

OncoVerity Overview

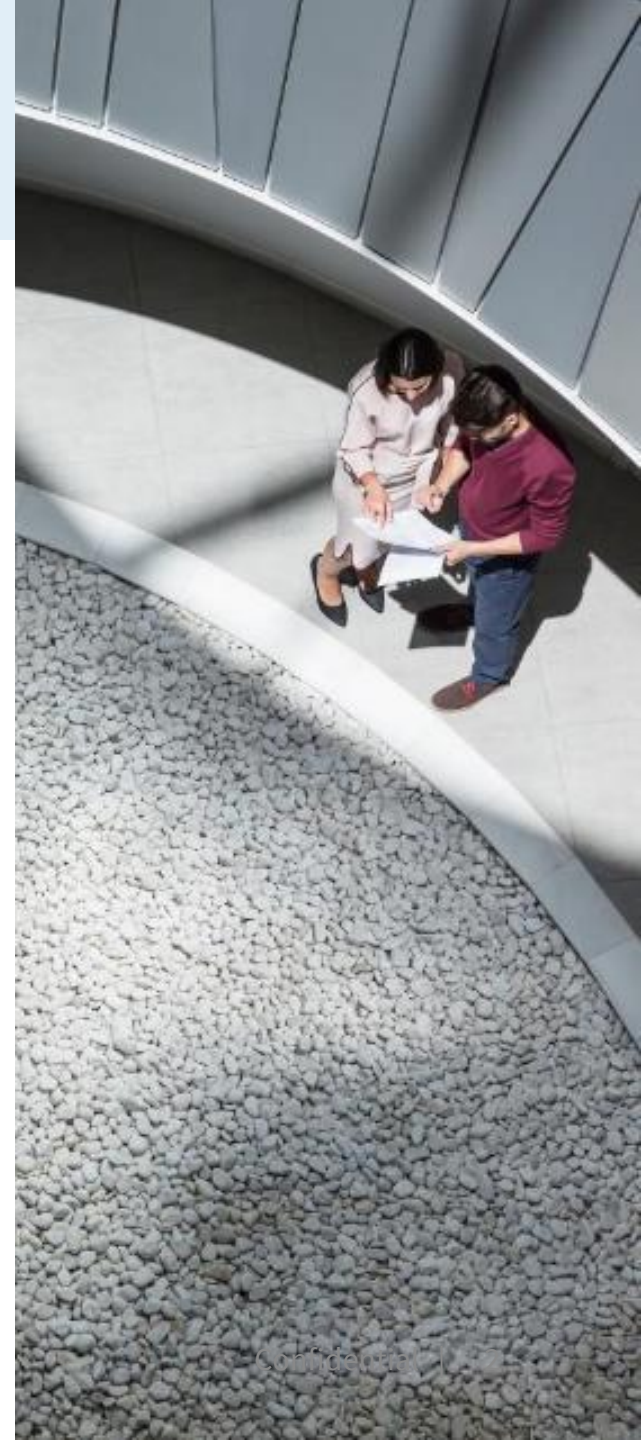
Forward looking statement

Information in this presentation and related comments of presenters contain forward-looking statements as defined in the Private Securities Litigation Reform Act of 1995 and other federal securities laws. These statements are based on current expectations, forecasts, assumptions, and other information available to the company as of the date hereof. Forward-looking statements include, but are not limited to, implied and express statements about the company's strategy, future business plans, functionality, and capabilities; plans and timelines for clinical development of the company's therapies, including therapeutic potential and efficacy, clinical benefits, safety profiles, and plans to submit investigational new drug (IND) applications; the potential size of the commercial market for the company's treatment programs; the company's long-term financial targets, prospective financial results, return of capital plans, expectations about addressable markets and market share; and future business outlook, such as forward-looking statements about the company's expectations, beliefs, intentions, or strategies. All statements other than statements of historical facts contained in this presentation, including express or implied statements regarding our strategy, future financial conditions and operations, projected costs, plans, objectives of management and expected market growth, are forward-looking statements.

In some cases, forward-looking statements use terminology such as "anticipate", "believe", "could", "expect", "may", "estimate", "intend", "ongoing", "plan", "potential", "should", "will", and "would", although not all forward-looking statements contain these identifying words.

The Company's actual results, performance, or events may differ materially from these forward-looking statements made or implied due to a number of factors, risks, and uncertainties relating to the Company's business, including but not limited to: the timing and anticipated results of our current and future clinical trials, supply chain, strategy, and future operations; the risk that the results of prior preclinical and clinical studies may not be predictive of future results in connection with current or future clinical trials; the timing and outcome of any interactions with or approvals by regulatory authorities; obtaining, maintaining, and protecting our intellectual property; our relationships with existing and future investors and collaboration partners; the impacts of current macroeconomic and geopolitical events. The Company disclaims any warranties or representations (expressed or implied) related to the accuracy of forward-looking statements and you should not place undue reliance on our forward-looking statements. The company assumes no obligation and disclaims any obligation to update any forward-looking or other information included in this presentation, whether as a result of new information, future events or otherwise. This presentation contains trademarks, trade names, and trademarks of other companies, which are the property of their respective owners. This presentation is not intended for distribution to, or use by, any person or entity in any jurisdiction or country where such distribution or use would be contrary to

local law or regulation or require any registration or licensing within such jurisdiction.



Randomized data in hand for a mechanism built to solve the highest unmet need in AML



Durability of response, not response itself, is the highest unmet need in unfit AML



Cusatumab (Cusa), first-in-class anti-CD70 antibody, is built for depth of response



Randomized Phase 2 fully enrolled, primary analysis Q1 2027



AI-enabled precision medicine informs an efficient, targeted Phase 3 path



Validated asset, protected position, and pipeline beyond AML

Leadership team with 100+ years of combined experience including physician-scientists who have treated the patients we aim to serve



**Max
Colao, MBA**

Chief Executive Officer &
Board Chairman

- Over 30 years biotech leadership experience in oncology, inflammation and rare diseases
- Leadership across 13 therapeutic launches in the US and ex-US
- Track record in both startup and large biotech



**Clay
Smith, MD**

Founder;
Scientific Advisor

- Over 40 years experience treating cancer patients, of which over 30 years in oncology research, clinical care and clinical trials
- Pioneered clinical and single cell multiomics infrastructure



**Michael
Boyiadzis, MD, MHSc**

Chief Medical Officer;
Head of Research & Development

- Over 25 years translational and clinical research experience in hematology-oncology
- Professor of Medicine at the University of Pittsburgh, Senior Medical Director at Genentech/Roche
- Director of the Acute Leukemia Program and Clinical and Translational Research Center at UPMC Hillman Cancer Center

OUR TEAM HAS A CENTURY WORTH OF COMBINED EXPERIENCE IN ONCOLOGY AND BIOPHARMA



Depth and durability of response remain unsolved in AML

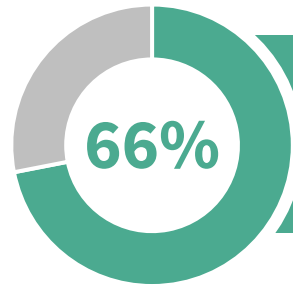
Standard of care (Ven+Aza) delivers modest outcomes for those unfit for intensive chemo

An estimated **20K US cases of AML** are diagnosed annually with **11K deaths** (the second highest among blood cancers)

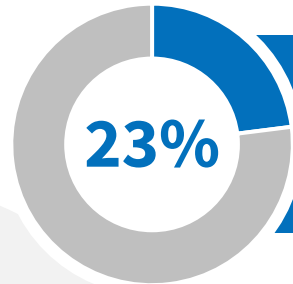
Median age of diagnosis is 69 and most patients are unfit for intensive chemo with just a **5-year survival rate of ~33%**

Up to 70% of patients achieving first CR will **relapse within 1 year**

New therapies must deliver deeper and more durable responses to overcome limited survival and high relapse rates.



Response is not the key barrier -- 2/3 of patients do respond to SOC (CR+CRi of 66.4%) (*)



But depth is rarely achieved -- MRD negativity in only in 23.4% of responders and majority relapse (*)



And responses do not last -- median OS of only 14.7 months

TP53-mutant AML: remission is achievable, survival is not

DEEP RESPONSES ARE RARE AND REMISSIONS ARE BRIEF

87%

MRD positive
among responders

47% reach composite response with
Ven+Aza, yet residual disease persists.

**MRD positivity is associated with poor
overall survival.**

SURVIVAL IS LIMITED IN TP53-MUTANT AML

6.6 mo

median OS with Ven+Aza

TP53-mutant clones persist after therapy,
**even when morphologic remission is
achieved.**

FAILURE IS STEM-CELL DRIVEN

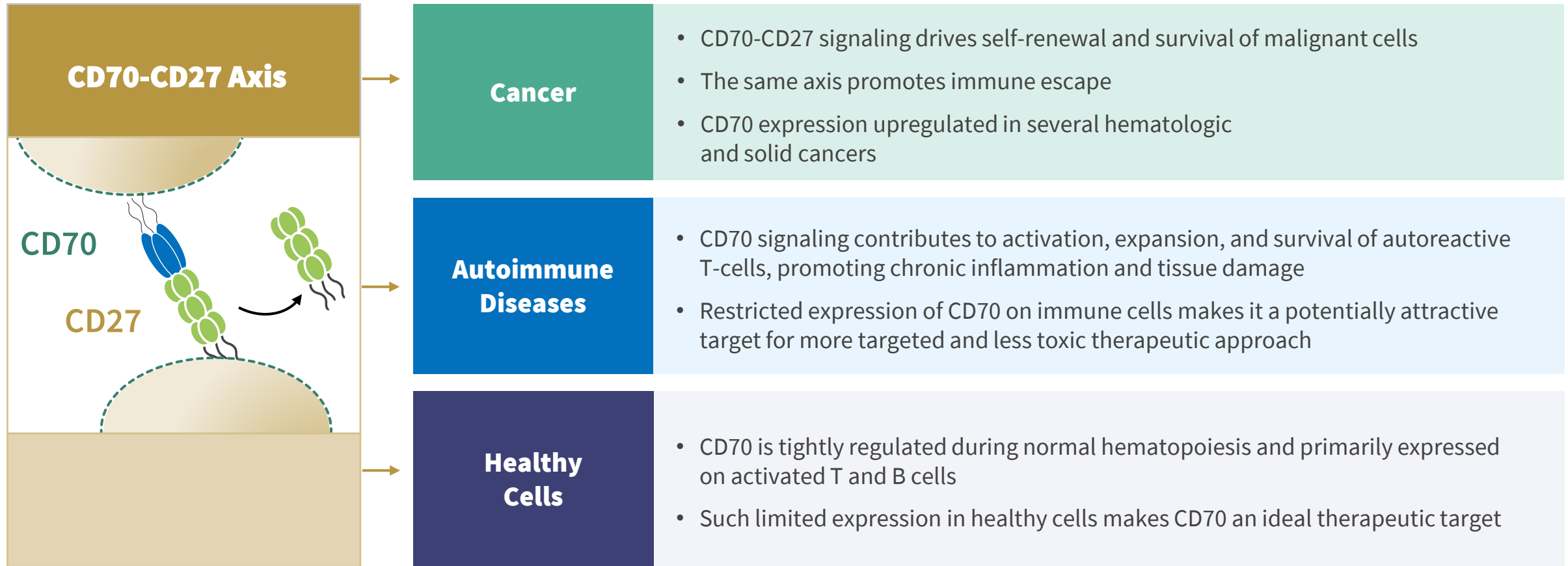
Enriched for stem cells. TP53-mutated AML
carries a higher burden of leukemia stem cells.

Self-renewal signaling. CD70/CD27 drives
leukemic stem cell self-renewal and survival.

Origin of relapse. Relapses frequently arise from
residual TP53-mutant stem cells that current
therapy does not clear.

CD70, expressed on leukemic stem cells, provides an actionable target for stem cell elimination

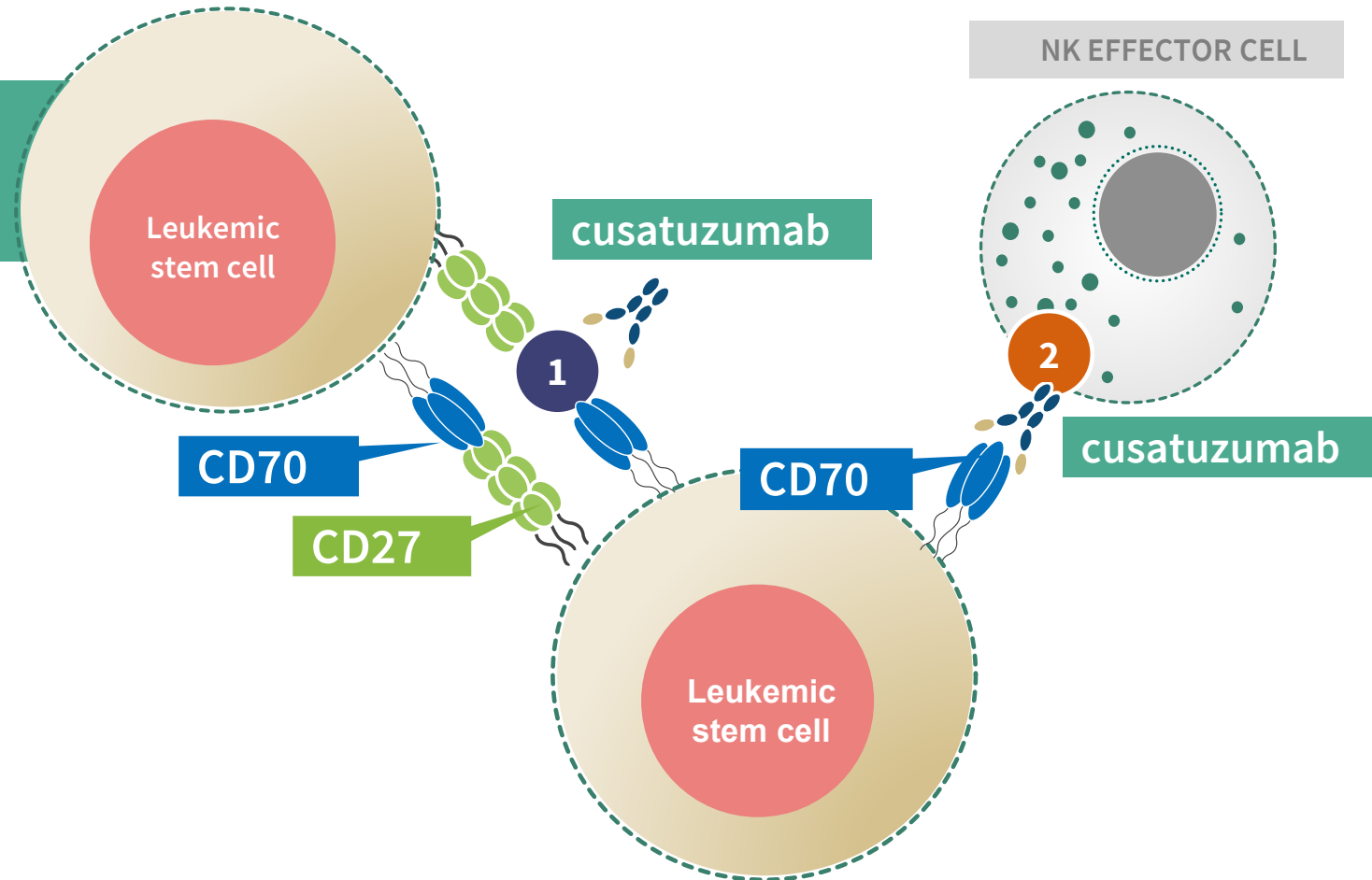
CD70-CD27 axis drives malignant cell survival and self-renewal, with limited CD70 expression in healthy tissue



Cusatuzumab shuts down leukemic stem cell self-renewal and enhances NK cells to eliminate AML

Two Mechanisms of Action

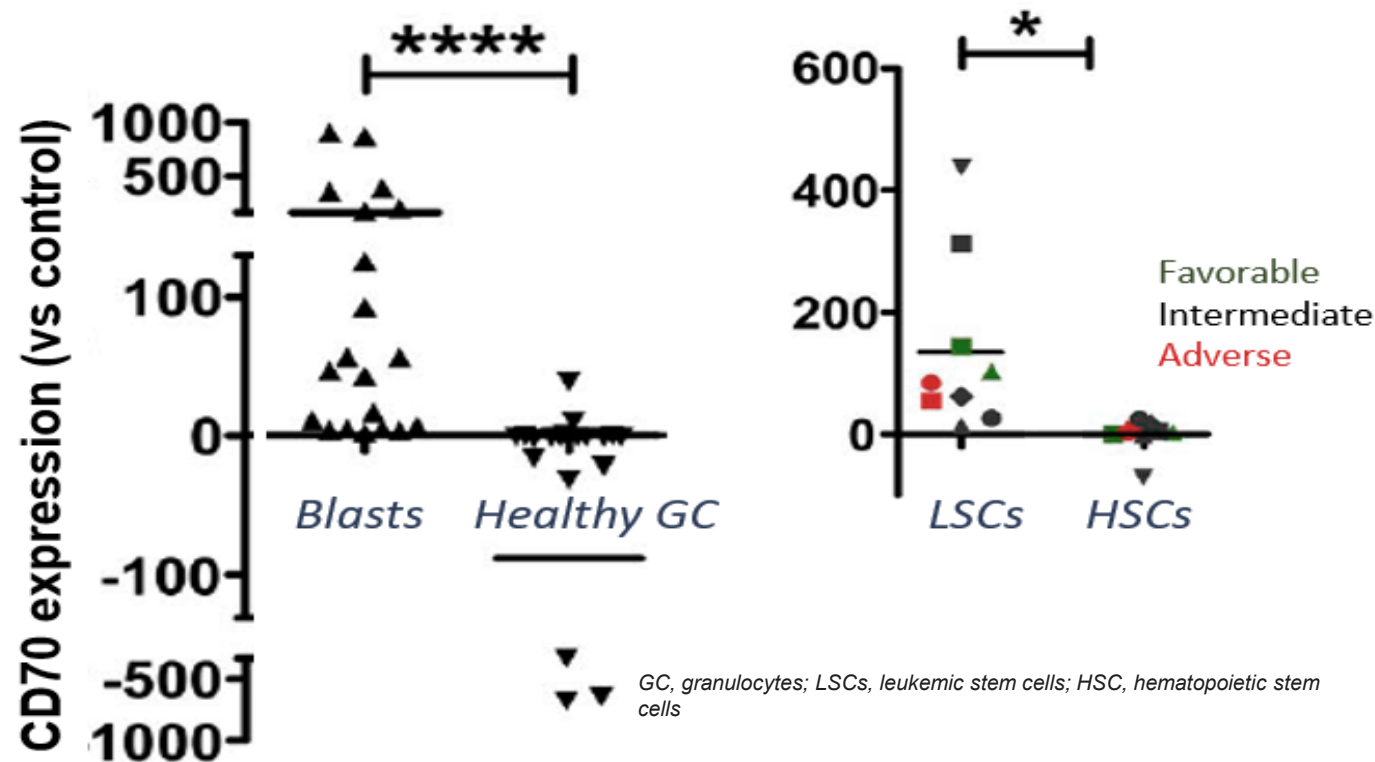
- 1 BLOCKS** CD70 self-renewal and survival signal
- 2 KILLS** tumor cells through enhanced NK mediated ADCC



CD70 is expressed on leukemic blasts and stem cells but not on healthy hematopoietic stem cells

Expressed on nearly all blasts

Selective for leukemic stem cells



Cusatuzumab's safety and tolerability were established across ~400 AML patients



2017

Complete

Phase 1/2 | ARGX-1601

KEY TAKEAWAY

No dose limiting toxicities



2019

On-Going Treatment and Observation

Phase 2 | CULMINATE (Cusa + SoC (Aza))

KEY TAKEAWAY

Dose-dependent efficacy signal and strong safety & tolerability at 20 mg/kg dose level



2020

On-Going Treatment and Observation

Phase 1b | ELEVATE (Cusa + SoC (Ven/Aza))

KEY TAKEAWAY

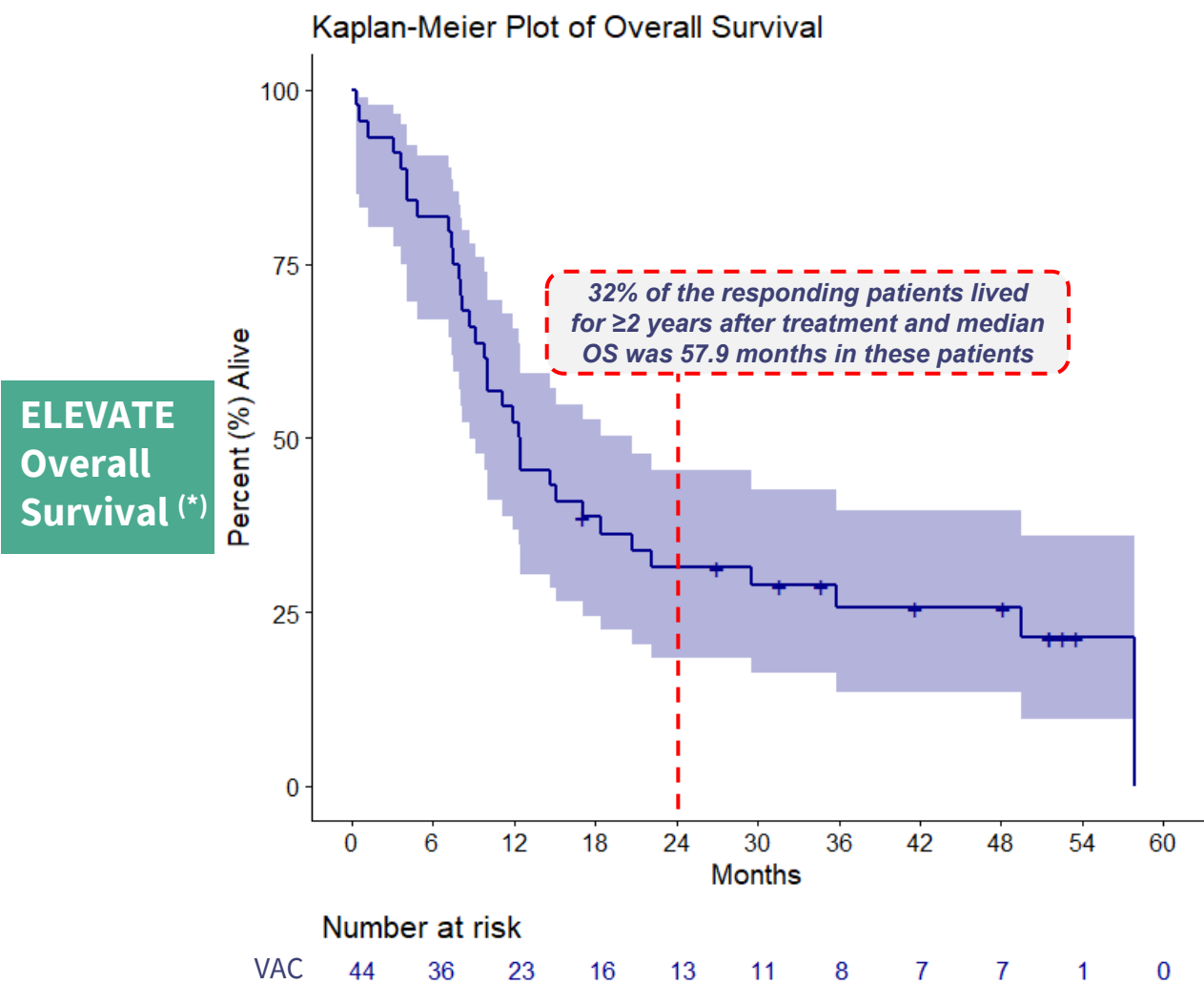
Deep responses even among severely ill patient population



Safety

- Well tolerated with no MTD identified
- Safety profile consistent with Ven/Aza, with the exception of infusion-related reactions (IRRs)
- IRRs are typically low grade and manageable, and can be reduced with premedication

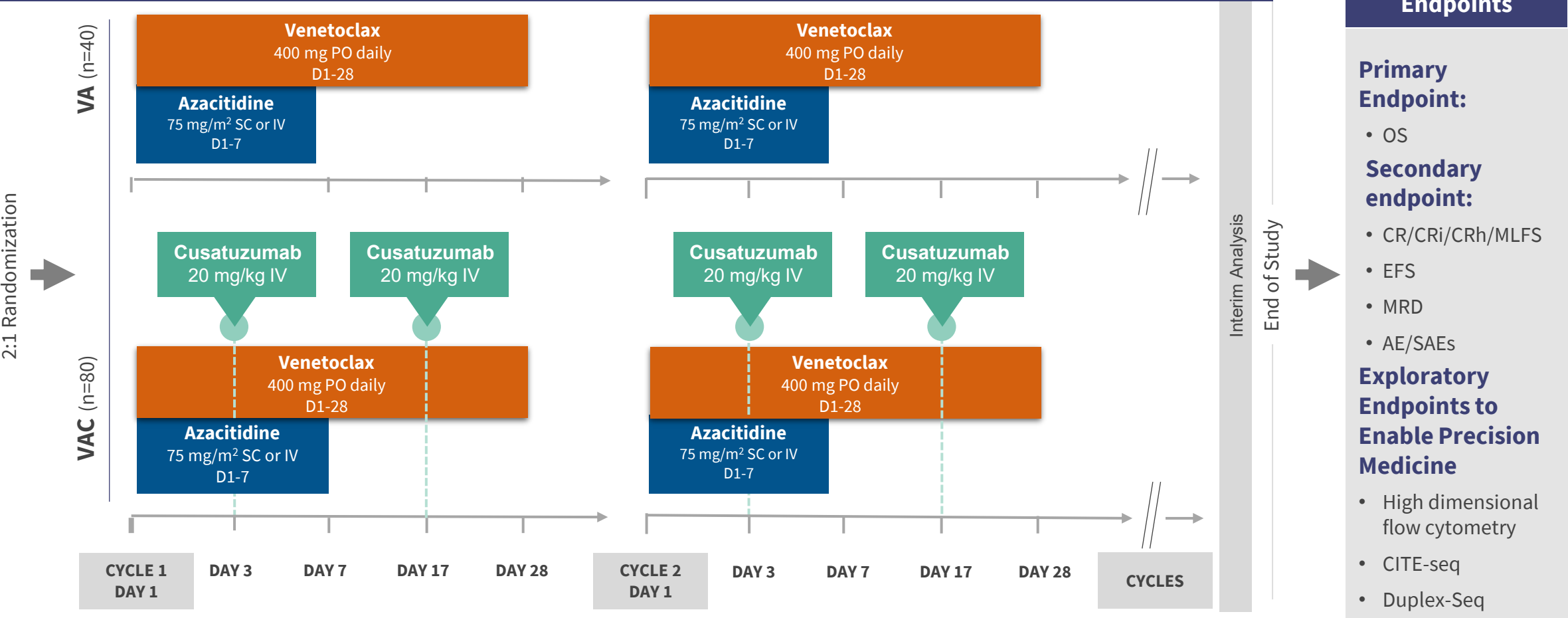
ELEVATE Deep responses, including MRD clearance, in a heavily pre-treated patient population



	ELEVATE (Ven/Aza/Cusa) N=44
ORR (Complete Remission + CRh + CRi)	77%
CR	48%
CRi	9%
CRh	21%
MLFS	11%
ORR + MLFS	89%
MRD Negativity	53%
Time to First Response	5.5 weeks
mOS	12.0 months
30-day Mortality	4.5%
Transfusion Independence	60%

Enrollment completed: randomized phase 2 study in newly diagnosed AML patients unfit for intensive chemotherapy, VAC vs VA

Randomized, open label, multicenter, multinational study with 120 patients to enroll



Emerging data track to cusa's predicted profile

Enrollment: 137 AML patients enrolled in AML-1231

120 pts in Part A (VAC:79, VA:41, completed enrollment Jan. 2026
17 pts Part B, VAC only (project Optimus), completed enrollment Mar.2026

PART A (n=120)		
Risk Group	VAC N=79	VA N=41
Favorable (n=27)	17	10
Intermediate (n=52)	35	17
Adverse (n=41)	27	14

Part A Patient Treatment Progress	Treatment Cycle	Patients (C/VA)
	Cycle 6	34
	Cycle 7	29
	Cycle 8	18
	Cycle 9	12
	Cycle 10	7
	Cycle 11	5
	Cycle 12	3
	Cycle 13	3

Event Forecast for Part A

June 30 th	Sep 30 th	Dec 31 st
~50 deaths	~64 deaths	76 deaths

What 1231 shows at 7 months treatment follow up

- Comparable early response between VAC and VA arms
- Differentiation in depth of response, concentrated in higher-risk subgroups
- Safety consistent with prior experience across ~400 patients; no new signals
- Safety monitored by external safety committee

AI-enabled precision medicine prospectively embedded in OV-AML-1231

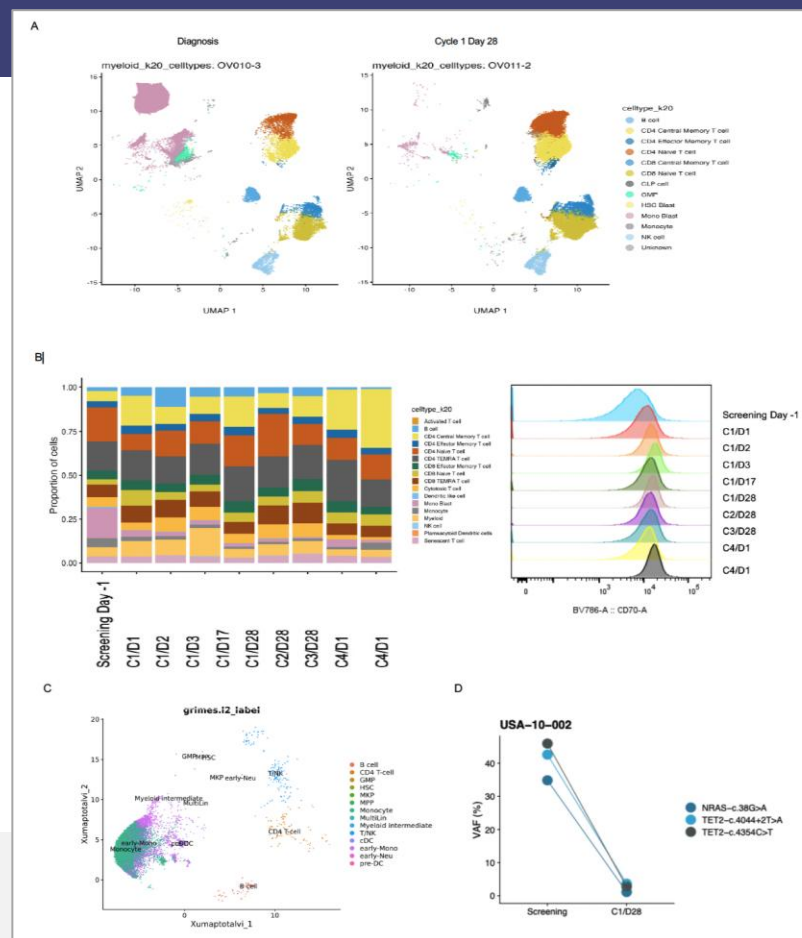
Precision Medicine Analytics

- High dimensional flow cytometry analysis of bone marrow and peripheral blood collected at protocol defined times
- Comprehensive CITE-seq Atlas: 251,081 high quality cells mapping the cellular landscape and differentiation trajectories across treatment
- Duplex-Seq characterization of responder and non-responder patients at screening and follow-up tracking variant allele frequencies for clinically relevant mutations

Single patient example of each modality

A. Flow cytometry BMMCs. B. Flow Cytometry PBMCs.

C. CITE-seq. D. Duplex-sequencing.



What this produced

- Patient-level analysis of response, resistance and immune effect, not just aggregate outcomes
- Characterization of how cusa acts on leukemic subpopulations, and where resistance emerges
- **The stratification hypothesis underlying the Phase 3 design** — derived from randomized data

Potential phase 3 registrational study paths

PHASE 3 | STUDY DESIGN

1

VAC vs VA newly diagnosed AML

Risk-stratified based on AML-1231 results
Primary end point: Overall survival



TRIGGER

*1231 DATA MATURITY,
1231 Primary end-point: Dec 2026- Q1 2027*

PHASE 3 | STUDY DESIGN

2

VAC vs VA newly diagnosed AML

with TP53 mutation or other potential subset



TRIGGER

*1231 Data generation forthcoming to inform strategy,
with potential for earlier decision making than option 1
since high-risk AML*

Differentiated oncology pipeline anchored by cusatuzumab

Program	Indication	Discovery	Preclinical	Phase 1	Phase 2	Phase 3
Cusatuzumab <i>In combination with Venetoclax + Azacitidine (Ven+Aza)</i>	1L AML <i>Lead Indication</i>					
Cusatuzumab <i>Combination therapy</i>	TP53 MDS					
Cusatuzumab <i>In combination with Belinostat</i>	R/R TFHL PTCL NOS					
Cusatuzumab <i>Monotherapy (with and without NK cells)</i>	R/R AML					
CD70 Targeting ADC	Solid Tumors					
Novel Antibody <i>(Under Negotiation)</i>	Undisclosed					

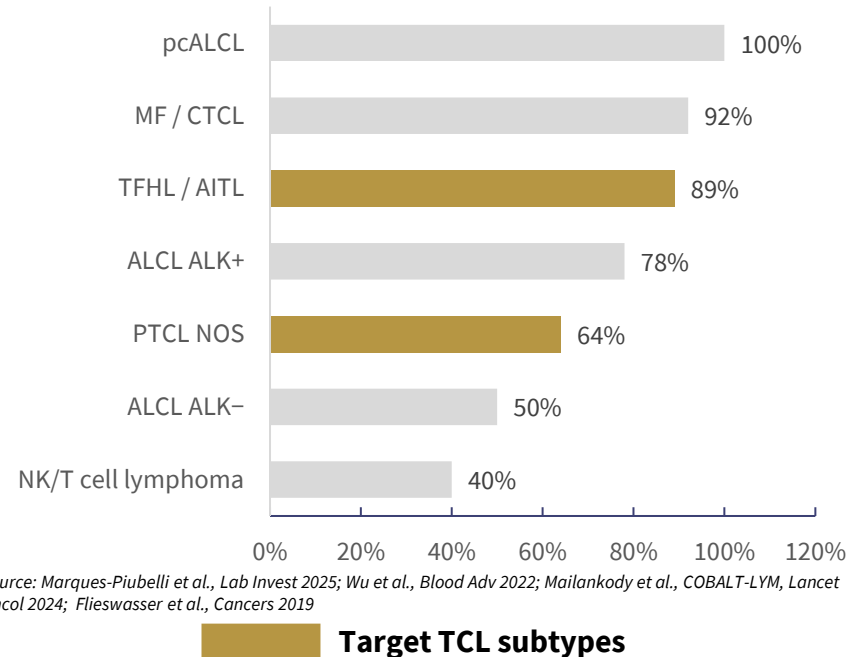
Cusatuzumab addresses a large unmet need in T cell Lymphoma

HIGH UNMET NEED

- TFHL and PTCL NOS represent **65-75% of all PTCL cases**
- Available salvage options achieve only **~25% ORR with no durable benefit**
- **5-year OS of only 25-35%** from diagnosis
- **~75% of patients relapse** after frontline therapy
- Virtually **all r/r patients ultimately succumb to disease**

STRONG CD70 TARGETING RATIONALE

CD70 Expression by T Cell Lymphoma Subtype (%)



CUSATUZUMAB CTCL PHASE 1 DATA

23%

Global ORR (single agent)

50%

ORR in Sezary Syndrome

Favorable

Safety profile at 5 mg/kg max dose

- n=27 heavily pretreated r/r CTCL; highest dose studied was 5 mg/kg
- **Significant dose escalation headroom**, activity signals achieved well below therapeutic ceiling

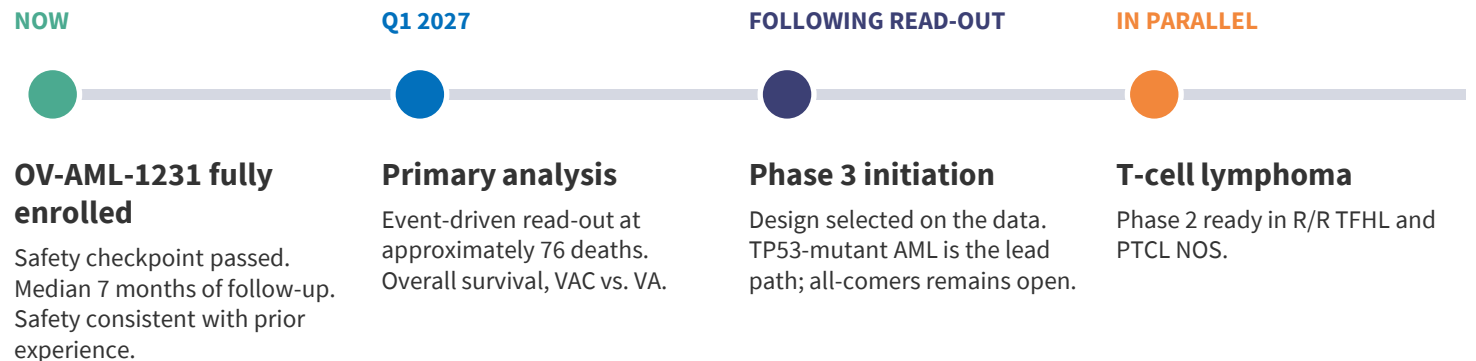
Leupin et al., Cancer 2022;128:1004-1014



Cusatuzumab is a clinically validated, mechanism-differentiated asset in a high-unmet-need space — a co-development partner can accelerate PTCL development

Near-term milestones, and what is available under CDA

MILESTONES



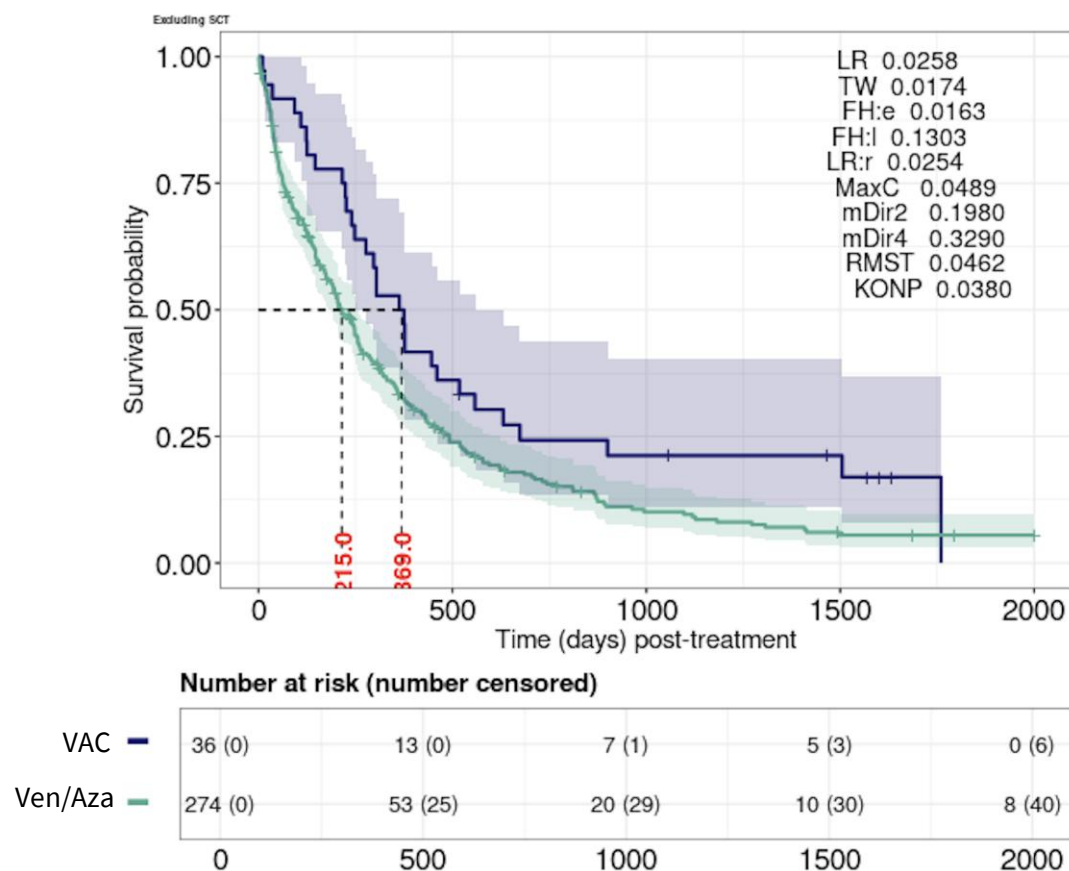
AVAILABLE UNDER CDA

- Randomized depth-of-response data by risk group, VAC vs. VA
- Subgroup survival analyses, including TP53-mutant patients
- Full precision medicine dataset and the stratification analysis underlying the Phase 3 design
- Phase 3 protocol synopsis and regulatory strategy
- T-cell lymphoma development plan

OncoVerity is engaging with partners on co-development and strategic transactions across the AML and T-cell lymphoma programs

Appendix

ELEVATE vs. real-world Ven/Aza data: overall survival



12.1 mo

median OS
ELEVATE:VAC (n=36)
369 days

7.1 mo

median OS
Real-world Ven/Aza (n=274)
215 days · University of Colorado database

+5.1 mo

longer median overall survival (+154 days), with curve separation sustained beyond 1,000 days

Unadjusted comparison of independent datasets; Stem Cell Transplant excluded. Real-world cohort: consecutive Ven/Aza-treated patients from a well-curated University of Colorado database.

Robust intellectual property portfolio

Composition of Matter Patents:

Several issued patents in the US, Europe, and other major markets directed to the lead anti-CD70 antibody with a term extending to 2032
Several patents pending for CD70 combination therapy with nucleoside metabolic inhibitors, with and without Venetoclax, in all major markets extending from 2038 to 2040

Method of Use Patents:

Several issued patents in the US, Europe, and other major markets directed to the treatment of myeloid malignancies, such as acute myeloid leukemia (AML) and myelodysplastic syndrome (MDS), using the lead anti-CD70 antibody with a term extending to 2032

Pending applications in the US, Europe, and other major markets directed to treatment of myeloid malignancies, such as acute myeloid leukemia (AML) and myelodysplastic syndrome (MDS), combination therapies that include the lead anti-CD70 antibody in combination with a second therapy, such as a BCL-2 inhibitor or a hypomethylating agent, or in combination with an antibody directed to a leukemic stem cell target (e.g., TIM-3), with terms extending from 2038 to 2041

Methods for Targeting Therapy to a Responsive Subject

Pending applications in the US and other major markets directed to methods for identifying a subject responsive to anti-CD-70 antibody treatment and methods for treating such a subject, with terms extending from 2040 to 2043

Will pursue patent term extensions of up to 5 years, where possible in various countries, based on delays in obtaining regulatory approval

Combined TP53 patient opportunity: AML now, TP53 MDS next

AML — near-term (VAC: Ven + Aza + Cusa) · randomized Ph.2 ongoing

DE NOVO AML		THERAPY-RELATED AML	
US newly dx AML (2026E)	22,010	US newly dx AML (2026E)	22,010
Less t-AML (15%)	18,709	Therapy-related AML (15%)	3,302
TP53, de novo (12.5%)	2,339	TP53, t-AML (30%)	990
Projected to 2030E (+0.6%/yr)	2,395	Projected to 2030E (+1.6%/yr)	1,055
Unfit for intensive chemo (80%)	1,916	Unfit for intensive chemo (80%)	844
Addressable — frontline HMA (75%)	1,437	Addressable — frontline HMA (75%)	633



TP53 MDS — next step (Cusa + Aza) · requires a Ph.2 with azacitidine

DE NOVO MDS		THERAPY-RELATED MDS	
US newly dx MDS	15,000	US newly dx MDS	15,000
Less t-MDS (15%)	12,750	Therapy-related MDS (15%)	2,250
TP53, de novo (9.6%)	1,224	TP53, t-MDS (32.6%)	734
Projected to 2030E (+0.6%/yr)	1,254	Projected to 2030E (+1.6%/yr)	782
Addressable — frontline HMA (75%)	940	Addressable — frontline HMA (75%)	586

~3,600 US addressable patients / yr (2030E) AML ~2,070 (near-term) MDS ~1,526 (next step)