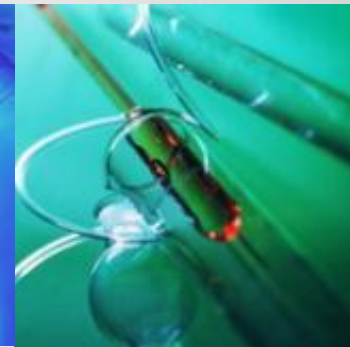




Puma Biotechnology

Corporate Presentation

September 2026



Forward-Looking Safe-Harbor Statement

This presentation contains forward-looking statements, including statements regarding commercialization of NERLYNX® and the potential indications and development of our drug candidates. All forward-looking statements involve risks and uncertainties that could cause our actual results to differ materially from the anticipated results and expectations expressed in these forward-looking statements. These statements are based on our current expectations, forecasts and assumptions, and actual outcomes and results could differ materially from these statements due to a number of factors, which include, but are not limited to, any adverse impact on our business or the global economy and financial markets, generally, and the risk factors disclosed in our periodic and current reports filed with the Securities and Exchange Commission from time to time, including our Annual Report on Form 10-K for the year ended December 31, 2025, and subsequent filings. Readers are cautioned not to place undue reliance on these forward-looking statements, which speak only as of the date hereof. We assume no obligation to update these forward-looking statements except as required by law.



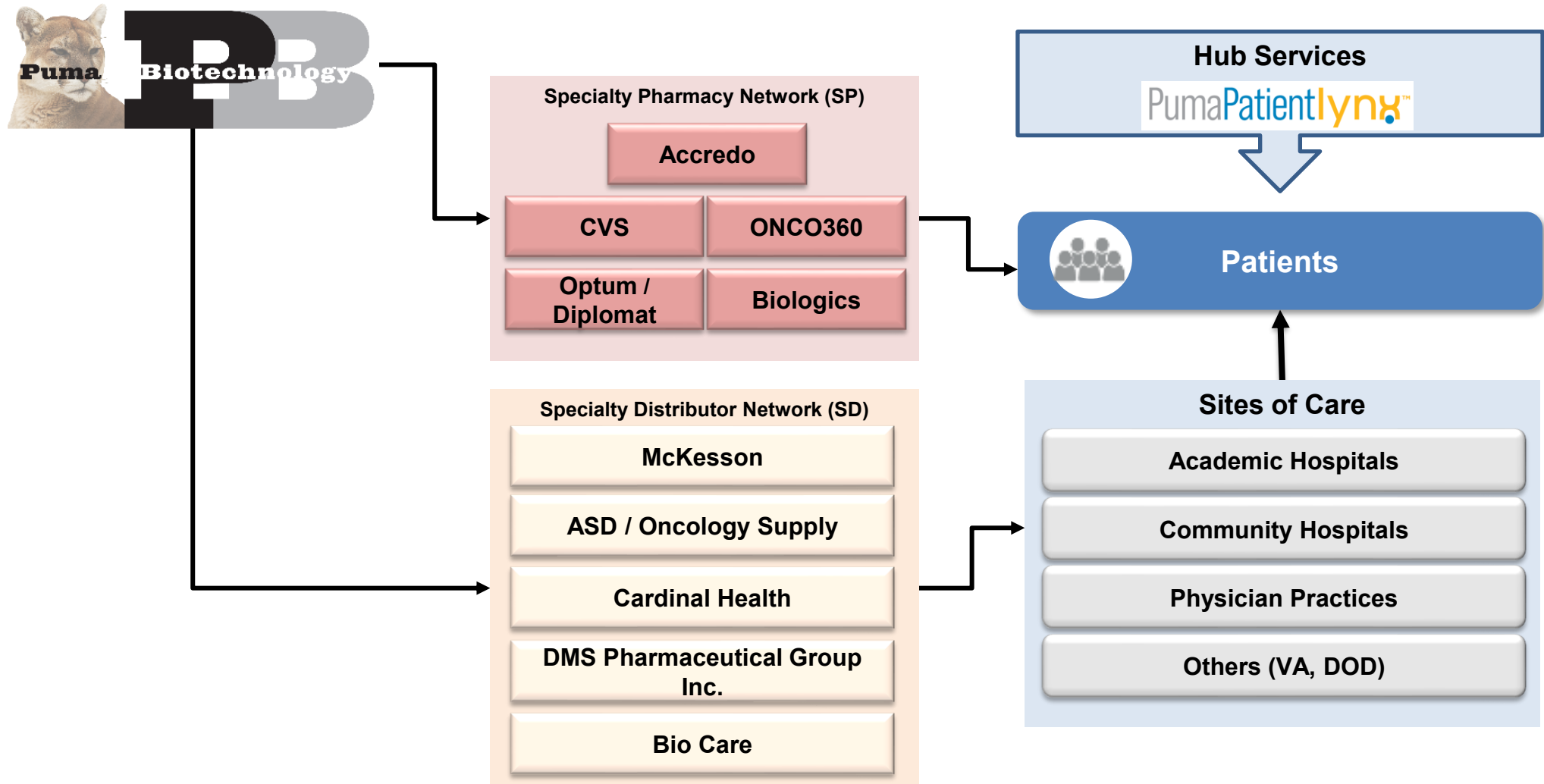
Product Pipeline

	Phase I	Phase II	Phase III	Registration	Approval
<u>Neratinib: Tyrosine kinase inhibitor</u>					
HER2+ Breast Cancer	ExteNET (Phase III HER2+ EBC*)				
Extended adjuvant <i>Neratinib monotherapy</i>	CONTROL				
Metastatic <i>Monotherapy or combo therapy</i>	NALA (Phase III 3rd Line HER2+ MBC**)				
Metastatic HER2 amplified/mutated <i>Combo with trastuzumab deruxtecan</i>	NCT05372614				
<u>Alisertib: Aurora kinase A inhibitor</u>					
HRc+*** HER2-negative MBC	ALISCA[®]-Breast1 (alisertib+endocrine)				
Small cell lung cancer	ALISCA[®]-Lung1 (PUMA-ALI-4201)				

*

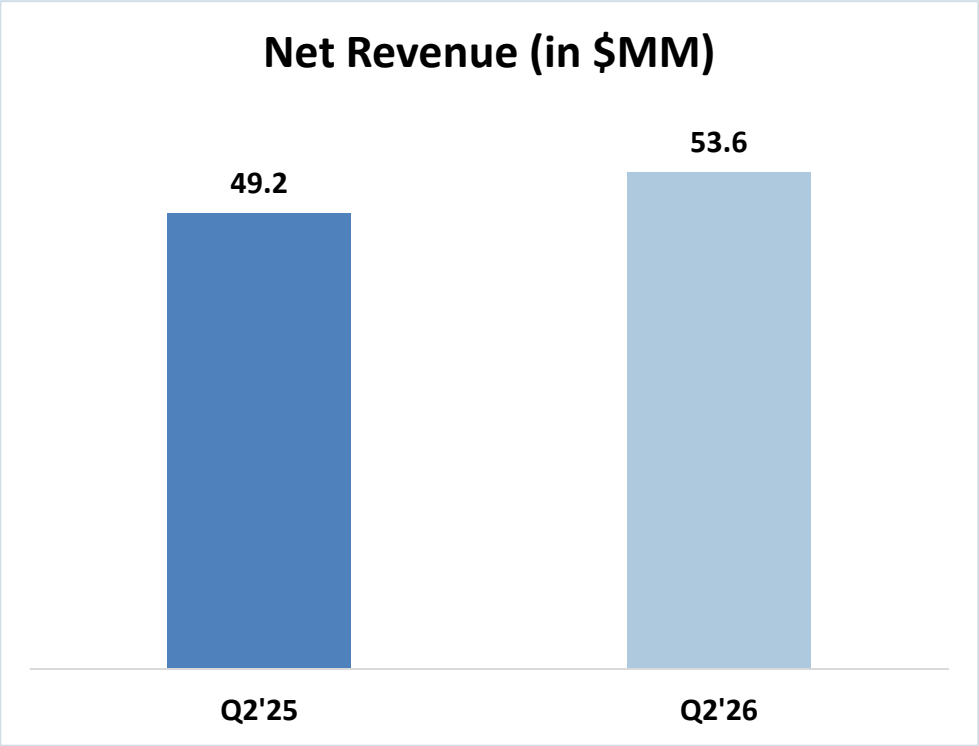
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Puma's Pharmacy and Distributor Network



\$53.6 Million Net NERLYNX Revenue in Q2'26

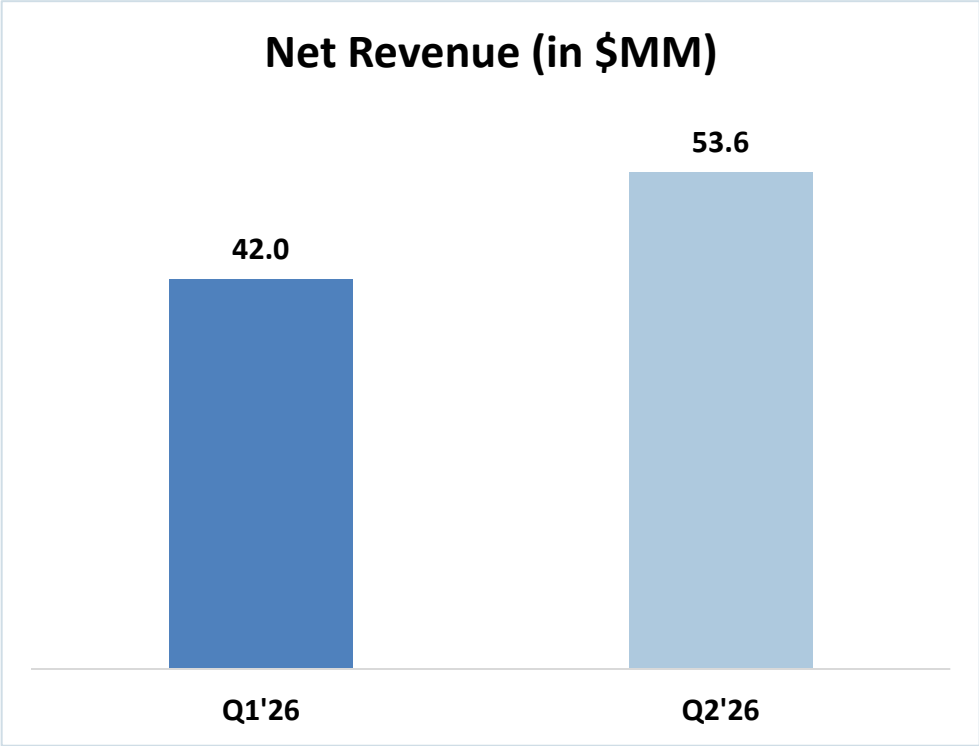
~9% increase in Q2'26 compared to Q2'25



Inventory Change (\$)

Q2'25	Q2'26
-\$1.3 mil	-\$1 mil

~28% increase in Q2'26 compared to Q1'26

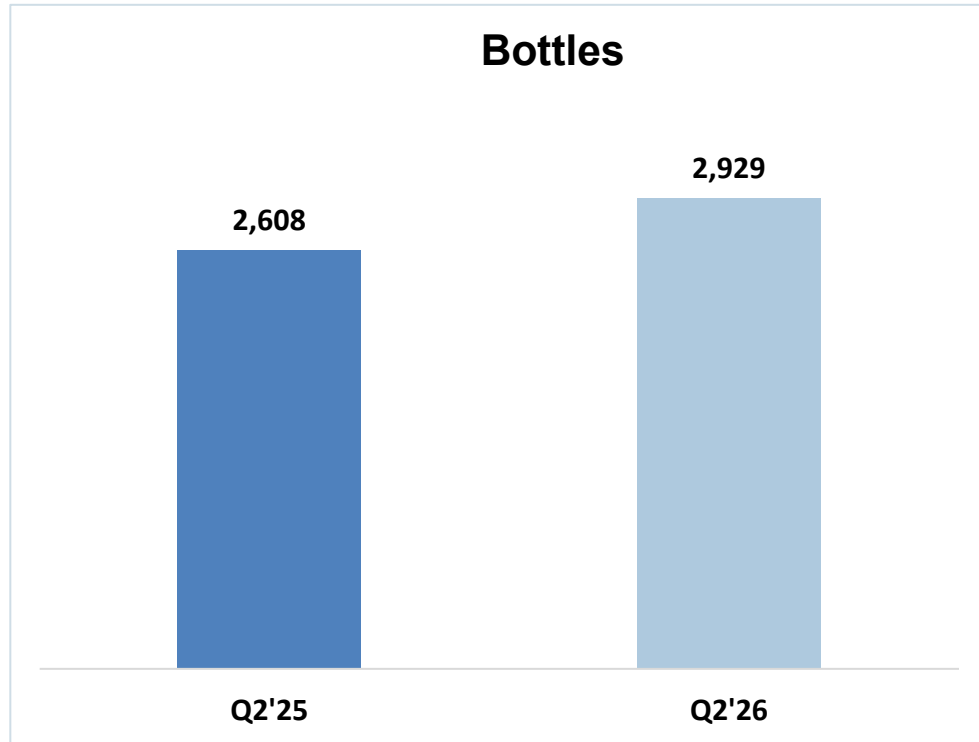


Inventory Change (\$)

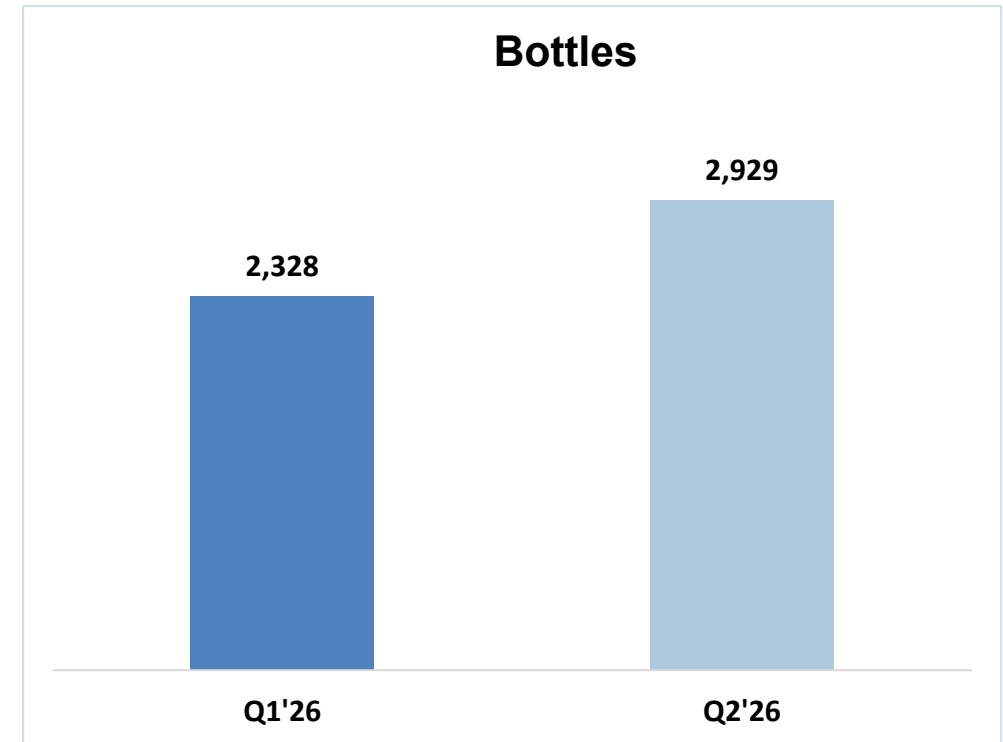
Q1'26	Q2'26
-\$7.9 mil	-\$1 mil

2,929 Ex-Factory Bottles Were Sold in Q2'26

~12% increase in Q2'26 compared to Q2'25

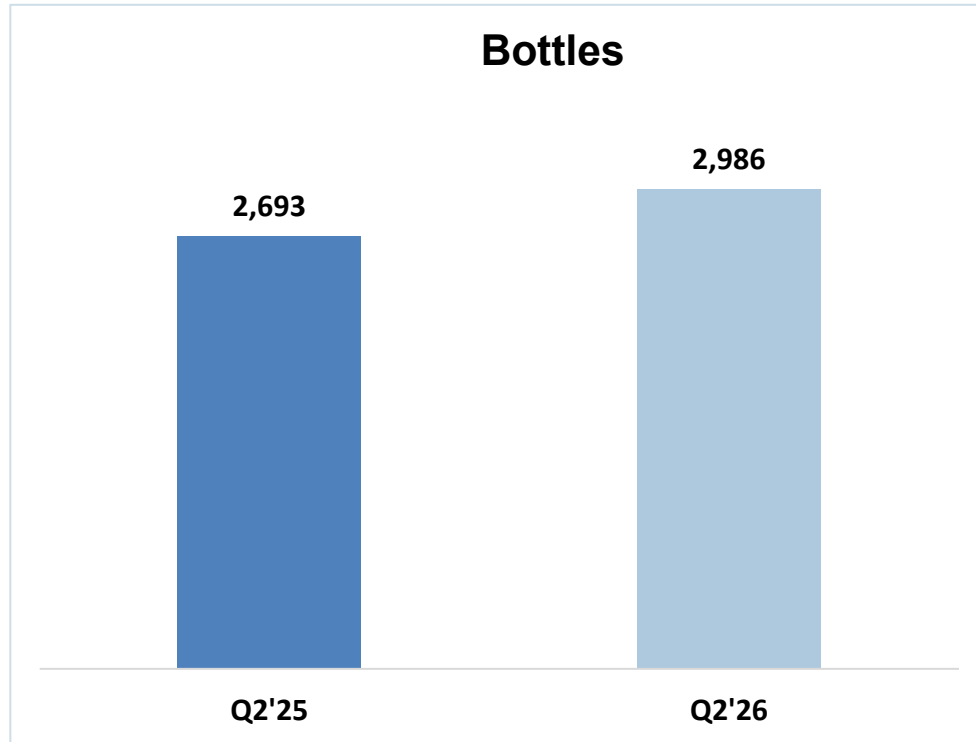


~26% increase in Q2'26 compared to Q1'26

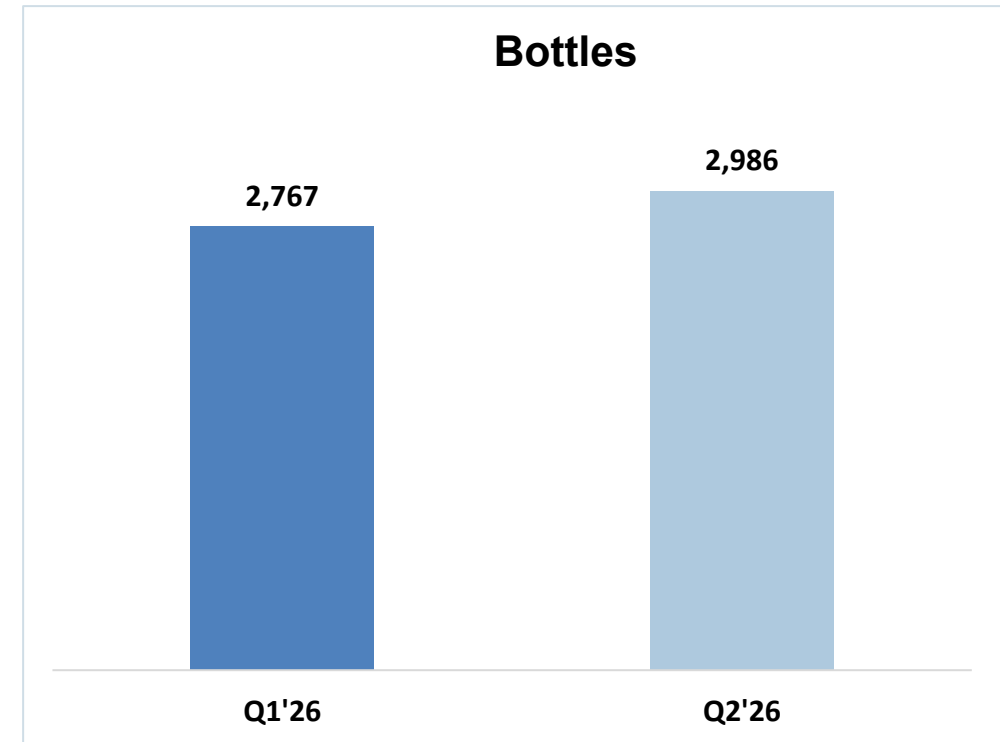


2,986 bottles of U.S. Commercial Demand in Q2'26

~11% increase in Q2'26 compared to Q2'25



~8% increase in Q2'26 compared to Q1'26



Rest of World Partnerships – Timelines

Region	Partner	Regulatory Approvals	Commercial Launches
Australia / SE Asia		• 2019 – Ext. Adj. in Australia, Singapore • 2020 – Ext. Adj. in Brunei, Malaysia, New Zealand • 2022 – Ext. Adj. in the Philippines; mBC in Singapore • 2023 – mBC in Malaysia • 2024 – Ext. Adj. and mBC in Thailand	• 2020 – Singapore • 2021 – Malaysia, Brunei, New Zealand • Q1 2026 - Thailand
Israel		• 2020 – Approved in Ext. Adj. and mBC	• 2020 – Launched
Canada		• 2019 – Ext. Adj. approved • 2021 – mBC approved	• 2020 – Launched
Latin America		• 2019 – Ext Adj in Argentina • 2020 – Ext. Adj in Chile, Ecuador; mBC in Argentina • 2021 – Ext Adj. and mBC in Peru; mBC in Chile; Ext. Adj. in Brazil • 2022 – Ext. Adj. in Mexico; mBC in Ecuador • 2023 – mBC in Colombia and Mexico • 2024 – mBC in Brazil	• 2020 – Argentina • 2021 – Chile and Peru • 2022 – Brazil • 2023 – Mexico and Colombia
Europe Greater China Middle East North and West Africa South Africa Turkey		• 2019 – Ext. Adj. EMA and Hong Kong • 2020 – Ext. Adj. in China, Taiwan • 2021 – mBC in Taiwan • 2023 – Ext. Adj. in Morocco, South Africa, and UAE • 2024 – Ext. Adj. in Syria, Saudi Arabia, Algeria, Turkey • 2025 – Ext. Adj. in Lebanon	• 2019 – Germany, UK, Austria • 2020 – Sweden, Finland, Scotland, Switzerland, Denmark, HK • 2021 – China, Taiwan, Greece, Czech Republic, Luxembourg • 2022 – Ireland, Spain • 2023 – Slovakia • 2024 – Morocco, South Africa, UAE, Turkey, Saudi Arabia • 2025 – Libya, Algeria
South Korea		• 2021 – Ext. Adj. in S. Korea	• 2022 – Launched
Russia/CIS		• Distribution agreement executed	

NERLYNX[®] Extended Adjuvant HER2+ Breast Cancer Market Size

- Approximately 28,300 patients (US) with early stage HER2+ breast cancer treated with adjuvant treatment¹
- Approximately 6,000 patients (US) with HR positive early stage HER2+ breast cancer and no pathological complete response to neoadjuvant treatment (high risk disease)
- Approximately 37,000 patients (EU) with early stage HER2+ breast cancer treated with adjuvant treatment¹
 - Approximately 65–70% of patients have HR positive disease

¹Roche epidemiology slides 09/18

Puma Financial Guidance for Q3 and FY 2026

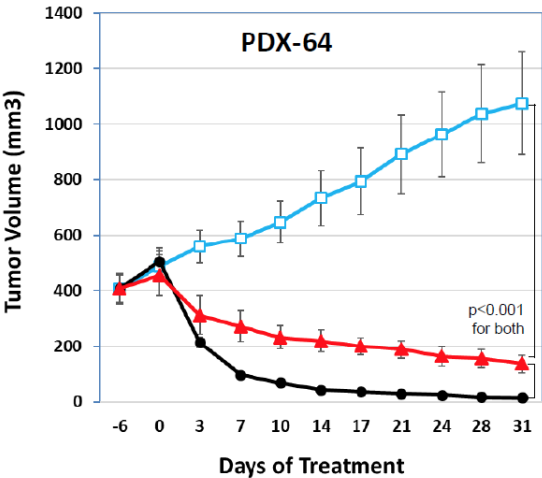
	<u>Q3 2026</u>	<u>(updated) Full Year 2026</u>	<u>(prior) Full Year 2026</u>
■ NERLYNX revenue guidance:	\$54–\$56 mil	\$205–\$209 mil	\$202–\$206 mil
■ NERLYNX royalty guidance:	\$2–\$3 mil	\$19–\$22 mil	\$20–\$23 mil
■ Total Revenue	\$56–\$59 mil	\$224–\$231 mil	\$222–\$229 mil
■ Net income*:	\$2–\$3.5 mil	\$17–\$20 mil	\$16–\$19 mil
■ Gross to net adjustment:	26%–27%	26.5%–27.5%	27.5%–28.5%

* The outlook above does not include any potential adjustments for tax valuation allowance

NCI ETCTN trial 10495 – Phase I safety study of Neratinib+T-DXd

Rationale

- 1. Neratinib enhances uptake of T-DXd.
- 2. Neratinib enhances the tumor regression from T-DXd in HER2 mutant breast cancer PDX's.



□ Vehicle
▲ T-DXd
● Neratinib + T-DXd

p < 0.001 for both comparisons.

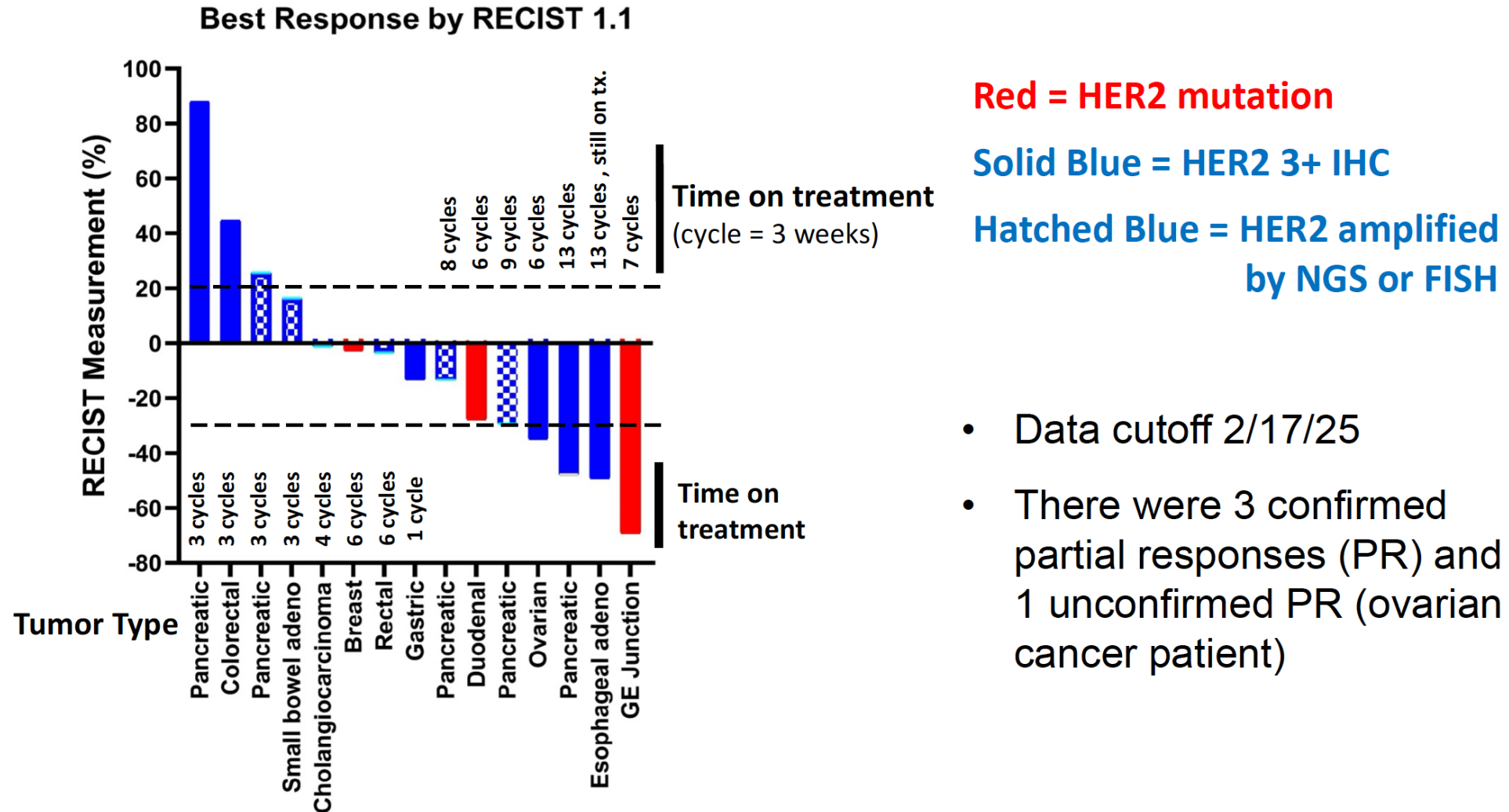
Dose escalation:

Dose Level	Neratinib	T-DXd
Level -1	120 mg PO, QD	5.4 mg/Kg, IV, q3 Week
Level 1*	120 mg PO, QD C1D1-7 160 mg, PO, QD C1D8 onward	5.4 mg/Kg, IV, q3 Week
Level 2	120 mg PO, QD C1D1-7 160 mg, PO, QD C1D8-14 200 mg, PO, QD C1D15 onward	5.4 mg/Kg, IV, q3 Week
Level 3	120 mg PO, QD C1D1-7 160 mg, PO, QD C1D8-14 240 mg, PO, QD C1D15 onward	5.4 mg/Kg, IV, q3 Week

Bose et al., SABCS 2020

Interim data reported H1 2025

Interim Data Presented at AACR 2025



- Data cutoff 2/17/25
- There were 3 confirmed partial responses (PR) and 1 unconfirmed PR (ovarian cancer patient)

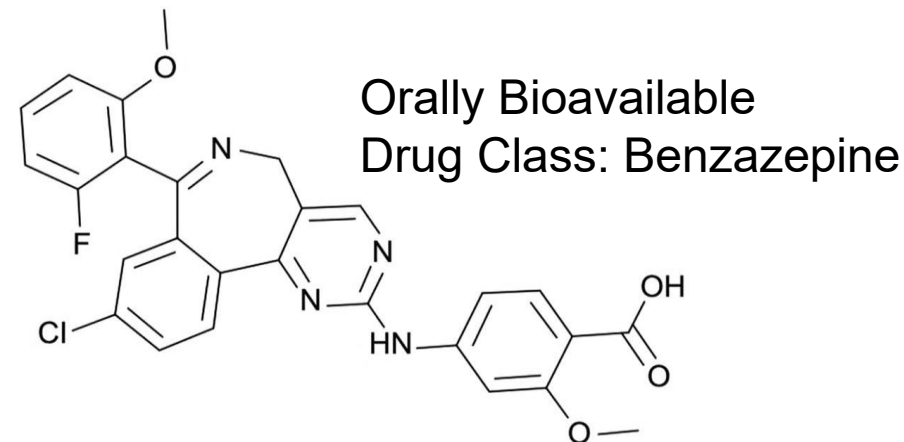
ALISERTIB

Breast Cancer and Small Cell Lung Cancer



Alisertib (MLN 8237)

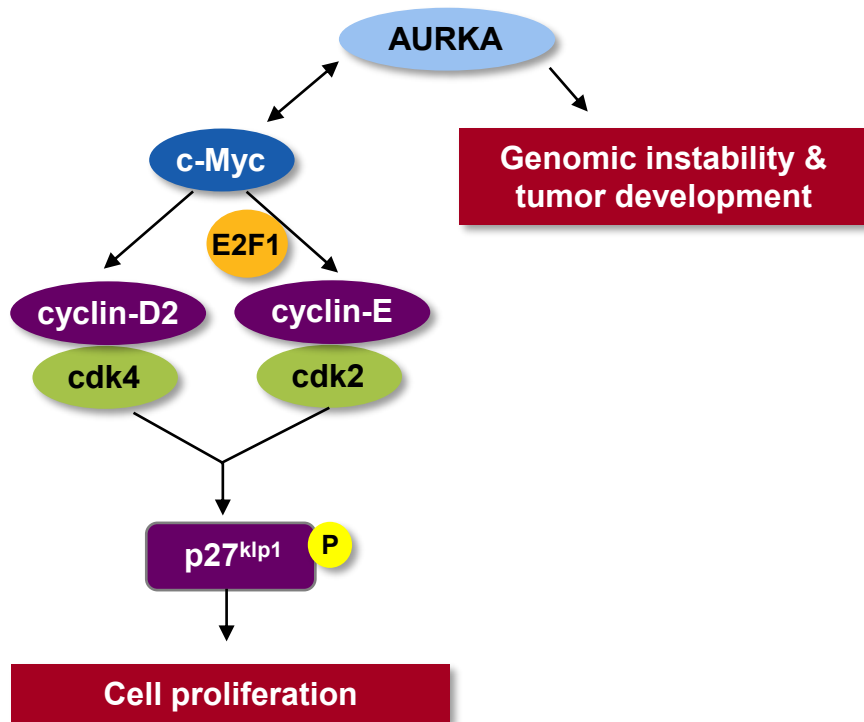
Aurora Kinase A
(AURKA) inhibitor



- Single-agent and combinational clinical activity in solid tumors including hormone receptor-positive breast cancer (HR+ MBC), triple negative breast cancer (TNBC), small cell lung cancer (SCLC), and head and neck cancer
- Single-agent clinical activity in hematologic malignancies including peripheral T-cell lymphoma (PTCL) and aggressive non-Hodgkin's lymphoma (NHL)
- Well-characterized safety profile: ~1,300 patients treated across 22 company-sponsored trials

AURKA and c-Myc Co-regulate Each Other

Nuclear AURKA exerts kinase-independent functions by acting as a transcription factor



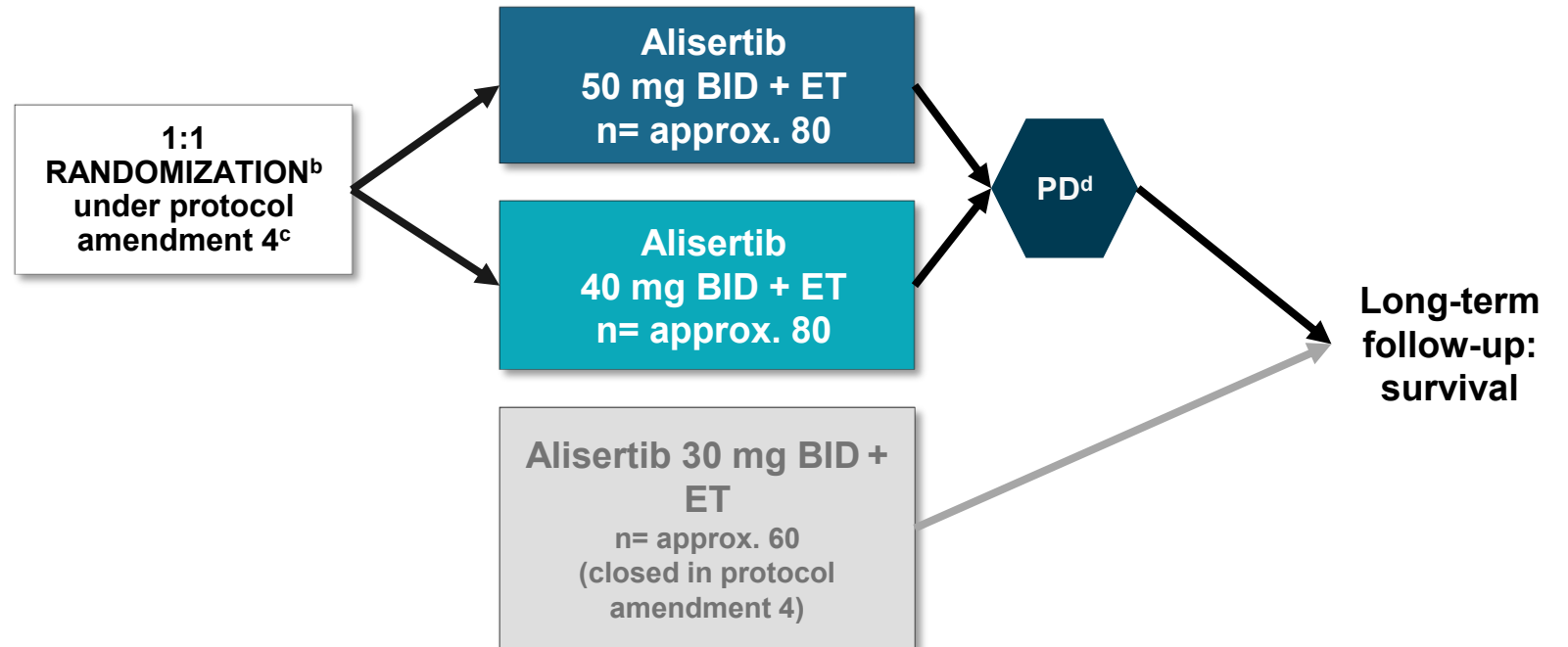
- AURKA and c-Myc transcriptionally upregulate each other, suggesting the existence of a positive feedback loop
- c-Myc upregulates Cyclin D2, CDK4, and cyclin-E, contributing to complex formation and subsequent phosphorylation of p27Kip1, which leads to cell proliferation

Clinical Development of Alisertib in Breast Cancer

ALISCA®-Breast1 (NCT06369285) Study Design^a

Patients with recurrent or metastatic HR+, HER2- breast cancer

- Progressed on/after ≥2 prior lines of ET, including CDK4/6i; recurrence during, or within 6 months of completing, adjuvant ET counts as 1 prior line
- No prior chemotherapy in the recurrent or metastatic setting
- Measurable disease per RECIST v1.1
- **Estimated enrollment N=225**



Alisertib BID orally on days 1–3, 8–10, and 15–17 of every 28-day cycle^e + investigator-selected ET (choice of anastrozole, exemestane, fulvestrant, letrozole, or tamoxifen not previously used^f)

^aThe ALISCA-Breast1 dose-optimization study design is current as of June 15, 2026 and was developed in agreement with the United States Food & Drugs Administration.

^bStratified by time to recurrence/progression after initiating CDK4/6i therapy in any setting (<12 months or ≥12 months) and presence of visceral disease (defined as liver, lung, brain, kidney, or adrenal metastasis: yes/no).

^c30 mg BID dose cohort closed to enrollment under protocol amendment 4.

^dOther reasons for discontinuation: unacceptable toxicity, withdrawal of consent, death.

^ePatients with grade 4 neutropenia (absolute neutrophil count <500/mm³) or any grade febrile neutropenia during previous treatments in metastatic setting must receive G-CSF after Day 17 dose of alisertib of each cycle (schedule and duration per institutional practice).

^fThe patient must not have received the selected ET in the recurrent or metastatic setting. The investigator may select an ET the patient received in the adjuvant setting if the patient did not have a recurrence while receiving the selected ET.

ALISCA®-Breast1 Summary of Prior Metastatic Anti-cancer Therapy

	50 mg BID (N=54)	40 mg BID (N=55)	30 mg BID (N=55)	Total (N=164)
Subjects with metastatic anti-cancer medication – n (%)	50 (92.6)	51 (92.7)	51 (92.7)	152 (92.7)
Prior metastatic endocrine – n (%)	50 (92.6)	51 (92.7)	51 (92.7)	152 (92.7)
Prior metastatic CDK4/6i – n (%)	47 (87.0)	50 (90.9)	51 (92.7)	148 (90.2)
Prior lines of treatment				
1	0	1 (1.8)	1 (1.8)	2 (1.2)
2	29 (53.7)	27 (49.1)	35 (63.6)	91 (55.5)
3	20 (37.0)	16 (29.1)	11 (20.0)	47 (28.7)
4	2 (3.7)	5 (9.1)	2 (3.6)	9 (5.5)
5	0	1 (1.8)	1 (1.8)	2 (1.2)
Missing	3 (5.6)	5 (9.1)	5 (9.1)	13 (7.9)

Alisertib Grades 3-4 TEAEs in Subjects with MBC

TBCRC041			ALISCA®Breast1 Alisertib + endocrine		
	Alisertib 50 mg BID (n=46) ¹	Alisertib + Fulvestrant 50 mg BID (n=45) ¹	50 mg BID (n=52) ²	40 mg BID (n=49) ²	30 mg BID (n=50) ²
Neutropenia	19 (41.3)	19 (42.2)	14 (26.9)	5 (10.2)	4 (8.0)
Anemia	8 (17.4)	4 (8.9)	2 (3.8)	0	1 (2.0)
Thrombocytopenia	3 (6.5)	2 (4.4)	1 (1.9)	1 (2.0)	1 (2.0)
Febrile neutropenia	1 (2.2)	2 (4.4)	2 (3.8)	0	0
Diarrhea	NR	NR	0	1 (2.0)	0
Somnolence	NR	NR	1 (1.9)	0	0
Stomatitis	1 (2.2)	1 (2.2)	1 (1.9)	0	0

NR=Not reported

¹Haddad, et. al. JAMA Oncology, 2023. ²Source: Data Extract

ALISCA®-Breast1 Summary of Clinical Benefit¹

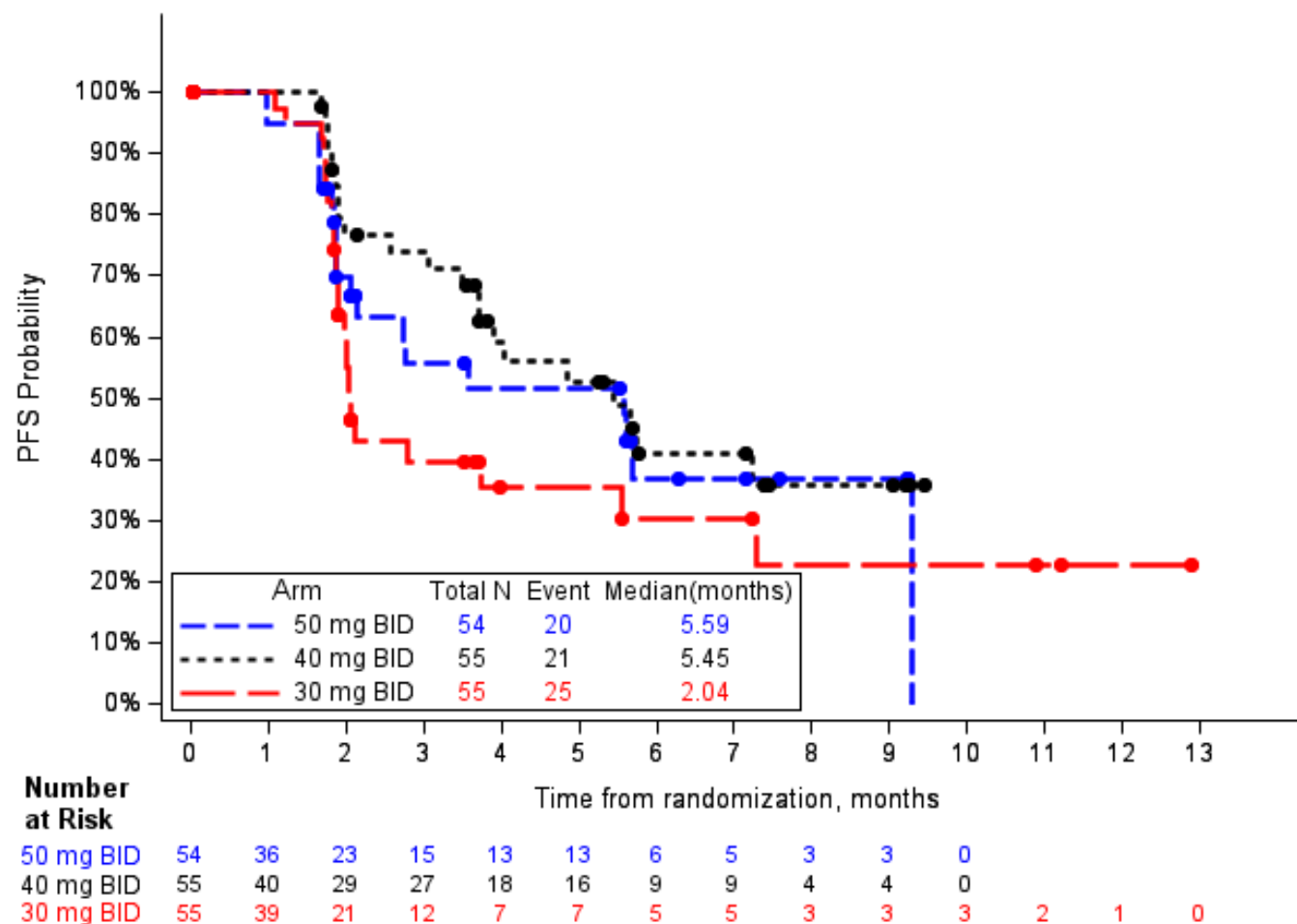
	50 mg BID (N=38)	40 mg BID (N=40)	30 mg BID (N=40)
Best overall response ^a - n (%)			
Complete response (CR)	0	0	0
Partial response (PR)	7 (18.4)	8 (20.0)	2 (5.0)
Stable disease (SD)	16 (42.1)	22 (55.0)	15 (37.5)
Non-CR/Non-PD	0	1 (2.5)	0
Disease progression (PD)	14 (36.8)	8 (20.0)	21 (52.5)
Not evaluable (NE)	0	0	0
Unavailable	1 (2.6)	1 (2.5)	2 (5.0)
Clinical benefit - n (%)			
Confirmed complete response (CR)	0	0	0
Confirmed partial response (PR)	4 (10.5)	5 (12.5)	1 (2.5)
Stable Disease (SD) ≥ 24 weeks	9 (23.7)	8 (20.0)	6 (15.0)

^a Best overall response (BOR) is not confirmed.

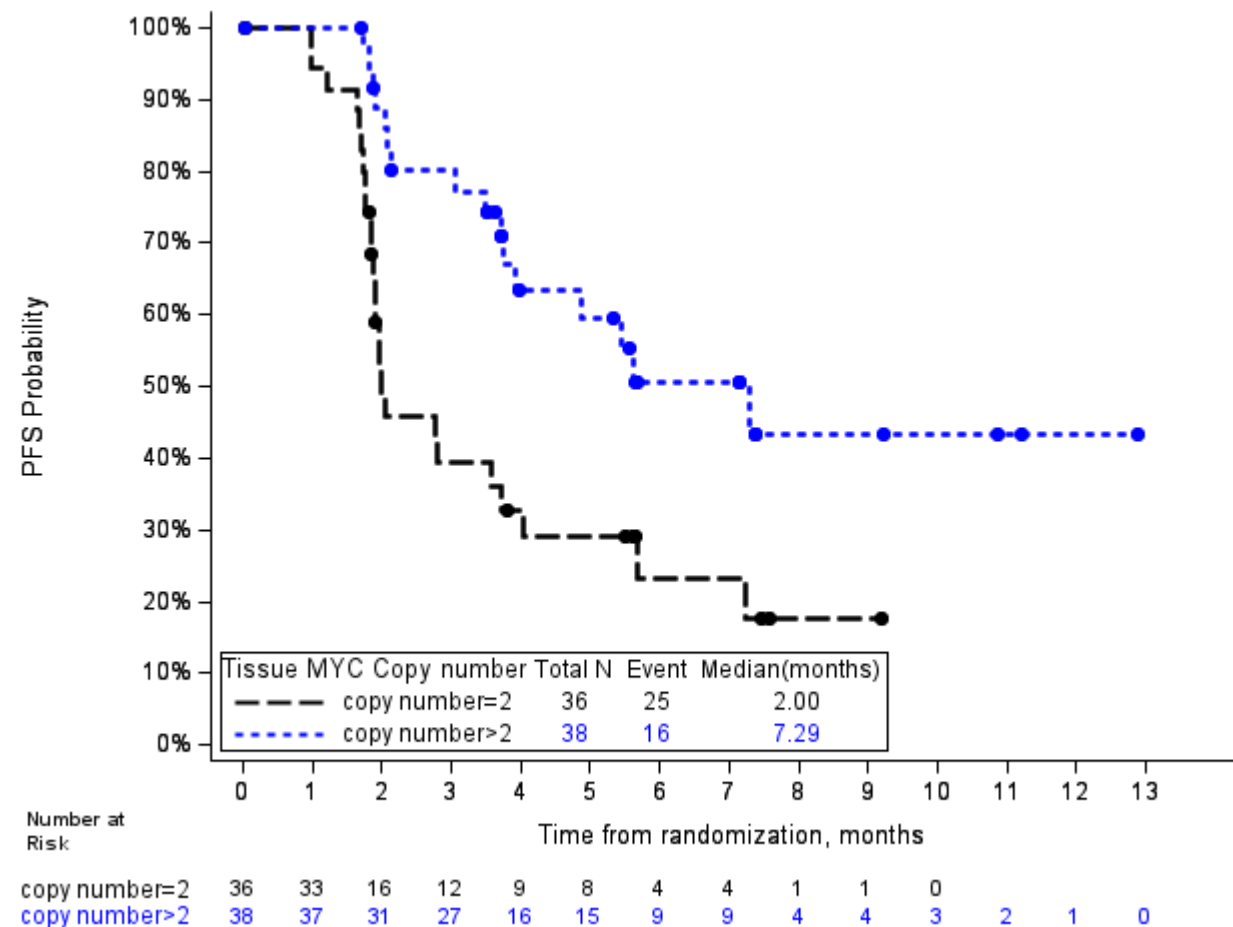
¹Subjects that have at least one post-baseline scan population: include all subjects in ITT with at least one post-baseline scan, or ended treatment or died before they got a scan.

ALISCA®-Breast1 PFS – ITT population

Progression Free Survival

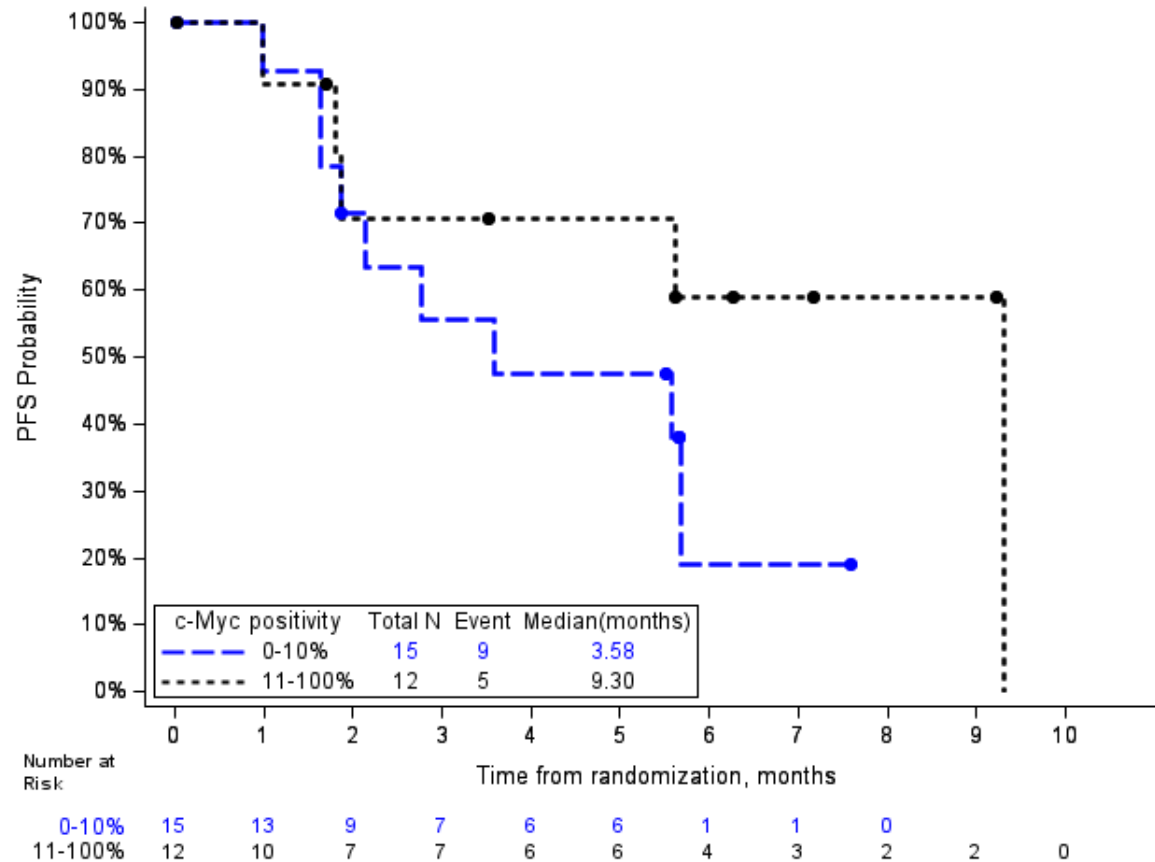


ALISCA[®]-Breast1 PFS *MYC* Copy Number

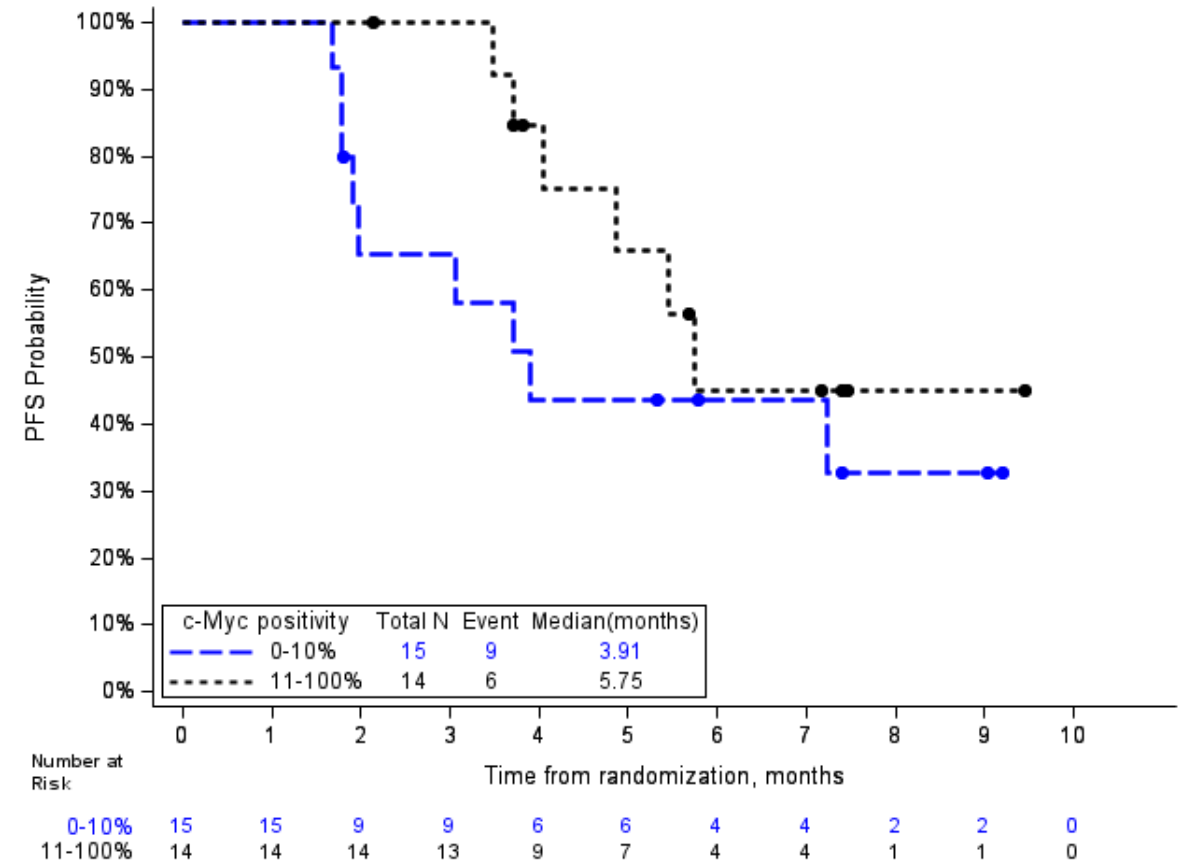


ALISCA®-Breast1 PFS by c-Myc % Positive Cells by Treatment Group

50mg BID

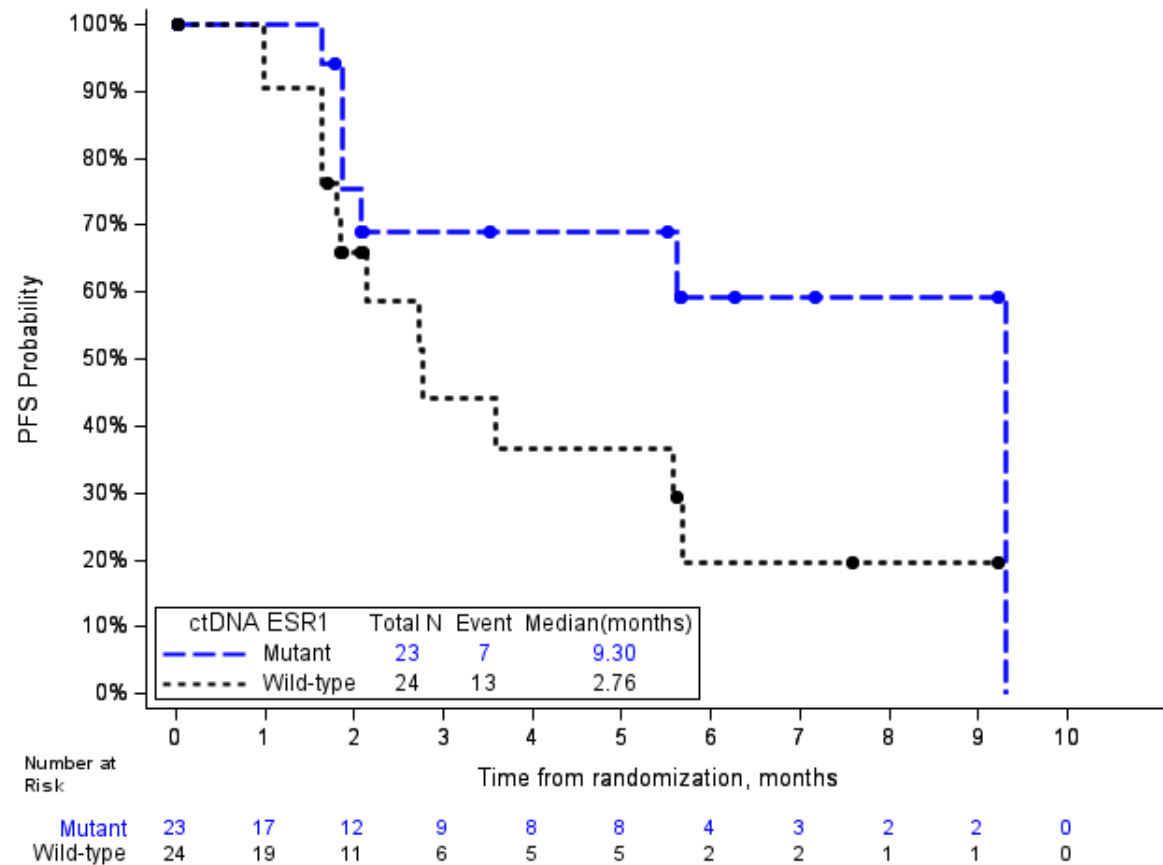


40mg BID

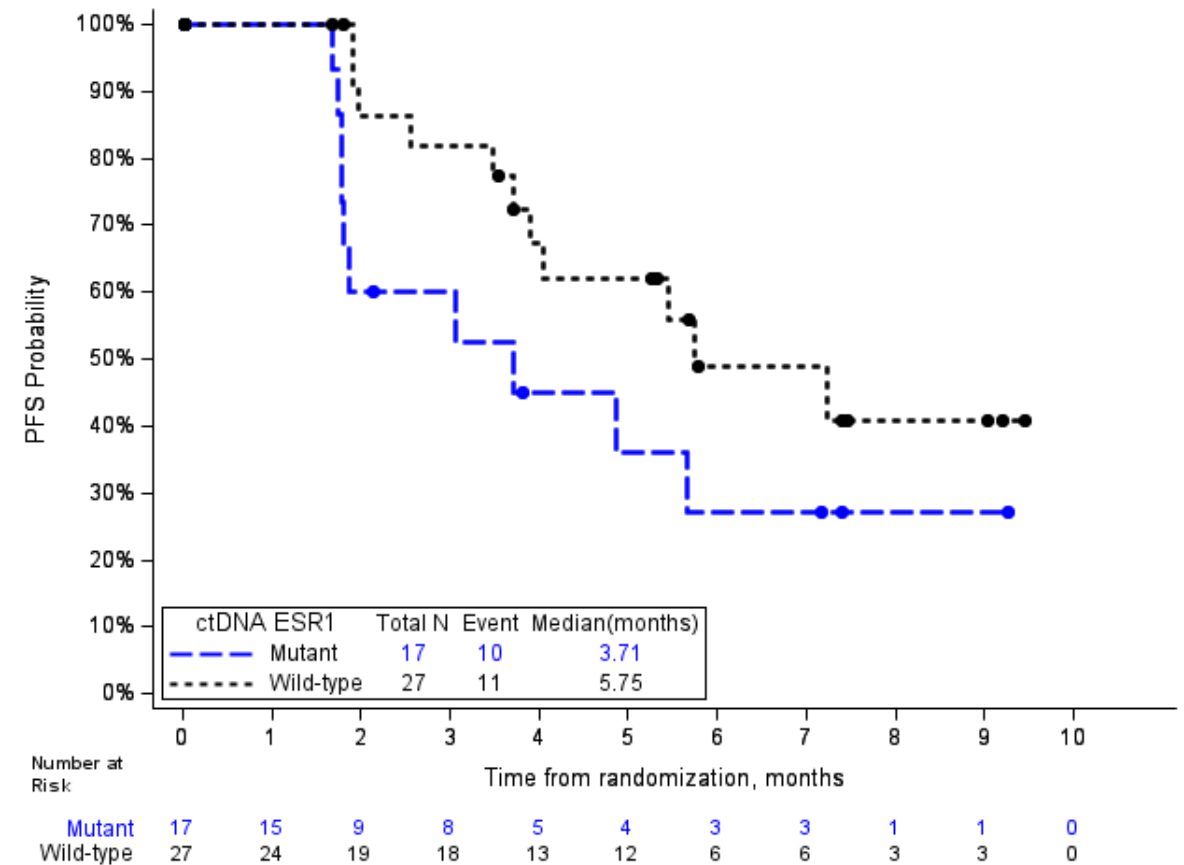


ALISCA®-Breast1 PFS by *ESR1* Mutation Status by Treatment Group – ctDNA

50mg BID

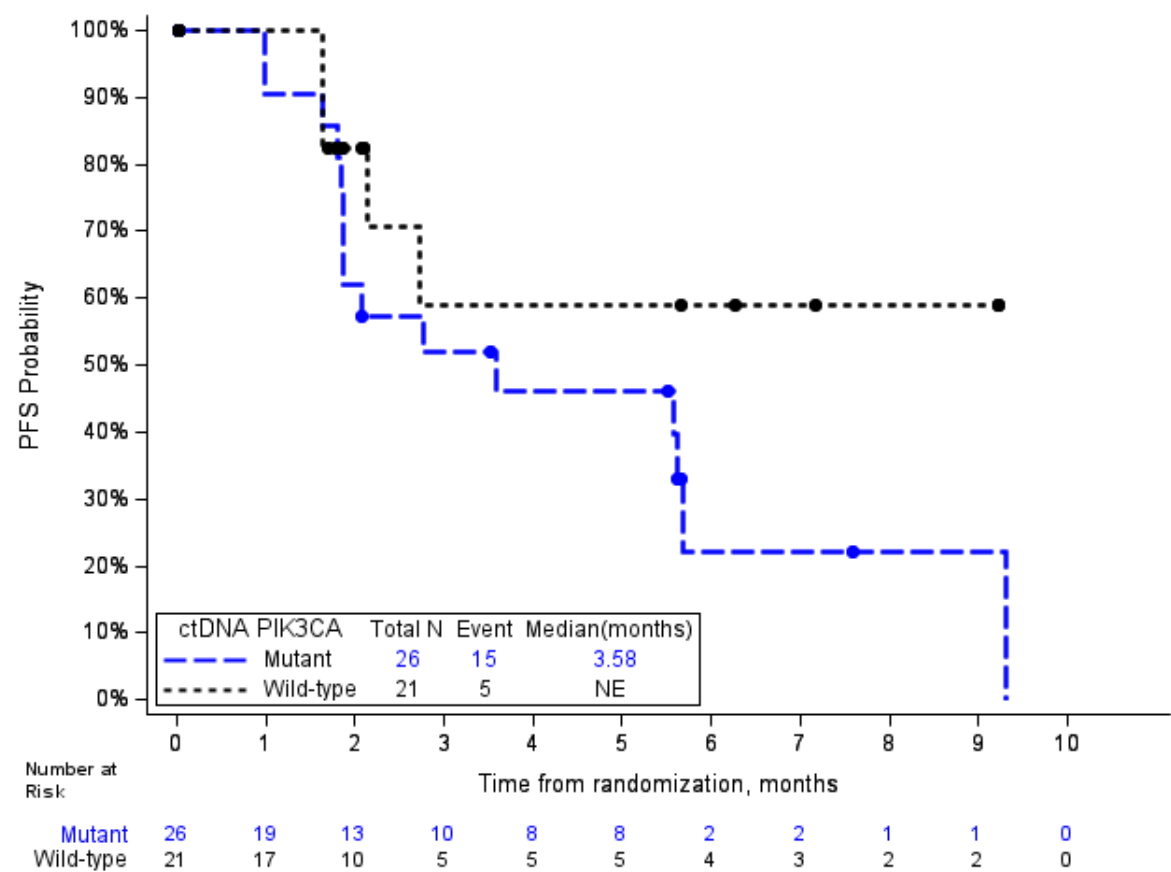


40mg BID

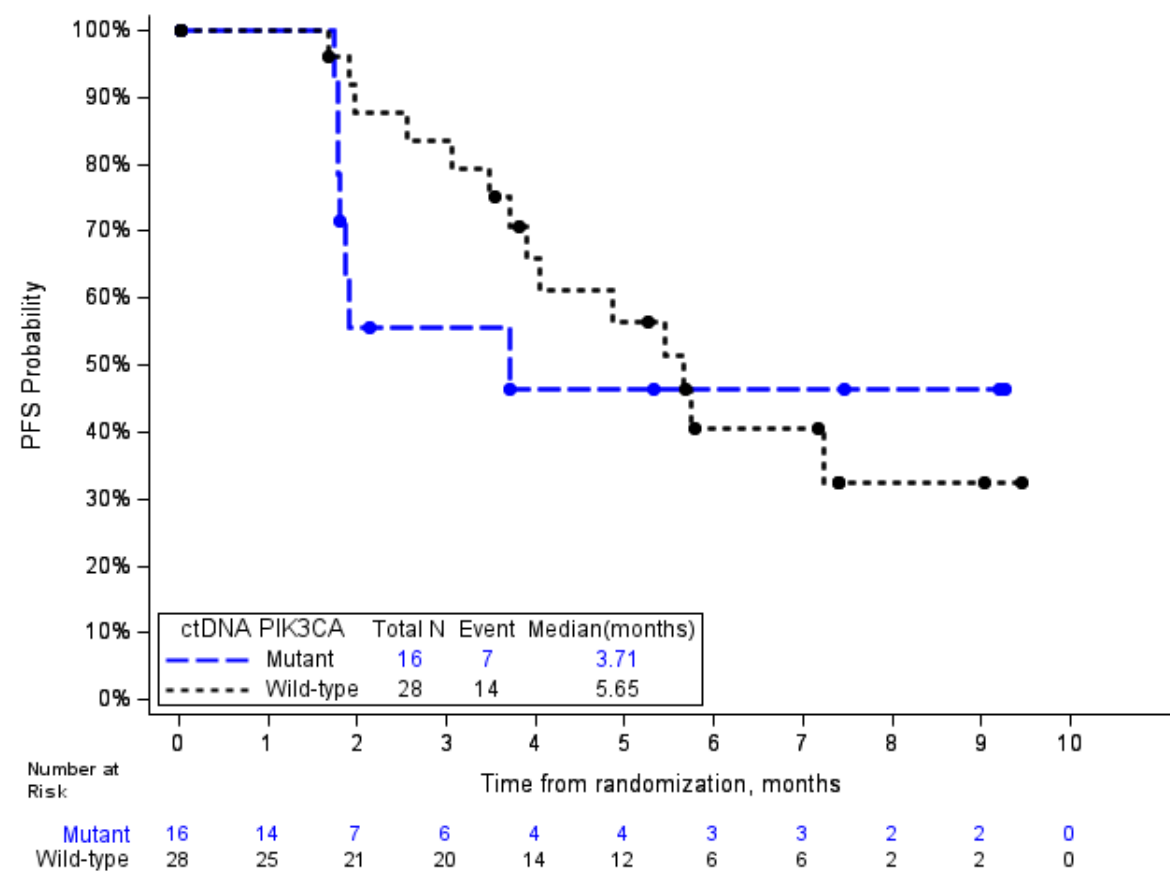


ALISCA®-Breast1 PFS by *PIK3CA* Mutation Status by Treatment Group – ctDNA

50mg BID

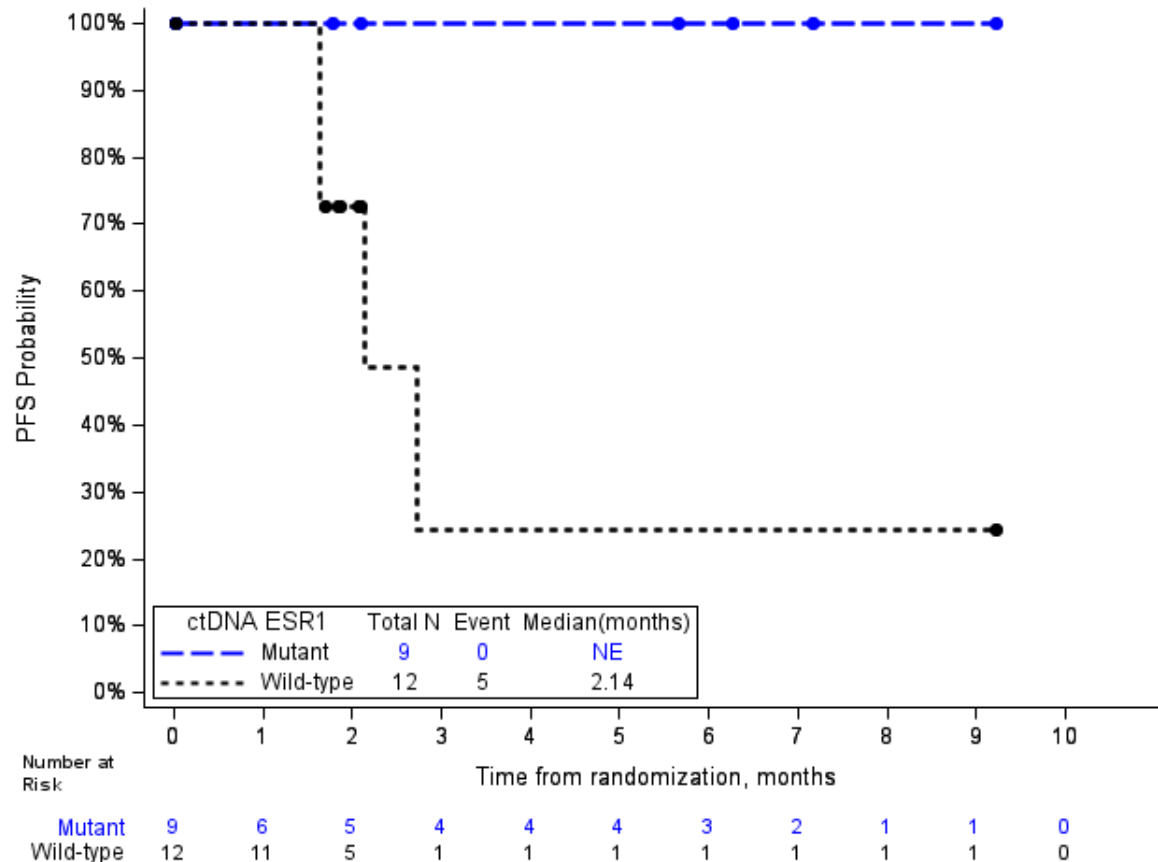


40mg BID

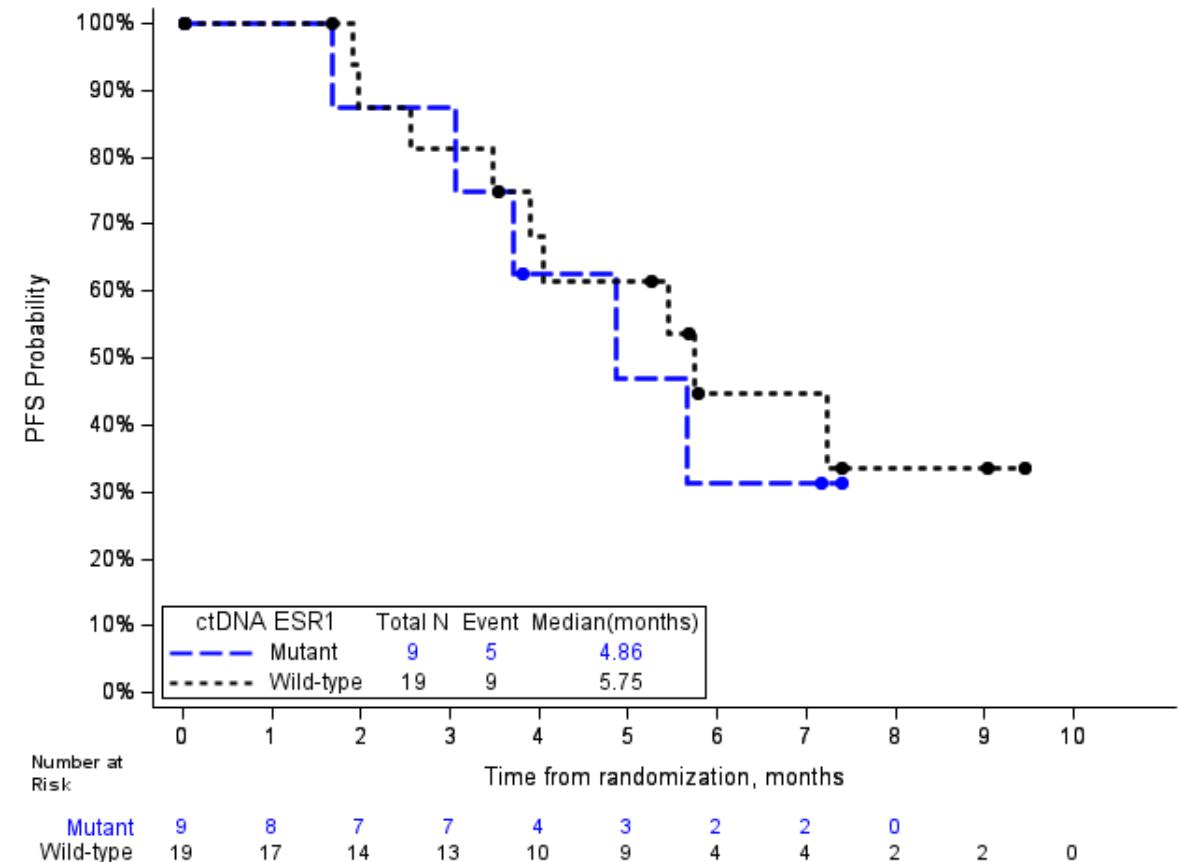


ALISCA[®]-Breast1 PFS Patients with *PIK3CA* Wild type by *ESR1* Mutation Status by Treatment Group – ctDNA

50mg BID



40mg BID

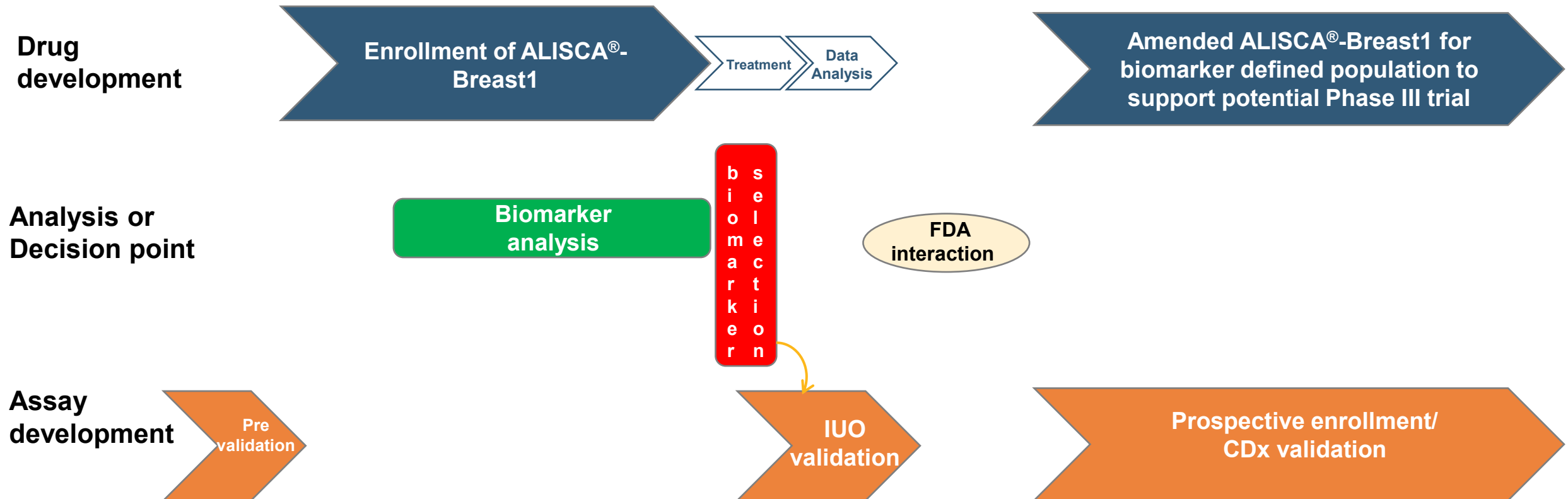


ALISCA®-Breast1 Patients with ESR1 mut and PIK3CA WT – Summary of FFPE tissue sample category and c-Myc positive cells

	Tissue DNA			ctDNA		
	PIK3CA Wild (N=42)	ESR1 Mutant (N=24)	PIK3CA Wild and ESR1 Mutant (N=17)	PIK3CA Wild (N=76)	ESR1 Mutant (N=59)	PIK3CA Wild and ESR1 Mutant (N=28)
c-Myc %positive cells (%) - n	40	23	16	46	33	17
Median	18.5	50.0	52.5	16.0	36.0	55.0
c-Myc %positive cells Category - n (%)						
0%	6 (14.3)	2 (8.3)	1 (5.9)	7 (9.2)	3 (5.1)	1 (3.6)
1-10%	11 (26.2)	3 (12.5)	2 (11.8)	13 (17.1)	6 (10.2)	2 (7.1)
11-100%	23 (54.8)	18 (75.0)	13 (76.5)	26 (34.2)	24 (40.7)	14 (50.0)

Parallel Clinical and Biomarker Development

- Comprehensive biomarker strategy supports clinical development and commercialization

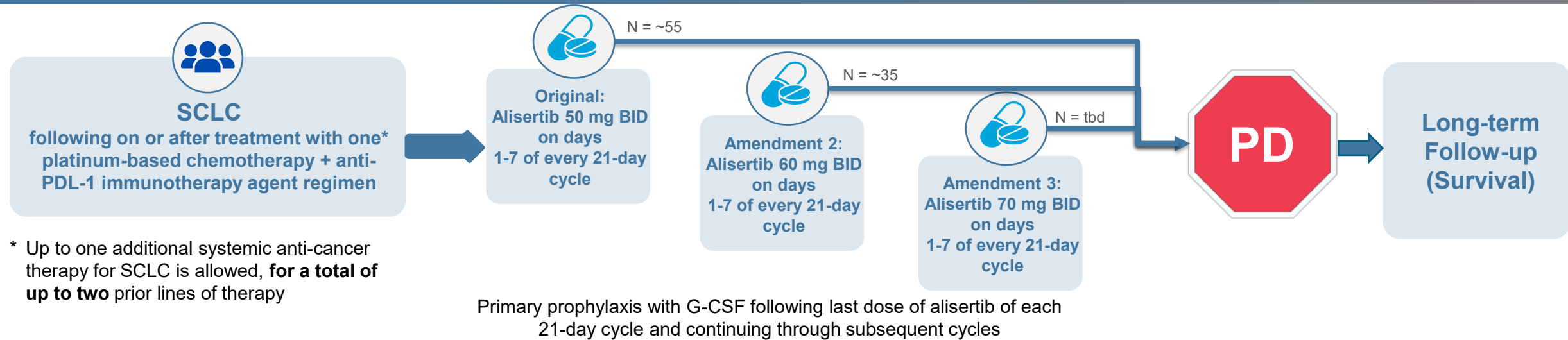


ALISCA[®]-Breast1 – Expected Milestones

- Expand enrollment in 40 mg and 50 mg cohorts to obtain more data on biomarker directed cohorts (H2 2026)
 - PIK3CA Wild Type
 - ESR1 Mutant
- Additional interim data from ALISCA[®]-Breast1, a Phase II clinical trial of alisertib in combination with endocrine therapy for the treatment of ER positive HER2 Negative Metastatic Breast Cancer (Q4 2026)

Clinical Development in Small Cell Lung Cancer

ALISCA[®]-Lung1 (PUMA-ALI-4201) Study Design – Alisertib Monotherapy



Study objectives and endpoints

Primary

- Determine whether any biomarker correlates with alisertib response by investigator-assessed ORR, DOR, DCR, PFS according to RECIST v1.1 within biomarker-defined subgroups from retrospectively evaluated patient samples

Secondary

- Determine investigator-assessed efficacy (ORR, DOR, DCR and PFS) according to RECIST v1.1
- Determine survival outcomes (OS)
- Determine the safety profile of alisertib (AE and SAEs per NCI CTCAE v 5.0)

ALISCA[®]-Lung1 SCLC History and Baseline Characteristics

	50 mg BID (N=52)	60 mg BID (N=27)	Total (N=79)
VALSG stage at initial diagnosis - n (%)			
Limited	7 (13.5)	6 (22.2)	13 (16.5)
Extensive	45 (86.5)	20 (74.1)	65 (82.3)
ECOG performance status at C1D1 – n (%)			
0	16 (30.8)	10 (37.0)	26 (32.9)
1	34 (65.4)	17 (63.0)	51 (64.6)
2	2 (3.8)	0	2 (2.5)
Tobacco smoking – n (%)			
Current	13 (25.0)	3 (11.1)	16 (20.3)
Never	2 (3.8)	2 (7.4)	4 (5.1)
Former	37 (71.2)	22 (81.5)	59 (74.7)
Location of disease at enrollment – n (%)			
Visceral	47 (90.4)	21 (77.8)	68 (86.1)
Not Visceral	5 (9.6)	3 (11.1)	8 (10.1)
Missing	0	3 (11.1)	3 (3.8)
Location of disease in the brain – n (%)			
Yes	21 (40.4)	9 (33.3)	30 (38.0)
No	31 (59.6)	15 (55.6)	46 (58.2)
Location of disease in the liver – n (%)			
Yes	25 (48.1)	13 (48.1)	38 (48.1)
No	27 (51.9)	11 (40.7)	38 (48.1)

ALISCA®-Lung1 Summary of Prior Anti-cancer Therapy

Prior anti-cancer therapy	50 mg BID (N=52)	60 mg BID (N=27)	Total (N=79)
Prior radiotherapy – n (%)			
No	16 (30.8)	12 (44.4)	28 (35.4)
Yes	36 (69.2)	15 (55.6)	51 (64.6)
Prior cancer-related surgery – n (%)			
No	44 (84.6)	25 (92.6)	69 (87.3)
Yes	8 (15.4)	2 (7.4)	10 (12.7)
Prior anti-cancer medication – n (%)			
No	0	1 (3.7)	1 (1.3)
Yes	52 (100.0)	26 (96.3)	78 (98.7)
Prior platinum based chemotherapy	52 (100.0)	24 (92.3)	76 (97.4)
Prior immunotherapy	52 (100.0)	24 (92.3)	76 (97.4)
Prior number of treatment regimens – n (%)			
1	40 (76.9)	16 (59.3)	56 (70.9)
2	12 (23.1)	10 (37.0)	22 (27.8)

ALISCA®-Lung1 Incidence of Grade 3 or 4 TEAEs Compared to Study C14007

	C14007 Alisertib monotherapy 50 mg BID 7D (n=60) ¹	PUMA-ALI-4201 Alisertib monotherapy 50 mg BID 7D (n=52) ²	PUMA-ALI-4201 Alisertib monotherapy 60 mg BID 7D (n=27) ²
Subjects with at least one reported AESI - n (%)	28 (46.7)	12 (23.1)	7 (25.9)
Neutropenia	22 (36.7)	7 (13.5)	3 (11.1)
Febrile neutropenia	5 (8.3)	2 (3.8)	2 (7.4)
Thrombocytopenia	9 (15.0)	2 (3.8)	1 (3.7)
Anemia	11 (18.3)	8 (15.4)	4 (14.8)
Diarrhea	2 (3.3)	0	0
Stomatitis	4 (6.7)	1 (1.9)	3 (11.1)
Somnolence	1 (1.7)	0	0

¹Data on file. SCLC subjects only ²Source: Data Extract

ALISCA®-Lung1 Summary of Clinical Benefit (Subjects with at Least One Post-baseline Scan or Ended Treatment Prior to First Scan)

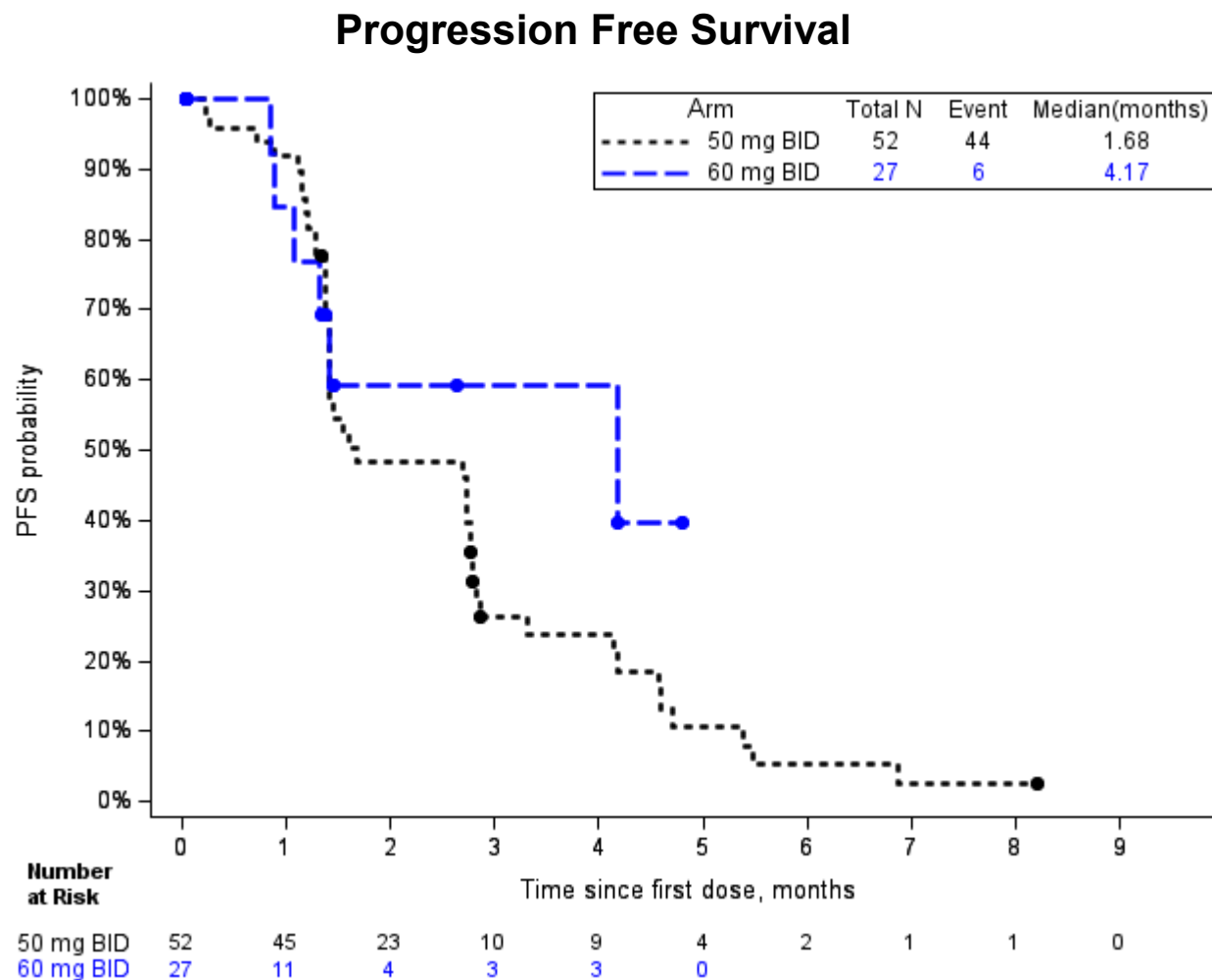
Response, n (%)	50 mg BID (N=52)	60 mg BID (N=15)
Best overall response		
Complete response (CR)	0	0
Partial response (PR)	6 (11.5)	1 (6.7)
Stable disease (SD)	18 (34.6)	7 (46.7)
Disease progression (PD)	22 (42.3)	2 (13.3)
Not evaluable (NE)	1 (1.9)	0
Unavailable*	5 (9.6)	5 (33.3)
Clinical benefit - n (%)		
Confirmed complete response (CR)	0	0
Confirmed partial response (PR)	3 (5.8)	1 (6.7)
Stable disease $\geq$ 12 weeks (SD)	19 (36.5)	2 (13.3)
Objective response (Confirmed CR or PR) – n(%)	3 (5.8)	1 (6.7)
Disease control rate ^a (95% CI)	42.3 (28.7, 56.8)	20.0 (4.3, 48.1)
Median duration of response (months)	4.2	NA
Median PFS (months)	1.7	4.2

*Unavailable are subjects who ended treatment or died prior to any on-treatment scan

Best overall response (BOR) is not confirmed.

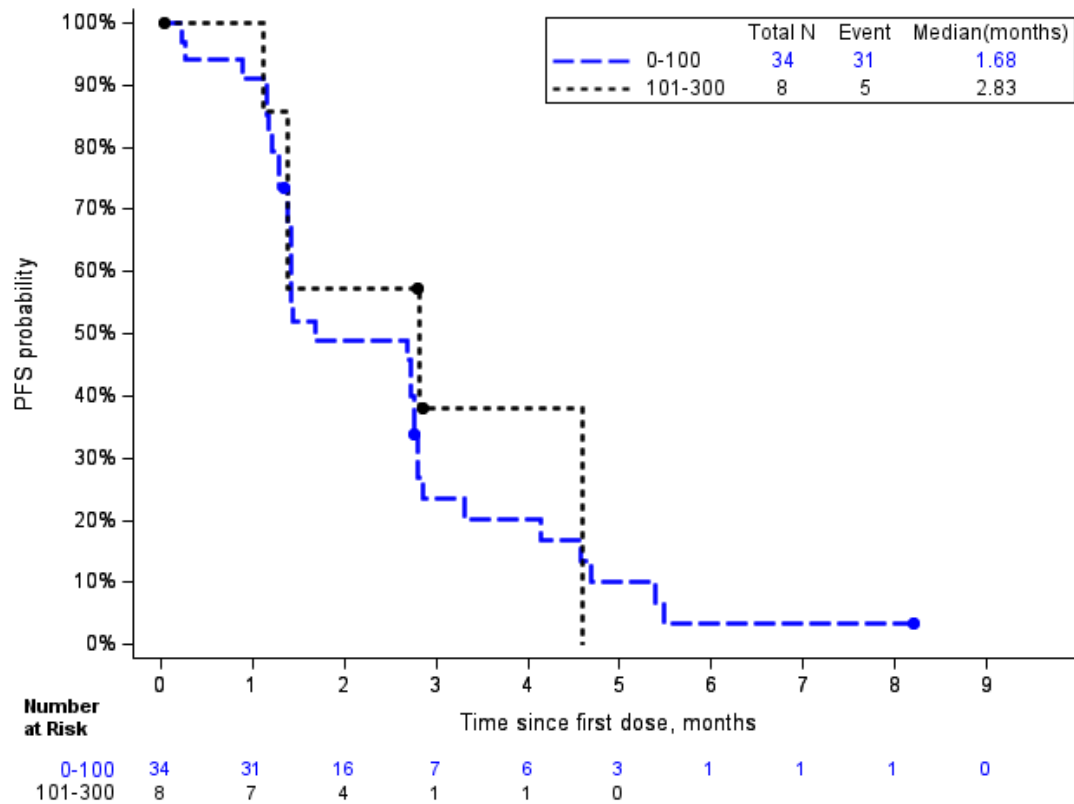
^aDCR=CR+PR+SD $\geq$ 12 wks

ALISCA®-Lung1 PFS – ITT Population by Treatment Group

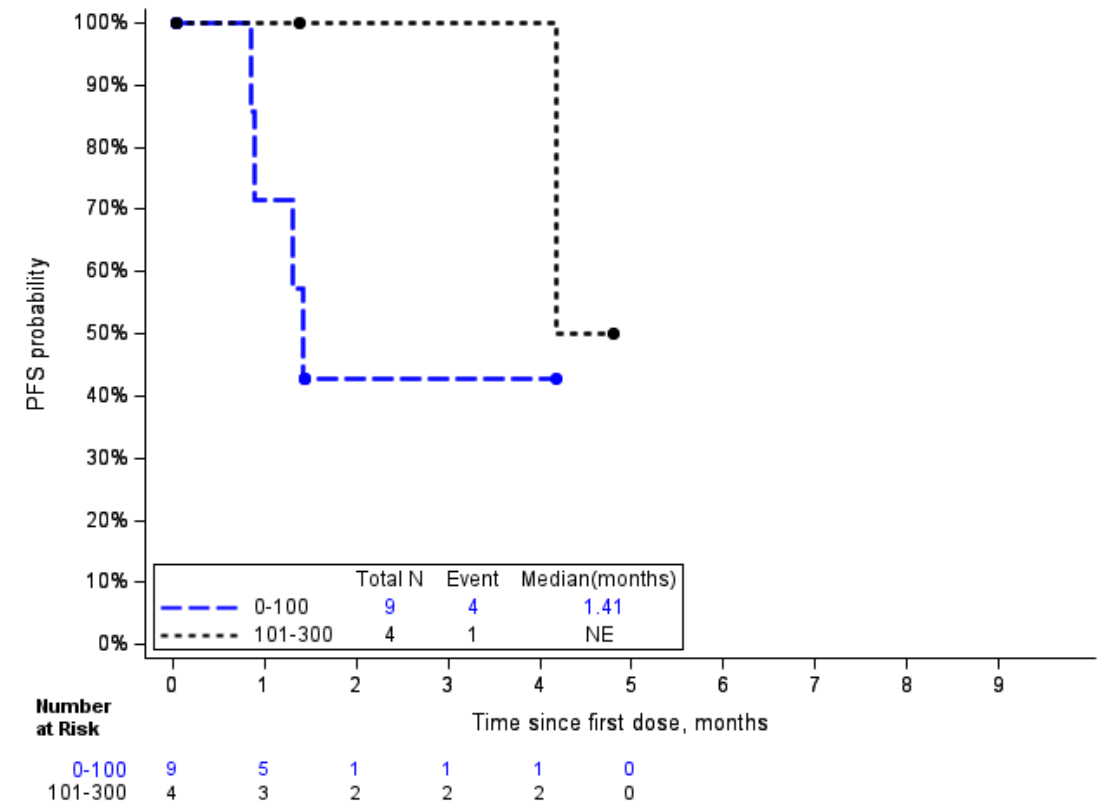


ALISCA®-Lung1 PFS by c-Myc H-score by Treatment Group

50 mg BID

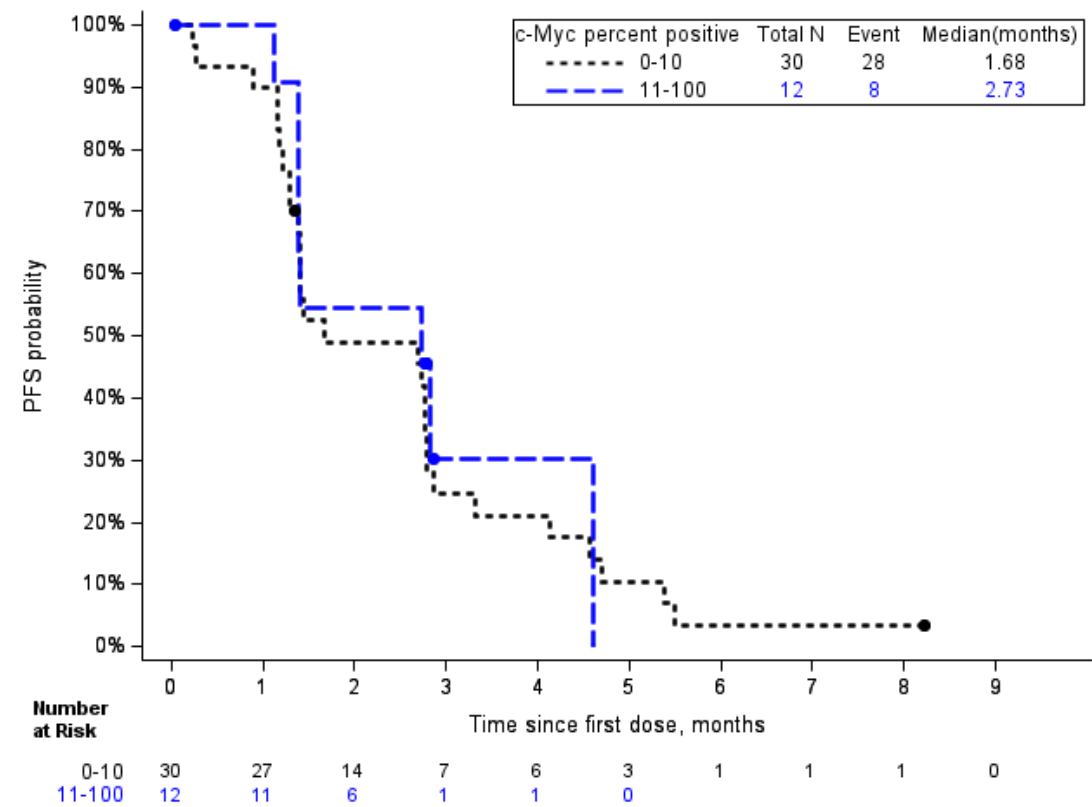


60 mg BID

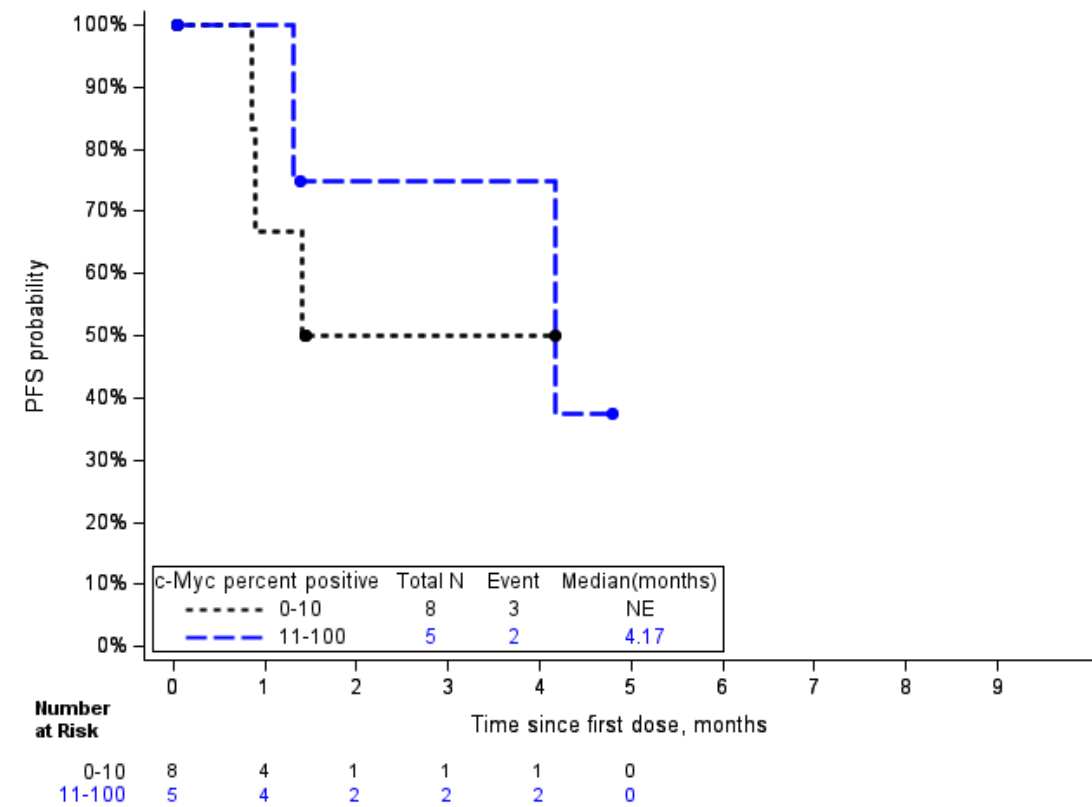


ALISCA[®]-Lung1 PFS by c-Myc % Positive Cells by Treatment Group

50 mg BID



60 mg BID



ALISCA[®]-Lung1 – Expected Milestones

- ✓ Initiate enrollment of 70 mg BID monotherapy cohort in ALISCA[®]-Lung1(H2 2026)
- Initiate enrollment of ALISCA[®] Lung2 – Phase I/II trial of alisertib in combination with paclitaxel (Q3 26)
- Additional interim data from ALISCA[®]-Lung1, a Phase II clinical trial of alisertib monotherapy for the treatment of extensive-stage small cell lung cancer (H2 2026/H1 2027)

Intellectual Property for NERLYNX (neratinib)

- Composition of matter patent issued (expires 2030)
 - Extended by USPTO in November 2021 per Hatch/Waxman
- Use in the treatment of cancer issued (expires 2025)
- Two polymorph patents issued (both expire 2028)
- Combination with capecitabine (expires 2031)
- Use in extended adjuvant breast cancer (expires 2030)
- Composition of specific salt of neratinib (recently issued)

Intellectual Property for alisertib

- Composition of matter patent issued (expires 2029)
- Use in the treatment of proliferative disorders (expires 2032)
- Use in the treatment of small cell lung cancer (expires 2033)
- Use in the treatment of breast cancer (expires 2034)
- Additional patents being filed and prosecuted

Potential for up to 5-year Hatch/Waxman extension on expiration date of above listed patents

Puma – Expected Milestones

- ✓ Report interim data from ALISCA[®]-Breast1, a Phase II trial of alisertib in combination with endocrine treatment in patients with chemotherapy-naïve HER2-negative, hormone receptor-positive metastatic breast cancer (Q2 2026)
- ✓ Additional interim data from ALISCA[®]-Lung1, a Phase II clinical trial of alisertib monotherapy for the treatment of extensive-stage small cell lung cancer (Q2 2026)
- Initiate enrollment of ALISCA[®]-Lung2 – Phase I/II trial of alisertib in combination with paclitaxel (Q3 26)
- Expansion of enrollment in ALISCA[®]-Breast1, a Phase II trial of alisertib in combination with endocrine treatment in patients with chemotherapy-naïve HER2-negative, hormone receptor-positive metastatic breast cancer (H2 2026)
- Expansion of ALISCA[®]-Lung1, a Phase II clinical trial of alisertib monotherapy for the treatment of extensive-stage small cell lung cancer (H2 2026)
- Presentation of updated data from ALISCA[®]-Breast1, a Phase II trial of alisertib in combination with endocrine treatment in patients with chemotherapy-naïve HER2-negative, hormone receptor-positive metastatic breast cancer (Q4 2026)
- Additional interim data from ALISCA[®]-Lung1, a Phase II clinical trial of alisertib monotherapy for the treatment of extensive-stage small cell lung cancer (H2 2026/H1 2027)

Experienced Management Team

Alan H. Auerbach

Chairman, Chief Executive Officer, President, Founder

- *Chief Executive Officer, President, Founder, Cougar Biotechnology*

Maximo F. Nougues

Chief Financial Officer

- *Getinge AB, Boston Scientific, The Clorox Company*

Douglas Hunt

Chief Scientific Officer (interim)

Chief Regulatory Affairs, Medical Affairs and Pharmacovigilance Officer

- *ArmaGen, Baxter Healthcare, Amgen*

Heather Blaber

Senior Vice President, Marketing

- *Amgen, Wyeth, Pfizer*

Roger Storms

Senior Vice President, Sales

- *Amgen, Boehringer Ingelheim*

Board of Directors

Alan H. Auerbach

Chairman, Chief Executive Officer, President, Founder, Puma Biotechnology, Inc.

Alessandra Cesano, MD, PhD

Former Chief Medical Officer, ESSA Pharmaceuticals; NanoString; Cleave Biosciences; Nodality; Amgen; Biogen; SmithKline

Allison Dorval

CFO, Merida Biosciences; CFO, AIRNA; CFO, Verve Therapeutics; CFO Voyager Therapeutics, Inc.; VP and Controller, Juniper Pharmaceuticals, Inc.

Michael Miller

Former EVP U.S. Commercial, Jazz Pharmaceuticals; VP, Sales & Marketing, Genentech

Jay Moyes

Former CFO, Sera Prognostics, Inc.; Former CFO, Myriad Genetics

Adrian Senderowicz, MD

Senior Advisor and former SVP and Chief Medical Officer, Constellation Pharmaceuticals; Ignyta; Sanofi; AstraZeneca; FDA (Division of Oncology Drug Products)

Brian Stuglich, R.Ph.

Former CEO, Verastem; Founder, Proventus Health Solutions; Former VP and Chief Marketing Officer, Eli Lilly Oncology

Troy Wilson, PhD, JD

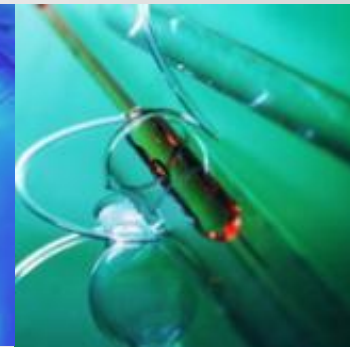
President and CEO, Kura Oncology; CEO, Wellspring Biosciences; Chairman, Avidity Biosciences; Former CEO, President, Intellikine

Puma Biotechnology – Financial

- Currently trading on NASDAQ: PBYY
- Cash, cash equivalents and marketable securities at June 30, 2026: \$93.9 million
- Net income in Q2 2026: \$8.2 million
- Cash burn in Q2 2026: \$9.7 million
- Private placements:
 - March 2022: 3,584,228 shares issued to Alan Auerbach and Athyrium Capital Management
 - December 2022: 568,181 shares issued to Alan Auerbach
- Shares issued and outstanding: 51.1 million

Company Highlights

- NERLYNX® – first HER2-directed drug approved by FDA for extended adjuvant treatment of early-stage HER2+ breast cancer in patients who have received prior trastuzumab
- NERLYNX® – first HER2-directed tyrosine kinase inhibitor approved in both early stage and metastatic HER2+ breast cancer
- Retain full U.S. commercial rights to NERLYNX®
- Clinical activity demonstrated for alisertib in Phase II clinical trials in HR-positive, HER2-negative breast cancer, Triple Negative Breast Cancer (TNBC), Small Cell Lung Cancer (SCLC)
- Potential for novel biomarker directed commercial opportunities with alisertib compared to other marketed drugs and drugs in development



Puma Biotechnology

Corporate Presentation

September 2026



Puma Biotechnology

Appendix

September 2026



Phase II Study of Alisertib Monotherapy in Solid Tumors

- Breast Cancer Cohorts

Study design:

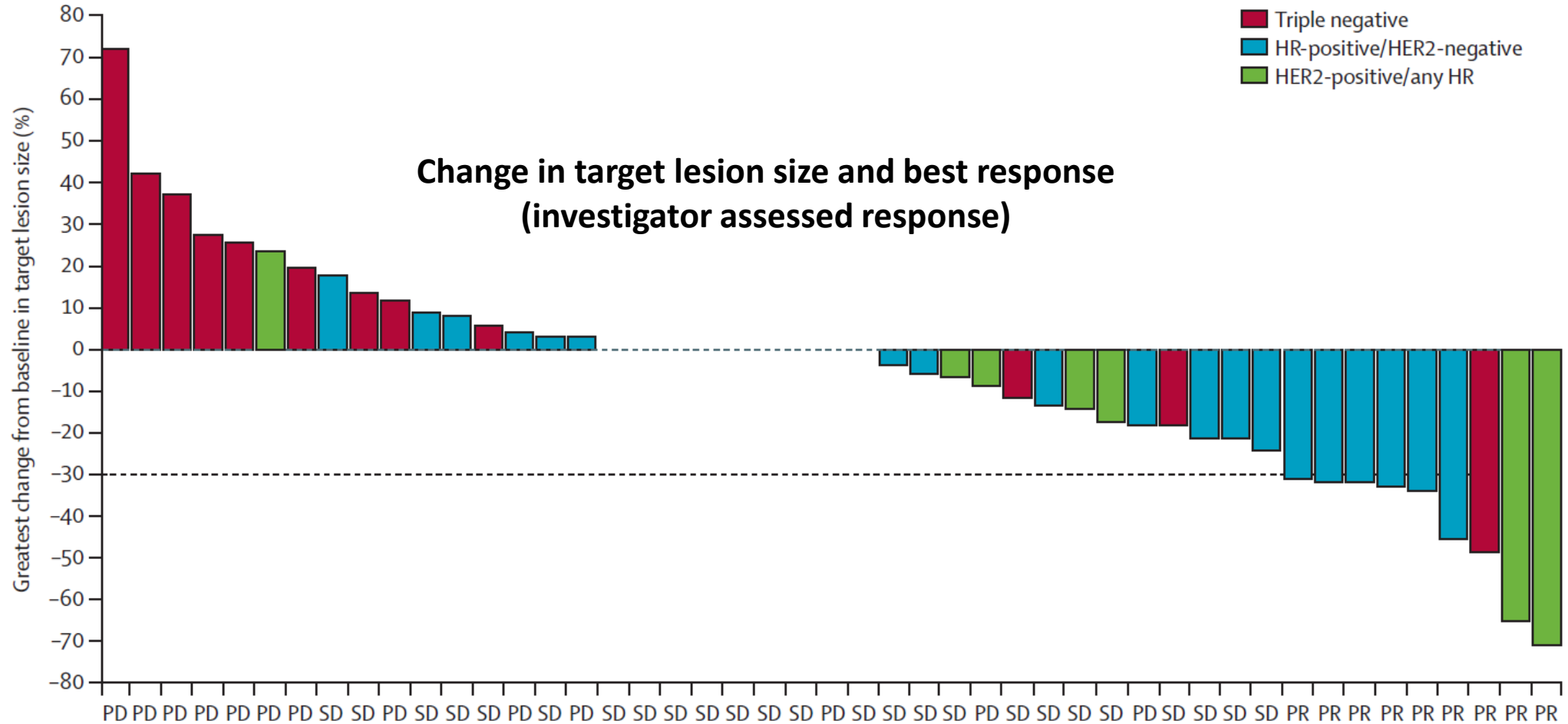
- Pts had to have undergone ≤ 2 previous cytotoxic regimens, not including adjuvant or neoadjuvant treatments
- Alisertib administered orally in 21-day cycles at 50 mg twice daily for 7 days followed by a break of 14 days
- 1° Endpoint: Objective Response Rate (RECIST 1.1)

	All (n=49)	Hormone receptor-positive and HER2-negative (n=26)	HER2-positive (n=9)	Triple negative (n=14)
Median (range) number of cycles	4.0* (1-23)	8.0 (1-23)	6.0 (1-19)	2.0 (1-14)
Best response				
Objective response†	9 (18%) (9-32)	6 (23%)	2‡ (22%)	1 (7%)
Stable disease	25 (51%) (36-66)	17 (65%)	3 (33%)	5 (36%)
Stable disease for ≥ 6 months	10 (20%)	8 (31%)	1 (11%)	1 (7%)
Progressive disease	15 (31%) (18-45)	3 (12%)	4 (44%)	8 (57%)
Duration of response (months)	5.6 (2.8-12.0)	4.2	11.2	4.2
Progression-free survival (months)	5.4 (2.6-7.9)	7.9 (4.2-12.2)	4.1 (0.95-15.0)	1.5 (1.2-3.2)
Time to progression (months)	5.4 (2.6-7.9)	7.9 (4.2-12.2)	4.1 (0.95-15.0)	1.5 (1.2-3.2)

Data are either number of patients (%) (95% CI), or median (95% CI), unless otherwise stated. For the breast cancer subgroup, numbers of patients were too small to calculate 95% CIs. *Safety population. †All were partial responses. ‡ These two patients had the only hormone receptor-negative tumors in the cohort. All responses were based on investigator tumor assessments (RECIST v1.1).

- Breast Cancer Cohorts

9 / 49 patients (18%; 95% CI 9–32) had an objective response; all responders achieved a partial response



PD=progressive disease. SD=stable disease. PR=partial response. Dotted line at -30% represents a partial response, according to RECIST 1.1 (investigator tumor assessments).

Phase II Study of Alisertib Monotherapy in Solid Tumors

- Breast Cancer Cohorts

All-cause adverse events in safety evaluable breast cancer cohort (n=53)

	Grade 1-2	Grade 3-4
Any adverse event	8 (15%)	44 (83%)
Neutropenia	3 (6%)	30 (57%)
Fatigue	23 (43%)	6 (11%)
Anaemia	17 (32%)	4 (8%)
Alopecia	26 (49%)	NA
Diarrhoea	25 (47%)	2 (4%)
Nausea	15 (28%)	2 (4%)
Leukopenia	5 (9%)	19 (36%)
Stomatitis	16 (30%)	8 (15%)
Decreased appetite	13 (25%)	0
Vomiting	11 (21%)	1 (2%)
Thrombocytopenia	8 (15%)	4 (8%)
Somnolence	14 (26%)	1 (2%)
Dyspnoea	9 (17%)	3 (6%)
Constipation	9 (17%)	0
Pyrexia	4 (8%)	1 (2%)
Peripheral oedema	9 (17%)	0
Headache	11 (21%)	0
Insomnia	6 (11%)	0
Cough	8 (15%)	1 (2%)
Asthenia	2 (4%)	3 (6%)
Dehydration	5 (9%)	3 (6%)

Table adapted from Melichar B Lancet Oncol 2015. Data are number of patients with AE (%) for AEs of any grade in at least 10% of patients overall. NA = not applicable

Phase II Randomized Trial of Alisertib + Fulvestrant vs Alisertib in Advanced HR+ Breast Cancer

Patients (n=96 randomized)

Inclusion Criteria

- Post-menopausal women
- Histologically-proven ER+ (>10% expression) and HER2 negative
- No more than two prior chemotherapy regimens
- Prior treatment with fulvestrant in the metastatic setting required
- Disease that is measurable as defined by the RECIST criteria

Regimen & Schedule

- **Alisertib + Fulvestrant:** Alisertib 50 mg PO BID on days 1-3, 8-10, 15-17 q 28-day cycle with fulvestrant 500 mg IM on days 1 and 15 of cycle 1 then day 1 of all subsequent cycles
- **Alisertib Alone:** Alisertib 50 mg PO BID on days 1-3, 8-10, 15-17 q 28-day cycle

Patient Characteristics		
	Alisertib (n=46)	Alisertib + Fulvestrant (n=45)
Prior Chemotherapy (Neo)Adjuvant Setting	27 (58.7%)	27 (60.0%)
Metastatic Setting	22 (47.8%)	31 (68.9%)
Prior (Neo)Adj Endocrine Therapy		
Aromatase Inhibitor	30 (65.2%)	26 (57.8%)
SERM	16 (34.8%)	22 (48.9%)
Fulvestrant	7 (15.2%)	2 (4.4%)
Prior Endocrine Therapy for MBC		
Anastrozole/Letrozole	29 (63.0%)	37 (82.2%)
Exemestane	16 (34.8%)	26 (57.8%)
Fulvestrant	45 (97.8%)	45 (100.0%)
Prior Targeted Therapy for MBC		
CDK 4/6 inhibitor	46 (100%)	45 (100%)
Everolimus	17 (37.0%)	26 (57.8%)

Clinical Outcomes		
	Alisertib (n=46)	Alisertib + Fulvestrant (n=45)
Confirmed Responses	9 PR	1 CR; 8 PR
Objective Response Rate	19.6% (90% CI: 10.6-31.7%)	20.0% (90% CI: 10.9-32.3%)
Clinical Benefit Rate (24-week)	41.3% (90% CI: 29.0-54.5%)	28.9% (90% CI: 18.0-42.0%)
Medan PFS (months)	5.6 (95%CI: 3.9-10.0)	5.4 (95%CI: 3.9-7.8)
Estimated mOS	22.7 mos	19.8 mos
12-month OS rate	75.1% (95% CI: 63.4-89.0%)	62.7% (95% CI: 49.7-79.0%)

Phase II Randomized Trial of Alisertib + Fulvestrant vs Alisertib in Advanced HR+ Breast Cancer

Safety				
	Alisertib (n=46)		Alisertib + Fulvestrant (n=45)	
	Gr3	Gr4	Gr3	Gr4
Hematologic Adverse Events				
Anemia	15%	2%	9%	0%
Lymphocyte Count Decreased	4%	0%	13%	0%
Neutrophil Count Decreased	24%	17%	20%	22%
White Blood Cell Count Decreased	13%	4%	22%	9%
Non-Hematologic Adverse Events				
Fatigue	0%	0%	9%	0%

Reason for Treatment Discontinuation	Alisertib (n=46)^	Alisertib + Fulvestrant (n=45)^
Disease progression	38*	31
Intolerability	2	6
Patient Refusal	0	4
Physician Decision	1	0
Second Primary Cancer	0	1
Death	2	1

*17/37 patients who discontinued due to PD crossed over to alisertib + fulvestrant.
 ^3 patients continued on alisertib and 2 patients continued on alisertib + fulvestrant at time of data lock on January 10, 2022.

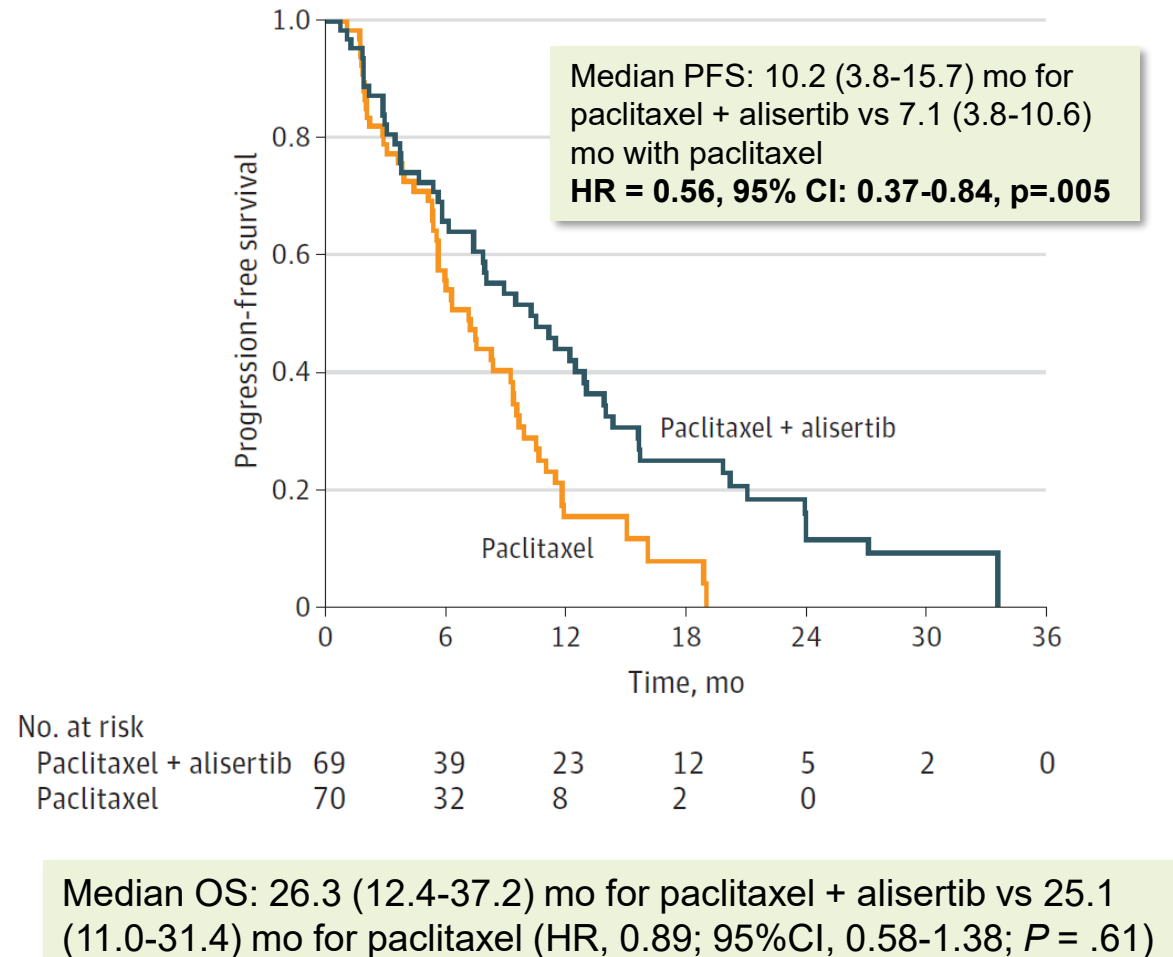
Phase II Randomized Study of Paclitaxel + Alisertib vs Paclitaxel Alone

- Efficacy in ER+/HER2- MBC Cohort

Study design:

- Patients with ER+/HER2- or triple negative metastatic breast cancer stratified by prior neo or adjuvant taxane and by line of metastatic therapy
- Randomized 1:1 to paclitaxel + alisertib or paclitaxel alone in 28-day cycles
- Paclitaxel 60mg/m² intravenously (IV) on days 1, 8, and 15 plus alisertib 40 mg twice daily on days 1 to 3, 8 to 10, and 15 to 17 of a 28-day cycle or to single agent paclitaxel 90mg/m² IV on days 1, 8, and 15 of a 28-day cycle
- 1° endpoint PFS

PFS in ER+/HER2- ITT



Phase II Randomized Study of Paclitaxel + Alisertib vs Paclitaxel Alone

- Efficacy in ER+/HER2- MBC Cohort Pretreated with Palbociclib

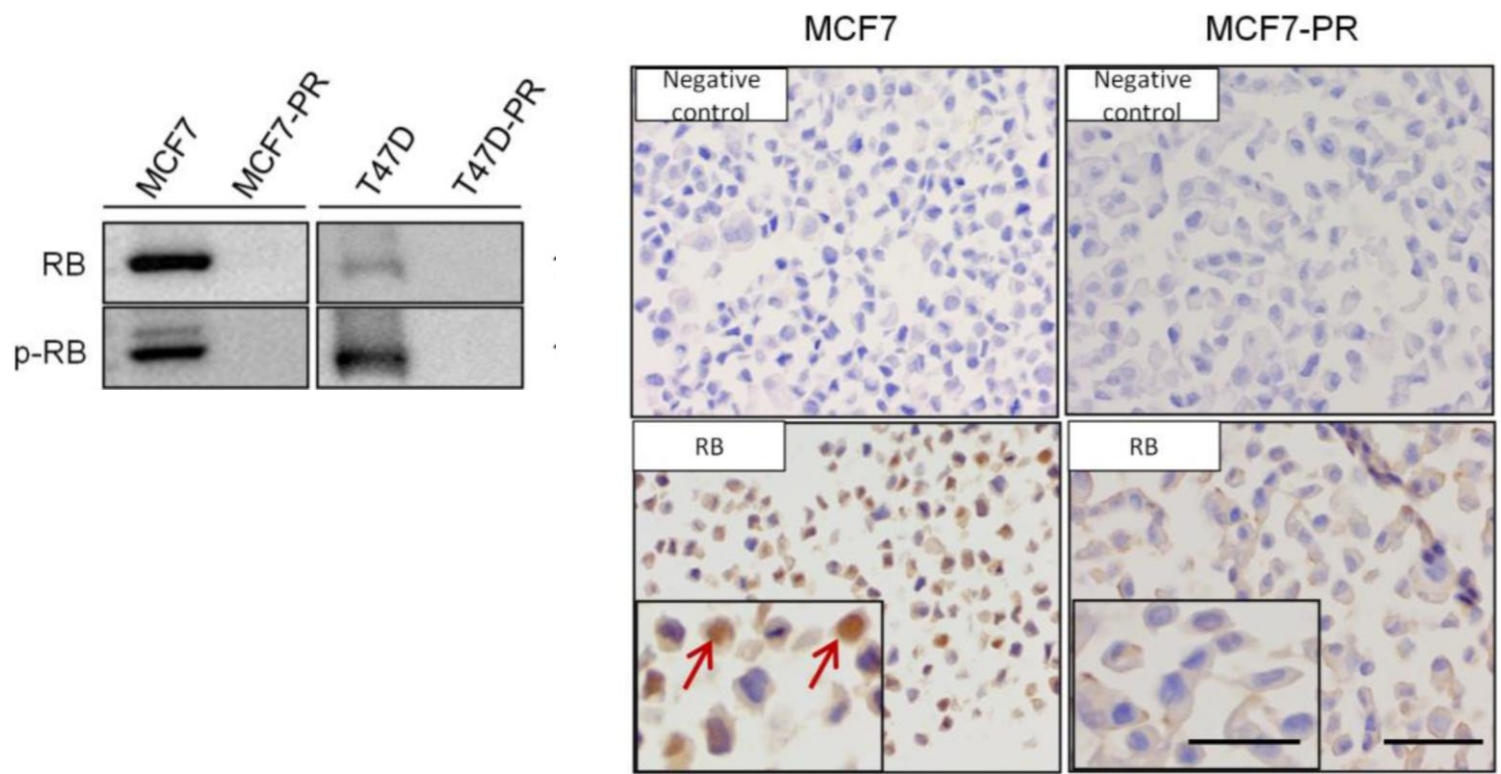
Efficacy in patients pretreated with palbociclib (n=30)

- Median PFS: 13.9 (5.6-15.6) mo (14 pts) w/ paclitaxel + alisertib vs 5.6 (3.0-10.6) mo (16 pts) w/ paclitaxel alone (HR, 0.58; 95%CI, 0.26-1.32; $P = .19$)
- CBR: 61.5% w/ paclitaxel + alisertib (95%CI, 31.6%-86.1%) vs 37.5% (95%CI, 15.2%-64.6%) w/ paclitaxel alone

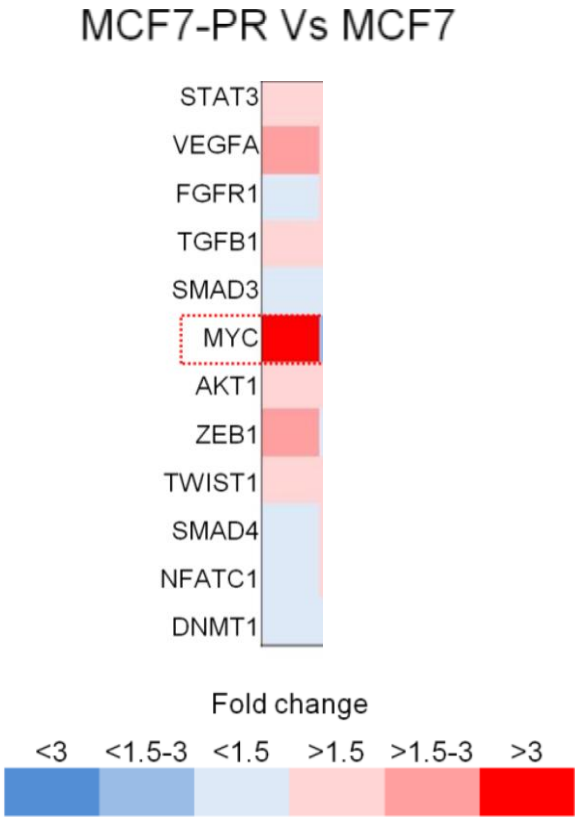
Rb1 Loss and c-Myc Upregulation Correlate with Palbociclib Resistance

Both RB1 loss and MYC upregulation were observed in palbociclib-resistant HR+ breast cancer cell lines, supporting a role for alisertib in this setting

RB1 Loss



C-Myc Upregulation



Phase II Study of Alisertib Monotherapy in Solid Tumors

- SCLC Cohorts

Study design:

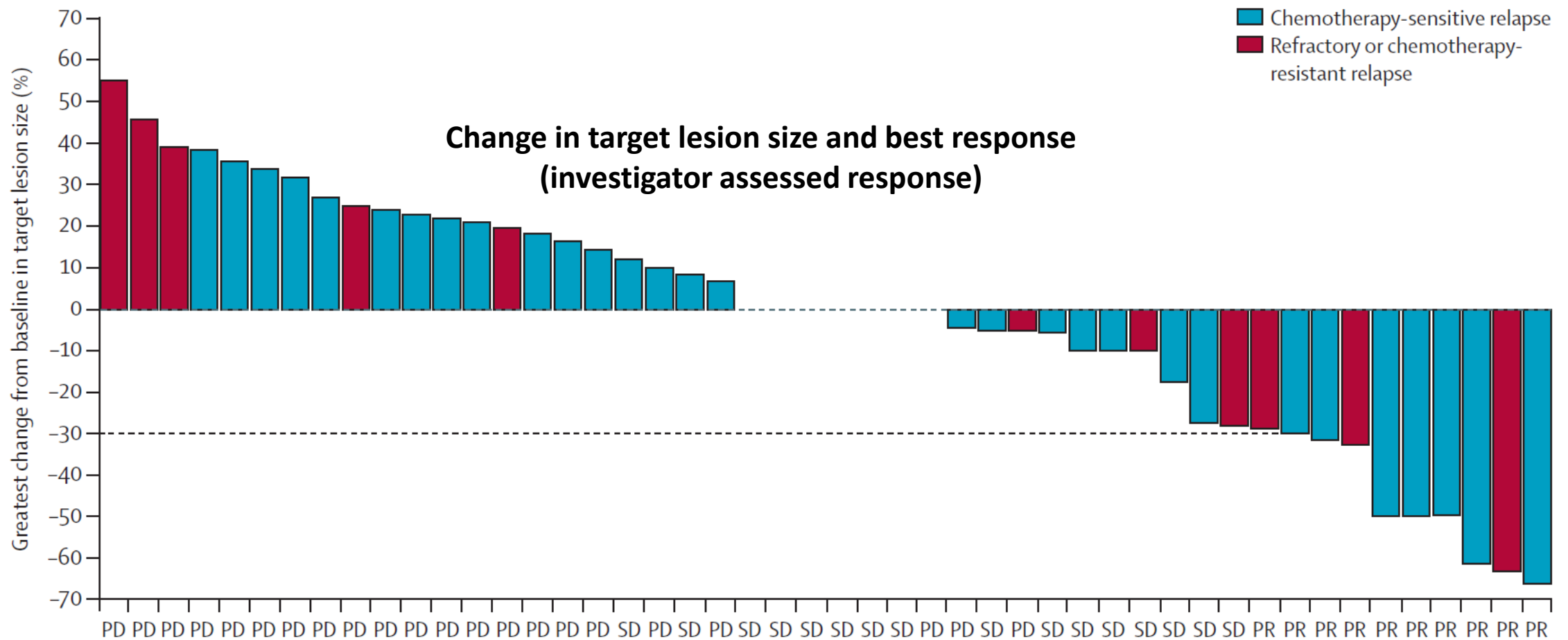
- Pts had to have undergone ≤ 2 previous cytotoxic regimens, not including adjuvant or neoadjuvant treatments
- Alisertib administration: orally in 21-day cycles at 50 mg twice daily for 7 days followed by a break of 14 days
- 1° Endpoint: Objective Response Rate (RECIST 1.1)

	All (n=48)	Chemotherapy-sensitive relapse (n=36)	Refractory or chemotherapy-resistant relapse (n=12)
Median (range) number of cycles	2.0* (1-17)	3.5 (1-17)	2.0 (2-6)
Best response			
Objective response†	10 (21%) (10-35)	7 (19%)	3 (25%)
Stable disease	16 (33%) (20-48)	13 (36%)	3 (25%)
Stable disease for ≥ 6 months	2 (4%)	2 (6%)	0
Progressive disease	22 (46%) (31-61)	16 (44%)	6 (50%)
Duration of response (months)	4.1 (3.1-NE)	3.1	4.3
Progression-free survival (months)	2.1 (1.4-3.4)	2.6 (1.4-3.7)	1.7 (1.2-3.9)
Time to progression (months)	2.6 (1.4-3.8)	2.8 (1.4-3.9)	1.4 (1.2-4.4)

Table adapted from Melichar B Lancet Oncol 2015. Data are either number of patients (%) (95% CI), or median (95% CI), unless otherwise stated. NE=not estimable. *Safety population. †All were partial responses. All responses were based on investigator tumor assessments (RECIST v1.1).

- SCLC Cohorts

10 (21%; 95% CI 10–35) of 48 patients had an objective response; all responders achieved a partial response



PD=progressive disease. SD=stable disease. PR=partial response. Dotted line at -30% represents a partial response, according to RECIST 1.1 (investigator tumor assessments).

Phase II Study of Alisertib Monotherapy in Solid Tumors

- SCLC Cohorts

All-cause adverse events in safety evaluable SCLC cohort (n=60)

	Grade 1-2	Grade 3-4
Any adverse event	14 (23%)	43 (72%)
Neutropenia	5 (8%)	22 (37%)
Fatigue	23 (38%)	5 (8%)
Anaemia	9 (15%)	10 (17%)
Alopecia	16 (27%)	NA
Diarrhoea	16 (27%)	2 (3%)
Nausea	18 (30%)	0
Leukopenia	4 (7%)	8 (13%)
Stomatitis	9 (15%)	4 (7%)
Decreased appetite	18 (30%)	0
Vomiting	10 (17%)	1 (2%)
Thrombocytopenia	5 (8%)	6 (10%)
Somnolence	8 (13%)	1 (2%)
Dyspnoea	10 (17%)	0
Constipation	5 (8%)	0
Pyrexia	4 (7%)	0
Peripheral oedema	4 (7%)	0
Headache	8 (13%)	1 (2%)
Insomnia	7 (12%)	0
Cough	5 (8%)	0
Asthenia	6 (10%)	1 (2%)
Dehydration	3 (5%)	3 (5%)

Table adapted from Melichar B Lancet Oncol 2015. Data are number of patients with AE (%) for AEs of any grade in at least 10% of patients overall. NA = not applicable

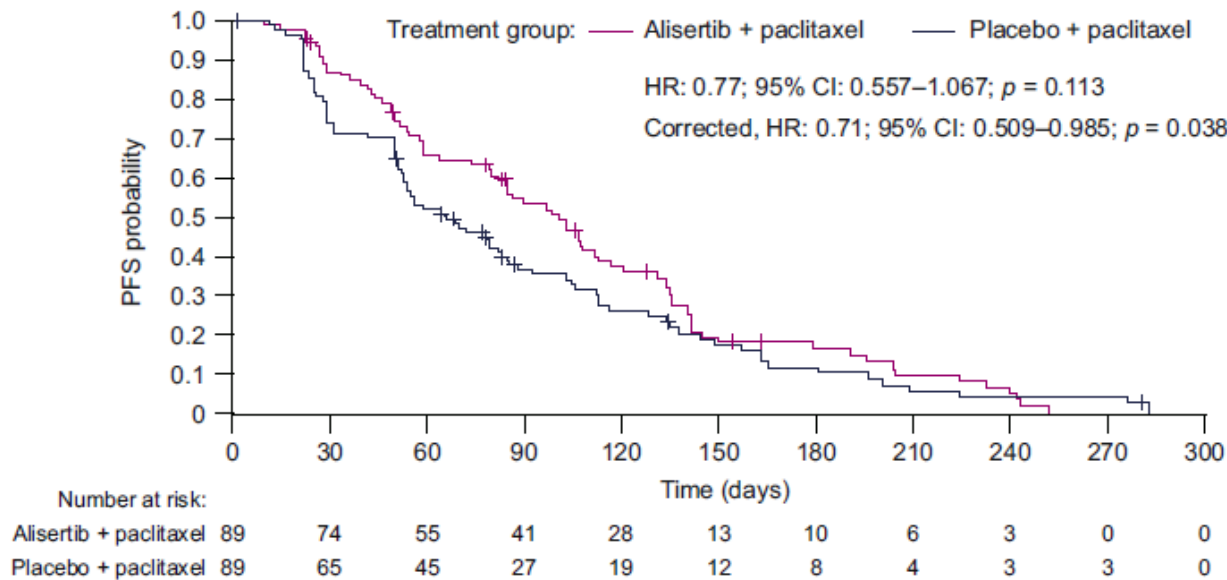
Randomized Phase II Study of Paclitaxel plus Alisertib vs Paclitaxel plus Placebo as Second-Line SCLC: Primary Analysis

Study design:

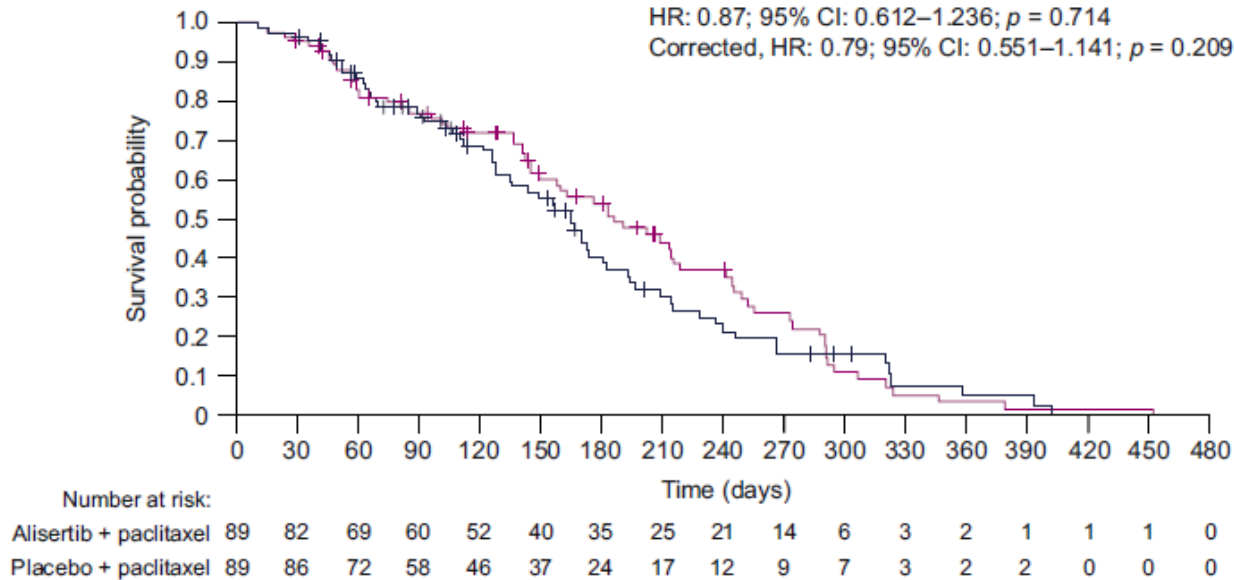
- Patients with relapsed or refractory SCLC stratified by relapse type (sensitive vs resistant or refractory)
- Randomized 1:1 to alisertib + paclitaxel or placebo + paclitaxel in 28-day cycles
- Alisertib (40 mg BID for 3 weeks on days 1–3, 8–10, and 15–17) plus paclitaxel (60 mg/m² intravenously on days 1, 8, and 15) or placebo plus paclitaxel (80 mg/m² intravenously on days 1, 8, and 15) in 28-day cycles
- 1° endpoint PFS

Biomarkers: associations between c-Myc expression in tumor tissue (prespecified) and genetic alterations in ctDNA (retrospective) with clinical outcome

PFS in ITT



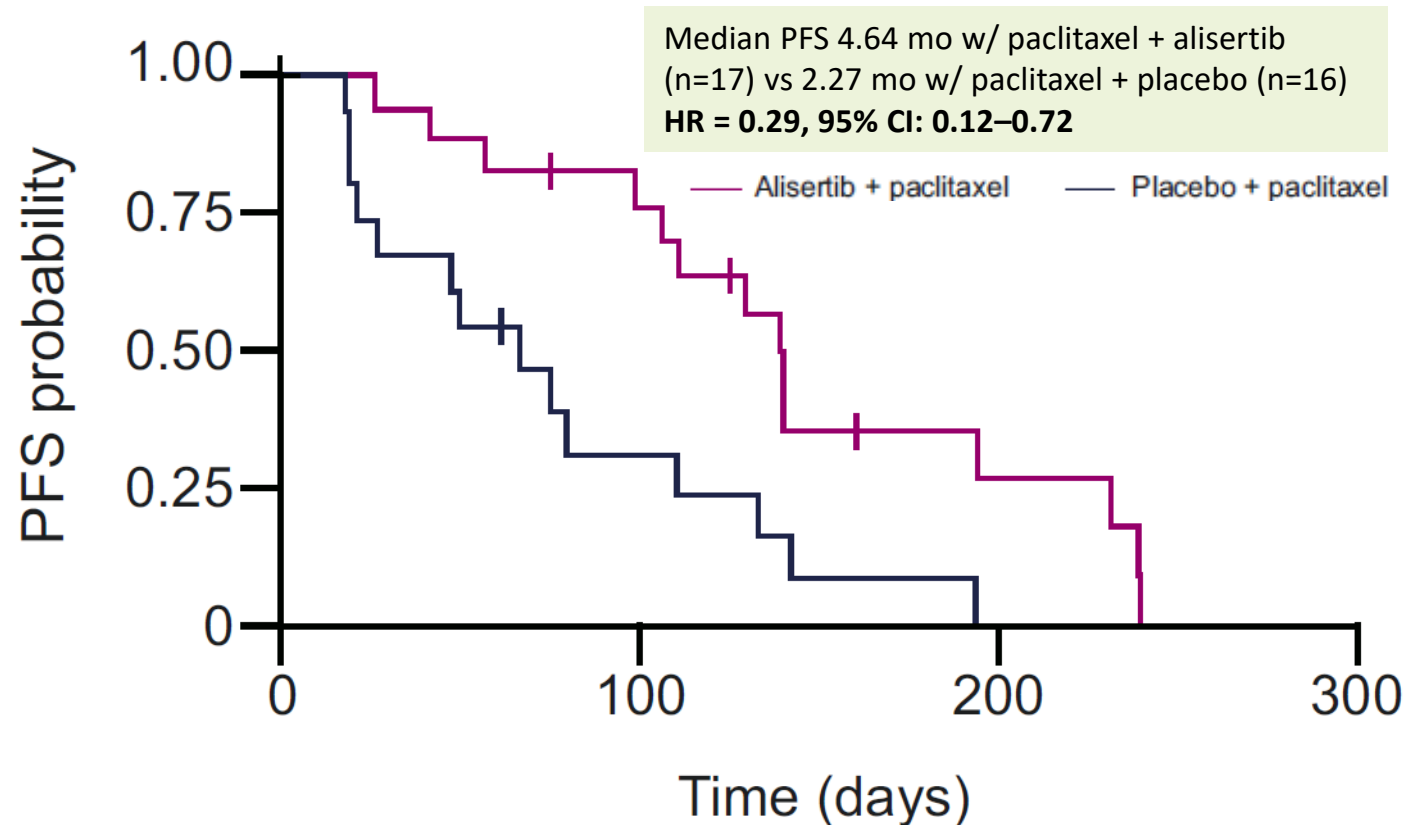
OS in ITT



Randomized Phase II Study of Paclitaxel plus Alisertib vs Paclitaxel plus Placebo as Second-Line SCLC: Correlative Biomarker Analysis

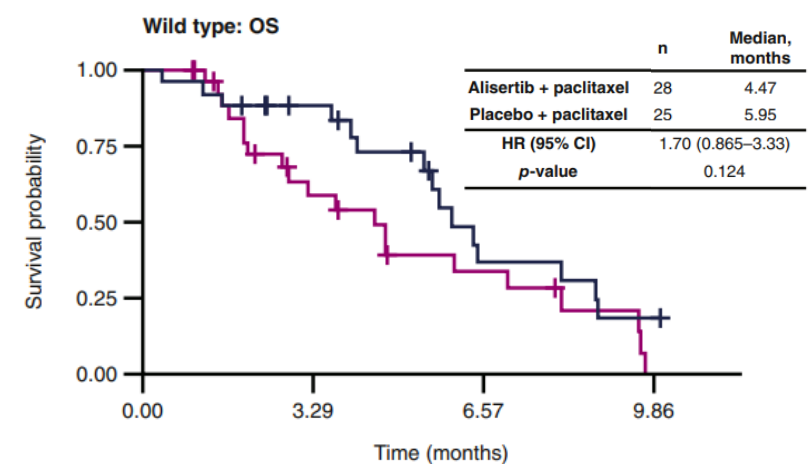
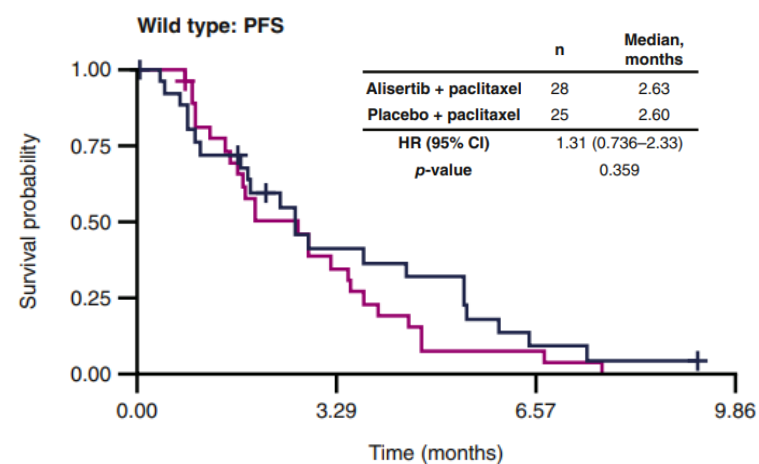
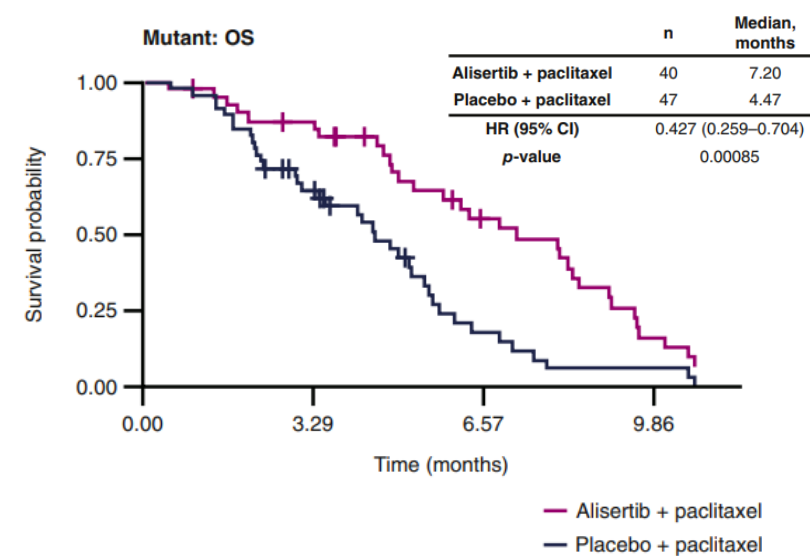
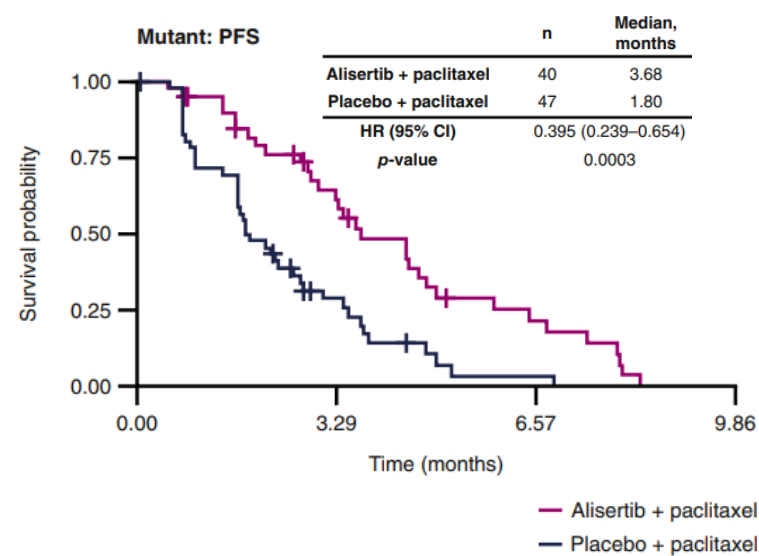
Improved PFS observed among patients positive versus negative for *c-Myc* expression

PFS in patients positive for *c-Myc* expression



Randomized Phase II Study of Paclitaxel plus Alisertib vs Paclitaxel plus Placebo as Second-Line SCLC: Correlative Biomarker Analysis

Improved outcomes among pts with genetic alternations in cell cycle genes *CDK6*, *RBL1*, *RBL2*, and *RB1* (collectively referred to as “mutant”)



Randomized Phase II Study of Paclitaxel plus Alisertib vs Paclitaxel plus Placebo as Second-Line SCLC: Safety

Table 3. Most Frequently Reported All-Cause and Drug-Related Treatment-Emergent AEs, Occurring in at Least 15% (All-Cause) or at Least 10% (Drug-Related) of Patients Overall (Any Grade) in Either Arm, Respectively, with the Corresponding Grade 3 or higher AEs (Safety Population), and All Drug-Related Fatal AEs

AE	Alisertib/Paclitaxel (n = 87)		Placebo/Paclitaxel (n = 89)	
	Any Grade	Grade ≥ 3	Any Grade	Grade ≥ 3
All-cause AE, n (%)	86 (99)	66 (76)	85 (96)	45 (51)
Diarrhea	51 (59)	14 (16)	18 (20)	1 (1)
Fatigue	38 (44)	9 (10)	29 (33)	5 (6)
Nausea	29 (33)	2 (2)	30 (34)	4 (4)
Anemia	38 (44)	12 (14)	18 (20)	3 (3)
Neutropenia	43 (49)	35 (40)	7 (8)	5 (6)
Vomiting	28 (32)	2 (2)	21 (24)	3 (3)
Decreased appetite	29 (33)	3 (3)	19 (21)	3 (3)
Dyspnea	21 (24)	4 (5)	19 (21)	2 (2)
Stomatitis	29 (33)	12 (14)	6 (7)	2 (2)
Cough	17 (20)	0	17 (19)	0
Constipation	8 (9)	1 (1)	21 (24)	0
Asthenia	14 (16)	3 (3)	11 (12)	0
Dizziness	14 (16)	0	8 (9)	0
Alopecia	14 (16)	0	5 (6)	0
Leukopenia	13 (15)	7 (8)	5 (6)	2 (2)
Decreased neutrophil count	14 (16)	11 (13)	4 (4)	1 (1)
Weight decreased	13 (15)	0	5 (6)	0
Drug-related fatal AE, n (%)				
Neutropenic sepsis	—	1 (1)	—	0
Sepsis	—	1 (1)	—	0
Febrile neutropenia	—	1 (1)	—	0
Septic shock	—	1 (1)	—	0

AE, adverse event