

IMPROVING ON THE WORLD'S BIGGEST DRUGS

BACKED BY STAND-ALONE EFFICACY

June 2026

 BioInvent

Disclaimer

This presentation is not a prospectus or other offer document and has not been approved by any regulatory authority in any jurisdiction. The information contained in this presentation has been prepared solely for information purposes. It is not intended for potential investors and does not constitute or form part of, and should not be construed as, an offer or solicitation of an offer to subscribe for or purchase any shares or any other securities in BioInvent International AB ("BioInvent"). This presentation does not purport to contain comprehensive or complete information about the company. Neither shall the presentation or any part of it, nor the fact of its distribution or communication, form the basis of, or be relied on in connection with, any contract, commitment or investment decision in relation thereto. Any decision to invest in any securities of the company should only be made on the basis of a thorough and independent investigation of the company itself and not on the basis of this presentation.

This presentation contains forward-looking statements, which are subject to risks and uncertainties because they relate to expectations, beliefs, projections, future plans and strategies, anticipated events or trends and similar expressions concerning matters that are not historical facts. All statements other than statements of historical fact included in this presentation are forward-looking statements. Forward-looking statements give BioInvent's current expectations and projections relating to its financial condition, results of operations, plans, objectives, future performance and business. These statements may include, without limitation, any statements preceded by, followed by or including words such as "target," "believe," "expect," "aim," "intend," "may," "anticipate," "estimate," "plan," "project," "will," "can have," "likely," "should," "would," "could" and other words and terms of similar meaning or the negative thereof. Such forward-looking statements involve known and unknown risks, uncertainties and other factors, which may cause the actual results, performance or achievements of BioInvent or the industry in which it operates, to be materially different than any future results, performance or achievements expressed or implied by such forward-looking statements. Given these risks, uncertainties and other factors, recipients of this presentation are cautioned not to place undue reliance on these forward-looking statements. The forward-looking statements referred to above speak only as at the date of the presentation. BioInvent will not undertake any obligation to release publicly any revisions or updates to these forward-looking statements to reflect future events, circumstances, anticipated events, new information or otherwise except as required by law or by any appropriate regulatory authority. The information included in this presentation may be subject to updating, completion, revision and amendment and such information may change materially.

BioInvent is under no obligation to update or keep current the information contained in this presentation and any opinions expressed in relation thereto are subject to change without notice. BioInvent make no guarantee, representation or warranty, express or implied, as to the accuracy, completeness or fairness of the information and opinions contained in this presentation, and no reliance should be placed on such information. BioInvent does not accept any responsibility or liability whatsoever for any loss howsoever arising from any use of this presentation or its contents or otherwise arising in connection therewith.

BioInvent is Developing the New Standard of Care for Recurring Ovarian Cancer

- \$1.5 billion in estimated peak sales

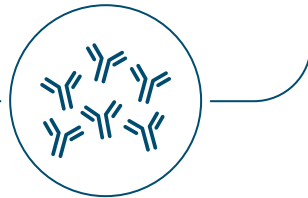
We are Developing Next-generation IO Therapies Designed to Address One of the Biggest Remaining Unmet Needs in Cancer Treatment

What the opportunity is

Checkpoint inhibitors created a major oncology market

Many patients still fail to respond due to resistance

Large pharma seeks differentiated next-generation IO combinations ahead of the PD-1 patent cliff

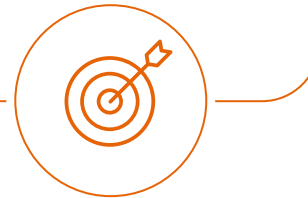


Why BioInvent

BI-1808 and BI-1206 target immune resistance beyond current therapies

Strong anti-tumor activity with favorable safety profile

Potential to enhance efficacy and durability of existing immunotherapies



Why we are well-positioned

Proprietary human-first platform with in-house manufacturing

Multiple Phase 2 studies with upcoming readouts

Proven strategic partnerships backed by leading global healthcare investors



Human biology first. Platform-driven discovery. Breakthrough therapeutics.

Backed by Leading Global Biotech Investors for the Next Phase of Growth

Why this matters



Deep due diligence
Top-class biotech investors with proven expertise



Long-term capital
Institutional investors with a long-term investment horizon



Ability to fund development
Strong financial backing to accelerate clinical programs

Investor takeaway

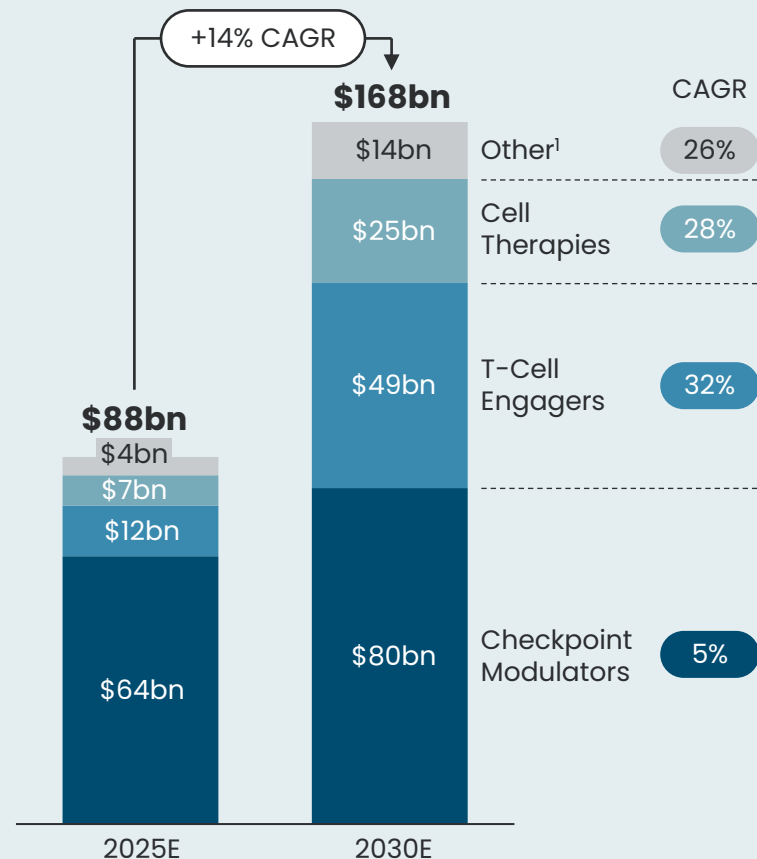


Validated by specialist investors

| Top investors | About the investor | Selected successful investments | | | Ownership |
|--|---|--|--|---|--------------|
| Redmile Group | Leading US biotech investor with deep domain expertise and active ownership | BIONTECH <i>COVID-19 vaccine leader</i> | immur.gen <i>acquired by AbbVie for \$10B</i> | ARRAY BIOPHARMA <i>Acquired by Pfizer for \$11B</i> | 15.2% |
| Van Herk Groep | Global biotech investor with a strong track record of building leading biopharma companies | ZEAL& ZEALAND PHARMA <i>Rare disease leader</i> | argenx <i>Vyvgart® (efgartigimod)</i> | Abylynx <i>Acquired by Sanofi for \$3.9B</i> | 13.8% |
| Forbion. | Forbion is a leading venture capital firm working with Scientists/entrepreneurs to build companies | argenx <i>Vyvgart® (efgartigimod)</i> | Versanis <i>Acquired by Eli Lilly for 2b</i> | uniQure <i>AMT-061 (hemophilia B) approved (US, EU)</i> | 9.8% |
| HBM Healthcare Investments | Global healthcare investor backing high-growth and transformative companies. | ABIVAX <i>RNA immune-modulation</i> | argenx <i>Vyvgart® (efgartigimod)</i> | CATHAY INDUSTRIAL BIOTECH <i>Industrial synthetic-biology leader</i> | 7.7% |
| OMEGA FUNDS | Global life sciences investor focused on the world's most urgent medical needs | IMMUNOCORE <i>First TCR therapy approved</i> | bridgebio <i>Rare disease Nasdaq IPO</i> | Prevail THERAPEUTICS <i>Acquired by Lilly for \$1B</i> | 3.8% |
| FJÄRDE AP-FONDEN | Swedish national pension fund deploying long-term capital into high-conviction listed and private biotech | BIOARCTIC <i>Lecanemab® approved (US, EU)</i> | camurus. <i>Buvidal® approved</i> | calliditas THERAPEUTICS <i>Acquired by Asahi Kasei for \$1.2B</i> | 6.1% |
| Total ownership by top investors: 56.4% | | | | | |

The Immuno-Oncology (IO) Market Continues to Grow as Licensing Activity Accelerates

The immuno-oncology market is a \$168bn opportunity...



...but there is a few bottlenecks²

- #1 Immunosuppressive tumor microenvironment
- #2 Tumor heterogeneity
- #3 Low immunogenicity of tumor
- #4 Lack of suitable target antigens
- #5 Clinically relevant biomarkers

BioInvent targets the #1 challenge in IO therapy



Key insights

\$64bn

Checkpoint Modulators market in 2025. BioInvent's core target market.











\$150bn

US & EU IO licensing deal value reached peak levels in 2023, highlighting strong partnering demand

Notes: 1) Other include cancer vaccines, oncolytic viruses and cytokines, 2) High-Prescriber Survey (March 2025)
Source: GlobalData.

The Coming IO Patent Cliff Creates a Strategic Opening

Key IO therapies facing loss of exclusivity

| Drug (brand) | Company | Target | 2025 sales | Earliest expected LOE / biosimilar entry | | Notes |
|--|---|--------|-----------------------|--|----------------------------|--|
| | | | | US | EU | |
|  (pembrolizumab) |  | PD-1 | \$31.6bn | 2028 (earliest) | ~2031 (earliest) | Numerous patents expire 2028-2031 across key markets |
|  (nivolumab) |  | PD-1 | \$10.0bn | 2028 (earliest) | ~2030 (earliest) | Broad patent estate with key expiry 2028-2030 |
|  (atezolizumab) |  | PD-L1 | \$4.6bn ¹⁾ | ~2029-2031 | ~2029-2032 | PD-L1 class patents expire across 2028-2035 |
|  (durvalumab) |  | PD-L1 | \$6.0bn | ~2029-2031 | ~2029-2032 | PD-L1 class patents expire across 2028-2035 |
|  (Cemiplimab) |  | PD-1 | \$1.4bn | ~2032 | ~2033 | Later LOE relative to other PD-1 franchises |

What this means

> ~\$56bn in annual sales exposed to biosimilar competition



> Large pharma will need new mechanisms to defend, extend or replace revenue streams





> Strong strategic incentive to partner on differentiated assets that enhance PD-1 / PD-L1 therapies



> Combination innovation will be critical to drive differentiation and sustain growth



BiolInvent has First-in-class Clinical Assets Advancing Across Multiple Indications

| Compound/Indication | | Phase 1 | Phase 2a | Phase 2b | Milestone |
|---|--|---------|----------|-------------------|---|
|  <p>TNFR2</p> <p>BI-1808</p> | Ovarian cancer Pembrolizumab ¹ | | Ongoing | | → Phase 2a data at ASCO |
| | Ovarian cancer Pembrolizumab ¹ + Paclitaxel | | Planned | | → Phase 2a initiation end 2026 / data expected end 2027 |
| | CTCL Single agent | | Ongoing | Preparatory phase | → Phase 2a data June 2026 (EHA) |
| | CTCL Pembrolizumab ¹ | | Ongoing | | → Phase 2a data June 2026 (EHA) |
|  <p>FcγRIIB</p> <p>BI-1206</p> | NHL (FL, MCL, MZL) Rituximab + Acalabrutinib ² | | Ongoing | Preparatory phase | → Phase 2a data June 2026 (EHA) |
| | NSCLC 1L Pembrolizumab ¹ | | Ongoing | Preparatory phase | → Phase 2a data expected H2 2026 |
| | Uveal melanoma 1L Pembrolizumab ¹ | | Ongoing | | → Phase 2a data expected H2 2026 |

1L: First line treatment

CTCL: Cutaneous T-cell Lymphoma, NHL: Non-Hodgkin's Lymphoma, FL: Follicular Lymphoma, MCL: Mantle Cell Lymphoma, MZL: Marginal Zone Lymphoma, NSCLC: Non-small cell lung cancer

Notes: 1) Supply agreement with Merck, 2) Supply agreement with AstraZeneca

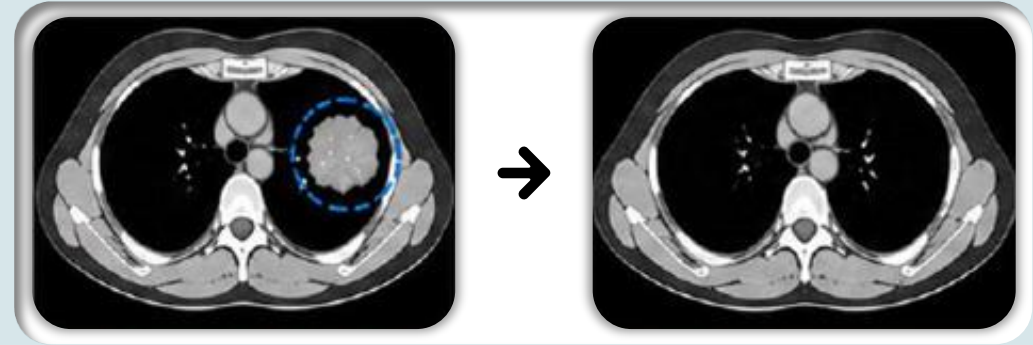
BioInvent Phase 1/2 Responses Demonstrate Strong Anti-tumor Activity

200+ patients have so far been included in BI-1808 and BI-1206 clinical trials • ~ 50 patients with CRs and PRs combined



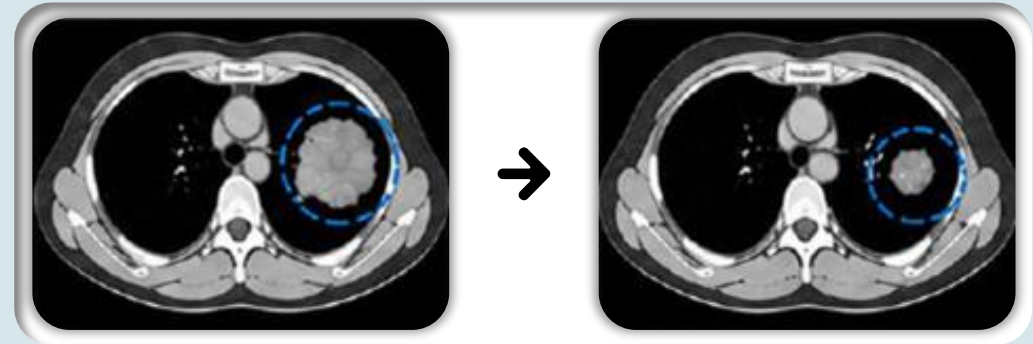
**Complete
Response
(CR)**

Tumor disappears



**Partial
Response
(PR)**

Tumor shrinks



**Why this
matters**

- *Strong signal of drug efficacy*
- *Large unmet medical need for new, safer treatments with longer duration of response*
- *Supports progression to later-stage and registrational trials*



BioInvent Phase 2 programs BI-1808 and BI-1206



ANTI-TNFR2

BI-1808 in Ovarian Cancer

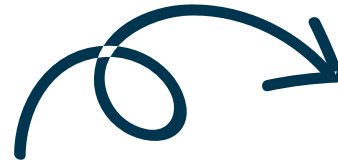
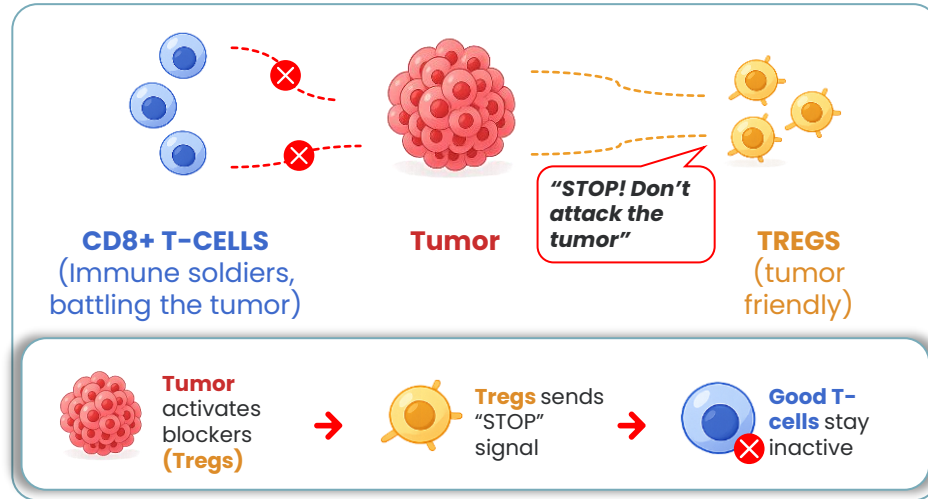
BI-1808 in T-cell Lymphoma



BI-1808 in Ovarian Cancer – Reactivates Immune System by Targeting Tregs

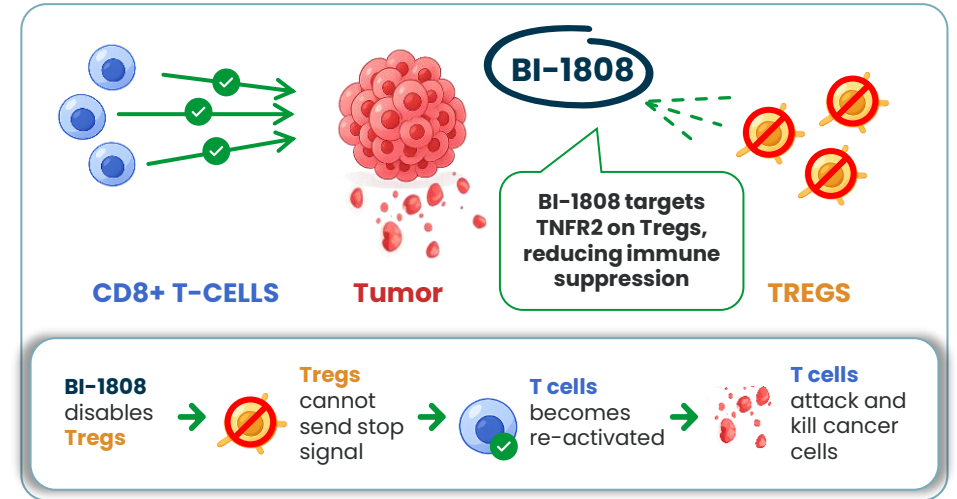
Transitioning the microenvironment from tumor friendly to tumor hostile

Targets TNFR2 on Tregs, reducing tumor-driven immune suppression



BI-1808

BI-1808 induces Treg depletion and myeloid reprogramming to unleash CD8+ T cells



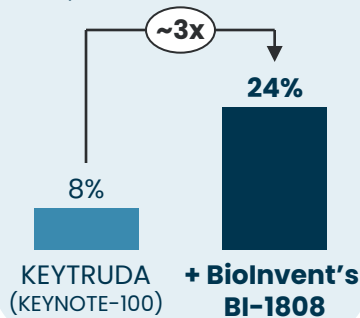
Best-in-class potential

First-in-class TNFR2 antibody with strong efficacy/safety profile

TNFR2 = Immune receptor regulating suppressive Tregs

Enhances the effect of standard therapies

Response in combination¹



Combination potential

Designed for combination with existing therapies like Keytruda® and other standard-of-care treatments

Strong safety profile

Well-tolerated in early clinical studies

Durable responses

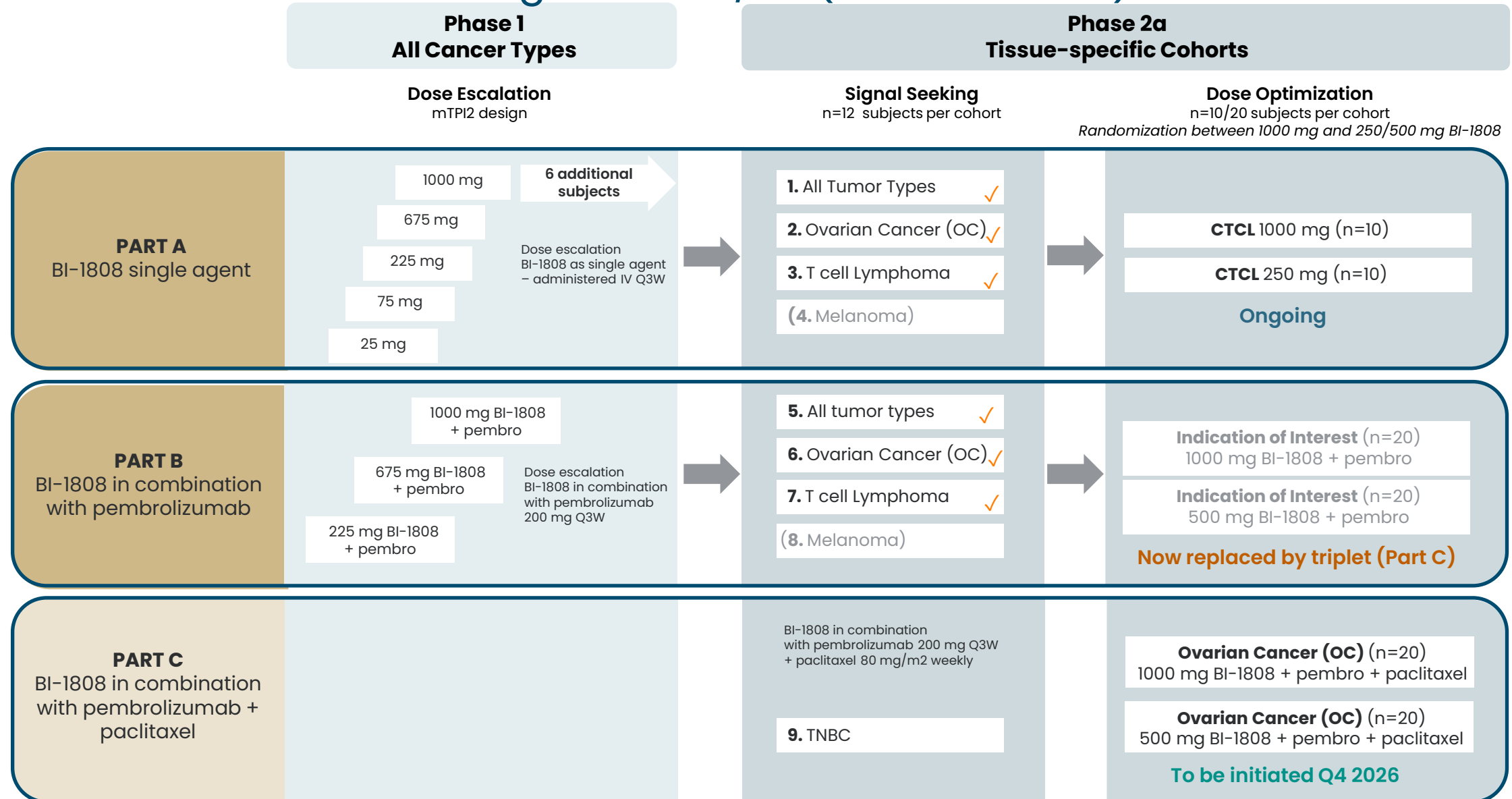
Durable responses observed (up to ~3 years)

Opportunity

Large and expanding combination market

Notes: 1) ORR In combination with Keytruda Pembrolizumab in MSS CRC (NCT05493767), 2) Durability data from ongoing clinical programs across indications; complete responses up to ~3 years observed in some patients.

BI-1808 Clinical Trial Design Phase 1/2A (KEYNOTE-D20)

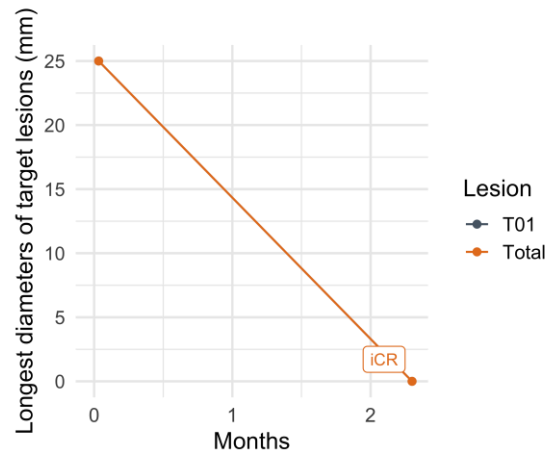


BI-1808 Single Agent Case Study: Complete Response in Ovarian Cancer

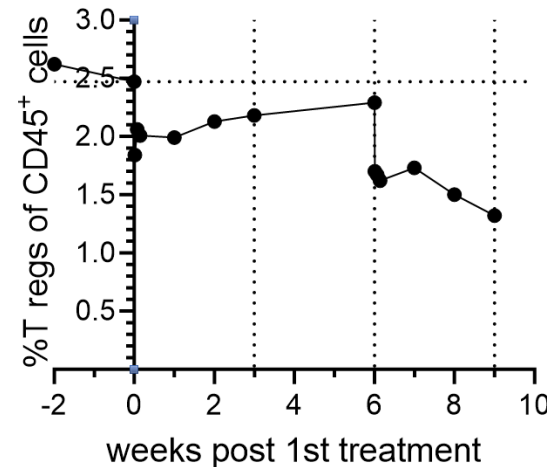
Baseline



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:

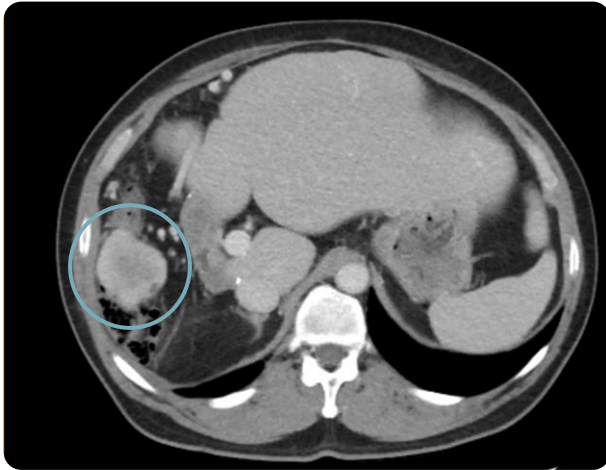
- Paclitaxel/carboplatin
- Carboplatin/doxorubicin
- Olaparib
- Bevacizumab/topotecan

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

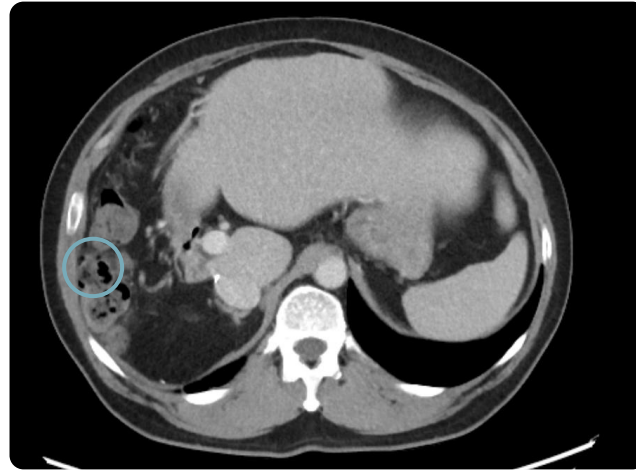
At first post-treatment scan, 9 weeks after the start of treatment, no quantifiable tumor mass could be measured.

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

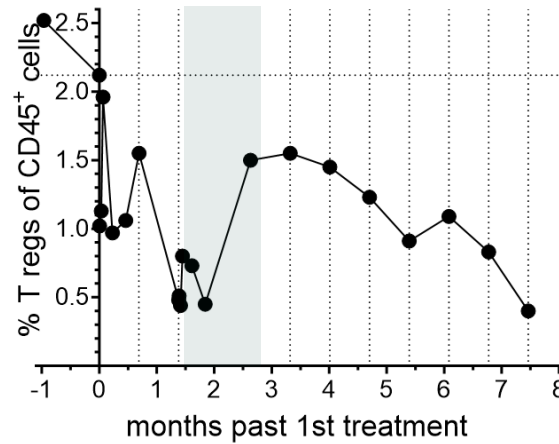
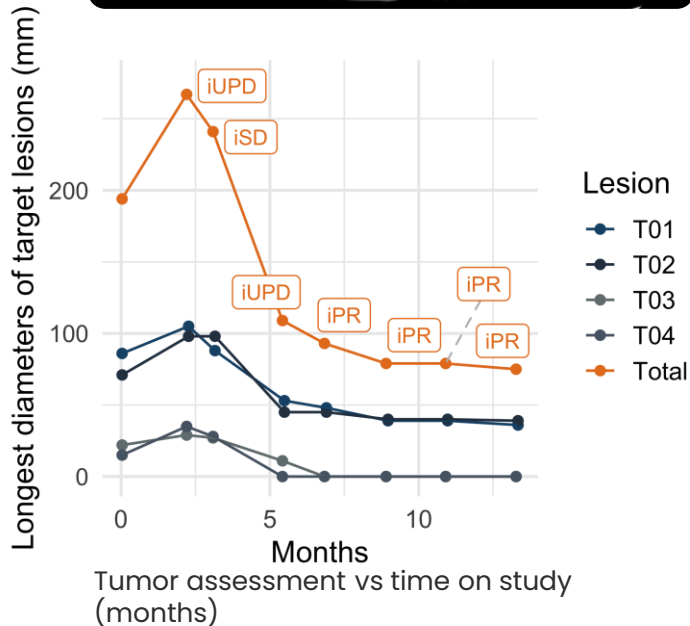
Baseline



Follow-up 13 months

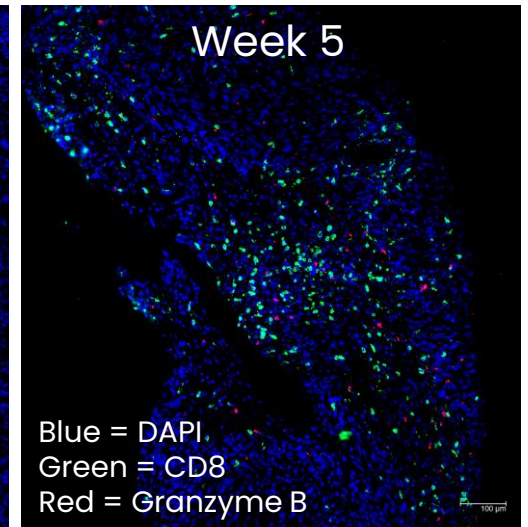
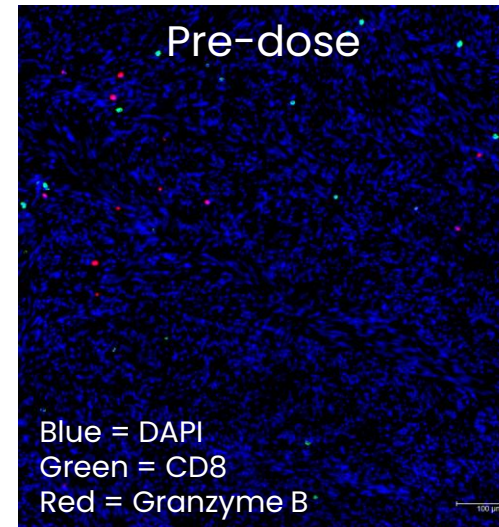


55-year-old male patient with GIST, who presented with clinical PD for more than six months with multiple metastatic lesions.
12 previous lines of therapy.



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

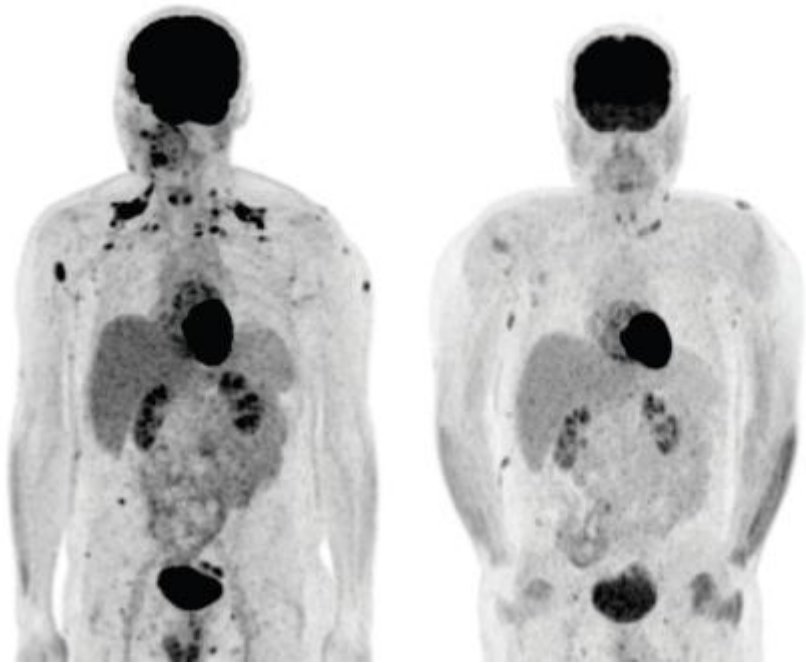
*GIST: Gastrointestinal Stromal Tumor
ASCO 2024 Poster #2641 BI-1808

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)



WHAT'S NEXT?

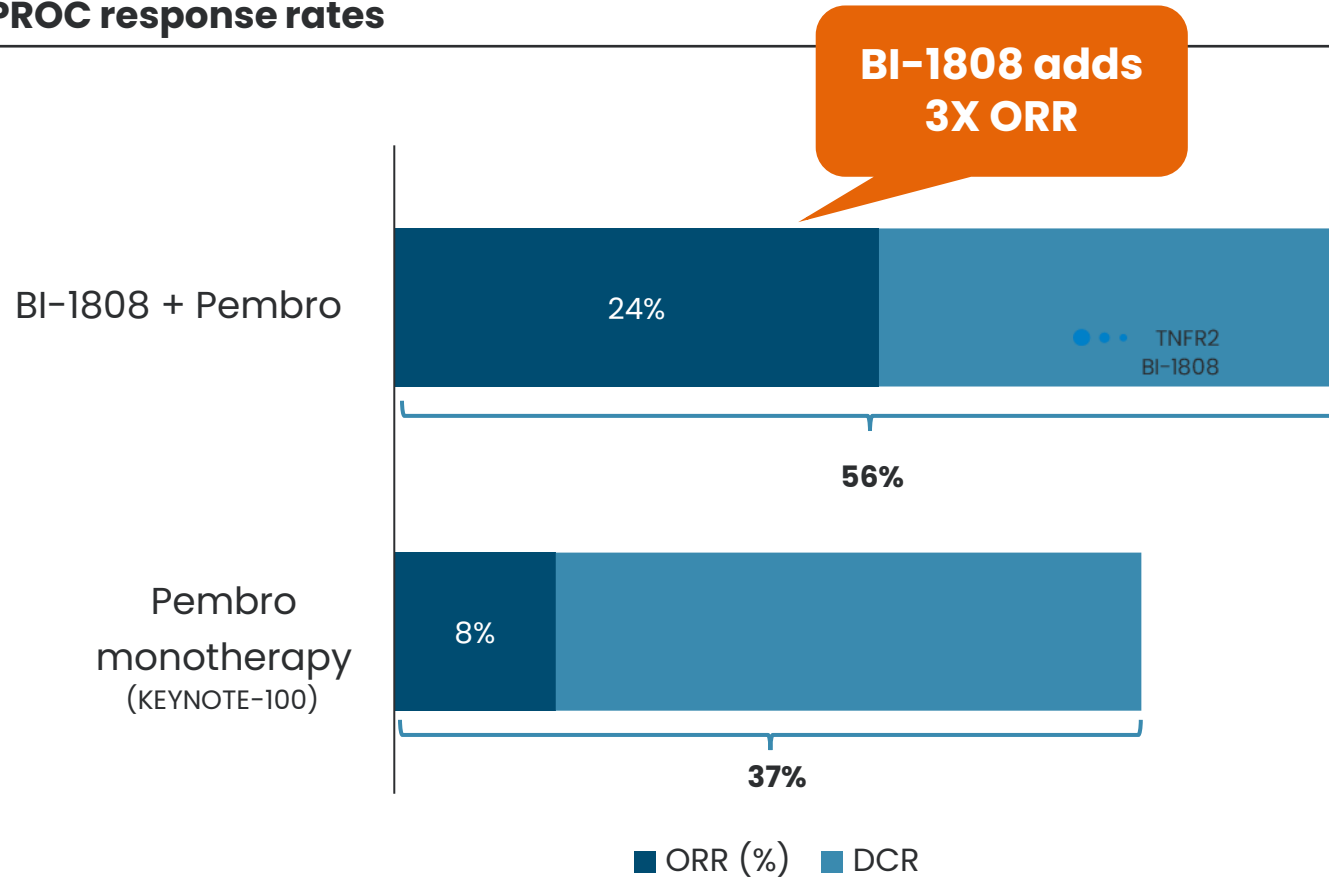
Additional monotherapy and combination data, **KOL event June 11, 2026**

BI-1808 in Ovarian Cancer

Despite Global Dominance in Oncology, Pembrolizumab has Demonstrated Underwhelming Response Rates in Ovarian Cancer

BioInvent's BI-1808 + pembrolizumab are outperforming pembro alone (Phase 2a data)

PROC response rates

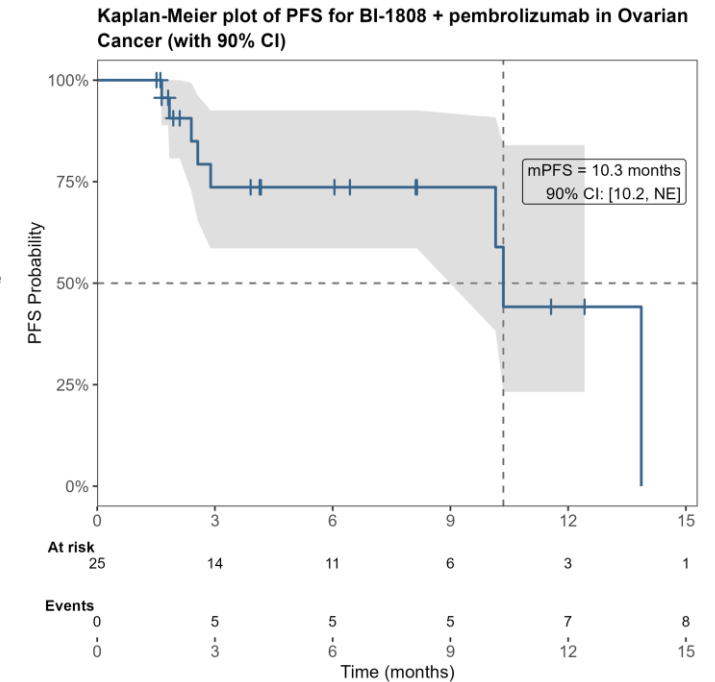
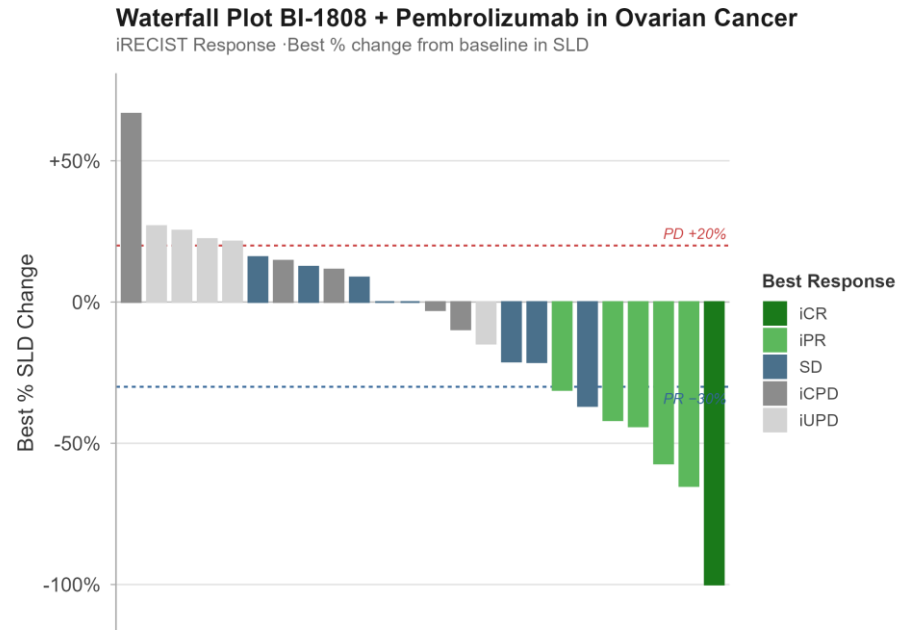


BI-1808 + Pembrolizumab: Promising Efficacy In Ovarian Cancer

Phase 2a Design

| Phase / Design | Population | N | Dosing | Sites | Key Endpoints | Data Cut-off |
|---------------------------|-------------------|----------|--|-------------------|---------------------------|--------------|
| Ph2a single arm (doublet) | OC (all subtypes) | 25 of 40 | BI-1808 1000 mg Q3W Pembro 200 mg Q3W | 8 (OC) in EU & UK | Safety ORR exploratory | 2026-04-20 |

- **24% ORR, 56% DCR** in 25 evaluable patients: 1 CR + 5 PR + 8 SD (several durable beyond 10 months and ongoing)
- **Activity in both subtypes:** high-grade serous (HGSA) and clear cell (ccOC)
- **mPFS 10.3 months (90% CI: 10.2, NE):** 9/25 patients still on treatment – PFS continues to mature and final readout expected H2 2026 (n=40)



Late Responses Signal Deeper, More Durable Activity: A Feature of BI-1808's Mechanism

HGSA (high-grade serous) — responses observed

ccOC (clear cell) — responses observed

Both subtypes represented in the spider plot.

Late responses: a hidden positive feature

Some lesions increase in size initially before decreasing — consistent with pseudoprogression often seen with other immunotherapies.

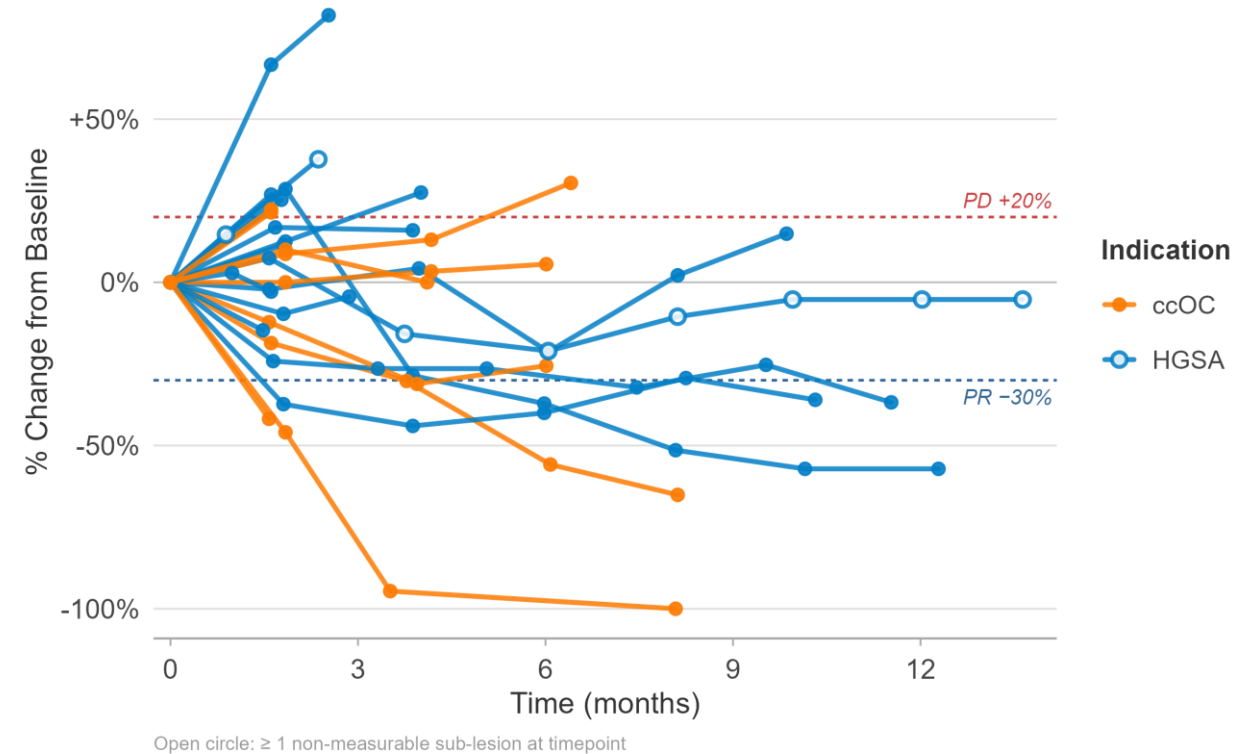
- ✓ Consistent with BI-1808's mechanism: CD8+ T-cell expansion takes time
- ✓ Confirmed preclinically in vivo — not an artifact

9 of 25 patients still on treatment

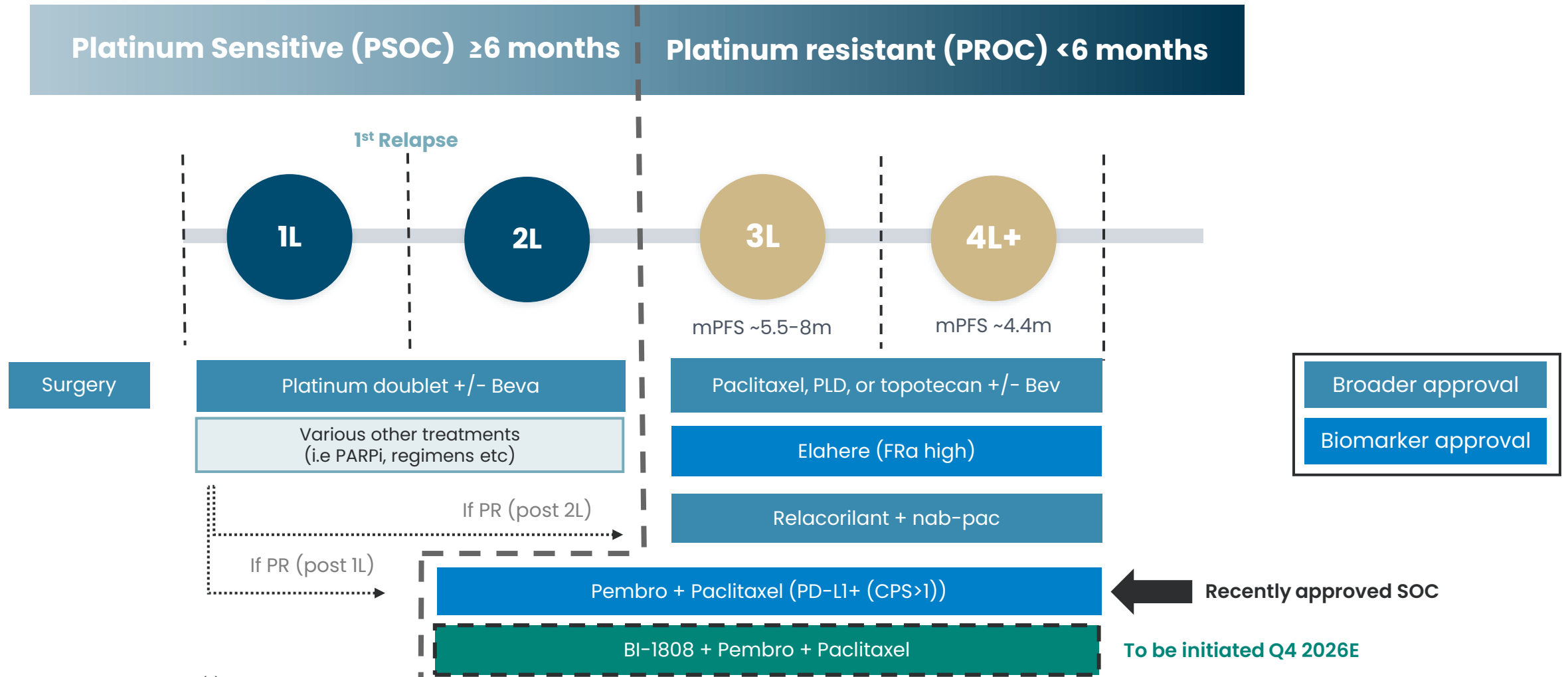
Responders may not yet be captured in the interim 24% ORR, suggesting the final readout could be stronger

BI-1808 + Pembrolizumab in Ovarian Cancer

Change in sum of longest diameters from baseline · iRECIST



The Treatment Paradigm is Shaped by Platinum Sensitivity and Biomarker Status; With Few Recent Approvals in PROC*



*PROC: Platinum-Resistant Ovarian Cancer

1. Poveda A et al Lancet Oncol. 2021 May;22(5):620-631
2. Mirza MR et al N Engl J Med. 2016 Dec 1;375(22):2154-2164.
3. Aghajanian C J et al. Clin Oncol. 2012 Jun 10;30(17):2039-45.
4. Coleman RL et al. Lancet. 2017 Oct 28;390(10106):1949-1961
5. Harker LC, et al. Ann Oncol. 2012;23(10):2605-12
6. González-Martín et al. Ann Oncol. 2023 Oct;34(10):833-848

BioInvent's BI-1808 as the Next Standard of Care in Ovarian Cancer

If BI-1808 Target Product Profile in PROC is met, the peak sales is estimated at ~\$1.5 billion (base-case)




CURRENT

- Standard of care (SoC) in ovarian cancer the chemotherapy drug paclitaxel added to Keytruda, but **survival still poor**

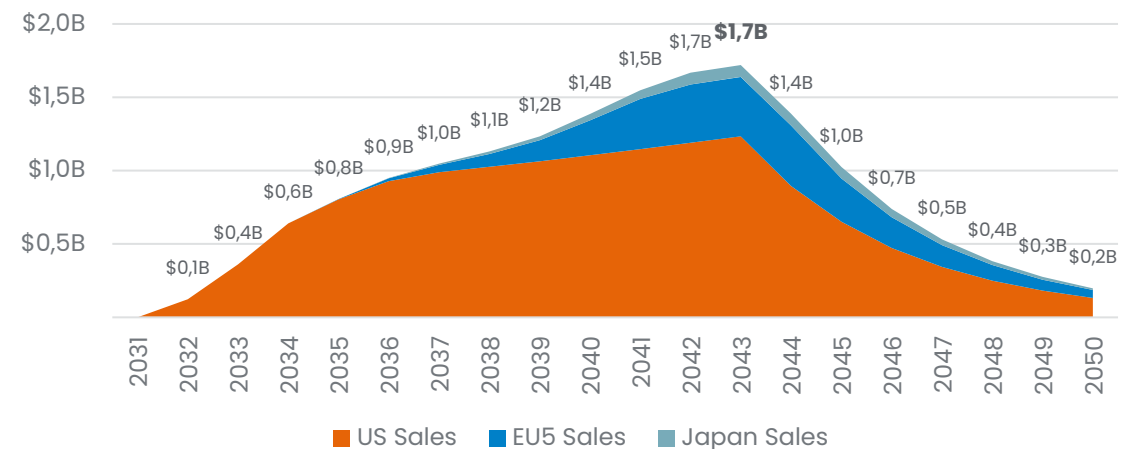
NEXT

- BI-1808 on top of current SoC: preclinical results show **effect beyond current therapies**
- In upside**, all-comer case: % increase in potential patients will yield similar % increase in peak sales

FORECAST

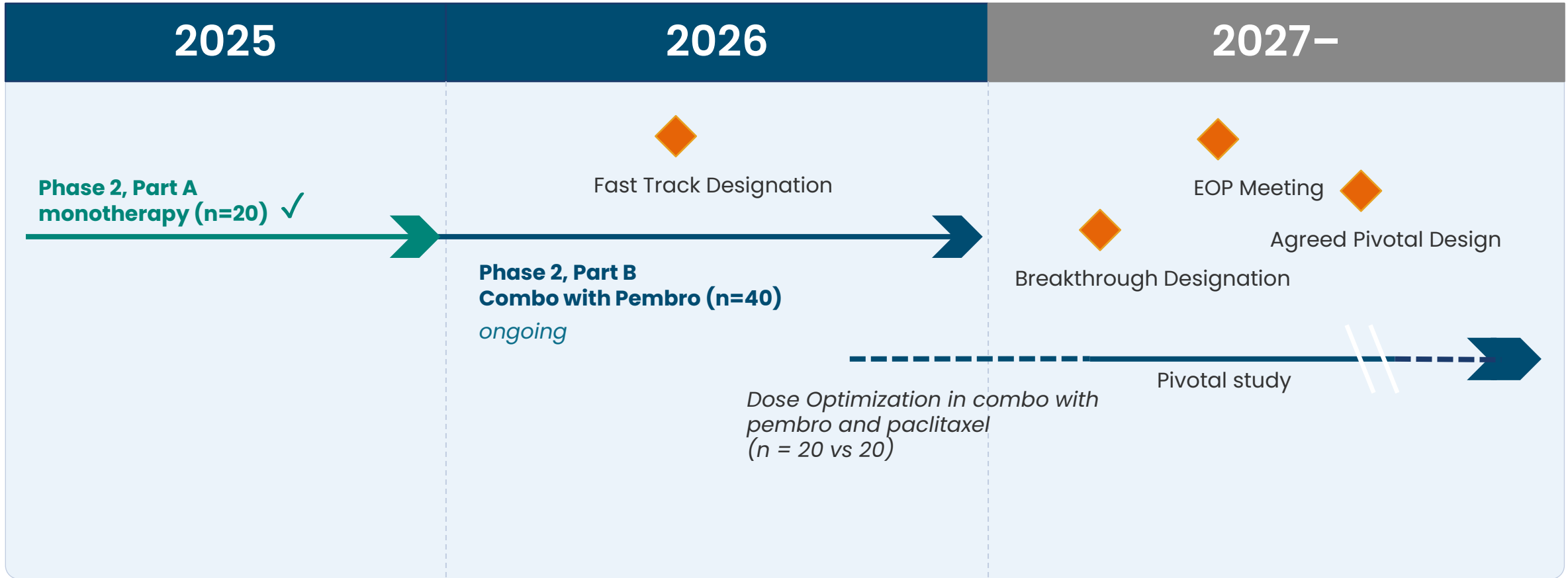
| Region | Peak Sales | Peak Year |
|---|--------------------|-------------|
|  US Sales (\$K) | \$988,608 | 2037 |
|  EU5 Sales (\$K) | \$396,504 | 2042 |
|  Japan Sales (\$K) | \$82,250 | 2042 |
| 7MM Total Sales (\$K) | \$1,719,786 | 2043 |

7MM Revenue Forecast



SoC: a recognized benchmark of competence, quality, and broadly accepted practice. This is a very preliminary 7MM forecast, given the early stage of the program. Many assumptions are placeholders until more is known about the program, its' data and the market. Current assumptions have not been tested in market research.

BI-1808 In Ovarian Cancer: Pivotal Path* With Milestones in Sight



Where we are today:

Interim doublet data at ASCO 2026 (24% ORR, 56% DCR, n=25/40) | Final doublet readout H2 2026 (n=40) | Triplet initiation H2 2026

EOP: End of Phase 2 meeting with FDA to agree pivotal trial design; pembro: pembrolizumab; ORR: Overall Response Rate; DCR: Disease Control Rate

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

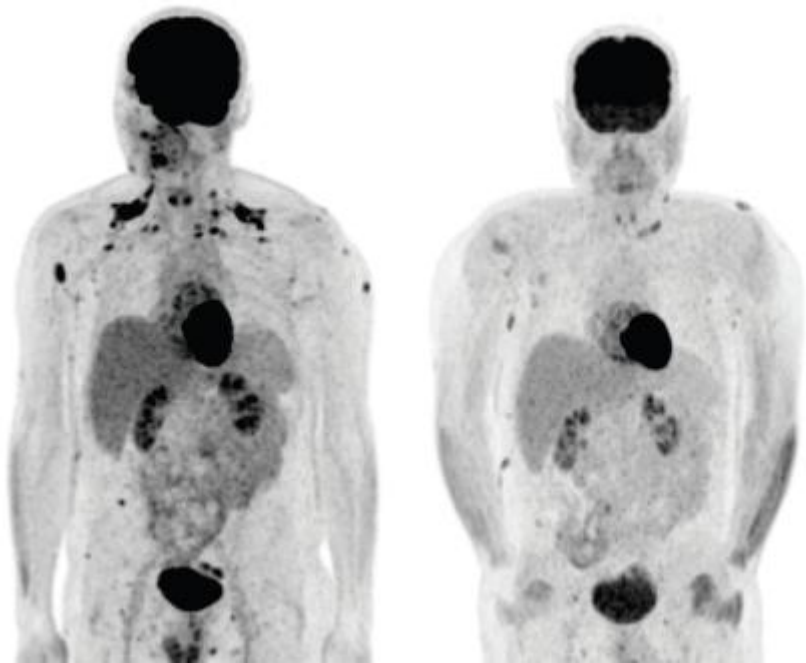
BI-1808 in CTCL

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)



Baseline

Week 9

CTCL Patient

(stage IIb MF, 5 prior lines of treatment)



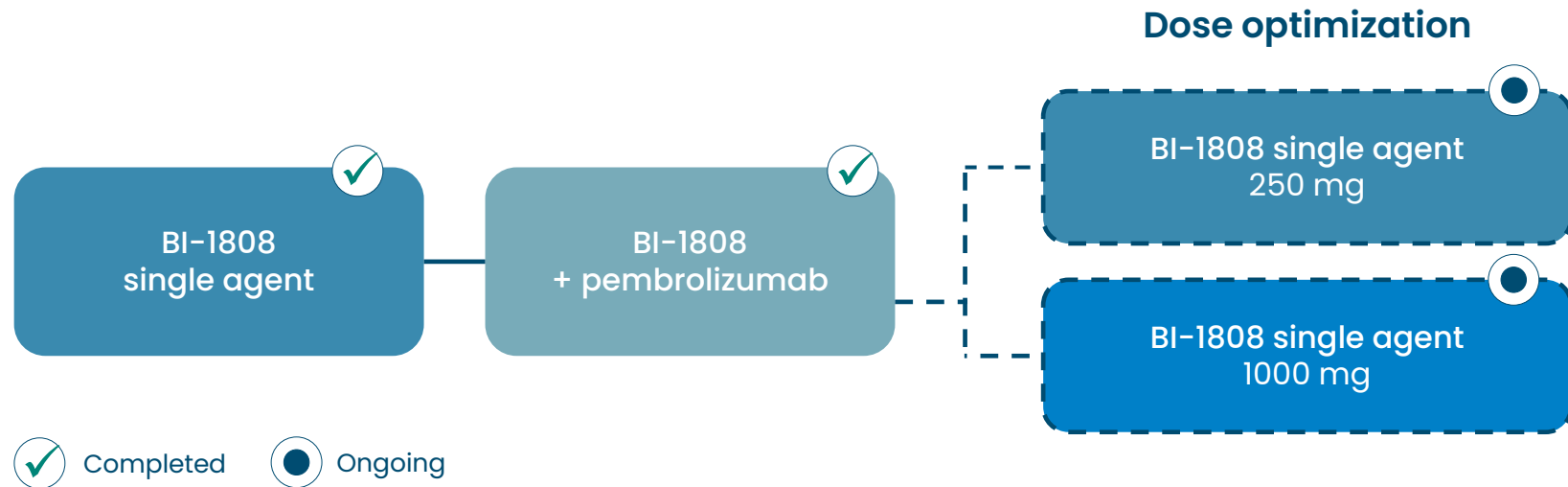
Baseline

Week 21

BI-1808 Clinical Phase 1/2a Study Overview

- Safety and preliminary efficacy currently investigated in CTCL patients (sub-cohort of the ongoing Phase 2a clinical trial)
- 20 patients enrolled for BI-1808 1000 mg as single agent every third week (Q3W)
- Followed by 10 patients treated with the combination of BI-1808 and pembrolizumab
- Currently enrolling 10 vs 10 patients evaluating BI-1808 at 250 mg vs 1000 mg Q3W as single agent

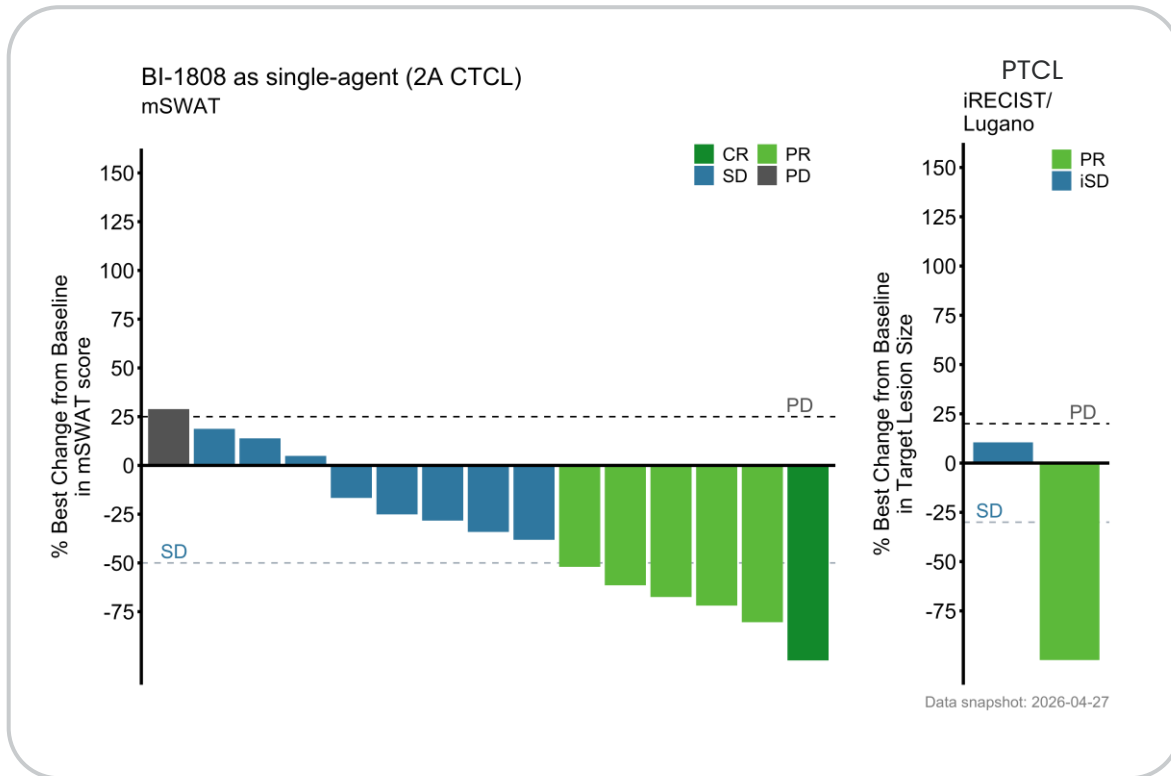
Orphan Drug Designation for TCL
Fast Track Designation for CTCL



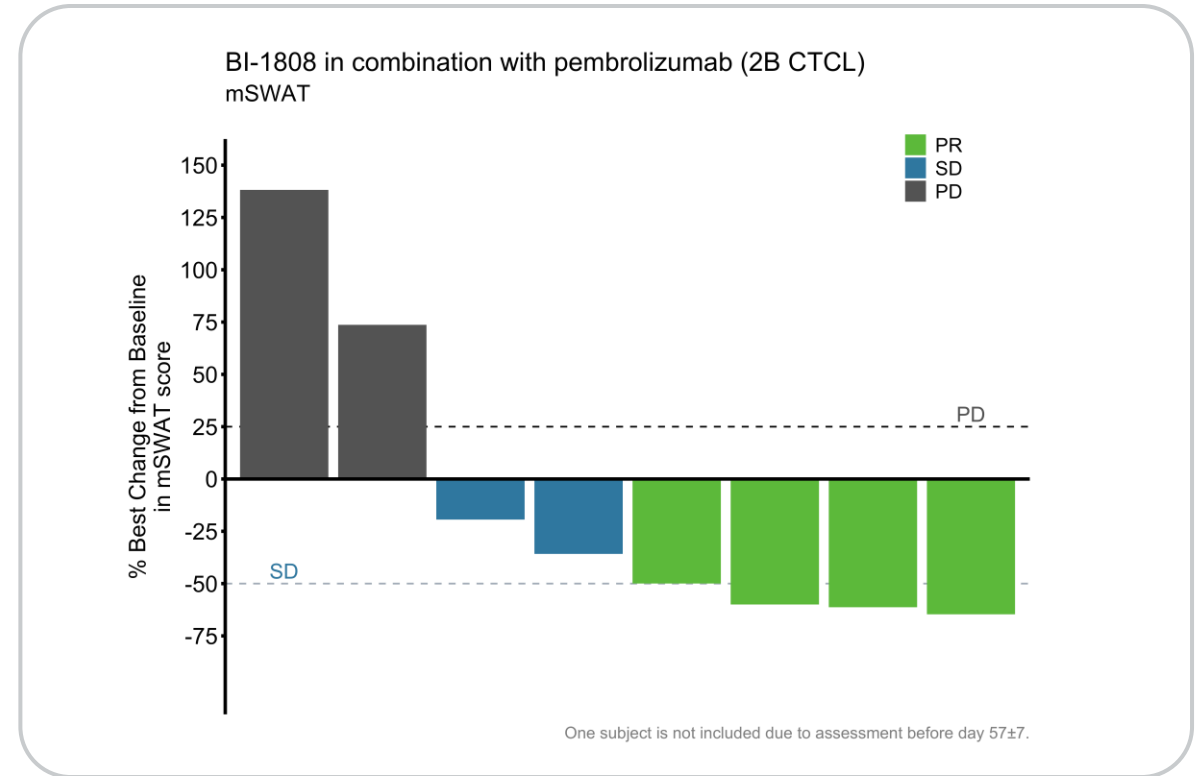
BI-1808 Shows Promising Efficacy in CTCL (and PTCL)

EHA 2026 poster Phase 2a monotherapy & combination data

Single Agent (2A CTCL) – mSWAT



+ Pembrolizumab (2B CTCL) – mSWAT



40%

ORR

5 PRs + 1 CR

93%

DCR

15 evaluable pts

1 CR

SS ongoing 2+ yrs

50%

ORR

4 PRs

75%

DCR

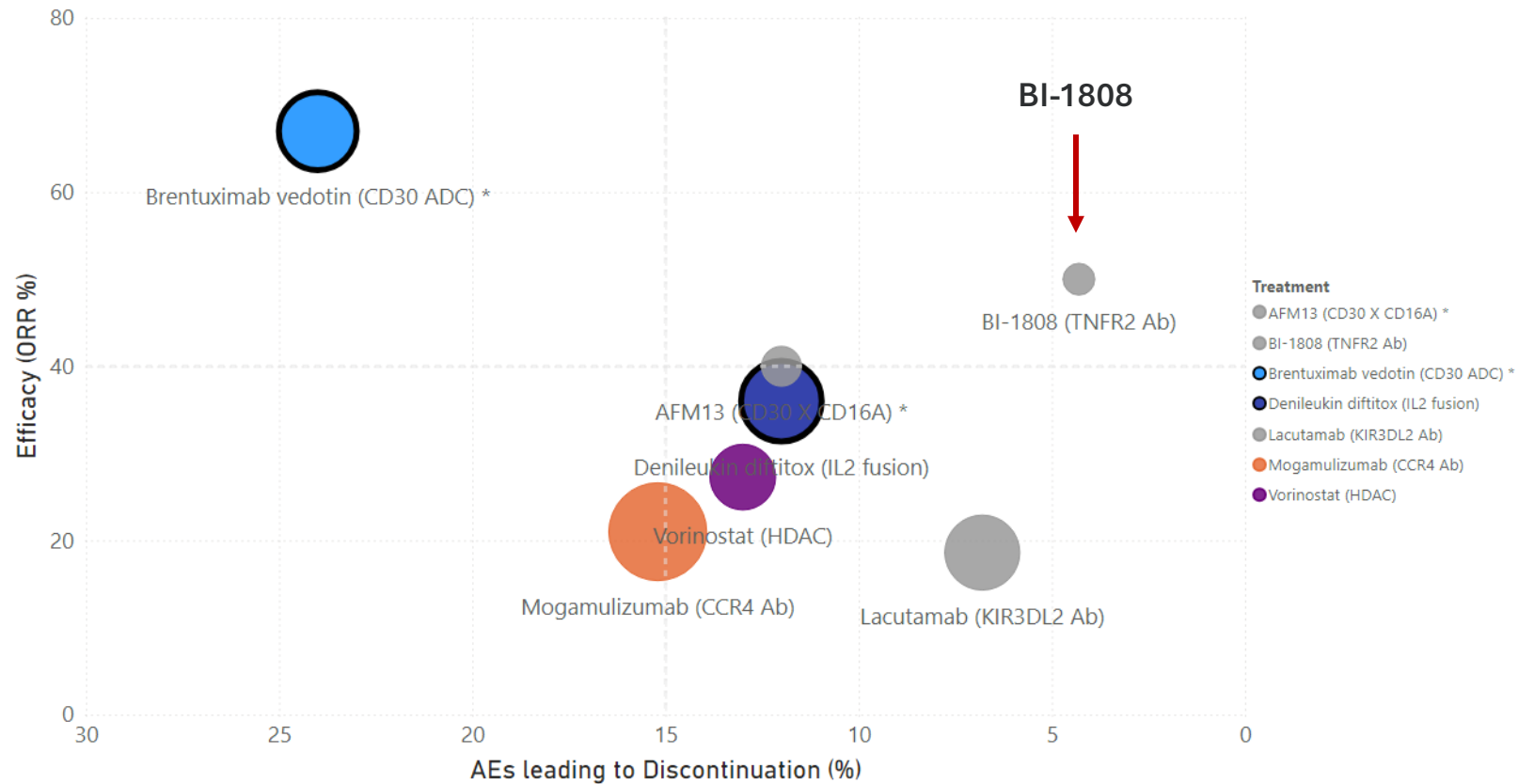
8 evaluable pts

4 PR

BI-1808 is Differentiated Where it Matters Most: Mycosis Fungoides

MF represent the majority of CTCL patients (~70%), and where incumbents are weakest

MF CTCL Competitive Landscape



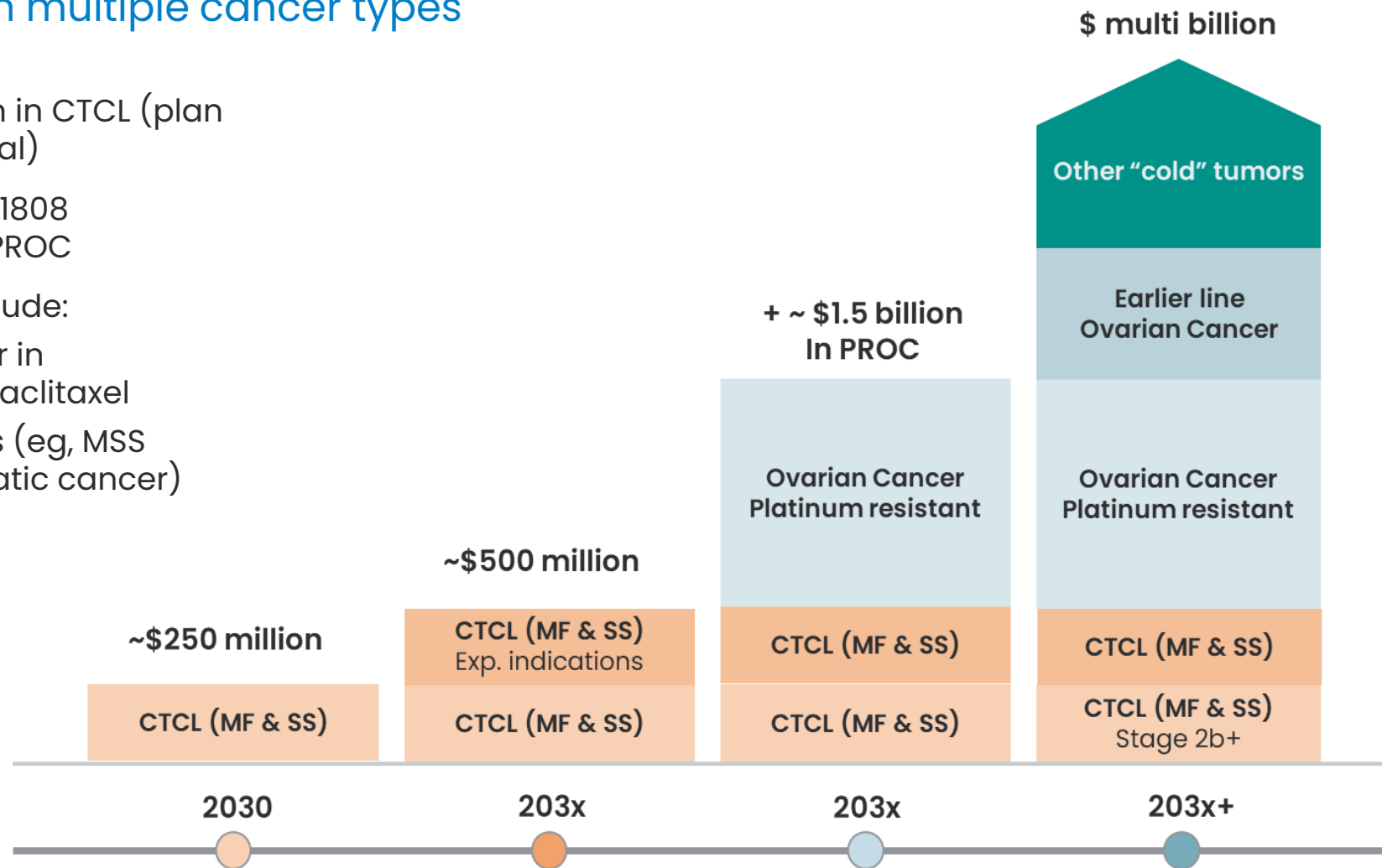
- Higher efficacy in MF than all other treatments except for brentuximab (30% of patients, black box warning)
- No biomarker restriction
- Best-in-class tolerability with only 4% discontinuation

* Biomarker-selected subpopulation; Bubble size represents number of patients in reported dataset; Colored bubbles are approved treatments; Grey bubbles are unapproved treatments; Dark outline signifies black box warning

A Pragmatic Development Strategy With Billion-Dollar Potential

BI-1808 market potential in multiple cancer types

- Pursue **Fast to market** indication in CTCL (plan for BTM and accelerated approval)
- **Develop triplet regimen** with BI-1808 +pembrolizumab+paclitaxel in PROC
- Future development options include:
 - Earlier lines of ovarian cancer in combination with pembro+paclitaxel
 - Other myeloid-driven tumors (eg, MSS Colorectal cancer or pancreatic cancer)
 - Other “cold” tumors



ANTI-FcγRIIB

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

BI-1206 in Solid Tumors



BI-1206 in NHL

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

Similar Treatments

Lenalidomide-based regimens

- Prolonged **management of side effects** requiring frequent clinic visits and monitoring



Infection Rates



Adverse Events



Grade 3-4 neutropenia

Bispecific T-cell engagers

- **45-65%** of patients experience **CRS**¹
- Frequent clinic visits and hospital admissions required



CAR-T

- Antibiotic treatment and IVIG infusions required
- Treatment at **specialized centers** requiring in-patient stays and frequent visits
- Very **high cost**



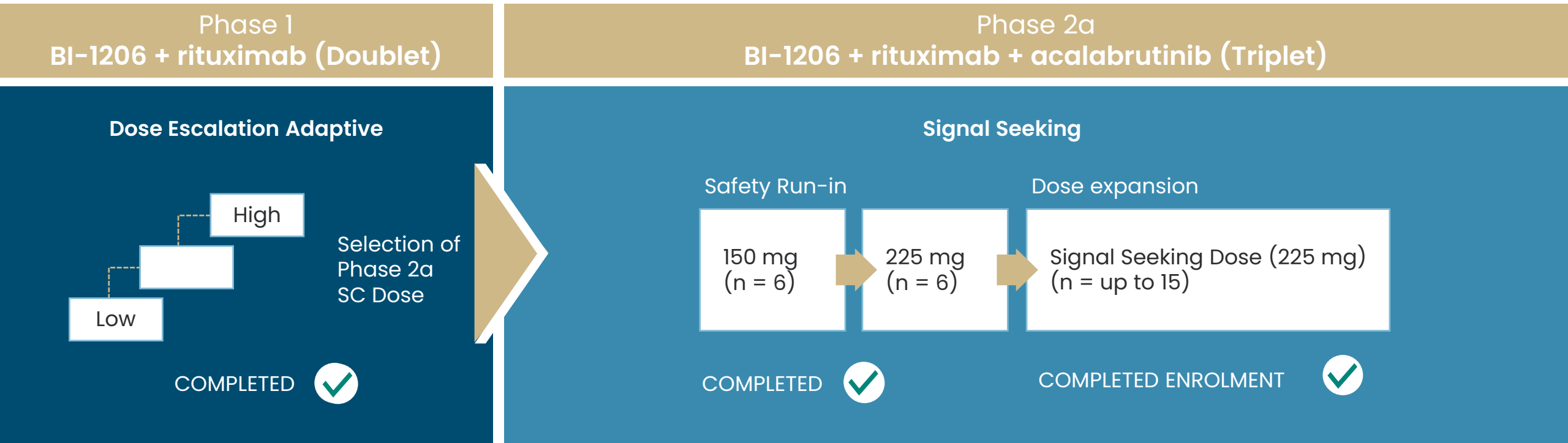
Prolonged cytopenias

In contrast:

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

BI-1206 Clinical Study Overview

- Phase 1: BI-1206 enhances the activity of rituximab
- Phase 2a: Adding acalabrutinib to the combination results in impressive efficacy and safety



Triplet Combination Results in High Response Rates Across NHL Subtype

83% ORR (n=23)

48% CRR

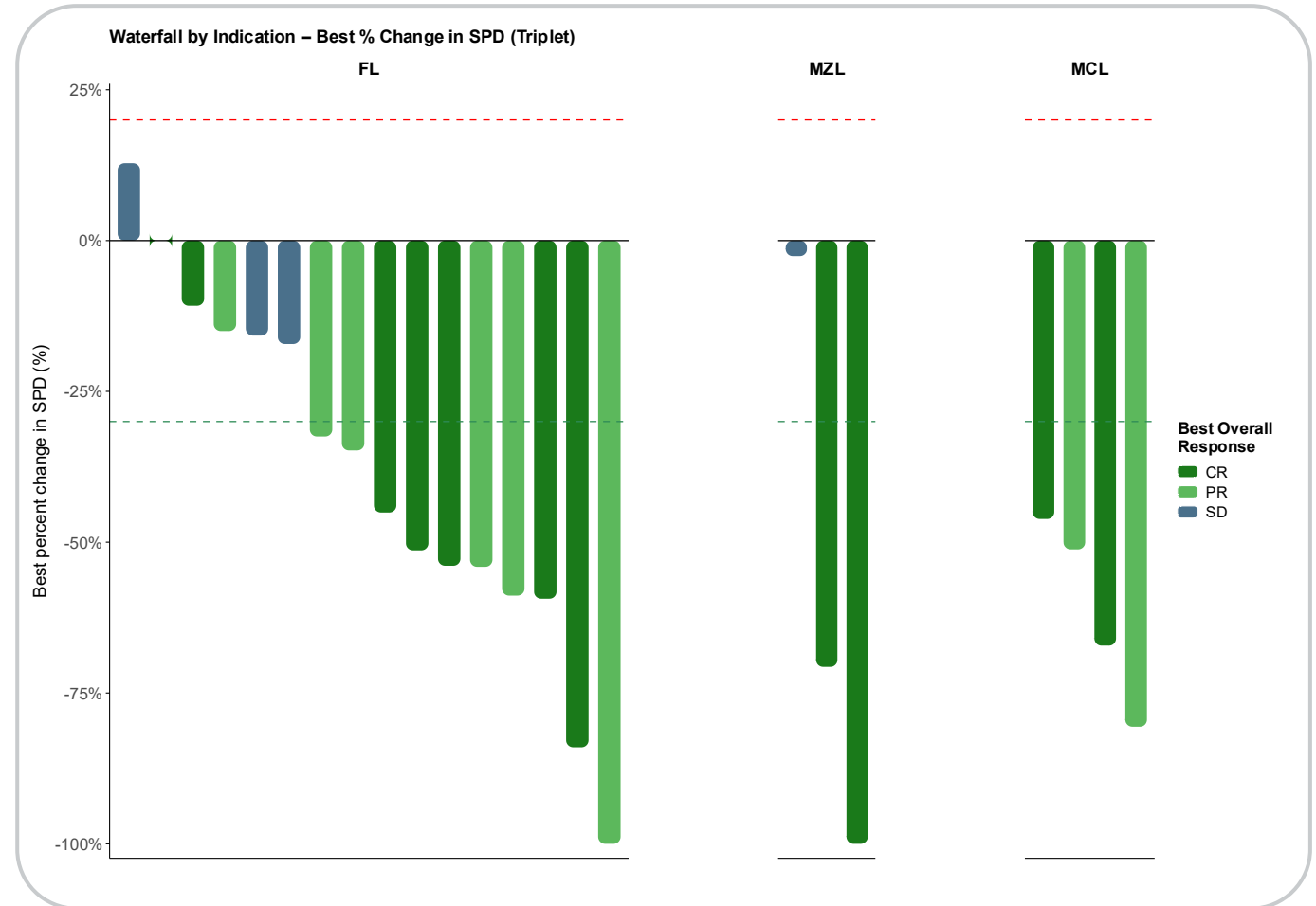
100% DCR

81% ORR in FL (n=16)

44% CRR in FL

No CRS · No ICANS
No increased infection rate

- **ORR of 83%, CRR of 48% and DCR of 100%** (n=23)
- Best Response in 23 evaluable patients:
 - 11 complete responses (CR)
 - 8 partial responses (PR)
 - 4 Patients with stable disease (SD)
- In the **follicular lymphoma (FL) subset (n=16)**, ORR was **81%** and **CRR 44%**
- The treatment has been **well-tolerated with no safety or tolerability concerns**
 - No CRS
 - No ICANS
 - No increased rate of infections

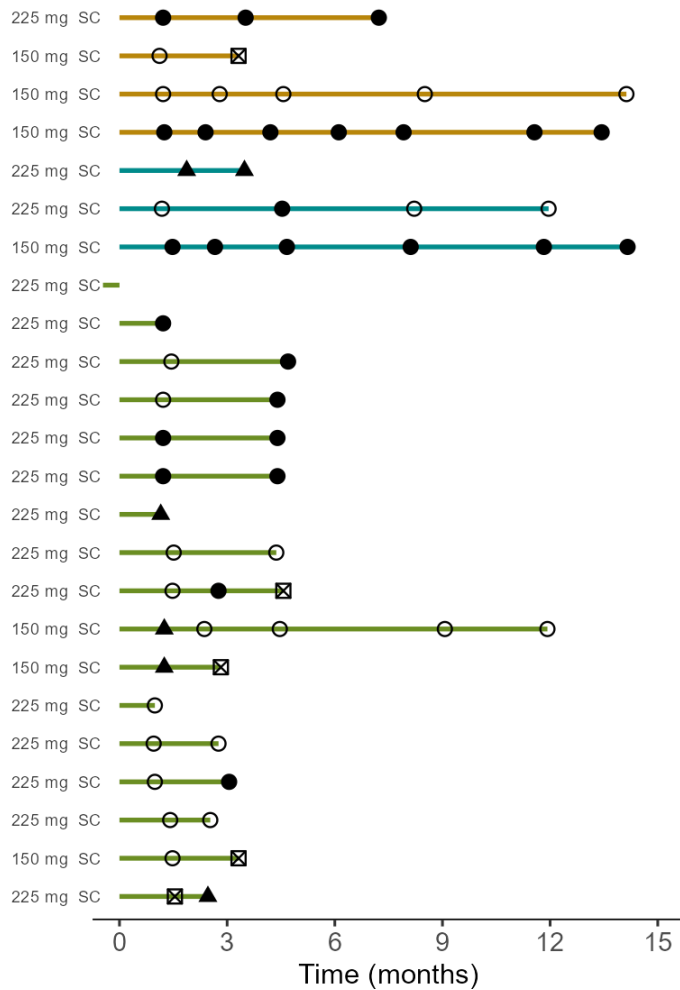


Waterfall plot of **BI-1206 + rituximab + acalabrutinib** triplet across NHL subtype. Response assessed through FDG-PET according to Lugano criteria (changes in metabolic parameters).

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

Swimmer Plot (Triplet)

Data cut-off: 2026-05-06



Overall Response

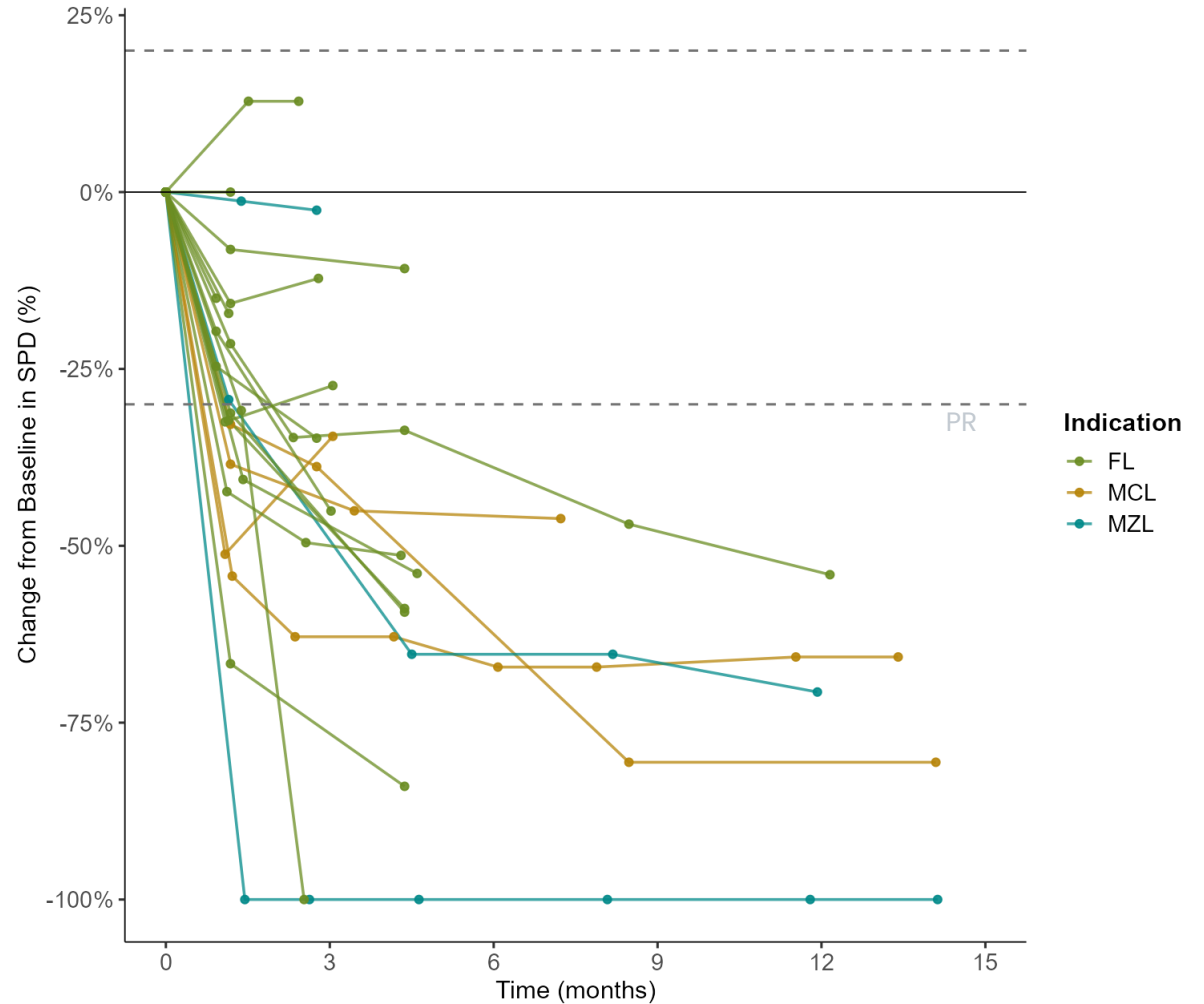
- CR
- PR
- ▲ SD
- ⊠ PD

Indication

- FL
- MCL
- MZL

Spider Plot – Change from Baseline in SPD (Triplet)

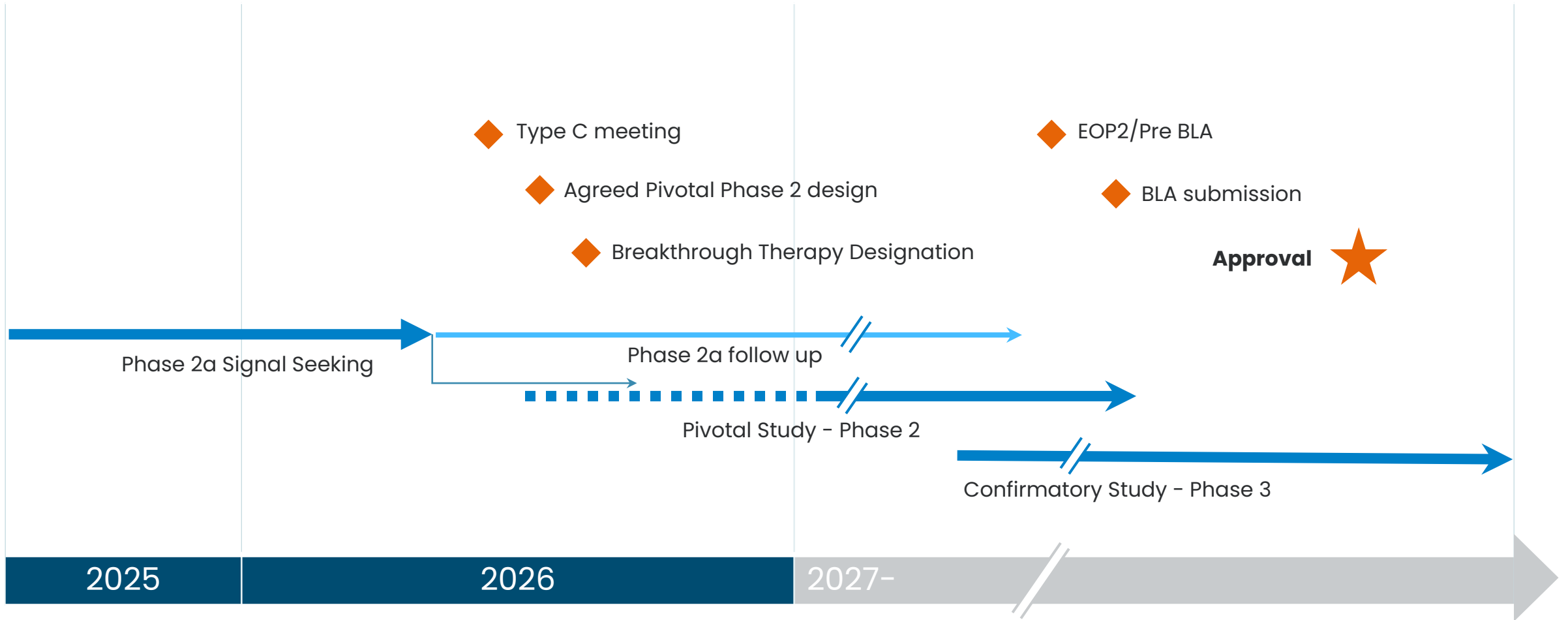
Data cut-off: 2026-05-06



* Acalabrutinib, supplied by AstraZeneca. Data cut-off 2026-05-06

BI-1206 in NHL: Combination with Rituximab and Acalabrutinib

Potential Timelines*



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

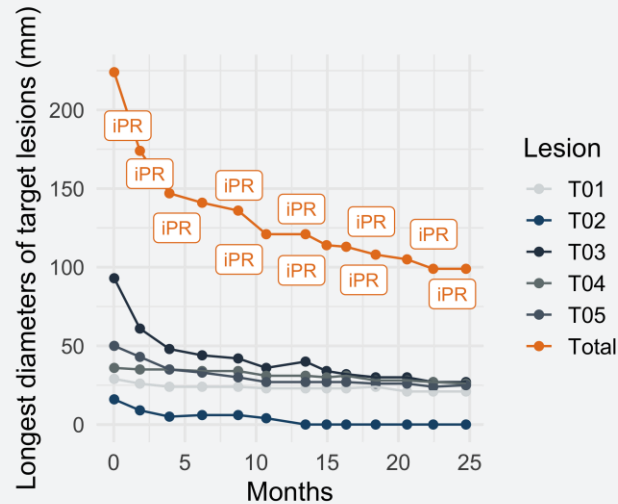
BI-1206 in Solid Tumors: Non-Small Cell Lung Cancer Uveal Melanoma

Co-administration of BI-1206 with Pembrolizumab

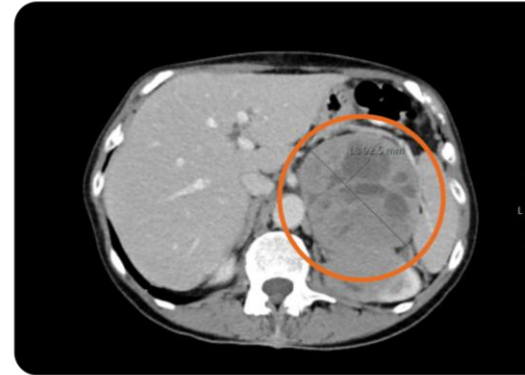
- Promising Responses in Uveal Melanoma Who Previously Failed anti-PD-1

Case study: PR

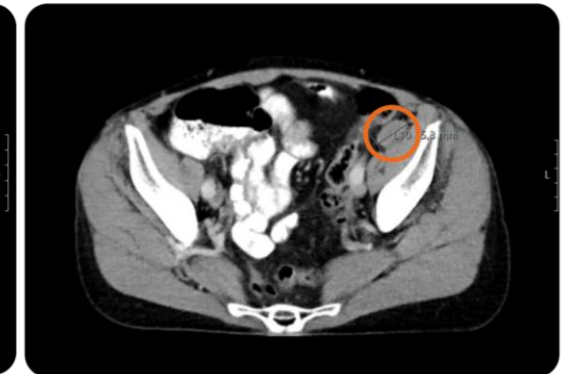
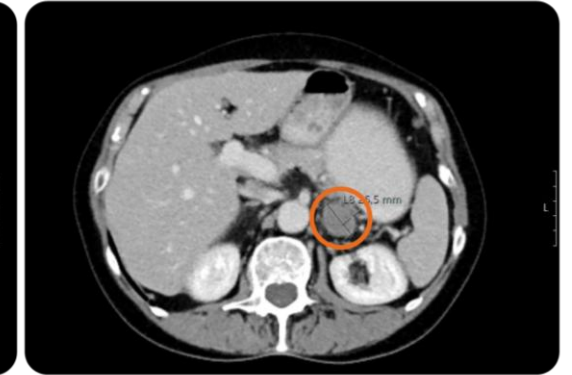
69 YO female with uveal melanoma. No response to prior immunotherapy or chemotherapy. Multiples lines of ICIs and Chemo. Progressing when entering study. Showed early partial response at first scan on BI-1206 + pembrolizumab, continued PR deepening during whole study duration (2 years) with tumor burden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



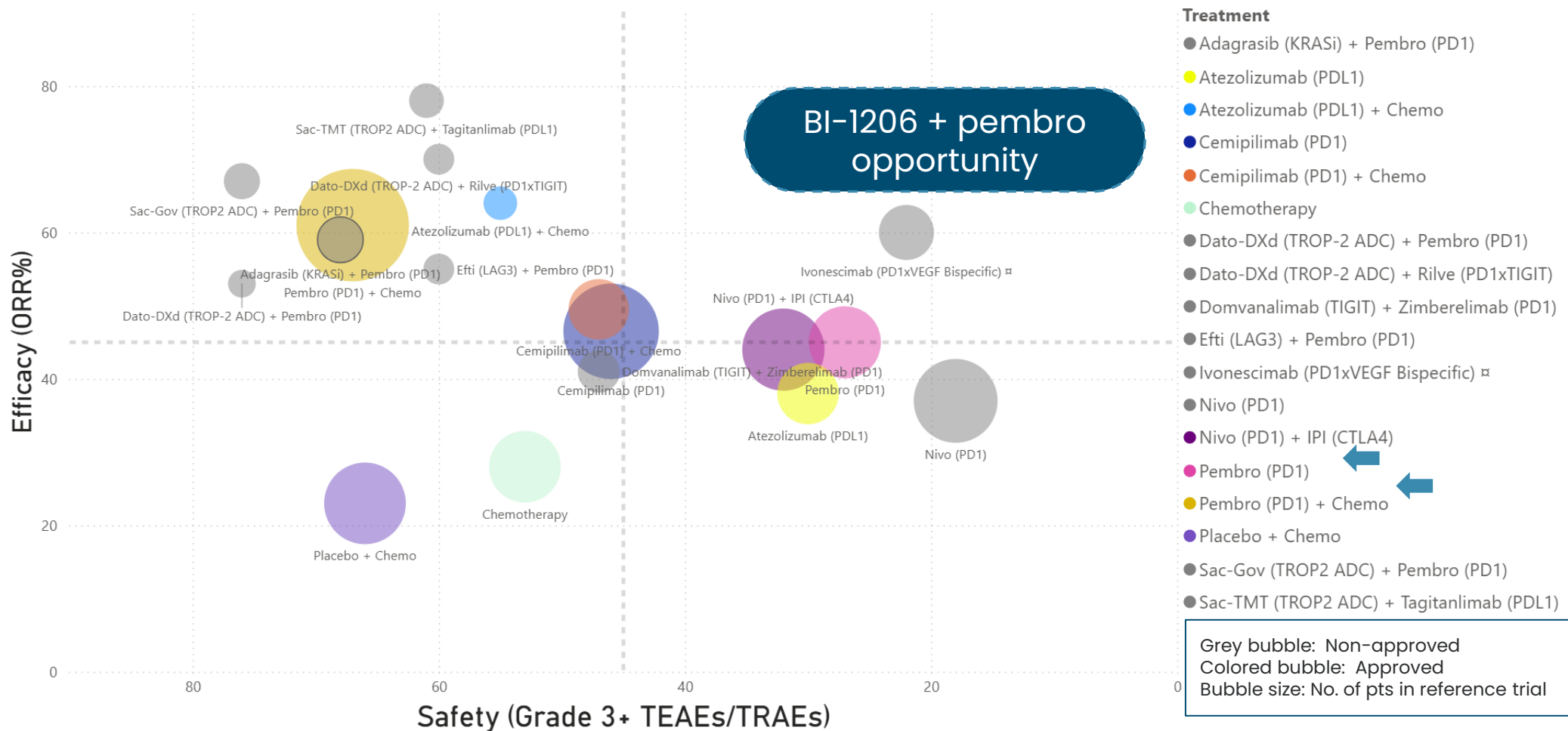
Baseline



End of treatment 2 years



Competitive Landscape in PD-L1 High NSCLC

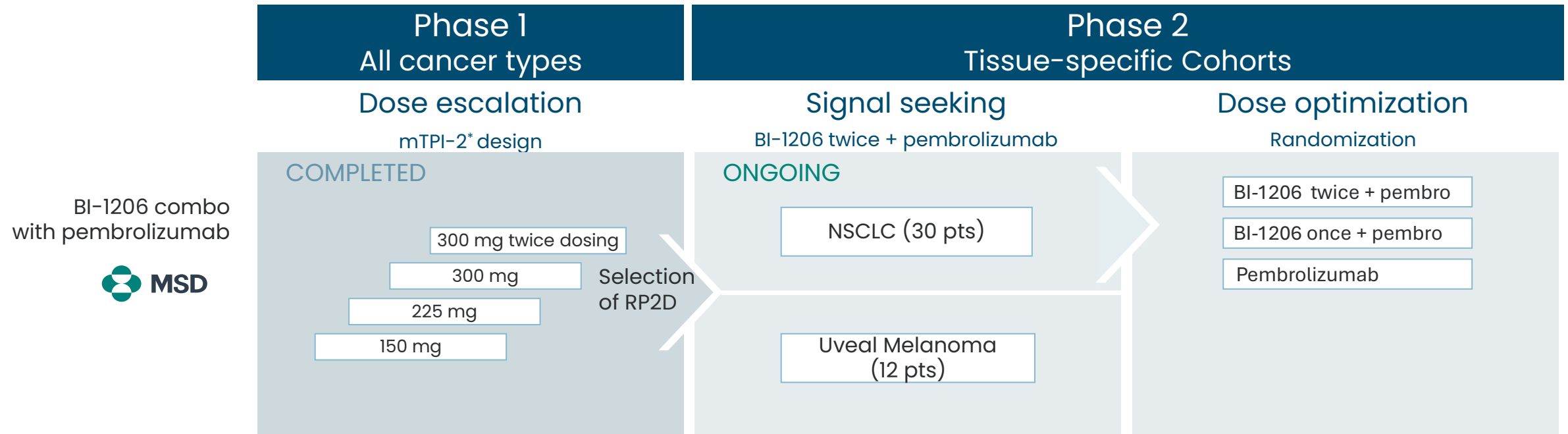


Key - Size of bubble : No. of pts.; Colored Bubbles : Approved treatments in US or EU; Grey Bubbles : Unapproved treatments; α : China-run trial

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

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



WHAT'S NEXT?

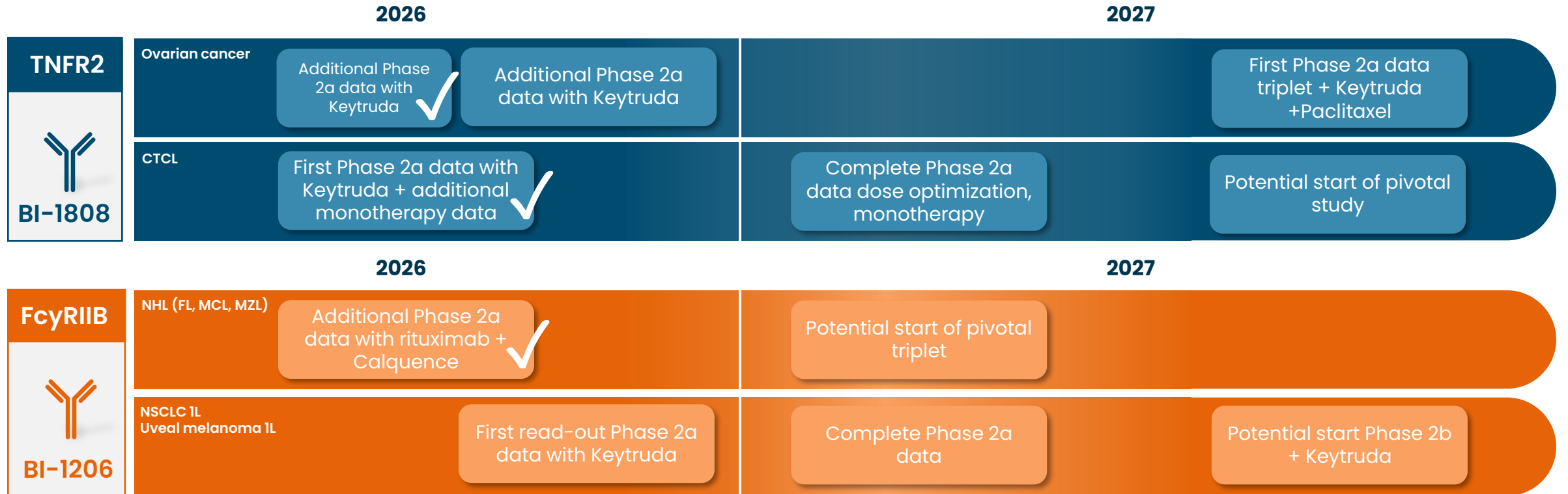
First Phase 2a data in front-line NSCLC and uveal melanoma H2 2026E

* modified Toxicity Probability Interval 2

Key Expected Milestones 2026-2027



Key Expected Milestones 2026–2027



1L: First line treatment

CTCL: Cutaneous T-cell Lymphoma, NHL: Non-Hodgkin's Lymphoma, FL: Follicular Lymphoma, MCL: Mantle Cell Lymphoma, MZL: Marginal Zone Lymphoma, NSCLC: Non-small cell lung cancer



Why invest in BioInvent now?

- 1 Improving the Effectiveness of the World's Leading Cancer Therapies**
- 2 Two Clinical Assets Developed from Proprietary Human-First Platforms**
- 3 Strong Anti-Tumor Activity Combined with Favorable Safety**
- 4 Multiple Strategic Licensing and Partnering Opportunities**
- 5 Backed by Leading Global Biotech Investors**



Improving the effectiveness and safety of the world's leading cancer therapies



Unleashing Immunity
To Fight Cancer



www.bioinvent.com

Anti-PD-1 is Well Entrenched in First-line NSCLC (TPS > 50)

Pembrolizumab monotherapy is the standard of care in first-line NSCLC (TPS > 50)

Anti-PD-1 Ab

KEYTRUDA[®]
(pembrolizumab) Injection 100 mg

- Treatment of choice as a single agent, 1st (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-CTLA-4

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

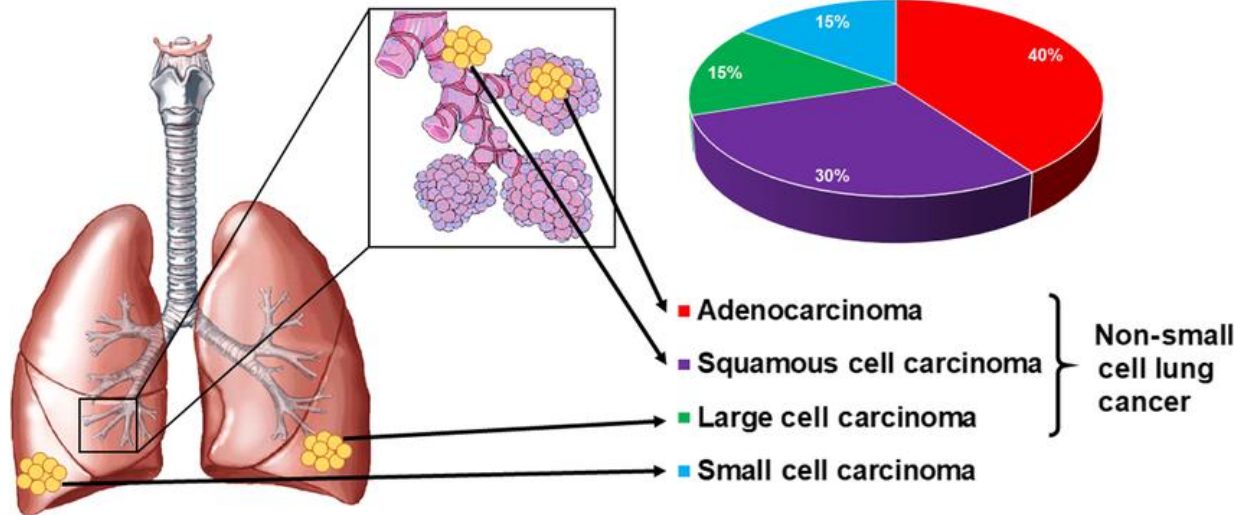
Chemoimmunotherapy



- In combination with anti-PD-1
- 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.

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

CD3-gp100 fusion protein



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

Liver directed



- 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



- 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-PD-1