Unleashing Immunity To Fight Cancer

BioInvent

March 2026

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Key Highlights

1. **Two promising antibodies** with clinical **proof of concept**, targeting significant high-value markets in **Ovarian cancer, NSCLC, CTCL, Uveal Melanoma**
2. **BI-1808** a novel, first in class anti-TNFR2 mAb with demonstrated **single agent activity** and **durable responses in Ovarian cancer.** A new potential standard of care
3. **BI-1206**, an **anti-FcγRIIB mAb**, a significant opportunity in **Follicular Lymphoma, NHL, NSCLC and Uveal Melanoma, and many other solid tumors**
4. Multiple **value driving catalysts** on the horizon including mid-2026 **Phase 2a readouts** across BI-1808 and BI-1206 programs
5. Leadership team with a **demonstrated track record** and **validated investors** to drive success

Redmile Group · Van Herk Groep · Forbion · HBM Healthcare Investments · Fjärde AP-fonden · Omega Funds

BioInvent has a Strong Proprietary Clinical Pipeline with Multiple Value Drivers in 2026

BI-1808 (TNFR2)	Study Arm	Phase 1	Phase 2a	Phase 2b	Next data
2L Ovarian cancer	+ pembrolizumab[1]				H2 2026
2L Ovarian cancer	+ pembrolizumab[1] + paclitaxel				
CTCL	single agent				Mid-2026
CTCL	+ pembrolizumab[1]				Mid-2026

BI-1206 (FcγRIIB)	Study Arm	Phase 1	Phase 2a	Phase 2b	Next data
NHL (FL, MCL, MZL)	+ rituximab & acalabrutinib[2]				Mid-2026
1L NSCLC	+ pembrolizumab[1]				H2 2026
1L Uveal melanoma	+ pembrolizumab[1]				H2 2026

1 Supply agreement with Merck
2 Supply agreement with AstraZeneca

Complete and Partial Responses (CRs and PRs) observed in all clinical programs

CTCL: Cutaneous T-cell Lymphoma
NHL: Non-Hodgkin's Lymphoma
NSCLC: Non-small cell lung cancer

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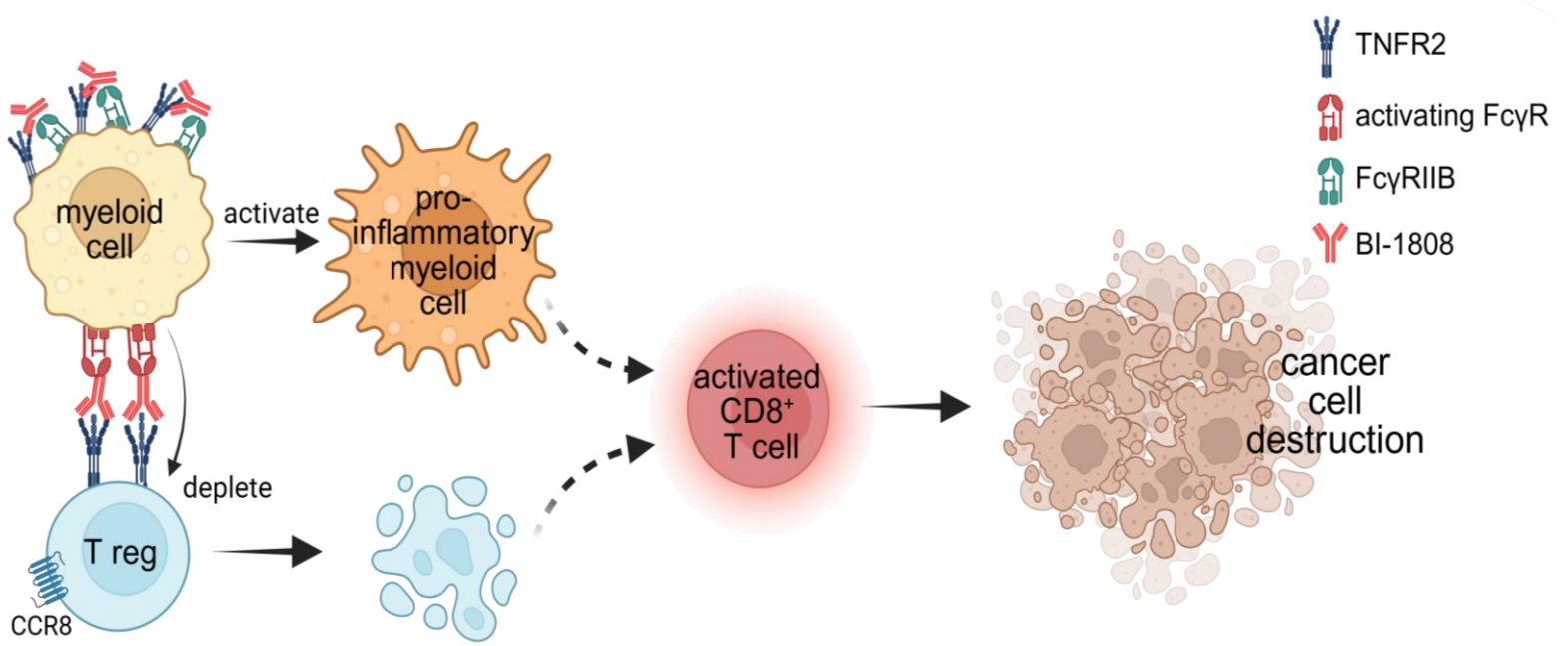
ANTI-TNFR2

BI-1808 in Ovarian Cancer

BI-1808 in T-cell Lymphoma

BI-1808's Differentiated Mechanism of Action



Mechanism of Action

- Binds to TNFR2
- Depletes immunosuppression
- Activates myeloid cells
- Expand antitumor CD8+ T cells
- Reprogrammes macrophages positive

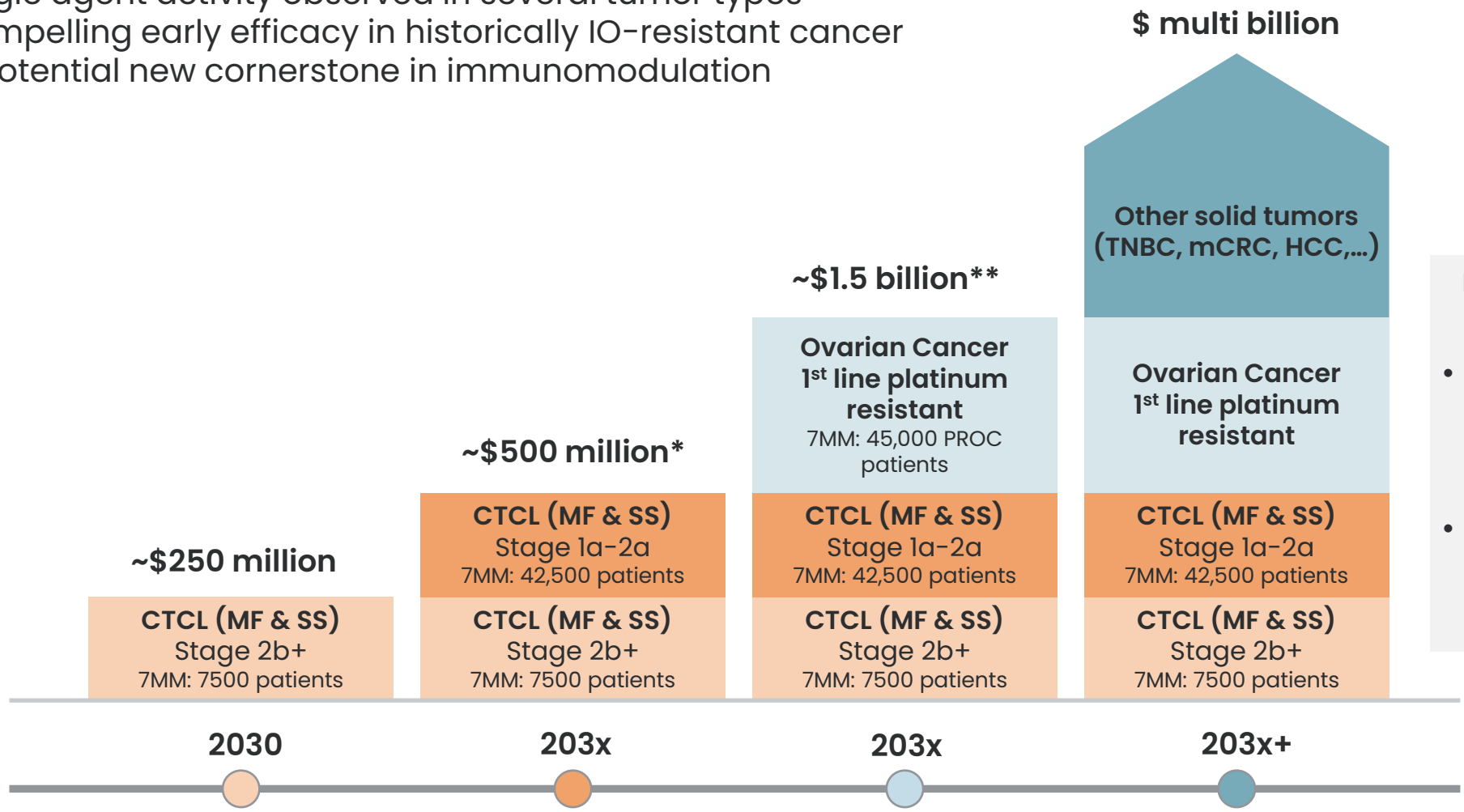
mAb Characteristics

- Human recombinant IgG1 antibody
- Blocks TNF-a binding to TNFR2
- Engages activating and inhibitory FcgRs to trigger antitumor activity

Mårtensson et al, BioRxiv

BI-1808 a Potential Blockbuster in Ovarian Cancer and CTCL

- Targets resistant, non-responding, poorly T cell-infiltrated “cold” tumors
- Single agent activity observed in several tumor types
- Compelling early efficacy in historically IO-resistant cancer
- A potential new cornerstone in immunomodulation



Data releases for BI-1808 planned during 2026

- Phase 2a CTCL update for BI-1808 monotherapy and pembrolizumab combination, mid-2026
- Phase 2a solid tumor data for BI-1808 / pembrolizumab combination, H2 26

*Assumes capture of
** Peak sales potential based on to be confirmed with market research
7MM= 7 Major Markets, i.e US, France, Germany, Italy, Spain, UK, Japan

MF: Mycosis Fungoides
SS: Sézary Syndrome
PROC: Platinum-Resistant Ovarian Cancer

BI-1808 in Ovarian Cancer

BI-1808: Promising Efficacy in Ovarian Cancer (OC)

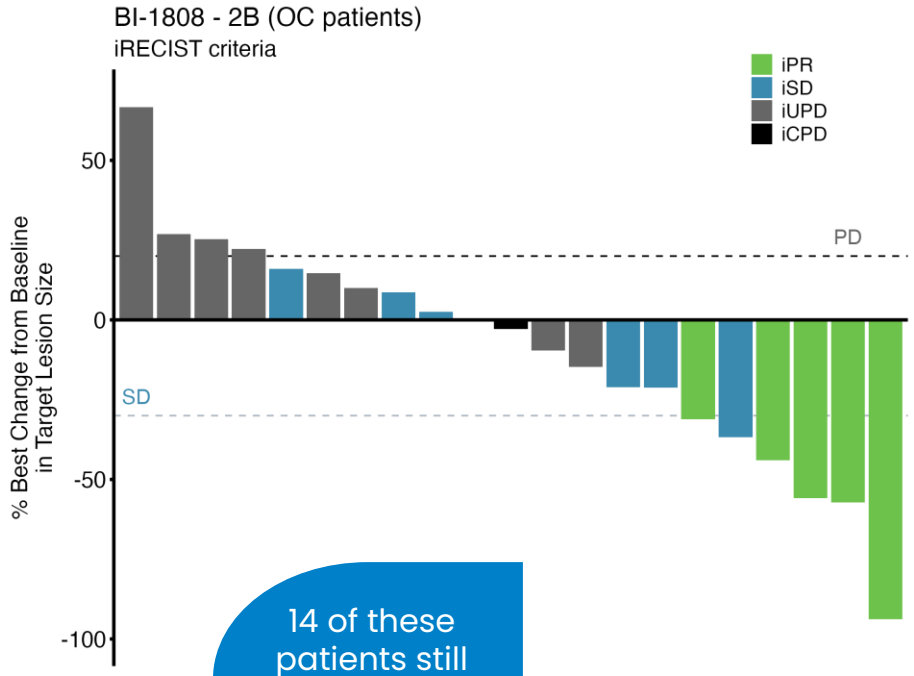
Phase 2a Design

Phase / Design	Population	N	Dosing	Sites	Key Endpoints	Data Cut-off
Ph2a single arm (doublet)	OC (all subtypes)	21 of 40	BI-1808 1000 mg Q3W Pembro 200 mg Q3W	8 (OC) in EU & UK	Safety ORR exploratory	2026-02-18

BI-1808 in combination with pembrolizumab

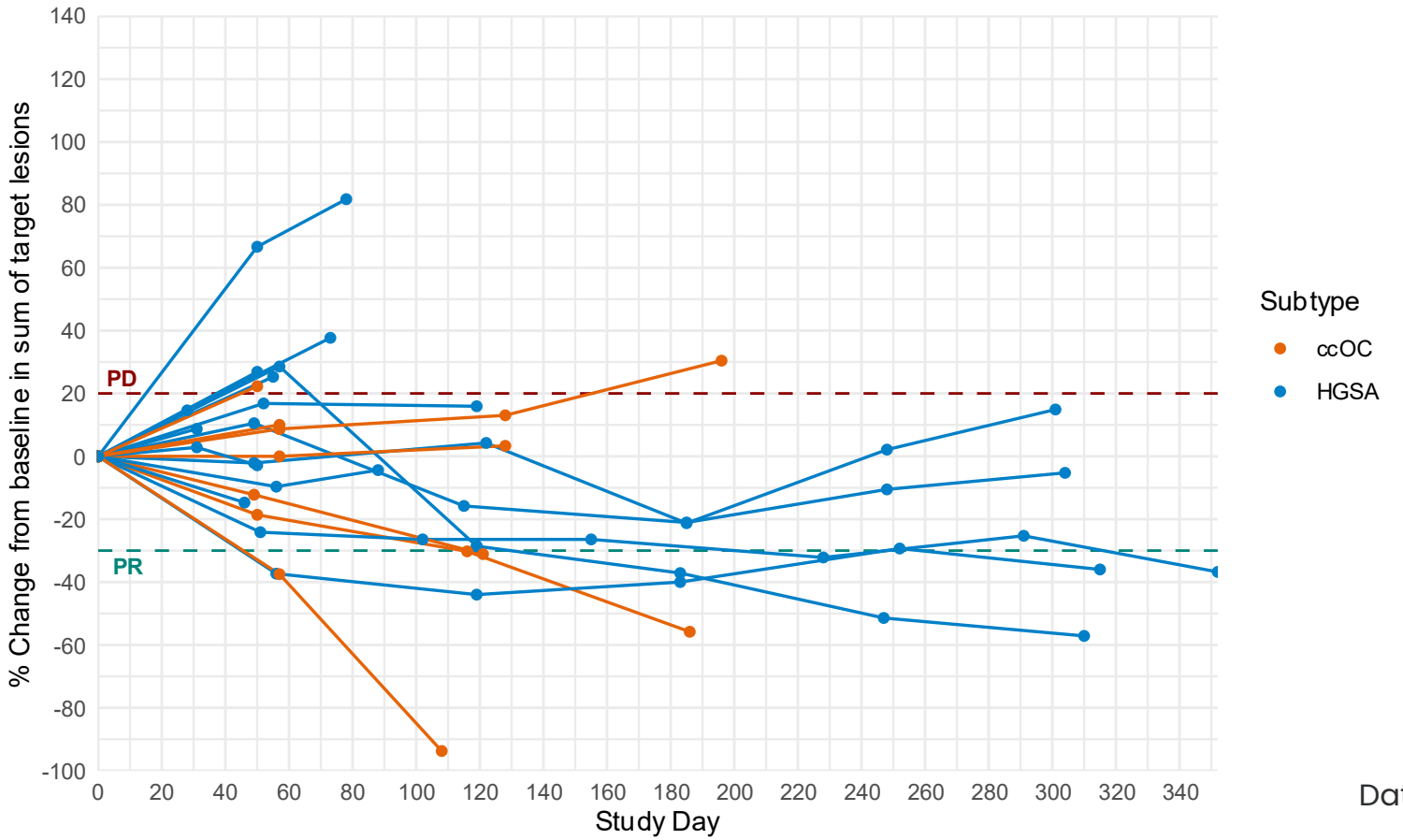
24% ORR, 57% DCR in 21 evaluable OC patients:

- 5 patients with Partial Response (PR)
- 7 patients with Stable Disease (SD), several durable SD beyond ten months and ongoing
- Safe and well-tolerated; all adverse events manageable with standard medical treatments
- Strong activity in both high-grade serous and clear cell ovarian cancer subtypes
- Expected final readout in H2 2026



ORR: Overall Response Rate
DCR: Disease Control Rate

BI-1808 Phase 2a Combo Data Shows Promising Efficacy in Ovarian Cancer (cont'd)



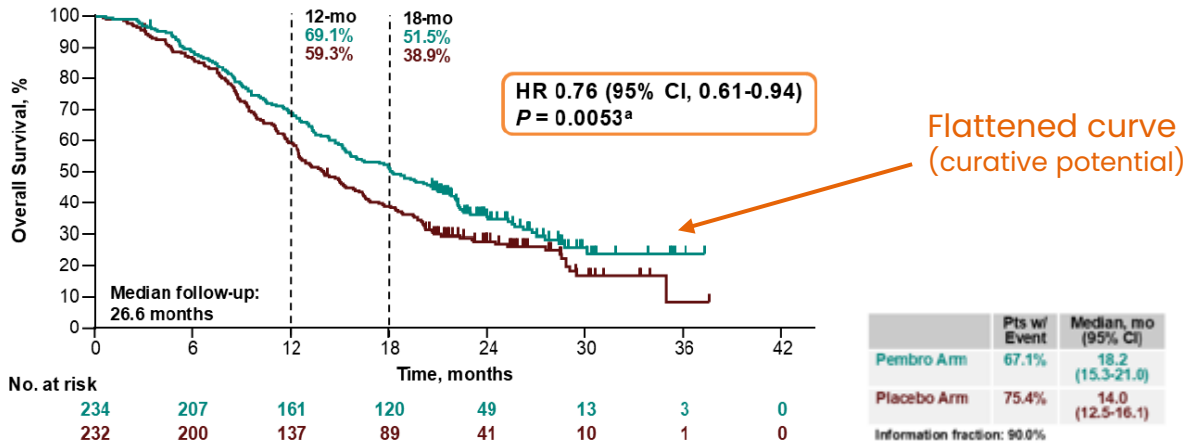
Data cut-off 2026-02-18

WHAT'S NEXT? Additional Phase 2a data in ovarian cancer H2 2026E

OC: Ovarian Cancer

Compelling Rationale for BI-1808 Triplet in Ovarian Cancer

I. anti-PD-1 (pembrolizumab) + paclitaxel has curative potential in Ovarian Cancer



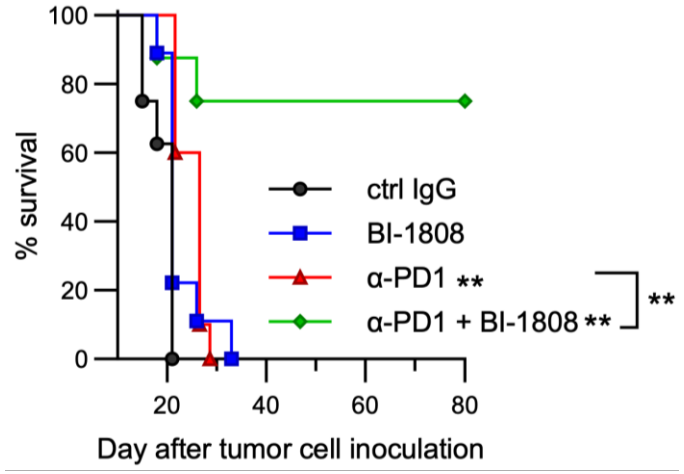
	Pts w/ Event	Median, mo (95% CI)
Pembro Arm	67.1%	18.2 (15.3-21.0)
Placebo Arm	75.4%	14.0 (12.5-16.1)

Information fraction: 90.0%

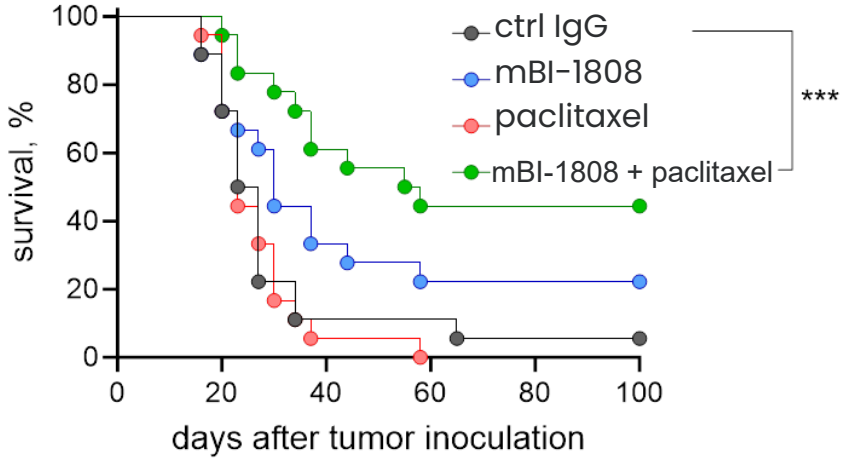
- BI-1808 + pembro have synergistic activity (**II**)
- BI-1808 + paclitaxel have additive activity (**III**, **IV**)

Thus, the triplet can only be better

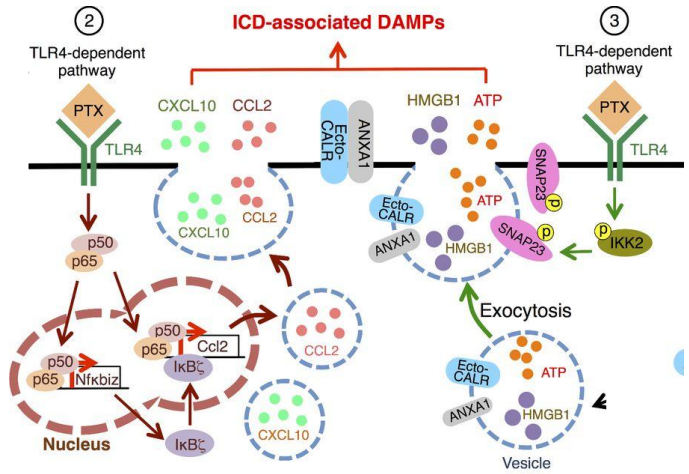
II. BI-1808 + anti-PD-1 synergize



III. Paclitaxel enhances BI-1808 efficacy

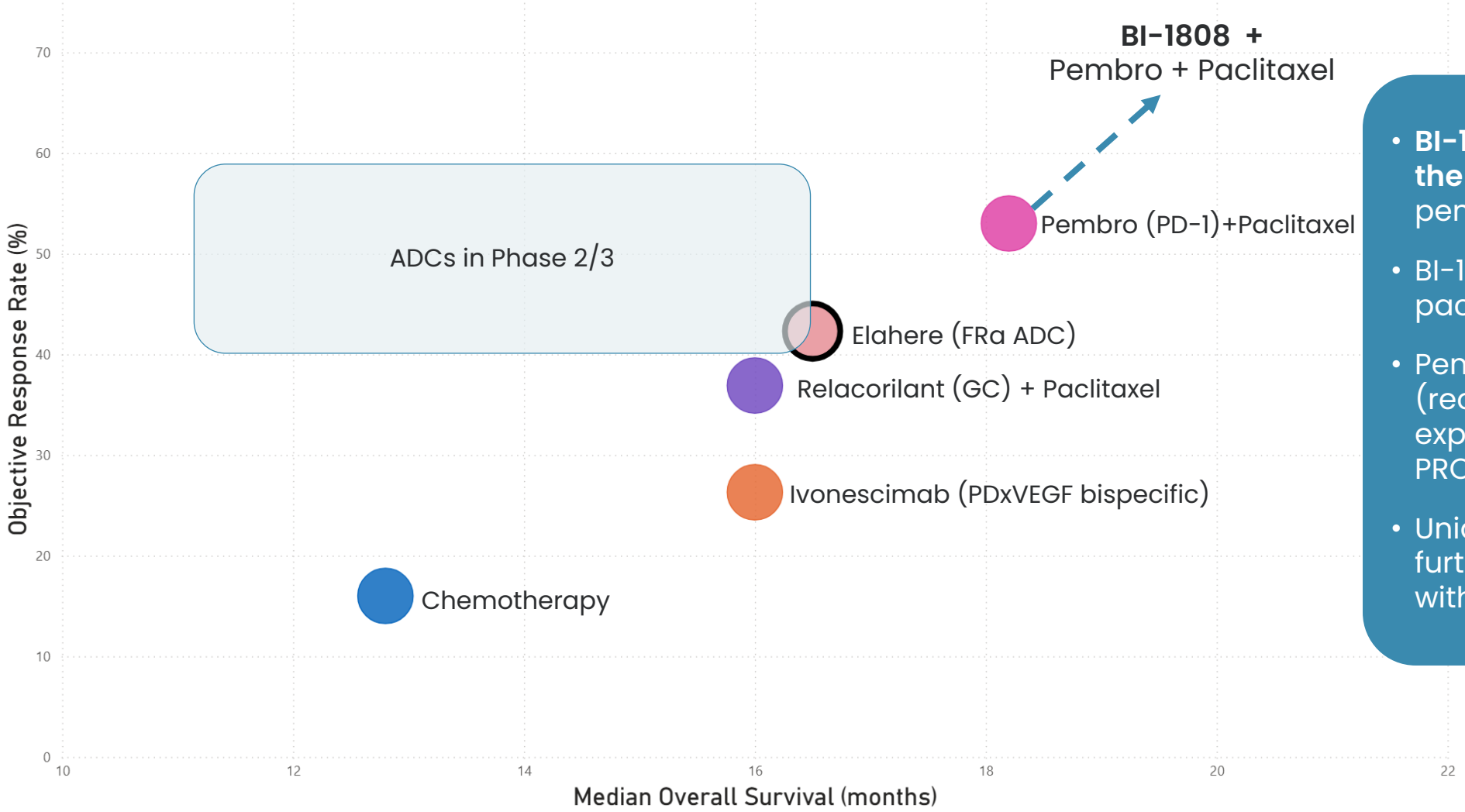


IV. BI-1808 + Paclitaxel activate myeloid cells



Figures. Compelling rationale for BI-1808 in Ovarian Cancer.
I. Anti-PD-1 has curative potential in Ovarian Cancer, as demonstrated by improved overall survival in pembro + paclitaxel compared with paclitaxel arm of Keynote B96 study. **II.** BI-1808 and aPD-1 synergize in "cold" tumor models in vivo (Mårtensson, BioRxiv). **III.** Paclitaxel enhances the antitumor activity of the BI-1808 surrogate antibody in mice. **IV.** BI-1808 and Paclitaxel activate myeloid cells (Lau, Cancer Immunol Res, 2020).

BI-1808 Will Likely Improve the Newly Approved SoC Pembro + Paclitaxel



- **BI-1808** + pembro has **3X the ORR** as compared to pembro alone
- BI-1808 synergizes with paclitaxel
- Pembro + paclitaxel (recently approved) expected to become SoC for PROC*, but survival still poor
- Unique opportunity to further enhance OS and ORR with the addition of BI-1808

* Platinum resistant ovarian cancer (PROC)

*Footnote : Black box warning is represented with black outline * Estimated median OS value based on results reported*

BI-1808: A New Immunologic Foothold in Ovarian Cancer

The Solid Tumor Opportunity

- Recurrent ovarian cancer remains highly resistant all treatments
- Anti-PD-1 show limited activity (low ORR, modest durability). However, pembrolizumab + paclitaxel, newly approved, represents a new standard of care with survival benefit
- Despite these recent results, survival is poor with an urgent need for new treatments

Why BI-1808 Matters

- A Different mechanism that addresses poorly T cell-infiltrated “cold” tumors
- Selectively reduces regulatory T cells, activates macrophages and expands CD8+ T cells
- Synergizes with PD-1 blockade for deeper, more durable responses

Competitive Differentiation

- Competing combinations (CTLA-4, PARP, VEGF) limited by toxicity or modest efficacy
- No approved therapy directly targets TNFR2 → clear first-in-class potential
- Mechanism is orthogonal to existing IO strategies, enabling broad combination possibilities

Strategic Value Creation

- Addresses a large, underserved market with limited IO success to date
- Strong biological rationale + early clinical validation de-risking the program
- A potential to build on pembro’s recent approval to provide a durable-possibly curative-treatment
- Platform potential across poorly responsive solid cancers

Positioning BI-1808 in Recurring Ovarian Cancer

- **First-in-class BI-1808** depletes immunosuppressive Tregs and reprograms macrophages to expand and activate CD8+ effector T cells, converting the tumor microenvironment from “cold" to “hot."
- Pembrolizumab + paclitaxel achieved 53% ORR, and **18.2 months of OS**,[1] establishing a **new standard of care** in recurring ovarian cancer. It was approved by the FDA in February 2026.
- **BI-1808 + pembrolizumab** current on a **24% ORR and 57% DCR** in recurring OC patients, representing a **meaningful improvement** over the **8% ORR of pembrolizumab** monotherapy, in addition to a target-validating CR in an OC patient treated with BI-1808 monotherapy.
- While **ADCs** show relatively high ORR (44-57% ORR), PFS (and eventually OS) is not better than the lasting responses that can be achieved with immunotherapy, based on available data and experience with chemotherapeutic agents
- **Adding BI-1808 to pembrolizumab + paclitaxel** is a biomarker-agnostic treatment expected to **enhance efficacy** higher than the 53% KEYNOTE-B96 benchmark with a more **durable** activation of the immune response, establishing a new SOC in recurring Ovarian Cancer.
- This regimen will **not compete with ADCs** in development which can be administered prior or after treatment with this regimen

[1]KEYNOTE-B96, ESMO 2025
PFS: Progression-Free Survival, OS: Overall Survival

BI-1808 in CTCL

BI-1808 Phase 2a Monotherapy Shows Promising Efficacy in **CTCL and PTCL**

Phase 2a Design

Phase / Design	Population	N	Dosing	Sites	Key Endpoints	Data Cut-off
Ph 2a single arm (monotherapy)	Advanced CTCL/PTCL	15 of 40	1000 mg Q3W	10	Safety ORR exploratory	2025-10-06

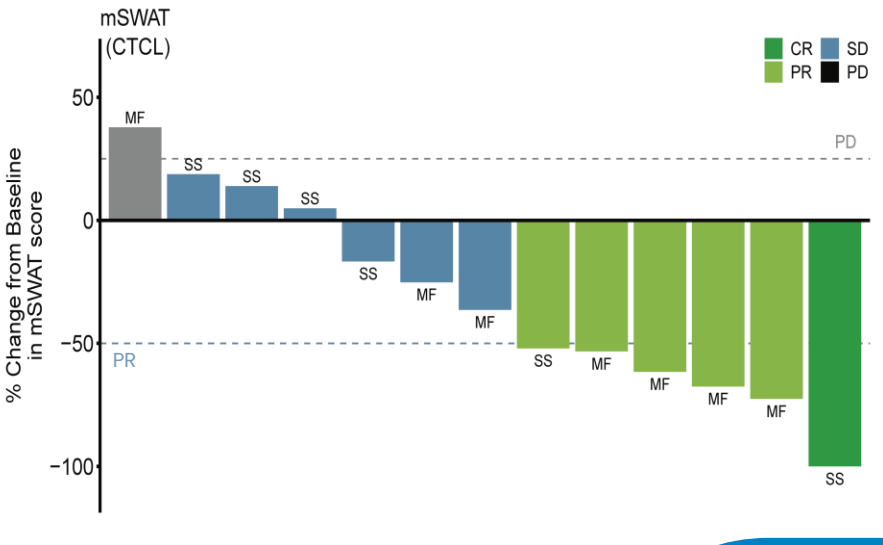
ASH 2025 poster

46% ORR, 92% DCR in 13 evaluable CTCL patients:

- 1 CR: Sézary Syndrome (SS)
- 5 PR: 4 Mycosis Fungoides (MF), 1 SS
- 6 patients with SD
- 1 MF patient with PD

2 evaluable patients with PTCL:

- 1 PR
- 1 patient with SD



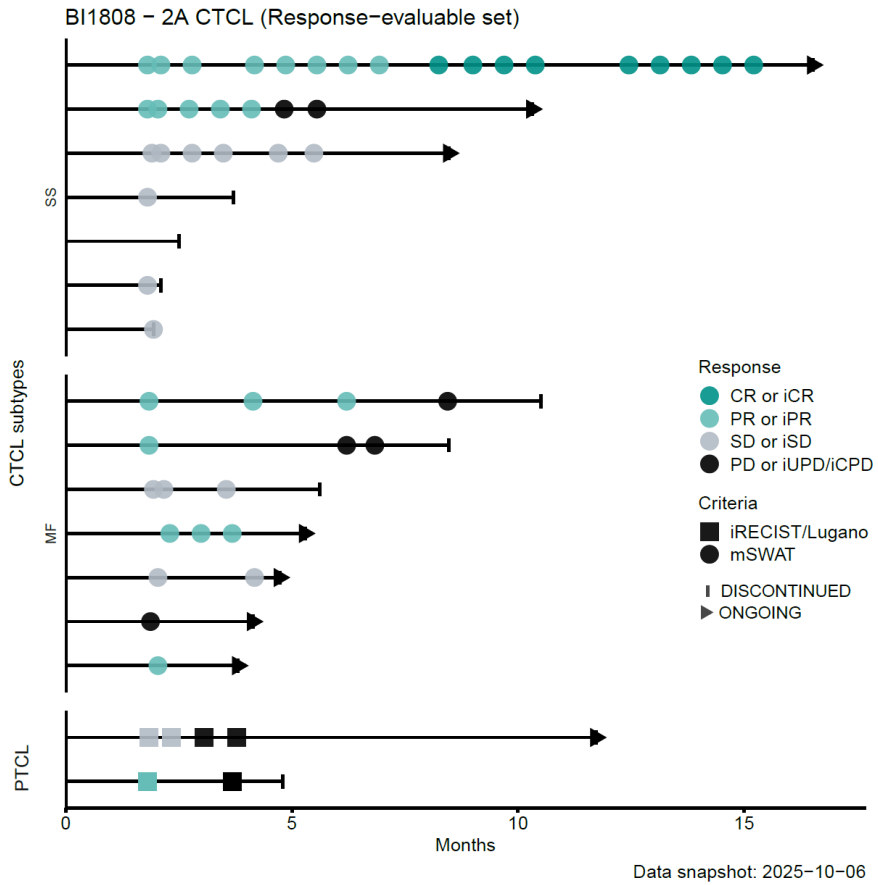
- Well tolerated with primarily mild to moderate adverse events (Grade 1-2)
- Immune activation observed early on, with depletion of regulatory T cells and an influx of CD8+ T cells into the skin

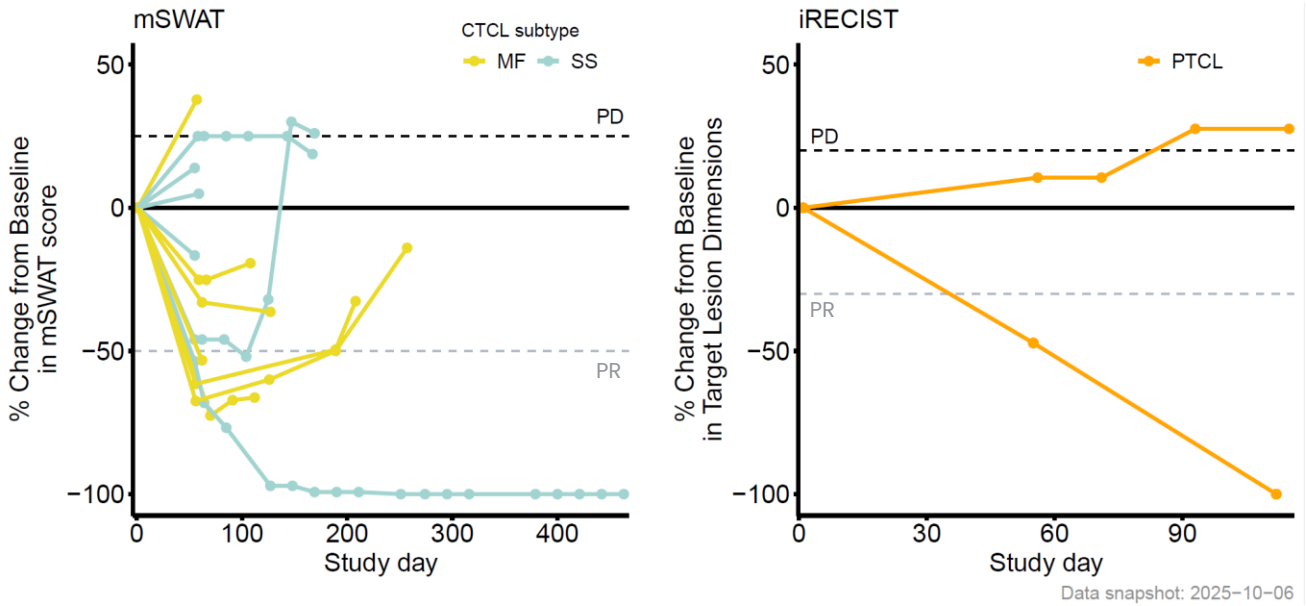
Orphan Drug Designation for TCL

Fast Track Designation for CTCL

CTCL: Cutaneous T-cell Lymphoma, PTCL: Peripheral T-cell Lymphoma

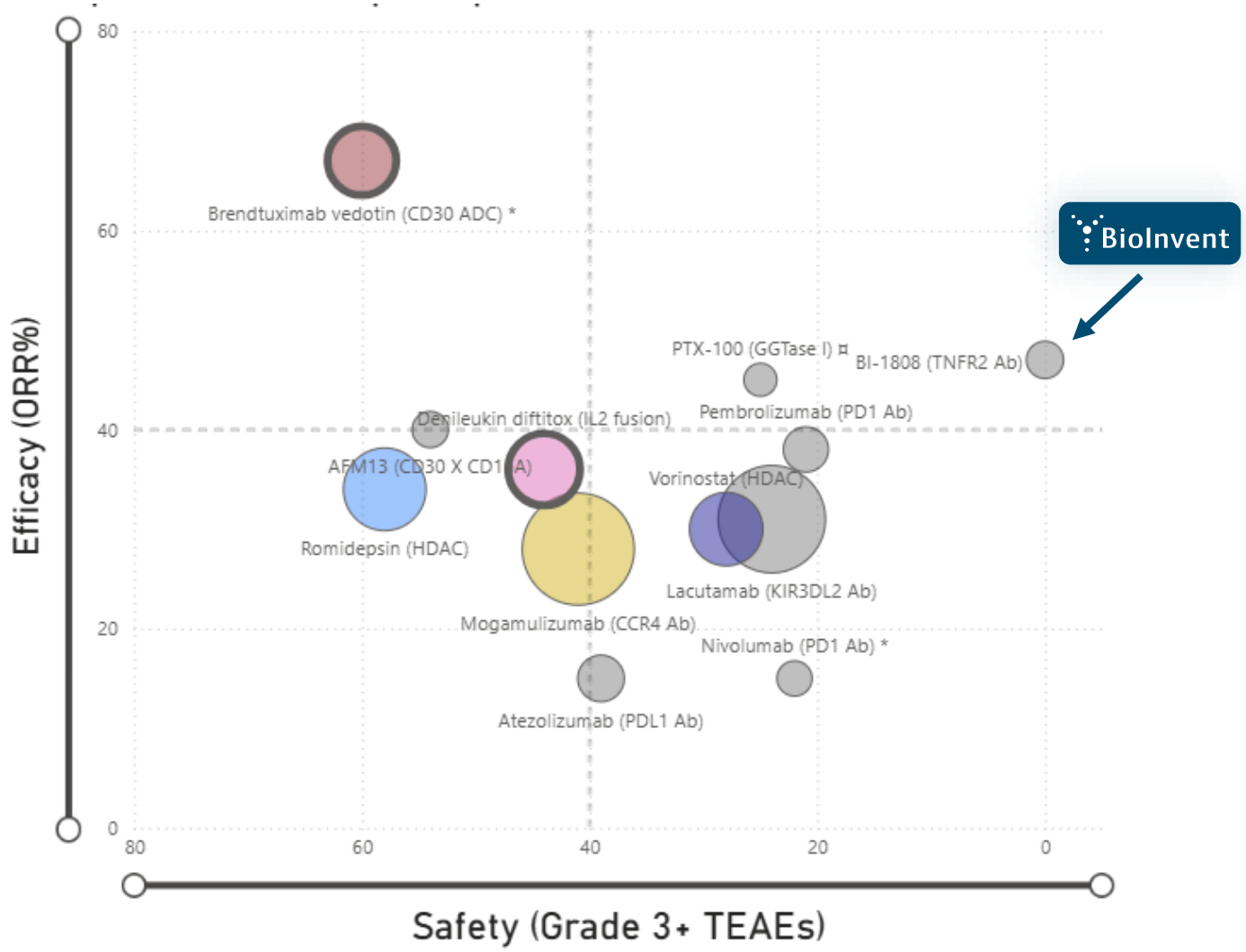
BI-1808 Phase 2a Monotherapy Shows Promising Efficacy in **CTCL and PTCL** (cont'd)





WHAT'S NEXT? Phase 2a data in CTCL (additional mono and first combo) mid-2026E

BI-1808 Efficacy and Safety is Best-in-Class Compared to Other Systemic Therapies for CTCL



Approved Treatments (Major)

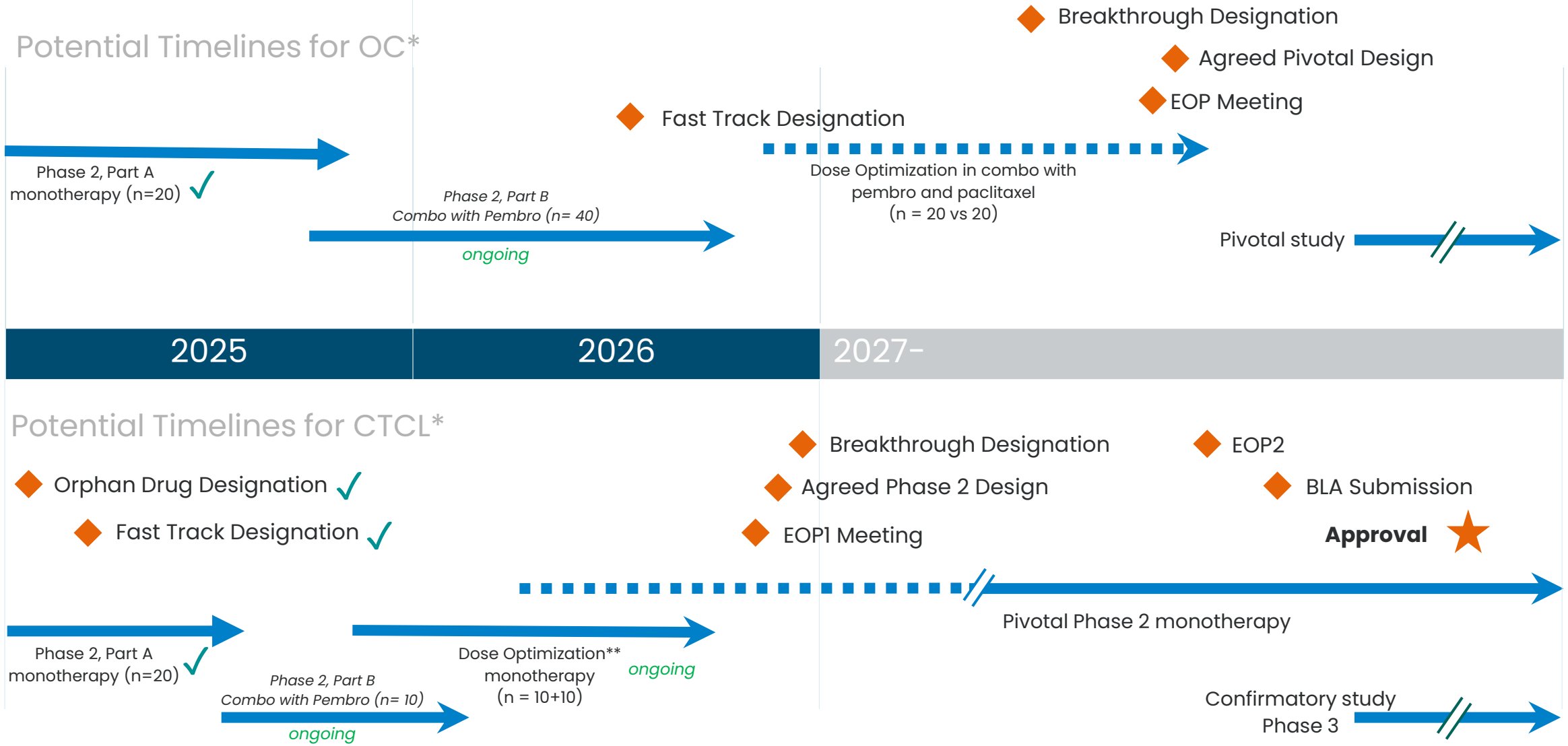
Romidepsin	Class I HDAC	Bristol Myers Squibb
Vorinostat	Pan-HDAC	MERCK
Mogamulizumab	anti-CCR4 mAb	KYOWA KIRIN
Brentuximab vedotin	CD30 ADC	Pfizer, Takeda
Denileukin diftitox	IL2-fusion	CITIUS Oncology

Black-Box warning	○
Size of bubble	No. of pts
Investigational drugs	Grey bubble
Approved treatments	Colored bubble
Approved for a sub-population	^

Patients
9
186

Public sources

BI-1808 Potential Path to Approval – US



* Depending on partnering discussions and acceptance of development plan by FDA
** Clinical study protocol approved in the US

ANTI-FcγRIIB

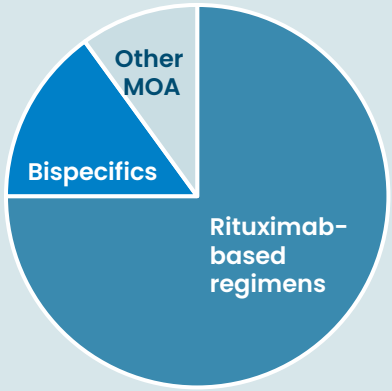
BI-1206 in Non-Hodgkin's Lymphoma (NHL)

BI-1206 in Solid Tumors

BI-1206 in NHL

Paired with Entrenched Rituximab, BI-1206 can Compete in a Highly Competitive FL Market

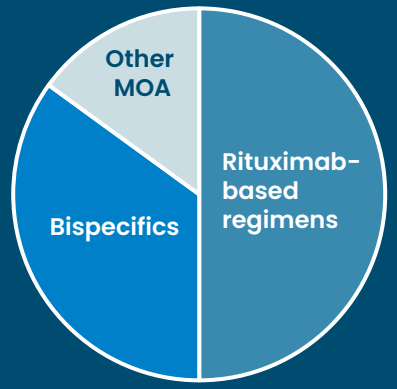
Now



Follicular Lymphoma (FL) Market Shifts

- Increasing bispecific options
- Expansion of other MOAs (BTKi, CAR-T)
- Switch to rituximab biosimilars

2030



Opportunities for BI-1206

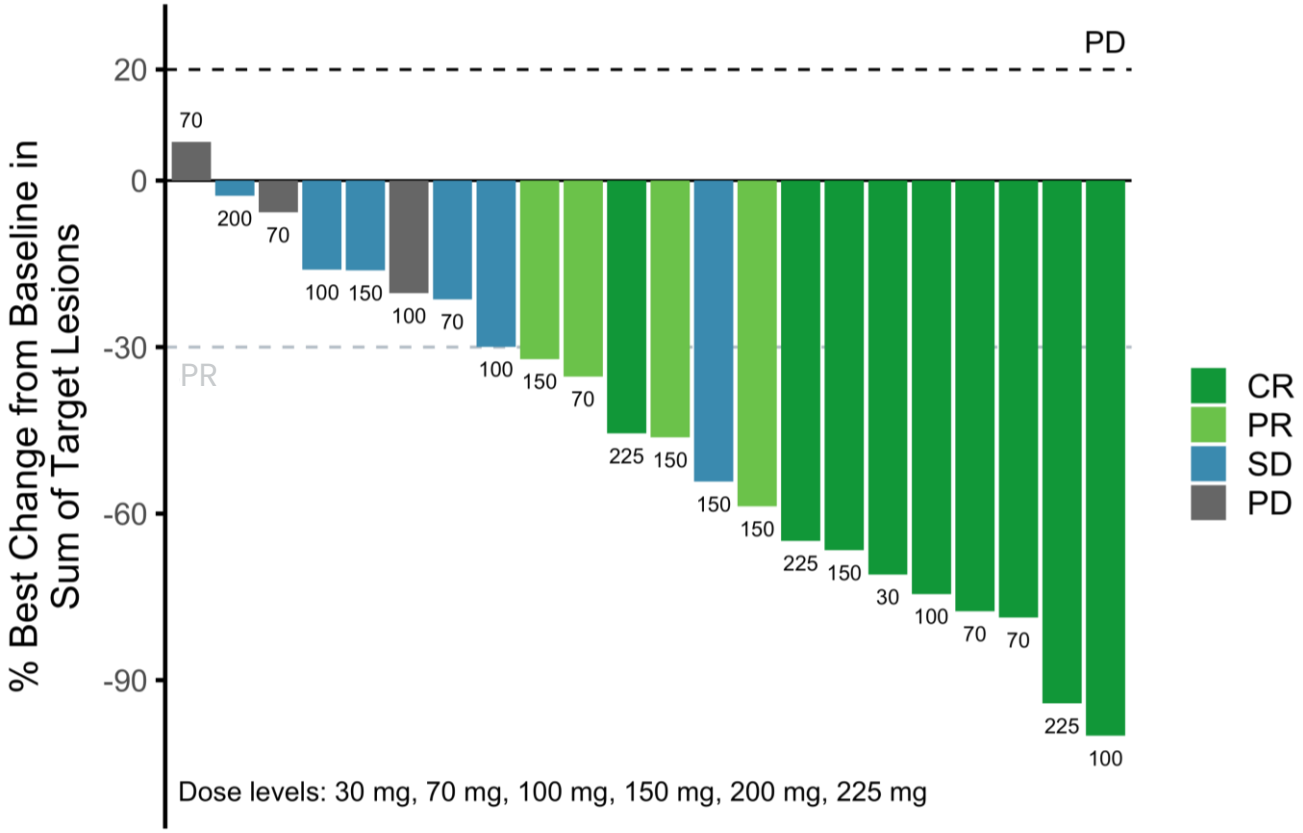
- Capturing 2nd line after 1st line bispecific (CD19XCD3)
- First anti-CD20 after bispecific will increase response rates of the triplet
- Safe and convenient, community hospital-friendly backbone (no CRS, neurotoxicity, neutropenia, infections, or hospital logistics associated with bispecifics/CAR-Ts)
- Combines with biosimilar rituximab, which remains the drug of choice for a majority of hematologists

Eversana market research
CRS: Cytokine Release Syndrome

BI-1206 SC + Rituximab (**Doublet**) is Well Tolerated with Promising Efficacy in Follicular Lymphoma

Phase 1 Design

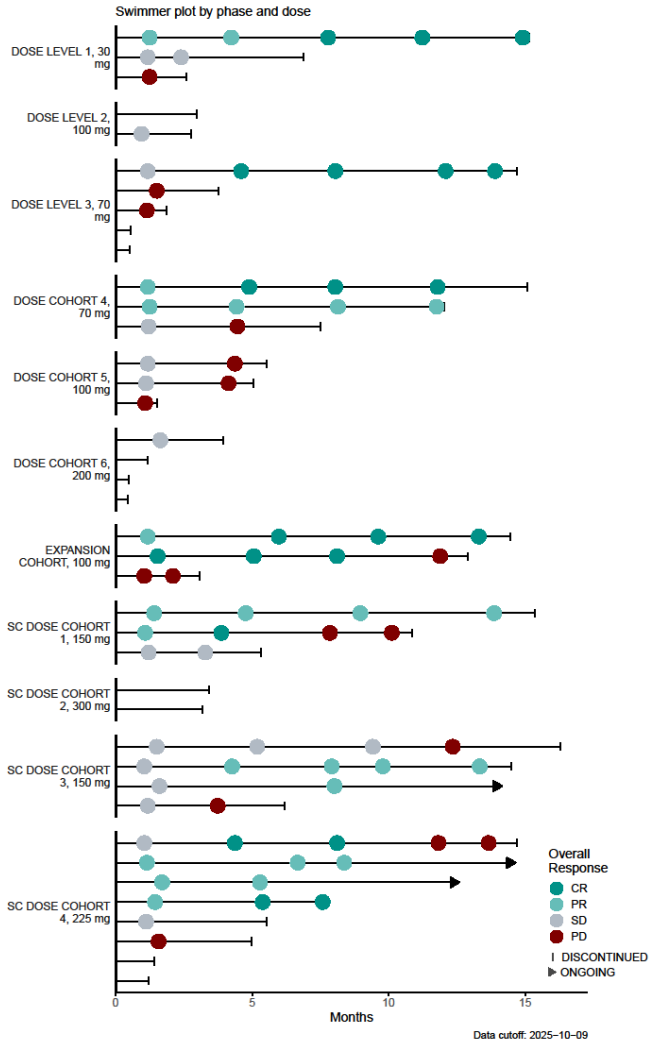
Phase / Design	Population	N	Dosing	Sites	Key Endpoints	Data Cut-off
Ph 1 Dose escalation	R/R FL (as part of r/r NHL)	22 FL (out 30 NHL)	Escalating doses IV and SC	12 EU. 3 BR, 2 US	Safety ORR exploratory	2025-10-28

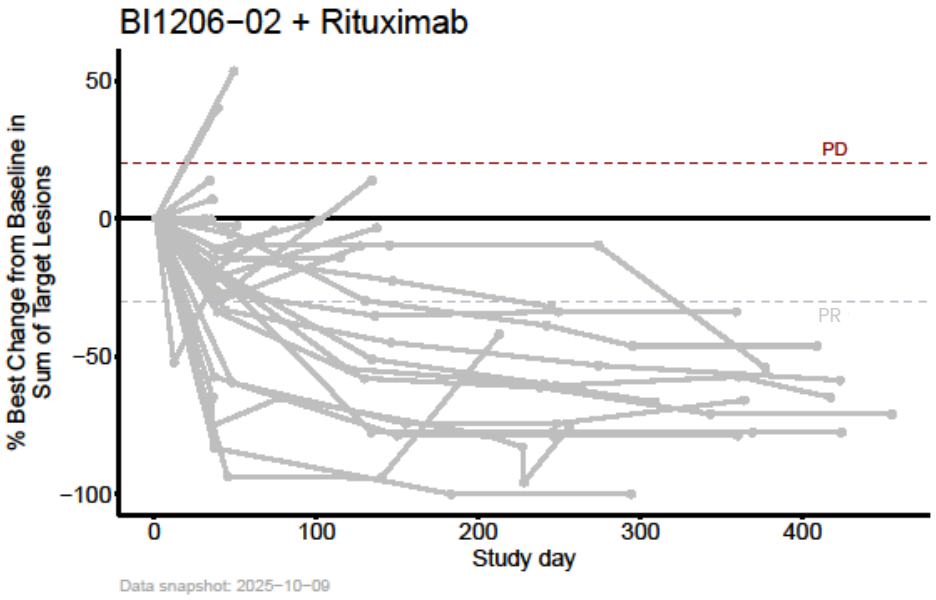


- ORR of 59%, CRR of 41%, DCR 86% in FL
  - 9 complete responses (CR)
  - 4 partial responses (PR)
  - 6 patients with stable disease (SD)
- CRs have been long-lasting, 3 of them lasting years after end of treatment
- No safety or tolerability concerns
- All TEAEs were manageable and resolved without clinical complication

ORR: Overall Response Rate, CRR: Complete Response Rate, DCR: Disease Control Rate, TEAE: Treatment-Emergent Adverse Event

BI-1206 SC + Rituximab (Doublet) is Well Tolerated with Promising Efficacy in Follicular Lymphoma (cont'd)



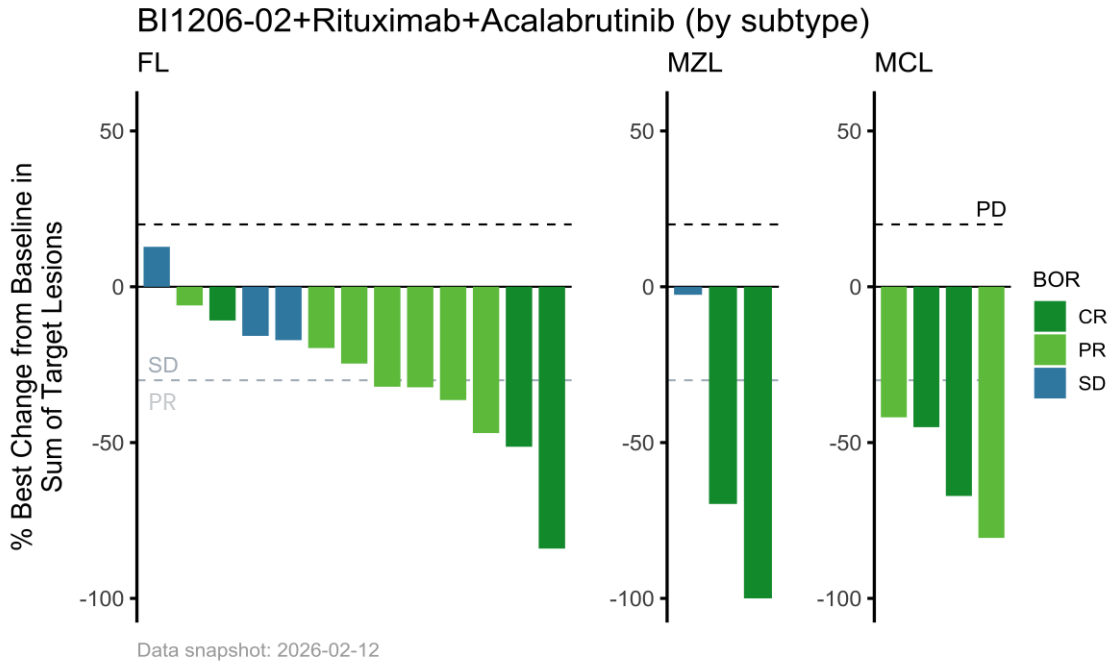


BI-1206 + Rituximab + Acalabrutinib* **(Triplet)**: Best Response (FL, MZL, MCL)

Phase 2a Design

Phase / Design	Population	N	Dosing	Sites	Key Endpoints	Data Cut-off
Phase 2a single arm (triplet)	R/R NHL	20 of 30	BI-1206 150 mg or 225 mg SC	8 BR, 9 EU, 1 US	Safety ORR exploratory	2026-02-12

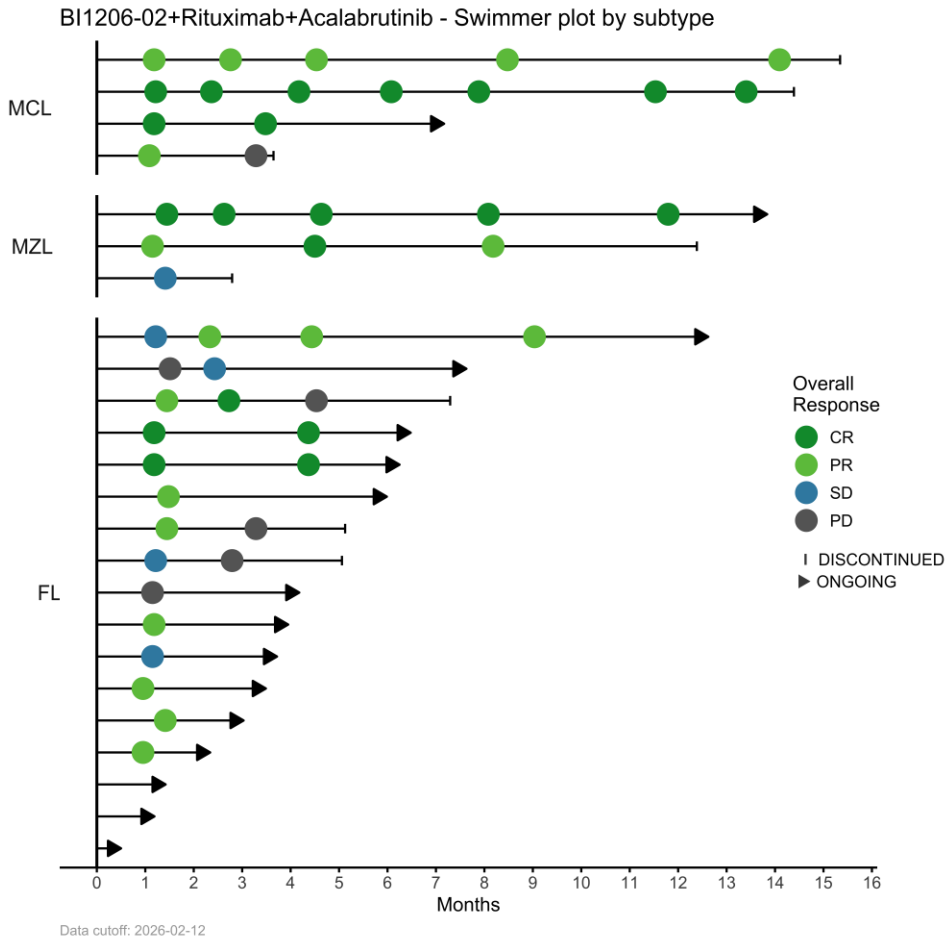
- ORR of 80%, CRR of 35% and DCR of 100%
- Best Response in 20 evaluable patients:
  - 7 CR
  - 9 PR
  - 4 SD
- In FL subgroup ORR 77%
- The treatment has been well-tolerated with no safety or tolerability concerns
- No apparent difference in safety between 150 mg and 225 mg BI-1206 SC

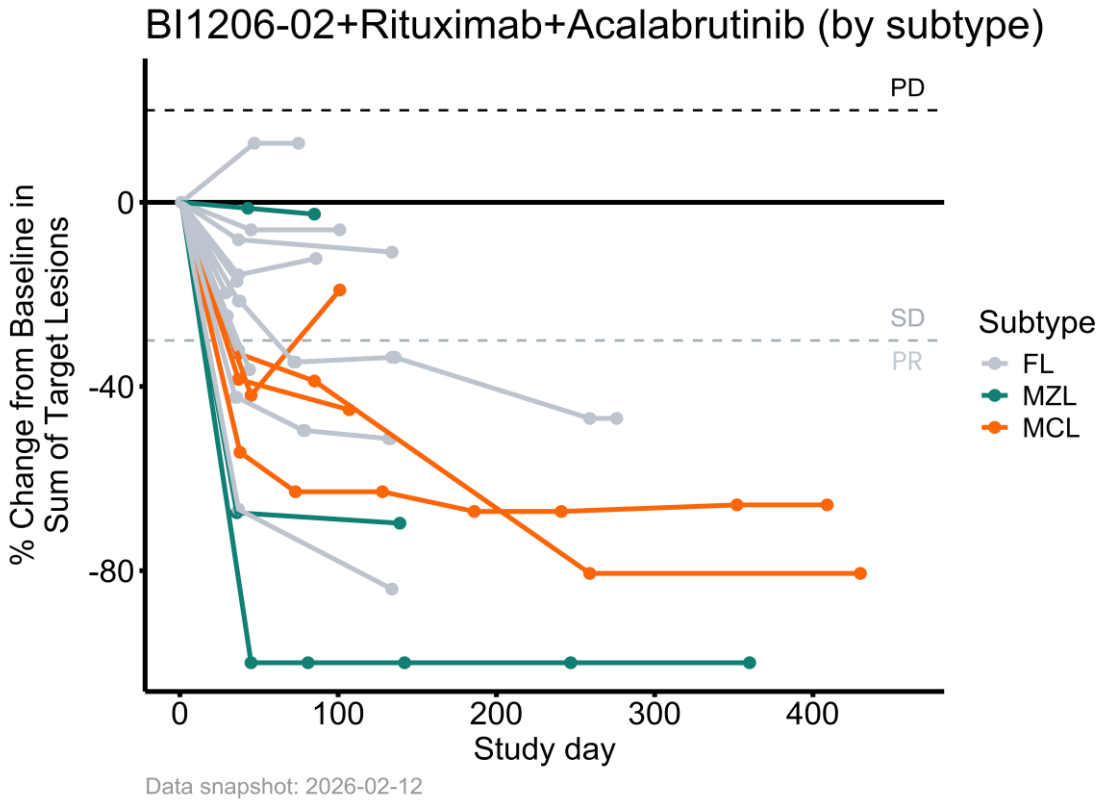


*Supplied by AstraZeneca

FL: Follicular Lymphoma, MZL: Marginal Zone Lymphoma, MCL: Mantle Cell Lymphoma

BI-1206 + Rituximab + Acalabrutinib* **(Triplet)**: Best Response (FL, MZL, MCL) (cont'd)





* Supplied by AstraZeneca

Need for More Convenient, Safer Treatments for R/R Follicular Lymphoma

Similar Treatments	Infection Rates	Adverse Events
Lenalidomide-based regimens • Prolonged **management of side effects** requiring frequent clinic visits and monitoring	63%	50%
Bispecific T-cell engagers • **45-65%** of patients experience **CRS**[1] • Frequent clinic visits and hospital admissions required	45-50%	20-30%
CAR-T • Antibiotic treatment and IVIG infusions required • Treatment at **specialized centers** requiring in-patient stays and frequent visits • Very **high cost**	>50%	30-40%

Grade 3-4 neutropenia

Prolonged cytopenias

In contrast, BI-1206 + RTX + acalabrutinib is an effective, convenient treatment that is easily administered, **well-tolerated**, with no associated severe toxicities

Source: Desk research based on public sources
1. Cytokine Release Syndrome

BI-1206 Positioning in Follicular Lymphoma

- In FL, repeated exposure to **Rituximab leads to resistance** via FcγRIIB-mediated internalization; **BI-1206 blocks** this escape route, potentially "resensitizing" the tumor to CD20 therapy even in heavily pre-treated patients.
- While BTK inhibitors (e.g., zanubrutinib) are approved in FL, their monotherapy activity is modest; this triplet aims to exceed the efficacy of the zanubrutinib + obinutuzumab standard (69% ORR) by **adding a distinct mechanism of action without adding chemotherapy**.
- Designed as **an effective alternative to bispecific antibodies** (mosunetuzumab, epcoritamab) but with no risk of CRS or ICANS, allowing for **easy administration** in community oncology practices without complex monitoring.
- Positions the **therapy for "early progressors“** or frail elderly patients who need deep responses but cannot tolerate the toxicity of chemotherapy or the logistics of CAR-T.
- Combines intracellular B-cell receptor blockade (**acalabrutinib**) with optimized extracellular immune clearance (**BI-1206 + rituximab**) to attack the indolent lymphoma clone from two independent angles.
- With the subcutaneous (SC) formulation of BI-1206, this creates a **patient-friendly, injection-based regimen that avoids the burden of long infusions.**

BTK: Bruton’s Tyrosine Kinase, ICANS: Immune Effector Cell-Associated Neurotoxicity Syndrome

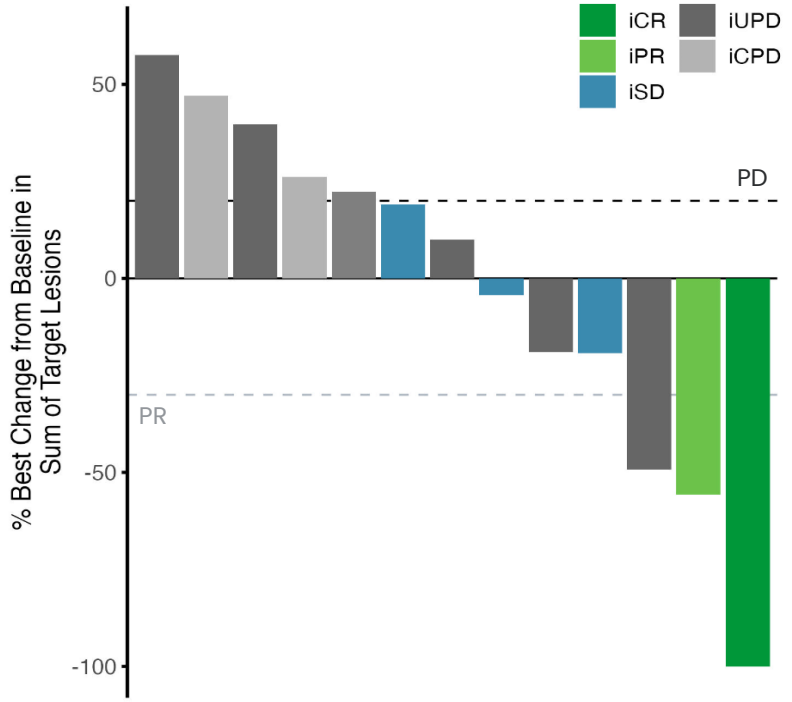
BI-1206 in Solid Tumors:
Non-Small Cell Lung Cancer
Uveal Melanoma

Promising Efficacy Signals in Phase 1b BI-1206 + Pembrolizumab* Combination

Phase 1b and 2a Design

Phase / Design	Population	N	Dosing	Sites	Key Endpoints	Data Cut-off
Ph 1b	Melanoma (as part of solid tumors)	13 (40)	Escalating doses BI-1206 150-300 mg	3 EU 4 US	Safety, ORR exploratory	2025-06-10
Ph 2a	NSCLC Uveal melanoma	30 12	300 mg SC twice in three-week cycle	20	Safety, ORR exploratory	N/A

- Phase 1b: 13 evaluable melanoma patients (relapsed after prior anti-PD-1 therapy)
  - 1 complete response (CR) (lasting for ~two years)
  - 1 partial response (PR) in uveal melanoma
  - 3 patients with stable disease (SD) including one long-lasting (≥2.5 years)
- Co-administration of BI-1206 with pembrolizumab was well tolerated in a heavily pretreated population



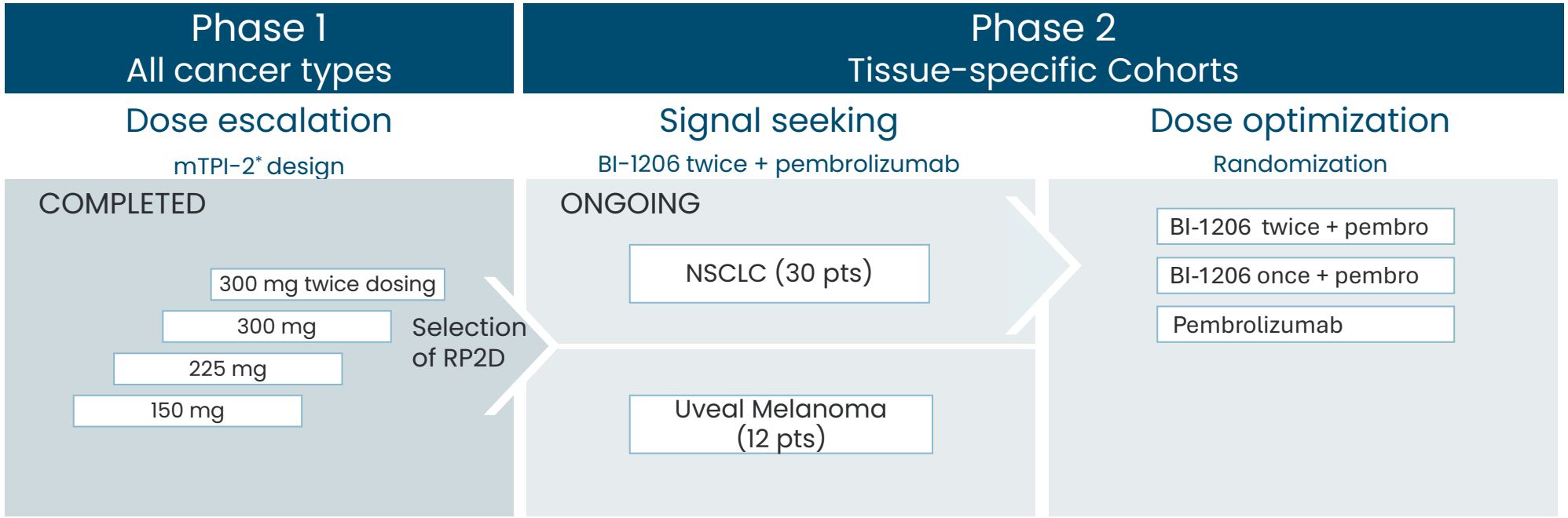
* Supplied by MSD International Business GmbH, a subsidiary of Merck & Co., Inc., Rahway, NJ, USA

Phase 2a study Ongoing: BI-1206 + Keytruda in Treatment-Naïve Patients

- To evaluate safety and efficacy of BI-1206 in combination with pembrolizumab
- Advanced or metastatic NSCLC and uveal melanoma
- Patients will be enrolled at sites in Georgia, Germany, Poland, Rumania, Spain, Sweden and the US

BI-1206 combo with pembrolizumab

MSD



WHAT'S NEXT? First Phase 2a data in front-line NSCLC and uveal melanoma H2 2026E

* modified Toxicity Probability Interval 2

Anti-PD-1 is Well Entrenched in 1st Line NSCLC (TPS > 50)

Pembrolizumab monotherapy is the standard of care in 1st line NSCLC (TPS > 50)

Anti-PD1 Ab

KEYTRUDA® (pembrolizumab) Injection 100 mg

- Treatment of choice as a single agent, 1st line (35% patients are TPS high)
- Generally well tolerated; toxicities can include pneumonitis, colitis
- 85,000 – 95,000 lung cancer patients eligible annually in 7 major markets

Anti-PD-1 + Anti-CTLA4

OPDIVO® (nivolumab)

YERVOY™ (ipilimumab)

- Approved for 1st line NSCLC but reserved as an alternative to chemoimmunotherapy
- Significant toxicities are common and include immune-mediated colitis, pneumonitis, hepatitis

Anti PD-L1 Ab

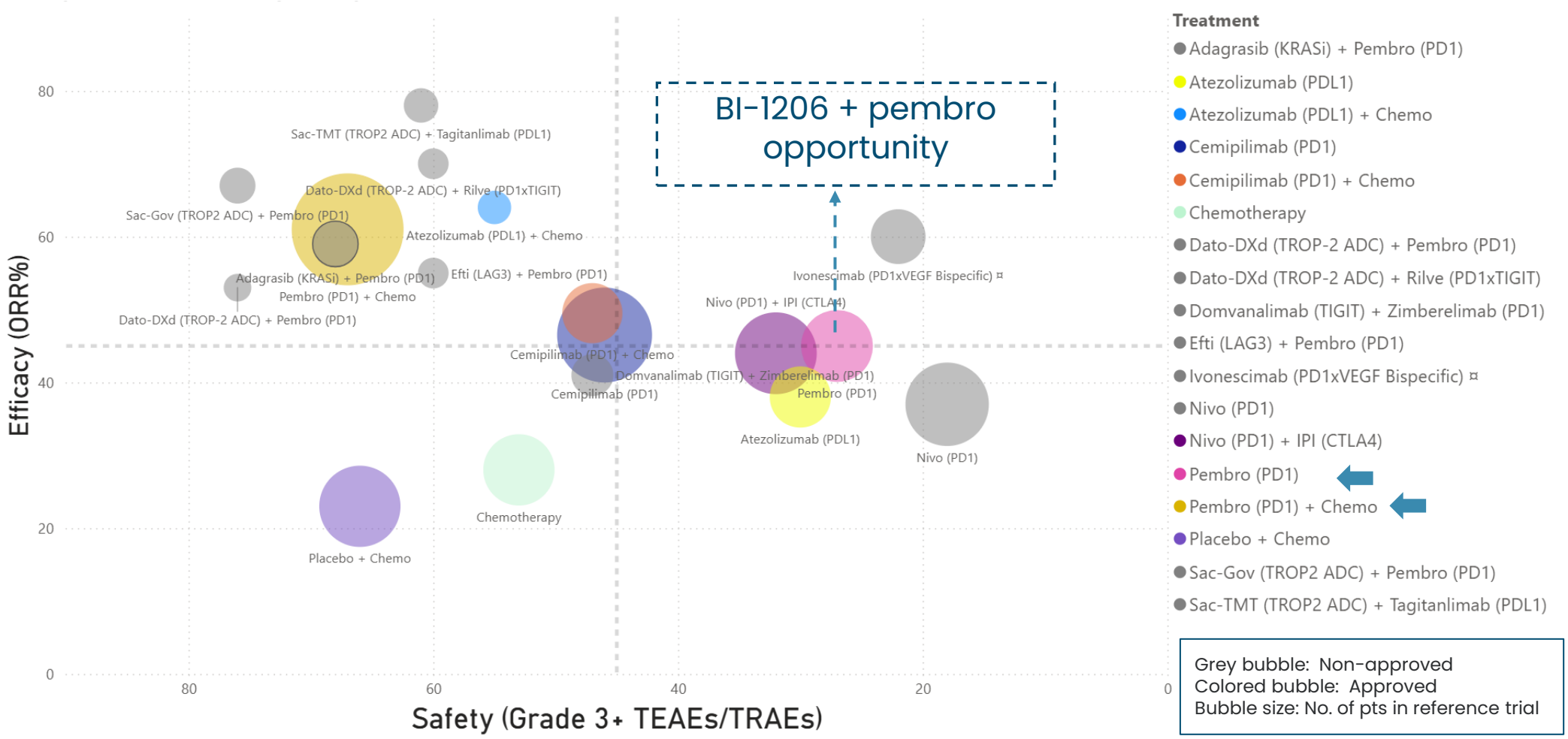
TECENTRIQ® atezolizumab 840 mg / 1200 mg INJECTION FOR IV USE

- Not the preferred choice compared to pembro
- Could have slightly more favorable toxicity profile

Chemoimmunotherapy

- In combination with anti-PD1
- Carboplatin, pemetrexed, paclitaxel depending on tumor type and other factors
- Typical toxicities associated with chemotherapy

Competitive Landscape in PD-L1 high NSCLC



Key - Size of bubble : No. of pts.; Colored Bubbles : Approved treatments in US or EU; Grey Bubbles : Unapproved treatments; ¤ : China-run trial

Main toxicities : ICI : Pneumonitis, colitis, hepatitis, severe skin reactions. ICI + Chemo : Increased risk/severity of irAEs, Pneumonitis, sepsis. ICI+ TKI : Markedly increased ILD/pneumonitis

Positioning of BI-1206 in Non-Small Cell Lung Cancer

- BI-1206 blocks FcγRIIB (CD32b), a receptor on myeloid cells that actively removes anti-PD-1 antibodies off T-cells, internalizing and degrading them. By **blocking FcγRIIB, BI-1206 prevents the removal of pembrolizumab** from the T-cell surface, extending receptor occupancy and potential therapeutic activity. This would work in **any pembro combination** treatment.

- Despite high PD-L1 expression (TPS >50%), approximately **40–50% of patients do not respond to pembrolizumab monotherapy**. BI-1206 may also capture part of this specific segment by overcoming FcγRIIB-mediated resistance.

- This doublet offers a **strategy that avoids the severe toxicity** of platinum-based chemotherapy. It positions itself as a **superior "all-immunotherapy" option** for patients who cannot tolerate or wish to avoid chemo-associated side effects.

- Early clinical data (Phase 1/2a) demonstrated **proof-of-concept with durable responses** (including Complete Responses) in **heavily pre-treated**, anti-PD-1 refractory patients—suggesting the mechanism translates from the lab to the clinic.

- Moving to the 1st-line setting targets patients with healthier immune systems, **maximizing the potential synergy**. Success here opens access to the largest and most lucrative segment of the NSCLC market.

- **Phase 2 in 1st line NSCLC and uveal melanoma** in combination with pembrolizumab is **ongoing** (first data readout H2 2026).

Only Two Treatments with Limited Efficacy are Approved for Metastatic Uveal Melanoma

CD3-gp100 fusion protein	Liver directed	Anti-PD-1 + Anti-CTLA-4
KIMMTRAK® (tebentafusp-tebn) Injection for Intravenous Use 100 mcg/0.5 mL	HEPZATO KIT™ (melphalan) for Injection/ Hepatic Delivery System (HDS)	OPDIVO® (nivolumab) YERVOY™ (ipilimumab)
•Approval restricted to HLA-A*02:01 positive patients (40-50%) •Common toxicities include CRS, severe skin reactions, and liver enzyme elevation	•Percutaneous hepatic perfusion: liver-directed infusion of melphalan to treat liver mets •Black box warning for hematological toxicities (thrombocytopenia) •Complex procedure with risk of liver damage, bleeding	•Frequently used off-label •Significant toxicities are common and include immune-mediated colitis, pneumonitis, hepatitis

- > 50% of patients are not eligible for tebentafusp
- Immunotherapies and chemotherapy, while used off label, are not effective
- Clinical-stage drugs to watch:
  - Darovasertib (PKC inhibitor): Targets GNAQ/GNA11 mutations (80% mUM) Phase 2/3
  - RP2 (oncolytic virus)+ anti-PD1
  - Sitravatinib (kinase inhibitor) + anti-PD1

Competitive Landscape for Metastatic Uveal Melanoma

Positioning of BI-1206 in Uveal Melanoma

- Metastatic uveal melanoma is historically **resistant to single agent anti-PD-1 therapy** (ORR <5%). **BI-1206** blocks FcγRIIB, a receptor that pulls pembrolizumab away from T-cells and internalizes it for degradation, theoretically **restoring PD-1 sensitivity** in this refractory indication.
- Few approved therapies, poorly tolerated with limited efficacy. The only life-extending therapy, Tebentafusp, is approved only for HLA-A*02:01 positive patients (50%). The **current alternative** (ipilimumab + nivolumab) has **high toxicity** (Grade 3/4 AEs >50%).
- In the Phase 1/2a dose-escalation of **BI-1206 + pembro**, a heavily pre-treated metastatic uveal melanoma patient achieved **a long-lasting partial response** (>24 months), providing a strong de-risking signal for the 1st line trial.
- Phase 1 data suggests the **doublet maintains a safety profile** comparable to pembrolizumab monotherapy, a significant advantage over the ipi/nivo regimen and chemotherapy.
- The 1st line trial utilizes the new **subcutaneous (SC) formulation of BI-1206**. With the recent approval of SC pembrolizumab, this treatment would provide a **convenient alternative** for patients and HCPs.

HLA: Human Leukocyte Antigen

BioInvent

Key Catalysts

2026-2027

Expected Key Clinical Milestones 2026-2027

	2026		2027	
TNFR2 platform				
BI-1808 in TCL	First Ph 2a data with pembro + additional mono		Complete Ph 2a data dose optimization, mono	Potential start of pivotal study
BI-1808 in solid tumors		Ph 2a data with pembro		First Ph 2a data *triplet* +pembro+paclitaxel
FcγRIIB platform				
BI-1206 in NHL	Additional Ph 2a data with rituximab + acalabrutinib		Potential start of pivotal triplet	
BI-1206 in solid tumors		First read-out Ph 2a data with pembrolizumab	Complete Phase 2a data 1L NSCLC	Potential start Ph 2b BI-1206 + pembro 1L NSCLC

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bringing antibodies to life

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Appendix

BioInvent Management Team

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Chief Executive Officer
8

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Chief Financial Officer
28

Andres McAllister, M.D., Ph.D.
Chief Medical Officer
9

Björn Frendéus, Ph.D.
Chief Scientific Officer
25

Ashley Robinson
SVP Strategy & Finance
2

Ingunn Munch Lindvig, Ph.D.
SVP Regulatory Affairs
3

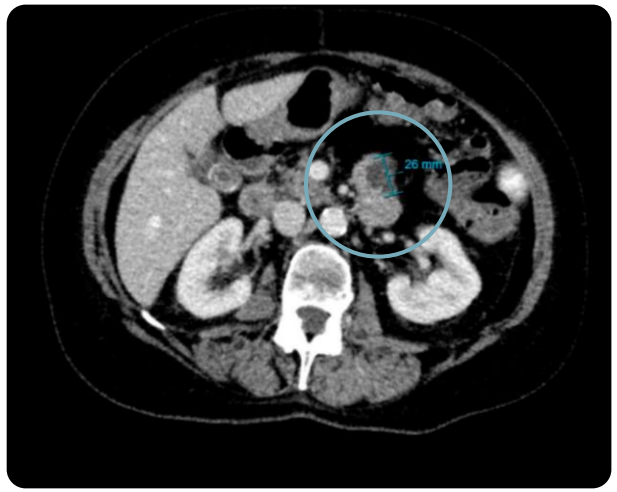
Kristoffer Rudenholm Hansson
SVP Technical Operations
10

Sylvie Ryckebusch, Ph.D.
Chief Business Officer
4

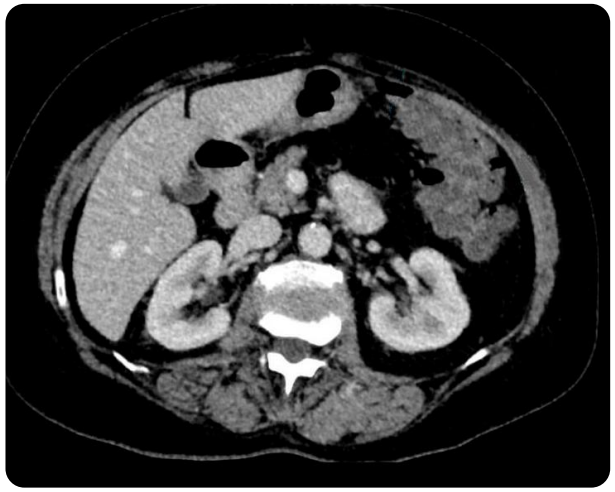
X Years at BioInvent

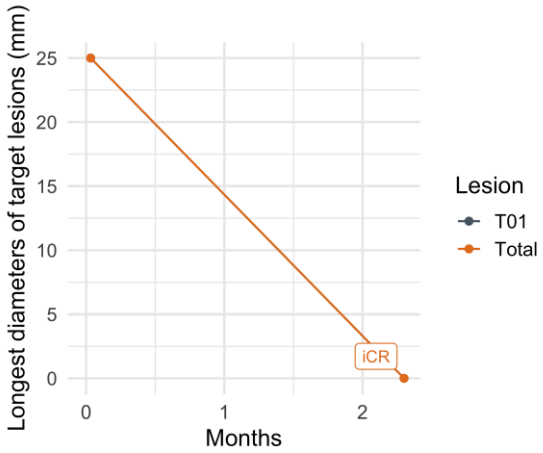
BI-1808 Single Agent Case Study: Complete Response in Ovarian Cancer

Baseline

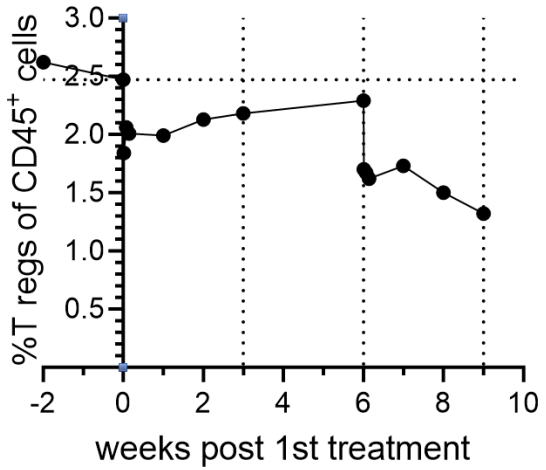


2 months





Tumor assessment vs time on study



T reg levels vs time on study
Dashed lines indicate administration of BI-1808

63-year-old patient with ovarian cancer, Stage IIIA at diagnosis, entered the study with PD.

Four previous lines of treatment:

- Paclitaxel/carboplatin
- Carboplatin/doxorubicin
- Olaparib
- Bevacizumab/topotecan

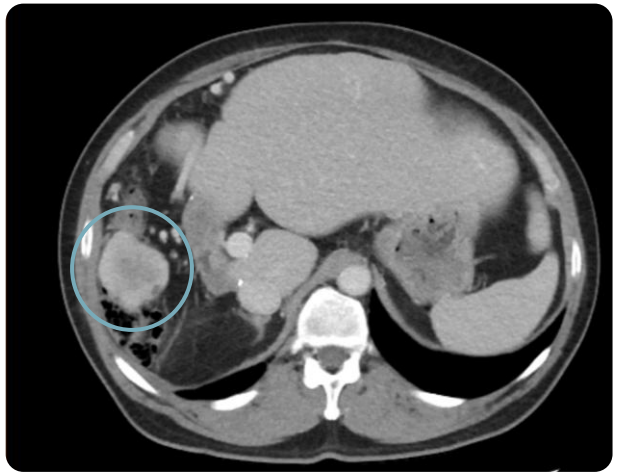
Patient had one target lesion of 25 mm and two larger non-target cystic lesions.

At first post-treatment scan, 9 weeks after the start of treatment, no quantifiable tumor mass could be measured.

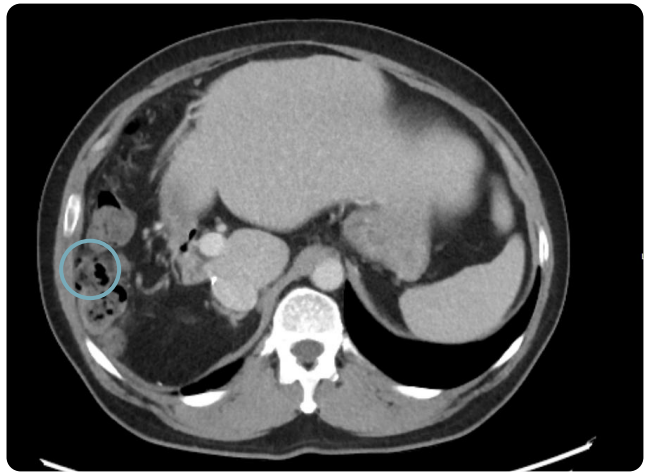
ASCO 2024 Poster #2641 BI-1808

BI-1808 Single Agent Case Study: Robust PR in a Patient with GIST*

Baseline



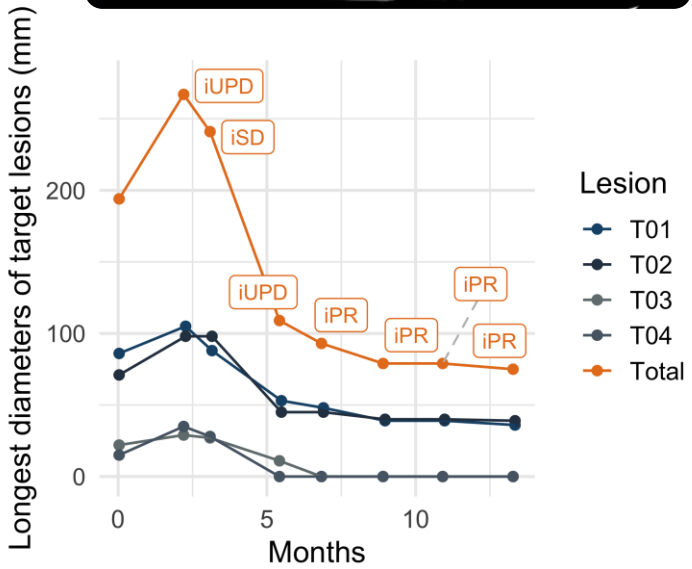
Follow-up 13 months



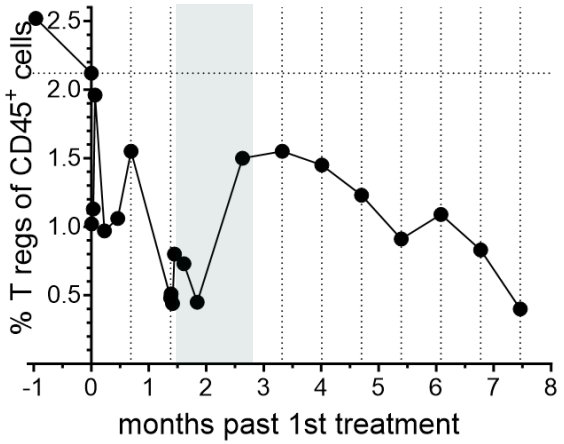
55-year-old male patient with GIST, who presented with clinical PD for more than 6 months with multiple metastatic lesions.

12 previous lines of therapy.

The partial response continues to improve after more than 80 weeks (Dec 2024).

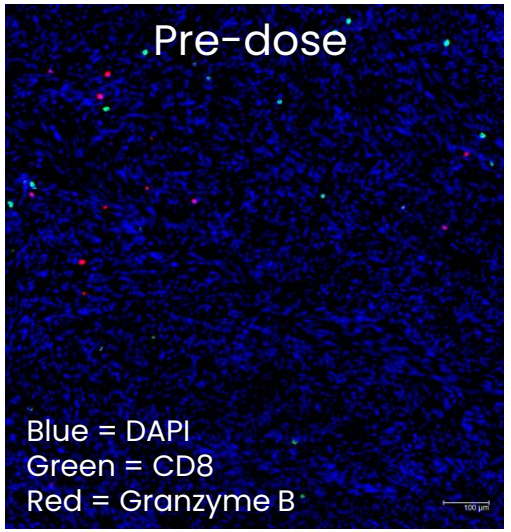


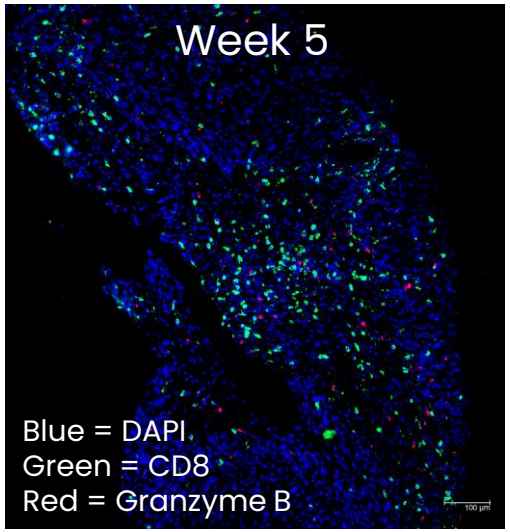
Tumor assessment vs time on study (months)



T reg levels vs time on study. Dashed lines indicate administration of BI-1808.

Note treatment paused



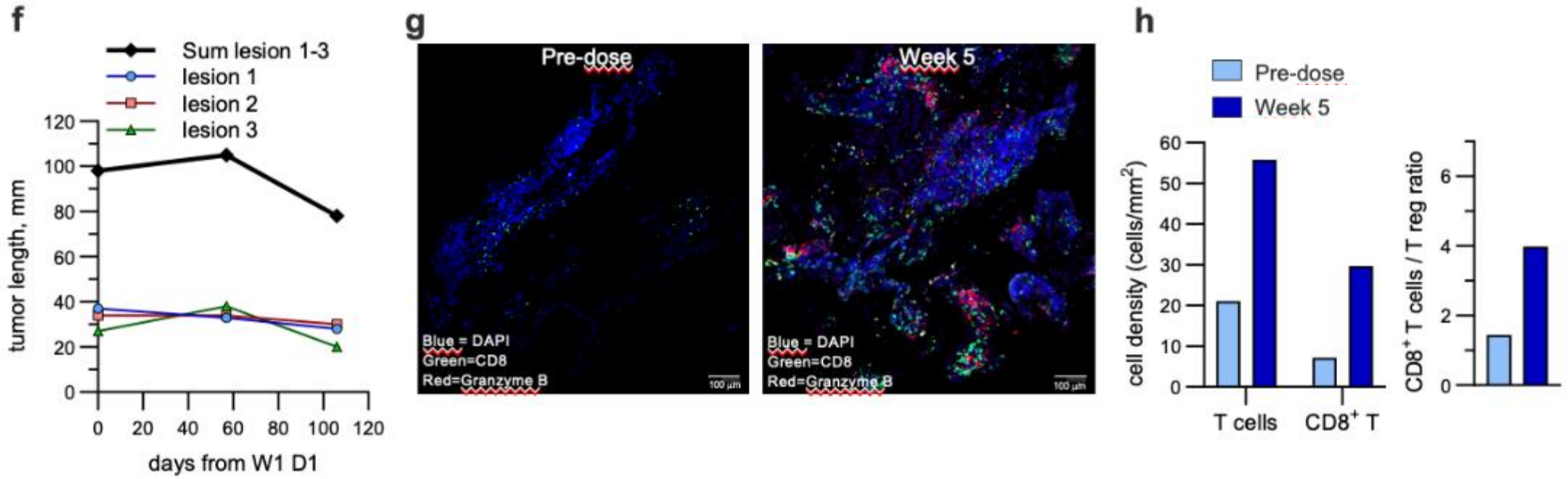


BI-1808 shows evidence of CD8+ tumor infiltration which is associated with tumor regression

*GIST: Gastrointestinal Stromal Tumor
ASCO 2024 Poster #2641 BI-1808

BI-1808 has Shown Single Agent Activity in a Patient with NSCLC

Antitumor activity correlates with CD8+ T-cell activation



Male patient with non-small cell lung cancer (NSCLC)

Treated with 75 mg BI-1808

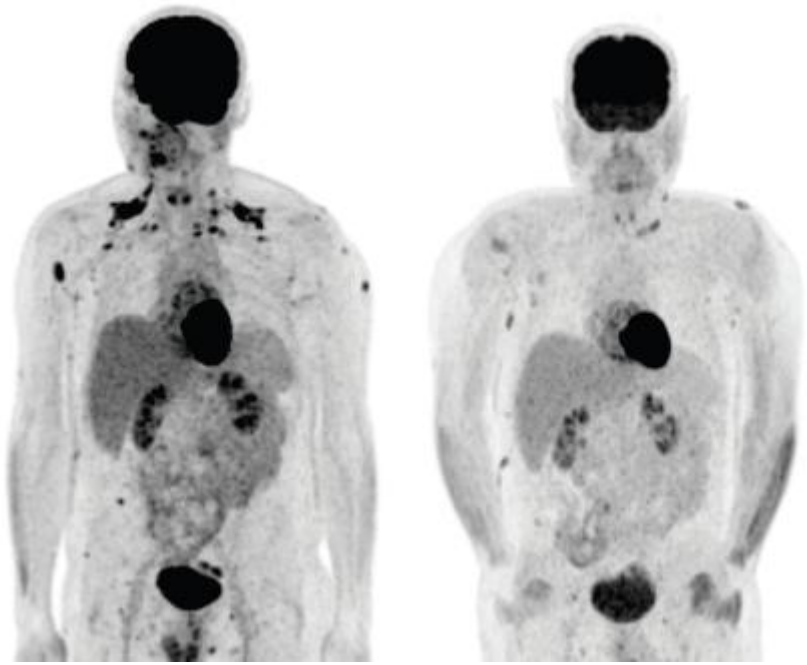
First radiography scan showed SD, followed by regression of all four target lesions (including a liver lesion) at 2nd scan

Taken off study per protocol due to detection of unrelated prostate cancer lesion

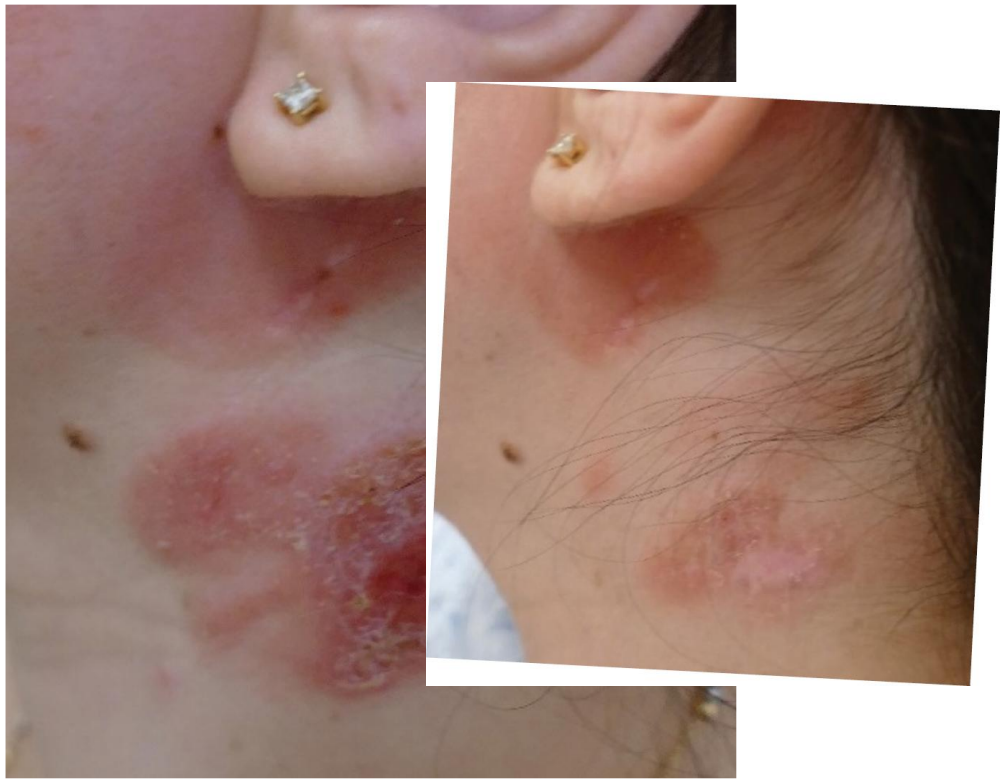
Impressive Responses Were Observed in Heavily Pre-treated Patients with PTCL or CTCL Treated with BI-1808 Monotherapy

Case Studies

PTCL Patient (stage IV, 6 prior lines of treatment)	**CTCL Patient** (stage IIb MF, 5 prior lines of treatment)



Baseline Week 9

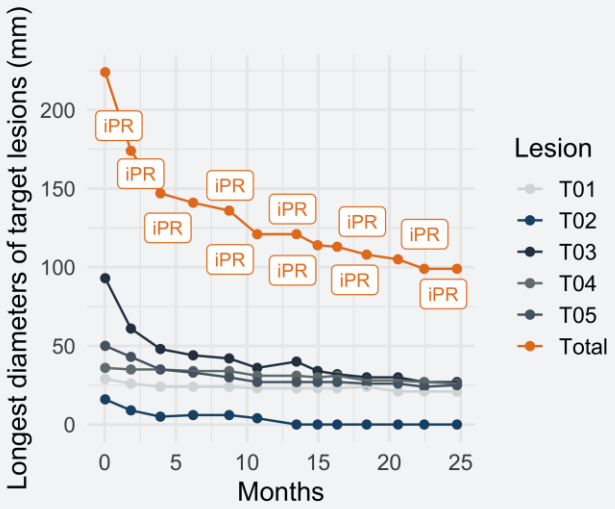


Baseline Week 21

Co-administration of BI-1206 with Pembrolizumab Promising Responses Observed in Uveal Melanoma, who Previously Failed Anti-PD-1 Therapy

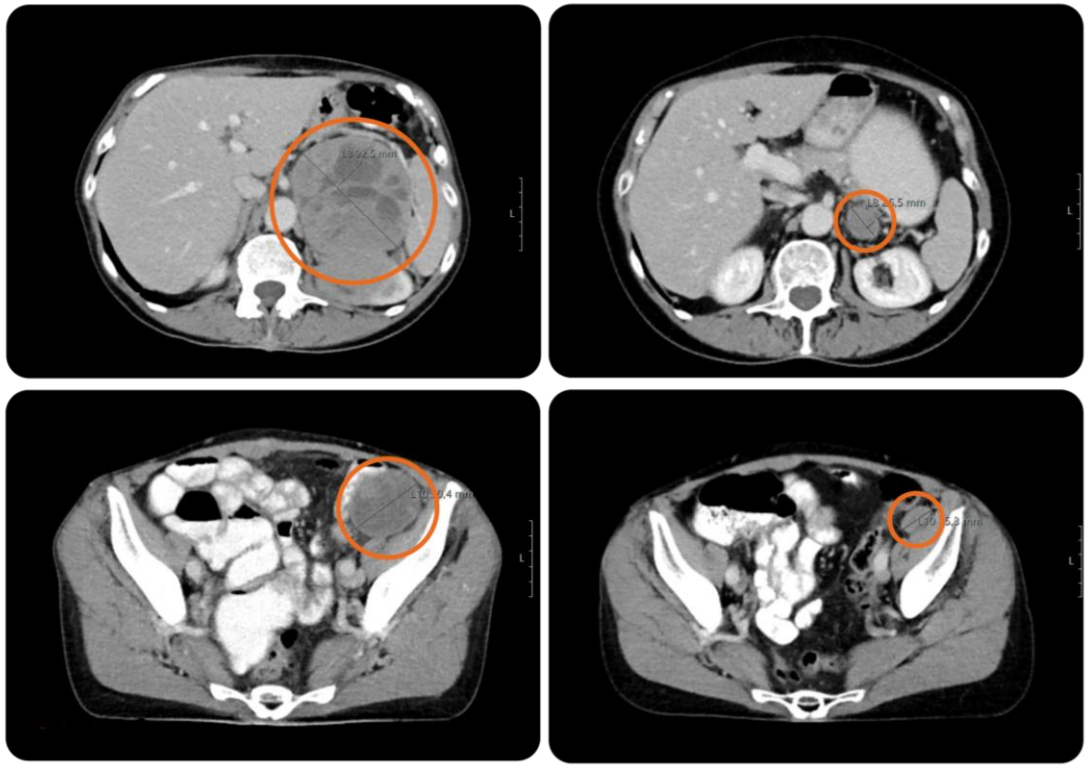
Case study: PR

69 YO female with uveal melanoma.
No response to prior immunotherapy or chemotherapy. Multiples lines of ICIs and Chemo. Progressing when entering study. Showed early partial response at first scan on BI-1206 + pembrolizumab, continued PR deepening during whole study duration (2 years) with tumor burden reduced by 56% at end of trial.



Baseline

End of treatment 2 years

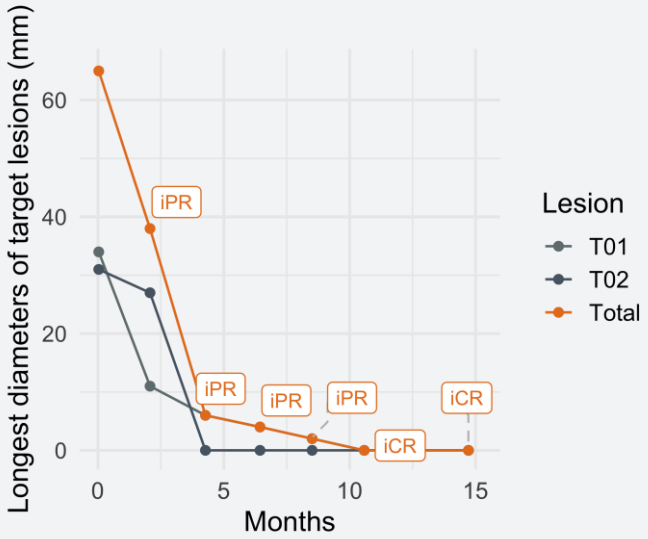


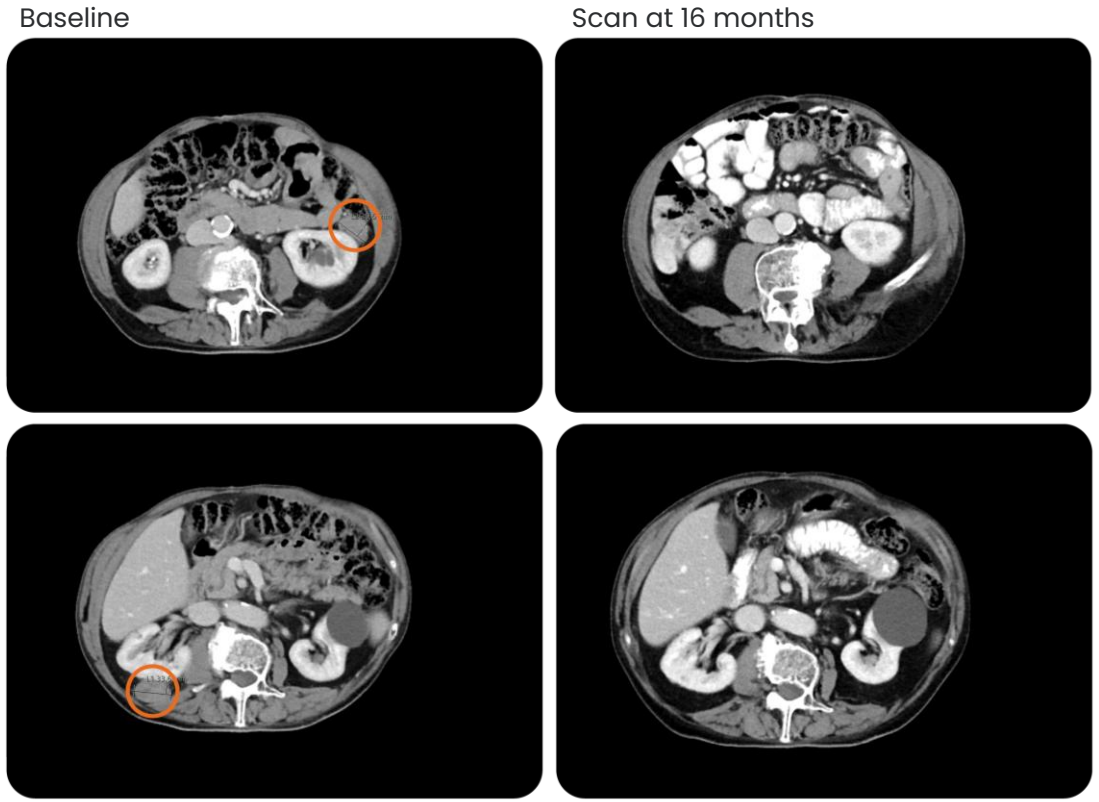
ASCO 2024 Abstract #2593 BI-1206

Co-administration of BI-1206 with Pembrolizumab Promising Responses Observed in Melanoma, who Previously Failed Anti-PD-1 Therapy

Case study: CR

77 YO male melanoma patient, stage IV.
Deep Partial Response at first scan at 2 months, evolving to CR at 10 months, still ongoing at 16 months. Three lines of previous ICI therapy, with PR as best prior response to ipilimumab + nivolumab.

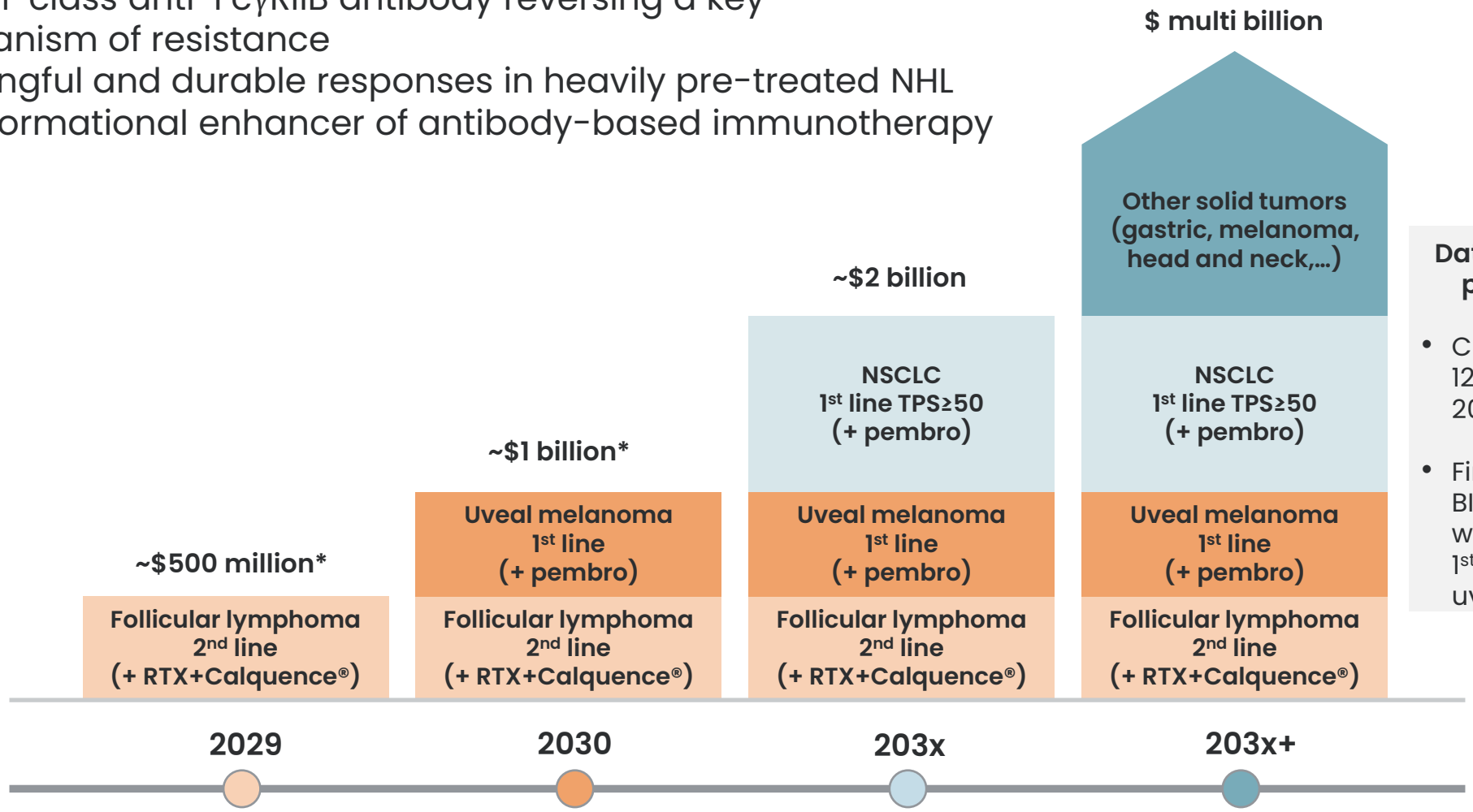




ASCO 2024 Abstract #2593 BI-1206

BI-1206 Vision From First Approval to Expansion

- First-in-class anti-FcγRIIB antibody reversing a key mechanism of resistance
- Meaningful and durable responses in heavily pre-treated NHL
- Transformational enhancer of antibody-based immunotherapy



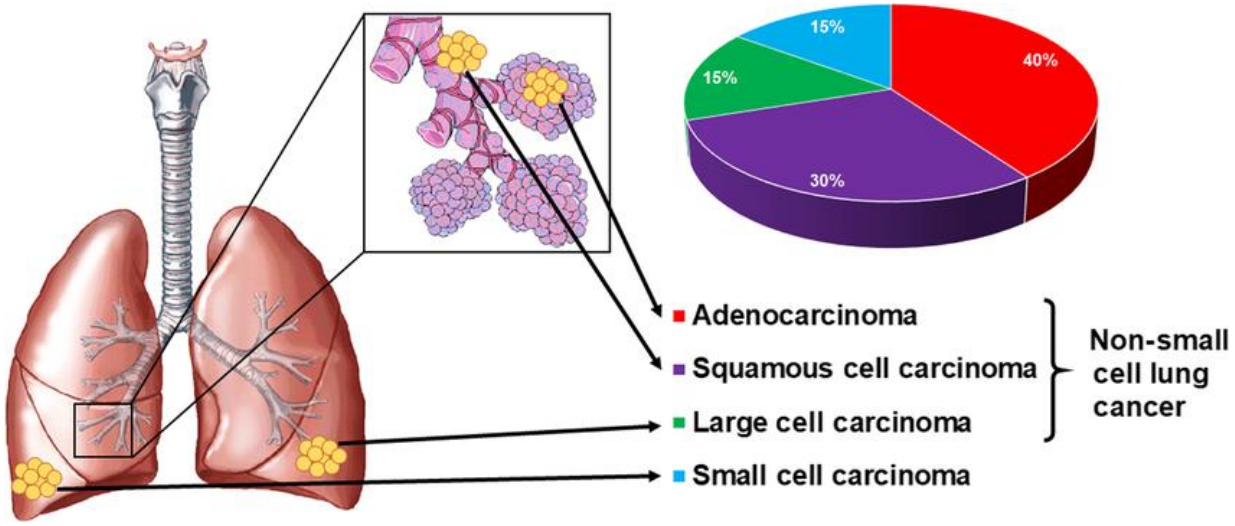
Data releases for BI-1206 planned during 2026

- Clinical update for BI-1206 triplet in NHL, mid-2026
- First Phase 2a data for BI-1206 in combination with pembrolizumab for 1st line NSCLC and 1st line uveal melanoma, H2 '26

*Approximate peak sales potential

Lung Cancer Backgrounder

American Cancer Society



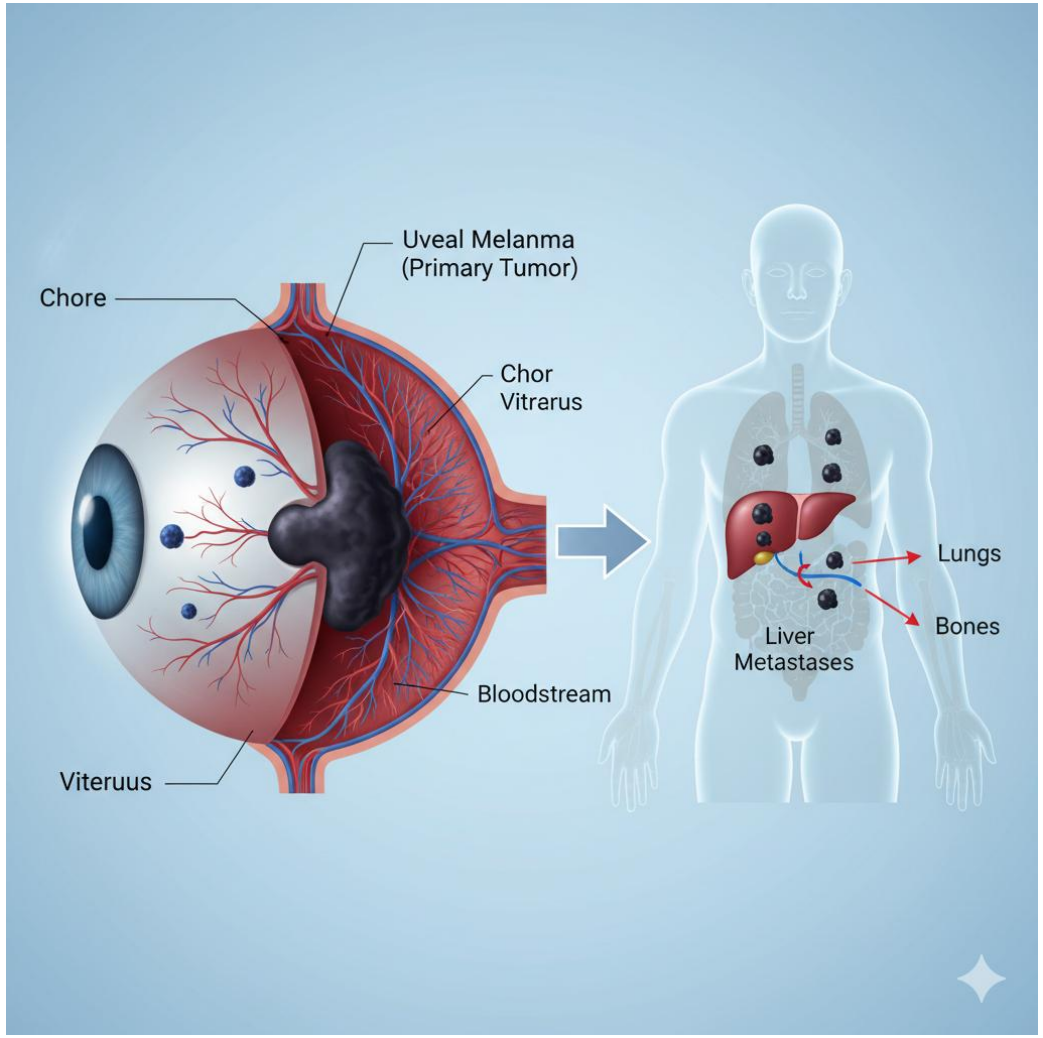
- NSCLC accounts for approximately 85% of all diagnosed lung cancer cases globally.
- Lung cancer is the leading cause of cancer-related death worldwide, with over 2.5 million new cases diagnosed in 2022. Metastatic NSCLC has a 5-year survival of 12%.
- The NSCLC therapeutics market is projected to exceed $70 Billion by 2034, driven by a CAGR ~12%
- Key treatments include:
  - Targeted Therapy for patients with specific mutations (e.g., EGFR, ALK)
  - Immunotherapy
- Despite treatment advances, NSCLC faces major challenges, including the fact that 80% of cases are diagnosed at an advanced stage and the development of drug resistance to targeted therapies.

What Do We Need to Achieve in PD-L1 high 1st Line NSCLC ?

Therapy Class	Regimen	Stage	ORR	Median PFS	Median OS	Status/Notes
PD-1 MAb	Pembrolizumab	Approved SOC	45%	10.3 mo	30.0 mo	Gold Standard. The benchmark to beat.
PD-1 MAb	Cemiplimab	Approved SOC	46%	8.2 mo	26.1 mo	Validated alternative PD-1 monotherapy option.
PD-1 MAb + Chemo	Pembro + Chemo	Approved SOC	61%	8.8 mo	22 mo	
LAG-3 + PD-1	Fianlimab + Cemiplimab	Phase 2	61%	13-15 mo		
PD-1 + VEGF	Ivonescimab (AK112)	Phase 3	50%	11.1 mo		Ph3 trial ongoing in China only.
TROP2 ADC + PD-1	Sacituzumab Govitecan + Pembro	Phase 2	67%	13.1 mo		Adds chemo-like toxicity (neutropenia/diarrhea).
TROP2 ADC	MK-2870 (Sac-TMT) + Pembro	Phase 2	87%			Small number of patients
PD1 x TIGIT Bispecific	Rilvegostomig	Phase 2	62%	12.3 mo		
BI-1206 + PD-1	**BI-1206 + Pembrolizumab**	**Target Profile**	**> 60–65%**	**> 12 mo**		

Uveal Melanoma is a Rare Cancer with Particularly Poor Prognosis

- A rare and aggressive cancer that develops from melanocytes in the uvea of the eye. It's the most common primary eye cancer in adults.
- High risk of metastasis to other parts of the body, particularly the liver, which occurs in about 50% of patients and carries a poor prognosis.
- ~3000 patients in the 7 major markets, with 6-12 months average survival
- The only approved treatment is tebentafusp-tebn (Kimmtrak®), a bispecific T cell engager (gp100/CD3) with ORR of 10% but survival benefit (limited)

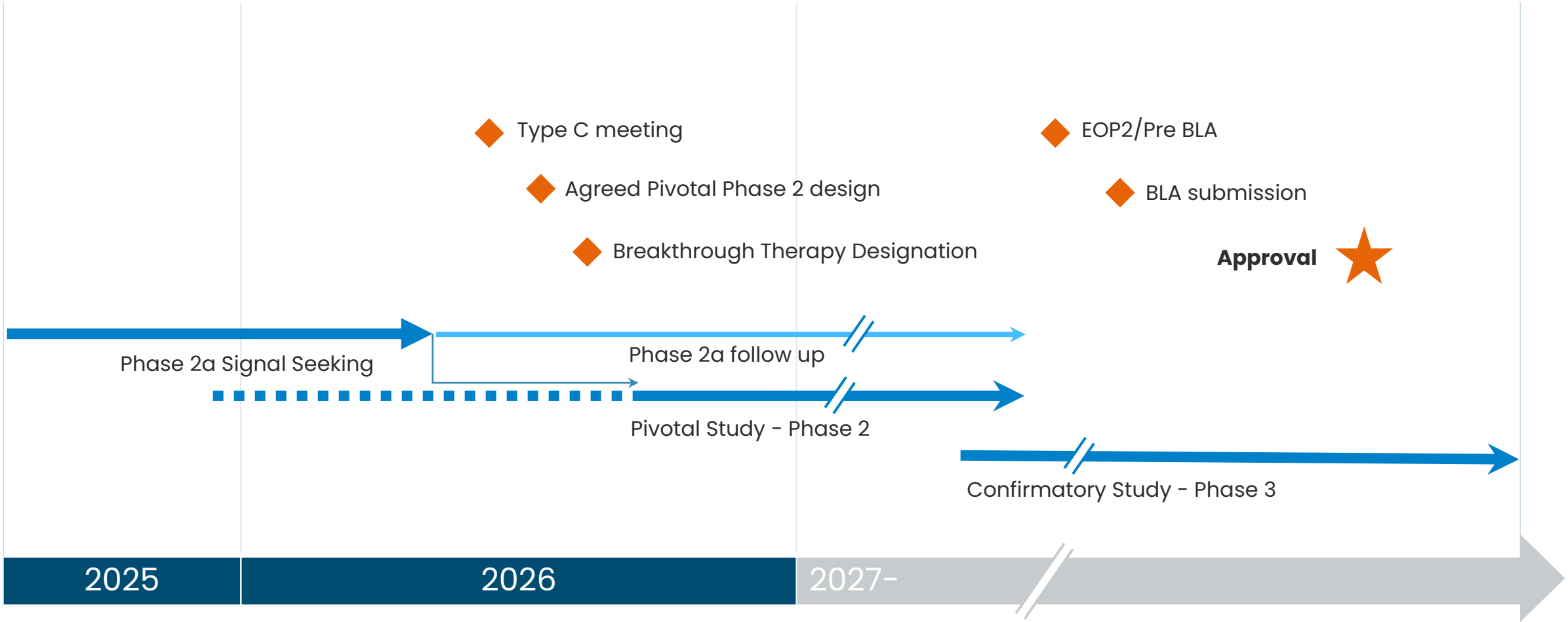


Approved and Investigational Therapies for Metastatic Uveal Melanoma

Therapy	Target	Status	Patients	ORR	CR	PFS	OS	Toxicities & Notes
Tebentafusp (Kimmtrak)	CD3 –gp100	Approved	HLA-A*02:01+ (~50% of pts)	9%	<1%	3.3 mo	21.7 mo	CRS, Rash (83%), Pyrexia
Pembrolizumab (Keytruda)	PD-1	Approved	All	12%	0%	3.8 mo		Safe but ineffective as monotherapy
Hepzato (Melphalan/HDS)	chemo	Approved	Liver Mets	36%	7%	9.0 mo	20.5 mo	G3/4 neutropenia / thrombocytopenia (>80%) due to filter leak, procedurally complex (surgical hepatic perfusion)
Ipilimumab + Nivolumab	CTLA4 – PD-1	SOC (off-label)	HLA-Negative	11-18%	0 – 2%	5.5 mo	19.1 mo	G3/4 AEs: ~57%, immune tox, colitis, hepatitis, hypophysitis, high discontinuation rate.
Darovasertib + Crizotinib	PKC - c-MET	Phase 2/3	HLA-Negative	34%	0%	7.0 mo	21.1 mo	Nausea, vomiting, diarrhea, edema, oral regimen.
RP2 + Nivolumab	OV (CTLA4) – PD-1	Phase 2/3	All	29%	0%			Pyrexia, chills, hypotension. Intratumoral injection.
Sitravatinib + Tislelizumab	Multi-kinase – PD-1	Phase 2	Liver Mets	19%	0%	8.3 mo		Investigator-initiated trial. Hypertension, diarrhea. Discontinued in other indications so uncertain commercial future
BI-1206 + pembrolizumab	**FcγRIIB – PD-1**	**Phase 2**	**All**	**Target: >20-25%**		**Target: >7 mo**	**Target: >20 mo**	**Good safety (<20% GR3/4 AEs)**

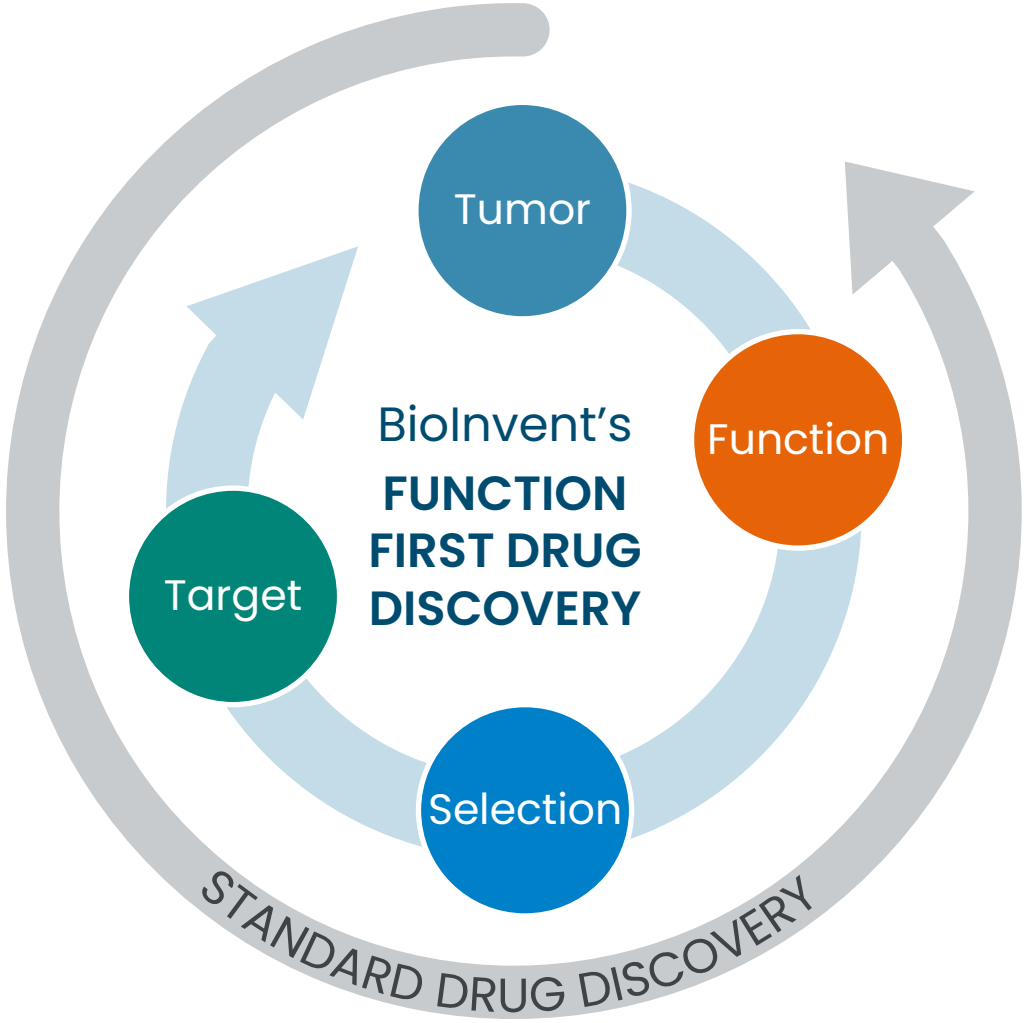
BI-1206 in NHL: Combination with Rituximab and Acalabrutinib

Potential Timelines*



*Depending on partnering discussions and acceptance of development plan by FDA

Building a Pipeline: Our State-of-the-Art Antibody Technology



Proprietary F.I.R.S.T™ platform is the engine discovering novel cancer treatments

We discover the function - and the efficacy– first

- Novel IO targets (e.g. , TNFR2 and FcγRIIB)
- Uniquely functional epitopes on validated targets (e.g., CTLA-4)

Functional **I**nterrogation of **R**ecombinant (Molecular) Librarie**S** for **T**herapeutics

BI-1808 in CTCL Benchmark References

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