

THE NEXT-GENERATION IMMUNOTHERAPY OF CANCER

October 2026



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

- \$1.7 billion in estimated peak sales

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

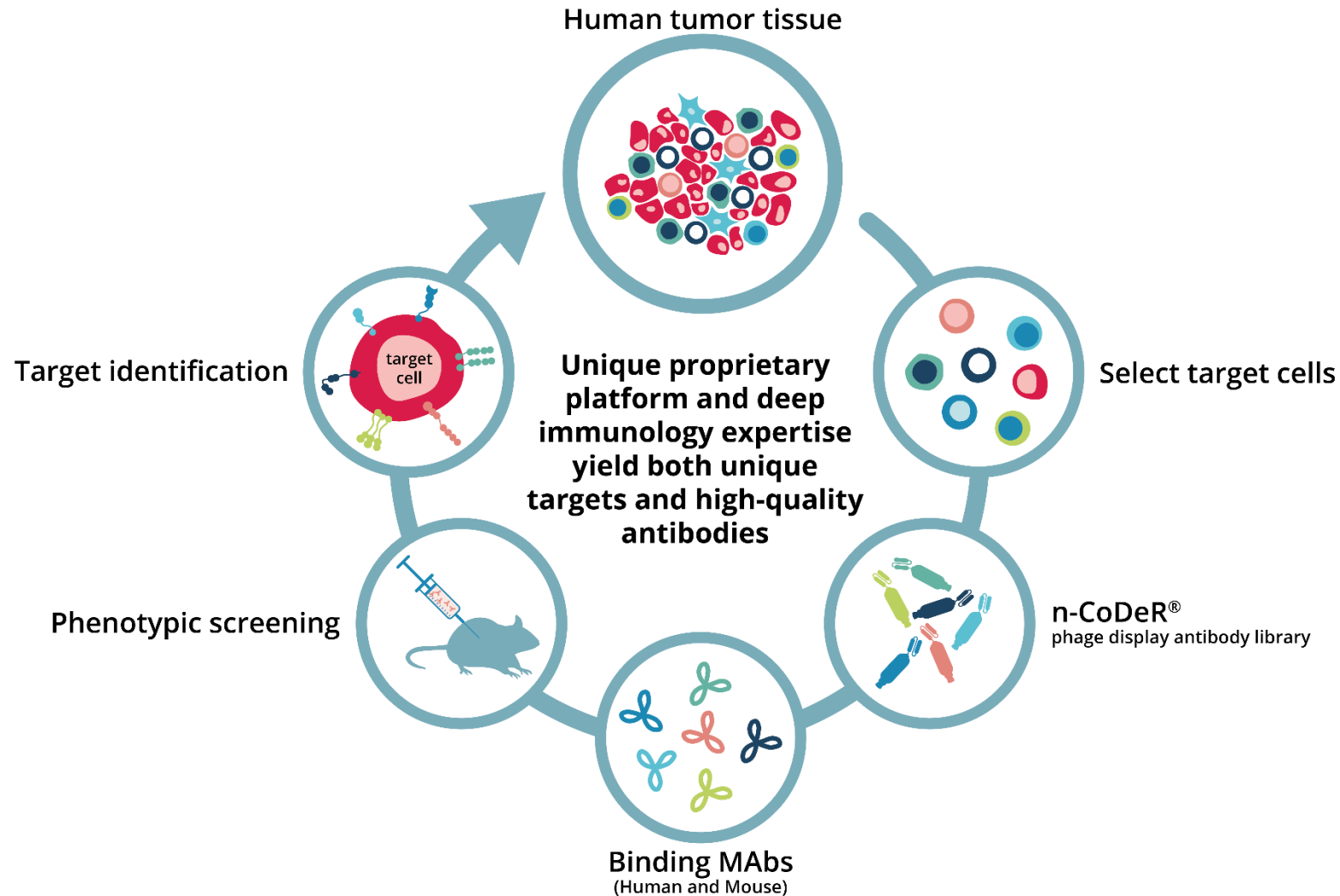
Core Capabilities Fuel Pipeline Expansion

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

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



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

Compound/Indication		Phase 1	Phase 2a	Phase 2b	Milestone
 TNFR2 BI-1808	Ovarian cancer Pembrolizumab ¹	Ongoing			→ Complete Phase 2a data H1 2027
	Ovarian cancer Pembrolizumab ¹ + Paclitaxel		Planned		→ First Phase 2a data expected end 2027
	CTCL Single agent	Ongoing		Preparatory phase	→ Complete Phase 2a data dose optimization H1 2027
	CTCL Pembrolizumab ¹	Ongoing			→ Conclude Phase 2a
 FcγRIIB BI-1206	NHL (FL, MCL, MZL) Rituximab + Acalabrutinib ²	Ongoing		Preparatory phase	→ Potential start of pivotal triplet H1 2027
	NSCLC 1L Pembrolizumab ¹	Ongoing		Preparatory phase	→ Phase 2a data expected H1 2027
	Uveal melanoma 1L Pembrolizumab ¹	Ongoing			→ Phase 2a data expected H1 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

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

ANTI-TNFR2

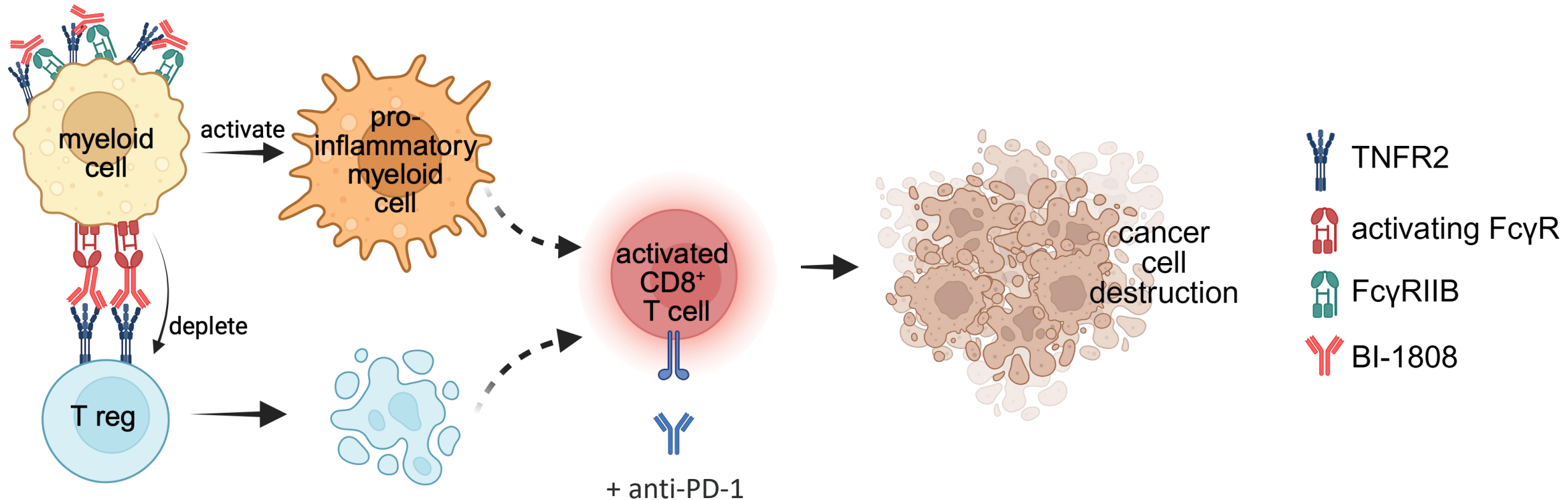
BI-1808 in Ovarian Cancer

BI-1808 in T-cell Lymphoma

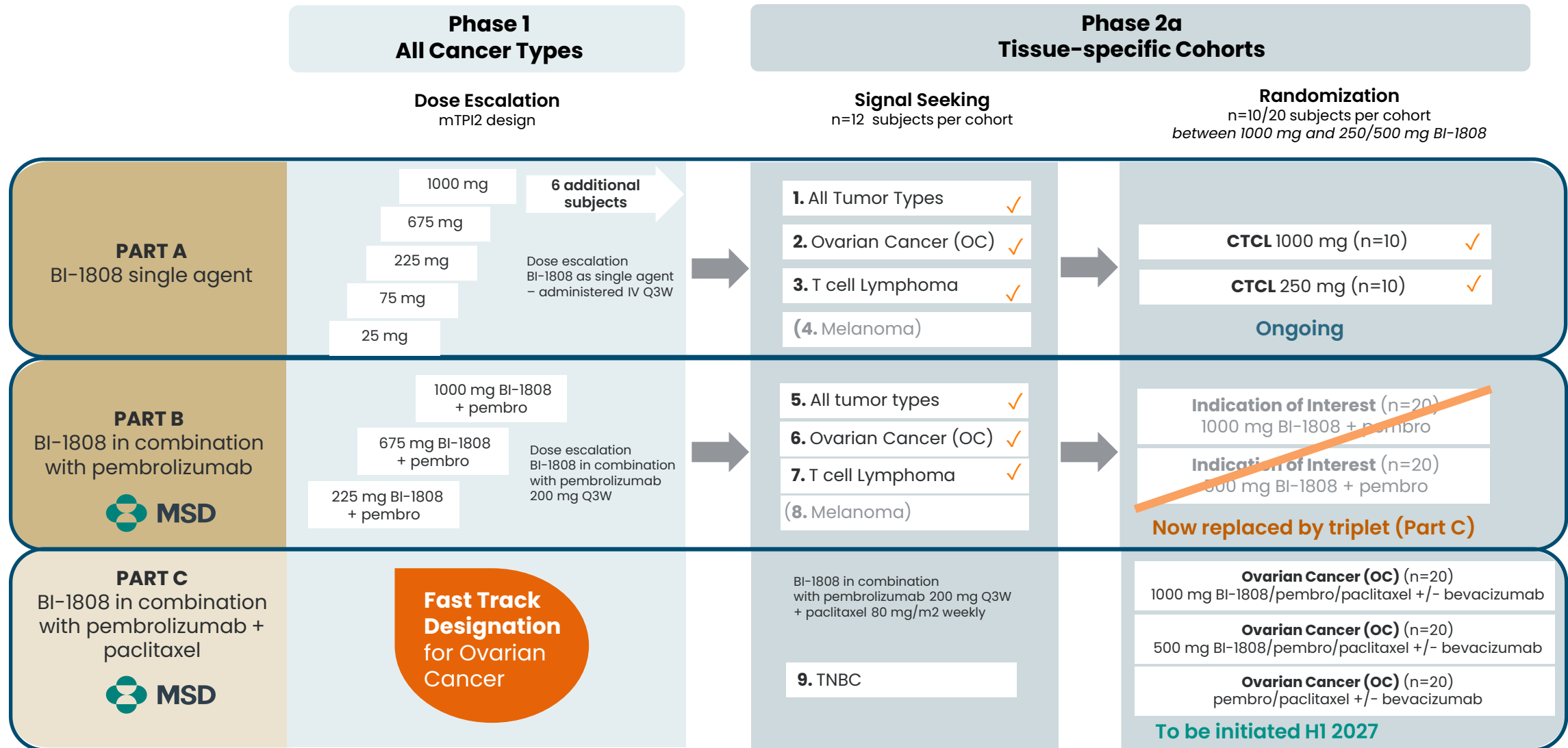


BI-1808's Differentiated Mechanism of Action

Depletes Tregs and activates macrophages to induce CD8⁺ T cell antitumor immunity



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



BI-1808: Strong Single Agent Activity in Solid Tumors

- **Heavily pre-treated, end-of the-line patients**
- 1 complete response (**CR**) in ovarian cancer
- 1 partial response (**PR**) in GIST that continued through the full study treatment. Multiple biopsies with no tumor tissue detectable.
- 9 stable disease (**SD**) out of 26 evaluable patients
- Favorable Safety profile with **no grade 3-4 AEs** and no SAEs at highest dose

Link to poster



ASCO 2024 Poster Presentation

Abstract #2641

19-BI-1808-01, a Phase 1/2a Clinical Trial of BI-1808, a Tumor Necrosis Factor Receptor 2 (TNFR2) Blocker/Depleter with or without Pembrolizumab

Conclusions

Early data from dose escalation phase show strong evidence of single agent antitumor activity of BI-1808 across various indications. BI-1808 induces significant regulatory T cell depletion, as well as clear signs of CD8-T cell activation in responding patients. BI-1808 has a favorable safety profile with no notable safety findings as monotherapy, and is also well tolerated combined with pembrolizumab.

Background

BI-1808 is a fully human IgG1 mAb that targets TNFR2 by blocking interaction of TNFR2 with ligand TNF- α , a critical T cell-dependent regulator of Treg and mediates expression of inhibitory CD8-T cells, as preclinical studies. Mouse homologue antibody can also regulate immune activity, by neutralizing TNFR2 expression on tumor cells, and also on immune cells. In humans, BI-1808 has been shown to deplete Tregs, and activate CD8-T cells. In patients with heavily pre-treated, end-of the-line, solid tumors, BI-1808 has shown promising results in terms of tumor response and safety. Thus, targeting TNFR2 using the approach offers a promising and novel treatment of cancer patients.



Methods

Safety and tolerability profile of BI-1808 as a single agent and in combination with pembrolizumab is currently being investigated in the Phase 1/2a clinical trial. The study consists of three dose escalation cohorts with increasing doses of BI-1808, and one cohort with BI-1808 in combination with pembrolizumab. The primary endpoint is to determine the maximum tolerated dose (MTD) and to evaluate the safety and tolerability of BI-1808 as a single agent and in combination with pembrolizumab. The secondary endpoint is to evaluate the antitumor activity of BI-1808 as a single agent and in combination with pembrolizumab. The study is ongoing and will continue to enroll patients.



Single agent activity demonstrated across various tumor types by BI-1808, a first-in-class ligand-blocking TNFR2 targeting antibody

Targeting TNFR2 with a ligand blocking and FcγR engaging antibody is a new and exciting potential treatment opportunity, and may add further antitumor activity when combined with anti-PD1 treatment.

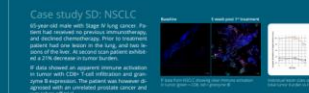
Case study PR: GIST

48-year-old patient with gastric cancer, stage III, relapsed after surgery and chemotherapy. The patient was heavily pre-treated with multiple lines of chemotherapy and targeted therapy. The patient was enrolled in the study and received BI-1808 as a single agent. The patient had a partial response (PR) to BI-1808 monotherapy. The patient's tumor size decreased by 30% after 12 weeks of treatment. The patient is currently on treatment and will continue to be followed up.



Case study CR: Ovarian Cancer

62-year-old patient with ovarian cancer, stage IV, relapsed after surgery and chemotherapy. The patient was heavily pre-treated with multiple lines of chemotherapy and targeted therapy. The patient was enrolled in the study and received BI-1808 as a single agent. The patient had a complete response (CR) to BI-1808 monotherapy. The patient's tumor size decreased by 100% after 12 weeks of treatment. The patient is currently on treatment and will continue to be followed up.



Case study SD: NSCLC

65-year-old patient with non-small cell lung cancer, stage IV, relapsed after surgery and chemotherapy. The patient was heavily pre-treated with multiple lines of chemotherapy and targeted therapy. The patient was enrolled in the study and received BI-1808 as a single agent. The patient had stable disease (SD) to BI-1808 monotherapy. The patient's tumor size remained stable after 12 weeks of treatment. The patient is currently on treatment and will continue to be followed up.



Results

As of April 18, 2024, 44 subjects received doses of 25 mg, up to 1000 mg BI-1808 as monotherapy. 20 and 10 subjects received BI-1808 in combination with pembrolizumab 200 mg Q3W.

At doses of a 25 mg Q3W, BI-1808 was well tolerated and was leading to activation of T cells, leading to complete response across the dose range, with no larger organ toxicity observed. No severe adverse events were observed.

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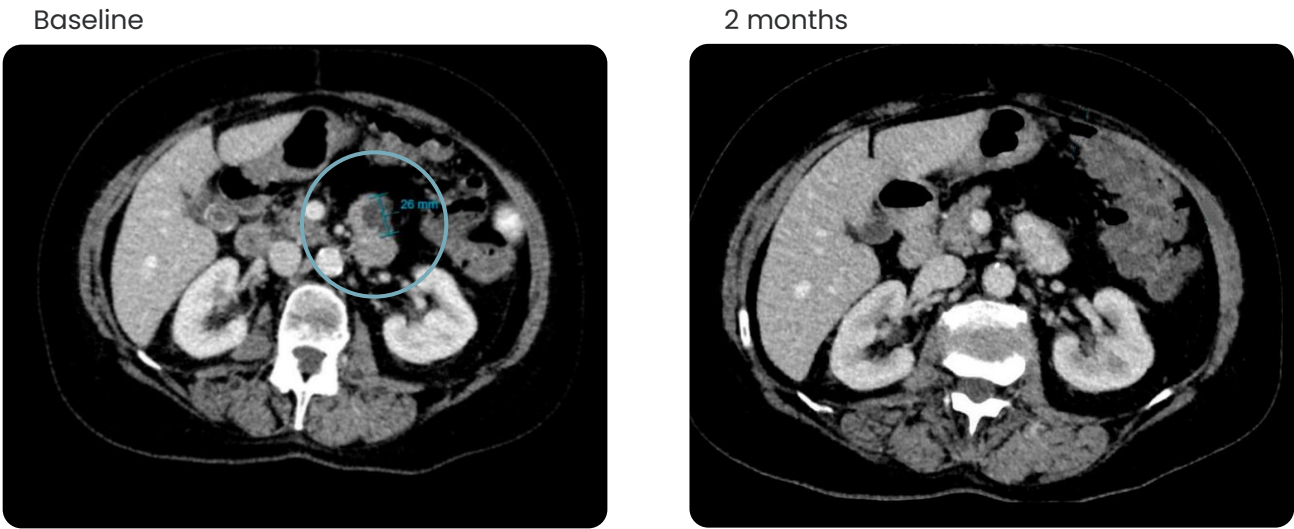
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BI-1808 Single Agent Case Study: Complete Response in Ovarian Cancer



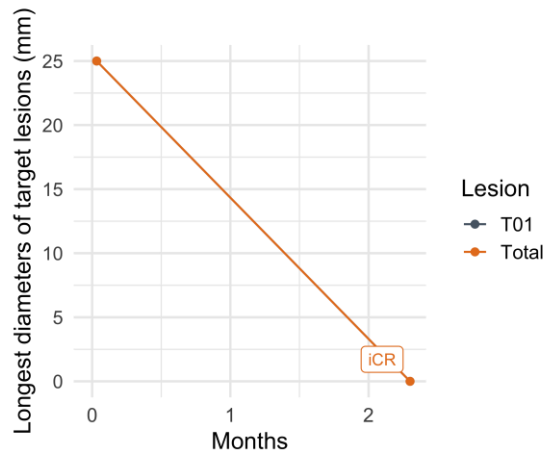
63-year-old patient with ovarian cancer, Stage IIIA at diagnosis, entered the study with PD.

Four previous lines of treatment:

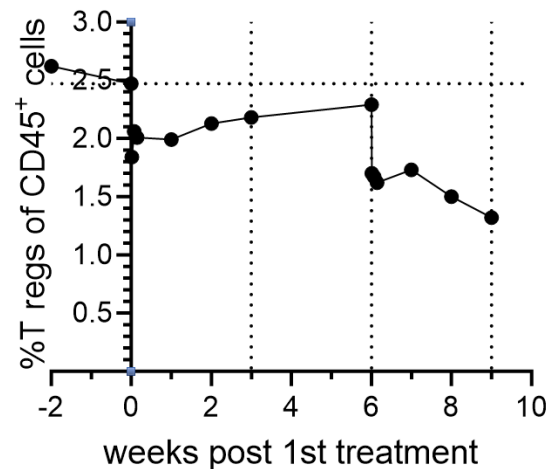
- Paclitaxel/carboplatin
- Carboplatin/doxorubicin
- Olaparib
- Bevacizumab/topotecan

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.



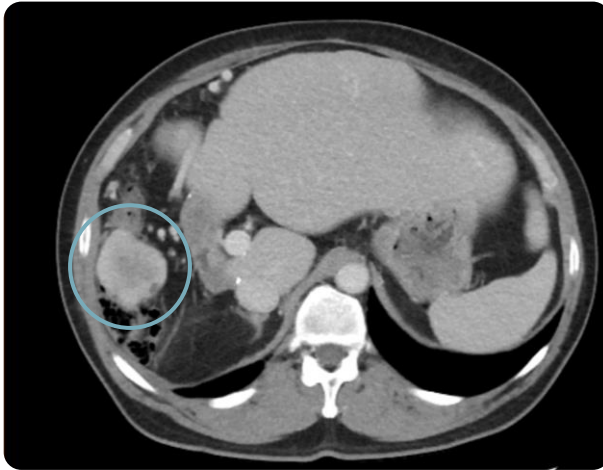
Tumor assessment vs time on study



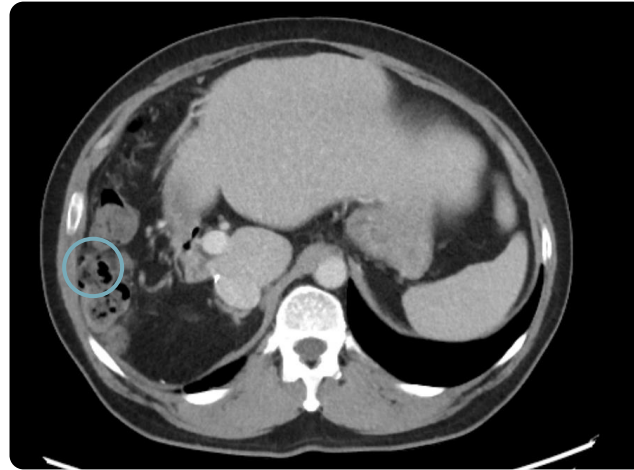
T reg levels vs time on study
Dashed lines indicate administration of BI-1808

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

Baseline

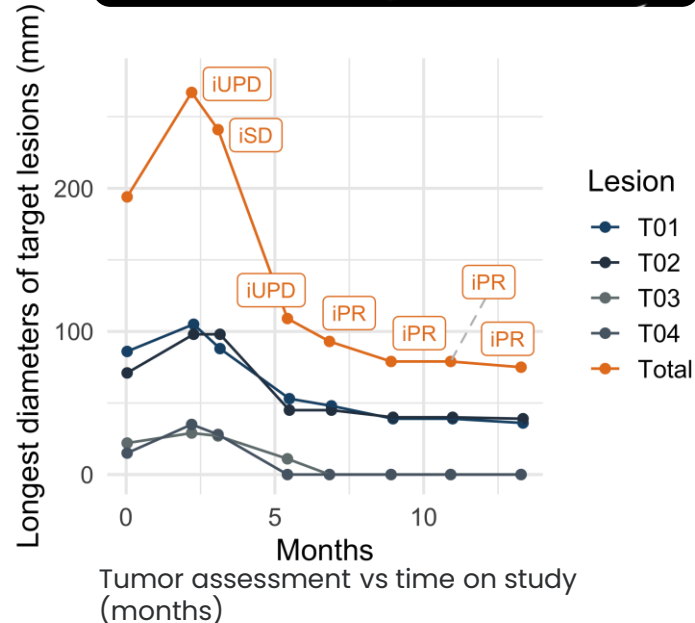
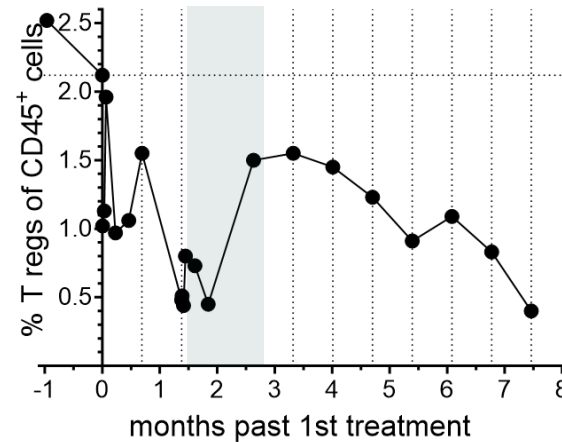


Follow-up 13 months



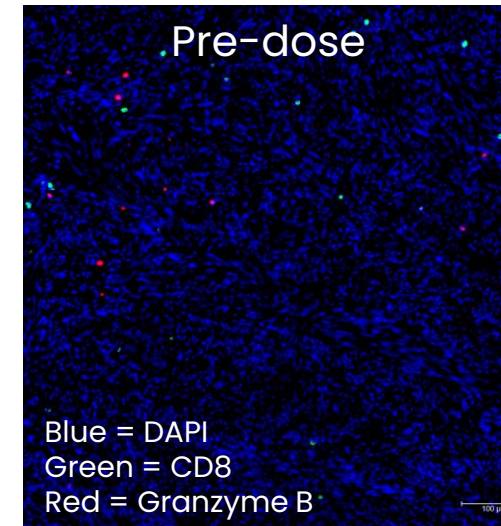
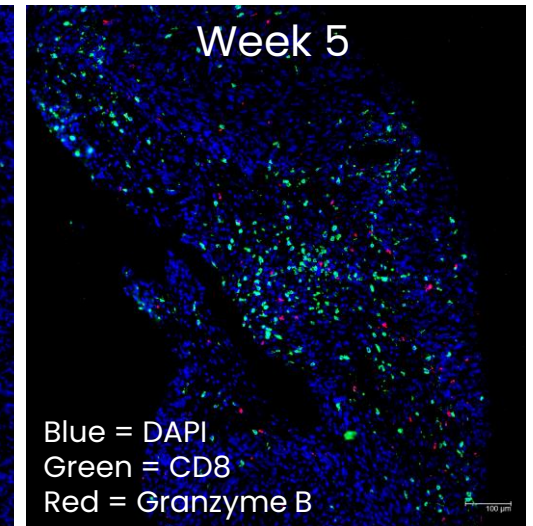
55-year-old male patient with GIST, who presented with clinical PD for more than six months with multiple metastatic lesions.

12 previous lines of therapy.



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

BI-1808 in Ovarian Cancer

BI-1808 + Pembrolizumab Achieves 24% ORR in Heavily Pretreated Recurrent Ovarian Cancer Patients

Chemotherapy-free Regimen | ESMO 2026 Best Poster Award, Investigational Immunotherapy

PATIENT PROFILE

34

Evaluable patients

Tumor Subtypes

HGSA 20 (59%)

ccOC 14 (41%)

Median age: 62 yrs (range 35–79)
Liver involvement: 8 (24%)

TREATMENT HISTORY

4

median prior lines

Prior Treatment (1–10 prior lines)

100% platinum-based therapy

88% had ≥ 3 prior lines.
14.7% prior anti-PD-(L)-1

Heavily pretreated, chemo-resistant population

TREATMENT RESPONSE

24%

overall response rate (ORR)

Best Response (n=34)

CR 1 (3%)

PR 7 (21%)

SD 10 (29%)

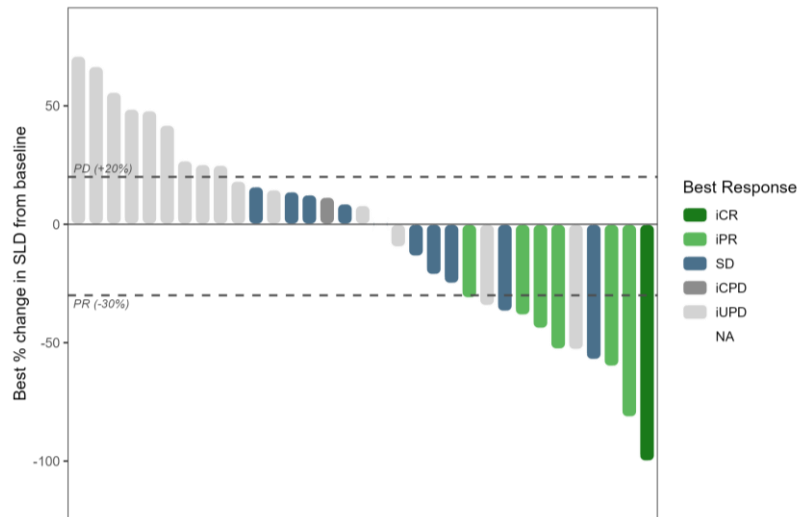
DCR 53% | mPFS 4.1 mo
miPFS (iRECIST) 10.3 mo

BI-1808 in **Combination** with Pembrolizumab: Promising Efficacy in Ovarian Cancer

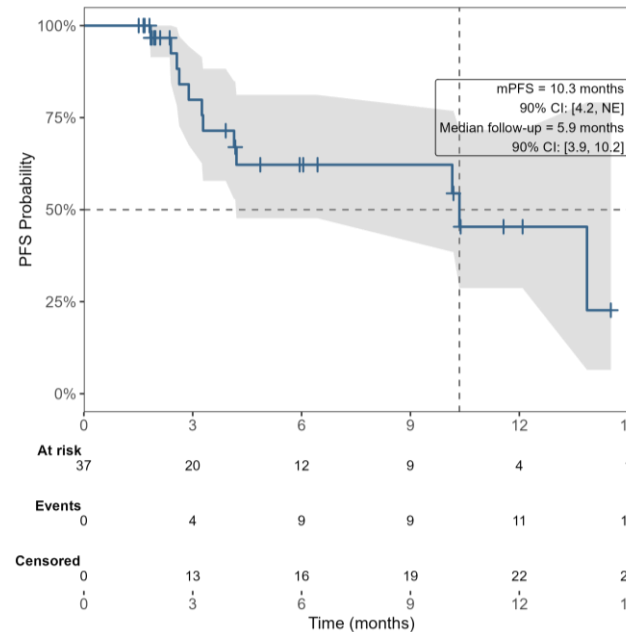
Summary of ESMO 2026 Ph 2a data (cut-off date Sep 14, 2026)

- **24% ORR, 53% DCR** in 34 evaluable patients: 1 complete response (CR), 7 partial response (PR) and several cases of stable disease (SD) exceeding 10 months
- Median progression-free survival (mPFS) assessed by RECIST of **4.1 months** as compared to 2.1 months for pembrolizumab monotherapy.
- mPFS assessed per iRECIST (**miPFS**) was **10.3 months**, highlighting the impact of delayed and durable response previously reported for BI-1808. Median duration of response not met (median follow-up 11.6 mo).

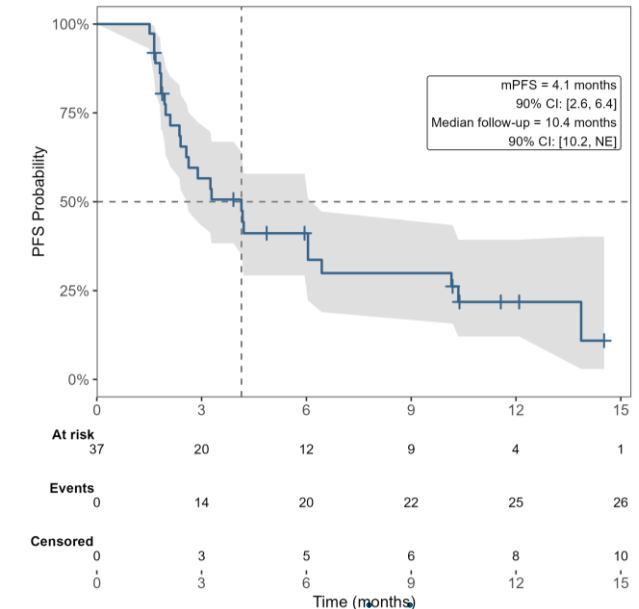
Waterfall plot BI-1808 + Pembrolizumab in Ovarian Cancer
iRECIST Response Best % change from baseline in SLD



Kaplan-Meier plot of iPFS, indicating a miPFS of 10.3 months as per iRECIST. This metric reflects a delayed onset and long duration of response.



KM plot of PFS, indicating a mPFS of 4.1 months as per RECIST.

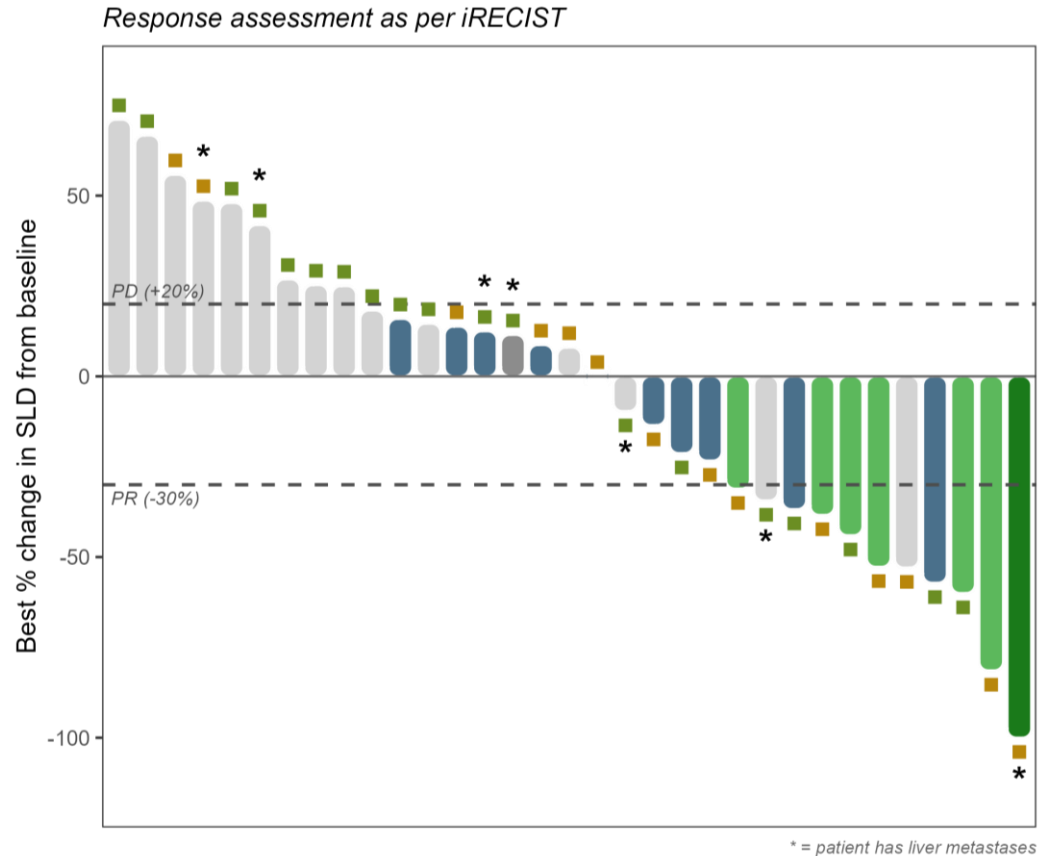


ORR: Overall Response Rate
DCR: Disease Control Rate

Phase 2a Part B – BI-1808 + Pembrolizumab in Ovarian Cancer

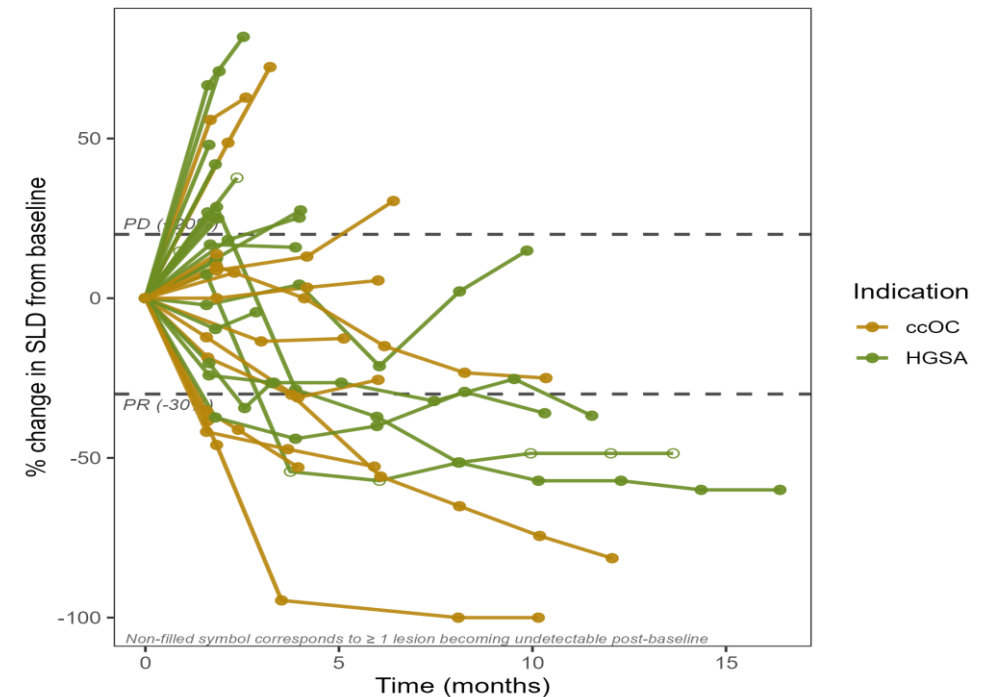
Population distribution ccOC vs HGSA

- Solid response signal in both clear cell and high-grade serous histology, with a very favorable safety profile. Less than AE-related 5% treatment discontinuations, and several patients are still receiving treatment.



Note: One patient with PR does not have post-baseline tumor size entered in EDC at cut-off date and cannot be presented in waterfall plot for technical reasons.

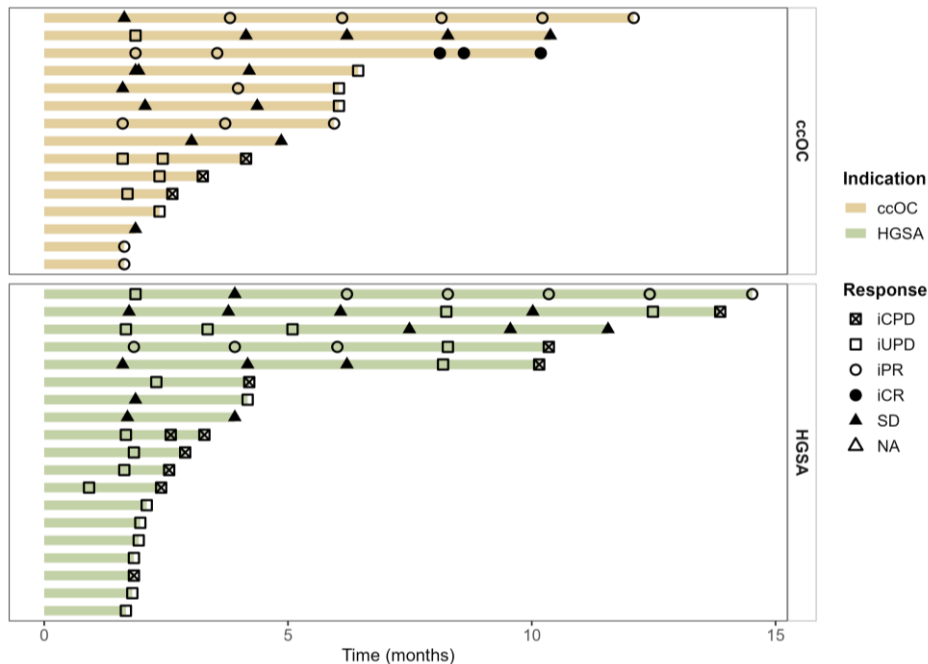
Spider plot for BI-1808 + pembrolizumab in Ovarian Cancer



PFS Analysis in the Combination Cohort, RECIST v.1.1 vs iRECIST

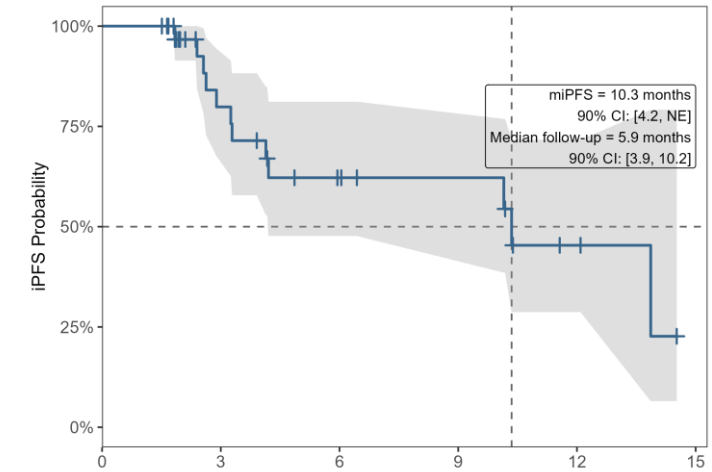
RECIST criteria does not fully reflect long-term disease control or possibility of pseudo-progression

- RECIST v. 1.1 criteria do not reflect long-term disease control, as does iRECIST criteria mPFS at 10.3 months.
- As most progressive disease cases were unconfirmed, the disconnect between PFS and iPFS becomes informative – i.e., patients continuing trial achieve benefit.
- Median duration of response was not met at cut-off (median duration of follow-up 11.6 months).

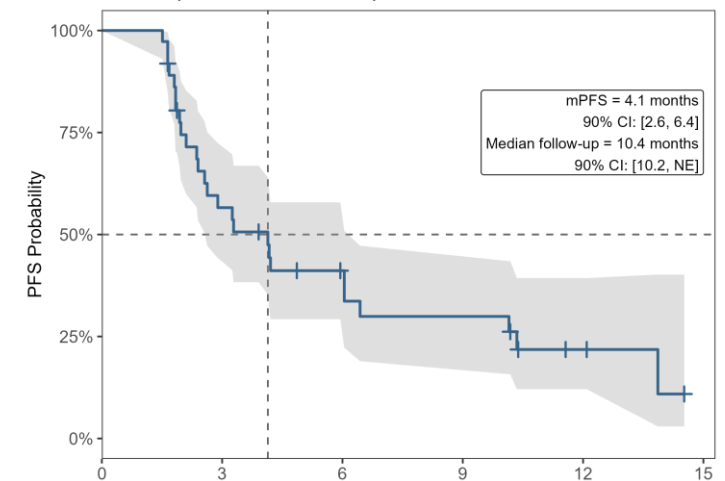


Swimmer plot of response evaluable population. This graph shows that several of early recruited patients exited treatment despite unconfirmed PD at first scan, while some patients with iUPD at first scan that stayed on treatment eventually benefited of durable disease control or response. (Response assessment as per iRECIST)

Kaplan-Meier plot of iPFS for BI-1808 + pembrolizumab in Ovarian Cancer (iRECIST, with 90% CI)



Kaplan-Meier plot of PFS for BI-1808 + pembrolizumab in Ovarian Cancer (RECIST, with 90% CI)



Patient Population Comparison

BI-1808 study population much heavier pretreated than the KEYNOTE-B96 population

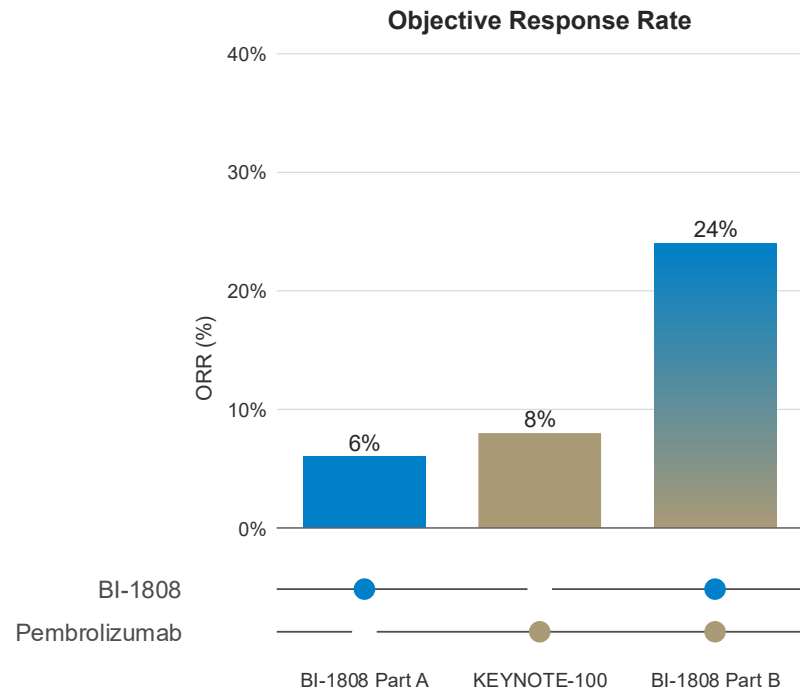
- Compared to KEYNOTE-B96, patients in Study 19-BI-1808-01 were much heavier pretreated than the KEYNOTE population
- In addition, preclinical data indicates BI-1808 to combine even better with paclitaxel, than what is observed for pembrolizumab
- The assumption around added benefit of BI-1808 in this population is thus realistic, and even conservative

Characteristic	BI-1808	KNB96 - pembro	Differences
N	34	322	-
Age, median	62 (35-79)	62 (IQR 53-69)	Comparable
Clear cell histology	41%	7%	Major
High-grade serous histology	59%	86%	Major
Prior lines, media (range)	4 (1-10)	2 (max 2)	Major
1-2 prior lines	12% (4/34)	100% (by elig.)	Major
>=3 prior lines	88.2% (30/34)	<1%	Major
FIGO IV at diagnosis	35%	36%	Comparable
Prior bevacizumab	62%	46%	Minor
Prior PARP inhibitor	56%	35%	Comparable
Prior anti-PD-(L)1	15%	2%	Major
Prior paclitaxel	94%	Not tabulated	Moderate
Prior platinum	100%	100%	Comparable
Liver involvement	23.5%	Not tabulated	Unknown

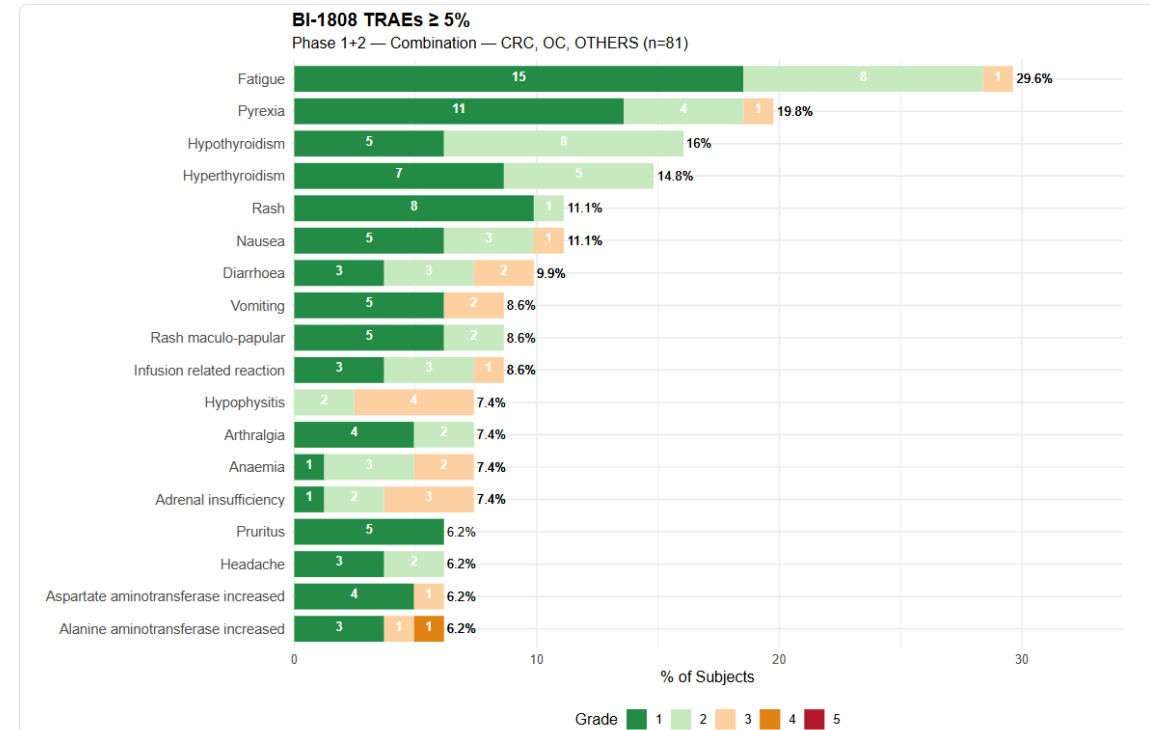
KN-B96 figures: Colombo et al, Lancet 2026;407:1525-37, Table 1. Prior lines and histology are the binding differences.

BI-1808 + pembrolizumab show response in a setting where IO has previously failed to deliver

- Immuno-oncology agents (atezolizumab, avelumab, nivolumab and ipilimumab) **have all failed** in PROC
- Addition of BI-1808 to pembrolizumab highlights the benefit of simultaneous PD-1 and TNFR2 inhibition, **without chemotherapy**



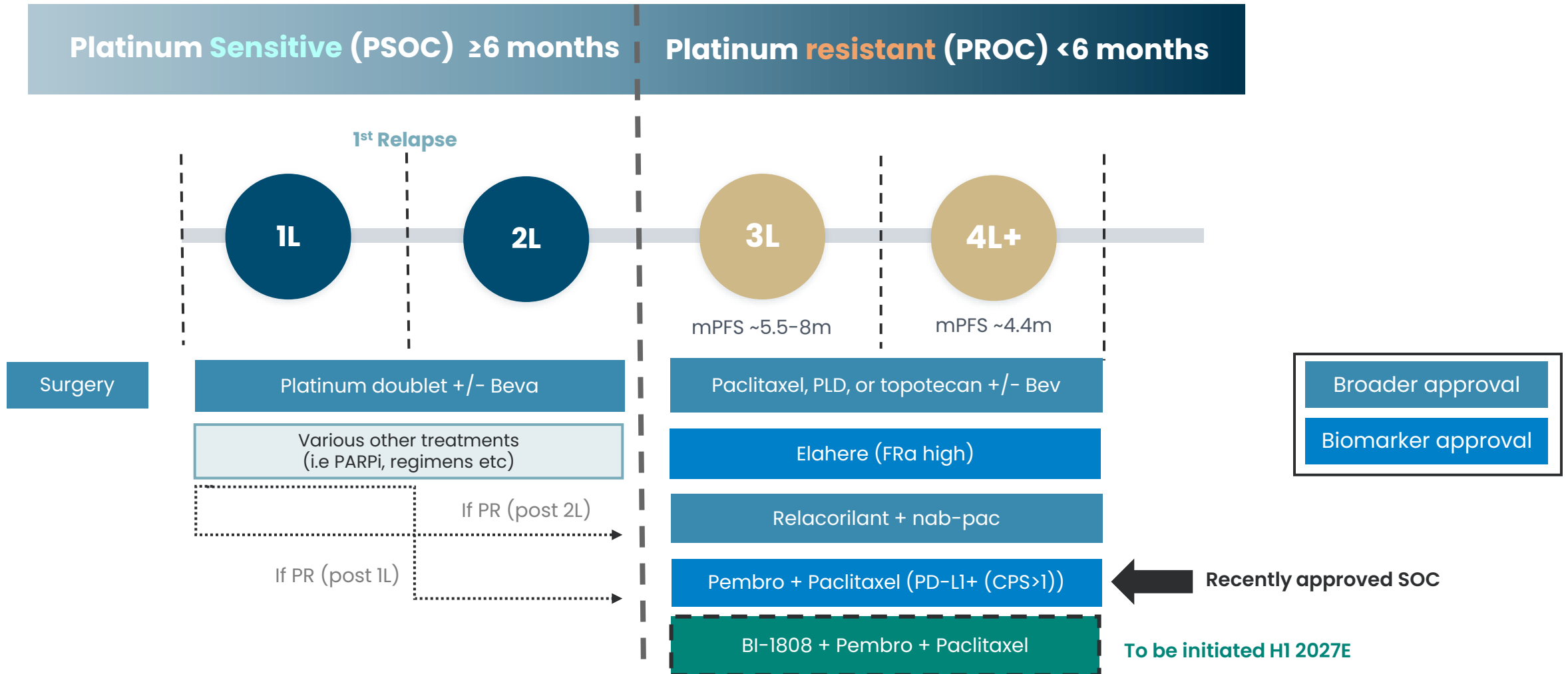
- These results are impressive considering the heavy pretreatment history (median 4, range 1-10) prior lines. As a reference, the ADC Elahere response rate drop from 47% in early lines to 10% after >3 lines¹.



- The excellent safety of the doublet combination points to a treatment option for patients who cannot tolerate cytotoxic therapy (chemo/ADC)

1) https://www.ema.europa.eu/en/documents/assessment-report/elahere-epar-public-assessment-report_en.pdf

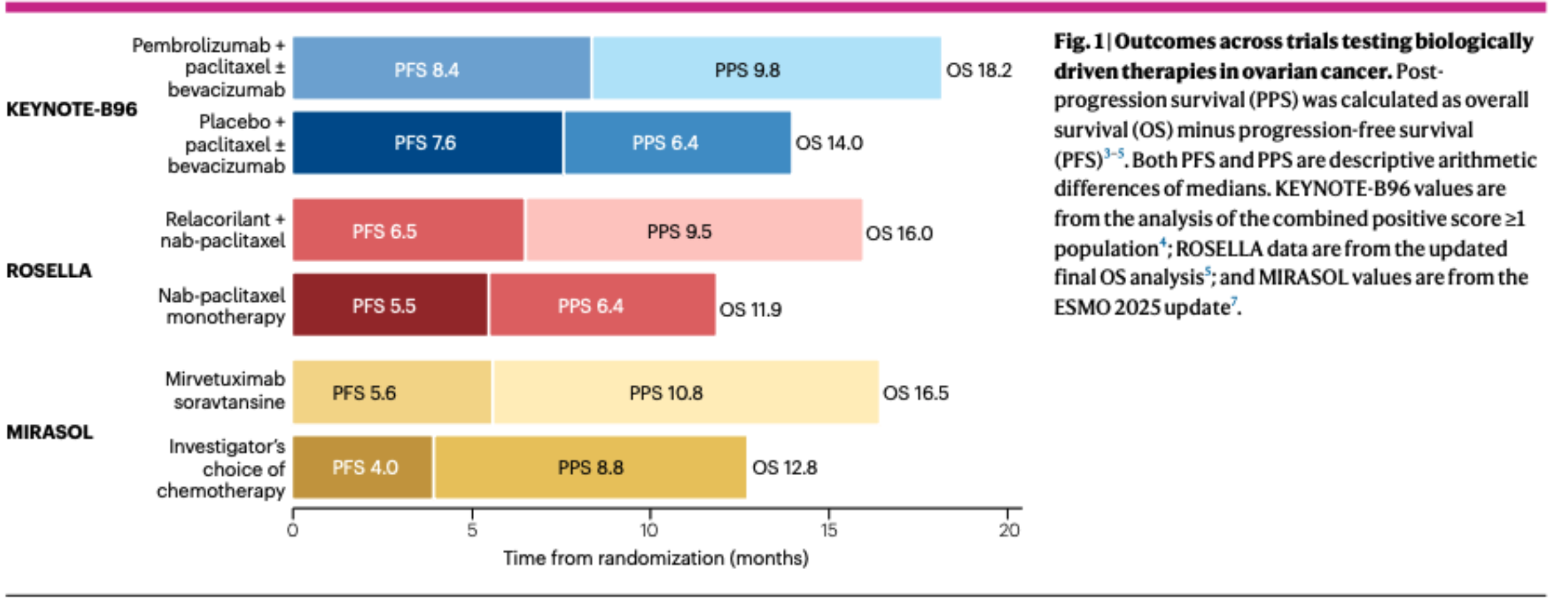
The Treatment Paradigm is Shaped by Platinum Sensitivity and Biomarker Status; With Few Recent Approvals in PROC*



*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. Hanks LC, et al. Ann Oncol. 2012;23(10):2605-12
6. González-Martín et al. Ann Oncol. 2023 Oct;34(10):833-848

The Treatment Paradigm is Changing with Few Recent Approvals in PROOC



ADCs are not a Competitive Threat — and They may Complement BI-1808

Four structural limitations of the ADC class



Significant toxicity

Boxed warnings across the class: ocular toxicity (MIRV, TV) and ILD (T-DXd, ~2% fatal). 91% any-grade and 46% grade ≥ 3 AEs across 22,000+ patients. Targeted delivery doesn't lower payload MTD.



Biomarker-restricted

MIRV requires FR α -high — only ~34–44% of HGSOc qualify. T-DXd requires HER2 IHC 3+ — ~5% of HGSOc. Assay variability and uneven tumor expression shrink the eligible pool further.



Near-universal resistance

Resistance develops in almost all patients. ~69% show cross-resistance to a second ADC that shares a target or payload class, limiting sequential ADC strategies.



Only two payload classes

The entire pipeline rests on microtubule and topoisomerase-1 inhibitors. Crowding around two payloads concentrates risk and drives pan-resistance.

BI-1808 is complementary, not competitive



Before an ADC

Biomarker-agnostic IO treats the full population and primes anti-tumor immunity; ADCs are reserved for biomarker-positive progressors.



Alongside an ADC

ADC-induced immunogenic cell death pairs with BI-1808's TME reprogramming — orthogonal mechanisms, no shared resistance.



After an ADC

Extends durability as ADC responses wane, and rescues biomarker-negative or ADC-resistant patients.

Orthogonal immune mechanism — no cross-resistance with cytotoxic ADC payloads. BI-1808 can precede, accompany, or follow an ADC.

Source: Moore et al., Antibody–drug conjugates in gynaecological cancers. Nat Rev Clin Oncol 2026. Supporting data: MIRASOL, DESTINY–PanTumor02, InnovaTV 301; class-wide AE meta-analysis (169 trials, >22,000 patients). MIRV, mirvetuximab soravtansine (Elahere); T-DXd, trastuzumab deruxtecan; TV, tisotumab vedotin.

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

Estimated peak sales of BI-1808 in PROC of ~\$1.7 billion (base-case) for current target product profile (TPP)

CURRENT

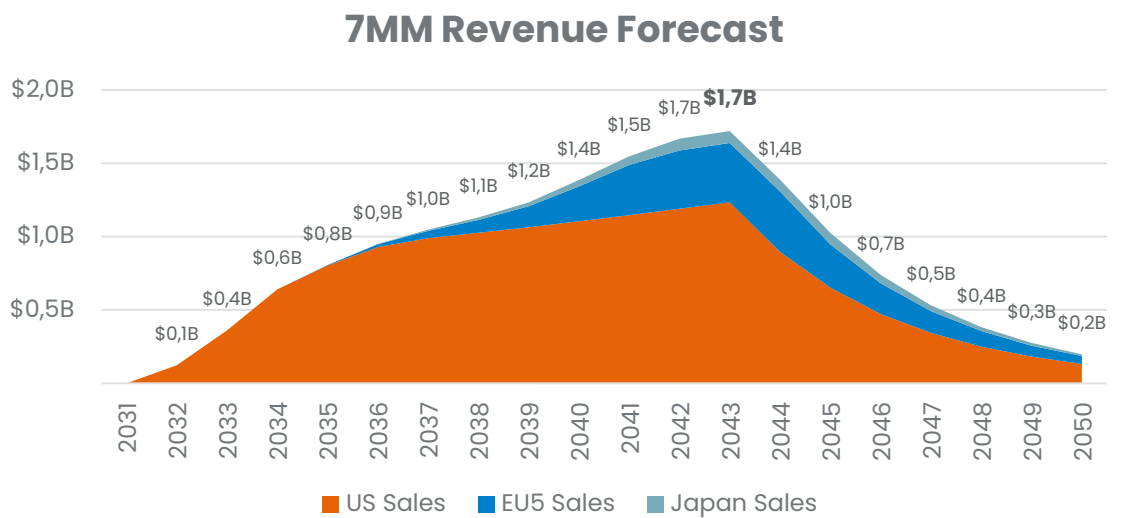
- Standard of care (**SoC**) in ovarian cancer the chemotherapy drug paclitaxel added to Keytruda, but **survival still poor**

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



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.

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 53% 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

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

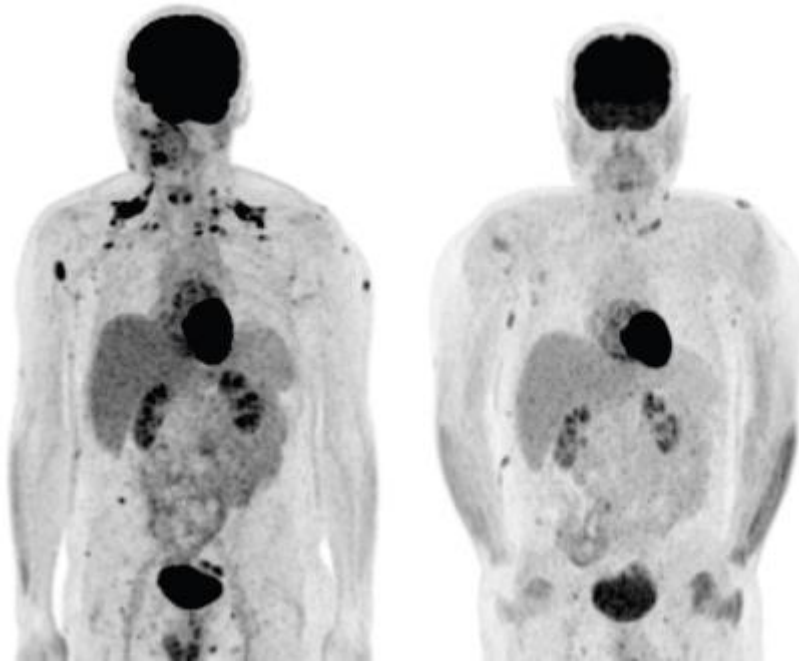
BI-1808 in CTCL

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

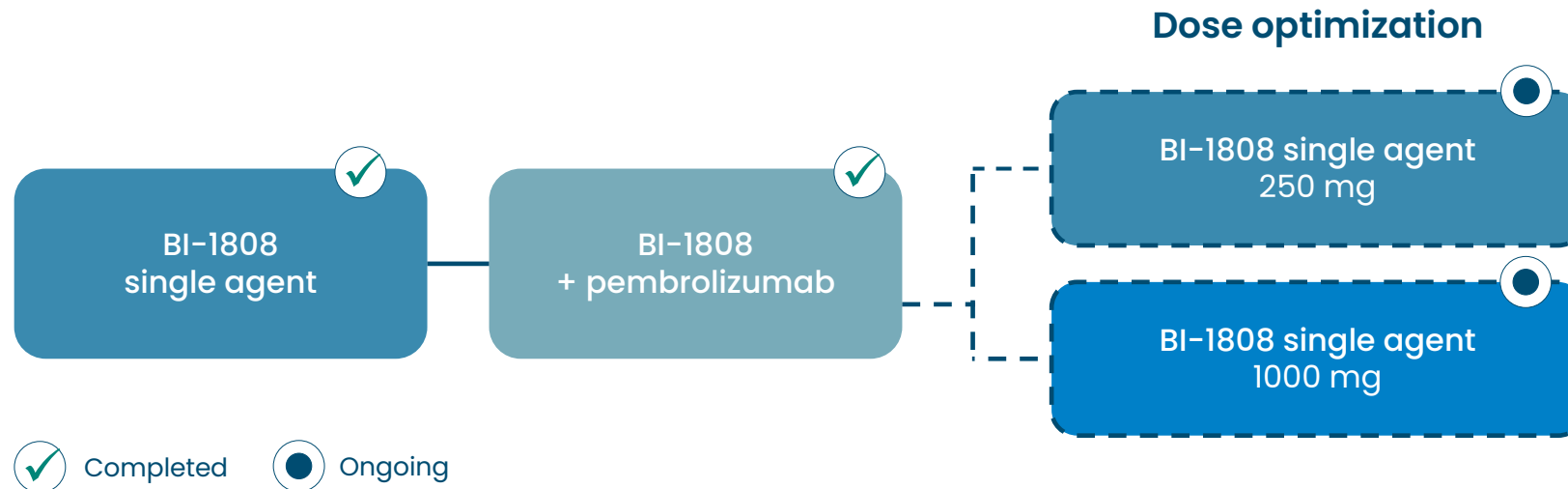
Week 21

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

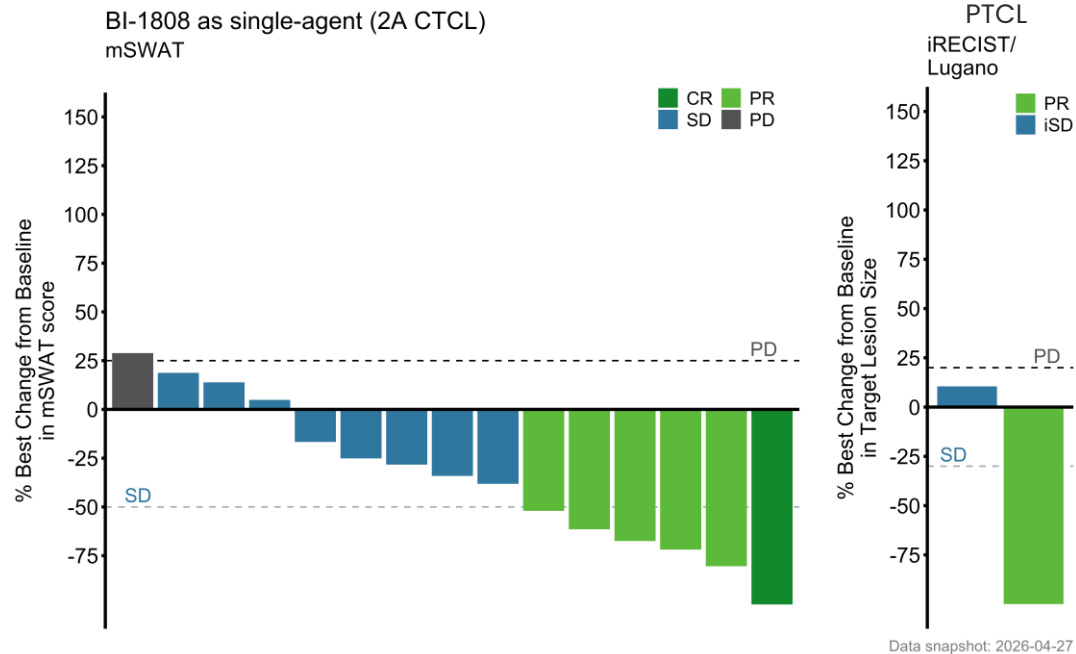
Fast Track
Designation
for CTCL



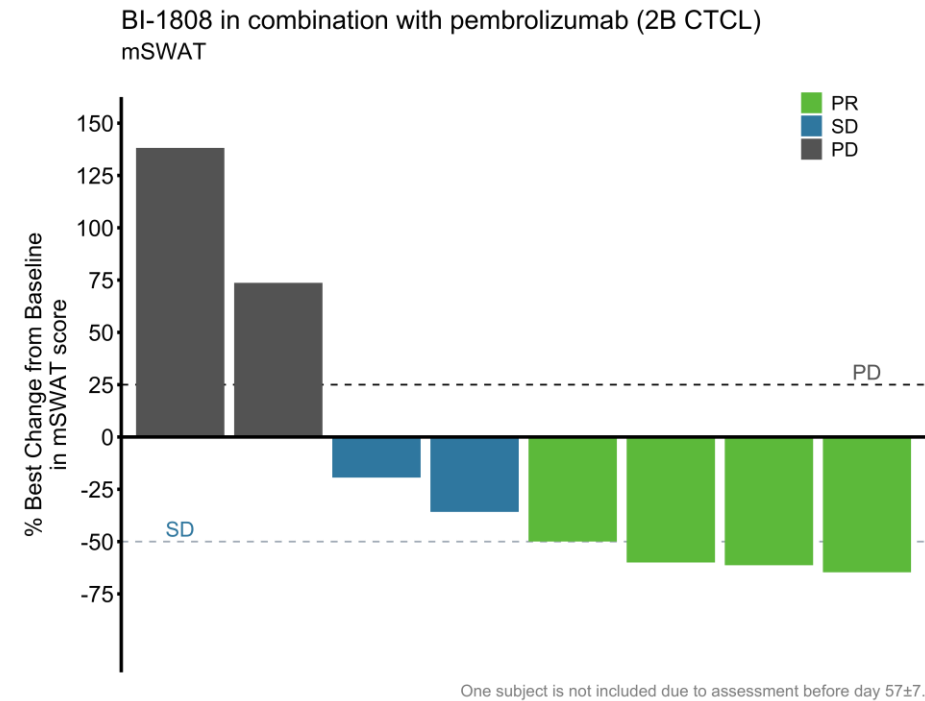
BI-1808 Shows Promising Efficacy in CTCL (and PTCL)

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

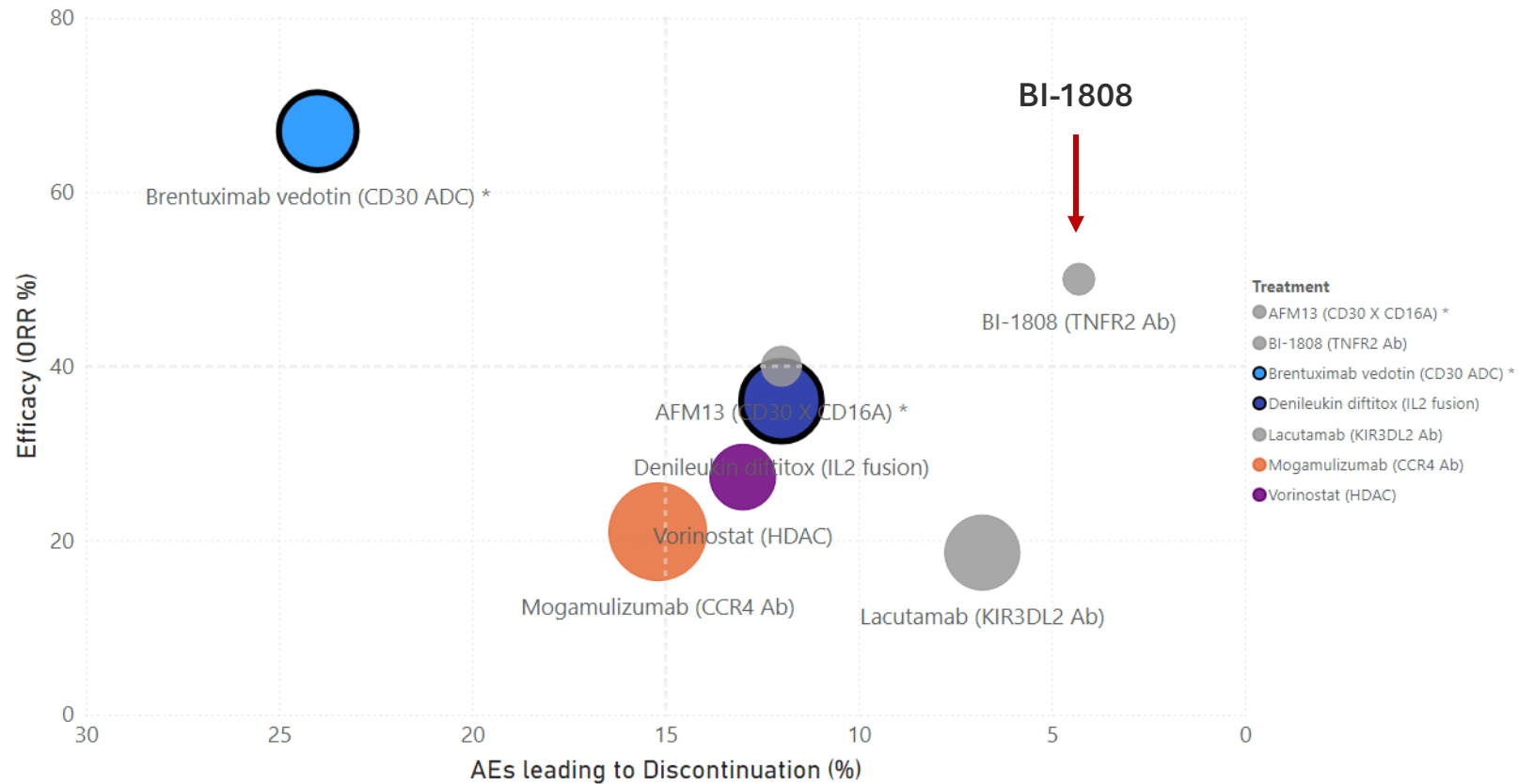
8 evaluable pts

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

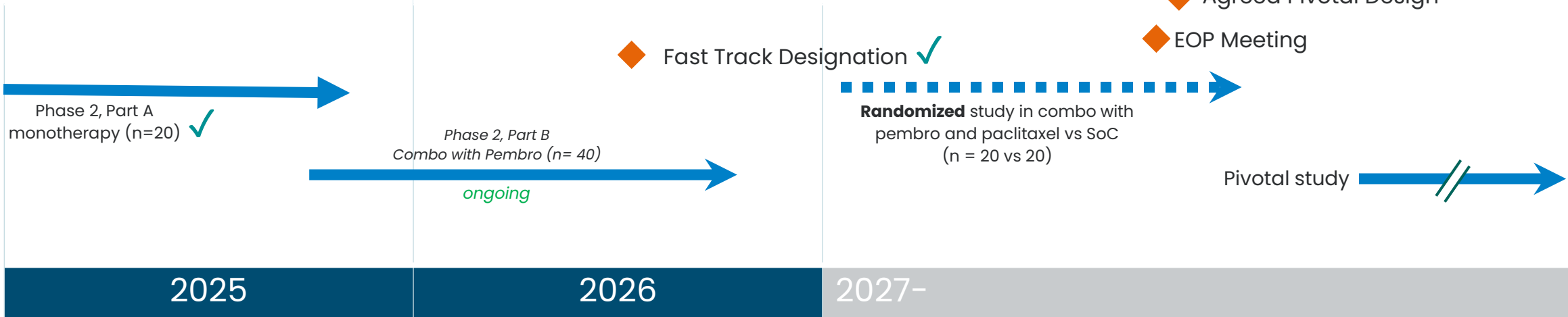


- Higher efficacy in MF than all other treatments except for brentuximab (30% of patients, black box warning)
- No biomarker restriction
- Best-in-class tolerability with only 4% discontinuation

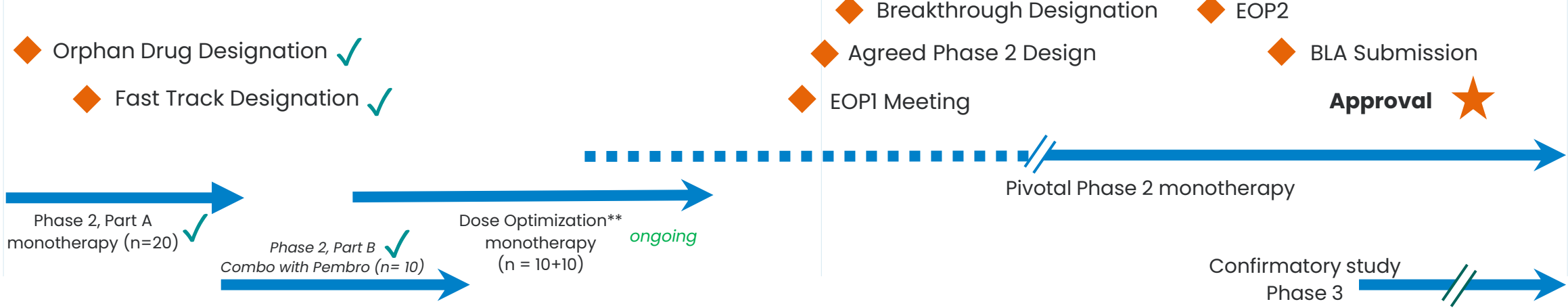
* Biomarker-selected subpopulation; Bubble size represents number of patients in reported dataset; Colored bubbles are approved treatments; Grey bubbles are unapproved treatments; Dark outline signifies black box warning

BI-1808 Potential Path to Approval – US

Potential Timelines for Ovarian Cancer*



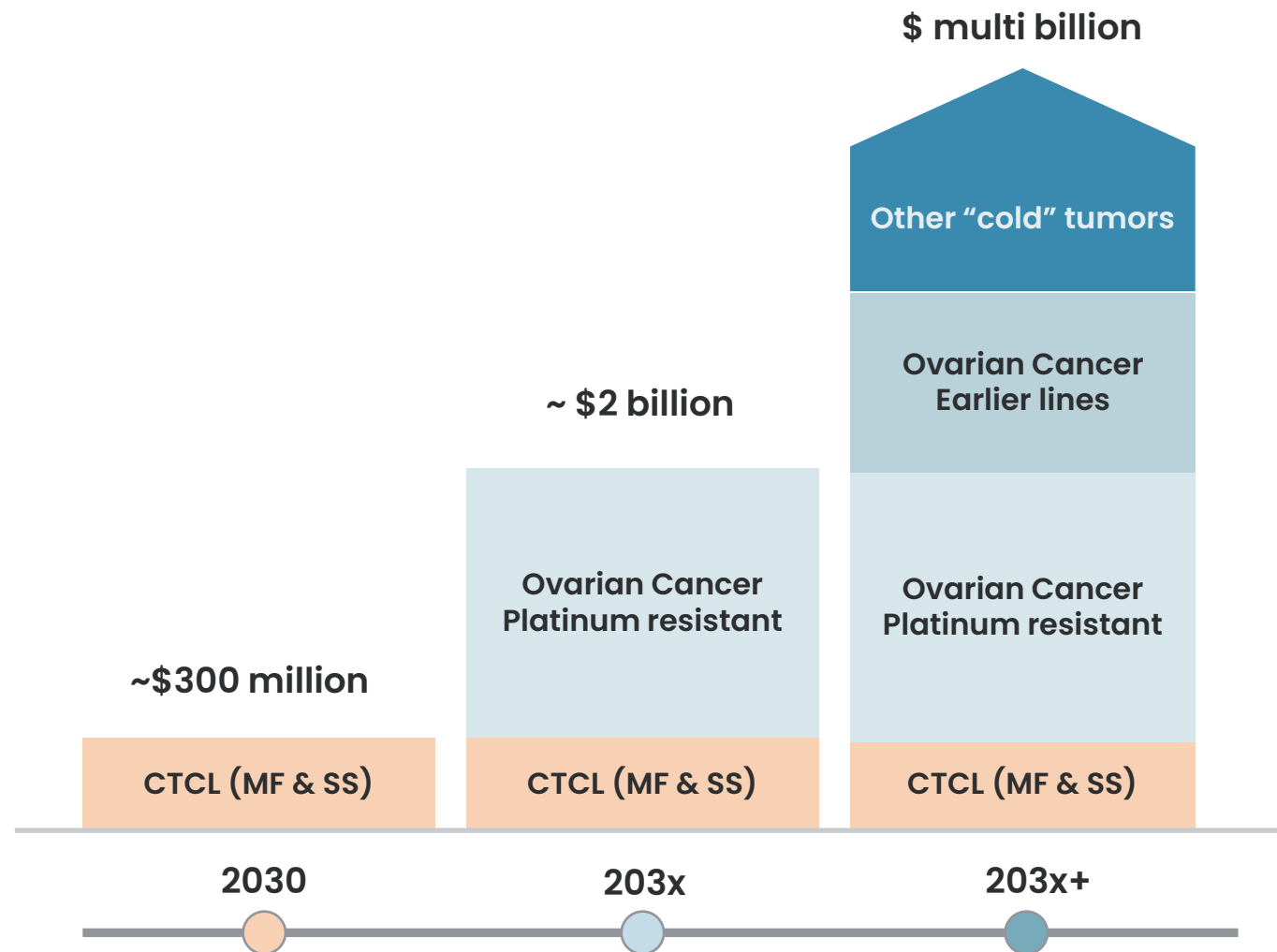
Potential Timelines for CTCL*



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

** Clinical study protocol approved in the US

A Pragmatic Development Strategy With Billion-Dollar Potential



- Pursue **Fast to market** indication in CTCL (plan for BTD 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 (e.g., MSS Colorectal cancer, TNBC or Small cell lung cancer)
 - Other "cold" tumors

ANTI-FcγRIIB

BI-1206 in Solid Tumors

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



BI-1206 in Solid Tumors:

Non-Small Cell Lung Cancer

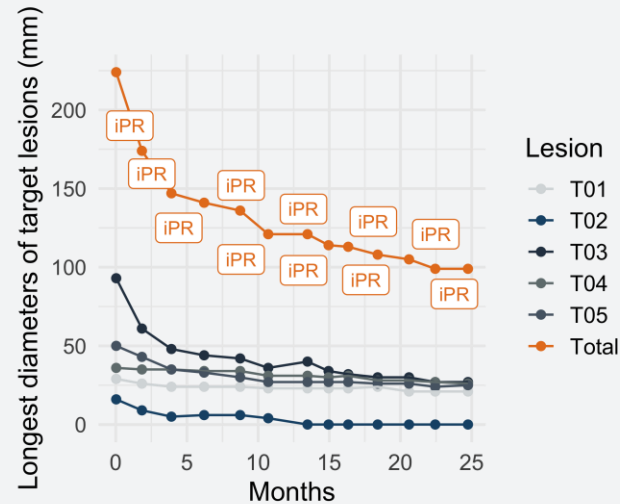
Uveal Melanoma

Co-administration of BI-1206 with Pembrolizumab

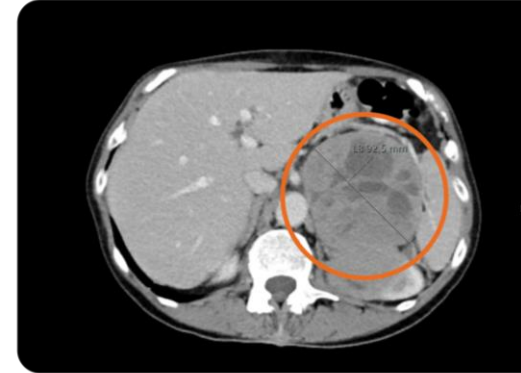
- Promising Responses in Uveal Melanoma who Previously Failed anti-PD-1

Case study: PR

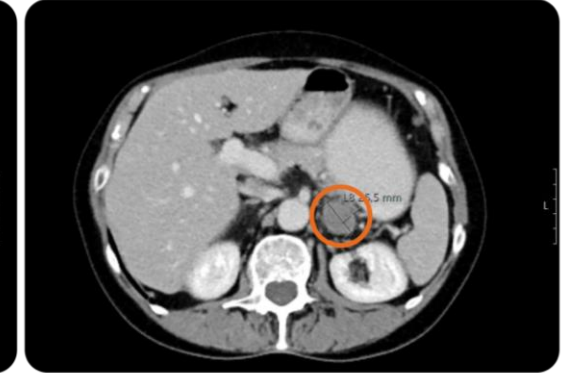
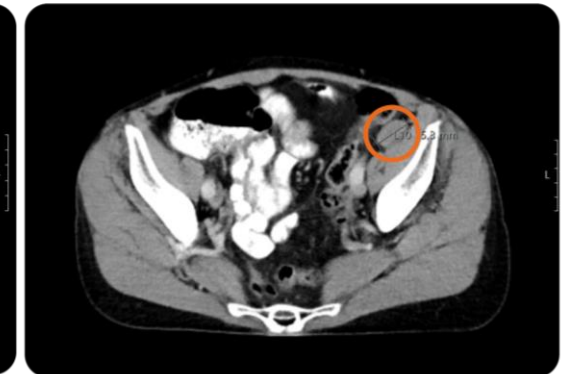
69 YO female with uveal melanoma.
No response to prior immunotherapy or chemotherapy. Multiples lines of ICIs and Chemo. Progressing when entering study. Showed early partial response at first scan on BI-1206 + pembrolizumab, continued PR deepening during whole study duration (2 years) with tumor burden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



Baseline



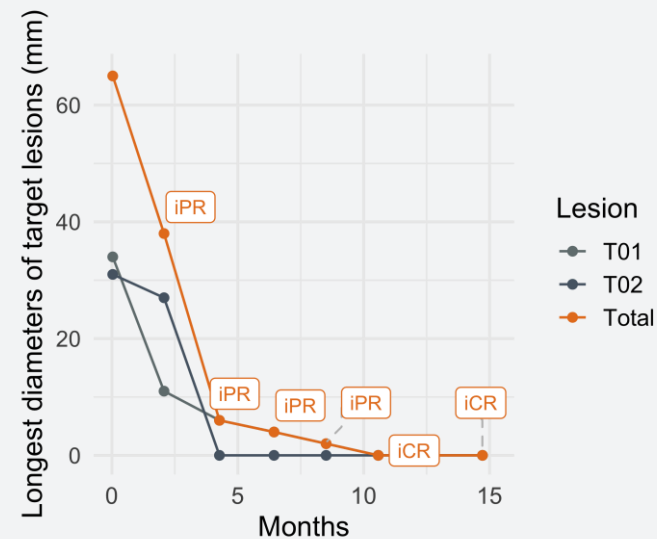
End of treatment 2 years



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.



Baseline

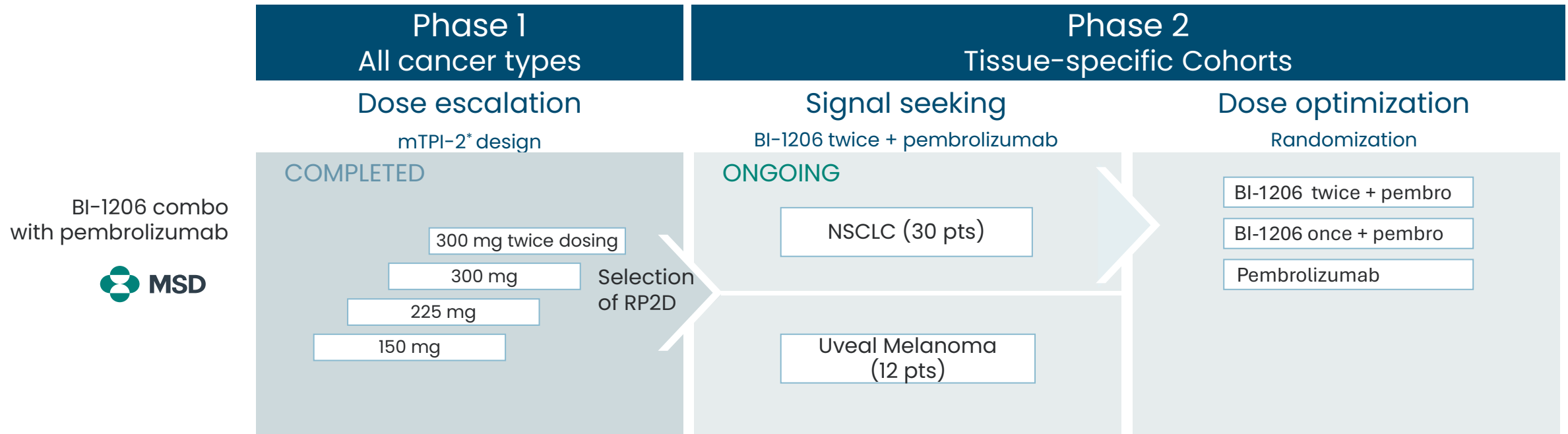


Scan at 16 months



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

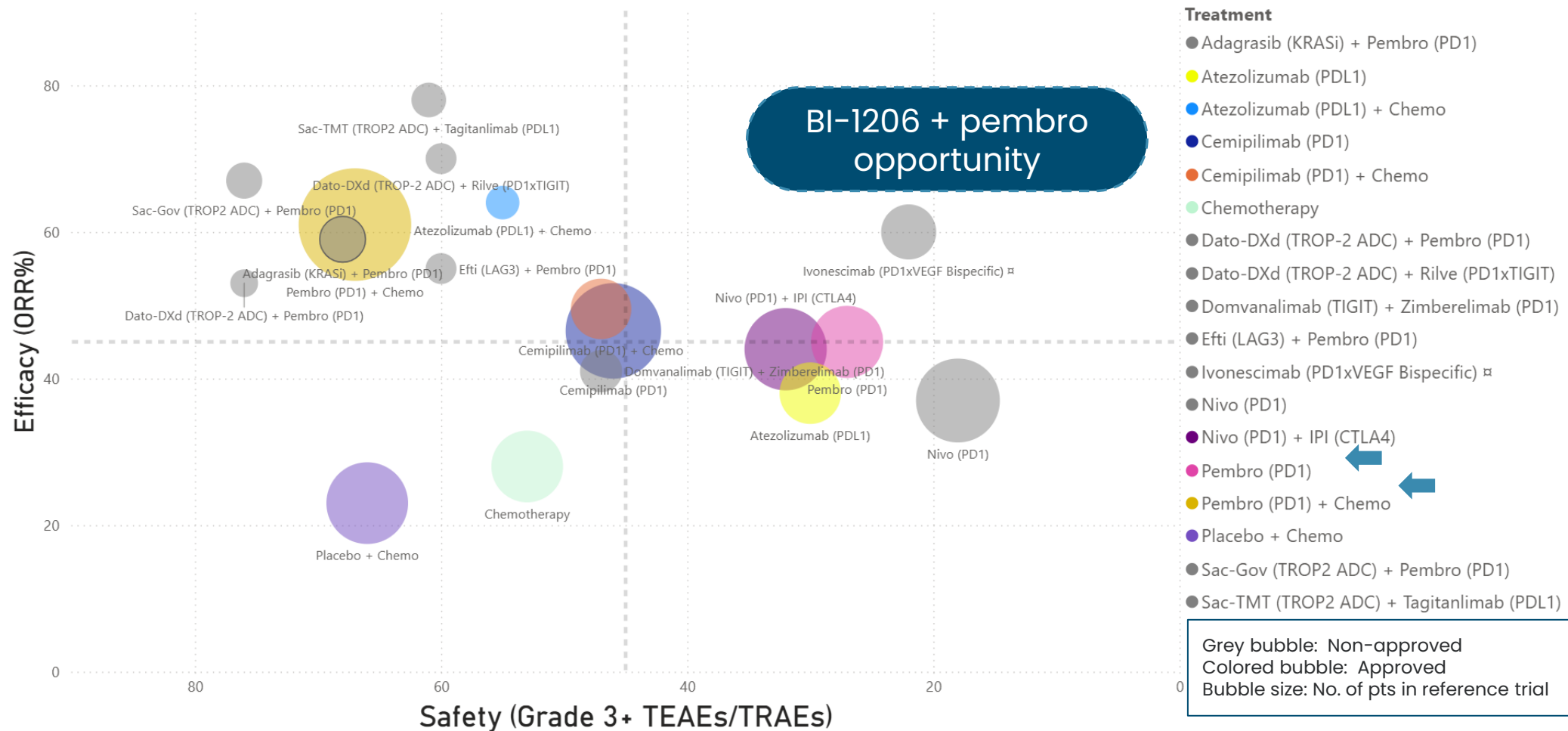
- To evaluate safety and efficacy of BI-1206 in combination with pembrolizumab
- Advanced or metastatic NSCLC and uveal melanoma
- Patients will be enrolled at sites in Georgia, Germany, Poland, Romania, Spain, Sweden and the US



WHAT'S NEXT?

First Phase 2a data in front-line NSCLC and uveal melanoma H1 2027E

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

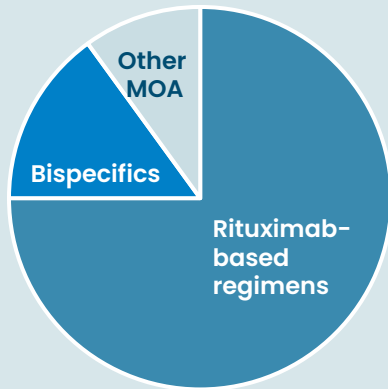
Positioning of BI-1206 in Non-Small Cell Lung Cancer

- 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).

BI-1206 in NHL

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

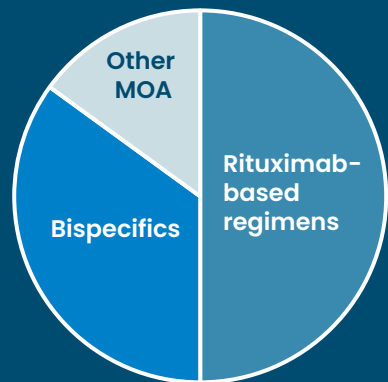
Now



Follicular Lymphoma (FL) Market Shifts

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

2030

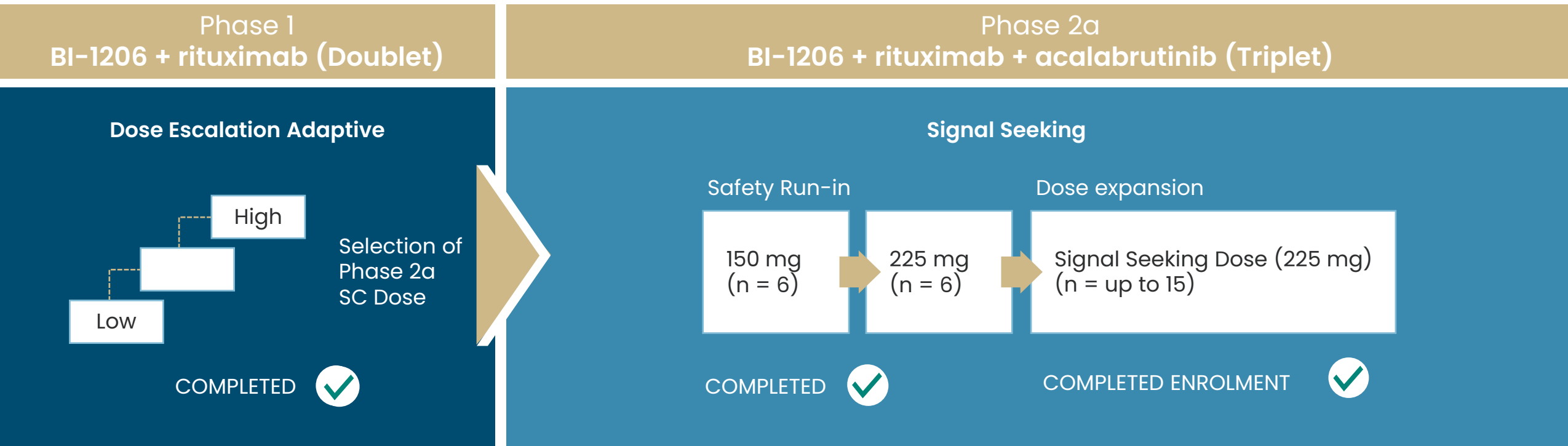


Opportunities for BI-1206

- 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

BI-1206 Clinical Study Overview

- Phase 1: BI-1206 enhances the activity of rituximab (*next slide*)
- 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

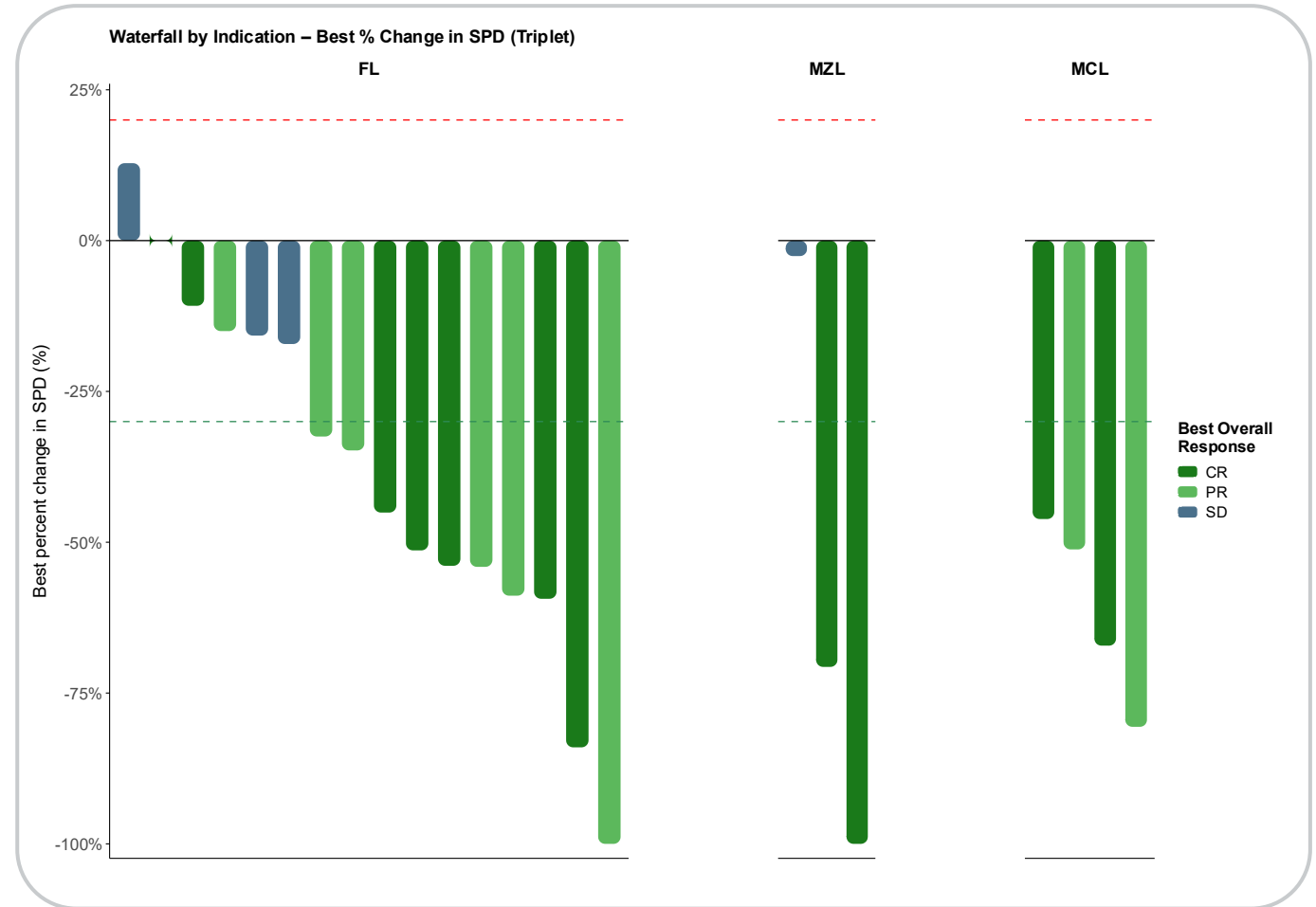
100% DCR

81% ORR in FL (n=16)

44% CRR in FL

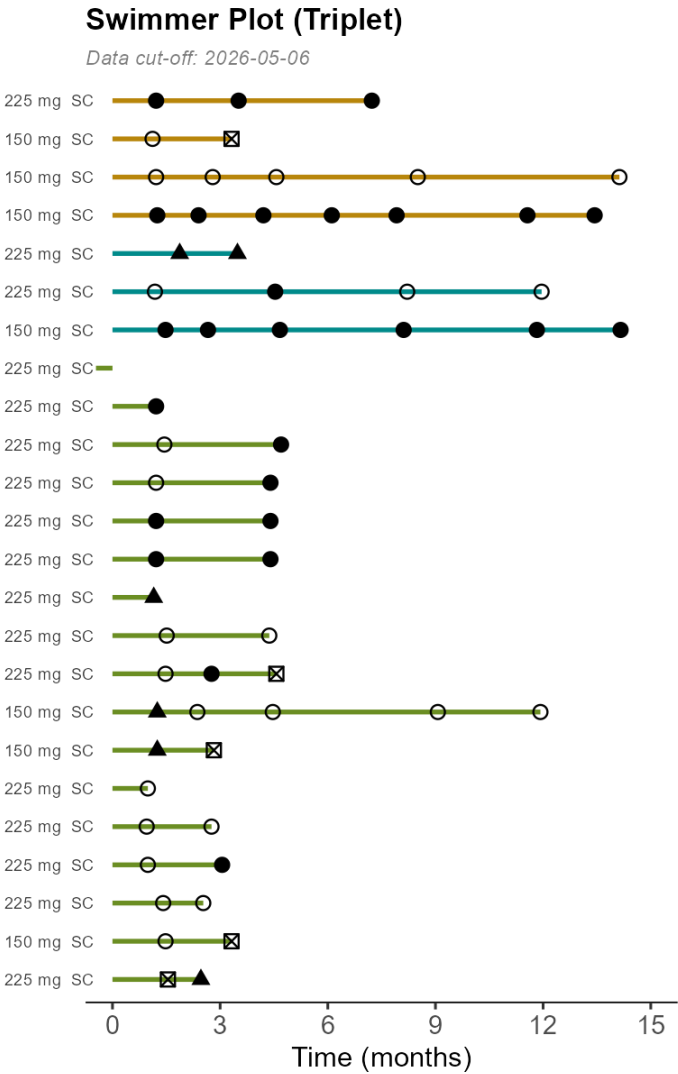
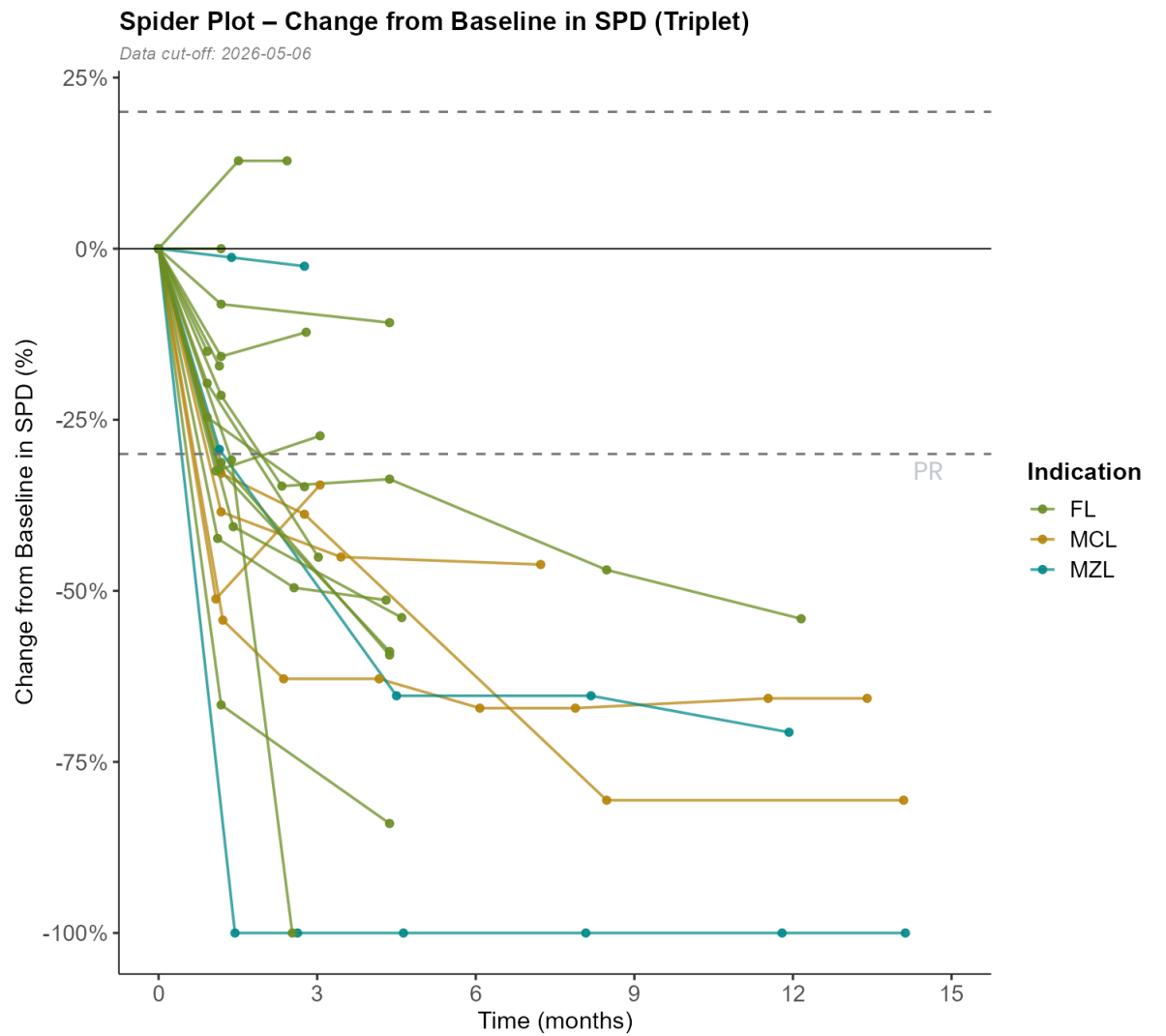
No CRS · No ICANS
No increased infection rate

- **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).

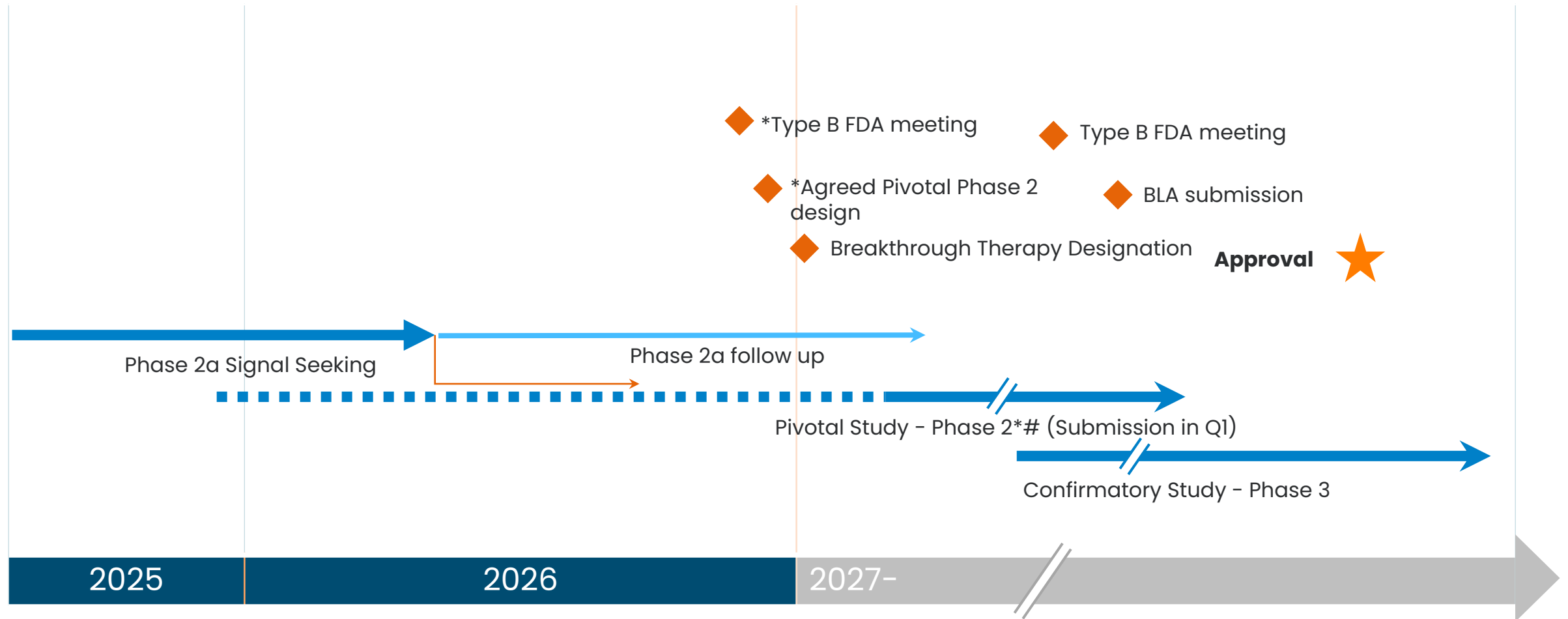
BI-1206 + Rituximab + Calquence* Triplet: Best Response (FL, MZL, MCL)



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

BI-1206 in NHL: Combination with Rituximab + Acalabrutinib

- Potential Timelines



*Depending on partnering discussions

Depending on 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**.

Key Expected Milestones 2026-2027

2026		2027	
TNFR2  BI-1808	Ovarian cancer	Additional Phase 2a data with Keytruda ✓	Additional Phase 2a data with Keytruda ✓
	CTCL	First Phase 2a data with Keytruda + additional monotherapy data ✓	Complete Phase 2a data dose optimization, monotherapy
2026		2027	
FcyRIIB  BI-1206	NHL (FL, MCL, MZL)	Additional Phase 2a data with rituximab + Calquence ✓	Potential start of pivotal triplet
	NSCLC 1L Uveal melanoma 1L	First read-out Phase 2a data with Keytruda	Potential start Phase 2b + Keytruda



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Appendix



BiolInvent Management Team



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8



Stefan Ericsson
Chief Financial Officer

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Chief Medical Officer

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Björn Frenhéus, Ph.D.
Chief Scientific Officer

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SVP Strategy & Finance

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Ingunn Munch Lindvig, Ph.D.
SVP Regulatory Affairs

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Kristoffer Rudenholm Hansson
SVP Technical Operations

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Sylvie Ryckebusch, Ph.D.
Chief Business Officer

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