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A BGBx Special Report | In conjunction with ASCO 2026

Is Oncology Ready?

Four Forces Defining the Next Five Years

Developed by the BGBx Oncology Strategy Team

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Why the Next 5 Years Are Different

Oncology is entering one of its most consequential periods. The forces shaping the next five years are not incremental refinements. They represent a fundamental restructuring of how cancer is prevented, detected, treated, and managed.

> *"...the science is advancing faster than the systems built to support it."*

Four forces are driving this transformation simultaneously. Immunotherapy is undergoing a generational transition, as the first era of checkpoint inhibition gives way to more precise and personalized approaches. Antibody-drug conjugates have moved from breakthrough innovation to strategic backbone, and the field is now grappling with differentiation, resistance, and durability. Earlier detection is rewriting the rules of treatment intent, with multi-cancer early detection tests reshaping the landscape before a patient ever reaches an oncologist. And artificial intelligence is delivering on its clinical potential by augmenting, not replacing, human judgment.

What unites all four forces is a single tension: the science is advancing faster than the systems built to support it. Faster than clinical workflows, reimbursement frameworks, the oncology workforce, and commercial infrastructure. The organizations that will define oncology's next chapter are those that can close the gap between scientific breakthrough and real-world impact.

Each of the four forces reshapes a different dimension of cancer care: how it is prevented, detected, treated, and managed. Together they define the terrain every oncology stakeholder will need to navigate through 2031.

FORCE	TITLE	THE CENTRAL QUESTION
01	The New Backbone of Immunotherapy	*Where does IO go after the first generation?*
02	ADCs Grow Up	*What separates the leaders from the noise in a crowded class?*
03	The Cancer You Never Saw Coming	*Is oncology ready for a world where more cancers are found earlier?*
04	AI Moves from Boardroom to Bedside	*How does AI become a clinical tool, not just a conversation?*

Editor's Note: *This report was developed in the weeks leading up to ASCO 2026, drawing on current clinical evidence, pipeline data, and perspectives from BGBx's oncology strategy and medical affairs teams. Real-time insights from the meeting appear in designated callout boxes throughout, updated following the conclusion of ASCO 2026.*

FORCE 01

The New Backbone of Immunotherapy

What checkpoint inhibitors did was not complete the immunotherapy story. They began it. The first generation proved that the immune system could be a durable weapon against cancer. The next five years will be defined by the field's ability to build something far more precise, personalized, and accessible on top of that proof.

What the First Generation Proved

The first approved immune checkpoint inhibitors demonstrated something the field had theorized but never proven: that cancer could be held in check indefinitely by the immune system alone. In melanoma, patients are now living beyond ten years.[1] That outcome required reimagining treatment response evaluation, new endpoints, new imaging protocols, and a field-wide education on phenomena like pseudoprogression. The patent landscape for first-generation PD-1 inhibitors is now shifting, with biosimilar competition expected around 2028-2029.

The Next Generation: Bispecifics and Dual-Target Thinking

The most important architectural shift in IO is the move from single-target to dual-target engagement. Bispecific antibodies engineered to bind two targets simultaneously represent both an evolution of checkpoint inhibition and a genuinely new paradigm.

The PD-1 x VEGF bispecific class is attracting the most immediate clinical attention, simultaneously blocking the PD-1 checkpoint on T cells and VEGF-driven tumor angiogenesis. Ivonescimab demonstrated a significant PFS benefit versus pembrolizumab monotherapy in PD-L1-expressing locally advanced or metastatic NSCLC (regardless of histology) in HARMONi-2.[2]

Beyond PD-1 x VEGF, constructs targeting PD-1 x CTLA-4, PD-1 x LAG-3, and PD-L1 x TIGIT are advancing in development. T-cell engagers, which physically bridge cancer cells and T cells, are also growing in relevance. Tarlatamab (Imdelltra) has established activity in extensive-stage small cell lung cancer.[3] A key clinical question: does early-trial superiority data apply broadly across bispecific classes, or specifically to mechanisms like PD-1 x VEGF? That distinction matters for prescribing and communication.

Personalized mRNA Cancer Vaccines: The Race to Scale

Personalized neoantigen vaccines are designed from scratch for each patient, encoding the specific mutational fingerprint of their tumor. Five-year data from KEYNOTE-942 (intismeran autogene plus pembrolizumab in resected high-risk melanoma) demonstrated a 49% reduction in recurrence or death versus pembrolizumab alone.[4] The platform encodes up to 34 patient-specific neoantigens. Manufacturing timelines of six to eight weeks and per-patient cost remain the primary barriers to adoption. BioNTech and others are advancing competing platforms. The race is no longer about whether this works. It is about who can make it accessible.

Combination Strategy and Treatment Sequencing

Combination strategy and sequencing are related but distinct. Combinations use multiple agents concurrently; the evidence base is substantial and the question has shifted from whether to combine to which combinations produce the most durable outcomes. Sequencing refers to the order of therapies across a patient's treatment journey, and it is one of the most consequential and least settled questions in the field.

The movement of highly active therapies into perioperative, neoadjuvant, and adjuvant settings is reshaping treatment success. Pathologic complete response is increasingly recognized as a surrogate for long-term survival, as KEYNOTE-522 established in triple-negative breast cancer.[5] Treatment-free survival is emerging as a patient-centered endpoint that PFS and OS do not capture: the quality of time, not just the quantity.

The Tumor Microenvironment (TME) plays a critical role in whether IO strategies succeed. Hot tumors with high immune infiltration respond well to checkpoint inhibition. Cold tumors that evade immune detection remain a major unresolved challenge, and converting cold to hot will be a defining area of clinical investigation.

Insights from ASCO 2026

Ivonescimab (HARMONi-6) delivered one of the meeting's more closely watched lung cancer readouts, showing a 34% reduction in the risk of death in squamous NSCLC and surpassing many investor expectations. Despite the strength of the topline result, the mood in the room was surprisingly restrained. During the discussion, the Johns Hopkins discussant repeatedly emphasized that the study was conducted in a Chinese patient population, raising questions about whether the magnitude of benefit would translate to the older, more medically complex squamous NSCLC patients commonly seen in Western practice. Concerns were also raised about the safety and broader applicability of VEGF inhibition in this setting. As a result, there was a clear sense that the field is reserving judgment until results from the global HARMONi-3 study become available.

At the same time, enthusiasm around the broader PD-1 x VEGF bispecific class remained evident throughout the meeting. Early phase 2 data from BioNTech and Pfizer reported response rates ranging from 57% to 68% in NSCLC, reinforcing growing confidence in the mechanism and highlighting the momentum building across the pipeline—even as questions remain about the global generalizability of the lead program.

> *"While these results are provocative, the applicability to the global, generally older, squamous lung cancer population is unclear."*
>
> *Dr. Julie Brahmer, Director, Thoracic Oncology Program, Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins, ASCO 2026 discussant, HARMONi-6 Plenary Session*

What Does This Mean For You?

Oncologists and Investigators: The central question is no longer whether IO works but in whom, in what combination, and when. Biomarker-driven selection and MRD-guided sequencing will define best practice.

Payers and Market Access: Personalized vaccine manufacturing at scale carries per-patient costs existing frameworks are not designed for. Outcomes-based contracting conversations need to begin before approval.

Medical Affairs: Communicating the distinction between first-generation IO and next-generation approaches requires proactive scientific exchange. The lexicon is changing faster than most field teams can keep pace.

Commercial and Brand Teams: Brands that define the next IO backbone early will inherit the market the first generation built. Lifecycle planning must account for biosimilar pressure and the window opening for next-generation mechanisms.

BGBx PERSPECTIVE

BGBx has been part of the immunotherapy story since the very beginning. When the first IO therapy became available, we helped build the clinical lexicon, educate oncologists on new response endpoints, and navigate the concept of pseudoprogression for a field trained to interpret tumor growth as treatment failure. Before immunotherapy, median overall survival in melanoma was roughly eight months. Today patients are living more than ten years. That history gives BGBx a perspective on where IO goes next that very few agencies can match.

FORCE 02

ADCs Grow Up

The antibody-drug conjugate story is one of an elegant idea that took decades to execute. Attach a cancer-killing drug to an antibody that finds the tumor, deliver the payload precisely, spare healthy tissue. The concept was straightforward. The biology was not.

The current generation has addressed many early limitations. Fifteen FDA approvals by 2025, hundreds of active trials, and a global market valued at approximately $19 billion in 2026 with projections of $28 billion by 2035 [6] reflect a field that has moved decisively from experimental to established. But maturity brings its own challenges. The question is no longer whether ADCs work. It is which ADCs work best, in which patients, and alongside what else.

The Architecture of the Next Generation

First-generation ADCs operated on simple principles: one antibody, one linker, one payload. The next generation is considerably more sophisticated. Bispecific ADCs engage two tumor antigens simultaneously, improving selectivity and reducing antigen-downregulation resistance. Dual-payload ADCs deliver two cytotoxic agents through a single conjugate to address tolerance mechanisms. Novel linker chemistry enables more precise payload release based on pH differentials or tumor microenvironment enzyme activity.[7]

Radioligand therapy (RLT) represents a distinct but related modality: a radioactive isotope attached to a targeting ligand delivers localized radiation to cancer cells expressing a specific target. Lutetium-177-PSMA-617 (Pluvicto) has established RLT in metastatic castration-resistant prostate cancer, and the platform is expanding. AI-driven target discovery is further widening the addressable landscape, with one platform identifying more than 2,000 potential bispecific target pairings.[8]

Clinical Challenges the Field Has Not Yet Solved

Resistance mechanisms remain poorly understood. Antigen downregulation removes the ADC's ability to find its target. Efflux pump upregulation expels the payload before it acts. These are primary reasons ADC responses do not always endure. Toxicity management is equally unresolved: interstitial lung disease and ocular toxicities have led to treatment discontinuations and deaths in multiple programs.

Sequencing strategy is the most clinically consequential open question. As approvals multiply, oncologists face decisions about when to use an ADC relative to IO, chemotherapy, and targeted therapy, and whether prior ADC exposure compromises subsequent ADC efficacy. The bystander effect, a payload released from a targeted cell killing neighboring non-expressing cells, may enhance efficacy in heterogeneous tumors but raises additional questions about off-target exposure.

The Commercial and Strategic Landscape

M&A activity reflects how strategically the class is viewed. Pfizer's $650 million upfront partnership with Innovent Biologics, which includes multiple ADCs and bispecific ADCs, Gilead's $3.15 billion acquisition of Tubulis, AbbVie's c-Met ADC development, and AstraZeneca's continued investment are not isolated bets. They are a conviction that ADC capability is a strategic imperative.

IT-DXd (Enhertu) and Dato-DXd (Datroway) are emerging as potential ADC backbones with expanding data across tumor types and into earlier lines.[9] As the market crowds, differentiation is increasingly clinical rather than mechanistic. Real-world evidence generation and patient identification are no longer secondary considerations. They are core to commercial success.

Insights from ASCO 2026

ADCs remained one of the dominant themes throughout ASCO 2026, with multiple presentations reinforcing both the clinical impact of established agents and the rapid evolution of next-generation programs. Among the most practice-changing datasets, enfortumab vedotin plus pembrolizumab continued to impress in urothelial carcinoma, delivering a median overall survival of 33.6 months compared with 15.9 months for chemotherapy. The data were presented with little controversy, reflecting the growing consensus that ADC-plus-immunotherapy combinations are becoming a foundational treatment approach in this disease.

Interest was equally strong in emerging ADC targets. One of the more closely watched early-stage presentations featured SYS6043, a first-in-human B7-H3-targeting ADC that demonstrated encouraging activity across multiple solid tumors with a manageable safety profile. The presentation generated discussion around how AI-enabled target discovery is accelerating the identification of novel tumor antigens that were previously considered difficult to drug, potentially expanding the ADC opportunity beyond well-established targets.

In colorectal cancer, trastuzumab rezetecan delivered a significant progression-free survival benefit in chemotherapy-refractory HER2-positive disease, adding to the growing body of evidence supporting ADCs in later-line settings. Across sessions and discussions, a common theme emerged: while novel targets and payload technologies continue to attract attention, enthusiasm increasingly hinges on comparative clinical performance. The sense from many presentations was that ADC differentiation is now being determined by head-to-head efficacy, safety, and durability data rather than mechanism alone.

What Does This Mean For You?

Oncologists and Investigators: Sequencing ADCs alongside or after IO is one of the most consequential unanswered questions in clinical practice. Cross-resistance will increasingly drive later-line treatment decisions.

Payers and Market Access: ADC manufacturing complexity drives high price points. Health economic modeling capturing the full value of precision delivery will be critical for formulary access.

Medical Affairs: Community oncologists have limited ADC toxicity and resistance experience. Scientific exchange programs must address practical clinical management, not just efficacy data.

Commercial and Brand Teams: Clinical differentiation must be built into launch strategy from development, not added after approval. In a market that crowded quickly, late differentiation is not a strategy.

BGBx PERSPECTIVE

BGBx's experience with bispecific T-cell engagers in an earlier wave of precision oncology taught us what it means to launch a novel mechanism before the market is ready: how to build class credibility, educate a skeptical field, and differentiate when competition accelerates faster than anyone anticipated. As the ADC market faces its own version of that challenge simultaneously, those lessons are directly applicable. When the science becomes table stakes, the agency that navigated class-level differentiation before is the strategic partner that matters most.

FORCE 03

The Cancer You Never Saw Coming

For most of oncology's history, the limiting factor in outcomes has not been the quality of treatment. It has been the stage at which cancer is found. In pancreatic cancer, five-year survival for localized disease exceeds 40%. For metastatic disease, it falls below 3%.[10] The mathematical argument for earlier detection is compelling. But it is also incomplete. Earlier detection does not just change when cancer is found. It reshapes every dimension of what happens next.

Multi-Cancer Early Detection: From Research Tool to Clinical Reality

Multi-cancer early detection (MCED) tests use liquid biopsy to identify circulating tumor DNA and other biomarkers in a standard blood draw, detecting multiple cancer types at earlier stages.[11] The leading platforms, Galleri (GRAIL) and CancerGuard (Exact Sciences), are moving into broader commercial availability. As PCPs begin offering these tests routinely, oncology will face a wave of earlier-stage diagnoses from patients who would never previously have reached an oncologist.

The clinical implications are significant. Treatment algorithms built for symptomatic, advanced disease may not translate to asymptomatic, screen-detected presentations. When a positive MCED result cannot be confirmed or localized by tissue biopsy, a scenario called a signal of uncertain significance, it creates one of the most challenging clinical and communication problems the field faces. Minimal residual disease (MRD) monitoring, using ctDNA to detect small numbers of residual cancer cells post-treatment, is an emerging complement that guides escalation and de-escalation decisions.[12]

What Earlier Detection Actually Changes

Earlier detection shifts treatment intent from palliative to curative for cancers previously caught late. The most consequential new approvals over the next five years will increasingly be in early-stage indications. Survivorship care demands will expand dramatically: the US cancer survivor population is projected to reach 26 million by 2040,[13] with PCPs bearing growing responsibility for long-term management in systems not yet designed for it. The oncology workforce is not sized to absorb this shift. With a median oncologist age of 53 and nearly one in five approaching retirement, the supply-demand gap will widen precisely as MCED-driven diagnoses increase demand.

Treatment Moves Out of the Hospital

Cancer treatment is migrating away from inpatient settings through converging forces. CAR T, historically requiring hospitalization for lymphodepletion and monitoring, is increasingly administered in experienced outpatient centers.[14] Next-generation designs are being engineered to eliminate the lymphodepletion requirement. T-cell engagers are also expanding beyond inpatient settings as CRS management experience matures. Wearable monitoring devices enabling remote fever and safety tracking are removing primary barriers to outpatient administration. For patients, this shift means something outcomes data rarely captures: sleeping in one's own bed, maintaining family routines, a treatment experience that does not require surrendering normal life.

Prevention: The Next Frontier

Emerging evidence suggests the early detection conversation may need to expand to include preventing cancer from advancing at all. Data presented at ASCO 2026 (Abstract 3143) suggest GLP-1 receptor agonists, widely used for type 2 diabetes and obesity, may be associated with meaningful reductions in metastatic progression across obesity-related solid tumor types.[15]

The study compared GLP-1 RA users with DPP-4 inhibitor patients across a propensity-matched cohort of 12,112 patients with stage I-III cancer, finding statistically significant reductions in progression to stage IV in four tumor types: NSCLC (10% vs 22%), breast (10% vs 20%), colorectal (13% vs 22%), and hepatocellular carcinoma (19% vs 28%). High tumor GLP-1 receptor expression was associated with a 33% lower risk of death across all seven tumor types studied, and a 45% lower risk in breast cancer specifically.

These findings are observational; randomized trial data are needed to establish causation and identify the mechanisms involved, whether anti-inflammatory, immunomodulatory, or metabolic. The consistency of signal across tumor types and the scale of the dataset warrant prospective investigation. If the anti-cancer effects of GLP-1 agonists survive prospective scrutiny, the boundary between metabolic medicine and oncology prevention will blur in ways the healthcare system is not yet organized to address. BGBx's experience spanning oncology, cardiovascular disease, and obesity puts us at that intersection.

Insights from ASCO 2026

Few moments at ASCO 2026 generated as much excitement as the presentation of daraxonrasib in pancreatic cancer. Midway through the session, before the presenter had even reached the final slides, the audience rose for a standing ovation—a rare sight at ASCO and one that drew attention throughout the convention center. The reaction reflected the magnitude of the data: in the RASolute 302 study, daraxonrasib doubled overall survival compared with chemotherapy in previously treated patients (13.2 vs. 6.7 months; HR 0.40) and delivered an objective response rate nearly three times higher (31.6% vs. 11.2%). Following the presentation, ASCO President Eric Small remarked that the audience response was well deserved, underscoring the significance many attendees attached to the results in a disease that has seen relatively few major breakthroughs.

Beyond oncology therapeutics, the growing intersection between cancer care and metabolic medicine remained a recurring topic throughout the meeting. Additional data on GLP-1 receptor agonists drew considerable interest, including an ASCO analysis showing that adding a GLP-1 therapy to standard treatment was associated with a 30% reduction in mortality risk among patients with HR+/HER2- metastatic breast cancer. While questions remain about mechanism and patient selection, the findings contributed to a broader sense that GLP-1s may have implications that extend beyond weight management and diabetes.

Meanwhile, GRAIL's Galleri study prompted a more nuanced discussion. Although the UK study did not meet its primary endpoint, the company's leadership emphasized evidence of stage migration, pointing to increased detection of stage III cancers and a corresponding reduction in stage IV diagnoses. Conversations following the presentation reflected both optimism and skepticism. Many attendees acknowledged the potential value of shifting cancer detection earlier, but questions around implementation, cost-effectiveness, clinical workflow integration, and the ultimate impact on outcomes remain unresolved. The session reinforced that while enthusiasm for multicancer early detection remains high, the path to widespread adoption is still being defined.

> *"It felt like 20 years of work all rolled into 12 minutes."*
>
> *Dr. Brian Wolpin, Dana-Farber Cancer Institute, on the daraxonrasib standing ovation*

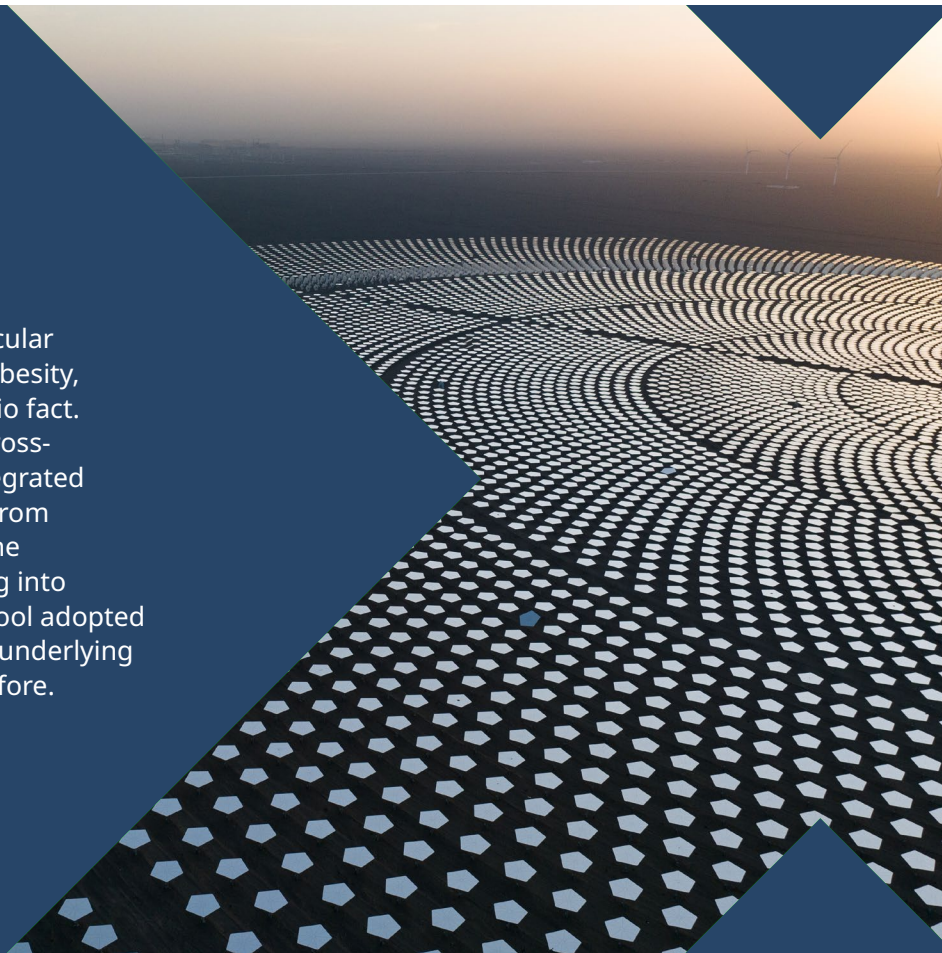
What Does This Mean For You?

Oncologists and Investigators: MCED-identified cancers present differently than symptom-driven diagnoses. Treatment algorithms require systematic recalibration for screen-detected, asymptomatic presentations.

Payers and Market Access: MCED coverage decisions today will shape the stage distribution of diagnosed cancer for the next decade. The economics of early detection versus late-stage treatment need rigorous modeling now.

Medical Affairs: The early detection scientific exchange strategy must reach primary care, not just oncology. The detection story begins before the treatment conversation, and most field teams are not organized to engage PCPs at scale.

Commercial and Brand Teams: Brands built around metastatic indications must follow the science into earlier lines as MCED drives stage migration. Lifecycle planning must account for this shift explicitly.



BGBx PERSPECTIVE

BGBx's experience spans oncology, cardiovascular disease, and metabolic conditions including obesity, an intersection that is no longer just a portfolio fact. As prevention and treatment converge, our cross-therapeutic expertise provides a uniquely integrated perspective. We also bring direct experience from biomarker and MRD launch work, including the operational realities of integrating new testing into clinical workflows. Getting a novel detection tool adopted requires as much strategic investment as the underlying science. We have navigated that challenge before.

FORCE 04

AI Moves from Boardroom to Bedside

The accurate description of AI in oncology today is not that it is universally transformative. It is that it is transformative in specific, well-defined applications, and counterproductive when deployed without clarity of purpose. The organizations making the most progress are not investing most broadly. They are investing most deliberately: identifying high-value use cases, building the evidence base, and scaling from there. What has changed in the past two years is not the technology. It is the clarity. The field is moving from theoretical excitement and proof-of-concept pilots to actual implementation, clinical validation, and consequences for patients.

Where AI Is Already Changing Practice

Several AI applications have moved into meaningful clinical integration. In diagnostic imaging, algorithms are performing comparably to or exceeding expert radiologists in lung nodule classification, mammography screening, and selected pathology slide analysis.[16] In genomics, AI platforms integrating variant data with guidelines and outcomes are compressing time from sequencing result to actionable recommendation for molecular tumor boards. In clinical decision support, autonomous agents integrating multimodal patient data with guidelines are showing early promise in treatment recommendation accuracy.[17] In drug discovery, AI is surfacing target combinations and compressing early-stage timelines in ways conventional screening cannot.

The Workforce Multiplier: AI as a Patient Access Tool

The most underappreciated AI application in oncology is workforce augmentation. With a median oncologist age of 53, nearly one in five approaching retirement, and cancer incidence growing with an aging population, demand for oncology services will substantially outpace supply.[18] AI tools that reduce per-patient cognitive and administrative burden are not productivity improvements. They are patient access tools. Every hour an oncologist spends on documentation or prior authorization is an hour not spent with patients. The challenge is equity: early-adopter academic centers are implementing AI in ways community practices cannot yet access or afford. If productivity gains accrue only to already well-resourced institutions, the workforce gap will widen where it matters most.

The Equity and Trust Problem

If AI training data reflects historical disparities in cancer care, those systems will replicate and amplify those disparities at scale. Algorithmic bias has been documented across diagnostic imaging, treatment recommendation, and risk stratification tools. The populations most underrepresented in training data are those for whom AI errors are most likely and most consequential.[19] Trust is not a secondary concern. It is a clinical adoption prerequisite. Clinicians who do not trust AI tools will not use them, regardless of validation performance. Interpretable, explainable systems are not a nice-to-have. They are a requirement for long-term integration. The organizations that will succeed are not those with the most advanced models. They are those that can demonstrate, in clinical terms, that their tools work for the patients in their waiting rooms.

Insights from ASCO 2026

One of the clearest signals from ASCO 2026 was how firmly artificial intelligence has moved from a future-looking research topic to an active clinical priority. That shift was evident throughout the meeting, but perhaps most visibly in the dedicated education session on *Integrating AI Applications Into Clinical Practice, Cancer Research, and Publishing.* The conversation was no longer centered on whether AI has a role in oncology; instead, speakers focused on the practical challenges of implementation, governance, and responsible use in real-world settings.

The growing emphasis on execution was reinforced by NCI Director Tony Letai, who outlined plans for a coordinated approach to AI across cancer research. Particular attention was given to applications with near-term clinical utility, including trial eligibility screening and patient matching—areas where attendees repeatedly highlighted the potential to reduce administrative burden and improve access to studies.

AI's prominence extended beyond the scientific sessions. Throughout the meeting, ASCO's own programming reflected the topic's growing importance, including new ASCO Daily News AI-focused podcasts such as *No Margin for Error: What to Know Before Implementing AI in Clinical Practice.* The title itself captured a theme that surfaced repeatedly across presentations and discussions: enthusiasm for AI remains high, but expectations are becoming more rigorous. There was a noticeable consensus that the field is moving beyond experimentation and pilot projects toward accountability, validation, and measurable clinical impact. The takeaway from ASCO 2026 was clear: the question is no longer whether oncology will adopt AI, but how to implement it thoughtfully, safely, and at scale.

What Does This Mean For You?

Oncologists and Investigators: AI as clinical decision support requires the same validation rigor as any other diagnostic tool. The question is not whether it is impressive in a demo. It is whether it improves outcomes for your patients.

Payers and Market Access: AI-driven diagnostics and decision support tools require reimbursement frameworks that do not yet exist. Early engagement with CMS and payer policy teams is strategically important before approvals arrive.

Medical Affairs: AI is reshaping how medical affairs teams synthesize field intelligence and support evidence generation. The opportunity is to deploy it with the intentionality the science demands and compliance require.

Commercial and Brand Teams: AI-enabled patient identification, HCP segmentation, and engagement analytics are near-term realities. Brands that build AI into their go-to-market strategy now have a structural advantage.

BGBx PERSPECTIVE

At BGBx, we apply AI not as a future ambition but as a present-day practice. Our proprietary Audience Simulator uses digital twinning and behavioral science to model how oncologists and other stakeholders respond to scientific and commercial messaging, compressing weeks of research into near real-time insight. The most powerful AI applications are not always the most complex. They are the ones that answer a specific, well-defined question faster and more accurately than any alternative. BGBx brings both the strategic framework and the practical experience to help clients deploy AI with the intentionality oncology demands.

What Comes Next: A Call To Purposeful Action

The four forces in this report do not operate independently. The personalized vaccine depends on the genomic intelligence AI accelerates. The ADC's clinical position depends on the sequencing question that earlier detection reshapes. The outpatient care model depends on the monitoring technology enabling safe discharge. The early detection ecosystem depends on a primary care workforce prepared to act on novel biomarker results.

What is emerging is a new infrastructure for cancer care: more precise, more distributed, more data-driven, and more demanding of every stakeholder simultaneously. The science is advancing faster than the systems built to support it. That gap is not a failure. It is the defining challenge and defining opportunity of the next five years.

Closing that gap requires translating discovery into clinical practice, clinical evidence into commercial strategy, and commercial strategy into patient access. It requires understanding not just what a new therapy does, but what it means for the oncologist making the prescribing decision, the payer building the formulary, the patient navigating treatment, and the industry partner building a sustainable business around all of the above. That translation capacity will separate the organizations that define oncology's next chapter from those that struggle to keep pace.

> *"Many patients and family members and oncologists have historically thought of pancreatic cancer as the untreatable cancer. Sunday was proof that clinical trials work, that persistence pays off, and that this moment in oncology is genuinely different."*
>
> *Brendon Phalen MD MBA, Founding Partner, BGBx*

ASCO 2026 confirmed what this paper argues. The daraxonrasib standing ovation in Hall B1 was not just a celebration of one drug. It was a recognition that oncology is entering a new era, one where cancers once considered untreatable are yielding to precisely targeted science. The HARMONi-6 debate about global applicability, the GRAIL implementation questions, the AI education sessions asking about margin for error: all of it reflects a field grappling with the same fundamental tension this paper describes. The science is ready. The systems are catching up. The organizations that will define the next five years are the ones helping to close that gap.

The organizations that will define oncology's next chapter are not necessarily those with the largest pipelines. They are the ones that can move with the science without losing sight of the patient, engage with complexity without being paralyzed by it, and build for the future without abandoning the clinical credibility they have earned.

The next five years will reward those who think carefully and move purposefully. If you want to think through what any of these forces means for your brand, your pipeline, or your organization, BGBx is ready for that conversation. More than 1,000 years of cumulative oncology experience and 60+ assets supported across every stage of the product lifecycle means we have likely navigated something close to whatever you are facing.

Let's talk.

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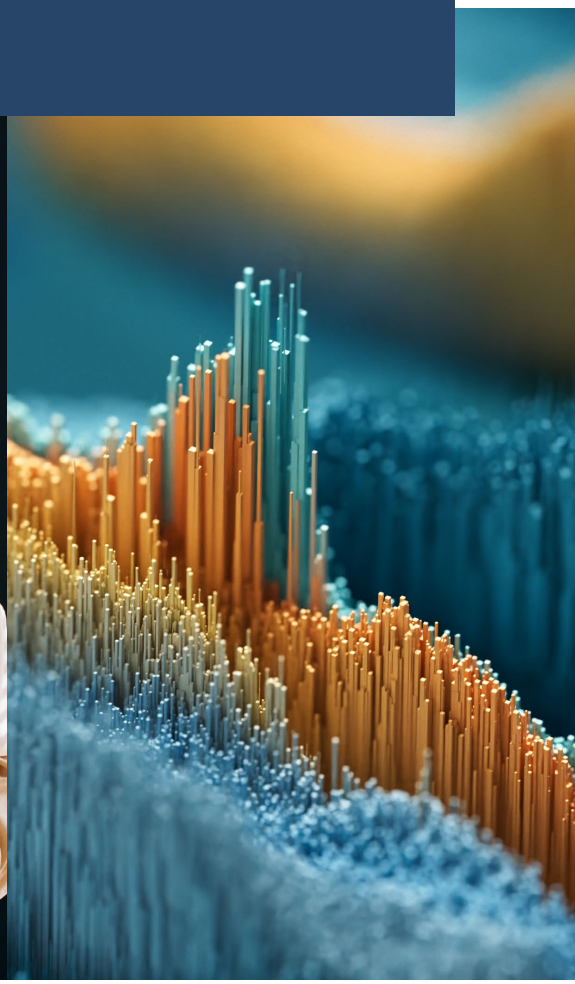

About BGBx

BGBx is an independent commercial solutions partner for pharmaceutical and life science companies and their brands, combining consulting, communications, science, creativity, data, technology, innovation, and digital capabilities to deliver breakthrough results. Through BGBx Consulting and BGBx Communications, the company helps clients set strategy early, stay aligned throughout the product lifecycle, and execute through marketing and communications programs that drive impact. BGBx is Built for Breakthrough. Learn more at bgbx.com.

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This report was developed by the BGBx Oncology Strategy Team and reflects the collective expertise of BGBx's medical affairs, scientific communications, and commercial strategy practices. Contributors include:

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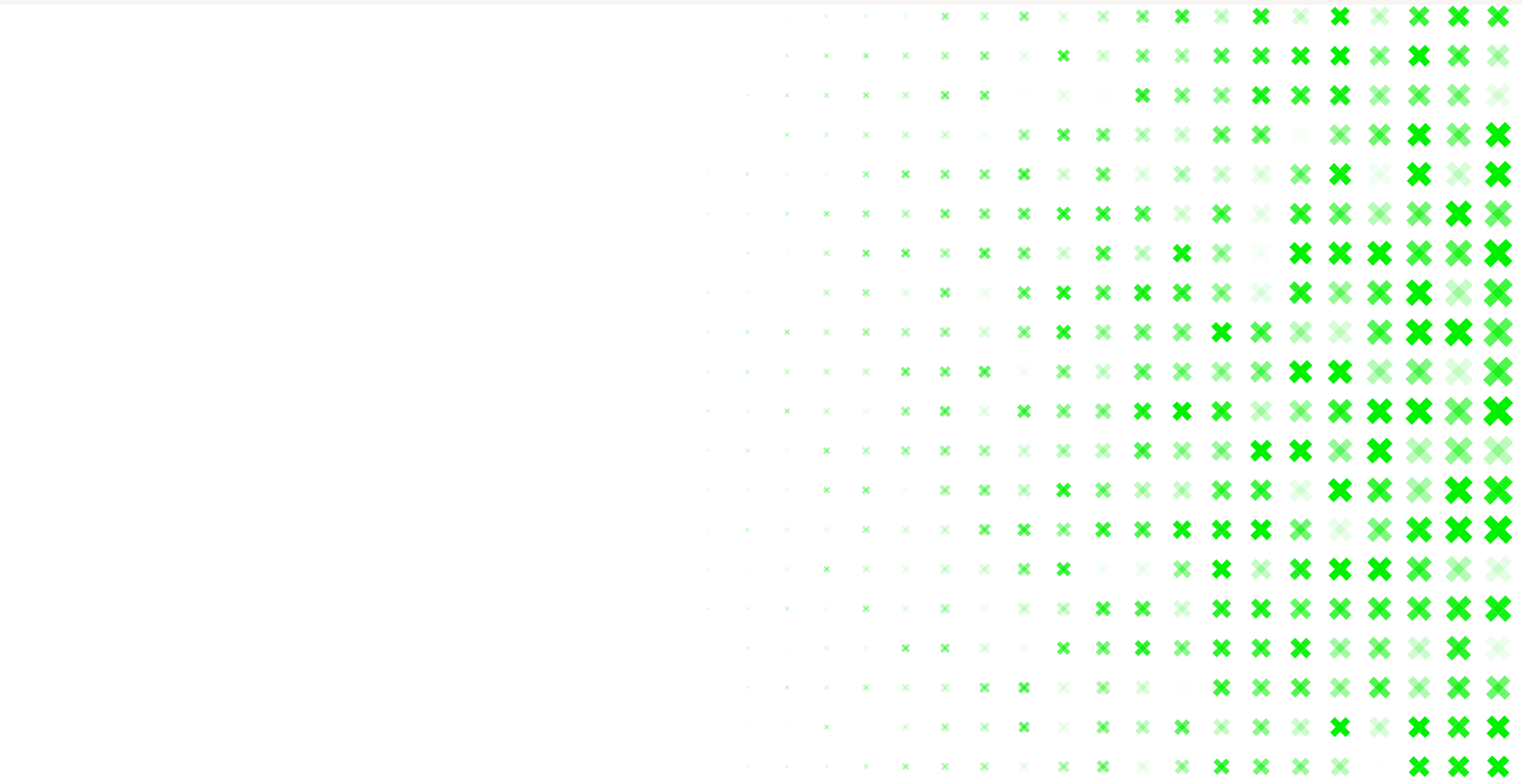

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