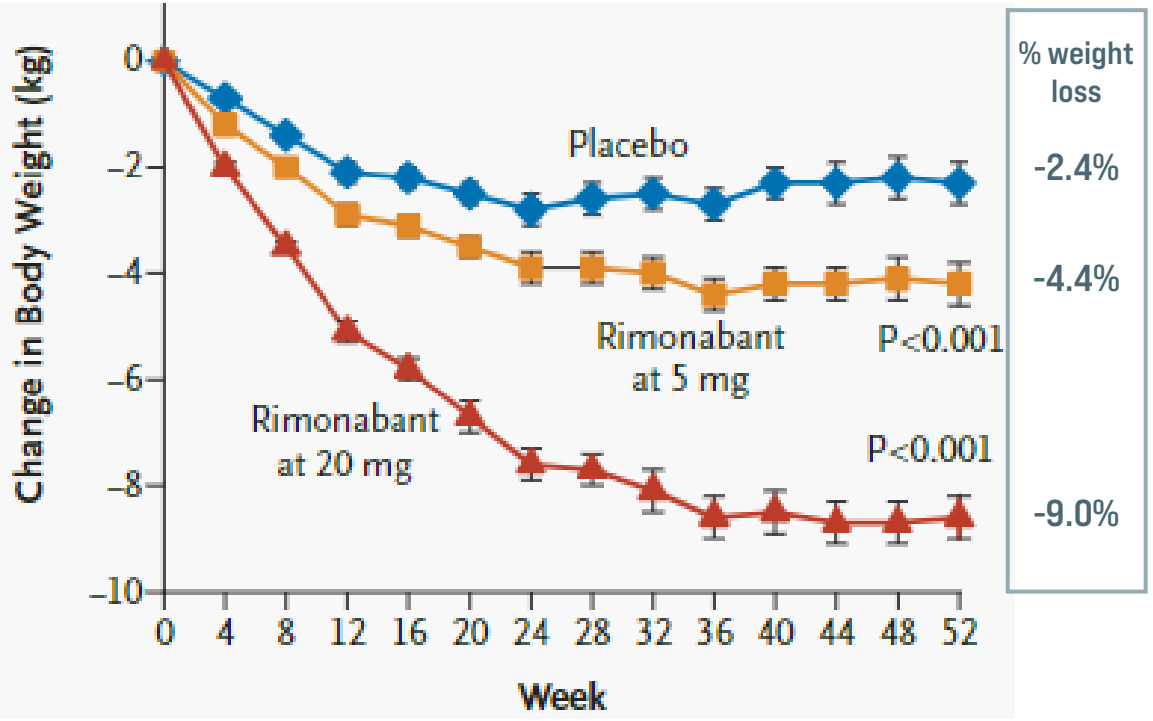


Source(s): Targeting the endocannabinoid system in diabesity: Fact or fiction?, Drug Discovery Today, Deeba et al. Mar 2021.

The CB1 MOA is clinically validated in obesity: data from 1st gen drugs

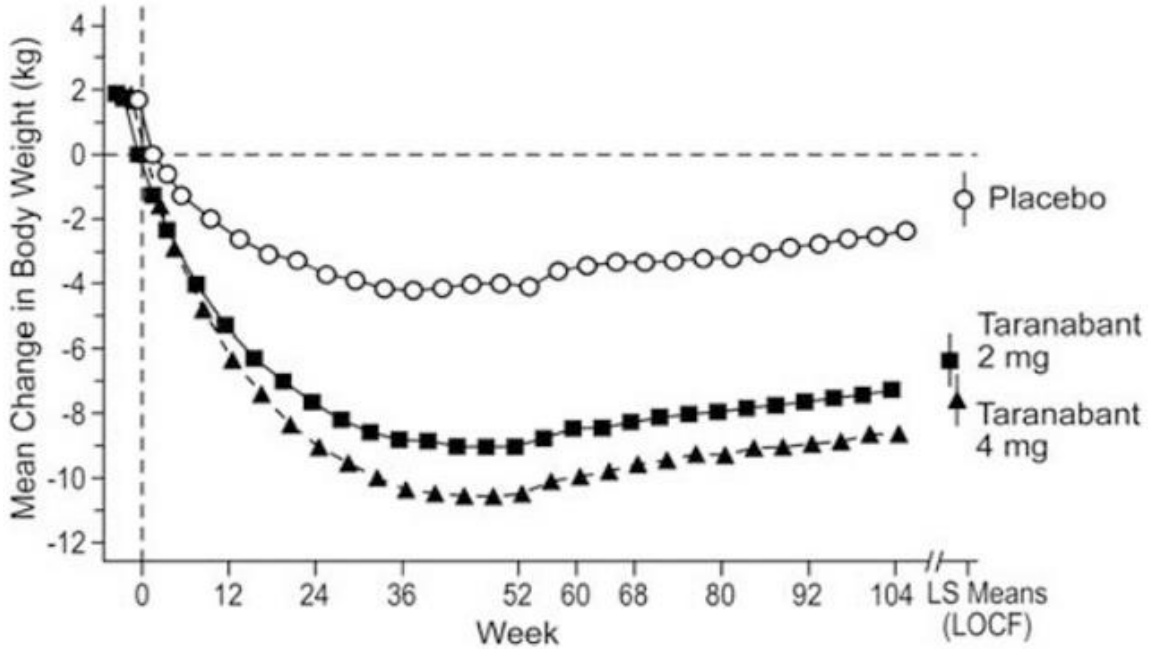
Rimonabant[1]

RIO-Lipids Phase 3 study
Placebo (n=342);
5 mg rimonabant (n=345); 20 mg rimonabant (n=346)



Taranabant[2]

Completed Phase 3 studies (2 and 4 mg) (2 yr)
Placebo (n=417);
2 mg taranabant (n=414); 4 mg taranabant (n=415)



Source(s): 1. Effects of rimonabant on metabolic risk factors in overweight patients with dyslipidemia, Després et al, NEJM, Nov 2005.
2. A clinical trial assessing the safety and efficacy of taranabant, a CB1R inverse agonist, in obese and overweight patients: a high-dose study, Aronne et al, Nature, Feb 2010.

Rimonabant weight loss was not associated with reduction of lean mass in obese patients

Phase 3 RIO study DEXA-scanned subgroup (n=146)

	Total body mass	Total fat mass	Fat mass/body mass	Lean mass
Rimonabant vs. placebo	↓	↓	↓	Unchanged

Body composition was measured with body DEXA in a subset of patients in RIO Lipids. Decreases in the rimonabant 20 mg group relative to placebo were observed in the total body mass ($p<0.001$), the total body fat mass ($p=0.001$) and the fat mass/total body mass ratio ($p=0.007$). There was no statistically significant difference between the 20 mg and the placebo groups in lean mass loss between groups.

Rimonabant NDA (page 21)

Muscle-CB1 KO leads to increase in muscle mass in obese mice (Gonzalez-Mariscal et al, 2019)

Muscle cannabinoid 1 receptor regulates Il-6 and myostatin expression, governing physical performance and whole-body metabolism

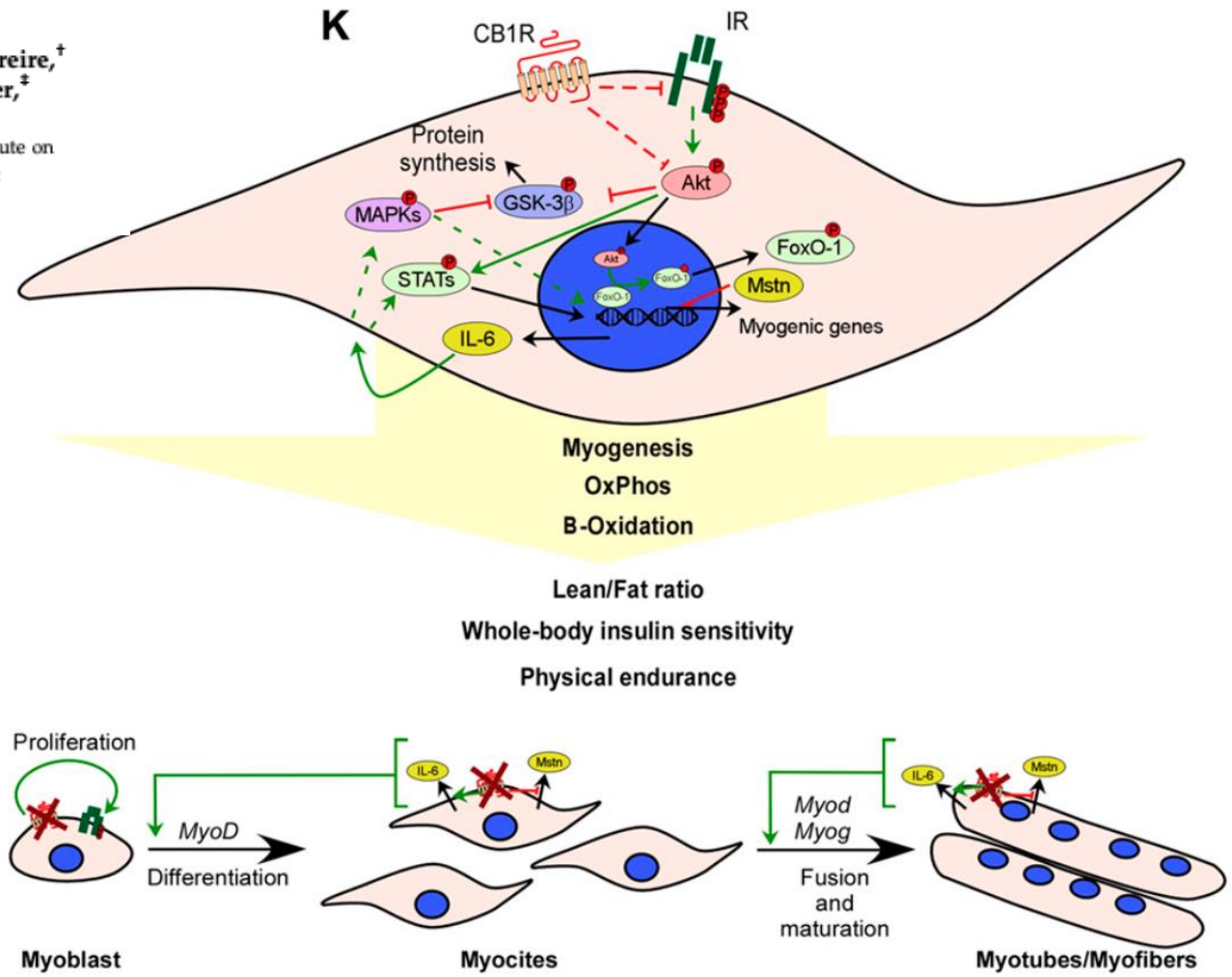
Isabel González-Mariscal,*[,1] Rodrigo A. Montoro,* Jennifer F. O'Connell,* Yoo Kim,* Marta Gonzalez-Freire,† Qing-Rong Liu,* Irene Alfaras,† Olga D. Carlson,* Elin Lehrmann,‡ Yongqing Zhang,‡ Kevin G. Becker,‡ Stéphan Hardivillé,§ Paritosh Ghosh,* and Josephine M. Egan*[,2]

*Laboratory of Clinical Investigation, †Translational Gerontology Branch, and ‡Laboratory of Genetics and Genomics, National Institute on Aging, National Institutes of Health, Bethesda, Maryland, USA; and §Unité de Recherche 8576–Unité de Glycobiologie Structurale et Fonctionelle (UGSF), Centre National de la Recherche (CNRS), Université Lille, Lille, France

Key finding:

Muscle-CB1 KO mice…

- Increase in muscle mass and strength
- Increase in biomarkers of muscle growth
- Increase in mitochondrial metabolism
- Increase in energy expenditure
- Increase in calorie consumption w/o weight gain
- Increase in fat metabolism
- Enhanced insulin sensitivity in muscle tissue
- Reduction in body fat content
- Reduction in sleep



Next generation CB1 inverse agonists are peripherally restricted

First generation (2000-2007)	Next generation (2020 onwards)
• Designed to target the brain with high BBB penetration → FDA rejection due to safety concerns (2007) SANOFI — Rimonabant Pfizer — Otenabant Bristol Myers Squibb — Ibipinabant MERCK — Taranabant	• Designed to be peripherally restricted with minimal BBB penetration → avoid safety issues novo nordisk — INV-202 CORBUS PHARMACEUTICALS — CRB-913

Source(s): Cinar et al 2020

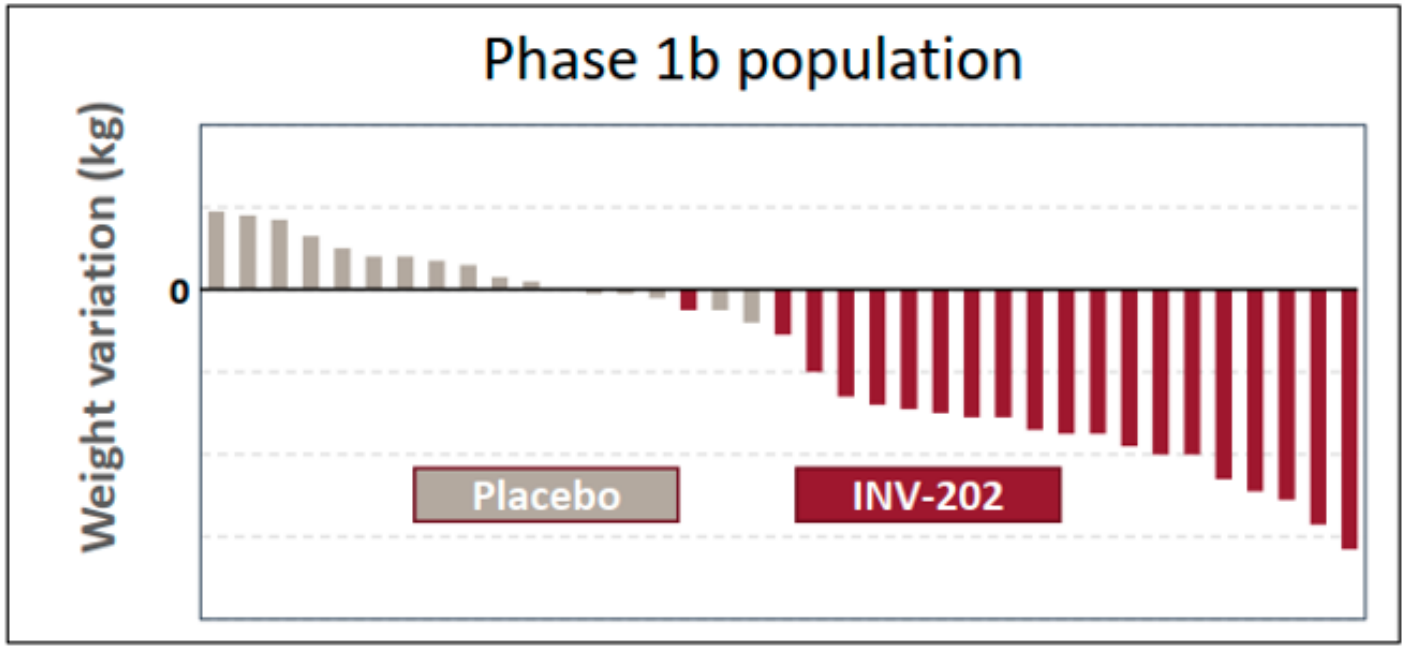
Novo Nordisk acquisition of Inversago marks return of CB1 as an MOA in obesity

BIOTECH

STAT+

Novo acquires Inversago for up to $1 billion, spotlighting troubled weight loss approach

Aug. 10, 2023



1. Single-dose INV-202 (25mg QD)
2. N = 37
3. Adults with metabolic syndrome
4. Weight loss: -3.50 kg (INV-202) vs +0.55Kg (placebo)

Source(s): Inversago corporate presentation

CRB-913: oral CB1 inverse agonist for combination therapy with incretins

OBESITY SYMPOSIUM

Obesity Biology and Integrated Physiology

Obesity A Research Journal | THE OBESITY SOCIETY | WILEY

Novel cannabinoid receptor 1 inverse agonist CRB-913 enhances efficacy of tirzepatide, semaglutide, and liraglutide in the diet-induced obesity mouse model

Marshall Morningstar | Andrew Kolodziej | Suzie Ferreira | Tracy Blumen | Rachael Brake | Yuval Cohen

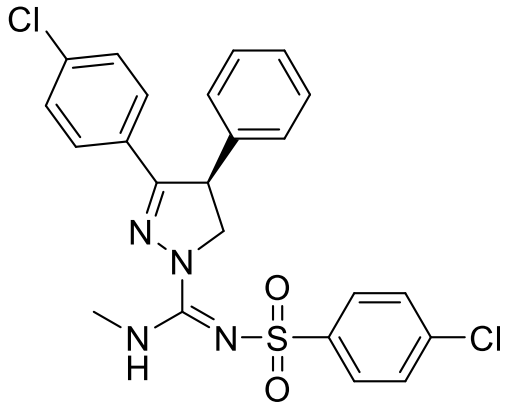
Nov. 2023

CRB-913: designed to be a best-in-class next generation CB1 inverse agonist

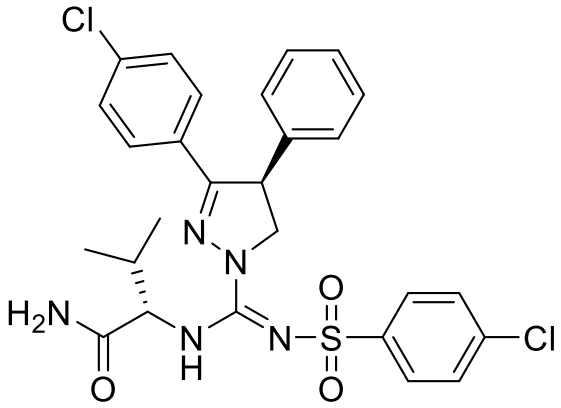
Design Goals

- Best-in-class peripheral restriction
- Protect lean mass (muscle)
- Retain 1st gen efficacy
- Enhance efficacy of incretin analogs

CRB-913 is the outcome of a multi-year medicinal chemistry campaign



Ibipinabant
(2004-2008)



JD-5037 (2012-2018) /
CRB-4001 (2018-2021)

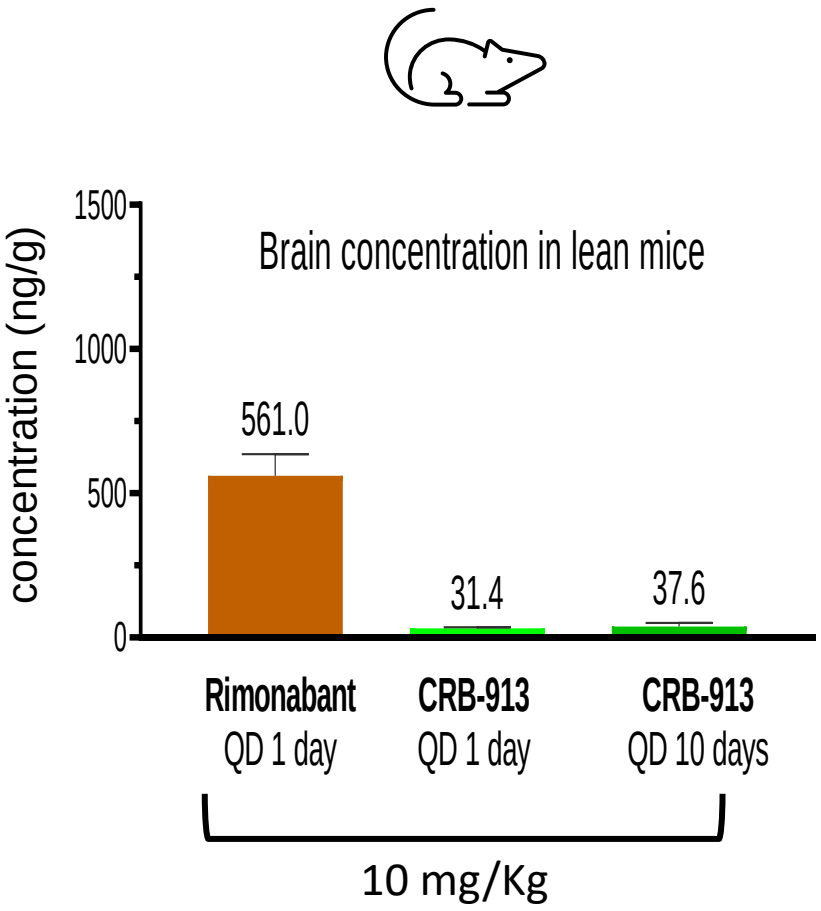
CRB-913

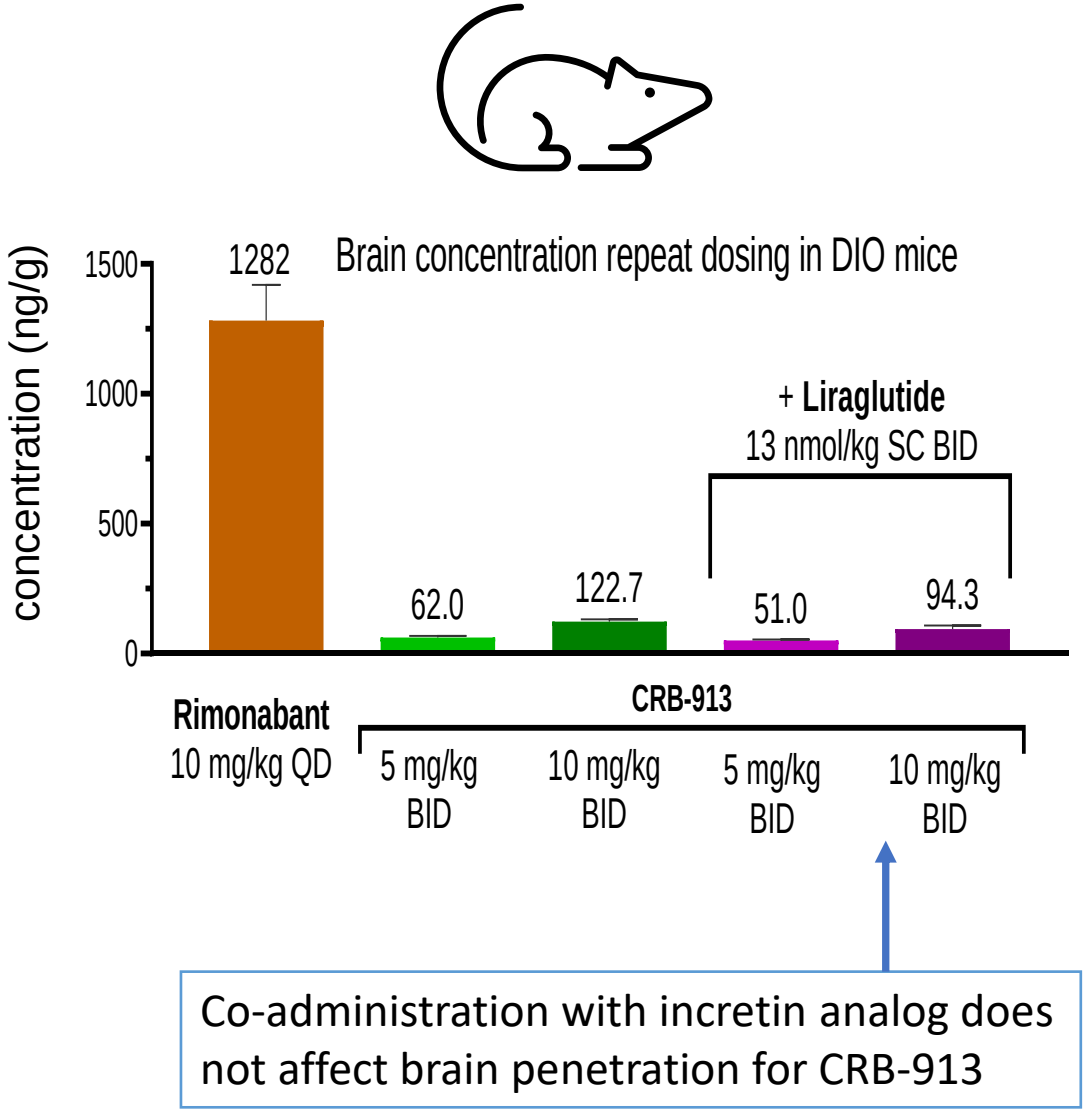
- Completed Phase IIb (Solvay/BMS)
- Small, lipid soluble molecule
- High BBB penetration
- Oral

- CRB-4001 (JD5037) licensed from Jenrin in 2018
- Extensive pre-IND studies carried out
- PK didn't support TPP
- Oral

- New IP published – patent coverage through 2043
- PK profile optimized for TPP
- Favorable multi-species bioavailability (>50%)
- Lower mfg. cost vs. incretins
- Oral

CRB-913: marked peripheral restriction vs. rimonabant in both lean and obese mice





Co-administration with incretin analog does not affect brain penetration for CRB-913

Source(s): Morningstar *et al* 2023

CRB-913: higher degree of peripheral restriction than INV-202

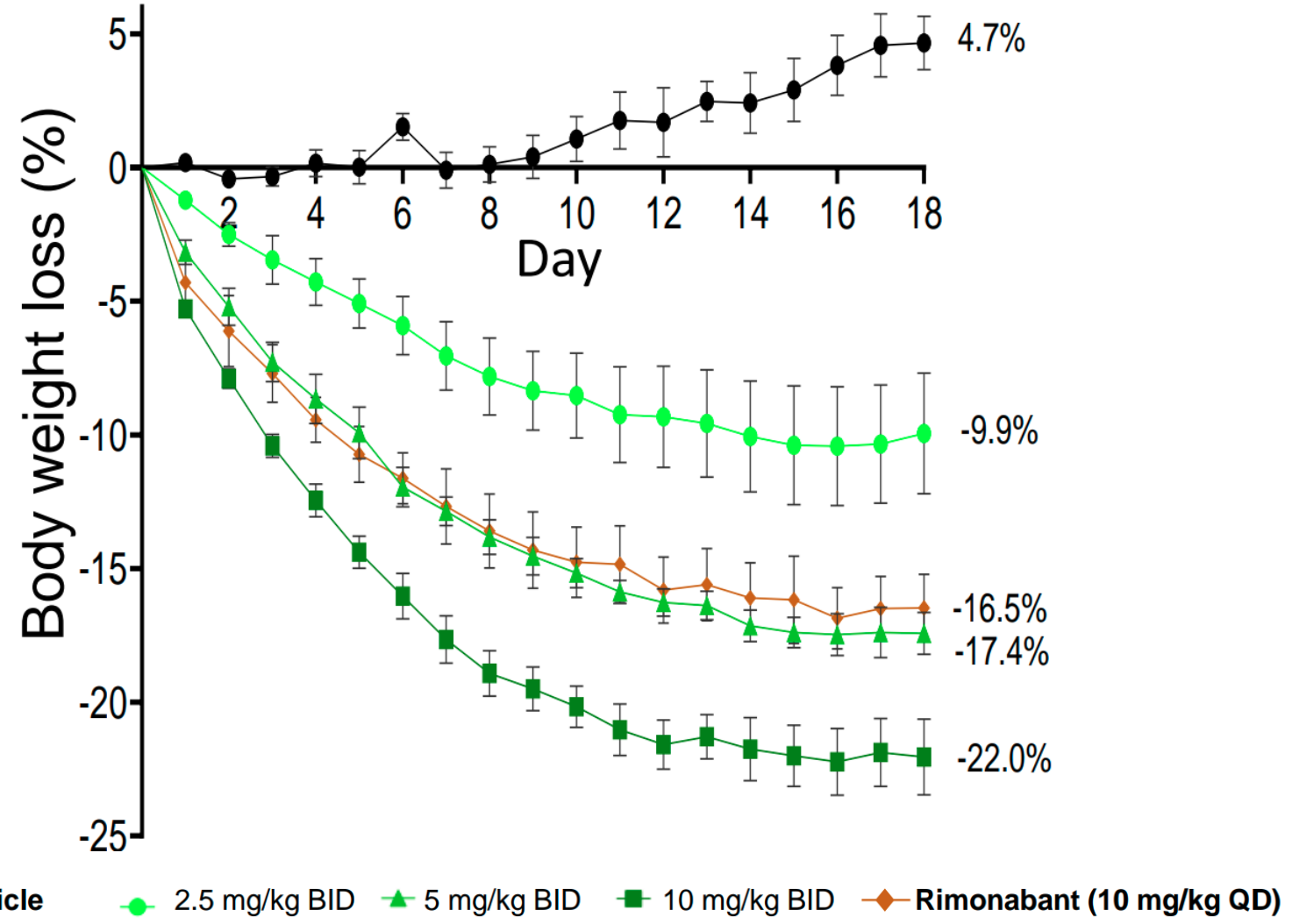
Brain concentration (ng/g)			
single acute dose	CRB-913 (lean mice)	INV-202 (lean mice)	Rimonabant (lean mice)
10 mg/Kg	26*	319**	561*

1:12

1:21

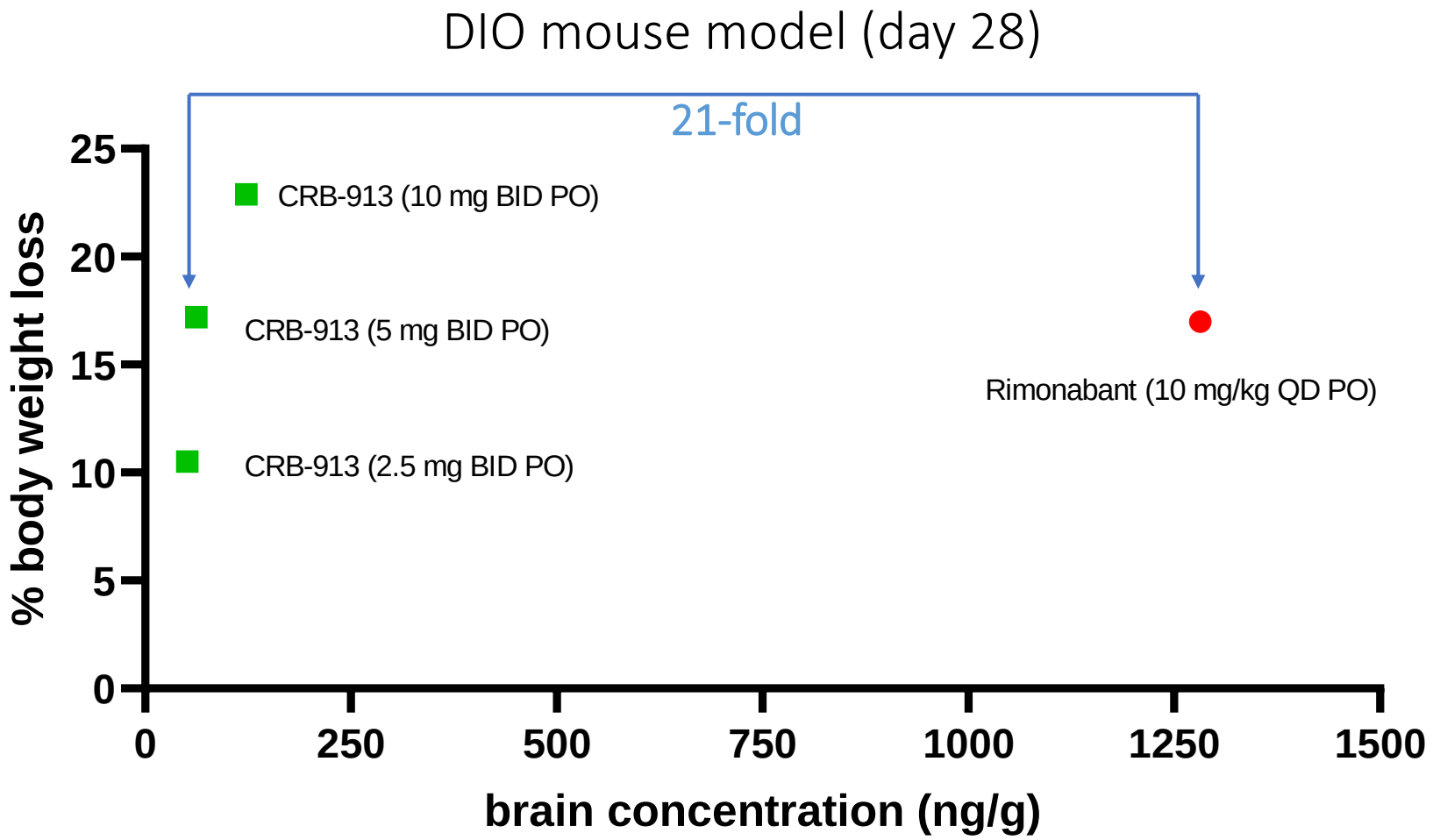
Source(s): *Morningstar *et al* 2023 and **Liu *et al* 2021

CRB-913: similar weight loss vs. rimonabant at same daily doses in DIO mice



Source(s): Morningstar et al 2023

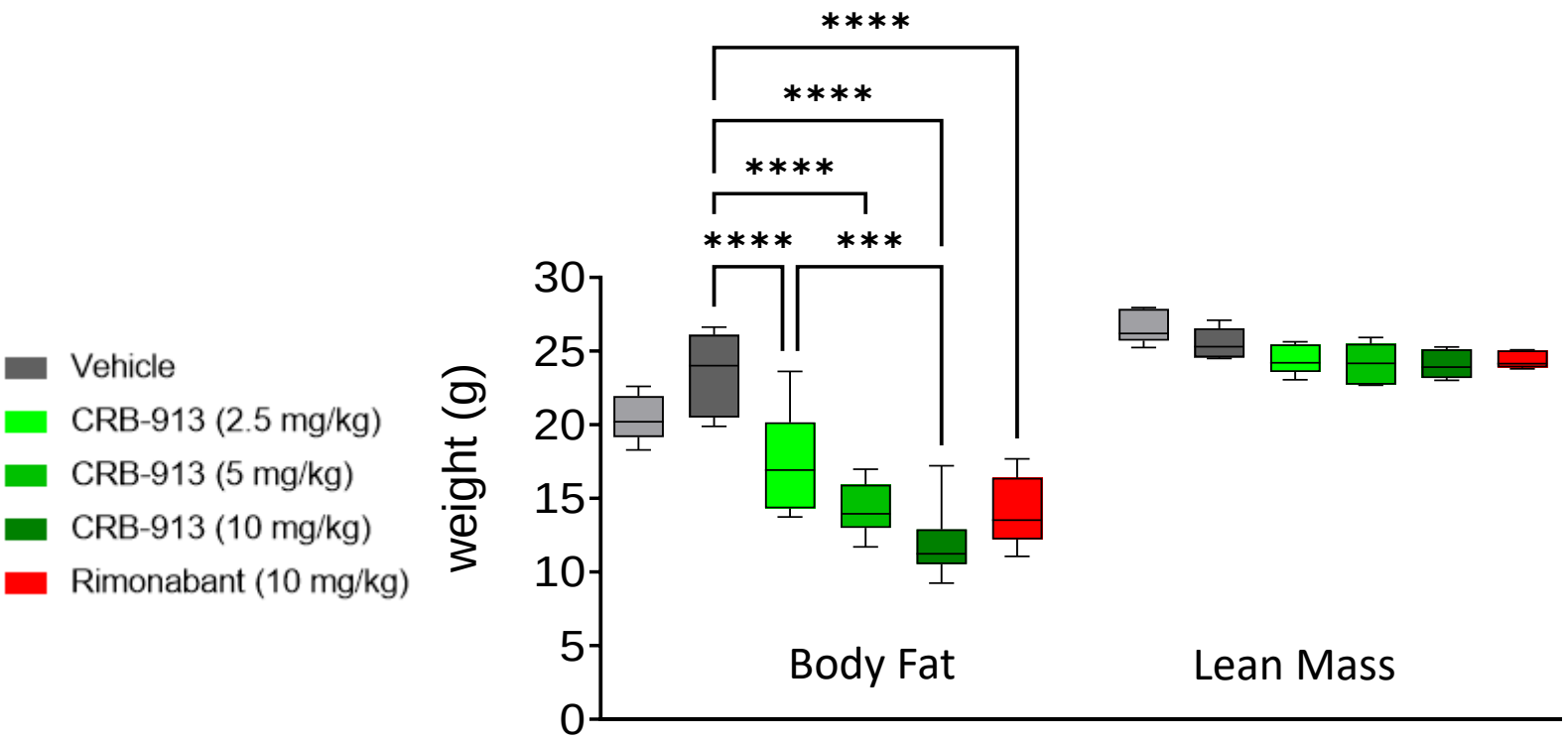
CRB-913: similar weight loss despite markedly lower brain concentrations vs. rimonabant



- DIO mouse model with C57BL6/N mice (n=10) fed a continuous high fat diet for 22 weeks prior and during 28 days of treatment
- Brain collected 1 h post final dose (C_{max})

Source(s): Company data on file.

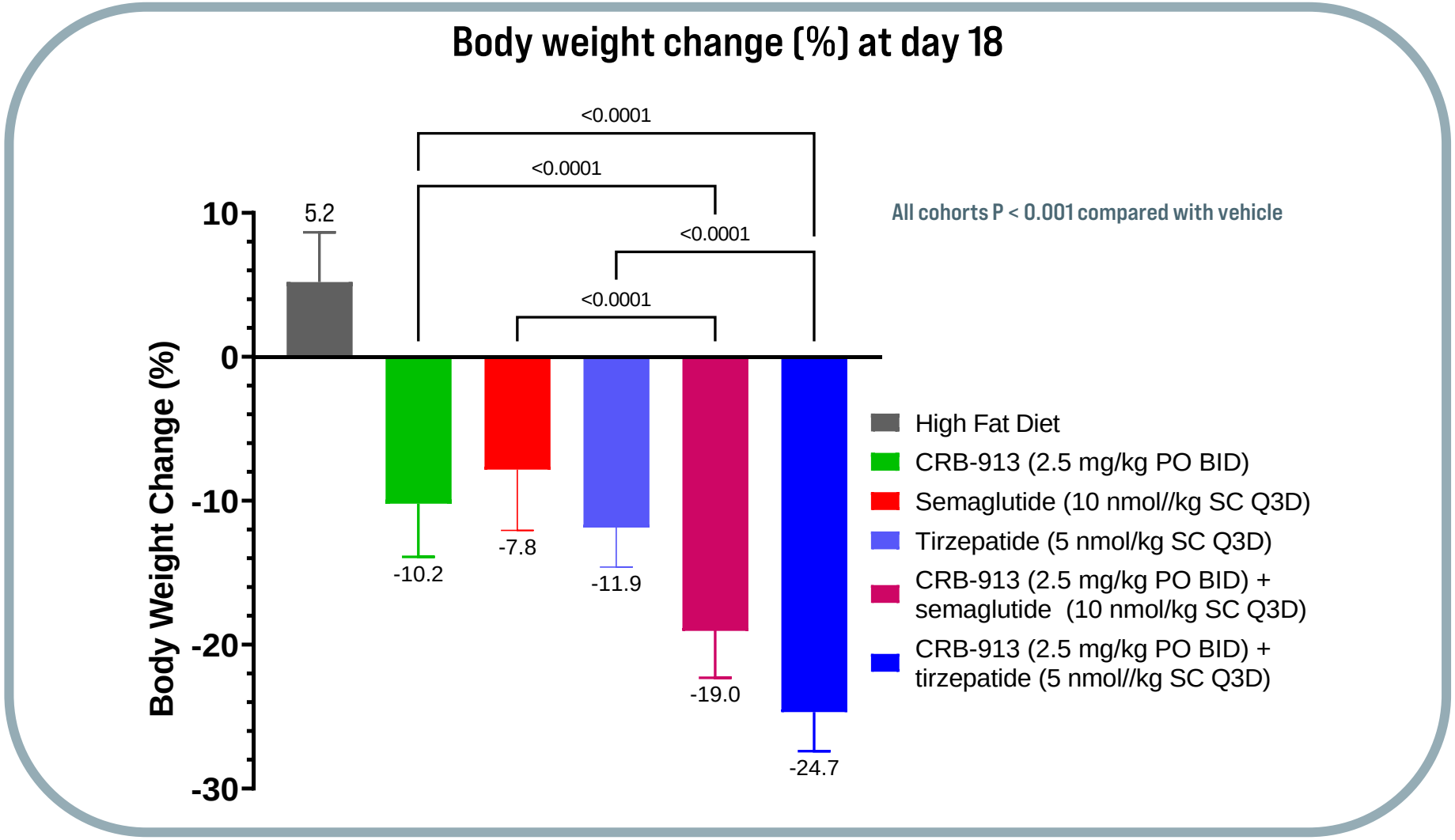
CRB-913 demonstrates significant reduction in body fat content but not lean mass



- DIO mouse model with C57BL6/J mice (n=10) fed a continuous high fat diet for 22 weeks prior
- Body fat by MRI determined on Day 20

Source(s): Morningstar et al 2023

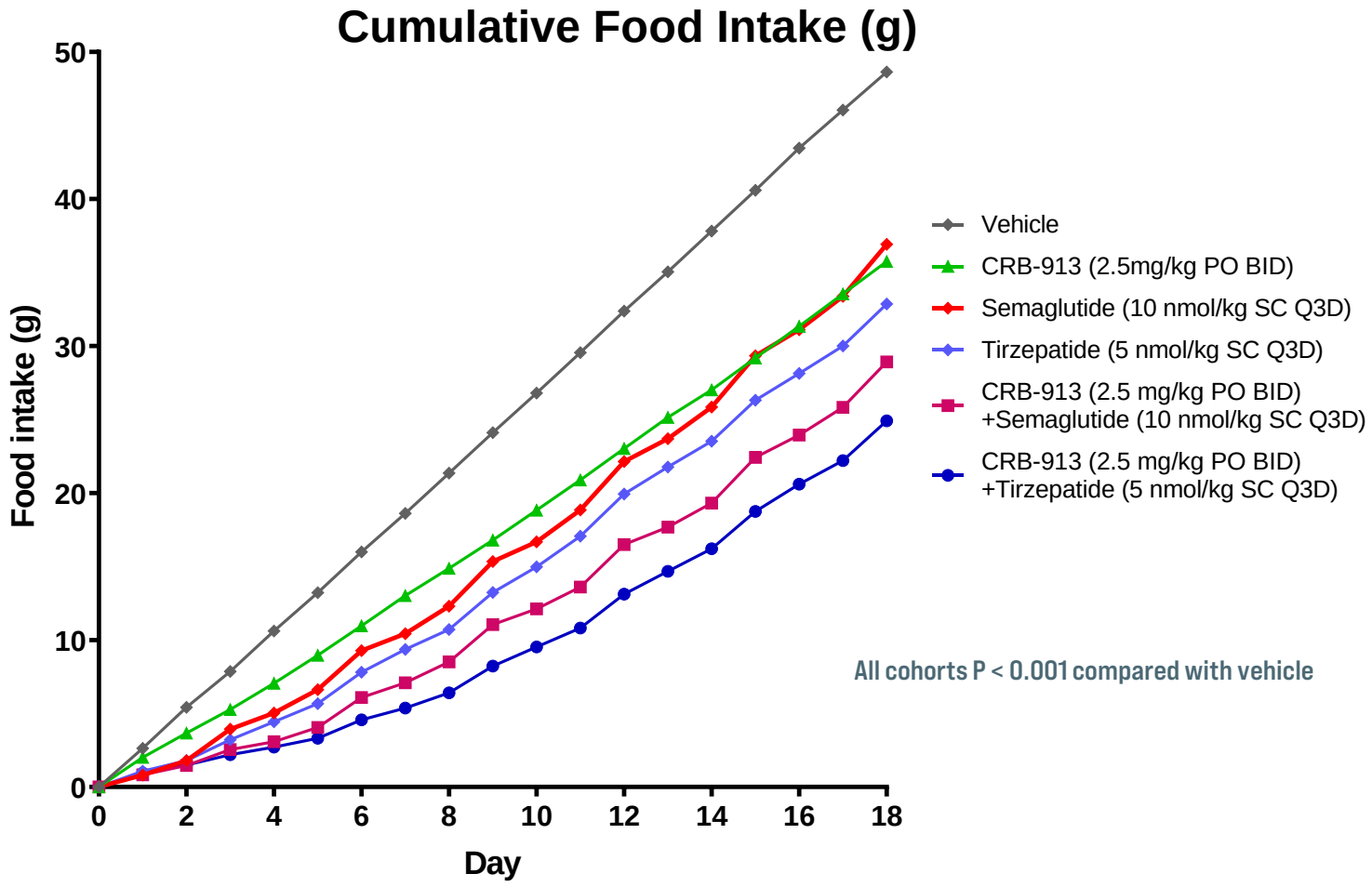
CRB-913: enhanced combo effect with semaglutide or tirzepatide



DIO mouse model with C57BL6/J mice (n=10) fed a continuous high fat diet for 22 weeks prior and during 18 days of treatment
(Similar effect also seen when CRB-913 was combined with liraglutide)

Source(s): Company data on file.

CRB-913 reduces food consumption alone or in combination with semaglutide or tirzepatide



Food Consumption

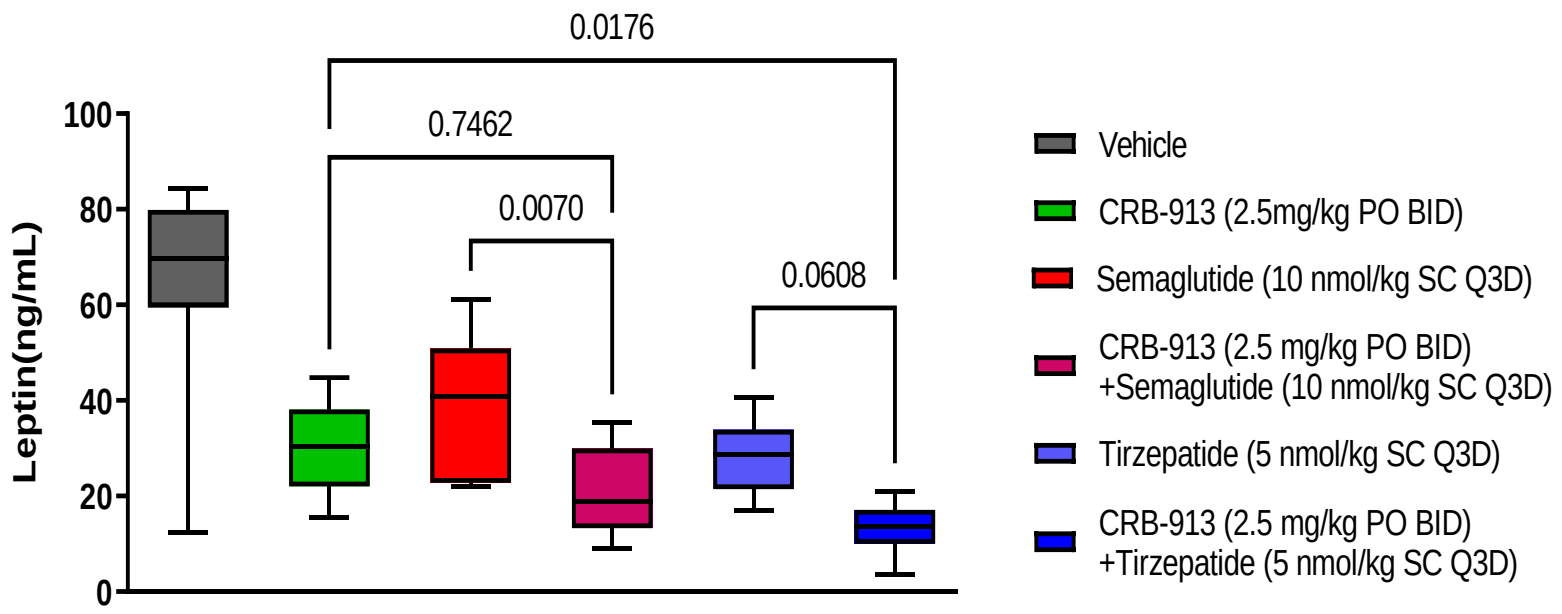
- CRB-913, semaglutide and tirzepatide each results in food intake reductions
- Significant further reductions in food consumption when CRB-913 is combined with semaglutide or tirzepatide (p=0.001)

DIO mouse model with C57BL6/J mice (n=10) fed a continuous high fat diet for 22 weeks prior

Source(s): Company data on file.

CRB-913 reverses leptinemia alone and in combination with semaglutide or tirzepatide

All cohorts P < 0.001 compared with vehicle



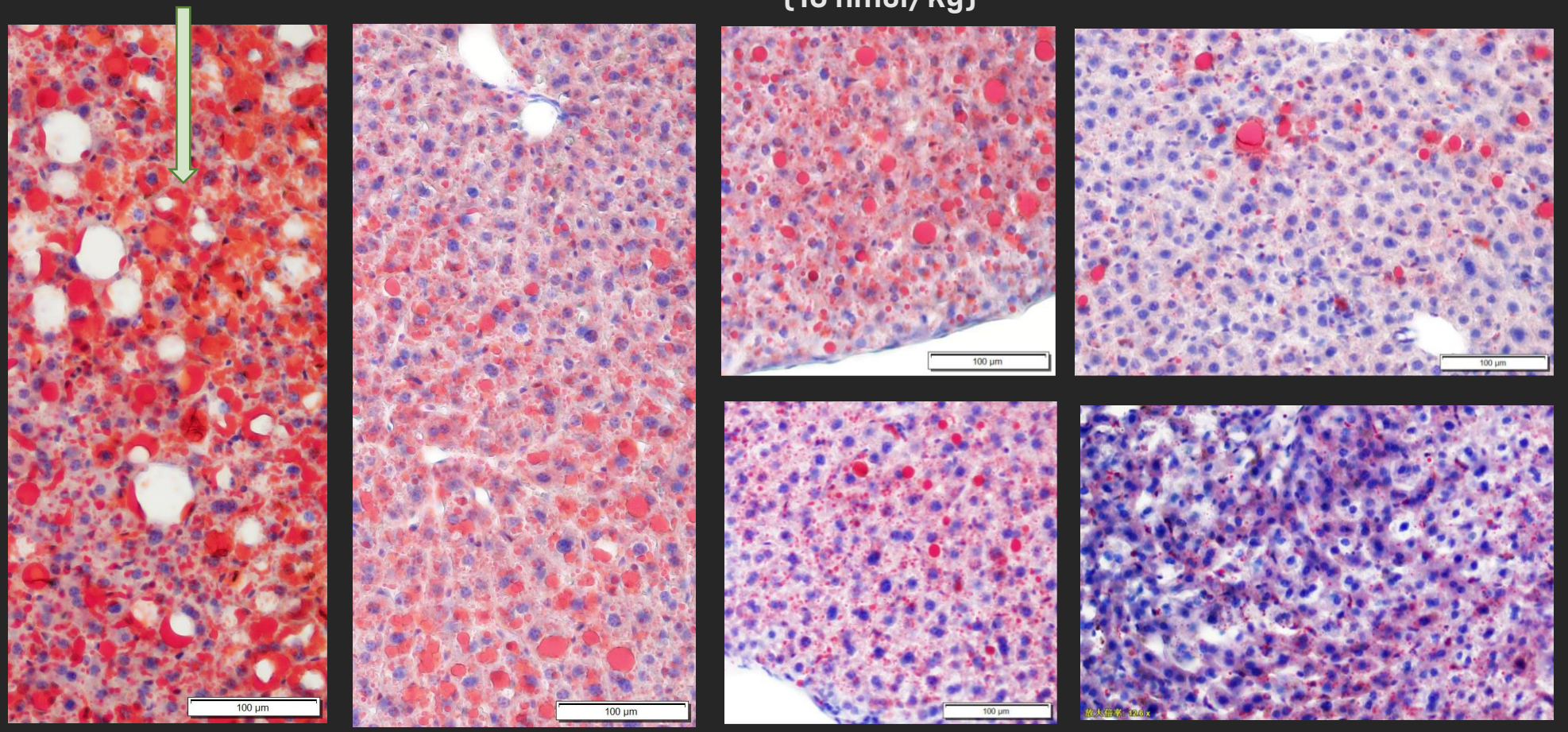
- DIO mouse model with C57BL6/J mice (n=10) fed a continuous high fat diet for 22 weeks prior
- Leptin measured at Day 28 of treatment

The Role of Leptin

- The hormone leptin regulates food intake
- Normally, leptin signals satiety (feeling "full")
- In obesity, resistance to leptin develops and hunger persists despite high leptin levels ("leptinemia")
- A reduction in leptin levels is believed to be important for weight loss[1]

Source(s): [1]Leptin and the maintenance of elevated body weight, Pan and Myers, Nature Reviews, Jan 2018. Company data on file.

CRB-913 reduces liver fat alone and in combination with semaglutide or tirzepatide



*liver oil red stain

Source(s): Company data on file.

CRB-913: Clinical development pathway and potential clinical usage

IND	SAD → MAD	Monotherapy 28 days (3 doses)	Co-admin with incretin analog
Q4 2024	H1 2025	H2 '25 – H1 '26	H2 '26 – H1 '27

Potential clinical applications:

- Incretin analog therapy insensitive/intolerant/high-risk patients
- Combination with oral incretin agonists → enhance efficacy OR improve tolerability
- "Induction/maintenance" model: maintain weight loss post incretin analog therapy

Expected Milestones

Produce drug for toxicology and clinical studies	Q2-2024
Complete toxicology and IND enabling studies	Q3-2024
File IND	Q4-2024
Dose first patient	Early 2025

CRB-913: designed to be a best-in-class next gen CB1 inverse agonist

- Best-in-class peripheral restriction ✓
- Protect lean mass (muscle) ✓
- Retain 1st gen efficacy ✓
- Enhance efficacy of incretin analogs ✓

Leadership
Upcoming catalyst
Financials

Management Team

Yuval Cohen, PhD

Chief Executive Officer, Director

Corbus co-founder and Chief Executive Officer since 2014. Previously the President and co-founder of Celsus Therapeutics from 2005.

Sean Moran, CPA, MBA

Chief Financial Officer

Corbus co-founder and Chief Financial Officer since 2014. Prior senior financial management experience in emerging biotech and medical device companies.

Dominic Smethurst, PhD

Chief Medical Officer, MA MRCP

Dr. Smethurst, MA MRCP, joined Corbus as our Chief Medical Officer in February 2024. He most recently served as CMO of Bicycle Therapeutics.

Christina Bertsch

Head of Human Resources

Accomplished senior human resource executive providing strategic HR consulting services to both large and small businesses across a variety of industries.

Board of Directors

Amb. Alan Holmer Ret.
Chairman of the Board

More than two decades of public service in Washington, D.C. including Special Envoy to China; Former CEO of PhRMA.

Anne Altmeyer, PhD, MBA, MPH
Director

20 years of experience advancing oncology R&D programs and leading impactful corporate development transactions; currently President & CEO of TigaTx.

Avery W. (Chip) Catlin
Director

More than 25 years of senior financial leadership experience in life science companies; Former CFO and Secretary of Celldex Therapeutics.

Yuval Cohen, PhD
Chief Executive Officer, Director

Corbus co-founder and Chief Executive Officer since 2014. Previously the President and co-founder of Celsus Therapeutics from 2005.

Rachelle Jacques
Director

More than 25-year professional career, experience in U.S. and global biopharmaceutical commercial leadership, including multiple high-profile product launches in rare diseases; CEO of Akari Therapeutics. (NASDAQ: AKTX)

John K. Jenkins, MD
Director

Distinguished 25-year career serving at the U.S. FDA, including 15 years of senior leadership in CDER and OND.

Pete Salzmann, MD, MBA
Director

20 years of industry experience and currently serves as Chief Executive Officer of Immunovant (NASDAQ: IMVT), a biopharmaceutical company focused on developing therapies for patients with autoimmune diseases.

Yong (Ben) Ben, MD, MBA
Director

25 years of oncology R&D experience across industry and academia. Held two industry CMO positions, most recently at BeiGene (BGNE).

Expected Corporate Milestones

CRB-701

First patient dosed in U.S. dose escalation study: Q1-2024
Clinical data update on China dose escalation study: Mid-2024
Complete U.S. dose escalation study: Fall-2024
Present U.S. dose escalation data: Q4-2024 / Q1-2025

CRB-913

File IND: Q4-2024
First patient dosed: early 2025

CRB-601

IND cleared: January-2024 ✓
First patient dosed: Summer 2024

CORBUS PHARMACEUTICALS®

Appendix

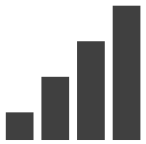
CRB-601

Potential “best-in-class” αvβ8 mAb

CRB-601 has the potential to enhance checkpoint inhibition

Novel mechanism to target TGFβ in the tumor microenvironment

Focus on adopting a precision-targeted approach



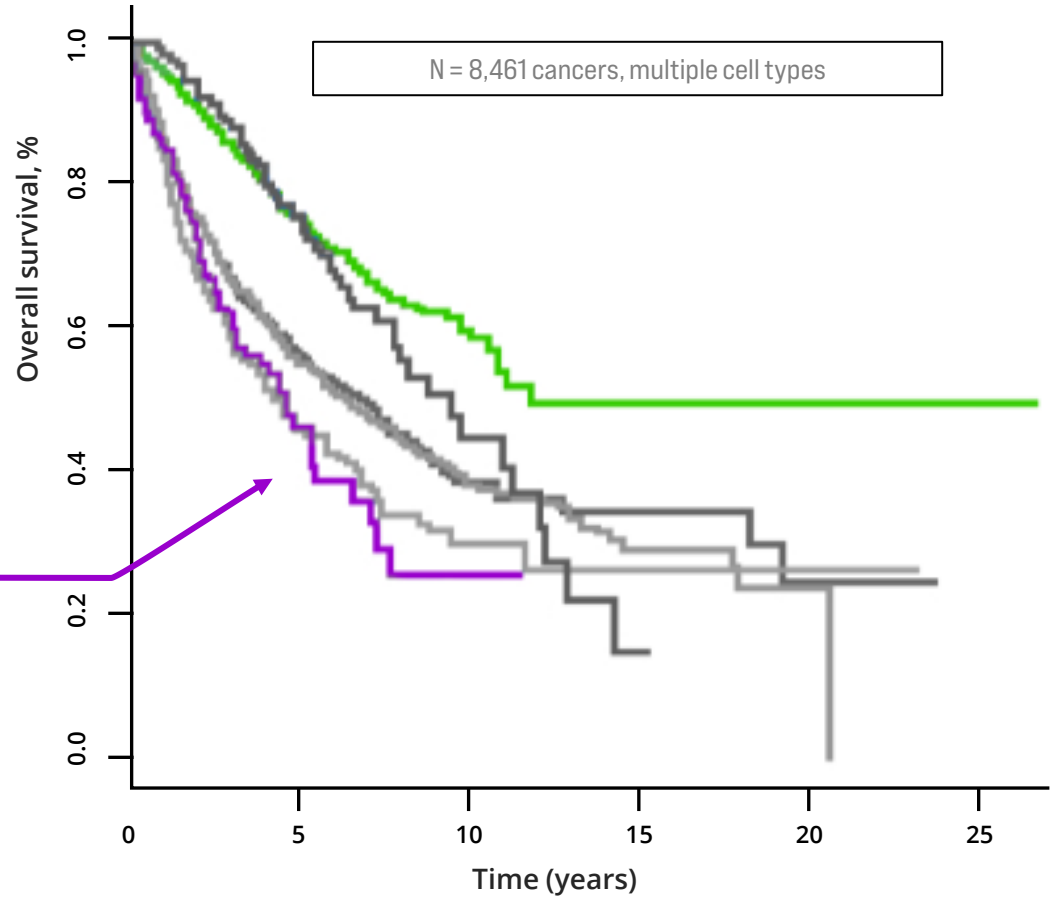
Large opportunity potential if POC is validated

TGFβ predicts poor clinical outcomes in a subset of cancer patients

Immunogenomic subtypes in cancer

- C1 WOUND HEALING
- C2 INF-γ DOMINANT
- C3 INFLAMMATORY
- C4 LYMPHOCYTE DEPLETED
- C5 IMMUNOLOGICALLY QUIET
- C6 TGFβ DOMINANT

TGFβ predominance gene signature



Gene expression, immune cell quantification & network mapping

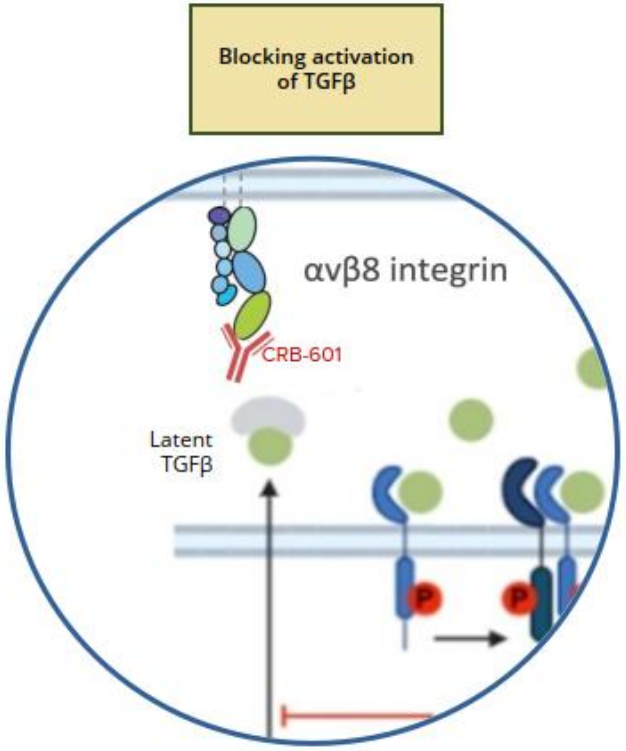
- 33 different cancer types / 8,000+ tumors

Source(s): Thorsson, et al. The Immune Landscape of Cancer, Immunity. 2018; 48:817

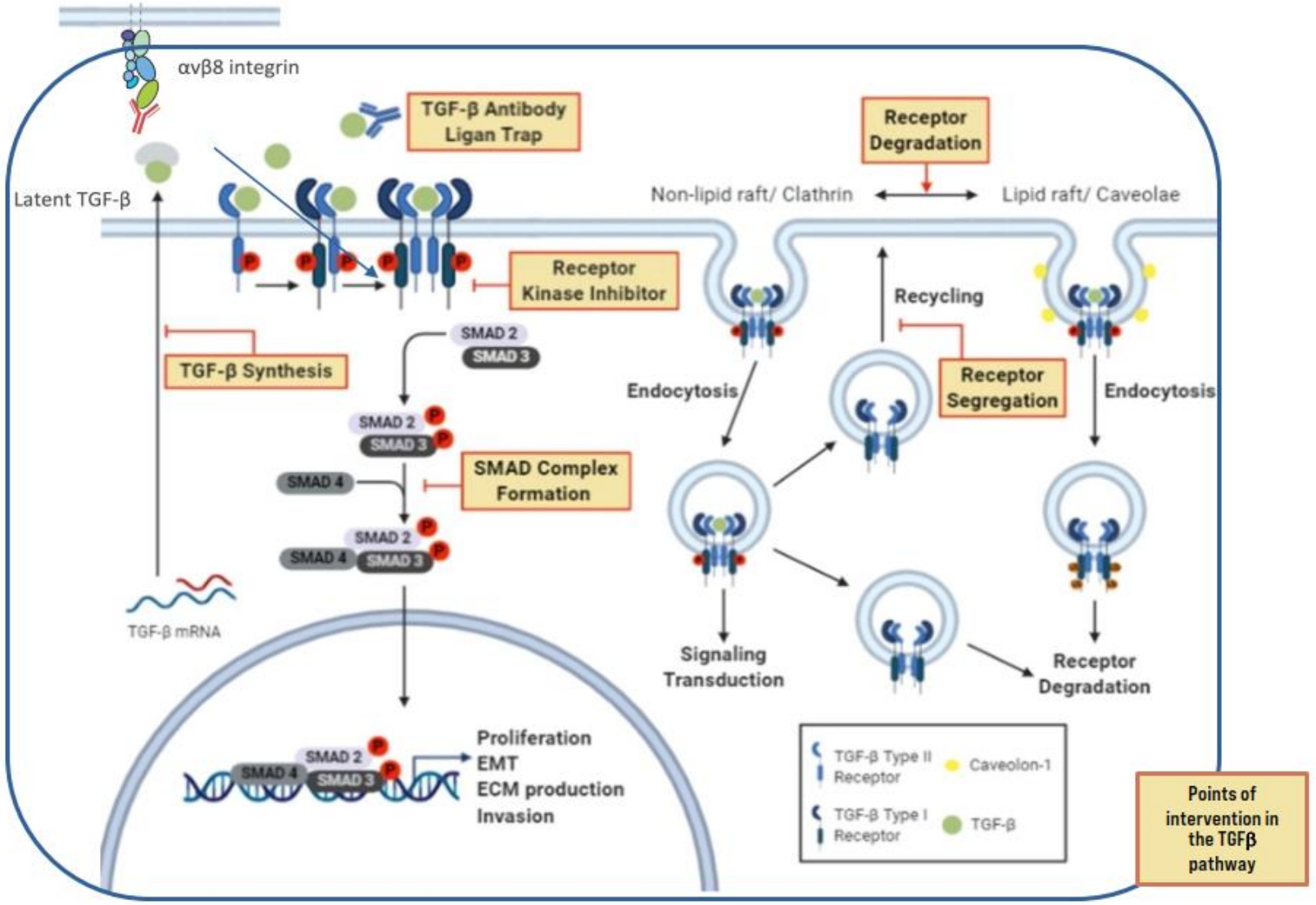
Targeting the integrin αvβ8 represents a novel approach to regulating TGFβ

Novel point of therapeutic intervention

Blocking the αvβ8 activation of TGFβ in the local tumor microenvironment



CRB-601 binds at the interface between latent TGFβ and αvβ8



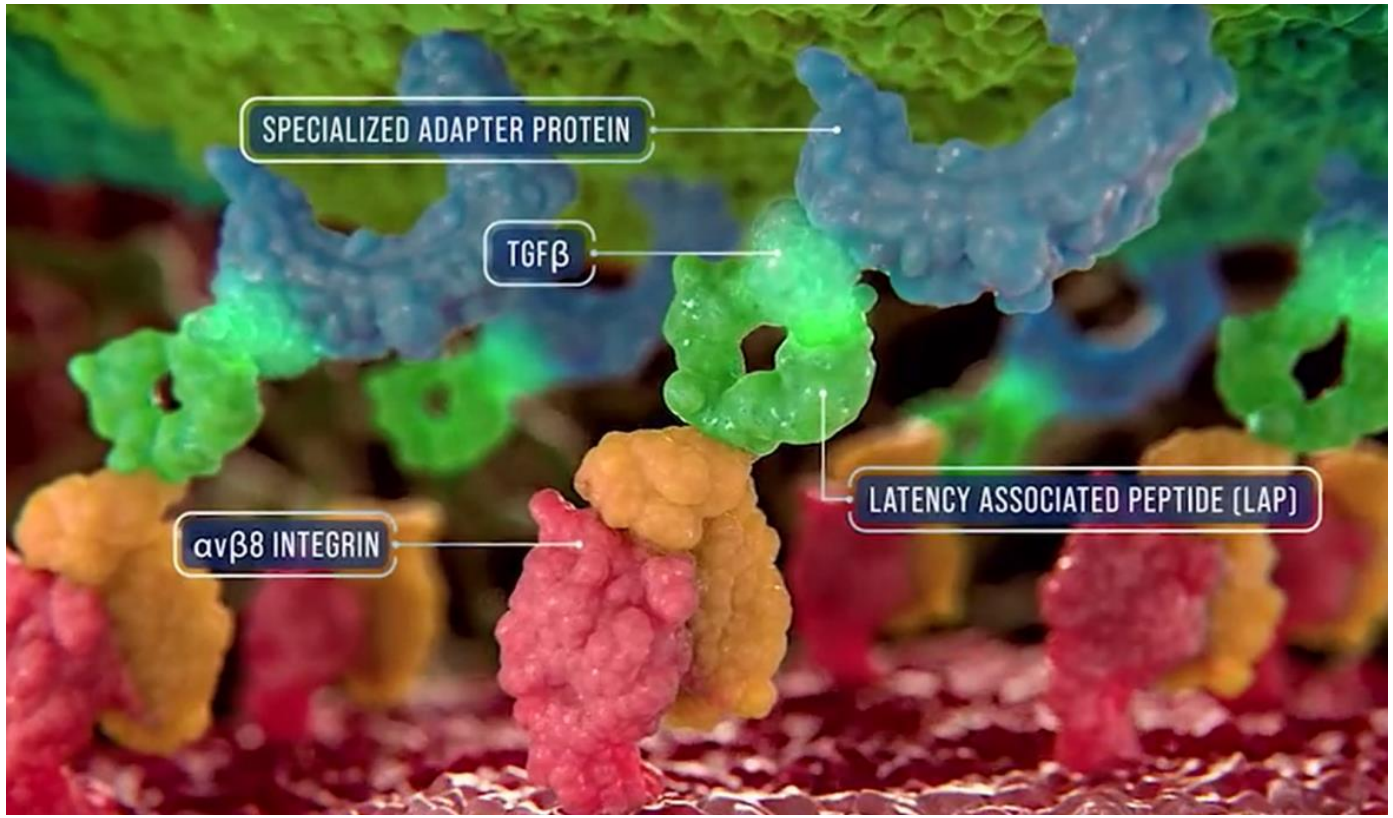
Source(s): Huang et al., 2021. Recent progress in TGFβ inhibitors for cancer therapy.

CRB-601 is targeting latent -TGFβ by blocking the integrin αvβ8

The integrin αvβ8 is expressed in the tumor microenvironment (TME)

Latent-TGFβ is also expressed in the TME

CRB-601 is a blocking antibody preventing the interaction of these two proteins



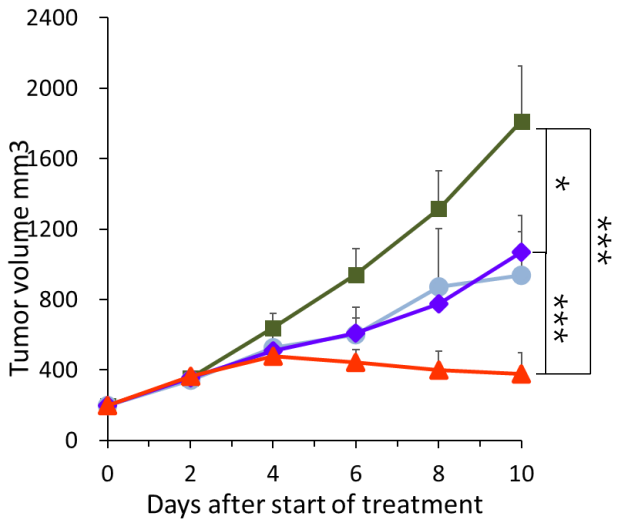
mAbs targeting TGFβ activation are advancing clinically

	CRB-601	PF-06940434	SRK-181	ABBV-151	RG6440
MOA	αvβ8	αvβ8	L-TGFβ	GARP (TGFβ1)	L-TGFβ
Clinical Stage	IND Cleared Jan 24	Phase 1/2	Phase 1	Phase 2	Phase 1
Indications	Solid Tumors	Solid Tumors	Solid Tumors	HCC Updated 11/23	Solid Tumors
Type	Monoclonal Antibody	Monoclonal Antibody	Monoclonal Antibody	Monoclonal Antibody	Monoclonal Antibody
ROA	IV	IV	IV	IV	IV

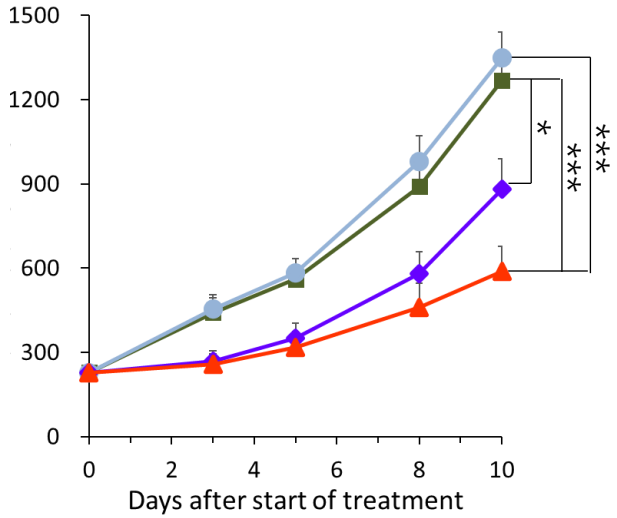
Source(s): Company websites. Clinicaltrials.gov. Internal analysis.

CRB-601 enhances anti-PD-1 therapy in checkpoint inhibition sensitive and resistant murine tumor models

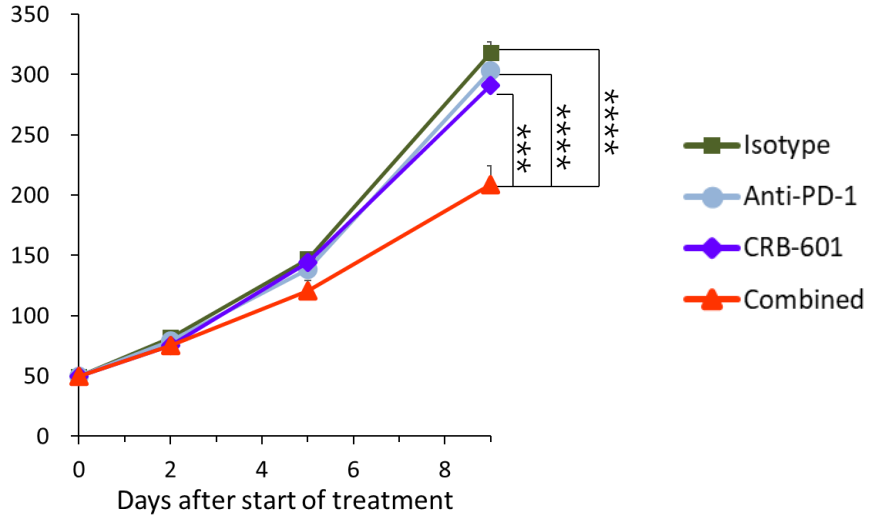
MC38 (Inflamed Tumor)



EMT6 (Excluded Tumor)



4T1 (Desert Tumor)



Checkpoint blockade sensitivity

Sensitive → **Resistant**

% TGI	MC38	EMT6	4T1
Anti-PD-1	54	-8	6
CRB-601	46	37	10
Combo	89	65	41

CRB-601: 10 mg/kg BIW

Anti-PD-1: 10 mg/kg BIW

10 animals / group

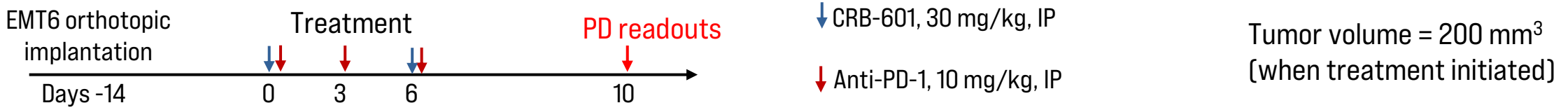
Animals randomized at 50-80 mm^3

Comparisons across arms

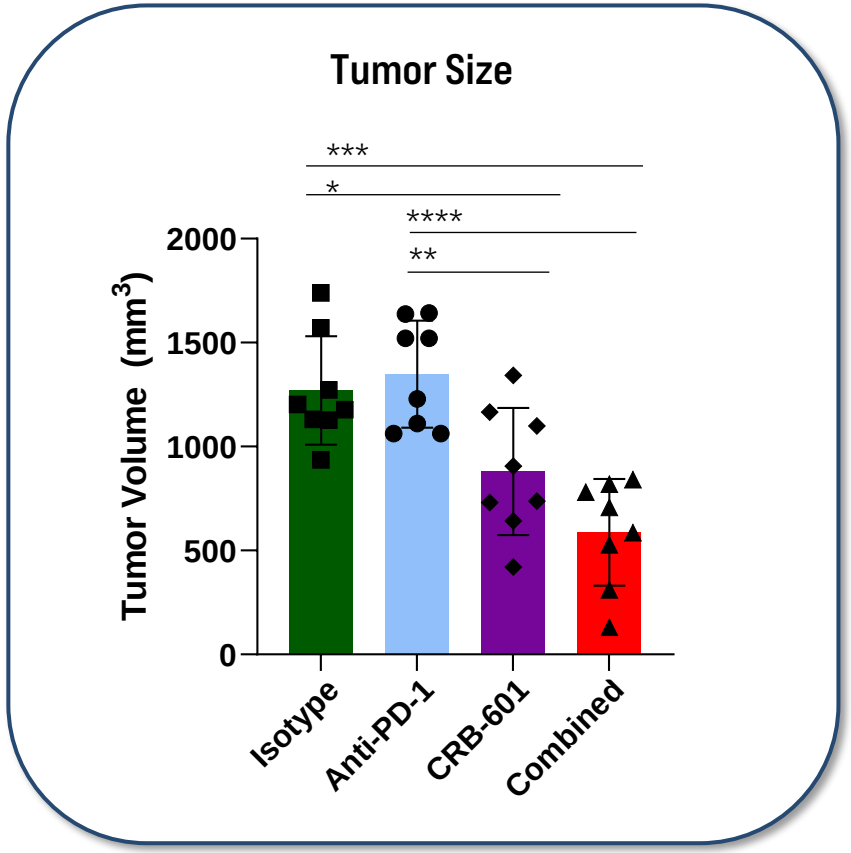
*p<0.05, ***p<0.001, ****p<0.0001

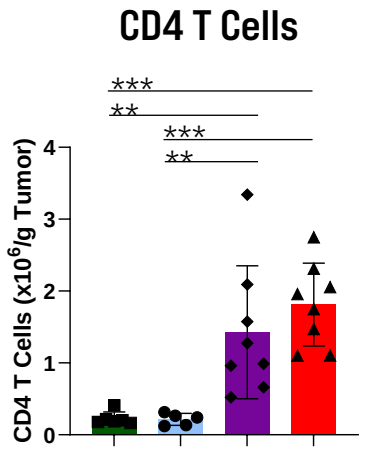
Source(s): Corbus data on file

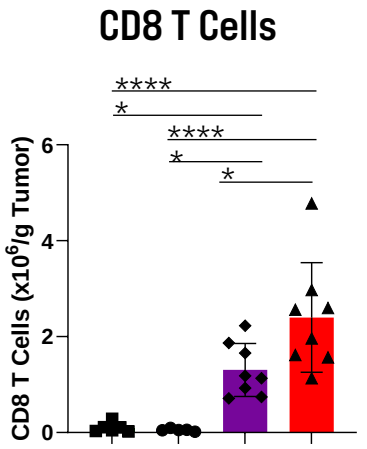
Blockade of αvβ8 in combination with anti-PD-1 increased TIL populations in immune excluded EMT6 tumors

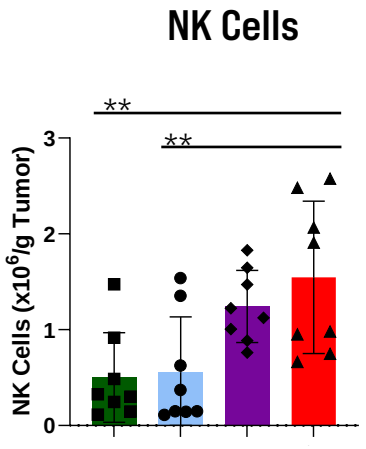


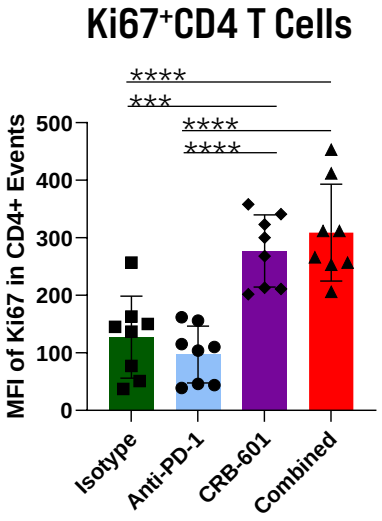
Tumor volume = 200 mm^3 (when treatment initiated)

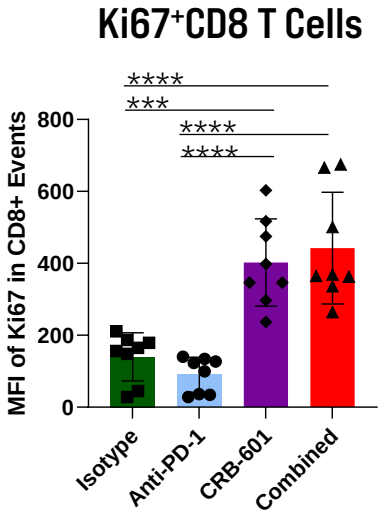


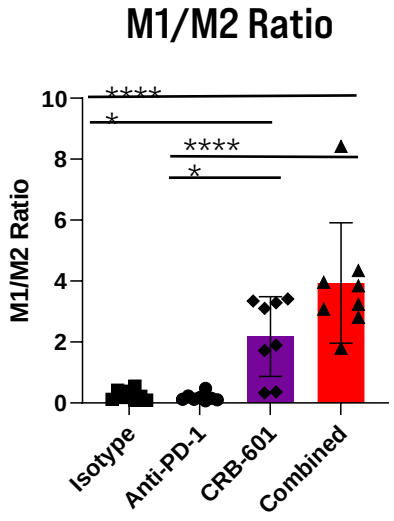








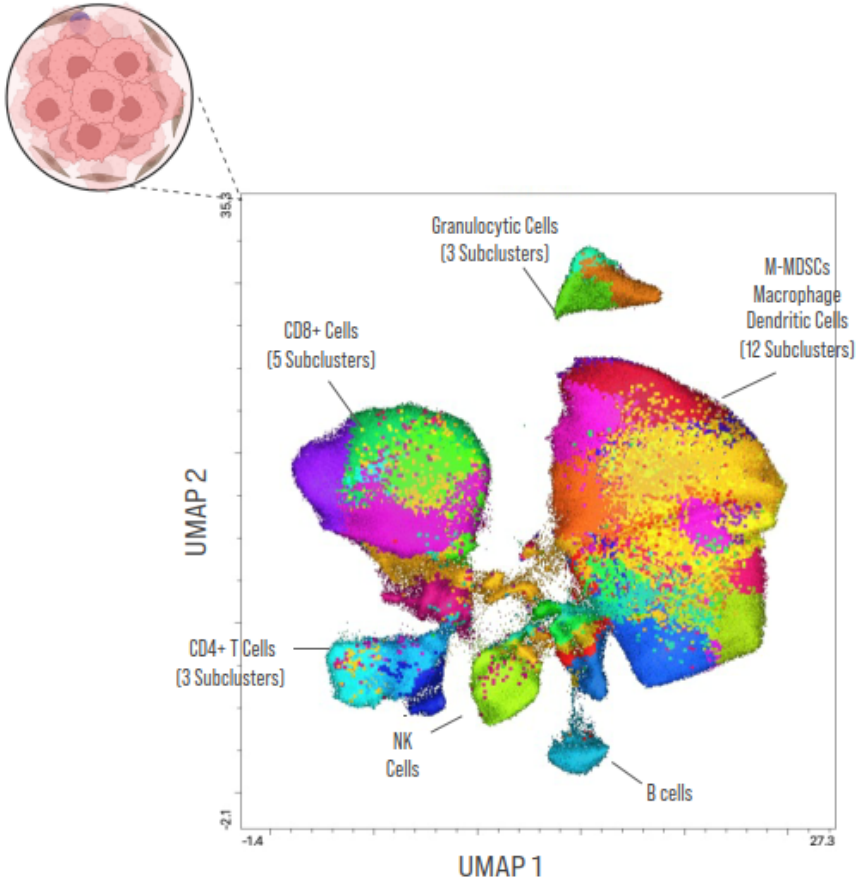




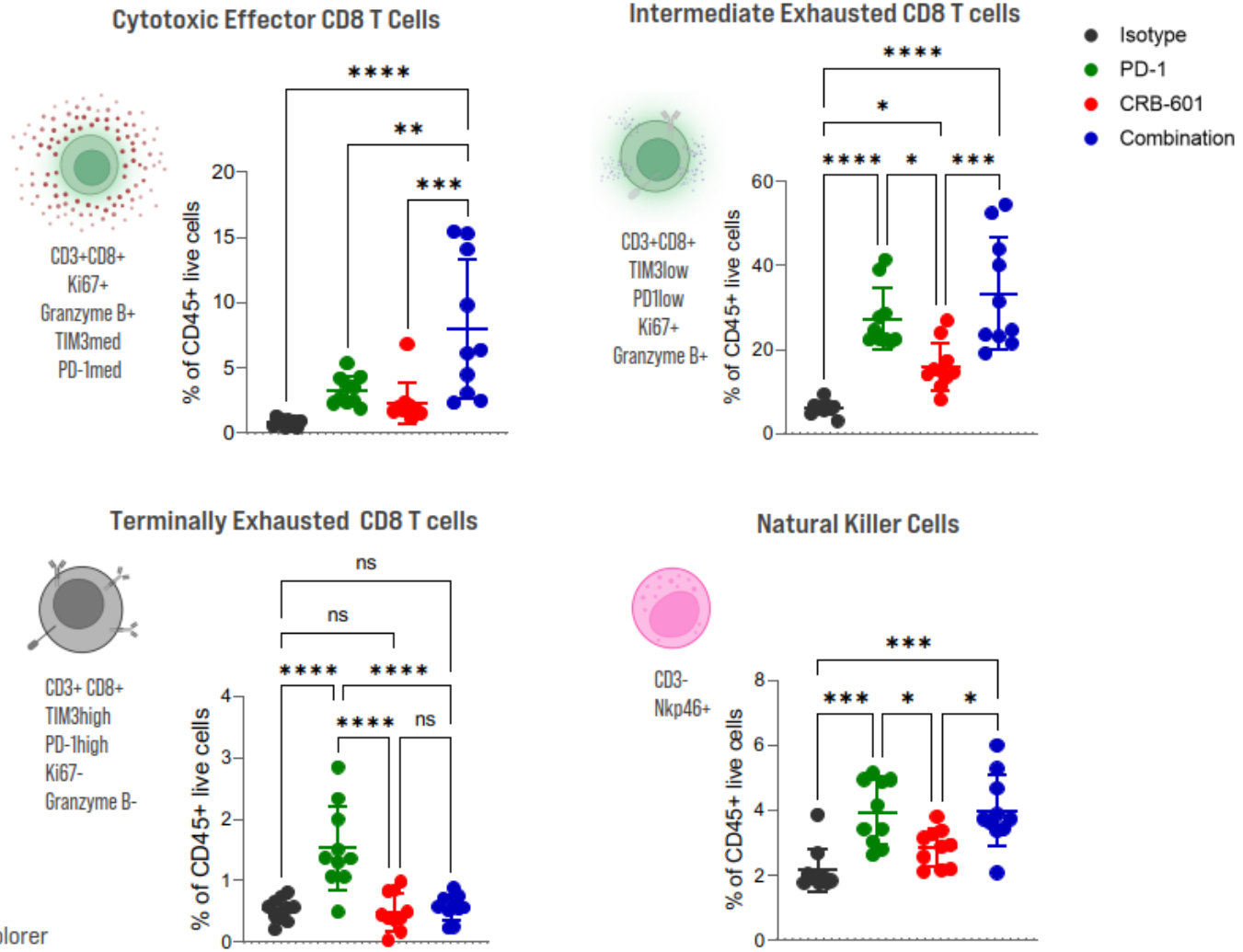
*p<0.05; **p<0.01; ***p<0.001; ****p<0.0001

Source(s): Corbus data on file

CRB-601 reshapes the landscape of effector T and NK cells in MC38 tumors



- 22 antibody flow cytometry panel
- 1.25 million live CD45+ cells analyzed
- 31 immune clusters from high dimensional flow analysis
- Sample processing (1) Downsample (2) UMAP (3) X-Sift (4) Euclid (5) Cluster Explorer
- Animals have undergone 10 days of treatment.

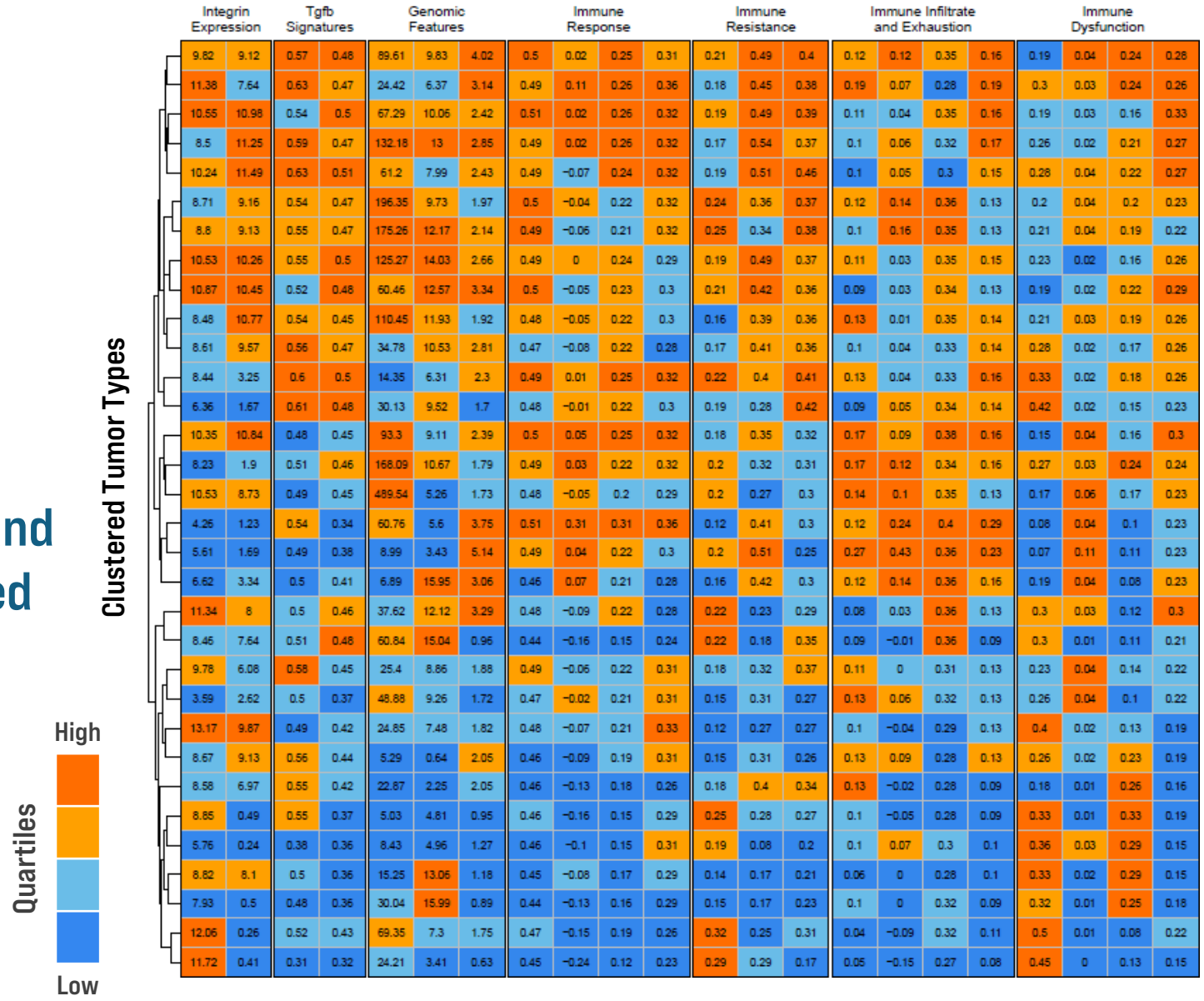


Source(s): Corbus data on file

Applying a proprietary algorithm to define the clinical focus for CRB-601

A multi-parametric, immune-focused algorithm has refined indications for CRB-601

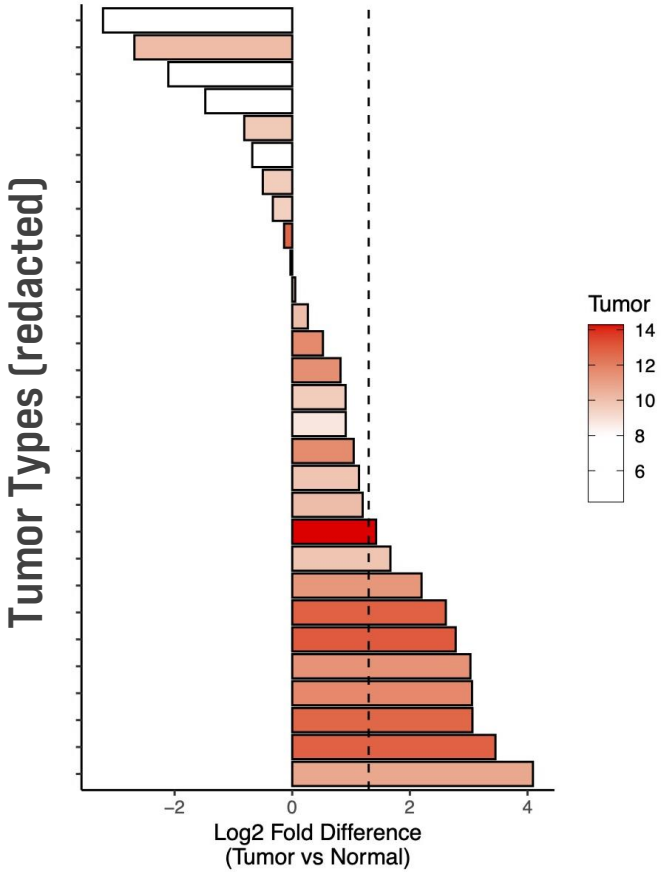
The combination of immune features and gene expression profiles have identified 9 indications for clinical priority

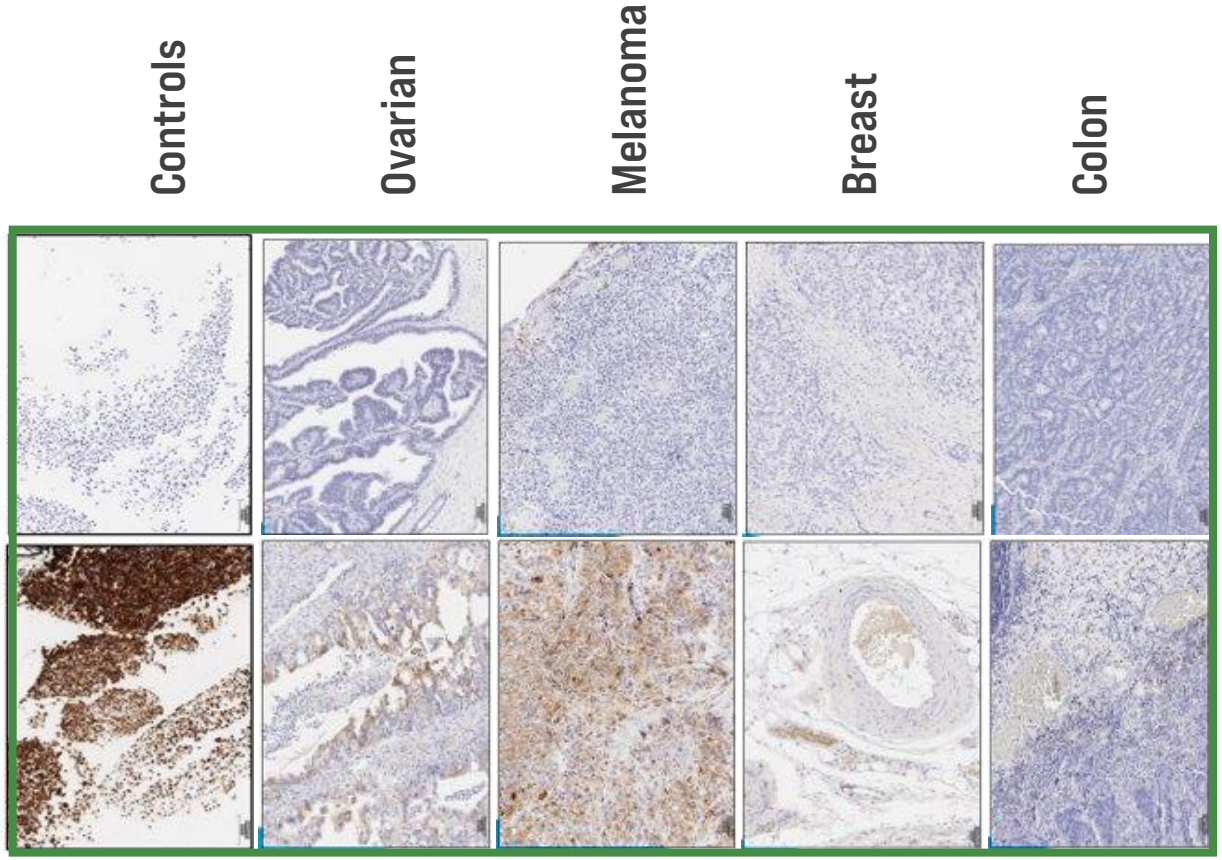


Source(s): Corbus proprietary analysis

Patient selection strategies will enhance the probability of success

Prioritization of indications with differential gene expression vs. normal tissues will emphasize focus on the tumor potential of αvβ8





Development of a NEW patient enrichment biomarker will assist in enriching for responses and addressing the right immune resistant patient population with CRB-601

Source(s): Corbus proprietary analysis: Log2 fold change of Nectin-4 expression as a ratio to normal tissue

Expected Milestones

IND cleared	January 2024
First patient dosed	Summer 2024
Dose escalation and confirmation	2nd Half of 2024