Unleashing Immunity To Fight Cancer

BioInvent
bringing antibodies to life

May 2026

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We are a Swedish Clinical-stage Biotech Developing First-in-Class Immune-modulating Antibodies to Treat Cancer

4 Ongoing Clinical Programs

- Cancer immunotherapies with novel MoAs and excellent safety profiles
- Phase 2 trials ongoing with early evidence of efficacy
- History of successful partnerships to accelerate and expand our current efforts

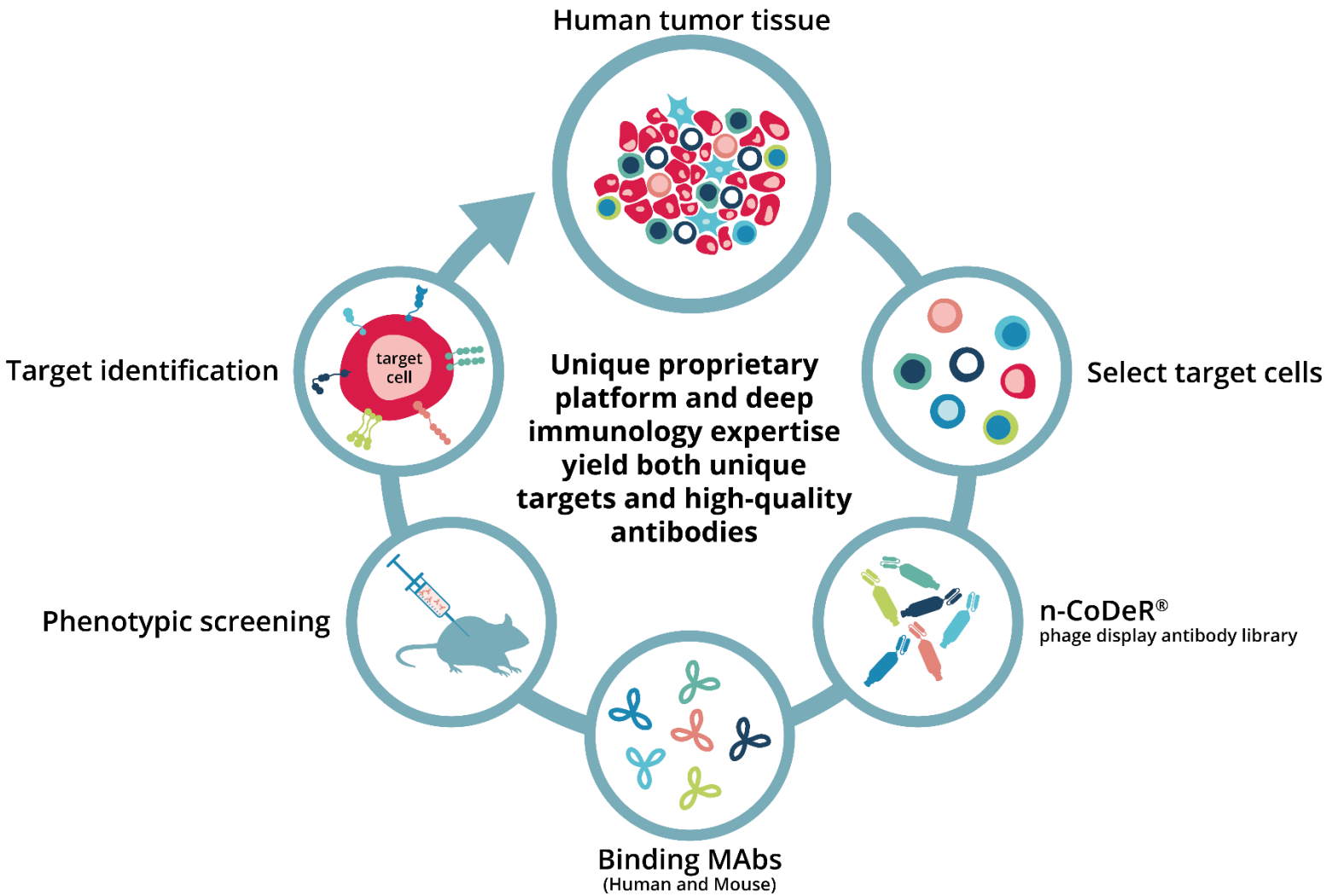
Core Capabilities Fuel Pipeline Expansion

- Unique and validated target discovery platform
- World class scientific team and development capabilities
- In-house GMP manufacturing site

Solid Financial and Investor Base

- Listed on NASDAQ OMX Stockholm MidCap (BINV)
- Strong international shareholder base
- Operations funded to Q1 2027

Function F.I.R.S.T™ Enables Discovery of New Oncology Targets and Antibodies



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]				Mid-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

Completed Ongoing Planned

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

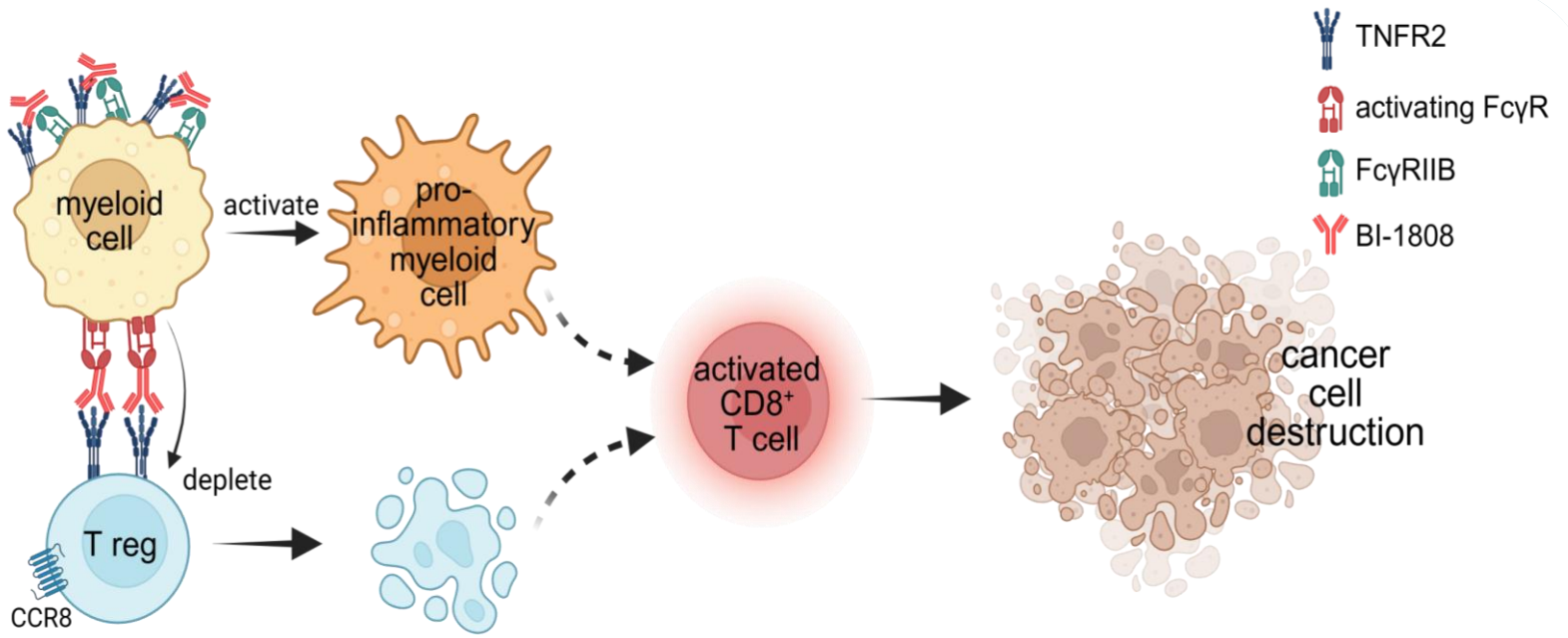
BioInvent

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 Tregs
- Re-programs myeloid cells
- Expands antitumor CD8+ T cells

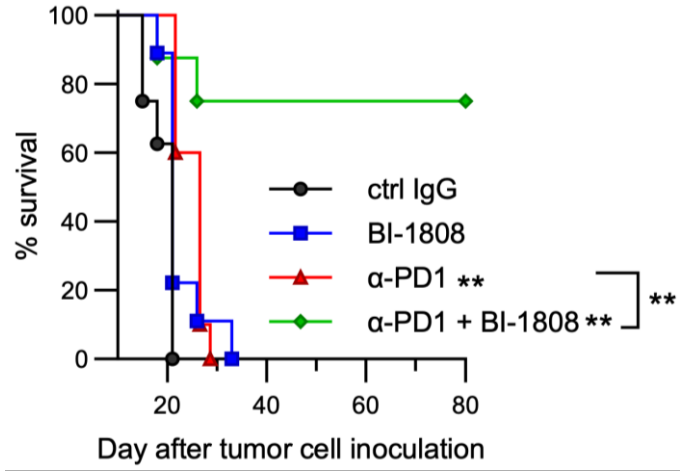
mAb Characteristics

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

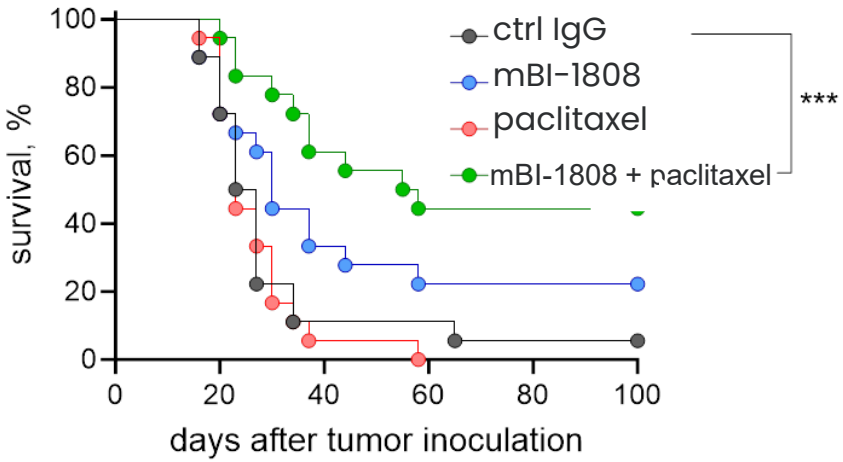
Mårtensson et al, BioRxiv

Compelling Rationale for BI-1808 Triplet in Ovarian Cancer

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



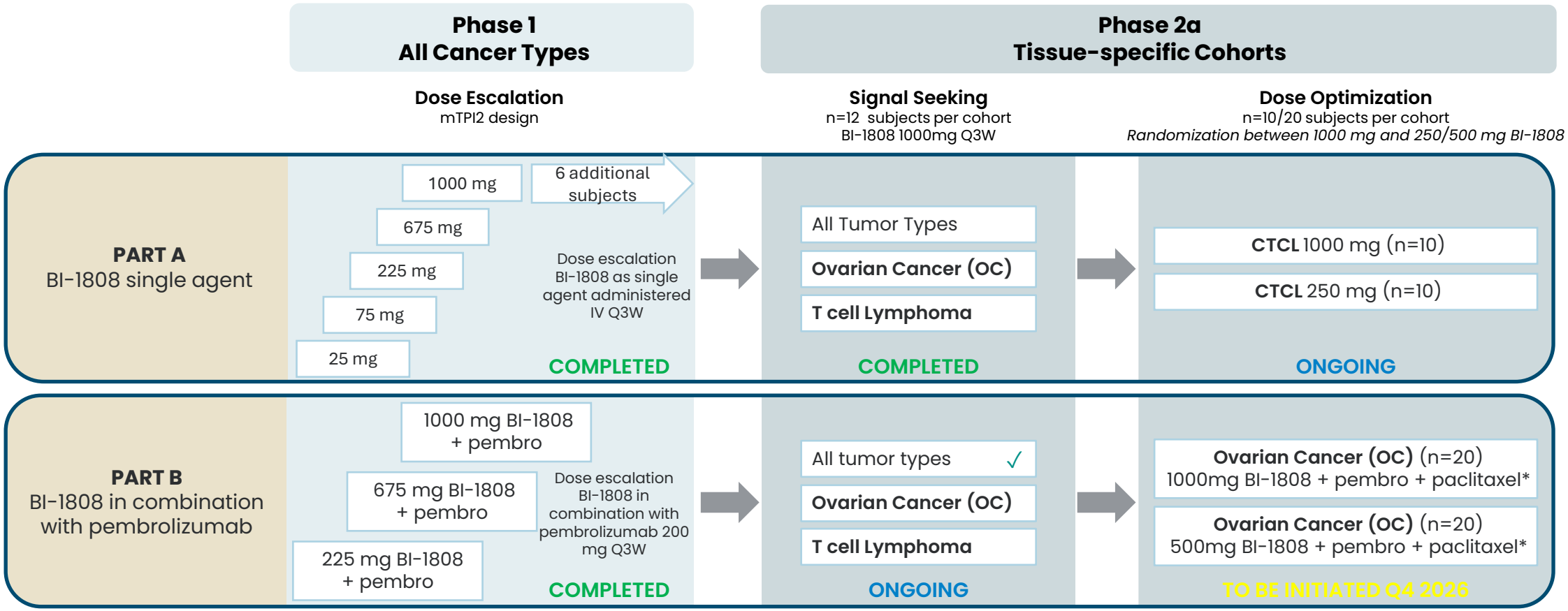
II. Paclitaxel enhances BI-1808 efficacy



Figures. Compelling rationale for BI-1808 in Ovarian Cancer.
I. BI-1808 and aPD-1 synergize in "cold" tumor models in vivo (Mårtensson, BioRxiv).
II. Paclitaxel enhances the antitumor activity of the BI-1808 surrogate antibody in mice.)

- BI-1808 + pembro have synergistic activity in animal models (**I**)
- BI-1808 + paclitaxel have additive activity (**II**)
  Thus, the triplet can only be better

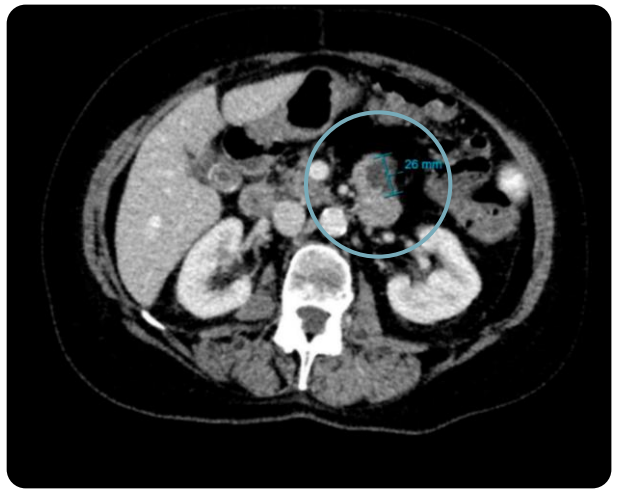
KEYNOTE-D20 trial of BI-1808 single agent and pembrolizumab combo



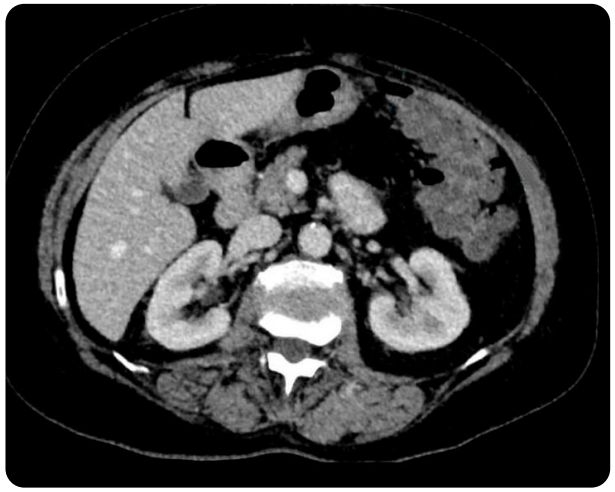
Notes: *paclitaxel administered Q1W at 80mg/m2; pembrolizumab provided by Merck & Co under supply agreement

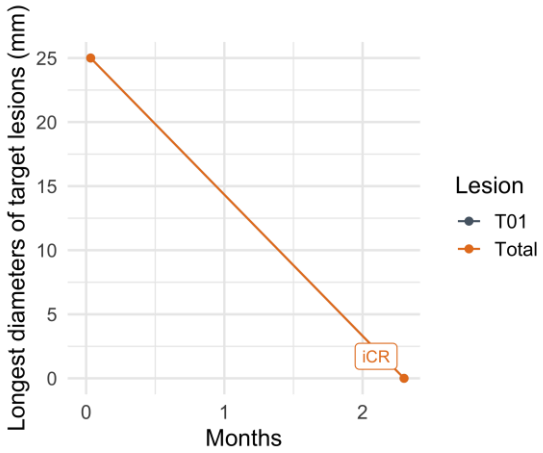
BI-1808 Single Agent Case Study: Complete Response in Ovarian Cancer

Baseline

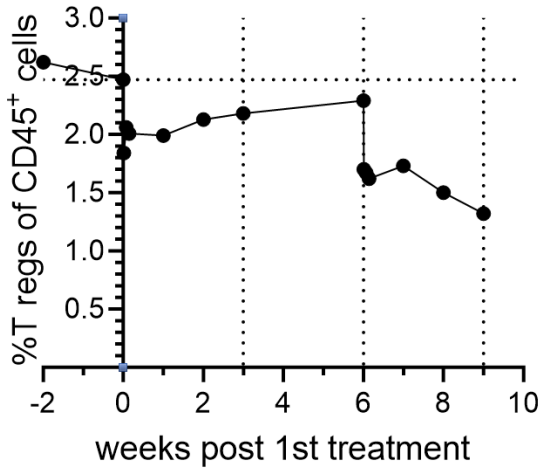


2 months





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

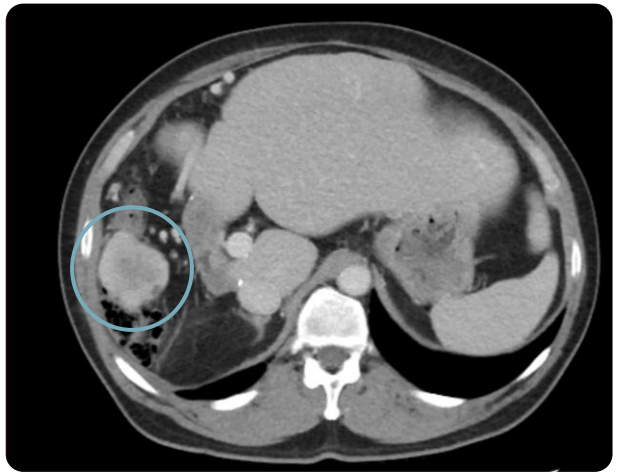
Patient had one target lesion of 25 mm and two larger non-target cystic lesions.

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

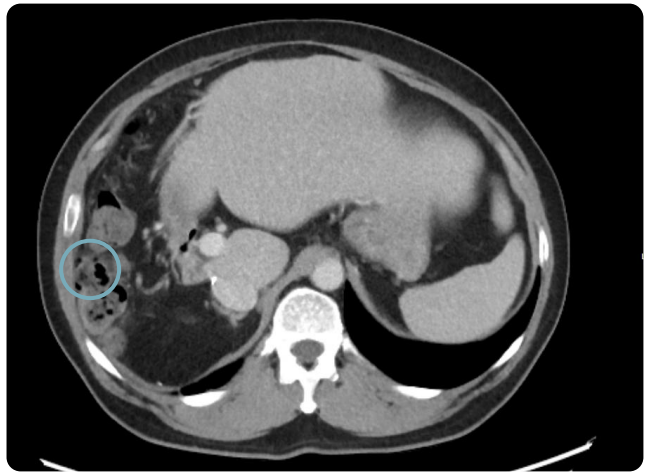
ASCO 2024 Poster #2641 BI-1808

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

Baseline

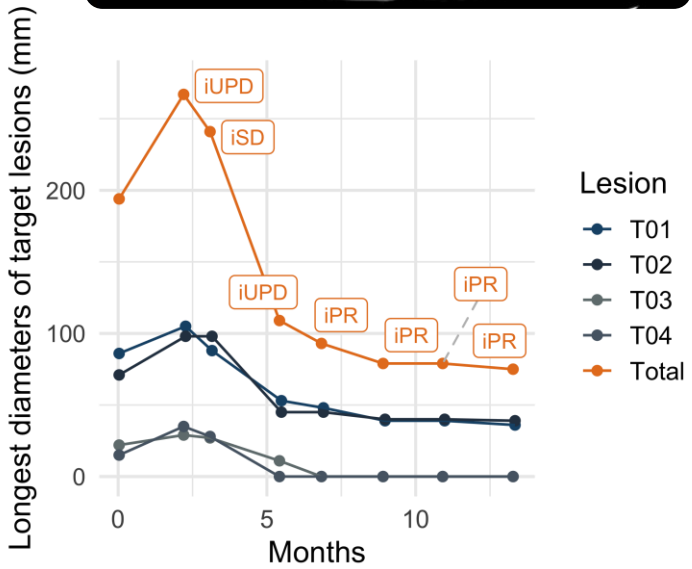


Follow-up 13 months

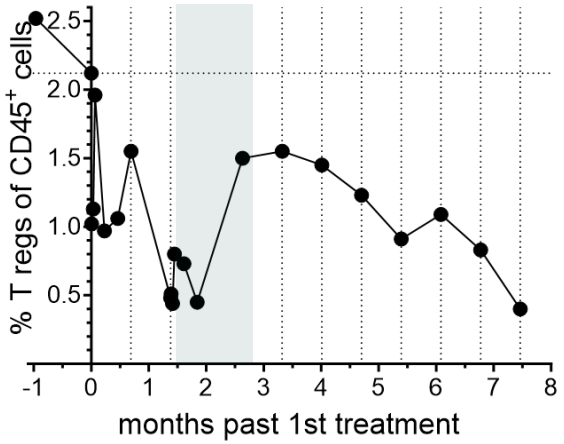


55-year-old male patient with GIST, who presented with clinical PD for more than six months with multiple metastatic lesions.

12 previous lines of therapy.

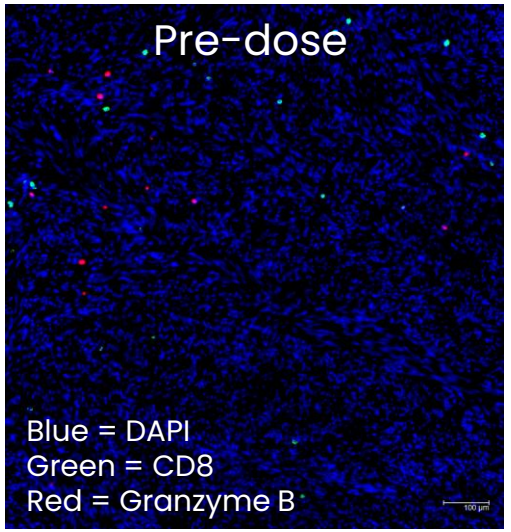


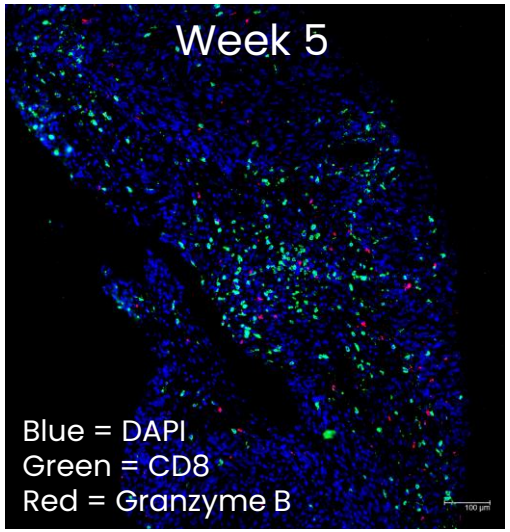
Tumor assessment vs time on study (months)



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

Note treatment paused



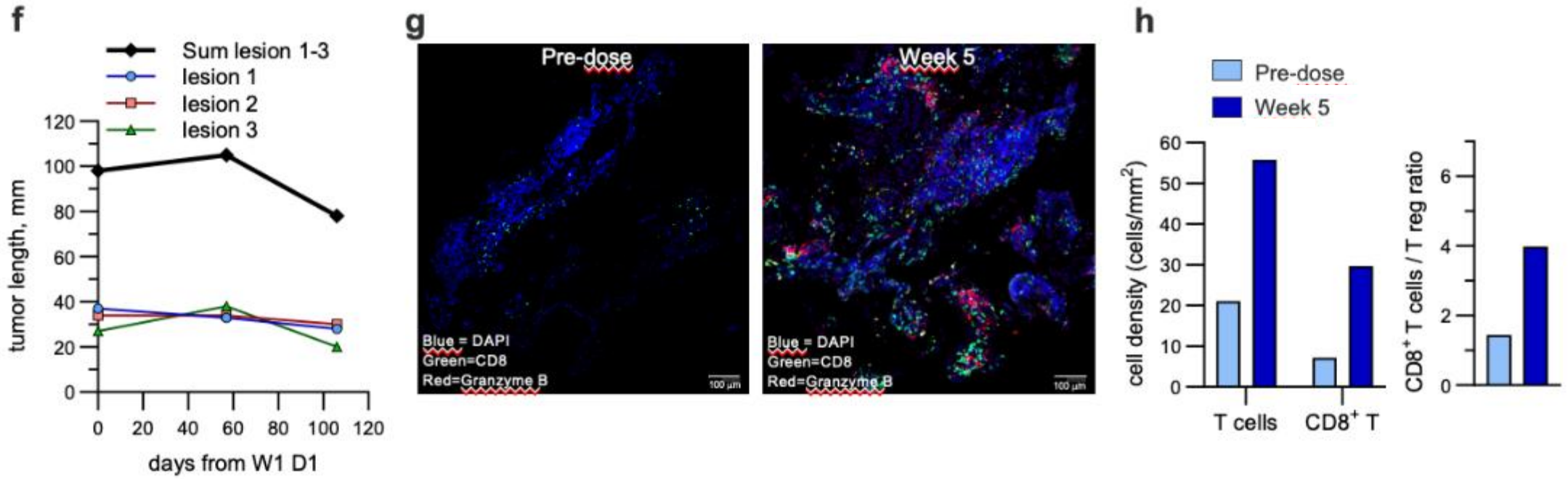


BI-1808 shows evidence of CD8+ tumor infiltration which is associated with tumor regression

*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

BI-1808 in Ovarian Cancer

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

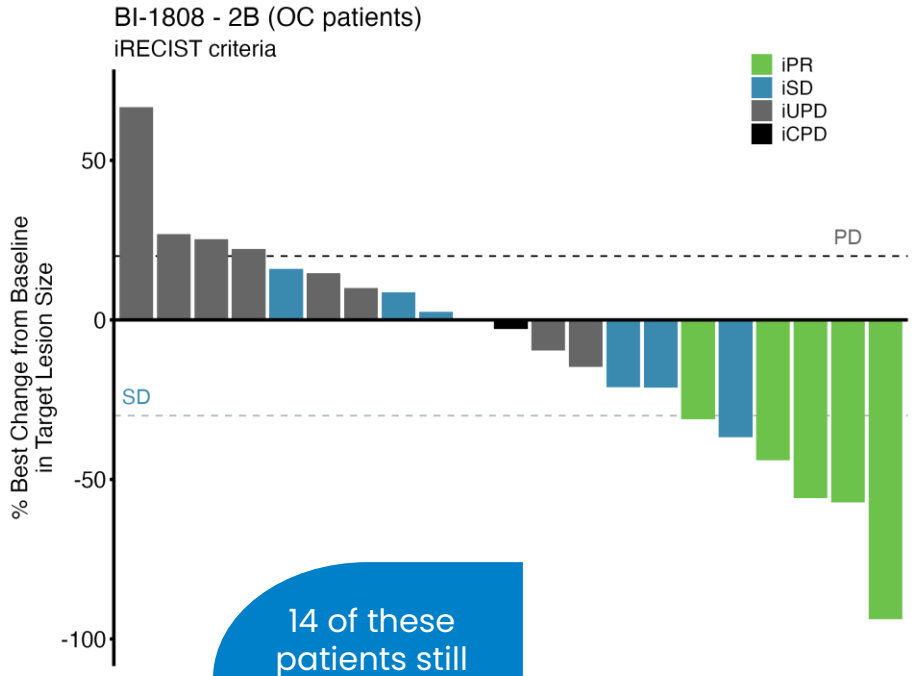
Phase 2a Design

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

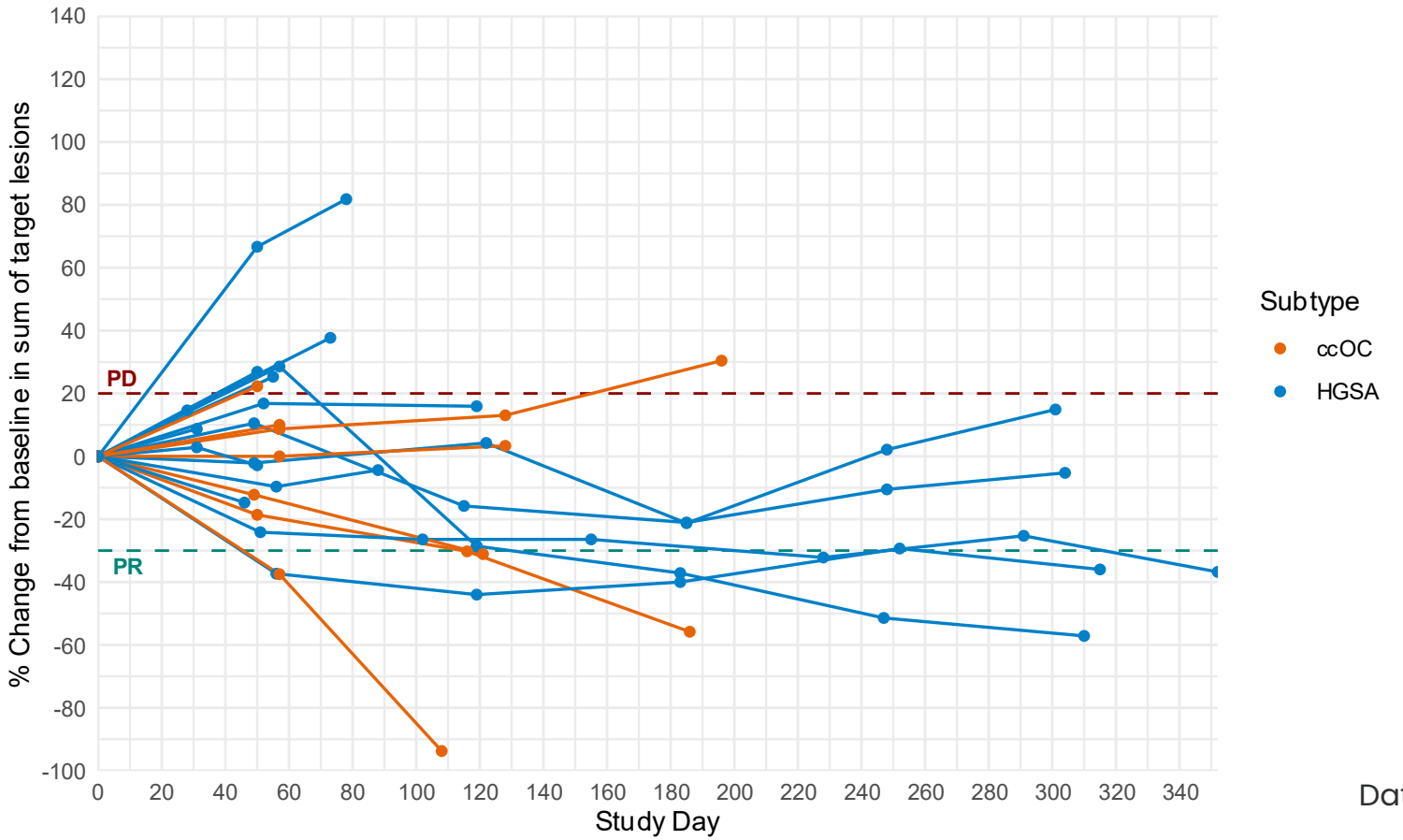
24% ORR, 57% DCR in 21 evaluable OC patients:

- 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)

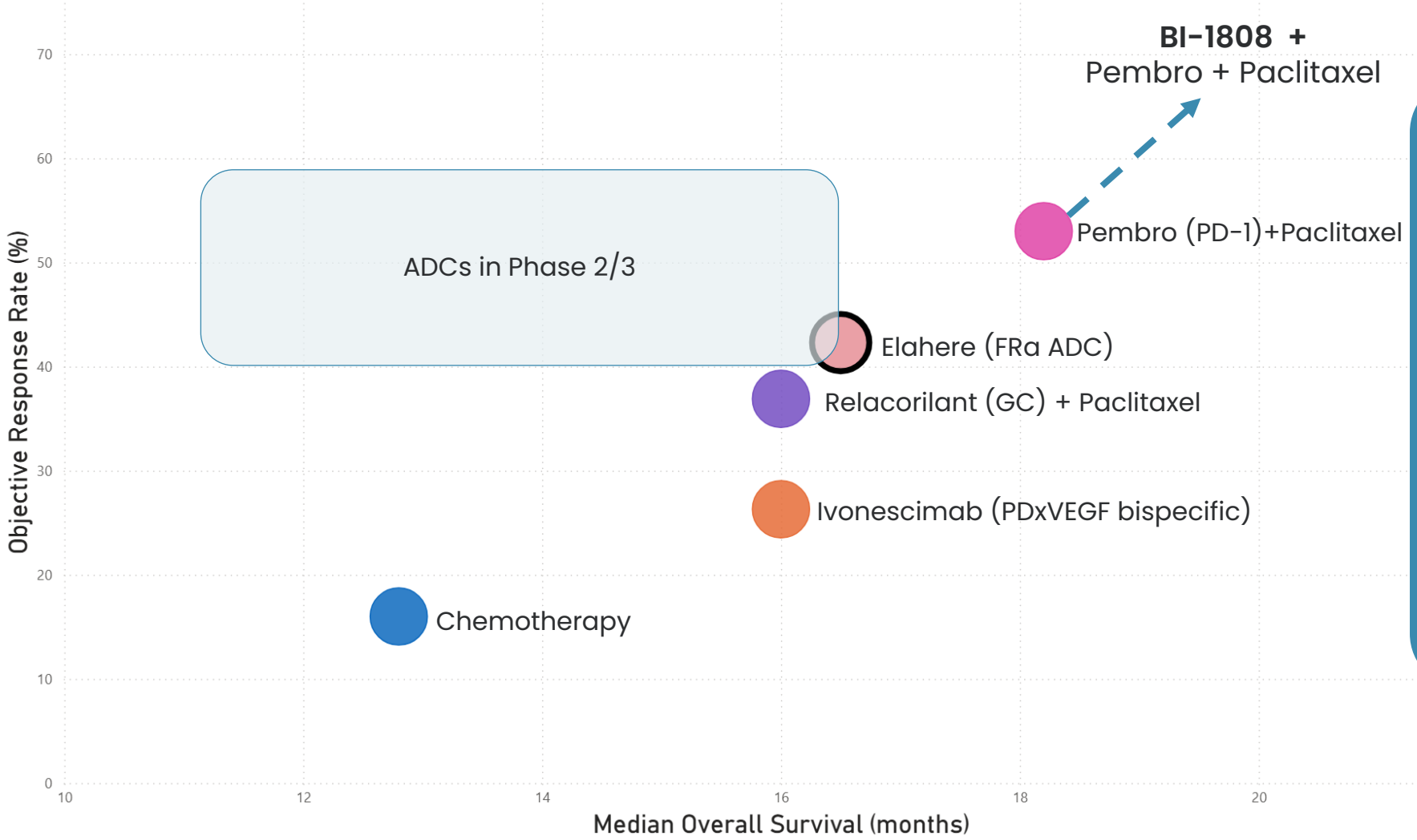


Data cut-off 2026-02-18

WHAT'S NEXT? Additional Phase 2a data in ovarian cancer at ASCO 2026 (end of May)

OC: Ovarian Cancer

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*

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 Shows Promising Efficacy in **CTCL and PTCL**

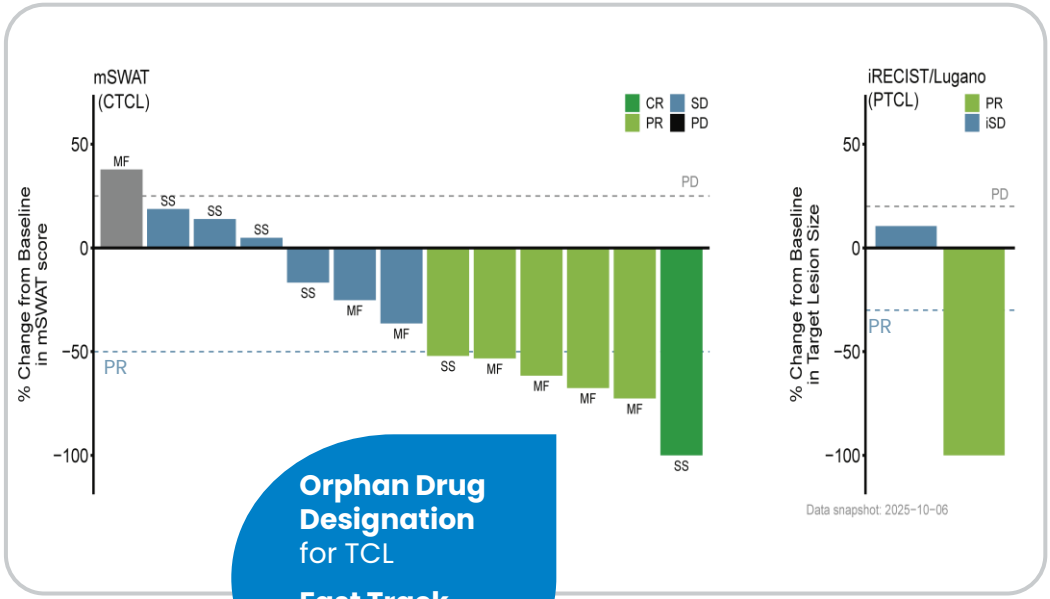
EHA 2026 abstract Phase 2a monotherapy and combination data (cut-off Feb 2026)

- **40% objective response rate (ORR) as single agent in heavily pre-treated patients with advanced cutaneous T-Cell lymphoma (CTCL), 92% DCR:**

  15 evaluable patients with CTCL:
  - 1 CR: Sézary Syndrome (SS) ongoing at two years
  - 5 PR: 4 Mycosis Fungoides (MF), 1 SS

  2 evaluable patients with PTCL whereof 1 PR

- **50% ORR in combination with KEYTRUDA® (pembrolizumab)**
- **Favorable safety profile with mostly mild to moderate treatment-related adverse events**
- Immune activation observed early on, with depletion of regulatory T cells and an influx of CD8+ T cells into the skin



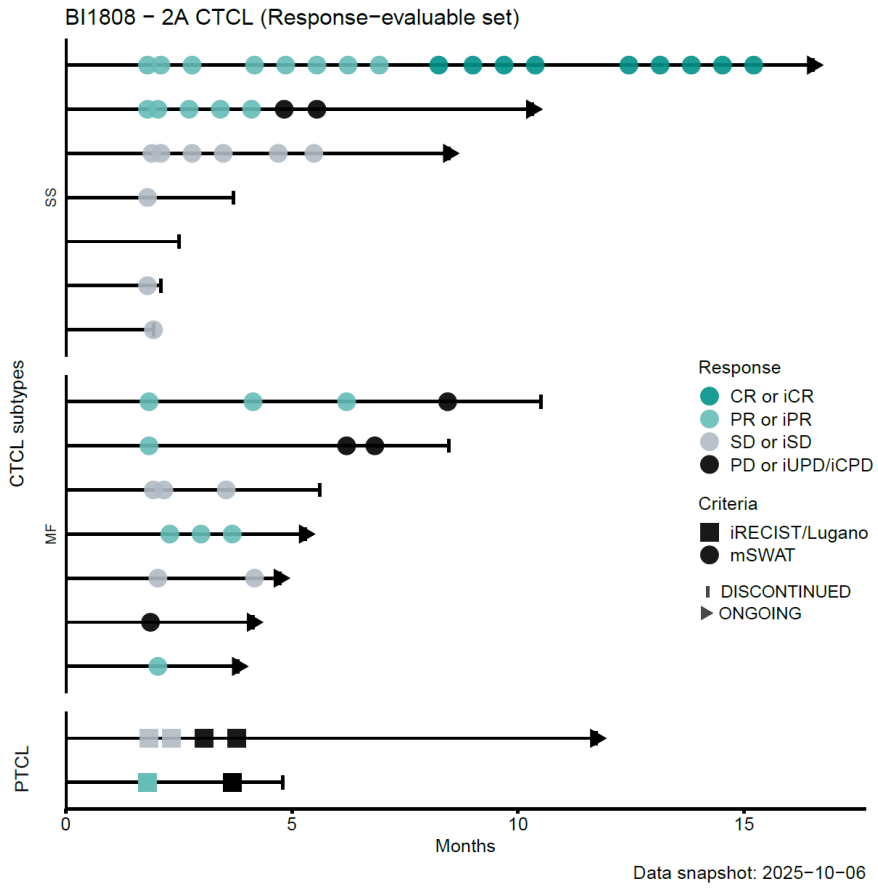
Orphan Drug Designation for TCL

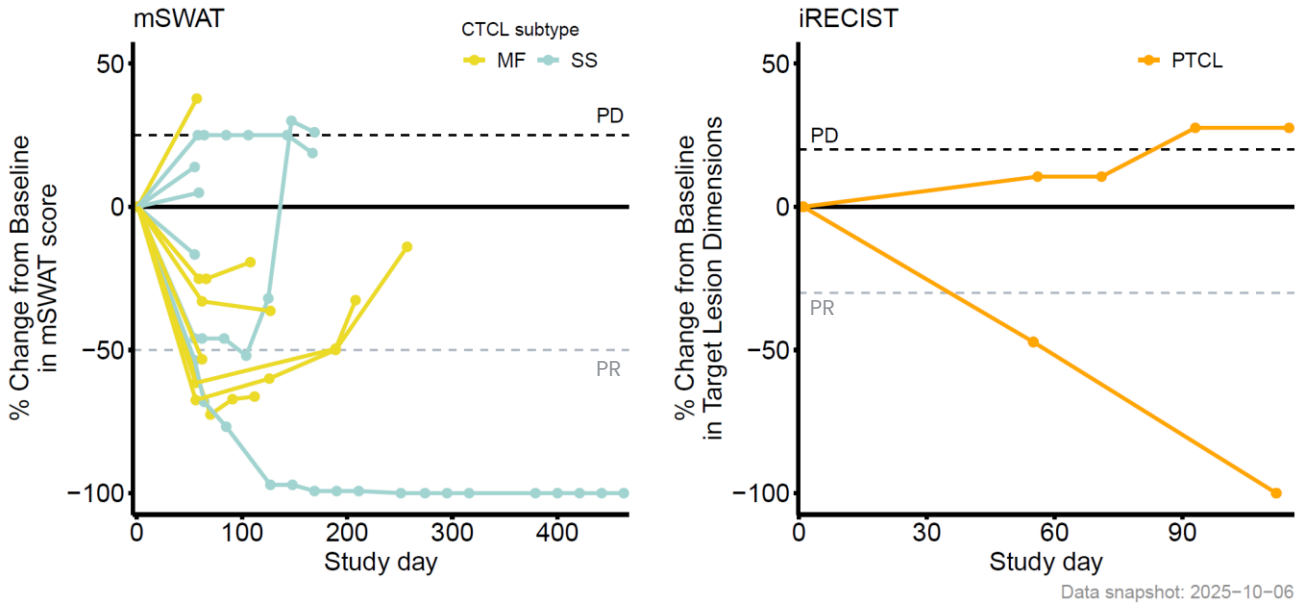
Fast Track Designation for CTCL

WHAT'S NEXT? Additional monotherapy and combination data June 2026 (EHA)

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

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

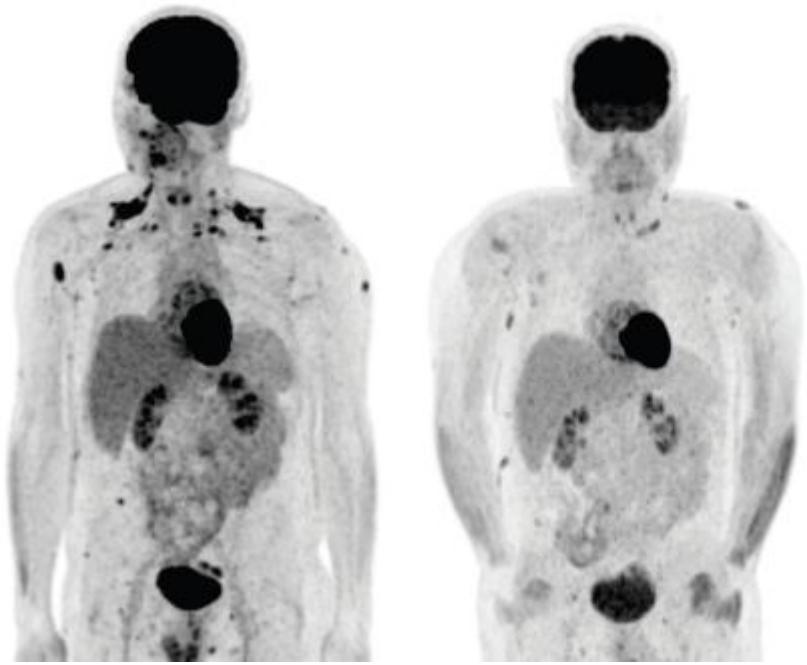




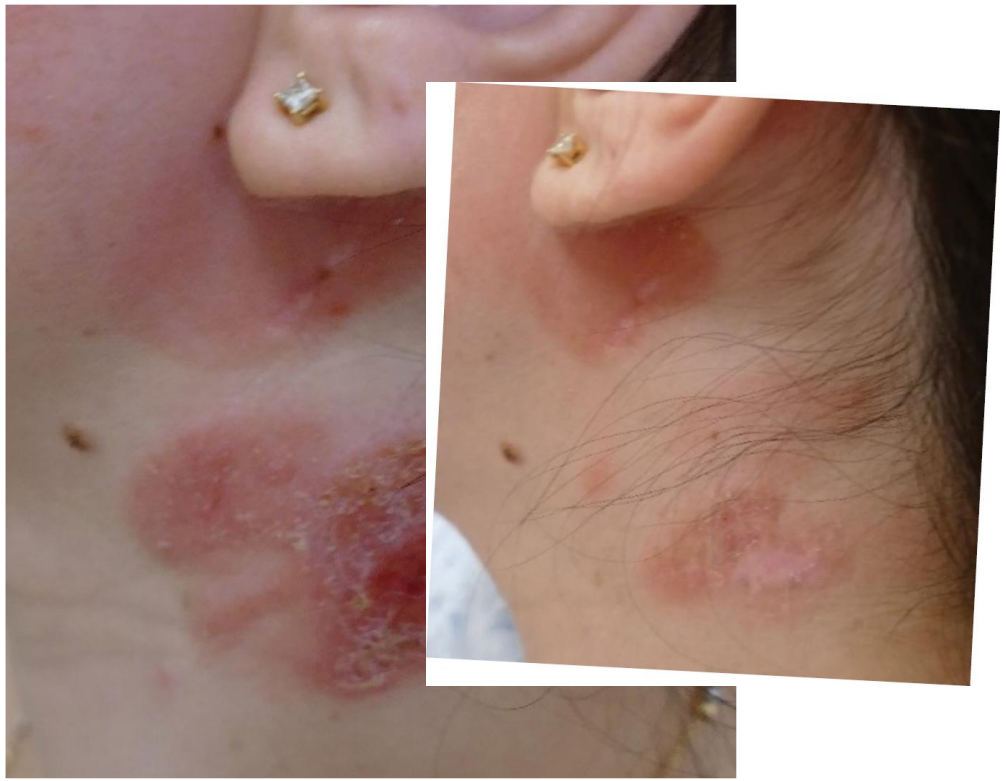
Impressive Responses Were Observed in Heavily Pre-treated Patients with PTCL or CTCL Treated with BI-1808 Monotherapy

Case Studies

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

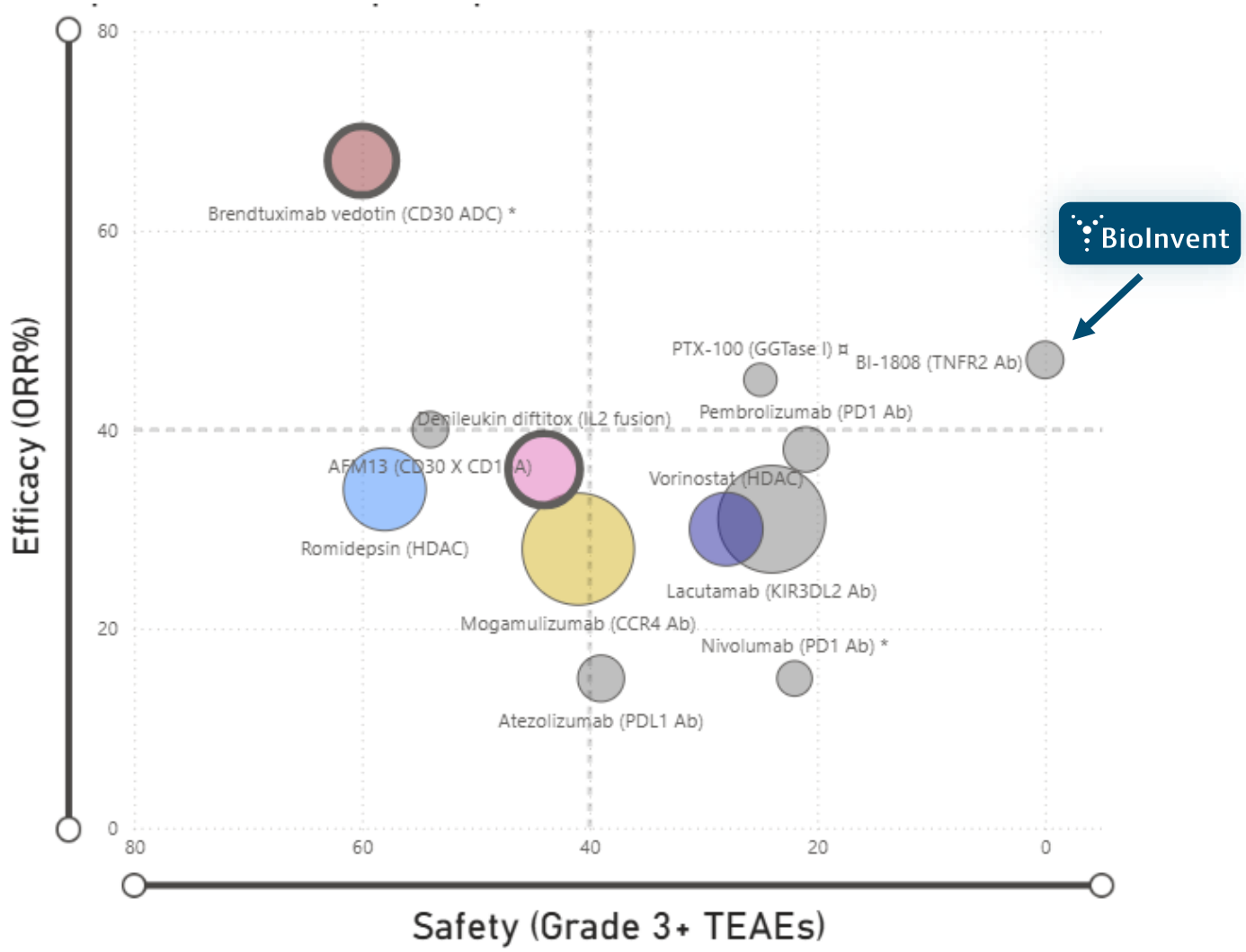


Baseline Week 9



Baseline Week 21

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



Approved Treatments (Major)

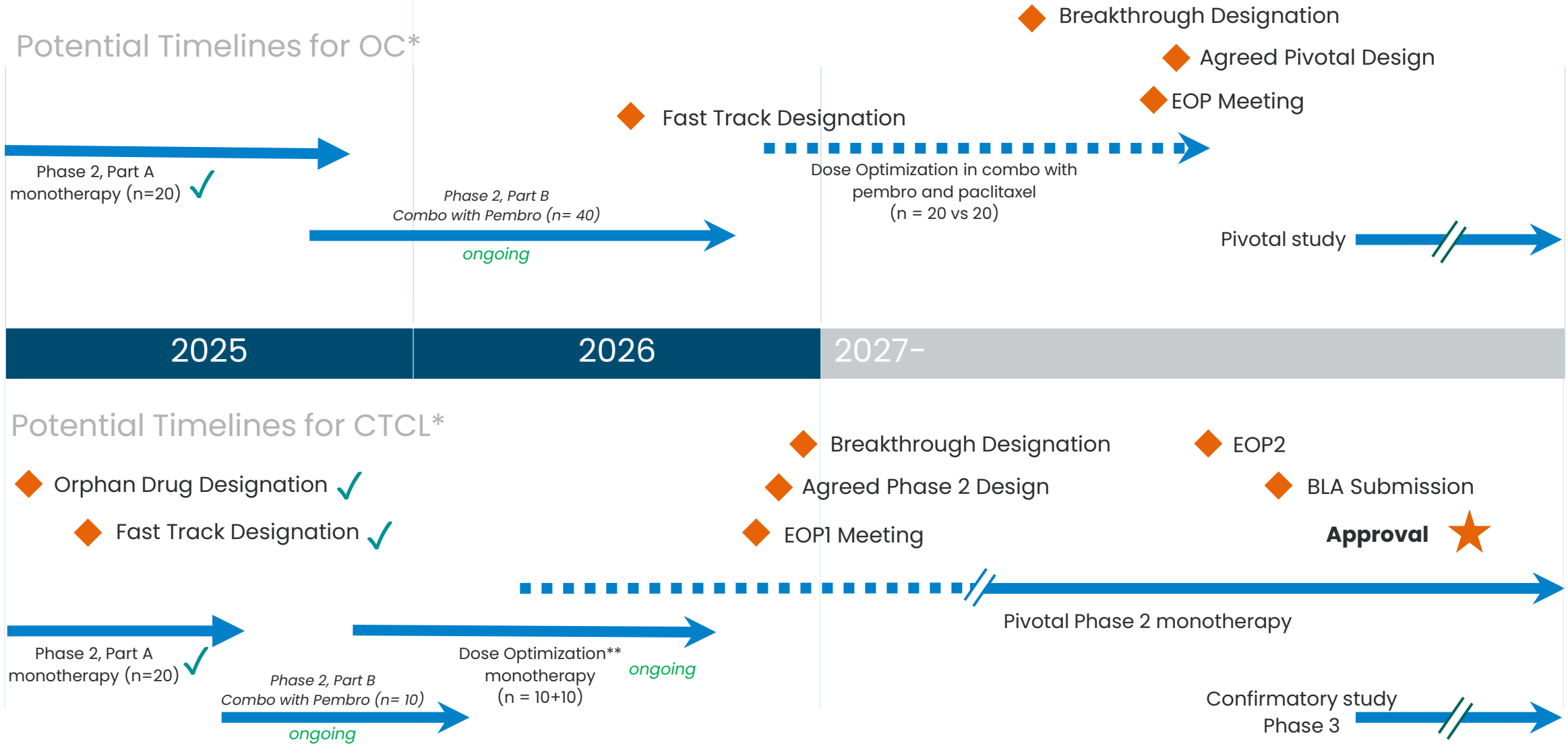
Romidepsin	Class I HDAC	Bristol Myers Squibb
Vorinostat	Pan-HDAC	MERCK
Mogamulizumab	anti-CCR4 mAb	KYOWA KIRIN
Brentuximab vedotin	CD30 ADC	Pfizer, Takeda
Denileukin diftitox	IL2-fusion	CITIUS Oncology

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

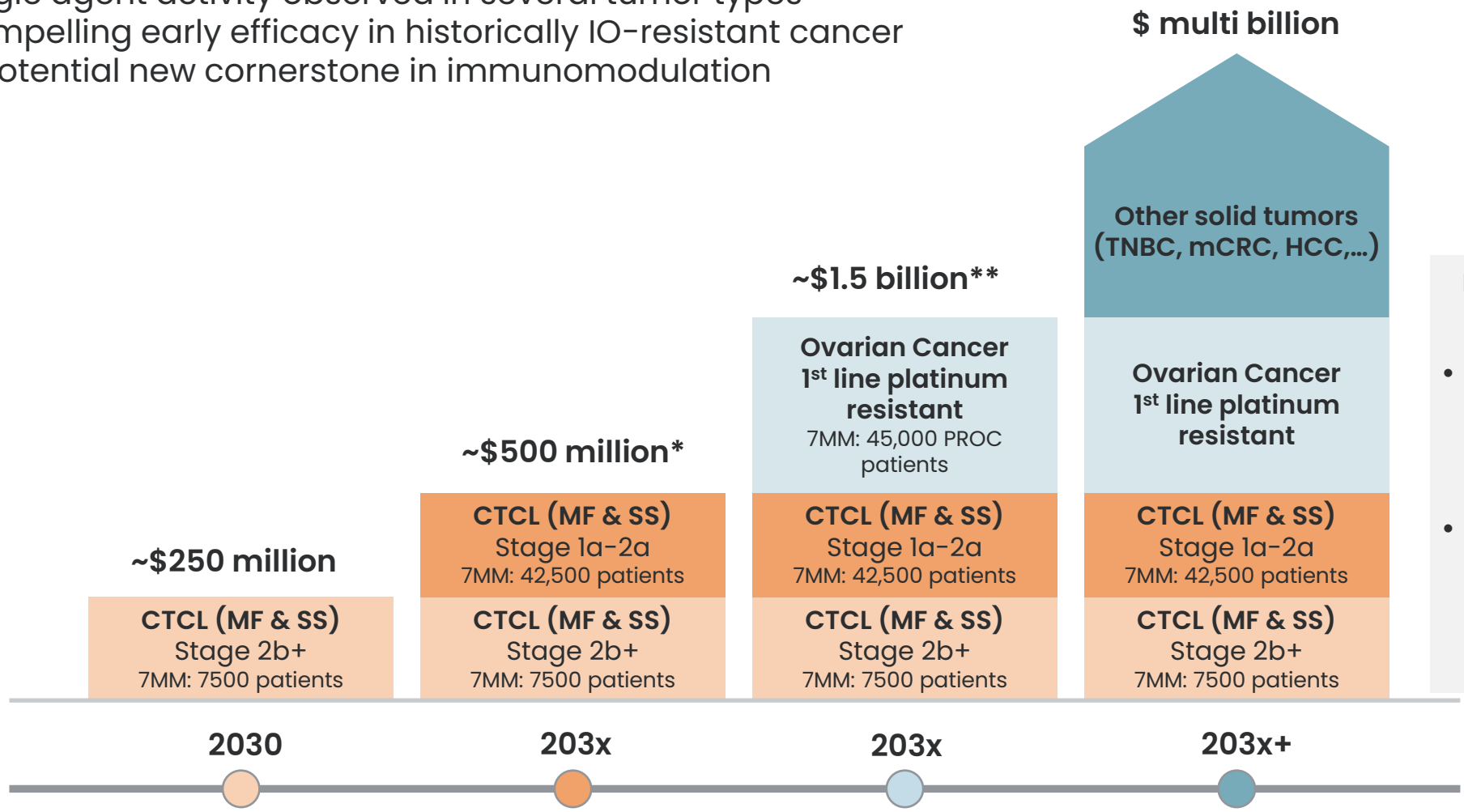
BI-1808 Potential Path to Approval – US



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

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 at ASCO 2026 (end of May)

*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

ANTI-FcγRIIB

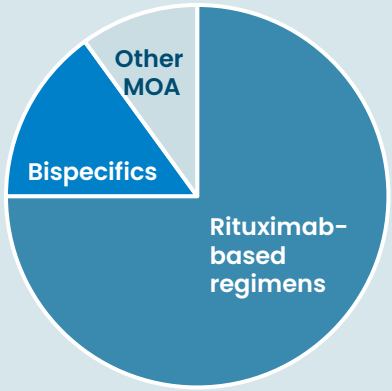
BI-1206 in Non-Hodgkin's Lymphoma (NHL)

BI-1206 in Solid Tumors

BI-1206 in NHL

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

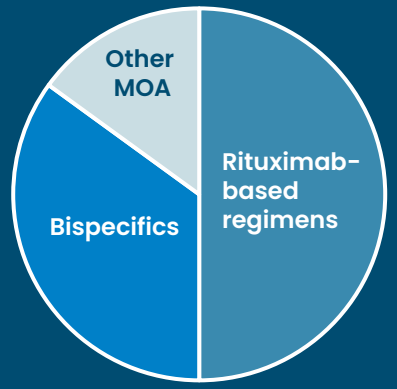
Now



Follicular Lymphoma (FL) Market Shifts

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

2030



Opportunities for BI-1206

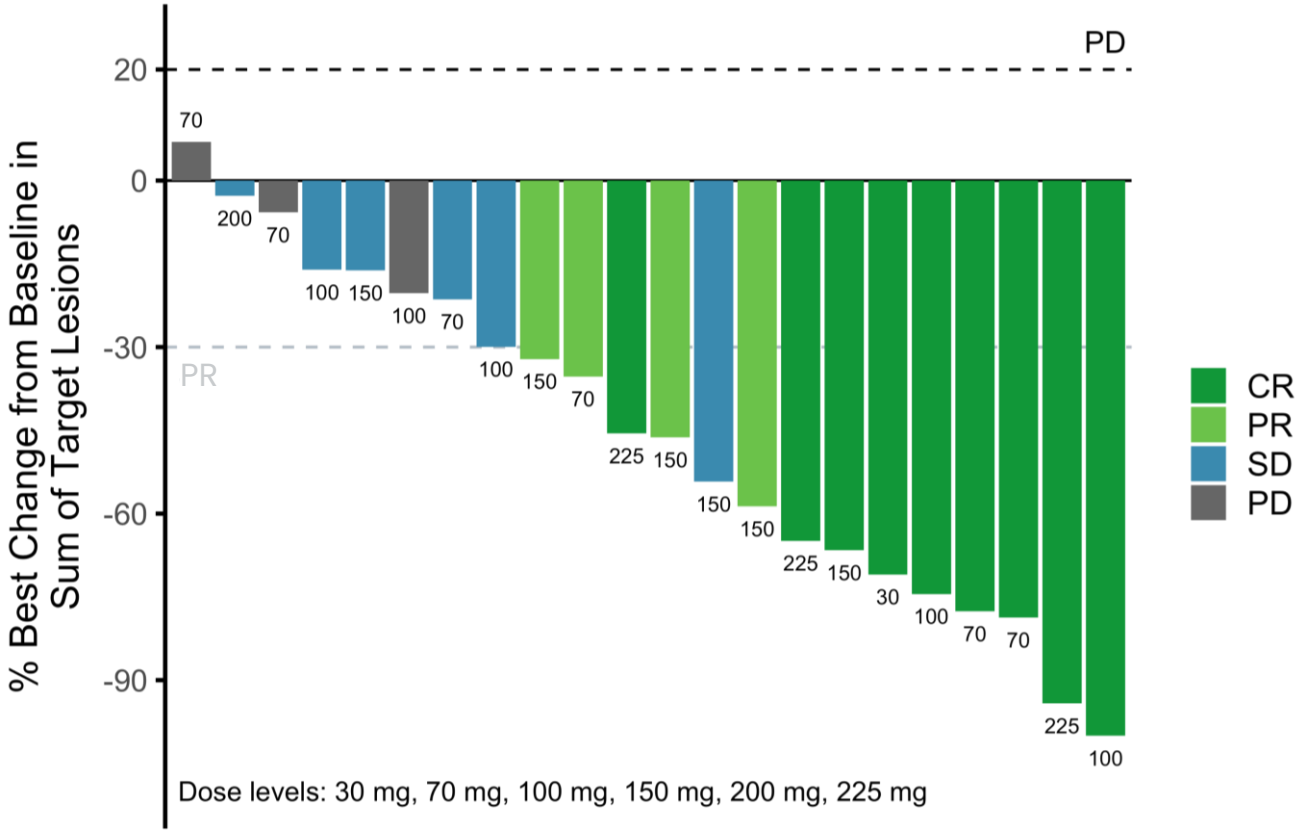
- Capturing 2nd line after 1st line bispecific (CD19XCD3)
- First anti-CD20 after bispecific will increase response rates of the triplet
- Safe and convenient, community hospital-friendly backbone (no CRS, neurotoxicity, neutropenia, infections, or hospital logistics associated with bispecifics/CAR-Ts)
- 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

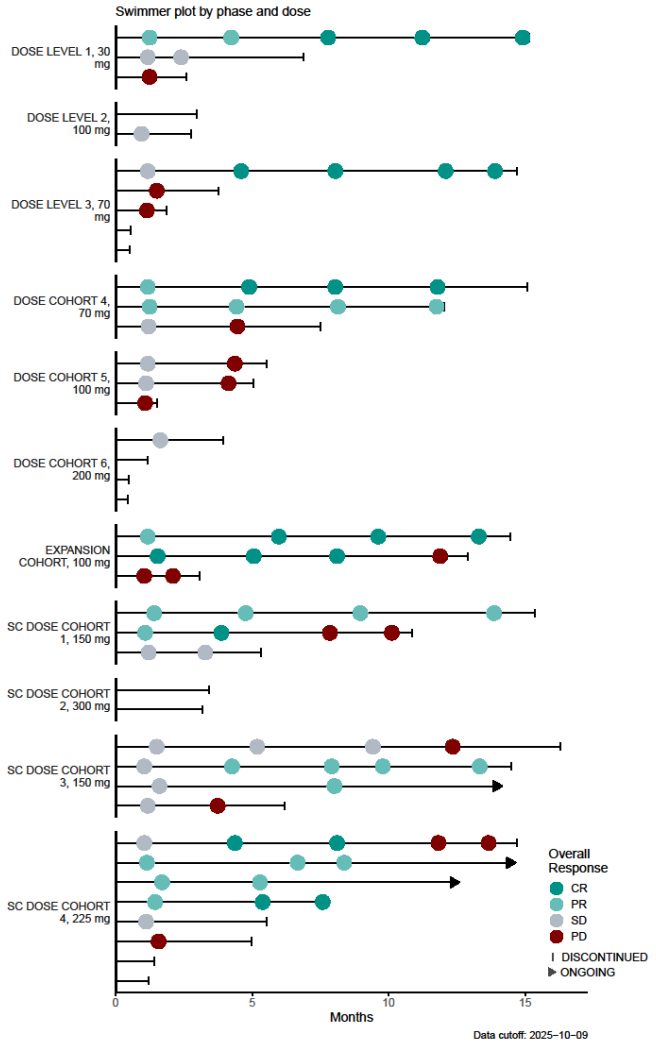
Phase / Design	Population	N	Dosing	Sites	Key Endpoints	Data Cut-off
Ph 1 Dose escalation	R/R FL (as part of r/r NHL)	22 FL (out 30 NHL)	Escalating doses IV and SC	12 EU. 3 BR, 2 US	Safety ORR exploratory	2025-10-28

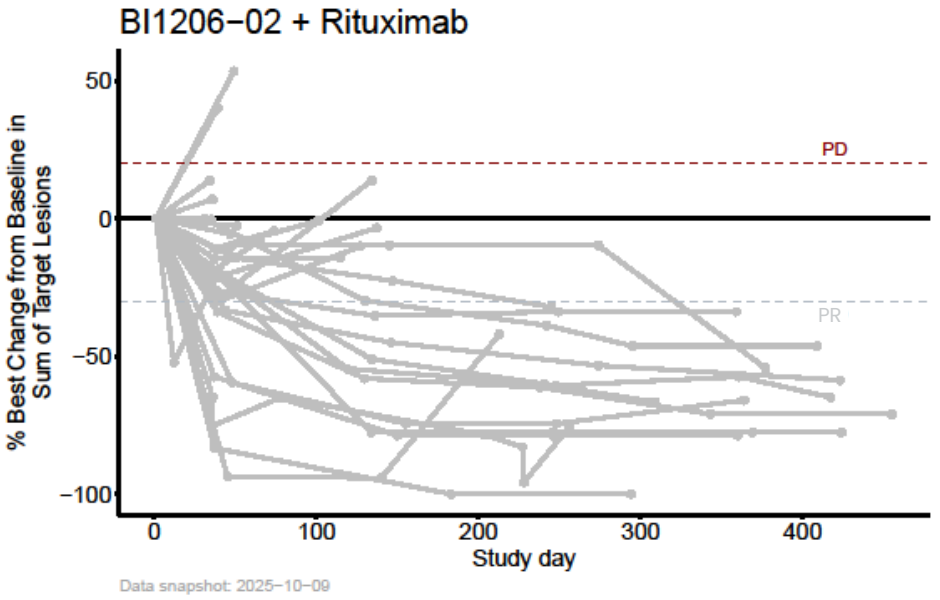


- ORR of 59%, CRR of 41%, DCR 86% in FL
  - 9 complete responses (CR)
  - 4 partial responses (PR)
  - 6 patients with stable disease (SD)
- CRs have been long-lasting, 3 of them lasting years after end of treatment
- No safety or tolerability concerns
- All TEAEs were manageable and resolved without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





Rationale for triplet combination

Obinutuzumab	ROSEWOOD[1] trial in R/R FL ORR 45%
Obinutuzumab + Zanubrutinib	ROSEWOOD[1] trial in R/R FL ORR 69%
Rituximab + Acalabrutinib	ORR 31% in R/R FL[2]
Rituximab + BI-1206	ORR 59% CRR 41% in FL [3]
Rituximab + Acalabrutinib + BI-1206	ORR 80% CRR 35% (per cut-off 2026-02-12) in R/R FL+MCL+MZL

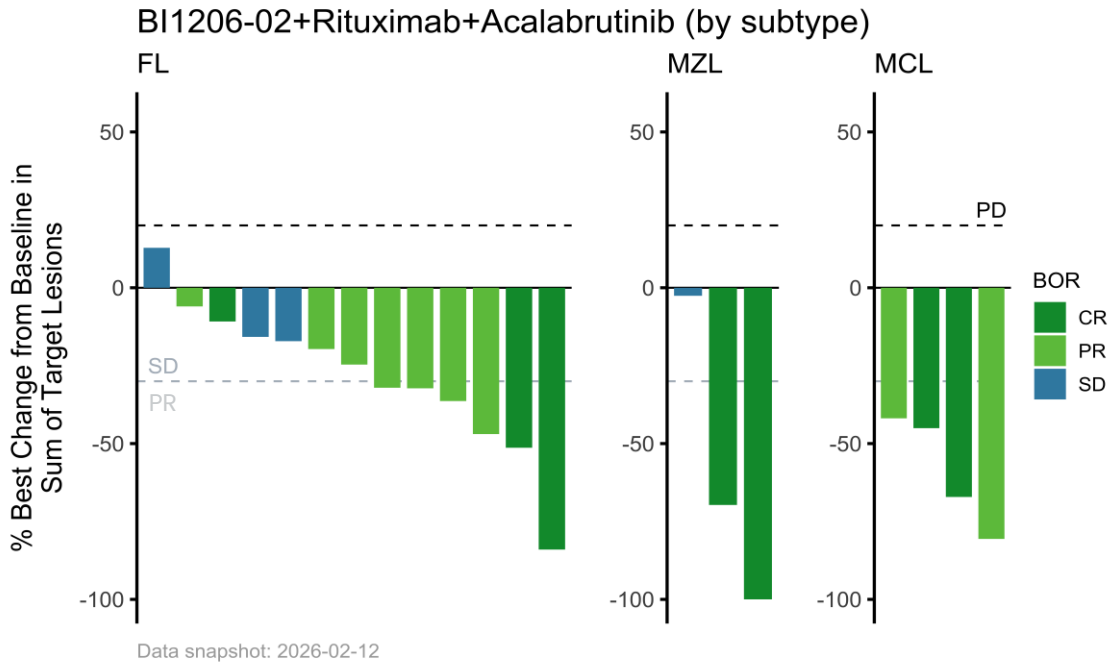
References: [1]Zinzani et al JCO 2023 41(33), [2]Strati et al Br J Hem 2024 205(6), [3]EHA 2024 Abstract P1135

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

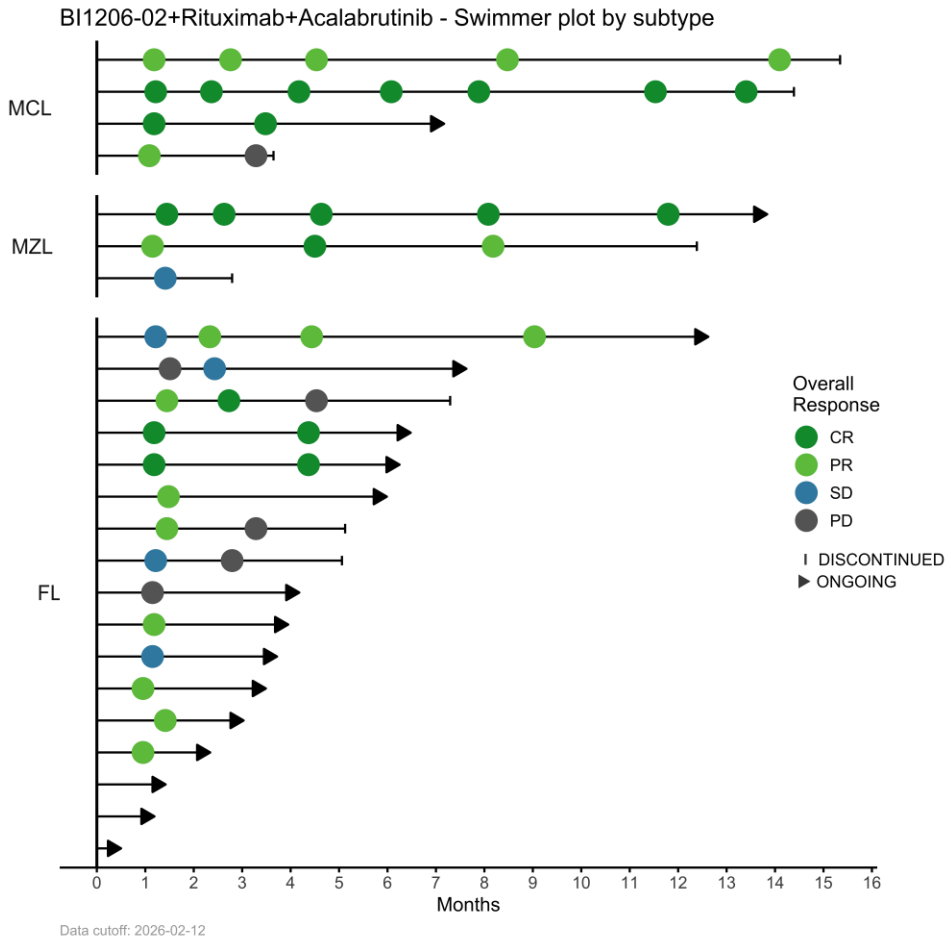
- ORR of 80%, CRR of 35% and DCR of 100%
- Best Response in 20 evaluable patients:
  - 7 CR
  - 9 PR
  - 4 SD
- In FL subgroup ORR 77%
- The treatment has been well-tolerated with no safety or tolerability concerns
- No apparent difference in safety between 150 mg and 225 mg BI-1206 SC

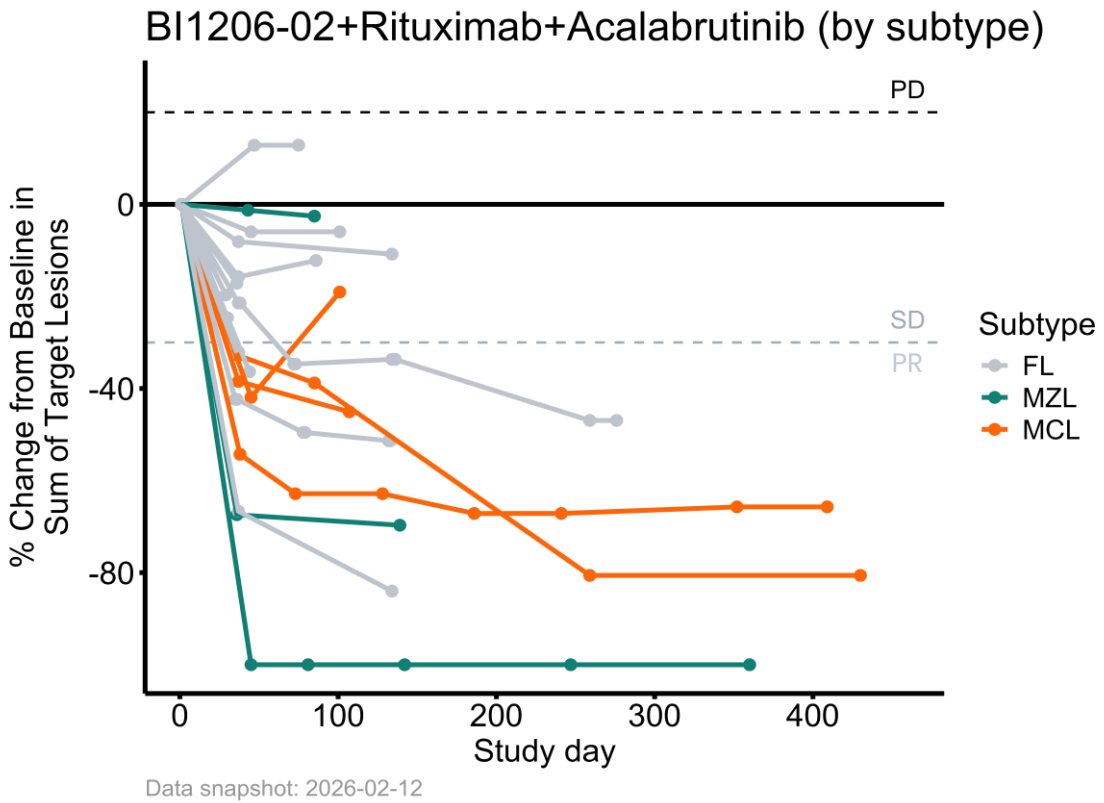


WHAT'S NEXT? Updated Phase 2a data to be shared in a poster at EHA (June 2026)

*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

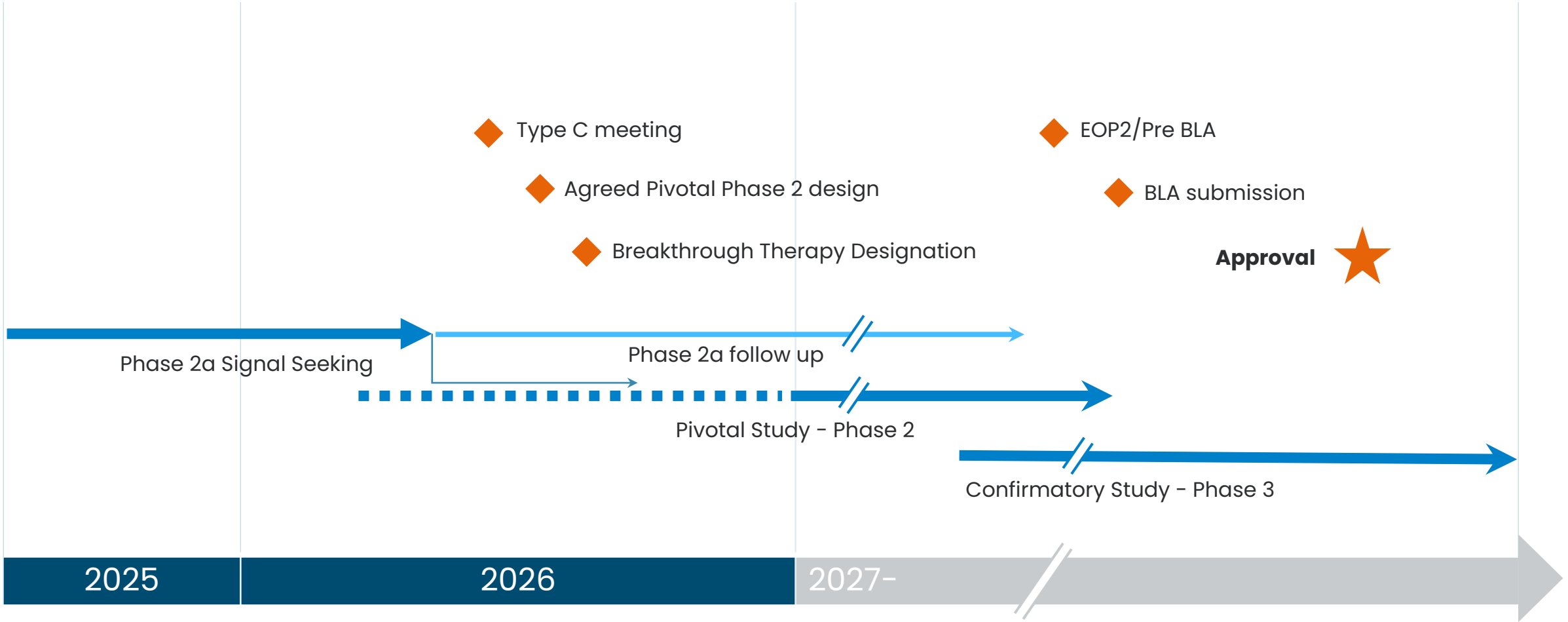
Prolonged cytopenias

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 in NHL: Combination with Rituximab and Acalabrutinib

Potential Timelines*



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

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.**

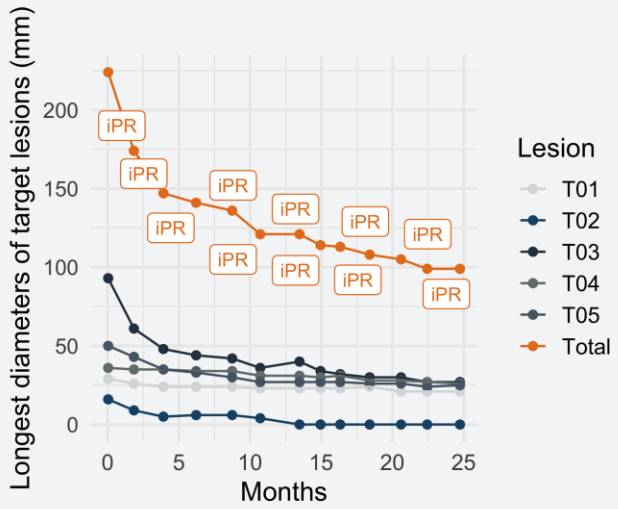
BTK: Bruton’s Tyrosine Kinase, ICANS: Immune Effector Cell-Associated Neurotoxicity Syndrome

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

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

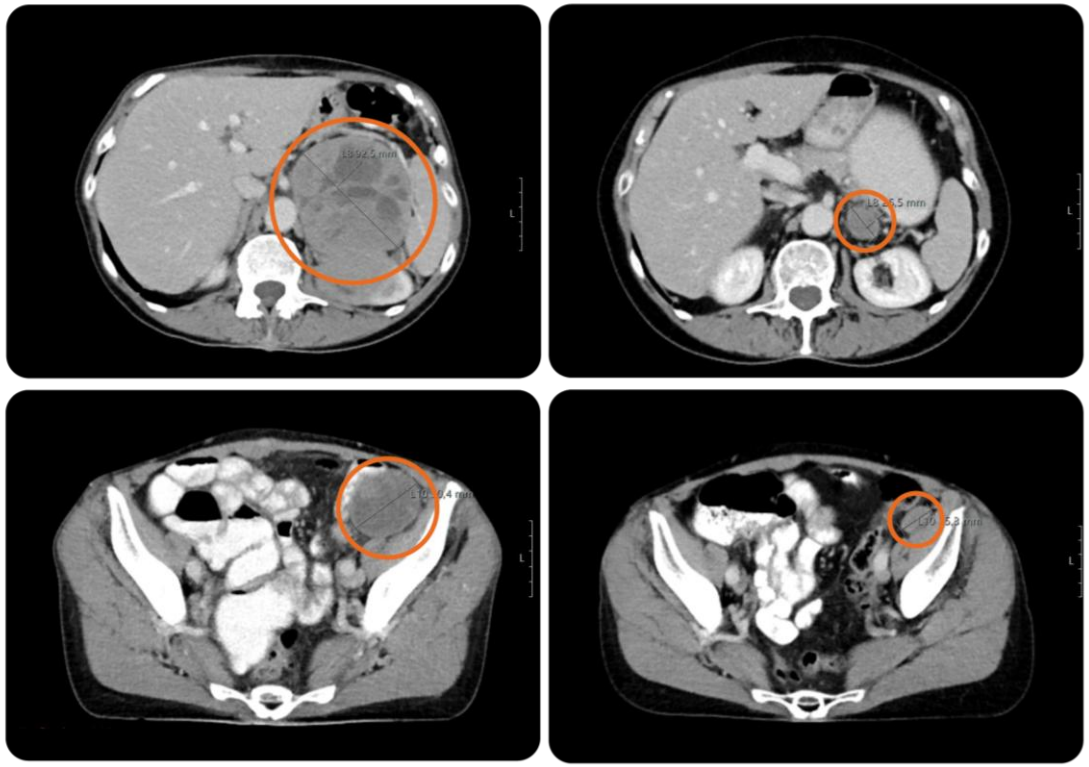
Case study: PR

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

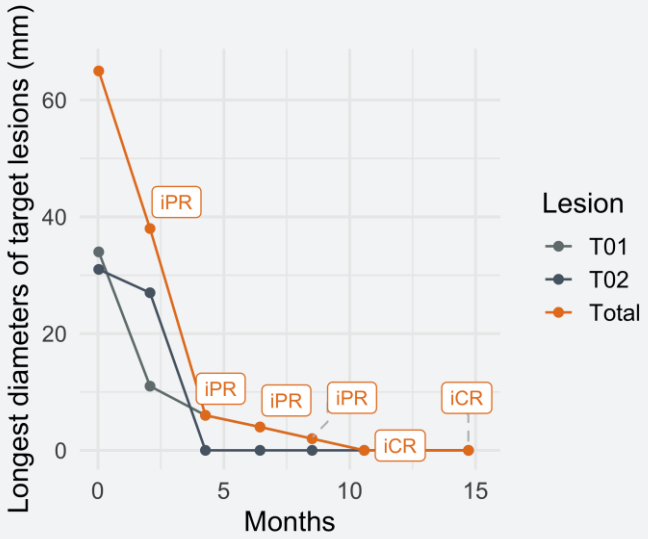


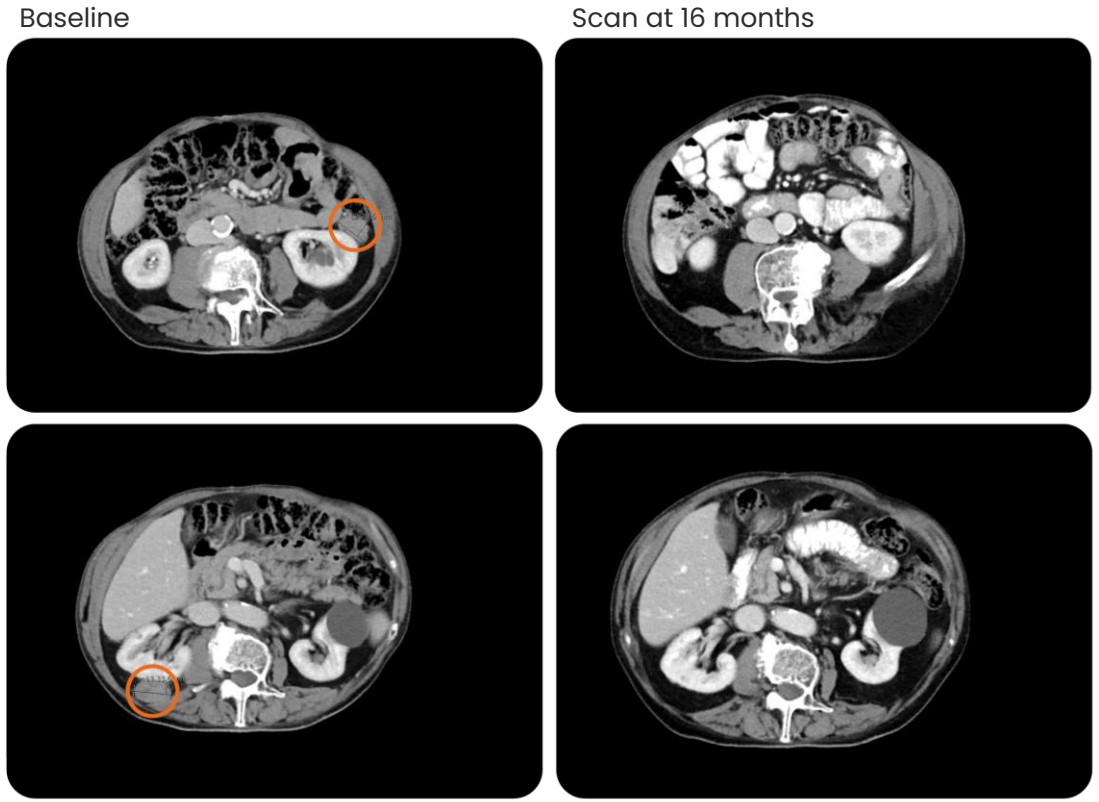
ASCO 2024 Abstract #2593 BI-1206

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.





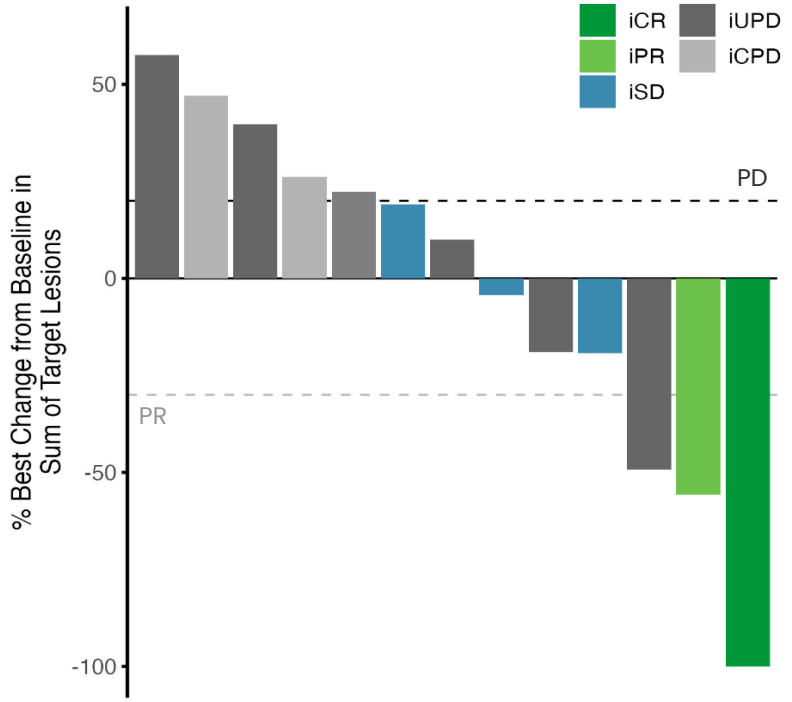
ASCO 2024 Abstract #2593 BI-1206

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



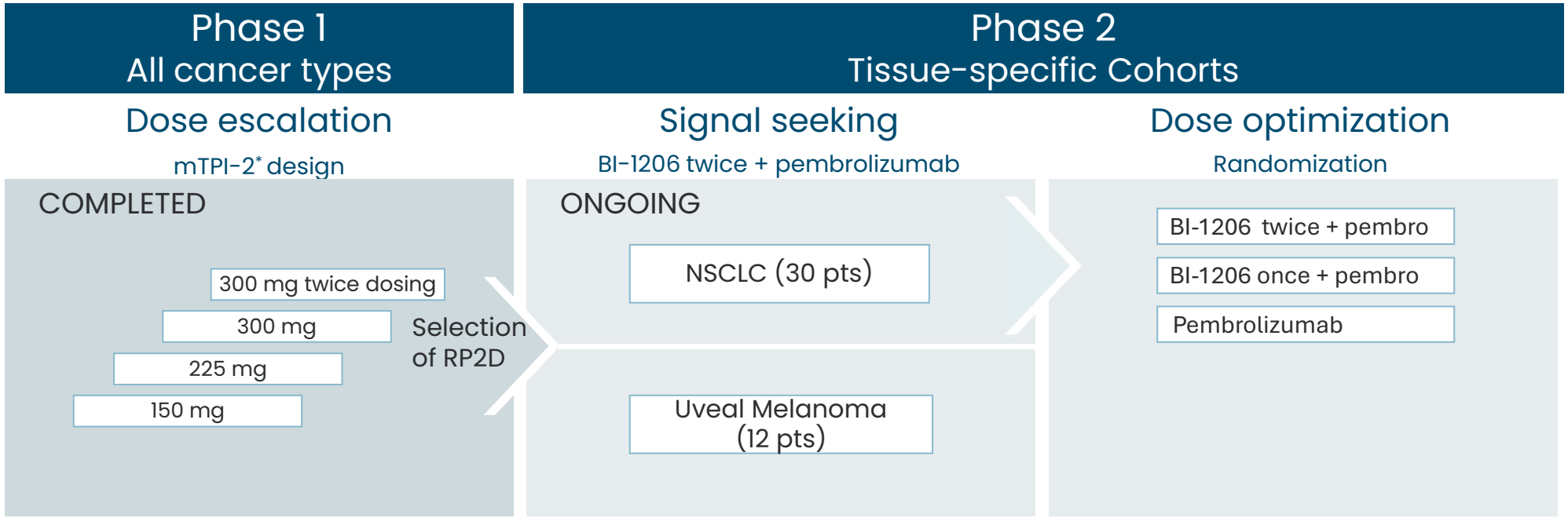
* Supplied by MSD International Business GmbH, a subsidiary of Merck & Co., Inc., Rahway, NJ, USA

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, Romania, Spain, Sweden and the US

BI-1206 combo with pembrolizumab

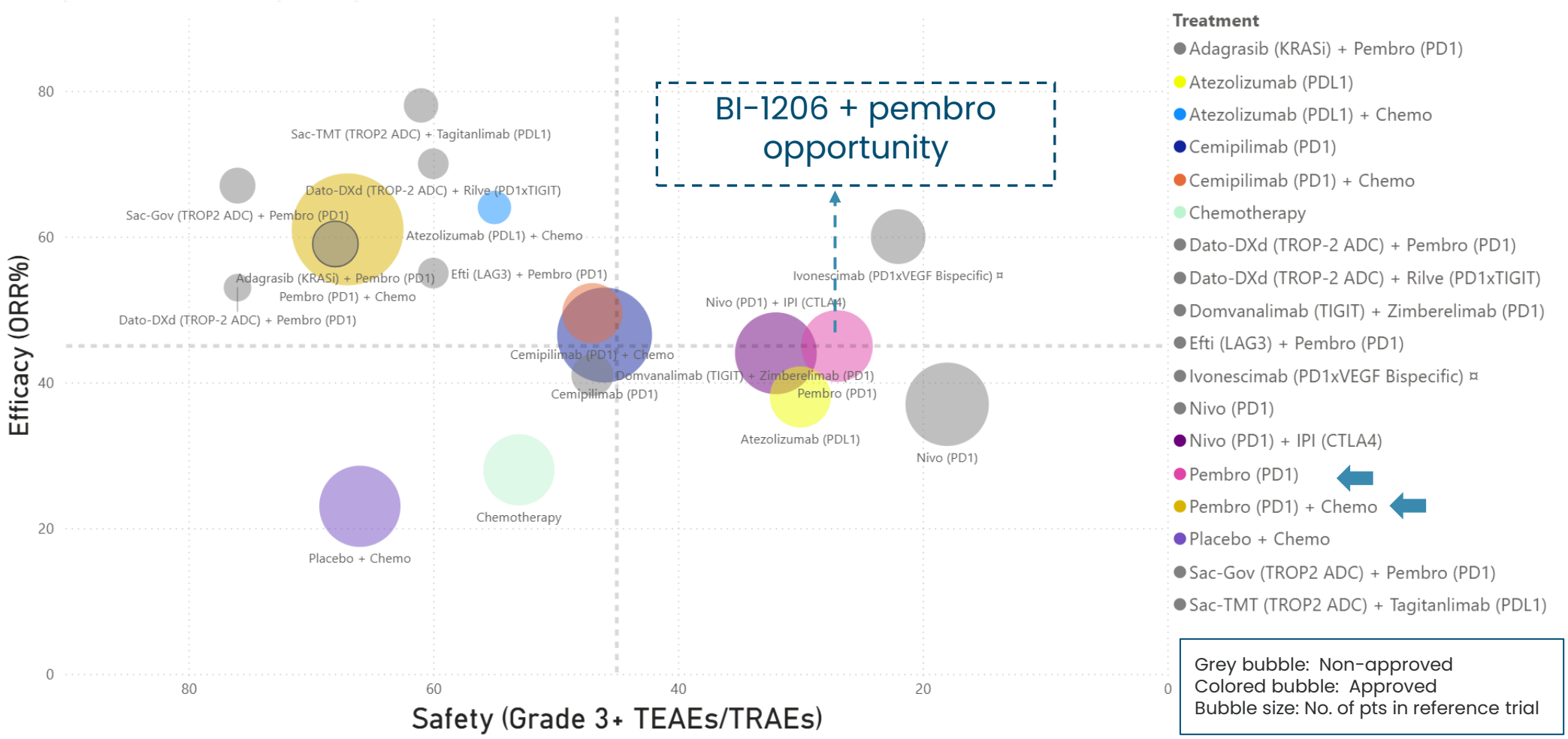
MSD



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

* modified Toxicity Probability Interval 2

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).

Competitive Landscape for Metastatic Uveal Melanoma

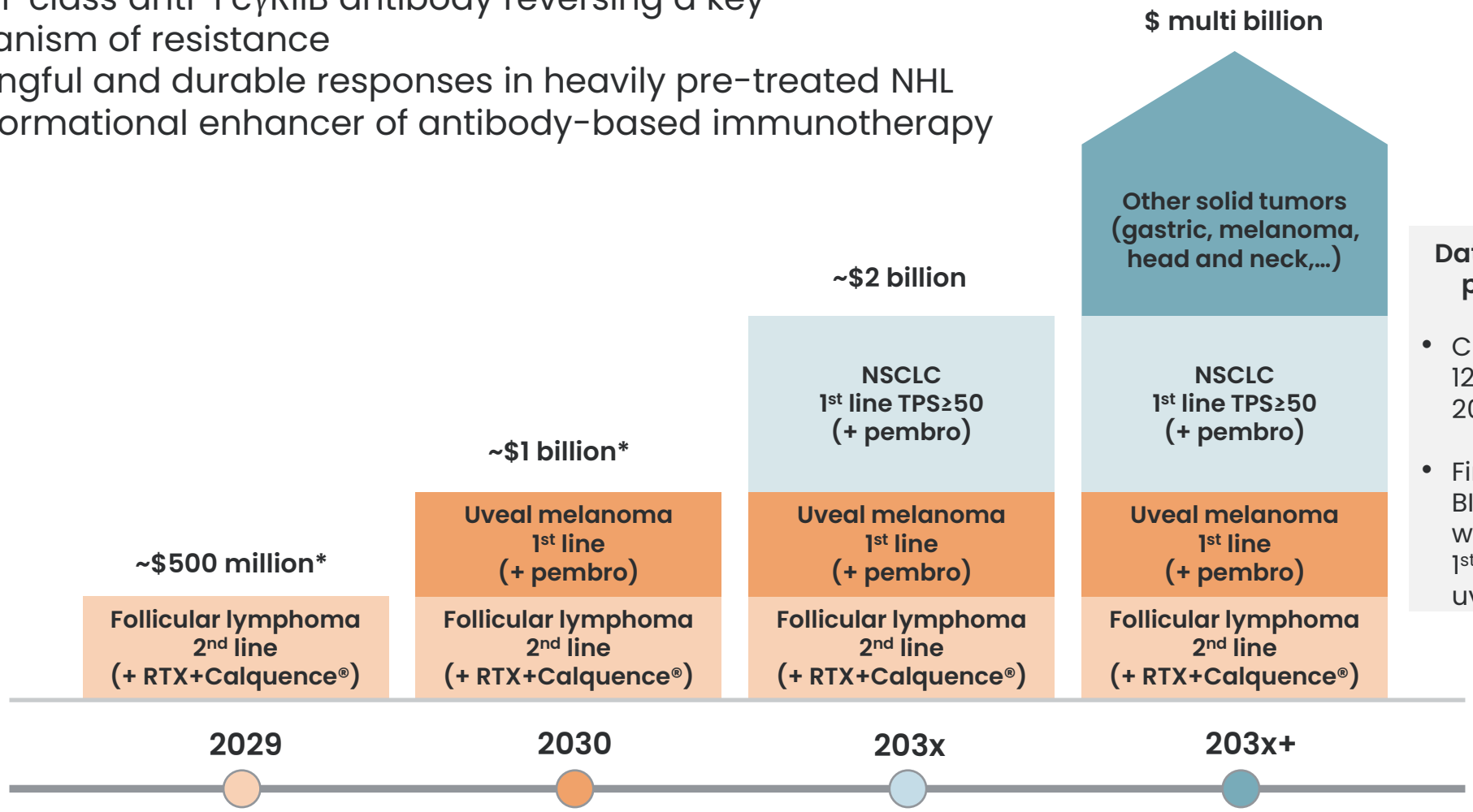
Positioning of BI-1206 in Uveal Melanoma

- 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

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

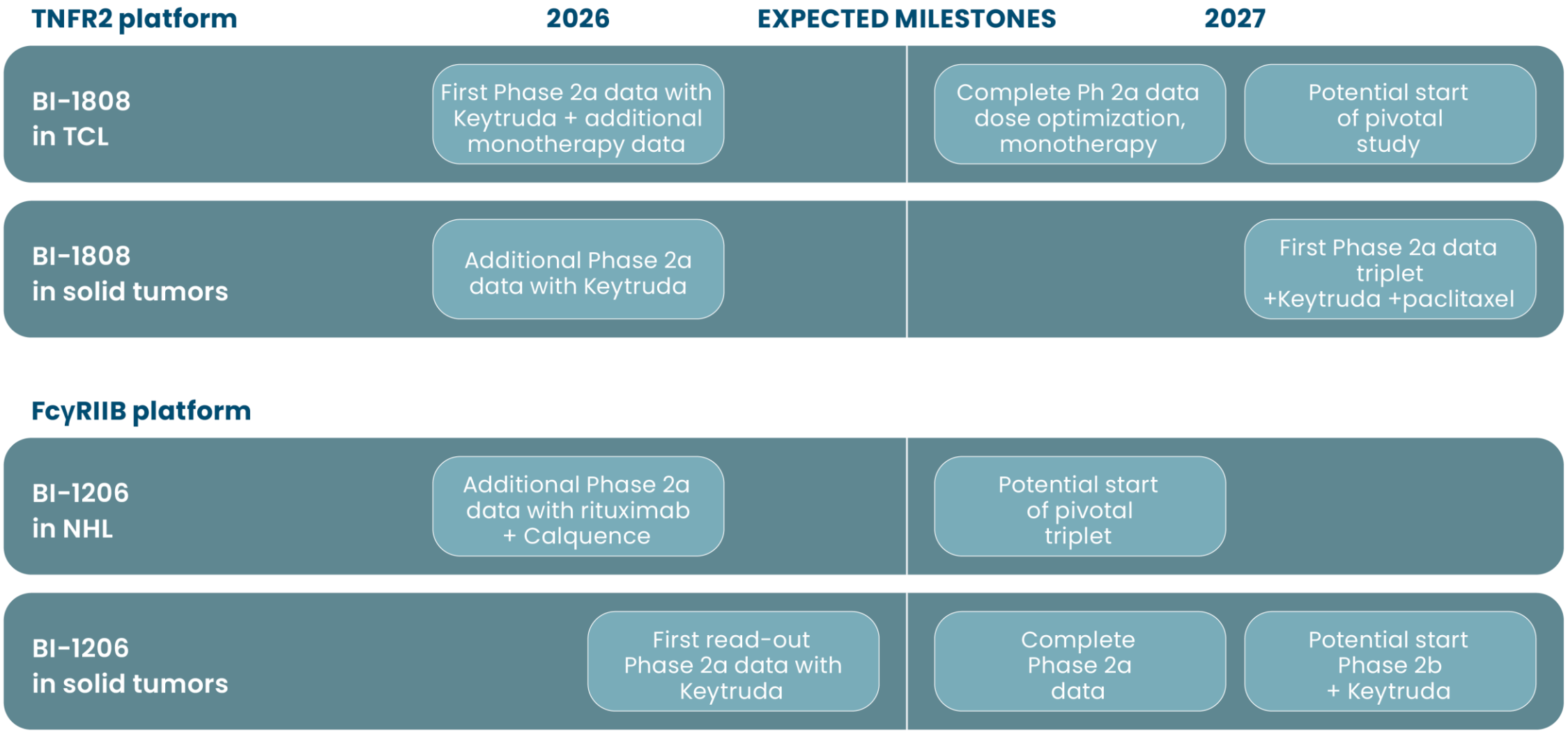
*Approximate peak sales potential

BioInvent

Key Catalysts

2026-2027

Key Expected Milestones 2026-2027



- **Two KOL events: May 27 (BI-1808 in OC) and June 11 (BI-1206 in NHL and BI-1808 in CTCL)**

BioInvent: Unlocking New Immuno-Oncology Pathways

- Two de-risked, first-in-class assets: BI-1206 (FcγRIIB) and BI-1808 (TNFR2)
- Clinical proof of concept achieved: overcoming rituximab resistance in NHL with BI-1206 and efficacy in ovarian cancer and CTCL with BI-1808

Differentiated Pipeline

- High-impact data readouts expected in 2026 in NSCLC and uveal melanoma
- Cash runway through key value inflexions (Q1 2027)
- Cash-efficient operations with fully integrated research capabilities and in-house GMP manufacturing

Efficient Use of Cash

- Multi-Billion Dollar Potential in both hematology (NHL, CTCL) and solid tumor indications (Ovarian, NSCLC, melanoma)
- Flexible partnering terms

Market Potential

BioInvent

bringing antibodies to life

www.bioinvent.com

Appendix

BioInvent Management Team

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Chief Executive Officer
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Stefan Ericsson
Chief Financial Officer
28
pwc · Skatteverket

Andres McAllister, M.D., Ph.D.
Chief Medical Officer
9
UCSF · Institut Pasteur · Debiopharm · bioMérieux · Pierre Fabre · idm Pharma

Björn Frendéus, Ph.D.
Chief Scientific Officer
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Ashley Robinson
SVP Strategy & Finance
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LifeSci Advisors · Guggenheim · Lehman Brothers · Leerink Partners

Ingunn Munch Lindvig, Ph.D.
SVP Regulatory Affairs
3
circio · Nordic Nanovector · Photocure · GE HealthCare

Kristoffer Rudenholm Hansson
SVP Technical Operations
10
AGC Biologics · Your friendly CDMO expert · Dako · Servier · Symphogen

Sylvie Ryckebusch, Ph.D.
Chief Business Officer
4
Merck · Domain Therapeutics · Index Ventures · McKinsey & Company

X Years at BioInvent

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

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

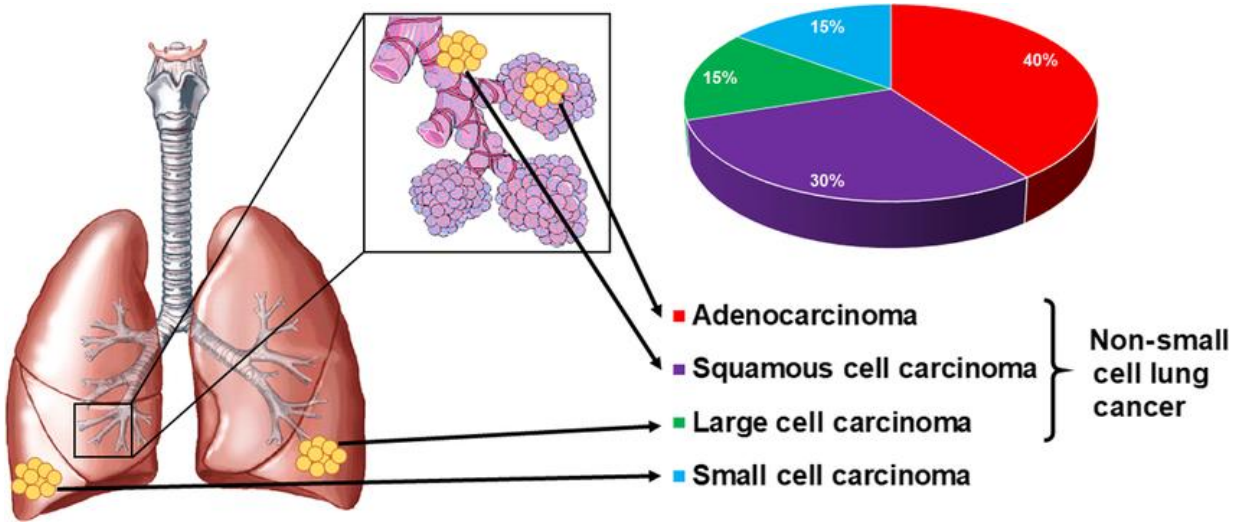
- Not the preferred choice compared to pembro
- Could have slightly more favorable toxicity profile

Chemoimmunotherapy

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

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**		

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

CD3-gp100 fusion protein

KIMMTRAK® (tebentafusp-tebn)
Injection for Intravenous Use 100 mcg/0.5 mL

- Approval restricted to HLA-A*02:01 positive patients (40-50%)
- Common toxicities include CRS, severe skin reactions, and liver enzyme elevation

Liver directed

HEPZATO KIT™
(melphalan) for Injection/
Hepatic Delivery System (HDS)

- 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

Anti-PD-1 + Anti-CTLA-4

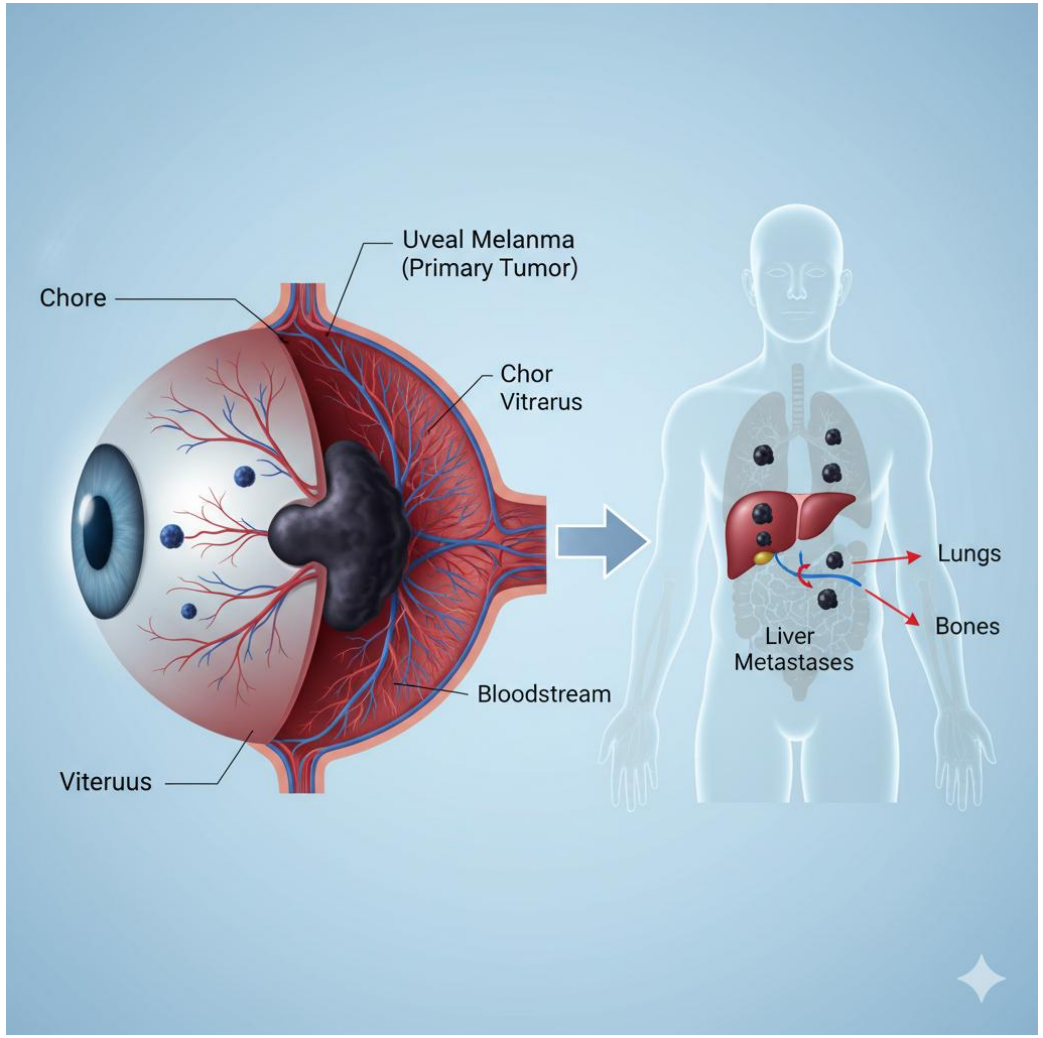
OPDIVO® (nivolumab)
YERVOY™ (ipilimumab)

- 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

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

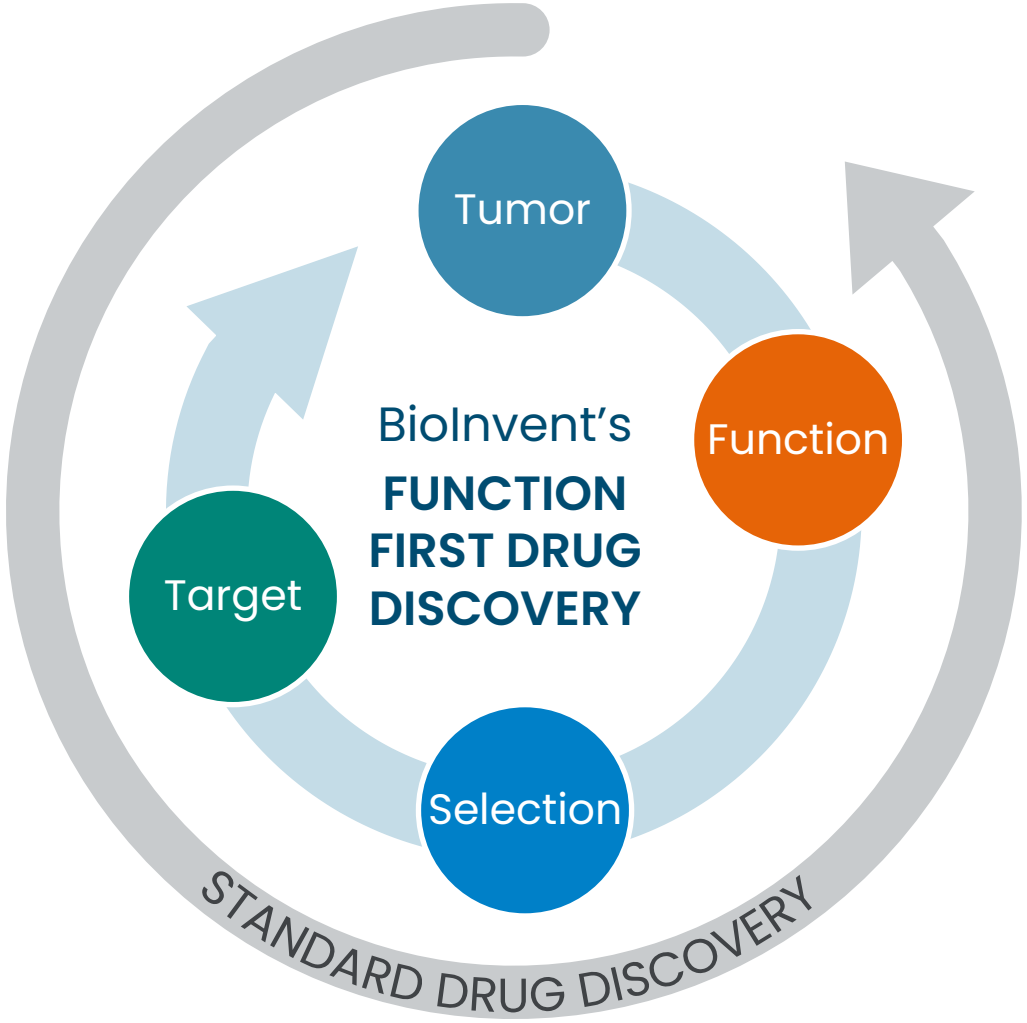
Therapy	Target	Status	Patients	ORR	CR	PFS	OS	Toxicities & Notes
Tebentafusp (Kimmtrak)	CD3 –gp100	Approved	HLA-A*02:01+ (~50% of pts)	9%	<1%	3.3 mo	21.7 mo	CRS, Rash (83%), Pyrexia
Pembrolizumab (Keytruda)	PD-1	Approved	All	12%	0%	3.8 mo		Safe but ineffective as monotherapy
Hepzato (Melphalan/HDS)	chemo	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)**

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

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

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