OSE IMMUNO THERAPEUTICS

Breaking Through the Therapeutic Ceiling with First-In-Class Immunotherapies

February 2025

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Investment highlights

Late-stage compelling products	**Promising clinical data from the Phase 3 oncology asset Tedopi®** **Positive Phase 2 I&I asset Lusvertikimab (UC)**
Large market opportunities	**Focus on multi-billion $ markets** • **I&I:** IBD (Ulcerative Colitis), Cardiovascular-Renal-Metabolic diseases (MASH), Kidney Transplantation, • **I/O:** NSCLC, HNSCC, Leukemia
Strong pharma partnerships	**Sustainable business through multi-partnership strategy** **> €2.1bn milestones:** AbbVie, Boehringer Ingelheim, Veloxis
Long duration IP portfolio	**IP extends to 2040's** **I/O:** Tedopi® (>2038), BI770371 (>2037), OSE-279 (>2039), CLEC-1 (>2040) **I&I:** OSE-127 (>2037), FR104 (>2035), ABBV-230 (>2040)
Multiple upcoming catalysts	**Multiple key clinical and regulatory milestones expected in next 12-18 months** • **Tedopi®:** Confirmatory pivotal phase 3 NSCLC 2L and combination Phase 2 update • **Lusvertikimab (OSE-127):** Full dataset efficacy results Ulcerative Colitis Phase 2 (Open-label extension) • **BI 770371:** Phase 1b results in solid tumors/Phase 2 update in MASH • **FR104/VEL-101:** Phase 2 start in Kidney Transplantation • **ABBV-230:** IND/Phase 1
Financial position	**Cash visibility until 2027** **€80.7 million** level of cash as of June 30, 2024, providing solid financial position and visibility until 2027

An experienced executive leadership team

Nicolas Poirier, PhD
CEO

- 20+ years of experience in biotech/immunotherapy
- Previously CSO, advanced 6 novel immunotherapies to clinic, leading to 6 pharma deals
- Global Management & Finance (INSEAD, HEC)

Sonya Montgomery, MD
CHIEF DEVELOPMENT OFFICER

- 20+ years in Pharma / Biotech
- Global management, portfolio strategy, development plans, regulatory, from discovery through registration (Pfizer, Gyroscope Tx, Evox Tx, Transition Tx, Relypsa, ProQR, Vasogen …)

Silvia Comis, MD
CHIEF CLINICAL RESEARCH OFFICER

- 30+ years in Pharma
- Previously Senior Medical Director IQVIA, and European Head of Early Products Medical Affairs in oncology at Novartis

Jean-Jacques Mention, PhD
CHIEF BUSINESS OFFICER

- 15+ years of Research in Immunology at King's College London & Institut Pasteur
- 10 years experience in Business Development

Anne-Laure Autret-Cornet
CHIEF FINANCIAL OFFICER

- 15+ years in Finance / Biotech
- Graduated from ESSCA Management school
- Corporate Finance, HEC

Fiona Olivier
CHIEF CORPORATE AFFAIRS & INVESTOR RELATIONS OFFICER

- 30+ years in international communications, public affairs and patient engagement at global companies (Sanofi, AbbVie, Abbott, GSK)
- Degree in Communications (DCU) & Master in Public Affairs (Sciences Po)

Aurore Morello, PhD
HEAD OF RESEARCH

- 10+ years in Immunotherapy (mAb, bispecific, CAR-T)
- International Post-doctoral Fellowship (MSKCC, NYC)

Clinical Pipeline

Combining a clinical portfolio of first-in-class immunotherapies and diversified assets in IO and I&I

I&I

Product candidate	Target	Indication	Research	IND-enabling	Phase Ia/Ib	Phase II	Phase III
OSE-127 *Lusvertikimab*	Anti-IL-7R	**Ulcerative Colitis**					**Positive Results**
BI 770371	Anti-SIRPα (Boehringer Ingelheim)	MASH					
FR104/VEL-101	Anti-CD28 (Veloxis)	Kidney Transplantation					
ABBV-230	Anti-ChemR23 (abbvie)	Chronic Inflammation					
OSE-220 *Pro-Resolutive mAbs*	Undisclosed GPCR Agonist	Chronic Inflammation					

Upcoming Milestones

- **Extension data** *Strategic update*
- *Phase 2a update*
- *Phase 2 start*
- *Phase 1 start*
- Preclinical update

I-O

Product candidate	Target	Indication	Research	IND-enabling	Phase Ia/Ib	Phase II	Phase III
Tedopi	Neoepitopes immunotherapy	**NSCLC Mono post-ICI 2L**					**Pivotal Phase 3 EU + US**
		PDAC Combo *(exploratory eIIS)*					
		OC Mono or Combo *(eIIS)*					
		NSCLC Combo 2L post-ICI *(eIIS)*					
OSE-279	Anti-PD1	Solid tumors					
BI 770371	Anti-SIRPα (Boehringer Ingelheim)	Solid tumors (HNSCC)					
IL-7R CAR-T	IL-7R CAR-T (Memorial Sloan Kettering Cancer Center)	IL-7R+ tumors					
Anti-PD1/cytokine	Undisclosed (Boehringer Ingelheim)	Solid tumors					

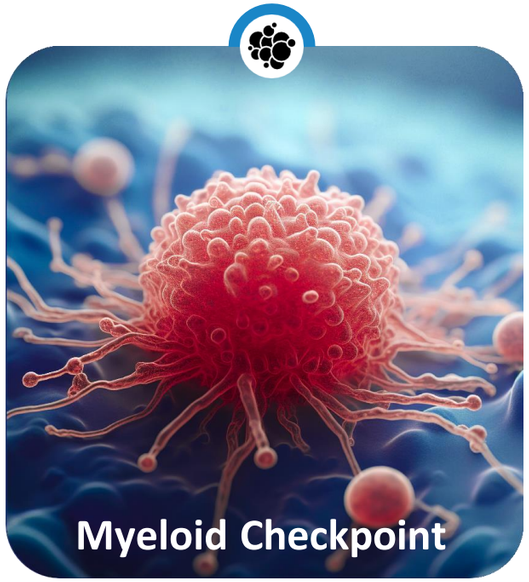
Upcoming Milestones

- Phase 3 update
- ***Phase 2 readout H1-2025***
- ***Phase 2 readout H1-2026***
- ***Phase 2 readout H2-2026***
- Phase 1b combo data
- *Phase 1b results*
- *IND*
- *Preclinical update*

NSCLC: Non-Small Cell Lung Cancer; **PDAC:** Pancreatic Ductal AdenoCarcinoma; **OC:** Ovarian Cancer; **ALL:** Acute Lymphoblastic Leukemia. **UC:** Ulcerative Colitis.
IND: Investigational New Drug Application.

Research platforms

Extra(not) Ordinary Research PowerHouse



- Anti-SIRPα
- Anti-CLEC-1 mAbs

- Anti-PD1/cytokine
- Cis-Demasking technology

- Anti-ChemR23
- Undisclosed new pro-resolutive GPCRs

- IL-35 mRNA
- Undisclosed programs

Partnered Asset

Strategic partners provide industry-leading clinical support & strong financial foundations

Over €2.1bn in potential milestones; €219m* already received

Immuno-Oncology
Immuno-Inflammation
Potential
Received

BI 770371
+ anti-PD1/cytokine
Solid tumors & Metabolic Diseases

Boehringer Ingelheim

Up to **€1.1bn**

€104m received

+ Tiered royalties
on Global Sales

ABBV-230
Chronic Inflammation

abbvie

Up to **$713m**

$48m upfront

+ Tiered royalties
on Global net Sales

FR104/VEL-101
Kidney transplant

Veloxis PHARMACEUTICALS
an Asahi Kasei company

Up to **€315m**

€13.9m received

+ Tiered royalties
on Global Sales

* Including upfront, milestones and reinvoiced R&D costs + previous license agreement with J&J and Servier

Key potential catalysts*

Readouts

- **Lusvertikimab**
  - ✓ Full data set Phase 2 induction UC results
  - ✓ UC phase 2 safety results
  - Extension period Phase 2 UC results
- **Tedopi®**
  Phase 2 PDAC results
- **BI 770371 *(partnered)**
  Phase 1b results in solid tumors

Progress

- **Lusvertikimab**
  Strategic update
- **Tedopi®**
  Phase 3 NSCLC 2L update
  Phase 2 combination completion
- **FR104/VEL-101 *(partnered)**
  Phase 2 start in Kidney Tx
- **ABBV-230 *(partnered)**
  IND/Phase 1

Readouts

- **Tedopi®**
  Phase 3 results in NSCLC 2L
  Phase 2 combination results
- **Lusvertikimab**
  New study results
- **BI 770371 *(partnered)***
  Phase 1b onco + Phase 2 MASH results
- **FR104/VEL-101 *(partnered)***
  Phase 2 results in Kidney Transplantation
- **ABBV-230 *(partnered)***
  Phase 1 results + Phase 2 results

Progress

- **Undisclosed internal Programs**
  IND/Phase 1
- **New Research programs/platforms**
  New partnering opportunities

2025 | 2026-2027

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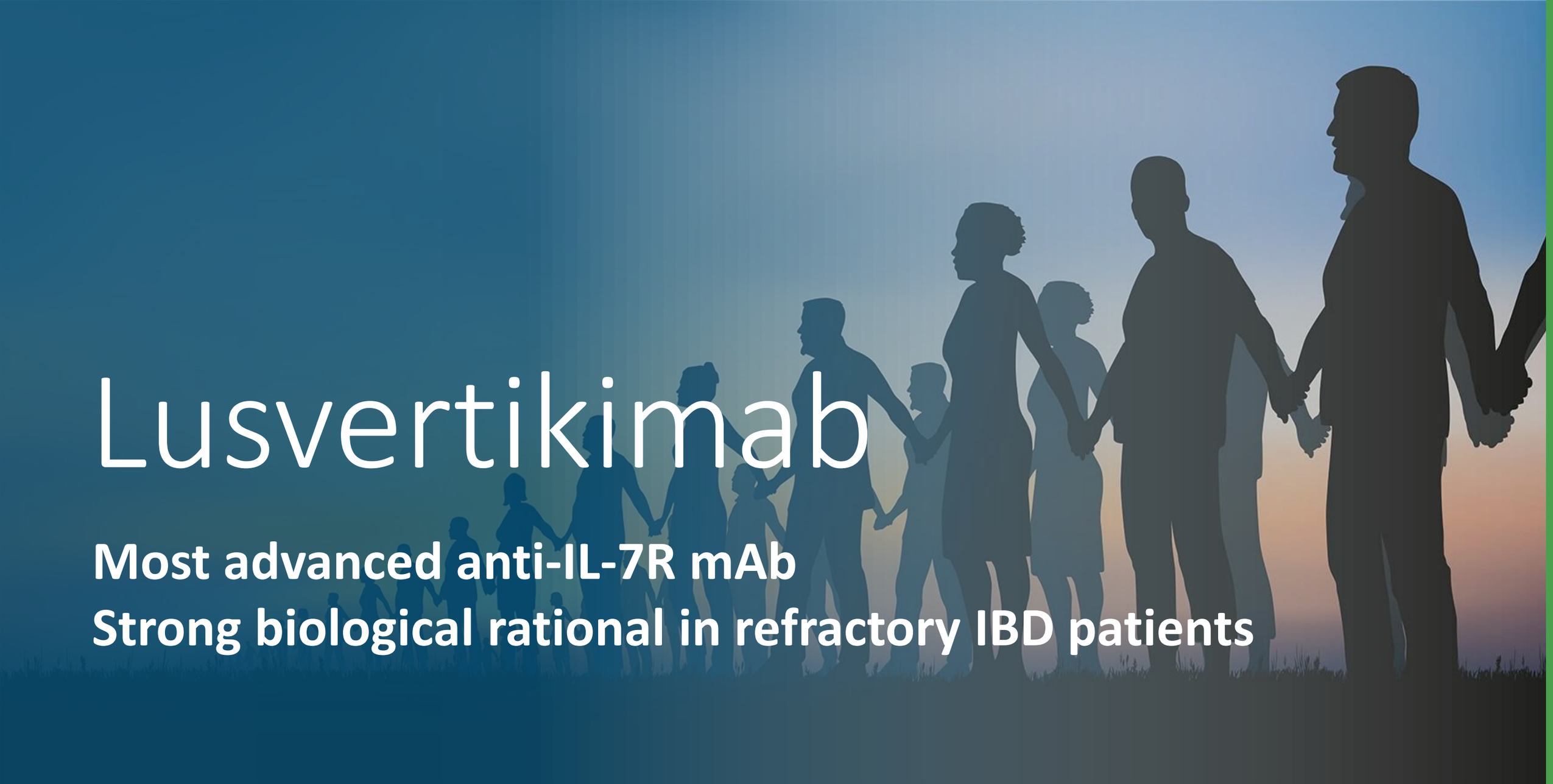
* Best estimate from the Management - not binding

Proprietary clinical programs



Lusvertikimab

Most advanced anti-IL-7R mAb

Strong biological rational in refractory IBD patients

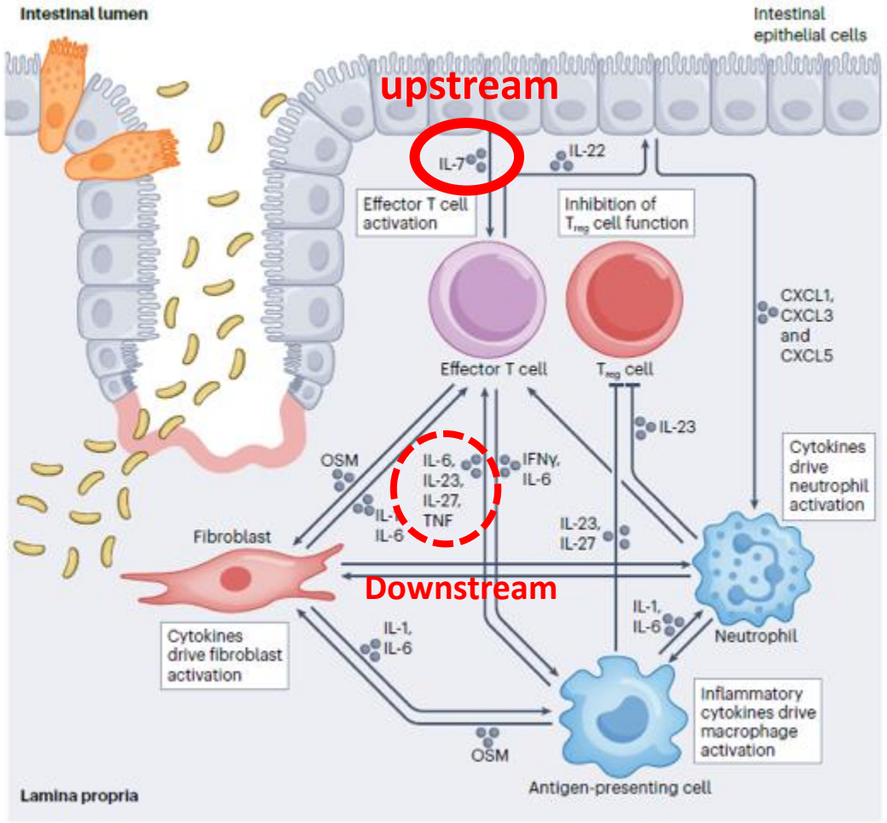
IL-7 fuels chronic inflammation in Tissues

Upstream mechanism of resistance in hyper-inflammation

The ‘angry’ cell concept and resistance to anti-cytokine therapies.

“Recent evidence suggests the presence of highly pro-inflammatory — or ‘angry’ — cells in the intestinal mucosa in inflammatory bowel disease (IBD) that drive molecular resistance to anti-cytokine therapy (such as anti-TNF and anti-IL-12/IL-23 therapies). »

« Intestinal epithelial cells (IECs) produce cytokines such as **IL-7** to activate effector T cells and can produce chemokines such as CXCL1, CXCL3 and CXCL5 to induce neutrophil recruitment and activation.”

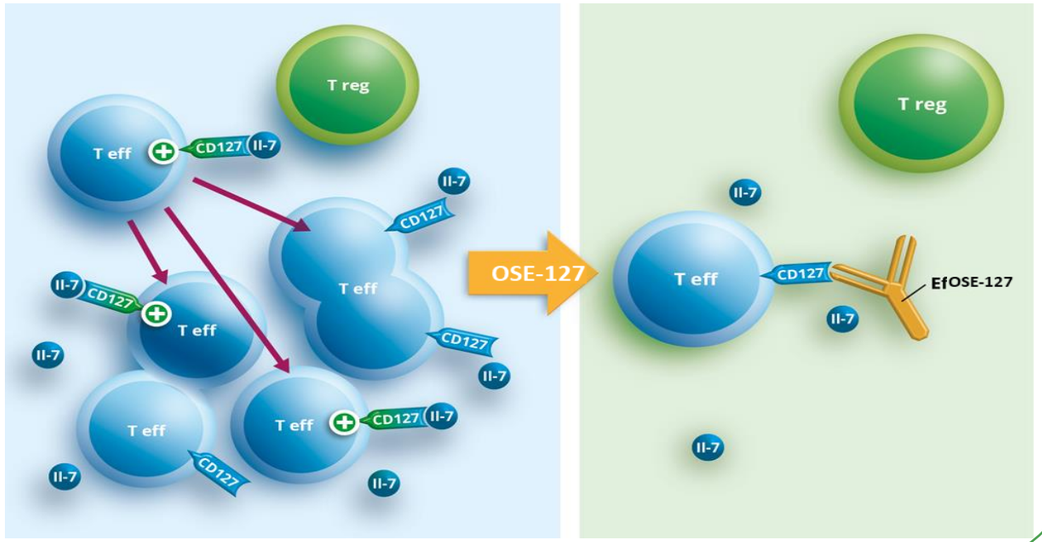


Neurath M. **Nature Review Immunology 2024**

Lusvertikimab / OSE-127

Pure IL-7 receptor antagonist mAb

Tackling the fuel of memory T-lymphocytes while sparing Tregs



A differentiated and highly qualified candidate

- IL-7 produced by inflamed tissues sustain **T-cell survival and chronicity**, **drives Th1 and Th17** T cell differentiation
- IL-7R pathway overexpression in anti-TNF IBD non-responders[1]
- Lusvertikimab, first non-internalizing (fully antagonist) acting as pure antagonist anti-IL-7R mAb[2] – no antagonist activity on TSLP
- **Good safety, PK/PD profile in Phase 1[3], no cytokine release, confirmed target-engagement**
- **Positive Phase-2 study in UC Top-line Results Q3 2024**

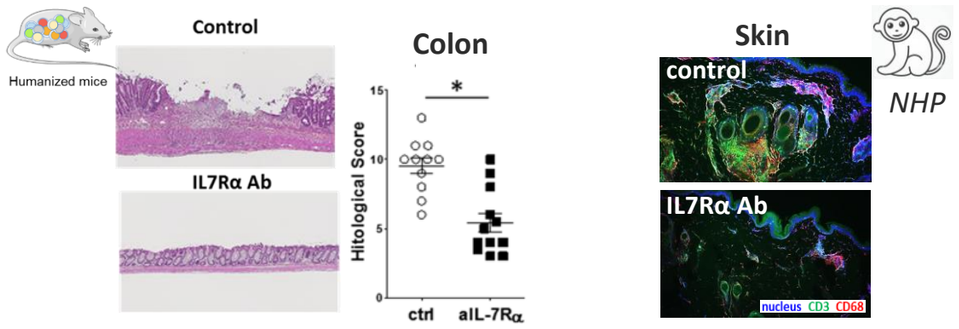
- High preclinical activity in acute leukemia (T and B-ALL)[4]
  ASH Merit Award 2024

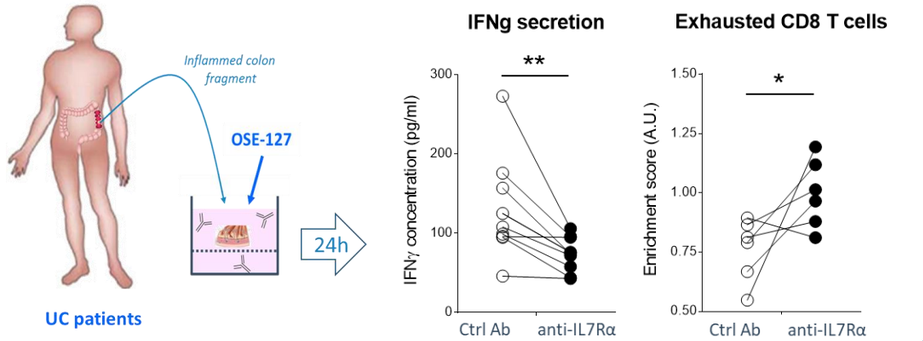
1: **Belarif et al. JCI 2019.** 2: **Belarif et al. Nature Communication (2018).** 3: **Poirier et al. Journal of Immunology 2023.**
4: **https:**//www.ose-immuno.com/wp-content/uploads/2022/11/EN_221103_ASH_OSE-127.pdf

Preclinical & Translational research of IL-7 in IBD

High preclinical efficacy *in-vivo* and *ex-vivo* + High target expression in diseased tissues

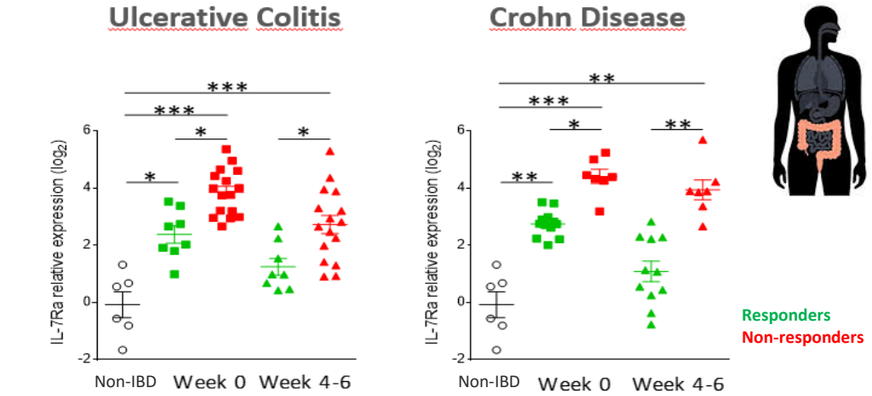
High preclinical efficacy in different models

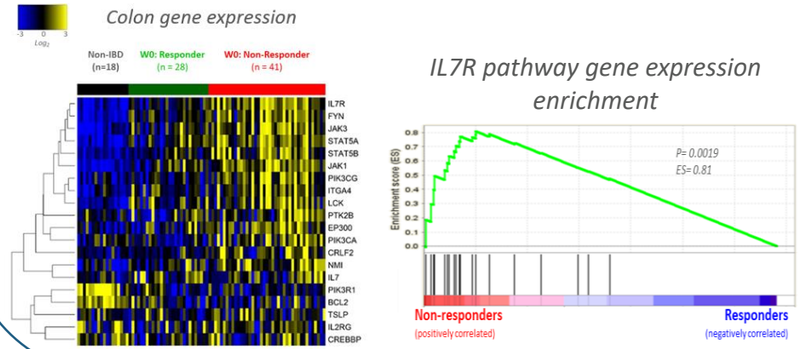




Mucosal IL7R pathway over-expression in IBD

High correlation with SOC unresponsiveness



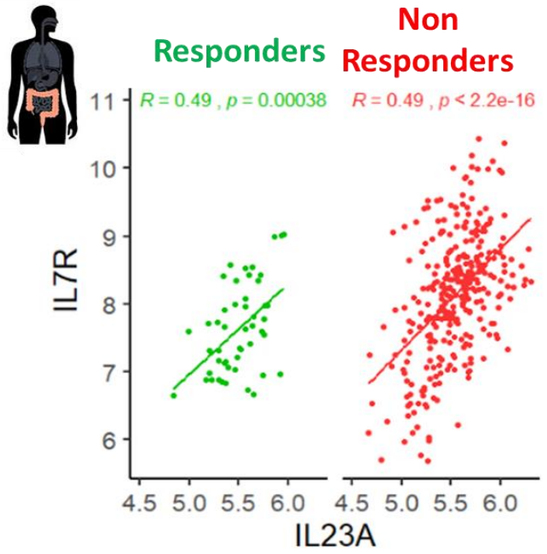


Belarif et al. Nature Com 2018

Belarif et al. JCI 2019

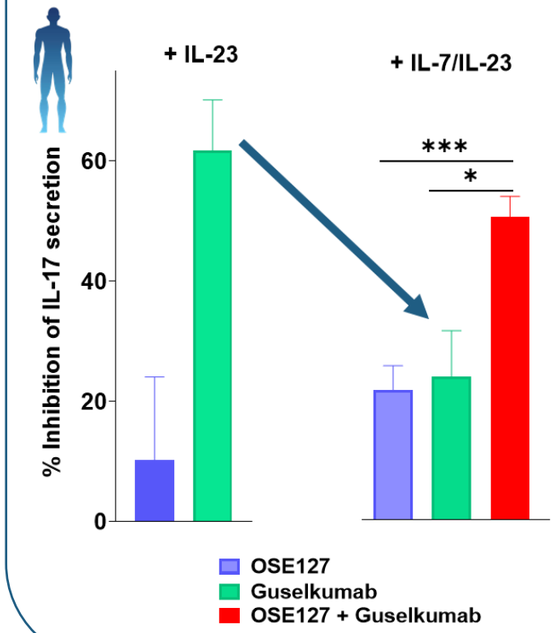
Anti-IL-7R + IL-12/23 combination preclinical & translational rational

IL-7R and IL-23 cytokine mucosal over-expression in Ustekinumab UC patients



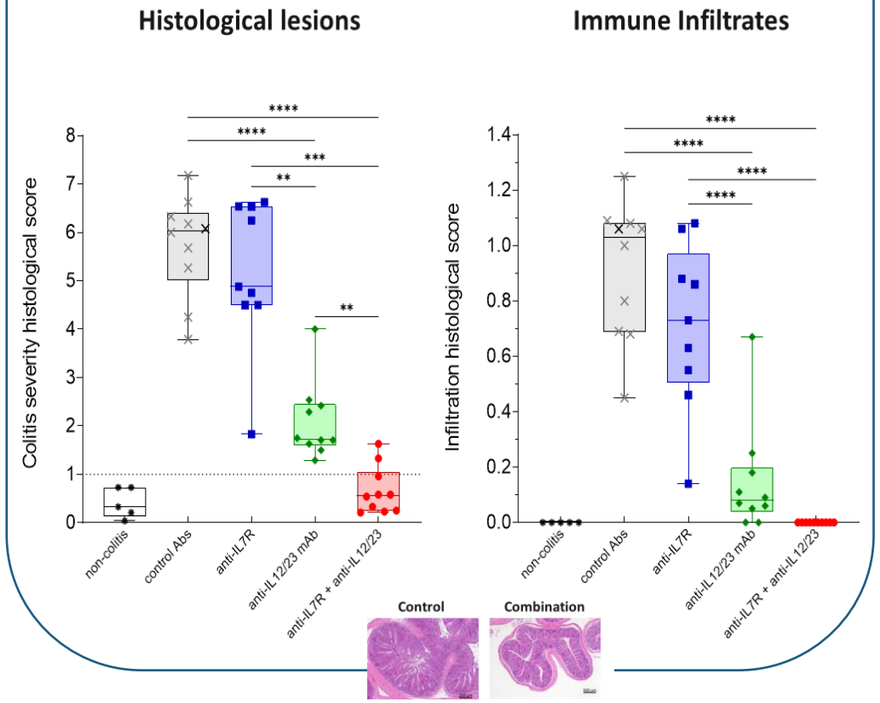
UC colon transcriptomic analysis (GSE206285)

IL-7 drives IL-23 antagonist resistance



<u>In-vitro model</u>: naive human primary Th17 cells differentiation

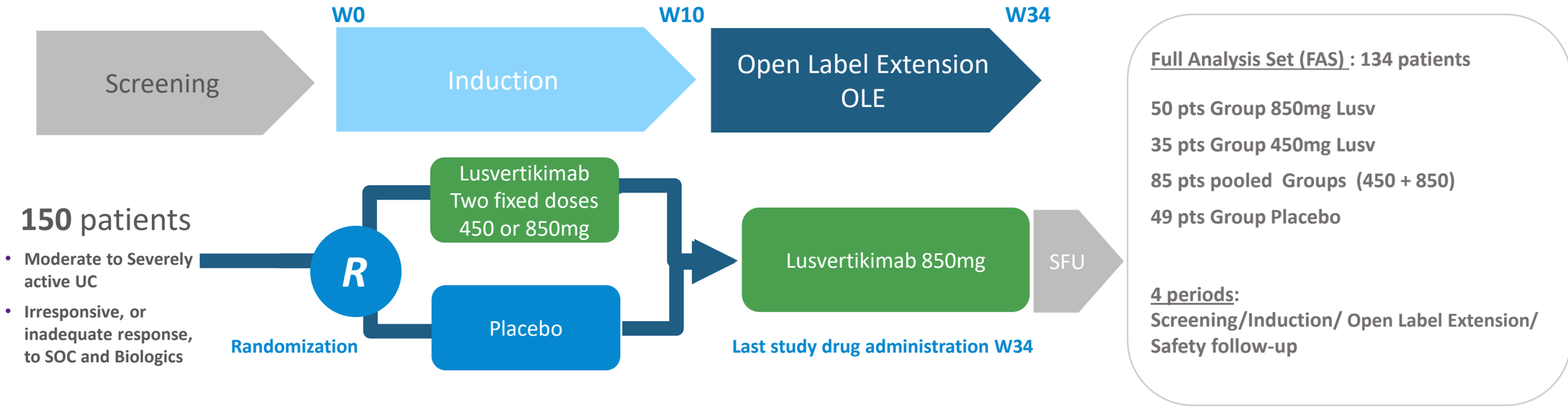
IL-7R + IL-12/23 blockade synergizes to induce complete mucosal healing in chronic colitis



<u>In-vivo model</u>: mouse chronic colitis T-cell transfer model (Epistem)

CoTikiS Phase 2 randomized study of Lusvertikimab

Moderate-to-severe Ulcerative Colitis



Multicenter, randomized, double-blind, placebo-controlled, parallel-group Phase 2 study in patients with moderate to severe active UC

Induction: Lusv group 450mg/ Lusv group 850mg/ Placebo: IV infusions at Week 0, Week 2, Week 6. **Analysis at W10**

Open Label Extension OLE: At Week 10, additional infusions proposed for all patients at 850mg every 4 weeks for 6 months (W10, 14, 18, 22, 26, 30, 34)

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Patients included with a rectal bleeding score ≥ 1, a stool frequency score ≥ 1 (sub-score calculated before bowel preparation), an endoscopic sub-score ≥ 2.

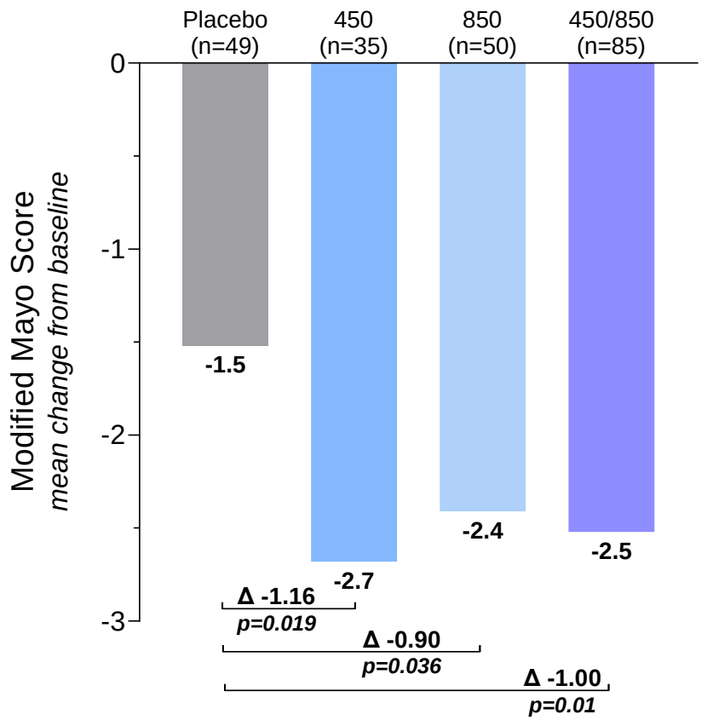
Demographics and disease characteristics

	L850 mg (n=50)	L450 mg (n=35)	Placebo (n=49)	Total (n=134)
Age: mean (SD)	42.5 (15.1)	38.8 (10.5)	42.7 (15.9)	41.6 (14.4)
Sex: Male	27 (54.0%)	22 (62.9%)	28 (57.1%)	77 (57.5%)
Weight (kg) Mean (SD)	71.5 (18.0)	72.8 (16.2)	75.3 (15.2)	73.2 (16.5)
Never Smoker	43 (86.0%)	25 (71.4%)	39 (79.6%)	107 (79.9%)
Never Alcohol Consumption	40 (80.0%)	25 (71.4%)	34 (69.4%)	99 (73.9%)
Region: EU Country	22 (44.0%)	8 (22.9%)	22 (44.9%)	52 (38.8%)
UC Duration (Years) Mean (SD)	9.3 (8.6)	7.2 (6.5)	8.2 (7.5)	8.4 (7.7)
Previous Exposure to Biologics	**19 (38.0%)**	**5 (14.3%)**	**19 (38.8%)**	**43 (32.1%)**
Previous biologics: 2+	***13 (68.8%)***	***2 (40%)***	***11 (57.9%)***	***26 (60.4%)***
Previous biologics: 3+	*6 (31.5%)*	*0 (0%)*	*5 (26.3%)*	*11 (25.6%)*
Concomitant Use of Steroids	25 (50.0%)	18 (51.4%)	23 (46.9%)	66 (49.3%)
Modified Mayo Score (MMS) Mean (SD)	6.5 (1.0)	6.0 (1.4)	6.6 (1.2)	6.4 (1.2)
Category of MMS				
5-6	25 (50.0%)	17 (48.6%)	21 (42.9%)	63 (47.0%)
7-9	**25 (50.0%)**	**13 (37.1%)**	**26 (53.1%)**	**64 (47.8%)**
Endoscopic Subscore Mean (SD)	2.6 (0.5)	2.4 (0.5)	2.5 (0.5)	2.5 (0.5)
Category of Endoscopic Subscore: 3	**32 (64.0%)**	**15 (42.9%)**	**26 (53.1%)**	**73 (54.5%)**
C-Reactive Protein (mg/L) Mean (SD)	11.2 (18.1)	9.4 (16.7)	8.6 (13.6)	9.8 (16.1)
Serum Albumin (g/L) Mean (SD)	40.8 (5.4)	42.6 (4.5)	42.3 (4.4)	41.8 (4.9)
FCP (µg/g) Mean (SD)	1191.8 (1603.3)	1088.0 (1600.5)	1459.5 (1865.0)	1261.6 (1696.7)

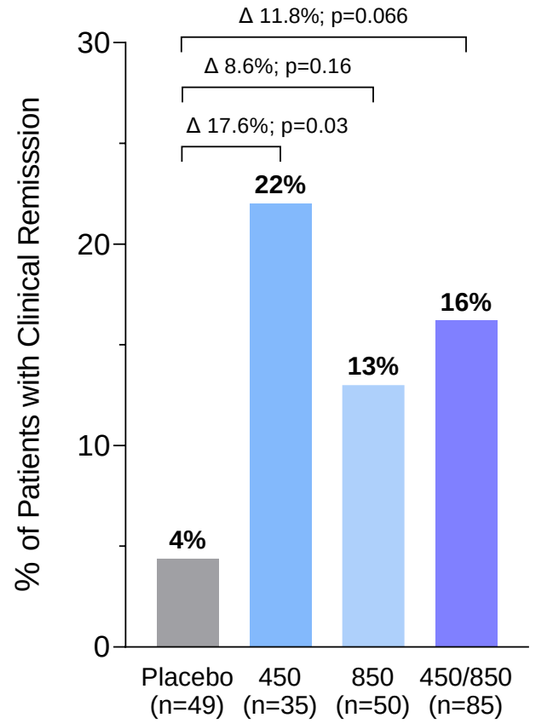
Clinical induction results at week-10

Clinically and statistically relevant clinical remission in the Lusvertikimab groups

Primary Endpoint: Modified Mayo Score Improvement (MMS)*µ at W10



Clinical Remission at W10



clinical remission: MMS ≤2 with no subscore >1 and a RB 0, SF ≤ 1, MES 0 or 1

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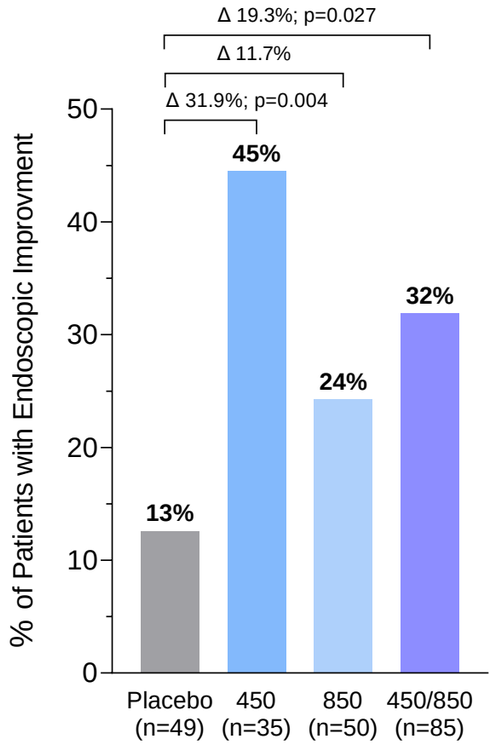
*__Modified Mayo Score Improvement__ defined on mean change at Week-10 from baseline on the 3 subscores: rectal bleeding, stool frequency, endoscopic (central reading)

µ Least Square Mean Difference between Lusvertikimab and placebo= difference between groups of the Mean change in MMS between baseline and W10

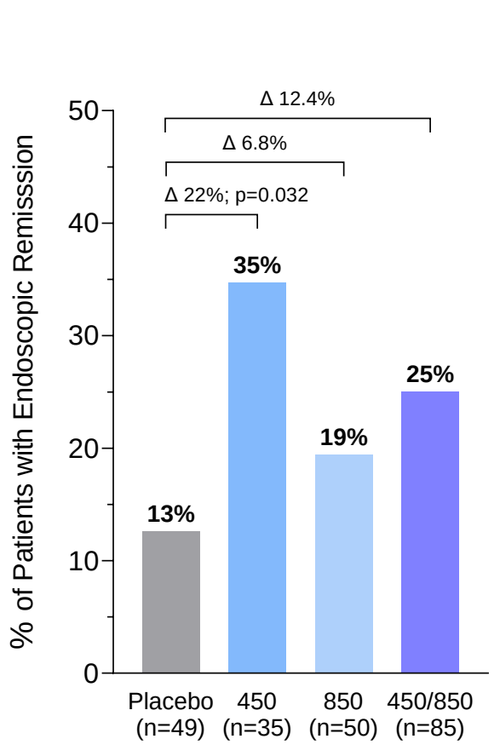
Clinical induction results at week-10

Clinically meaningful and significant endoscopic improvement and remission

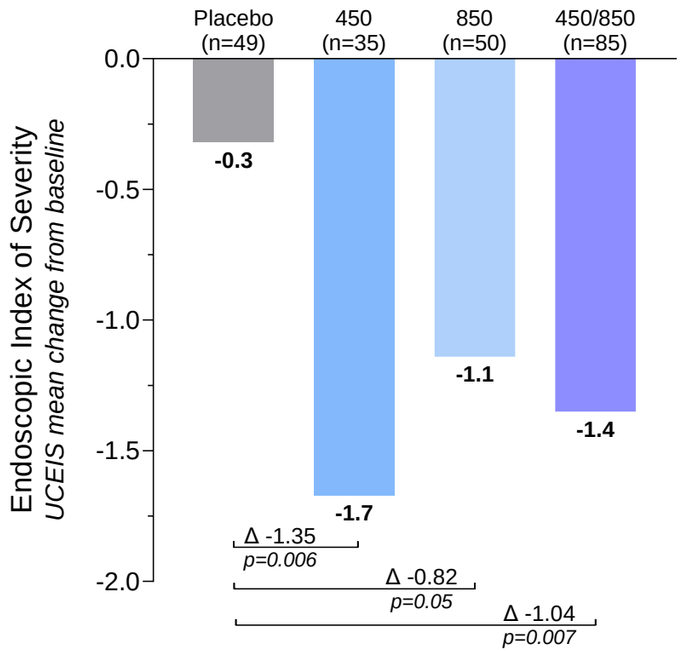
Endoscopic Improvement* at W10



Endoscopic Remission** at W10



UC Endoscopic Index of Severity UCEIS*** change from baseline at W10



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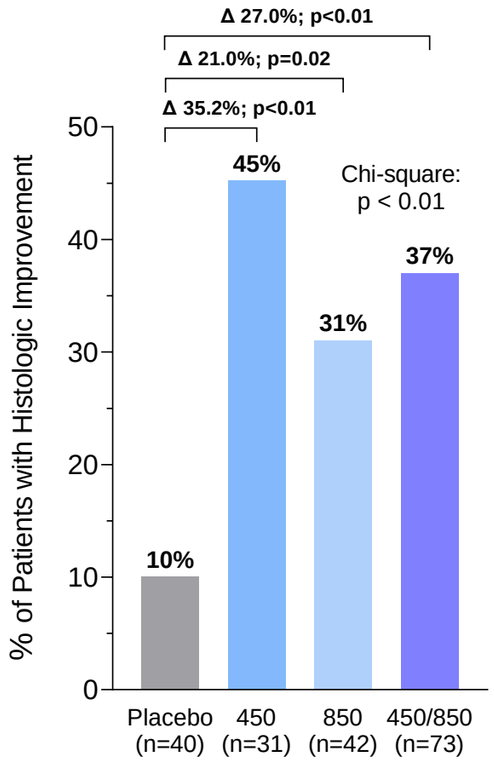
*Endoscopic Remission = endoscopic Mayo score = 0 / ** Endoscopic Improvement: endoscopic Mayo score ≤ 1 point /
*** UCEIS: index of severity measured by three disease severity subscores: vascular pattern: 0 to 2 / Bleeding: 0 to 3/ /Erosions-ulcerations 0 to 3

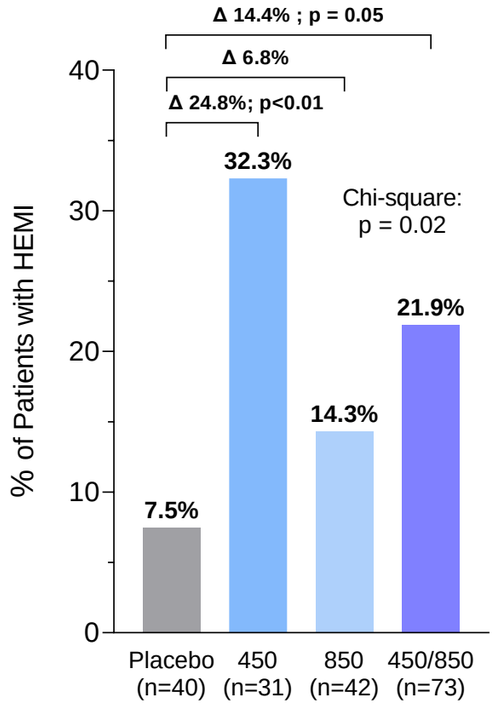
Clinical induction results at week-10

Clinically meaningful and significant histologic and histo-endoscopic mucosal improvement

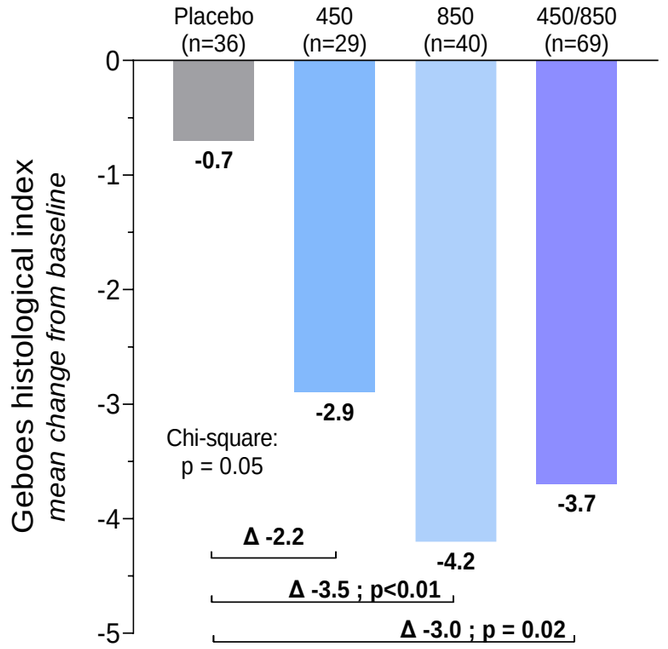
Histological Improvement at W10*



Histo-Endoscopic Mucosal Improvement (HEMI) at W10**



Histological Geboes index change from baseline at W10



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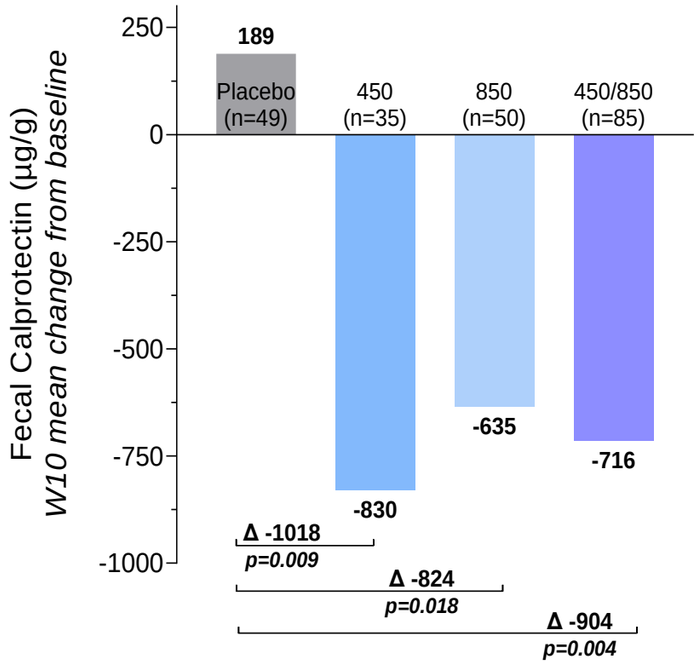
* Histological Improvement: Nancy Histological Index (NHI) ≤ 1

** Histo-Endoscopic Mucosal Improvement (HEMI): NHI ≤ 1 + MES ≤ 1

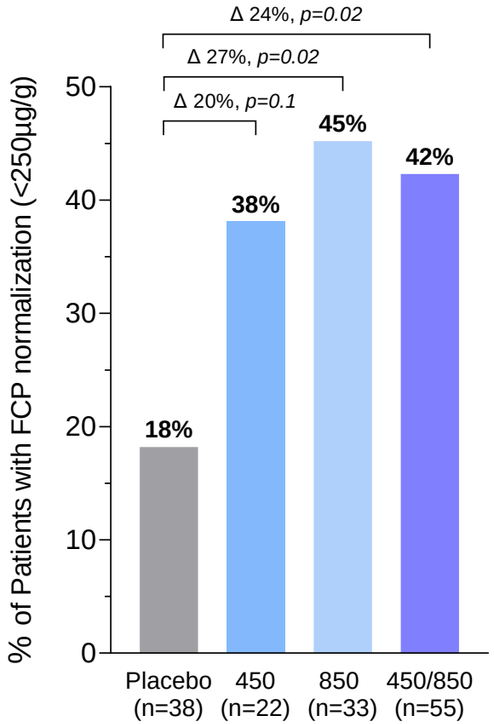
Clinical induction results at week-10

Significant Fecal Calprotectin decrease and normalization

Fecal Calprotectin (FCP) changes from baseline at W10



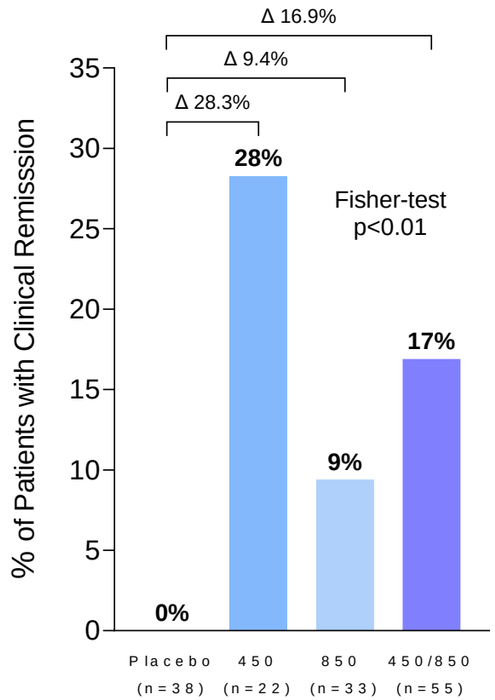
FCP normalization at W10 in patients with high baseline FCP (>250µg/g)



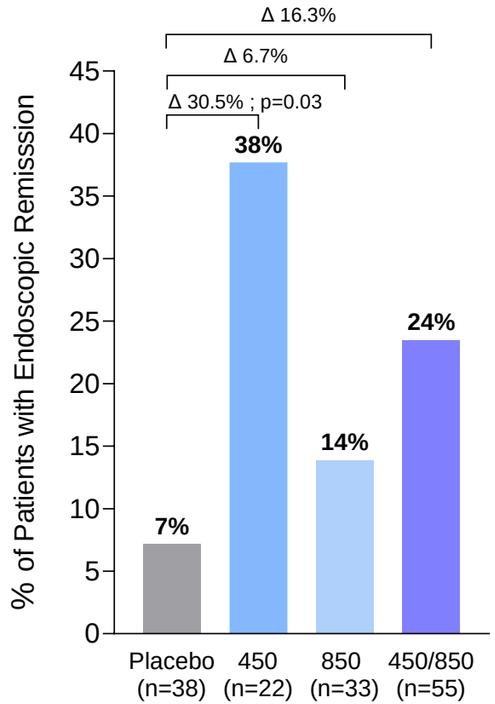
Clinical induction results at week-10

Clinically meaningful and significant clinical and endoscopic remission in patients with high baseline FCP (>250µg/g)

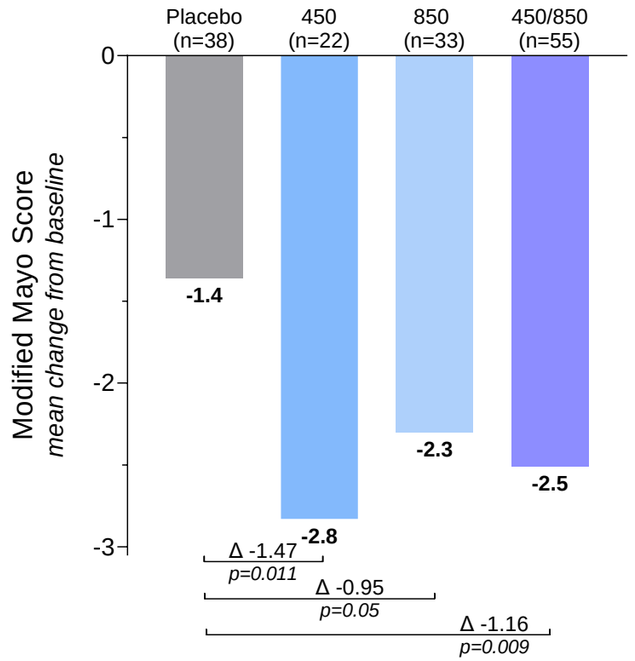
Clinical Remission at W10 in patients with high baseline FCP



Endoscopic Remission at W10 in patients with high baseline FCP



MMS Improvement at W10 in patients with high baseline FCP



Safety during induction period

	L450 mg (N=36) N(%) [E]	L850 mg (N=51) N(%) [E]	Placebo (N=49) N(%) [E]	Total (N=136) N(%) [E]
At least one TEAE	17 (47.2) [33]	20 (39.2) [42]	16 (32.7) [29]	53 (39.0) [104]
At least one TEAE related to study treatment	3 (8.3) [4]	4 (7.8) [14]	1 (2.0) [1]	8 (5.9) [19]
At least one serious TEAE	2 (5.6) [3]	2 (3.9) [3]	3 (6.1) [3]	7 (5.1) [9]
At least one serious TEAE related to study treatment	1 (2.8) [1]	0 (0.0) [0]	0 (0.0) [0]	1 (0.7) [1]
At least one severe TEAE	1 (2.8) [2]	0 (0.0) [0]	2 (4.1) [2]	3 (2.2) [4]
At least one severe TEAE related to study treatment	1 (2.8) [1]	0 (0.0) [0]	0 (0.0) [0]	1 (0.7) [1]
At least one related TEAE leading to death	0 (0.0) [0]	0 (0.0) [0]	0 (0.0) [0]	0 (0.0) [0]
At least one TEAE leading to drug withdrawal	2 (5.6) [3]	0 (0.0) [0]	3 (6.1) [3]	5 (3.7) [6]
At least one TEAE leading to drug interruption	1 (2.8) [1]	0 (0.0) [0]	2 (4.1) [2]	3 (2.2) [3]
At least one TEAE leading to study discontinuation	2 (5.6) [3]	0 (0.0) [0]	3 (6.1) [3]	5 (3.7) [6]
At least one AESI	7 (19.4) [7]	9 (17.6) [10]	6 (12.2) [7]	22 (16.2) [24]
At least one infection	5 (13.9) [5]	7 (13.7) [8]	6 (12.2) [7]	18 (13.2) [20]
At least one lymphopenia < 500 10^6/L	2 (5.6) [2]	2 (3.9) [2]	0 (0.0) [0]	4 (2.9) [4]

Lusvertikimab was well tolerated with an acceptable safety profile

Lymphopenia was transient, not associated with a higher rate or severity of infection, was more frequent in patients treated with corticosteroids or with baseline values <1*10^9/L and did not lead to treatment discontinuation

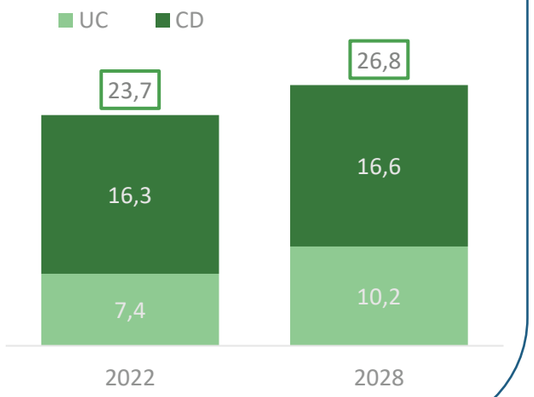
N: number of patients with the event - [E]: number of events

Significant opportunity in Ulcerative Colitis
& Pipeline-in-a-Product potential (Multi-indications asset)

Ulcerative Colitis (UC)

- UC affects 3.3 million patients in US, Europe and Japan
- ~50% UC patients “moderate to severe”, requiring methotrexate, corticosteroids, anti-TNFa, JAK etc.
- Despite broad options, remission rates are of only 25-30% leaving most patients without satisfactory treatment

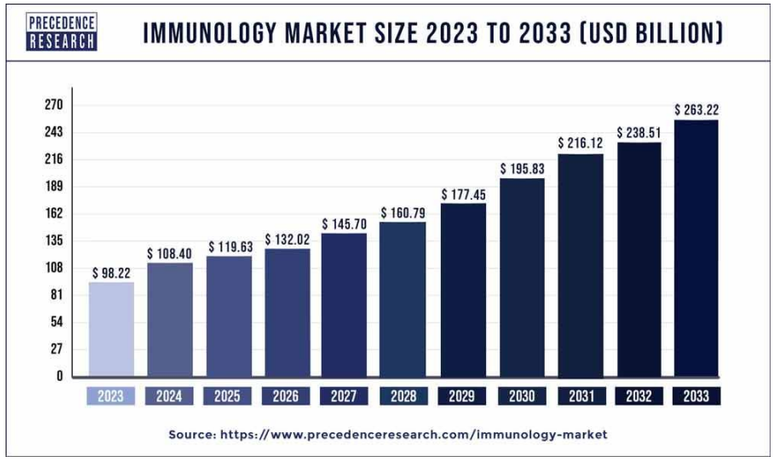
IBD global market projections for G7 major markets (USDbn[1])



Immuno & Inflammation (I&I) space

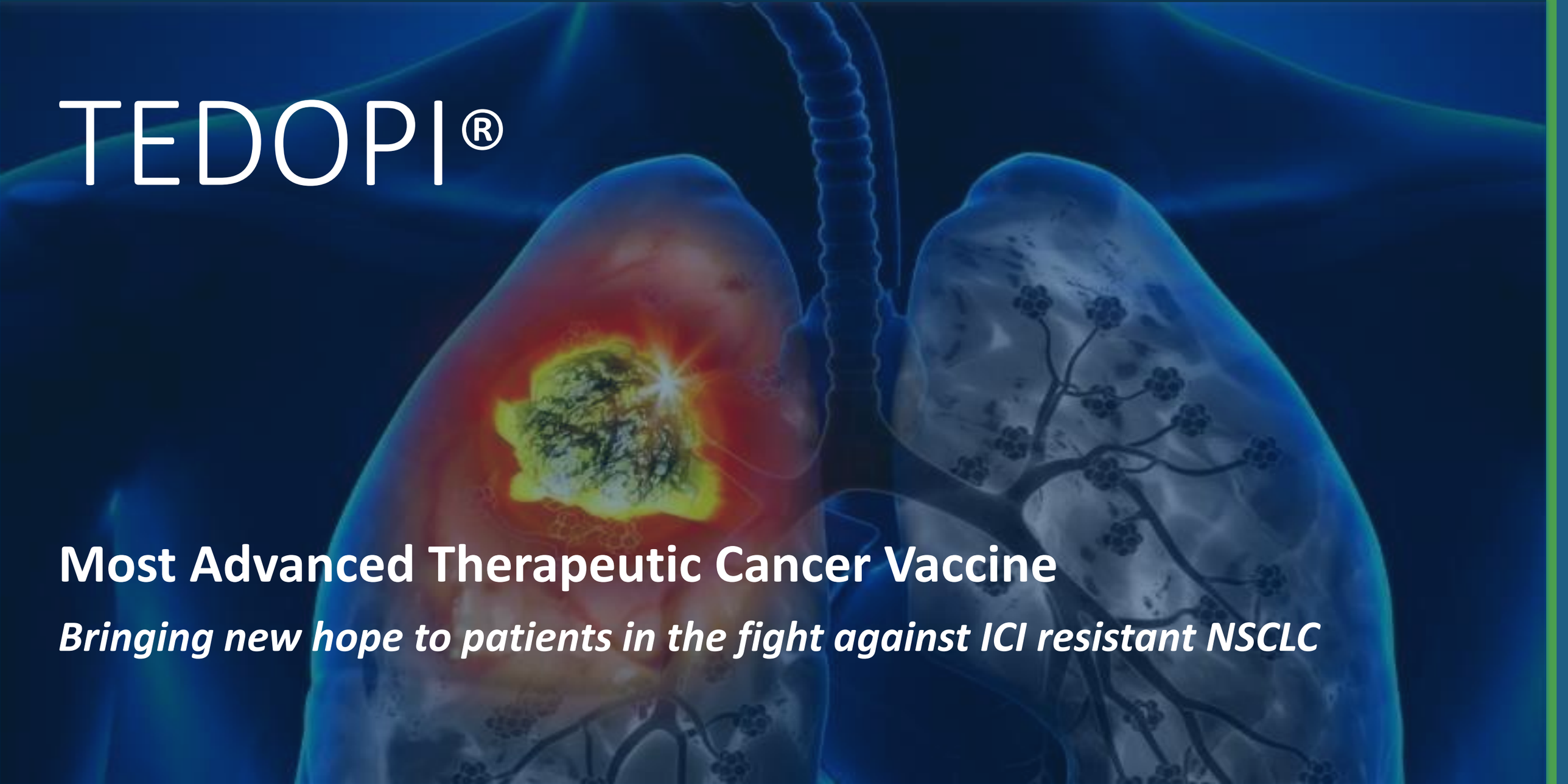
Key Therapeutic Areas

- IBD
- Dermatology
- Rheumatology
- Neuro-Inflammation
- Systemic Autoimmune
- Nephrology



1: Evaluate Pharma

TEDOPI®

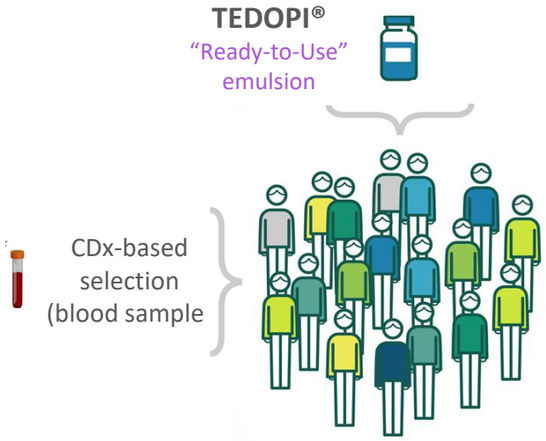


Most Advanced Therapeutic Cancer Vaccine

Bringing new hope to patients in the fight against ICI resistant NSCLC

Personalized vs *Off-the-Shelf* cancer vaccines

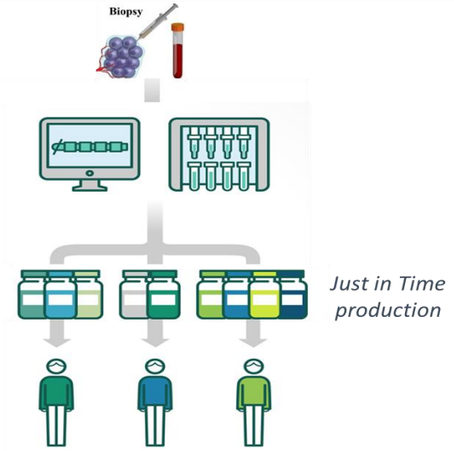
Neoepitope cancer vaccine
= Precision Medicine
-> Off-the-Shelf



Homogeneous HLA-A2+ population (~45%)
Strong CD8+ CTL responses

Positive data to extend survival in metastatic disease
(randomized Phase III NSCLC)

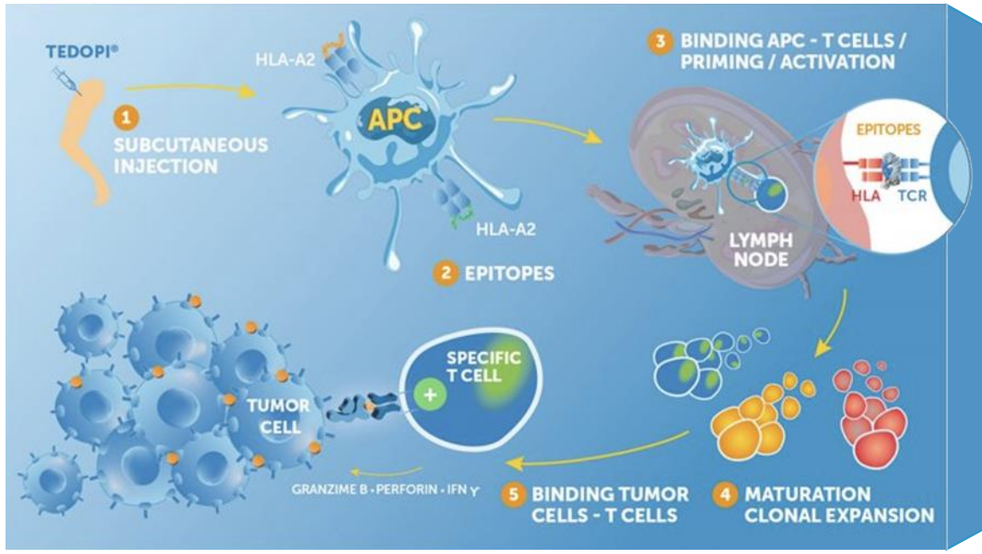
Neoantigen cancer vaccine
= Personalized Medicine
-> Custom



Cons: Tumor biopsy, **Cost**, Time
Epitope prediction robustness
Variable responses/immunogenicity

Adjuvant treatment at early stage to prevent tumor relapse
(non-randomized phases I/II to date)

An immunotherapy activating specific T-cells to revive anti-tumor response



Most advanced Cancer Vaccine in clinical development

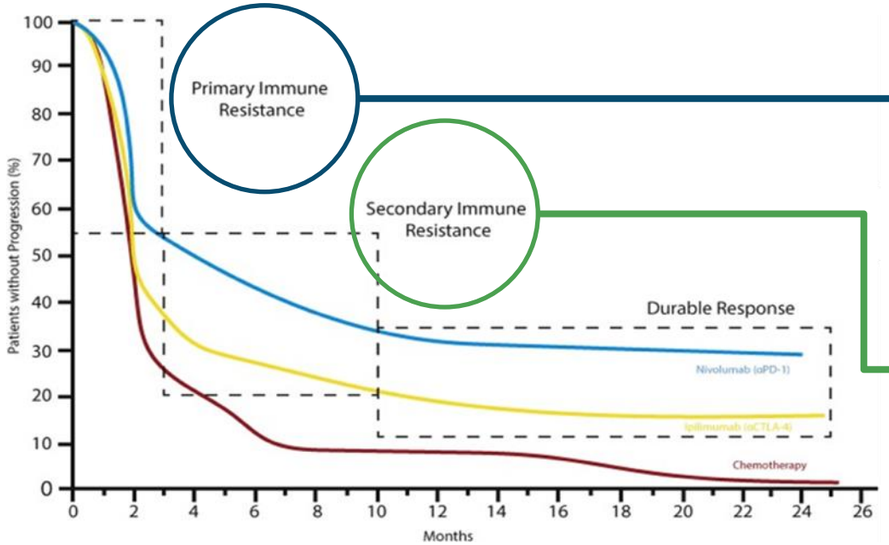
- **Unique** combination of **neoepitopes**: small peptides deriving from **tumor specific** antigens* expressed in various cancers
- Strong **binding to HLA-A2** receptor (45% population)
- Direct activation of tumor specific T-cells **differs from checkpoint inhibitors** releasing the break of immune response

Proprietary combination (9 **optimized neoepitopes** + 1 epitope giving universal T helper response)	Induces early T cell **memory** responses + **Migration** in tissues	**Ready to Use subcutaneous** formulation with Q3W injection	**Orphan Drug** Designation (FDA) **>1,000 injection** in clinical trials	Strong IP position until **2038**[1] (US / EU / Asia)

1: *OSE Immunotherapeutics Receives New European Patent*

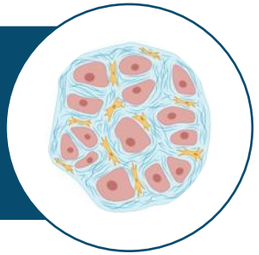
Tedopi® is a novel cancer vaccine with a strong biological rational in post-ICI secondary resistance

Shifting paradigms with cancer vaccine immunotherapy



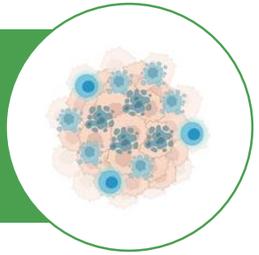
Primary (intrinsic) resistance
Patients who do not respond to ICIs with a rapid disease progression
→ **Immune refractory tumors**

No T-cell refractory tumors



Secondary (acquired) resistance[1]
Patients who have a period of initial ICI therapy benefit followed by disease progression
→ **Immuno-sensitive tumors**

T-cell exhausted & dying



Tedopi® has the **potential to rejuvenate & refresh specific TILs** in immuno-sensitive tumors.
Neoepitope-specific T cells have tumor killing potential and limited side effects.

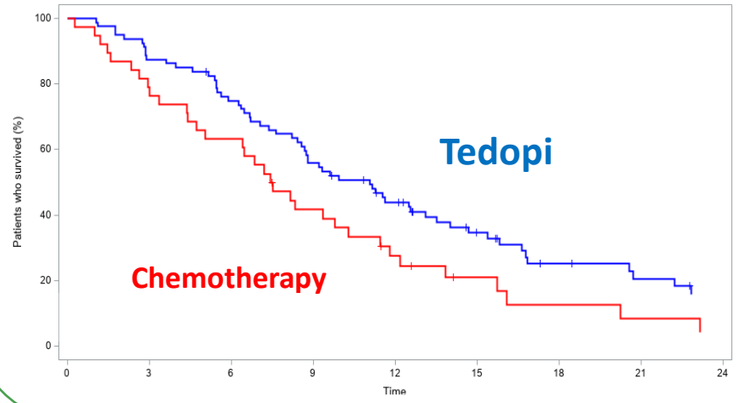
Figure: Schoenfeld AJ, Hellman MD. Cancer Cell 2020. Baxter MA, et al Br J Cancer 2021. **1:** After at least 12 weeks of ICI treatment in monotherapy (Task force SITC 2020 - Kluger H et al 2020).
ICI: immune checkpoint inhibitor. **TILs:** Tumor-infiltrating lymphocytes.

Clinically meaningful benefit of Tedopi® in 3rd line NSCLC

Randomized Phase 3 with positive results vs. standard of care (SOC)

Overall Survival

secondary resistance post anti-PD(L)1



OS rate at 12 months
44%
in **Tedopi®** vs.
27.5%
in SoC

Delta OS: **3.6** months

Tedopi® 11.1 months
vs
SoC 7.5 months

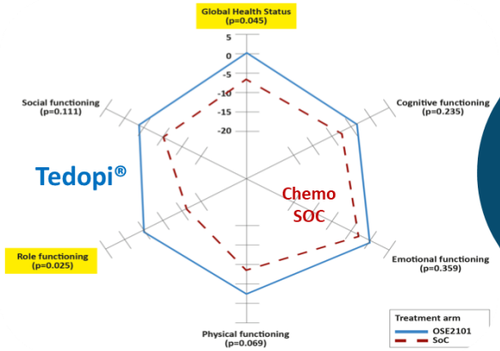
HR 0.59 /
p-value=0.017

Risk of Death reduced by 41% *versus chemo.*

Significantly safer than Chemo.

11% *vs* **35%** *grade 3-5 AEs*

Better Quality of Life



Positive Net Treatment Benefit vs SOC:
P=0.032

OSE IMMUNO THERAPEUTICS

Besse et al. Annals of Oncology 2023

ANNALS OF ONCOLOGY
driving innovation in oncology

Tedopi® in NSCLC : ARTEMIA study

KEY ELIGIBILITY CRITERIA

- HLA-A2+
- Metastatic squamous & non-squamous NSCLC without actionable mutations
- In 2d line treatment after 1st-line CT- immune checkpoint inhibitor (ICI) with secondary resistance to ICI
- ECOG PS 0 to 1
- No brain metastasis or previously treated brain metastasis

R 2:1

ARM A
Tedopi® (n=242)
Q3W for 6 subcut. inj.,
then Q8W until end Year 1,
then Q12W up to end Year 2
Until loss of clinical benefit

ARM B
Docetaxel (n=121)
Q3W iv infusion
Until loss of clinical benefit

Stratification
- Histology (squamous vs non-squamous)
- ECOG PS (0 vs 1)

PRIMARY ENDPOINT:
Overall Survival*

SECONDARY ENDPOINTS:
- PRO : QLQ-C30 Physical functioning, Role functioning & Global Health Score
- Time to ECOG deterioration (PS >2)

*Final analysis with 269 death-events in 363 patients assuming a hazard ratio of 0.70 (power 80%, 2-sided log-rank test at 5%) with an interim futility analysis after 107 events

HLA: Human leukocyte antigen; NSCLC: Non-small cell lung cancer; SoC: Standard of care; CT: chemotherapy; ICI=Immune checkpoint inhibitors; ECOG PS: Eastern Cooperative Oncology Group Performance Status; PD: Progressive disease; subcut: subcutaneous; inj: injection; iv: intravenous, QLQ-C30: Quality of life questionnaire-core30

Protocol V2.0 on 14-MAR-24 (US, Canada) , 2.1 on 11-JUN-24 (UK), 2.3 on 23-AUG-24 (EU)

Tedopi® answers to real medical need in NSCLC

Tedopi® has the potential to become the new standard for recurrent patients in 2L NSCLC presenting HLA-A2 phenotype

LUNG CANCER : High prevalence, mortality and unmet need - worldwide

- Highest mortality among 36 cancer types and 2nd most frequently diagnosed cancer type (based on data collected from 185 countries)*
- About 2,206,771 new cases of lung cancer diagnosed (11,4% of all cancers) and 1,796,144 deaths from lung cancer (18%)*
- The mortality is associated with a high degree of malignancy and late diagnosis. More than 65.33% of men diagnosed with lung cancer are in stage III-IV
- Majority of NSCLC patients without actionable mutation are treated with immune checkpoint inhibitors (ICI) as 1st line of treatment.

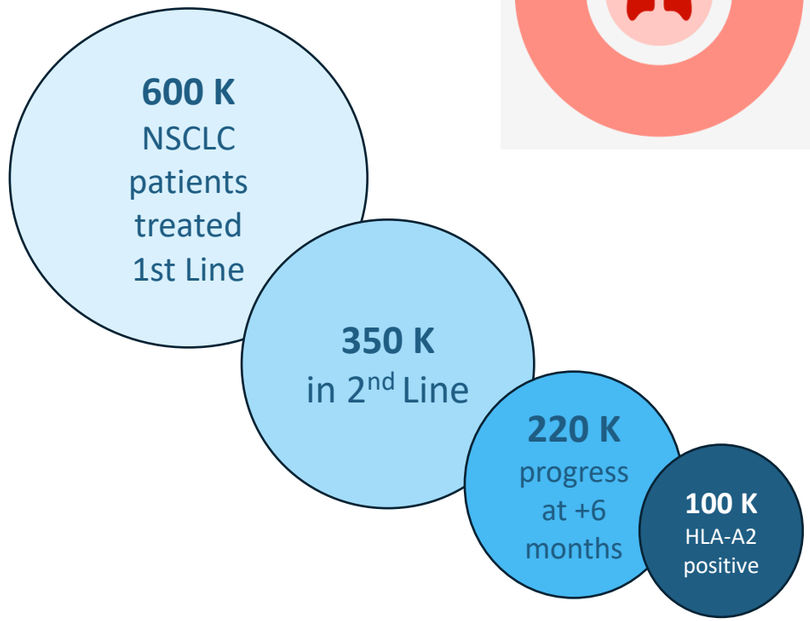
Treatment paradigm in NSCLC with no driver mutation

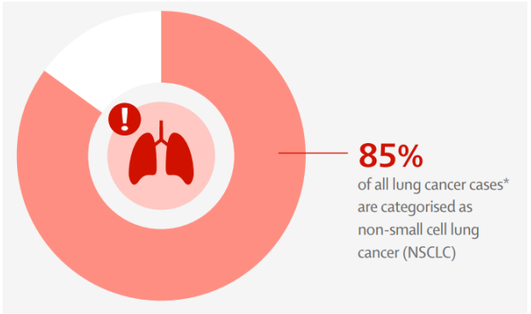
- L1 : treatment anti-PD(L)1 based with/w/out chemotherapy
- L2 : docetaxel remains standard with its limited efficacy and toxicity

Opportunity for Tedopi®

- Great opportunity for new standard without chemotherapy in a remaining high medical need after 1st line of treatment
- HLA-A2 patients represent about 45% of the patients

Incidence of advanced NSCLC in the US/EU5/Japan + China**





* Bray, F et al. CA Cancer J. Clin. 2018; Sung, H et al. CA Cancer J. Clin. 2021; Rodak, O et al Cancers 2021 **Datamonitor projection in 2030

Tedopi® delivers important clinical benefits vs competition

Better Safety profile and QoL in current landscape of late-stage drug development post CT-IO

Company	OSE IMMUNO THERAPEUTICS	MIRATI THERAPEUTICS	Roche / EXELIXIS / IPSEN	MERCK / Eisai	gsk	BIONTECH / OncoC4	AstraZeneca / Daiichi-Sankyo	GILEAD	SANOFI	abbvie
Target	**Multi-epitopes vaccine**	**TKIs (anti-angiogenic)**			**Checkpoint Inhibitors**		**ADCs**			
					TIM-3	CTLA-4	TROP2	TROP2	CEACAM5	c-MET
Current Study	**ATALANTE-1**	SAPPHIRE	CONTACT-01	LEAP-008	COSTAR Lung	PRESERVE-003	Tropion-LUNG1	EVOKE-01	CARMEN-LC03	NCT04928846
n	**219** **118 (secondary resistant)**	500	350	405	750	600	604	580	554	698
Therapy	**Tedopi® vs docetaxel**	Sitra + Opdivo vs. docetaxel	Cabo+Tecentriq vs. docetaxel	Lenva + Keytruda vs. docetaxel	Cobolimab + Jemperli vs. docetaxel	Gostistobart vs. docetaxel	datopotamab deruxtecan vs docetaxel	Sacituzumab Govitecan-hziy vs docetaxel	SAR408701 vs. docetaxel	Telisotuzumab Vedotin vs. Docetaxel
Primary endpoints	**OS**	OS	OS	PFS and OS	OS	OS	PFS and OS	OS	PFS and OS	PFS and OS
Initiation	**2017**	Q3 2019	Q3 2020	Q2 2019	Dec 2020	Q2 2023	Q4 2020	Q4 2021	Q1 2020	Q1 2022
Read-out	**2022**	**Failed**	**Failed**	**Failed**	Q2 2025	Q2 2026	**Failed**	**Failed**	**Failed**	Q1 2028
		Safety data from early-stage trials in NSCLC post-ICI								
- TEAEs G3/4	**11%**	**53%**	**39%**	**78%**	n.a.	**43%**	**25-30%**	**> 50%**	**36%**	**36%**
Source	**Besse et al. 2023**	Borghaei et al, Annals Oncol 2023	Neal et al, ASCO 2022	Taylor et al, J. Clin. Oncol. 38, 1154–1163.	Davar et al, SITC 2018	He et al, ASCO 2023	ESMO 2023 WCLC 2024	ASCO 2024	Gazzah et al, ASCO 2020	Camidge DR, et al. WCLC 2021

1 - OSE internal analysis based on publicly available information. **2** - World Health Organization. Globocan 2020 Fact Sheet. Available at: https://gco.iarc.fr/today/data/factsheets/populations/900-world-fact-sheets.pdf. Accessed December 2021. OSE Internal analysis based on publicly available data. Note: No direct head-to-head data available. Caution advised when comparing across studies

Further additional potential clinical value in combination NSCLC, PDAC and OC

Phase 2 ISS trials in combination with immunotherapy or chemotherapy treatments

2nd line post 1st line chemo IO

CombiTED - NSCLC
In combination with nivolumab

Tedopi® Plus Docetaxel or Tedopi Plus Nivolumab as 2nd line Therapy in Metastatic NSCLC failing standard 1st line Chemo-immunotherapy[1]

Sponsored by FoRT
PI: Federico CAPPUZZO
(Roma Cancer Institute)
Italy /Spain/ France

Readout expected H2 2026

Maintenance setting post standard of care

TEDOVA - Ovarian Cancer
In combination with pembrolizumab

Tedopi® Alone or in Combination With Pembrolizumab vs Best Supportive Care as Maintenance in Patients with Platinum-Sensitive Recurrent Ovarian Cancer[2]

Sponsored by ARCAGY-GINECO
PI: Alexandra LEARY
(Gustave Roussy Institute)
France/ Germany/ Belgium

Recruitment completed Q4 2024

Readout expected in Q2 2026

TEDOPaM - Pancreatic Cancer
In combination with FOLFIRI

Tedopi® plus FOLFIRI vs FOLFIRI as Maintenance Treatment in Controlled Advanced or Metastatic Pancreatic Ductal Adenocarcinoma after 8 Cycles of Folfirinox[3]

Sponsored by GERCOR PRODIGE
PI: Cindy NEUZILLET
(Curie Institute)
France

Recruitment completed Q2 2023

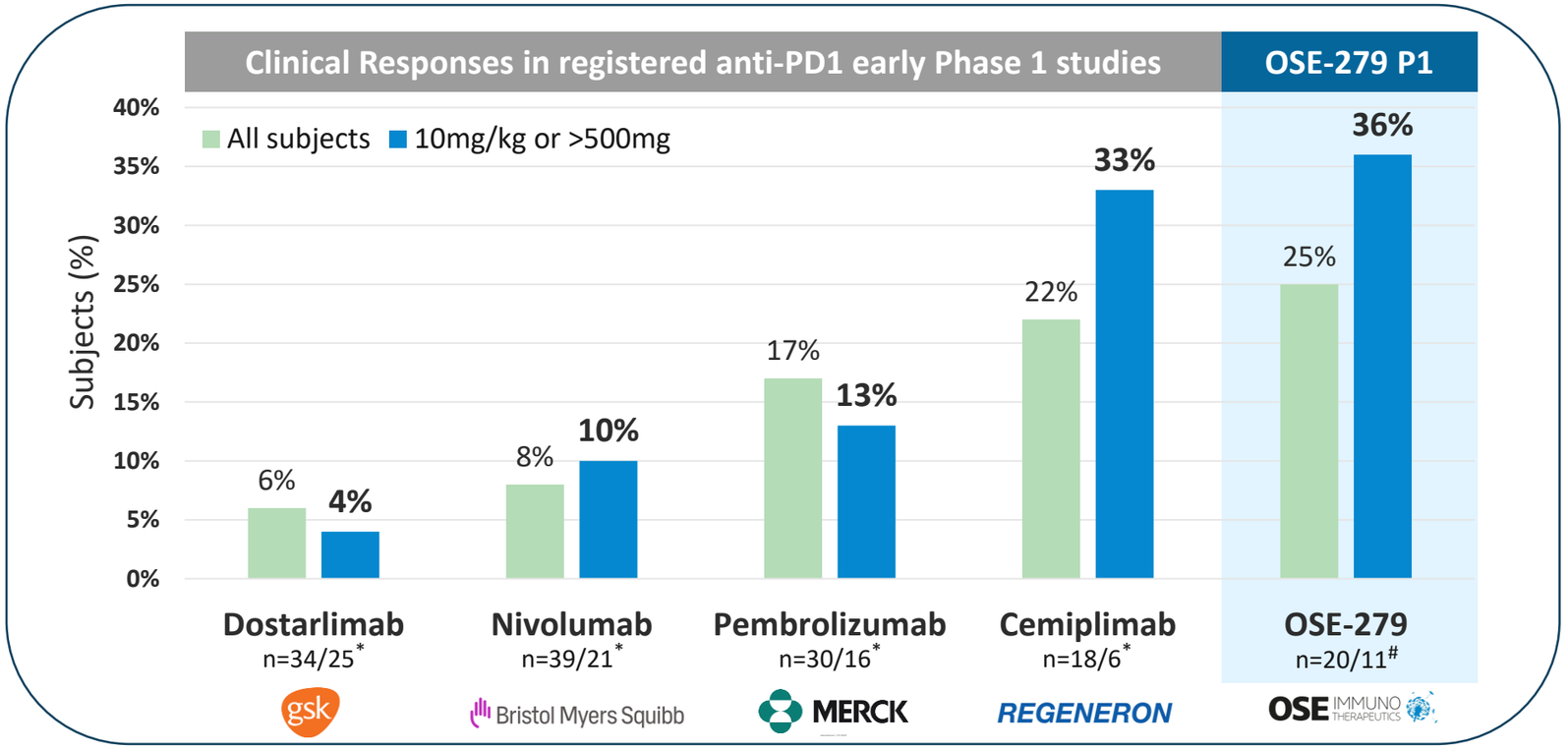
Readout expected in H1 2025

1 - NCT04884282 105 Patients planned
2 - NCT04713514 180 Patients - Recruitment completed
3 - NCT03806309 136 patients - Recruitment completed

OSE-279: Proprietary anti-PD1 mAb

High affinity PD-1 antibody, recent patent granted in US, Europe, China, Japan

- Potential of combo with internal asset
- Potential for partnership with biotech/biopharma in combo with external assets
- Potential future marketing approvals in orphan indications with strong unmet medical needs



Not a head-to-head comparison. Differences exist between trial designs and subject characteristics, and caution should be exercised when comparing data across trials.
For illustrative purposes only.

OSE IMMUNO THERAPEUTICS

* Patnaik et al. Cancer Chem & Pharm 2021; Brahmer et al. JCO 2010; Patnaik et al. Clin Cancer Res 2015; Papadopoulos et al. Clin Cancer Res 2020
# Robert et al. ESMO-TAT 2024

Partnered clinical programs

Resolution of inflammation

Pr. C. Serhan, Harvard
seminal works
(OSE SAB member)

HARVARD UNIVERSITY

NEWS | FEATURES

Science AAAS

Inflammation's STOP SIGNALS

Inflammation doesn't just peter out. The body actively shuts it down, using signals that researchers hope to transform into therapies *By* **Mitch Leslie**

Players in the endgame

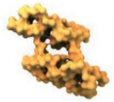
An assortment of molecules shut down inflammation and promote tissue healing by targeting different cells.

Lipoxins
Lipids whose jobs include stimulating macrophages and preventing neutrophils from slipping between endothelial cells to enter damaged tissue.

Resolvins
Family of lipids that block neutrophils' exit from the bloodstream and prod macrophages to eat cellular debris.

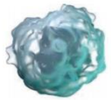
Maresins
Made by macrophages, lipids that spur tissue repair and act on nerves to ease pain.

Protectins
Lipids that curtail release of inflammation-promoting molecules and are protective in the nervous system.



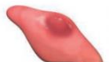
Annexin A1
A protein released by dying neutrophils, its functions include preventing other neutrophils from entering the injured site.

Hydrogen sulfide
Message-carrying gas that reduces pain and stimulates neutrophils to commit suicide.



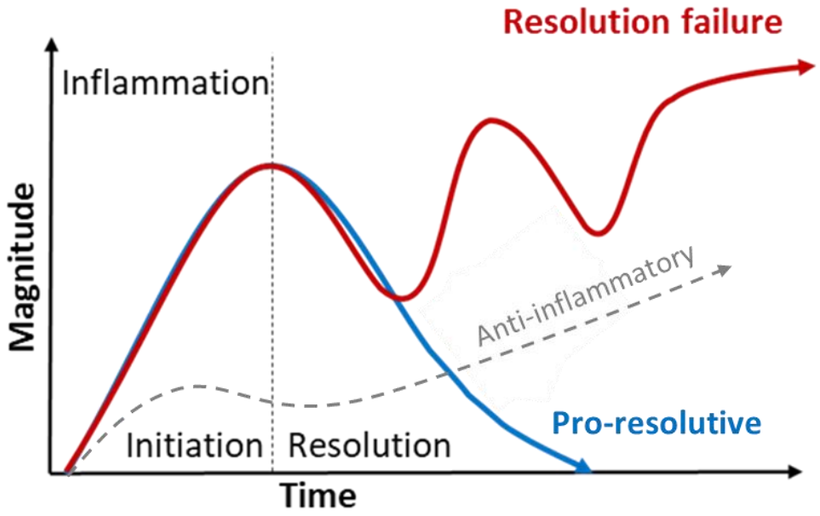
Macrophages
After clearing an infection, these immune cells consume proinflammatory cellular remains.

Neutrophils
First responders to wounds and infections, they release inflammatory cytokines.



Endothelial cells
These cells form the walls of blood vessels and make H_2S.

Nerves
Inflammatory molecules trigger nerve cells, creating pain and itchiness.



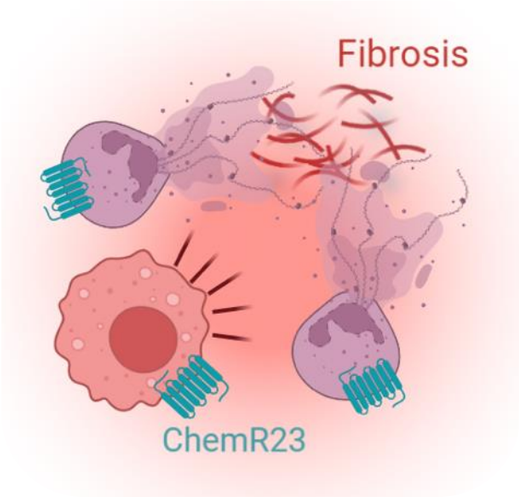
Serhan CN: Nature Review Immunol 2013, Immunity 2014, Nature 2014, Science 2015, …

ABBV-230 - Resolving inflammation is an active immune process

abbvie

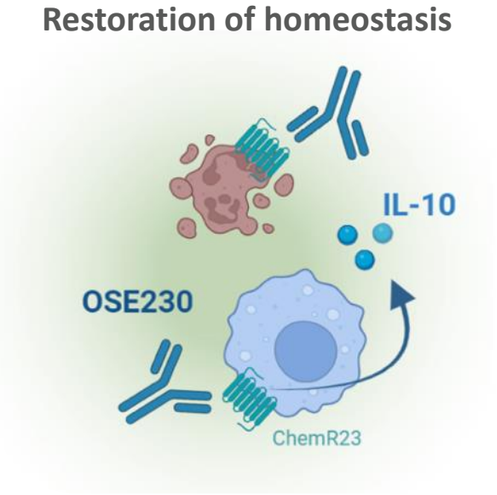
During chronic inflammation

Dying neutrophils **send out inflammatory signals (e.g. NETosis)** that are important in maintaining chronic inflammation & fibrosis



With ChemR23 agonistic mAbs

ABBV-230 limits recruitment, survival & NETosis of inflammatory neutrophils & reprograms macrophages, **removing further chronic inflammatory signals**



Potential First-in-class pre-IND candidate

Published in Science Advances AAAS

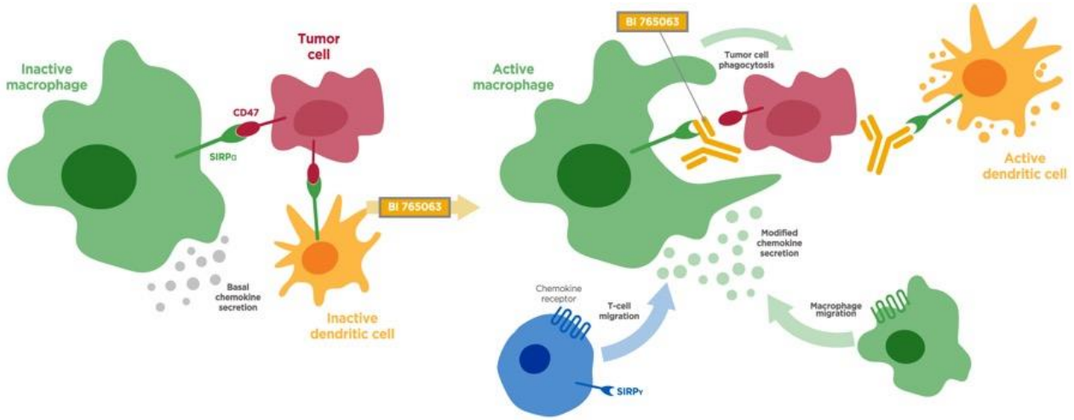
Trilleaud et a. Science Advances 2021; Poirier N. PEGS 2022

SIRPα inhibition may have a synergistic antitumour effect when combined with ICIs

Boehringer Ingelheim

- Infiltrating **myeloid cells promotes immune evasion**, and this has generated interest in **myeloid-immune targets**[1,2]
  - The CD47–SIRPα interaction transduces inhibitory signals on macrophages and other myeloid cells[2]
- Preclinical studies have indicated that **CD47 or SIRPα blockade in combination with ICIs** may have a synergistic antitumour effect[3]

The use of SIRPα antagonists to enhance antitumour immunity is currently being explored[4]



	Anti-CD47	Anti-SIRPα	
Broad/restricted expression	Broad	Restricted to cells of the myeloid lineage	Limited **side effects** expected and less frequent dosing
Safety signals	Acute anemia, Thrombocytopenia	**No hematotoxicity**	Higher therapeutic window expected
Interaction CD47/SIRPγ	**Inhibit human T cells**	OSE-172 is SIRPα specific	Favors T cell responses in solid tumors

CD: cluster of differentiation; ICI: immune checkpoint inhibitor; SIRPα: signal regulatory protein-α.

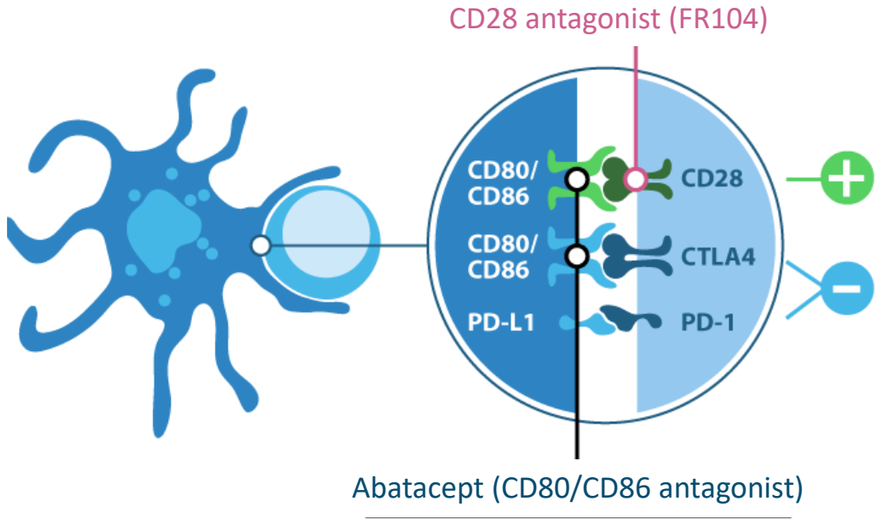
OSE IMMUNO THERAPEUTICS

1: Khair DO, et al. Front Immunocol 2019;10:453; **2:** Weiskopf K, et al. Eur J Cancer 2017;76:100-9; **3:** Murata Y, et al. Cancer Sci 2018;109(8):2349-57; **4:** Boehringer Ingelheim. Data on file.

FR104/VEL-101
CD28 antagonist in organ transplantation

Veloxis PHARMACEUTICALS
an Asahi Kasei company

Selective CD28 antagonist mAb in Kidney Transplantation



Ambitious Partnership & Development Plan with Veloxis

- **Veloxis** is a global leader in transplantation with leading product Envarsus XR (tacrolimus) realizing **c. USD 140m**[1] turnover; Joined **Asahi Kasei** in FY2019[2], a **USD 17bn** annual turnover conglomerate with healthcare representing 17% of sales

- **Strong Preclinical data in Kidney & Cardiac transplantation + GVHD**[3,4,5]
- **Positive Phase 1/2 in kidney transplantation** (intravenous)[6]
- **Positive Phase 1 subcutaneous**[7]

Phase 2 in kidney transplantation (subcutaneous) under preparation by Veloxis

OSE IMMUNO THERAPEUTICS

1 – https://www.asahi-kasei.com/ir/library/presentation/pdf/211005.pdf
2 – https://www.asahikasei.com/ir/library/presentation/pdf/191125eng.pdf
3 – Poirier et al. Science Transl. Medicine 2010
4 – Poirier et al. Am J Transplant 2015
5 - Watkins et al. Journal of Clinical Investigation 2018
6 - PR OSE of June 5th, 2024: Presentation at the 2024 ATC
7 - PR Veloxis of May 30th, 2024: Presentation at the 2024 ATC

FR104/VEL-101 - Transforming kidney transplant management

Veloxis PHARMACEUTICALS

Positive results of the FIRsT phase I/II clinical evaluation in kidney transplantation[1]

Good Safety profile and early sign of efficacy:

- *Drug exposure allow high receptor occupancy maintenance during the one-year follow-up.*
- *No acute rejection under FR104/VEL-101 treatment, including after calcineurin-inhibitor (CNI) discontinuation.*
- *No biopsy-proven acute rejection (BPAR) observed at 1-year*
- *No donor-specific antibodies (DSA) detected at 1-year*

Kidney Transplant Market:
A multi-billion-dollar commercial opportunity

- **45k+** new kidney transplant annually for an estimated **500k+** people living with a functioning kidney graft in G7 countries
- 90k+ Americans in transplant waiting list, many transplanted patients require repeat transplants
- Chronic exposure to **CNIs** is associated with **renal toxicity**, cardio-metabolic complications, **insufficient** graft protection as well as **cancer** and **infections**
- FR104/VEL-101 seeks to address challenges associated with current immunosuppressive transplantation regimens using CNI-based therapies

1 – PR OSE of June 5th, 2024: Presentation at the 2024 ATC

OSE’s Boards

A **Board of Directors** combining international expertise in medicines development, industry & finance, and experience in listed biotech companies

Didier Hoch, MD
Chairman

25+ years in pharma and vaccine industry (Sanofi-Pasteur MSD, Rhone-Poulenc)

Several functions incl. commercial, marketing, general management

Maryvonne Hiance
Vice Chairwoman

Founder and CEO of Effimune

General Manager SangStat Atlantic, DrugAbuse Sc.

Former President & Vice President of France Biotech

Nicolas Poirier, PhD
Director, CEO & Chief Scientific Officer

20 years in biotech/immunotherapy

Advanced 6 novel therapies to clinic leading to 6 pharma deals

Global Management (INSEAD,HEC)

Anne-Laure Autret-Cornet
Chief Financial Officer

15+ years in Finance & Biotech
ESSCA Management School
Finance Corporate, HEC

Marc Dechamps
Independant Director

35+ years in pharma industry (GSK, ViiV Healthcare)
Expertise in market development for new products, I&I, I/O, vaccines
CEO of Bioxodes

Markus Goebel, MD, PhD, MBA
Independent Director

30+ years in the Life Science industry (Novartis, Roche)

Positions in BD&L, Corporate M&A, Corporate Venture Funds

Founder & CEO of M&G Advisor

Certified MD in oncology/hematology, MBA

Martine George, MD
Independent Director

30+ years in pharma & academic in the US (Pfizer, J&J, Sanofi, Sandoz-Novartis)
Service Chief Gustave Roussy, Cancer center

Expertise in clinical research, drug development, medical and regulatory affairs specializing in oncology

Eric Leire, MD
Independent Director

Genflow Bioscience CEO
Previously chairman & CEO of several biotech companies listed in US
Previous Marketing Director position in Pharma US & EU

Cécile Nuyen-Cluzel
Independent Director

Extensive experience in financial engineering & healthcare private equity. Senior advisor in healthcare for France & Europe at Apposite Capital. Master 2 « Ingénierie financière & « Leading the digital transformation in healthcare »certification from Harvard Medical School

Brigitte Dréno, MD
Independent Director

25+ years in pharma and vaccine industry (Sanofi-Pasteur MSD, Rhone-Poulenc)

Several functions incl. commercial, marketing, general management

International research Scientific Advisory Board (research SAB) - renowned experts in IO and I&I

UNIVERSITÉ PARIS DESCARTES

Wolf-Hervé Fridman, MD

Chairman of the SAB, Professor Emeritus of Immunology at the Université de Paris, France

Mount Sinai

Myriam Merad, MD, PhD

Director of the Precision Immunology Institute at Mount Sinai School of Medicine in New York and Director of the Mount Sinai Human Immune Monitoring Center (HIMC)

HARVARD UNIVERSITY

Charles N. Serhan, PhD, DSc

Professor of Anaesthesia (Biochemistry and Molecular Pharmacology) at Harvard Medical School, Professor of Oral Medicine, Infection and Immunity at Harvard School of Dental Medicine

THE UNIVERSITY OF TEXAS MD Anderson Cancer Center

Jennifer Wargo, MD, M.M.Sc

Professor of Genomic Medicine & Surgical Oncology, UT MD Anderson Cancer Center

cnrs Ciml IMMUNOLOGY

Bernard Malissen, PhD

Group Leader at Centre d'Immunologie de Marseille-Luminy and Founding-Director of Center for Immunophenomics, Marseille, France

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Sophie Brouard, PhD

Immunologist and Director in Veterinary Sciences, Director of Research at the Institut National de la Santé et Recherche Médicale (Inserm, National Institute for Health and Medical Research) in Nantes

OSE IMMUNO THERAPEUTICS

Breaking through the therapeutic ceiling with first-in-class immunotherapies

Immuno-Oncology & Immuno-Inflammation

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