OSE IMMUNO THERAPEUTICS

Delivering on Our 3-Year Value Enhancing Strategic Plan

2026 Q2

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A Business Oriented Team to Leverage OSE's Leading Research and Development Capabilities

Marc Le Bozec

Chief Executive Officer

- Currently supports numerous biotech companies as an advisor, board member and investor
- Previously created and managed two biotech investment funds within Financière Arbevel
- Former CFO of Cellectis

Thomas Gidoin

Deputy Chief Executive Officer / Chief Financial Officer

- 15+ years in pharma / biotech
- 10+ years as CFO in both private and public biotechs, Euronext and US Nasdaq IPOs

Sonya Montgomery, ND

Chief Development Officer

- 20+ years of experience in pharma / biotech
- Global management, portfolio strategy, translational, clinical and regulatory leadership roles (CMO, Head of clinical development) from discovery through registration

Silvia Comis, MD

Chief Clinical and Medical Research Officer

- 30+ years of pharma experience
- Previously held positions of Senior Director COE, European Head of Early Products Medical Affairs and Clinical Development in Oncology
- Certified pharmacologist and endocrinologist

Jean-Jacques Mention, PhD

Chief Business Officer

- 15+ years of academic research in Immunology and virology at Necker-Enfants Malades Hospital, King's College of London & Institut Pasteur of Paris
- 10 years' experience in BD and innovation

Aurore Morello, PhD

Chief Scientific Officer

- 7 years of academic research in Immunology and oncology at at the Memorial Sloan Kettering Cancer Center in New York and the French National Center for Scientific Research (CNRS) in Paris
- Joined OSE in 2016
- PhD in immunology and oncology

Our 3-Year Development Plan Focused on Shareholder Value

Large Partnered Indications vs Smaller Go-Alone Indications

Strategy to maximize Return on Investment while managing risk:
- Large indication assets to be developed up to end of Phase 2
- Smaller indication assets to be developed up to commercialization

3

Development Strategies

Lusvertikimab in Chronic Pouchitis
Rare/Specialist Indication
Target population 45k patients

Phase 2 to start in H2 2026

Lusvertikimab in Ulcerative Colitis
Strong Phase 2 data as IV
Reformulation as SC
Potential to be licensed out

Multi-Billion potential

Tedopi® in NSCLC
1st Phase 3: mOS benefit vs SOC
2nd Phase 3: ongoing
Potential approval in 2029

Multi-Billion potential

Strong Pharma Partnerships Capabilities

Proven ability to deliver attractive partnerships
Over €150m in upfront received and over €2.1bn in potential milestones + tiered royalties via partnerships with AbbVie, Boehringer Ingelheim and Veloxis

Multiple Key Inflection Points Over the Next 24 Months

Key clinical announcements at least every 6 months over our 3-year development plan

Clinical Pipeline Focused on Achievable Deliverables

3-Year Plan Focused on Proprietary Assets

Product Candidate	Target	Indication	Pre-Clinical	Phase 1a/1b	Phase 2	Phase 3	Addressable Market	Upcoming Milestones
Lusvertikimab SC	Anti-IL-7R	Ulcerative Colitis				*Ph 2 completed in IV SC ready mid 27*	***$1bn+***	***Ph 2b/3 to be licensed out or financed***
Lusvertikimab IV		Chronic Pouchitis					*45k patients*	***Ph 2 interim read-out Q4 27***
Tedopi	Neoepitopes immunotherapy	NSCLC Mono post-CT-ICI 2L *(US Orphan Drug Designation)*					***$1bn+***	***Futility Analysis Q3 26 Ph 3 read-out Q1 28***
		Pancreatic cancer Combo (ISS)					*$500m - $1bn*	*3-yr LT Survival H2 26*
		Ovarian cancer Combo (ISS)					*$500m*	*OS data following positive topline*
		NSCLC Combo 2L (ISS)					*$500m*	*Read-out H2 26*
		NSCLC 1L Combo OSE-279					*$500m*	

Partnered Clinical Assets

Product Candidate	Target	Indication	Pre-Clinical	Phase 1a/1b	Phase 2	Phase 3	Upcoming Milestones
BI 770371 Boehringer Ingelheim	Anti-SIRPα	Solid tumors (HNSCC)					*Ph 1b read-out*
Pegrizeprument (FR104) Veloxis	Anti-CD28	Kidney Transplantation (US Orphan Drug Designation)					

Immunology & Inflammation **Immuno-Oncology**

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NSCLC: Non-Small Cell Lung Cancer. **HNSCC**: Head and Neck Squamous Cell Carcinoma. **ISS**: Investigator-Sponsored Study

Potential Catalysts Every 6 Months Over Our 3-Year Strategic Plan*

H1 **Tedopi®** ✓
ISS Phase 2 positive read-out in Ovarian Cancer as monotherapy or in combo with pembrolizumab

H2 **Lusvertikimab in Chronic Pouchitis**
Phase 2 start in rare disease indication leveraging IV formulation for early POC data generation

Tedopi®
ISS Phase 2 read-out in 2L NSCLC combo with nivolumab or docetaxel

Pivotal Phase 3 DSMB futility analysis on 107 events in HLA-A2+ NSCLC patients post Chemotherapy (CT) and Immune Checkpoint Inhibitors (ICI)

H1 **Lusvertikimab Subcutaneous**
Subcutaneous formulation ready for all indications (Ulcerative Colitis, Chronic Pouchitis)

H2 **Lusvertikimab in Chronic Pouchitis**
Interim Phase 2 results generating clinical PoC in a rare disease

Lusvertikimab in Ulcerative Colitis
Phase 2b/3 initiation
(subject to partnering/financing)

H1 **Tedopi®**
Phase 3 read-out in HLA-A2+ 2L NSCLC

FY **Lusvertikimab in Chronic Pouchitis**
Full Phase 2 results generating clinical PoC in a rare disease

2026 | 2027 | 2028

*Estimates based on Management expectation – Some of these events depend on external factors OSE has no control over

Lusvertikimab

Most Advanced Anti-IL-7R mAb

Strong biological rationale in refractory IBD patients and inflammatory dermatologic diseases

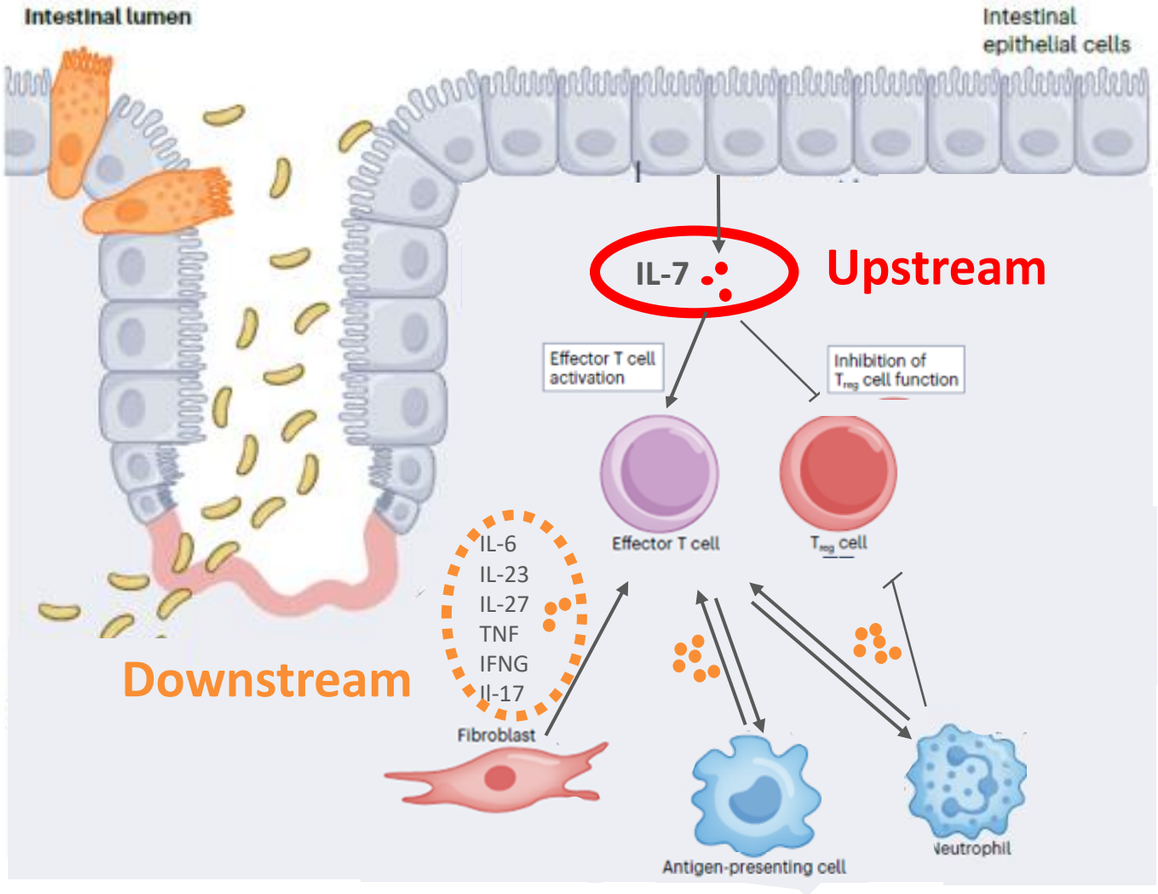
IL-7 Fuels Chronic Tissues Inflammation – Lusvertikimab Tackles It

Upstream mechanism of resistance in hyper-inflammation

"…Highly pro-inflammatory cells in the intestinal mucosa in Inflammatory Bowel Disease (IBD) 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. **IL-7R expression on colitogenic CD4 T cells is vital for induction of chronic colitis**"

Pr. Neurath, ***Nature Review Immunology 2024***

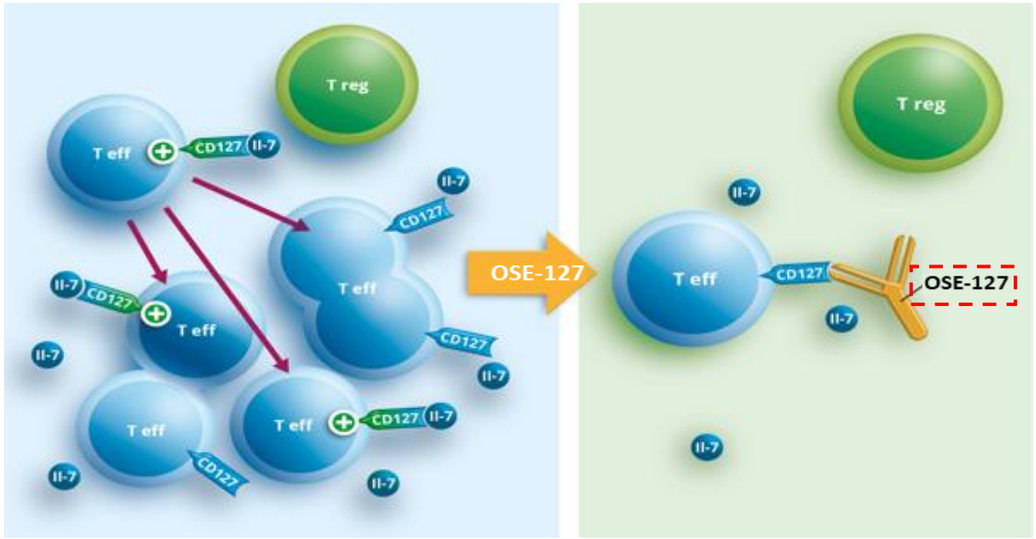
Blocking the IL-7 receptor prevents molecular signalling transmission by IL-7 through the JAK/STAT5 pathway (responsible for chronic inflammation), while sparing Tregs necessary for healthy immune response



Adapted from Neurath M. **Nature Review Immunology 2024**

Lusvertikimab – First Pure IL-7 Antagonist that Maintains Healthy Immune System

Calming down overexpressed immune response while maintaining healthy immune response



A differentiated IL-7R antagonist solely targeting the immune system at the root cause of chronic inflammation

- IL-7R pathway is overexpressed in bio-refractory IBD patients[1,2], Pouchitis and Hidradenitis Suppurativa
- First non-internalizing pure antagonist anti-IL-7R mAb[3]
- No antagonist activity on TSLP* that has a protective effect on the gut mucosa
- Inhibit activation, differentiation of pathogenic Th1, Th17 and resident memory T cells while sparing Tregs
- Limit migration of T cells into the gut
- Limit immune chronicity and favor healthy immune microenvironnment
- Good safety, PK/PD profile in Clinical trials[4]; no cytokine release

*__TSLP__: Thymic Stromal Lymphopoietin.

1. Belarif et al. JCI 2019. 2. Poirier, ECCO 2025. 3. Belarif et al. Nature Communication 2018. 4. Poirier et al. Journal of Immunology 2023.

Lusvertikimab – Most Advanced and Differentiated First-in-Class Anti-IL-7R mAb

	OSE IMMUNO THERAPEUTICS	Q32 BIO / Bristol Myers Squibb	zurabio / Pfizer	gsk
Isotype	**IgG4**	**IgG1**	**IgG1**	**IgG1**
MoA	• **Non-Internalizing**[1] • **Full Antagonist IL-7R** • **No Depletion**	• TSLP Antagonist • T-cell Decrease	• Internalizing • Antago + Partial Agonist IL-7R • TSLP Antagonist • T-cell Decrease[2]	• Internalizing • Antago + Partial Agonist IL-7R
Phase	**Phase 2**	**Phase 2a**	**Phase 1b**	*Discontinued*
Indications	• **Ulcerative Colitis** • **Chronic Antibiotic-Refractory Pouchitis**	~~• Atopic Dermatitis~~ *Failed endpoint in Part B*[5] • Alopecia Areata *Results expected H1 26*	• Alopecia Areata *Not initiated*	• Multiple Sclerosis *Discontinued post Phase 1* *High Immunogenicity*[3,4]

1. Belarif et al. Nature Com 2018; 2. Herold et al. JCI Insight 2019; 3. Ellis et al. Br J Clin Pharmacol 2019; 4. Liao et al. PlosOne 2021
5. https://www.prnewswire.com/news-releases/q32-bio-provides-bempikibart-program-update-including-next-steps-for-advancing-alopecia-areata-development-program-302328042.html

Lusvertikimab – A Pragmatic Development Plan

Lusvertikimab in Chronic Pouchitis

Rare/Specialist Indication – To be developed by OSE

Chronic Antibiotic-Refractory Pouchitis – 45k US/EU/JP patients

- Leverage IV GMP material currently available
- c.30% of UC patients require surgery; c.70% of patients with IPAA experiencing Pouchitis over 10 years, o/w c.15% develop Chronic Pouchitis
- 35-40% of patients fail currently approved biologic drugs

Lusvertikimab in Ulcerative Colitis

To be Outlicensed or Financed

Ulcerative Colitis – 200-500k patients in the US alone require advanced therapy

- $9-11bn Ulcerative Colitis Market mostly generated by anti-TNFα and JAK/IL-23 inhibitors
- 30-40% of patients do not respond sufficiently to anti-TNFα and JAK/IL-23 inhibitors leading to significant need for therapeutic alternatives
- Strong Phase 2 data generated with IV formulation
- Subcutaneous formulation in development to fit the current treatment paradigm
- Minimal costs expected until licensing takes place
- To be developed by partner or financed by OSE

IPAA: Ileal Pouch-Anal Anastomosis.

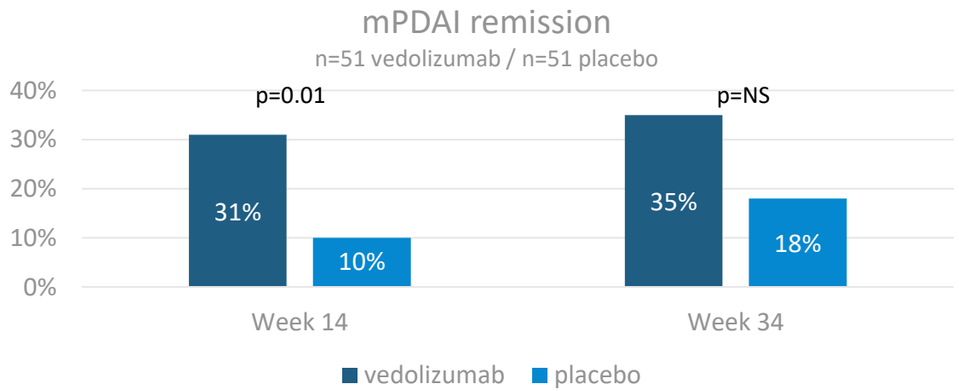
Chronic Antibiotic-Refractory Pouchitis – A Rare IBD Indication

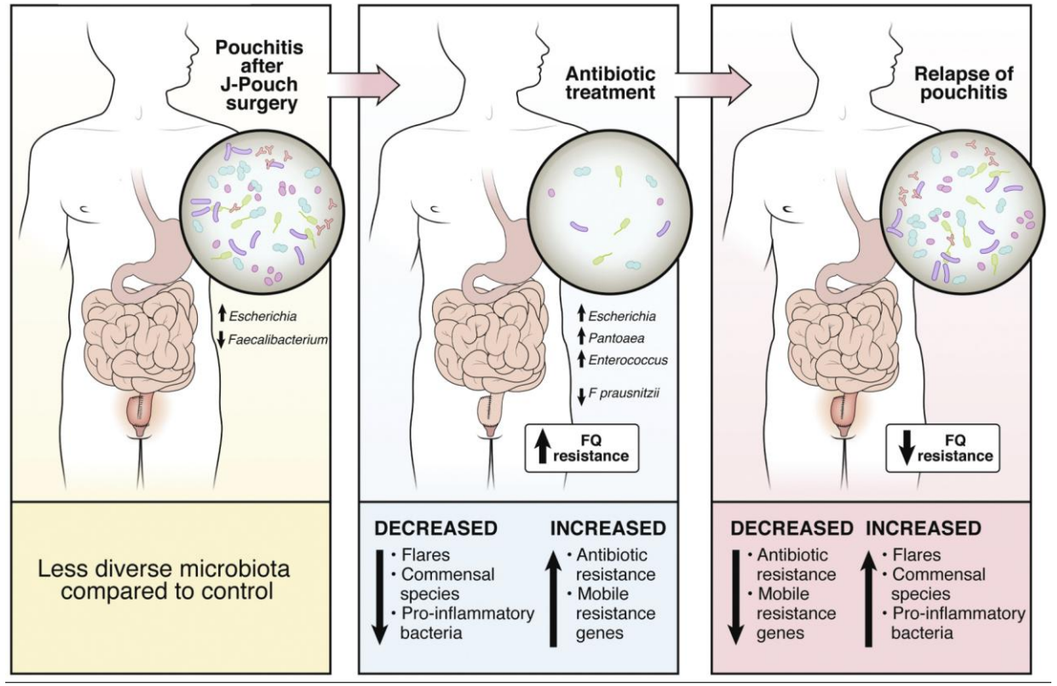
45k patients in the US/EU/Japan

- Complication of restorative proctocolectomy with ileal pouch-anal anastomosis (IPAA) in patients with ulcerative colitis (UC) and familial adenomatous polyposis (FAP).
- 30% of UC patients are refractory to available therapies and require proctocolectomy with ileal pouch-anal anastomosis (IPAA)[1]
- 70% of them develop Pouchitis of which 15% is chronic[2]
- Symptoms include increased stool frequency and fluidity, rectal bleeding, fecal urgency, incontinence, abdominal cramps, fever and extra-intestinal manifestations

No FDA approved biologic treatment post antibiotics

- Vedolizumab (Entyvio®) only EU approved product with limited efficacy



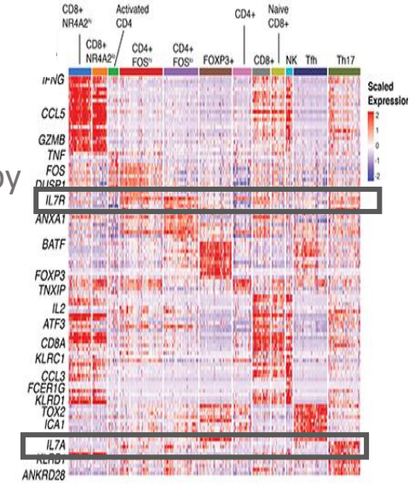


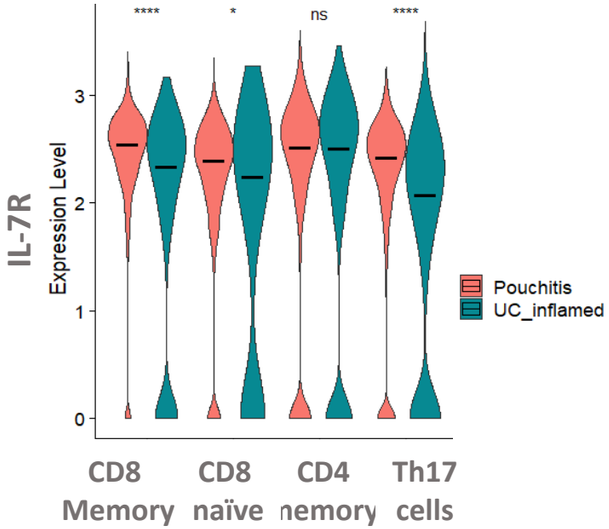
1. Sriranganathan D, Kilic Y, Nabil Quraishi M, et al. Colorectal Dis 2022;24:27–39
2. Inflammatory Bowel Diseases, Volume 31, Issue 2, February 2025, Pages 597–600
3. Figure from Fritsch J, Abreu M et al, Gastroenterology, 2019; 158, 470-472

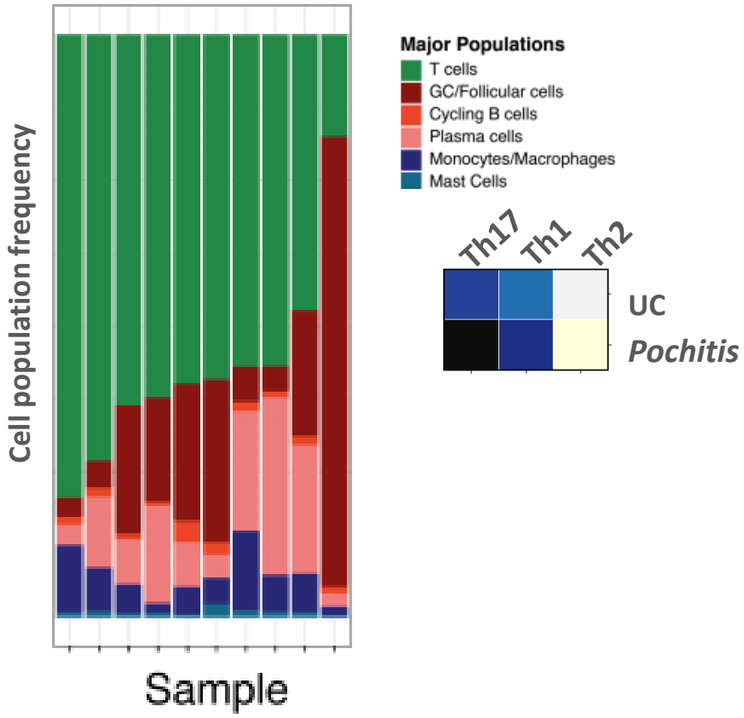
Chronic Antibiotic-Refractory Pouchitis – Scientific Rationale

IL-7R expressed by CD4/CD8/Th17

IL-7 expressed by TH17







Inflammatory disease with similar pathogenesis to UC

- Refractory Pouchitis and UC have similar inflammatory mechanisms and significant infiltration of TH1/Th17 T cells to an even higher extent than UC[1]
- Overexpression of IL-7R by Th1 and Th17 mucosa infiltrating cells, high IL-7 expression in the tissue & higher expression of IL-7R over UC in CD4, CD8 T cells
- Vedolizumab in Pouchitis supports rationale for Lusvertikimab (share one MoA). Stronger clinical benefit of Lusvertikimab over Vedolizumab expected and supported by preclinical data[2]
- Lusvertikimab blocks Teff migration and activation while preserving Treg trafficking, whereas Vedolizumab blocks both Treg and Teff homing without blocking direct effector function of T cells, potentially enabling a more favorable safety profile in chronic indications such as Pouchitis

Lusvertikimab multi-axis efficacy

Inhibits proliferation, survival and activation of intra-tissue effector T cell subsets (Th1, Th17, CD8 memory) while maintaining Treg for tissue homeostasis

1. Ben Shachar et al., 2013 2/Braga-Neto Gut, 2025
2. Belarif et al. , JCI 2019

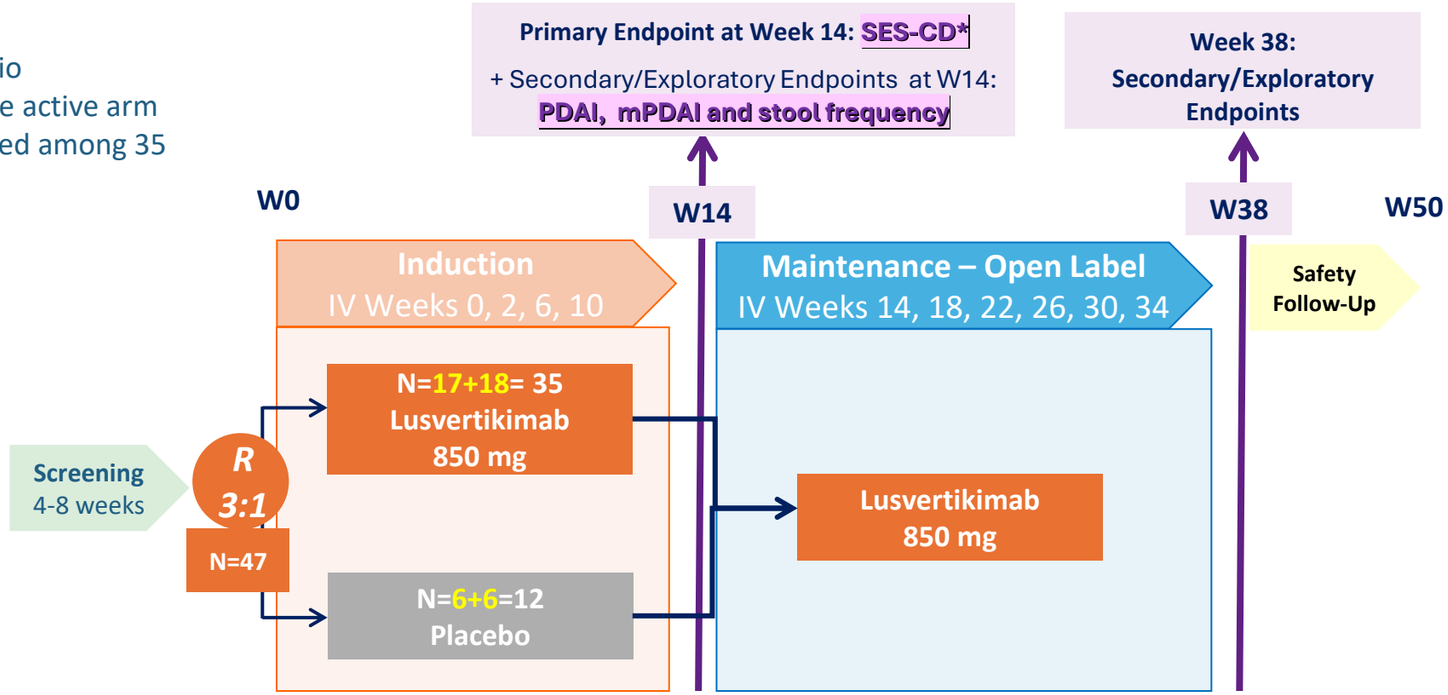
Chronic Antibiotic-Refractory Pouchitis – Ph 2a Design & Expected Timeline

- **PoC -** *Non-comparative* randomized design
- N=47 → 3 : 1 - Lusvertikimab : Placebo

- A primary evaluation focused on the Lusvertikimab arm
- A two-stage Fleming/Simon-type design
- An internal placebo calibration arm randomized in a 3:1 ratio
- Interim futility assessment after 17 evaluable patients in the active arm
- Final success criterion based on the # of responders observed among 35 evaluable Lusvertikimab-treated patients.

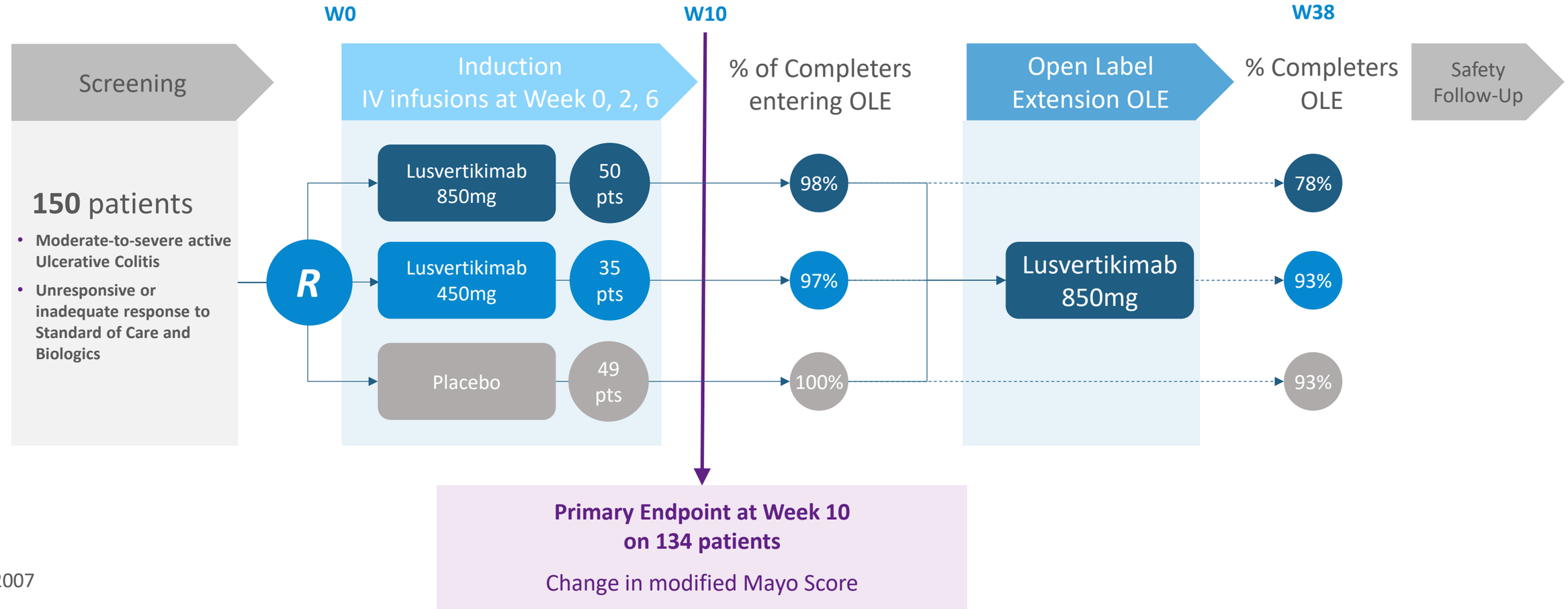
⇒ **2-stage phase II single-arm Simon design**

- **In the 1st stage:**
  - 17 subjects
  - Futility if ≤1 respond to the treatment.
    → READ OUT 3Q27
- **In the 2nd stage:**
  - The additional 18 subjects → 35 subjects
  - If the >4 responses the study is declared positive for the continuation to the next phase.
    → READ OUT 4Q27



SES-CD: Simple Endoscopic Score for Crohn's disease (in the pouch)

CoTikiS – POC in Chronic Inflammation
Lusvertikimab IV Phase 2 in Moderate-to-Severe UC

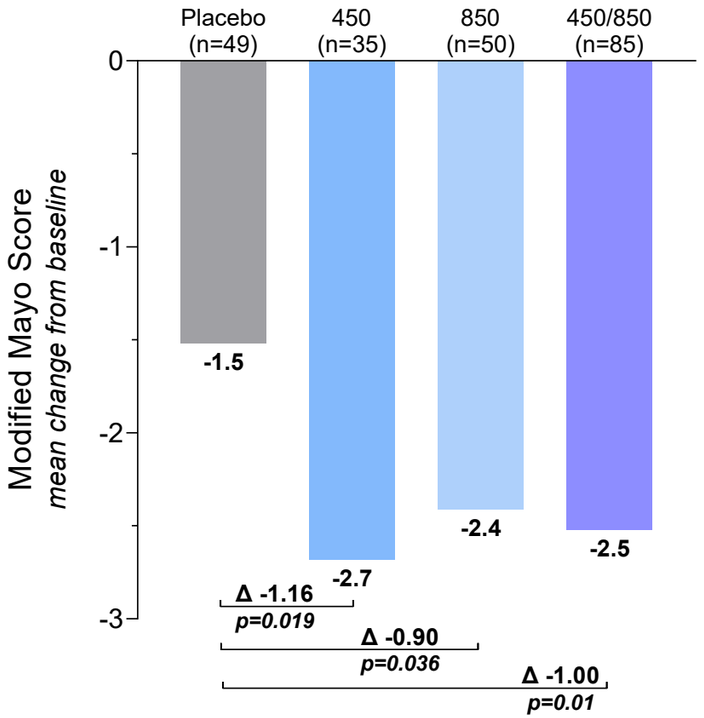


NCT04882007

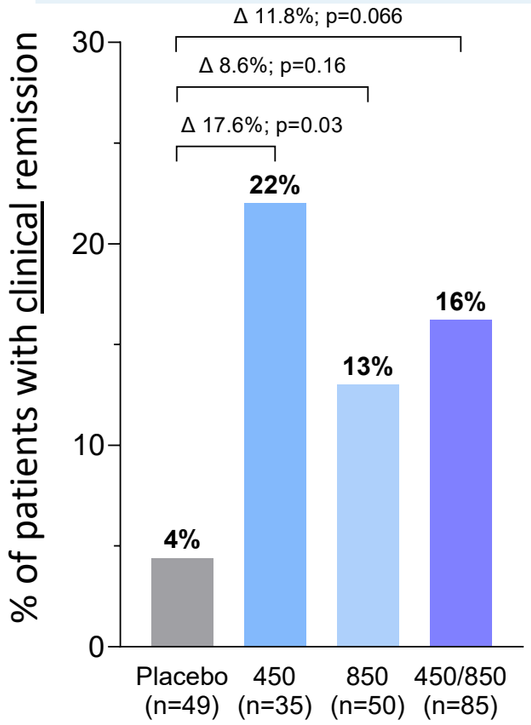
Patients included with a rectal bleeding score ≥ 1, a stool frequency score ≥ 1 and an endoscopic sub-score ≥ 2
In the OLE, 42 patients from the placebo arm entered and 39 completed, 31 patients from the 450mg arm entered and 29 completed, 46 patients from the 850mg arm entered and 36 completed

Clinically and Statistically Meaningful Remission at Week 10 with Lusvertikimab

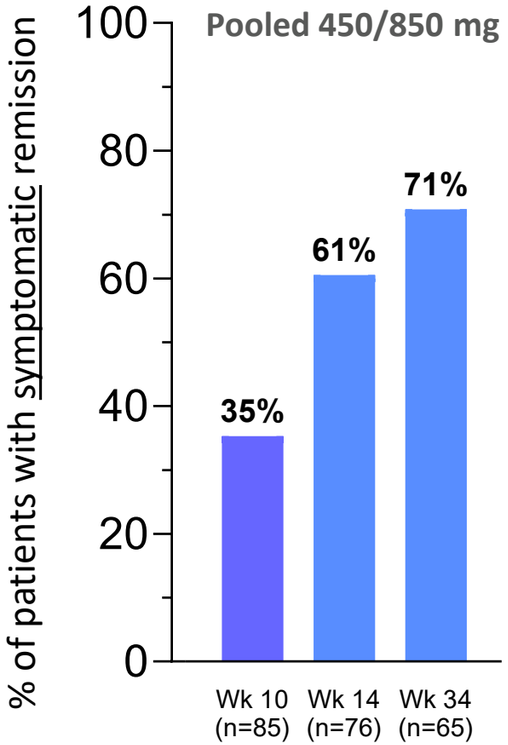
Primary Endpoint: Modified Mayo Score Improvement (MMS)*µ at W10



Clinical Remission at W10



Sustained benefit beyond W10[1]



All patients received 850 mg every 4 weeks from week 10 through 34

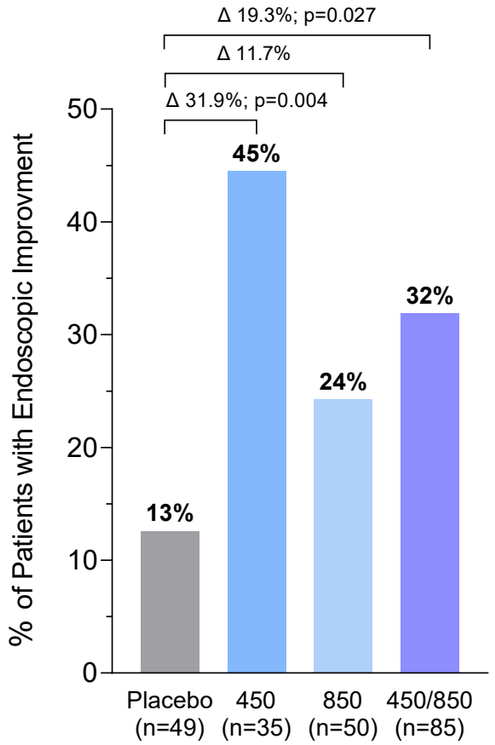
clinical remission: MMS ≤2 with no subscore >1 and a RB 0, SF ≤ 1, MES 0 or 1

*__MMS Improvement__ defined on mean change at Wk 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
A. Boureille et al, Journal of Crohn's and Colitis, 19, Suppl_1, 2025, i71–i72. Oral communication at ECCO 2025
1. Data in house

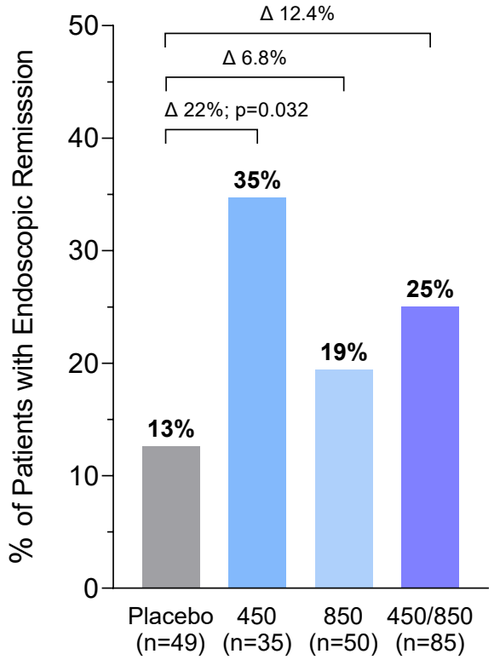
Induction Results at Week 10

Clinically meaningful and significant endoscopic improvement and remission

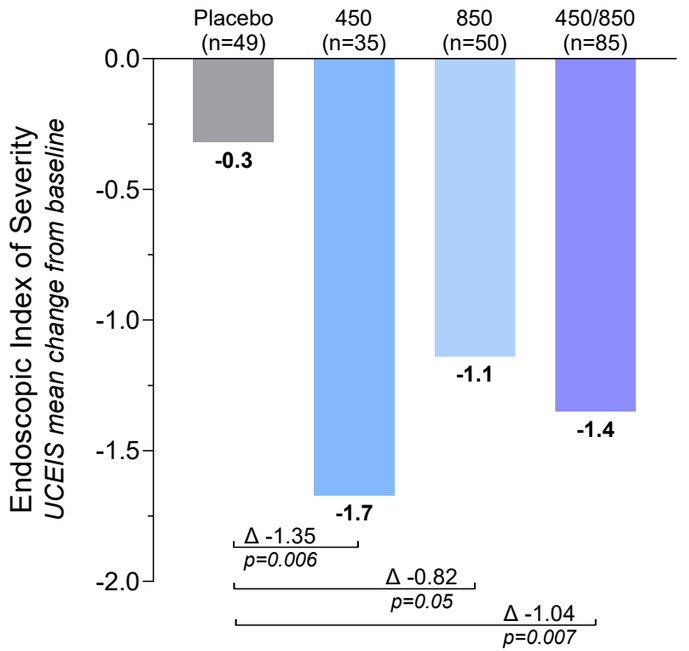
Endoscopic Improvement** at W10



Endoscopic Remission*at W10



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



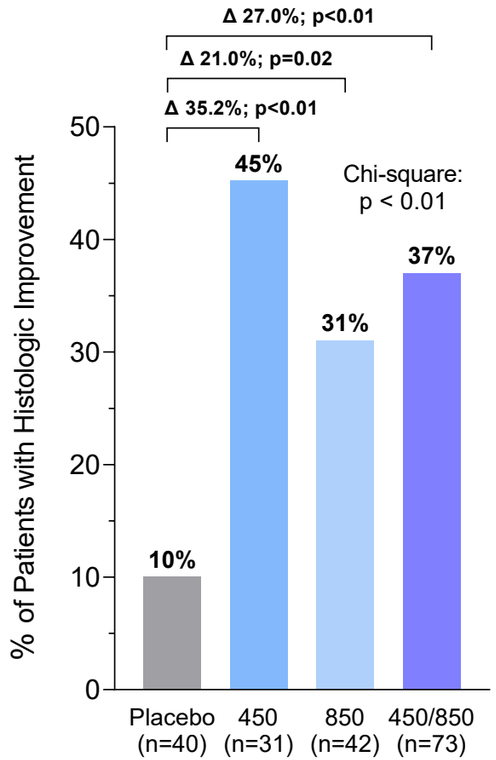
*Endoscopic Remission = endoscopic Mayo score = 0 / ** Endoscopic Improvement: endoscopic Mayo score ≤ 1 point / *** UCEIS: index of severity measured by three disease severity subscores: vascular pattern: 0 to 2 / Bleeding: 0 to 3/ /Erosions-ulcerations 0 to 3

A. Boureille et al, Journal of Crohn's and Colitis, 19, Suppl_1, 2025, i71–i72. Oral communication at ECCO 2025

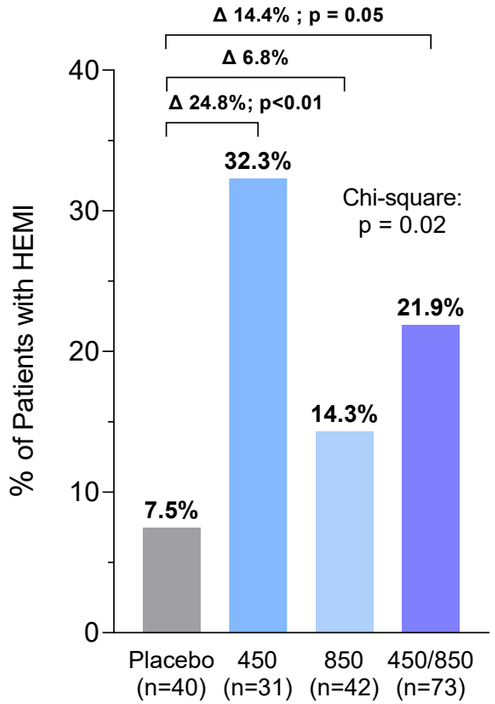
Induction Results at Week 10

Clinically meaningful and significant histologic and histo-endoscopic mucosal improvement

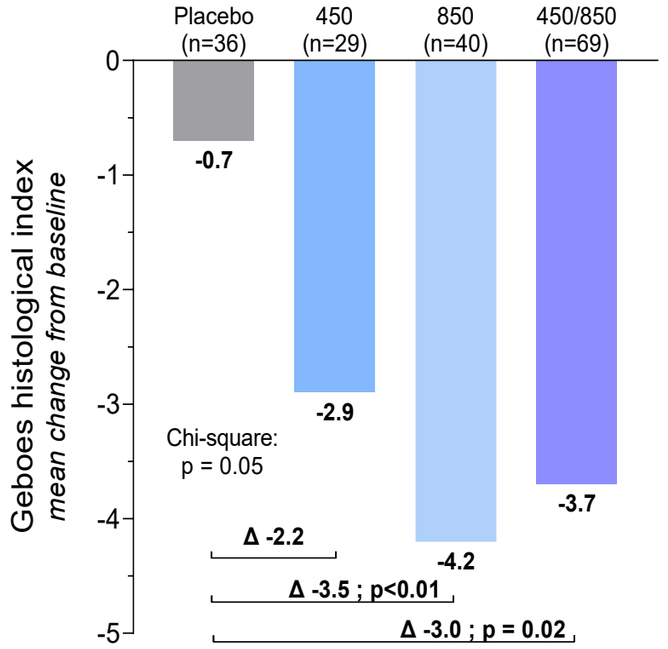
Histological Improvement at W10*



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

A. Boureille et al, Journal of Crohn's and Colitis, 19, Suppl_1, 2025, i71–i72. Oral communication at ECCO 2025; A. Boureille et al.Gastroenterology, 169, 1, Suppl S-219, 2025. Oral communication at DDW 2025

CoTikiS – 850 mg Group More Severe Disease than 450 mg and/or Placebo Groups

Demographics and disease characteristics

	Placebo (n=49)	450 mg (n=35)	850 mg (n=50)	Total (n=134)
Age: mean (SD)	42.7 (15.9)	38.8 (10.5)	42.5 (15.1)	41.6 (14.4)
Sex: male	28 (57.1%)	22 (62.9%)	27 (54.0%)	77 (57.5%)
Weight (kg) mean (SD)	75.3 (15.2)	72.8 (16.2)	71.5 (18.0)	73.2 (16.5)
Never smoker	39 (79.6%)	25 (71.4%)	43 (86.0%)	107 (79.9%)
Never alcohol consumption	34 (69.4%)	25 (71.4%)	40 (80.0%)	99 (73.9%)
Region: EU Country	22 (44.9%)	8 (22.9%)	22 (44.0%)	52 (38.8%)
UC duration (years) mean (SD)	8.2 (7.5)	7.2 (6.5)	9.3 (8.6)	8.4 (7.7)
Previous exposure to biologics	**19 (38.8%)**	**5 (14.3%)**	**19 (38.0%)**	**43 (32.1%)**
Previous biologics: 2+	*11 (57.9%)*	*2 (40%)*	*13 (68.8%)*	*26 (60.4%)*
Previous biologics: 3+	*5 (26.3%)*	*0 (0%)*	*6 (31.5%)*	*11 (25.6%)*
Concomitant use of steroids	23 (46.9%)	18 (51.4%)	25 (50.0%)	66 (49.3%)
Modified mayo score (mMS) Mean (SD)	6.6 (1.2)	6.0 (1.4)	6.5 (1.0)	6.4 (1.2)
Category of mMS				
5-6	21 (42.9%)	17 (48.6%)	25 (50.0%)	63 (47.0%)
7-9	**26 (53.1%)**	**13 (37.1%)**	**25 (50.0%)**	**64 (47.8%)**
Endoscopic subscore mean (SD)	2.5 (0.5)	2.4 (0.5)	2.6 (0.5)	2.5 (0.5)
Category of endoscopic subscore: 3	**26 (53.1%)**	**15 (42.9%)**	**32 (64.0%)**	**73 (54.5%)**
C-Reactive protein (mg/L) Mean (SD)	8.6 (13.6)	9.4 (16.7)	11.2 (18.1)	9.8 (16.1)
Serum albumin (g/L) Mean (SD)	42.3 (4.4)	42.6 (4.5)	40.8 (5.4)	41.8 (4.9)
FCP (µg/g) mean (SD)	1459.5 (1865.0)	1088.0 (1600.5)	1191.8 (1603.3)	1261.6 (1696.7)

OSE IMMUNO THERAPEUTICS

A. Boureille et al, Journal of Crohn's and Colitis, 19, Suppl_1, 2025, i71–i72. Oral communication at ECCO 2025

Lusvertikimab – Well Tolerated & Good Safety Profile

	Placebo (N=49) N(%) [E]	450 mg (N=36) N(%) [E]	850 mg (N=51) N(%) [E]	Total (N=136) N(%) [E]
At least one TEAE in induction phase	16 (32.7) [29]	17 (47.2) [33]	20 (39.2) [42]	53 (39.0) [104]
At least one TEAE related to study treatment	1 (2.0) [1]	3 (8.3) [4]	4 (7.8) [14]	8 (5.9) [19]
At least one serious TEAE	3 (6.1) [3]	2 (5.6) [3]	2 (3.9) [3]	7 (5.1) [9]
At least one serious TEAE related to study treatment	—	1 (2.8) [1]	—	1 (0.7) [1]
At least one severe TEAE	2 (4.1) [2]	1 (2.8) [2]	—	3 (2.2) [4]
At least one severe TEAE related to study treatment	—	1 (2.8) [1]	—	1 (0.7) [1]
At least one related TEAE leading to death	—	—	—	—
At least one TEAE leading to drug withdrawal	3 (6.1) [3]	2 (5.6) [3]	—	5 (3.7) [6]
At least one TEAE leading to drug interruption	2 (4.1) [2]	1 (2.8) [1]	—	3 (2.2) [3]
At least one TEAE leading to study discontinuation	3 (6.1) [3]	2 (5.6) [3]	—	5 (3.7) [6]
At least one AESI	6 (12.2) [7]	7 (19.4) [7]	9 (17.6) [10]	22 (16.2) [24]
At least one infection	6 (12.2) [7]	5 (13.9) [5]	7 (13.7) [8]	18 (13.2) [20]
At least one lymphopenia < 500 10^6/L	—	2 (5.6) [2]	2 (3.9) [2]	4 (2.9) [4]

Lusvertikimab tested in 174 individuals to date

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

OSE IMMUNO THERAPEUTICS

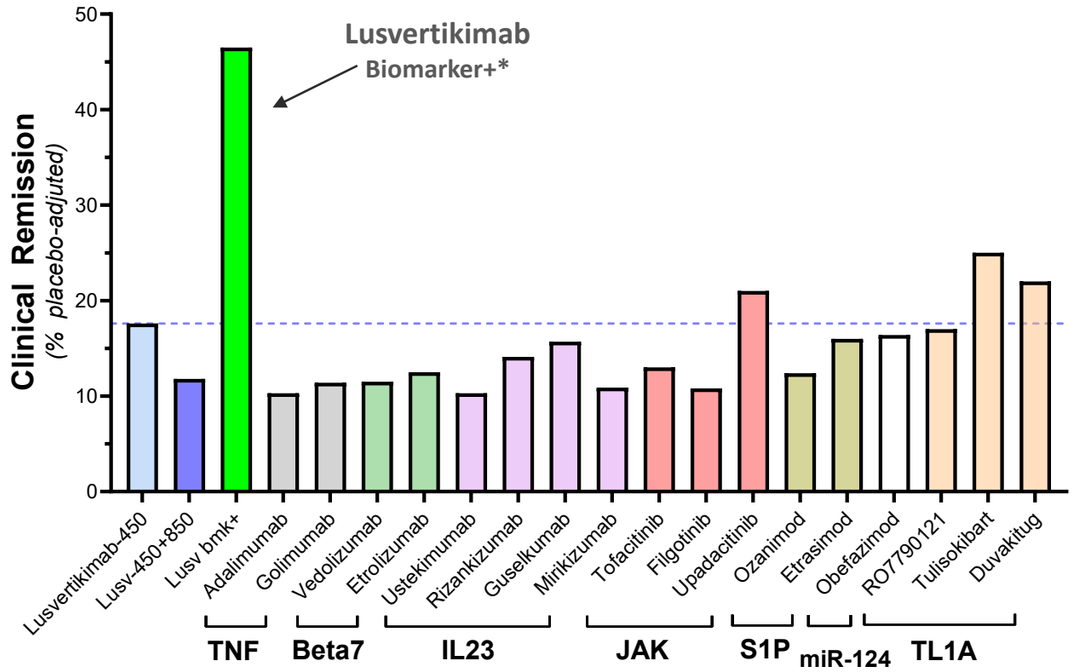
A. Boureille et al, Journal of Crohn's and Colitis, 19, Suppl_1, 2025, i71–i72. Oral communication at ECCO 2025
Number of individuals: data in house

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

Biomarker+ Could Boost Efficacy 4x in c.30-40% of UC Population Tested*

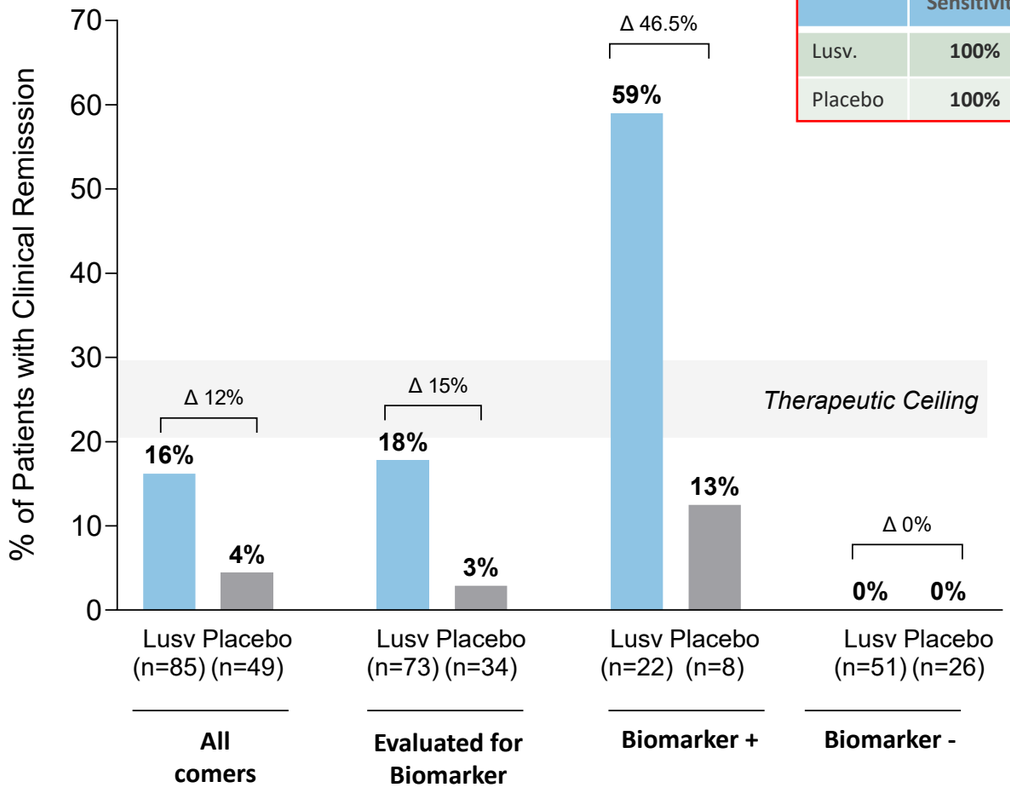
Confirmatory ex-vivo data to be generated over next 2 years

Clinical Remission (Placebo-adjusted)

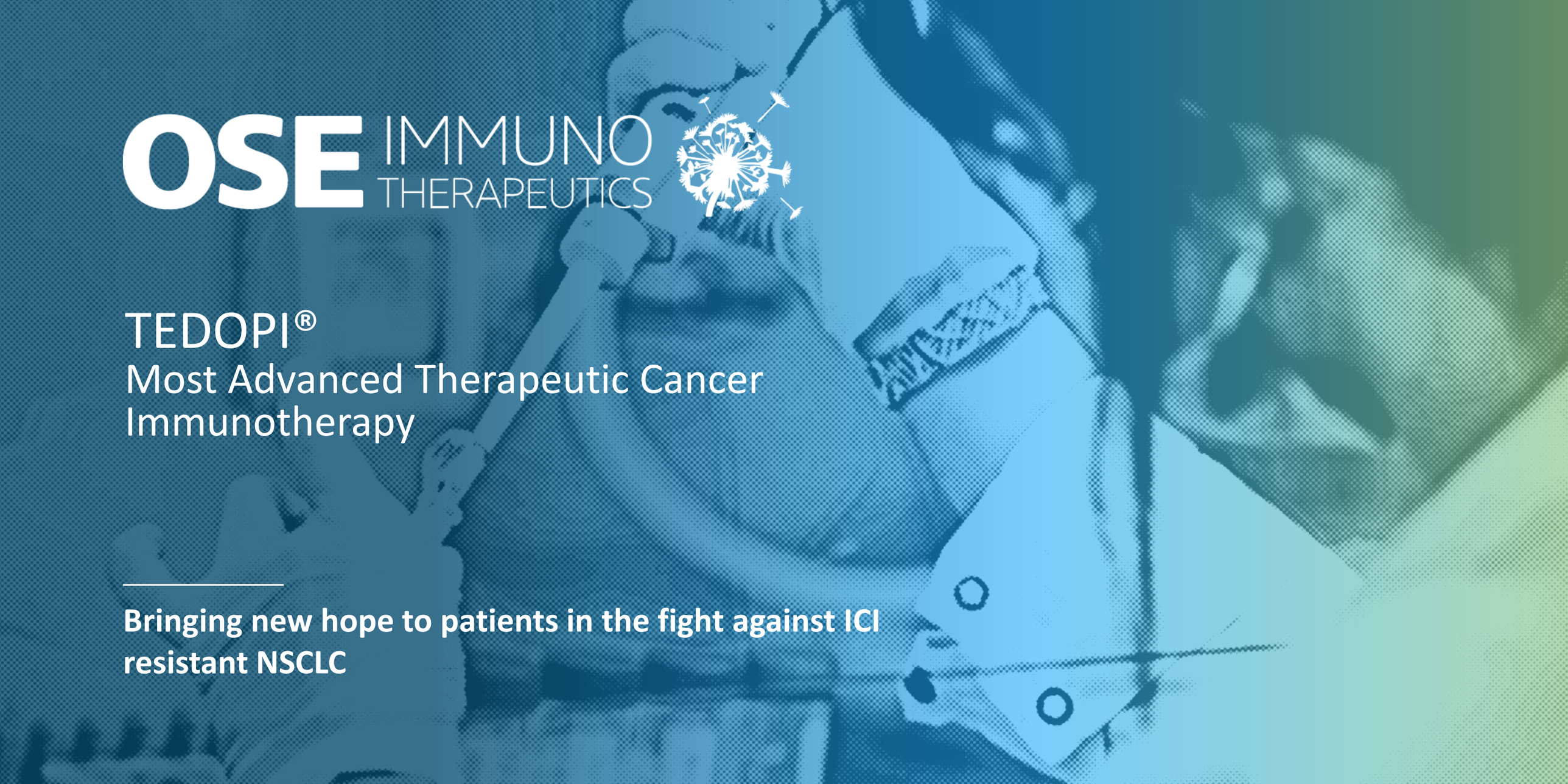


Clinical remission based on Lusvertikimab Biomarker

	Sensitivity	Specificity
Lusv.	**100%**	85%
Placebo	**100%**	78.8%



Composite IL-7R axis biomarker identified with fine-tuning on CoTikiS Phase 2



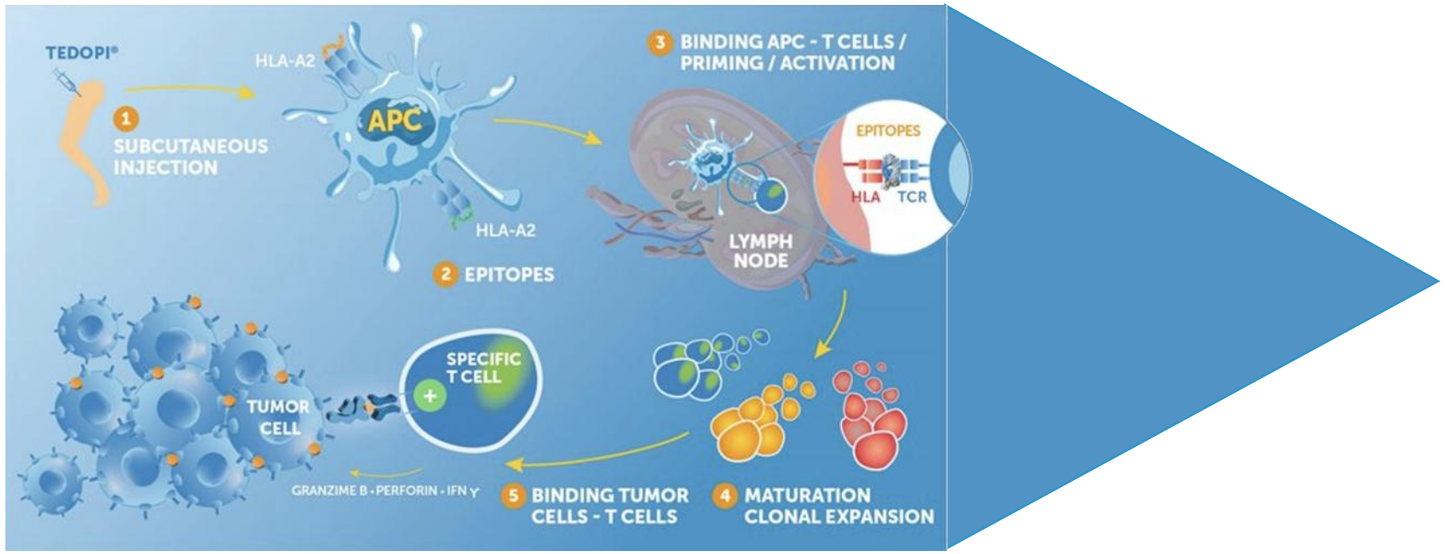
OSE IMMUNO THERAPEUTICS

TEDOPI®

Most Advanced Therapeutic Cancer Immunotherapy

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

An Immunotherapy Activating Specific T-Cells to Revive Anti-Tumor Response



- 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

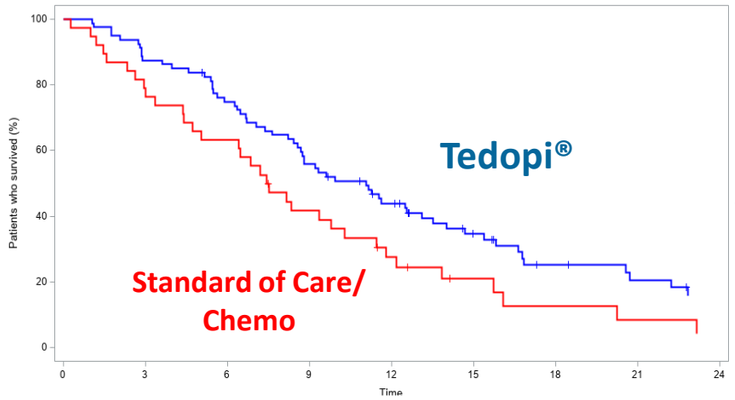
Orphan Drug Designation (FDA) **> 700 patients treated** in clinical trials

Strong IP position until **2038**[1] (US / EU / Asia)

1. OSE Immunotherapeutics Receives New European Patent

ATALANTE: Survival Benefit with Tedopi® in Phase 3 in 3L HLA-A2+ NSCLC with Secondary Resistance to Immune Checkpoint Inhibitors

Overall Survival
secondary resistance post anti-PD(L)1



Delta mOS: 3.6 months

Tedopi® 11.1 months vs SoC 7.5 months

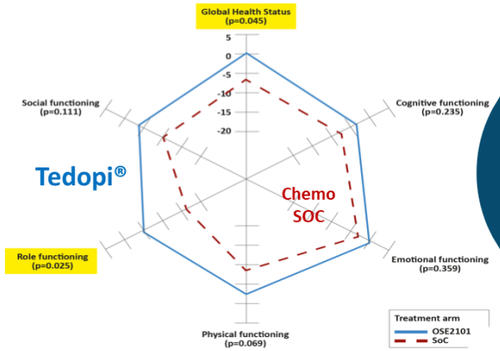
HR 0.59 / p-value=0.017

Risk of Death reduced by 41% *vs chemo*

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

Significantly safer than SoC
11% vs 35% grade 3-5 related AEs

Better Quality of Life



Positive Net Treatment Benefit vs SOC: P=0.032

OSE IMMUNO THERAPEUTICS

Besse et al. Annals of Oncology 2023. Note that Tedopi® is also known as OSE2101.

ANNALS OF ONCOLOGY driving innovation in oncology

ARTEMIA - Ongoing Tedopi® Phase 3 in HLA-A2+ NSCLC Patients Post Immune Checkpoint Inhibitors

KEY ELIGIBILITY CRITERIA

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

R 2:1

Tedopi® (n=242)
Q3W for 6 SC cycles,
then Q8W until end Year 1,
then Q12W up to end Year 2
Until
Progression/toxicity/withdrawal

Docetaxel (n=121)
Q3W IV infusion
Until progression/toxicity/withdrawal

PRIMARY ENDPOINT:
Overall Survival

SECONDARY ENDPOINTS:

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

Q3 2026
DSMB Futility Analysis
on 107 events

Q1 2028
Phase 3 Read-Out

HLA: Human leukocyte antigen; **NSCLC**: Non-small cell lung cancer; **CT**: chemotherapy; **ICI**=Immune checkpoint inhibitors; **ECOG PS**: Eastern Cooperative Oncology Group Performance Status; **SC**: Subcutaneous; **IV**: intravenous, **QLQ-C30**: Quality of life questionnaire-core30

Tedopi® Targets 100k Patients in 2nd Line NSCLC Post ICI

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

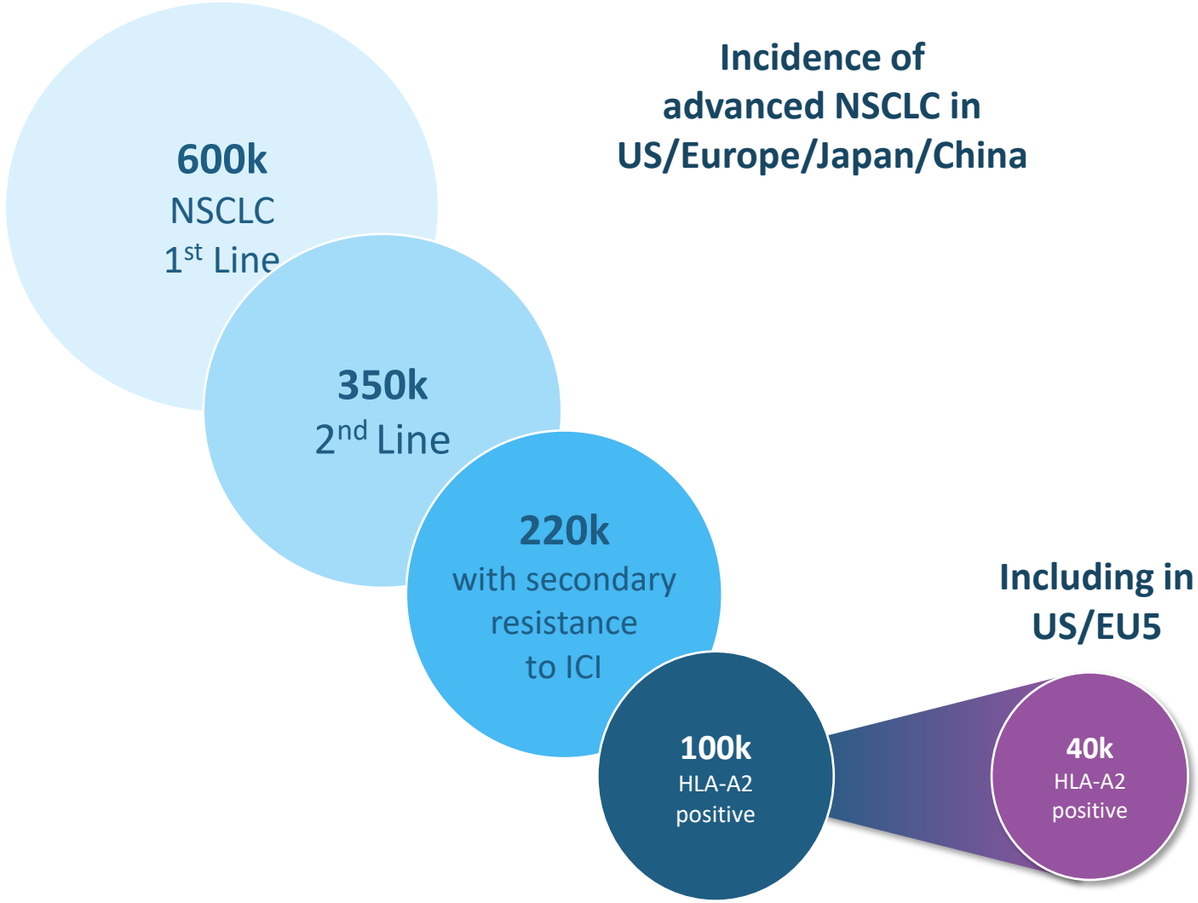
- 2nd most frequently diagnosed cancer type*
  - c.2m new cases of lung cancer diagnosed per year
  - c.1.8m deaths from lung cancer per year**
- Highest mortality among 36 cancer types
- Majority of NSCLC patients without actionable mutation are treated with Immune Checkpoint Inhibitors (ICI) as 1st line of treatment

Treatment paradigm in NSCLC with no driver mutation

- L1: anti-PD(L)1 based with / without chemotherapy
- L2: docetaxel remains standard with limited efficacy and high toxicity

Opportunity for Tedopi®

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



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*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

Additional Read-Out in 2026 in NSCLC, Ovarian and Pancreatic Cancer

Phase 2 ISS trials in combination with immunotherapy or chemotherapy treatments

Maintenance setting post standard of care

TEDOVA - Ovarian Cancer
In combination with pembrolizumab
185 patients

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

Primary Endpoint: Progression Free Survival

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

ARCAGY - GINECO

Positive Topline Result[5] in May 2026

TEDOPaM - Pancreatic Cancer
In combination with FOLFIRI
106 patients

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

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

GERCOR

Positive Topline Result[4] in 2025

Long-term OS follow-up ongoing

2nd line post 1st line chemo IO

CombiTED - NSCLC
In combination with nivolumab
105 patients

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

Primary Endpoint: Overall Survival

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

FoRT

Recruitment completed

Readout H2 2026

1. NCT04884282 105 Patients randomised
2. NCT04713514 185 Patients randomized
3. NCT03806309 106 patients
4. Primary endpoint met and data presented at ASCO 2025
5. Primary endpoint met and data presented at ASCO 2026

OSE IMMUNO THERAPEUTICS

Financials

Financials

Company Overview	
Market Cap*:	€80m
Cash Position: (March 31, 2026)	€17.0m
Cash Runway:	End of December 2026
Outstanding Shares:	23.6m
Latest Equity Raised: (March 2021)	€30m
Equity raised to date	€53m
Deal upfronts to date	€179m
IPO Date	March 30, 2015

*As of June 22, 2026

Analyst Coverage	
Invest Securities	Jamila El Bougrini (FR)
EDISON	Arron Aatkar (UK) Jyoti Prakash (UK)
ODDO BHF	Martial Descoutures (FR)
Kepler Cheuvreux	Nicolas Pauillac (FR)
Degroof Petercam	David Seynnaeve (BE)
BioMed Impact	Lionel Labourdette (FR)

2026 Corporate Calendar	Date
2025 Full-Year Financial Update and Statements	April 30, 2026
2026 1Q Cash Position	April 30, 2026
Annual General Meeting	June 24, 2026
2026 First-Half Financial Update and Statements	**September 28, 2026**
2026 3Q Cash Position	October 27, 2026
2026 4Q Cash Position	January 26, 2027

Our 3-Year Development Plan Focused on Shareholder Value

Large Partnered Indications vs Smaller Go-Alone Indications

Strategy to maximize Return on Investment while managing risk:
- Large indication assets to be developed up to end of Phase 2
- Smaller indication assets to be developed up to commercialization

3

Development Strategies

Lusvertikimab in Chronic Pouchitis
Rare/Specialist Indication
Target population 45k patients
Phase 2 to start in H2 2026

Lusvertikimab in Ulcerative Colitis
Strong Phase 2 data as IV
Reformulation as SC
Potential to be licensed out
Multi-Billion potential

Tedopi® in NSCLC
1st Phase 3: mOS benefit vs SOC
2nd Phase 3: ongoing
Potential approval in 2029
Multi-Billion potential

Strong Pharma Partnerships Capabilities

Proven ability to deliver attractive partnerships
Over €150m in upfront received and over €2.1bn in potential milestones + tiered royalties via partnerships with AbbVie, Boehringer Ingelheim and Veloxis

Multiple Key Inflection Points Over the Next 24 Months

Key clinical announcements at least every 6 months over our 3-year development plan

OSE IMMUNO THERAPEUTICS

Immuno-Oncology & Immuno-Inflammation

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22, boulevard Bénoni Goullin
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75014 Paris, France

Company Information: http://ose-immuno.com/en/