NeOnc Technologies Holdings, Inc.

Corporate Presentation

Clinical-stage CNS therapeutics. Intranasal delivery designed to bypass the blood–brain barrier, with two platforms — NEO100 and NEO212 — in clinical development for primary brain tumors and brain metastases.

NASDAQ: NTHI	**CNS oncology focus & delivery**	**179 patents (issued & pending)**	**4 clinical-stage programs**

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CLINICAL PIPELINE

Clinical development & pipeline

Important disclaimer: this development & clinical pipeline is subject to regulatory approval, risks and uncertainties, and potential changes beyond our control.

Drug Candidate	Application	Indication	Preclinical	IND Enabling*	Clinical Development: Phase I	Clinical Development: Phase II	Clinical Development: Phase III	Commercialization
NEO100-01	**Intranasal NEO100**	Recurrent Grade III or IV Astrocytoma Brain Tumor w/ IDH1 Mutation	**Phase 2a (Completed)**					
NEO100-02	**Intranasal NEO100**	Meningioma Brain Tumors	**Phase 2**					
NEO100-03	**Intranasal NEO100**	Pediatric Brain Tumors	**Phase 1**					
NEO212	**Oral NEO212**	All Brain Tumors	**Phase 2**					

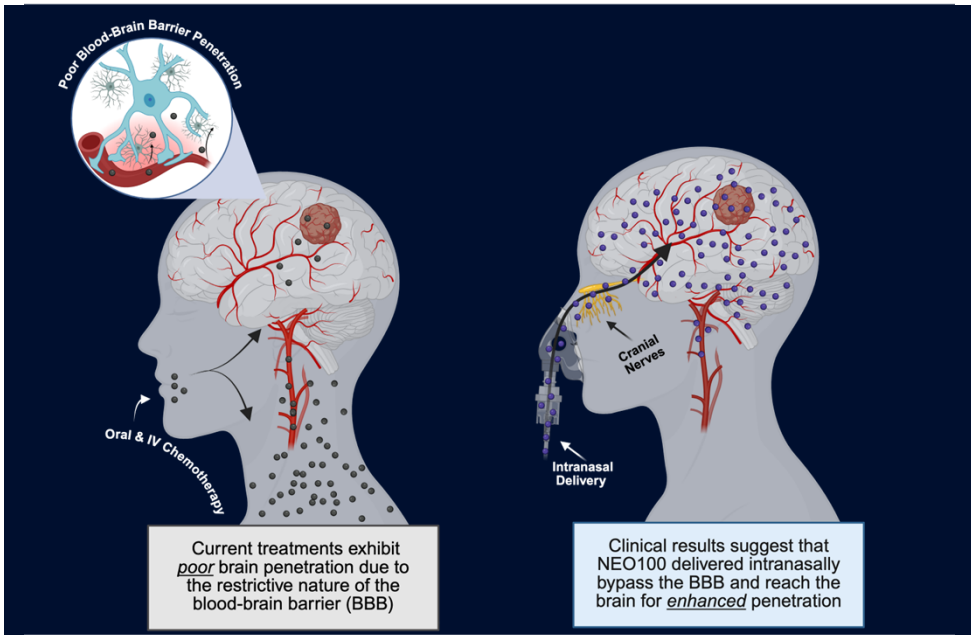
Our clinical pipeline continues to expand to include other applications of NEO100 & NEO212

NEO100 and NEO212 are investigational product candidates; neither has been approved by the FDA or any other regulatory authority and their safety and efficacy have not been established. ***IND Enabling:** research to establish whether a compound is reasonably safe for initial use in humans and exhibits pharmacological activity that justifies commercial development. Pipeline subject to regulatory approval and change.

PLATFORM

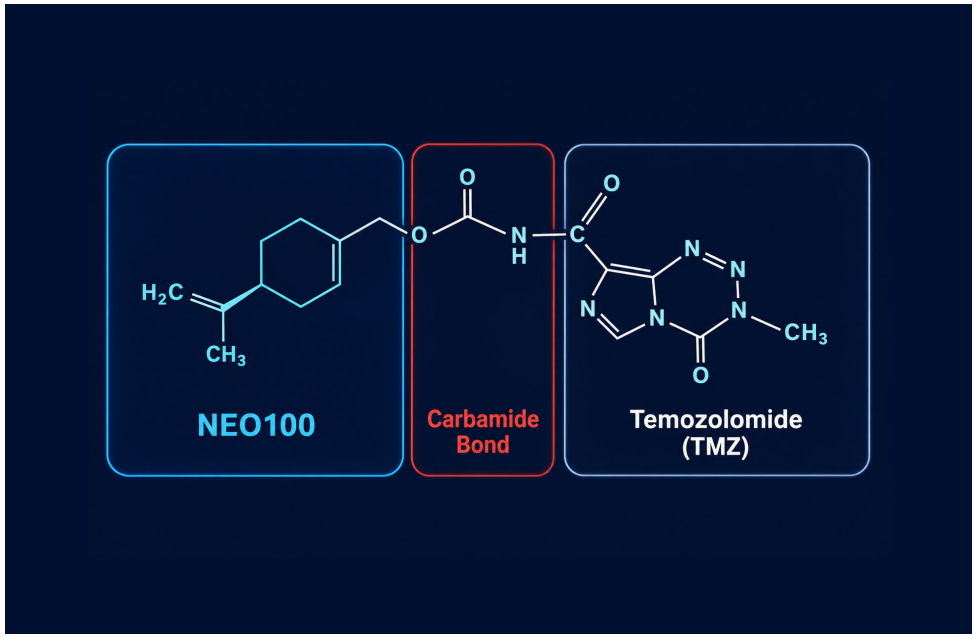
Two platforms, one enabling technology: NEO100's BBB penetration powers both

NEO100 — Drug Delivery Platform (core technology)



- Designed as a direct, non-invasive CNS delivery patented technology
- Clinically practical, patient-friendly dosing suitable for chronic use
- Patented platform designed for efficient, brain-targeted pharmacokinetics

NEO212 — Drug Conjugation Platform (built on NEO100)



- Conjugates NEO100 to established cytotoxic agents
- Inherits NEO100's BBB-penetrating chemistry as the delivery mechanism
- Designed to overcome drug resistance & systemic toxicity

NEO100 is the enabling chemistry in both platforms — NEO212 conjugates temozolomide to NEO100.

PLATFORM 1 · INTRANASAL DELIVERY

NEO100 — ultra-pure perillyl alcohol, delivered nose-to-brain

NEONC TECHNOLOGIES HOLDINGS, INC.

NEO100

Phase 2a complete in recurrent IDH1-mutant grade III–IV glioma (NCT02704858) — self-administered intranasally, four times daily

48.9% — PFS-6 (RANO 2.0)	**26.09 mo —** median OS from recurrence	**5 of 24 —** remained on treatment at data cut

Primary endpoint met: PFS-6 was 48.9% versus the protocol benchmark of ≤20% (one-sided p = 0.0047) in a single-arm study of 24 patients with no concurrent control.

Secondary endpoint met: Median overall survival was 26.1 months measured from the start of NEO100 at recurrence — a setting in which current salvage therapy delivers roughly 6–9 months.

Sources: NEO100 is an investigational product candidate. It has not been approved by the FDA or any other regulatory authority, and its safety and efficacy have not been established. NEO100-01 (NCT02704858) Phase 2a in recurrent/progressive IDH1-mutant grade III–IV glioma; ITT N = 24; statistical output, data updated November 2026 (database not locked). PFS-6 (RANO 2.0) 48.9% (95% CI 26.3, 68.1), one-sided p = 0.0047 versus the protocol $H_0 \leq 20\%$ (§11.3). Median OS 26.09 months (95% CI 8.54, 27.10) measured from the start of NEO100 at recurrence. RANO 2.0 disease control 66.7% (PR 3/24, SD 13/24) — Wen et al., J Clin Oncol 2023. Recurrence benchmark OS ~6–9 months — Wick, NEJM 2017; Lombardi, Lancet Oncol 2019; Fazzari, Crit Rev Oncol Hematol 2022. Single-arm study without a concurrent control; all cross-study comparisons are non-randomised and not head-to-head.

THE STARTING LINE MATTERS · U.S. BURDEN

IDH1-mutant survival is quoted from diagnosis — in years

IDH1-mutant grade 3–4 astrocytomas are the “long-survivor” subset of glioma — **but that survival is measured from initial diagnosis, and the treated U.S. population is large and growing.**

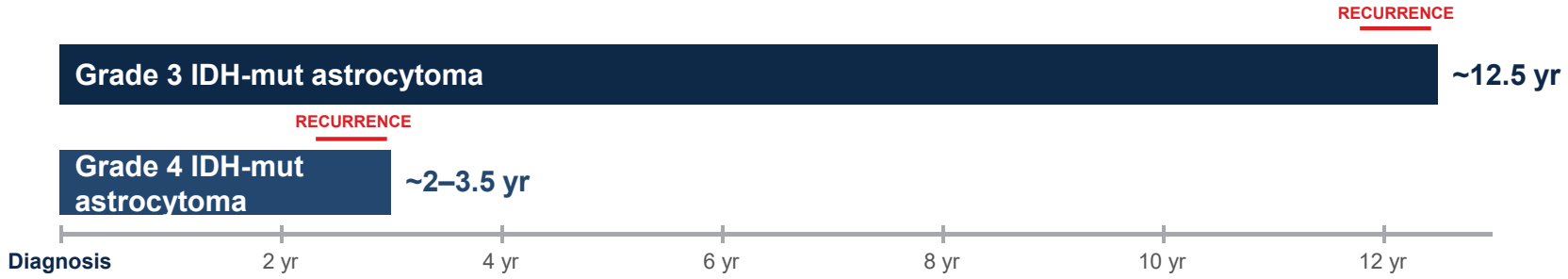
26,480 / yr
Malignant primary brain & CNS tumors diagnosed in the U.S.
(CBTRUS, 2025 est.)

~2,400 / yr
new IDH-mutant gliomas in the U.S

~7,000–11,000
estimated **U.S. patients living** with grade 3-4 IDH1-mutant glioma (long-survivor subset)

~100% recur
Essentially all relapse — recurrent grade 3–4 IDH1-mut / yr (NEO100 target)

Median overall survival FROM INITIAL DIAGNOSIS (years)



The trap: these are from-diagnosis figures — quoted as if they apply at recurrence, where the reality is completely different.

Sources: NEO100 is an investigational product candidate; it has not been approved by the FDA or any other regulatory authority and its safety and efficacy have not been established. U.S. incidence — CBTRUS Statistical Report: Primary Brain and Other CNS Tumors Diagnosed in the U.S. in 2018–2022 (Neuro-Oncology 2025;27(Suppl 4):iv1): an estimated 107,100 new primary brain/CNS tumors and 26,480 malignant tumors in the U.S. in 2025 (glioblastoma 13,930). IDH-mutant gliomas — molecular incidence, U.S. 2018–2021 (Neuro-Oncology 2025;27(Suppl 5):v191, EPID-25): IDH-mutant astrocytoma 0.36 and IDH-mutant/1p19q-codeleted oligodendroglioma 0.32 per 100,000/yr; U.S. population ~335M → ~2,300–2,600 new IDH-mutant gliomas/yr. Grade 3–4 share: >40% of grade 2–3 and ~2% of grade 4 astrocytomas are IDH-mutant → ~800–1,000 new grade 3–4 IDH-mutant/yr (Front Mol Neurosci 2025, doi:10.3389/fnmol.2025.1662414). Prevalence modelled as incidence × mean survival by grade → ~20,000–30,000 living with IDH-mutant glioma overall, of whom ~7,000–11,000 are grade 3–4; modelled estimate — no registry reports prevalence by grade. From-diagnosis OS: grade 3 ~12.5 yr (CATNON); grade 4 ~2–3.5 yr (Biomedicines 2024;12:2256). IDH-mutant grade 3–4 gliomas are incurable → essentially all relapse. IDH1 ≈90% of IDH mutations.

THE CLOCK RESETS

At recurrence, prognosis collapses to 6–9 months — grade 3 and 4

High-grade gliomas virtually always recur despite maximal therapy. Once the tumor progresses after radiation and temozolomide, the survival clock no longer runs from diagnosis — it **restarts at recurrence.**

FROM DIAGNOSIS

Years

Surgery → radiation → temozolomide, then a long stable interval. This is the survival most literature reports.

AT RECURRENCE (post RT + TMZ)

6–9 months

Median OS in the salvage setting. Objective responses are uncommon; tumors become more aggressive and resistant to therapy; no approved systemic therapy has changed this for grade 3/4.

Same disease, different clock: the “years” belong to the newly-diagnosed patient; the recurrent patient has ~6–9 months. That is the population NEO100 is being investigated to treat.

Sources: NEO100 is an investigational product candidate; it has not been approved by the FDA or any other regulatory authority and its safety and efficacy have not been established. Recurrent high-grade glioma median OS ~6–9 mo — Wick et al., N Engl J Med 2017 (EORTC 26101; lomustine OS 8.6 mo); Lombardi et al., Lancet Oncol 2019 (REGOMA; lomustine 5.6 mo); Fazzari et al., Crit Rev Oncol Hematol 2022 (median OS 3–17.6 mo across 48 recurrent-glioma RCTs). Objective responses uncommon with salvage therapy — Fazzari et al. 2022. Dedicated recurrent IDH-mutant grade-4 OS data are limited; figures reflect the recurrent high-grade glioma salvage setting and are historical, not head-to-head comparisons.

THE PLATFORM

NEO100: ultra-pure perillyl alcohol, delivered nose-to-brain



Ultra-pure, patented POH

NEO100 is a pharmaceutical-grade form of perillyl alcohol (POH), a natural monoterpene from citrus and peppermint oils.

Proprietary synthesis

Manufactured via a patented crystalline intermediate designed to provide consistent, pharmaceutical-grade purity.

Non-invasive nose-to-brain

Intranasal delivery is designed to bypass the blood–brain barrier for rapid, selective CNS exposure — no infusion, no surgery.

Patient-friendly chronic dosing

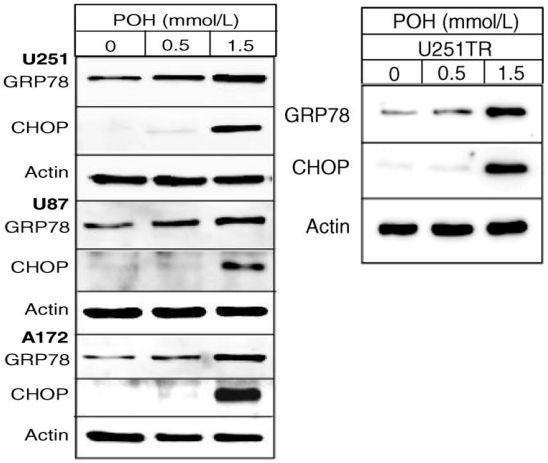
Self-administered at home, four times daily — practical for continuous treatment until progression.

Sources: NEO100 is an investigational product candidate; it has not been approved by the FDA or any other regulatory authority and its safety and efficacy have not been established. NEO100 composition, ultra-pure perillyl alcohol and proprietary crystalline manufacturing process — NeOnc Technologies (patented process; internal). Intranasal nose-to-brain delivery of perillyl alcohol — Schönthal AH et al., Neurooncol Adv 2021. The delivery figure is a schematic illustration, not clinical trial data.

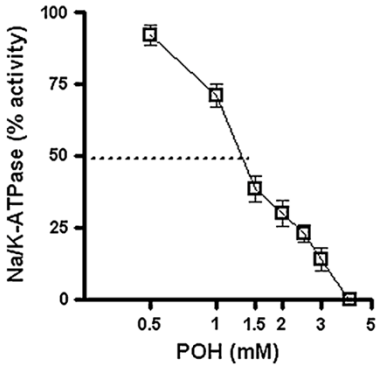
MECHANISM OF ACTION

NEO100's proposed mechanism of action in resistant tumors

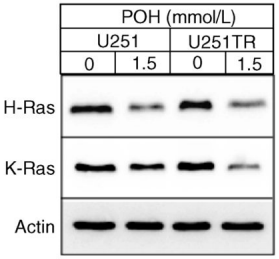
ER Stress Induction



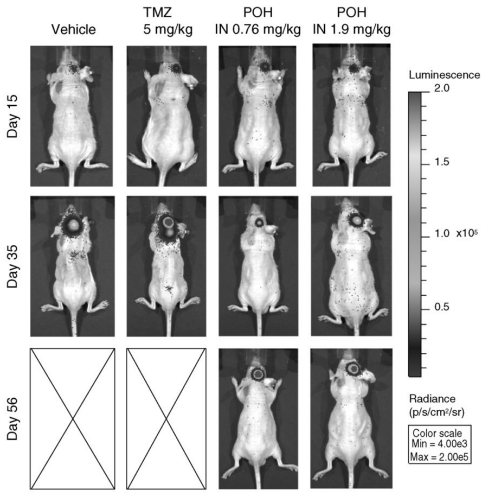
Na/K -ATPase Inhibition

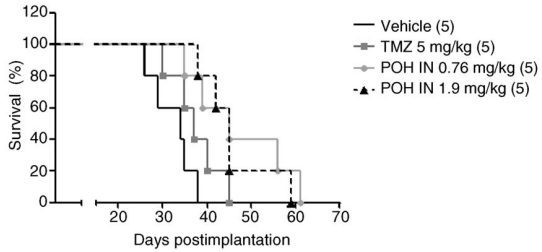


RAS Inhibition



In vivo



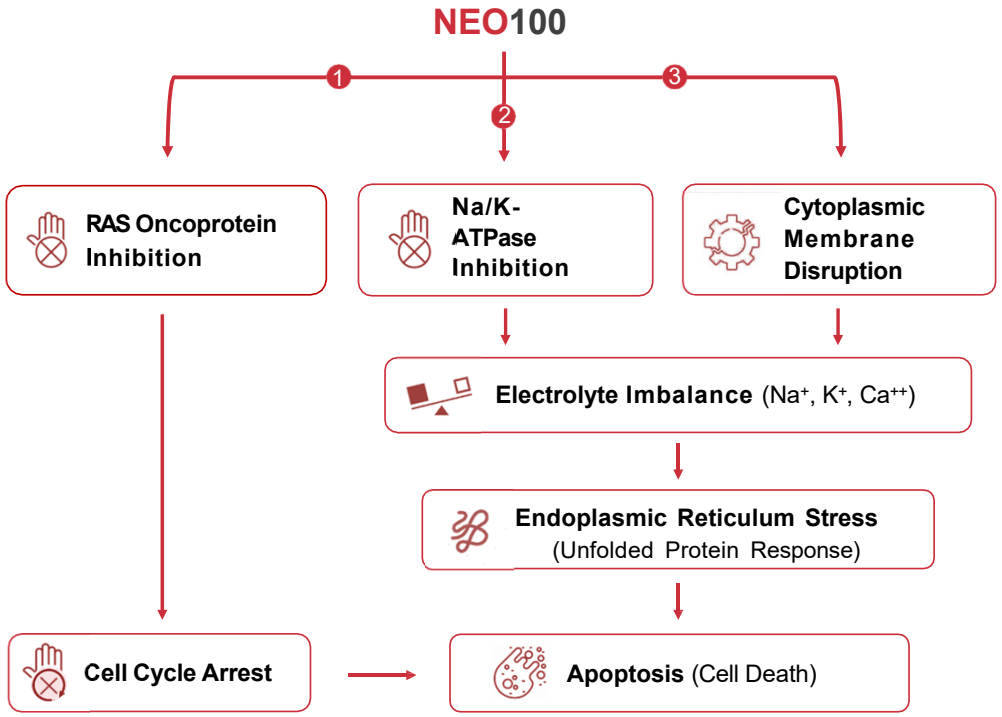


Sources: NEO100 is an investigational product candidate; it has not been approved by the FDA or any other regulatory authority and its safety and efficacy have not been established. Garcia DG et al., Mol Cell Biochem 2010; Cho HY et al., Mol Cancer Ther 2012; Marín-Ramos NI et al., Neurosurg Focus 2019; Wang W et al., Neuro-Oncology 2021; Schönthal AH et al., Neurooncol Adv 2021. Mechanistic data are preclinical (in vitro and animal models) and have not been confirmed in patients.

MECHANISM OF ACTION

NEO100's proposed mechanism of action in resistant tumors

In preclinical models, NEO100 is proposed to act on resistant glioma through three convergent mechanisms:



Second-line rationale: by inducing ER stress and inhibiting Na^+/K^+-ATPase while down-regulating RAS, NEO100 is designed to remain active in the TMZ-resistant setting where recurrent tumors progress.

Sources: NEO100 is an investigational product candidate; it has not been approved by the FDA or any other regulatory authority and its safety and efficacy have not been established. Garcia DG et al., Mol Cell Biochem 2010; Cho HY et al., Mol Cancer Ther 2012; Marín-Ramos NI et al., Neurosurg Focus 2019; Wang W et al., Neuro-Oncology 2021; Schönthal AH et al., Neurooncol Adv 2021. Mechanistic data are preclinical (in vitro and animal models) and have not been confirmed in patients; the mechanism shown is proposed, not established.

PHASE 1 — FOUNDATION

Intranasal NEO100 was well tolerated, with an early survival signal

NEONC TECHNOLOGIES HOLDINGS, INC.

1. Trial design

Multi-center U.S. study, n = 12; recurrent GBM after RT + temozolomide; continuous intranasal dosing 384–1,152 mg/day (4×/day) until progression.

2. Efficacy signal

PFS-6 ~30–33%, OS-12 ~55%, median OS ~15 months — vs a ~6–9-month historical benchmark (non-head-to-head).

3. Safety

Generally, well tolerated at the dose levels studied; no dose-limiting toxicities reported.

4. Durability & biomarker

IDH1-mutant long-term survivors were observed; non-invasive delivery enabled sustained dosing, supporting the durable-control hypothesis carried into Phase 2a.

Sources: NEO100 is an investigational product candidate; it has not been approved by the FDA or any other regulatory authority and its safety and efficacy have not been established. NEO100-01 Phase 1 dose-escalation, recurrent glioblastoma after radiation + temozolomide, n=12 — NeOnc Technologies (database not locked). Historical recurrent-GBM benchmark OS ~6–9 months — Schönthal AH et al., Neurooncol Adv 2021; the comparison is cross-trial and not head-to-head.

PHASE 2a — OBJECTIVES

What the study set out to show in recurrent disease

Why this population

Recurrent / progressive IDH1-mutant grade III–IV glioma is the setting of greatest unmet need.

At recurrence, survival collapses to ~6–9 months, objective responses are rare, and no approved therapy has been shown to durably extend survival.

The endpoints are built to detect durable disease control — the outcome that matters most for these patients.

Why a single-arm design

When NEO100-01 opened, single-arm was the standard approach in this setting: a peer-reviewed analysis of 417 U.S. primary brain tumor trials initiated 2005–2016 found that 90% of recurrent-disease Phase 2 trials were not designed as randomized controlled studies (Vanderbeek et al., Neuro-Oncology 2018).

Testing against a historical benchmark was the conventional signal-seeking path — and a randomized controlled trial is the appropriate next step to confirm these results.

PRIMARY OBJECTIVE & ENDPOINT

Progression-free survival at 6 months (PFS-6) — the percentage of patients progression-free from Cycle 1 Day 1 through 6 months.

What we tested against: a 20% PFS-6 benchmark — historically, only about 1 in 5 patients with recurrent high-grade glioma is still free of tumor growth six months after starting another therapy. NEO100 had to beat that bar to be worth pursuing.

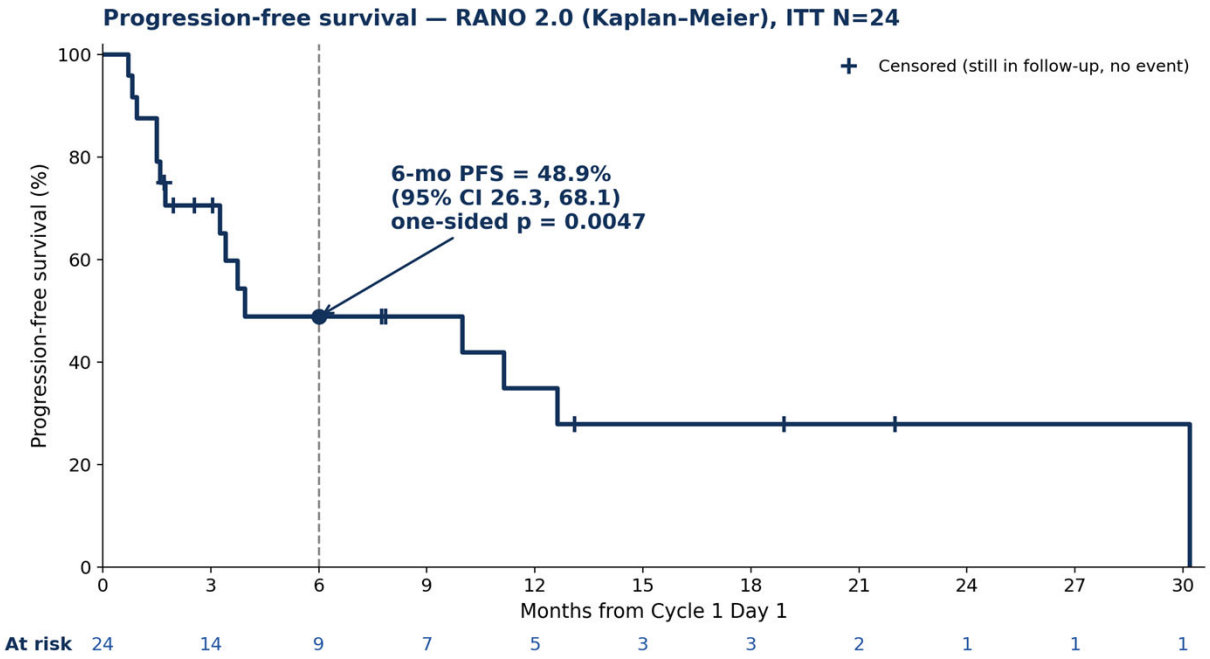
SECONDARY OBJECTIVES

- Overall survival (OS) and landmark OS rates
- Objective response & duration (RANO 2.0)
- Safety and tolerability

Sources: NEO100 is an investigational product candidate; it has not been approved by the FDA or any other regulatory authority and its safety and efficacy have not been established. NEO100-01 protocol §11.3 — primary endpoint PFS-6; $H_0 \leq 20\%$ vs $H_a \geq 45\%$, one-sided $\alpha = 0.05$, 80% power, planned enrolment 28. The 20% null reflects historical PFS-6 in recurrent high-grade glioma — Wong ET et al., J Clin Oncol 1999 (8 pooled phase II trials, n = 375: 15% in glioblastoma, 31% in anaplastic astrocytoma). Single-arm context — Vanderbeek AM et al., Neuro-Oncology 2018;20(8):1034–1043: of 417 U.S. glioblastoma trials initiated 2005–2016, 90% of recurrent-disease phase II trials were not designed as RCTs; the same analysis argues that uncontrolled phase II data has contributed to low phase III success, supporting a randomized confirmatory study. NEO100-01 (NCT02704858) was registered in 2016. Recurrence OS ~6–9 mo — Wick, NEJM 2017; Lombardi, Lancet Oncol 2019; Fazzari, Crit Rev Oncol Hematol 2022. RANO 2.0 — Wen et al., J Clin Oncol 2023.

PHASE 2a · PROGRESSION-FREE SURVIVAL AT 6 MONTHS

Primary objective met: PFS-6 of 48.9% vs the 20% benchmark



KM = Kaplan–Meier; Greenwood variance, complementary log–log 95% CI. ITT N=24; time from Cycle 1 Day 1. Grade III included with grade IV. + = censored. Confidence-interval band omitted for legibility; interval estimates are reported numerically above and in the accompanying slide.
Source: NEO100-01 statistical output, 08 Aug 2026 (database not locked). Median PFS 3.91 mo (95% CI 1.87, NR); p vs 20% SOC benchmark.

Key figures

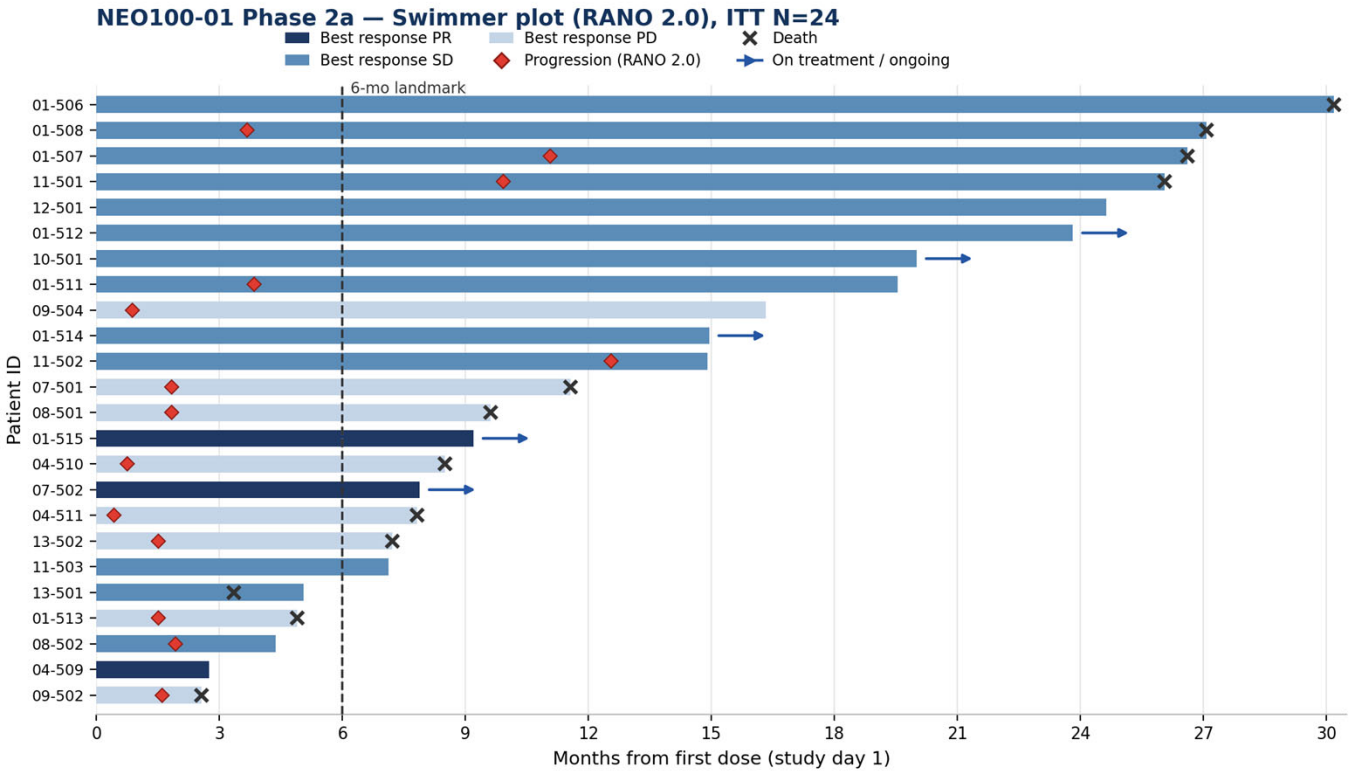
6-month PFS (KM)	48.9%
95% CI	26.3-68.1
vs 20% SOC (§11.3)	p = 0.0047 ✓ significant
Clock origin	Recurrence — NEO100 first dose (C1D1)

At recurrence: the entire PFS curve is measured from first dose at recurrence (study day 1) — not from initial diagnosis.

Sources: NEO100 is an investigational product candidate; it has not been approved by the FDA or any other regulatory authority and its safety and efficacy have not been established. NEO100-01 statistical output, data updated November 2026. PFS-6 (RANO 2.0) 48.9% (95% CI 26.3, 68.1); one-sided p = 0.0047 vs the 20% standard-of-care benchmark (protocol §11.3); median PFS 3.91 mo (95% CI 1.87, not reached). Kaplan–Meier with Greenwood variance and complementary log–log 95% CI (interval estimates reported numerically; band omitted for legibility). RANO 2.0 — Wen et al., J Clin Oncol 2023.

PHASE 2a · TIME ON TREATMENT AT RECURRENCE

Swimmer plot — Durable tail past 20 months from recurrence (first dose)



Reading the plot

Each bar = time on study from first dose at recurrence for each patient, colored by RANO 2.0 best response.

◆ = progression (RANO 2.0)

× = death → = still on treatment

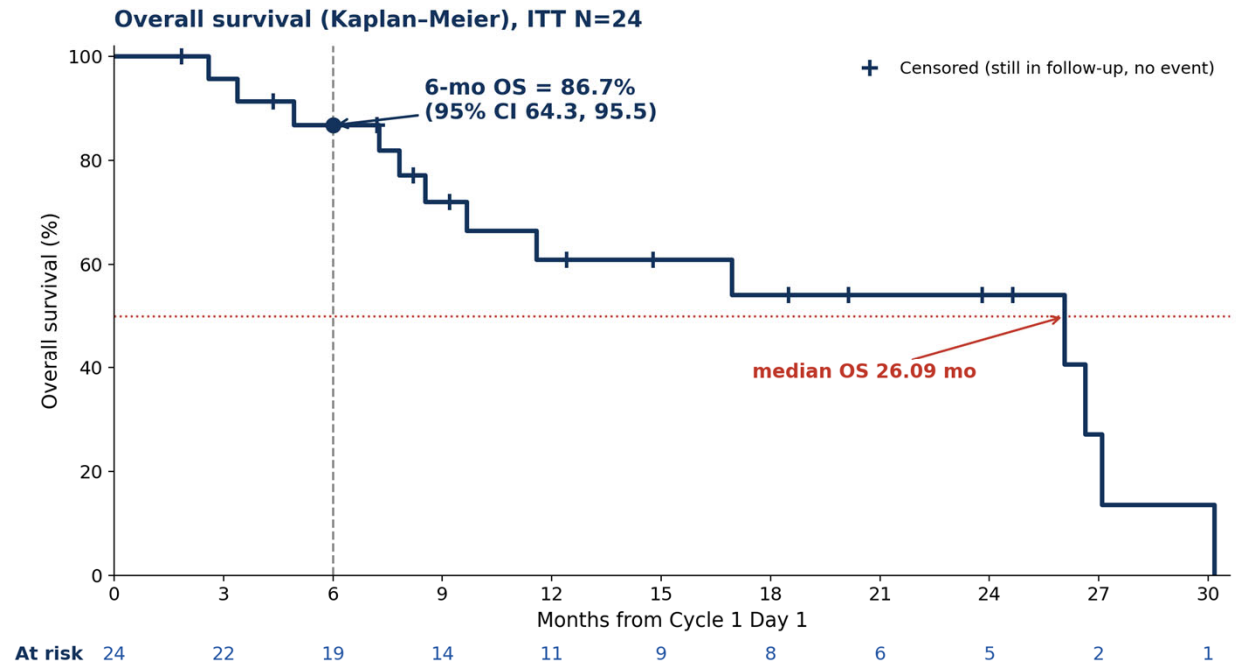
Durable tail past 20 months

5 patients remain on treatment, the two longest ongoing at ~24 and ~20 months; 10-501 progression-free at ~19 mo by RANO 2.0; 07-502 in an ongoing partial response sustained 114 days — all measured from first dose at recurrence.

Sources: NEO100 is an investigational product candidate; it has not been approved by the FDA or any other regulatory authority and its safety and efficacy have not been established. NEO100-01 RANO 2.0 summary table and statistical output, data updated November 2026. Bar = time from first dose (Cycle 1 Day 1) to last follow-up, coloured by RANO 2.0 best response; ◆ = RANO 2.0 progression, × = death, → = on treatment. RANO 2.0 best response PR 3/24 (12.5%), SD 13/24 (54.2%), PD 8/24 (33.3%); 5 patients remain on treatment. PFS-6 (RANO 2.0) 48.9% (95% CI 26.3, 68.1), one-sided p = 0.0047 vs the 20% benchmark (protocol §11.3). RANO 2.0 — Wen et al., J Clin Oncol 2023.

PHASE 2a · OVERALL SURVIVAL AT RECURRENCE

Median OS 26.09 months from recurrence — vs a 6–9-month benchmark



KM = Kaplan–Meier; Greenwood variance, complementary log–log 95% CI. ITT N=24; time from Cycle 1 Day 1. Grade III included with grade IV. + = censored. Confidence-interval band omitted for legibility; interval estimates are reported numerically above and in the accompanying slide.
Source: NEO100-01 statistical output, 08 Aug 2026 (database not locked). Median OS 26.09 mo (95% CI 8.54, 27.10).

Survival summary

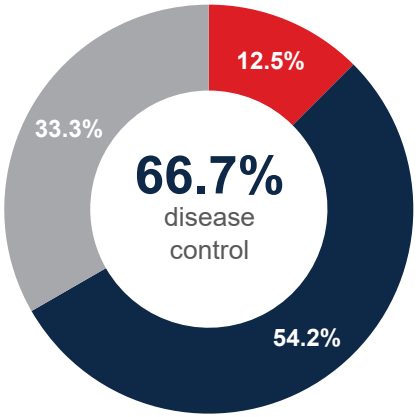
Deaths / N	12 / 24
Median OS (KM)	**26.09 months**
OS at 6 months	86.7% (64.3-95.5)
OS at 12 months	60.9% (36.4-78.4)
OS at 24 months	54.1% (29.5-73.4)
ORR (RANO 2.0)	12.5%
Clock origin	**Recurrence — NEO100 first dose (C1D1)**

At recurrence: the entire OS curve runs from first dose at recurrence (study day 1) — median 26.09 months here is not a from-diagnosis figure.

Sources: NEO100 is an investigational product candidate; it has not been approved by the FDA or any other regulatory authority and its safety and efficacy have not been established. NEO100-01 statistical output, data updated November 2026. OS-6 86.7% (95% CI 64.3, 95.5); OS-12 60.9% (95% CI 36.4, 78.4); OS-18 and OS-24 54.1% (95% CI 29.5, 73.4); median OS 26.09 mo (95% CI 8.54, 27.10). Kaplan–Meier with Greenwood variance and complementary log–log 95% CI (interval estimates reported numerically; band omitted for legibility). Times are measured from first dose (Cycle 1 Day 1) at recurrence, not from initial diagnosis.

RANO 2.0 RESPONSE & IMAGING

Disease control, with radiographic response



RANO 2.0 best response (N=24)

- **Partial Response** 3/24 · 12.5%
- **Stable Disease** 13/24 · 54.2%

66.7%

- **Progressive Disease** 8/24 · 33.3%

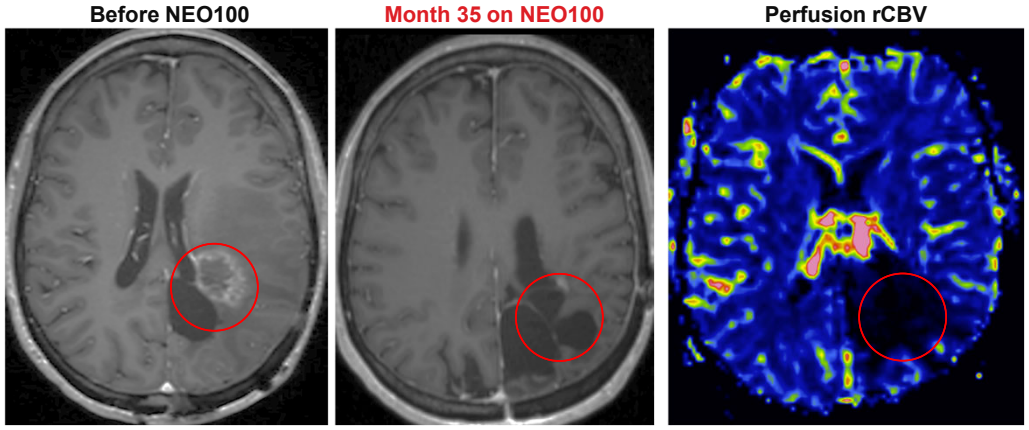
55%

long-term survivors
(16 / 29, Phase 1+2)
surviving > 1 year

2.2 yr

median OS among
long-term survivors
(range 1.2–8.1 yr)

Radiographic remission — representative long-term survivor



*Currently on Month 43

In a representative long-term survivor, perfusion rCBV decreased toward normal and the enhancing lesion largely resolved — findings a 2D “stable disease” label may understate.

Sources: NEO100 is an investigational product candidate; it has not been approved by the FDA or any other regulatory authority and its safety and efficacy have not been established. RANO 2.0 best response — NEO100-01 RANO 2.0 summary table and statistical output, data updated November 2026, Phase 2a ITT N=24 (PR 3/ SD 13 / PD 8; ORR 12.5%, disease control 66.7%). RANO 2.0 — Wen et al., J Clin Oncol 2023. Long-term survivors — 16/29 (Phase 1 + Phase 2a) alive >1 yr; median OS 2.2 yr (range 1.2–8.1 yr), NeOnc internal. Imaging — NEO100-01 representative responder (post-contrast T1 at baseline and month 35; perfusion rCBV map); rCBV is exploratory advanced imaging, distinct from RANO 2.0, and a single case does not establish a treatment effect.

THE DIFFERENTIATION

Recurrent grade 3–4 is an open failure — NEO100's target

Trial (agent)	Grade 3–4 studied?	Grade 3–4 result	Implication
INDIGO (vorasidenib)	No — grade 2 only	Not studied (mPFS 27.7 mo in grade 2)	Recurrent grade 3–4 unaddressed
STELLAR (eflornithine + lomustine)	Yes — IDH-mut & IDH-wt gr 4	No benefit in grade 4 (OS HR ~1.5); IDH-wt gr4 PFS 3.4 vs 6.8 mo	Grade 4 remains an open failure
Salvage chemo / anti-angiogenics	Recurrent HGG	Median OS ~6–9 mo; low ORR; PFS ≠ OS	No durable survival benefit
NEO100 — Phase 2a	**Yes — IDH-mut gr 3–4 (21/24 gr4)**	**Median OS 26.09 mo; OS-12 60.9%**	**Durable OS where others fail**

Bottom line: IDH-inhibitors stop at grade 2 and eflornithine fails in grade 4. In the Phase 2a study, NEO100 showed a 26.1-month median OS at recurrence in the grade 3–4 population; comparisons with other programs are cross-trial and not head-to-head.

Sources: NEO100 is an investigational product candidate; it has not been approved by the FDA or any other regulatory authority and its safety and efficacy have not been established. INDIGO — Mellinghoff et al., N Engl J Med 2023 (grade 2). STELLAR — Colman et al., J Clin Oncol 2025 (IDH-mutant & IDH-wildtype grade 4; no grade-4 benefit; IDH-wt grade 4 PFS 3.4 vs 6.8 mo). Salvage therapy — Wick, NEJM 2017; Lombardi, Lancet Oncol 2019; Fazzari, Crit Rev Oncol Hematol 2022. NEO100 — NEO100-01 Phase 2a statistical output, data updated November 2026 (ITT N=24; median OS 26.09 mo; OS-12 60.9%). All cross-study comparisons are non-randomised and not head-to-head; differences in population, era and response criteria limit interpretation.

CONCLUSIONS

Phase 2a: primary endpoint met— survival is the standout signal

48.9%

PFS-6 (RANO 2.0, KM)

primary endpoint MET vs H_0 ≤20% · p=0.0047

26.09 mo

median overall survival after recurrence

vs 6-9 months current salvage benchmark

60.9%

alive at 12 months

OS-12 (95% CI 36.4–78.4)

Durable disease control: 66.7% disease control (PR+SD); durable tail past 20 months; 5 of 24 still on treatment.

Generally well tolerated: adverse events were predominantly low-grade in this cohort; no dose-limiting toxicities reported.

Differentiated at recurrence: ~3–4× longer than the ~6–9-month historical salvage benchmark (cross-trial, non-head-to-head), in a grade 3–4 population addressed by few other programs.

Sources: NEO100 is an investigational product candidate; it has not been approved by the FDA or any other regulatory authority and its safety and efficacy have not been established. NEO100-01 Phase 2a, recurrent/progressive IDH1-mutant grade III–IV glioma, ITT N=24; statistical output, data updated November 2026. Kaplan–Meier with Greenwood variance and complementary log–log 95% CI. PFS-6 (RANO 2.0) 48.9% (95% CI 26.3, 68.1) vs protocol H_0 ≤ 20% (§11.3), one-sided p = 0.0047. Median OS 26.09 mo (95% CI 8.54, 27.10); OS-12 60.9% (95% CI 36.4, 78.4); RANO 2.0 disease control 66.7% (PR 3/24, SD 13/24). Historical salvage benchmark OS ~6–9 mo — Wick, NEJM 2017; Lombardi, Lancet Oncol 2019; Fazzari 2022 (cross-trial, non-head-to-head). RANO 2.0 — Wen, JCO 2023.

NEXT STEPS

Proposed registrational Phase 3 intended to seek Accelerated Approval (subject to FDA)

The regulatory goal

Accelerated Approval → traditional registrational approval, in one pivotal trial.

Per FDA's Dec 2024 guidance, a single adequate & well-controlled trial can support Accelerated Approval on an interim intermediate endpoint and verify benefit via final OS in the same study.

Phase 2a (26.09-mo median OS vs a 6–9-mo historical benchmark; cross-trial) supports the End-of-Phase-2 / Type B meeting request. Outcomes are subject to FDA review; no assurance of approval.

Proposed Phase 3 design

- **Randomized, NEO100 vs lomustine**
- Population: recurrent IDH1-mutant WHO grade 3/4 astrocytoma
- Primary endpoint: overall survival (OS)
- One pre-specified interim analysis supporting Accelerated Approval

1. **EOP2 / Type B FDA meeting**
2. **Align on single-trial AA design**
3. **Launch Phase 3 NEO100-301**
4. **Interim analysis → Accelerated Approval**
5. **Final OS → registrational**

Sources: Proposed design — NEO100-301 (subject to FDA feedback; no assurance any application will be submitted or approved). FDA Accelerated Approval guidance — Expedited Programs for Serious Conditions: Accelerated Approval of Drugs and Biologics (FDA, Dec 2024); Consolidated Appropriations Act, 2023. Phase 2a — NEO100-01 statistical output, data updated November 2026 (database not locked). Lomustine control OS 5.6–8.6 mo — Lombardi, Lancet Oncol 2019; Wick, NEJM 2017.

PLATFORM 2 · DRUG CONJUGATION

NEO212 — built on NEO100, aimed at TMZ resistance

NEO212

Brain-optimized temozolomide bioconjugate designed to enhance brain tumor targeting

Phase 1 — dose escalation complete	**MGMT —** degraded in preclinical models	**~3× —** brain:serum ratio vs TMZ, preclinical

The gap NEO212 targets: temozolomide's benefit is capped by recurrence, MGMT-driven resistance and marrow suppression. NEO212 is designed to address all three.

Sources: NEO212 is an investigational product candidate. It has not been approved by the FDA or any other regulatory authority, and its safety and efficacy have not been established. Chen TC et al., Cancer Lett 2015;358(2):144–151. Cho HY et al., Neurooncol Adv 2020;2(1):vdaa160. Cho HY et al., Mol Cancer Ther 2014;13(8):2004–17. NEO212 Phase 1 dose-escalation study in astrocytoma IDH-mutant, glioblastoma IDH-wildtype or brain metastasis (170–810 mg QD, Days 1–5 of each 28-day cycle; N=14 across 5 cohorts) — NeOnc Technologies data on file, November 2026. Program status as of November 2026.

THE TMZ CEILING

Temozolomide validated the market — and defined its own limits

RECURRENCE

~70–80%

of patients progress within 12 months of frontline TMZ; median frontline PFS ~6–7 months

TMZ RESISTANCE

~6–9 mo

median survival after recurrence — salvage therapies give variable, non-durable benefit

MGMT

~35–45%

are MGMT-methylated; the unmethylated majority derives reduced benefit, yet TMZ is used regardless of status

MARROW SUPPRESSION

Dose-limiting

systemic AIC exposure drives myelosuppression, cutting dose intensity and duration

2nd-line recurrent brain tumor benchmarks

Therapy	Median OS (mo)	OS-12 (%)	Key Trial Context
CCNU (lomustine) alone	5.6–8.6	~20–35%	REGOMA (~20%); EORTC 26101 (~30–35%)
Bevacizumab (Avastin) alone	~9.2	~38–43%	BRAIN Trial
CCNU + Bevacizumab*	~9.1	~35–40%	EORTC 26101
TTFields alone	~6.6	~20–25%	EF-11

Bottom line: TMZ proved the commercial demand in GBM (~$3–4B peak sales) but recurrence, MGMT-driven resistance and marrow suppression cap what it can deliver — the four limits NEO212 is designed to address.

Sources: NEO212 is an investigational product candidate; it has not been approved by the FDA or any other regulatory authority and its safety and efficacy have not been established. Frontline TMZ — Stupp R et al., N Engl J Med 2005;352(10):987–996. MGMT methylation frequency and predictive value — Hegi ME et al., N Engl J Med 2005;352(10):997–1003. TMZ myelosuppression / AIC exposure — temozolomide prescribing information; Cho HY et al., Neurooncol Adv 2020;2(1):vdaa160. Recurrent-setting benchmarks: CCNU — REGOMA (Lombardi G et al., Lancet Oncol 2019) and EORTC 26101 (Wick W et al., N Engl J Med 2017); bevacizumab — BRAIN trial (Friedman HS et al., J Clin Oncol 2009;27(28):4733–4740); TTFields — EF-11 (Stupp R et al., Eur J Cancer 2012;48(14):2192–2202). Salvage-setting median OS ~6–9 mo — Wick 2017; Lombardi 2019; Fazzari FGT et al., Crit Rev Oncol Hematol 2022. Peak TMZ sales are third-party market estimates. All cross-study comparisons are non-randomised and not head-to-head; differences in population, era and assessment criteria limit interpretation.

THE MOLECULE

NEO212: brain-optimized temozolomide bioconjugate

Novel bioconjugate — NEO100 covalently linked to temozolomide in a single molecule.

Dual mechanism — complementary activity from NEO100 and TMZ in one agent.

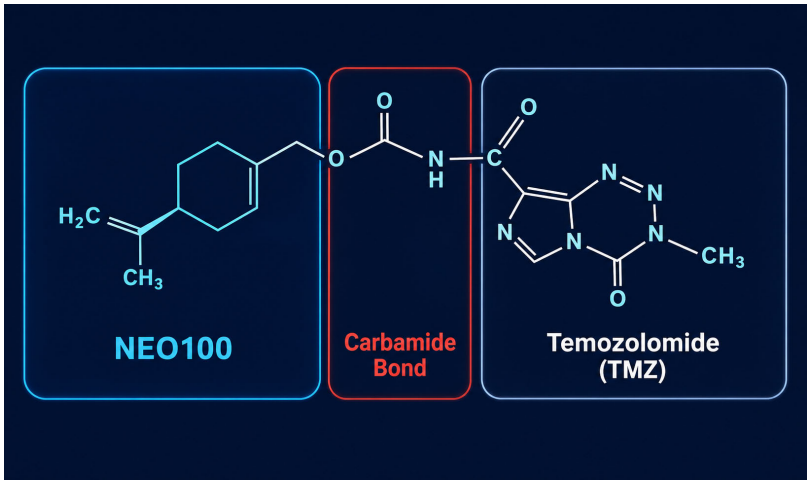
Built on the GBM standard — a TMZ backbone engineered for improved brain delivery and durability of response.

BBB penetration — designed to reach brain tumors more effectively than TMZ.

Optimized PK — bioconjugation intended to improve pharmacokinetics and CNS exposure.

Clinically ready — primary and secondary malignant brain cancers, including GBM and brain metastases; oral and intranasal routes under evaluation.

NEO212 bioconjugated molecule

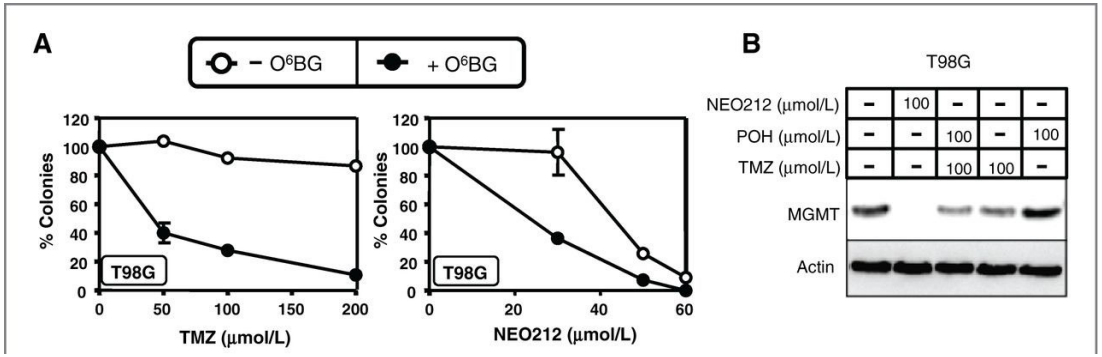


Sources: NEO212 is an investigational product candidate. It has not been approved by the FDA or any other regulatory authority, and its safety and efficacy have not been established. Chen TC et al., Cancer Lett 2015;358(2):144–151. Cho HY et al., Neurooncol Adv 2020;2(1):vdaa160. Cho HY et al., Mol Cancer Ther 2014;13(8):2004–17. NEO212 composition of matter and conjugation chemistry — NeOnc Technologies patent portfolio and data on file, November 2026. Oral and intranasal routes are planned; intranasal NEO212 has not been evaluated in a clinical study.

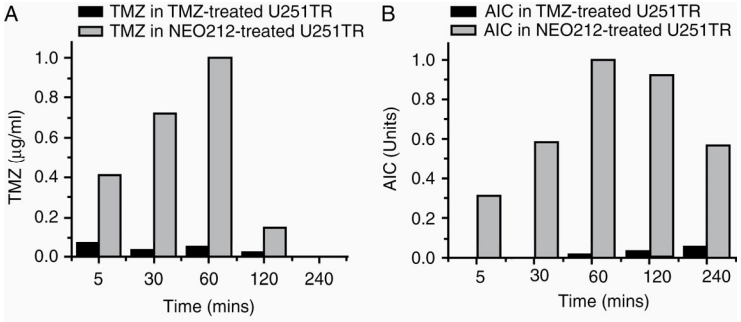
PRECLINICAL — RESISTANCE

Results suggest NEO212 degrades MGMT and overcomes TMZ resistance in GBM

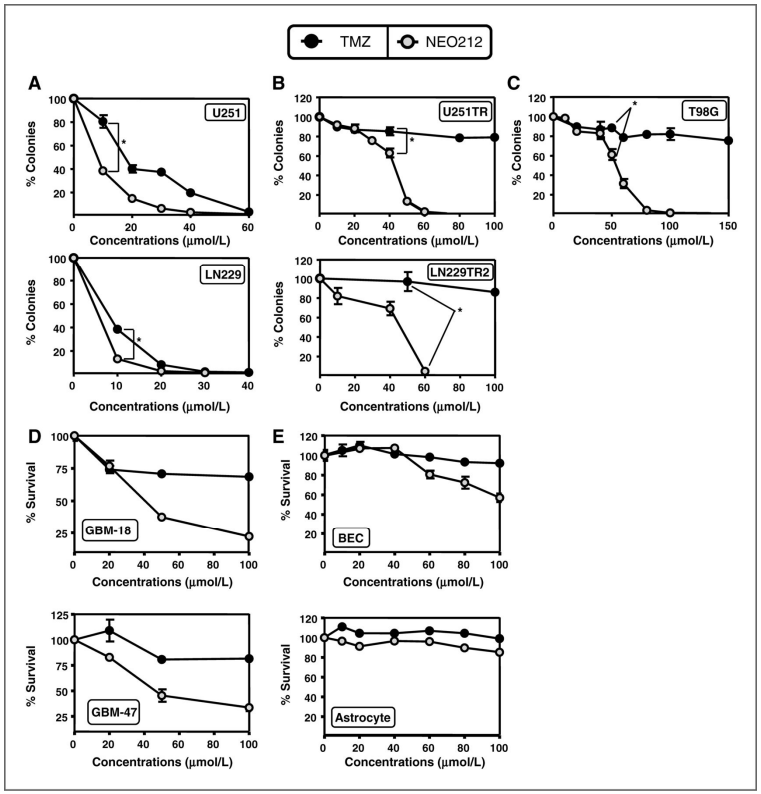
Clinical results suggest NEO212 degrades MGMT and kills TMZ-resistant GBM without O⁶BG



Clinical results suggest higher intratumoral TMZ/AIC exposure in TMZ-resistant GBM



Clinical results suggest NEO 212 may have greater cytotoxicity than TMZ in human GBM cell lines

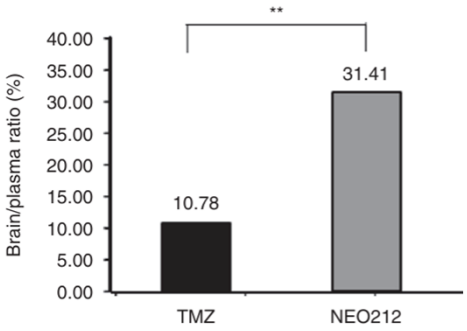


Sources: NEO212 is an investigational product candidate. It has not been approved by the FDA or any other regulatory authority, and its safety and efficacy have not been established. Chen TC et al., Cancer Lett 2015;358(2):144–151. Cho HY et al., Neurooncol Adv 2020;2(1):vdaa160. Cho HY et al., Mol Cancer Ther 2014;13(8):2004–17. Panels reproduced from the cited publications; preclinical (in vitro and xenograft) data — not predictive of clinical outcome.

PRECLINICAL — BRAIN DELIVERY

NEO212: results suggest enhanced brain delivery and antitumor activity in TMZ-resistant GBM

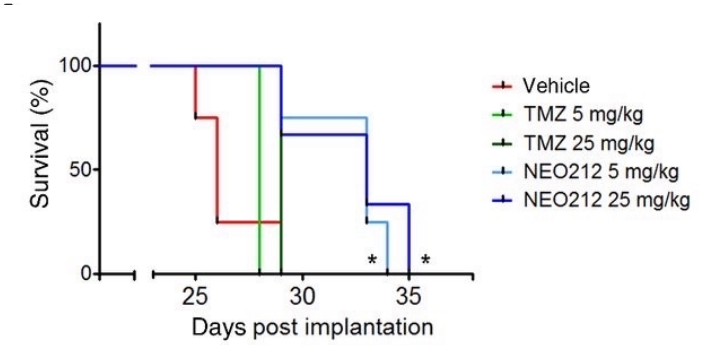
Clinical results suggest ≈3× higher brain-to-serum ratio vs temozolomide

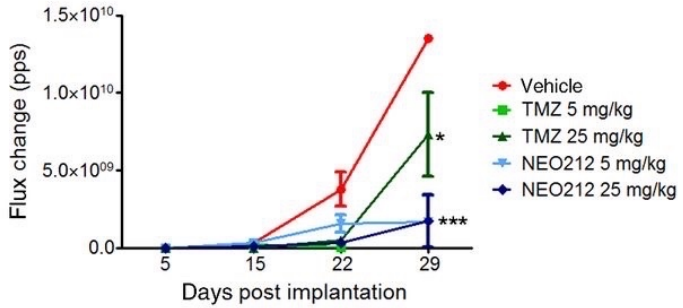


Observed in preclinical models

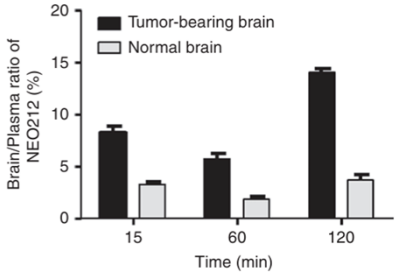
- ↑ BBB penetration
- ↑ Overall survival
- ↓ Tumor size

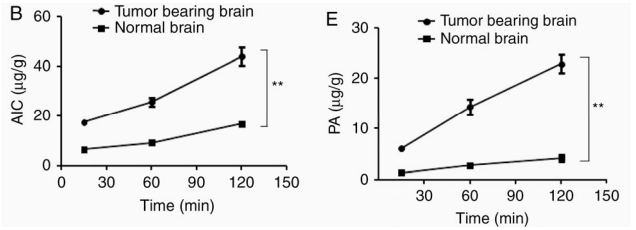
Clinical results suggest Intracranial xenograft — patient-derived USC-02 MGMT⁺ GBM





Clinical results suggest rising NEO212 and metabolite (PA, AIC) levels in tumor tissue t

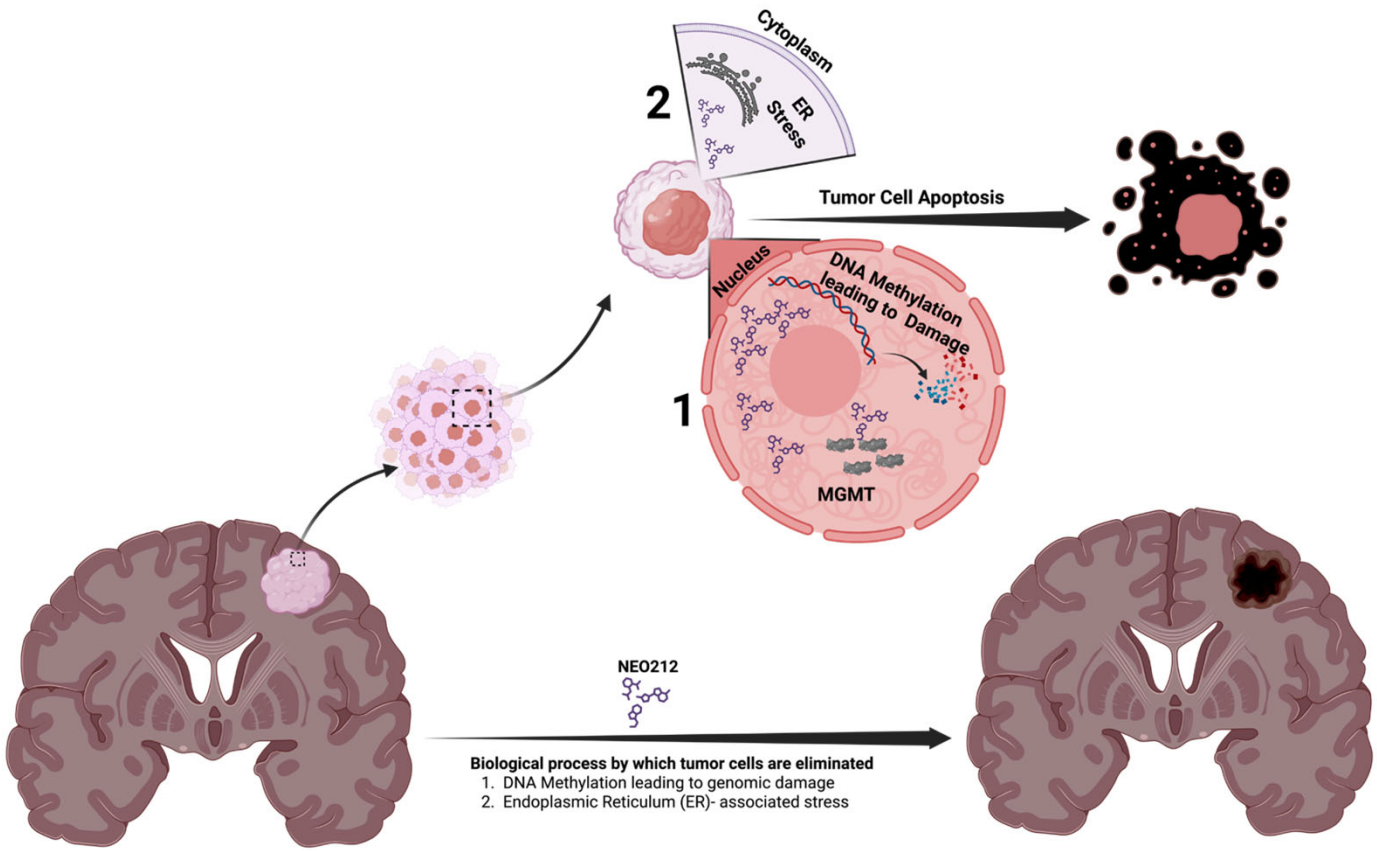




Sources: NEO212 is an investigational product candidate. It has not been approved by the FDA or any other regulatory authority, and its safety and efficacy have not been established. Chen TC et al., Cancer Lett 2015;358(2):144–151. Cho HY et al., Neurooncol Adv 2020;2(1):vdaa160. Cho HY et al., Mol Cancer Ther 2014;13(8):2004–17. Intracranial xenograft model: patient-derived USC-02 MGMT-positive GBM. Preclinical data — not predictive of clinical outcome.

MECHANISM OF ACTION

NEO212 proposed mechanism of action in resistant tumors



Sources: NEO212 is an investigational product candidate. It has not been approved by the FDA or any other regulatory authority, and its safety and efficacy have not been established. Chen TC et al., Cancer Lett 2015;358(2):144–151. Cho HY et al., Neurooncol Adv 2020;2(1):vdaa160. Cho HY et al., Mol Cancer Ther 2014;13(8):2004–17. Mechanism of action is proposed and based on preclinical models; it has not been confirmed in humans.

PROGRAM SNAPSHOT

NEO212: novel alkylating therapy in clinical development for brain tumors

NEONC TECHNOLOGIES HOLDINGS, INC.

Broad scope

Primary brain tumors and brain metastases, as monotherapy and in combination with SOC

Differentiation vs TMZ

Up to 10× greater activity than TMZ in preclinical models, including MGMT-positive (TMZ-resistant) tumors, via NEO212-mediated MGMT inactivation

Safety advantage

Lower systemic toxicity and myelosuppression than TMZ observed in preclinical models

Brain delivery

~3× higher BBB penetration (brain:serum ratio) than TMZ in preclinical models

Phase 1 (completed)

Dose escalation assessing safety, tolerability and preliminary activity in primary brain tumors and solid-tumor brain metastases

Strategic opportunity

Being developed with the intent to replace or augment TMZ across primary and metastatic brain cancer indications

Positioning: one molecule designed against the two failure modes that limit temozolomide — MGMT-driven resistance and marrow suppression. Comparative statements reflect preclinical models, not head-to-head clinical trials.

Sources: NEO212 is an investigational product candidate. It has not been approved by the FDA or any other regulatory authority, and its safety and efficacy have not been established. Chen TC et al., Cancer Lett 2015;358(2):144–151. Cho HY et al., Neurooncol Adv 2020;2(1):vdaa160. Cho HY et al., Mol Cancer Ther 2014;13(8):2004–17. NEO212 Phase 1 dose-escalation study in astrocytoma IDH-mutant, glioblastoma IDH-wildtype or brain metastasis (170–810 mg QD, Days 1–5 of each 28-day cycle; N=14 across 5 cohorts) — NeOnc Technologies data on file, November 2026. Comparative statements versus temozolomide derive from preclinical models and are not based on a head-to-head clinical trial.

PHASE 1 — DESIGN

Phase 1: safety and efficacy of NEO212 in astrocytoma IDH-mutant, glioblastoma IDH-wildtype or brain metastasis

NEONC TECHNOLOGIES HOLDINGS, INC.

Primary objectives (dose escalation)

- Safety and tolerability of increasing dose levels of oral NEO212 in astrocytoma IDH-mutant, glioblastoma IDH-wildtype or select solid tumors with uncontrolled brain metastases
- Identify the maximum tolerated dose (MTD)
- Determine the recommended Phase 2 dose (RP2D)

Secondary objectives

- Characterize the pharmacokinetics (PK) of NEO212
- Evaluate anti-tumor activity in astrocytoma IDH-mutant, glioblastoma IDH-wildtype and patients with select solid tumors with uncontrolled brain metastases

NEO212 Phase 1 — patient distribution by cohort

Subjects received NEO212 orally once daily on Days 1 through 5 of each 28-day treatment cycle. *[1]Equivocal = indeterminate MGMT methylation result.*

	Tumor Type	MGMT Status	Total Subjects
Cohort 1 (170mg/day)	Squamous NSCLC-to-Brain Metastasis	N=1, Not applicable	3
	GBM *IDH1*-wildtype	N=2 Methylated	
Cohort 2 (220mg/day)	GBM *IDH1*-wildtype	N=2 Methylated, N=1 Unmethylated	3
Cohort 3 (400mg/day)	Esthesioneuroblastoma-to-Brain Metastasis	N=1, Not applicable	3
	Breast-to-Brain Metastasis	N=1, Not applicable	
	GBM *IDH1*-wildtype	N=1, Methylated	
Cohort 4 (610mg/day)	GBM *IDH1*-wildtype	N=1 Equivocal1, N=1 Unmethylated, N=1 Methylated	3
Cohort 5 (810mg/day)	GBM *IDH1*-wildtype	N=2 Methylated	2

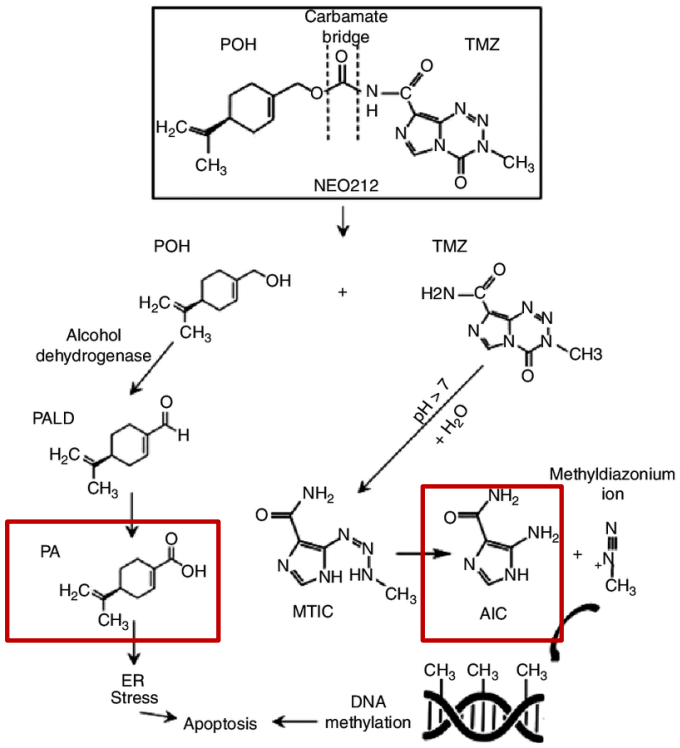
Sources: NEO212 is an investigational product candidate. It has not been approved by the FDA or any other regulatory authority, and its safety and efficacy have not been established. NEO212 Phase 1 dose-escalation study in astrocytoma IDH-mutant, glioblastoma IDH-wildtype or brain metastasis (170–810 mg QD, Days 1–5 of each 28-day cycle; N=14 across 5 cohorts) — NeOnc Technologies data on file, November 2026. Protocol-defined objectives, dose levels and cohort assignments per the Phase 1 study protocol; MGMT promoter methylation determined by the central laboratory. [1]Equivocal = indeterminate MGMT methylation result.

PHASE 1 — PHARMACOKINETICS

Low peripheral blood detection of NEO212 metabolites (AIC and PA)

NEO212 metabolic pathway

A



Plasma metabolite levels by cohort — Phase 1 PK samples

	Cohort 1 (170 mg/QD)	Cohort 2 (220 mg/QD)	Cohort 3 (400 mg/QD)	Cohort 4 (610 mg/QD)	Cohort 5 (810 mg/QD)
N (evaluable)	3	3	3	3	2
Mean Peak AIC (ng/mL)	1.94	2.52	12.19	16.8	3.25
AIC Range (ng/mL)	0– 49.6	0 – 47.0	0 – 117.0	0 – 120.0	0– 36.0
Mean Peak PA (ng/mL)	0.17	0.07	2.04	13.83	6.96
PA Range (ng/mL)	0-27.7	0-12.5	0-21.2	0– 80.2	0– 43.6

What this suggests

Reduced systemic metabolite exposure and potential enhanced tumor targeting — consistent with the preclinical observation of tumor uptake and intratumoral metabolism, and potentially associated with lower systemic toxicity compared with temozolomide.

Sources: NEO212 is an investigational product candidate. It has not been approved by the FDA or any other regulatory authority, and its safety and efficacy have not been established. NEO212 Phase 1 dose-escalation study in astrocytoma IDH-mutant, glioblastoma IDH-wildtype or brain metastasis (170–810 mg QD, Days 1–5 of each 28-day cycle; N=14 across 5 cohorts) — NeOnc Technologies data on file, November 2026. Plasma AIC and PA concentrations by validated LC-MS/MS; N evaluable per cohort as shown. Preclinical tumour-uptake and intratumoral-metabolism comparison — Cho HY et al., Neurooncol Adv 2020;2(1):vdaa160.

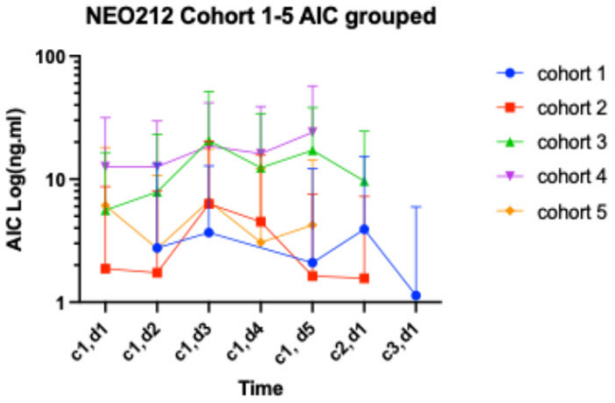
PHASE 1 — SYSTEMIC EXPOSURE

Clinical results suggest 39× lower AIC levels with NEO212 vs temozolomide

Adjusted for body weight, cliical results suggest NEO212 achieves higher CNS delivery vs TMZ

Brain-adjusted exposure NEO212 vs TMZ 200 mg/m² (Cycle 2+)						
NEO212 (mg/day)		NEO212 total over 5 days (mg)	NEO212 total 5-day dose (TMZ-equivalent, mg; conversion ratio = 0.521)	TMZ total over 5 days (mg)	Relative Exposure compared to TMZ	Brain-adjusted relative (3x BBB-permeable)
Cohort 1	170	850	443	1800	0.25	0.73
Cohort 2	220	1,100	573	1800	0.32	0.93
Cohort 3	400	2,000	1,042	1800	0.58	1.69
Cohort 4	610	3,050	1,589	1800	0.88	2.56
Cohort 5	810	4,050	2,110	1800	1.17	3.40

NEO212



	cohort 1	cohort 2	cohort 3	cohort 4	cohort 5
Cmax (ng/ml)	3.91	6.29	20.54	24.01	6.62
Mean (ng/ml)	1.94	2.52	12.19	16.78	3.25
Std. Deviation	1.62	2.13	5.71	4.76	2.64
Std. Error of Mea n	0.61	0.81	2.33	2.13	1.00
Lower 95% CI of mean	0.44	0.54	6.20	10.87	0.81
Upper 95% CI of mean	3.44	4.49	18.18	22.69	5.69

TMZ

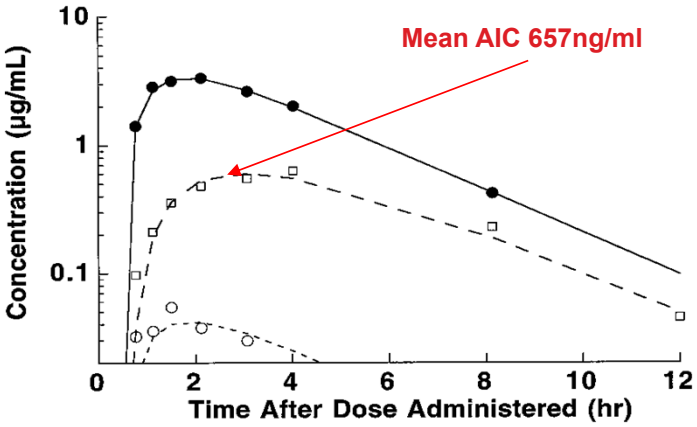
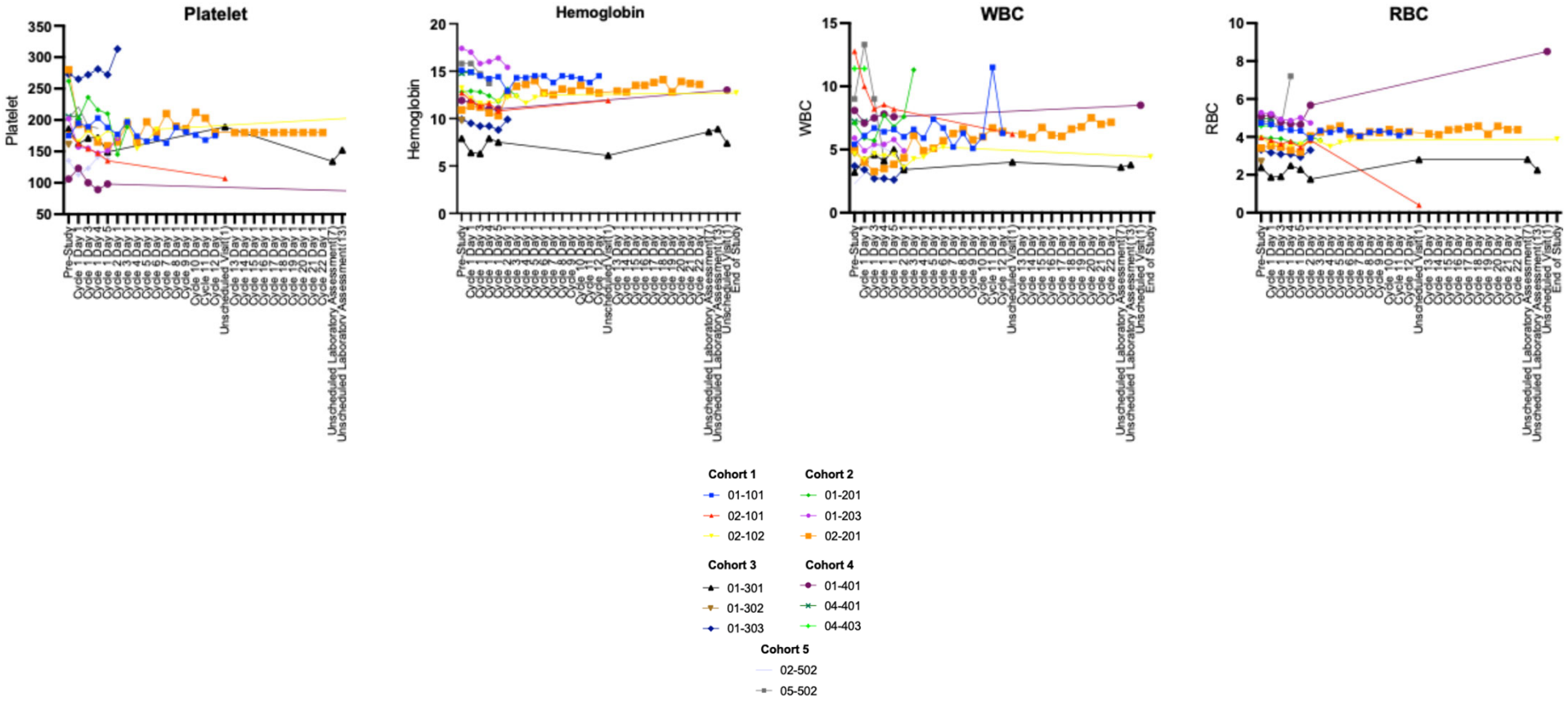


Fig. 4 Representative TMZ (F), MTIC (E), and AIC (□) concentra-tion-time profiles from a patient who received 200 mg of TMZ. *Solid* and *dashed lines*, best-fit curves from the model-estimated parameters.

Sources: NEO212 is an investigational product candidate. It has not been approved by the FDA or any other regulatory authority, and its safety and efficacy have not been established. NEO212 exposure and AIC concentrations — NEO212 Phase 1 dose-escalation study in astrocytoma IDH-mutant, glioblastoma IDH-wildtype or brain metastasis (170–810 mg QD, Days 1–5 of each 28-day cycle; N=14 across 5 cohorts) — NeOnc Technologies data on file, November 2026. Brain-adjusted exposure calculation assumes a TMZ-equivalent conversion ratio of 0.521 (molecular-weight basis) and a 3× brain:serum ratio observed preclinically (Chen TC et al., Cancer Lett 2015;358(2):144–151.). TMZ comparator profile: mean AIC 657 ng/mL after a single 200 mg/m² dose — Cho HY et al., Neurooncol Adv 2020;2(1):vdaa160. All cross-study comparisons are non-randomised and not head-to-head; differences in population, era and assessment criteria limit interpretation.

PHASE 1 — HAEMATOLOGY

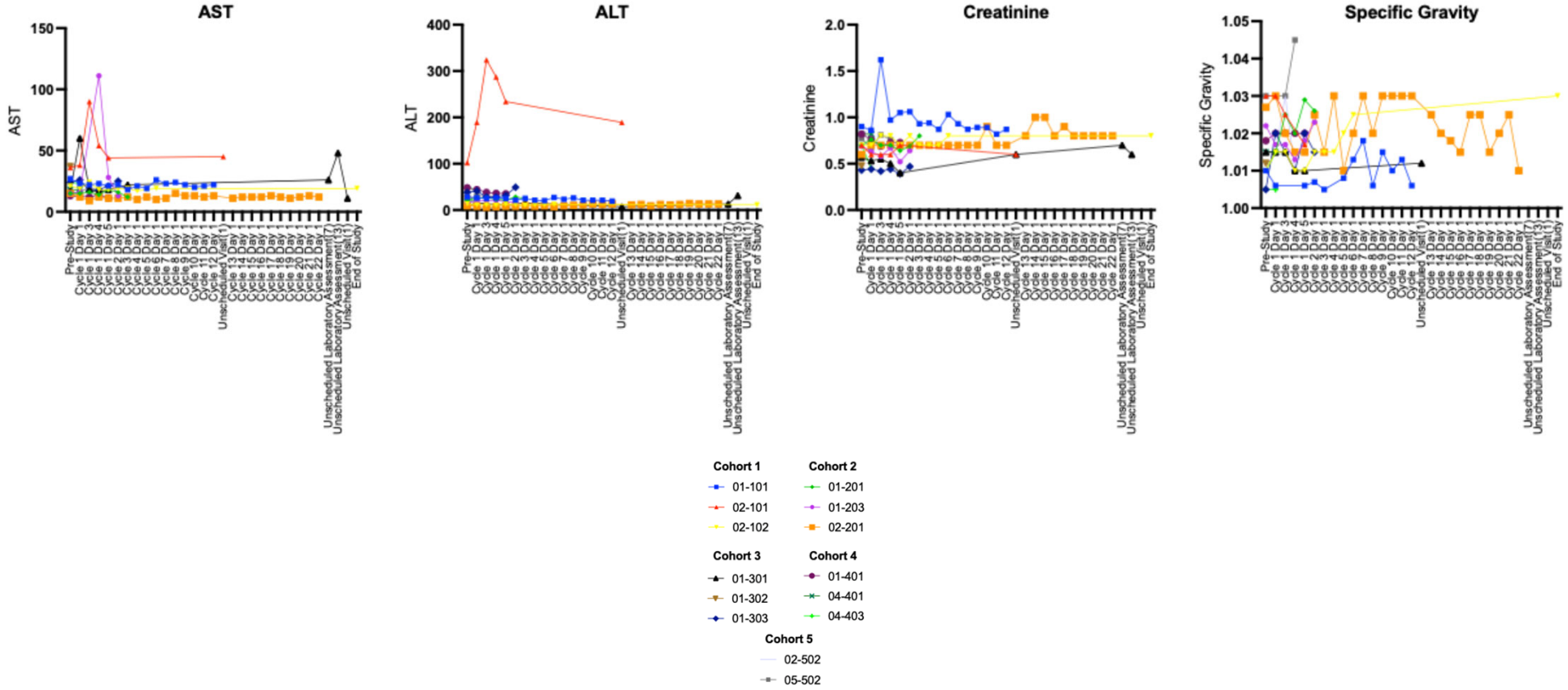
No clinically meaningful myelosuppression observed in Phase 1



Sources: NEO212 is an investigational product candidate. It has not been approved by the FDA or any other regulatory authority, and its safety and efficacy have not been established. NEO212 Phase 1 dose-escalation study in astrocytoma IDH-mutant, glioblastoma IDH-wildtype or brain metastasis (170–810 mg QD, Days 1–5 of each 28-day cycle; N=14 across 5 cohorts) — NeOnc Technologies data on file, November 2026. Haematology parameters (haemoglobin, platelets, absolute neutrophil count, white blood cell count) by scheduled and unscheduled laboratory assessment; each trace is one subject. No dose-limiting haematologic toxicity was reported through the MTD cohort.

PHASE 1 — HEPATIC & RENAL

No hepatic or renal/urinary toxicity signal observed in Phase 1



Sources: NEO212 is an investigational product candidate. It has not been approved by the FDA or any other regulatory authority, and its safety and efficacy have not been established. NEO212 Phase 1 dose-escalation study in astrocytoma IDH-mutant, glioblastoma IDH-wildtype or brain metastasis (170–810 mg QD, Days 1–5 of each 28-day cycle; N=14 across 5 cohorts) — NeOnc Technologies data on file, November 2026. Hepatic and renal/urinary laboratory parameters by scheduled and unscheduled assessment; each trace is one subject. No hepatic or renal toxicity signal was reported through the MTD cohort.

PHASE 1 — SAFETY

MTD cohort 5 (810 mg QD) — key learnings

Observed SAEs were consistent with complications commonly seen in advanced recurrent GBM and reported during temozolomide Phase 1 dose-escalation studies.

Brain-adjusted exposure NEO212 vs TMZ 200 mg/m² (Cycle 2+)						
NEO212 (mg/day)		NEO212 total over 5 days (mg)	NEO212 total 5-day dose (TMZ-equivalent, mg; conversion ratio = 0.521)	TMZ total over 5 days (mg)	Relative Exposure compared to TMZ	Brain-adjusted relative (3x BBB-permeable)
Cohort 1	170	850	443	1800	0.25	0.73
Cohort 2	220	1,100	573	1800	0.32	0.93
Cohort 3	400	2,000	1,042	1800	0.58	1.69
Cohort 4	610	3,050	1,589	1800	0.88	2.56
Cohort 5	810	4,050	2,110	1800	1.17	3.40

Across the Phase 1 dose-escalation experience (N = 14):

No signal of clinically meaningful myelosuppression

No hepatic or renal toxicity signal

Interpretation: these observations may differentiate NEO212's systemic profile from the hematologic suppression associated with temozolomide. Phase 1 was small, uncontrolled and not designed to establish comparative safety.

Sources: NEO212 is an investigational product candidate. It has not been approved by the FDA or any other regulatory authority, and its safety and efficacy have not been established. NEO212 Phase 1 dose-escalation study in astrocytoma IDH-mutant, glioblastoma IDH-wildtype or brain metastasis (170–810 mg QD, Days 1–5 of each 28-day cycle; N=14 across 5 cohorts) — NeOnc Technologies data on file, November 2026. Serious adverse events assessed by the investigator against the background rate in advanced recurrent GBM and in published temozolomide Phase 1 dose-escalation experience. Brain-adjusted exposure assumptions as on the preceding slide. All cross-study comparisons are non-randomised and not head-to-head; differences in population, era and assessment criteria limit interpretation.

Antitumor activity observed in Phase 1

Measurable antitumor activity was observed in the NEO212 Phase 1 study

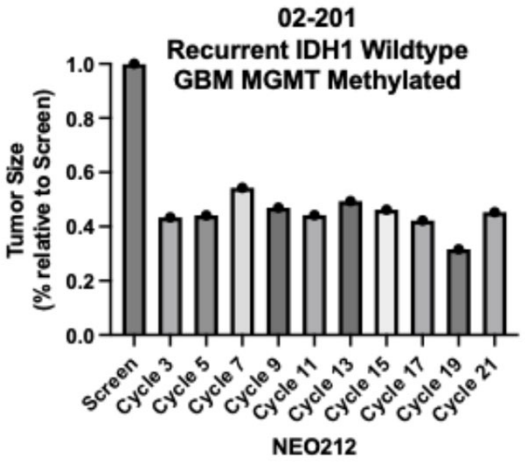
The two cases that follow are individual investigator-assessed responses from an open-label, uncontrolled dose-escalation study (N = 14).

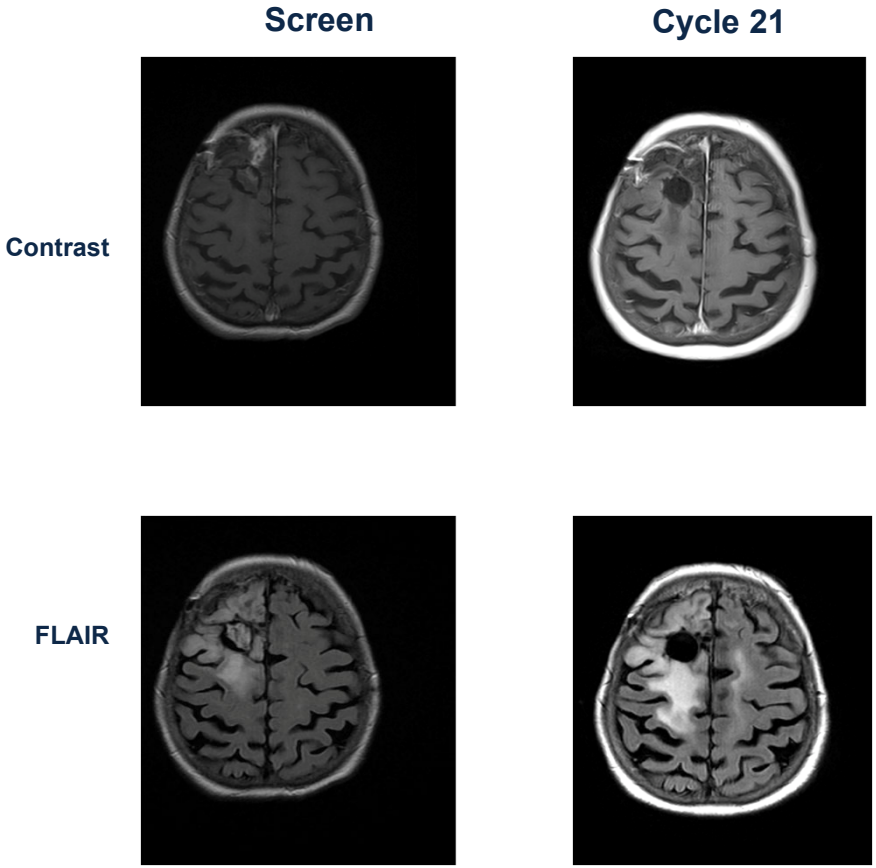
Sources: NEO212 is an investigational product candidate. It has not been approved by the FDA or any other regulatory authority, and its safety and efficacy have not been established. NEO212 Phase 1 dose-escalation study in astrocytoma IDH-mutant, glioblastoma IDH-wildtype or brain metastasis (170–810 mg QD, Days 1–5 of each 28-day cycle; N=14 across 5 cohorts) — NeOnc Technologies data on file, November 2026. Antitumour activity assessed by investigator review of serial MRI.

PHASE 1 — CASE 1

Partial response in recurrent IDH1 wild-type, MGMT-methylated GBM

Primary diagnosis: 8/25/2023
Prior therapy: XRT + TMZ (10/23–4/24)
Progressed on TMZ after 6 cycles
NEO212 C1D1: 6/10/2024
On Cycle 22 of NEO212





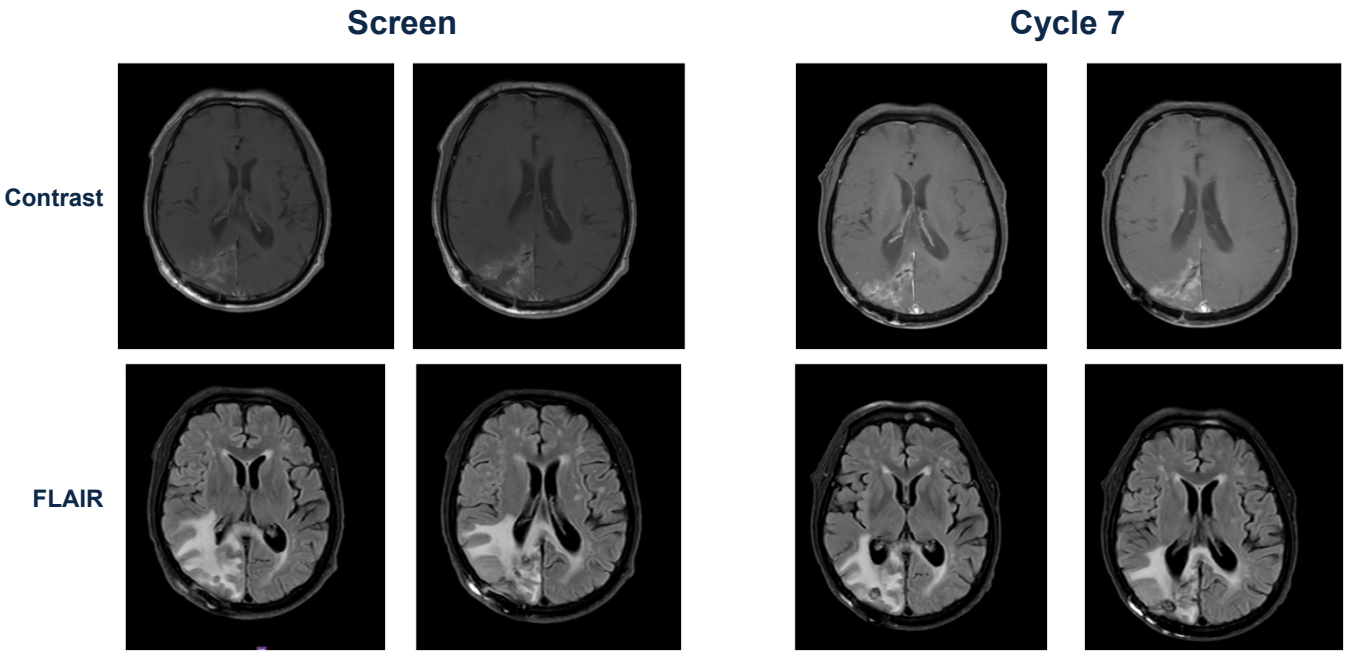
Sources: NEO212 is an investigational product candidate. It has not been approved by the FDA or any other regulatory authority, and its safety and efficacy have not been established. NEO212 Phase 1 dose-escalation study in astrocytoma IDH-mutant, glioblastoma IDH-wildtype or brain metastasis (170–810 mg QD, Days 1–5 of each 28-day cycle; N=14 across 5 cohorts) — NeOnc Technologies data on file, November 2026. Single-patient case: recurrent IDH1 wild-type, MGMT-methylated GBM; contrast-enhanced T1 and FLAIR MRI at screening and Cycle 21. Response assessed by investigator review. Individual case outcomes are anecdotal and may not be representative.

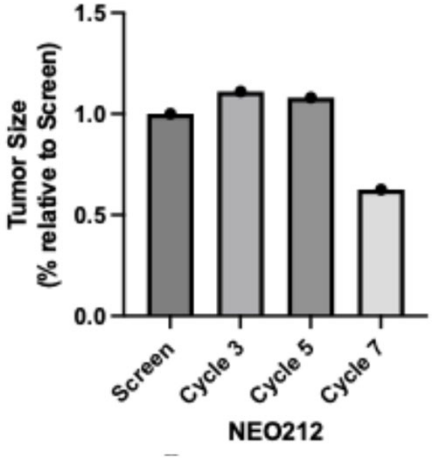
PHASE 1 — CASE 2

Lung-to-brain metastasis — 55 months since diagnosis, last 16 months on NEO212

Brain met diagnosis: squamous NSCLC (7/20/2021) **NEO212 C1D1:** 3/25/2024

Prior therapy: Taxol/carboplatin (7/2018); Keytruda, Alimta (5/2020) **On Cycle 16**





Sources: NEO212 is an investigational product candidate. It has not been approved by the FDA or any other regulatory authority, and its safety and efficacy have not been established. NEO212 Phase 1 dose-escalation study in astrocytoma IDH-mutant, glioblastoma IDH-wildtype or brain metastasis (170–810 mg QD, Days 1–5 of each 28-day cycle; N=14 across 5 cohorts) — NeOnc Technologies data on file, November 2026. Single-patient case: squamous NSCLC lung-to-brain metastasis; contrast-enhanced T1 and FLAIR MRI at screening and Cycle 7. Response assessed by investigator review. Individual case outcomes are anecdotal and may not be representative.

NEO212 — NEXT STEPS

Proposed next steps and Accelerated Approval strategy

Proposed advancement into two randomized Phase 2 clinical trials, subject to FDA feedback:

Trial 1 — recurrent GBM

Randomized evaluation of single-agent NEO212 versus standard-of-care therapy

Trial 2 — brain metastases

Randomized evaluation of NEO212 in combination with standard-of-care therapy versus standard-of-care therapy alone

>30%

of adult cancer patients develop brain metastases, with no durable systemic standard of care

~$3.0–4.0B

estimated primary GBM market opportunity)

~10×

estimated brain-metastasis opportunity relative to primary GBM (third-party estimate)

Sources: NEO212 is an investigational product candidate. It has not been approved by the FDA or any other regulatory authority, and its safety and efficacy have not been established. This slide contains 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; actual results may differ materially. See the forward-looking statements disclaimer in this presentation and the company's SEC filings for a discussion of risk factors. Proposed Phase 2 designs are subject to FDA feedback; no assurance an application will be submitted or approved. Accelerated Approval framework — FDA, Accelerated Approval of Drugs and Biologics (Dec 2024); FDORA 2023. Brain-metastasis incidence (>30% of adult cancer patients) — published epidemiology; see Ostrom QT et al., Neuro Oncol (CBTRUS statistical report). GBM TAM ~$3.0–4.0B and the ~10× brain-metastasis multiple are third-party market estimates, not company guidance. NEO212 Phase 1 dose-escalation study in astrocytoma IDH-mutant, glioblastoma IDH-wildtype or brain metastasis (170–810 mg QD, Days 1–5 of each 28-day cycle; N=14 across 5 cohorts) — NeOnc Technologies data on file, November 2026.

NEO212 — DEVELOPMENT STRATEGY

Phase 1 data informing a proposed Phase 2 strategy in TMZ-resistant GBM and brain metastases

1 Safety foundation established

- Systemic tolerability was favorable at the dose levels evaluated (N = 14, uncontrolled)

Why it matters
Temozolomide's dose ceiling is bone marrow suppression. NEO212 may enable sustained alkylator therapy without that hematologic limitation.

2 Early signals of activity in recurrent GBM

- Disease control observed in individual heavily pretreated patients
- Biological rationale supported by activity in TMZ-resistant, MGMT-high preclinical models
- Designed to enhance brain delivery while preserving cytotoxic potency

Why it matters
~70–80% of GBM patients progress within 12 months of TMZ. NEO212 is being evaluated for activity where TMZ fails.

3 Phase 2 targets the highest-value unmet segment

- Focus on MGMT-unmethylated and TMZ-refractory patients
- Includes patients who discontinued TMZ due to hematologic toxicity
- Randomized versus standard of care for a clean efficacy signal
- ORR primary endpoint intended to support Accelerated Approval

Why it matters
Phase 2 would test NEO212 in the population most underserved by current standard therapy — resistance-driven and toxicity-limited patients.

Sources: NEO212 is an investigational product candidate. It has not been approved by the FDA or any other regulatory authority, and its safety and efficacy have not been established. NEO212 Phase 1 dose-escalation study in astrocytoma IDH-mutant, glioblastoma IDH-wildtype or brain metastasis (170–810 mg QD, Days 1–5 of each 28-day cycle; N=14 across 5 cohorts) — NeOnc Technologies data on file, November 2026. Chen TC et al., Cancer Lett 2015;358(2):144–151. Cho HY et al., Neurooncol Adv 2020;2(1):vdaa160. Cho HY et al., Mol Cancer Ther 2014;13(8):2004–17. ~70–80% progression within 12 months of frontline TMZ — Stupp R et al., N Engl J Med 2005 and subsequent series. Phase 2 endpoint and population assumptions are proposed and subject to FDA feedback. All cross-study comparisons are non-randomised and not head-to-head; differences in population, era and assessment criteria limit interpretation.

WHY IT MATTERS

NEO100 and NEO212: impact and significance

NEO100 — intranasal ultra-pure perillyl alcohol

48.9%	26.09 mo	66.7%
PFS-6 (RANO 2.0)	median OS from recurrence	disease control

Primary endpoint met: PFS-6 of 48.9% versus the 20% protocol benchmark (one-sided p = 0.0047).

Survival at recurrence: median OS 26.09 months versus a 6–9-month historical salvage benchmark — cross-trial, not head-to-head.

Durable control, chronic dosing: 66.7% disease control; 5 of 24 remained on therapy; adverse events predominantly low-grade with no dose-limiting toxicities reported.

2 upcoming FDA Meetings: 1) December 3 2026 (CMC), 2) Jan 2027 (Phase 3 Accelerated Approval & Confirmatory)

NEO212 — temozolomide bioconjugate

~3×	39×	N = 14
brain:serum ratio, preclinical	lower AIC than TMZ	Phase 1 dose escalation

Designed against TMZ resistance: MGMT degraded in preclinical models, including TMZ-resistant GBM.

Systemic exposure profile: 39× lower AIC than temozolomide in Phase 1; no clinically meaningful myelosuppression observed in this small, uncontrolled cohort.

Proposed next step: two randomized Phase 2 trials in recurrent GBM and brain metastases, subject to FDA feedback.

FDA Meetings: 1) CMC Phase 2 (Met and Approved), 2) November 23, 2026 (Amended Phase 2 with interim analysis for potential AA)

Sources: NEO100 and NEO212 are investigational product candidates. Neither has been approved by the FDA or any other regulatory authority, and their safety and efficacy have not been established. NEO100 — NEO100-01 (NCT02704858) Phase 2a, recurrent/progressive IDH1-mutant grade III–IV glioma, ITT N = 24, statistical output, data updated November 2026 (database not locked); PFS-6 (RANO 2.0) 48.9% (95% CI 26.3, 68.1), one-sided p = 0.0047 vs protocol $H_0 \leq 20\%$ (§11.3); median OS 26.09 mo (95% CI 8.54, 27.10); RANO 2.0 disease control 66.7% (PR 3/24, SD 13/24) — Wen et al., J Clin Oncol 2023; single-arm, no concurrent control. NEO212 — Phase 1 dose escalation (170–810 mg QD, Days 1–5 of each 28-day cycle; N = 14 across 5 cohorts), NeOnc Technologies data on file, November 2026; preclinical MGMT and brain-delivery findings — Chen TC et al., Cancer Lett 2015;358(2):144–151; Cho HY et al., Neurooncol Adv 2020;2(1):vdaa160; Cho HY et al., Mol Cancer Ther 2014;13(8):2004–17. Recurrence benchmark OS ~6–9 months — Wick, NEJM 2017; Lombardi, Lancet Oncol 2019; Fazzari, Crit Rev Oncol Hematol 2022. All cross-study comparisons are non-randomised and not head-to-head. Planned Phase 2 and Phase 3 studies are subject to regulatory review; no assurance is given that any study will begin or that any application will be approved.

THE OPPORTUNITY

NeOnc's positioning in refractory neuro-oncology

Delivery approach

Non-invasive intranasal delivery for central nervous system disease, currently in clinical development

Intellectual property

Global portfolio of 179 patents issued and pending

Near-term milestones

Q4 2026 Commence Phase 1 NEO100-03 in pediatric pHGG (n=6)

Q1 2027 Implement NEO100-01 (Phase 3) and NEO212 (Phase 2)

Global expansion

Sub-licensing platform established for the GCC/MENA region

Approved IND (NEO100 and NEO212) in UAE

Therapeutic focus

CNS drug delivery and tumor targeting, supported by preclinical and early clinical data

Leadership

Experienced management team supported by medical and scientific advisors

Sources: NEO212 is an investigational product candidate. It has not been approved by the FDA or any other regulatory authority, and its safety and efficacy have not been established. This slide contains 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; actual results may differ materially. See the forward-looking statements disclaimer in this presentation and the company's SEC filings for a discussion of risk factors. Patent portfolio (179 patents issued and pending, global) and Middle East expansion — NeOnc Technologies data on file, November 2026. Milestone timing is management's current expectation and is subject to change. NEO212 Phase 1 dose-escalation study in astrocytoma IDH-mutant, glioblastoma IDH-wildtype or brain metastasis (170–810 mg QD, Days 1–5 of each 28-day cycle; N=14 across 5 cohorts) — NeOnc Technologies data on file, November 2026.

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THE FUTURE OF DRUG DELIVERY

Appendix

LEADERSHIP

Senior Management Team

Our management team possesses significant experience in capital markets, with a track record of building shareholder value in clinical biotech companies.



Amir F. Heshmatpour

CEO, Executive Chairman & President

Mr. Heshmatpour served on NeOnc Technologies Holdings, Inc.'s board of directors since January 2023, President since April 2025 and CEO since November 2025. Mr. Heshmatpour founded AFH Holding and Advisory LLC ("AFH") in July 2005. Since July 2005, Mr. Heshmatpour has been the Managing Director of AFH. Mr. Heshmatpour, through AFH, his family office, has been involved in multiple biotech transactions from private to public.

From 2018 to 2022, through a special purpose vehicle, Shuttle Pharmaceuticals Holdings Inc. ("SPH"), Mr. Heshmatpour restructured the board of directors, management, and recapitalized an IPO of a Georgetown phase II oncology asset. The SPV was created in 2018 and eventually was successfully listed on NASDAQ in 2022. Since then, he has been involved in NeOnc Technologies Inc., where he has provided strategic advisory services.

Mr. Heshmatpour has a certification from the UCLA Anderson School of Business in corporate governance. He is also involved in the UCLA Anderson School of Business Management, Price Center, as a member of the Board of Advisors. In February 2024, Mr. Heshmatpour joined the Board of Directors of Make-A-Wish CVS in Los Angeles. We believe that Mr. Heshmatpour's extensive corporate and leadership experience qualifies him to serve on our Board of Directors.



Thomas Chen, MD, Ph.D.

Founder, CMO & CSO

Dr. Chen has served as NeOnc Technologies Holdings, Inc.'s Chief Executive Officer since April 2023 through October 2025 and Chairman of the Board since its inception. Dr. Chen also serves as its Chief Medical Officer and Chief Scientific Officer.

Since July 1997, Dr. Chen has worked as a Neurosurgeon at Keck Medicine of USC and a Professor Neurological Surgery at the University of Southern California Keck School of Medicine ("USC"). He has been the Director of Surgical Neuro-Oncology and Professor of Neurosurgery & Pathology.

Dr. Chen's work is widely published, including 148+ peer-reviewed clinical studies. He maintains a clinical practice in both surgical neuro-oncology and spine surgery, as well as heads a research laboratory focused on glioma biology.

He graduated summa cum laude from the University of Illinois at Urbana-Champaign with Bronze Tablet honors and Phi Beta Kappa. He graduated from University of California San Francisco with M.D. degree, and was in the top 10% of his class, awarded Alpha Omega Alpha. He earned his Ph.D. in pathobiology from University of Southern California where he wrote his thesis on the role of immunotherapy in malignant brain tumors.

We believe that Dr. Chen's extensive knowledge of NeOnc's business and his extensive corporate and leadership experience as the founder of NeOnc and its Chief Executive Officer qualifies him to serve on our Board of Directors.



Josh Neman, PhD

Chief Clinical Officer

Dr. Neman has served as Chief Clinical Officer of NeOnc Technologies Holdings, Inc. since June 2024, where he leads clinical strategy and translational development across the Company's neuro-oncology pipeline.

Dr. Neman is an established cancer scientist and academic leader in brain tumor and brain metastasis research. Since July 2014, he has served as an Associate Professor of Neurological Surgery, Neuroscience, and Physiology at the Keck School of Medicine of the University of Southern California. His research program focuses on the biology of malignant brain tumors, brain metastases, tumor–microenvironment interactions, and mechanisms of therapeutic resistance, with an emphasis on translating laboratory discoveries into clinically actionable strategies.

In addition to his faculty appointment, Dr. Neman has held multiple leadership roles at USC, including Program Chair of the Cancer Biology and Genomics Ph.D. Program since July 2019 and Scientific Director of the USC Brain Tumor Center since July 2021, where he has overseen interdisciplinary research initiatives spanning basic, translational, and clinical neuro-oncology.

In January 2021, Dr. Neman co-founded Synaptical Inc., a digital health company focused on providing cancer patients with education, guidance, and care-navigation resources, and currently serves as its Chief Executive Officer. He also founded CNSMENDER Consulting LLC in January 2022, where he advises on clinical development and translational strategy in oncology and CNS disorders. Dr. Neman earned his Bachelor of Science and Doctor of Philosophy (Ph.D.) in Neurobiology from the University of California, Los Angeles.



Keithly A. Garnett

Chief Financial Officer

Mr. Garnett has served as NeOnc Technologies Holdings, Inc.'s Chief Financial Officer since April 2023 and served as a director from January 2023 to March 2025.

Mr. Garnett spent over 17 years with Ernst & Young LLP in their Transaction Advisory Services practice. During that time, he specialized in business valuation modelling and strategy. His services were provided in support of audit related work for financial reporting, tax planning and management planning. His client list included companies such as Amgen, Edwards Life Sciences, Medtronic, etc. In any given year, he led over 50 transaction analyses and/or review for publicly traded companies, in connection with their SEC financial reporting requirements.

From March 2017 to January 2023, Mr. Garnett was a Director at Sycamore Valuation. Since January 2021, Mr. Garnett has worked as the Chief Financial Officer of AFH Holding & Advisory, a single member family office based in Malibu. From 2018 to 2022, he was involved with the Shuttle Pharmaceutical Holdings public offering, which was successfully listed on the Nasdaq in 2022.

Mr. Garnett holds a Master's in Business Administration with a concentration in Corporate Financial Management, and a Bachelor of Science degree in Business Management. He also completed the Columbia University Executive Education program with a certificate from the Chief Financial Officer program.



David Choi, CPA

Chief Accounting Officer

David Choi was appointed Chief Accounting Officer of NeOnc Technologies Holdings Inc. in 2026. In this role, he oversees the Company's accounting, financial reporting, internal controls, and corporate governance as NeOnc advances its clinical-stage biotechnology platform and expands globally. He focuses on strengthening financial reporting processes, building scalable accounting infrastructure, and supporting the Company's growth as a public company.

Mr. Choi brings more than a decade of experience in accounting, financial reporting, and internal controls. Prior to joining NeOnc, he was a Director at Blythe Global Advisors, advising companies on technical accounting matters, SEC reporting, and SOX compliance, and leading projects involving financial reporting transformation and accounting for complex transactions.

Earlier in his career, he held roles at Grant Thornton and Ernst & Young, providing audit and technical accounting advisory services.

Mr. Choi is a Certified Public Accountant (CPA) and holds a Master of Professional Accountancy and a Bachelor of Arts in Business Economics with a minor in Accounting from the University of California, Irvine.

GOVERNANCE

Board of Directors

NEONC TECHNOLOGIES HOLDINGS, INC.

Also serving



Amir F. Heshmatpour
CEO, Exec. Chairman & President



Thomas Chen, MD, PhD
Founder, CMO & CSO



Victoria Medvec, PhD
Compensation Committee Chair

20+ years as CEO of Medvec & Associates, advisory firm servicing more than a third of Fortune 100.

Advising on regulatory negotiations, partnerships and global market access. Clients have included Amgen, Sanofi, Astra Zeneca, Bristol Myers Squibb, Pfizer and Gilead.

Founding member of Extraordinary Women on Boards. Frequent speaker and author of best-selling book, "Negotiate Without Fear.

Accomplished public & private board director, specializing in mergers and acquisitions, customer growth, revenue maximization, supply chain, human capital, and risk management. Applying expertise in negotiations and decision-making to drive revenue expansion.



Bader Al Monawer
Audit Committee Chair

More than a decade of experience in venture capital, investment banking, and business consulting and development.

Currently serves as managing partner of Arabian Group, overseeing venture capital investments. Previously founded the VC fund, Oasis Capital, investing in numerous startups, many of which have grown into multibillion-dollar corporations.

Extensive background in investment banking and consulting at McKinsey & Company, Citigroup's M&A advisory, Wafra's Alternative Investments Division, and the World Bank.

MBA, Massachusetts Institute of Technology (MIT);Master's degree in economics and financial policy, Cornell University.



Ali Alabedin

More than three decades of international banking experience across the Middle East and Asia Pacific.

Currently serves as Head of Islamic Banking Group at First Abu Dhabi Bank (FAB), overseeing wholesale, investment, retail, and private banking activities, as well as international operations.

Extensive background in senior leadership roles at Standard Chartered Bank, ANZ Banking Group, and Dubai Islamic Bank, spanning financial institutions, corporate banking, distribution, and strategic relationships.

Previously founded Dubai Islamic Financial Services, serving as Chief Executive Officer and subsequently as an executive board member.

Master of International Business, University of Wollongong, Australia; Aspiring Directors Programme, INSEAD.



Jim Delshad
Corporate Governance Chair

Served two terms as Mayor of Beverly Hills, starting in 2007, pioneering "Smart City" initiatives that transformed the city into a model of technological advancement and security. He holds the honorary title of "Goodwill Ambassador of Beverly Hills" in recognition of his contributions to the city.

Served as former President and Chairman of Magbit Foundation

Over the past two decades he has provided management consulting services, which includes strategic advisory services across private, public, and non-profit sectors.



Nasim Shomali, MBA

Nasim Shomali is a biomedical engineer and executive advisor with more than 13 years of experience guiding Fortune-20 companies through growth, operational transformation, and infrastructure modernization. From 2013 to 2026, she served as a Strategy Executive at Accenture, working with senior leaders across the medtech, hyperscale technology, software, energy, and retail sectors to shape first-of-their-kind initiatives; she has led cross-functional teams delivering multi-hundred-million-dollar ROIs and shaped product, cloud, and AI direction for companies with trillion-dollar market capitalizations, drawing on prior roles in private equity diligence and medical device engineering.

Ms. Shomali holds an M.B.A. in finance from the UCLA Anderson School of Management and dual bachelor's degrees in Bioengineering and Mathematics from the University of Washington, and completed the Sustainable Leadership Development Executive Program at the Yale School of Management.

ADVISORS

Scientific Advisory Board

Our Scientific Advisory Board provides objective perspective and guidance in product development, clinical trials, regulatory compliance, and biotech commercialization strategies.



Henry S. Friedman, MD
Chair, SAB

Senior neuro-oncologist at Duke and deputy director of The Preston Robert Tisch Brain Tumor Center.

Holds the James B. Powell, Jr. Distinguished Professorship in the Duke School of Medicine.

Cares for adult and pediatric patients at the Duke Cancer Center's Brain Tumor Clinic.

Internationally recognized authority in neuro-oncology with 500+ peer-reviewed works and decades of national and international presentations.

Research focuses on clinical trials and translational work in high-grade glioma, medulloblastoma, and ependymoma.

Helped shape treatment standards for challenging CNS tumors through sustained leadership and collaborative, multi-center research.



Axel H. Schönthal, PhD

Associate Professor, Department of Molecular Microbiology & Immunology at Keck School of Medicine at University of Southern California.

Research focused on novel agents and delivery methods for improving cancer therapeutic regimens, particularly for brain cancers.

Authored or coauthored 180 scholarly articles with an H-Index of 50.

Over past 10 years, engaged in grant reviews for The Qatar National Research Fund. Includes applications for Undergraduate Research Experience Program that engages students in research projects under the guidance of academic and business mentors.

PhD, University of Karlsruhe, Germany. Postdoc in molecular & cellular cancer biology at USC, San Diego.



Steven L. Giannotta, MD

Chair Emeritus of Neurological Surgery at USC.

Research primarily centers around cerebral blood flow and protecting the brain from ischemia.

Specializes in surgical strategies for cranial base lesions, including acoustic neuromas. Has surgically removed 400+ acoustic neuromas.

Treated 1,000+ intracranial aneurysms and developed a comprehensive approach to cerebrovascular conditions, employing techniques such as microsurgical clip ligation, coil embolization, and stereotactic radiosurgery.

Medical degree and residency at the University of Michigan.



Alexandra M. Miller, MD, PhD

Chief of the Division of Neuro-Oncology at NYU Langone's Perlmutter Cancer Center and Co-Director of the Brain & Spine Tumor Center.

Leads the Neuro-Oncology Program, with a clinical and research focus on primary brain tumors, particularly malignant gliomas.

Oversees multidisciplinary care and strategic planning at a major NCI-designated cancer center.

Holds clinical faculty appointments in Medicine and Neurology at NYU Grossman School of Medicine.

Works at the intersection of neurology, oncology, and clinical trials.

Recognized for leadership, invited talks, program development, and collaborative research in neuro-oncology.



David M. Ashley, MBBS (Hons), FRACP, PhD

CEO of VCCC Alliance in Australia. Previously was the Rory David Deutsch Distinguished Professor of Neuro-Oncology and Director of The Preston Robert Tisch Brain Tumor Center at Duke.

Dr. Ashley trained and led major neuro-oncology programs in Australia before joining Duke.

Practices adult and pediatric neuro-oncology and oversees one of North America's largest dedicated brain tumor centers.

Leads integrated efforts in clinical care, translational research, and education.

Research focuses on CNS tumor biology, immuno-oncology, and clinical trials.

Served as principal investigator on national and international studies shaping current practice.

Internationally recognized for advancing patient-centered innovation in neuro-oncology.

COMPANY OVERVIEW

Company overview & investment highlights

Founded in 2023, NTHI is a clinical-stage life sciences company.

Focused on development & commercialization of central nervous system (CNS) therapeutics.

Platform for novel drug candidates & delivery tech.

Designed to address the persistent challenge in overcoming the blood-brain barrier (BBB).

Robust IP portfolio.

Holds 179 biotech-related patents developed at the University of Southern California (USC).

Non-invasive intranasal CNS delivery.

Intranasal CNS drug delivery, reflecting a focus on non-invasive investigational therapies for brain tumors.

63 scientific published studies.

Highlight the potential of perillyl alcohol (POH) and its conjugates as efficient chemotherapeutic delivery platforms against brain tumors.

Advancing pipeline.

Two drug candidates in Phase II trials (NEO100-01, NEO100-02) and two in Phase I (NEO100-03, NEO212).

Multi-billion-dollar, high-growth addressable markets.

Significant unmet need in a large addressable market.

Experienced leadership.

Extensive track record in capital markets, medical, scientific, and biotech value creation.

NEO100 and NEO212 are investigational product candidates; neither has been approved by the FDA or any other regulatory authority and their safety and efficacy have not been established. NeOnc Technologies Holdings, Inc. — company overview. IP: 179 patents (USC). Pipeline: NEO100-01/-02 (Phase II), NEO100-03 & NEO212 (Phase I).

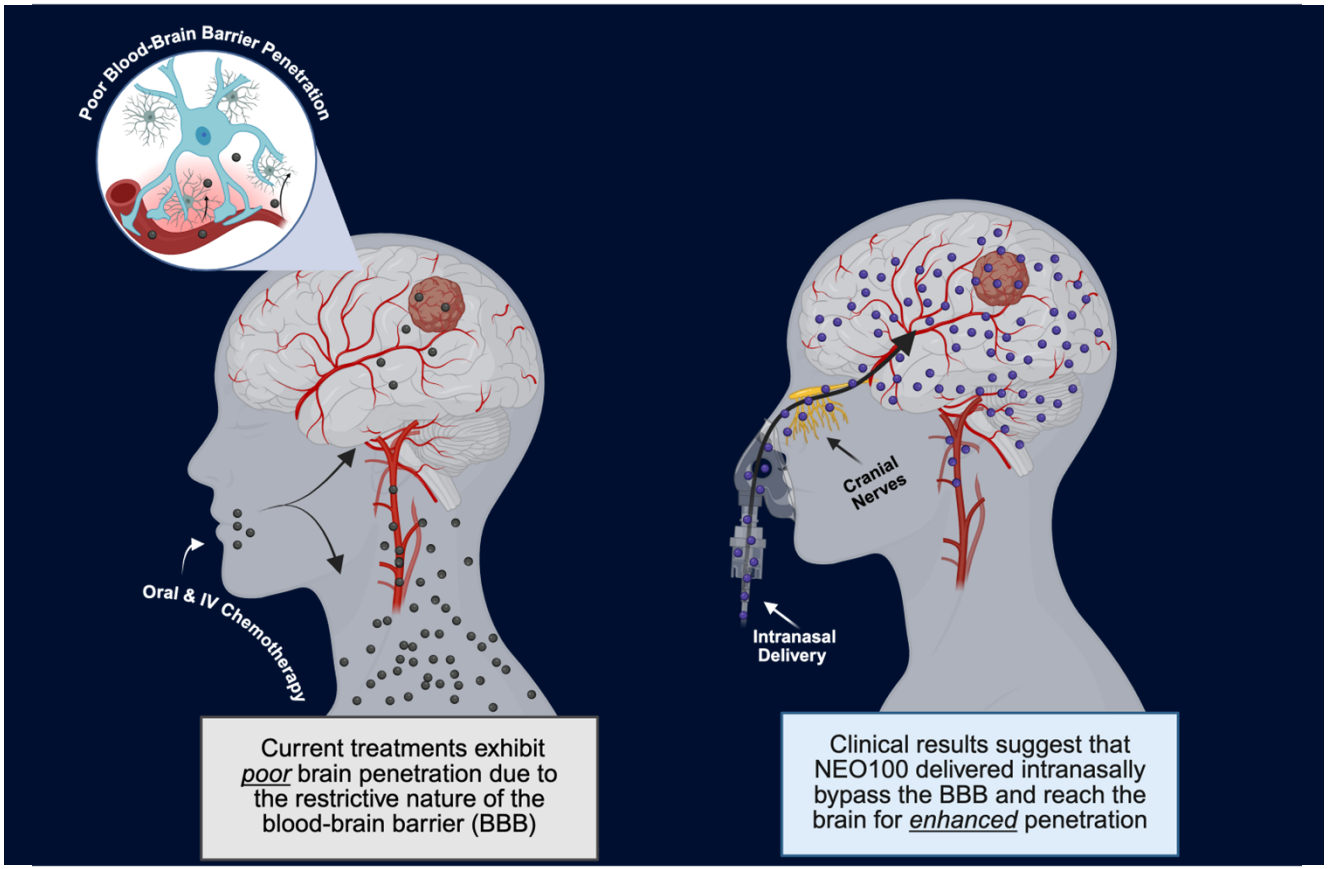
STRATEGY

Intranasal chemotherapy designed to bypass the blood-brain barrier and target brain tumors

Direct brain access: Intranasal delivery is designed to enable small-molecule therapeutics to bypass the BBB via the olfactory and trigeminal nerves, reaching the brain through the CSF.

Non-invasive & patient-friendly: Administered with a nasal mask and nebulizer, this method is designed to be simple, non-invasive, and suitable for self-use — potentially reducing costs and improving adherence.

Enhanced efficiency: Intranasal delivery is designed to avoid first-pass metabolism, allow rapid onset, and enable targeted drug delivery to brain tumors such as GBM.



Sources: NEO100 is an investigational product candidate; it has not been approved by the FDA or any other regulatory authority and its safety and efficacy have not been established. Intranasal delivery characteristics are design intent supported by preclinical and early clinical data; they have not been established in an adequate and well-controlled trial.

MARKET NEED

The Need

~1 million

Americans living with a primary brain tumor

~26%

of all brain & CNS tumors are malignant

#1

leading cause of cancer-related death in children (ages 0–14)

107,100

new primary brain & CNS tumors expected in the U.S. in 2025

≈4,800 in children (ages 0–19)

18,330

deaths from malignant brain & CNS tumors in 2025

≈24,820 new malignant cases

1 in 143

lifetime risk of a malignant brain/CNS tumor (men; ~1 in 186 women)

Sources: Prevalence & pediatric-leading-cause — National Brain Tumor Society, Brain Tumor Facts (2025). Incidence — CBTRUS Statistical Report 2018–2022 (Neuro-Oncology 2025): 107,100 new primary brain/CNS tumors in 2025; ~26% malignant; ≈4,800 children (0–19)/yr. Malignant new cases & deaths — American Cancer Society, Cancer Facts & Figures 2025 (≈24,820 new malignant; ≈18,330 deaths). Lifetime risk — ACS (≈1 in 143 men, 1 in 186 women).

PEDIATRIC

Pediatric Brain Cancer

The Need

#1 Brain tumors are the leading cause of cancer-related death among children (ages 0–14) and the most common solid tumor of childhood.

~4,800 children & adolescents (ages 0–19) are diagnosed with a primary brain tumor in the U.S. each year.

~40% Pediatric high-grade gliomas (pHGG, including DIPG) account for roughly 40% of childhood brain-tumor deaths.

The Challenge

Radiation & chemotherapy for children with high-grade gliomas are:

- Complex
- Time consuming
- Prognosis remains poor

These challenges underscore the importance of developing effective therapies that are:

- Less invasive
- More tolerant for such populations

Our Solution

NEO100: our first therapeutic being developed for pediatric patients diagnosed with pHGG.

We believe our novel **intranasal delivery** makes a study in a pediatric population easier than other methods.

In consultation with the FDA under **Orphan Drug & Fast-Track status,** we intend to collect clinical-trial data to evaluate the potential of NEO100 in pHGG.

Sources: NEO100 is an investigational product candidate; it has not been approved by the FDA or any other regulatory authority and its safety and efficacy have not been established. National Brain Tumor Society, Brain Tumor Facts (2025); CBTRUS Statistical Report 2018–2022 (Neuro-Oncology 2025), pediatric analysis. Brain tumors are the most common solid tumor and the leading cause of cancer death in children ages 0–14. Pediatric high-grade glioma (incl. DIPG) mortality share per pediatric neuro-oncology literature. Children = ages 0–19 unless noted.

PRIMARY BRAIN TUMORS · WHO CNS5 (2021)

Primary brain tumors and the IDH1 divide

Primary brain tumors start in the CNS itself. **Adult-type diffuse gliomas** are the most common malignant kind — and since WHO 2021 they are defined first by **IDH mutation status**, not by appearance alone. IDH1 status splits one microscopic picture into two different diseases.

ADULT-TYPE DIFFUSE GLIOMA

↓ classified first by IDH mutation status

IDH-MUTANT

Astrocytoma, IDH-mutant
grades 2, 3, 4 · ATRX-lost, no 1p/19q codeletion

Oligodendroglioma, IDH-mutant
& 1p/19q-codeleted · grades 2, 3

IDH-WILDTYPE

Glioblastoma, IDH-wildtype
grade 4
The term "glioblastoma" is now reserved for IDH-wildtype tumors only.

	IDH1-MUTANT astrocytoma	IDH1-WILDTYPE glioblastoma
Typical age	30s–40s (younger)	60s+ (older)
How it arises	Often from a lower-grade glioma	De novo / primary
Genetic hallmark	IDH1/2 mutation (IDH1 R132H ≈ 90%)	No IDH mut; TERT, EGFR amp, +7/−10
Biology	Mutant IDH makes 2-HG → DNA/histone hypermethylation (G-CIMP)	RTK/RAS/PI3K-driven; no 2-HG
WHO 2021 name	"Astrocytoma, IDH-mutant, grade 4" — NOT glioblastoma	"Glioblastoma, IDH-wildtype, grade 4"
Grade-4 trigger	Necrosis/MVP or CDKN2A/B homozygous deletion	Necrosis/MVP or TERT / EGFR / +7−10
Median survival from diagnosis	**~3–5 yr at grade 4 (years at lower grades)**	**~15–18 months**
Prognosis	Better at every grade	Worst of the gliomas

Key teaching point: since WHO 2021, "glioblastoma" means **IDH-wildtype only**. A grade-4 **IDH1-mutant** tumor is no longer called GBM — it is "Astrocytoma, IDH-mutant, grade 4."

Same look under the microscope, but a different disease — younger patients, distinct biology, and far longer survival. That recurrent grade 3–4 IDH1-mutant population is exactly what NEO100 targets.

Sources: NEO100 is an investigational product candidate; it has not been approved by the FDA or any other regulatory authority and its safety and efficacy have not been established. WHO classification — Louis DN et al., "The 2021 WHO Classification of Tumours of the Central Nervous System: a summary," Neuro-Oncology 2021;23(8):1231–1251. Major-changes review — "Major Changes in the 2021 WHO Classification of CNS Tumors," RadioGraphics 2021 (doi:10.1148/rg.210236). Biology — Yan H et al., NEJM 2009 (IDH1/2 in gliomas); Noushmehr H et al., Cancer Cell 2010 (G-CIMP). Survival — IDH-wildtype GBM median OS ~15–18 mo (Stupp R et al., NEJM 2005; Lancet Oncol 2009); IDH-mutant grade-4 astrocytoma ~3–5 yr. IDH1 R132H ≈ 90% of IDH mutations.

UNMET NEED

The Challenge

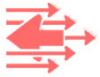
While the FDA has approved many drugs for treating malignant glioblastomas (GBM), **survival rates remain low with no significant improvement in prognosis over the past 50 years.**

Lack of progress primarily due to natural resistance mechanisms that limit efficacy of GBM treatments

Therapeutics cannot enter
the central nervous system (CNS) due to the blood-brain barrier (BBB).



Heterogeneity of GBMs
contributes to therapeutic resistance by preventing adequate control of the entire tumor mass by a single drug.



Natural brain responses
(i.e. tumor microenvironment) counteract tumor-targeting medications.

Stem cell-like characteristics of GBMs resist current standard treatment options:

Treatment	Resistance Mechanism
Chemotherapy	Upregulation of efflux transporters
Radiation	Promotion of glioblastoma stem-cell proliferation in neurogenic zones
Immunotherapy	Immune suppression

Metabolic cascades in GBMs prevent effective treatments through:

- Optimization of glucose use
- Alternative nutrient precursors for energy production
- Induction of hypoxia to enhance tumor growth

Source: Challenges in the Treatment of Glioblastoma: Multisystem Mechanisms of Therapeutic Resistance, Aug. 2018.

VERSATILITY

NEO100 has potential applications across clinical and commercial settings (investigational)

Designed to act as a regulator

for neurologic pathways associated with tumor cell growth.

When delivered intranasally,

its small molecular size is designed to allow it to bypass the blood-brain barrier (BBB).

When delivered intra-arterially,

it may create a temporary opening in the BBB, allowing larger-molecule therapeutics to pass through.

In high concentrations,

may act as a therapeutic for brain cancers.

In low concentrations,

to act as a solvent for traditional large-molecule therapeutics, which may enable them to bypass the BBB.

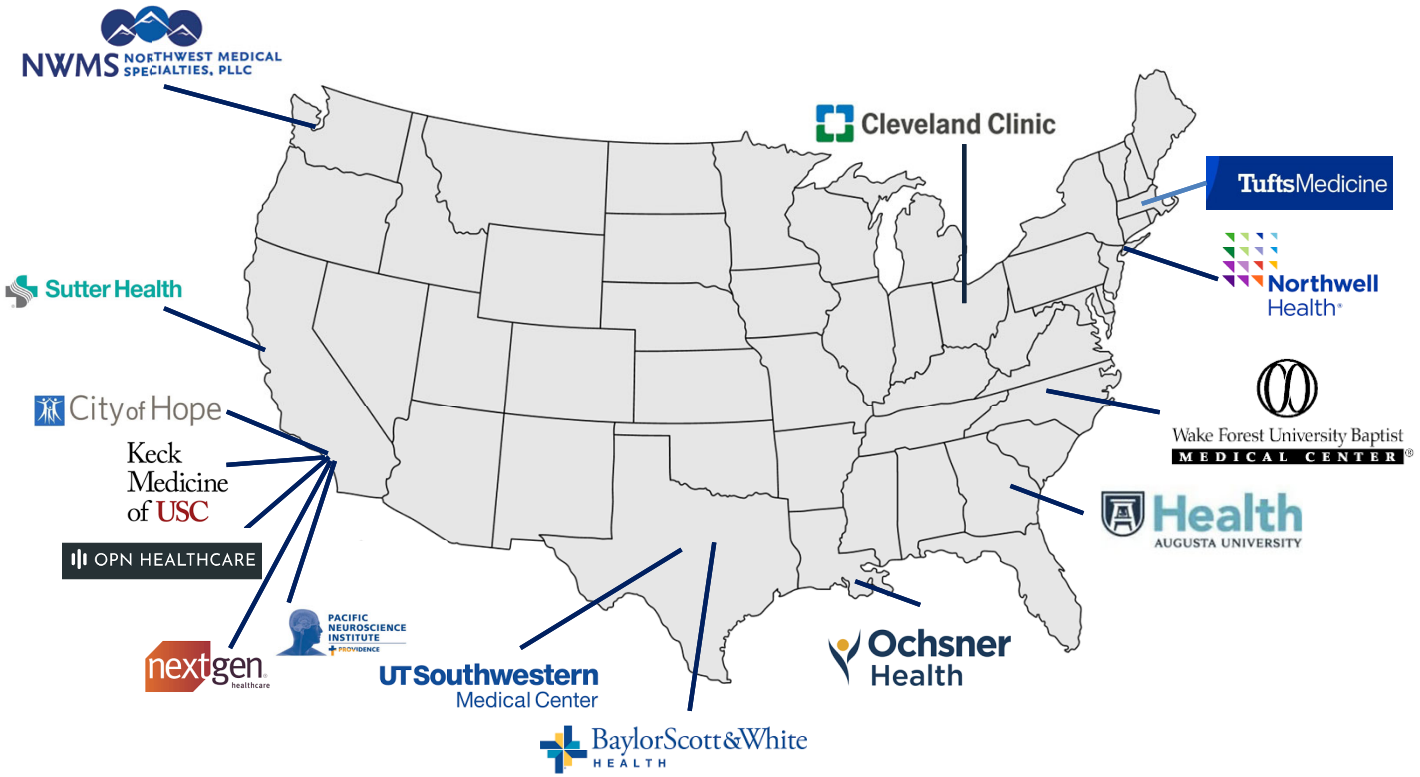
Conjugate with other CNS therapeutics

to create compound formulations that may be capable of BBB penetration & greater therapeutic effect.

Sources: NEO100 is an investigational product candidate; it has not been approved by the FDA or any other regulatory authority and its safety and efficacy have not been established. The applications shown are potential and investigational. None has been approved, and several have not been evaluated in a clinical study. Intra-arterial administration is exploratory.

FOOTPRINT

Clinical Trial Sites



Pending Sites

Penn State
Washington University
Johns Hopkins
Harvard / Mass General Hospital
New York University
Tampa General
University of South Carolina
Northwestern University
Beverly Hills Cancer Center
University of Vermont
Westchester Medical Center
Michigan University
Duke University
Children's Orange County (CHOC)
Children's Hospital of Los Angeles
Alabama
UCSF
Maine Health
United Arab Emirates (5 sites)
Israel (Tel Aviv)

Sources: NEO100 is an investigational product candidate; it has not been approved by the FDA or any other regulatory authority and its safety and efficacy have not been established. Active and pending clinical trial sites as of November 2026. Pending sites are subject to contracting and institutional review board approval; no assurance is given that any site will activate.

MARKET

Therapeutic innovations aligned with rapidly expanding global markets

Global Market Outlook & Drivers

- **Global CNS treatment market** is projected to grow at an **8.6% CAGR, reaching $285.7 billion by 2035.[1]**
- **Global brain tumor drugs market** is expected to grow at a **9.3% CAGR, reaching $5.2 billion by 2034.[2]**

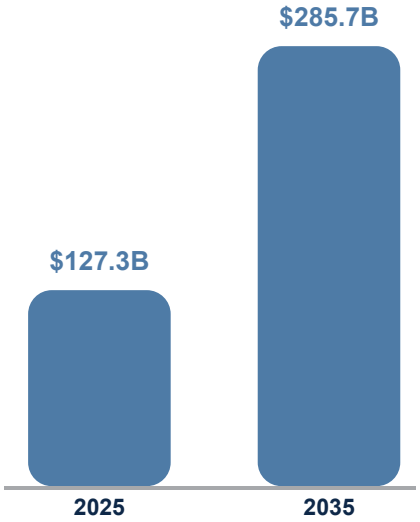
Major Market Drivers

- Rising incidence of CNS disorders driven by an aging global population.
- Increased FDA approvals for novel and combination therapies.
- Drug therapy remains limited by poor delivery across the blood-brain barrier (BBB) — the gap NEO100 is designed to close.

CNS Treatment Market

Global, USD billions [1]

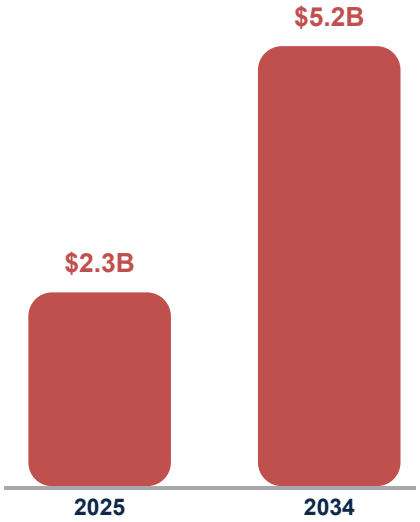
↗ 8.6% CAGR



Brain Tumor Drugs Market

Global, USD billions [2]

↗ 9.3% CAGR



Sources: NEO100 and NEO212 are investigational product candidates; neither has been approved by the FDA or any other regulatory authority and their safety and efficacy have not been established. [1] Precedence Research, "Central Nervous System Therapeutic Market" (2026 update): USD 127.29 B (2025) → 285.72 B (2035), CAGR 8.64% (2026–2035). [2] Fortune Business Insights, "Brain Tumor Drugs Market," report 105025 (2026 update): USD 2.29 B (2025) → 5.20 B (2034), CAGR 9.30% (2026–2034). Market-size and CAGR figures are third-party analyst projections and vary by report scope and methodology.

MIDDLE EAST

Middle East expansion plan

Integrated GCC/MENA platform

NuroMENA and NuroCure (controlled by NuroMENA) hold the exclusive sub-license to 178 NTHI patents in the GCC and MENA. NTHI retains 20% non-dilutive equity and negative control rights over the corporate board and management.

Government engagement

Partnership with GCC government stakeholders; access to sovereign wealth fund investment is being pursued and is not a committed financing.

510M population access

Expanding CNS clinical trial enrollment across the GCC/MENA region, intended to address unmet medical need and support regulatory submissions.

Global expansion platform

Partnerships with oncology and neuro-oncology institutions intended to create a scalable model for entry into other regions.

Capital and sub-licensing

Sub-licensing is intended to generate recurring revenue and broaden NTHI's reach; amounts and timing are not assured.

Long-term alignment

Government alignment, NTHI innovation and governance rights are intended to support long-term value for patients and shareholders.

Forward-looking statements: the arrangements described are subject to definitive agreements, regulatory approval and other conditions. No assurance is given as to timing, revenue or completion.

Sources: NEO212 is an investigational product candidate. It has not been approved by the FDA or any other regulatory authority, and its safety and efficacy have not been established. This slide contains 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; actual results may differ materially. See the forward-looking statements disclaimer in this presentation and the company's SEC filings for a discussion of risk factors. NuroMENA / NuroCure exclusive GCC and MENA sub-license covering 178 NTHI patents; NTHI retains 20% non-dilutive equity and negative control rights over the corporate board and management — executed agreements, NeOnc Technologies data on file, November 2026. GCC/MENA population of ~510 million — World Bank population estimates. Sovereign-wealth-fund access and partnership discussions are not committed financings; no assurance of completion.

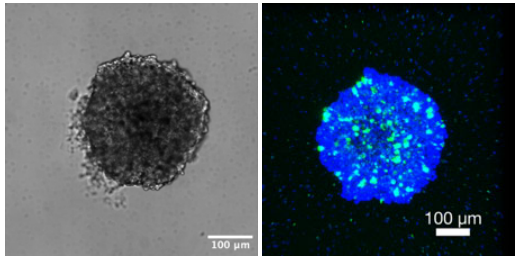
TECHNOLOGY ACQUISITION

Acquisition of SilicoVitro technology from McMaster University & USC

Adds SilicoVitro's AI engine and patented 3D bioprinting platform (US Patent No. 11,788,057 B2), intended to expand NeOnc's R&D capability in CNS cancer research and broaden its intellectual property portfolio.

AI Drug Modeling (USC)	3D Bioprinting (McMaster)
➢ Simulates blood-brain barrier penetration and ROS generation ➢ Models tumor response to ultrasound ➢ Personalizes therapy for each patient ➢ Identifies optimal drug combinations for trials Impact: Enables in-silico testing to guide clinical decisions	➢ Creates realistic human tumor organoids ➢ Models neurodegenerative diseases like Alzheimer's & Parkinson's ➢ Produces organoids for liver, lung, and kidney ➢ Replaces animal models in preclinical testing Impact: Enhances accuracy and predictability of trial outcomes

Breast to Brain Metastasis
3D-Printed Sphere



Preclinical: in-silico and organoid findings are preclinical, have not been validated in humans and are not predictive of clinical outcome.

Sources: This slide contains 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; actual results may differ materially. See the forward-looking statements disclaimer in this presentation and the company's SEC filings for a discussion of risk factors. SilicoVitro acquisition and 3D-bioprinting platform — US Patent No. 11,788,057 B2; NeOnc Technologies data on file, November 2026. Supporting preprint and publication: biorxiv.org/content/10.1101/2025.11.25.690556v1; journals.plos.org/plosone/article?id=10.1371/journal.pone.0354981. In-silico and organoid findings are preclinical and not predictive of clinical outcome.

INTELLECTUAL PROPERTY

Our expanding global patent portfolio supports a competitive position

U.S. Patents

32 issued

19 pending

International Patents

97 issued

31 pending

USC University of Southern California

Protected under exclusive global licensing agreement with USC.

NEO™ is a proprietary platform

Protected by patents in the U.S., Canada, China, UK & EU

- Patents cover agent composition & methods of use, including enhanced methods designed to deliver pharma-based therapeutics to the brain.
- Patents secured under exclusive global licensing agreement with USC — considered USC's largest IP license for commercialization of chemotherapies related to brain & CNS diseases.[1]
- Biotechnology innovations based on research and development at USC led by NeOnc CEO, Dr. Chen.
- Platform technology has produced an IP portfolio of novel drug candidates, including conjugates and formulations of FDA-approved drugs, with patents extending to 2031–2038.

Composition & Method Claims

Issued & pending patent applications

NEO100 Ultrapure POH — issued patents expiring 2031: U.S., Canada, UK, EU, China.

POH conjugates (NEO212 / NEO214) — issued patents expiring 2031: U.S., UK, EU, Japan.

NEO400 POH + linoleic acid — pending applications, anticipated 2031: U.S., EU, China.

NEO412 POH + fatty acid / TMZ / Rolipram — issued patents expiring 2036: U.S., UK, EU, China, Japan, Australia.

NEO218 POH + bromopyruvate — issued U.S. patent expiring 2037; pending in China, EU, Japan.

NEO216 POH + valproic acid — pending applications, anticipated 2038: U.S., EU, China.

NEO100 and NEO212 are investigational product candidates; neither has been approved by the FDA or any other regulatory authority and their safety and efficacy have not been established. USC article published Oct. 19, 2023 — USC licensing agreement reached with faculty-led & founded company; considered the largest IP transfer for commercialization of chemotherapies related to brain and CNS disease.