

Lumantia | Cancer Progress

Cancer Progress

35+ YEARS OF SCIENTIFIC
DISCUSSIONS AND CONNECTIONS

LIVE EVENT

8:15 AM – 8:00 PM

APRIL 9, 2026

NEW YORK GENOME CENTER

101 6TH AVENUE, NEW YORK, NY 10013



 Lumanity | Cancer Progress

Thank you to all our 2026 Sponsors in support of Damon Runyon Cancer Research Foundation

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PHARMA

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injections

 NanOlogy

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DAMON RUNYON
CANCER RESEARCH
FOUNDATION

NOW | 8:15 AM – 09:00 AM

Registration and Morning Networking

NEXT | 9:00 AM – 9:15 AM

Opening Remarks

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Patient-Centric Innovations: Transforming Cancer Care

10:35 AM – 10:50 AM

Coffee Break

10:50 AM – 12:10 PM

Driving First & Best-in-Class Innovation: Balancing Technical and Commercial Risk Early in Oncology

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Opening Remarks



Jeffrey Bockham, PhD

EVP, Oncology
Lumanity



John Westwood

SVP, Strategy Consulting
Lumanity

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Patient-Centric Innovations: Transforming Cancer Care



Angela Wheeler

President, Insight USA &
Patient Center of Excellence Lead
Lumanity

MODERATOR



Ebonie Michelle, MPH

Founder & CEO
Prowl The LAB
Lived Experience Expert



Barry Nelson

Patient Advocate
Lived Experience Expert

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Driving First & Best-in-Class Innovation: Balancing Technical and Commercial Risk Early in Oncology



Jeffrey Bockman, PhD

EVP, Oncology
Lumantia

MODERATOR



Kapil Dhingra

Managing Member
KAPital Consulting LLC



Amy Han

Vice President,
Global Commercialization,
Genmab



Anil Kapur

Board Member,
Nurix Therapeutics
and Verastem Inc.



Alex Snyder, MD

SVP, Translational Medicine
& Discovery, Oncology
Merck



Leon 'Jun' Tang

Founder InScienceWeTrust
BioAdvisory

As one would surmise, published data suggests that follow-on agents without strong differentiation have limited ROI

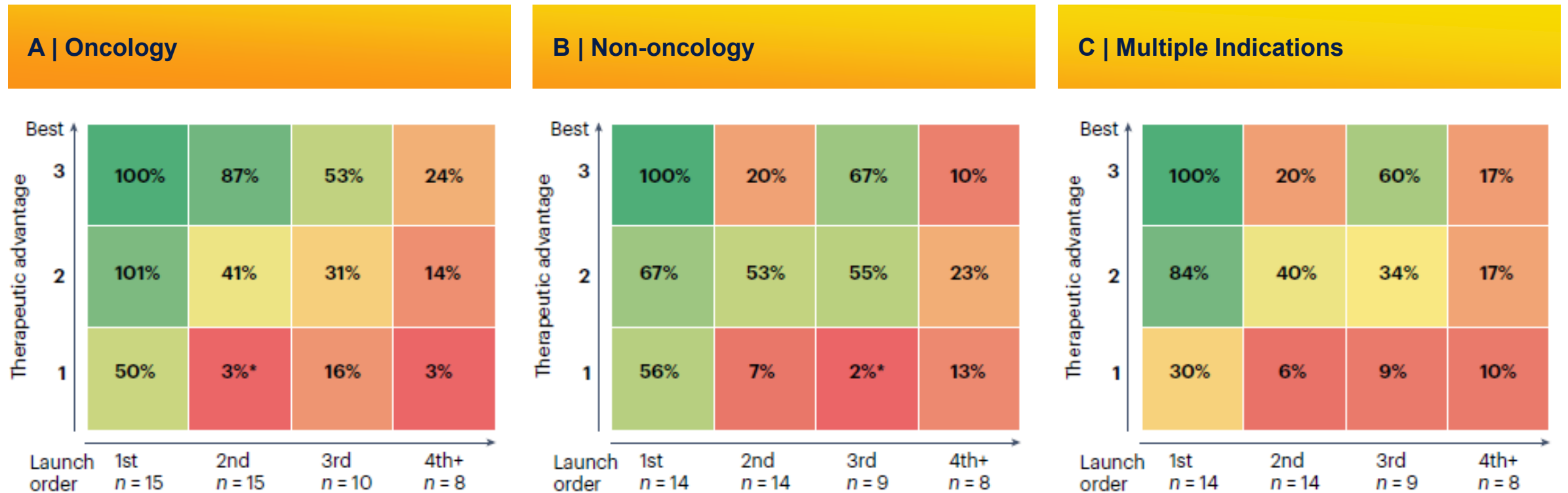
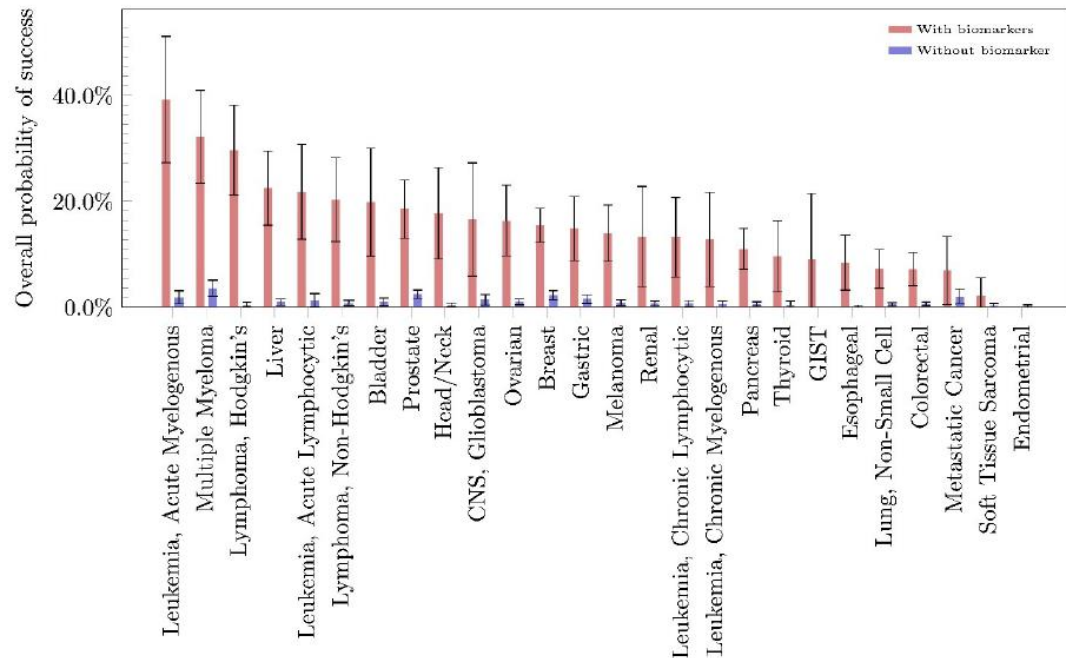


Fig. 2 | Influence of market dynamics on value captured. Value is expressed in terms of the average percentage of the present value of global sales relative to the average for products that were first-to-launch and best-in-class, for oncology products (a), non-oncology products (b) and products with multiple indications (c). Values with asterisks are based on n = 1. See Supplementary information for details.

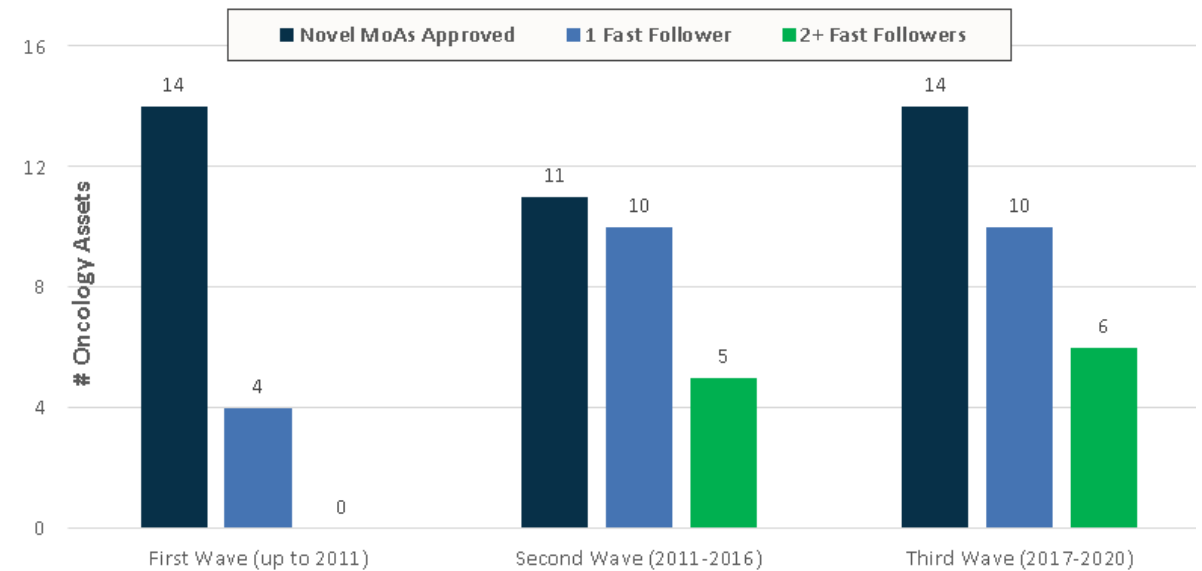
Technical risk is well understood—yet time to next-gen agents is shrinking as follow-on entrants increase

Clinical Development Risk



Competition/Commercial Risk

#Approved Oncology Assets/Fast Followers over Time

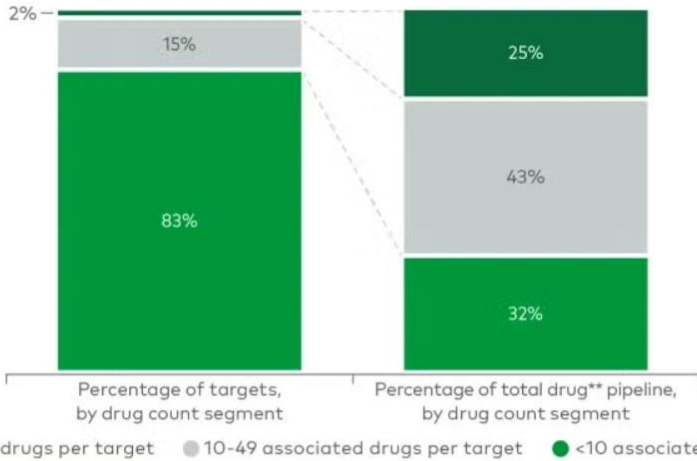


Fast follower = additional asset approved within 5 years of 1st approved asset (within the same MoA class)

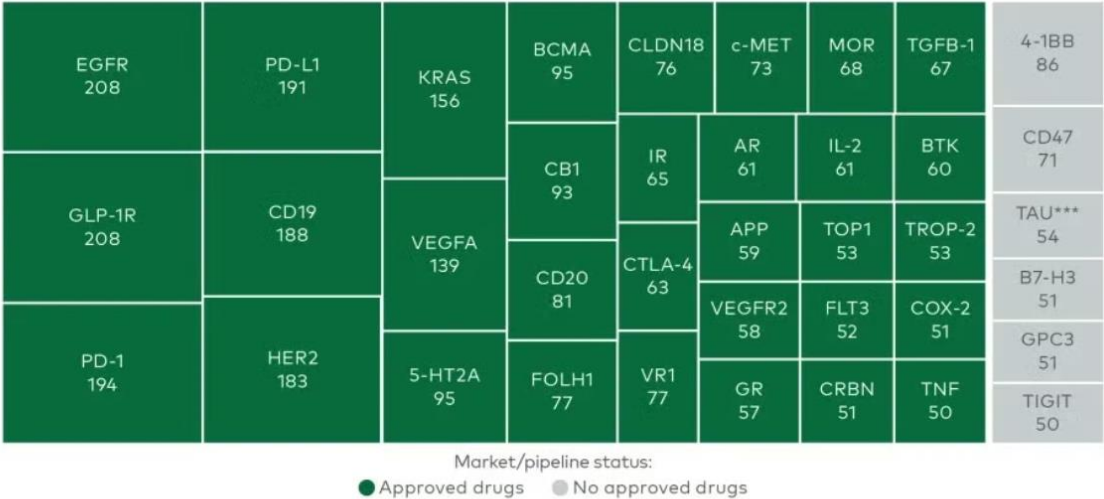
Overcrowding around well-validated targets really means companies have traded technical risk for commercial risk

The annual rate at which novel targets enter the pipeline has dropped significantly — from around 100 a decade ago to just 30 in 2024. This decline in early-stage innovation isn't due to a lack of new drugs in development or reduced early-stage venture capital funding. In fact, the overall R&D pipeline has nearly doubled in size, growing from approximately 11,000 active drug programs in 2015 to about 21,000 by the end of 2024, even after accounting for product launches, program pauses and terminations.

Worldwide preclinical and clinical R&D pipeline activity* (2024)



Number of drugs** per target



Note: *Based on preclinical and clinical pipeline activity. Unspecified / Not applicable targets excluded from analysis (~11,000 associated drugs with Unspecified or Not applicable target pairs). CD3 (~240 associated drugs) excluded from the since CD3 mechanism is not commonly the primary target of drug (e.g., bispecific molecules); **Drugs with multiple targets are counted individually for each associated target. ~10,000 unique drugs are associated with known targets. The ~10,000 drugs represented here along with the drugs having Unspecified / Not applicable targets sum to the ~21,000 drugs in the R&D pipeline
Source: Citeline Pharmaprojects (January 2025)

*Based on preclinical and clinical pipeline activity; unspecified/not applicable targets excluded from analysis (~11,000 associated drugs with unspecified or not applicable target pairs); CD3 (~240 associated drugs) excluded from the since CD3 mechanism is not commonly the primary target of drug (e.g., bispecific molecules)
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***Not including approval of a diagnostic tau product
Source: Citeline Pharmaprojects (January 2025)

First-in-class in Oncology has historically translated into a default best-in-class situation

The playbook for oncology that was pioneered by BMS with Taxol and Aventis (Sanofi) with Taxotere of extensive LCM within and across cancers has been replicated time and again.



We built a wall so high and so deep that no one could get through.

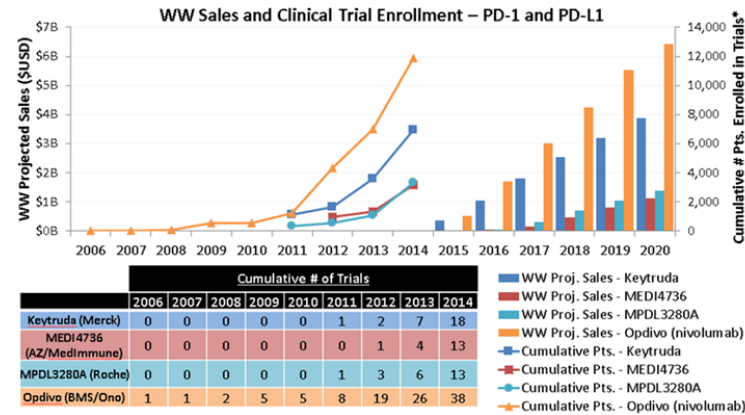
Roy Baynes



Oncology requires smart clinical development, for sure, but perhaps equally important is the sheer investment in LCM, with numerous examples demonstrating how in competitive spaces the company investing the most, with the most trials (smart trials, of course) will likely win the race, even if coming up from a close second position, as Merck did with Keytruda.

Pre-launch Through 2014 Trial Data Sales Projection Through 2020

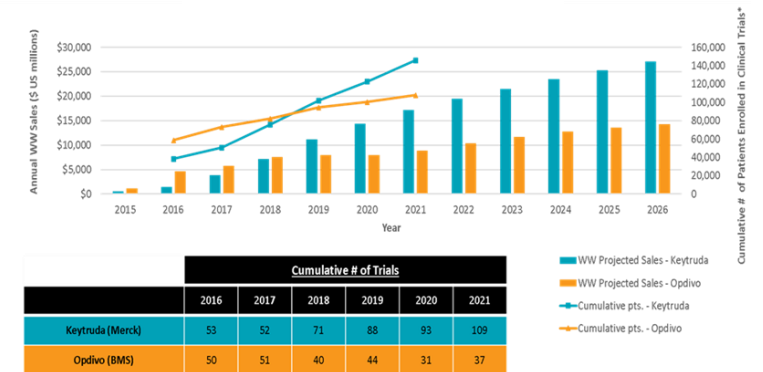
Anti-PD-1 and PD-L1 Agents
Clinical Trial Investment vs. Forecasted Sales Return



*Assumes that final/target enrollment was reached in year of trial initiation
ClinicalTrials.gov, EvaluatePharma, Defined Health analysis

Trial Data 2015-2021 Sales Projections 2015-2026

WW Sales and Clinical Trial Enrollment – Keytruda and Opdivo



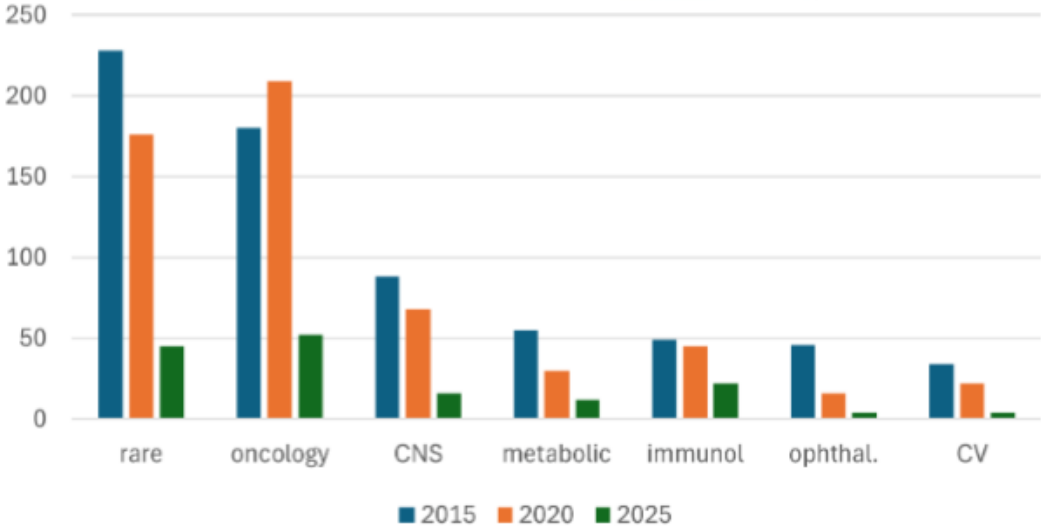
*Assumes that final/target enrollment was reached in year of trial initiation
ClinicalTrials.gov, EvaluatePharma, OBC analysis

*Projections in 2014 were kept for figure on the left; sales projections were amended subsequently by analysts as Merck pushed ahead past BMS, and figure on the right shows projections now with updated historical data from real sales.

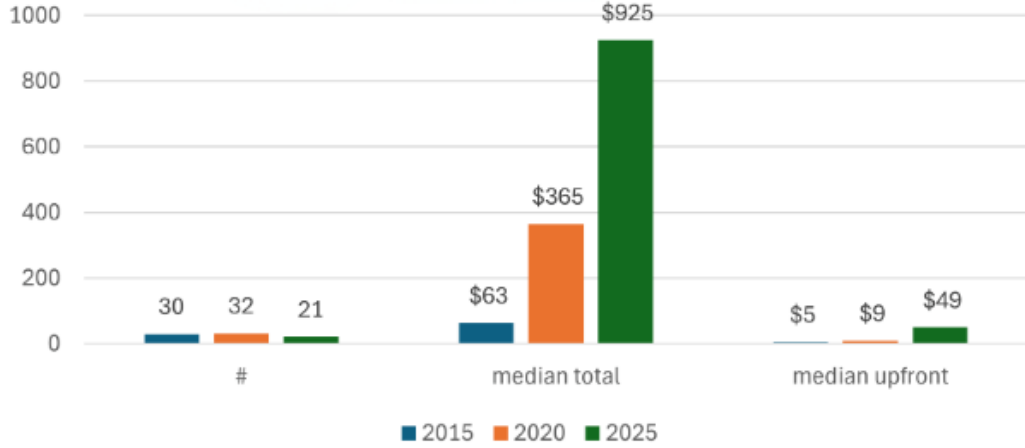
But despite these challenges...there seems to be a swing back to platforms, too

Rare Diseases And Oncology Are The Biggest TA For Preclinical Deals In 2025

#Preclinical Deals by TA and Year



Deal Terms For Global Company To Company Deals With Preclinical As Highest Stage



Overarching question for FIC vs BIC: to deploy the technology against well validated targets and if so, can clinically relevant diffraction be achieved; or to go after less validated targets? Or in other words, how to balance clinical/commercial risk versus technical risk

Defining First-in-Class and Best-in-Class in Oncology

- The distinction between first-in-class and best-in-class therapies is evolving, with increasing debate about whether being first still confers a durable advantage given the rapid emergence of next-generation agents
- Best-in-class status is now often determined not just at the molecule level but also at the regimen or combination level, reflecting the complexity of modern oncology development
- There is ongoing uncertainty about how regulatory agencies perceive and reward first-in-class status, especially as scrutiny increases and the definition of meaningful differentiation shifts

Challenges and Strategies for Biotech and Pharma

- US biotechs face acute capital constraints, making it difficult to generate early clinical data and forcing tough prioritization decisions for target advancement
- Smaller biotechs often lack the commercial and strategic expertise needed for optimal partnering, leading to suboptimal contracts and missed opportunities for value creation
- Agility and the ability to pivot based on evolving data and competitive landscapes are critical for both small and large companies, as the environment is highly dynamic and unpredictable

Sources of Innovation: Academia, Biotech, Pharma, and China

- Most first-in-class innovations originate from academia and small biotechs, with large pharma excelling at identifying and accelerating external innovations rather than generating them internally
- A growing trend involves Western academic ideas being spun out into biotechs, which then conduct early clinical trials in China before partnering with or being acquired by large pharma

Impact of China on Global Drug Development

- China's ability to rapidly move from target discovery to first-in-human trials is shortening the time between first-in-class and best-in-class globally, intensifying competition and accelerating innovation cycles
- Chinese companies are saturating R&D opportunities, particularly in areas like in vivo CAR-T and B-cell depletion, leading to a highly competitive environment where first-mover advantage is less pronounced
- US and European biotechs increasingly leverage China for efficient early clinical development, with many Western-originated assets now running first-in-human trials in China before being acquired by large pharma

Overarching question for FIC vs BIC: to deploy the technology against well validated targets and if so, can clinically relevant diffraction be achieved; or to go after less validated targets? Or in other words, how to balance clinical/commercial risk versus technical risk

Translatability and the Role of Human Data

- Translatability from preclinical to clinical outcomes remains a major challenge, with many surprises—both positive and negative—emerging only in early human studies
- Remarkable agents can sometimes be identified early in clinical development if the right patients are selected, but this is not always predictable, especially with complex modalities like ADCs

Evolution and Limitations of Target Product Profiles (TPPs)

- While TPPs are foundational for development strategy, they are often wrong or incomplete due to the dynamic nature of oncology and the emergence of new mechanisms and resistance pathways
- Companies must focus on evolving their TPPs to account for new dimensions of differentiation, including manufacturing and microcontrast, rather than relying solely on traditional endpoints

Future Outlook and Industry Dynamics

- The window between first-in-class and next-in-class approvals is narrowing, especially with China's accelerated development capabilities, challenging the traditional ability to entrench first-in-class products
- The future of oncology innovation will likely involve hybrid models, with companies leveraging both Western scientific origins and Chinese clinical execution to optimize speed and differentiation

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Michael Parisi, MBA

Chief Client Officer
Lumantia

MODERATOR



Francesca Barone, MD, PhD

CSO
Candel Therapeutics



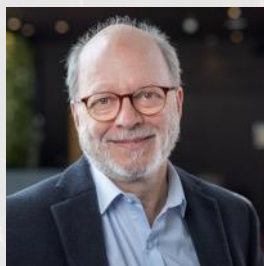
Brigid DeCoursey Bondoc

Partner
Morrison Foerster



Matthew Huddleston

EVP, Chief Commercial Officer
Enable Injections



Andres McAllister, MD, PhD

CMO
BioInvent



Denise Reinke, MBA

Co-Chair, Sarcoma Patient
Advocate Global Network

Today's definition of neglected cancers

Factors that support our definition



Cancers with little to no government investment or funding

Most Underfunded: Uterine/endometrial, cervical, liver, bile duct, and pancreatic cancers are consistently ranked at the bottom for nonprofit and federal funding in the US.



Cancers that have had little change to SOC over the past 5-10 years

Glioblastoma (GBM): has seen minimal improvements in treatment, with few new drugs showing lasting efficacy in clinical trials, primarily due to the blood-brain barrier.

Pancreatic Cancer: progress in treatment has been minimal compared to other cancers, often due to late diagnosis and high resistance to conventional therapies.



Cancers that are highly complex / have many subtypes and treatment approaches

Sarcomas are over 100 subtypes with very different cancer biology.

Other factors impacting research

Current clinical trials in rare vs neglected tumors



Late Detection

Certain cancers; liver, pancreatic and mesothelioma often show symptoms only when they are significantly progressed.



Tumor Resistance

Many tumors, such as triple-negative breast cancer, have developed high resistance to traditional chemotherapy and even new targeted drugs.

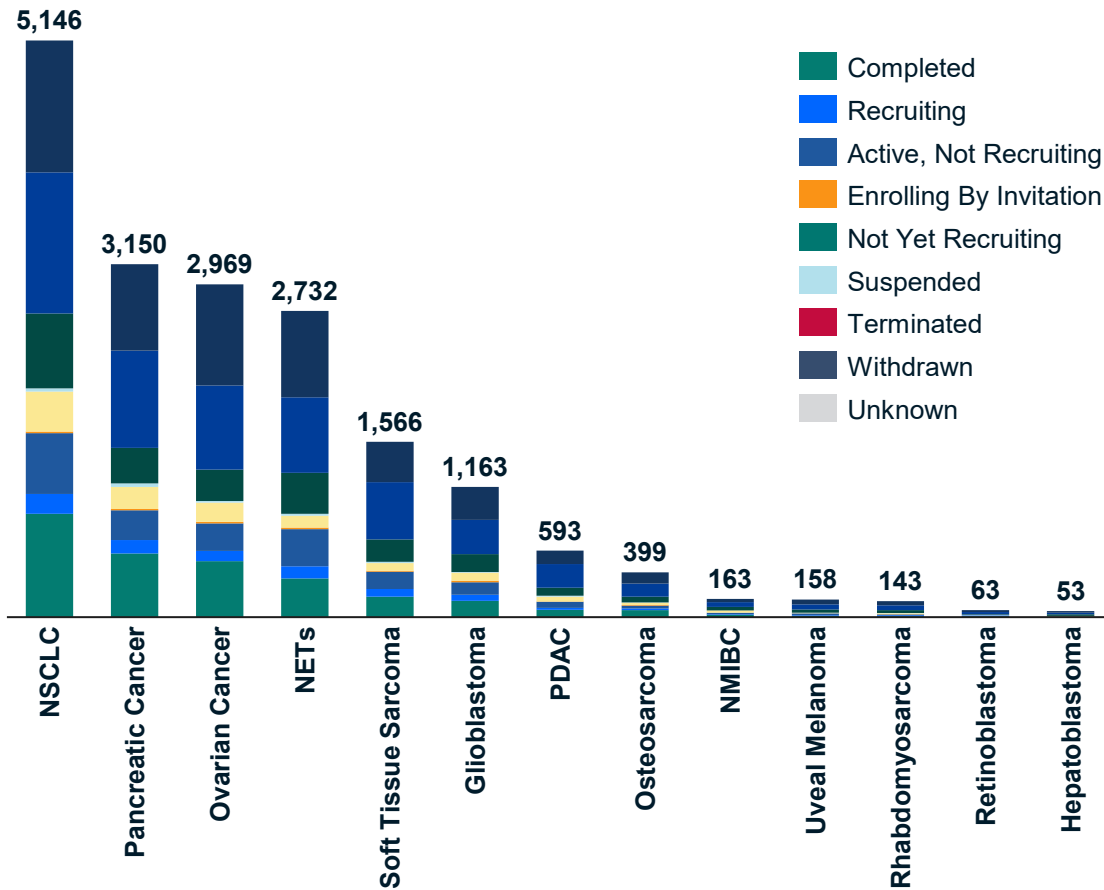


Biological Barriers

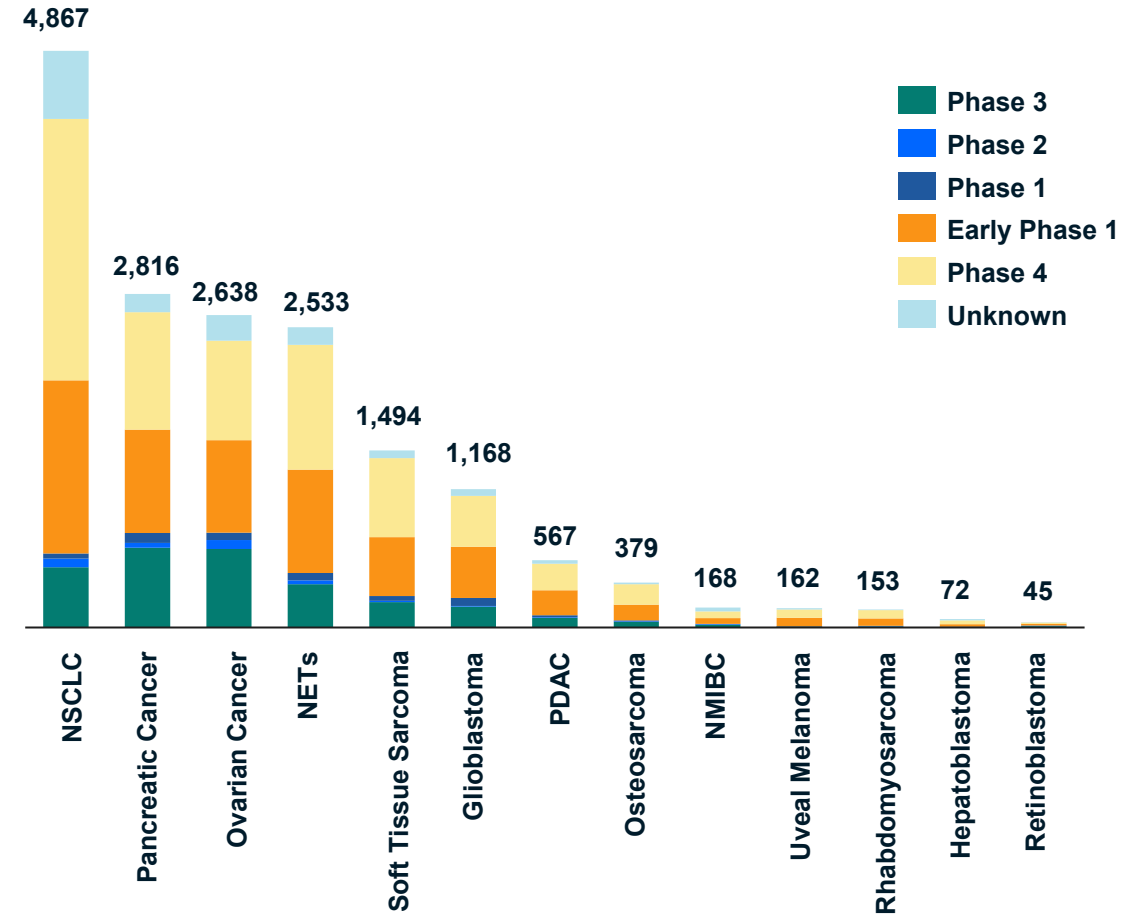
In brain cancers like glioblastoma, the blood-brain barrier effectively blocks many new treatments from reaching the tumor.

Selected Rare and/or Neglected Cancers: Clinical Trials Analytics

Rare and/or Neglected Cancers: Registered Trials Count (2015 – Present)²

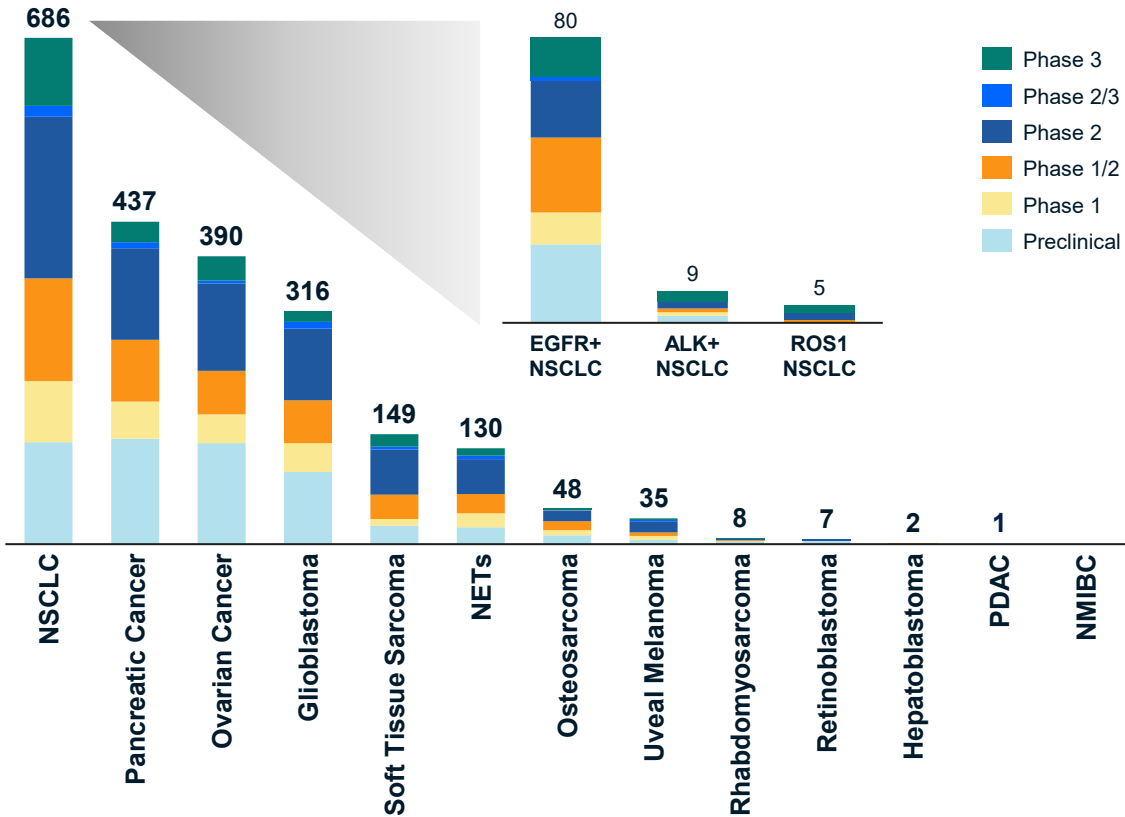


Rare and/or Neglected Cancers: Study Phase (2015 – Present)²

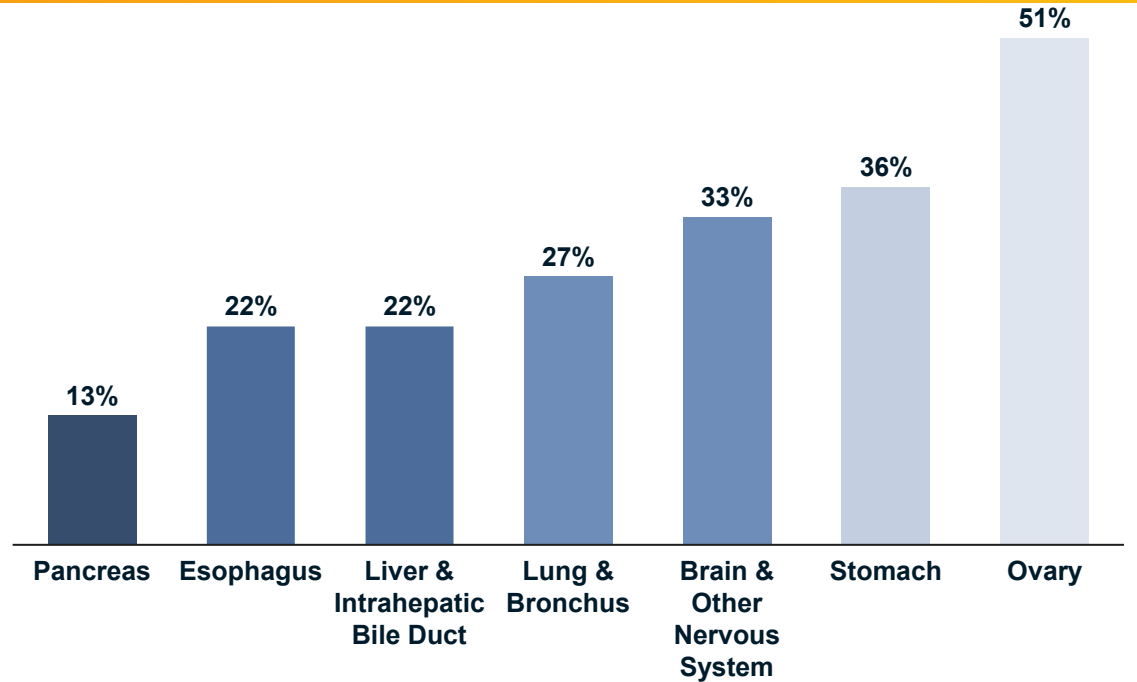


Selected Rare and/or Neglected Cancers: Pipeline Analytics & Survival Rates

Rare and/or Neglected Cancers: Assets In Development Count by Phase (WW)²



Deadliest Cancer Sites: 5-year Relative Survival Rates (%), US, 2014 - 2020^{3,4}



Rates are age adjusted for normal life expectancy and based on cases diagnosed in the SEER 22 areas, excluding Illinois and Massachusetts, for 2014-2020; all cases were followed through 2021; the standard of error is between 5 and 10 percentage points

*Assets development was not reported for NMIBC within the database



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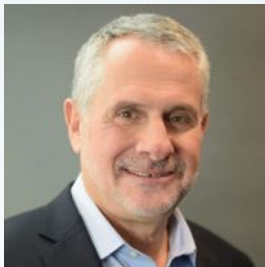
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Ed Saltzman

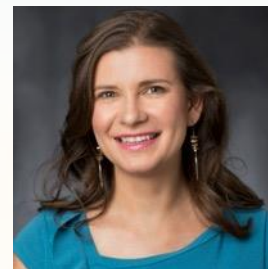
Senior Strategic Advisor
Lumantia

MODERATOR



Kapil Dhingra

Managing Member
KAPital Consulting LLC



Daina Graybosch, PhD

Sr. Managing Director, Biotech
Analyst, immuno-Oncology
Leerink Partners



Axel Hoos, MD, PhD

CEO & Founder
Stealth Biotech



Meredith Sondler-Bazar

Managing Director, Healthcare
Investment Banking Ladenburg
Thalman & Co.



Maren Winnick, MBA

Senior Managing Director
Evercore

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Dennis Chang, PhD

SVP, Strategy Consulting
Lumantity

MODERATOR



Joe Guidi, PhD

VP, Worldwide Head of
Immunology, Medical Affairs
Bristol Myers Squibb



Axel Hoos, MD, PhD

CEO & Founder
Stealth Biotech



Zhen Su, MD MBA

CEO
Marengo Therapeutics

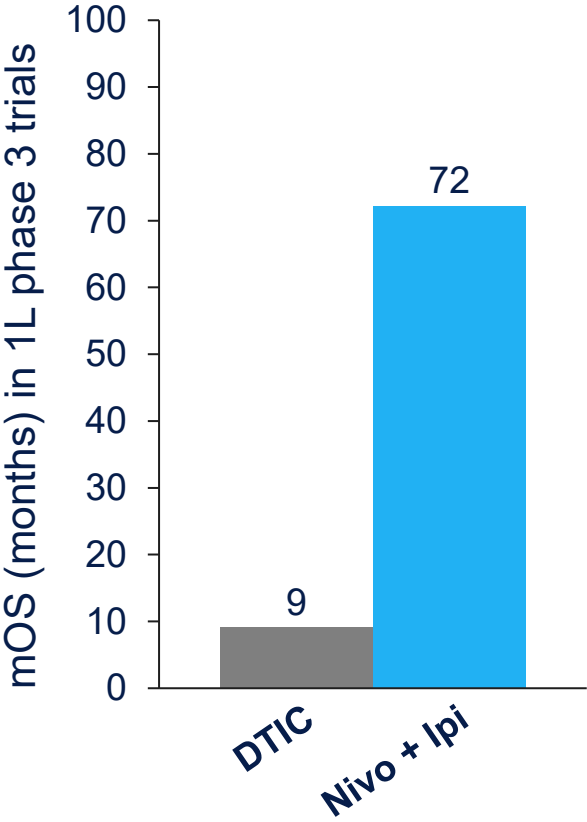


Alicia Zhou, PhD

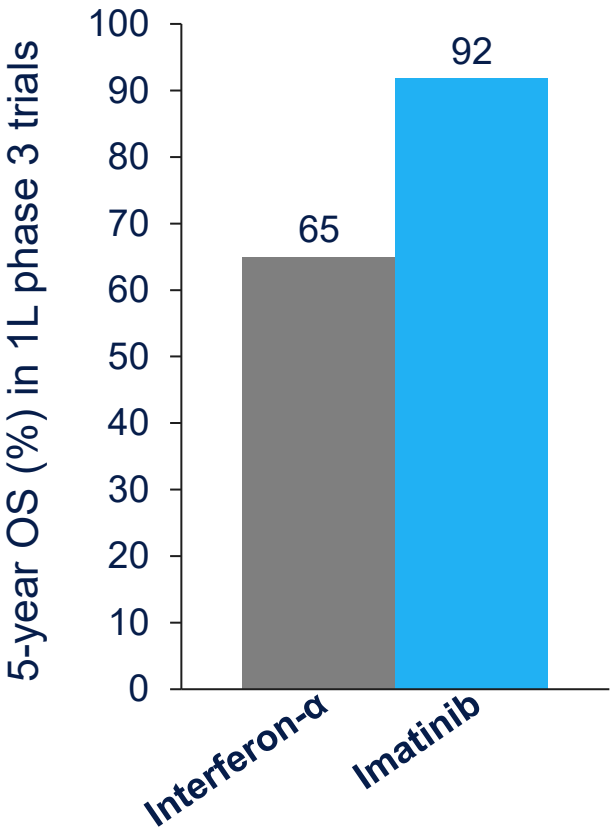
CEO
Cancer Research Institute

Examples of Past Breakthroughs

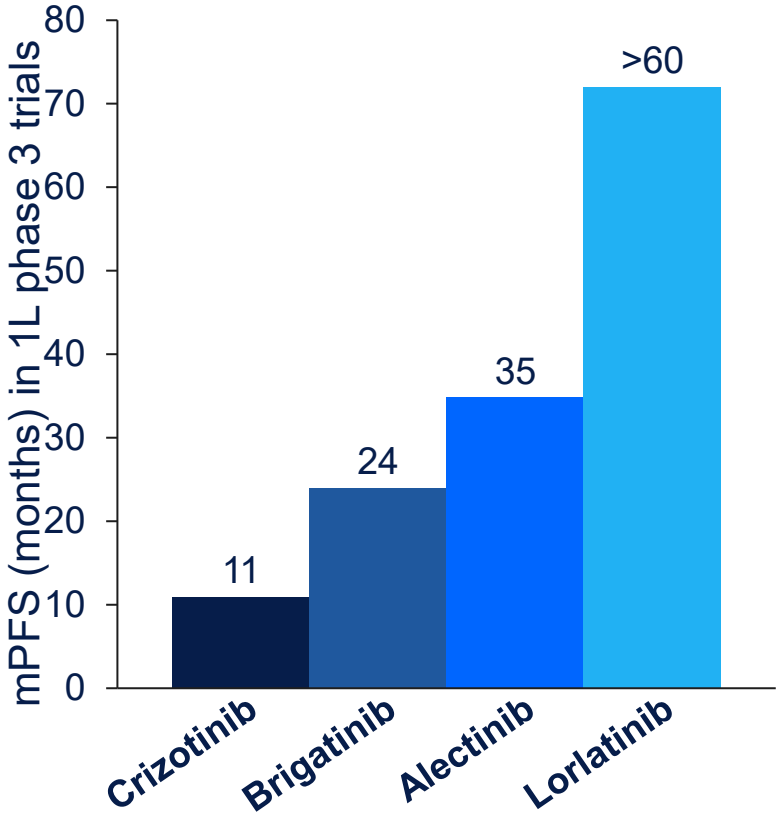
Immunotherapy for Melanoma



Tyrosine Kinase Inhibition for CML

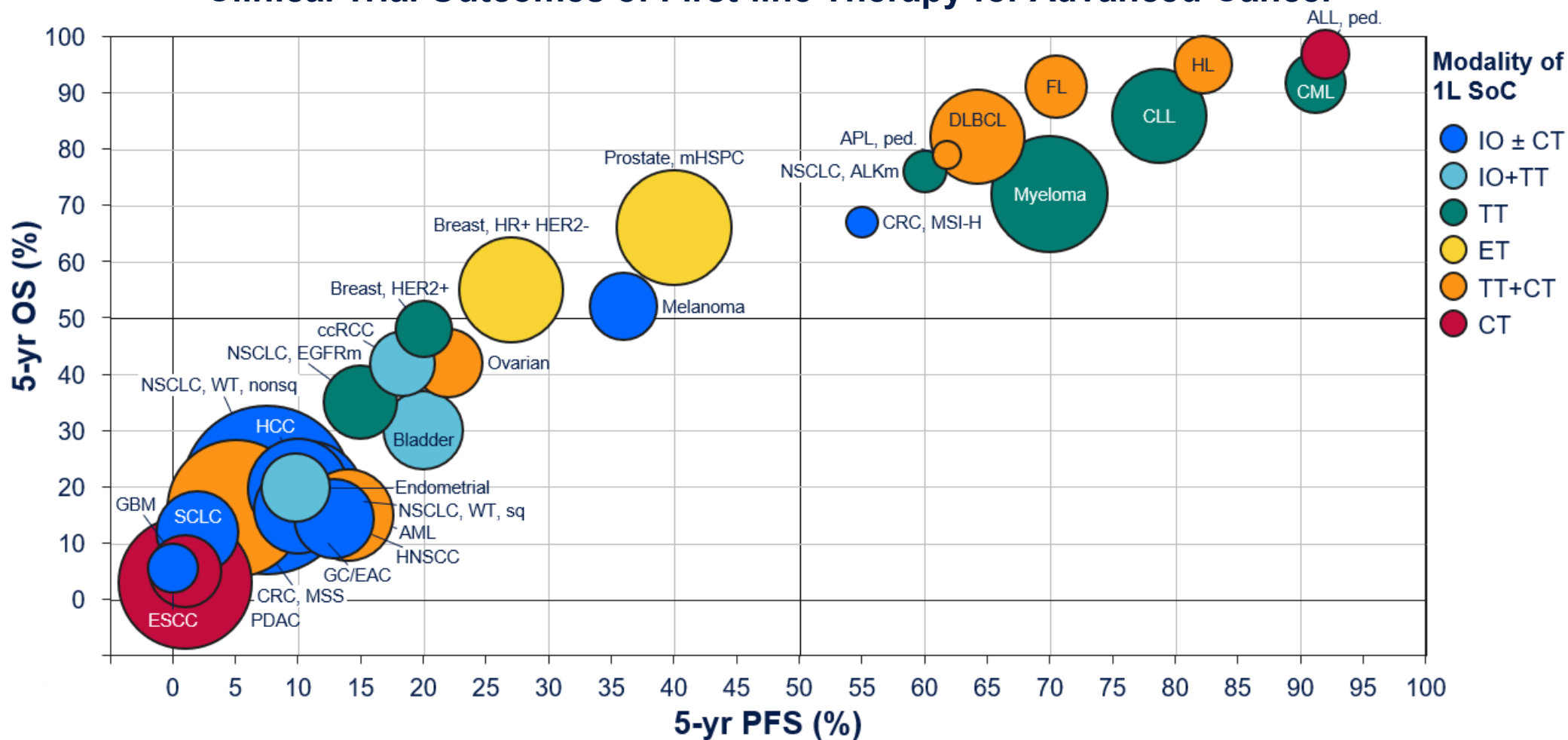


Tyrosine Kinase Inhibition for ALK-fusion NSCLC

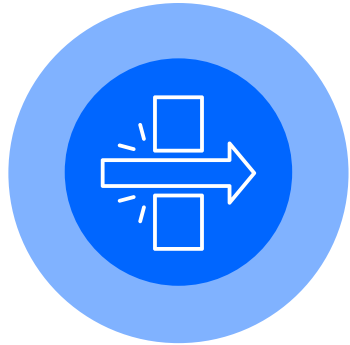


The Need for More Breakthroughs

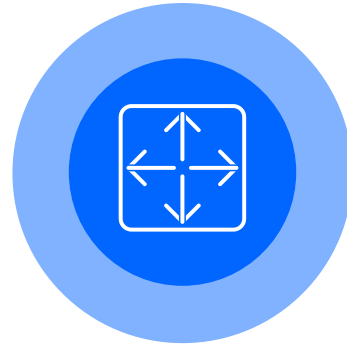
Clinical Trial Outcomes of First-line Therapy for Advanced Cancer



Lessons from Past Successes & Failures



**Breakthroughs
are possible**



**Not
one-size-fits-all**



**Must fit the biology
of the disease**



**But: the biology is
complex, heterogeneous,
and incompletely
understood**

How should we engineer future breakthroughs?

Spaghetti Against the Wall



Incentives & Disincentives for Transformational Therapies



Disincentives

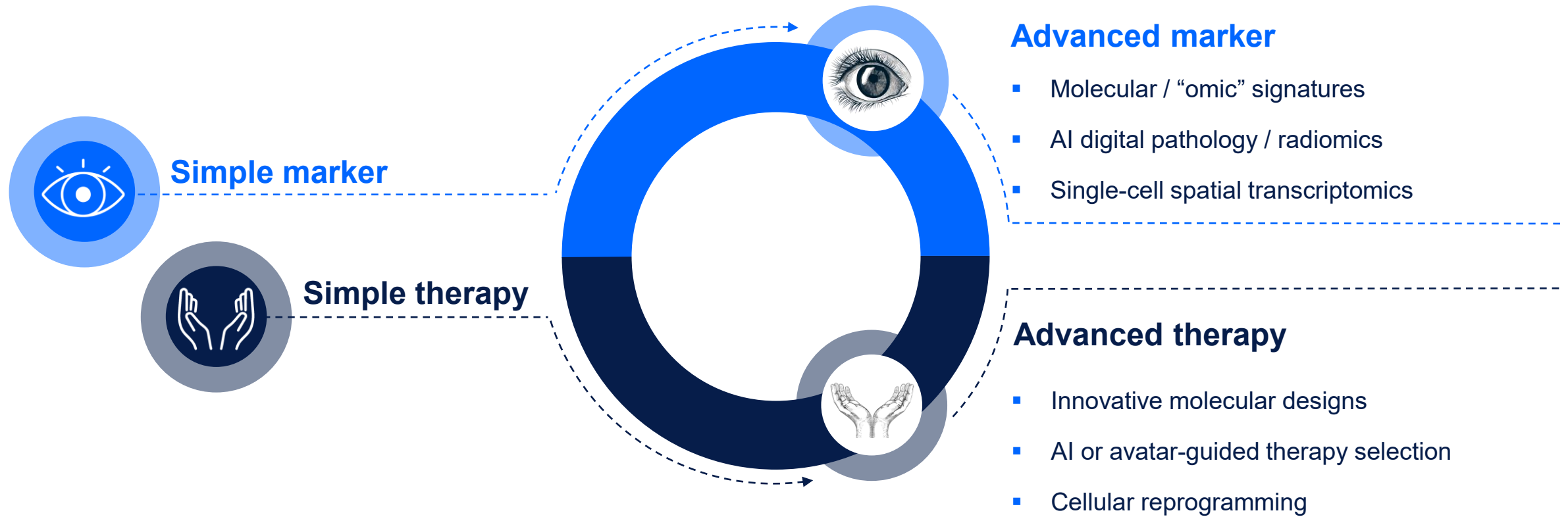
- **Technical risk** for new targets / modalities
- **FOMO**
- **Challenging economics** for disruptive paradigms e.g. one-time treatment
- **Prioritization of large markets** where even incremental benefit is valuable and transformation is more difficult
- **Costs of development path innovation**
- **Early incentives to advance weak signals**



Incentives

- **First-mover advantage**
- **Differentiated narrative** for investors, partners, investigators, patients
- **Potentially long duration of therapy**
- **Health economics** of transformational benefit

The Future of Precision Oncology



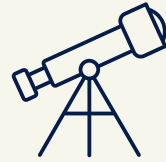
Roles for AI in Transforming Cancer Therapy



Make possible what was once impossible

Examples

- In silico biological modeling
- Virtual target / drug screening
- Virtual clinical trials



Gain more insight from existing data

- AlphaFold / structural biology
- Biomarker discovery
- Digital twin-based control arms
- Drug repurposing



Do what we already do, but do it faster

- Lead optimization
- Manufacturing automation
- Regulatory submissions
- Pharmacovigilance

What Therapeutic Concepts Should We Prioritize?



“Cutting the fuel lines”

- Inhibiting oncogenic driver / “addiction” pathways
- E.g. ALK, EGFR, HER2



“Guided missiles”

- Using cancer cell markers to direct cytotoxic agents
- E.g. ADCs, TCEs



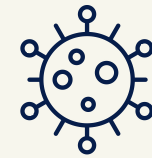
“Kryptonite”

- Exploiting “synthetic lethal” vulnerabilities specific to cancer cells
- E.g. PARPi



“Early interception”

- Preventing emergence of metastatic disease
- E.g. targeting carcinogenesis, cancer evolution

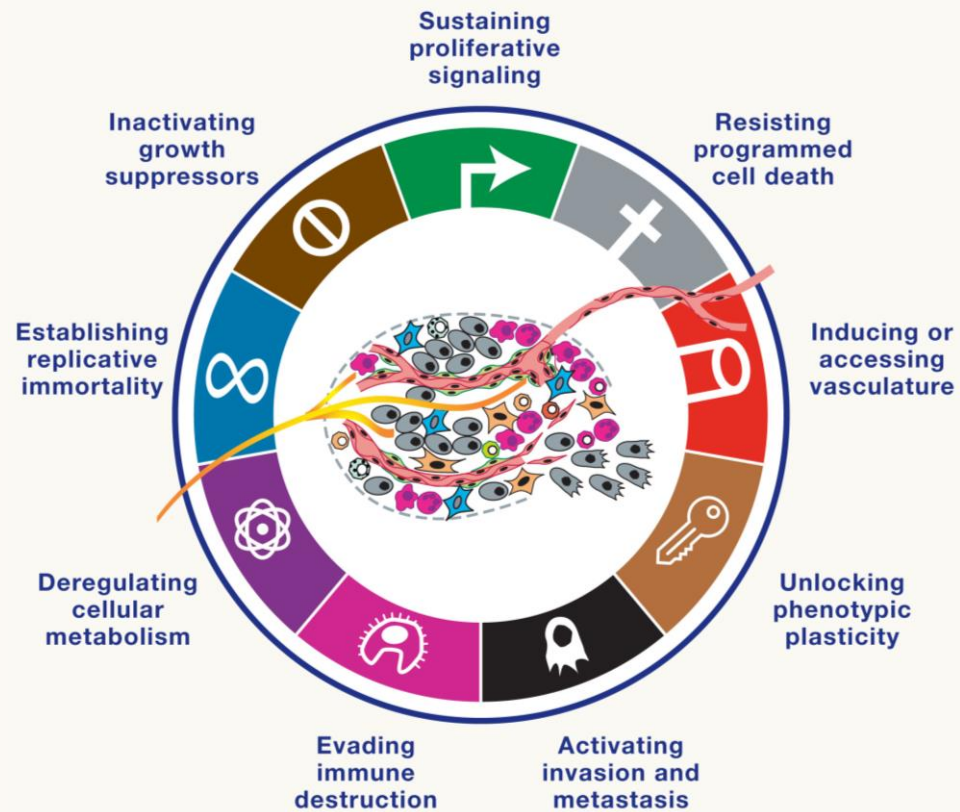


“Reprogramming”

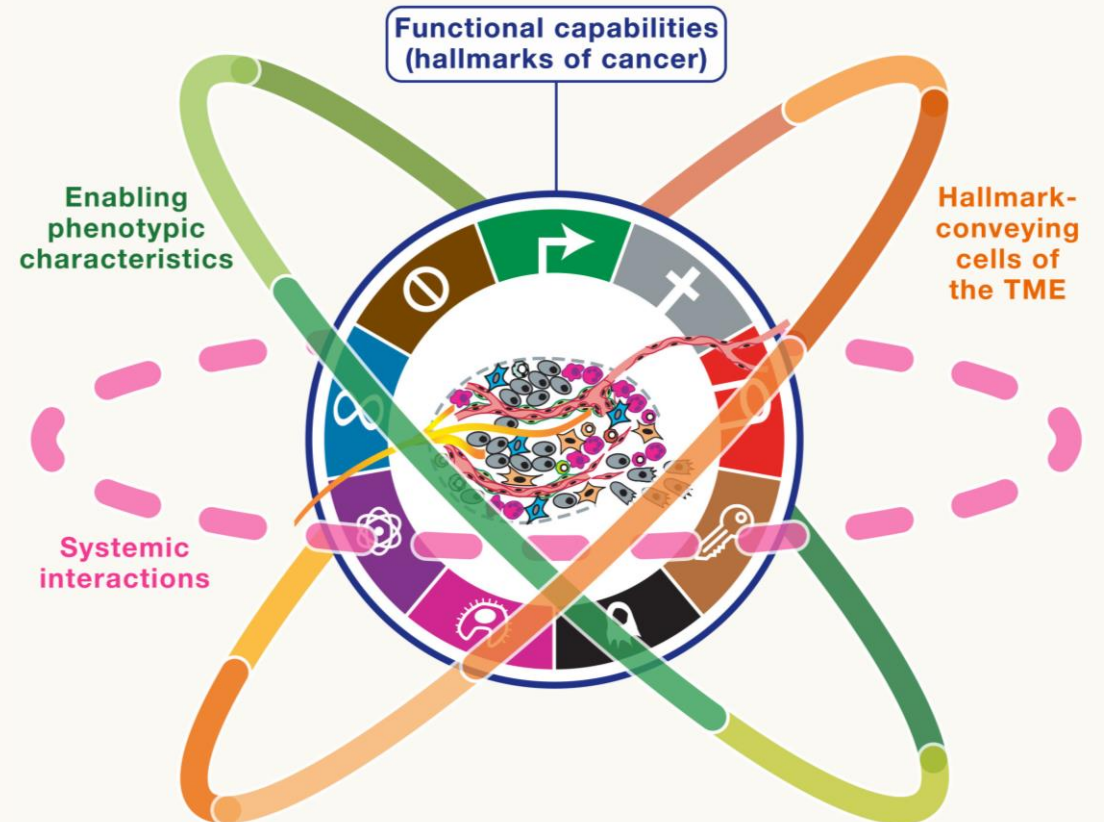
- Converting cancer into a nonlethal entity
- E.g. via gene therapy

What Cancer Biology Should We Target?

Functional Capabilities (hallmarks of cancer)



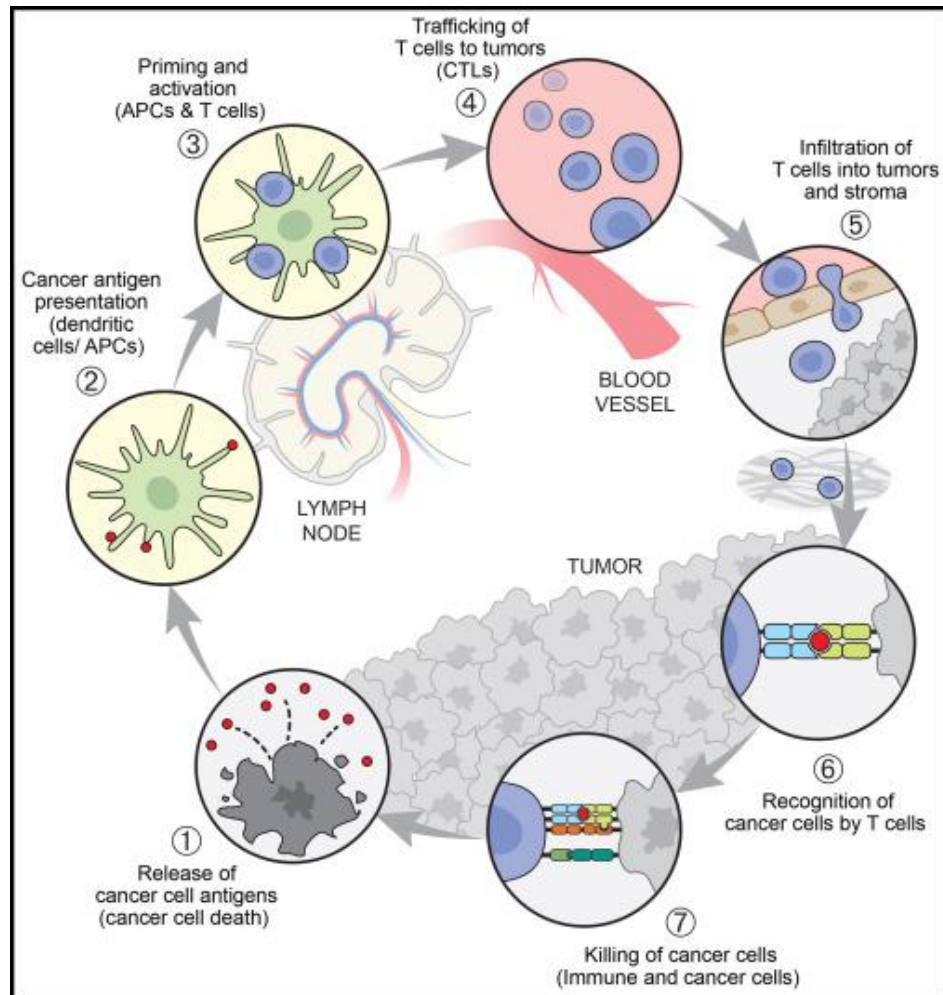
Dimensions of Cancer



Immune Cell Targets (Non-exhaustive)

Category	Approved	Active Ph 3 Programs	Failed Programs		
T cell inhibitory checkpoint inhibitors	<ul style="list-style-type: none"> PD1 / PD-L1 CTLA4 LAG3 	<ul style="list-style-type: none"> PD-(L)1 × VEGF (multiple) PD-(L)1 × CTLA4 (multiple) PD1 × TIGIT (rilvegostomig) 	<ul style="list-style-type: none"> A2A CD38/CD73 CD96 	<ul style="list-style-type: none"> Glutaminase IDO PVRIG 	<ul style="list-style-type: none"> TIGIT TIM3 VISTA
T cell receptor agonists		<ul style="list-style-type: none"> CD40 (mitazalimab) OX40 (INBRX-106) 	<ul style="list-style-type: none"> 4-1BB CD27 CD40 	<ul style="list-style-type: none"> GITR ICOS OX40 	
T-reg inhibitors/depleters		<ul style="list-style-type: none"> CCR8 (multiple) 	<ul style="list-style-type: none"> CCR4 CD25 	<ul style="list-style-type: none"> Helios NRP1 	<ul style="list-style-type: none"> TIGIT
Pathogen-associated molecular pattern (PAMP) agonists	<ul style="list-style-type: none"> TLR7/8 for BCC 		<ul style="list-style-type: none"> RIG-I STING TLR2/6 	<ul style="list-style-type: none"> TLR4 TLR5 TLR9 	
Myeloid cell modulators	<ul style="list-style-type: none"> CSF1R for TGCT 	<ul style="list-style-type: none"> CD47/SIRPα (multiple) 	<ul style="list-style-type: none"> AXL CCR2/CCL2 CD47/SIRPα 	<ul style="list-style-type: none"> CSF1 Siglec-15 TREM2 	
Cytokine inhibitors		<ul style="list-style-type: none"> PD1 × TGF-β (INCA33890) 	<ul style="list-style-type: none"> IL-1β IL-10 	<ul style="list-style-type: none"> TGF-β 	
Cytokine agonists	<ul style="list-style-type: none"> IL-2 IFN-α IFN-β IL-15 for NMIBC 	<ul style="list-style-type: none"> PD1 × IL-2 (IBI-363) L19-IL-2 (Nidlegly) L19-TNF (Fibromun) IL-12 (TheraPlas) 	<ul style="list-style-type: none"> IL-2 IL-12 	<ul style="list-style-type: none"> IL-15 	

What Immune Biology Should We Target?



- **Direct anti-cancer immunity**
 - T cell engagers
 - Ex vivo T cell therapies: CAR-T, TCR-T, TILs
 - In vivo CAR-T
 - Non-T-cell ACT: CAR-M, CAR-NK, etc.
- **Effector T cell enhancement**
 - Next-gen checkpoint blockade
 - Next-gen TCR agonists
- **TME modification / reprogramming**
 - Treg inhibition/depletion
 - Myeloid cell reprogramming
 - Next-gen cytokines
 - Oncolytic viruses
 - Immune payloads on ADCs
- **Host immunity alteration**
 - Vaccines: mRNA, peptide, DC, etc.
 - Microbiome modification

Final Thoughts?



NOW | 5:00 PM – 5:30 PM

Closing Remarks

NEXT | 6:00 PM – 8:00 PM

Reception and Networking

8:15 AM – 9:00 AM

Registration and Morning Networking

9:00 AM – 9:15 AM

Opening Remarks

9:15 AM – 10:35 AM

Patient-Centric Innovations: Transforming Cancer Care

10:35 AM – 10:50 AM

Coffee Break

10:50 AM – 12:10 PM

Driving First & Best-in-Class Innovation: Balancing Technical and Commercial Risk Early in Oncology

12:10 PM – 1:15 PM

Lunch and Networking

1:15 PM – 2:35 PM

Beyond the Mainstream: Addressing Neglected Tumor Types

2:35 PM – 3:55 PM

Raising the Bar: How Biotech Can Meet the Challenge

3:55 PM – 4:10 PM

Coffee Break

4:10 PM – 5:30 PM

Beyond “Next-gen”: How Should We Engineer Future Breakthroughs

5:00 PM – 5:30 PM

Closing Remarks

6:00 PM – 8:00 PM

Reception and Networking

NOW | 5:00 PM – 5:30 PM

Closing Remarks



Yung S. Lie, PhD

President and CEO
Damon Runyon Cancer Research Foundation



Jeffrey Bockman, PhD

EVP, Oncology
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NOW | 6:00 PM – 8:00 PM

Reception and Networking

Jimmy SOHO, 15 Thompson St, New York, NY 10013

