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Obsidian Therapeutics

Corporate Presentation

August 2026

Forward-Looking Statements

This presentation includes forward looking statements. All statements other than statements of historical facts contained in this presentation, including express or implied statements regarding our future results of operations and financial position, expected clinical development and regulatory milestones, the timing and results of clinical trials, our clinical and regulatory strategy and plans, the potential benefits and attributes of our product candidates, potential growth opportunities, addressable market opportunity, our expected cash runway, and our expectations for future operations, are forward looking statements. The words "believe," "may," "will," "estimate," "continue," "anticipate," "design," "expect," "could," "plan," "potential," "predict," "seek," "should," "would," or the negative version of these words and similar expressions are intended to identify forward looking statements. We have based these forward-looking statements on our current expectations and projections about future events and trends that we believe may affect our financial condition, results of operations, strategy, short- and long-term business operations and objectives, and financial needs. These forward-looking statements are subject to a number of risks, uncertainties and assumptions including, but not limited to, risks relating to clinical development, regulatory approval, our ability to achieve anticipated milestones, the timing and results of clinical trials, our estimates regarding market opportunities and our expected cash runway, as well as those described under the heading “Risk Factors” in our filings with the Securities and Exchange Commission (the “SEC”) as well as any subsequent filings we make with the SEC. Although we believe that the expectations reflected in the forward-looking statements are reasonable, we cannot guarantee that the future results, levels of activity, performance or events and circumstances reflected in the forward-looking statements will be achieved or occur. Except as required by applicable law, we undertake no obligation to publicly update or revise any forward-looking statements contained herein, whether as a result of any new information, future events, changes circumstances or otherwise.

This presentation contains estimates and other information concerning our industry, our patient populations, our business and the markets for our product candidates. Information that is based on estimates, third party sources, market research or similar methodologies is inherently subject to uncertainties, and actual events or circumstances may differ materially from events and circumstances that are assumed in this information. Although we believe the industry and market data to be reliable as of the date of this presentation, this information could prove to be inaccurate. Projections, assumptions and estimates of our future performance and the future performance of the industry in which we operate are necessarily subject to a high degree of uncertainty and risk due to a variety of factors. These and other factors could cause results to differ materially from those expressed in our estimates and beliefs and in the estimates prepared by independent parties. This presentation discusses product candidates that are investigational only and have not yet been approved for marketing by the U.S. Food and Drug Administration. No representation is made as to the safety or effectiveness of these product candidates for the use for which such product candidates are being studied. The trademarks included herein are the property of the owners thereof and are used for reference purposes only. Such use should not be construed as an endorsement of such products.

Obsidian Therapeutics: Novel Engineered TIL Cell Therapies

Amsoki-cel (OBX-115):
Differentiated, Patient-centric TIL cell therapy

- Engineered with regulatable mbIL15; IL2-sparing
- Robust, proprietary scalable CMC process
- Favorable tolerability profile and lower treatment burden
- Fast Track & RMAT designations in advanced melanoma

Melanoma Ph 2:
67% ORR

YE 2027: Topline melanoma data from registration-enabling cohort

NSCLC
Ph 1 Ongoing

1H 2027: Phase 1 NSCLC data

Team and resources to advance pipeline through clinical development

Strong TIL & oncology expertise

Preclinical development to expand cytoDRiVE platform into next-gen cellular therapies

$350 million raised in oversubscribed PIPE to fund company into 2H 2028

Nasdaq: OBX

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Amsoki-cel, amsokigene autoleucel; IL2, interleukin 2; mbIL15, membrane-bound interleukin 15; NSCLC, non-small cell lung cancer; ORR, objective response rate; PIPE, private investment in public equity; RMAT, Regenerative Medicine Advanced Therapy; TIL, tumor-infiltrating lymphocytes.

Robust Executive Leadership with Deep TIL Expertise

Madan Jagasia, M.D., M.S.
Chief Executive Officer

IOVANCE BIOTHERAPEUTICS · VANDERBILT UNIVERSITY MEDICAL CENTER

Parameswaran Hari, M.D., M.S.
Chief Medical Officer

IOVANCE BIOTHERAPEUTICS · MEDICAL COLLEGE OF WISCONSIN

Julie Feder
Chief Financial Officer

aura · genzyme · VERASTEM ONCOLOGY

Dana Alexander
Chief Technical Officer

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Jennifer Peterson
Chief People Officer

INARI · INTRA LINKS · Monotype.

Maria Fardis, Ph.D., M.B.A.
Board Chair

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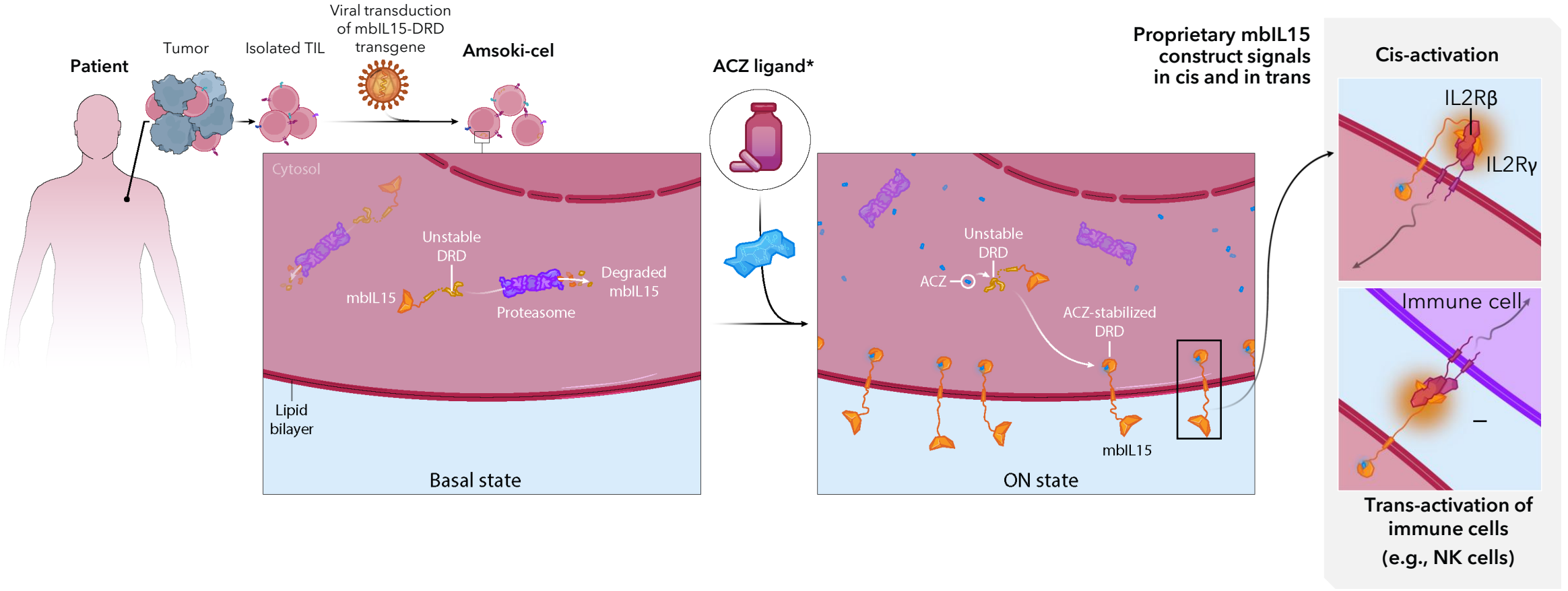
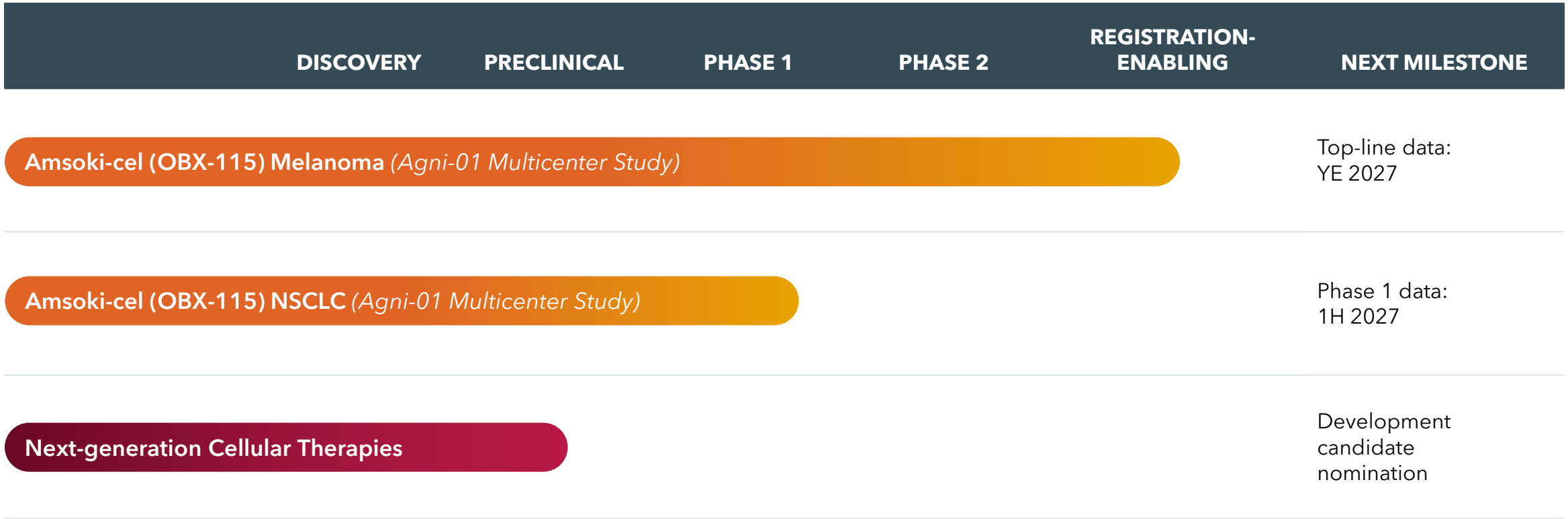
TIL, tumor-infiltrating lymphocytes.

Harnessing Regulatable mbIL15 to Enhance Amsoki-cel (OBX-115)



*ACZ, or acetazolamide, is an oral FDA-approved small molecule (brand name Diamox).
ACZ, acetazolamide; DRD, drug-responsive domain; IL2, interleukin 2; mbIL15, membrane-bound interleukin 15; TIL, tumor-infiltrating lymphocytes.

Our Pipeline



Current Approved Cell Therapy for 2L+ Melanoma Limited By Tolerability Profile

Available cell therapy option for 2L+ melanoma:

Non-engineered TIL cell therapy

Approved based on 31.5% ORR[1]

However, profile associated with tolerability and logistical challenges

- **High-dose IL2**
  IL2-dependent, terminally exhausted effector cells, severe AEs[1]
- **Standard-dose LD**
  ~4× more Cy vs approved CAR-T regimens
- **Black box warning**
  7.5% treatment-related mortality[1]
- **Inpatient administration**
  23.6% ICU transfer [2]
  17-day hospital stay [3]
- **Surgical excision required for tumor tissue procurement**
- **High patient attrition (34%) [1] post-TTP**

1. AMTAGVI Package Insert. 2. BLA Clinical Review and Evaluation BLA 125773. 3. FY2025 Lifileucel NTAP Cost Criterion Codes and MS-DRGs in CMS Public Application Summary. 4. Iovance Earning Report (Feb 24, 2026).
2L+, second-line and beyond;; CAR, chimeric antigen receptor; Cy, cyclophosphamide; ICU, intensive care unit; IL2, interleukin-2; LD, lymphodepletion; ORR, objective response rate; TTP, tumor tissue procurement.

Obsidian Leverages Regulatable mbIL15 to Deliver Patient-centric Cell Therapy in Melanoma

Transduced with regulatable mbIL15

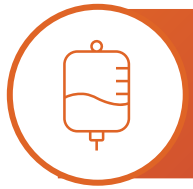
- CD8+ cytotoxic, stem-like T cells with memory phenotype
- ACZ to regulate mbIL15 expression

More Convenient Tissue Procurement Procedure

- Core needle biopsy feasible
- Enables outpatient procedure
- High manufacturing success rate

No IL2

- Favorable tolerability profile
- No DLT, no TRM observed



Less Intense Lymphodepletion

- ~50% less Cy vs. non-engineered TIL
- Compatible with outpatient administration

67% ORR

(n=10/15; incl. 2 CRs)

- Promising efficacy profile
- 8 of 10 responses ongoing at ~18-week study follow-up
- 93% disease control
- High unmet need population

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Betof et al. ASCO 2026 (Abstract 9507).
ACZ, acetazolamide; CR, complete response; Cy, cyclophosphamide; DLT, dose-limiting toxicity; IL2, interleukin-2. LD, lymphodepletion; mbIL15, membrane-bound interleukin 15; ORR, objective response rate; Ph, phase; TIL, tumor-infiltrating lymphocytes; TRM, treatment-related mortality.

~$3B+ Potential US Market Opportunity for Amsoki-cel (OBX-115)

2L+ Adult Patients with Advanced (Unresectable or Metastatic) Melanoma

~10K patients [1]

- ✓ Sufficient fitness & health performance
- ✓ Disease kinetics amenable to cell therapy
- ✓ Caregiver access / support

Cell Therapy Eligible

~6K patients [2]

- ✓ Amsoki-cel maximizes cell therapy eligibility via no IL2, low-dose LD, and CNB TTP

Amsoki-cel Opportunity

~5K patients [2]

IL2 Dependence Limits Addressable Market for Non-eng. TIL:

Eligibility for non-engineered TIL limited to 25% of 2L+ melanoma

Restricted to patients with adequate heart, liver, kidney function[3]

Potential for Amsoki-cel to Address Broadest Patient Population:

No IL2, low-dose LD, and **core needle biopsy TTP** expand eligibility to 50% of 2L+ melanoma

~$3B+ addressable US market opportunity for amsoki-cel [4] in melanoma

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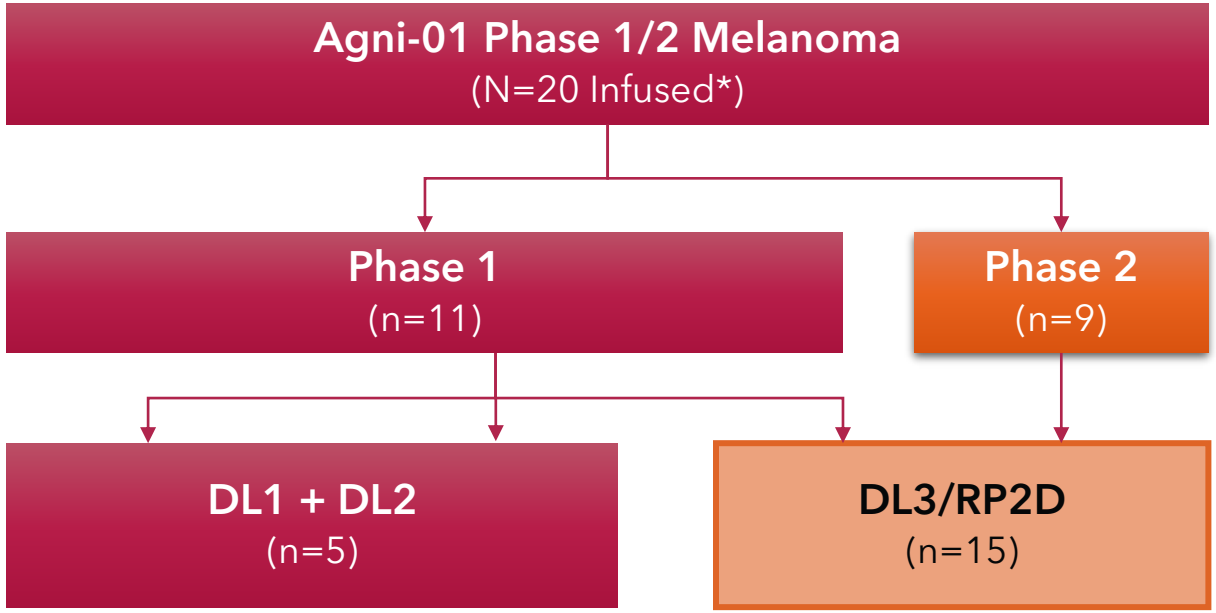
1. DRG Melanoma Market Forecast (Nov 2023). 2. The Dedham Group KOL Market Research (2025). 3. Due to high-dose IL2 and standard lymphodepletion regimen (The Dedham Group KOL Market Research (2025). 4. Based on ~$600k/patient estimated net price for Amtagvi + IL2; source: Wall Street Research (2025)
2L+, second-line and beyond; CNB, core needle biopsy; IL2, interleukin 2; LD, lymphodepletion; ORR, objective response rate; SOC, standard of care; TTP, tumor tissue procurement

Amsoki-cel (OBX-115) in Advanced Melanoma

Agni-01 Phase 1/2 Study Ongoing

Agni-01 Phase 1/2 Melanoma Patient Schema



	DL1	DL2	DL3/RP2D
Amsoki-cel	30 × 10^9 cell maximum† (n=3)	100 × 10^9 cell maximum (n=2)	100 × 10^9 cell maximum (n=15)
ACZ	250 mg/day, Days 0–13	250 mg/day, Days 0–13	500 mg/day, Days 0–6, 14–20

At DL3/RP2D:

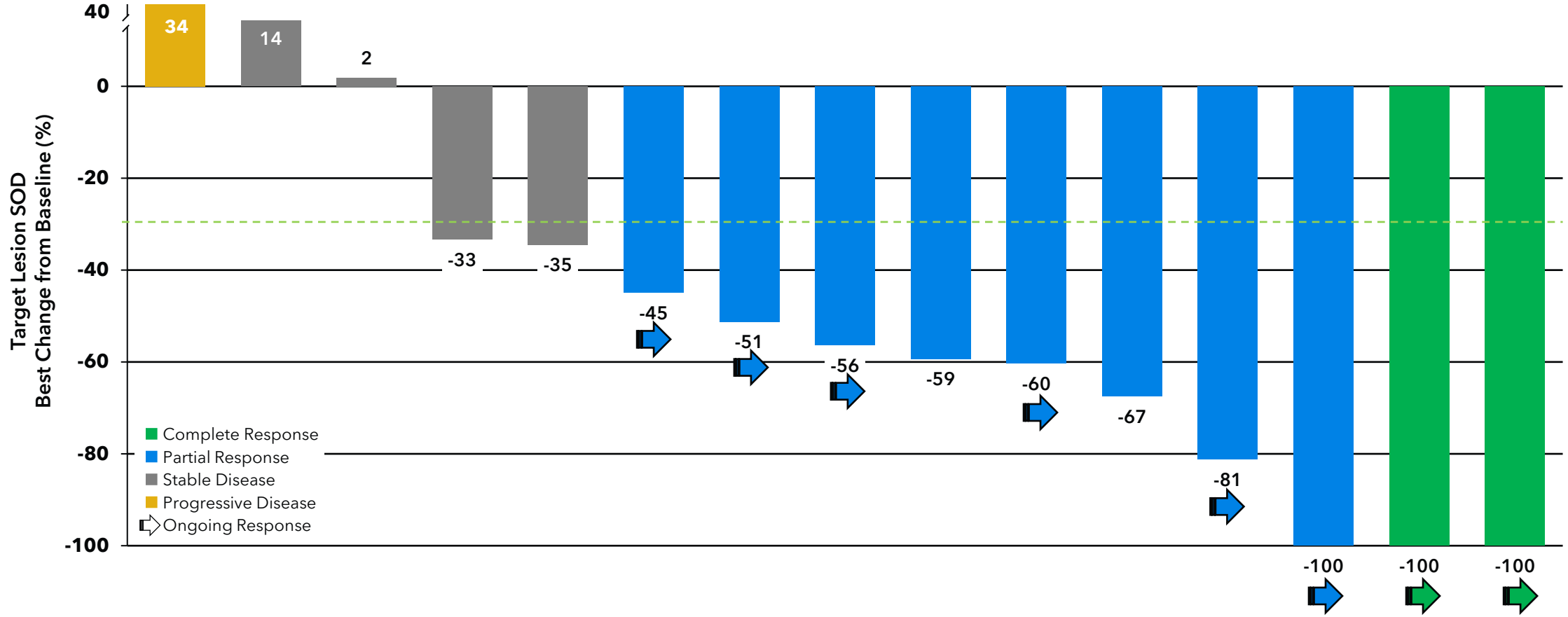
4 outpatient lymphodepletion

100% of ACZ redosing in outpatient setting†

Betof et al. ASCO 2026 (Abstract 9507). Data cutoff: 22 January 2026. *3 additional patients were enrolled and not infused: n=2 discontinued prior to treatment due to disease progression during DLT stagger phase; n=1 manufacturing failure.
†Per-protocol maximum allowed infused cell dose.
ACZ, acetazolamide; D, Day; DL, dose level; RP2D, recommended phase 2 dose.

67% ORR, with SOD Reduction in 80% of Patients

TTP method	Surg	Surg	Surg	Surg	Surg	**CNB***	Surg	Surg	Surg	**CNB***	Surg	Surg	Surg	Surg	Surg
Amsoki-cel dose (cells × 10^9)	94.8	100	55.8	60.9	34.2	99.2	81.6	37.2	77.4	100	86	83.4	89.2	65.7	97.6
ACZ redosing	+	+	-	+	+	+	+	+	+	+	+	+	+	+	+
Patient ID	**41**	**39**	**13**	**32**	**9**	**33**	**35**	**34**	**12**	**31**	**11**	**38**	**37**	**15**	**14**



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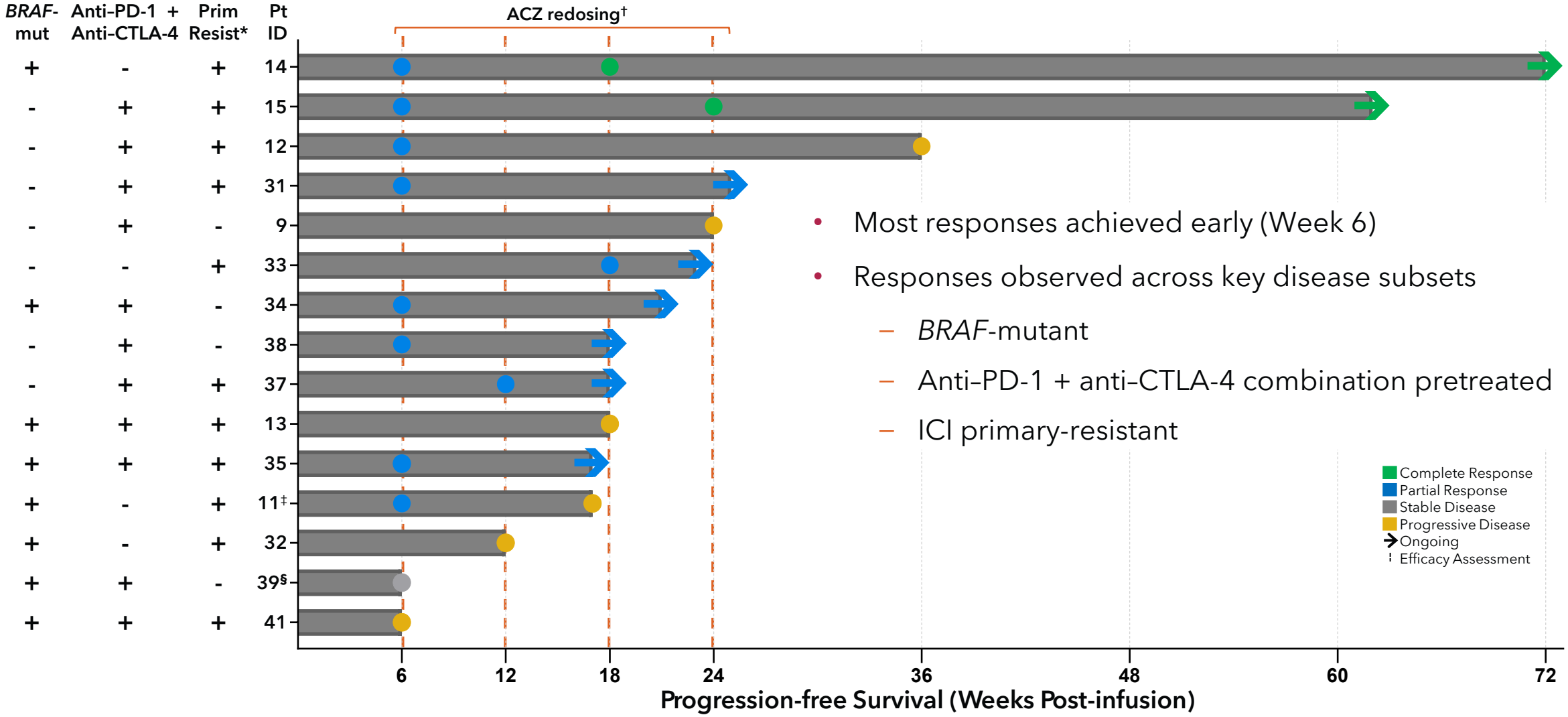
Betof et al. ASCO 2026 (Abstract 9507). Data cutoff: 22 January 2026. *Both patients with CNB tumor tissue procurement responded to therapy.
ACZ, acetazolamide; CNB, core needle biopsy; SOD, sum of diameters; Surg, surgery; TTP, tumor tissue procurement.

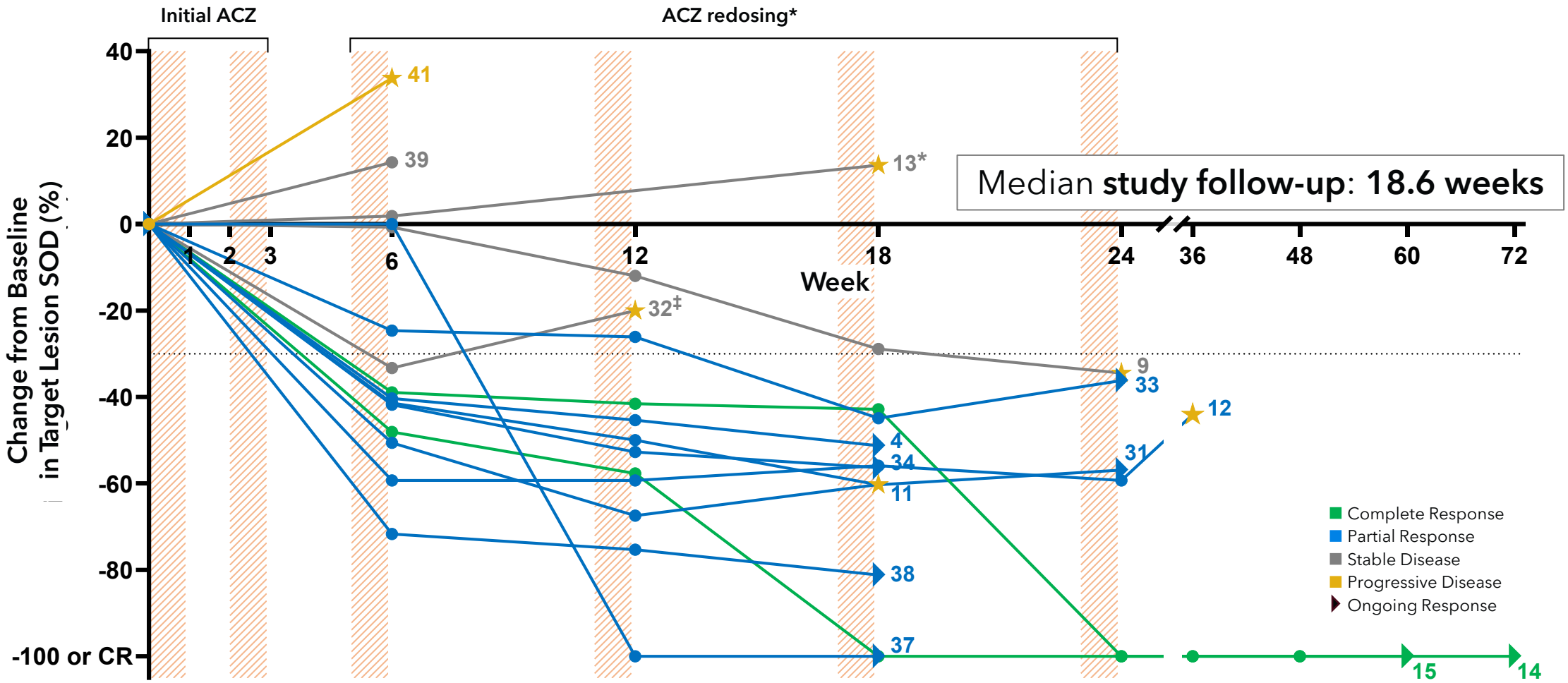
Favorable Onset and Duration of Response



- Most responses achieved early (Week 6)
- Responses observed across key disease subsets
  - *BRAF*-mutant
  - Anti–PD-1 + anti–CTLA-4 combination pretreated
  - ICI primary-resistant

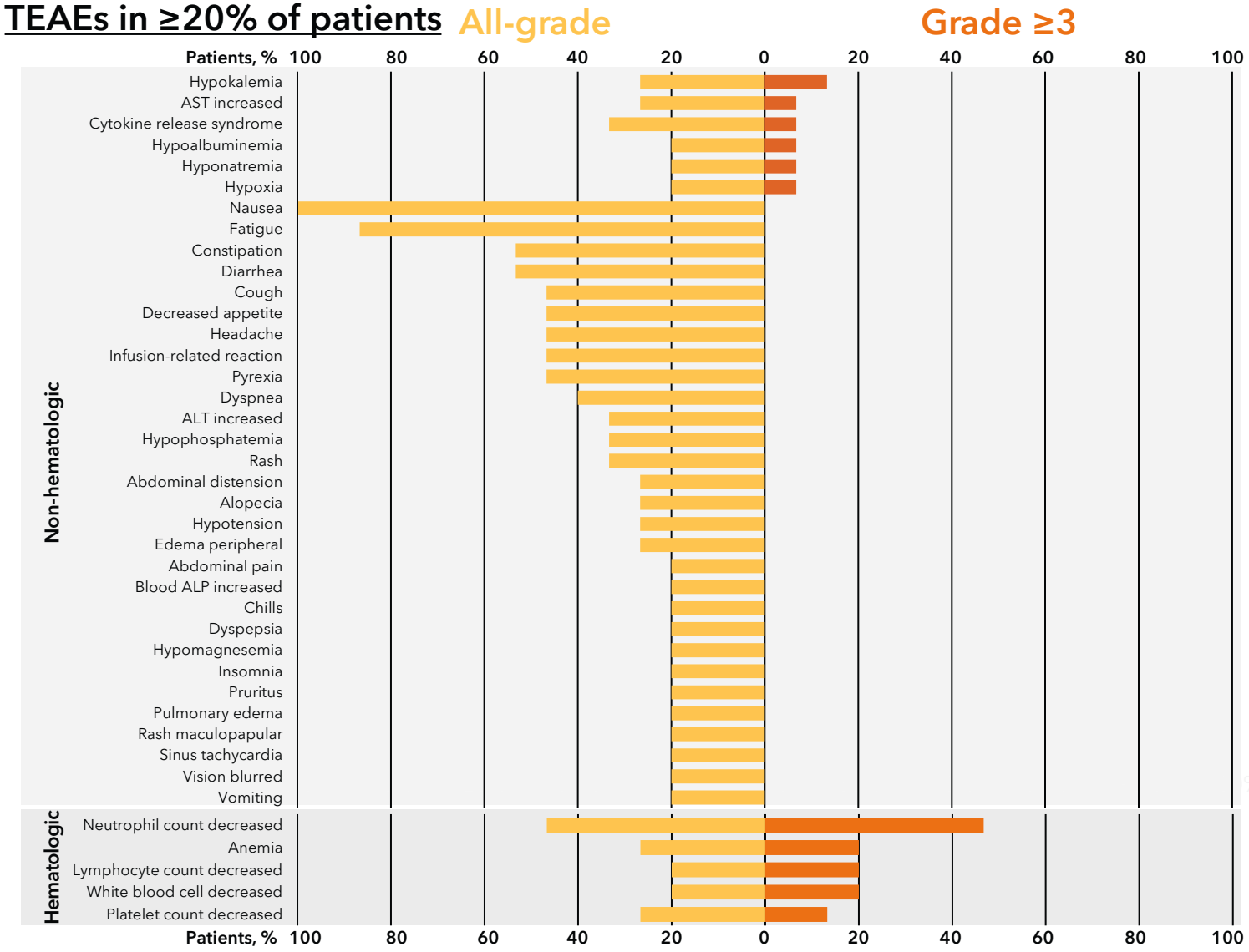
Betof et al. ASCO 2026 (Abstract 9507). Data cutoff: 22 January 2026. *ICI primary-resistant disease (monotherapy or combination therapy). †ACZ was redosed after recovery from lymphodepletion for 7 days every 6 weeks until Week 24. ‡Patient 11 did not receive combination anti–PD-1 therapy. §Patient 39 censored prior to Week 12.
ACZ, acetazolamide; CTLA-4, cytotoxic T-lymphocyte antigen-4; ICI, immune checkpoint inhibitor; mut, mutant; PD-1, programmed cell death protein-1; prim resist, primary-resistant.

Deepening and Durable Responses



Betof et al. ASCO 2026 (Abstract 9507). Data cutoff: 22 January 2026. *Patient 13 did not receive ACZ redosing. ‡Patient 32 had BRAF-refractory small-volume disease and a new satellite lesion at Week 12 that was biopsy-proven.
ACZ, acetazolamide; CR, complete response; SOD, sum of diameters.

Favorable Safety & Tolerability Profile



- **Grade ≥3 non-hematologic toxicity was uncommon**
- **CRS** was reported for 5 patients (33%)
  - **1 event (7%) was Grade 3**
- **Hematologic toxicity was favorable**
  - 1 event (7%) of febrile neutropenia (Grade 3)
- **No DLTs**
- **No ICANS**
- **No ICU** transfer

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Betof et al. ASCO 2026 (Abstract 9507). Data cutoff: 22 January 2026. TEAE defined as any AE occurring after first dose of lymphodepletion, excluding AEs not related to amsoki-cel (OBX-115) or ACZ after Day 84.
ALP, alkaline phosphatase; ALT, alanine aminotransferase; AST, aspartate aminotransferase; CRS, cytokine release syndrome; DLT, dose-limiting toxicity; ICANS, immune effector cell-associated neurotoxicity syndrome; ICU, intensive care unit; TEAE, treatment-emergent adverse event.

Patients Had Difficult-to-treat Post-ICI Disease, With Majority Previously Exposed to Anti–PD-1 Combination

Baseline Patient and Disease Characteristics	Amsoki-cel (N=15)
Age, median (range), years	55 (41–78)
Sex, n (%) Female	6 (40.0)
ECOG PS, n (%) 0 1	 12 (80.0) 3 (20.0)
LDH >ULN, n (%)	6 (40.0)
Melanoma subtype, n (%) Cutaneous **Mucosal** **Acral**	 9 (60.0) **3 (20.0)** **3 (20.0)**
Mutation status, n (%) *BRAF* V600-mutant *NRAS*-mutant	 8 (53.3) 3 (20.0)
Brain and/or liver lesions, n (%)	**3 (20.0)**
Target lesion SOD, mean (SD), mm	58.0 (14.2–213.0)

Treatment Characteristics	Amsoki-cel (N=15)
Lines of prior systemic therapy, median (range)* **Lines of prior ICI therapy**	2.0 (1–5) **2.0 (1–5)**
Prior systemic therapy, n (%) Anti–PD-1 monotherapy only **Anti–PD-1 combination** **Anti–PD-1 + anti–CTLA-4** Anti–PD-1 + anti-LAG3 **BRAF ± MEK TKI**	15 (100.0) 1 (6.7) **14 (93.3)** **11 (73.3)** 8 (53.3) **6/8 (75.0)**
Primary-resistant (SITC criteria), n (%) Anti–PD-1[1] Anti–PD-1 combination[2]	**11/15 (73.3)** 5/9 (55.6) 8/14 (57.1)

- Patients had advanced and difficult-to-treat disease
- Disease progressed on several lines of standard-of-care therapies
  - **73% with prior anti–PD-1 + anti–CTLA-4 combination**
- Limited remaining treatment options

Betof et al. ASCO 2026 (Abstract 9507). Data cutoff: 22 January 2026. *Multiple prior lines were permitted.
1. Kluger HM et al. J Immunother Cancer 2020;8(1). 2. Kluger H et al. J Immunother Cancer 2023;11(3).
CTLA-4, cytotoxic T-lymphocyte antigen-4; ECOG PS, Eastern Cooperative Oncology Group performance status; ICI, immune checkpoint inhibitor; LAG3, lymphocyte activation gene 3; LDH, lactate dehydrogenase; PD-1, programmed cell death protein-1; SITC, Society for Immunotherapy of Cancer; SOD, sum of diameters; TKI, tyrosine kinase inhibitor; ULN, upper limit of normal.

Proprietary Manufacturing Process Enables Advantages in Phenotype, Yield, Process Control, and Procurement Method

Ex Vivo Manufacturing

Tumor tissue procurement
Compatible with core needle biopsy

Optimized pre-REP

Activation/ mbIL15 transduction*

Optimized REP

Cryo-preservation

Enhancements vs non-engineered TIL

- 4-1BB agonism in pre-REP
- iFeeder cells expressing IL21 and 4-1BBL
- ACZ (IL15)-driven expansion (no IL2)

Optimized product: median **>90%** CD8+; effector-memory phenotype, stem-like signature, minimally exhausted[1,2]

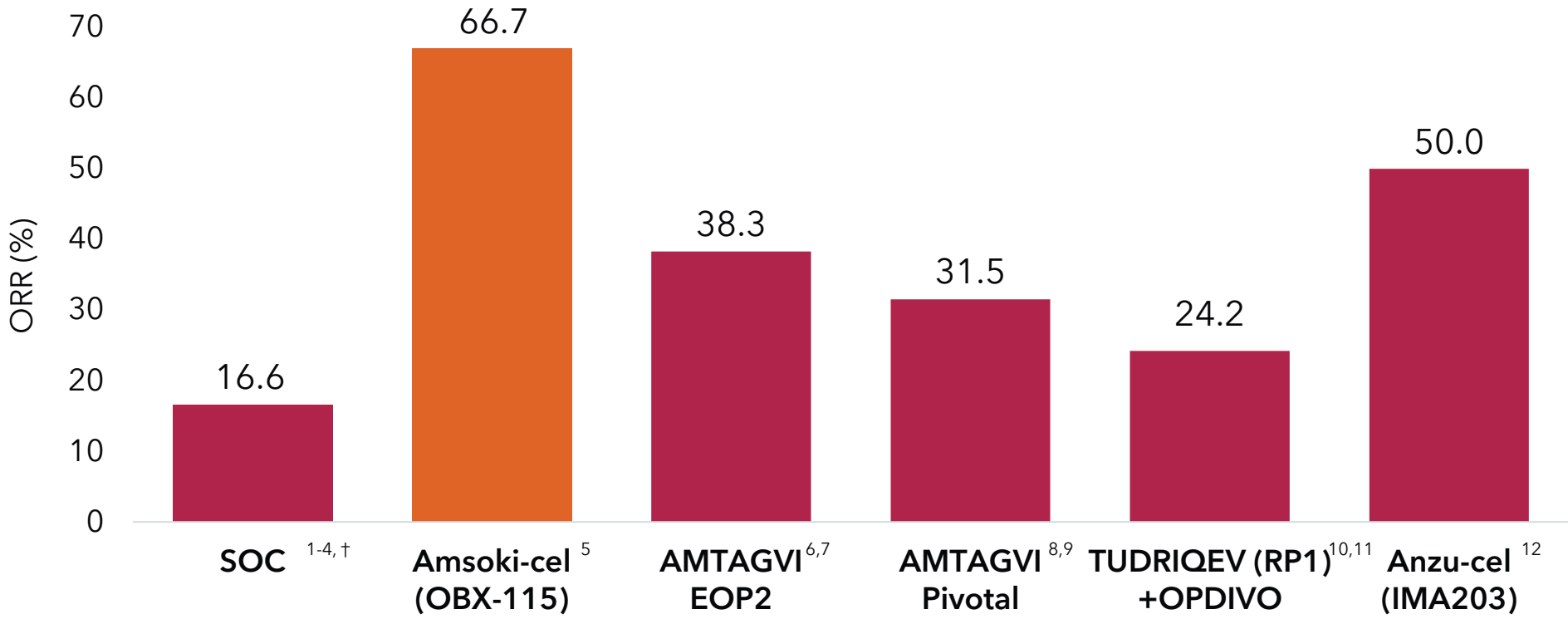
High process control

Robust manufactured cell dose yield: median ~129B vs. 21.1B[3] non-engineered TIL

Core needle biopsy enabled for amsoki-cel manufacturing

*Anti-CD3 Ab; retroviral vector.
1. Amaria RN et al. ASCO 2024 (Abstract 9515). 2. Amara RN et al. AACR 2024 (Poster CT176). 3. Journal for ImmunoTherapy of Cancer2022;10:e005755.
ACZ, acetazolamide; CNB, core needle biopsy; IL2, interleukin 2; IL15, interleukin 15; IL21, interleukin 21; mbIL15, membrane-bound IL15; REP, rapid expansion protocol; TIL, tumor-infiltrating lymphocytes.

Encouraging Efficacy Profile in 2L+ Melanoma Across Modalities



	SOC [1-4, †]	Amsoki-cel (OBX-115) [5]	AMTAGVI EOP2 [6,7]	AMTAGVI Pivotal [8,9]	TUDRIQEV (RP1) +OPDIVO [10,11]	Anzu-cel (IMA203) [12]
N	971 [1-4]	15	47	73	91	14
Received anti–PD-1 + anti–CTLA-4 (or anti-LAG3) combination	12% [1,2]	93%	Not reported	58%	44%	71%
Primary-resistant to ICI	~64% [1]	73%	Not reported	71%	66%	Not reported

Comparisons based on historical published data. No head-to-head studies have been conducted and cross-trial comparisons may not be reliable due to differences in molecule composition, trial design, and patient population and characteristics.

†SOC therapies include: Ipi+Nivo (ORR 28%),[1] Chemo (ORR 11%),[2] Rela+Nivo (ORR 12%),[3] and ICI recycling (ORR 15.5%).[4]

1. VanderWalde A, Nat Med. 2023 Sep;29(9):2278-2285. 2. Goldinger SM Eur J Cancer 2022; 162:22-33. 3. Ascierto PA J Clin Oncol 2023;41(15):2724-2735. 4. Reschke R, J Dtsch Dermatol Ges. 2020; 18(5): 429-436. 5. Betof et al. ASCO 2026 (Abstract 9507). 6. Iovance Press Release. Oct 11, 2018. 7. Sarnaik A, SITC 2018 (Poster O22). 8. AMTAGVI (lifileucel) Prescribing Information. February 2024. 9. Chesney J. J Immunother Cancer 2022; 10:e005755. 10. Wong MK et al J Clin Oncol 202511. TUDRIQEV (vusolimogene oderparepvec-wtpg) Prescribing Information. August 2026. 12. Diwakar D ASCO 2026 (Abstract 9508).

CTLA-4, cytotoxic T-lymphocyte-associated protein 4; EOP2, end of phase 2; ICI, immune checkpoint inhibitors; LAG3, lymphocyte activation gene 3 protein; ORR, objective response rate; PD-1, programmed cell death protein-1; SOC, standard of care; Tx, therapy.

Amsoki-cel is Positioned Favorably vs Other Melanoma Cell Therapies

		AMSOKI-CEL *Agni-01 Ph 2 ongoing*	AMTAGVI *Approved*	ANZU-CEL *SUPRAME reg. trial ongoing*
Efficacy	ORR	**67%** [1] (N=15)	31.5% [2] (N=73)	50% [3] (N=14)
AE Profile Drivers	IL2-sparing	✓	✗	✗
	Low-dose LD	✓	✗	✓
	No TRM	✓	✗	✓
	No CRS Gr >3 or ICANS	✓	✗	✗
Treatment Burden	Outpatient-compatible	✓	✗	✓
	No ICU	✓	✗	?
	Material Procurement	**CNB eligible**	Surgical resection	Leukapheresis
Patient Eligibility	≥50% of 2L+ Mel.	✓	25% eligible; restricted to adequate heart, liver, kidney function[4]	~30% eligible: restricted to cutaneous (~90%)[5], LDH <2× ULN (~80%),[6] & HLA restricted (~40%)[7]

Information for approved products based on FDA-approved labeling and publicly available data. Comparisons based on historical published data; no head-to-head studies have been conducted and cross-trial comparisons may not be reliable due to differences in molecule composition, trial design, and patient population and characteristics.

1. Betof et al. ASCO 2026 (Abstract 9507). 2. AMTAGVI (lifileucel) Prescribing Information. February 2024. 3. Diwakar D ASCO 2026 (Abstract 9508). 4. Due to high-dose IL2 and standard lymphodepletion regimen, restricted to patients with adequate heart, liver, kidney function (The Dedham Group KOL Market Research 2025). 5. Long GV et al. The Lancet. 2023; 402(10400):485-502. 6. Koczka K et al. Cancer Med. 2023 Feb;12(3):2427-2439. 7. Li X et al. Mol Oncol. 2021 Jul;15(7):1764-1782.
2L, second-line; AE, adverse event; CRS, cytokine release syndrome; DOR, duration of response; ICANS, immune effector cell-associated neurotoxicity syndrome; ICU, intensive care unit; IL2, interleukin 2; mDOR, median duration of response; NR, not reached; ORR, objective response rate; FDA, Food and Drug Administration; PDUFA, Prescription Drug User Fee Act; TRM, treatment-related mortality; Tx, therapy.

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Advancing Amsoki-cel (OBX-115) to Registration-enabling Study

FDA feedback obtained on a **single-arm trial design** for accelerated approval (at Sponsor's risk)

For amsoki-cel in patients with advanced melanoma progressing after ICI therapy

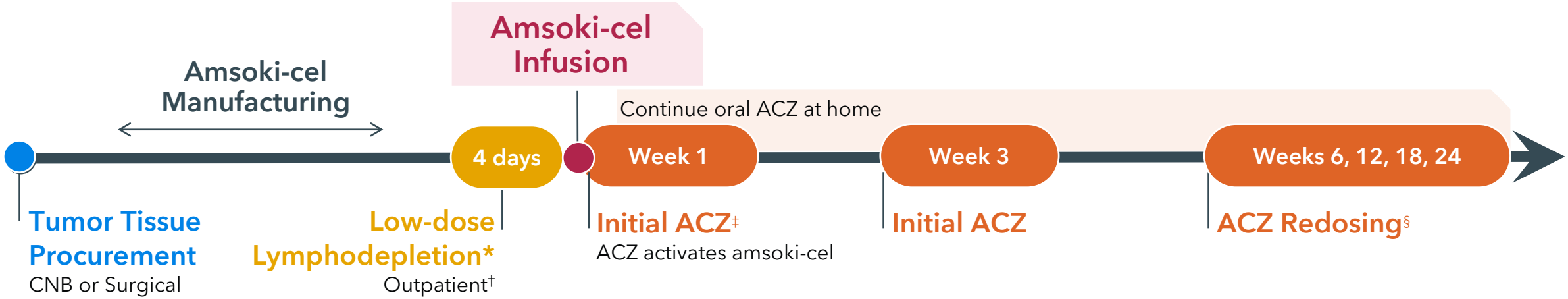
FDA alignment on:

- Sufficiency of durable **ORR** as an endpoint that predicts clinical benefit
- **Sample size** for safety dataset
- No changes to proposed **eligibility criteria**
- Drug product **potency assay** development and qualification

Mid-2026: Enrollment underway in registration-enabling cohort of existing multi-center study

A **confirmatory study** will be underway at the time of BLA action

Agni-01 Melanoma Registration-enabling Study Design: Outpatient-compatible Regimen



Key Eligibility Criteria

- Post-ICI advanced melanoma
- ≤2 prior lines of systemic therapy
- BRAFi/MEKi therapy not mandated in BRAF-mut disease
- ≥1 lesion suitable for tumor tissue procurement
- ≥1 remaining lesion amenable to RECIST v1.1 response assessment

Primary Endpoints

- Blinded independent central reviewer (BICR)-assessed ORR

Key Secondary Endpoints

- DOR (BICR-assessed)
- Safety and tolerability of the amsoki-cel regimen
  - Incidence, severity, seriousness, relationship to study intervention, and characteristics of treatment-emergent adverse events (TEAEs)

NCT06060613.*Cy 750 mg/m^2 × 3 days and Flu 30 mg/m^2 × 4 days. † Outpatient or inpatient administration, at the discretion of the treating physician. ‡ Initial ACZ is administered once daily starting day of amoki-cel (OBX-115) infusion for ≤14 days, split into two ≤7-day periods within 28 days (Day 0–6 or until ALC ≥5000 cells/μL whichever is earlier, and restarting between Day 14 and 21). § Additional ACZ dosing for ≤7 days at periodic intervals until Week 24, and upon progression when new anticancer therapy is not immediately warranted.
ACZ, acetazolamide; BICR, blinded independent central review; CNB, core needle biopsy; Cy, cyclophosphamide; DOR, duration of response; Flu, fludarabine; ICI, immune checkpoint inhibitor; LD, lymphodepletion; ORR, objective response rate; RECIST, Response Evaluation Criteria in Solid Tumors; TTP, tumor tissue procurement.

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Amsoki-cel (OBX-115) in NSCLC

Agni-01 Phase 1/2 Study Ongoing

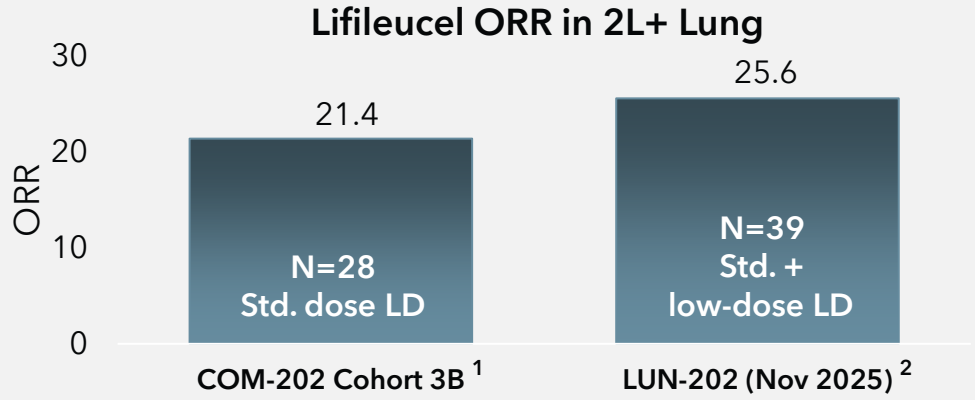
Amsoki-cel (OBX-115) Potential to Deliver Improved Profile in NSCLC

Amsoki-cel: Potential to Improve NSCLC TPP & Expand Market Opportunity

- ✓ IL2-free regimen
- ✓ Low-dose LD
- ✓ Core needle biopsy compatible
- ✓ Tumor reduction signal (amsoki-cel monotherapy) observed in early Phase 1 data

NSCLC prevalence ~10× that of advanced melanoma

Lifileucel: Efficacy in 2L+ NSCLC, But Associated with Toxicity Risk



Proof of TIL efficacy & durability in NSCLC, however, concerning safety signals [3]:

- – 12% died in first 30 days post-treatment
- – G5 toxicity led to temporary clinical hold (2023)

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1. Schoenfeld AJ, et al. Cancer Discov 2024;14(8):1389-1402. 2. Iovance Press Release, November 2025. 3. Safety analysis from Amtagvi BLA Clinical Review & Evaluation report.
2L+, second-line and beyond; Gr, grade; IL2, interleukin 2; LD, lymphodepletion; NSCLC, non-small cell lung cancer; ORR, objective response rate; TPP, therapeutic product profile.

NSCLC Dose Escalation Leveraged Melanoma Experience; Dose Optimization at DL3 Ongoing

- ✓ Completed NSCLC dose escalation to get to DL3
- ✓ Exploring new intermediate cell dose cap (~60B) to maximize ACZ regimen
- ✓ Study enrollment ongoing

Infused Patients*		Melanoma		NSCLC
Dose Level		Phase 1 (N=11)	Phase 2 (N=9)	Phase 1 (N=10)
DL1	30B cell dose cap ACZ: 250 mg/day, Days 0–13 Planned 28-day cumulative dose: 3500 mg	3	0	1
DL2	100B cell dose cap ACZ: 250 mg/day, Days 0–13 Planned 28-day cumulative dose: 3500 mg	2	0	1
DL3	100B cell dose cap ACZ: 500 mg/day, Days 0–6, 14–20 Planned 28-day cumulative dose: 7000 mg	6	9	4*
DL3	DL3 Expansion in NSCLC **Intermediate cell dose cap (~60B)** ACZ: 500 mg/day, Days 0–6, 14–20 Planned 28-day cumulative dose: 7000 mg + Extended ACZ redosing every other wk	0	0	4*

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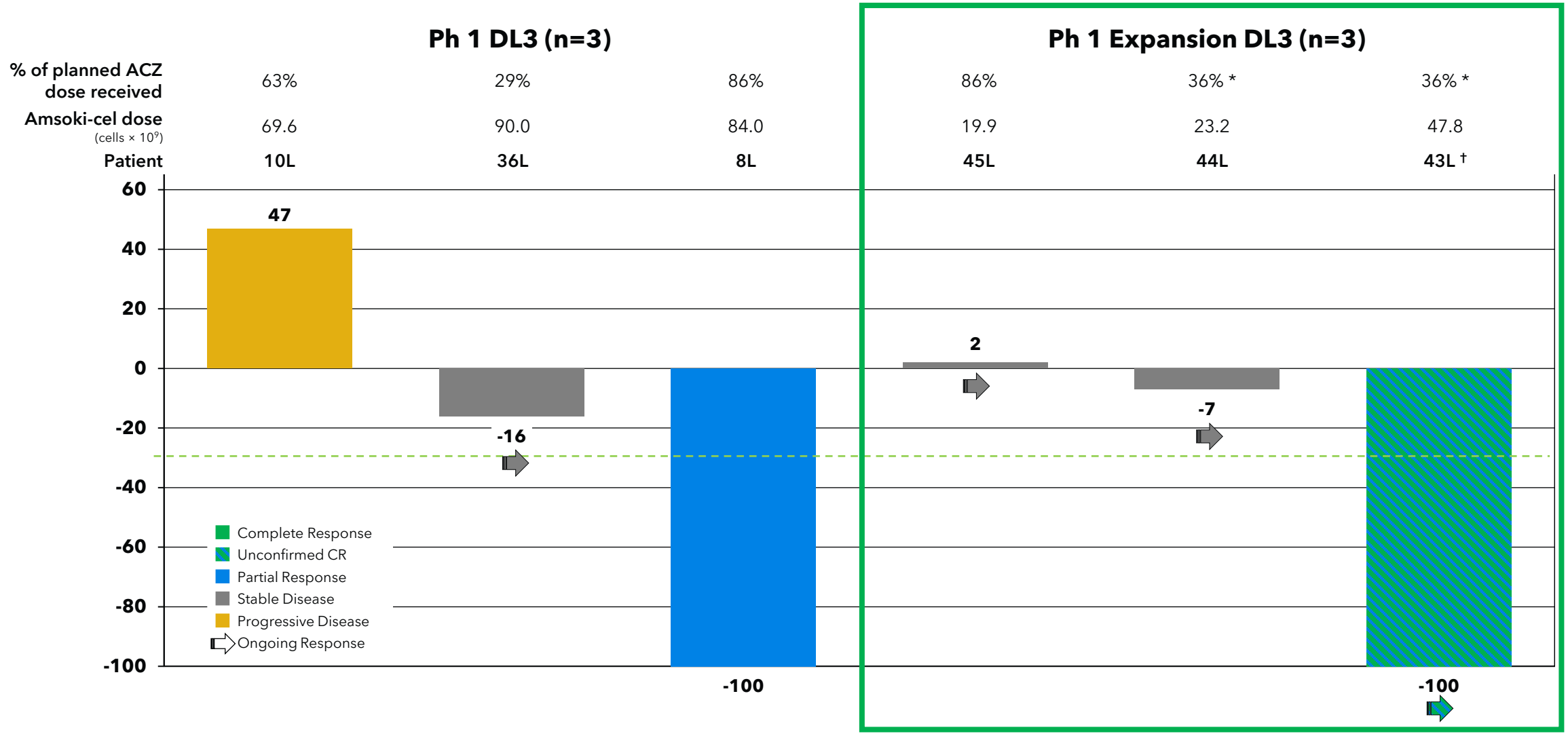
Data cut-off Jan 22, 2026.
*4 infused, of which 3 were efficacy-evaluable.
ACZ, acetazolamide; B, billion; DL, dose level; NSCLC, non-small cell lung cancer; Ph, phase.

Encouraging Signal in NSCLC Patients Treated at 60B Cell Dose Cap



Data cut-off Jan 22, 2026.
*Both patients (43L and 44L) had ALC >5000 at Days 10–14 and Week 3 doses omitted. †Patient 43L Baseline ctDNA (160 ppm) was undetectable at D14 and D42.
ACZ, acetazolamide; CR, complete response; DL, dose level; NSCLC, non-small cell lung cancer; Ph, phase.

Expected Milestones Through 2027

Recent Achievements

- Enrollment underway in registration-enabling cohort for melanoma
- Positive Ph 2 data in Agni-01 melanoma multicenter study
- FDA clarity on melanoma registrational pathway and potency assay
- Fast Track & RMAT designations in advanced melanoma
- NSCLC monotherapy response signal from early Ph 1 regimen-optimization data

Anticipated Milestones

- Melanoma Ph 1/2 update **Q4 2026**
- Melanoma top-line data from registration-enabling cohort **YE 2027**
- NSCLC Phase 1 data **1H 2027**

Plan to Continue

Preclinical development and expand platform into next-gen cell therapies

Manufacturing and infrastructure investments to support future commercial scale

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NSCLC, non-small cell lung cancer; RMAT, Regenerative Medicine Advanced Therapy.

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Thank you