



Corporate Presentation (NASDAQ:CNSY)
September 30, 2026

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Introduction

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The forward-looking statements included in this presentation could differ materially from those expressed or implied by these forward-looking statements because of risks, uncertainties, and other factors that include, but are not limited to, the following: the early stage of the Company’s product candidates and therapies; the results of the Company’s research and development activities, including uncertainties relating to the clinical trials of its product candidates and therapies; the Company’s liquidity and capital resources and its ability to raise additional cash; the Company’s ability to fund its operations in the near-term and long-term, on terms acceptable to it or at all; the outcome of the Company’s partnering/licensing efforts; risks associated with laws or regulatory requirements applicable to the Company; market conditions; product performance; litigation or potential litigation; competition within the cancer diagnostics and therapeutics field; ability to develop and protect proprietary intellectual property or obtain licenses to intellectual property developed by others on commercially reasonable and competitive terms; manufacturing supply chain risks; and material security breach or cybersecurity attack affecting the Company’s operations or property. This list of risks, uncertainties, and other factors is not complete. The Company discusses some of these matters more fully, as well as certain risk factors that could affect its business, financial condition, results of operations, and prospects, in its reports filed with the SEC, including its annual report on Form 10-K for the fiscal year ended 2025 and subsequent filings made by the Company, which are available through the SEC’s website at www.sec.gov. Any or all forward-looking statements the Company makes may turn out to be wrong and can be affected by inaccurate assumptions it might make or by known or unknown risks, uncertainties, and other factors, including those identified in this presentation. Accordingly, you should not place undue reliance on the forward-looking statements made in this presentation, which speak only as of its date. The Company assumes no responsibility to update or revise any forward-looking statements to reflect events, trends or circumstances after the date they are made unless the Company has an obligation under U.S. federal securities laws to do so.

Introduction

An Integrated CNS Oncology Company

- Central nervous system cancers are the largest underserved segment in US oncology
- Improving patient outcomes favor coordinated systems approaches rather than isolated innovations
- Cerenome is a commercial company designed to improve how CNS cancers are detected, treated, and understood

Think it solvable.



Houston, Texas Headquarters

Execution

Senior Leadership Team



Marc H. Hedrick,
M.D., MBA
President & Chief
Executive Officer



Russell Bradley
President & GM,
CNSide Diagnostics



Russ Havranek,
MS, MBA
EVP, Commercial
& Corporate Strategy



Andrew Sims,
CPA, ACA
Vice President &
Chief
Financial Officer



Eric J. Daniels,
M.D., MBA
Chief Development
Officer



Samantha Fowlkes
VP & Head of
Commercial Sales



Andrew Brenner,
M.D., PhD
Professor Medicine and
Neuro-Oncology
Clinical Investigator/Advisor



Introduction

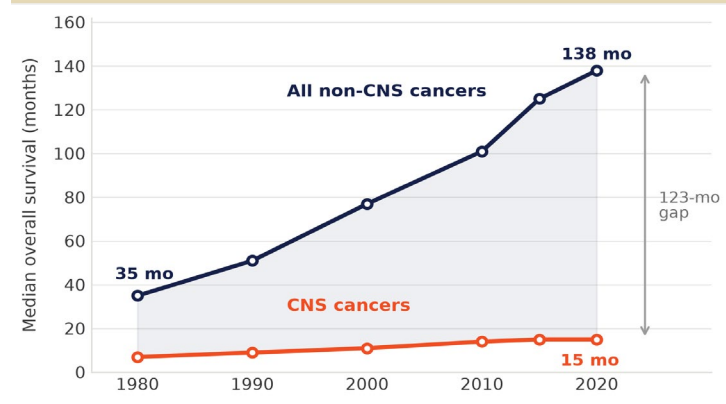
Cerenome: Anticipated Twelve-Month Value Drivers

Milestones	Details
Diagnostic - Commercial Adoption	• Growth in annualized test run rate • Expansion of platform & subsequent reimbursement • VP Commercial Sales hired Q3 2026; sales team deploying Q4 2026
Diagnostic - Revenue & Collections	• Begin billing & collections 2H 2026 • Growing covered lives • Medicare rate effective Jan 2027; Novitas coverage underway
Therapeutic - Multiple Phase 2 data read outs	• LM phase 2 interim analysis Q4 2026 • GBM phase 2 read out 1H 2027
Data Analytics & Artificial Intelligence - Return on data	• Building & mining a unique CSF oncology library/biobank • Native AI expected to improve lab efficiency & cost profile

The CNS Oncology Problem

Two Multi-Decade Trends Define the CNS Oncology Problem

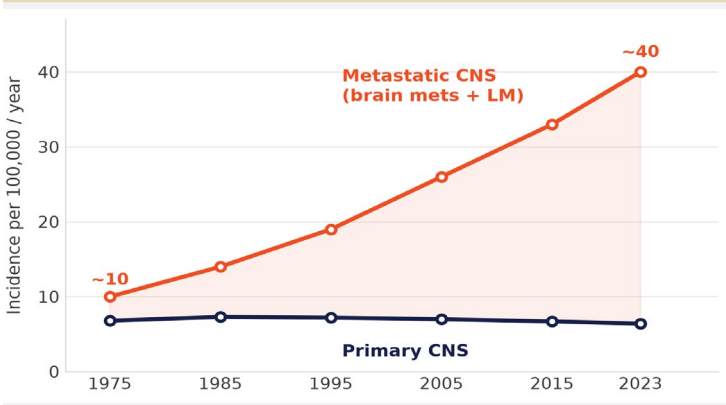
TREND 1 • THE UNMET NEED



Every oncology revolution has bypassed the CNS

Non-CNS median OS nearly quadrupled (35 → 138 months) but CNS OS has barely moved past one year

TREND 2 • THE GROWING CNS CANCER DISEASE BURDEN



Metastatic CNS cancer is an epidemic

An estimated **2 million** Americans are at risk for developing CNS metastatic disease

The CNS Oncology Problem

US CNS Metastases Epidemiology & Total Addressable Market

EPIDEMIOLOGY

US cancer survivors

Prevalence, all sites, all stages

18,600,000

CNS-at-risk pool

Prevalence of Metastatic CNS-tropic + non-metastatic solid at elevated risk + hematologic

2,000,000

95% UI 1.7–2.4M

Incidence - Receive a CNS work-up

Incidence of brain or spine imaging/LP, symptom-triggered or guideline-directed

600,000

95% UI 410–830K

Brain metastasis diagnosed

Incidence consensus estimate. US registries capture only 63,000 of these – a 3× coding gap

190,000

95% UI 170–210K

Leptomeningeal metastasis

Incidence of patients diagnosed today – the accepted clinical figure, 5.2% of incident US cancer

110,000

95% UI 94–129K

Leptomeningeal metastasis (actual)

Annual incidence of patients with malignant cells in the CSF (true LM burden)

345,000

95% UI 244,000–466,000

TOTAL ADDRESSABLE MARKET- DIAGNOSTIC

CNSide w/Expanded Testing Menu

~\$2.7B

~110K LM Cases

Broader CNSide Diagnostic Market

+ ~\$2.8B

~600K Annual CNS Work-Ups

~190K Brain Metastases Cases

TOTAL ADDRESSABLE MARKET-THERAPEUTIC

REYOBIQ (LM only)

~\$10B

~67K treatment-eligible US patients in 2030 × \$150,000 assumed WAC per course x 1 course per patient

The CNS Oncology Problem

CNS Cancer: An Integrated Approach is Essential

MULTIPLE SYSTEMS GOVERN INDIVIDUAL OUTCOMES



CERENOME INTEGRATES ACROSS 3 BUSINESS AREAS



Assess

Diagnostics

Assess/Diagnostics

CNSide CSF Assay Platform to Detect, Quantify & Characterize CNS Cancer

One cerebrospinal fluid (CSF) specimen – One comprehensive clinical report

STEP 1

Diagnosis & Monitoring

Is LM present, and burden?



Tumor Cell Enumeration (TCE)

Sensitive tumor cell detection and quantification; enables serial residual disease monitoring

Available today

STEP 2

Characterization & Therapy Selection – on the same CSF specimen

Which mutations & therapies?



CNSide CSF Molecular Profile

DNA & RNA sequencing of 300+ DNA genes & 1,600+ RNA transcripts to guide therapy selection

Planned October 12, 2026

What kind of tumor cells?



CNSide CSF Cellular Biomarkers

Protein expression tests; first group focused on breast cancer: ER, PR & HER2

Planned November 2026

Which chromosomal changes?



Targeted Chromosomal & Gene Alterations

Designed to detect and monitor chromosomal & gene alterations to guide therapy selection

In development

Residual Disease Monitoring Creates Testing Annuity Across the Care Continuum – NCCN Supports CSF Re-Evaluation Every 4–8 Weeks

Assess/Diagnostics

CNSide CSF Tumor Cell Enumeration Assay Detects & Quantifies LM

Overcomes limitations of existing standard of care

Comparative Performance**: CNSide vs. Standard of Care (SoC) Established CNSide Peer-Reviewed Evidence Base

MRI	Qualitative	Sensitivity 76%	Specificity 77%
Cytology	Qualitative	Sensitivity 50%	Specificity 100%
CNSide TCE	Quantitative	Sensitivity 92%	Specificity 95%

Appel et al., Neuro-Oncology Advances (2024) CNSide CSF TCE identified all CSF cytology-confirmed cases plus 13 additional cases, increasing diagnostic yield by 56.5%
Sweed et al., Arch Pathol Lab Med (2025) Validated microfluidic assay demonstrated accurate, reproducible tumor cell detection & quantification across clinical CSF specimens
Onoichenco et al., Neuro-Oncology Advances (2026) CNSide CSF TCE quantification & NGS informed treatment decisions, including targeted therapy selection & proton craniospinal irradiation

CNSide CSF TCE Adds Sensitive, Quantitative Tumor Cell Detection = Actionable LM Insights

TCE = Tumor Cell Enumeration

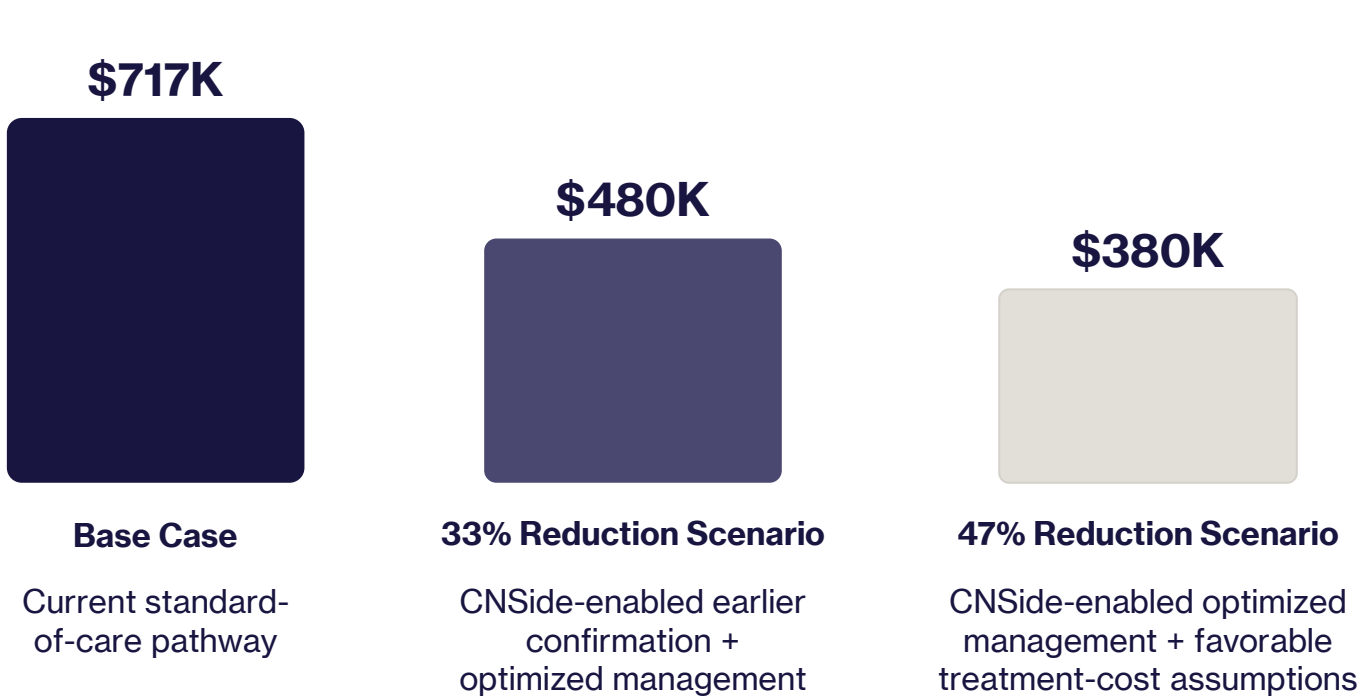
**Performance figures as reported in the cited publications; see appendix

Assess/Diagnostics

Payer Value & Payment Pathway: Earlier LM Management May Reduce Cost of Care

Modeled six-month cost of care declines with earlier LM detection; contracted access & proprietary reimbursement code establish the payment pathway

SIX-MONTH COST OF CARE PER LM PATIENT · MODELED SCENARIOS



Modeled savings persist across a range of treatment & cost assumptions

~40%
midpoint modeled reduction in six-month cost of care (33-47% across modeled scenarios)

- PAYER ACCESS & CODING STATUS**
- ✓ **158M contracted covered lives** (63% of non-Medicare)
 - ✓ Targeting largest national and regional payers
 - ✓ Payer billing underway
 - ✓ Proprietary reimbursement code effective July 1, 2026
 - ✓ Medicare billing number established (34M lives)
 - ✓ Medicare rate expected effective Jan 1, 2027; CMS final pricing expected November 2026

Selection of Contracted payers:



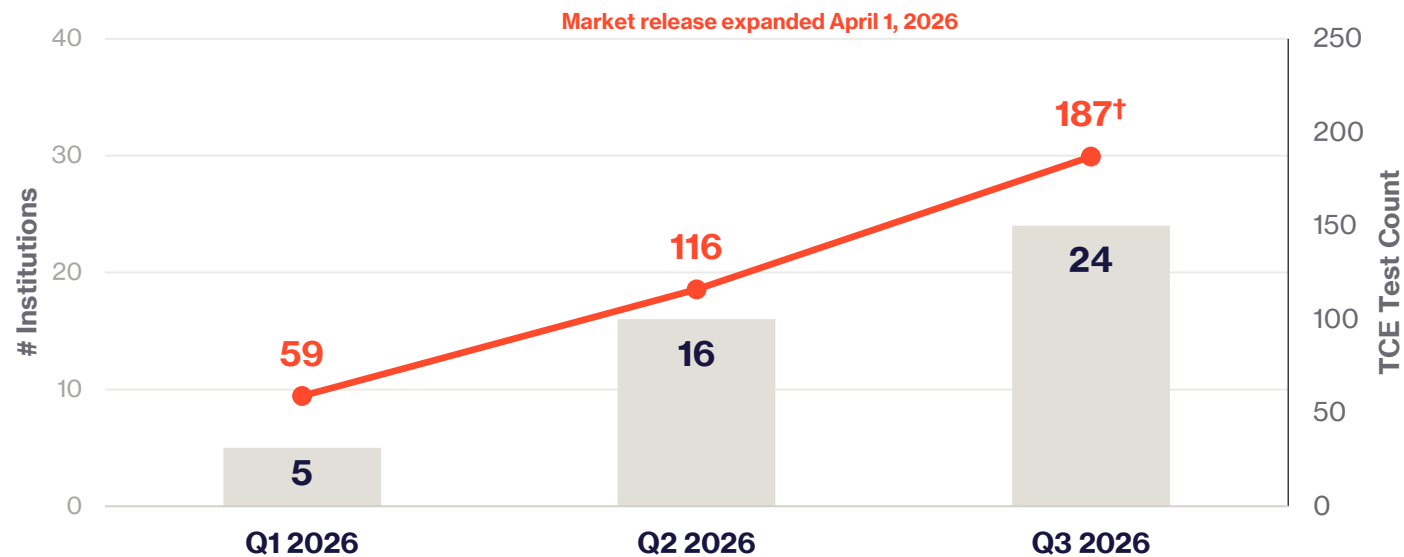
CNSide-Enabled Earlier LM Detection & Optimized Management **May Meaningfully Reduce LM Cost of Care**

Assess/Diagnostics

CNSide Commercial Adoption Broadens as Repeat Ordering Increases

Cumulative ordering institutions grew from 5 in Q1 to 24 in Q3 to date ~ 5x expansion

Ordering Institutions & Quarterly Commercial TCE Volume



Columns (left axis) = aggregate commercial ordering institutions, cumulative and de-duplicated; Q3 2026 is actual at September 30, 2026.
Line (right axis) = commercial CNSide TCE specimens received in the quarter, reported actuals.
† Q3 2026 = July, August and September 2026 actuals.

Actual basis; commercial ordering institutions only, clinical-trial specimens excluded. Commercial TCE specimens: Q1 59, Q2 116; Q3 2026 of 187 = July 66 + August 55 actual + September 66 actual. Year to date 362. Q3 2026 total CNSide TCE tests including clinical-study specimens: ~203. Quarter-over-quarter growth cited on the September 30, 2026 call (64%; ~41%) is on that total-tests basis; this chart shows commercial TCE only.
Aggregate ordering institutions = distinct commercial ordering institutions with ≥1 specimen, cumulative and de-duplicated: Q1 5, Q2 16, and 24 actual at September 30, 2026. Q1 2026 was Early Access Program only, capped at 5 institutions through Mar 31, expanded Apr 1. Repeat-ordering institutions = institutions ordering in ≥2 separate calendar months; 97% = 352 of 362 commercial specimens year to date.
Figures are actuals through September 30, 2026; they are not guidance and not a projection of financial results. Source: CNSide company data, September 30, 2026. See Forward-Looking Statements at the front of this presentation.

Commercial Momentum

43

Ordering providers across 24 institutions

97%

of YTD TCE volume from the 15 institutions ordering in 2+ months

42%

Institutions using CNSide for ongoing patient monitoring

0

Field-based salespeople deployed to date

Select ordering institutions:



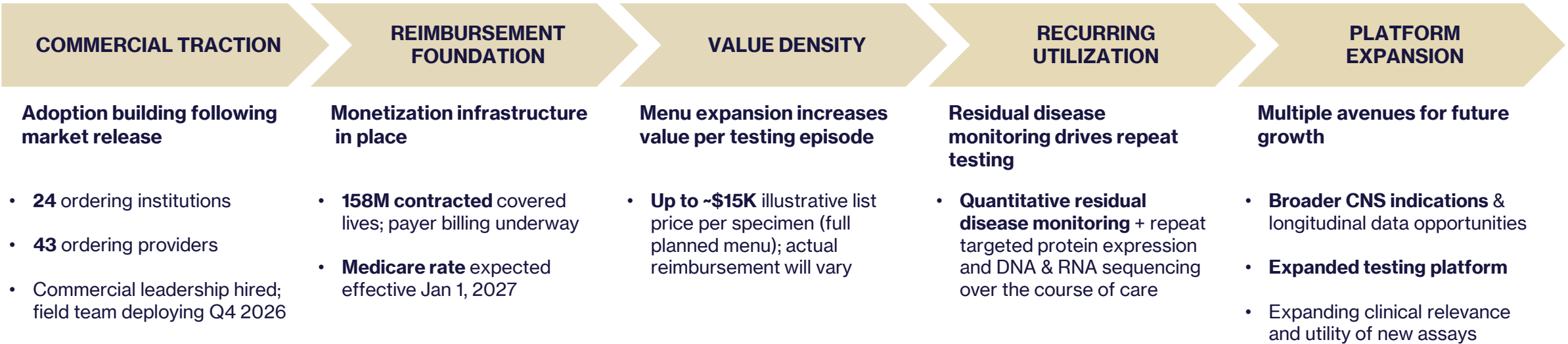
Early Adoption & Repeat Utilization **Demonstrate Growing Commercial Traction** Ahead of Field Sales Expansion

Assess/Diagnostics

CNSide Diagnostics: Value Creation Framework

Multiple near-term growth drivers

Five Growth Pillars



Near-Term Value Drivers



CNSide is Positioned to Scale From a Single Commercial Assay Into a Broad CNS Diagnostics Platform

Intervene

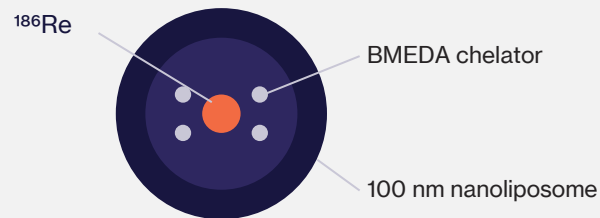
Therapeutics

Intervene/Therapeutics

Lead Asset – REYOBIQ: a first-in-class targeted CNS radiotherapeutic

3 PART DRUG FORMULATION

Radioisotope · Small molecule · Carrier = Unified MoA



Beta Particles = Lethal DS-DNA breaks in tumor cells
Gamma Particles = real-time SPECT imaging (theranostic)

Rhenium-186

- Well-established Mechanism of Action (MoA) to kill tumor cells at short distance (2mm tissue range)

BMEDA chelator

- Locks the isotope inside the carrier, so ^{186}Re travels with the particle rather than dispersing freely

100 nm nanoliposome

- Sized to remain in the CSF compartment or the tumor

Radiation remains local

2 DELIVERY MODALITIES*

CSF Compartment OR Brain



Intraventricular catheter
(Ommaya reservoir)



Convection-enhanced
delivery (CED)

Intrathecal – leptomeningeal metastases

- Compartmental direct delivery into the affected tumor area

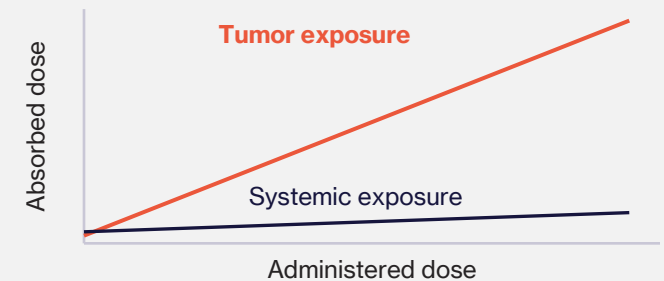
CED – glioblastoma and pediatric

- Infused under positive pressure directly into the tumor bed

Blood-brain barrier bypassed

1 BROAD THERAPEUTIC IMPACT

CNS Tumor Radiation vs. Systemic Exposure



Much higher radiation doses vs. standard of care

- Formulation allows up to 20x radiation dose vs. standard of care with minimal systemic exposure = high therapeutic index

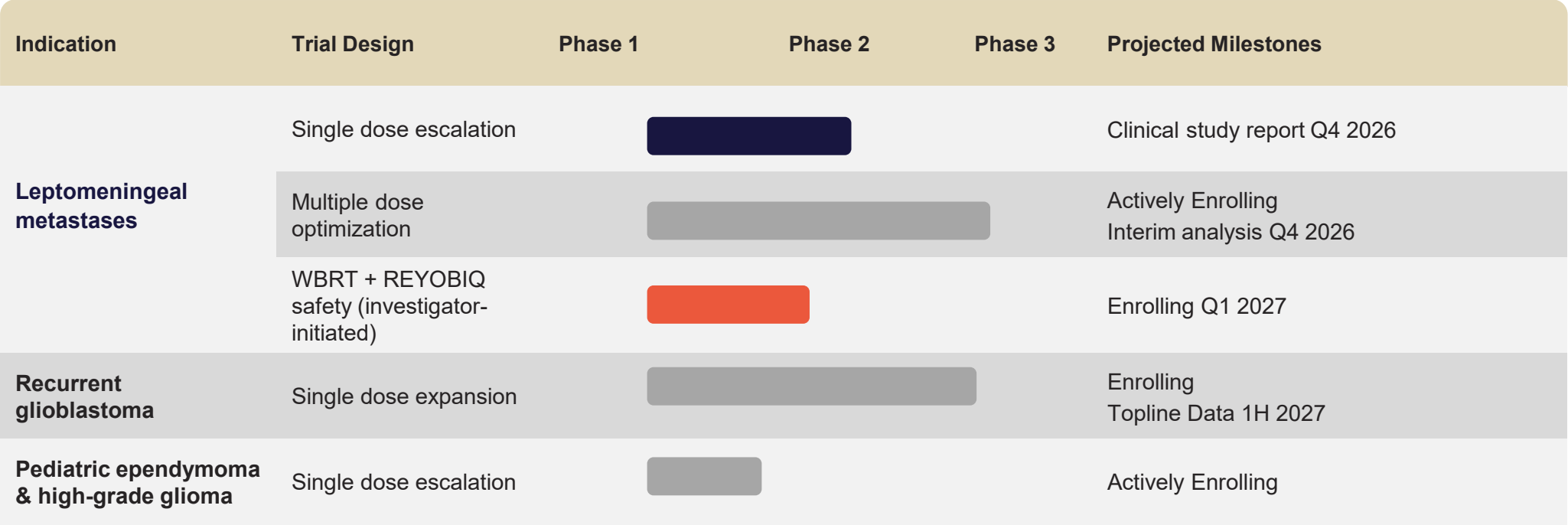
Extended pharmacokinetics

* more than 98% of all small-molecule drugs and nearly 100% of large-molecule drugs fail to reach the CNS

Intervene/Therapeutics

Pipeline - Five REYOBIG trials deliver mid-stage readouts across next 12-months

Leptomeningeal metastases studies plus recurrent glioblastoma and pediatric programs, each funded by non-dilutive grants.



Completed Enrolling now Enrollment opening

WBRT = whole brain radiation treatment

Intervene/Therapeutics

ReSPECT-LM: Phase 1a – Single Dose Trial Completed

N=29 patients enrolled; (NCT05034497)

Safety & Tolerability

44.1 mCi

RP2D established

2 of 29

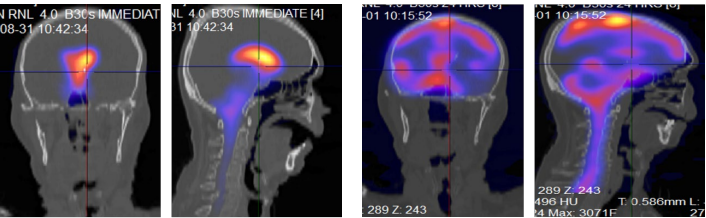
Patients with dose limiting toxicity

What the Safety Dataset Shows

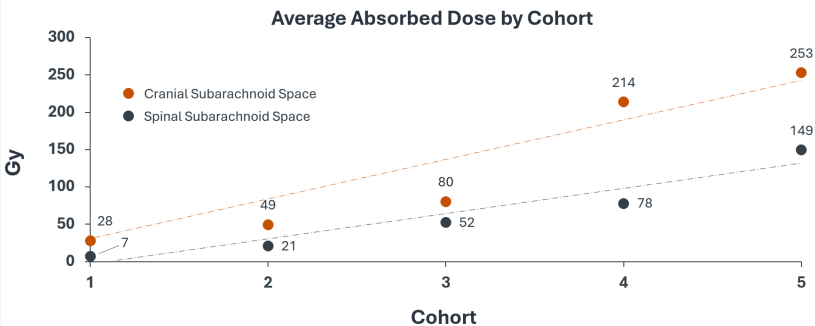
- AEs predominantly Grade 1–2; 33% of patients had a Grade ≥3 event
- Most common: headache 48% (none Grade ≥3)
- 2 Dose Limiting Toxicities: highest & 2nd highest dose related to thrombocytopenia & responsive to therapy
- No treatment-related deaths and no discontinuations for serious adverse reactions

Generally Safe & Well Tolerated

Dosimetry



Radiation remains local = targeted therapy



Radiation doses >> standard of care (30Gy)

Clinical Benefit

Circulating Tumor Cells (CTC) Response

93%

14 of 15 patients

MRI Imaging Response

76%

13 of 17 patients

Clinical Response (CR+PR+SD)

87%

13 of 15 patients

Median Overall Survival

9 months

N = 16 patients

CR = complete response, PR = partial response, SD = stable disease

Intervene/Therapeutics

REYOBIQ Clinical Development Plan for LM

Phase 1a (Dose Exploration)

Single Dose

N=29 Patients
Dosing = 6.6mCi – 75mCi
RP2D = 44.1 mCi

1° Endpoint	Safety
2° Endpoints	Clinical Response
	MRI response
	Circulating Tumor Cell Count
	Overall Survival

Radiation To Target: 30-250 Gy vs. 30 Gy using conventional methods

Data Presented at SNO ASCO 2025

Status: complete, Manuscript in preparation

Phase 2a (Dose Optimization + Randomization)

Multi Dose

N=80-90 Patients
Dose Optimization = 13.2 mCi – 44.1mCi + interval
Dose Randomization = TBD

1° Endpoint	Safety
2° Endpoints	Composite Neurological Fxn.
	Patient Reported Outcomes
	Clinical Response
	MRI response
	Circulating Tumor Cell Count
	Overall Survival



Status: Enrolling



Registration (Randomized Controlled Trial)

Multi Dose

N=~150 Patients
Dosing = TBD

1° Endpoints	Composite Neurological Fxn.
	Patient Reported Outcomes
	Overall Survival
2° Endpoints	Clinical Response
	MRI response
	Circulating Tumor Cell Count
	Safety

Status: estimated to begin 2H 2028

Intervene/Therapeutics

ReSPECT-GBM: Program Overview – Phase 2 Enrollment Completion in Q4 2026

NCT01906385

Up to 20X radiation dose

Radiation dosed to tumor vs. current standard of care

~3x longer survival

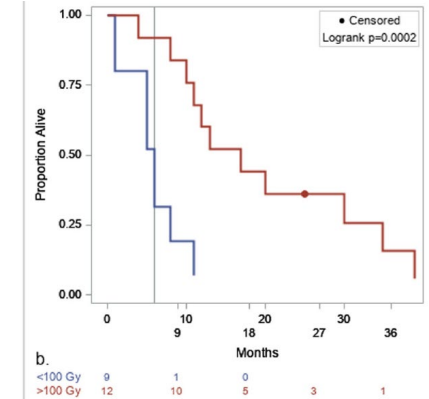
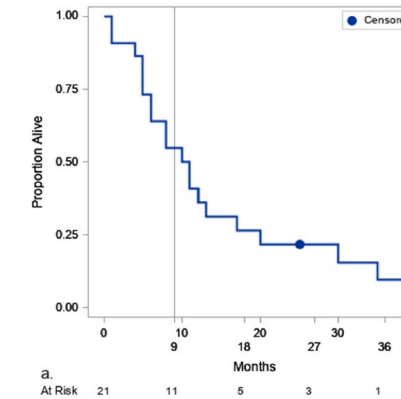
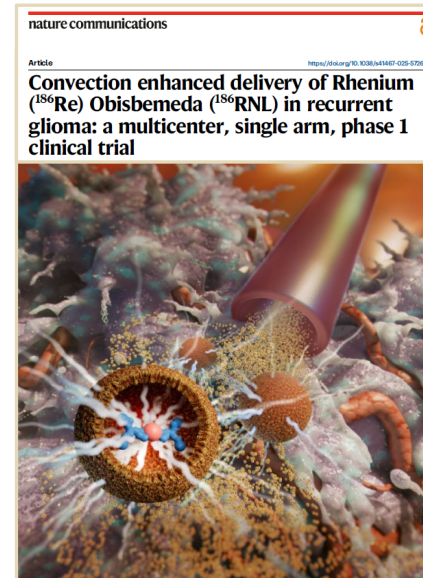
Patients receiving >100Gy vs. those receiving <100Gy

PHASE 1 DOSE ESCALATION – KEY FINDINGS

- Radiation dose to tumor up to 740 Gy, average dose greater than 300 Gy
- Patients receiving >100 Gy had 17 months mOS vs 6 months <100 Gy ($p=0.001$)
- P1 data analyzed against 2 ‘real-world’ control arms:
 - 113% for patients receiving therapeutic dose radiation (≥ 100 Gy; 38% improvement for entire population)

PHASE 2 – INTERIM DATA & NEXT STEPS

- Median overall survival (mOS) in 15 patients from Phase 2 study was 13 months, 63% better than current standard of care (8 months)
- Median progression free survival (mPFS) 11 months, vs. SOC at 4 months
- Advancing program (e.g., pivotal, out-licensing) data dependent



a For all patients, mOS was 11.0m (95% CI 5.0–17.0 m). **b** When dichotomized by absorbed dose, patients who received <100 Gy had a mOS of 6.0m (95% CI 1.0–11.0m) and those with ≥ 100 Gy had a mOS of 17.0m (95% CI 8.0–35.0m).

Dose, not patient selection, drives survival; **Phase 2 Single Dose Trial to read out 1H 2027**

Intervene/Therapeutics

ReSPECT-PBC: REYOBIQ for Radiation Sensitive Pediatric Brain Cancer

NCT07061626

EPENDYMOMA

~200

Annual US cases

|

50-70%

5-year survival

HIGH-GRADE GLIOMA

~500

Annual US cases

|

10-15%

5-year survival



DOSE-ESCALATION DESIGN FOR RECURRENT EPENDYMOMA AND HIGH-GRADE GLIOMA

Part	Tumor size cap	Concentration	Estimated absorbed dose
Phase 1a — Cohort A	≤2 cm / ≤4.2 mL	0.5 mCi/mL	~87.5 Gy
Phase 1b — Cohort B	≤3.5 cm / ≤22.4 mL	1.0 mCi/mL	~176 Gy
Phase 2a — efficacy	Per recommended dose	Recommended dose	MTD-derived

SITE STATUS, CONSTRAINTS AND OPTIONALITY

Where the Program Stands

- Lurie Children's Hospital of Chicago activated and actively identifying patients
- Expect to enroll and treat 7 subjects over the next 12 months
- Potential eligibility for a rare pediatric disease priority review voucher, subject to program availability

ReSPECT-PBC extends REYOBIQ into an orphan pediatric indication funded by US DoD grant – actively enrolling

Learn

Data Analytics

Learn/Data Analytics

Valuing Data: Healthcare Data Comparables

As frontier models commoditize, unique deep data set compounds & native AI unlocks

“Everyone has access to the same models.
The differentiator is your data.”

Michael Dell
Founder & CEO, Dell Technologies · May 2026

“We believe the cure for cancer may live in this
valuable data.”

Erik Wexler
President & CEO, Providence · January 2025

“Tempus has spent the last decade investing billions
of dollars into collecting the necessary data needed
for a foundation model of this kind to take shape.”

Eric Lefkofsky
Founder & CEO, Tempus AI · April 2025

WHAT BUYERS HAVE PAID FOR PROPRIETARY CLINICAL DATA

\$1.9B

Roche acquires Flatiron Health –
oncology real-world evidence (2018)

\$320M

Truveta raises at a >\$1B valuation on
120M+ patient records (2025)

\$305M

TTAM acquires 23andMe and its
15M+ DNA profiles (2025)

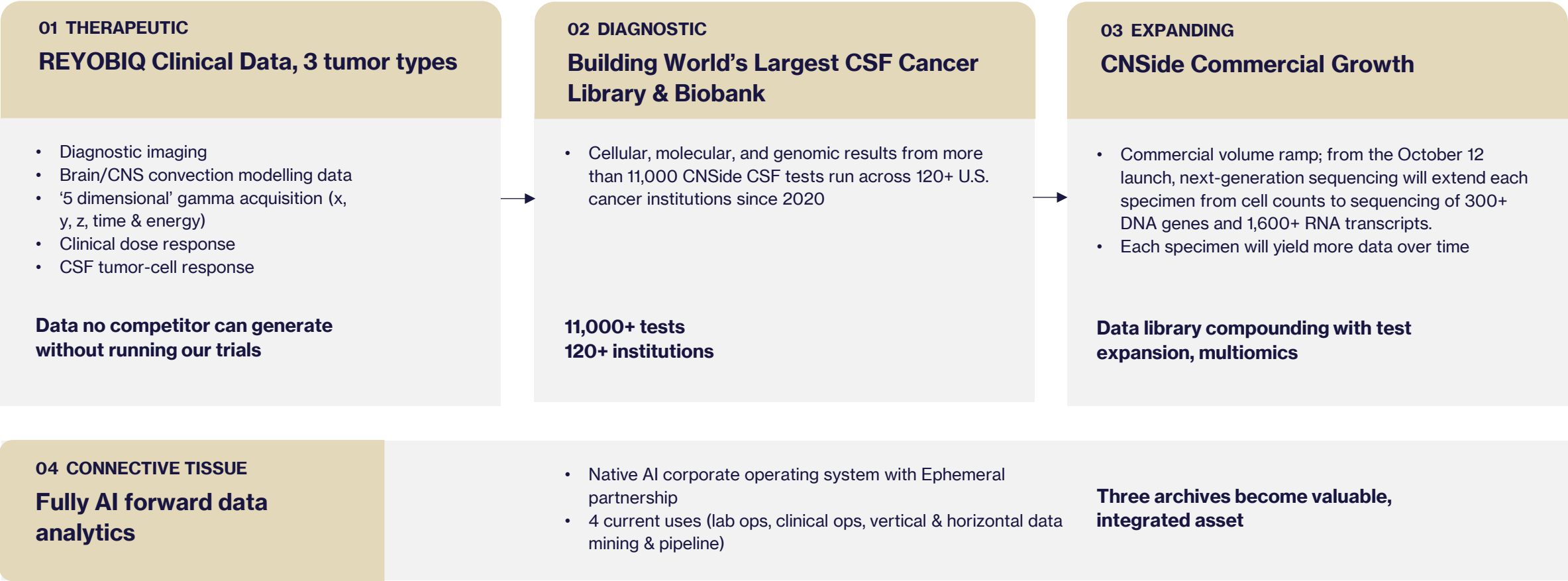
\$200M

AstraZeneca and Pathos license
Tempus oncology data (2025)

Learn/Data Analytics

Multiple Data Assets Married to Native AI Backbone

Deep CNS data most companies do not see – therapy, diagnostics, and outcomes on the same patients.



Calculating Return on Data - Operational Examples

Projected near-term impact of the native AI on key operations

01 · CAPACITY

~4x

More Diagnostic Throughput

Automating purchasing, manufacturing queueing, and intake cuts hands-off tech time, freeing CLIA and MFG to run more cycles per week

Modeled: 16–36 → 64–120 specimens / week (typical-peak)

02 · QUALITY

~2.8x

Fewer Process Errors

Each of the 10 diagnostic process steps carries an estimated 1% error rate; full automation removes a step's error, partial automation halves it

Modeled: 9.56% → 3.45% chance of ≥1 error per run

03 · CLINICAL

1–2 FTEs

Leaner, Faster Trials

Automated site activation, enrollment tracking, and monitoring let Clinical Operations take on bigger trials without adding headcount, and target an earlier data close

Modeled: 2–3 months earlier close vs. monodose baseline

Execution

Upcoming Anticipated Milestones

Diagnostic

- ✓ Reach >150 million covered lives for CNSide Diagnostic platform; achieved in August; ~158M as of September
- Obtain Medicare and Medicaid coverage; on track – Medicare rate expected effective Jan 1, 2027; Novitas coverage and Medicaid underway
- Establish order rate of 1,250 total tests per annum; on track
- Establish 50 or more ordering physicians for CNSide in 2026; on track – 39 physicians among 43 ordering providers
- Expand platform and launch additional CSF tumor characterization tests; on schedule – Molecular Profile Oct 12; Cellular Biomarkers Nov 2026 (SNO)

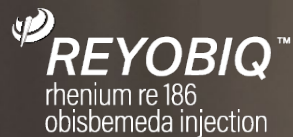
Therapeutic

- Complete enrollment in ReSPECT-GBM Phase 2 trial for recurrent glioblastoma
- Define optimal dose/interval for REYOBIQ in ReSPECT-LM Phase 2 expansion trial and begin enrollment
- Complete manufacturing scale-up for REYOBIQ commercial drug availability
- Enroll first patient in the ReSPECT-PBC pediatric brain cancer Phase 1 trial with REYOBIQ

On track to hit all key milestones in 2026



Think it solvable.



Contact us at investor@cerenome.com

