
**UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, D.C. 20549**

FORM 8-K

CURRENT REPORT

Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934

Date of Report (Date of earliest event reported): October 15, 2026

CORBUS PHARMACEUTICALS HOLDINGS, INC.

(Exact name of Registrant as Specified in Its Charter)

Delaware
(State or Other Jurisdiction
of Incorporation)

001-37348
(Commission File Number)

46-4348039
(IRS Employer
Identification No.)

**500 River Ridge Drive
Norwood, Massachusetts**
(Address of Principal Executive Offices)

02062
(Zip Code)

Registrant's Telephone Number, Including Area Code: (617) 963-0100

Not Applicable

(Former Name or Former Address, if Changed Since Last Report)

Check the appropriate box below if the Form 8-K filing is intended to simultaneously satisfy the filing obligation of the registrant under any of the following provisions:

- ☐ Written communications pursuant to Rule 425 under the Securities Act (17 CFR 230.425)
- ☐ Soliciting material pursuant to Rule 14a-12 under the Exchange Act (17 CFR 240.14a-12)
- ☐ Pre-commencement communications pursuant to Rule 14d-2(b) under the Exchange Act (17 CFR 240.14d-2(b))
- ☐ Pre-commencement communications pursuant to Rule 13e-4(c) under the Exchange Act (17 CFR 240.13e-4(c))

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Trading Symbol(s)	Name of each exchange on which registered
Common Stock, par value \$0.0001 per share	CRBP	The Nasdaq Capital Market

Indicate by check mark whether the registrant is an emerging growth company as defined in Rule 405 of the Securities Act of 1933 (§ 230.405 of this chapter) or Rule 12b-2 of the Securities Exchange Act of 1934 (§ 240.12b-2 of this chapter).

Emerging growth company ☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Item 7.01 Regulation FD Disclosure.

Corbus Pharmaceuticals Holdings, Inc. updated its presentation used by management to describe its business. A copy of the presentation is furnished as Exhibit 99.1 and incorporated herein by reference.

The information in this Current Report on Form 8-K under Item 7.01, including the information contained in Exhibit 99.1, is being furnished to the Securities and Exchange Commission, and shall not be deemed to be “filed” for the purposes of Section 18 of the Exchange Act, or otherwise subject to the liabilities of that section, and shall not be deemed to be incorporated by reference into any filing under the Securities Act or the Exchange Act, except as shall be expressly set forth by a specific reference in such filing.

Item 9.01 Financial Statements and Exhibits.

(d) Exhibits:

Exhibit No.	Description
99.1	Investor Presentation
104	Cover Page Interactive Data File (embedded within the Inline XBRL document).

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned hereunto duly authorized.

Corbus Pharmaceuticals Holdings, Inc.

Date: October 15, 2026

By: /s/ Yuval Cohen

Name: Yuval Cohen

Title: Chief Executive Officer



Connecting Innovation to Purpose

Corporate Presentation

October 15, 2026



www.corbuspharma.com

@corbuspharma

NASDAQ: CRBP

Forward-Looking Statements

This presentation contains certain forward-looking statements within the meaning of Section 27A of the Securities Act of 1933 and Section 21E of the Securities Exchange Act of 1934 and Private Securities Litigation Reform Act of 1995, as amended, including those relating to the Company's trial results, product development, clinical and regulatory timelines, including timing for completion of trials and presentation of data, market opportunity, competitive position, possible or assumed future results of operations, business strategies, potential growth opportunities, sufficiency of cash runway and other statements that are predictive in nature. These forward-looking statements are based on current expectations, estimates, forecasts and projections about the industry and markets in which we operate and management's current beliefs and assumptions.

These statements may be identified by the use of forward-looking expressions, including, but not limited to, "expect," "anticipate," "intend," "plan," "believe," "estimate," "potential," "predict," "project," "should," "would" and similar expressions and the negatives of those terms. These statements relate to future events or our financial performance and involve known and unknown risks, uncertainties, and other factors on our operations, clinical development plans and timelines, which may cause actual results, performance or achievements to be materially different from any future results, performance or achievements expressed or implied by the forward-looking statements. Such factors include those set forth in the Company's filings with the Securities and Exchange Commission, including those described in our Annual Report on Form 10-K for the year ended December 31, 2025. Prospective investors are cautioned not to place undue reliance on such forward-looking statements, which speak only as of the date of this presentation. The Company undertakes no obligation to publicly update any forward-looking statement, whether as a result of new information, future events or otherwise, except as required by law.

This presentation includes limited observations derived from separate clinical settings that are not, and should not be interpreted as, direct or indirect head-to-head comparisons of CRB-701 or CRB-913 with any other product. The observations described herein are subject to change as additional data become available, and future clinical trials of CRB-701 or CRB-913 may not reproduce, validate, or otherwise confirm these observations.

All product names, logos, brands and company names are trademarks or registered trademarks of their respective owners. Their use does not imply affiliation or endorsement by these companies.



Differentiated portfolio in Oncology and Obesity

Pipeline of promising clinical assets targeting large commercial opportunities with significant unmet needs

Oncology

CRB-701



Nectin 4 ADC – OPSCC (lead), cervical cancer

- Promising Phase 1/2 2L data: 43% ORR at 3.6 mg/kg in OPSCC
- Registrational 2L OPSCC study (TEMPO-1) underway
- CRB-701 + pembrolizumab data in 1L OPSCC in Q1 2027
- Potential BLA filing in 2L OPSCC in 2H 2028
- Large TAM: ~14k 2L OPSCC eligible patients

Obesity

CRB-913



Peripherally restricted CB1 inverse agonist for obesity

- Competitive 5% placebo adjusted weight loss in Phase 1b at 12 weeks
- Favorable emerging safety and tolerability profile
- Phase 2 monotherapy study expected to start 1H 2027
- > 1 billion people worldwide living with obesity

Focused and diversified pipeline

Therapy	Mechanism of Action	Indication (rights)	Pre-Clinical	Phase 1	Phase 2	Phase 3	Milestones
CRB-701	Nectin-4 ADC positive solid tumors	2L OPSCC (US + Europe)					First patient dosed in TEMPO-1 in Sept. 2026
		1L OPSCC (US + Europe)					Topline ORR data expected in Q1 2027
		Cervical (US + Europe)					Broad alignment with the FDA on registrational study
CRB-913	Highly peripherally-restricted CB1 inverse agonist	Obesity (Global)					Phase 2 monotherapy study expected to commence 1H 2027

\$118M

Cash, cash equivalents & investments as of June 30, 2026: approximately 18.7M common shares issued and outstanding (~22.4M fully diluted shares)

Senior Management Team



Yuval Cohen, PhD

Chief Executive Officer, Director

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



Sean Moran, CPA, MBA

Chief Financial Officer

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



Ian Hodgson, PhD

Chief Operating Officer

Dr. Hodgson joined Corbus in 2022. Previously he held senior leadership positions in biotech and contract research organizations. Most recently served as V.P., Head of Clinical Services at TMC Pharma.



Nishant Saxena, MBA

Chief Business Officer

Mr. Saxena joined Corbus in May 2026. Most recently he was CFO at Jeune Aesthetics, Inc. and previously was a healthcare investment banker at Evercore.



Leo Nicacio, MD

Chief Medical Officer

Dr Nicacio joined Corbus in August 2026. Most recently he was the CMO at Protara and previously was VP of Clinical Development at Seagen.

Board of Directors



Rachelle Jacques

Chair of the Board

More than 30-year professional career, experience in U.S. and global biopharmaceutical commercial leadership, including multiple high-profile product launches in rare diseases; CEO of Vasque Bio and former CEO of Enzyvant Therapeutics (now Sumitomo Pharma) and Akari Therapeutics (NASDAQ: AKTX)



Anne Altmeyer, PhD, MBA, MPH

Director

Greater than 25 years of experience advancing oncology R&D programs and leading impactful corporate development transactions; former CEO of Tigris (acquired by Epsilon Ltd.)



Winston Kung, MBA

Director

More than 20 years of senior financial, business development and investment banking experience; currently CFO of ArriVent. (NASDAQ: AVBP)



John K. Jenkins, MD

Director

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



Yong (Ben) Ben, MD, MBA

Director

25 years of oncology R&D experience across industry and academia. CMO of BridgeBio Oncology Therapeutics and former CMO of BeiGene



Yuval Cohen, PhD

Chief Executive Officer, Director

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



Brent Pfeifferberger, PharmD, MBA

Director

President and CEO of Century Therapeutics (NASDAQ: IPSC). Former SVP Head of U.S. Oncology at BMS

Anticipated corporate milestones

CRB-701

[Link](#) to slides

Commence registrational study in 2L OPSCC

Sept 2026



CRB-701 + pembrolizumab in 1L OPSCC data

Q1 2027

Interim ORR readout in 2L OPSCC

1H 2028

Potential BLA filing for 2L OPSCC

2H 2028

CRB-913

[Link](#) to slides

Additional Phase 1b data at *ObesityWeek®* 2026

November 2026

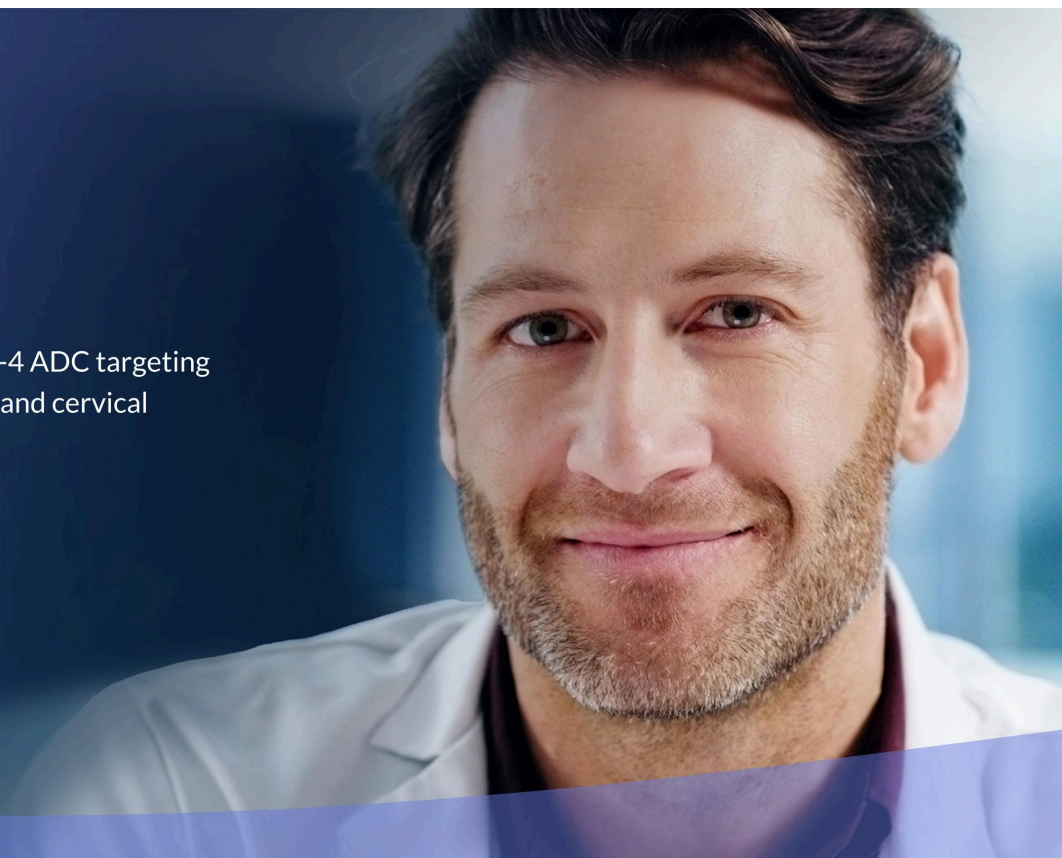
Initiate Phase 2 monotherapy study

1H 2027



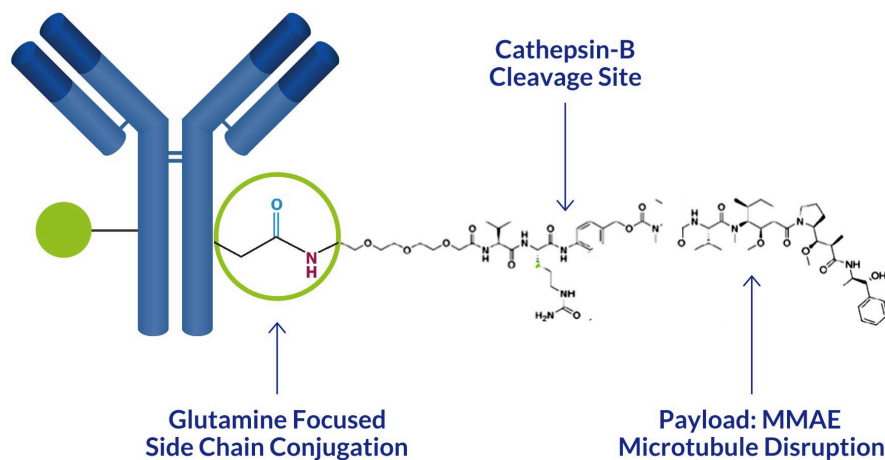
CRB-701

Next-Generation Nectin-4 ADC targeting
oropharyngeal (OPSCC) and cervical
cancers



CRB-701: Reimagining the next-generation Nectin-4 ADC

Novel Nectin-4 Antibody
ADCC + CDC functionality



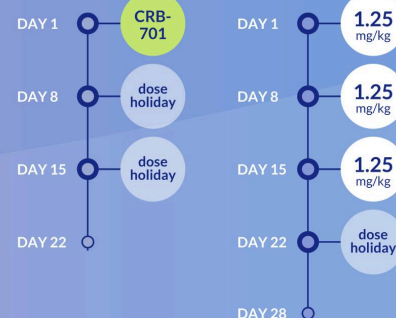
Precise & stable DAR of 2

2x internalization vs. PADCEV®

Reduced free MMAE

CRB-701

PADCEV
enfortumab vedotin-ej/v

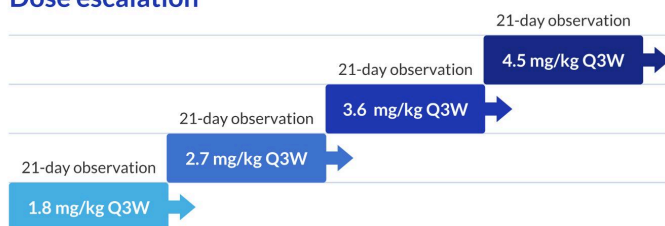


CRB-701-01 Study design (U.S. and Europe)

BERLIN 2025 **ESMO** congress

Dose escalation/
de-escalation decisions
were made based on the
occurrence of DLTs

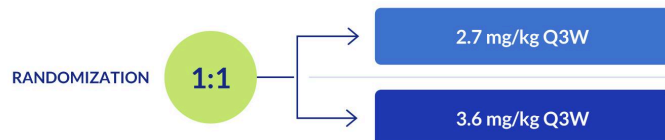
Dose escalation



2026 **ASCO**
ANNUAL MEETING

Dose levels in part B
were defined by the
pharmacologically
active dose range
identified in part A

Dose Optimization (Project Optimus): HNSCC & cervical



CRB-701
+ pembrolizumab
data expected
in Q1 2027

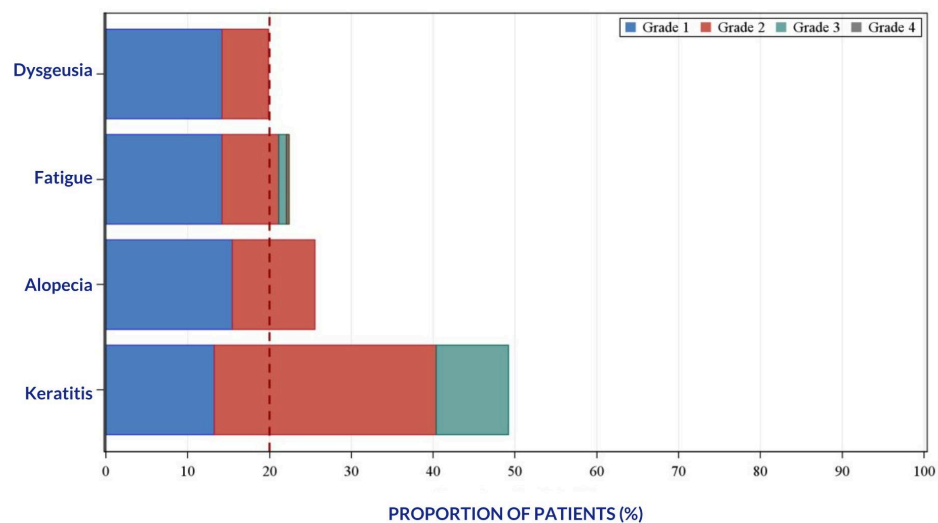
ASCO 2026: Key characteristics & tumor types

Enrolled Tumor Types	Safety Population	Efficacy Evaluable Population	Non-evaluable*
Study Population treated with monotherapy CRB-701 (All tumors, all doses, parts A+B of study)	317	NA	NA
HNSCC (2.7 mg/kg and 3.6 mg/kg)	75	71	4
Cervical (2.7 mg/kg and 3.6 mg/kg)	72	70	2

*Patients enrolled but did not reach first scan

Baseline Characteristic	HNSCC	Cervical
Median age (range)	62 (24–78)	54 (32–78)
Sex (M/F)	89.3% / 10.7%	NA / 100%
ECOG PS** 0, 1, 2	47%, 52%, 1%	44%, 56%, 0%
Weight in kg mean (range)	75.2 (41.3–132.8)	64.3 (39.0–99.0)
Prior therapies median (range)	3 (1–9)	3 (1–7)

ASCO 2026: Study safety population TRAEs $\geq 20\%$ (n=317)



TRAE	n=317 (%)
Grade 3	19.2%
Grade 4	0.9%
Grade 5	None
PERIPHERAL NEUROPATHY (<i>broad terms*</i>)	
Grade 1 and 2	7.3%
Grade >3	None
SKIN (most common, excluding alopecia)	
Pruritus	14.2%
Dry skin	13.2%
Rash	5.7%
Grade 3 - rash	0.3%
Grade ≥ 4	None
OCULAR	
Overall	66.2%
Grade 3	12.6%
Grade 4	0.3%**
DISCONTINUATIONS	
Due to AE	2.8%
Due to ocular AE	1.9%

ASCO 2026: Safety Summary (TRAEs, N=317)



Potentially best-in-class for peripheral neuropathy

7.3% (all Grade 1 or 2)*



Low rates of skin adverse events

ONLY
1 in 4
Patients experienced
skin AEs (excluding alopecia)

JUST A SINGLE
Grade 3 event (1/317**) & NO
Grade >4

NO
Cases of Stevens-Johnson
syndrome (SJS) or toxic
epidermal necrolysis
(TEN)



Eye toxicities
manageable with
prophylaxis and
dose modification

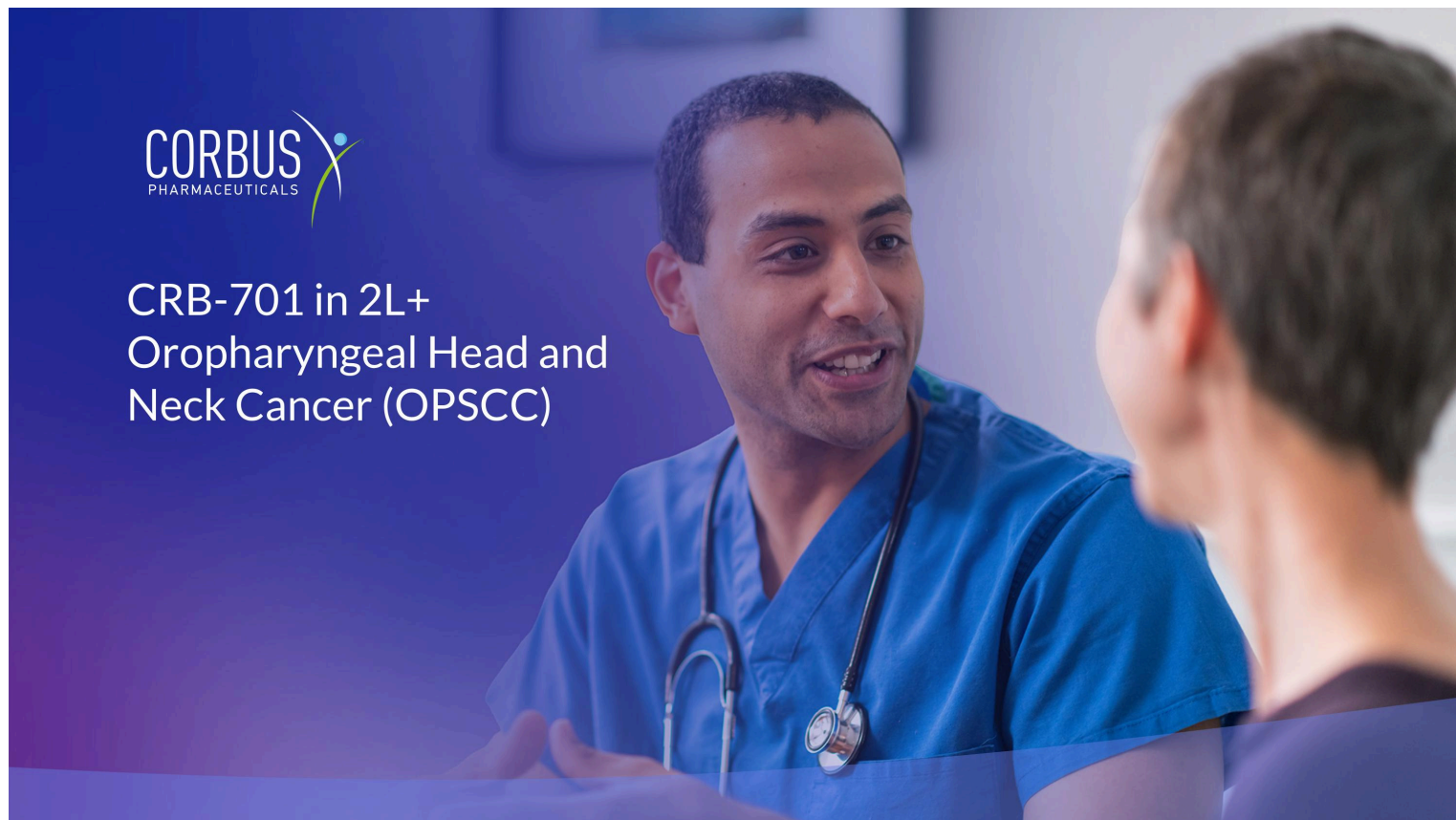
15.5%
Patients with
dose reductions

37.2%
Patients with
dose interruptions

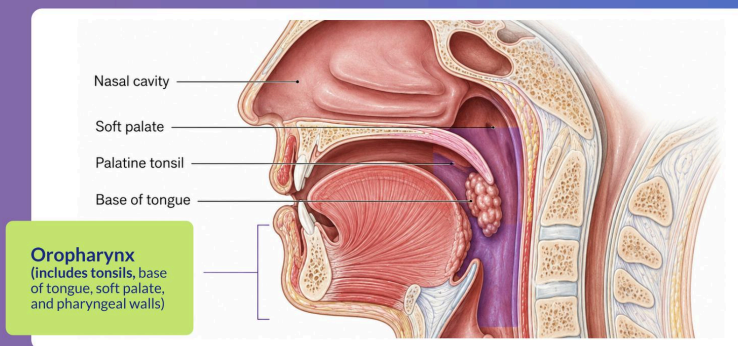
1.9%
Few discontinuations
due to eye toxicities



CRB-701 in 2L+
Oropharyngeal Head and
Neck Cancer (OPSCC)



What is Oropharyngeal Squamous Cell Carcinoma (OPSCC)?



HPV+ tumors
(80–90% of OPSCC)¹

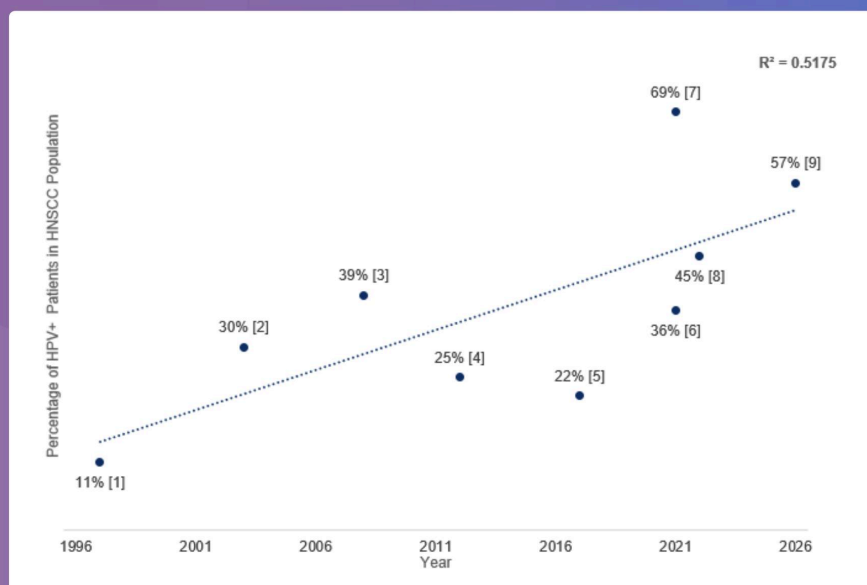


Associated with higher Nectin-4 expression²

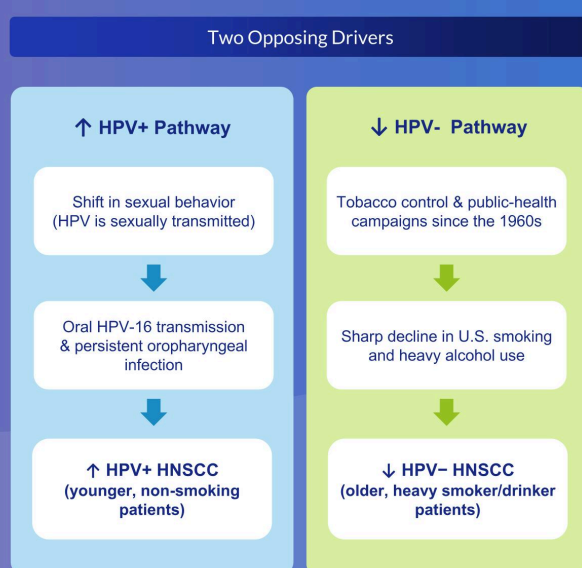
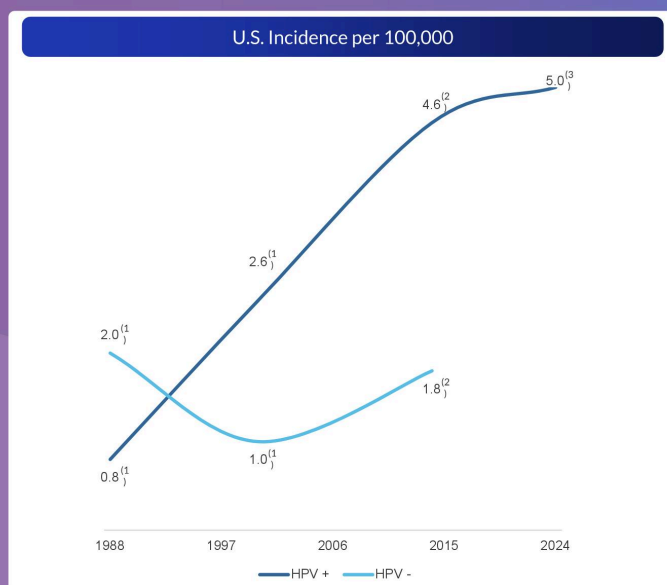


HPV+ selectivity seen with PADCEV® in 1L HNSCC³

OPSCC is on the rise in the U.S. as prevalence of HPV+ in HNSCC is increasing: 11% → 57% over last 30 years



OPSCC growing in HNSCC: HPV+ incidence is growing while HPV- is decreasing



Summary of OPSCC U.S. Epidemiology and Treatment Eligibility



Total Prevalence:
~114,000*



Total Annual Incidence:
~23,000*



Annual Growth: ~2%
through 2040*



Annual U.S. Deaths:
~7,000**

~23 K*

Total Incident OPSCC

Incurable Setting: Recurrent locally
Advanced or Metastatic Disease

~18 K*

1L

Keytruda
monotherapy
or
Keytruda® +
Platinum +/-
5FU or taxane

~14 K*

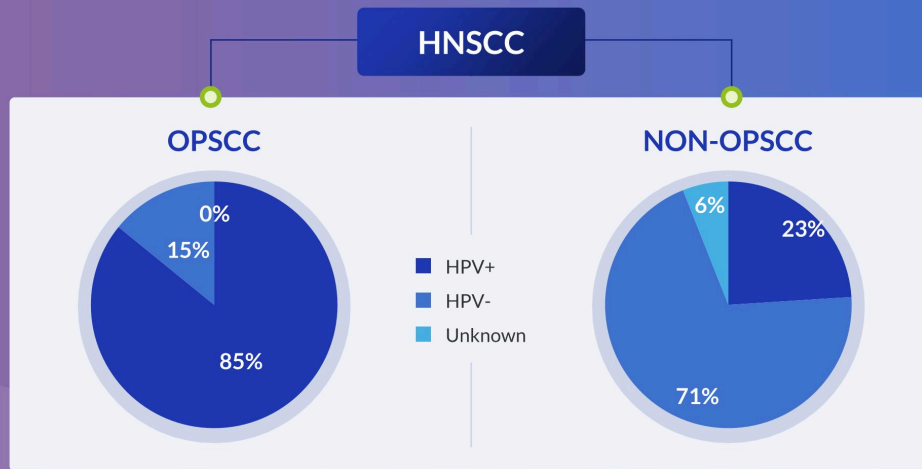
2L+

Taxanes,
cetuximab or
5FU
monotherapy or
in combination

ASCO 2026: Key characteristics in HNSCC and subsets

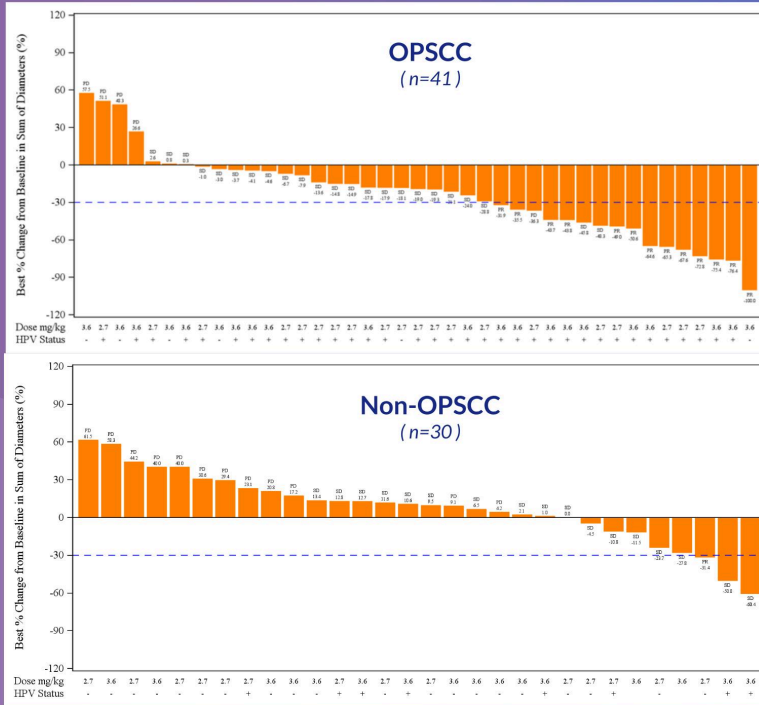
Enrolled Tumor Types	HNSCC All-comers (n=75)	OPSCC Subset (n=41)	Other HNSCC anatomical subsets (n=34)
Median age (range)	62 (24–78)	62.0 (36–77)	62 (24–78)
Sex (M/F)	89.3% / 10.7%	90.2% / 9.8%	88.2% / 11.8%
ECOG PS 0, 1, 2	47%, 52%, 1%	58.5%, 41.5%, 0%	32.4%, 64.7%, 2.9%
Weight in kg mean (range)	75.2 (41.3, 132.8)	79.0 (51.8, 132.8)	70.5 (41.3, 105.2)
Prior therapies median (range)	3 (1–9)	3 (1–9)	2 (1–7)
HPV Status (Positive, Negative, Missing)	57.3%, 40%, 2.7%	85.4%, 14.6%, 0%	23.5%, 70.6%, 5.9%
Disease status (Locally Advanced or Metastatic)	16%, 84%	4.9%, 95.1%	29.4%, 70.6%

ASCO 2026: OPSCC associated with HPV positivity in our study (as expected) and higher nectin-4 levels



Nectin-4 H score>150	1 in 3	1 in 10
Nectin-4 H score>175	1 in 4	1 in 12
Nectin-4 H score>200	1 in 6	1 in 30

ASCO 2026: CRB-701 confirmed responses favor OPSCC

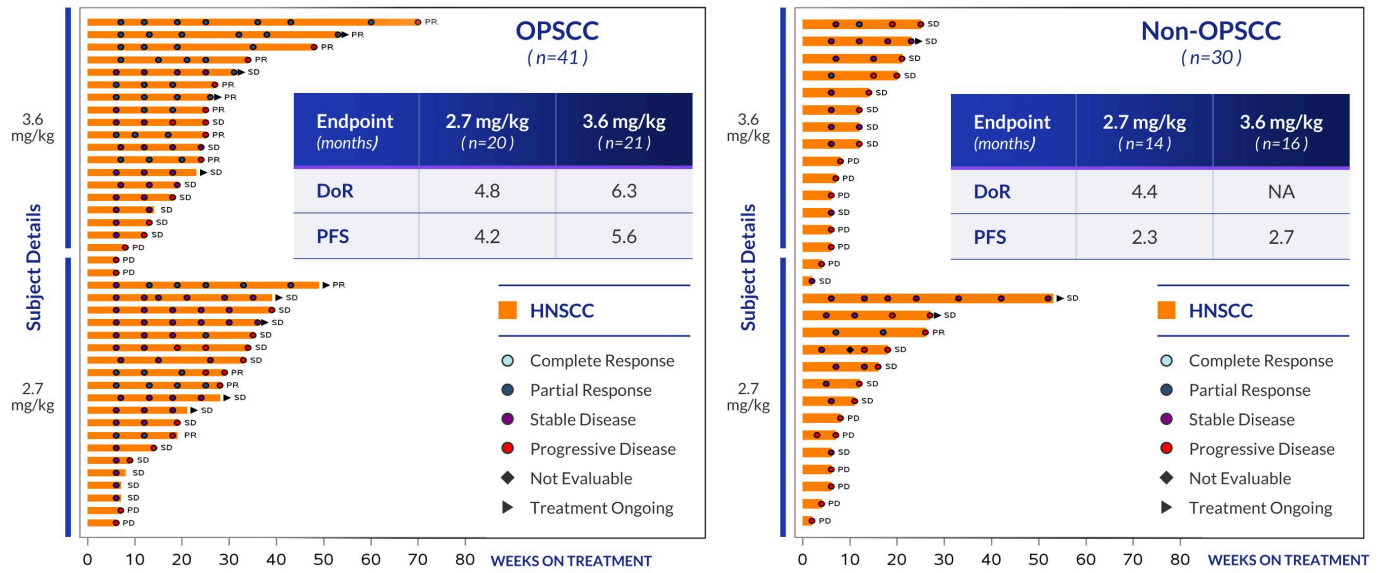


	2.7 mg/kg	3.6 mg/kg
cORR	20.0% (4/20)	42.9% (9/21)
DCR	90.0% (18/20)	85.7% (18/21)

	2.7 mg/kg	3.6 mg/kg
cORR	7.1% (1/14)	0.0% (0/16)
DCR	57.1% (8/14)	62.5% (10/16)

21 Source(s): ASCO April 1, 2026 data cut; Patients are summarized on the treatment and dose level assigned at enrollment/randomization. Best Overall Response is displayed at the end of each bar. HNSCC = Head & Neck Squamous Cell Carcinoma; OPSCC = Oropharyngeal anatomical subset of HNSCC; cORR = confirmed Objective Response Rate; DCR = Disease Control Rate

ASCO 2026: CRB-701 had longer durability in OPSCC



ASCO 2026: Efficacy summary at 3.6 mg/kg Q3W

3.6 mg/kg Q3W	OPSCC (n=21)	Non-OPSCC (n=16)
cORR	42.9%	0%
DCR	85.7%	62.5%
DoR (months)	6.3	NA
PFS (months)	5.6	2.7
% responders HPV+	89% (8 out of 9)	NA

OPSCC is
indication
of choice



Supports 3.6 mg/kg
dose for registrational
studies

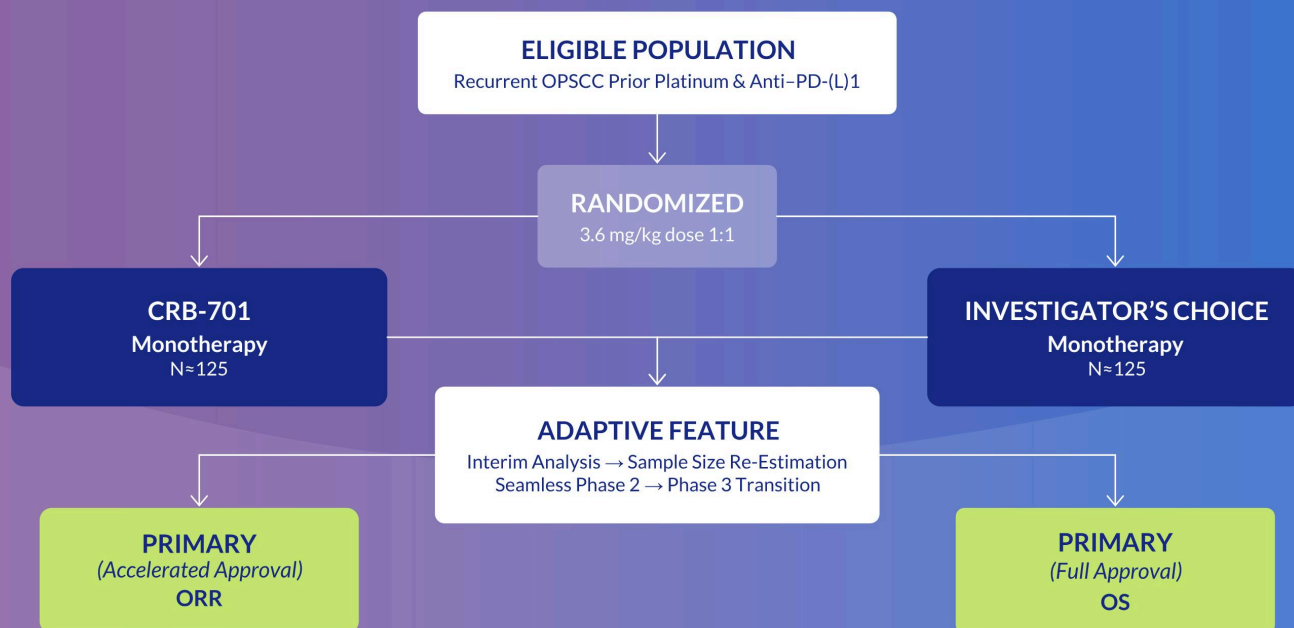


Contextualizing monotherapy CRB-701 and petosemtamab in 2L HPV+/OPSCC

RP2D OPSCC population →	Petosemtamab* (n=15)***	CRB-701** (n=21)
Dosing regimen	1500 mg Q2W	3.6 mg/kg Q3W
Efficacy (cORR)	13% (2/15) in OPSCC HPV+ only	50% (8/16) in OPSCC HPV+ only 43% (9/21) in OPSCC all types
Median DoR (months)	6.2 in HNSCC	6.3 in OPSCC (ongoing)
PFS (months)	4.9 in HNSCC	5.6 in OPSCC (ongoing)
TRAEs Grade 3 & greater	59% in HNSCC	14.3% in OPSCC

Sources(s): * ESMO ASIA data Dec 2024. ** ASCO April 1, 2026 data cut; *** Petosemtamab's DOR, PFS and TRAE was based total HNSCC study population(n=75)
 OPSCC = Oropharyngeal Squamous Cell Carcinoma; HNSCC = Head and Neck Squamous Cell Carcinoma; cORR = confirmed Objective Response Rate; DoR = Duration of Response; PFS = Progression-Free Survival

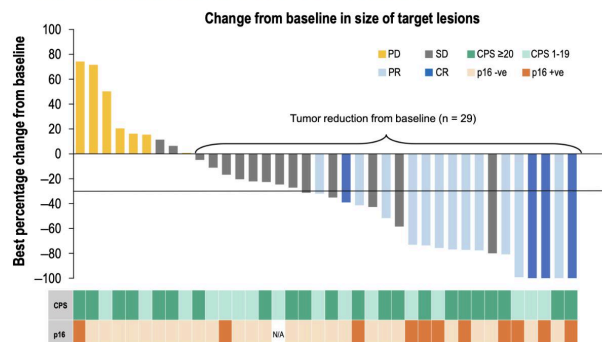
TEMPO-1 Registrational Study



1L OPSCC potential: the precedent of Padcev® + Keytruda® in 1L

Investigator-assessed cORR

- Confirmed responses were achieved in 16 patients



R/M HNSCC (n = 41)	
Best confirmed overall response, n (%)^a	
Confirmed complete response	4 (9.8)
Confirmed partial response	12 (29.3)
Stable disease	15 (36.6)
Progressive disease	7 (17.1)
Not evaluable	3 (7.3)
Confirmed objective response rate, n (%)^b [95% CI]^c	
PD-L1 CPS 1-19 (n = 16)	7 (43.8) [19.8-70.1]
PD-L1 CPS ≥20 (n = 25)	9 (36.0) [18.0-57.5]
HPV positive – yes (n = 11)	9 (81.8) [48.2-97.7]
HPV positive – no (n = 30) ^d	7 (23.3) [9.9-42.3]
Disease control rate, n (%)^e [95% CI]^c	
	31 (75.6) [59.7-87.6]

CI, confidence interval; cORR, confirmed objective response rate; CPS, combined positive score; CR, complete response; HNSCC, head and neck squamous cell carcinoma; N/A, not available; PD, progressive disease; PD-L1, programmed death-ligand 1; PR, partial response; RECIST v1.1, Response Evaluation Criteria in Solid Tumors version 1.1; R/M, recurrent or metastatic; SD, stable disease. ^aDefinition of best overall response followed RECIST v1.1. Complete and partial responses must have been confirmed by 2 scans, a minimum of 4 weeks apart. The minimum duration for stable disease was 49 days after the date of the first dose of EV or pembrolizumab. ^bConfirmed objective response rate was defined as the proportion of patients whose best overall response was a confirmed complete response or a partial response as per RECIST v1.1. ^cCalculated using the Clopper-Pearson method. ^dPatients without oropharynx cancer were considered HPV negative; 1 patient had an unknown HPV status. ^eDisease control rate was defined as the proportion of patients who have a best overall response of confirmed complete response, partial response, or stable disease (≥7 weeks).

Paul L. Swiecicki

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Padcev® + Keytruda®	cORR
All	39% (16/41)
HPV+	82% (9/11)
HPV-	23% (7/30)
Notes: • TRAEs ≥ Grade 3: 41% • Peripheral neuropathy: 32%	
HPV+	cORR
Peto + Keytruda® ²	50% (4/8)
Ficerafusp Alfa + Keytruda® ³	27% (3/11)

Padcev® added to the 2026 NCCN treatment guidelines* for HNSCC



National
Comprehensive
Cancer
Network®

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NCCN Guidelines Version 2.2026
Head and Neck Cancers

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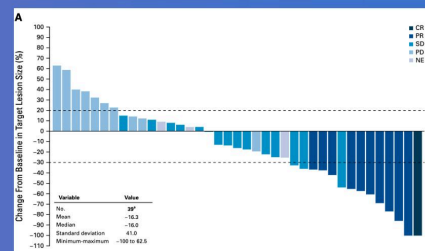
PRINCIPLES OF SYSTEMIC THERAPY FOR NON-NASOPHARYNGEAL CANCERS
(Oral Cavity [including mucosal lip], Oropharynx, Glottic Larynx, Supraglottic Larynx, Ethmoid Sinus, Maxillary Sinus, and Occult Primary)^a

Recurrent, Unresectable, or Metastatic Disease (with no surgery or RT option)		
Preferred	Other Recommended (First- and Subsequent-Line)	Useful in Certain Circumstances (First- and Subsequent-Line)
First-Line^d • Carboplatin/Infusional Fluorouracil + Pembrolizumab (category 1)⁴² • Cisplatin/Infusional Fluorouracil + Pembrolizumab (category 1)⁴² • Pembrolizumab (for tumors that express PD-L1 with CPS ≥1)⁴² (category 1) Subsequent-Line (if not previously used) • Nivolumab⁴³ (if disease progression on or after platinum therapy) (category 1) • Pembrolizumab⁴⁴⁻⁴⁶ (if disease progression on or after platinum therapy) (category 1)	Combination Regimens • Carboplatin/Infusional Fluorouracil + Cetuximab⁴⁷ (category 1) • Cisplatin/Infusional Fluorouracil + Cetuximab⁴⁷ (category 1) • Cisplatin + Cetuximab⁴⁸ • Cisplatin or Carboplatin/Docetaxel⁴⁹ or Paclitaxel⁵⁰ • Cisplatin/Infusional Fluorouracil^{50,51} • Cisplatin or Carboplatin/Docetaxel + Cetuximab⁵² • Cisplatin or Carboplatin/Paclitaxel + Cetuximab⁵³ • Carboplatin/Docetaxel + Pembrolizumab^{42,50,54} • Carboplatin/Paclitaxel + Pembrolizumab^{42,49} • Cisplatin/Paclitaxel + Pembrolizumab^{42,50,54} Single Agents • Capecitabine⁵⁵ • Carboplatin⁵⁶ • Cetuximab^{57,58} • Cisplatin^{48,59} • Docetaxel^{60,61} • Infusional Fluorouracil⁵⁹ • Methotrexate^{51,62} • Paclitaxel⁶³ • Afatinib⁶⁴ (subsequent-line only, if disease progression on or after platinum therapy) (category 2B)	Useful in Certain Circumstances (First- and Subsequent-Line) • Squamous cell carcinoma ▶ Cetuximab + Nivolumab⁵⁵ ▶ Cetuximab + Pembrolizumab⁶⁶ ▶ Paclitaxel + Cetuximab⁵⁷ • Pembrolizumab (for MSI-H, dMMR, or TMB-H [≥10 mut/Mb] tumors)⁶⁸ • Cisplatin/Pemetrexed (for PS 0-1) (category 2B)⁶⁹ • Docetaxel + Cetuximab (category 2B)⁵² • Gemcitabine/Paclitaxel (category 2B)⁷⁰ • Ipilimumab + Nivolumab (PD-L1 positive [CPS ≥20] and first-line only) (category 2B)⁷¹ • Enfortumab vedotin-efv (if disease progression on or after platinum therapy and a PD-1/PD-L1 inhibitor) (category 2B)⁷² • Erdafitinib for <i>FGFR</i> mutations or gene fusion positive tumors and disease progression with at least one line of prior systemic therapy and no availability of an alternative systemic therapy (category 2B)⁷³ • Fam-trastuzumab deruxtecan-nxki (for HER2+ [IHC 3+] solid tumors; subsequent line only with no satisfactory alternative treatment options) (category 2B)⁷⁴ • For select ethmoid/maxillary sinus cancers (ie, small cell, SNEC, high-grade olfactory esthesioneuroblastoma, SNUC with neuroendocrine features): ▶ Cisplatin/Etoposide or Carboplatin/Etoposide¹⁹ ▶ Cyclophosphamide/Doxorubicin/Vincristine (category 2B)⁵⁰

Phase II Trial of Enfortumab Vedotin in Patients With Previously Treated Advanced Head and Neck Cancer

Paul L. Swiecicki, MD¹, Emrah Yilmaz, MD, PhD², Ari Joseph Rosenberg, MD³, Takao Fujiwara, MD⁴, Justine Yang Brink, MD⁵, Changping Meng, MD⁶, Michele Wozniak, PhD⁷, Yanguan Zhao, PhD⁷, Michael Mihm, PhD⁷, Jason Kaplan, MD⁸, Seema Gupta, MD⁹, and Jessica L. Cooper, MD¹

Swiecicki et al 2024**



Padcev® 2L+

cORR

All-comers

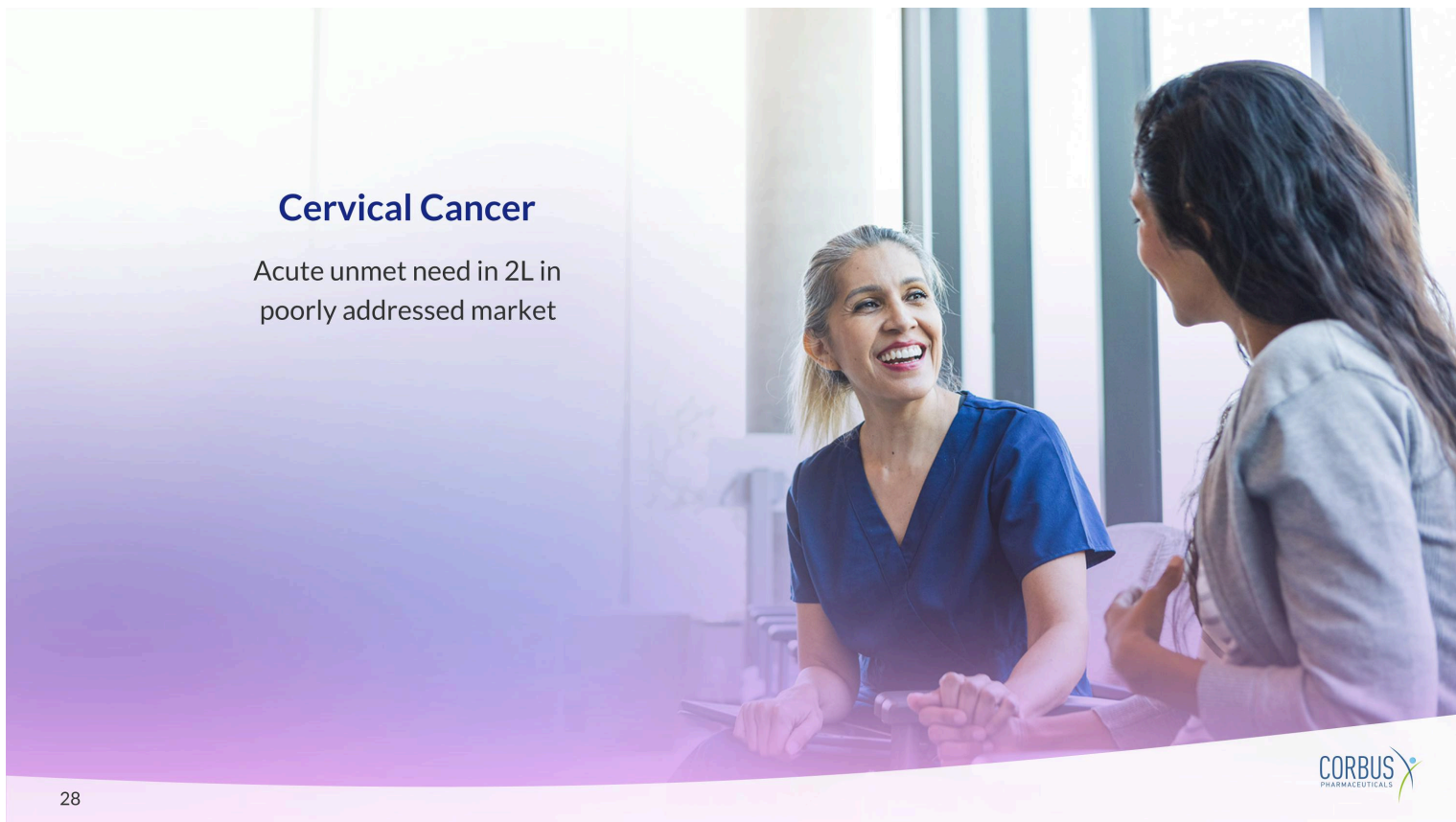
24% (11/46)

Notes:

- Demographics: 65% U.S. & 35% Japan
- No breakdown by p16
- TRAEs ≥ Grade 3: 35%
- Peripheral neuropathy: 24%

Cervical Cancer

Acute unmet need in 2L in
poorly addressed market



Cervical Cancer: Commercial Opportunity for CRB-701

14,000¹

- Annual new cases in U.S.
- 4,000 annual deaths

**Numbers
rising²**

- Immigration of unvaccinated adult women
- Socio-economics and vaccine hesitancy

39%³

- Girls ages 13–15 remain unvaccinated for HPV (2022 NIH data)

\$1.8B⁴

- U.S. market for cervical cancer treatment

Few options for 2L cervical cancer

1L

Carbo + Paclitaxel +/- Beva
+/- Pembrolizumab

2L

Tisotumab vedotin
Single-Agent Chemo

2021

ACCELERATED APPROVAL

2024

FULL APPROVAL

The NEW ENGLAND
JOURNAL of MEDICINE

CURRENT ISSUE ▼ SPECIALTIES ▼ TOPICS ▼

ORIGINAL ARTICLE

f x in e

**Tisotumab Vedotin as Second- or Third-Line Therapy
for Recurrent Cervical Cancer**

Tivdak® demonstrates a commercial potential that could be further improved

USA numbers	Value
R/M patients receiving 2L treatment	38%*
Annual price (WAC)	\$466,208**
Annualized sales (global)	\$328mm***

Adverse event profile****		Efficacy****	
Ocular (Black Box)	55% (all grades)	ORR	17.8%
Peripheral neuropathy	39% (all grades)	PFS	4.2 months
Bleeding	51% (all grades)	OS	11.5 months
Rash	25% (all grades)		

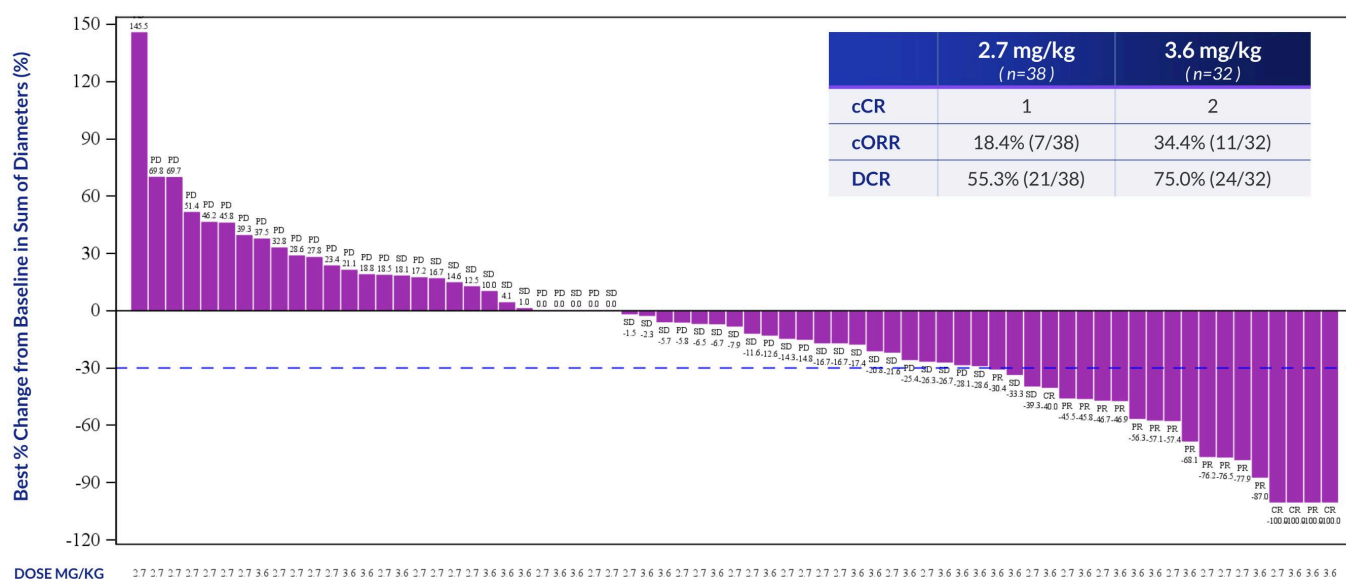


ASCO 2026: Key characteristics & tumor types

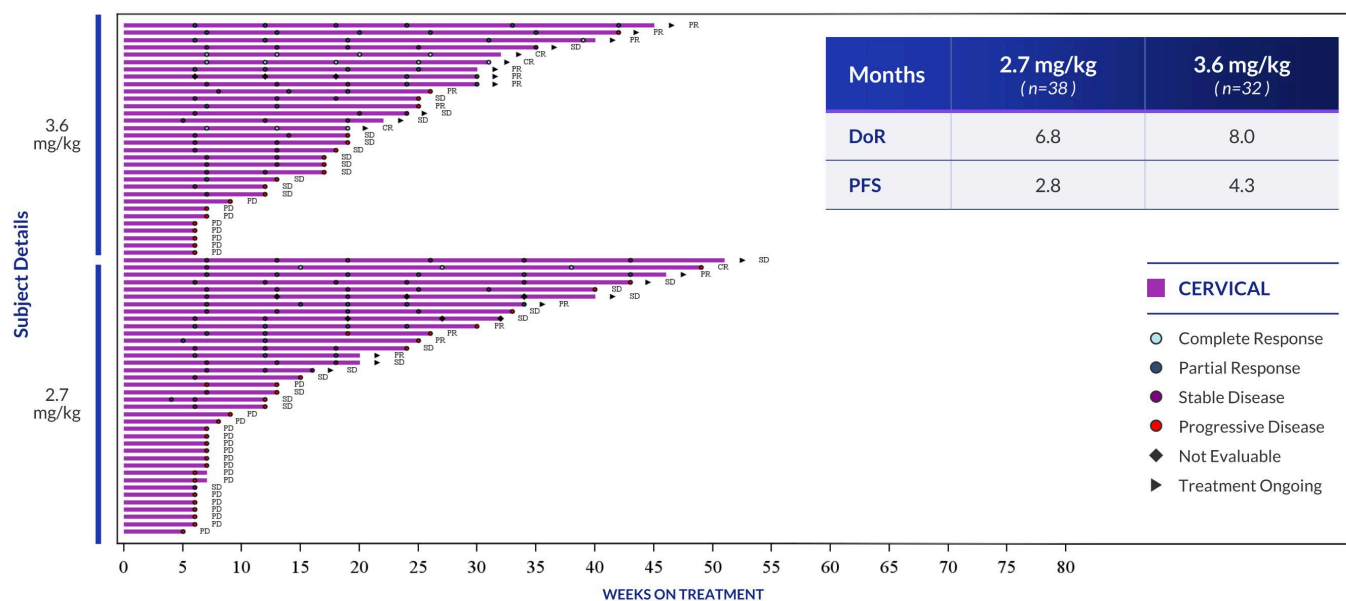
Enrolled Tumor Types	Safety Population	Efficacy Evaluable Population
Cervical	72	70

Baseline Characteristic	Cervical
Median age (range)	54 (32, 78)
Sex (M/F)	NA/100%
ECOG PS 0, 1, 2	44.4%, 55.6%, 0%
Weight in kg mean (range)	64.3 (39.0–99.0)
Prior therapies median (range)	3 (1–7)

CRB-701 ASCO 2026: Waterfall plot (N=70)



CRB-701 ASCO 2026: Swimmer plots (N=70)



CRB-701 potential to differentiate from current standard of care in 2L

	CRB-701* (n=32)	Tivdak® (n=253**)	IC Chemo 2L+ (n=249***)
Mechanism	Nectin-4 ADC with MMAE payload (DAR 2)	Tissue factor ADC with MMAE payload (DAR 4)	Anti-metabolite, cytoskeleton disruption, topoi inhibition etc.
Target population	2L	2L	2L
Dosing regimen	3.6 mg/kg Q3W	2 mg/kg Q3W	various
Efficacy (ORR)**	34.4%	17.8%	5.2%
DoR months**	8.0	5.3	5.7
PFS months	4.3	4.2	2.9
OS months	TBD	11.5	9.5



CRB-913

Daily oral small molecule
targeting obesity



CANYON-1 summary



Enrolled 254 patients across 15 U.S. clinical sites

- Trial representative of U.S. obesity population
- BMI average of 37 kg/m² and 71% of participants female



5% placebo adjusted average weight loss at 12 weeks (60mg)

- Effect started early and deepened without plateauing
- All participants completing treatment with 60mg dose lost weight



Emerging favorable safety and tolerability profile

- Favorable GI tolerability profile vs. published data on GLP-1s
- Psychiatric AEs broadly in line with published data on GLP-1s

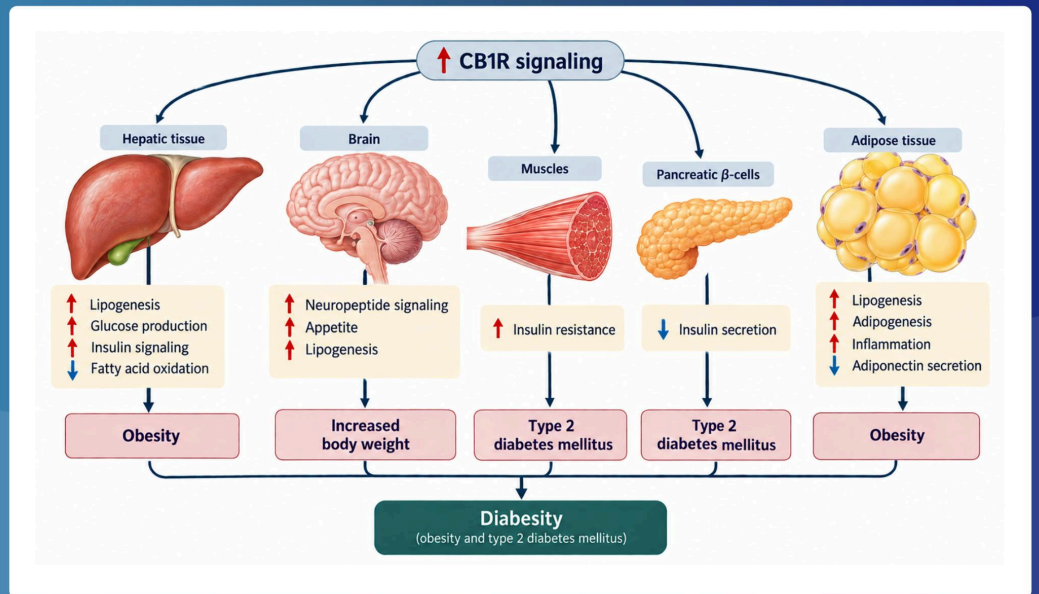


Data support
CRB-913's
potential
to deliver a novel non-
incretin oral therapy
for obesity

Cannabinoid Type-1 (CB1) is a well-characterized receptor (GPCR) in metabolism

**10K
PAPERS**

in PubMed
on CB1 and
metabolism



CRB-913 higher peripheral exposure and lower brain exposure vs. prior CB1s



A 12-week Phase 1b randomized double-blinded placebo-controlled study in adults with obesity

Randomization 1:1:1:1
n=254

All 15 sites located in US

Primary endpoint:
Safety and tolerability

Secondary endpoints:

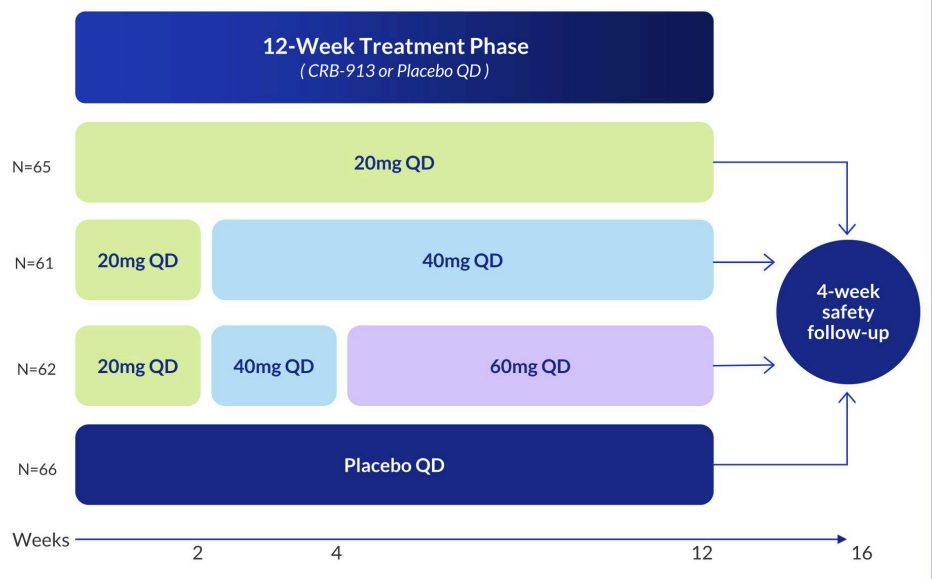
Placebo adjusted weight loss from
baseline and related outcomes

Psychiatric safety assessments :

GAD-7: Anxiety symptoms

PHQ-9: Depressive symptoms

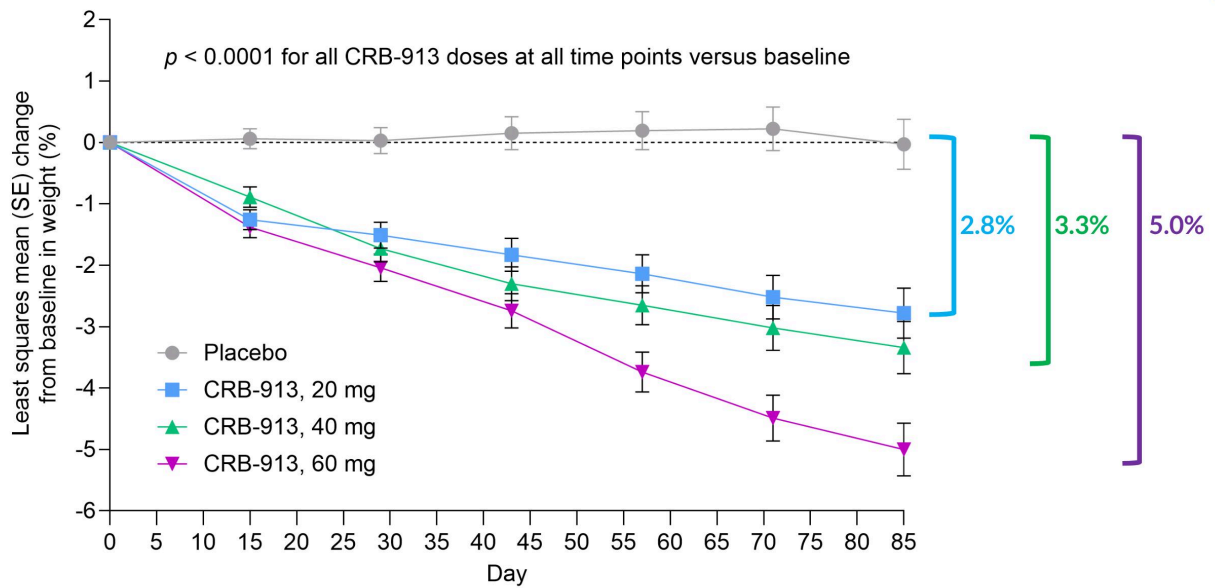
C-SSRS: Suicidal ideation



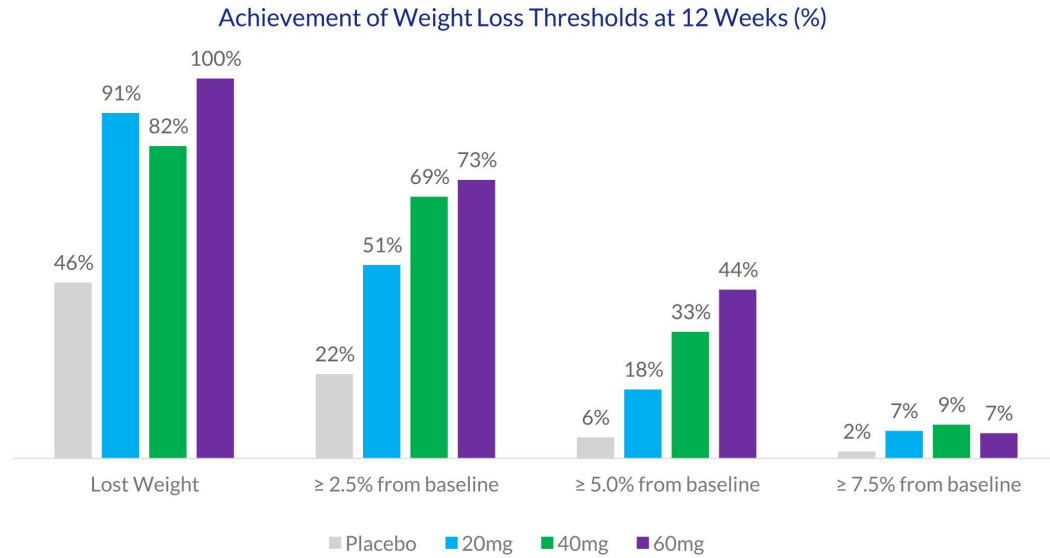
Demographics

	CRB-913 20mg (n=65)	CRB-913 40mg (n=61)	CRB-913 60mg (n=62)	Placebo (n=66)	Overall (n=254)
Female (%)	69.2	72.1	72.6	69.7	70.9
Caucasian (%)	67.7	65.6	75.8	54.5	65.7
Black or African American (%)	30.8	31.1	17.7	36.4	29.1
Other (%)	1.5	3.2	6.4	9.0	5.2
Average age (years)	48.8	49.1	49.5	44.3	47.9
Average Weight (kg)	104.0	106.9	105.7	104.2	105.2
Average BMI kg/m ²	37.6	38.0	37.2	37.1	37.5

Dose-dependent weight loss at 12 weeks with no plateauing



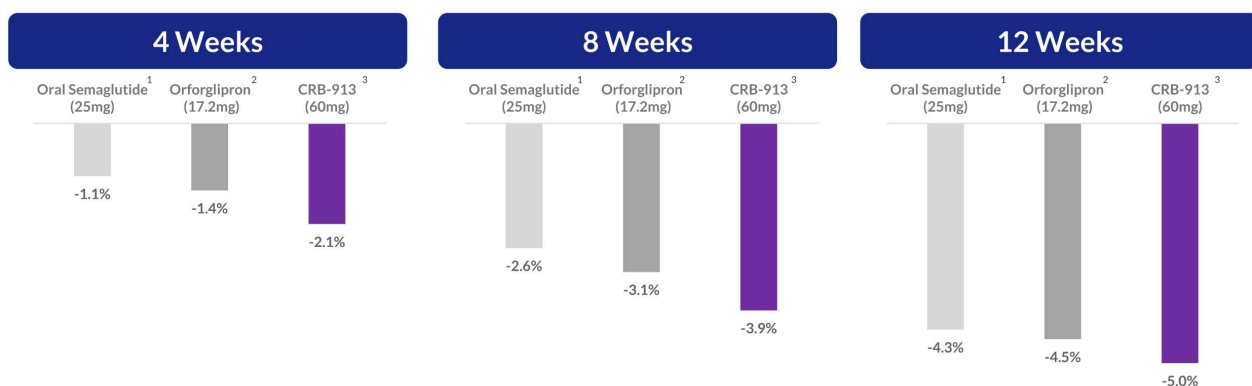
Majority of participants lost weight on CRB-913 compared to placebo



Note: Efficacy estimand. Analysis represents weight loss from baseline measured at day 85 for those participants who completed the study. Responder thresholds are cumulative; a participant who achieves a higher percentage of body-weight loss is also included in each lower-threshold category

Source: Corbus Pharmaceuticals (data on file)

Comparable weight loss to oral GLP-1s published data at 12 weeks



CRB-913 placebo adjusted weight loss at 60mg dose, competitor weight loss data is a cross-trial comparison based on published studies

Note: Efficacy estimand. These limited observations are derived from separate clinical settings, and do not represent head-to-head comparisons. For orforglipron, early clinical development evaluated a 36 mg capsule formulation; subsequent bridging established pharmacokinetic bioequivalence to the 17.2 mg tablet commercial formulation. Competitor weight loss data at 12 weeks reflects published data from a 68-week study (oral semaglutide 25 mg, N Engl J Med 2025) and 36-week study (orforglipron, N Engl J Med 2023).

Sources:

1. Wharton, S. et al. Oral Semaglutide at a Dose of 25 mg in Adults with Overweight or Obesity; N Engl J Med 2025 ([link](#))
2. Foundayo prescribing info ([link](#))
3. Corbus Pharmaceuticals (data on file)

Favorable safety profile with low discontinuations and no serious TRAEs (assignment by cohort)

	CRB-913 20mg (n=65)	CRB-913 40mg (n=61)	CRB-913 60mg (n=62)	Placebo (n=66)
All Treatment-Emergent AEs (TEAEs)	39 (60.0%)	45 (73.8%)	45 (72.6%)	28 (42.4%)
Severe TEAEs	3 (4.6%)	2 (3.3%)	1 (1.6%)	0
Severe Psych TEAEs	0	0	0	0
Severe GI TEAEs	0	0	0	0
Serious TEAEs	2 (3.1%)	1 (1.6%)	1 (1.6%)	0
All Treatment-Related AEs (TRAEs)	27 (41.5%)	34 (55.7%)	33 (53.2%)	14 (21.2%)
Severe TRAEs	0	1 (1.6%) (headache)	0	0
Serious TRAEs (SAEs)	0	0	0	0
Treatment Discontinuations due to AEs	2 (3.1%)	8 (13.1%)	8 (12.9%)	3 (4.5%)
Treatment Discontinuations for any reason	10 (15.4%)	16 (26.2%)	16 (25.8%)	12 (18.2%)

Discontinuations due to AEs vs. oral GLP-1 class

	CRB-913 ¹ (60mg)	Orforglipron ³ (36mg capsule - Cohort 1)	Orforglipron ³ (36mg capsule - Cohort 2)	Oral semaglutide ² (25mg)
 # of patients assigned drug	62	29	29	205
 Duration of study	12 weeks	36 weeks	36 weeks	64 weeks
 AE Treatment discontinuation	12.9%	10.3%	20.7%	6.9%
 Titration Schedule	2 titrations (every 2 weeks)	6 titrations (every week)	4 titrations (every 3 weeks)	3 titrations (every 4 weeks)

Note: These limited observations are cross trial comparison derived from separate clinical settings and do not represent head-to-head comparisons. For orforglipron, early clinical development evaluated a 36mg capsule formulation; subsequent bridging established pharmacokinetic bioequivalence to the 17.2mg tablet commercial formulation

Sources:

1. Corbus Pharmaceuticals (data on file). Represent treatment emergent GI AE's
2. Wharton, S. et al. Oral Semaglutide at a Dose of 25 mg in Adults with Overweight or Obesity; N Engl J Med 2025 ([Link](#))
3. Wharton S, et al. Daily oral GLP-1 receptor agonist orforglipron for adults with obesity. N Engl J Med. 2023 ([Link](#))

In-depth analysis of psychiatric safety profile



Suicidality, depression and anxiety were mostly mild, all transient, and don't appear dose-related

	CRB-913 20mg (n=65)	CRB-913 40mg (n=61)	CRB-913 60mg (n=62)	Placebo (n=66)
 Suicidality	0	0	0	0
 Depressive symptoms	0	0	1 (1.6%) (moderate)	0
 Anxiety	2 (3.1%)	5 (8.2%)	3 (4.8%)	3 (4.5%)

- Treatment-emergent psychiatric AEs were mild or moderate with no serious or severe AEs
- Placebo cohort experienced psych AEs
- 50% of psych AEs occurred in first 28 days (similarly to GLP-1s¹)
- All psych AE cases resolved with the majority continuing treatment

Suicidality, depression and anxiety were in line with published GLP-1 studies

	CRB-913 (All doses)	Liraglutide ¹	Semaglutide ²	Tirzepatide ³
 Suicidality	0%	1%	0.3%	0.6%
 Depressive symptoms	0%–1.6%	3.0%	2.8%–4.6%	2.0%
 Anxiety	3.1%–8.2%	2.7%	3.3%–7.2%	1.9%

Note: These limited observations are cross trial comparison derived from separate clinical settings and do not represent head-to-head comparisons. Published safety data reflect adverse events reported over study durations longer than the 12-week CANYON-1 treatment period: 56-week study (liraglutide, Diabetes Obes Metab. 2017), 68-week study (semaglutide, JAMA Intern Med. 2024), and 72-week study (tirzepatide, Obesity 2026). Sources:

1. O'Neil et al. "Neuropsychiatric safety with liraglutide 3.0 mg for weight management: Results from randomized controlled phase 2 and 3a trials. Diabetes Obes Metab. 2017 ([link](#))
2. Wadden et al. et al. "Psychiatric Safety of Semaglutide for Weight Management in People Without Known Major Psychopathology: Post Hoc Analysis of the STEP 1, 2, 3, and 5 Trials. JAMA Intern Med. 2024 ([link](#))
3. Wadden et al. "Psychiatric Safety of Tirzepatide in People With Obesity and No Known Major Psychopathology: A Post Hoc Analysis of SURMOUNT." Obesity 2026 ([link](#))

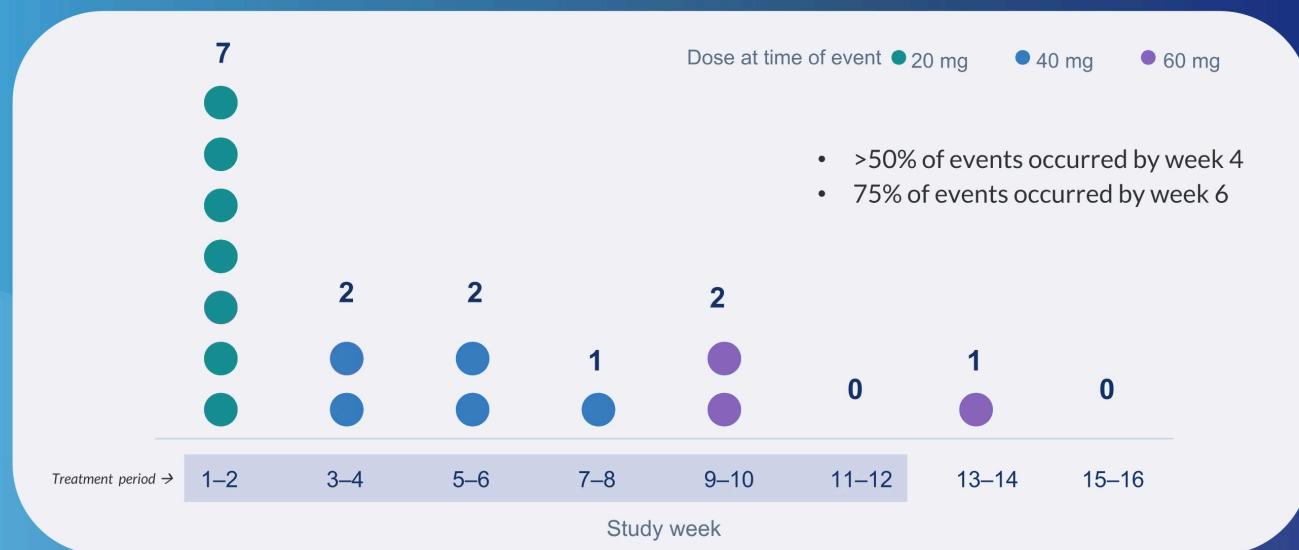
Irritability occurred early, was always mild + transient → did not lead to any discontinuations

Irritability AE:				
	Placebo	20mg CRB-913	40mg CRB-913	60mg CRB-913
By assigned cohort	0	4 (6.2%)	5 (8.2%)	6 (9.7%)
By dose at time of AE	0	7	5	3

- All cases were mild and resolved → patients report no impact on daily function
- 12 out of 15 involved concomitant non-psych AEs (e.g., GI, migraines, ear infection, etc.)
- 15 out of 15 cases coincided with weight loss
- >50% of incident events occurred by week 4 (75% by week 6)
- **None caused discontinuations**

Onset of irritability was concentrated in the first 2 weeks

First onset of Irritability



Analysis of psych AEs discontinuations based on dose vs. assigned cohort (factoring for titration)

Psych AE discontinuations:				
	Placebo	20mg CRB-913	40mg CRB-913	60mg CRB-913
By assigned cohort	1 (1.5%)	1 (1.5%)	3 (4.9%)	5 (8.1%)
By dose at time of AE	1	3	2	4

- 1 participant on placebo discontinued due to moderate anxiety
- No discontinuation due to irritability
- 5 out of 10 discontinuations on CRB-913 occurred by week 6, and none after week 10

CRB-913 demonstrates favorable psych safety to monlunabant in a cross-trial comparison (assignment by cohorts)

	CRB-913 (20/40/60mg) n = 188	Monlunabant ¹ (10/20/50mg) n = 180
 Depression	0%–1.6%	3%–8%
 Anxiety	3.1%–8.2%	10%–27%
 Irritability	6.2%–9.7%	10%–17%
 Insomnia	0%–4.9%	7%–17%
 AE study discontinuation	1.5%–9.8%	13%–42%
 Severe psych AE	None	2%–7%
 Unresolved psych AEs	None	5%–17%

Note: These limited observations are derived from separate clinical settings, and do not represent head-to-head comparisons with monlunabant which has been discontinued by Novo. Published safety data reflect adverse events reported over longer time periods than the 12-week CANYON-1 treatment period

Source:

1. Knop, F.K. et al. Efficacy and safety of monlunabant in adults with obesity and metabolic syndrome: a double-blind, randomised, placebo-controlled, phase 2a trial. The Lancet 2025 ()

In-depth analysis of GI safety profile



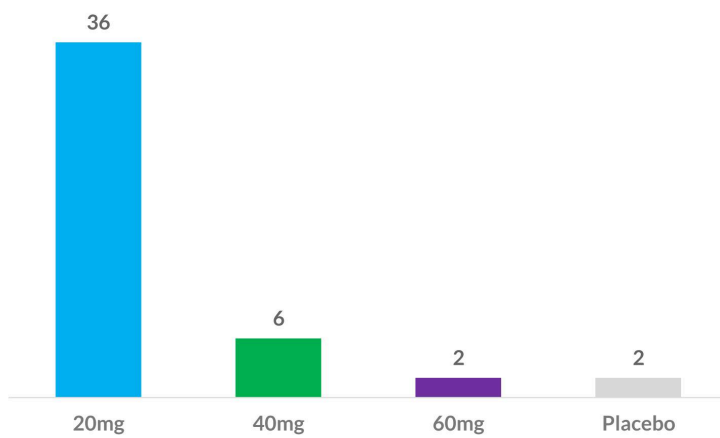
Treatment-emergent GI AEs of special interest were mild or moderate with no serious or severe AEs (by cohort assignments)

	CRB-913 20mg (n=65)	CRB-913 40mg (n=61)	CRB-913 60mg (n=62)	Placebo (n=66)
 Vomiting	3 (4.6%)	5 (8.2%)	1 (1.6%)	0
 Nausea	10 (15.4%)	16 (26.2%)	14 (22.6%)	3 (4.5%)
 Constipation	3 (4.6%)	1 (1.6%)	3 (4.8%)	2 (3.0%)
 Diarrhea	14 (21.5%)	16 (26.2%)	14 (22.6%)	2 (3.0%)

- No severe or serious GI TEAEs
- Treatment discontinuations due to GI AE: 2 on CRB-913 and 1 on placebo

Diarrhea occurs early, never serious or severe

Diarrhea (by dose at time of AE)



- 70% of events occurred in first 2 weeks while on 20mg dose
- 85% cases mild; 15% moderate
- No cases of severe diarrhea

Potentially improved GI tolerability vs. commercial oral GLP-1s (by assigned cohort)

	CRB-913 ¹ (60mg cohort)	Oral semaglutide ² (25mg)	Orforglipron ³ (36mg capsule - Cohort 1)	Orforglipron ³ (36mg capsule - Cohort 2)	Orforglipron ⁴ (FDA Label)
 Vomiting	1.6%	31%	28%	14%	24%
 Nausea	22.6%	47%	41%	48%	35%
 Constipation	4.8%	20%	28%	24%	24%
 Diarrhea	22.6%	18%	3%	14%	25%

GI AEs were mild or moderate with no serious or severe AEs

Note: These limited observations are cross trial comparison derived from separate clinical settings and do not represent head-to-head comparisons. For orforglipron, early clinical development evaluated a 36mg capsule formulation; subsequent bridging established pharmacokinetic bioequivalence to the 17.2mg tablet commercial formulation. Published safety data reflect adverse events reported over longer time periods than the 12-week CANYON-1 treatment period

Sources:

1. Corbus Pharmaceuticals (data on file). Data represents treatment emergent GI AEs
2. Wharton, S. et al. Oral Semaglutide at a Dose of 25 mg in Adults with Overweight or Obesity; N Engl J Med 2025 ([Link](#))
3. Wharton S, et al. Daily oral GLP-1 receptor agonist orforglipron for adults with obesity; N Engl J Med. 2023 ([Link](#))
4. Prescribing information for orforglipron ([Link](#))

Summary and next steps



Data supports CRB-913 potential as new class of oral non-incretin obesity medicines



5% weight loss at 12 weeks with
no evidence of plateauing
(comparable to oral GLP-1)



Psych AE profile supports
benefits of peripheral
restriction of CB1 therapy



Favorable GI profile



**Competitive monotherapy
& potential to evaluate in
combination with GLP-1**

CRB-913 moving forward →Phase 2



- Present CANYON-1 dataset at ObesityWeek as a late breaker
- Engage with FDA regarding clinical development plan
- Initiate Phase 2 monotherapy study in 1H 2027 ("CANYON-2")
- Evaluate potential combination therapies

Addressable market opportunity for CRB-913 is significant

Target Markets

Monotherapy

Combination therapy

Lifelong maintenance

>1 billion people
worldwide with obesity¹

~ 3 billion people
worldwide overweight²

>200
associated co-morbidities³

~20% non-responders⁴
to incretins

~23% intolerant
to incretins⁴

64% of GLP-1 users
discontinue at 1 Yr⁴

Sources:

1. NCD Risk Factor Collaboration (NCD-RisC). Worldwide trends in underweight and obesity from 1990 to 2022: a pooled analysis of 3663 population-representative studies with 222 million children, adolescents, and adults. The Lancet 2024 ([Link](#))
2. World Health Organization. Obesity and overweight. WHO Fact Sheet 2025 ([Link](#))
3. American Medical Association. ([Link](#))
4. Cartwright et al 2025; **AP Nov 2024



Thank you!

