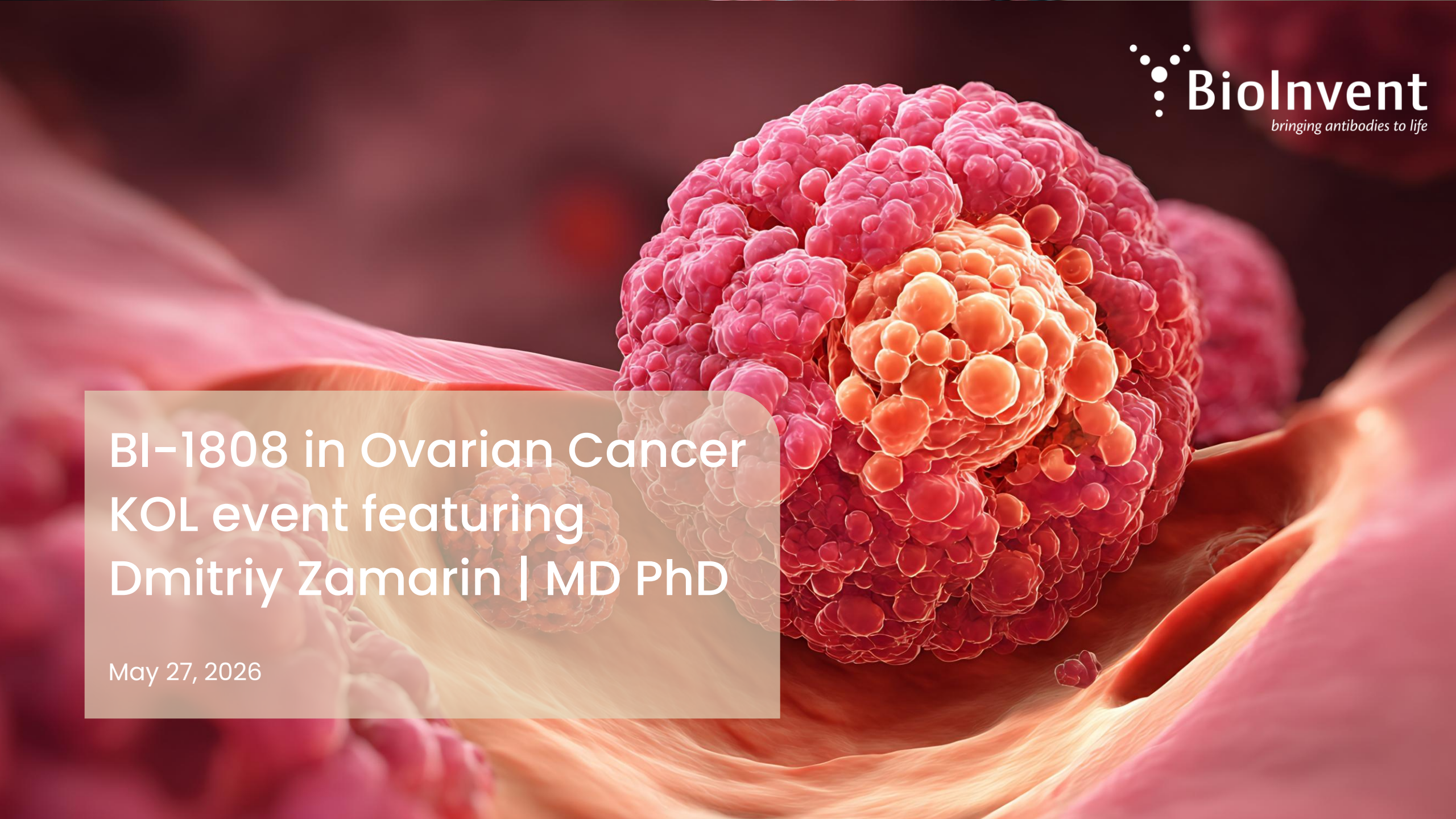

BioInvent
bringing antibodies to life

BI-1808 in Ovarian Cancer KOL event featuring Dmitriy Zamarin | MD PhD

May 27, 2026

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Welcome – Agenda for today

08:00 am	BioInvent, Poised for growth	*Martin Welschof, CEO*
08:05 am	Ovarian cancer treatment landscape, medical need, future treatment of ovarian cancer	*Dmitriy Zamarin, MD PhD*
08:25 am	BI-1808's Differentiated Mechanism of Action	*Björn Frendéus, CSO*
08:30 am	BI-1808 in Ovarian cancer • Targeting TNFR2 to Unlock Checkpoint Inhibitor Efficacy • Enhancing PD-1 Blockade in Recurrent Ovarian Cancer	*Andres McAllister, CMO*
08:50 am	Translational data: Dynamics of responses	*Björn Frendéus, CSO*
09:05 am	Market opportunity for BI-1808	*Sylvie Ryckebusch, CBO*
09:15 am	Final remarks	*Martin Welschof, CEO*
	Q&A	*All*

Martin Welschof

CEO

Today's Speakers

Dmitriy Zamarin | MD PhD

Dmitriy Zamarin MD PhD is Professor of Oncology, Section Head of Gynecologic Medical Oncology, and co-director of Center of Excellence for Gynecologic Cancers at the Tisch Cancer Center at Icahn School of Medicine at Mount Sinai.
Dr. Zamarin has served as a principal investigator and a translational chair on multiple institutional and cooperative group clinical trials exploring novel immunotherapy combinations in gynecologic cancers and other solid tumors and serves as the translational research co-chair on the NRG Oncology Cervical Cancer committee. In the laboratory, his research is focused on understanding of the mechanisms by which gynecologic cancers are recognized by the immune system and on identification of biomarkers predictive of response and resistance to immunotherapy.

Björn Frendéus | CSO

Andres McAllister | CMO

Sylvie Ryckebusch | CBO

BioInvent
bringing antibodies to life

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

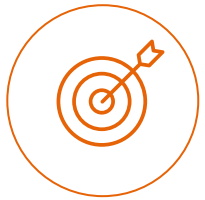
Large pharma seeks differentiated next-generation IO combinations ahead of the PD-1 patent cliff

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

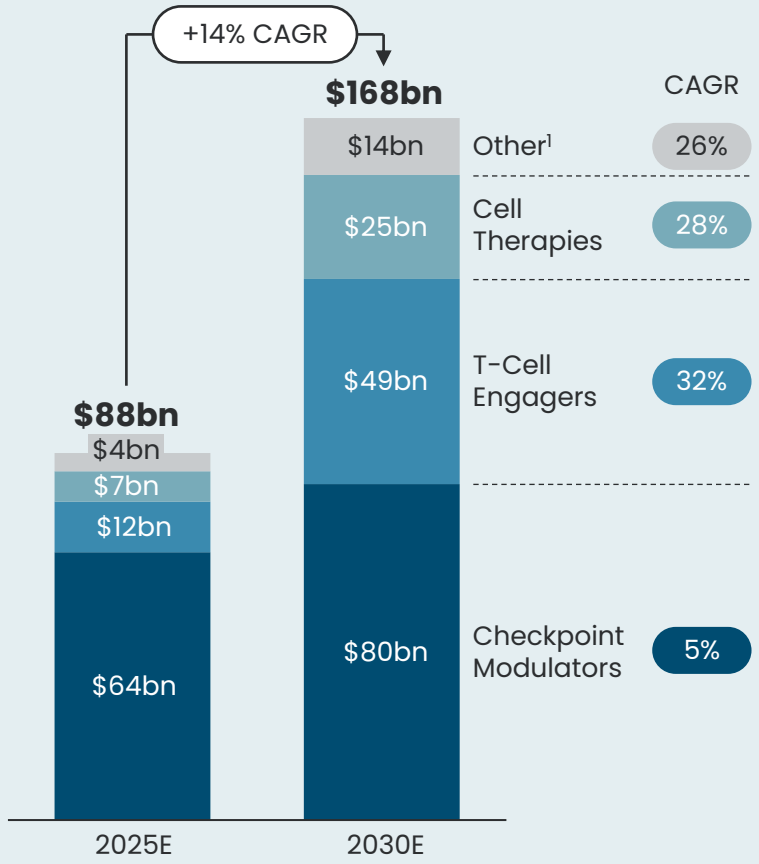
Multiple Phase 2 studies with upcoming readouts

Proven strategic partnerships backed by leading global healthcare investors

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

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 bottlenecks[2]

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

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

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

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	
KEYTRUDA (pembrolizumab)	MERCK	PD-1	$31.6bn	**2028** (earliest)	**~2031** (earliest)	Numerous patents expire 2028-2031 across key markets
OPDIVO (nivolumab)	Bristol Myers Squibb	PD-1	$10.0bn	**2028** (earliest)	**~2030** (earliest)	Broad patent estate with key expiry 2028-2030
TECENTRIQ atezolizumab	Roche	PD-L1	$4.6bn[1)]	**~2029-2031**	**~2029-2032**	PD-L1 class patents expire across 2028-2035
IMFINZI durvalumab	AstraZeneca	PD-L1	$6.0bn	**~2029-2031**	**~2029-2032**	PD-L1 class patents expire across 2028-2035
LIBTAYO (Cemiplimab)	SANOFI REGENERON	PD-1	$1.4bn	**~2032**	**~2033**	Later LOE relative to other PD-1 franchises

Source: FactSet as of 2026-05-07. Note(s): 1) CHF/USD exchange rate of 1.29 used for conversion

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**

BioInvent Could Help Unlock the Full Potential of Immuno-Oncology (IO)

Checkpoint inhibitors: transformative, but response rates remain inadequate

The Challenge

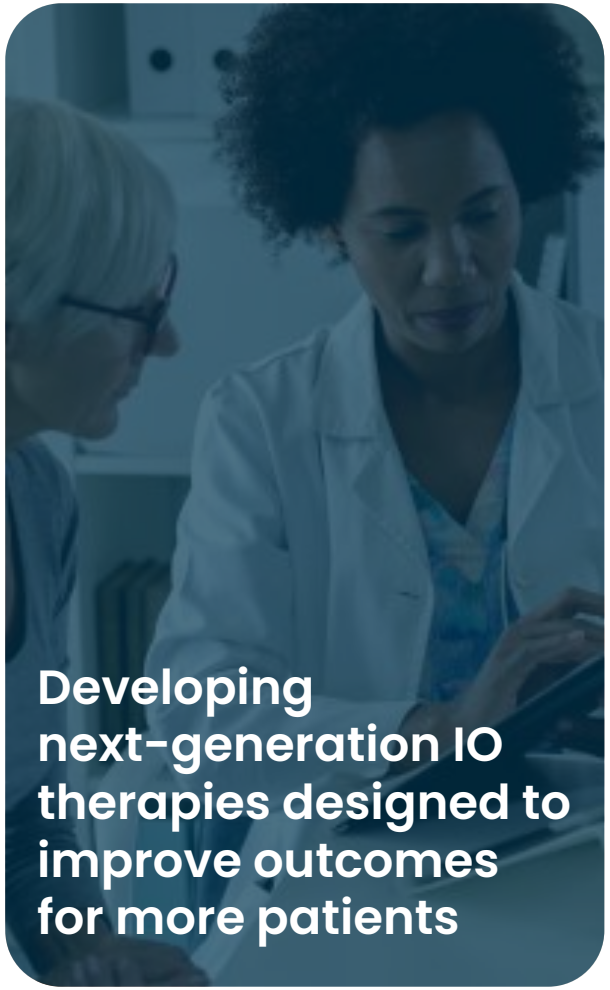
- **Too few patients respond**
  No response or less than 25% in many solid tumors
- **Responses often don't last**
  Relapses and progression common
- **Tumors develop resistance**
  Tumor microenvironment (TME)
- **IO still has untapped potential**
  Current therapies not optimized

Impact on patients today

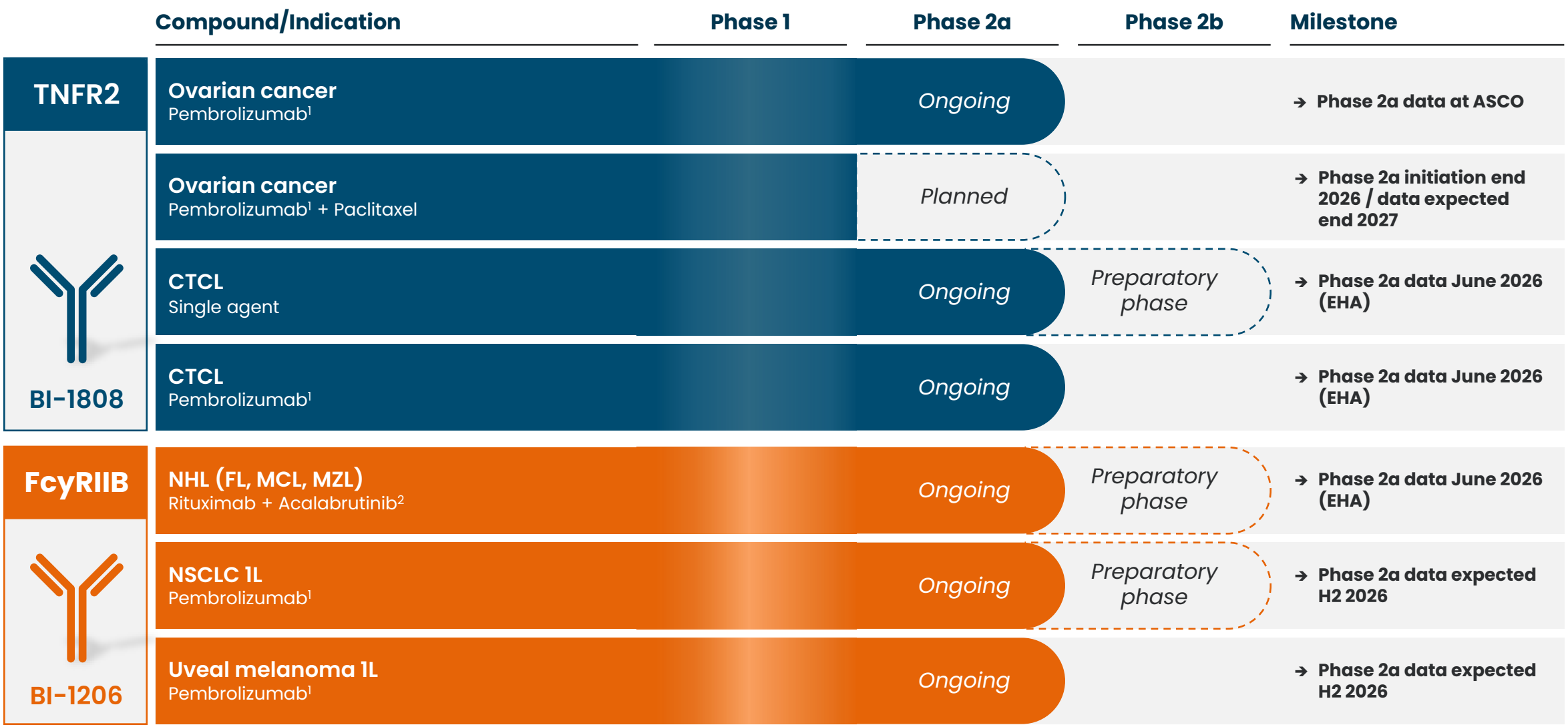
- **Many patients still do not respond**
- **Responses are often not durable**
- **Resistance limits long-term benefit**
- **Outcomes remain suboptimal**

How BioInvent is different

- **Increase response rates**
- **Favorable safety enables broader use**
- **Deliver deeper and longer-lasting responses**
- **Target resistance in the TME**
- **Unlock the full potential of IO**



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



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

Dmitriy Zamarin

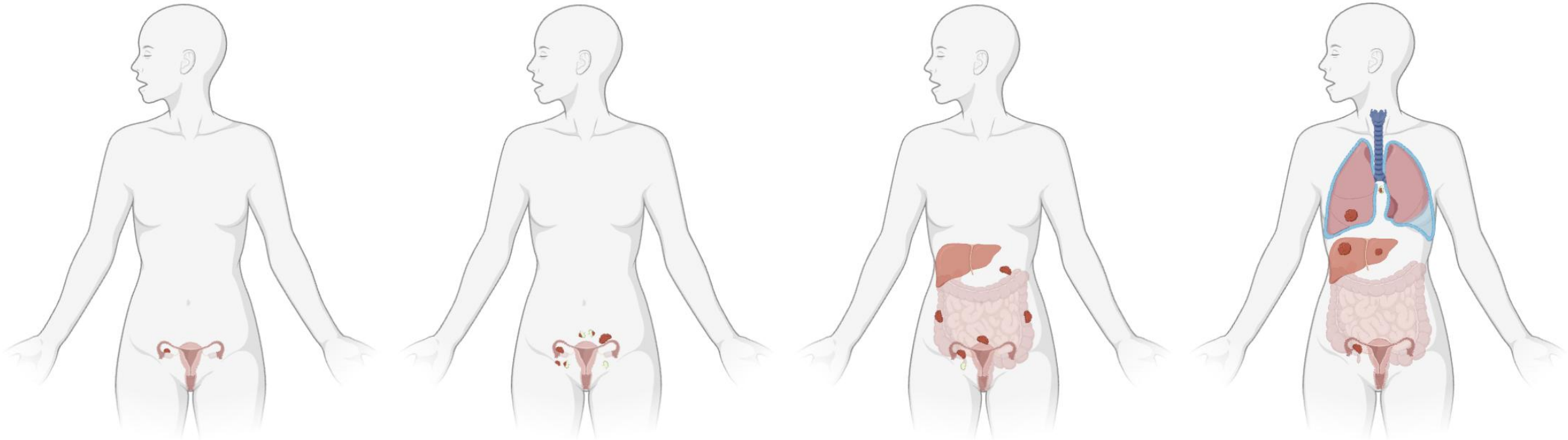
MD PhD

Treatment landscape of platinum-resistant ovarian cancer

Dmitriy Zamarin MD PhD
Professor
Section Head, Gynecologic Medical Oncology
Icahn School of Medicine at Mount Sinai
May 27, 2026

Icahn School of Medicine at Mount Sinai

Simplified staging of ovarian cancer



Stage I

Limited to one or both ovaries

Stage II

Limited to pelvis

Stage III

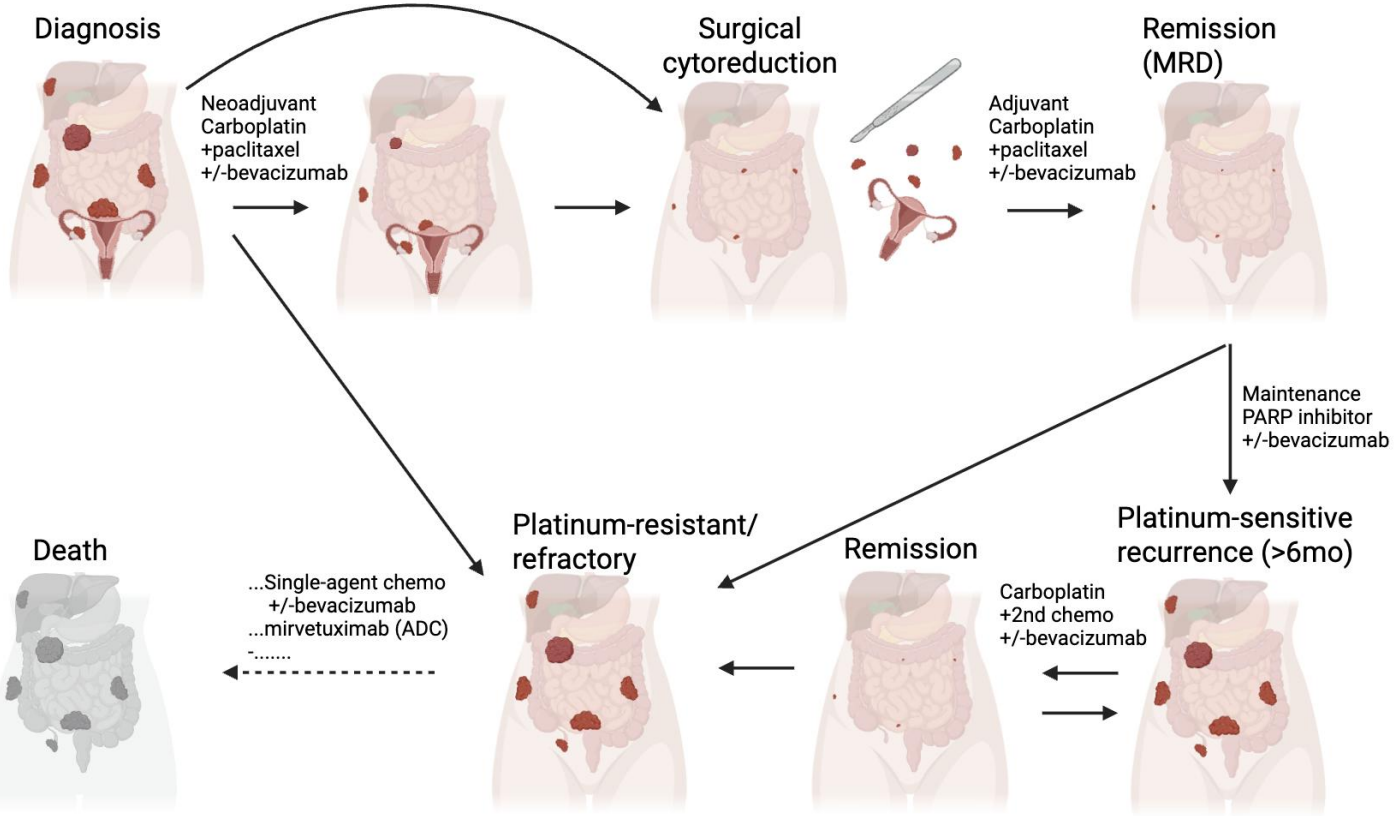
Limited to abdomen (no parenchymal organ involvement

Stage IV

Parenchymal organ involvement or extra-abdominal spread

Advanced stage ovarian cancer (stage III-IV): an ongoing therapeutic challenge

- High grade serous (HGSOC) is the most common histology
- Presents in metastatic stage in >80% of cases
- After initial therapy, >80% of patients relapse and eventually succumb to disease
- **Cytotoxic therapy remains the mainstay of treatment**



Ascites and Carcinomatosis

Current treatment paradigms:

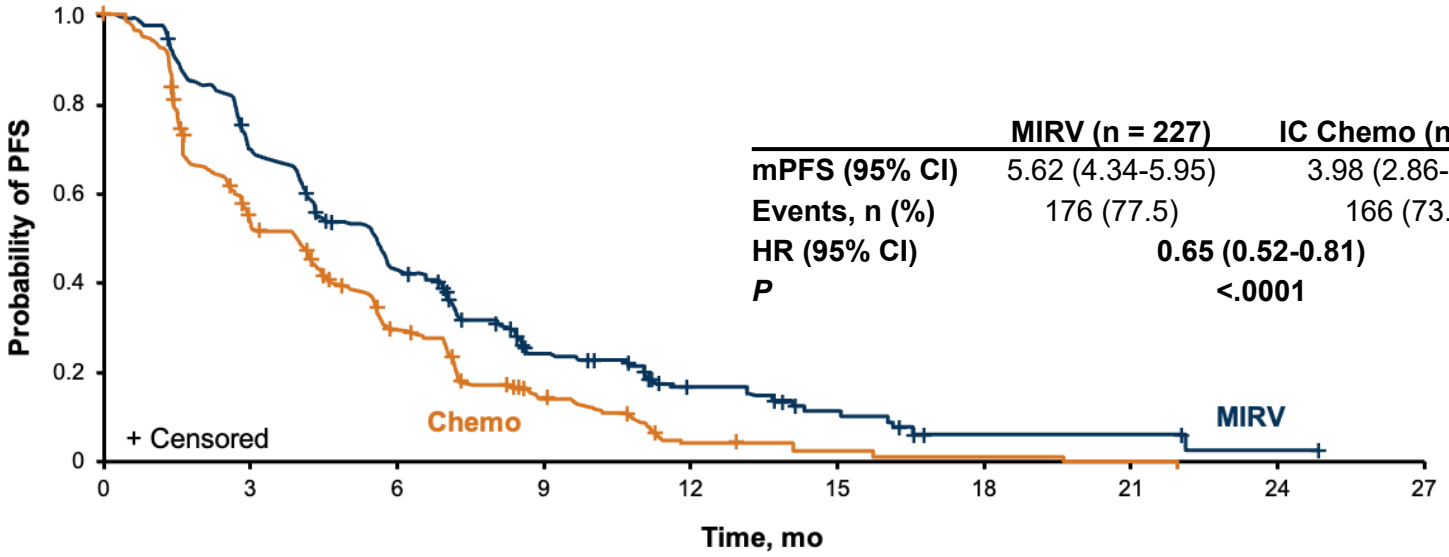
- **Newly-diagnosed:** carboplatin+paclitaxel +/- bevacizumab with maintenance +/- PARP inhibitor maintenance (for HRD+ and BRCA-mutant cancers only): ~80% of patients experience eventual disease recurrence

- **Platinum-sensitive recurrence:** Platinum doublet chemotherapy +/- bevacizumab with maintenance +/- PARP inhibitor maintenance (only for BRCA-mutant, rare): >90% of patients experience eventual disease recurrence

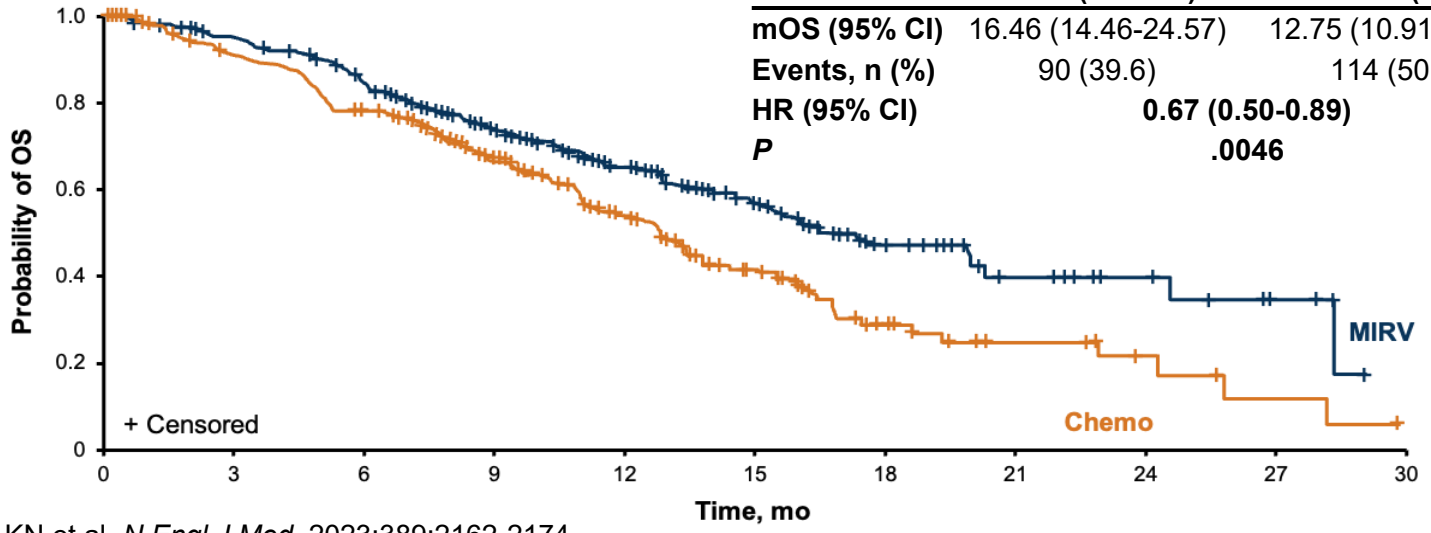
- **Platinum-resistant recurrence:**
  - Mirvetuximab soravtansine (for FOLR1+ cancers)
  - Pemrolizumab + paclitaxel +/- bevacizumab (for PD-L1+ cancers)
  - Relacorilant + nab-paclitaxel
  - Single-agent chemotherapy +/- bevacizumab
  - Trastuzumab deruxtecan (for HER2+ cancers)
  - Irrespective of therapy, virtually all patients experience disease progression

Current and emerging therapies in platinum-resistant ovarian cancer

Mirvetuximab Soravtansine: Folate receptor alpha (FRα)- targeted ADC in patients with FRα-high ovarian cancer



	MIRV (n = 227)	IC Chemo (n = 226)
mPFS (95% CI)	5.62 (4.34-5.95)	3.98 (2.86-4.47)
Events, n (%)	176 (77.5)	166 (73.5)
HR (95% CI)	**0.65 (0.52-0.81)**	
P	**<.0001**	

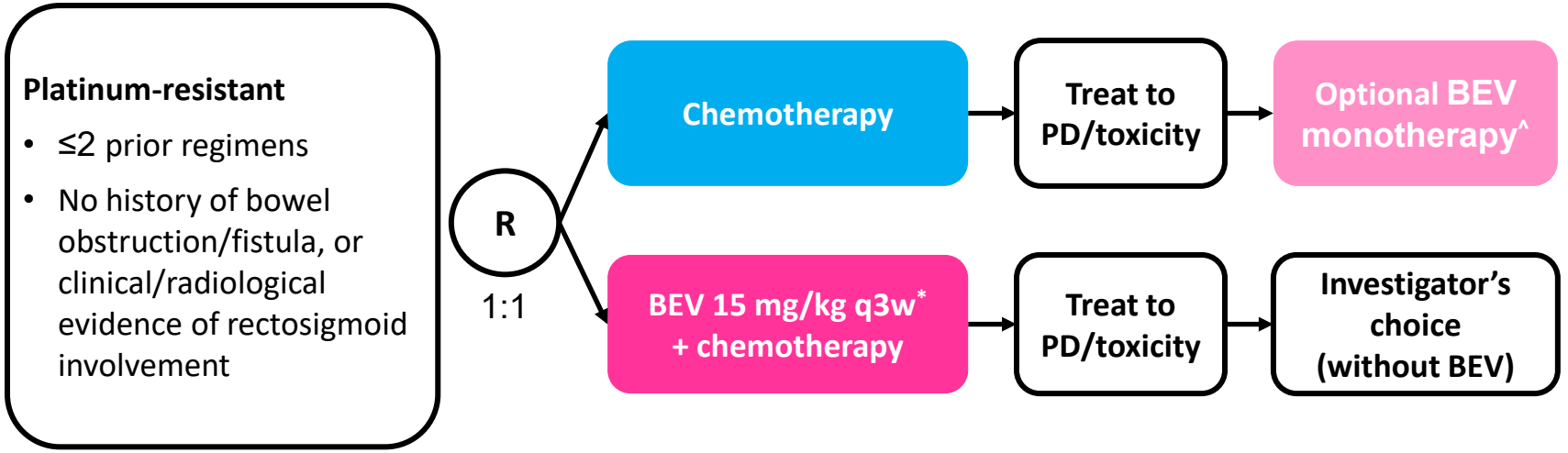


	MIRV (n = 227)	IC Chemo (n = 226)
mOS (95% CI)	16.46 (14.46-24.57)	12.75 (10.91-14.36)
Events, n (%)	90 (39.6)	114 (50.4)
HR (95% CI)	**0.67 (0.50-0.89)**	
P	**.0046**	

FDA-approved for FRα-high ovarian cancer

1. Moore KN et al. *N Engl J Med.* 2023;389:2162-2174.

AURELIA: single-agent chemotherapy with or without bevacizumab



Stratification factors:

- Chemotherapy selected
- Prior anti-angiogenic therapy
- Treatment-free interval (PFI <3 vs 3–6 months)

Chemotherapy options (investigator's choice):

- Paclitaxel 80 mg/m^2 days 1, 8, 15 & 22 q4w
- Topotecan 4 mg/m^2 days 1, 8 & 15 q4w (or 1.25 mg/m^2, days 1–5 q3w)
- PLD 40 mg/m^2 day 1 q4w

J Clin Oncol 2014;32(13):1302-8

Or 10 mg/kg q2w

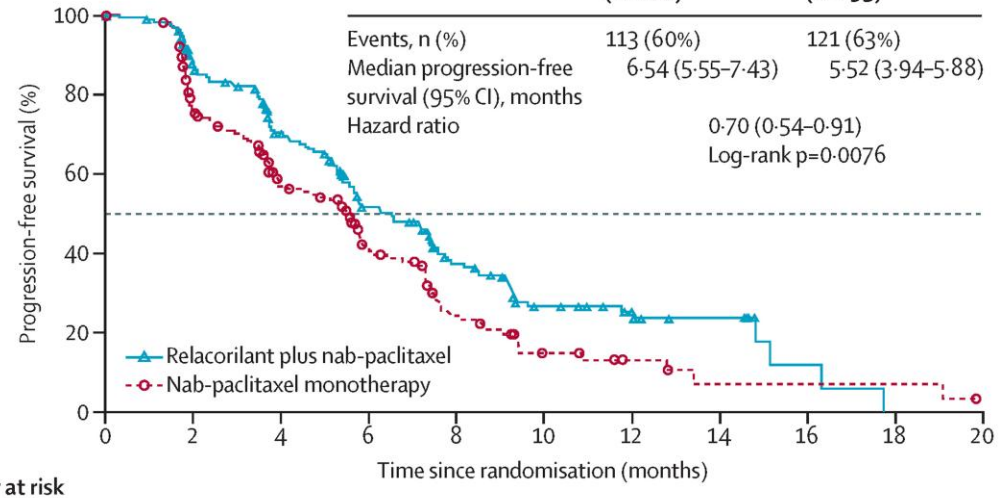
^15 mg/kg q3w, permitted on clear evidence of progression

AURELIA: single-agent chemotherapy with or without bevacizumab

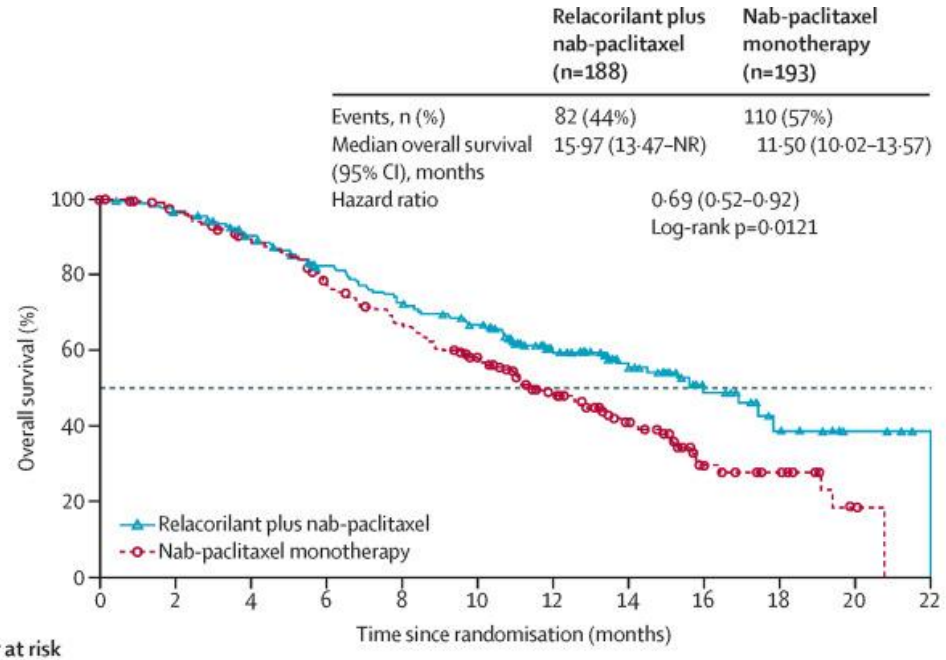
	RR Chemo alone	RR Chemo + Bev	Median PFS Chemo alone (months)	Median PFS Chemo + Bev (months)	HR	Median OS Chemo Alone (months)	Median OS Chemo + Bev (months)	HR
Overall Study	**11.8%**	**27.3%**	**3.4**	**6.7**	**0.48 (0.38-0.60)**	13.3	16.6	0.85 (0.66-1.08)
Paclitaxel	30.2%	53.3%	3.9	10.4	0.46 (0.30-0.71)	13.2	22.4	0.65 (0.42-1.02)
PLD	7.8%	13.7%	3.5	5.4	0.57 (0.39-0.83)	14.1	13.7	0.91 (0.62-1.36)
Topotecan	0%	17%	2.1	5.8	0.32 (0.21-0.49)	13.3	13.8	1.09 (0.72-1.67)

J Clin Oncol 2014;32(13):1302-8; J Clin Oncol 2015;33:3836-3838

ROSELA: Phase III trial of nab-paclitaxel +/- glucocorticoid receptor antagonist relacorilant in patients with platinum-resistant ovarian cancer



Number at risk (censored)											
Relacorilant plus nab-paclitaxel	188 (0)	151 (15)	109 (28)	70 (40)	43 (49)	24 (57)	16 (64)	11 (68)	2 (75)	0 (75)	..
Nab-paclitaxel monotherapy	193 (0)	129 (22)	85 (35)	47 (53)	21 (62)	9 (67)	5 (70)	2 (71)	2 (71)	2 (71)	0 (72)



Number at risk (censored)												
Relacorilant plus nab-paclitaxel	188 (0)	180 (2)	162 (8)	143 (13)	126 (13)	111 (18)	77 (42)	49 (65)	24 (86)	10 (97)	4 (103)	0 (106)
Nab-paclitaxel monotherapy	193 (0)	179 (8)	160 (14)	137 (17)	115 (19)	93 (26)	65 (40)	40 (56)	16 (71)	11 (75)	3 (81)	0 (83)

Olawaiye et al., Lancet 2026

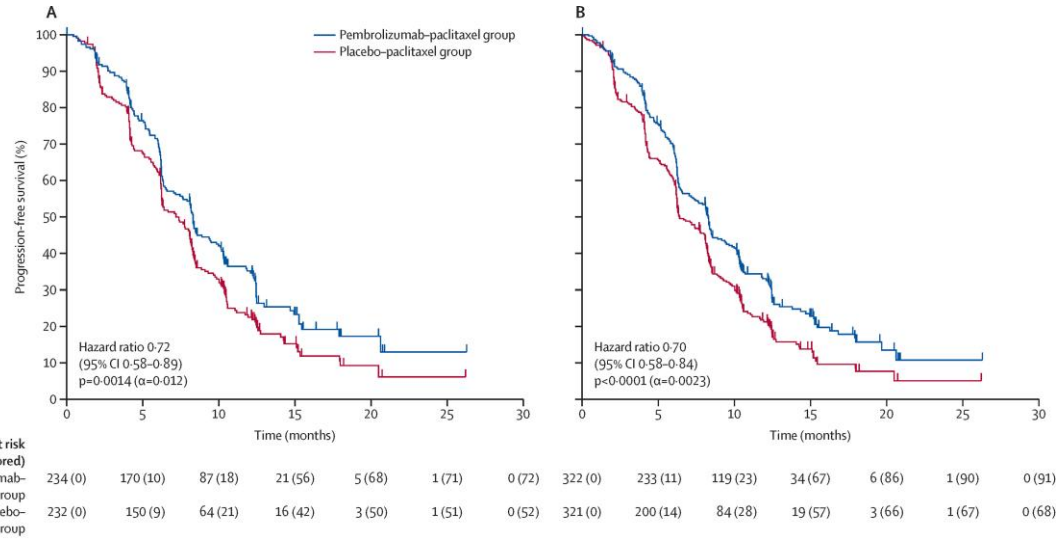
Immune checkpoint blockade in ovarian cancer: mostly negative trials

Trial name/ref.	Treatment	Phase	Study population	Biomarker-based patient selection	ORR (%)	mPFS (months)
IMagyn050/GOG 3015/ENGOT-ov39 [19]	Atezolizumab + chemo + bevacizumab vs chemo + bevacizumab	Phase 3	Frontline, newly diagnosed advanced OC	PD-L1 subgroup (small benefit)	No significant improvement	No significant improvement
KEYNOTE-100 [26]	Pembrolizumab monotherapy	Phase 2	Recurrent OC	PD-L1 CPS >10 (ORR 10%); CPS <1 (ORR 4.1%)	8–10% (depending on CPS)	Not significant
JAVELIN Ovarian 200 [28]	Avelumab ± chemotherapy	Phase 3	Recurrent OC	No biomarker correlation (PD-L1, BRCA not predictive)	ORR 8–12%	No survival benefit
NINJA [25]	Nivolumab vs standard chemotherapy	Phase 3	Recurrent OC	Not biomarker-based	ORR ~8–22%	No survival benefit
NRG-GY003 [33]	Nivolumab ± ipilimumab	Phase 2	Recurrent OC	Not biomarker-based	31% (combo) vs 12% (NIVO alone)	3.9 (combo) vs 2.0 (NIVO)
Pembrolizumab + bevacizumab + cyclophosphamide [34]	Triplet combination	Phase 2 (single arm)	Recurrent OC (single-arm)	Not biomarker-based	47.5%	10 months
Nivolumab + bevacizumab [35]	Combination	Phase 2	Recurrent OC	Higher activity in platinum-sensitive vs resistant	28.9% (40% platinum-sensitive, 16.7% platinum-resistant)	Not specified
DUO-O [29]	Durvalumab + olaparib + chemo + bevacizumab	Phase 3	Frontline OC	HRD-positive subgroup (modest benefit)	Not specified	Modest benefit in HRD+
ATHENA-COMBO [30]	Rucaparib + nivolumab vs rucaparib	Phase 3	Frontline OC	Not biomarker-based	No improvement	No improvement
KEYLYNK-001 [31]	Pembrolizumab + olaparib vs chemo	Phase 3	Frontline OC	Not biomarker-based	No improvement	No improvement
FIRST (ENGOT-ov44) [32]	Dostarlimab + niraparib + chemo	Phase 3	Frontline OC	Not biomarker-based	No improvement	No improvement
ARTISTRY-7 [94]	Nemvaleukin alfa + ICI	Phase 3	Platinum-resistant OC	Not reported	Ongoing	Ongoing
KEYNOTE-B96/ENGOT-vc65 [10]	Pembrolizumab + paclitaxel ± bevacizumab	Phase 3	Platinum-resistant OC	Benefit in PD-L1+ and all-comers	Improved	Improved PFS (OS benefit in PD-L1+)

KEYNOTE B96: Phase III trial of weekly paclitaxel +/- pembrolizumab +/- bevacizumab in patients with platinum-resistant ovarian cancer

PFS

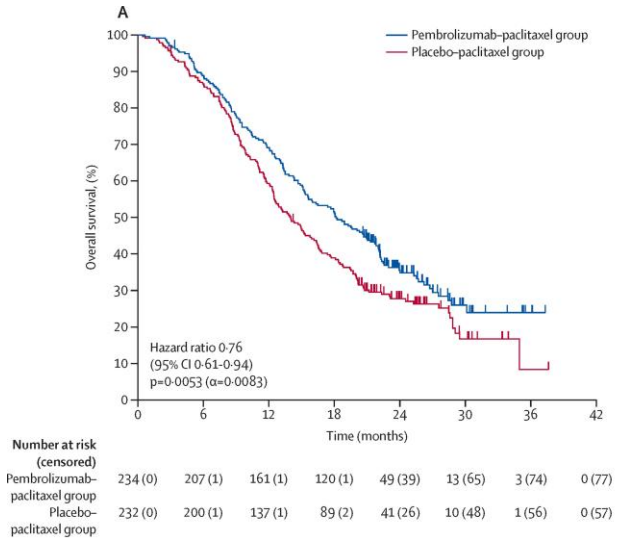
PD-L1+



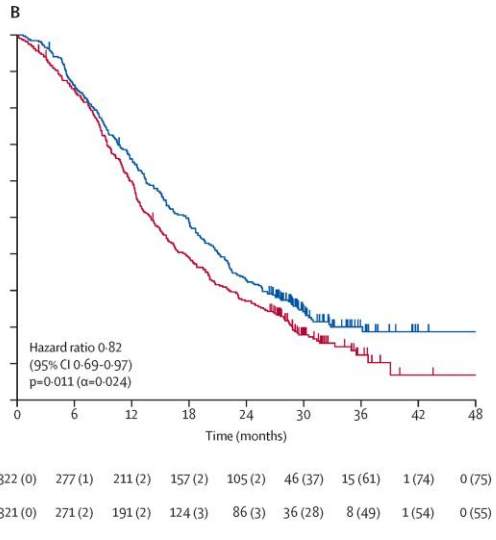
overall

OS

PD-L1+



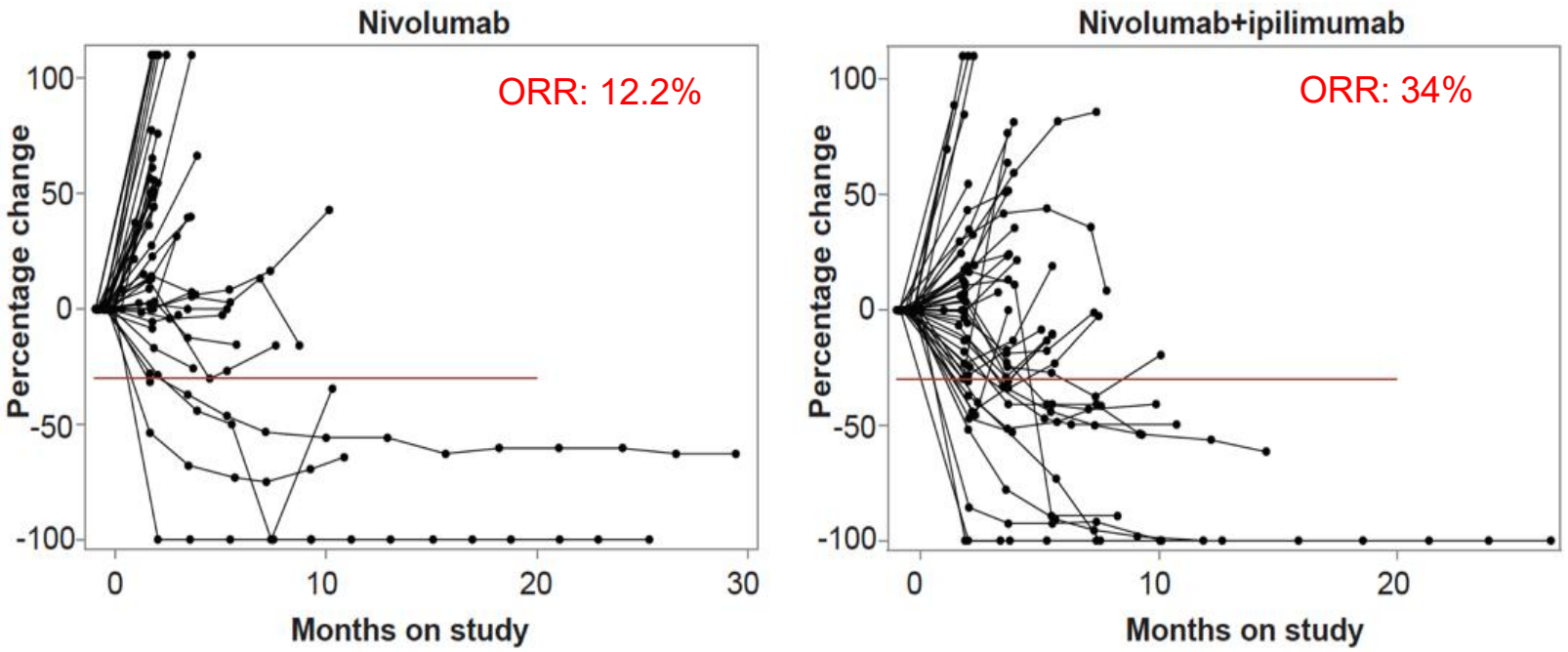
overall



Colombo et al., Lancet 2026

Combinations of immune checkpoint inhibitors (anti-CTLA-4 and anti-PD-1) can overcome immune resistance in some ovarian cancer patients

NRG-GY003: randomized trial of nivolumab (anti-PD-1) vs. nivolumab with ipilimumab (anti-PD-1 plus anti-CTLA-4) in platinum- resistant ovarian cancer

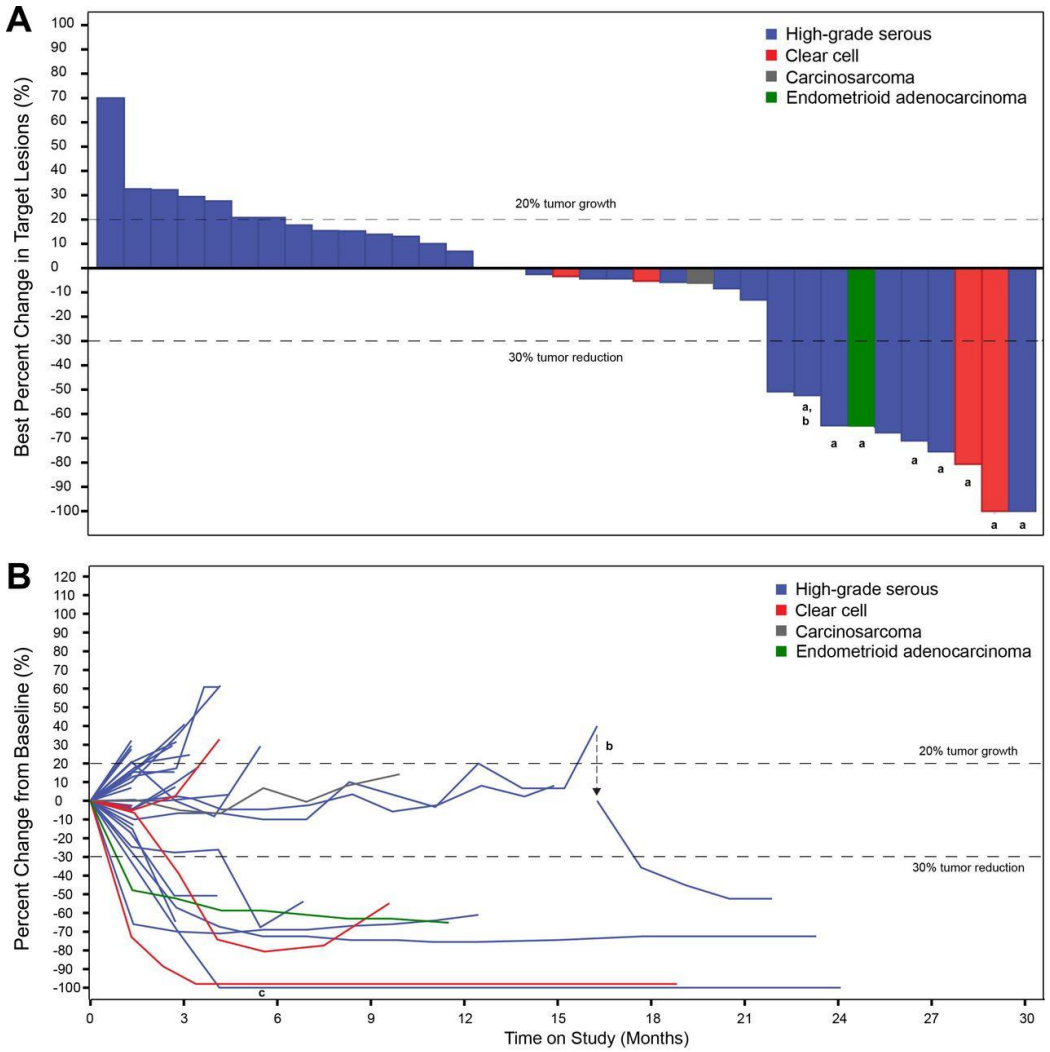


NRG ONCOLOGY
Advancing Research. Improving Lives.™

Zamarin D, Burger RA, … Powell DJ et al., *J. Clin. Oncol*. 2020

Combinations of immune checkpoint inhibitors (anti-CTLA-4 and anti-PD-1) can overcome immune resistance in some ovarian cancer patients

Balstilimab (anti-PD-1) with botensilimab (anti-CTLA-4) in platinum- resistant ovarian cancer



Porter R et al., JITC 2025

Ovarian cancer: T cell engagers (CLDN6 most common)

BNT142-01: Clinical activity in ovarian cancer

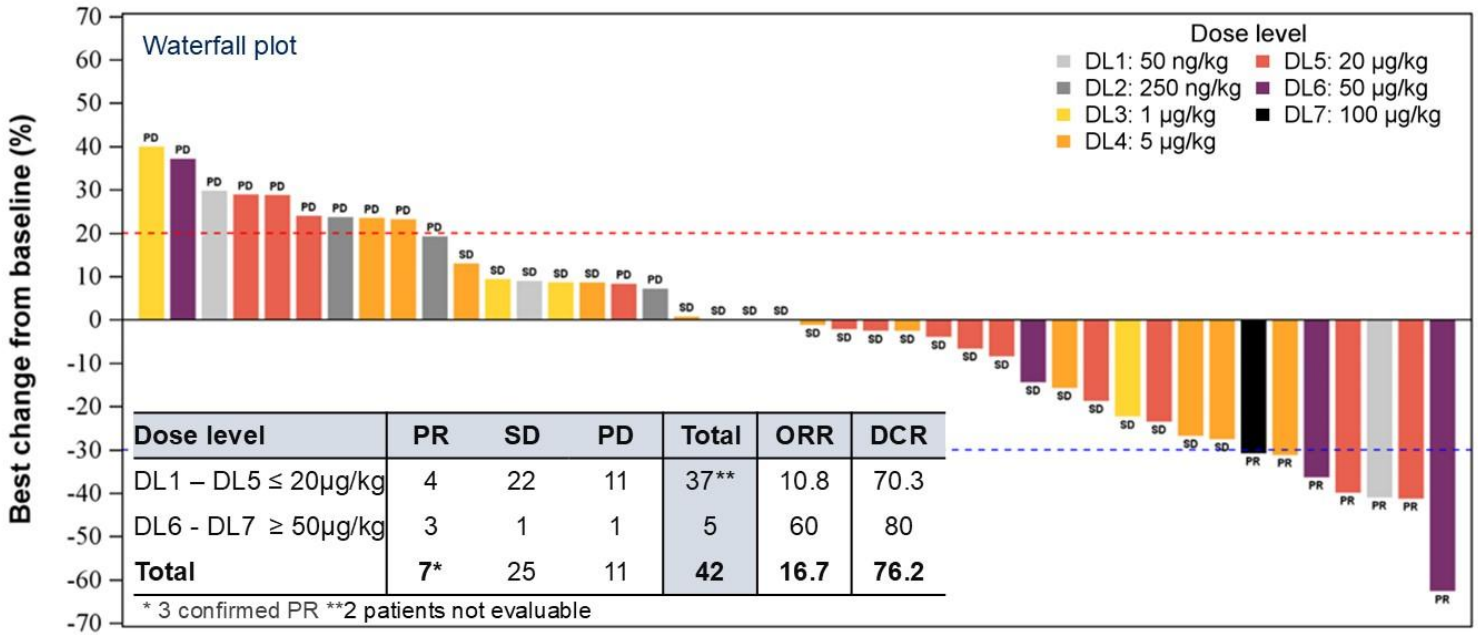
44 treated; 42 evaluable

Number of lines of prior systemic anticancer therapy n (%)	Total N = 44
2	4 (9.1)
3	7 (15.9)
≥4	33 (75.0)
Prior systemic anticancer therapy* n (%)	Total N = 44
Platinum	44 (100)
Bevacizumab	37 (84.1)
PARP inhibitor	32 (72.7)
Immune checkpoint inhibitors	6 (13.6)
Mirvetuximab	4 (9.1)

*most common/relevant

Platinum sensitivity n (%)	Total N = 44
Platinum-resistant[1] ovarian cancer	34 (77.3)
Partially platinum sensitive[2] ovarian cancer	10 (22.7)

[1] Progression during or within 6 months after the last platinum containing treatment
[2] Progression within 6-12 months after the last platinum containing treatment



Dose level	PR	SD	PD	Total	ORR	DCR
DL1 – DL5 ≤ 20µg/kg	4	22	11	37**	10.8	70.3
DL6 - DL7 ≥ 50µg/kg	3	1	1	5	60	80
Total	**7***	25	11	**42**	**16.7**	**76.2**

* 3 confirmed PR **2 patients not evaluable

DOR: 6 patients > 4 months, 3 patients > 6 months

Encouraging preliminary anti-tumor activity in heavily pre-treated, mainly platinum-resistant ovarian cancer patients

DCR, Disease control rate; DL, Dose level; ORR, Objective response rate (unconfirmed); PD, Progressive disease; PR, Partial response; SD, Stable disease.

Ovarian cancer: therapies on the horizon

- **ADCs:** CDH6, FOLR1, TROP-2, Claudin-6, NaPi2B, others

  -Advantages: high response rate (over 50% with new agents), often durable

  -Disadvantages:

  1) 2 main payload classes (TOPO1-targeted or tubulin-targeted): there is likely cross-resistance between different ADCs with the same payload.

  2) Toxicity profile is often similar to chemotherapy

- **T cell engagers**: Claudin-6, MUC16 (still early, but promising signals of activity in some studies)

- **Adoptive cell therapies:** still early, promising signals of activity in some studies, difficult to scale

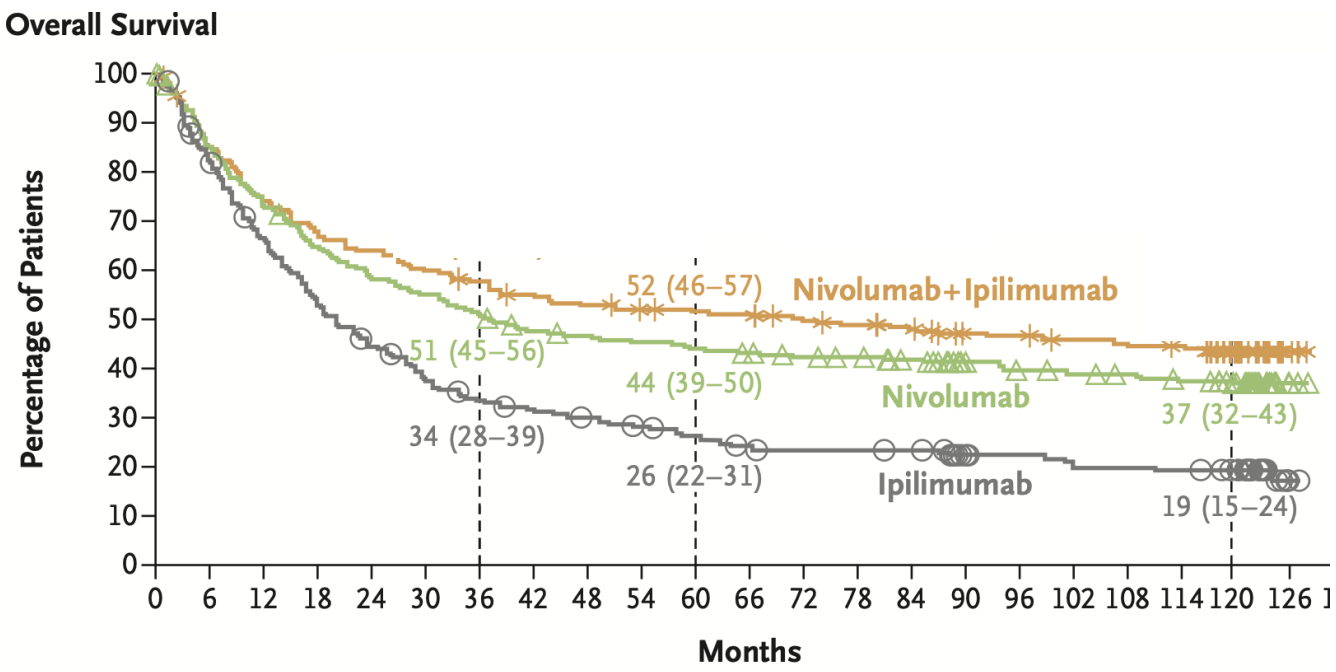
- **Targeted therapies:** Wee1, ATR, CHK2, … (relatively early)

Björn Frendéus

CSO

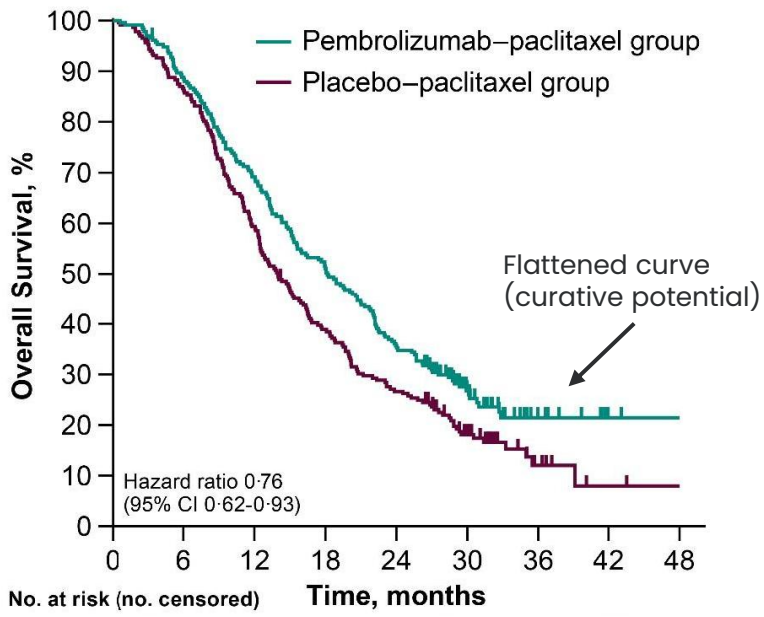
Immune Oncology is Transforming Cancer Survival

T-cell Infiltrated “Hot” Tumor



Wolchock, NEJM, 2024

Poorly T-cell Infiltrated “Cold” Tumor



Colombo, Lancet, 2026

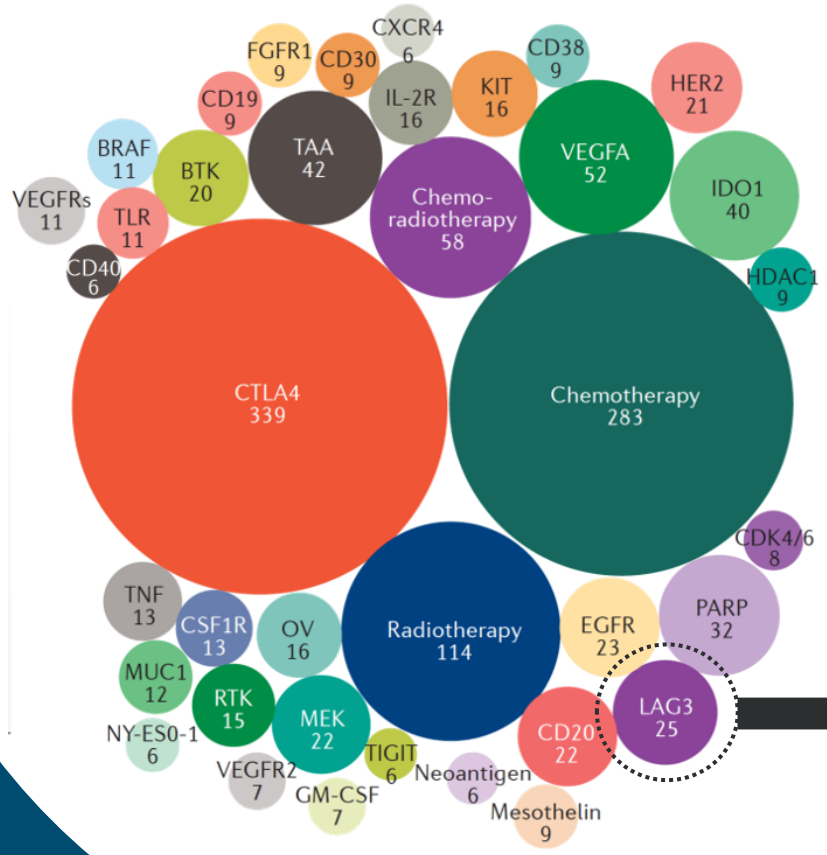
...with room for improval

Key challenges to improving cancer survival

(with retained quality of life)

1. Identify **safe & powerful** immunotherapies

2. **Enhance activity** and **overcome resistance** to the existing safe and effective drugs



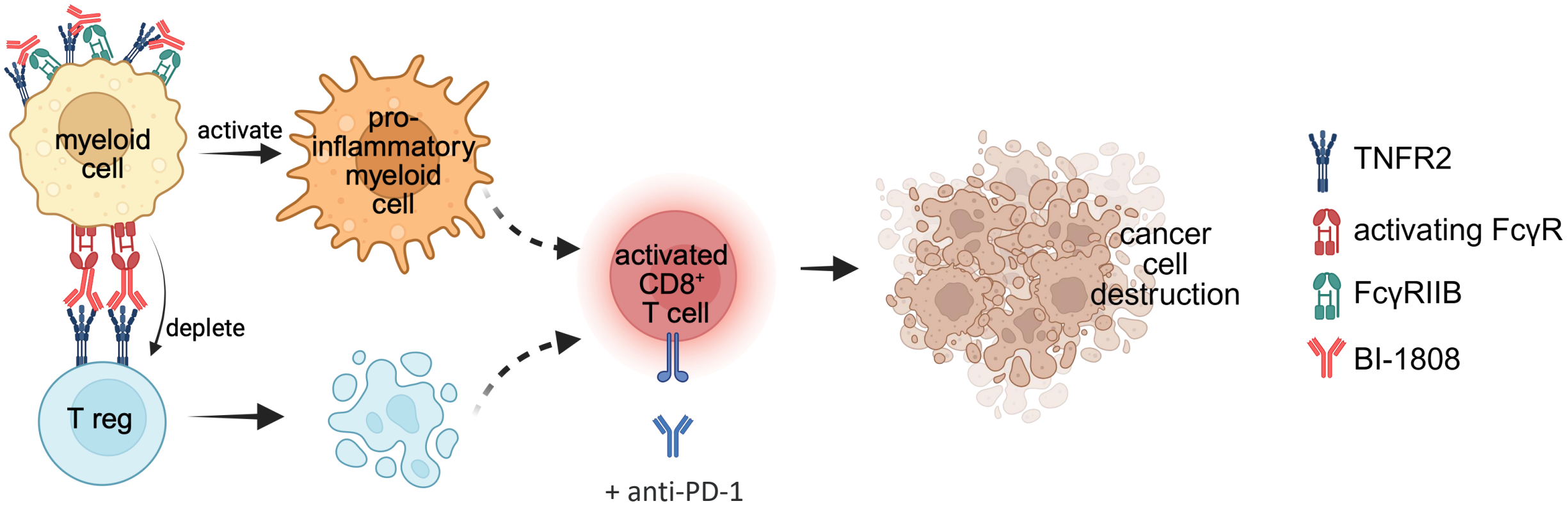
Despite extensive efforts only one approved:

Relatlimab
(anti-LAG3)

Tang, Nat Rev Drug Discov, 2018

BI-1808's Differentiated Mechanism of Action

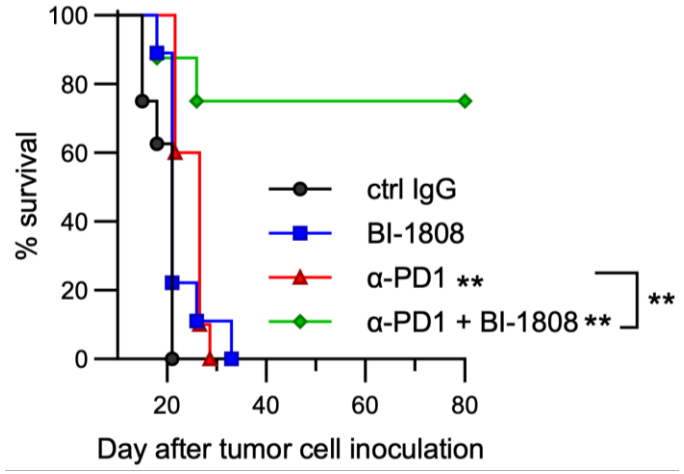
Depletes Tregs and activates macrophages to induce CD8+ T cell antitumor immunity



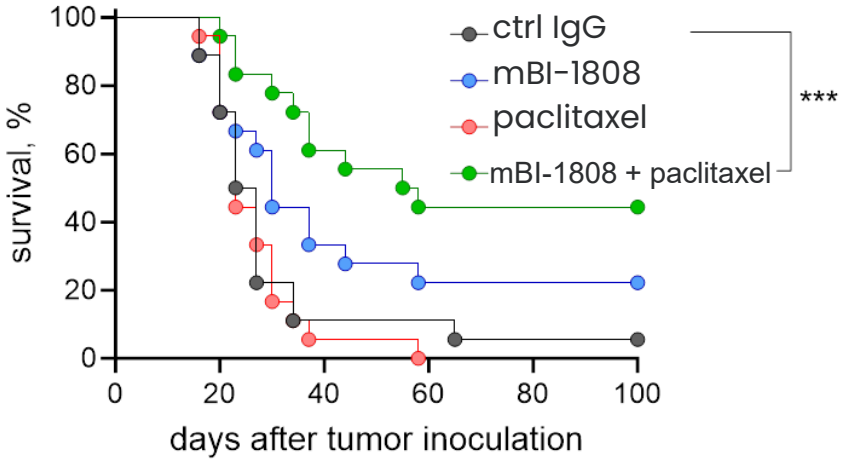
BI-1808's Differentiated Mechanism of Action

Enhances anti-PD-1 and Paclitaxel

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



II. Paclitaxel enhances BI-1808 efficacy



BI-1808's Differentiated Mechanism of Action

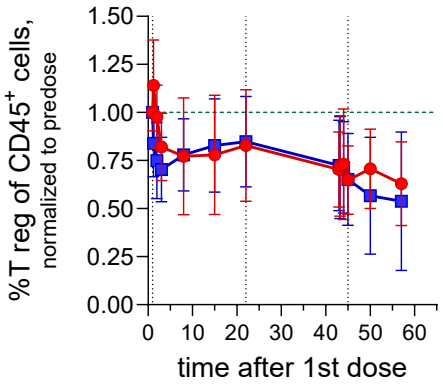
Induces Tumor Microenvironment-Modulating Cytokines in Ovarian Cancer Patients

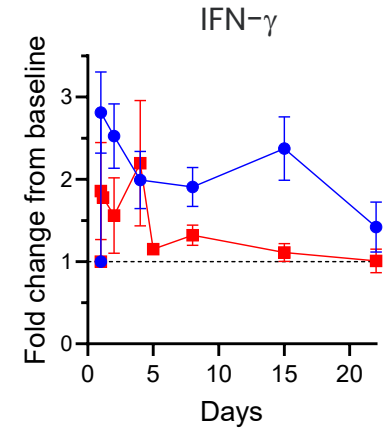
Treg

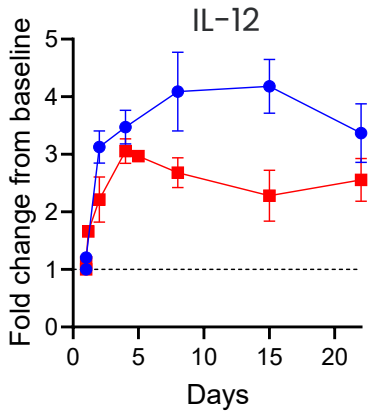
Effector T cell

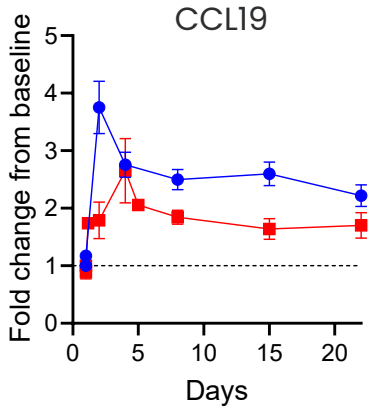
MΦ

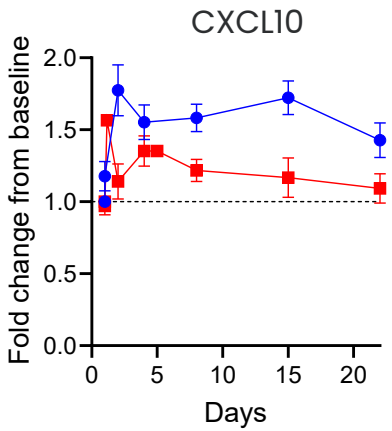
TLS

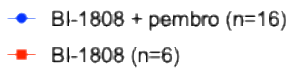












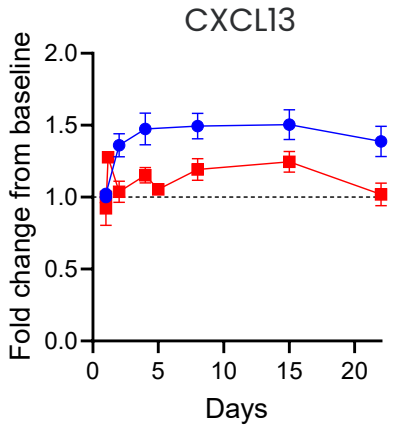
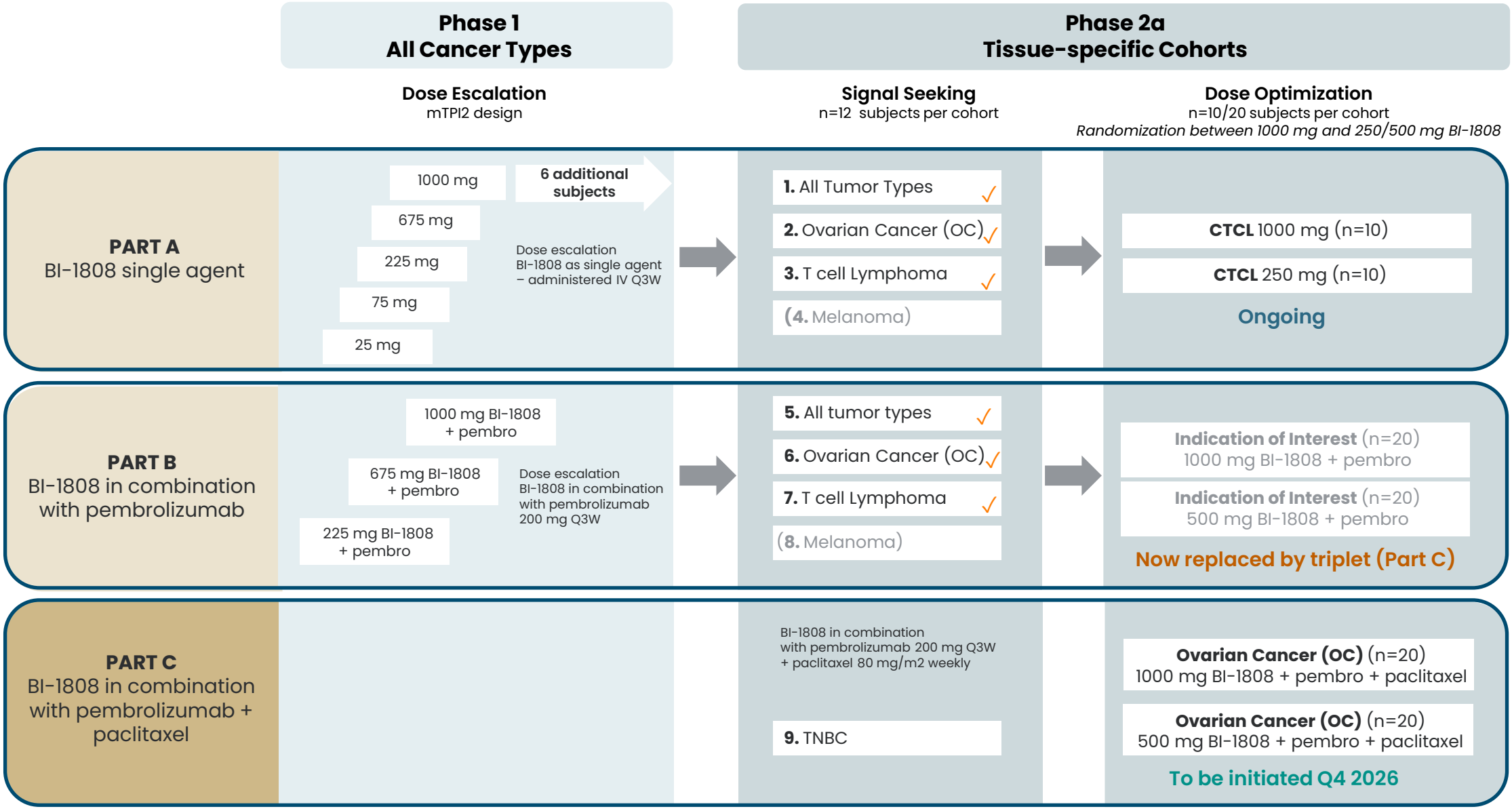


Figure. Treg levels and serum levels of cytokines associated with Effector T cell and myeloid activation, and tertiary lymphoid structure formation in BI-1808 monotherapy (N=6) or BI-1808 + Pembrolizumab treated (N=16) patients during the first reatment cycle (22 days). Values are normalized to predose. Data aquired using O-link Target 96 Immuno-oncology.

Andres McAllister

CMO

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



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

No Chemotherapy Regimen!

PATIENT PROFILE

26

Enrolled patients, 25 evaluable

Tumor Subtypes

- HGSA 17 (65%)
- ccOC 9 (35%)

Median age: 62 yrs (range 46–79)

TREATMENT HISTORY

5

median prior lines

Prior Treatment (1–10 prior lines)

100% platinum-based therapy

All patients received at least one platinum-containing regimen

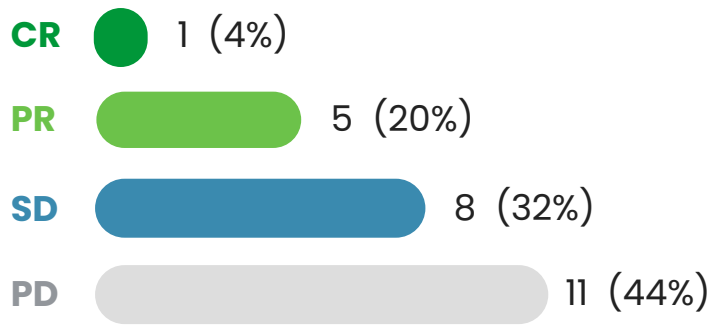
Heavily pretreated, chemo-resistant population entering the study

TREATMENT RESPONSE

24%

overall response rate (ORR)

Best Response (n=25)



DCR 56% | mPFS 10.3 mo (maturing)

HGSA: High-Grade Serous Adenocarcinoma; ccOC: Clear Cell Ovarian Carcinoma; OC: Ovarian Cancer; ORR: Overall Response Rate; DCR: Disease Control Rate; mPFS: Median Progression-Free Survival; CR: Complete Response; PR: Partial Response; SD: Stable Disease; PD: Progressive Disease; UNK: Unknown stage. | BI-1808 + pembrolizumab, Ph2a single arm doublet, 8 EU & UK sites | Data cut-off: 20-April-2026

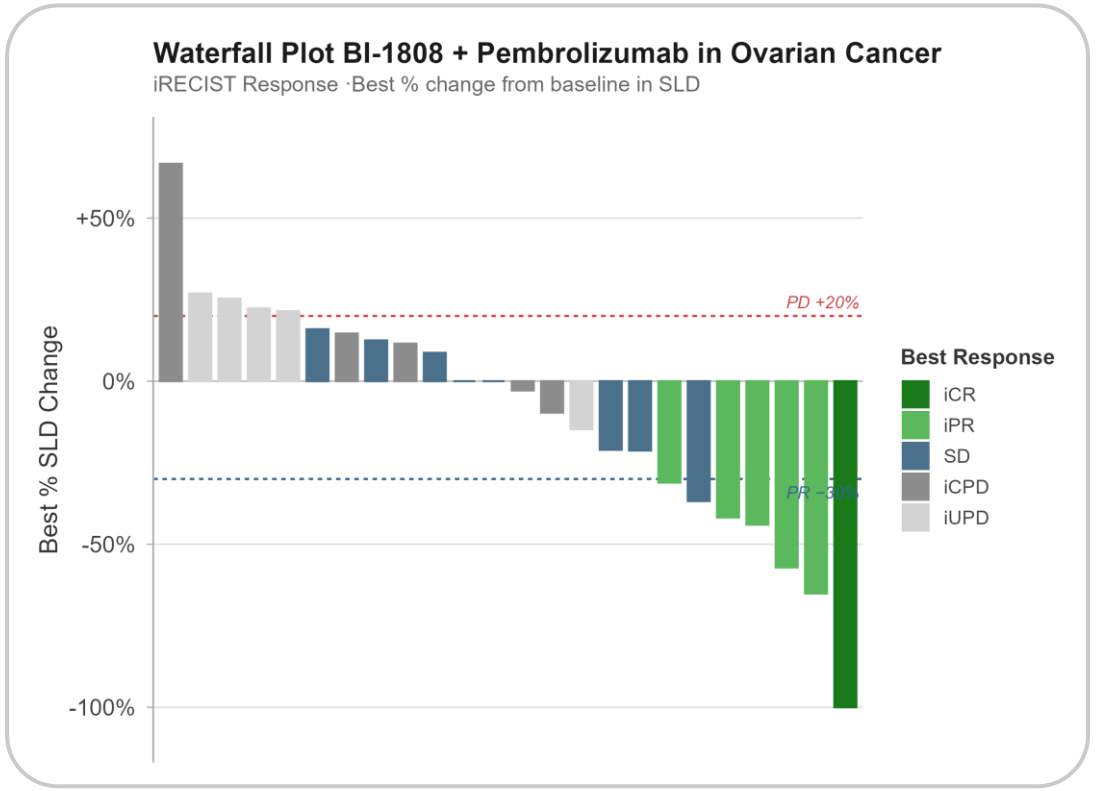
BI-1808 + Pembrolizumab: Promising Efficacy In Ovarian Cancer

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

BI-1808 in combination with pembrolizumab

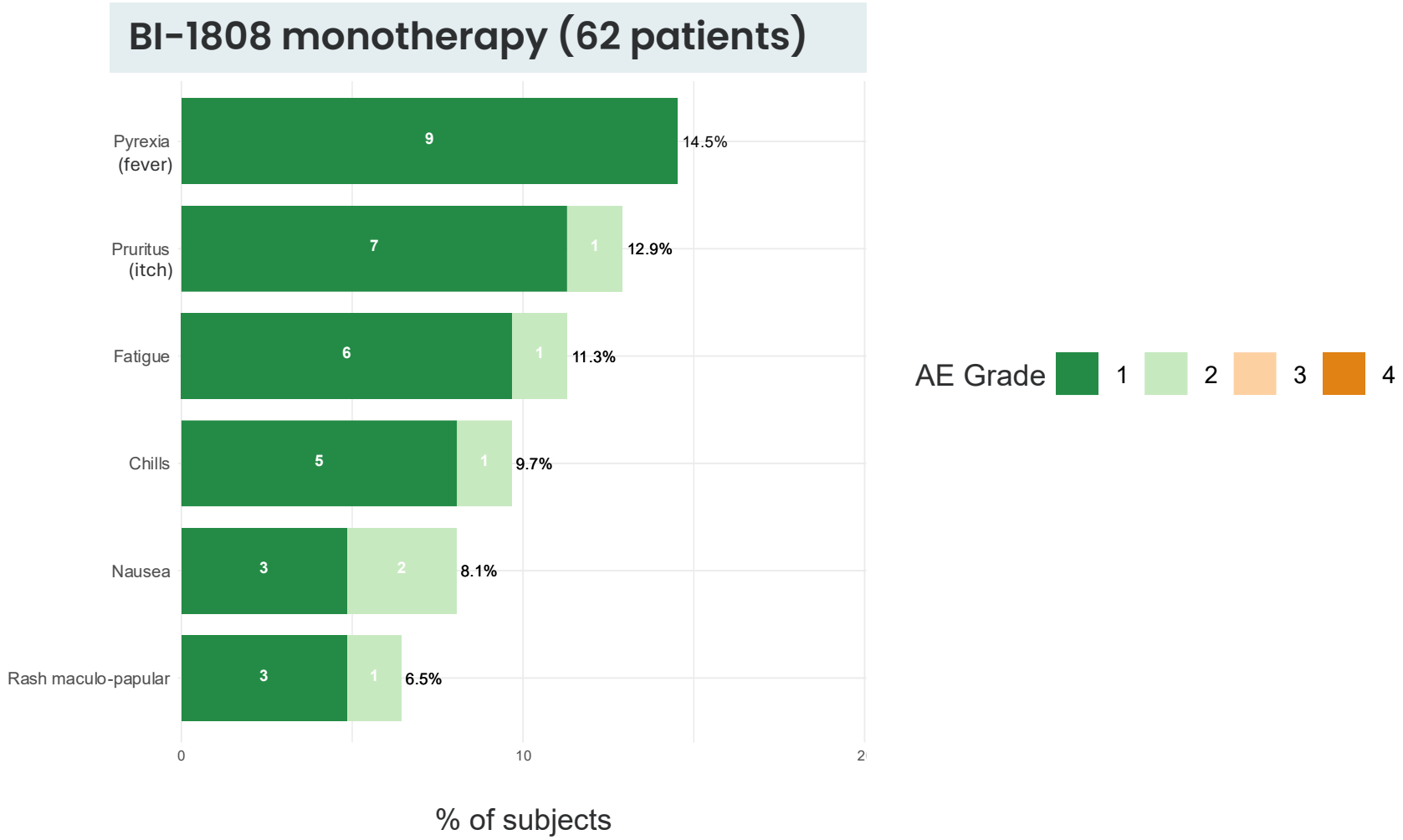
- **24% ORR, 56% DCR** in 25 evaluable patients: 1 CR + 5 PR + 8 SD (several durable beyond 10 months and ongoing)
- **Activity in both subtypes:** high-grade serous (HGSA) and clear cell (ccOC)
- **mPFS 10.3 months (90% CI: 10.2, NE):** 9/25 patients still on treatment — PFS continues to mature and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



ORR: Overall Response Rate
DCR: Disease Control Rate

BI-1808 Has an Impressive Safety Profile

Zero Grade 3+ adverse events (AE) in BI-1808 monotherapy



BI-1808 + Pembrolizumab: Safety Profile Supports Broader Use and Combination Therapy

Discontinuation Rate

<5%

treatment-related discontinuations in combination arm

vs. 10%–20%

typical for checkpoint inhibitor combinations

74 solid cancer patients treated

AEs higher than 10% (any grade)

Fatigue	27%
Pyrexia	22%
Hypothyroidism	14%
Hyperthyroidism	11%
Diarrhea	11%

Predominantly Grade 1–2; manageable with standard medical treatment

Why It Matters

Immune-related AEs are manageable

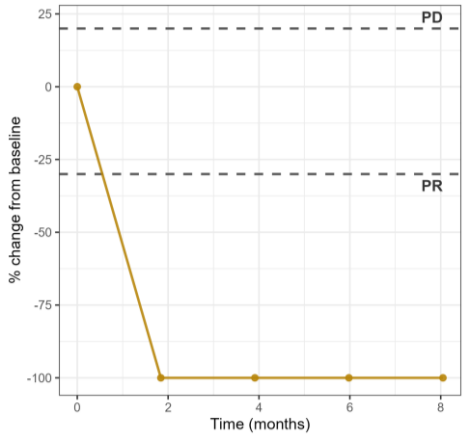
- ✓ Favorable safety enables use in a broader patient population, including those with comorbidities
- ✓ Low discontinuation rate means more patients complete treatment and derive benefit
- ✓ Clean profile supports addition of paclitaxel in the triplet — no compounding toxicity concern
- ✓ No black box warnings; no requirement for special monitoring programs

TEAE: Treatment-Emergent Adverse Event; AE: Adverse Event; OC: Ovarian Cancer; pembro: pembrolizumab; Grade 3+: severe or higher adverse event per CTCAE grading; IO: Immuno-Oncology

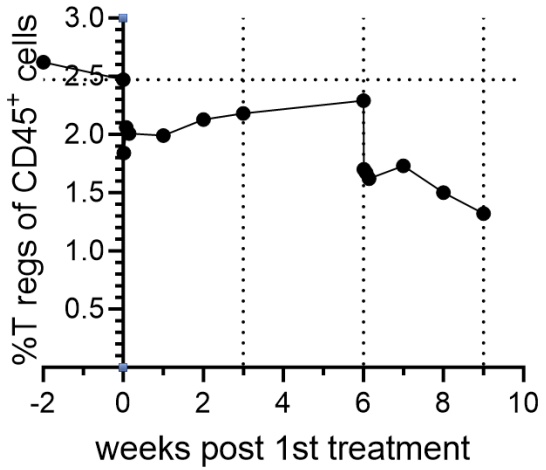
BI-1808 Single Agent Case Study: Complete Response in Ovarian Cancer

Baseline

2 months



Tumor assessment vs time on study



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

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

Four previous lines of treatment:

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

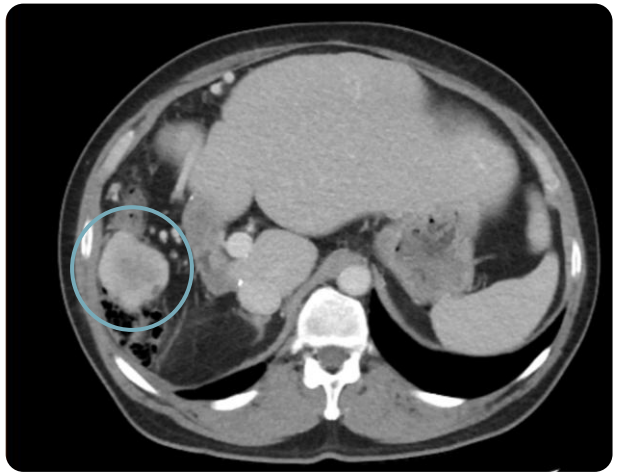
Patient had one target lesion of 25 mm and two larger non-target cystic lesions.

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

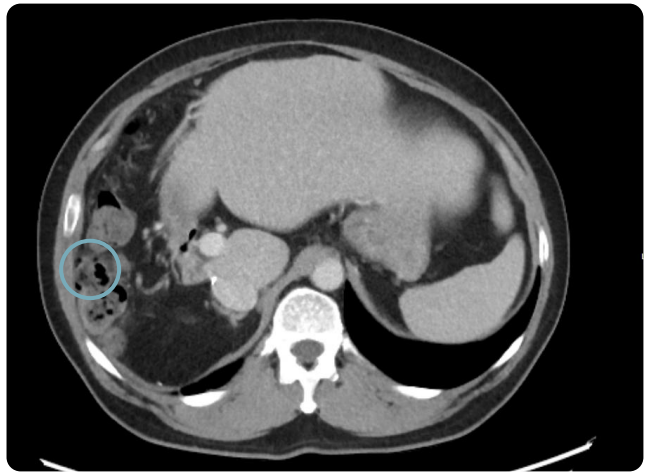
ASCO 2024 Poster #2641 BI-1808

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

Baseline

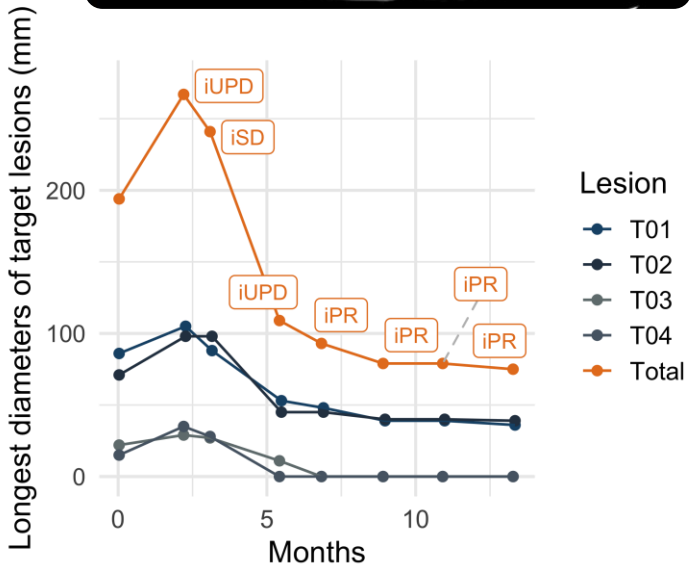


Follow-up 13 months

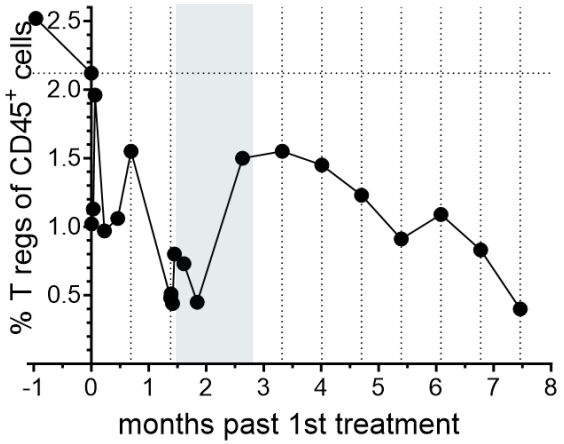


55-year-old male patient with GIST, who presented with clinical PD for more than 6 months with multiple metastatic lesions.

The patient had 12 previous lines of therapy before entering the study.

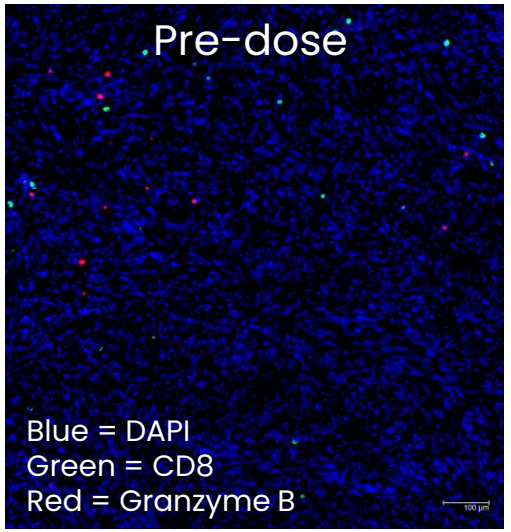


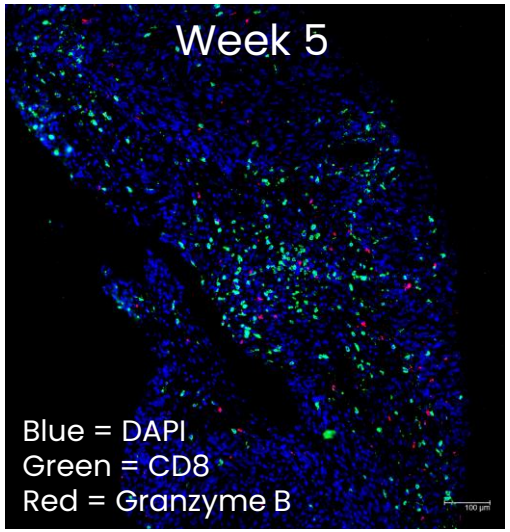
Tumor assessment vs time on study (months)



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

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

Activity confirmed across both subtypes

HGSA (high-grade serous) — responses observed

ccOC (clear cell) — responses observed

Both subtypes represented in the spider plot.

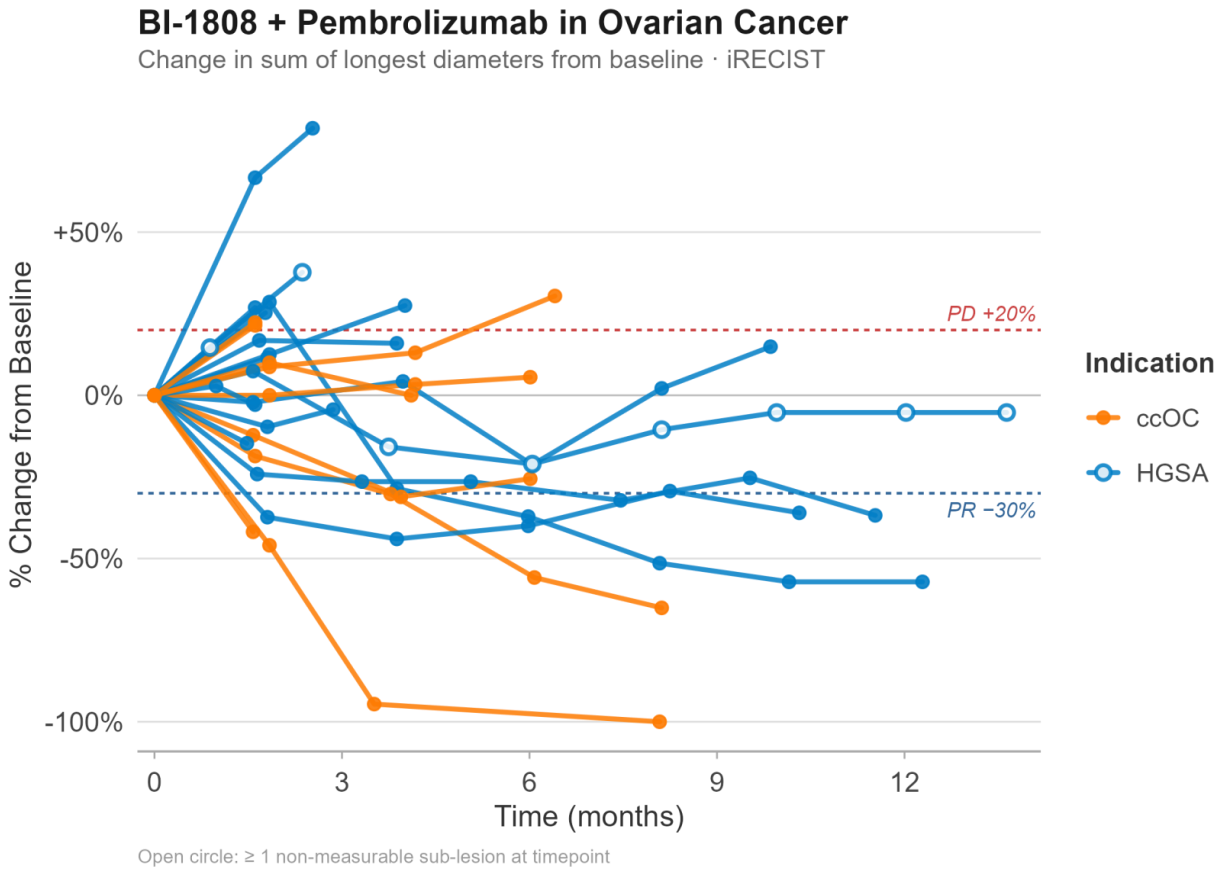
Late responses: a hidden positive feature

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

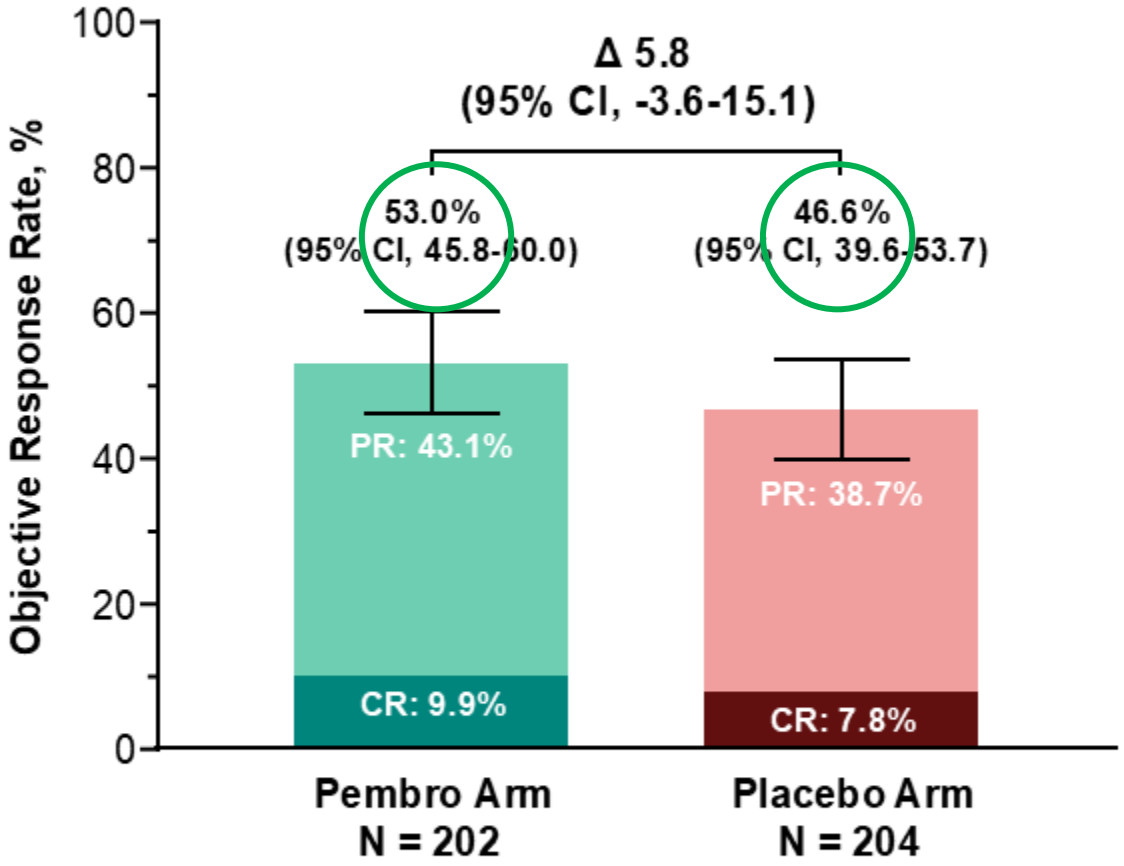
9 of 25 patients still on treatment

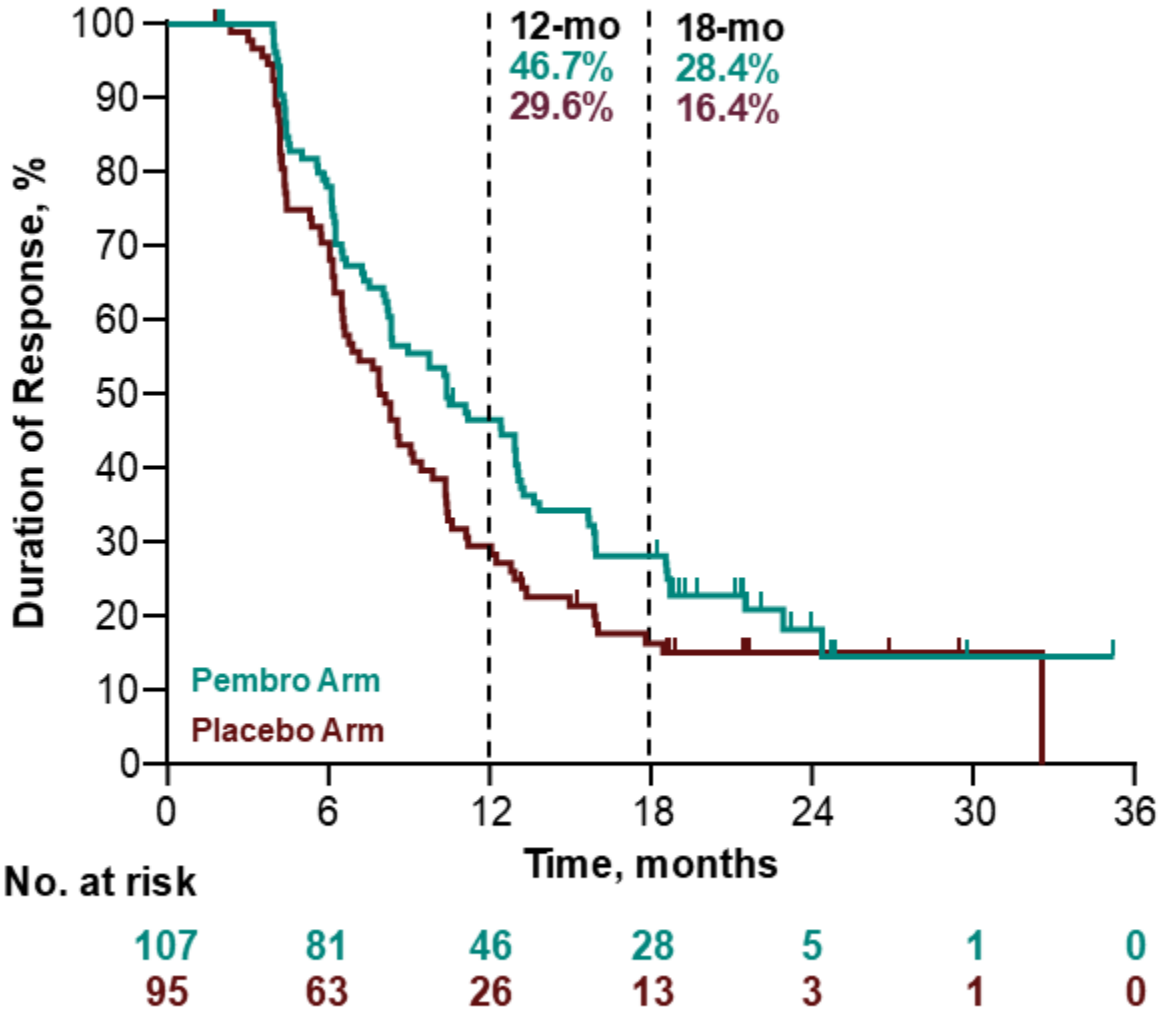
Responders may not yet be captured in the interim 24% ORR, suggesting the final readout could be stronger



SLD: Sum of Longest Diameters; PR: Partial Response (≥30% decrease); PD: Progressive Disease (≥20% increase); ccOC: Clear Cell Ovarian Carcinoma; HGSA: High-Grade Serous Adenocarcinoma; ORR: Overall Response Rate | Data cut-off: 20-April-2026

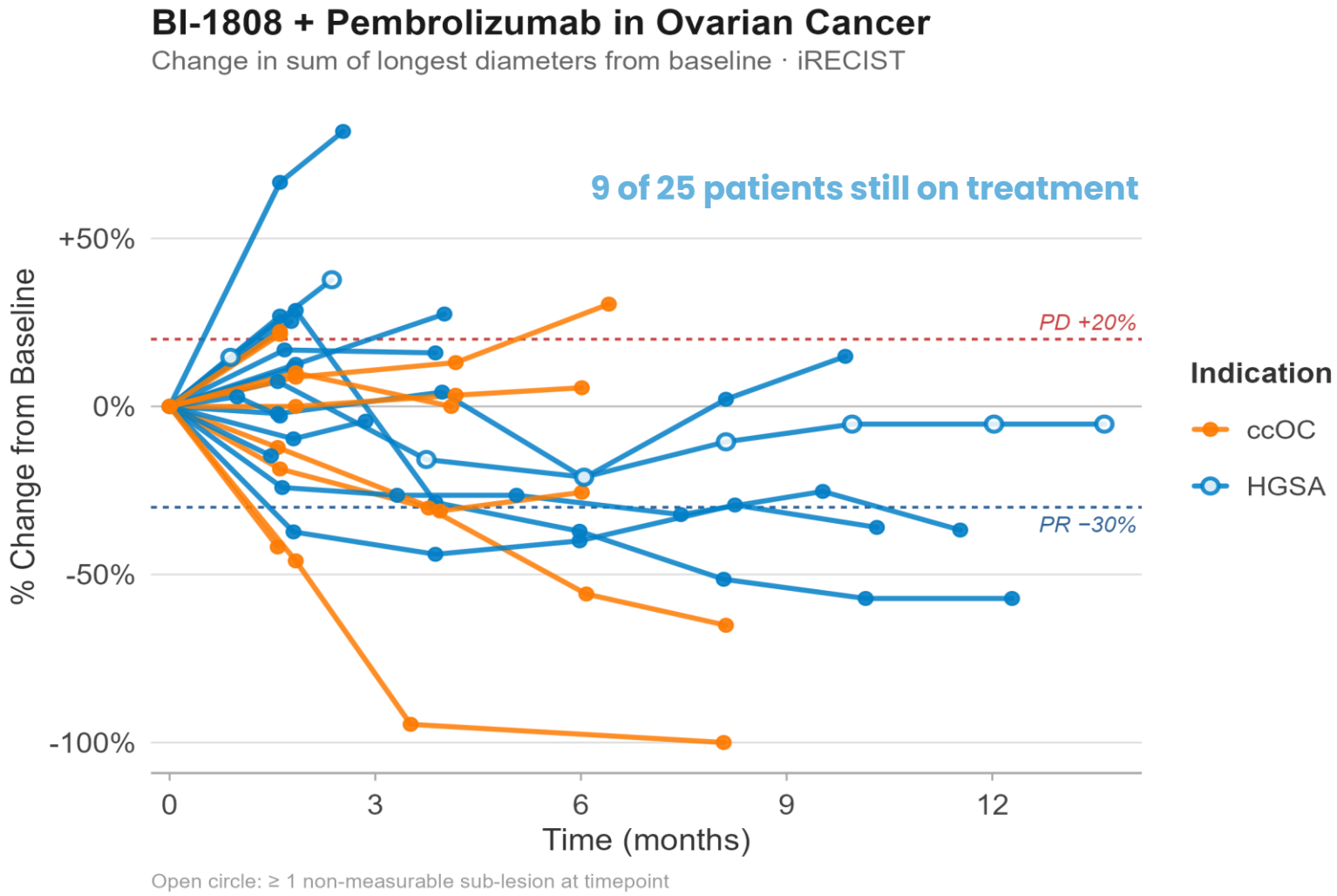
Objective Response Rate and Response Duration in CPS ≥1 Population at IA2





Response assessed per RECIST v1.1 by investigator review. Data cutoff date: March 5, 2025.

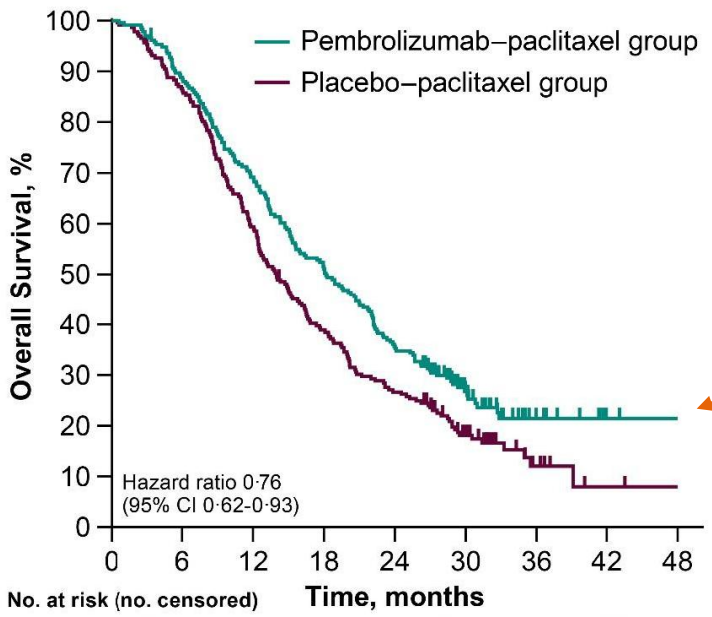
Late Responses Signal Deeper, More Durable Activity: A Feature of BI-1808's Mechanism



SLD: Sum of Longest Diameters; PR: Partial Response (≥30% decrease); PD: Progressive Disease (≥20% increase); ccOC: Clear Cell Ovarian Carcinoma; HGSA: High-Grade Serous Adenocarcinoma; ORR: Overall Response Rate | Data cut-off: 20-April-2026

Why The Triplet Will Be Even Better

Anti-PD-1 (pembrolizumab) + paclitaxel have shown curative potential in ovarian cancer (KEYNOTE-B96)



Flattened curve
(curative potential)

Colombo, Lancet, 2026

Three Independent Lines Of Evidence

- Immunotherapy has curative potential in ovarian cancer
- BI-1808 + pembrolizumab have at least additive activity
- BI-1808 + paclitaxel have additive activity

Thus, the triplet can only be better

BI-1808 + Pembrolizumab: Promising Early Efficacy In Recurrent Ovarian Cancer With Pivotal Trial On The Horizon

24%
Overall Response Rate
6 responders / 25 evaluable pts

56%
Disease Control Rate
6 PR + 8 SD in 25 evaluable pts

10.3 mo
Median PFS (early est.)
Data still maturing

9/25
Still on treatment
Durable control ongoing

Heavily pretreated: Median 5 prior lines; all received platinum

Subtypes: Activity in both HGSA and clear cell OC

Safety: Well-tolerated; <5% treatment discontinuations

vs. pembro monotherapy: 24% ORR vs. ~8% with pembrolizumab alone

Interim doublet data (ASCO 2026): n=25/40

Final doublet data: H2 2026 (n=40)

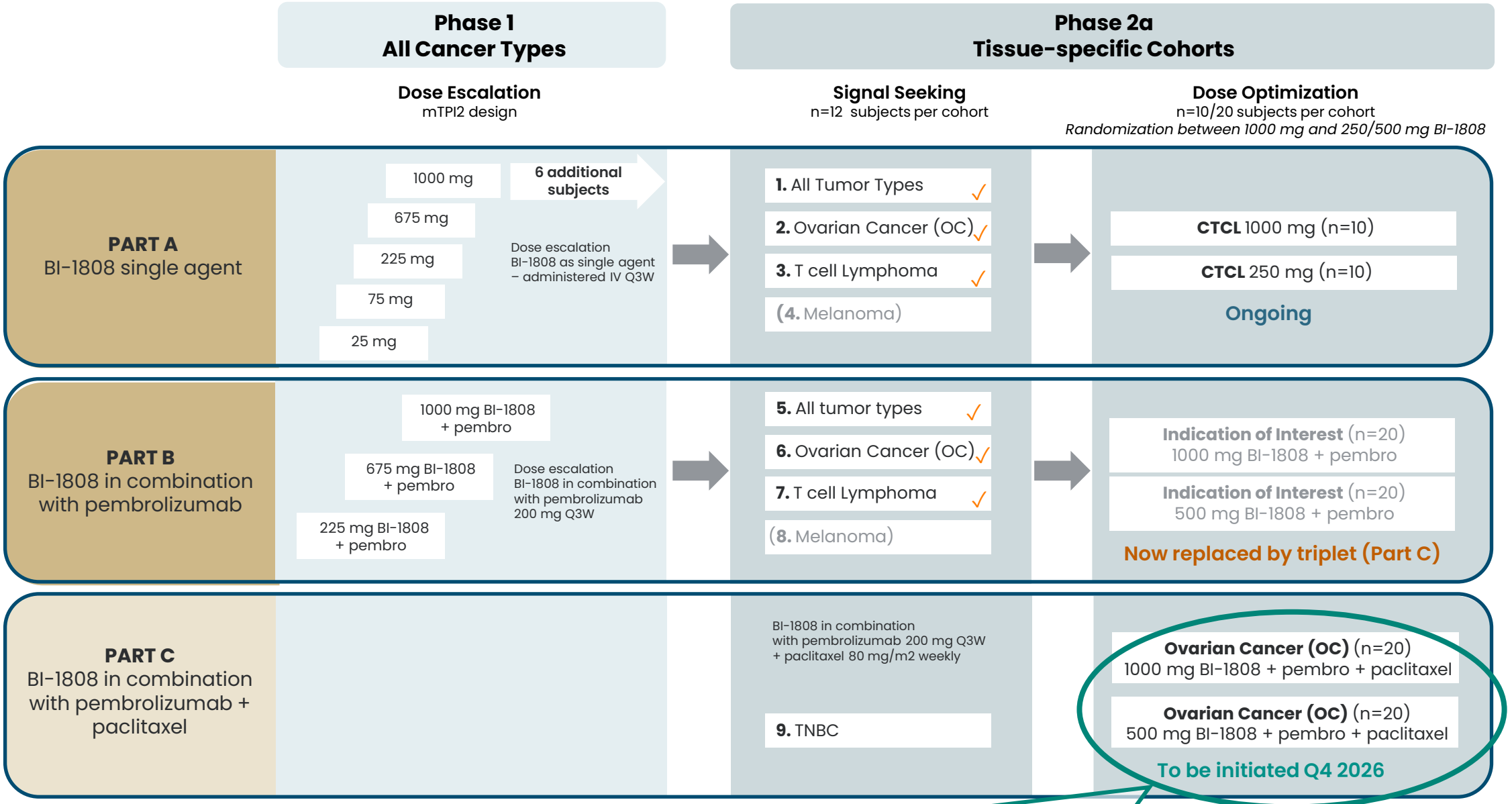
Triplet (Part C) data: BI-1808 + pembro + paclitaxel; to be initiated Q4 2026

End of Phase 2 (EOP) meeting: Pivotal trial design with FDA

Pivotal Phase 3: TBD

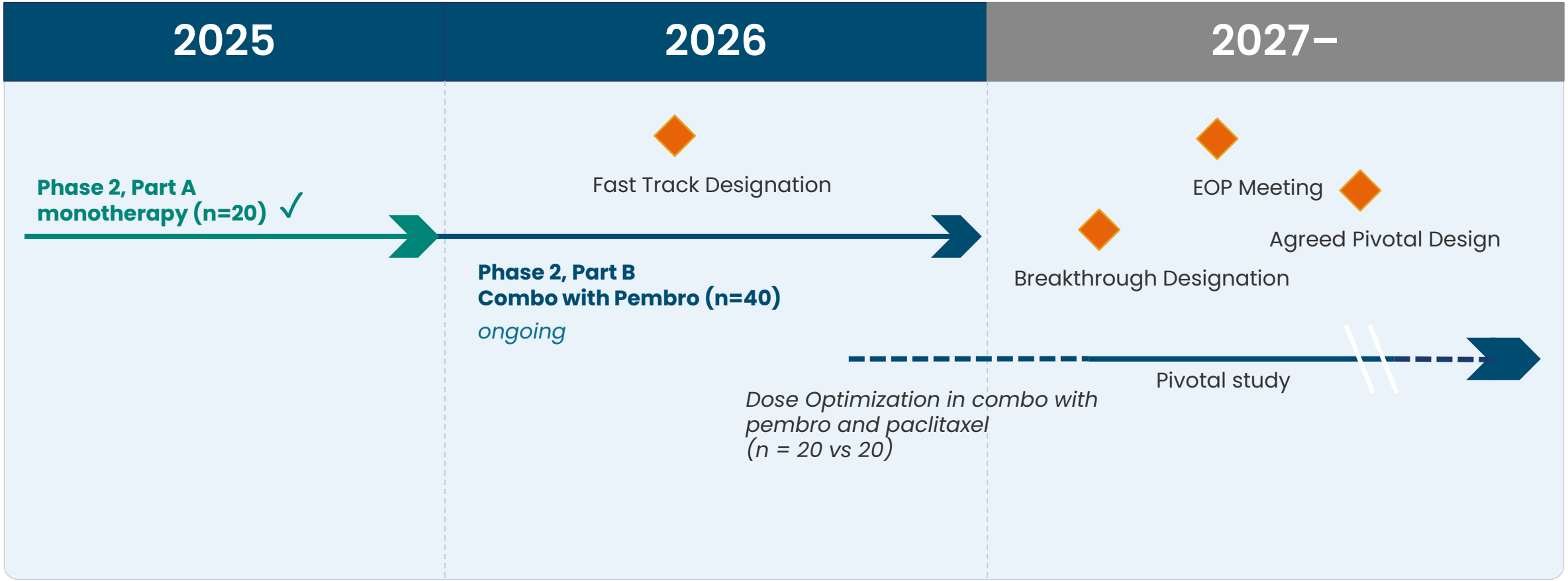
CR: Complete Response; PR: Partial Response; SD: Stable Disease; PD: Progressive Disease; DCR: Disease Control Rate; ORR: Overall Response Rate; mPFS: Median Progression-Free Survival; HGSA: High-Grade Serous Adenocarcinoma; ccOC: Clear Cell Ovarian Carcinoma; OC: Ovarian Cancer; EOP: End of Phase 2 meeting with FDA; pembro: pembrolizumab; pts: patients evaluated for response

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



Project Optimus and first dosing in combination with paclitaxel

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

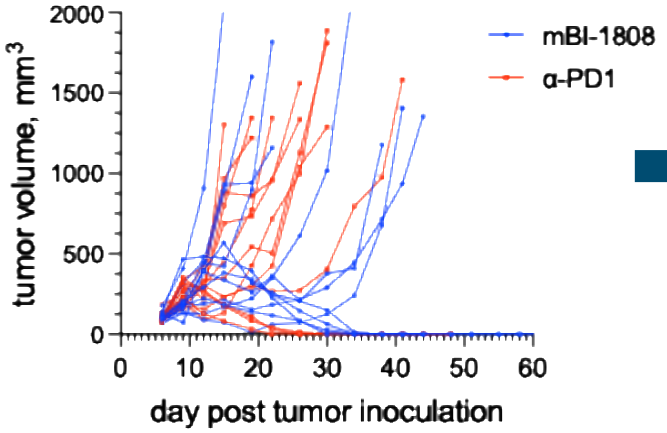
EOP: End of Phase 2 meeting with FDA to agree pivotal trial design; pembro: pembrolizumab; ORR: Overall Response Rate; DCR: Disease Control Rate
** Depending on partnering discussions and acceptance of development plan by FDA*

Björn Frendéus

CSO

The BI-1808 Response Takes Longer Compared with αPD-1

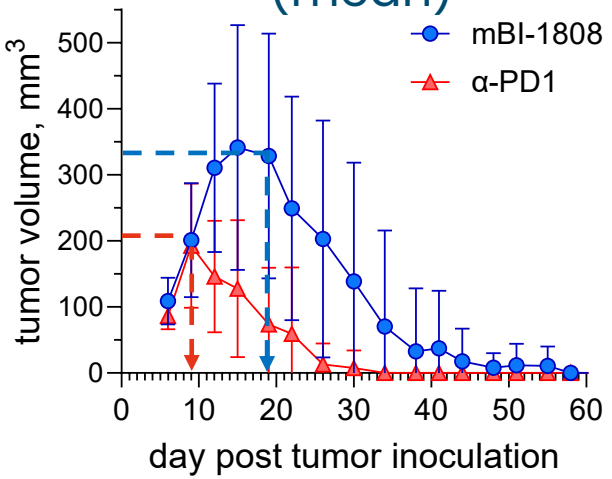
Tumor growth (individual)



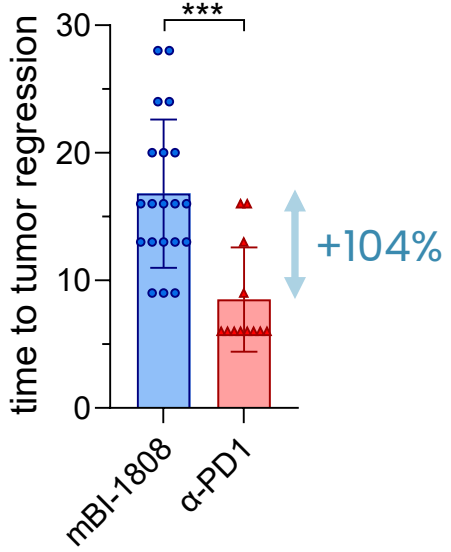
Assess time to response

-time to tumor regression
-eight pooled experiments (n=37-75)

Tumor growth (mean)



Time to response



Survival

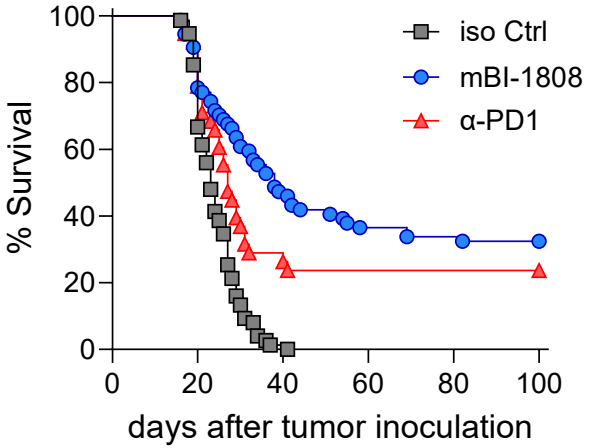


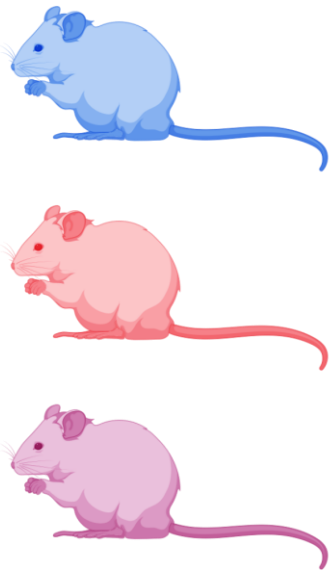
Figure. Left upper graph. Individual tumor growth curves of tumor-bearing mice treated withanti-PD-1 or mBI-1808 (representative experiment, n= 16 per treatment group). **Center panel:** Tumor growth dynamics of responding mice (upper panel) from eight (8) combined experiments, BALB/c EMT6, n=37-75 per group. **Left lower panel** shows survival from the same eight pooled experiments. **Right panel**: Time to response (tumor regression) of mice cured in A. (mBI-1808 (N=20) or α-PD1 (N=9).

Combining mBI-1808 with αPD-1 Decreases the Time to Response In Vivo

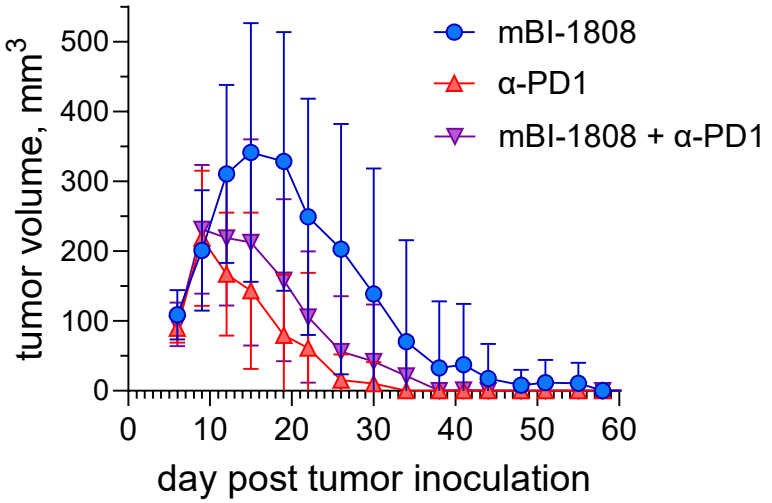
mBI-1808

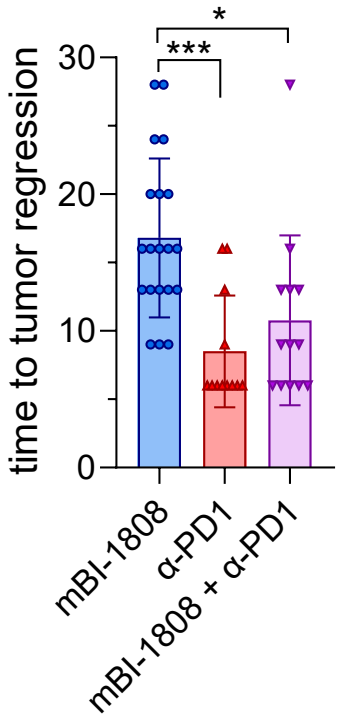
αPD-1

mBI-1808 +αPD-1



Time to response



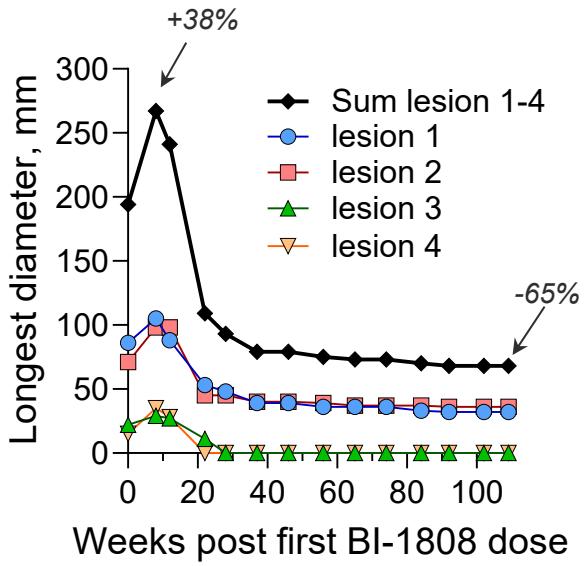


+33%

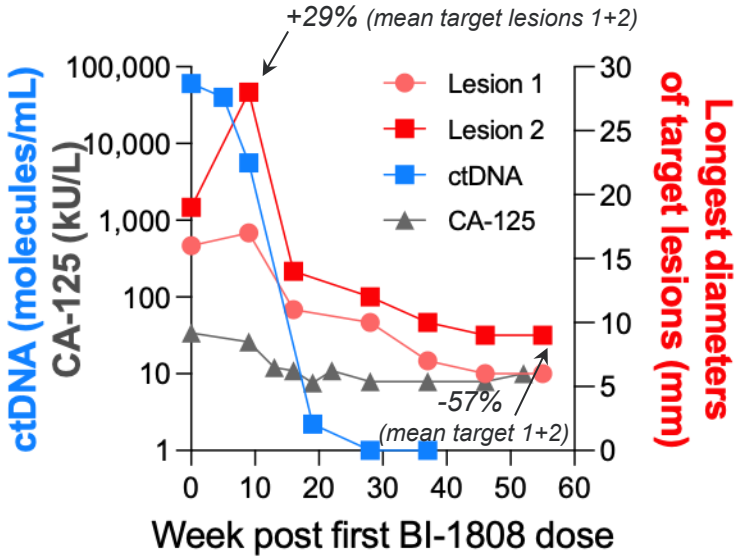
Clinically Meaningful "Late" BI-1808 Responses In Patients

Preclinical → Clinical: Late responses seen in mice, now confirmed in patients. ctDNA may allow early identification of responders, keeping patients on treatment through apparent pseudoprogression

Case study 1:
A gastrointestinal sarcoma patient treated with BI-1808 as monotherapy.



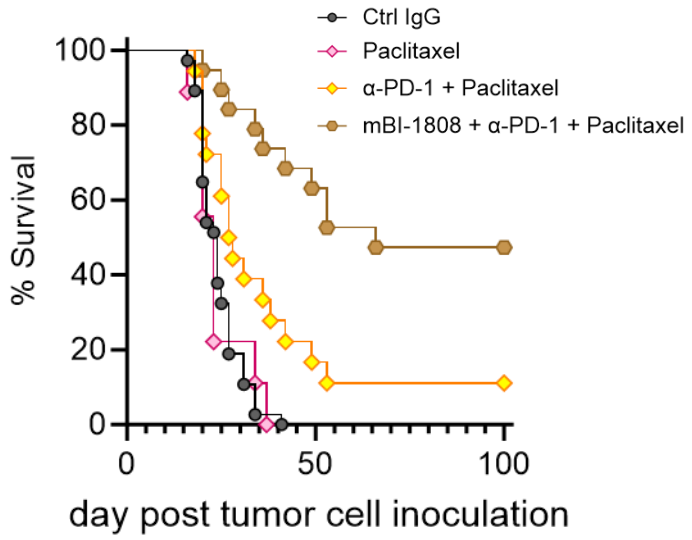
Case study 2:
An ovarian cancer patient treated with BI-1808 + Pembrolizumab.

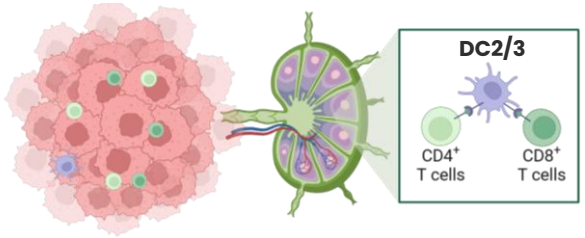


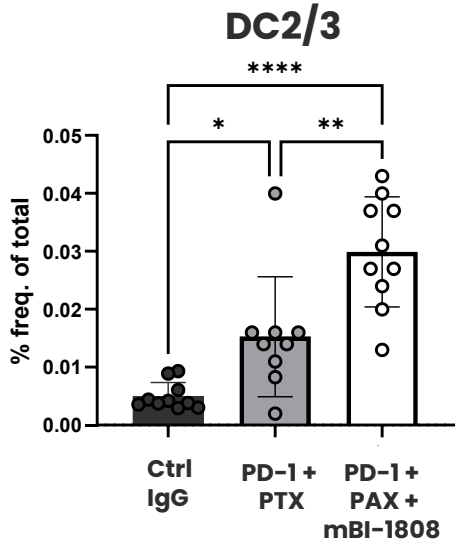
- Clinically meaningful "late" responses/pseudoprogression observed among BI-1808-treated patients
- ctDNA analysis has potential for early identification of BI-1808 responders

BI-1808 “Triplet” Enhances the New Immune Oncology SoC in Ovarian Cancer

Key finding: The triplet (mBI-1808 + αPD-1 + paclitaxel) achieves superior long-term survival in vivo. Strong rationale for Part C of KEYNOTE-D20.



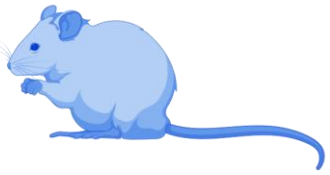




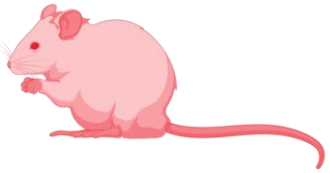
BI-1808 "Triplet" Maximizes the Likelihood of Observing Responses

Key finding: Triple combination of mBI-1808 with αPD-1 and paclitaxel
- decreases the time to response
- maximizes chances of patients staying on and benefiting from treatment

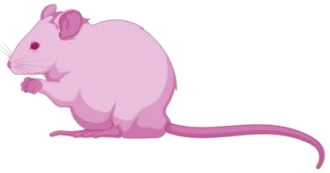
mBI-1808



aPD-1

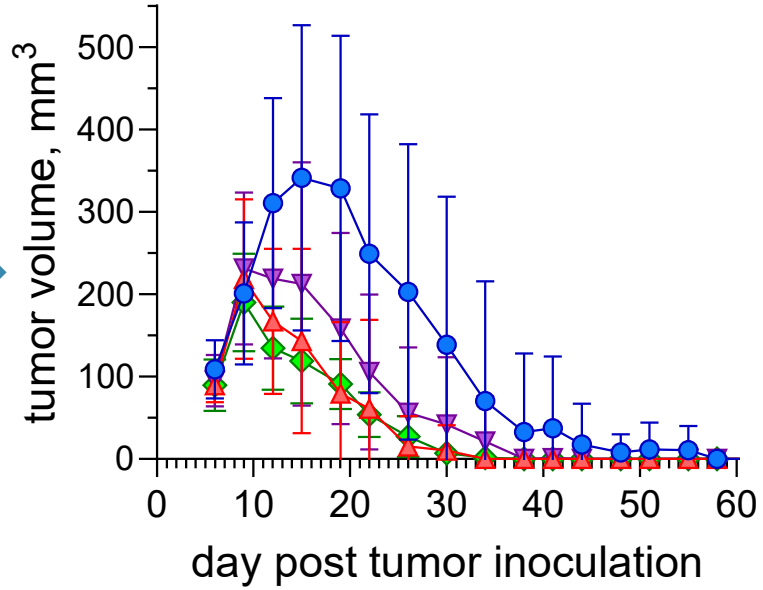


mBI-1808
+aPD-1

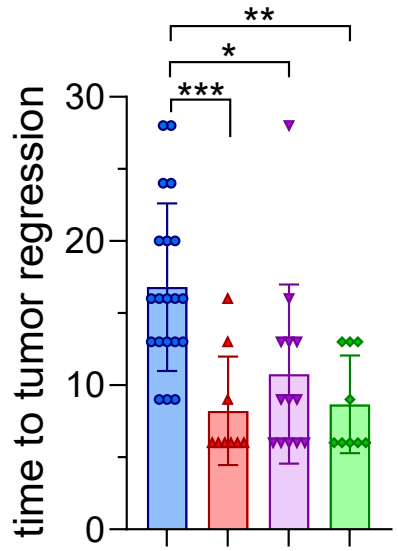


mBI-1808
+aPD-1
+paclitaxel

Time to response



Time to response



BI-1808 Preclinical to Clinical: The Evidence Story

The narrative: Preclinical data predict a triplet benefit — and clinical data are beginning to confirm it. ctDNA offers a path to keep responders on treatment through apparent progression.

01

Doublet accelerates response in vivo

Adding αPD-1 to mBI-1808 reduces time to tumor regression by 33% in preclinical models.

02

Late responses in patients

Preclinical pseudo-progression is also observed in patients. ctDNA enables early identification of responders, keeping patients on treatment.

03

Triplet achieves ~50% long-term survival

Neither doublet achieves durable survival in vivo. Paclitaxel unlocks BI-1808's potential.

04

Triplet minimizes time to response

The triplet achieves the fastest tumor regression across all arms — maximizing the window in which patients can benefit from treatment.

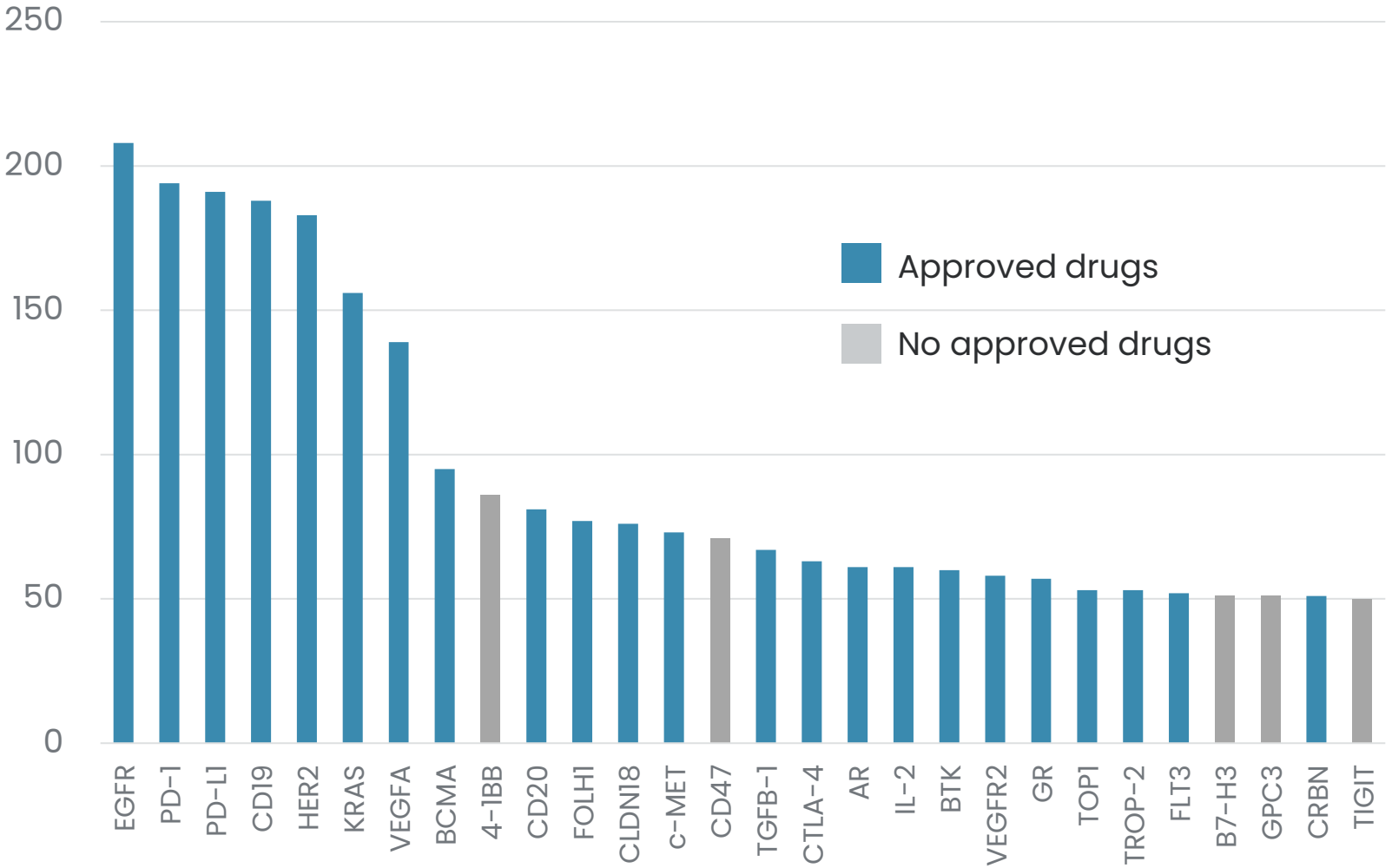
Clinical implication: Preclinical data strongly support the triplet regimen to be tested in KEYNOTE-D20 Part C. Late responses and pseudoprogression are real; ctDNA monitoring is the key to keeping patients on treatment long enough to benefit.

Sylvie Ryckebusch

CBO

The Oncology Field Is Crowded With Me-too Assets

Number of pipeline programs per oncology target in 2024



- TIGIT and CD47 failures collectively add up to **121** doomed programs
- Other targets, such as TGFB-1, IL-2, and 4-1BB are on life support with the field likely to shrink
- New targets such as **TNFR2** are **rare** and potentially **valuable**

L.E.K Consulting, Citeline Pharmaprojects, January 2025

Ovarian Cancer Is a Deadly Disease With Very High Unmet Need

11th most common cancer among women

5th leading cause of cancer-related death among women

55% of cases are diagnosed late (Stage III/IV)

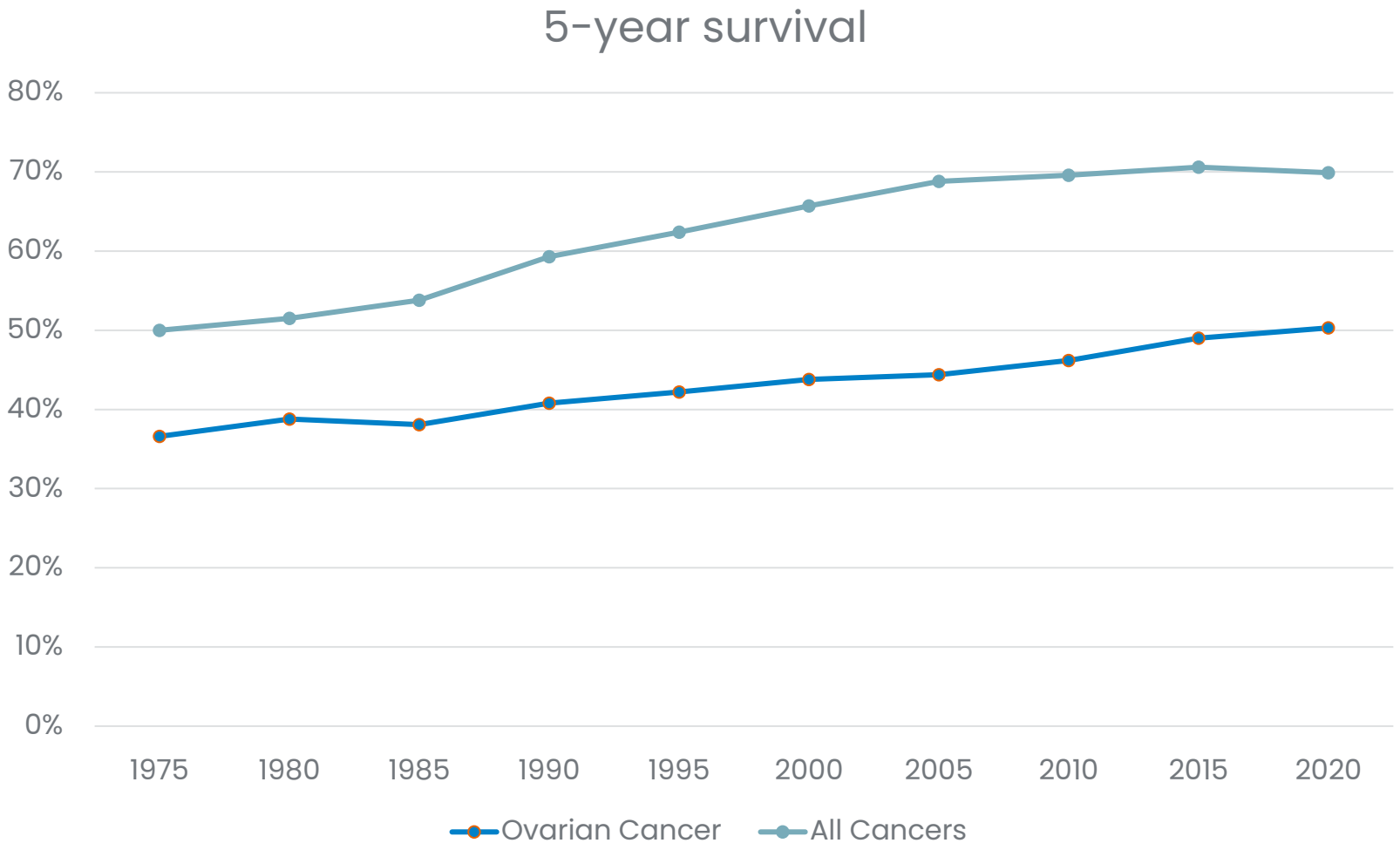
<32% rate of 5-year survival in Stage III/IV

75% of advanced ovarian cancer will recur

25% of cases have primary platinum resistance

American Cancer Society, 2025; SEER 21 2015–2021; SEER Cancer.gov, Sciencedirect.com

Survival Rates Have Improved Less in Ovarian Cancer Than For Other Tumor Types in 50 Years



- 5-year survival rates in ovarian cancer have improved only slightly in 50 years: from 37% to 50%
- Despite advances in treatment, ovarian cancer remains a deadly cancer with high unmet medical need

Sources: American Cancer Society, 2025; SEER 21 2015–2021; SEER Cancer.gov, Sciencedirect.com

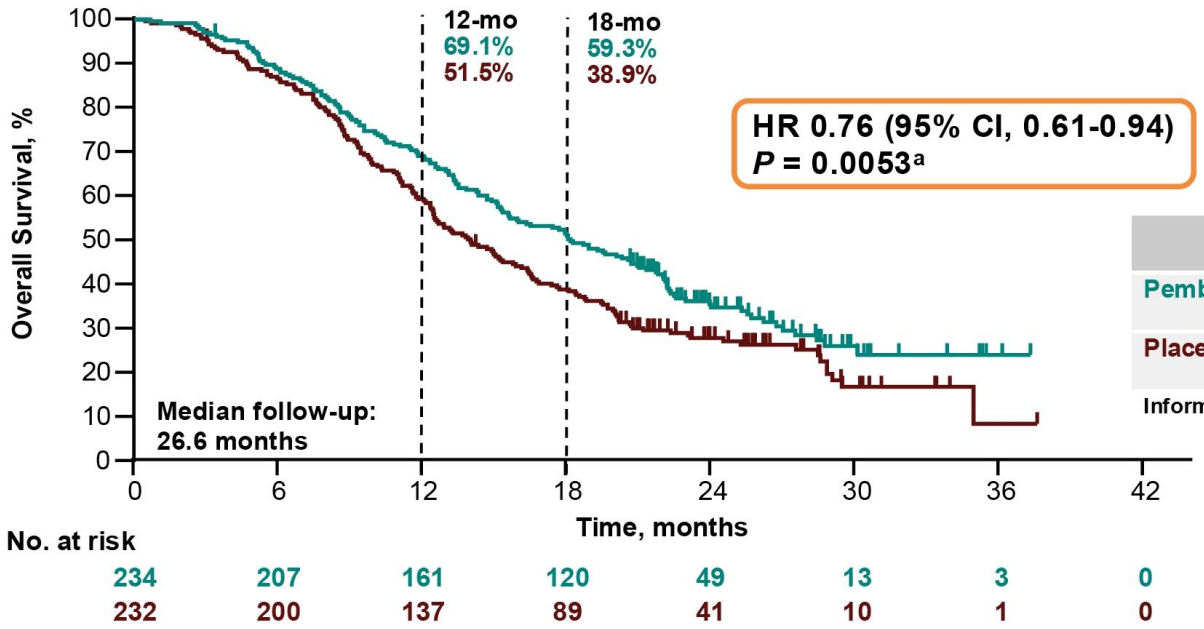
How Do Major Treatment Classes Stack Up In Ovarian Cancer?

Treatment class	Era	Status in OC	Survival impact	Key limitation
Platinum chemotherapy	1970s–	Standard of care	Foundational but not curative	Resistance — primary in 25%, acquired in most
Bevacizumab (anti-VEGF)	2000s–	Approved, widely used	Modest PFS gain, no meaningful OS benefit	Incremental — does not alter disease course
PARP inhibitors	2014–	Approved (maintenance)	Significant PFS benefit in HRD+ patients; OS benefit in 1st line only	Biomarker-restricted late-line approvals withdrawn; not curative
ADCs	2022–	1 approval (mirvetuximab)	~3.5 month OS gain vs. chemo	Months, not years biomarker-restricted
Immunotherapy	2014–	Multiple therapies tested and failed until the recent approval of Pembrolizumab + Paclitaxel in February 2026!		

Pembrolizumab + Paclitaxel Regimen Was Approved In February 2026 After Showing OS Benefit in Platinum-resistant Ovarian Cancer (PROC)

ORR of 53%, CR of 8%, PFS 8.3 months, OS 18.2 months

Key Secondary Endpoint: Overall Survival in the CPS ≥1 Population at IA2



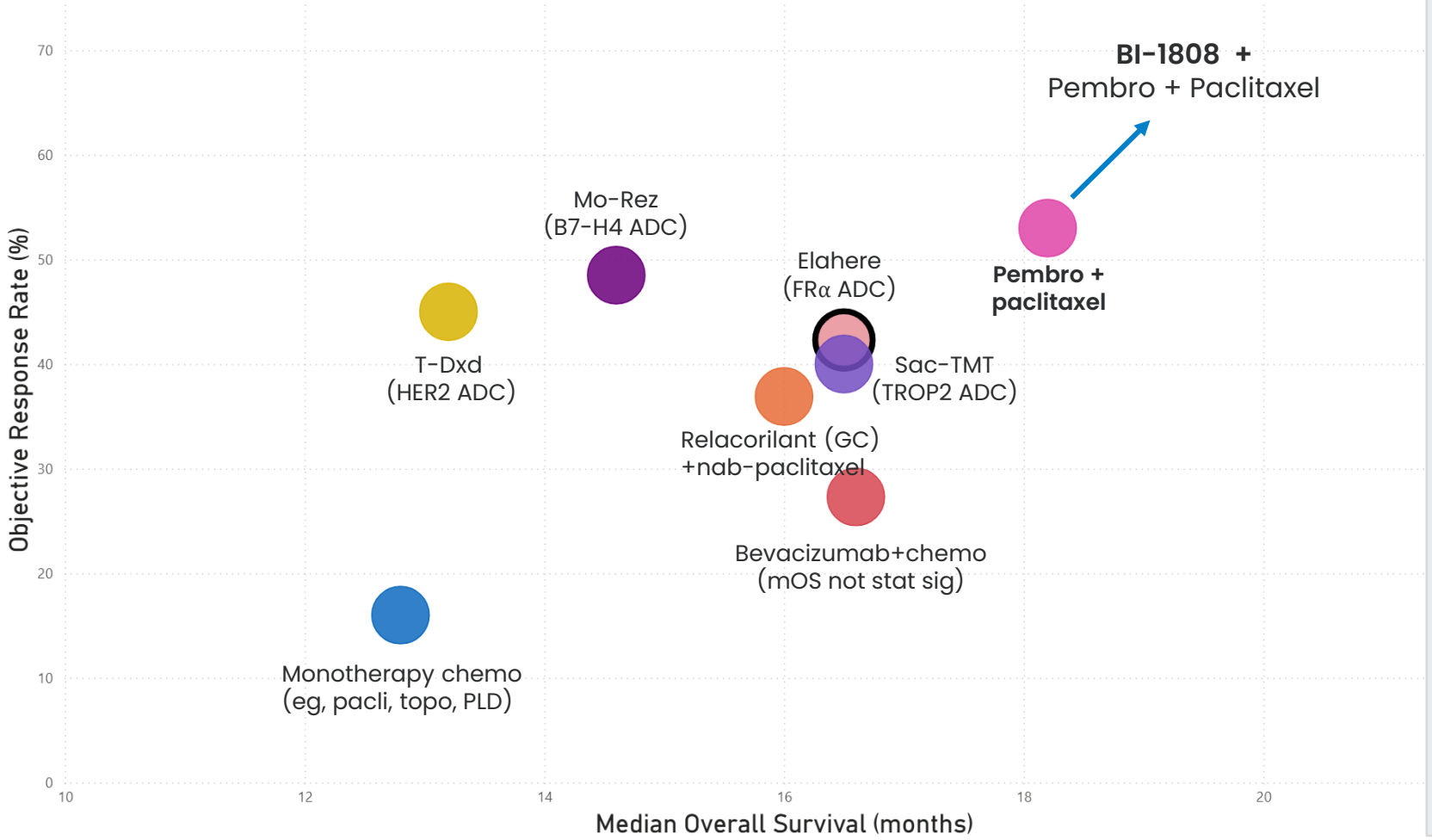
	Pts w/ Event	Median, mo (95% CI)
Pembro Arm	67.1%	18.2 (15.3-21.0)
Placebo Arm	75.4%	14.0 (12.5-16.1)

Information fraction: 90.0%

[a]The observed p-value crossed the prespecified nominal boundary of 0.0083 at this planned second interim analysis. Data cutoff date: March 5, 2025.

Source: Colombo et al., The Lancet, 2026. Both arms +/- bevacizumab

Adding BI-1808 to Pembrolizumab + Paclitaxel Can Further Improve On a Winning Combination In PROC



- Numerous late-stage ADCs
  - Most with Topo1 payload
  - Several targeting FRa; others target CDH6, HER2, TROP2
  - Studies in both PROC and 2L PSOC maintenance settings
- We expect:
  - No ADC will deliver a mOS outcome that exceeds 18 mo
  - Potential expansion of ADC-eligible patients (not just FRα+)
  - ADCs will cannibalize each other's share in PROC
  - **Efficacy of BI-1808 + pembro + paclitaxel will exceed that of any other regimen**

Footnote : Black box warning is represented with black outline; PROC = Platinum Resistant Ovarian Cancer

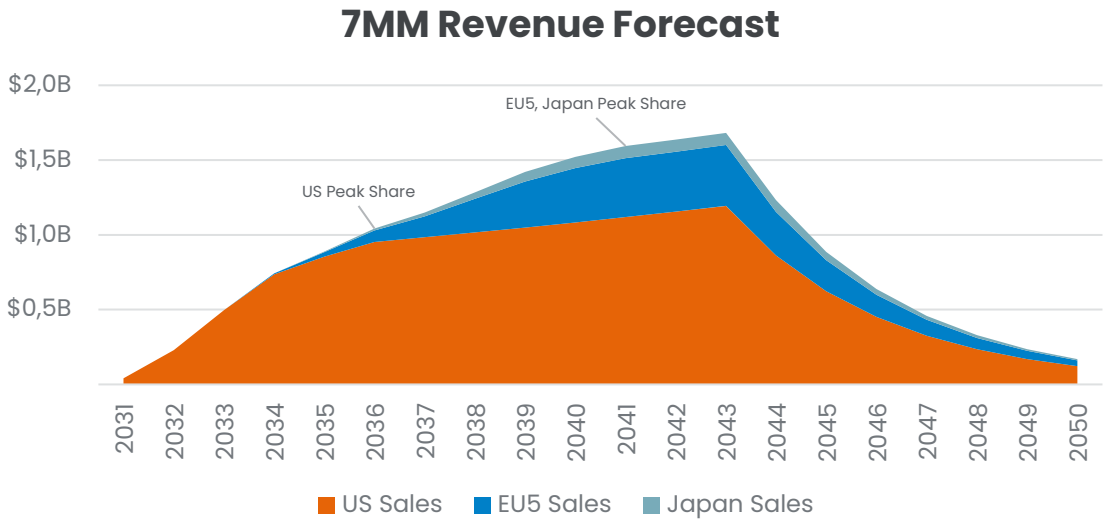
BI-1808 Peak Sales Is Estimated at ~$1.5b (Base-case) With Upside Potential for an All-comer Label

ASSUMPTIONS

- Pivotal trial in same patient population as KEYNOTE B96
- Accelerated approval in US, full approvals ex-US
- 26,260 drug treated 2L+ patients in 7MM
- Initial approval restricted to PDL1+ (CSP≥1) patients (~60%)
- In upside, all-comer case: % increase in potential patients will yield similar % increase in peak sales

FORECAST

Region	Sales at Peak Share
US Sales ($K)	$988,608
EU5 Sales ($K)	$396,504
Japan Sales ($K)	$82,250



PROC: Platinum resistant ovarian cancer (2L-4L+)
Preliminary 7MM forecast by FP Associates. Current assumptions have not been tested in primary market research.

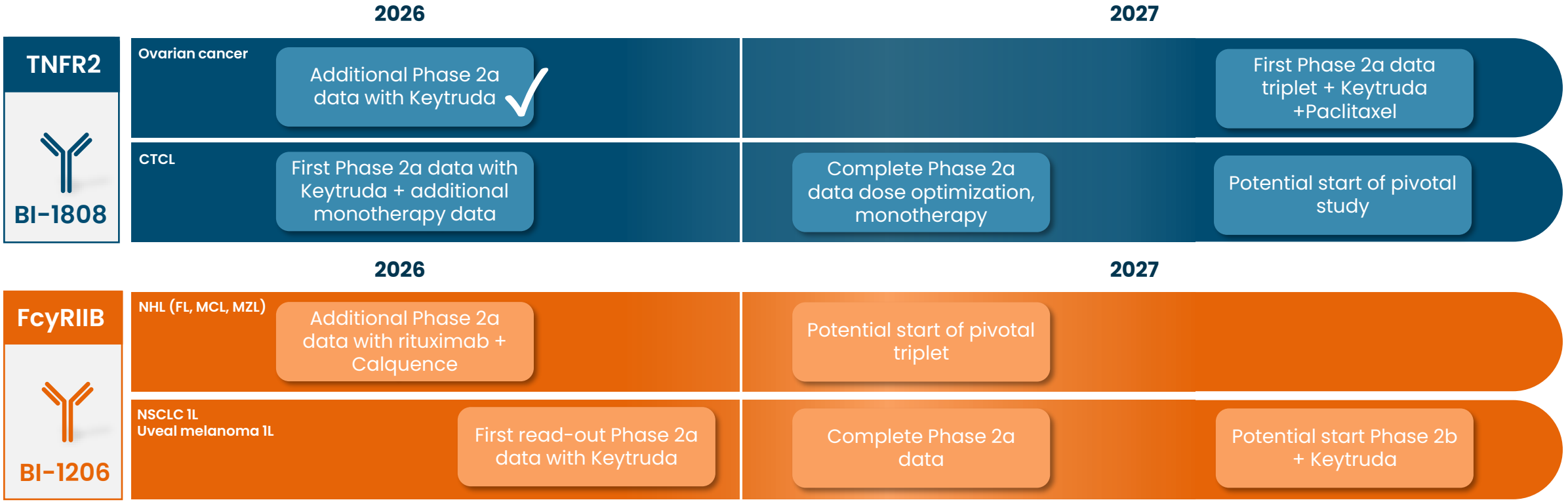
The BI-1808 Opportunity

✓ **New Immunotherapy Mechanism**	Depletes the most suppressive Tregs and reprograms myeloid cells to more robustly activate CD8+ T cell antitumor immunity
✓ **Impressive Efficacy**	The addition of BI-1808 triples the ORR of pembro in PROC (24%) with a pure immunotherapy regimen
✓ **Outstanding Safety Profile**	No Grade 3+ AEs as a single agent – toxicities mainly associated with pembrolizumab in the combo
✓ **Long-lasting Responses**	Early mPFS estimates of 10.2 months already superior to 8.3 months for pembro + paclitaxel
✓ **First-in-Class**	The most advanced TNFR2 blocker in development – a first-mover advantage!

Q & A

BioInvent

Key Expected Milestones 2026-2027



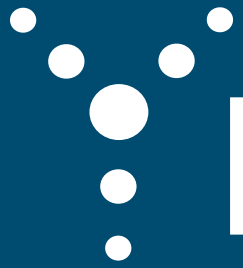
Next KOL event June 11 (BI-1206 in NHL and BI-1808 in CTCL)

1L/2L: First/second 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

BioInvent
bringing antibodies to life

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

- $1.5 billion in estimated peak sales



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Unleashing Immunity
To Fight Cancer

www.bioinvent.com

Appendix